Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS
9 October 2025
10.30am

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

AGENDA

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

Standard Items

1	Chair's welcome and introduction (verbal)	Chair	10.30am
2	Apologies for absence (verbal)	Chair	
3	Declarations of interest (verbal)	All	
4	Minutes of the Board meeting held on 14 August 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 7 October 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	11.00am
11	NHS Oversight Framework, Quarter 1 2025/26	EDS&T	11.25am

BAF Risk 1: Safe Staffing

12	Appraisal, revalidation and job planning of doctors	EMD	11.30am
13	Getting the basics right for resident doctors	EMD	11.40am
14	Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard & publication of staff equality information	EDP&C	11.50am

BREAK 12.00pm – 12.10pm

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	12.10pm
16	Publication of Patient Information 2025	EDoT	12.20pm
17	Leadership walkabouts feedback	EDCA&I	12.25pm

BAF RISK 10: Regulatory Compliance

18	Report of the Chair of Mental Health Legislation Committee	Cmt Chair	12.30pm

BAF Risk 13: Public Confidence

19	Report of the Chair of the Charitable Funds Committee *(verbal update from meeting held on 8 October 2025)*	Cmt Chair	12.40pm
20	Communications update	EDCA&I	12.50pm

Governance

21	Board Assurance Framework (verbal)	Chair	1.00pm

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	-

BREAK 1.05pm – 1.35pm

CONFIDENTIAL SESSION

Standard Items

23	Minutes of the confidential session of the last Board meeting held on 12 June 2025	Chair	1.35pm
24	Board Confidential Action Log	Chair	

Strategic Items

25	Chief Executive's Confidential report	CEO	1.40pm
26	Reportable Issues Log	CN	1.55pm
27	Report of the Chair of Audit & Risk Committee	Cmt Chair	2.05pm

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	Cmt Chair	2.15pm
29	Medium Term Plan 2026/27 – 2030/31	EDFE&F EDS&T	2.25pm
30	Month 5 2025/26 Finance Report	EDFE&F	2.45pm

Governance

31	NHS England Provider Capability Self-Assessment	EDS&T Co Sec	2.55pm
32	Board Assurance Framework - Quarter 1 2025/26	Co Sec	3.15pm
33	Committee terms of reference and appointments	Co Sec	3.25pm
34	Notification of use of the Board of Directors emergency powers (for information)	Co Sec	-

Matters for information:

35	To receive and note the minutes of the meetings of the following committees (for information): a. Resources and Planning Committee, March 2025 b. Mental Health Legislation Committee, May 2025 c. Audit and Risk Committee, May 2025 d. Resources and Planning Committee, June 2025 e. Audit and Risk Committee, June 2025 f. Quality Assurance Committee, July 2025	Co Sec	-

Evaluation

36	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
3 October 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 14 AUGUST 2025 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS

Present:
B Reilly, Interim Trust Chair (Chair)
Z Campbell, Managing Director, North Yorkshire, York and Selby Care Group
C Carpenter, Non-Executive Director
N Lonergan, Interim Managing Director, Durham, Tees Valley and Forensic Care Group
J Maddison, Non-Executive Director
B Murphy, Acting Interim Chief Executive
J Preston, Non-Executive Director
J Robinson, Non-Executive Director
L Romaniak, Executive Director of Finance, Estates and Facilities
C Wood, Non-Executive Director
S Dexter-Smith, Joint Executive Director for People, Culture and Diversity (non-voting)
K Ellis, Executive Director for Strategy and Transformation (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)
S Beattie, Guardian of Safe Working (for agenda item 16)
N Black, Chief Information Officer
L Howey, Associate Director of Therapies (on behalf of H Crawford)
S Paxton, Head of Communications (on behalf of A Bridges)
B Sinha, Consultant Psychiatrist (on behalf of K Kale)
D Williams, Freedom to Speak up Guardian (for agenda item 14)
R Weddle, Deputy Chief Nurse

Observer:
L Daniel, Business Administration Apprentice
L Hodge, Deputy Director of People and Culture
S Leggett, Ideal Health
T Morris, Governor
M Roughley, public

85. CHAIRS WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting and acknowledged the powerful story the board had received about Fred from a Clinical Nurse Specialist.

She noted that the Board would attend Autism training the following week and confirmed that, as the meeting would take place over the course of the day, time had been set aside for the Board to have a break.

She welcomed the clarity and quality of papers provided and invited presenters to focus their presentation on those areas that required board attention.

86. APOLOGIES FOR ABSENCE

Apologies for absence were received from A Bridges, Executive Director for Corporate Affairs and Involvement, H Crawford, Executive Director for Therapies, K Kale, Executive Medical Director, Patrick Scott, Interim Chief Executive and from C Carpenter, Non-Executive Director and J Robinson, Non-Executive Director for lateness.

Apologies for absence were also received from K North, Joint Executive Director for People and Culture, whose attendance was not required as S Dexter-Smith was present.

87. DECLARATIONS OF INTEREST

None.

88. MINUTES OF THE ORDINARY BOARD MEETING HELD ON 12 JUNE 2025

Agreed: *the minutes are an accurate record of the meeting, subject to the inclusion of N Black, Chief Information Officer who was present at the meeting.*

Matters arising

The Chair confirmed that R Bourne, Non-Executive Director at CNTW had attended the CEO appointment panel.

89. MINUTES OF THE SPECIAL BOARD MEETING HELD ON 25 JUNE 2025

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

BOARD ACTION LOG

In discussion:

1. B Murphy undertook to confirm that the themes from the transformation programme had been reported into Quality Assurance Committee [action 118].
2. L Romaniak advised that rectification works to the ventilation system had been completed and minor works would take place on the external fencing [action 7].
3. S Dexter-Smith confirmed that advocacy arrangements ensured sufficient supply of interpreters and offered to provide additional information if needed [action 57].

90. INTERIM CHAIRS REPORT

The Chair presented her report, which outlined areas of focus and internal and external meetings she had attended over the previous two-month period.

She drew attention to engagement around the NHS 10-Year Plan and the Trust's categorisation in segment 2 of the National Oversight Framework and noted her attendance at a range of external meetings, to maintain key relationships, and visits to services. These included with the Freedom to Speak up Guardian, the CAMHS Team in Stockton-on-Tees and Birch Ward, which provided a valuable insight into services. She also welcomed the impactful board seminar where learning was shared by colleagues from Nottingham and that the Board had the opportunity to discuss the report by Penny Dash and had attended health and safety training.

Looking ahead, she welcomed the level of communication she had with the incoming CEO and she extended the board's gratitude to B Murphy, who had stepped into the role of Interim CEO.

91. QUESTIONS RAISED BY GOVERNORS

P Bellas noted that the Board had received the following questions from N Hutchinson, public Governor for Durham:

As a newly appointed Governor, I want to acknowledge that I received the meeting papers only on Friday evening, which has limited my ability to review them thoroughly and prepare questions ahead of the upcoming meeting. I appreciate the importance of timely information for effective scrutiny and would be grateful if, in future, I could receive papers with more notice and with clearer support to help Governors fulfill their statutory duties.

In this context, I would like to submit the following questions for the Board's consideration and response, as part of my statutory role:

1. ***Meeting Paper Distribution:***
   How far in advance do Directors and Governors typically receive meeting papers? Is there a formal policy to ensure Governors have sufficient time to review these materials before meetings?

2. ***Strategic Challenges:***
   What are the main challenges currently facing the Board in delivering the Trust's strategic priorities? How is the Board responding to these challenges?

3. ***Governance and Decision-Making:***
   How does the Board ensure that its decisions and actions align with the Trust's core purpose of delivering safe, effective, and patient-centred care, while maintaining high standards of governance, transparency, and accountability?

Please could you confirm that these questions will be shared with the full Board or relevant governance team, and advise on how I will receive their responses, given that I will be unable to attend the meeting in person.

In response and before turning to the individual questions, he reminded the Board that the Council of Governors, collectively, held Non-Executive Directors to account for the performance of the board, not individual Governors. To support the Council, the 2012 Act required public papers to be provided to them together with the agendas for confidential sessions of board meetings. This provision was made as, at the time, there were issues with some Trusts minimising information provided to Governors and thereby undermining their ability to fulfil their role.

The ability for Governors to ask questions at Board meetings was a local choice and not directly related to their statutory role and was introduced to enable Governors to seek clarity on matters included in reports to the meeting and also, in recognition that the Council of Governors only met quarterly, it provided a vehicle for Governors to ask questions in between those meetings on matters of pressing concern to their constituents.

He then outlined the following response to the individual questions raised:

1. Papers for Board meetings are published three clear days before the meeting in accordance with the Constitution. A clear day being one which excludes the day of publication, the day of the meeting, weekends and any public holidays. This time period is quite usual across a range of sectors.

   There is a balance to be struck between providing sufficient time for papers to be reviewed and the timeliness of the information contained in them.
2. The principal risks to the delivery of the strategic goals are set out in the Board Assurance Framework. This includes details of the relevant controls and mitigating actions being taken to address any gaps in control and assurance.
3. High standards of governance, transparency and accountability are intrinsic to the delivery of safe effective and patient centred care.

Decisions and actions should be aligned to the delivery of the strategy including our strategic goal 'we will cocreate high quality care'.

The Trust's governance arrangements support the delivery of the strategy based on the chain of accountability. The executives are held to account by the Board for the delivery of the strategy, the Non-Executive Directors are held to account by the Council of Governors for the performance of the Board. The Board is assisted in undertaking its role and duties by committees which provide capacity for more in-depth discussions and testing of assurances that would otherwise not be possible. These arrangements are supported by the Constitution, including the Reservation of Powers to the Board, the Scheme of Delegation and Standing Financial Instructions.

The business cycles for the Board and its committees are driven by the Board Assurance Framework which sets out the principal risks to the delivery of the strategic goals. All reports are aligned to the strategic goals and the strategic risks as articulated in the Board Assurance Framework. The basis for decisions or assurances provided in reports are drawn from a range of sources whether internal – the committees or the executive, or external – partners or regulators including NHS England and the CQC.

Action logs are in place to enable the implementation of decisions to be tracked.

Underpinning all decisions and actions are our values and the Nolan Principles, which the Board has a duty to uphold.

In discussion, Board noted a previous piece of work had been undertaken by a Council of Governors' task and finish group on the role of governors and agreed that it was helpful to provide clarity for governors on their role and the distinction between Non-Executive Directors and Executive Directors, given that membership of the Council changed regularly.

92. BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

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

The Chair noted that the agenda provided an opportunity for the board to consider any changes or additions to the strategic risks at the end of the agenda and she invited committee Chairs to reflect on risks with the greatest variance between their present and target risk score and risks with the greatest variance between their present score and tolerance.

93. CHIEF EXECUTIVE'S REPORT

B Murphy presented the report, which briefed the board on topical issues of concern and summarised strategic and operational developments since the previous board meeting.

In respect of the GMC trainee survey 2025, she clarified that trainees had ranked the Trust first in the North East and in Yorkshire and Humber and sixth nationally. Trainers had ranked the Trust ninth nationally out of 220 Trusts.

In discussion:

1. The Board welcomed the Trust's placement in segment 2 of the National Oversight Framework as a significant achievement.
2. Concern was expressed about the ability of Trusts to respond to the NHS 10 Year Plan and the shift from hospital-based to community-based care, where there remained high numbers of patients who were clinically ready for discharge.

Reflecting on Fred's story, B Murphy commented the importance of understanding the needs of local communities to inform available funding. The Trust had benefited from temporary funding to support development of an Intensive Support Team, which had a positive impact for Fred and supported the shift to community-based care. However, long-term funding was required to sustain the initiative.

3. The Board welcomed the positive feedback from the Getting it Right First Time Team visit to the Crisis Assessment Suite and queried if the Trust continued to take learning from others.

   In response, B Murphy confirmed that exemplar Trusts had been identified and TEWV would remain actively involved in learning, given the importance and development of mental health emergency departments.

   Commenting further, K Ellis noted a paper on the agenda on the integrated planning process and proposals that sought to ensure transformation was guided by best practice.

4. The Board noted that minimal disruption had been caused by the industrial action of resident doctors and queried the status of negotiations and risk of further action.

   In response, B Murphy advised that negotiations had continued and there remained a risk of further action.

94. INTEGRATED PERFORMANCE REPORT

K Ellis presented the report, which provided oversight of the quality and performance of Trust delivery and provided assurance to the Board on the actions taken to improve performance in the required areas.

She advised that the Board would consider a report in October on proposals to align the Integrated Performance Report (IPR) with the national standards outlined in the new National Oversight Framework. She drew attention to areas of increased performance assurance and positive assurance, areas of reduced performance assurance and a small number of measures that would continue to be a focus for improvement.

In respect of patients clinically ready for discharge, she noted the Trust had taken a dual approach with short- and medium-term actions to maintain visibility of patients and longer-term transformational activity, aligned to the NHS 10-Year Plan shift to community-based care.

N Lonergan noted there had been an increase in patients clinically ready for discharge in the Durham and Tees Valley and Forensic Care Group, particularly in the Mental Health Services for Older People (MSHOP) and focused work had taken place to track patients and report through agreed escalation arrangements. She also commented on broader system-wide initiatives aimed at early intervention to reduce admission and the contribution of discharge intelligence to the integrated care board (ICB) to support strategic commissioning. She noted that accommodation and provider capacity remained a barrier to discharge and there was an additional impact where providers sought lengthy section 17 arrangements to facilitate a discharge.

Z Campbell reported similar pressures in North Yorkshire, York and Selby Care Group, where Adult Mental Health and MHSOP services were under pressure and the discharge of patients clinically ready for discharge was hindered by the lack of appropriate accommodation and provider availability. She commented on longer-term efforts to stimulate the provider market and expressed confidence that neighbourhood models and hub provision would impact positively to reduce admissions and waiting lists.

K Ellis then drew attention to the recurrent Cash Releasing Efficiency Savings (CRES) position, where there was a focus on long-term transformation to drive meaningful change; the focus on the Talking Therapies and implementation of reliable improvement measures; and work underway with the ICB to address waiting times for neurodevelopmental assessments.

Commenting further, Z Campbell noted reference in the IPR to a Trust-wide action plan for Talking Therapies and advised that outline proposals to approve the pathway for neurodevelopmental services within the current financial envelope had been approved by the Humber and North Yorkshire Provider Collaborative Executive for further development.

N Lonergan shared that joint clinical development sessions had taken place with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust to consider a model for the future for neurodevelopmental services and the ICB would consider a proposal to move to a commissioning policy.

In discussion:

1. Attention was drawn to the detailed analysis in the board confidential papers on the implications of delayed transfers of care and the Chair noted that at June 2025, 80 beds were occupied by people who were clinically ready for discharge. This equated to a cost of £2m per month, the equivalent of 4.3 wards.

   N Lonergan and Z Campbell commented on the challenges faced by providers and in discussion the Board acknowledged that there was insufficient provider capacity to meet patient need and whilst this was not a new issue it had become increasingly prominent and highlighted limitations in local authority funding.

   L Romaniak welcomed the engagement of Durham County Council who sought to confirm they had done all they could for each person in their area whose transfer was delayed. She also commented on efforts to lobby nationally to help articulate these challenges and the implications that arise from the lack of appropriate resourcing.

   Board agreed to discuss the matter further at the next board seminar and recognised that while NHS 10-Year Plan was ambitious, the challenge lay in the ability to translate that into actionable change.

[J Robinson joined the meeting]

2. L Romaniak noted that lobbying had taken place on the limitations of productivity measures used by NHS England, which failed to account for the complexity of mental health care and that she would continue to provide more accurate analysis to support improved decision-making. B Murphy also noted that CEOs nationally would continue to advocate for greater flexibility, given the difference in care that could be achieved as a result.
3. L Romaniak commented on the key drivers of slippage against the planned £27m CRES target for 2025/26 and noted that recent intelligence suggested an improved trajectory, with some indicators nearing the run rate required to meet the exit run rate plan.

   The Board recognised that it would become increasingly difficult to deliver recurrent CRES and welcomed the processes in place to manage resources against plan.
4. A query was raised about the expected benefit of MARS and processes in place to ensure that critical posts were not lost.

   In response, B Murphy advised that approx. 300 applications had been received and each application would receive a recommendation from the service and be considered by a panel of executives to understand the service and financial impact. Once all

applications had been considered, executive directors would take a decision based on the overall impact. L Romaniak noted that, as the Trust was already in quarter 2 of 2025/26, it would be difficult to demonstrate pay-back in-year and there may be an opportunity to offer a similar scheme in future years.

Board welcomed the assurance provided on the robustness of the process and its consideration of service implications.

Agreed: *there is -*

i. Good controls assurance regarding the oversight of the quality of services being delivered.

ii. Reasonable performance assurance (previously good) regarding the Integrated Performance Dashboard.

iii. Good performance assurance (previously reasonable) regarding the National Quality Requirements and Mental Health Priorities.

iv. Reasonable performance assurance regarding waiting times however, recognising the Trust has limited assurance about the quality impact on those patients who are waiting to access services, which Quality Assurance Committee is actively monitoring.

95. CORPORATE RISK REGISTER

R Weddle presented the report, which provided assurance on the management of risk and oversight of organisational wide risks rated as high risk in the Corporate Risk Register (CRR), and which proposed there was good assurance on risk management processes in place.

In discussion:

1. The Board welcomed the increased focus given to risk management and the achievement of 100% risk review compliance for corporate risks.
2. The Board noted the inclusion of three additional risks related to digital and data, which may be due to increased focus as a result of the appointment of the Chief Information Officer, and sought assurance that the Trust had the necessary capacity, capability and resources to mitigate those risks.

   In response, N Black noted that significant work had taken place over the past year to stabilise the team and enhance their skills, in recognition of the range of services provided. He advised that risk scores had increased due to a number of environmental factors and that gaps in Wi-Fi coverage would be addressed through proposed changes to the Capital Plan. He expressed confidence in the improvement in capacity and capability and proposed that risks would reduce over the coming six months.

   It was proposed and agreed that the new digital and data risks would be reviewed by Resource and Planning Committee with assurance to be provided to Audit and Risk Committee. **Action: N Black**

   It was noted that Resources and Planning Committee had previously received reports and taken assurance from the Chief Information Officer. This had included a baseline assessment, detailed review of each BAF risk and intelligence on the Trust's performance against national and regional benchmarks. Commenting further, N Black emphasised the importance of understanding the actual level of risk and noted the Trust was within the 10% of Trusts nationally for Microsoft Defender Monitoring and a comprehensive review of cyber risk issues had placed the Trust second overall out of 76 organisations.

B Murphy reflected on the importance of maintaining visibility on digital and data risk, given the importance of digital to providing safe care and recent challenges faced by other sectors.

3. In response to a query, S Dexter-Smith advised that risk 1137 [DTVF Management – that TEWVision is unable to provide compliance and assurance of supervision] was multifaceted and would be escalated to a Trust-wide risk, albeit there was increased confidence in the position.
4. The Chair invited committee Chairs to consider static risks, as relevant to their committees and B Murphy advised that Executive Risk Group had reviewed the position of each static risk.

Agreed: *there is good assurance over risk management processes in place, the consideration of risks for addition to the Corporate Risk Register and the ongoing management of these risks.*

Turning to the agenda, the Chair expressed concern that insufficient time had been allocated to allow for meaningful discussion of the NHS 10-Year Plan and Our Journey to Change reports and proposed there was an opportunity for learning in how future agendas were prepared.

P Bellas invited the Board to consider those strategic items in the context of broader, ongoing discussions and noted, for example, that the Board had considered the NHS 10-Year Plan at a recent seminar and the report aimed to provide assurance to the Board and wider assurance that the Board was cognisant of the issues raised. There would be further reports and opportunities for the Board to discuss these strategic items in more detail.

96. NHS 10 YEAR PLAN SUMMARY AND IMPLICATIONS

K Ellis presented the report, which summarised the content and implications for the Trust of 'Fit For the Future: 10 Year Health Plan for England' and provided assurance that the Trust was actively engaged to understand and respond to the opportunities and challenges the plan presented. She proposed that, while the Trust was well positioned, it was important to recognise the depth of change required by the plan.

In discussion, the Board commented on the implications of the shift from analogue to digital and agreed that while this was a major component of the 10 Year Plan, there were challenges related to digital disparities across Trust communities and implications for how staff operated, which suggested that a broader lens was needed to understand communities, assess impact and co-create models of care that accommodated a spectrum of needs.

The Chair thanked report authors for the clarity of the report.

Agreed: *the board notes –*

i. The main aspects of the 10 Year Plan and action underway to mitigate the risks/ pursue opportunities that arise.

ii. Executive Directors Group has commenced a planning process to ensure that the Trust can submit a medium term financial plan, underpinned by a set of transformation initiatives closely linked to the three shifts and to boosting productivity by improving how the Trust works.

97. OUR JOURNEY TO CHANGE – NEXT CHAPTER

K Ellis presented the report, which provided an update on progress to implement our Journey to Change - the Next Chapter and described the Trust's approach to advance integrated business planning, linked to the shifts in the 10-Year Plan, the medium-term financial plan and workforce planning. She drew attention to the appendix to the report, which provided

assurance on work underway to distil the impact of transformation, to address Board feedback that reports had focused on process and activity, rather than measurable impact.

Agreed:

i. The report is received with reasonable assurance.

ii. Board notes the progress being made to communicate the next chapter of Our Journey to Change.

iii. The planning framework and approach, as the organising structure for strategic transformation, is endorsed, noting the alignment with national priorities and oversight expectations.

iv. Board notes that 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.

v. Board notes the work that continues to articulate the impact of transformation work to date as a basis for ensuing strengthened articulation of impact in future work.

98. REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN

D Williams presented the report, which outlined the activity of the Freedom to Speak up Guardian in the last quarter and the initial stages of the move to a new provider. He acknowledged there had been a reduction in the number of cases, which he attributed to the reduction in proactive engagement and expressed confidence that this would increase under the new provider. He thanked the Board for its longstanding commitment to the role and extended thanks to S Dexter-Smith and J Preston for their support, guidance and patience.

The Chair recognised D Williams' contribution to the Trust and placed on record the Board's appreciation for his 50 years of NHS service.

S Dexter-Smith also placed on record her thanks to D Williams and agreed that the reduction in cases was due to the decrease in proactive engagement. She went on to comment on the progress made by the Speak Up Group to understand issues and develop clear plans and provided assurance on the transition to the new provider, where recruitment was underway, a clear communications plan was in place and approach agreed on how they would work with the Trust. She noted the importance of ensuring staff were aware of the safe handover and that strong provision would continue.

In discussion:

1. D Williams expressed willingness to support the handover process, given the value of continuity.
2. The Chair invited D Wiliams to reflect on the current position of the service and he proposed that the Trust was in the best position it had been during his tenure. He noted that fewer staff requested anonymity when speaking up, which suggested increased confidence in the process and there had been an increase in word-of-mouth referrals, reflecting trust in the system and a belief that speaking up was worthwhile.
3. J Preston commended D Williams for his role in building staff confidence and proposed that the transition to an independent provider was an opportunity to further strengthen the independence of the service. He stressed the importance of monitoring arrangements to ensure there was continued improvement.

   In response, S Dexter-Smith confirmed that quarterly reports would be submitted to the Board and she, the Chair and CEO would meet with the guardian each month.

Agreed:

i. There is good assurance that the service being provided to employees is safe and provides good governance to board though various mechanisms in place to ensure independence and oversight.

ii. Board welcomes the movement in the provision to the external FTSU provider and notes that a more detailed update will be provided to the next People, Culture and Diversity Committee, as the contract gets underway.

99. REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

J Preston presented the report and summarised the key areas of discussion at the committee meeting on 3 July 2025.

J Preston and B Murphy drew attention to: the reported limited assurance that DTVF Care Group was able to demonstrate the quality of supervision; an incident of prone restraint and discussions with Mersey Care on potential for related training; assurance on existing practice provided by the Trust to the Coroner in response to a Regulation 28; and the reduction in compliance with planning for safe Section 17 leave, which had dropped from 85% to 68% in North Yorkshire, York and Selby Care Group.

In discussion:

1. In respect of Section 17 leave compliance, Z Campbell advised that related wards had been identified and, whilst rates had not returned to previous levels, the trajectory had improved. Work would be undertaken to understand why the reduction had occurred.
2. S Dexter-Smith noted that national work related to mandatory and statutory training had evidenced that increased training requirements would impact negatively on the delivery of care.

100. REPORT OF THE GUARDIAN OF SAFE WORKING HOURS FOR POSTGRADUATE DOCTORS

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

In discussion:

1. B Sinha raised concerns about the ongoing industrial action of junior doctors and noted that it may affect exception reporting and rota compliance in future periods.
2. J Preston queried the purpose of the Non-Executive Director lead role for safe working and the Chair proposed that the position be clarified following the meeting.

Action: P Bellas

101. LEARNING FROM DEATHS REPORT

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

In discussion:

1. The Chair queried the position in relation to previously reported delays in LeDeR reviews and R Weddle confirmed the ICB had worked through the backlog and she undertook to provide an update to the next Quality Assurance Committee.

Action: R Weddle

2. B Murphy reflected on the potential for learning through further engagement with external partners, for example Greater Manchester Mental Health Trust - where working with families and carers was embedded in their culture - to understand if the Trust would increase its impact through a similar approach.

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

102. LEADERSHIP WALKABOUTS

S Paxton presented the report, which provided high level feedback from leadership walkabouts that took place in June 2025.

Agreed: *the report is received with good assurance.*

103. REPORT OF THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE

J Preston, Chair of the Charitable Funds Committee, presented the report which outlined areas of discussion at the committee meeting held on 16 June 2025.

He noted that committee had queried the trustee status of executive directors who did not have a voting right at the Board of Directors and L Romaniak confirmed that only executive directors with voting rights were trustees and the Charitable Funds Annual Report and Accounts had been updated accordingly.

104. COMMUNICATIONS UPDATE

S Paxton presented the report, which provided an overview of communication activity and delivery of the communications strategy during the period June to July 2025. In addition to that reported, she noted that 661 staff nominations had been received for the Star Awards, an increase of 34% from the previous year, which reflected the increased engagement of staff and their interest in sharing the good work that took place across the Trust.

Agreed: *there is good assurance on the delivery of the communications strategy and related targets.*

105. BOARD ASSURANCE FRAMEWORK (VERBAL)

The Chair invited the board to consider if there had been any matters arising from the discussion at the meeting that changed the position outlined in the Board Assurance Framework.

B Murphy proposed that content of the BAF would be reviewed to ensure it appropriately reflected concerns about delayed transfers of care.

106. EXCLUSION OF THE PRESS AND 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 business, the meeting ended at 3.08pm.

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Board of Directors
Public Action Log

RAG Ratings:

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

Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
10/10/2025	118	Transformation Programme	It was requested that a summary be provided to Quality Assurance Committee on each theme of the transformation programme, linked to the Integrated Performance Report/Board Assurance Framework and assurance to be provided to the Board.	P Scott	May-25	Closed Jun25	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. Aug25: B Murphy undertook to confirm that the themes had been reported into QAC. **Oct25 update: it was agreed the Interim CEO that the link between Transformation Board and Quality Assuarance Committee (QAC) will be an iten on the QAC developmental session, which will be held in quarter 1 of the new Chair being in place for QAC.**
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	Closed Aug25	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. **Aug25: L Romaniak advised that rectification works to the ventilation system had been completed and minor works would take place on the external fencing.**
12/06/2025	51 (3)	IPR - clinically ready for discharge	Resources and Planning Committee (RPC) and Quality Assurance Committee (QAC) to discuss delayed transfers of care and report into the Board	L Romaniak C Carpenter B Murphy J Maddison	Oct-25	In progress	**Oct25 update: RPC discussed the scope of a trustwide review of clinically ready for discharge at the meeting held on 1 October 2025.** **This was also discussed in detail at QAC, including with Integrated Care Board attednance and noted to the board in the QAC report to the board.**

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
14/08/2025	95 (2)	Digital and Data Risks	The new digital and data risks included in the Corporate Risk Register to be reviewed by Resource and Planning Committee (RPC), with assurance to be provided to Audit and Risk Committee.	N Black		In progress	**Oct25 update: RPC completed a review of BAF Risk 7 - digital security and protection at the meeting held on 1 October 2025.**
14/08/2025	100	Non-Executive Director lead role for safe working	P Bellas to clarify the purpose of the role.	P Bellas	Oct-25	**Completed**	**Oct25 update: The Non-Executive Director appointed by the board of directors to whom concerns regarding the performance of the Guardian of safe working hours can be escalated where they are not properly resolved through the usual channels.**
14/08/2025	101	LeDeR reviews	R Weddle to provide an update to Quality Assurance Committee on reported delays in LeDeR reviews by the ICB	R Weddle	Oct-25	**Completed**	**Oct25 update: Contact with the integrated care board has confirmed the backlog is significantly reduced and there are six cases left to review (was 68).**

Interim Chair Report

Public Board Meeting 9th October 2025

External Meetings

It has been a busy few months for everyone. Following the publication of the 10 Year Health Plan, there has been a number of national, regional and Integrated Care Board (ICB) meetings. Recognising there is a lot yet to be worked out on future form between NHS England, The Department of Health and Social Care and ICBs, it is clear we need to focus on good provision of services and delivery of the 10 Year Health Plan, encompassing the three shifts.

Key themes from the Chairs meeting include:

- National Operating Framework segmentation (TEWV have maintained segment 2) and anticipation of additional metrics. This is commonly referred to as "league tables".
- Finance, productivity, efficiency alongside the absolute need to safeguard quality of care.
- Understanding of the newly published "Model Region" and how that works alongside the "Model ICB" and what it means for provider organisations.
- Aligning strategic plans to the 3 shifts and transformation

Beverley Murphy and I represented the Trust at a meeting with Daniel Elkeles, the new Chief Executive of NHS Providers. Discussion was focused on how both the NHS Confederation and NHS Providers could work more closely together. Daniel had visited some of our services on the morning of the meeting and was incredibly impressed.

I attended the National Mental Health, Learning Disability and Autism (MHLDA) Chairs meeting and was invited to speak on what it was and indeed still is, like to be a Trust under scrutiny.

I have had the opportunity to meet with Darren Best, Chair at Cumbria, Northumberland and Tyne and Wear NHS Mental Health and Learning Disability Trust. We are both committed to working alongside each other to support learning, improvement and innovation for our populations.

The CEO, a number of Executive Directors and I attended a Strategic Finance and Performance Review with North East and North Cumbria ICB.

Council of Governors Activity

I have chaired the Council of Governors Nomination and Renumeration Committee, and we successfully agreed an excellent shortlist for the vacant Non-Executive Director role and Associate Non-Executive Directors. Working with our recruitment partners during

August and September, I met with all shortlisted candidates. Thank you to all who contributed throughout the robust process. Stakeholder sessions were held on 30th September, and formal interviews were conducted on 1st and 2nd October. Information on the outcome will be announced in due course as appointments will be approved by the Council of Governors.

I have had regular 1:1 meetings with our Lead Governor to ensure he is appraised appropriately. I have also had individual discussions with Governors appropriately.

I chaired the North Yorkshire, York and Selby Locality meeting with Governors. The transformation work at Hummingbird House and Catterick Garrison is progressing well. It was also good to hear about our co-creation reset.

Quality Improvement

I had a very useful catch up and learning session with Steven Bartley on our Quality Improvement journey. I would encourage Board members and indeed wider staff to engage with QI Foundation learning module – its only 18 minutes. QI will be a significant part of TEWV as we move forward together.

STAR Awards Shortlist

I had the extremely difficult job of reviewing all of the tremendous shortlisted applications to decide upon considerations for the Chairs Award. I was extremely proud to read about how much good work is going on throughout our Trust and in many cases, in collaboration with service users, carers, volunteers and our system and wider partners. Choosing my top 3 was incredibly difficult. I look forward to the annual ceremony in November.

Living The Values Awards

Huge congratulations to Kezia Finch, CAMHS in Peterlee and Tunstall Ward at Lanchester Road Hospital. It was a pleasure to meet staff who are so enthusiastic about their work and are truly living our values.

Consultant Recruitment

I was delighted to chair a panel for a Consultant in Mental Health Services for Older People in York. Congratulations to the successful candidate and the warmest of welcomes in your new role.

Leadership Walkabout

It was fascinating to meet staff in our Access and Treatment Team based at Foxrush House in Redcar on our last walkabout visit. I am grateful to them for helping me learn further. We had a great conversation on how we may better improve services for more rural populations using the 10 Year Health Plan and in support of the 3 shifts.

Interim Chair – Out and About

I have asked to get out and about as much as I can. Thank you to Dr Ranjeet Shah for taking time out with me to see staff at our Intensive Home Support Services and Crisis Teams at Wessex House in Stockton. Similarly, thank you to Sarah Tweddle for facilitating a visit to Willow Ward at West Park. A patient asked me to draw with them which I duly did. The picture they gave me is now on my office wall.

Board Strategic Seminar

A significant Board Seminar was held on 11th September led by Kathryn Ellis and Chris Lanighan. As expected of the Board, we considered our current operating environment. We asked ourselves a series of questions in the context of what we know and may anticipate to ensure we are in the very best position possible to deliver mental health, learning disabilities and autism services fit for future purpose. We will be reviewing this in our Private Board Session today.

Annual General Meeting

Our AGM will be held on Thursday 23rd October 2025 at Teesside University's The Hub Campus Heart, Middlesbrough.

Bev Reilly

Interim Chair

9th October 2025

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9 October 2025**
Title:	**BAF Summary Report**
Executive Sponsor(s):	**Alison Smith, 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** - **Negative** **IPR**: Staff in post with a current appraisal (metric 21) - *reduced performance assurance*	-	**Public Agenda Item 12** - Appraisal, revalidation and job planning of doctors **Public Agenda Item 13** - Getting the basics right for resident doctors
											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** **IPR:** Unique Caseload (metric 23) - *increased performance assurance* **Negative** -	-	-
											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 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			

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									Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services			
											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 (2/10/25):** Good assurance related to the quality and safety of tissue viability provision across the Trust **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* ▪ Medication Errors with a severity of moderate harm and above (metric 13) - *increased performance assurance* **Negative** **QuAC (2/10/25):** Limited assurance relating to the overall quality of care and experience for perinatal services albeit that there are early indications	-	-

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.	that there are improvements in responsiveness **IPR:** ▪ PSII reported on STEIS (metric 14) - *reduced performance assurance* ▪ CYP showing measurable improvement following treatment - patient reported (metric 4) - *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** **RPC (1/10/25):** Good controls assurance regarding Digital, Data & Technology Skills and Knowledge and Secure IT infrastructure and Asset Management **Negative** -	-	-
											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 **caused by** constrained capital resources **resulting in** an inability to adequately maintain, enhance or	**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 of CSR to not project reduction in score before 2028/29	**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 Capital Collaborative and Infrastructure Board meetings	**Positive** **RPC (1/10/25):** Good assurance that the Trust continued to	-	-

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	transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.							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	improve on PLACE scores, monitored the quality of the environment utilising PAM assessment and understood ERIC data, and that actions were progressing on all 3 areas **Negative** -		
											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** **RPC (1/10/25):** Certain reasonable controls assurances	-	-
											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	*(please refer to the report)*		
											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 (2/10/25):** ▪ Good assurance on the oversight and governance of perinatal services ▪ Good assurance relating to the operational and strategic oversight of the Quality Assurance schedule and clinical effectiveness activities **Negative** **QuAC (2/10/25):** Reasonable assurance relating to the strategic oversight of the quality and safety measures within the Quality Dashboard	-	-
											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			

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												
												delivery levels with a role to assess delivery of care standards			
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 Strategic Framework	▪ 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 ▪ Visibility of Strategic Framework through internal / external comms (so that it is widely known what our strategic Goals and Objectives are)	**Positive** **RPC (1/10/25):** Good assurance that Executive Directors were discussing TEWV engagement in: ▪ The national debate regarding the impending review of mental health ▪ The national shift from worklessness into treatment **Negative** -	-	-

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												
									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 (8/9/25):** ▪ Good assurance that the BAF and underlying processes remained adequate to indicate the degree of achievement of corporate objectives and the effectiveness of the management of the principal risks to the organisation ▪ Good assurance relating to the ongoing development and embeddedness of the risk management framework and strategy ▪ Good	-	**Public Agenda Item 11 -** NHS Oversight Framework, Quarter 1 2025/26 **Public Agenda Item 14** - Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard & publication of staff equality information **Public Agenda Item 16** – Publication of Patient Information **Confidential Agenda Item 29** - Medium Term
											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			

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								**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	assurance from the ERG (meeting held on 4/8/25) relating to: ▪ The Group's strong oversight of and responsiveness to the Trust's strategic risks ▪ The use and compliance of the InPhase risk management system ▪ Internal audit and counter fraud recommendations **QuAC (2/10/25):** ▪ Good assurance relating to progress against the Integrated Oversight Plan, as well as CQC activity ▪ Good assurance that a robust process has been followed to analyse patient data by protected groups to meet the Equality Act duties **MHLC (1/9/25):** ▪ Good assurance on the robustness of data provided, that there has been appropriate scrutiny and consideration of the matters by the care groups at operational level and that MH legislation has been correctly applied ▪ Good assurance in regard to MHL		Plan 2026/27 – 2030/31 **Confidential Agenda Item 31** - NHS England Provider Capability Self-Assessment
											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			

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									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	Multi-Agency Operational Groups acknowledging that there remain some challenges getting the right stakeholders round the table for meetings in NYYS **RPC (1/10/25):** ▪ Good assurance that the strategic risks continue to be managed effectively ▪ Good assurance on Trust processes and oversight of risk and reasonable assurance on those risks relevant to the Committee ▪ Good assurance that that no audit recommendations exceeded their original or agreed revised implementation date and overall on the assurance level from 4 recent reports assigned to Committee **NHS Oversight Framework**: Good assurance on the Trust's current segmentation **EDI:** Good assurance that the Trust followed a robust process in analysing its staff data by protected group for the WRES, WDES, SOWES & Publication of Staff Equality Information and that the actions		
											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			

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										provide a clear response to the concerns raised **Negative** **MHLC (1/9/25):** ▪ Reasonable assurance for compliance improvement with regard to section 17 leave however limited assurance that the standards are currently being sustained. ▪ Reasonable assurance relating to the internal MH legislation operational groups with strengthened membership needed in NYYS ▪ Reasonable assurance demonstrated of progress implementing the Trustwide Positive & Safe Strategy ▪ Reasonable, arising from MHA Inspections due to outstanding actions and ongoing issue with breaches, which were repeat breaches **RPC (1/10/25):** Reasonable assurance on the steps taken to ensure we meet the requirement to submit a 5-Year Plan **NHS Oversight Framework** – Reasonable assurance that the Trust's current segmentation can		

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										be maintained		
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park and impacted by limited access to capital funding **could adversely affect** our service quality, safety, financial, and regulatory standing.	**DoFE**	**Board**	**High 16 (C4xL4)**	**Moderate (12) (-1L)**	TBC Rectification date for works – subject to access to national capital (uncertain) and Trust cash position / scope of works	**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** - **Negative** -	-	-
											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)			
											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	**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** **RPC (1/10/25):** ▪ Good assurance that: the Month 4 revenue, capital and cash positions and related final KPI status were on track to deliver within Trust plan parameters ▪ Good assurance that the Trust was on track to reduce growth above 2019/20 inflation adjusted levels as per the NHS planning requirement ▪ Good assurance that the Trust had been responsive in quickly analysing 2024/25 benchmarking output reports ▪ Good assurance that processes had been developed to ensure the Trust meets NHSE requirements to	-	**Confidential Agenda Item 29** - Medium Term Plan 2026/27 – 2030/31
											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.			

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												
									financial plan outcomes (recurrent financial position)			(Reporting into FSB and EDG with assurances into P&PC and Board)	deliver a Medium-Term Financial Plan (MTFP) **Negative** -		
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** -	-	-
											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				

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												
											System Partnerships				
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** - **Negative** -	-	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9 October 2025**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**Alison Smith, Chief Executive**
Author(s):	**Alison Smith**

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***

EXECUTIVE SUMMARY:

Purpose:

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

Proposal:

To receive and note the contents of this report.

Overview:

A range of topics to update the board.

Prior Consideration and Feedback:

n/a

Implications:

No additional implications.

Recommendations:

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

Introduction
During my on boarding and before joining the Trust on 8th September 2025, I would like to thank colleagues for their generosity of time, spirit and for sharing so openly with me as I endeavour to learn more about the Trust. My focus has been to listen with curiosity, to understand and to introduce myself both personally and professionally to create relationships that enable trust, honesty and respect. The welcome I have received has been humbling due to the warmth and hospitality that has been offered to me.

In addition, much of my time has also been focused on our partners in our systems and communities both in terms of attending system meetings and introductions. This has included National NHSE meetings, NEYHMHF Conference, our local MP's, third sector/VCSE's and Council Officers.

Matters of strategic Performance

NHS Oversight Framework
The leagues tables for the NHS Oversight Framework 2025/26 have been publicised and confirmed our segment status as 2. We are also aware that further work will be progressed on the MH metrics and invites are being asked to support these discussions, which we have responded to positively.

NHSE Communication
Sir Jim Mackey, NHSE CEO presented his priorities at the National NHSE CEO meeting followed by a letter on 18/09/2025 titled Building on our progress in the second half of 2025/26, detailing the priorities as:

- Continued focus on Elective recovery, UEC with a focus on the four-hour target, Ambulance handovers, Primary care and Dentistry.
- Mid year review process to be led by regions, and underpinned by the Oversight Framework, with ICBs and providers over the next 6 weeks.
- Resilience during winter, our acute care colleagues will be seeking greater capacity up to the Christmas period, to support providers and commissioners, and ensure join up across the system, NHS England will commence its own national and regional operational coordination response 7 days a week from 27 October.
- Leadership and our people, all to step up and lead our people through this challenging period. Emphasising our need to redouble our efforts to be mindful of the experience of all staff, especially during periods of high demand and pressure. The best performing organisations make this an organisation wide priority and I would like us to make this more of a central focus for all of us, sitting alongside the focus on patient experience.
- Looking ahead to 2026/27, completing plans for 2025/26, closing gaps and shaping your strategy for the following years and how we bring the intent of the 10 Year Health Plan to life.
- On workforce transformation, we are working with you to build the 10 year workforce plan that will enable the delivery of the 10 Year Health Plan. That will be ready in the coming months and will help us all to plan for the longer term. Technology and digital solutions are going to be vital for longer term transformation and unlocking our productivity.

Single joint Department of Health and Social Care and NHS England executive team
In March, the Prime Minister announced NHS England would be brought back into DHSC to end the duplication resulting from 2 organisations doing the same job in a system currently holding staff back from delivering for patients. By stripping back layers of red tape and

bureaucracy, more resources will be put back into the frontline rather than being spent on unnecessary admin.

A single joint executive team will be established at the Department of Health and Social Care (DHSC) and NHS England as part of the transition to one organisation.

It will provide unified leadership across both organisations, bringing policy and delivery together. The team will manage Directors from related work areas from 3 November 2025 and will begin to combine resources.

Mutually Agreed Resignation Scheme (MARS)
The process for MARS has remained on track and timelines achieved. Discussions with services and Directors have taken place with the final business case approved at EDG in September. Individual applicant conversations are taking place and a final update will be received in Decembers Trust Board.

Sustainability
We remain focused on our financial compliance and sustainability, as do our ICB colleagues and over the coming weeks, system partners are meeting to review and plan for financial delivery against plans.

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

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9th October 2025**
Title:	**Board Integrated Performance Report as 31st August 2025**
Executive Sponsor(s):	**Kathryn Ellis, Interim Executive Director of Transformation & Strategy** **Naomi Lonergan, Interim Managing Director, Durham, Tees Valley & Forensic Care Group** **Zoe Campbell, Managing Director, North Yorkshire, York & Selby Care Group**
Report Author(s):	**Sarah Theobald, Associate Director of Performance** **Jane Smith, Senior Performance Manager**

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.
6	Estates & Physical Infrastructure	There is a risk of delayed or reduced essential investment caused by constrained capital resources resulting in an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.
7	Data Security & Protection	There is a risk of data breach or loss of access to systems, caused by successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and information integrity, reputational damage and loss of confidence in the organisation.
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.
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.
11	Roseberry Park	There is a risk that the necessary Programme of rectification works at Roseberry Park, limited access to capital funding, and associated PFI termination legal case could adversely affect our service quality, safety, financial, and regulatory standing.
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** regarding the Integrated Performance Dashboard (IPD)
- **Good performance assurance** 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 no change in the levels of control and performance assurance this month.

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 and some gaps in assurance 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 **20** measures (65%) with good or substantial assurance (previously 21).

Key changes this month:

Increased performance assurance (from good to substantial)	• 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 Medication Errors with a severity of moderate harm and above
Increased performance assurance (from reasonable to good)	• Unique Caseload
Reduced performance assurance (from substantial to good)	• PSII reported on STEIS • Staff in post with a current appraisal
Reduced Performance (from good to limited)	• Percentage of CYP showing measurable improvement following treatment - patient reported

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

There are a small number of measures, we are advising continue to be a focus for improvement, which now also includes Mandatory and Statutory face to face training below standard.

- **Outcomes:** The Trust-wide Clinical Outcomes improvement Plan continues to progress, except for those actions' dependant on CITO development, the remainder remain of track for delivery. There are 3 actions on track for delivery by end of September 2025. An update on the Outcomes Improvement Plan was presented to the Quality & Performance EDG in September.

- **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*).

- **Mandatory & Statutory Training –** We are continuing to achieve the standard and have made significant progress in reducing the number of mandatory training courses below the 85% standard, moving the issue from an area of concern to one of improvement; however, further targeted actions are needed to address the remaining issues. Currently there are 10 courses below the standard; 8 are showing an improved position compared to the previous month, 2 are showing a reduced position. The Training and Education Task Group have identified several actions that will support staff to complete mandatory training and People & Culture are supporting operational services to maintain oversight of wasted spaces, including DNAs, with specific focus on reducing late course cancellations. Following a detailed discussion and review of the courses below standard at the Quality & Performance EDG in September, it was agreed that all Executive Directors would review their areas with compliance below 80% and take steps to reduce the number of 'reds' in the next 4 weeks, aiming for a measurable reduction rather than complete elimination due to the volume in some areas. These will be captured as SMART actions and reported in the September IPR.

- **Agency Price Cap Compliance** - Most price cap breaches relate to medical locums (with a reducing number of shifts providing prison mental health nursing cover) for hard to fill vacancies. The recruitment of consultant psychiatrists is challenging nationally and actions taken to recruit internationally have a significant (3 years plus) lead time and double running cost, limiting the numbers of posts that can be supported. Weekly medical review meetings have operated since 2024/25 and are supporting the development of trajectories for medical staffing as our main overall driver of breaches and overall expenditure (representing 54% all agency cost in August and 96% price cap breaches). The Temporary Staffing Sub-Group has taken on the leadership and oversight of this work, with focus on supporting the required reductions in Agency and Overtime and supporting reductions in Bank staffing. This recognises that we will need to set up more bank arrangements to give alternatives to Agency and Overtime use, which may see bank costs increase (or not decrease) whilst substantive staff are brought into post. From July a DTV bank has become operational for crisis/liaison, planned to support related overtime reductions. Further key milestones will impact overtime from October.

The actual areas of concern as show below, which now also includes sickness absence.

- Whist bed occupancy is not identified as an area of concern; we remain concerned about **patients classified as clinically ready for discharge.** In the supporting measure, 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. As per discussion at the August Board a more detailed report on clinically ready for discharge improvement actions

will be brought to the next Board. At Trust level, patients classified as clinically ready for discharge in August equated to an average of 72.9 beds (45.1 Adult and 27.8 Older Adult beds), with an associated direct cost of c.£1.42m (including £0.031m independent sector bed costs). Of the cost, c.£0.80m relates to Adult and c.£0.62m relates to Older Adult.

DTVFCG are working closely with system partners to strengthen a system wide approach to supporting those clinically ready for discharge. Proposals for a transfer of care hub in Tees Valley were presented and agreed in principle, however, no funding is available in 2025/26; the proposal for Durham is expected to be completed in October 25. The Business Case for the new Crisis House will be presented to EDG in October 2025 and a Clinically Ready for Discharge pilot role, aimed at reducing delays within Urgent Care in Adults and Older Peoples services, will commence in December for 18 months.

In NYYSCG the MHSOP General Manager has met with Humber & North Yorkshire ICB to review the escalation process in the system related to patients clinically ready for discharge, and work will now be completed by the ICB; no timescales have been agreed. The proposed development of Safe Havens is pending ICB investment and in the interim, the ICB-led review of the crisis team has commenced across North Yorkshire & York with a scoping meeting taking place in August 2025. In addition, North Yorkshire County Council has invited the MHSOP General Manager to support their work to re-commission the approved provider list (APL) for older peoples' support, care and accommodation packages in North Yorkshire to reduce clinically ready for discharge delays.

The Associate Director of Nursing is compiling a Trust-wide report on the impact of the restricted patients within our Assessment and Treatment wards, which will be presented to the Combined Governance in October 2025 and next steps agreed. In addition, a Trust-wide paper on Clinically Ready for Discharge will be presented to EDG in October 2025.

- **Sickness** – Whilst there is no (statistical) significant change, an increasing (worsened) position is visible and above standard; therefore, we are moving this from being a focus of improvement to an area of concern. A series of supporting actions were agreed at EDG People & Resources Meeting in September, which include reviewing absence management modules and considering new well-being, absence, grievance, and disciplinary policies. The Performance Team are reviewing benchmarking data to identify our position relative to peers and will share findings with People & Culture to support discussions with other organisations to identify effective practices. The People Partners and Performance Leads will work with the areas with high sickness rates to identify the underlying issues and improvement actions with the aim to present these at the Quality & Performance EDG in October as part of a wider workforce deep dive.

- **Financial Plan: SOCI - Final Accounts - Surplus/Deficit** – Key risks to delivery of the plan for 2025/26 include delivering the recurrent level of targeted savings, including savings associated with reducing temporary staffing and controlling staff numbers, and mitigating impacts from the underfunding of nationally negotiated pay awards through tariff uplifts that do not recognise the Mental Health sector's higher pay cost weight. To support workforce controls, Vacancy Control Board principles have been tightened, and Care groups have implemented 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 in DTV have been tasked to have plans in place by September 30th. Overperformance on non-recurrent schemes is mitigating the recurrent schemes under-performance. Suggestions on mitigating

actions and short-term reduction in spend which were identified at the Sustainability event in early July are being assessed for potential impact and will be shared with relevant officers to progress. Mitigations for under-delivery are being worked up.

To note: Following the procurement of a new patient experience system, there will be no data available for the three patient and carer experience measures in the next IPR whilst the system is fully configured and linked into our Integrated Information Centre. It is anticipated that data will be available for the November IPR, which will include September and October's data.

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 (the same position as 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 and Reliable Recovery** (County Durham & Tees Valley) – Whilst we are not achieving the financial year to date standards, we have achieved the standards for the month of August. The trust wide action plan includes 14 improvement actions, all of which should be completed by December 25. One action has been delayed until November (from September). All other actions are on track.

- **Specialist Community Perinatal Mental Health Services** (York) – It should be noted that York place remains 1 below the target and there is special cause improvement indicated in the SPC chart. The Perinatal team is continuing to be supported with a service recovery plan. Two new vacancies have now been recruited, and maternity leave cover is being progressed through the recruitment process, remaining interviews are planned during September 25. DTVFCG are providing interim operational support to the York and Scarborough, Whitby & Ryedale teams and additional clinical support is being provided from the wider multidisciplinary teams and EIP service.

- **CYP 1 contact** (North Yorkshire and York combined due to changes in GP practice boundaries in 24/25). A joint meeting of both care group CYP representatives has been held to discuss the findings of the analysis. It has been agreed that a QI event will be held to review the clinical processes and recording of key data across all Neuro services to ensure consistency, which was supported by the Quality & Performance EDG in September.

Waiting Times

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

  - Recommendations from regional clinical model and prioritisation events in July aimed at developing short and medium actions to reduce demand and improve access will be presented to ICB in September. In addition, as part of the Valuing Neuro Diversity work, the ICB are leading a piece of work to review the under-5 pathway (multiagency partnership) with an aim to improve waiting times and identify efficiencies. Timescales are to be confirmed.

    CYPS – There is a recovery plan in place which includes ten actions that 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. The evaluation of the clinical protocol will be completed by 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 posts have been recruited with staff progressing through induction processes; appointment to the final 2 posts is in train. The initial findings relating to the increase in the waiting list in April, have indicated that a number of additional patients should have been included in the original cohort of patients to be transferred but were not, due to data quality issues. Further work is being undertaken with support from Business Intelligence to confirm this and this will be complete by the end of September 25.

  North Yorkshire & York

  A paper was presented and approved at the HNY MHLDA Collaborative Executive in August, which recommended a re-design of autism and ADHD services within existing resources so that service provision is tiered, supporting early identification, specialist input across all tiers, and timely access to focussed specialist interventions/input. The level of intervention is to be determined through a Humber & North Yorkshire-wide clinical policy, based on functional impact. Whilst it is unlikely that the new model will have a material impact on waiting lists, it is anticipated that there will be some positive result on waiting times/numbers.

  CYPS - A report with recommendations for York and Selby teams to manage their neurodiversity assessment waiters has been completed and was shared with the Specialty Improvement Group (SIG) in July. The team is working through actions to ensure no further efficiencies can be made prior to a final paper being shared with SIG and subsequently Care Group Board in November 2025.

It is anticipated that this will allow us to agree a way forward as to how we manage the demand coming into the team with the workforce capacity we have, however it should be noted that without investment from the ICB our ability to make largescale improvement in waiting times and numbers is limited.

The Scarborough ADHD team has a recovery plan in place. The service has recruited to all vacant posts, and they are working to ensure that they are using their existing resources efficiently and effectively. The identification of any remaining efficiencies has been further delayed and will now be shared through governance meetings by end of October 2025 (previously July, then September). 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 includes 14 improvement actions, all of which should be completed by December 25. One action has been delayed until November (from September). All other actions are on track. Within NYYSCG one individual has now commenced in post; however, further recruitment is currently on hold pending the qualification of the current PWP cohort.

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
- Estate / Physical Infrastructure
- Data Security and Protection
- Quality Governance**
- Regulatory Compliance
- Roseberry Park
- 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. We have developed an agreed programme of work focusing initially on clinical safety and statutory monitoring. This will be presented to the Cito Improvement Group for approval, prior to submission to EDG in October. In addition, a "CITO Clinical Specialist" started attending key care group meetings where data quality is routinely discussed to support operational and clinical staff from August.*

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 confirm that there is good controls assurance on the operation of the Performance Management Framework; reasonable performance assurance on the IPD, good performance assurance on the National Quality requirements/Mental Health Priorities and reasonable performance assurance on the Waiting Times and that the strategic risks are being managed effectively.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

For the period ending 31st August 2025

Report produced by: Laura Wheater, Performance Lead, and Jane Smith, Senior Performance Manager
Date the report was produced: 26th September 2025

For any queries on the content of this report please contact: Ashleigh Lyons, Head of Performance
Contact Details: Ashleigh.lyons@nhs.net

journey to change

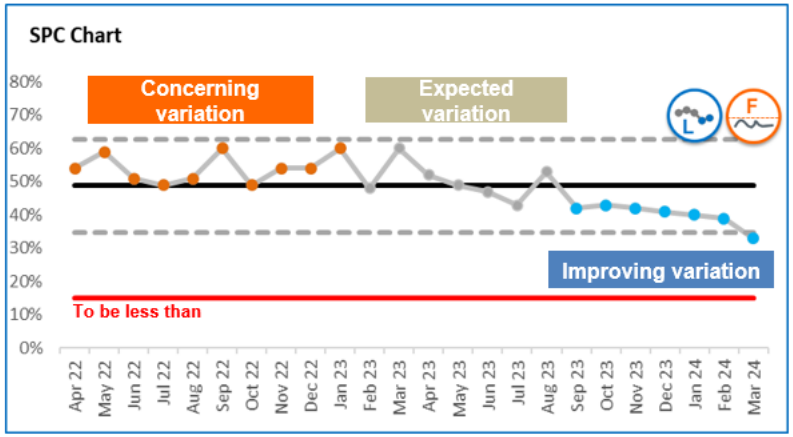
CONTENTS

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
Tees, Esk and Wear Valleys
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These icons provide a summary view of the important messages from SPC charts.

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

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

Our Approach to Data Quality

Tees, Esk and Wear Valleys NHS Foundation Trust

Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The most recent assessment was completed in quarter 1 2025/26 and scores are included in this 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
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
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 August 2025

NHS
Tees, Esk and Wear Valleys
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Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	93.48%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC		?	75.00%	75.95%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	82.51%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	P	35.00%	48.48%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC		F	55.00%	46.94%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	?	50.00%	59.49%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC	H	F	30.00%	26.29%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	L	F	85.00%	93.03%
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			6
11)	The number of Incidents of moderate or severe harm	QAC	L			115
12)	The number of Restrictive Interventions Used	QAC				4,400
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				2
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				2
15)	The number of uses of the Mental Health Act	MHLC				1,685

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			60.00%	55.54% (Jul-2025)
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D			65.00%	61.83% (Jul-2025)
18)	Staff Leaver Rate	PC&D	L	?	11.00%	9.70%
19)	Percentage Sickness Absence Rate (month behind)	PC&D		?	5.50%	6.01%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	P	85.00%	91.04%
21)	Percentage of staff in post with a current appraisal	PC&D	H	?	85.00%	88.76%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				39,278
23)	Unique Caseload (snapshot)	S&RC	L			62,943

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	2,689,000	1,736,499
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	3,325,000	3,240,390
25b)	Agency price cap compliance	S&RC	67.00%	64.04%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	6,086,000	3,917,874
28)	CRES Performance - Non-Recurrent	S&RC	3,188,444	4,923,593
29)	Capital Expenditure (CDEL)	S&RC	4,362,000	4,113,495
30)	Cash against plan	S&RC	42,828,000	51,646,543

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 we are achieving all standards. There is special cause improvement in the number of responses received for carer involvement and no significant change for the patient experience measures.

- **Outcomes:** in CYP there is special cause concern 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. There is special cause improvement in the number of timely paired outcomes recorded for the CYP and Adult CROM; however, there is no significant change for the CYP PROM and special cause concern in the AMH/MHSOP.

- **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 August 2025.

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

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

- **People:** in the July Pulse Surveys, 55.18% of staff reported they would recommend the Trust as a place to work; 61.17% reported they felt they were able to make improvements happen in their areas of work. 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; however, there is special cause improvement for unique caseload and no significant change for 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 31st August 2025 is a deficit of £1.736m, which is £0.956m better than planned for the period. The in-month position improved in August with benefits from reduced spend on agency, drugs, and minor works, and additional income on school services. CRES delivery for the year to date at month 5 was £8.84m against a target of £9.27m, £433k below plan. The adverse variance to plan is reducing (£54k in Month 4 compared to £133k in Month 3), although there is still work needed to get ahead of plan and recover the shortfall, largely on flexible staffing schemes.

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. Whilst we are achieving the standard for carers feeling involved and percentage of inpatients reporting that they feel safe whilst in our care, we have failed to achieve the standard for the percentage of patients surveyed reporting their recent experience as very good or good. There is special cause improvement in the number of responses received for carers feeling involved, with no significant change in the percentage of patients surveyed reporting their recent experience as very good or good and patients feeling safe.

  Following the procurement of a new patient experience system, there will be no data available for this measure whilst the system is fully configured and linked into our integrated information centre. Timescales for reporting are to be confirmed.

- **Outcomes** – there is special cause concern for CYP for the PROM but special cause improvement for CROM and both areas remain above standard. There is no significant change in the number of patients discharged with a paired outcome measure for PROM, but special cause improvement for CYP CROM. 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 –** in the July Pulse Surveys, 55.60% of staff reported they would recommend the Trust as a place to work; 60.53% reported they felt they were able to make improvements happen in their areas of work**.** 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 active caseload, however there is special cause improvement in unique caseload.

- **Finance - The DTVF Care Group**, planned to spend £117.08m as at August, and actual spend was £118.89m, which is £1.807m more than planned with CRES delivery £0.4m below plan. For 25/26, August agency spend has decreased to £267k from £321k in July, Total Spend for the financial year is £1.762m (1.5% of pay spend), of which £1.417m relates to Medical Agency This will continue to be under review monthly.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

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

Risks / Issues*

- Outcomes
- Bed Pressures
- Financial Plan

Mitigations

Outcomes: CYP and Adults & Older Persons PROMs - The Trust-wide Clinical Outcomes improvement Plan continues to progress with the exception of those actions dependent on Cito developments. The remainder remain on track for delivery. 3 items remain on track for delivery at the end of September.

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.
- Directors of Operations and General Managers are asked to focus on eliminating agency spend via replacing with substantive recruitment.

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 within AMH & CYP – carers feeling actively involved.
- **Outcomes:** In CYP, there is special cause improvement for CROM and PROM has changed from no significant change to special cause concern, both are above standard. For PROM, AMH is reporting no significant change and MHSOP reporting special cause improvement and concern remains due to being under standard. For CROM we are reporting no significant change at care group level and special cause improvement for both specialities. Both AMH & MHSOP is reporting below the standard. Overall, there remains concern in the number of timely paired outcomes recorded for all measures.
- **Bed Pressures:** there special cause improvement (decrease) for bed occupancy at care group level and AMH. We are reporting special cause improvement for the number of inappropriate OAP bed days external to the Trust.
- **Patient Safety:** there is no significant change for patient safety incident investigations at care group level however MHSOP is reporting special cause concern; (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 special cause improvement for incidents of moderate of severe harm, no significant change for restrictive interventions at care group level, ALD special cause concern and no significant change for the number of medication errors. There were 0 unexpected Inpatient unnatural deaths reported on STEIS during August.
- **Uses of Mental Health Act:** no significant change is reported at Care Group or speciality level within the reporting period except MHSOP which is reporting special cause variation of an increasing nature where up is not necessarily improving nor concerning.
- **People:** In the July Pulse Surveys, 53.17% of staff reported they would recommend the Trust as a place to work; 56.35% reported they felt they were able to make improvements happen in their areas of work. There is special cause improvement reported for staff leaver rate and remained above standard with ALD reporting no significant change & CYP special cause concern. 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 appraisal and above standard except CYP and management which are reporting no significant change.
- **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 CYP special cause variation of decrease where down is not necessarily improving or concerning. Caseload is reporting special cause improvement at Care Group level, with special cause improvement for ALD, MHSOP and AMH and Children reporting concern, however, the service has confirmed this is not an actual concern.
- **Finance:** Ongoing pressure on government department spending in 2025/26, therefore aiming to manage within budgeted funding levels. 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 developed by the Trust.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Bed Pressures (Bed Occupancy, OAP bed days)
- Number of incidents of moderate or severe harm
- People (Staff leaver Rate, Appraisals)
- Unique Caseload

Risks / Issues

- Outcomes
- Face to face Mandatory and Statutory Training
- Finance (Financial Plan, Agency expenditure, Surplus/Deficit, Agency price cap compliance)

Mitigations

Outcomes

The Trust-wide Clinical Outcomes improvement Plan continues to progress, with the exception of those actions' dependant on CITO development, the remainder remain of track for delivery by the end of September. An update on the Outcomes Improvement Plan will be presented at EDG on 23rd September 2025.

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

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.

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 • Compliance with ALL mandatory and statutory training	• Adults and Older Persons showing measurable improvement following treatment - clinician reported • Bed Occupancy (AMH & MHSOP A & T Wards) • PSII reported on STEIS-***reduced performance assurance*** • Incidents of moderate or severe harm Staff Leaver Rate • Staff in post with a current appraisal ***reduced performance assurance*** • Unique Caseload ***Increased performance***		
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 • Unexpected Inpatient unnatural deaths reported on STEIS • Medication Errors with a severity of moderate harm and above ***increased performance assurance*** • Uses of the Mental Health Act	• Restrictive Intervention Incidents Used • New unique patients referred • CRES Performance – Non-Recurrent	• Adults and Older Persons showing measurable improvement following treatment - patient reported • 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 • Use of Resources Rating - overall	
Negative		• Financial Plan: SOCI - Final Accounts - Surplus/Deficit • Cash balances (actual compared to plan)	• Financial Plan: Agency expenditure compared to agency • Agency price cap compliance Capital Expenditure (Capital Allocation)	• CYP showing measurable improvement following treatment - patient reported ***reduced performance*** • CRES Performance – Recurrent

***NOTES**: 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

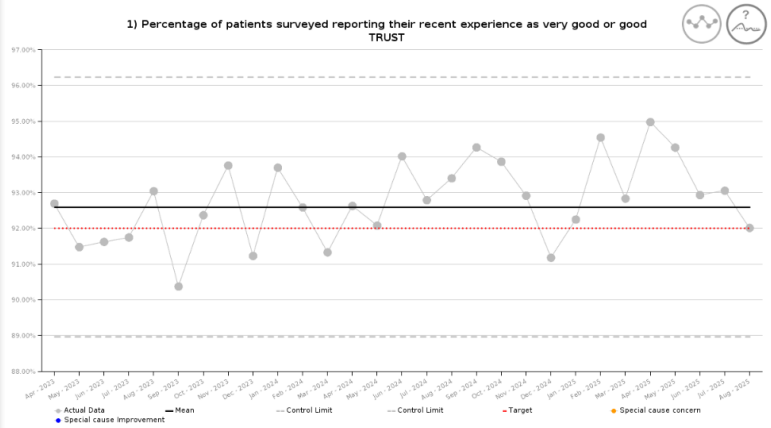
What does the chart show/context:
During August **1077** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **991 (92.01%)** scored "very good" or "good".

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

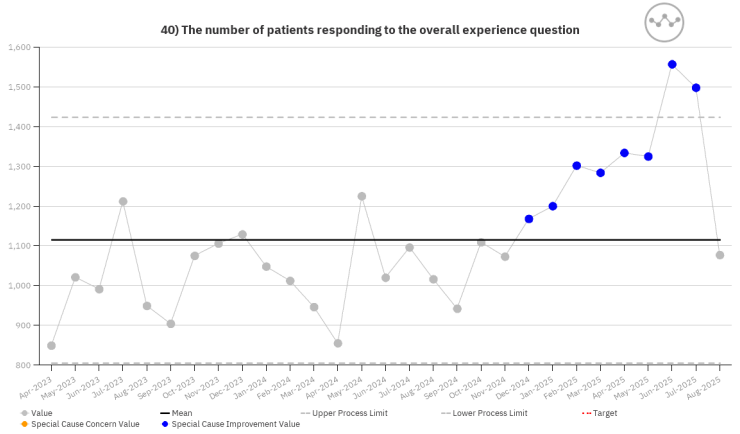
The latest National Benchmarking data (July 2025) shows the England average (including Independent Sector Providers) was **89**% and we were ranked **12** out of 67 trusts (1 being the best with the highest ratings), we were also ranked 5th highest for total number of responses received.

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

Actions:
- 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 September 2025 **(Complete)**
- DTVFCG General Managers and Associate Directors of Nursing to review the teams/wards with zero responses to identify any underlying issues and improvement actions. An update will be provided to the August 2025 Care Group Combined Governance meeting. (**Partially Complete)** A review of teams has been undertaken and those incorrectly named or that no longer exist have been corrected or removed. Speciality Senior Leadership Teams will identify teams with zero responses in their monthly service reports from November 25.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

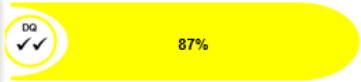
What does the chart show/context:
During August **494** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **377 (76.32%)** scored "yes, always".

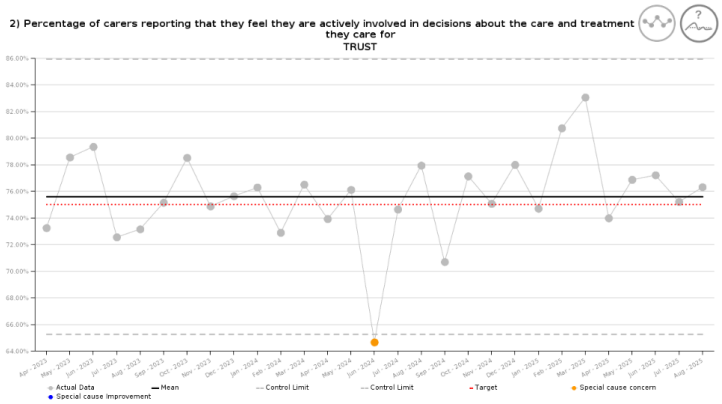
There is no significant change at Trust and Care Group level in the reporting period. There is special cause improvement in the number of patients who have responded to this question at Trust and for Durham Tees Valley and Forensic Care Group.

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

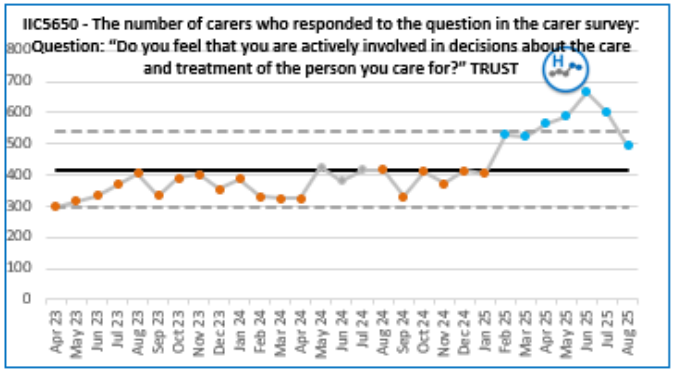
Underlying issues:
- A lack of awareness of the Triangle of Care within Trust Services.

Actions:
- Patient & Carer Experience Team to present the Triangle of Care feedback report from the Carers Trust, including recommendations, to the Care Group Quality Assurance & Improvement Groups in August and September 2025. **(Complete)** No new actions agreed.
- 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. **(Complete)**





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

NHS
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.

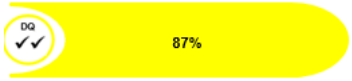
What does the chart show/context:
During August **178** patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **145 (81.46%)** scored “yes, always“ and “quite a lot”.

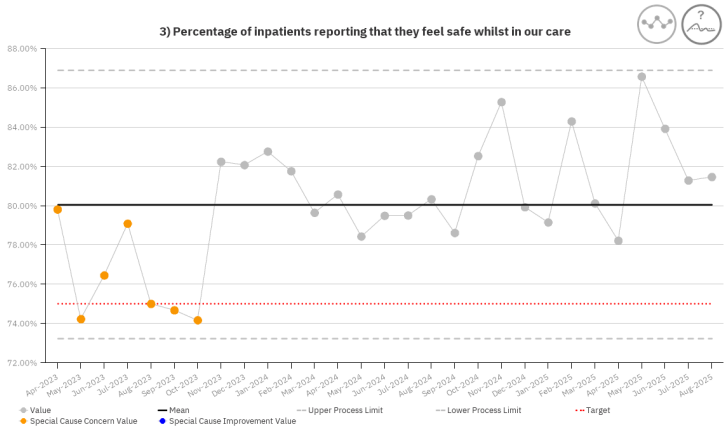
There is no significant change at Trust and Care Group level in the reporting period; and in the number of patients who have responded to this question at Trust and Care Group level.

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.

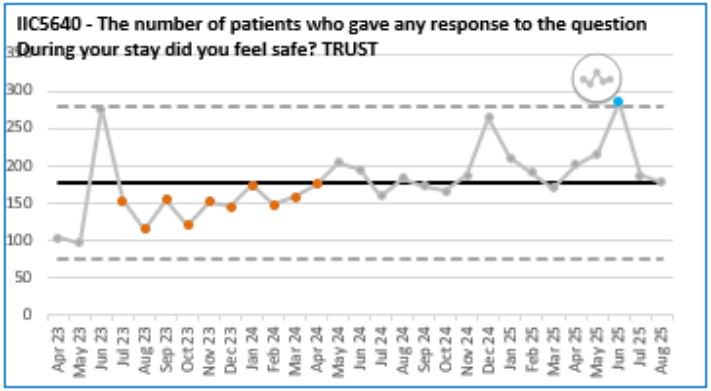
Underlying issues:
There are no underlying issues to report.

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.



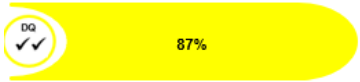


The below chart represents the number of patients that responded to the safety question.



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.

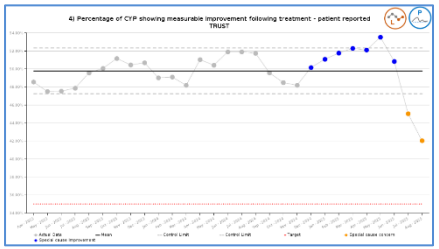
- Further analysis confirms that collection rates for current caseloads are continuing to increase; however, as some patients remain under our care/treatment for longer periods of time, improvements in paired rates will not be visible until the point of discharge (approximately 70% of patients will be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

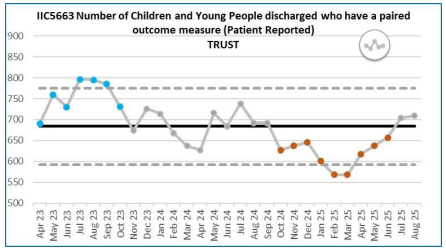
Actions:
The Trust-wide Clinical Outcomes improvement Plan continues to progress, except for those actions' dependant on CITO development, the remainder remain of track for delivery. The following actions are on track for delivery by end of September 2025:

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)

An update on the Outcomes Improvement Plan was presented at Quality & Performance EDG in September.

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





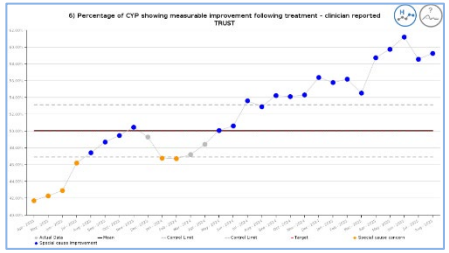
Background / standard description:
We are aiming for 35% of CYP showing measurable improvement following treatment - patient reported

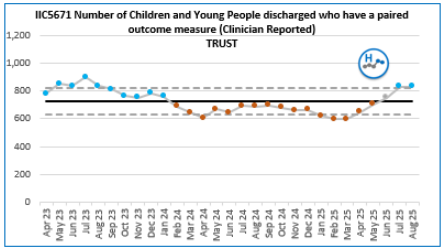
What does the chart show/context:
For the 3-month rolling period ending August, **709** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **300 (42.31%)** made a measurable improvement.

There is special cause concern at Trust and Care Group level in the reporting period; performance is above standard at all levels There is no significant change for the number of patients discharged with a paired outcome measure at Trust and 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 August, **832** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **493 (59.25%)** made a measurable improvement.

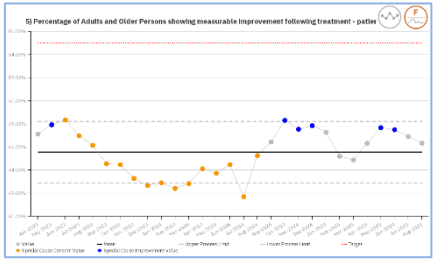
There is special cause improvement at Trust and Care Group level in the reporting period, and performance is above standard at all levels. There is special cause improvement in the number of patients discharged with a paired outcome measure at Trust and Care Group level.

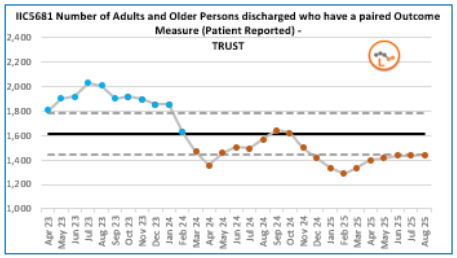
The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

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, PHQ-9, GAD-7 and CORE-10.
- 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 CYP General Managers will pull together a task group to review the PROMs data to try to understand the drop in performance. The initial meeting will take place before the end of October 25.

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





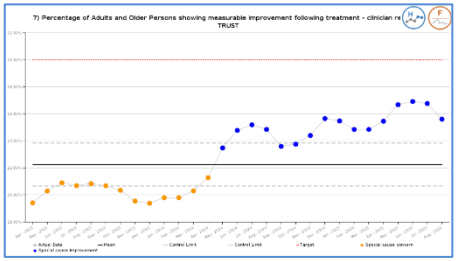
Background / standard description:
We are aiming for 55% of Adults and Older Persons showing measurable improvement following treatment - patient reported

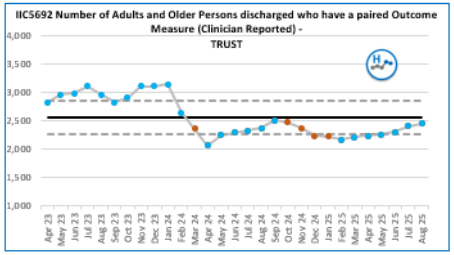
What does the chart show/context:
For the 3-month rolling period ending August, **1,441** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 667 (46.29%)** made a measurable improvement.

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 improvement in the number of patients discharged with a paired outcome measure at Trust level; however, there is special cause concern at Care Group level.

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 August **2,449** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 627 (25.60%)** made a measurable improvement.

There is special cause improvement at Trust and for Durham Tees Valley and Forensic Care Group. There is no significant change for North Yorkshire and York level in the reporting period. There is special cause improvement for both specialties in both Care Groups; however, the low performance in MHSOP continues to be a concern. Adult Mental Health in both Care Groups are achieving standard. There is special cause improvement in the number of patients discharged with a paired outcome measure at Trust level and for NYYSCG; there is special cause concern for DTVFCG.

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 **(Closed)** *See below action*
- Section Head of Research & Statistics, Clinical Outcomes and Business Analytics to scope an IIC solution; timescales to be confirmed. (This has been added to the Trust-wide Outcomes Improvement Plan to formally govern the progress of the issue). (*See Outcomes update on page 18).*

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

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 August, **10,850** daily beds were available for patients; of those, **9,783 (90.17%)** were occupied. There were no independent sector beds used during August**.**

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.

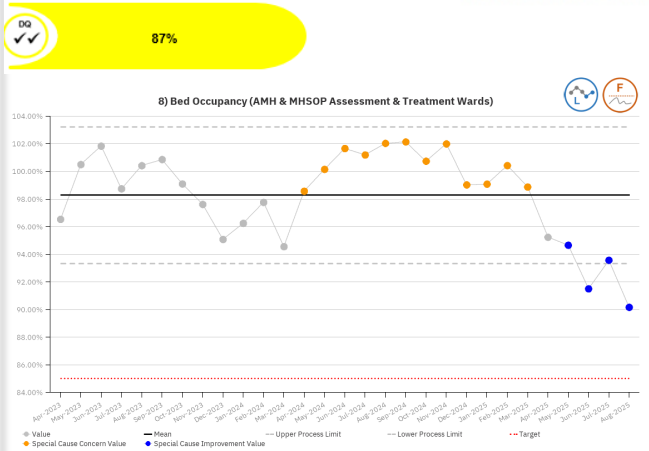
Underlying issues:
- Patients clinically ready for discharge are having a significant impact on occupancy *(see bottom right of page)*, as is the availability of specialist packages of care and specialist placements.
- Ministry of Justice (MoJ) patients.

Actions:
- DTVFCG are working closely with system partners to strengthen a system wide approach to supporting those clinically ready for discharge. Proposals for a transfer of care hub in Tees Valley were presented and agreed in principle, however, no funding is available in 2025/26; the proposal for Durham is expected to be completed in October 25.
- The Business Case for the new Crisis House will be presented to EDG in October 2025.
- A Clinically Ready for Discharge pilot role, aimed at reducing delays within Urgent Care in Adults and Older Peoples services, will commence in December for 18 months.

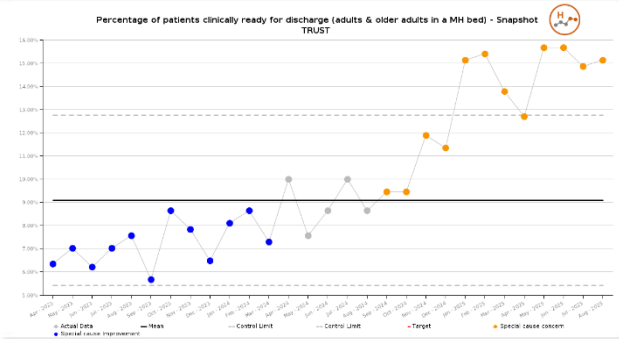
- NYYSCG MHSOP General Manager met with Humber & North Yorkshire ICB in August to review the escalation process in the system related to patients clinically ready for discharge. **(Complete).**This work will now be completed by the ICB; timescales are to be confirmed.
- The proposed development of Safe Havens is pending ICB investment. In the interim, the ICB led review of the crisis team has started across NYY; a scoping meeting took place in August.
- North Yorkshire County Council has invited the MHSOP General Manager to support their work to re-commission the approved provider list (APL) for older peoples' support, care and accommodation packages in North Yorkshire to reduce clinically ready for discharge delays.

- Performance Team to undertake analysis to understand the impact of Ministry of Justice bed use with a view to identifying any issues and requirement improvement actions. This analysis will be completed by the end of August 2025. **(Complete)-** *See below action*
- The Associate Director of Nursing is compiling a Trustwide report on impact of the restricted patients within our Assessment and Treatment wards. This will be presented to the Combined Governance in October 25 and next steps agreed.

Tees, Esk and Wear Valleys NHS Foundation Trust



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 August equated to an average of 72.9 beds (45.1 Adult and 27.8 Older Adult beds), with an associated direct cost of c.£1.42m (including £0.031m independent sector bed costs). Of the cost, c.£0.80m relates to Adult and c.£0.62m 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 August, **0** days were spent by patients in beds away from their closest hospital.

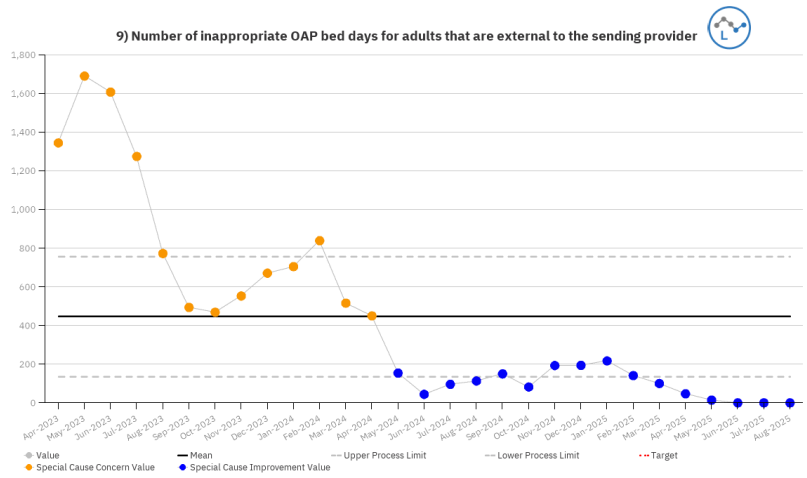
There is special cause improvement at Trust and Care Group level in the reporting period.

There were 0 active OAP placements as at 31st August 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)

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

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

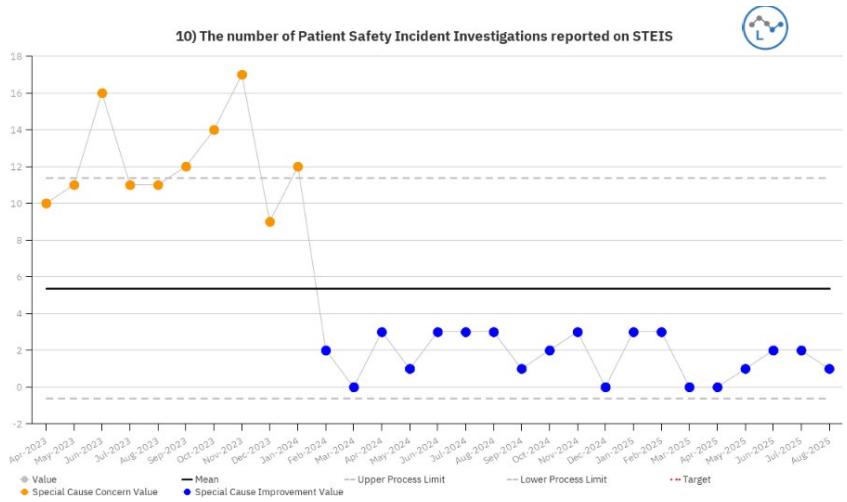
Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is special cause improvement at Trust and for Durham Tees Valley and Forensic Care Group however, there is no significant change in North Yorkshire and York Care Group. *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 AAR database on Inphase which the Care Groups have sight of. The position of overdue AARs is reported 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*.
- Planning is underway for the After Action Review process Quality Improvement workstream with Patient Safety and colleagues from AMH Planned Care services. A mapping event is scheduled for October followed by 2 full day workshops in November.



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is a reduction (not necessarily an improvement as indicated in the SPC chart) at Trust and Care Group level 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.

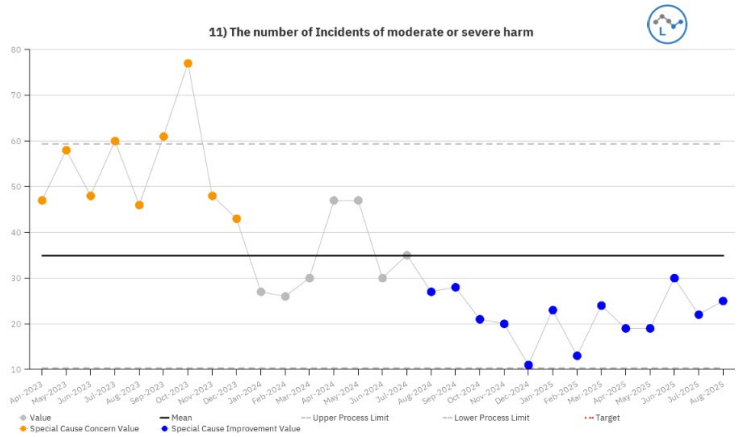
As incidents are reviewed, the severity could be reduced or increased (severity is usually reduced).

Underlying issues:
As at the 8th September 2025, there were 441 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 Patient Safety Quality Improvement project is underway to enable the development of a robust ward to Board incident management governance and oversight flow. The project is currently focused on incident reporting in MHSOP and CYP services, focusing on restrictive interventions and identifying when a self-harm event is a patient safety incident respectively. Decision making tools and guidance have been developed and shared with the teams that will be involved in the testing phase. Engagement sessions will run through August and September 2025.
- Planning is underway for the After Action Review process QI workstream with Patient Safety and colleagues from AMH Planned Care services. A mapping event is scheduled for October followed by 2 full day workshops in November 25.

DQ ✓✓ 87%



12) The number of Restrictive Intervention Used

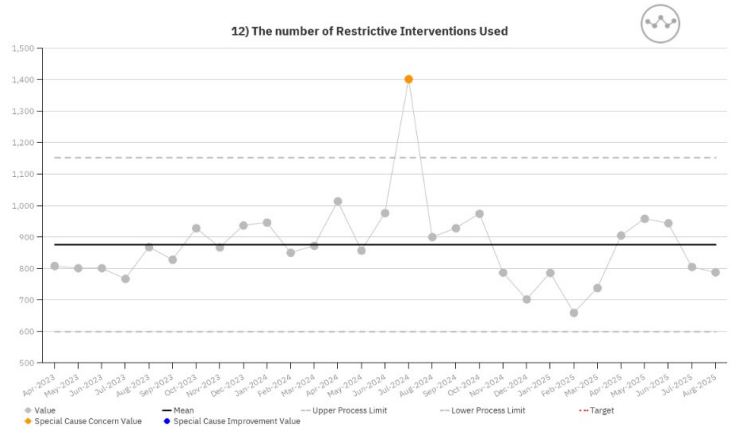
Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is no significant change at Trust and Care Group level in the reporting period. There is special cause improvement in Adult Mental Health in DTVFCG; however, there is special cause concern in Adult Learning Disabilities in North Yorkshire and York. The service have confirmed this is not an area of concern. Whilst there is no significant change within ALD in DTVFCG, there remain significant concerns (*see underlying issues below*).

Underlying issues:
- Concerns remain in DTVFCG ALD where there are a high number of interventions used for a small number of patients presenting with complex needs.
- In DTVFCG AMH services, there have been a small number of admissions of individuals with Autism which have led to an increased number of interventions being used on Cedar ward.

Actions:
- There are several actions ongoing in relation to DTVFCG ALD services:
    - Monitoring the use of restrictive interventions and seeking support from the Specialist Practitioner for Positive & Safe where appropriate.
    - CCTV reviews continue to be key in informing care planning and the aim to reduce restrictive practices and learning from best practice.
    - More targeted clinical supervision is being undertaken to support staff nurses to implement Positive Behaviour Support plans.
- DTVFCG AMH Cedar Ward are receiving additional support from the Specialist Practitioner for Positive & Safe with specific patients and the development of sustainable discharge support.
- Across the Trust, a rolling programme of Reducing Restrictive Intervention Panels have been established for those patients identified as needing specific support. Plans will be developed for each patient as needed. 1 patient from DTVFCG ALD has been through the panel and has extra support in place.



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

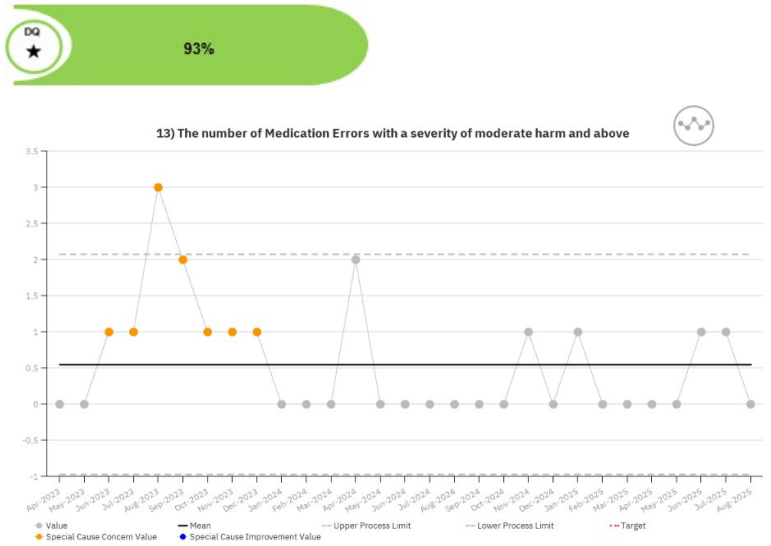
What does the chart show/context:
0 medication errors were recorded during August.

There is no significant change at Trust and Care Group level in the reporting period. Whilst there is special cause concern for Adult Mental Health, no issues have been identified. There is special cause improvement for Adult Learning Disabilities and Health and Justice in Durham, Tees Valley & Forensic Care Group and Mental Health Services for Older People in both Care Groups.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



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

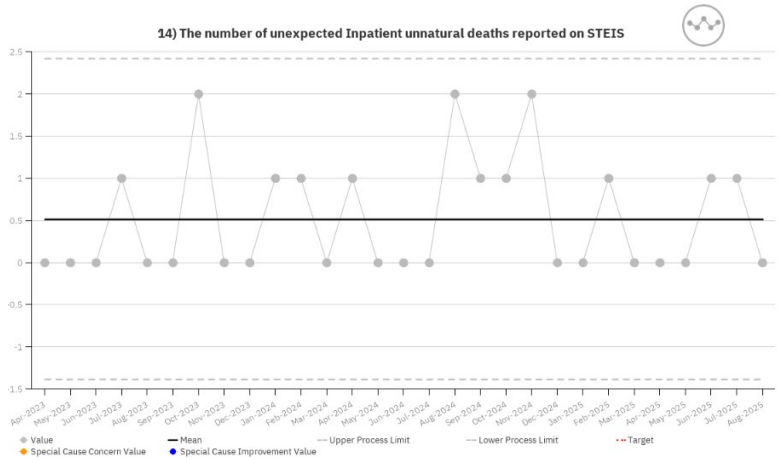
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
0 unexpected inpatient unnatural deaths were reported on the Strategic Executive Information System (STEIS) during August.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



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 **325** uses of the Mental Health Act during August.

There is no significant change at Trust and Care Group level in the reporting period.

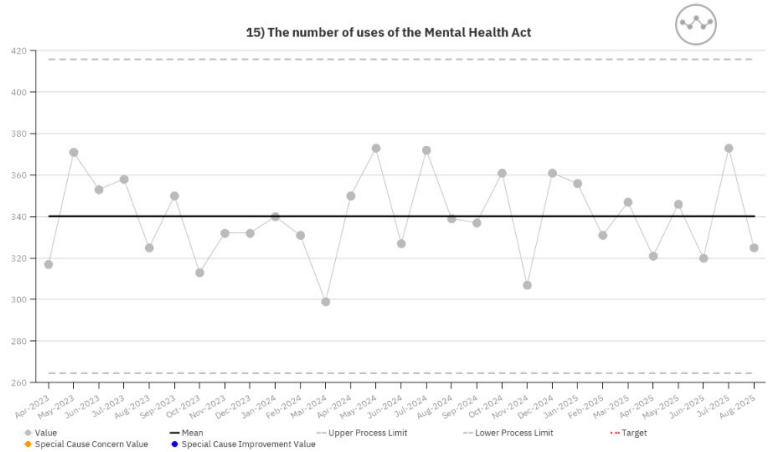
The latest national Mental Health Act data (2023/24) produced by NHS Digital has been analysed by Business Intelligence. Expected rates of detention by gender and ethnicity showed that Trust followed the same trend as the national rate of the higher the level of deprivation, the higher the rate of detention.

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.

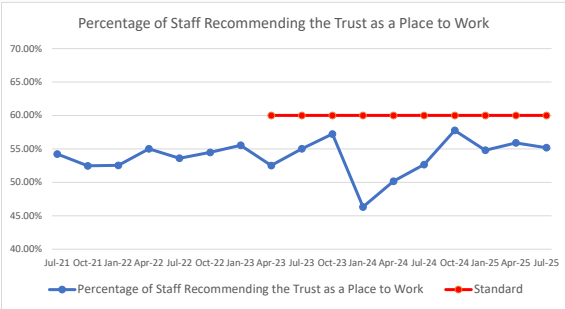
Underlying issues:
Analysis of the latest national Mental Health Act data (2023/24) shows some areas of inequality in our detention rates.

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. **(Complete)**
- Medical Director to meet with the Section Head of Research & Statistics, Clinical Outcomes and Business Analytics and the Consultant in Public Health by the end of October 2025 to agree the next steps.

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:
1370 staff responded to the July Pulse Survey. In relation to the question "I would recommend my organisation as a place to work", **756 (55.18%)** 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:
1370 staff responded to the July Pulse Survey. In relation to the question "I am able to make improvements happen in my area of work", **838 (61.17%)** 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 July Pulse Survey equates to approximately 16% of staff.

Actions:
The following two actions have not been completed and are no longer being progressed:

- 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 September (previously June) Trust Leadership Events.
- 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. **(Complete)**
- Whilst it was agreed at EDG in July that People & Culture would facilitate some trust-wide improvement work, two actions have been agreed which are to provide targeted support in those areas with low engagement.

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 **7292.29** staff in post, **707.22 (9.70%)** had left the Trust in the 12-month period ending August 2025.

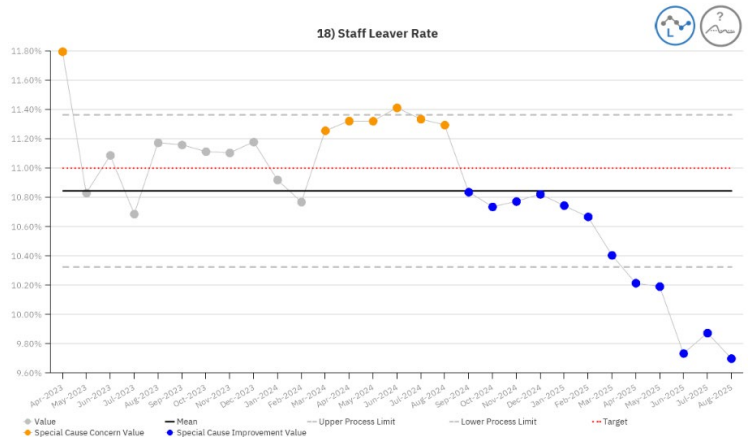
There is special cause improvement at Trust level and for a number of Directorates in the reporting period. However, there is special cause concern for Estates & Facilities Management, Therapies, Management in Durham Tees Valley & Forensic Care Group and Children & Young Peoples Services in North Yorkshire,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

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)

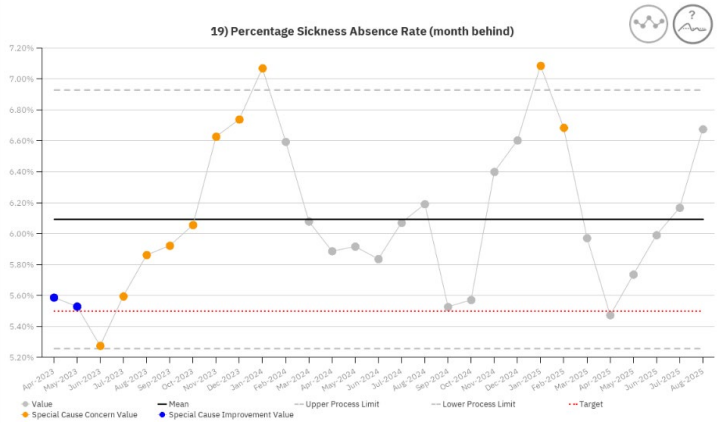
What does the chart show/context:
There were **234,403.79** working days available for all staff during August 2025 (reported month behind); of those, **15,646.24 (6.67%)** days were lost due to sickness.

There is no significant change at Trust and for most Directorates in the reporting period. There is special cause concern for Estates & Facilities Management, and Management within North Yorkshire, York & Selby Care Group; however, the directorates have confirmed there is no actual concern at this stage. There is also special cause concern in Adult Learning Disabilities within Durham, Tees Valley & Forensic Care Group.

National Benchmarking for NHS Sickness Absence Rates published 28th August 2025 (data ending April 2025) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.51**%** compared to the Trust mean of **6.03%**, with the Trust ranked 36 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.
- Whilst we have high levels of sickness within several areas, further work is required to understand the underlying issues and actions being taken.

Actions:
- A People Management Bitesize Training module has been developed to support Managers when working with staff through the procedure. Training will commence on the 4th September 2025. **(Complete)**
- A series of supporting actions were agreed at EDG People & Resources Meeting in September, which include reviewing absence management modules and considering new well-being, absence, grievance, and disciplinary policies.
- The Performance Team will review benchmarking data to identify our position relative to peers and will share findings with People & Culture to support discussions with other organisations to identify effective practices by the beginning of October 2025.
- The People Partners and Performance Leads will work with the areas with high sickness rates to identify the underlying issues and improvement actions with the aim to present these at the Quality & Performance EDG in October as part of a wider workforce deep dive.



20) Percentage compliance with ALL mandatory and statutory training

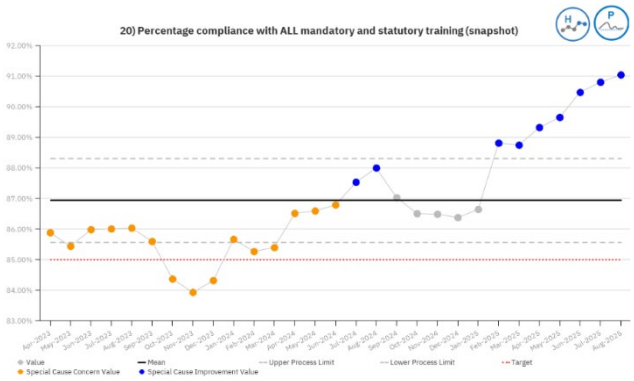
Background / standard description:
We are aiming for 85% compliance with mandatory and statutory training

What does the chart show/context:
160,346 training courses were due to be completed for all staff in post by the end of August. Of those, **145,984 (91.04%)** were completed.

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

As at the 31st August 2025, by exception compliance levels below 85% are as follows.

Directorate	Number compliant	Total Number	% Compliant
CHIEF EXECUTIVE OFFICE	87	105	82.86%



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 Temporary Staffing (bank staff) and the Chief Executive Office on the Electronic Staff Record.
- Inappropriate courses on Senior Nurse training matrix

Actions:
- Temporary Staffing Services Manager to oversee completion of outstanding bank staff training by the end of August 2025**. (Complete)**
- Temporary Staffing Services Manager to work with Workforce and Finance to ensure all staff allocated to Temporary Staffing (bank staff) are correct. This work will be completed by the end of September 2025.
- Strategic Lead Workforce Information and Resourcing Systems to work with Finance to ensure all staff allocated to the Chief Executive Office are correct. This work will be completed by the end of October 2025.
- 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).
- The Director of Nursing to meet with the Deputy Head of Workforce Development to discuss the removal of inappropriate training courses from Senior Nurse training matrices. Timescale to be confirmed.

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 **10** courses that are currently below the standard (previously **11** 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 August 2025 there has been an average of 43% wasted spaces (including 15% DNAs) across the mandatory face to face training courses.

Actions:
- Workforce Training to remove Autism Tier 2 mandatory training from all Care Group clerical staff. This will be complete by the end of September 25.
- Workforce Training to introduce some focused work, directly contacting staff that have not completed their e-learning competencies to increase compliance. The process will be in place by the end of August 2025. **(Complete)**
- The Training and Education Task Group have identified several actions that will support staff to complete mandatory training.
- People & Culture will support operational services to maintain oversight of wasted spaces, including DNAs, with specific focus on reducing late course cancellations.
- Executive Directors to review their areas with compliance below 80% and take steps to reduce the number of 'reds' by the end of October 2025, aiming for a measurable reduction rather than complete elimination due to the volume in some areas.

Course Name	Number Compliant	Total Number	% Compliant
Positive & Safe Care Level 1*	3316	4483	73.97%
Resuscitation - Level 1 - 1 Year*	1990	2634	75.55%
Rapid Tranquilisation 1**	235	310	75.81%
Positive and Safe Care Level 2 Update*	1316	1710	76.96%
Annual Medicines Optimisation Module**	1665	2090	79.67%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1660	2030	81.77%
Moving and Handling - Level 2 - 2 Years*	715	868	82.37%
Incident Management-Corporate	154	183	84.15%
Incident Management-Clinical	1547	1834	84.35%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	837	988	84.72%

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

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
Of the **6,960** eligible staff in post at the end of August; **6,960 (88.76%)** had an up-to-date appraisal.

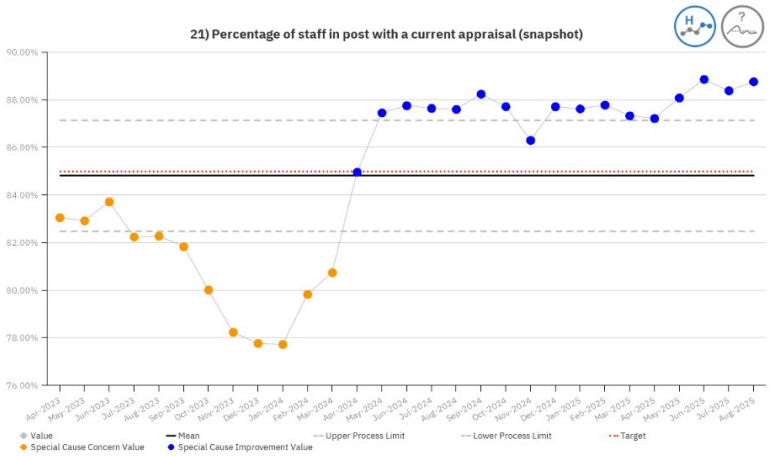
There is special cause improvement at Trust level and for a number of Directorates in the reporting period; there is no significant change in all other areas with the exception of Finance where there is special cause concern.

As at the 31st August 2025, by exception compliance levels below 85% are as follows:

Directorate	Number compliant	Total Number	% Compliant
FINANCE	37	54	68.52%
THERAPIES	32	38	84.21%

Underlying issues:
- Whilst there are no underlying issues to report, there are two directorates not achieving standard (as outlined above).
- There is a number of staff incorrectly allocated to the Chief Executive Office on the Electronic Staff Record.

Actions:
- Outstanding appraisals to be undertaken in Therapies by the end of October 2025.
- Outstanding appraisals to be undertaken in Finance by end of September 25
- Strategic Lead Workforce Information and Resourcing Systems to work with Finance to ensure all staff allocated to the Chief Executive Office are correct. This work will be completed by the end of October 2025.
- Outstanding appraisals to be undertaken in Chief Executive Office by end of September 2025 (previously June). **(Complete)**
- North Yorkshire & York Care Group Management and Children & Young People's Services 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 September 25 (previously August 25).
- Durham, Tees Valley and Forensic Care Group Management to ensure appraisals are booked and will be completed by the end of September 2025.
- The Managing Director in DTVFCG is working with finance and workforce to identify a solution to the staff who have been incorrectly coded to the Management line by the end of September 25



Actions continued:
- Organisational Development to implement an annual internal audit of appraisal paperwork from November 2025, to ensure good quality appraisals are delivered by Trust managers. Findings will be reported into Executive Directors Group.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

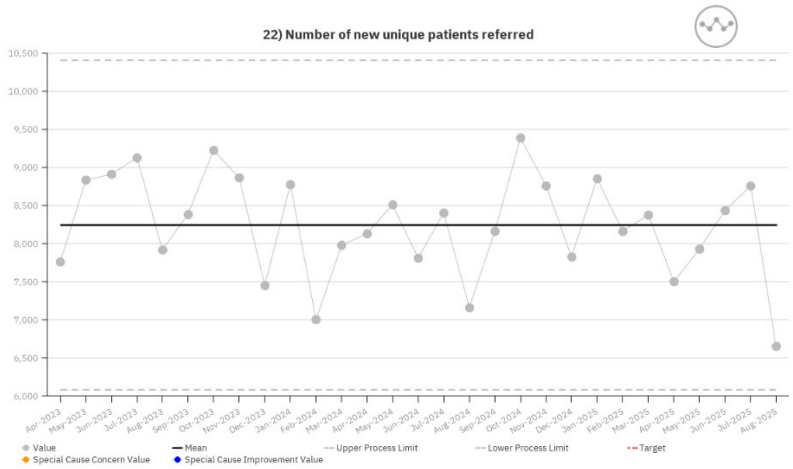
What does the chart show/context:
6,653 patients referred in August that are not currently open to an existing Trust service.

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 Children and Young People's services in both Care Groups and Health & Justice within Durham, Tees Valley & Forensic Care Group. There are high shifts for-Adult Mental Health in North Yorkshire, York & Selby Care Group. The Care Groups have confirmed there are no underlying issues.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

DQ 80%



23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

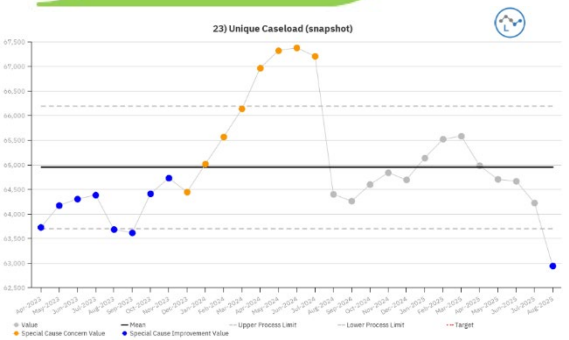
What does the chart show/context:
62,943 cases were open, including those waiting to be seen, as at the end of August 2025; **53,389** were active.

There is special cause improvement at Trust level and for both Care Groups in the reporting period. There is special cause concern for Children & Young Peoples Services in North Yorkshire and York Care Group. There is special cause improvement for Adult Mental Health and Adult Learning Disabilities in both Care Groups and for Mental Health Services for Older People in both Care Groups and in Children and Young People's Services in DTVFCG.

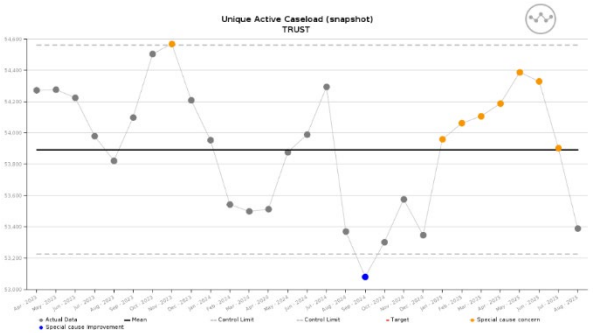
The **additional** SPC chart representing **Active Caseload** (excluding patients waiting for first contact) shows no significant change at Trust level, and for both care groups. There is special cause concern in Adult Mental Health within DTVFCG and in Children & Young Peoples Services within NYYSCG. There is special cause improvement in Adult Learning Disabilities, Children and Young People Services and Mental Health Services for Older People in DTVF There is special cause improvement in Adult learning Disabilities, Adult Mental Health and Mental Health Services for Older People in NYYSCG.

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:
- Section Head of Research & Statistics, Clinical Outcomes and Business Analytics shared options for a revised Active Caseload measure with the Associate Director of Performance in July 2025 and a preferred option has been identified. General Managers will be consulted on the proposal by the end of September 25 (previously August 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 31st August 2025 against which Trust performance is assessed is a deficit of **£1.74m which is £0.96m better than planned**. The Trust submitted a breakeven plan for 2025/26 which assumes delivery of challenging £27.41m Cash Releasing Efficiency Schemes (CRES).

- **Unfunded Pay Award:** Pay awards were paid for almost all groups of staff in August. Due to the way inflation is funded in national tariff uplifts, we will receive £1.9m (£0.8m YTD) less income than the additional costs (above plan) of the final pay award (costs above 2.8% nationally assumed at plan). NENC ICB have currently identified additional non recurrent support of £0.4m in 2025/26 to help mitigate this.

- **Agency expenditure** for the year to date is **£3.24m and is £0.08m below plan.** The trajectory for expenditure reductions rises during 2025/26 to deliver the nationally required 40% reduction in agency costs, meaning that delivery risk also increases. Plans will require the reduction, from an actual of 2.1% of paybill in April 2025, to just 0.84% of paybill in March 2026. Whilst costs reflect a broadly consistent downward trajectory over the last two financial years, a significant proportion of residual costs relates to medical agency with hard to recruit consultant posts. In-month costs were £0.44m and decreased by £0.18m compared to prior month and represented **1.21% of paybill**, which is **1.35 percentage points** lower than the 2024/25 average of 2.56%. Delivery of targeted reduction in costs remains an ongoing challenge, although the trust is ahead of plan at month 5, the trust must maintain the rigor and control embedded during the year to ensure performance continues 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. Medical Care Group colleagues are working on revised trajectories for medical agency staffing reductions, aiming to minimise exit run rates. The Trust has **no off-framework agency assignments**.

- **Independent sector beds** - the Trust used **31 non-Trust bed days in August** (21 in July) 2025. **Year to date costs were £88k**, including estimates for unvalidated periods of occupancy and average observation levels pending billing and were **£1k above 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 unprecedented average 2025/26 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 £0.43m behind plan, but with **recurrent schemes delivering £2.17m below plan**, and non-recurrent schemes delivering £1.74m higher than planned. Currently we are still expecting to deliver the full savings requirement through non recurrent mitigations, but the unmitigated forecast includes an in-year shortfall of £4.04m on recurrent schemes, currently supported by non recurrent mitigations. Actions to quantify recurrent full year effects of schemes where there has been year to date slippage, and to then identify new recurrent mitigations and schemes are progressing, with the Full Year Effect of recurrent schemes being forecast at £16.5m.

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 36% 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 the last year).

Actions:

- 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.
- 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

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Year to date agency costs of **£3.24m at Month 5 are £0.08m below 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 1.21% (↓) 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. The Trust faces an increasing challenge as it seeks to deliver a rising profile of planned reductions and recover overspending to date (current average costs of 1.77% paybill YTD).

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 185 worked Whole Time Equivalent (WTE) between April 2023 and August 2025** (falling from 240 to 55 WTE), and related annualised premia for price cap breaches reduced from £4.0m in April 2023 to £1.8m in August 2025 (£2.2m reduction). Whilst the trend for medical WTE and price cap breaches was broadly positive between April 2023 and August 2025, Medical Agency WTE's increased in April and May 2025, going against trend and impacting premia incurred, before reducing to its lowest level in the last year. 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.

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.

25b) Agency price cap compliance

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

1,001 agency shifts were worked in August 2025, with **641 shifts compliant** (64%) and **360 non-compliant** (36%) (prior month 809 shifts or 63% compliant and 473 or 37% non-compliant) **with national price caps, representing a decrease in overall shifts worked, and an improvement 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, 84% of non-compliant shifts (96% by value of breaches) were medical and 16% of non-compliant shifts (4% by value of breaches) were nursing.
- Of the nursing agency breaches, 100% of shifts related to prisons (100% by value of shifts).
- **Medical shifts breaching reduced by 86 shifts**, decreasing from 390 shifts in July to 304 in August 2025 (100% shifts breach price cap).

281 less overall agency shifts were worked this month compared to last, with shifts worked being equivalent to **approximately 32 shifts per day** (41 in July and 39 in June). The 281 shifts decrease included 86 less higher cost medical, 127 less nursing, and 68 less HCA agency shifts. If sustained this would have a favourable impact the cost per average WTE agency worker due to less medical premia rates.

This reflects **a reduction in total shifts worked of 1,039 (51%) over the last 12 months** from 2,040 shifts worked in August 2024 and **a reduction of 47% or 314 shifts breaching price cap since August 2024** (674 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 31st August 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 -0.79% which is a **rating of 3**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.43% 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 £3.2m are below plan by £85k and would therefore be **rated as a 1.** The Trust's year to date agency costs were 1.77% 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 31st August 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

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Recurrent CRES performance for the period ending 31st August was **£3.92m and £2.17m 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, key recurrent CRES plans included:

- **Pay schemes (£9.3m):** 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 (£7.4m):** Actions to eliminate Independent Sector bed reliance, reduce pressures from 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 (£1.54m YTD).

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 year.

Corporate actions have been put in place to support Care Groups in reducing overtime (£2.1m) and Agency (£4.4m), including restrictions on the use of agency and overtime through Healthroster, and creation of more staff banks. Additionally Care Groups have put controls in place to control use of agency and overtime. Further key planned dates for effecting stepped overtime reductions fall in October, following Executive Directors Group approval of related proposals. There is a risk that bank utilisation increases as other more costly temporary staffing options are restricted..

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

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
Non Recurrent CRES performance was ahead of plan by £1.74m for the period ending 31st August, with £4.92m 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 planned 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 in-year 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 £1.74m over achievement year to date on non-recurrent schemes includes, £0.55m reduction on PDC and Depreciation expenses, £0.08m additional income from out of area bed utilisation, £0.72 slippage on developments, £0.32m management of cash to achieve maximum interest, offset by under achievement of planned learning disability schemes £0.16m.

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 **£4.11m** at the end of August, which was £0.05m less than allocation.

£13.80m 2025/26 capital schemes were approved by the Trust from nationally delegated capital allocated via North East and North Cumbria Integrated Care Board (ICB) system arrangements however in line with the revised plan agreed in August 2025 the trust now has £14.47m of approved schemes following an agreed overspend against allocation with the ICB.

Of this, £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 original 2025/26 £13.80m capital programme.

The Trust was allocated a further £1.21m centrally cash backed PDC funding to support Solar panel installation, and £0.48m of PFI lifecycle works (not measured in capital allocation) giving a composite £13.80m capital allocation and £16.16m capital programme (including PFI).

Due to the risk around Roseberry park phase 2 capital works, the ICS colleagues have supported the Trust to spend £0.67m more than allocation. Spend on this scheme will be monitored throughout the year and feed back as appropriate to systems colleagues.

In August, Board accepted EDG's recommendation of a revised capital plan linked to the confirmation of phase 2 works expenditure in year, and inclusive of the £0.67m additional allocation mentioned above.

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)

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£51.65m** at the end of August 2025 which exceeded planned cash balances of **£44.04m** by **£7.61m,** reflecting a £4.60m higher than planned opening cash balance linked to higher than anticipated accrued expenditure, and income received in advance of the period it relates to.

- **Prompt Payment of Suppliers:** The Trust has achieved a combined Better Payment Practice Code (BPPC) compliance of **96.7%** 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 31st August 2025 was £2.4m, with **debts exceeding 90 days amounting to £0.76m** (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?

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%	92.62%
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%	78.99%
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%	88.23%
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%	87.02%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)	H	F	95%	95%	79.31%

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	L	?	42.0	42.6	35.58
Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48%	48%	47.14%
Talking Therapies - Reliable improvement rate for those completing a course of treatment		?	67%	67%	66.60%
Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months	H	N/A	N/A	N/A	1622
Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact		N/A	N/A	N/A	29772
Number of people accessing IPS services (rolling 12 month)	H	N/A	N/A	N/A	961

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. There is special cause concern for York. For the month of August there were 2 patients that did not receive treatment within the 4-week standard.
  - Urgent referrals - We have failed standard at Trust level and commissioned place level with the exception of Tees Valley. There is special cause concern for North Yorkshire and York. For the month of August there were 0 patients that did not receive treatment within the 1-week standard.

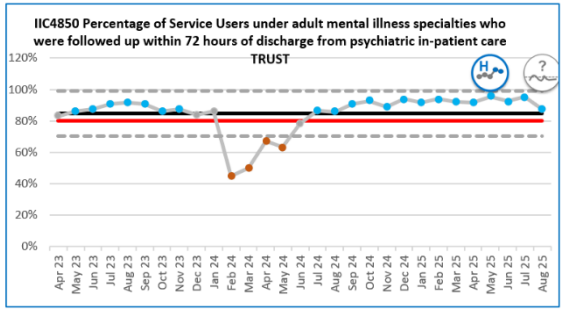
Mental Health Priorities

- **Active OAP (inappropriate):** Achieved Trust plan for August
- **Average Length of stay for Adult acute beds *(new measure)*:** Achieved Trust plan for August.
- **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*):** the plans for this measure link to funding agreed with the ICBs; however, not all funding has been released and recruitment, where it has been released, is in progress.

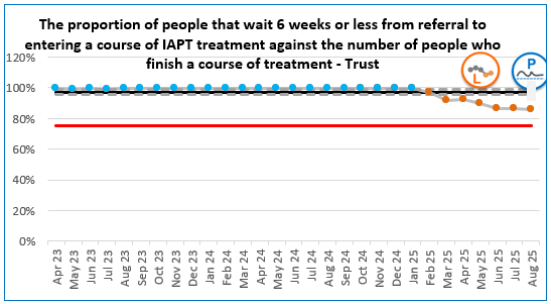
*All headlines are based on financial year to date unless otherwise stated.

National Quality Requirements

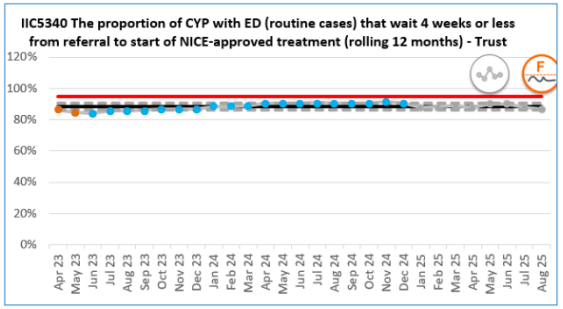
Tees, Esk and Wear Valleys NHS Foundation Trust



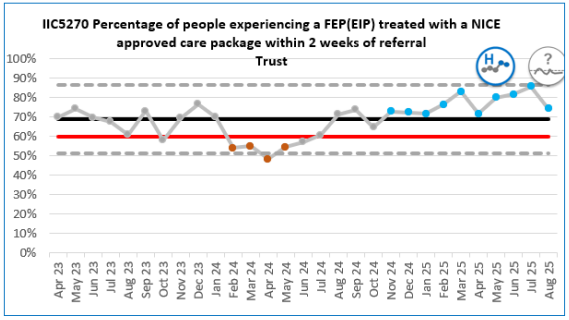
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	80%	92.62%			
County Durham	80%	93.01%			
Tees Valley	80%	92.38%			
North Yorkshire	80%	96.46%			
York	80%	90.15%			



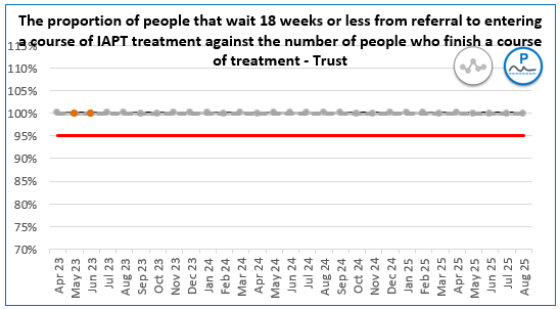
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	75%	88.23%			
County Durham	75%	78.68%			
Tees Valley	75%	78.86%			
North Yorkshire	75%	98.60%			
York	75%	95.35%			



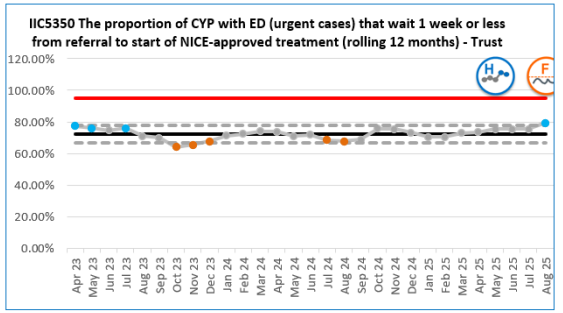
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	87.02%			
County Durham	95%	82.28%			
Tees Valley	95%	97.67%			
North Yorkshire	95%	81.67%			
York	95%	80.00%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	60%	78.99%			
County Durham	60%	73.56%			
Tees Valley	60%	78.36%			
North Yorkshire	60%	90.00%			
York	60%	71.88%			



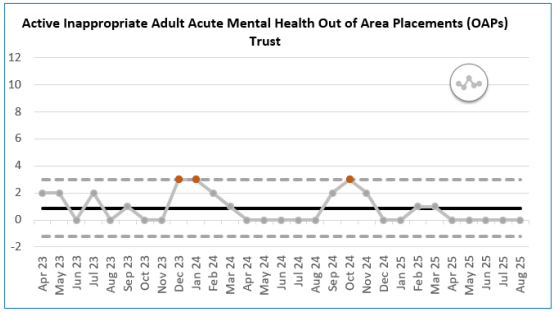
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	99.91%			
County Durham	95%	99.86%			
Tees Valley	95%	99.83%			
North Yorkshire	95%	99.96%			
York	95%	100.00%			



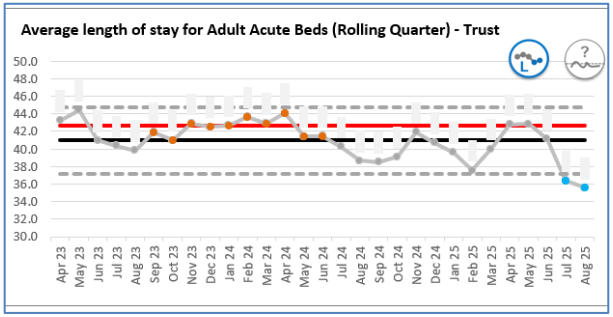
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	79.31%			
County Durham	95%	84.62%			
Tees Valley	95%	100.00%			
North Yorkshire	95%	66.67%			
York	95%	42.86%			

Mental Health Priorities

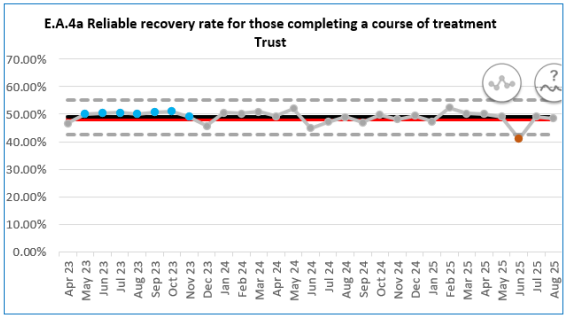
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



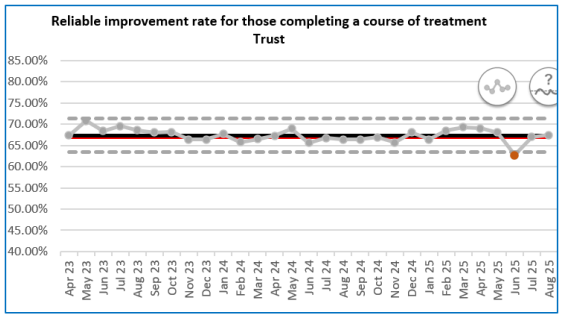
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	0	0			



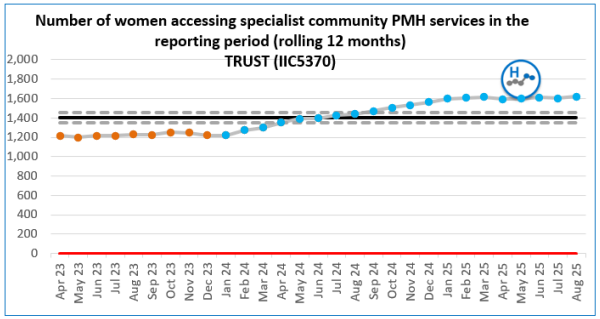
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	42.6	35.6			



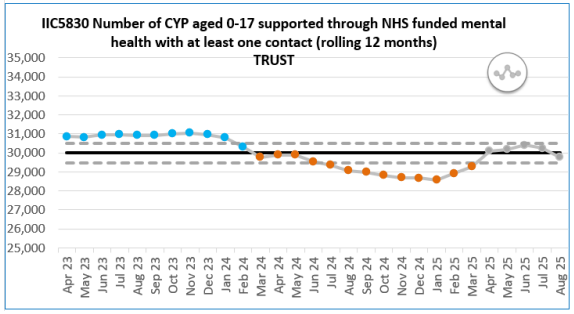
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	48%	47.14%			
County Durham	48%	43.54%			
Tees Valley	48%	46.24%			
North Yorkshire	48%	50.27%			
York	48%	49.66%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	67%	66.60%			
County Durham	67%	63.75%			
Tees Valley	67%	62.91%			
North Yorkshire	67%	69.08%			
York	67%	70.72%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	1622			
County Durham	456	525			
Tees Valley	447	514			
North Yorkshire	368	402			
York	156	155			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	29772			
County Durham		10529			
Tees Valley		11356			
North Yorkshire		4508			
York		2820			

Number of people accessing IPS services (rolling 12 months)

Organisation	Standard	Actual	ICB Actual	Plan Met
Trust	N/A	961		
County Durham	789	290	640	
Tees Valley		350		
North Yorkshire	347	182	308	
York		126		

Average length of stay for Adult Acute Beds

Tees, Esk and Wear Valleys NHS Foundation Trust

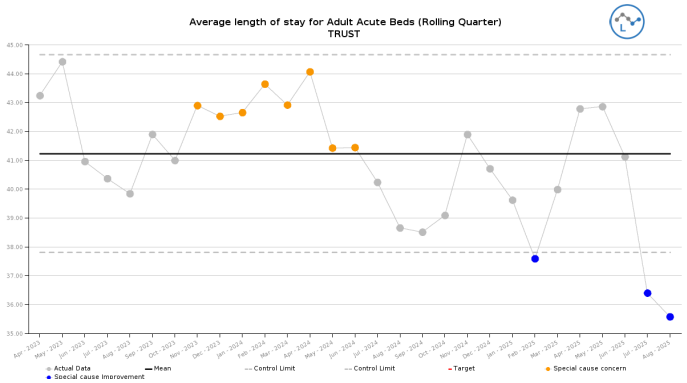
Background / standard description:
Whilst we are aiming to reduce our average length of stay within our adult acute inpatient beds to 42.0 days by the end of March 2026, by the end of September we are aiming to have an average length of stay of **42.6** days.

What does the chart show/context:
During the 3-month period ending August 2025, there were **763** discharged hospital spells from adult acute beds for patients aged 18+, accounting for a total of **27,147** bed days which equates to an average length of stay of **35.58** days.

There is special cause improvement at Trust level, for Durham, Tees Valley & Forensic Care Group and for Adult Mental Health within that Care Group; however, there is special cause concern for NYYSCG and for Adult Mental Health within that Care Group.

Underlying issues:
No concerns have been identified at this stage as long lengths of stay are largely impacted by the discharge of patients that are clinically ready for discharge; however, this remains under review.

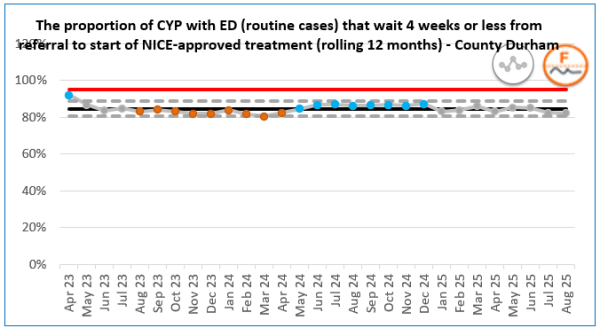
Actions:
There are no specific improvement actions required.



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	41.1	36.4	35.6							

The proportion of CYP with ED (routine cases) that wait 4 weeks, from referral to start of NICE-approved treatment (rolling 12 months) - *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



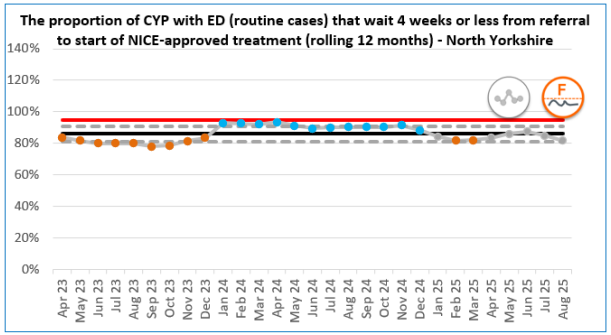
Background / standard description:
We are aiming to have 95% of suspected eating disorder cases for routine referrals seen within 4 weeks from referral to start of NICE approved treatment.

What does the chart show/context:
In the rolling 12 months ending August 2025, there were **79** children and young people with a routine referral, of which **65 (82.28%)** started treatment within 4 weeks in **County Durham**.

In August, there were **5** children and young people with a routine referral, of which **4 (80.00%)** started treatment within 4 weeks.

Underlying issues:
For the 1 patient that did not receive timely treatment: this was due to a breakdown in process. The patient commenced NICE treatment on day 45.

Actions:
There are no specific improvement actions required, the use of the huddle board has been reiterated and learning share to prevent reoccurrence.



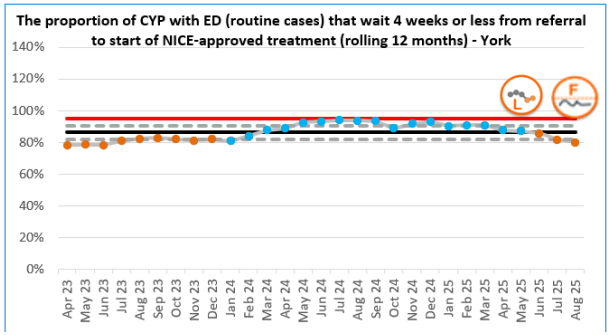
Background / standard description:
We are aiming to have 95% of suspected eating disorder cases for routine referrals seen within 4 weeks from referral to start of NICE approved treatment.

What does the chart show/context:
In the rolling 12 months ending August 2025, there were **60** children and young people with a routine referral, of which **49 (81.67%)** started treatment within 4 weeks in **North Yorkshire**.

In August, there was **1** child and young person with a routine referral, of which **0 (0.00%)** started treatment within 4 weeks. This was as a result of patient choice.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



Background / standard description:
We are aiming to have 95% of suspected eating disorder cases for routine referrals seen within 4 weeks from referral to start of NICE approved treatment.

What does the chart show/context:
In the rolling 12 months ending August 2025, there were **28** children and young people with a routine referral, of which **35 (80.00%)** started treatment within 4 weeks in **York**.

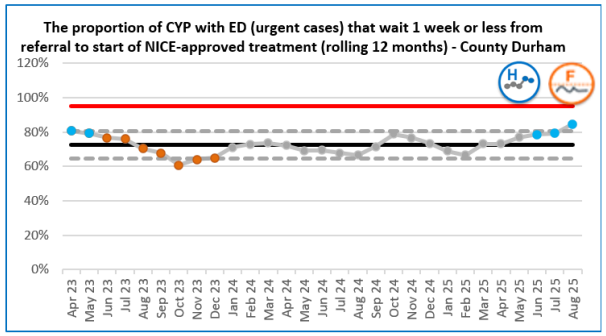
In August, there were **4** children and young people with a routine referral, of which **3 (75.00%)** started treatment within 4 weeks. This was as a result of patient choice.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months) - *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



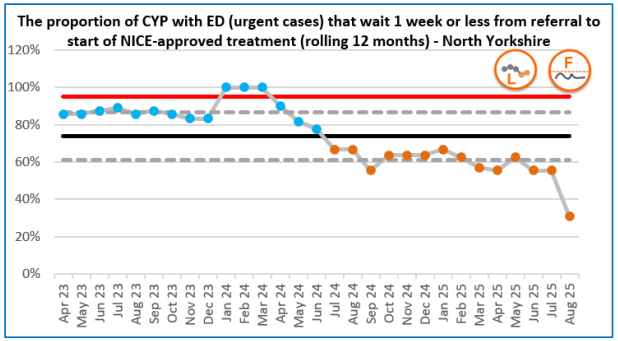
Background / standard description:
We are aiming to have 95% of suspected eating disorder cases for routine referrals seen within 4 weeks from referral to start of NICE approved treatment.

What does the chart show/context:
In the rolling 12 months ending August 2025, there were **26** children and young people with a routine referral, of which **22 (84.62%)** started treatment within 4 weeks in **County Durham**.

In August, there has been no urgent referrals.

Underlying issues:
There are no underlying issues to report.

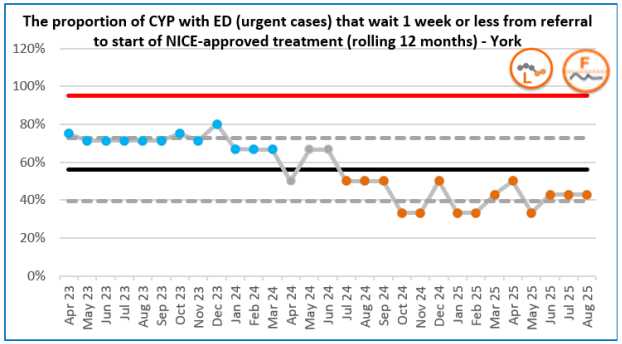
Actions:
There are no specific improvement actions required.



Background / standard description:
We are aiming to have 95% of suspected eating disorder cases for urgent referrals seen within 1 week from referral to start of NICE approved treatment.

What does the chart show/context:
In the rolling 12 months ending August, there were **12** child or young people with an urgent referral, of which **8 (30.77%)** started treatment within 1 week in **North Yorkshire**.

In August, there was **3** child/young people with an urgent referral, of which **3 (100.00%)** started treatment within 1 week.



Background / standard description:
We are aiming to have 95% of suspected eating disorder cases for urgent referrals seen within 1 week from referral to start of NICE approved treatment.

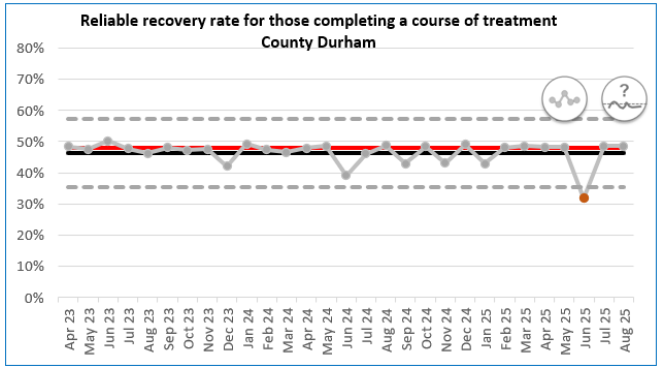
What does the chart show/context:
In the rolling 12 months ending August, there were **7** child or young people with an urgent referral, of which **3 (42.86%)** started treatment within 1 week in **York**.

In August, there has been no urgent referrals.

Update:
In July, there were 2 patients in NYY that did not receive treatment within the standard due to a breakdown in process. The General Manager ensured that with immediate effect the administration processes within the team were robust and all urgent referrals were prioritised.

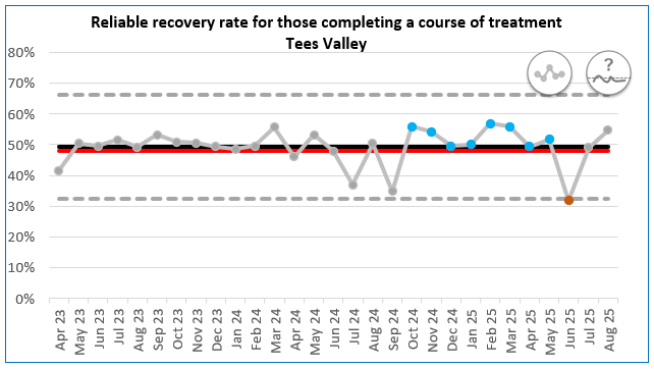
Talking Therapies: Reliable recovery rate for those completing a course of treatment – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



Background / standard description:
We are aiming for 48% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:
Whilst the financial year to date position is 43.54%, during August, **48.63%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**.



Background / standard description:
We are aiming for 48% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:
Whilst the financial year to date position is 46.24%, During August, **54.65%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**.

Underlying issues:

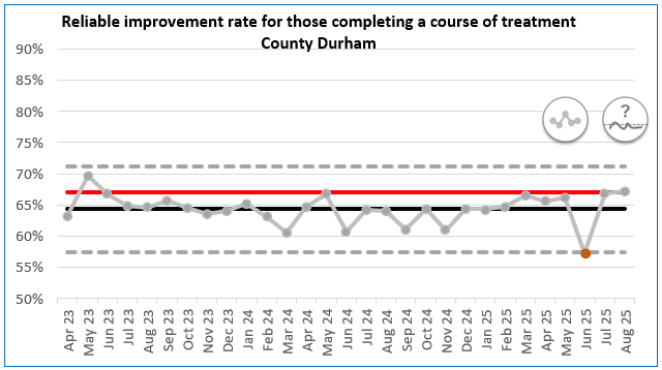
- Increase in complexity and severity of patient's presentation, which makes it more challenging to see a 6-point (Patient health questionnaire - PHQ9) or a 4-point (Generalised anxiety disorder - GAD) shift.

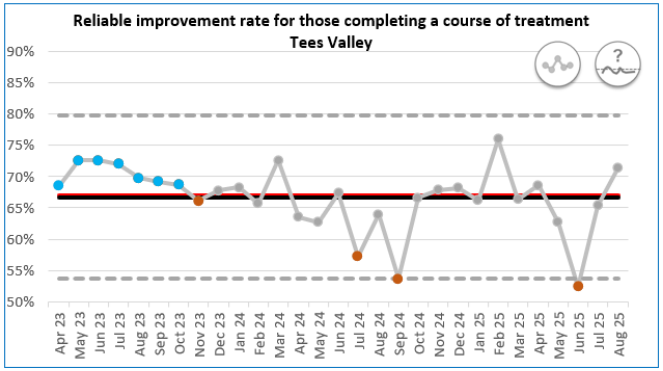
Actions:

- The Trust-wide action plan will be monitored through the Trust-wide Talking Therapies Group was relaunched in July and the first quarterly update was presented to Care Group and Executive Directors Group in August. **(Complete)**
- The trust wide action plan includes 14 improvement actions, all of which should be completed by December 25. One action has been delayed until November (from September). All other actions are on track.
- 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. **(Complete)** Maternity backfill has been agreed.
- The service have been allocated two trainee PWPs through Autumn Statement monies and will commence in post January 2026.
- The Service Manager has developed two Quality Impact Assessments focusing on the proposals for review of subcontracting arrangements for consideration by the Care Group Board in September.

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:
Whilst the financial year to date position is 63.75%, during August, **67.16%** 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:
Whilst the financial year to date position is 62.91% during August, **71.43%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**.

Underlying issues:

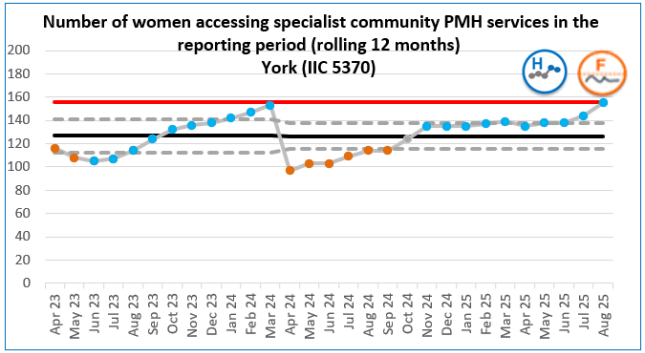
- High levels of complex patients are seeing a reliable improvement on two outcome measures (Patient health questionnaire - PHQ9 and Generalised anxiety disorder - GAD7); however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the 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 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 was relaunched in July and the first quarterly update was presented to Care Group and Executive Directors Group in August. **(Complete)**
- The trust wide action plan includes 14 improvement actions, all of which should be completed by December 25. One action has been delayed until November (from September). All other actions are on track.
- 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. **(Complete)** Maternity backfill has been agreed.

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 August 2025 there were **155** women accessing a specialist community Perinatal Mental health services in **York**.

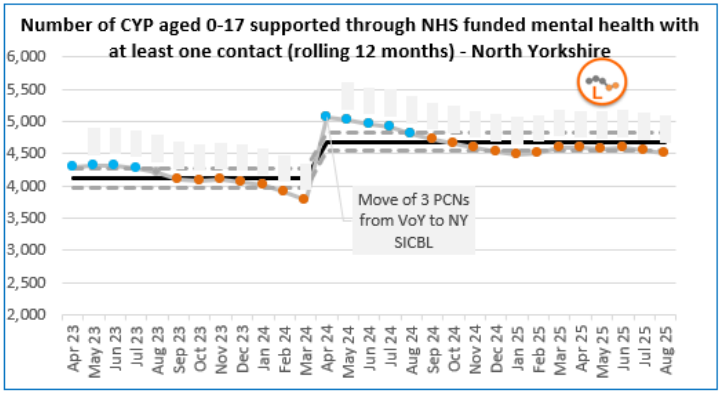
There is special cause improvement as indicated in the SPC chart above.

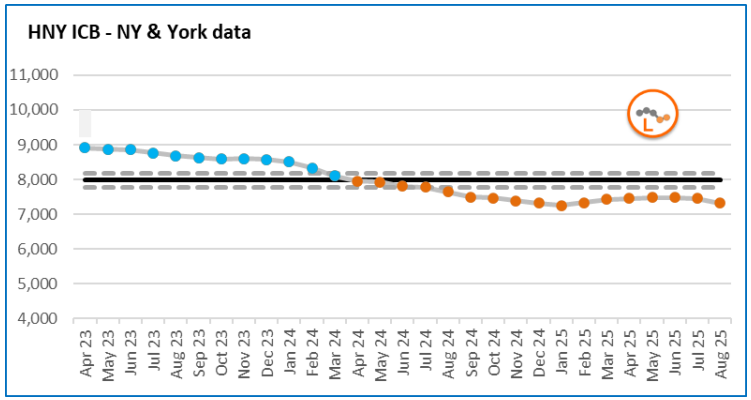
Underlying issues:
- Capacity issues within the Perinatal services, linked to sickness, vacancies, maternity leave and staff on formal support processes.
- Changes made to the assessment criteria in the recent RPIW has led to an increase in the caseload, however staff capacity cannot meet this demand

Actions:
- The Perinatal teams are currently being supported through a service recovery plan in line with business continuity processes. Two new vacancies have now been recruited, and maternity leave cover is being progressed through the recruitment process, remaining interviews are planned during September 25.
- An options appraisal paper was presented to EDG in July 25. A preferred option has been identified pending a quality impact assessment and in the interim, operational support from wider Trust services is being explored. *(See below action*)
- DTVFCG are providing interim operational support to the York and Scarborough, Whitby & Ryedale teams and additional clinical support is being provided from the wider multidisciplinary teams and EIP service.
- 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.

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 August 2025 **4,508** 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. For patients who receive multiple referrals within a 12-month period, there is an additional risk that they won't be counted if the required contact does not occur during their initial referral.

Actions:
- A joint meeting of both care group CYP representatives will be held by the end of September to discuss the findings of the analysis undertaken by Business Intelligence (Complete). See new action below
- A QI event will be held to review the clinical processes and recording of key data across all Neuro services to ensure consistency, which was supported by Quality & Performance EDG in September.

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		2472	836	615	344	492	130	39	15	0	1	10	240
Adults with a learning disability Waiting for an Assessment		60	34	18	3	4	1	0	0	0	0	5	31
Adults in Health and Justice services Waiting for an Assessment		39	23	14	2	0	0	0	0	0	0	4	12*
Children and Young People Waiting for an Assessment		730	293	233	88	59	31	7	14	5	0	10	151*
Children and Young People Waiting for Treatment (excluding Neuro)		1773	74	193	267	452	236	142	205	85	119	43	296
Older People Waiting for Assessment		2622	749	654	397	514	281	25	2	0	0	11	82*

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		4777	77	95	82	391	307	326	1222	1354	923	100	350
Children and young people waiting for an Autism Assessment		5432	38	112	135	325	481	441	2452	1307	141	80	219*
Adults waiting for an Autism Assessment		4083	73	67	61	346	180	170	983	1230	973	109	381*
Children and young people waiting for an ADHD Assessment		4779	77	174	192	557	488	453	1579	895	364	70	215
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2172	33	74	49	115	130	198	472	895	206	95	203

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)		64	25	19	16	1	0	0	3	5	120*
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		0	0	0	0	0	0	0	0	0	0
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		28	8	5	9	1	3	2	0	3	10*

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		4291	731	598	1498	529	543	392	12	56

NOTE: *an asterisk denotes a data quality issue*

Waiting Times Headlines

NHS
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 **240 weeks** in DTVFCG. The majority (97%) 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 **31 weeks** in NYYSCG. The majority (92%) of adults are waiting less than 3 months for an assessment.
- **H&J** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our genuine longest wait time is **10 weeks** in DTVFCG. The majority (59%) (73%) of adults are waiting less than 1 month for an assessment.
- **CYP** There is no significant change in the number waiting for an assessment. Our longest wait time is currently **133 weeks** in DTVFCG. The majority (72%) 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 **296 weeks** in DTVFCG. The majority (69%) of children and young people are waiting between 1 and 9 months for treatment.
- **MHSOP** There is special cause concern in the numbers waiting for an assessment. Our longest wait time is currently **55 weeks** in NYYSCG. The majority (99%) of older adults are waiting less than 9 months for an assessment.

Waiting Times Neuro Services

- **AMH ADHD** There is special cause improvement (a reduction) in the number of waiting for an ADHD assessment. Our longest genuine wait time is **350 weeks** (6.7 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 **284 weeks** (5.4 years) in DTVFCG. The majority (78%) of adults are waiting over 1 year for an assessment.
- **CYP Autism** There is special cause improvement in the numbers waiting for an autism assessment. Our longest wait time is **218 weeks** (4.1 years) in DTVFCG. The majority (71%) 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 **215 weeks (**4 years) in DTVFCG. The majority (59%) 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 **203 weeks** (3.8 years) in DTVFCG. The majority (42%) of children and young people are waiting between 2-3 years for an assessment.

National Waiting Times

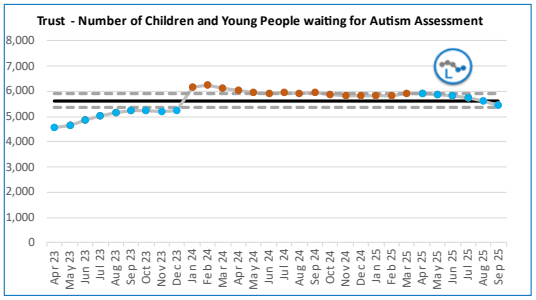
- **EIP** There is special cause improvement (a reduction) in the number of waiting for EIP Treatment. Our longest wait time is currently **7 weeks** in DTVFCG. The majority (69%) of adults are waiting less than 2 weeks for treatment
- **CED Urgent** There is no significant change in the number waiting 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 **7 weeks** in DTVFCG. The majority (**78%)** of children and young people are waiting less than 4 weeks for treatment.

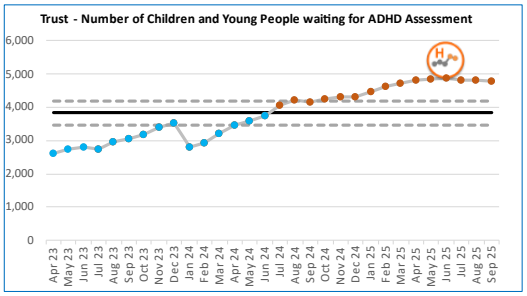
Waiting Times Talking Therapies

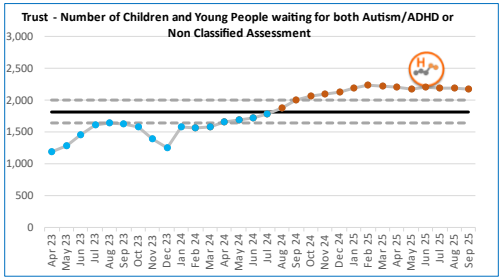
- There is no significant change in the number of adults waiting for their second contact with Talking Therapies. Our longest wait time is currently 55 **weeks** in DTVFCG. The majority (74%) of adults are waiting between 4 and 28 weeks for their second appointment.

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	5432	80	219	
DTVF Care Group	4485	86	219	
NYY&S Care Group	947	51	133	

Commentary on Longest waits

DTVF: Data Quality - Specialist Assessment Commenced (longest genuine wait - 1529 days - specialist assessment booked)
NYY&S: Data Quality - Specialist Assessment Commenced (longest genuine wait - 929 days - specialist assessment booked)

Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4779	70	215	
DTVF Care Group	4066	73	215	
NYY&S Care Group	713	51	157	

Commentary on Longest waits

DTVF: Genuine Waiter - Specialist Assessment Booked.
NYY&S: Data Quality - Specialist Assessment Commenced (longest genuine wait - 952 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	2172	95	203	
DTVF Care Group	1572	117	203	
NYY&S Care Group	600	37	126	

Commentary on Longest waits

DTVF: Genuine wait - Specialist Assessment Required
NYY&S: Data Quality - Specialist Assessment Commenced (longest genuine wait - 812 days - specialist assessment required.

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 Scarborough ADHD teams
- Long wait times and projected waiting times for children on the under 5s pathway (South Durham)

Actions (Partnership-wide):

- Recommendations from regional clinical model and prioritisation events in July aimed at developing short and medium actions to reduce demand and improve access will be presented to ICB in September.
- As part of the Valuing Neuro Diversity work, the ICB are leading a piece of work to review the under 5 pathway (multiagency partnership) with an aim to improve waiting times and identify efficiencies. Timescales are to be confirmed.
- A paper was presented and approved at the HNY MHLDA Collaborative Executive in August, which recommended a re-design of autism and ADHD services within existing resources so that service provision is tiered, supporting early identification, specialist input across all tiers, and timely access to focussed specialist interventions/input. The level of intervention is to be determined through a Humber & North Yorkshire-wide clinical policy, based on functional impact. Whilst it is unlikely that the new model will have a material impact on waiting lists, it is anticipated that there will be some positive result on waiting times/numbers.

Waiting Times Neuro Services: Children & Young People

Tees, Esk and Wear Valleys NHS Foundation Trust

Actions (Trust):

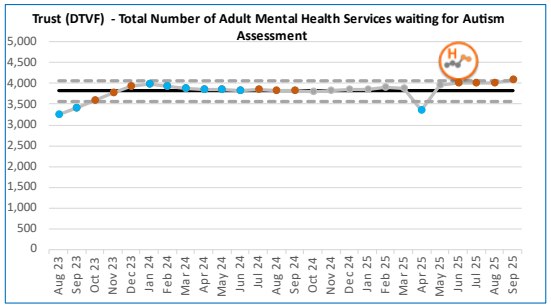
- DTVFCG have a recovery plan in place with Phase 2 testing on dual assessments continuing in Darlington locality. The full evaluation of the clinical protocol is on track for completion at the end of October (previously April, then June 25). All actions within the recovery plan are progressing, while demand currently continues to outweigh capacity, the service continues to deliver favourably against its commissioned levels of activity.
- An Away Day has been planned for 10th September to look at standardising the ADHD pathway in Tees.
- A report with recommendations for York and Selby teams to manage their neurodiversity assessment waiters has been completed and was shared with the Specialty Improvement Group (SIG) in July. The team is working through actions to ensure no further efficiencies can be made prior to a final paper being shared with SIG and subsequently Care Group Board in November 2025.
- The Scarborough ADHD team has a recovery plan in place. The service has recruited to all vacant posts, and they are working to ensure that they are using their existing resources efficiently and effectively. The identification of any remaining efficiencies has been further delayed and will now be shared through governance meetings by end of October 2025 (previously July, then September). Whilst some improvement can be made, the demand outstrips the capacity of the service.

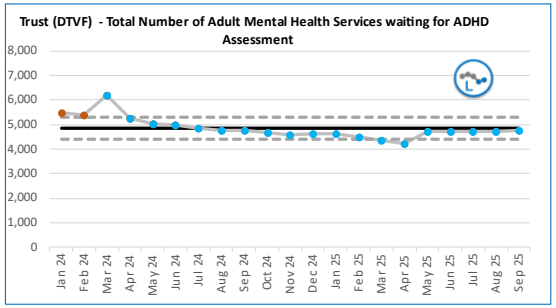
To Note: The trajectory submitted to NENC ICB, factoring in the additional assessments, remains on track for delivery.

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 mon		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**	**10339**	**10123**							
Change		**99**	**10**	**-43**	**10**	**-149**	**-138**	**-216**							

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)	4083	109	381	

Commentary on Longest waits

DTVF: Data Quality - Assessment Complete (longest genuine wait - 1989 days - specialist assessment required)

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
)TVF Care Group)	4777	100	350	

Commentary on Longest waits

DTVF: Genuine Wait - Assessment Required

Underlying issues:

Delivery of the trajectory has been impacted by several factors:

- High levels of demand outweighing commissioned capacity
- There are a small number of patients that have been transferred to the new Neuro teams with an incorrect referral action.
- CITO issues in relation to referrals
- The recruitment of 4 additional staff to undertake extra assessments is not complete.
- A number of additional patients have been identified from the waiting lists that should have been included in the original cohort of patients when setting the trajectories.

Actions (Partnership-wide):

- 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. (**Complete)**
- Recommendations from regional clinical model and prioritisation events in July aimed at developing short and medium actions to reduce demand and improve access will be presented to ICB in September.

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. (Partially Complete) Initial findings have indicated that a number of additional patients should have been included in the original cohort of patients to be transferred but were not, due to data quality issues. Further work is being undertaken with support from Business Intelligence to confirm this and this will be complete by the end of September 25.
- Of the 4 additional posts funded to support the provision of increased assessments 2 have been recruited and are progressing through induction processes; the appointment to the final 2 posts is in train. The anticipated additional assessments will be provided from the end of November.
- General Manager to identify improvements within community services to increase assessments from September 2025. This will include a specific trajectory for community teams to deliver which will be monitored through governance processes. **(Complete).**

Waiting Times Neuro Services: Adult Services

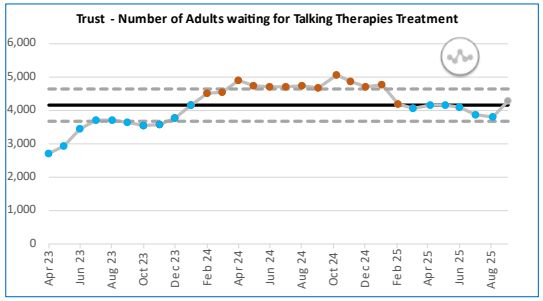
Tees, Esk and Wear Valleys NHS Foundation Trust

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 mon		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**	**4731**	**4777**							
Change		**-117**	**-143**	**475**	**24**	**-2**	**-2**	**46**							

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	4291	12	56	
DTVF Care Group	2279	11	56	
NYY&S Care Group	2012	14	52	

Commentary on Longest waits

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

Underlying issues (DTVFCG):

- Capacity of Psychological Wellbeing Practitioner (PWP) (high levels of step 2 vacancies/absence/sickness)
- High levels of people accessing Step 3 care, bypassing Step 2 appropriately
- 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)

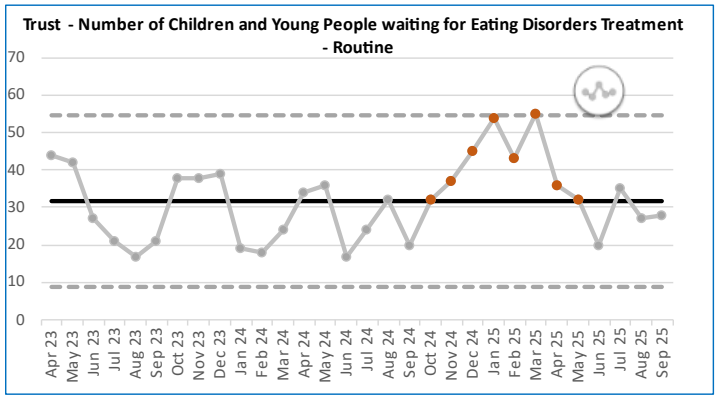
- The Trust-wide action plan will be monitored through the Trust-wide Talking Therapies Group was relaunched in July and the first quarterly update was presented to Care Group and Executive Directors Group in August. **(Complete)**
- The trust wide action plan includes 14 improvement actions, all of which should be completed by December 25. One action has been delayed until November (from September). All other actions are on track.

Actions (NYYSCG)

- One individual has now commenced in post; however, further recruitment is currently on hold pending the qualification of the current PWP cohort.

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	28	3	10	
DTVF Care Group	20	3	10	
NYY&S Care Group	8	4	8	

DTVF: Data Quality - Treatment not suitable for patient's presentation (longest genuine wait - 47 days - treatment not yet commenced
NYY&S: Genuine Wait - Treatment appointment booked.

Summary:
There are 6 children and young people **reported** as waiting more than 4 weeks; **2** of these are genuine waiters:

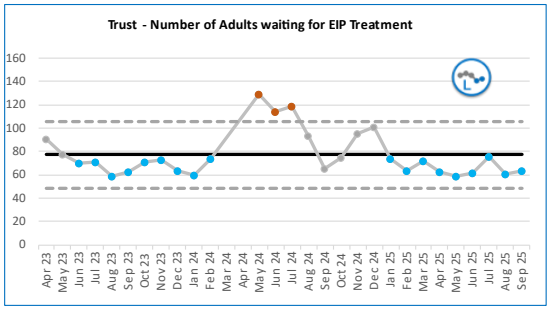
- 1 patient (8 weeks) has an appointment in September (outside 4 weeks at family request due to being on holiday).
- 1 patient (6 weeks) was not brought to an appointment (within 4 weeks). An appointment is booked in September.

Of the remaining 4 patients:
- 2 patients has been assessed (within 4 weeks) and services are not suitable for their needs; they are in the process of being discharged from the services.
- 1 patient has been assessed (outside 4 weeks due to failed appointments) and has since told the service they no longer wish to commence treatment. They are now in process of being discharged from the service.
- 1 patient has been assessed (outside 4 weeks due to failed attendance) and the service is not suitable for their needs; they are in the process of being referred to generic CAMHS and neuro following reasonable adjustments being made.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

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



Adults Waiting for EIP Treatment - 2 week standard

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	64	5	120	
DTVF Care Group	44	5	120	
NYY&S Care Group	20	5	66	

Commentary on Longest waits

DTVF: Data Quality - Incorrect Referral Reason. (Longest genuine Wait - 50 days - Treatment appointment booked).
NYY&S: Data Quality - Incorrect Referral Reason. (Longest genuine Wait - 22 days - Treatment appointment booked). .

Summary:
There are **20** adults **reported** as waiting more than 2 weeks of which **13** are genuine waits:

- **9** patients failed to attend appointments that were offered within 2 weeks. New appointments are now booked during September.
- **2** patients requested appointments outside of the 2 weeks due to other commitments
- **1** patient cancelled an appointment (outside of 2 weeks due to team capacity), a new appointment is now booked.
- 1 patient has an appointment booked outside of 2 weeks due to requiring a joint assessment with another service.

Of the remaining **7** patients:
- **1** patient has been assessed however EIP treatment is not appropriate. The service are in the process of discharging this patient.
- **6** are attributable to data quality; 4 have been subsequently resolved and calls are logged with Digital & Data Services to resolve the remaining issues on Cito.

Underlying issues:
- Failed Appointments
- Data Quality

Actions:
There are no specific improvement actions required.

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9th October 2025**
Title:	**NHS Oversight Framework Quarter 1 2025/26**
Executive Sponsor(s):	**Kathryn Ellis, Interim Executive Director of Transformation & Strategy**
Report Author(s):	**Sarah Theobald, Associate Director 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 .
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:

This paper aims to provide the Board of Directors with an overview of the quarter 1 published data, oversight of current performance, where available, including actions being taken to improve performance in the required areas and our plans for future reporting.

Proposal:

Executive Directors Group are proposing that the Board of Directors receives this report with **good** assurance of the Trust's current segmentation, but with **reasonable** assurance that this can be maintained.

Overview:

Background

The NHS Oversight Framework (NOF) describes a consistent and transparent approach to assessing NHS providers in 2025/26. For this transitional year, each provider will be scored against a focused set of metrics that target the priorities set out in the 2025/26 NHS priorities and operational planning guidance and allocated to a segment based on their performance against these metrics.

At the beginning of September 2025, NHSE published the first NOF assessment for all NHS providers. Two dashboards have been released for scrutiny and oversight; one for NHS systems and one for the public. Whilst the data contained within each dashboard is the same, there is different functionality and presentation; both have been used for the purposes of this report.

Under the Framework, the Trust is allocated a segment, which indicates its level of delivery from 1 (high performing) to 4 (poorly performing) with an additional segment 5 to indicate the most intensive support requirement. The segment indicates the degree of support and improvement that is required, and guides where formal intervention may be required. There are 6 domains within the Framework, 5 of which are scored during 2025/26. Each domain comprises a set of measures (scored and contextual). The aggregation of the measure scores informs the domain scores, the aggregation of which then inform the overall segmentation.

Each measure is placed into a quartile. The upper quartile for a metric is the value that separates the top 25% of data from the bottom 25% when the data is arranged from the lowest to highest value; the lower quartile is the value that separates the bottom 25% of data from the top 75%. It is important to note when looking at the quartile in which a measure appears, that for some measures (eg sickness) a low value is good, whereas in others a low value is bad (eg, staff engagement). Only 11 measures have been released as part of the initial release. NHS England have advised they have started to work on the contextual data and expect this to be released during September.

The dashboards also provide a recommended peer list for benchmarking purposes, based on the trusts most similar, in terms of factors that determine your productivity (cost per Weighted Activity Unit (WAU). In addition, a "range of ranking" is applied, which represents the range an organisation's rank could fall in, with 95% certainty, depending on the combination of metrics included. If a trust performs consistently well or consistently poorly across a lot of different metrics, its range will be narrow. If a trust does well on some things and poorly on others, it's range will be wider, showing more uncertainty about where it truly stands.

Our Performance (Q1 25/26)

The report at Appendix A, provides details of our Q1 25/26 position. The Trust is currently placed within **segment 2** (*the organisation has **good performance** across most domains - Specific issues exist*) and ranked 24th out of 61 non-acute Trusts.

The Trust's current range of ranking is **3 – 52**, representing a higher degree of uncertainty of future ranking as we are performing well on some measures and less well on others.

Out of the 5 domains within the NHS Oversight Framework:

- 2 have a NOF score of 1 (Effectiveness & Experience of Care and Finance & Productivity)
- 1 has a NOF score of 2 (Patient Safety)
- 2 have a NOF score of 4 (Access to Services and People & Workforce)

The measures of most concern, where we need to drive improvements are within those domains scoring 4:

- Annual percentage change in the number of children and young people accessing NHS funded mental health services
- Staff survey engagement theme score
- Staff sickness rate

Our published performance and segmentation were discussed at the Board Seminar in September; with our leaders in the quarterly Leadership events that took place late September and in detail at the Quality and Performance Executive Directors Group in September. In addition, our Communications Team have sent out information on our published performance across our social media platform and through our internal bulletin.

Oversight and Next Steps

To maintain oversight of performance including actions being undertaken, we will provide a formal update report each quarter, in line with the NHS Oversight Framework publication, supplemented by monthly monitoring where appropriate within the Board IPR. We will also incorporate the measures, where appropriate, at all levels, within the existing Integrated Performance Dashboards so there is floor to board oversight.

Several measures already feature in our Board IPR and a small number of these are already subject to improvement work as outlined in the attached report. As part of our IPR improvement we will look to consolidate and report progress as effectively as possible. Work is planned during October, to review all measures individually, both within our peer group; but also more widely in identify higher performing organisations that we can contact as part of our improvement work.

Prior Consideration and Feedback:

This report has been compiled in consultation with relevant service leads and discussed in detail at the Quality and Performance Executive Directors Group in September.

Implications:

The NHS Oversight Framework forms a fundamental component of our Board Assurance Framework. The implications of those domains that are allocated a score of 4 impact on:

- Safe Staffing
- Demand
- Quality of Care
- Regulatory Compliance
- Financial Sustainability
- Public Confidence

Recommendations:

The Board of Directors is asked to confirm that there is good assurance on the Trust's current segmentation, however reasonable assurance that this can be maintained given range of rank, and to note that we will be working to provide further assurance as part of the next reporting to Board.

Tees, Esk and Wear Valleys
NHS Foundation Trust

NHS Oversight Framework

Quarter 1 2025/26

journey to change

Date the report was produced: 26th September 2025
For any queries on the content of this report please contact: Ashleigh Lyons, Head of Performance
Contact Details: Ashleigh.lyons@nhs.net

Our Performance:

- The Trust segmentation is 2.

- We are ranked 24 noting that **our likely range* of rank is 3 – 52, representing a higher degree of uncertainty of future ranking**.

  **The Likely Range of Rank intervals represent the range an organisation's rank could fall in, with 95% certainty, depending on the combination of metrics included. If a trust performs consistently well or consistently poorly across a lot of different metrics, its range will be narrow. If a trust does well on some things and poorly on others, it's range will be wider, showing more uncertainty about where it truly stands.*

- Out of the 5 domains:
  - **2 have a NOF score of 1 (Effectiveness & Experience of Care and Finance & Productivity)**
  - 1 has a NOF score of 2 (Patient Safety)
  - **2 have a NOF score of 4 (Access to Services and People & Workforce)**

- The measures of most concern are within those domains scoring 4:
  - Annual percentage change in the number of children and young people accessing NHS funded mental health services
  - Staff survey engagement theme score
  - Staff sickness rate

Overall Segment and Domain Scores

NHS Oversight Framework

The tables below provide details of our overall segment and domain scores which was articulated in the previous summary slide

Overall Segment and Domain Scores

Headlines	Data period	Provider value	Peer average		National value	National value method	Chart
Adjusted segment			Q1 2025/26	2	NOF Score	Provider value	
Average metric score			Q1 2025/26	2.28	NOF Score	Provider value	
Unadjusted segment			Q1 2025/26	2	NOF Score	Provider value	
Financial override	Q1 2025/26	No	Yes		Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q1 2025/26	No	No		No	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q1 2025/26	4	NOF Score	
Effectiveness and experience of care domain segment	Q1 2025/26	1	NOF Score	
Patient safety domain segment	Q1 2025/26	2	NOF Score	
People and workforce domain segment	Q1 2025/26	4	NOF Score	
Finance and productivity domain segment	Q1 2025/26	1	NOF Score	

NHS Oversight Framework Rankings

NHS Oversight Framework

Trust Type	Trust	Average_score	Segment	Rank	Likely Range of Rank
Mental Health and Learning Disability	North Staffordshire Combined Healthcare NHS Trust	1.73	1	1	1 to 22
Mental Health and Learning Disability	Midlands Partnership NHS Foundation Trust	1.74	1	2	1 to 18
Mental Health and Learning Disability	Berkshire Healthcare NHS Foundation Trust	1.79	1	3	1 to 29
Community	Cambridgeshire Community Services NHS Trust	1.82	1	4	1 to 41
Community	Central London Community Healthcare NHS Trust	1.82	1	4	1 to 19
Mental Health and Learning Disability	North East London NHS Foundation Trust	1.82	1	4	1 to 17
Community	Kent Community Health NHS Foundation Trust	1.87	1	7	1 to 40
Mental Health and Learning Disability	Northamptonshire Healthcare NHS Foundation Trust	1.87	1	7	1 to 26
Mental Health and Learning Disability	Kent and Medway NHS and Social Care Partnership Trust	1.91	1	9	1 to 42
Mental Health and Learning Disability	West London NHS Trust	1.94	1	10	2 to 25
Community	Norfolk Community Health and Care NHS Trust	2.01	1	11	2 to 38
Community	Wirral Community Health and Care NHS Foundation Trust	2.02	1	12	2 to 42
Mental Health and Learning Disability	Oxford Health NHS Foundation Trust	2.03	1	13	3 to 37
Mental Health and Learning Disability	Central and North West London NHS Foundation Trust	2.06	2	14	3 to 38
Mental Health and Learning Disability	Leeds and York Partnership NHS Foundation Trust	2.13	2	15	2 to 48
Community	Sussex Community NHS Foundation Trust	2.13	2	15	3 to 42
Community	Derbyshire Community Health Services NHS Foundation Trust	2.16	2	17	2 to 51
Mental Health and Learning Disability	Leicestershire Partnership NHS Trust	2.16	2	17	6 to 42
Community	Shropshire Community Health NHS Trust	2.16	2	17	5 to 40
Mental Health and Learning Disability	Surrey and Borders Partnership NHS Foundation Trust	2.16	2	17	4 to 44
Mental Health and Learning Disability	Gloucestershire Health and Care NHS Foundation Trust	2.18	2	21	6 to 42
Mental Health and Learning Disability	Humber Teaching NHS Foundation Trust	2.22	2	22	6 to 47
Mental Health and Learning Disability	Dorset Healthcare University NHS Foundation Trust	2.26	2	23	7 to 44
Mental Health and Learning Disability	**Tees, Esk and Wear Valleys NHS Foundation Trust**	**2.28**	**2**	**24**	**3 to 52**
Mental Health and Learning Disability	Mersey Care NHS Foundation Trust	2.3	2	25	7 to 50
Mental Health and Learning Disability	South West Yorkshire Partnership NHS Foundation Trust	1.77	3	26	23 to 32
Mental Health and Learning Disability	Oxleas NHS Foundation Trust	1.8	3	27	23 to 32
Community	Hertfordshire Community NHS Trust	2.04	3	28	24 to 39
Mental Health and Learning Disability	Hertfordshire Partnership University NHS Foundation Trust	2.13	3	29	24 to 46
Mental Health and Learning Disability	Rotherham Doncaster and South Humber NHS Foundation Trust	2.16	3	30	24 to 49
Mental Health and Learning Disability	Lincolnshire Partnership NHS Foundation Trust	2.25	3	31	25 to 49
Community	Herefordshire and Worcestershire Health and Care NHS Trust	2.32	3	32	26 to 49
Mental Health and Learning Disability	Hampshire and Isle of Wight Healthcare NHS Foundation Trust	2.33	3	33	8 to 49
Mental Health and Learning Disability	South London and Maudsley NHS Foundation Trust	2.38	3	34	7 to 53
Mental Health and Learning Disability	Pennine Care NHS Foundation Trust	2.41	3	35	7 to 55
Mental Health and Learning Disability	Essex Partnership University NHS Foundation Trust	2.45	3	36	27 to 54
Mental Health and Learning Disability	Cambridgeshire and Peterborough NHS Foundation Trust	2.48	3	37	14 to 52
Mental Health and Learning Disability	Avon and Wiltshire Mental Health Partnership NHS Trust	2.5	3	38	11 to 56
Community	Bridgewater Community Healthcare NHS Foundation Trust	2.53	3	39	26 to 59
Mental Health and Learning Disability	East London NHS Foundation Trust	2.53	3	39	15 to 54
Community	Lincolnshire Community Health Services NHS Trust	2.54	3	41	8 to 58
Care Trust	North London NHS Foundation Trust	2.56	3	42	11 to 58
Mental Health and Learning Disability	Tavistock and Portman NHS Foundation Trust	2.59	3	43	1 to 61
Mental Health and Learning Disability	South West London and St George's Mental Health NHS Trust	2.6	3	44	14 to 57
Mental Health and Learning Disability	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	2.65	4	45	28 to 58
Mental Health and Learning Disability	Black Country Healthcare NHS Foundation Trust	2.67	4	46	27 to 60
Mental Health and Learning Disability	Derbyshire Healthcare NHS Foundation Trust	2.67	4	46	17 to 58
Care Trust	Sheffield Health & Social Care NHS Foundation Trust	2.7	4	48	29 to 60
Mental Health and Learning Disability	Cheshire and Wirral Partnership NHS Foundation Trust	2.77	4	49	18 to 60
Mental Health and Learning Disability	Cornwall Partnership NHS Foundation Trust	2.77	4	49	23 to 58
Mental Health and Learning Disability	Coventry and Warwickshire Partnership NHS Trust	2.79	4	51	30 to 60
Community	Leeds Community Healthcare NHS Trust	2.8	4	52	15 to 60
Care Trust	Bradford District Care NHS Foundation Trust	2.84	4	53	23 to 60
Mental Health and Learning Disability	Lancashire & South Cumbria NHS Foundation Trust	2.84	4	53	31 to 60
Mental Health and Learning Disability	Birmingham and Solihull Mental Health NHS Foundation Trust	2.9	4	55	39 to 60
Mental Health and Learning Disability	Nottinghamshire Healthcare NHS Foundation Trust	2.92	4	56	33 to 61
Mental Health and Learning Disability	Norfolk and Suffolk NHS Foundation Trust	2.94	4	57	35 to 61
Mental Health and Learning Disability	Greater Manchester Mental Health NHS Foundation Trust	3.02	4	58	38 to 61
Mental Health and Learning Disability	Sussex Partnership NHS Foundation Trust	3.07	4	59	39 to 61
Mental Health and Learning Disability	Devon Partnership NHS Trust	3.14	4	60	37 to 61
Community	Birmingham Community Healthcare NHS Foundation Trust	3.34	4	61	56 to 61

130

This table shows out position in the overall rankings (shaded dark blue).

Peer organisations are shaded light blue. Our recommended peers list is based on the trusts most similar to our Trust, in terms of factors that determine your productivity (cost per Weighted Activity Unit (WAU)).

Domains and Individual Measures Scores

NHS Oversight Framework

Domain	Metrics	Status	TEWV NOF		TEWV Result		Peer Average	National Value	Date Period
Access to Services	Annual change in number of children and young people accessing NHS-funded MH services	Scored	3.37	Amber/Red	0.44%	quartile 1 lowest 25% (red)	4.06%	7.06%	Jun-25

Domain	Metrics	Status	TEWV NOF		TEWV Result		Peer Average	National Value	Date Period
Effectiveness and experience of care	Percentage of inpatients with >60 day length of stay	Scored	1.13	Green	11.78%	quartile 1 lowest 25% (green)	22.78%	24.74%	Jun-25
	Community mental health survey satisfaction rate	Scored	2	Amber/Green	N/A		N/A	N/A	tbc

Domain	Metrics	Status	TEWV NOF		TEWV Result		Peer Average	National Value	Date Period
Patient Safety	NHS Staff Survey – raising concerns sub-score	Scored	3.15	Amber/Red	6.60	quartile 2 mid-low 25% (amber/red)	6.76	6.74	2024
	CQC safe inspection score (if awarded within the preceding 2 years)	Scored	3	Amber/Red	N/A		N/A	N/A	tbc
	Percentage of patients in crisis to receive face-to-face contact within 24 hours	Scored	1.07	Green	97.70%	quartile 4 highest 25% (green)	63.88%	57.22%	Jun-25

Domain	Metrics	Status	TEWV NOF		TEWV Result		Peer Average	National Value	Date Period
People and Workforce	Sickness absence rate	Scored	3.32	Amber/Red	6.06%	quartile 4 highest 25% (red)	6.09%	5.35%	Mar-25
	NHS staff survey engagement theme score	Scored	3.55	Amber/Red	6.86	quartile 1 lowest 25% (red)	7.02	7.07	Dec-24

Domain	Metrics	Status	TEWV NOF		TEWV Result		Peer Average	National Value	Date Period
Finance and productivity	Planned surplus/deficit	Contextual	1	Green	0.00%	quartile 4 highest 25% (green)	0.00%	0/00%	Apr-25
	Variance year-to-date to financial plan	Scored	1	Green	0.68	quartile 4 highest 25% (green)	0.02	0.00	Jun-25
	Relative difference in costs	Contextual	1.22	Green	79.03%	quartile 1 lowest 25% (green)	91.15%	103.12%	Mar-24

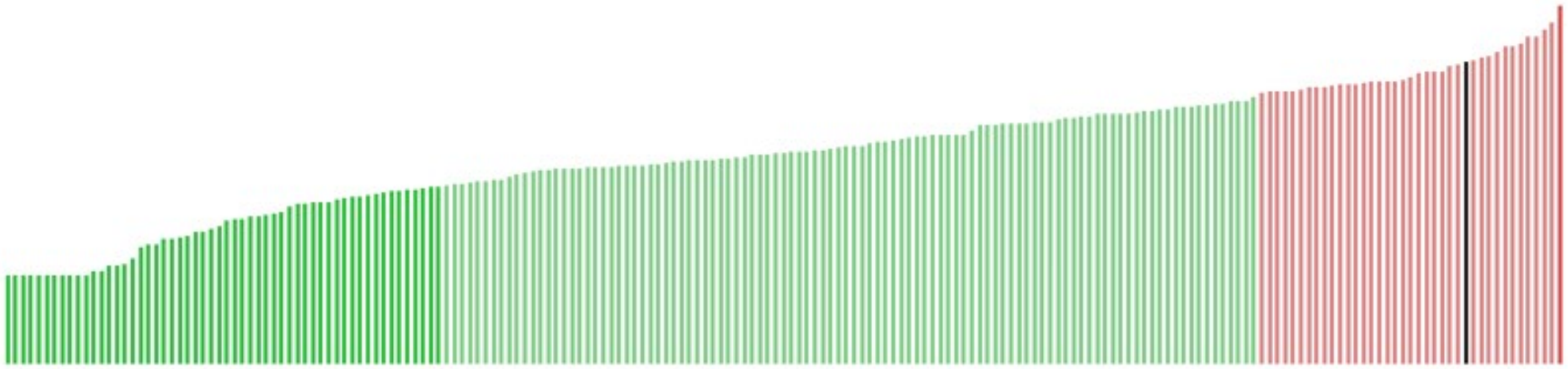
Access to Services Domain

NHS Oversight Framework

Segment	Access to services domain segment
2 - Above average	4 - Low performing

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Access to services	Mental health care	Annual change in the number of children and young people accessing NHS-funded MH services	Jun 24 - Jun 25 vs Jun 23 - Jun 24	0.44	percentage points	3.37	36 out of 46	4.57	

3.37 NOF Score is [amber / red]



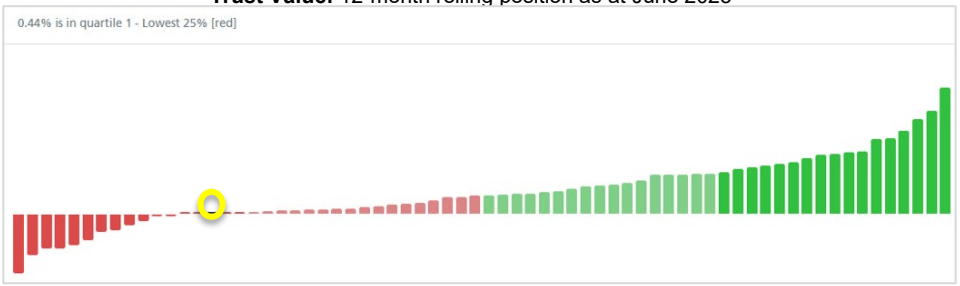
Where we are at in terms of domain segmentation?

There is currently only one measure contributing towards this domain and we have been scored at 3.37 which is segment 4 – Low performing. Please see overleaf for further information on our score(s).

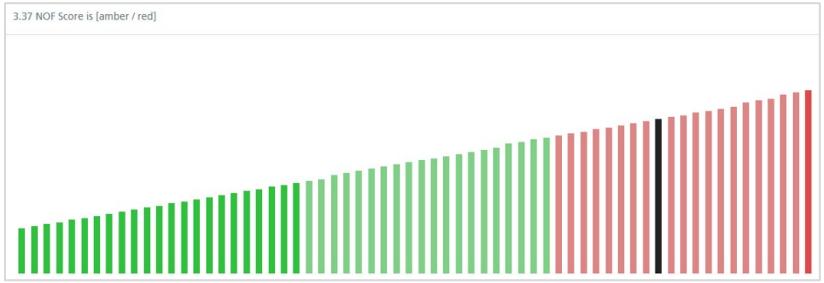
Access to Services: Measure 1
Annual percentage change in the number of children and young people accessing NHS funded mental health services

Trust value	Trust score	National average value
0.44 percentage points	3.37 - Below average	4.57

Trust Value: 12-month rolling position as at June 2025



Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

Organisations are scored on a ranked percentage change where higher is better; the Trust has had minimal growth in the number of children & young people accessing our services over the 12-month period ending June 2025. The Trust is currently ranked **36** out of 46 Trusts for this measure. Trust analysis indicates a higher growth (**2.43%**) for quarter 1; therefore, we are querying this with NHSE.

Our internal analysis is showing a change of **0.38**% as at the end of **August 2025**; however, there is significant variation in Care Group performance with DTVF reporting a positive 2.03% growth and NYYS reporting a negative 4.6% decrease.

What are our thoughts are in terms of improving performance?

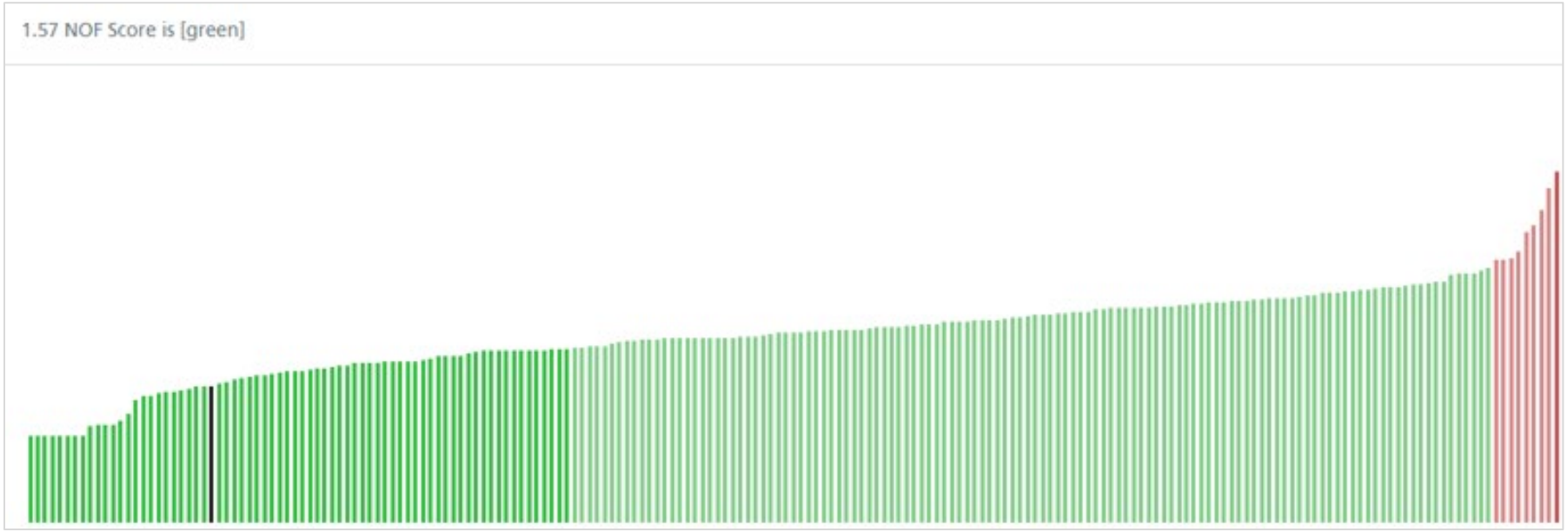
- A reduction in access could be anticipated from January 2026 when we establish the new Tees Valley Getting Help Service. Whilst we are the lead provider, activity for this new service will be recorded on two external systems managed by two of the subcontractors. We are currently exploring the option of merging the activity from these external systems with our activity from our internal system into one merged Mental Health Services Dataset to ensure we capture and report all activity.
- Linked to an existing IPR action for NYYS (see page 58 of the Board IPR), it has been agreed that a QI event will be held to review the clinical processes and recording of key data across all Neuro services to ensure consistency.

Effectiveness & Experience of Care Domain

NHS Oversight Framework

Segment	Effectiveness and experience domain segment
2 - Above average	1 - High performing

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Effectiveness and experience	Effective flow and discharge	Percentage of inpatients with >60 day length of stay	Q1 2025/26	11.78	percent	1.13	3 out of 47	24.67	
Effectiveness and experience	Patient experience	CQC community mental health survey satisfaction rate	2024		score	2.00			



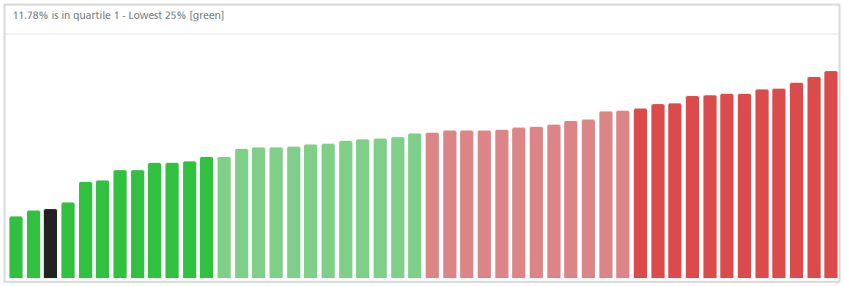
Where we are at in terms of domain segmentation?

There are currently two measures contributing towards this domain and we have been scored at 1.57 which is segment 1 – High performing. Please see overleaf for further information on our score(s).

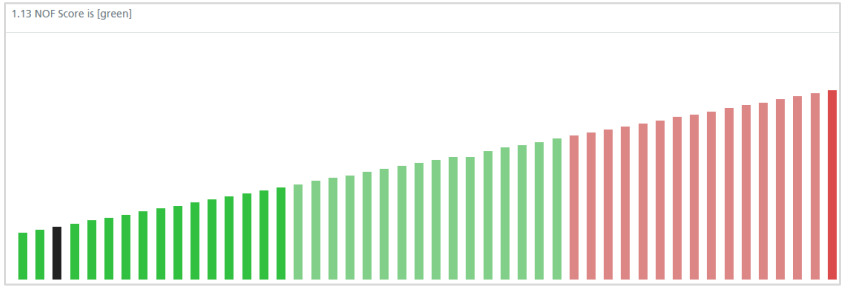
Effectiveness & Experience of Care: Measure 1
Percentage of adult inpatients with a length of stay over 60 days at discharge

Trust value	Trust score	National average value
11.78 percent	1.13 - High performing	24.67

Trust Value: quarterly position as at June 2025



Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

Organisations are scored on a ranked percentage of delayed patients where lower is better. The Trust is currently ranked **3** out of 47 Trusts.

Our internal analysis indicates **9.14**% of adult inpatients with a length of stay over 60 days at discharge for the 3 months ending August 2025 however, there is significant variation in Care Group performance with DTVF reporting 6.49% of patients discharged having a length of stay over 60 days; 12.93% within NYYS.

What are our thoughts are in terms of sustaining and/or improving our performance?

- The services are confident that robust processes are in place to monitor patients at 30/60/90 days stays, which will support sustainment and improvement of this position, noting there is currently cause for concern in the number of patients that are clinically ready for discharge.
- Within NYYS focused work is underway within the York system to facilitate timely discharge of patients, in addition to supporting the discharge of long-term Ministry of Justice patients.
- There is a risk that as patients with longer lengths of stay are discharged, there will be an impact on this measure; however, that impact is anticipated to be short term.

Effectiveness & Experience of Care: Measure 2
CQC community mental health survey satisfaction rate

Trust Score
2 – Above Average

Trust Score: allocated NOF score

Where we are at in terms of NOF performance?

Satisfaction is determined on positive responses to the question "*Overall, in the last 12 months, how was your experience of using the NHS mental health services?*" The Trust response for 2024 was **6.56**; an amber rating.

Whilst this question is only asked annually there is a potential proxy measure monitored as part of the Integrated Performance Report; the percentage of responses to the patient survey question "*Thinking about your recent appointment or stay overall how was your experience of our service?*". As at July 2025, this reported **92.01%** and showed no significant change.

What are our thoughts are in terms of sustaining and/or improving our performance?

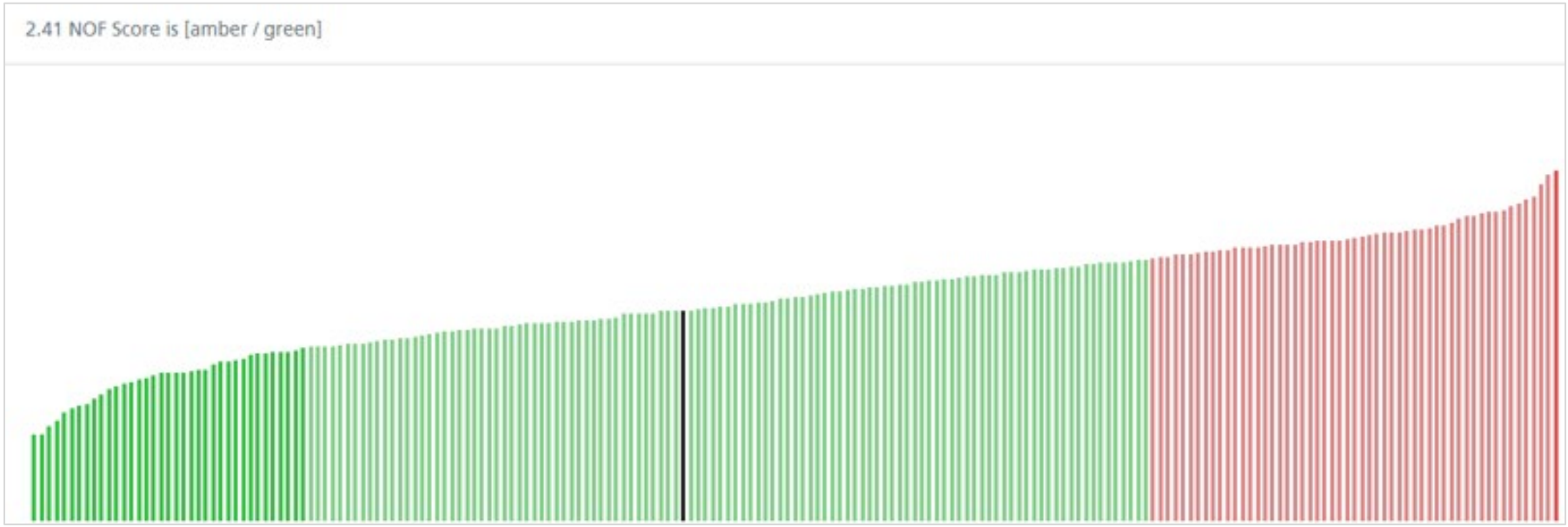
The community survey is limited to a 1250 sample selection of patients, for which there is historically a high rate of non-submission. We need further discussion to explore potential improvement actions to be confident this position can be sustained or improved. This will be incorporated into our routine performance management processes from October and progress reported as part of the Integrated Performance Report.

Patient Safety Domain

NHS Oversight Framework

Segment	Patient safety domain segment
2 - Above average	2 - Above average

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Patient safety	Patient safety	CQC safe inspection	Latest published if awarded post August 2023		score	3.00			
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.60	out of 10	3.15	44 out of 61	6.81	
Patient safety	Patient safety	Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours	Q1 2025/26	97.70	percent	1.07	2 out of 45	58.00	



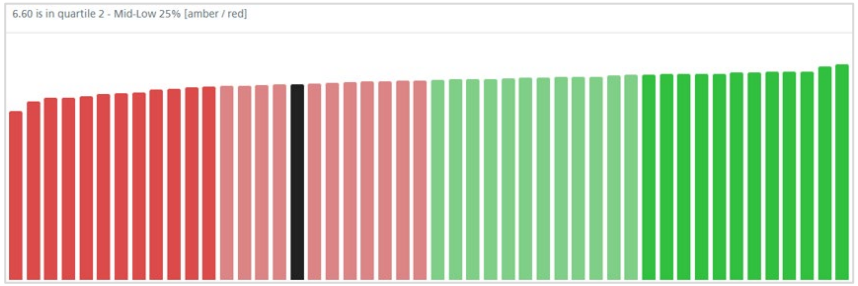
Where we are at in terms of domain segmentation?

There are currently three measures contributing towards this domain and we have been scored at 2.41 which is segment 2 – Above average. Please see overleaf for further information on our score(s).

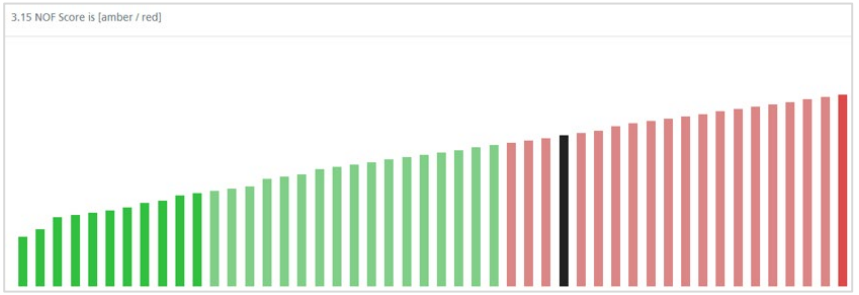
Patient Safety: Measure 1
Staff survey – raising concerns sub-score

Trust value	Trust score	National average value
6.60 out of 10	3.15 - Below average	6.81

Trust Value: 2024 Staff Survey



Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

Performance is determined on positive responses to 4 questions comprising the "*Raising Concerns*" sub-score within the Annual NHS Staff Survey. The Trust response for 2024 was **6.60**; an amber rating. The Trust is currently ranked **37** out of 61 Trusts.
There is currently no routine proxy measure in relation to this area.

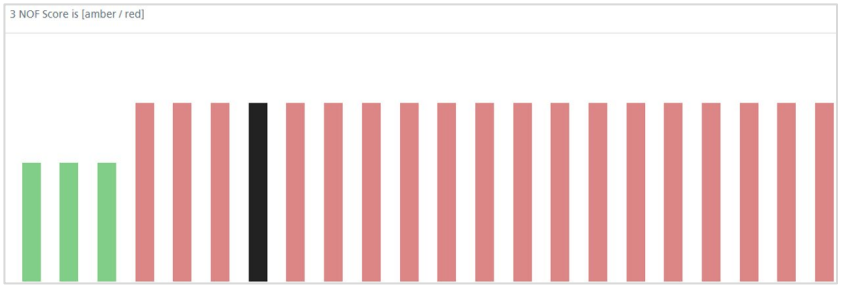
What are our thoughts are in terms of improving that performance?

We need further discussion to explore potential improvement actions to improve our position. This will be incorporated into our routine performance management processes from October and progress reported as part of the Integrated Performance Report.

Patient Safety: Measure 2
CQC safe inspection score

Trust Score
3 – Below Average

Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

The CQC rating is based on a physical inspection, with possible ratings of outstanding, good, requires improvement or inadequate. The Safe Assessment Framework covers learning culture, safe systems, pathways and transitions, safeguarding, involving people to manage risks, safe environments, safe and effective staffing, infection prevention and control, and medicines optimisation. The last full CQC inspection took place in 2023. The Trust was scored **requires improvement.**

What are our thoughts are in terms of improving that performance?

It can be expected that we should sustain or improve on our current assessment. Following the 2023 inspection a number of areas of improvement were identified: reduction in waiting times, reduction in uses of restraint (particularly prone), ensuring mandatory training was completed, ensuring we had good learning from incidents, ensuring we had high-quality handovers, ensuring patients' physical needs were look after, ensuring we had oversight of the use of mechanical restraints, safely managing s.17 leave, ensuring seclusion reviews are in place, and ensuring we are adequately staffed. We can evidence increased governance on the use of restraint and have nearly eradicated the use of prone restraint. We have closed down a number of key vacancies and can demonstrate safe staffing throughout our services, undertaking structured work on leave-planning and staff handovers. There has also been a focus on staff training, ensuring are staff are undertaking all appropriate mandatory and statutory training. We have reduced bed occupancy and have a number of beds available for admission and can demonstrate that we have improved the physical healthcare provided to our patients.

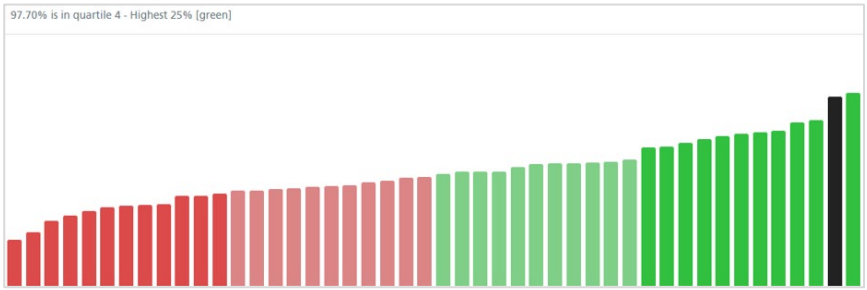
To note:

- A number of the NOF measures will influence the safety of our patients.
- The CQC Single Assessment Framework under which this sits, is currently under view. At this stage we do not have any indication what the future framework will include.

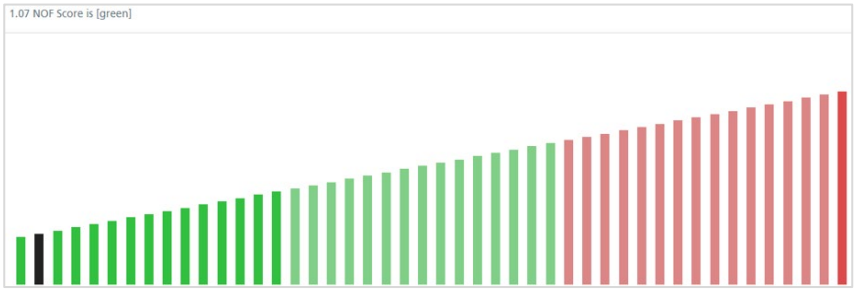
Patient Safety: Measure 3
Percentage of crisis response patients to receive face to face contact within 24 hours

Trust value	Trust score	National average value
97.70 percent	1.07 - High performing	58.00

Trust Value: quarterly position as at June 2025



Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

Organisations are scored on a ranked absolute percentage where higher is better; the Trust is currently ranked **2** out of 45 Trusts.

Our internal analysis reports **98.47%** as at the end of August 2025, however there is some variation in care group performance.

What are our thoughts are in terms of sustaining and/or improving our performance?

The services have robust validation and monitoring processes in place that provide a strong level of oversight; they are confident that a high level of performance can be sustained. **However**, recent analysis undertaken by Business Intelligence has identified several issues impacting the data following the implementation of Cito. Whilst it is not possible at this stage to fully understand the impact of these data quality issues, some investigatory analysis has been undertaken, which suggest **we could anticipate an approximate 8% reduction**. Based on current NOF scoring, we would anticipate this to remain a 1. Work is being expedited by Digital & Data Services to rectify the issues on Cito which will ensure future data is correct; deployment is scheduled for mid-October pending successful testing. Investigations are underway to explore the correction of historic data.

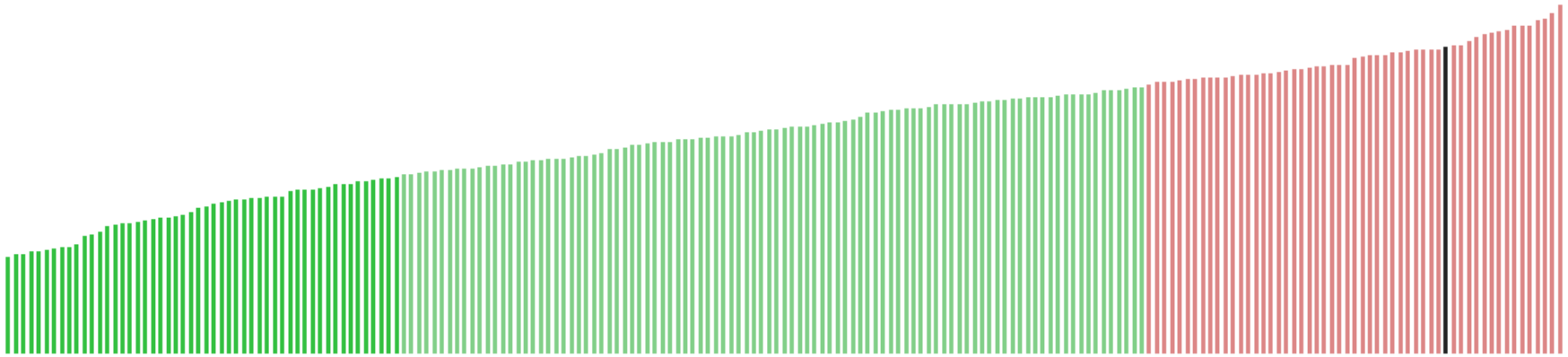
People & Workforce Domain

NHS Oversight Framework

Segment	People and workforce domain segment
2 - Above average	4 - Low performing

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	6.86	out of 10	3.55	52 out of 61	7.08	
People and workforce	Retention and culture	Sickness absence rate	Q4 2024-25	6.06	percent	3.32	41 out of 61	5.65	

3.44 NOF Score is [amber / red]



Where we are at in terms of domain segmentation?

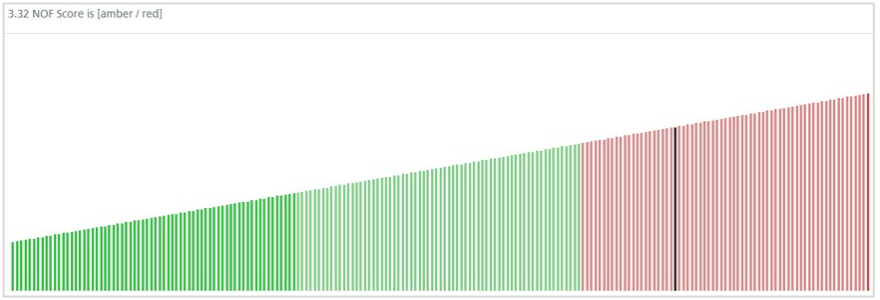
There are currently two measures contributing towards this domain and we have been scored at 3.44 which is segment 4 – Low performing. Please see overleaf for further information on our score(s).

People & Workforce : Measure 1
Staff sickness rate

Trust value	Trust score	National average value
6.06 percent	3.32 - Below average	5.65

Trust Value: quarterly position as at March 2025

Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

Organisations are scored on a 3-month rolling aggregate where lower is better. The Trust is currently ranked **41** out of 61 Trusts.

Whilst we do not currently report sickness absence in the Board IPR as a 3-month rolling position, our internal measure shows an increasing trend (worsening position) significantly above Trust standard and we have identified this as an area of concern within the Board IPR (see page 31).

What are our thoughts are in terms of improving that performance?

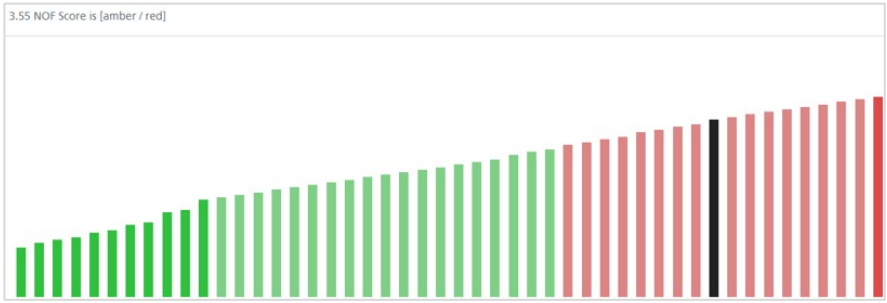
There are several actions included in the Board IPR that we have identified to support improvements in sickness absence (see page 31)

People & Workforce : Measure 2
Staff survey engagement theme score

Trust value	Trust score	National average value
6.86 out of 10	3.55 - Low performing	7.08

Trust Value: 2024 Staff Survey

Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

Organisations are scored based on a ranked percentage based on 3 individual sub-scores covering motivation, involvement and advocacy. The Trust is currently ranked **52** out of 61 Trusts, with only Trust Board reporting above the national best result and 8 areas reporting below the average result.

Whilst there is currently no routine proxy measures in relation to staff engagement, the 2 staff survey measures within the Board IPR, may provide an indication of how well our staff feel engaged.

What are our thoughts are in terms of improving that performance?

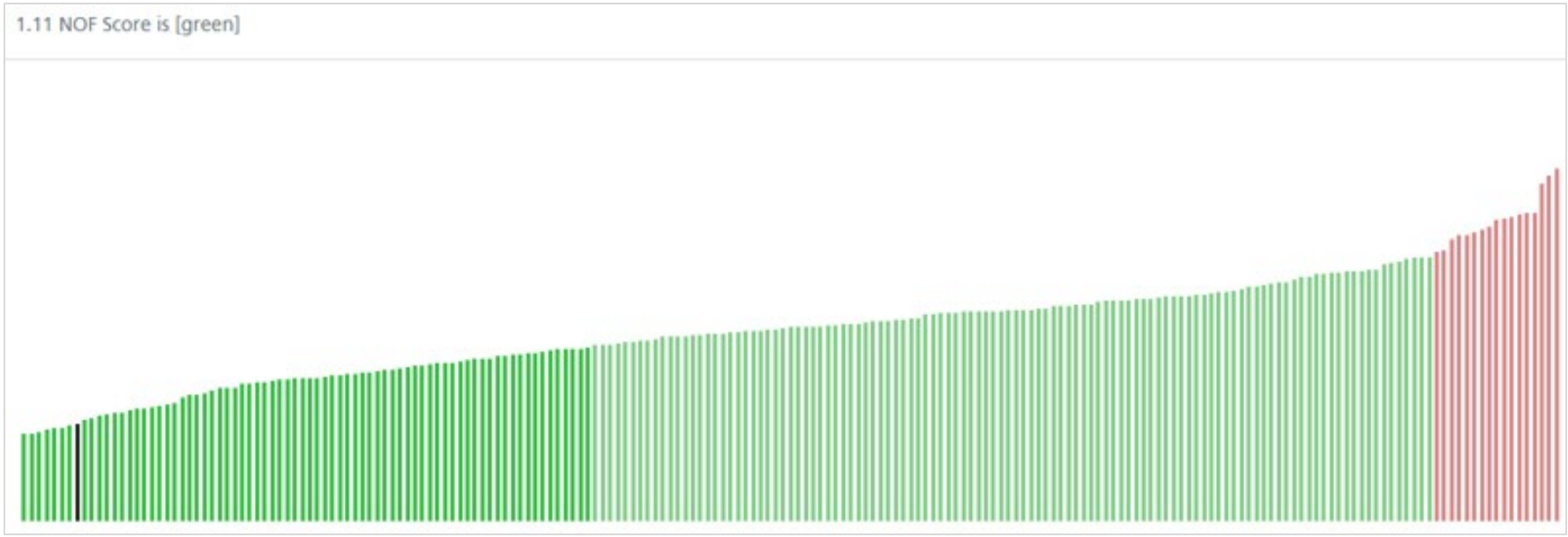
Our new Head of Inclusive Cultures will commence in post on the 1st October 2025; a key function of this role will be working with our staff to help them develop a sense of belonging not just to their team, but also to the Trust. In addition, the action plans for the Workforce Disability Equality Standard and Workforce Race Equality Standard will be submitted to Board of Directors for approval in October. Key actions within the plans focus on working with those staff groups that have low engagement scores.

Finance & Productivity Domain

NHS Oversight Framework

Segment	Finance and productivity domain segment
2 - Above average	1 - High performing

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Finance and productivity	Finance	Combined finance	Q1 2025/26		score	1.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	0.00	percent	1.00	15 out of 61	0.00	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 3 2025	0.68	percent	1.00	3 out of 61	0.00	
Finance and productivity	Productivity	Relative difference in costs	2023/24	79.03	percent	1.22	5 out of 60	105.39	



Where we are at in terms of domain segmentation?

There are currently three measures contributing towards this domain and we have been scored at 1.11 which is segment 1 – High performing. Please see overleaf for further information on our score(s).

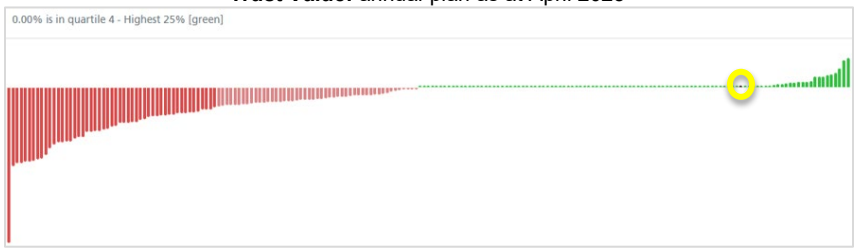
Finance & Productivity: Combined Score

NHS Oversight Framework

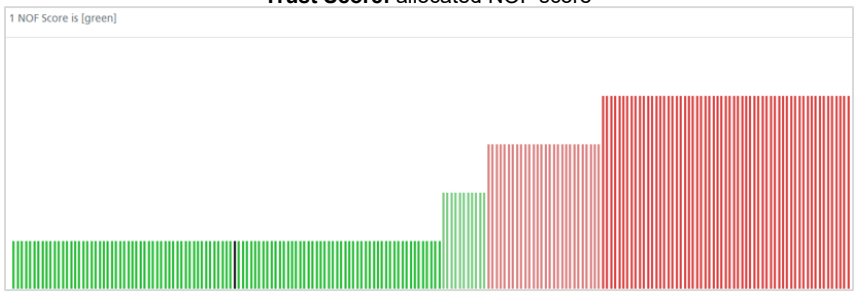
Measure 1: Planned surplus/deficit

Trust value	Trust score	National average value
0.00 percent	1.00 - On plan or better	0.00

Trust Value: annual plan as at April 2025



Trust Score: allocated NOF score

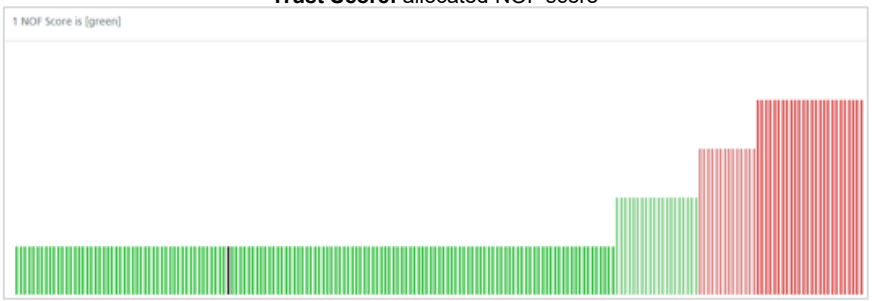


Measure 2: Variance year-to-date to financial plan

Trust value	Trust score	National average value
0.68 percent	1.00 - On plan	0.00

Trust Value: year to date variance as at June 2025

Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

The score is based on planned level of deficit; 1.00 = 0% or surplus.
The Trust is currently ranked **15** out of 61 Trusts.

The score is based on variation from plan; 1.00 = on plan or better.
The Trust is currently ranked **3** out of 61 Trusts.
The financial position to 31st August 2025 against which Trust performance is assessed is a deficit of **£1.74m which is £0.96m better than planned**.

A combined score takes the two individual scores for planned surplus/deficit and variance year to date as inputs into an overall finance score. **The Trust Combined Score is NOF Score 1.**

What are our thoughts are in terms of sustaining that performance?

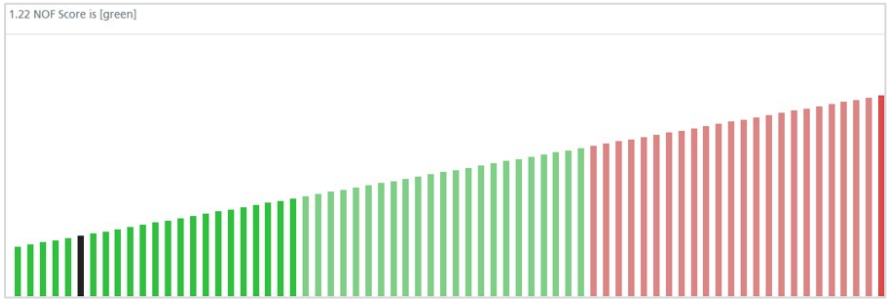
As at August 2025 we are ahead of plan and expect to sustain this position through the year. There has been some slippage in the Trust Savings Plan; agency, overtime and temporary staffing are behind plan and a number of schemes are pushing back recurrent savings; however, we anticipate to end the year on plan.

Finance & Productivity : Measure 3
Relative difference in costs score

Trust value	Trust score	National average value
79.03 percent	1.22 - High performing	105.39

Trust Value: National Cost Collection Index March 2024

Trust Score: allocated NOF score



Where we are at in terms of NOF performance?

The National Cost Collection Index (NCCI) is a measure of the relative cost difference between NHS providers. This metric is an interim measure of productivity/efficiency until implied productivity figures are available at non-acute trust level. Organisations are scored between 1.00 and 4.00 based on ranked comparative cost value where lower is better. The Trust is currently ranked **5** out of 60 Trusts.

What are our thoughts are in terms of sustaining that performance?

This is an annual cost collection index and the most recent collection is currently being assessed and will be published during September/October. We are aware that our costings will be impacted by a data quality issues on Cito in quarter 1 that resulted in Trust activity reporting a decrease; therefore, we are anticipating NCCI to be higher than the previous assessment. However, we still expect our score to be below index and, therefore, a positive position, noting that our scoring is dependent on the performance of other Trusts.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9th October 2025**
Title:	**Revalidation, Appraisal & Job Planning Report**
Executive Sponsor(s):	**Dr Kedar Kale**
Report Author(s):	**Dr Kedar Kale, Dr Lenny Cornwall, Elaine Corbyn, Chloe Casson and Jenny Miller**

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***
	Governance & Assurance	*The absence of a clear line of sight from ward to board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risk to patients.*

EXECUTIVE SUMMARY:

Purpose:

The Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) is requested by NHS England each year and has been designed to assist responsible officers in providing assurance to their organisations Board that the doctors working in their organisations remain up to date and fit to practice.

It highlights compliance rates for appraisal and revalidation amongst our doctors for the previous appraisal year (2024-25) and the supporting narrative explains the processes we have in place. The report also shows the number of doctors who were managed under 'Responding to Concerns' and demographic information relating to such concerns during the reporting period. It also details Job Planning information regarding compliance and disputes. for the Job Planning Season 2025.

Proposal:

All Responsible Officers are asked to present an annual report to their Board or equivalent management team along with the statement of compliance (Annex A) in order to provide a

substantial level of assurance that our doctors are fit to practice. The statement of compliance should be signed off by the Chief Executive or Chairman of the Designated Body's Board or management team and submitted to NHS England by 31st October 2025.

Overview:

The purpose of revalidation is to provide **assurance** to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise. This aim will be achieved through annual appraisal and processes supporting revalidation. By presenting our appraisal and revalidation data within this report which shows we have strong compliance in these areas, it is hoped this will give **good assurance** that we uphold a strong system for appraising and revalidating our doctors.

Prior Consideration and Feedback:

This updated report is brought to the attention of the Board annually for assurance, this has provided the assurance that all doctors are up to date and fit to practice.

Implications:

Failure to submit a signed version of the Board report and Statement of Compliance to NHS England by the required date means our appraisal and revalidation data will not be recognised and compared to that of other NHS organisations.

Recommendations:

The Board are required to confirm a level of assurance as proposed within the report. If assurance is met, the Statement of Compliance should be signed off by the Chief Executive or Chairman of the designated body's Board or management team and then the report can be submitted to NHS England.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ANNUAL REPORT
REVALIDATION / APPRAISAL, RESPONDING TO CONCERNS AND JOB PLANNING

1st April 2024 – 31st March 2025

Management of Appraisal and Revalidation

Responsible Officer:	Dr Kedar Kale
Associate Responsible Officer:	Dr Lenny Cornwall
Medical Development and	Mr Bryan O'Leary
Medical Management:	Mrs Elaine Corbyn
	Mrs Chloe Casson/Miss Jenny Miller
	Dr Tolu Olusoga (GMD – NYY Care Group)
	Dr Ranjeet Shah (GMD – DTVF Care Group)
	Dr Hany El Sayeh (Director of Medical Education)

Activity Levels

Number of doctors that TEWV are responsible body for (263)	Consultant		SAS includes IFD Doctors		Trust Doctors	
	2023–24	2024–25	2023-24	2024–25	2023-24	2024–25
Adult Mental Health	62	60	30	46	19	17
Mental Health Services for Older People	34	30	19	24	6	7
Child and Young Person's Services	33	35	8	6	1	0
Learning Disabilities	12	12	3	3	0	0
Forensic Services	14	16	2	4	4	2
Total:	**155**	**153**	**62**	**84**	**30**	**26**

Comments:
A total of **263** doctors had a **prescribed connection** with TEWV as at 31st March 2025. This year the International Fellowship doctors (IFD Doctors) have been included in the SAS doctors figures, which is why the figures for 2024-25 for SAS doctors have increased from last year. Last year IFD's were included with the Trust doctors. We felt this is more appropriate as IFD's are working at SAS doctor level.

Number of doctors who were due for an appraisal (236)	Consultant		SAS includes IFD Doctors		Trust Doctors	
	2023-24	2024–25	2023-24	2024–25	2023-24	2024–25
Adult Mental Health	59	56	22	39	15	17
Mental Health Services for Older People	29	28	16	22	6	5
Child and Young Person's Services	31	31	7	5	1	0
Learning Disabilities	12	12	2	2	0	0
Forensic Services	14	13	2	4	4	2
Total	**145**	**140**	**49**	**72**	**26**	**24**

Comments:
The table above illustrates the number of doctors that were due an appraisal in the last appraisal year between 1st April 2024 -31st March 2025.

You will see that there is a difference of 13 in the consultant figure of prescribed connection and appraisals. This is due to 13 new consultants commencing employment with the trust within the last year and therefore were not due an appraisal as of 31st March 2025, as they will have already undertaken an appraisal with their previous organisation before joining TEWV or may not have worked with the trust for the minimum time period required to have a trust appraisal.

In addition, there were 12 new SAS doctors who were not due an appraisal at this time, this included 3 International Fellowship Doctors (IFDs) who are counted as SAS Doctors. There were also 2 Trust Doctors who were not due a 'priming appraisal' as at 31st March 2025. A 'priming appraisal' is a pre-appraisal that introduces the doctor to the appraisal process and allows the doctor to set a PDP for the coming year, which can help the doctor to prepare for their formal appraisal

Number of doctors who have had an appraisal in the appraisal year (231)(97.88%)	Consultant		SAS includes IFD Doctors		Trust Doctors	
	2023-24	2024–25	2023-24	2024–25	2023-24	2024–25
Adult Mental Health	57	54	20	39	15	17
Mental Health Services for Older People	28	28	16	20	6	5
Child and Young Person's Services	30	30	6	5	1	0
Learning Disabilities	12	12	2	2	0	0
Forensic Services	12	13	2	4	4	2
Total	**139 (96%)**	**137 (98%)**	**46 (94%)**	**70 (97%)**	**26 (100%)**	**24 (100%)**

Comments:
The figures in the table above show the number of doctors that have had an appraisal between 1st April 2024 - 31st March 2025. The figures include ARCP's undertaken whilst in training for any new consultants who have started in post within the last year and priming appraisals with TEWV.

The reasons that a doctor may have missed their annual appraisal is detailed in the next section under exceptions.

Exceptions

The table below illustrates the 'approved missed or incomplete appraisals'. This cohort are doctors that could not complete their appraisal in the appraisal year for a reason that was accepted and signed off by the Associate Responsible Officer on behalf of the Responsible Officer.

For an appraisal to be an 'approved missed or incomplete', the Trust needs to produce documentation to demonstrate that they have agreed the postponement as reasonable. These requirements are set out by NHS England.

Number of 'approved missed or incomplete appraisals'	Consultant	SAS including IFD Doctors	Trust Doctors
Adult Mental Health	1	0	0
Mental Health Services for Older People	1	2	0
Child and Young Person's Services	1	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**3**	**2**	**0**

Comment:

The Consultant exceptions are due to:

- 1 Consultant being on long term sick
- 1 Consultant on adoption leave until March 2025.
- 1 Consultant due an appraisal in January 2025, did not have appraisal before they left their previous role, started with TEWV in February 2025. It was agreed to reset the appraisal month to November 2025 to allow them time to gather evidence in their new role.

The SAS doctor exceptions are due to:

- 1 SAS doctor on maternity leave
- 1 SAS doctor due an appraisal in November 2024 but did not start with TEWV until August 2024. It was agreed to reset their appraisal month to May 2025 to allow them time to gather evidence in new role.

This resulted in the doctors not being able to do an appraisal before 31st March 2025.

The table below illustrates the 'unapproved missed or incomplete appraisals'. This group of doctors have not completed their appraisal in the appraisal year, neither have they sought any agreement of this from the Associate Responsible Officer.

Number of 'unapproved missed or incomplete appraisals'	Consultant	SAS includes IFD Doctors	Trust Doctors
Adult Mental Health	0	0	0
Mental Health Services for Older People	0	0	0
Child and Young Person's Services	0	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**0**	**0**	**0**
Comments: There are no unapproved missed or incomplete appraisals in this appraisal year.			

Revalidation

Number of doctors completing revalidation cycle (58)	Consultant		SAS includes IFD Doctors		Trust Doctors	
	2023-24	2024–25	2023-24	2024–25	2023-24	2024–25
Adult Mental Health	14	19	3	10	0	1
Mental Health Services for Older People	8	7	10	3	0	0
Child and Young Person's Services	6	13	2	0	0	0
Learning Disabilities	2	4	0	0	0	0
Forensic Services	5	1	2	0	1	0
Other	0	0	0	0	0	0
Total	**35**	**44**	**16**	**13**	**1**	**1**

Number of doctors receiving revalidation recommendations (58)	Consultant		SAS including IFD's		Trust Doctors	
	2023-24	2024–25	2023-24	2024–25	2023-24	2024–25
Adult Mental Health	14	19	3	10	0	1
Mental Health Services for Older People	8	7	9	3	0	0
Child and Young Person's Services	6	13	2	0	0	0
Learning Disabilities	2	4	0	0	0	0
Forensic Services	5	1	2	0	1	0
Other	0	0	0	0	0	0
Total	**35**	**44**	**16**	**13**	**1**	**1**
Comments: Between 1 April 2024 – 31 March 2025, there were 58 doctors who were due to be revalidated. 58 doctors were revalidated during the timescales allowed. 4 of the 58 doctors initially were deferred but were revalidated thereafter. The reasons for deferments were that two doctors were deferred due to insufficient evidence, one due to sick leave and unable complete their MSF in time and the other doctor had only returned to the UK in the past year and started at TEWV, therefore it was agreed to defer their revalidation to give them time to complete an audit and MSF.						

Performance Review, Support and Development of Appraisers

Training of Appraisers

	Consultant		SAS	
	2023-24	2024-25	2023-24	2024-25
Number of enhanced appraisers-47	45	43	5	4
Number of enhanced appraisers carrying out appraisals in appraisal year-47	44	43	5	4
The Trust trained 3 new appraisers in February 2024, they were ready to start the role in April 2024. However, we also had 5 appraisers step down or leave the Trust before 1st April 2024.				

Support and Development of Appraisers

Update/Support Sessions	
5th June 2024	6th November 2024
11th September 2024	5th March 2025
Comment: There are two different training sessions held each year and these are both repeated once, providing greater opportunity for colleagues to attend. The sessions in June and March were face to face, whilst September and November operated on MS Teams virtually. This provides appraisers with options of how they wish to attend. As part of the session, the Trust provides appraisers with an opportunity to share feedback and/or issues that they may have experienced.	

Performance Review of Appraisers

Each appraiser's performance is reviewed by their appraisee after every appraisal that they complete. A set of standardised questions are sent to each appraisee of which they answer them on a scale from 'strongly agree' to 'strongly disagree'. On a yearly basis the feedback is anonymised, collated and fed back to the appraisers in a report. Part of this report allows the appraiser to reflect on the information fed back to them and include it in their own appraisal to contribute to any development discussions and/or PDP objectives.

If any trends are identified from the feedback received, this is then discussed with the Associate Responsible Officer who then incorporates this into the quarterly Appraiser Update Sessions and the Annual Trustwide Appraisal Session, which is held each year before the start of the new appraisal year.

Quality Assurance of Appraisals

The Trust took 44 appraisal summaries from doctors who were revalidated in the previous year 2023/24. These summaries were anonymised, and 9 volunteer appraisers were selected to rate either 8 or 9 summaries each as part of a quality improvement exercise.

Each summary was rated by two different appraisers. This will be repeated in Summer 2026 for the doctors who were revalidated throughout 2025/26 due to changing to SARD Appraisal Version 7.1.

Responding to Concerns about doctors in TEWV

Total Number of All doctors who were managed under 'Responding to Concerns' (includes 'Low Level' and 'Investigations')	Consultant				SAS/IFD				Trust Doctors			
	2023/24		2024/25		2023/24		2024/25		2023/24		2024/25	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	1	0	1	0	0	0	0
Durham & Darlington	0	1	1	1	0	0	0	0	1	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	1	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	1	0	0	0	0	0	0	0	0	0
North Yorkshire & York	1	0	0	1	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	1	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**1**	**3**	**2**	**0**	**2**	**0**	**1**	**1**	**0**	**0**	**0**

The total issues dealt with in Medical Development in terms of investigations and low level concerns this year was six. This consisted of three investigations and three low level concerns. The three investigations were all done via informal fact finding in the first instance, meaning that it was felt further information was required before making a final decision on next steps. The findings were discussed at a Decision Making Group (DMG) where it was felt the three instances could be dealt with via Action Plans being put in place, therefore not requiring a 'formal' investigation.

In addition to the details documented in this report, Medical Development also deal with other issues and concerns in relation to our doctors, but do not specifically fall into the categories stated such as agency doctors or those employed by the Lead Employer Trust (LET).

Total Number of doctors spoken to under 'Low Level Concerns'	Consultant				SAS/IFD				Trust Doctors			
	2023/24		2024/25		2023/24		2024/25		2023/24		2024/25	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	0	0	1	0	0	0	0
Durham & Darlington	0	1	1	1	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	1	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	1	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**1**	**1**	**1**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**

Comments:

Low level concerns are dealt with by a medical manager or a relevant manager. They will organise a meeting with the individual to discuss the issues that have been raised or that might be causing some concern and which they would like to address before those issues become more serious. We have a low level concern form that managers' complete and a copy is given to the doctor and Medical Development for recording purposes.

The purpose of the low level concern form is to allow concerns to be documented and monitored so that should there be any future concerns raised there are records to show that actions had already been taken before making the matter more formal. An example of concerns raised may be comments made by colleagues in relation to a doctor's behaviour or how they communicate with others etc.

This year there were three low level concerns raised. Medical Development work closely with managers at a very early stage to try and prevent the need to formally investigate an issue or concern.

Total Number of doctors where investigation was necessary 'More Serious Concerns'	Consultant				SAS/IFD				Trust Doctors			
	2023/24		2024/25		2023/24		2024/25		2023/24		2024/25	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	1	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	1	0	0	0
North Yorkshire & York	0	0	0	1	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	1	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	1	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**2**	**1**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**

Comments:
In 2024/25 there were three investigations. All three cases required further initial fact finding to understand the situations further before The Decision Making Group could take a decision on next steps. All three cases did not require a formal investigation and therefore no disciplinary hearings were held. All three outcomes were action plans put in place to be monitored and reflections required for their annual appraisals.

JOB PLAN COMPLIANCE 2025

Number of doctors who were due for a Job Plan between 1st January – 31st March 2025.	Consultant		SAS/IFD	
(Data taken on 31 March 2025)	2024	2025	2024	2025
Total	150	157	66	73

NORTH CARE GROUP JOB PLANS				
SPECIALITY	% Completed	% Not Completed	% Disputed	No. of Job Plans above 12PAs
AMH	100%	0%	0%	16
CAMHS	100%	0%	0%	1
FORENSIC	100%	0%	0%	4
LD	100%	0%	0%	2
MHSOP	100%	0%	0%	2

Comments: All Job Plans for North Care Group have been completed.

SOUTH CARE GROUP JOB PLANS				
SPECIALITY	% Completed	% Not Completed	% Disputed	No. of Job Plans above 12 PAs
AMH	100%	0%	0%	5
CAMHS	87%	13%	0%	0
LD	100%	0%	0%	1
MHSOP	100%	0%	0%	1

Comments: Reason for non completion - x2 Consultants had not signed off their Job Plans. One was on annual leave and the other had moved roles so there was a delay in completing.

TRUSTWIDE JOB PLANS				
SPECIALITY	% Completed	% Not Completed	% Disputed	No. of Job Plans above 12 PAs
AMH	100%	0%	0%	21
CAMHS	95%	5%	0%	1
FORENSIC	100%	0%	0%	5

LD	**100%**	**0%**	**0%**	**3**
MHSOP	**100%**	**0%**	**0%**	**3**

Job Planning Consistency Panels	
22nd August 2024 - CYPS	4th November 2024 - LD
24th October 2024 - AMH	20th November 2024 - Forensics
31st October 2024 - MHSOP	
Comment: The Trust held five job plan consistency panels for each specialty which began in August 2024 and these meetings helped to identify areas where further training was required. The Job Planning training was subsequently delivered in December 2024 before the 2025 job planning round began. Executive Medical Director or Group Medical Directors Chair these meetings, and all Associate Medical Directors and Lead Psychiatrists are invited to attend the meeting for their speciality along with the Associate Responsible Officer, Medical Devlopment colleagues and LNC Rep.	

Training/Support Sessions	
9th December 2024	10th April 2024
	18th September 2024
Comment: Dr Cornwall runs an annual Job Planning Training Session for all doctors in December ahead of the Job Planning season. This training session includes updates from any issues picked up in the Job Planning Consistency Panels. Dr Cornwall also runs Job Plan Training sessions throughout the year for any new consultants and SAS Doctors that start with the Trust.	

Ongoing Actions

Appraisal & Revalidation

In February 2025 we took part in a face to face 'Peer to Peer' review of our appraisal and revalidation process with Harrogate and District Foundation Trust and Calderdale and Huddersfield Foundation Trust. Each Trust shared their own appraisal and revalidation processes and then we discussed any challenges and made recommendations thereafter that each Trust could work towards. This was our first time doing a peer review and we found it useful to share areas of best practice. One of the noticeable points we took away from the review was that the other two Trust's pay their appraisers in monetary value, whereas TEWV's appraisers receive SPA time for undertaking appraisals.

The challenge we currently face is retaining and recruiting appraisers, as every year we lose appraisers either due to doctors leaving the Trust or wanting to relinquish the appraiser role because they have other commitments and very few (if any) new doctors wish to take up the appraiser role. Our current number of appraisers is insufficient and so as of April 2025 we are relying on what we are calling 'super appraisers' who are 3 retired consultants doing minimal work for TEWV that have agreed to each undertake 12 appraisals within the year. We have agreed they should only undertake the role for a maximum of 3 years if they are not doing clinical work alongside this, so that they are not too far removed from clinical practice.

Learning from Revalidation

The Trust continues to have a robust electronic system and team in place to help manage revalidation and this ensures the process runs efficiently.

Our medical Appraisal Policy and Procedure was last updated and published in December 2022 and is due to be updated by January 2026. Our Job Planning Policy was updated and published in March 2023 and is also currently undergoing updates.

Responding to Concerns – Remediation/Disciplinary

Our Responsible Officer(Executive Medical Director), Associate Responsible Officer and Associate Director of Medical Development attend regular sessions with the GMC representative throughout the year. These sessions allow for any concerns to be raised and advice to be given from a GMC perspective – additional to these sessions the representative from the GMC is always available to be contacted with queries throughout the year.
In addition our Responsible Officer also attends the Responsible officer Network meeting organised by Regional NHSE.

The Policy followed in relation to Career Grade Medical Staff doctors is called 'Dealing with concerns affecting medical staff policy'.

Job Planning

The information/data in relation to job planning, detailed above in the report, is the first year we have had to provide information relating to our job plan sign off rates following a letter from the National Medical Director. The letter from Professor Meghana Pandit, Mark Brassington and Professor Stella Vig, highlighted the key points related to job planning and the ASK from NHS England.

- The need for Job Planning Data Submissions
- Visibility of data at Board Level
- Achieving 95% sign-ff of job plans by the next financial year

- In the future to achieve 98% delivery of sessional direct clinical care activity, delivered in the most productive way possible.

There are ongoing meetings and information being released by NHS England and this will continue to be actioned over the coming months and year.

Our Executive Medical Director chairs the Mental Health job planning task and finish group for NEY region to help improve the rate of completion of job plans across the region and focus on improving quality of job planning in line with the ask from NHSE. He is also a member of the regional job planning steering group chaired by the Regional Medical Director

Electronic IT System

SARD JV continues to be used as the electronic system for appraisals, revalidation and Job Planning. The Associate Responsible Officer continues to deliver training sessions to support the use of SARD for the purpose of appraisal and job planning for all new Consultant and SAS doctors that join TEWV, with sessions ran every 4 months.

From 1st April 2025 we have moved to a new version of SARD appraisal v7.1 in line with Good Medical Practice standards 2024 and Dr Lenny Cornwall has worked with SARD to adapt the appraisal portfolio on SARD to make it more streamlined for our medics.

We have also altered the process of appraisal for our Trust doctors, by designing a separate appraisal portfolio that is specific to Trust doctors. Trust doctors previously used the same portfolio as consultant and SAS doctors. In doing so they no longer need to upload their HORUS training E-portfolio to SARD as SARD is now much more catered to their appraisal needs.
Trust doctors have a priming appraisal in the first three months of joining the Trust, where they agree a PDP with their appraiser for the year ahead. They have a full appraisal around month 10 if they remain in post.

The Trust continues to use the 360 MSF module on SARD JV for the production of patient and colleague feedback for medics in AMH & MHSOP services. The format of the feedback forms mirrors the structure of questionnaires in use by the GMC. Medics in CYPS, LD and Forensic services may use the ACP 360 (which is from RCPsych) as this has a slightly different patient questionnaire which is more 'user friendly'.

The Trust also continues to use the e-leave function on SARD, which allows our doctors to request annual leave via SARD and to have that signed off by managers in a more streamlined process. We continue to provide training and advice where needed and we will be looking to gain feedback on how this has been going over the next 12 months.

Furthermore, the Trust continues to use SARD e-job planning for medical staff to complete an annual job plan. The form aims to consider job planning as a process, taking stock of commitments in each year and their appropriateness, alongside developing continuity between years ensuring amendments to work practices and financial impact are accurately captured and can be reviewed when needed. The system will have a key role in ensuring all quality improvement requirements of NHSE can be achieved for job planning.

Our contract with SARD is due to expire in October 2025, after we chose the option to extend for a further 12 months in October 2024. There is also the option to extend for a further 12 months in October this year, which we have now taken until October 2026. We began working with IT to explore other electronic systems to see if there are any better systems on the market and to ensure SARD is cost effective and can continue to meet our needs going forward. We are currently engaging in some informal demo's from other suppliers to see what is on the market before we decide whether to procure for a new supplier.

SARD Guidance has been updated to reflect new system layout following the implementation of the appraisal portfolio. The Associate Responsible Officer has developed local guidance for doctors to help them when using the new system for the first time which helps with adapting to the new layout.

Other Information:
We are closely looking at educational roles and undertook an audit on activity against roles.
We also formed a sub group to consider fairness and proportionality in relation to investigations. This will be updated further in the report next year.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: Tees, Esk and Wear Valleys NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	No change expected
Comments:	Yes, Dr Kedar Kale, Executive Medical Director was appointed Responsible Officer on 27th June 2022 and remains in post to date.
Action for next year:	No change expected.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	No change was expected.
Comments:	The Trust ensures we have the funds and staffing to support the role of Responsible Officer. TEWV as the designated body hosts the Medical Development team with dedicated members of admin and an Associate Responsible Officer to support the Responsible Officer.
Action for next year:	No change expected.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	We continue to use our current process of maintaining a prescribed connection with GMC Connect.
Comments:	Medical Development Team under the management of Dr Kedar Kale ensures that all our medical practitioners have a prescribed connection to GMC Connect, this is also linked to our electronic system SARD.
Action for next year:	The process will remain in place as described above.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Policies and Procedures to be reviewed in August 2025.
Comments:	We are currently updating our Appraisal Policies and Procedures which will be ready for January 2026.
Action for next year	There will be no action for next year, as the next policy update will be due in 2028/29.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	To continue to undertake a peer review of a selection of appraisal summaries to review their quality and improve our processes.
Comments:	Within our organisation this exercise is currently in its sixth year of being carried out and last took place between July-September 2024. We use the appraisal summaries for those doctors who were revalidated in the last year. We have seen an improvement in the

	quality of our appraisal summaries in the previous years. We provide feedback of the results of this exercise at our appraiser networks which we run 4 times a year. This is an internal peer review process. In 2024/25 we worked alongside Harrogate and Calderdale NHS Trusts to carry out a Trust to Trust peer review. It was useful to share areas of good practice and we also discussed areas for improvement. Strengths identified were that we have a good compliance rate for our doctors' completing appraisals. We discussed that one of our largest challenges currently is retaining and recruiting new appraisers as we don't offer a financial incentive to our appraisers like some other Trusts do, so this was a recommendation to focus on for TEWV. Currently Appraisers undertake this within their job plan as part of their Supporting Professional Activity. (SPA)
Action for next year:	To work on the recommendations above.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Continue with the process below.
Comments:	We provide exit reports for agency locum doctors that have worked with us for a minimum of 3 months upon leaving the Trust, which states details of any leave / sickness / complaints / investigations and comments from line managers. Longer term locums are provided with time to complete CPD. We provide supporting info to all our doctors (including those not prescribed to us) to enable them to input into their appraisal. For TEWV employed locums they are provided with software to access appraisals, coaching, CPD etc.
Action for next year	Continue with the process above

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Implementation of Appraisal 2022 model template.

Comments:	All appropriate information in relation to serious incidents, complaints, sickness etc is provided centrally for each individual's appraisal.
Action for next year:	Continue with the process above

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	No action identified.
Comments:	We have an appraisal policy and procedure in place which is followed in this instance.
Action for next year:	Continue with the process above

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Policy Review due in 2025.
Comments:	Our Trust appraisal policy and procedure were last updated in August 2022 and were approved at the Medical Directorate management meeting. The policy and procedure follows national guidance. We are currently reviewing these as it has been 3 years since we last updated.
Action for next year:	Update Policy & Procedure by 31st January 2026 then it will be 3 years until the next review is due.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	Currently trying to identify new appraisers due to the increase in IMG and Trust Doctors

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	There were 47 appraisers for 263 Doctors in 2024 – 2025. Unfortunately, due to a variety of factors we have seen a reduction in our appraisers this year. These include retirement, leaving the Trust and work pressures. We have employed from 2025, 3 Super Appraisers who have each agreed to undertake 12 appraisals across the appraisal year for a 3 year period.
Action for next year:	Continue looking at how we can attract more appraisers to take up the role.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	To continue providing training sessions.
Comments:	We normally hold four training sessions a year, of which appraisers must attend at least two. These are held in June, September, November and February. We also provide feedback to appraisers from appraises and these are discussed at the appraiser's own appraisal. - We have added a piece to the Medical Directors Bulletin to advise people need to attend two sessions and that we are monitoring attendance. We have also emailed all appraisers to advise them of this.
Action for next year:	Continue with process above

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	We follow a process whereby a group of appraisers undertake a peer review of appraisal summaries from the previous revalidation year, the findings are then fed back to the medical directorate management group and our appraiser group. Our appraisal process is quality assured through the use of feedback questionnaires following appraisal and then a report is collated for each appraiser at the end of the appraisal year.
Action for next year:	Due to the implementation of new guidance on SARD in 2025/26 we will not be undertaking the peer review of appraisal summaries but will continue to provide feedback for individual appraisers.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this

does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	We ensure that all fitness to practice recommendations are undertaken in a timely manner and where this is not possible we record the reasons and actions taken. Good communications exist with no concerns raised from either side. In addition regular meetings occur between the Responsible Officer and the GMC's ELA which are minuted – these allow for ongoing concerns and low level concerns to be regularly reviewed.
Action for next year:	To continue with the process above.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	Doctors are informed following the Revalidation Meeting of the recommendation, this is confirmed in a letter from the Responsible Officer. In terms of any deferrals or non-engagement these would have been discussed in advance of a revalidation meeting and communicated with the Doctor.
Action for next year:	To continue with process above.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	There are effective and well established processes in place for pre-employment checks, medical appraisal and revalidation, and responding to concerns. Within this, roles and responsibilities are clearly defined. The medical directorate has dedicated expertise and is adequately resourced to carry out its function.
Action for next year:	To continue with process above.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	**Yes**
Action from last year:	To continue with the process below.
Comments:	There is a disciplinary policy for maintaining high professional

	standards called 'Dealing with Concerns affecting Medical Staff'. Issues around conduct and performance can be identified from multiple sources, including formal complaints, SIs, Guardian of Safe Working, and the Freedom to Speak up Guardian, Monitoring of any conduct and performance issue is undertaken within the medical development team. Processes are in place to allow this to be done under a variety of different formats, depending on the seriousness of the concern e.g. low level concerns and disciplinary investigations. The department receives Complaints and SI reports each month and this is documented on the supporting information which is sent to doctors ahead of their appraisal. All doctors have a line manager who monitors performance. We also email Line Managers to ask for comments on the supporting information in regards to the doctors performance or if there are any concerns.
Action for next year:	To review and update the Dealing with Concerns affecting Medical Staff Policy in 2025, looking at the Framework for fairness and proportionality that was published by NHSE in 2025.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	We continue to update the Supporting Information template as and when necessary**.**
Comments:	Supporting Information template is populated 1-2 months in advance of the appraisal and uploaded into the SARD Portfolio. Supporting Information includes; Sickness, SUI's,& Complaints, Educational Events attended, Appraiser Details where appropriate.
Action for next year:	We continue to update the Supporting Information template as and when necessary**.**

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	To continue to use the below policy and if necessary, update accordingly.
Comments:	We have a Dealing with concerns affecting Medical Staff Policy which deals with Low Level Concerns and more serious investigations. In addition, actions to address non serious issues include putting action plans in place, offering coaching sessions and referrals to employee support or other relevant services are part of the above policy.
Action for next year:	Implementing any changes to Dealing with concerns affecting Medical Staff Policy.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent

governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	To continue to follow the below.
Comments:	In our annual report to the Board, we include an analysis of the number of disciplinary cases/low level concerns, type and outcome. In addition we provide information through the trust MWRES which includes analysis of the protected characteristics of the doctors concerned.
Action for next year:	To continue to follow the above.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	To continue to follow the below.
Comments:	We complete an MPIT form for doctors who work for us and are connected to us to pass to a doctor's new organisation. The medical development team inform the RO of any concerns, who would then directly contact the doctor's new Designated Body. If there are issues concerning agency doctors, we would contact the agency and ask that our concerns are discussed with their RO. If they wanted to discuss with our RO we would arrange this.
Action for next year:	To continue to follow the above.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	To follow the below.
Comments:	All doctors have clinical manager supervision, annual appraisal and annual job planning. Quality assurance systems are in place checking our processes. The medical revalidation team are part of the medical directorate which meets weekly for huddles and quarterly to discuss and agree issues in relation to appraisals and revalidation. All doctors are treated equally and any issues would be dealt with following our procedures. We have a complaints team and a dedicated medical development team that deal with all issues/concerns as they arise.
Action for next year:	To continue to follow the above.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	We will continue to ensure our processes remain fit for purpose**.**
Comments:	Our governance arrangements and assurance processes for doctors employed by TEWV remain robust and fit for purpose. We receive updates from RO networks and from regional Appraiser meetings, GMC etc.
Action for next year:	To continue to follow the above.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	To follow the below.
Comments:	Our appraisals are now more nuanced to reflect each profession's standards and development needs. Professional input is requested for disciplinary processes where professional standards are being queried.
Action for next year:	To continue to follow the above.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	**Yes**
Action from last year:	To ensure all pre-employment check standards are completed.
Comments:	Yes, we ensure that all six NHS pre-employment check standards are completed. This is done by medical staffing.
Action for next year:	To ensure all pre-employment check standards are completed.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last	To continue with the below.

year:	All new clinical leaders will now take part in the new managers programme to ensure that all senior staff have the same understanding of how the 'national expectations of senior managers' resources can support all our development.
Comments:	Yes, there are quarterly Leadership Timeout Sessions which explore quality, safety, learning from other organisations, Freedom to Speak Up. The Trust has undertaken a Culture Audit. Weekly bulletin and monthly Medical Directors Webinar support this agenda. The Trust has launched Show Racism the Red Card from September 2024. The restructure set up a formal expectation that our decision making would be clinically led, with clinical networks for each specialty to support. Our nursing and governance team developed and led the culture of care tool which is peer led by clinicians across our services. This links to our culture on a page oversight and our speak up group where representatives from teams come together to highlight any low level concerns they have about any teams. We engage with clinical leaders and managers in the same way that we engage with operational leaders – through quarterly events (recently covering organisational learning, quality, safety, learning from other organisations), and a core three year leadership and management development programme. The Freedom to Speak Up Guardian speaks at Senior Medical Staff Committee as well as Trust Board and our People Committee.
Action for next year:	To continue to follow the above.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue with the below. Work is underway to look into why some groups are over-represented in our disciplinary processes.
Comments:	All staff undertake necessary mandatory training and follow Trust Values and Behaviours as part of Our Journey to Change. We launched work with Show Racism the Red Card from September 2024, and invited clinical leaders from our BAME staff network to introduce this work and speak to board. We report all our statutory data but add extra monitoring to ensure we track all the experiences of our staff including through our employee relations processes which are reported to board. Staff networks are discussed at trust welcome session so that all staff know the opportunities for being part of the networks. Anti discriminatory training, upstander training and EDI champions are a key part of our work this year, with involvement in developing that work with clinicians from our staff networks. Staff and patients share stories of the organisation at committees and board on a regular basis. All staff networks have an exec sponsor and chairs meet with the director of people and culture every other month. The mandatory leadership and management programme includes work on understanding our impact on others, who we in/exclude, the way we behave in line with values and any access to wider

	development programmes requires evidence of paying it forward to colleagues and doing something to tackle health and social inequality.
Action for next year:	To continue to follow the above.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue with the below.
Comments:	In addition to comments above, we have a transparent process in place including the deputy director of People and Culture and the NED champion for any individual who believes they have experienced detriment as a result of speaking up. All senior staff undertake a values and a knowing yourself workshop. The organisational learning group is chaired by one of our clinical executives. The clinical executive triumvirate lead on multiple forums to ensure clinical and professional standards are consistent and embedded.
Action for next year:	To continue to follow the above.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	To continue with the below.
Comments:	Yes. Connected Doctors are able to provide feedback directly about their individual appraisal and also the general process for appraisals. In relation to Job Plans, doctors are able to escalate issues to the Job Planning Lead / Associate RO. All doctors can make complaints through the formal process or raise concerns through their team structures. The deputy director of people and culture and the associate director of medical development meet regularly to ensure our processes are consistent. The Associate Director of Medical Development is a member of the Freedom to Speak up group to ensure that professional work is joined up across the organisation.
Action for next year:	To continue with the above.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	We monitor information on all our Doctors involved in any concerns and quality information is provided as part of our MWRES return.
Action for next year:	To continue with the process above.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	To continue to attend Regional Appraiser Network meetings and RO meetings and continue to share best practice.
Comments:	Attendance at Regional Appraiser Networks and RO meetings, contacts made with other Trust colleagues to share information and best practice.
Action for next year:	To continue to attend Regional Appraiser Network meetings and RO meetings and continue to share best practice.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .
All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	263
Total number of appraisals completed	258
Total number of appraisals approved missed	5
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	58
Total number of late recommendations	2
Total number of positive recommendations	58
Total number of deferrals made	4 (Revalidated further along the appraisal year)
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	3
Total number of trained case managers	5
Total number of concerns received by the Responsible Officer[2]	7
Total number of concerns processes completed	7
Longest duration of concerns process of those open on 31 March (working days)	131
Median duration of concerns processes closed (working days)[3]	60
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	56
Total number of new employment checks completed before commencement of employment	56
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld[4]	Tribunal has not yet taken place.

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

detail not included elsewhere in this report.

General review of actions since last Board report
• Medical Revalidation Policy and Procedure is being reviewed and due for completion in January 2026. • To continue to undertake an internal peer review of a selection of appraisal summaries to review their quality and improve our processes. • To liaise with another organisation to consider external peer review – we did complete this with Harrogate and Calderdale NHS Trusts in February 2025. • Currently trying to identify new appraisers due to the increase in IMG and Trust Doctors – we have taken on 3 super appraisers in 2025 to help with this but we are still trying to recruit new appraisers.
Actions still outstanding
We are currently updating our Medical Revalidation Policy and Procedure and this will be completed by January 2026. A peer review of appraisal summaries was put on hold for 2025 due to the appraisal form on SARD being updated from April 2025 in line with Good Medical Practice 2024. We wanted to focus on embedding the new form this year and then undertake a peer review in 2026.
Current issues
We have had issues in trying to recruit new appraisers despite promoting and seeking support from medical colleagues, this is an ongoing issue that needs to be resolved.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
a. To review and update the Dealing with Concerns affecting Medical Staff Policy in 2025/26, looking at the Framework for fairness and proportionality that was published by NHSE in 2025. b. Plan to undertake quality assurance of appraisals in 26-27. c. To continue working on recommendations from the external peer review.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Our governance arrangements and assurance processes for doctors employed within TEWV remain robust and fit for purpose. We have successfully completed and learnt from an external peer review.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers)

Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Tees, Esk & Wear Valleys NHS Foundation Trust

Name:	Alison Smith
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Kedar Kale
Email address:	kedar.kale2@nhs.net

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Trust Board of Directors**
Date:	**9 October 2025**
Title:	**Getting the basics right for resident doctors**
Executive Sponsor(s):	**Dr Kedar Kale, Executive Medical Director**
Report Author(s):	**Bryan O'Leary** **Dr Hany El Sayeh**

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

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

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

Strategic risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
	Safe staffing	Failure to ensure a good working environment for resident doctors will have an impact on the future recruitment of resident doctors into career grade roles in the Trust. This would subsequently correlate to high locum and agency costs and poor morale of those colleagues remaining who cover recruitment gaps.

EXECUTIVE SUMMARY:

Purpose:

This paper has been written to provide assurance to the Trust Board that the organisation has considered the NHS England mandate that sets out clear expectations in the form of a ten-point plan to improve the working lives of resident doctors. The Trust will be asked to provide updates on those actions and demonstrate compliance throughout Autumn and into next year and this first report provides assurance on the current position and oversight of the agreed actions it has set to date.

Proposal:

A good level of assurance is being proposed. The Board are requested to note the contents of the paper and decide on the recommendations as detailed below. The Medical Education Leadership team (MELT) will be responsible for tracking progress against these measures

and will formally report back through the Medical Education Committee. The nominated Trust Leads, Dr Hany El Sayeh and Bryan O'Leary will continue to update the Board.

Overview:

In early September 2025, NHS England wrote to all NHS Trusts setting out a ten-point plan to improve resident doctors' working lives and to fix unacceptable working practices to help ensure that organisations got the basics right for resident doctors. NHS England have included adherence to the plan in the new NHS Oversight Framework and have asked organisations to provide updates and oversight of this work to the Trust Board. Below is a summary version from NHS England of their ten-point plan:

1. Trusts should take action to improve the working environment and wellbeing of resident doctors.
2. Resident doctors must receive work schedules and rota information in line with the Code of Practice.
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing.
4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
5. Resident doctors should never experience payroll errors due to rotations.
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating.
7. Resident doctors must be enabled and encouraged to exception report to better support doctors working beyond their contracted hours.
8. Resident doctors should receive reimbursement of course related expenses as soon as possible.
9. Reduce the impact of rotations upon resident doctors' lives while maintaining service delivery.
10. Minimise the practical impact upon resident doctors of having to move employers when they rotate.

Prior Consideration and Feedback:

The Faculty of Medical Education convened a meeting of resident doctor representatives on 23rd September 2025. The meeting set out and shared the plan and the group discussed and agreed an initial position of compliance with some immediate actions. (Appendix 1)

The Faculty consider many indicators when reviewing whether it has been able to provide quality undergraduate and postgraduate placements. One such measurement is the annual GMC Trainee Survey that compares the organisation with other Trusts and provides a national ranking score. This indicator puts the Trust in the Top 10 provider organisations in the whole of the UK which would suggest our initial compliance with the above is at a good level.

Implications:

Failure to meet the standards in the plan, as well as the many other quality indicators for medical education, would have a direct impact on the future recruitment of resident doctors into career grade roles in the Trust. This would subsequently correlate to high locum and agency costs and poor morale of those colleagues remaining who cover recruitment gaps.

Recommendations:

1) The Trust Board to confirm the level of assurance.
2) That the Board continues to receive regular updates in relation to the Trust action plan, with future updates provided by the nominated resident doctor leads.
3) The Trust Board should consider having the Ten Point Plan as a standard agenda item.

Appendix 1: Trust Action Plan

	Ten Point Plan	Trust Position	Status ✓/✗ Partial	Actions including lead	Progress
1.	**Improve workplace wellbeing for our resident doctors** Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so trusts can adapt implementation to reflect local needs and operational realities in these and other areas:	The Trust has developed a strong Faculty of Medical Education to oversee the delivery of both undergraduate and postgraduate placements and has created it's own standard operating framework for GMC compliance. The Faculty monitor compliance and satisfaction through the annual GMC survey, forums, feedback at organised clinics, end of placement job review forms and the annual internal audit event. In 2025, the Trust was ranked 6th best placement provider for overall satisfaction in the whole UK by resident doctors in the GMC Survey. The Trust has quarterly Postgraduate Forums during the year where junior doctor representatives attend and provide updates on their placements. The Forum receives an update on wellbeing as a standing agenda item and the group discuss issues affecting resident doctors working and rest environments. In attendance at the forum is the Director of Medical Education (DME), Guardian of Safe Working, Training Programme Director, representatives from the Faculty of Medical Education and colleagues from medical development. In addition, there are bi-monthly meetings held with junior doctor representatives and the Medical Staffing Manager to pick up more local matters associated with placements. During the past year five task and finish groups (Race / IMG, Disability, Gender, LGBTQ+ and Religious Practice) have been created with regular meetings taking place to formulate plans to address any negative feedback / outliers received from both internal and external quality visits and surveys. The Medical Education Leadership Team (MELT) continues to work closely with the Trust Strategic Lead for Equality, Diversity, Inclusion (EDI) and Engagement and the Director of People and Culture.	Status disc for next Forum	Medical Education Board Report to be written and submitted in December 25'. Lead : Hayley Lonsdale	

		Whilst the Trust provides ongoing assurance to relevant governing bodies, the Faculty identified that findings and actions from external quality visits did not always align to the internal feedback collected from resident doctor clinics, end of placements review meetings and Trust rankings in the GMC Trainee survey and so implemented its own internal audit framework to enhance the quality monitoring systems and receive genuine feedback first hand. These events now run annually with colleagues from one Care Group visiting the other to undertake an assessment and are a source of rich feedback, from which actions are set. This was described as exemplar at the Quality Management Visit.			
		The Faculty has developed a buddy support system to ensure that early year Registrars, Trust Doctors, Foundation Doctors and GP Registrars feel appropriately supported. It helps rotating doctors to understand the systems in place and points of contact.		Dr Jordan Williams outlined a SOP used by the Yorkshire and Humber School of Psychiatry to offer support to SpR's. MELT agreed to consider using a system like this or lobby the School of Psychiatry. Lead : Dr Hany El Sayeh	MELT Agenda (Medical Education Leadership Team)
		The Faculty has recently introduced VASCO. This initiative is essentially access to middle tier and consultant level advice out of hours. It is proactive support by providing Vertical Advice and Support for Colleagues On-call.		Audit the effectiveness and feedback from the lengthened conversation in August 2025. Lead : MELT	
		At the start of each OOH shift, a senior doctor makes contact with the resident doctor to 'check in' and discuss likely complex cases. Colleagues are also encouraged to have a lengthened conversation when it is the resident doctors first OOH shift in psychiatry (Aug 25') and are reminded by medical staffing when this is the case.			
		In 2025, MELT developed a Charter for resident doctor in TEWV. Some of those measures relate directly with improving the wellbeing and working environment and include:		The Faculty plan to survey resident doctors in 2026 to understand if it meets the standards outlined.	

				Lead : Hayley Lonsdale	
		• Effective and tailored individuals work schedules. • Paid opportunities available to shadow colleagues out of hours before undertaking the first shift. • Access and use of a personal laptop and mobile phone within two weeks of starting. • Opportunities to receive face-to-face or virtual coaching sessions with qualified coaches. • Access to free Royal College CPD learning and BAP modules. • Access to free, high quality internal CPD and professional development, including modules that complement the weekly teaching programme and MRCPsych. • Access to senior advice out of hours and proactive support through VASCO at the start of each shift. • Support from resident doctor representatives in each rota area with additional support from a Dignity at Work Champion and Wellbeing representatives, both roles being developed by the Trust. • Support to take a zero-tolerance stance on issues of any kind in relation to discrimination. • Opportunity to attend face to face wellbeing symposia focussed on doctors in training, developed by reps.			
	Where possible, [provide designated on-call parking spaces]	No designated spaces are granted on Trust sites. However, it has been agreed that resident doctors can park in designated disabled spaces whilst on-call. This is shared with doctors at induction.		Check with resident doctors that this approach is acceptable. Make this more prominent in the induction information so that it is understood by all. Lead : Dimitra Papakosta	
	The autonomy to complete portfolio and self-directed learning	Every doctor has an individualised laptop and has access to a workspace they can use.			

	from an appropriate location for them				
	Access to mess facilities, rest areas and lockers in all hospitals, including new builds	Every doctor has access to a junior doctor room on each main site. The Trust has rest rooms and facilities at each main hospital site and lockers are available as below: RPH – yes WPH – no lockers but metal draws are available LRH – TBC for next meeting FPH – yes CLH – yes			
	A 24/7 out-of-hours menu offering hot meals and cold snacks for staff	There are no cafeterias that operate out of hours on Trust sites. However, we have worked with local resident doctors to determine a choice of free ready meals and snack. This includes microwave hot meals, pot noodles, porridge, soup, as well as savoury snacks and biscuits. There is access to hot water and microwave on all sites.		Standing agenda item at rep meeting with medical staffing manager. Lead : Dimitra Papakosta	
	Within the next 12 weeks every trust should: Conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plans must be approved by the trust's people committee or equivalent body. Trusts will be expected to provide updates for national reporting on progress.	An annual survey will be created to understand the quality and facilities provided by the Trust. The group also discussed the BMA Fatigue and Facilities charter and this will be shared with the working group. A discussion was held to consider how progress against the plan could be reported back to the Trust and whether it was more appropriate for		It was agreed to set up a working group to design a survey that will be shared amongst doctors. This will include the standards of the ten-point plan and more aspirational standards to consider. Members include Dr Heba Saeed, Dr Aqsa Ghazanfar, Dr Sharon Kwagiri and Dr Oluwadara Akintunde. Lead : Chair of Working Group	

		the Medical Education Committee or People and Culture Group to oversee, and this will be discussed further with colleagues in the Trust			
2.	**Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice (COP)** **From now,** and for all rotations going forward NHS England must provide at least 90% of trainee information to trusts 12 weeks prior to rotations commencing. **From now,** Trusts must use this information to ensure that resident doctors receive their work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are not met corrective action must be taken. Performance data must be submitted by trusts, and NHS England will monitor and report on national compliance across all stages of the process	This is delivered by the Lead Employer Trust (LET) for colleagues in DTV Care Group • The LET maintains establishment reports of training placements and notifies each Lead Employer Placement (LEP) of expected trainees 12 weeks in advance of the rotational start date to comply with COP • The LET works to ensure compliance with COP by ensuring Work Schedules are issued to the trainee 8 weeks prior to commencement of an individual trainee's work schedule. • Overall, NE compliance rate with COP typically exceeds 90% with regards to the LET notifying the Lead Employer Trust (LEP)12 weeks in advance. • Some non-compliance is not locally driven, and the result of nationally implemented recruitment timelines. The Medical Staffing team is responsible for issuing work schedules to resident doctors in NYY Care Group. Overall compliance with COP (August 2025 rotation): • 100% compliance as rotas were compiled and distributed providing the required 6 week notice (it was noted that the NYY resident doctor rota had to be amended in Aug 25' and some changes made to Work Schedules. • 95% compliance with issuing all work schedules with 8 weeks notice. The delay of the remaining work schedules was caused as we waited confirmation of non work days of LTFT resident doctors. • Compliance with the COP will be monitored via the Resident Doctor Forums and data will be presented in future forums.			

3.	**Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing** It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery. **Within 12 weeks, NHS England will:** conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts.	As a Mental Health Trust, it is important to differentiate between resident doctors who remain on placement within the organisation (core and higher training) and resident doctors who rotate and join the organisation for a fixed period of time (FP and GP).		Consider whether a formal policy for annual leave is required for resident doctors. Action : Dimitra Papakosta	
		The Trust still finds some Foundation doctors seek pre-approval for annual leave whilst in a previous placement. It can also find that the distribution of leave is not consistent so this can negatively impact on the amount of time on leave when on placement in the MH Trust. This is a matter discussed with the Foundation School.			
		Annual leave is discussed and agreed within the service and where possible leave requested is agreed, whilst ensuring that patient care is maintained. A minimum of six weeks' notice is generally provided by the resident doctors.			
		Following a discussion, it was agreed that resident doctors should be able to seek approval for annual leave outwith their current rota cycle as this would support 'life planning'.		Once approval is granted a confirmation letter will be sent by Medical Staffing and they will take this into consideration when planning rota cycles. Lead : Bryan O'Leary	
		Additionally, annual leave requests should consider how the medical role impacts staff differently across the various tiers of medical cover and not solely granting approval for the resident doctor.		Medical managers will be asked to consider a process to capture this. Action : Hany El Sayeh	
		Before the rotas are compiled, resident doctors are asked by the medical staffing team to indicate specific dates (using MS Forms) to be avoided for on-call purposes. This system, where residents give notice of dates they wish to avoid, helps to create a fair and more balanced rota for resident doctors and it is appreciated.			

		The medical staffing team are currently considering an e-rostering solution that could allow doctors to indicate the dates to be avoided and ensure a fair and transparent scheduling process for all.		Medical Staffing Manager to oversee and report back when pilot rota site agreed. Lead : Dimitra Papakosta	
4.	**All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board** Within 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board. **In Sept 2025, NHS England will:** publish a national role specification for the board lead. The senior lead will formally take on this responsibility within an existing role, supported by a national role specification to be published by NHS England in September. The resident doctor lead will act as a peer representative and enable trust	Dr Kedar Kale, Executive Medical Director is appointed as the Board Lead.		The Trust will seek to understand the national profiles and consider as necessary. Lead : Bryan O'Leary	
		Dr Hany El Sayeh and Bryan O'Leary are appointed as the Senior Leaders			
		During the meeting held 23/09/25, the process to appoint a peer representative from the resident doctor body was discussed and agreed.			
		It was agreed that Bryan O'Leary would send communication to resident doctors about the appointment process and ask for expressions of interest to form a panel, made up of resident doctors and a member of MELT. This group would shortlist, interview and appoint a representative.		A letter was sent 24/09/25 Lead : Bryan O'Leary Raised at the SpR Forum 25/09/25	
		It was also agreed that the application to apply for this role would be open for all resident doctors, mindful that colleagues with more experience and at the end of core training or in higher training would and in representative roles would be more likely to succeed in this role.		Closing date 10/10/25 Lead : Bryan O'Leary	

	boards to hear directly from resident doctors themselves. They should be invited to attend board level discussions on issues which specifically relate to improving doctors' working lives. Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses	The Faculty produce a Medical Education Annual Board Report that outlines performance over the last year, challenges and risk and this provides assurance of placement activity.		To be tabled December 2025 Lead : MELT	
5.	**Resident doctors should never experience payroll errors due to rotations** Following a successful pilot that has reduced errors by half, we are extending the learning from this work to all NHS trusts. **Within the next 12 weeks, every trust should:** Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All organisations are required to establish a board-level governance framework to monitor and report	This is delivered as part of existing Lead Employer arrangement for resident doctors in DTV Care Group: With effect from 1/5/2025, the LET's Payroll Service is outsourced to NHS Payroll Services (provided by Northumbria NHS Foundation Trust) and is managed through an SLA by the LET.		John Chapman has been approached to be the finance lead that oversees payroll matters.	

	payroll accuracy and begin national reporting as required.				
		This element of the LET contract specification remains outsourced meaning that, irrespective of any change to the host organisation in the future, the LET continues to liaise with NHS Payroll Services to ensure onward delivery of these services. The LET continues to work with LEPs to ensure timely and accurate work schedules are received and the decision to outsource was to ensure a robust and consistent delivery of payroll services could be achieved as being part of a large payroll-specific team of experts. Performance standards are agreed by the LET and NHS Payroll Services along with specific KPIs the Payroll Services are performance managed against. These are in areas including accuracy and timeliness of payments (salary and approved expenses), overpayments, correspondence response times and meeting statutory deadlines. In terms of the resident doctors employed by TEWV, we work closely with payroll in order to ensure that any payroll errors are minimised and we have agreed that going forward a quarterly report will be produced and presented to LNC and the Resident Doctor Forums that would detail any issues in relation to accuracy and timeliness of payments as well as any errors resulting in overpayments or underpayments.			
6.	**No resident doctor will unnecessarily repeat statutory and mandatory training** **Within the next 12 weeks if they are not already doing so, every trust should:** Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of prior training.	Delivered as part of existing Lead Employer arrangements for resident doctors in DTV Care Group: The LET oversees compliance of Statutory and Mandatory training (via ESR). Given the LET model, this irradicates duplication of training as all employees managed as per annual cycle of requirements only irrespective of rotations. As part of the MOU, the Trust accept prior learning from all Core Skills Training Framework except Safeguarding. (The Trust will accept			

	By April 2026, NHS England will: reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England.	Safeguarding if the individual has completed both adult and children at the same level as TEWV deliver it combined and the CSTF has it separate). The Trust only accepts these from another NHS Organisation as per the MOU. Currently, resident doctors undertaking locum shifts are required to complete outstanding mandatory and statutory training prior to booking a shift - even if similar training has been completed under another organisation. This is because the locum bank is a separate employment contract with the Trust. TEWV accept prior learning for other National e-learning programmes: • Patient Safety Level 1 and 2 • Speak Up • Listen Up • Follow Up • Mental Capacity Act modules TEWV adheres to the People Policy Framework for Mandatory Learning agreed on 1 May 2025. The Workforce Development Lead is part of the national group and TEWV are with all Trust working towards the end goal. The TEWV document is not yet finalised, but it will go to the next Governance Oversight Group identified in the policy for agreement		The Medical Staffing Manager will meet with colleagues in the Trust to understand whether we can make this simpler. Lead : Dimitra Papakosta	
7.	**Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours** A new national Framework Agreement for Exception Reporting was agreed on 31 March 2025 and will be rolled out for implementation in due course. The	Awaiting roll-out of new national Framework Agreement for Exception Reporting (agreed March 2025).			

	changes agreed simplify the reporting process for resident doctors, ensure they are being fairly compensated for the additional hours they are required to work, and will support the safety of their working hours. We are committed to implementing these reforms as soon as practicable.				
		The LET is a key player given the new approach within the Framework which indicates Trainees will be obliged to submit Exception Reports to the Employer. TEWV has recently upgraded to DRS5 as exception reporting platform and in preparation for the roll-out of the national framework agreement.			
		The Trust provides written guidance and a step by step guide on how to submit exception reports as well as an overview of the system at each Resident Doctor Induction. We ensure that all exception reports are responded to in a timely manner and all data are presented in the Resident Doctor Forums as well as the Quarterly Guardian Reports.			
		Exception reporting was highlighted at the Trust Annual Audit event. It was agreed that there would be an additional session put on by medical staffing to practically illustrate how to use the system.		In place for December 2025. Lead : Dimitra Papakosta	
8.	**Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims**	This is delivered as part of existing Lead Employer arrangement for resident doctors in DTV Care Group :			

	We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a resident doctor has attended a course/activity, to one where reimbursement is provided as soon as possible after the expense is incurred. **Within the next 12 weeks every trust should:** Review their current processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsistence.	Specifically for Study Leave, the LET already has a long-standing process to ensure early re-imbursement of approved activity for trainees opting to apply this way (i.e. approved Study Leave costs can be submitted for re-imbursement at the time of booking rather than after the event). During the meeting, resident doctors raised concerns that they are unable to book study or training in NYY Care Group due to stricter course booking processed by the School of Psychiatry. This creates a system within the Trust that is inequitable, unfair and inconsistent. For resident doctors in NYY • Trainees submit their study leave on Accent (electronic study leave system), including expected expenses for approval as normal • Once the trainee has attended the training they then have to submit a TEWV expenses form to us for approval (see attached) along with any receipts. • The medical Development team then check the claim form against Accent to check the study leave / expenses were approved • If matches the expenses form is signed off, added to our monitoring spreadsheet and then sent to finance for payment • Expenses are signed off on Accent as approved / claimed (this is what has replaced the old “returns” system we used to have so HEYH know what has been claimed back by the trainee)		This is a longstanding issue and had been raised with the Dean. The DME will again highlight this disparity and provide challenge on behalf of the doctors, using this framework. Lead : Dr Hany El Sayeh	

9.	**We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery** A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority. **Within 12 weeks, NHS England will:** develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.	This is not a matter for the Trust. The NE LET shared their position: FP: National competitive recruitment, overseen by UKFPO, dictates that all applicants are matched to two-year Foundation Programmes with a specific LEP at the outset with all 6 x 4-month placements (specialty and location) also confirmed at that point. The Northern Foundation School (NFS) have limited flexibility to change their 'offer'. All Foundation Programmes are quality assured and checked to ensure that they provide a good balance of specialties and that each LEP is compliant with the requirement to offer exposure to Psychiatry. NFS offer Specialised FP pre-matching for 1/3rd of our programmes (7/21). NFS considers the personal circumstances of all applicants allocated to our School under pre-allocation on a case-by-case basis to facilitate a match to their first choice of LEP and Programme in the locality closest to their home address. What the Specialty Training team does at present is: Core psychiatry: doctors are either placed in the North (with CNTW) or South (with TEWV) for the whole 3 years. IMT: around half of their doctors spend 2 of their 3 years in a single trust. Head of School looked at the data which shows: • 2023 - 53% of doctors had 2 years in the same trust • 2024 - 44% of doctors had 2 years in the same trust • 2025 - 49% of doctors had 2 years in the same trust		The Medical Education Lead has written to Head of School to seek clarity on how they would support this action. Lead : Hayley Lonsdale	
10.	**We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model**	This is not a matter for the Trust. This is a matter for NHS England to work with partners.			

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9th October 2025**
Title:	**WRES, WDES, SOWES & Publication of Staff Equality Information**
Executive Sponsor(s):	**Sarah Dexter-Smith Executive Director of People & Culture**
Report Author(s):	**Lisa Cole, Head of Inclusive Cultures**

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**	The feedback from the WRES, WDES, SOWES and publication of information allows the Trust to better understand the experiences and outcomes for staff from protected groups, to act where necessary and in doing so to improve employee experience and retention.

EXECUTIVE SUMMARY:

Purpose:

This paper is presented to the Board to provide assurance that the Trust is meeting the requirements of the NHS Standard Contract by gathering data for the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) and request a decision that the Board supports publishing the results and associated action plans on its website by 31st October 2025. The Trust also undertakes and publishes a Sexual Orientation Workforce Equality Standard (SOWES). Publishing staff equality data also helps to meet the obligations under the Public Sector Equality Duty of the Equality Act 2010.

Proposal:

The paper proposes that there is good assurance that the Trust has followed a robust process in analysing its staff data by protected group and that the actions provide a clear response to the concerns raised. In doing so it is meeting its NHS Standard Contract requirements and Equality Act duties. The paper asks the Board to confirm that they support the publication of the information onto the external website.

Overview:
The Trust is obliged to meet its NHS Standard Contract requirements and Public Sector Equality Duties as outlined above.
The proposal for good assurance is based on the information in the appendix which demonstrates that a robust analysis has been carried out on WRES data, WDES data, SOWES data and equality data for staff from other protected characteristic groups, prior to publication on the Trust's website.

Areas of progress
The percentage of the workforce that identify as BAME **9.7%** compared to **7.9%** last year, percentage of the workforce declaring having a disability is **11.64%** compared to **9.23%** last year.
Increase in declaration rates for sexual orientation (**92%** declaration) and disability (**89%** declaration).
The percentage of staff that require reasonable adjustments and have had them in place has increased from **74% to 77%.**

Concerns
There are a number of immediate concerns identified actions to address these are in place and will be closely monitored - see Appendix 1. The full detail is presented in Appendix 2**.**
The arrows indicate whether the result has improved (↑) or is worse than last year (↓).

Harassment, bullying or abuse.
From patients, relatives, or the public – overall trust score 22.55%
BAME staff 39.57% (↓), Gay or lesbian 28.18% (↓), Bisexual 33.98% (↓), Gender not the same as assigned at birth 53.85% (↓), Muslim staff 32.56% (↑).
From colleagues – Overall trust score 13.87%
BAME 18.91% (↓), Staff with LTHC 18.02% (↑) Gender not the same as assigned at birth 38.46% (↓).

Discrimination
From manager/team leader or other colleague - Overall trust score 6.6%
BAME 18.48% (↓), Gender not the same as assigned at birth 23.08% (↓),
Buddhist staff 13.33% (↓), Muslim staff 20.93% (↓), LTHC 11.13% (↓).

Likelihood of being appointed from shortlisting
Likelihood of a white applicant being appointed from shortlisting compared to a BAME applicant 2.57 (↓) times more likely.

Likelihood of entering the disciplinary process
BAME staff are 2.46 (↑) times more likely compared to white staff to enter disciplinary processes.
Men are 2 (↓) times more likely compared to women.

Believing the Trust acts fairly in relation to career progression and promotion
Overall trust score 64%
BAME staff 53% (↓), Bisexual staff 54% (↓), Gender not the same as assigned at birth 49% (↓).

Board Diversity
The Board diversity does not reflect the current workforce (ethnicity, gender and sexual orientation).

Staff living in the 3 areas of highest deprivation.
In the Trust overall 33.87% of staff live in the 3 areas of highest deprivation. In the DTVF care group this is 37.52% of staff. In the NYYS care group 14.12% of staff live in the 3 areas of highest deprivation.

Prior Consideration and Feedback:
The development of the data has been undertaken by the Trust's Business Analytics and Clinical Outcomes Information Department and the Equality, Diversity, Inclusion and Human Rights Team. Staff networks have been involved in the development of the WRES, WDES and SOWES actions plans, through consultation events.
A version of this report and information has been to the Equality, Diversity, Inclusion and Human Rights Steering Group in July, Executive Directors Group and JCC in Sept 2025. Due to the timing of meetings this report will go to PCDC on 13th Oct.

Implications:
Failure to undertake the WRES and WDES or understand the differences in outcomes and experiences of our staff from protected groups in accordance with the Public Sector Equality Duties and the NHS Standard Contract may have regulatory and reputational consequences. Failure to act to reduce differences in outcomes and experiences of our staff from protected groups may impact on the ability of the Trust to recruit and retain staff.

Recommendations:
1. Confirm that the Trust has good assurance that a robust process has been undertaken when developing the attached data and actions for the WRES, WDES, SOWES and the Publication of Staff Information
2. Confirm that the Board approves the data for publication on the Trust website

Appendix 1
Areas of concern and actions

Harassment, bullying or abuse from patients, relatives, or the public.
BAME staff, gay, lesbian and bisexual staff, staff whose gender is not the same as assigned at birth and Muslim staff all report higher levels of harassment, bullying or abuse from patients, relatives, or the public.

Actions
Deliver the Show Racism the Red Card (SRTRC) overarching education/training programme – focus on cultural competency and addressing racism
Update the keeping staff safe at work poster campaign
Review the support for staff procedure following incidents
Review the Verbal and Physical Aggression Procedure

Harassment, bullying or abuse from colleagues and discrimination from manager, team leader or other colleagues
BAME staff, staff with long term health conditions, staff whose gender is not the same as assigned at birth all report higher levels of bullying, harassment, or abuse from colleagues.
BAME staff, staff whose gender is not the same as assigned at birth, Buddhist staff and Muslim staff and staff with long term health conditions all report higher levels of discriminations from their manager/ team leader or other colleagues.

Actions
Develop race equality/anti-discrimination policy as included in the Anti Racist Charter the organisation signed in Oct 2024
Develop and deliver managers bitesize training programme – including unconscious bias in the recruitment process, WRES/WDES/SOWES data, addressing discrimination, cultural competency
Pilot conversation cafés (sharing cultural and community differences and similarities)
Reverse mentoring opportunities – promote to managers and BAME, staff with LTHC's and LGB staff
Develop the buddy system via the BAME staff network to support staff experiencing racism & to support international staff who are new to TEWV
Triangulate data from exit interviews and intention to leave as included in the Anti Racist Charter the organisation signed in Oct 2024
Reasonable Adjustment module to be included in the new managers training
Develop a 12-month lunch and learn programme focusing on educating staff on different health conditions

Likelihood of entering disciplinary process
BAME staff are 2.57 times more likely to enter the disciplinary process compared to white staff and men are 2 times more likely to enter the disciplinary process than women.

Actions
Following changes in the PAG process identify ways to involve the EDI team in the disciplinary decision-making process

Likelihood of being appointed from shortlisting
Likelihood of a white applicant being appointed from shortlisting compared to a BAME applicant 2.57 times more likely. There has been a large increase in the number of BAME applicants, 3643 applicants this year compared to 1400 in 2024 (160% increase). There has also been an increase in white applicants but not the same % increase (33% increase).

Other regional trusts are reporting similar trends and are exploring if there is any explanation linked to BAME applicants being shortlisted but not having the right to work or being eligible for sponsorship, therefore effecting the likelihood figures.

Actions
Including unconscious bias in the recruitment process in the bitesize managers training
Analyse recruitment data to explore if there are any links to eligibility to be appointed (right to work, sponsorship, visa's)

Believing the Trust acts fairly in relation to career progression and promotion
In relation to career progression and promotion BAME staff are 11% less likely to believe the Trust acts fairly compared to white staff. Bisexual staff are 11% less likely than heterosexual staff, staff with LTHC are 6% less likely than staff without a LTHC, and staff identifying as not the same sex as assigned at birth 19% less likely compared to staff who identify the same sex as assigned at birth.

Actions
Undertake a survey and work with staff networks to understand the barriers to career progression
Reverse mentoring opportunities – promote to managers and BAME staff, staff with LTHC's and LGB staff

Staff engagement
Staff with LTHC's, bisexual staff and staff whose gender is not the same as assigned at birth have lower levels of engagement compared to the Trust overall score.

Actions
Embed "belonging" into the how we work project – celebrating diversity and what it means to belong to TEWV
Promote the permanency of the Reasonable Adjustment Team and all that it can offer
Explore funding to develop a Long-Term Health Conditions (LTHC) video
To understand the guidance to be released in August following the Supreme Court Ruling and support staff across the Trust and release communications
Develop an allyship toolkit

Board Diversity
10% of the workforce are BAME, 5% of the Board are BAME
12% of the workforce have a disability, 11% of the Board have a disability
79% of the workforce are women, 68% of Board are women
5% of the workforce identify as LGB, 0% of the Board identify as LGB
There is demographic information that is not declared or not stated.
26% of the Board hasn't not declared if they have a disability, 32% have not stated their sexual orientation, 37% do not wish to disclose their religion.

Actions
Encourage Board members to review their demographic information and update as required

EDIHR Department

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Workforce Race Equality Standard (WRES) 2025

2025

WRES

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- Mandated as part of the NHS standard contract
- 9 indicators
- Been collecting data since 2015
- Submit data into a national system
- Develop and publish annual action plans
- Governance – EDG, PCDC, JCC & Board
- 9.7% of the workforce identify as BAME (814)
- Census data – Local population identify as BAME 5.2%
- Consultation event held with staff networks

Indicator 1 – Workforce ethnicity
% of workforce who are BAME

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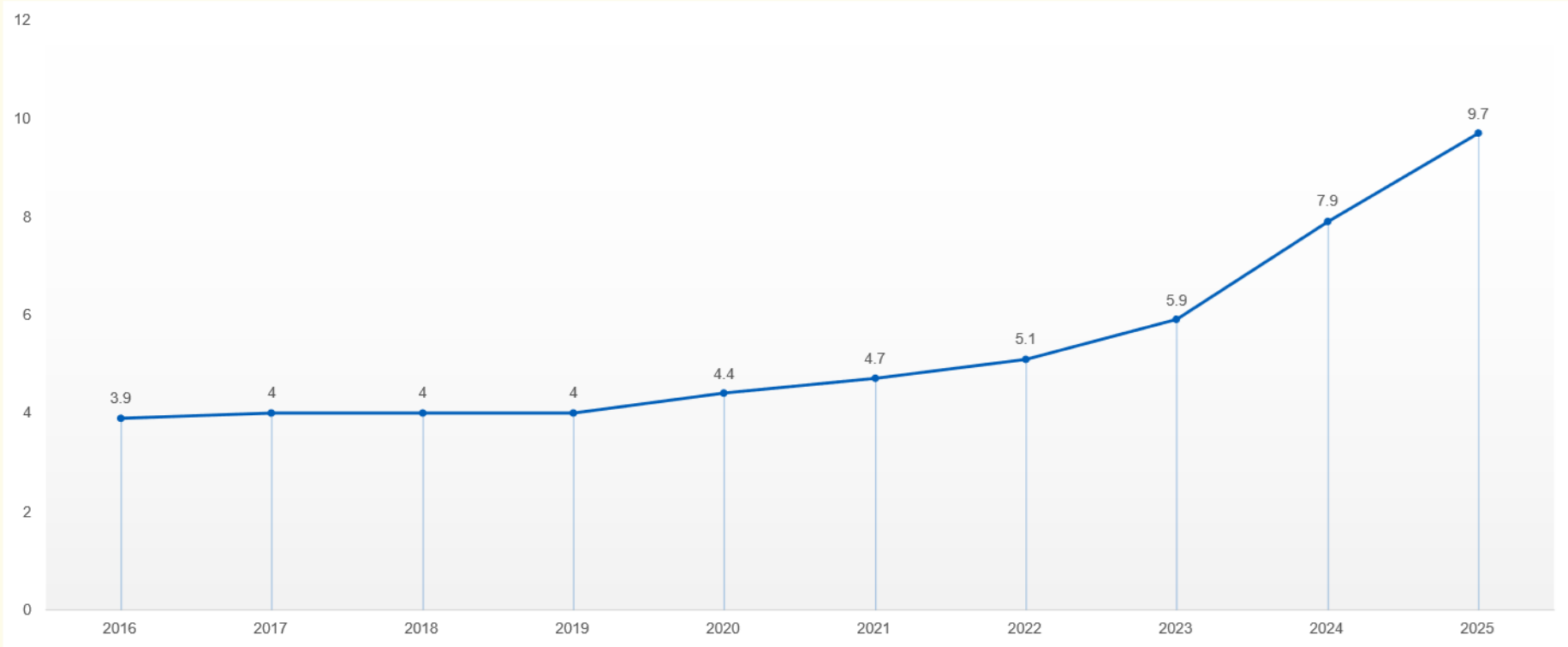

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Indicator 1 – Workforce ethnicity

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Indicator		Data Item			WHITE		BME		ETHINICITY UNKNOWN/ NULL	
					Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1	0	0%	0	0%	0	0%
			2	Band 1	12	100%	0	0%	0	0%
			3	Band 2	435	91%	33	7%	9	2%
			4	Band 3	532	93%	36	6%	2	0%
			5	Band 4	349	94%	19	5%	2	1%
			6	Band 5	172	91%	15	8%	1	1%
			7	Band 6	125	94%	7	5%	1	1%
			8	Band 7	122	92%	11	8%	0	0%
			9	Band 8a	56	98%	1	2%	0	0%
			10	Band 8b	47	98%	0	0%	1	2%
			11	Band 8c	17	94%	1	6%	0	0%
			12	Band 8d	12	100%	0	0%	0	0%
			13	Band 9	2	100%	0	0%	0	0%
			14	VSM	28	85%	3	9%	2	6%
		1b) Clinical workforce of which Non Medical	15	Under Band 1	7	64%	2	18%	2	18%
			16	Band 1	0	0%	0	0%	0	0%
			17	Band 2	11	100%	0	0%	0	0%
			18	Band 3	1144	82%	238	17%	15	1%
			19	Band 4	332	92%	25	7%	2	1%
			20	Band 5	828	85%	134	14%	9	1%
			21	Band 6	1682	94%	88	5%	20	1%
			22	Band 7	957	96%	32	3%	11	1%
			23	Band 8a	252	95%	13	5%	0	0%
			24	Band 8b	89	94%	5	5%	1	1%
			25	Band 8c	110	96%	2	2%	2	2%
			26	Band 8d	14	100%	0	0%	0	0%
			27	Band 9	7	100%	0	0%	0	0%
			28	VSM	0	0%	0	0%	0	0%
		OR which Medical & Dental	29	Consultants	95	58%	61	37%	9	5%
			30	of which Senior medical manage	0	0%	0	0%	0	0%
			31	Non-consultant career grade	53	32%	88	54%	23	14%
			32	Trainee grades	0	0%	0	0%	0	0%
			33	Other	0	0%	0	0%	0	0%
					7490	89%	814	10%	112	1%

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Indicator 1 – Workforce ethnicity

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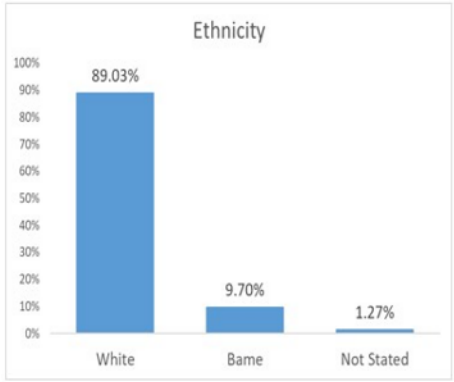

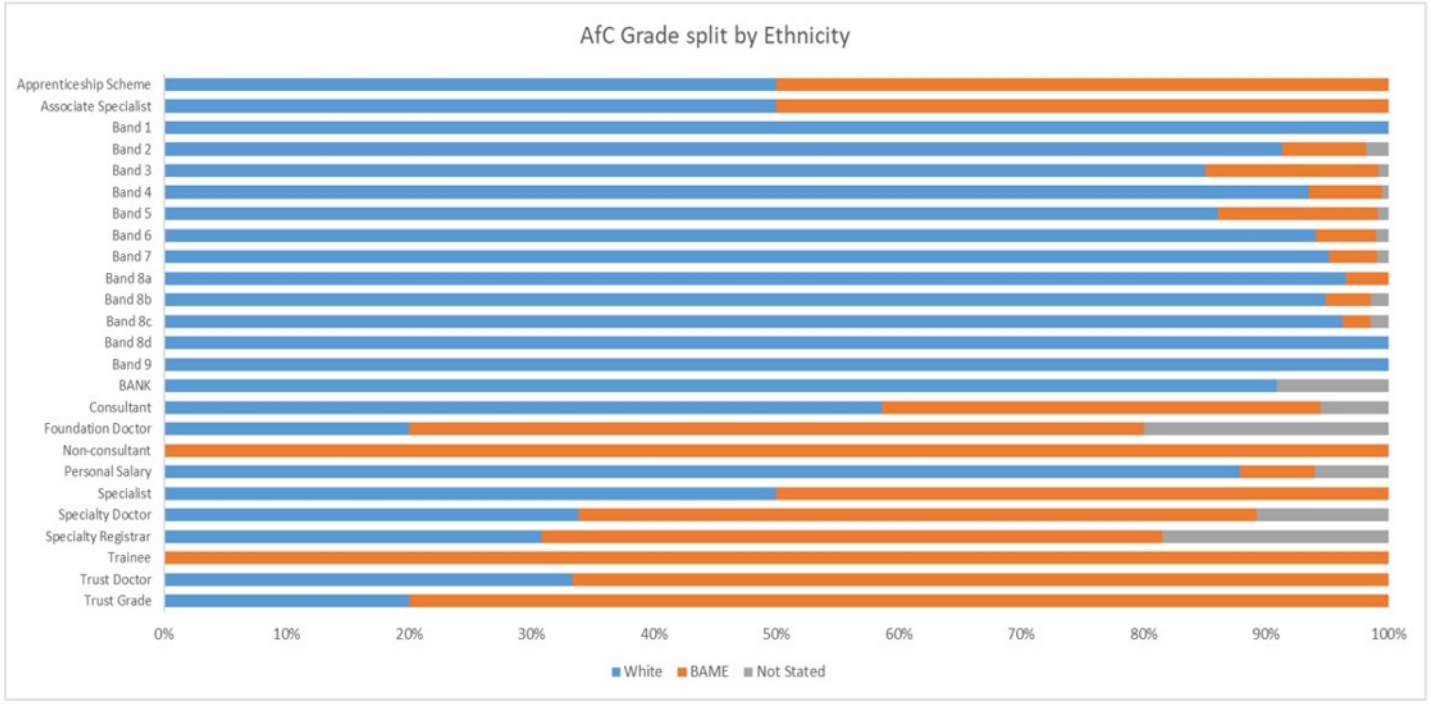

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Indicator 1 – Workforce Model Employer

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	Proportion of BAME workforce (as 31st March 2018)	Proportion of BAME workforce (as 31st March 2019)	Proportion of BAME workforce (as 30th November 2020)	Proportion of BAME workforce (as 31st March 2021)	Proportion of BAME workforce (as 31st March 2022)	Proportion of BAME workforce (as 31st March 2023)	Proportion of BAME workforce (as 31st March 2024)	Proportion of BAME workforce (as 31st March 2025)	**Trajectory for 2025**	Additional recruitment over next 3 years	Total BAME staff by 2028 to reach equity
Band 8a	6	9	9	9	14	13	11	14	9	0	10
Band 8b	0	2	2	2	2	5	7	5	3	0	4
Band 8c	1	1	2	1	1	1	3	3	3	1	4
Band 8d	0	0	0	1	1	0	0	0	1	1	1
Band 9	0	0	0	0	0	0	0	0	0	0	0
VSM	0	0	1	1	0	1	2	3	0	0	1

Indicator 2 – Recruitment

likelihood of a white applicant being appointed from shortlisting compared to a BAME applicant

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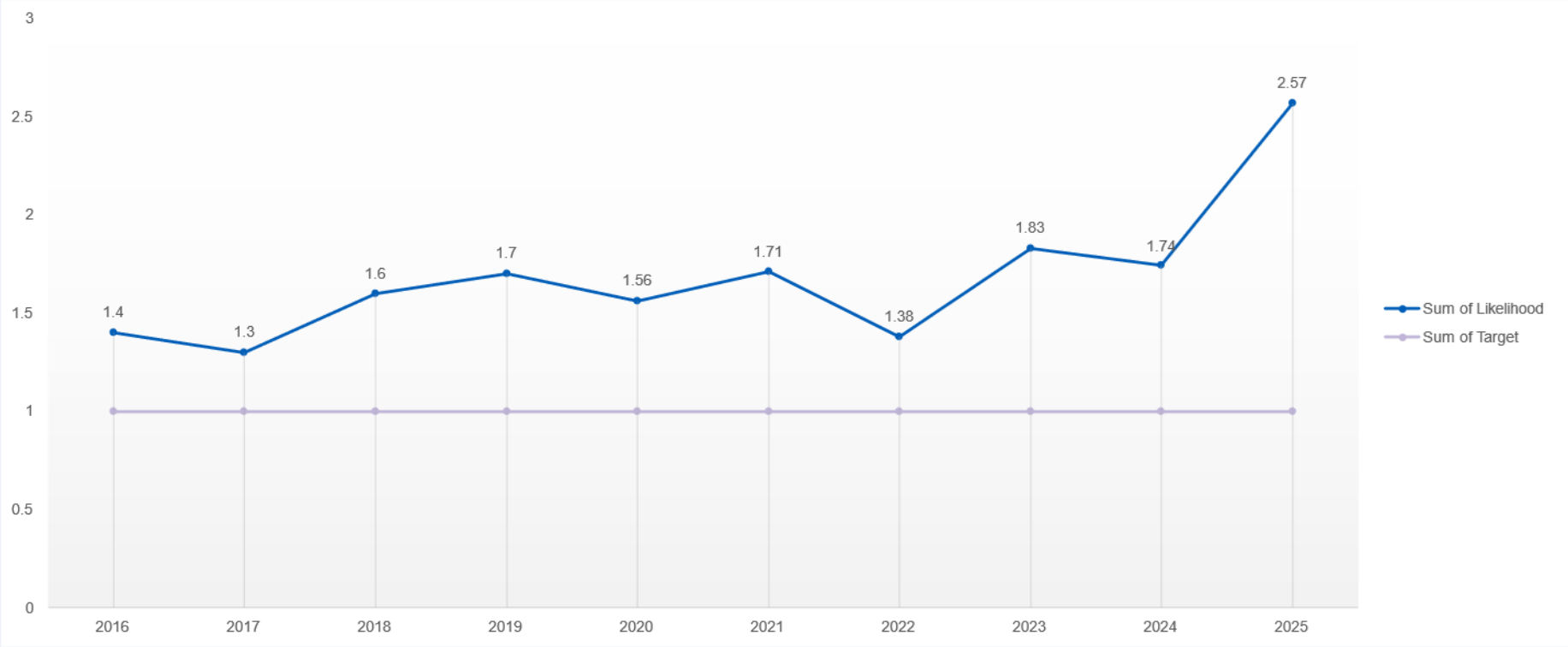

3643 BAME applicants shortlisted; 383 BAME applicants offered posts (in 2024 – 1400, 249)
5082 White applicants shortlisted; 1370 White applicants offered posts (in 2024 3823, 1185)

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Indicator 3 – Disciplinary

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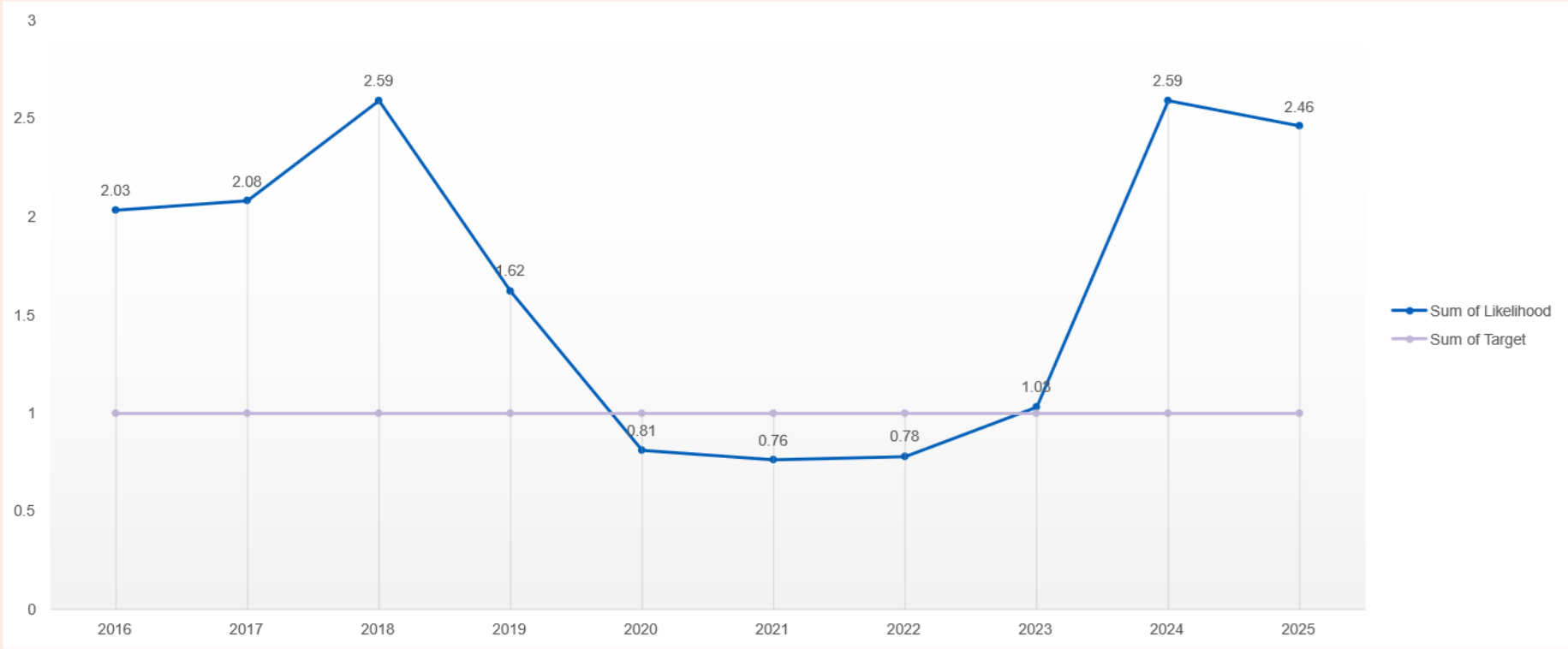
Likelihood of BAME staff entering disciplinary processes compared to white staff



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Indicator 4 – Likelihood of white staff reporting they have access to non -mandatory training/CPD compared to BAME staff

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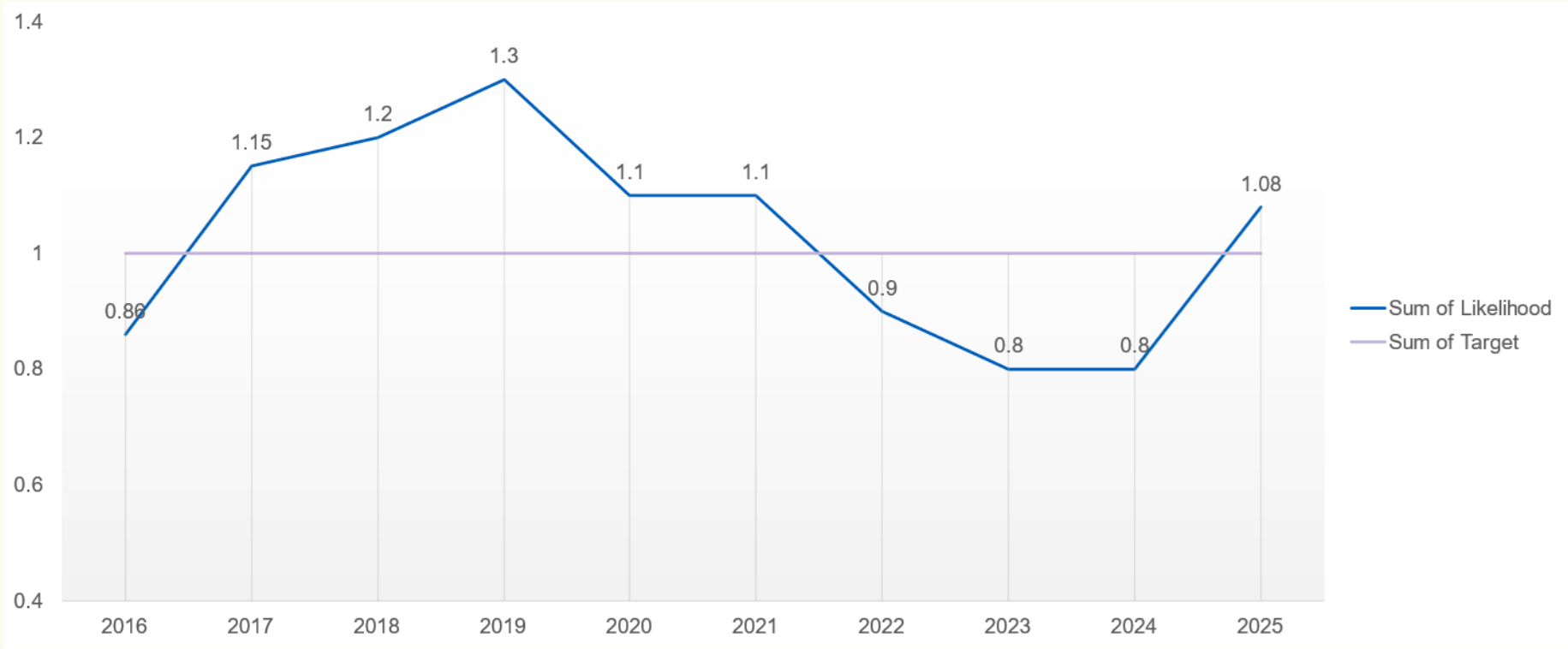

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Indicator 5 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

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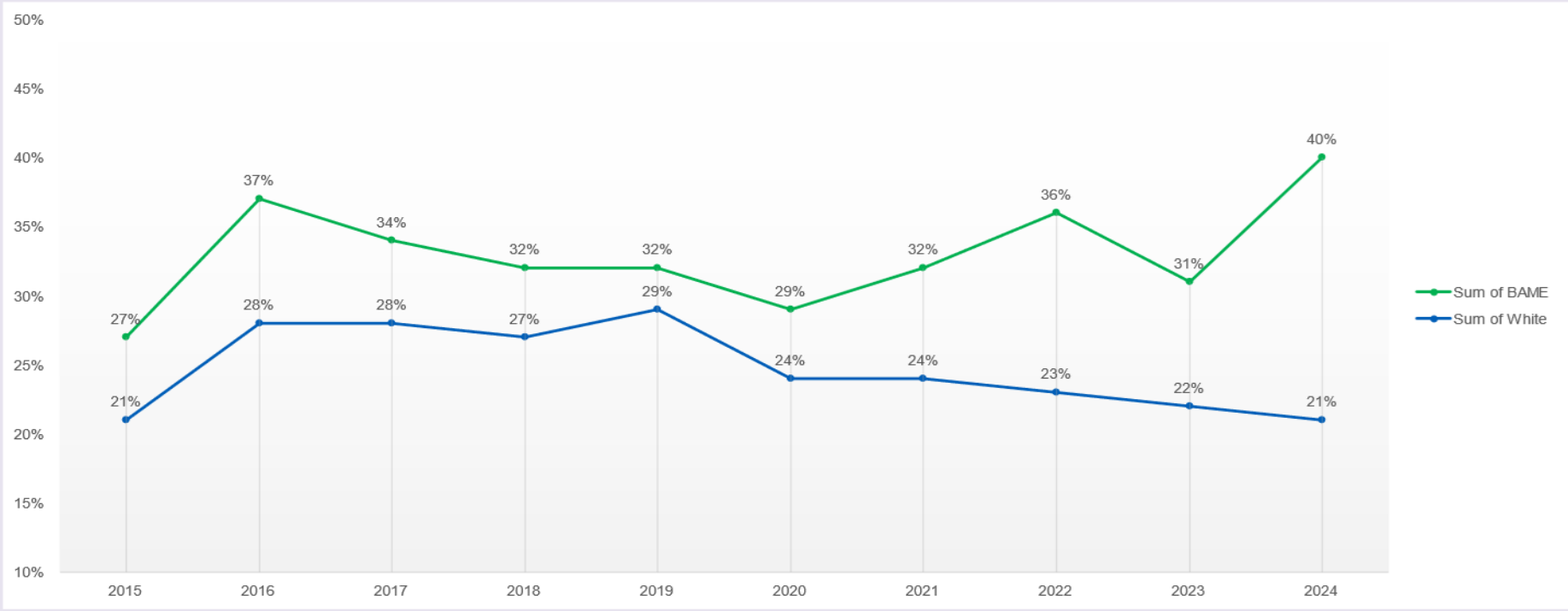

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Staff Survey response rates: BAME 278, White 3206

Benchmark - **White staff 21%, BAME staff 32%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts

Indicator 6 - % of staff experiencing harassment, bullying or abuse from staff in the last 12 months

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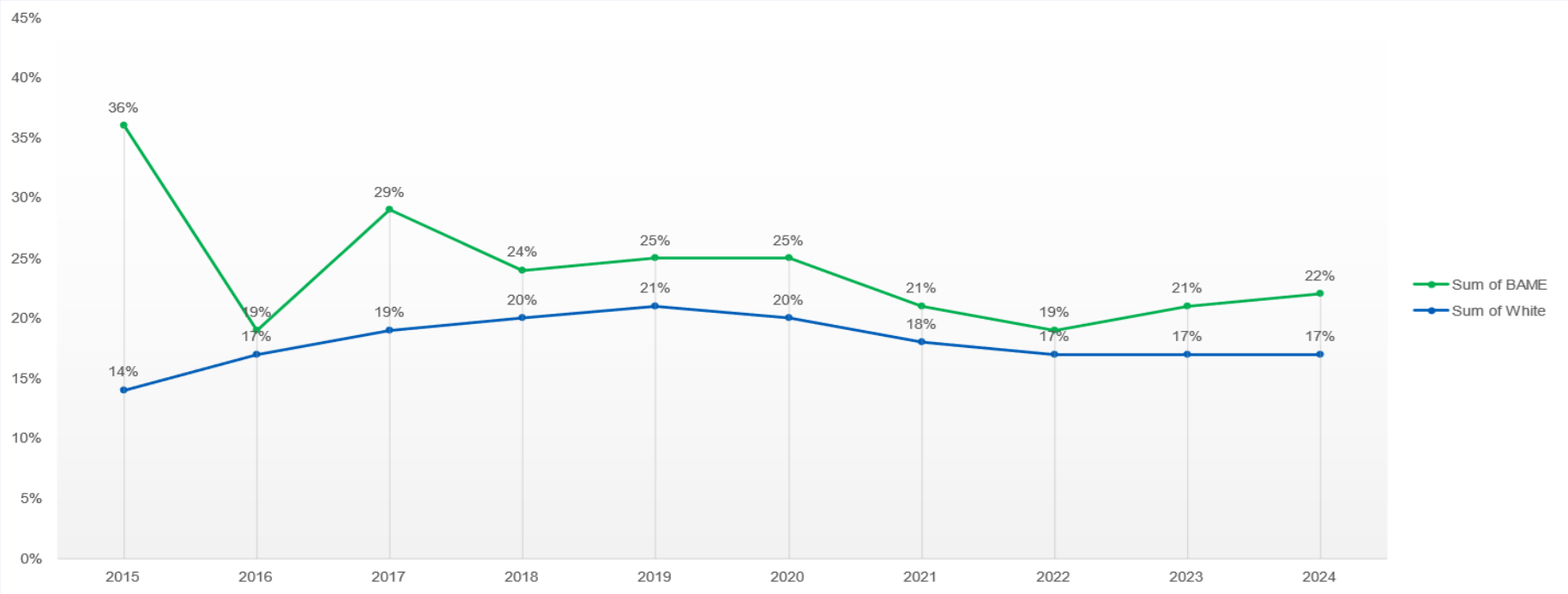
Tees, Esk and Wear Valleys
NHS Foundation Trust



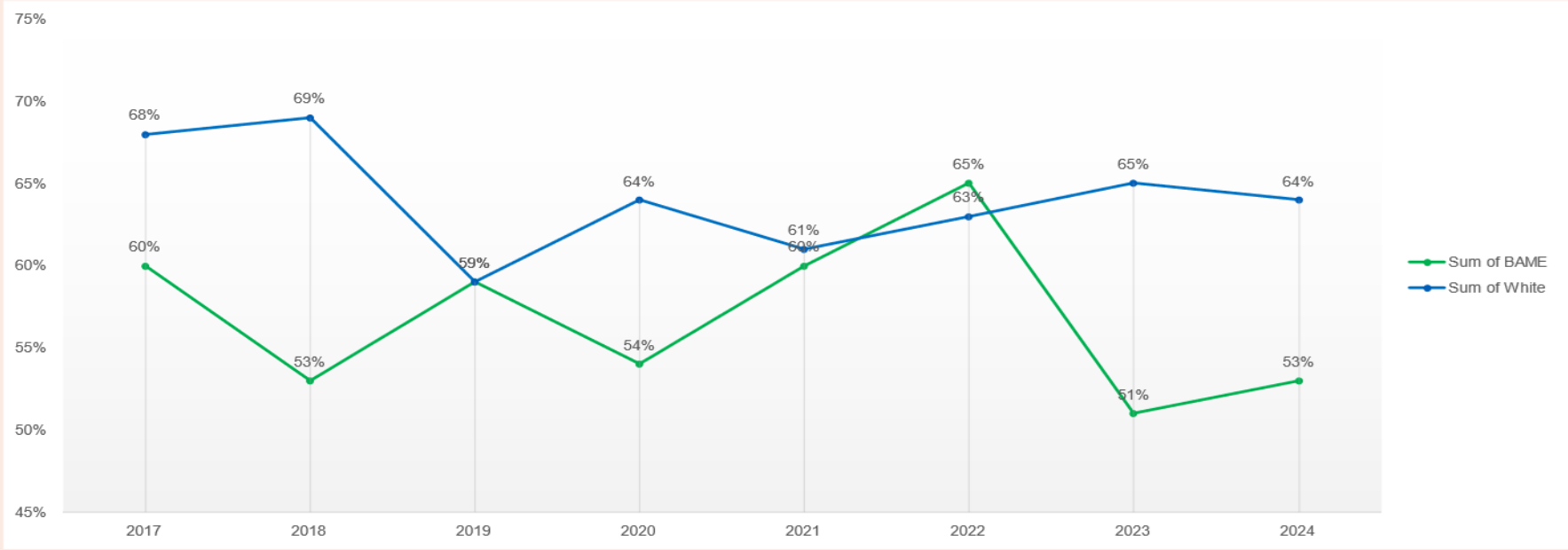
11

Staff Survey response rates: BAME 277, White 3210

Benchmark - **White staff 16%, BAME staff 21%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 7 - % of staff the believe the Trust acts fairly with regards to career progression and promotion

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



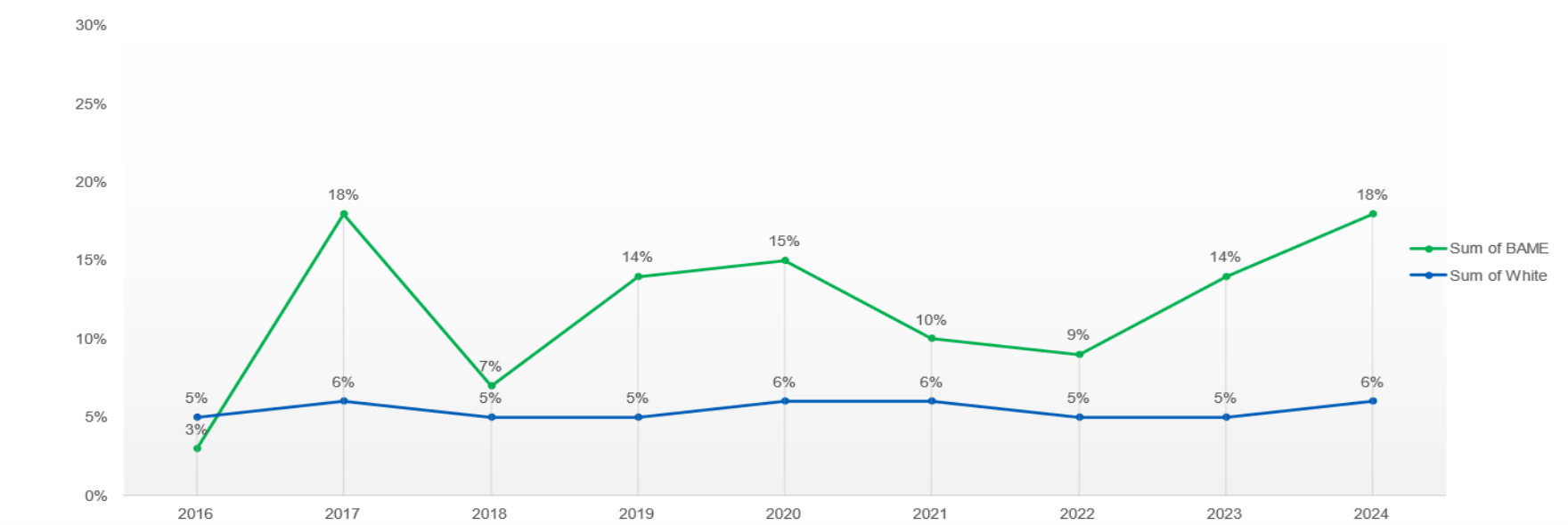
12

Staff Survey response rates: BAME 278, White 3197

Benchmark - **White staff 61%, BAME staff 51%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 8 - % have personally experienced discrimination at work from manager/team leader or other colleagues In the last 12 months

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



13

Staff Survey response rates: BAME 276, White 3173

Benchmark - **White staff 6%, BAME staff 13%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 9 - Board diversity

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Percentage difference between organisations boards membership and its overall workforce is

-4.3%

Percentage difference between organisations boards voting membership and its overall workforce is

-2%

Percentage difference between organisations board executive membership and its overall workforce is

-0.6%

14

EDIHR Department

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Workforce Disability Standard (WDES)

2025

WDES

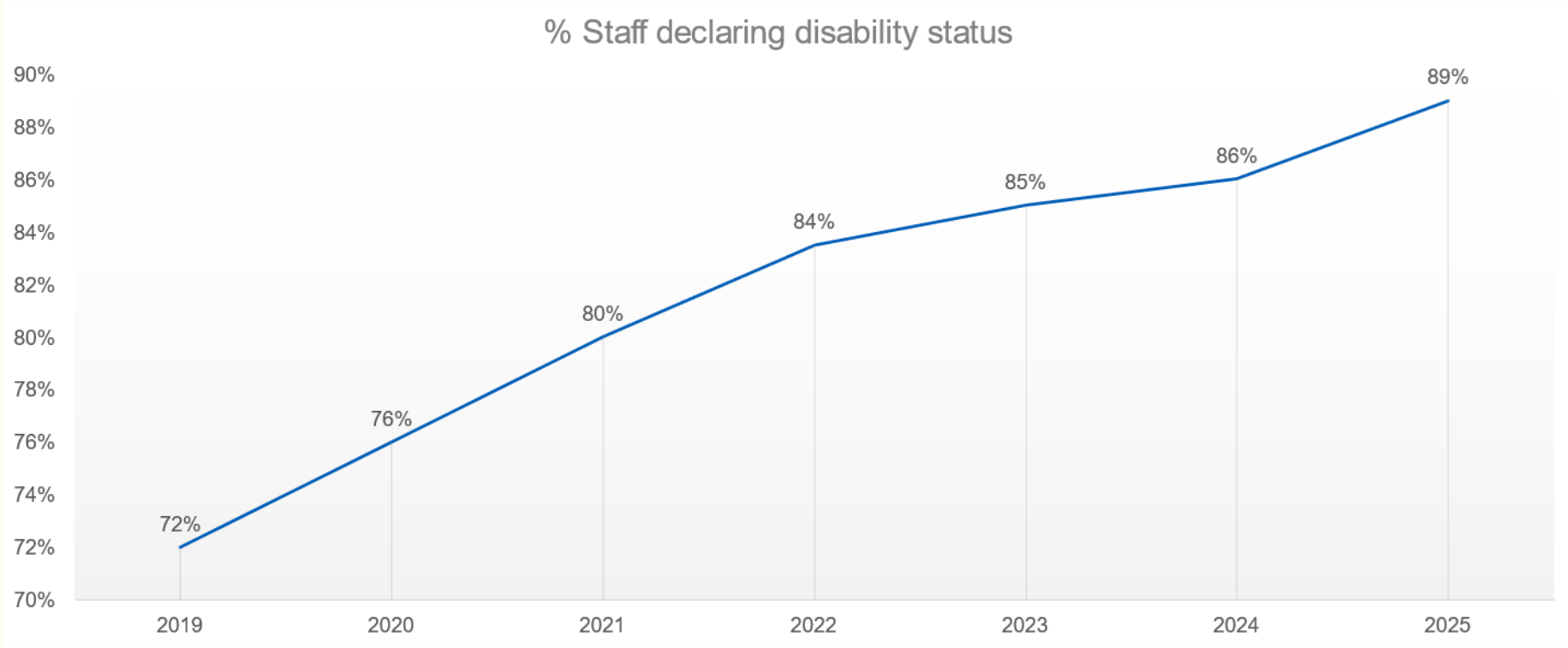
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- Mandated as part of the NHS standard contract
- Been collecting data since 2019
- Submit data into a national system
- Develop and publish annual action plans
- Governance – EDG, PCCD, JCC,Board
- 12% of the workforce identify as having a disability on ESR (980)
- Census data – 7.94% Local population have a disability
- Consultation event held with staff networks

2

Indicator 1 – Workforce disability status

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



3

Indicator 1 – Workforce disability status

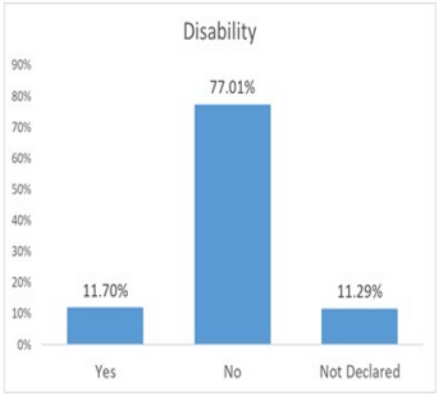
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

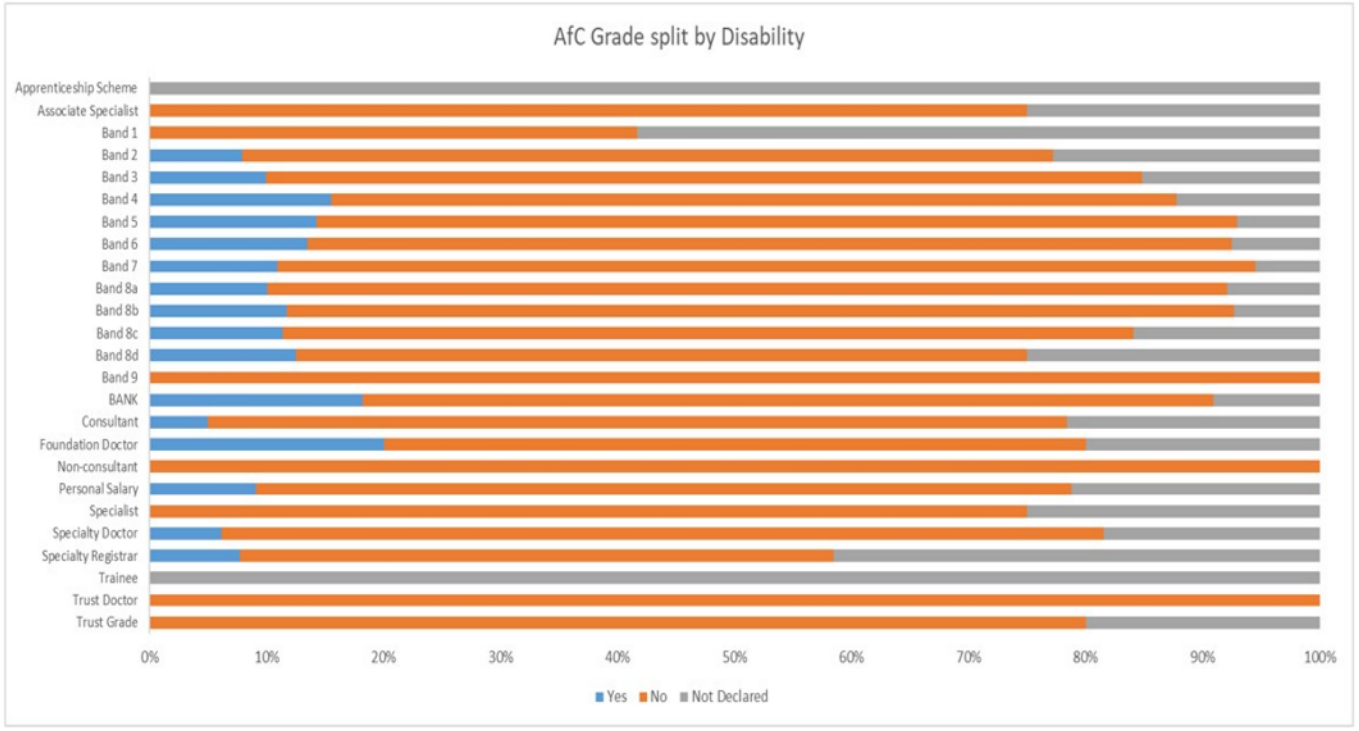
Indicator		Data Item			Measure	DISABILITY		NON DISABLED		DISABILITY NOT DECLARED	
						Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1	Headcount	0	0%	0	0%	0	0%
			2	Band 1		0	0%	5	42%	7	58%
			3	Band 2		38	8%	329	69%	110	23%
			4	Band 3		69	12%	449	79%	52	9%
			5	Band 4		45	12%	273	74%	52	14%
			6	Band 5		14	7%	156	83%	18	10%
			7	Band 6		25	19%	100	75%	8	6%
			8	Band 7		19	14%	99	74%	15	11%
			9	Band 8a		7	12%	43	75%	7	12%
			10	Band 8b		6	13%	37	77%	5	10%
			11	Band 8c		3	17%	10	56%	5	28%
			12	Band 8d		1	8%	7	58%	4	33%
			13	Band 9		0	0%	2	100%	0	0%
			14	VSM		2	6%	25	76%	6	18%
		1b) Clinical workforce of which Non Medical	15	Under Band 1		0	0%	7	64%	4	36%
			16	Band 1		0	0%	0	0%	0	0%
			17	Band 2		0	0%	10	91%	1	9%
			18	Band 3		127	9%	1025	73%	245	18%
			19	Band 4		67	19%	254	71%	38	11%
			20	Band 5		149	15%	757	78%	65	7%
			21	Band 6		233	13%	1419	79%	138	8%
			22	Band 7		107	11%	844	84%	49	5%
			23	Band 8a		25	9%	222	84%	18	7%
			24	Band 8b		10	11%	78	82%	7	7%
			25	Band 8c		12	11%	86	75%	16	14%
			26	Band 8d		2	14%	9	64%	3	21%
			27	Band 9		0	0%	7	100%	0	0%
			28	VSM		0	0%	0	0%	0	0%
		OR which Medical & Dental	29	Consultants		9	5%	121	73%	35	21%
			30	of which Senior medical manage		0	0%	0	0%	0	0%
			31	Non-consultant career grade		10	6%	105	64%	49	30%
			32	Trainee grades		0	0%	0	0%	0	0%
			33	Other		0	0%	0	0%	0	0%

4

Indicator 1 – Workforce disability status

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

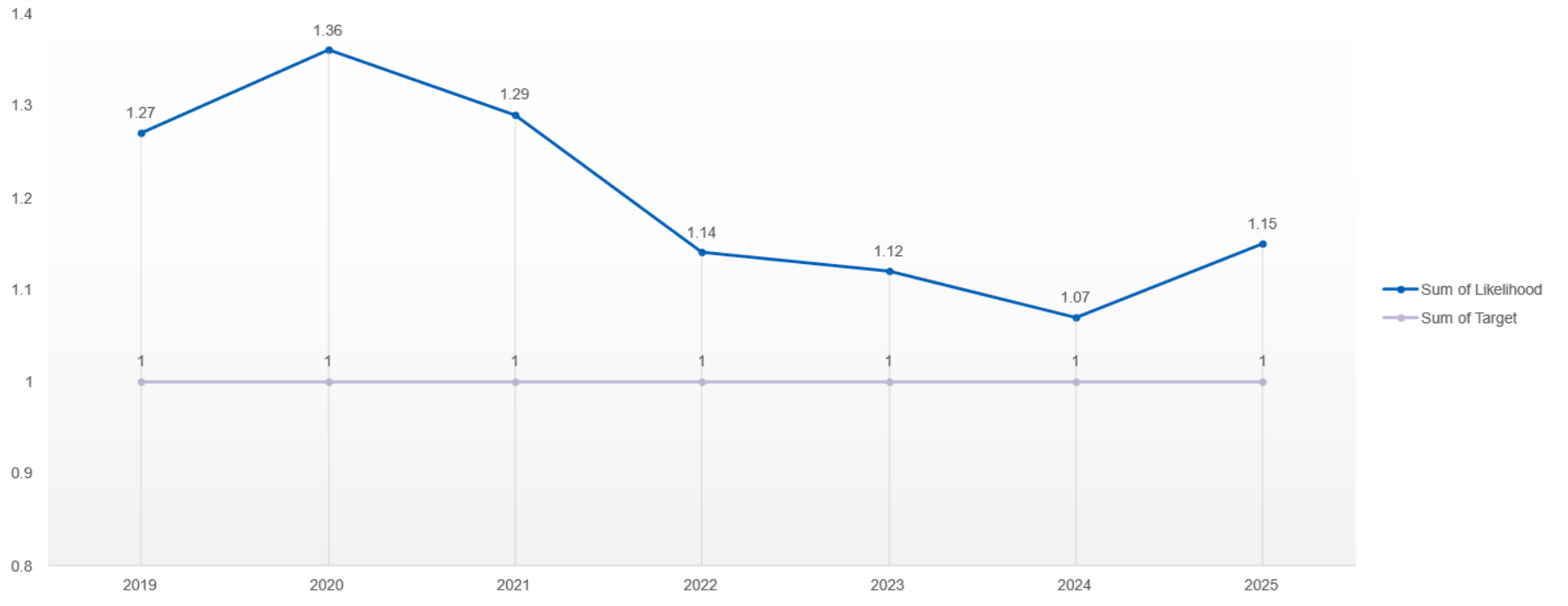




5

Indicator 2 – likelihood of an applicant without a disability being appointed from shortlisting compared to an applicant with a disability

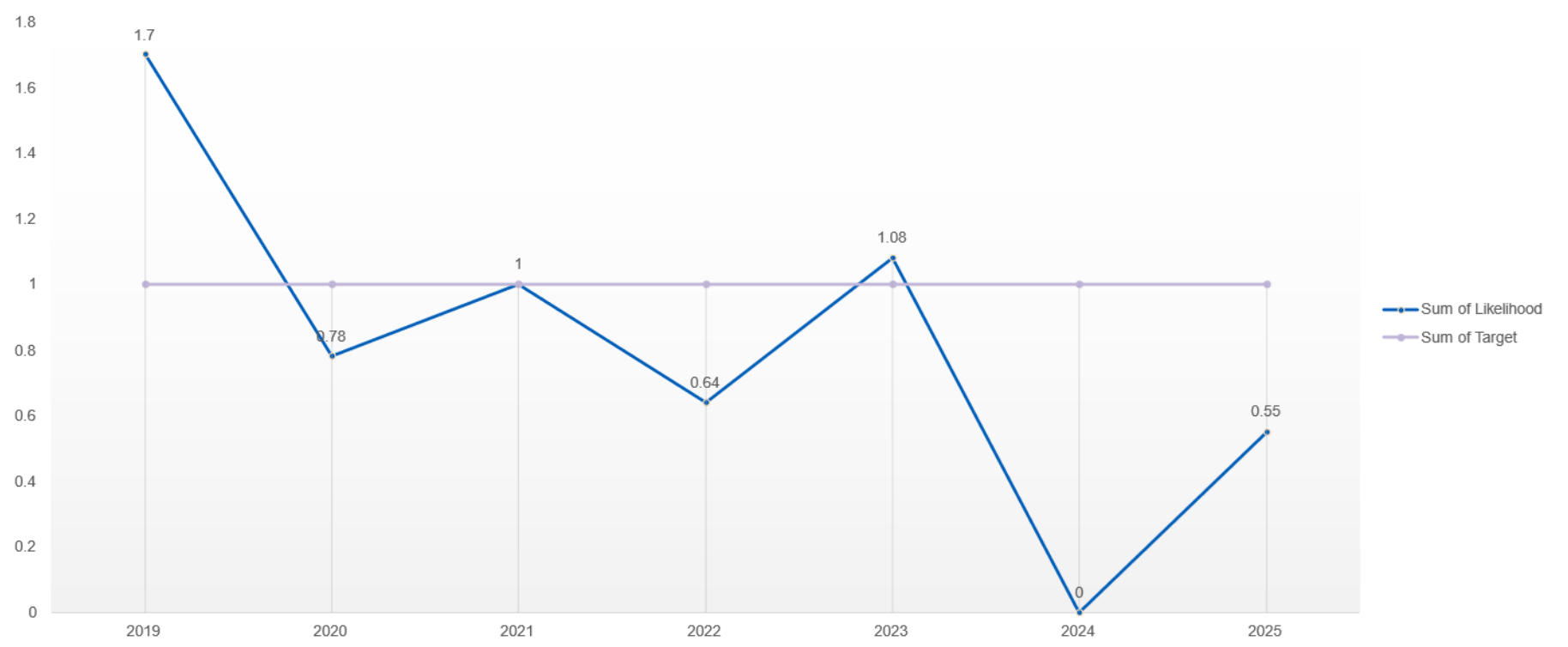
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



6 1080 applicants with disabilities shortlisted; 192 applicants with disabilities offered posts
7506 applicants without disabilities shortlisted;1536 applicants without disabilities offered posts

Indicator 3 – likelihood of someone with a disability entering the capability process compared to someone without a disability

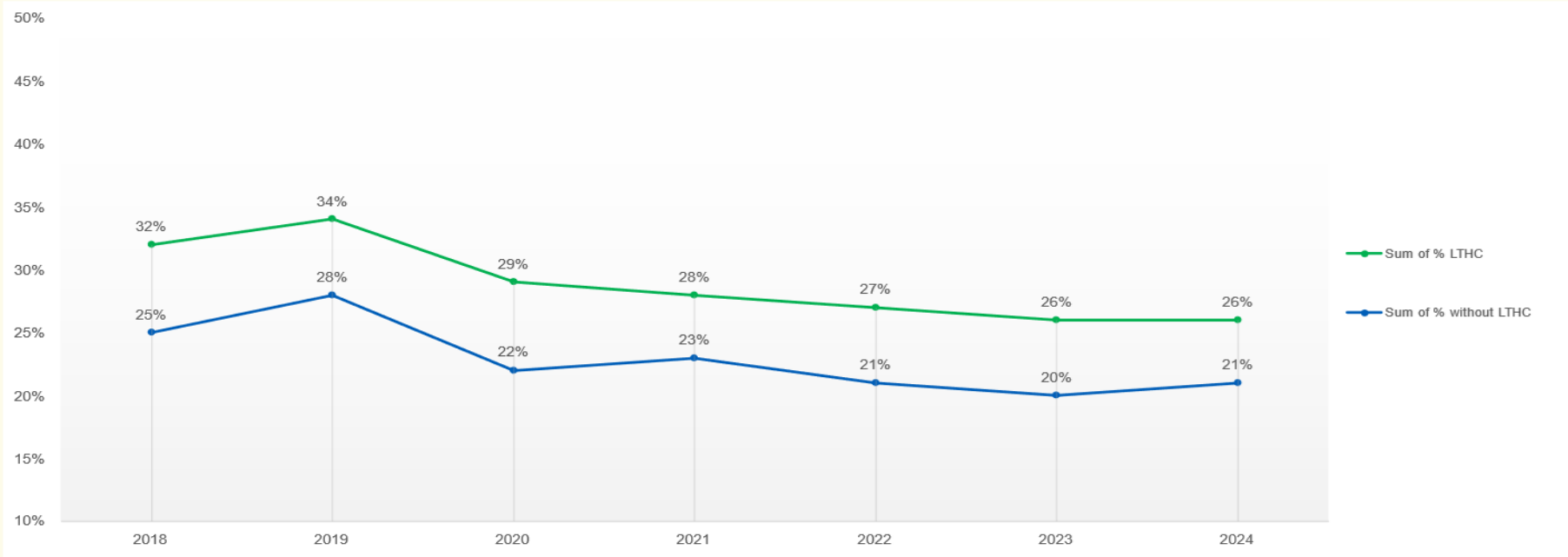
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



7

Indicator 4 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



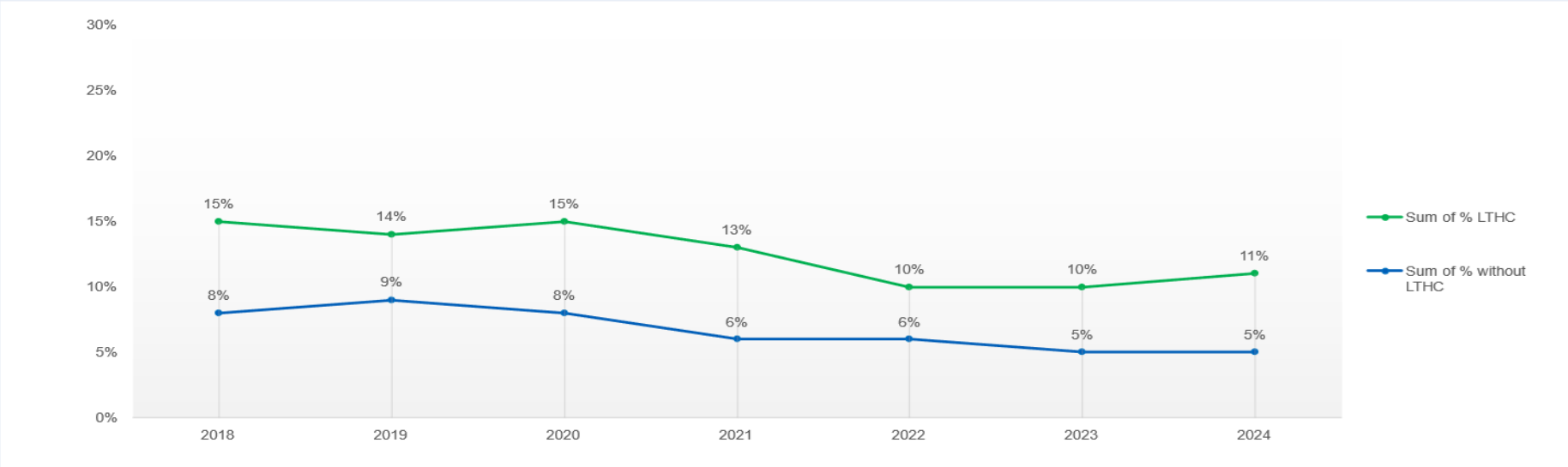
Staff Survey Responses – Staff without a LTHC 2240, staff with LTHC 1216

8

Benchmark - **staff without LTHC 22%, staff with LTHC 27%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 4 - % of staff experiencing harassment, bullying or abuse from manager In the last 12 months

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



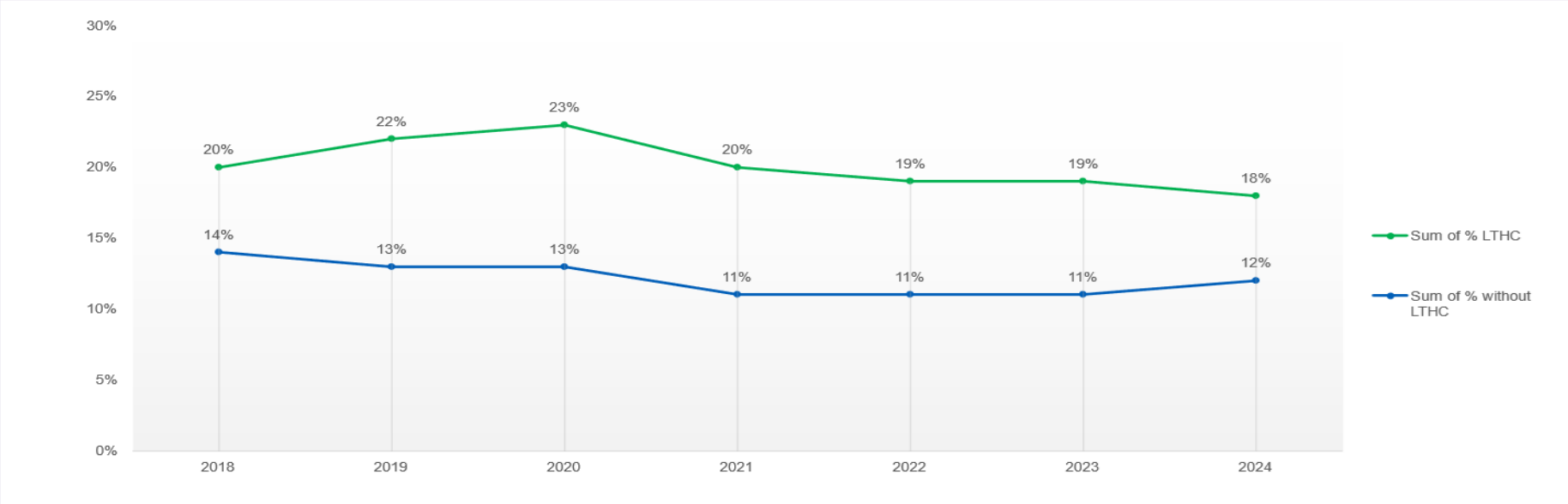
Staff Survey Responses – Staff without a LTHC 2225, staff with LTHC 1212

9

Benchmark - **staff without LTHC 6%, staff with LTHC 12%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 4 - % of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



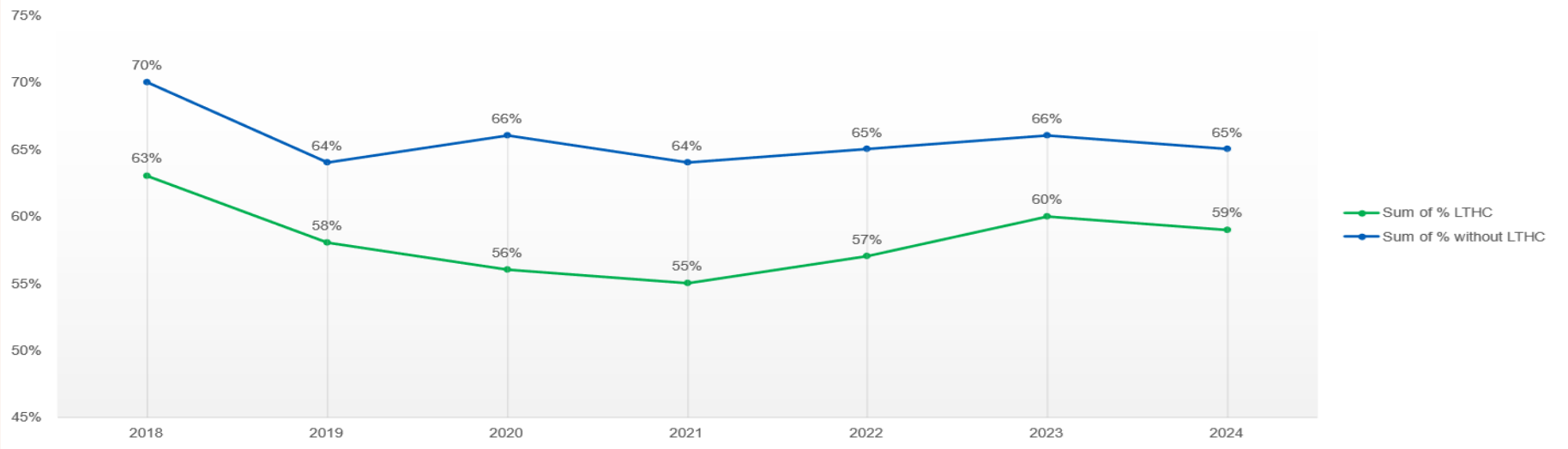
Staff Survey Responses – Staff without a LTHC 2215, staff with LTHC 1199

10

Benchmark - **staff without LTHC 12%, staff with LTHC 18%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 5 - % of staff the believe the Trust acts fairly with regards to career progression and promotion

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



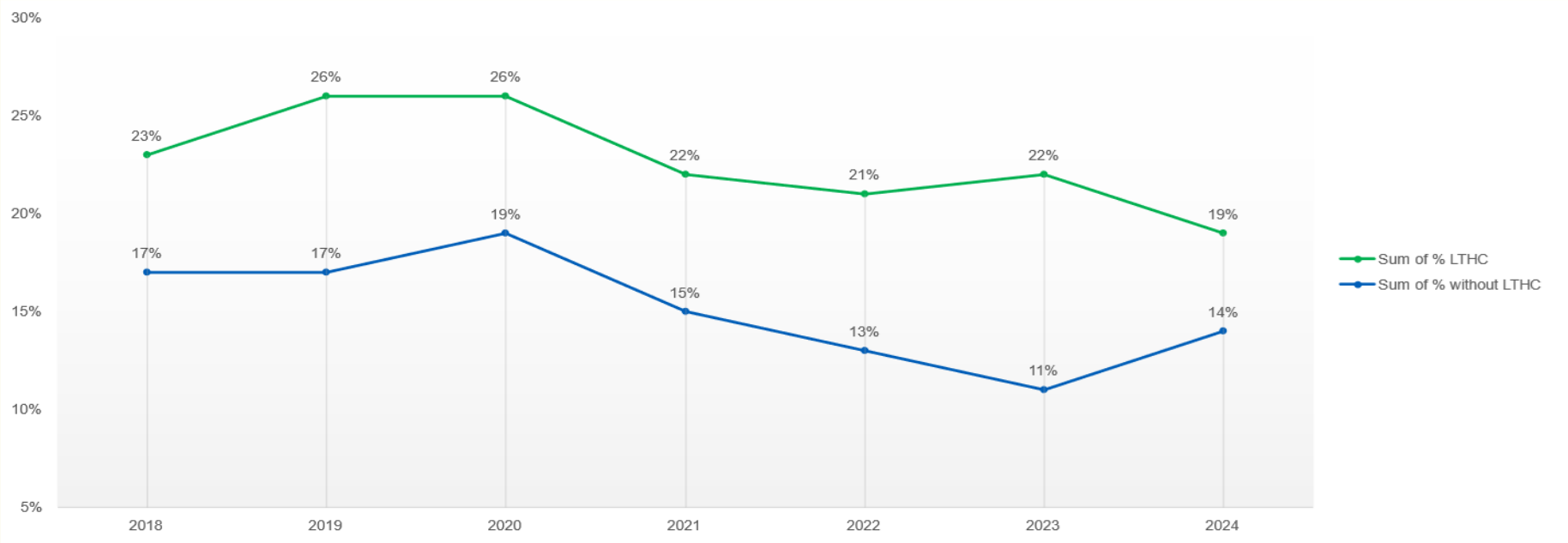
Staff Survey Responses – Staff without a LTHC 2238, staff with LTHC 1209

11

Benchmark - **staff without LTHC 61%, staff with LTHC 55%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 6 – % felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



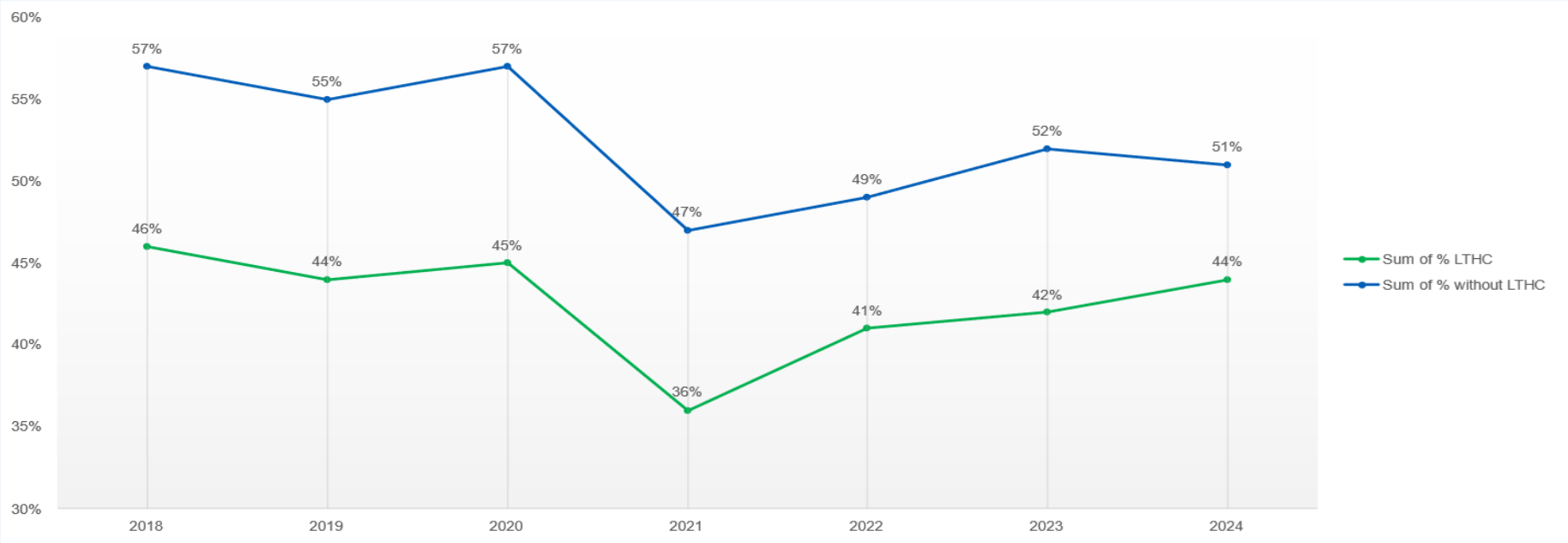
Staff Survey Responses – Staff without a LTHC 1017, staff with LTHC 822

12

Benchmark - **staff without LTHC 12%, staff with LTHC 18%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 7 - % satisfied with the extent to which their organisation values their work

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



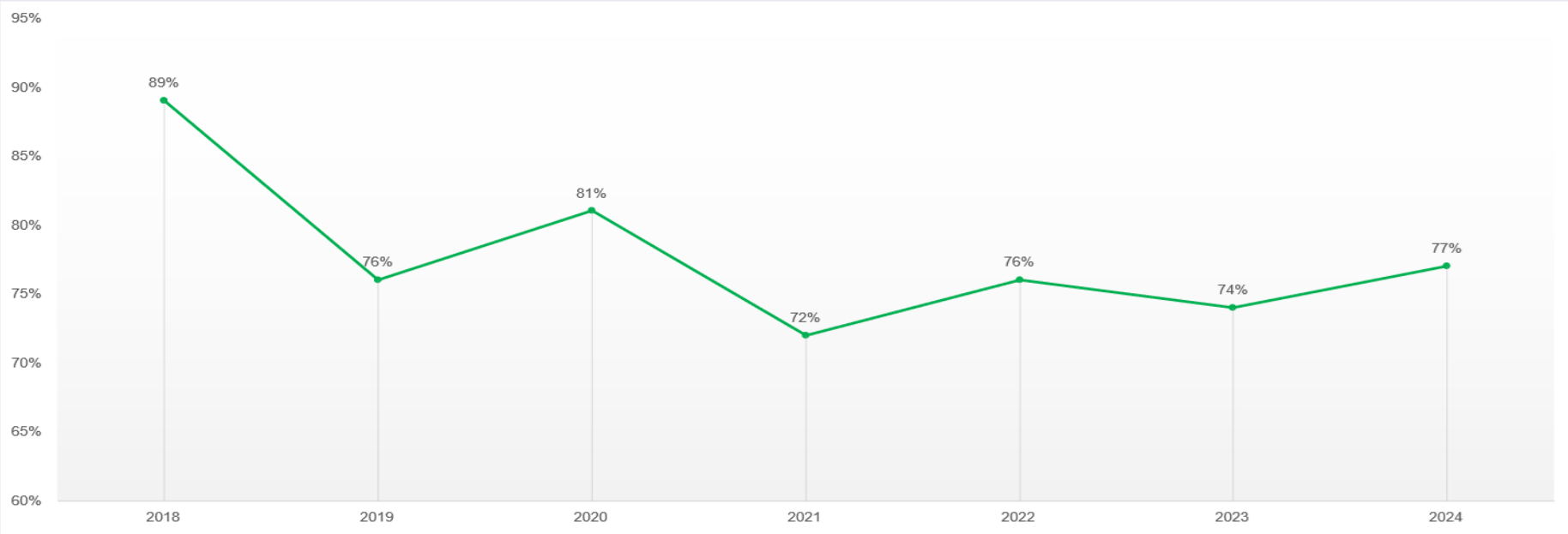
Staff Survey Responses – Staff without a LTHC 2251, staff with LTHC 1221

13

Benchmark - **staff without LTHC 54%, staff with LTHC 44%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 8 - % employer has made adequate adjustment(s) to enable them to carry out their work

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



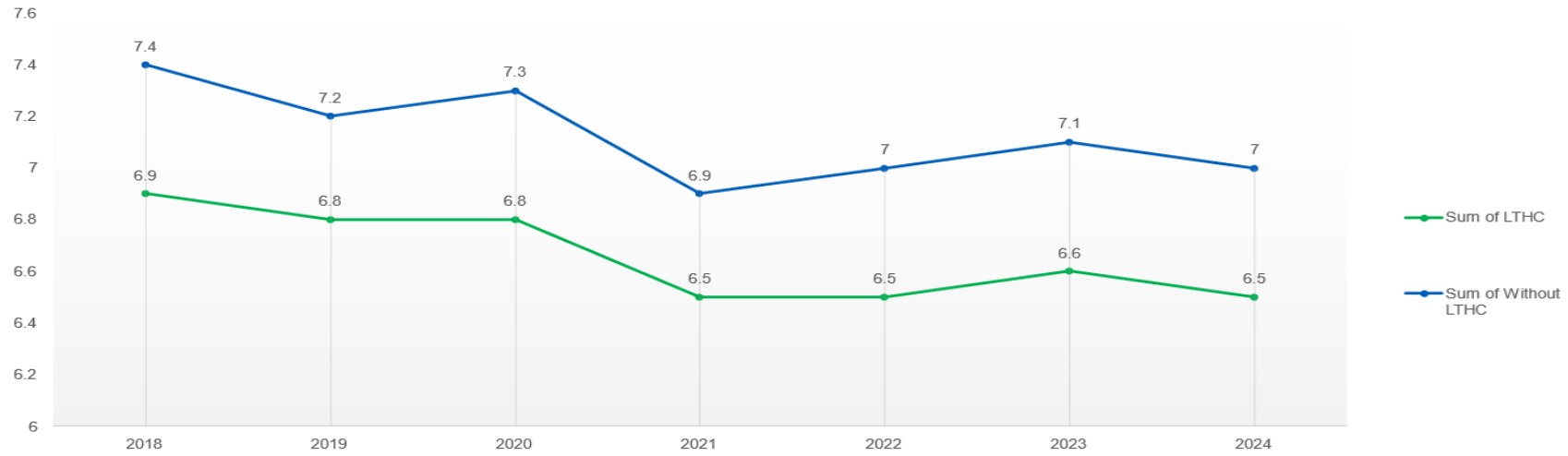
Staff Survey Responses –staff with LTHC 769

14

Benchmark - **staff with LTHC 80%**(Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 9 – Engagement Scores

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



The score for the staff engagement theme is derived from the nine questions, grouped into three themes: motivation; involvement; and advocacy.
Staff Survey Responses – Staff without a LTHC 2253, staff with LTHC 1221

15

Benchmark - **staff without LTHC 7.19%, staff with LTHC 6.72%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Indicator 10 – Board Diversity

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Members of the Board have identified as having a LTHC

Overall -1.11%

Voting membership – 4.5%

Executive membership -2.55%

16

EDI & HR Team

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Sexual Orientation Workforce Equality Standard (SOWES)

2025

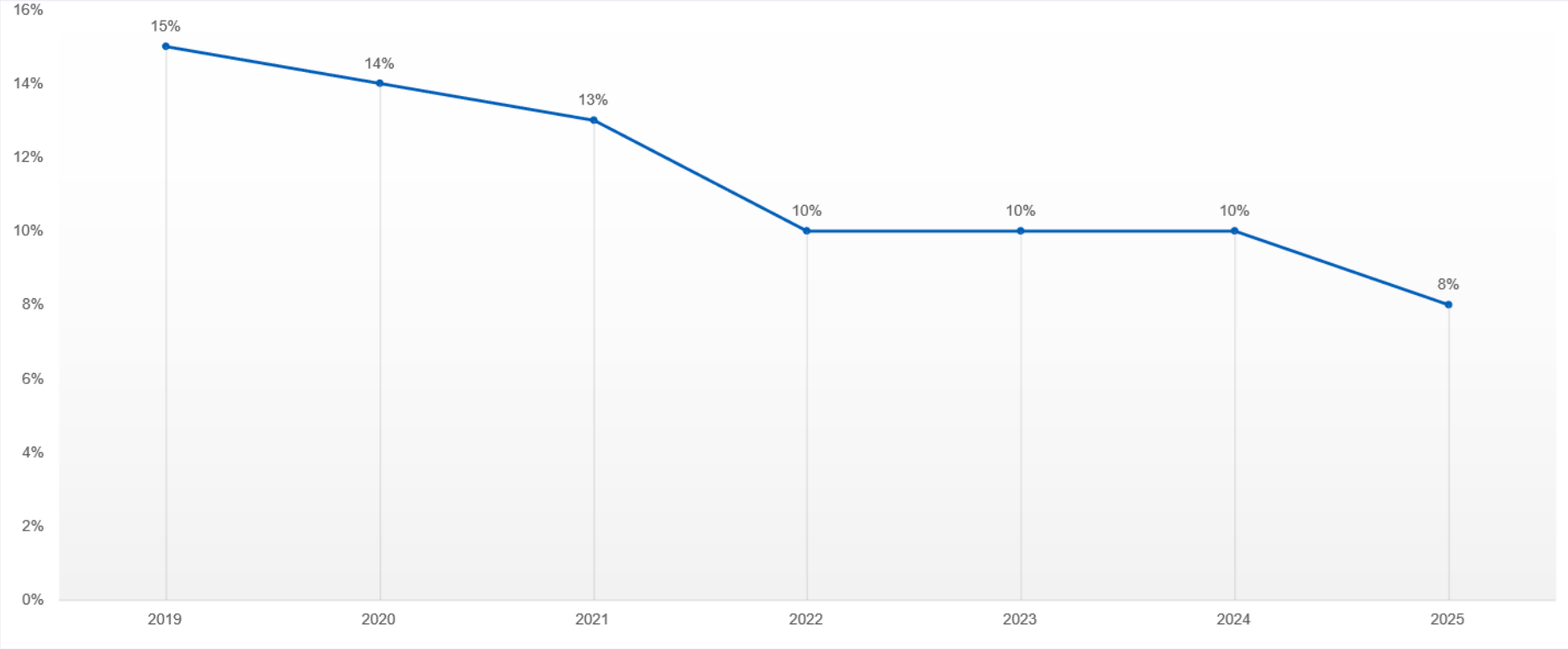
SOWES

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- The Trust developed the SOWES in 2019 to ensure we were measuring the experience of LGB staff in the organisation
- The Indicators mirror the WRES and WDES, which are mandated standards in the NHS contract
- 2022 staff survey result have provided some data on the experience of staff that identify as sex not the same as assigned by birth, this has continued in the 2024 results with 13 staff identifying as not the same sex as assigned at birth
- 5% of staff identify as LGB (412 staff members)
- Trust locality Census comparison – Heterosexual: 90.71%, Gay/Lesbian: 1.4%, Bisexual: 1.21%, not stated: 6.4%, other(not listed): 0.55%,

% of staff not declared sexual orientation

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



3 7304 staff identified as heterosexual, 412 identified as LGB, 15 identified as undecided, 685 did not declare

Indicator 1 – Workforce sexual orientation

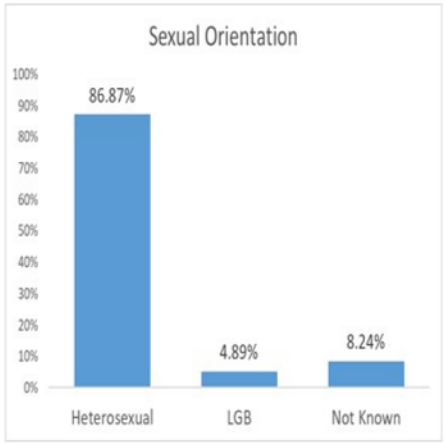
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

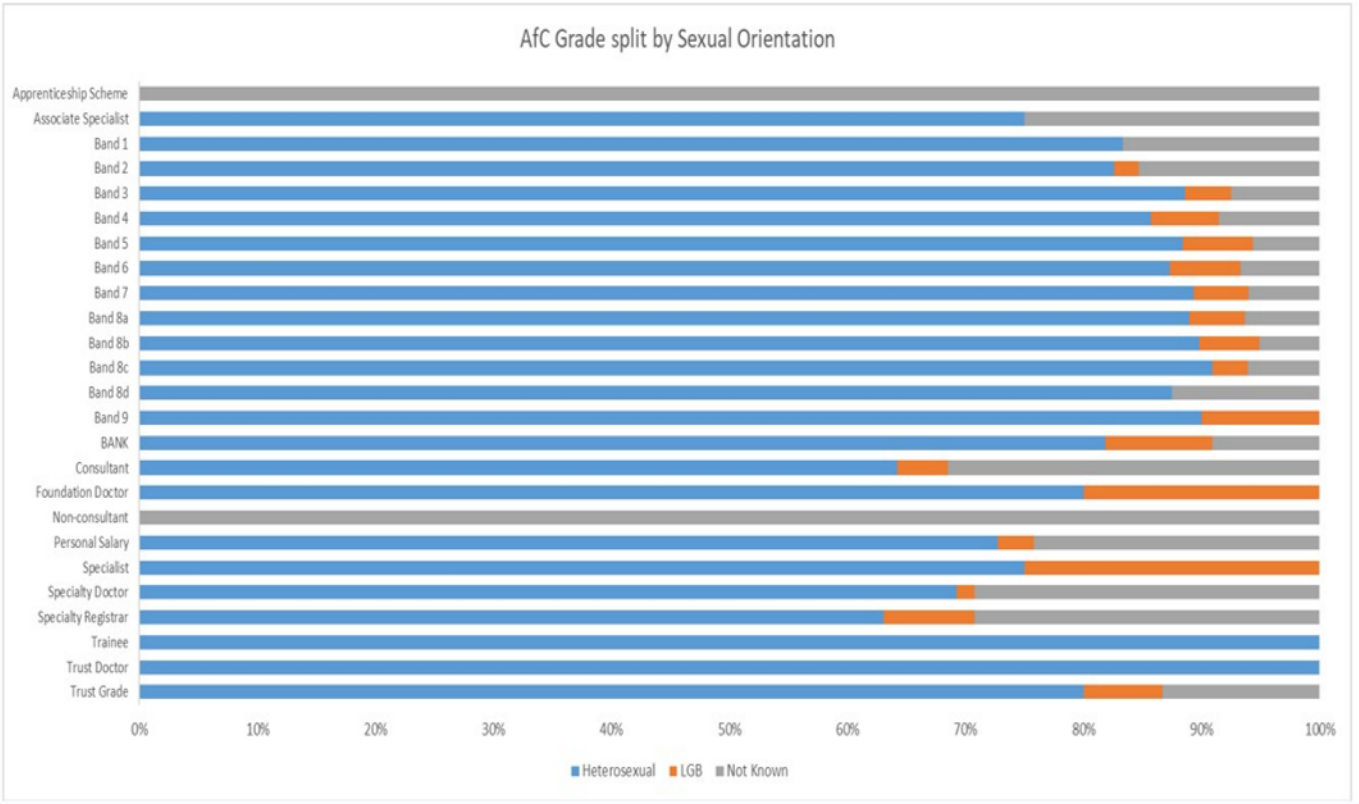
Indicator	Data Item			SEXUAL ORIENTATION HETRO		SEXUAL ORIENTATION LGB		SEXUAL ORIENTATION UNDECIDED		SEXUAL ORIENTATION NOT DECLARED	
				Figure	%	Figure	%	Figure	%	Figure	%
Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1	0	0%	0	0%	0	0%	0	0%
		2	Band 1	10	83%	0	0%	0	0%	2	17%
		3	Band 2	392	82%	10	2%	2	0%	73	15%
		4	Band 3	529	93%	13	2%	1	0%	27	5%
		5	Band 4	328	89%	9	2%	1	0%	32	9%
		6	Band 5	172	91%	8	4%	0	0%	8	4%
		7	Band 6	117	88%	5	4%	0	0%	11	8%
		8	Band 7	122	92%	5	4%	0	0%	6	5%
		9	Band 8a	53	93%	1	2%	0	0%	3	5%
		10	Band 8b	43	90%	2	4%	0	0%	3	6%
		11	Band 8c	16	89%	0	0%	0	0%	2	11%
		12	Band 8d	11	92%	0	0%	0	0%	1	8%
		13	Band 9	2	100%	0	0%	0	0%	0	0%
		14	VSM	25	76%	1	3%	0	0%	7	21%
	1b) Clinical workforce of which Non Medical	15	Under Band 1	7	64%	0	0%	0	0%	4	36%
		16	Band 1	0	0%	0	0%	0	0%	0	0%
		17	Band 2	10	91%	0	0%	0	0%	1	9%
		18	Band 3	1211	87%	67	5%	2	0%	117	8%
		19	Band 4	299	83%	32	9%	0	0%	28	8%
		20	Band 5	853	88%	62	6%	4	0%	52	5%
		21	Band 6	1560	87%	110	6%	4	0%	116	6%
		22	Band 7	889	89%	46	5%	1	0%	64	6%
		23	Band 8a	234	88%	15	6%	0	0%	16	6%
		24	Band 8b	85	89%	6	6%	0	0%	4	4%
		25	Band 8c	102	89%	4	4%	0	0%	8	7%
		26	Band 8d	11	79%	0	0%	0	0%	3	21%
		27	Band 9	6	86%	1	14%	0	0%	0	0%
		28	VSM	0	0%	0	0%	0	0%	0	0%
	OR which Medical & Dental	29	Consultants	110	67%	6	4%	0	0%	49	30%
		30	of which Senior medical manager	0	0%	0	0%	0	0%	0	0%
		31	Non-consultant career grade	107	65%	9	5%	0	0%	48	29%
		32	Trainee grades	0	0%	0	0%	0	0%	0	0%
		33	Other	0	0%	0	0%	0	0%	0	0%
				7304	87%	412	5%	15	0%	685	8%

4

Indicator 1 – Workforce sexual orientation

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

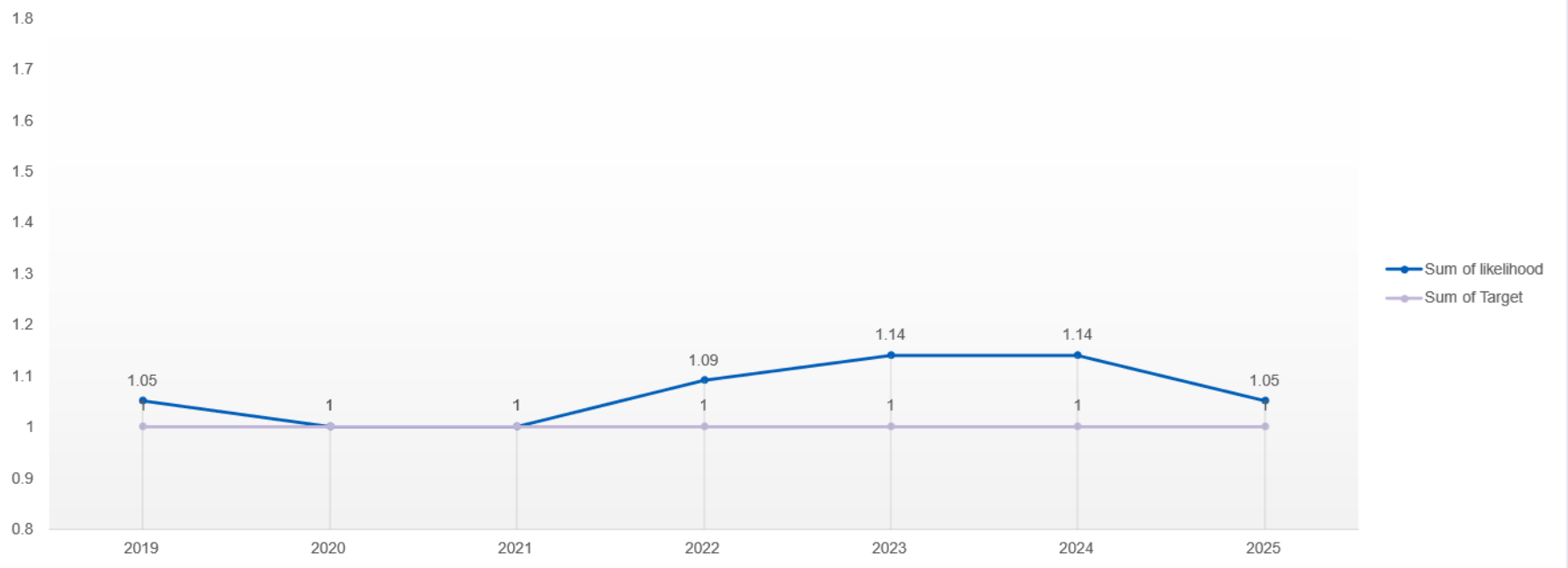




5

Recruitment – likelihood of a heterosexual applicant being appointed from shortlisting compared to LBG applicant

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

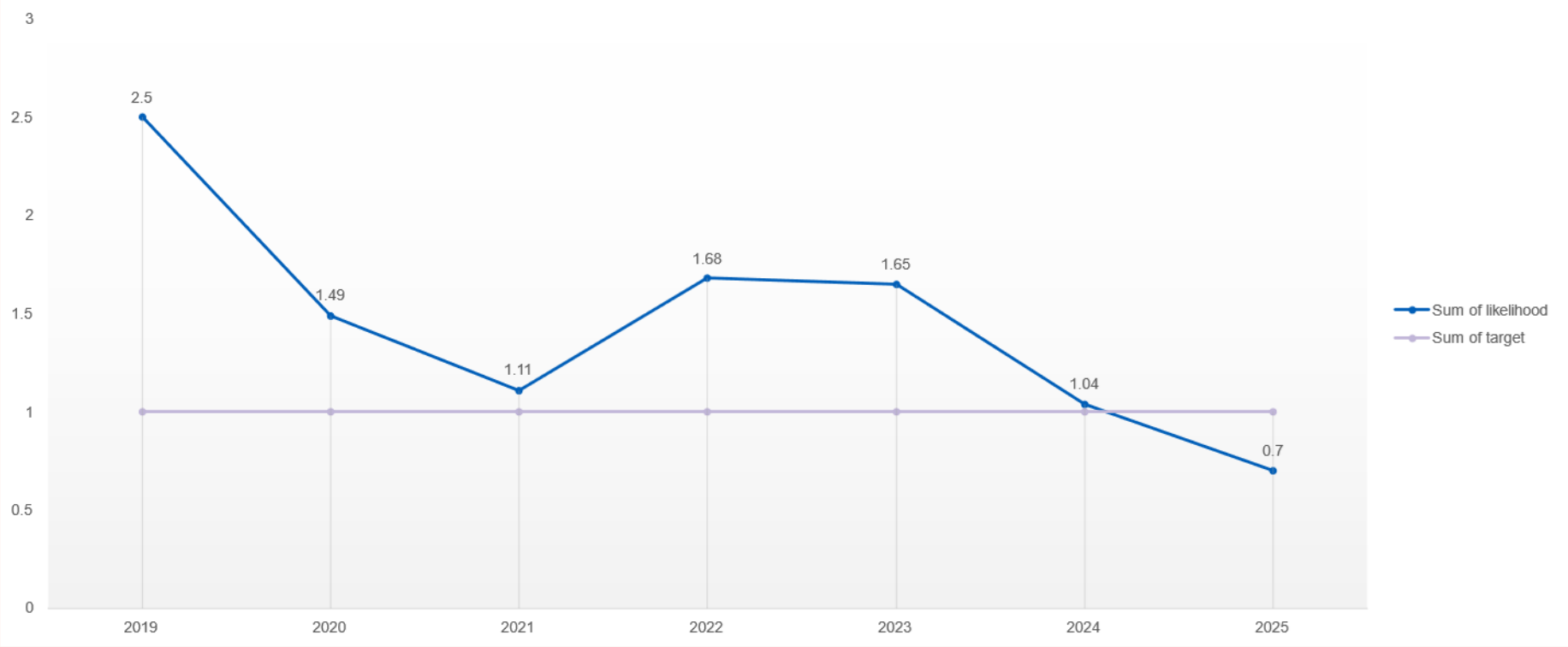


629 LGB applicants shortlisted; 120 LGB applicants offered posts
7845 Heterosexual applicants shortlisted; 1588 Heterosexual applicants offered posts

6

Disciplinary – likelihood of LGB staff entering the disciplinary processes compared to heterosexual staff

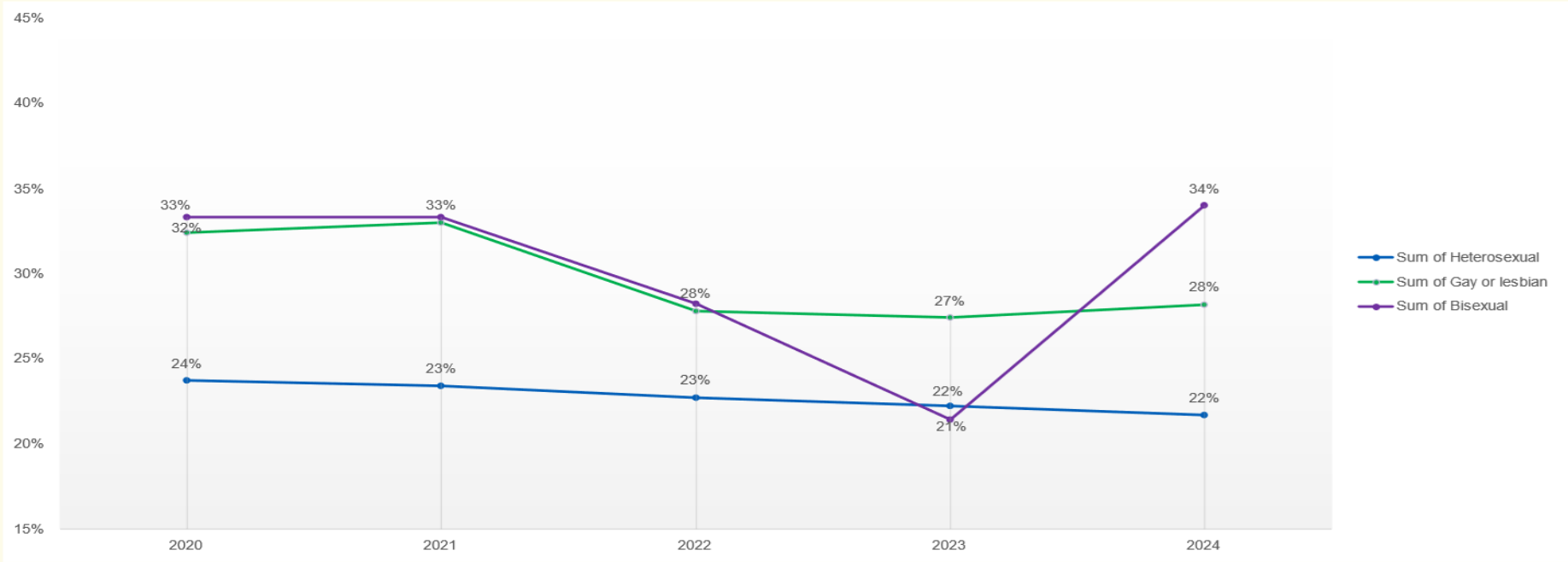
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



7

Indicator 5 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



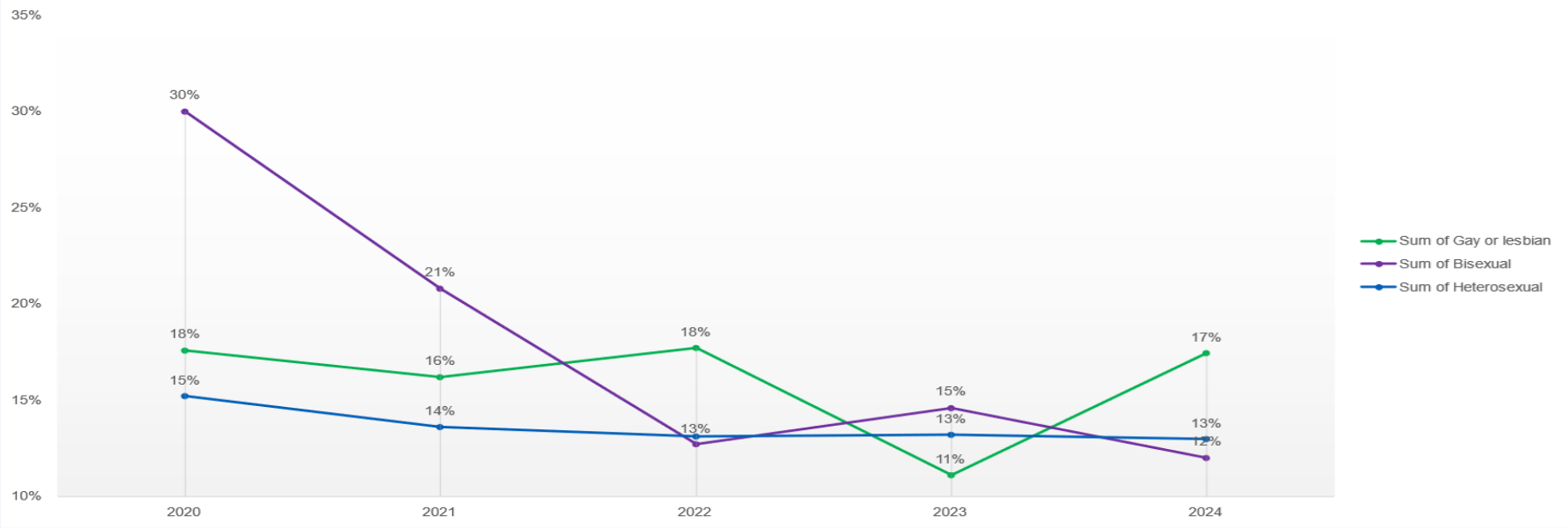
Staff Survey Responses: heterosexual – 3056, gay or lesbian 110, bisexual 103

8

Benchmark - **heterosexual staff 23%, gay or lesbian staff 28%, bisexual staff 30%**
(Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

% of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



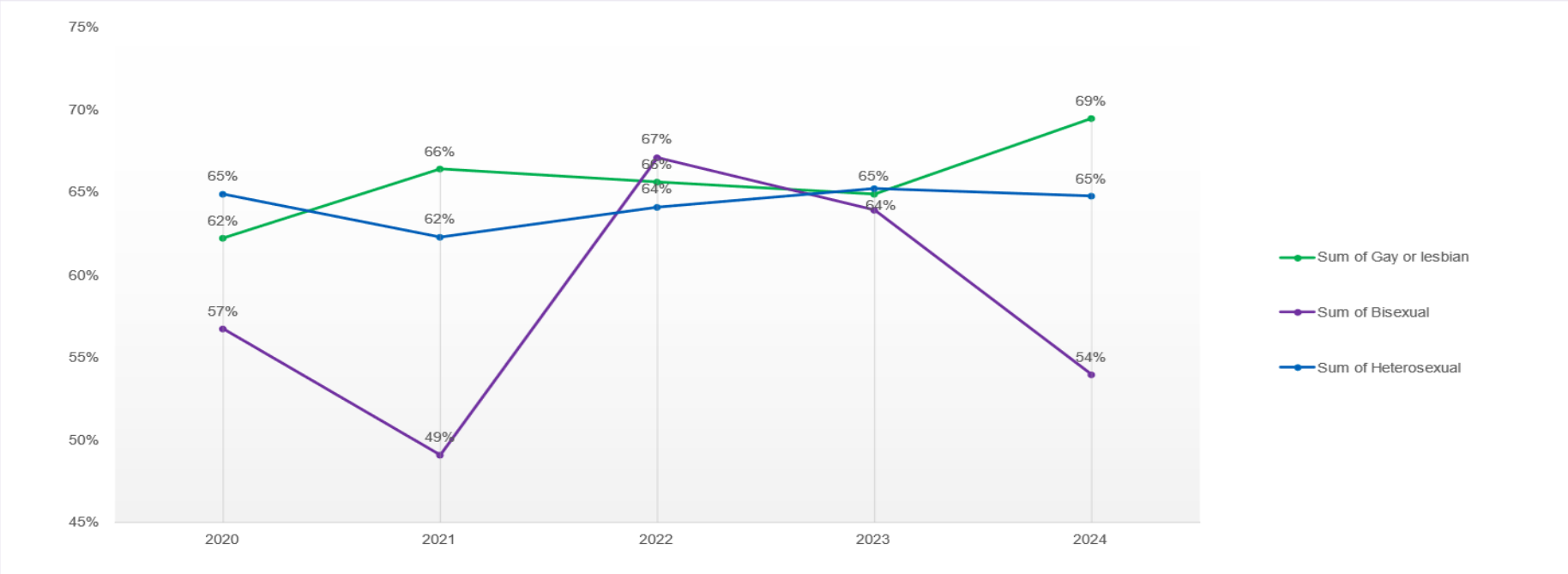
9

Staff Survey Responses: heterosexual – 3023, gay or lesbian 109, bisexual 100

Benchmark - **heterosexual staff 13%, gay or lesbian staff 17%, bisexual staff 16%**
(Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

% of staff the believe the Trust acts fairly with regards to career progression and promotion

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



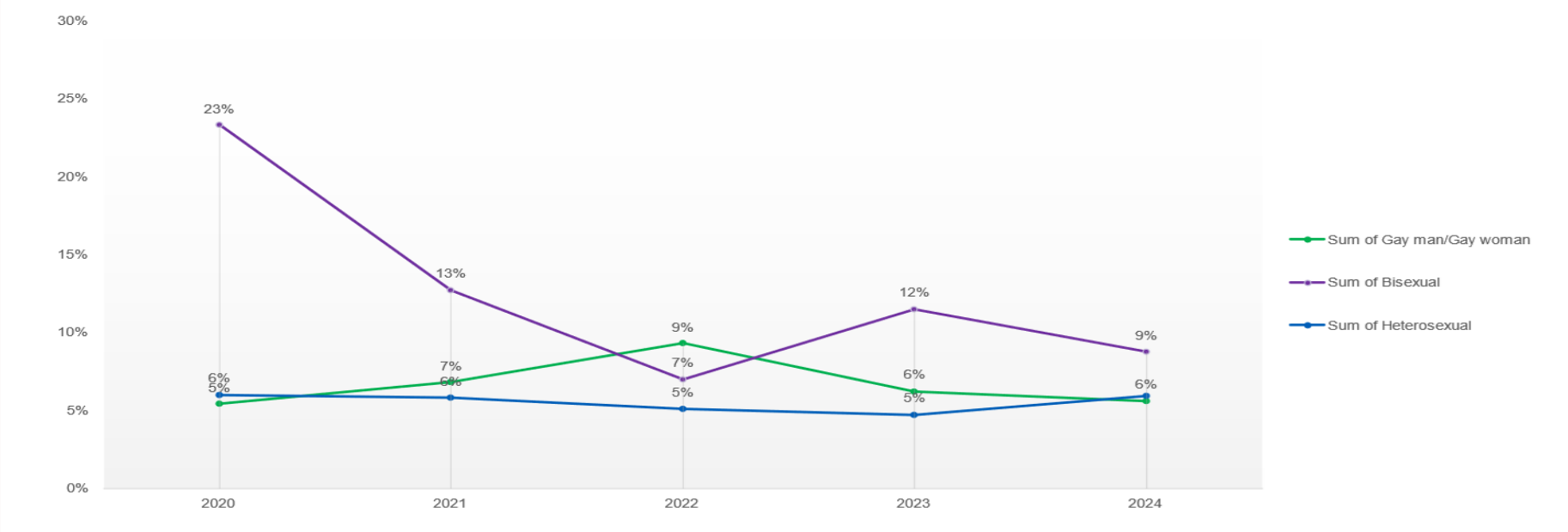
10

Staff Survey Responses: heterosexual – 3049, gay or lesbian 108, bisexual 102

Benchmark - **heterosexual staff 60%, gay or lesbian staff 63%, bisexual staff 57%**
(Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

% have personally experienced discrimination at work from manager/team leader or other colleagues In the last 12 months

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



11

Staff Survey Responses: heterosexual – 3025, gay or lesbian 107, bisexual 103

Benchmark - **heterosexual staff 7%, gay or lesbian staff 10%, bisexual staff 11%**
(Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

Board

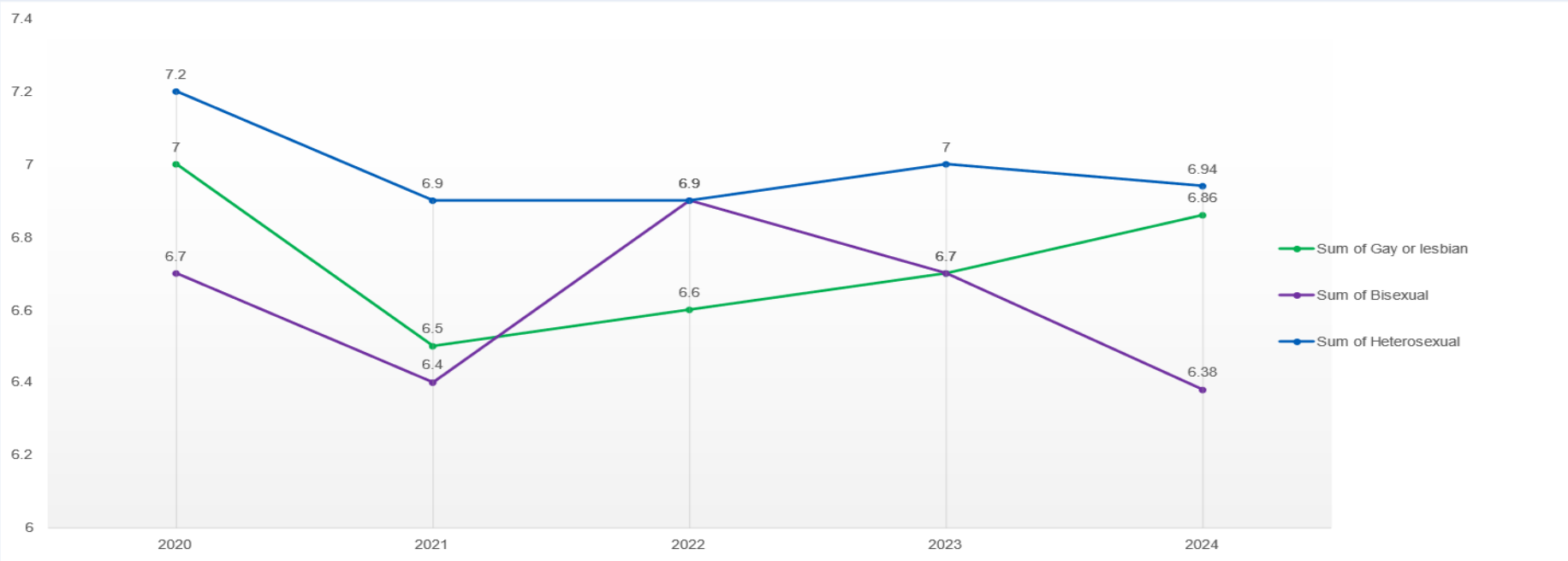
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- No one on the Board identifies as LGB
- - 5% Overall difference

12

Engagement Scores

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



Staff Survey Responses: heterosexual – 3072, gay or lesbian 110, bisexual 103

The score for the staff engagement theme is derived from the nine questions, grouped into three themes: motivation; involvement; and advocacy.

13

Benchmark - **heterosexual staff 7.13%, gay or lesbian staff 6.9%, bisexual staff 6.74%**
(Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

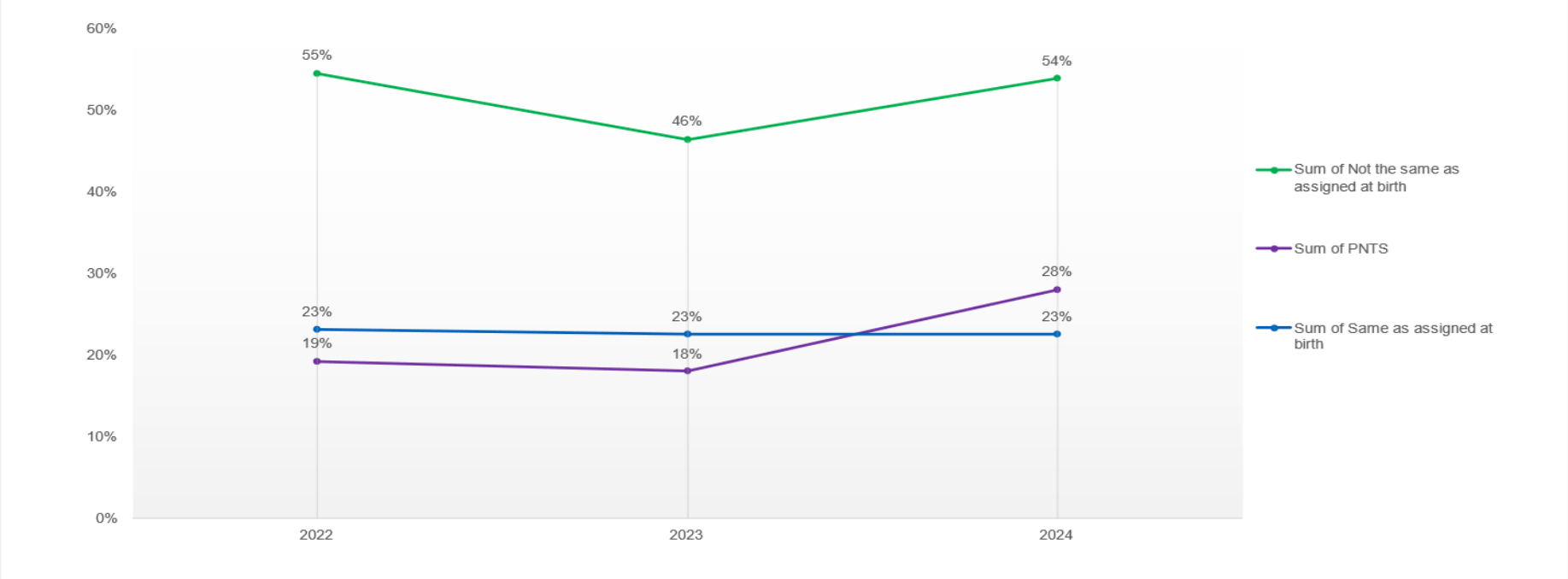
Gender Identity

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- 13 staff identifying as not the same sex as assigned at birth completed the staff survey

% of staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

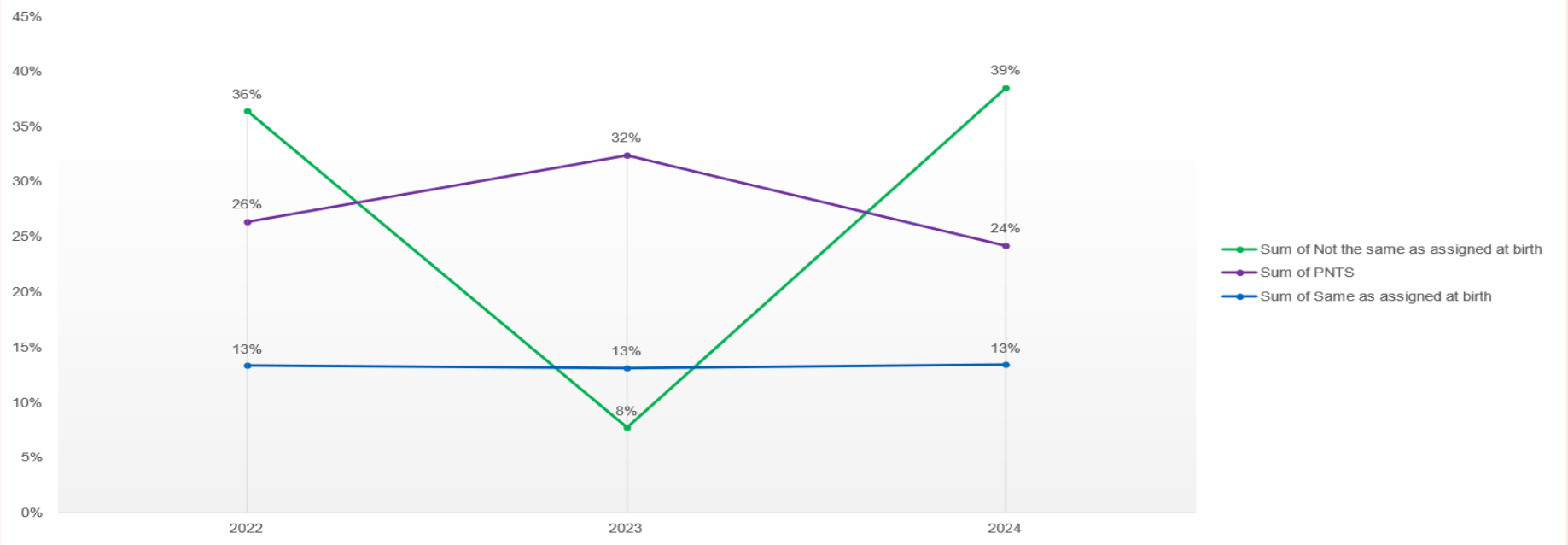


15 Staff survey responses -Not the same as assigned at birth 13, prefer not to say (PNTS) 100, same as assigned at birth 3497

Benchmark - **Staff identifying as same as assigned at birth 23%, Staff identifying as not the same as assigned at birth 33%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

% of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

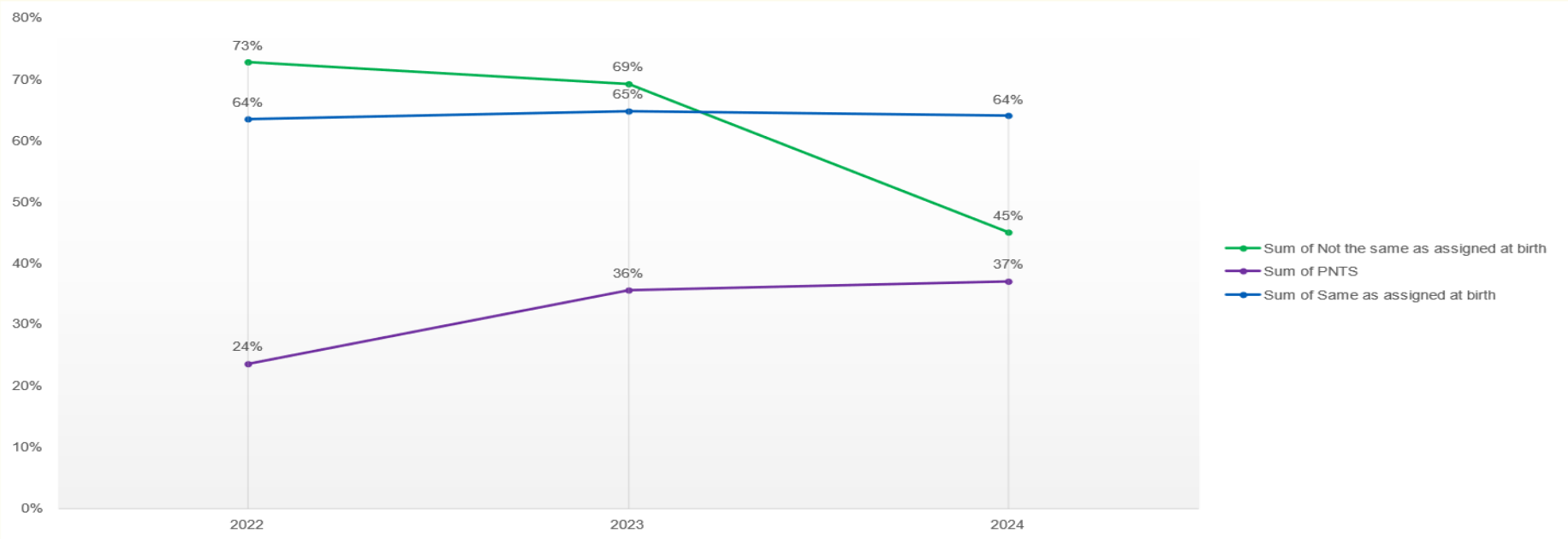


16 Staff survey responses -Not the same as assigned at birth 13, prefer not to say (PNTS) 99, same as assigned at birth 3334

Benchmark - **Staff identifying as same as assigned at birth 14%, Staff identifying as not the same as assigned at birth 19%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

% of staff the believe the Trust acts fairly with regards to career progression and promotion

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

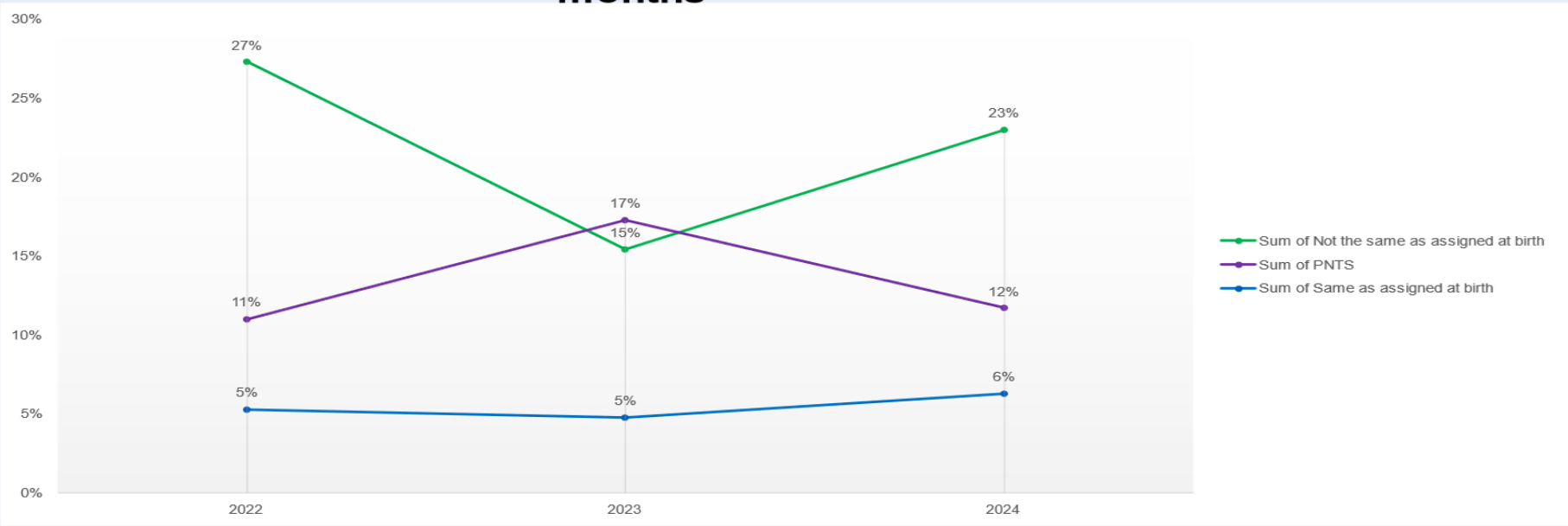


17 Staff survey responses -Not the same as assigned at birth 13, prefer not to say (PNTS) 104, same as assigned at birth 3364

Benchmark - **Staff identifying as same as assigned at birth 60%, Staff identifying as not the same as assigned at birth 47%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

% have personally experienced discrimination at work from manager/team leader or other colleagues In the last 12 months

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



Staff survey responses -Not the same as assigned at birth 13, prefer not to say (PNTS) 103, same as assigned at birth 3339

18

Benchmark - **Staff identifying as same as assigned at birth 7%, Staff identifying as not the same as assigned at birth 18%** (Benchmark =Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts)

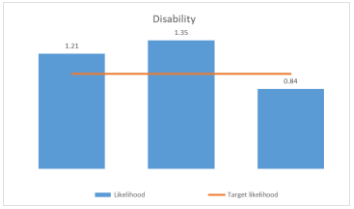
Staff Information Report:

Staff Equality and Diversity Report for the period of April 2024 - March 2025

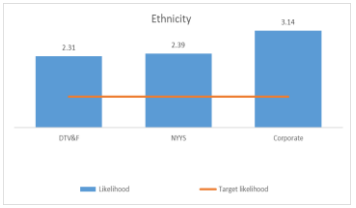
Title		Information	Link to page
Recruitment including medical staff		The charts on this tab look at all protected characteristics and compare the likelihood of a person with a particular characteristic being offered a role in relation to another characteristic. All characteristics are broken down by both care groups and corporate.	*Click here*
Disciplinary including medical staff		The charts on this tab show the likelihood of the different protected characteristic groupings entering the disciplinary process. Likelihood for this is calculated by taking the number of staff who have gone through this process as a % of the Trust staff make up, and comparing them to one another (for example, the number of BAME staff who have gone through the disciplinary process as a % of the trusts BAME figures, compared to the number of white ethnicity staff who have as a % of the trusts white ethnicity figures, then comparing these two percentages to one another to get the likelihood).	*Click here*
Staff figures, care board figures and the census data		These charts look at the current staff make up across the Trust and the Care board information, it then compares these figures to the 2022 census information. The figures are shown as a percentage of that particular protected characteristic. The information is shown at Trust level.	*Click here*
Care group protected charateristic information	Durham, Tees Valley and Forensics	These tabs present visual summaries that illustrate the composition of Trust staff across various protected characteristics. The focus is on four key areas: Gender, Ethnicity, Sexual Orientation, and Disability. For each characteristic, two types of graphs are provided: A percentage breakdown showing the overall representation of staff by that characteristic. A staff banding breakdown that highlights how representation varies across different staff bands.	*Click here*
	North Yorkshire, York & Selby		*Click here*
	Trust		*Click here*
Staff banding broken down by Age		This tab shows the different staff bandings broken down into the age categories, it is shown at Trust level	*Click here*
Staff banding broken down by Religion		This tab shows the different staff bandings broken down into the religions , it is shown at Trust level	*Click here*
Areas of Deprivation		This tab shows information about where staff live in relation to areas of deprivation, broken down by the two care groups and corporate. Areas of deprivation are broken down into 10 deciles, with 10 being the least deprived.	*Click here*
Areas of Deprivation - Trustwide		This tab shows information about where staff live in relation to areas of deprivation at Trust level. Areas of deprivation are broken down into 10 deciles, with 10 being the least deprived.	*Click here*
Leavers		This tab shows the information of the staff that have left the Trust in the reporting period, broken down by the different protected characteristics. The figures shown are the number of leavers in the time period that is being looked at as a percentage of the staff figures as at the end of that reporting period.	*Click here*
Sickness		This tab shows the sickness rates across the Trust. The figures shown are the number of absences in the time period that is being looked at, as a percentage of the staff figures as at the end of that reporting period. Absences are only counted once in the time period, so if a staff member has had 5 episodes of sickness, this will only be counted once to avoid over inflating the figures.	*Click here*
Staff Survey		These tabs show the staff survey scores.	*Click here*

Recruitment data

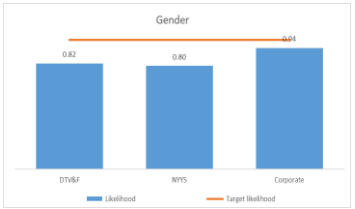
The below Disability chart looks at the relative likelihood of those with no disability being offered a role in comparison to those with a disability.



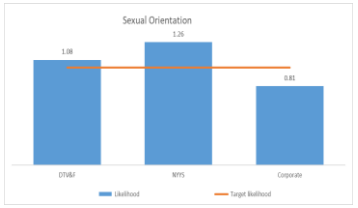
The below Ethnicity chart looks at the relative likelihood of White ethnicity being offered a role in comparison to those from BAME ethnicity.



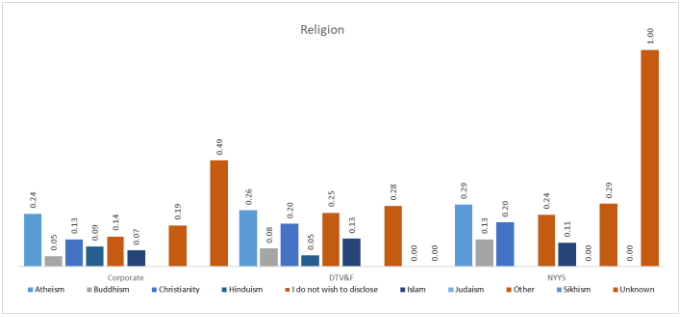
The below Gender chart looks at the relative likelihood of a Male being offered a role in comparison to a Female.



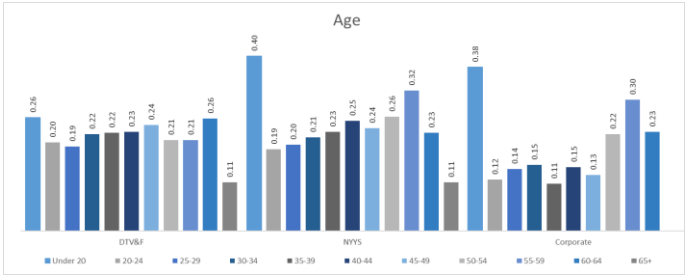
The below Sexual Orientation chart looks at the relative likelihood of those identifying as Heterosexual being offered a role in comparison to those who identify as LGB.



The below religion chart looks at the relative likelihood of being offered a role depending on the religion of the person applying.



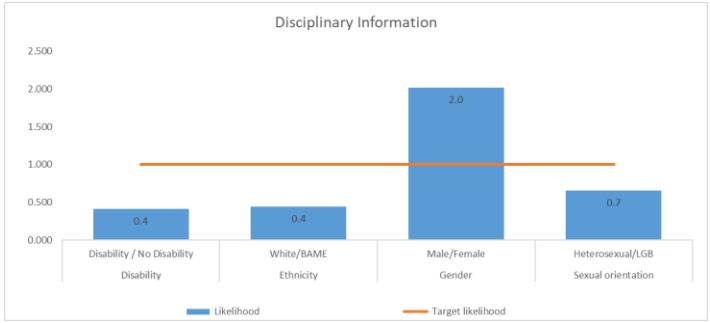
The below Age chart looks at the relative likelihood of being offered a role depending on the age group of the person applying.



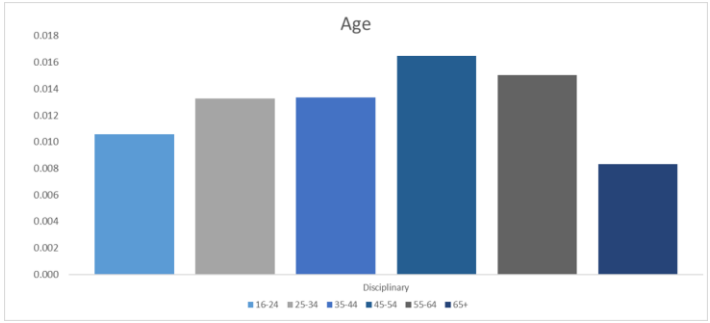
Disciplinary Data

N.B: for the likelihood graphs below, 0.0 indicates that the likelihood calculation could not be done, this is due to there being no data available.

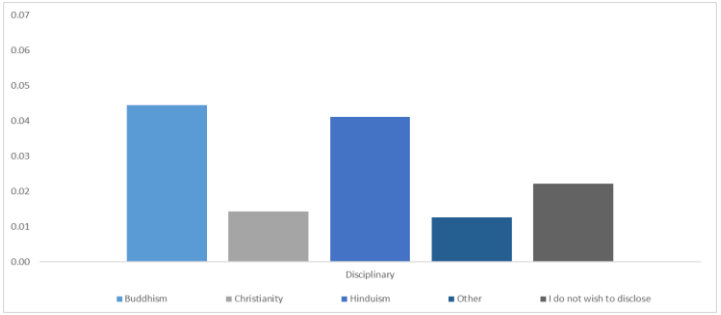
The below graph looks at the relative likelihood for the following
- Those with a disability compared to those without
- White ethnicity compared to BAME ethnicity
- Males compared to females
- Those who identify as Heterosexual compared to those who identify as LGB



The below Age graph does not look at the relative likelihood of the age categories compared to one another, instead it looks at the overall figures of each age category compared to the trust figures.

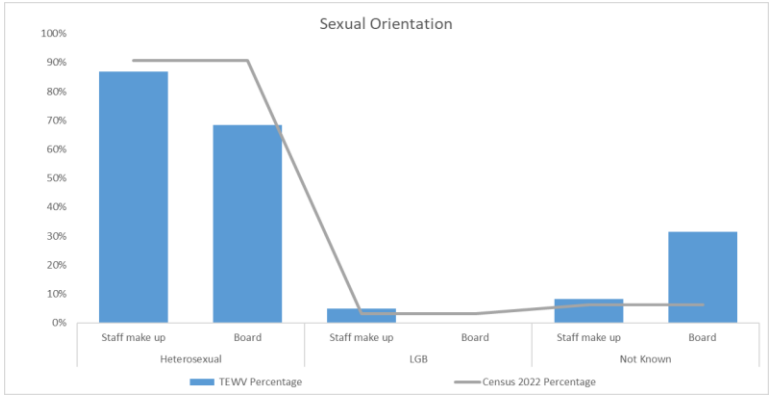


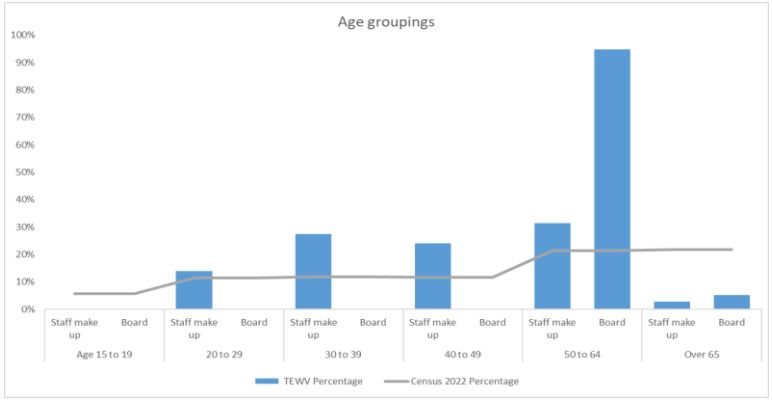
The below Religion graph does not look at the relative likelihood of the religion categories compared to one another, instead it looks at the overall figures of each religion category compared to the trust figures.

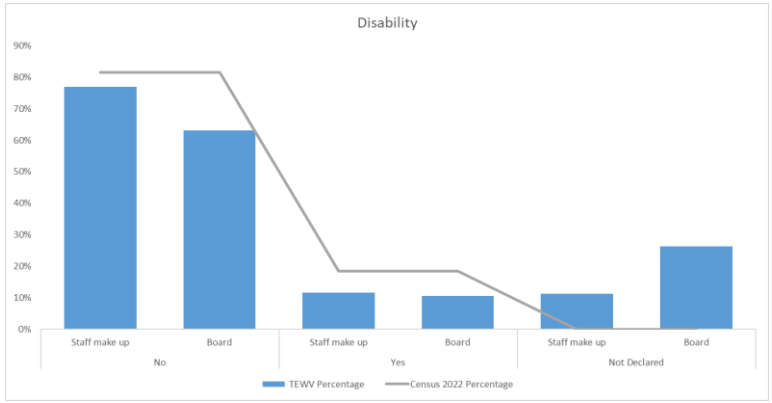


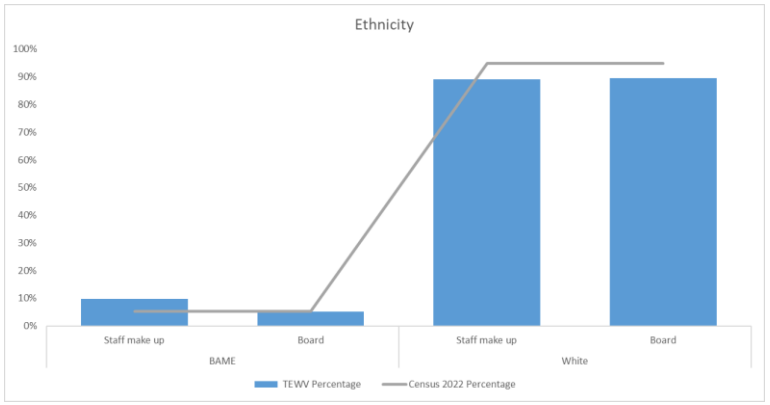
Staff figures and care board figures compared to the 2022 census figures

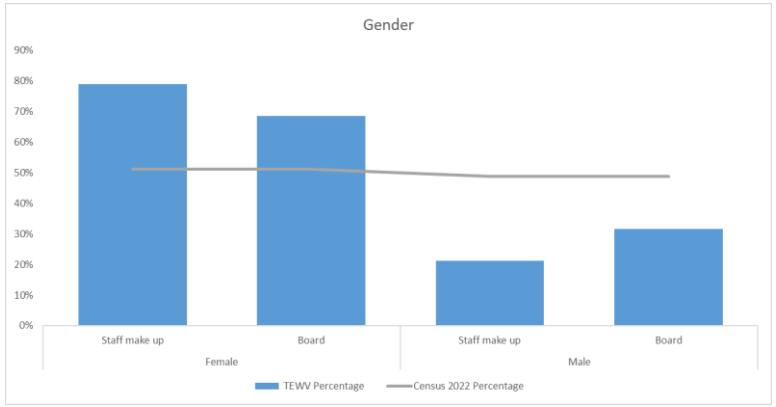
N.B. the below graphs chart the staff figures and the care board figures, broken down by the different protected characteristics. The grey line running through the charts is the 2022 census figures.

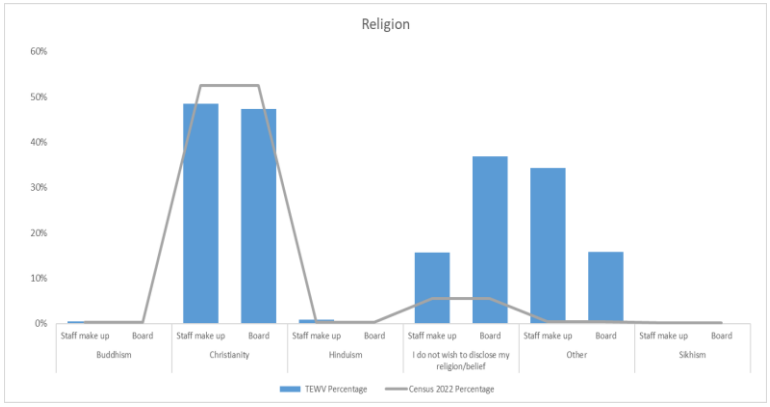








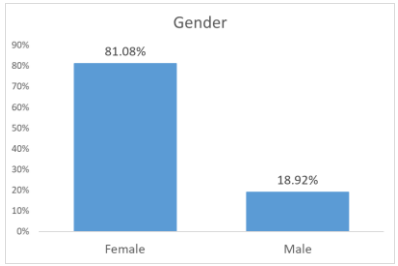


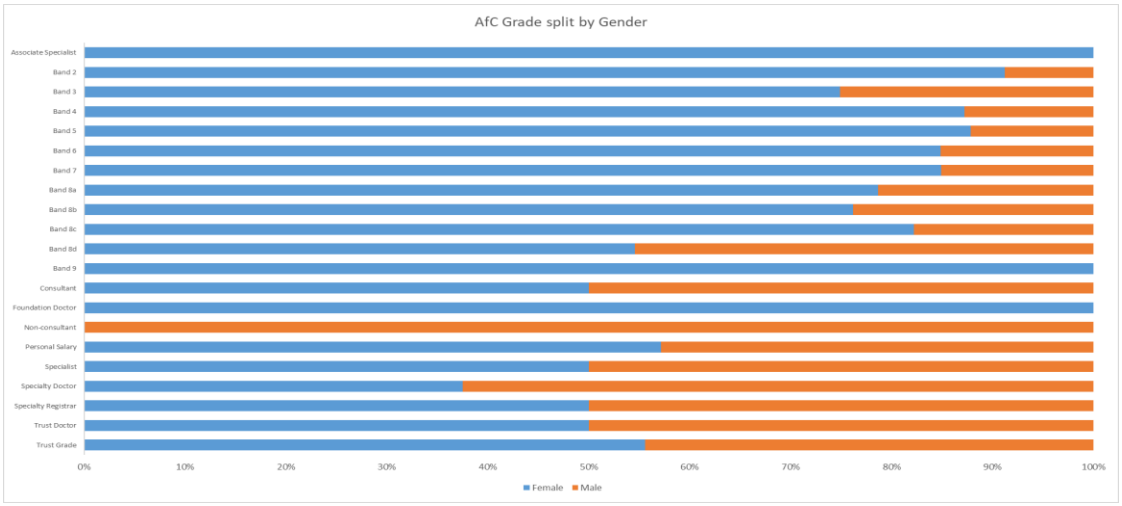


DTV& F Breakdown

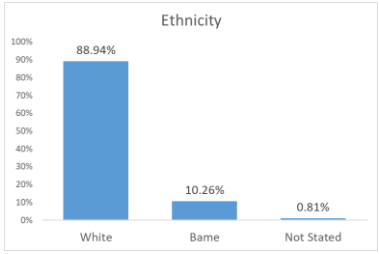
The below charts show the staff make up across the Trust, broken down by Gender.

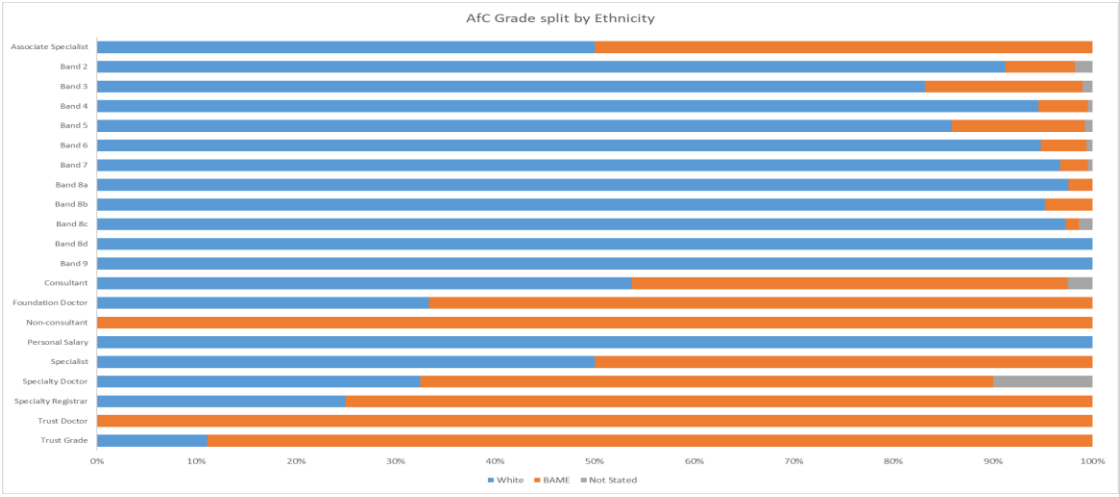
Gender



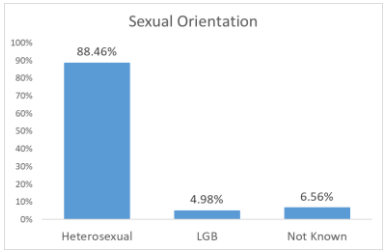


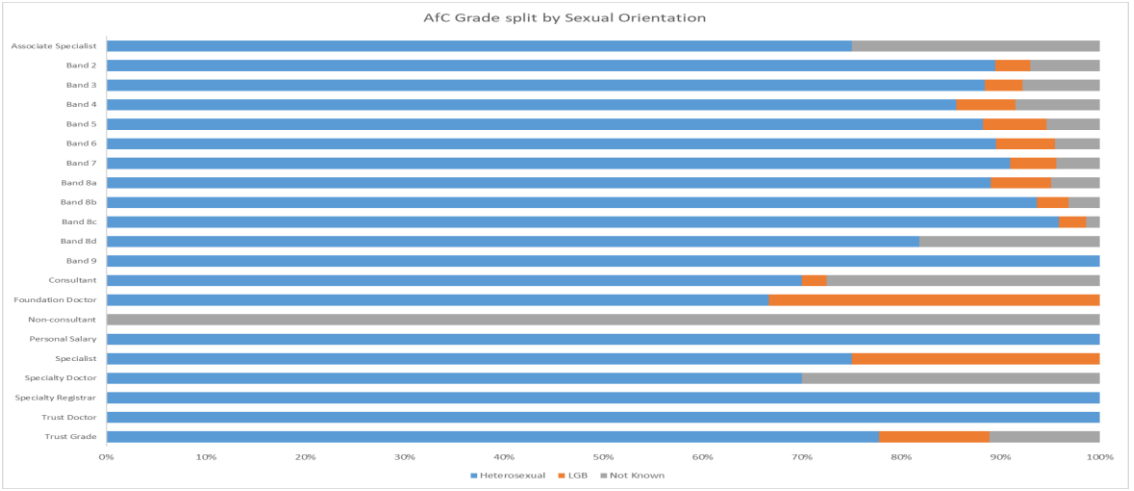
Ethnicity



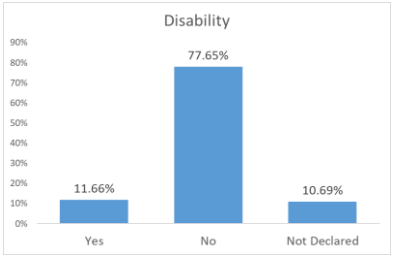


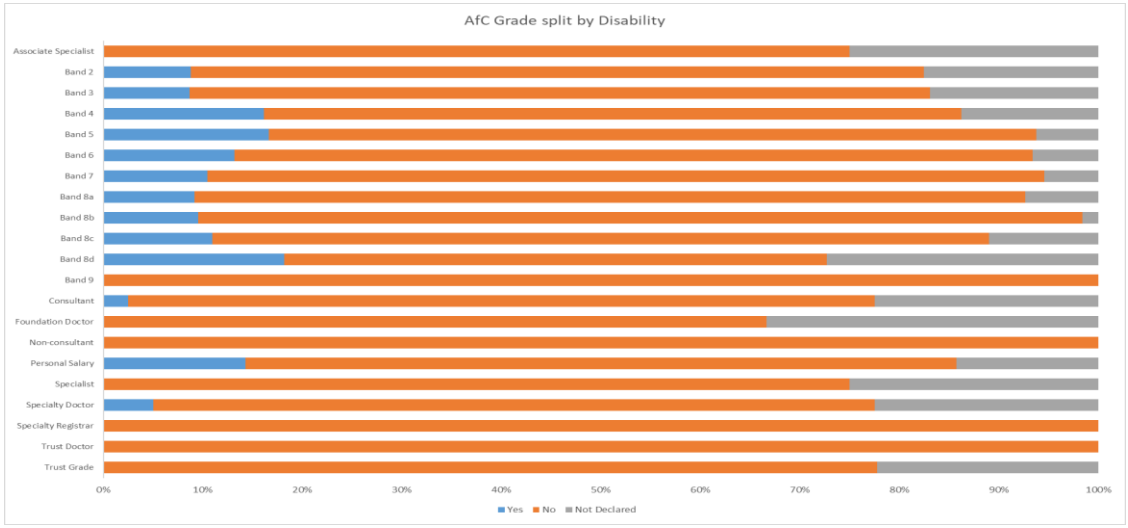
Sexual Orientation





Disability

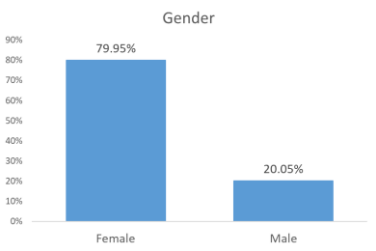


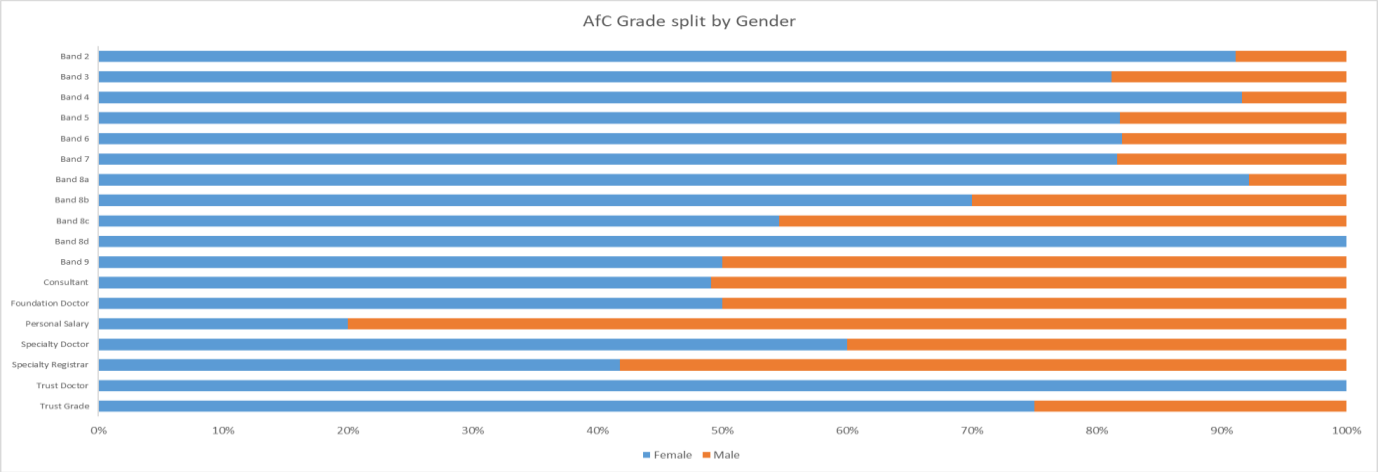


NYYS Breakdown

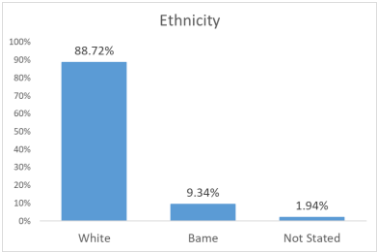
The below charts show the staff make up across the Trust, broken down by Gender.

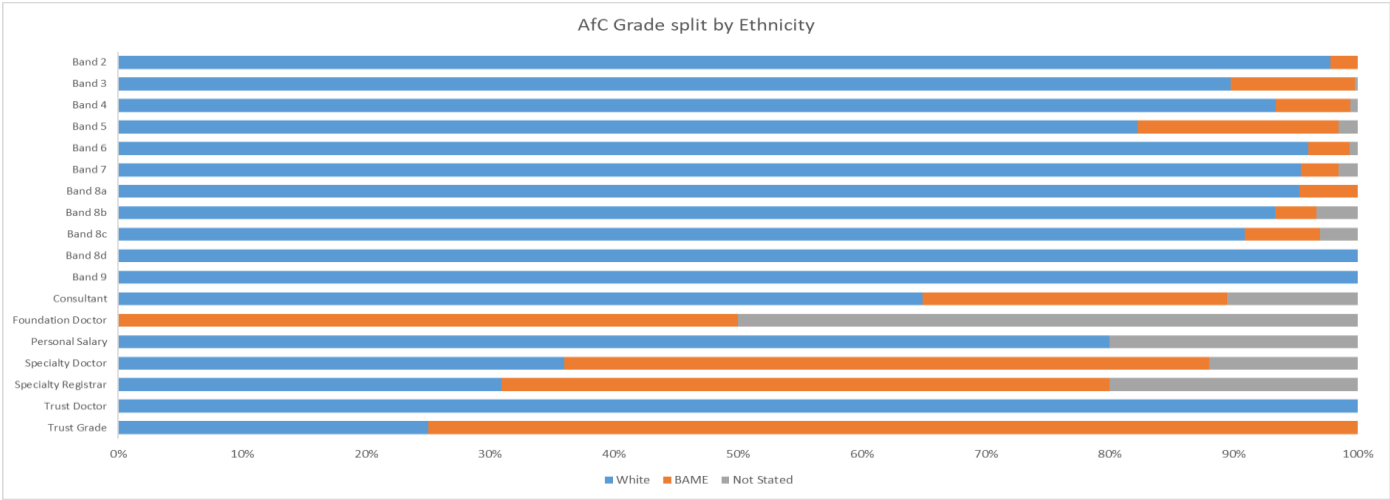
Gender



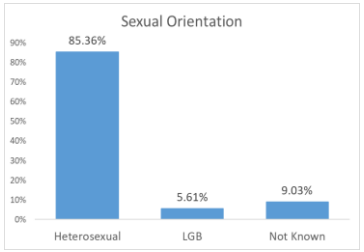


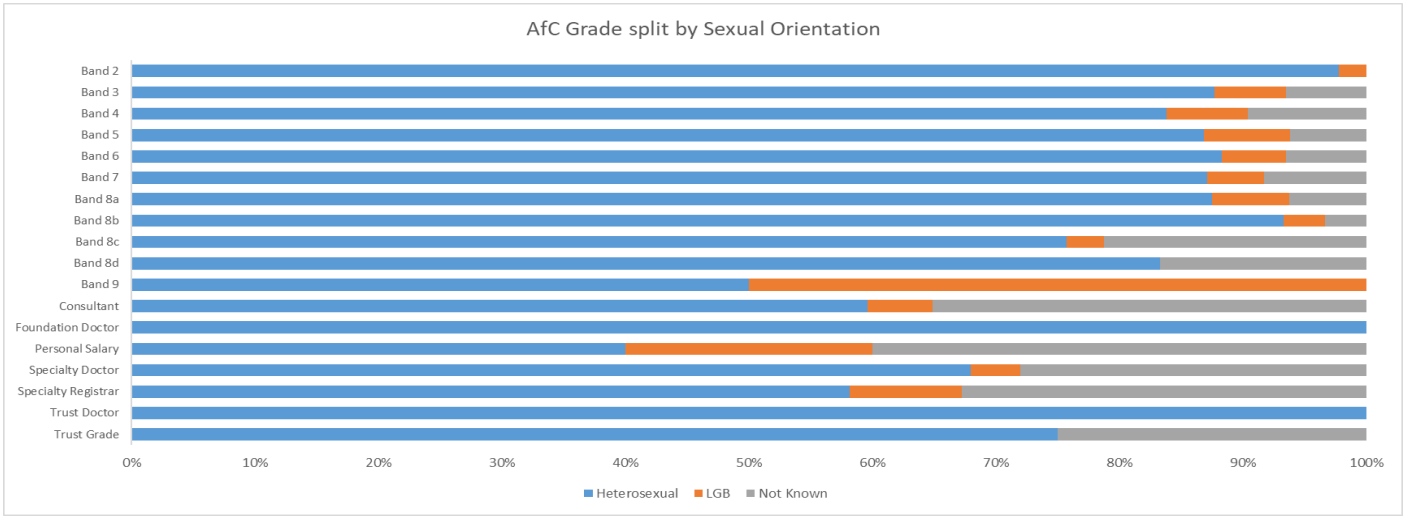
Ethnicity



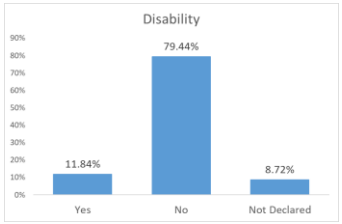


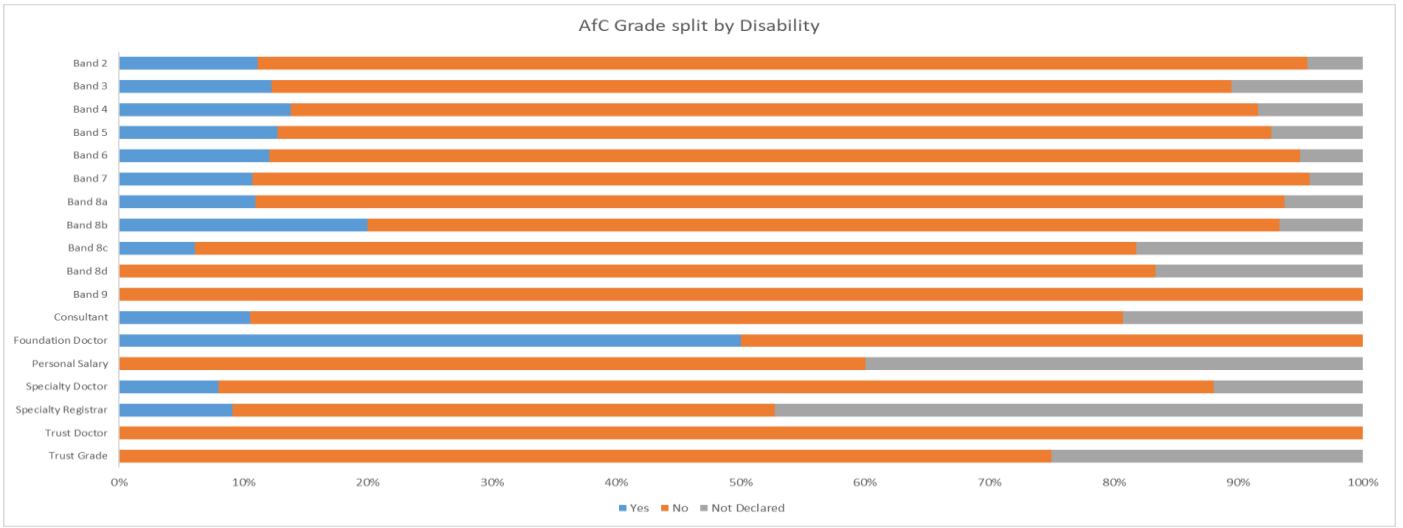
Sexual Orientation





Disability

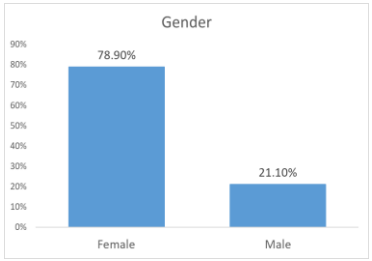


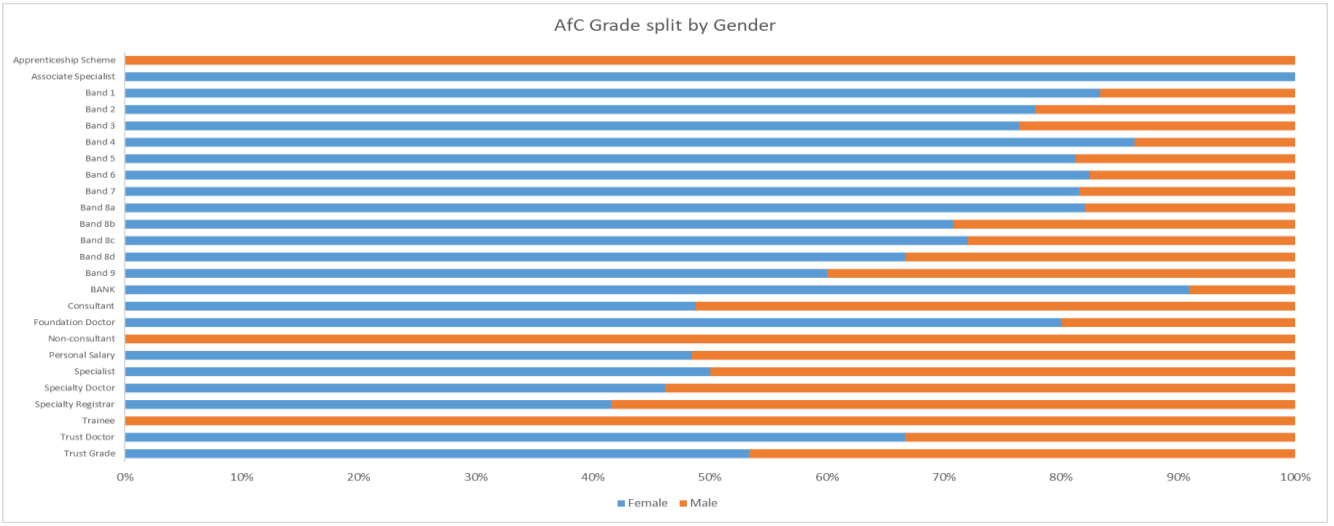


Trust Breakdown

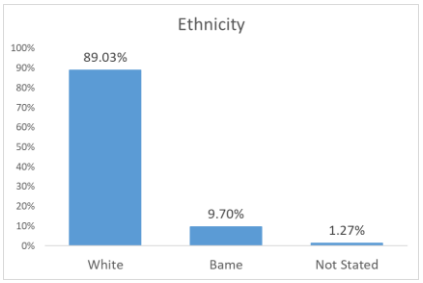
The below charts show the staff make up across the Trust, broken down by Gender.

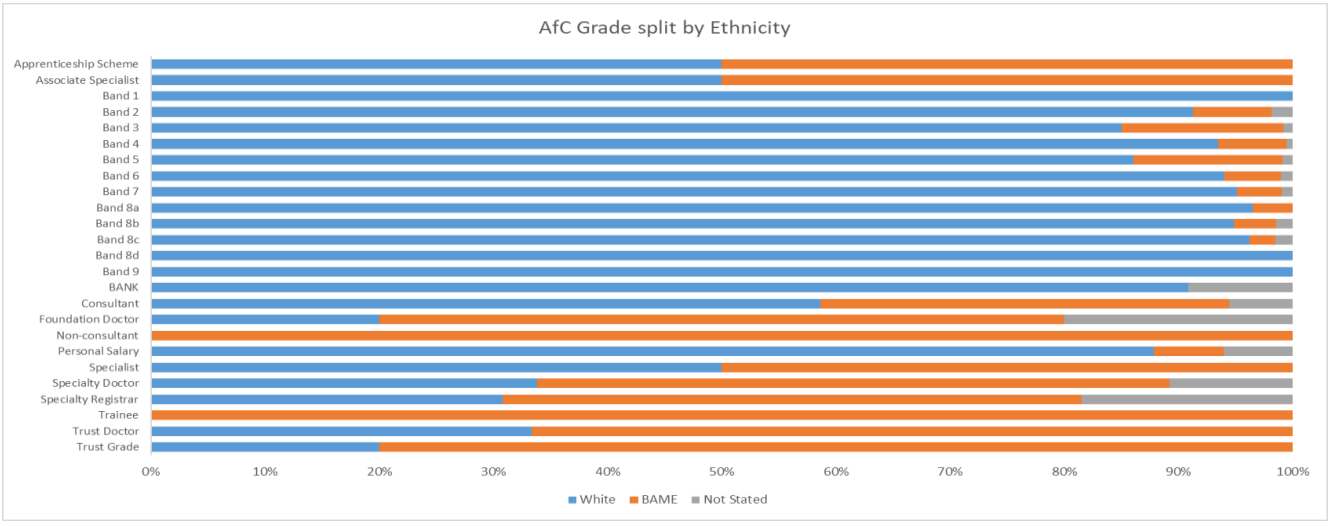
Gender



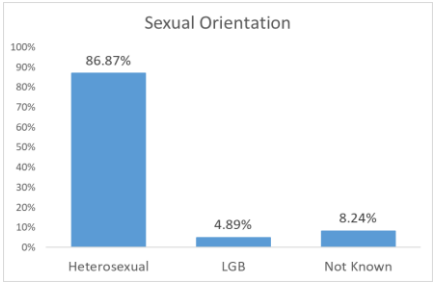


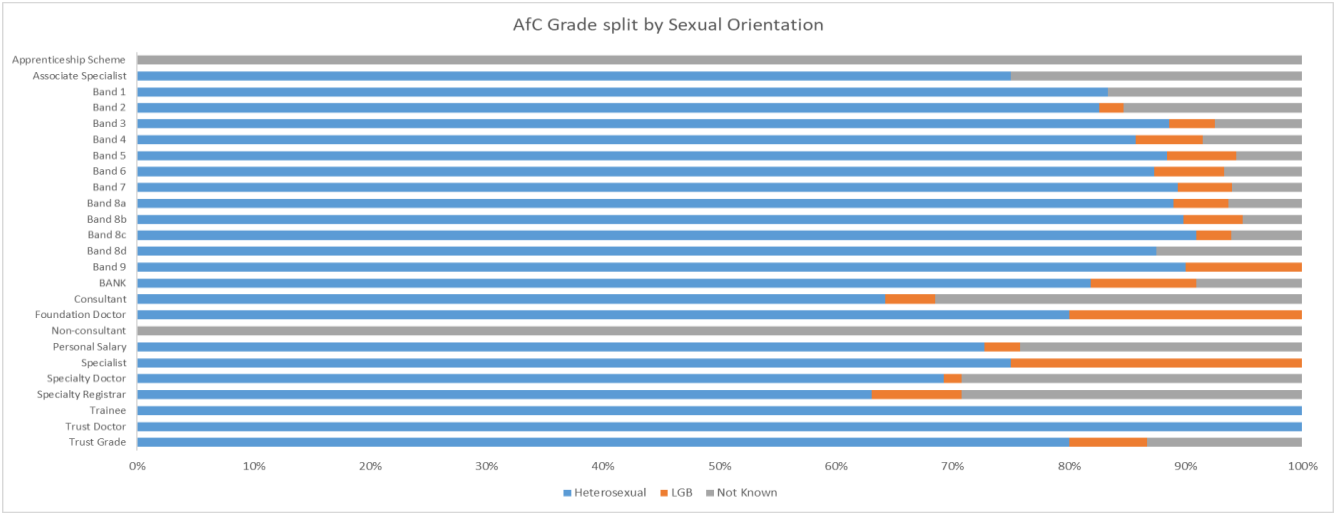
Ethnicity



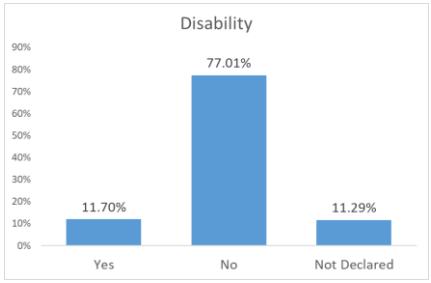


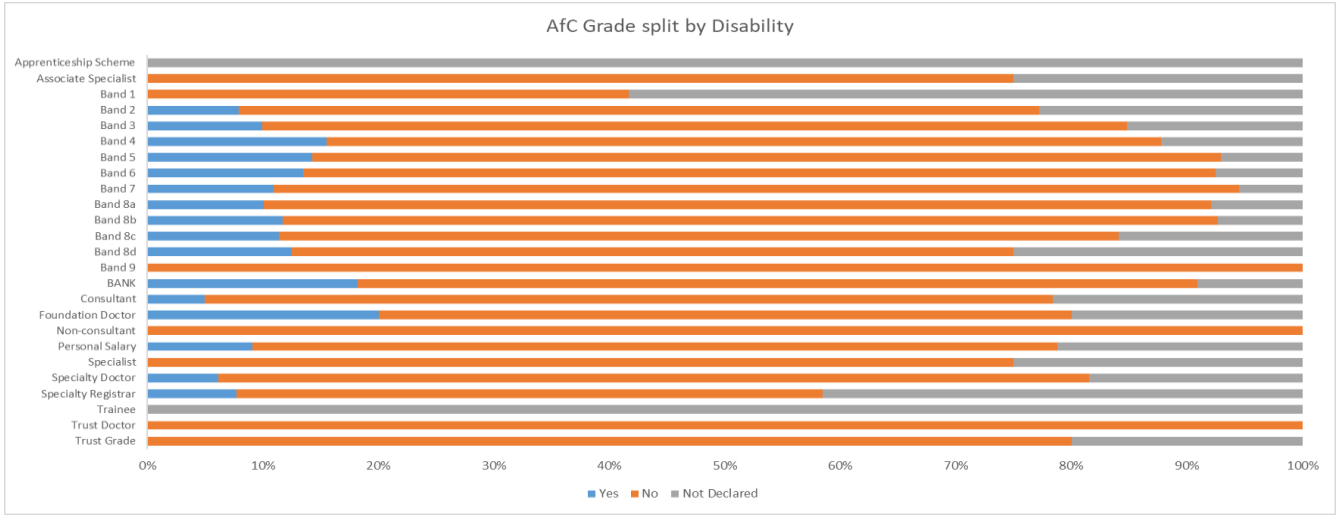
Sexual Orientation





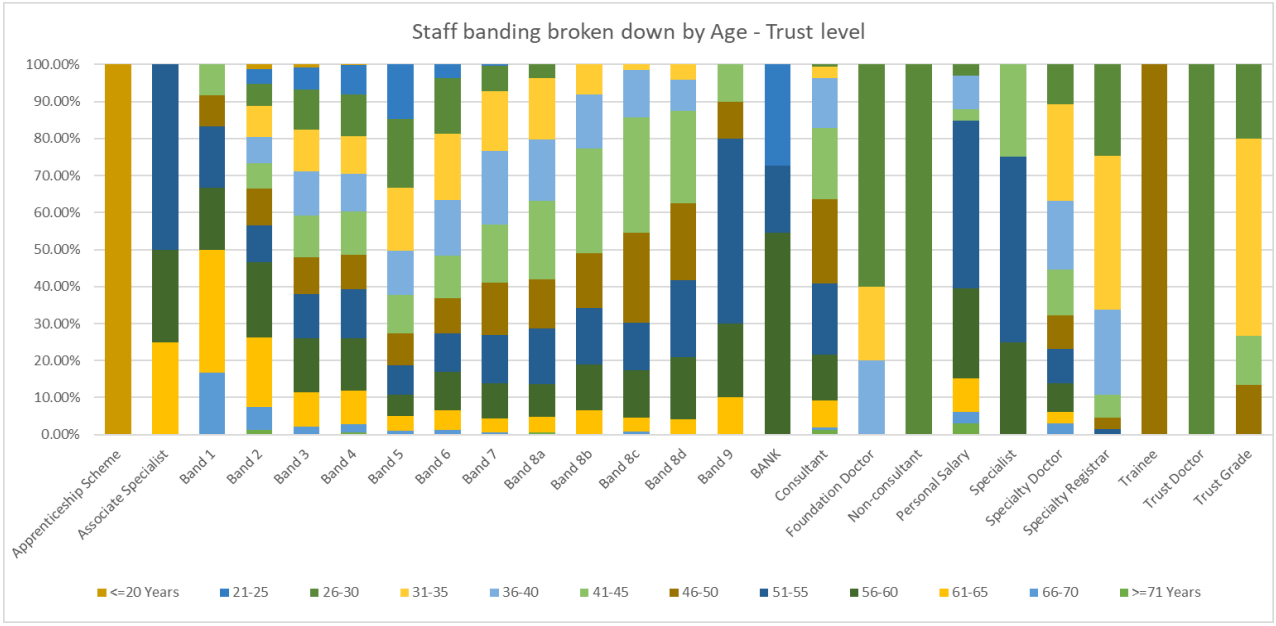
Disability





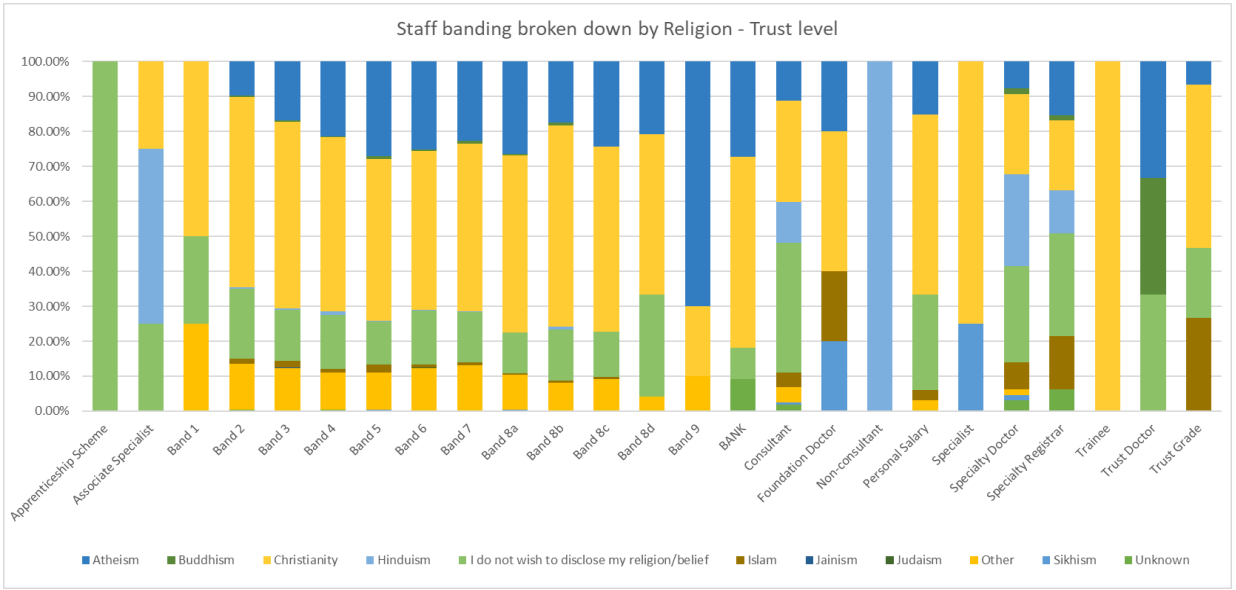
Staff banding broken down by Age category - shown at Trust level

	Age Band											
Band	**<=20 Years**	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**	**>=71 Years**
Apprenticeship Scheme	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Associate Specialist	0%	0%	0%	0%	0%	0%	0%	50%	25%	25%	0%	0%
Band 1	0%	0%	0%	0%	0%	8%	8%	17%	17%	33%	17%	0%
Band 2	1%	4%	6%	8%	7%	7%	10%	10%	20%	19%	6%	1%
Band 3	1%	6%	11%	11%	12%	11%	10%	12%	15%	9%	2%	0%
Band 4	0%	8%	11%	10%	10%	12%	9%	13%	14%	9%	2%	1%
Band 5	0%	15%	19%	17%	12%	10%	9%	8%	6%	4%	1%	0%
Band 6	0%	4%	15%	18%	15%	11%	9%	10%	10%	5%	1%	0%
Band 7	0%	0%	7%	16%	20%	16%	14%	13%	10%	4%	0%	0%
Band 8a	0%	0%	4%	16%	17%	21%	13%	15%	9%	4%	0%	1%
Band 8b	0%	0%	0%	8%	15%	28%	15%	15%	12%	7%	0%	0%
Band 8c	0%	0%	0%	2%	13%	31%	24%	13%	13%	4%	1%	0%
Band 8d	0%	0%	0%	4%	8%	25%	21%	21%	17%	4%	0%	0%
Band 9	0%	0%	0%	0%	0%	10%	10%	50%	20%	10%	0%	0%
BANK	0%	27%	0%	0%	0%	0%	0%	18%	55%	0%	0%	0%
Consultant	0%	0%	1%	3%	14%	19%	23%	19%	12%	7%	1%	1%
Foundation Doctor	0%	0%	60%	20%	20%	0%	0%	0%	0%	0%	0%	0%
Non-consultant	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Personal Salary	0%	0%	3%	0%	9%	3%	0%	45%	24%	9%	3%	3%
Specialist	0%	0%	0%	0%	0%	25%	0%	50%	25%	0%	0%	0%
Specialty Doctor	0%	0%	11%	26%	18%	12%	9%	9%	8%	3%	3%	0%
Specialty Registrar	0%	0%	25%	42%	23%	6%	3%	2%	0%	0%	0%	0%
Trainee	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
Trust Doctor	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Trust Grade	0%	0%	20%	53%	0%	13%	13%	0%	0%	0%	0%	0%

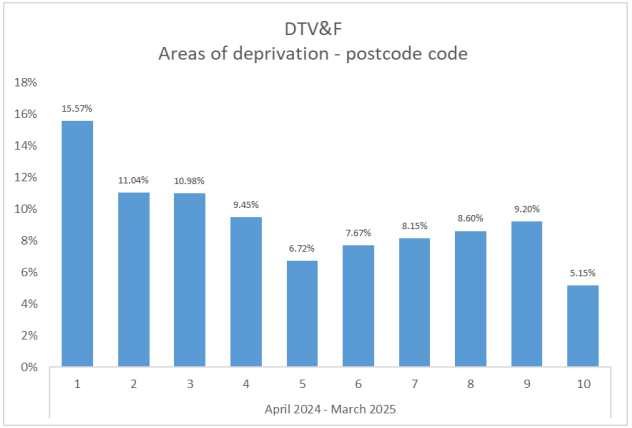


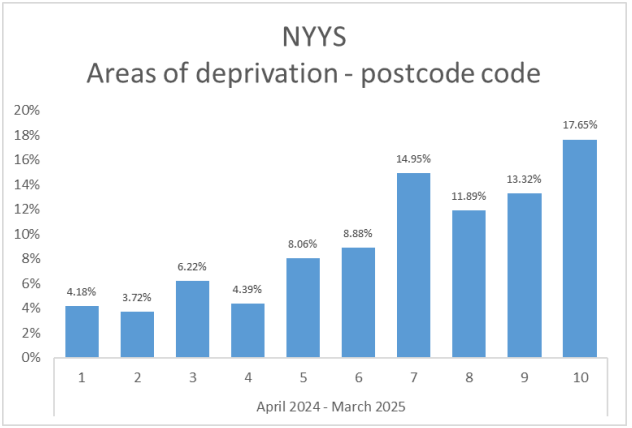
Staff banding broken down by Religion - shown at Trust level

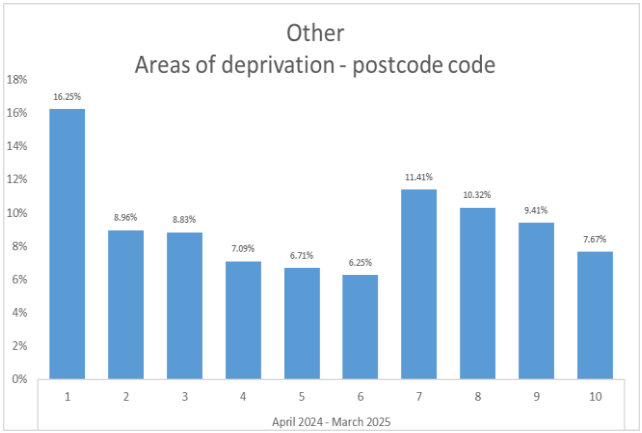
Band	Religious Belief										
	Atheism	Buddhism	Christianity	Hinduism	I do not wish to disclose my religion/belief	Islam	Jainism	Judaism	Other	Sikhism	Unknown
Apprenticeship Scheme	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	0%
Associate Specialist	0%	0%	25%	50%	25%	0%	0%	0%	0%	0%	0%
Band 1	0%	0%	50%	0%	25%	0%	0%	0%	25%	0%	0%
Band 2	10%	0%	54%	0%	20%	1%	0%	0%	13%	0%	0%
Band 3	17%	0%	53%	0%	15%	2%	0%	0%	12%	0%	0%
Band 4	21%	0%	50%	1%	15%	1%	0%	0%	11%	0%	0%
Band 5	27%	1%	46%	0%	12%	2%	0%	0%	11%	0%	0%
Band 6	25%	1%	45%	0%	15%	1%	0%	0%	12%	0%	0%
Band 7	23%	1%	48%	0%	14%	1%	0%	0%	13%	0%	0%
Band 8a	26%	0%	51%	0%	12%	0%	0%	0%	10%	0%	0%
Band 8b	18%	1%	58%	1%	15%	1%	0%	0%	8%	0%	0%
Band 8c	24%	0%	53%	0%	13%	1%	0%	0%	9%	0%	0%
Band 8d	21%	0%	46%	0%	29%	0%	0%	0%	4%	0%	0%
Band 9	70%	0%	20%	0%	0%	0%	0%	0%	10%	0%	0%
BANK	27%	0%	55%	0%	9%	0%	0%	0%	0%	0%	9%
Consultant	11%	0%	29%	12%	37%	4%	0%	0%	4%	1%	2%
Foundation Doctor	20%	0%	40%	0%	0%	20%	0%	0%	0%	20%	0%
Non-consultant	0%	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%
Personal Salary	15%	0%	52%	0%	27%	3%	0%	0%	3%	0%	0%
Specialist	0%	0%	75%	0%	0%	0%	0%	0%	0%	25%	0%
Specialty Doctor	8%	2%	23%	26%	28%	8%	0%	0%	2%	2%	3%
Specialty Registrar	15%	2%	20%	12%	29%	15%	0%	0%	0%	0%	6%
Trainee	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%
Trust Doctor	33%	33%	0%	0%	33%	0%	0%	0%	0%	0%	0%
Trust Grade	7%	0%	47%	0%	20%	27%	0%	0%	0%	0%	0%



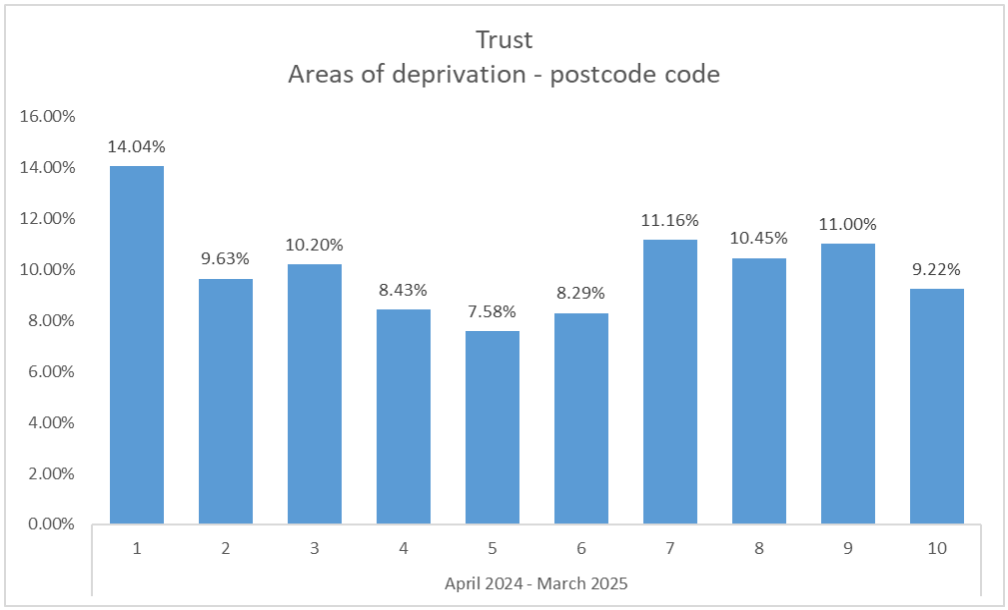
Staff postcode broken down by Areas of Deprivation





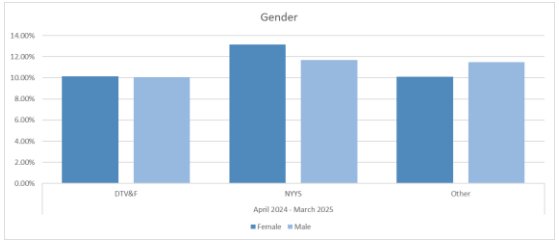


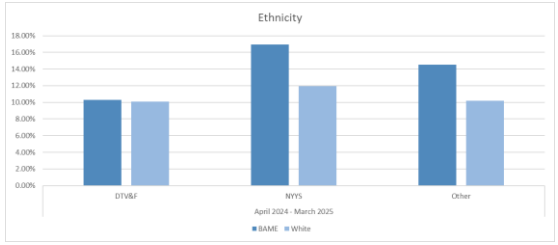
Staff postcode broken down by Areas of Deprivation

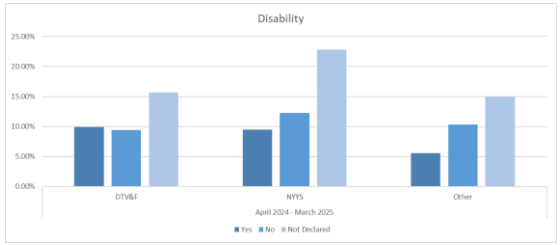


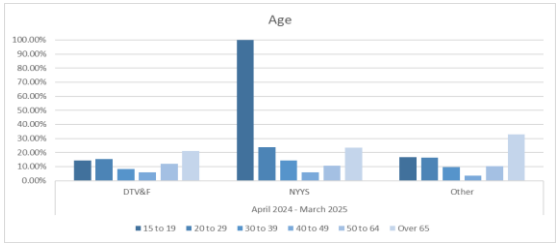
Leavers Information

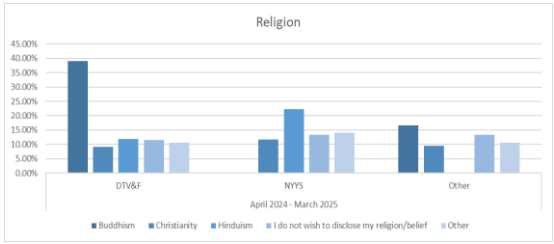
NB: the figures shown are the number of leavers in the time period that is being looked at, as a percentage of the staff figures as at the end of that reporting period. For example, In DTV&F, if the number of leavers in that 6 month period is 10 males and 10 females, and the staff make up at the end of the reporting period is 100 males and 100 females, the percentages shown would be 10% for females and 10% for males (10 leavers / 100 staff make up)

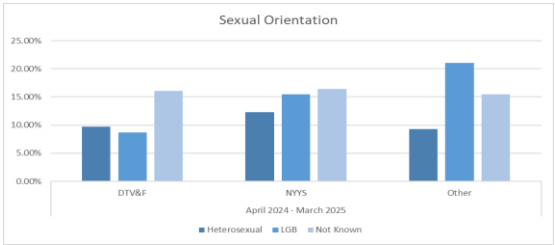






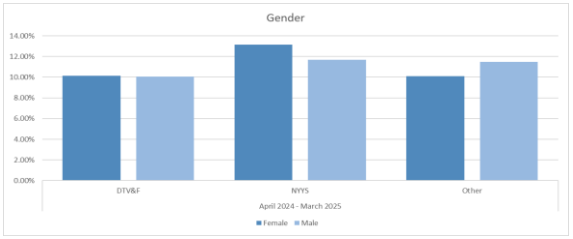


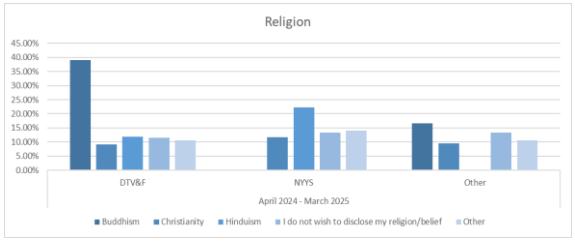


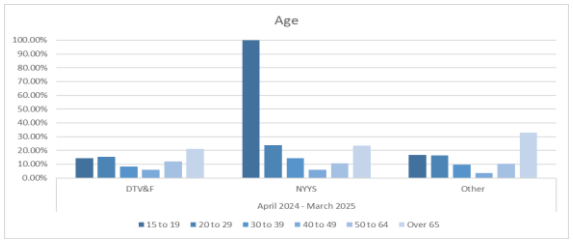


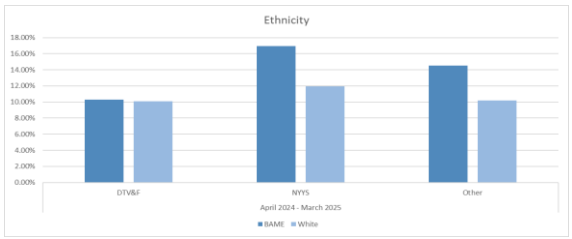
Sickness Information

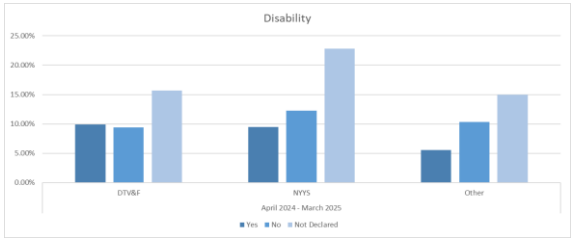
NB: the figures shown are the number of absences in the time period that is being looked at, as a percentage of the staff figures as at the end of that reporting period. Absences are only counted once in the time period, so if a staff member has had 5 episodes of sickness, this will only be counted once to avoid over inflating the figures.

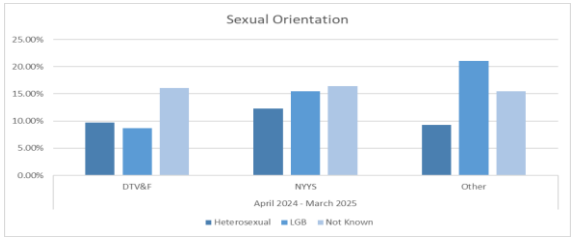












Staff Survey Results

The national staff survey was sent to all staff, and they were asked to respond to questions and to freely declare their long-term health condition status, gender, age, ethnicity and sexual orientation. The data is measured by those that agree with a series of questions and offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling NHS England and NHS Improvement to explore staff experience across different parts of the NHS and work to bring about the necessary improvements. The data was published March 2025.

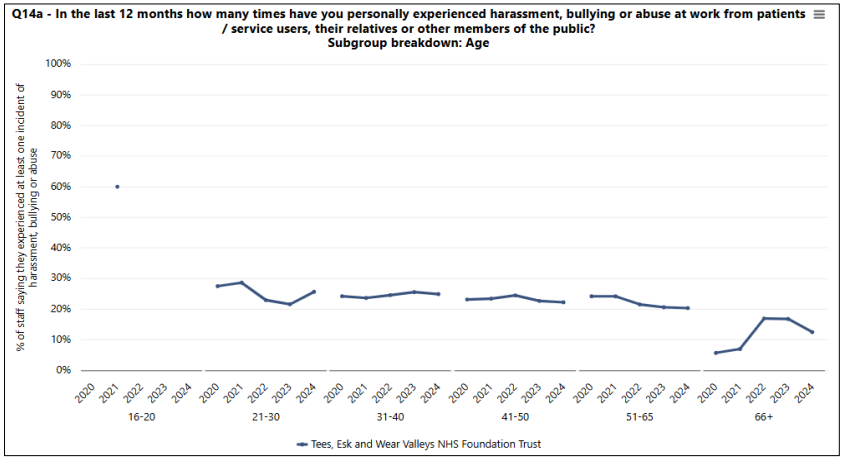
- Disabled compared to non-disabled (with a LTHC compared to without a LTHC)
- BAME compared to white.
- Age categories compared to one another.
- Gender compared to one another.
- Sexual orientation compared to one another.
- Religions compared to one another.
- Gender identity compared to one another. Further clarity around the category - Does the persons gender now, reflect their sex registered at birth. Three possible answers; yes, no or prefer not to say.

Questions were selected for further analysis and the NHS Staff Survey dashboard found at https://nhssurveys.co.uk/nss/questions/organisational was utilised in order to produce a graph detailing the current scores and previous years scores.
The questions selected are listed below, with a link to the relevant charts.

Question Number	Question	*Page Link*
Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	*Click here*
Q14c	Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months.	*Click here*
Q15	Percentage believing that Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?	*Click here*
Q16b	In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues.	*Click here*
SE	Staff Engagement Score	*Click here*
Q31b	**Only for Disability**: Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry out their work	*Click here*

Back to Main survey page

AGE

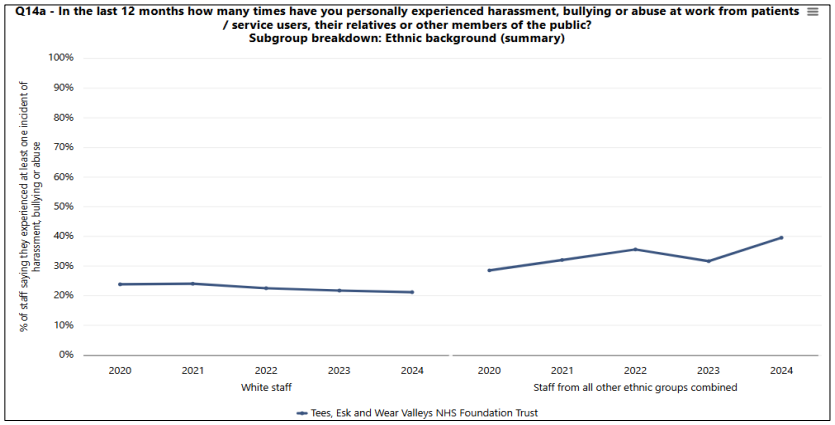


% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Age	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	16-20	-	60.00%	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	21-30	27.51%	28.66%	22.95%	21.61%	25.68%
Tees, Esk and Wear Valleys NHS Foundation Trust	31-40	24.24%	23.66%	24.59%	25.57%	24.92%
Tees, Esk and Wear Valleys NHS Foundation Trust	41-50	23.17%	23.43%	24.51%	22.70%	22.25%
Tees, Esk and Wear Valleys NHS Foundation Trust	51-65	24.21%	24.20%	21.56%	20.63%	20.35%
Tees, Esk and Wear Valleys NHS Foundation Trust	66+	5.71%	6.98%	16.95%	16.79%	12.50%

ETHNICITY

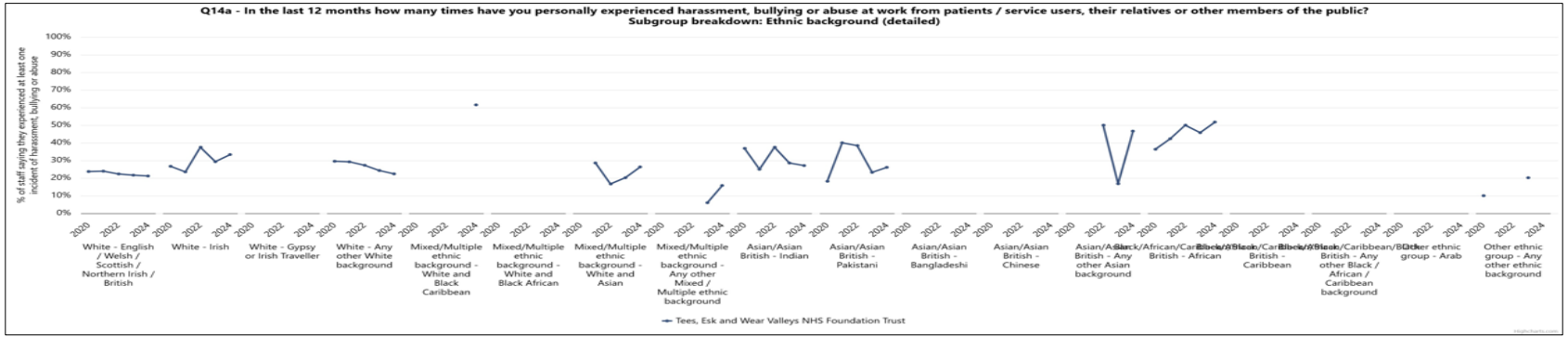
Summary



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Ethnic background (summary)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White staff	23.87%	24.07%	22.56%	21.78%	21.24%
Tees, Esk and Wear Valleys NHS Foundation Trust	Staff from all other ethnic groups combined	28.57%	32.09%	35.62%	31.67%	39.57%

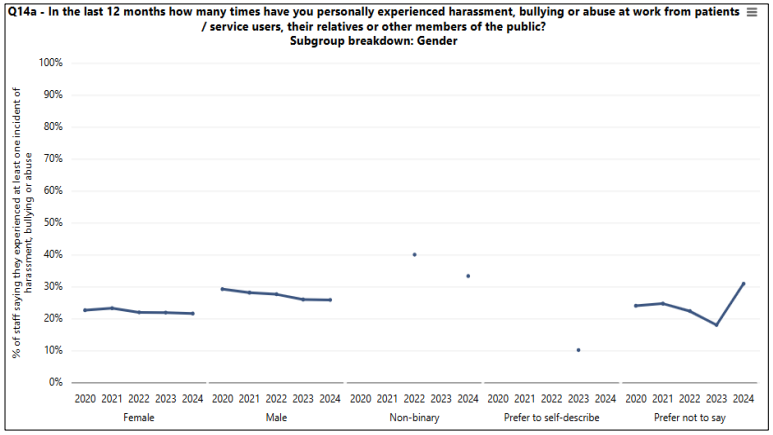
Detail



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Ethnic background (detailed)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White - English / Welsh / Scottish / Northern Irish / British	23.72%	23.92%	22.34%	21.64%	21.17%
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Irish	26.67%	23.53%	37.50%	29.32%	33.33%
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Gypsy or Irish Traveller	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Any other White background	29.55%	29.23%	27.27%	24.29%	22.39%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black Caribbean	-	-	-	-	61.54%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black African	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Asian	-	28.57%	16.67%	20.21%	26.32%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - Any other Mixed / Multiple ethnic background	-	-	-	6.00%	15.79%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Indian	36.84%	25.00%	37.50%	28.54%	27.08%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Pakistani	18.18%	40.00%	38.46%	23.26%	26.09%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Bangladeshi	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Chinese	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Any other Asian background	-	-	50.00%	16.80%	46.67%
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - African	36.36%	42.31%	50.00%	45.79%	51.79%
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Caribbean	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Any other Black / African / Caribbean background	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Arab	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Any other ethnic background	10.00%	-	-	20.18%	-

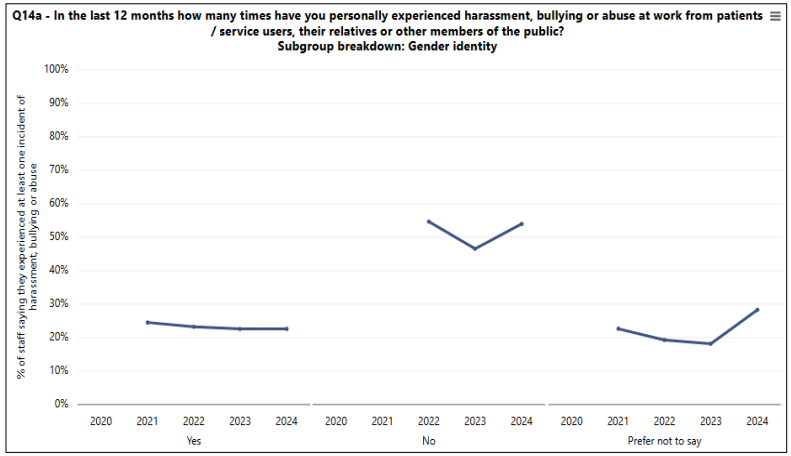
GENDER



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Gender	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Female	22.61%	23.24%	21.96%	21.90%	21.58%
Tees, Esk and Wear Valleys NHS Foundation Trust	Male	29.21%	28.13%	27.61%	25.98%	25.84%
Tees, Esk and Wear Valleys NHS Foundation Trust	Non-binary	-	-	40.00%	-	33.33%
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer to self-describe	-	-	-	10.17%	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	24.00%	24.69%	22.35%	17.99%	30.91%

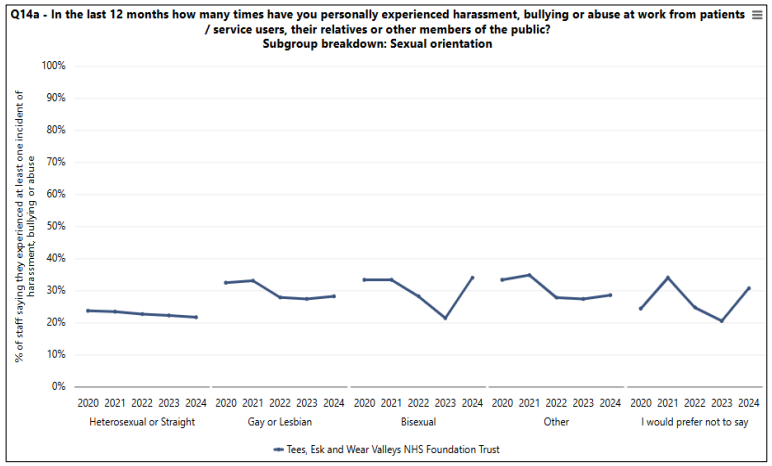
Gender Identity



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Gender identity	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	-	24.41%	23.11%	22.47%	22.50%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	-	-	54.55%	46.42%	53.85%
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	-	22.54%	19.18%	18.05%	26.16%

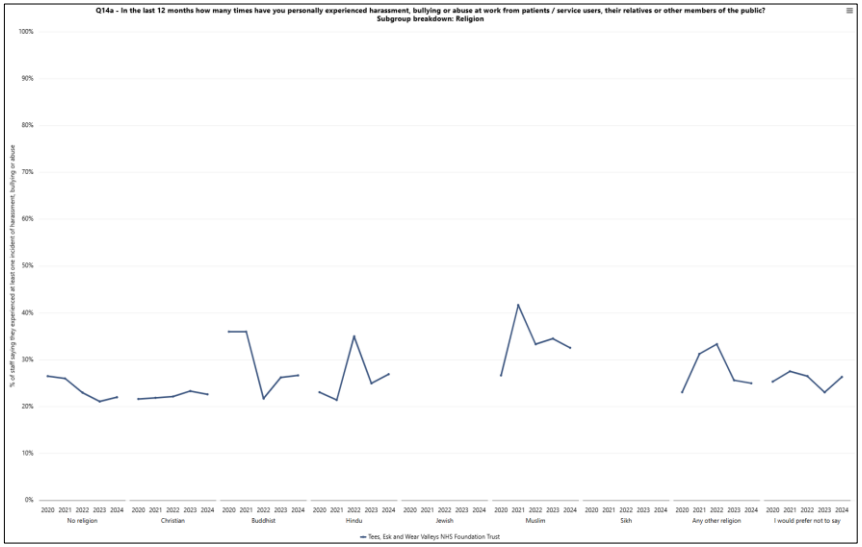
SEXUAL ORIENTATION



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Sexual orientation	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Heterosexual or Straight	23.67%	23.39%	22.65%	22.23%	21.66%
Tees, Esk and Wear Valleys NHS Foundation Trust	Gay or Lesbian	32.43%	33.04%	27.84%	27.39%	28.18%
Tees, Esk and Wear Valleys NHS Foundation Trust	Bisexual	33.33%	33.33%	28.17%	21.40%	33.98%
Tees, Esk and Wear Valleys NHS Foundation Trust	Other	33.33%	34.78%	27.78%	27.35%	28.57%
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	24.38%	34.00%	24.69%	20.52%	30.69%

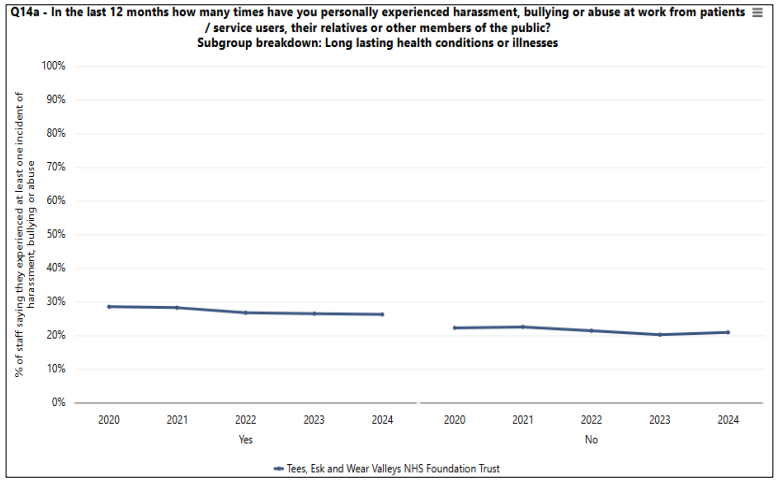
RELIGION



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Religion	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	No religion	26.51%	26.02%	23.01%	21.11%	22.01%
Tees, Esk and Wear Valleys NHS Foundation Trust	Christian	21.64%	21.89%	22.16%	23.33%	22.64%
Tees, Esk and Wear Valleys NHS Foundation Trust	Buddhist	36.00%	36.00%	21.74%	26.23%	26.67%
Tees, Esk and Wear Valleys NHS Foundation Trust	Hindu	23.08%	21.43%	35.00%	24.98%	26.92%
Tees, Esk and Wear Valleys NHS Foundation Trust	Jewish	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Muslim	26.67%	41.67%	33.33%	34.52%	32.56%
Tees, Esk and Wear Valleys NHS Foundation Trust	Sikh	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Any other religion	23.08%	31.25%	33.33%	25.64%	25.00%
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	25.34%	27.54%	26.51%	23.07%	26.34%

LONG LASTING HEALTH CONDITION OR ILLNESS



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Long lasting health conditions or illnesses	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	28.51%	28.23%	26.73%	26.46%	26.23%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	22.25%	22.53%	21.39%	20.22%	20.89%

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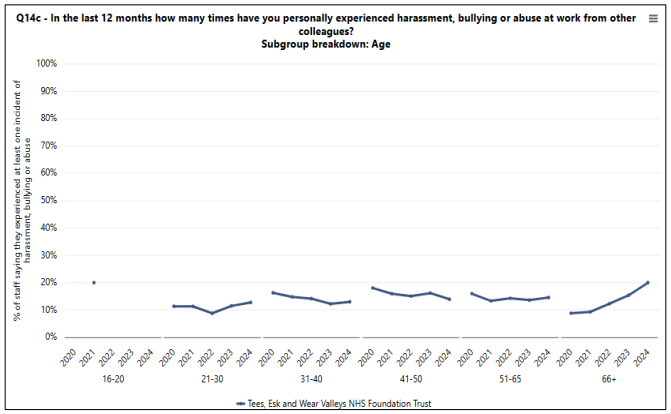
AGE

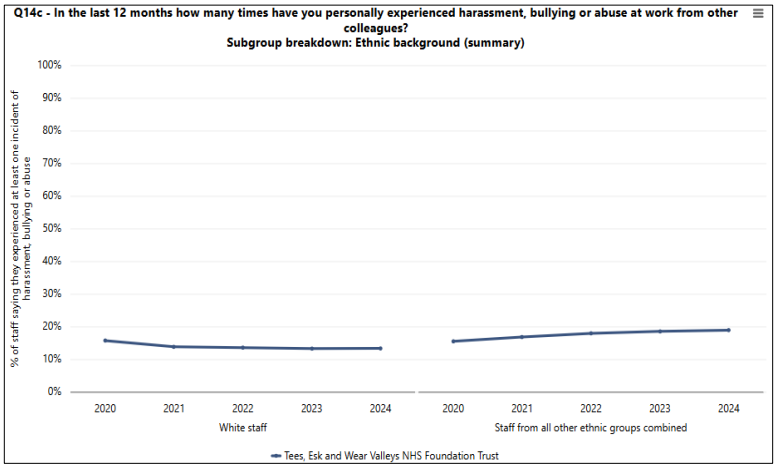


% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Age	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	16-20	-	20.00%	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	21-30	11.36%	11.33%	8.80%	11.51%	12.77%
Tees, Esk and Wear Valleys NHS Foundation Trust	31-40	16.29%	14.80%	14.17%	12.24%	13.00%
Tees, Esk and Wear Valleys NHS Foundation Trust	41-50	18.06%	15.95%	15.07%	16.19%	13.93%
Tees, Esk and Wear Valleys NHS Foundation Trust	51-65	15.99%	13.32%	14.30%	13.63%	14.58%
Tees, Esk and Wear Valleys NHS Foundation Trust	66+	8.82%	9.30%	12.28%	15.41%	20.00%

ETHNICITY

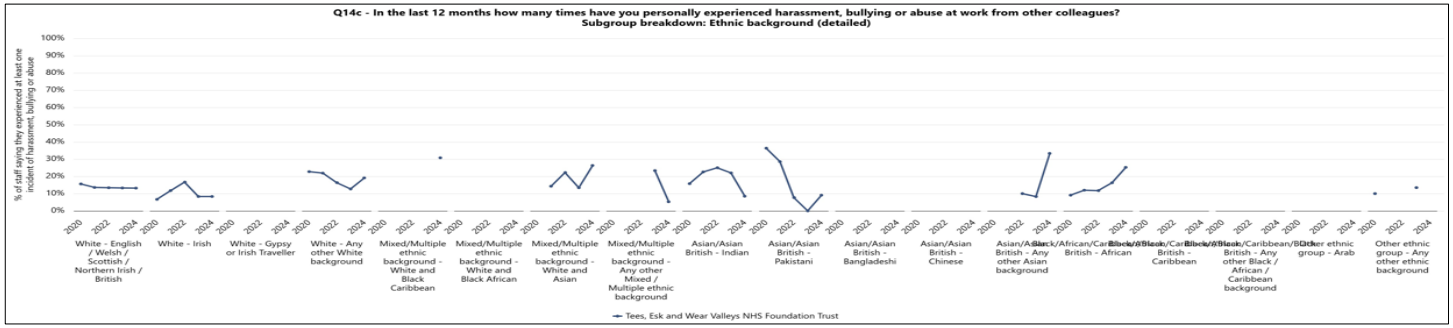
Summary



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Ethnic background (summary)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White staff	15.72%	13.79%	13.55%	13.25%	13.30%
Tees, Esk and Wear Valleys NHS Foundation Trust	Staff from all other ethnic groups combined	15.48%	16.79%	17.93%	18.51%	18.91%

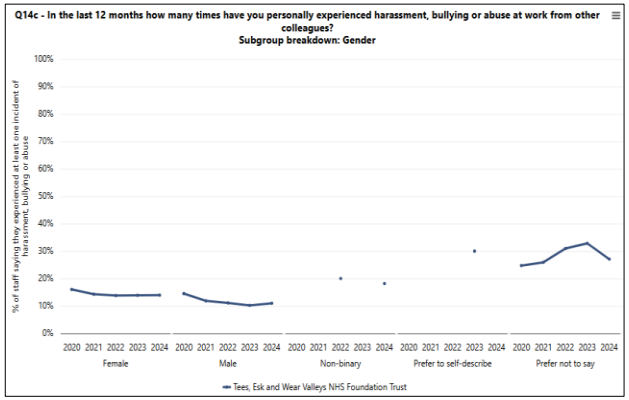
Detail



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Ethnic background (detailed)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White - English / Welsh / Scottish / Northern Irish / British	15.62%	13.58%	13.42%	13.27%	13.19%
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Irish	6.67%	11.76%	16.67%	8.35%	8.33%
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Gypsy or Irish Traveller	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Any other White background	22.73%	21.88%	16.36%	12.70%	19.12%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black Caribbean	-	-	-	-	30.77%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black African	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Asian	-	14.29%	22.22%	13.42%	26.32%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - Any other Mixed / Multiple ethnic background	-	-	-	23.35%	5.26%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Indian	15.79%	22.58%	25.00%	22.00%	8.51%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Pakistani	36.36%	28.57%	7.69%	0.00%	9.09%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Bangladeshi	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Chinese	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Any other Asian background	-	-	10.00%	8.30%	33.33%
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - African	9.09%	12.00%	11.76%	16.32%	25.23%
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Caribbean	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Any other Black / African / Caribbean background	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Arab	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Any other ethnic background	10.00%	-	-	13.48%	-

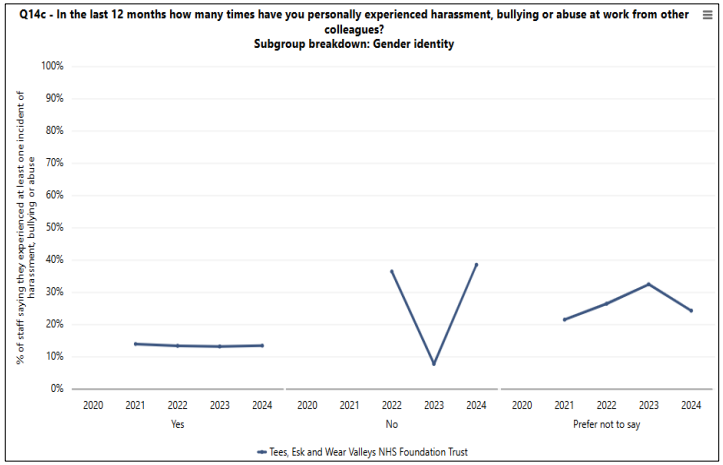
GENDER



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Gender	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Female	16.02%	14.29%	13.79%	13.87%	13.93%
Tees, Esk and Wear Valleys NHS Foundation Trust	Male	14.53%	11.85%	11.09%	10.21%	11.00%
Tees, Esk and Wear Valleys NHS Foundation Trust	Non-binary	-	-	20.00%	-	18.18%
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer to self-describe	-	-	-	30.01%	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	24.75%	25.93%	30.95%	32.84%	27.10%

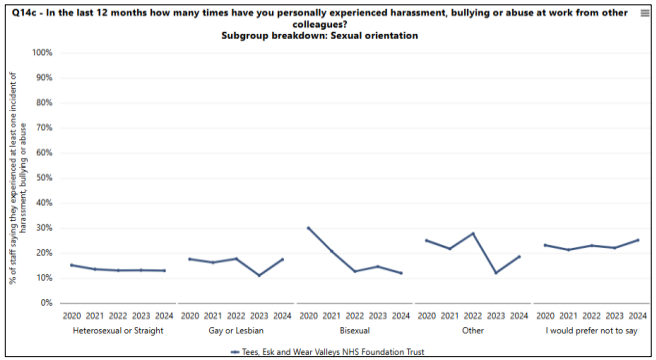
GENDER IDENTITY



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Gender identity	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	-	13.92%	13.34%	13.14%	13.38%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	-	-	36.36%	7.73%	38.46%
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	-	21.43%	26.39%	32.40%	24.24%

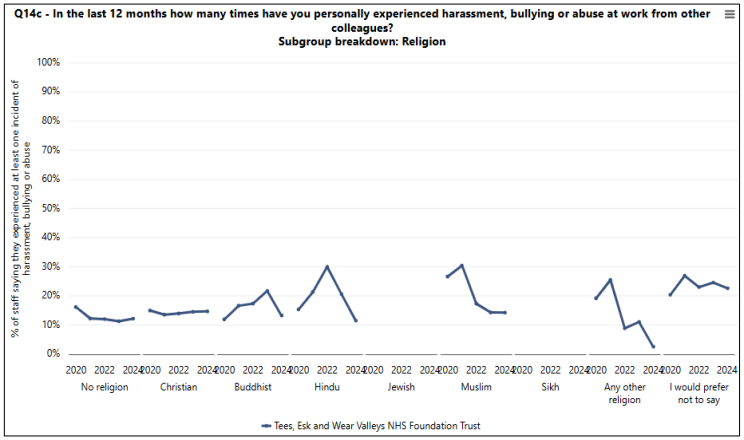
SEXUAL ORIENTATION



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Sexual orientation	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Heterosexual or Straight	15.16%	13.56%	13.06%	13.15%	12.97%
Tees, Esk and Wear Valleys NHS Foundation Trust	Gay or Lesbian	17.57%	16.22%	17.71%	11.07%	17.43%
Tees, Esk and Wear Valleys NHS Foundation Trust	Bisexual	30.00%	20.75%	12.68%	14.60%	12.00%
Tees, Esk and Wear Valleys NHS Foundation Trust	Other	25.00%	21.74%	27.78%	12.06%	18.52%
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	23.13%	21.33%	22.98%	22.06%	25.14%

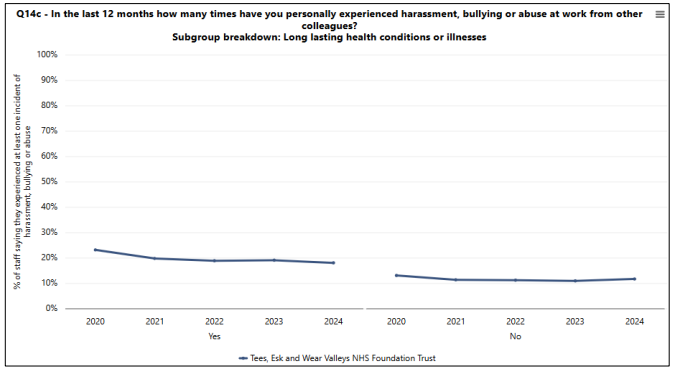
RELIGION



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Religion	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	No religion	16.22%	12.31%	12.08%	11.35%	12.22%
Tees, Esk and Wear Valleys NHS Foundation Trust	Christian	15.02%	13.60%	14.02%	14.59%	14.74%
Tees, Esk and Wear Valleys NHS Foundation Trust	Buddhist	12.00%	16.67%	17.39%	21.74%	13.33%
Tees, Esk and Wear Valleys NHS Foundation Trust	Hindu	15.38%	21.43%	30.00%	20.64%	11.54%
Tees, Esk and Wear Valleys NHS Foundation Trust	Jewish	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Muslim	26.67%	30.43%	17.39%	14.37%	14.29%
Tees, Esk and Wear Valleys NHS Foundation Trust	Sikh	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Any other religion	19.23%	25.53%	8.93%	11.10%	2.63%
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	20.41%	26.95%	23.03%	24.62%	22.65%

LONG LASTING HEALTH CONDITION OR ILLNESS



% of staff saying they experienced at least one incident of harassment, bullying or abuse

Organisation	Long lasting health conditions or illnesses	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	23.10%	19.74%	18.85%	19.06%	18.02%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	13.04%	11.33%	11.18%	10.91%	11.65%

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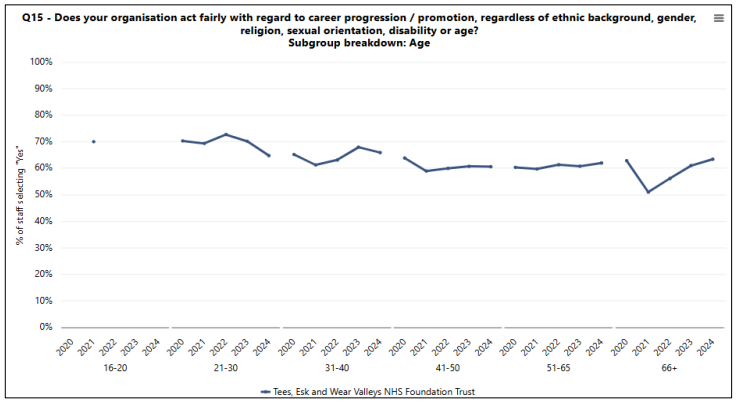
AGE

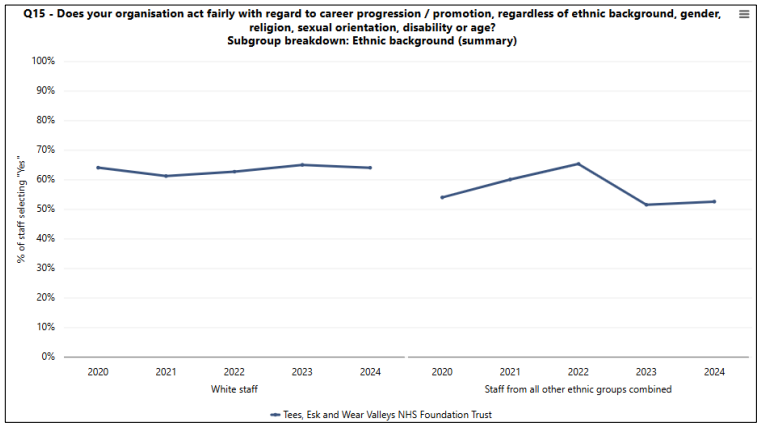


% of staff selecting "Yes"

Organisation	Age	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	16-20	-	70.00%	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	21-30	70.29%	69.36%	72.71%	70.13%	64.77%
Tees, Esk and Wear Valleys NHS Foundation Trust	31-40	65.18%	61.25%	63.12%	67.93%	65.90%
Tees, Esk and Wear Valleys NHS Foundation Trust	41-50	63.84%	58.95%	59.95%	60.72%	60.59%
Tees, Esk and Wear Valleys NHS Foundation Trust	51-65	60.35%	59.72%	61.32%	60.78%	61.97%
Tees, Esk and Wear Valleys NHS Foundation Trust	66+	62.86%	51.02%	56.14%	61.02%	63.41%

ETHNICITY

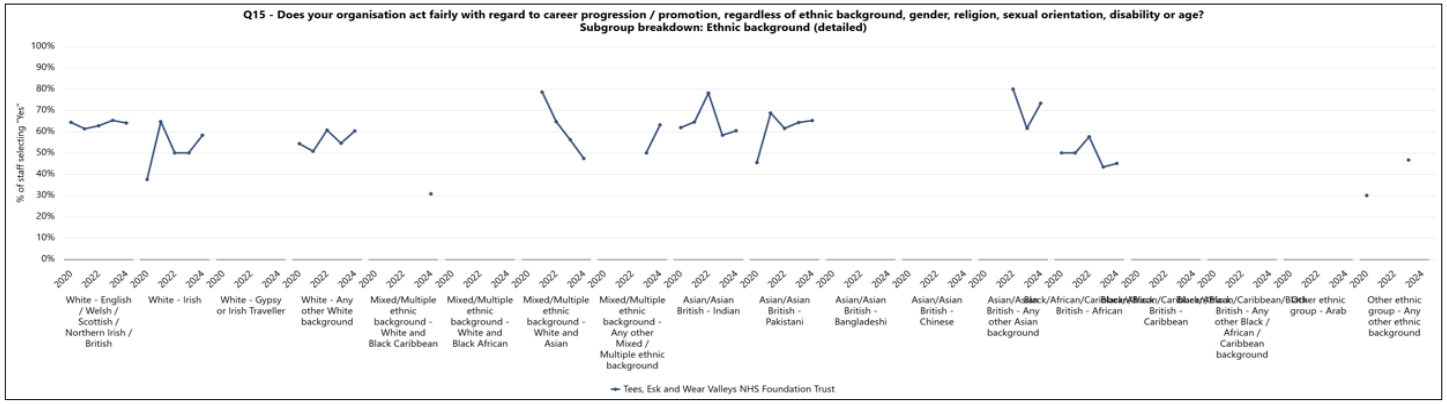
Summary



% of staff selecting "Yes"

Organisation	Ethnic background (summary)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White staff	64.00%	61.17%	62.65%	64.95%	63.97%
Tees, Esk and Wear Valleys NHS Foundation Trust	Staff from all other ethnic groups combined	53.93%	60.00%	65.28%	51.45%	52.52%

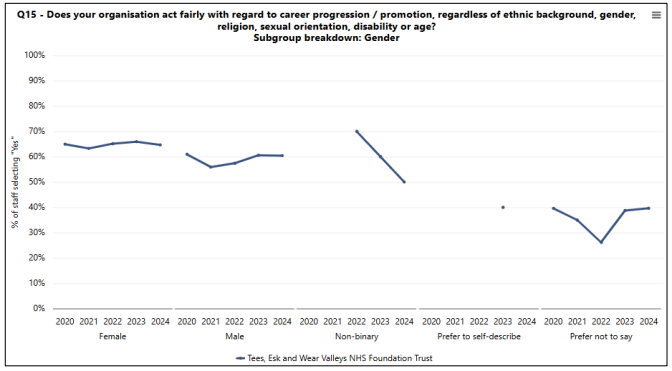
Detail



% of staff selecting "Yes"

Organisation	Ethnic background (detailed)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White - English / Welsh / Scottish / Northern Irish / British	64.36%	61.33%	62.76%	65.28%	64.07%
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Irish	37.50%	64.71%	50.00%	50.00%	58.33%
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Gypsy or Irish Traveller	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Any other White background	54.35%	50.77%	60.71%	54.55%	60.29%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black Caribbean	-	-	-	-	30.77%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black African	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Asian	-	78.57%	64.71%	56.25%	47.37%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - Any other Mixed / Multiple ethnic background	-	-	-	50.00%	63.16%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Indian	61.90%	64.52%	78.13%	58.33%	60.42%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Pakistani	45.45%	68.75%	61.54%	64.29%	65.22%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Bangladeshi	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Chinese	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Any other Asian background	-	-	80.00%	61.54%	73.33%
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - African	50.00%	50.00%	57.58%	43.37%	45.05%
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Caribbean	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Any other Black / African / Caribbean background	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Arab	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Any other ethnic background	30.00%	-	-	46.67%	-

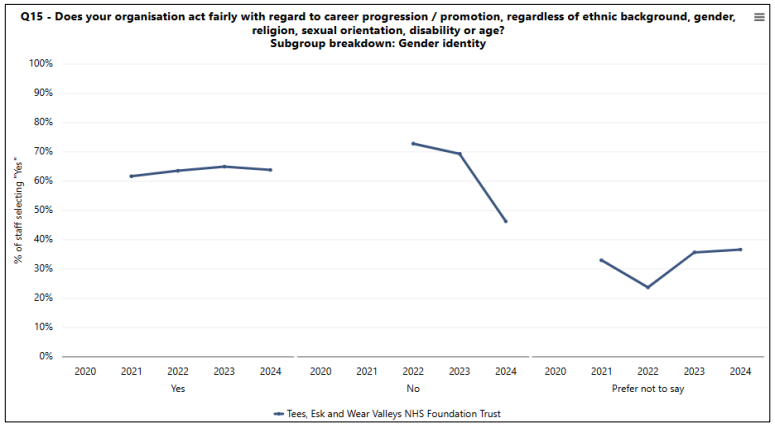
GENDER



% of staff selecting "Yes"

Organisation	Gender	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Female	64.94%	63.29%	65.14%	65.92%	64.66%
Tees, Esk and Wear Valleys NHS Foundation Trust	Male	60.95%	55.93%	57.41%	60.57%	60.44%
Tees, Esk and Wear Valleys NHS Foundation Trust	Non-binary	-	-	70.00%	60.00%	50.00%
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer to self-describe	-	-	-	40.00%	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	39.60%	35.00%	26.19%	38.74%	39.64%

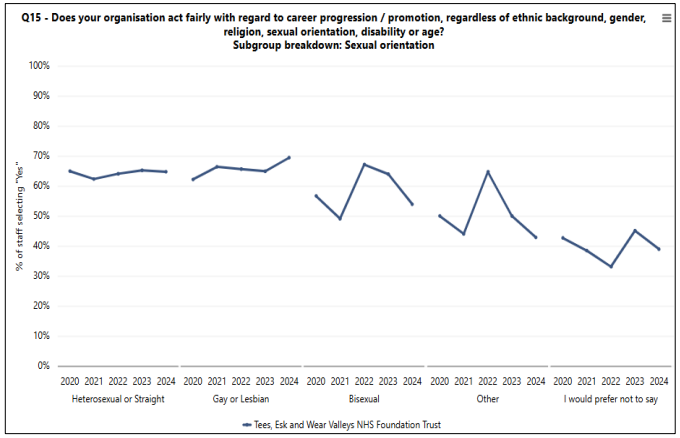
Gender Identity



% of staff selecting "Yes"

Organisation	Gender identity	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	-	61.57%	63.45%	64.86%	63.73%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	-	-	72.73%	69.23%	46.15%
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	-	32.88%	23.61%	35.58%	36.54%

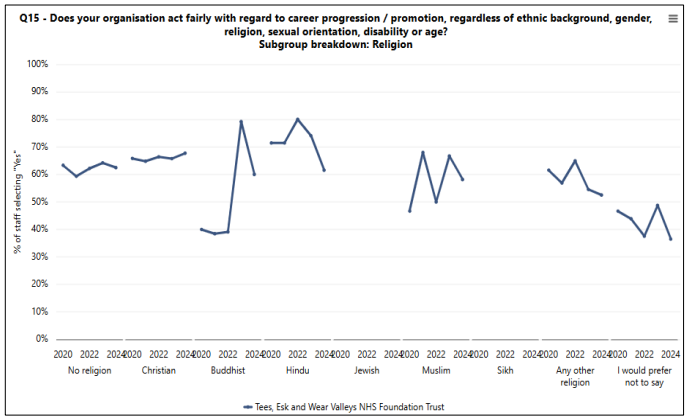
SEXUAL ORIENTATION



% of staff selecting "Yes"

Organisation	Sexual orientation	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Heterosexual or Straight	64.94%	62.32%	64.06%	65.21%	64.74%
Tees, Esk and Wear Valleys NHS Foundation Trust	Gay or Lesbian	62.16%	66.38%	65.63%	64.91%	69.44%
Tees, Esk and Wear Valleys NHS Foundation Trust	Bisexual	56.67%	49.09%	67.14%	63.95%	53.92%
Tees, Esk and Wear Valleys NHS Foundation Trust	Other	50.00%	44.00%	64.71%	50.00%	42.86%
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	42.68%	38.46%	33.13%	45.08%	38.95%

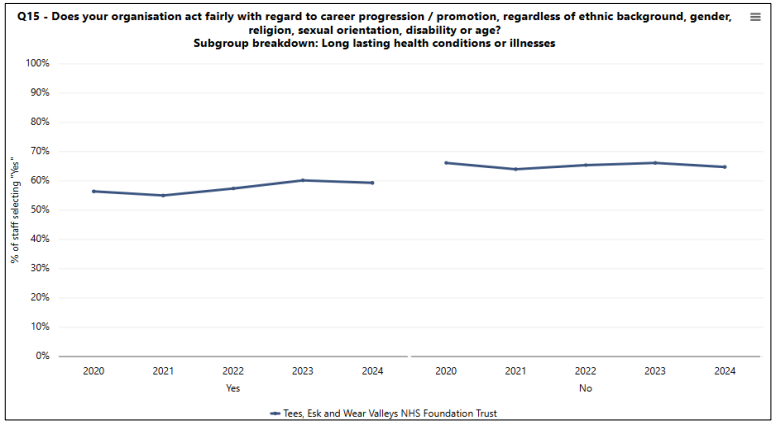
RELIGION



% of staff selecting "Yes"

Organisation	Religion	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	No religion	63.32%	59.32%	62.18%	64.19%	62.46%
Tees, Esk and Wear Valleys NHS Foundation Trust	Christian	65.80%	64.80%	66.36%	65.76%	67.70%
Tees, Esk and Wear Valleys NHS Foundation Trust	Buddhist	40.00%	38.46%	39.13%	79.17%	60.00%
Tees, Esk and Wear Valleys NHS Foundation Trust	Hindu	71.43%	71.43%	80.00%	74.07%	61.54%
Tees, Esk and Wear Valleys NHS Foundation Trust	Jewish	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Muslim	46.67%	68.00%	50.00%	66.67%	58.14%
Tees, Esk and Wear Valleys NHS Foundation Trust	Sikh	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Any other religion	61.54%	56.86%	64.91%	54.55%	52.50%
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	46.67%	43.86%	37.58%	48.74%	36.51%

LONG LASTING HEALTH CONDITION OR ILLNESS



% of staff selecting "Yes"

Organisation	Long lasting health conditions or illnesses	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	56.32%	54.91%	57.30%	60.09%	59.22%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	66.06%	63.90%	65.29%	66.04%	64.66%

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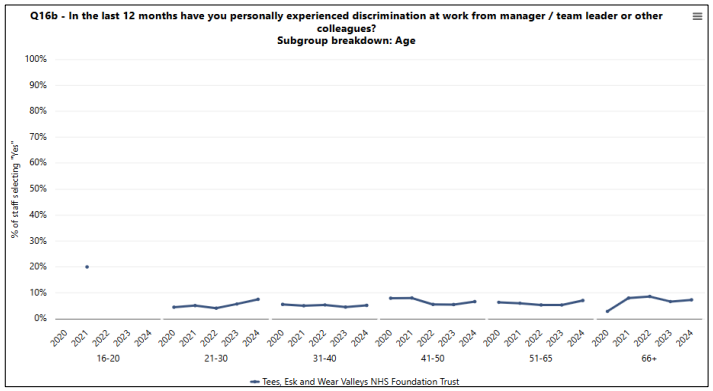
AGE

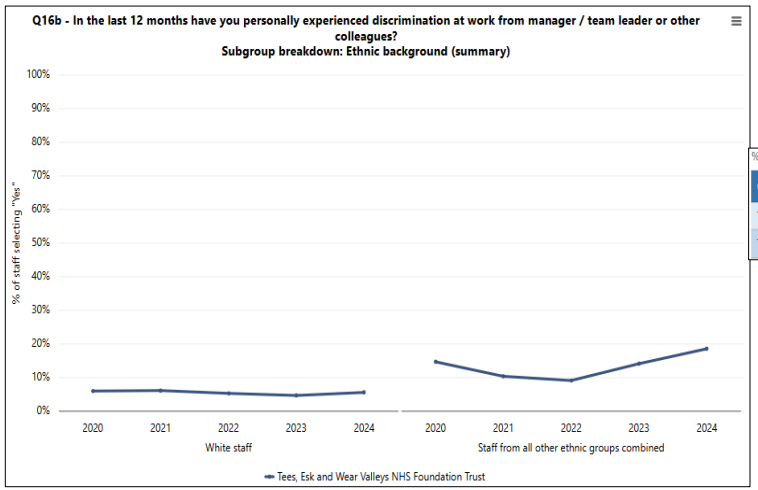


% of staff selecting "Yes"

Organisation	Age	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	16-20	-	20.00%	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	21-30	4.49%	5.11%	4.11%	5.73%	7.52%
Tees, Esk and Wear Valleys NHS Foundation Trust	31-40	5.58%	5.05%	5.34%	4.54%	5.19%
Tees, Esk and Wear Valleys NHS Foundation Trust	41-50	7.95%	8.04%	5.56%	5.51%	6.64%
Tees, Esk and Wear Valleys NHS Foundation Trust	51-65	6.36%	6.01%	5.35%	5.31%	7.08%
Tees, Esk and Wear Valleys NHS Foundation Trust	66+	2.86%	8.00%	8.62%	6.67%	7.32%

ETHNICITY

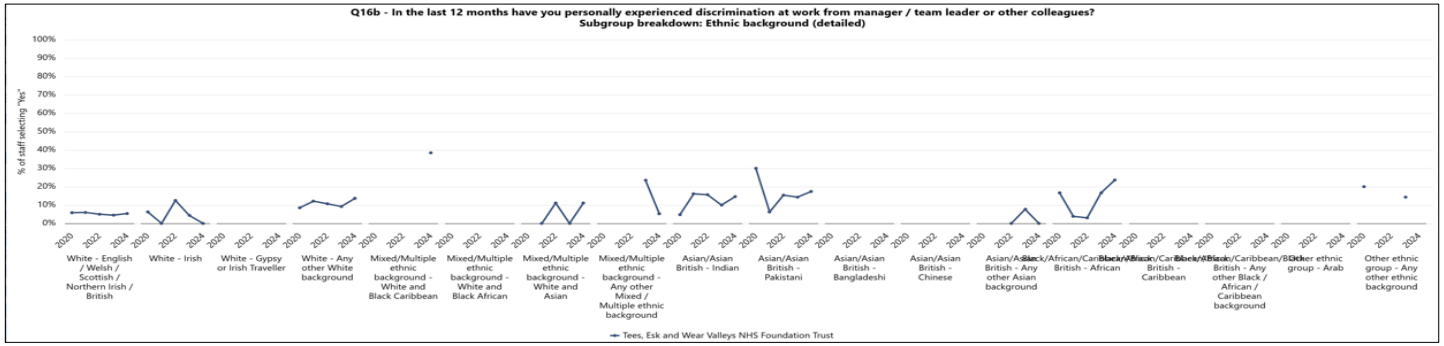
Summary



% of staff selecting "Yes"

Organisation	Ethnic background (summary)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White staff	5.87%	6.02%	5.18%	4.60%	5.52%
Tees, Esk and Wear Valleys NHS Foundation Trust	Staff from all other ethnic groups combined	14.61%	10.29%	9.03%	14.05%	18.48%

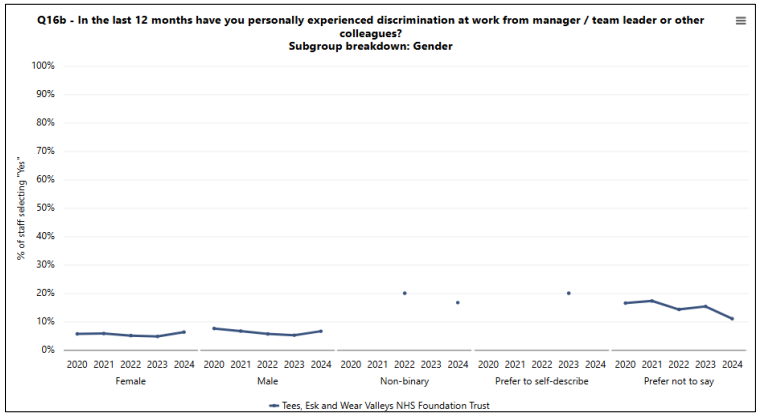
Detail



% of staff selecting "Yes"

Organisation	Ethnic background (detailed)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White - English / Welsh / Scottish / Northern Irish / British	5.82%	5.93%	4.99%	4.49%	5.36%
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Irish	6.25%	0.00%	12.50%	4.35%	0.00%
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Gypsy or Irish Traveller	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Any other White background	8.51%	12.12%	10.71%	9.23%	13.64%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black Caribbean	-	-	-	-	38.46%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black African	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Asian	-	0.00%	11.11%	0.00%	11.11%
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - Any other Mixed / Multiple ethnic background	-	-	-	23.53%	5.26%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Indian	4.76%	16.13%	15.63%	10.00%	14.58%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Pakistani	30.00%	6.25%	15.38%	14.29%	17.39%
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Bangladeshi	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Chinese	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Any other Asian background	-	-	0.00%	7.69%	0.00%
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - African	16.67%	3.85%	3.03%	16.67%	23.64%
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Caribbean	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Any other Black / African / Caribbean background	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Arab	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Any other ethnic background	20.00%	-	-	14.29%	-

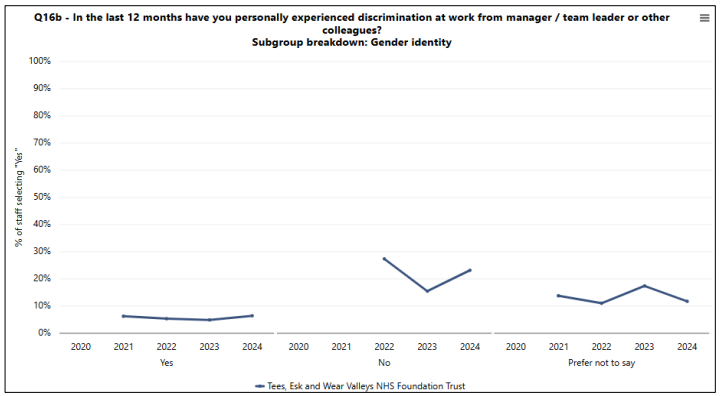
GENDER



% of staff selecting "Yes"

Organisation	Gender	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Female	5.69%	5.82%	5.09%	4.79%	6.30%
Tees, Esk and Wear Valleys NHS Foundation Trust	Male	7.58%	6.68%	5.67%	5.21%	6.63%
Tees, Esk and Wear Valleys NHS Foundation Trust	Non-binary	-	-	20.00%	-	16.67%
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer to self-describe	-	-	-	20.00%	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	16.50%	17.28%	14.29%	15.32%	11.01%

Gender Identity



% of staff selecting "Yes"

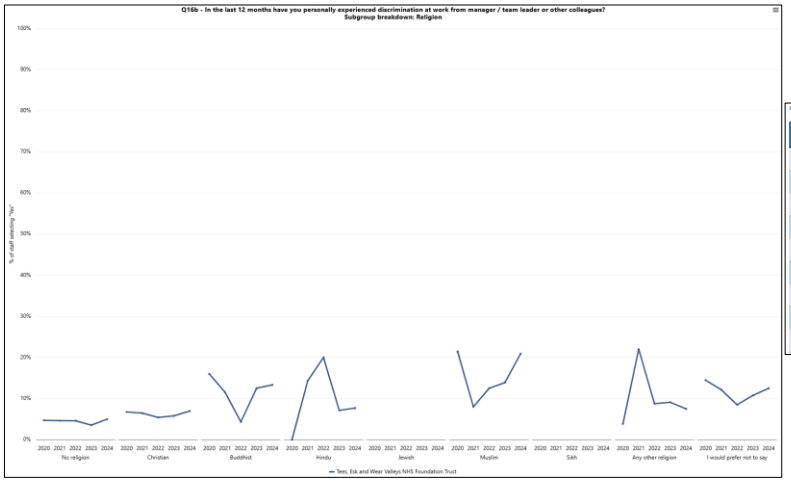
Organisation	Gender identity	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	-	6.17%	5.26%	4.81%	6.32%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	-	-	27.27%	15.38%	23.08%
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	-	13.70%	10.96%	17.31%	11.65%

SEXUAL ORIENTATION

% of staff selecting "Yes"

Organisation	Sexual orientation	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Heterosexual or Straight	5.99%	5.85%	5.13%	4.69%	5.95%
Tees, Esk and Wear Valleys NHS Foundation Trust	Gay or Lesbian	5.41%	6.84%	9.28%	6.19%	5.61%
Tees, Esk and Wear Valleys NHS Foundation Trust	Bisexual	23.33%	12.73%	7.04%	11.49%	8.74%
Tees, Esk and Wear Valleys NHS Foundation Trust	Other	0.00%	12.00%	11.11%	7.69%	17.86%
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	10.91%	12.18%	6.83%	9.42%	13.83%

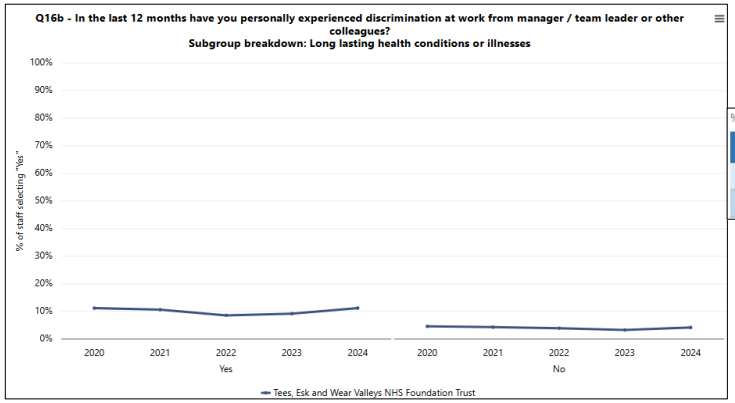
RELIGION



% of staff selecting "Yes"

Organisation	Religion	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	No religion	4.71%	4.64%	4.61%	3.54%	4.97%
Tees, Esk and Wear Valleys NHS Foundation Trust	Christian	6.74%	6.46%	5.40%	5.79%	6.96%
Tees, Esk and Wear Valleys NHS Foundation Trust	Buddhist	16.00%	11.54%	4.35%	12.50%	13.33%
Tees, Esk and Wear Valleys NHS Foundation Trust	Hindu	0.00%	14.29%	20.00%	7.14%	7.69%
Tees, Esk and Wear Valleys NHS Foundation Trust	Jewish	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Muslim	21.43%	8.00%	12.50%	13.89%	20.93%
Tees, Esk and Wear Valleys NHS Foundation Trust	Sikh	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Any other religion	3.85%	22.00%	8.77%	9.09%	7.50%
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	14.47%	12.14%	8.48%	10.77%	12.50%

LONG LASTING HEALTH CONDITION OR ILLNESS



% of staff selecting "Yes"

Organisation	Long lasting health conditions or illnesses	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	11.10%	10.53%	8.49%	9.11%	11.13%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	4.50%	4.21%	3.84%	3.20%	4.10%

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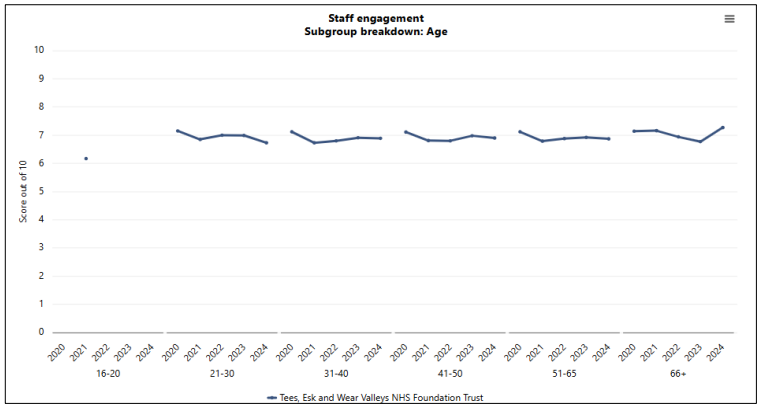
AGE

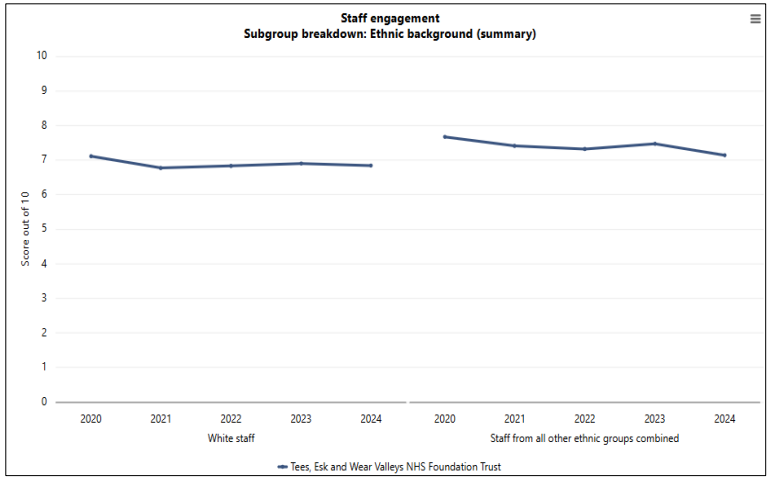


Score out of 10

Organisation	Age	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	16-20	-	6.17	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	21-30	7.15	6.85	7.00	6.99	6.73
Tees, Esk and Wear Valleys NHS Foundation Trust	31-40	7.12	6.73	6.80	6.91	6.89
Tees, Esk and Wear Valleys NHS Foundation Trust	41-50	7.11	6.81	6.80	6.98	6.90
Tees, Esk and Wear Valleys NHS Foundation Trust	51-65	7.12	6.79	6.88	6.92	6.87
Tees, Esk and Wear Valleys NHS Foundation Trust	66+	7.14	7.16	6.94	6.77	7.27

ETHNICITY

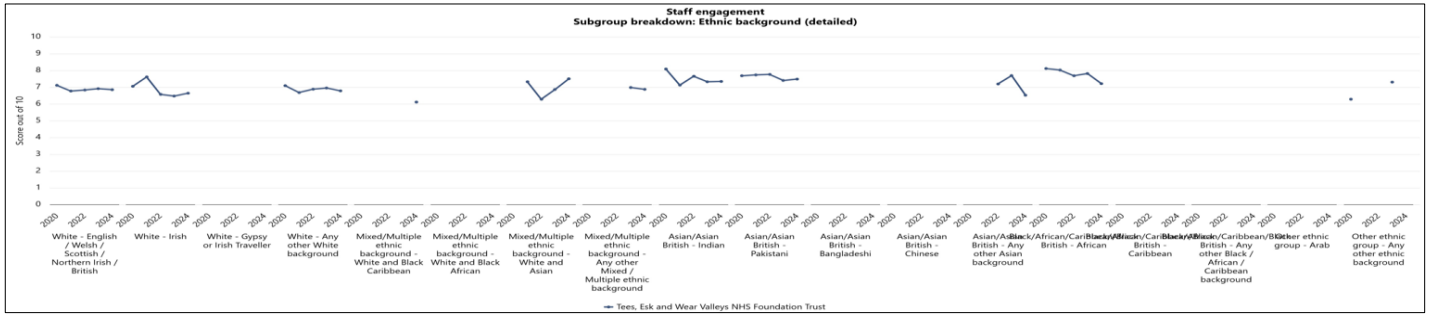
Summary



Score out of 10

Organisation	Ethnic background (summary)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White staff	7.11	6.77	6.83	6.90	6.84
Tees, Esk and Wear Valleys NHS Foundation Trust	Staff from all other ethnic groups combined	7.67	7.41	7.32	7.47	7.14

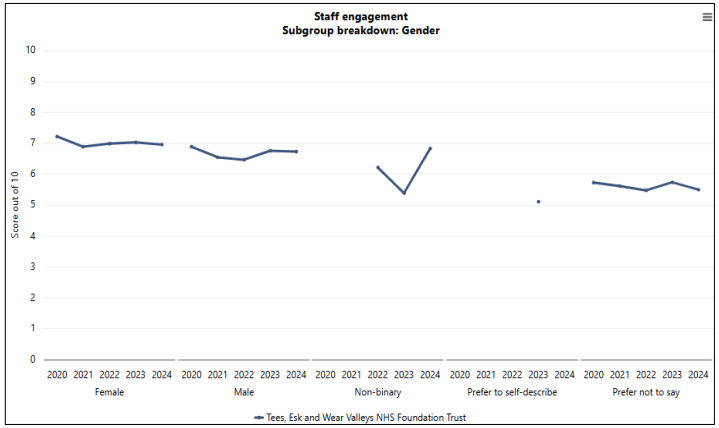
Detail



Score out of 10

Organisation	Ethnic background (detailed)	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	White - English / Welsh / Scottish / Northern Irish / British	7.11	6.77	6.83	6.91	6.85
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Irish	7.05	7.61	6.57	6.47	6.64
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Gypsy or Irish Traveller	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	White - Any other White background	7.09	6.68	6.88	6.95	6.78
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black Caribbean	-	-	-	-	6.11
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Black African	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - White and Asian	-	7.32	6.28	6.86	7.50
Tees, Esk and Wear Valleys NHS Foundation Trust	Mixed/Multiple ethnic background - Any other Mixed / Multiple ethnic background	-	-	-	6.98	6.87
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Indian	8.08	7.12	7.65	7.32	7.34
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Pakistani	7.68	7.73	7.76	7.40	7.48
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Bangladeshi	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Chinese	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Asian/Asian British - Any other Asian background	-	-	7.19	7.69	6.52
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - African	8.11	8.02	7.68	7.81	7.21
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Caribbean	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Black/African/Caribbean/Black British - Any other Black / African / Caribbean background	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Arab	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Other ethnic group - Any other ethnic background	6.28	-	-	7.30	-

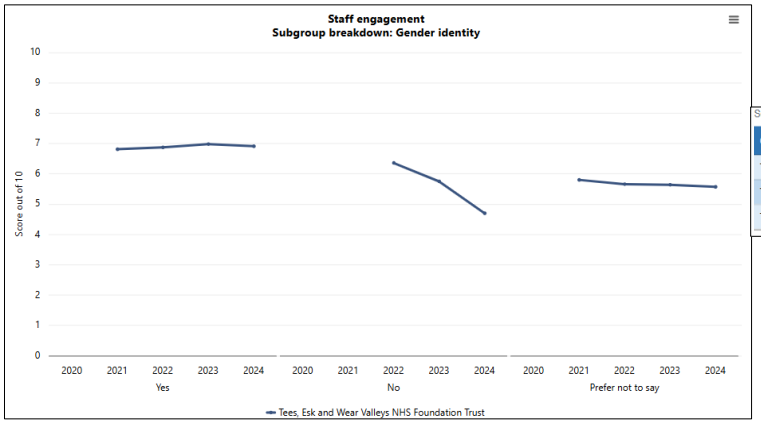
GENDER



Score out of 10

Organisation	Gender	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Female	7.22	6.89	6.99	7.03	6.96
Tees, Esk and Wear Valleys NHS Foundation Trust	Male	6.89	6.55	6.47	6.76	6.73
Tees, Esk and Wear Valleys NHS Foundation Trust	Non-binary	-	-	6.22	5.39	6.83
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer to self-describe	-	-	-	5.11	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	5.73	5.62	5.48	5.74	5.50

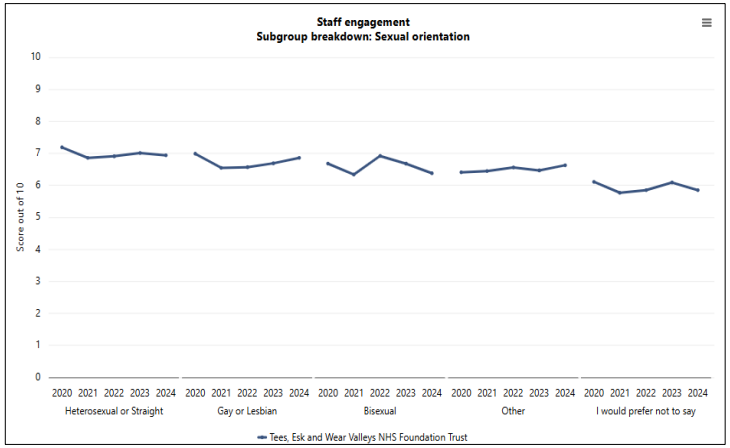
Gender Identity



Score out of 10

Organisation	Gender identity	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	-	6.81	6.87	6.98	6.91
Tees, Esk and Wear Valleys NHS Foundation Trust	No	-	-	6.36	5.75	4.70
Tees, Esk and Wear Valleys NHS Foundation Trust	Prefer not to say	-	5.80	5.66	5.64	5.57

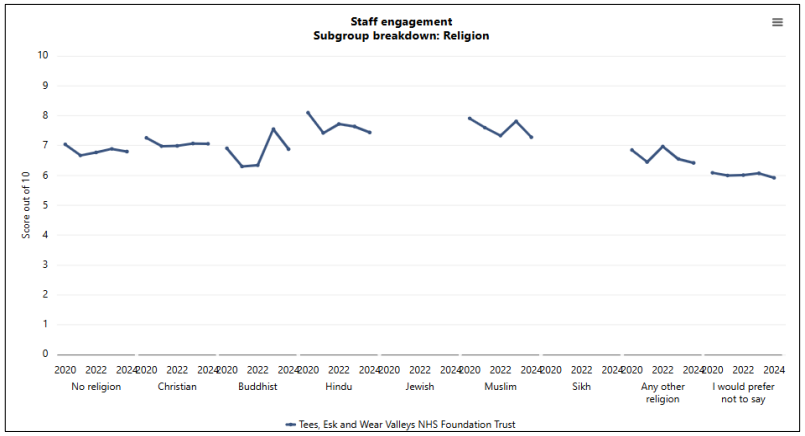
SEXUAL ORIENTATION



Score out of 10

Organisation	Sexual orientation	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Heterosexual or Straight	7.19	6.86	6.91	7.01	6.94
Tees, Esk and Wear Valleys NHS Foundation Trust	Gay or Lesbian	6.99	6.55	6.57	6.69	6.86
Tees, Esk and Wear Valleys NHS Foundation Trust	Bisexual	6.68	6.34	6.92	6.68	6.38
Tees, Esk and Wear Valleys NHS Foundation Trust	Other	6.41	6.45	6.56	6.47	6.63
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	6.11	5.77	5.85	6.09	5.85

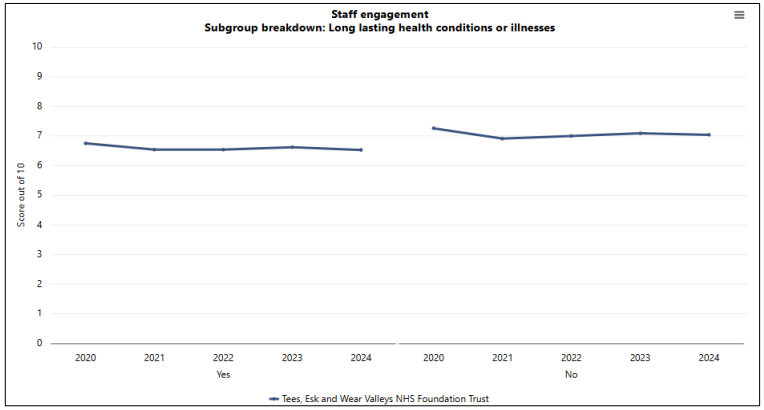
RELIGION



Score out of 10

Organisation	Religion	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	No religion	7.04	6.67	6.77	6.89	6.80
Tees, Esk and Wear Valleys NHS Foundation Trust	Christian	7.26	6.98	6.99	7.07	7.06
Tees, Esk and Wear Valleys NHS Foundation Trust	Buddhist	6.91	6.30	6.34	7.55	6.88
Tees, Esk and Wear Valleys NHS Foundation Trust	Hindu	8.10	7.42	7.72	7.64	7.44
Tees, Esk and Wear Valleys NHS Foundation Trust	Jewish	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Muslim	7.91	7.60	7.33	7.81	7.28
Tees, Esk and Wear Valleys NHS Foundation Trust	Sikh	-	-	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	Any other religion	6.85	6.45	6.97	6.55	6.42
Tees, Esk and Wear Valleys NHS Foundation Trust	I would prefer not to say	6.09	6.00	6.01	6.07	5.92

LONG LASTING HEALTH CONDITION OR ILLNESS



Score out of 10

Organisation	Long lasting health conditions or illnesses	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	6.75	6.54	6.54	6.62	6.53
Tees, Esk and Wear Valleys NHS Foundation Trust	No	7.26	6.91	7.00	7.09	7.04

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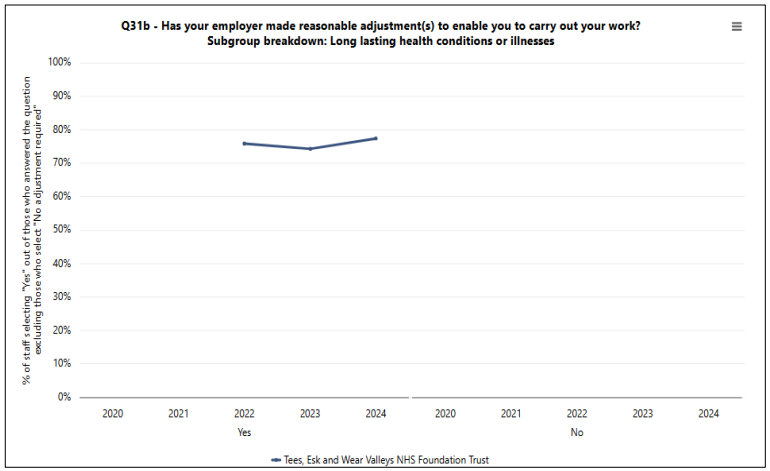
LONG LASTING HEALTH CONDITION OR ILLNESS



% of staff selecting "Yes" out of those who answered the question excluding those who select "No adjustment required"

Organisation	Long lasting health conditions or illnesses	2020	2021	2022	2023	2024
Tees, Esk and Wear Valleys NHS Foundation Trust	Yes	-	-	75.83%	74.27%	77.37%
Tees, Esk and Wear Valleys NHS Foundation Trust	No	-	-	-	-	-

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 9 October 2025		
Date of last meeting: 2 October 2025	**Report of: The Quality Assurance Committee**	
	Quoracy was achieved.	
1	**Agenda -** The Committee considered the following matters: • Minutes of meeting held on 4 September 2025 • Board Assurance Framework • Summary of the Executive Review of Quality Group meeting held on 23 September 2025 • Trust Level Quality Governance Report • Quality Assurance Schedule • CQC Activity and Delivery of the Integrated Oversight Plan and Improvement actions • Annual Patient Publication of Information • Unannounced informal mental health Act CQC visits • Trust wide level loading across nursing workforce • Winter Plan Approval Process • NYYS Perinatal Team • Tissue Viability Annual Report 2024/25 • Committee Workplan - noted	
2a	**Alert**	The Committee alerts the Board on the following matters: A follow up action has been requested from the care groups into the timeliness of incident reviews within four days due to a small number outstanding for a prolonged period. The Committee is asking that reports including the quality dashboard and the integrated performance dashboard should include benchmarking data where it is available. There has been a development with Mental **Health Act inspections**, with eight unannounced visits from MHA Reviewers to adult wards, with the purpose to review progress with actions identified within Provider Action Statements following previous visits. Staff are being supported to adapt to this new approach, which is expected to become the norm going forward and a Trust wide briefing has been shared. Committee confirmed they were comfortable that there was good assurance linked to the approach being taken in response and processes to support the change. Good progress was reported following actions taken in response to a prolonged restraint on Westerdale ward, which had been proactively reported by a ward manager and identified some links with appropriate positive and safe training for RNs. Committee will give increased focus and scrutiny to monitoring improvements linked to **clinical supervision**, paying attention also to the quality of the supervision. **Level loading across Nursing Workforce** is under continued scrutiny, as whilst we have good assurance across inpatient areas for the use of rosters, with improvements seen on using resources, there is less assurance across community services. E Rostering is currently being rolled out across community services. Some fundamental flaws to staffing templates will be rectified by workforce and Committee is seeking timescales on when this will be resolved. Committee confirmed there is good assurance relating to the oversight and governance of **perinatal services**, however limited assurance relating to the overall quality of care and experience albeit that there are early indications that there are improvements in

		responsiveness. Care groups are working collaboratively to support this service and there have been improvements made to patient access and waiting times. Recruitment and sickness levels are also moving in the right direction. Associate Directors of Nursing undertook a deep dive to establish the impact of DNAs in the service following an issue identified in one case. Individual caseloads will also be reviewed. A scoping paper has been reported to Resource and Planning Committee to set out the approach and next steps for those **clinically ready for discharge**, which has been an ongoing concern for a significant period.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: Very positive to note that there have been zero use of tear proof clothing for the last three months. The positive shift of a seclusion room on one of the PICUs not being utilised for a full month was noted. **Board Assurance Framework:** Committee agreed in September 2025 that the description of BAF ref. 14 should be reviewed. The following revised narrative was considered at the October meeting and supported, with a recommendation to Board for final approval. *"There is a risk that health inequalities are exacerbated/opportunities to reduce health inequalities are not realised caused by lack of service reach into underserved communities and barriers within service design and delivery resulting in increased risk of late/crisis presentation, increased complexity, disengagement, suboptimal outcomes and experience."* Committee also supported a proposal from the Chief Nurse that BAF risk 8: Quality governance and BAF risk 4: Quality Care be brought together and re-stated, based on evidence that over time quality governance is robust and sensitive enough to pick up risks to quality and that the target score had been met. **The Board is asked to consider this.** The **Tissue Viability Annual Report 2024/25** was received and Committee confirmed there is good assurance related to the quality and safety of tissue viability provision across the Trust. Committee received a paper which provides good assurance relating to the operational and strategic oversight of the Quality Assurance schedule and clinical effectiveness activities. Improvement work is taking place to revise the process and tool with the aim of strengthening the methodology and processes. Committee confirmed there is reasonable assurance relating to the strategic oversight of the quality and safety measures within the **Quality Dashboard**. Improvements are evidenced through a number of measures, including reduction in moderate patient safety incidents within ALD, H&J and SIS and a reduced numbers of incidents involving restrictive interventions. Additionally, patients responding to the patient experience question has increased. For clinical effectiveness outcomes there is positive assurance that we are increasingly able to show measurable improvement following treatment – clinician reported. There is further improvements to make and the Committee understand the issues related to the time this takes. Notable improvements have been made with compliance with safety planning for patients taking section **17 leave** during August 2025. This position is being sustained. Committee confirmed good assurance relating to progress against the **Integrated Oversight Plan**, as well as CQC activity. There are six actions complete out of 14 in the Improvement Plan, with the remaining eight on track to complete deadlines.

		Committee approved change requests to two actions (14b and 10) relating to review of policy for blanket restrictions Positive feedback received from the CQC following an inspection to HMP Northumberland.
	Advise	The Committee wishes to advise on the following matters to the attention of the Board: Committee approved the **Patient Publication of Information 2025** and recommend it to Board for approval, confirming that there is good assurance that a robust process has been followed to analyse patient data by protected groups to meet the Equality Act duties. Narrative will be included to support the data before it is published on the website. There is more to do from a strategic perspective and Committee are keen to understand under representation of most ethinc groups accessing community services and higher rates of people spending time in hospital who are black/black British. The Director of Therapies is going to lead on this work. Committee is curious to understand more fully the number of deaths of people with a learning difficulty or a diagnosis of autism. Committee is seeking further assurance with regards to **rehabilitation services**, with some benchmarking to be done to look at exemplar services, to ensure we are providing the communities we serve and people struggling to leave an institutional setting the best care. The Chief Nurse and Managing Director will work with the care groups on the ask, to be able to set out the levels of assurance, gaps in services and outcomes for rehabilitation pathways to be able to work towards a model of best practice. Further assurance to be sought on the impact to quality of care once the installation of "hhatch's" inseclusion rooms is completed. There are possible unintended consequences for patients which we need to safeguard against. A verbal update was given on the **Winter Plan,** which Non-Executive Directors considered under emergency powers. Support was given to the approach and the Plan approved. QAC will receive the full copy of the Plan at the November Committee meeting. **Restrictive practice:** • Within normal variation at Trust and Care Group levels. • 4 Mechanical Restraint applications, soft cuffs SIS. 2 Jay, 1 Brambling related to external Trust appointments. 1 Linnet to facilitate leave. • 1 Cedar Mechanical restraint application (cuffs) by secure transport staff. Physical health review undertaken on patient return to ward. • No use of Tear Proof Clothing. • 2 Intentional Prone Restraint SIS 1 Sandpiper seclusion. 1 Cedar seclusion exit. • 1 Unintentional Prone Restraint Bransdale. (1 unintentional prone restraint Minster occurred in July not previously reported). Committee has requested sight of the paper on **ADHD/waiting times** that was recently considered at the Quality and Performance Executive Directors meeting. A variation to standard practice was noted when ECT was administered in a general hospital, the issue was considered by the Chief Nurse in advance with appropriate safety in place. The **Committee developmental day,** due to take place in July 2025 was postponed due to changes in the senior executive roles. Given the new substantive Chair of Committee, J Robinson will be incumbent from February 2026 (no meeting in January), the day will take place at the end of Quarter 4/beginning of Quarter 1. This is also timed to allow for the publication of the national quality strategy, which will shape and form what our quality management system is going to look like for TEWV.
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**	*i) that the report be noted, confirming there is good assurance with regards to the governance, oversight and management of risks to quality of care.* *ii) To note that there is a strategic risk with regards to safe staffing due to variance in practice with e roster templates.* *iii) that the revised risk description to BAF risk 14: health inequalities be approved.* *iv) That the Publication of Patient Information 2025 be approved, for publication on the website.*
4	**Report compiled by**	John Maddison, Acting Chair of the Quality Assurance Committee, Beverley Murphy, Interim Deputy Chief Executive/Chief Nurse and Donna Keeping, Corporate Governance Manager

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**The Board of Directors**
Date:	**9 October 2025**
Title:	**Patient Publication of information 2025**
Executive Sponsor(s):	**Hannah Crawford, Director of Therapies**
Report Author(s):	**Abigail Holder Equality, Diversity, Inclusion and Human Rights Officer** **Lisa Cole Inclusive Community Engagement Lead**

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*
4	**Quality of Care**	To ensure that we deliver quality care to all our diverse communities the Trust needs to understand differences in access and outcomes for patients from different communities.
2	**Demand**	To ensure we understand if there are communities that underrepresented or overrepresented in our services, leading to poorer experiences and outcomes.

EXECUTIVE SUMMARY:

Purpose:

This paper is presented to the Board to provide good assurance that the Trust is meetings its obligations under the Public Sector Equality Duty of the Equality Act 2010 to:
Have due regard to the need to eliminate discrimination, harassment, and victimisation. Advance equality of opportunity between people who share a protected characteristic and those who do not. Foster good relations between those who share protected characteristics and those who do not.
The Board is asked to confirm if they support the publication of this information, the Trust must publish information annually to demonstrate its compliance with the general equality duty. This information must include information relating to patients who share a relevant protected characteristic who are affected by its policies and practices. A more detailed document is attached to this report which contains patient data.

Proposal:

The Board is asked to confirm that it has good assurance that the Trust has followed a robust process in analysing its patient data by protected group and in doing so is meeting its Equality Act duties. The Board is asked to approve the proposed publication of patient information prior to publication on the Trust website as is required.

Overview:

The Trust is obliged to meet its public sector equality duties as outlined above. The proposal for good assurance is based on the patient data information in Appendix 7 which demonstrates that:
A robust analysis has been carried out on the patient EDI data the Trust currently has available.
The data in Appendix 7 includes trust wide and care group information for April 24 / March 25 on access to services; inpatient services and length of stay; disengagement rates; clinical outcomes; mental health data; patient experience; rates of access to services and admissions. Information on age, gender, sexual orientation, ethnicity, religion, and deprivation are included.
There continues to be high levels of data incompleteness, especially with regards to ethnicity, religion, and sexual orientation which significantly limits the ability to draw robust conclusions. This is a recurring concern, with up to 32% or more of ethnicity data not stated, and similar gaps for other protected characteristics. This year it was agreed that high level Trust themes would be drawn out across all protected characteristics. Recommended actions are included in Appendix 6.

Access to Services (Appendix 1)

There is underrepresentation of most ethnic groups in access to services compared to the census data, but this will be skewed by missing data (32% of ethnicity data not stated) (Figure 1).

Younger people (under the age of 20), 20–29 age group and 30–44 age group are accessing services at higher-than-expected rate. The 45–64 age group is accessing services at a lower rate than expected, despite being a high-risk group for suicide (Figure 2). National Confidential Inquiry into Suicide and Safety in Mental Health- Annual report 2025: UK patient and general population data, 2012-2022 noted “highest suicide rates in middle-aged groups, especially 40-44- and 45-49-year age groups.”

Patients are disproportionately from the most deprived deciles, highlighting the link between deprivation and mental health service use (Figure 3).

Rates of people who spent time in hospital per 100 people accessing services are highest for Black/ Black British other followed by Asian/ Asian British Pakistani, Black/ Black British African, Asian/ Asian British Indian, Asian/ Asian British Bangladesh, Asian/ Asian British Other and Mixed White / Black African (Figure 4)

Disengagement and DNA Rates (Appendix 2)

Disengagement rates by ethnicity are inconclusive due to low numbers and incomplete data (Figure 1). DNA and cancellation rates are higher in the most deprived areas (Figure 2).

Inpatient Length of Stay (Appendix 3)

White British patients have the highest admissions and discharges, but not the longest stays. Black/ Black British Other and Other Ethnic Groups have longer than average stays despite low admission numbers (Figures 1 & 2).

Trust wide males have slightly longer inpatient stays than females, but this varies by care group. Data may be skewed as they include services in SIS (Figure 3, 4 & 5).

People identifying as 'attracted to the same sex' have notably higher average lengths of stay, but this may be skewed by outliers (Figure 6).

Mental Health Act Detentions (Appendix 4)

Highest detention rates are for Other Ethnic Groups and Black/ Black British even when absolute numbers are low (Figure 1) and patients from the most deprived areas have higher detention rates (Figure 2).

Older adults (65+) have the highest number of detentions, followed by the age group (30 – 64) (Figure 3).

Patient Experience and Outcomes (Appendix 5)

Patient experience is generally reported as good or very good across most groups but is lower amongst those who do not report their ethnicity or amongst Black/African/Caribbean/Black British patients (Figure 1).

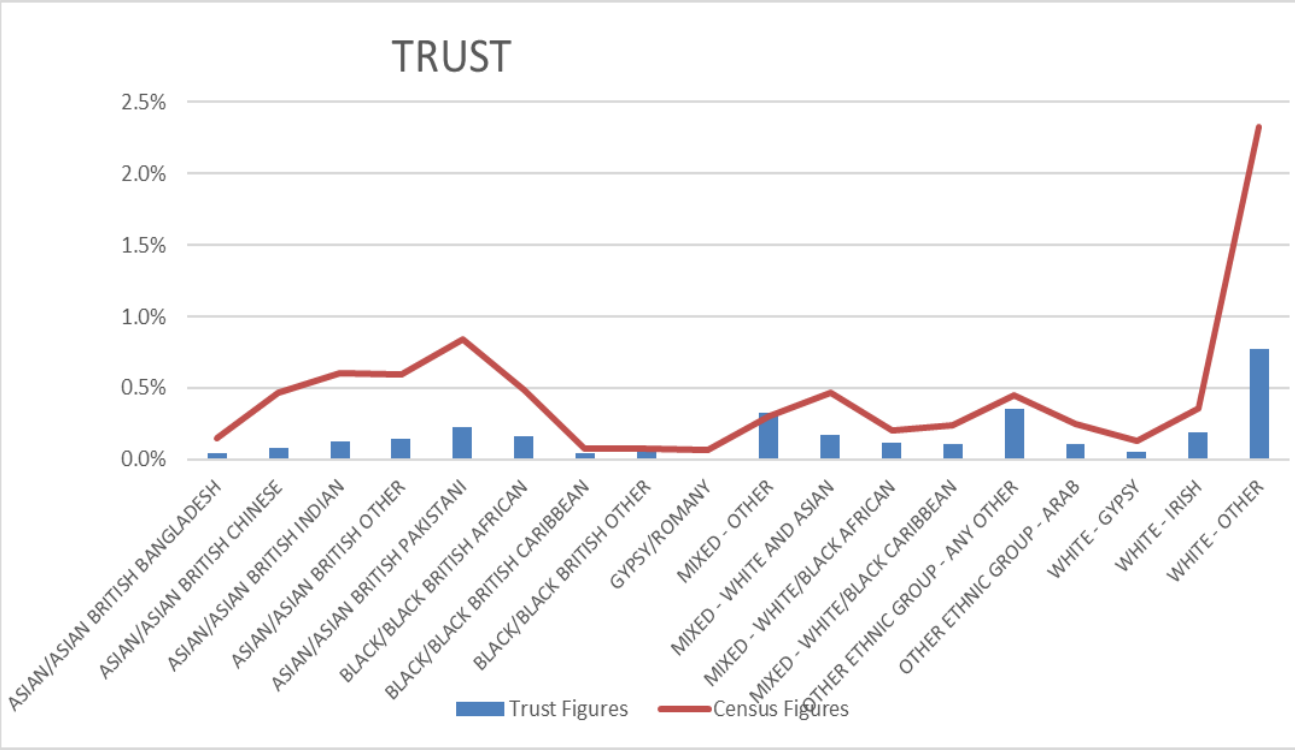
Prior Consideration and Feedback: The Trust's Business Analytics and Clinical Outcomes Information Department have undertaken the development of the patient data.

Implications: Failure to understand the differences in outcomes and experiences of our patients from protected groups in accordance with the public sector equality duties may have regulatory and reputational consequences. Failure to act to reduce differences in outcomes and experiences of our patients from protected groups may impact on their outcomes and experiences.

Recommendations: The Board is asked to: Confirm that it has good assurance that a robust process has been undertaken when developing the attached data on patients from protected groups and to agree to its publication on the Trust website as required by the Equality Act 2010.

Appendix 1 - Access to Services

Figure 1 Access to Services - Ethnicity



NB: The graph above does not include the White British ethnicity category; this is due to it being so high that is masks the other %'s listed

Figure 2 – Access to Services - Age

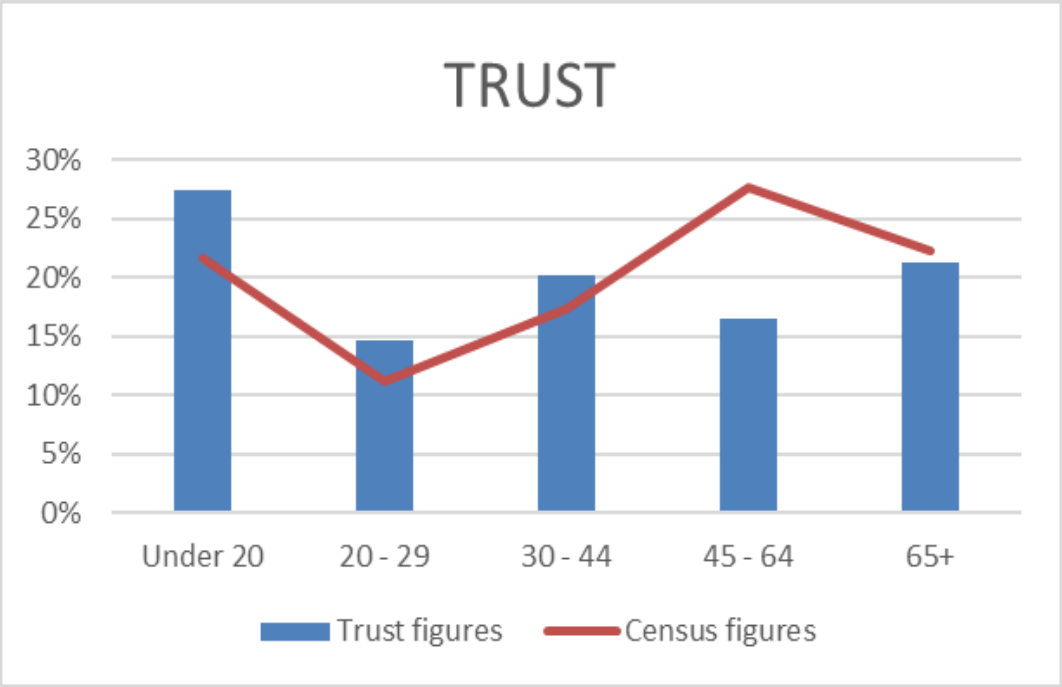
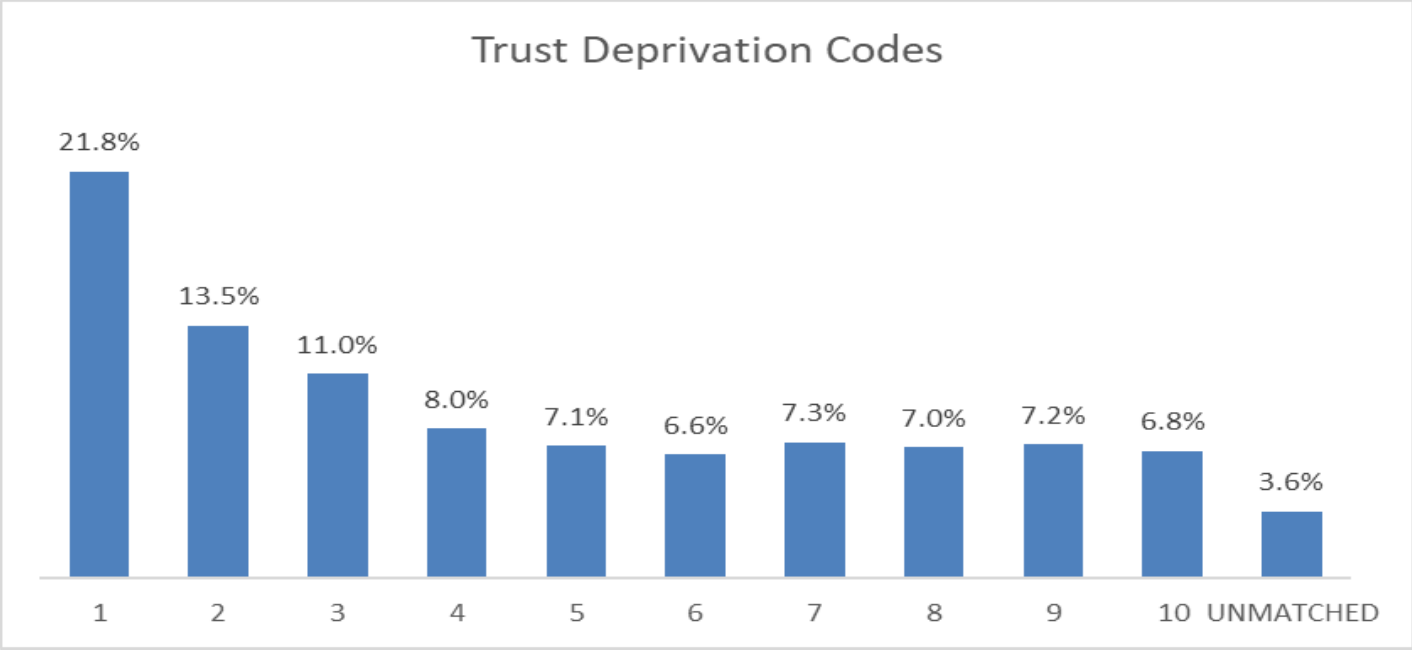
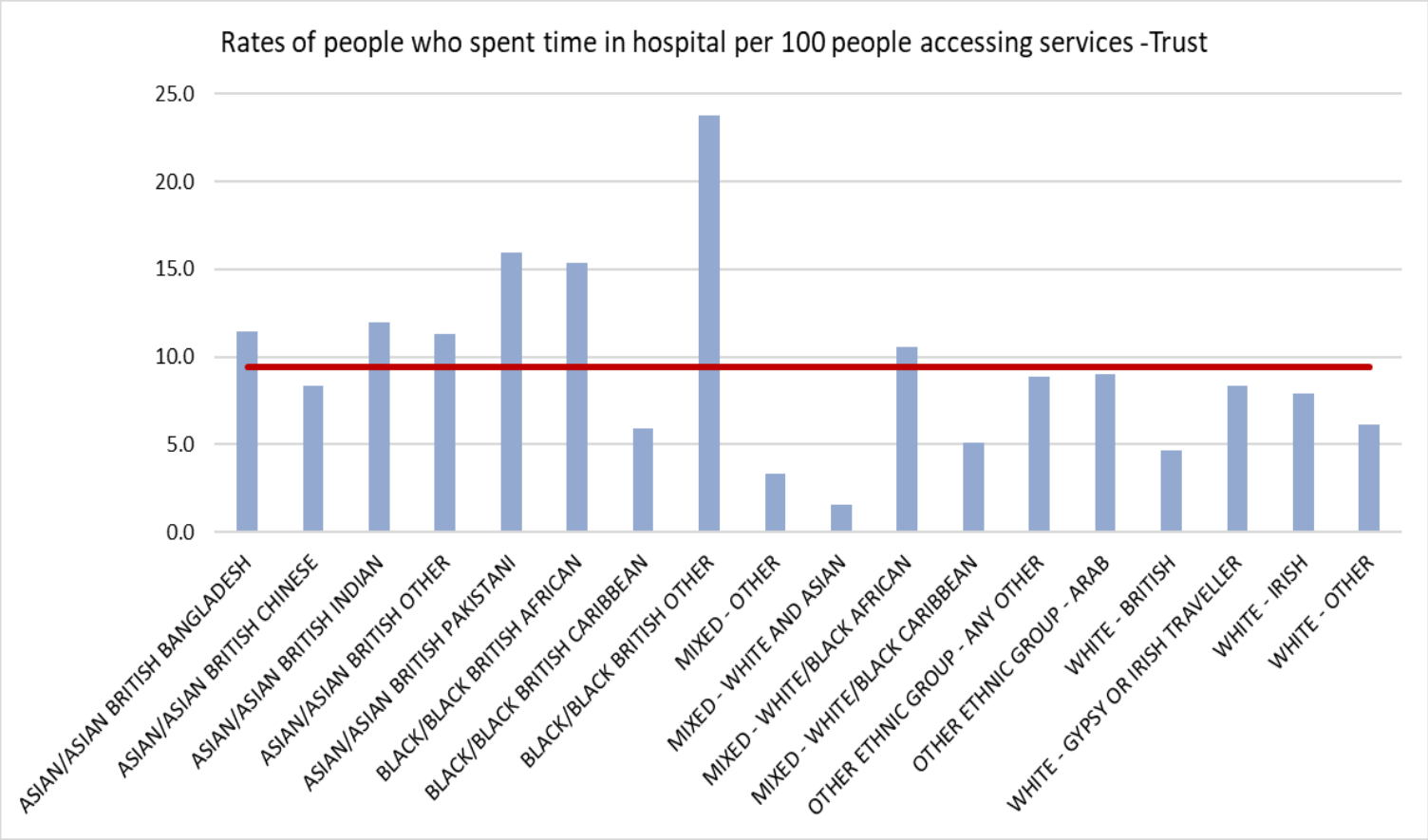


Figure 3 – Access to Services – Deprivation Codes



NB: 1 Most Deprived – 10 Least Deprived
Unmatched means that there is no deprivation code available for that postcode, TEWV use the English indices of deprivation (2019)

Figure 4 – Hospital admissions - Ethnicity



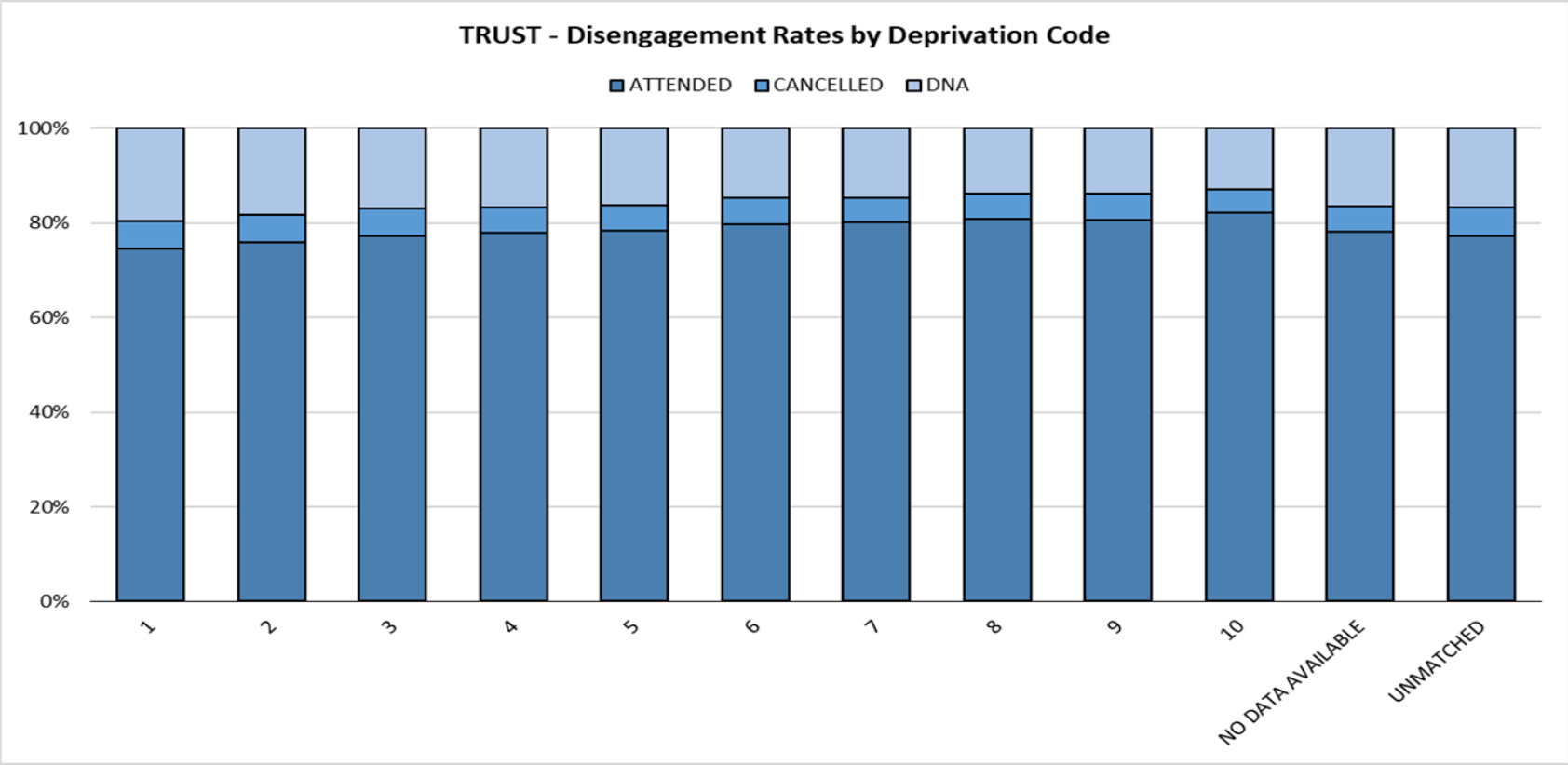
NB: The graph above shows that for every 100 people accessing TEWV services, how many go on to have an inpatient admission. The graph shows which communities maybe accessing services later in their mental health journey and therefore require hospital admission, and vice versa (groups who are seeking help sooner and only require community input). The red lines represent the average.

Appendix 2 - Disengagement and DNA Rates

Figure 1 - Disengagement and DNA Rates - Ethnicity

Ethnicity			
	ATTENDED	CANCELLED	DNA
ASIAN/ASIAN BRITISH BANGLADESH	26	Below 5	5
ASIAN/ASIAN BRITISH CHINESE	46	Below 5	8
ASIAN/ASIAN BRITISH INDIAN	99	10	22
ASIAN/ASIAN BRITISH OTHER	86	8	24
ASIAN/ASIAN BRITISH PAKISTANI	138	15	31
BLACK/BLACK BRITISH AFRICAN	86	9	25
BLACK/BLACK BRITISH CARIBBEAN	27	Below 5	11
BLACK/BLACK BRITISH OTHER	38	5	14
MIXED – OTHER	201	18	65
MIXED – WHITE AND ASIAN	92	Below 5	20
MIXED – WHITE/BLACK AFRICAN	52	Below 5	22
MIXED – WHITE/BLACK CARIBBEAN	68	6	24
OTHER ETHNIC GROUP – ANY OTHER	205	18	52
OTHER ETHNIC GROUP – ARAB	49	6	10
IRANIAN	Below 5	Below 5	
TRAVELLER	Below 5		
EASTERN EUROPEAN	Below 5		
WHITE – BRITISH	41252	3134	8929
WHITE – GYPSY	41	Below 5	10
WHITE – IRISH	121	13	24
WHITE – IRISH TRAVELLER	Below 5	Below 5	Below 5
WHITE – OTHER	510	48	126
DECLINE TO DISCLOSE	101	Below 5	17
NOT STATED	1370	82	306
UNKNOWN	8277	381	1487

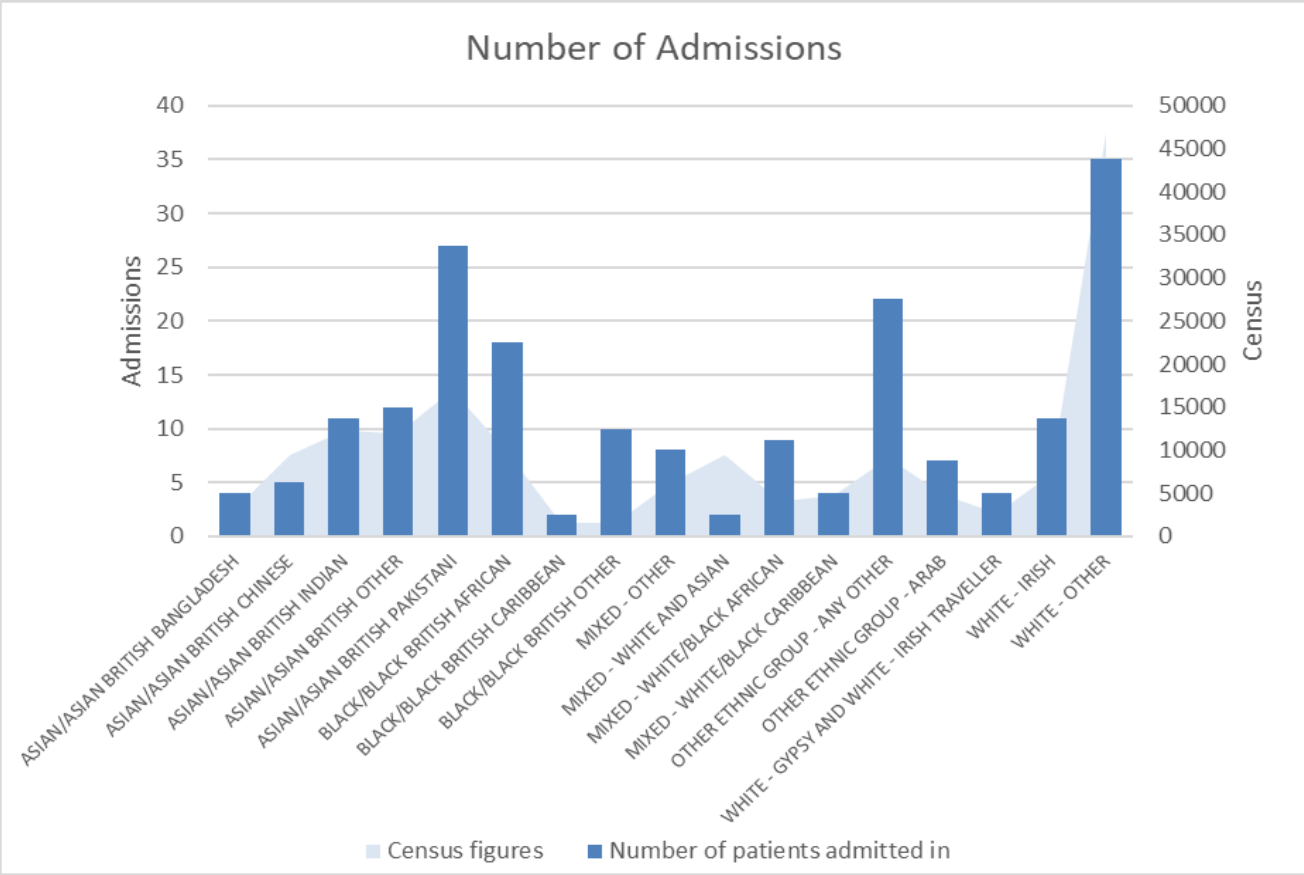
Figure 2 – Disengagment Rates – Deprivation Code



NB – 1 Most Deprived – 10 Least Deprived
Unmatched means that there is no deprivation code available for that postcode, TEWV use the English indices of deprivation (2019)

Appendix 3 - Inpatient Length of Stay

Figure 1 – Inpatient Stay - Ethnicity



NB: Unknown ethnicity has been removed from the graphs also White British has been removed from the graphs, due to it having such large numbers it was masking the other data

Figure 2 – Discharges & Length of Stay – Ethnicity

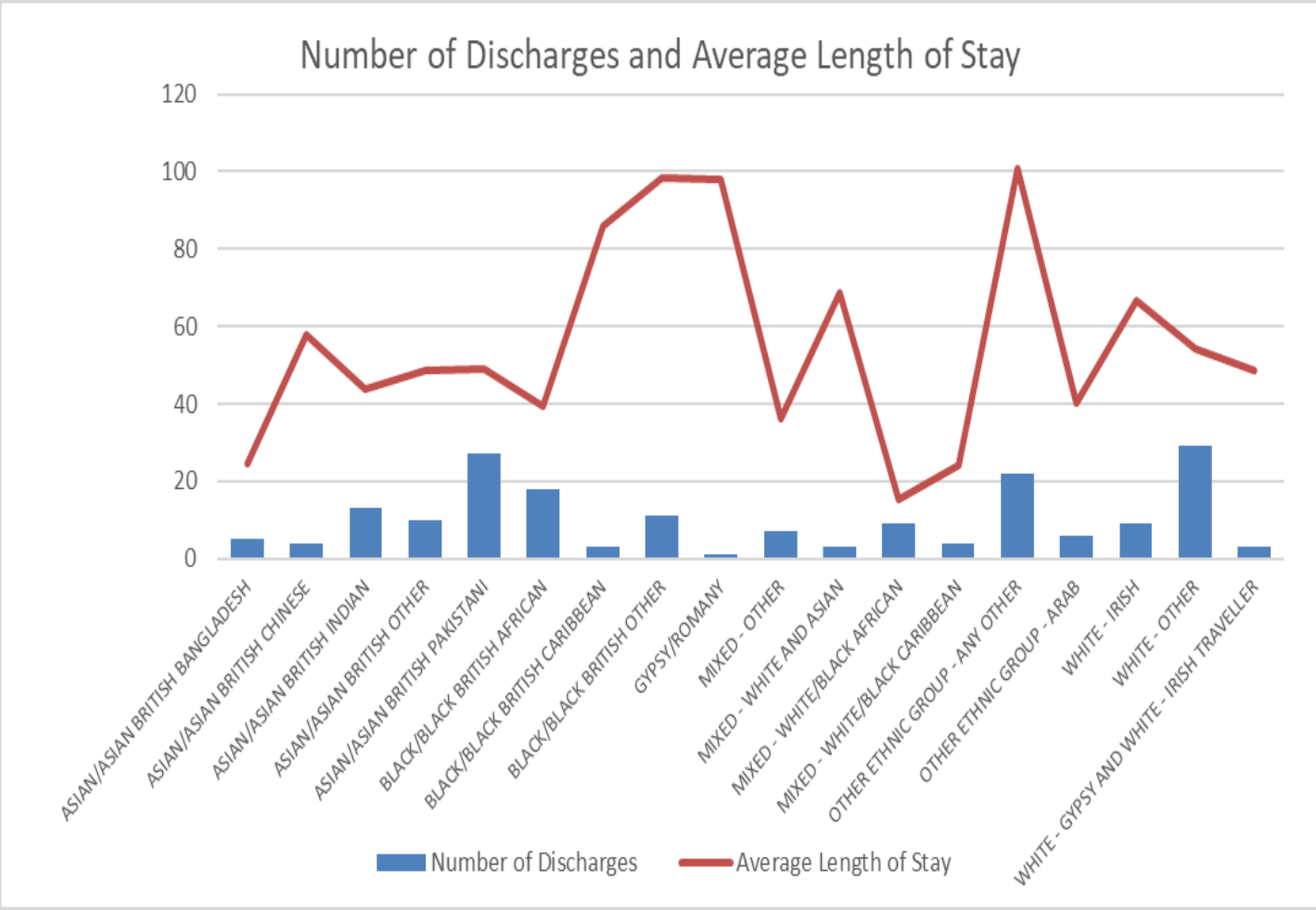
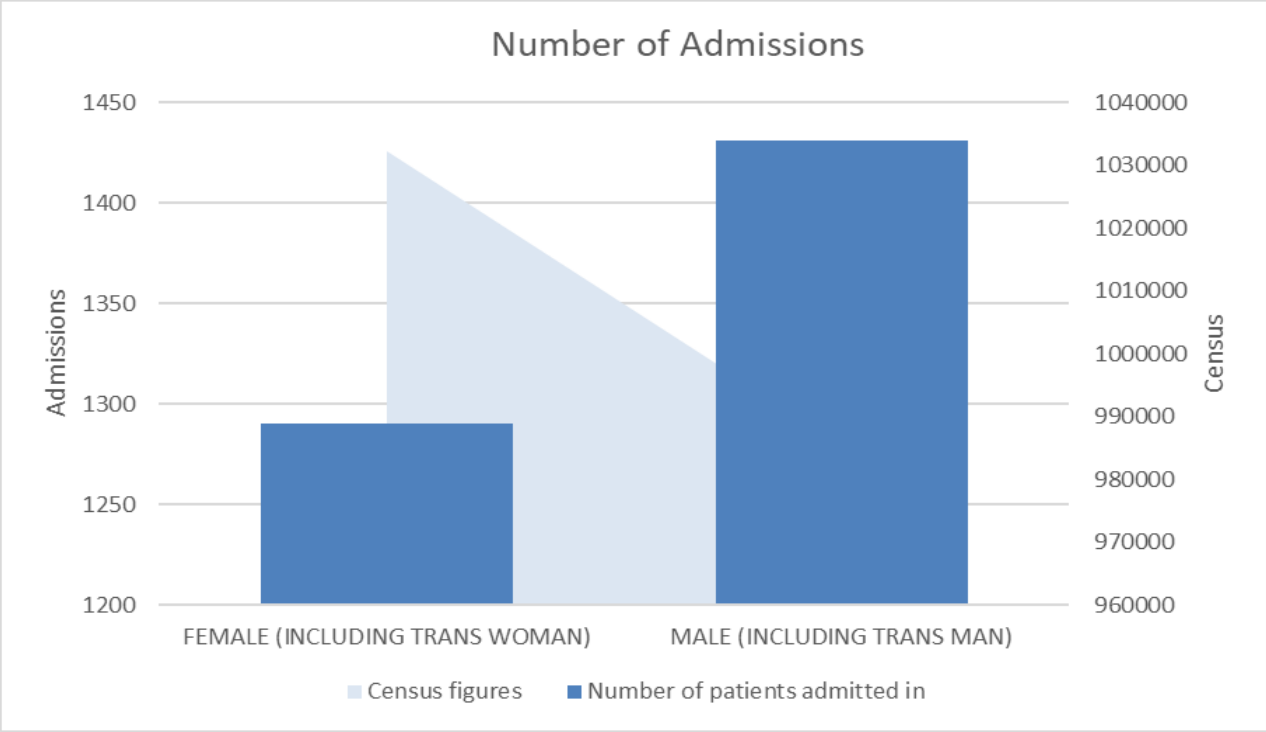


Figure 3 – Length of Stay - Gender

Gender	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
FEMALE (INCLUDING TRANS WOMAN)	1290	1297	72.97
MALE (INCLUDING TRANS MAN)	1431	1445	81.02
NON-BINARY	6	7	101.57
UNKNOWN	36	34	46.85

Figure 4 – Admissions - Gender



NB: The graph includes services in SIS. Please note.The graphs exclude Non - binary, Indeterminate and Not Known gender caegories.

Figure 5 – Discharges & Length of Stay - Gender

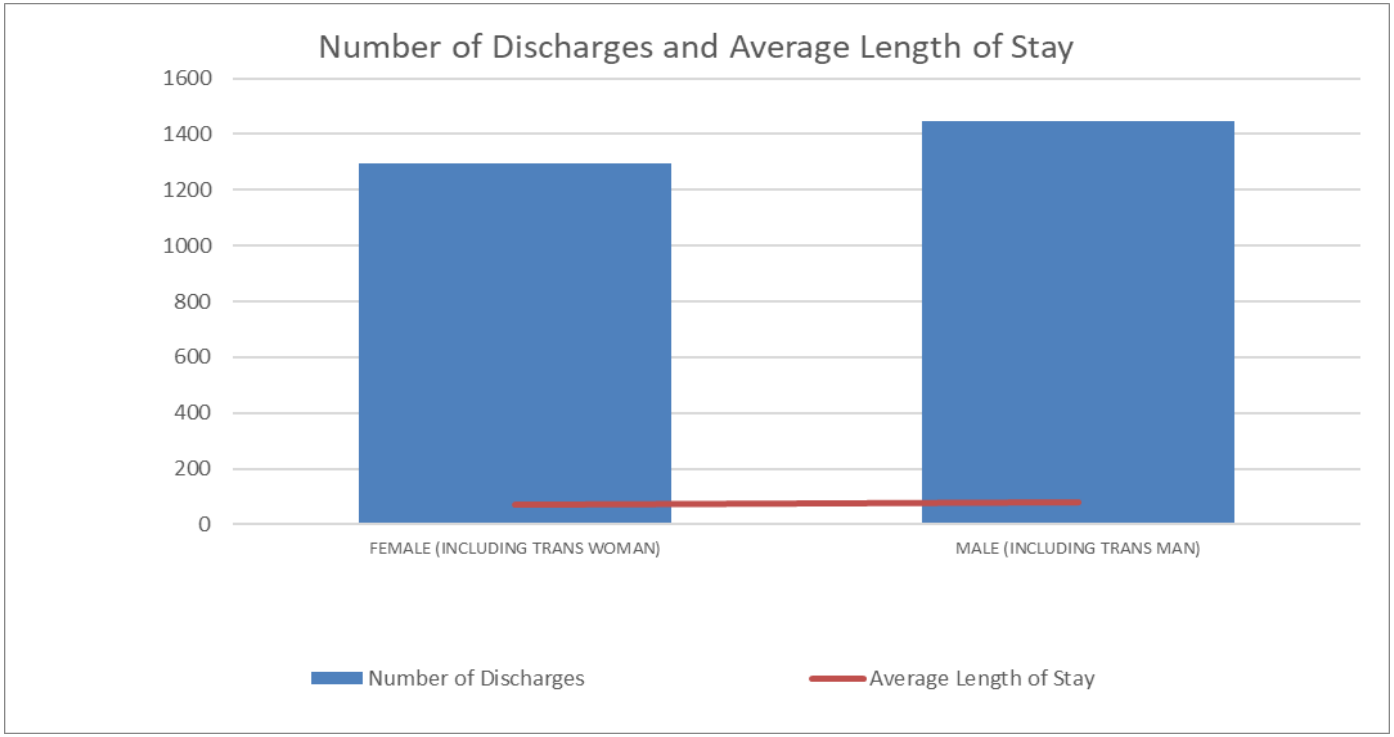


Figure 6 – Length of Stay – Sexual Orientation

Sexual Orientation	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
NOT AGE APPROPRIATE	67	65	30.83
NOT DEVELOPMENTALLY APPROPRIAT	54	54	26.06
OTHER	Below 5	Below 5	163.50
PERSONS OF OPPOSITE SEX	1728	1771	75.88
PERSONS OF SAME OR OPP SEX	46	42	56.45
PERSONS OF SAME SEX	36	35	287.91
UNKNOWN	829	814	77.96

Appendix 4 - Mental Health Act Detentions

Figure 1 – Detention Rates - Ethnicity

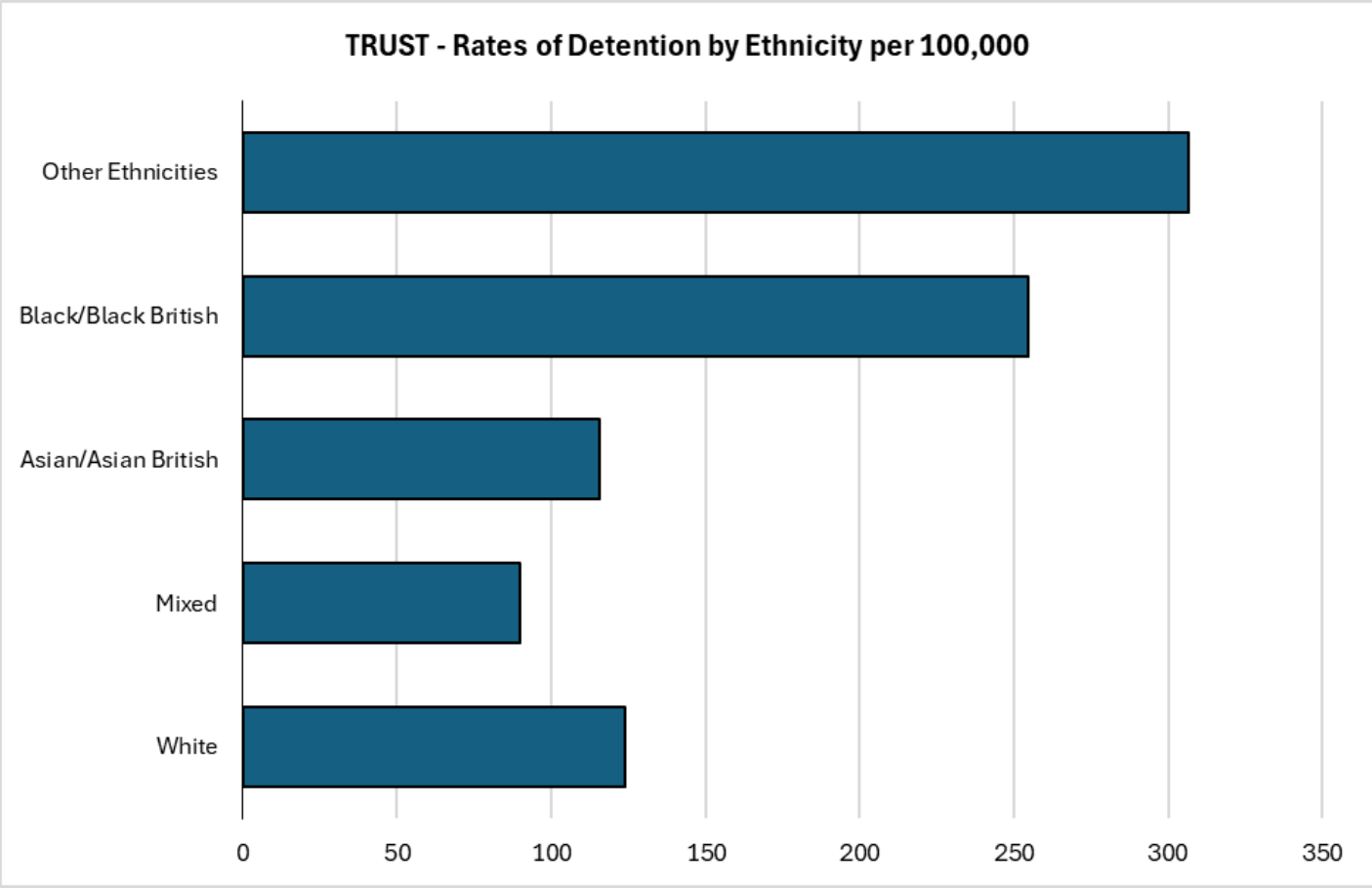


Figure 2 – Detention Rates – Deprivation Codes

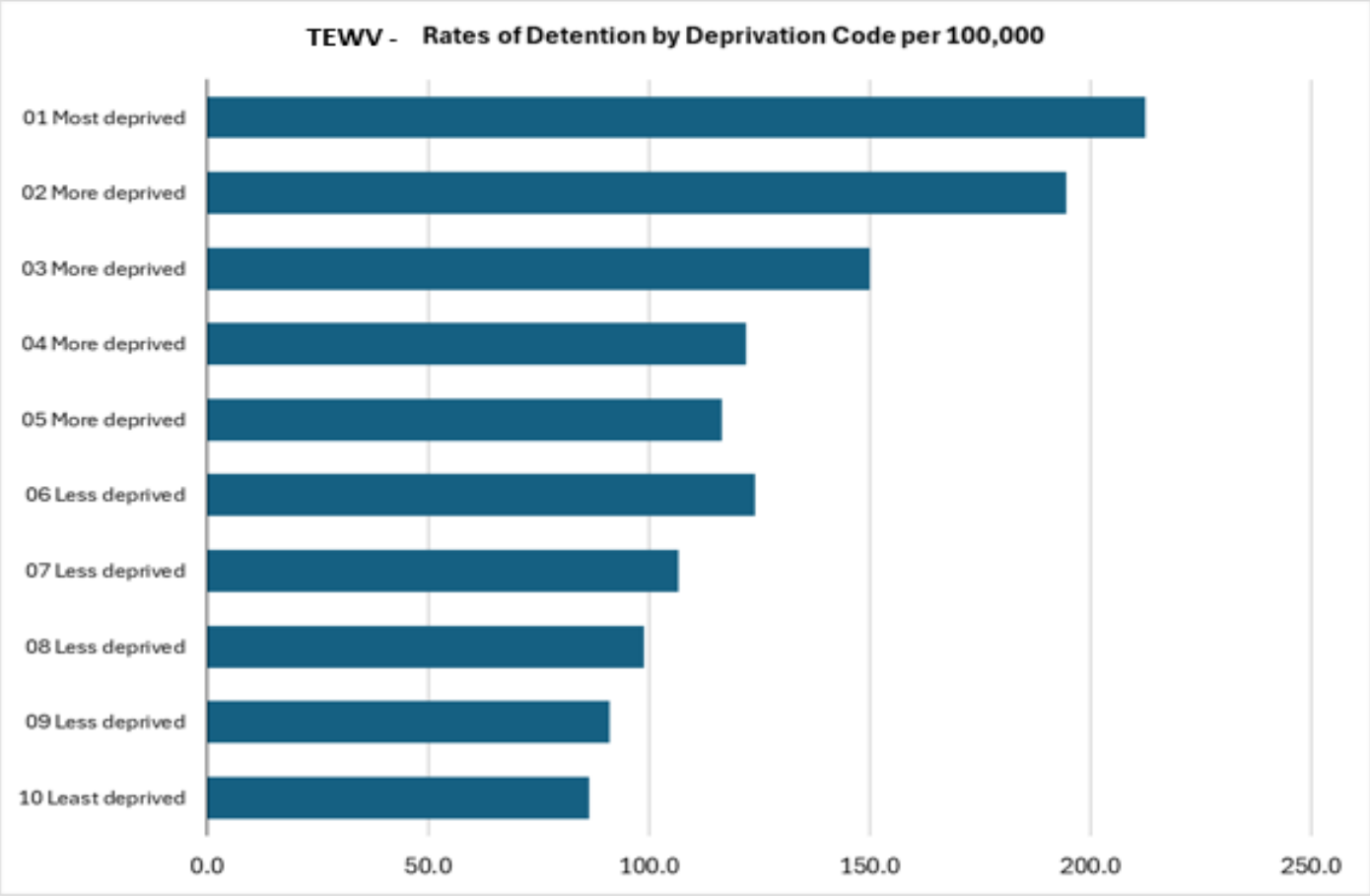
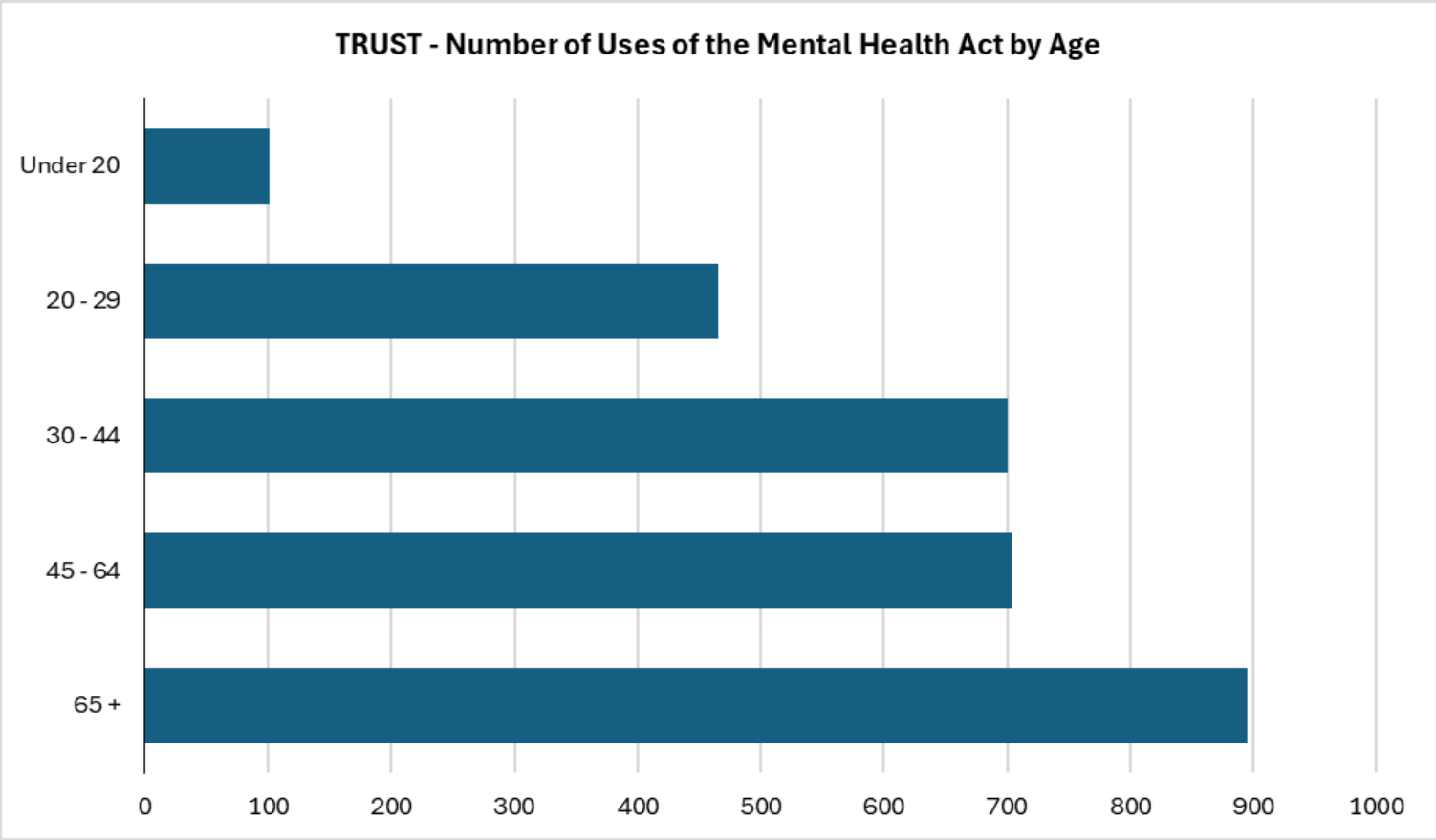
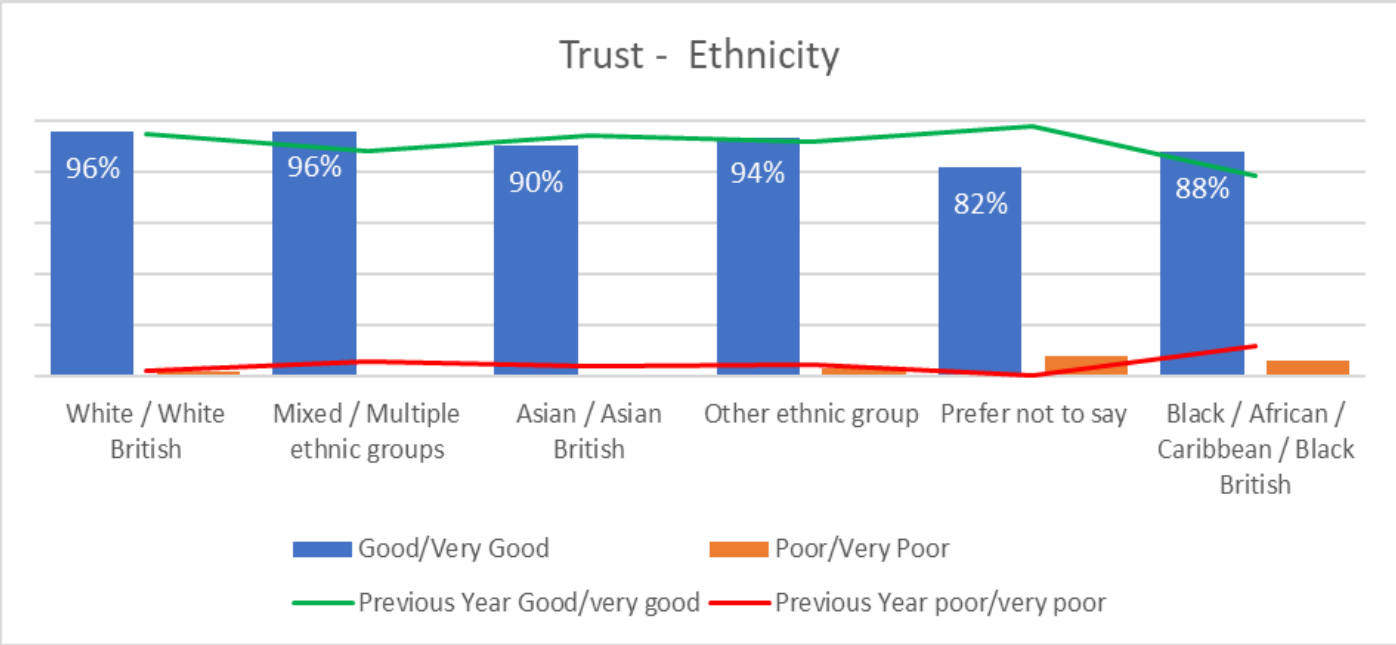


Figure 3 – MHA - Age



Appendix 5 - Patient Experience and Outcomes

Figure 1 – Patient Experience - Ethnicity



Appendix 6

Recommended Actions

- Agree that there is a piece of work that needs to be completed to identify which services need support with recording of data to help improve staff awareness and system prompts to increase data recording rates and to improve data completeness and quality.
- Agree that Care groups look at their data and identify actions to address the issues identified in this report.
- Agree that figures from the previous year are compared to the current year to enable comparisons to be made to commence in 2026 with comparisons to 2025's data.
- Agree that a piece of work is carried out to identify the routes that people are taking to access services.
- Agree that a piece of work is carried out to remove data relating to SIS from figures in relation to gender and length of stay to identify if this shows a different picture in relation to length of stay for male patients.

Appendix 7

Publication of Patient Information

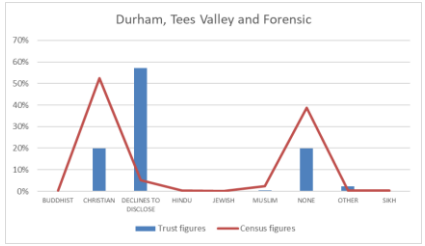
Equality and Diversity Patient Report 2025

Title		Service	Information	Link to page
Access to Services	Durham, Tees Valley and Forensics		These tabs show the number of people who accessed services in the reporting year. The numbers shown are for patient journeys that started in the reporting year only and each patient is only counted once, regardless of the number of referrals they had throughout the year. This is to avoid over inflation when comparing the number who access services to the census data. The data is shown broken down by; Age, Gender, Ethnicity, Sexual Orientation, Religion and Area of Deprivation (this is found using the patient's postcode at the point of accessing services).	Click here
	North Yorkshire, York and Selby			Click here
	Trust			Click here
Inpatient Services and Length of Stay	Durham, Tees Valley and Forensics		These tabs show the number of patients who were discharged from an inpatient bed in the reporting year and the number of patients who were admitted to an inpatient bed in the reporting year, they are not the same cohort of patients, however there may be a crossover. Each patient is only counted once per cohort, regardless of how many admissions/discharges they had within the year. The graphs that show the number of admissions also show the census figures for that area, on the charts showing the number of discharges, there is a line running through each one that shows the average length of stay (the average length of stay is taken from all inpatient discharges throughout the year, if a patient has had 5 inpatients stays, this will be included in the average calculation as a total length of stay for that patient). The data is shown broken down by; Age, Gender, Ethnicity, Sexual Orientation and Religion.	Click here
	North Yorkshire, York and Selby			Click here
	Trust			Click here
Disengagement rates	Durham, Tees Valley and Forensics		These tabs show the number of appointments that were attended, cancelled and the patient did not attend (disengaged) throughout the reporting year, it is shown as a stacked percentage as to demonstrate where there are differences within the data. The data is shown broken down by; Ethnicity and Area of Deprivation.	Click here
	North Yorkshire, York and Selby			Click here
	Trust			Click here
Clinical Outcomes	Durham, Tees Valley and Forensics	AMH/MHSOP	These tabs show the number of patients discharged in the reporting period who had a paired outcome measure completed within their journey. The reports show both the Patient Reported Outcome Measure (PROM) and the Clinician Reported Outcome Measure (CROM) across Adult and MHSOP services and Children's services. The data is shown broken down by; Age, Gender, Ethnicity, Sexual Orientation and Religion. Each graph has an average line plotted on it, this is to help indicate those groups that are above or below the average of the data.	Click here
		CYP		Click here
	North Yorkshire, York and Selby	AMH/MHSOP		Click here
		CYP		Click here
	Trust	AMH/MHSOP		Click here
		CYP		Click here
Mental Health Act Data	Durham, Tees Valley and Forensics		These tabs show the number of detentions that took place throughout the reporting year, there is a tab labelled ***'MHA-Report Logic'*** which details the logic that has been applied to the data, including a definition of the different detentions. The data is shown broken down by; Age, Ethicnity, Area of Deprivation and rates per 100,000 (using the figures from the census data for the area that TEWV covers).	Click here
	North Yorkshire, York and Selby			Click here
	Trust			Click here
Patient Experience	Durham, Tees Valley and Forensics		These tabs show the response rate to the question *Thinking about your recent appointment overall, how was your experience of our service? Answer options are; Very good, Good, Neither good nor poor, Poor, Very poor, Don't know* Each graph excludes 'neither good nor poor' and 'Dont know' so as to focus on the 'Good' and 'Poor' responses. Each graph also shows the previous years response rate for comparison. The data is shown broken down by; Age, Gender, Ethnicity and Disability	Click here
	North Yorkshire, York and Selby			Click here
	Trust			Click here
Access to services > Admissions			This tab shows the number of people accessing services per 100,000 of the population. It also seperately shows the rates of people who spent time in hospital per 100 people accessing services. Each patient is only counted once per cohort, regardless of how many times they were open to services, or how many hospital stays they had within the year. This is to avoid over inflation when comparing those who accessed services to the census data. Each graph has an average line plotted against it.	Click here

Access to Services - Durham, Tees Valley and Forensic services

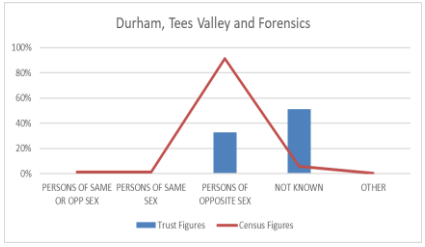
Religion

Religion	Trust figures	Census figures
BUDDHIST	0.06%	0.26%
CHRISTIAN	19.97%	52.43%
DECLINES TO DISCLOSE	57.20%	5.14%
HINDU	0.04%	0.34%
JEWISH	0.01%	0.04%
MUSLIM	0.51%	2.36%
NONE	19.84%	38.83%
OTHER	2.32%	0.37%
SIKH	0.04%	0.24%



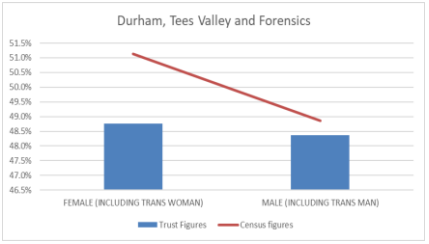
Sexual Orientation

Sexual Orientation	Trust Figures	Census Figures
PERSONS OF SAME OR OPP SEX	0.63%	1.10%
PERSONS OF SAME SEX	0.38%	1.44%
PERSONS OF OPPOSITE SEX	32.95%	91.17%
Not Age Appropriate	8.24%	Not Available
NOT DEVELOPMENTALLY APPROPRIAT	2.72%	Not Available
NOT KNOWN	51.31%	6.04%
OTHER	0.12%	0.25%



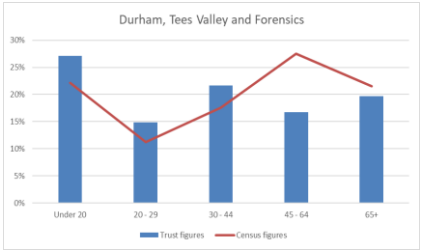
Gender

Gender	Trust Figures	Census figures
BIRTHSEX FEMALE - GENDER NEUTR	0.03%	Not Available
BIRTHSEX MALE - GENDER NEUTRAL	0.01%	Not Available
FEMALE (INCLUDING TRANS WOMAN)	48.76%	51.14%
INDETERMINATE	0.00%	Not Available
MALE (INCLUDING TRANS MAN)	48.36%	48.86%
NON-BINARY	0.04%	Not Available
NOT KNOWN	2.77%	Not Available
OTHER (NOT LISTED)	0.03%	Not Available



Age Grouping

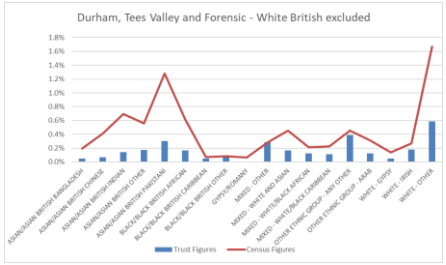
Age grouping	Trust figures	Census figures
Under 20	27.14%	22.16%
20 - 29	14.87%	11.22%
30 - 44	21.61%	17.61%
45 - 64	16.73%	27.52%
65+	19.65%	21.49%



Ethnicity

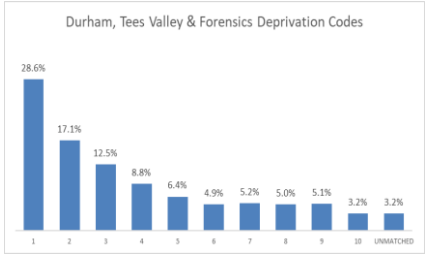
Ethnicity	Trust Figures	Census Figures
ASIAN/ASIAN BRITISH BANGLADESH	0.05%	0.19%
ASIAN/ASIAN BRITISH CHINESE	0.07%	0.41%
ASIAN/ASIAN BRITISH INDIAN	0.14%	0.70%
ASIAN/ASIAN BRITISH OTHER	0.17%	0.56%
ASIAN/ASIAN BRITISH PAKISTANI	0.30%	1.28%
BLACK/BLACK BRITISH AFRICAN	0.17%	0.61%
BLACK/BLACK BRITISH CARIBBEAN	0.05%	0.07%
BLACK/BLACK BRITISH OTHER	0.07%	0.09%
DECLINE TO DISCLOSE	0.05%	Not Available
GYPSY/ROMANY	0.00%	0.06%
MIXED - OTHER	0.29%	0.28%
MIXED - WHITE AND ASIAN	0.17%	0.45%
MIXED - WHITE/BLACK AFRICAN	0.12%	0.21%
MIXED - WHITE/BLACK CARIBBEAN	0.11%	0.22%
NOT STATED	29.75%	Not Available
OTHER ETHNIC GROUP - ANY OTHER	0.39%	0.46%
OTHER ETHNIC GROUP - ARAB	0.13%	0.31%
WHITE - BRITISH	67.16%	92.01%
WHITE - GYPSY	0.05%	0.14%
WHITE - IRISH	0.18%	0.27%
WHITE - OTHER	0.59%	1.67%

N.B for the chart below, White British ethnicity is excluded, this is due to it been so high that is masks the other %s listed



Areas of Deprivation

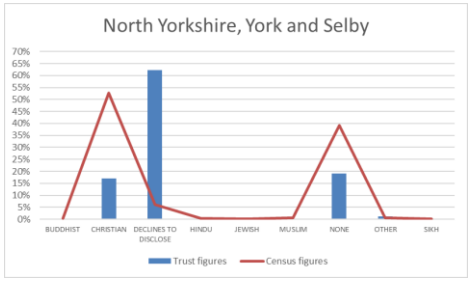
Deprivation code	Trust Figures
1	28.65%
2	17.09%
3	12.51%
4	8.84%
5	6.41%
6	4.92%
7	5.17%
8	4.97%
9	5.06%
10	3.17%
UNMATCHED	3.21%



Access to Services - North Yorkshire, York and Selby

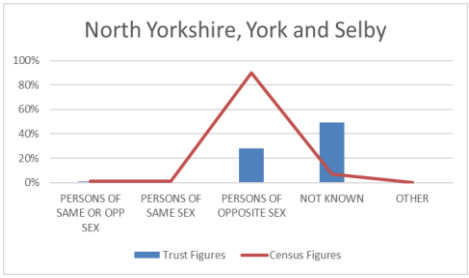
Religion

Religion	Trust figures	Census figures
BUDDHIST	0.06%	0.38%
CHRISTIAN	17.02%	52.73%
DECLINES TO DISCLOSE	62.30%	6.07%
HINDU	0.02%	0.33%
JEWISH	0.06%	0.11%
MUSLIM	0.23%	0.67%
NONE	19.10%	39.16%
OTHER	1.20%	0.49%
SIKH	0.01%	0.06%



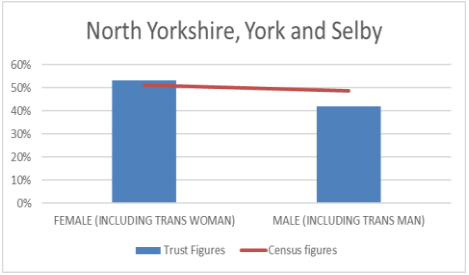
Sexual Orientation

Sexual Orientation	Trust Figures	Census Figures
PERSONS OF SAME OR OPP SEX	1.03%	1.36%
PERSONS OF SAME SEX	0.28%	1.35%
PERSONS OF OPPOSITE SEX	28.19%	90.05%
Not Age Appropriate	15.52%	Not Available
NOT DEVELOPMENTALLY APPROPRIAT	0.94%	Not Available
NOT KNOWN	49.25%	6.92%
OTHER	0.06%	0.32%



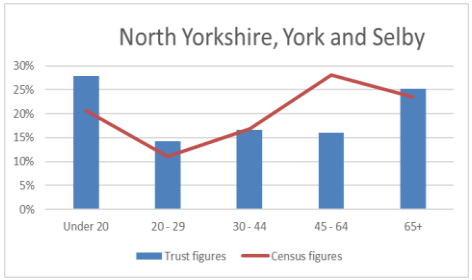
Gender

Gender	Trust Figures	Census figures
BIRTHSEX FEMALE - GENDER NEUTR	0.07%	Not Available
BIRTHSEX MALE - GENDER NEUTRAL	0.01%	Not Available
FEMALE (INCLUDING TRANS WOMAN)	53.37%	51.23%
MALE (INCLUDING TRANS MAN)	42.11%	48.77%
NON-BINARY	0.21%	Not Available
NOT KNOWN	4.18%	Not Available
OTHER (NOT LISTED)	0.04%	Not Available



Age Grouping

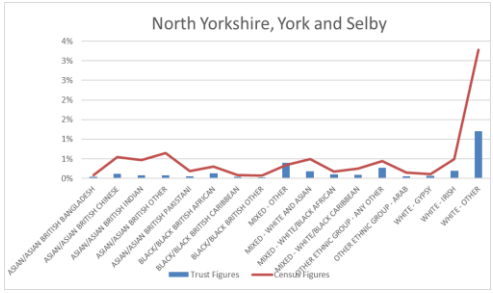
Age grouping	Trust figures	Census figures
Under 20	27.90%	20.61%
20 - 29	14.22%	11.07%
30 - 44	16.59%	16.77%
45 - 64	16.05%	28.02%
65+	25.24%	23.53%



Ethnicity

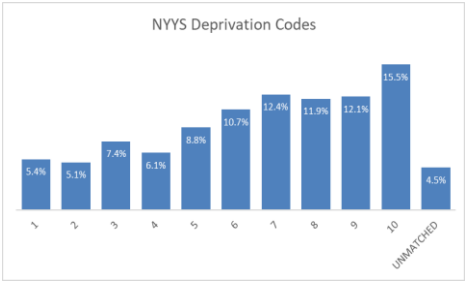
Ethnicity	Trust Figures	Census Figures
ASIAN/ASIAN BRITISH BANGLADESH	0.04%	0.09%
ASIAN/ASIAN BRITISH CHINESE	0.11%	0.55%
ASIAN/ASIAN BRITISH INDIAN	0.08%	0.47%
ASIAN/ASIAN BRITISH OTHER	0.08%	0.65%
ASIAN/ASIAN BRITISH PAKISTANI	0.05%	0.19%
BLACK/BLACK BRITISH AFRICAN	0.14%	0.30%
BLACK/BLACK BRITISH CARIBBEAN	0.04%	0.09%
BLACK/BLACK BRITISH OTHER	0.03%	0.07%
DECLINE TO DISCLOSE	0.30%	Not Available
MIXED - OTHER	0.40%	0.35%
MIXED - WHITE AND ASIAN	0.18%	0.50%
MIXED - WHITE/BLACK AFRICAN	0.10%	0.18%
MIXED - WHITE/BLACK CARIBBEAN	0.10%	0.25%
NOT STATED	36.81%	Not Available
OTHER ETHNIC GROUP - ANY OTHER	0.28%	0.44%
OTHER ETHNIC GROUP - ARAB	0.05%	0.14%
WHITE - BRITISH	59.74%	91.78%
WHITE - GYPSY	0.07%	0.11%
WHITE - IRISH	0.20%	0.49%
WHITE - OTHER	1.20%	3.28%

N.B for the chart below, White British ethnicity is excluded, this is due to it been so high that is masks the other %s listed



Areas of Deprivation

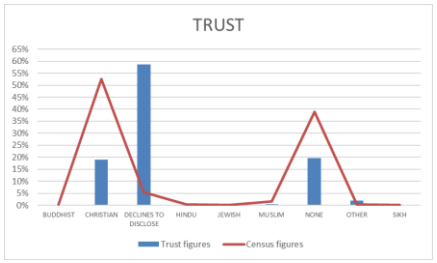
Deprivation code	Trust Figures
1	5.4%
2	5.1%
3	7.4%
4	6.1%
5	8.8%
6	10.7%
7	12.4%
8	11.9%
9	12.1%
10	15.5%
UNMATCHED	4.5%



Access to Services - Trust

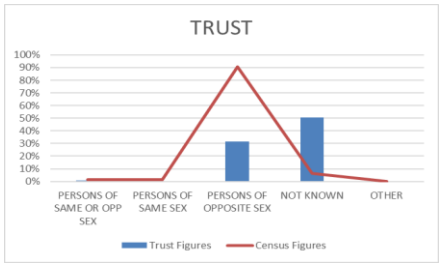
Religion

Religion	Trust figures	Census figures
BUDDHIST	0.06%	0.34%
CHRISTIAN	19.10%	52.55%
DECLINES TO DISCLOSE	58.71%	5.52%
HINDU	0.03%	0.34%
JEWISH	0.02%	0.07%
MUSLIM	0.42%	1.68%
NONE	19.62%	38.96%
OTHER	1.99%	0.42%
SIKH	0.03%	0.17%



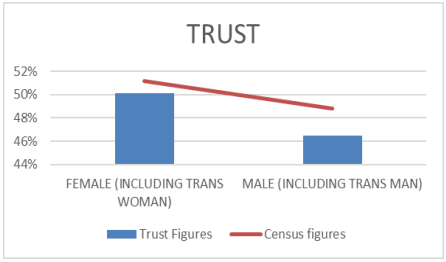
Sexual Orientation

Sexual Orientation	Trust Figures	Census Figures
PERSONS OF SAME OR OPP SEX	0.75%	1.21%
PERSONS OF SAME SEX	0.35%	1.40%
PERSONS OF OPPOSITE SEX	31.54%	90.71%
Not Age Appropriate	10.39%	Not Available
NOT DEVELOPMENTALLY APPROPRIAT	2.20%	Not Available
NOT KNOWN	50.70%	6.40%
OTHER	0.11%	0.28%



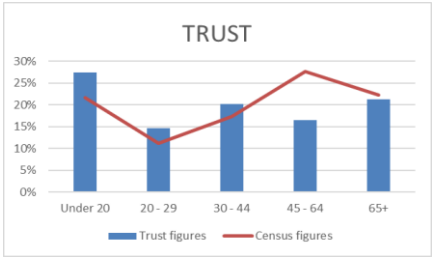
Gender

Gender	Trust Figures	Census figures
BIRTHSEX FEMALE - GENDER NEUTR	0.04%	Not Available
BIRTHSEX MALE - GENDER NEUTRAL	0.01%	Not Available
FEMALE (INCLUDING TRANS WOMAN)	50.13%	51.17%
INDETERMINATE	0.00%	Not Available
MALE (INCLUDING TRANS MAN)	46.51%	48.83%
NON-BINARY	0.09%	Not Available
NOT KNOWN	3.19%	Not Available
OTHER (NOT LISTED)	0.03%	Not Available



Age Grouping

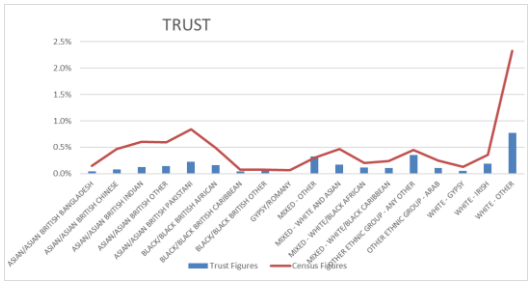
Age grouping	Trust figures	Census figures
Under 20	27.36%	21.62%
20 - 29	14.68%	11.17%
30 - 44	20.13%	17.31%
45 - 64	16.53%	27.69%
65+	21.30%	22.21%



Ethnicity

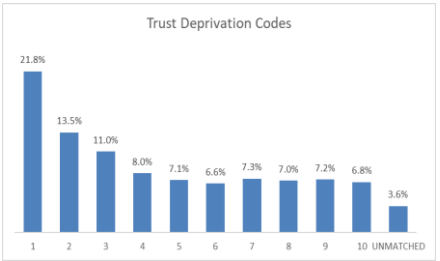
Ethnicity	Trust Figures	Census Figures
ASIAN/ASIAN BRITISH BANGLADESH	0.05%	0.15%
ASIAN/ASIAN BRITISH CHINESE	0.08%	0.47%
ASIAN/ASIAN BRITISH INDIAN	0.12%	0.61%
ASIAN/ASIAN BRITISH OTHER	0.14%	0.59%
ASIAN/ASIAN BRITISH PAKISTANI	0.23%	0.84%
BLACK/BLACK BRITISH AFRICAN	0.16%	0.49%
BLACK/BLACK BRITISH CARIBBEAN	0.05%	0.08%
BLACK/BLACK BRITISH OTHER	0.06%	0.08%
DECLINE TO DISCLOSE	0.12%	
GYPSY/ROMANY	0.00%	0.07%
MIXED - OTHER	0.32%	0.31%
MIXED - WHITE AND ASIAN	0.17%	0.47%
MIXED - WHITE/BLACK AFRICAN	0.11%	0.20%
MIXED - WHITE/BLACK CARIBBEAN	0.11%	0.24%
NOT STATED	31.84%	
OTHER ETHNIC GROUP - ANY OTHER	0.36%	0.45%
OTHER ETHNIC GROUP - ARAB	0.10%	0.24%
WHITE - BRITISH	64.97%	91.92%
WHITE - GYPSY	0.06%	0.13%
WHITE - IRISH	0.19%	0.36%
WHITE - OTHER	0.77%	2.32%

N.B for the chart below, White British ethnicity is excluded, this is due to it been so high that is masks the other %s listed



Areas of Deprivation

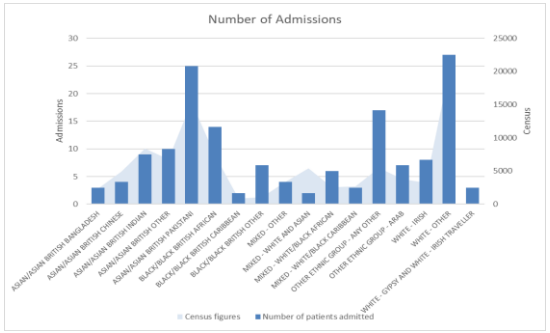
Deprivation code	Trust Figures
1	21.78%
2	13.54%
3	10.98%
4	8.04%
5	7.13%
6	6.64%
7	7.30%
8	7.02%
9	7.15%
10	6.83%
UNMATCHED	3.60%

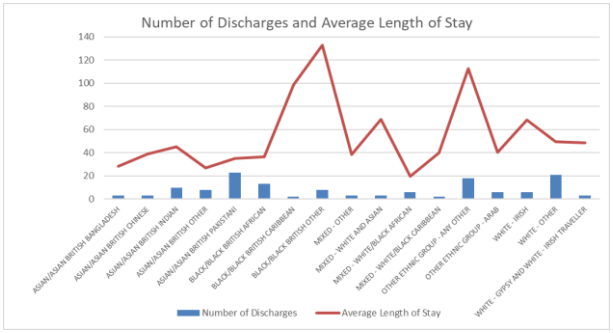


Inpatient Admissions, Discharges and Average Length of stays - Durham, Tees Valley and Forensic services

Ethnicity (Please note: White British has been removed from the graphs, due to it having such large numbers it was masking the other data).

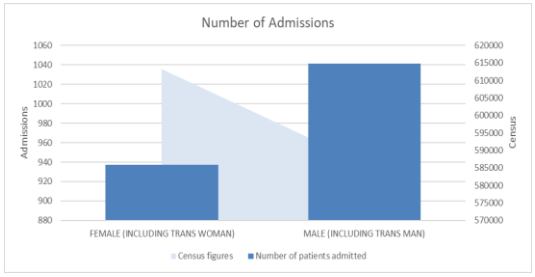
Ethnicity	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	Below 5	28.33
ASIAN/ASIAN BRITISH CHINESE	Below 5	Below 5	38.67
ASIAN/ASIAN BRITISH INDIAN	9	10	45.20
ASIAN/ASIAN BRITISH OTHER	10	8	27.00
ASIAN/ASIAN BRITISH PAKISTANI	25	23	34.83
BLACK/BLACK BRITISH AFRICAN	14	13	36.69
BLACK/BLACK BRITISH CARIBBEAN	Below 5	Below 5	98.50
BLACK/BLACK BRITISH OTHER	7	8	133.00
MIXED - OTHER	Below 5	Below 5	38.33
MIXED - WHITE AND ASIAN	Below 5	Below 5	68.67
MIXED - WHITE/BLACK AFRICAN	6	6	19.50
MIXED - WHITE/BLACK CARIBBEAN	Below 5	Below 5	40.00
OTHER ETHNIC GROUP - ANY OTHER	17	18	112.72
OTHER ETHNIC GROUP - ARAB	7	6	40.17
WHITE - BRITISH	1670	1706	82.08
WHITE - IRISH	8	6	68.17
WHITE - OTHER	27	21	49.57
UNKNOWN	187	165	41.67
WHITE - GYPSY AND WHITE - IRISH TRAVELLER	Below 5	Below 5	48.67

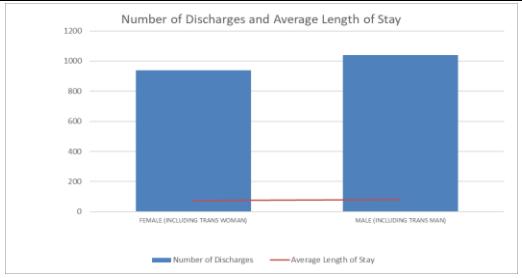




Gender (Please note: The graphs exclude Non - binary, Indeterminate and Not Known gender groupings).

Gender	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
FEMALE (INCLUDING TRANS WOMAN)	937	940	72.81
MALE (INCLUDING TRANS MAN)	1041	1040	81.18
NON-BINARY	Below 5	Below 5	150.00
UNKNOWN	26	25	48.96

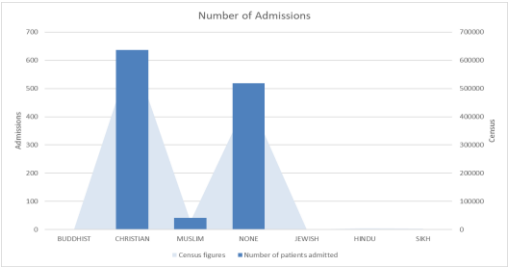


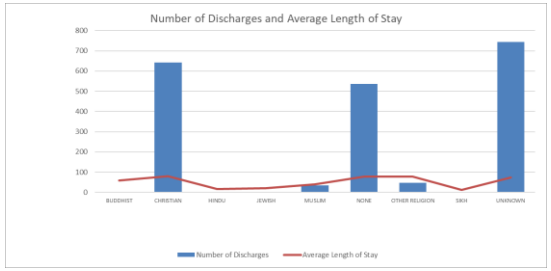


Please note: this graph excludes Non - binary, Indeterminate and Not Known as census figures are not available for these groupings.

Religion

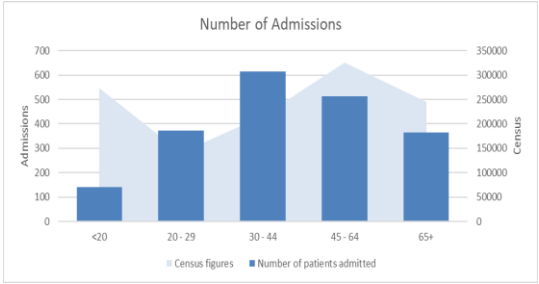
Religion	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
BUDDHIST	Below 5	Below 5	60.00
CHRISTIAN	636	643	81.18
HINDU	Below 5	Below 5	17.00
JEWISH	Below 5	Below 5	21.00
MUSLIM	41	35	41.03
NONE	519	537	77.37
OTHER RELIGION	48	47	79.00
SIKH	Below 5	Below 5	12.00
UNKNOWN	759	743	74.94

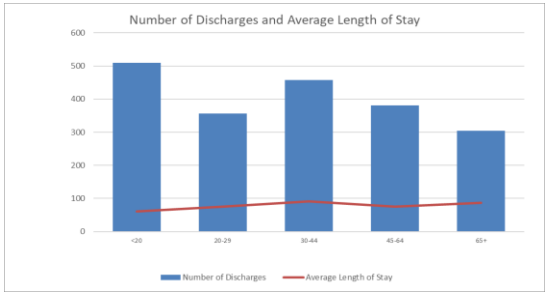




Age groupings

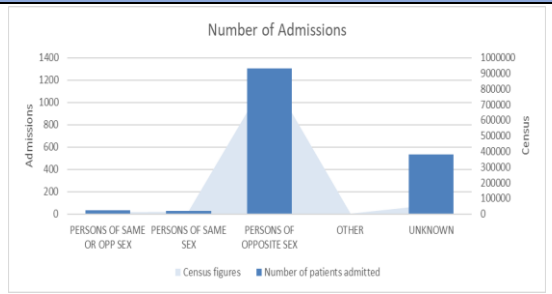
Age Groupings	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
<20	141	509	61.14
20 - 29	373	356	74.90
30 - 44	614	458	90.85
45 - 64	514	381	75.45
65+	366	305	87.03

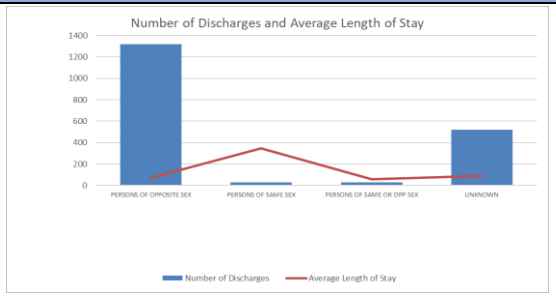




Sexual Orientation (Please note: the graphs exclude 'Person asked and does not know', 'Not Age appropriate' and not developmentally appropriate' sexual orientation groupings)

Sexual Orientation	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
PERSONS OF OPPOSITE SEX	1302	1321	70.48
PERSONS OF SAME SEX	28	28	348.25
PERSONS OF SAME OR OPP SEX	32	29	58.79
NOT AGE APPROPRIATE	56	56	31.88
NOT DEVELOPMENTALLY APPROPRIAT	54	54	26.06
UNKNOWN	535	519	90.20

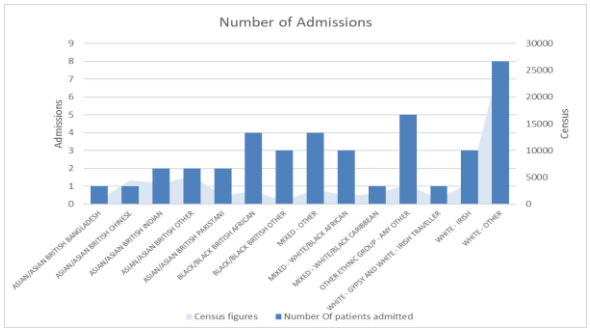


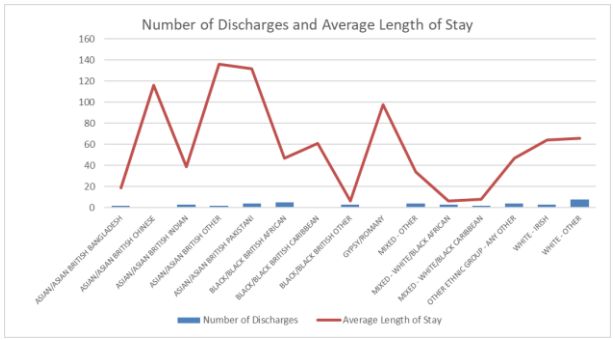


Inpatient Admissions, Discharges and Average Length of stays - North Yorkshire, York and Selby

Ethnicity (Please note: White British has been removed from the graphs, due to it having such large numbers it was masking the other data).

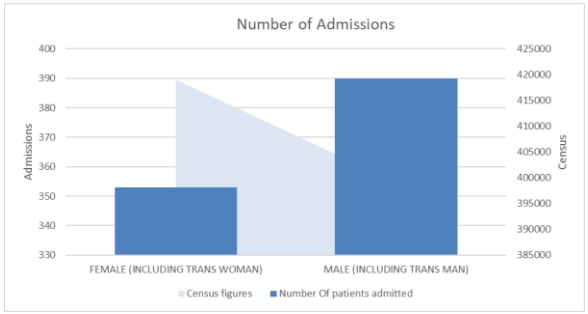
Ethnicity	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	Below 5	19.00
ASIAN/ASIAN BRITISH CHINESE	Below 5	Below 5	116.00
ASIAN/ASIAN BRITISH INDIAN	Below 5	Below 5	38.67
ASIAN/ASIAN BRITISH OTHER	Below 5	Below 5	136.00
ASIAN/ASIAN BRITISH PAKISTANI	Below 5	Below 5	131.75
BLACK/BLACK BRITISH AFRICAN	Below 5	5	46.80
BLACK/BLACK BRITISH OTHER	Below 5	Below 5	6.67
MIXED - OTHER	Below 5	Below 5	34.25
MIXED - WHITE/BLACK AFRICAN	Below 5	Below 5	6.67
MIXED - WHITE/BLACK CARIBBEAN	Below 5	Below 5	8.00
OTHER ETHNIC GROUP - ANY OTHER	5	Below 5	46.75
WHITE - BRITISH	578	589	74.18
WHITE - IRISH	Below 5	Below 5	64.00
WHITE - OTHER	8	8	66.00
GYPSY/ROMANY	Below 5	Below 5	98.00
UNKNOWN	136	138	45.99
WHITE - GYPSY AND WHITE - IRISH TRAVELLER	Below 5		

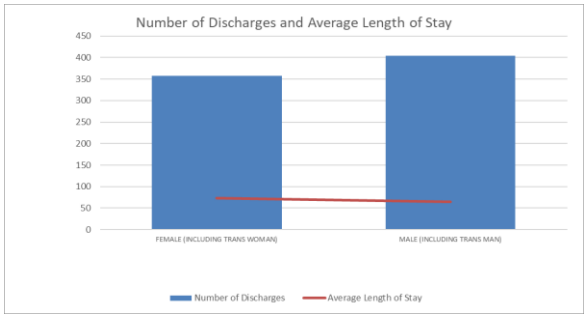




Gender (Please note: The graphs exclude Non - binary, Indeterminate and Not Known gender groupings).

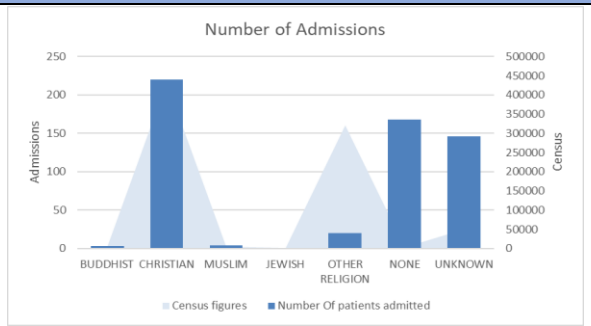
Gender	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
FEMALE (INCLUDING TRANS WOMAN)	353	357	73.39
MALE (INCLUDING TRANS MAN)	390	404	64.15
NON-BINARY	Below 5	Below 5	37.00
UNKNOWN	10	9	41.00

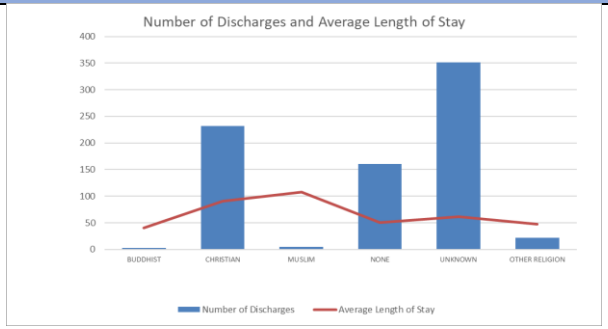




Religion

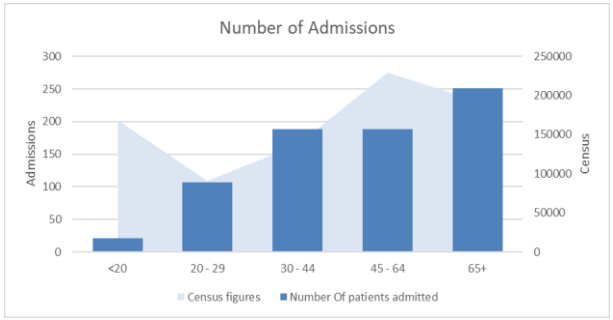
Religion	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
BUDDHIST	Below 5	Below 5	40.67
CHRISTIAN	220	232	91.06
MUSLIM	Below 5	5	108.20
NONE	168	160	50.81
JEWISH	Below 5		
UNKNOWN	339	351	61.62
OTHER RELIGION	20	22	47.91

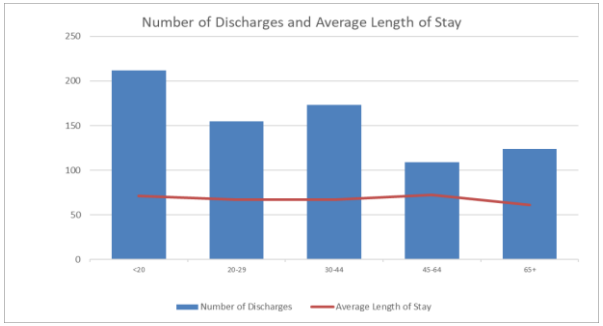




Age groupings

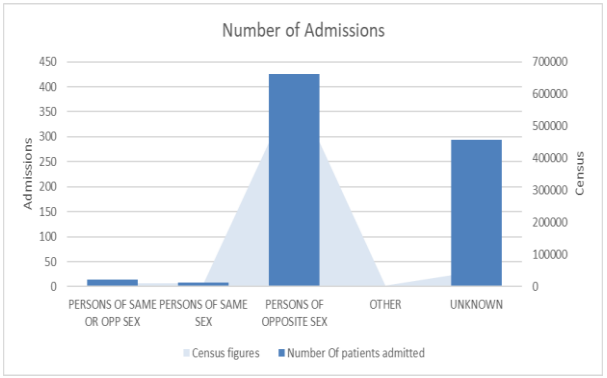
Age Groupings	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
<20	21	212	71.23
20 - 29	107	155	66.99
30 - 44	188	173	67.20
45 - 64	188	109	72.22
65+	251	124	61.43

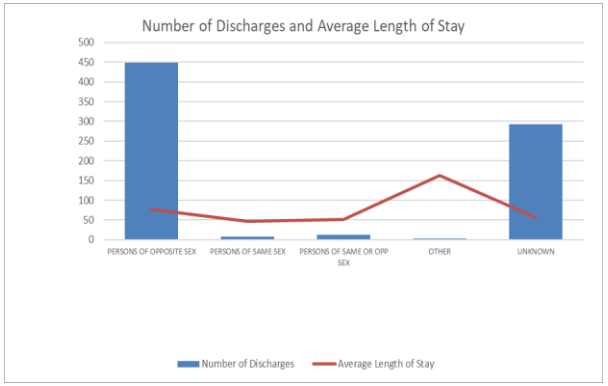




Sexual Orientation (Please note: the graphs exclude 'Person asked and does not know', 'Not Age appropriate' and not developmentally appropriate' sexual orientation groupings)

Sexual Orientation	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
PERSONS OF OPPOSITE SEX	426	449	76.91
PERSONS OF SAME SEX	8	7	46.57
PERSONS OF SAME OR OPP SEX	14	13	51.23
NOT AGE APPROPRIATE	11	9	24.33
OTHER	Below 5	Below 5	163.50
UNKNOWN	294	293	56.42

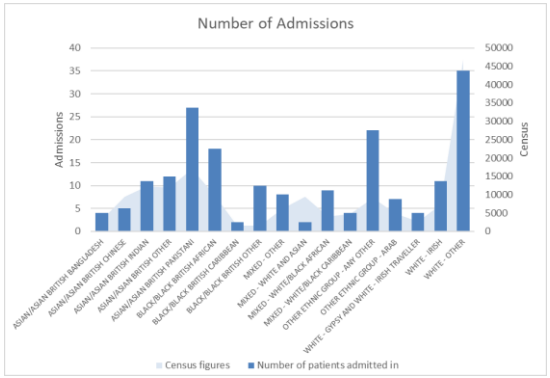


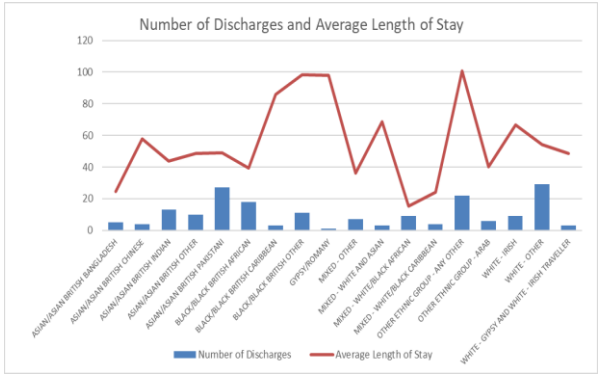


Inpatient Admissions, Discharges and Average Length of stays - Trust

Ethnicity (Please note: Unknown ethnicity has been removed from the graphs also White British has been removed from the graphs, due to it having such large numbers it was masking the other data).

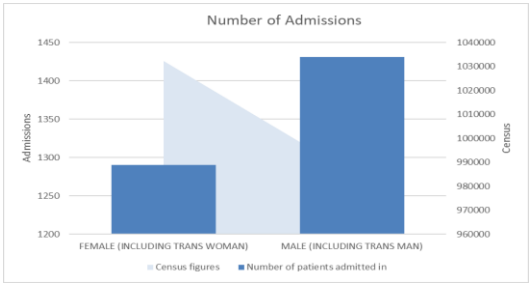
Ethnicity	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	5	24.60
ASIAN/ASIAN BRITISH CHINESE	5	Below 5	58.00
ASIAN/ASIAN BRITISH INDIAN	11	13	43.69
ASIAN/ASIAN BRITISH OTHER	12	10	48.80
ASIAN/ASIAN BRITISH PAKISTANI	27	27	49.19
BLACK/BLACK BRITISH AFRICAN	18	18	39.50
BLACK/BLACK BRITISH CARIBBEAN	Below 5	Below 5	86.00
BLACK/BLACK BRITISH OTHER	10	11	98.55
MIXED - OTHER	8	7	36.00
MIXED - WHITE AND ASIAN	Below 5	Below 5	68.67
MIXED - WHITE/BLACK AFRICAN	9	9	15.22
MIXED - WHITE/BLACK CARIBBEAN	Below 5	Below 5	24.00
OTHER ETHNIC GROUP - ANY OTHER	22	22	100.73
OTHER ETHNIC GROUP - ARAB	7	6	40.17
WHITE - BRITISH	2248	2296	82.95
WHITE - IRISH	11	9	66.78
WHITE - OTHER	35	29	54.10
GYPSY/ROMANY	Below 5	Below 5	98.00
UNKNOWN	323	303	43.64
WHITE - GYPSY AND WHITE - IRISH TRAVELLER	Below 5	Below 5	48.67

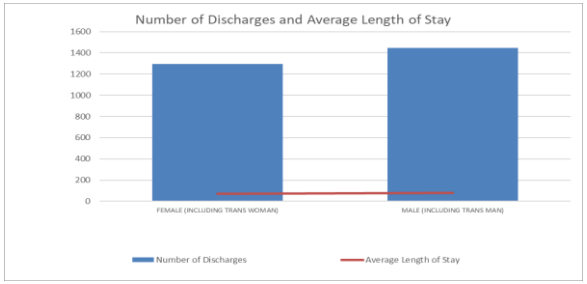




Gender (Please note: The graphs exclude Non - binary, Indeterminate and Not Known gender groupings).

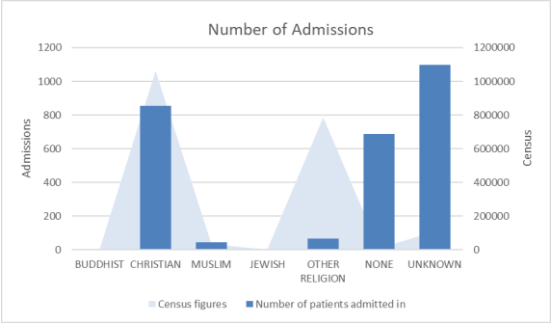
Gender	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
FEMALE (INCLUDING TRANS WOMAN)	1290	1297	72.97
MALE (INCLUDING TRANS MAN)	1431	1445	81.02
NON-BINARY	6	7	101.57
UNKNOWN	36	34	46.85

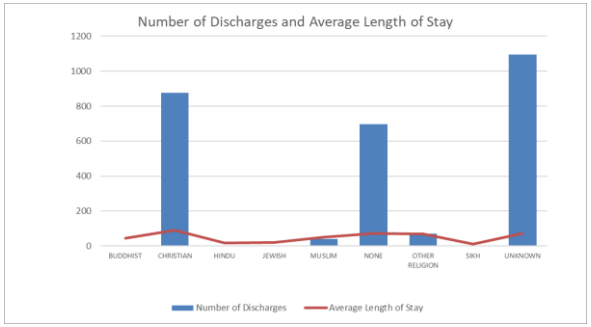




Religion

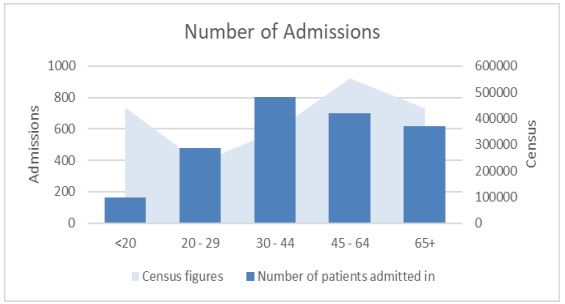
Religion	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
BUDDHIST	Below 5	Below 5	45.50
CHRISTIAN	856	876	91.39
HINDU	Below 5	Below 5	17.00
JEWISH	Below 5	Below 5	21.00
MUSLIM	45	40	49.43
NONE	687	697	71.27
OTHER RELIGION	68	69	69.09
SIKH	Below 5	Below 5	12.00
UNKNOWN	1098	1094	70.67

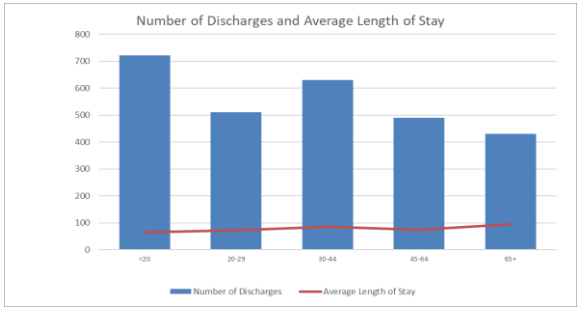




Age groupings

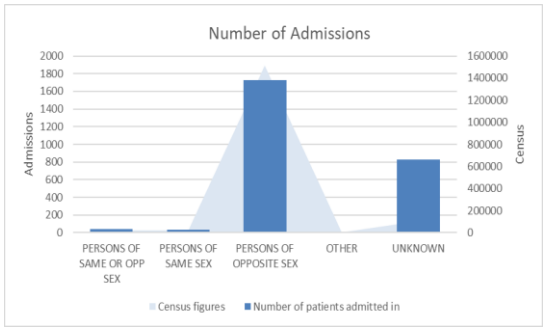
Age Groupings	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
<20	162	721	64.11
20 - 29	480	511	72.50
30 - 44	802	631	84.36
45 - 64	702	490	74.73
65+	617	430	95.11

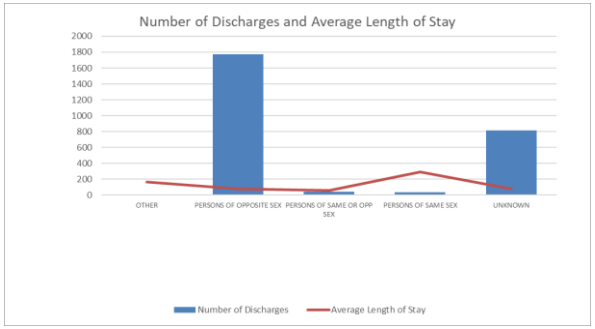




Sexual Orientation (Please note: the graphs exclude 'Person asked and does not know', 'Not Age appropriate' and not developmentally appropriate' sexual orientation groupings)

Sexual Orientation	Number of patients admitted	Number of Patients discharged	Average length of stay (days)
NOT AGE APPROPRIATE	67	65	30.83
NOT DEVELOPMENTALLY APPROPRIAT	54	54	26.06
OTHER	Below 5	Below 5	163.50
PERSONS OF OPPOSITE SEX	1728	1771	75.88
PERSONS OF SAME OR OPP SEX	46	42	56.45
PERSONS OF SAME SEX	36	35	287.91
UNKNOWN	829	814	77.96

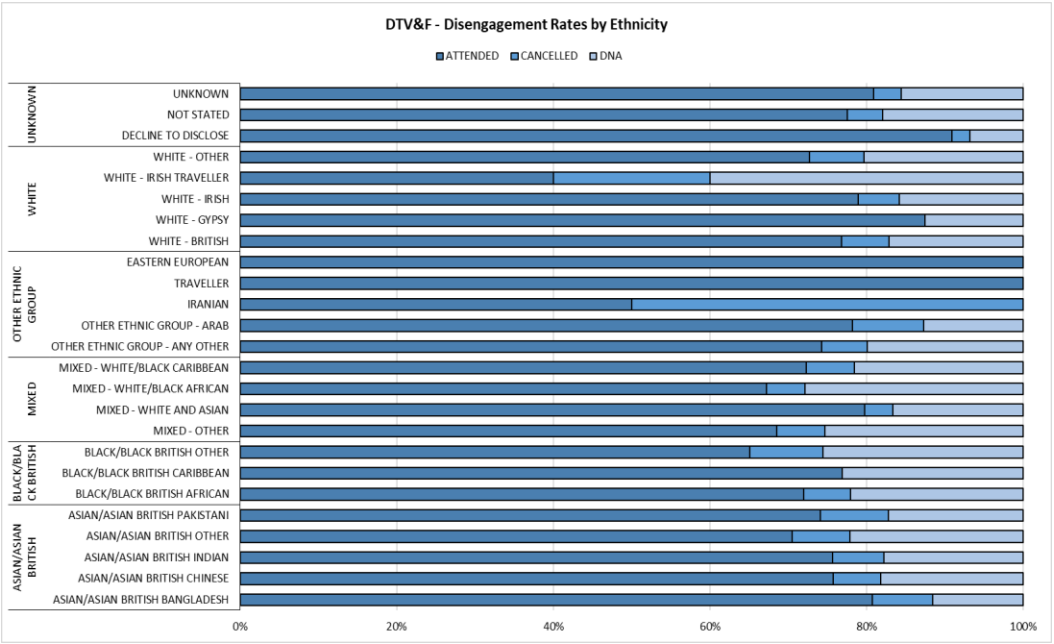




Disengagement rates for Durham, Tees Valley and Forensics

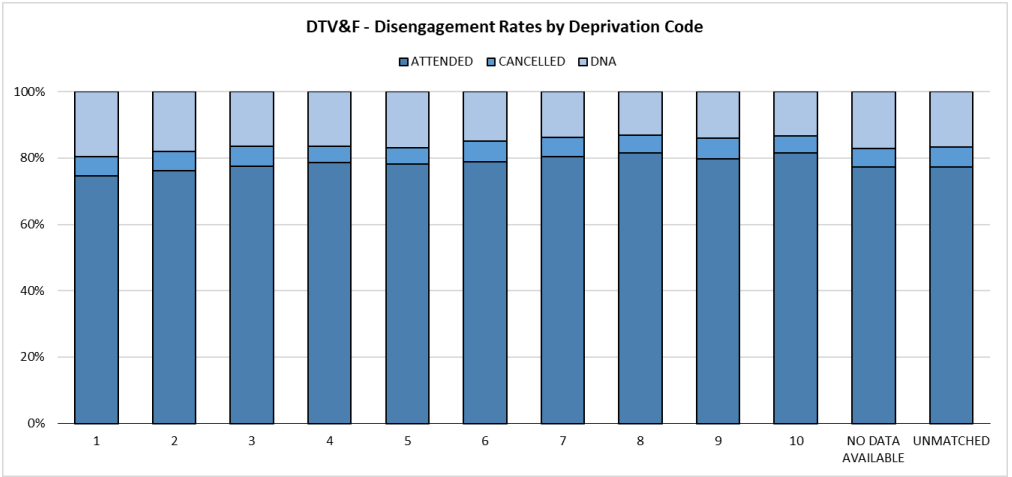
Ethnicity

Ethnicity			
	ATTENDED	CANCELLED	DNA
ASIAN/ASIAN BRITISH BANGLADESH	21	Below 5	Below 5
ASIAN/ASIAN BRITISH CHINESE	25	Below 5	6
ASIAN/ASIAN BRITISH INDIAN	81	7	19
ASIAN/ASIAN BRITISH OTHER	67	7	21
ASIAN/ASIAN BRITISH PAKISTANI	129	15	30
BLACK/BLACK BRITISH AFRICAN	72	6	22
BLACK/BLACK BRITISH CARIBBEAN	20		6
BLACK/BLACK BRITISH OTHER	28	Below 5	11
MIXED - OTHER	122	11	45
MIXED - WHITE AND ASIAN	67	Below 5	14
MIXED - WHITE/BLACK AFRICAN	41	Below 5	17
MIXED - WHITE/BLACK CARIBBEAN	47	Below 5	14
OTHER ETHNIC GROUP - ANY OTHER	153	12	41
OTHER ETHNIC GROUP - ARAB	43	5	7
IRANIAN	Below 5	Below 5	
TRAVELLER	Below 5		
EASTERN EUROPEAN	Below 5		
WHITE - BRITISH	29244	2307	6533
WHITE - GYPSY	28		Below 5
WHITE - IRISH	75	5	15
WHITE - IRISH TRAVELLER	Below 5	Below 5	Below 5
WHITE - OTHER	283	27	79
DECLINE TO DISCLOSE	40	Below 5	Below 5
NOT STATED	862	50	199
UNKNOWN	5171	229	994



Deprivation Code

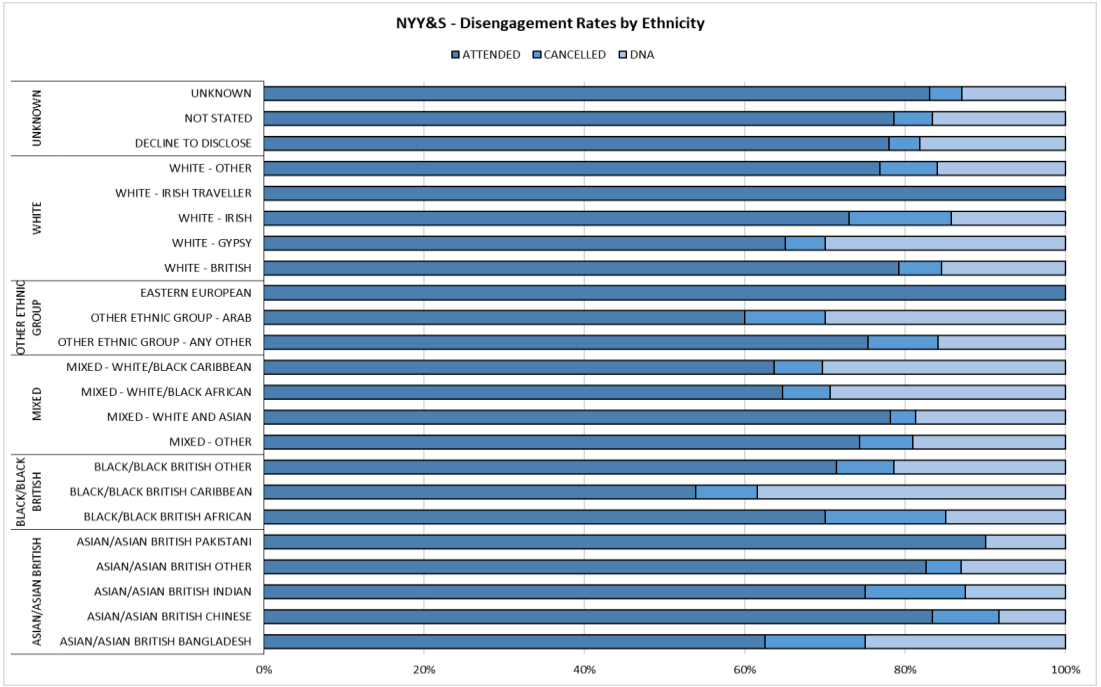
Deprivation Code			
	ATTENDED	CANCELLED	DNA
1	9010	718	2361
2	5906	450	1404
3	4250	319	906
4	3085	196	645
5	2270	146	491
6	1804	140	341
7	1799	131	308
8	1669	107	269
9	1870	145	327
10	1123	70	185
NO DATA AVAILABLE	2508	178	559
UNMATCHED	1332	102	289



Disengagement rates for North Yorkshire, York and Selby

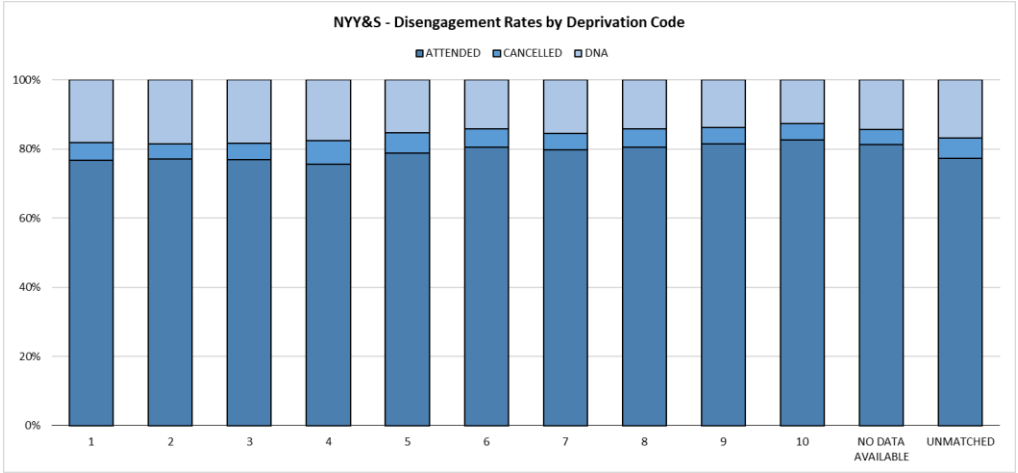
Ethnicity

Ethnicity	ATTENDED	CANCELLED	DNA
ASIAN/ASIAN BRITISH BANGLADESH	5	Below 5	Below 5
ASIAN/ASIAN BRITISH CHINESE	20	Below 5	Below 5
ASIAN/ASIAN BRITISH INDIAN	18	Below 5	Below 5
ASIAN/ASIAN BRITISH OTHER	19	Below 5	Below 5
ASIAN/ASIAN BRITISH PAKISTANI	9		Below 5
BLACK/BLACK BRITISH AFRICAN	14	Below 5	Below 5
BLACK/BLACK BRITISH CARIBBEAN	7	Below 5	5
BLACK/BLACK BRITISH OTHER	10	Below 5	Below 5
MIXED - OTHER	78	7	20
MIXED - WHITE AND ASIAN	25	Below 5	6
MIXED - WHITE/BLACK AFRICAN	11	Below 5	5
MIXED - WHITE/BLACK CARIBBEAN	21	Below 5	10
OTHER ETHNIC GROUP - ANY OTHER	52	6	11
OTHER ETHNIC GROUP - ARAB	6	Below 5	Below 5
EASTERN EUROPEAN	Below 5		
WHITE - BRITISH	11720	788	2286
WHITE - GYPSY	13	Below 5	6
WHITE - IRISH	46	8	9
WHITE - IRISH TRAVELLER	Below 5		
WHITE - OTHER	225	21	47
DECLINE TO DISCLOSE	60	3	14
NOT STATED	507	31	107
UNKNOWN	3085	148	483



Deprivation Code

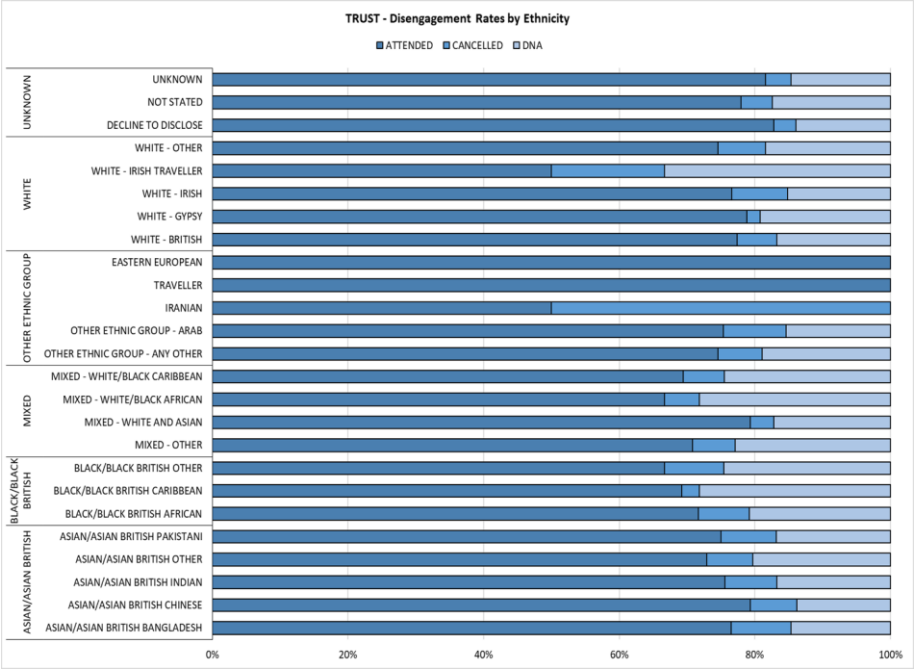
Deprivation code	ATTENDED	CANCELLED	DNA
1	760	49	180
2	737	42	177
3	1077	67	256
4	862	79	200
5	1311	97	255
6	1706	110	300
7	1806	109	349
8	1870	127	327
9	1861	110	313
10	2332	134	355
NO DATA AVAILABLE	882	48	155
UNMATCHED	750	58	162



Disengagement rates for the Trust

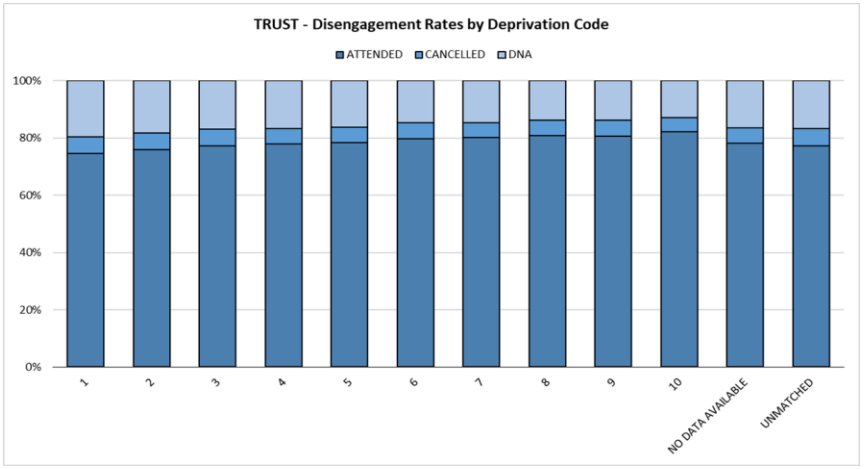
Ethnicity

Ethnicity			
	ATTENDED	CANCELLED	DNA
ASIAN/ASIAN BRITISH BANGLADESH	26	Below 5	5
ASIAN/ASIAN BRITISH CHINESE	46	Below 5	8
ASIAN/ASIAN BRITISH INDIAN	99	10	22
ASIAN/ASIAN BRITISH OTHER	86	8	24
ASIAN/ASIAN BRITISH PAKISTANI	138	15	31
BLACK/BLACK BRITISH AFRICAN	86	9	25
BLACK/BLACK BRITISH CARIBBEAN	27	Below 5	11
BLACK/BLACK BRITISH OTHER	38	5	14
MIXED - OTHER	201	18	65
MIXED - WHITE AND ASIAN	92	Below 5	20
MIXED - WHITE/BLACK AFRICAN	52	Below 5	22
MIXED - WHITE/BLACK CARIBBEAN	68	6	24
OTHER ETHNIC GROUP - ANY OTHER	205	18	52
OTHER ETHNIC GROUP - ARAB	49	6	10
IRANIAN	Below 5	Below 5	
TRAVELLER	Below 5		
EASTERN EUROPEAN	Below 5		
WHITE - BRITISH	41252	3134	8929
WHITE - GYPSY	41	Below 5	10
WHITE - IRISH	121	13	24
WHITE - IRISH TRAVELLER	Below 5	Below 5	Below 5
WHITE - OTHER	510	48	126
DECLINE TO DISCLOSE	101	Below 5	17
NOT STATED	1370	82	306
UNKNOWN	8277	381	1487



Deprivation Code

Deprivation Code			
	ATTENDED	CANCELLED	DNA
1	9848	777	2578
2	6717	504	1615
3	5374	396	1180
4	3968	277	849
5	3601	245	746
6	3515	250	644
7	3616	241	659
8	3546	236	600
9	3748	257	645
10	3460	204	541
NO DATA AVAILABLE	3413	227	723
UNMATCHED	2089	162	454

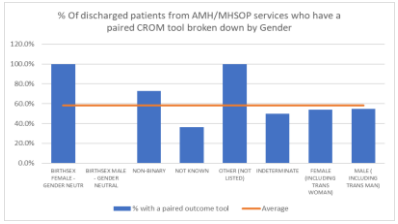


Clinical outcomes - Measureable improvement for Durham, Tees Valley and Forensic services

Gender

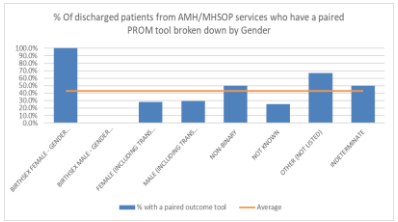
AMH/MHSOP - CROM

Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BIRTHSEX FEMALE - GENDER NEUTR	Below 5	Below 5	100%
BIRTHSEX MALE - GENDER NEUTRAL	Below 5	0	0%
NON-BINARY	11	8	73%
NOT KNOWN	58	21	36%
OTHER (NOT LISTED)	Below 5	Below 5	100%
INDETERMINATE	Below 5	Below 5	50%
FEMALE (INCLUDING TRANS WOMAN)	5499	2957	54%
MALE (INCLUDING TRANS MAN)	4256	2334	55%



AMH/MHSOP PROM

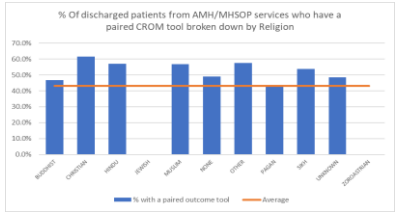
Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BIRTHSEX FEMALE - GENDER NEUTR	Below 5	Below 5	100%
BIRTHSEX MALE - GENDER NEUTRAL	Below 5	0	0%
FEMALE (INCLUDING TRANS WOMAN)	5879	1663	28%
MALE (INCLUDING TRANS MAN)	4726	1393	29%
NON-BINARY	10	5	50%
NOT KNOWN	115	29	25%
OTHER (NOT LISTED)	Below 5	Below 5	67%
INDETERMINATE	Below 5	Below 5	50%



Religion

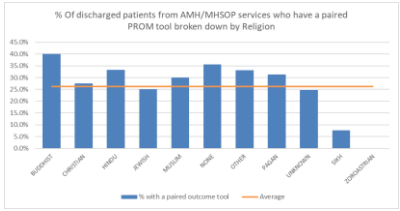
AMH/MHSOP - CROM

Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BUDDHIST	15	7	47%
CHRISTIAN	3979	2448	62%
HINDU	7	Below 5	57%
JEWISH	Below 5	0	0%
MUSLIM	88	50	57%
NONE	2407	1182	49%
OTHER	214	123	57%
PAGAN	16	7	44%
SIKH	13	7	54%
UNKNOWN	3086	1496	48%
ZOROASTRIAN	Below 5	0	0%



AMH/MHSOP PROM

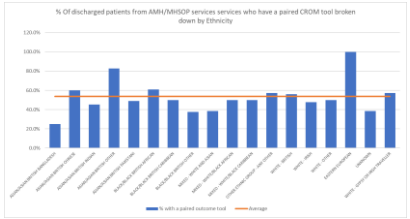
Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BUDDHIST	15	6	40%
CHRISTIAN	4159	1148	28%
HINDU	9	Below 5	33%
JEWISH	Below 5	Below 5	25%
MUSLIM	100	30	30%
NONE	2675	953	36%
OTHER	232	77	33%
PAGAN	16	5	31%
UNKNOWN	3514	870	25%
SIKH	13	Below 5	8%
ZOROASTRIAN	Below 5	0	0%



Ethnicity

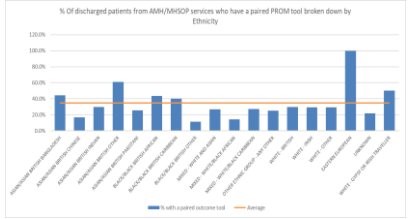
AMH/MHSOP - CROM

Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	8	Below 5	25%
ASIAN/ASIAN BRITISH CHINESE	5	Below 5	60%
ASIAN/ASIAN BRITISH INDIAN	31	14	45%
ASIAN/ASIAN BRITISH OTHER	23	19	83%
ASIAN/ASIAN BRITISH PAKISTANI	45	22	49%
BLACK/BLACK BRITISH AFRICAN	23	14	61%
BLACK/BLACK BRITISH CARIBBEAN	6	Below 5	50%
BLACK/BLACK BRITISH OTHER	8	Below 5	38%
MIXED - OTHER	25	15	60%
MIXED - WHITE AND ASIAN	13	5	38%
MIXED - WHITE/BLACK AFRICAN	6	Below 5	50%
MIXED - WHITE/BLACK CARIBBEAN	10	5	50%
OTHER ETHNIC GROUP - ANY OTHER	42	24	57%
OTHER ETHNIC GROUP - ARAB	13	8	62%
WHITE - BRITISH	8472	4746	56%
WHITE - IRISH	23	11	48%
WHITE - OTHER	88	44	50%
EASTERN EUROPEAN	Below 5	Below 5	100%
UNKNOWN	981	378	39%
WHITE - GYPSY OR IRISH TRAVELLER	7	Below 5	57%



AMH/MHSOP PROM

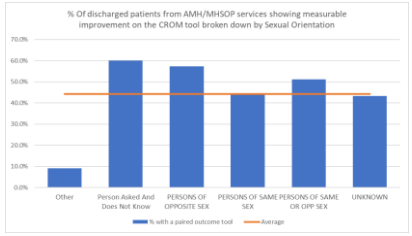
Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	9	Below 5	44%
ASIAN/ASIAN BRITISH CHINESE	6	Below 5	17%
ASIAN/ASIAN BRITISH INDIAN	37	11	30%
ASIAN/ASIAN BRITISH OTHER	23	14	61%
ASIAN/ASIAN BRITISH PAKISTANI	51	13	25%
BLACK/BLACK BRITISH AFRICAN	23	10	43%
BLACK/BLACK BRITISH CARIBBEAN	5	Below 5	40%
BLACK/BLACK BRITISH OTHER	9	Below 5	11%
MIXED - OTHER	28	9	32%
MIXED - WHITE AND ASIAN	15	Below 5	27%
MIXED - WHITE/BLACK AFRICAN	7	Below 5	14%
MIXED - WHITE/BLACK CARIBBEAN	11	Below 5	27%
OTHER ETHNIC GROUP - ANY OTHER	52	13	25%
OTHER ETHNIC GROUP - ARAB	18	3	17%
WHITE - BRITISH	9101	2703	30%
WHITE - IRISH	24	7	29%
WHITE - OTHER	92	27	29%
EASTERN EUROPEAN	Below 5	Below 5	100%
UNKNOWN	1218	263	22%
WHITE - GYPSY OR IRISH TRAVELLER	8	Below 5	50%



Sexual Orientation (n.b 'Not age appropriate' and 'Not developmentally appropriate' are not included in the graphs)

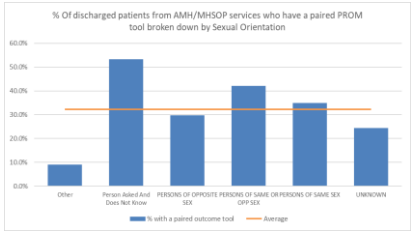
AMH/MHSOP - CROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	53	23	43%
Not Developmentally Appropriate	10	Below 5	30%
Other	11	Below 5	9%
Person Asked And Does Not Know	15	9	60%
PERSONS OF OPPOSITE SEX	7491	4298	57%
PERSONS OF SAME SEX	76	34	45%
PERSONS OF SAME OR OPP SEX	168	86	51%
UNKNOWN	2006	870	43%



AMH/MHSOP PROM

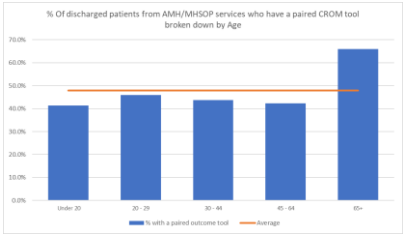
Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	59	15	25%
Not Developmentally Appropriate	11	Below 5	18%
Other	11	Below 5	9%
Person Asked And Does Not Know	15	8	53%
PERSONS OF OPPOSITE SEX	8041	2392	30%
PERSONS OF SAME OR OPP SEX	185	78	42%
PERSONS OF SAME SEX	89	31	35%
UNKNOWN	2327	567	24%



Age

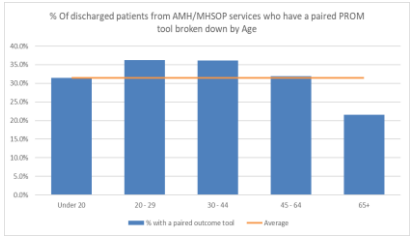
AMH/MHSOP - CROM

Age	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Under 20	312	129	41%
20 - 29	1318	606	46%
30 - 44	1803	789	44%
45 - 64	1767	747	42%
65+	4630	3053	66%



AMH/MHSOP PROM

Age	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Under 20	343	108	31%
20 - 29	1528	554	36%
30 - 44	2148	776	36%
45 - 64	2021	645	32%
65+	4698	1011	22%

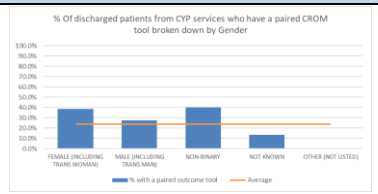


Clinical outcomes - Measureable improvement for Durham, Tees Valley and Forensic services

Gender

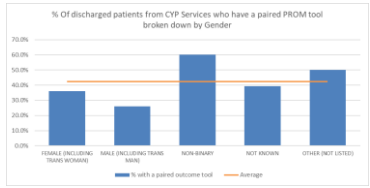
CYP - CROM

Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
FEMALE (INCLUDING TRANS WOMAN)	2352	912	39%
MALE (INCLUDING TRANS MAN)	1400	386	28%
NON-BINARY	5	Below 5	40%
NOT KNOWN	22	Below 5	14%
OTHER (NOT LISTED)	Below 5	0	0%



CYP - PROM

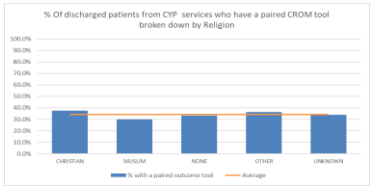
Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
FEMALE (INCLUDING TRANS WOMAN)	2591	936	36%
MALE (INCLUDING TRANS MAN)	1533	399	26%
NON-BINARY	5	Below 5	60%
NOT KNOWN	28	11	39%
OTHER (NOT LISTED)	Below 5	Below 5	50%



Religion

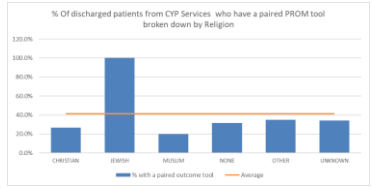
CYP - CROM

Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
CHRISTIAN	554	208	38%
MUSLIM	10	Below 5	30%
NONE	1030	342	33%
OTHER	406	148	36%
UNKNOWN	1781	602	34%



CYP - PROM

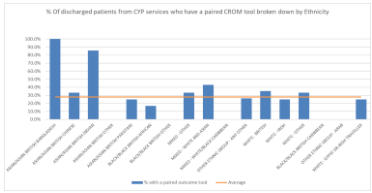
Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
CHRISTIAN	603	161	27%
JEWISH	Below 5	Below 5	100%
MUSLIM	10	Below 5	20%
NONE	1116	352	32%
OTHER	435	152	35%
UNKNOWN	1994	682	34%



Ethnicity

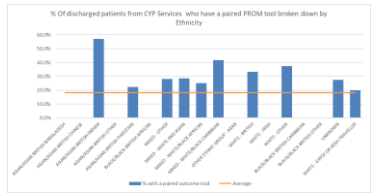
CYP - CROM

Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	Below 5	100%
ASIAN/ASIAN BRITISH CHINESE	Below 5	Below 5	33%
ASIAN/ASIAN BRITISH INDIAN	7	6	86%
ASIAN/ASIAN BRITISH OTHER	7	0	0%
ASIAN/ASIAN BRITISH PAKISTANI	8	Below 5	25%
BLACK/BLACK BRITISH AFRICAN	6	Below 5	17%
BLACK/BLACK BRITISH OTHER	Below 5	0	0%
MIXED - OTHER	27	9	33%
MIXED - WHITE AND ASIAN	7	Below 5	43%
MIXED - WHITE/BLACK AFRICAN	12	Below 5	17%
MIXED - WHITE/BLACK CARIBBEAN	11	0	0%
OTHER ETHNIC GROUP - ANY OTHER	19	5	26%
WHITE - BRITISH	3302	1169	35%
WHITE - IRISH	Below 5	Below 5	25%
WHITE - OTHER	30	10	33%
BLACK/BLACK BRITISH CARIBBEAN	Below 5	0	0%
OTHER ETHNIC GROUP - ARAB	Below 5	0	0%
UNKNOWN	328	92	28%
WHITE - GYPSY OR IRISH TRAVELLER	Below 5	Below 5	25%



CYP - PROM

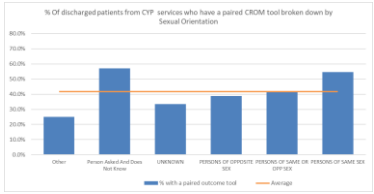
Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	0	0%
ASIAN/ASIAN BRITISH CHINESE	Below 5	0	0%
ASIAN/ASIAN BRITISH INDIAN	7	Below 5	57%
ASIAN/ASIAN BRITISH OTHER	7	0	0%
ASIAN/ASIAN BRITISH PAKISTANI	9	Below 5	22%
BLACK/BLACK BRITISH AFRICAN	6	0	0%
MIXED - OTHER	32	9	28%
MIXED - WHITE AND ASIAN	7	Below 5	29%
MIXED - WHITE/BLACK AFRICAN	12	Below 5	25%
MIXED - WHITE/BLACK CARIBBEAN	12	5	42%
OTHER ETHNIC GROUP - ANY OTHER	19	5	26%
OTHER ETHNIC GROUP - ARAB	Below 5	0	0%
WHITE - BRITISH	3612	1202	33%
WHITE - IRISH	Below 5	0	0%
WHITE - OTHER	32	12	38%
BLACK/BLACK BRITISH CARIBBEAN	Below 5	0	0%
BLACK/BLACK BRITISH OTHER	Below 5	0	0%
UNKNOWN	382	105	27%
WHITE - GYPSY OR IRISH TRAVELLER	5	Below 5	20%



Sexual Orientation (N.B 'Not age appropriate', 'Person asked and does not know' and 'Not developmentally appropriate' are not included in the graphs)

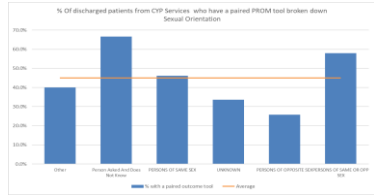
CYP - CROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	1579	556	35%
Other	Below 5	Below 5	25.0%
Person Asked And Does Not Know	7	Below 5	57%
UNKNOWN	1708	572	33%
Not Developmentally Appropriate	207	61	29%
PERSONS OF OPPOSITE SEX	248	96	38.7%
PERSONS OF SAME OR OPP SEX	17	7	41.2%
PERSONS OF SAME SEX	11	6	54.5%



CYP - PROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	1707	550	32%
Other	5	Below 5	40%
Person Asked And Does Not Know	9	6	67%
PERSONS OF SAME SEX	13	6	46%
UNKNOWN	1903	639	34%
Not Developmentally Appropriate	227	65	29%
PERSONS OF OPPOSITE SEX	276	71	26%
PERSONS OF SAME OR OPP SEX	19	11	58%

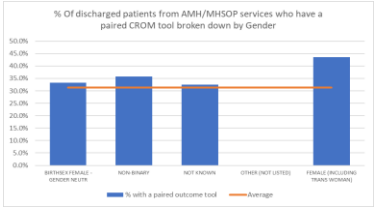


Clinical outcomes - Measureable improvement for North Yorkshire, York and Selby services

Gender

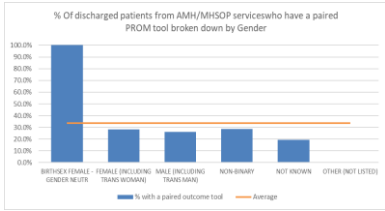
AMH/MHSOP - CROM

Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BIRTHSEX FEMALE - GENDER NEUTR	Below 5	Below 5	33%
BIRTHSEX MALE - GENDER NEUTRAL	0	0	0%
NON-BINARY	14	5	36%
NOT KNOWN	83	27	33%
OTHER (NOT LISTED)	Below 5	0	0%
INDETERMINATE	0	0	0%
FEMALE (INCLUDING TRANS WOMAN)	3325	1446	43%
MALE (INCLUDING TRANS MAN)	2244	964	43%



AMH/MHSOP PROM

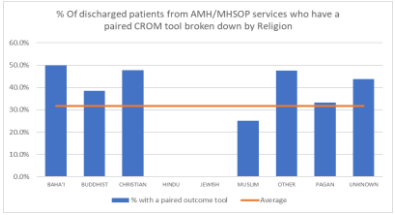
Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BIRTHSEX FEMALE - GENDER NEUTR	Below 5	Below 5	100%
FEMALE (INCLUDING TRANS WOMAN)	3455	974	28%
MALE (INCLUDING TRANS MAN)	2353	611	26%
NON-BINARY	14	Below 5	29%
NOT KNOWN	93	18	19%
OTHER (NOT LISTED)	Below 5	0	0%



Religion

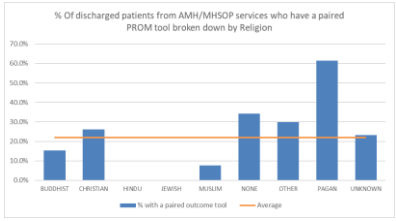
AMH/MHSOP - CROM

Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BUDDHIST	13	5	38%
BAHA'I	Below 5	Below 5	50%
CHRISTIAN	1796	858	48%
HINDU	Below 5	0	0%
JEWISH	Below 5	0	0%
MUSLIM	12	Below 5	25%
OTHER	145	69	48%
PAGAN	12	Below 5	33%
UNKNOWN	2224	974	44%



AMH/MHSOP PROM

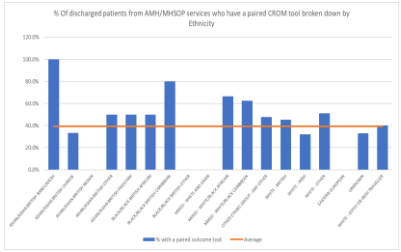
Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BUDDHIST	13	Below 5	15%
CHRISTIAN	1842	481	26%
HINDU	Below 5	0	0%
JEWISH	Below 5	0	0%
MUSLIM	13	Below 5	8%
NONE	1539	527	34%
OTHER	144	43	30%
PAGAN	13	8	62%
UNKNOWN	2353	547	23%



Ethnicity

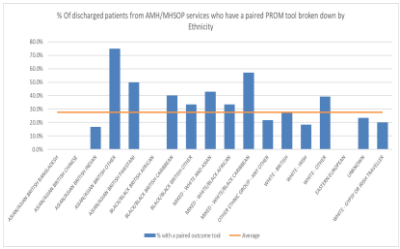
AMH/MHSOP - CROM

Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	Below 5	100%
ASIAN/ASIAN BRITISH CHINESE	6	Below 5	33%
ASIAN/ASIAN BRITISH INDIAN	6	0	0%
ASIAN/ASIAN BRITISH OTHER	Below 5	Below 5	50%
ASIAN/ASIAN BRITISH PAKISTANI	Below 5	Below 5	50%
BLACK/BLACK BRITISH AFRICAN	Below 5	Below 5	50%
BLACK/BLACK BRITISH CARIBBEAN	5	Below 5	80%
BLACK/BLACK BRITISH OTHER	Below 5	0	0%
MIXED - OTHER	17	8	47%
MIXED - WHITE AND ASIAN	6	0	0%
MIXED - WHITE/BLACK AFRICAN	Below 5	Below 5	67%
MIXED - WHITE/BLACK CARIBBEAN	8	5	63%
OTHER ETHNIC GROUP - ANY OTHER	23	11	48%
OTHER ETHNIC GROUP - ARAB	Below 5	0	0%
WHITE - BRITISH	4474	2023	45%
WHITE - IRISH	25	8	32%
WHITE - OTHER	86	44	51%
EASTERN EUROPEAN	Below 5	0	0%
UNKNOWN	992	327	33%
WHITE - GYPSY OR IRISH TRAVELLER	5	Below 5	40%



AMH/MHSOP PROM

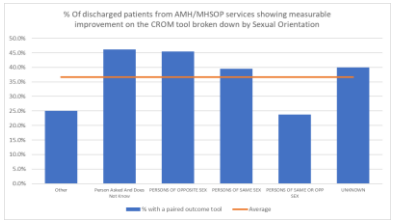
Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	0	0%
ASIAN/ASIAN BRITISH CHINESE	6	0	0%
ASIAN/ASIAN BRITISH INDIAN	6	Below 5	17%
ASIAN/ASIAN BRITISH OTHER	Below 5	Below 5	75%
ASIAN/ASIAN BRITISH PAKISTANI	Below 5	Below 5	50%
BLACK/BLACK BRITISH AFRICAN	6	0	0%
BLACK/BLACK BRITISH CARIBBEAN	5	Below 5	40%
BLACK/BLACK BRITISH OTHER	Below 5	Below 5	33%
MIXED - OTHER	17	6	35%
MIXED - WHITE AND ASIAN	7	Below 5	43%
MIXED - WHITE/BLACK AFRICAN	Below 5	Below 5	33%
MIXED - WHITE/BLACK CARIBBEAN	7	Below 5	57%
OTHER ETHNIC GROUP - ANY OTHER	23	5	22%
OTHER ETHNIC GROUP - ARAB	Below 5	0	0%
WHITE - BRITISH	4630	1290	28%
WHITE - IRISH	27	5	19%
WHITE - OTHER	89	35	39%
EASTERN EUROPEAN	Below 5	0	0%
UNKNOWN	1077	251	23%
WHITE - GYPSY OR IRISH TRAVELLER	5	Below 5	20%



Sexual Orientation (N.B 'Not age appropriate' and 'Not developmentally appropriate' are not included in the graphs)

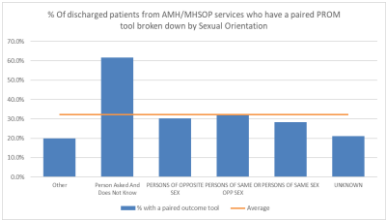
AMH/MHSOP - CROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Other	Below 5	Below 5	25%
Person Asked And Does Not Know	13	6	46%
PERSONS OF OPPOSITE SEX	3636	1653	45%
PERSONS OF SAME SEX	38	15	39%
PERSONS OF SAME OR OPP SEX	97	23	24%
UNKNOWN	1825	730	40%



AMH/MHSOP PROM

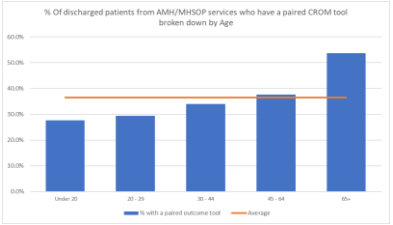
Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Other	5	Below 5	20%
Person Asked And Does Not Know	13	8	62%
PERSONS OF OPPOSITE SEX	3757	1137	30%
PERSONS OF SAME OR OPP SEX	103	33	32%
PERSONS OF SAME SEX	39	11	28%
UNKNOWN	1941	409	21%



Age

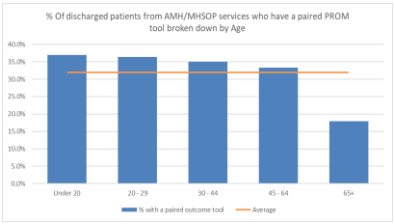
AMH/MHSOP - CROM

Age	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Under 20	217	60	28%
20 - 29	767	225	29%
30 - 44	981	333	34%
45 - 64	1038	391	38%
65+	2670	1434	54%



AMH/MHSOP PROM

Age	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Under 20	230	85	37%
20 - 29	814	296	36%
30 - 44	1067	374	35%
45 - 64	1118	372	33%
65+	2693	483	18%

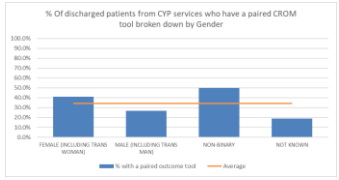


Clinical outcomes - Measureable improvement for North Yorkshire, York and Selby services

Gender

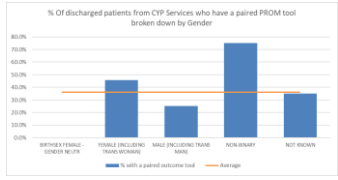
CYP - CROM

Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
FEMALE (INCLUDING TRANS WOMAN)	1169	481	41%
MALE (INCLUDING TRANS MAN)	801	213	27%
NON-BINARY	Below 5	Below 5	50%
NOT KNOWN	16	Below 5	19%



CYP - PROM

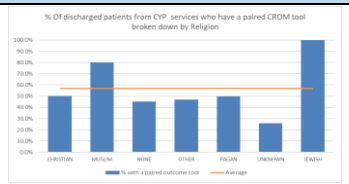
Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BIRTHSEX FEMALE - GENDER NEUTR	Below 5	0	0%
FEMALE (INCLUDING TRANS WOMAN)	1320	605	46%
MALE (INCLUDING TRANS MAN)	842	212	25%
NON-BINARY	Below 5	Below 5	75%
NOT KNOWN	20	7	35%



Religion

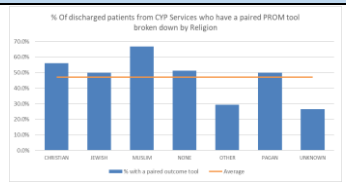
CYP - CROM

Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
CHRISTIAN	346	174	50%
MUSLIM	5	Below 5	80%
NONE	473	214	45%
OTHER	17	8	47%
PAGAN	Below 5	Below 5	50%
UNKNOWN	1146	297	26%
JEWISH	Below 5	Below 5	100%



CYP - PROM

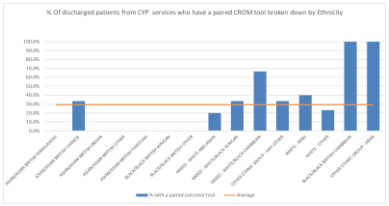
Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
CHRISTIAN	376	211	56%
JEWISH	Below 5	Below 5	50%
MUSLIM	6	Below 5	67%
NONE	532	273	51%
OTHER	17	5	29%
PAGAN	Below 5	Below 5	50%
UNKNOWN	1252	332	27%



Ethnicity

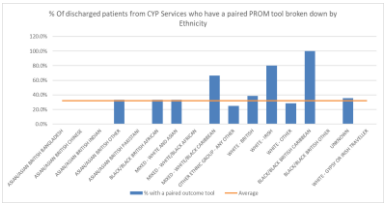
CYP - CROM

Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	0	0%
ASIAN/ASIAN BRITISH CHINESE	6	Below 5	33%
ASIAN/ASIAN BRITISH INDIAN	Below 5	0	0%
ASIAN/ASIAN BRITISH OTHER	Below 5	0	0%
ASIAN/ASIAN BRITISH PAKISTANI	Below 5	0	0%
BLACK/BLACK BRITISH AFRICAN	Below 5	0	0%
BLACK/BLACK BRITISH OTHER	Below 5	0	0%
MIXED - OTHER	17	Below 5	12%
MIXED - WHITE AND ASIAN	5	Below 5	20%
MIXED - WHITE/BLACK AFRICAN	6	Below 5	33%
MIXED - WHITE/BLACK CARIBBEAN	Below 5	Below 5	67%
OTHER ETHNIC GROUP - ANY OTHER	6	Below 5	33%
WHITE - BRITISH	1691	601	36%
WHITE - IRISH	5	Below 5	40%
WHITE - OTHER	39	9	23%
BLACK/BLACK BRITISH CARIBBEAN	Below 5	Below 5	100%
OTHER ETHNIC GROUP - ARAB	Below 5	Below 5	100%



CYP - PROM

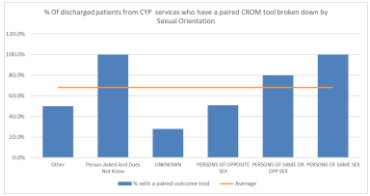
Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	0	0%
ASIAN/ASIAN BRITISH CHINESE	6	0	0%
ASIAN/ASIAN BRITISH INDIAN	Below 5	0	0%
ASIAN/ASIAN BRITISH OTHER	Below 5	Below 5	33%
ASIAN/ASIAN BRITISH PAKISTANI	Below 5	0	0%
BLACK/BLACK BRITISH AFRICAN	Below 5	Below 5	33%
MIXED - OTHER	17	5	29%
MIXED - WHITE AND ASIAN	6	Below 5	33%
MIXED - WHITE/BLACK AFRICAN	6	0	0%
MIXED - WHITE/BLACK CARIBBEAN	Below 5	Below 5	67%
OTHER ETHNIC GROUP - ANY OTHER	8	Below 5	25%
OTHER ETHNIC GROUP - ARAB	Below 5	Below 5	100%
WHITE - BRITISH	1850	714	39%
WHITE - IRISH	5	Below 5	80%
WHITE - OTHER	42	12	29%
BLACK/BLACK BRITISH CARIBBEAN	Below 5	Below 5	100%
BLACK/BLACK BRITISH OTHER	Below 5	0	0%
UNKNOWN	230	82	36%
WHITE - GYPSY OR IRISH TRAVELLER	Below 5	0	0%



Sexual Orientation (N.B 'Not age appropriate', 'Person asked and does not know' and 'Not developmentally appropriate' are not included in the graphs)

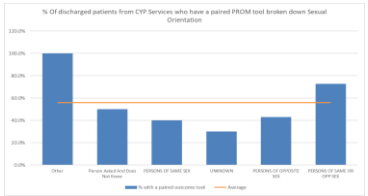
CYP - CROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	1342	497	37%
Other	Below 5	Below 5	50%
Person Asked And Does Not Know	Below 5	Below 5	100%
UNKNOWN	539	150	28%
Not Developmentally Appropriate	39	12	31%
PERSONS OF OPPOSITE SEX	55	28	51%
PERSONS OF SAME OR OPP SEX	10	8	80%
PERSONS OF SAME SEX	Below 5	Below 5	100%



CYP - PROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	1459	599	41%
Other	Below 5	Below 5	100%
Person Asked And Does Not Know	Below 5	Below 5	50%
PERSONS OF SAME SEX	5	Below 5	40%
UNKNOWN	594	178	30%
Not Developmentally Appropriate	44	7	16%
PERSONS OF OPPOSITE SEX	70	30	43%
PERSONS OF SAME OR OPP SEX	11	8	73%

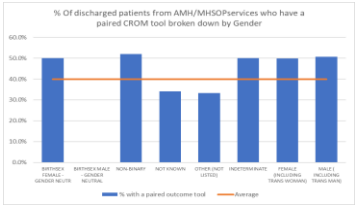


Clinical outcomes - Measureable improvement for the Trust

Gender

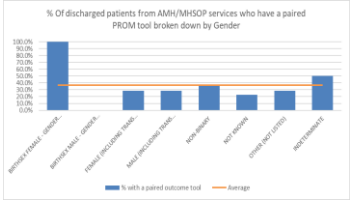
AMH/MHSOP - CROM

Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BIRTHSEX FEMALE - GENDER NEUTR	Below 5	Below 5	50%
BIRTHSEX MALE - GENDER NEUTRAL	Below 5	0	0%
NON-BINARY	25	13	52%
NOT KNOWN	141	48	34%
OTHER (NOT LISTED)	6	Below 5	33%
INDETERMINATE	Below 5	Below 5	50%
FEMALE (INCLUDING TRANS WOMAN)	8824	4403	50%
MALE (INCLUDING TRANS MAN)	6500	3298	51%



AMH/MHSOP PROM

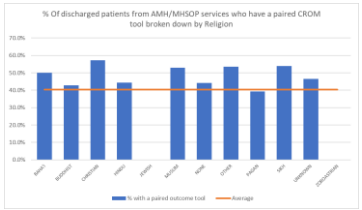
Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BIRTHSEX FEMALE - GENDER NEUTR	Below 5	Below 5	100%
BIRTHSEX MALE - GENDER NEUTRAL	Below 5	0	0%
FEMALE (INCLUDING TRANS WOMAN)	9334	2637	28%
MALE (INCLUDING TRANS MAN)	7079	2004	28%
NON-BINARY	24	9	38%
NOT KNOWN	208	47	23%
OTHER (NOT LISTED)	7	Below 5	29%
INDETERMINATE	Below 5	Below 5	50%



Religion

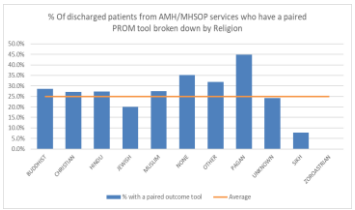
AMH/MHSOP - CROM

Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BAHA'I	Below 5	Below 5	50%
BUDDHIST	28	12	43%
CHRISTIAN	5775	3306	57%
HINDU	9	Below 5	44%
JEWISH	5	0	0%
MUSLIM	100	53	53%
NONE	3873	1711	44%
OTHER	359	192	53%
PAGAN	28	11	39%
SIKH	13	7	54%
UNKNOWN	5310	2470	47%
ZOROASTRIAN	Below 5	0	0%



AMH/MHSOP PROM

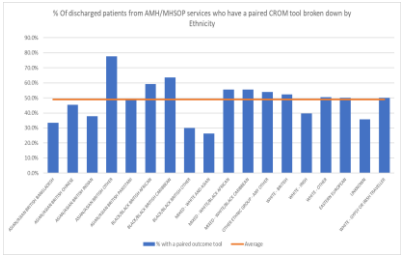
Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BUDDHIST	28	8	29%
CHRISTIAN	6001	1629	27%
HINDU	11	Below 5	27%
JEWISH	5	Below 5	20%
MUSLIM	113	31	27%
NONE	4214	1480	35%
OTHER	376	120	32%
PAGAN	29	13	45%
UNKNOWN	5867	1417	24%
SIKH	13	Below 5	8%
ZOROASTRIAN	Below 5	0	0%



Ethnicity

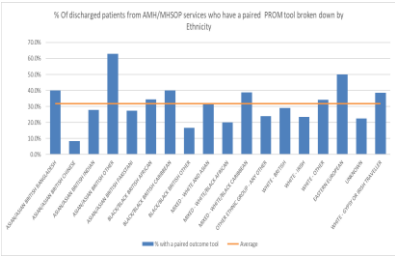
AMH/MHSOP - CROM

Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	9	Below 5	33%
ASIAN/ASIAN BRITISH CHINESE	11	5	45%
ASIAN/ASIAN BRITISH INDIAN	37	14	38%
ASIAN/ASIAN BRITISH OTHER	27	21	78%
ASIAN/ASIAN BRITISH PAKISTANI	49	24	49%
BLACK/BLACK BRITISH AFRICAN	27	16	59%
BLACK/BLACK BRITISH CARIBBEAN	11	7	64%
BLACK/BLACK BRITISH OTHER	10	Below 5	30%
MIXED - OTHER	42	23	55%
MIXED - WHITE AND ASIAN	19	5	26%
MIXED - WHITE/BLACK AFRICAN	9	5	56%
MIXED - WHITE/BLACK CARIBBEAN	18	10	56%
OTHER ETHNIC GROUP - ANY OTHER	65	35	54%
OTHER ETHNIC GROUP - ARAB	14	8	57%
WHITE - BRITISH	12946	6769	52%
WHITE - IRISH	48	19	40%
WHITE - OTHER	174	88	51%
EASTERN EUROPEAN	Below 5	Below 5	50%
UNKNOWN	1973	705	36%
WHITE - GYPSY OR IRISH TRAVELLER	12	6	50%



AMH/MHSOP PROM

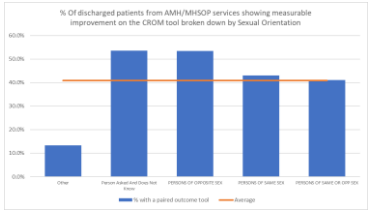
Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	10	Below 5	40%
ASIAN/ASIAN BRITISH CHINESE	12	Below 5	8%
ASIAN/ASIAN BRITISH INDIAN	43	12	28%
ASIAN/ASIAN BRITISH OTHER	27	17	63%
ASIAN/ASIAN BRITISH PAKISTANI	55	15	27%
BLACK/BLACK BRITISH AFRICAN	29	10	34%
BLACK/BLACK BRITISH CARIBBEAN	10	Below 5	40%
BLACK/BLACK BRITISH OTHER	12	Below 5	17%
MIXED - OTHER	45	15	33%
MIXED - WHITE AND ASIAN	22	7	32%
MIXED - WHITE/BLACK AFRICAN	10	Below 5	20%
MIXED - WHITE/BLACK CARIBBEAN	18	7	39%
OTHER ETHNIC GROUP - ANY OTHER	75	18	24%
OTHER ETHNIC GROUP - ARAB	19	Below 5	16%
WHITE - BRITISH	13731	3993	29%
WHITE - IRISH	51	12	24%
WHITE - OTHER	181	62	34%
EASTERN EUROPEAN	Below 5	Below 5	50%
UNKNOWN	2295	514	22%
WHITE - GYPSY OR IRISH TRAVELLER	13	5	38%



Sexual Orientation (XLS 'Not age appropriate' and 'Not developmentally appropriate' are not included in the graphs)

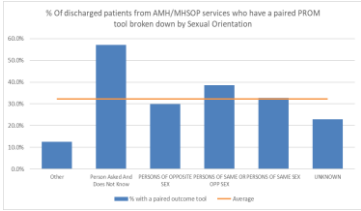
AMH/MHSOP - CROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	102	34	33%
Not Developmentally Appropriate	21	7	33%
Other	15	Below 5	13%
Person Asked And Does Not Know	28	15	54%
PERSONS OF OPPOSITE SEX	11127	5951	53%
PERSONS OF SAME SEX	114	49	43%
PERSONS OF SAME OR OPP SEX	265	109	41%



AMH/MHSOP PROM

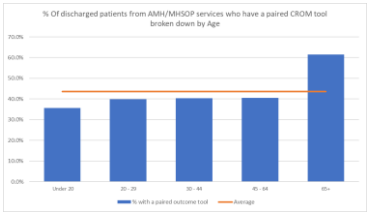
Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	112	23	21%
Not Developmentally Appropriate	22	5	23%
Other	16	Below 5	13%
Person Asked And Does Not Know	28	16	57%
PERSONS OF OPPOSITE SEX	11798	3529	30%
PERSONS OF SAME OR OPP SEX	288	111	39%
PERSONS OF SAME SEX	128	42	33%
UNKNOWN	4268	976	23%



Age

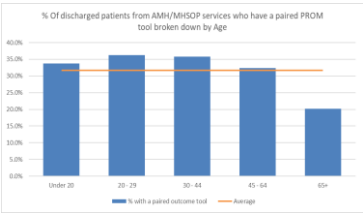
AMH/MHSOP - CROM

Age	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Under 20	528	189	36%
20 - 29	2085	831	40%
30 - 44	2784	1122	40%
45 - 64	2805	1138	41%
65+	7300	4487	61%



AMH/MHSOP PROM

Age	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Under 20	573	193	34%
20 - 29	2342	850	36%
30 - 44	3215	1150	36%
45 - 64	3139	1017	32%
65+	7391	1494	20%

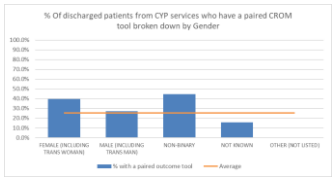


Clinical outcomes - Measureable improvement for the Trust

Gender

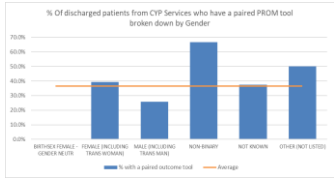
CYP - CROM

Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
FEMALE (INCLUDING TRANS WOMAN)	3521	1393	40%
MALE (INCLUDING TRANS MAN)	2201	599	27%
NON-BINARY	9	Below 5	44%
NOT KNOWN	38	6	16%
OTHER (NOT LISTED)	Below 5	0	0%



CYP - PROM

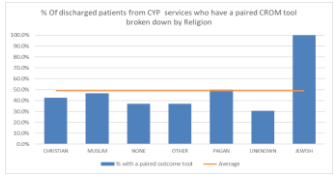
Gender	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
BIRTHSEX FEMALE - GENDER NEUTR	Below 5	0	0%
FEMALE (INCLUDING TRANS WOMAN)	3911	1541	39%
MALE (INCLUDING TRANS MAN)	2375	611	26%
NON-BINARY	9	6	67%
NOT KNOWN	48	18	38%
OTHER (NOT LISTED)	Below 5	Below 5	50%



Religion

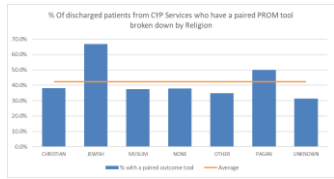
CYP - CROM

Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
CHRISTIAN	900	382	42%
MUSLIM	15	7	47%
NONE	1503	556	37%
OTHER	423	156	37%
PAGAN	Below 5	Below 5	50%
UNKNOWN	2927	899	31%
JEWISH	Below 5	Below 5	100%



CYP - PROM

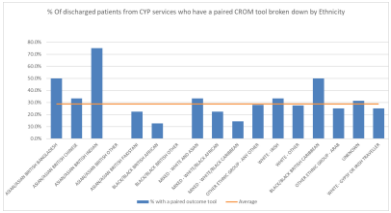
Religion	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
CHRISTIAN	979	372	38%
JEWISH	Below 5	Below 5	67%
MUSLIM	16	6	38%
NONE	1648	625	38%
OTHER	452	157	35%
PAGAN	Below 5	Below 5	50%
UNKNOWN	3246	1014	31%



Ethnicity

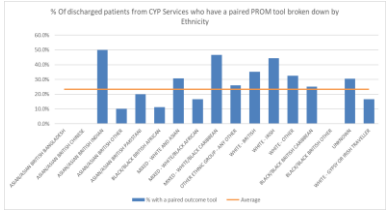
CYP - CROM

Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	Below 5	50%
ASIAN/ASIAN BRITISH CHINESE	9	Below 5	33%
ASIAN/ASIAN BRITISH INDIAN	8	6	75%
ASIAN/ASIAN BRITISH OTHER	8	0	0%
ASIAN/ASIAN BRITISH PAKISTANI	9	Below 5	22%
BLACK/BLACK BRITISH AFRICAN	8	Below 5	13%
BLACK/BLACK BRITISH OTHER	Below 5	0	0%
MIXED - OTHER	44	11	25%
MIXED - WHITE AND ASIAN	12	Below 5	33%
MIXED - WHITE/BLACK AFRICAN	18	Below 5	22%
MIXED - WHITE/BLACK CARIBBEAN	14	Below 5	14%
OTHER ETHNIC GROUP - ANY OTHER	25	7	28%
WHITE - BRITISH	4993	1770	35%
WHITE - IRISH	9	Below 5	33%
WHITE - OTHER	69	19	28%
BLACK/BLACK BRITISH CARIBBEAN	Below 5	Below 5	50%
OTHER ETHNIC GROUP - ARAB	Below 5	Below 5	25%
UNKNOWN	530	166	31%
WHITE - GYPSY OR IRISH TRAVELLER	Below 5	Below 5	25%



CYP - PROM

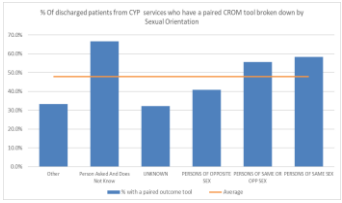
Ethnicity	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
ASIAN/ASIAN BRITISH BANGLADESH	Below 5	0	0%
ASIAN/ASIAN BRITISH CHINESE	9	0	0%
ASIAN/ASIAN BRITISH INDIAN	8	Below 5	50%
ASIAN/ASIAN BRITISH OTHER	10	Below 5	10%
ASIAN/ASIAN BRITISH PAKISTANI	10	Below 5	20%
BLACK/BLACK BRITISH AFRICAN	9	Below 5	11%
MIXED - OTHER	49	14	29%
MIXED - WHITE AND ASIAN	13	Below 5	31%
MIXED - WHITE/BLACK AFRICAN	18	Below 5	17%
MIXED - WHITE/BLACK CARIBBEAN	15	7	47%
OTHER ETHNIC GROUP - ANY OTHER	27	7	26%
OTHER ETHNIC GROUP - ARAB	5	Below 5	20%
WHITE - BRITISH	5462	1916	35%
WHITE - IRISH	9	Below 5	44%
WHITE - OTHER	74	24	32%
BLACK/BLACK BRITISH CARIBBEAN	Below 5	Below 5	25%
BLACK/BLACK BRITISH OTHER	Below 5	0	0%
UNKNOWN	612	187	31%
WHITE - GYPSY OR IRISH TRAVELLER	6	Below 5	17%



Sexual Orientation (N.B 'Not age appropriate', 'Person asked and does not know' and 'Not developmentally appropriate' are not included in the graphs)

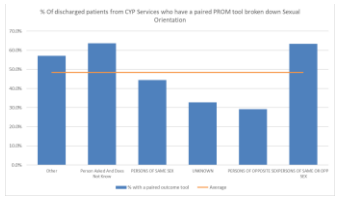
CYP - CROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	2921	1053	36%
Other	6	Below 5	33%
Person Asked And Does Not Know	9	6	67%
UNKNOWN	2247	722	32%
Not Developmentally Appropriate	246	73	30%
PERSONS OF OPPOSITE SEX	303	124	41%
PERSONS OF SAME OR OPP SEX	27	15	56%
PERSONS OF SAME SEX	12	7	58%



CYP - PROM

Sexual Orientation	Number discharged	Number discharged with a paired outcome tool	% discharged with a paired outcome tool
Not Age Appropriate	3166	1149	36%
Other	7	Below 5	57%
Person Asked And Does Not Know	11	7	64%
PERSONS OF SAME SEX	18	8	44%
UNKNOWN	2497	817	33%
Not Developmentally Appropriate	271	72	27%
PERSONS OF OPPOSITE SEX	346	101	29%
PERSONS OF SAME OR OPP SEX	30	19	63%



Mental Health Act Detentions Data Logic

Included	
Type	**Description**
2	The individual has a mental disorder. They need to be detained for a short time for assessment and possibly medical treatment. It is necessary for their own health or safety or for the protection of other people. This section is up to 28 days and may be assessed at the end of this time to see if sectioning under Section 3 is needed.
3	The individual has a mental disorder. They need to be detained for their own health or safety or for the protection of other people and if treatment can't be given unless they are detained in hospital. This section can last up to 6 months and can be renewed and extended.
37, 37N and 37/41	This is also called a 'hospital order' made by the Crown/Magistrates Court. If they think that the individual should be in hospital instead of prison. This section can last up to 6 months and can be renewed.
47/49	A sentenced prisoner who was handed down a custodial sentence but later been transferred to a hospital on the recommendation of two doctors that they need treatment for mental disorder. This section can last up to 6 months and can be renewed.
48/49	A prisoner on remand without sentence but is in the course of waiting for their hearing/trial or sentencing and have been transferred to a hospital on the recommendation of two doctors that they need treatment for mental disorder.

Excluded	
Type	**Description**
135	If there is reasonable cause to suspect that an individual has a mental disorder. A magistrate can issue a warrant authorising the police with a mental health professional to enter any premises where the individual is believed to be and take them to a place of safety. This section can last up to 24 hours (can be extended to 36 hours in some circumstances).
136	If it appears to the police that the individual has a mental disorder and are "in need of immediate care or control" they can take you to a place of safety. The individual is then kept in this place until they are examined by a doctor and interviewed by an approved mental health professional. This section can last up to 24 hours (can be extended to 36 hours in some circumstances).
4	The individual has a mental disorder. It is urgently necessary for them to be admitted to hospital and detained, and waiting for a second doctor to confirm that they need to be admitted to hospital on a section 2 would cause "undesirable delay". This section can last up to 72 hours.
5(2)	This gives doctors the ability to detain someone in hospital for up to 72 hours, during which time they should receive an assessment that decides if further detention under the Mental Health Act is necessary. This section can last up to 72 hours.
5(4)	This is a legal power that allows a nurse to keep you in hospital until they have been seen by the person in charge of your treatment, or their deputy. The nurse believes they have a mental disorder and are not well enough to leave. This section can last up to 6 hours.
36	This section empowers the Crown Court to order someone to be admitted to a hospital for treatment of a mental disorder if they believe it is necessary. The court can use this section at any point during a court case if they think the person needs to be in hospital for treatment.
Community Treatment Orders	A Community Treatment Order (CTO) allows individuals who have been detained in a hospital for mental health treatment to be treated in the community under specific conditions, with the possibility of being recalled to hospital if necessary.

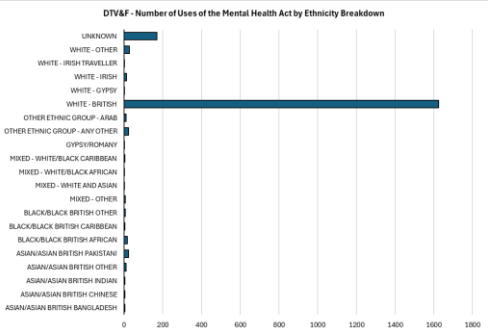
Report Logic - Included Detentions	
1	Any detentions with a start date within the stated period (e.g. April 2024 - March 2025)

Detention Rates - Durham, Tees valley and Forensics

Ethnicity

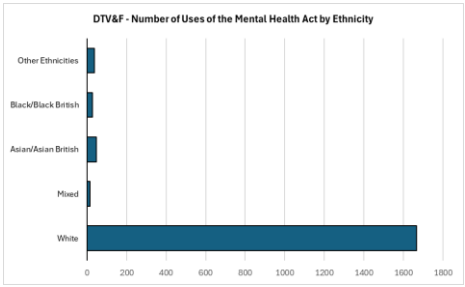
Ethnicity - Ungrouped

Ethnicity	NO. DETENTIONS
ASIAN/ASIAN BRITISH BANGLADESH	Below 5
ASIAN/ASIAN BRITISH CHINESE	5
ASIAN/ASIAN BRITISH INDIAN	5
ASIAN/ASIAN BRITISH OTHER	10
ASIAN/ASIAN BRITISH PAKISTANI	24
BLACK/BLACK BRITISH AFRICAN	17
BLACK/BLACK BRITISH CARIBBEAN	Below 5
BLACK/BLACK BRITISH OTHER	7
MIXED - OTHER	6
MIXED - WHITE AND ASIAN	Below 5
MIXED - WHITE/BLACK AFRICAN	Below 5
MIXED - WHITE/BLACK CARIBBEAN	5
GYPSY/ROMANY	Below 5
OTHER ETHNIC GROUP - ANY OTHER	24
OTHER ETHNIC GROUP - ARAB	10
WHITE - BRITISH	1625
WHITE - GYPSY	Below 5
WHITE - IRISH	12
WHITE - IRISH TRAVELLER	Below 5
WHITE - OTHER	27
UNKNOWN	169



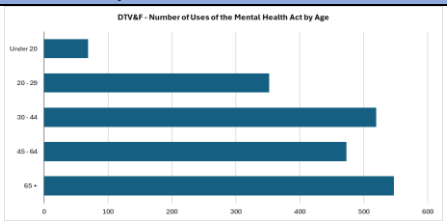
Ethnicity - grouped to match census data

	ETHNICITY	NO. DETENTIONS
Matches Census Ethnicity Breakdown	White	1668
	Mixed	14
	Asian/Asian British	47
	Black/Black British	27
	Other Ethnicities	36



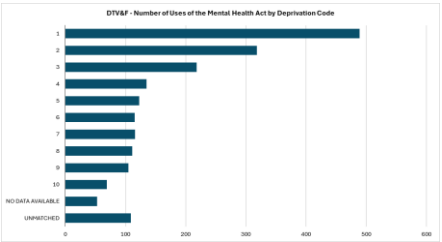
Age

	AGE GROUP	NO. DETENTIONS
Matches Census Age Breakdown	Under 20	69
	20 - 29	352
	30 - 44	519
	45 - 64	473
	65 +	547



Areas of deprivation

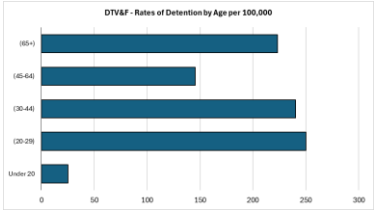
DEPRIVATION CODE	Grand Total
1	489
2	318
3	218
4	135
5	123
6	115
7	116
8	111
9	105
10	69
NO DATA AVAILABLE	53
UNMATCHED	109



Rates per 100,000

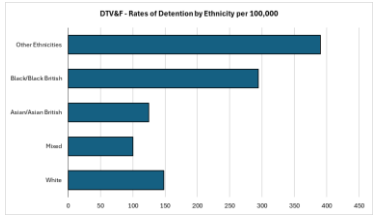
Age

AGE GROUP	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
Under 20	69	25.3	273000
(20-29)	352	250.2	140700
(30-44)	519	240.4	215900
(45-64)	473	145.5	325100
(65+)	547	223.1	245200



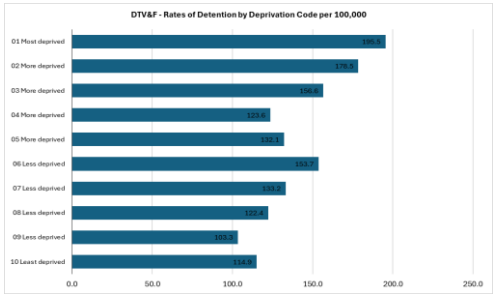
Ethnicity

ETHNICITY	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
White	1668	147.7	1129136
Mixed	14	99.9	14015
Asian/Asian British	47	124.7	37702
Black/Black British	27	294.4	9170
Other Ethnicities	36	390.3	9223



Deprivation Code

DEPRIVATION CODE	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
01 Most deprived	489	195.5	250083
02 More deprived	318	178.5	178176
03 More deprived	218	156.6	139231
04 More deprived	135	123.6	109181
05 More deprived	123	132.1	93125
06 Less deprived	115	153.7	74828
07 Less deprived	116	133.2	87081
08 Less deprived	111	122.4	90690
09 Less deprived	105	103.3	101662
10 Least deprived	69	114.9	60034

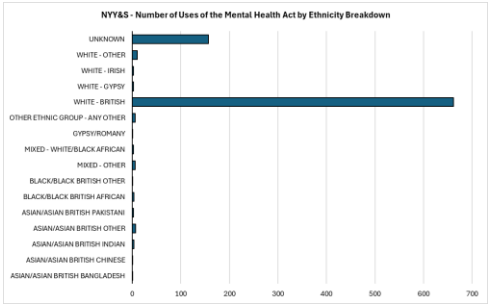


Detention Rates - North Yorkshire, York and Selby

Ethnicity

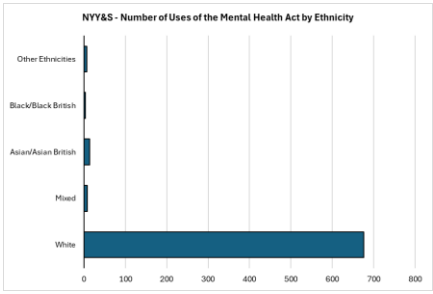
Ethnicity - Ungrouped

Ethnicity	NO. DETENTIONS
ASIAN/ASIAN BRITISH BANGLADESH	Below 5
ASIAN/ASIAN BRITISH CHINESE	Below 5
ASIAN/ASIAN BRITISH INDIAN	Below 5
ASIAN/ASIAN BRITISH OTHER	7
ASIAN/ASIAN BRITISH PAKISTANI	Below 5
BLACK/BLACK BRITISH AFRICAN	Below 5
BLACK/BLACK BRITISH OTHER	Below 5
MIXED - OTHER	6
MIXED - WHITE/BLACK AFRICAN	Below 5
GYPSY/ROMANY	Below 5
OTHER ETHNIC GROUP - ANY OTHER	6
WHITE - BRITISH	662
WHITE - GYPSY	Below 5
WHITE - IRISH	Below 5
WHITE - OTHER	10
UNKNOWN	157



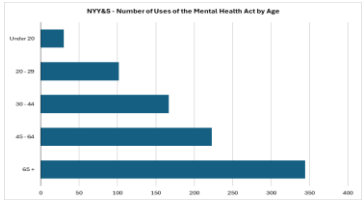
Ethnicity - grouped to match census data

	ETHNICITY	NO. DETENTIONS
Matches Census Ethnicity Breakdown	White	676
	Mixed	8
	Asian/Asian British	14
	Black/Black British	Below 5
	Other Ethnicities	7



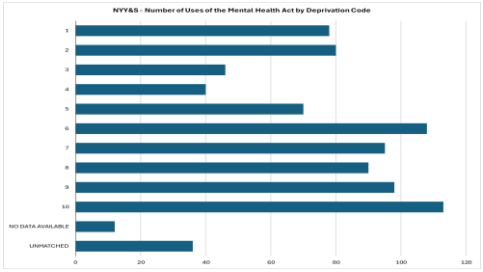
Age

	AGE GROUP	NO. DETENTIONS
Matches Census Age Breakdown	Under 20	30
	20 - 29	102
	30 - 44	167
	45 - 64	223
	65 +	344



Areas of deprivation

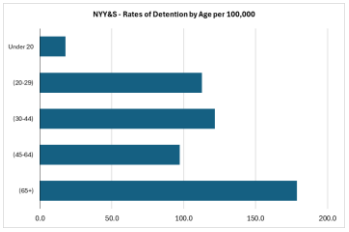
DEPRIVATION CODE	Grand Total
1	78
2	80
3	46
4	40
5	70
6	108
7	95
8	90
9	98
10	113
NO DATA AVAILABLE	12
UNMATCHED	36



Rates per 100,000

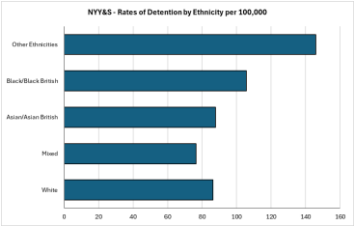
Age

AGE GROUP	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
Under 20	30	17.8	168600
(20-29)	102	112.6	90600
(30-44)	167	121.7	137200
(45-64)	223	97.3	229200
(65+)	344	178.7	192500



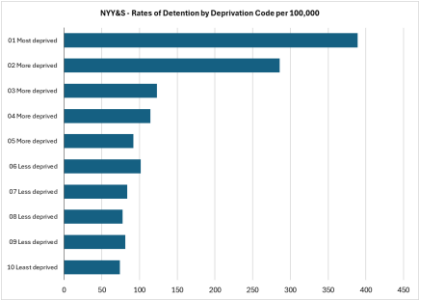
Ethnicity

ETHNICITY	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
White	676	86.3	783322
Mixed	8	76.5	10463
Asian/Asian British	14	87.8	15954
Black/Black British	Below 5	105.7	3784
Other Ethnicities	7	145.9	4797



Deprivation Code

DEPRIVATION CODE	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
01 Most deprived	78	389.3	20035
02 More deprived	80	285.8	27994
03 More deprived	46	122.9	37427
04 More deprived	40	114.1	35046
05 More deprived	70	92.0	76052
06 Less deprived	108	101.3	106583
07 Less deprived	95	83.9	113272
08 Less deprived	90	77.4	116348
09 Less deprived	98	80.9	121170
10 Least deprived	113	74.1	152485

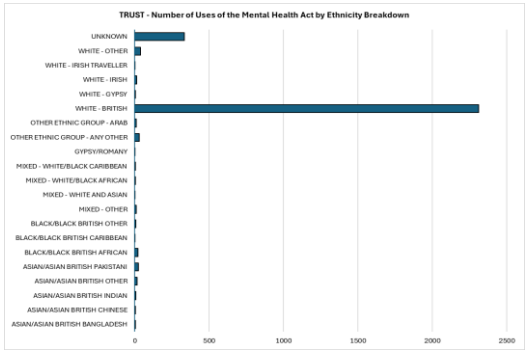


Detention Rates - Trust

Ethnicity

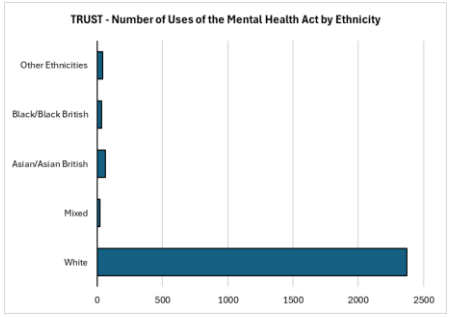
Ethnicity - Ungrouped

Ethnicity	NO. DETENTIONS
ASIAN/ASIAN BRITISH BANGLADESH	Below 5
ASIAN/ASIAN BRITISH CHINESE	6
ASIAN/ASIAN BRITISH INDIAN	9
ASIAN/ASIAN BRITISH OTHER	17
ASIAN/ASIAN BRITISH PAKISTANI	26
BLACK/BLACK BRITISH AFRICAN	21
BLACK/BLACK BRITISH CARIBBEAN	Below 5
BLACK/BLACK BRITISH OTHER	9
MIXED - OTHER	12
MIXED - WHITE AND ASIAN	Below 5
MIXED - WHITE/BLACK AFRICAN	Below 5
MIXED - WHITE/BLACK CARIBBEAN	5
GYPSY/ROMANY	Below 5
OTHER ETHNIC GROUP - ANY OTHER	30
OTHER ETHNIC GROUP - ARAB	10
WHITE - BRITISH	2313
WHITE - GYPSY	Below 5
WHITE - IRISH	14
WHITE - IRISH TRAVELLER	Below 5
WHITE - OTHER	38
UNKNOWN	335



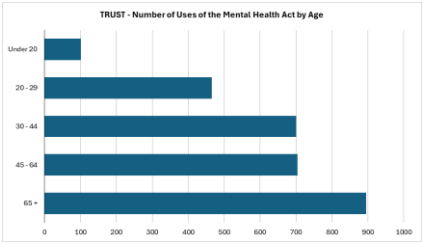
Ethnicity - grouped to match census data

	ETHNICITY	NO. DETENTIONS
Matches Census Ethnicity Breakdown	White	2371
	Mixed	22
	Asian/Asian British	62
	Black/Black British	33
	Other Ethnicities	43



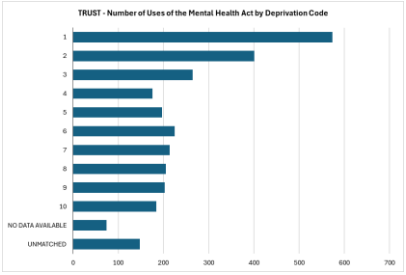
Age

	AGE GROUP	NO. DETENTIONS
Matches Census Age Breakdown	Under 20	101
	20 - 29	465
	30 - 44	700
	45 - 64	704
	65 +	895



Areas of deprivation

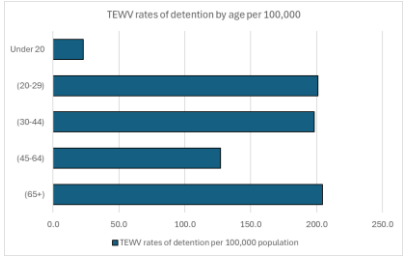
DEPRIVATION CODE	Grand Total
1	574
2	401
3	265
4	176
5	197
6	225
7	214
8	205
9	203
10	184
NO DATA AVAILABLE	74
UNMATCHED	148



Rates per 100,000

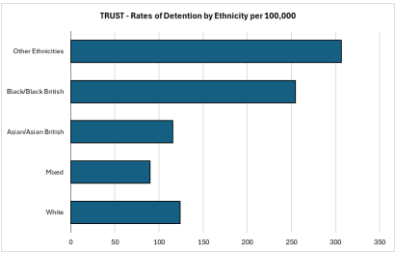
Age

AGE GROUP	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
Under 20	101	22.9	441600
(20-29)	465	201.0	231300
(30-44)	700	198.2	353100
(45-64)	704	127.0	554300
(65+)	895	204.5	437700



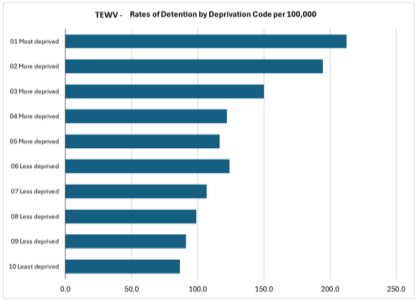
Ethnicity

ETHNICITY	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
White	2371	124.0	1912458
Mixed	22	89.9	24478
Asian/Asian British	62	115.6	53656
Black/Black British	33	254.7	12954
Other Ethnicities	43	306.7	14020



Deprivation Code

DEPRIVATION CODE	Actual numbers of detentions in TEWV	TEWV rates of detention per 100,000 population	CENSUS FIGURES
01 Most deprived	574	212.5	270118
02 More deprived	401	194.5	206170
03 More deprived	265	150.0	176658
04 More deprived	176	122.0	144227
05 More deprived	197	116.4	169177
06 Less deprived	225	124.0	181411
07 Less deprived	214	106.8	200353
08 Less deprived	205	99.0	207038
09 Less deprived	203	91.1	222832
10 Least deprived	184	86.6	212519



Patient Experience - Durham, Tees Valley and Forensic

This tab shows the response rate to the question

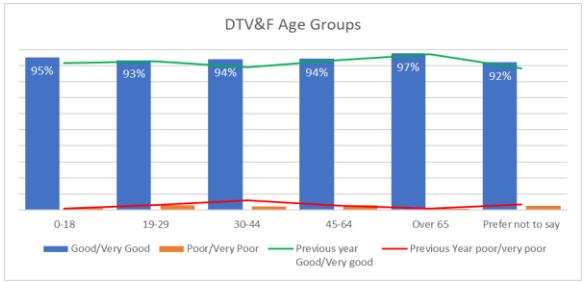
Thinking about your recent appointment overall, how was your experience of our service? Answer options are; Very good, Good, Neither good nor poor, Poor, Very poor, Don't know

Each graph excludes *'neither good nor poor'* and *'Dont know'* so as to focus on the 'Good' and 'Poor' responses.

Last years repsonses are shown in each graph as a tracked line.

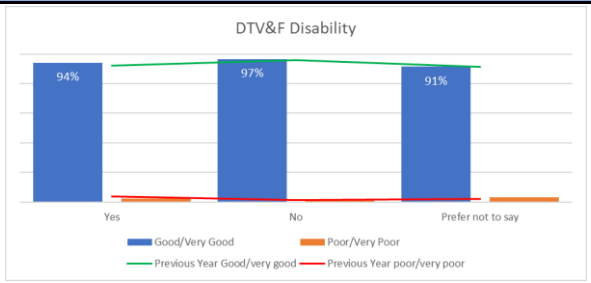
Age

	Response				
Age Groupings	Very Good	Good	Neither good nor poor	Poor	Very poor
0-18	666	469	44	10	Below 5
19-29	422	142	23	8	10
30-44	776	231	39	12	12
45-64	784	212	32	9	20
Over 65	839	127	18	Below 5	Below 5
Prefer not to say	87	28	7	0	Below 5



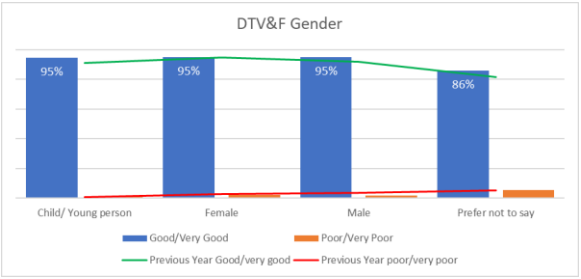
Disability

	Response				
Disability	Very Good	Good	Neither good nor poor	Poor	Very poor
Yes	1812	484	82	27	35
No	1238	345	36	9	8
Prefer not to say	206	93	17	5	6



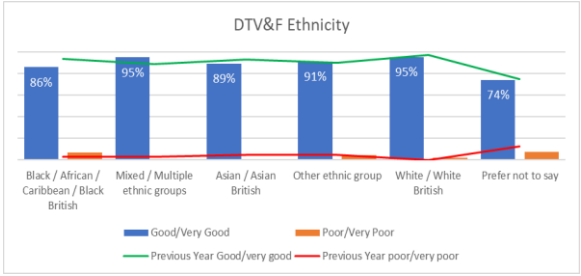
Gender

	Response				
Gender	Very Good	Good	Neither good nor poor	Poor	Very poor
Child/ Young person	289	294	27	Below 5	Below 5
Female	1741	501	66	23	28
Male	1502	385	64	15	18
Prefer not to say	49	32	8	Below 5	Below 5



Ethnicity

	Response				
Ethnicity	Very Good	Good	Neither good nor poor	Poor	Very poor
Black / African / Caribbean / Black British	27	10	Below 5	0	Below 5
Mixed / Multiple ethnic groups	53	26	Below 5	0	0
Asian / Asian British	61	15	9	0	0
Other ethnic group	29	12	Below 5	Below 5	Below 5
White / White British	3110	860	110	38	42
Prefer not to say	18	11	7	Below 5	Below 5



Patient Experience - North Yorkshire, York and Selby

This tab shows the response rate to the question

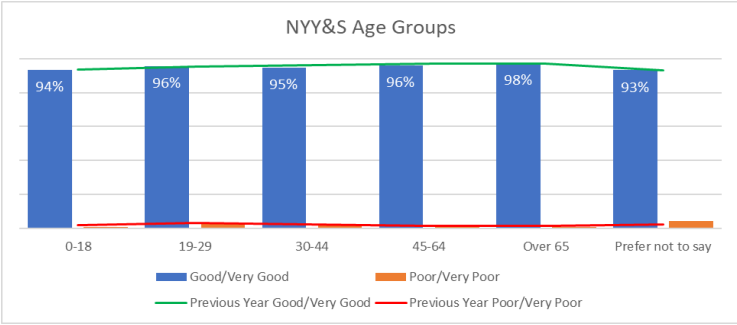
Thinking about your recent appointment overall, how was your experience of our service? Answer options are; Very good, Good, Neither good nor poor, Poor, Very poor, Don't know

Each graph excludes *'neither good nor poor'* and *'Dont know'* so as to focus on the 'Good' and 'Poor' responses.

Last years repsonses are shown in each graph as a tracked line.

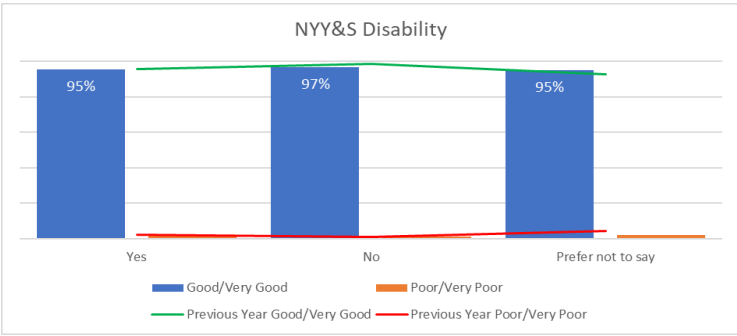
Age

	Response				
Age Groupings	**Very Good**	**Good**	**Neither good nor poor**	**Poor**	**Very poor**
0-18	406	362	46	Below 5	5
19-29	311	57	3	9	Below 5
30-44	379	60	15	Below 5	6
45-64	580	89	16	Below 5	6
Over 65	550	87	10	5	0
Prefer not to say	49	20	Below 5	Below 5	Below 5



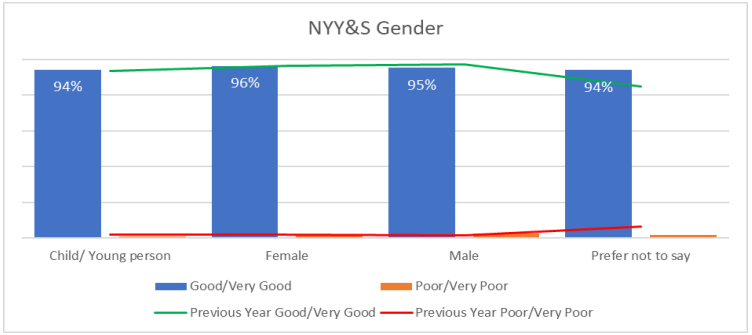
Disability

	Response				
Disability	**Very Good**	**Good**	**Neither good nor poor**	**Poor**	**Very poor**
Yes	947	191	30	12	12
No	886	142	23	8	5
Prefer not to say	111	21	Below 5	Below 5	Below 5



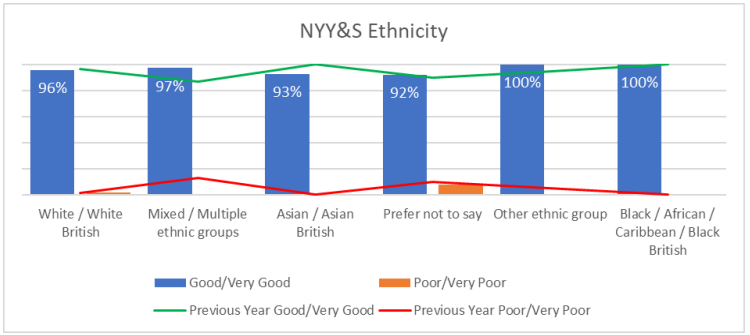
Gender

	Response				
Gender	Very Good	Good	Neither good nor poor	Poor	Very poor
Child/ Young person	289	283	30	Below 5	Below 5
Female	1233	207	34	8	11
Male	725	156	22	15	7
Prefer not to say	35	29	Below 5	0	Below 5



Ethnicity

	Response				
Ethnicity	Very Good	Good	Neither good nor poor	Poor	Very poor
White / White British	1874	341	56	22	17
Mixed / Multiple ethnic groups	31	7	Below 5	0	0
Asian / Asian British	20	5	Below 5	0	0
Prefer not to say	20	Below 5	0	0	Below 5
Other ethnic group	13	Below 5	0	0	0
Black / African / Caribbean / Black British	6	0	0	0	0



Patient Experience - Trust

This tab shows the response rate to the question

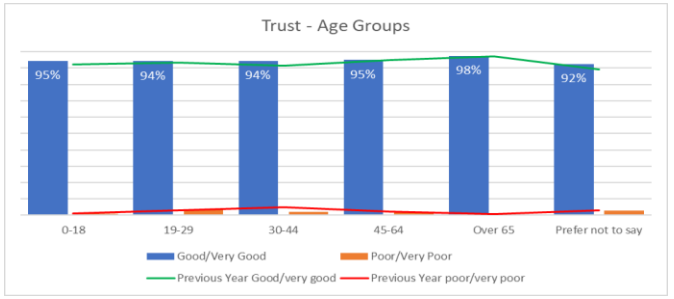
Thinking about your recent appointment overall, how was your experience of our service? Answer options are; Very good, Good, Neither good nor poor, Poor, Very poor, Don't know

Each graph excludes *'neither good nor poor'* and *'Dont know'* so as to focus on the 'Good' and 'Poor' responses.

Last years repsonses are shown in each graph as a tracked line.

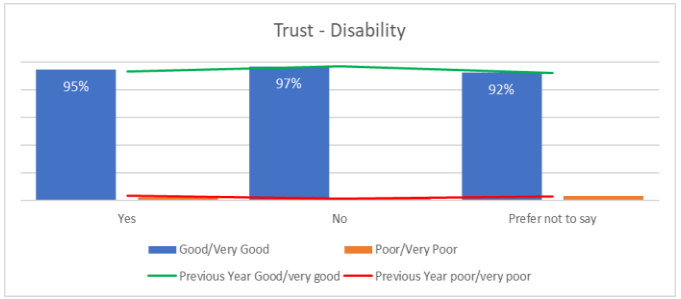
Age

	Response				
Age Groupings	Very Good	Good	Neither good nor poor	Poor	Very poor
0-18	1072	831	90	11	9
19-29	733	199	26	17	14
30-44	1155	291	54	15	18
45-64	1364	301	48	13	26
Over 65	1389	214	28	9	Below 5
Prefer not to say	136	48	9	Below 5	Below 5



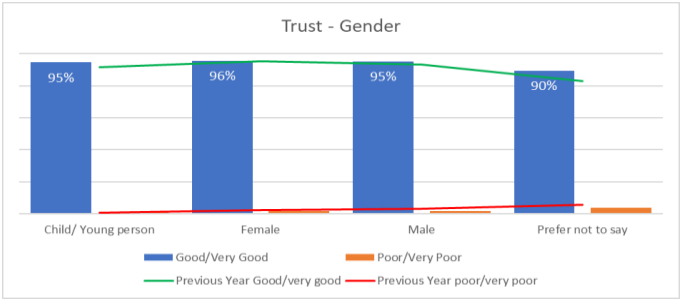
Disability

	Response				
Disability	Very Good	Good	Neither good nor poor	Poor	Very poor
Yes	2759	675	112	39	47
No	2124	487	59	17	13
Prefer not to say	317	114	21	7	7



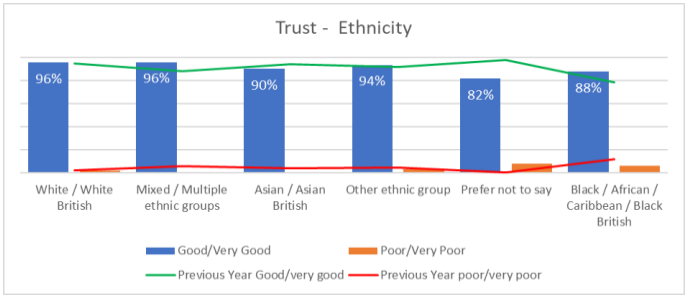
Gender

	Response				
Gender	Very Good	Good	Neither good nor poor	Poor	Very poor
Child/ Young person	578	577	57	Below 5	5
Female	2974	708	100	31	39
Male	2227	541	86	30	25
Prefer not to say	84	61	11	Below 5	5



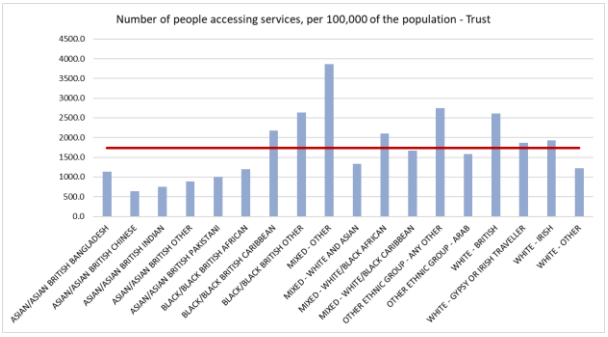
Ethnicity

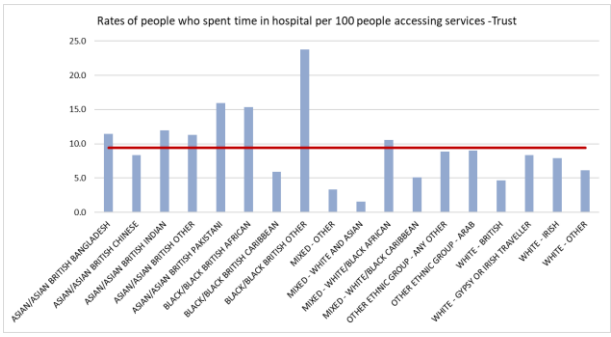
	Response				
Ethnicity	**Very Good**	**Good**	**Neither good nor poor**	**Poor**	**Very poor**
White / White British	4984	1201	166	60	59
Mixed / Multiple ethnic groups	84	33	5	0	0
Asian / Asian British	81	20	11	0	0
Other ethnic group	42	16	Below 5	Below 5	Below 5
Prefer not to say	38	15	7	Below 5	Below 5
Black / African / Caribbean / Black British	33	10	Below 5	0	Below 5



Trust

Ethnicity	Number accessing services	Census data	Crude rate per 100,000	Number who occupied an inpatient bed	Rates of people who spent time in hospital per 100 people accessing services
ASIAN/ASIAN BRITISH BANGLADESH	35	3070	1140.1	Below 5	11.4
ASIAN/ASIAN BRITISH CHINESE	60	9393	638.8	5	8.3
ASIAN/ASIAN BRITISH INDIAN	92	12244	751.4	11	12.0
ASIAN/ASIAN BRITISH OTHER	106	11997	883.6	12	11.3
ASIAN/ASIAN BRITISH PAKISTANI	169	16952	996.9	27	16.0
BLACK/BLACK BRITISH AFRICAN	117	9801	1193.8	18	15.4
BLACK/BLACK BRITISH CARIBBEAN	34	1560	2179.5	Below 5	5.9
BLACK/BLACK BRITISH OTHER	42	1593	2636.5	10	23.8
MIXED - OTHER	239	6195	3857.9	8	3.3
MIXED - WHITE AND ASIAN	127	9494	1337.7	Below 5	1.6
MIXED - WHITE/BLACK AFRICAN	85	4037	2105.5	9	10.6
MIXED - WHITE/BLACK CARIBBEAN	79	4752	1662.5	Below 5	5.1
OTHER ETHNIC GROUP - ANY OTHER	249	9080	2742.3	22	8.8
OTHER ETHNIC GROUP - ARAB	78	4940	1578.9	7	9.0
WHITE - BRITISH	48314	1854483	2605.3	2248	4.7
WHITE - GYPSY OR IRISH TRAVELLER	48	2579	1861.2	Below 5	8.3
WHITE - IRISH	139	7206	1928.9	11	7.9
WHITE - OTHER	571	46863	1218.4	35	6.1

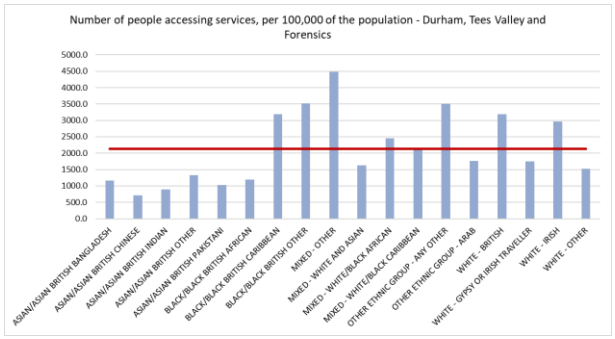


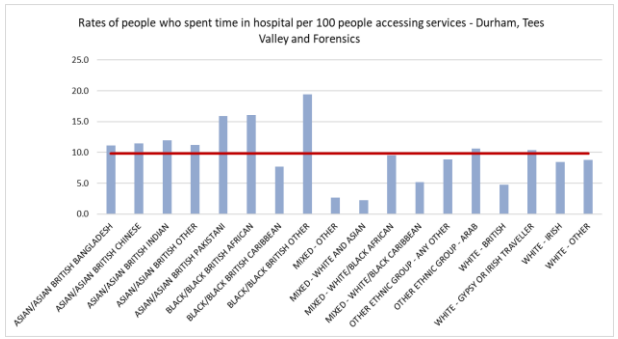


*red line = Average

Durham, Tees Valley and Forensics

Ethnicity	Number accessing services	Census data	Crude rate per 100,000	Number who occupied an inpatient bed	Rates of people who spent time in hospital per 100 people accessing services
ASIAN/ASIAN BRITISH BANGLADESH	27	2326	1160.8	27	11.1
ASIAN/ASIAN BRITISH CHINESE	35	4930	709.9	35	11.4
ASIAN/ASIAN BRITISH INDIAN	75	8360	897.1	75	12.0
ASIAN/ASIAN BRITISH OTHER	89	6716	1325.2	89	11.2
ASIAN/ASIAN BRITISH PAKISTANI	157	15370	1021.5	157	15.9
BLACK/BLACK BRITISH AFRICAN	87	7329	1187.1	87	16.1
BLACK/BLACK BRITISH CARIBBEAN	26	816	3186.3	26	7.7
BLACK/BLACK BRITISH OTHER	36	1025	3512.2	36	19.4
MIXED - OTHER	150	3350	4477.6	150	2.7
MIXED - WHITE AND ASIAN	88	5419	1623.9	88	2.3
MIXED - WHITE/BLACK AFRICAN	63	2561	2460.0	63	9.5
MIXED - WHITE/BLACK CARIBBEAN	58	2685	2160.1	58	5.2
OTHER ETHNIC GROUP - ANY OTHER	192	5468	3511.3	192	8.9
OTHER ETHNIC GROUP - ARAB	66	3755	1757.7	66	10.6
WHITE - BRITISH	35163	1103455	3186.6	35163	4.7
WHITE - GYPSY OR IRISH TRAVELLER	29	1661	1745.9	29	10.3
WHITE - IRISH	95	3208	2961.3	95	8.4
WHITE - OTHER	307	20055	1530.8	307	8.8

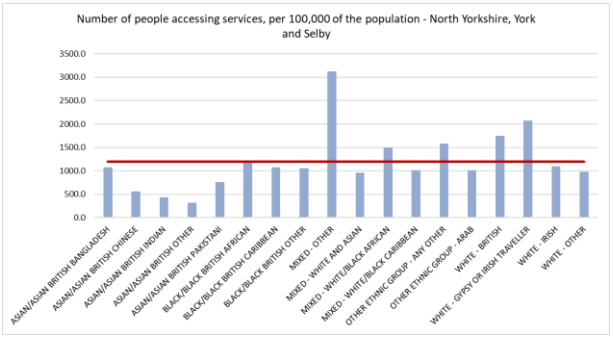


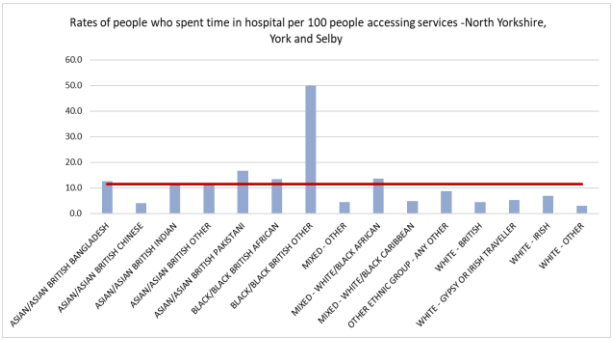


*red line = Average

North Yorkshire, York and Selby

Ethnicity	Number accessing services	Census data	Crude rate per 100,000	Number who occupied an inpatient bed	Rates of people who spent time in hospital per 100 people accessing services
ASIAN/ASIAN BRITISH BANGLADESH	8	744	1075.3	Below 5	12.5
ASIAN/ASIAN BRITISH CHINESE	25	4463	560.2	Below 5	4.0
ASIAN/ASIAN BRITISH INDIAN	17	3884	437.7	Below 5	11.8
ASIAN/ASIAN BRITISH OTHER	17	5281	321.9	Below 5	11.8
ASIAN/ASIAN BRITISH PAKISTANI	12	1582	758.5	Below 5	16.7
BLACK/BLACK BRITISH AFRICAN	30	2472	1213.6	Below 5	13.3
BLACK/BLACK BRITISH CARIBBEAN	8	744	1075.3		
BLACK/BLACK BRITISH OTHER	6	568	1056.3	Below 5	50.0
MIXED - OTHER	89	2845	3128.3	Below 5	4.5
MIXED - WHITE AND ASIAN	39	4075	957.1		
MIXED - WHITE/BLACK AFRICAN	22	1476	1490.5	Below 5	13.6
MIXED - WHITE/BLACK CARIBBEAN	21	2067	1016.0	Below 5	4.8
OTHER ETHNIC GROUP - ANY OTHER	57	3612	1578.1	5	8.8
OTHER ETHNIC GROUP - ARAB	12	1185	1012.7		
WHITE - BRITISH	13151	751028	1751.1	578	4.4
WHITE - GYPSY OR IRISH TRAVELLER	19	918	2069.7	Below 5	5.3
WHITE - IRISH	44	3998	1100.6	Below 5	6.8
WHITE - OTHER	264	26808	984.8	8	3.0





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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9 October 2025**
Title:	**Leadership Walkabouts Feedback – August 2025**
Executive	**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 summarised feedback from leadership walkabouts that took place in August 2025.

Proposal*:*
This report is presented to Board as good assurance. Full feedback reports are received by Management Group 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 18 August 2025 across several service areas. These are summarised as follows.

<u>Group 1 - Secure Outreach Transitions Team (SOTT): Durham Tees Valley. Roseberry Park</u>
The Secure Outreach Transitions Team (SOTT) provides multi-professional, flexible, and compassionate support for patients transitioning from inpatient secure services to community settings, covering Durham Tees Valley and addressing complex needs including learning disabilities and autism. The team emphasises partnership work, patient-centred care, and continuous staff development.

- **Team strengths:** The team is proud of its experience, professionalism, multi-disciplinary

approach, strong internal support, and ability to provide individualized, flexible patient care. Low staff turnover reflects good team support and leadership.

- **Maximising strengths:** Clearer communication about the team's role, promotion of services, team-building activities, and prioritising staff wellbeing. Educational materials and outreach efforts are being developed to clarify the team's remit internally and externally.
- **Measuring impact:** Success is gauged through client feedback, recovery observations, patient contact data, and therapy outcome measures. Challenges include capturing engagement during slower patient transitions and sharing positive outcomes more effectively in team meetings.
- **Key challenges:** The team faces difficulties with supporting inpatient discharge due to limited community housing and support, managing referrals outside their remit, and handling urgent (cito) requests. Complex patient profiles with offending histories add to these challenges.
- **Referral management:** To address referral misunderstandings, the team provides detailed feedback and signposting to appropriate services when they cannot accept cases. This helps educate referrers and manage expectations.
- **Support needs:** The team requests realistic service guidelines and increased access to locations for patient interventions. Updated literature and feedback mechanisms aim to improve clarity about service capabilities.
- **Administrative concerns:** Staff raised issues about mileage claim allowances given the large geographical area covered, seeking clarity on whether allowances might be adjusted monthly to ease financial burden. Feedback on visit communication and expectations was also requested.

Group 2 - Communications Team, Corporate Affairs and Involvement Department

The Communications Team believe they demonstrate resilience and compassion while managing complex challenges, including COVID-19 and intense media scrutiny. They emphasise strategic planning, professional recognition, and continuous improvement to enhance their impact and effectiveness.

- **Pride in resilience and expertise:** The team maintains resilience and compassion, supports each other through challenges, and possess diverse skills supported by professional development and a people-focused approach. They strategically highlight positive news through proactive and planned campaigns.
- **Maximising strengths through strategy:** Greater involvement in organisational strategic planning and clear communication objectives would enable the team to shift from reactive to more creative and planned work. They seek support to clarify requests and prioritisation, and executive support to advocate for recognition of communications as a profession.
- **Measuring impact and success:** Success is tracked through improved press relations, data-driven Board reports, post-campaign reviews, and compliance with national accessibility standards. Sponsorships for awards also indicate external engagement.
- **Challenges and support needs:** The team faces resource constraints, emotional impacts from public scrutiny, and technical limitations affecting communication targeting. They request technical improvements, software solutions for monitoring, and better integration with business planning to anticipate communications needs.

Group 3 – Elm Ward, West Park Hospital, Darlington

Elm Ward offers inpatient acute admissions for female adults in County Durham, with short term admission to experiencing mental illness.

- **Strong multidisciplinary team and morale:** The ward team is resilient, highly skilled, and praised by medical staff, with effective partnerships and continuous professional development. Training initiatives, such as for pregnant patients, have been successfully implemented.
- **Staff retention and capacity management:** Internal transfer processes have supported staff retention and career development. Maintaining a steady patient capacity around 18–19 helps manage ward atmosphere and care quality.
- **Challenges with patient turnover and complexity:** High patient turnover limits time to build relationships and increasing patient acuity adds complexity to care needs. Staffing support roles like the STR Worker previously had significant positive impact however are currently

unfunded.

- **Action plans for improvement:** Plans include discussions to prioritise inpatient discharge to community services, developing a business case for reinstating the STR Worker role, addressing immediate patient concerns such as medication errors and hygiene, and enhancing patient engagement with activities. The visit was positively received with open, honest staff communication.

Group 4 – Kilton View Day Service, Saltburn-by-the-Sea

Kilton View Day Service provides day care services for adults with severe learning disabilities who have complex physical and associated health needs in Teesside.

- **Pride in person-centered care:** The team values their knowledge of individual needs, therapeutic relationships, and engagement with multidisciplinary teams, which supports effective care coordination.
- **Need for bespoke training and policy development:** There is a call for tailored physical health training to meet client needs and enhance staff development, alongside efforts to develop and approve relevant policies such as TPN and tracheostomy protocols.
- **Measuring impact through feedback and outcomes:** Success is gauged by reduced hospital admissions, physical health metrics, and qualitative feedback from parent carers, with ongoing work to improve outcome measurement tools.
- **Challenges with physical health crises, staffing, and facilities:** Staff face emotional strain from service users' physical health deterioration, staffing pressures, and difficulties in building maintenance and adaptation due to leasing arrangements, with health and wellbeing of service users prioritised.

Group 5 - Redcar and Cleveland Community Team, Foxrush House, Kirkleatham, Redcar

Redcar and Cleveland Community Team highlighted significant transformation achievements, ongoing challenges, and future priorities. The team has evolved and improved to being recognised as exemplary, with strong staff retention and collaborative community engagement.

- **Transformation and leadership success:** The team turned around from a historically underperforming group to one described as "best in class," leading system-wide projects and maintaining high staff retention for around 24 months. They have become a model for other community teams seeking guidance on process and patient care.
- **Maximising service strengths:** Continued opportunities to lead pilot processes are valued, supported by a talented leadership and clinical team. Regular communication through monthly bulletin/bi-monthly staff meetings fosters real-time feedback and celebration of good practice.
- **Measuring impact:** Success is gauged through real-time staff feedback, strong retention, and reduced caseloads by one-third over 18 months. The team is exploring patient progress measures such as SWEMWBS and Dialog to track journeys without formal CPA.
- **Key challenges identified:** Space constraints at Foxrush House limit timely psychology and OT services, shared care management for patients on lithium or ADHD treatment strains staff capacity, and future workload growth is a concern. Shared care management is the highest priority challenge.
- **Support needed for challenges:** Plans to utilize vacant space at East Cleveland Hospital as a hub are underway, involving partner agencies and requiring senior leadership support. Addressing ADHD shared care management requires system-wide agreement and GP collaboration to manage growing caseloads effectively.
- **Positive reception of leadership visits:** The informal leadership walkabout approach is appreciated for building connections between director-level staff and frontline teams, helping reduce apprehension and fostering engagement. The team is proud of its transformation and readiness to share best practices.
- **Additional notes on team rebuilding and service flow:** The team was rebuilt after staffing issues during transformation in 2023, adopting new recruitment approaches and innovative communication tools like text messaging. Patient flow is efficient with quick referral to appointment times and open forums for allocations.

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Tees, Esk and Wear Valleys NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report to the Board of Directors		
Report Date:	9 October 2025	
Date of last meeting:	1 September 2025 – committee was quorate	
1	**Agenda: The Committee considered the following agenda items during the meeting** • Mental Health Legislation Combined Assurance Report • Positive and Safe: Use of Force Act including restrictive interventions • Multi-agency Mental Health Legislation Operational Group/Internal MH Op Groups • Mental Capacity Act/DOLS Report • Mental Health Act Detention Rates • Section 17 Leave and time away from the ward • CQC Mental Health Act Monitoring Activity • Case Study • Revised policies/procedures Section 135 Policy, Hospital Manager procedure, Mental Capacity Act 2005 Policy, Missing Patients Procedure. • Annual Committee Performance Evaluation 2024/25 • Terms of Reference • MHLC Workplan 2024/25 - noted	
2a	**Alert: The Committee alerts members of the Board to the following:** • It has emerged that a doctor was working on a ward acting in a consultant capacity without the approved clinician status. They had completed their training and had eight years' experience in psychiatry as inpatient consultant and thereafter as community AC but had not handed in their certificate demonstrating completion of the course. This is being investigated. All patient records over a three-month period have been checked and 14 patients were directly affected, meaning that their detentions or renewals were not lawful. All patients have received a letter of apology and there has been no direct harm to them. **Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS)** • Capacity assessments completed for patients admitted informally or remaining informally after a period of detention in the quality assurance schedule are transitioning to Inphase. • Bankfields have reported some improvements with the number of authorisations of DoLS by Middlesbrough Local Authority and overall there has been good progress made over the last six months. • The MH Legislation team continue to provide bespoke training on the Mental Capacity Act and there are additional resources available on the MCA intranet page. • Strong focus continues to ensure there is use of advocacy services through monitoring detention rates alongside the referral rates for these services in collaboration with 'We Are People First' and 'Cloverleaf'. **Section 17 Leave and time away from the ward** • Progress with regards to section 17 leave is reasonable assurance for compliance improvement, however limited assurance that the standards are currently being sustained. (DTVF 85% and NYYS 82%). • The levels of assurance were dropped following discussion at EDG on 26 August 2025. More focus is to be directed at ensuring that the accompanying person is informed about the risks and conditions of leave, before they take responsibility for the patient. • Associate Directors of Nursing are working on a variety of actions, including a daily oversight checklist, prompt report out to record pre-leave discussions and improvement to the inpatient quality tool.	

	Section 5 • A deep dive has been requested following four lapsed section 5's during the reporting period, March 2025 – June 2025. Approximately 24% of section 5's were applied within 24 hours of admission, which demonstrates a disparity with the application. The final report will be presented to the internal operational groups and Committee has requested that attendance at these groups by the care groups is made a priority.
2b	**Assurance: The Committee confirms assurance to the Board on the following:** **Mental Health Legislation (MHL) Combined Assurance Report** • In striving for good governance, Committee received the first MHL combined assurance report in September 2025. The report has been through the governance cycle and includes information previously presented on the agenda through individual reports. The decision to move to one report follows the establishment of the internal MH operational groups and the external mental health multi-agency groups, where the data is considered first by the care groups, to allow for the operational matters to be discussed and appropriate mitigations put in place, to then report into Committee with the proposed levels of assurance. (The matters covered include detained patients discharged without their rights being read, section 5, AWOL, discharges by MH Tribunal and Hospital Managers, S136 reaching 24 hours and extended and nearest relative discharge notifications). • The report was well received with good assurance on the robustness of data provided, that there has been appropriate scrutiny and consideration of the matters by the care groups at operational level and that the legislation has been correctly applied. • Attendance at the NYYS internal MH operational group needs to be made a priority for future meetings. **Multi-agency and internal MH Legislation Operational Groups** • These relatively new groups, chaired by the Care Group Medical Directors, are now reporting through the governance layers, presenting to care group board and EDG (quality and performance week 4). The multi-agency groups are considering matters including a recent regulation 28 from the Teesside Coroner, making improvements to the payment process for mental health act assessments and timeliness and availability of doctors at MHA assessments. • Overall Committee confirms good assurance and acknowledges that there remain some challenges getting the right stakeholders round the table for meetings in NYYS. • There is reasonable assurance relating to the internal MH legislation operational groups with strengthened membership needed in NYYS. These groups are looking at topics including patients discharged without their rights, use of section 5, section 136 that reach 24 hours and those extended, patients absent without leave and discharges by the MH tribunal and Associate Hospital Managers. **Positive and Safe** • The Committee confirms there is reasonable assurance demonstrated of progress implementing the Trust wide Positive & Safe Strategy, including a review of recent restrictive practice use within quarter 1 of 2025 -2026 and changes the organisation must make to comply with the Mental Health Units Use of Force Act. • There were 1,529 reported restrictive interventions in quarter 1, this is an increase from 1335 in 24/25 quarter 4. • Durham, Tees Valley and Forensic Care Group (DTVF) accounted for 1272 of these incidents and North Yorkshire, York and Selby Care Group (NYYS) 256, this is within normal SPC variation for each of the care groups. • TEWV is within top three highest users of seclusion and rapid tranquilisation (deep dive work underway) and more recent data is showing a decrease. We are reporting as lowest user for prone, long-term segregation and mechanical restraint for trusts that have nationally reported their data. • High frequency, low duration use of seclusion across Adult Learning Disability (ALD) services is highlighting TEWV as a national outlier. If ALD services were excluded from the current data set TEWV would rank 2nd from lowest user of seclusion nationally.

	CQC Mental Health Act Monitoring Activity • Committee were notified that mental health act inspections will now be every two years, rather than 18 months, however there is a three-year period for some. • There was a visit by a CQC MHA reviewer to acute wards at West Park Hospital and Lanchester Road Hospital, prior to the two-year period to build relationships with service colleagues and to review team progress regarding implementation of Provider Action Statements following previous visits. • Several issues were raised linked to Oak ward in the main relating to the building not being fit for purpose. • There were 31 outstanding actions (>31 days) from MHA inspections involving nine wards. • Committee confirmed that assurance was reasonable, rather than the initially proposed good assurance, due to outstanding actions and ongoing issue with breaches, which were repeat breaches. **Annual Committee Performance Evaluation 2024/25** • The results of the annual Committee performance evaluation for 2024/25 were positive with marked improvements on last year. Members commented positively on being focused on strategic issues, risk and assurance with straying occasionally into operational detail. Holding three meetings annually plus a developmental time out session is welcomed and members agreed that some improvements could be made to clarify the cross-cutting matters across board committees. • Committee is looking forward to the implementation of a new performance dashboard in the new year.
2c	**Advise: The Committee advises the Board on the following:** **MHA Detention Rates** • Committee considered TEWV detention rates through an equality lens to evaluate detentions made under the Mental Health Act disaggregated by ethnicity, gender, age and deprivation. It is recognised that the national benchmarking data is not adjusted for socio economic status. The Trust is reported as detaining at a higher rate for all areas when looking at national rates and Committee is keen to understand why there are higher rates of detention in protected characteristics. • A request has been made to reach out to national team to provide additional data representing interaction between deprivation code and other protected characteristics. Looking at the governance route for this data before it comes to Committee in addition to exploring the next steps is being considered by the Medical Director, Paula Hay, Head of Business Intelligence and Catherine Parker, Public Health Consultant. **Case Study** • A case study was considered relating to an individual who had suffered from anorexia nervosa since the age of 15 and her care with TEWV over the past four years, which included repeated mental health tribunals and a continued community treatment order (CTO). The Committee considered the ethical dilemma of the MHA, which sets out the legal framework for CTOs to be for the duration of six months and the Code of Practice and NICE guidance emphasising CTOs should not be longer than clinically necessary. Committee is assured that the care pathway is in the best interest of the patient. The **terms of reference** were approved, with no material changes other than to update the strategic objectives of the organisation and are recommended to the Board of Directors for formal ratification. Eve Newbury, Associate Director of Nursing, attends Committee meetings as a representative for Beverley Murphy, Chief Nurse and this will be made clear in the annual report for 2025/26. The Committee is pursuing how to enable service user and carer involvement in the Committee (ToR 3.3: to gain assurance that the Trust actively listens to, and learns from, the experience of service users, families and carers in the application of the mental health legislation). The patient experience survey has been updated to include questions

	The following policies/procedures were approved: Section 135 Policy, Hospital Manager Procedure, Mental Capacity Act 2005 Policy and Missing Patients Procedure.	
2d	**Review of Risks**	No additional risks were identified.
Recommendation: The Committee proposes that the Board of Directors: *i) Note the report and confirm the levels of assurance provided across reporting.* *ii) Approve the MHLC terms of reference.*		
3	**Actions to be considered by the Board: There** are no actions for the Board to consider.	
4	**Report prepared by***: Roberta Barker, Chair of Committee/Non-Executive Director, Kedar Kale, Executive Medical Director and Donna Keeping, Corporate Governance Manager*	

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9 October 2025**
Title:	**Communications update**
Executive Sponsor(s):	**Ann Bridges, Executive Director of Corporate 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 August and September 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 August and September.

In summary, we're continuing to take a more proactive approach to communications and this continues to have a positive impact across a range of communications channels and activities.

However, it's important to highlight that our communications are also reflecting reality. In September the majority of our media enquiries related to an inquest. This is then reflected in the sentiment of our media coverage. Importantly though, in these instances, we always lead with compassion and are open, honest and transparent in our response.

1. Press coverage and campaigns:

   - The team proactively worked on securing timely coverage around GCSE results alongside our Wellbeing in Mind team. This included an article in the Yorkshire Post and accompanying tips and videos on social media.

   - Human interest stories continued to be a focus, with a story about Darryl Benson's family raising money for Woodside Hub securing coverage in Teesside Live and reaching over 12,000 people on Facebook.

   - The team proactively worked on securing coverage on a new VR-powered mindfulness therapy service.

   - As mentioned above, there was substantial media coverage related to an inquest.

2. Media and online presence:

   - 11 media releases were issued (6 in August and 5 in September) which exceeds our KPI.

   - 27 media enquiries were managed including an inquest, calls for a public inquiry and waiting times. The majority of those enquiries were in relation to an inquest. It was attended by a number of journalists, including the Press Association, and as a result, there was substantial coverage regionally and nationally.

   - In total there were 278 pieces of coverage across online news, TV, and radio (15 in August and 263 in September).

   - Media sentiment varied considerably between August and September.
     - In August, media sentiment was 93% positive and 7% neutral.
     - Understandably, the media coverage of the inquest had an impact on media sentiment for September as it accounted for the majority of cover that month - 92% of coverage was negative, 4% was positive and 4% was neutral.

- Following media coverage on calls for a public inquiry and waiting times in York Press, we subsequently met with the editor, which was useful. We've agreed further meetings and we're also meeting with the chief reporter in October.

3. Our digital channels
    - Our website had 74,085 page views in August and September. The top four visited pages were careers, services and locations and contact us.

    - Our staff intranet had 151,662 in August and September. Top staff intranet news stories included the new patient and carer experience system go live, workshops to support policy and document development, the announcement pf our multiprofessional conference, living our values winners and the pre-launch for the flu vaccination campaign.

4. Social media engagement:
    - Across August and September our social media content reached 129,579 people, with 68 total posts and 29,042 total followers.

    - Overall, our social media engagement during August and September 2025 remains strong and successful in reaching a wide-ranging audience, generating positive interactions including:
        - Visit from NHS England's 'getting it right first time' leads
        - Money raised for Woodside Dementia Hub
        - World Suicide Prevention Day
        - New VR mindfulness therapy
        - Star awards shortlist announced

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:

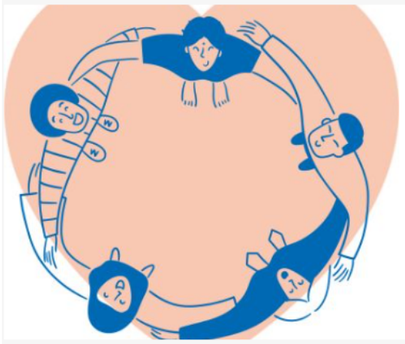
The Board of Directors is asked to note the progress made and take good assurance.

Communications Dashboard

August 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights



[New Respectful Resolution supporting TEWV to be a great place to work]

We've launched an inspiring series of bespoke guides to help colleagues understand each other better. It will resolve issues in a positive and kinder way - making TEWV a great place to work.

- *Announced the launch of Respectful Resolution guides to help make TEWV a great place to work*

We celebrated our trust's fifth consecutive year on the Voyage to Recovery

News › Teesside News › NHS

Lasting legacy for 'miracle' Teesside grandad who died 20 years after being given months to live

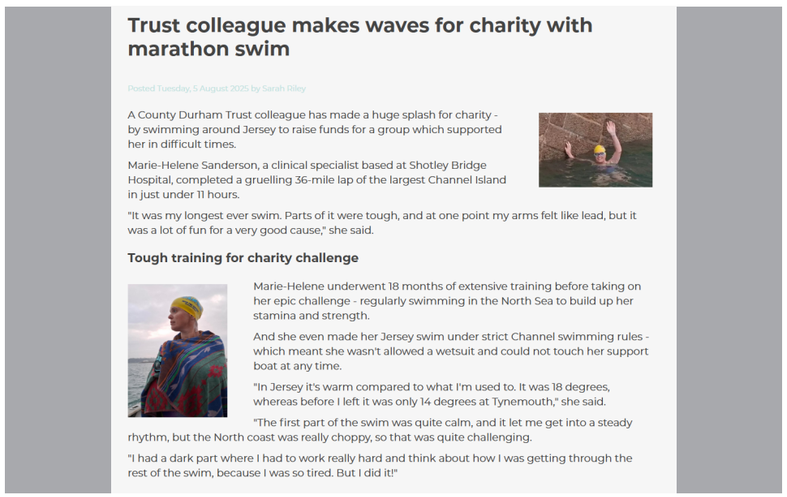
Darryl Benson dedicated years to helping others with mental health conditions

NEWS By Annette Belcher
01:04, 3 AUG 2025

Bookmark Comments 4

Darryl Benson dedicated years to helping others with mental health conditions

Gained news coverage of funds raised for Woodside Dementia Hub in memory of an involvement member



Trust colleague makes waves for charity with marathon swim

Posted Tuesday, 5 August 2025 by Sarah Riley

A County Durham Trust colleague has made a huge splash for charity - by swimming around Jersey to raise funds for a group which supported her in difficult times.

Marie-Helene Sanderson, a clinical specialist based at Shotley Bridge Hospital, completed a gruelling 36-mile lap of the largest Channel Island in just under 11 hours.

"It was my longest ever swim. Parts of it were tough, and at one point my arms felt like lead, but it was a lot of fun for a very good cause," she said.

Tough training for charity challenge

Marie-Helene underwent 18 months of extensive training before taking on her epic challenge - regularly swimming in the North Sea to build up her stamina and strength.

And she even made her Jersey swim under strict Channel swimming rules - which meant she wasn't allowed a wetsuit and could not touch her support boat at any time.

"In Jersey it's warm compared to what I'm used to. It was 18 degrees, whereas before I left it was only 14 degrees at Tynemouth," she said.

"The first part of the swim was quite calm, and it let me get into a steady rhythm, but the North coast was really choppy, so that was quite challenging.

"I had a dark part where I had to work really hard and think about how I was getting through the rest of the swim, because I was so tired. But I did it!"

We celebrated a trust colleague's 36-mile charity swim around Jersey

Shared practical tips to families of year 11 students from our school mental health team for results day

Nominations for the 2025 Star Awards have now closed

Nominations are now closed

12 August 2025

We're thrilled to announce that we've smashed last year's record for online nominations so thank you to everyone who nominated their #TEWVstars.

We can't wait to read them all!

Announced nominations have closed for Star Awards 2025 and moved forward with judging nominees

Communications Objectives

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

Objectives	Key pieces of our work that support our objectives
Increase public confidence	• Good news stories and proactive messaging on GCSE results day • Star Award nominations closed with record entries of 661 • AGM planning • Planning for vaccination campaign
Enhance staff engagement	• Encouraged our colleagues to nominate in the Star Awards • Support and recommendations on Cito communications • Launched new workshops to support policy and document development
Strengthen partnerships	• Sent our partner newsletter • Planning our Review of the Year • Celebrated a visit from NHS England's Get It Right First Time clinical leads • Planning filming in the York 24/7 hub with NHS England
Support a culture of co-creation	• Promoting the opening of co-created Hummingbird House in Harrogate, with a launch expected in September • Creating an animation for our new Patient and Carer strategy launch • Culture of Care programme updates
Provide accessible and timely information	• Freedom of Information requests • Trialling our new patient and carer information process • Implemented new easy read accessibility features to our website • Creating new CEO welcome pack

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

4 ↓
Media enquiries handled by the team

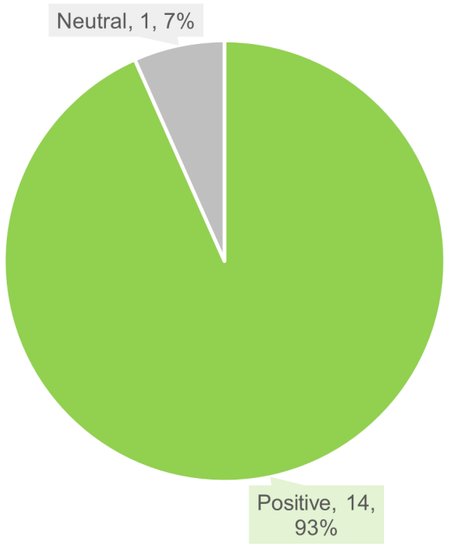
6 ↑
Media releases issued

15 ↓
Total pieces of coverage across online news, TV, and radio

Some of our news stories

- 'Lasting legacy for 'miracle' Teesside grandad who died 20 years after being given months to live' – *Teesside Live*
- 'Families of patients who took their lives under mental health trust demand public inquiry decision' – *ITV News*
- 'Dance therapy project boosts mental health patients in York' – *The Yorkshire Post*
- 'Harrogate mental health clinic to be converted to flats' – *The Stray Ferret*
- 'School mental health team support families to ease results day anxiety' – *The Yorkshire Post*
- 'Visit to Tees, Esk and Wear Valleys NHS Foundation Trust' – *NHS Providers*

Media sentiment



Our website

34,503 ↓
page views

Top three visited pages

1. Careers
2. Services
3. Contact us

Staff intranet

68,072 ↓
page views

Top staff intranet news stories

1. Patient and carer experience system procurement project go live date
2. New workshops to support policy and document development
3. School mental health team support families to ease results day anxiety

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

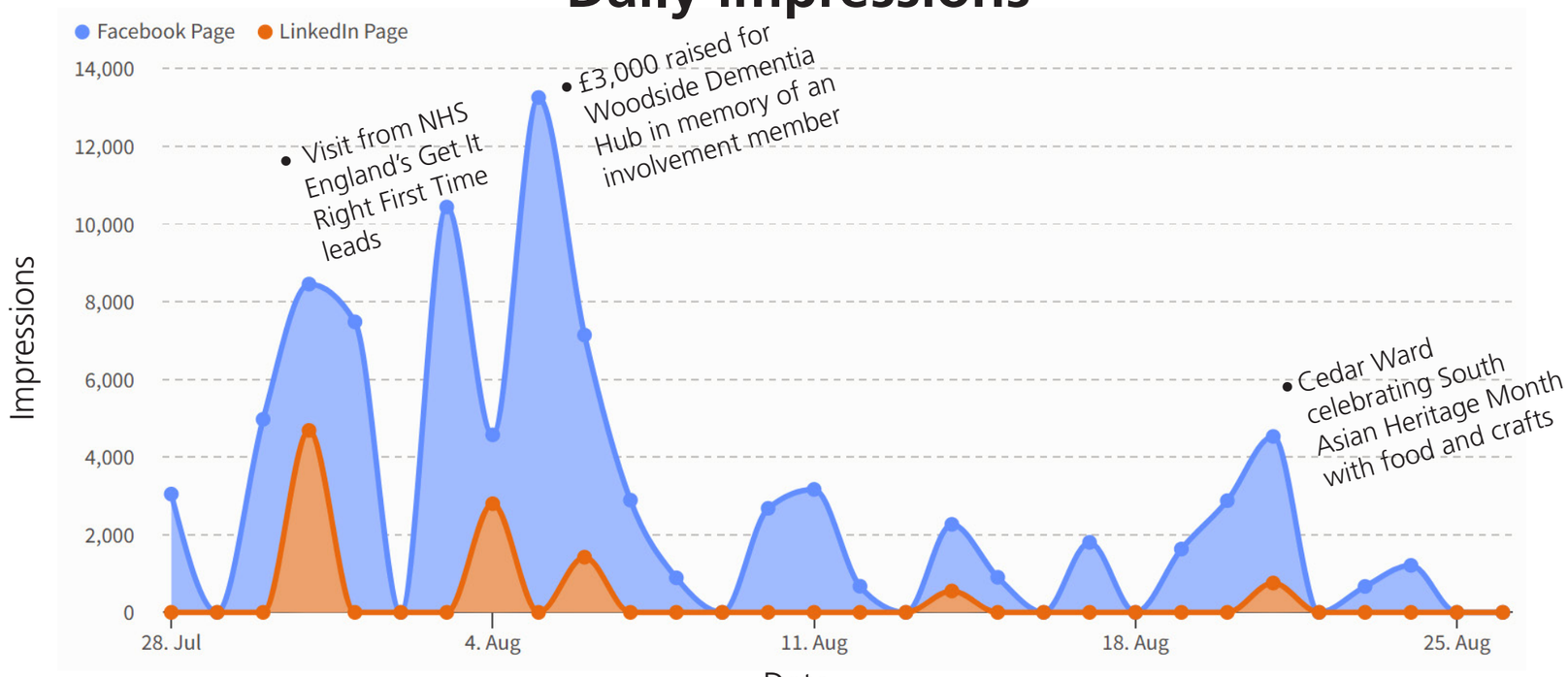
28,919 ↑
Total followers

145 ↓
New followers

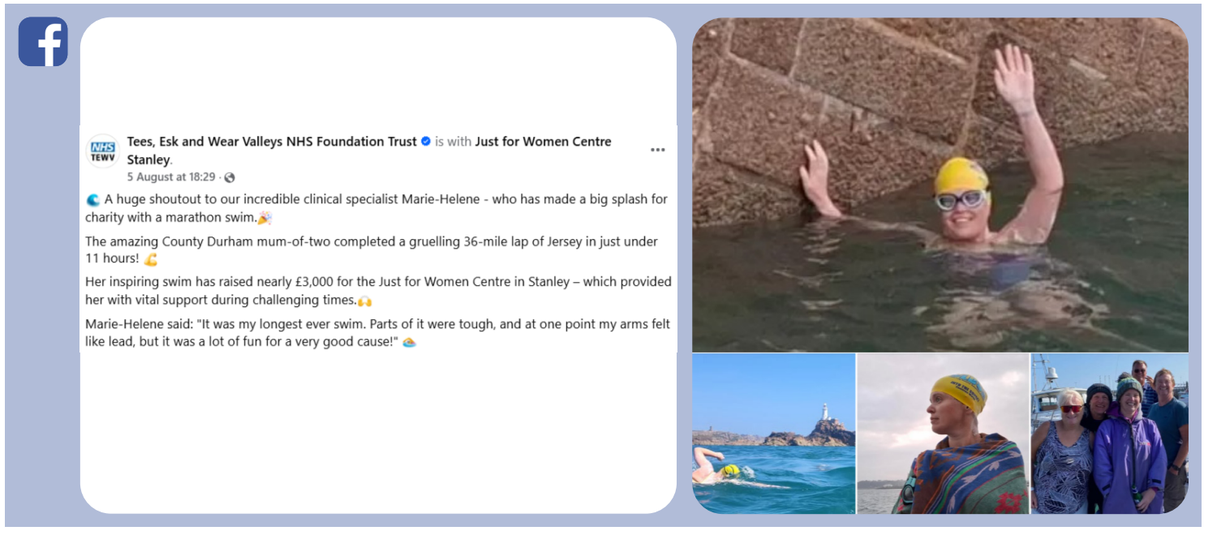
85,519 ↓
People who saw our content - impressions

39 ↑
Total posts

Daily impressions



Top posts



Views 13,777 - Engagement 139

Impressions 4,685 - Engagement 108

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
16
stories posted
~4 a week

Email enquires
657
email requests
~22 a day

Team TEWV
staff Facebook group
98 posts
393 comments
2,535
total members
30 new members

All staff emails
18
sent
~4.5 a week

Patient information
7
updated

Policies
104 total policies
279 total procedures and guidelines
4 consultations open
11 revised and published

Freedom of Information requests
31 received
~7.7 a week
43 responded to
~10.7 a week

Partner newsletter
16
stories shared

What we're working on

We're excited to be working on the return of the Annual General and Members Meeting, planned to take place on 23 October at the Hub, Teesside University.

The much-loved services marketplace will also be making a comeback, and preparations are already underway to ensure the full breadth and depth of #TeamTEWV is well represented.

Partners are invited to attend both the formal meeting and the marketplace. If you work with any who may be interested, please contact the Communications Team.

Whilst the event was originally created to fulfil statutory purposes for our public members, it has grown to become a great showcase for our Trust and those working within it.

All colleagues are welcome, and the event will be broadcast online for those unable to attend in person.

More details - including timings and this year's theme - will be shared shortly.

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.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

This month's focus

Volunteers' Week (2-8 June) is an annual UK-wide campaign to celebrate the contributions of volunteers and thank them for their invaluable efforts. In our trust, we have a total of 282 volunteers. They volunteer for an average of 463 hours every month - or 5,556 hours over the year.

Campaign objectives

Increase visits to volunteering webpage by 10% during the campaign period
Outcome: 22% increase in visits (compared to preceding period)

Increase visits to voluntary services intranet page by 20% during the campaign period
Outcome: Low views for our volunteering intranet page but a 733% increase was demonstrated during the campaign week (compared to the preceding period)

Ensure volunteers are recognised and valued by reaching over 1,000 people via Facebook posts
Outcome: High views and engagement on social media posts

Generate 5 enquiries / expressions of interest from those interesting in becoming a volunteer
Outcome: 29 enquiries during the week

Generate 10 enquiries / expressions of interest from TEWV staff about recruiting a volunteer for their team
Outcome: 3 services contacted our volunteer team to arrange a volunteer for their service

Staff comments

"So lovely to hear from Dave, he transports a number of our service users, and they appreciate it so much. Thank you, Dave and the volunteer team!"

"Volunteers are so valuable and bring so much to the service"

"Thank you to all our Trust volunteers, people like you make the world go round and you are very precious"

"I think the volunteers in our service such as Sophie and Daisy are our unsung heroes, I know Sophie and Daisy dedicate a huge amount of time to raise the spirits of our patients and having worked directly with Sophie and Daisy, I have seen the results first hand. These guys have a huge positive effect and I thank them for all they do."

How we measured success

Media coverage and case studies
Lee's story widely covered by regional and national press including MSN and Yahoo.

- County Durham man credits NHS volunteering with recovery | The Northern Echo - The Northern Echo
- Former County Durham addict turns life around with NHS volunteering - Yahoo News
- 'My family disowned me and sold everything in my flat to feed my addiction' - Teesside Live - Teesside Gazette

Volunteering webpage
During campaign week:

- 37th most visited page on Trust website
- 33 views with 38 seconds average engagement time
- 22% increase in visits (compared to preceding period)

Intranet

- News stories generated significant engagement via comments (28 in total)
- Lee's story received 304 views – the top performing news story
- 10 pieces of content, volunteer stories and case studies received a total of 1,514 views
- Low views for our volunteering intranet page but a 733% increase was demonstrated during the campaign week (compared to the preceding period)

Social media

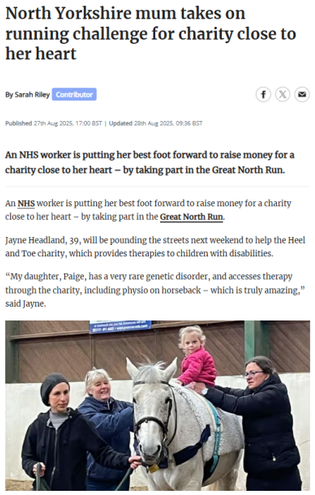
- Lee's story reached 14,179 people on Facebook, with 65% of those non-followers of our page
- Lee's story was also the third top performing post in the month of June
- Other high performing posts included Laura and her therapy dog Bella, and a call-out for volunteer drivers in North Yorkshire

Communications Dashboard

September 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights



North Yorkshire mum takes on running challenge for charity close to her heart

By Sarah Riley Contributor

Published 27th Aug 2025, 17:00 BST | Updated 28th Aug 2025, 09:36 BST

An NHS worker is putting her best foot forward to raise money for a charity close to her heart – by taking part in the Great North Run.

An NHS worker is putting her best foot forward to raise money for a charity close to her heart – by taking part in the Great North Run.

Jayne Headland, 39, will be pounding the streets next weekend to help the Heel and Toe charity, which provides therapies to children with disabilities.

"My daughter, Paige, has a very rare genetic disorder, and accesses therapy through the charity, including physio on horseback – which is truly amazing," said Jayne.

Gained news coverage around one of our colleagues taking part in the Great North Run for charity

Get your winter flu vaccine from next week

Posted Thursday, 25 September 2025 by Adrian Flanagan

Be Wise. Immunise against Flu this winter.

With flu season just around the corner, our flu vaccination campaign is about to launch. Have you felt unwell recently or know someone who has? Now's the chance to get ready to protect yourself and others

NHS England have written to all NHS Trusts, urging them to encourage colleagues to have their flu vaccine this winter. They've set a national target for all trusts of a 5% increase in uptake over last year's vaccinations.

So, this year we've come together as a region, working in collaboration with other NHS Trust's across northern England, to share one message - Be Wise. Immunise. Over the coming months you'll hear from colleagues from Northumbria, Newcastle, North and South Tees and more, as we come together to let you know why getting vaccinated is so important.

Clinics here at our trust start From Wednesday 1 October.

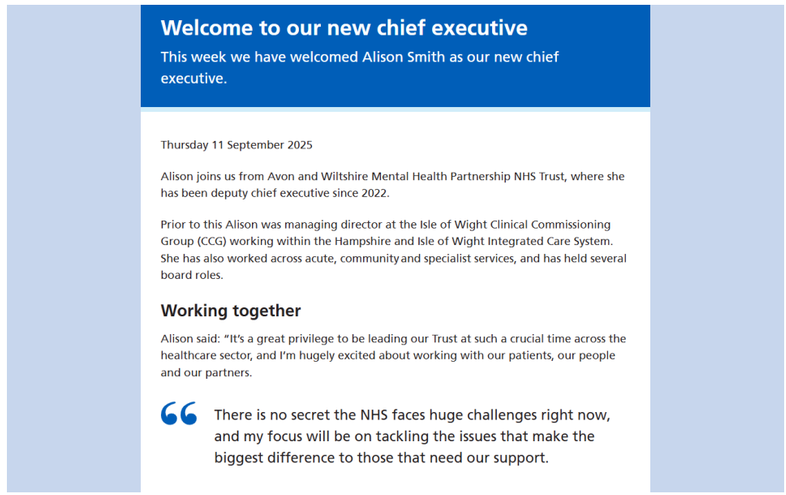
Full list of October's flu clinic dates, locations and times

Started the build-up to our annual flu vaccination campaign, announcing the first clinics

Shared personalised care planning animations that were co-created with staff and people in our care

Marked Suicide Prevention Day and shared a video from our preventing suicide lead

Announced that entries are open for the 2026 TEWV 10k



Welcome to our new chief executive

This week we have welcomed Alison Smith as our new chief executive.

Thursday 11 September 2025

Alison joins us from Avon and Wiltshire Mental Health Partnership NHS Trust, where she has been deputy chief executive since 2022.

Prior to this Alison was managing director at the Isle of Wight Clinical Commissioning Group (CCG) working within the Hampshire and Isle of Wight Integrated Care System. She has also worked across acute, community and specialist services, and has held several board roles.

Working together

Alison said: "It's a great privilege to be leading our Trust at such a crucial time across the healthcare sector, and I'm hugely excited about working with our patients, our people and our partners.

> There is no secret the NHS faces huge challenges right now, and my focus will be on tackling the issues that make the biggest difference to those that need our support.

Welcomed our new chief executive Alison Smith

Communications Objectives

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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	• Responded to several media enquiries around calls for a public and high-profile inquests and arranged a meeting with York Press editor • Communications planning for annual vaccination campaign alongside NENC ICB and other trusts in our region • Star Awards planning • AGM planning
Enhance staff engagement	• Communications planning for the national staff survey launching in October • Marked World Suicide Prevention Day and World Patient Safety Day • Continued workshops to support policy and document development
Strengthen partnerships	• Prepared briefings for upcoming MP meetings to support senior colleagues • Sent our partner newsletter • Planning governor training and preparing responses for the upcoming Council of Governors meeting • Planning filming in the York 24/7 hub with NHS England
Support a culture of co-creation	• Developed three animations to support the personalised approach to care programme • Planning the next stage of communications for Hummingbird House in Harrogate • Creating an animation for our new patient and carer strategy launch • Developing a communications plan for a video that was recorded with the mother of a woman who died in our care
Provide accessible and timely information	• Updated colleagues on the MARS scheme • Freedom of Information requests • Trialling our new patient and carer information process • Explained the National Oversight Frameworks (NOF) league tables to our colleagues

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

23 ↑
Media enquiries handled by the team

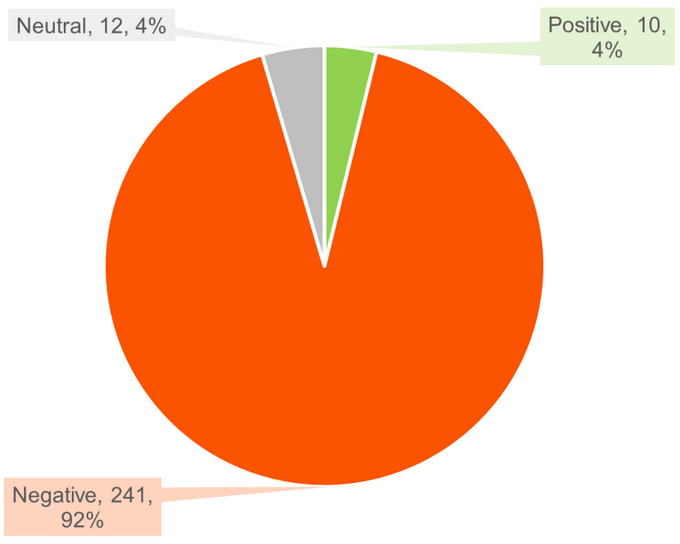
5 ↓
Media releases issued

263 ↑
Total pieces of coverage across online news, TV, and radio

Some of our news stories

- **Thornaby mum whose daughter suffers rare genetic disorder set to take on Great North Run** – *Teesside Live*
- **Family of nurse found dead in river say she was failed by 'systemic neglect'** – *Guardian Online and blanket coverage across UK local newspapers*
- **Rachael Maskell MP calls for public inquiry into TEWV trust** – *Northern Echo*
- **Coroner issues Prevention of Future Deaths Report after death of Malton woman Victoria Taylor** – *ITV News Online*
- **Hundreds of mental health patients wait a year to be seen by TEWV** – *York Press*
- **New VR-powered mindfulness therapy service** – *Scarborough News*

Media sentiment



Our website

39,582 ↑
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

83,590 ↑
page views

Top staff intranet news stories

1. Announcing TEWVs multiprofessional conference
2. Living our Values winners
3. Get your winter flu vaccine from next week

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

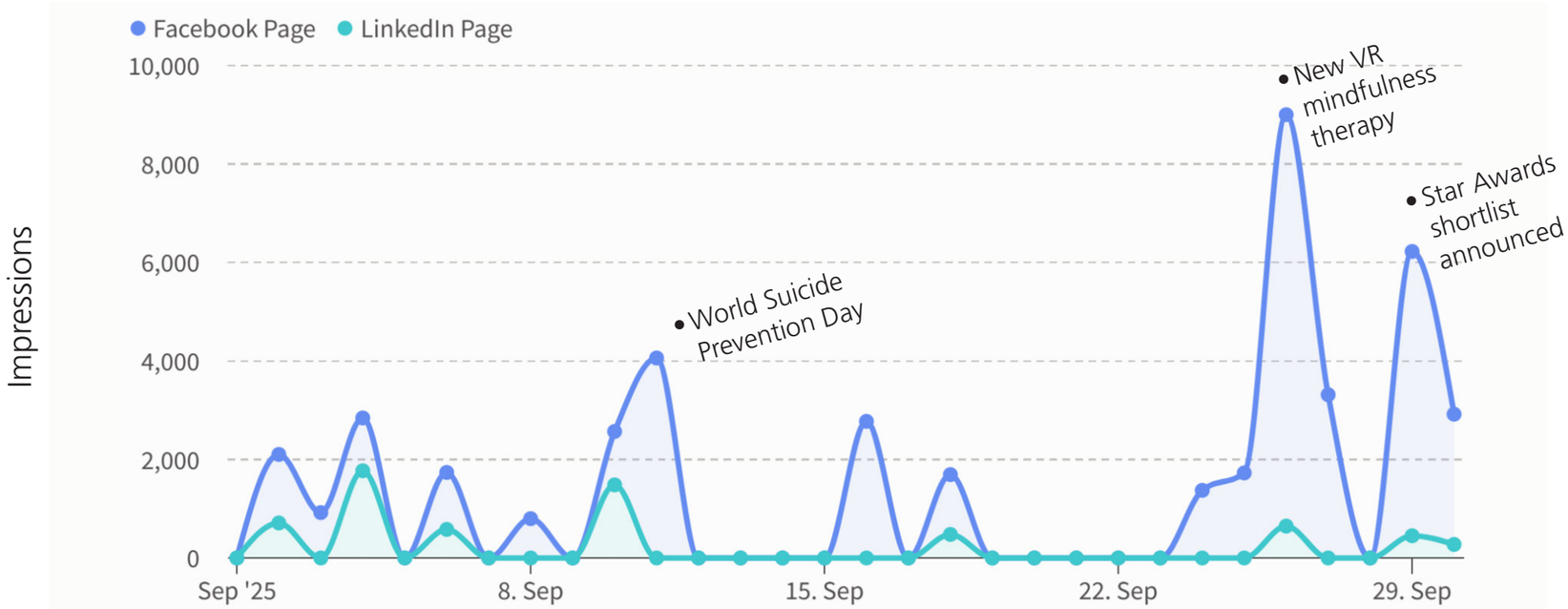
29,042 ↑
Total followers

135 ↓
New followers

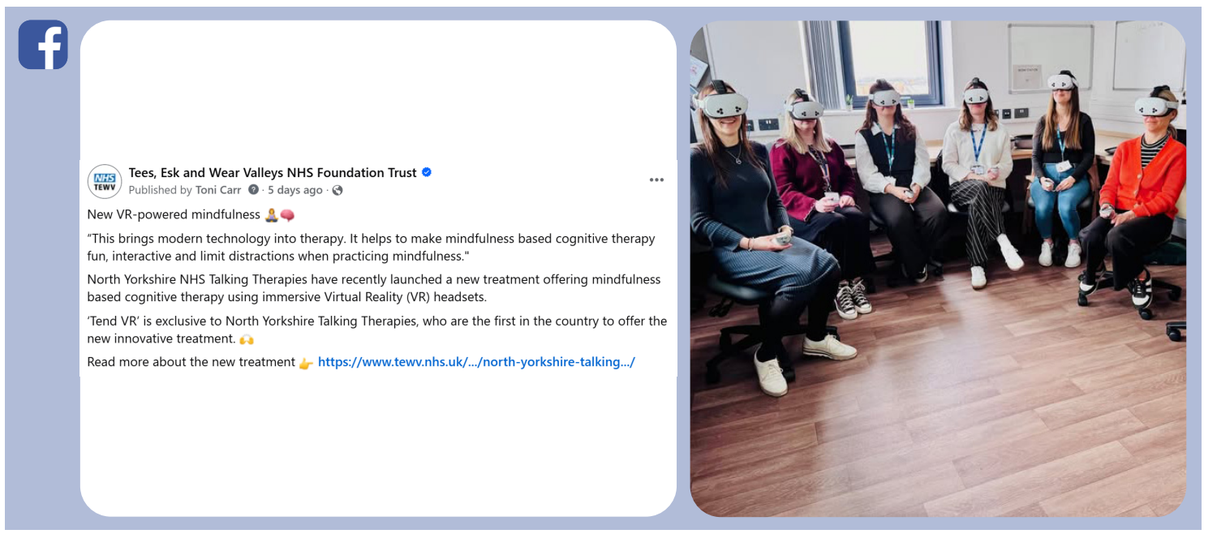
44,060 ↓
People who saw our content - impressions

29 ↓
Total posts

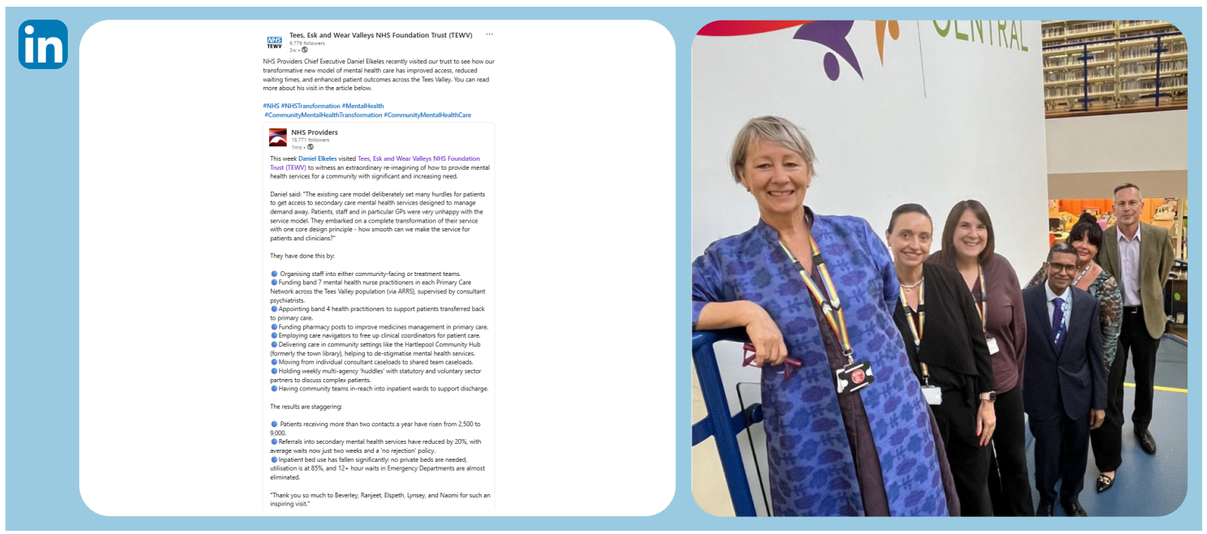
Daily impressions



Top posts



Views 9,123 - Engagement 66



Impressions 1,771 - Engagement 88

Our work

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our ongoing work

Communications:

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- Agreed awareness weeks/days
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- 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
23
stories posted

Email enquires
580
email requests

Team TEWV
staff Facebook group
139 posts
461 comments
2,560
total members
25 new members

All staff emails
12
sent

Patient information
6
updated

Policies
104
total policies
279
total procedures and guidelines
6
consultations open
16
revised and published

Freedom of Information requests
51
received
28
responded to

Partner newsletter
12
stories shared

MP briefings
2

What we're working on

We've been planning for the launch of the national NHS Staff Survey in October.

The survey is a valuable opportunity for our colleagues to share honest feedback about their experiences, and it plays a key role in shaping how we continue to improve as an organisation.

The campaign will be a big focus throughout October and November, with regular updates on the intranet, tailored emails to staff, posts on the Team TEWV Facebook group, and features in the weekly staff briefing.

We're aware that not all colleagues can access digital platforms regularly, so working alongside other teams, we'll also be co-ordinating the distribution of letters to our estates and facilities colleagues, and visiting multiple sites in person, to make sure everyone has the chance to have their say.

Our wide-reaching communications aims to capture as many responses as possible, giving our colleagues a voice and making sure their views contribute to local and national improvements across the NHS.

Insights

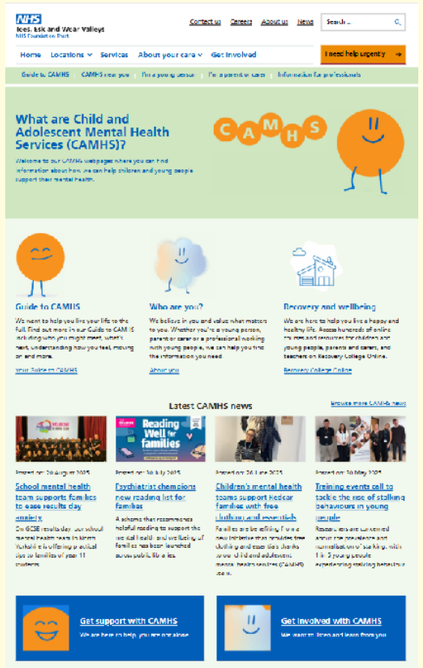
Each month our team develops an 'insights' case study on a project we've worked on and evaluated. This demonstrates the impact of that project and enables us to continuously reflect, celebrate successes and improve.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

This month's focus

Our children and young people's mental health services (CAMHS) web project started in 2020. Following extensive engagement, our new CAMHS web section was launched in October 2024. It includes:

- Co-created webpages dedicated to supporting children and young people's mental health
- Practical tips and advice
- Signposting to useful information and self-help resources
- Bespoke CAMHS guides
- Clear information on how to get help
- A new look and feel aimed at a younger audience



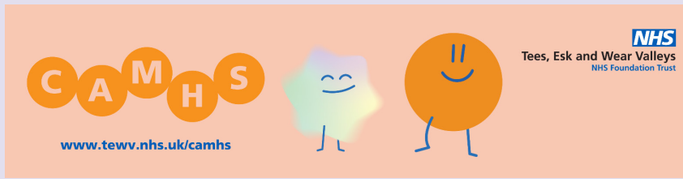
Co-creation

Co-creation was a big part of the project. We listened and acted on feedback from young people, families, staff and partners. The site also includes video tours, filmed and narrated by young people from CAMHS. They wanted to reduce anxiety for people visiting for the first time and show them what to expect.

Quantitative insights

CAMHS homepage:

- 219 views in the last 28 days (up to 15 September)
- 10th most viewed webpage across the whole of our trust website (in the last 28 days up to 15 September)
- Users are engaging with the page for an average of 21 seconds
- Consistently been in the top 10 of trust webpages every month since May 2025
- The last 28 days, the CAMHS homepage has seen a 6% decrease in page views compared to the previous 28 days (possibly due to summer holidays)



Qualitative insights

Through user testing, comments about the CAMHS web section included:

- "It made me feel safe and calm." A young person
- "It made me feel relaxed and not stressing over things." A young person
- "It was quite easy to read and understand." A young person
- "It looks pretty and nice. I feel calm as I know what's going on or going to happen the first time I go to CAMHS. My mam would use it. I like the mobile version best and it's easier to use." A young person
- "The whole idea is great - a collection of approved information." A parent / carer
- "It's informative - if I met families who didn't know about CAMHS, they could get a level of basic knowledge by visiting the website." A CAMHS colleague

Conclusion and considerations for the future

- A monthly trustwide website steering group, chaired by Lynne Brown (CAMHS service manager) tracks improvements and helps plan developments
- Continue to monitor performance of CAMHS webpages every month through Google Analytics
- Continue to evolve with roll out of CAMHS development plan phase two
- Ad hoc updates on useful links and resources for young people / parents and carers at the request of CAMHS service manager to make sure they are relevant and up to date
- New event and training web section – coming soon

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