Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS
11 December 2025
at 10.30am

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

AGENDA

NOTE: there will be a confidential session at 10.00am 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 last Board meeting held on 9 October 2025	Chair	
5	Board Action Log	Chair	
6	Interim Chair Report	Chair	10.40am
7	Questions raised by Governors in relation to matters on the agenda (verbal) *(To be received by 10am on 9 December 2025)*	Co Sec	10.50am

Strategic Items

8	Board Assurance Framework Summary Report	Co Sec	10.55am
9	Chief Executive's Report	CEO	11.00am
10	Integrated Performance Report	Int EDS&T	11.10am
11	Corporate Risk Register	CN	11.40am

11:50pm BREAK

BAF Risk 1: Safe Staffing

12	Report of the Chair of People, Culture and Diversity Committee *(for information – verbal report provided at the last meeting)*	Cmt Chair	-
13	Annual Safe Staffing Establishment Review 2024-2025	CN	12.00pm

14	Quarterly Report of the Guardian of Safe Working Hours for Postgraduate Doctors	GoSW	12.10pm
15	Medical Education Annual Board Report *(in attendance: Dr Hany El-Sayeh, Director of Medical Education)*	EMD	12.20pm

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

16	Report of the Chair of the Quality Assurance Committee *(September report is provided for information – verbal report provided at the last meeting)*	Cmt Chair	12.30pm
17	Learning from Deaths Report Quarter 2 2025/26	EMD	12.40pm
18	Research and Development Annual Report 2024/25 *(in attendance: Sarah Daniel, Head of Research)*	EMD	12.45pm
19	Innovations Annual Report 2024/25 *(in attendance: Lauren Bennett, Innovations Project Manager)*	EMD	12.55pm
20	Leadership Walkabout Feedback	EDCA&I	1.05pm

BAF Risk 13: Public Confidence

21	Report of the Chair of the Charitable Funds Committee *(for information – verbal report provided at the last meeting)*	Cmt Chair	-
	a. Recommended for approval: - Charitable Trust Fund Annual Report and Accounts for 2024/25	EDFE&F	1.10pm
22	Communications update	EDCA&I	1.20pm

Governance

23	Board Assurance Framework (verbal)	Chair	1.30pm

Matters for Information

24	Register of Sealing	Co Sec	-

Exclusion of the Public:

25	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	1.35pm

1.35pm BREAK

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

26	Report of the Chair of Resources & Planning Committee	Cmt Chair	2.05pm
27	Medium Term Plan	EDFE&F Int. EDS&T	2.15pm
28	2025/26 Month 7 Finance Report	EDFE&F	2.30pm

BAF Risk 11: Roseberry Park

29	Report of the Chair of Roseberry Park Hospital Sub-Group	Chair	2.40pm

Strategic Items

30	Chief Executive's Confidential Report	CEO	2.50pm
31	NHS Oversight Framework	Int EDS&T	3.05pm
32	Reportable Issues Log	CN	3.15pm

33	DTV Rehabilitation Services	Int. Care Group MD	3.20pm
34	Report of the Chair of Audit & Risk Committee *(verbal update from the meeting held 8 December 2025)*	Cmt Chair	3.30pm

Governance

35	Board Assurance Framework Quarter 2 2025/26	Co Sec	3.40pm
36	Board Committee Terms of Reference and Membership	Co Sec	3.50pm
37	Use of the Board of Directors emergency powers *(for information)*	Co Sec	-

Standard Items

38	Minutes of:	Chair	3.55pm
	a. The confidential session of the ordinary Board meeting held 9 October 2025		
	b. The confidential special Board meeting held on 13 November 2025		
	c. The confidential special Board meeting held on 19 November 2025		
39	Board Confidential Action Log	Chair	

Matters for information

40	To receive and note the minutes of the meetings of the following committees: a. People, Culture and Diversity Committee, May 2025 b. Charitable Funds Committee, June 2025 c. Quality Assurance Committee, September 2025 d. Quality Assurance Committee, October 2025	Co Sec	-

Evaluation

41	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
5 December 2025

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

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

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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD AT 10.30AM ON 9 OCTOBER 2025 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS

Present:
B Reilly, Interim Chair
A Smith, Chief Executive
R Barker, Non-Executive Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
C Carpenter, Non-Executive Director
K Kale, Executive Medical Director
N Lonergan, Interim Managing Director, Durham, Tees Valley and Forensic Care Group
J Maddison, Non-Executive Director
B Murphy, Chief Nurse
J Preston, Non-Executive Director and Senior Independent Director
J Robinson, Non-Executive Director
L Romaniak, Executive Director of Finance, Estates and Facilities
C Wood, Non-Executive Director
A Bridges, Executive Director of Corporate Affairs and Involvement (non-voting)
H Crawford, Executive Director of Therapies (non-voting)
S Dexter-Smith, Executive Director for People and Culture (non-voting)
K Ellis, Interim Executive Director of Strategy and Transformation (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)
L Cole, Head of Inclusive Cultures (for agenda item 14)
B O'Leary, Associate Director of Medical Development (for agenda item 13)

Observers:
C Hague, Governor
T Morris, Governor
J Williams, Governor

120. CHAIR'S WELCOME AND INTRODUCTION

The Chair opened the meeting and extended a warm welcome to the new Chief Executive, A Smith.

The Chair acknowledged that this would be Z Campbell's final meeting and she placed on record the Board's thanks for the contribution she had made to the Trust. She also noted that it would be the last meeting for C Carpenter and conveyed her appreciation for the significant contribution she had made to the Board.

She invited presenters to keep the presentation of report concise and proposed that S Dexter-Smith provide an evaluation at the end of the meeting.

121. APOLOGIES FOR ABSENCE

Apologies for absence were received from N Black, Chief Information Officer, from C Carpenter for lateness and from Z Campbell who needed to leave early.

122. DECLARATIONS OF INTEREST

None

123. MINUTES OF THE BOARD MEETING HELD ON 14 AUGUST 2025

Agreed: *The minutes are an accurate record, subject to the inclusion of R Barker in those present at the meeting.*

124. ACTION LOG

The following updates were provided:

- Action 118 [transformation programme] B Murphy advised that the link between the Transformation and Delivery Board and Quality Assurance Committee would be discussed at a committee developmental session early 2026, following the change in committee Chair.
- Action 51 (3) [IPR – clinically ready for discharge] N Lonergan advised that, as action owner, she had presented a scoping document to Resources and Planning Committee and would bring a report to Board in December.
- Action 95 (2) [digital and data risks] It was noted that the BAF risks would be considered by Resources and Planning Committee as the relevant committee, prior to Board and assurance on process would be provided to Audit and Risk Committee.

125. 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 noted an amendment to the report, as she had been unable to attend the strategic finance and performance review and drew attention to: the Trust's categorisation in segment 2 of the National Oversight Framework and publication of the model region blueprint; the recruitment of a Non-Executive Director and two Associate Non-Executive Directors, subject to final approvals; shortlisting for the Star Awards; and her recent visit to Willow Ward. She went on to welcome the Board seminar held on 11 September and noted the forthcoming Annual General and Members' Meeting on 23 October 2025.

126. QUESTIONS RAISED BY GOVERNORS

None.

127. BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

P Bellas presented the report, which provided information on risks included in the Board Assurance Framework to support discussion at the meeting. He drew attention to key changes, which included: proposed new risks related to health inequalities and transformation, amendments to the partnership and system working risk and adjustments to risk scores, including the target risk score for public confidence, where it was judged that although controls had improved, the Trust's ability to reduce the score was more limited than previously assessed.

In discussion:

1. Board queried if 'stakeholder confidence' may be more appropriate than 'public confidence' and, whilst an increase in target risk score was supported, given the Trust's operating environment, it was observed that no positive and negative assurances were provided in the report, despite the increased target risk score.

   In response, P Bellas advised that no new assurance information had been presented to a committee since the last board meeting.

A Bridges reflected on the challenge to address public confidence in the context of calls for a public inquiry and coroner inquests. Responding to a query, she noted that the risk was owned by the Board and would therefore not be reviewed by Quality Assurance Committee.
It was acknowledged that it was important to maintain the BAF summary report, as a public facing document and noted that the summary document provided an assessment of governance flow, with the full BAF scheduled for discussion later on the Board agenda.

2. Board welcomed the inclusion of a new BAF risk on health inequalities and proposed this would help to strengthen the connection between the NHS Oversight Framework and the BAF.

   L Romaniak noted there were a number of interlinked items on the board agenda and proposed that the framework provided a regulatory lens to work to coordinate data on different communities and track health inequalities.

3. B Murphy drew attention to BAF risk 4 [Quality of Care] and BAF risk 8 [Quality Governance] where the target risk score had been achieved and proposed, as supported by Executive Risk Group, to amalgamate and restate the risk to reflect the Trust's revised circumstances.

4. A query was raised on the report assurance process prior to Board and A Smith advised that executives would consider how assurance was provided to the Board through the Trust's governance arrangements. P Bellas proposed to discuss further with J Maddison following the meeting.

   J Maddison reflected on the purpose of the report; as an aide memoir to enable the Board to consider whether any items on the agenda had implications for the strategic risks, and he proposed that, as a live document, it may not always reflect real-time changes.

128. CHIEF EXECUTIVE'S REPORT

A Smith presented the report, which briefed the Board on topical issues of concern and summarised strategic and operational developments since the previous Board meeting.

She welcomed the support she had received since taking the role and the kindness, enthusiasm and professionalism of colleagues she had met. She went on to comment on: the importance of engagement with external stakeholders to build strong relationships; engagement with the Trust's leadership group and the opportunity to use those forums to strengthen relationships and foster open communication; the national context including potential for a national review of mental health services and collaboration between the Department of Health and Social Care and NHS England; colleagues who had been shortlisted for the Royal College of Psychiatrists Awards; and the strong regional focus on sustainability, given financial pressures.

129 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 drew the Board's attention to: reduced performance assurance in relation to patient safety incidents, albeit this was not a significant shift in position; further targeted action that would be taken in relation to mandatory and statutory face to face training and sickness absence; challenges related to achievement of the recurrent CRES target; and collaborative work underway to help reduce neurodevelopmental waiting times.

Commenting further, B Murphy proposed that, given the small numbers of patient safety incidents, a more nuanced approach to capture and analyse the data should be developed. She provided assurance that the reduction in performance assurance did not represent a deterioration in the timeliness of investigations leading to learning.

N Lonergan and Z Campbell summarised reported challenges for the care groups and drew attention to: targeted work underway to understand and address sickness absence, compliance with face to face mandatory and statutory training and clinical and management supervision; ongoing challenges in relation to patients clinically ready for discharge across Adult Mental Health Services and Mental Health Services for Older People; and the reduction in patients within rehab pathways, albeit delivery of complex care packages by the wider system continued to be a challenge.
Z Campbell also commented on collaboration with system partners to support the development of additional extra care and supported housing initiatives.

In respect of the finance measures reported, L Romaniak commented on the position in relation to Cash Releasing Efficiency Saving (CRES) proposals, which were weighted towards the end of the financial year, and drew attention to: the 40% reduction in agency and 10% reduction in bank staff to date; action taken to move from premia rate overtime to use of bank staffing; progress on delivery of recurrent CRES targets and to mitigate non-recurrent CRES; and the reduction in bed occupancy to 88%, which brought the Trust broadly in line with commissioned capacity and provided more confidence on safe staffing.

In discussion:

1. A query was raised about the number of patient safety incidents of no or low physical harm waiting investigation and N Lonergan advised that whilst significant progress had been made, there was a challenge in some areas where data cleansing was required or there had been a delay in securing sufficient information to close the investigation. B Murphy confirmed the matter had been discussed at Quality Assurance Committee.
2. The reduction in bed occupancy was welcomed.
3. S Dexter-Smith noted that sickness absence was a regional challenge and the Trust was focused on actions to improve attendance by supporting staff with long-term conditions to return to work. She also noted efforts to improve organisational grip and control and to review policies with staff side representatives and proposed that, although many health and wellbeing interventions were offered, their impact was not well evidenced. She noted a discussion would be held at People, Culture and Diversity Committee to provide assurance to the Board.
4. K Ellis advised that a dedicated session would be held with a range of colleagues to review both in-year and recurrent CRES.
5. Board sought assurance on the effectiveness of the keeping in touch process and N Lonergan advised that the process aimed to keep families informed and aware of escalation routes should circumstances change and she acknowledged that feedback from families in relation to neurodevelopmental waits, suggested they did not find the process impactful. She noted the additional challenge posed by the clinical time required to maintain the process and discussed the opportunity to explore productivity improvements to free up clinicians to help improve waiting times.

   K Kale discussed work undertaken by the Trust-wide ADHD and Autism Transformation Group to consider alternative support for those on waiting lists, including a pilot for online psychological therapies.

   B Murphy confirmed that Executive Directors Group was working with clinical leaders to respond to the question of patient experience and safety during waits and she assured the Board that improvements had been seen and that each person would be considered individually to ensure there was appropriate support was provided.

   The Chair noted that the Board has previously sought assurance on how the Trust knew people were safe while waiting and she referred to a recent visit to Fox Rush House, where the importance of primary care and the role of GP advocates had been discussed.
6. A query was raised about the discrepancy between the reported reduction in children and young people patient reported outcome measures PROMs and the improvement in clinician reported outcome measures CROMs.

B Murphy highlighted that outcomes would not be recorded where someone had transitioned into adult services prior to completion of their treatment and she suggested a more nuanced approach should be taken to reporting outcomes, which may better reflect performance, particularly for children and young people.

K Ellis proposed that the review of the IPR provided an opportunity to finesse the contextual narrative and it was noted that Quality Assurance Committee had recommended that benchmarking be incorporated into the report to provide additional context.

Agreed:

i. There is good controls assurance on the operation of the Performance Management Framework.
ii. There is reasonable performance assurance on the IPD.
iii. There is good performance assurance on the National Quality Requirements/ Mental Health Priorities.
iv. There is reasonable performance assurance on waiting times.
v. The strategic risks are being managed effectively.

130. NHS OVERSIGHT FRAMEWORK, QUARTER 1 2025/26

K Ellis presented the report, which provided an overview of the quarter 1 published data, oversight of current performance, where available, actions taken to improve performance in the required areas, and plans for future reporting.

She proposed that the Trust's position in segment 2 aligned with the Integrated Performance Report and reflected sustained organisational effort over several months. She noted the Trust was at the higher end of the 'range of ranking' indicator, which suggested movement over time was more varied than other Trusts and work would be undertaken to understand this – using the framework to benchmark against peers - and consider opportunities for learning and improvement and how to maintain and enhance performance over time.

In discussion:

1. L Romaniak discussed the issue of volatility in performance metrics and noted that while some metrics would change regularly some, such as those linked to annual submissions, would remain static throughout the year. She referenced the quarterly national cost collection submission through the federated data platform and proposed that national data systems increasingly supported Trusts to understand their own data and to benchmark against others.
2. B Murphy noted that the patient safety score reflected the outcome of the CQC inspection in 2022 and, as no unannounced inspection was planned, the score would be unlikely to change in the short term. She went on to advise that she had requested an inspection of Bankfields to demonstrate improvements in service delivery and provided assurance that the Trust had addressed concerns related to patient safety incidents, staffing levels, the environment and contact while waiting to access services.
3. A query was raised on whether the framework shifted emphasis away from CQC inspections and A Smith noted that performance measures had not been finalised and the Trust had worked with the national team to help shape metrics for mental health services. She proposed there would be a focus on metrics that mattered most for the Trust, whilst balancing regulatory and Trust priorities with the financial context.

   K Ellis suggested there some was commonality between the domains of the framework and the CQC approach and that quarterly reporting provided a tool for the Trust to regularly assess if the organisation had the right balance and was focused on what mattered most.
4. L Romaniak reflected on the lack of context around commonly used metrics and emphasised the need to understand and interpret data to accurately inform decision-making and performance improvement.

5. K Kale expressed concern that the access to services measure did not reflect the Trust's ambition for community transformation and may create a perverse incentive to see everyone, rather than a focus on what was right for each person.

Agreed: *Board receives the report with good assurance of the Trust's current segmentation, but with reasonable assurance that this can be maintained.*

131 APPRAISAL, VALIDATION AND JOB PLANNING OF DOCTORS

K Kale presented the report, which provided assurance to the Board that licensed doctors who worked in the Trust remained up to date and fit to practice.

Board queried the high number of consultants with 12 or more Programmed Activities and K Kale advised that some consultants balanced clinical duties with leadership responsibilities and/or provided cover for vacancies not filled by agency locums. He acknowledged that there would be a negative impact where consultants had a high level of Programmed Activities and advised that he had set a cap at 13, to safeguard their health and wellbeing. He also noted a significant reduction in the mind the gap metric, which reported on instances of staff cover for sickness.

Agreed: *there is good assurance that the Trust upholds a strong system for appraising and revalidating its doctors and the Statement of Compliance can be signed by the Chief Executive and submitted to NHS England.*

132 GETTING THE BASICS RIGHT FOR RESIDENT DOCTORS

K Kale and B O'Leary presented the report, which provided assurance that the Trust had considered the NHS mandate that set out expectations in the form of a ten-point plan to improve the working lives of resident doctors on placement with the Trust.

In discussion:

1. B O'Leary highlighted that the GMC survey results had placed the Trust in the top 10 nationally and he noted the Trust had implemented a resident doctors charter and forums for engagement, which helped doctors feel heard. He noted that facilities remained an area for improvement and suggested that overall resident doctors were satisfied with their placements.
2. K Kale advised that he had shared the report with the regional medical director who indicated the Trust appeared to be the best in the north east.
3. A query was raised about the link to the Non-Executive Director (NED) role for safe working and P Bellas/K Kale clarified that the NED role was linked to the Guardian of Safe Working, who monitored and reported to the Board on safe working conditions for doctors, including their on-call duties and would escalate concerns about working patterns to the NED, if required.
4. It was proposed and agreed that the Board would receive a regular update on the Trust action plan, alongside the report of the Guardian of Safe Working. **Action: K Kale**
5. Assurance was provided that the Trust would monitor any unintended consequences arising from the agreement that resident doctors were able to park in designated disabled spaces whilst on-call.

Agreed: *there is a good level of assurance that the Trust has considered the NHS mandate and expectations set out in the ten-point plan to improve the working lives of resident doctors.*

133 WORKFORCE RACE EQUALITY STANDARD, WORKFORCE DISABILITY EQUALITY STANDARD, SEXUAL ORIENTATION WORKFORCE EQUALITY STANDARD AND PUBLICATION OF STAFF EQUALITY INFORMATION

S Dexter-Smith/L Cole presented the report, which provided assurance that the Trust had met the requirements of the NHS Standard Contract by gathering data for the WRES, WDES and sought

approval from the Board to publish the results and the associated action plan. It was noted that the Trust also undertook and published data for the SOWES.

S Dexter-Smith advised that the report would be discussed in detail at the next People, Culture and Diversity Committee and suggested that the appointment of a Head of Inclusive Cultures would ensure a coherent Trust response and reflected a move away from a focus on statutory reporting to impact.

In discussion:

1. Board emphasised the need to provide context to the data and clearly communicate actions taken in response.
2. Reference was made to feedback the Board received through the staff network story prior to the meeting and the Trust's responsibilities to respond to concerns about suicide rates among individuals whose gender differed from their birth gender and where data showed harassment of staff from patients and colleagues.

   S Dexter-Smith confirmed that the Trust would take a robust approach to any concerns and expressed admiration for staff who continued to perform despite carrying a significant emotional burden.

Agreed:

i. There is good assurance that the Trust has followed a robust process in analysing its staff data by protected group and the actions provide a clear response to the concerns raised, and in doing so has met its NHS Standard Contract requirements and Equality Act duties.

ii. Data can be published onto the external website.

134 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

J Preston provided a verbal update on the key areas of discussion at the committee meeting on 4 September 2025 and drew attention to: proposals to maintain increased oversight on Orchard Ward; delays in the discharge of seven individuals from Bankfields; and concerns about crisis triage calls, albeit anecdotal feedback from a service user was positive. He also advised that committee had sought assurance that patients had received a copy of their care plan and had received reasonable assurance on section 17 leave, compliance with duty of candour, clinical outcomes and progress against the positive and safe strategy. Committee was able to provide assurance to the Board in relation to quality priorities; unannounced Mental Health Act inspections; the Medicines Optimisation and Pharmacy Annual Report; and reporting and learning in line with national guidance for learning from deaths.

The Chair confirmed that a written report would be provided to the next Board meeting.

J Maddison welcomed the rigour and constructive challenge brought to committee by the Chief Nurse and he summarised the key areas of discussion at the committee meeting held on 2 October 2025, drawing attention to: good assurance received on the approach taken in response to the development of Mental Health Act Inspections; progress on level loading across the nursing workforce; and good assurance received on the oversight and governance of perinatal services and limited assurance regarding the overall quality of care and experience. Committee was able to provide assurance to the Board on the use of tear proof clothing; the improvement in compliance with section 17 leave; and positive feedback from the CQC inspection of HMP Northumberland. He also advised that committee had sought further assurance on rehabilitation services and considered that there was good assurance that risks to quality were understood and managed appropriately.

Commenting further, B Murphy proposed that discussion at the Board meeting demonstrated there was good triangulation across internal governance and noted the proposal to use EDI data in a more sophisticated way alongside benchmarking data to help inform understanding.

She reiterated her proposal to restate the BAF quality risk, now that the tolerance threshold had been reached, to reflect the Trust's revised circumstances. She welcomed sustained improvement in the reduced use of tear proof clothing and safety planning for section 17 leave and noted there was an opportunity to collaborate and define best practice for rehabilitation services, led by the clinical specialty networks.

Board noted the recommendation of committee that the revised risk description for BAF Risk 14 [Health Inequalities] be approved and that the Publication of Patient Information 2025 be approved and published to the Trust website.

135 PUBLICATION OF PATIENT INFORMATION 2025

H Crawford presented the report, which provided good assurance that the Trust was meeting its obligations under the Public Sector Equality Duty of the Equality Act 2010.

She commented on plans to improve data completeness and strengthen oversight of data and actions, focused on how insights were understood, acted on and embedded into business practice. She noted that data was not weighted against local population demographics, and context would be provided to ensure clarity and accurate interpretation.

The report had been considered by Executive Directors Group, Quality Assurance Committee and Mental Health Legislation Committee and was recommended for approval. Alongside its publication the Trust would publish the Patient and Carer Race Equality Framework data, for completeness.

In discussion:

1. L Romaniak highlighted a discussion at Executive Directors Group, where additional analysis had been requested to understand the relationship between deprivation, ethnicity and access to services and how data would be used to inform action plans and weight resource allocation to care delivery in areas of disadvantage.
2. K Ellis indicated that she would provide feedback to the national team that the metrics of the health inequalities domain in the NHS Oversight Framework did not fully reflect genuine health inequalities. She proposed that the next iteration of the Integrated Performance Report would use a bundle of metrics to improve Board visibility and create a golden thread that linked oversight to organisational actions. She also stressed the importance of partner engagement in addressing health inequalities, acknowledging that not all issues were within the Trust's control.
3. K Kale noted that he had contacted the national team to understand the analysis of detention rates by ethnicity and deprivation, following discussion at Mental Health Legislation Committee.
4. P Bellas confirmed that the Board report included a section on 'prior consideration and feedback' to clarify where reports had been considered by committee in advance of the Board.

Agreed:

i. There is good assurance that a robust process has been undertaken when developing the data on patients from protected groups.

ii. Data can be published on the Trust website, as required by the Equality Act 2010.

136 LEADERSHIP WALKABOUTS FEEDBACK

A Bridges presented the report, which summarised feedback from leadership walkabouts that took place in August 2025.

In discussion it was agreed that a bi-annual progress update on the action log would be included in the report.

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

137 REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

R Barker shared her reflections on the committee's progress, noting the positive contribution that the lived experience director made to the meeting and the inclusion of case studies to illustrate how legislation had translated into practice. She also highlighted improvements in governance, including through the multi-agency operational sub-groups where attendance had become consistent and productive over time.

She went on to summarise the key areas of discussion at the committee meeting on 1 September 2025 and drew attention to: the continued focus on the Mental Capacity Act and Deprivation of Liberty Standards, where improvements had been noted; delivery of bespoke training and resources on the intranet by the Mental Health Legislation Team to support staff; and the positive feedback received through the annual committee performance evaluation and optimism on the insights that would be provided by the new performance dashboard.

Board noted the recommendation of the committee that its revised terms of reference be approved.

138 CHARITABLE FUNDS COMMITTEE

J Preston provided a verbal update on the key areas of discussion at the committee meeting on 8 October 2025 and drew attention to: clarity provided that voting members of the Board were Trustees of the charity; the re-determination of funds as 'restricted' with donations linked to specific services or geographical area and the availability of the Trustee Fund for wider use; development of the charitable funds strategy and appointment of a fundraising officer; Trust attendance at a regional charitable funds forum; discussion on use of expired IT equipment to support the voluntary and community sector to deliver access to services; and potential to launch the charity alongside the Trust's anniversary celebrations in May 2026.

A Bridges reflected on the opportunity for the charity to develop a strategy, increase its awareness and position it as the preferred choice for fundraising. She welcomed learning from the regional forum and discussed the need for a stronger online presence, including development of a platform for donations.

She also referred to the potential to link the recycling of digital devices to the CAMHS programme, which had become increasingly digital and B Murphy went on to note that she had links to mental health charities in Nigeria and Ghana and welcomed the opportunity to be involved.

139 COMMUNICATIONS UPDATE

A Bridges presented the report, which provided an update on progress to deliver the Trust's communications strategy in August and September 2025, including an overview of key pieces of work, how they supported the Trust's objectives and metrics to demonstrate how the impact of communications was measured.

She noted there were a number of factors that influenced delivery against the BAF risk and drew attention to: media coverage during the period, which had been dominated by a high-profile inquest and had significantly influenced sentiment in August and September; press and campaign activity; the profile of digital channels and social media, which showcased community health team visits and other positive stories; and noted positive visits by the Getting it Right First Time Team and the CEO of NHS Providers. She concluded by reminding the Board of the AGM on 23 October and award ceremonies on 6 November and 23 November.

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

140 BOARD ASSURANCE FRAMEWORK (VERBAL)

The Board agreed that there were no matters arising from the discussion at the meeting that changed the position reported in the Board Assurance Framework.

141 EVALUATION

S Dexter-Smith provided feedback on the meeting and suggested that it was calm, warm and purposeful with clear strategic oversight maintained throughout. She proposed: that more time be dedicated to the Integrated Performance Report and NHS Oversight Framework, given their importance; that BAF risks were not always reflected in the content of reports; and that more detail could be provided in the 'prior consideration' section of reports to provide clarity on the depth of committee level scrutiny that occurred prior to the Board.

142 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 3.57pm.

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
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	N Lonergan	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 Quality Assurance Committee, including with Integrated Care Board attedance and noted to the board in the Quality Assurance Committee report to the board. **Dec25 update: work completed on AMH and MHSOP but further work is planned. EDG to consider a report in February 2026 prior to Board in April 2026.**
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	Oct-25	**Completed**	Oct25 update: Resources and Planning Committee completed a review of BAF Risk 7 - digital security and protection at the meeting held on 1 October 2025.
09/10/2025	**132**	**Getting the Basics Right for Resident Doctors**	**Regular update on the Trust action plan to be provided to the Board alongside the report of the Guardian of Safe Working.**	**K Kale**	**Jun-26**		**Update scheduled on the Board Workplan for April 2026**

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Interim Chair Report

Public Board Meeting December 11th 2025

External Meetings

It has been another busy few months for everyone. As ever, there has been a number of national, regional and Integrated Care Board (ICB) meetings, with particular focus on the NHS England Medium Term Planning Framework – delivering change together 2026/27 to 2028/29. The framework clearly articulates:

- The end of short-termism which means we are able to move away from annual to medium term financial and delivery cycles
- It supports the closure of the gap between the national centre and local services
- The return of locally led ambition which allows Boards and leaders to produce plans in line with what our communities need

As expected, this has required a significant amount of intensive work with challenging timescales to meet submission requirements by 17th December 2025. This is an extremely important plan for us. NHS England have made their expectations of Boards very clear. This is a substantial agenda item in our Private Board Meeting today.

Recognising the future operating model for NHS England, The Department of Health and Social Care and Integrated Care Boards will formally commence on 1st April 2027, it is clear we need to continue to focus on delivery of our strategy, good provision of services, and play our part in the delivery of the 10 Year Health Plan, encompassing the three shifts and submit and honest Medium Term Plan with appropriate Board assurance statements. The refreshed operating model provides the means for achieving the vision.

Key themes from the Chairs meeting include:

- Challenges of timescales attached to the Medium Term Planning Framework and the caveats attached to submission on 17th December 2025
- Finance, productivity, and efficiency alongside the absolute need to safeguard quality of care.
- Assurance on the delivery of Winter plans – heightened last week due to the announcement on further Resident Doctors planned action prior to Christmas.
- Further understanding of the role of Advanced Foundation Trusts and Integrated Healthcare Organisations and the future role of Governors.

I continue to attend the National NHS Confederation Mental Health, Learning Disability and Autism (MHLDA) Chairs meetings. Again, finance remains a constant topic and we received a presentation on the future role of Mayors and health commissioning.

I continue 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. We have asked to meet jointly with CEOs in the New Year.

I, along with the CEO, attended the NHS Providers Conference in Manchester for two days in November. The agenda was packed with a wide variety of speakers. It was great to listen to Daniel Elkeles, NHS Provider CEO champion TEWV in his opening speech. There were also visuals of our work in the exhibitors hall where we, along with others were described as "trailblazers" in our approach to community transformation in Hartlepool.

I attended a NHS Provider Chairs and CEO event online on 2nd December. There were a lot of takeaways for me. A very powerful set of presenters spoke about Anti Racism. One in particular that I have shared with our Director for People and Culture where a local Trust describes treating racial abuse as a "never event" which we need to explore further. I also took the opportunity to introduce myself (and TEWV) to Dr Toli Onon, the Chief Inspector of Hospitals for the CQC and ask her a question about honest, open and transparent relationships with trust at the CQC centre and a secondary question on follow up inspection timescales.

Council of Governors Activity

I have chaired the Public and Private Council of Governors Meeting on 22nd October. It was well attended both in the room and online. There was also good attendance and excellent feedback on the development session held on 6th November. Thanks to our Safeguarding Team for providing Governors with statutory training.

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 attended Durham, Tees Valley and Forensics Locality meeting on 3rd December with an informative Q&A session was facilitated by the Interim Managing Director.

Annual General Meeting

I was delighted to attend and speak at our Annual General Meeting on 23rd October at Teesside University. It was lovely to see so many people in the room and online. A huge thanks to our staff who did a tremendous job in showcasing their work so proudly. We are proud of our achievements in 2024/25 as described in our Annual Report. Our new CEO was very clear in our collective view that we will move TEWV forward in 2026/27 and beyond. Also thank you to our Communications Team who helped to ensure things ran smoothly.

On a personal note, I benefitted hugely from attending:

1. I had my flu jab
2. I joined our Library
3. I made contact with our Practice Development Team and invited myself along to some learning sessions with Students in the New Year. I will use this as part of my Revalidation Reflective Studies when I revalidate with the Nursing and Midwifery Council Next Year.

STAR Awards

The 6th November 2025 was a proud night for us all. The annual STAR Awards were absolutely fantastic. Recognising staff for the amazing work they do day in and day out has been the highlight during my time as Interim Chair. I will never forget that night, the emotion in the room, the compassion, the passion, the joy, the happiness, and of course the tears! I am proud to be your colleague.

Ridgeway Awards

Another evening of celebration that is always a highlight in many colleagues diaries are the Ridgeway Awards. They were held on 23rd October and attended by some of our community stakeholders. Our patients were celebrated for their contributions and achievements in many categories. We heard from many talented people from poetry recital, to guitar playing and singing. Ridgeway – you have talent! Some of our patients also worked with a locally bakery and made the bread for the evening meal. Our CEO has signed up for bread making lessons.

Living The Values Awards

Congratulations to all of our Living the Values Awards winners during the last 2 months. I was delighted to visit Birch Ward at West Park and not only learn about adult in patient eating disorders, but to meet Sean Palmer and staff and handover their gift.

Leadership Walkabout

Thank you to Gemma Readman and staff on Willow Ward at West Park for hosting Group 5s leadership visit on 27th October. It was lovely to meet up with my painting buddy again, although they were off on a home visit so no time to paint this time. The group were in awe of a compassionate patient story from Gemma and of her ideas in how we could consider re purposing estate.

Board Strategic Seminar

I attended the Board seminar session on 13th November led by NHS Providers Digital Team. It was informative and challenging of us which we welcome. A set of actions will be revisited in the New Year as we understand our journey through a key shift – analogue to digital.

Interim Chair – Out and About

I continue to get out and about in my quest to meet our staff, listen, learn and connect. The staff, patient and carer voices are incredibly important to me.

I would like to see more "I listened, I did" as part of our responsibility and accountability values. #ILID I will discuss with our CEO in the New Year.

I finally managed to visit our York Hub on 15th October. Thank you to Madeleine Vernon-Smith and colleagues for a very informative discussion and walkabout. We talked about outcomes, impact and evaluations. Our Medical Director and Care Group Medical Director are supporting. I met with users of the service who certainly gave me very positive views of the service.

Huge thanks to Chris Morton and Mark Allen from our Lived Experience Team. Collectively, the LET have delivered on their promise to set me some objectives during my time as Interim Chair. I will do my best! It is always a pleasure to meet with them as their work is invaluable to us as a Trust. I have also met with our Staff Network Chairs and asked the same of them too.

Thank you to Jo Cook and Emma Cassie our suicide prevention leads for meeting with me and taking me through work being undertaken by TEWV and our partners in preventing suicide across our geography. I have asked that the Board have a bespoke seminar session as part of our learning, understanding, development and assurance.

About 12 months ago, I visited our Individual Placement Support (IPS) service at Parkside in Middlesbrough to present Dave Hutchinson, Senior IPS Advisor with a LTV Award. Very powerful story of how he had worked with a gentleman to get him back into paid employment. The nomination was from a Mum. Dave invited me to a lunch event to promote the service. Thank you to Dave and Mark Fryett for making my day on 29th November. Not only did I get to find out even more about the service, I met a young adult who has starting their first shift back at work on the next day. But, Dave brought the Mum who nominated him for the LTV into the room to meet me. It was a fabulous experience and great to get an update. This service is amazing and does not just help one individual, but creates a human domino effect for so many others.

I was incredibly proud to visit Westerdale North and Westerdale South at Roseberry Park on 3rd December. Thank you to Kelliann Facchini, staff and patients for having me. I have brought a lot away with me once again. The reality of hearing impactful stories from front line staff of patients who are ready to be discharged, but for many reasons, their discharge is delayed, links the Floor to the Board understanding in a way that a performance discussion could not.

Finally, a significantly wonderful surprise visit to Val Heard, Secretary at Westerdales. Val turned 80 on 3rd December and she was at work! With 25 years NHS experience

across Teesside, it was an absolute pleasure to meet her and give her some gifts on behalf of the Board, along with a Happy Birthday and our best wishes. Val gets 3 buses to work and 3 back home and during Covid – she was 75 - got a bus and a train to Hartlepool and back (personal protective equipment on), never missed a day....and never caught Covid. I am very pleased to say that she has no retirement plans! I am also very pleased and proud Val is our colleague.

Bev Reilly

Interim Chair

4th December 2025

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11 December 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 2, 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 11 (Roseberry Park) – External Audit – 2nd line
   - BAF 14 (Health Inequalities – Draft) – all controls

(2) 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)

(3) The following risks are recommended for closure:
   - BAF 4 (Quality of Care)
   - BAF 8 (Quality Governance)

(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

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** **PCDC (13/10/25):** ▪ Good assurance that the Trust has followed a robust process in recruiting, training, and inducting volunteers ▪ Good assurance on the delivery of the People Journey ▪ Good assurance on the link between the indicators for a strong and healthy culture aligned with Trust values and related interventions ▪ Good assurance that the Trust upholds a strong system for appraising and revalidating its doctors. **QuAC (27/11/25):** Good assurance on the oversight of staffing, with a downward trend in the number of agency staff **Annual Staffing Establishment Review:** Proposed good assurance that the Trust has: ▪ Met the National Quality Board requirements to complete and report out the annual Safer Staffing Review ▪ Improved the risks associated with short staffing consistently since 2023 **Medical Education:** Proposed good assurance from the Medical Education Leadership Team on medical education activity during the last twelve months **Negative** **PCDC (13/10/25):** ▪ Reasonable assurance that the interventions regarding culture and retention, based on the	-	**Public Agenda Item 13** - Safe Staffing **Public Agenda Item 14** - Quarterly Report of the Guardian of Safe Working **Public Agenda Item 15** - Medical Education Annual Report
											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			

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	1	2	3										data provided, are achieving the impact expected *The Committee noted:* ▪ *That sickness absence now forms part of a formal Trust-wide performance plan and learning will be sought from Trusts who have made an impact on this metric* ▪ *The need for greater awareness of work being undertaken within Medical Development in areas of shared focus* ▪ *The proposed governance arrangements for future reporting in respect of the existing Health and Wellbeing report, a new Workforce data report and a combined Inclusive Cultures report (including Culture and Retention)* ▪ Reasonable assurance on the impact of the alignment and oversight of health and wellbeing activity *The Committee noted that there was clarity regarding gaps in control and plans to strengthen assurance levels*		
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** -	**-**	
											Demand Modelling	▪ Associate Director of Strategic Planning and Programmes – Lead for demand modelling in the Trust	**Negative** -		
											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			

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									▪ On-call arrangements – Agreement of actions in response escalation ▪ Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand ▪ Daily Lean Management Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services			
											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** **QuAC (27/11/25):** Good assurance in relation to oversight of risks to lived experience and co-creation activity **EDCAI Update:** ▪ Draft reimbursement policy now drafted and consulted upon extensively – for approval Q4 2025/26. ▪ Workshops taken place over 12-18 months on how team structures embed the Co-creation framework and the strategy ▪ Positive feedback of more developed support and training for involvement members. ▪ Train the trainer – co-creation champions have been trained on a "whistle stop tour of co-creation **Negative** **QuAC (27/11/25):** Reasonable assurance in relation to actions to mitigate against progress of the lived experience strategy *Action:* ▪ *Reset being undertaken, with support from DTV care group / Co-creation Board representatives re combined governance and learning.* ▪ *Restructure of the Co-creation Service - formal consultation extended*	-	
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	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	**Positive** **QuAC (27/11/25):** Good assurance on complaints compliance **IPR:** ▪ Carers reporting that they feel they are actively involved in decisions about the care and treatment of the	-	

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												
				and a breach in the Health and Social Care Act.								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. ▪ 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.	person they care for (metric 2) - *increased controls assurance* ▪ Inpatients reporting that they feel safe whilst in our care (metric 3) - *increased controls assurance* ▪ Adults and Older Persons showing measurable improvement following treatment - patient reported (metric 5) - *increased performance and controls assurance* **Negative** **QuAC (27/11/25):** Reasonable for patient/carer experience *Action: Issues with limited reporting due to transition to new system to be resolved with full report to the Committee's meeting in December* **IPR:** Restrictive Intervention Incidents Used (metric 12) - *reduced performance assurance / reduced performance assurance* *Actions:* ▪ *In relation to DTVFCG ALD services:* ▪ *Monitoring the use of restrictive interventions and seeking support from the Specialist Practitioner for Positive & Safe* ▪ *More targeted clinical supervision to support implementation of Positive Behaviour Support plans* ▪ *Positive & Safe Clinical Skill training into Bankfields Court to support safe management* ▪ *Specialist Practitioner for Positive & Safe to provide additional supervision and reflection sessions*		
												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 organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the			

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									patient experience metric (based on FFT data)	*throughout November 2025* ▪ *Across the Trust, a rolling programme of Reducing Restrictive Intervention Panels has been established for those patients identified as needing specific support.* ▪ *PDTVFCG SIS to progress a proposal to split the ground space within Ivy/Clover ward into two inpatient areas to support the management of those patients with complex needs.* ▪ *Specialist Practitioner for Positive & Safe and Professional Nurse Advocate to provide additional support to SIS on holding techniques*		
											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 ▪ 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			

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	1	2	3												
											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** **CIO Update:** ▪ Release 3.1, 3.2 and 3.3 of cito now live. Release 3.4 expected for testing early December. ▪ Cito optimisation training programme concluded. Additional support provided through cito community of practice. ▪ Digital strategy will be refreshed by end March 2026 to align with business priorities, NHS 10-year plan and to include focus on EPR Implementation. ▪ IIC CITO data quality dashboard now live with additional measures created. ▪ Digital roadmaps created and shared monthly with DPB. ▪ Propose to review and reduce CITO risks scores at next cito improvement group meeting. **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	▪ Digital Management Meeting ▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (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												
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 transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.	**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** - **Negative** -	-	
											Estates Master Plan	▪ EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework ▪ Finance Department – Responsible for the preparation of the annual capital and revenue financial plans for Board approval			
											CIG & CPSG	▪ Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements			
											Estates, Facilities & Capital Directorate Management Team Meeting	▪ All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital			
											ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring ↑	▪ EFM Directorate responsible for: ▪ **PLACE** ▪ Organising (with CA&I) the PLACE assessment visits ▪ Compiling the information ▪ Submission of the information to NHSE ▪ Preparation of the Action Plan ▪ **ERIC** Compiling and submitting ERIC submission to NHSE and considering actions taken in response to benchmarked outputs ▪ **PAM** Self-assessment against the questions included in the PAM and on the delivery of resultant action plans, processes in train to ensure timely submission			
											Environmental Risk Group	▪ Director of Estates, Facilities and Capital ensures aligned CPSG and ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs ▪ Directors of Operations / Operational teams support identification of environmental issues ▪ Service desk tracks levels of maintenance issues			

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												
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 information integrity, reputational damage and loss of confidence in the organisation.	**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** **CIO Update:** ▪ Cito training compliance on ESR with additional support materials provided for Medics and Junior doctors. Training needs analysis commenced in Q3 2025/26. ▪ NHS Providers Digital Board training held in November 2025. Cyber board training booked for March 2026. **Negative** **CIO Update:** DSPT actions are behind schedule *Action plan in place to address this.*	-	
											Secure IT infrastructure and asset management.	▪ DPAG			
											Cyber Security and Incident Management	▪ DPAG			
											Data Security and Protection Toolkit (DSPT) and Information Risk Management fully operational	▪ DPAG			
											Robust Clinical Safety and Change Control	▪ DPAG ▪ DPB ▪ Digital Change Assurance Board			
											Digital service delivery monitoring	▪ Digital Programme Assurance Group (DPAG)			
8	✓	✓	✓	**Quality Governance** **There is a risk** that our floor to Board quality governance does not provide thorough insights into quality risks **caused by** the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information **resulting in** inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	**CN**	**QuAC**	**Moderate 9** (C3 x L3) ↓	**Moderate 9** (C3 x L3) **Target Achieved**	**Target Achieved**	**Good**	Open and transparent culture working to organisational values steered by Our Journey to Change	▪ Cohesive Board ▪ Engaged and visible Executive ▪ High Quality Care Group Directors ▪ Substantive recruitment of service leadership and clinical teams	**Positive** **QuAC (27/11/25):** ▪ Good assurance relating to progress against the Integrated Oversight Plan, as well as CQC activity ▪ Good assurance relating to the approach, pipeline and governance over Quality Impact Assessments (QIA) ▪ Good assurance on the development and progress of medical device services. Corrective measures are being taken to address remaining gaps in asset data completeness and incident reporting ▪ Good assurance also on the current standards, processes to meet compliance with regulation in Resuscitation services	-	**Public Agenda Item 17** - Learning from Deaths Report **Public Agenda Item 18** - Research and Development Annual Report 2024/25 **Public Agenda Item 19** - Innovations Annual Report 2024/25
											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.			

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	1	2	3												
											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 delivery levels with a role to assess delivery of care standards	**Learning from Deaths:** Proposed good assurance on the reporting and learning from deaths in line with national guidance **Negative** **QuAC (27/11/25):** Concerns linked to compliance with clinical supervision, following the outcome of the Internal Audit report, with limited assurance Action: *A compliance report on clinical supervision is due to be considered by the Committee on 22/12/25*		
9			✓	**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	**Good**	Active engagement in Collaborative forum at regional, ICB and local level to help shape system strategic planning and delivery	▪ Engagement in a wide range of partnership functions and committees/ groups across each place, in line with individual place governance structures ▪ Joint work / operational processes with local authorities and other partners including PCNs ▪ Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future	**Positive** - **Negative** -	-	
											Strategic Framework	▪ Visibility of Strategic Framework through internal / external comms (so that it is widely known what our strategic Goals and Objectives are)			

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	1	2	3												
									and place based sub-committees and other key 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** Target Achieved	31/3/25 Delivery of CQC Improvement Plan (-1L) Target Achieved	**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** **PCDC (13/10/25):** ▪ Good assurance in respect of the risk management processes in place ▪ Good assurance that the strategic 'Safe Staffing' risk continues to be managed effectively ▪ Good assurance that the Trust has followed a robust process in analysing its staff data by protected group and that in doing so it is meeting its NHS Standard Contract requirements and Equality Act duties **RPC (3/12/25):** Good assurance on the management of the strategic risks assigned to the Committee **QuAC (27/11/25):** ▪ Good assurance that the strategic risks included in the BAF continue to be managed effectively	**-**	**Public Agenda Item 21** - Charitable Trust Annual Report and Accounts **Confidential Agenda Item 27** – Medium Term Plan **Confidential Agenda Item 31** - NHS Oversight Framework
											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			

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	1	2	3								↑	▪ Estates & Facilities DMT maintain routine operational oversight	▪ Good assurance on the oversight and management of the organisation's corporate risks **Negative** -		
											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			
											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 –			

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	1	2	3									▪ Consider capture and maintain risks raised by staff in local risk registers ▪ Develop and implement action plans to ensure risks identified are appropriately treated ▪ Ensure that appropriate and effective risk management processes are in place and that all staff are made aware of the risks within their work environment ▪ Other Executive Directors - Responsible for ensuring effective systems for risk management, are in place within their directorate ▪ Head of Risk Management – Day to day management of the Trust Risk Register			
											Health Safety and Security (HSS)	▪ The Trust has a Health, Safety and Security Team who manage the day-to-day Health and Safety requirements in line with all relevant parliamentary acts ▪ Reporting system is in place for the reporting of incidents which fall under the requirements of Reporting of Incidents of Disease and Dangerous Occurrences regulation (RIDDOR) ▪ Provision of HSS information for new employees at Trust induction. ▪ HSS awareness training forming part of all staff mandatory package. ▪ HSS online tool kit available for all services, wards and departments across the trust. ▪ Regular workplace audits undertaken by the HSS team. ▪ Incidents recorded on 'InPhase' are shared with relevant service leads, including HSS. This enables investigation of incidents to identify trends and flag any remedial actions			
											Executive and Care Group Leadership, management and governance arrangements	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolio ▪ Individual staff compliance with the range of policies relating to regulatory compliance e.g. health and safety			
											Inquests and Coroners	▪ Inquest Team - Management of the Inquest process from a Trust perspective including: ▪ Arranging and compiling witness statements and submission to Coroner ▪ Instruction of Solicitors ▪ Co-ordination and compilation of information ▪ Provision of support for staff ▪ Preparation of responses to Regulation 28 Reports by staff nominated by the CEO			

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												
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 financial plan outcomes (recurrent financial position)	**Good**	ICB Financial Governance including Mental Health LDA Arrangements and CEO Leadership and DoF financial planning groups and sub groups	▪ DoFE member of ICS DoF/CFO group ▪ DoFE member of ICS Resource Allocation Steering Group ▪ CEO member of NENC CEO provider collaborative group ▪ CEO connected to HNY provider collaborative work for MHLDA ▪ DCEO / CNTW COO leading Provider collaborative work to assess implications for beds / pathways and clinical models	**Positive** - **Negative** -	**-**	**Confidential Agenda Item 27** – Medium Term Plan
											Executive Directors Group (Financial Sustainability Focus	▪ Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of underlying financial position			
											Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	▪ DCEO -Responsible for the delivery of the Business Planning Framework ▪ DoFEF and EDG – Responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers ▪ Managing Directors (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. (Reporting into FSB and EDG with assurances into P&PC and Board)			

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	1	2	3												
13	✓	✓	✓	**Public confidence** **There is a risk that** ongoing external scrutiny and adverse publicity **could lead to** low public and stakeholder perception and confidence in the services we provide	**DoCAI**	**Board**	**High 20** (C5 x L4)	**High 20** (C5 x L4)	Risk score unlikely t0 change in the medium term	Reasonable	Communications Strategy	▪ Director of Corporate Affairs and Involvement ▪ Head of Communications ▪ Communications team	**Positive** **EDCAI Update:** ▪ In 2025 (Jan–Nov), there was an increase in proactive news releases, rising from 51 in 2024 to 114 so far this year ▪ Volume of media coverage increased this year, with 632 pieces in 2025 (Jan–Nov) ▪ Sentiment analysis (reported from Jan 25), shows 68% of coverage positive or neutral ▪ Monttly communications strategy update approved by EDG (2/12/25) with 'good' assurance on 2 Dec 2025. **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	✓	✓	✓	**Health Inequalities** 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."	**DCEO**	**QuAC**	**High 16 (C4 x L4)**	**Moderate 12** (C=4 x L=3) **TBC**	**TBC** (-1L)	**Limited**	Build public health capability and capacity		**Positive** - **Negative** -	-	
											Use of Data, insight, evidence and evaluation				
											Strategic leadership & accountability				
											System Partnerships				

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												
15			✓	**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** -	-	

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For General Release

Meeting of:	**Board of Directors**
Date:	**11th December 2025**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**N/A**
Report Author(s):	**Alison Smith, Chief Executive**

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

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

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

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
N/A		

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

My on-boarding, getting to know the Trust has continued both in terms of travelling to various locations visiting services, wards and colleagues, alongside continuing to meet local leaders, NHS, system partners and voluntary sector organisations. I was also honoured to represent TEWV at the Remembrance service in Darlington and the Road Traffic Accident Remembrance service in Durham.

I intend to reduce the introductory meetings in the New Year, hopefully, to focus on visiting TEWV services and facilities, whilst also getting to know the local communities by engaging with Patient Representative Groups who play a critical role across our NHS.

Matters of strategic Performance

NHSE Communication
Sir Jim Mackey, NHSE CEO and the team have been very focused on preparation for winter both in terms of managing the compliance in reducing those waiting for planned, elective procedures, reducing ambulance waits and cancer diagnosis. This focus could have been distracted by the recent Drs in Training industrial action for the week of 14th November however the planning, familiarisation and support ensured there was little impact. However, with further industrial action planned on the run up to Christmas we are doing all we can to be prepared during this busy time. In addition, the modelling of the impact of flu based on our Southern Hemisphere health responses and impacts is suggesting that respiratory diseases will increase the risk of lack of flow and longer delays for those needing care. We have promoted and supported schemes to increase the Flu vaccination uptake, alongside our partner NHS organisations and will continue to do so over the coming weeks and month.

NHS Providers and NHS Confederation
Mathew Taylor and Daniel Elkeles confirmed their merger on the 29th of October 2025, subject to there being no material issues emerging from the due diligence. This paves the way for a single membership body to represent NHS organisations across England, Wales and Northern Ireland more effectively. Its purpose will be to improve the NHS and the health of the people of the UK as the independent membership body providing an influential voice for NHS leaders and supporting its members to drive improvement.

Integrated Care Systems
In April 2025, NHS England chief executive Sir James Mackey outlined key NHS reform priorities for 2025/26. This included putting measures in place to address the underlying deficit for the NHS and the need to achieve overall financial balance. At this time, it was made clear that all 42 ICBs were to support this by reducing their running and programme costs by around 50%. There has been a delay however the secretary of state shared the consultation was now imminent during his speech at NHS Providers Conference in November. The strategic commissioning framework clarifies that the purpose of ICBs as a strategic commissioner is to ensure that they continuously plan in an evidenced based way, purchase, monitor and evaluate services with the overarching aim of improving population health, reducing inequalities and improving equitable access to consistent high quality health care. ICBs have a responsibility to ensure they have implemented an operating model that supports this way of working. ICBs purpose will focus on improving population health and ensuring access to consistently high-quality services.

ICBs will provide system leadership for population health, setting evidence-based and long-term population health strategy, and working as a healthcare payer to deliver this, maximising the value that can be created from the available resources.

NHSE Regions

The model region is to become the key part of the new NHS Operating Model in England, providing clarity on the organisational responsibilities, help improve operational performance and devolve decision-making. The new regional Blueprint comes ahead of the abolition of NHSE as the NHS merge into the Department of Health and Social Care (as shared at our last board). The blueprint demonstrates the core functions of the regional team which will maintain their geographical footprints, emphasize their performance management role and emphasise the enhanced and expanded roles for the regional team. Which will be supported by new governance structures with an executive team, chief executive and non-executive chair in each region.

Celebrate

Since we last met we have held our Annual General Meeting to celebrate and acknowledge not only submitting our annual accounts, also, celebrating the last year where TEWV saw 317, 122k patients, 108,747 calls to our crisis lines, 93% of our patients rated our services as good or very good to name a few of the incredible things achieved in the last 12 months.

TEWV held its annual staff awards, awarding 12 awards in an evening of celebration, recognition and humility for all those who care for others.

Sustainability

We remain focused on our financial compliance and sustainability, as do our ICB colleagues and over the coming weeks, we with others will be submitting our medium-term operational plan.

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

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11th December 2025**
Title:	**Board Integrated Performance Report as 31st October 2025**
Executive Sponsor(s):	**Kathryn Ellis, Interim Executive Director of Transformation & Strategy** **Naomi Lonergan, Interim Managing Director, Durham, Tees Valley & Forensic Care and North Yorkshire & York Care Groups**
Report Author(s):	**Sarah Theobald, Associate Director of Performance** **Ashleigh Lyons, Head of Performance**

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

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

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

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	Safe Staffing	There is a risk that some teams are unable to safely and consistently staff their services caused by factors affecting both number and skill profile of the team. This could result in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.
2	Demand	There is a risk that people will experience unacceptable waits to access services in the community and for an inpatient bed caused by increasing demand for services, commissioning issues and a lack of flow through services resulting in a poor experience and potential avoidable harm.
4	Quality of Care	There is a risk that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; caused by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions resulting in a variance in

		experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.
5	Digital – supporting change	There is a risk of failure to delivery Our Journey To Change goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems.
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** on the operation of the Performance Management Framework.
- **Good performance assurance** on the Trust's current NOF segmentation; however, with **reasonable** assurance that our NOF segmentation can be maintained.
- **Reasonable performance assurance** on the IPD, National Quality requirements/Mental Health Priorities and on 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 has been a reduction in the performance assurance for national Quality requirements/Mental Health Priorities this month, which previously provided Good assurance.

Overview:

Updates to note this month

Controls Assurance: Our Controls Assurance Framework is determined based on Statistical Process Control (SPC) variance or, where this is not appropriate, using forecast position or national benchmarking data. The framework has been updated in November 2025 in conjunction with Company Secretary, to reflect the application of the 'Neither' rule, i.e. those measures where good performance is not necessarily indicated by an increase or decrease in activity.

Patient and Carer Experience: Following the implementation of the new patient experience system in mid-September; only partial data is available for our measures and whilst data is available for the whole of October, a significant reduction is visible in response rates (and corresponding increase in performance in the measures). We continue to embed the new patient experience system and paper versions of several surveys have now been developed, which are anticipated to have a positive impact.

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 Integrated Care Group Governance 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 **21** measures (68%) with good or substantial assurance (no change compared to previous month).

Key changes this month:

Increased performance assurance (from reasonable to good)	Adults and Older Persons showing measurable improvement following treatment - patient reported
Reduced performance assurance (from good to reasonable)	Restrictive Intervention Incidents Used

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

- Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for*
- Percentage of inpatients reporting that they feel safe whilst in our care*
- 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

***To note:** *please see updates to note this month.*

There are a small number of measures, we are advising continue to be a focus for improvement which are shown below:

- **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 6 actions being progressed, of which 4 are on track for delivery, 1 has been extended following EDG approval in September and 1 is overdue, which will now be completed by the end of December 2025.

- **Bed Occupancy** – Whilst special cause improvement is being demonstrated we are still exceeding the commissioned and funded level of 85%. The main areas of concern are DTVFCG AMH and MHSOP which are 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 (now 7 courses below the standard compared to 10 courses in the previous month). As part of the Workforce deep dive at the Quality & Performance EDG in October, it was agreed that the Workforce Development Lead would develop a flow chart for

managers to know where to go (and to who) if issues with accuracy of training data (e.g. what to do if completed and not showing, what to do if course not applicable etc.)

- **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, however, 22 nursing breaches related to Adult Mental Health – NYYS Community teams. 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 are supporting the development of trajectories for medical staffing as our main overall driver of breaches and overall expenditure (representing 68% of all agency cost in October and 68% price cap breaches). The Temporary Staffing Sub-Group has leadership and oversight of this work. The Medical Director has been asked to consider wider options to reduce and to work to aim to eliminate medical agency reliance.

The actual areas of concern are shown below:

- We remain concerned about **patients classified as clinically ready for discharge** as this is impacting bed occupancy**.** There is special cause concern in all services. Clinically Ready for Discharge was a focused discussion at the Quality & Performance EDG in November 2025, led by the Interim Managing Director for the Integrated Care Group Board. This will be taken to Resources & Planning Committee in January then into Board of Directors in February. In addition, following the EDG discussion, a proposal for a Trust-wide Improvement Programme was supported, which will be presented to the Quality & Performance EDG in February 2026.

  At Trust level, patients classified as clinically ready for discharge in October equated to an average of 78.2 beds (52.4 Adult and 25.8 Older Adult beds), with an associated direct cost of c.£1.51m (including £0.024m independent sector bed costs). Of the cost, c.£0.93m relates to Adult and c.£0.59m relates to Older Adult. The annualised impact of patients classified as clinically ready for discharge is £2.26m (£3.55m at October 24)

  Both care groups are working closely with system partners to strengthen a system wide approach to supporting those clinically ready for discharge. 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; a further paper will be resubmitted to the Tees Valley Place Committee in Common in December 2025. A pilot hub in Durham was implemented in November and will be evaluated by the end of February 2026. Funding for a Clinically Ready for Discharge pilot role aimed at reducing delays within Urgent Care in Adults and Older Peoples services has been agreed and the recruitment process is underway.

  Within York the Trust is participating in a second system wide event with the local authority to look at supporting discharge effectively, alongside how system partners can work together to reduce admissions and re-admissions. The event is to be confirmed, but it is hoped it will be before the end of December 2025. In North Yorkshire we are exploring access to community residential and nursing homes linked to discharge hubs in the acute hospital sites, this would increase the range of discharge options for older people who are clinically ready for discharge in the area.

- We remain concerned about **Sickness Absence** which is continuing to increase. Following a detailed discussion at the Quality & Performance EDG in October, several

actions were identified, which are detailed in the IPR, which have been themed into the following strategic priorities to support improvement in this area:

- Strengthen Policy Compliance and Management Capability
- Enhance Oversight and Assurance
- Improve Communication and Access to Resources
- Advance Health and Wellbeing Initiatives
- Drive Collaborative Improvement
- Strengthen Data Insight and Governance

The Executive Director of People & Culture & Associate Director of Performance will repeat a further Workforce Deep Dive on sickness absence at the Quality & Performance EDG in January 2026, to assess whether the actions are having a positive impact.

- **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, tighter Vacancy Control Board arrangements are operating, 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 have been implemented in recent months. Additional Overtime approval processes have been agreed in the last month and will operate from November 2025. Work is underway to support the level loading of roster headroom (unavailability) across Trust services with the Chief Nurse leading a wider peer review of inpatient E rostering.

- **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. Overperformance on non-recurrent schemes is mitigating recurrent scheme under-performance. Suggestions on mitigating actions and short-term reduction in spend are being taken to EDG for consideration. Mitigations for under-delivery are being worked up, but with full year effects of recurrent schemes currently forecast to fully deliver planned recurrent savings.

Other Information

Bed Occupancy - Following approval at the October People & Resources Executive Directors Group, a proposal to amend the measure to include Psychiatric Intensive Care Unit activity has been circulated to Resources & Planning Committee for approval. If supported, approval will be sought from Board of Directors in December 2025.

National Quality Requirements and Mental Health Priorities

The overall **reasonable** level of **performance assurance** for the National Quality Requirements and Mental Health Priorities has been underpinned by Statistical Process Control Charts, which demonstrates **68%** of measures are achieving standard (compared to 70% last month). We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

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

- 72-hour follow up
- EIP Waiting Times
- Talking Therapies waiting times (6 and 18 weeks)
- Active OAPs (inappropriate)
- Average length of stay for Adult Acute Beds

The actual areas of concern are as follows:

- **Child Eating Disorders (4-week standard)** Our ability to meet the rolling 12-month measure is a concern and it is unlikely we will achieve Place level plans this financial year in all areas. A small number of breaches, often due to patient choice, can disproportionately affect the rolling measure. A thorough validation of 'breaches' and rectification of data quality issues in a timely manner is required to improve our position, which will be supported by the new automated Patient Tracker Lists (PTLs).

- **Talking Therapies Reliable Improvement and Reliable Recovery** (County Durham & Tees Valley). It should be noted that County Durham has achieved standard for the month of October, although from a financial year to date perspective it is still below. The trust wide action plan includes 14 improvement actions, all of which were planned for completion by the end of December 25. One action has been delayed to the end of Quarter 4 due to a delay in information coming to Trusts from the National Team; however, all other actions are on track. An update on progress was presented to the Quality & Performance EDG in November. Performance has been impacted by staff sickness and maternity leave; backfill posts have been approved by vacancy control and are currently out to advert. The Talking Therapies Senior Leadership Team have held 2 improvement events to explore options to reduce the waiting list for patients waiting for 2nd treatment appointments with a view to supporting improvement in reliable recovery and improvement. Output, including costings for a digital solution, will be considered by the General Manager and senior clinical leaders by the end of December 2025. In addition, in October, online webinars were introduced within Talking Therapies and patients are given 28 days to view the sessions and complete the associated clinical questionnaires. These webinars are primarily expected to have a positive impact on waiting times from January 2026; however, it is anticipated that a reduction in waiting times would positively impact recovery and improvement.

- **CYP 1 contact** (Tees, North Yorkshire and York combined, due to changes in GP practice boundaries in 24/25). Tees are showing a significant concern (a reduction) for the first time and as part of the analysis work already planned in relation to the National Oversight Framework (NOF) measure, Business Intelligence are to review the numbers accessing services to better understand the position. This work will be completed by the end of December 2025. For patients who receive multiple referrals within a 12-month period, there is a risk that they won't be counted if the required contact does not occur during their initial referral, which is the case in some Neuro services. A quality improvement event is planned for early December to review the clinical processes and recording of key data across all Neuro services to ensure consistency.

<u>Waiting Times</u>

The overall **reasonable** level of **performance assurance** for Waiting Times has been underpinned by Statistical Process Control Charts; however, we recognise we have limited assurance about the quality impact on those patients who are waiting to access our services

which Quality Assurance Committee are actively monitoring. We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

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

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

- Within CYP, AMH and MHSOP services we have a Keeping In Touch (KIT) process for all patients that are waiting that keeps contact with the patient and/or their family and supports them with initiating escalation based on need. The KIT process is applied to patients that have already had contact with our services and have been triaged or assessed in accordance with the relevant clinical pathway. 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)**

  <u>Durham and Tees Valley</u>

  The Trust is working closely with the ICB and Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust to develop the next steps of a proposal, which includes a clear process and framework for clinical prioritisation and the development of an aligned regional process for the management and assessment of referrals. 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 by the ICB.

  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 in Darlington and the evaluation of the clinical protocol has completed. The General Manager has held a Clinical Transformation workshop to look at the recommendations from the protocol review and an away day is scheduled for February 2026 to agree a plan for full roll out. The trajectory submitted to NENC ICB, factoring in the additional assessments, remains on track for delivery. The Service Manager to explore the potential options for improving waiting times for patients on the under-5 pathway. Proposals will be submitted to the Care Group Board in December for approval.

  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; and a number of additional patients that should have been included in the original cohort of patients to be transferred but were not, due to data quality issues. All 4 additional staff have been recruited to support the delivery of extra assessments; the anticipated additional assessments will be provided from the end of November.

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 work has not reached a conclusion at present, and we await confirmation from the ICB of the expected sign off and implementation.

CYPS - 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 November 2025. Whilst some improvement can be made, the demand outstrips the capacity of the service.

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

  Please note commentary above relating to the Mental Health Priorities for Talking Therapies Reliable Improvement and Reliable Recovery in relation to the Trust-wide action plan and DTVFCG specifics. Within NYYSCG recruitment to the vacant PWP posts has completed; however, treatment capacity has been converted to assessment capacity from the middle of October 25 to address a backlog of patients waiting for 1st treatment appointment, which is impacting on the waiting time for 2nd treatment appointments. This will be completed by the end of December 2025.

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.* An action plan was presented to the Quality & Performance EDG in October; however further information was requested. Although there are historic data issues that cannot generally be fixed in bulk, they can be rectified on a case-by-case basis. There are no new data capture risks that do not have mitigations. A further paper will be presented to the Quality & Performance EDG in November.

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

Recommendations:

Board of Directors is asked to confirm that there is:

- **Good controls assurance** on the operation of the Performance Management Framework.
- **Good performance assurance** on the Trust's current NOF segmentation; however, with **reasonable** assurance that our NOF segmentation can be maintained.
- **Reasonable performance assurance** on the IPD, National Quality requirements/Mental Health Priorities and on 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.
- 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 October 2025

Report produced by: Laura Wheater, Performance Lead, and Ashleigh Lyons, Head of Performance
Date the report was produced: 19th November 2025

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

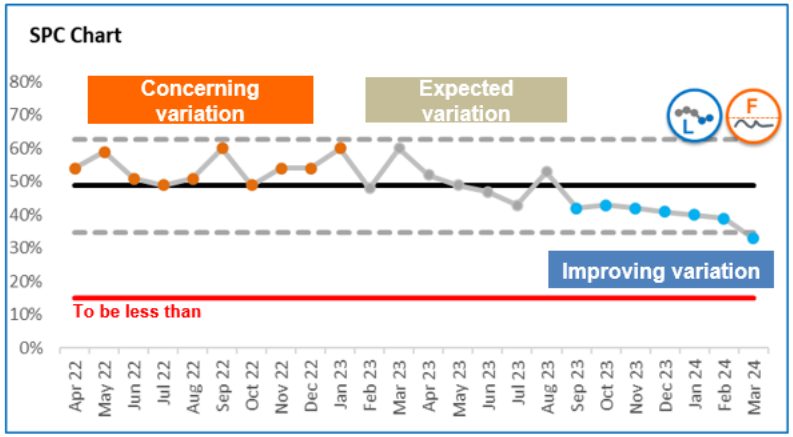
CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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



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

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

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

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

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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. The next assessment was planned for quarter 3; however, due to other priorities this was postponed. We will review the timescales for the next assessment in early January 2025.

	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 **OR** We are achieving the standard **HOWEVER** we have the Trust and both Care Group/several directorates all showing a concern	We have the Trust and both Care Group/several directorates 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. The framework has been updated in November 2025 in conjunction with Company Secretary, to reflect the application of the 'Neither' rule, i.e. those measures where good performance is not necessarily indicated by an increase or decrease in activity.

Controls Assurance Rating		
Positive	**Neutral**	**Negative**
We have Positive controls assurance when: • the SPC chart indicates Special Cause Improvement; **OR** • the SPC chart indicates an unexpected upward or downward shift, which is **confirmed by the service** as a positive shift; **OR** • Forecast position is positive; **OR** • National benchmarking data indicates we are in the lowest (most positive) quartile	We have Neutral controls assurance when: • the SPC chart indicates Common Cause; **OR** • the SPC chart indicates an unexpected upward or downward shift, which is **confirmed by the service** as a neutral shift	We have Negative controls assurance when: • the SPC chart indicates Special Cause Concern; **OR** • the SPC chart indicates an unexpected upward or downward shift, which is **confirmed by the service** as a negative shift; **OR** • Forecast position is negative; **OR** • 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
IPR	Integrated Performance Report
IPS	Individual Placement Support
LTS	Long Term Sickness
MHSOP	Mental Health Services for Older People
MoJ	Ministry of Justice
NENC	North East & North Cumbria Integrated Care Board
Neuro	Neurodevelopmental services
NOF	NHS Oversight Framework
NYYSCG	North Yorkshire, York & Selby Care Group
OAP	Out of Area Placement
OD	Organisational Development
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
QI	Quality Improvement
SIS	Secure Inpatient Services
SMART	Specific, Measurable, Achievable, Relevant, & Time-bound
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STS	Short Team Sickness
STEIS	Strategic Executive Information System
UoRR	Use of Resources Rating
WTE	Whole time equivalent

Integrated Performance Dashboard

Board Integrated Performance Dashboard – for the period ending October 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	93.68%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC	H	?	75.00%	77.70%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	H	?	75.00%	83.86%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	P	35.00%	47.13%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC	H	F	55.00%	46.97%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	?	50.00%	59.53%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC	H	F	30.00%	25.65%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	L	F	85.00%	92.54%
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				7
11)	The number of Incidents of moderate or severe harm	QAC	L			143
12)	The number of Restrictive Interventions Used	QAC				6,661
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				2,332

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%	55.18% (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%	9.59%
19)	Percentage Sickness Absence Rate (month behind)	PC&D	H	?	5.50%	6.30%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	P	85.00%	91.89%
21)	Percentage of staff in post with a current appraisal	PC&D	H	?	85.00%	89.23%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				55,795
23)	Unique Caseload (snapshot)	S&RC	L			62,461

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	2,615,000	1,582,142
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	4,515,000	4,129,908
25b)	Agency price cap compliance	S&RC	67.00%	55.12%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	8,819,000	6,404,176
28)	CRES Performance - Non-Recurrent	S&RC	5,284,889	7,712,093
29)	Capital Expenditure (CDEL)	S&RC	5,997,000	5,163,904
30)	Cash against plan	S&RC	45,117,000	47,951,042

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

- **Patient and Carer Experience:** Following the implementation of the new patient experience system in mid-September; only partial data is available for our measures and whilst data is available for the whole of October, a significant reduction is visible in response rates (and corresponding increase in performance in the measures). We continue to embed the new patient experience system and paper versions of several surveys have now been developed, which are anticipated to have a positive impact.

- **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 special cause improvement in both the PROM and CROM; however, we are below standard for both measures. There is no significant change in the number of timely paired outcomes recorded for the CYP PROM and CROM; however, there is special cause concern in the AMH/MHSOP PROM and CROM.

- **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 October 2025.

- **Patient Safety:** the number of patient safety incident investigations and incidents of moderate or severe harm have now been reprofiled to reflect actual process changes that have occurred; there is no significant change in either measure. There is no significant change for restrictive interventions and medication errors. There were no unexpected inpatient unnatural deaths reported on STEIS during October.

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

- **People:** there is special cause improvement, and we are achieving standard for leaver rate, mandatory training and appraisals; however, there is special cause concern in sickness levels, and we are above the standard. Whilst we are achieving the standard for mandatory training, there are 7 face to face training courses for which compliance remains below the 85% standard.

- **Demand:** There is no significant change in referrals; however, there is special cause improvement for unique caseload and active caseload.

- **Finance:** The Trust's 2025/26 financial plan targets delivery of a break-even position, which assumes delivery of a challenging 5.35% £27.41m Cash Releasing Efficiency Schemes (CRES) requirement. The financial position to 31st October 2025 is a deficit of £1.582m, which is £1.035m better than planned for the period. The in-month position improved again in October, reporting a surplus of £128k, with reduced spend on agency and purchase of healthcare costs, but with increased travel and drugs costs offset by additional income from out of area commissioners. CRES delivery for the first 7 months was £14.12m against a target of £13.92m, which is £196k above plan.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience** –there is no significant change for patient experience and special cause improvement for carer involvement and inpatients feeling safe; all measures are achieving standard. There is no significant change in the number of responses received for patient experience; however, there is special cause concern for carer involvement and inpatients feel safe.
- **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 special cause improvement in the number of patients discharged with a paired outcome measure for CYPS PROM, and 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 incidents of moderate or severe harm. No significant change in patient safety incident investigations, 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 special cause concern in sickness.
- **Demand –** there is no significant change in referrals, however there is special cause improvement in unique and active caseloads.
- **Finance -** The Care Group, planned to spend £163.7m as at October, and actual spend was £166.2m, which is £2.6m more than planned with CRES delivery £0.276m behind plan.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

•Inappropriate OAP bed days
•People (Leaver rate, Appraisals, Training)

Risks / Issues*

- Outcomes
- Sickness
- Financial Plan

Mitigations

Outcomes: CYP and Adults & Older Persons PROMs: The Trust-wide Clinical Outcomes improvement Plan currently has 14 actions, 2 of which is included on the CYP PROM slide. The Improvement Plan continues to progress, except for those actions' dependant on CITO development of which there are 8.

Of the ongoing 6 actions, 4 are on track for delivery:

1. Undertake quarterly webinars to organisation
2. To use data meaningfully at all levels (e.g. clinical supervision, team meetings, care group meetings, board meetings)
3. Appraising & identifying more accurate psychometric outcome tools to assist in the collection and calculation of outcomes measures
4. Implement training for new outcome measures linked to community transformation (Dialog, ReQoL 10, Goal-Based Outcomes GBO)

Updates for the remaining 2 actions are covered on the CYP PROM slide.

In addition, 1 action has been completed; to develop a clinical procedure for embedding the use of clinical outcomes. The procedure has been approved and is with the policy team for publication.

Sickness: Across our Learning Disability Services, the Senior Leadership Team will develop a Sickness Performance Improvement Plan, which will be presented to the Care Group Board in November ~~October~~. In addition, a detailed discussion look place in the Quality and Performance EDG in October where several actions were identified and are detailed within the IPR but include actions related to ensuring sickness policy compliance and the establishment of task and finish groups to develop smart actions in specific areas.

Finance - Financial plan

The key areas underlying the care group position in 25/26 are:

- Identified unfunded posts with care groups, which roadmaps for recovery are in
- Permitted overspends for AMH, MHSOP and ALD wards
- Use of Agency and bank for both Medical and Nursing

- 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.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** For October 2025, there is no significant change for all patient and carer experience measures and patients reporting they feel safe whilst in our care and special cause improvement for carers feeling actively involved. Following procurement of the new patient experience system, data is available and back dated to September for the measure following full configuration of the system and linkage into our Integrated Information Centre.
- **Outcomes:** In CYP, there is continues to be special cause improvement for CROM and special cause concern for PROM, both are above standard. For PROM, AMH & MHSOP are reporting no significant change and concern remains due to being under standard. For CROM we are reporting special cause improvement at care group level and for both specialities. AMH is reporting above standard & MHSOP 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 both specialities. 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 Children and Young People services is reporting special cause improvement within the reporting period however, this is not necessarily an actual improvement, as there was a change in process the end of January 2024, when the Trust transitioned to the National Patient Safety Incident Framework (PSIRF). There is no significant change reported for incidents of moderate of severe harm, medication errors and number of restrictive interventions. There were 0 unexpected Inpatient unnatural deaths reported on STEIS during October.
- **Uses of Mental Health Act:** no significant change is reported at Care Group or speciality level within the reporting period.
- **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 attributed to ALD, CYP and Management. There is no significant change for sickness absence, and reporting above standard across all specialities except CYP which is reporting special cause concern and 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 management which are reporting no significant change.
- **Demand:** There is no significant change in unique referrals; AMH is reporting special cause variation of an increasing nature where up is not necessarily improving nor concerning and CYP is reporting special cause variation of a decrease nature where down is not necessarily deterioration nor concern. Unique Caseload is reporting special cause improvement at Care Group level and Children reporting concern.
- **Finance:** The Trust has planned for a breakeven position for 2025/26. Across the Care Group, we had planned to deliver a £0.106m surplus in October, actual delivery was a £0.128m Surplus in month, a positive variance of £0.022m to plan (YTD Plan of £2.617m deficit, YTD £1.582m actual deficit, £1.035m positive variance to plan), although the in- month position still benefitted from some non recurrent items, so additional work to reduce costs is still required to consistently deliver a positive run rate, to recover the YTYD deficit. Plans are phased to deliver more expenditure reductions as the year progresses, largely due to phased savings plans.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Carers Experience
- Bed Pressures (Bed Occupancy, OAP bed days)
- 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** currently has 14 actions, 2 of which is included on the CYP PROM slide. The Improvement Plan continues to progress, except for those actions' dependant on CITO development of which there are 8.

Of the ongoing 6 actions, 4 are on track for delivery:

1. Undertake quarterly webinars to organisation
2. To use data meaningfully at all levels (e.g. clinical supervision, team meetings, care group meetings, board meetings)
3. Appraising & identifying more accurate psychometric outcome tools to assist in the collection and calculation of outcomes measures
4. Implement training for new outcome measures linked to community transformation (Dialog, ReQoL 10, Goal-Based Outcomes GBO)

Updates for the remaining 2 actions are covered on the CYP PROM slide.

In addition, 1 action has been completed; to develop a clinical procedure for embedding the use of clinical outcomes. The procedure has been approved and is with the policy team for publication.

Face to Face Mandatory Training

Staff unable to be released to attend training (high DNA rate and wasted spaces) - Executive Director of People & Culture and Workforce Development Lead to meet with General Managers to establish action plans to reduce wated spaces and DNAs by the end of November 2025. The Training and Education Task Group have identified several actions that will support staff to complete mandatory training.

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.

We recognise that agency expenditure is significantly impacting our financial plan. To address this, we have developed a Performance Improvement Plan that defines the actions that are being taken to support improvement and increased assurance.

Performance & Controls Assurance Overview

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive	• Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for ***increased controls assurance*** • Inpatients reporting that they feel safe whilst in our care ***increased controls assurance*** • 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 • Staff in post with a current appraisal	• Adults and Older Persons showing measurable improvement following treatment - patient reported ***increased performance and controls assurance*** • Adults and Older Persons showing measurable improvement following treatment - clinician reported • Bed Occupancy (AMH & MHSOP A & T Wards) • Staff Leaver Rate • Unique Caseload		
Neutral	• Patients surveyed reporting their recent experience as very good or good • PSII reported on STEIS *SPC* ***reprofiled to reflect a change in process*** • Incidents of moderate or severe harm ***reprofiled to reflect a change in process*** • Medication Errors with a severity of moderate harm and above • Unexpected Inpatient unnatural deaths reported on STEIS • Uses of the Mental Health Act	• New unique patients referred • CRES Performance – Non-Recurrent	• Restrictive Intervention Incidents Used ***reduced performance assurance*** • Staff recommending the Trust as a place to work • Staff feeling they are able to make improvements happen in their area of work	
Negative		• Financial Plan: SOCI - Final Accounts - Surplus/Deficit • Cash balances (actual compared to plan)	• CYP showing measurable improvement following treatment - patient reported • Financial Plan: Agency expenditure compared to agency • Agency price cap compliance • Use of Resources Rating – overall • CRES Performance – Recurrent • Capital Expenditure (Capital Allocation)	• Percentage Sickness Absence Rate

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

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

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

Update:
Following the implementation of the new patient experience system in mid-September; only partial data is available and whilst data is available for the whole of October, a significant impact is visible in response rates (and corresponding performance in the measure)

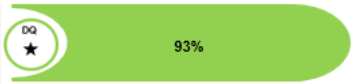
What does the chart show/context:
During October **684** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent contact overall, how was your experience of out service?". Of those, **647 (94.59%)** scored "very good" or "good".

There is no significant change at Trust and Care Group level in the reporting period; there is special cause improvement for Mental Health Services for Older People in Durham, Tees Valley & Forensic Care Group. There is no significant change in the number of patients who have responded to this question at Trust level and for Durham, Tees Valley & Forensic Care Group. There is special cause concern for North Yorkshire, York & Selby.

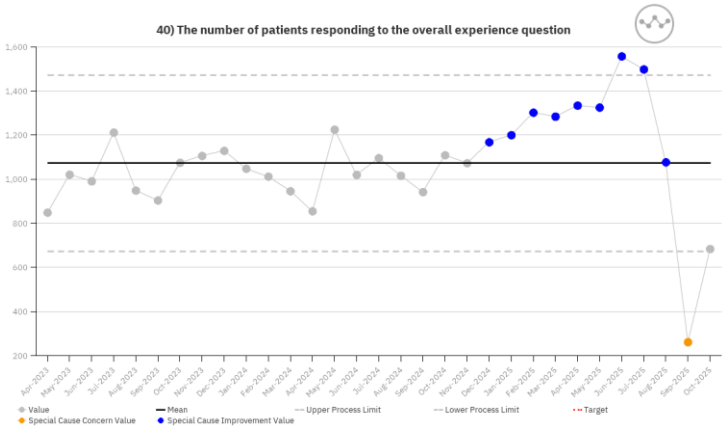
The latest National Benchmarking data (August 2025) shows the England average (including Independent Sector Providers) was **88.49**% and we were ranked **13** out of 64 trusts (1 being the best with the highest ratings), we were also ranked 2nd highest for total number of responses received.

Underlying issues:
See update above

Actions:
We are continuing to embed the new patient experience system and paper versions of several surveys have now been developed, which are anticipated to have a positive impact.



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



Please note: the new patient experience system was implemented mid-September 2025 (*see update*)

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.

Update:
Following the implementation of the new patient experience system in mid-September; only partial data is available and whilst data is available for the whole of October, a significant impact is visible in response rates (and corresponding performance in the measure)

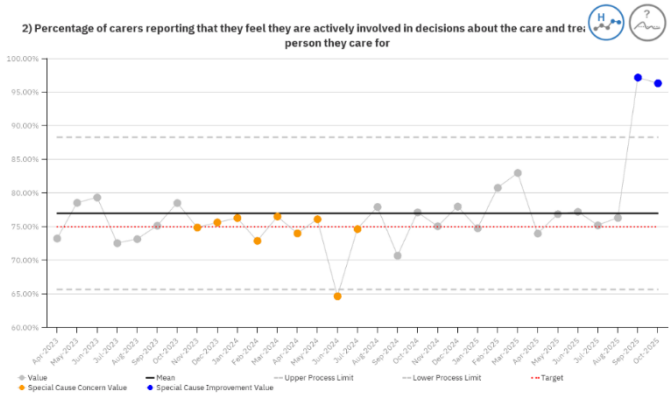
What does the chart show/context:
During October **163** carers responded to the question in the carer survey: Question: "Are you offered choices about the care being provided?". Of those, **157 (96.32%)** scored "yes, always".

There is special cause improvement at Trust and Care Group level in the reporting period, and for Adult Mental Health and Mental Health Services for Older People in Durham, Tees Valley & Forensic Care Group. There is special cause concern in the number of patients who have responded to this question at Trust and Care Group level.

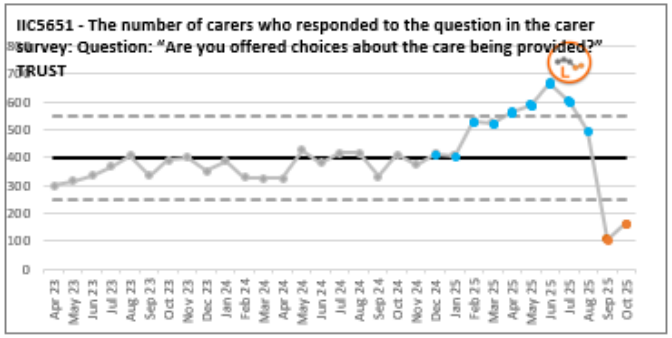
Underlying issues:
See update above

Actions:
We are continuing to embed the new patient experience system and paper versions of several surveys have now been developed, which are anticipated to have a positive impact.

DQ ✓✓ 87%



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



Please note: the new patient experience system was implemented mid-September 2025 (*see update*)

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

Update:
Following the implementation of the new patient experience system in mid-September; only partial data is available and whilst data is available for the whole of October, a significant impact is visible in response rates (and corresponding performance in the measure)

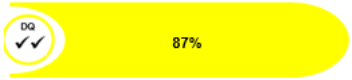
What does the chart show/context:
During October **68** patients responded to the overall experience question in the patient survey: "During your stay, did you feel safe?". Of those, **68 (100%)** scored "yes, always" and "quite a lot".

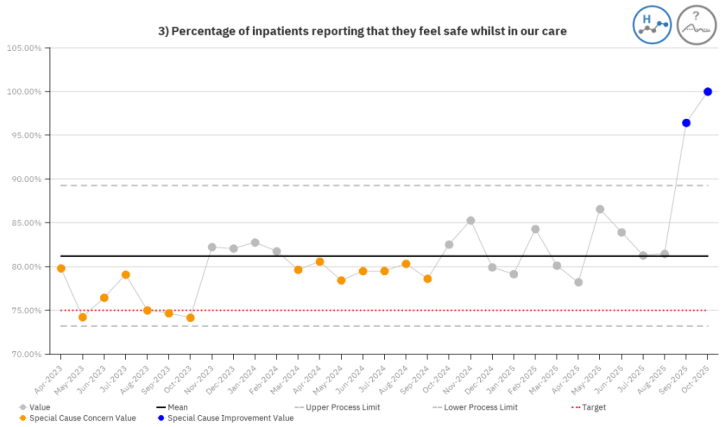
There is special cause improvement at Trust level, for Durham, Tees Valley & Forensic Care Group and for Adult Mental Health Services within that Care Group, in the reporting period; there is no significant change for North Yorkshire, York & Selby Care Group. There is no significant change in the number of patients who have responded to this question at Trust level and for Durham, Tees Valley & Forensic Care Group; there is no significant change for North Yorkshire, York & Selby.

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.

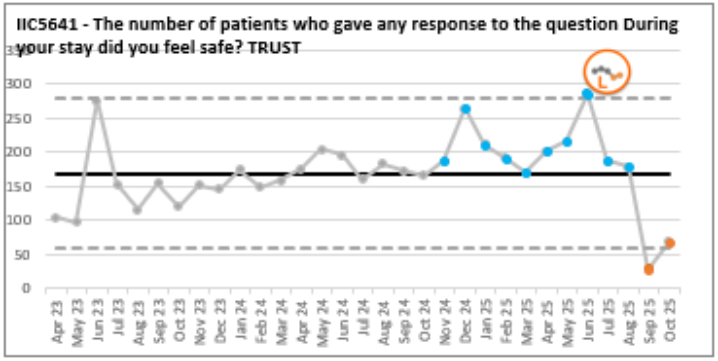
Underlying issues:
See update above

Actions:
We are continuing to embed the new patient experience system and paper versions of several surveys have now been developed, which are anticipated to have a positive impact.





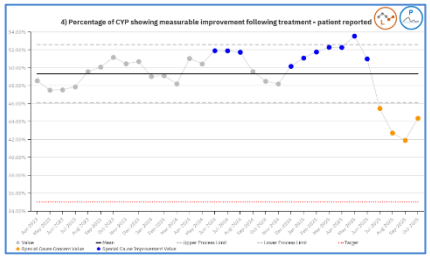
The below chart represents the number of patients that responded to the safety question.

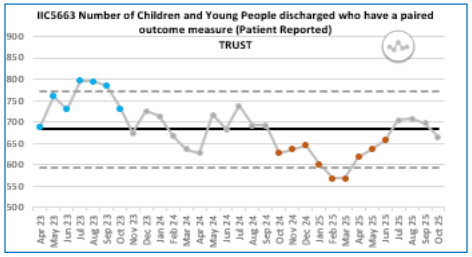


Please note: the new patient experience system was implemented mid-September 2025 (*see update*)

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

87%





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

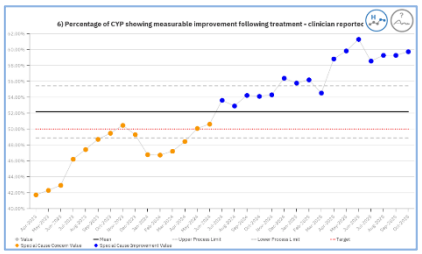
What does the chart show/context:
For the 3-month rolling period ending October, **665** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **295 (44.39%)** made a measurable improvement.

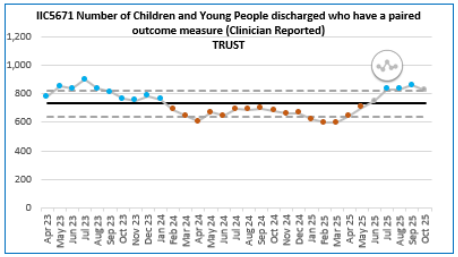
There is special cause concern at Trust and Care Group level in the reporting period; however, performance is above standard at all levels. There is no significant change for the number of patients discharged with a paired outcome measure at Trust level; there is special cause improvement for DTVFCG and special cause concern for NYYSCG.

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

87%





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 October, **822** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **491 (59.73%)** made a measurable improvement.

There is special cause improvement at Trust and Care Group level in the reporting period, and performance is above standard at all levels. There is no significant change in the number of patients discharged with a paired outcome measure at Trust level; there is special cause improvement for DTVFCG and special cause concern for NYYSCG.

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

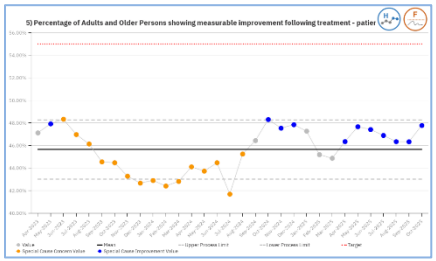
For underlying issues and action, please see overleaf

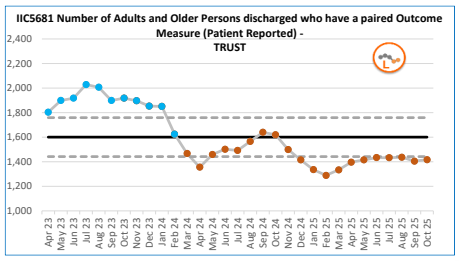
04) Percentage of CYP showing measurable improvement following treatment - patient reported

Underlying issues	Actions
Over the past three months, we have observed a decline in measurable improvement rates across CYP services. This trend is attributable to several interrelated factors: • **Seasonal disengagement**: CYP engagement typically drops during school holidays, resulting in incomplete treatment pathways and a rise in disengagement-related discharges. • **Rolling measurement impact**: The outcome metric is based on a three-month rolling window, meaning the cumulative effect of summer disengagement is now fully reflected in the data. • **Routine outcome measure embedding**: While the use of routine outcome measures has improved significantly, many CYP now have paired measures where the final score does not represent treatment completion due to early disengagement. This skews the outcome profile and underrepresents actual therapeutic progress. These factors collectively contribute to the observed decline and should be considered when interpreting performance trends for the period.	Not required
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. *(*This is included within the Trust-wide Improvement Plan)*	1. Develop a Reliable Change Index for a small number of measures (EDEQ/EDEA/Gaslight) (Originally September 25, extended to December 25) 2. Flow GBO from Cito into IIC by end of September **(Not complete)** This will now be completed by the end of December 2025.
Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV	Business Intelligence have identified the changes required to include those patients that transition between CYP and AMH; however, these require scoping in terms of technical design. The scoping was to be completed by the end of Quarter 2 (September 2025) **(Not Complete)** Scoping work will now be completed by the end of March 2026.
NEW Following a change to Cito it has been identified that RCADs has not been flowing into the measure since 13th May 2025; we expect this will have a small positive impact.	Head of Business Intelligence & Clinical Outcomes to investigate and provide a briefing paper to inform the next steps by the end of November 2025.

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

87%





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

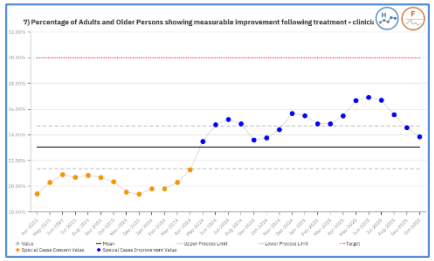
What does the chart show/context:
For the 3-month rolling period ending October, **1417** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 677 (47.78%)** made a measurable improvement.

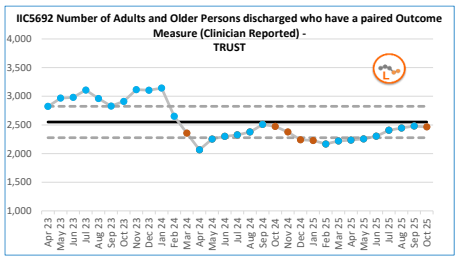
There is special cause improvement at Trust level, for Durham, Tees Valley & Forensic Care Group and for Mental Health Services for Older People in that Care Group; there is no significant change for North Yorkshire & York Care Group. Performance is below standard at all levels. There is special cause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

87%





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 October, **2466** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 588 (23.84%)** made a measurable improvement.

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

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

Adult and Older Persons PROM - Underlying issues	Actions
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).	Head of Business Intelligence & Clinical Outcomes to scope an IIC solution by the end of December 2025.

Measures 04 – 07 Percentage of CYP/Adults and Older Persons showing measurable improvement following treatment – patient/clinician reported

Underlying issues and actions:

The **Trust-wide Clinical Outcomes improvement Plan** currently has 14 actions, 2 of which is included on the CYP PROM slide. The Improvement Plan continues to progress, except for those actions' dependant on CITO development of which there are 8.

Of the ongoing 6 actions, 4 are on track for delivery:

1. Undertake quarterly webinars to organisation
2. To use data meaningfully at all levels (e.g. clinical supervision, team meetings, care group meetings, board meetings)
3. Appraising & identifying more accurate psychometric outcome tools to assist in the collection and calculation of outcomes measures
4. Implement training for new outcome measures linked to community transformation (Dialog, ReQoL 10, Goal-Based Outcomes GBO)

Updates for the remaining 2 actions are covered on the CYP PROM slide.

In addition, 1 action has been completed; to develop a clinical procedure for embedding the use of clinical outcomes. The procedure has been approved and is with the policy team for publication.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

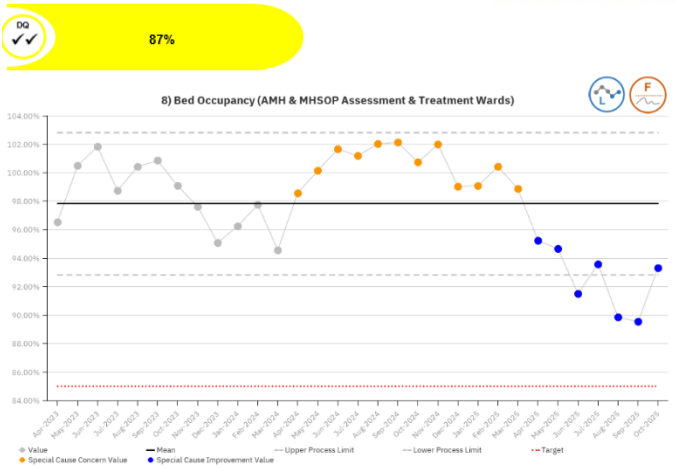
What does the chart show/context:
During October, **10,850** daily beds were available for patients; of those, **10,125 (93.32%)** were occupied. There were no independent sector beds used during October**.**

There is special cause improvement at Trust and Care Group level in the reporting period, and for Adult Mental Health in both Care Groups and Mental Health Services for Older People in North Yorkshire, York & Selby. Performance remains above standard at Trust level and for Durham, Tees Valley & Forensic Care Group; however, is below standard for North Yorkshire, York & Selby Care Group

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 following page)*, as is the availability of specialist packages of care and specialist placements.
- Ministry of Justice (MoJ) patients.

Actions:
- The Associate Director of Nursing & Quality is compiling a Trust-wide report on the impact of restricted patients within our Assessment and Treatment wards. This will be presented to the Quality & Performance EDG in December 2025.
- In DTVFCG the Business Case for the new Crisis House was approved by the People & Resources EDG in October 2025. This will provide a crisis facility for shorter term intervention, preventing unnecessary admissions to assessment & treatment wards. **(Complete)**
- The DTVFCG AMH General Manager to develop a business case for a crisis assessment centre in Durham by the end of March 2026. This will provide a further crisis facility, preventing/reducing unnecessary admissions to assessment & treatment wards.
- In NYYSCG the proposed development of Safe Havens is pending ICB investment. That will include an ICB-led review of the crisis teams and will support the provision of appropriate patient care in the community, thereby reducing inpatient admissions. The first weekly project meeting will be held by the end of November 2025.



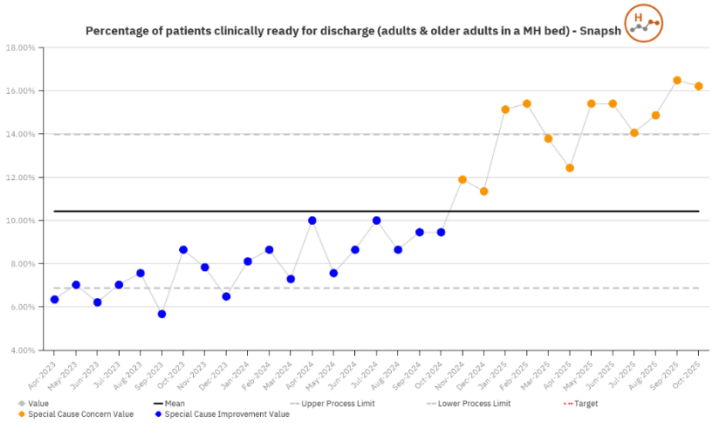
Additional Information - Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed) (Snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
At the end of October 2025, there were **60** adults clinically read for discharge occupying adult MH, older adult MH or PICU beds, accounting for **16.22%** of our **370** acute beds open to admission.

There is special cause concern in the percentage of patients clinically ready for discharge at Trust, Care Group level and specialty level.

At Trust level, patients classified as clinically ready for discharge in October equated to an average of 78.2 beds (52.4 Adult and 25.8 Older Adult beds), with an associated direct cost of c.£1.51m (including £0.024m independent sector bed costs). Of the cost, c.£0.93m relates to Adult and c.£0.59m relates to Older Adult. The annualised impact of patients classified as clinically ready for discharge is £2.26m (£3.55m at October 24)



Underlying issues:
- Availability of specialist packages of care and specialist placements.

Actions:
Both care groups 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 paper will be resubmitted to Committee in December 2025.
- The proposal for Durham was completed in October 25. **(Complete)** A pilot hub was implemented in November 2025 and will be evaluated by the end of February 2026.
- In York we are participating in a second system wide event with the local authority to look at supporting discharge effectively, alongside how system partners can work together to reduce admissions and re-admissions. The event is to be confirmed, but it is hoped it will be before the end of December 2025.
- In North Yorkshire we are exploring access to community residential and nursing homes linked to discharge hubs in the acute hospital sites, this would increase the range of discharge options for older people who are clinically ready for discharge in the area.

- A Clinically Ready for Discharge pilot role in DTVFCG, aimed at reducing delays within Adults and Older Peoples services, will not commence in December as anticipated. Funding has been secured, and the recruitment process is underway.
- Clinically Ready for Discharge was a focused discussion at the Quality & Performance EDG in November 2025, led by the Interim Managing Director for the Integrated Care Group Board. **(Complete)** A proposal for a Trust-wide Improvement Programme was supported, which will be presented to the Quality & Performance EDG in February 2026.

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

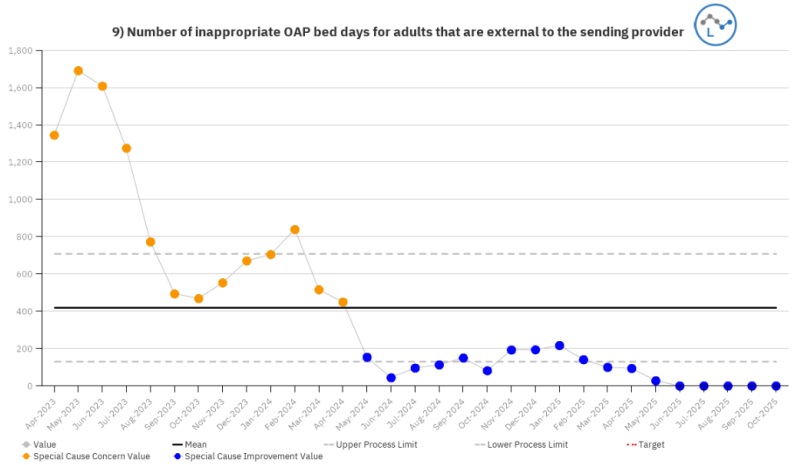
There is special cause improvement at Trust and Care Group level in the reporting period.

There were 0 active OAP placements as at 31st October 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	0	0	0	0	0	0	0
	Actual	0	0	0	0	0	0	0					

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

Tees, Esk and Wear Valleys NHS Foundation Trust

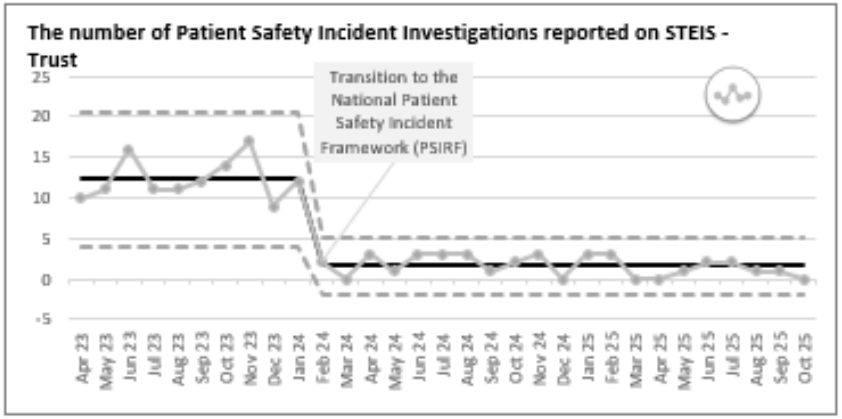
What does the chart show/context:
0 Patient Safety Incident Investigations (PSII) were reported on the Strategic Executive Information System (STEIS) during October.

The SPC chart has been reprofiled to reflect the change in process late January 2024, when the Trust transitioned to the National Patient Safety Incident Framework (PSIRF), which advocates a more proportionate approach to investigations.

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

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 was held in October with follow up workshops planned for November, December and January.



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

The SPC chart has been reprofiled to reflect the change that occurred late October 2023, with the introduction of the new National NHS system - Learn from Patient Safety Events (LFPSE). The statistical reduction was first noted in August 2024 and has been sustained since then.

There is common cause at Trust and Care Group level.

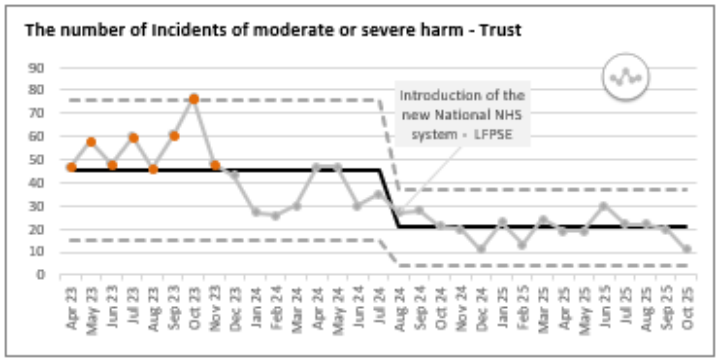
Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

DQ ✓✓ 87%



12) The number of Restrictive Intervention Used

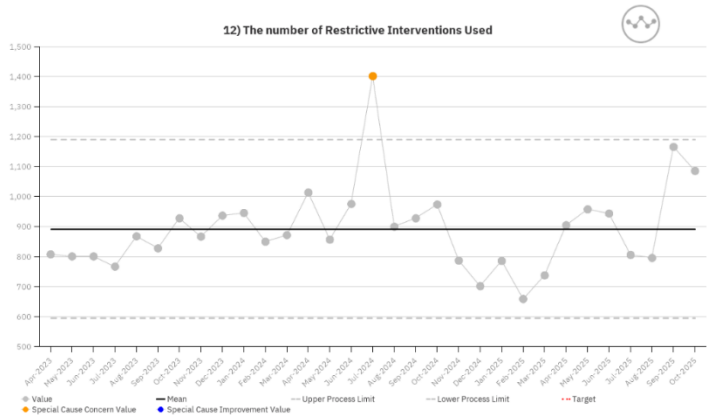
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
1,086 types of Restrictive Interventions were used during October.

There is no significant change at Trust and Care Group level in the reporting period. There is special cause improvement in Adult Mental Health and Health & Justice in Durham, Tees Valley & Forensic Care Group; however, there is special cause concern for Adult Learning Disabilities and Secure Inpatient Services in DTVFCG. There is also special cause concern for Mental Health Services for Older People in DTVFCG; however, this is not an actual concern. Quality improvement work recently undertaken identified that restrictive interventions were not being recorded correctly and the concern (increase) reflected in the SPC is attributable to improved recording within the service.

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 SIS there is a small number of patients with high acuity and complex needs, particularly impacting Ivy/Clover 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.
    - More targeted clinical supervision is being undertaken to support staff nurses to implement Positive Behaviour Support plans.
    - Positive & Safe Clinical Skill training into Bankfields Court to support safe management of one patient presenting with higher levels of physical aggression
    - Specialist Practitioner for Positive & Safe to provide additional supervision and reflection sessions throughout November 2025.
- 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. *This is now business as usual.*
- DTVFCG SIS to progress a proposal to split the ground space within Ivy/Clover ward into two inpatient areas to support the management of those patients with complex needs. This was shared with Care Group Board by the end of October 2025. **(Complete)**
- Specialist Practitioner for Positive & Safe and Professional Nurse Advocate to provide additional support to SIS on holding techniques.



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

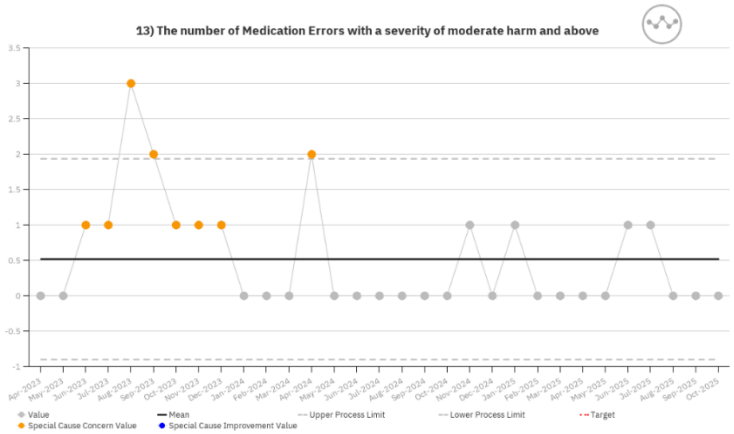
What does the chart show/context:
0 medication errors were recorded during October.

There is no significant change at Trust and Care Group level in the reporting period. There is special cause improvement for Adult Learning Disabilities and Health & 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

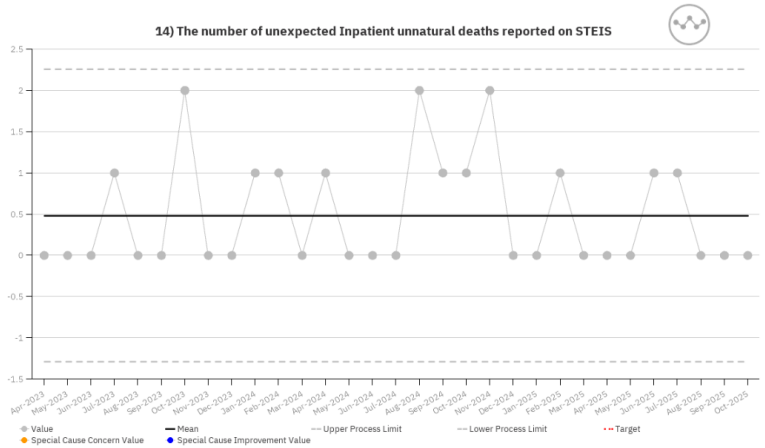
What does the chart show/context:
0 unexpected inpatient unnatural deaths were reported on the Strategic Executive Information System (STEIS) during October.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

DQ ★ 93%



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 **352** uses of the Mental Health Act during October.

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

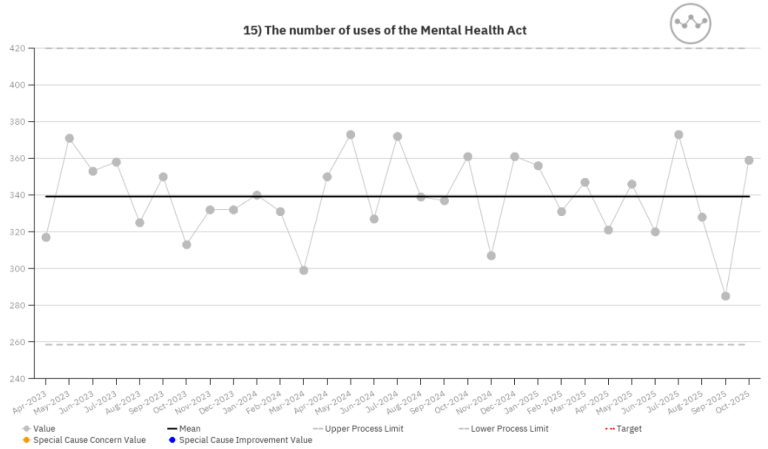
The latest national Mental Health Act data (2023/24) produced by NHS Digital has been analysed by Business Intelligence. Expected rates of detention by gender and ethnicity showed that Trust followed the same trend as the national rate of the higher the level of deprivation, the higher the rate of detention.

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.

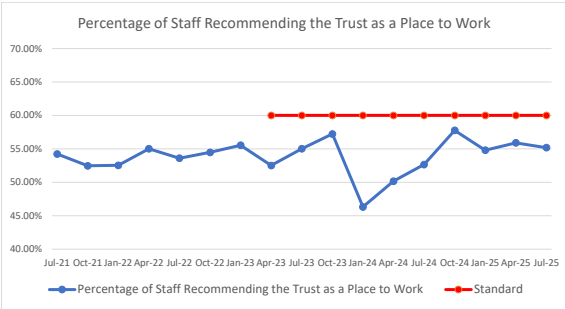
Underlying issues:
Analysis of the latest national Mental Health Act data (2023/24) shows some areas of inequality in our detention rates.

Actions:
- 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. **(Complete)**
- Scoping work has commenced on a project to map patient journeys into inpatient settings, focusing on people from black African backgrounds and exploring health inequalities; combining quantitative data with qualitative insights. **Timescale to be confirmed**

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:
- Responses to the July Pulse Survey equate to approximately 16% of staff; therefore, this is not a comprehensive picture.
- We have low numbers of staff that would recommend the Trust as a place of work or feel they can make improvements happen in their areas and do not fully understand the reasons for this.

Actions:
- People & Culture are providing targeted support in those areas with low engagement which include ensuring services facilitate a 20-minute slot to enable staff to complete the Staff Survey; the establishment of a People & Culture and Communications-led task & finish group to promote completion of the Annual Staff Survey; daily monitoring of completion of the Staff Survey by Organisational Development; and the provision of paper copies to Estates & Facilities Management and a number of wards that may not have easy access to complete the survey online.
- Organisational Development to promote the national Staff Survey through October and November 2025.
- Whilst no SMART actions were identified during the Workforce Deep Dive at the October Quality & Performance EDG (focus was sickness absence); there are two specific strands of work, which we would anticipate to have a positive impact in this area:
    1. 'How We Work' sits under One Team TEWV, encompassing both our workforce plan and how we work together. It supports the organisation's three strategic shifts—analogue to digital, sickness to prevention, and hospital to community—by providing a simple, everyday guide that enables safer care today and drives service transformation.
    2. The Trust-wide Staff Experience Group has been established to triangulate information about staff experiences, which are then measured using staff survey scores and other staff metrics such as sickness rates, retention rates, employee relation information, OD indictors.

18) Staff Leaver Rate

NHS
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).

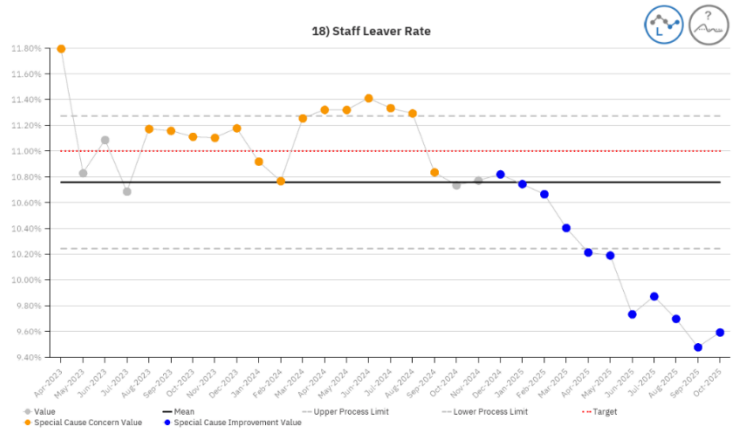
What does the chart show/context:
From a total of **7,036.28** staff in post, **675 (9.59%)** had left the Trust in the 12-month period ending October 2025.

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 and Management in Durham Tees Valley & Forensic Care Group. The directorates have confirmed there is no actual concern at this stage.

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)

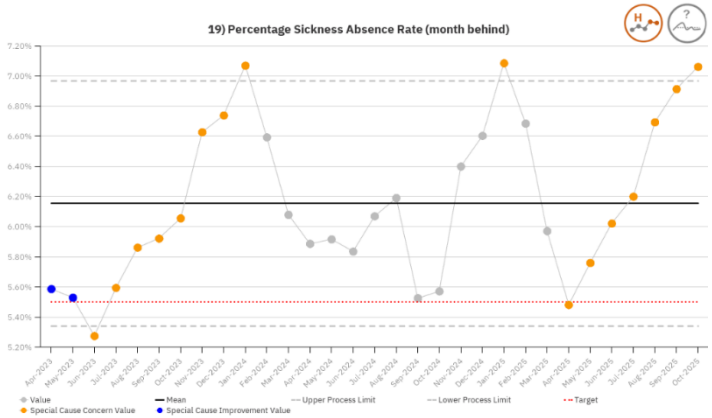
What does the chart show/context:
There were **227,554.18** working days available for all staff during October 2025 (reported month behind); of those, **16,067.16 (7.06%)** days were lost due to sickness.

There is special cause concern at Trust level in the reporting period and for Corporate Affairs & Involvement, Digital & Data Services, Estates & Facilities Management, Durham, Tees Valley & Forensic Care Group, Adult Learning Disabilities and Children & Young Peoples Services within that Care Group and Children & Young Peoples Services in North Yorkshire, York & Selby Care Group..

National Benchmarking for NHS Sickness Absence Rates published 30th October 2025 (data ending June 2025) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.50%** compared to the Trust mean of **6.03%**, with the Trust ranked 42 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:
Following a detailed discussion at the Quality & Performance EDG in October on sickness absence, the following actions have been identified:
- Executive Directors to ensure sickness policy compliance (documentation and ESR updates) and timely Long Term Sickness team contact for absences >28 days by the end of November 2025; then ensure managers have necessary skills for sickness management by the end of March 2026.
- People Partners to undertake spot checks on policy compliance by the end of December 2025 and identify managers needing training and deliver it by the end of March 2026.
- Strategic Leads for Health & Wellbeing to provide a summary of the sickness policy to managers and brief managers on LTS team by the end of November 2025; then brief on evidence-based interventions for LTS/STS by the end of December 2025.
- Head of Workforce Strategy & Systems to review the ESR automated prompts and explore the “bot” for policy search by the end of December 2025.
- Executive Director of People & Culture to explore the public health contribution to plan by the end of December 2025



Actions continued:
- Head of Performance & Heads of People & Resourcing to establish a Corporate Task & Finish Group for specific improvement actions; explore a Trust-wide Inpatient Task & Finish Group and a DTV Community Task & Finish Group (timescales TBC)
- Performance Team & Workforce Information to analyse sickness absence data (long/short term, SPC charts) by end Nov 2025
- Executive Director of People & Culture & Associate Director of Performance to repeat Workforce Deep Dive on sickness absence in Jan 2026 (EDG Week 4)

- Deputy Director of People & Culture to contact those peer organisations reporting better sickness absence rates as identified by the NHS Oversight Framework scores for sickness by the end of October 2025, with a view to identifying potential improvement actions. Meeting planned with Avon & Wiltshire Mental Health Partnership NHS Trust in November 2025.

20) Percentage compliance with ALL mandatory and statutory training

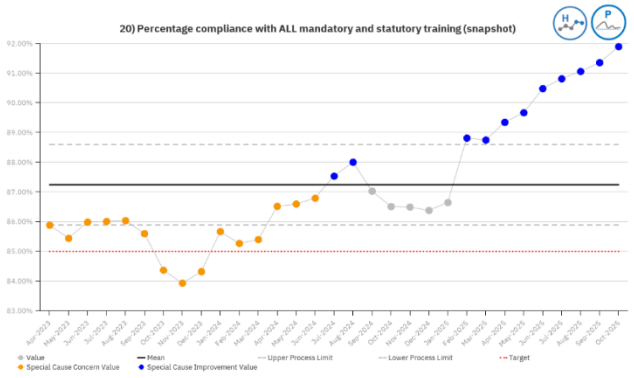
Background / standard description:
We are aiming for 85% compliance with mandatory and statutory training

What does the chart show/context:
158,160 training courses were due to be completed for all staff in post by the end of October. Of those, **145,333 (91.89%)** were completed.

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

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

Directorate	Number Compliant	Total Required	% Compliant
CHIEF EXECUTIVE OFFICE	90	108	83.33%



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.
- There are a number of roles that still require their competencies reviewing to ensure they are aligned correctly.

Actions:
- 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. **(Not Complete)** Temporary Staffing Services Manager to escalate with Finance for a timescale by the end of November.
- Head of Workforce Strategy & Systems to work with Finance and Business Intelligence to ensure all staff allocated to the Chief Executive Office are correct. Exploratory meeting to be held by the end of November 2025.
- Workforce Development Lead to review the training matrix for General Managers, Service Managers, Associate Director of Nursing and Modern Matron to ensure the competencies align to their management and clinical roles where appropriate. The review will be completed and presented to the Training and Education Governance group for approval by the end of December 2025.

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 **7** courses that are currently below the standard (compared to 10 in the previous month). 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 October 2025 there has been an average of 37% wasted spaces (including 13% DNAs) across the mandatory face to face training courses.
- There is high sickness within the training team, which is impacting on the provision of Resuscitation Level 3 and Moving & Handling. In addition, there is currently an issue with the availability of spaces to deliver Resuscitation Level 3.

Actions:
- The Training and Education Task Group have identified several actions that run through to April 2026 which will support staff to complete mandatory and wider training.
- Executive Director of People & Culture and Workforce Development Lead to meet with General Managers by the end of November 2025 to establish action plans to reduce wasted spaces and DNAs.
- 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. This was part of the Workforce deep dive at Quality & Performance EDG in October. **(Complete - improvement noted in the reduction of courses below the standard)**
- Workforce Development Lead to develop a flow chart for managers to know where to go (and to who) if issues with accuracy of training data (e.g. what to do if completed and not showing, what to do if course not applicable etc.).
- Workforce Development Lead to scope training for the Positive & Safe Care trainers to provide Resus & Moving & Handling training by the end of November 2025, with a view to updating the training rotas by the end of December 2025.
- Workforce Development Lead is liaising with Resuscitation lead to look at extra capacity.

	Number Compliant	Total Number	% Compliant
Positive and Safe Care Level 2 Update *	1290	1693	76.20%
Resuscitation - Level 3 - Adult Immediate Life Support - 1Year*	787	1015	77.54%
Positive & Safe Care Level 1*	3452	4446	77.64%
Annual Medicines Optimisation Module**	514	657	78.23%
Resuscitation - Level 1 - 1Year*	2046	2610	78.39%
Moving and Handling - Level 2 - 2Years*	703	864	81.37%
Resuscitation - Level 2 - Adult Basic Life Support - 1Year*	1630	1986	82.07%

**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 **7,076** eligible staff in post at the end of October; **6,314 (89.23%)** had an up-to-date appraisal.

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

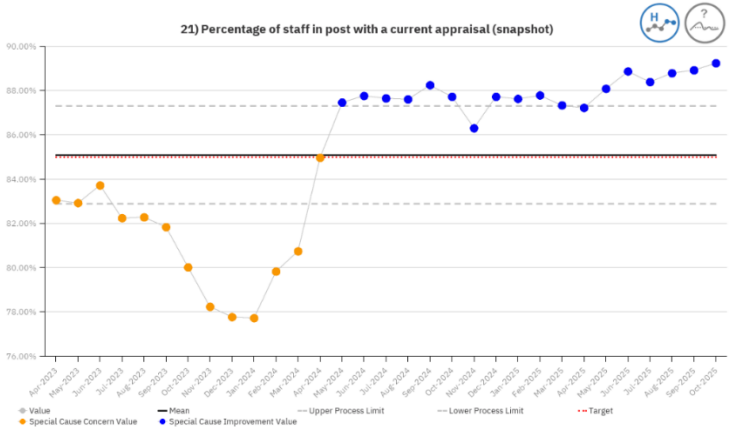
As at the 31st October 2025, by exception compliance levels below 85% are as follows:

Directorate	Number Compliant	Total Required	% Compliant
CAPITAL PROGRAMME	7	9	77.78%
PEOPLE AND CULTURE	99	119	83.19%
THERAPIES	37	44	84.09%
CORPORATE AFFAIRS AND INVOLVEMENT	32	38	84.21%

Underlying issues:
- In a small number of areas staff are incorrectly allocated to the wrong cost centre.

Actions:
- Target dates have been established for those directorates not achieving standard:
  - Capital Planning - end of October 2025 **(Not complete)** Extended to November
  - People & Culture - end of October 2025. Achieving standard at time of reporting
  - Therapies - end of October 2025. Achieving standard at time of reporting
  - Corporate Affairs & Involvement - end of December 2025
- Head of Workforce Strategy & Systems to work with Finance and Business Intelligence to ensure all staff allocated to the Chief Executive Office are correct. Exploratory meeting to be held by the end of November 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 December 2025.
- Organisational Development to undertake an annual internal audit of appraisal paperwork by the end of November 2025, to ensure good quality appraisals are delivered by Trust managers. Findings will be reported into the People & Resources Executive Directors Group in February 2026.

DQ ★ 93%



22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
8,231 patients referred in October that are not currently open to an existing Trust service.

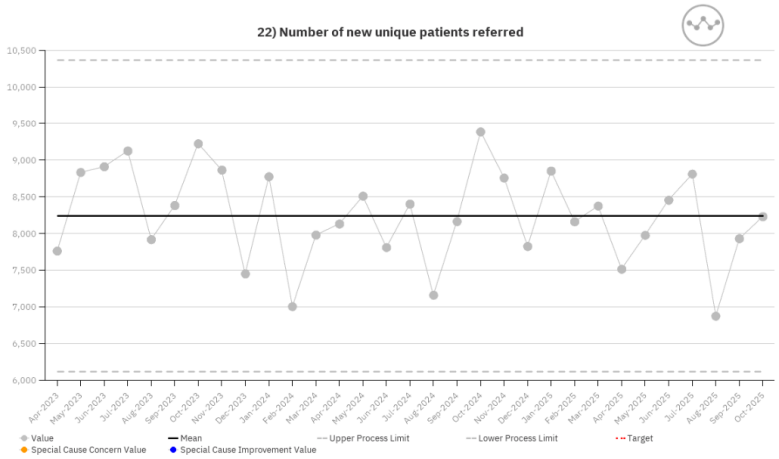
There is no significant change at Trust and Care Group level in the reporting period. However, there are a number of unexpected shifts of referrals. There is a low shift in referrals for Children & Young Peoples Services in both care groups and Health & Justice within Durham, Tees Valley & Forensic Care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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

DQ

80%



23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

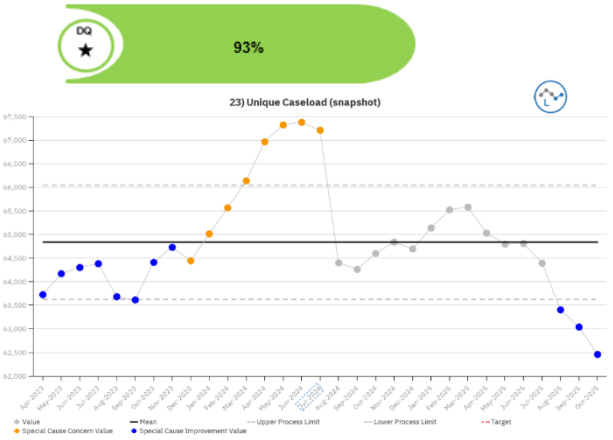
What does the chart show/context:
62,461 cases were open, including those waiting to be seen, as at the end of October 2025; **53,242** were active.

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

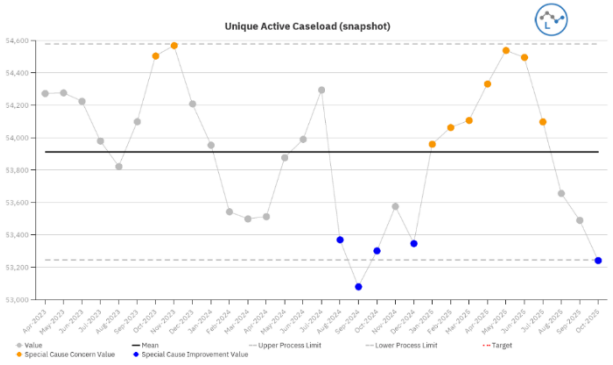
The **additional** SPC chart representing **Active Caseload** (excluding patients waiting for first contact) shows special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group; there is no significant change for North Yorkshire, York & Selby Care Group. There is special cause concern in Secure Inpatient Services within DTVFCG and in Children & Young Peoples Services within NYYSCG. There is also special cause concern in Adult Mental Health; however, the service has confirmed this is not an actual concern. There is special cause improvement in Adult Learning Disabilities and Mental Health Services for Older People in both Care Groups, Children & Young People Services in DTVFCG, and Adult Mental Health 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.

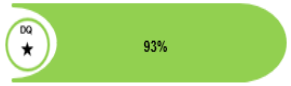
Actions:
- Head of Business Intelligence & Clinical Outcomes to draft a briefing note on the current position and consideration of the new option for the People & Resources EDG in November 2025. **(Complete)** Following presentation of the option, EDG have requested data to demonstrate the impact of the construct change. That data will be provided for the Quality & Performance EDG in November.
- Following the deep dive into CYP Caseload that was presented to EDG in September 2024, a response from the Care Groups was presented to the Quality & Performance EDG in November 2025. **(Complete)**
- Business Intelligence to undertake a patient-level analysis to identify the reasons for the increase in caseload within Secure Inpatient Services by the end of November 25.



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



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



What does the data show/context:

The financial position to 31st October 2025 against which Trust performance is assessed is a deficit of **£1.58m which is £1.04m better than planned**. The Trust submitted a breakeven plan for 2025/26 which assumes delivery of challenging £27.41m Cash Releasing Efficiency Schemes (CRES).

- **Temporary Staffing Expenditure** is monitored to deliver the nationally required reductions of 40% on Agency (outturn spend 24/25 £10.2m, savings planned £4.4m) and 10% on Bank spend (outturn spend £15.1m, savings required £1.43m) as compared to 2024/25. Work to reduce Agency costs is delivering better than planned reductions to date. Bank cost reductions have been (and will continue to be) impacted by actions to enhance existing bank arrangements to support delivery of premia rate Agency and Overtime cost reductions (bank costs representing better value for money).

- **Bank costs** were at £1.33m in April and increased to £1.40m in October (the plan required a reduction to average run rate of £119k / exit run rate of £1,219k). Overtime costs have reduced from £430k in April to £173k in October, delivering £85k more savings than planned in month (£40k year to date). Bank costs were £9.6m to date and £354k more than planned.

- **Agency expenditure** for the year to date is **£4.13m and is £0.38m below plan.** Planned cost reductions were phased to deliver more in the second half of the year to meet the national 40% agency cost reduction, meaning that delivery risk increases. Plans require the reduction, from an actual cost of 2.1% of paybill in April 2025, to just 0.84% of paybill by 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 £0.35m and decreased by £0.20m compared to prior month and represented **0.94% of paybill (1.28% excluding prior months' adjustment)**, which is **1.62 percentage points (63.3%)** lower than the 2024/25 average of 2.56%. Delivery remains an ongoing challenge and, although the trust is ahead of plan at month 7, continued rigor will be necessary in future periods. Costs in October would represent an annualised £5.9m agency cost, compared to a straight line projection £7.1m, and 2025/26 target cost of £6.5m. The probable case is achievement of target, with some risk.
- Residual agency costs include high premia rate cover of medical vacancies and (a small number of residual price cap breaches, where) cover for geographically more remote Health and Justice nursing vacancies. The recruitment and Temporary Staffing Teams have already supported Health and Justice to achieve 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 and are considering alternatives to like for like agency medical cover. The Trust has **no off-framework agency assignments**.

- **Independent sector beds** - the Trust used 0 **non-Trust bed days in October** (8 in September) 2025. **Year to date costs were £158k**, including estimates for unvalidated periods of occupancy and average observation levels pending billing and were **£36k above plan**. This remains a key area of volatility due to ongoing bed pressures, and consequently clinical and management focus is required. Flow pressures, including from unprecedented average 2025/26 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 challenging. OPEL and bed management processes (Monday to Friday) operate to support optimal daily management and flow.

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

- 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 £0.20m ahead of plan, but with **recurrent schemes delivering £2.4m below plan**, and **non-recurrent schemes delivering £2.6m above plan**. Full delivery of the £27.4m planned savings is forecast, but with **an in-year shortfall of £3.9m on recurrent schemes**, currently more than fully mitigated 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 £4.3m**, which would equate to a total recurrent Full Year Impact of CRES of £18.2m (£0.4m more than planned) if achieved.

Underlying issues:

- CRES schemes underpin achievement of our financial plan, with recurrent programmes needed to address 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 for discharge, to reduce and achieve nil reliance on independent sector beds. This will require support from local authority system partners, including due to rising and sustained extremely high levels of patients who are clinically ready for discharge.
- We recognise that high occupancy, safe staffing requirements and temporary expenditure are impacting our financial plan, with ward staffing remaining above funded levels. Agency price cap breaches at premia rates, with 45% of (a continuously reducing number of overall) agency shifts being above price cap, are impacting overall value for money, with medical and Health and Justice vacancy hotspots (impacts from the latter having reduced markedly in the last year).
- There are significant risks of delivery to a number of schemes, with forecast delivery of £0.5m and full year effect of £1m. Work is ongoing to improve the likelihood of delivery, and identify mitigating savings against the risk.

Actions:

- The Temporary Staffing sub group oversees and supports work on reduction of all temporary staffing, and has put in place additional bank arrangements, restrictions on overtime and reductions in agency use. Further actions and/or controls are being considered linked to agreement for a system reforecast of flexible staffing costs.
- 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 identified sustainability and transformation programmes to identify and realise associated benefit.
- 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

87%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Year to date agency costs of **£4.13m at Month 7 are £0.38m below plan.**

NHS planning guidance for 2025/26 introduced a requirement to reduce agency costs 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 0.94% (↓) 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 1.5% planned paybill.

Continuing to effect further reductions in use of agency shifts and on medical (and a reducing number of health and justice) shifts paid above national price caps remains a key focus. Agency **shifts reduced by the equivalent of 195 worked Whole Time Equivalent (WTE) between April 2023 and October 2025** (falling from 240 to 45 WTE), and related annualised premia for price cap breaches reduced from £4.0m in April 2023 to £2.3m in October 2025 (£1.7m reduction). Whilst the trend for medical WTE and price cap breaches was broadly positive between April 2023 and October 2025, Medical Agency WTEs increased in April and May 2025, going against trend and impacting premia incurred, before reducing to its lowest level in August. 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 high 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. At a recent NENC workshop providers committed to complete peer reviews of rostering by January 2026.
- . Providers were recently asked by NHS England to cease all Band 2 and 3 HCA agency shifts from November.

25b) Agency price cap compliance

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

1,010 agency shifts were worked in October 2025 (1,032 shifts prior month), with **478 shifts compliant** (47%) and **532 non-compliant** (53%) (prior month 595 shifts or 58% compliant and 437 or 42% non-compliant) **with national price caps, representing a decrease in overall shifts worked, but a deterioration in both the 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, 68% of all non-compliant shifts (92% by value of breaches) were medical and 32% of non-compliant shifts (8% by value of breaches) were nursing.
- 87% of the nursing agency breaches related to prisons (84% by value of shifts).
- **Medical shifts breaching decreased by 6 shifts**, decreasing from 370 shifts in September to 364 in October 2025 (100% shifts breaching price cap).

22 fewer overall agency shifts were worked this month compared to last, with shifts worked being equivalent to **approximately 33 shifts per day** (34 in September and 32 in August). The 22 shifts decrease included 6 fewer higher cost medical, 39 more nursing, and 55 less HCA agency shifts. If sustained this would have a favourable impact on the cost per average WTE agency worker due to medical premia rates.

This reflects **a reduction in total agency shifts worked of 1,123 (53%) over the last 12 months** from 2,133 shifts worked in October 2024 and **a reduction of 17% or 365 shifts breaching price cap since October 2024** (897 shifts breached).

- The Trust's ability to reduce price cap breaches has, in recent months, almost entirely stemmed from recruitment challenges for medical and health and justice vacancies, but with both on downward trajectories currently. In month 7 services have also breached for nursing.
- 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 developed medical staff recruitment and locum trajectories for 2025/26. Linked to actions for a NENC system reforecast of flexible staffing costs, medical colleagues are considering other alternatives to medical agency staffing.
- 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 October 2025 and on plan.
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 -0.52% which is a **rating of 3**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.26% (favourable) which is a **rating of 1.**
- The agency expenditure metric assesses costs compared to planned levels that target delivery of a phased 40% reduction against 2024/25. Costs of £4.1m are below plan by £385k and would therefore be **rated as a 1.** The Trust's year to date agency costs were 1.61% 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 October 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. Recovery actions need to be identified and progressed to target future year breakeven and to continue to reduce agency costs and prices cap breaches. These will support achievement of the associated individual UoRR metrics and overall UoRR rating. The Trust needs to consider wider options to achieve further agency cost reductions beyond 2025/26, with a significant proportion of cost, and most price cap breaches (by value) now relating to medical vacancy cover.

Actions:
There are no specific improvement actions required albeit that the Trust's medium term financial planning activities will support progress to ensure the Trust remains on a sustainable financial footing.

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

80%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Recurrent CRES performance for the period ending 31st October was **£6.40m and £2.44m 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 (£9.2m):** 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, progress water rectification works, security contracts, and reduce printing and taxi usage.

Bank staffing reductions are £0.42m behind plan. Agency staffing reductions are slightly ahead of trajectory, and overtime is over-achieving.

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 and Directorates 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. Care Groups have additional controls on use of agency and overtime shifts. Further stepped overtime reductions are expected from October, the second key milestone date, following Executive Directors Group approval of related proposals early in 2025/26. Additional overtime controls are being introduced in November 2025. There is an increased risk that bank utilisation increases as use of other, more costly, temporary staffing options is restricted.

Actions:
Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.
- To develop plans for all schemes, ensure timely EQIA 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 implement new overtime controls by December 2025.
- To identify additional mitigations and to consider whether any of those could be achieved recurrently.

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

80%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Non Recurrent CRES performance was **ahead of plan by £2.63m** for the period ending 31st October, with £7.71m 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, and EQIA's are booked for nearly all schemes. 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 £2.63m over achievement year to date on non-recurrent schemes includes, £0.66m reduction on PDC and Depreciation expenses, £1.74m other actions, £0.44m management of cash to achieve maximum interest, offset by under achievement of planned learning disability savings £0.21m.

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 EQIA 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 **£5.16m** at the end of October, which was £0.73m less than the revised programme (£0.31m less than original 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. In August 2025 the Board agreed it was likely that the approved revised programme of £14.47m would likely generate overspending against the ICB allocation, with the system capital lead alerted accordingly. 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 £1.4m 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).

The Trust has received confirmation that it has been awarded an additional £2.22m to support Solar panel installation on 5 further Trust sites.

There is potential that confirmed phasing of Teesside hospital works will mean that costs are lower than the Board approved programme in 2025/26 (and higher in 2026/27), and that the benefit from the sale of Dragon Parade will not be realised until 2026/27. The Trust is communicating with system partners to ensure delivery of costs to within allocated expenditure.

Underlying issues:

Liquidity, due to reducing Trust cash balances and increasingly constrained national and regional capital allocations relative to need, are of significant concern going forward, especially given the 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 due to be submitted to NHS England, aligned to medium term financial planning.

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 **£47.95m** at the end of October 2025 which exceeded planned cash balances of **£45.12** by **£2.83m,** reflecting a higher than planned opening cash balance, and income received in advance of the period it relates to. This is partly offset by capital funding not yet received that is included in year to date planned capital expenditure.

- **Prompt Payment of Suppliers:** The Trust has achieved a combined Better Payment Practice Code (BPPC) compliance of **96.1%** 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 October 2025 was £3.1m, with **debts exceeding 90 days amounting to £0.63m** (excluding amounts being paid via instalments and PIPS loan repayments). Progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

Underlying issues:

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

Actions:

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

National Quality Requirements & Mental Health Priorities

National Quality Requirements and Mental Health Priorities

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

National Quality Requirements	Variation	Assurance	Annual Standard	Standard (FYTD)	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	?	80.00%	80.00%	93.07%
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	?	60.00%	60.00%	79.26%
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	75.00%	75.00%	88.80%
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	95.00%	95.00%	99.91%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)	L	F	95.00%	95.00%	86.31%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)	H	F	95.00%	95.00%	76.36%

Mental Health Priorities	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)
Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider (OAPs)	L	?	0	0	0
Average length of stay for Adult Acute Beds (Rolling Quarter)		?	42	42.5	39.7
Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48.00%	48.00%	47.60%
Talking Therapies - Reliable improvement rate for those completing a course of treatment		?	67.00%	67.00%	66.65%
Number of women accessing (1+ contact) specialist community PMH services in the previous 12 months	H	N/A	N/A	N/A	1,642
Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact	L	N/A	No significant change	No significant change	29,607
Number of people accessing IPS services (rolling 12 month)	N/A	N/A	N/A	N/A	957

Mental Health Priorities

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

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

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

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 October there were 5 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 October there was 1 patient that did not receive treatment within the 1-week standard.

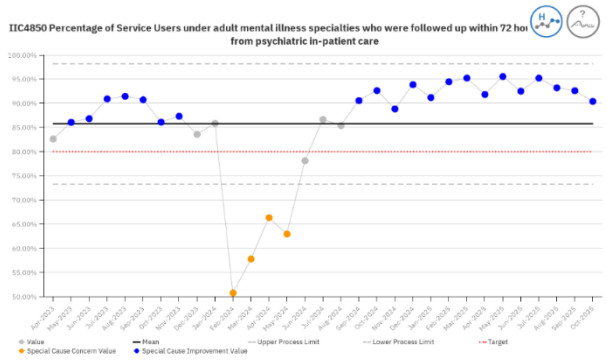
Mental Health Priorities

- **Active OAP (inappropriate):** Achieved Trust plan for October.
- **Average Length of stay for Adult acute beds *(new measure)*:** Achieved Trust plan for October.
- **Talking Therapies Reliable Recovery:** National Standard not achieved at Trust and commissioned place level, with the exception of North Yorkshire and York, noting that we have achieved the standard for the month of October in County Durham.
- **Talking Therapies Reliable Improvement:** National Standard not achieved at Trust and commissioned place level with the exception of North Yorkshire and York, noting that we have achieved the standard for the month of October in County Durham.
- **Specialist Community Perinatal Mental Health (PMH) services** Plan achieved at commissioned place level.
- **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 and there is special cause concern across the combined position for Humber & North Yorkshire ICB. The plan has also not been achieved in Tees Valley.
- **Number of people accessing individual placement support (*new measure*):** Plans not achieved at commissioned place level.

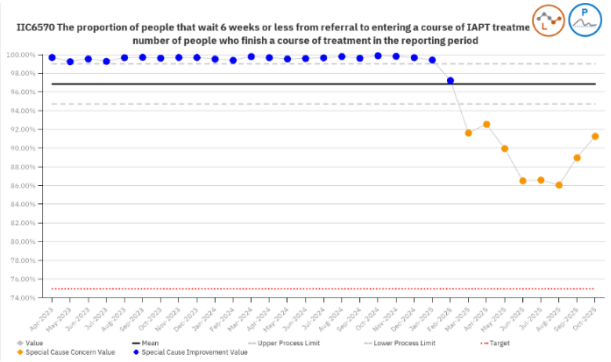
*All headlines are based on financial year to date unless otherwise stated.

National Quality Requirements

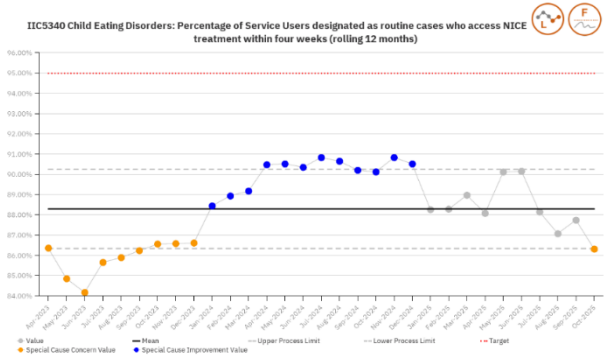
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



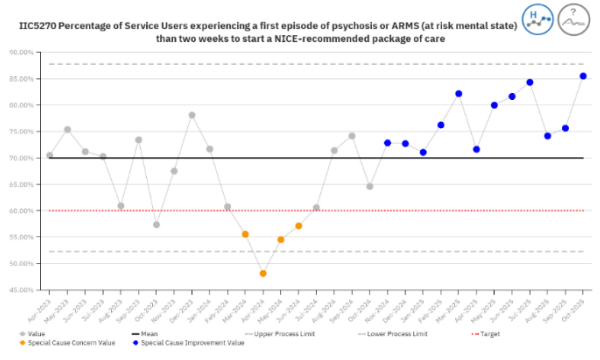
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	80%	93.07%			
County Durham	80%	93.75%			
Tees Valley	80%	92.27%			
North Yorkshire	80%	96.67%			
York	80%	93.30%			



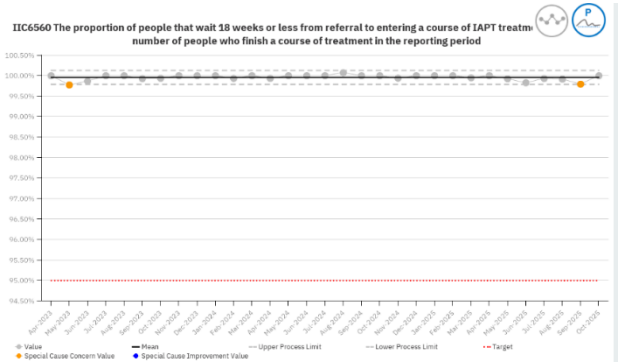
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	75%	88.80%			
County Durham	75%	80.30%			
Tees Valley	75%	81.70%			
North Yorkshire	75%	98.22%			
York	75%	92.99%			



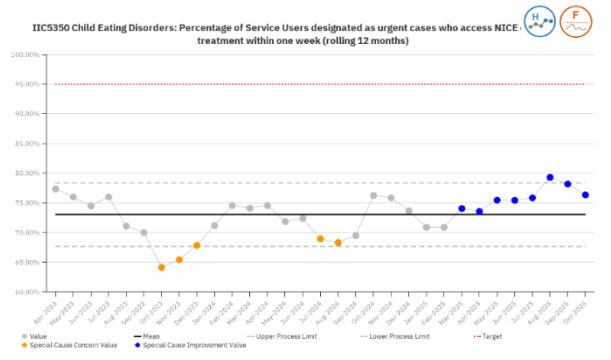
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	86.31%			
County Durham	95%	81.18%			
Tees Valley	95%	97.62%			
North Yorkshire	95%	83.33%			
York	95%	73.33%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	60%	79.26%			
County Durham	60%	71.67%			
Tees Valley	60%	81.35%			
North Yorkshire	60%	87.20%			
York	60%	71.70%			



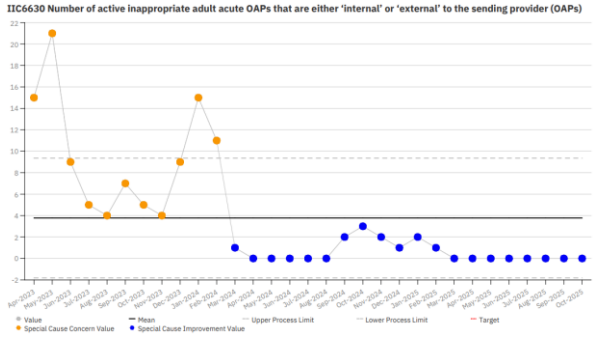
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	99.91%			
County Durham	95%	99.88%			
Tees Valley	95%	99.74%			
North Yorkshire	95%	99.97%			
York	95%	99.93%			



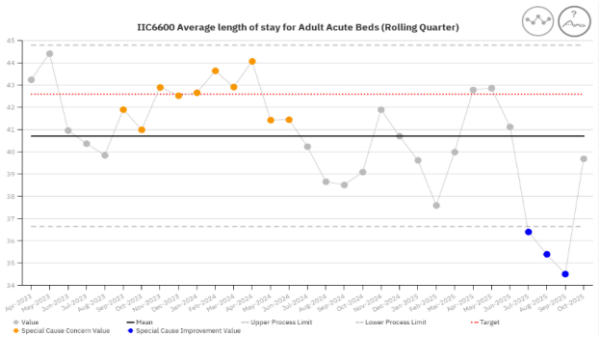
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	95%	76.36%			
County Durham	95%	82.61%			
Tees Valley	95%	100.00%			
North Yorkshire	95%	60.00%			
York	95%	50.00%			

Mental Health Priorities

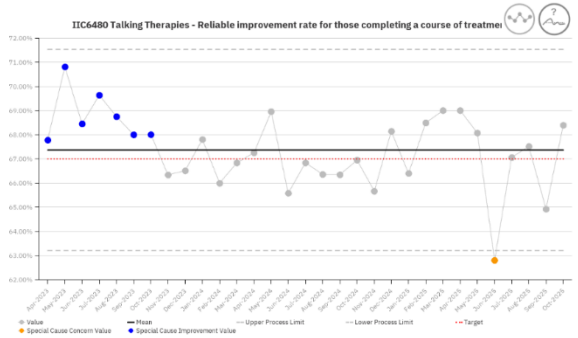
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



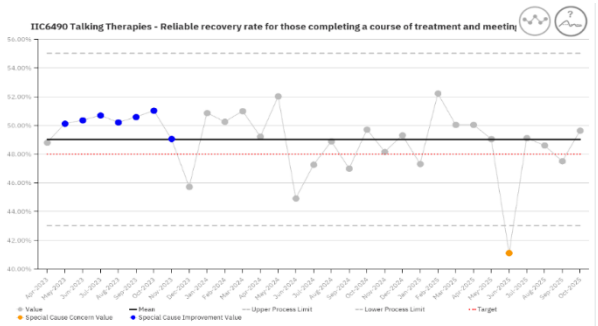
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	0	0			



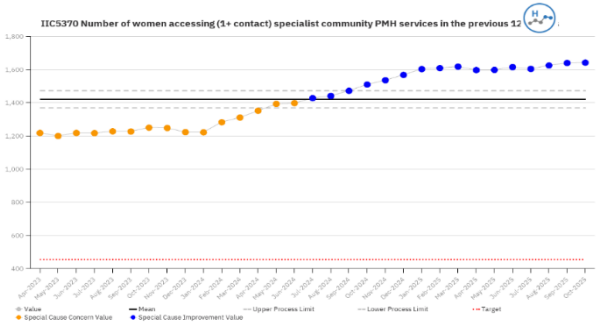
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	42.5	39.7			



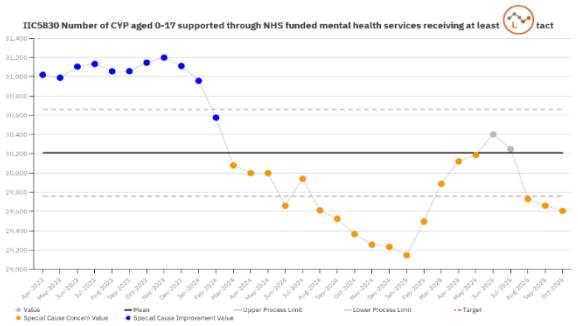
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	67%	66.65%			
County Durham	67%	63.83%			
Tees Valley	67%	62.88%			
North Yorkshire	67%	69.57%			
York	67%	69.38%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	48%	47.60%			
County Durham	48%	43.91%			
Tees Valley	48%	46.33%			
North Yorkshire	48%	50.65%			
York	48%	50.35%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	1642			
County Durham	456	489			
Tees Valley	447	531			
North Yorkshire	368	425			
York	156	166			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	29607			
County Durham		10444			
Tees Valley		11212			
North Yorkshire		4572			
York		2882			

Number of people accessing IPS services (rolling 12 months)

Organisation	Standard	Actual	ICB Actual	Assurance	Plan Met
Trust	N/A	957			
County Durham	789	275	633		
Tees Valley		358			
North Yorkshire	347	194	311		
York		117			

Average length of stay for Adult Acute Beds

Tees, Esk and Wear Valleys NHS Foundation Trust

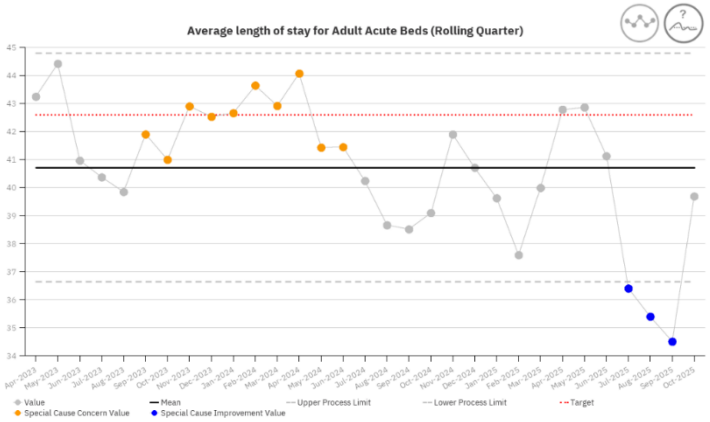
Background / standard description:
Whilst we are aiming to reduce our average length of stay within our adult acute inpatient beds to 42.0 days by the end of March 2026, by the end of October we are aiming to have an average length of stay of **42.5** days.

What does the chart show/context:
During the 3-month period ending October 2025, there were **733** discharged hospital spells from adult acute beds for patients aged 18+, accounting for a total of **29,091** bed days which equates to an average length of stay of **39.69** days.

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

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.

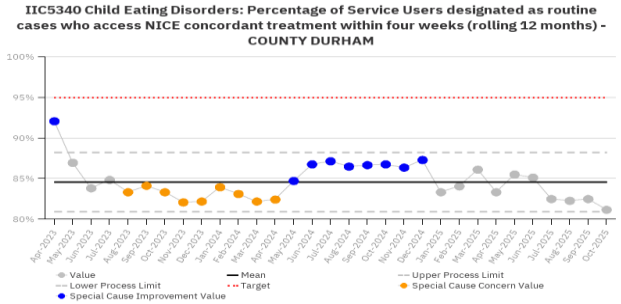
Actions:
There are no specific improvement actions required.



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	35.4	34.5	39.7					

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.

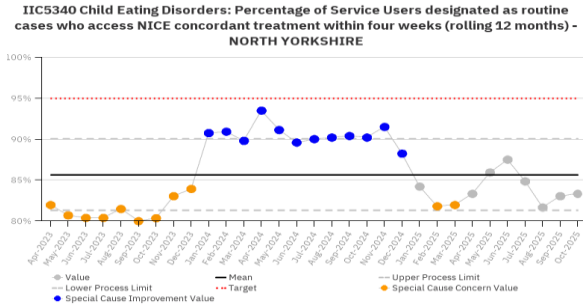
What does the chart show/context:
In the rolling 12 months ending October 2025, there were **86** children and young people with a routine referral, of which **70 (81.40%)** started treatment within 4 weeks in **County Durham**.

In October, there were **8** children and young people with a routine referral, of which **6 (80.95%)** started treatment within 4 weeks.

Underlying issues:
Of the 2 patients that did not receive timely treatment :

- 1 was attributable to patient choice. Treatment commenced on day 32.
- 1 patient was a re-referral and assessment was delayed to enable a discussion with the previous therapist. Treatment commenced on day 35.

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 October 2025, there were **60** children and young people with a routine referral, of which **50 (83.33%)** started treatment within 4 weeks in **North Yorkshire**.

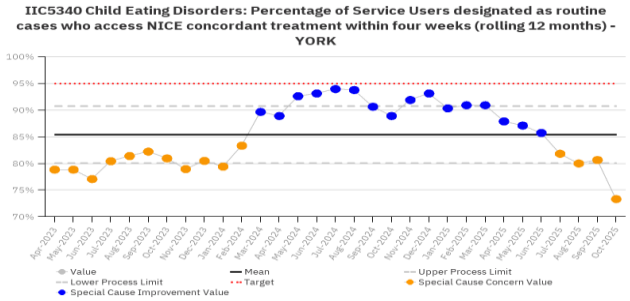
In October, there were **5** children and young people with a routine referral, **all** of which **(100.00%)** started treatment within 4 weeks.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

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 October 2025, there were **30** children and young people with a routine referral, of which **22 (73.33%)** started treatment within 4 weeks in **York**.

In October, there were **3** children and young people with a routine referral, **0** of which **(0.00%)** started treatment within 4 weeks.

Underlying issues:
For the 3 patients that did not receive timely treatment:

- 1 was due to patient choice. The patient commenced NICE treatment on day 35.
- 1 had insufficient physical health information on their referral form. The patient commenced NICE treatment on day 29.
- The remaining 1 was due to the high number of primary care referrals to the Adult York Access & Wellbeing Service is impacting on the waiting time for young people with an eating disorder referred to that service. The patient commenced NICE treatment on day 36.

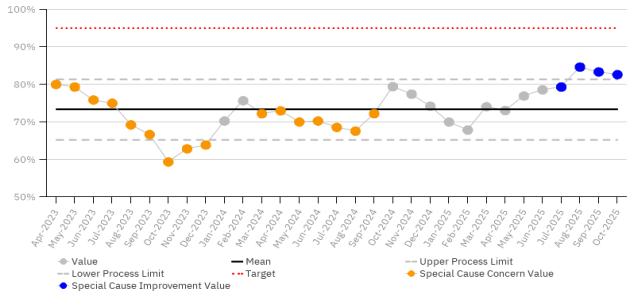
Actions:

- Adult York Access & Wellbeing Service Team Manager has reallocated staff to increase assessment capacity from October. A trajectory to reduce the backlog will be established by the end of November 2025.
- In addition, primary care referrals for patients within the York Community Mental Health Hub footprints have been redirected to the Hubs from October; releasing assessment capacity for the Adult York Access & Wellbeing Service.

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

IIC5350 Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months) - COUNTY DURHAM



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.

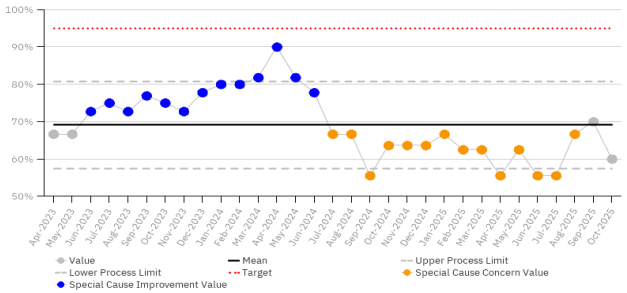
What does the chart show/context:
In the rolling 12 months ending October 2025, there were **23** children and young people with a routine referral, of which **19 (82.61%)** started treatment within 4 weeks in **County Durham**.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

IIC5350 Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months) - NORTH YORKSHIRE



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.

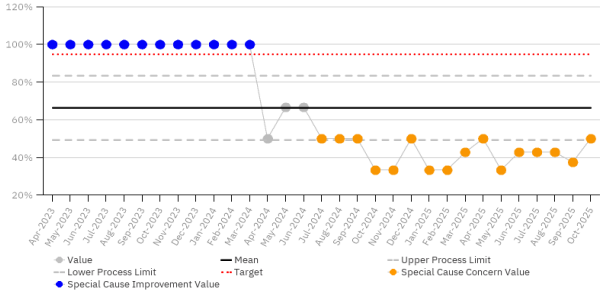
What does the chart show/context:
In the rolling 12 months ending October there were **10** child or young people with an urgent referral, of which **6 (60%)** started treatment within 1 week in **North Yorkshire**.

In October, there were **2** children / young people with an urgent referral, of which, **1 (50.00%)** started treatment within 1 week.

Underlying issues:
For the 1 patient that did not receive timely treatment: this was due to patient choice. The patient commenced NICE treatment on day 16.

Actions:
There are no specific improvement actions required.

IIC5350 Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months) - YORK



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 October, there were **10** child or young people with an urgent referral, of which **5 (50.00%)** started treatment within 1 week in **York**.

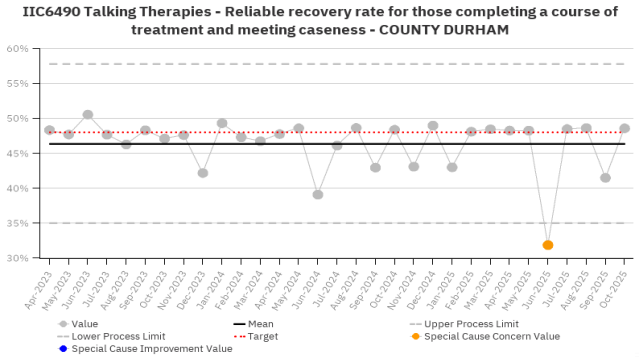
In October, there were **2** children / young people with an urgent referral, of which, **2 (100.00%)** started treatment within 1 week.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

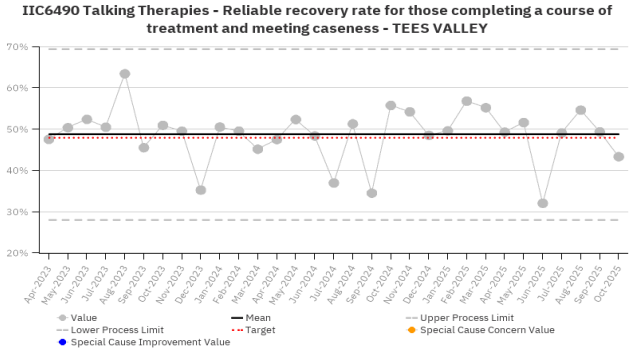
Talking Therapies: Reliable recovery rate for those completing a course of treatment – *by exception*

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 we are not achieving the target for the financial year to date, during October, **48.59%** 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:
During October, **43.37%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**.

Underlying issues:

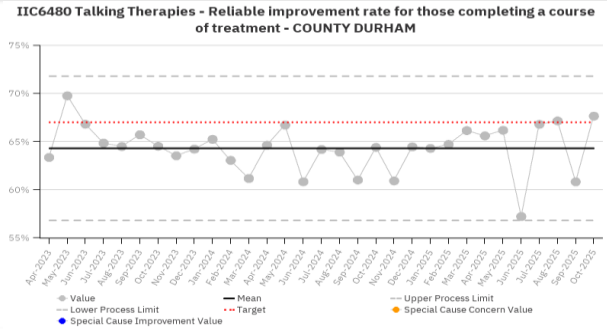
- Increase in complexity and severity of patient's presentation, which makes it more challenging to see a 6-point (Patient health questionnaire - PHQ9) or a 4-point (Generalised anxiety disorder - GAD) shift.
- A number of staff members on maternity leave and high levels of sickness are resulting in caseloads being reallocated or patients being added back to the waiting list which is impacting on the measure.

Actions:

- The Trustwide action plan includes 14 improvement actions, all of which were planned for completion at end of December 2025. One action has been delayed to the end of Quarter 4 due to a delay in information coming to Trusts from the National Team in order for us to progress. All other actions are on track. A further update will be provided to the Integrated Care Group Board and Quality & Performance Executive Directors Group in November.
- Service Manager has submitted a number of posts to Vacancy Control to backfill maternity leave and improvement actions will be incorporated into the wider work on sickness absence. **(Complete)** All posts have been advertised
- Where appropriate, patients waiting for Counselling for Depression are being offered Interpersonal Therapy as an alternative treatment. The impact of these sessions is anticipated from the end of November 2025.
- Talking Therapies Senior Leadership Team to explore options to reduce the waiting list for patients waiting for 2nd treatment appointments with a view to supporting improvement in reliable recovery and improvement. These improvement events will take place in October and November 2025. **(Complete)** Output, including costings for a digital solution, will be considered by the General Manager and senior clinical leaders by the end of December 2025.

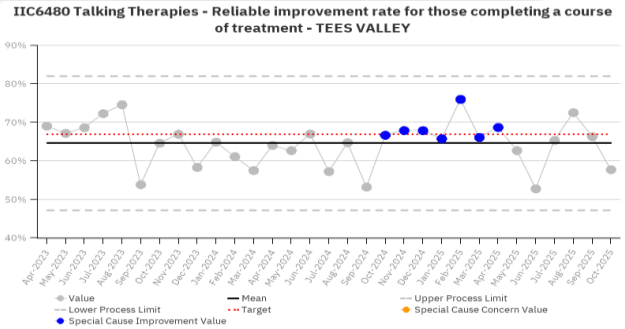
Talking Therapies: Reliable improvement rate for those completing a course of treatment – *by exception*

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 we are not achieving the target for the financial year to date, during October, **67.65%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**.



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

What does the chart show/context:
During October, **57.73%** 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 the measure.

Actions:

- The Trustwide action plan includes 14 improvement actions, all of which were planned for completion at end of December 2025. One action has been delayed to the end of Quarter 4 due to a delay in information coming to Trusts from the National Team in order for us to progress. All other actions are on track. A further update will be provided to the Integrated Care Group Board and Quality & Performance Executive Directors Group in November.
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- Where appropriate, patients waiting for Counselling for Depression are being offered Interpersonal Therapy as an alternative treatment. The impact of these sessions is anticipated from the end of November 2025.
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Number of people accessing IPS services (rolling 12 month) – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
In the 12 months ending October 2025, we are aiming for 862 people across **North East & North Cumbria** to access individual placement & support services.

What does the chart show/context:
In the 12 months ending October 2025, **633** people accessed IPS services; of which, **275** were within **County Durham** and **358** were in **Tees Valley**.

Background / standard description:
In the 12 months ending October 2025, we are aiming for 545 people across **Humber & North Yorkshire** to access individual placement & support services.

What does the chart show/context:
In the 12 months ending October 2025, **311** people accessed IPS services; of which, **194** were within **North Yorkshire** and **117** were in **York**.

E.H.35	Number of people accessing Individual Placement and Support Number of people accessing IPS services (rolling 12 month).											
NENC	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
TEWV- Ambition	752	752	752	752	789	825	862	899	936	972	1,009	1,046
TEWV- Actual	**576**	**592**	**605**	**622**	**641**	**633**	**633**					
HNY	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
TEWV- Ambition	230	230	230	347	347	347	545	553	562	570	578	586
TEWV- Actual	**302**	**301**	**308**	**313**	**309**	**312**	**311**					

Update:
Within NENC we have had funding released to fulfil the March 2026 ambition and recruitment is underway as shown below:

4.6 B4 Employment Specialists in pre-employment checks
1.0 B6 Team Leader starts November 2025
2.0 B4 Employment Specialists out to advert
0.7 B3 Employment Assistant out to advert

Underlying issues:
There are no underlying issues to report.

Actions:
Senior Performance Manager to discuss latest performance with the Service Manager to better understand whether performance is reflective of actual staffing based on access expectations. This will be complete by the end of November 2025.

Update:
Within HNY, the future ambition is based on additional funding which has not yet been released impacting the service's ability to recruit. We have signalled to commissioners as part of the planning submissions what we can commit to in terms of delivery under the current level of funding.

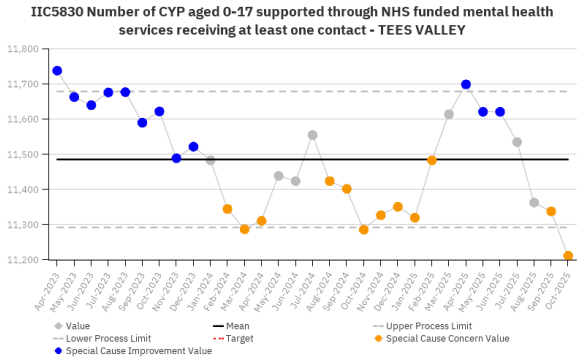
2.0 B4 Employment Specialists in pre-employment checks

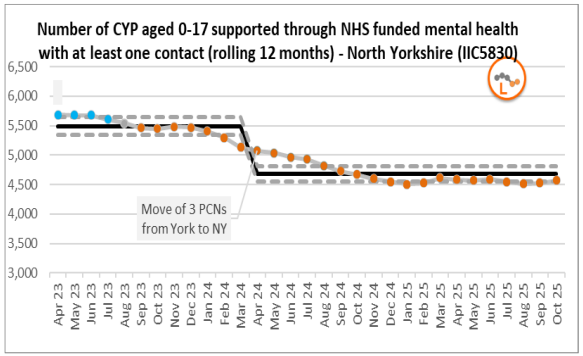
Underlying issues:
There are no underlying issues to report.

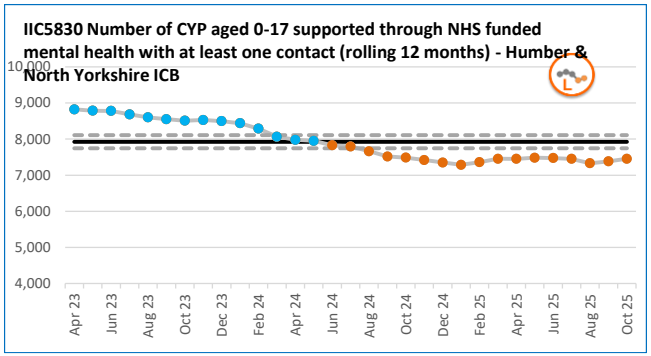
Actions:
Senior Performance Manager to discuss latest performance with the Service Manager to better understand whether performance is reflective of actual staffing based on access expectations. This will be complete by the end of November 2025.

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 October 2025 **11,212** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **Tees Valley**.

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

Underlying issues:
Whilst there is a decreasing trend, further work is required to understand whether there is an underlying issue.

Actions:
Business Intelligence to review the numbers accessing services to better understand the position. This work will be completed by the end of December 2025.

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 October 2025 **4,572** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **North Yorkshire**.

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

Underlying issues:
The national metric is only including new patients being referred to services within a rolling 12-month period and does not consider demand on services from a patient who has been previously referred within that same period. 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 QI event is being planned for December 2025 to review the clinical processes and recording of key data across all Neuro services to ensure consistency.

Waiting Times

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		2333	885	576	306	415	145	5	1	0	0	9	72*
Adults with a learning disability Waiting for an Assessment		71	45	21	5	0	0	0	0	0	0	4	12
Adults in Health and Justice services Waiting for an Assessment		48	34	8	4	2	0	0	0	0	0	4	16*
Older People Waiting for Assessment		2460	788	599	295	537	212	26	3	0	0	11	64
Children and Young People Waiting for an Assessment		878	479	236	49	63	21	5	14	10	1	9	157
Children and Young People Waiting for Treatment (excluding Neuro)		1795	178	312	129	415	230	112	213	81	125	42	311

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)
Children and young people waiting for an Autism Assessment		5345	77	108	33	320	355	508	2184	1578	182	84	227
Children and young people waiting for an ADHD Assessment		4601	120	124	54	509	499	446	1753	871	225	71	228*
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2095	59	28	39	164	108	143	576	689	289	96	211
Adults waiting for an ADHD Assessment		4767	121	122	81	242	376	294	1121	1450	960	102	359
Adults waiting for an Autism Assessment		4066	54	75	81	202	316	180	760	1315	1083	113	317

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)		60	23	19	13	5	0	0	0	2	6*
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		2	1	0	1	0	0	0	0	2	3*
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		17	6	7	3	0	1	0	0	2	8

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		4963	963	671	1566	671	667	425	12	60

NOTE: *an asterisk denotes a data quality issue*

Waiting Times Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

Waiting Times Assessment & Treatment

- **AMH** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our longest genuine wait time is **45 weeks** in NYYSCG. The majority (**94**%) 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 wait time is **12 weeks** in DTVFCG. The majority (**93**%) of adults are waiting less than 2 months for an assessment.
- **H&J** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our longest genuine wait time is **12 weeks** in DTVFCG. The majority (**71**%) of adults are waiting less than 1 month for an assessment.
- **MHSOP** There is no significant change in the numbers waiting for an assessment. Our longest wait time is **64 weeks** in NYYSCG. The majority (**90**%) of older adults are waiting less than 6 months for an assessment.
- **CYP** There is special cause improvement in the number of children and young people waiting for an assessment. Our longest wait time is **157 weeks** in DTVFCG. The majority (**81**%) 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 **311 weeks** in DTVFCG. The majority (**61**%) of children and young people are waiting between 1 and 9 months for treatment.

Waiting Times Neuro Services

- **CYP Autism** There is special cause improvement in the numbers waiting for an autism assessment. Our longest wait time is **227** weeks (4.4 years) in DTVFCG. The majority (**70%**) of children and young people are waiting between 1-3 years for an autism assessment.
- **CYP ADHD** There is special cause improvement (a reduction) in the numbers waiting for an ADHD assessment. Our longest genuine wait time is **219** weeks (4.2 years) in DTVFCG. The majority (**57%**) of children and young people are waiting between 1 and 3 years for an assessment.
- **CYP both/not yet categorised** There is special cause improvement (a reduction) in the numbers waiting for a neuro assessment. Our longest wait time is **211 weeks** (4.1 years) in DTVFCG. The majority (**60%**) of children and young people are waiting between 1-3 years for an assessment.
- **AMH ADHD** There is special cause improvement (a reduction) in the number of waiting for an ADHD assessment. Our longest wait time is **359 weeks** (6.9 years) in DTVFCG. The majority (**74**%) 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 **359** weeks (6.9 years) in DTVFCG. The majority (**78%**) of adults are waiting over 1 year for an assessment.

National Waiting Times

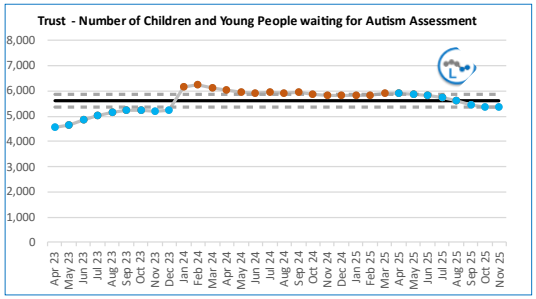
- **EIP** There is special cause improvement (a reduction) in the number of waiting for EIP Treatment. Our longest genuine wait time is currently **5 weeks** in NYYSCG. The majority (**70%**) of adults are waiting less than 2 weeks for treatment
- **CED Urgent** There is no significant change in the number waiting from an urgent referral within our Eating Disorder Service. Our longest genuine wait time is **6 days in DTVFCG.** The 1 wait reported in excess of the standard is attributable to data quality, which has subsequently been addressed.
- **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 **8 weeks** in NYYSCG. The majority (**76%)** of children and young people are waiting less than 2 weeks for treatment.

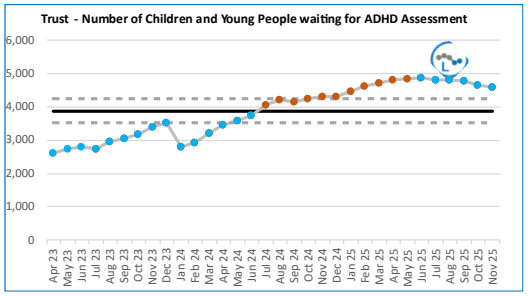
Waiting Times Talking Therapies

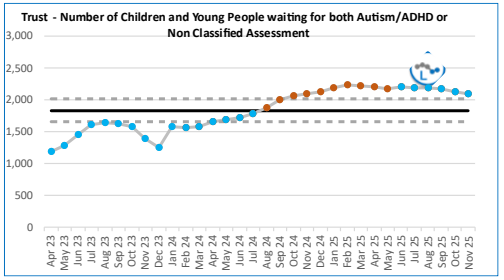
- There is no significant change in the number of adults waiting for their second contact with Talking Our longest wait time is currently **60 weeks** in NYYSCG. The majority (**91%**) of adults are waiting less than 28 weeks for their second appointment.

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	5345	84	227	
DTVF Care Group	4377	91	227	
NYY&S Care Group	968	53	124	

Commentary on Longest waits

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

Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4601	71	228	
DTVF Care Group	3977	74	228	
NYY&S Care Group	624	53	145	

Commentary on Longest waits

DTVF: Data Quality - Specialist Assessment Complete (longest genuine wait - 1535 days - specialist assessment booked).
NYY&S: Data Quality - Specialist Assessment Complete (longest genuine wait - 815 days - specialist assessment booked).

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

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2095	96	211	
DTVF Care Group	1456	121	211	
NYY&S Care Group	639	40	98	

Commentary on Longest waits

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

Underlying issues:

- High levels of demand outweighing capacity
- Long wait times and projected waiting times in the County Durham areas
- Long-term sickness absences within the Scarborough ADHD team
- Long wait times and projected waiting times for children on the under 5s pathway (South Durham)

Actions (Partnership-wide):

- The Trust is working closely with the ICB and Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust to develop the next steps of a proposal, which includes a clear process and framework for clinical prioritisation and the development of an aligned regional process for the management and assessment of referrals.
- 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 by the ICB.
- 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 work has not reached a conclusion at present, and we await confirmation from the ICB of the expected sign off and implementation.

Waiting Times Neuro Services: Children & Young People

Tees, Esk and Wear Valleys NHS Foundation Trust

Actions (Trust):

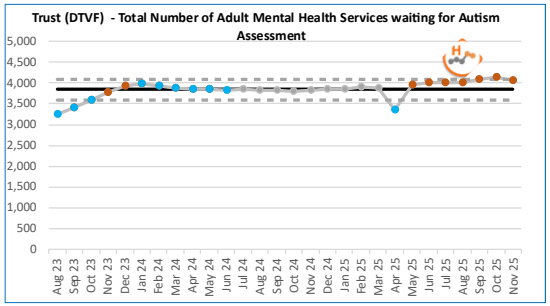
- DTVFCG have a recovery plan in place with Phase 2 testing on dual assessments continuing in Darlington locality. The full evaluation of the clinical protocol is on track for completion at the end of October (previously April, then June 25). **(Complete)** All remaining actions within the recovery plan are progressing, while demand currently continues to outweigh capacity, the service continues to deliver favourably delivering against the trajectory we set out.
- DTVFCG CYP General Manager has held a Clinical Transformation workshop in November 2025 to look at the recommendations from the protocol review and agree the logistics for roll out. **(Complete)** An away day is scheduled for February 2026 to agree a plan for full roll out.
- Service Manager to explore the potential options for improving waiting times for patients on the under-5 pathway. Proposals will be submitted to the Care Group Board in December 2025 (previously November) for approval.
- 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 December 2025 (previously July, then September, October and November). Whilst some improvement can be made, the demand outstrips the capacity of the service.

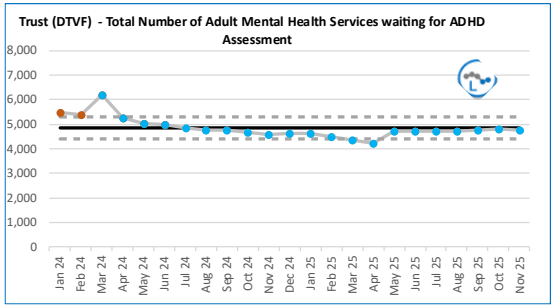
To Note: The trajectory submitted to NENC ICB, factoring in the additional assessments, remains on track for delivery.

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**	**9914**	**9810**					
Change		99	10	-43	10	-149	-138	-216	-209	-104					

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
t (DTVF Care Group)	4066	113	317	

Commentary on Longest waits

DTVF: Genuine Wait - Assessment Required

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
t (DTVF Care Group)	4767	102	359	

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
- 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):

- The Trust is working closely with the ICB and Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust to develop the next steps of a proposal, which includes a clear process and framework for clinical prioritisation and the development of an aligned regional process for the management and assessment of referrals.

Actions (Trust):

- All 4 additional posts funded to support the provision of increased assessments have been recruited and are in post **(Complete)** The anticipated additional assessments will be provided from the end of November.

Waiting Times Neuro Services: Adult Services

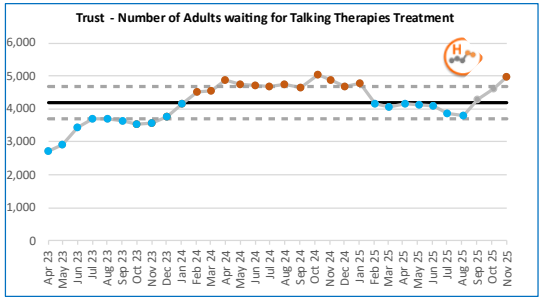
Tees, Esk and Wear Valleys NHS Foundation Trust

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**	**4817**	**4767**					
Change		**-117**	**-143**	**475**	**24**	**-2**	**-2**	**46**	**40**	**-50**					

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	4963	12	60	
DTVF Care Group	2712	11	49	
NYY&S Care Group	2251	14	60	

Commentary on Longest waits

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

Underlying issues (DTVFCG):

- Capacity of Psychological Wellbeing Practitioner (PWP) (high levels of step 2 vacancies/absence/sickness)
- High levels of people accessing Step 3 care, bypassing Step 2 appropriately
- Counselling for Depression demand exceeds capacity
- Sickness is resulting in caseloads being reallocated or added back to the waiting list which is impacting on recovery, improvement and wait times

Underlying issues (NYYSCG):

- Underfunding within Step 2 and Step 3
- Treatment capacity has been converted to assessment capacity from the middle of October 25 to address a backlog of patients waiting for 1st treatment appointment, which is impacting on the waiting time for 2nd treatment appointments.

Actions (Trustwide)

- The Trustwide action plan includes 14 improvement actions, all of which were planned for completion at end of December 2025. One action has been delayed to the end of Quarter 4 due to a delay in information coming to Trusts from the National Team in order for us to progress. All other actions are on track. A further update will be provided to the Integrated Care Group Board and Quality & Performance Executive Directors Group in November.

Actions (DTVFCG)

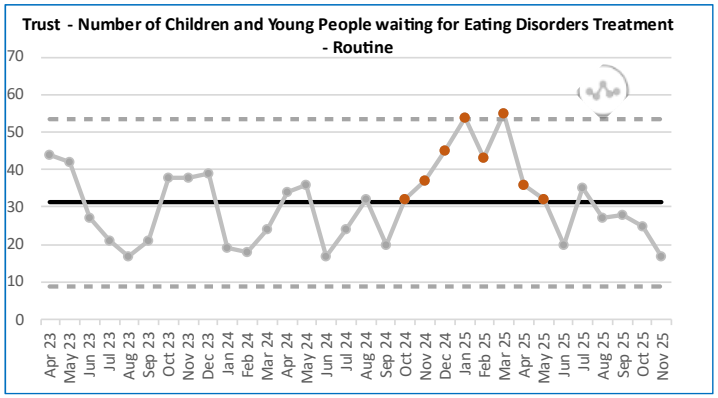
- Senior Leadership Team to explore options to reduce the waiting list for patients waiting for 2nd treatment appointments; two improvement events were held by the end of November 2025. **(Complete)** A thematic review of the sessions and proposed actions are to be completed by the end of December 2025.

Actions (NYYSCG)

- One PWP has now commenced in post; of the 3 PWP trainees, 2 have qualified and the remaining 1 will qualify by the end of October. **(Complete)**
- The work to convert treatment capacity to assessment capacity to address the backlog of patients waiting for 1st treatment appointment will be completed by the end of December 2025.

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	17	2	8	
DTVF Care Group	13	2	4	
NYY&S Care Group	4	3	8	

DTVF: Genuine Wait - Treatment appointment booked.
NYY&S: Genuine Wait - Treatment appointment booked.

Summary:

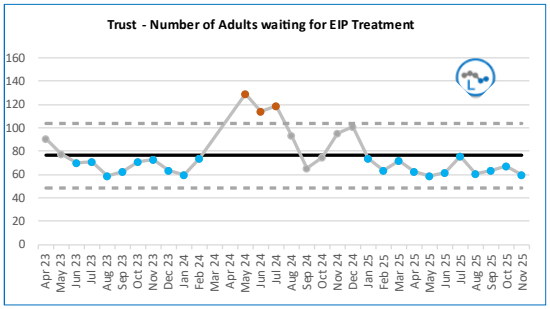
There is 1 child or young person **reported** as waiting more than 4 weeks; this is a genuine wait:

- 1 patient (waiting 8 weeks) declined an appointment (offered outside of 4 weeks as they required a joint appointment with the Adult Community Mental Health Team). An appointment is booked in November.

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	60	2	6	
DTVF Care Group	39	2	6	
NYY&S Care Group	21	2	5	

Commentary on Longest waits

DTVF: Data Quality - Referral to be closed. (Longest genuine Wait - 35 days - Treatment appointment required.
NYY&S: Genuine Waiter - Treatment appointment booked.

Summary:
There are **18** adults **reported** as waiting more than 2 weeks of which **11** are genuine waits:

- **6** patients (longest wait 5 weeks) failed to attend an appointment (within 2 weeks). Five patients have appointments booked in November; the service is liaising with external services to arrange a further appointment for the remaining patient.
- 4 patients (longest wait 5 weeks) failed to attend appointments (outside 2 weeks). Three patients have appointments booked in November; the service is in the process of arranging a further appointment for the remaining patient.
- **1** patient attended an appointment (within 2 weeks); the service are validating the appointment.

Of the remaining **7** patients:
- **3** patients have been assessed and treatment is not suitable for their presentation. The service is in the process of closing referrals.
- **4** are attributable to data quality; 3 have been subsequently resolved, and 1 is logged with the Service Desk for resolution.

Underlying issues:
- Failed Appointments
- Data Quality

Actions:
There are no specific improvement actions required.

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

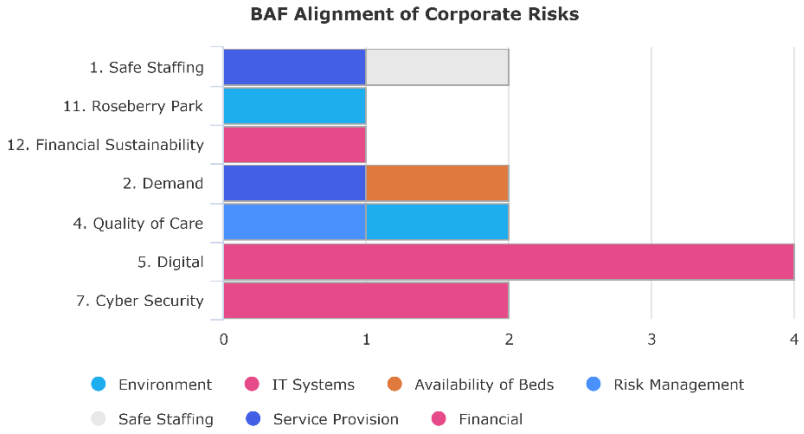
Meeting of:	**Board of Directors**
Date:	**11th December 2025**
Title:	**Corporate Risk Register**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Report Author(s):	**Kendra Marley, Head of Risk Management**

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

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

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

Strategic Risks relating to this report:



EXECUTIVE SUMMARY:

Purpose:

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

Proposal:

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

Overview:

This paper presents to the Board the risks on the Corporate Risk Register as of 20th November 2025, reflecting any movement and changes since 2nd August 2025.

There are currently 14 risks on the Corporate Risk Register (was 13).

1 new risk added to the register as a result of replacement of the closed finance risk is:

- **Risk 1682 – Finance** – There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs.

Reduced Risks in the period:

1 risk has been reduced in the period, but is retained on the register until a Joint Care Group risk can be added to replace it, this reflects the recognition of risk reduction specifically in this area, but wider triangulation of wider risk and impact trustwide.

- **Risk 1219, DTVF – CAMHS** - Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience. (reduced from 15>12) The risk rating was reviewed by the CAMHS Subgroup, resulting in an updated score. The risk has been downgraded due to a one-point reduction in likelihood, attributed to ongoing GP engagement in shared care and monitoring of pilot outcomes.

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

- **Risk 909 - NYY Management** - risk relating to consultant recruitment, as although position improved in NYY, the strategic workforce review does highlight consultants as an area of risk. This risk will remain until a central risk relating to strategic workforce gaps is considered/added.
- **Risk 1044, N&G** – Incidents that are more serious than initially reported are not identified within appropriate timescales. (reduced from 15 to 10)
- **Risk 1137 – DTVF Management** - The current system (TEWVision) is unable to provide compliance and assurance of supervision. (Reduced from 16 to 12)
- **Risk 1529, DTVF AMH -** Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards. (reduced from 16 to 12)
- **1646 – Digital and Data** – risk relating to cyber and our operational incident response, for ongoing monitoring in light of national and worldwide events.

Compliance with reviews

Risk review compliance for corporate risks is at 93% as one risk is awaiting update. (previously 100%)

A summary breakdown for each committee is included at the end of the report, which now includes an overview of current risk rating across the last 12 months, as well as an action extract, and a summary of each risk.

Actions across corporate risks are in place, with a total of 44 (increase of 9) current open actions across 14 risks. 3 of the actions (7%, previously 2/35(9%)) are past their due (or planned revised completion) date.

Increased oversight and monitoring is being established to fully embed and improve monthly control effectiveness and action progress update.

Prior Consideration and Feedback:

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

Implications:

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

Recommendations:

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

Further Information

Report Title: Corporate Risk Register

1. Proposal

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

2. Prior Consideration and Feedback

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

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

3. Commentary

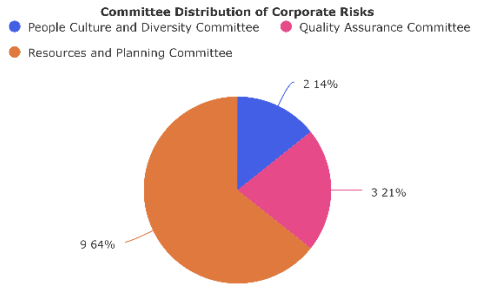
This paper presents to the Group the ≥15 risks on the Corporate Risk Register as of 20th November 2025, reflecting any movement and changes from 2nd August 2025.

3.1 Corporate Risk Register

The There are currently 14 risks on the Corporate Risk Register, this is an addition of 1 as the Executive Risk Group agreed addition of the 25/26 finance risk. 8 are above 15 with 6 risks at 12 or below, 1 of which was reduced since the last meeting. All continue to be monitored on the Corporate Risk Register.

3.2 Committee & Care Group Alignment

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

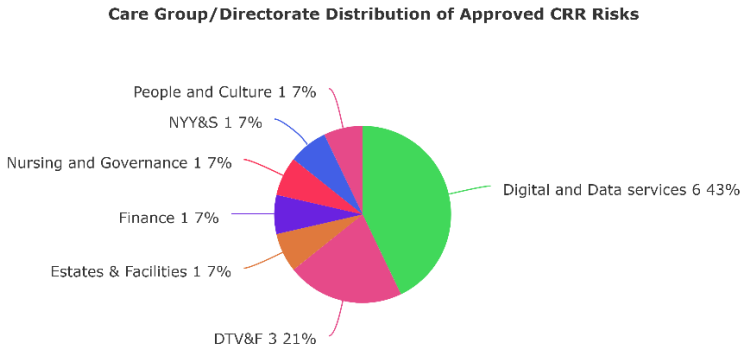


This shows that there are now

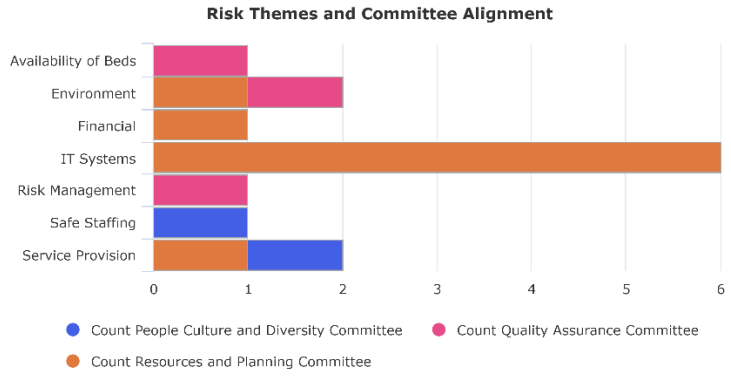
- 3 risks aligning to the Quality Assurance Committee
- 9 risks aligning to the Resources and Planning Committee
- 2 risks aligning to the People, Culture and Diversity Committee

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

Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 43% of the current Corporate Risk Register is made up of risks from Digital & Data Services, 21% Durham Tees Valley and Forensics Care Group, with North Yorkshire, York Care Group, Finance, Estates and Facilities, Nursing & Governance and People and Culture all at 7%.



3.3 Risk Themes



The 14 risks fall under the following themes within the Committee Alignment, with higher numbers of risks relating to IT Systems.

3.4 Risk Movements

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

The following key indicates the movement and Committee alignment.

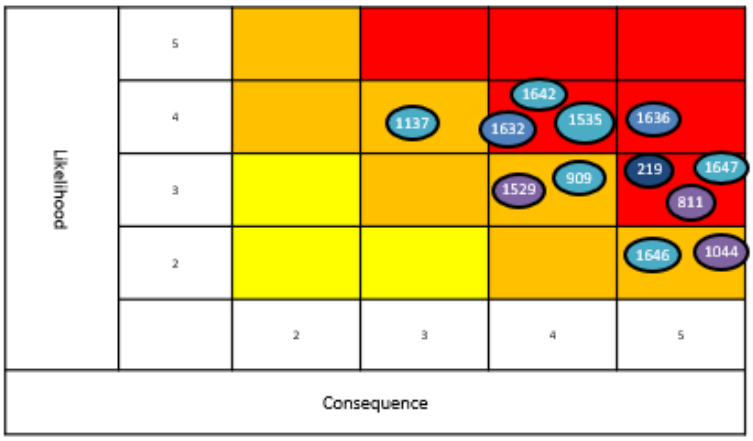
Outline – movement in period
- Black – static
- Green – reduced
- Red – increased

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

Risks with no movement in the period

The 12 risks on the register that remain static are shown on the following matrix.

Corporate risks at ≥15 remaining static in period

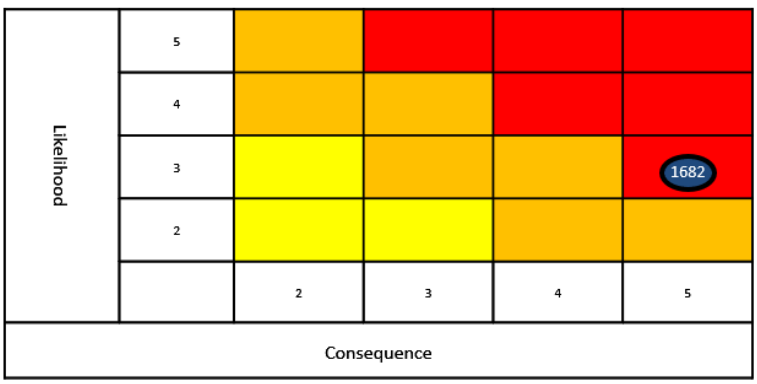


Risks are shown based on current risk rating

New risks added

1 risk has been added in the period

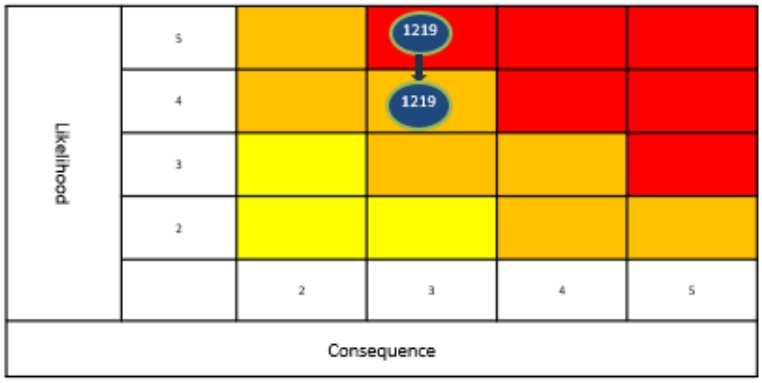
Risks added to Corporate Risk Register in the period



Reduced Risks

1 risk has been reduced in the period

Risks reduced in the period



1 new risk had been added following agreement by Executive Risk Group in October 2025:

Risk 1682 – Finance – There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs.

1 risk has been reduced in the period.

Risk 1219, DTVF – CAMHS - Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience. (reduced from 15>12)

The risk rating was reviewed by the CAMHS Subgroup, resulting in an updated score. The risk has been downgraded due to a one-point reduction in likelihood, attributed to ongoing GP engagement in shared care and monitoring of pilot outcomes.

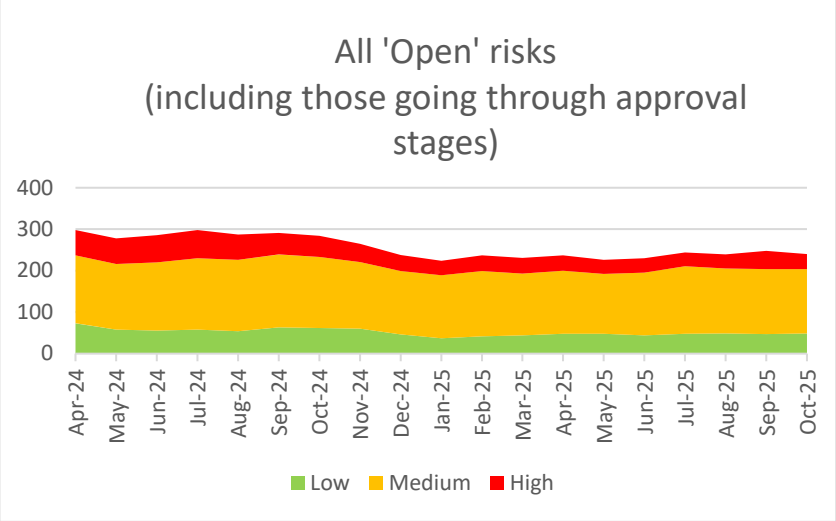
5 reduced and agreed risks remain on the register for oversight:

- NYY risk relating to consultant recruitment. (909)
- Nursing & Governance risk re Incident management. (1044)
- Supervision Risk (TEWV Vision and oversight) that was sat with DTVF has been transferred to PCD. (1137)
- DTVF AMH risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards. (1529)
- Digital risk on Cyber. (1646)

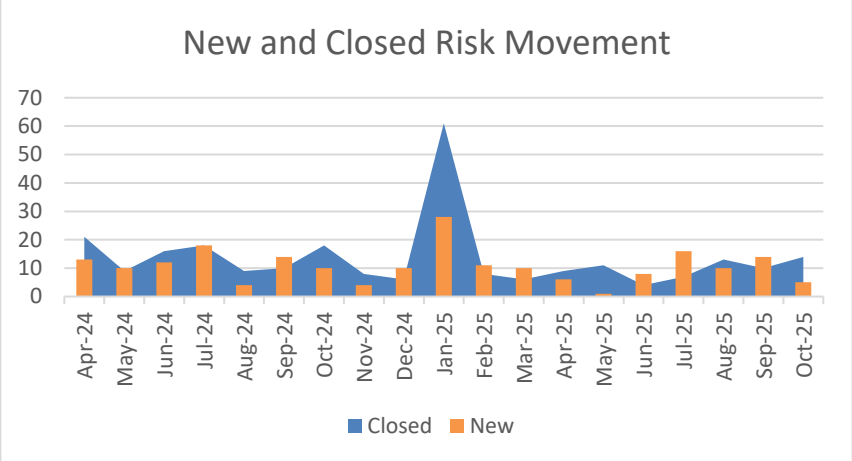
3.5 Detailed review of risks at ≥15 and changing risk profile

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

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



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



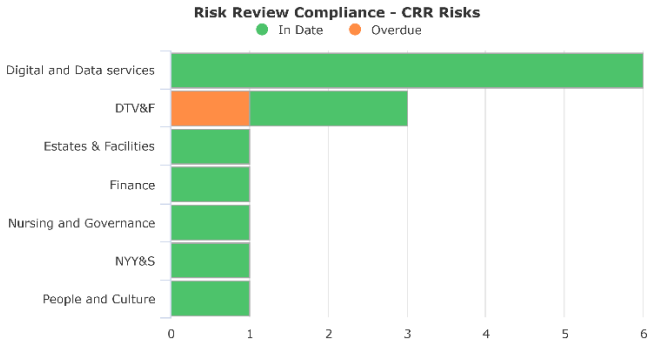
This years (2024/2025) Internal Audit of Risk Management and the Board Assurance framework provides substantial assurance and reflects year on year improvement over the last 2 years.

3.6 Risk and Action Review Compliance

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

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

At the time of writing the paper the compliance of timely risk review for the Corporate Risk Register is 93% (previously 100%). 1 risk is showing overdue review (DTVF – 811 – relating to risk of suicide/ligature) and this is already in hand as a more robust update is planned. (post submission note: this has since been updated reflecting a detailed review to be undertaken and this is booked for 15th December)



Actions across corporate risks are in place, with a total of 44 (increase of 9) current open actions across 14 risks. 3 of the actions (7%, previously 2/35(9%)) are past their due (or planned revised completion) date.

New Risk Quality Assurance reporting has been introduced, and discussions are underway with Care Groups and Directorates to increase monitoring and oversight. This will strengthen assurance over full risk completion, review of risks and actions as well as aiding to fully embed and improve monthly control effectiveness and action progress update.

Further information

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

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

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

Review and addition of the BAF risks and creation of an electronic BAF on InPhase is well underway and work ongoing to fully update and complete any entries.

The initial report views are being kept familiar, aimed at reflecting the word documents where possible to make transition easier. Advice was also sought from Internal Audit so as not to lose any progress made over the last couple of years and to ensure we maintain our substantial assurance rating. This concluded that the planned capture and reporting was fit for purpose, although routine updates will be key to be able to demonstrate overall management.

5. Conclusions

Governance meetings are being undertaken in line with policy and risks reviewed, and the re-design of detailed review and assurance processes through the Executive Risk Group demonstrates how the group continue to evolve processes to improve the assurances received. The ongoing cyclic review is having a positive impact on risk review and increased information within risks, and therefore improved understanding and action. While more detailed work is needed on some of the current risks as controls

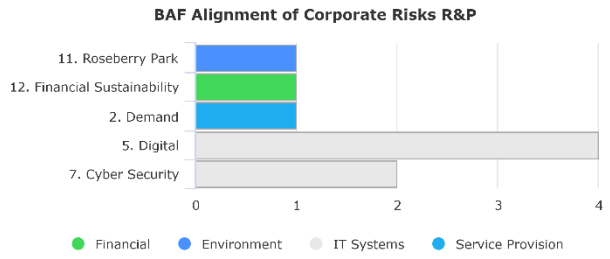
and assurances are not fully reflected and actions are overdue, this work will continue to progress and improve capture and update.

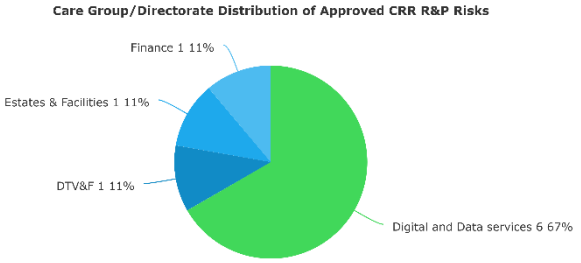
Compliance with review of corporate risks this month dipped slightly to 93%, with 1 risk overdue. A full in-depth review of this risk is planned. Action compliance is being maintained with 9% overdue, notwithstanding a significant increase in action numbers.

6. Recommendations

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

Resources and Planning Aligned Risks





There are now 9 risks aligned to Resources and Planning. This is as a result of the addition of the 25/26 Financial year finance risk being added.

Current Risk Rating Movements

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

The 2 risks remaining below 15 are 1646, Digital, cyber response (10), and 1219, DTVF CAMHS Neurodevelopmental pathway (12) The risk has been downgraded due to a one-point reduction in likelihood, attributed to ongoing GP engagement in shared care and monitoring of pilot outcomes. However further discussion at Care Group Board highlighted wider elements to this risk and review will be undertaken to consider trust wide risk.

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025	31 Aug 2025	30 Sep 2025	31 Oct 2025	30 Nov 2025
Resources and Planning Committee	Risk 00000219	Risk of a H&S incident at Roseberry park Hospital	Actual	15	15		15	15	15	15	15	15		15	15	15
	Risk 00001219	CAMHS Neurodevelopmental assessment pathway	Actual		15		15	15	15	15	15	15	15	15	12	12
	Risk 00001535	Risk of escalation due to inability to provide appropriate information to external bodies	Actual	16	16	12	16	12	12	16	16	16	16	16	16	16
	Risk 00001632	Risk that CITO benefits are not realised	Actual	n/r	n/r	16			16	16		16	16		16	16
	Risk 00001636	Incomplete or inaccurate patient record displayed on Cito	Actual	n/r	n/r	20	20		20	20	20	20	20	20	20	20
	Risk 00001642	TEWV Critical digital network infrastructure failure	Actual	n/r	n/r	12	12	12	12	16		16	16	16	16	16
	Risk 00001646	Cyber and operational incident response gaps	Actual	n/r	n/r	10	10	10	10	10		10			10	10
	Risk 00001647	Cyber security vulnerbilities	Actual	n/r	n/r	10	15	10	10	15		15		15	15	15
	Risk 00001682	Delivery of financial plan	Actual	n/r	n/r	n/r	n/r	n/r	n/r	15		15	15		15	15

The current summary of the register is shown in the following table and reflects the 2 risks now below 15. You will note from control effectiveness not all show in the period, and we will continue to develop the reporting and capture of these to improve reporting.

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	30 Nov 2025			
								Control Effectiveness		RM03 Risk Rating	
								Current	Target	Current	Target
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	08 Sep 2016	24/11/2025	Simon Adamson	15		Phase 2 rectification works			15	10
Risk 00001219	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	01 Apr 2021	31/10/2025	Jamie Todd	16	▪ Activity levels and outputs ▪ Capacity and demand ▪ Capacity and demand work ▪ Clinical prioritisation ▪ Closely monitoring the changing picture nationally re ADHD meds supply. ▪ KiT processes ▪ PTLs ▪ Recovery and Improvement Plan ▪ Support whilst waiting and signposting	ICB independent sector capacity for longest waiters across the region	Good		12	6
Risk 00001535	Since the implementation of Cito, the organisation has been unable to provide all of the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO). There is a risk that this could escalate to a level which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations including CQC regulatory frameworks.	25 Mar 2024	31/10/2025	Nick Black	16	▪ Development of Action Plan for EDG Review ▪ R1535 - Monitoring of Data Quality Maturity Index (DQMI) score for datasets ▪ R1535 - Validation prior to submission of MHSDS	Produce development plan for the IIC and/or Cito to address the gaps in data provision	Good		16	4
Risk 00001632	There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.	13 Jan 2025	18/11/2025	Nick Black	20	▪ Cito Simplification and Stablisation and Project active ▪ Service desk ▪ Shared issue resolution plan ▪ Staff usability survey completed ▪ System speed issues addressed	▪ R1632 - Data Retention/Saving Requirements ▪ R1632 - Cito benefits realisation ▪ R1632 - Performance/stability management ▪ R1632 - Clinical change/ engagement tasks to support end users ▪ R1632 - Clarify and reinforce documentation requirements	Good		16	8
Risk 00001636	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	15 Jan 2025	18/11/2025	Lorraine Sellers	25	▪ Access to Great North Care Record and Yorkshire Care Record ▪ Cito training mandated for new starters from 1 Jan 2025 ▪ Data migration (documents) completed ▪ Robust test scripts developed ▪ Speed issues with the system resolved ▪ Stabilisation programme in place for release management ▪ Standard Operating Procedures in place ▪ User confidence training ▪ User guides updated	▪ R1636 Complete data rectification for 4 issues ▪ R1636 Enhance automated testing ▪ R1636 Cito Improvement Programme - wifi/infrastructure ▪ Cito Practice Leads Audit - undertake baseline and post training audit to evidence improvements	Good	Substantia	20	10
Risk 00001642	There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. Including UPS, Network, Servers Links to KPIs that will be reported through DPAG	16 Jan 2025	18/11/2025	Steven Forster	20	▪ Network infrastructure lifecycle ▪ Network Infrastructure Maintenance and Support - in hours ▪ Network infrastructure patching ▪ Network resilience and operational function	▪ CAF - Define essential functions ▪ Complete installation of Wi-Fi at all priority sites. ▪ High Severity Alert (CC-4703) Cisco firewall exploitation ▪ High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks) ▪ Improve resilience on internet facing firewalls (iNet) ▪ Crisis and Professional Telephone lines replacement for PSTN Switchoff ▪ End-to-end connection monitoring to support essential services (Thousandeyes)	Good		16	6
Risk 00001646	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	17 Jan 2025	19/11/2025	Nick Black	25	▪ Cyber awareness training for all staff ▪ DSPT 2025/26 submission ▪ Incident Response Framework ▪ MDE secure score ▪ Privileged Access Controls	▪ Deploy Privileged Access Management solution - Supply chain ▪ CAF - Define essential functions ▪ SIEM delivery ▪ Incident response excercise in conjunction with services. ▪ Incident response follow up Audit November 2025	Reasonable		10	5
Risk 00001647	There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	17 Jan 2025	31/10/2025	Steven Forster	25	▪ Continuous patching ▪ Data Security & Protection Toolkit ▪ Independent Penetration test ▪ Multi Factor Access (MFA) ▪ Network & Perimeter security ▪ NHS Cyber Alert ▪ Regular scanning	▪ TEWV secure boundary tenant utilised for all internet traffic ▪ Vulnerability scanning of non-MDE hosts ▪ SIEM delivery ▪ Extend the use of MFA ▪ High Severity Alert (CC-4703) Cisco firewall exploitation ▪ High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks)	Good		15	5

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	30 Nov 2025			
								Control Effectiveness		RM03 Risk Rating	
								Current	Target	Current	Target
Risk 00001682	There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs.	01 May 2025	21/11/2025	Liz Romaniak	15	▪ Financial reporting ▪ Roster approvals and reviews	▪ Improve level loading of headroom and all rosters to be approved on time ▪ Flexible staffing group overtime reduction ▪ Health Roster reason codes standardisation ▪ Level loading of headroom on Health Roster ▪ Progressing schemes identified at Sustainability and Transformation events ▪ Capital charge review following changes to guidance. ▪ Discretionary spend control increases ▪ Forecast outturn with scenario planning to be reported to EDG ▪ Plans on a Page and EQIA of CRES schemes ▪ EDG Paper Further actions to reduce trust reliance on Medical Agency...	Reasonable	Good	15	8

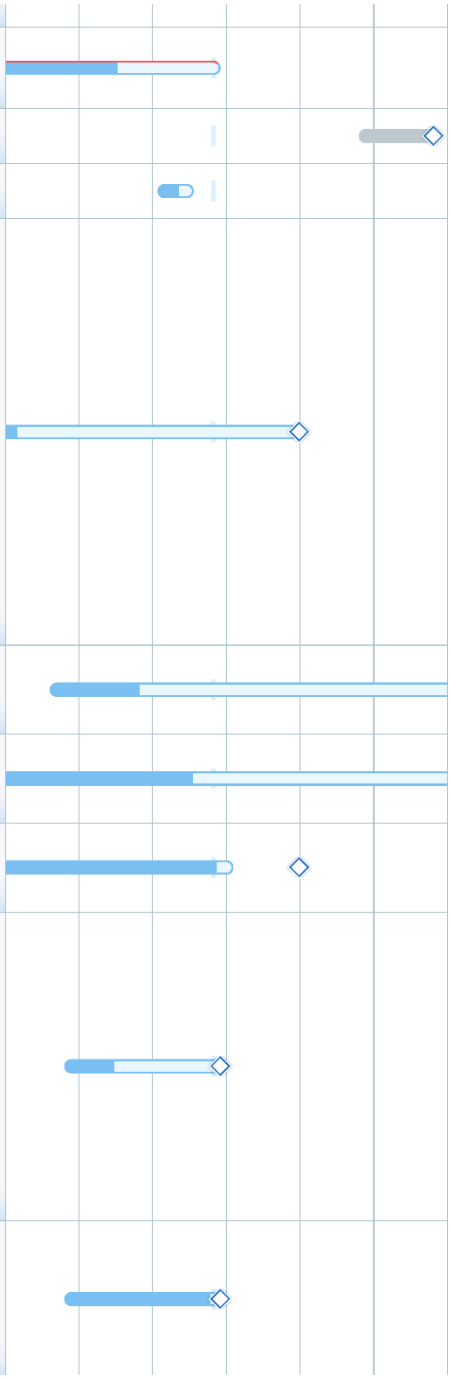
The following table shows all current actions related to these risks. There are currently 2 actions which are overdue. Some new actions added are linked to more than one risk.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	Phase 2 rectification works	18 Sep 2026	18 Sep 2026	Simon Adamson	5%
Risk 00001219	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	ICB independent sector capacity for longest waiters across the region	31 Mar 2026	31 Mar 2026	Claire Farley	30%
Risk 00001535	Since the implementation of Cito, the organisation has been unable to provide all of the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO). There is a risk that this could escalate to a level which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations including CQC regulatory frameworks.	Produce development plan for the IIC and/or Cito to address the gaps in data provision	31 Dec 2025	31 Dec 2025	Paula Hay	80%
Risk 00001632	There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.	R1632 - Cito benefits realisation	01 Jan 2026	31 Dec 2025	Jo Turner	25%
		R1632 - Clarify and reinforce documentation requirements	31 Mar 2026	31 Dec 2025	Gemma Pickering	50%
		R1632 - Clinical change/ engagement tasks to support end users	31 Dec 2025	31 Dec 2025	Gemma Pickering	70%
		R1632 - Data Retention/Saving Requirements	31 Dec 2025	31 Dec 2025	Andrea Shotton	20%
		R1632 - Performance/stability management	28 Feb 2026	31 Mar 2026	Vianne Chapman	90%
Risk 00001636	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	Cito Practice Leads Audit - undertake baseline and post training audit to evidence improvements	31 Dec 2025	31 Dec 2025	Gemma Pickering	40%
		R1636 Cito Improvement Programme - wifi/infrastructure	31 Mar 2026	31 Mar 2026	Steven Forster	40%
		R1636 Complete data rectification for 4 issues	31 Jan 2026	31 Jan 2026	Gemma Pickering	75%
		R1636 Enhance automated testing	31 Mar 2026	31 Mar 2026	Vianne Chapman	26%
Risk 00001642	▪ There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG	Crisis and Professional Telephone lines replacement for PSTN Switchoff	30 Nov 2026	01 Dec 2026	Dale Hopper	0%
		End-to-end connection monitoring to support essential services (Thousandeyes)	30 Jan 2026	30 Jan 2026	Dale Hopper	10%
		Improve resilience on internet facing firewalls (iNet)	28 Nov 2025	28 Nov 2025	Dale Hopper	50%
▪ Risk 0000164 ▪ Risk 0000151 ▪ Risk 0000141	▪ Risk 00001413: There is a risk that IT systems will be less accessible when it is critical to patient safety due to the problems with wifi provision on the Ridgeway site. It is a concern that this will impact on operational delivery further. ▪ Risk 00001512: Due to poor wifi connections across RPH, LRH and WPH hospital sites there is a risk to patient and staff safety and experience due to the delays being experienced when using Trust systems such as EMPA, CITO, Health Roster, MS teams and also when attempting to make contact with colleagues and family members. This results in lack of timely availability of accurate and concise patient information to support clinical decision making and does not support positive experience for staff or patients. ▪ Risk 00001642: There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG	Complete installation of Wi-Fi at all priority sites.	11 Mar 2026	11 Mar 2026	Dale Hopper	40.5%
Risk 00001646	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	Deploy Privileged Access Management solution - Supply chain	01 May 2025	28 Nov 2025	Fayraz Hussain	80%
		Incident response excercise in conjunction with services.	23 Feb 2026	23 Feb 2026	Steven Forster	0%
		Incident response follow up Audit November 2025	31 Mar 2026	17 Nov 2025	Fayraz Hussain	60%

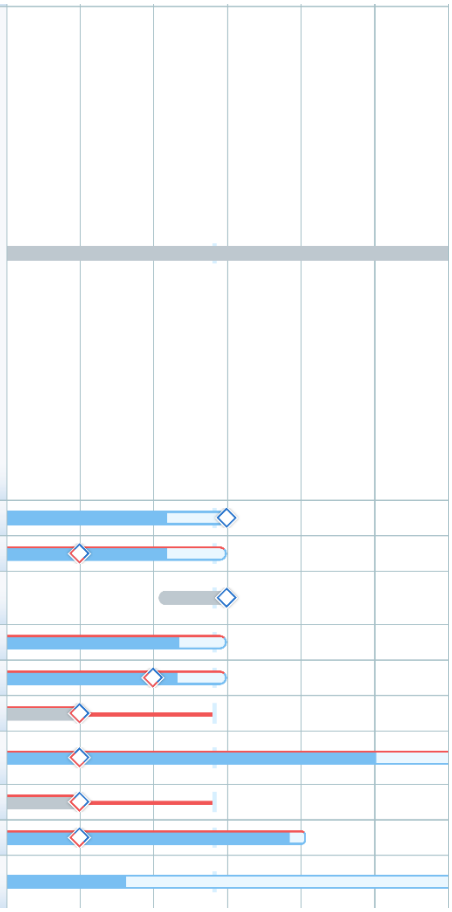
Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete
	through DPAG					
Risk 00001646	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	Deploy Privileged Access Management solution - Supply chain	01 May 2025	28 Nov 2025	Fayraz Hussain	80%
		Incident response excercise in conjunction with services.	23 Feb 2026	23 Feb 2026	Steven Forster	0%
		Incident response follow up Audit November 2025	31 Mar 2026	17 Nov 2025	Fayraz Hussain	60%
▪ Risk 00001646 ▪ Risk 00001642	▪ Risk 00001642: There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG ▪ Risk 00001646: There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	CAF - Define essential functions	31 Dec 2025	31 Dec 2025	Steven Forster	45%
Risk 00001647	▪ There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ ▪ Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	Extend the use of MFA	01 Oct 2027	01 Oct 2027	Steven Forster	5%
		TEWV secure boundary tenant utilised for all internet traffic	31 Mar 2026	31 Mar 2026	Fayraz Hussain	45%
		Vulnerability scanning of non-MDE hosts	31 Dec 2025	03 Dec 2025	Michael Fincken	95%
▪ Risk 00001647 ▪ Risk 00001642	▪ Risk 00001642: There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG ▪ Risk 00001647: There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ ▪ Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks)	28 Nov 2025	28 Nov 2025	Steven Forster	32%
		High Severity Alert (CC-4703) Cisco firewall exploitation	28 Nov 2025	28 Nov 2025	Steven Forster	95%



Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completic Date	Owner	Percentage Complete
▪ Risk 0000164 ▪ Risk 0000164	▪ Risk 00001646: There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ Risk 00001647: There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ ▪ Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	SIEM delivery	31 Mar 2027	30 Oct 2026	Steven Forster	0%
Risk 00001682	There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs.	Capital charge review following changes to guidance.	30 Nov 2025	30 Nov 2025	John Chapman	75%
		Discretionary spend control increases	30 Sep 2025	30 Nov 2025	John Chapman	75%
		EDG Paper Further actions to reduce trust reliance on Medical Agency...	30 Nov 2025	30 Nov 2025	Ranjeet Shah	0%
		Flexible staffing group overtime reduction	28 Aug 2025	30 Nov 2025	Lesley Hodge	90%
		Forecast outturn with scenario planning to be reported to EDG	31 Oct 2025	30 Nov 2025	Richard Mellor.	80%
		Health Roster reason codes standardisation	30 Sep 2025	30 Sep 2025	Elspeth Devanney	0%
		Improve level loading of headroom and all rosters to be approved on time	30 Sep 2025	31 Mar 2026	Beverley Murphy	90%
		Level loading of headroom on Health Roster	30 Sep 2025	30 Sep 2025	Elspeth Devanney	0%
		Plans on a Page and EQIA of CRES schemes	30 Sep 2025	02 Jan 2026	Richard Mellor.	95%
		Progressing schemes identified at Sustainability and Transformation events	31 Mar 2026	31 Mar 2026	Chris Lanigan	25%



Summary of risks

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

Owner – Simon Adamson

Initial rating 15 (C5, L3), Current Rating 15 (C5, L3), Target Rating 10 (C5, L2), Date to reduce risk 6 January 2032.

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

Assurance – Reasonable Assurance – The current updates reflects that Phase 2 contractors now on site with cabins to be set up by mid November. A review to change this risk to reflect a subset of risks which are contained within this instead of a broad H&S risk is still being considered, and we hope to reach a decision this month as controls are still not present in the risk. This is to enable a way to visibly monitor individual risks as some could be reduced and would show progress to date.

Risk 1219 – DTVF CAMHS - There is a risk that young people being referred for specialist neurodevelopmental assessment face unacceptable waits for commencement and conclusion due to a significant increase in referral demand post-pandemic and exacerbated by the backlogs created during

the national lockdowns; resulting in a dissatisfactory experience for families, complaints, knock on effect of long waits for diagnosis-specific support, & reputational damage for TEWV.

Owner – Jamie Todd

Initial rating 16 (C4, L4), Current Rating 12 (C3, L4), Target Rating 6 (C2, L3), Date to reduce risk 31 March 2026.

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

Assurance – Reasonable Assurance – the risk has been reviewed and controls are reflected in the risk, with assurances levels beginning to be captured. The risk was reduced (a one-point reduction in likelihood reflected in last months report), attributed to ongoing GP engagement in shared care and monitoring of pilot outcomes. However wider discussion in Care Group Board reflected the need to consider the risk trust wide.

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

Owner – Nick Black

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

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

Assurance – Reasonable Assurance – the entry requires strengthening with sources of assurance, details of assurance and effectiveness of controls. Work is underway with Digital and Data to address this.

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

Owner – Lorraine Sellers

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

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

Assurance – Reasonable Assurance – the entry is being strengthened with sources of assurance, details of assurance and effectiveness of controls, however some still to add. Work is underway with Digital and Data to address this.

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

Owner – Nick Black

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

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

Assurance – Reasonable Assurance – controls effectiveness are beginning to be reflected, and the digital leadership are in the processes of reviewing and updating these further..

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

Owner – Steven Forster

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

Risk Review – in date, Action Delivery – 7 current actions, in date.

Assurance – Reasonable Assurance – the entry has been strengthened with sources of assurance, and the team are now looking to include effectiveness of controls.

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

Owner – Nick Black

Initial rating 25 (C5, L5), Current Rating 10 (C5, L2), Target Rating 5 (C5, L1), Date to reduce risk 30 November 2028.

Risk Review – in date, Action Delivery – 3 actions in place, in date.

Assurance – Reasonable Assurance – this risk has been updated to reflect controls in place and assurance sources, however control effectiveness is still to be added and work is underway with the team.

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

Owner – Steven Forster

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

Risk Review – in date, Action Delivery – 7 actions ongoing, in date.

Assurance – Reasonable Assurance – the entry has been strengthened with sources of assurance, although effectiveness of controls is yet to be added which the team are working on.

Risk 1682 – Finance - There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs. (current rating 15)

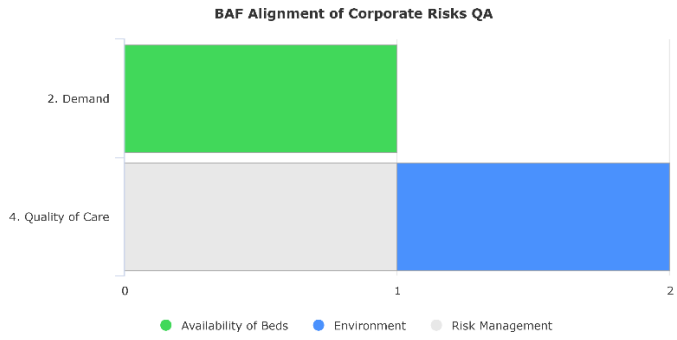
Owner – Liz Romaniak

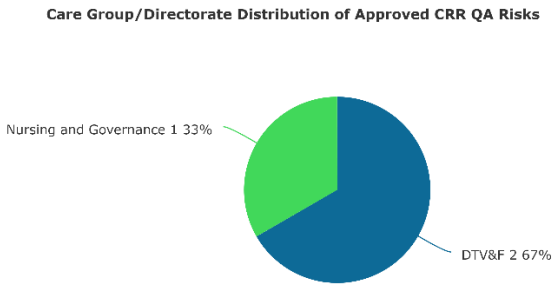
Initial rating 15 (C5, L3), Current Rating 15 (C5, L3), Target Rating 8 (C4, L2), Date to reduce risk 31 March 2026

Risk Review – in date, Action Delivery – 10 actions ongoing, 2 overdue.

Assurance – Reasonable Assurance – the entry has been strengthened with sources of assurance, although effectiveness of controls is yet to be added which the team are working on.

Quality Assurance Aligned Risks





Current Risk Rating Movements

The following table below shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. Note that while the last period shows to the end of the current month, it reflects updates to the date of the report. 2 risks remain at below 15, risk 1044 and risk 1529.

CRR risks - monthly current rating

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

The current summary of the register is shown below. You will note from control effectiveness not all show in the period, and we will continue to develop reporting and process to improve reporting on this.

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	30 Nov 2025			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000811	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.	01 Jun 2020	29/09/2025	Naomi Lonergan	20		R903 - Phase 3 delivery			15	10
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	08 Aug 2022	20/11/2025	Rachel Weddle	20	▪ INC - Patient Safety Huddle Daily - reviews moderate and above incidents ▪ Staff understand the initial review process and timelines	R1044 - QI work on operational management and governance of incidents from ward to board	Good		10	5
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	29 May 2024	01/10/2025	Shaun McKenna	20	▪ Incident Data ▪ Patient Flow Work ▪ Performance reporting	▪ Develop Patient Flow Transformation workstream ▪ Develop an electronic live visual bed state in conjunction with IT and our digital journey to change ▪ Develop the "Transforming Mental Health Discharge" workstream ▪ Review of CRFD Escalation Processes	Good	Good	12	9

The below table shows the actions ongoing in relation to the risks, 1 is overdue.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete	30/09/25	31/10/25	30/11/25	31/12/25	31/01/26	28/02/26
Risk 00000811	▪ There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation. ▪	R903 - Phase 3 delivery	30 Sep 2025	30 Sep 2025	Simon Adamson	50%						
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	R1044 - QI work on operational management and governance of incidents from ward to board	30 Sep 2025	31 Mar 2026	Kendra Marley	80%						
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	Develop an electronic live visual bed state in conjunction with IT and our digital journey to change	30 Nov 2025	30 Nov 2025	Shaun McKenna	0%						
		Develop Patient Flow Transformation workstream	31 Mar 2026	31 Mar 2026	Shaun McKenna	0%						
		Develop the "Transforming Mental Health Discharge" workstream	31 Mar 2026	31 Mar 2026	Shaun McKenna	0%						
		Review of CRFD Escalation Processes	30 Nov 2025	30 Nov 2025	Polly Mennell	0%						

Summary of risks

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

Owner – Naomi Lonergan

Initial rating 20 (C5, L4), Current Rating 15 (C5, L3), Target Rating 10 (C5, L2), Date to reduce risk 30 September 2025. (this has passed so will be followed up)

Risk Review – overdue, Action Delivery – 1 action ongoing, overdue.

Assurance – Reasonable Assurance – The current controls and management as well as actions being taken are discussed regularly in the Environmental Risk Group, and the risk had been transferred to enable operational input and focus. The transfer has not aided improved reflection in the risk of the strength of local controls and the risk requires comprehensive update. A meeting with leads to undertake this will be completed this month.

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

Initial rating 20 (C5, L4), Current Rating 10 (C5, L2), Target Rating 5 (C5, L1) Date to reduce 31 March 2026.

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

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

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

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

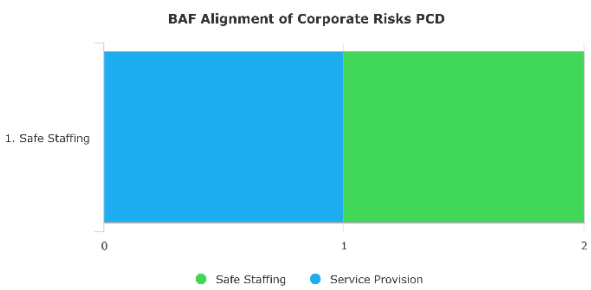
Owner – Shaun McKenna

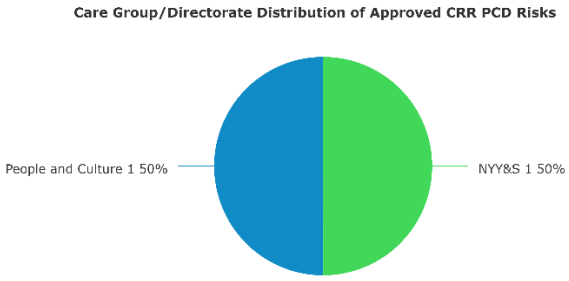
Initial rating 20 (C4, L5), Current Rating 12 (C3, L4), Target Rating 9 (C3, L3), Date to reduce risk – 31 March 2026. Date revised from June 2025, reduced in May 2025 to 12, but not yet to target, and further work ongoing with partners.

Risk Review – in date, Action Delivery – 4 actions now identified and ongoing, in date.

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

People, Culture & Diversity Aligned Risks





Current Risk Rating Movements

The table below shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. Note that while the last period shows to the end of the current month, it reflects updates to the date of the report. Risk 909 and risk 1137 remain below 15.

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	30 Nov 2024	31 Dec 2024	31 Jan 2025	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025	31 Aug 2025	30 Sep 2025	31 Oct 2025	30 Nov 2025
People Culture and Diversity Committee	Risk 00000909	Inability to recruit to vacant consultant posts	Actual	16		16	16	12	12	12	12		12	12		12
	Risk 00001137	Supervision Compliance and Assurance	Actual	15	12	12	15		15	15	15	12	12	12		12

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	30 Nov 2025 Control Effectiveness Actual	Control Effectiveness Target	RM03 Risk Rating Actual	RM03 Risk Rating Target
Risk 00000909	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20 Oct 2020	03/11/2025	Himanshu Garg	20	▪ Employment of international fellowship Doctors to fil gaps and reduce locun mind the gap ▪ Mind the Ga arrangement ▪ Retention of Existing Consultant workforce ▪ Substantive recruitment to vacant consultant posts		Reasonabl	Substantia	12	9
Risk 00001137	There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care.	22 Mar 2022	24/11/2025	Sarah Dexter-Smith	15	▪ Manual Recording Systems ▪ TEWVision	▪ All ward team managers to be using the same clinical supervision recording system TEWVision ▪ Routine performance monitoring of clinical supervision compliance with TEWVision in specialties	Limited		12	6

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

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completic Date	Owner	Percentage Complete	30/09/25	31/10/25	30/11/25	31/12/25	31/01/26	28/02/26
Risk 00001137	▪ There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. ▪ ▪ ▪ ▪	All ward team managers to be using the same clinical supervision recording system TEWVision	01 Jan 2026	25 Feb 2027	Sarah Dexter-Smith	60%						
		Routine performance monitoring of clinical supervision compliance with TEWVision in specialties	31 Oct 2025	31 Dec 2025	Sarah Dexter-Smith	45%						

Summary of risks

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

Owner – Himanshu Garg

Initial rating 20 (C4, L5), Current Rating 12 (C4, L3), Target Rating 9 (C3, L3), Date to reduce risk - 30 September 2025. (date to be reviewed based on current controls (including ongoing recruitment etc which is part of business as usual activity) as no new actions are required)

Risk Review – in date, Action Delivery – No current actions. Note that additional actions are not required as mitigation is all within core business as usual recruitment activity.

Assurance – Good Assurance – this risk was part of a detailed review to ERG in August 2025. A comprehensive overview of the current position and improvements in addressing consultant vacancies was provided. The risk is expected to persist with subtle variations due to financial constraints and NHS workforce challenges, particularly affecting team composition and consultant retention. While the risk remains above tolerance, no new actions are reflected as recruitment activity is part of business as usual controls.

Risk 1137 – DTVF Management - Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. Current system unable to provide assurance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered.

Owner – Sarah Dexter-Smith

Initial rating 15 (C3, L5), Current Rating 12 (C3, L4), Target Rating 6 (C3, L2), Date to reduce risk changed to 31 March 2026.

Risk Review – In date, Action Delivery – 2 actions ongoing, in date.

Assurance – Reasonable Assurance – this risk was part of a detailed review to ERG in August 2025, and has now transferred to People, Culture and Diversity under the management of the Director. Controls effectiveness is being assessed and reflected, and actions progressed.

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

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

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

Corporate Risk Register

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00000219 **BAF Risk Alignment :** 11. Roseberry Park **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Estates & Facilities **Specialty/ Department :** EFM - Estates **Ward/Team :** Estates Department	21 Nov 2025 **Opened Date :** 08 Sep 2016 **Last Review Date :** 21 Oct 2025	Simon Adamson **Risk Manager :** Steven Boon	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	15		15.00	➡	1 **Actions :** Phase 2 rectification works	10	06 Jan 2032
Risk 00000811 **BAF Risk Alignment :** 4. Quality of Care **Committee Alignment :** Quality Assurance Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** DTV&F **Specialty/ Department :** DTV&F - Management **Ward/Team :** Estates Department	21 Nov 2025 **Opened Date :** 01 Jun 2020 **Last Review Date :** 29 Sep 2025	Naomi Lonergan **Risk Manager :** Beverley Murphy	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.	20		15.00		1 **Actions :** R903 - Phase 3 delivery	10	30 Sep 2025
Risk 00000909 **BAF Risk Alignment :** 1. Safe Staffing **Committee Alignment :** People Culture and Diversity Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** NYY&S **Specialty/ Department :** NYY&S Management **Ward/Team :** North Yorkshire And York Management	03 Feb 2026 **Opened Date :** 20 Oct 2020 **Last Review Date :** 03 Nov 2025	Himanshu Garg **Risk Manager :** Himanshu Garg	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20	Employment of international fellowship Doctors to fill gaps and reduce locum mind the gap **First line of Assurance :** Successful recruitment of these posts has substantially reduced our locum reliance in MHSOP South. other specialty updates will follow. **Second Line of Assurance :** **Third Line of Assurance :** Mind the Gap arrangements **First line of Assurance :** Lead Psychiatrists report that the locum doctors are present at work. **Second Line of Assurance :** Finance reports confirming payments to locum doctors **Third Line of Assurance :** Retention of Existing Consultant workforce **First line of Assurance :** Quarterly meeting with all career grade doctors within the care group Monthly meeting with individual specialty career grade doctors **Second Line of Assurance :** Sickness absence is below the Trustwide percentages. Increasing numbers of approved flexible working requests Increase in LTFT colleagues. **Third Line of Assurance :** Substantive recruitment to vacant consultant posts **First line of Assurance :** Posts are regularly re-advertised where needed and appropriate incentives financial or developmental are added to make them more attractive **Second Line of Assurance :** **Third Line of Assurance :**	12.00		0 **Actions :**	9	30 Sep 2025

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001044 **BAF Risk Alignment :** 4. Quality of Care **Committee Alignment :** Quality Assurance Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Nursing and Governance **Specialty/ Department :** N&G - Quality governance **Ward/Team :** Patient Safety Management	12 Jan 2026 **Opened Date :** 08 Aug 2022 **Last Review Date :** 20 Nov 2025	Rachel Weddle **Risk Manager :**	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	20	INC - Patient Safety Huddle Daily - reviews moderate and above incidents **First line of Assurance :** Daily Huddle undertaken. Incidents looked at have the record updated in InPhase to reflect the review and discussion and any outcome/ action needed. Senior leaders report is generated post huddle every day. Report query's extended to pick up deaths (via clinical outcome box) that are low/no harm **Second Line of Assurance :** **Third Line of Assurance :** Staff understand the initial review process and timelines **First line of Assurance :** Numbers of staff who have been trained in the process and use of the system (against those given access to undertake this role). Staff undertaking incident reviews Requests for support Number of Incidents awaiting 4 day review (reported into CG and EROQG) Numbers of incidents overdue 4 day review and age of these Number of incidents in stages of process and length of time in the process. **Second Line of Assurance :** New e-learning training compliance **Third Line of Assurance :**	10.00		1 **Actions :** R1044 - QI work on operational management and governance of incidents from ward to board	5	31 Mar 2026
Risk 00001137 **BAF Risk Alignment :** 1. Safe Staffing **Committee Alignment :** People Culture and Diversity Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** People and Culture **Specialty/ Department :** PCD - Director **Ward/Team :**	04 Nov 2025 **Opened Date :** 22 Mar 2022 **Last Review Date :** 01 Oct 2025	Sarah Dexter-Smith **Risk Manager :**	There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care.	15	Manual Recording Systems **First line of Assurance :** Locally updated Reported through specialty governance **Second Line of Assurance :** **Third Line of Assurance :** Audit one clinical supervision Audit TEWVVision **First line of Assurance :** Individuals record supervision Line managers monitor **Second Line of Assurance :** Form July 25 able to report out from TEWV Vision in terms of compliance for each specialty. Reporting from TEWVVision to CG Specialty and CG Board **Third Line of Assurance :**	12.00		2 **Actions :** All ward team managers to be using the same clinical supervision recording system TEWVision Routine performance monitoring of clinical supervision compliance with TEWVision in specialties	6	31 Mar 2026

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001219 **BAF Risk Alignment :** 2. Demand **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** DTV&F **Specialty/ Department :** DTV&F - CAMHS **Ward/Team :**	28 Nov 2025 **Opened Date :** 01 Apr 2021 **Last Review Date :** 31 Oct 2025	Jamie Todd **Risk Manager :** James Graham	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	16	Activity levels and outputs **First line of Assurance :** SM Q&P huddle **Second Line of Assurance :** GM Q&P huddle **Third Line of Assurance :** DoOps Q&P huddle Capacity and demand **First line of Assurance :** Q&P huddle at SM level on a weekly basis **Second Line of Assurance :** Q&P huddle at GM level on a weekly basis **Third Line of Assurance :** Q&P huddle at DoOps level on a weekly basis Capacity and demand work **First line of Assurance :** **Second Line of Assurance :** **Third Line of Assurance :** Clinical prioritisation **First line of Assurance :** TMs and SM to ensure waiters are reviewed in an effective and timely manner to be assured around risk management and patient safety. **Second Line of Assurance :** Once identified these waiters will be prioritised for an assessment. In order to identify needs and offer support required. **Third Line of Assurance :** Closely monitoring the changing picture nationally re ADHD meds supply. **First line of Assurance :** Comms from Pharmacy Team. **Second Line of Assurance :** Weekly huddles **Third Line of Assurance :** National updates KiT processes **First line of Assurance :** TMs and SM to ensure that KiT information is sent to YP and families and that these comms are timely and accurate. **Second Line of Assurance :** **Third Line of Assurance :** PTLs **First line of Assurance :** TMs and SMs to have a robust and timely process for management of PTLs **Second Line of Assurance :** Provides oversight of the people waiting, there assessment dates and assurance KIT letters have been sent. **Third Line of Assurance :** Recovery and Improvement Plan **First line of Assurance :** The Recovery plan provides assurance and oversight of the current improvement work been undertaken by the service **Second Line of Assurance :** Reviews of the recovery plan allow sight of the progress against the milestones **Third Line of Assurance :** Support whilst waiting and signposting **First line of Assurance :** KIT letters offer local signposting support and inform families of who to contact if mental health or risk changes **Second Line of Assurance :** **Third Line of Assurance :**	12.00	↓	1 **Actions :** ICB independent sector capacity for longest waiters across the region	6	31 Mar 2026

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001529 **BAF Risk Alignment :** 2. Demand **Committee Alignment :** Quality Assurance Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** DTV&F **Specialty/ Department :** DTV&F - AMH **Ward/Team :**	30 Nov 2025 **Opened Date :** 29 May 2024 **Last Review Date :** 01 Oct 2025	Shaun McKenna **Risk Manager :** Polly Mennell	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	20	Incident Data **First line of Assurance :** Number of incidents reported via InPhase linked to delays **Second Line of Assurance :** **Third Line of Assurance :** Patient Flow Work **First line of Assurance :** Total number of DTV AMH patients reported as clinically ready for discharge **Second Line of Assurance :** Monitoring of key inpatient bed performance data including length of stay, bed occupancy and number of discharges **Third Line of Assurance :** Performance reporting **First line of Assurance :** Weekly CRFD report from corporate reporting team **Second Line of Assurance :** Weekly Q&P dashboard reporting total patients who are CRFD **Third Line of Assurance :** Use of OPTICA for reporting of CRFD patients	12.00	➡	4 **Actions :** Develop Patient Flow Transformation workstream Develop an electronic live visual bed state in conjunction with IT and our digital journey to change Develop the "Transforming Mental Health Discharge" workstream Review of CRFD Escalation Processes	9	31 Mar 2026
Risk 00001535 **BAF Risk Alignment :** 5. Digital **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - Business intelligence, clinical outcomes **Ward/Team :** Bi And Co Management	03 Dec 2025 **Opened Date :** 25 Mar 2024 **Last Review Date :** 31 Oct 2025	Nick Black **Risk Manager :** Paula Hay	Since the implementation of Cito, the organisation has been unable to provide all of the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO). There is a risk that this could escalate to a level which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations including CQC regulatory frameworks.	16	Development of Action Plan for EDG Review **First line of Assurance :** Review by BICO Management Group Meeting **Second Line of Assurance :** Review by Cito Improvement Group **Third Line of Assurance :** Review by Executive Directors Group and on-going monitoring of progress R1535 - Monitoring of Data Quality Maturity Index (DQMI) score for datasets **First line of Assurance :** MHSDS Team review of National DQMI publication for TEWV (monthly monitoring) **Second Line of Assurance :** BICO Management Group monthly review **Third Line of Assurance :** Monthly reporting via Digital Performance and Assurance Group (DPAG) R1535 - Validation prior to submission of MHSDS **First line of Assurance :** Step 1 – Self-validation of submission Review table counts against previous months and investigate any changes over 5%. Apply the same check to selected DQMI indicators **Second Line of Assurance :** A Band 7 or above reviews table counts, DQMI checks, and the submission portal to confirm record totals match and the submission is not marked as a test. **Third Line of Assurance :** NHSE emails monthly summary statistics on submissions, which we review. Any ad hoc queries from NHSE require us to provide a narrative response.	16.00	➡	1 **Actions :** Produce development plan for the IIC and/or Cito to address the gaps in data provision	4	30 Sep 2027

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001632 **BAF Risk Alignment :** 5. Digital **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - It & systems **Ward/Team :** Patient Systems	17 Dec 2025 **Opened Date :** 13 Jan 2025 **Last Review Date :** 18 Nov 2025	Nick Black **Risk Manager :** Gemma Pickering	There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.	20	Cito Simplification and Stablisation and Project active **First line of Assurance :** workstream leads are assigned for all actions on the plan and this is reviewed weekly in the simplification and stabilisation project meeting. **Second Line of Assurance :** oversight and monitoring with weekly reporting to EDG and monthly CIG. **Third Line of Assurance :** AUDIT for clinical change element measuring quality and safety of record keeping compliance. NHSE involvement and reviews on progress. Service desk **First line of Assurance :** **Second Line of Assurance :** **Third Line of Assurance :** Shared issue resolution plan **First line of Assurance :** Performance is monitored and fully supported operationally by patient Systems team and supplier, and any issues encountered managed through the formal issue management process in place **Second Line of Assurance :** oversight and monitoring, governance groups etc - Performance monitored at service review meetings, DPAG and CIG **Third Line of Assurance :** External audits undertaken periodically with plans in place for outstanding actions and key functionality included in ongoing audit plans with clinical effectiveness team Staff usability survey completed **First line of Assurance :** User support calls monitored by patient systems team **Second Line of Assurance :** Training effectiveness action plan tabled quarterly at CIG Training compliance tabled monthly at CIG **Third Line of Assurance :** Information on training compliance included in EDG monthly report System speed issues addressed **First line of Assurance :** system is fully supported operationally with performance and functionality continuously monitored by patient Systems team and supplier, and any issues encountered managed through the formal issue management process in place **Second Line of Assurance :** Performance monitored at service review meetings DPAG and CIG **Third Line of Assurance :** External audits undertaken periodically with plans in place for outstanding actions.	16.00	?	5 **Actions :** R1632 - Data Retention/Saving Requirements R1632 - Cito benefits realisation R1632 - Performance/stabilit management R1632 - Clinical change/ engagement tasks to support end users R1632 - Clarify and reinforce documentation requirements	8	22 Oct 2026

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001636 **BAF Risk Alignment :** 5. Digital **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - Quality governance **Ward/Team :** Information Governance	17 Dec 2025 **Opened Date :** 15 Jan 2025 **Last Review Date :** 18 Nov 2025	Lorraine Sellers **Risk Manager :** Vianne Chapman	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	25	Access to Great North Care Record and Yorkshire Care Record **First line of Assurance :** Report loss of service to Information service desk and second line patient systems team **Second Line of Assurance :** Availability of systems and outage reports taken to DPAG for assurance and approval **Third Line of Assurance :** Cito Improvement group system report Cito training mandated for new starters from 1 Jan 2025 **First line of Assurance :** Cito training reports available to line managers via ESR **Second Line of Assurance :** Cito Improvement group receives regular training compliance reports alongside the Education and Training governance group **Third Line of Assurance :** Information shared within EDG monthly CITO report for training compliance and also on BAF 7 bi-monthly risk report Data migration (documents) completed **First line of Assurance :** Identification of data issues via Data Quality Working Group **Second Line of Assurance :** Issues articulated within system report to CIG on monthly basis **Third Line of Assurance :** Any significant issues would be raised via EDG monthly CITO report and at DPB Robust test scripts developed **First line of Assurance :** Identification of bugs/issues within the test system **Second Line of Assurance :** Error trapping **Third Line of Assurance :** Regular weekly meetings with system supplier to identify resolutions to bugs and issues, alongside monthly system supplier performance meeting. Speed issues with the system resolved **First line of Assurance :** Call logging via IT help desk for affected users **Second Line of Assurance :** Patient systems escalation processes to system supplier via their helpdesk procedures **Third Line of Assurance :** Monthly reports to CIG Supplier monthly service performance review meeting Stabilisation programme in place for release management **First line of Assurance :** Reported progress on weekly stabilisation meeting calls **Second Line of Assurance :** Reported progress via CIG monthly **Third Line of Assurance :** Progress reported as part of the monthly CITO report to EDG Standard Operating Procedures in place **First line of Assurance :** Continual monitoring of effectiveness of SOPs via fault/problem logging **Second Line of Assurance :** KPI's provided to monthly DPAG meeting **Third Line of Assurance :** Monthly supplier review performance meeting	20.00	➡	4 **Actions :** R1636 Complete data rectification for 4 issues R1636 Enhance automated testing R1636 Cito Improvement Programme - wifi/infrastructure Cito Practice Leads Audit - undertake baseline and post training audit to evidence improvements	10	22 Apr 2026

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
						User confidence training **First line of Assurance :** Pre and post training measurement ongoing via audit and training feedback **Second Line of Assurance :** Reported to CIG monthly Liaison with operational business managers Shared intelligence via Practice leads Community of Practice **Third Line of Assurance :** Reported to EDG via monthly CITO report					
						User guides updated **First line of Assurance :** KPI monitoring - reduction in help requests via patient systems and digital learning teams **Second Line of Assurance :** CITO practice leads community of practice discussions, messages and requests for support **Third Line of Assurance :** Monitored via DPAG in relation to KPI's Team output reported to Education and Training governance group					

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001642 **BAF Risk Alignment :** 5. Digital **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - It & systems **Ward/Team :** Technology Networks	18 Dec 2025 **Opened Date :** 16 Jan 2025 **Last Review Date :** 18 Nov 2025	Steven Forster **Risk Manager :** Dale Hopper	There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. Including UPS, Network, Servers Links to KPIs that will be reported through DPAG	20	Network infrastructure lifecycle **First line of Assurance :** Network team patch network infrastructure on a continual basis inline with the release of vendor patches. Network segmentation in place to provide mitigation while patches are applied to vulnerable devices. Multiple firewalls in place to prevent direct access to network infrastructure. **Second Line of Assurance :** Reporting compliance levels to cyber security group and DPAG. **Third Line of Assurance :** DSPT annual submission and associated annual audit. Network Infrastructure Maintenance and Support - in hours **First line of Assurance :** This includes frontline IT teams and service delivery functions. They are responsible for identifying, owning, and managing risks directly. For example, your IT-NTWK-SOP-0065-v1 Digital and Data Network Configuration procedure outlines how network leads and system owners monitor systems, raise incidents, and maintain documentation to mitigate operational risks. **Second Line of Assurance :** Cyber Security Team, Information Governance, and Digital Programme Assurance Group. These teams ensure that controls are effective, policies are followed, and risks are escalated appropriately. The Resource and Planning - BAF 7 update report - Sep 25 and IT-0010-v7 Information Security and Risk Policy draft both detail how second-line functions support assurance through structured governance and compliance frameworks. Root cause analysis reports are created after major incidents and reflected upon as a lessons learnt exercise and communicated across relevant teams **Third Line of Assurance :** DSPT annual response provide assurance that controls are effective. In addition these controls are audited. Internal audit and external reviews provide independent assurance that risk management and internal controls are functioning as intended. Annual penetration tests validate that controls are effective and highlight any additional risk for remediation. Network infrastructure patching **First line of Assurance :** Operational teams patch devices inline with release of CVE's associated with devices inline with IT-NTWK-SOP-0065-V1 & NHS England Cyber alerts. **Second Line of Assurance :** Patching compliance measured by IThealth platform and Microsoft Defender for endpoint. Results summarised monthly and shared with Head of Technology and Chief Information Officer. Compliance of any High severity vulnerabilities reported formally to NHS England through the cyber alert dashboard. **Third Line of Assurance :** DSPT annual response provide assurance that control is effective. In addition these controls are audited. Internal audit and external reviews provide independent assurance that risk management and internal controls are functioning as intended. Annual penetration tests validate that patching remains compliant, effective and highlight any further remediation required,	16.00	➡	7 **Actions :** CAF - Define essential functions Complete installation of Wi-Fi at all priority sites. High Severity Alert (CC-4703) Cisco firewall exploitation High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks) Improve resilience on internet facing firewalls (iNet) Crisis and Professional Telephone lines replacement for PSTN Switchoff End-to-end connection monitoring to support essential services (Thousandeyes)	6	01 Mar 2027

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
						Network resilience and operational function **First line of Assurance :** Operational teams to identify single points of failure and through Architecture board implement methods of best practice. **Second Line of Assurance :** **Third Line of Assurance :**					
Risk 00001646 **BAF Risk Alignment :** 7. Cyber Security **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - It & systems **Ward/Team :** Technology Services	19 Feb 2026 **Opened Date :** 17 Jan 2025 **Last Review Date :** 19 Nov 2025	Nick Black **Risk Manager :** Steven Forster	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	25	Cyber awareness training for all staff **First line of Assurance :** Uptake measured via metacompliance monthly **Second Line of Assurance :** Uptake summary taken to cyber security group **Third Line of Assurance :** Metrics presented for review at DPAG bi-monthly.	10.00	?	5 **Actions :** Deploy Privileged Access Management solution - Supply chain CAF - Define essential functions SIEM delivery Incident response excercise in conjunction with services. Incident response follow up Audit November 2025	5	30 Nov 2028
						DSPT 2025/26 submission **First line of Assurance :** Operational teams evidence DSPT toolkit annually **Second Line of Assurance :** Oversight of Information governance team with at least annual reporting to SIRO/CIO through DPAG on current risk position and gap analysis. **Third Line of Assurance :** DSPT interim annual annual audit, outcome and any associated actions presented to service and oversight through Audit & Risk Committee					
						Incident Response Framework **First line of Assurance :** Cyber incident response plan in place and reviewed annually in addition to desktop exercise. **Second Line of Assurance :** Incident response plan ratified at DPAG. Supporting evidence submitted as part of annual DSPT submission. **Third Line of Assurance :** Incident response audited 23-25 by independent audit.					
						MDE secure score **First line of Assurance :** Secure score is provided in the national MDE platform dynamically and is monitored via operational teams **Second Line of Assurance :** Monthly position report within Cyber security Group **Third Line of Assurance :** Data is reported nationally against all organisations registered on the MDE platform and provided monthly. The Trust score within the top 20 each month. Data presented b-monthly to DPAG					
						Privileged Access Controls **First line of Assurance :** MFA monitored inline with essential function requirements (DSPT) **Second Line of Assurance :** MFA mandated across NHSmail via national policy. An exclusions are by exception and must be agreed by SIRO. **Third Line of Assurance :** Annual DSPT submission and supporting report to SIRO/CIO through DPAG would highlight any residual risk.					

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001647 **BAF Risk Alignment :** 7. Cyber Security **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - It & systems **Ward/Team :** Technology Services	03 Dec 2025 **Opened Date :** 17 Jan 2025 **Last Review Date :** 31 Oct 2025	Steven Forster **Risk Manager :** Steven Forster	There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	25	Continuous patching **First line of Assurance :** Patch triage meeting bi-weekly to ensure low level compliance. **Second Line of Assurance :** Updates provided to cyber security group with escalation to DPAG. Reporting via IT health monthly to CIO/SIRO and head of technology **Third Line of Assurance :** DSPT annual submission along with annual report to SIRO via DPAG with any gaps in remediation. Data Security & Protection Toolkit **First line of Assurance :** Annual DSPT submission to plan within operational teams. **Second Line of Assurance :** Any gaps highlighted and submitted as part of DSPT reports with SIRO review via DPAG. **Third Line of Assurance :** Annual DSPT interim audit. Independent Penetration test **First line of Assurance :** Independent Penetration test performed annually by Dionach on behalf of NHS england (CREST approved) **Second Line of Assurance :** Operational team review and interim updates on progress via cyber security group and team management huddles. **Third Line of Assurance :** Cyber security Group update and DPAG update with progress against annual test. Multi Factor Access (MFA) **First line of Assurance :** The Trust complies with the MFA national policy and DSPT standards by applying computer based certificates for all corporate devices interacting with the Trusts always on VPN service. The MyDesktop remote access service which is a web based system for use with staff and 3rd parties has a dedicated MFA software token to provide secure access. **Second Line of Assurance :** **Third Line of Assurance :** Network & Perimeter security **First line of Assurance :** Web applications firewalls deployed at edge and within critical network segments. Client firewalls deployed on all endpoints. **Second Line of Assurance :** Uptime of firewalls monitored through PRTG monitoring platform and any non-compliance with client firewalls monitored through national defender for endpoint tenant and through IT health dashboard. **Third Line of Assurance :** NHS Cyber Alert **First line of Assurance :** National mandate which is underpinned by the National Cyber Security Centre. **Second Line of Assurance :** Follow up with Regional cyber security consultant as part of Trust Cyber reviewed (Quarterly). **Third Line of Assurance :** Annual DSPT submission and associated interim audit	15.00	➡	6 **Actions :** TEWV secure boundary tenant utilised for all internet traffic Vulnerability scanning of non-MDE hosts SIEM delivery Extend the use of MFA High Severity Alert (CC-4703) Cisco firewall exploitation High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks)	5	30 Nov 2028

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
						Regular scanning **First line of Assurance :** National reporting as part of Microsoft MDE endpoints enrolled on the national tenant. The Trust perform well nationally and demonstrate a high level of compliance each month. **Second Line of Assurance :** Nessus scans monthly against non-windows assets and reported into operational teams and by exception at cyber security group monthly. **Third Line of Assurance :**					
Risk 00001682 **BAF Risk Alignment :** 12. Financial Sustainability **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Finance **Specialty/ Department :** FIN - Financial management **Ward/Team :** Director Of Finance	28 Nov 2025 **Opened Date :** 01 May 2025 **Last Review Date :** 03 Nov 2025	Liz Romaniak **Risk Manager :** John Chapman	There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs.	15	Financial reporting **First line of Assurance :** Finance team preparing monthly reports; budget holders reviewing financial positions; principal finance business partners validating figures. **Second Line of Assurance :** Executive Directors reviewing reports; Planning & Resources Committee scrutinising financial performance; internal performance dashboards, non executive members reviewing reports and adding constructive challenge. **Third Line of Assurance :** Internal audit of financial reporting processes; external audit of financial statements; NHSE financial oversight; Board-level scrutiny of financial risks. Roster approvals and reviews **First line of Assurance :** Ward managers, service leads, and roster support team ensuring rosters are approved on time and aligned to staffing requirements. **Second Line of Assurance :** Safe Staffing Group reviewing compliance with roster timelines, benchmarking against agreed targets, and escalating issues. May include HR or workforce planning teams. **Third Line of Assurance :** Internal audit of rostering processes; external reviews (e.g. NHSE workforce efficiency assessments / benchmarking of roster efficiency against peers); Board-level scrutiny of staffing KPIs and financial impact.	15.00	?	10 **Actions :** Improve level loading of headroom and all rosters to be approved on time Flexible staffing group overtime reduction Health Roster reason codes standardisation Level loading of headroom on Health Roster Progressing schemes identified at Sustainability and Transformation events Capital charge review following changes to guidance. Discretionary spend control increases Forecast outturn with scenario planning to be reported to EDG Plans on a Page and EQIA of CRES schemes EDG Paper Further actions to reduce trust reliance on Medical Agency...	8	31 Mar 2026

Tees, Esk and Wear Valleys NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 11 December 2025		**Report of: People, Culture and Diversity Committee**
Date of last meeting: 13 October 2025		The meeting was quorate.

1	**Agenda: The following agenda items were considered during the meeting:**
	• Colleague Story/Experience
	• Minutes of the meetings held on 29 May 2025
	• Key Issues Report for 29 May 2025
	• Corporate Risk Register
	• Board Assurance Framework
	• Voluntary Services' Annual Report
	• People Journey Delivery
	  o People Journey Delivery report
	  o Equality Diversity and Inclusion Statutory Data: WRES, WDES, SOWES & Publication of Staff Equality Information (Report, Staff information and Presentation)
	  o Health and Wellbeing Update
	  o Culture and Retention Report
	• Appraisal, Revalidation, Disciplinary and Job Plans – Annual Report
	• Workplan	

2a	**Alert: The Committee wishes to alert the Board on the following matters:** **-**	
2b	**Assurance: The Committee can confirm assurance on the following matters:** **Corporate Risk Register** The Committee agrees good assurance in respect of the risk management processes in place, the consideration of risks for inclusion in the Corporate Risk Register and the ongoing management of these risks. It notes the maintenance of risk review compliance at 100% for CRR and 92% for action reviews. In addition, it notes that in respect of Risk 909 - NYY Management, the risk had been identified in the Care Group and had been escalated to a Trust-wide risk due to the challenges in securing patient safety through operational cross-cover in areas where recruitment difficulties were being experienced. Trajectories were being developed in relation to 2 additional posts and weekly scrutiny of agency staff and supervision arrangements. Furthermore, regarding Risk 1137 – DTVF Management, the Committee notes that this has also been extended Trust-wide to ensure that staff are receiving both adequate supervision and quality of supervision, which links to assurance issues regarding links between IIC, ESR and team matrices. The Committee welcomes the innovative recruitment approaches being adopted in specific services, such as Health and Justice, including use of billboards, social media and bonus payments for isolated geographical areas. It suggests that future 'Time Out' topics might be Workforce Plans and the Board Assurance Framework to discuss the above in further detail. **Board Assurance Framework** The Committee confirms there is good assurance that the strategic 'Safe Staffing' risk continues to be managed effectively. The Committee notes that the introduction of InPhase to support this work has been helpful. It was acknowledged that it was often challenging to measure the impact of the collective delivery of actions which would mitigate risks. However, sustained improvements could be achieved through the application of consistent controls. **Voluntary Services' Annual Report** The Committee confirms that it has good assurance that the Trust has followed a robust process in recruiting, training, and inducting volunteers. The Volunteer Team and the Volunteers, plus 21 therapy dogs support the Trust's 'Journey to Change' and strategic goals through supporting better patient outcomes and staff wellbeing. Volunteering improves people's mental and physical health and gives them the opportunity to acquire skills that enhance their ability to gain employment. It also links to the Trust's role as an anchor institution. There is a total of 282 volunteers in the Trust (2024/2025), with 69% from DTVF and 31% from NYY which compares to 63% and 37% respectively the previous year. There has been a 19% increase in volunteers from 2023/2024. The demographics for volunteers indicates that they are far more diverse than the paid workforce, for example: Volunteers are 54% Female and 46% Male compared with a staff	

workforce 79% female and 21% Male; 59% heterosexual, 7% LGB/other, 34% not declared, compared with a staff workforce 85% heterosexual, 5% LGB, 8% not declared; 56% White, 10% BAME, 34% not declared, compared with a staff workforce 89% White, 10% BAME, 1% unknown; and 55% not-disabled, 8% with a disability compared, 37% not declared, compared with a staff workforce comprising 77% not-disabled, 12% with a disability, 11% not declared.

The Committee notes that 42 people attended the Step Toward Employment Programme (STEP) programme for volunteers which enables them to overcome barriers, such as not having a laptop to complete application forms, and access paid work in the Trust. An evaluation of the programme using a 1-5 scale (where 5 is the most positive rating) showed participants giving an overall rating of 4.5 for usefulness and a rating of 4.2 for 'feeling prepared to apply for a post with the Trust'. In addition, the Trust is also working with the Armed Forces on a Volunteer to Career Programme, is co-creating a Youth Volunteering programme and working with partner Trusts and HNY ICB on a Volunteer to Career programme. There are 9 volunteers on these pathways. The Committee notes that future developments include better tracking of individual volunteers' journeys and improving the offer to volunteer drivers.

WRES WDES SOWES and Publication of Staff Equality Information
The Committee confirms that there is good assurance that the Trust has followed a robust process in analysing its staff data by protected group and that in doing so it is meeting its NHS Standard Contract requirements and Equality Act duties. The Committee notes the following areas of progress: the percentage of the workforce who identify as BAME is 9.7% compared with 7.9% the previous year, percentage of the workforce declaring a disability is 11.64% compared with 9.23% last year. In addition, there has been an increase in declaration rates for sexual orientation (92% declaration) and disability (89% declaration). The percentage of staff requiring reasonable adjustments who have them in place has increased from 74% to 77%.

Areas of concern were identified as follows [NB: The arrows indicate whether the result has improved (↑) or is worse than the previous year (↓)]:

- Harassment, bullying or abuse - firstly, from patients, relatives, or the public, the overall trust score was 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% (↑)); and secondly, from colleagues, the overall trust score was 13.87% (BAME 18.91% (↓), staff with long term health conditions (LTHC) 18.02% (↑) Gender not the same as assigned at birth 38.46% (↓)).
- Discrimination - from manager/team leader or other colleague, the overall Trust score was 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 - the likelihood of a white applicant being appointed from shortlisting compared with a BAME applicant was 2.57 (↓) times more likely.
- Likelihood of entering the disciplinary process - BAME staff were 2.46 (↑) times more likely compared with white staff to enter disciplinary processes. Men were 2 (↓) times more likely compared with 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 - does not reflect the current workforce (ethnicity, gender and sexual orientation).
- Staff living in the 3 areas of highest deprivation - 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.

The Committee notes the work of the Anti-Racist Steering Group and the planned work for the Board of Directors in respect of diversity and cultural competencies. The Committee agrees to delegate review of the detail of the data to be published to Roberta Barker, Jules Preston and Sarah Dexter-Smith.

People Journey Delivery Report
The Committee confirms good assurance, noting the progress on the following which is contributing to reduce the risks outlined in the Board Assurance Framework:

- Retention rates have remained healthy with a 9.7% leaver rate in the latest IPR, appraisal rates remain above compliance (88%), bank fill rates have shown special cause improvement and

agency use continues to fall. There are no sustained changes in grievance or disciplinary numbers;

- EDG have agreed to fund the small Reasonable Adjustments team on a permanent basis to support colleagues and improve the Trust's ability to meet statutory requirements;
- The final appraisal audit gave good assurance;
- The new external Freedom to Speak Up service provision (The Guardian Service) is in its commissioning phase, with the new F2SU guardian (Adam Howe) meeting key stakeholders, following commencement with the Trust on 13 October 2025. Dewi Williams remains at the Trust until 30 November 2025, whilst the new service is initiated;
- The new occupational health provider is in place and receiving largely positive feedback;
- National and regional returns have been completed for
  - Workforce deployment solutions (WDS) - attainment for e-roster and e-job planning (subsequently feeds into model hospital database).
  - Provider workforce returns; and
- Whilst national concerns about nursing profiles for Band 5 and 6 roles have been a significant issue for many local trusts, this was mitigated for a range of roles over 5 years ago in the Trust in partnership with staff side through the process of job evaluation linked to updated job profiles. The first of the quarterly submissions to the NHSE is due by 21 October 2025.

The Committee notes three areas of outstanding concern which were subject to a 'Deep Dive' by Executive Directors' Group in October. Firstly, whilst compliance has recently improved Trust-wide (including bank staff) for Mandatory And Statutory (M&S) training and DMA rates for face-to-face training had noticeably fallen in September, the improvement was not consistent enough for the Trust to meet its trajectories for all courses or for the Trust to be fully and sustainably compliant with the national framework on reforming M&S training. Secondly, the ability to report consistently on clinical supervision for predominantly Nursing and Therapies Agenda for Change groups remains variable. Accordingly, the responsibilities for clinical supervision have been realigned, with standards and policy being within the remit of the Executive Chief Nurse and Executive Director of Therapies (and subject to review) and the system and reporting remaining with the Executive Director of People and Culture. Thirdly, sickness absence remains above the target set by the ICB and a Trust-wide performance plan will be in place by the end of October 2025. The position regarding sickness absence is the same across the ICB footprint.

The Committee notes the ongoing work in respect of the national expectation to reduce the whole-time equivalent spend and headcount at the same time as reducing temporary staffing numbers and costs. The MAR (Mutually Agreed Resignation) scheme has resulted in 60 staff being approved for settlement under the scheme with approximately £3million recurrent savings. In relation to visa changes, there is a potential risk to services and a definite risk to the well-being of staff in respect of staff on time limited visas. The recruitment team are working with the relevant individuals to identify options for those whose 'Right to Work' expires before 31 March 2026 (18 individuals) and those in the cohort from 1 April 2026 to 31 March 2027 where different rules apply (60 individuals) to salary thresholds for time limited visas.

The Committee notes that from 1 October 2025, Kate North is on secondment for 6 months to NCIC. In addition, this change has coincided with the implementation of the new Head of Inclusive Cultures & Head of Workforce Strategy & Systems roles. In addition, the Committee acknowledges that this is Dewi Williams last meeting and thanks him for his work as 'Freedom to Speak up Guardian' over the years.

Culture and Retention update

The Committee notes that there is good assurance on the link between the indicators for a strong and healthy culture aligned with Trust values and the interventions, such as the new people management programme through the 'Leadership and Management Academy', the work on 'Belonging' and initiatives such as the introduction of a professional body for operational staff with the recent introduction of 'Proud2BeOps' and training of PDPs in resilience based clinical supervision. However, there is only reasonable assurance that the interventions, based on the data provided, are achieving the impact expected.

The Annual Staff Survey is now a core part of the National Oversight Framework (NOF) segmentation ratings. Although the Trust's overall NOF segmentation is positive at level 2 (green), the People and

Workforce score within that is at level 4 (red). This is further broken down into firstly, sickness absence rate and, secondly, staff survey engagement. In respect of the sickness rate, in March 2025 when the NOF segments were decided, this was 6.06% for the Trust (peer average 6.09%, national average 5.35%). The target agreed with the NENC is 5.01%. This is now part of a formal Trust-wide performance plan and we aim to learn from Trusts who have made an impact on this metric, for example, through developing an increasing focus on the health inequality/socioeconomic background and different communities which our staff live in (NB: this metric is also included in the annual staff survey for the first time in 2025).

Retention rates are a key indicator of cultural health and are close to the industry standard of 90% - this minimises costs associated with staff leaving, whilst indicating positive staff engagement and workforce stability. The Committee notes the need for greater awareness of work being undertaken within Medical Development in areas of shared focus, for example, recruitment and retention strategy, engagement plan, stay and exit conversations, and work on induction, mentoring and leadership. In addition, it supports the proposed governance arrangements for future reports in respect of the existing Health and Wellbeing report, a new Workforce data report and a combined Inclusive Cultures report (including Culture and Retention).

Health and Wellbeing Update
The Committee confirms that there is good assurance for the alignment and oversight of health and wellbeing activity, and reasonable assurance for impact at this point. In addition, it notes that there is clarity regarding gaps in control and plans to strengthen assurance levels.

The key areas of activity include:

- Violence and Aggression - The governance arrangements for the oversight of staff experiencing violence and aggression are being reviewed, with plans for a newly established operational group to report into the Strategic Health & Wellbeing Governance Group. Plans are underway to create a dashboard via the Inphase team to be available from November 2025. The NHS sexual safety assurance framework has been refreshed and work is ongoing with the three police forces to agree a procedure for gathering evidence and criminal incident reporting;
- Sickness Absence - along with the majority of the NENC FTs, the Trust is not meeting the ICB target of 5.5% and has agreed to be part of the regional Scaling Up Programme with the aim of reducing the existing level by 1%. Anxiety/stress/depression remains the main reason for sickness absence both in the Trust and in England. The Trust sickness absence rate for the previous rolling 12-months is currently 6.24%. It has been above the target for the past 24 months. A Trust-wide performance plan is in place;
- Occupational Health contract implemented from 1 April 2025 - KPIs are being met (except for face-to-face clinics). Feedback from staff and managers has been largely positive (employee score 8.5/10; manager score 8.7/10). Discussions taking place regionally on options for ‘scaling up’ core occupational health services, with next steps to be identified in January 2026;
- Health & Wellbeing Strategy 2025-2028 – Consultation process has commenced to identify the priorities for the workforce;
- Staff Experience Group – Quarterly forum to triangulate data and soft intelligence across the organisation;
- Better Health at Work Awards – evidence has been submitted and will be assessed on 17 October 2025 for ‘Continuing Excellence’ level; and
- Managers training on Health and Wellbeing – a 3-hour training programme is now part of the expectations for Line Managers in relation to the People Management training programme.

Appraisal, Revalidation, Disciplinary and Job Plans – Annual Report
The Committee notes that the Responsible Officer has presented an annual report to the Board and this Committee along with a statement of compliance to provide a substantial level of assurance to patients and the public, employers and other healthcare professionals that licensed Trust-employed doctors are up to date and fit to practice. The Committee confirms that the report provides sufficient details of the annual appraisal and other processes supporting revalidation to demonstrate strong compliance in these areas and gives good assurance that the Trust upholds a strong system for appraising and revalidating its doctors.

	The Committee supports the 'sign off' of the statement of compliance and its submission to NHS England by 31 October 2025.	
2c	**Advise: The Committee would like to advise the Board on the following matters:** **Colleague Story/Experience** A colleague shared the impact of peer support on her life. For context, she described her lived experience of adverse childhood experiences which had impacted on her well-being and resulted in maladaptive coping mechanisms, whilst recognising the strong and supportive village community within which she had grown up. Working with the Peer Team over a 7-year period had given her purpose and drive. She identified her job as a major protective factor for her mental health. She felt proud of the service as it worked hard to provide a bridge and eliminate the barriers service users experienced when accessing services/support, which she had personal knowledge of in the past when 'connections' were not there. In particular, she welcomed the awards the team had received for Peer work, for example, the Positive Practice in Mental Health Awards. The process for appointing and inducting Peer roles in a team was explained, along with the framework for ongoing support for Peer workers.	
2d	**Risks**	No new risks were identified.
Recommendation: The Board is asked to note the contents of the report.		
3	**Any Items to be escalated to another Board Sub-Committee/Board of Directors**	The Committee wishes to highlight that in future there will be a brief report from the 'Time Out' session to the next meeting
4	**Report compiled by:** Deborah Miller, Corporate Governance Manager, Roberta Barker, Non-Executive Director (Committee Chair), Sarah Dexter-Smith, Executive Director of People and Culture	

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11th December 2025**
Title:	**Annual Staffing Establishment Review 2024-2025**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Report Author(s):	**Joe Bergin, Nurse Consultant Safer Staffing**

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	✓

Contribution to the delivery of the Strategic Goal(s):

To consistently deliver high quality and safe care we need to have establishments that meet patient need, and as a Quality Assurance Committee (QAC) we need to understand any risk to delivery and that the review was in accordance with national requirements. The annual review ensures that we understand the dependency needs of people in our care and that we understand the risks to meeting those needs as they pertain to staffing levels. This clearly links to all strategic goals.

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, and a negative impact on the wellbeing and morale of staff.
4	**Quality of care**	Risk to embedding improvements in the quality of care consistently and at the pace required across all services.
8	**Quality governance**	Risk that that floor to Board quality governance does not provide thorough insights into quality risks.

Executive Summary:

Purpose:
To assure the Board that the annual establishment review 2025 was conducted in line with national regulatory requirements for all inpatient wards.

To inform the Board of the risks to quality and recommendations being taken forward to address the risks.

Proposal:
The Board to take good assurance that we have met the National Quality Board requirements to complete and report out the annual Safer Staffing Review.

For the Board to take good assurance that we have improved the risks associated with short staffing consistently since 2023.

For the Board to be assured that we understand where focus is needed to further improve the use of staffing resources to enable consistently high-quality care.

Overview:
In line with National Quality Board requirements, we conduct a review at least annually using the Mental Health Optimal Staffing Tool (MHOST) to assess our ability to deploy staff to provide safe and high-quality care. The outcome of the review has been reported through our governance structures to the Executive Directors group (EDG) and to the Quality Assurance Committee September 2025. A full and detailed set of information was made available to both EDG and the QAC, this is a summary of the process and findings.

The report delivers against expectation 1 (Right Staffing) and 2 (Right skills) of the NQB requirements and discusses expectation 3 (Right time and place). The methodology also included engagement with clinical and operational leaders from the ward teams provided professional judgement reports and feedback relating to the workforce data and patient outcomes from the teams regarding their staffing establishments.

Summary of key findings:

Adult Admissions and PICUs
During the reporting period there was high acuity, high bed occupancy, and high staffing fill rates, but low Care Hours Per Patient Day (CHPPD) compared to peer Trusts. Several wards were operating above planned staffing levels especially for Healthcare Assistant (HCA) coverage.

DTVF wards have high night Registered Nurse (RN) fill rates high due to an unbudgeted local agreement, leading to overspend.

Rehabilitation and Eating Disorder (ED) (Birch) wards
During the reporting period there was a high impact from sickness absence across DTVF wards. Lustrum Vale and Willow Ward continue to utilise a significant amount of temporary staffing to support the need of the patients. This is a sustained picture.
The skill mix on the ED unit showed some variance to the planned skill mix due to short term unexpected absences.

Rehabilitation wards in Health and Justice (Oakwood and Langley)
Focus is needed to ensure effective rostering, data quality, and workforce planning. Oakwood's challenges are noted with prolonged sickness and change management needs supported by organisational development.

Secure Inpatient Services
There has been a continuous improving picture, but consistently high fill rates for unregistered nurses on night shifts.

Ensuring individualised safe care for people in seclusion can impact the deployment of staffing across the SIS wards.

Learning Disabilities (Bankfields Court)
An improved staffing position is indicated since November 2024. However, to ensure person cantered care a decision was taken 2022 – 23 to employ a pool of 23 additional HCAs as permitted expenditure. The staff continue to be deployed, and a consideration is being given about the possibility of establishing these posts.
Bankfields Court staffing is heavily influenced by the patient population at any time and requires a dynamic approach beyond the annual review.

Older Adults
At the time of reporting the wards hade high acuity, high occupancy, and elevated levels of temporary staff and yet comparatively low values of CHPPD for some of the MHSOP wards.

Temporary staffing use
Short term sickness absence is the main driver of temporary staffing use across all wards as well as the significant demands on teams to release staff for training and non-clinical duties. The impact of discretionary training can be significant.

However, the use of agency staff has been eradicated from the majority of DTVF wards and has been on a downward trend since on NYY wards since Jan 2025. In addition, there is limited use of overtime which is also on a consistently downward trend.

In year improvement in assessment of position:
We can report that the assessment of safer staffing when compared to the previous two years shows an in-year improvement from 2023 to 2024 and 2024 to 2025. This indicates that the risk to safer staffing has improved.

RAG Rating - Comparison 2025, 2024 and 2023															
Service Setting	Red			Red Amber			Amber			Amber Green			Green		
Year	2025	2024	2023	2025	2024	2023	2025	2024	2023	2025	2024	2023	2025	2024	2023
AMH&PICU	0	0	0	0	0	0	0	6	13	11	4	1	3	0	0
SIS	0	0	0	0	3	1	7	10	10	8	0	0	0	0	0
MHSOP	0	0	0	0	2	0	4	5	5	6	2	5	0	1	1
Rehab & ED	0	0	1	0	0	0	2	3	4	2	2	0	1	0	0
LD	0	0	2	0	0	2	0	0	1	1	1	0	0	0	0
H&J	0	0	0	0	0	0	1	2	0	1	0	2	0	0	0
Summary	**0**	**0**	**3**	**0**	**5**	**3**	**14**	**26**	**33**	**29**	**9**	**8**	**4**	**1**	**1**

Further considerations and key themes

Headroom: a review of needs by clinical and operational managers, the training department, and the finance department is suggested to ensure the current headroom is achievable. This could result in an increase in headroom or the need to curtail nonclinical draws on ward-based staff time.

E roster management: across all areas needs to continue the current momentum to address level loading and management of unavailability and roster Key Performance Indicators (KPIs) to support efficient and effective rostering.

SafeCare: usage and compliance across all ward areas needs to be improved to ensure we consistently understand clinical demands.

Evaluation of the current review process: from this recent establishment review cycle, ensuring that key learning and core understanding of requirements from this iteration are

carried forward. Also to consider how to effectively incorporate the MDT and scale to community teams.

Care Hours Per Patient Day: needs to be monitored and to understand the differences between peer wards internal to the Trust, and to gain a better understanding amongst selected peer Trusts for external comparisons.

Staffing Models: and deployment in certain areas to better consider effective use of staff, for example the use of a Seclusion and Response team within Secure Inpatient Services to minimise the impacts on wards within the service should incidents occur.

2025 – 2026 annual staffing review
This review is underway and is being conducted at a time when the ward occupancy has reduced and is closer to the commissioned occupancy levels. This review is also being undertaken at a time when we are actively considering the national principles for Enhanced Care, a publication by the National Forum for Mental Health and Learning Disability Nursing Directors about the use of additional observations in inpatient care. This work is leading to some reduction in the use of increased observations, working with people differently to maintain safety.

Peer Staffing reviews
We are required to conduct peer staffing reviews as a part of the NHS approach to productivity. We are partnering with Greater Manchester Mental Health Trust to consider our staffing models in the care of older people. This is in addition to staffing comparison work with CNTW in 2025.

Prior Consideration and Feedback
The review has been conducted in conjunction with the clinical and operational leaders, including Associate Directors of Nursing and General Managers.

The review has been further considered by the Executive Directors Group (EDG) and the Quality Assurance Committee.

Implications
The Board Assurance Framework recognises that the inability to staff services safely and consistently could result in ‘unacceptable variance in the quality of care we provide.’

The following clinical risks are associated with inadequate nursing and care staffing capacity and capability:

- Inadequate staffing numbers and skill mix may compromise effective, safe, and compassionate care.
- Poor monitoring of staffing capacity and capability can lead to unacceptable patterns of inadequate staffing.
- If unsafe staffing levels, go undetected or become accepted practice risks may not be effectively mitigated.

Failure to provide required staffing could present a breach in our ability to meet the requirements of the Health and Social Care Act.

Recommendations:
The Board to take good assurance that we have met the national regulatory requirements.
The Board to consider the key findings and areas for further consideration.

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11th December 2025**
Title:	**Quarterly Report of the Guardian of Safe Working Hours for Postgraduate Doctors**
Executive Sponsor(s):	**Dr Kedar Kale, Executive Medical Director**
Report Author(s):	**Dr Sharon Beattie, Guardian of Safe Working**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

Purpose:

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

The Board receives annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for resident doctors. This is the Q2 report for 2025-2026. The appendices have been provided to me by Medical Staffing, and they include aggregated data on exception reports, details of fines levied against departments, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting, when needed, good practice and/or persistent concern. Reports and appendices are shared with the corresponding NHS England body for the different sectors.

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

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

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

Proposal:

- I am satisfied that all exception reports submitted by resident doctors on the 2016 contract have been actioned by Medical Staffing. Some exception reports may yet be submitted by doctors in relation to the quarter. In terms of timescales, there were some delays in processing exception reports in both the North and South care groups but these arose due additional information being needed for 6 of the DTV exception reports and clarification being needed around compensation entitlements related to the 2 educational exceptions in NYY.

- All fines have been levied due to breach of the 5 hours overnight rest requirement on NROC rotas. There has been a recent rota intensity exercise for the middle tier rotas throughout the Trust. The data collected from this has suggested that the NROC rotas are significantly quieter than was previously predicted. This is resulting in a reduction in the payments for on-call work on these rotas. There is the risk that this could lead to increased exception reports later in the financial year.

- The internal system for covering out of hours rota gaps appears to generally continue to function well in that there is no reported use of agency locums on out of hours postgraduate doctors' rotas. There have been occasions when doctors on the higher tiers have had to 'act down' for periods of time when internal locums cannot be appointed at short notice.

Overview:

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

- In the North Care Group there were 20 exception reports in Q2, which was an increase from Q1 (4) but similar to the numbers from Q3 (17) and Q4 (17) from the previous year. Seven of the 20 exceptions were made by a middle tier doctor who was required to work late due to temporary staffing issues within the department but the exception reports detailed that local measures were being taken to ensure that this did not continue to be an issue. The other exceptions were due to a mixture of staying late (6) due to consultations overrunning or new doctors shadowing on-calls, NROC additional hour claims (2) and one educational exception report.

- In the South Care Group there were 24 exception reports in Q2, which is also an increase from Q1 (11) and Q4 (7) but is similar to Q2 (39) and Q3 (20) of the previous year. However, unlike previous quarters a significant number of these were educational exceptions (18), which appear to be linked with the new out of hours tier 1 rota in the South Care Group. The group medical director and medical education team are currently consulting with the resident doctors within this rota to consider the implications of the new roster. Only 2 of the exceptions were related to working late and 4 due to not receiving 5 hours continuous rest.

- Additional information about reasons for the exception reports are given within the appendices.

- I continue to emphasise the importance of exception reporting to resident doctors' representatives in the resident doctors training fora (RDTFs) and at inductions.

- All seven of the fines this quarter have been levied for breach of the requirement for 5 hours of continuous overnight rest on NROC rotas. Three of the fines were from the North Care Group and four of the fines were from the South Care Group. One additional fine related to this quarter (from the North Care Group) will be processed in the next quarter.

- Data for the number of locum shifts picked up by resident doctors for out of hour shifts has been listed. All doctors who have taken on these shifts have opted out of the 48 hour week. Although for some of the second tier doctors this increases the weekly hour worked substantially, we know from NROC monitoring and exception reporting that in reality the actual hours worked are less as these are NROC shifts. We continue to monitor this.

- Vacancies for normal working day posts are given within the appendices along with the number of shifts remaining uncovered after use of the Trust Doctor Scheme or, where necessary, agency locums. The remaining uncovered normal working day shifts, after accounting for annual leave, have been presented. It is important to note that the Trust does not cover GP ITP and ST4-7 resident doctor vacancies as these posts are considered to be primarily for training. Also, not all posts can be filled at any one time as there are more available training posts than trainees.

Implications:

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

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

  From February 2026, following the implementation of exception report reforms, all resident doctors must receive their choice of either payment or time off in lieu (TOIL) for all time worked above contracted hours following exception, except when a breach of safe working hours mandates the award of TOIL. All resulting payments and TOIL must be facilitated by responsible parties and must not be substituted without residents' consent. Historically TOIL has been the standard for additional hours worked and so there may be a change in the cost to the Trust with this reform. At present there is not a high level of exception reporting for working late but this can vary depending on cohorts, and it is difficult to predict whether there will be an increase in reporting with the option of payment. The contract mandates that TOIL is mandated when there is a breach of safe working, and so this is likely to limit the financial impact. I have attached a summary of changes associated with the exception report reform in appendix 3 and a summary created by the medical staffing manager of the exception reporting framework of information provided by NHS employers in appendix 4

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

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

- **Other Implications:**
  There is potential for industrial action to impact the number of exception reports.

  Fines for breaches in rest are likely to continue to be generated, particularly from the middle tier rota, in relation to NROC rotas and as detailed above. Established patterns of breaches such as these should continue to be reviewed by the Trust. As highlighted above it is difficult to predict how the exception reporting reforms and the updated terms and conditions of employment will impact on additional payments related to exception reporting of staying late. Consideration needs to be made regarding the governance arrangements related to the approval of these exceptions, and medical staffing are currently liaising with our providers to look at this.

  With the implementation of exception report reforms there will be the risk of addition fines in the following circumstances:
  - Failing to provide system access to a doctor within seven days of them starting a new post.
  - Breaching confidentiality of exception reporting data
  - Failing to process reports within the specified timeframes (initially 10 days, reducing to 7 days from August 2026).

Recommendations:

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

Background Papers:

Appendices 1, 2: detailed information on numbers, exception reports and locum usage - North and South Care Groups respectively. These appendices have been written and provided by the Medical Staffing Manager.
Appendices 3, 4: these summaries of the exception reporting reforms have been written and provided by the Medical Staffing Manager.

Appendix 1 DTV&F (North Care Group)

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

High level data

Number of doctors / dentists in training (total): 139

Number of doctors / dentists in training on 2016 TCS (total): 139

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

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

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

Exception reports (regarding working hours) from 1st July 2025 – 30th September 2025.

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services	0	3	3	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2/GP - Teesside & Forensic Services	0	3	3	0
CT1-2/GP –North Durham	0	0	0	0
CT1-2/GP – South Durham	0	0	0	0
CT3 – Teesside & Forensic Services	0	0	0	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 – Teesside & Forensic Services Seniors	0	10	10	0
ST4-6 –North & South Durham	0	4	4	0

Seniors				
Trust Doctors - Teesside	0	0	0	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Total	**0**	**20**	**20**	**0**

Exception reports were due to:

- *F2 stayed late (consultations over ran) x2*
- *F2 shadowing (prior to first on call) x1*
- *CT stayed late (due to lack of staff in team) x1*
- *CT shadowing (prior to first on call) x2*
- *ST didn't achieve 5 hours continuous rest x4*
- *ST stayed late x7*
- *ST educational exception report due to missing weekly teaching x1*
- *ST claiming additional NROC hours x2*

Exception reports by Rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services (F2/CT1-3/ GP/ trust doctor)	0	6	6	0
North Durham (F2/ CT1-3/GP/trust)	0	0	0	0
South Durham (F2/ CT1-3/GP/trust)	0	0	0	0
Teesside & Forensic Senior Registrars	0	9	9	0
South Durham Senior Registrars	0	2	2	0
North Durham Senior Registrars	0	0	0	0
DTV CYPS Senior Registrars	0	3	3	0
Total	**0**	**20**	**20**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	0	3	3	0
Teesside &	1	8	1	0

Forensic Senior Registrars				
North Durham Juniors	0	0	0	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	2	0	0	0
North Durham Senior Registrars	0	0	2	0
Total	**3**	**11**	**6**	**0**

Work schedule reviews.

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

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

Bank Shifts Via Patchwork

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	2	0	0	24	0
	CT1	81	34	0	757.5	331.5
	CT3	0	8	0	0	57
	Trust Doctor	0	35	0	0	360.5
	Middle Tier (SR/SAS)	14	12	0	264	216
North Durham	F2	0	0	0	0	0
	CT1	20	8	0	199	66
	CT3	0	7	0	0	79
	Trust	0	5	0	0	54

	Doctor					
	Middle Tier (SR/SAS)	27	22	0	504	416
South Durham	F2	0	1	0	0	12.5
	CT1	32	13	0	340.5	145.5
	CT3	0	9	0	0	95.5
	Trust Doctor	0	5	0	0	62.5
	Middle Tier (SR/SAS)	8	5	0	152	96
CAMHS	Middle Tier (SR/SAS)	43	31	0	792	576
Total		**227**	**195**	**0**	**3033**	**2568**

The discrepancies in the figures are due to:

- *In Teesside, 6 shifts were picked up SAS (IFDs or SAS who didn't have S12) equating to 32.5 hours*
- *In South Durham, 2 shifts were picked up by SAS (IFDs or SAS who didn't have S12) equating to 16.5 hours, and 2 shifts were picked up by the middle tier acting down due to late notice sickness equating to 8 hours*
- *On Teesside middle tier, 2 shifts were picked up by SAS equating to 48 hours*
- *On North Durham middle tier, 5 shifts were picked up by SAS equating to 88 hours*
- *On South Durham middle tier, 3 shifts were picked up by SAS equating to 56 hours*
- *On North CAMHS rota, 12 shifts were picked up by SAS equating to 216 hours*

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	38	31	0	485	405
Incomplete M&S training	5	4	0	40	16
Sickness	42	35	0	551	482
On call cover	20	12	0	352	208
Paternity/maternity leave	24	24	0	189.5	189.5
On call restrictions	50	44	0	790.5	694.5
Industrial Action	33	31	0	437	409
Special leave	10	10	0	102.5	102.5
Annual Leave	5	4	0	85.5	61.5
Total	**227**	**195**	0	**3033**	**2568**

Locum work carried out by trainees						
Grade	**Rota**	**Number of shifts**	**Number of hours worked**	**Rostered weekly hours**	**Actual weekly hours**	**Opted out of WTR**
A (CT3)	Teesside	1	12.5	43.75	46	Y
	NYY	1	16			
B (CT1/2/3/GP)	North Durham	5	54	42	46.25	Y
C (CT3)	Teesside	2	16	43.75	50	Y
	South Durham	3	29			
	Scarborough	1	16			
	NYY	2	18.5			
D (CT1/2/GP)	North Durham	2	8	33.25	34	Y
E (TD)	Teesside	13	154	43.75	55.75	Y
F (TD)	Teesside	8	74.5	43.75	53.25	Y
	North Durham	3	37.5			
	South Durham	1	12.5			
G (TD)	North Durham	2	16.5	42	43:25	Y
H (CTF)	South Durham	1	12.5	43.25	44:25	Y
I (CT1/2/GP)	Teesside	1	12.5	43.25	46:25	Y
	South Durham	2	25			
J (CT1/2/GP)	Teesside	1	4	30.25	30:75	Y
K (TD)	Teesside	4	50	43.75	47:75	Y
L (CT3)	Teesside	2	8	26.50	27:00	Y
M (CT1/2/GP)	South Durham	2	25	43.25	45:25	Y
N (TD)	Teesside	9	78	43.25	52:25	Y
	South Durham	4	50			
O (CT1/2/GP)	Teesside	2	16.5	43.25	54:50	Y
	South Durham	6	75			
	North Durham	1	12.5			
	NYY	5	66			

P (CT1/2/GP) *	Teesside	4	33	43.75	45:75	Y
Q (CT3)	North Durham	3	29	42	45.25	Y
	South Durham	1	12.5			
R (CT1/2/GP)	Teesside	13	128.5	43.75	56.50	Y
	North Durham	1	12.5			
	NYY	2	25			
S (TD) *	Teesside	1	4	43.75	44.25	Y
T (CT3)	Teesside	1	12.5	43.75	45.75	Y
	South Durham	1	12.5			
U (CT1/2/3/GP)	South Durham	1	4	42	43.25	Y
	North Durham	1	12.5			
V (CT1/2/3/GP)	South Durham	2	16.5	43.75	52	Y
	North Durham	1	12.5			
	NYY	4	50			
	Scarborough	3	40.5			
W (CT1/2/GP)	South Durham	1	12.5	43.25	44.25	Y
X (CT1/2/GP)	Teesside	10	99.5	43.75	51.50	Y
Y (CT1/2/GP)	Teesside	1	12.5	43.75	44.75	Y
Z (CT3)	Teesside	2	8	43.75	51.75	Y
	South Durham	3	29			
	NYY	5	66			
AA (CT1/2/GP)	Teesside	2	25	42	44.25	Y
	North Durham	1	4			
AB (SR) *	North Durham Middle Tier	2	32	43	45.50	Y
AC (SR)	Teesside Middle Tier	4	72	43.25	50.75	Y
	South Durham Middle Tier	1	24			
AD (SR)	Teesside Middle Tier	4	72	35.25	54.25	Y
	North Durham Middle Tier	3	56			
	North CYPS Middle Tier	8	152			
	Scarborough Middle Tier	15	280			

AE (SR)	North Durham Middle Tier	1	16	34	35.25	Y
AF (SR) *	Teesside Middle Tier	1	64	43.25	65.30	Y
	South Durham Middle Tier	3	56			
	North Durham Middle Tier	1	16			
	North CYPS Middle Tier	8	152			
AG (SR)	North Durham Middle Tier	3	56	43	64	Y
	North CYPS Middle Tier	3	56			
	NYY Middle Tier	1	16			
	Scarborough Middle Tier	6	120			
	South CYPS Middle Tier	1	24			
AH (SR)	North CYPS Middle Tier	3	48	42	45.75	Y
AI (SR)	Teesside Middle Tier	2	40	43.25	46.25	Y
AJ (SR)	Teesside Middle Tier	1	24	43.25	57.75	Y
	North Durham Middle Tier	3	72			
	Scarborough Middle Tier	5	104			
AK (SR)	North Durham Middle Tier	1	16	34.50	37	Y
	North CYPS Middle Tier	1	16			
AL (SR) *	Scarborough Middle Tier	1	16	43	44.25	Y
AM (SR) *	North Durham Middle Tier	1	16	43	49.75	Y
	Scarborough Middle Tier	4	72			
AN (SR) *	South Durham Middle Tier	1	16	43.25	44.50	Y
AO (SR)	North Durham Middle Tier	2	40	43	46	Y
AP (SR)	North CYPS Middle Tier	4	80	42	48	Y
AQ (SR)	North Durham Middle Tier	2	40	43.25	46.25	Y

The discrepancies in the figures are due to:

- ** These doctors have now rotated out of the trust*
- *The NYY shifts have been removed from the NYY report*
- *Middle tier are non-resident on call for 16 or 24 hours, however, the actual work carried out is much less.*

Vacancies

Vacancies by month						
Locality	**Grade**	**Month 1**	**Month 2**	**Month 3**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2					
	CT3					
	ST4 -6	3	2	2	2.3	355.25
	GP	4 (ITP)	3 (ITP)	3 (ITP)	3.3	507.5
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2					
	CT3					
	ST4 -6	0	0	0	0	0
	GP	1 (ITP)	1	1	1	152.25
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2					
	CT3					
	ST4 -6	3	0	0	1	152.25
	GP	2 (ITP)	0	0	0.6	101.5
Total		**13**	**6**	**6**	**8.3**	**1268.75**

The higher trainee and ITP GP vacancies are due to there being more trainers than posts available, therefore some posts are classed as fallow. This means there was only 1 true vacancy in August/September.

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	1	£377.85
North Durham	2	£1511.40
South Durham		£00.00
Total	**3**	**£1889.25**

All breaches were for not receiving 5 hours continuous rest. The remaining breach in South Durham amounting to £151.14 will be processed in the next quarter as although it occurred and was reported on this quarter, due to a delay in gaining approval, finance will process it in the next quarter.

Appendix 2 NYY&S (South Care Group)

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

High level data

Number of doctors / dentists in training (total):	78
Number of doctors / dentists in training on 2016 TCS (total):	78
Amount of time available in job plan for guardian to do the role:	1 PA
Admin support provided to the guardian (if any):	4 days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (regarding working hours) from 1st June to 30th September 2025

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - Scarborough	0	0	0	0
F2 - York	0	0	0	0
CT1-3 / GP - Northallerton	0	2	2	0
CT1-3 / GP – Harrogate	0	6	6	0
CT1-3 / GP - Scarborough	0	0	0	0
CT1-3 / GP - York	0	13	13	0
ST4-6 - Northallerton	0	0	0	0
ST4-6 - Harrogate	0	2	2	0
ST4-6 - Scarborough	0	0	0	0
ST4-6 - York	0	1	1	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	0	0	0
Trust Doctors - York	0	0	0	0
Total	**0**	**24**	**24**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
NYY (F2/CT1-3/ GP/trust doctor)	0	21	21	0
Scarborough (F2/CT1-3/ GP/trust doctor)	0	0	0	0
NYY middle tier	0	3	3	0
Scarborough middle tier	0	0	0	0
South CYPS middle tier	0	0	0	0
Total	**0**	**24**	**24**	**0**

Exception reports were for:

- *CT – Missed teaching/psychotherapy (due to out of hour shifts) x16*
- *CT – Worked on zero hour day (CBT session) x2*
- *CT – Stayed late after long days x2*
- *CT – Did not receive 5 hours continuous rest x1*
- *ST – Did not receive 5 hours continuous rest x3*

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
NYY Resident doctors	15	4	2	0
NYY Middle tier	3	0	0	0
Scarborough Resident doctors	0	0	0	0
Scarborough Middle tier	0	0	0	0
Total	**18**	**4**	**2**	**0**

Work Schedule reviews

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

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

Bank Shifts Via Patchwork

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Harrogate, Northallerton, Selby & York (NYY)	F2	0	0	0	0	0
	CT1/CT2/GP	63	29	0	607.5	316.5
	CT3	0	9	0	0	94
	Trust Doctor	0	9	0	0	81.5
	Middle Tier (SR/SAS)	14	9	0	272	168
Scarborough	F2	0	0	0	0	0
	CT1/CT2/GP	12	9	0	163	125.5
	CT3	0	1	0	0	12.5
	Trust Doctor	0	2	0	0	25
	Middle Tier (SR/SAS)	79	53	0	1472	1000
South CYPS Middle Tier	Middle Tier (SR/SAS)	62	61	0	1128	1112
Total		**230**	**182**	**0**	**3642.5**	**2935**

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

- *In NYY, 14 shifts were taken by SAS (IFDs or SAS without S12) and 1 SR who was required to act down (equates to 109.5 hours). One shift was a twilight shift that wasn't covered (equates to 6 hours)*
- *On NYY middle tier, 5 shifts were picked up by SAS (equates to 104 hours)*
- *In South CYPS middle tier, 1 shift was picked up by SAS (equates to 16 hours)*
- *In Scarborough middle tier, 25 shifts were picked up by SAS (equates to 456 hours) and 1 shift was picked up by a consultant who was required to act down (equates to 16 hours)*

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	165	133	0	2875	2337
Sickness	42	31	0	486	385
OH restrictions	9	6	0	95.5	75
Industrial action	12	12	0	138	138
Total	**230**	**182**	**0**	**3642.5**	**2935**

Locum work carried out by trainees						
Grade	**Rota**	**Number of shifts**	**Number of hours worked**	**Rostered weekly hours**	**Actual weekly hours**	**Opted out of WTR**
A (CT1-2/GP)	Scarborough	4	53	44	48	Y
B (CT1-2/GP)	NYY	8	104.5	35.75	43.75	Y
C (TD)	NYY	5	28.5	44.75	47	Y
D (TD)	Scarborough	2	25	44	46	Y
E (TD) *	NYY	2	25	44.75	46.75	Y
F (CT1-2/GP)	Scarborough	1	12.5	44	45	Y
G (TD) *	NYY	1	24	44.75	46.50	Y
H (CT1-2/GP)	NYY	1	4	44.75	45.25	Y
I (TD) *	NYY	1	4	44.75	45.25	Y
J (CT1-2/GP)	NYY	2	16.5	44.75	46	Y
K (CT2-3/GP)	NYY	8	44	44.75	49.25	Y
	Scarborough	1	16			
L (SR) *	NYY Middle Tier	1	16	43	44.25	Y
M (SR) *	Scarborough Middle Tier	2	32	43	45.50	Y
N (SR) *	NYY Middle Tier	1	24	43	45.75	Y
O (SR) *	S CYPS Middle Tier	14	240	42	60.50	Y
P (SR)	N CYPS Middle Tier	2	40	43	71.25	Y
	NYY Middle Tier	1	16			
	Scarborough Middle Tier	11	208			
	S CYPS Middle Tier	4	64			
Q (SR) *	S CYPS Middle Tier	8	128	42	50	Y
R (SR) *	S CYPS Middle Tier	19	252	43	60.50	Y

S (SR)	S CYPS Middle Tier	5	80	42	46.25	Y
T (SR)	NYY Middle Tier	1	24	34.25	36.25	Y
U (SR) *	Scarborough Middle Tier	1	24	34.25	36.25	Y
V (SR) *	NYY Middle Tier	4	72	43	54.75	Y
	Scarborough Middle Tier	6	104			
W (SR) *	S CYPS Middle Tier	10	224	42	57.50	Y

The discrepancies in the figures are due to:

- *Fifty eight shifts were carried out by doctors who were based in the north part of the trust (equates to 970 hours) and are included in the DTV report*
- ** These doctors have now rotated out of the trust*
- *All middle tier shifts, week days in Scarborough, plus some NYY prior to August are non resident on call for 16 or 24 hours, resulting in high weekly hours, however, the actual amount of work done is always less.*

Vacancies

Locality	Grade	Month 1	Month 2	Month 3	Average no of vacancies	Number of shifts uncovered (days)
Northallerton	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	1	0	0	0.3	50.75
	Trust Doctor	0	0	0	0	0
Harrogate	F1	0	2	2	1.3	203
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	0	1	1	0.6	101.5
	GP	1	0	0	0.3	50.75
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	2(1ITP+1GP)	1	1	1.3	203
	Trust Doctor	0	0	0	0	0
York	F1	0	0	0	0	0
	F2	1	0	0	0.3	50.75

	CT1-3	0	0	0	0	0
	ST4 -6	2	2	2	2	304.5
	GP	1	1 (ITP)	1 (ITP)	1	152.25
	Trust Doctor	0	0	0	0	0
Total		**8**	**7**	**7**	**7.1**	**1116.5**

The higher trainee and ITP GP vacancies are due to there being more trainers than posts available, therefore some posts are classed as fallow.

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	0	0
Harrogate, Northallerton & York	4	£309.23
Total	**4**	**£309.23**

Appendix 3 Exception Report Reform Summary

Exception reporting reforms are being introduced across the NHS for resident doctors on the 2016 contract, with full implementation being mandatory by February 4, 2026. The changes that have been agreed by the BMA and NHS Employers aim to simplify the process, ensure fair compensation for additional hours worked, and improve patient safety by identifying unsafe working patterns. These reforms, part of the 2024 pay deal, are a response to previous issues where doctors felt discouraged from reporting due to fear of negative consequences or overly complex administrative processes. NHS Employers and the BMA have published guidance and webinars to support the implementation of these changes, although some details around the changes are yet to be confirmed

The reforms introduce the following changes to the existing exception reporting system:

- Confidentiality and Sign-off: The resident doctor's clinical and educational supervisors are removed from the sign-off process for additional hours worked, addressing fears of detriment and conflicts of interest. Reports for additional hours will now go to medical Staffing (no change in the way that exception reports are currently being processed in TEWV as this is already in place), while educational exception reports will go to the Director of Medical Education (DME). The Guardian of Safe Working (GOSW) remains involved in the processing of exception reports, approving payments/TOIL where appropriate. There are recommended data checks as part of the approval of payment for additional hours, if chosen, which are subject to financial governance framework.

- Compensation Choice: Doctors can choose between payment or TOIL, for up to 2 hours time, worked above contracted hours. This is when, due to unplanned circumstances, there is a duty to work beyond the work beyond the hours described in the work schedule, in order to secure patient safety. The only exception to the choice is when a breach of safe working hours or rest requirements mandates TOIL for safety reasons.

- Streamlined Process: The new system aims to become more streamlined as a 3 level process is introduced:
    - Level 0 (Standard): medical staffing reviews evidence and approves the report.
    - Level 1 (Clarification): medical staffing contacts the doctor for clarification if discrepancies exist.
    - Level 2 (Escalation): If a dispute remains, the GoSW makes the final decision.

- Extended Submission Window: The time limit for doctors to submit an exception report is extended to 28 days from the date of the occurrence.

- Enforcement and Fines: New contractual financial penalties are introduced for employers who fail to comply with the new rules. Fines will be levied for:
    - Failing to provide system access to a doctor within seven days of them starting a new post.
    - Breaching confidentiality of exception reporting data.
    - Failing to process reports within the specified timeframes (initially 10 days, reducing to 7 days from August 2026).

- Focus on Safety: For reports of more than two additional hours, an investigation will be triggered, but the focus will be on maintaining safe staffing levels and identifying

systemic issues, not on challenging the doctor's professional judgement to stay and work.

- Guardian's Enhanced Role: The GoSW retains oversight of all reports, monitors patterns and trends, and oversees quarterly reports regarding potential detriment or information breaches. The GoSW also remains responsible for levying fines and ensuring the funds are used for doctor wellbeing or education initiatives.

Appendix 4: Summary of Exception Reporting Framework Agreement

This reform is part of the July 2024 pay offer and was developed by the Resident Deal Implementation Group, including NHS Employers and the BMA.

- Exception Reporting is reiterated as a joint mechanism to ensure safe working hours, protect patient safety, support educational opportunities, and compensate doctors for additional work.
- The framework aims to reduce under reporting, streamline processes, and empower doctors to report exceptions without fear of detriment.
- Applies to all doctors in training under the 2016 TCS.
- Encourages extension to academic trainees, armed forces trainees, public health trainees, and locally employed doctors with similar terms (Trust Doctors).

Key Principles

Access to Exception Reporting

- Resident Doctors must have system access within 7 days of starting or transitioning roles.
- Failure to provide access results in escalating fines (£250/week rising to £500 from Feb 2026).
- List of employed doctors and grade generated from ESR is given to GoSW to cross validate with the list of doctors accessing DRS

Time Off in Lieu (TOIL)

- Resident Doctors can choose TOIL or payment for extra hours unless TOIL is mandated for safety.
- TOIL must be arranged within 1–10 days depending on urgency and recorded post-use.

Protection from Detriment

- Resident Doctors must not face discouragement or detriment for submitting Exception Reports.
- Exception Reporting data is confidential and not shared outside of approved list
- access to Exception Reporting system to be tightly controlled.
- List of names who have access to reports should be shared with trainees at start and upon new access
- Proven breaches to incur fines (£500 per instance).

Penalties and Fines

- Fines for access failures and information breaches are clearly defined.
- Fines are pooled and used for resident wellbeing initiatives, not paid directly to doctors.

Exception Reporting Processing

- A three-level review system (Levels 0–2) ensures fair and efficient processing:
    - Level 0: Basic checks by Medical Staffing (reports should be made within 28 days and reviewed by Medical Staffing within 10 days. If MSA unavailable, arrangements need to be made to pass to another nominated person)
    - Level 1: Clarification with the doctor (Anything over 2 hours of additional work should be investigated)
    - Level 2: GOSWH involvement if disputes persist.
- Doctors can withdraw exception reports, but data remains for safety oversight.

Safeguarding Public Funds

- GOSWH monitors data for patterns suggesting misuse.
- Escalation follows local counter-fraud procedures if needed.

Exception Reporting Content and Submission

- Systems must be simple, accessible, and allow remote use.
- Mandatory fields are limited; optional fields require mutual agreement.
- Categories include early starts, late finishes, missed breaks, educational issues, etc.

Non-Resident On Call (NROC)

- All NROC hours above scheduled must be exception reported.

Educational Exceptions

- Educational Exception Reports go to the Director of Medical Education (DME).
- Educational reports should be anonymous and identifiable data shared with DME/supervisor upon trainee consent
- Academic time must be protected and exception reported if compromised.

Monitoring and Implementation

- Via quarterly and annual reports by GOSWH
- Via Resident Doctor Forum

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	Board of Directors Meeting
Date:	Thursday 11th December 2025
Title:	Medical Education Annual Board Report
Executive Sponsor(s):	Dr Kedar Kale, Executive Medical Director
Report Author(s):	Hayley Lonsdale, Head of Medical Education Medical Education Leadership Team (MELT)

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.*
9	*Partnerships and System Working*	*There is a risk that failure to take a proactive role and engage effectively with partners caused by capacity and financial challenges will limit our ability to effectively train our doctors and medical students and improve the health of the communities we serve.*

EXECUTIVE SUMMARY:

Purpose:

This annual report provides an overview of medical education activity during the last twelve months (2024 / 2025) and outlines key priorities for the next academic year (2025 / 2026).

Proposal:

To provide good assurance to Board members regarding the placements of medical students and resident doctors in the Trust.

Overview:

TEWV has 225 resident doctor posts approved for training. During the 2024 / 2025 academic year almost 500 resident doctors rotated through these approved posts. In addition to this TEWV hosted 472 medical student placements from four medical schools and a further 39 Physician Associate (PA) student placements from four Universities.

Last year the Trust received over £10.6 million from NHS England (NHSE) via the NHS Education Funding Agreement (EFA) to support the salaries and educational infrastructure required to provide medical education placements.

The Trust has a legal responsibility through the EFA and the GMC (General Medical Council) to quality assure the delivery of medical education, and this is undertaken through a cycle of quality control, namely the self-assessment report (SAR) and quality improvement plan (QIP). These reports are shared with NHSE to demonstrate how the Trust meets the GMC domains for training.

The GMC national training survey (NTS) provides an opportunity for resident doctors and trainers to provide feedback, and this allows the Trust to benchmark the level of training provided against other similar organisations. A significant highlight within the last year is TEWV being ranked 5th in England (6th nationally) from the 220 active Trusts within the 2025 trainee survey results and 8th in England (9th nationally) within the 2025 trainer survey results. This is the first time TEWV has been ranked in the top 10 Trusts nationally for both the trainee and trainer survey.

This year the Trust has demonstrated an exceptionally high level of training across all programmes, despite the constant challenges the Faculty of Medical Education (FoME) face ensuring the provision of high quality training placements whilst dealing with a shortage of consultant psychiatrists / accredited trainers due to the number of consultant vacancies.

In early September 2025, NHSE 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. NHSE have included adherence to the plan in the new NHS Oversight Framework and have asked organisations to provide oversight of this work to the Trust Board. The first update on the ten-point plan was presented to the Trust Board in October 2025.

Prior Consideration and Feedback:

Contents of this report were discussed and agreed by the Medical Education Leadership Team (MELT).

Implications:

- The Trust currently has some challenges in meeting the EFA.
    - Having sufficient substantive trainers to provide supervision is an ongoing issue.
    - The Trust does not have adequate facilities to train medical students and resident doctors at all Trust sites (the Trust has to frequently book external venues).
- Therefore, providing good assurance of the delivery of medical education via the EFA may be affected.

Recommendations:

- It is recommended that the Trust Board note the content of this paper which provides a comprehensive summary of medical education activity, key achievements, horizon scanning, action planning and conclusions. MELT believe this report will provide a good level of assurance.

Further information

Report Title: Summary of Medical Education Activity September 2024 – August 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Summary of Medical Education Activity September 2024 – August 2025

CONTENTS

1. INTRODUCTION & PURPOSE

This report will provide an overview of medical education activity in the last twelve months (2024 / 2025) and outline key priorities for the next academic year (2025 / 2026).

2. BACKGROUND INFORMATION

2.1 The Trust currently hosts 225 approved resident doctor placements in Foundation, GP, core, and higher training. The configuration of these posts is outlined in the document embedded below.

Medics Post Configuration Sprea

An illustration of the training pathway in psychiatry created by the Royal College of Psychiatrists (RCPsych) is provided below.

During the 2024-2025 academic year the Trust hosted 472 medical student placements from four Universities and 39 Physician Associate (PA) student placements. *Appendix 1* provides an overview of medical student internal feedback for the last academic year. Detailed below is a breakdown of medical student and PA student numbers and their placement stage.

Medical Schools (Medical students)	Stage	Number of students
Newcastle AST (Durham, Darlington and Teesside localities)	5	113
Newcastle ICCP (Durham, Darlington and Teesside localities)	3	121
Sunderland (Durham & Darlington & localities)	3	108
Leeds (Harrogate locality)	4	30
Hull and York (York locality)	3	53
Hull and York (Scarborough locality)	3	31
Hull and York (South Tees locality)	3	16

Universities (Physician Associates)	Stage	Number of students
Newcastle University (Durham, Darlington and Teesside localities)	2	11
Leeds University (Harrogate locality)	1	6
University of Bradford (York locality)	2	6
Hull and York (York & Scarborough locality)	2	16

2.2 Internal governance of postgraduate medical education is overseen through Resident Doctor Training Forums (RDTF). These represent the two care groups in the Trust and oversee the delivery of registrar and senior registrars training and placement satisfaction. Separate committee meetings are held to oversee the training of Foundation doctors and GP registrars. Similarly, there are local undergraduate groups in each care group, overseen by a Trustwide Undergraduate Governance Board (UGB). The Medical Education Committee (MEC) oversees the remit of these groups and sets out the strategic direction of the Faculty.

2.3 The NHS Education Funding Agreement (EFA) covers both education and placement providers until 31 March 2027. https://www.england.nhs.uk/terms-and-conditions-2/new-nhs-education-contract/

The 2024 / 2027 agreement supports non-competitive, equitable activities listed in the Department of Health and Social Care Education and training tariff guidance and NHS Education funding guidance published yearly, regarding: education and placements funding, salary support funding (where not directly commissioned to a provider and where not under a host / lead contract) education and training grants for programmes published by NHSE.

Through these standards, placement providers are required to work with NHSE and other stakeholders to support learners in their career pathways and transition from healthcare education programmes to employment, while also working collaboratively with system partners to maintain and improve practice placement capacity and capability.

2.4 The ongoing cycle of quality control in medical education is undertaken through a self-assessment report (SAR) and quality improvement plan (QIP). These reports are shared with NHSE and set out how the Trust meets the General Medical Council (GMC) domains for training https://www.gmc-uk.org/education

2.5 The quality improvement schedule for medical education is set out in the 2024 / 2025 Quality Improvement Plan and Self-Assessment Report.

Appendix 2: *2024 / 2025 Quality Improvement Plan (QIP)*

Appendix 3: *2024 Self-Assessment Report (SAR)*

2.6 The GMC national training survey (NTS) provides opportunity for resident doctors and trainers to provide feedback to the Trust in regard to training satisfaction. It allows the Trust to benchmark the level of training provided against other similar organisations.

This year the Trust demonstrated a remarkedly high level of training across all programmes. The most significant of the highlights include TEWV being ranked **5th in England (6th nationally)** from the 220 active Trusts within the 2025 trainee survey results (9th nationally in 2024) and **8th in England** (**9th nationally)** within the 2025 trainer survey results (30th nationally in 2024). **This is the first time TEWV has been ranked in the top 10 Trusts nationally for both the trainee and trainer survey.**

The Trust overall dashboard for the **trainee survey** confirmed **all of the 18 indicators were above this year's national average**. Overall data confirmed there were **17 green outliers** (areas of strength) compared to 14 green outliers in 2024. There were no overall red or pink outliers (areas of weakness). In addition to the 17 overall green outliers there were a **further 35 strong areas** when drilling down the data **by site** and a **further 35 strong areas** by **specialty** and **post specialty**.

The Trust overall dashboard data for the **trainer survey** showed **all of the 9 indicators were above this year's national average** and also above the previous year's results. Overall data confirmed there were 3 green outliers and no overall red or pink outliers. Last year saw a total of 1 green area of strength overall and a further 30 strong areas across all sites. This year, there are **3 green areas of strength overall and a further 53 strong areas.**

Appendix 4: *2025 GMC Trainee Survey Report*

Appendix 5: *2025 GMC Trainer Survey Report*

2.7 The Faculty of Medical Education (FoME) continue to host annual Internal Educational Audit visits to enhance quality monitoring and assurance for all postgraduate and undergraduate activity within the Trust. The last visit held in October 2024 audited the North care group. The feedback gleaned was invaluable and action plans were created to address any negative areas for concern.

Appendix 6: *TEWV Internal Educational Audit Framework v8.0*

2.8 The Medical Education Operating Framework (MEOF) was created to provide an overview of the function of the FoME and summarises the governance framework used within the Trust to oversee all undergraduate and postgraduate activity. The framework continues to be reviewed and updated on an annual basis.

Appendix 7: *Medical Education Operating Framework v16.0*

2.9 In February 2024 NHSE published the Safe Learning Environment Charter (SLEC). The SLEC aimed to strengthen the NHS workforce and was developed by over 2482

learners, educators, and key stakeholders in health education. The SLEC set out the supportive learning environment required to allow learners to become well-rounded professionals with the right skills and knowledge to provide safe and compassionate care of the highest quality.

The SLEC was designed for learners and those responsible for supporting placement learning across all learning environments and all professions within them. It was aligned to the NHS People Promise in recognition that learners are vital to the workforce and are included in the promises we must all make to each other, to improve everyone's experience of working in the NHS.

The Head of Medical Education (HME) is a member of the Trust working group which was established in March 2024 to ensure a combined Trust-wide approach across all professions were represented when completing the maturity matrix Maturity Matrix (1,2,3) required for NHSE.

The maturity matrix was submitted to NHSE as part of the SAR submission in 2024 and since then the Trust working group has commenced work on creating a Trust strategic plan to implement SLEC. The group meet monthly to track progress against the implementation plan and have agreed 3 top level objectives for each professional group to address any areas on the maturity matrix that did not score a 3 (optimal score).

Appendix 8: *NHS England Safe Learning Environment Charter*

3. KEY ACHIEVEMENTS IN MEDICAL EDUCATION

Detailed below are the key achievements in the last 12 months.

3.1 Simulation Progress

In July 2025 the FoME were delighted to open the medical education simulation suite at Lanchester Road Hospital. These modern facilities immerse University and career grade learners in realistic mental healthcare environments and offers a psychologically safe place to learn that is as close to reality as possible.

The rooms are equipped with real-time video and sound streaming and the simulation suite consists of four multipurpose rooms:

- An outpatient clinic
- A bedroom
- A physical health clinic room
- A debriefing room

There is also a control centre room which oversees what activity is being undertaken in the multipurpose rooms.

The FoME continues to employ a Simulation Tutor whose main role responsibilities are to focus on the delivery of the "Simulation Strategy" *(Appendix 9)* and gain a greater awareness of the current simulation footprint across existing Faculty activities and also to develop an in-house training programme for simulation (which involves an MDT component where possible). The Simulation Tutor played a pivotal role in the opening of the simulation suite and continues to oversee the development of material and programmes.

With medical school expansion in progress, simulation allows authentic delivery of content without overloading clinical services and patient volunteers and also allows application of theoretical knowledge in a safe way for our patients. There is evidence for productiveness in medical education including facilitating acquisition of skills, knowledge, and attitudes with the use of simulation.

In February 2025 the FoME created and appointed to a simulation teaching fellow post. The simulation teaching fellow contributes to the development, planning, delivery and monitoring of teaching for relevant medical students and acts as a direct source of educational advice offering guidance to clinical and medical staff on all aspects of the simulation agenda.

In addition to this, the fellow plans improves and delivers simulation teaching activities and is involved in facilitation and delivery of simulation projects run by the FoME and in collaboration with the Simulation Tutor. This currently includes 'Physical Health Emergencies in a Psychiatric Setting' (RAMPPS) and 'New IMG Psychiatric Simulation' (NIPS), "Teach-the teacher Simulation" sessions and other developed simulation teaching.

The FoME are now currently exploring how a mobile simulation offering can be developed and implemented for the South care group.

3.2 Development of Trust Charters to improve standards

The FoME oversees the placements for all medical students and resident doctors within the Trust with an overall aim of providing quality educational opportunities for all medical students, physician associate students and resident doctors in line with the NHSE SLEC.

Whilst the governance for such is strong, it is important that the FoME continue to strive for excellence and recognition as one of the best regional and national training providers, year on year, as validated by excellent local feedback through audits and evaluations, medical school feedback and GMC NTS survey feedback.

The TEWV Medical Workforce Charter 2023 already committed to effective job planning, appraisal, admin support and protected space for all trainers (*Appendix 10*). To further strengthen the Medical Workforce Charter the FoME felt that it was equally important to create a charter for the trainer workforce to outline what support a trainer can expect in TEWV. The Trainer Charter can be accessed at *Appendix 11.*

In 2024 the FoME developed the Resident Doctor Charter (*Appendix 12*) and has since developed a Medical Student Charter (*Appendix 13*) for undergraduate medical learners. This charter outlines 16 key areas which clearly depicts what each student can expect to receive prior to and during their Psychiatry placement within TEWV.

These charters provide a commitment to the aspirational target of establishing a safe learning environment that provides an inclusive, psychologically safe place for both learners and trainers.

The HME and Nurse Leads in Medical Education will monitor compliance of all charters on an ongoing basis and will provide regular reports and updates at MEC meetings where charter compliance will be a standard agenda item.

3.3 Ambitious Continuing Professional Development (CPD) Programme

The role of the CPD Tutor was designed to create high quality CPD training for medical staff within the Trust. It was originally developed as a pillar of work under the FoME intentionally to exploit the expertise within the Trust. The CPD Tutor role is now fully embedded, and the post holder has developed a coherent programme (*Appendix 14)* of internal CPD that is now supporting all grades of doctors in the Trust.

The CPD Tutor worked with colleagues in I.T. to ensure the most up to date technological solutions were available to maximise CPD participation through use of technology and has worked collaboratively with the Simulation Tutor to support the increased use of simulation as part of the FoME wider CPD strategy.

The potential to develop a CPD Academy which would provide opportunities for interprofessional collaboration within the Trust and external collaboration with independent and third sector organisations with a potential for income generation for the Trust still remains a strong aspiration for the FoME and will be a strategic priority for MELT in 2026.

3.4 Supporting, Promoting and Developing Educational Environments (SPADE)

In recent years the FoME has achieved excellent results when applying interventions to situations that have required formal input. To provide further structure and to enable the FoME to provide the required levels of informal guidance and pastoral support it was decided that Supporting, Promoting and Developing Educational Environments (SPADE) (*Appendix 15*) would be created to provide a more structured approach and guidance that will govern interventions whilst also ensuring necessary resources and processes are utilised to achieve improvements both efficiently and effectively.

SPADE will help remedy any trainers and clinical teams facing difficulties in providing high quality training placements in a supportive and facilitative manner and will be an informal approach that provides assurance but not a long lasting impact on cultural change where staff feel both supported and included.

The process will be led by the SPADE Tutor who will be impartial and will act in a best practice advisory capacity akin to the Guardian of Safe Working (GoSW) role.

Using survey data and local intelligence MELT will be responsible for identifying any teams and / or individuals who may benefit from SPADE. It is to be noted that SPADE does not replace the following Trust policy or procedure:

- "Dealing with concerns affecting Medical Staff" policy
- "Grievance reporting and resolution Procedure"

The FoME have recently appointed a SPADE Tutor on a voluntary basis. The SPADE Tutor is a former Core Training Programme Director and GoSW and will work to identify concerns, create action plans and share these with colleagues affected. The action plans will be developmental, and solution focussed. Timescales will be allocated to each individual action and action owners. Actions will be subject to future monitoring to assess improvement.

Supportive interventions that SPADE will adopt may include but are not limited to:

- Creation of focus groups to address negative feedback / outliers
- 360° emotional intelligence
- Counselling
- Coaching
- Additional support from Organisational Development Practitioner / Medical Development team
- Investigations (informal / formal)
- Conflict resolution
- Surveys
- Workshops – doctors / teams in difficulty
- Informal visits

First and foremost the FoME will strive to ensure that SPADE is utilised as a supportive intervention and any learning from such interventions will be shared accordingly to allow good practice.

3.5 Resident Doctor Handover Process

Clinical handover between shifts is a long-standing issue in psychiatric settings as they function differently to acute hospital settings with teams of doctors included in waking shifts. In TEWV, handover between shifts occurs as a built-in process in which our inpatient units and community teams have these built into the daily "report outs" and "daily huddles".

Resident doctors working OOH shifts cover many large hospital sites spread over the large geography of the Trust resulting in it being impractical to offer individual handover to all clinical areas. A pilot handover process using Microsoft Teams was designed and implemented successfully by the resident doctors in one locality and was later formally implemented in all other localities across the Trust.

The handover process involves a Microsoft Teams meeting handover where all resident doctors from all relevant clinical areas join between shifts to handover clinical information. The times for handover have now been included in the resident doctor's

work schedules to ensure there is no scope for missed handovers. A process for stage wide escalation of any missed handovers on any given day, is now included in the handover process.

The FoME will continually engage resident doctors in the forums to ensure there is appropriate communications to allow for consistency during resident doctor change over times and are currently considering future plans to ensure the handover process provides value added learning for resident doctors.

Whilst there is room for improvement to ensure resident doctors gain value added learning from handovers, the GMC NTS trainee results in 2025 confirmed that TEWV scored 74.67% in relation to handover which is well above the national average of 69.91% and also higher than the 2024 GMC NTS trainee survey results when TEWV scored 72.45%.

3.6 Task and Finish Groups

MELT continues to work closely with the Trust Strategic Lead for Equality, Diversity, Inclusion (EDI) and Engagement and the Director of People and Culture to oversee equality for both resident doctors and career grade colleagues.

In 2024 five task and finish groups (Race / IMG, Disability, Gender, LGBTQ+ and Religious Practice) were created. The overarching purpose of these groups was to consider agendas from what you would describe as disadvantaged groups and / or those with protected characteristics.

Regular meetings continue to be held to formulate plans to address any negative feedback / outliers received from both internal and external quality visits and surveys. The overarching aims for each task and finish group in addition to a recently updated action plan are detailed in *Appendix 16.*

3.7 MRCPsych Examination Pass Rates

Each registrar working within the Trust must pass two written and one practical examination before they can gain membership to the RCPsych and progress to higher training https://www.rcpsych.ac.uk/training/exams The FoME in conjunction with several Consultants and suitably qualified Specialty doctors and Specialist grade doctors (SAS) continue to provide MRCPsych Paper A and Paper B practice groups and CASC practice clubs free of charge for all registrars and any Trust or SAS doctors who are preparing for their MRCPsych examinations.

Over the last year there has been an increase in the overall pass rate for TEWV registrars. In one diet of the Paper A examination there was an 80% pass rate, one diet of the Paper B examination generated an 82% pass rate, and a 62% pass rate was attained in one of the two diets of the CASC examination. Whilst multiple factors are at play the introduction of a Trust CASC club and simulation suite have helped the FoME be pro-active in the support they provide.

3.8 Senior GP Education and Liaison Roles

In late 2023 the FoME successfully appointed to two senior GP Education and Liaison roles. The roles were developed as a new pillar of work under the Medical Education team to help strengthen GP and mental health networks whilst offering support to our Psychiatry in-house training programme. The roles are Trust-wide positions and were part of trust priorities at the time and were funded by monies received from a local Integrated Care Board (ICB).

One postholder has been focussing on an educational component and has been concentrating on developing a high quality Continuing Professional Development (CPD) programme for general practitioners working in practices linked with our organisation across the North East and North Yorkshire footprint.

The second postholder has been focussing on the relational component focusing on nurturing stronger ties with local general practitioners and networks, and to help facilitate better two-way communication between primary and secondary care and looking for new opportunities to collaborate. Numerous CPD events continue to be held, and work continues to improve the relationship between TEWV and local GP networks.

The FoME would like to highlight to the Board that the fixed-term contract for one of the Senior GP Education and Liaison roles will expire in February 2026 with the second role expiring in July 2026. The FoME are keen for both posts to continue as funding is identified within current run rates and are currently in discussions with Medical Leaders regarding the future of the roles.

3.9 2025 MELT Objectives

Included in the 2024 Medical Education Annual Board Report were a copy of the MELT objectives for 2025 (*Appendix 17*). Excellent progress has been made against each objective as detailed below.

- ***Ensure TEWV is a safe environment to learn and work for Trainers, Undergraduate and Postgraduate learners*** – Extensive work has been carried out in relation to the implementation of SLEC in addition to the progress made within the five task and finish groups.

- ***Trainer commitment – Objective to create a Trainer Charter*** – Trainer Charter created and implemented. Impact following the introduction of the Chater will be monitored closely throughout 2026.

- ***Work towards the development of a coordinated simulation strategy*** – Comprehensive simulation strategy developed in addition to the creation of a Simulation Teaching Fellow role and the opening of the Medical Education Simulation Suite.

- ***Develop a comprehensive CPD programme for TEWV*** – High quality CPD programme has been developed as outlined in *Appendix 14*.

- ***Enhancing the clinical exposure of medical students by reviewing placement models*** – A comprehensive review of all medical student placement models was conducted by UG FoME members and UG Nurse Leads in Medical Education. Changes were made and implemented for the 2025 / 2026 academic year and will be monitored accordingly.

3.10 **2025 Differential Attainment Report**

Differential attainment (DA) refers to the gap in attainment levels of different groups of doctors in domains such as examinations or career progression. It occurs across many professions and is not unique to medicine or Psychiatry. Variation in attainment can be observed across groups when split by several protected characteristics, including age, gender and race. As there is no single agreed cause of these variations this can make it difficult to identify a single factor or specific area that should be targeted with an intervention.

DA exists in both undergraduate and postgraduate contexts across exam pass rates, and postgraduate contexts across Annual Review of Competence Progression (ARCP) outcomes and can be an indicator that training and medical education may not be fair. Differentials that exist because of ability are expected and appropriate. Differentials connected solely to age, gender or ethnicity of a particular group is unfair.

The GMC standards require training pathways to be fair for everyone (https://www.gmc-uk.org/). Each year the HME compiles a comprehensive report which explores DA within the TEWV medical workforce. The HME then presents the report to MELT, FoME and Medical Leaders. In May 2025 the fourth DA report (*Appendix 18*) was produced. Findings have since been shared and action plans agreed to address outliers.

4. IMPLICATIONS / RISKS

4.1 **Quality:**

4.1.1 The QIP outlines the quality objectives to be delivered in the next reporting period.

4.2 **Financial:**

4.2.1 The Trust received over ***£10.6 million*** in 2024 / 2025 to support the salaries and educational infrastructure required to deliver medical education placements. Following recent conversations between the FoME, Newcastle Medical School and the Trusts Associate Director for Financial Management, the University confirmed that they were in support with the Trusts request to retain funds if underspent.

The FoME are now in the process of compiling a paper for the Executive Directors Group to provide an overview and idea of scale of potential underspends and outline what the FoME would utilise the savings for. The paper will also provide details around how many years the funds may potentially be accumulating for and will also request support in principle for having small scale plans "on the shelf" in case there are year-end underspends that could be utilised.

4.3 **Legal and Constitutional:**

4.3.1 The Trust has a legal responsibility through the EFA to quality assure the delivery of medical education.

4.4 **Equality and Diversity:**

4.4.1 There are no implications to consider.

4.5 **Other Risks:**

4.5.1 **Estates and Facilities**

The Trust does not have sufficient facilities to train medical students and resident doctors at all Trust sites. Whilst this has been highlighted before, there still remains no definitive decision on a remedy for such. The majority of medical student teaching remains off-site at external venues incurring a large cost to the Trust. In addition to this postgraduate teaching sessions which are held face to face are also hosted at external venues due to a lack of large capacity meeting rooms within the Trust required to meet current needs.

Whilst the FoME welcomed the opening of the Simulation Suite at Lanchester Road Hospital, there are no plans for such a facility within the South care group causing disparity of access and limiting learning opportunities for those based in the South.

The NHSE Quality Interventions Review report produced following the 2022 joint quality visit from the Northern Foundation School and Newcastle University Medical School confirmed that the Trust is not currently meeting the GMC standards for training in relation to the standard of education facilities.

The lack of dedicated medical education facilities throughout the Trust is and will become a significant burden as the Trust risks not being able to participate in future medical student expansion or continue to offer placements at the current scale.

4.5.2 **Trainer capacity and protected time in Job Plans**

Regrettably, having sufficient substantive trainers to provide supervision still remains a challenge. The amount of medical vacancies, increase on clinical demand and number of Mind the Gap (MTG) arrangements in situ continue to put huge pressure on the trainer workforce.

An audit undertaken in October 2024 regarding the correct allocation of Supporting Professional Activities (SPA) in clinical and educational supervisor job plans was undertaken by the HME. The audit report confirmed that only 35% of clinical supervisors had the correct allocation of SPA time within their job plan with even fewer educational supervisors (5%) having the correct amount of dedicated time to train. It is of note that only postgraduate medical education SPA time was audited as at present there are no SPA incentives (other than agreement to protect time in job plans) for involvement with undergraduate medical education provision. The FoME hope to have SPA time for undergraduate involvement mandated within job plans in the future as the majority of learners are undergraduate.

Despite SPA time not being explicitly recorded within the job plans audited the FoME do have assurance from intelligence gathered during resident doctor clinics, internal audit visits and GMC NTS survey results to demonstrate that regular supervision is happening. It is of note that the audit

A re-audit of SPA in clinical and educational supervisor job plans is currently being undertaken, and updated audit results will be provided to MELT for consideration and action. Should the Trust not seek a remedy, this could lead to a decrease in resident doctor training posts alongside the associated funding which in turn would increase agency locum costs.

4.5.3 **Undergraduate medical education provision**

Simulation: Following the recent opening of the new simulation suite at Lanchester Road Hospital, we appointed a simulation teaching fellow. Since appointment, this role has reviewed the undergraduate teaching resources to ensure simulation is embedded - a direction of travel from the medical schools with an eye on increasing medical student numbers in the future. The simulation fellow role is a fixed term 12 month post with no recurring fund. It is of paramount importance that we continue to have this role established in the FoME to ensure the rate of simulation continues to increase and that we make the best use of the facilities developed by the Trust. In Autumn 2025, the FoME will request that this role be approved for recurrent funding because without such, the simulation suite and further developments of mobile simulation for other parts of the Trust would stagnate.

Clinical Teaching Fellows: There are now five teaching fellows in the Trust. These roles significantly contribute to the induction, teaching and support of medical students on placement, and this lessens the need to use front line clinicians and take them away from their clinical roles at high volume, with the alternative of cancelled sessions should we be unable to do so. The FoME will review the resource allocation of the teaching fellows and the support from our team of nurse specialists this year to determine whether the skill mix and the amount of time to support medical students is sufficient.

Job planning to support undergraduate medical education activities: Accurate job planning is essential. Currently there are no SPA incentives for involvement (other than

agreement to protect time in job plans) and neither is there a consequence for not being involved in the delivery of undergraduate medical education in terms of SPA time. At present there are senior medical colleagues who are heavily involved in the delivery of undergraduate medical education due to their enthusiasm (as well as their teams), but other teams declining hosting students, which in turn leads to limitation of student placements. We will continue to meet with those teams to encourage participation and involvement and reduce the saturation in other parts.

Capacity in clinical teams: The FoME are also limited in some areas due to clinicians declining to host placements due to a lack of space within the team building and yet the same team continues to host nursing students and other non-medical professions. It would appear at times that other inter-professional groups are given preference over medical students, and this could be because medical students offer no service input whereas other groups do. This pressure was particularly evident amongst the clinical teams we approach to host our Newcastle medical students which resulted in a large quality improvement project during the summer of 2025 to ensure that we could provide the required number of placements. It will be challenging to accept higher numbers of medical students in the future, including any new medical schools that are being developed (e.g. Teesside).The FoME believe that proactive teams who welcome medical students should receive some form of incentivisation, understanding that to manage future increased patient capacity, we need to embrace and encourage medical student placements alongside nursing, psychology, and pharmacy students etc and that colleagues supporting this work are already remunerated by the Trust. Having opportunities to experience different teams is vital in developing and valuing medical education going forward and space is required to host our clinical teams and students as it is vital for future growth, development, and partnership building.

5. HORIZON SCANNING

To ensure the FoME remains proactive in its approach to continual improvement, several initiatives are planned for the next academic year.

5.1 Medical Educators and Medical Leaders Event

In November 2025 the FoME will again host a Medical Educators and Medical Leaders event which will run over two days. This will be the third event of this kind. Numerous sessions are planned for the 2025 event which include:

Medical Educators and Medical Leaders – Day 1

- *Directorate Panel: Questions / topics / ideas you would like to ask / discuss / share*
- *Where are we Now, and what's our Destination?*
- *Our Medical Journey to Change - five-year plan (including Trust structures and governance)*
- *Operational Structure, Roles of Individuals and Governance of Care Groups*
- *NHS Finance (National and Local)*
- *Supporting, Promoting and Developing Educational Environments (SPADE)*
- *Coaching conversations in difficult circumstances*

Medical Leaders – Day 2

- *What's the point of job planning?*
- *Use of IIC for job planning purposes*
- *Understanding and using 'Maintaining High Professional Standards in the Modern NHS' (MHPS) effectively*
    - *How concerns arise*
    - *Dealing with concerns*
    - *Escalating concerns*
    - *Behaviours affecting performance*
- *Directorate Panel - Your opportunity to have your questions answered, topics discussed, or share your ideas (Medical Educators will join this session)*

Medical Educators – Day 2

- *State of the nation year in Summary*
- *Review of 2025 objectives*
- *Did we meet the 2025 objectives set?*
- *Overview of 2026 objectives*
- *Workshop to determine Faculty objectives*
- *Review of Developmental Review Framework*
- *Review of resident doctor role*
- *Educational debate*
- *Management challenge*

The event will again allow networking and provide an arena for collaborative working between the FoME and medical leaders.

5.2 **NHSE 10 Point Plan to improve resident doctors' working lives**

In early September 2025, NHSE 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. NHSE have included adherence to the plan in the new NHS Oversight Framework and have asked organisations to provide oversight of this work to the Trust Board.

The ten-point plan NHS England » 10 Point Plan to improve resident doctors' working lives is as follows:

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 two 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.

In mid-September MELT members, the Medical Dignity at Work Champion alongside the Medical Staffing Manager met with resident doctor representatives and discussed and agreed a provisional position for the organisation and set some actions. It was agreed the group would meet regularly to update progress and report back to the Trust Board.

One of the actions from the meeting held was the appointment process for a new peer representative that would have regular contact with the Executive Lead, Dr Kedar Kale, Executive Medical Director, and would also report to the Trust Board (point 4). Communication was sent regarding the process alongside a request for expressions of interest to be submitted. This was to allow a panel to be formed, made up of resident doctors and a member of MELT, who would then shortlist, interview and appoint a representative. Once appointed the named doctor will attend Trust Board meetings and provide updates and progress from the working group.

5.3 **Assessing the cost-effectiveness of the Faculty of Medical Education**

MELT have agreed that an exercise will be undertaken to provide assurance to assess the cost-effectiveness and efficiency of all FoME tutor posts to provide assurance to the Trust Board that the FoMe is "Value for Money" and that resources are correctly allocated.

As reported in the executive summary section TEWV received over **£10.6 million** during the 2024 / 2025 academic year via the EFA to support the salaries and educational infrastructure required to deliver both undergraduate and postgraduate medical education placements. TEWV utilised these funds to support the costs associated with FoME tutor posts *(Appendix 19)* with a further proportion of the funding being allocated to clinical service budgets to support all multi-professional groups involved with the delivery of medical education.

To ensure transparency and assurance regarding the utilisation of the funding received via the EFA, MELT has already commenced work to introduce regular FoME

developmental reviews and have designed and agreed upon a template (*Appendix 20*) to use whilst conducting developmental review meetings. MELT have also agreed a developmental review structure (*Appendix 21*) and all MELT members are aware of which FoME tutor post they will be the reviewer for once the process is introduced at the Medical Educators and Medical Leaders event.

In order to enhance this new process MELT will ensure that each FoME tutor post has at least one measurable KPI set each year. The individual KPIs will be agreed collectively by MELT and will align to the overarching MELT strategic objectives and will be measured during MEC meetings throughout the year.

6. ACTIONS

6.1 To address the risks outlined in this report, MELT have agreed high level objectives for 2026. These objectives are detailed below and also in *Appendix 22.*

- With input from an identified Senior Registrar review the role of resident doctors within an inpatient setting – ADME North / ADMD
- Implementation and monitoring of Faculty developmental review structure – HME
- Introduction of a CPD Academy – ADMD / HME
- Enhance quality assurance processes to ensure resident doctor inductions are effective – ADME South
- Explore the effectiveness, motivation and impact on providing UG Clinical placements by incentivisation – ADME UG
- Utilising Out Of Hours provision for medical students on placement – ADME UG
- Developing a practical approach to increase opportunities for the use of artificial intelligence in medical education - DME

7. CONCLUSIONS

7.1 The Trust continues to have a pro-active and strong FoME. Feedback demonstrates more than ever that despite ongoing challenges; the Trust continues to achieve exceptionally high results in relation to the delivery of all medical education programmes.

8. RECOMMENDATIONS

8.1 It is recommended that the Trust Board note the content of this paper and take good assurance from it.

Authors: **Hayley Lonsdale, Head of Medical Education**
Medical Education Leadership Team (MELT)

Appendices

Appendix 1: Medical Student Internal Feedback 2024 / 2025

Appendix 2: 2024 / 2025 Quality Improvement Plan (QIP)

Appendix 3: 2024 Self-Assessment Report (SAR)

Appendix 4: 2025 GMC Trainee Survey Report

Appendix 5: 2025 GMC Trainer Survey Report

Appendix 6: TEWV Internal Educational Audit Framework v8.0

Appendix 7: Medical Education Operating Framework v16.0

Appendix 8: NHS England Safe Learning Environment Charter

Appendix 9: Simulation Strategy

Appendix 10: TEWV Medical Workforce Charter 2023

Appendix 11: Trainer Charter

Appendix 12: Resident Doctor Charter

Appendix 13: Medical Student Charter

Appendix 14: CPD Programme

Appendix 15: Supporting, Promoting and Developing Educational Environments

Appendix 16: Task and Finish Focus Group Actions – October 2025

Appendix 17: 2025 MELT Objectives

Appendix 18: 2025 TEWV Differential Attainment Report

Appendix 19: Faculty of Medical Education Structure Chart – October 2025

Appendix 20: Faculty of Medical Education Developmental Review - Template

Appendix 21: Faculty of Medical Education Developmental Review Structure

Appendix 22: 2026 MELT Objectives

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 11 December 2025		
Date of last meeting: 4 September 2025	**Report of: The Quality Assurance Committee**	
	Quoracy was achieved.	
1	**Agenda -** The Committee considered the following matters: • Minutes of meetings held on 3 July 2025 • Board Assurance Framework • Summary of the Executive Review of Quality Group meetings held on 22 July and 26 August 2025 • Trust Level Quality Governance Report • CQC Activity and Delivery of the Integrated Oversight Plan and Improvement actions • Quality Priorities • Waiting Times • Clinical Outcomes Improvement Plan • Drug and Therapeutics • Rehabilitation Service Model • Learning from Deaths • Positive and Safe • Organisational Learning Group • Appreciative Inquiry of Unexpected Inpatient Deaths • Quality Impact of Services Requiring Additional Support (SRAS) - NYYS • Acute Care – Occupancy and Flow • Annual Staffing Establishment Review 2024-2025 • Section 17 Leave • Duty of Candour • Outcome of the Annual Committee Performance Assessment 2024/25 • Terms of Reference • Committee Workplan	
2a	**Alert**	The Committee alerts the Board on the following matters: There is increased oversight on Orchard ward linked to clinical leadership. A peer review exercise has been undertaken in liaison with DTVF with weekly update meetings in place to monitor progress. After action reviews are being checked to ensure high priority patients are considered first. Seven individuals on Bankfields remain ready for discharge. Discussions with key stakeholders continue. The answer rate for crisis triage calls is a concern. A deep dive by general managers is underway, which DTVF are supporting.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: TEWV has won numerous awards at the positive practice mental health awards. There is good assurance on progress with the quality priorities. The CQC have begun recent unannounced MHA visits in September and the quality governance team are preparing staff and responding appropriately. A full briefing will be provided to the October Committee meeting.

		Committee confirmed there is reasonable assurance for clinical outcomes. Substantial assurance was confirmed for the Medicines Optimisation and Pharmacy Annual Report 45/45. There is good assurance on reporting and learning in line with national guidance for learning from deaths. There is reasonable assurance demonstrated on progress against the positive and safe strategy. There is good assurance from the Organisational Learning Group on outputs and shared learning.
	Advise	The Committee wishes to advise on the following matters to the attention of the Board: Assurance was sought on patients receiving copies of care plans. Ongoing challenges were noted linked to Cito. The clinical audit on supervision is due to report to the Audit and Risk Committee in December. A substantive report was requested by the Chief nurse from the care groups on clinical supervision. BAF: Committee supported the reduction of risk scores for BAF risk 4: quality of care and 8: quality governance. It has been agreed that the BAF will now also report into the Executive Risk Group. Committee took good assurance on the management of the strategic risks assigned to it. Perinatal service NYYS. Monitoring and oversight is being stepped back down to the Executive Directors' Group governance layer, following evidence of improvements considered in the meeting. Reasonable assurance for section 17 leave. Reasonable assurance for compliance with duty of candour. **Restrictive Practice:** Tear proof clothing – 2 uses. Mechanical restraint – 7 uses, 2 of soft cuffs in SIS, 3 Northdale and 4 Jay linked to appointments. NYY – no seclusion Two intentional prone restraint (Merlin to exit seclusion) One unintentional prone restraint (incident on Bransdale) Seclusion – no remote seclusion reviews Long Term Segregation – Sis 1 Eagle, 1 Osprey, 1 ALD. Reviews undertaken in line with policy.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that the risks to quality are understood and are being managed appropriately.
3	**Actions to be considered by the Board**	That the Board note the report and take good assurance that there is good oversight and management of risks to quality of care.
4	**Report compiled by**	Jules Preston, Acting Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Kedar Kale, Executive Medical Director and Donna Keeping, Corporate Governance Manager

Committee Key Issues Report		
Report Date to Board of Directors – 11 December 2025		
Date of last meeting: 27 November 2025		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda -** The Committee considered the following matters: • Minutes of meeting held on 2 October 2025 • Board Assurance Framework • Corporate Risk Register • Summary of the Executive Review of Quality Group meeting, held on 28 October 2025 • Trust Level Quality Governance Report, including Quality Dashboard • CQC Activity and Delivery of the Integrated Oversight Plan and Improvement actions • Safer Staffing • Impact of statutory/mandatory compliance on regulation and quality of care • Timeliness of Incident Reviews • Lived Experience Strategic Leadership and Advisory Group • Complaints and Carer/Patient Experience • Changes to Quality Governance at an Executive Level • Update on System and Trust approach to all age assessment and treatment for ADHD and autism • Quality Impact Assessments • Winter Plan – final submission • Medical Devices • Resuscitation Service • Committee Workplan - noted	
2a	**Alert**	The Committee alerts the Board on the following matters: The combined Integrated Care Group Governance Quality Report, November 2025 considering October 2025 brought attention to: • Ongoing concerns linked to those waiting to access community mental health in Ripon/York and Selby. • Tunstall and Danby wards have triggered more focus required on the quality of care, although improvements have been seen in recent weeks. • The Royal Victoria Infirmary, Newcastle has given notice on ward 31A, eating disorders and have asked if there is a possibility that Birch ward could accommodate the inpatient requirements across the provider collaborative. • Services continue to highlight concerns in relation to their ability to access patient record systems in a timely way due to ongoing issues with CiTO. • As of 1 October, there were 369 incidents overdue initial review. This is a reduction on the previous month 116↓ in DTVF and 253↓ in NYY. Review of outstanding incidents has identified that for two teams with the highest incidents are all historic non-patient safety incidents and for one team the majority are non-patient safety incidents. Committee expressed ongoing and significant concern linked to compliance with clinical supervision, following the outcome of the Internal Audit report, with limited assurance. Clinical supervision is a substantive issue on the December QAC agenda due to it being a recognised risk.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board:

- Improvements have been made in Perinatal Services in NYY and ongoing monitoring will be looking for an embedded position and sustainability of improvements in waiting times and caseloads.
- The trajectory of improvements for reducing restrictive interventions continues and is monitored via the care groups and the Quality Assurance Committee. The aspiration is to eradicate the use of prone restraint, which is now down to single numbers and to reduce further uses of other floor-based restraints.

Board Assurance Framework:
Committee agreed:

i) that the BAF (Quarter 2) provides good assurance that the strategic risks continue to be managed effectively.
ii) That a recommendation be made to the Board of Directors to formally close BAF risk 4 (Quality of Care) and 8 (Quality Governance), noting the Chief Nurse's proposal to restate the former risk clearly narrating that we will always be looking for variants in quality, with more nuanced actions set out.

Corporate Risk Register:
Good assurance is confirmed relating to the oversight and management of the organisation's corporate risks.
Committee requested that:

i) The risk relating to supervision be re-visited considering the outcome of the Internal Audit report.
ii) Risk 811 be restated to include other means and methods of self-harm, not just ligature anchor points.
iii) The outcome of Internal Audit reports and recommendations are aligned with the CRR.
iv) The reduction of the risk score 129: CYP neuro waiting times be re- visited following the reduction in score from 15 to 12.

The six-monthly reports were received from Medical Devices and Resuscitation services for information with good assurance on the development and progress of medical device services; however, gaps remain in asset data completeness and incident reporting – corrective measures are being implemented. Good assurance also on the current standards, processes to meet compliance with regulation in Resuscitation services.

A new triple A report was well received from Quality Governance, which highlighted the key matters linked to the Quality Assurance Dashboard, CQC regulatory activity and the Quality Assurance Programme.

Committee confirms there is good assurance relating to progress against the Integrated Oversight Plan, as well as CQC activity. Eight out of fourteen actions are now complete in the Improvement Plan, with two behind target dates for completion relating to review of policies for blanket restrictions and training to support staff understanding patients' rights (Action 47). An extension was approved to extend action 47 to March 2026, to allow time for delivering the training, the other over due action is due for completion week commencing 8 December 2025.

Good assurance is confirmed through the ongoing improvements in the oversight of staffing, with a downward trend in the number of agency staff. A written plan about level loading leave is being considered to drive forward further efficiencies.

There is good assurance relating to the approach, pipeline and governance over Quality Impact Assessments (QIA).

Reasonable assurance is confirmed in relation to actions to mitigate against progress of the lived experience strategy. Multiple awards have been won for the Trust's peer support worker initiative and there are now 40 across the organisation. Committee are interested in

		the disparity of peer support across the care groups with a much smaller peers working across NYY services.
	Advise	The Committee wishes to advise the Board on the following matters: Consideration was given to a report on statutory/mandatory compliance, where improvements are noted, however further understanding is needed on any impact to the provision of quality care, especially in relation to ensuring training is undertaken and staff are fully compliant to practice. The uptake of the flu campaign has been slow, which is a regional and national picture. (Position is 39%). Following the verbal update on the Winter Plan**,** which Non-Executive Directors considered under emergency powers in October, the final version was received for information. **Restrictive practice:** The number of restrictive interventions used at Trust and Care Group level has increased in month, however, remains within normal variation. **Seven Mechanical Restraint:** applications, soft cuffs Secure Inpatient Services, Four Jay, one Brambling, one Merlin, one Sandpiper related to external Trust appointments. **Two uses of Tear Proof Clothing:** one Bedale, one Cedar (to prevent risk to self). **Three Intentional Prone Restraint:** one Cedar (initiated by police), two Bedale seclusion exit. **Five Unintentional Prone Restraint:** one Merlin, one Newtondale, three Bankfields Court. Committee challenged the increased rate of assurance from good to substantial for incidents of tear proof clothing and mechanical restraint, which after having a period of improvements had declined in the last month. Committee received a paper on the Trust wide approach to all age assessment and treatment for ADHD/autism and noted the ongoing collaboration with both ICS' about to the future service models and the emerging approach to clinical prioritisation. With the introduction of a new patient feedback platform (I Want Great Care), the changeover in system has as expected led to a reduced number of responses being received: (411) 93.19% had a positive experience. DTVF 292 responses (92.47% reporting a positive experience). NYYS 119 responses (94.96% reporting a positive experience). Carer experience is unavailable due to the introduction of I Want Great Care. Committee agreed there is good assurance for complaints (94% response rate) and reasonable for patient/carer experience. The Committee time out day will take place on 2 February 2025 and as well as considering matters linked to governance, members are keen to understand the plans and progress being made to improve compliance with clinical supervision and the impact on providing quality care, something which crosses over People and Culture and Resources and Planning. Looking ahead to 2026, Committee will prioritise the areas of highest risk linked to the organisation's strategic risks, together with ensuring fundamental standards are being met. Consideration is being given to reporting at Executive level. Two workshops will be held by the Executive Director's Group, one has taken place in November with the second in December to discuss and identify any improvements in the governance arrangements relating to quality.
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**	*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) That the recommendation to formally close BAF risk 4 (Quality of Care) and 8 (Quality Governance) be supported.*

	by the Board	
4	**Report compiled by**	Jules Preston, Acting Chair of the Quality Assurance Committee, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manager

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11 December 2025**
Title:	**Learning from Deaths**
Executive Sponsor(s):	**Kedar Kale, Executive Medical Director**
Author(s):	**Amy Taylor, Head of Patient Safety**

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

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

1: We will co-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*
8	**Quality Governance** - There is a risk that our floor to Board quality governance does not provide thorough insights into quality risks caused by the need to further develop and embed our governance and reporting including triangulating a range of quality and performance information resulting in inconsistent understanding of key risks and mitigating actions, leading to variance in standards.	There is a risk that if we fail to embed key learning from deaths, patient safety and quality will be compromised and the people we serve will lose confidence in the services we provide. This paper sets out key processes for mortality reviews and learning from deaths including patient safety incident investigations across the Trust to reduce and mitigate this risk.
10	**Regulatory compliance** - There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation	

Executive Summary:

Purpose:

The national guidance on learning from deaths requires each Trust to collect and publish specific information. This report covers the period from July to September 2025 (Quarter 2). Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

All NHS Trusts must publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy and have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an

initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) are in Appendix 2.

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

Overview:
In line with National Guidance the Learning from Deaths Dashboard at appendix 1 details Q2 information for the Trust and includes 2024/25 data for comparison.

- During Q2 508 deaths were reported on Inphase of patients who had been in contact with our services in the 6 months preceding the date of death. Of these, 309 patients were still open to a Trust service at the time of their death, of which 7 patients were open to an Adult Learning Disability service. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were open to the Trust's caseload which is largely community and includes older people and memory services (>70,000).
- 4 inpatient deaths were reported. 2 of these deaths were expected and subject to part 1 reviews. Both deaths occurred in Mental Health Services for Older People (MHSOP) wards.
- Of the remaining 2 deaths, 1 occurred in an Adult Mental Health (AMH) ward and 1 occurred in an MHSOP ward. Both deaths have been reported on the national Strategic Executive Information System (StEIS) and are subject to a Patient Safety Incident Investigation (PSII). The AMH patient death was reported as suspected suicide and occurred on the ward and the MHSOP patient death was reported as physical health related.
- 2 unexpected community deaths were reported on StEIS during the reporting period and are being investigated as a PSII.
- Immediate After Action Reviews were conducted or are in progress for all the above PSII deaths and where appropriate, rapid improvements have been made to improve patient safety.
- All PSIIs have commenced.
- 15 Part 2 Structured Judgement Reviews (SJRs) were requested.
- 69 Part 1 reviews and 22 SJRs were completed.
- 7 Patient Safety Incident Investigations for unexpected deaths were completed.
- 20 patient deaths were reported to LeDER during Q2. 19 of the 20 patient deaths occurred in Q2 and 1 in Q1. All deaths of people with either a learning disability or a diagnosis of autism require reporting to LeDER in line with national requirements over the reporting period. Deaths are reported to LeDER via the clinical teams and the Patient Safety Team have added a prompt to all After Action Review and Mortality Review documents. It has also been built into the InPhase reporting system since 30th October 2023. Any discrepancies in reporting are being followed up by the Patient Safety team. Reasons given for not reporting have been identified as deaths occurring in the Acute Trust or a Care home and it was assumed by the TEWV clinical team that the team providing 24-hour care had submitted the referral. Teams are being asked to confirm this with those providers.

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

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

- 2 in relation to environmental risks and issues (Oxehealth)
- 2 in relation CITO recording and alerts
- 2 in relation to medical devices.
- 1 in relation to other clinical systems (Web ICE)

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

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

Prior Consideration and Feedback

Updates and assurance aligned to improvement work relating to learning from deaths is reported to the Executive Directors Group. This includes regular updates on the Quality Assurance schedule (providing assurance of compliance against key patient safety policies such as leave, clinical record keeping, risk assessment and management, observation and engagement) as well as updates on key areas that sit within our Quality and Clinical journeys that relate to themes from patient safety incidents such as progress following implementation of the patient safety incident response framework (PSIRF). Themes of learning are reported into the Trust wide Organisational learning group to support organisation wide learning. Quality Assurance will have the opportunity to review the report in detail at its meeting on 22 December – this would usually take place prior to Board, but it was necessary to move the committee meeting.

Implications:

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

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

Recommendations:

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

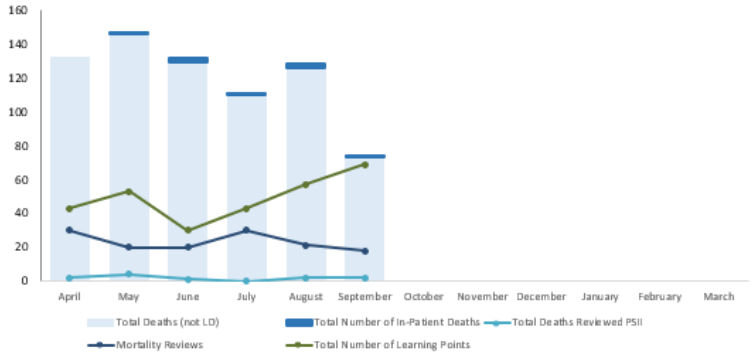
Appendix 1: Learning from Deaths Dashboard Q2 2025/26

Learning from Deaths Dashboard - Data Taken from Cito
Reporting Period - Q2 2025-26

Summary of total number of deaths and total number of cases reviewed under the Patient Safety Incident Response Framework (PSIRF) or Mortality Review

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

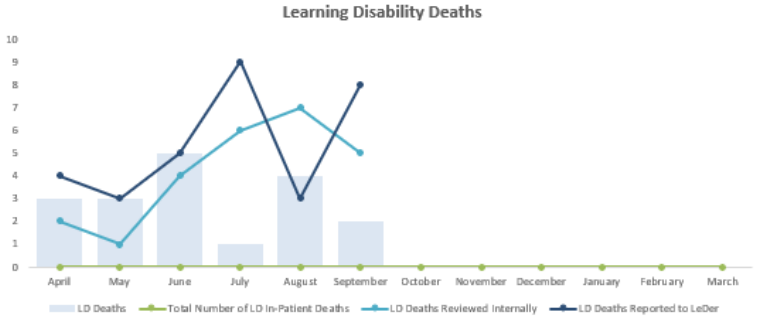
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed PSII		Mortality Reviews		Total Number of Learning Points	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2024/25	2024/25
Q1	407	↘ 453	4	↘ 5	7	↘ 32	70	↗ 52	126	↗ 123
Q2	309	↘ 445	4	↘ 7	4	↘ 28	69	↗ 55	169	↗ 125
Q3	0	↘ 483	0	↘ 8						
Q4	0	↘ 460	0	↘ 6						
YTD	716	↘ 1841	8	↘ 26	11	↘ 60	139	↗ 107	295	↗ 248



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

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

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25
Q1	11	↘ 25	0	↘ 1	7	↗ 6	12	↗ 9
Q2	7	↘ 20	0	↔ 0	18	↗ 9	20	↗ 14
Q3	0	↘ 26	0	↔ 0				
Q4	0	↘ 19	0	↔ 0				
YTD	18	↘ 90	0	↘ 1	25	↗ 15	32	↗ 23



Appendix 2

Mortality Reviews 2025/2026

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

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

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

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

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

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2025/2026

22 structured judgement reviews were discussed and reviewed by the Mortality Review Panel during Q2.

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

- Clinical Effectiveness Personalised Care (consideration of Dual Diagnosis needs)
- Safeguarding
- Medicines Management

Learning from actions/assurance

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

Learning from mortality reviews often demonstrate similar themes identified during After Action Reviews (AARs) or Patient Safety Incident Investigations (PSIIs). The themes from mortality reviews are triangulated with learning from AARs/PSIIs to establish any new themes occurring.

1.2 Learning from deaths and patient safety incidents

Within Quarter 2 there were a total of 169 learning points identified through Patient Safety Incident Investigations, After Action Reviews and mortality reviews following patient deaths. The most frequent actionable learning theme identified related to Communication. Clinical Effectiveness/Personalised Care was the second most frequent learning theme identified.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

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

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Any significant issues identified by the OLG are escalated to the Executive Directors Group – Quality and Performance for further discussion and or actions. The OLG now has a 12-month workplan based on the recurring themes identified.

Monthly Organisational learning webinars take place which are designed to encourage collaboration and share valuable insights across our clinical communities. Topics that have been explored during Quarter 2 have included The Patient Carer Race Equality Framework and The Power of Family Engagement within Patient Safety.

1.3.3 Patient Safety Incident Management/Investigation

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

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

1.3.4 The Environmental Risk Group

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

1.3.5 Recruitment and Retention/staffing establishment reviews

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

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NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**Thursday 11th December 2025**
Title:	**Research & Development Annual Report 24/25**
Executive Sponsor(s):	**Dr Kedar Kale, Executive Medical Director**
Report Author(s):	**Sarah Daniel, Head of Research**

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

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

1: We will co-create high quality care	**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*
4	**Quality of Care**	There is a risk that we will be unable to make improvements in the quality of care consistently and at the pace required across all services caused by shortage of research and innovation funding resulting in a variance in experience of care and limiting access to innovative treatments.

EXECUTIVE SUMMARY:

This paper and the accompanying annual report provide an update on the 2021-2026 R&D plan. 2024/25 marked another period of significant achievement for R&D in TEWV. During this year we continue to provide assurance in maintaining high standards of research governance through regular audits and performance monitoring which safeguard the integrity and quality of research activities. We have increased activity in all stages of the research cycle from ideas development through to delivery, dissemination and implementation with a strong focus on co-production through each stage.

Notable this year is the number of interventional research studies that we are delivering to people using our services. This provides people with the opportunity to access a wider range of new innovative research treatments during their care pathway including individual and group therapies and novel drug treatments.

As we come to the end of our current 5-year R&D plan in 2026, we recognise the challenges ahead in capacity to lead large scale grant applications in TEWV and look forward to collaborating with key stakeholders to discuss, develop and plan our next ambitious priorities.

We thank our staff, research participants and partners for their continued commitment to research and look forward to building on this year's successes.

Purpose:

To provide assurance to Board of Directors on R&D activity in TEWV for the period 1st April 2024 to 31st March 2025.

Proposal:

As above

Overview:

Research Governance Assurance is overseen by the Research Governance Group and reported into the Quality Assurance Committee biannually. This report for Board of Directors provides a wider annual report celebrating the key achievements and successes and demonstrating the growth of research activity in TEWV. Key successes include:

- TEWV ranked 4th nationally for the number of interventional portfolio studies open to recruitment
- We have increased commercial research activity providing more treatment options for people using our services
- 90% of participants would consider taking part in research again
- Monitoring and auditing of research on track with target
- We were awarded 3 new NIHR grants totalling £2.2M
- Key findings from research sponsored by TEWV has been reported in The Lancet Healthy Longevity
- We developed a wider range of career development opportunities suitable from student level to experienced staff and are a key partner working with a Mental Health Leader Award in Teesside
- Our Research finance totalled £3.1M in 24/25 demonstrating the growth in research activity and supported by TEWV
- We celebrated an annual R&D conference showcasing our research activity to over 150 attendees
- We are regularly disseminating results of research studies
- 75 High and Low intensity CBT therapists have been trained in a one session phobia treatment for children demonstrating how research results can be translated into practice.

Prior Consideration and Feedback:

Presented and discussed at Executive Directors Group 02/12/25 feedback included considerations and plans for maintaining external funding streams in future years.

Implications:

Clinical research is now a key part of improving patient care. Research is written into the NHS Constitution, and this is backed up through the CQC inspection process. We have a duty to offer research opportunities to people receiving services across our geographies and through our clinical networks.

External R&D research income to TEWV for 24/25 was £2.9M, an increase in £1.7M from 19/20. This funding is directly spent to deliver research projects demonstrating the growth in research activity in the organisation.

Work is planned during 25/26 to record further details on equality diversity and inclusion of people taking part in research across the Trust.

Recommendations:

To receive and approve the TEWV R&D Annual Board Report 24/25

journey to change

NHS
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NHS Foundation Trust

Respect Compassion Responsibility

RESEARCH AND DEVELOPMENT

2024/2025

Annual Board Report

NIHR | Be Part of Research

NIHR | National Institute for Health and Care Research

Join dementia research

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Executive Summary

The financial year 2024/2025 marked another period of significant achievement for Research and Development at Tees, Esk and Wear Valleys NHS Foundation Trust. This annual report provides a summary highlighting key outcomes.

The Trust continued to advance its 5-year R&D plan, focusing on three main priorities:

- ✓ Demonstrating growth in research activity.
- ✓ Developing pathways for the next generation of researchers and research careers for TEWV staff.
- ✓ Working in partnership with key stakeholders to develop new research and increase research income.

During this year we continue to provide assurance in maintaining high standards of research governance through regular audits and performance monitoring which safeguard the integrity and quality of research activities. We have increased activity in all stages of the research cycle from ideas development through to delivery, dissemination and implementation with a strong focus on co-production through each stage.

As we come to the end of our current 5-year R&D plan in 2026, we recognise the challenges ahead in capacity to lead large scale grant applications and look forward to collaborating with key stakeholders to discuss, develop and plan our next ambitious priorities.

We thank our staff, research participants and partners for their continued commitment to research and look forward to building on this year's successes.

NIHR Portfolio Research Activity

Ranked 10th nationally*

428
Participants took part in NIHR Research

281 10th
Participants in Interventional Research

29
NIHR Portfolio Studies Open to Recruitment

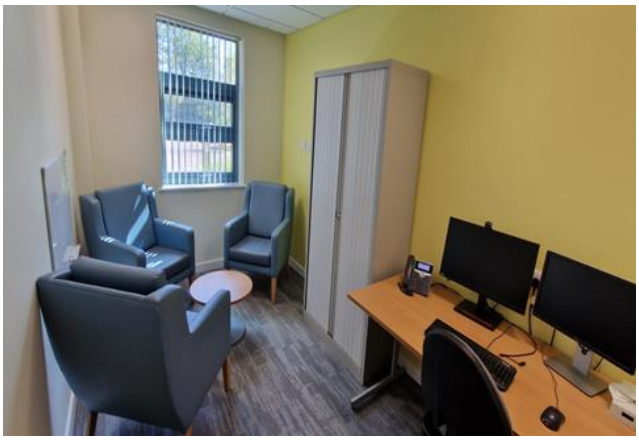
18 4th
NIHR Interventional Portfolio Studies Open to Recruitment

Ranked joint 4th nationally*

*Out of 54 Mental Health Trusts

Commercial and Interventional Research

As part of our partnership with the University of York, we provide a shared space at Foss Park Hospital in York to deliver more interventional and commercial research trials offering new treatments and therapies to people in our Trust.



In 2024/2025, we recruited 10 participants to a commercial study with adult ADHD.

We have expressed an interest with commercial sponsors to attract new research to our Trust and have been selected as a site for a new disease modifying treatment for Alzheimer's disease.

Participants in Research Experience Survey (PRES)

100

Participants completed the survey

90%

"I would consider taking part in research again"

95%

"Research staff always treated me with courtesy and respect"

"I feel taking part in research is a positive thing."

"It was a good opportunity, and I found it beneficial."

"Knowing it may help others."

Helps us to understand the condition better and it helps people in the future."

"Everyone was compassionate and respectful and made me feel safe and cared about."

"I found it a good experience, and I would advise anyone to do it."

Research Governance

The Research Governance Group meets quarterly and reports into the Quality and Assurance Committee. Research Governance Group provides assurance to Board of Directors through monitoring of quality and performance indicator data, ensuring the Trust is compliant with the UK Policy Framework for Health and Social Care Research.

DELIVERABLE	CURRENT STATUS
Studies on course to achieve local recruitment target	• We have **73.91%** of studies currently recruiting to time and target
% of new studies set-up within 40 days	• Currently 3 studies are with Information Security Team for review of Data Flow Forms • Studies set up within 40 days for this financial year is **56%**
% Clinical Networks engaged in grant research	• All Clinical Networks are active in applying for grant funded and sponsored research
Monitoring/audit (3 visits target per quarter)	• Continue to be on track with completing 3 audits/visits per quarter

Research Grant Success

The 2024/2025 was our busiest financial year to date for supporting the development of new grant applications. We applied for a total of **33 new research grants (5 as a sponsor and 28 as a co-applicant).**

We were awarded 3 new grants as sponsor:

Lifestyle Energy Activity and Nutrition (LEAN) programme in Learning Disabilities **Led by Jo Smith, TEWV and Prof. Emma Giles, Teesside University**	**£96,479**
Partnership working with Gypsy, Roma and Traveller communities to co-design accessible services for mental health **Led by Prof. Martin Webber, University of York**	**£153,721**
Mental health as a determinant of work: Evaluating the impact of the national NHS Talking Therapies Employment Advisers Programme on mental health, work, inequalities, costs, and the economy (Support2Work) **Led by Prof, Rowena Jacobs University of York**	**£1,986,402**

And

7 x Grants Awarded with TEWV as the co-applicant	**Total £41,779**

Studies Sponsored by TEWV in 24/25

Managing Multiple Health Conditions in Older Adults and Behavioural Activation in Social IsoLation

NIHR awarded £2.8M. Prof. Dave Ekers TEWV and Prof. Simon Gilbody, University of York. 2018-2025

Community-based Behavioural Activation Training for Depression in Adolescents.

NIHR awarded £2.1M. Prof. Lina Gega, University of York. 2021-2026

AD ASTRA Adjunctive dog-assisted interventions to improve mental health: a research development programme

NIHR awarded £163K. Dr Elena Ratschen, University of York. 2023-2027

Increasing accessibility of affordable healthy food to adults living with Severe Mental Illness in Middlesbrough

NIHR awarded £128K. Jo Smith, TEWV and Prof. Amelia Lake, Teesside University. 2023 – 2024

Strengthening Crisis Team Provision for Young People via Technology-enhanced Assessment and Training (SCriPT)

NIHR awarded £153K. Prof. Paul Tiffin, University of York. 2024 –2025

Crossing boundaries: Exploring effective approaches to partnership working with Gypsy, Roma and Traveller communities to co-design accessible services and support for mental health

NIHR awarded £153K. Prof. Martin Webber, University of York. 2024 – 2026

SIESTA - Co-designing a low-intensity sleep intervention for adults in a psychiatric inpatient setting

NIHR awarded £153K. Dr Anne Aboaja, TEWV and Prof Amanda Perry, University of York. 2024 –2026

Developing an NHS, university, voluntary and community sector team to develop a Lifestyle Energy Activity and Nutrition (LEAN) programme in Learning Disabilities

NIHR awarded £96K. Jo Smith, TEWV and Prof Emma Giles, Teesside University. 2025

Spotlight studies

MODS and BASIL+

Prof. Dave Ekers TEWV and Prof. Simon Gilbody, University of York

Older adults with multiple long-term conditions (LTCs) are 2–3 times more likely to experience depression, which can worsen health outcomes and quality of life. The MODS (Multi Morbidity in Older Adults) programme focused on people aged 65 and over with two or more LTCs and depression. The aim was to develop and evaluate a brief psychological intervention specifically behavioural activation (BA) to improve both physical and mental wellbeing in this population.

In March 2020, the COVID-19 pandemic halted the MODS programme of research. The MODS team discussed how the COVID-19 pandemic, especially the lockdowns, significantly disrupted the lives of older adults, increasing social isolation a known risk factor for loneliness and depression. The team developed the BASIL research programme (Behavioural Activation in Social Isolation) as an adaptation of the MODS intervention to address the unique challenges posed by social isolation during the pandemic. A full randomised controlled trial, BASIL+ starting national recruitment in February 2021.

The BASIL booklet was co-developed with stakeholders, and support was provided by trained BASIL Support Workers. The intervention was delivered remotely (telephone or video call), in up to 8 sessions, with an average of 5.2 sessions completed. 449 older adults were recruited from 12 sites across England and Wales and results are published in The Lancet Healthy Longevity.

- Behavioural activation is an effective and potentially scalable intervention that can reduce symptoms of depression and emotional loneliness in at-risk groups in the short term.
- The findings of this trial add to the range of strategies to improve the mental health of older adults with multiple long-term conditions.
- These results can be helpful to policy makers beyond the pandemic in reducing the global burden of depression and addressing the health impacts of loneliness, particularly in at-risk groups

Increasing accessibility of affordable healthy food to adults living with Severe Mental Illness in Middlesbrough

Jo Smith, TEWV and Prof. Amelia Lake, Teesside University

Over 50% of adults with SMI in Northern England experience food insecurity, while the UK food industry wastes 10.7 million tonnes of surplus food annually. This study tested a co-produced intervention to improve diet quality and wellbeing using surplus food.

People with a Severe Mental Illness were invited to attend 15 weekly group sessions to develop healthy recipes and three people chose to attend. They planned, cooked, and tasted four different meals and chose their favourite. The meal was then made into frozen ready meals at Teesside University and taken to three different Eco Shops in Middlesbrough. Customers selected the ready meals from the Eco Shops and answered a questionnaire about this. They were given a £10 voucher for their time. An online team survey was distributed to the research team to evaluate the new partnership working.

Three people with Severe Mental Illness attended the group and all continued attending for 15 weeks. They enjoyed the sessions and said the group helped their physical and mental health. They ate better at the end of the sessions and found it easier to afford food. The Eco Shop customers enjoyed the lentil bolognaise meal and said they would buy this again. Nine participants completed the team evaluation survey. The survey found mixed satisfaction on a range of issues including unclear leadership, and communication issues, particularly with ethical approvals and institutional procedures. However, participants valued the interdisciplinary collaboration and professional growth.

This project found that a recipe planning and cookery group was feasible and acceptable for people with SMI experiencing food insecurity. While the evaluation survey suggested partnership working had some challenges, learning points were identified for future collaborative working.

Developing the next generation of researchers and research careers

- ✓ We have developed spoke student placements with our research team for nurses and Allied Healthcare Professionals (AHPs).
- ✓ We have increased the numbers of medical and psychology staff trained supporting research across the Trust including a Rater training on a variety of Rating scales.
- ✓ We have supported the staff who have been successful in securing funded places on the Master's in Clinical Research Delivery programme and have provided mentorship during their studies.
- ✓ We have collaborated with local universities to support the staff with access to fee waiver PhDs and developed a regular intake pathway with York St John University.
- ✓ We have appointed a second clinical academic AHP post in partnership with Teesside University.
- ✓ TEWV have been represented by our staff at international research conferences.
- ✓ We have supported career development awards and pathways across our professions.
- ✓ In 24/25, our staff have published 58 articles in peer reviewed journals.

The NIHR Mental Health Leader Award (MHLA) Teesside University

TEWV is a formal mentor on a £2.5 million National Institute for Health and Care Research (NIHR)-funded Mental Health Leaders Award (MHLA) that commenced in January 2025. This five-year award is one of three national awards forming the NIHR Mental Health Research Initiative which focuses on applied mental health research in regions and/or groups where mental health research is most needed.

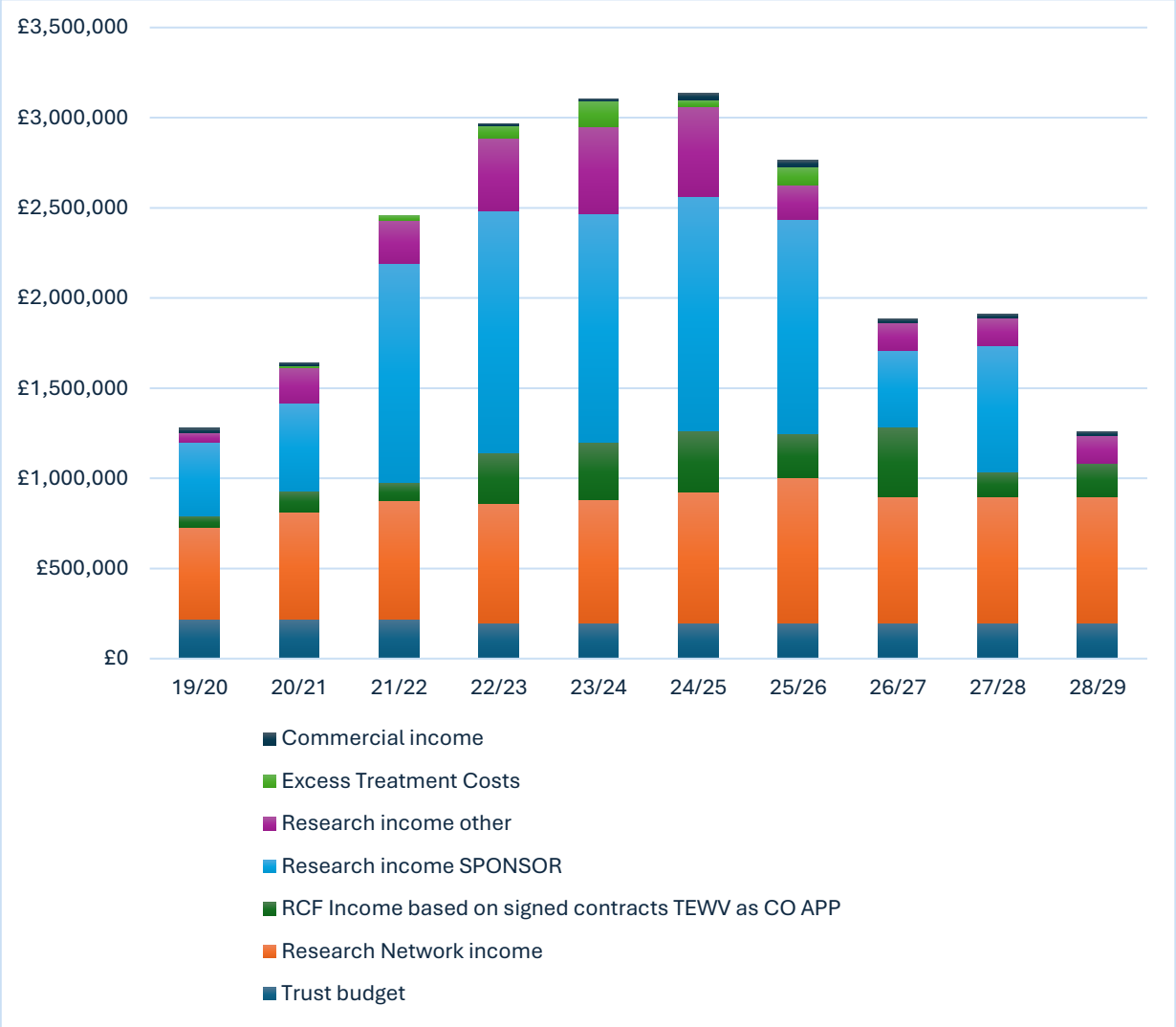
The over-arching aim of the Tees Valley MHLA is to establish a collaborative partnership across the Teesside University, the Tees, Esk and Wear Valleys NHS Foundation Trust, and the University of Manchester, to work collaboratively and complementarily to address the mental health needs of the population within the Tees Valley and wider North-East and North Cumbria (NENC) region to co-produce strategic priorities that will foster better mental health and social care research for those living in the area.

Early progress on the award includes a range of stakeholder engagement activities such as town hall-style events; a survey distributed to health, social care and voluntary sector staff; and the development of a Public and Patient Involvement and Engagement (PPIE) formal group and informal workshops. Further progress includes the development of a risk management and escalation procedure and restorative supervision for mental health researchers; the implementation of a seed corn funding competition for university staff; the development of a Research Strategy and PPIE Strategy; a successful launch event; and the co-creation of the Tees Valley MHLA logo and branding.

Plans for the next 12-months include refining the research priorities arising from the stakeholder engagement work undertaken and developing an application to become a Mental Health Research Group that will be submitted in the Autumn of 2027.

Research Funding

Research funding in 24/25 totalled £3,137,231. The largest proportion of income was from our sponsored research studies. £335K Research Capability Funding (RCF) was received and has been used to fund the increased sponsorship requirements in addition to supporting development of new NIHR grant applications in development.



Research and Development Conference 2024

The TEWV Research Conference held in May 2024 brought together over 150 leading researchers, clinicians, and professionals to showcase our innovative research activity in the Trust. The event featured a keynote address from Professor Ruth Endacott NIHR, Director of Nursing, sharing an update on NIHR career development opportunities for Health and Care Professionals.

Speakers covered a diverse range of topics including co-production in research, a showcase of our open research studies, and results from completed studies. The agenda included a series of workshops on research leadership, behavioural activation, sleep in mental health, patient and public involvement, and fostering innovation.

The conference concluded with presentations on impactful research projects, including the COMBAT and ASPECT studies, Dr Anne Aboaja presenting research impact from the forensic clinical network, followed by the recognition of outstanding poster presentations.

Dissemination of results and delivering research into practice

In collaboration with the Executive Clinical Leaders Sub-Group, a Research Brief document has been developed to provide key updates and share findings from research studies conduced in the Trust. The research brief is produced quarterly and aims to close the loop between studies delivered in TEWV and updating clinicians and staff on the findings from these.


Research brief
Report Date: 01/11/2025 - 31/01/2026
Issue: 0005

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What's happening now

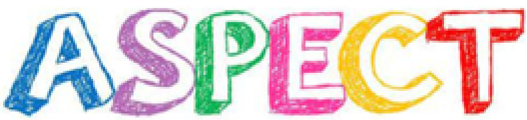
- Adult mental health research - intranet.tewv.nhs.uk/amh-research
- CAMHS research - intranet.tewv.nhs.uk/camhs-research
- Forensic services research - intranet.tewv.nhs.uk/forensic-services-research
- Staff and Other research - intranet.tewv.nhs.uk/other-research
- MHSOP research - intranet.tewv.nhs.uk/mhsop-research
- Learning Disability research - intranet.tewv.nhs.uk/ld-research

16
Studies opened and recruited into in financial year 2025/2026

305
Service users, carers or staff recruited into studies in the financial year 2025/2026

Findings From Completed Projects

Prepared by tewv.researchanddevelopment@nhs.net 1



Following a 5-year research project called ASPECT **(Alleviating Specific Phobias Experienced by Children Trial**) it was found that a 3-hour one session treatment (OST) was just as clinically effective as using graded exposure therapy which may last around 8 weeks.

Following this trial, researchers and practitioners have worked with the clinical network to train High Intensity and Low Intensity CBT therapists in OST. To date 75 professionals in TEWV across North Yorkshire and Tees have been trained. Not only has this helped with professional development, but it has ensured that our service users in TEWV are accessing evidence-based treatments

For further information please contact:

tewv.researchanddevelopment@nhs.net

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NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11.12.25**
Title:	**Innovations Annual Report**
Executive Sponsor(s):	**Kedar Kale**
Report Author(s):	**Lauren Bennett**

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**	**There is a risk that we will be unable to make improvements in the quality of care consistently and at the pace required across all services caused by shortage of research and innovation funding resulting in a variance in experience of care and limiting access to innovative treatments.**

EXECUTIVE SUMMARY:

2024/25 continues to be a successful year for Innovations in TEWV. This report presents a summary of progress to highlight some of the key outcomes, opportunities and challenges. The Innovation service has continued to champion transformative change, foster a culture of continuous improvement, and support the development and adoption of new technologies and service models that enhance patient care and operational efficiency.

In 2020 TEWV signed an SLA with Health Innovations North East and North Cumbria (HINENC) to support innovation development within the Trust to improve patient experience and deliver better health outcomes whilst contributing to economic growth. The innovations team have supported 40 staff ideas, 13 clinical challenges and 15 external collaboration opportunities.

Funding has been achieved by the current 2 part time members of the innovations team through developing strong collaborations. This is on a yearly basis and as such limits long term planning. Currently innovations are managed within R&D with oversight from the CD for R&D.

Purpose:
To provide assurance on the Innovation activity for the period 1st April 2024 to 31st March 2025

Proposal:

The Board is asked to receive the 2024/2025 Annual Innovation Report

Overview:

Background information and Context:
In 2020, TEWV signed a Service Level Agreement (SLA) with Health Innovations North East and North Cumbria (HI NENC) to support innovation development within the Trust, improve patient experience and health outcomes, and contribute to economic growth. The SLA provides £25k/year membership fee for innovation support.

- The innovations team consists of 0.5 WTE Project Manager and 0.7 WTE Coordinator, funded annually through collaborations.

TEWV's innovation programme focuses on:

1. Collating and supporting staff ideas through the innovation pathway.
2. Identifying problems and presenting solutions to enhance patient and staff care.
3. Evaluating and adopting external innovations.

- Current management: Innovations embedded within R&D, overseen by the Clinical Director for R&D.
- Limited long-term planning due to short-term funding and small team capacity.

Key Issues:

- Achievements (2024/25):

The Innovation team have supported 40 staff ideas, 13 unmet clinical needs, and 15 external innovation opportunities.
Intellectual Property supported: 6 copyright, 1 patent, 1 licensing agreement, 1 design rights.

- Exemplar Projects include:
  - AliveCor Remote ECG: This project contributed to changed NICE guidelines, saved £327k/year, improved patient dignity and staff efficiency.
  - Third Age Therapeutics Spin-Out: Partnership with University of York to reduce depression and isolation; financial benefit upon sale of the company and reputational benefits.
  - Reducing Restrictive Interventions: Innovative approach to reducing restrictive practice in ED inpatient services; patent pending.
- Collaboration Successes: Strong partnerships with industry (e.g., AliveCor) and academia.
- Challenges:
  - Limited capacity (loss of coordinator role in June 2025).
  - Need for investment in IP protection, product development and commercialisation.
  - Lack of business expertise to exploit commercial opportunities.
- Future Opportunities:
  - Innovation Academy Pilot to upskill workforce.
  - National and International commercialisation via Department of Business and Trade.
  - Potential partnerships with AliveCor and Healthcare UK.

Prior Consideration and Feedback:

The Annual Innovations Report has been considered at ECG on 02.12.25. The report was accepted and recommendations to consider included:
- linking with wider improvement work ongoing in the Trust
- productivity outcomes of innovation evaluations
- how digital innovations transition to business as usual

Implications:

Positive Implications

1. **Enhanced Patient Care and Outcomes**
    - Innovations like AliveCor Remote ECG demonstrate tangible benefits: improved patient dignity, efficiency, and cost savings (£327k/year).
2. **Reputational Gains**
    - Successful projects (e.g., NICE guideline influence, spin-out company) position TEWV as a leader in mental health innovation.
    - Strong partnerships with academia and industry enhance credibility and attract future collaborations.
3. **Economic Contribution**
    - Spin-outs and licensing agreements create potential revenue streams and contribute to regional economic growth.
    - Commercialisation opportunities via Department of Business and Trade could bring national/international recognition.
4. **Workforce Development**
    - Innovation Academy pilot could upskill staff, fostering a culture of creativity and problem-solving.

Challenges and Risks

1. **Sustainability of Innovation Programme**
    - Current reliance on short-term funding and collaborations limits long-term planning.
    - Loss of coordinator role in June 2025 reduces capacity, risking slower progress and staff disengagement.
2. **Commercialisation Barriers**
    - Lack of in-house business expertise means missed opportunities for IP exploitation and revenue generation.
    - Need for investment in IP protection and product development—without this, innovations may stall or be lost to external organisations.
3. **Financial Pressure**
    - £25k/year SLA is relatively modest compared to the scale of ambitions; additional funding streams are essential.
    - If commercialisation fails, the Trust bears the cost without financial return.
4. **Governance and Risk Management**

Embedding innovation within R&D is positive, but limited oversight and unclear accountability for commercial ventures could pose reputational and compliance risks.

Recommendations:

The Board is asked to receive the 2024/2025 Annual Innovation Report

Health Innovation
North East and North Cumbria

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Innovations Annual Report 2024-25

journey to change

Contents

Executive summary

2024/25 continues to be a successful year for Innovations in TEWV. This report presents a summary of progress to highlight some of the key outcomes, opportunities and challenges. The Innovation service has continued to champion transformative change, foster a culture of continuous improvement, and support the development and adoption of new technologies and service models that enhance patient care and operational efficiency.

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Background and context

- In 2020 TEWV signed an SLA with Health Innovations North East and North Cumbria (HINENC) to support innovation development within the Trust to improve patient experience and deliver better health outcomes whilst contributing to economic growth. Funding has been achieved by the innovations team (0.5wte Innovations Project Manager & 0.7wte Innovations coordinator) through developing strong collaborations. This is on a yearly basis.

- NHS England established Health Innovations Networks (HIN) in 2013 (formerly Academic Health Science Network) to aid adoption and spread of innovations and to improve health outcomes. There are 15 HIN's across England, each offering different services. HI North East North Cumbria choose to focus on supporting NHS innovations through an NHS Innovation programme, awarding NHS Trusts an SLA with an associated £25k pa to support innovations through the innovation pathway. The Trust pay £25k pa to HI NENC for membership which ensures the Trust is eligible for their innovation support.

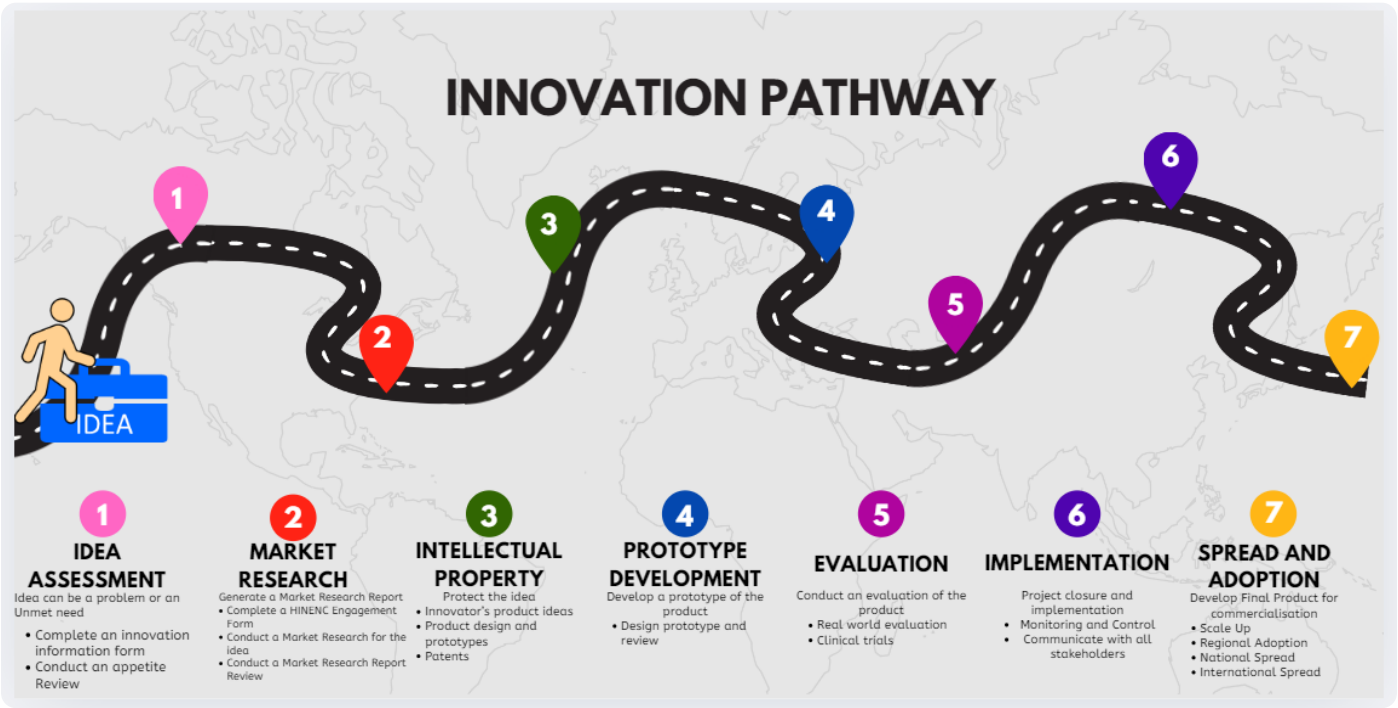
- In 2020 the Trust were successful in negotiating an SLA with HI NENC to deliver on 3 key areas: collate and support staff ideas through the innovations pathway, identify problems, present solutions to enhance patient and staff care and experience, and evaluate and adopt external innovations.

Key Outcomes and Deliverables

Intellectual Property Protection

*See IP Protection Appendix for full details

Innovation Pathway Development



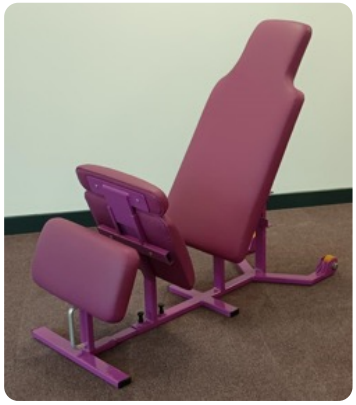
TEWV are believed to be the first Trust to co-create an innovation pathway with service users, carers and staff to combine the key stages of HI NENC innovation pathway, working with Yorkshire and Humber National Institute of Health Research ARC to input implementation science principles to increase change implementation success.

This has interest from Trusts nationally, HI NENC, HNY ICB and Department of Business and Trade due to its unique co-creation method and addition of implementation principles which should increase success rate of adoption of novel interventions. To knowledge, this is the first of its kind and regional Trusts are keen to adopt TEWV's innovation pathway.

Key exemplar projects

Key Projects	Impact and outcomes
AliveCor Remote ECG project: adoption of technology and development of a new pathway to implement the technology ALIVECOR® 	• Contributed to changing NICE Guidelines • Reduction of £327, 605 per year in time saving and technology and equipment cost savings. • 72 hours saved per team per year- can be used providing therapeutic care • Staff and service user preference • Improved service user experience, dignity, privacy, comfort, acceptance • Reported reduced instances of service users refusing an ECG • TEWV are considered the 'gold standard' of innovations and national leaders in remote ECGs in mental healthcare settings as this changed NICE guidelines • International and national presentations

Spin Out Company created between TEWV and University of York.
 	
Third Age Therapeutics: delivering behavioural activation training to reduce depression and isolation, born out of the partnership between TEWV and University of York
 	
THIRD AGE THERAPEUTICS UNIVERSITY of York
	• Intended outcomes
	  • Trust equity- financial benefit upon sale of the company
	  • Reputational gain
	  • Company will reduce loneliness, isolation and depression
	  • Joint ownership allows TEWV use of evidence-based training and materials for Trust staff and service users, providing clinical benefits

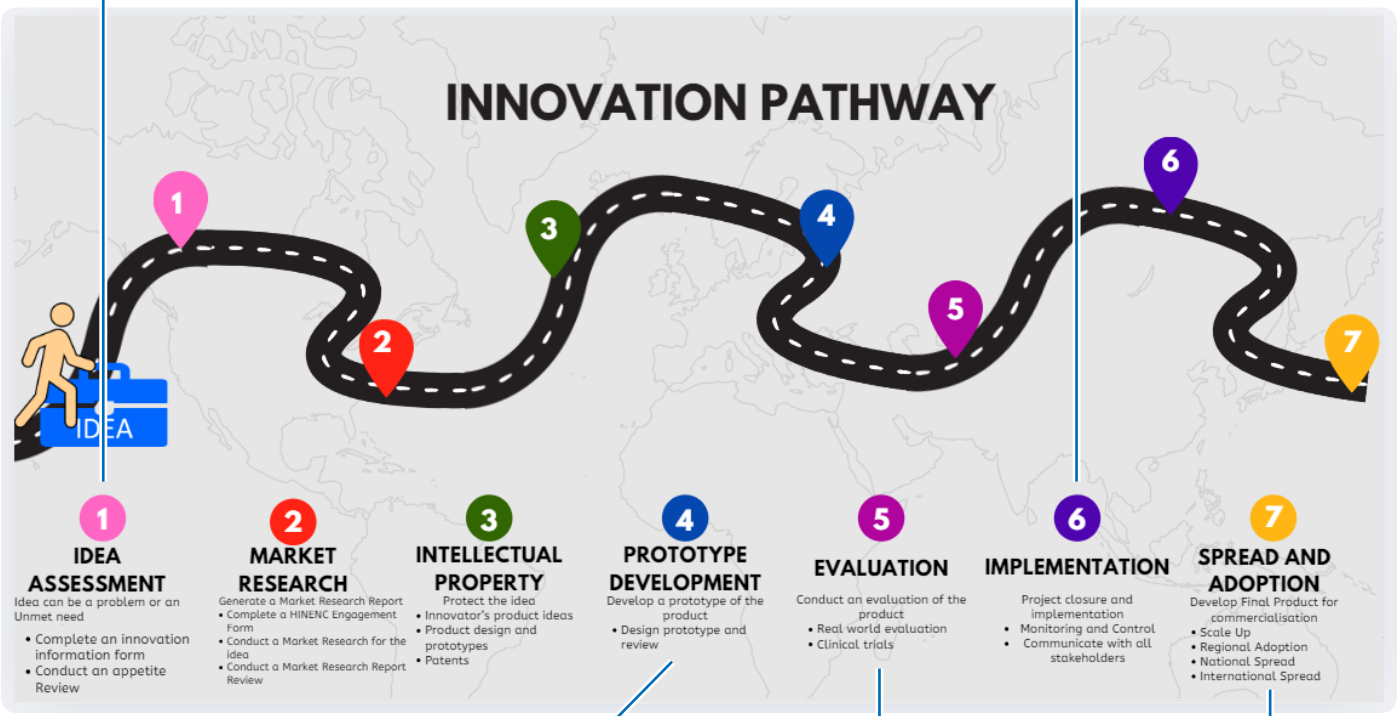
Reducing restrictive intervention for young people in ED inpatient services using an innovative approach
 	
 
	• Intended outcomes
	  • Reduce the number of staff involved in nasogastric feeding restraint and length of intervention
	  • Reduce restrictive practice and increase staff and patient safety
	  • Reduced physical and psychological harm for the service user and staff
	  • National interest in purchasing
	  • Design rights and international patent pending

Collaboration Successes

ALIVECOR®

"It was a real privilege to work with Tees, Esk and Wear Valleys NHS Foundation Trust, on the evaluation comparing portable 6-lead ECGs with standard 12-lead ECGs in patients receiving antipsychotic medication. Their focus on what was right for the service user and how this could best be demonstrated, was central to establishing a close working partnership from the very beginning of the evaluation. AliveCor look forward to future opportunities to collaborate on similarly impactful projects"

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)



Samson Forth
Associates Limited

NHS
Northumbria Healthcare
NHS Foundation Trust

UNIVERSITY of York

External Opportunities offered to the Trust

The Innovation Service has shared digital, medical, and process innovations to cut waiting times and introduce new treatments.

11
Organisations
Innovations to improve efficiencies and outcomes across multiple services

Resulting in
2
Funding applications

Resulting in
1
Real-World Evaluation

Lessons learned and challenges

Capacity to support innovations	Limited team capacity and the end of the innovation coordinator role in June 2025 are slowing progress on new ideas, such as AI-driven prevention. Adequate support enables income generation, reinvestment, and collaboration with emerging technologies to improve care. We have learned that with capacity to support innovations, we are able to generate income which is reinvested back into the Trust. We can also understand and exploit opportunities to collaborate and engage with the latest technologies and improvements in care.
Investments to progress innovation and protect Intellectual Property	Progressing innovation requires investment in legal, development, and evaluation activities, alongside robust processes to protect Trust IP. While small funding sources exist for early-stage innovation, resources for IP protection and commercialisation remain limited. For some innovations intellectual property (IP) has not been identified or protected and as such has been given away unknowingly. Processes need to be developed to protect and manage Trust IP.
Innovation business support to capitalise on opportunities	The innovations team receive opportunities to collaborate with industry and academia to develop, evaluate or adopt innovations to solve challenges for TEWV. The Department of Business and Trade offer trade mission opportunities to present NHS commercial and adoption ready innovations globally. Although commercial products exist within TEWV, there is a lack the innovation business expertise to identify and set up commercial opportunities, such as training, therefore these opportunities are declined. When innovations reach commercialisation and spread and adoption phases, support is required for business models and income strategies (e.g royalties, equity) to capitalise on these opportunities.

Opportunities for the Future

Innovation Academy Pilot Programme
- to upskill our workforce in innovations

Department of Business and Trade:
International Commercialisation and
Collaboration

Scoping Potential Commercial Industry
Partnership with AliveCor

Healthcare UK Surge Support to develop
International Commercial Offer

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11 December 2025**
Title:	**Leadership Walkabout Feedback – Sept and Oct 2025**
Executive Sponsor(s):	**Ann Bridges, Executive Director of Corporate Affairs and Involvement**
Report Author(s):	**Ann Bridges**

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

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

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

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All		*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 September and October 2025.

Proposal:

This report is presented to Board as good assurance. Full feedback reports are recorded 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 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 29 September 2025 and 27 October 2025 across various service areas. Common themes across the visits are summarised below, with more detailed breakdown in further information.

1. Staffing pressures and recruitment challenges: Nearly all groups highlighted ongoing difficulties with recruitment, staff retention, and the impact of vacancies or acting positions. This was especially acute in specialist roles (e.g psychologists, nurses, healthcare assistants) and was compounded by external factors such as visa changes and financial constraints. Staffing shortages led to increased workloads, limited protected time for staff development or audits, and affected staff wellbeing and morale.
2. Service environment and resource constraints: Many teams reported challenges related to physical environments: lack of confidential rooms, overcrowding, limited parking, and design limitations (e.g., mixed-gender wards affecting privacy and dignity). Resource constraints also included limited access to equipment, administrative burdens, and difficulties with IT systems (e.g., CITO system navigation and training).
3. High demand and complex caseloads: Services are experiencing high demand, with increasingly complex cases (e.g., mental health, trauma, self-harm, comorbidities). This has led to increased caseloads, bottlenecks in service transitions (especially for young people turning 18), and pressure on staff to maintain quality care.
4. Team strengths: commitment, collaboration, and values: Despite challenges, teams consistently demonstrated strong commitment to person-centred care, effective multidisciplinary collaboration, and alignment with Trust values. Teams were proud of their supportive environments, innovative practices (e.g., music therapy research, creative engagement activities), and positive relationships with service users and carers.
5. Need for improved processes and change management: Several groups raised concerns about unclear or rapidly changing policies (e.g., DNA policies, multiple simultaneous Trust process changes), which can create confusion and reduce staff confidence. There were calls for clearer communication, better change management, and more tailored policies to fit specific service needs.
6. Opportunities for service improvement: Suggestions included enhancing staff training (especially in physical health, end-of-life care, and learning disabilities), improving the working environment, expediting recruitment, and increasing collaboration with partner agencies. Teams also requested more visible and validating leadership, better external communication of service achievements, and more structured opportunities for team development.
7. Measurement of impact and success: Teams used a mix of qualitative (client trust, engagement, feedback) and quantitative (clinical audits, outcome measures like SWEMWEBS and FFT, readmission rates) indicators to assess their impact. There was recognition of the need to improve how feedback is used to drive service improvements.

Prior consideration and feedback:

Feedback from these visits will be shared with Executive Directors Group and fed into the combined care group governance groups and triangulated with relevant service improvement and action plans. Actions are assigned to key individuals and monitored on an ongoing basis.

Implications:

No direct implications, however, it is important that teams being visited feel that their voices are being heard and that we are acting on their feedback.

Recommendations:

Board is invited to take this report and feedback and actions contained as good assurance.

Further information

Report Title: Leadership Walkabout Feedback – Sep and Oct 2025

1 Proposal

This report is presented to Board as good assurance. Full feedback reports are recorded and actions reviewed and monitored for completion.

2 Prior Consideration and Feedback:

Feedback from these visits will be shared with Executive Directors Group and fed into the combined care group governance groups and triangulated with related improvement and action plans. Actions are assigned to key individuals and monitored on an ongoing basis.

3 Commentary:

Leadership walkabouts took place on 29 September 2025 across the following service areas. These are summarised as follows:

Group 1 – Forensic Community Service, Roseberry Park Hospital, Middlesbrough

The Forensic community service is a regional service which provides care and treatment for adults who have a history of offending and/or pose a risk to others.

- **Team strengths and service impact:** The service is proud of its strong teamwork, excellent communication, and the ability to build therapeutic relationships before discharge, helped by a manageable caseload of 53. Success is measured by positive outcomes such as sustained community living for complex patients previously on Community Treatment Orders.
- **Challenges faced by the service:** The main challenges include difficulty finding placements due to selective providers, the pressure to place patients in their own homes which can lead to recall, and perceptions of the service as a barrier by Adult Mental Health (AMH). The highest priority challenge is securing placements and accommodation.
- **Support and actions agreed:** The service identified the need for police support during risky home visits, a dedicated social worker to liaise with housing services, and a step-down facility. An action was agreed to liaise with County Durham and Darlington Police to improve police support by the Medical Director.

Group 2 - Wold View Ward, Foss Park Hospital, York

Wold View is an inpatient ward located at Foss Park Hospital in Yor and provides inpatient care to older adults, particularly those with complex mental health needs, including dementia and other psychiatric conditions.

- **Service strengths**: The ward demonstrated a strong multidisciplinary team approach with clear leadership, medical presence, and a focus on high-quality, holistic patient care. Innovations include collaboration on music therapy research and audited medicines management, alongside robust carer support, and person-centred care initiatives.
- **Areas for maximising strengths**: Suggested improvements include enhancing staff training to meet evolving patient needs, particularly in physical health and end-of-life care and supporting staff wellbeing through protected reflection time.
- **Key challenges faced**: The ward faces with prolonged patient stays due to social care delays, privacy and dignity issues arising from a mixed-gender ward environment with design limitations, and staffing resource constraints influenced by visa changes affecting healthcare assistants.

- **Actions and outcomes**: Planned actions involve addressing ventilation and improving hospital admission interfaces. A subsequent mechanical estates visit resolved multiple ventilation faults, enhancing ward comfort significantly.

Group 5 - Redcar and Cleveland Community Team, Foxrush House, Kirkleatham, Redcar

South Durham CAMHS Getting More Help Team is part of the Child and Adolescent Mental Health Services (CAMHS) and provides targeted, intensive mental health support for children and young people whose needs go beyond what universal or early help services can offer.

- **Service environment challenges:** The team operates across multiple services in a building with space issues, limited confidential rooms, and parking difficulties, impacting work and client privacy. Flexible working and hot desking are used due to space constraints.
- **High demand and staffing pressures:** The service faces high demand with complex cases involving self-harm, trauma, and mental health issues, compounded by staff turnover, budget cuts, and difficulty filling vacancies. Caseloads have increased rapidly, affecting staff wellbeing and patient safety.
- **Service structure and commissioning issues:** There are bottlenecks between “Getting Help” and “Getting More Help” teams due to commissioning gaps, with limited capacity to deliver the full ITHRIVE model and challenges in managing transitions for clients turning 18.
- **Team strengths and values:** The team is proud of its supportive, psychologically safe environment, high-quality care, strong leadership, and effective collaboration with multidisciplinary teams and partners. They consistently live the trust values and prioritize person-centered care.
- **Opportunities for improvement:** Enhancing collaboration with partner agencies, improving communication, reviewing the working environment to address overcrowding, and expediting vacancy recruitment are identified as ways to maximize service strengths.
- **Policy and procedural concerns:** Staff note difficulties with DNA (Did Not Attend) policies and the need for clearer, more engaging policies. Multiple simultaneous changes in trust processes create confusion and reduce staff confidence.
- **Measuring impact:** Success is gauged through qualitative indicators such as client trust, engagement, and feedback, along with CROMS, clinical audits, and goal-based outcomes, though improvements in feedback use are needed.
- **Prioritised challenges and support needs:** The top priority is reviewing commissioning and the core clinical offer to address demand and service gaps. Additional funding, clearer plans to resolve clinical gaps, and better change management are requested to meet challenges effectively.

Group 6 – Rowan Lee, Cross Lane Hospital, Scarborough

Rowan Lea is a 20-bedded assessment and treatment unit specialising in mental health services for older people. The ward provides care for patients with both functional and organic mental health needs, such as dementia and other psychiatric conditions.

- **Service strengths and care quality:** The ward is proud of its person-centred care, staff engagement with patients and carers, use of safe ward practices, student work experience integration, supportive psychiatrist involvement, and various initiatives to enhance practice and staff wellbeing. The environment is noted as calming with ample intervention opportunities.
- **Areas for service improvement:** The ward faces challenges due to limited clinical nurse specialists, reduced nursing and HCA posts, absence of a psychologist except for a brief recent period, and stretched staff resources. Enhancing multidisciplinary parity and psychology support are seen as key to further service improvement.

- **Challenges impacting the ward:** Staffing and rostering difficulties, high patient acuity and mixed patient needs, financial constraints limiting agency staff use, and administrative workload pressures are primary concerns, with staffing considered the top priority to address.
- **Support and action plans:** Protected time for tasks is limited due to staffing shortages, impacting carers' engagement and audit completion. Recruitment for a shared psychologist is underway, and leadership actions include coordination with bed managers to optimize patient placement and processes requiring registered nurse input.

Leadership walkabouts also took place on 27 October 2025 across the following service areas. These are summarised as follows:

Group 1 - Darlington Community Hub and Darlington Treatment and Intervention Team

he Darlington Community Hub offers a wide range of support, acting as a “one-stop-shop” for advice and help. The Darlington Treatment and Intervention Team is part of the affective disorders community intervention teams, supporting adults (aged 18–65).

- **Cross-team collaboration and patient experience:** The two teams share leadership and have increased cross working since June to support a smooth patient pathway, resulting in good patient feedback. Challenges include balancing assessment needs with long-term care and managing administrative burdens. Staff appreciate visible senior leadership and value the opportunity to share experiences during the leadership visit, requesting more validation from senior leaders.
- **Team strengths and staff wellbeing:** The teams emphasised wellbeing with positive, collective leadership, regular away days, and strong relationships with ARRS. Psychological therapy wait times have significantly improved.
- **Service promotion and external communication:** Suggestions include better showcasing positives externally and addressing a provision gap between talking therapies and community services, with ongoing work to reduce inappropriate referrals.
- **Key challenges:** Issues include potential patient loss due to removal of the pathway toolkit, increased inappropriate referrals from Talking Therapies, unrealistic patient expectations from GP referrals, and room availability constraints for therapy sessions.
- **Recruitment and staffing:** The team has recently recruited or is recruiting to vacancies, focusing on needs assessments for roles, with noted difficulty recruiting Band 6 nurses and targeted development for occupational therapy.
- **Actions planned:** These include addressing pathway toolkit removal risks, enhancing psychological therapy staff development awareness, improving communication between Talking Therapies and the service, streamlining room booking, and improving signage at the entrance.

Group 3 – Baysdale Unit, Roseberry Park Hospital, Middlesbrough

Baysdale is a service that offers respite care for children, particularly those with profound and multiple learning disabilities and complex health needs.

- **Service strengths:** The team has developed strong relationships with children, parents, and carers, provides personalized care, supports families in crisis, and works collaboratively with advocacy as a priority. They possess specialist skills for children with profound and multiple learning disabilities and create stimulating environments.
- **Challenges faced:** Key challenges include staffing and nurse recruitment, policies not tailored to the service’s specific needs, and lack of child-specific training, especially related to learning disabilities. Recruitment of nurses is the top priority.
- **Impact and measurement of success:** Success is primarily measured through feedback from parents, indicating the service’s positive effect on families.
- **Actions planned:** Agreed actions include a six-month recruitment drive, policy updates with local procedures for better fit, discussions on physical health needs, updating

observation and engagement policies, liaising on equipment needs, debriefing with related services, and executive commitment to provide staff feedback on the service's future.

Group 4 – Foxrush House, Kirkleatham Lane, Redcar

Foxrush House is primarily a base for Early Intervention in Psychosis (EIP) teams, providing care and support for adults with mental health problems.

- **Team achievements and culture:** The EIP team is recognised as a top performer within the care group, with strong team culture and service user involvement through volunteering and co-creation initiatives. Creative engagement activities and innovative feedback collection methods were also noted.
- **Operational improvements:** The new model at Foxrush House has improved referral flow to Community Mental Health Teams, and the team actively participates in collaborative presentations and trust-wide events, demonstrating commitment to partnership working.
- **System and resource challenges:** Challenges with the CITO system, including navigation issues and training burdens, were raised alongside limited availability and inefficiency of bookable rooms. Suggestions included having a dedicated CITO team member on-site and exploring additional nearby facilities.
- **Complex caseload and safety measures:** The team manages high-risk, complex cases with multiple comorbidities, preferring clinic-based approaches for safety. They are piloting alarm badges for community visits and engaging forensic teams and multidisciplinary discussions to enhance risk management and support.

Group 5 – Willow Ward, West Park Hospital, Darlington

Willow Ward is a Level 2 High Dependency Rehabilitation and Recovery Inpatient Ward. This means it is designed for adults (aged 18 and over) with complex mental health needs who require a higher level of support and structured care than standard rehabilitation unit.

- **Service strengths**: The team were proud of their patient-centred approach to care and recovery, often involving innovative thinking beyond standard practices. They express a strong staff and team leadership committed to patient care, and effective teamwork within the ward, highlighting a strong focus on holistic and collaborative care delivery.
- **Maximising strengths**: to further leverage these strengths, the team recommended supporting and facilitating team development days. This would help advance the ward's role and vision, particularly to better meet the needs of a high-dependency client group. Finding time to do this as a whole team was a challenge.
- **Measuring impact and success:** Impact is measured primarily through readmission rates. Additionally, they use tools such as SWEMWEBS (Short Warwick-Edinburgh Mental Well-being Scale) and the Friends and Family Test (FFT) on a regular basis to assess outcomes and patient experience.
- **Key challenges and actions:** Recruitment and staffing issues, including ongoing acting positions, especially with upcoming wider service changes related to Primrose Lodge. Bed flow and patient management difficulties, which affect staff morale and motivation. The ward experiences situations where patients are placed who do not align with the ward's ethos, resulting in mere boarding rather than appropriate care. Environmental concerns were raised and co-location with the community rehabilitation team to improve service integration. The team expressed the need for a longer-term plan that includes relocating the service to work closely with the community rehabilitation team, facilitating better collaboration and service delivery.

4 Conclusion:

Board is invited to take this report and feedback and actions contained as good assurance.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report				
Report Date: 5 December 2025		**Report of the Charitable Funds Committee**		
Date of last meeting:		8 October 2025 – The meeting was quorate		
1	**Agenda**	The agenda included: - Charitable funds quarterly transaction report - Charitable funds strategy - Update from the NENC ICB charity chairs and senior officer meeting - Recycle of expired IT equipment		
2a	**Alert**	Committee agreed to delegate approval of charitable fund applications (excluding the Trustee fund) of a value above 10k to Fund Managers [service directors], to ensure that applications are dealt with in a timely way, but with good governance. All applications continue to be subject to review by the finance department to ensure they are used for non-NHS funded core activity.		
2b	**Assurance**	Committee received a transaction report for quarter 1 2025/26, to be assured that the funds continue to be used appropriately. Internal audit has commenced a review of the charitable funds, and the outcome will be reported to the next committee meeting. Assurance was sought on the reclassification of funds as 'restricted' in the annual report and accounts, reflecting their donation to a particular geography or service area, and it was agreed that this would be discussed with the external auditor to ensure there were no unintended consequences. Assurance was provided that services who received no direct donations would be able to access charity funds through the Trustee Fund.		
2c	**Advise**	Committee discussed and supported the proposed areas of focus for the charitable fund's strategy and a draft will be discussed at the next meeting in December 2025. Committee discussed the challenges faced by the voluntary and community sector in accessing digital equipment to support our communities. Equipment is also needed to facilitate the involvement of Trust governors. The Trust is in the process of exploring options to repurpose aged devices and it was agreed that links should be made to local authority/Director of Public health digital poverty strategies. Committee received feedback from the NENC ICB Charity Chairs and Senior Officers meeting, which provided an opportunity for learning and a forum to discuss collaborative activity.		
2d	**Review of risks**	There are no BAF risks relevant to this committee and no risks were identified.		
3	**Actions to be considered by the Board**	The Board is recommended to approve the Charitable Funds Annual Report and Accounts, subject to the report of the external auditor, which will be considered by Audit and Risk Committee on 8 December 2025.		
4	**Report compiled by**	J Preston, Chair and A Bridges, Executive Director for Corporate Affairs and Involvement	**Minutes available from**	K Christon Deputy Company Secretary

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	11th December 2025
Title:	Adoption of the Charitable Trust Fund Annual Report and Accounts for 2024/25
Executive Sponsor(s):	Liz Romaniak, Director of Finance, Estates and Facilities
Report Author(s):	John Chapman, Head of Accounting and Governance

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***
12	Financial Sustainability	Submission of Charity accounts is an annual statutory requirement. Trust funds are used to enhance the care provided to our service users – the accounts and annual report detail the activities through the year.

EXECUTIVE SUMMARY:

Purpose:

To support the submission of accurate 2024/25 Charitable Trust Fund accounts and annual report in line with Charities Commission deadlines.

Proposal:

The report includes the annual report and accounts for consideration, which have been subject to an independent review by Mazars.

Overview:

Appendix A contains the Charitable Trust Fund (CTF) annual report and accounts. In the financial year the fund increased by £4k in net resources mainly due to grants received from NHS Charities Together to support wellbeing. The overall balance of the funds as at 31 March 2025 was £585k.

An independent review by Mazars LLP completed during December 2025, with an update due to be presented at the December Audit and Risk Committee and expected to confirm no changes were made to the draft annual report or accounts. The timing of the Board meeting means this paper is being drafted ahead of that final confirmation. The auditor's final independent review report will be signed following the December Board of Directors meeting.

Once the independent review is approved and signed it will be included in page 9 of the accounts prior to submission to the Charities Commission (a draft from last year is included for completeness). The Trust is required to submit the final (signed) accounts to the Charities Commission by 31st January 2026.

Prior Consideration and Feedback:

The independently reviewed annual report and accounts are due to be received by Audit and Risk Committee members on 8th December 2025, and the committee is expected to recommend that the Board of Directors approve the submission of the Annual Report and Accounts of the Charitable Trust Fund, as shown in appendix A.

The Audit and Risk Committee previously received the draft annual report and accounts for consideration at its June 2025 meeting, with feedback incorporated into the documents as required.

An independent review of the accounts and annual report is completed by Mazars LLP. An independent review provides a limited (by scope) assurance report on the information included within the annual report and accounts. This is less intensive than an external audit but is appropriate for the size and value of transactions within the fund.

Implications:

If supported, the annual report will be uploaded to the charities commission by 31st January 2026 and demonstrate compliance with requirements and document the activities on the Charity.

Recommendations:

The Board of Directors is recommended to approve the submission of the Annual Report and Accounts of the Charitable Trust Fund as recommended by the Audit and Risk Committee, and as shown in appendix A to the charities commission.

The Board of Directors is recommended to ensure appropriate signatures are made on the following pages of the accounts:

- Page 1 – statement of trustee responsibilities
  - Chairman and Chief Executive
- Page 3 – balance sheet
  - Chief Executive

Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Trust

General Charitable Fund

Fund Number: 1061486

Annual Report 2024-25

CONTENTS PAGE

Tees, Esk and Wear Valleys NHS Foundation Trust

General Charitable Trust Fund

Annual Report 2024-25

1. Tees, Esk and Wear Valleys NHS Foundation Trust General Charitable Trust Fund

The Charity is administered by Tees, Esk and Wear Valleys NHS Foundation Trust and was formed as the "umbrella" Charity for the former Tees and North East Yorkshire NHS Trust and County Durham and Darlington Priority Services NHS Trust charitable funds.

2. Objectives of the Charity

The Tees, Esk and Wear Valleys NHS Foundation Trust Charitable Trust Fund Deed (which is the governing document for the charitable funds) states the Charity's principal objectives as being:

"... for any charitable purpose or purposes relating to the National Health Service".

The governing document does not place any specific restrictions on the use of the funds other than that implied by the Charity's main object. All bids are made on an ad-hoc basis with no commitment or strategic deployment from any one individual fund.

All charities must demonstrate, explicitly, that their charitable purposes are for the public benefit and adhere to the following two key principles:

Principle 1: There must be an identifiable benefit or benefits

Principle 2: Benefit must be to the public, or section of the public

The Trustee confirms that they have had regard to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the trust's aims and objective and in planning future activities and setting grant making policy for the year. It is the opinion of the Trustee that it has followed this guidance by:

- Providing additional amenities, events or equipment for service users and carers, and employees of the Trust throughout the year.

- Ensuring there is no detriment or harm that, in their view, might arise from carrying out the charity's aims.

Further details of specific activities that have been provided can be referenced in Section 4 – Achievements and performance.

3. Organisational structure and relationships

3.1 Organisation structure

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate Trustee of the charity. Delegated responsibility is allocated to the executives and non-executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board. All those with delegated responsibility of the Trustee are legally co-opted from the Foundation Trust Board and training and development

needs are addressed through the Foundation Trust appraisal process.

Those with delegated responsibility of the Trustee received no remuneration or expenses, and no remuneration or expenses have been paid to any employee.

The newly established Charitable Funds Committee receives and examines reports on Charitable Trust Funds at three month intervals. The membership of this committee was:

Mr Jules Preston, Chair & Non-executive director
Mrs Beverley Reilly, Non-executive director
Mrs Liz Romaniak, Director of Finance, Estates and Facilities Management
Mrs Ann Bridges, Director of Corporate Affairs and Involvement

In order to safeguard the assets of the Charity and ensure income is applied appropriately the Trustee requires charitable funds procedures to comply with the Trust's Standing Financial Instructions and Scheme of Delegation.

For day to day operational and management purposes the Charity is divided into sub funds. These are managed by Trust officers who have delegated authority to apply the funds within the objects of the Charity.

The Head of Accounting and Governance has overall responsibility for the administration of the funds, supplying regular reports to the Charitable Funds Committee and completing the annual accounts and annual report for the charitable funds.

An administration charge is levied at the sub funds to reflect the financial and clerical work that Tees, Esk and Wear Valleys NHS Foundation Trust provides. The basis of apportionment for this charge is the value of restricted and unrestricted funds as a percentage of the total funds held.

3.2 Relationships

The Charity's principal relationship is with Tees, Esk and Wear Valleys NHS Foundation Trust.

During the year no member of the Trust's Board had any related party transactions with the Charity.

4. Achievements and performance

The following funds had material movement in balances within the year:

Chime Fund
The purpose of this fund is to manage funds for Ridgeway café and shop for the benefit of users, carers and staff and to facilitate the selling and purchasing of items with a therapeutic purpose. The trading account reduced by £8k linked to community wellbeing sessions purchased.

Health and Wellbeing Fund
The purpose of this fund is to support the wellbeing of Tees Esk and Wear Valley employees. The fund decreased by £28k due to expenditure on Trustwide wellbeing, including the organisations of a 10k run.

5. Review of activities

Individual funds were subjected to a review during 2024-25, supported by Trustees, to reduce the number of individual funds held and increase the average value of funds. It is expected that

this will improve access to the fund and mean that donations can be better used to add value to clinical services.

This review aligns existing funds (and donator wishes) to Trust services, which ensures funds are used in the geography and clinical service that the initial donation was made for. It protects the fund from management structure / location changes in the trust.

Remaining funds have all been classed as restricted to protect initial donator wishes, meaning they can only be used for the service and geography they are assigned to.

An internal audit review was undertaken by Audit North in July 2019 which gave a good level of assurance. All recommendations have been implemented. Due to materiality a full internal audit review is completed periodically, however, should any process change it is reviewed by internal auditors before being implemented. The pandemic interrupted the review cycle, and we are working to reinstate established processes. The accounts payable and receivable systems are audited annually as part of the corporate trustee audit.

6. Financial activity

A full set of accounts for the financial year 2024-25 are included with this report. Forvis Mazars LLP undertakes an independent examination of the accounts.

6.1 General review

The year under review saw an increase of £4k in net resources mainly due to grants received from NHS Charities together to support wellbeing. The overall balance of the funds as at 31 March 2025 was £585k.

Income is derived from donations, legacies, raising funds, grants and investment income. Income from raising funds is mainly received from the shop within the learning disabilities' day centre, and the shop and café at the Ridgeway Centre at Roseberry Park.

During the period 1 April 2024 to 31 March 2025 total investment income was £9k which was an increase on the previous year. Investment income has continued to be less than the administration costs of the Charitable Funds – due predominantly to the current economic climate and low interest rates being available. The Trust continues to look for appropriate investment opportunities to improve the rate of return received on cash balances.

There is a fund administered by the Trustee for which bids can be made for goods or services where there is no individual specific Trust Fund to draw on. There were no bids approved by the Trustee in 2024-25. NHS Charities Together grants were moved from trustee funds into its own Health and Wellbeing fund in the year, to be managed by the Health and Wellbeing Committee.

The funds classed as "Others" in note 8 of the accounts are further broken down as follows:

	"Others" Balance	Number Of Funds	Average Fund Balance
Restricted	£52,185	12	£4,349

6.2 Incoming resources

Total income for the year was £257k, an increase of £48k on last year. Actual figures were:

	2024-25 £000	2023-24 £000
Donations	33	8
Legacies	11	1
Other trading activities	121	144
Income from investments	9	7
Grants received	83	51
Total	**257**	**211**

See Appendix 1 for chart showing the split of income sources.

6.3 Material donations and legacies

The Charitable Fund received legacies totalling £11k in 2024-25 and received donations of £33k to various funds.

6.4 Resources expended

Expenditure for the year was £253k, an increase of £81k when compared with £172k spent in the previous year. Analysis of expenditure:

	2024-25 £000	2023-24 £000
Purchasing goods for resale	95	114
Patients' welfare	74	38
Staff welfare	73	9
Governance costs	11	11
Total	**253**	**172**

Expenditure has increased from the previous financial year, mainly due to increased expenditure on staff wellbeing and enhancing the patient experience.

See Appendix 2 for chart showing the split of expenditure categories.

6.5 Management and administration costs

The administration costs include the internal audit fee, bank charges, and the Trust cost of administering the funds. Charity Commission guidelines state that if a charity does not exceed £1,000k gross income in a financial year and does not have aggregate value of assets of more than £3,260k, it is eligible to have an independent examination rather than a full audit of its accounts. The assets held by the fund are lower than this minimum value, and as such accounts are eligible for an independent examination.

Following discussions with the Trust's auditors, Forvis Mazars LLP, it was decided that it would be appropriate for the charitable funds to have an independent examination of the accounts. This means the overall management costs per annum are £9k, and account for 3.6% of total expenditure.

The basis of apportionment for the administration costs is the value of funds as a percentage of the total funds held.

6.6 Material expenditure

There were four instances of material expenditure from the funds (e.g. in excess of £5k) in 2024-25 from a single fund, detail below:

- Community wellbeing support sessions
- Landscape gardening of an inpatient area
- Supporting service users to join the Voyage to Discovery sailing expedition
- Expenditure on staff wellbeing.

6.7 Going concern

The fund's activities, together with the factors likely to affect its future development, performance and position are set out in the annual accounts on pages 2-8.

The fund has maintained its level of financial resources due to its long-standing policy of only funding one-off in-year applications to the fund, and has no future commitments to discharge other than creditors as disclosed in the balance sheet which reports £27k of creditors compared to £612k of cash in hand.

The return on deposit account investments, even though interest rates have increased, has been poor throughout the year due to low interest rates available on the market. The low return on investment has resulted in all funds suffering a charge to cover governance costs.

The Trustee's view is that the Charity is a going concern and can make the disclosure as recommended by the accounting standards board that:

After making enquiries, the Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing the annual report and accounts.

7. Funds managed for and on behalf of other NHS organisations.

Within the balances of the Funds held by the Tees, Esk and Wear Valleys NHS General Charitable Fund there were no balances relating to other NHS Organisations.

8. Policy on reserves and investments

8.1 Reserves

The Trustee considers that it should aim to hold sufficient reserves to be able to provide funds to meet charitable expenditure as it is incurred and to review the position on an annual basis. Access to the funds is encouraged so that cash is used often and the trust can bring the associated benefits to its patients.

There are limitations on expenditure that can be realised within restricted funds (as it must be related to the purpose of the fund), so a minimum level target is not appropriate for funds currently held.

8.2 Investments

8.2.1 Statement of policy on investments

The Charity's funds were invested in an interest bearing deposit account with Virgin Money UK at an agreed interest of 1.26%, with a minimal balance in a lower interest bearing account at

Barclays Bank PLC. The Trust is exploring other investment accounts to improve this rate of return and generate additional funds.

Funds were invested in this manner, with the objective to provide maximum security and availability. This allows a flexible and prudent level of control over the charity's funds.

8.2.2 Exposure to risks

The Trustee has identified the major risks to the Charity. The main risks can be summarised as:

1. That the Charity is not operating within its objectives.
2. That accounting transactions are inappropriately or inadequately reported.
3. Expenditure is inappropriate, or inappropriately authorised or not spent for the purposes intended.
4. That income is not appropriated to specific sub-funds in accordance with the intention of the donor.
5. Investments are not properly safeguarded, resulting in loss of funds.
6. Registered fund holders do not respond to requests for actions relating to the timely and appropriate administration of funds.

The Trustee has established systems to ensure these risks are kept at a minimum. Namely:

1. The existence and compliance with Standing Financial Instructions.
2. An adequately qualified and resourced finance function.
3. The establishment of internal financial control systems which are reviewed annually by an Internal Audit Department.
4. Reporting and review of audit findings to an Audit and Risk Committee.

8.2.3 Planned future activities of the Charity

The NHS is an ever changing environment and the future direction of the Charity will be shaped by these changes. The priorities for spending charitable funds are determined primarily by the fund holders who are managers in the service. By delegating the responsibility of expending charitable funds to this level ensures that those able to make the decisions are best placed to know the exact needs of service.

9. Legal and administrative information

Registered charity number
1061486

Registered address
The Flatts Lane Centre
Flatts Lane
Normanby
Middlesbrough
TS6 OSZ

Trustee
Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate Trustee of the Charity. Delegated responsibility for Trustee duties for the period covered by this report is allocated to members of the Board of Directors. These were:

Non-executive directors:
Mr David Jennings
Mrs Beverley Reilly
Mr John Maddison
Dr Charlotte Carpenter
Mrs Jillian Murray (left 31 August 2024)
Mr Jules Preston
Mrs Roberta Barker
Mrs Jane Robinson (started 01 December 2024)
Ms Catherine Wood (started 01 December 2024)

Executive directors
Mr Brent Kilmurray
Mrs Zoe Campbell
Mrs Naomi Lonergan (Started 01 September 2024)
Mr Patrick Scott
Mrs Liz Romaniak
Mrs Beverley Murphy
Dr Kedar Kale
Dr Sarah Dexter-Smith
Mrs Kate North (started 01 September 2024)
Mr Mike Brierley (left 31 August 2024)
Mrs Ann Bridges
Dr Hannah Crawford

All Board of Directors appointments are made in accordance with the policy and procedures laid down in the NHS code of good practice.

The Secretary of State for Health, in line with statutory requirements approved the Chairman's appointment, and a panel comprising the minimum statutory members, including the Chairman and an expert independent assessor, made the Chief Executive's appointment.

All other executive and non-executive appointments to the Trust Board were made following external advertisement and robust and transparent selection procedures.

Independent examiners
Forvis Mazars LLP
The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF

Legal advisors
Ward Hadaway
Sandgate House
102 Quayside
Newcastle upon Tyne
NE1 3DX

Bankers

Yorkshire Bank PLC
7 Linthorpe Road
Middlesbrough
TS1 1RF

Barclays Commercial Bank
PO Box 190, 2 Floor,
1 Park Row,
Leeds, LS1 5WU

10: Charitable Fund Account

Statement of trustee responsibilities

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate trustee of the fund. Delegated responsibility of the trustee is applied to executive and non executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board.

The trustee is responsible for preparing the trustees' Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales/Scotland/Northern Ireland requires the trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements the trustee is required to:

select suitable accounting policies and then apply them consistently;

observe the methods and principles in the Charities SORP;

make judgements and estimates that are reasonable and prudent;

state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and

prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2022, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed . It is also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the charity and financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

The trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 1-8 attached have been complied from and are in accordance with the financial records maintained by the trustee.

By Order of the trustee, and those with delegated responsibility

Chair…..……..…….. Date……

Executive Director ……..…… Date ……..

Statement of Financial Activities for the year ended 31 March 2025

	Note	31 March 2025 Unrestricted Funds £000	31 March 2025 Restricted Funds £000	31 March 2025 **Total Funds £000**	31 March 2024 Total Funds £000
Incoming resources					
Income and endowments from:					
Donations		27	6	**33**	8
Legacies		11		**11**	1
Grants received	5.1	83	-	**83**	51
Income from investments	5.2	3	6	**9**	7
Other trading activities	5.3	-	121	**121**	144
Total income and endowments		**124**	**133**	**257**	**211**
Resources expended					
Expenditure on:					
Raising funds	3.3	-	(95)	**(95)**	(114)
Charitable Activities	3.1	(51)	(107)	**(158)**	(58)
Total resources expended	4	**(51)**	**(202)**	**(253)**	**(172)**
Transfers between funds	6	(342)	342	-	-
Total transfers	6	**(342)**	**342**	**0**	**0**
Net movement in funds	6	**(269)**	**273**	**4**	**39**
Reconciliation of funds:					
Fund balances brought forward at 1 April		269	312	**581**	542
Fund balances carried forward at 31 March		**-**	**585**	**585**	**581**

There were no other recognised gains or losses in the year.

Balance Sheet as at 31 March 2025

	Notes	**Total (restricted funds) at 31 March 2025 £000**	Total at 31 March 2024 £000
Current assets			
Debtors		**-**	5
Short Term Deposit Investment		**612**	586
Total current assets		**612**	591
Current liabilities			
Creditors: Amounts falling due within one year	7	**(27)**	(10)
Total current liabilities		**(27)**	(10)
Total current assets less current liabilities		**585**	**581**
Total net assets		**585**	**581**
Funds of the Charity			
Income Funds:			
Restricted	8.1	**585**	312
Unrestricted	8.2	**-**	269
Total funds		**585**	**581**

Notes numbered 1 to 13 form part of the accounts.

Signed:

Date:

Notes to the Account

Accounting policies

1 The principal accounting policies are summarised below. They have been applied consistently through out the reporting year 2024-25 and throughout the comparators shown for the previous reporting year 2023-24.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant note(s) to these accounts. The accounts have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014, and with the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and with the Charities Act 2022.

The charity constitutes a public benefit entity as defined by FRS 102

1.2 Incoming resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors are met:

entitlement - control over the rights or other access to the economic benefit has passed to the charity;

probable - it is more likely than not that the economic benefits associated with the transaction or gift will flow to the charity;

measurement – the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.

Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estate that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

Offsetting

There has been no offsetting of assets and liabilities, or income and expenses.

Grants and donations

Grants and donations are only included in the SoFA when the general income recognition criteria are met.
No performance related grants were received.

Tax reclaims on donations and gifts

Gift Aid receivable is included in income when there is a valid declaration from the donor. Any Gift Aid amount recovered on a donation is considered to be part of that gift and is treated as an addition to the same fund as the initial donation unless the donor or the terms of the appeal have specified otherwise.

1.3 Resources expended and creditors

The Charity accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Cost of generating funds

The cost of generating funds are the costs associated with generating income for the funds held on trust.

Governance costs

These are accounted for on an accruals basis and are recharges of appropriate proportions of the funds administration costs from Tees, Esk and Wear Valleys NHS Foundation Trust, plus Internal and External Audit charges for 2024-25. These costs are apportioned across the funds

Creditors

The charity has creditors which are measured at settlement amounts.

1.4 Structure of funds

Individual funds were subjected to a review during 2024-25, supported by Trustees, to reduce the number of individual funds held, and increase the average value of funds. It is expected that this will improve access to the fund, and mean that donations can be better used to add value to clinical services.

This review aligns existing funds (and donator wishes) to Trust services, which ensures funds are used in the geography and clinical service that the initial donation was made for. It protects the fund from management structure / location changes in the trust.

Remaining funds have all been classed as restricted to protect initial donator wishes, meaning they can only be used for the service and geography they are assigned to.

1.5 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.6 Pensions contributions

The Charity does not employ staff and does not make pension contributions.

1.7 Change in the basis of accounting

There has been no change in the accounting policy or accounting estimates in the year.

1.8 Prior year adjustments

There are no prior year adjustments in these accounts.

1.9 Going concern

After making enquiries, the Trustee have a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Please see section 6.7 within the Annual Report for further details

1.10 Stock

A small balance of stock is held to support the activities of the Ridgeway Cafe / Shop and LD Forensic Day Services however, having reviewed the balance of stocks held over time, the Trustee has confirmed that the stocks are both stable and immaterial in value. Consequently stocks are not recognised within the financial statements rather are treated as expenditure as they are purchased.

2 Related party transactions

During the year no members with delegated responsibility for the Trustee, or members of the key management staff or parties related to them has undertaken any material transactions with the Tees, Esk and Wear Valleys NHS Trust General Charitable Fund (2023-24, £nil).

The Charitable Fund does not have the facility to pay creditors therefore, Tees, Esk and Wear Valleys NHS Foundation Trust makes the payments on the Fund's behalf and is re-imbursed on a monthly basis by the Fund.

Certain income for the Charitable Fund is initially banked through Tees, Esk and Wear Valleys NHS Foundation Trust. This income is re-imbursed to the Fund on a monthly basis.

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate trustee of the fund. Delegated responsibility of the trustee is applied to executive and non executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board (names listed below). All are also members of Tees Esk and Wear Valleys NHS Foundation Trust.

Mr Brent Kilmurray
Mrs Zoe Campbell
Mrs Naomi Lonergan (Started 01 September 2024)
Mr Patrick Scott
Mrs Liz Romaniak
Mrs Beverley Murphy
Dr Kedar Kale
Dr Sarah Dexter-Smith
Mrs Kate North (started 01 September 2024)
Mr Mike Brierley (left 31 August 2024)
Mrs Ann Bridges
Dr Hannah Crawford
Mr David Jennings
Mrs Beverley Reilly
Mr John Maddison
Dr Charlotte Carpenter
Mrs Jillian Murray (left 31 August 2024)
Mr Jules Preston
Mrs Roberta Barker
Mrs Jane Robinson (started 01 December 2024)
Ms Catherine Wood (started 01 December 2024)

3 Details of resources expended on charitable activities

3.1 Activities in furtherance of charities objectives

	Unrestricted Funds	Restricted Funds	**Total 2025**	Total 2024
	£000	£000	**£000**	£000
Patients welfare and amenities	(7)	(67)	**(74)**	(38)
Staff welfare and amenities	(39)	(34)	**(73)**	(9)
Governance costs (see 3.2 below)	(5)	(6)	**(11)**	(11)
	(51)	**(107)**	**(158)**	(58)

3.2 Analysis of governance costs

	Unrestricted Funds	Restricted Funds	**Total 2025**	Total 2024
	£000	£000	**£000**	£000
Establishment costs	(2)	(5)	**(7)**	(6)
Internal / External audit fee*	(1)	(1)	**(2)**	(2)
NHS Charities Together membership	(2)	-	**(2)**	(3)
	(5)	**(6)**	**(11)**	(11)

*Independent examination of the accounts cost £2,000

3.3 Details of costs incurred in raising funds

	Unrestricted Funds	Restricted Funds	**Total 2025**	Total 2024
	£000	£000	**£000**	£000
Purchasing goods for re-sale	-	(95)	**(95)**	(114)
	-	**(95)**	**(95)**	(114)

4 Analysis of total resources expended

	Costs of raising funds	Costs of activities for charitable objectives	**Total 2025**	Total 2024
	£000	£000	**£000**	£000
Internal / External audit fee	-	(2)	**(2)**	(2)
Compliance costs for Trust Funds	-	(7)	**(7)**	(6)
NHS Charities Together membership	-	(2)	**(2)**	(3)
Charitable activities	(95)	(147)	**(242)**	(161)
	(95)	**(158)**	**(253)**	(172)

5 Analysis of income

5.1 Grants received

	Unrestricted Funds	Restricted Funds	**Total 2025**	Total 2024
	£000	£000	**£000**	£000
NHS Charities Together	83	-	**83**	51
	83	**-**	**83**	-

5.2 Income from investments

Income from investments of £9k relates to interest received on individual fund balances held by the Charity. These investments are held in the UK.

5.3 Details of other trading activities

The £121k income from other trading activities was delivered from the re-sale of goods purchased at a cost of £95k, and amounts received for training income.

6 Changes in resources available for charity use

	Unrestricted Funds	Restricted Funds	**Total 2025**	Total 2024
	£000	£000	**£000**	£000
Net movement in funds for the year before transfers	73	(69)	**4**	39
Internal transfers	(342)	342	**-**	-
Net increase /(decrease) in funds for the year	**(269)**	**273**	**4**	39

7 Analysis of creditors

	Balance at 31 March 2025 £000	Balance at 31 March 2024 £000
Trade creditors	(27)	(10)
Total amounts falling due within one year	**(27)**	**(10)**

8 Details of material funds

8.1 Restricted funds

	Balance 1 April 2024 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2025 £000**	**Description of the nature and purpose of each fund**
AMH Total - NYY	192	2	(7)	**187**	To provide funds for adult mental health services in North Yorkshire and York
Health and Wellbeing - P&C	128	1	(29)	**100**	To provide funds for health and wellbeing of staff and service users
AMH - DTV	51	0	(0)	**51**	To provide funds for adult mental health services in Durham and Tees Valley
Chime - SIS	53	27	(35)	**44**	To provide funds for the well being of patients within Ridgeway
Learning Disabilities - DTV	40	0	(0)	**40**	To provide funds for learning disabilities services in Durham and Tees Valley
MHSOP - DTV	30	0	(2)	**28**	To provide funds for mental health services for older people in Durham and Tees Valley
AHP - NYY	21	0	(0)	**21**	To provide funds for allied health professional services in North Yorkshire and York
Child & YP - DTV	15	0	(0)	**15**	To provide funds for children's services in Durham and Tees Valley
MHSOP - NYY	13	2	(0)	**14**	To provide funds for mental health services for older people in North Yorkshire and York
Learning Disabilities - NYY	12	0	(0)	**12**	To provide funds for learning disabilities services in North Yorkshire and York
AHP - DTV	11	0	(0)	**11**	To provide funds for allied health professional services in Durham and Tees Valley
Trustees Funds - Finance	10	0	(0)	**10**	To provide funds for use across the Tees, Esk and Wear Valleys geography
Others (12 Funds)	54	0	(3)	**52**	
Total	629	33	(77)	**585**	

9 Connected organisations

	2024-25		2023-24	
	Turnover of Connected Organisation £000	Net Deficit for the Connected Organisation* £000	Turnover of Connected Organisation £000	Net Surplus for the Connected Organisation** £000
The charity is administered by Tees, Esk and Wear Valleys NHS FT	**537,170**	**(19,920)**	501,566	(11,608)

* The deficit for 2024-25 includes expenditure for unanticipated impairments of fixed assets totalling £20,407k, and other technical adjustments of £450k. Excluding these non operating items would result in a surplus of £37k.

** The deficit for 2023-24 includes expenditure for unanticipated impairments of fixed assets totalling £9,725k, and other technical adjustments of £1,887k. Excluding these non operating items would result in a surplus of £4k.

10 Other funds held for and on behalf of other NHS organisations

Within the balances of the Funds held by the Tees, Esk and Wear Valleys NHS General Charitable Fund there were no balances relating to other NHS Organisations.

11 Cash flow

The charity has taken advantage of the exemption available to it under section 7 of FRS102 not to produce a cash flow statement due to its size.

12 Taxation liability

As a registered charity, Tees, Esk and Wear Valleys NHS Charitable Fund is potentially exempt from taxation of income and gains falling within Part 10 of the Income Tax Act 2007 and s256 Taxation and Chargeable gains Act 1992. No tax charge has arisen in the year.

13 Post Balance Sheet events

There are no post balance sheet events to report.

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEE OF TEES, ESK AND WEAR VALLEYS NHS TRUST GENERAL CHARITABLE FUND

I report on the financial statements of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund for the year ended 31 March 2024, which are set out in Section 10

Respective responsibilities of trustees and examiner

The charity's trustee is responsible for the preparation of the financial statements. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the financial statements under section 145 of the 2011 Act;
- follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustee as a body. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the financial statements presented with those records. It also includes consideration of any unusual items or disclosures in the financial statements, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the financial statements present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, which is complete, no matters have come to my attention which give me reasonable cause to believe that in any material respect:

- accounting records were not kept in respect of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund in accordance with section 130 of the 2011 Act; or
- the financial statements do not accord with those records; or
- the financial statements do not comply with the applicable requirements concerning the form and content of financial statements set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the financial statements give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which, in my opinion, attention should be drawn in order to enable a proper understanding of the financial statements to be reached.

Signed:

Name: Gavin Barker (CPFA) for and on behalf of Mazars LLP
Relevant professional qualification or body: CIPFA
Address: The Corner, Bank Chambers, 26 Mosley Street, Newcastle upon Tyne, NE1 1DF
Date: 02-Dec-24

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11 December 2025**
Title:	**Communications update**
Executive Sponsor(s):	**Ann Bridges, Exec Director of Corp Affairs & Involvement**
Report Author(s):	**Sarah Paxton, Head of Communications**

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

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

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

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
13	***Public confidence***	*There is a risk that ongoing external scrutiny and adverse publicity could lead to low public and stakeholder perception and confidence in the services we provide. The report impacts public confidence with a focus on providing a clear, compelling and consistent narrative, demonstrating change, and showing the positive impact of these changes.* *This will support us to proactively build public confidence and trust.*

EXECUTIVE SUMMARY:

Purpose:

This report provides an update on the progress made on delivery of the Trust's communications strategy in October and November 2025.

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.

Press coverage and campaigns:

- 14 media releases were issued (6 in October and 8 in September) which is a 28% increase from our last board report and exceeds our KPI. This included a police officer who shared his recovery story, promotion of our TEWV 10k event, the opening of Hummingbird House and several award wins.

- We managed 9 media enquiries. This is lower than our last board update where we reported 27 media enquiries (however, the majority of those in August and September related to an inquest).

- In total there were 94 pieces of coverage across online news, TV, and radio (69 in October and 25 in November).

- All media enquiries we received across October and November were linked to negative issues including calls for a public inquiry and enquiries specifically about patient/family concerns or inquests. As a result, in October 45% of media sentiment was positive or neutral. In November, this increased to 64% positive or neutral.

- Following our meeting with York Press, we've had a helpful follow up meeting with the chief reporter. We also continue to have regular contact and strengthen our links with other journalists, media outlets and partners.

Our digital channels

- Our website had 79,878 page views in October and November (up 8% on our previous report). The top visited pages continue to be careers, services and locations.

- Our staff intranet had 165,065 in October and November (up 9% on our previous report). Top staff intranet news stories included the Star awards, our multiprofessional conference launch and staff survey winners.

Social media engagement:

- Across October and November our social media content reached 229,828 people (a 77% increase on our last report), with 70 total posts and 29,261 total followers.

- Overall, our social media engagement during October and November 2025 remains strong and successful in reaching a wide-ranging audience, generating positive interactions including world mental health day, our Annual General Meeting And RCPsych awards

Prior Consideration and Feedback:

Public confidence and trust cannot be managed solely through communications. Our communications reflect reality. 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

October 2025

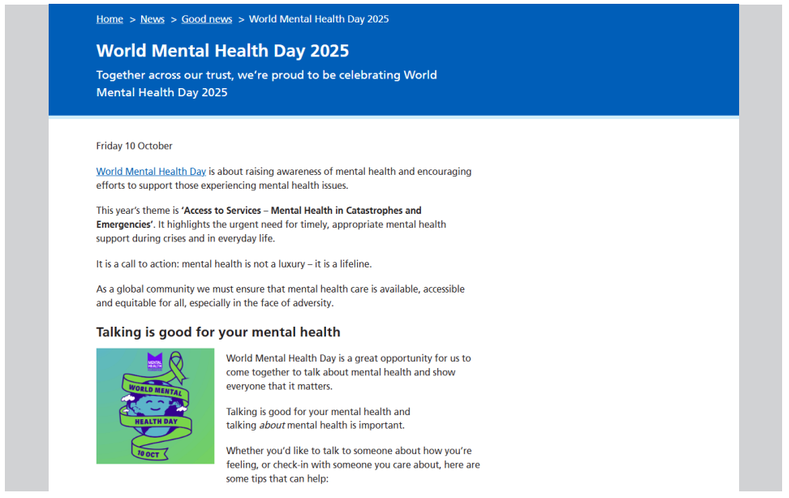
Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights

Publicised the opening of the new Yor Community Wellbeing Hub in York

Launched our Staff Survey communications campaign, announcing our first round of prize winners

Held our annual general meeting and staff marketplace at Teesside University



Marked World Mental Health Day by sharing top tips on our website and social media

Gained news coverage around patients from Primrose Lodge taking part in The Great British Beach Clean

Highlighted a 'Cape of Good Health' created by patients at Foss Park Hospital for World Mental Health Day

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	• Continued good news stories released to the media • Celebrated World Mental Health Day on 10 October • Organised and hosted our annual general and members meeting attended by over 200 people (online and in person) at Teesside University • Planning the Star Awards 2025, taking place on Thursday 6 November
Enhance staff engagement	• Launched this year's staff flu vaccination campaign • Continued workshops to support policy and document development • Launched the 2025 annual staff survey campaign • Supported Black History Month
Strengthen partnerships	• Partners included in the services marketplace of the AGM which was held at Teesside University • Produced our 2024/25 Review of the Year • Prepared briefings for upcoming MP meetings to support senior colleagues • Sent our partner newsletter
Support a culture of co-creation	• Planning an official launch for Hummingbird House in Harrogate in December • Planning and creating the next co-creation newsletter • Finalising video filmed with the mother of a person who died in our care
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

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

6 ↓
Media enquiries handled by the team

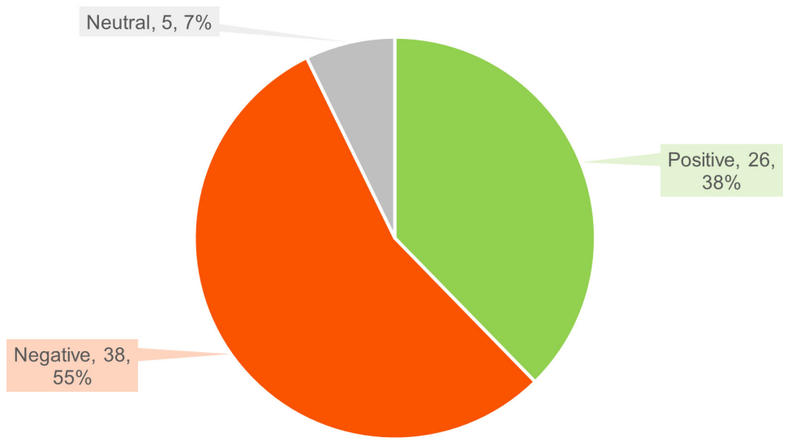
8 ↑
Media releases issued

69 ↓
Total pieces of coverage across online news, TV, and radio

Some of our news stories

- **Community 10k to return to York Racecourse next year** – *York Press*
- **Man who had taken a drug mix targeted lone walker in Darlington park** – *Northern Echo*
- **Meeting by Healthwatch York to discuss mental health support** – *Gazette & Herald*
- **North Yorkshire Police officer shares mental health recovery** – *York Press*
- **Bishop Auckland MP challenges Sir Keir Starmer during PMQs** – *Northern Echo*
- **'One of a kind' great-gran vows to carry on working for NHS - despite her upcoming 80th birthday** – *Teesside Live*
- **Primrose Lodge patients join South Shields beach clean** – *Northern Echo*

Media sentiment



Our website

39,582 ↑
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

81,068 ↑
page views

Top staff intranet news stories

1. Dedicated trust colleague vows to keep on working when she turns 80
2. Announcing TEWV's multiprofessional conference 2025
3. Staff survey our latest 20 voucher winners

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

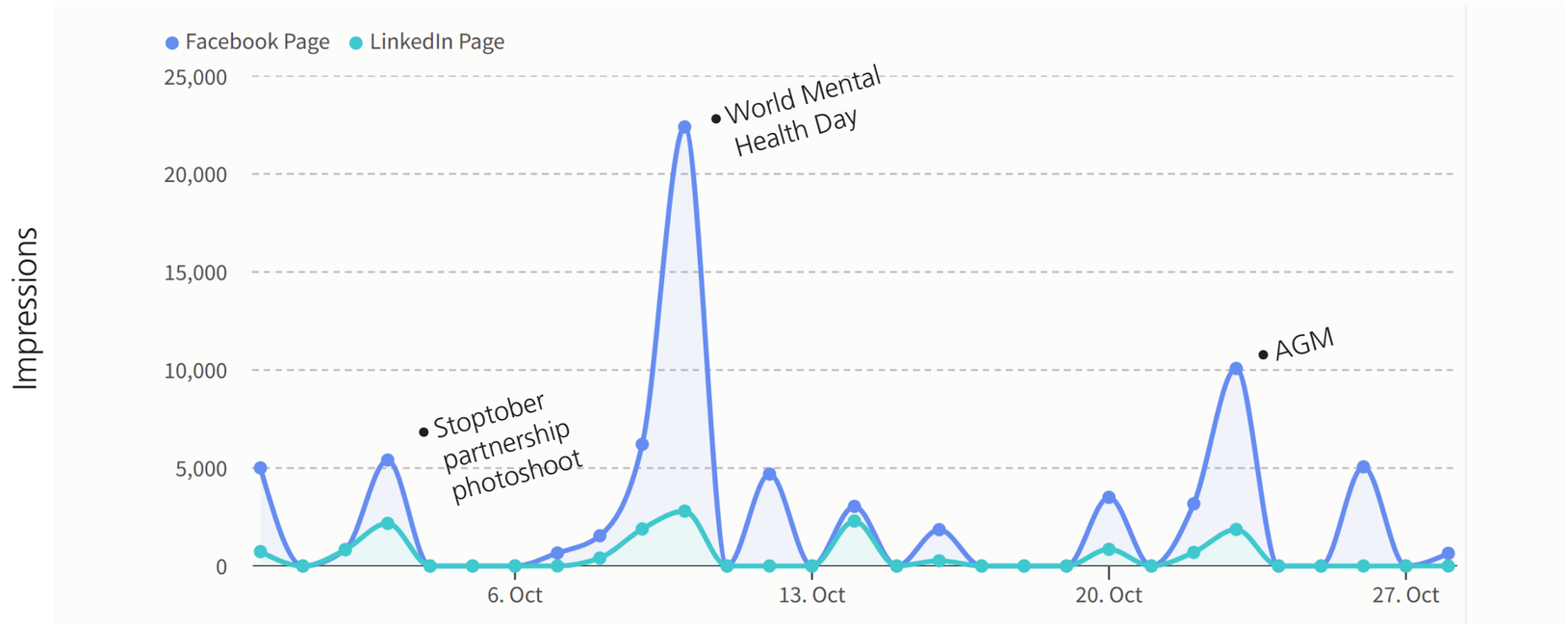
29,155 ↑
Total followers

145 ↑
New followers

74,103 ↑
People who saw our content - impressions

41 ↑
Total posts

Daily impressions



Top posts

Views 9,123 - Engagement 66

Impressions 1,771 - Engagement 97

Our work

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our ongoing work

Communications:

- Campaign planning
- 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
29
stories posted

Email enquires
491
email requests

Team TEWV
staff Facebook group
197 posts
535 comments
2,583 total members
23 new members

All staff emails
11
sent

Patient information
3
updated

Policies
104 total policies
278 total procedures and guidelines
9 consultations open
14 revised and published

Freedom of Information requests
45 received
27 responded to

Partner newsletter
6
stories shared

MP briefings
4

What we're working on

In November, our communications focus shifts to supporting the regional flu vaccination drive under the shared #BeWiseImmunise banner. Working alongside NHS partners across the North East and North Cumbria, we're aligning to one clear message so colleagues see and hear consistent prompts - why getting the flu jab matters and how to get it.

We'll be making it easy to find a clinic and get protected: signposts on the intranet to on-site pop-ups and roving clinics, weekly staff-briefing features, targeted all-staff emails, screensavers/desktop images, and updates on our staff social channels. For teams with limited digital access, we'll use line-manager cascades and in-person site visits to make sure no one misses out.

This year's regional campaign runs through winter, and eligibility includes frontline health and social care workers and all trust colleagues - so please take up your jab and encourage your teams to do the same. The more of us who get vaccinated, the better we protect our patients, our colleagues and our services.

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

World Mental Health Day marked annually on 10 October, aims to raise awareness of mental health and encourage efforts to support those experiencing mental health issues. The theme this year was 'Access to Services – Mental Health in Catastrophes and Emergencies'. It highlights the urgent need for timely, appropriate mental health support during crises and in everyday life.

Campaign objectives

Objective: Raise awareness of mental health and wellbeing by posting content on Facebook and LinkedIn reaching 1,000 viewers.

Outcome: high performing social posts and partnership working

How we measured success

- 7 pieces of content generated and shared across web, intranet, internal comms channels and social media
- An engaged social media audience (including non-followers)
- Activities captured from across the Trust's wide geographical area
- Achieved objectives to increase social media reach, which evidences the impact of the campaign
- Staff happy for their content to be shared externally

Facebook

In last 28 days (30 Sep – 28 Oct):

- There were 29,986 views of our World Mental Health Day content. Our posts reached 17,163 people and there were 212 interactions (such as 'likes')
- One of our World Mental Health Day posts was the top performing post this month, with 12,538 views (82% were non-followers), a reach of 7,594 and 103 interactions

Top Facebook posts	Views	Reach	Interactions
It's World Mental Health Day!	12,538	7,594	103
World Mental Health Day 2025 Round-up	7,937	3,815	51
"It's OK not to be OK." - Mark Foster's story	6,429	4,061	36
Cape of Good Health	3,082	1,693	22

LinkedIn

In last 28 days (30 Sep – 28 Oct):

- There were 2,771 views of our World Mental Health Day content. Our posts had 184 interactions (such as 'likes')
- Our most viewed World Mental Health Day post on LinkedIn had 1,232 views (30.8% were non-followers) and 79 interactions

Top LinkedIn posts	Views	Interactions	Article views
"It's OK not to be OK." - Mark Foster's story	1,232	79	23
It's World Mental Health Day!	780	61	N/A
Cape of Good Health	759	44	10

Communications Dashboard

November 2025

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights

New autism pilot diagnoses older people for the first time

Our Easington mental health service for older people is one of the first nationally to pilot diagnosing autism within the service.

Posted Tuesday, 25 November 2025 1 comment

Announced a new autism pilot that diagnoses older people for the first time, one of the first in the country

Marked the opening of Hartlepool's new 'One Life Centre' that our Adult Community Mental Health Team has moved into

Our annual Star Awards took place at Ramside Hall Hotel, honouring those who go the extra mile across our trust

Ridgeway Education rated 'outstanding' by City & Guilds in quality assurance inspection

Vocational programme celebrates patient success, partnerships, and pathway to college status.

4 November 2025

Ridgeway Education, a vocational learning service for patients in our Trust, has successfully passed its first full external quality assurance inspection by City & Guilds.

The service was graded 'outstanding' for exceeding quality standards, a major milestone in becoming a recognised college.

This rating means Ridgeway Education can move toward independently managing enrolment, deliver teaching, conduct examinations, and hold direct claims status that will give patients greater access to accredited learning opportunities.

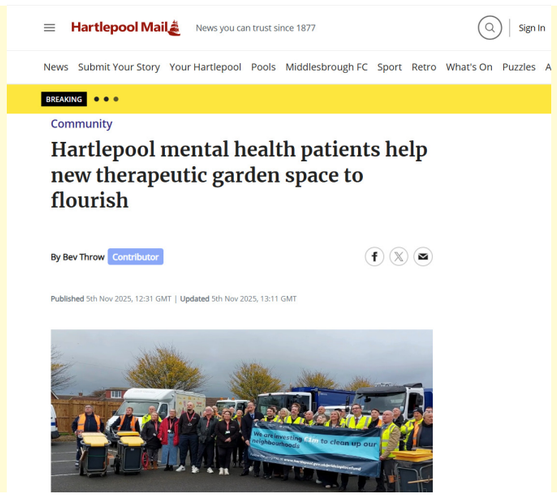
In September and October, our patients completed 18 City & Guilds functional skills exams, with all participants passing Maths and/or English, some achieving a perfect 100%.

Since 2023, over 200 AQA accredited units have also been awarded to our Ridgeway learners, including bespoke units developed to meet individual needs.

The education team includes a specialist teacher, lifelong learning tutor (joinery) and learning support assistant and has built strong partnerships with internal services and local organisations.

These include MGL Group, an engineering contractor that has supported wood

Publicised our Ridgeway Education vocational learning service being rated 'outstanding' in it's first external quality assurance inspection



Hartlepool Mail — News you can trust since 1877 — Sign In

News Submit Your Story Your Hartlepool Pools Middlesbrough FC Sport Retro What's On Puzzles A

BREAKING

Community

Hartlepool mental health patients help new therapeutic garden space to flourish

By Bev Throw Contributor

Published 5th Nov 2025, 12:31 GMT | Updated 5th Nov 2025, 13:11 GMT

Gained news coverage around a therapy garden in Hartlepool, supporting our adult mental health teams

Shared the news of our MHSOP clinical network group winning the top prize at the RCPsych awards

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	• Staged our annual Star Awards, which was the biggest event we've held so far • Continued good news stories released to the media • Supported with communications on the industrial action • Further work on the second phase of our brand – safe and kind care • Working with NHS England on incorporating the 24/7 mental health hub into their winter comms
Enhance staff engagement	• Promoted our new freedom to speak up service, including trustwide mailout of promotional materials • Promoted our 2025 staff flu vaccination campaign • Continued the 2025 annual staff survey campaign • Meeting teams across our trust as part of our staff personas work
Strengthen partnerships	• Working with partners on the Tees Valley CAMHS getting help service • Attended the official opening of One Life Centre in Hartlepool with MP Jonathan Brash • Prepared briefings for upcoming MP meetings to support senior colleagues • Sent our monthly partner newsletter • Planning the upcoming governor training and development days
Support a culture of co-creation	• Finalising video filmed with the mother of a person who died in our care
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 • Policy updates • Training for policy leads across our trust

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

3 ↓
Media enquiries handled by the team

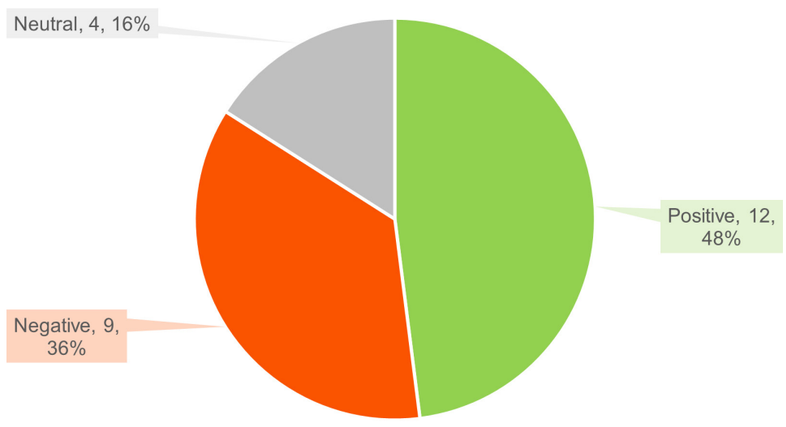
6 ↓
Media releases issued

25 ↓
Total pieces of coverage across online news, TV, and radio

Some of our news stories

- **Tees, Esk and Wear Valleys NHS Foundation Trust triumphs at prestigious national awards** – *Scarborough News*
- **Hartlepool mental health patients help new therapeutic garden space to flourish** – *Hartlepool Mail*
- **Ridgeway Education rated 'outstanding' by City & Guilds** – *Northern Echo*
- **New £2.1m mental health facility opens in Harrogate** – *Greatest Hits Radio*
- **Prime Minister provides TEWV public inquiry update** – *Northern Echo*
- **Inquest into death of Shildon' Curtis Davies delayed** – *Northern Echo*

Media sentiment



Our website

40,296 ↑
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

83,997 ↑
page views

Top staff intranet news stories

1. A glittering night at Star Awards
2. Patients and staff celebrate Black History Month with joyful event
3. Triumph at Royal College of Psychiatrists awards

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

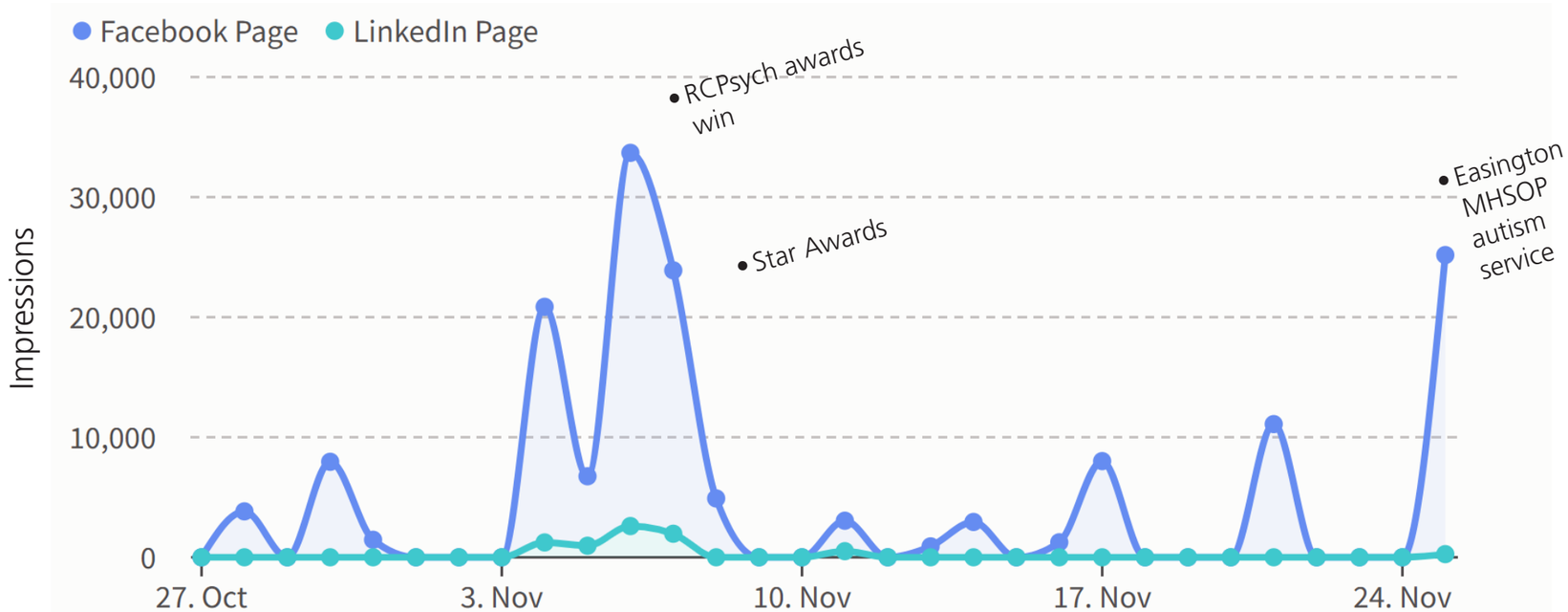
29,261 ↑
Total followers

148 ↑
New followers

155,725↑
People who saw our content - impressions

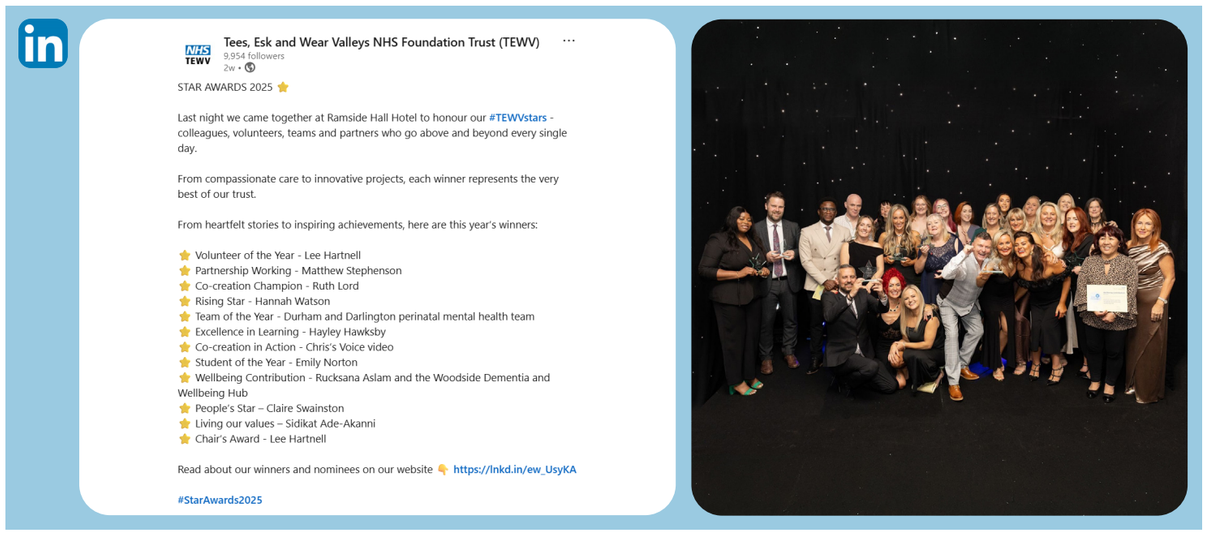
29 ↓
Total posts

Daily impressions



Top posts

Reach 16,797 - Interactions 379



Impressions 1,961 - Clicks 276

Our work

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our ongoing work

Communications:

- Campaign planning
- 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
25
stories posted

Email enquires
851
email requests

Team TEWV
staff Facebook group
190 posts
651 comments
2,609 total members
37 new members

All staff emails
9
sent

Patient information
3
updated

Policies
105 total policies
279 total procedures and guidelines
4 consultations open
13 revised and published

Freedom of Information requests
25 received
30 responded to

Partner newsletter
9
stories shared

MP briefings
5

What we're working on

As we look ahead to the new year we're planning a burst of promotion for the TEWV 10k.

Our very own running event will return for a third year on Sunday 26 April 2026 at the Knavesmire, York Racecourse – with entries now open.

The event is open to anyone and attracts up to 500 participants who all receive a medal when they cross the finish line.

We're the only NHS trust in the region, and we think the country, to organise our own running event, which continues to be a strong key message for us.

January is a key time to promote health and wellbeing and we'll take advantage of this with targeted promotion to our colleagues and the public.

This includes social media ads to people living in and around York, posters mailed out to York leisure centres and our trust sites, a desktop background, human interest stories, and more.

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 Trust Annual General and Members Meeting

We held our annual general and members meeting on Thursday 23 October at Teesside University, Middlesbrough. This was to present our trust's Annual Report, Annual Accounts and External Auditor's report for the end of the latest financial year. We shared the work that's taking place to drive forward our commitment to the NHS 10-year health plan and held an information to showcase our trust teams and services.

How we promoted the event

- All staff emails
- Governor emails
- Directors email
- Partner email
- Direct mail letter to everyone registered as a trust member
- Press release
- Newspaper advert
- Intranet news story
- Updates in the staff briefings
- Website – front page banner, news story and information page
- Social media posts

Quantitative Outcomes

Attendance

- 247 people attended the event in total. This is a record attendance for the event.
- 112 attended virtually
- 134 attended in person.
  - Of the in-person attendees 76% were staff, 6% were governors / non-executive directors, 9% were partners, 2% were volunteers or involvement members and 7% were students or members of the public.
- We are awaiting helpdesk support to establish information about the online audience.

Reach and engagement with our promotional content

- 12 facebook posts reached 24,268 people and had 177 engagements.
- 4 Linkedin posts were shown to users 2,143 times and had 57 engagements.
- 55 people viewed our staff intranet news story.
- There were 65 views of our website information

Q&A's

- 16 questions were asked, all of which were responded to. The questions covered a diverse range of topics. Most people thought their questions were answered well.

Online recording

- Since the event 17 people have viewed the video of our annual general and members meeting online.

Marketplace

- This year we had over 40 stalls including both TEWV services and partners.

Content and delivery

- Feedback regarding the content and presentations was generally positive.

Event objective

- Deliver our statutory responsibility of presenting our annual report, annual accounts and external auditor's report.
- Provide members, staff, patients, carers, partners and the public, with an opportunity to learn more about the trust and our current position.
- Give people the opportunity to ask questions, hold our leadership accountable and challenge our performance.

Learning

- Too much time was spent trying to find a suitable venue in North Yorkshire / York. This delayed the booking of a venue and the announcement of our AGM date, time and location. We were also investigating an online-only event to save costs.
- Visits to other NHSFTs annual general meetings inspired us to change the format of the event, in some cases bringing in elements such as the video content late in planning.
- The service marketplace continues to be popular with staff. There was a good variety of services and programmes represented and we received positive feedback.
- People liked the floor layout of the venue but were disappointed in the lack of free onsite parking. Together with weather and heavy traffic on the day this caused challenges for people, especially those attending the marketplace that needed to carry several items.
- The cost of mailing a letter to our members and placing a newspaper advert sees minimal return in general member attendance figures. This is reported across similar NHSFTs. We have been told by CoSec that this is in the Trust constitution, and we are questioning changing it.
- Online viewers experienced technical issues with the way the event displayed on their screens. This appears to be due to venue Wi-Fi issues

Future considerations

- Reviewing format of the event.
- Looking to make communications more efficient and removing 'paid for' elements of promotion.
- A provisional date for the 2026 AGM is already in diaries.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Communications update: a year-on-year comparison of media coverage

Board of directors meeting - December 2025

Respect Compassion Responsibility journey to change

Year on year comparison of media coverage

Tees, Esk and Wear Valleys NHS Foundation Trust

We've carried out some analysis of our media relations, to review the impact that our change in approach in 2025 has had compared to 2024.

In 2025 we've applied a more proactive communications strategy, with greater media coverage. Whilst we've seen a shift towards more challenging media enquiries, the majority of coverage maintained a positive or neutral sentiment. This indicates an effective management of public messaging during a period of increased scrutiny.

The table below provides some of the key analysis of our media relations for 2024 and 2025:

Year	No. of proactive news releases	No. of media enquiries	% of enquiries linked to negative issues	% of enquiries specifically about patient/family concerns or inquests	Pieces of media coverage	Average sentiment (% positive or neutral)
2024	51	97	51%	42%	437	Not reported in 2024
2025 – please note that this is only Jan-Nov	114	85	67%	59%	632	68%*

**To note - an inquest which took place in September was attended by Press Association resulting in widespread media coverage. Prior to that, on average 92% of media coverage was positive or neutral.*

Year on year comparison of media coverage

Tees, Esk and Wear Valleys NHS Foundation Trust

Over the past two years, we've seen a shift in our media engagement. In 2025 (Jan–Nov), there was a marked increase in proactive news releases, rising from 51 in 2024 to 114 so far this year. This reflects our more assertive communications approach to support our objective to build trust and increase public perception.

So far this year the number of media enquiries received decreased slightly, from 97 in 2024 to 85 in 2025. However, the nature of these enquiries shifted: a greater proportion were linked to negative issues (67% in 2025, up from 51% in 2024), and more specifically addressed patient/family concerns or inquests (59% in 2025, compared to 42% in 2024). This indicates that the complexity and sensitivity of topics raised have intensified.

The volume of media coverage increased this year, with 632 pieces in 2025 (Jan–Nov) versus 437 in 2024. This increase reflects both the heightened proactive output and the complex media enquiries. It's helpful to note that a high number of media coverage was also seen in September due to an inquest attended by Press Association (and subsequently led to wide-spread coverage).

Sentiment analysis, which we started to report in 2025, shows that 68% of coverage was positive or neutral, suggesting that despite the negative enquiries, the overall tone of media reporting remained largely balanced. And prior to the inquest in September referenced above, on average 92% of media coverage was positive or neutral.

We know that campaigns such as the launch of our ‘You Matter’ campaign and human interest stories work well. These remain a focus for our team.

A sizeable proportion of our media enquiries continue to be focused on people’s negative experience of our trust and on inquests. We work closely with our colleagues in legal, patient safety and safeguarding to ensure we are continuously horizon scanning to ensure we’re prepared. However, this does take time to plan and manage. A lot of work also goes on behind the scenes to provide any context that we’re able to share with the media and to influence, as far as possible, the balance of coverage.

We’ve also focused on strengthening our relationships with local media. This has had a positive impact enabling us to build trusted relationships with some of our local press, as well as an increase in media coverage with outlets such as Teesside Live. Despite challenges with the Northern Echo (which we understand other organisations experience), there has been some progress. Over the last year it has published more of our positive news stories. This is reflective of the quality of the news releases and also follows some open and honest conversations with journalists.

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11 December 2025**
Title:	**Register of Sealing**
Executive Sponsor(s):	**Alison Smith, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

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

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

1: 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:

To advise the Board of the use of the Trust's seal in accordance with Standing Order 15.2.

Proposal:

The Board is asked to receive and note this report.

Overview

The Trust's seal has been used as follows:

Ref	Document	Sealing Officers
446	Deed of Novation (Geoffrey Robinson Ltd and BGP Consulting) relating to the Phase 2 Remedial Works and Roseberry Park Hospital	Naomi Lonergan, Interim Managing Director Phil Bellas, Company Secretary

Ref	Document	Sealing Officers
447	Consultant Collateral Warranty (Geoffrey Robinson Ltd) relating to the Phase 2 Remedial Works and Roseberry Park hospital	Naomi Lonergan, Interim Managing Director Phil Bellas, Company Secretary
448	Deed of Novation (Geoffrey Robinson Ltd and P+HS Architects Ltd) relating to the Phase 2 Remedial Works and Roseberry Park Hospital	Naomi Lonergan, Interim Managing Director Phil Bellas, Company Secretary
449	Consultant Collateral Warranty (Geoffrey Robinson Ltd and Services Design Partnership) relating to the Phase 2 Remedial Works and Roseberry Park Hospital	Naomi Lonergan, Interim Managing Director Phil Bellas, Company Secretary
450	Deed of Novation (Geoffrey Robinson Ltd and Services Design Partnership) relating to the Phase 2 Remedial Works and Roseberry Park Hospital	Naomi Lonergan, Interim Managing Director Phil Bellas, Company Secretary
451	Consultant Collateral Warranty (BB7 Consulting Ltd) relating to the Phase 2 Remedial Works and Roseberry Park Hospital	Naomi Lonergan, Interim Managing Director Phil Bellas, Company Secretary
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453	Consultant Collateral Warranty (Geoffrey Robinson Ltd and BGP Consulting Ltd) relating to the Phase 2 Remedial Works and Roseberry Park Hospital	Naomi Lonergan, Interim Managing Director Phil Bellas, Company Secretary
454	Performance Bond	Ann Bridges, Executive Director for Corporate Affairs and Involvement Phil Bellas, Company Secretary

Prior Consideration and Feedback

None relating to this report.

Implications:

None relating to this report.

Recommendations:

The Board is asked to note this report.