Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

12 February 2026
at 10.30am

The Boardroom, West Park Hospital, 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 Board meeting held on 11 December 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 10 February 2025)*	Co Sec	10.50am

Strategic Items

8	Board Assurance Framework Summary Report	Co Sec	10.55am
9	Chief Executive's Public Report	Dep CEO	11.00am
10	Integrated Performance Report at 31 December 2025	Int EDS&T Int CG MD	11.10am

11.50AM BREAK

BAF Risk 1: Safe Staffing

11	Report of the Chair of People, Culture and Diversity Committee, which includes the following statutory reports to Board: a. Pay Gaps Report (gender, ethnicity, disability) b. Equality Delivery System 22 c. Report of the Freedom to Speak up Guardian	Cmt Chair EDfP&C EDfP&C FTSUG	12.00pm 12.10pm 12.15pm 12.20pm
12	Quarterly Report of the Guardian of Safe Working Hours for Postgraduate Doctors, Quarter 3 2025/26	GoSW	12.35pm
13	Getting the Basics Right for Resident Doctors	Resident Doctor Peer Lead	12.45pm

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

14	Report of the Chair of the Quality Assurance Committee, which includes the following statutory report to Board: a. Quarterly Learning from Deaths Report, Quarter 3 2025/26	Cmt Chair EMD	12.55pm 1.05pm
15	Leadership Walkabout Feedback – January 2026	EDCA&I	1.10pm

BAF Risk 10: Regulatory Compliance

16	Report of the Chair of Mental Health Legislation Committee	Cmt Chair	1.15pm

BAF Risk 13: Public Confidence

17	Communications update	EDCA&I	1.20pm

Governance

18	Board Assurance Framework (verbal)	Chair	1.30pm

Exclusion of the Public:

19	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	1.40pm

1.40PM BREAK

Strategic Items

20	Chief Executive's Confidential Report	Dep CEO	2.10pm
21	Reportable Issues Log	CN	2.25pm
22	Report of the Chair of Audit & Risk Committee *(for information - verbal update provided 11 December 2025)*	Cmt Chair	-

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

23	Report of the Chair of Resources & Planning Committee, which includes the following reports to Board:	Cmt Chair	2.30pm
	a. Electronic Patient Record *(verbal)*	CIO	2.40pm
	b. NHS Health and Safety Standards	EDFE&F	2.45pm
	c. Medium Term Plan	Int. EDS&T EDFE&F	2.50pm
	d. 2025/26 Month 9 Finance Report	EDFE&F	3.05pm

Governance

24	Board Assurance Framework	Co Sec	3.15pm

Standard Items

25	Minutes of the confidential session of the Board of Directors meeting held on 11 December 2025	Chair	3.35pm
26	Board Confidential Action Log	Chair	

Matters for information

27	To receive and note the minutes of the meetings of the following committees: a. Audit & Risk Committee, September 2025 b. Mental Health Legislation Committee, September 2025 c. People, Culture & Diversity Committee, October 2025 d. Resources & Planning Committee, October 2025 e. Quality Assurance Committee, November 2025 f. Quality Assurance Committee, December 2025	Co Sec	-

Evaluation

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

B Reilly
Interim Chair
6 February 2026

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 11 DECEMBER 2025 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS

Present:
B Reilly, Interim Chair
A Smith, Chief Executive
N Adetuberu, Non-Executive Director
R Barker, Non-Executive Director
K Kale, Executive Medical Director
N Lonergan, Interim Care Group Managing Director
J Maddison, Non-Executive Director
B Murphy, Chief Nurse
J Preston, Non-Executive Director and Senior Independent Director
L Romaniak, Executive Director of Finance, Estates and Facilities
C Wood, Non-Executive Director
D Butcher, Associate Non-Executive Director (non-voting)
E Gorringe, Associate Non-Executive Director (non-voting)
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
L Bennett, Innovations Project Manager (for agenda item 19)
N Black, Chief Information Officer
K Christon, Deputy Company Secretary (minutes)
S Daniel, Head of Research (for agenda item 18)
H El-Sayeh, Director of Medical Education (for agenda item 15)

Observing:
A Ghanzarfar, Resident Doctor Lead

164. CHAIRS WELCOME AND INTRODUCTION

The Chair opened the meeting and extended a welcome to N Adetuberu, D Butcher and E Gorringe and introductions were provided.

The Chair invited D Butcher to provide an evaluation at the end of the meeting and welcomed changes that had been made to the agenda, following the evaluation at the last meeting.

165. APOLOGIES FOR ABSENCE

Apologies for absence were received from J Robinson, Non-Executive Director.

166. DECLARATIONS OF INTEREST

None.

167. MINUTES OF THE LAST BOARD MEETING HELD ON 9 OCTOBER 2025

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

168. BOARD ACTION LOG

Agreed*: Board notes the action log and acknowledges there are no outstanding actions where no progress had been reported.*

169. INTERIM CHAIR REPORT

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

She drew attention to national and regional meetings she had attended and the focus on medium term planning, and the NHS Providers Conference, where the Trust had been referred to as a trailblazer, in relation to its approach to the community transformation work undertaken in Hartlepool.

She also welcomed the engagement at the last Council of Governors meeting and the Trust's Annual General and Members' Meeting in October and noted the recent leadership walkabouts and the strategic seminar attended by Board members.

She went on to reflected on the Staff Star Awards and the Ridgeway Awards and commended all those who had been nominated or won an award. She also commented on her visit to Westerdale North and Westerdale South and recognised the work of V Heard, a long-serving employee who had recently celebrated her 80th birthday and who continued to work, despite a lengthy commute.

170. QUESTIONS FROM GOVERNORS

None received.

171. BOARD ASSURANCE FRAMEWORK

P Bellas presented the report, which provided information on risks included in the Board Assurance Framework (BAF) to support discussion at the meeting.

In discussion:

1. B Murphy noted that the last Board meeting had acknowledged that the target score for BAF risk 4 [quality of care] and BAF risk 8 [quality governance] had been achieved and she welcomed the approval of Board to discuss with Quality Assurance Committee the option to amalgamate and restate the risks to reflect the Trust's revised circumstances.

   P Bellas acknowledged that the proposal would fit with the timing for the full review of the BAF before the end of 2025/26.

   It was proposed and agreed that the current risks would remain open until Board received a recommendation via Quality Assurance Committee on restated risks, aligned to the full review of the BAF. **Action: B Murphy/P Bellas**
2. It was noted that the BAF review also provided an opportunity to review and restate BAF risk 2 [demand].

3. It was acknowledged that the full BAF report reflected the position at quarter 2 2025/26 and there had been subsequent changes. The refresh of the BAF would also reflect a more challenging financial context, as discussed at Audit and Risk Committee.
4. K Kale provided assurance that a focus would be given to completion of BAF risk 14 [health inequalities] and the Chair emphasised the importance of a fully populated report, with further detail provided in the confidential BAF report.
5. R Barker advised that People, Culture and Diversity Committee had considered relevant BAF risks and changes it would propose to reflect medium term planning, as part of the BAF review.
6. The Chair reminded the Board that the report served as an aide memoire during the meeting and invited committee chairs to consider at their next committee meetings those risks where there was a variance between the present and target risk score and/or between the present risk score and tolerance. **Action: Committee Chairs**

172. 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 drew attention to the national focus given to the robustness of winter plans and support that would be provided to system partners should that be required. She also referenced integrated care system reforms, the Trust Annual General and Members' meeting, the Star Awards and the continued focus on financial sustainability and delivery of Medium Term Plan submissions in December 2025 and February 2026.

In discussion:

1. K Ellis noted that development of the regional blueprint would consider the function and role of regional teams and commented on the positive discussions between the specialist provider collaborative and the regional team on how change may support innovation and build on existing work.
2. K Kale provided assurance on plans in place for the forthcoming strike action by resident doctors. He noted that 70% of doctors had taken strike action during the last strike action, an increase from 50%.

   A Smith welcomed the support provided by doctors in training during periods of industrial action.
3. B Murphy advised that staff uptake of the flu vaccination had reached approx. 40% and progress had been slow. The Trust would continue to provide clinics and mobile sessions and would take every opportunity to highlight the impact of flu and the duty to protect those in the Trust's care.

Agreed: *Board receives and notes the content of the report.*

173. 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 21 measures where there was good or substantial assurance and highlighted areas of positive assurance in relation to carers feeling actively involved, inpatients feeling safe in the Trust's care, children and young people showing a measurable improvement from treatment and the continued achievement of zero out of area placements, which would be a national target from April 2026. She went on to highlight

areas of focus for further improvement, which included outcomes, bed occupancy and rates of mandatory and statutory training.

Commenting further, N Lonergan drew attention to continued concerns about the level of patients who were clinically ready for discharge across adult and older adult services. She commented on work in progress with partners in North Yorkshire and with regional directors of social services on shared challenges and potential solutions, and further work that would be completed to understand related challenges in secure services and health and justice and on the potential for avoidable harm while waiting for discharge. She also noted that a reduction in patients who had been clinically ready for discharge for some time, would have a negative impact on length of stay.

She went on to highlighted that whilst there had been sustained improvement in waiting times, there were pressures in York, Harrogate and Ripon and the annual standard for children eating disorders would not be achieved. However, except for a small number of breaches, the Trust was able to offer patients appointments within required timescales.

In respect of staffing, she noted the improvement in face-to-face training and continued focus on management of sickness absence.

Commenting further, L Romaniak confirmed the Trust remained on track to deliver the breakeven plan for 2025/26 as a result of the significant effort to deliver challenging cost reductions, maintain workforce levels and ensure grip and control over flexible staffing. She reflected on action taken to reduce overtime and use of agency staff from 4.45% of pay bill in 2023/24 to 1.61% year to date, and the positive impact of this on quality.

She corrected the clinically ready for discharge annualised costs quoted in the report [page 53, slide 82], which should read £10.4m year to date and £17.8m full year cost and noted this represented a significant opportunity cost.

She then commented on preparation for 2026/27, where the Trust would be required to detail further transformative actions for the February Medium Term Plan submission, which reflected continued sector and system pressures.

In discussion:

1. A Smith confirmed that the Trust remained accountable for patients who remained in its care, while clinically ready for discharge and would do its best to maintain the enhancements they had achieved. She proposed the Trust would use its influence to support discussions with social care, housing and voluntary sector partners to understand improvements that would support more timely discharge.

   In respect of accountability for timely discharge, she referenced N Lonergan's engagement with directors of social care and chief executives and confirmed that concerns had been escalated to the integrated care boards. She proposed that the system would prioritise actions that responded to challenges faced by acute trusts and that this did not preclude the Trust from using its influence through good working relationships to refresh agreed actions.
2. L Romaniak acknowledged the position reflected a national challenge and outlined an example of transformation activity within adult learning disability services, where work had been undertaken with North East North Cumbria Integrated Care Board (NENC ICB) to divert investment into intensive support teams to support patients to remain well in the community, to reduce the risk of admission.

She also commented on left shift initiatives that provided an alternative to admission for those in crisis, such as the Darlington Crisis House.

3. K Kale confirmed that Quality Assurance Committee had discussed concerns about the level of patients clinically ready for discharge and the potential that this may cause unnecessary harm.
4. K Ellis advised that discussions with directors of social care included the immediate escalation of people who were in the Trust's care in addition to a longer-term focus on how partners would work together to commission support for patients with specialist needs.
5. The Board welcomed the clarity the report provided on causes, impact and solutions to support non-executive directors to understand risks, actions taken in mitigation and anticipated timescales, albeit that significant movement in some areas may not be seen in the short term.
6. Emphasis was given to the importance of linking board discussions to the Board Assurance Framework and it was recognised that while risks sat with the Trust, a response was not always within its control. It was also proposed that risks related to partnership and system working may increase over time as sector-wide challenges increased.
7. J Maddison provided assurance on the scrutiny and oversight at Resources and Planning Committee and he commended work undertaken to achieve recurrent reductions and to reduce use of agency, which had a major impact on quality of care and financial performance.

   He acknowledged that the report was lengthy and took a significant amount of time to produce and proposed that it may be an opportune time to revisit the report and how it was used, with a view to reducing the workload, whilst maintaining robust assurance.
8. The Chair reflected on the quality impact following a recent visit to a mental health ward for older people. Staff discussed the real impact on patients and their families who had experienced significant discharge delays. One gentleman who was placed on an end-of-life pathway whilst waiting for discharge and passed away on the ward. The Chair reminded the Board of the importance of the Board to ward/service connection.

   She proposed that, while the family had expressed gratitude for the compassionate care provided, the case highlighted the sad consequences of system delays and she queried what had been achieved over recent years and requested a progress update to the next Board meeting. **Action: N Lonergan**

9. Responding to the patient story highlighted in discussion, A Smith proposed that whilst the Trust provided a safe and comfortable environment, it was not the most appropriate place to reside but may be the only option when alternative placements were not available.

   She proposed that, given the complexity of financial, demand and acuity challenges, the adoption of an end-to-end pathway that focused on prevention of unnecessary admissions and provided robust community support, was the right approach to take.

   She suggested that, as a complex situation, the Trust may need to manage its expectations regarding the outcome of discussions with partners and would focus on support to those who were in the Trust's care and transformation of care delivery towards intensive community based support.

Agreed: *Board receives the report with:*

i. Good controls assurance on the operation of the Performance Management Framework.

ii. *Good performance assurance on the Trust's current NOF segmentation. However, reasonable assurance that our NOF segmentation can be maintained.*
iii. *Reasonable performance assurance on the IPD, National Quality requirements/ Mental Health Priorities and on Waiting Times. However, recognising there is limited assurance about the quality impact of those patients who are waiting to access services, which Quality Assurance Committee is actively monitoring.*
iv. *Assurance that the strategic risks are being managed effectively.*

174. CORPORATE RISK REGISTER

B Murphy presented the report, which proposed there was good assurance on the management of risk and oversight of organisational wide risks rated as high in the Corporate Risk Register (CRR). She drew attention to the inclusion of a new finance risk related to delivery of the 2025/26 financial plan and reported there was good risk review compliance.

In discussion:

1. Assurance was sought on progress to reduce potential ligature points [risk 811] where the level of assurance was described as reasonable.

   In response, B Murphy advised that Quality Assurance Committee had agreed that the risk required a review and possible restatement. She outlined the distinction between risks associated with patients using a ligature and those involving an anchor point and discussed the Trust's rigorous approach to continuous risk assessment across all inpatient units to identify potential anchor points and inform environmental changes, monitored by the bi-monthly Environmental Risk Group.

   She went on to note that nationally mental health services often encountered patients who used ligatures only as a coping mechanism. Nevertheless, this presented a risk that influenced the overall risk score in the CRR more than environmental factors.

   It was noted that Quality Assurance Committee had received a summary explanation of work undertaken and proposed that it would be useful to share this to provide assurance to Board that there was significant focus on this issue. **Action: B Murphy**
2. J Maddison advised that Audit and Risk Committee had taken good assurance on the oversight of risks by care groups, Executive Risk Group and by each Board committee.
3. Board noted an expectation that Executive Risk Group would review the level of risk associated with clinical supervision.
4. The Chair noted that 14 risks were distributed across the Board committees, with a significant share of the responsibility held by Resource and Planning Committee, and she proposed to review committee membership to ensure the committee had appropriate representation. **Action: B Reilly**

   It was also noted that some risks were cross cutting.

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

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

As a verbal report had been provided at the last meeting, Board noted the report.

The Chair proposed that, whilst there had been some improvement in discrimination statistics, the figures remained unacceptable if the organisation was committed to anti-

racism and she highlighted the opportunity to adopt good practice by other organisations where appropriate.

In response, S Dexter-Smith advised that following the committee meeting, staff had the opportunity to reflect on the data and actions that would have the greatest impact. She concurred that learning was valuable and the Trust was able to demonstrate the number of times complaints were followed up and brought to a conclusion.

Agreed: *Board receives and notes the contents of the report.*

176. ANNUAL SAFE STAFFING ESTABLISHMENT REVIEW 2024-2025

B Murphy presented the report, which provided good assurance that the annual establishment review 2025 had been conducted in line with national regulatory requirements for all inpatient wards.

She advised that the detailed supporting analysis had been considered by care groups and Quality Assurance Committee and provided assurance that the review had adhered to the required methodology, alongside professional judgement. She highlighted:

- The reduction in health care workers fulfilling the duties of Registered Nurses, with further work to do.
- The improvement in the vacancy rates in Secure Inpatient Services, which were often at zero for Registered Nurses - with rates between zero to 10% - and reflected the substantial efforts of service leaders.
- The improvement in HealthRoster and SafeCare systems, supported by good engagement in monthly safer staffing meetings, chaired by herself and supported by the Head of Workforce Strategy and Systems.
- Despite generous headroom, some services continued to operate beyond agreed staffing levels and further clarity was needed on the level of non-clinical duties that took staff away from core responsibilities.
- Further work to be carried out in relation to care hours per patient day, where the data did not align with investment across multiprofessional roles.
- The improved risk rating for teams using the mental health optimisation tool, which evidenced progress in safer staffing from 2023 to 2025. The 2026 review was underway in the context of reduced bed occupancy, and further improvements were expected.

In discussion:

1. S Dexter-Smith referenced the earlier Board discussion on the Board Assurance Framework safe staffing risk and she welcomed the clarity provided by the report, to support workforce planning.

   She went on to commend the strength, rigour and oversight of Board reports presented at the meeting, which reflected the Trust's commitment to meeting the needs of patient groups.
2. J Maddison welcomed the assurance provided to Quality Assurance Committee on work undertaken and noted an expectation that further work would be carried out in relation to level loading.
3. It was suggested that staff perceptions highlighted during leadership walkabouts, may not align with the information presented and in response, B Murphy provided an example from a recent ward visit, where staff considered they were short staffed despite operating with more staff that budgeted. She agreed that there was more to do to bridge the gap in perspectives and ensure a shared understanding of budgets and clinical need.

4. L Romaniak noted that the Board had agreed to deploy additional staff to address identified challenges, for example to accommodate patients with complex needs, and proposed that as patients were discharged and support was provided in the community to prevent readmission, there was an opportunity to stabilise the budget and staffing levels in wards without an impact on patient care.
5. K Ellis emphasised the need to use all available data to help inform future workforce planning and transformation to ensure there was an optimal balance and a collective view by the Board on any tensions.
6. The Chair welcomed the eradication of use of agency staff from the majority of DTVF care group services.
7. The Chair welcomed the opportunity for the board to receive assurance on safe staffing within community services and therapies, as a significant proportion of the workforce.

   In response, B Murphy noted that she was only required to report to Board on safe staffing within inpatient services and advised that the Trust had implemented eRoster in crisis services with reports provided to safer staffing meetings and had agreed a roll out programme, which included community services. This would provide an improved level of oversight and required coordination across multiple teams to ensure consistency, alongside other responsibilities.

   Commenting further, N Lonergan advised of work underway to map current community resources and opportunities. H Crawford also noted work undertaken to understand the wider therapies establishment and demand, and national tools to contribute to the professional opinion. The Chair welcomed the opportunity to see the outputs from his work. **Action: N Lonergan/H Crawford**

Agreed: *there is good assurance that the Trust has met the National Quality Board requirements to complete and report out the annual Safer Staffing Review.*

The Chair varied the order of the agenda.

177. LEARNING FROM DEATHS RPEORT QUARTER 2 2025/26

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

He drew attention to: the reported inpatient and community deaths that had occurred during the quarter and those where patient safety investigations or mortality reviews had been completed; the circulation of two patient safety bulletins; and discussion of learning themes at fundamental standards, the Organisational Learning Group and the Medical Director webinar. He also noted the in-house development of the quality dashboard to include mortality reviews.

He confirmed that the report would be considered in detail at the next Quality Assurance Committee.

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

178. MEDICAL EDUCATION ANNUAL BOARD REPORT

H El-Sayah presented the report, which provided an overview of medical education activity during 2024/25 and outlined key priorities for the academic year 2025/26. He drew attention to key successes during the year and noted challenges linked to trainer capacity, educational estate limitations, budget constraints and vacancies.

In discussion:

1. L Romaniak advised that while a scheme for the development of the estate at Lanchester Road Hospital had been developed, the university had not been able to confirm trainee numbers and its viability could not be confirmed. A collective decision had therefore been taken not to proceed. Discussions were ongoing with funders to identify alternative opportunities for investment.
2. It was proposed that learning centres be developed that would be open to all professions, recognising this would support staff retention and benefit the local community, from which staff were recruited.

   H El-Sayed acknowledged the point raised and noted the Trust had previously had an interprofessional tutor within the faculty and more recently had reestablished the interprofessional working group to identify commonalities that would support interdisciplinary and team-based learning and to use resources more widely.

   N Black concurred with the need to link education to innovation, research and development and he emphasised the opportunity to use technology to drive transformation through the redesign processes to enable people to work differently.
3. Board welcomed the ranking of the Trust in the top 10 by trainees and trainers, which reflected the Trust's strong organisational culture and values despite financial pressures.
4. A query was raised about how the Trust aimed to address the challenge of availability of trainers for supervision and in response H El-Sayah indicated this was a regional challenge. He also noted workforce planning concerns related to the future retirement and flexible working of staff aged 55 plus, which would create pressure across Trust services.

   He reflected on the need to find a balance between clinical, managerial, educational and research priorities and noted the future benefits that the Trust would achieve through an investment in education. He went on to propose that measures of success would be the ability to recruit locally and from non-traditional backgrounds and the progression of students to foundation doctor status.

   K Kale added that the Trust had an established recruitment and retention strategy for the medical workforce and had been successful in the recruitment of a number of additional consultants during 2025.

The Chair brought the discussion to a close and thanked the Medical Education Leadership Team for all their work during the year.

Agreed: *there is good assurance regarding the placements of medical students and resident doctors in the Trust.*

[E Gorringe left the meeting]

179. GUARDIAN OF SAFE WORKING

S Beattie, Guardian of Safe Working Hours, presented the report, which provided assurance that postgraduate doctors were safely rostered and their working hours were safe and complied with their terms and conditions of service. She confirmed that there were no patterns of unsafe working and drew the Board's attention to:

- The downward trend in non-residential on-call exception reports in NYYS Care Group, which indicated that doctors had not worked beyond their contracted hours.

- The increase in education exception reports in NYYS Care Group, where the Executive Medical Director and Head of Medical Education would meet with resident doctors to understand the impact of recent rota changes.
- Changes to exception reporting from February 2026, which may lead to additional fines and change the format of guardian's report. The Trust already operated in line with the requirement to restrict access to related data.
- Work that would be undertaken to ensure governance arrangements were in place to support the new payment process, where resident doctors opted to receive payment for working up to two hours beyond their work schedule due to patient safety, rather than take time off in lieu.

In discussion, K Kale noted a rota review and monitoring of activity completed for middle tier doctors had indicated that there was not a higher level of activity that may lead to an increase in exception reporting.

Agreed: *there is good assurance that the Guardian of Safe Working function is working well and resident doctors are safely rostered and that their working hours are safe and in compliance with their terms and conditions of service.*

180. REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

The Chair noted the Board papers included a report from the committee meeting held in September 2025, as reported verbally at the last meeting.

J Preston, Chair of Quality Assurance Committee (QAC), presented the report and summarised the key areas of discussion at the committee meeting held on 27 November 2025. He drew the Board's attention to a concern about compliance with clinical supervision and the related discussion at Audit and Risk Committee following the outcome of the internal audit report.

In discussion:

1. S Dexter-Smith confirmed that clinical supervision was raised at the last CQC inspection and the internal audit report showed that there was greater assurance on Trust practice, but data was not able to be drawn easily from the system. She also reflected that the existing policy was overly complex and would be rewritten as part of a sequence of work.
2. B Murphy concurred with the position outlined and noted that QAC had previously been briefed on medical supervision, where there was a gap between supervision delivered and recorded, and the Trust's ability to demonstrate that. A paper would be presented to a future committee meeting to confirm the position, next steps and outcomes that would be delivered and when. She went on to note the Board's discussion on staff sickness and safe care and reflected on how supervision contributed to staff who felt supported and valued.
3. K Kale confirmed that doctors were expected to report all clinical supervision and demonstrate frequency to meet the CQC requirement for continuous supervision. A template had been introduced and reinforced via the Medical Staff Committee, webinar, weekly bulletins and the Local Negotiating Committee.
4. H Crawford confirmed that the requirement also applied to therapies and noted that a metric would be developed through the Integrated Performance Report, to give wards visibility on the position.
5. Clarity was sought on the timeline for actions and how progress would be reported to Board to provide assurance and S Dexter-Smith confirmed that an action plan would be considered by Audit and Risk Committee and reported via the committee report to Board.

J Maddison confirmed that Audit and Risk Committee would monitor progress and receive updates via other Board committees and had also discussed lessons learned from any limited assurance report.

It was agreed that an update on progress against all actions would be provided to the Board in six months. **Action: S Dexter-Smith**

Agreed: *the report is received with good assurance with regards to the governance, oversight and management of risks to quality of care.*

181. RESEARCH AND DEVELOPMENT ANNUAL REPORT 2024/25

S Daniel presented the report and accompanying slides, which provided an update on the 2021-2025 research and development plan and provided assurance on research and development activity in the Trust for the period 1 April 2024 to 31 March 2025.

Apologies for absence were received from D Ekers, Clinical Director of Research and Development.

In discussion:

1. K Kale highlighted research facilitated by the team on the request of NHS England in relation to mental health job planning for consultants.
2. B Murphy reiterated a previous query about the allocation of funding for the development of research and how that may be used to involve more nurses in research. She also expressed interest in a piece of work to assess the impact on quality of care should inpatient wards receive a significant amount of research and support.

   In response, S Daniel confirmed that research capability funding was available to support staff develop small research projects as groundwork to apply for a larger research award. 22 internal projects had been supported in 2025 and £150k would be available in 2026. She also noted that she was funded two days per week to support nursing research and acknowledged that nursing participated in less research than other professions.

   The Chair noted this position was also reflected in therapies.
3. A Smith emphasised the opportunity to refocus and prioritise the Trust's role in research and development, in line with its role as an anchor organisation and educator. She expressed her support for research activity and confirmed this remained a priority for the Trust.
4. H Crawford welcomed the progress in research activity. She discussed the responsibility of clinical leaders to model engagement in research and outlined an example of a dementia project, which had benefited from a multidisciplinary approach and supported delivery of Trust priorities.

   She went on to acknowledge challenges linked to the capacity of nursing staff to undertake research and discussed the importance of providing support to staff to undertake research and to understand the outcome of audits and service evaluation to highlight areas for improvement.

   S Daniel confirmed that, as research partners, the universities were keen to support the Trust to focus on its priorities.

5. S Dexter-Smith proposed that, as a genuine research driven organisation, all clinical and corporate staff should have the opportunity to engage in research activity.

Agreed: *Board approves the Research and Development Annual Board Report 2024/25.*

182. INNOVATIONS ANNUAL REPORT 2024/25

The Chair welcomed the introduction of the report for the Board and L Bennett presented the report, which provided assurance on innovation activity for the period 1 April 2024 to 31 March 2025.

In discussion:

1. L Romaniak provided assurance that there were no financial concerns about Trust involvement in the Third Age Therapeutics spin-out, in partnership with the University of York.
2. Board highlighted the need to maximise innovation for patient benefit and financial sustainability and the potential to consider its role in the development of the medium term plan.
3. K Kale noted the limited capacity of the team and discussed potential to consider invest to save options to provide additional capacity and L Romaniak acknowledged what had been achieved with limited resources and the positive impact innovation activity would have on staff engagement and recruitment.

   L Bennett went on to emphasise the potential for innovation and alternative arrangements in place at different Trusts. She also highlighted the support received from the Digital and Data team to support delivery of tangible benefits through the AliveCor project.

Agreed: *Board receives the Innovations Annual Report 2024/25.*

183. LEADERSHIP WALKABOUT FEEDBACK

A Bridges presented the report which summarised feedback from leadership walkabouts across various service areas that took place in September and October 2025 and proposed there was good assurance that visits were recorded and actions reviewed and monitored for completion.

In discussion:

1. L Romaniak highlighted that, whilst the Trust had a revenue budget of £55m for 2025/25, capital expenditure was limited to £11.4m across the Trust's estate of 110 sites. She welcomed the opportunity to listen to staff to identify changes that were able to be responded to within existing capital constraints and stressed the need to think creativity and work collaboratively with any landlords. She went on to note that the Trust's estate – particularly inpatient facilities - compared favourably to others and acknowledged that any issue highlighted had potential to impact on staff and patient experience.

   A Smith concurred the Trust's estate was exceptional, compared to that of many other mental health trusts and, whilst she acknowledged the aspiration to be perfect, she stressed the need to balance priorities and focus on identified risks.
2. Board noted there were a number of reoccurring themes and queried how feedback was provided to staff.

In response, A Bridges confirmed that feedback reports were shared with services and themes highlighted through the Organisational Learning Group and in committee discussions. She noted that executive directors were responsible for action follow-up, which was monitored monthly, and cited an example from Willow Ward, where an equipment request had been resolved promptly via the Trust's charitable funds.

3. A Smith proposed the development of a thematic feedback loop via an annual or bi-annual report to Board, which provided a summary of 'you said, we did' actions to provide process assurance. A Bridges noted this would also benefit Governors who attended visits and proposed it be shared with Council of Governors. It was agreed that executive directors would consider the proposal further and related timescales.

Action: A Bridges

4. A concern was expressed about the attendance on leadership walkabouts by Non-Executive Directors at 52% and noted that this was a commitment and important to support floor to board engagement. The Chair acknowledged the point raised and the challenge that NEDs faced in balancing capacity and demand.

   It was also acknowledged that attendance by Governors at leadership walkabouts had been limited.

Agreed: *Board receives the report with good assurance.*

184. REPORT OF THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE

As the Board had received a verbal update at the last Board meeting, the report was received for information.

J Preston, Chair of the committee, advised that Audit and Risk Committee had considered the Charitable Funds Annual Report and Accounts and received a report from the external auditor to confirm that expenditure was appropriate and not used to offset Trust costs. A query raised by the external auditor in relation to the determination of funds as 'restricted' had been resolved and he noted that, whilst the Trustee fund was restricted to approval by the Trustees, it was open to any staff application. The management of other funds had been delegated through the Trust's management structure.

Agreed: *Board receives and notes the contents of the report.*

185. CHARITABLE TRUST FUND ANNUAL REPORT AND ACCOUNTS FOR 2024/25

L Romaniak presented the report, which provided the Charitable Trust Fund annual report and accounts for consideration, following independent review by Mazars.

Agreed: *Board approves the submission of the Annual Report and Accounts of the Charitable Trust Fund, as recommended by Audit and Risk Committee.*

186. COMMUNICATIONS UPDATE

A Bridges presented the report, which provided an update on progress made on delivery of the Trust's communications strategy in October and November 2025 and proposed there was good assurance in terms of delivery of the strategy and related targets. She drew the Board's attention to the impact evaluation, following approval of the communications strategy in December 2024, which highlighted the increase in media releases from 51 to 114, the increase in coverage from pieces placed from 427 to 632 and positive or neutral sentiment reporting at 68%.

Agreed: *Board receives the report with good assurance.*

187. BOARD ASSURANCE FRAMEWORK (VERBAL)

The Chair confirmed with the Board that there were no matters arising from the discussion at the meeting that changed the position reported in the Board Assurance Framework (BAF).

A Smith noted the BAF was in the process of transition from a manual document to the InPhase system, to simplify data input and support improvements in reporting.

Commenting further, H Crawford confirmed that data on assurance, gaps and mitigation had been captured on InPhase for the Health Inequalities BAF risk and further work would be completed to ensure consistency between InPhase and the manual report during the transition period.

188. REGISTER OF SEALING

Agreed: *Board notes the content of the report.*

189. EXCLUSION OF THE PUBLIC

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

On conclusion of confidential business, the meeting ended at 3.41pm.

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	~~Oct25~~ Apr26		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.
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	Feb-26	**See agenda**	Update scheduled on the Board Workplan for Feb 2026
11/12/2025	**171 (1)**	**Review of BAF Risks**	**Board to receive a recommendation via Quality Assurance Committee on the recommendation that BAF risk 4 (quality of care), 8 (quality governance) be restated, as they had been achieved and to reflect the Trust's revised circumstances.**	**B Murphy**	**Apr-26**		For consideration in 2026/27 BAF
11/12/2025	**174 (1)**	**Corporate Risk 811 (ligature points)**	**The summary of work undertaken to reduce ligature points (as provided to Quality Assurance Committee) to be shared with the Board**	**B Murphy**	**Mar-26**		
11/12/2025	**174 (4)**	**Committee Membership**	**Trust Interim Chair to review board committee membership - in the context that Resources and Planning Committee has a higher proportion of strategic risks.**	**B Reilly**	**Mar-26**		**Under review with committee Chairs**
11/12/2025	**176 (7)**	**Safe staffing**	**Board to receive the output of work to map current community resources and opportunities and to understand the therapies establishment and demand.**	**N Lonergan H Crawford**	**Jun-26**		
11/12/2025	**178 (3)**	**Medical Education**	**Chief Executive to lead a conversation with the Director of Medical Education, Executive Medical Director and other executives to explore options for an integrated offer that incorporates education and learning, employment and R&D and to feedback to board on the timeline for this work.**	**A Smith**	**Apr-26**		
11/12/2025	**180 (5)**	**Clincial Supervision**	**Executive Director for People and Culture to provide an update to Board in six months on progress against identified actions.**	**S Dexter-Smith**	**Jun-26**		
11/12/2025	**183 (4)**	**Leadership Walkabouts**	**Proposed that a thematic feedback loop to be developed via a annual or bi-annual report to board, which provides a summary of 'you said, we did' to provide process assurance - Executive Directors to consider and confirm timescales**	**A Bridges**	**Jun-26**		

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Interim Chair Report

Public Board Meeting February 12th 2026

Public Inquiry

On the 11th December 2025, the Secretary of State for the Department of Health and Social Care announced that the Trust will be subject to a Public Inquiry, a decision taken following meetings with families who have lost loved ones in our care. We will respond to the inquiry with openness, transparency, respect, kindness and humility. The next steps will include the SoS appointing a Chair and working with the families to develop the scope of the inquiry.

We will communicate further to our staff and partners when we know more.

External Meetings

As expected in this role, 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 Chief Executive and I had an assurance meeting with senior colleagues from NHS England and our North East and North Cumbria Integrated Care Board. It went well and the feedback was fairly positive and helpful.

As expected, this has required a significant amount of intensive work with challenging timescales to meet final submission requirements on 12th February 2026. This is an extremely important plan for us. NHS England have made their expectations of Boards very clear. I would like to take the opportunity to thank everyone involved in ensuring that we submitted a credible plan that was approved at an Extra Ordinary Board Meeting on 5th February 2026.

Key themes from the Chairs meetings remain the same as my previous report

- Challenges of timescales attached to the Medium Term Planning Framework and the caveats attached to final submission on 12th February 2026
- Finance, productivity, and efficiency alongside the absolute need to safeguard quality of care.

I continue to attend the National NHS Confederation Mental Health, Learning Disability and Autism (MHLDA) Chairs meetings. Again, finance remains a constant topic. We received updates from our colleagues in Somerset on the integration of care between physical and mental health and from NHS England on the digital agenda.

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 had a meeting with both Chief Executives on provider collaborative work. An update will be coming to Board in April.

Board Activity

I have chaired a Special Board Seminar for a briefing update on the Medium Term Plan on 21st January. The purpose being to ensure we were updated, but gave an opportunity to check, challenge and seek assurance as a Board. I also Chaired the Extra Ordinary Board on 5th February to ensure that the Board have a final opportunity to review, challenge and seek assurance prior to our final submission. The CEO, Deputy CEO, the Director of Finance and Chair of the Resources and Planning Committee, have also had additional check and challenge session. It has been an incredibly busy time and once again, I am grateful to my colleagues.

I have also chaired two Board Nomination and Renumeration Committees.

I have Chaired the NEDs Group. Our Director of Finance was in attendance to provide an update on MTP but to discuss our approach to assurance at the request of the Audit and Risk Committee. Whilst we use Internal Audit we have looked at enhancing our approach. A revised approach will be brought to the Audit and Risk Committee for consideration.

I have had individual 1:1 conversations with NEDs.

Council of Governors Activity

I continue to meet with the Lead Governor to ensure he is appraised appropriately. I am grateful to Jules Preston, Senior Independent Director, for Chairing the CoG Nomination and Renumeration Committee as required. The Lead Governor and I jointly agreed the agenda for the CoG Meeting on 18th February.

Living The Values Awards

Congratulations to all of our Living the Values Awards winners during the last 2 months. Reading the nominations are very humbling with staff going above and beyond to ensure great care is delivered – in many departments and across the Trust. I am grateful to NED colleagues who attend in person to speak with the recipients and learn about the service.

Leadership Walkabout

Thank you to Gemma Lattaway and staff at South Durham Childrens and Young People Learning Disabilities Team, Ackley Centre, Newton Aycliffe for hosting Group 5s leadership visit on 26th January 2026. There were some clear messages from Gemma re transformation and staffing concerns in the reduction of Learning Disabilities and Autism qualified Nurses. Quite simply, the supply is not there with local universities. The formal feedback report has been approved by Gemma and has been presented to the Executive Directors Group for action.

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.

On my way to the Ackley Centre, I got lost. I popped into a local store and asked a lady and a young gentleman for directions. They put their shopping basket down and said "Come on, we will walk you there – we have just come from the CAMHS Team there". During what was a two minute walk, they told me of their positive and supportive experience of our CAMHS. I said I would feed it back and I have done so. What absolute kindness from complete strangers.

On the 12th December 2025, I attended our Health Café at Low Grange Health Centre in Eston, a service for adults with learning disabilities and autism. It was wonderful and I have shared the experience with NEDs and other Board members. It is exactly what we need to see more of for a very vulnerable community. It's a café, supported by a GP, Nurses, Social Worker, Support Workers and now our Individual Placement and Support Service for adults. Reflecting on the publication of the Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR) Annual Report, we must improve their care. It was good to meet with Anna Turley, MP for Redcar and Cleveland who was impressed with what she saw.

It was good to catch up with Chris Morton and Mark Allen from our Lived Experience Team to review my objectives from them. I am grateful to them for linking me in with our Peer Support Workers and look forward to spending time with them on 20th February and again on 4th March at Ridgeway.

Saturday 10th February will stay with me forever. I met with our Staff Network Chairs in November and asked them to give me some objectives. The first one was to attend their annual Network Celebration Event at the Acklam Green Centre. This year was African themed. The atmosphere, food, music and dancing was amazing. Our CEO, Director for People and Culture and I were very underdressed. It was incredibly uplifting and good to meet so many of our staff and their families.

I have met with Catherine Parker our Director of Public Health to discuss health inequalities and suicide prevention. She described the work that has been undertaken in terms of a clear strategy of focussed work. The Executive Director Group have oversight. I have asked that we have a Strategic Board Seminar on health inequalities and suicide prevention.

I have met with our new provider Freedom to Speak Up Service colleagues. I have received some good initial feedback on how they have been welcomed into our organisation and also some feedback from someone who has reached out and has been complimentary of the new approach.

On 5th February, I attended our BAME Staff Network meeting. They asked me to describe the role of the Chair and we had a really good question and answer session. It was a complete pleasure to attend and listen to the voices of a valued staff group.

Bev Reilly

Interim Chair

5th February 2026

Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 February 2026**
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.

The Board receives a range of scheduled reports to receive assurance on the position on the BAF risks and the effectiveness of controls.

A summary of the BAF risks is appended to this report.

In regard to progress on managing the BAF risks (as at Quarter 3, 2025/26):

(1) The present scores of the following risks have been reduced in year and achieved target:
BAF 4 (Quality of Care)
BAF 8 (Quality Governance)
BAF 9 (Partnership/System Working)
BAF 10 (Regulatory Compliance)

(2) During 2025/26 controls have been strengthen for:
BAF 1 (Safe Staffing)
BAF 4 (Quality of Care)
BAF 5 (Digital – Supporting Change)
BAF 6 (Estate/Physical Infrastructure)
BAF 8 (Quality Governance)
BAF 10 (Regulatory Compliance)

(3) 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

(4) 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 – Quarter 3, 2025/26

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	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 Ensuring that staff are recruited to and safely deployed to the right places Staff are appropriately trained to support people using our services ↑ Staff are supported to maintain their wellbeing, feel they belong and choose to stay and work here. Ensuring that local leaders and managers are equipped to lead and maintain safe staffing Early understanding of when things go wrong	**Public Agenda Item 10 -** Integrated Performance Report **Public Agenda Item 11** – Report of the People Culture and Diversity Committee including: ▪ Pay Gaps Report ▪ Equality Delivery System 22 ▪ Report of the Freedom to Speak up Guardian **Public Agenda Item 12 –** Report of the Guardian of Safe Working **Public Agenda Item 13** – Progress Report on the 10 Point Plan to improve resident doctors' working lives **Public Agenda Item 14 –** Report of the Quality Assurance Committee **Public Agenda Item 15 –** Leadership Walkabout Feedback
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 **Target achieved**	**Q4 25/26** Implement transformational developments (-1L)	**Good**	Partnership Arrangements Demand Modelling Operational Escalation Arrangements Integrated Performance Reporting Establishment Reviews Strengthen voice of Lived Experience	**Public Agenda Item 10 -** Integrated Performance Report at 31 December 2025 **Public Agenda Item 14 –** Report of the Quality Assurance Committee
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	*(Next report – QUAC Report – June 2026)*
4	✓	✓	✓	**Quality of Care**	**CN**	**QuAC**	**Moderate 9**	**Moderate 9**	**Target Achieved**	**Substantial** ↑	Complaints Policy ↑	**Public Agenda Item 10 -** Integrated Performance

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	Material Reports for consideration at the meeting
	1	2	3									
				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.			(C3 x L3)	(C3 x L3) Target Achieved			Friends and Family/Patient Experience Survey Our Quality and Safety Strategic Journey Incident management policies and procedures ↑ Governance arrangements at corporate, directorate and specialty levels Performance Management of Serious Incident Review Organisational Learning Group	Report **Public Agenda Item 14 –** Report of the Quality Assurance Committee including the Learning from Deaths Report **Public Agenda Item 15 –** Leadership Walkabout Feedback **Public Agenda Item 16 –** Report of the Mental Health Legislation Committee **Confidential Agenda Item 21 –** Reportable Issues Log
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 EPR deployment and optimisation programme: Integrated Information Centre optimisation programme: Digital and Data Delivery Plan	**Confidential Agenda Item 23 –** Report of the Resources and Planning Committee
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**	**High 20** (C4 x L5) ↑	**High 16** (C4 x L4) ↑	Four year indicative allocations incorporate revised capital formula adversely impacting TEWV CDEL allocation (5 further year indicative allocations). RPH Programme extends beyond this, so do not expect this risk score to reduce unless formula amended after 2029/30 (last year of 4-year allocation)	**Good**	NENC Infrastructure board Estates Master Plan CIG & CPSG Estates, Facilities & Capital Directorate Management Team Meeting ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring Environmental Risk Group	**Public Agenda Item 14 –** Report of the Quality Assurance Committee **Confidential Agenda Item 23 –** Report of the Resources and Planning Committee
7	✓	✓	✓	**Data Security and Protection** There is a risk of data breach or loss of access to systems, caused by successful cyber-	**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	**Good**	Digital, Data & Technology (DDAT) Skills and Knowledge	**Confidential Agenda Item 23 –** Report of the Resources and Planning Committee

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	Material Reports for consideration at the meeting
	1	2	3									
				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.					of Meets Standards; and control moves to substantial assurance (-1 L)		Secure IT infrastructure and asset management. Cyber Security and Incident Management Data Security and Protection Toolkit (DSPT) and Information Risk Management fully operational Robust Clinical Safety and Change Control Digital service delivery monitoring	
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**	**Substantial** ↑	Open and transparent culture working to organisational values steered by Our Journey to Change Executive and Operational Organisational Leadership and Governance Structure ↑ Quality Management System Oversight / Insight / Foresight	**Public Agenda Item 14 –** Report of the Quality Assurance Committee including the Learning from Deaths Report **Public Agenda Item 16 –** Report of the Mental Health Legislation Committee
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**	**Moderate 12 (C=4 x L=3)** ↓	**Moderate 12 (C=4 x L=3) Dec 25 (target achieved)**	**Dec 25** Cumulative impact of a range of mitigations **(target achieved**	**Good**	Active engagement in Collaborative forum at regional, ICB and local level to help shape system strategic planning and delivery Strategic Framework	**Confidential Agenda Item 23 –** Report of the Resources and Planning Committee
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 Provider Licence Environmental Sustainability Statutory Financial Duties Compliance with the CQCs Fundamental Standards of Quality and Safety	**Public Agenda Item 11** – Report of the People Culture and Diversity Committee including: ▪ Pay Gaps Report ▪ Equality Delivery System 22 ▪ Report of the Freedom to Speak up Guardian **Public Agenda Item 14 –** Report of the Quality

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	Material Reports for consideration at the meeting
	1	2	3								Compliance with Mental Health Legislation (MHL) Equality, Diversity, Inclusion and Human Rights Risk Management Arrangements Health Safety and Security (HSS) Executive and Care Group Leadership, management and governance arrangements Inquests and Coroners	Assurance Committee including the Learning from Deaths Report **Public Agenda Item 16 –** Report of the Mental Health Legislation Committee **Confidential Agenda Item 21 –** Reportable Issues Log **Confidential Agenda Item 23 –** Report of the Resources and Planning Committee
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 Capital Programme External Audit	**Confidential Agenda Item 23 –** Report of the Resources and Planning Committee
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) -	TEWV to develop medium term financial plan February 2026 Beyond 2028/29, the following are expected to impact on the risk: ▪ Trust to deliver medium term financial plan outcomes (recurrent financial position) ▪ Settlements beyond the confirmed 3 year allocations to 2028/29	**Good**	ICB Financial Governance including Mental Health LDA Arrangements and CEO Leadership and DoF financial planning groups and sub groups Executive Directors Group (Financial Sustainability Focus) Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	**Public Agenda Item 10 -** Integrated Performance Report
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 Stakeholder Communications and Engagement Strategy Social Media Policy	**Public Agenda Item 17 –** Communications Update **Confidential Agenda Item 21 –** Reportable Issues Log

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	Material Reports for consideration at the meeting
	1	2	3									
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."	**Med Dir**	**QuAC**	**High 16 (C4 x L4)**	**Moderate 12** (C=4 x L=3) **March 27**	**March 27** (-1L)	**Limited**	Public health capability and capacity Use of Data, insight, evidence and evaluation Strategic leadership & accountability System Partnerships	*(Next report – QUAC – April 2026)*
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**~~ **March 26**	**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	**Confidential Agenda Item 23 –** Report of the Resources and Planning Committee

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 February 2026**
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***
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: 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.

Mental Health Act 2025

The Mental Health Act 2025 (formerly the Mental Health Bill 2024-25) received Royal Assent on December 18, 2025, and is now law in England and Wales. However, not all the changes are effective straight away. The Act will be implemented in phases over approximately a decade. This legislation amends and aims to modernise the Mental Health Act 1983 to better reflect 21st-century standards of care and human rights. The reform is built on four guiding principles that should be used as a basis for all actions taken under the act: Choice and Autonomy, Least Restriction, Therapeutic Benefit, the Person as an Individual.

Key changes will be implemented in the following areas: Discharge(conditional), Definitions(Learning disability, Autism, Psychiatric disorder, Appropriate Medical treatment), Detention(serious harm), Nearest relative (Nominated person), IMHA(available to informal patients) and several more in terms of period of detentions, frequency of tribunals, Place of safety, advance choice documents, ICB responsibilities, Care and treatment plans. We have had a few strategic planning days since autumn last year in preparation for the implementation and initial training workshops for Responsible clinicians have been undertaken.

Public Inquiry

On the 11th of December 2025 the Secretary of State wrote to inform me of his decision to hold a statutory inquiry into the mental health services provided by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). The Secretary of State shared that this decision follows several tragic incidents of suicide among people under the care of TEWV which was brought to his attention.

We acknowledge the bravery, courage and dedication of those who have steadfastly sought a Public Inquiry in search of truth and to improve the care our services provide.

You will find attached my full response shared with partners and our communities following the Secretary of States announcement and I wanted to share some key messages in this report.

'We will co-operate fully with honesty, openness, grace and kindness.

It's an opportunity to hear and learn what we could have done better, how we improve the experiences for our patients, families, carers and staff and most importantly, enabling those who have been affected to hear how sorry we are.

We must keep reflecting, challenging ourselves, and holding compassion, humility and respect alongside responsibility in our minds.

It is important we remain focused on providing care to our communities, progressing our transformation work and supporting each other.'

Medium Term Financial Plan

We have progressed with our planning to submit our TEWV Medium Term Plan that aligns with the 10-year plan 3 key principles:

- Care from hospitals into the community
- Treatment to prevention
- Analogue to Digital

Transformation is key to financial sustainability, productivity and continual quality improvement and our clinicians, professionals are leading our workshops to identify our key programmes of innovation.

Meeting our people and patients

I have been extremely privileged to have visited many of our sites, teams, services and patients (some more than once) and I have been warmly welcomed at every opportunity. I have experienced and seen empathy, compassion and genuine connection. The skill, values driven, person centred and commitment to patients and families has been humbling and inspiring and I wanted to thank everyone for their generosity during my 4 months of onboarding.

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th February 2026**
Title:	**Board Integrated Performance Report as 31st December 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 Integrated Performance Dashboard (IPD)
- **Reasonable performance assurance** on the 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 an improvement in performance assurance level for the IPD this month, from reasonable to good.

Overview:

Controls Assurance

Our Integrated Performance Approach (IPA) enables us to have **good** oversight (i.e. controls assurance) of performance, by monitoring and reporting key measures that demonstrate the delivery of the quality of services we provide. The IPR is discussed and approved each month at 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

A select number of National Oversight Framework (NOF) measures have been incorporated into the IPR to monitor current performance alongside other key metrics; however, their inclusion does not reflect our assessment against the overall framework.

Update:

An issue affecting the flow of indirect contact information from our electronic patient record system into the reporting warehouse was recently identified and has been resolved. The data is now fully incorporated in our internal reporting. A briefing outlining the issue, the internal review, and the next steps was considered by the Quality & Performance Executive Directors Group in January 2026.

Integrated Performance Dashboard (IPD)

The overall **good** level of **performance assurance** for the IPD has been underpinned by the Performance and Controls Assurance Framework, which demonstrates **23** measures (74%) with good or substantial assurance (an improvement on the previous month).

Key changes this month:

Increased performance assurance (from good to substantial)	• Bed Occupancy (AMH & MHSOP A & T Wards)
Increased performance assurance (from reasonable to substantial)	• Percentage of CYP showing measurable improvement following treatment - patient reported
Increased performance assurance (from reasonable to good)	• Percentage of Patients surveyed reporting their recent experience as very good or good
Reduced performance assurance (from substantial to good)	• Number of inappropriate OAP bed days for adults that are 'external' to the sending provider • Percentage compliance with ALL mandatory and statutory training • Percentage of staff in post with a current appraisal

We have continued 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 - patient reported
- Percentage of CYP showing measurable improvement following treatment - clinician reported
- Staff Leaver Rate
- Compliance with ALL mandatory and statutory training
- Staff in post with a current appraisal
- Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent

There are a small number of measures, we are advising continue to be a focus for improvement which 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 5 are on track for delivery by the end of April 2026 and the remaining one is on hold pending external input (which we are awaiting). As part of our ongoing validation and review of outcomes it was identified that one of the outcome tools (RCADs) had not been flowing into the measure *Percentage of CYP showing measurable improvement following treatment - patient reported* since May 2025. The corrective work has been undertaken, and this is now reflected in the reported data.

- **Bed Occupancy** – Sustained special cause improvement is being demonstrated we have achieved the commissioned and funded level of 85% for the first time. However, the main

areas of concern remains linked to patients that are clinically ready for discharge (*see below*) in all services.

- **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 (8 courses below this month, 1 more than reported the previous month). We will repeat the deep dive in quarter 4 to assess the impact of improvement actions. Executive Directors Group are fully sighted on those training courses below standard and understand and are mitigating for any potential impacts.

- **Agency Price Cap Compliance** - The Trust has made significant strides to reduce the value and number of shifts breaching price cap reducing from 1002 breaches in December 2023 to 435 in December 2025. The reduced absolute number of breaches now relate to increasingly challenging areas. Most price cap breaches relate to medical locums for hard to fill vacancies (90% by value of price cap breaches), although 80 nursing breaches relate to Adult Mental Health – NYYS Community teams. The Temporary Staffing Sub-Group has leadership and oversight of this work. The Medical Director is considering wider options during January to plan to reduce and aim to eliminate medical agency reliance. It is expected that breaches relating to prison vacancy cover will reduce as recruitment to posts and to support two newer contracts progresses (posts being subject to longer associated security clearance).

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 and there is special cause concern in all services. A Trust-wide Improvement Programme is being developed as part of the Hospital to community Transformation workstream and medium-term plan. An update and improvement plan be taken back to the Quality & Performance EDG in March 2026. A paper will be taken to Resources & Planning Committee in February then into Board of Directors in March.

  At Trust level, patients classified as clinically ready for discharge in December equated to an average of 85.1 beds (56.5 Adult and 28.6 Older Adult beds), with an associated direct cost of c.£1.78m. Of the cost, c.£1.11m relates to Adult and c.£0.67m relates to Older Adult. The annualised impact of patients classified as clinically ready for discharge is £21.4m (£19.8m at November 25).

  Piloting of the new ways of working for the Tees Valley transfer of care hub will be undertaken with South Tees Local Authorities, commencing February 2026 with a series of planning meetings in January 2026. 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. We are on track to commence the pilot by the end of March 2026.

  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 will be held in January 2026. In North Yorkshire recruitment has commenced for a discharge liaison officer to support patient discharge within adult beds at Cross Lane Hospital.

- We remain concerned about **Sickness Absence** which is continuing to demonstrate special cause concern. A range of actions have been identified which are listed in full in

the IPR, and have been themed into the following strategic priorities to support improvement:

- 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

Several actions have now been completed which are detailed in the IPR and several new actions have been identified as a result which are now included. 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 February 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, decisions on service re-design, 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 on additional controls for overtime, has worked to expand staff banks and further restrict agency usage in recent months. Additional Overtime approval processes have been agreed in the last month and will operate from January 2026. 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. Mitigations for under-delivery are being worked up, with full year effects of recurrent schemes currently forecast to fully deliver planned recurrent savings.

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 **66%** of measures are achieving standard (compared to 68% last month). We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

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

- 72-hour follow up
- EIP Waiting Times

- Talking Therapies waiting times (6 and 18 weeks)

The actual areas of concern are as follows:

- **Child Eating Disorders (4-week and 1-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).

- ***New Average length of stay for acute beds**: long lengths of stay are largely impacted by the discharge of patients that are clinically ready for discharge. In the 3 months ending December 2025 there was no significant change in the number of patients discharged; however, 6 patients with lengths of stay exceeding 360 days were discharged. *See IPD comments for **patients classified as clinically ready for discharge** on page 5.*

- **Talking Therapies Reliable Improvement and Reliable Recovery** (County Durham & Tees Valley): The Trustwide action plan includes 14 improvement actions, all of which were completed by the end of December 2025, with the exception of action which 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. Two improvement events have taken place which focused on reducing waiting times. The outputs of the events are being reviewed and will be shared with the Trust-wide Task & Finish Group in January. It is anticipated that actions to improve waiting times should have a positive impact on reliable recovery and improvement.

- ***NEW Perinatal Mental Health Access – within a 12-month period** (County Durham): Over the last 12 months, Performance has been impacted by 4 members of staff who left their posts in succession at the end of 2024; these posts have all now been recruited to. At present, the service is currently impacted by maternity leave (1 wte), cover for which is currently advertised, and 1 wte medic vacancy, which has been appointed to and is due to start imminently.

- **CYP 1 contact:** (Tees). Tees continue to show a significant concern (a reduction) 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 has been delayed and will now be completed by the end of January 2026. A quality improvement event was held in December to review the clinical processes and recording of key data across all Neuro services to ensure consistency. Whilst several actions were identified, including ensuring consistency of recording in line with clinical processes; there was nothing specific which would have a direct positive impact on this measure. During the event concerns were raised about indirect triage contacts not appearing correctly in the IIC – *See update on page 3*.

Waiting Times

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

measure in more detail to determine the areas of positive assurance and actual areas of concern.

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

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

- 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.

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. The framework has now been finalised and a paper will be submitted to ICB MH Subcommittee in January 2026. As part of this work, the Trust has engaged in two design sprints for the future model of referral and triage with the ICB across Durham & Tees Valley, continuing with the outsourcing of assessments to the Owl centre as part of the ICB-led work. 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. 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 Service Manager has explored potential options for improving waiting times for patients on the under-5 pathway and concerns have been shared with NENC ICB; the ICB has confirmed that work is underway to address these concerns and that a briefing paper will be submitted to the February 2026 Mental Health, Learning Disabilities & Autism Collaborative meeting. We are consistently exceeding the trajectory submitted to NENC ICB, which is a result of the significant work that has been undertaken as part of community transformation.

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 including the identification of 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. Three additional staff have been recruited to support the delivery of additional assessments; this is now in place. The remaining monies will fund a medic to support the transformed model for local triage.

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 continues to have a recovery plan in place which is regularly reviewed. The service has recruited to vacant posts, and continue to review their existing resources in the most efficiently and effectively. There has been a delay in finalising the report to governance due to fluctuating challenges and the report drafted in December was no longer reflective of the current position. The overall position remains unchanged with the key issue remains demand outstripping capacity of the service and no further efficiencies can be made within the current financial envelope. The Service Manager has commenced a review of the overall budget and consideration will be given to the need to move posts from the generic team to better support the ADHD team. In addition, a further Stop the Line Day is scheduled for January 2026 to review progress with the Team and the CAMHS Leadership Cell.

- **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 treatment capacity had 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, which has been negatively impacting in-treatment waiting times. That work has now completed and the Service Manager is to develop a plan for recovery by the end of February 2026.

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 impacted several patient-based measures across the organisation. These data quality issues have been reviewed and an action plan developed. Whilst historic data issues cannot safely be fixed in bulk, individual records can be rectified on a case-by-case basis if required.*

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 Integrated Performance Dashboard
- **Reasonable performance assurance** on the 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 December 2025

Report produced by: Laura Wheater, Performance Lead, and Ashleigh Lyons, Head of Performance
Date the report was produced: 29th January 2026

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

journey to change

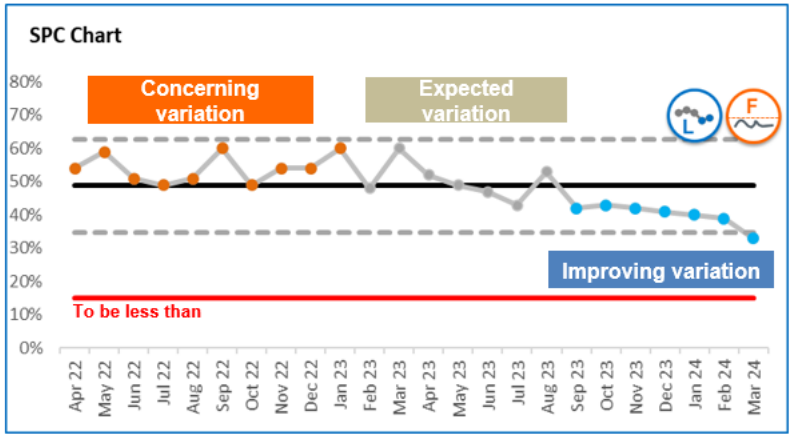
CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS Foundation Trust

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

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



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

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

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

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

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

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

NHS
Tees, Esk and Wear Valleys
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 will be undertaken in quarter 4 2025/26.

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

Our Approach to Performance and Controls Assurance

NHS
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.

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

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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
MHLDA	Mental Health, Learning Disabilities & Autism Collaborative
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
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 December 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%	93.39%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC	H	?	75.00%	80.14%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	H	?	75.00%	85.58%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	H	P	35.00%	53.43%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC	H	F	55.00%	47.30%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	?	50.00%	59.30%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC	H	F	30.00%	25.55%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	L	F	85.00%	91.09%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L	F	0	71
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC	L			13
11)	The number of Incidents of moderate or severe harm	QAC	L			185
12)	The number of Restrictive Interventions Used	QAC	H			9,024
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				3
15)	The number of uses of the Mental Health Act	MHLC				2,958

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
16)	Percentage of staff recommending the Trust as a place to work	PC&D			60.00%	55.54% (Jul-2025)
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D			65.00%	61.83% (Jul-2025)
18)	Staff Leaver Rate	PC&D	L	?	11.00%	10.02%
19)	Percentage Sickness Absence Rate (month behind)	PC&D	H	?	5.50%	6.51%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	P	85.00%	92.29%
21)	Percentage of staff in post with a current appraisal	PC&D	H	?	85.00%	88.70%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				72,135
23)	Unique Caseload (snapshot)	S&RC	L			62,406

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	2,142,000	338,073
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	5,505,000	4,966,530
25b)	Agency price cap compliance	S&RC	67.00%	47.90%
26)	Use of Resources Rating - overall score	S&RC	3	2
27)	CRES Performance - Recurrent	S&RC	11,789,000	8,970,520
28)	CRES Performance - Non-Recurrent	S&RC	7,381,333	10,263,313
29)	Capital Expenditure (CDEL)	S&RC	8,884,000	7,539,475
30)	Cash against plan	S&RC	39,197,000	45,554,253

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

- **Patient and Carer Experience:** There is special cause improvement for the carer experience and inpatient measures; no significant change for the patient experience measure. We are achieving standard for all patient and carer experience measures.

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

- **Bed Pressures:** there is special cause improvement for bed occupancy, which is below standard (positively) for the first time; however, whilst there is special cause improvement for out of area bed days, we are not achieving standard and there were 4 active OAPs as at the end of December 2025. There is special cause concern for patients clinically ready for discharge (supporting measure).

- **Patient Safety:** there is special cause concern for Restrictive Interventions; no significant change for all other patient safety measures. There were no unexpected inpatient unnatural deaths reported on STEIS during December.

- **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 8 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 December 2025 is a deficit of £0.338m, which is £1.804m better than planned for the year to date. The in-month position in December was a surplus of £904k, incorporating increased pay and bank costs, and purchase of healthcare costs offset by a non-recurring receipt of income. CRES delivered £19.23m for the first 9 months against a target of £19.17m, which is £63k 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; the standard is achieved for all areas. There is cause for concern in the number of responses received for carer involvement.
- **Outcomes** – there is special cause improvement for all outcome measures. We are above the standard in both CYP measures, however below the standard in both AMH/MHSOP measures. There is no significant change in the number of timely paired outcomes recorded for the CYP PROM; however, there is special cause improvement for the CROM. Special cause concern remains in the number of timely paired outcomes recorded for 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 2 active OAPs as at the end of December 2025.
- **Patient Safety** – there is special cause Improvement for Patient Safety Incidents investigations reported on STEIS and incidents of moderate or severe harm. No significant change in the number of medication errors. However, there is special cause concern in the number of restrictive interventions used. There were no unexpected inpatient unnatural deaths reported on STEIS during December.
- **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 6 face to face training courses for which compliance remains below the 85% standard.
- **Demand –** there is no significant change in unique patients referred, however there is special cause improvement in unique and active caseloads.
- **The DTVF Care Group**, planned to spend £209.9m as at December, and actual spend was £214.7m, which is £4.7m more than planned with CRES delivery £0.381m 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)
•Outcomes (CYP and AMH/MHSOP)

Risks / Issues*

- Outcomes (AMH/MHSOP)
- Restrictive Interventions
- Financial Plan

Mitigations

Restrictive Interventions – There is special cause concern noted at Care Group level, predominantly driven by Adult Learning Disabilities and Secure Inpatient Services. A series of actions are in place to provide additional support and training for staff.

Sickness: Attendance is being impacted by a series of short- and long-term sickness. In addition, sickness audits have shown that the Attendance Management Procedure is not being consistently followed throughout Trust services. A series of Trustwide actions have been put in place to understand the current position and ensure that processes are being effectively managed.

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, overtime and agency spend.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** Following the implementation of the new patient experience system in mid-September; only partial data was available for our measures and whilst full data is now available for subsequent months, a significant reduction continues to be visible in response rates. There is no significant change for the patient experience and feeling safe measures; there is special cause improvement for carer experience. We are achieving standard for all patient and carer experience measures.

- **Outcomes:** In CYP there is special cause improvement for the PROM and no significant change for the CROM. In AMH/MHSOP there is special cause improvement in the CROM and no significant change for the PROM. There is no significant change in the number of timely paired outcomes recorded for the CYP CROM; however, there is special cause concern for the CYP PROM, and 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 2 out of area placements during December.

- **Patient Safety:** there is no significant change for all patient safety measures. There were no unexpected inpatient unnatural deaths reported on STEIS during December.

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

- **People:** there is special cause improvement, and we are achieving standard for mandatory training and appraisals; however, whilst there is special cause improvement for leaver rate, we are not achieving standard. Whilst there is special cause concern in sickness levels, we are below the standard. Whilst we are achieving the standard for mandatory training, there are 11 face to face training courses for which compliance remains below the 85% standard.

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

- **Finance:** The Trust had planned to deliver a £0.3m Surplus in December. Actual delivery was a £0.90m Surplus in month, a positive variance of £0.61m to plan (YTD Plan of £2.142m deficit, YTD £0.34m actual deficit, £1.804m positive variance to plan). The in-month position benefitted from additional income, which mitigated the cost of the MARS scheme and increased our positive variance to plan. Plans are phased to deliver more expenditure reductions as the year progresses, largely due to phased savings plans, so additional work to reduce costs is still required to consistently deliver a positive run rate, to recover the YTD deficit.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Carers Experience
- CYP PROM
- Bed Occupancy
- People (Staff leaver Rate, Appraisals)
- Unique Caseload

Risks / Issues

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

Mitigations

Outcomes

The Trust-wide Clinical Outcomes improvement Plan continues to progress, except for those actions' dependant on CITO development, the remainder remain of track for delivery. There are 6 actions being progressed, of which 5 are on track for delivery; the development of a Reliable Change Index for a small number of CYP outcomes measures is subject to input from partner organisations to ensure consistency of practice and legitimacy and Executive Directors approved this be placed on hold pending confirmation of approach from partners (which we are awaiting).

Sickness Absence

A range of actions have been identified which are listed in full in the IPR and have been themed into the following strategic priorities to support improvement: Strengthen Policy Compliance and Management Capability, Enhance Oversight and Assurance, Improve Communication and Access to Resources, Advance Health and Wellbeing Initiatives, Drive Collaborative Improvement, and 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.

Face to Face Mandatory Training

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. In addition, 66 training spaces have been purchased from an external provider to support the provision of Resuscitation Level 3 .

Finance

The Care Group has reported an overspend to plan of £1.5m and an overspend to budget of £1.89m. The Care Group is behind the CRES target as at December by £927k. 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, a Performance Improvement Plan that defines the actions that are being taken to support improvement and increased assurance.

Performance & Controls Assurance Overview

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 • Inpatients reporting that they feel safe whilst in our care • CYP showing measurable improvement following treatment - patient reported ***improved performance and controls assurance*** • CYP showing measurable improvement following treatment - clinician reported • Bed Occupancy (AMH & MHSOP A & T Wards) ***improved performance assurance***	• Adults and Older Persons showing measurable improvement following treatment - patient reported • Adults and Older Persons showing measurable improvement following treatment - clinician reported • Inappropriate OAP bed days for adults that are 'external' to the sending provider ***reduced performance assurance*** • Staff Leaver Rate • Compliance with ALL mandatory and statutory training ***reduced performance assurance*** • Staff in post with a current appraisal ***reduced performance assurance*** • Unique Caseload		
Neutral	• Incidents of moderate or severe harm • Medication Errors with a severity of moderate harm and above • Unexpected Inpatient unnatural deaths reported on STEIS • Uses of the Mental Health Act	• Patients surveyed reporting their recent experience as very good or good ***improved performance assurance*** • PSII reported on STEIS • New unique patients referred • CRES Performance – Non-Recurrent	• 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 • Financial Plan: Agency expenditure compared to agency • Cash balances (actual compared to plan)	• Restrictive Intervention Incidents Used ***reduced controls assurance*** • 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

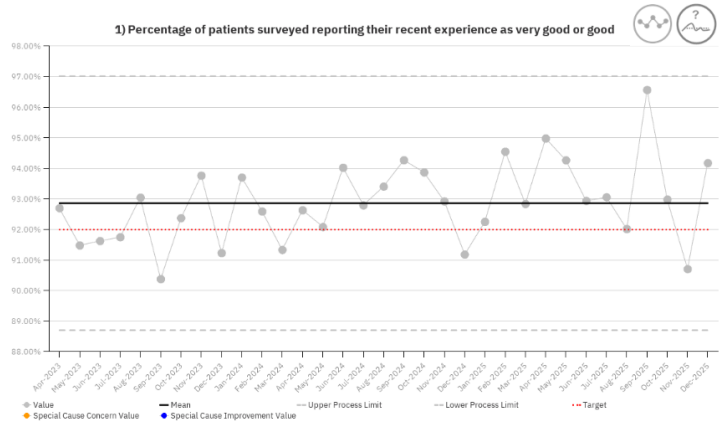
What does the chart show/context:
During December **978** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent contact overall, how was your experience of out service?". Of those, **921 (94.17%)** scored "very good" or "good".

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; however, there is special cause concern for Health & Justice. There is no significant change in the number of patients who have responded to this question at Trust and Care Group level.

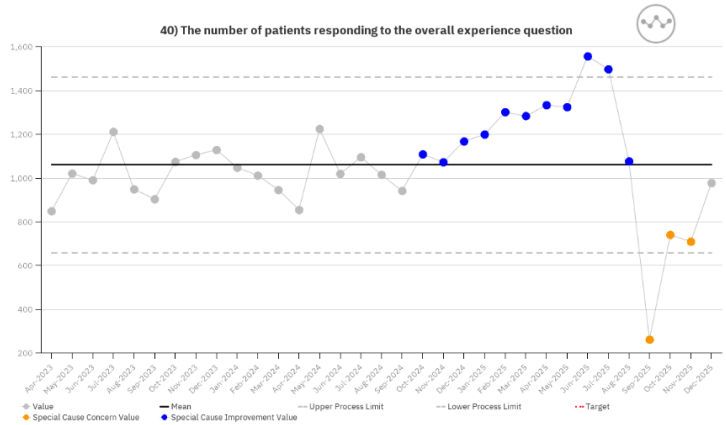
The latest National Benchmarking data (October 2025) shows the England average (including Independent Sector Providers) was **89.44**% and we were ranked **12** out of 64 trusts (1 being the best with the highest ratings), we were also ranked 7th (previously 26th) for total number of responses received.

Underlying issues:
- Cancelled visits and incidents within HMP Milsike (Health & Justice) have impacted overall patient experience

Actions:
- From January 2026, the Patient & Carer Experience Team have re-instigated support visits with a view to improving response rates which is anticipated to have a positive impact.
- An action plan to address the concerns in HMP Milsike has been completed and the team continue to embed recommendations, including regular fora to review complaint themes and patient feedback, strengthened appointment management processes, increasing capacity for medication reviews and reviewing communication processes.



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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
During December, **282** carers responded to the question in the carer survey: Question: "Are you offered choices about the care being provided?". Of those, **275 (97.16%)** scored "yes, always".

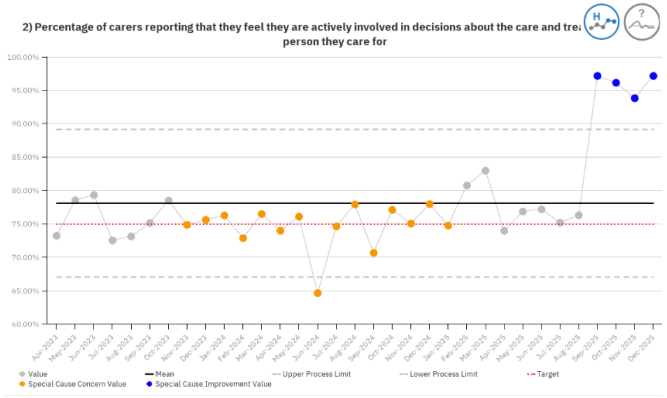
There is special cause improvement at Trust and Care Group level in the reporting period, and for Adult Mental Health in Durham, Tees Valley & Forensic Care Group and Children & Young Peoples Services and Mental Health Services for Older People in both Care Groups. There is special cause concern in the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

Underlying issues:
There are no underlying issues to report.

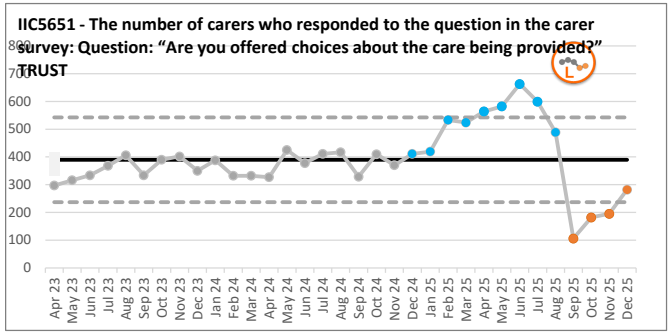
Actions:
Whilst there are no specific improvement actions required, from January 2026, the Patient & Carer Experience Team have re-instigated support visits with a view to improving response rates which is anticipated to have a positive impact.

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

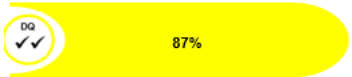
What does the chart show/context:
During December, **150** patients responded to the overall experience question in the patient survey: "During your stay, did you feel safe?". Of those, **143 (95.33%)** scored "yes, always" and "quite a lot".

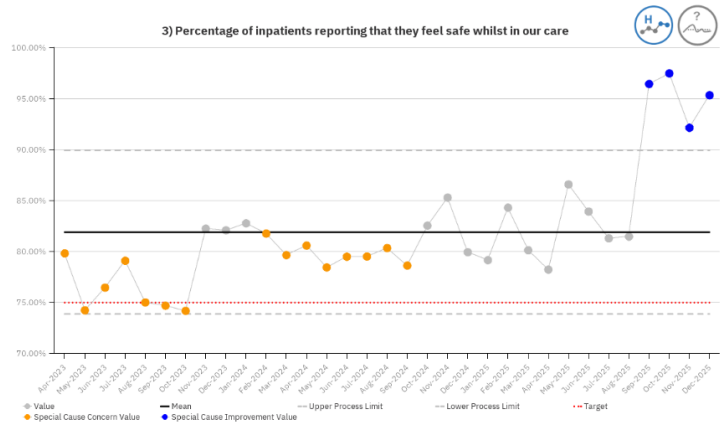
There is special cause improvement at Trust level, for Durham, Tees Valley & Forensic Care Group and for Adult Mental Health Services within that Care Group, in the reporting period; there is no significant change for North Yorkshire, York & Selby Care Group. There is no significant change in the number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

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

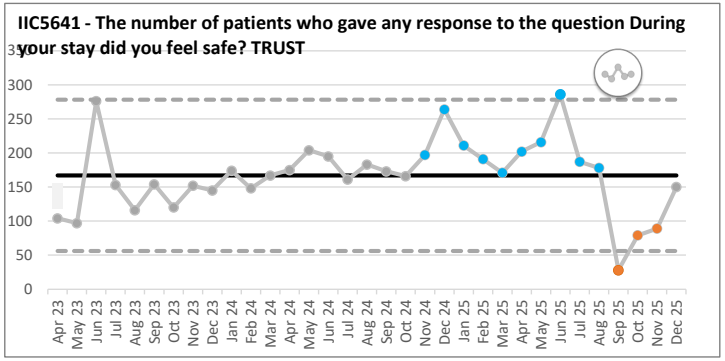
Underlying issues:
There are no underlying issues to report.

Actions:
Whilst there are no specific improvement actions required, from January 2026, the Patient & Carer Experience Team have re-instigated support visits with a view to improving response rates which is anticipated to have a positive impact.





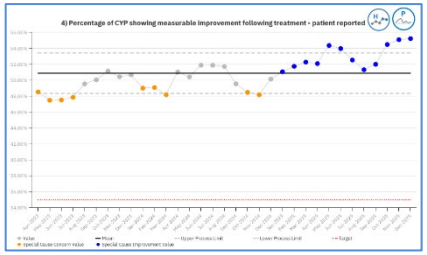
The below chart represents the number of patients that responded to the safety question.

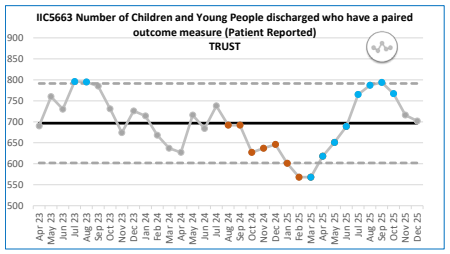


Please note: the new patient experience system was implemented mid-September 2025

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 December, **697** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **385 (55.24%)** made a measurable improvement.

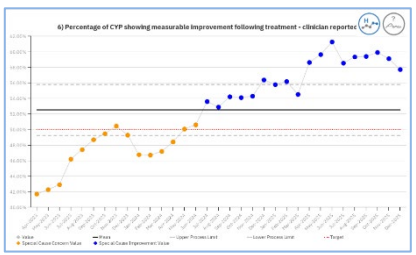
There is special cause improvement at Trust and Care Group level in the reporting period and performance is above standard at all levels. There is no significant change for the number of patients discharged with a paired outcome measure at Trust level and for DTVFCG; there is special cause concern for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

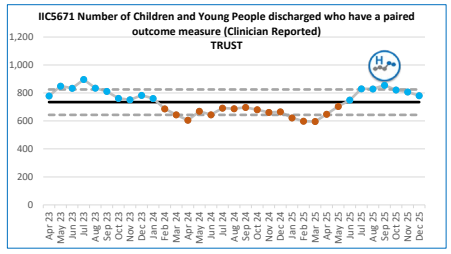
Update
As reported previously, following a change to Cito it had been identified that RCADs had not been flowing into the measure since 13th May 2025. The corrective work has been undertaken and is now reflected in the data.

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 December, **776** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **448 (57.73%)** made a measurable improvement.

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

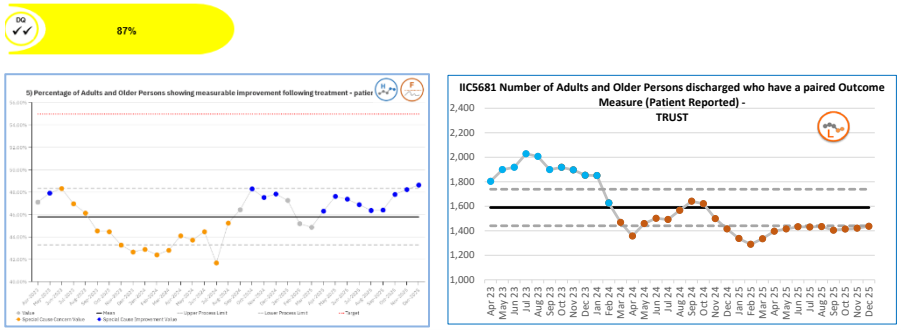
The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

For underlying issues and action, please see overleaf

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

Measure	Underlying issues	Actions
PROM	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) **(Complete)** EDG approved this action be placed on hold, pending the receipt of outstanding information from some partner organisations which is preventing completion of ethical approval. 2. Flow GBO from Cito into IIC by end of December 2025 (previously September) **(Partially Complete)** The work to flow the GBO into the IIC is complete however development work is required to incorporate the data into the metric. **Timescales to be confirmed**.
PROM and CROM	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 will be completed by the end of March 2026 (previously September 2025).

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



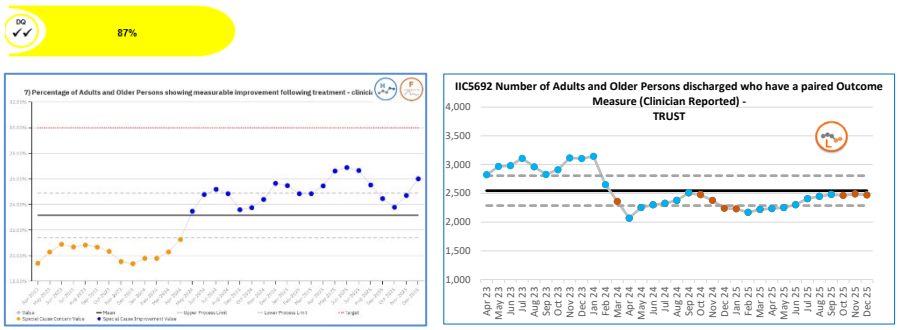
Background / standard description:
We are aiming for 55% of Adults and Older Persons showing measurable improvement following treatment - patient reported

What does the chart show/context:
For the 3-month rolling period ending December, **1437** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 699 (48.64%)** 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 both Care Groups; 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



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 December, **2472** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 643 (26.01%)** 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. **(Complete)** Remediation work to be complete by end of June 2026.

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 (end of January 2026)
2. To use data meaningfully at all levels (e.g. clinical supervision, team meetings, care group meetings, board meetings) (end of January 2026)
3. Appraising & identifying more accurate psychometric outcome tools to assist in the collection and calculation of outcomes measures (end of February 2026)
4. Implement training for new outcome measures linked to community transformation (Dialog, ReQoL 10, Goal-Based Outcomes GBO) (end of April 2026)

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

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.

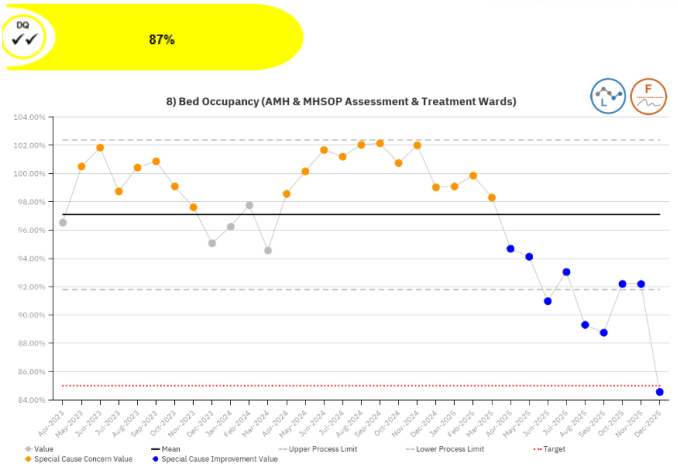
What does the chart show/context:
During December, **10,912** daily beds were available for patients; of those, **9,228 (84.57%)** were occupied. There were 4 patients admitted to independent sector beds used during December.

There is special cause improvement at Trust and Care Group level in the reporting period, and for Adult Mental Health in both Care Groups. Performance is below standard (positively) for the first time at Trust level and within North Yorkshire, York and 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. **(Not Complete)** The paper will now be presented at the February meeting.
- 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. The Strategic Outline of the Business Case will be presented to the Quality & Performance EDG in December 2025. **(Complete)** The full business case will be presented to the Quality & Performance EDG in March 2026.
- In NYYSCG the proposed development of alternatives to crisis services 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 weekly project meetings have now commenced.
- A proposal to close the MHSOP Organic beds in Springwood and develop a 24/7 crisis/care home in-reach/out-reach service for the Scarborough, Whitby Ryedale area, will be submitted to the January 2026 Care Group Board for approval. This service will provide enhanced community services, reducing the number of preventable admissions to our acute wards.



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

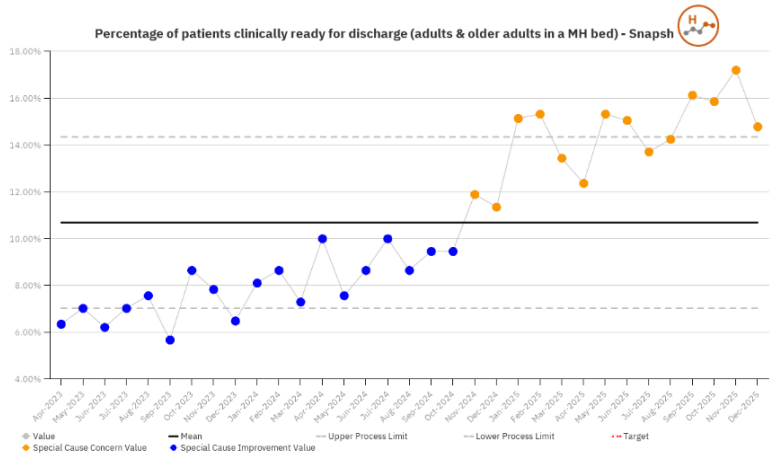
What does the chart show/context:
At the end of December 2025, there were **55** adults clinically read for discharge occupying adult MH, older adult MH or PICU beds, accounting for **14.78%** of our **372** acute beds open to admission.

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 December equated to an average of 85.1 beds (56.5 Adult and 28.6 Older Adult beds), with an associated direct cost of c.£1.78m. Of the cost, c.£1.11m relates to Adult and c.£0.67m relates to Older Adult. The annualised impact of patients classified as clinically ready for discharge is £21.4m (£19.8m at November 25).

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:
- Piloting of the new ways of working for the Tees Valley transfer of care hub will be undertaken with South Tees Local Authorities. This work will begin February 2026 with a series of planning meetings in January 2026.
- The pilot hub in Durham 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 will be held in January 2026.
- 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.
- The recruitment for the Clinically Ready for Discharge pilot role in DTVFCG, aimed at reducing delays within Adults and Older Peoples services has not started, as previously reported, however the pilot will commence by the end of March 2026.
- In North Yorkshire recruitment has commenced for a discharge liaison officer to support patient discharge within adult beds at Cross Lane Hospital.



Actions continued:
- A proposal for a Trust-wide Clinically Ready for Discharge Improvement Programme was supported by EDG in November. This 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

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

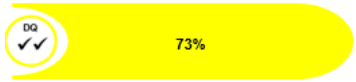
What does the chart show/context:
For the 3-month rolling period ending December, **71** days were spent by patients in beds away from their closest hospital.

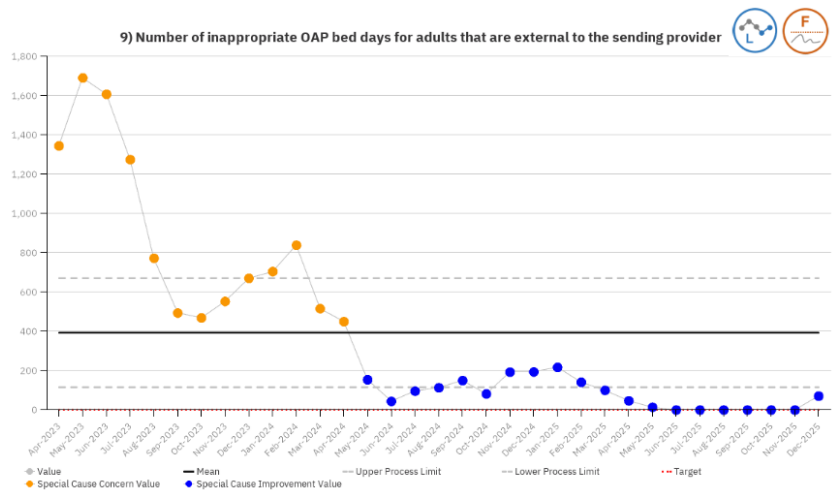
There is special cause improvement at Trust and Care Group level in the reporting period.

There were 4 active OAP placements as at 31st December 2025, which were attributable to a temporary closure of a PICU ward to support a patient with complex needs. The ward has subsequently reopened and 3 of the patients have been repatriated; the remaining patient is pending MoJ approval for repatriation.

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.





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	0	4			

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

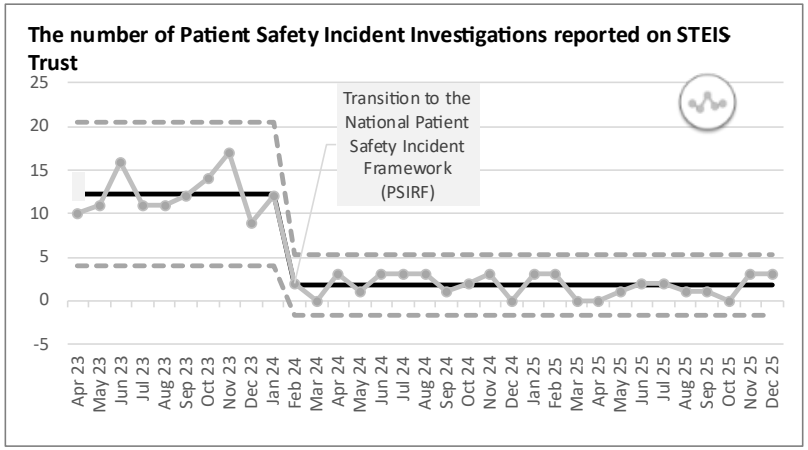
Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is no significant change at Trust and Care Group level in the reporting period. Whilst the SPC is indicating special cause concern for Mental Health Services for Older People within North Yorkshire, York & Selby Care Group, this relates to one incident and is not an actual concern.

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:
Patient Safety and colleagues from AMH Planned Care services are testing a new AAR process with the aim of reducing the lead time for completing AARs. Mapping events have been held through October 2025 to January 2026 and the new process will be rolled out to pilot teams from February 2026.



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.

11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is common cause at Trust and Care Group level. There is special cause improvement in DTVF Adult Learning Disabilities and Children and Young Peoples Services.

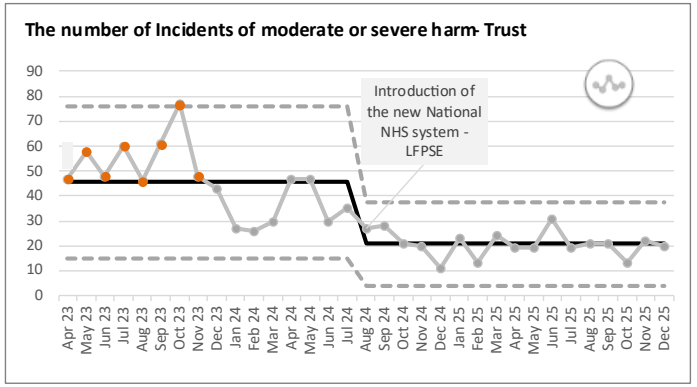
Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

DQ 87%



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.

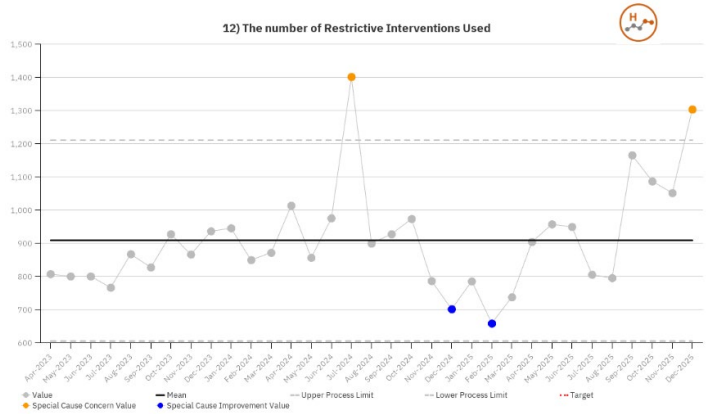
12) The number of Restrictive Intervention Used

What does the chart show/context:
1,304 types of Restrictive Interventions were used during December.

There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group and for Adult Learning Disabilities and Secure inpatient services within this care Group. There is no significant change for North Yorkshire, York & Selby Care Group level in the reporting period. There is special cause improvement in Health & Justice in Durham, Tees Valley & Forensic Care Group and Children & Young Peoples Services in North Yorkshire, York & Selby.

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 female patients with high acuity and complex needs, particularly impacting interventions.

Actions:
- Within DTVFCG ALD two actions are currently being progressed:
  - Monthly clinics are being provided by the Positive & Safe Clinical Skills Team to support ongoing confidence-building for teams on physical clinical skills
  - The Nurse Consultant is undertaking observations to support the correct use of interventions
- Within SIS, one female ward has been placed in a formalised status of Service Requiring Additional Support for current and new patients. Two actions are currently being progressed:
  - Monthly clinics are being provided by the Positive & Safe Clinical Skills Team, to support ongoing confidence-building for teams on physical clinical skills
  - Positive Behaviour Support Practitioner providing 3 months' focussed support into one female ward.



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

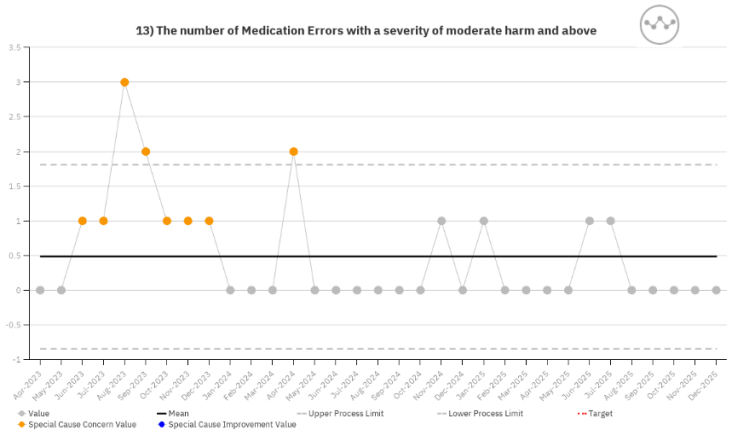
What does the chart show/context:
0 medication errors were recorded during December.

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

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

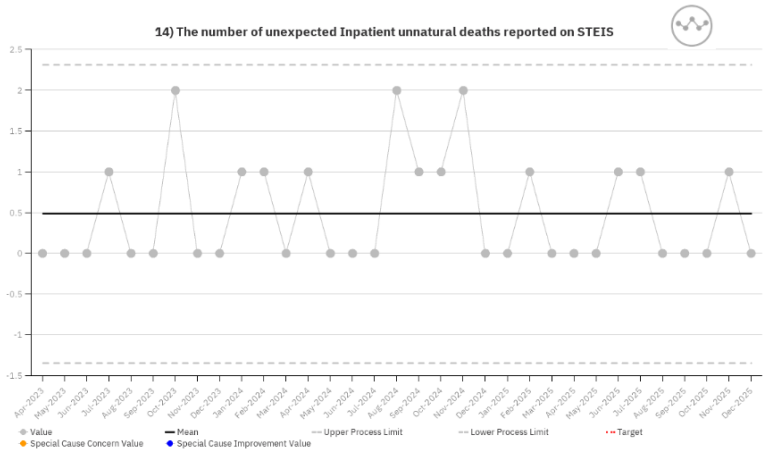
Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **325** uses of the Mental Health Act during December.

There is no significant change at Trust and Care Group level in the reporting period. There is an unexpected low shift in uses within Children and Young Peoples Services in North Yorkshire, York & Selby Care Group; however, this relates to 0 detentions and is not an actual concern.

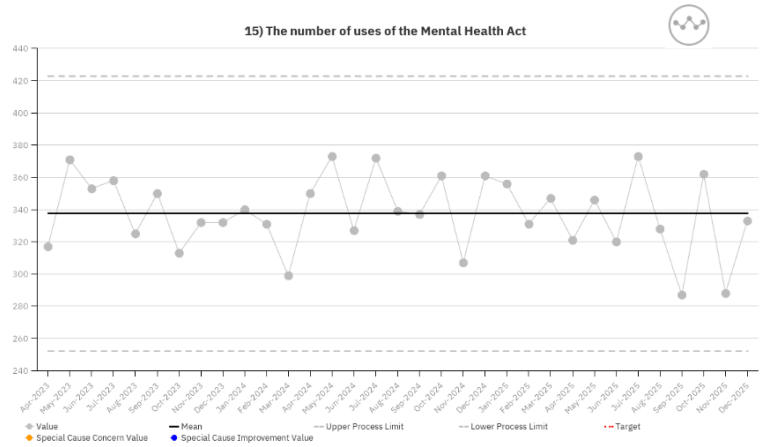
The latest national Mental Health Act data (2023/24) produced by NHS Digital has been analysed by Business Intelligence. Expected rates of detention by gender and ethnicity showed that Trust followed the same trend as the national rate of the higher the level of deprivation, the higher the rate of detention.

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

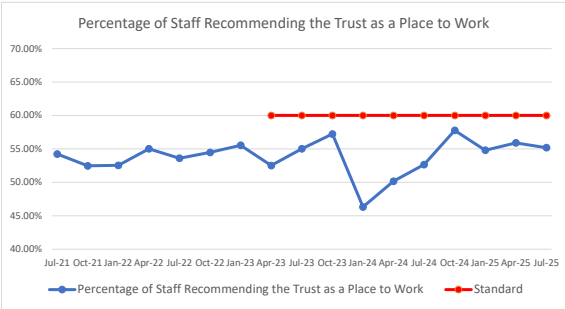
Underlying issues:
Analysis of the latest national Mental Health Act data (2023/24) shows some areas of inequality in our detention rates.

Actions:
- The Equality, Diversion & Inclusion (EDI) dashboard is now in testing phase and will give greater visibility of this data as well as providing team level segmentation. Work is progressing to secure clinical capacity to drive a mapping and insight project in inpatient setting through special interest sessions; we anticipate this to be secured by the end of February 2026.
- Funding for a 2-day per week EDI officer has also been ringfenced to support Patient & Carer Race Equality Framework delivery. This project remains on track for March 2027 completion.

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

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

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.

Update
The results from the 2025 Staff Survey have been released to Trust; these will be included once the embargo ends in March 2026.

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:
- One specific strand of work, which we would anticipate to have a positive impact in this area is 'How We Work', which sits under One Team TEWV and encompasses 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.
- Two key areas of concern in the last staff survey are being addressed Trust-wide, which we would also anticipate to have a positive impact are:
    - Experience of immediate manager: In response to this the new People Management Programme has been developed and launched. This is also helping to prepare us for the national regulation of managers
    - Approach to flexible working: we will review the way we approach this consistently across the Trust by the end quarter 2 2026/27.

18) Staff Leaver Rate

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

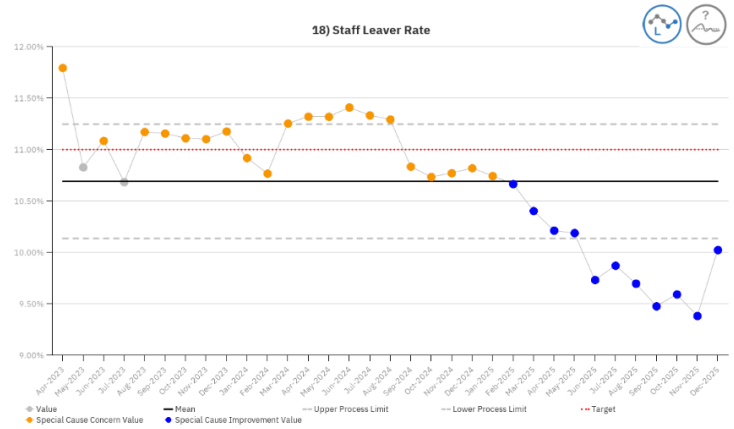
What does the chart show/context:
From a total of **7,407.15** staff in post, **742.54 (10.02%)** had left the Trust in the 12-month period ending December 2025.

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 Corporate Affairs & Involvement and Estates & Facilities Management. The directorates have confirmed there is no actual concern at this stage.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required, and controls are outlined in the Board Assurance Framework.

DQ ✓✓ 87%



19) Percentage Sickness Absence Rate

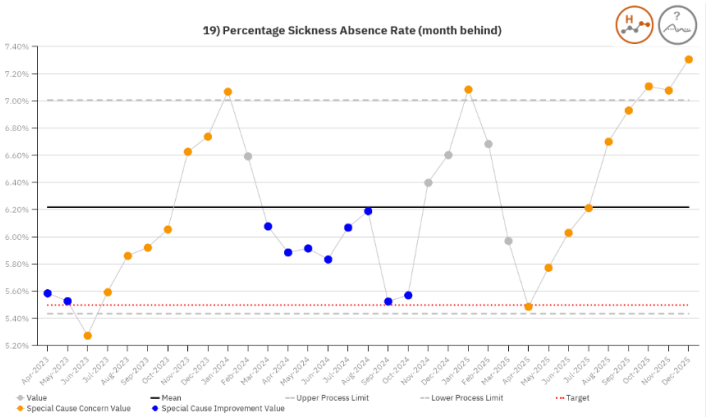
Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for sickness absence to be no more than 5.5%

What does the chart show/context:
There were **228,137.23** working days available for all staff during December 2025 (reported month behind); of those, **16,669.45 (7.31%)** 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, Durham, Tees Valley and Forensic Care Group, North Yorkshire, York & Selby Care Group, Adult Mental Health and Children & Young Peoples Services within both Care Groups and Adult Learning Disabilities within Durham, Tees Valley and Forensic Care Group.

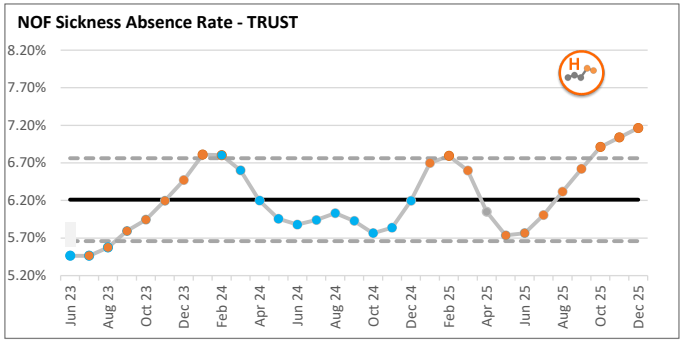
National Benchmarking for NHS Sickness Absence Rates published 8th January 2026 (data ending September 2025) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.54%** compared to the Trust mean of **6.13%**, with the Trust ranked 43 of 47 Mental health Trusts (1 being the best with the lowest sickness rate).



Sickness Absence Rate <u>rolling 3-month measure</u> (National Oversight Framework measure)

What does the chart show/context:
There were 690,590.70 working days available for all staff in the 3-month period ending December 2025 (reported month behind); of those, 49,471.46 (7.16%) days were lost due to sickness.

There is special cause concern at Trust level and for Estates & Facilities Management, Corporate Affairs & Involvement, Digital & Data Service, Durham, Tees Valley & Forensic Care Group, People & Culture, Assistant Chief Executive, Chief Executive Office and North Yorkshire, York & Selby Care Group. There is special cause improvement for Medical.



Underlying issues:
- Sickness audits have shown that the Attendance Management Procedure is not being consistently followed through Trust services.
- Long-term sickness is the main driver of overall absence rates, being consistently higher than short-term across all directorates and care groups
- Whilst we have high levels of sickness within several areas, further work is required to understand the underlying issues and actions being taken (these will be included once key actions have been completed which will provide this detail).

Actions:

The following actions were due for completion by the **end of October/November 25**:

1. 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. **(Complete)** Two organisations have been contacted and learning from those discussions have been considered and the following new actions identified.
    1. All People Partners to undertake Coaching Training to support managers in regular reviews of sickness absence (dates to be confirmed by end of January 26)
    2. Director led deep dives to be undertaken monthly supported initially by Heads of People & Resourcing (to commence by end of January 26)
    3. People Partners/Officers to provide training to all managers who have direct line management responsibility on Attendance Management (to commence from February 26 – end date to be confirmed following development of training plan)
    4. To review the existing Attendance Management policy (by end of January 26)
2. All Executive Directors to ensure the Sickness policy is being followed by all managers (including the completion of documentation and timely update of ESR) **(Complete)**
3. All Executive Directors to ensure managers contact the LTS team for absences over 28 days (or likely to be) in a timely manner **(Complete)**
4. Strategic Leads for Health & Wellbeing to provide a summary of the Sickness policy, including staff responsibilities for managers, to all managers **(Complete)**
5. Strategic Leads for Health & Wellbeing to provide a briefing in relation to the Long-Term Sickness team **(Complete)**
6. Performance Team and Workforce Information to extract and analyse sickness absence information split by long- and short-term, utilising SPC charts, to better understand whether there are trends in performance at the levels included within this report **(Complete)**

The following actions were due for completion by the **end of December 25:**

1. People Partners to undertake “spot checks” across care group and corporate directorates to check if sickness policy is being followed (**Complete)** Audits have taken place and will continue. The audit process has been streamlined, and results are now shared with General Manager following each audit.
2. Strategic Leads for Health & Wellbeing to provide a briefing on what interventions are generally evidence based for LTS and STS (or if not evidence based, available and good face value) **(Not Complete)** Research completed and briefing will be provided by end of January 26
3. Head of Workforce Strategy & Systems to review the automated prompts from ESR (e.g. ‘is this person still off’, ‘have you put a reason on’, ‘where is the recording of the return-to-work conversation’, ‘it’s been 25 days now, are you now moving to LTS’ or similar) **(Complete)** However, functionality not available in existing ESR
4. Head of Workforce Strategy & Systems to explore whether there is a “bot” to search other policies **(Not Complete)** This will now be completed by the end of February 26 given the work involved which include regional discussions on this topic

Actions:

The following actions were due for completion by the **end of December 25:**

5. Executive Director for People & Culture to explore whether public health could contribute to our plan **(Complete)** Head of Inclusive Culture to explore how socio-deprivation indicators can be used to influence our plan. **Timescale to be confirmed**
6. Head of Performance and Heads of People & Resourcing to establish a small Corporate Task & Finish Group to identify improvement actions where there are specific issues in individual areas **(Not Complete)** Meeting now planed for mid January 26
7. Head of Performance and Heads of People & Resourcing to explore with Integrated Care Group MD a Trust-wide Inpatient Task & Finish Group to identify improvement actions where there are specific issues in individual areas **(Not Complete)** EDG are asked to approve this be stood down pending completion of the Director-led deep dives commencing in January 2026.
8. Head of Performance and Heads of People & Resourcing to explore with Integrated Care Group MD a DTV Community Task & Finish Group to identify improvement actions where there are specific issues in individual areas **(Not Complete)** EDG are asked to approve this be stood down pending completion of the Director-led deep dives commencing in January 2026.

The following actions are due for completion during **Quarter 4 25/26:**

1. Executive Director for People & Culture and Associate Director of Performance to repeat Workforce Deep Dive on Sickness Absence to assess impact of actions EDG Week 4 January 26 **Deferred to EDG Week 4 February 26**
2. All Executive Directors to ensure new and existing managers have the necessary skills and knowledge to undertake management of sickness by the end of March 26
3. People Partners to identify managers who lack knowledge and provide training by the end of March 26

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
159,624 training courses were due to be completed for all staff in post by the end of December. Of those, **147,311 (92.29%)** were completed.

There is special cause improvement at Trust level and for most Directorates in the reporting period. There is special cause concern in Estates and Facilities Management; however, this is not an actual concern as performance is above standard.

As at the 31st December 2025, the below directorates are below 85%:

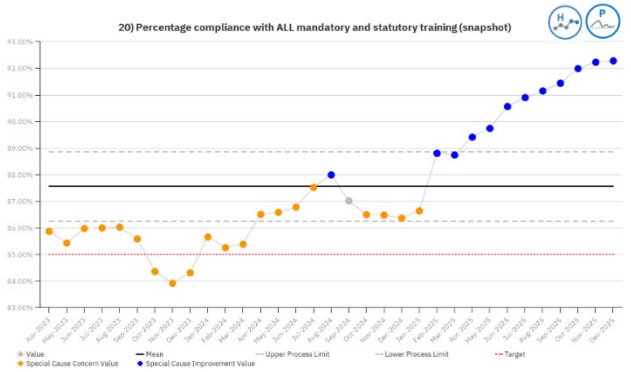
	Number Compliant	Total Number	% Compliant
CHIEF EXECUTIVE OFFICE	94	123	76.42%

Underlying issues:
- The volume of courses that staff have to complete is extremely time consuming and above the current headroom calculation.
- There is a number of staff incorrectly allocated to the Temporary Staffing (bank staff) directorate 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 was to be completed by the end of September 2025. **(Not Complete)** A meeting is to be arranged by the end of January 2026 to understand the impact and identify the required steps.
- 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 was to be held by the end of December 2025 (previously November) to agree next steps. **(Not Complete) Timescale to be confirmed**
- 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. **(Not Complete)** This will be complete by the end of February 2026.

DQ

93%



20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Courses below standard

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

What does the table show/context:
We have **8** courses that are currently below the standard (compared to 7 the previous month) - Incident Management – Corporate has now reported below standard. 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 December 2025 there has been an average of 29% 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 Levels 1 & 2 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.
- Workforce Development Lead to develop a guide 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.) **(Complete)** This will be published on the staff Intranet **Timescale to be confirmed**
- Workforce Development Lead to scope training for the Positive & Safe Care trainers to provide Resus and Moving & Handling training by the end of November 2025, with a view to updating the training rotas by the end of December 2025. **(Not Complete) Timescale to be confirmed**
- Sixty-six (66) training spaces for Resuscitation Level 3 have been purchased from an external provider; 48 for resident doctors and 18 for nursing staff.

	Number Compliant	Total Number	% Compliant
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year *	800	1033	77.44%
Positive and Safe Care Level 2 Update *	1305	1671	78.10%
Resuscitation - Level 1 - 1 Year *	2057	2605	78.96%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year *	1629	2019	80.68%
Annual Medicines Optimisation Module	553	676	81.80%
Moving and Handling - Level 2 - 2 Years *	702	858	81.82%
Positive & Safe Care Level 1 *	3749	4553	82.34%
Incident Management-Corporate*	166	198	83.84%

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

21) Percentage of staff in post with a current appraisal

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

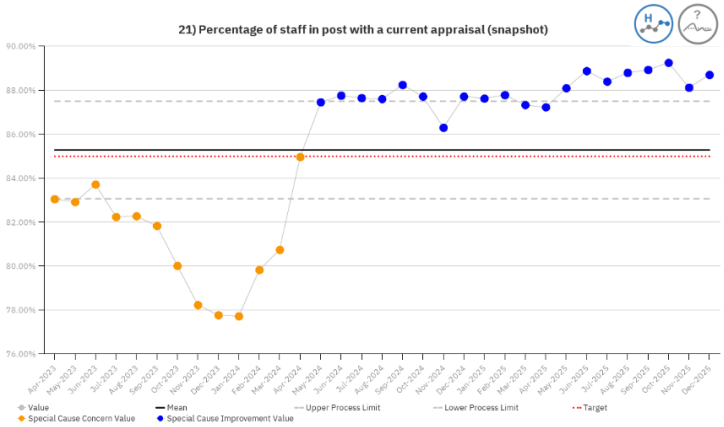
Background / standard description:
We are aiming for 85% of staff in post with a current appraisal

What does the chart show/context:
Of the **7,044** eligible staff in post at the end of December; **6,248 (88.70%)** had an up-to-date appraisal.

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

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

	Number Compliant	Total Number	% Compliant
CORPORATE AFFAIRS AND INVOLVEMENT	24	39	61.54%
PEOPLE AND CULTURE	110	132	83.33%



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

Actions:
- Corporate Affairs & Involvement had expected to achieve standard by the end of December 2025. **(Not Complete) Timescale to be confirmed**
- People & Culture have not achieved standard in December; however, are achieving standard at time of reporting.
- 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 was to be held by the end of December 2025 (previously November) to agree next steps. **(Not Complete) Timescale to be confirmed**
- 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 January 2026 (previously December 2025).
- Organisational Development has completed an annual internal audit of appraisal paperwork to ensure good quality appraisals are delivered by Trust managers. Findings will be reported into the People & Resources Executive Directors Group in February 2026.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

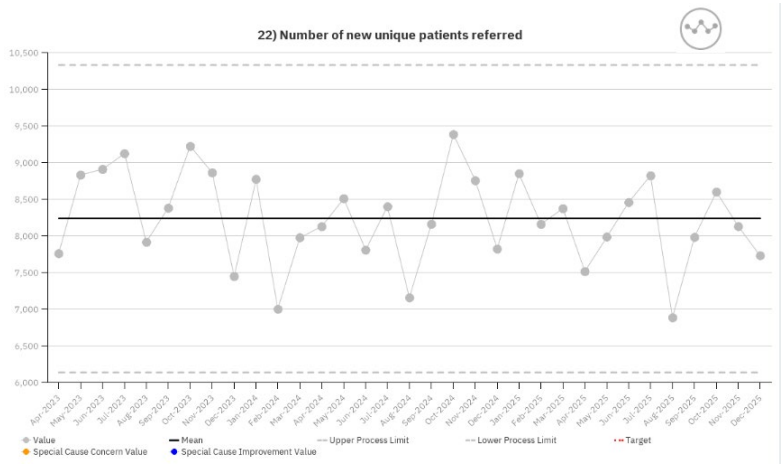
What does the chart show/context:
7,734 patients referred in December that are not currently open to an existing Trust service.

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

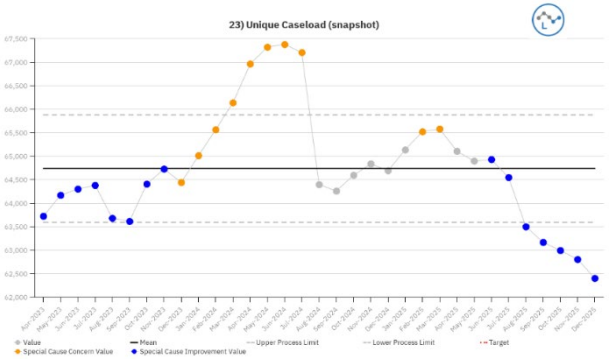
What does the chart show/context:
62,406 cases were open, including those waiting to be seen, as at the end of December 2025; **53,227** were active.

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.

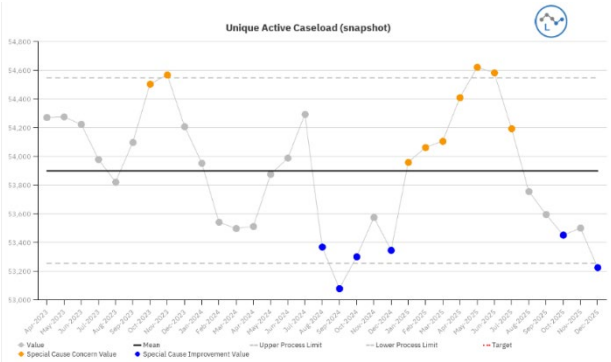
The **additional** SPC chart representing **Active Caseload** (excluding patients waiting for first contact) shows special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group; there is no significant change for North Yorkshire, York & Selby Care Group. There is special cause concern in Secure Inpatient Services and Children & Young Peoples Services in NYYSCG; there is also special cause concern in DTVFCG Adult Mental Health and Health & Justice; however, the services have 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.
- A number of data quality issues have been identified in the SIS caseload data.

Actions:
- Following the proposal to consider a new option for the Unique Caseload measure, the Head of Business Intelligence & Clinical Outcomes provided data to demonstrate the impact of the construct change to the Quality & Performance EDG in November. **(Complete)** The proposal was approved at the People & Resources EDG in November and will now be submitted to Resources & Planning Committee for approval. **Timescale to be confirmed**
- Service Manager to undertake a patient-level validation to identify the reasons for the increase in caseload within Secure Inpatient Services and any required improvement actions, by the end of December 2025. **(Complete)** *See below action*
- SIS Service Manager to work with Business Intelligence to resolve the data quality issues by the end of February 2026.



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 December 2025 against which Trust performance is assessed is a deficit of **£0.34m which is £1.80m 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 support delivery of the nationally required reductions of 40% on Agency (outturn spend 2024/25 £10.2m, savings planned £4.4m) and 10% on Bank spend (outturn spend 2024/25 £15.1m, savings required £1.43m) as compared to 2024/25. Actions to reduce Agency costs have delivered better than planned reductions to date. By contrast, 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 had increased to £1.43m in December (the plan required a reduction to average run rate of £119k pcm). Bank costs were £12.18m to date and £630k more than planned.
- **Overtime costs** reduced from £430k in April to £117k in December.
- **Agency expenditure** is **£4.97m** for the year to date and **£0.54m 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. Costs were planned to reduce from an actual proportion of 2.1% of paybill in April 2025, to 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 £0.45m and increased by £0.055m compared to prior month and represented **1.49% of paybill (**which is **1.07 percentage points (41.8%)** lower than the 2024/25 average of 2.56%. Delivering reducing expenditure run rates for the remaining periods will require ongoing rigour. Costs in December would represent an annualised £6.3m agency cost, compared to a straight line projection £6.6m, 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, for) 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, to minimise run rates and consider alternatives to like for like agency medical cover.
- The Trust has **no off-framework agency assignments**.
- **Independent sector beds** - the Trust used **102 non-Trust bed days in December** (0 in November) 2025. **Year to date costs were £230k**, including estimates for unvalidated periods of occupancy and average observation levels pending billing and were **£154k below 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 £10.5m non–recurrent.
- Year to date CRES are £0.06m ahead of plan, but with **recurrent schemes delivering £2.8m below plan**, and **non-recurrent schemes delivering £2.8m above plan**.
- Full delivery of the £27.4m planned savings is forecast, but with **an in-year shortfall of £3.3m 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 £4.2m**, which would equate to a **total recurrent Full Year Impact of CRES of £17.8m** (£0.9m 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. Premia rate Agency price cap breaches are an ongoing challenge, with 53% of (a continuously reducing number of overall) agency shifts remaining above price cap and impacting overall value for money. Medical and Health and Justice vacancy cover are long-standing hotspots although impacts from the latter have reduced markedly in the last year.
- There are still risks of delivery of CRES schemes included in the forecast. A review of the forecast, and full year effect, has been carried out in December. The Full Year Effect has reduced to £17.8m, with some reductions due to reassessment of schemes mitigated by transfer of a non recurrent scheme to recurrent.

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 **£4.97m to Month 9 are £0.54m 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 **1.49% (↑) 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 an average of 1.5% annual planned paybill, to deliver the national 40% reduction on prior year.

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 196 worked Whole Time Equivalent (WTE) between April 2023 and December 2025** (falling from 240 to 44 WTE), and related annualised premia for price cap breaches reduced from £4.0m in April 2023 to £1.7m in December 2025 (£2.3m reduction). The trend for medical WTE and price cap breaches has remained consistently positive between April 2023 and December 2025, and **Medical Agency WTEs have reduced to the lowest level reported in 2025/26** this month, **at 15 WTE**. Run rates demonstrate 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), ability to mobilise alternative bank shifts, 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. The Safe Staffing Group is 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. The scope for these has been extended and reviews will complete by March 2026.
- Providers were asked in November by NHS England to cease all Band 2 and 3 HCA agency shifts, with actions now progressing via the Care Groups to remove this agency spend. Total shifts were 82 in October, 40 in November and 48 in December. We need to have stopped all shifts by January 2026, unless an allowed exception is identified.

25b) Agency price cap compliance

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

835 agency shifts were worked in December 2025 (843 shifts prior month), with **400 or 48% of shifts compliant** and **435 or 52% non-compliant** (prior month 396 or 47% shifts compliant and 447 or 53% non-compliant) **with national price caps, representing an 8 or 0.95% decrease in overall shifts worked, and a reduction of 12 non-compliant shifts breaching with a slight reduction in percentage of breaches in-month due to reducing overall shifts worked**.

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

- 65% of all non-compliant shifts (90% by value of breaches) were medical and 35% of non-compliant shifts (10% by value of breaches) were nursing.
- 89% of the nursing agency breaches related to vacancy cover in prisons (86% by value of shifts).
- **Medical shift breaches decreased by 25 shifts**, and from 309 shifts in November to 284 in December 2025 (100% shifts breaching price cap).

8 fewer overall agency shifts were worked this month compared to last, with shifts worked being equivalent to **approximately 27 shifts per day** (28 in November and 33 in October). The 8 shifts decrease included 25 fewer higher cost medical, 9 additional nursing, and 8 additional 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 702 (46%) over the last 12 months** from 1,537 shifts worked in December 2024 and **a reduction of 26% or 151 shifts breaching price cap since December 2024** (586 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 9 services have also breached for nursing outside prisons.
- 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 2 for the period ending 31st December 2025 and better than 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 (year to date). The Trust has a capital service capacity **rating of 3**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is **rated as 1.**
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of -0.01% which is a **rating of 3**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.41% (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 £4.97m to date are £538k below plan and therefore **rated as a 1.**

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 **2** for the period ending 31st December 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 December was **£8.97m and £2.82m 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 £0.40m 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 were 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 December 2025. There is an increased risk that bank utilisation increases as use of other, more costly, temporary staffing options is restricted. Band 2 and 3 HCA restrictions nationally on agency may see a further swap out to bank alternatives, albeit reducing premia rates for shifts.

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 £2.89m** for the period ending 31st December, with £10.26m 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 and EQIA's are in place for most schemes. 1 QEIA is outstanding relating to an external business case, and dates are in for two other (low value £0.25m) 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 £2.89m over achievement year to date on non-recurrent schemes includes, £0.66m reduction on cost of capital, £1.95m other actions, £0.55m management of cash to achieve maximum interest, offset by under achievement of planned learning disability savings £0.27m.

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)

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Capital expenditure against the Trust's allocation was **£7.54m to the end of December**, which was £0.45m less than the revised Board approved programme (but £0.25m more than original plan, and Trust capital 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. Of this, £3.29m central cash-backed funding was allocated to TEWV via Provider Capital Collaborative Group arrangements. In 2024/25 TEWV supported system partners by agreeing to broker £1.40m capital slippage to support wider pressures, with those funds being returned and included in the original 2025/26 £13.80m capital programme.

The Trust was allocated a further £1.21m centrally cash backed PDC funding to support Solar panel installation, and £0.48m of PFI lifecycle works (not measured in capital allocation) giving a composite £13.80m capital allocation and £16.16m capital programme (including PFI). Mid-Year, follow award of a significant tender for Teesside works, the Board agreed it was likely that the approved revised programme of £14.47m would generate overspending against the ICB allocation, with the system capital lead alerted accordingly.

The Trust was awarded an additional £2.22m to support Solar panel installation on 5 further Trust sites, but due to timing constraints and/or structural works needed at 2 sites part of this funding (£1.55m) could not be progressed to active schemes in 2025/26. Expenditure on Solar installations this year will therefore be £1.88m

A further £0.68m of funding has been awarded for decarbonisation works (LED Lighting), the works are required to be completed within the current financial year which is currently an achievable timeframe.

There is potential that programmed Teesside hospital works will outturn below the Board approved programme in 2025/26 (but higher in 2026/27) following receipt of the contractor's cashflow, and that planned benefits from asset disposals will be consequently need to be deferred into 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 **£45.55m** at the end of December 2025 which exceeded planned cash balances of **£39.20m** by **£6.35m,** 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 where related scheme costs are included in year to date (and planned) capital expenditure.

- **Prompt Payment of Suppliers:** The Trust has achieved a combined Better Payment Practice Code (BPPC) compliance of **95.9%** to date by volume of invoices paid (97.9% by value) 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 December 2025 was £3.37m, with **debts exceeding 90 days amounting to £0.78m** (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

Tees, Esk and Wear Valleys NHS Foundation Trust

Rep Ref	National Quality Requirements	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)
IIC4850	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%	93.33%
IIC5270	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%	80.00%
IIC6570	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%	89.13%
IIC6560	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%	99.92%
IIC5340	Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)		F	95.00%	95.00%	87.87%
IIC5350	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%	78.18%

Rep Ref	Mental Health Priorities	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)
IIC6630	Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider (OAPs)		?	0	0	4
IIC6600	Average length of stay for Adult Acute Beds (Rolling Quarter)		?	42	42.3	44.3
IIC6490	Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48.00%	48.00%	47.46%
IIC6480	Talking Therapies - Reliable improvement rate for those completing a course of treatment		?	67.00%	67.00%	66.80%
IIC5370	Number of women accessing (1+ contact) specialist community PMH services in the previous 12 months	H	N/A	N/A	N/A	1,611
IIC5830	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact	H	N/A	No significant change	No significant change	32,037
IIC6610	Number of people accessing IPS services (rolling 12 month)		N/A	N/A	N/A	974

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 December there were no 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 & York. For the month of December there was 1 patient that did not receive treatment within the 1-week standard.

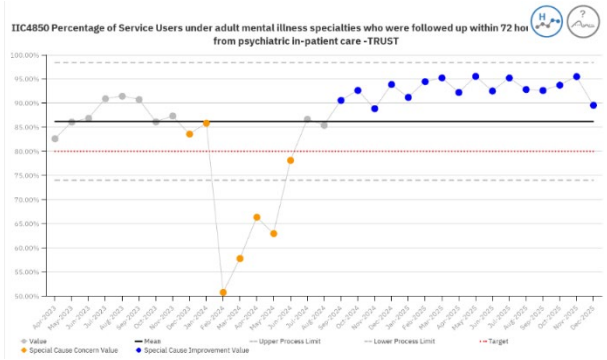
Mental Health Priorities

- **Active OAP (inappropriate):** Achieved Trust plan for December.
- **Average Length of stay for Adult acute beds *(new measure)*:** Plan not achieved Trust for December.
- **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 December in all places with the exception of Tees Valley.
- **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 December in North Yorkshire.
- **Specialist Community Perinatal Mental Health (PMH) services:** Plan achieved at commissioned place level with the exception of County Durham.
- **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 Tees Valley.
- **Number of people accessing individual placement support (*new measure*):** Plans not achieved at ICB level.

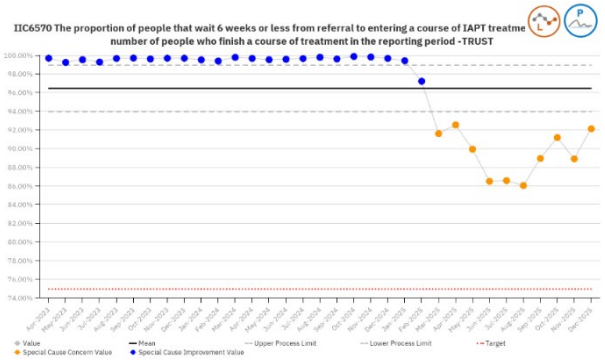
*All headlines are based on financial year to date unless otherwise stated.

National Quality Requirements

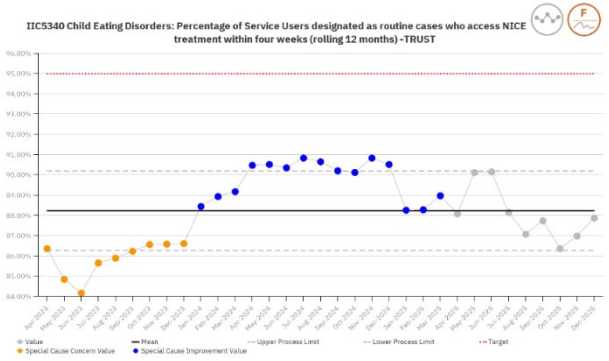
Tees, Esk and Wear Valleys NHS Foundation Trust



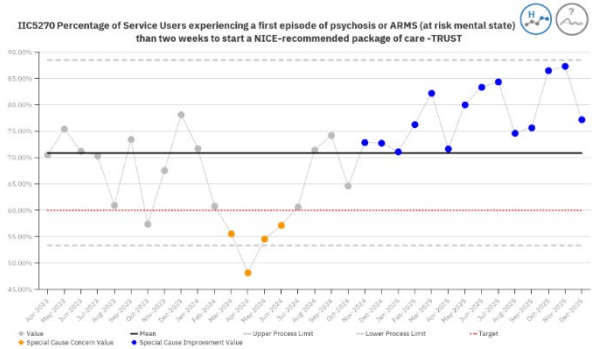
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	80%	93.33%			✓
COUNTY DURHAM	80%	95.08%			✓
TEES VALLEY	80%	92.44%			✓
NORTH YORKSHIRE	80%	96.39%			✓
YORK	80%	93.28%			✓



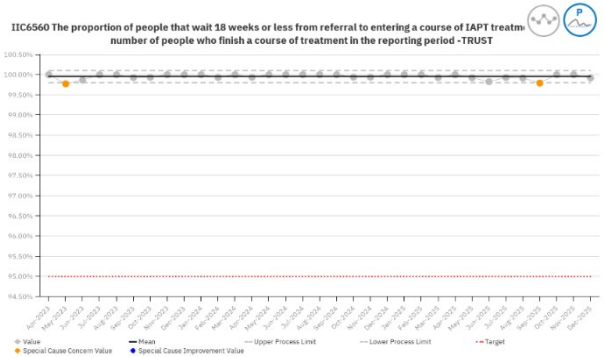
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	75%	89.13%			✓
COUNTY DURHAM	75%	81.54%			✓
TEES VALLEY	75%	83.37%			✓
NORTH YORKSHIRE	75%	97.99%			✓
YORK	75%	91.69%			✓



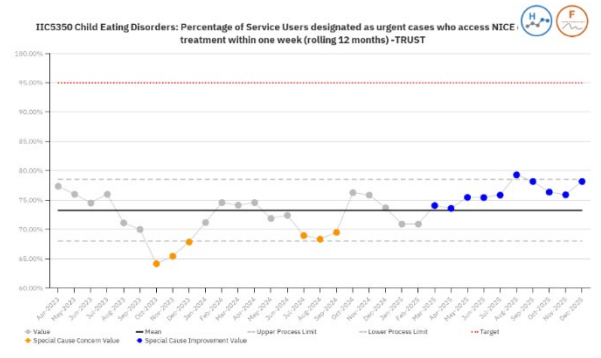
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	87.87%			✗
COUNTY DURHAM	95%	83.33%			✗
TEES VALLEY	95%	98.84%			✓
NORTH YORKSHIRE	95%	85.48%			✗
YORK	95%	71.43%			✗



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	60%	80.00%			✓
COUNTY DURHAM	60%	72.85%			✓
TEES VALLEY	60%	82.19%			✓
NORTH YORKSHIRE	60%	86.71%			✓
YORK	60%	73.08%			✓



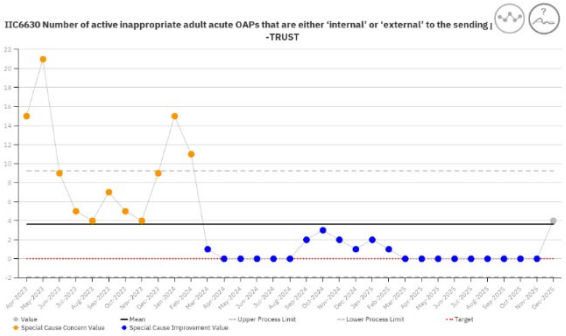
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	99.92%			✓
COUNTY DURHAM	95%	99.88%			✓
TEES VALLEY	95%	99.79%			✓
NORTH YORKSHIRE	95%	99.98%			✓
YORK	95%	99.95%			✓



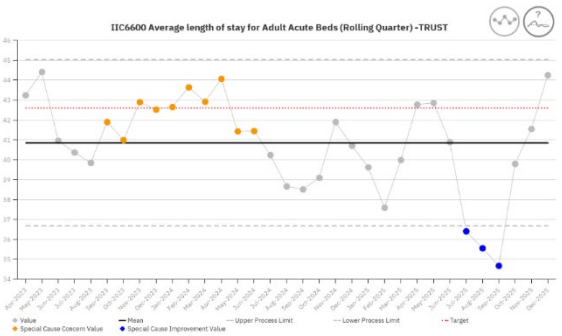
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	78.18%			✗
COUNTY DURHAM	95%	90.00%			✗
TEES VALLEY	95%	100.00%			✓
NORTH YORKSHIRE	95%	58.33%			✗
YORK	95%	50.00%			✗

Mental Health Priorities

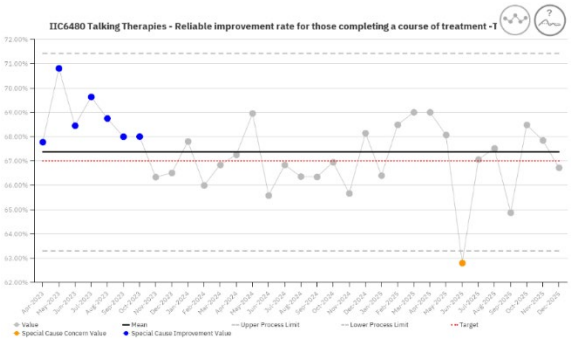
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



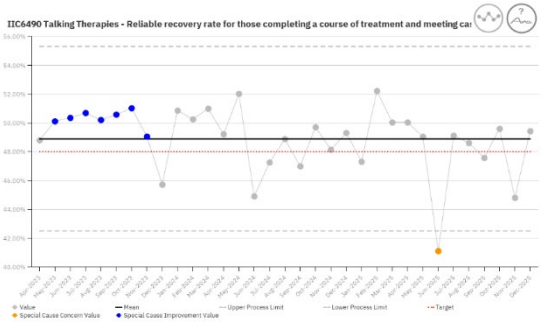
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	0	0			



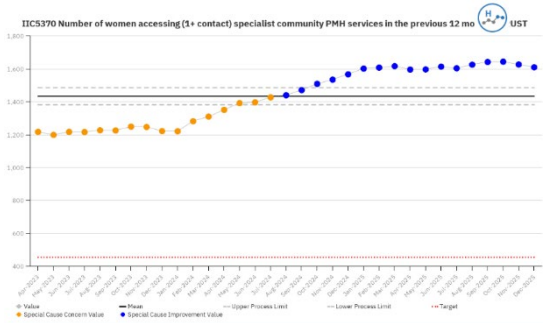
Organisation	Standard	Actual	Variation	Assurance	Plan Me
TRUST	42.3	44.26			



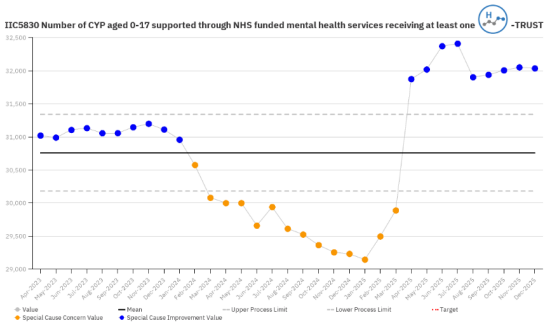
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	67%	66.80%			
COUNTY DURHAM	67%	64.18%			
TEES VALLEY	67%	62.32%			
NORTH YORKSHIRE	67%	69.84%			
YORK	67%	69.07%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	48%	47.46%			
COUNTY DURHAM	48%	43.47%			
TEES VALLEY	48%	46.20%			
NORTH YORKSHIRE	48%	50.83%			
YORK	48%	50.51%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,611			
COUNTY DURHAM	456	446			
TEES VALLEY	447	521			
NORTH YORKSHIRE	368	443			
YORK	156	171			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		32,037			
COUNTY DURHAM		11,374			
TEES VALLEY		11,474			
NORTH YORKSHIRE		5,345			
YORK		3,282			

Number of people accessing IPS services (rolling 12 months)

Organisation	Standard	Actual	ICB Actual	Plan Met
Trust	N/A	959		
County Durham	789	280	645	
Tees Valley		365		
North Yorkshire	347	204	314	
York		110		

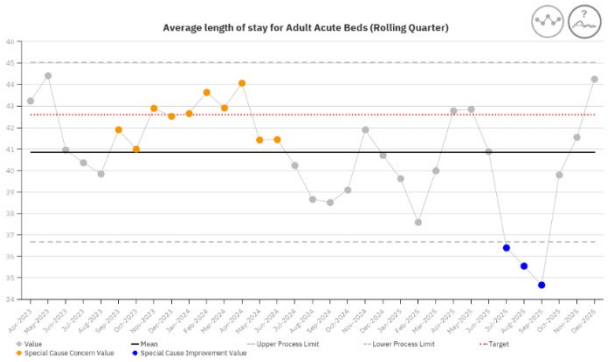
Average length of stay for Adult Acute Beds

NHS
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 December we are aiming to have an average length of stay of **42.3** days.

What does the chart show/context:
During the 3-month period ending December 2025, there were **767** discharged hospital spells from adult acute beds for patients aged 18+, accounting for a total of **33,944** bed days which equates to an average length of stay of **44.26** days.

There is no significant change at Trust level and for North Yorkshire, York & Selby Care Group; however, there is special cause concern for Durham, Tees Valley & Forensic Care Group and both services within that care group.



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	40.9	36.4	35.6	34.7	39.8	41.6	44.3			

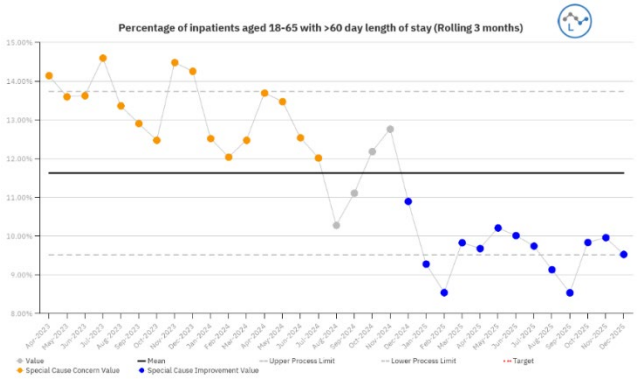
Underlying issues:
Long lengths of stay are largely impacted by the discharge of patients that are clinically ready for discharge. In the 3 months ending December 2025 there was no significant change in the number of patients discharged; however, 6 patients with lengths of stay exceeding 360 days were discharged.

Actions:
See *Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed)* on page 24 for action, noting 2 further discharges of super-stranded patients are planned for January 2026.

Percentage of adult inpatients with a length of stay over 60 days at discharge - rolling 3 months (National Oversight Framework measure)

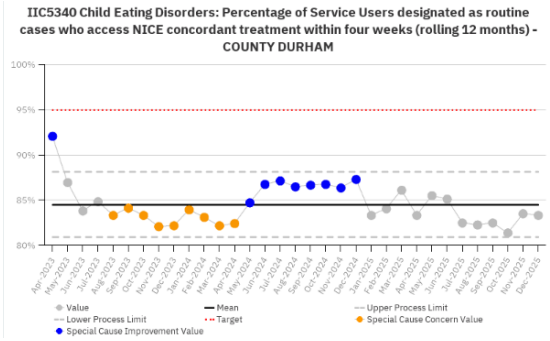
What does the chart show/context:
Over the 3-month period ending December 2025 there were **577** adult patients discharged from an adult acute (assessment & treatment) bed, of which **55** (**9.53%**) had a length of stay exceeding 60 days**.**

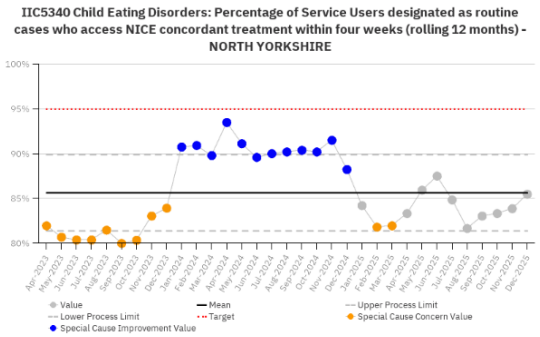
There is special cause improvement at Trust and Care Group level.

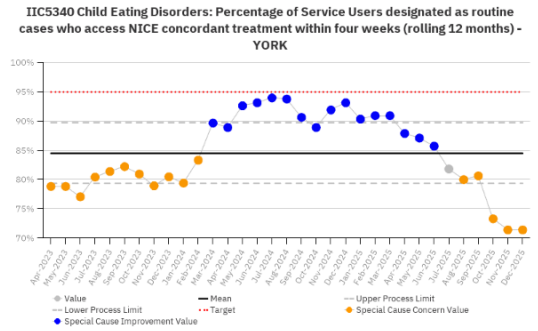


The proportion of CYP with ED (routine cases) that wait 4 weeks, from referral to start of NICE-approved treatment (rolling 12 months) - *by exception*

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 December 2025, there were **90** children and young people with a routine referral, of which **75 (83.33%)** started treatment within 4 weeks in **County Durham**.

In December, there were **5** children and young people with a routine referral, **all** of which **(100%)** started treatment within 4 weeks.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

What does the chart show/context:
In the rolling 12 months ending December 2025, there were **62** children and young people with a routine referral, of which **53 (83.33%)** started treatment within 4 weeks in **North Yorkshire**.

In December, there was **1** children and young people with a routine referral which **(100%)** started treatment within 4 weeks.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

What does the chart show/context:
In the rolling 12 months ending December 2025, there were **28** children and young people with a routine referral, of which **20 (71.43%)** started treatment within 4 weeks in **York**.

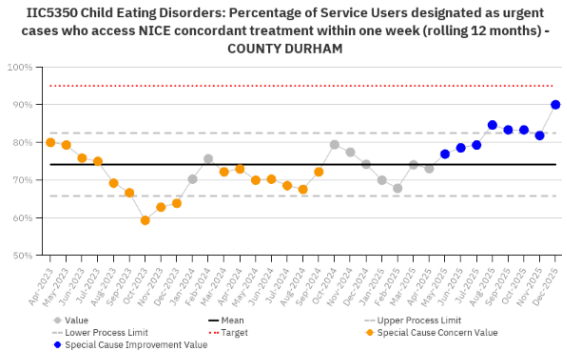
In December, there were 0 children and young people with a routine referral.

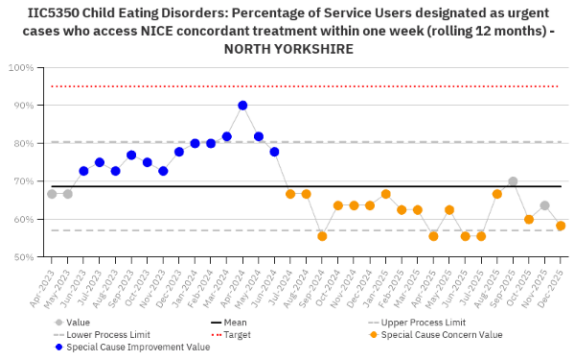
Underlying issues:
There are no underlying issues to report.

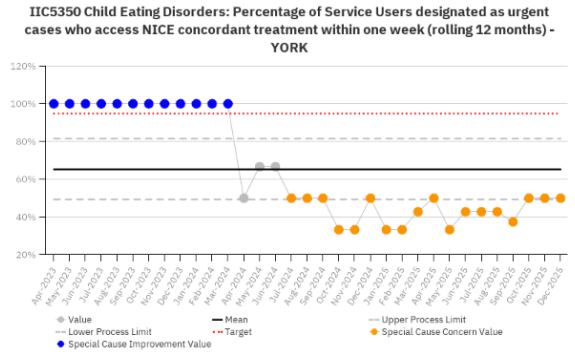
Actions:
There are no specific improvement actions required.

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

Tees, Esk and Wear Valleys NHS Foundation Trust







Background / standard description:
We are aiming to have 95% of suspected eating disorder cases for 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 December 2025, there were **20** children and young people with a routine referral, of which **18 (90.00%)** started treatment within 1 week in **County Durham**.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

What does the chart show/context:
In the rolling 12 months ending December there were **12** child or young people with an urgent referral, of which **7 (58.33%)** started treatment within 1 week in **North Yorkshire**.

In December, there were **2** children /young people with an urgent referral, of which, 1 **(50.00%)** did not start treatment within 1 week due to patient choice.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

What does the chart show/context:
In the rolling 12 months ending December, there were **10** child or young people with an urgent referral, of which **5 (50.00%)** started treatment within 1 week in **York**.

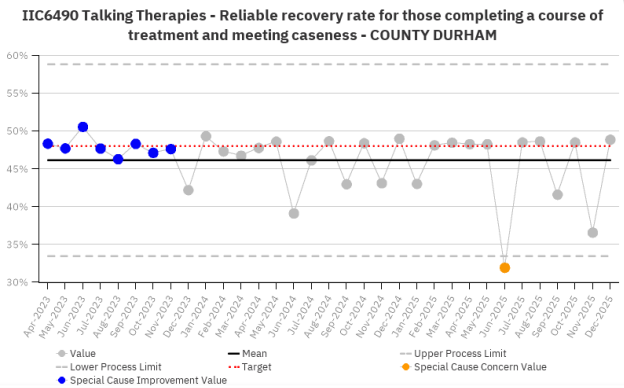
In December, there was **1** child / young person with an urgent referral who started treatment within 1 week (**100.00**%).

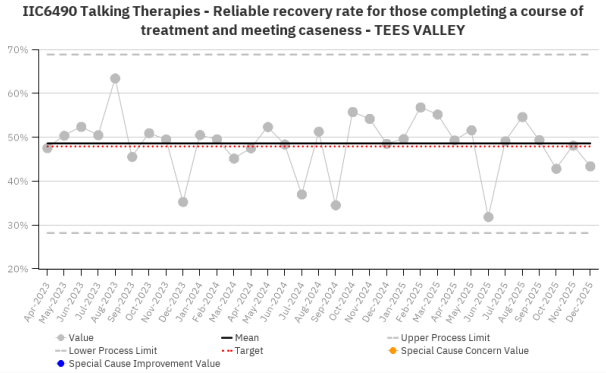
Underlying issues:
There are no underlying issues to report.

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.

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 December, **48.85%** 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 December, **43.42%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**.

Underlying issues:

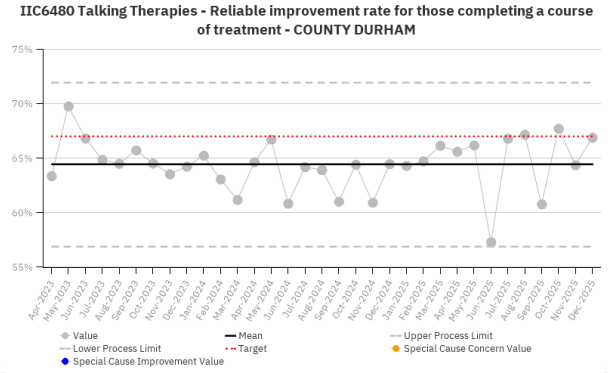
- Increase in complexity and severity of patient's presentation, which makes it more challenging to see a 6-point (Patient health questionnaire - PHQ9) or a 4-point (Generalised anxiety disorder - GAD) shift.
- A number of staff members on maternity leave and high levels of sickness are resulting in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

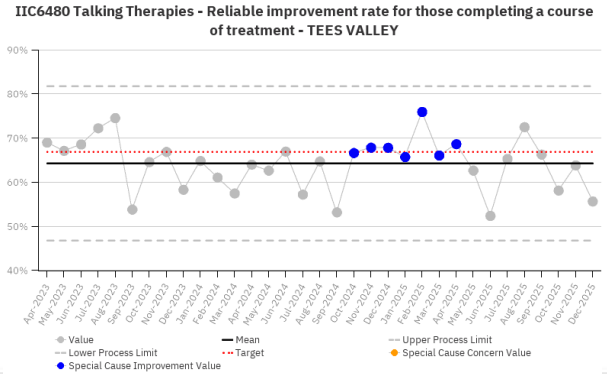
Actions:

- The Trustwide action plan includes 14 improvement actions, all of which were completed by the end of December 2025, with the exception of action which 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.
- Recruitment is underway for 3 High Intensity workers and 3 Psychological Wellbeing Practitioner to cover maternity leave. The HIWs have been appointed and are progressing through recruitment processes; however, the recruitment for PWPs was unsuccessful. Two trainee PWPs will commence in January 2026. Improvement actions for sickness will be incorporated into the Trust-wide for sickness absence actions.
- 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. **(Complete)** the desired impact on reliable improvement has not been achieved.
- Two improvement events have taken place which focused on reducing waiting times. The outputs of the events are being reviewed and will be shared with the Trust-wide Task & Finish Group in January. It is anticipated that actions to improve waiting times should have a positive impact on reliable recovery and improvement.

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

Tees, Esk and Wear Valleys NHS Foundation Trust





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

What does the chart show/context:
During December, **66.88%** 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 December, **55.68%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**.

Underlying issues:

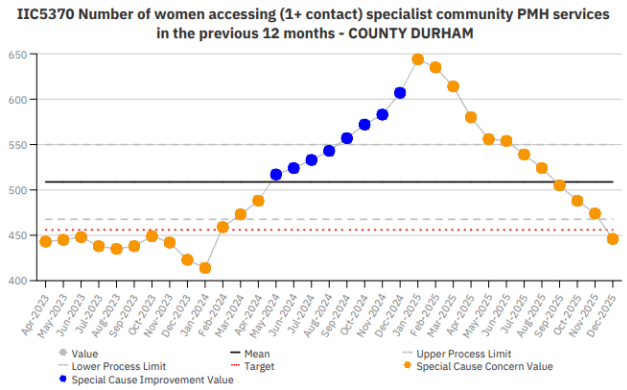
- High levels of complex patients are seeing a reliable improvement on two outcome measures (Patient health questionnaire - PHQ9 and Generalised anxiety disorder - GAD7); however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the 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 completed by the end of December 2025, with the exception of action which 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.
- Recruitment is underway for 3 High Intensity workers and 3 Psychological Wellbeing Practitioner to cover maternity leave. The HIWs have been appointed and are progressing through recruitment processes; however, the recruitment for PWPs was unsuccessful. Two trainee PWPs will commence in January 2026. Improvement actions for sickness will be incorporated into the Trust-wide for sickness absence actions.
- 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. **(Complete)** the desired impact on reliable improvement has not been achieved.
- Two improvement events have taken place which focused on reducing waiting times. The outputs of the events are being reviewed and will be shared with the Trust-wide Task & Finish Group in January. It is anticipated that actions to improve waiting times should have a positive impact on reliable recovery and improvement.

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

Tees, Esk and Wear Valleys NHS Foundation Trust



Background / standard description:
We are aiming to have 456 women accessing our specialist community PMH services within a 12-month period.

What does the chart show/context:
In the 12-month period ending December 2025 **446** women accessed our specialist community PMH services within **County Durham**.

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

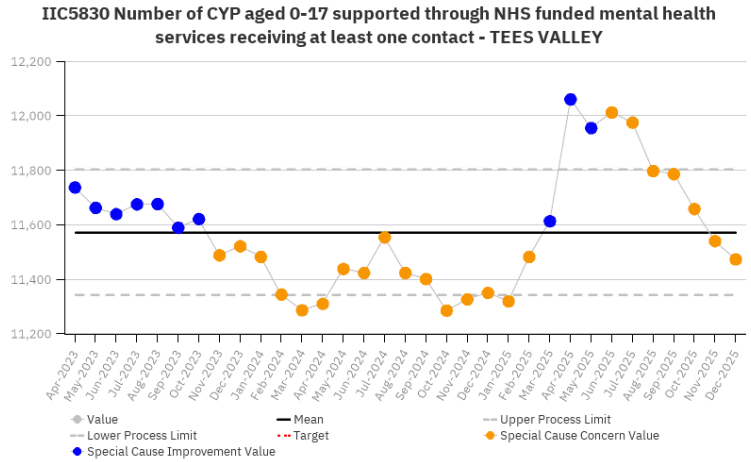
Underlying issues:
The service is currently impacted by maternity leave (1 wte) and 1 wte medic vacancy.

Note - Over the last 12 months, Performance has been impacted by 4 members of staff who left their posts in succession at the end of 2024 – these posts have all now been recruited to.

Actions:
The maternity leave is currently advertised, and the medic vacancy has been appointed to and is due to start imminently

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.

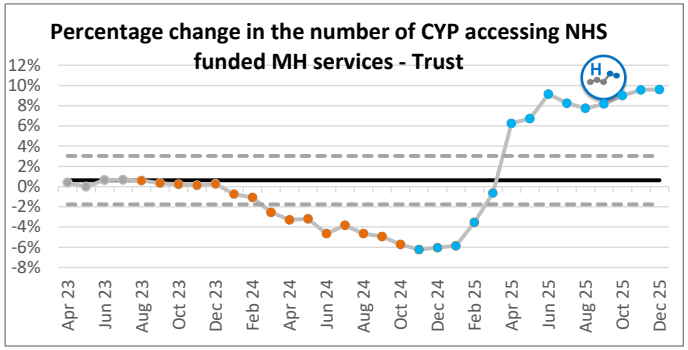
What does the chart show/context:
In the 12-month period ending December 2025 **11,474** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **Tees Valley**.

There is special cause concern as indicated in the SPC chart above. *See following page for issues and actions*

Percentage change in the number of CYP accessing NHS funded MH services – 12-month rolling (National Oversight Framework measure)

What does the chart show/context:
There were **32,039** CYP aged under 18 supported through NHS funded mental health with at least one contact in the 12-month period ending December 2025, compared to **29,233** in the 12-month period ending December 2024; a growth factor of **9.60%.**

The charts below show there is special cause improvement at Trust and Care Group level; however, there is a decline visible in DTVFCG.



CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months) *including annual change in number

Tees, Esk and Wear Valleys NHS Foundation Trust

Measure/Area	Underlying issue	Action
MHP measure - Tees Valley	Whilst there is a decreasing trend, further work is required to understand whether there is an underlying issue.	Business Intelligence to review the numbers accessing services to better understand the position. This work will be completed by the end of December 2025. **(Not Complete)** This will be completed by the end of January 2026.
MHP measure -North Yorkshire	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, which is the case in some Neuro services.	A QI event was held on the 9th December 2025 to review the clinical processes and recording of key data across all Neuro services to ensure consistency. **(Complete)** Whilst several actions were identified, including ensuring consistency of recording in line with clinical processes; there was nothing specific which would have a direct positive impact on this measure. During the event concerns were raised about indirect triage contacts not appearing correctly in the IIC - please see final new action.
NOF - Trust	There is an identified but small discrepancy between the Trust published data and that published within NHSE figures.	Business Intelligence to work with NHS England to understand differences between the published data and the Trust assessment to ensure Trust calculations are correct. This work will be completed by the end of November 2025. **(Not Complete)** It is anticipated this will now be completed by the end of February 2026.
	Our “ambition” for the **number** of children and young people accessing services which was agreed with our local commissioners as part of the NHS Plan submission, was that we would expect no significant change (from a statistical perspective) in the numbers accessing services in 2025/26, as there was no additional investment in services and demand was already high.	Head of Performance to establish joint clinical/corporate meetings with Trusts identified in the best performing quartile by the end of December 2025, to learn from any opportunities to adopt best practice approaches. **(Not Complete)** Peer Trusts have been contacted; awaiting response.
	Variation between the two care groups and a visible decline in DTVFCG	Business Intelligence have reviewed this measure alongside the work completed on numbers accessing services to better understand our position and provide assurance that there are no further underlying issues. **(Complete)** Analysis confirms the data is correct given the shape of local trends.

CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months) *including annual change in number

Tees, Esk and Wear Valleys NHS Foundation Trust

Measure/Area	Underlying issue	Action
Both measures	**NEW** An issue affecting the flow of indirect contact information from our electronic patient record system into the reporting warehouse was recently identified and has been resolved. The data is now fully incorporated in our internal reporting. A briefing outlining the issue, the internal review, and the next steps was considered by the Quality & Performance Executive Directors Group in January 2026.	A detailed briefing paper outlining the issue, impacts, and planned next steps will be presented to the Quality & Performance Executive Directors Group in January 2026.

Number of people accessing IPS services (rolling 12 month) – *by exception*

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Background / standard description:
In the 12 months ending December 2025, we are aiming for 936 people across **North East & North Cumbria ICB** to access individual placement & support services.

What does the table show/context:
In the 12 months ending December 2025, **645** people accessed IPS services.

Background / standard description:
In the 12 months ending December 2025, we are aiming for 562 people across **Humber & North Yorkshire ICB** to access individual placement & support services.

What does the table show/context:
In the 12 months ending December 2025, **314** people accessed IPS services.

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**	**646**	**645**			
Variance	**176**	**160**	**147**	**130**	**148**	**192**	**229**	**253**	**291**			
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**	**312**	**313**	**314**			
Variance	**72**	**71**	**78**	**-34**	**-38**	**-35**	**-233**	**-240**	**-248**			

NENC Ambition:
Within NENC we have funding to achieve the ambition. In terms of recruitment:

- 2 Employment Specialists; 1 post is to be advertised and 1 is in pre-employment checks.
- 1.7 Employment Assistants; 1 is to be advertised and 0.7 is out to advert.

HNY Ambition:
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. In terms of recruitment:

- 1.0 Employment Specialist is out to advert

Underlying issues:
Whilst recruitment/funding is impacting delivery of the ambitions across the respective ICBs, calculation of the ambition is potentially also an issue.

Actions:

- Associate Director of Performance to initially discuss current performance and calculation of ambition with NENC ICB and Cumbria, Northumberland & Tyne & Wear NHS Foundation Trust by the end of January 2026.

Other: Percentage of crisis response patients to receive face to face contact within 24 hours (National Oversight Framework measure)

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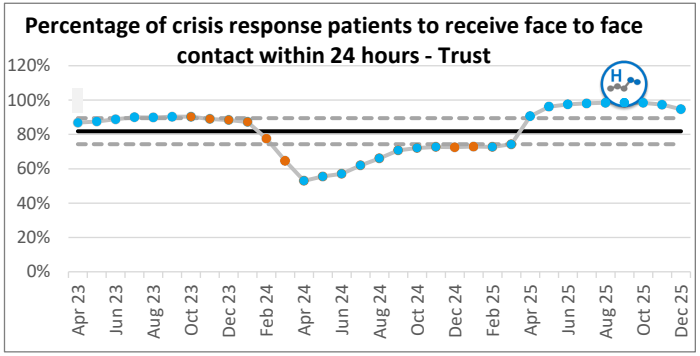


What does the chart show/context:
There were **3085** new urgent referrals to crisis services with a first face to face contact in the 3-month period ending December 2025, of which **2922** (**94.72%**) were seen within 24 hours of referral were seen within that timeframe.

There is special cause improvement at Trust and Care Group level.

Underlying issues:
- Analysis undertaken by Business Intelligence identified several issues impacting the data following the implementation of Cito. Work has been completed by Digital & Data Services to rectify this to ensure **future** data is correct (from mid-October onwards); however **historic** data cannot be corrected.

Actions:
- Business Intelligence are to work with NHS England to understand differences between the published data and the Trust assessment to ensure Trust calculations are correct. This work will be completed by the end of December 2025. **(Not Complete)** It is anticipated this will not be completed by the end of February 2026.

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		2496	30	675	348	402	220	11	0	1	0	10	111 **
Adults in Health and Justice services Waiting for an Assessment		43	27	9	6	0	0	0	1	0	0	6	89*
Children and Young People Waiting for an Assessment		971	449	279	120	70	7	17	19	10	0	9	151*
Adults with a learning disability Waiting for an Assessment		96	65	19	8	4	0	0	0	0	0	4	21
Older People Waiting for Assessment		2692	725	821	384	518	185	54	5	0	0	11	62

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		5286	81	79	81	240	296	419	1924	1918	248	89	204
Children and young people waiting for an ADHD Assessment		4419	44	86	120	316	458	511	1869	856	159	76	202
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2017	30	31	49	137	110	94	640	479	447	101	191
Adults waiting for an ADHD Assessment		4922	113	132	105	269	323	313	1054	1494	1119	106	341
Adults waiting for an Autism Assessment		4207	84	83	54	220	261	250	689	1370	1196	116	326

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)		66	15	17	22	12	0	0	0	3	6
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		1	0	0	0	0	1	0	0	7	7*
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		43	6	4	24	5	2	1	1	3	13

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		5268	592	819	708	1595	1002	552	14	61

NOTES:

- *An asterisk denotes a data quality issue*
- *** This patient is waiting for a neuro assessment; however, was also referred to AMH in December 2025 (length of wait is from initial referral to the Trust)*
- *The local Children & Young People Waiting for Treatment dashboard has now been stood down as we are now focusing on implementing the National waiting times standard.*

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 wait time is **111 weeks**** in DTVFCG. The majority (**57**%) of adults are waiting between 1 and 6 months for an assessment. *** See note on previous slide*
- **H&J** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our longest genuine wait time is **10 weeks** in DTVFCG. The majority (**63**%) of adults are waiting less than 1 month for an assessment.
- **CYP** There is special cause improvement in the number of children and young people waiting for an assessment. Our longest genuine wait time is **146 weeks** in DTVFCG. The majority (**75**%) of children and young people are waiting less than 2 months for an assessment.
- **ALD** There is no significant change in the numbers waiting for an assessment. Our longest genuine wait time is **19 weeks** in DTVFCG. The majority (**68**%) 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 **62 weeks** in NYYSCG. The majority (**91**%) of older adults are waiting less than 6 months for an assessment.

Waiting Times Neuro Services

- **CYP Autism** There is special cause improvement in the numbers waiting for an autism assessment. Our longest wait time is **204** weeks (3.9 years) in DTVFCG. The majority (**73%**) 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 **202** weeks (3.9 years) in DTVFCG. The majority (**62%**) 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 **191 weeks** (3.7 years) in DTVFCG. The majority (**78%**) of children and young people are waiting over 1 year for an assessment.
- **AMH ADHD** There is no significant change in the number waiting for an autism assessment. Our longest wait time is **341** weeks (6.3 years) in DTVFCG. The majority (**75%**) of adults are waiting over 1 year for an assessment.
- **AMH Autism** There is special cause concern (an increase) in the number of waiting for an ADHD assessment. Our longest wait time is **326 weeks** (6.5 years) in DTVFCG. The majority (**61**%) of adults are waiting over 2 years for an assessment.

National Waiting Times

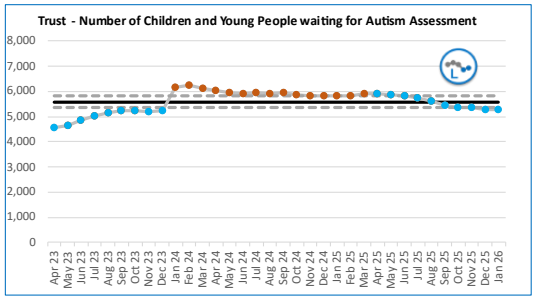
- **EIP** There is no significant change in the number of waiting for EIP Treatment. Our longest wait time is **6 weeks** in DTVFCG. The majority (**82%**) of adults are waiting less than 4 weeks for treatment
- **CED Urgent** There is no significant change in the number waiting from an urgent referral within our Eating Disorder Service. There are no patients waiting for urgent treatment; the 1 wait reported in excess of the standard is attributable to data quality and action is being taken to correct this on Cito.
- **CED Routine** There is no significant change in the number waiting from a routine referral within our Eating Disorder Service. Our longest wait time is **13 weeks** in DTVFCG. The majority (**56%)** of children and young people are waiting between 2 and 4 weeks for treatment.

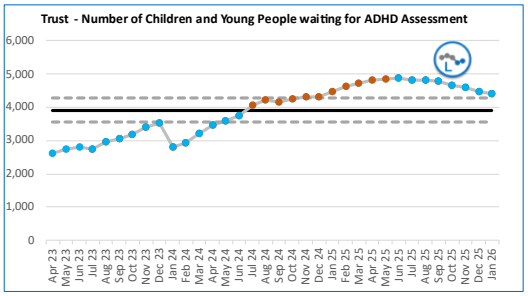
Waiting Times Talking Therapies

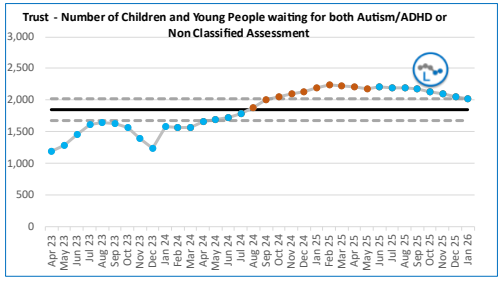
- There is special cause concern (an increase) in the number of adults waiting for their second contact with Talking Therapies. Our longest wait time is **61 weeks** in NYYSCG. The majority (**78%**) of adults are waiting between 4 and 28 weeks for their second appointment.

Waiting Times Neuro Services: Children & Young People

Tees, Esk and Wear Valleys NHS Foundation Trust







Children and young people waiting for an Autism Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	5286	89	204	
DTVF Care Group	4304	96	204	
NYY&S Care Group	982	58	134	

Commentary on Longest waits

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

Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4419	76	202	
DTVF Care Group	3928	78	202	
NYY&S Care Group	491	57	132	

Commentary on Longest waits

DTVF: Data Quality - Specialist Assessment Complete (longest genuine wait - 1379 days - specialist assessment booked).
NYY&S: Data quality - Specialist Assessment Complete (longest genuine wait - 832 Assessment required

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

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2017	101	191	
DTVF Care Group	1362	128	191	
NYY&S Care Group	655	45	102	

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. The next Clinical Prioritisation Group (regionally) is being held in December 2025 to finalise the framework. (**Complete)** Framework finalised and paper will be submitted to ICB MH Subcommittee in January 2026.
- The Trust has engaged in two design sprints for the future model of referral and triage with the ICB across Durham & Tees Valley and the outsourcing of assessments to the Owl centre is being progressed as part of the ICB-led work. This is part of the framework referenced above.
- 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. 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. A service away day is planned for May 2026 (previously March - delayed due to stakeholder availability) to agree a plan to roll out the clinical protocol work and further streamline processes around transformation.
- Service Manager to provide an update on the current position in respect of the patients on the under-5 pathway. Proposals will be submitted to the Care Group Board in December 2025 (previously November). **(Complete)** Concerns have been shared with the ICB who have confirmed there is work underway to address these concerns and that a briefing paper will be submitted to the February MHLDA Assurance meeting.
- The Scarborough ADHD team continues to have a recovery plan in place which is regularly reviewed. The service has recruited to vacant posts, and continue to review their existing resources in the most efficiently and effectively. There has been a delay in finalising the report to governance due to fluctuating challenges and the report drafted in December was no longer reflective of the current position. The overall position remains unchanged with the key issue remains demand outstripping capacity of the service and no further efficiencies can be made within the current financial envelope.
- The Service Manager has commenced a review and is looking at the overall budget and the need to move posts from the generic team to better support Scarborough ADHD team. **Timescale to be confirmed**
- A further Stop the Line Day is scheduled for January 2026 to review progress with the Team and the CAMHS Leadership Cell.

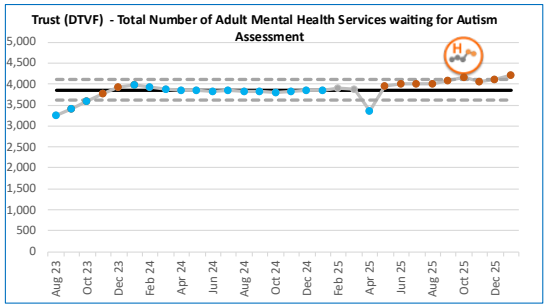
To Note: The trajectory submitted to NENC ICB, factoring in the additional assessments, remains on track for delivery.

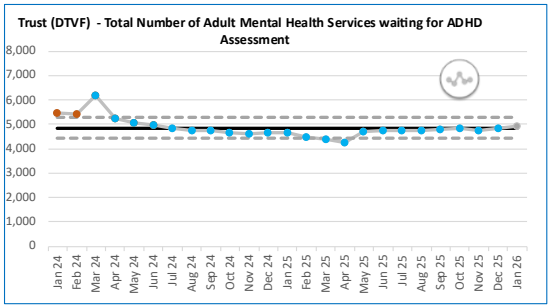
Total number of Children and Young People waiting for Neurodevelopmental Assessment (DTVF Care Group)

Forecasts:	01/02/2025 Baseline	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
1) Do Nothing (on average 100 per month increase)		10,650	10,750	10,850	10,950	11,050	11,150	11,250	11,350	11,450	11,550	11,650	11,750	11,850	**11,950**
2) Factoring in the additional 20 assessments per month		10,650	10,730	10,830	10,930	11,030	11,130	11,230	11,330	11,430	11,530	11,630	11,730	11,830	**11,930**
Actual position	**10,550**	**10,649**	**10659**	**10616**	**10626**	**10477**	**10339**	**10123**	**9914**	**9810**	**9665**				
Change		99	10	-43	10	-149	-138	-216	-209	-104	-145				

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
e Group)	4207	116	326	
Commentary on Longest waits				
DTVF: Genuine Wait - Assessment Required				

Adults waiting for an ADHD Assessment				
Organisation	Actual	Average wait	Longest wait	Assurance
e Group)	4922	106	341	
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. The next Clinical Prioritisation Group (regionally) is being held in December 2025 to finalise the framework. (**Complete)** Framework finalised and paper will be submitted to ICB MH Subcommittee in January 2026.

Actions (Trust):

- Three additional staff have been recruited to support the delivery of additional assessments; (**Complete**).
- The remaining monies will fund a medic to support the transformed model for local triage. A post will be established as a pilot to support the cardiac examination and shared care issues we have been highlighting to the ICB. **Timescales to be confirmed**

Waiting Times Neuro Services: Adult Services

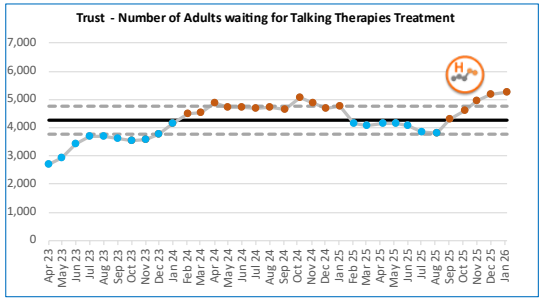
Tees, Esk and Wear Valleys NHS Foundation Trust

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

Total number of Adult Mental Health Services waiting for ADHD Assessment (DTVF Care Group)

Forecasts:	01/02/2025 Baseline	Mar-2025	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026	Apr-2026
1) Do Nothing		4,435	4,374	4,313	4,252	4,191	4,130	4,069	4,008	3,947	3,886	3,825	3,764	3,703	**3,642**
2) Factoring in the additional 40 assessments per month		4,435	4,334	4,273	4,212	4,151	4,090	4,029	3,968	3,907	3,846	3,785	3,724	3,663	**3,602**
Actual position	**4,496**	**4379**	**4236**	**4711**	**4735**	**4733**	**4731**	**4777**	**4817**	**4767**	**4836**				
Change		-117	-143	475	24	-2	-2	46	40	-50	69				

Waiting Times Talking Therapies



Talking Therapies - adults waiting for their second treatment contact

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	5268	14	61	
DTVF Care Group	2610	13	48	
NYY&S Care Group	2658	15	61	

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 completed by the end of December 2025, with the exception of action which 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.

Actions (DTVFCG)

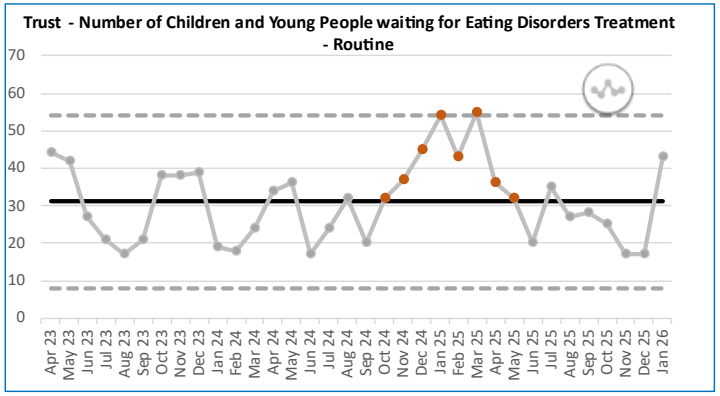
- Two improvement events have taken place which focused on reducing waiting times. The outputs of the events are being reviewed and will be shared with the Trust-wide Task & Finish Group in January. It is anticipated that actions to improve waiting times should have a positive impact on reliable recovery and improvement.

Actions (NYYSCG)

- The work to convert treatment capacity to assessment capacity to address the backlog of patients waiting for 1st treatment appointment is progressing as planned to be completed by the end of December 2025. (**Complete**) *See below action*
- Service Manager to develop a plan by the end of February 2026 for the recovery of wait time between 1st and 2nd appointment.

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	43	3	13	
DTVF Care Group	28	4	13	
NYY&S Care Group	15	3	7	

DTVF: Genuine Wait - Treatment appointment booked.
NYY&S: Treatment commenced, no longer showing as waiting

Summary:
There are **9** children or young people **reported** as waiting more than 4 weeks of which **4** are genuine waits:

- 1 patient (13 weeks) cancelled 2 appointments (first within 4 weeks); appointment booked in January.
- 1 patient has an appointment confirmed in January (outside 4 weeks) at patient request.
- 2 patients cancelled appointments (within 4 weeks); appointments booked in January

The remaining **5** are not genuine waits**:**

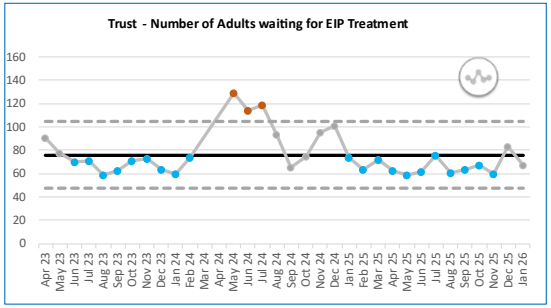
- 1 patient's family have declined treatment, and the patient is no longer showing as waiting.
- 1 patient has been assessed (within 4 weeks) and treatment is not suitable to the patient's presentation. The service have now discharged this patient.
- 3 patients are attributable to data quality, which has been rectified in Cito.

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)

Tees, Esk and Wear Valleys NHS Foundation Trust



Adults Waiting for EIP Treatment - 2 week standard

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	66	3	6	
DTVF Care Group	33	2	6	
NYY&S Care Group	33	3	6	

Commentary on Longest waits

DTVF: Genuine Wait - Treatment appointment booked.
NYY&S: Genuine Wait - Data quality - longest waiter is 43 days. Assessment bkd

Summary:
There are **34** adults **reported** as waiting more than 2 weeks of which **19** are genuine waits:

- **8** patients (longest 6 weeks) were offered an appointment(s) (within 2 weeks); 3 were cancelled due to staff sickness and the remaining failed to attend. All have assessments booked in January.
- **10** patients were offered appointments (outside 2 weeks); 3 were due to reduced staff capacity, 3 required a variety of additional requirements, 3 and 1 required a joint appointment with CAMHS. All have assessments booked in January.
- 1 patient was assessed (within 2 weeks) and has been placed on an extended pathway to establish the most suitable treatment option.

Of the remaining **15** patients:
- **6** patients have been assessed, and treatment is not suitable for their presentation. The service has now closed the referrals.
- **1** patient did not attend two offered appointments (first within 2 weeks) and has subsequently been discharged.
- **8** are attributable to data quality; 3 have been subsequently resolved, 4 are logged with the Service Desk for resolution and 1 is a patient within our Health & Justice Services and is being investigated.

Underlying issues:
- Reduced staff capacity within the York & Selby Early Intervention Team due to sickness and maternity leave.
- Reduced staff capacity within the North Durham EIP Team due to flu; staffing capacity is now back to expected levels.
- Failed Appointments
- Data Quality

Actions:
- Interviews are scheduled in January for 1 full time permanent band 6 key worker, 2 fixed term band 6 key worker posts, 1 fixed-term clinical specialist maternity leave cover and 1 manager secondment within the York & Selby Early Intervention Team. A meeting has been scheduled for January to develop an action plan.

Tees, Esk and Wear Valleys NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 6 February 2026	**Report of: People, Culture and Diversity Committee**	
Date of last meeting: 12 January 2026	The meeting was quorate.	

1	**Agenda: The following agenda items were considered during the meeting:**
	• Colleague Story
	• Key Issue Reports
	  o Board Report - 13 October 2025 PCDC meeting
	  o 'Time Out' Report – 1 December 2025 meeting
	• Board Assurance Framework
	• Workforce Strategy Delivery Report
	• Inclusive Cultures Progress Update Report
	• Employment Rights Act 2025 – Update
	• Health and Wellbeing Update, including Sexual Safety presentation
	• Equality Delivery System (EDS) 22 - 2025
	• Pay Gaps (Gender, Ethnicity and Disability)
	• Workforce Plan (linked to medium-term plan)
	• Freedom to Speak Up Guardian Update Report
	• Corporate Risk Register – Risks to PCD
	• 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:** **Board Assurance Framework** The Committee notes that a full review of the BAF has not been undertaken at Quarter 3, 2025/26 as it is being transferred to the 'InPhase' system. Instead, a high-level review of the strategic risk "Safe Staffing" (BAF ref 1) has been undertaken by the Director of People and Culture. The key change is the increase in the assurance rating for the control "Staff are appropriately trained to support people using our services" from reasonable to good. The overall indicative assurance rating for the risk remains as good. The Committee is aware that whilst BAF Risk 1 has not tracked its planned trajectory to reduce by Quarter 2, it anticipates that this risk score will be reduced with the implementation of mechanisms for tracking deployment of staff substantively against workforce plans and the development of specific workforce plans for each clinical and corporate service. In addition, further work will be progressed in relation to culture and in response to the Staff Survey. **Workforce Strategy Delivery Report** The Committee notes that in future the report will be referred to as the Workforce Strategy Delivery report, rather than The People Journey Delivery Report, to reflect the new strategic terminology, whilst encompassing the same areas of work. The Committee confirms that there is good assurance that the right work is being undertaken and that it supports progress on the BAF. In relation to Mandatory & Statutory Training, compliance was achieved over the previous quarter, with 7 mandatory training courses only being below the 85% standard in the previous month. The Committee reports that the Trust increased the completion rate from 44 to 52% for the national staff survey and is the second most improved Mental Health/Learning Disability Trust of those organisations using Picker. The Committee notes that Agency use continues to reduce in line with regional targets, including reductions in medical use due to stricter controls being put in place, The Trust's first MARS scheme has completed, with 56 of 300 applicants leaving by the end of December 2025. As requested, the Trust is not in the first wave of the new digital workforce solution (replacement for ESR). The Committee acknowledges the advantages of not introducing new risks alongside other scheduled digital developments. It also allows the Trust to learn from those in the first wave. The Committee notes that sickness absence continues to demonstrate special cause concern in the IPR and that Director level oversight for Long Term sickness absence cases (up to 350 at any point in	

time) commences in January 2026, with a focus on attendance rather than sickness and a coaching approach from People Partners, following learning from other Trusts.

The Committee notes that there is ongoing work related to the risks created by Supreme Court gender ruling and that legal advice is being obtained. Estates and Facilities Management are continuing to ensure the Trust is able to meet both the requirements of the Supreme Court and ensure all staff have dignified access to toilet/changing facilities where possible. The Committee has requested further feedback on the changes to the Apprenticeship Levy which will be known as the 'Growth and Skills levy' as of April 2026 with a changed remit.

Health and Wellbeing Update, including Sexual Safety presentation
The Committee confirms good assurance regarding the alignment of Health and Wellbeing activity and the impact of key staff support services. It notes that gaps in assurance have been identified and associated actions proposed, therefore, reasonable assurance can be taken in respect of the overall impact of the health wellbeing approach. Following the violence and aggression governance review, a range of actions have been taken, including: mapping violence and aggression information flows across the Trust and identification of gaps in reporting on sexual safety, verbal aggression and some forms of physical violence; the development of an initial version of the violence and aggression dashboard via Inphase; review and agreement on a new criminal incident reporting procedure across the three police forces; a refreshed sexual safety assurance framework subject to consultation within the Trust during January 2026. The Committee confirms that the Trust is on track to complete the sexual misconduct audit by 2 February 2026.

The Committee notes that reporting has been strengthened with both the new Staff Experience Group and the violence prevention work reporting into the Strategic Health and Wellbeing Group, plus the regular reporting of activity and impact from the other Health and Wellbeing offers available to staff. These new simplified governance arrangements allow comprehensive oversight of related work and have clarified tasks which, when completed, will lead to good assurance. The Committee is delighted to report that the Trust was awarded continuing excellence accreditation through the Better Health at Work Accreditation in December 2025.

Equality Delivery System (EDS) 22 - 2025
The Committee notes that EDS 22 is a requirement of the NHS contract and confirms that it has good assurance that the Trust has followed a robust process in completing and meeting its obligations in regard to EDS 22. The Trust has scored 2 (achieving) or above for the majority of outcomes, with the following exceptions:

- Outcome 1D (Score 1 – Developing) - Patients (service users) report positive experiences of the service
- Outcome 2B (score 1 - Developing) – When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
- Outcome 2D (score 1 - Developing) – Staff recommend the organisation as a place to work and receive treatment.

The Trust's overall score for EDS 2025 is 20 which is classed as Developing. The Committee approves the ratification of this score for EDS 22 for 2025 and agrees to the publication of EDS 22 on the Trust website as required.

The Committee notes that following discussion with the ICB, it was suggested during 2025 that, providing assurances could be provided that the content of the EDS 22 could be evidenced in other work carried out by the Trust, the completion of the EDS as a separate report could be discontinued. However, the Trust agreed to continue this for 2025. The Committee agrees that it should be provided through the Inclusive Communities report for 2026 and thereafter, where it can be placed in a broader context and be triangulated more effectively.

Pay Gaps (Gender, Ethnicity and Disability)
The Committee takes substantial assurance that the Trust can demonstrate adherence to the statutory requirements of gender pay gap reporting, along with demonstrating commitment to equality through voluntarily undertaking ethnicity and disability pay gap reporting for 2025.

Whilst there is still no legal requirement for ethnicity or disability pay gap reporting, it was decided that TEWV would continue to produce the reports voluntarily again this year. However, it was agreed that the additional four reports, for other protected characteristics such as religion, sexual orientation, age and marriage & civil partnership, would not be developed this year as previously reported. The analysis for the other protective characteristics has been mirrored on the approach to gender pay.

The Committee notes the findings for Gender pay as follows:

- The mean and the median pay gap have increased from 2024;
- The overall median gender pay gap has increased since last year from 0.00% to 2.03%;
- Females in other medical grades have seen a slight fluctuation, starting at 62% in 2017, to 54% in 2024 and has reduced to 46% in 2025; and
- Alongside an overall reduction in numbers of medical staff receiving a Clinical Excellence Award due to contractual changes, there was an increase in mean bonus pay overall and some gender differences with the payments (eg fewer female colleagues receiving them proportionally).

The Committee takes assurance that over the past 3 years, the Trust's mean gender pay gap appears stable. There has been a slight increase in 2025 which could indicate that the improvement made in 2024 has not being sustained. The mean gender pay gap, however, is not unusually high when compared to other NHS Trusts.

The Committee notes the findings for Ethnicity Pay gap as follows:

- The percentage of BAME staff receiving a long service award has increased from 2.5% in 2024 to 6.06 % in 2025;
- Whilst overall data shows that BAME staff average hourly pay is higher than White staff, when separating non-medical and executive pay and medical pay grades, the data shows that there is a pay gap evident in both groups;
- Similarly to last year, our BAME consultants are receiving higher bonus payments; and
- Very low levels of BAME staff are within higher bands, (excluding medical grades).

The Committee takes assurance that the Trust's mean ethnicity pay gap shows that the gap has narrowed since 2023. This is, however, heavily influenced by workforce composition which, therefore, may not necessarily reflect improvements for all BAME staff or fairer pay across pay bands.

The Committee notes the findings for Disability Pay gap as follows:

- There is likely to be under-reporting of the number of staff declaring themselves as having a disability; and
- The mean shows that staff declaring they do not have a disability are paid £0.82 more than staff who declare having a disability and £0.58 more when looking at the median.

The Committee takes assurance that the Trust's mean disability pay gap has increased slightly since 2024. Comparisons made over a one-year period, together with 'disability declaration' rates remaining low, have resulted in a limited picture for the Trust to consider this year.

The Committee notes that as part of the New Managers' training an awareness session regarding unconscious bias and an awareness campaign was to commence in respect of the completeness of staff data on ESR. The Committee supports the publication of Gender Pay Gap data on the Trust and Government websites by 30 March 2026.

Inclusive Cultures Progress Update Report

The Committee confirms good assurance on the link between the Inclusive Cultures indicators and the interventions, and the data provided, but only reasonable assurance that the impact is as expected in respect of the key controls and gaps associated with BAF Risk 1. The aspects covered include improvements in staff voice; progressing work on psychological safety and inclusive leadership through the Leadership and Management Academy (LAMA) and People Management Skills Programme (PMSP), plus increased Leadership Visibility through coffee break MS Teams sessions, webinars, Board visits to services, regular staff stories at Board of Directors/this Committee, and

	Executive Sponsorship of Staff Networks; continuing to collect, analyse and report on data which acknowledges ongoing challenges, including persistent workforce disparities, higher levels of discrimination and harassment experienced by some staff groups, and the continued difficulty in measuring the impact of interventions. Despite these challenges, the 2025 staff survey results indicate that the Trust performs better than the national average in relation to the proportion of staff reporting experiences of discrimination. In addition, anti-racist work is being progressed by developing an Anti-Hate Policy and reviewing aggression procedures, linking all actions to organisational belonging. The Trust is collaborating with the Provider Collaborative to explore scaling the Reasonable Adjustments Team as an innovative service. A Business Plan submission has been made to extend Accessibility Audits across the estate for 2026/2027. If not approved, audits will need to be considered on a targeted and affordable basis. Audits are recommended to be undertaken by an NRAC-accredited professional. The Committee notes that a Head of Inclusive Cultures was appointed in October 2025 to enhance strategic alignment across Equality, Diversity & Inclusion (EDI), Organisational Development (OD), and community engagement. **Workforce Plan (linked to medium-term plan)** The Committee notes an initial Workforce Plan was submitted in December 2025 to the ICB based on the finance plan with reference to the clinical models work. The plan accounted for identified CRES and transformation schemes where these were available and assumed proportionate reductions in substantive workforce to deliver the total efficiency savings required. Exceptions were built in based on the clinical models, with all assumptions being reviewed as the clinical model/workforce model mapping continues throughout January 2026, prior to the final submission in February 2026. Additional considerations during this iterative process in relation to the clinical models would include: • The workforce implications of the three strategic shifts; • Technological advances and opportunities, and potential impact on the workforce; and • Data from paired outcomes in high completion teams in each specialty, comparing workforce profiles with clinical impact. The Committee confirms good assurance on the process for developing the final submission for the Workforce Plan. **Corporate Risk Register** The Committee confirms 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. Whilst the Committee confirms reasonable assurance overall from the detailed risk reviews, it notes limited assurance in respect of the capture of all risks relating to digital across the organisation as the detailed review had highlighted a gap in NYY where no digital risks were recorded, notwithstanding discussion in the Risk Group indicating that risks were present. In addition, the Committee notes that 5% of risk reviews were overdue and were in the process of being updated. A new 'Risk Quality Assurance Oversight' report was being developed to identify gaps, for example, where risks had not reduced or where the target score was the same as the current score. **Freedom to Speak Up Guardian Update Report** The Committee takes good assurance from the initial experience of the new 24/7 FTSU Guardian service, noting that good progress has been made since it commenced providing services to staff from the end of October 2025, further to meetings being held with key departments/individuals such as people partners, complaints, communications, organisational development, service leads, the FTSU NED champion, CEO and Chair of the Trust Board as part of the 'embedding process'. Contract management arrangements are in place within People and Culture.
2c	**Advise: The Committee would like to advise the Board on the following matters:** **Colleague Story** A Peer Worker provided details of her background as a service user and her protective factors such as working part-time in her role and caring for her young child. She also described the levels of support she received from Senior Peer Workers, attending the Peer 'chill and chat' sessions to understand other lived experience roles across the Trust and how she was to take up the role of Sponsor of the Trust's Lived Experience Staff Network. It was suggested that a future 'Time Out' meeting would consider the

	Peer and Lived Experience roles across the Trust within the context of the Workforce Plans as this is an action on the safe staffing BAF. **Employment Rights Act 2025 – Update** The Committee notes that the Employment Rights Act 2025 (ERA 2025) received Royal Assent on 18 December 2025, with phased implementation from April 2026 through 2027. The only immediate change is the repeal of the Strikes (Minimum Service Levels) Act 2023. However, from April 2026 there will be changes to employment rights in respect of: Day one paternity/unpaid parental leave, whistleblowing protections, Fair Work Agency and Statutory Sick Pay reforms. In addition, from October 2026, there will be a ban on fire and re-hire, additional provisions regarding sexual harassment prevention, expanded union rights, changes to tribunal limitation periods, third party harassment protections, and public sector reforms. From 2027 there will be changes to zero hours contracts, flexible working rights, gender equality action plans, the introduction of a six-month unfair dismissal qualifying period, bereavement leave, and more. Many provisions are subject to ongoing government consultation, with key details (for example, eligibility, process and compliance) to be set by future regulations. People and Culture are monitoring developments and have reviewed current HR policies and procedures in light of the ERA 2025. Most policies remain compliant, but several key areas require updates or new provisions to ensure full alignment with the new legislation. Work is continuing with Staff side/Joint Consultative Committee and briefings being prepared for wider networks such as Quarterly Leadership and Management. **Workplan** The Agenda for the 'Time Out' meeting in March 2026 would include the opportunity to meet the new Freedom to Speak Up Guardian. The 'Time Out' meeting in November 2026 would feature Peer and Lived Experience Workforce Plans. Ideas to be requested for the Colleague Story.	
2d	**Risks**	• The forthcoming changes to Employment Legislation; and • Compliance with responsibilities under the Sexual Safety Framework

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 encourages Trust Board members, and particularly Non-Executive Directors, to complete their Equality Diversity and Inclusion (EDI) information on ESR; • The forthcoming changes to Employment Legislation; and • Within the new Sexual Safety Assurance Framework there is a greater emphasis on Boards' responsibilities relating to proactively governing, escalating emerging sexual misconduct risks, ensuring accountability, oversight, and early intervention across the organisation. Increased detail on responsibilities for line managers, training (including specialist training for certain staff groups) and when to share information/risks with future employers, Police and the Board are now explicit.
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	

DM/30/01/2026

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 February 2026**
Title:	**Pay Gaps (Gender, Ethnicity and Disability)**
Executive Sponsor(s):	**Sarah Dexter-Smith Director of People and Culture**
Author(s):	**Trevor Jacob, Data Analyst, Scott Rogers, Workforce Information Manager & Abigail Holder, EDI & HR Officer**

Report for:	***Assurance***		***Decision***	**X**
	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 partner	**X**
3: We will be a trusted partner	**X**

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	**Safe staffing**	Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post. The Trust is committed to understanding any pay differentials and taking appropriate action.

Executive Summary:

Purpose:

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation along with further context to explain any gender pay differences with a view to demonstrate our commitment to equality.

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination. One of these related to pay gaps and the requirement to analyse data to understand pay gaps by

protected characteristic and put in place an improvement plan.

While there is still no legal requirement for ethnicity or disability pay gap reporting, it was decided that TEWV would continue to produce the reports voluntarily again this year. It is recognised that continuing to complete the reports promotes transparency and equality.

As pay gap reporting is still not currently mandated by UK law for other protected characteristics such as religion, sexual orientation, age and marriage & civil partnership it was agreed that the additional four reports would not be developed this year as previously reported.

Attached to this report are detailed Gender (Appendix 1), Ethnicity (Appendix 2) and Disability (Appendix 3) pay gap reports. These reports include the required reporting fields, associated context and proposed actions.

Proposal:
To request confirmation that BoD has good assurance that the Trust is meeting its statutory requirements by producing data in relation to pay differences that exist within the organisation.

To request confirmation that BoD agree to the publication of the gender pay information on the Trust and government website as is required.

Overview:
Reporting on gender pay differences is a statutory requirement of the Equality Act 2010. This must be completed annually, reporting on the specific measures. The proposal for good assurance that we understand and are acting on our data is based on the information in the appendices which demonstrates that that the following has been reported upon in line with national guidance:

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender gap
- The proportion of males and females receiving a bonus payment
- The proportions of male and female in each quartile of pay.

The same metrics have been produced for the Trust's third Ethnicity Pay Gap report and the second Disability Pay Gap report.

Summary of key findings

Gender Pay Gap Report (Appendix 1)

- The mean and the median pay gap have increased from 2024.
- The overall median gender pay gap has increased since last year from 0.00% to 2.03%.
- Females in other medical grades have seen a slight fluctuation, starting at 62% in 2017, to 54% in 2024 and has reduced to 46% in 2025.
- The lower-middle quartile in 2025 has shown a decrease in the proportion of

females within that quartile from 84% in 2024 to 77% in 2025, and males increasing from 16% in 2024 to 23% in 2025.

- There were 46 eligible consultants who received a Clinical Excellence Award in 2025, 17 were females and were 29 males. This is a significant decrease from 2024 where 114 consultants received the Clinical Excellence Awards. This is due to the changes in relation to the contractual entitlement to access an award round which ceased in 2024.
- The mean bonus pay has increased from 64.59% in 2024 to 84.31% in 2025.

Ethnicity Pay Gap Report (Appendix 2)

- 1.95% of BAME staff received a bonus in 2025 compared to 8.3% in 2024.
- The percentage of BAME staff receiving a long service award has increased from 2.5% in 2024 to 6.06 % in 2025.
- The number of BAME staff within the organisation is low and a high percentage of the BAME workforce in the Trust are medical. Therefore, when calculating average pay for BAME staff, data could be skewed by smaller numbers of higher paid staff.
- Whilst overall data shows that BAME staff average hourly pay is higher than White staff, when separating non-medical & executive pay and medical pay grades, the data shows that there is a pay gap evident in both groups.
- Similar to last year our BAME consultants are receiving higher bonus payments.
- Very low levels of BAME staff are within higher bands, (excluding medical grades).

Disability Pay Gap Report (Appendix 3)

- This is the second disability pay gap report that the Trust has produced following the first report that was completed in 2024. Comparisons have therefore been able to take place this year.
- The number of staff who have declared themselves as having a disability is likely to be under reported, therefore the data analysis is likely to be impacted by this.
- 30.4% of consultants had not declared their disability status which is an increase from 2024 (23%). This will have an impact on the bonus section of this report.
- The mean shows that staff declaring they don't have a disability are paid £0.82 more than staff who declare having a disability and £0.58 more when looking at the median.
- The 'unknown' category shows a reported decrease across the majority of quartiles when compared to 2024 data. This could be due to Trustwide efforts to collect this data. This will increase the accuracy of the disability pay gap due to more data being available in ESR.
- 0.22% of staff who have declared themselves as having a disability received a bonus in 2025. This has decreased when comparing figures to 2024 where 0.32% of staff received a bonus.

Prior Consideration and Feedback	It was agreed in 2024 that future reports should be more concise and visual in presentation to ensure that they are more accessible to colleagues and the public. As it was the first year having a Data Analyst in post, it was agreed that changes to the reports would take place in 2026.
Implications:	Failure to complete and publish the Pay Gap reports in accordance with the requirements of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 may have regulatory consequences

Recommendations:
BoD is asked to take substantial assurance that we can demonstrate adherence to the statutory requirements of gender pay gap reporting legislation, ethnicity and disability pay gap reporting along with further context to demonstrate our commitment to equality.

BoD is asked to take assurance that over the past 3 years; the Trust's mean gender pay gap appears stable. There has been a slight increase in 2025 which could indicate that the improvement made in 2024 has not being sustained. The mean gender pay gap however is not unusually high when compared to other NHS Trusts.

BoD is asked to take assurance that the Trust's mean ethnicity pay gap shows that the gap has narrowed since 2023. This is however heavily influenced by workforce composition which therefore may not necessarily reflect improvements for BAME staff or fairer pay across pay bands.

BoD is asked to take assurance that the Trust's mean disability pay gap has increased slightly since 2024. Comparisons made over a one-year period, together with disability declaration rates still being low has resulted in a limited picture for the Trust to consider this year.

BoD is asked to agree to the publication of Gender Pay Gap data on the Trust and government website by 30 March 2026.

Appendix 1

Tees, Esk and Wear Valleys NHS Foundation Trust Gender Pay Gap Report – 2025

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

This is the eighth report and is based upon a snapshot date of **31st March 2025.** We are required to publish data on the Government Equalities Office website and on the Trust website by 30th March 2026 and annually going forward.

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as percentage of men's earnings for example, women earn 15% less than men.

The gender pay gap differs from equal pay in the following way. Equal pay deals with the pay differences between men and women who carry out **the same jobs, similar jobs or work of equal value**. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women.

The following report includes the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality.

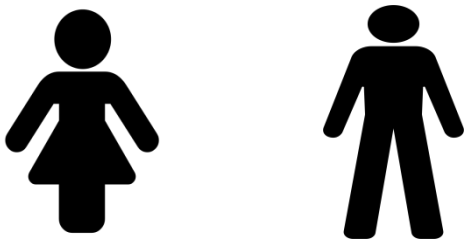
Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post.

The Trust is committed to understanding any differences identified in the gender pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

Finally, it is important to note that analysis of pay gaps are multi-dimensional and complex. Undertaking pay gap reports helps us to identify where pay differences exist and identify actions to understand those disparities better.

Reporting annually is an important step to allow us to see how our pay disparities are changing.

The gender profile of the Trust 2025



78% **22%**

The gender profile split in the Trust has changed with the proportion of females decreasing from 80% in 2024 to 78% in 2025, while the proportion of males has increased from 20% in 2024 to 22% in 2025.

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2025. This is in accordance with the Gender Pay Gap reporting requirements.

In line with gender pay gap reporting we are required to report annually on the following:

- Mean gender pay gap
- Median gender pay gap
- Mean bonus gender gap *
- Median bonus gender gap *
- The proportion of males receiving a bonus payment *
- The proportion of females receiving a bonus payment *
- Proportions of males and females in each quartile of pay band

*Under the regulation payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

Mean and Median Gender Pay Gap

The mean gender pay gap and median gender pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes.

In line with guidance, only staff on full pay are included in the calculations therefore staff on reduced pay for sickness, maternity or other reasons are excluded. Overtime payments are also excluded from these calculations.

Mean Gender Pay Gap

11.56% less than males - equating to £2.59 per hour less

Median Gender Pay Gap

2.03% less than males - equating to £0.38 per hour less

2025

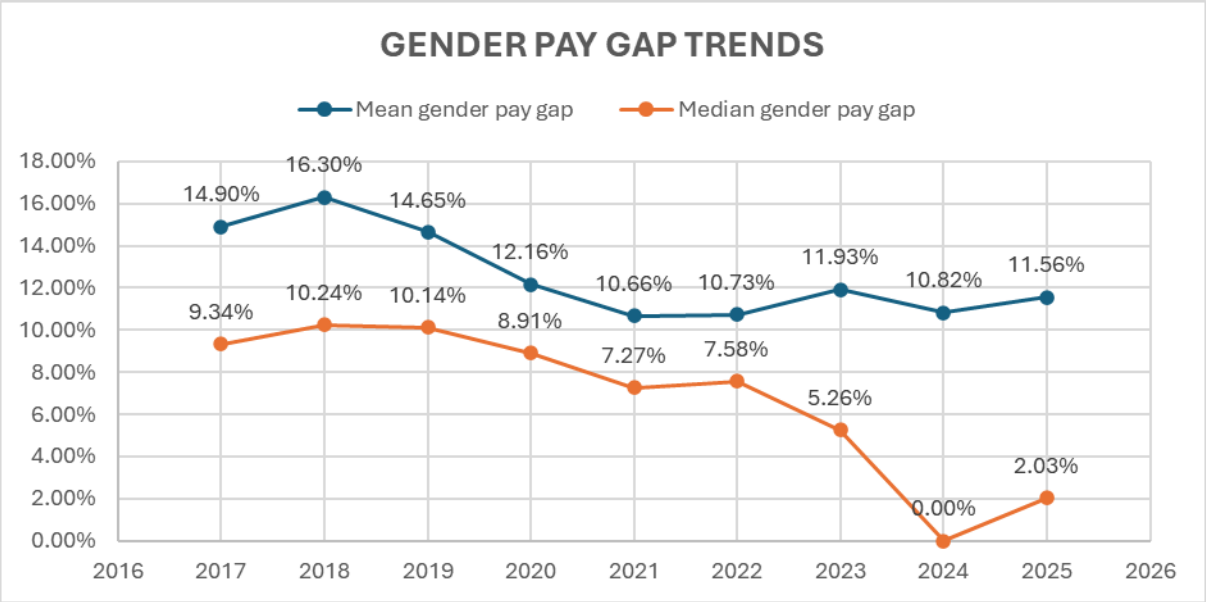
Mean	Gender	Mean Hourly Pay	Difference	Gap
Overall	Male	£22.41	**£2.59**	**11.56%**
	Female	£19.82		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
Overall	Male	£18.67	**£0.38**	**2.03%**
	Female	£18.29		

The mean gender pay gap linked to the amount a female is paid has increased in the past year from 10.82% in 2024 to 11.56% in 2025. From an hourly rate perspective this equates to a mean gender pay gap increase in the past year from £2.23 per hour to £2.59 per hour less than males.

The median gender pay gap has increased from 0.00% in 2024 to 2.03% in 2025, which from an hourly rate perspective equates to a median gender pay gap change in the past year from £0.00 per hour to £0.38 per hour less than males.

The graph below highlights the mean and median gender pay gap reported figures between March 2017 and March 2025 for comparison purposes.

2025



There are several possible contributory factors which can influence the gender pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median gender pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

It is important to note that some staff have more than one salary sacrifice in place (some have up to five) and that amounts of deductions can vary considerably.

2025

Row Labels	Count of Employee Number	%
Female	1343	78.54
Male	367	21.46
Grand Total	**1710**	**100**

As you would expect, in line with the gender split within the organisation, the majority of staff opting to participate in one or more salary sacrifice schemes are female (accounting for 78.54% of the salary sacrifices).

Agenda for Change and Very Senior Manager Pay

When medical staff are removed from the calculations, the gender pay gap decreases which is common amongst NHS Trusts. The mean and median gender pay gaps for those staff employed on Agenda for Change terms and conditions and Very Senior Managers (VSM) Pay is detailed below.

Mean Gender Pay Gap

(AfC & VSM Pay)

3.31% less than males - equating to £0.65 per hour less

Median Gender Pay Gap
(AfC & VSM Pay)

0.24% less than males – equating to £0.04 per hour more.

Comparing this 2025 data with the previous year shows the mean gender pay for staff on AFC & VSM pay has increased from the previous year from 1.75% in 2024 to 3.31%. The median gender pay gap has decreased from 13.43% in 2024 to 0.24%

AFC and VSM - 2025 data

Mean	Gender	Mean Hourly Pay	Difference	Gap
Overall	Male	£19.79	£0.65	3.31%
	Female	£19.14		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
Overall	Male	£17.90	£0.04	0.24%
	Female	£17.86		

Medical and Dental

The information below highlights the mean gender pay gap and median gender pay gap for those staff employed on **Medical and Dental terms and conditions**. The figures include the Clinical Excellence Awards payments that are paid to eligible medical staff.

Mean Gender Pay Gap (M&D) (M&D)

0.28% more than males - equating to £0.14 per hour more

Median Gender Pay Gap

18.43% more than males equating to £8.57 per hour more

2025

Mean	Gender	Mean Hourly Pay	Difference	Gap
Overall	Male	£49.09	-£0.14	-0.28%
	Female	£49.23		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
Overall	Male	£46.50	-£8.57	-18.43%
	Female	£55.07		

Compared with last year, there has been a reduction in the gender pay gap within the medical workforce from both a mean and median calculation.

The mean gender pay gap within the medical workforce has decreased from 3.70% in 2024 to -0.28% in 2025 showing that females earn slightly more on average than males.

The median gender pay gap has also decreased between male and females in the past year from 0.01% to -18.43%. Due to the significant difference from 2024, a manual visually check was carried out against the raw data for accuracy.

Bonus Payments

Under the regulations, payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

- **Clinical Excellence Awards (CEA)**

The contractual entitlement to access an annual award round ceased on 1 April 2024. The 2023/24 award round was the final Local Clinical Excellence Award round.

Pre-2018 LCEAs will be retained, remaining pensionable and consolidated, but their value is frozen. These changes will have an impact on future pay gap reports.

Based on current guidance, the table below shows the mean and median bonus pay linked to clinical excellence awards only.

2025

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£9,715.99	£9,048.00
Female	£4,902.78	£3,015.96
Difference	£4,813.21	£6032.04
Pay Gap %	49.54%	66.67%

There were 46 eligible consultants who received a Clinical Excellence Award in 2025, 17 were females and were 29 males. This is a decrease from 2024 where 114 consultants received the Clinical Excellence Awards.

There continues to be more males receiving larger monetary amounts due to the historical awards which is evident by the mean bonus gender gap percentage.

It is important to note that compared to the Trust gender split, within this staff group there is more of an even split of males and females.

Comparing this year's data with 2024, the pay gap for mean bonus has increased from 43.85% to 49.54%. The median bonus in 2024 was 53.08% and in 2025 it has increased to 66.67%. The change observed in 2025 reflects a higher proportion of male consultants receiving larger bonus awards.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 132 staff received an award. Of those awarded in 2025, **104 were female (79%)** and **28 were male (21%)**.

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included in the bonus calculations.

Total Bonus Payments

The table below provides **combined details of the clinical excellence awards and long service awards**.

- The mean bonus pay has increased from 64.59% in 2024 to 84.31% in 2025 which means that the mean for men is 84.31% higher than the mean for women.

- The median bonus pay has slightly decreased from 96.25% in 2024 to 95.03% in 2025.

2025

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£4,938.47	£2,010.70
Female	£774.77	£100
Difference	£4,163.70	£1,910.70
Pay Gap %	**84.31%**	**95.03%**

It is important to recognise when combining the bonus awards in this way the data is skewed as long service awards are predominantly paid to women, with a higher proportion of males receiving clinical excellence award payments. These payments are also not prorated.

Overall percentage of males and females receiving bonus payments

1.9 %

3.1 %

The guidance requires us to calculate the percentage of males and females who have received a bonus as a percentage of all employed males and females (not just those on full pay which other aspects of the gender reporting require us to do).

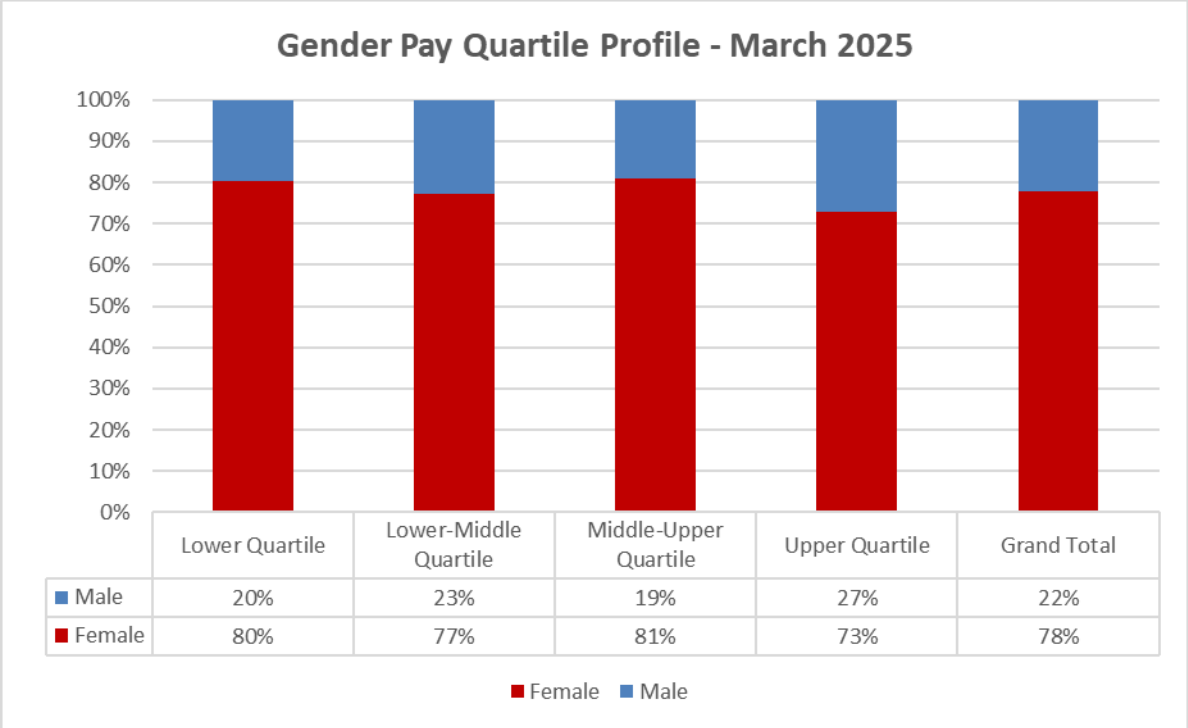
Gender Pay Quartile Profile

The following graph shows the proportion of males and females in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile.

The lower-middle quartile in 2025 has shown a decrease in the proportion of females within that quartile from 84% in 2024 to 77% in 2025, and males increasing from 16% in 2024 to 23% in 2025.

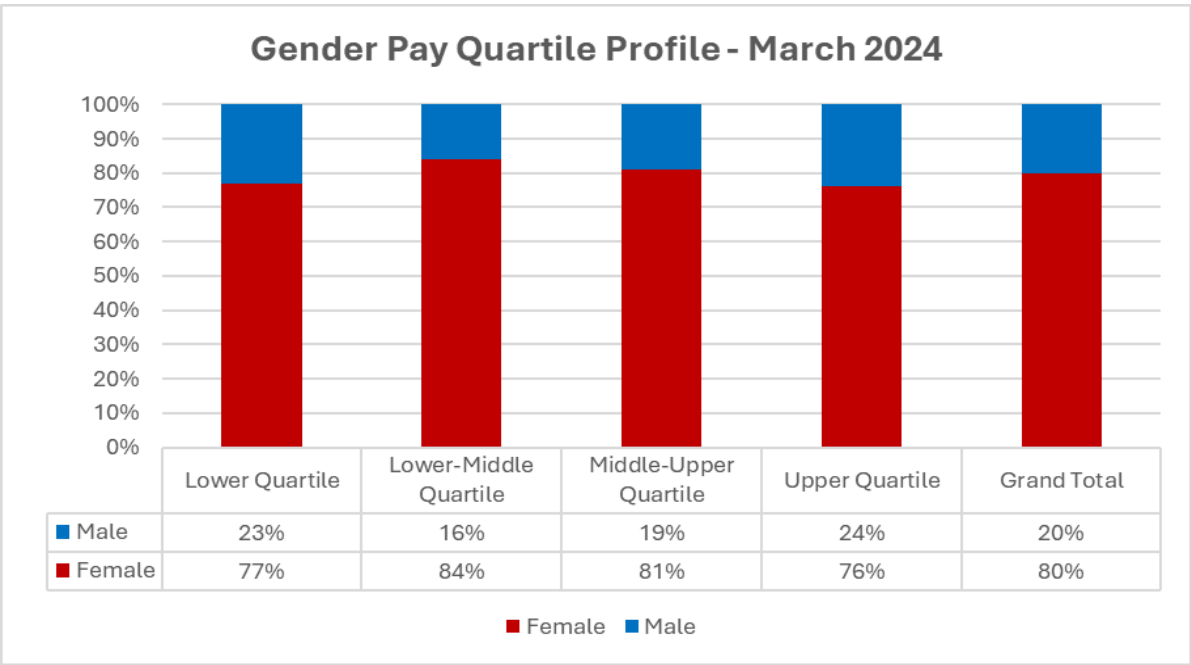
The upper quartile showed a decrease in the proportion of females, from 76% in 2024 to 73% in 2025, while the proportion of males increased from 24% to 27%.

2025



	Lower Quartile	Lower-Middle Quartile	Middle-Upper Quartile	Upper Quartile	Grand Total
Male	20%	23%	19%	27%	22%
Female	80%	77%	81%	73%	78%

2024



	Lower Quartile	Lower-Middle Quartile	Middle-Upper Quartile	Upper Quartile	Grand Total
Male	23%	16%	19%	24%	20%
Female	77%	84%	81%	76%	80%

Gender Breakdown by Pay Band

The three graphs below provide a comparison of the Trusts gender profile breakdown by pay band at March 2025, 2024, and March 2017 when reporting commenced.

The ratio between males and females comparing 2025 to 2024 have shown little change withing Band 9 and VSM roles. In 2024 females accounted for 56% of this group whereas in 2025 they account for 55%. Males in this banding have increased from 44% in 2024 to 45% in 2025.

Comparing data between 2017 and 2025 shows that the proportion of females in bands 8d, 9, VSM, and consultant posts have had the largest increases from 57% in 2017 to 67% in both 2024 and 2025.

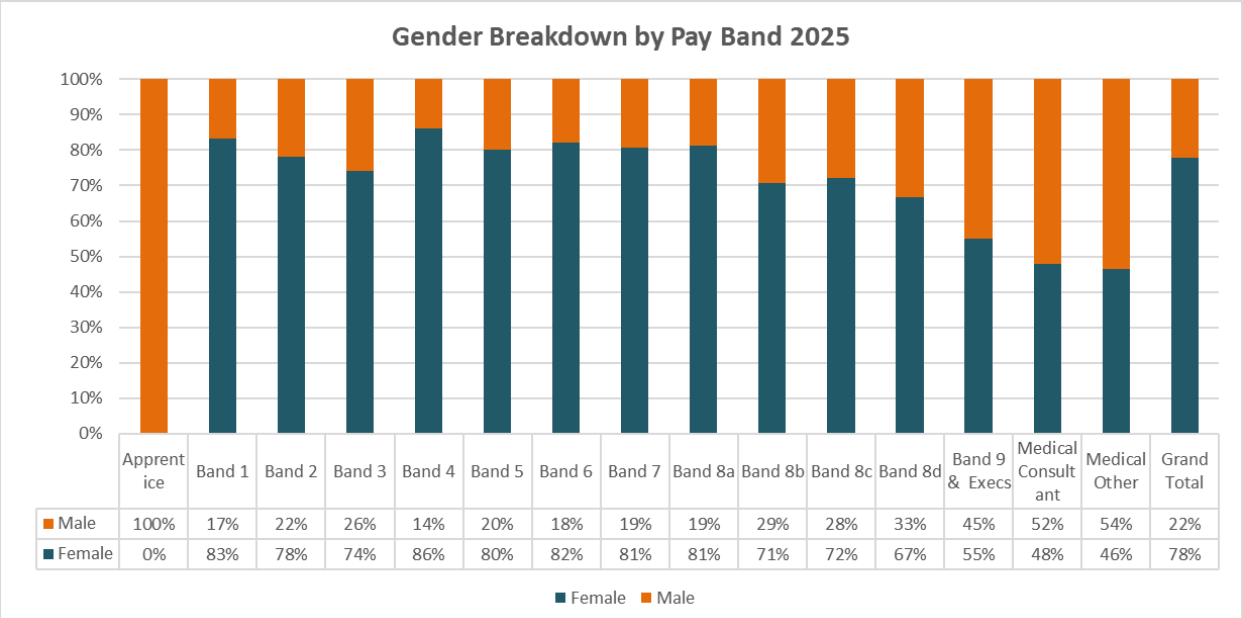
Comparing data from 2017 with 2025 shows that the proportion of females 8d, 9 and VSM pay and in consultant posts have had the largest increases.

Females in 8d posts have increased from 57% to 67% between 2017 and 2025. Band 9 and VSM pay grades have seen an increase in females from 43% to 69% in 2022, this has then decreased in 2025 to 55%.

The female consultant workforce has increased from 42% in 2017, to 49% 2024 and decreased to 48% in 2025.

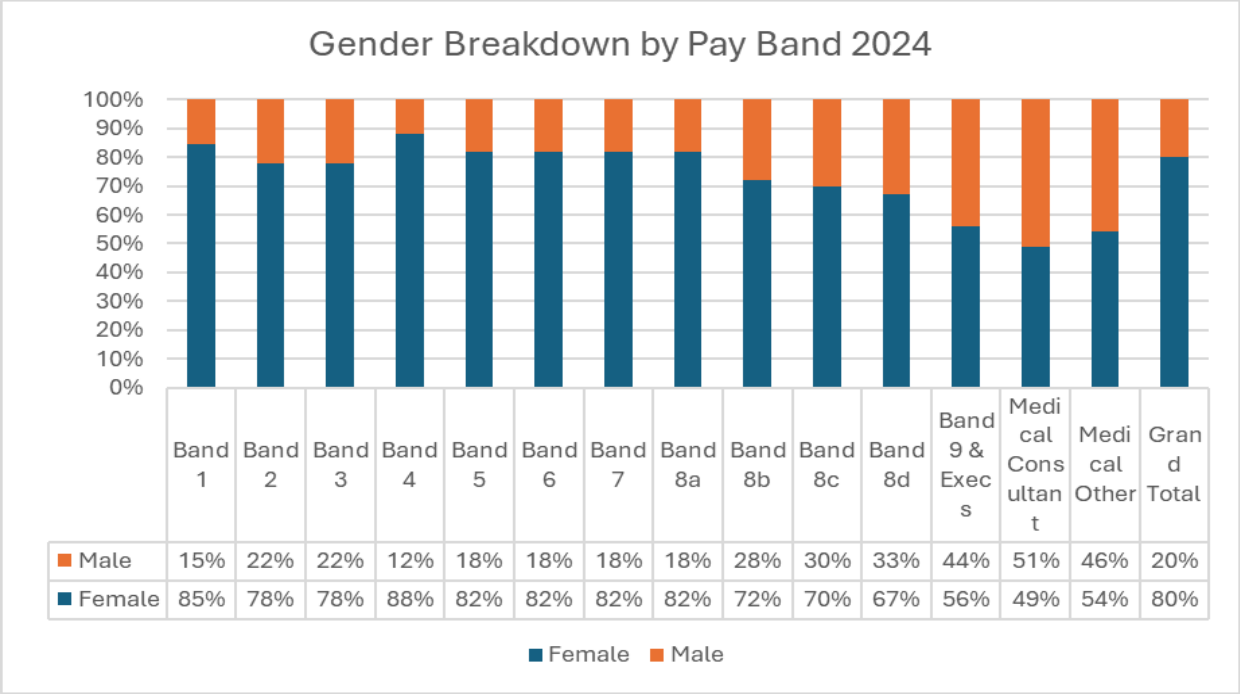
Females in other medical grades have seen a slight fluctuation, starting at 62% in 2017, to 54% in 2024 and has reduced to 46% in 2025.
Band 1 was closed to new entrants from 1 December 2018, therefore the number of overall staff in this banding will continue to reduce as people leave the role.

2025



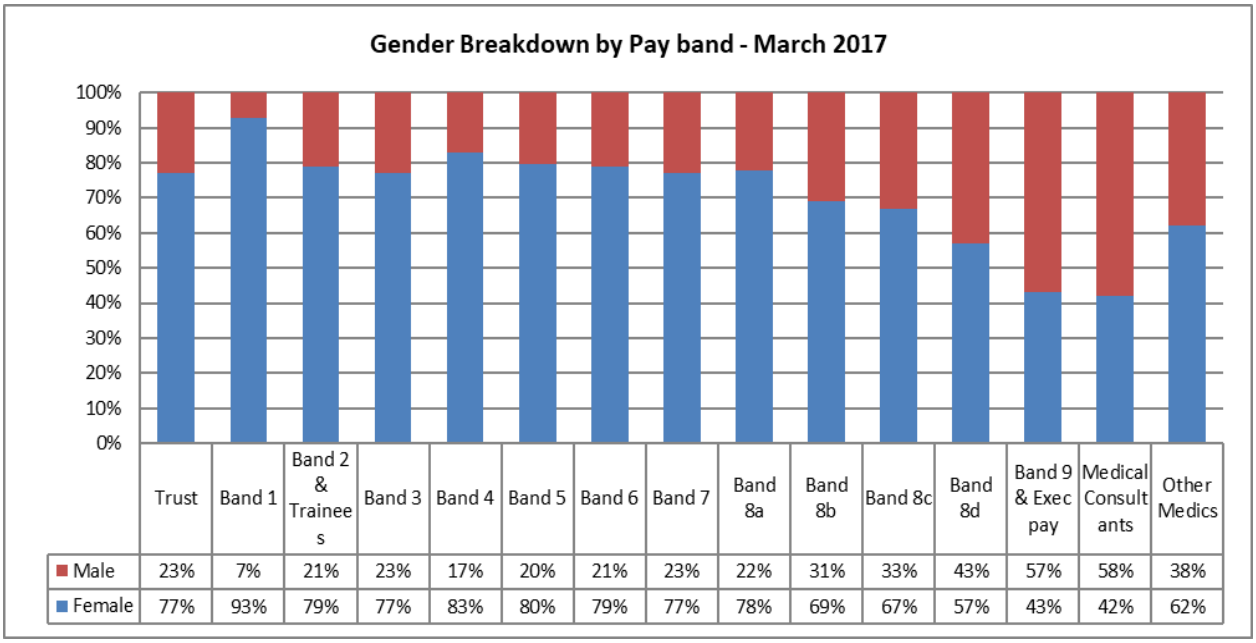
	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Medical Other	Grand Total
Male	100%	17%	22%	26%	14%	20%	18%	19%	19%	29%	28%	33%	45%	52%	54%	22%
Female	0%	83%	78%	74%	86%	80%	82%	81%	81%	71%	72%	67%	55%	48%	46%	78%

2024



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Medical Other	Grand Total
Male	15%	22%	22%	12%	18%	18%	18%	18%	28%	30%	33%	44%	51%	46%	20%
Female	85%	78%	78%	88%	82%	82%	82%	82%	72%	70%	67%	56%	49%	54%	80%

2017



	Trust	Band 1	Band 2 & Trainees	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultants	Other Medics
Male	23%	7%	21%	23%	17%	20%	21%	23%	22%	31%	33%	43%	57%	58%	38%
Female	77%	93%	79%	77%	83%	80%	79%	77%	78%	69%	67%	57%	43%	42%	62%

Key Findings:

- The mean and the median pay gap have increased from 2024.
- The overall median gender pay gap has increased since last year from 0.00% to 2.03%.
- Females in other medical grades have seen a slight fluctuation, starting at 62% in 2017, to 54% in 2024 and has reduced to 46% in 2025.

- The lower-middle quartile in 2025 has shown a decrease in the proportion of females within that quartile from 84% in 2024 to 77% in 2025, and males increasing from 16% in 2024 to 23% in 2025.
- There were 46 eligible consultants who received a Clinical Excellence Award in 2025, 17 were females and were 29 males. This is a significant decrease from 2024 where 114 consultants received the Clinical Excellence Awards. This is due to the changes in relation to the contractual entitlement to access an award round which ceased in 2024.
- The mean bonus pay has increased from 64.59% in 2024 to 84.31% in 2025.

Proposed Areas for Further Action Specific to the Gender Pay Gap Report:

- To continue to review how changes to the Clinical Excellence Awards impact on the gender pay gap.

Appendix 2

Tees, Esk and Wear Valleys NHS Foundation Trust Ethnicity Pay Gap Report – 2025

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

High Impact action three requires us to develop and implement an improvement plan to eliminate pay gaps.

We are required to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards.

A pay gap is the difference between the average hourly pay of employees in one group in comparison to another group. For example, women in comparison to men or LGBTQ+ in comparison to heterosexual.

This is different to equal pay. Equal pay is a person being paid the same for the same role and it is unlawful to pay someone differently for doing the same job based on a protected characteristic.

The Trust is committed to understanding any differences identified in the ethnicity pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post.

This is our third ethnicity pay gap report. We have analysed information using the categories: White, Not Stated (which includes not known) and BAME. BAME is all other ethnic minority groups combined.

At this stage we have not broken down BAME any further due to the small numbers in each category and recommendations are that there should be at least 50 staff in each group to ensure statistical robustness.

Guidance on ethnicity pay gaps has been produced in May 2023 with recommendations as to what metrics organisations can consider using to measure their ethnicity pay gap. We have applied the calculations and analysis methods used in Gender Pay Gap reporting.

It is recommended that we review the mean and median ethnicity pay gaps, mean and median bonus gaps and proportions of ethnicities in each quartile of pay bands.

Under the regulations, payments that would fall under the remit of a bonus includes Clinical Excellence Awards for consultants and Long Service Awards.

Finally, it is important to note that analysis of pay gaps are multi-dimensional and complex. Undertaking pay gap reports helps us to identify where pay differences exist and identify actions to understand those disparities better. Reporting annually is an important step to allow us to see how our pay disparities are changing.

The ethnicity profile of the Trust 2025

Ethnicity	Percentage
BAME	9.6%
Not Stated	1.1%
White	89.2%

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2025.

Mean and Median Ethnicity Pay Gap

The mean ethnicity pay gap and median ethnicity pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes. This includes enhancements, clinical excellence awards and long service awards. Overtime payments are excluded from these calculations.

In line with guidance, only staff on full pay are included in the calculations therefore staff on reduced pay for sickness, maternity or other reasons are excluded. Staff who did not state their ethnicity or are classified as unknown are not included within these figures.

2025

Mean	Ethnicity	Average Hourly Pay	Difference	Gap
Overall	White	£20.16	-£1.46	-7.23%
	BAME	£21.62		
Non-medical & exec	White	£19.50	£2.26	11.60%
	BAME	£17.24		
Medical only	White	£54.53	£9.44	17.31%
	BAME	£45.09		

The **overall** figures show that BAME staff are paid higher than White staff by £1.46.

By breaking down the pay gap to non-medical and staff on Very Senior Manager (VSM) pay and medical separately it can be seen that there is an ethnicity pay gap evident.

The reason for this difference is that overall, we have a low number of BAME staff employed compared to white staff. This impacts on the average hourly pay of that group of staff, compared with the average hourly rates of the much larger white workforce in each grade.

Also, our BAME workforce has a significantly higher proportion of medics within it which results in a higher average hourly rate.

The overall median ethnicity pay gap table below also appears to demonstrate that there is an ethnicity pay gap between white and BAME staff and that white staff are paid higher than BAME staff by £1.43.

A breakdown by non-medical and VSM pay and medical also shows that a pay gap exists, although the overall gap has decreased from £3.17 in 2024 to £1.43 in 2025.

The pay gap amongst medical only staff has increased from 23.98% (£12.50) in 2024 to 28.92% (£16.41) in 2025.

2025

Median	Ethnicity	Median Hourly Pay	Difference	Gap
Overall	White	£18.66	£1.43	7.69%
	BAME	£17.22		
Non-medical & exec	White	£18.49	£2.21	11.95%
	BAME	£16.28		
Medical only	White	£56.74	£16.41	28.92%
	BAME	£40.33		

In addition to the proportion of BAME staff employed by the Trust, there are other possible contributory factors which can influence the pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median ethnicity pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

2025

Row Labels	Count of Employee Number	%
BAME	107	6.3%
White	1593	93.2%
Not stated	10	0.6%
Grand Total	**1710**	**100%**

The numbers of BAME staff who have salary sacrifice deductions is very low, with 107 staff accessing this benefit compared with 1593 white staff. BAME staff accessing the scheme equates to 6.3% of all salary sacrifices within the Trust which shows BAME staff are less likely to access salary sacrifices.

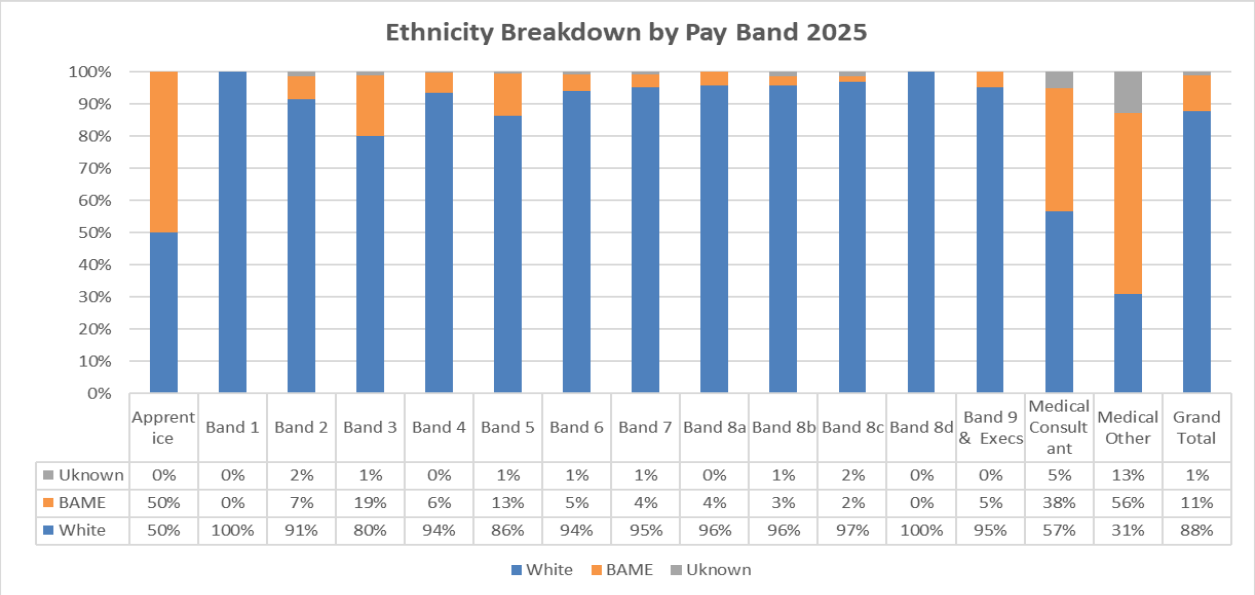
A breakdown by type of salary sacrifice for BAME staff has not been provided due to staff being potentially identifiable due to the low numbers involved.

Ethnicity Breakdown by Pay Band

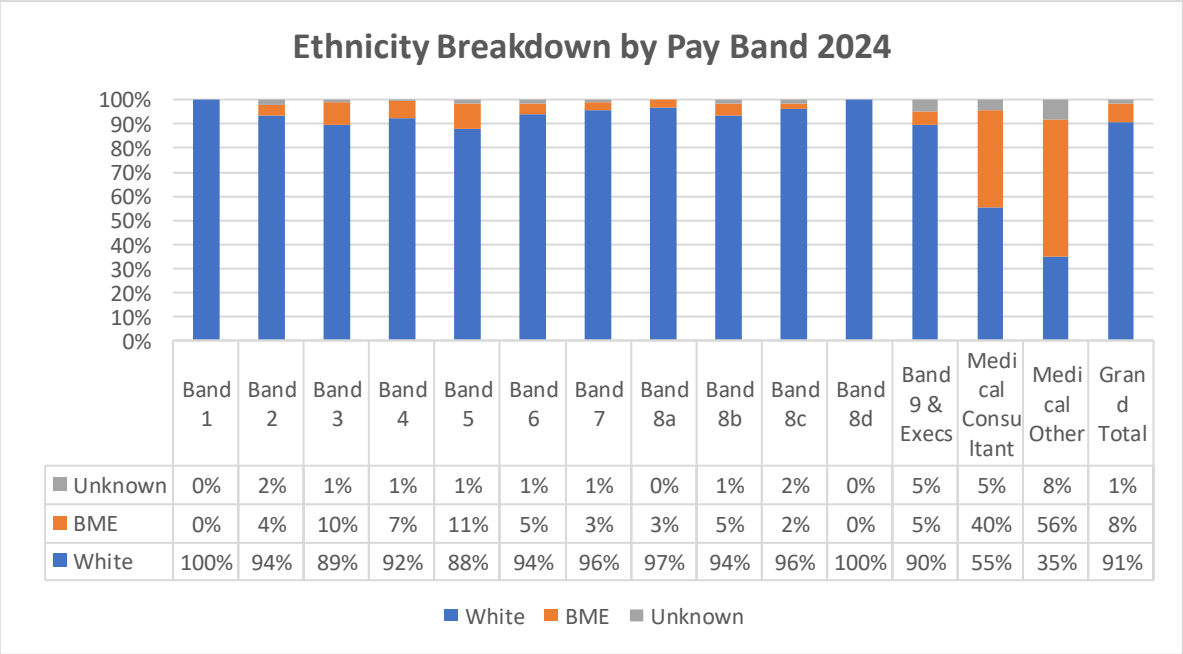
The following graph provides a breakdown of ethnicity by pay band. It is evident that the highest number of our BAME workforce are within the medical workforce.

Band 1 was closed to new entrants from 1 December 2018, therefore the number of overall staff in this banding will continue to reduce.

2025



2024



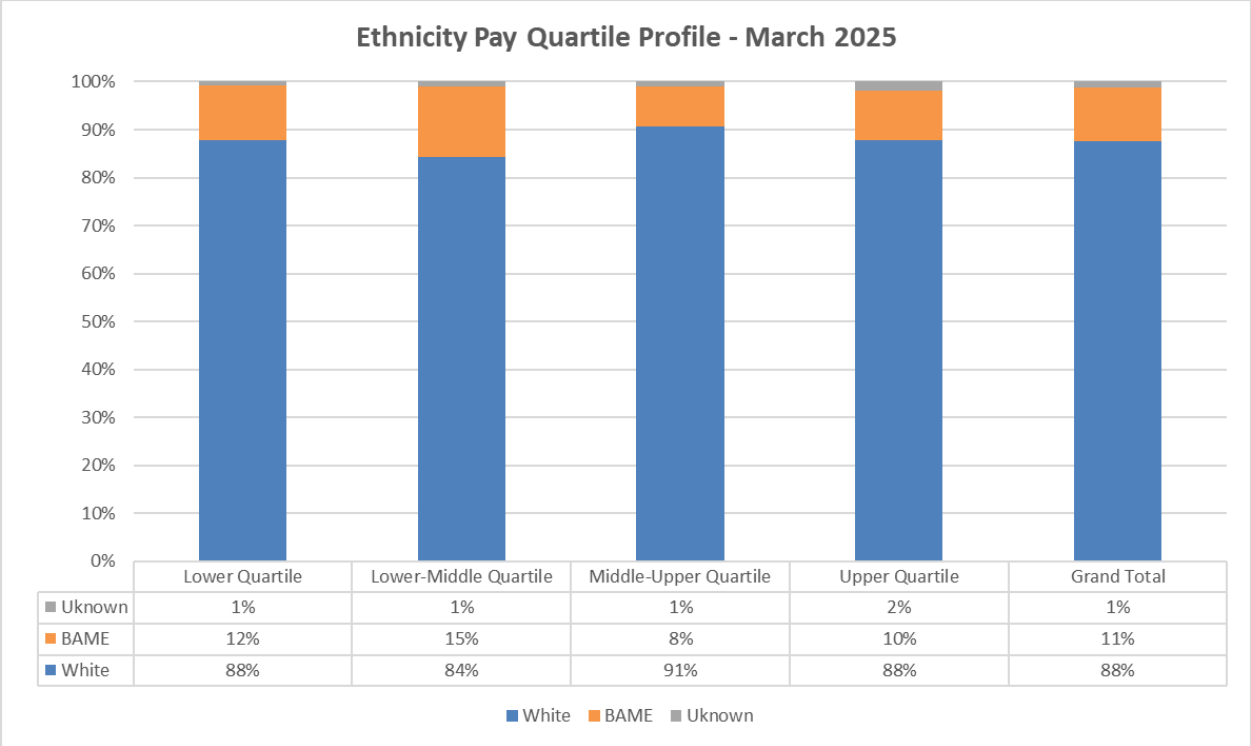
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Medical Other	Grand Total
Unknown	0%	2%	1%	1%	1%	1%	1%	0%	1%	2%	0%	5%	5%	8%	1%
BME	0%	4%	10%	7%	11%	5%	3%	3%	5%	2%	0%	5%	40%	56%	8%
White	100%	94%	89%	92%	88%	94%	96%	97%	94%	96%	100%	90%	55%	35%	91%

Ethnicity Pay Quartile Profile

The following graph shows the proportion of staff by ethnicity in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries.

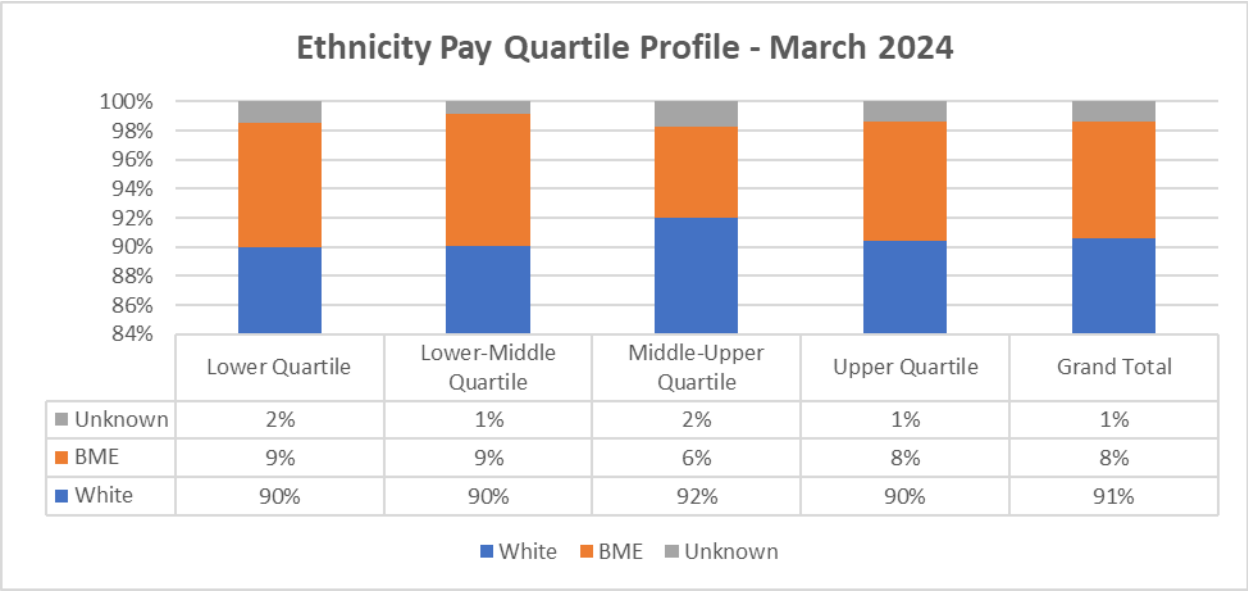
The Trust employs more white staff than BAME staff in every quartile. The highest percentage of BAME staff are within the lower quartile and lower-middle quartile

2025



	Lower Quartile	Lower-Middle Quartile	Middle-Upper Quartile	Upper Quartile	Grand Total
Uknown	1%	1%	1%	2%	1%
BAME	12%	15%	8%	10%	11%
White	88%	84%	91%	88%	88%

2024



	Lower Quartile	Lower-Middle Quartile	Middle-Upper Quartile	Upper Quartile	Grand Total
Unknown	2%	1%	2%	1%	1%
BME	9%	9%	6%	8%	8%
White	90%	90%	92%	90%	91%

Bonus Payments

Under the regulations, payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

- **Clinical Excellence Awards (CEA)**

The contractual entitlement to access an annual award round ceased on 1 April 2024. The 2023/24 award round was the final Local Clinical Excellence Award round.

Pre-2018 LCEAs will be retained, remaining pensionable and consolidated, but their value is frozen. These changes will have an impact on future pay gap reports.

Based on current guidance, the table below shows the mean and median bonus pay linked to clinical excellence awards only.

2025

Ethnicity	Mean Bonus Pay	Median Bonus Pay
White	£7,563	£3,015
BAME	£7,333	£6,032
Difference	£230	-£3,017
Pay Gap %	**1.38%**	**-100%**

46 eligible consultants received a Clinical Excellence Award in the reporting year of 2025. 24 consultants were white (52.2%), 19 consultants were from BAME backgrounds (41.3%), and 3 consultants had not stated / unknown ethnic origins (6.5%).

The data suggests that white consultants are paid more CEA amounts compared with BAME consultants. However, due to the small number of staff receiving these payments, one or 2 staff with high or low CEA levels can have a significant impact on the overall averages.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 132 staff received an award. Of which 118 were White (89.39%), 8 were from a BAME background (6.06%) and 6 had not stated their ethnicity (4.55%).

The percentage of BAME staff receiving a long service award has increased from 2.5% in 2024 to 6.06 % in 2025.

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above.

Guidance from ACAS states that such payments with a monetary value should be included in the bonus calculations.

Total Bonus Payments

The table below provides **combined details of the clinical excellence awards and long service awards**.

It should be noted that the numbers of BAME staff involved in these calculations is very low and overall, as a proportion of the workforce, the numbers of staff receiving bonus's as per these guidelines is very small. These payments are also not pro-rated.

When combining CEA and long service awards, this data suggests that BAME staff receive higher pay than white staff in relation to bonus.

2025

Ethnicity	Mean Bonus Pay	Median Bonus Pay
White	£1,361.44	£100.00
BAME	£5,189.90	£3,015.97
Difference	-£3,828.46	-£2,915.97
Pay Gap %	**-281.21%**	**-2915.97%**

Overall percentage of receiving bonus payments

The guidance requires us to calculate the percentage of white and BAME staff who have received a bonus as a percentage of all employed white and BAME staff (not just those on full pay which other aspects of the reporting require us to do).

- 1.95% of BAME staff received a bonus in 2025 compared to 8.3% in 2024
- 2.89% of white staff received a bonus in 2025 compared to 2.4% in 2024

The difference in percentages will be linked to the proportion of the BAME workforce which are medical and are therefore eligible for clinical excellence awards.

Key Findings:

1. 1.95% of BAME staff received a bonus in 2025 compared to 8.3% in 2024.
2. The percentage of BAME staff receiving a long service award has increased from 2.5% in 2024 to 6.06 % in 2025.
3. The number of BAME staff within the organisation is low and a high percentage of the BAME workforce in the Trust are medical. Therefore, when calculating average pay for BAME staff, data could be skewed by smaller numbers of higher paid staff.
4. Whilst overall data shows that BAME staff average hourly pay is higher than White staff, when separating non-medical & executive pay and medical pay grades, the data shows that there is a pay gap evident in both groups.
5. Similar to last year our BAME consultants are receiving higher bonus payments.
6. Very low levels of BAME staff are within higher bands, (excluding medical grades).

Proposed Areas for Further Action Specific to the Ethnicity Pay Gap Report:

- Continue explore the reasons for low numbers of BAME staff being eligible for long service awards and if this is linked with retention of our BAME workforce in the NHS and associated reasons.
- Continue to explore if there are any reasons for the lower numbers of BAME staff in certain pay grades within the Trust.

Appendix 3

Tees, Esk and Wear Valleys NHS Foundation Trust Disability Pay Gap Report – 2025

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

High Impact action three requires us to develop and implement an improvement plan to eliminate pay gaps.

We are required to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards.

A pay gap is the difference between the average hourly pay of employees in one group in comparison to another group. For example, women in comparison to men or LGBTQ+ in comparison to heterosexual.

This is different to equal pay. Equal pay is a person being paid the same for the same role and it is unlawful to pay someone differently for doing the same job based on a protected characteristic.

The Trust is committed to understanding any differences identified in the disability pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

This is the second disability pay gap report from the first report in 2024. We have analysed information using the categories: Declared a Disability, Not Declared (which includes not known) and Declared no Disability.

In the absence of specific guidance under this new reporting requirement, we have applied the calculations and analysis methods used in Gender Pay Gap reporting.

The disability profile of the Trust 2025

Disability	Percentage
Declared a Disability	**11.8%**
Not Stated	**11%**
Declared no Disability	**77.2%**

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2025. This is in accordance with the Gender Pay Gap reporting requirements.

In line with gender pay gap reporting we are required to report annually on the following:

- Mean gender pay gap
- Median gender pay gap
- Mean bonus gender gap *
- Median bonus gender gap *
- The proportion of males receiving a bonus payment *
- The proportion of females receiving a bonus payment *
- Proportions of males and females in each quartile of pay band

*Under the regulation payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

Mean and Median Disability Pay Gap

The mean disability pay gap and median disability pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes.

In line with guidance, only staff on full pay are included in the calculations therefore staff on reduced pay for sickness, maternity or other reasons are excluded. Overtime payments are also excluded from these calculations.

2025

Mean	Disability	Mean Hourly Pay	Difference	Gap
Overall	Declared no Disability	£20.40	£0.82	4.03%
	Declared a Disability	£19.58		
Non-medical & exec	Declared no Disability	£19.69	£0.10	0.51%
	Declared a Disability	£19.59		
Medical only	Declared no Disability	£50.29	£1.97	3.92%
	Declared a Disability	£48.32		

The mean disability pay gap shows that staff who declared they had a disability are paid £0.82 per hour less than staff that declared no disability.

2025

Median	Disability	Median Hourly Pay	Difference	Gap
Overall	Declared no disability	£20.85	£0.58	2.77%
	Declared a disability	£20.27		
Non-medical & exec	Declared no disability	£18.66	-£0.15	-0.80%
	Declared a disability	£18.81		
Medical only	Declared no disability	£55.09	£9.35	16.97%
	Declared a disability	£45.74		

The median disability pay gap shows that there is a pay gap of 2.77% identified and staff who declare no disability are paid £0.58 more per hour than staff who declare a disability.

There are a number of possible contributory factors which can influence the disability pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median disability pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

It is important to note that some staff have more than one salary sacrifice in place (some have up to five) and that amounts of deductions can vary considerably. The table below details the percentage of staff with salary sacrifices and their disability status.

2025

Row Labels	Percentage of Employees
Declared a Disability	12.22%
Declared no Disability	75.96%
Not stated	11.81%
Grand Total	**100%**

The schemes which are most popular are electronics and lease cars, the latter of which has the largest cost associated.

Bonus Payments

Under the regulations, payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

- **Clinical Excellence Awards (CEA)**

The contractual entitlement to access an annual award round ceased on 1 April 2024. The 2023/24 award round was the final Local Clinical Excellence Award round.

Pre-2018 LCEAs will be retained, remaining pensionable and consolidated, but their value is frozen. These changes will have an impact on future pay gap reports.

Based on current guidance, the table below shows the mean and median bonus pay linked to clinical excellence awards only.

2025

Disability	Mean Bonus Pay	Median Bonus Pay
Declared a Disability	£7,539.96	£7,539.96
Declared no Disability	£7,108.43	£3,015.97
Difference	-£431.53	-£4,523.99
Pay Gap %	**-6.07%**	**-150.00%**

All 46 eligible consultants received a Clinical Excellence Award in the reporting year. 65.2% of consultants had declared that they did not have a disability, 4.4% of consultants had declared that they had a disability, and 30.4% consultants had not stated / unknown disability status.

The data suggests that consultants who have declared a disability are paid less CEA amounts compared with those consultants who have not declared a disability. However, due to the small number of staff declaring that they have a disability and the relatively high percentage of consultants not declaring their disability status, this conclusion should be read with caution.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 132 staff received an award. Of which 84 had declared that they did not have a disability (63.6%), 16 staff had declared that they had a disability (12.1%) and 32 had not stated their disability status (24.2%).

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included in the bonus calculations.

Total Bonus Payments

The table below provides **combined details of the clinical excellence awards and long service awards**. It should be noted that the numbers of staff involved in these calculations and declaring that they have a disability is very low. Overall, as a proportion of the workforce, the numbers of staff receiving bonus's as per these guidelines is very small. These payments are also not pro-rated.

2025

Disability	Mean Bonus Pay	Median Bonus Pay
Declared a Disability	£926.66	£100.00
Declared no Disability	£1,944.32	£100.00
Difference	£1,017.66	£0.00
Pay Gap %	**52.34%**	**0.00%**

Overall percentage of receiving bonus payments

The guidance requires us to calculate the percentage of staff, by their disability status, as a percentage of all employed staff (not just those on full pay which other aspects of the reporting require us to do).

0.22% of staff who have declared themselves as having a disability received a bonus in 2025. This has decreased when comparing figures to 2024 where 0.32% of staff received a bonus.
1.37% of staff who declared that they did not have a disability received a bonus in 2025. This has decreased when comparing figures to 2024 where 2.24% of staff received a bonus.

It is likely that the number of staff who have not declared their disability status and received bonus payments this year impacts on the above percentage rates.

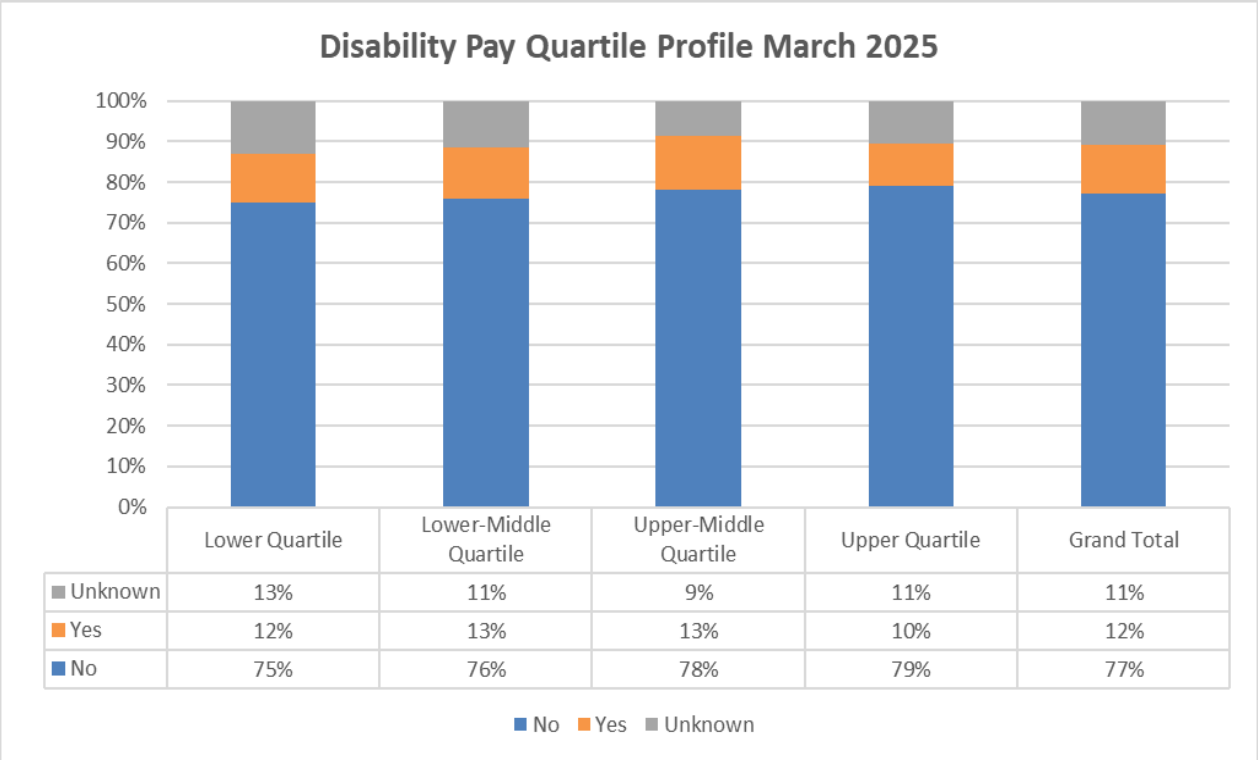
It is important to recognise when combining the bonus awards in this way the data is skewed as more staff receive long service awards than clinical excellence awards and long service awards are significantly lower monetary amounts. These payments are also not prorated.

Disability Pay Quartile Profile

The following graph shows the proportion of disabled staff and non disabled staff in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more staff that declare no disability than staff who declare a disability in every quartile.

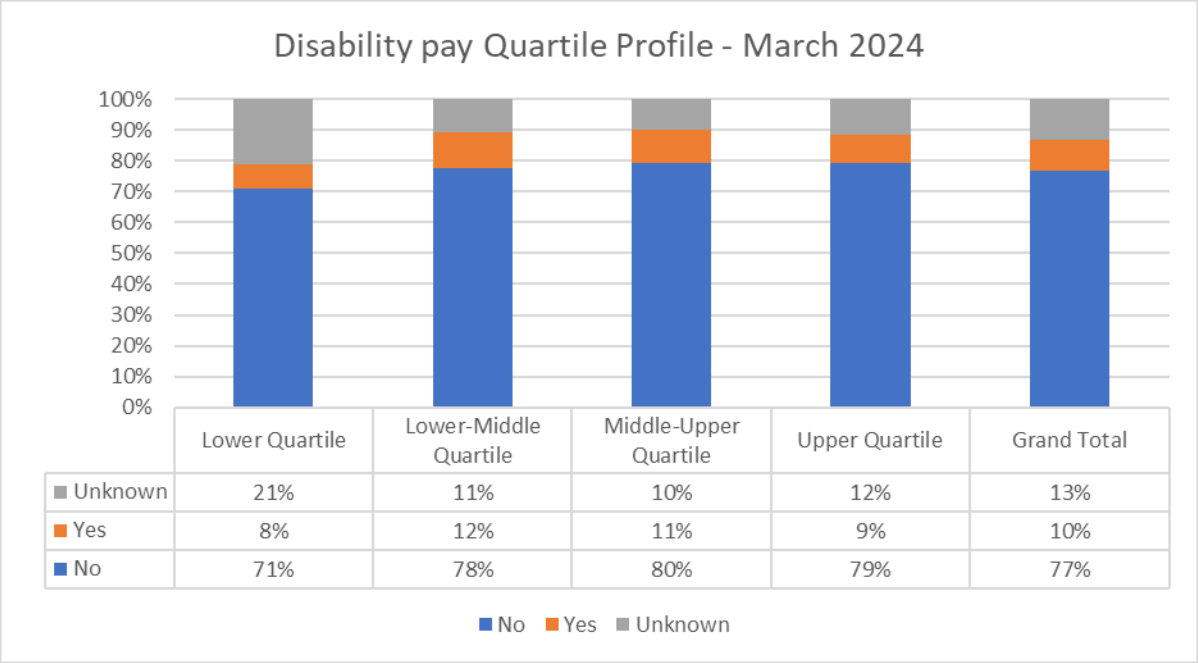
The 'unknown' category shows a reported decrease across the majority of quartiles when compared to 2024 data. This could be due to Trustwide efforts to collect this data. This will increase the accuracy of the disability pay gap due to more data being available in ESR.

2025



	Lower Quartile	Lower-Middle Quartile	Upper-Middle Quartile	Upper Quartile	Grand Total
Unknown	13%	11%	9%	11%	11%
Yes	12%	13%	13%	10%	12%
No	75%	76%	78%	79%	77%

2024

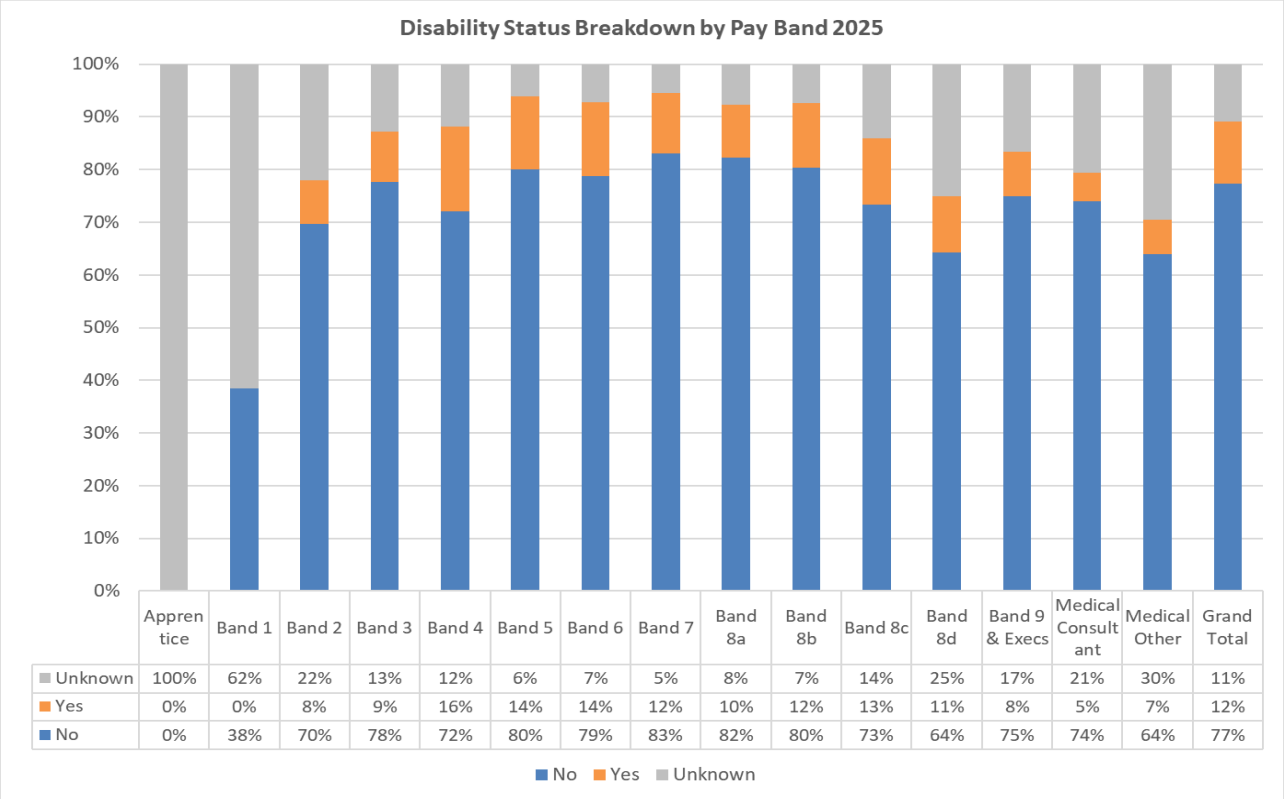


	Lower Quartile	Lower-Middle Quartile	Middle-Upper Quartile	Upper Quartile	Grand Total
Unknown	21%	11%	10%	12%	13%
Yes	8%	12%	11%	9%	10%
No	71%	78%	80%	79%	77%

Disability Breakdown by Pay Band

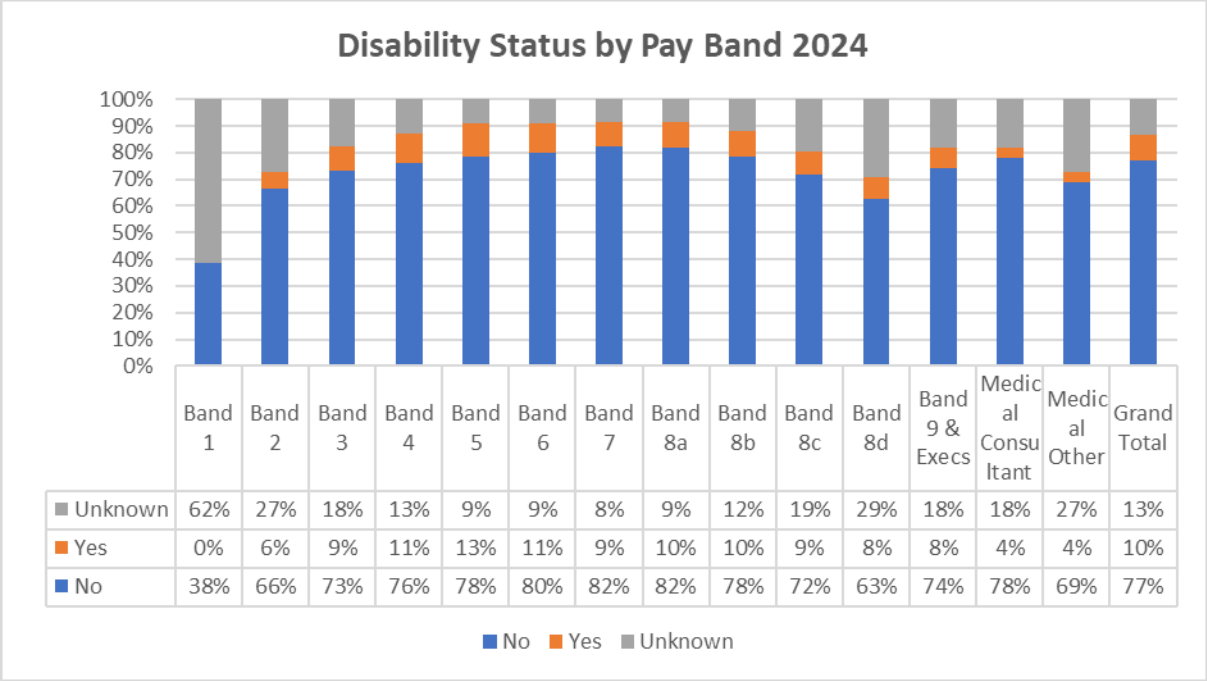
The graph below provides the Trusts disability profile breakdown by pay band as of March 2025 when reporting commenced.

2025



	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Medical Other	Grand Total
Unknown	100%	62%	22%	13%	12%	6%	7%	5%	8%	7%	14%	25%	17%	21%	30%	11%
Yes	0%	0%	8%	9%	16%	14%	14%	12%	10%	12%	13%	11%	8%	5%	7%	12%
No	0%	38%	70%	78%	72%	80%	79%	83%	82%	80%	73%	64%	75%	74%	64%	77%

2024



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Medical Other	Grand Total
Unknown	62%	27%	18%	13%	9%	9%	8%	9%	12%	19%	29%	18%	18%	27%	13%
Yes	0%	6%	9%	11%	13%	11%	9%	10%	10%	9%	8%	8%	4%	4%	10%
No	38%	66%	73%	76%	78%	80%	82%	82%	78%	72%	63%	74%	78%	69%	77%

Key Findings:

1. This is the second disability pay gap report that the Trust has produced following the first report that was completed in 2024. Comparisons have therefore been able to take place this year.
2. The number of staff who have declared themselves as having a disability is likely to be under reported, therefore the data analysis is likely to be impacted by this.
3. 30.4% of consultants had not declared their disability status which is an increase from 2024 (23%). This will have an impact on the bonus section of this report.
4. The mean shows that staff declaring they don't have a disability are paid £0.82 more than staff who declare having a disability and £0.58 more when looking at the median.
5. The 'unknown' category shows a reported decrease across the majority of quartiles when compared to 2024 data. This could be due to Trustwide efforts to collect this data. This will increase the accuracy of the disability pay gap due to more data being available in ESR.
6. 0.22% of staff who have declared themselves as having a disability received a bonus in 2025. This has decreased when comparing figures to 2024 where 0.32% of staff received a bonus.

Proposed Areas for Further Action Specific to the Disability Pay Gap Report:

- Continue to encourage staff, particularly medical staff, to declare on ESR their disability status.

Current Trust actions that impact on all Pay Gaps:

- Continue to promote the use of the virtual interview platform (SAMMI), which aims to reduce bias in the recruitment process.
- Promote the new managers training which will include unconscious bias.
- Continue to promote the central reasonable adjustments team to enable staff with underlying health conditions to fulfil their potential.
- Promote the Steps Towards Employment Programme (STEP) to people from communities who don't usually work for the NHS and carry out community engagement events across these communities.
- Carry out a Trust wide communication campaign around the importance of data completeness on ESR.

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 February 2026**
Title:	**Equality Delivery System (EDS) 22 - 2025**
Executive Sponsor(s):	**Sarah Dexter-Smith Director of People and Culture**
Author(s):	**Abigail Holder EDI & Human Rights Officer**

Report for:	***Assurance***		***Decision***	**X**
	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***
1	***Safe Staffing***	The Trust has a minimal appetite for risks relating to quality. Although the present score is above tolerance, an acceptable level of exposure can be achieved. Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels
4	***Quality of Care***	The Trust has a minimal appetite for risks. relating to quality. Although the present score is above tolerance, an acceptable level of exposure can be achieved
8	***Quality Governance***	The target risk score is above tolerance levels, and the Trust has a minimal appetite for regulatory risks. Urgent action to be taken to strengthen controls but a higher degree of exposure than acceptable will need to be tolerated

Executive Summary:

Purpose:

This paper is presented to the Board of Directors to provide assurance that the Trust is meetings its obligations under the NHS contract to complete EDS 22.

A more detailed document is attached to this report identifying the scores that have been agreed for the Trust and any areas of concern.

Proposal:
BoD is asked to confirm that it has good assurance that the Trust has followed a robust process in completing EDS 22 and is meeting its obligations with regards to the EDS 22.

BoD is asked to ratify the scores of EDS 22 for 2025 and to agree to the publication of EDS 22 on the Trust website as is required.

Overview:

EDS 22 is a requirement of the NHS contract and must be completed annually using the evidence available for each of the outcomes.

The proposal for good assurance is based on the information in the Appendix 1 which demonstrates that:

- Appropriate evidence has been gathered for each outcome.
- Consultation on the draft scoring has taken place as required by the technical guidance.
- EDS 22 for 2025 has gone through the appropriate approval routes.

Summary of key findings

The Trust has scored 2 (achieving) or above for the majority of outcomes, with the following exceptions:

- Outcome 1D (Score 1 – Developing) - Patients (service users) report positive experiences of the service
- Outcome 2B (score 1 - Developing) – When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
- Outcome 2D (score 1 - Developing) – Staff recommend the organisation as a place to work and receive treatment.
- The Trust's overall score for EDS 2025 is 20 which is classed as Developing.

Prior Consideration and Feedback	Following discussion with the ICB, it was agreed that if the content of the EDS 22 could be evidenced in other work carried out by the Trust that the completion of the EDS as a separate report could be discontinued. Due to the time taken to provide this evidence, it was agreed that the EDS would be completed for 2025 with a view to identify how this work can be evidenced and embedded in other ways for 2026. This paper will also be considered by EDG 13.1.26, BOD 12.2.26 and JCC 20.1.26.

Implications: Failure to complete EDS 22 in accordance with the requirements of the NHS contract may have regulatory consequences.

Recommendations:
BoD is asked to confirm that it has good assurance that a robust process has been undertaken when completing the proposed scoring and evidence for EDS 22 for 2025.

BoD is asked to take assurance that whilst the overall Trust score has decreased from 2024, scores cannot be directly compared with those of previous years as the set of services measured changes annually.

BoD is asked to ratify the scores of EDS 22 and to agree to the publication of EDS 22 on the Trust website as is required.

Appendix 1

EDS 22 for 2025

1. BACKGROUND INFORMATION AND CONTEXT.

1.1 EDS 22 has been developed by NHS England and NHS Improvement and supported by the NHS Equality and Diversity Council as an improvement tool to support NHS organisations to review and develop their services, workforces, and leadership. The completed version must be published on the Trust's website by 28th February 2026 following approval at Board level. EDS 22 should be carried out annually.

1.2 It comprises eleven outcomes spread across three Domains, which are:

1. Commissioned or provided services.
2. Workforce health and wellbeing
3. Inclusive leadership

1.3 Each outcome is evaluated, scored, and rated using available evidence and insight which assure or point to the need for improvement. The scoring system for each outcome is as follows:

- Undeveloped activity 0
- Developing activity 1
- Achieving activity 2
- Excelling activity 3

1.4 The scores are aggregated into an overall score for the organisation:

- Those scoring 8 or below are rated undeveloped.
- Those scoring between 8 and 21 are rated developing.
- Those scoring between 22 and 32 are rated achieving.
- Those who score 33 (the maximum score) are rated excelling.

1.5 For domain 1 the Trust had to choose 3 services.

1.6 The rating process is as follows:

- Domain 1 is rated by patients, the VCSE sector and NHS organisations.

- Domain 2 is rated by staff, staff networks, trade unions, and organisations.

- All scoring in Domain 3 must be independently tested, by a third party with no direct involvement in managing or working for the organisation.

2. KEY ISSUES

The key issues for consideration are as follows: -

2.1 The full rating scorecard and action plan is included at Appendix 1.

2.2 The Trust has scored 2 (achieving) for the majority of outcomes with the following exceptions:

- Outcome 2 B (score 1 - Developing) – When at work, staff are free from abuse, harassment, bullying and physical violence from any source. During the review / consultation process, it was recognised that a lot of work is going on in this area but feedback from staff via the National Staff Survey, incident reports and verbal feedback from staff has shown that there hasn't been enough of an improvement in this outcome from previous years self-assessments to warrant an increase in the score for this domain.

- Outcome 2D (score 1 - Developing) – Staff recommend the organisation as a place to work and receive treatment. In the 2024 staff survey 57.23% of staff recommended TEWV as a place to work and 55.41% were happy for a friend or relative to be cared for by the Trust. According to the guidance, to score a 2, over 70% of staff would need recommend the organisation as a place to work and receive treatment.

2.3 **The Trust's overall score for EDS 2025 is 20 which is classed as Developing.** The action plan at the back of the attached score card details actions the Trust will take in the next year to improve its score.

Classification: Official

Publication approval reference:

NHS Equality Delivery System 22
EDS Reporting Template

Third Version (test)

Version 0.8, 18 February 2022

Contents

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation		**Tees Esk and Wear Valleys NHS Foundation Trust**	**Organisation Board Sponsor/Lead**	
			Sarah Dexter-Smith (Director of People & Culture)	
Name of Integrated Care System		North East & North Cumbria ICB & Humber & North Yorkshire ICB		
EDS Lead	Lisa Cole (Head of Inclusive Cultures)		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	Staff / Staff Networks - 27.11.25 Freedom to Speak Up Guardian Service – 8.12.25, EDI Champions – 17.12.25 Unions & Chaplaincy - 18.12.25 People, Culture & Diversity Committee – 12.1.26 Board – 12.2.26 EDG – 13.1.26 JCC – 20.1.26 Integrated Care Board – 22.1.26		**Individual organisation**	Tees Esk and Wear Valleys NHS Foundation Trust
			Partnership* (two or more organisations)	County Durham and Tees Valley Mental Health, Learning Disability and Autism Partnership

			Integrated Care System-wide*	Reviewed by Chris Rowlands - Cumbria, Northumberland, Tyne and Wear Foundation Trust (5.12.25).

Date completed		**Month and year published**	February 2026
Date authorised		**Revision date**	

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance with scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services
Summary Domain 1 – Please see detailed ratings and evidence for the three services chosen

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**AMH: Whitby & Ryedale Integrated Care Team** The population of the Whitby and Ryedale areas combined is approximately 78,000 according to the 2021 census figures. The census records also show that between 95-98% of residents described themselves as predominantly white British, with very small proportions of the community identifying from the Black, Asian or Minority Ethnic backgrounds. Whitby and Ryedale Integrated Community Team provide accessible and equitable services across the Ryedale and Whitby area, taking into account the rural geography, population diversity and individual patient needs. Patients can access the service through multiple referral routes, including (but not limited to) direct referral via the patients GP, through other internal teams, and urgent referrals via crisis pathways. Clear referral criteria is published and shared with our partner organisations which is regularly reviewed collaboratively by the trust including input from our service user and experience group members. In recognition of the rural geography and the limitations of accessing public transport systems, the team offer a range of appointment formats, including face to face meetings within the clinic space, the patient's own home or other agreed mutually convenient community settings, telephone consultations and video appointments. The team consider the patients individual requests,	**2**	Team Manager: Patrick Appleby-Reid; Service Manager: Nicky Scott

		physical health conditions, disability or social circumstances when planning appointments. The service is able to make reasonable adjustments where required to ensure equitable access, particularly for individuals that may be socially isolated, digitally excluded or experiencing deprivation. We are able to work flexibly offering appointment times to meet the needs of the patients, to use interpreter/translator services, making adjustments for patients with neurodiversity or sensory needs. The team are proactive and follow the trusts Did Not Attend/ Was Not Brought policy whilst maintaining an assertive outreach style approach where appropriate. The team works closely with our local partners including those who provide voluntary sector services, patients carers and their families by facilitating/attending drop-in sessions and Multi Agency Meetings to ensure that any barriers to accessing care or treatment are discussed and mitigated where possible/appropriate. Patients/service users, their family or carers and partner organisation colleagues are encouraged to provide feedback on the service through our independent IT system. Feedback is continually reviewed by the team's carers champion and team manager in weekly KPI reports made to the trust leadership. Patient concerns or complaints are addressed locally through communication with the leadership within the CMHT or through the trust complaints management team.		

		Overall, the CMHT aim to ensure that all patients who are referred into the service are offered an initial assessment within the 28 days for a routine referral. **CAMHS: Selby CAMHS Team** We aim to offer children and young people in need of an assessment of emotional wellbeing which are currently within 4 weeks for an urgent assessment and 12 weeks for a routine assessment. Over the last year we have consistently met this target however, we are looking at improving this with the new quality care standards but recognise there is work to do around this as a team in terms of diary management and room availability to ensure this works. We also offer assessment for autism and ADHD within Selby CAMHS and are saddened that there are long waits for these assessments in terms of waiting for the triage panel and then an assessment within the pathway. We have recently asked staff who work within the emotional wellbeing pathway to support the neuro pathways and have undertaken training in both ADHD and autism to enable additional assessments to take place each week to lessen waiting times. There are minimal numbers of non-English speaking families in the area however the team have made use of interpreter services to aid communications with these families when required. A monthly joint meeting has been established with partners in the area to discuss the needs of local children to ensure that the right services are involved in their care, this has helped lessen referrals to service and offer a quicker response to families in need of support not provided/suitable for CAMHS intervention.	**2**	Team Manager: Adele Peacock; Service Manager: Rob Berry

		MHSOP: Memory Assessment Service York According to the 2021 census the population of York is 204,551. Within this population, 7% are classified as from an ethnic minority. Currently, we have ascertained that the proportion of people accessing our service who are from an ethnic minority is much less than this figure. We are awaiting a report from our IT team with the full figures. We are also aware that we need to ensure that the clinicians are always recording people's ethnic origin at assessment so we can be sure these figures are accurate. This is an action going forward. Connections have been made between York Memory Team and the York City Council diversity lead and their migrant lead, to explore ways to ensure that everyone who needs to access the memory service is able to. We have also made connections with the local mosque and are liaising with York Carers and the Community Volunteer service to maximise the reach of this work. As part of this work, we have been able to offer training to some of these services on positive approaches to care and communication with people with dementia. We plan to review progress in 6 months' time and to then plan to roll it out to the rest of our catchment areas (including Selby, Pocklington and Easingwold areas). We complete routine outcome measures at the beginning and then end of service users' journey within our service and have a high return rate of the feedback questionnaires that we give to patients. Over the last year we had 95% of responses advising that they had had a good or very good experience of our service. We respond to feedback suggesting changes; this has including ensuring that people are offered a drink during the appointments.	**2**	Team Manager: Rachel Cruickshanks Service Manager: Jeff Whiley

		Recently we have introduced appointment reminder calls and are planning to also offer text reminders also- to ensure people are always aware of the appointment being offered. If patients do not attend their appointments, clinicians always make contact by telephone to find out what has happened. If they cannot get in touch with them the GP is always informed, and they are offered another appointment following this.	**Average Score: 2**	
	1B: Individual patients (service users) health needs are met	**AMH: Whitby & Ryedale Integrated Care Team** The patients accessing Whitby and Ryedale Integrated Community team are able to have their individual health needs met. Living in a rural and coastal environment can influence the mental health needs of the local population with varying factors. Considerations need to be made around the patient's employment factors, such as being self-employed, working seasonally in tourism, hospitality or agriculture, which can contribute to financial insecurity, stress and fluctuating support needs. Living rurally or in social isolation can impact the health needs of our patients, especially when living in the smaller villages with limited transport options. Higher risks of social isolation, substance misuse, anxiety and mood disorders associated with rural deprivation can require significant multi agency approaches to meet the needs of the individuals accessing care. All patients are offered/engage with comprehensive biopsychosocial assessment taking into consideration their presenting mental health difficulties,	**2**	Team Manager: Patrick Appleby-Reid; Service Manager: Nicky Scott

		physical health and lifestyle factors, employment and financial status, housing stability, social networks, caring responsibilities and safeguarding concerns, cultural, communication and equality needs. Care planning and delivery is collaboratively created and co-produced with patients involving their family or carers where appropriate and with the consent of the patient. Plans are created to reflect the goals of the individual, with the plans being reflective, flexible and adaptive to meet changing needs. The team has access to a range of professionals working collectively as a Multi-Disciplinary Team. This includes colleagues in the Trust who do not work directly for the community team but provide interventions for specialist areas such as eating disorders or Perinatal Mental health. Patients can also be signposted to access care and support from partner organisations in the community to meet the complex needs of the individual.		

		CAMHS: Selby CAMHS Team The team have provided specific examples where they feel they have considered that individual needs are met, these include: 1. Utilising a different door to the main entrance where patients need relates to minimising noise, consideration of sensory needs and others accessing the service. 2. Appointments agreed in well in advance, so families/YP have the opportunity to plan and avoid change and disruption. Trying to ensure that the same room is booked for appointments each time for consistency. 3. Video sessions offered if this is preferred to face to face appointments 4. School visits offered if required 5. Food parcels obtained for families if they require support to access this service. 6. Text reminders to remind families of their appointments 7. Thursday afternoon clinics offering height, weight, blood pressure checks 8. ADHD parent psychoeducation group and resources. 9. Prescriptions	**2**	Team Manager: Adele Peacock; Service Manager: Rob Berry

		MHSOP: Memory Assessment Service York We consider adapting appointments to people's needs and engage different professions as required. If needed, we have offered to break the assessment down into 2 parts and time them according to people's requests if possible. We can adapt the cognitive testing that we do to people's cultural experience, under the guidance of our psychologist. We offer home visits to people who are housebound or without transport. We can also support people to arrange transport. The team have recently updated our patient information leaflet, and we have asked the service user cocreation group to review this to ensure it reads clearly. We regularly use the interpreter service at 'Everyday Language Solutions' commissioned by TEWV as needed to ensure everyone receives a parity of service. Clinicians are encouraged to take part on the free training that is offered on how to work effectively with interpreters.	**2**	Team Manager: Rachel Cruickshanks Service Manager: Jeff Whiley

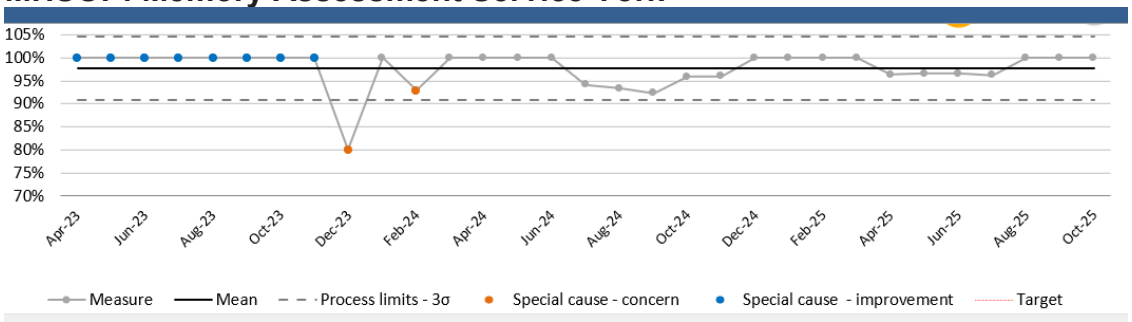
			Average Score: 2	
	1C: When patients (service users) use the service, they are free from harm	**AMH: Whitby & Ryedale Integrated Care Team** Working age adults in the Whitby and Ryedale area may experience risks associated with, rural isolation, employment insecurity/financial stress, substance misuse, delayed help seeking due to stigma in small rural communities. The local factors inform how the CMHT identify, manage and mitigate risks to ensure that patients are protected from avoidable harm. As part of the initial assessment, care planning and ongoing treatment/interventions provided by the CMHT risk is continuously reviewed using a comprehensive risk assessment tool documented in the patient's electronic health records.	**2**	Team Manager: Patrick Appleby-Reid; Service Manager: Nicky Scott

		Risks that are assessed are around the patients risk to self, risk to others and other risk factors such as substance use, social and environmental factors, physical health, social stressors such as housing or employment and safeguarding concerns. Other identified risks may include prescribed medication, administration/effectiveness or side effects and iatrogenic/unintentional harm. Safety summaries identify historical known risks and the patients current risk presentation. There are specific sections completed to reflect the patient's own views of their identified risks/needs, and the views and comments of their families or carers. Risk management plans are collaboratively created with the patient and their family/carers which can be shared with involved people with the consent of the patient. The plan will identify the role/actions that can be taken by the patient themselves, other involved people like carers and family members, then what services can provide that the patient has found useful/helpful/meaningful. The safety summary and plan will include factors that the patient can find triggering and will identify what the individual finds helpful at different stages in their mental health presentation so that early warning signs may be identified and responded to at the earliest opportunity to reduce harm.		

		CAMHS: Selby CAMHS Team All young people complete a collaborative risk assessment when meeting their key worker. This is regularly reviewed and updated through their journey with the service: • A trauma informed walkaround is completed with the support of service users • Staff have completed trauma informed care training • Staff safeguarding training is up to date • Confidentiality and safeguarding are explained at appointments • CCTV has been installed covering the care park as well as communal areas of the building • All staff have up to date DBS	**2**	Team Manager: Adele Peacock; Service Manager: Rob Berry

		MHSOP: Memory Assessment Service York Each patient that has an assessment with our service engages in an assessment of their safety. They are then given a clear safety plan with advice and numbers to contact if they should have concerns about safety in the future. Information is gathered from them, their carers (if appropriate) and primary care services. We have a clear transfer pathway to the community mental health teams if the person is presenting with risks that cannot be safely managed within the memory service. We also have ready access to the TEWV safeguarding team who will respond quickly to any questions or queries and give clear advice and support as to next steps to take to ensure people are safe guarded. There are posters clearly displayed in our waiting area to advise that we do not tolerate hate towards other people, with advice to inform the clinician they see if they do.	**3** **Average Score: 2**	Team Manager: Rachel Cruickshanks Service Manager: Jeff Whiley

	1D: Patients (service users) report positive experiences of the service	**AMH: Whitby & Ryedale Integrated Care Team** The team use I Want Great Care as a structured and accessible way for feedback to be collected of the experiences of patients, their families or carers and our partner organisation colleagues. Feedback can be provided anonymously and at different stages in care delivery. The questionnaire uses clear, simple questions that encourage honest responses. This approach can encourage patients to provide feedback that can be negative or positive and can be inclusive for those people who would be less likely to raise formal complaints or concerns. Feedback can be provided digitally or via a freepost paper version. Feedback can be used to provide service improvement initiatives. The team are able to display feedback to show that the team is listening and any themes or trends can be reviewed. Any service improvements are shared with the trust involvement colleagues and service user groups to ensure they are developed collaboratively to meet the needs of the community. Staff prioritise consistent, compassionate and person-centred interactions which are reflected in the feedback questionnaires received by the team. The results of percentage of patients reporting their experience of good or very good has consistently been around 90-100%, this is reviewed weekly and reported to the locality leadership.	**2**	Team Manager: Patrick Appleby-Reid; Service Manager: Nicky Scott

		CAMHS: Selby CAMHS Team There is limited information on IIC and IWGC in relation to recent feedback from families. The service will look at ways to encourage families to provide feedback about the service so that patient experience can be evidenced and monitored going forward. In December the team have received numerous cards and small gifts from families expressing their gratitude for the help and support that they have been offered. This is however not recognised formally.	**1**	Team Manager: Adele Peacock; Service Manager: Rob Berry
		MHSOP: Memory Assessment Service York  The graph above demonstrates that 95% of people accessing the York memory service last year rated it as good/ very good. We have a high rate of returns (on average 40 a month) for feedback and check these monthly, adapting our service where possible in response. In the future we plan to work with the patient experience leads in TEWV, to break down the feedback forms to have more of an understanding of how people from ethnic minorities are experiencing our service, compared with the wider population, so that we may adapt the service if needed.	**3** **Average Score: 2**	Team Manager: Rachel Cruickshanks Service Manager: Jeff Whiley

Domain 1: Commissioned or provided services overall rating			**8**	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

main 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Occupational Health Service Provision • Employee Support Service/Employee Psychology Service (including support groups such as Burnout group) • VIVUP wellbeing platform (includes 24-7 Counselling service for staff) • Long Term Health Conditions staff network and numerous other support network groups which meet regularly • Achieved Better Health at Work Award Scheme Gold level in 2024, working towards Continuing Excellence level (assessment October 2025 – campaigns have included Focus on Stress, Occupational Health service, Hard to Reach Staff Groups – Health & Justice (Prisons) Service), Mini MOT - Workplace Health Checks programme & Dignity at Work/Staff Engagement). • Long term sickness absence team • Permanent Reasonable Adjustments Team • Nutrition and weight management programmes • 370+ Health & Wellbeing (H&W) champions • Staff led Health Council meets every two months, four rounds of charitable monies have been allocated to staff following 66 successful project bids, amounting to over £124,000	**2**	Helen Cooke & Michelle Brown (Health & Well-being Leads), Lisa Cole (Head of Inclusive Cultures)

		• Focus on Violence & Aggression and wellbeing, including sexual safety in • the workplace and support for those impacted by domestic abuse • H&W pages on the staff Intranet reviewed and updated • Working carer support - network • Staff Mindfulness Programme • Bereavement Support • Central staff Health and Wellbeing team (2.4 wte's) • Bi-monthly Strategic Health & Wellbeing Group which meets made up of MDT staff and Services. • H&W coordinator (Durham & Darlington Locations) • Health & Wellbeing Conversations training programme/bite sized Health & Wellbeing topic to be rolled out across the Trust during 2025 and into 2026 • Face to face Trust Welcome for new staff (Induction) – twice monthly • Employee Psychology service demonstrating positive outcome data for individuals accessing the service. Most staff who access the EPS for support with work-related stress/trauma experience significant improvements in their mental health, general mental well-being and their functioning at work and home		

		• Employee support service receiving 87 referrals per month with 96% of staff recommending the service to colleagues. • Signatory to the Charter for Employers Positive About Mental Health (Mindful Employer) until the 16 April 2027. • Staff Mindfulness Programme providing education for 406 patients and staff per term and demonstrating positive outcome data for the 6 and 8-week courses in relation to mental health, functioning and compassion • Monthly delivery of Schwartz rounds where staff gain insights into how they feel about their work and the lives of patients and carers. • Face to face Trust Welcome for new staff (Induction) to be re-started from October 2024 • Review of Trust wide Managers Bitesize training programme to include health and wellbeing. • Staff Wellbeing Hub – Accessible via CNTW.		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Violence Reduction strategy development • Verbal & Physical Aggression procedure • Indicator 5 WRES – Staff experiencing harassment, bullying or abuse from patients, relatives, public. • Indicator 6 WRES - Staff experiencing harassment, bullying or abuse from staff. • Indicator 4 WDES • Indicator 5 SOWES • Indicator 6 SOWES • Publication of information Staff survey results (harassment, bullying & abuse) - Age and Gender • Co Facilitated LGBTQ+ Awareness training including lived experience. • Upstander Training available for staff to access trust wide • WRES/WDES/SOWES action plans • Equality objectives (include verbal & physical aggression actions) • Disciplinary data • Support offered following Inphase reported incidents. • Hate crime campaigns. • Staff Council • Staff Support – 24 / 7, 365 days Speak 24 / 7, 365 days Up Guardian service, ESS, EPS	**1**	Helen Cooke & Michelle Brown (Health & Well-being Leads), Lisa Cole (Head of Inclusive Cultures)

		• Training available including in leadership programmes • Domestic violence workstream, including toolkit and planned training. • Sexual Safety in the workplace workstream, including toolkit and planning training • Development of an Anti-Racism Steering Group that meets monthly • Show Racism the Red Card Programme and training offered trust wide to staff • Sign up to Anti-Racism Charter		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• The Trust has an EDIHR Team • Staff Networks which all have an Exec Sponsor • 24 / 7 Freedom to Speak Up Guardian Service • PNA – Professional Nurse Advocacy Service • Employee Support Service, VIVUP platform (including Counselling service), Employee Psychology Service • Input from Show Racism the Red Card for staff • The introduction of an Anti-Racism Steering Group • The development of an Anti-Racism Policy • The Trust signed up to the Anti Racism Charter • The EDIHR Team deliver Upstander Training to ward staff • The EDIHR Team have carried out outreach work on wards where high level of discrimination towards staff is being reported. Feedback from staff is escalated to senior management and is also taken to the Anti-Steering Group • The EDIHR Steering Group oversees incidents where discrimination is being reported. The EDIHR Team follow up incidents with staff and managers to offer	**2**	Helen Cooke & Michelle Brown (Health & Well-being Leads), Lisa Cole (Head of Inclusive Cultures)

		support and team support is offered by the EDIHR Team. • The EDIHR Team are working with the police to develop a poster / communications campaign for patient areas regarding incidents of racism, discrimination & sexual safety • Actively work with Unions • Equality Impact Assessments completed on all policies/procedures. • WRES/WDES/SOWES & Publication of Information data led to actions. • Chaplaincy Team • A relaunch of the Speaking Up Ambassadors • Speaking Up policy and includes information on how workers can access support for their wellbeing and Equality Impact Assessments these are also applied to other related policies. • Staff Survey Q21c & Q21d – Age, Ethnicity, Gender, LTHC, Sexual Orientation. • Overall recommend as a place to work: 57.77% • Overall happy for friend or relative to be cared for: 56.45% • Reasons for leaving data broken down by demographics. • Disciplinary data broken down by demographics		

		• Recruitment data by demographics • Trust wide Violence and Aggression Steering Group • Post Incident Peer Support network		
	2D: Staff recommend the organisation as a place to work and receive treatment	• Staff Survey Q21c & Q21d – Age, Ethnicity, Gender, LTHC, Sexual Orientation. • Overall recommend as a place to work – 2023 – 57.20% 2024 - 57.77%. • Overall happy for friend or relative to be cared for 2023 – 55.39% 2024 - 56.45%. • Reasons for leaving data broken down into demographics. • Disciplinary data broken down into demographics. • Recruitment data broken down into demographics. • Exit data presented by directorates/areas only.	**1**	Helen Cooke & Michelle Brown (Health & Well-being Leads), Lisa Cole (Head of Inclusive Cultures)
Domain 2: Workforce health and well-being overall rating			**6**	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• CEO / Senior staff Blogs/Vlogs include EDI • BoD & committees – EDI & Health Inequalities discussed (minutes) • Board members & senior leaders sponsor & attend staff networks • EDI Lunch & Learn sponsorship from BoD and Senior Leaders • Significant increase in board declarations of EDI characteristics and over representation of some characteristics at board compared to community • Commitment to review the new structure brought in April 2022 to check impact on protected characteristics which was completed • All execs have EDI specific objective • All networks have exec sponsor • Rates of discrimination reducing on staff survey • SRTRC has board sponsorship • Staff stories (and patients) are now a regular feature of board – including specific stories from our neurodiverse, Armed Forces, and Trans colleagues. • Management group papers on health inequalities	**2**	Sarah Dexter- Smith (Executive Director of People and Culture), Catherine Parker (Consultant in Public Health)

		• Management group minutes inequalities team challenge • Exec sponsorship and chairing of patient safety summit on health inequalities and reflective session • Lived experience 'lunch with leaders' session and health inequalities showcase • Benchmarking exercise against NHS provider inequalities tool completed and presented to EDG and informing future planning and exec objectives		
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• EDI & Health inequalities are discussed at BoD (minutes) • BAME staff risk assessments were completed during the pandemic. • EIAs are complete for policies & procedures and projects • Health inequalities challenge adopted by EDG. • Annual report section on health inequalities and presentation at AGM • EDG update on health inequalities exec objectives	**2**	Sarah Dexter- Smith (Executive Director of People and Culture), Catherine Parker (Consultant in Public Health)

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• BoD and committees monitor Gender Pay Gap, WRES (including Model Employer), WDES & SOWES, EDS, leavers information. • Executive clinical lead identified to oversee EDI data related to patient care. • CG leads in place to support this work. • Employee relations reports to EDG and committee now have detailed focus on protected characteristics and processes are changing as a result. • Health inequalities is a cross-cutting priority this this year's annual plan. Key milestones and objectives are monitored as part of annual plan governance. • A statement if information of health inequalities has been developed and will be published alongside this year's • annual report and prevented at AGM • Statement of information on health inequalities published Statement on information on health inequalities - Tees Esk and Wear Valley NHS Foundation Trust and refresh drafted • Executive leadership in place for PCREF	**2**	Sarah Dexter- Smith (Executive Director of People and Culture), Catherine Parker (Consultant in Public Health)

Domain 3: Inclusive leadership overall rating			**6**	
Third-party involvement in Domain 3 rating and review				
Trade Union Rep(s): JCC approval		**Independent Evaluator(s)/Peer Reviewer(s): Chris Rowlands CNTW 5.12.25**		

EDS Organisation Rating (overall rating): 20
Organisation name(s): Tees, Esk and Wear Valleys NHS Foundation Trust
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Lisa Cole	2025/26
EDS Sponsor	**Authorisation date**
Sarah Dexter-Smith	

AMH: Whitby & Ryedale Integrated Care Team

Domain	Outcome	Objective	Action	Completion Date
Domain 1: Commissioned or provided services.	1A: Patients (service users) have required levels of access to the service	To continue to develop the referral criteria, to include our main referrers and service users/lived experience colleagues in the process. To share any updates with partner organisations. To improve access and reduce waiting times for patients.	To work with senior leadership and trust to create a collaborative modernised version of the adult Mental Health Pathway.	April 2026
	1B: Individual patients (service users) health needs are met	To include information on all flexible appointment opportunities available to patients within our first contact/ offer of appointment.	To create a standard communication format that allows patients to be aware of options and make an informed decision about how they may engage with services. To discuss with senior leadership	April 2026

	1C: When patients (service users) use the service, they are free from harm	To continue to provide the opportunities for patients, carers and/ or their family to engage with and contribute to the creation of their risk management plan (safety summary and safety plan). To have this documented in the patient's electronic records and offered a printed version.	To ensure that all staff follow the trust guidance and trust policy on safety management/harm minimisation. To hold regular team meetings where learning can be shared.	April 2026
	1D: Patients (service users) report positive experiences of the service	To continue to use feedback to create/adapt and improve services across the Whitby and Ryedale area	Monitor and review feedback. Make contact with people who have provided feedback where appropriate. To discuss service improvement initiatives with senior leadership within the trust.	April 2026

CAMHS: Selby CAMHS Team

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services.	1A: Patients (service users) have required levels of access to the service	To ensure that families that require interpreters have a smooth and easy access to this service. To ensure that families requiring assessment through the emotional pathway have a prompt and timely service	Liaise with interpreter service ELS to enable families at assessments and follow up appointments access to interpreters The modern matrons are running a workshop with the team on the new quality care standards to introduce the new waiting time guidelines with the team. Ongoing capacity and demand work with the team to maximise appointment slots in diaries. Continuous work with SPA (single point of access) to ensure that the right people are offered appointments and cut down on wastage.	Ongoing 6.1.26 Ongoing Ongoing

	1B: Individual patients (service users) health needs are met	Continue to offer video sessions for young people if/as and when identified.	Identified at first appointment and agreed collaboratively to suit family and clinician need	Ongoing
		Continue sending text message reminders for appointments to minimise DNA rates.	Admin to continue sending these on a weekly basis until the CITO booking system is fully in place as reminders can be automatically sent via this system.	CITO Lead to offer a session in team meeting in March 26
		Increase the number of staff trained in physical health checks to offer wider based appointments than one afternoon	Discussions to take place with modern matron re training opportunities for health care assistants.	Requires follow up as no training identified previously.
	1C: When patients (service users) use the service, they are free from harm	Ensure staff training is up to date around trauma informed care and safeguarding	Verify training with ESR records within management supervision.	Ongoing
		Ensure staff using the building have an up to DBS	Ensure all staff are on the DBS update service and that no new recruits start without a DBS clearance.	Ongoing

	1D: Patients (service users) report positive experiences of the service	Increase the numbers of feedback obtained from friends and families for Selby CAMHS	Remind the team again about asking families for feedback at appointments Automatically send the feedback questionnaires with written/posted appointment/discharge letters Put more posters around the building with the feedback details Discuss with how other teams how they have increased their feedback loops and replicate where possible	Ongoing Ongoing Ongoing Date TBC

MHSOP: Memory Assessment Service York

Domain	Outcome	Objective	Action	Completion Date
Domain 1: Commissioned or provided services.	1A: Patients (service users) have required levels of access to the service	To gain a clear understanding of percentage of people with ethnic minorities who are accessing the memory service	To acquire a report from the IT team into the current figures. To ensure all clinicians are recording people's ethnic minorities into patient electronic record system- through discussion and team meetings	31st Jan 2026
	1B: Individual patients (service users) health needs are met	To send out patient information leaflet to everyone accessing the service.	To amend leaflet as suggested by co creation group then start sending out.	31st Jan 2026
	1C: When patients (service users) use the service, they are free from harm	For posters in main reception advising that TEWV do not tolerate hate to include contact details from someone outside of their care team	To speak to communication team and diversity lead in TEWV to find out how this can be put in place.	31st April 2026

	1D: Patients (service users) report positive experiences of the service	To gain a clear understanding of how people from ethnic minorities are experiencing the memory service compared with the wider population, so that we can adapt the service as needed	To meet with the patient experience leads to learn how best to break down this information and then report on this at the team meeting monthly	31st March 2026

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To promote and provide innovative initiatives for work-life balance, healthy lifestyles, encourages and provides opportunity to exercise.	The Health and Wellbeing Team will continue to run specific wellbeing campaigns on specific conditions such as COPD, Asthma and weight management, in the coming year (2025/26) campaigns have focussed on Focus on Stress, Occupational Health service, Hard to Reach Staff Groups – Health & Justice (Prisons) Service), Mini MOT - Workplace Health Checks programme & Dignity at Work/Staff Engagement	Ongoing

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Ensure we support and respond to staff who experience verbal & physical aggression and proactively reduce the number of incidents of verbal aggression from service users, carers, and members of the public towards staff.	To follow the actions detailed in the objective set in 2023 as one of the Trust's 2023-2026 Equality Objectives. Continue to Promote Procedure for Addressing Verbal & Physical Aggression Towards Staff by Patients, Carers Relatives Actions identified as part of the Trust self-assessment – Violence Prevention and Reduction Standard Sexual safety charter actions and support for those affected by domestic abuse.	Ongoing
		Continue to develop data and intelligence-led Wellbeing initiatives and evaluate Wellbeing sessions that have taken place to ensure topics are relevant and effective.	Agree outcome measures for specific wellbeing initiatives and continue to use pre and post evaluation metrics.	Ongoing

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source		Rolling out the new Respectful Resolution guides and eLearning - Respectful Resolution, Kind Life | TEWV Intranet	
	2D: Staff recommend the organisation as a place to work and receive treatment	To improve the % of staff reporting that they would recommend the organisation to work or receive treatment.	Promote People Management Bite Size Training sessions. All on Intranet Promote New Managers Programme. - this is being replaced by the Expectations of Line Managers Programme – October 2025. Promote TEWV Leadership and Management Academy. Information session rolled out in 2025. (face to face and MST)	Ongoing

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To improve organisational population health and inequalities planning and governance	Develop organisational population health and inequalities plan and governance framework	03/26
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To continue to adopt an approach to assess organisational progress in relation to health inequalities in line with the NHS Oversight and Assessment Framework	BoD to implement executive objectives identified from the health inequalities self-assessment.	Ongoing
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	For Board members and senior leaders to monitor the trusts approach to Health Inequalities.	BoD to implement the NHS Oversight and Assessment Framework. To review that all the following are monitored: WRES (including Model Employer), WDES, NHS Oversight and Assessment Framework, Impact Assessments, Gender Pay Gap reporting, staff risk assessments (for each relevant protected characteristic), SOM, end of employment exit interviews, (EDS	Ongoing

			subject to approval), Accessible Information Standard, partnership working – Place Based Approaches.	

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Meeting of:	Trust Board
Date:	12th February 2026
Title:	Freedom to speak up
Executive Sponsor(s):	Sarah Dexter-Smith, Director of People and Culture
Author(s):	Sarah Dexter-Smith

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1 and 4	**Safe Staffing and Quality of Care**	The confidence that staff have in raising concerns is fundamental to the quality of care we provide and the experience colleagues have of working in the Trust. A key independent part of the ability for staff to do that is the provision of an effective Freedom to Speak Up Guardian.

Executive Summary:	
Purpose:	The paper outlines the transition to the new FTSU service which began work with the Trust in October 2025 and was open to colleagues from mid November 2026, and the data available for how colleagues are using the service from The Guardian Service.

Proposal:	The board is invited to take good assurance that the new service provides us with a strong independent FTSU service.

Overview:

The new FTSU Guardian (Adam Howe) began work with us in October 2025. Through the set-up phase he met with key departments such as people partners, complaints, communications, organisational development, and service leads. As well as key individuals such as FTSU NED champion, CEO, chair. He has in place a key contact for each service line and we have established expectations for timeliness of responses to his queries.

The contract management is being carried out by a Head of People and Resourcing in People and Culture. Monthly meetings are in place with the Director of People and Culture.

Adam has visited key Trust sites ever since starting and has achieved a significant geographical and service coverage. He reports that services are friendly and open and receptive to his questions which in itself is a positive indicator of culture. Adam has also

visited Executive Directors' Group, joined the BAME staff network celebration event and will be joining a 'working in TEWV' coffee break.

The attached report provides the latest data from the Guardian Service and the overall data is provided at the end of this report. Each monthly report is accompanied by a monthly meeting with the Trust to go through qualitative information (additional meetings can be called at any point by either party). The report will clearly become more informative as extra months are added and themes can emerge. At this point in time our initial thoughts are:

- 39 people have used the service since the Guardian Service went live in mid November 2025. We are pleased that colleagues are using the service in consistent numbers, that show no drop off with the transition to a new service. The site visits will undoubtedly have built presence and confidence and we have tracked a recent uplift in contact from the NYY care group which is a positive indicator.
- It is unusual that there is a high proportion of people wanting to remain anonymous as this had changed significantly with the previous Guardian and nearly all concerns were followed up with the person directly. We have agreed to monitor this.
- Sites have had a rapid changeover of poster about the service provider with gaps being ironed out in January.
- Future reports will clarify the colour coding – red/patient or staff safety, amber/ bullying and harassment, which have different timescales for expected response from services. And explain reporting anonymously vs reporting with no name.
- Staff groups will be more closely aligned to our understanding rather than national ESR groups e.g. psychological professions are missing as a group which makes it harder to interpret themes.
- We will also clarify some language e.g. an initial reading led to an assumption that systems meant electronic systems but it covers a wide range of trust systems and process.

We take confidence from the way the report is provided at this early stage, as well as the broader updates provided by The Guardian Service on national issues.

Prior Consideration and Feedback	The first month report (data only, no written narrative) has been to EDG for comment, leading to some of the changes outlined above. A report has also been to the People Culture and Diversity Committee

Implications:	The new service has begun well and provides confidence in our future provision.

Recommendations:	That board takes good assurance from the new FTSU provision

The Guardian Service
Here to listen

Tees, Esk and Wear Valleys NHS Foundation Trust
January - 2026

Cases

New cases this month	16
Cases closed this month	8
Open cases year to date	24
Closed cases year to date	15
Total cases year to date	39

RAG status

	Open Cases This Month	Total Cases This Year
Red	4	7
Amber	3	6
Green	9	26
White	0	0
	16	39

Outcomes

	This Month	This Year
Written / Verbal	6	13
Chose not to pursue	1	1
No further contact	1	1
	8	15

Themes

	Primary only		All themes inc. primary	
	Month	Year	Month	Year
Patient safety / quality	5	8	5	8
Worker safety / wellbeing	0	0	1	2
Bullying / harassment	3	5	3	5
Other inappropriate behaviour or attitudes				
Behaviour / relationship	1	4	2	9
Discrimination / inequality	0	1	1	3
Management issue	2	9	12	29
Sexual misconduct	0	0	0	1
Additional Themes				
System / process	5	12	7	20
Other	0	0	0	0
Totals	16	39	31	77

Activity / Visits

	This Month	This Year
Promotion	26	90
Site briefing	4	6
Online briefing	2	12
Site meeting	0	0
Online meeting	0	3

Case-related activity

	This Month	This Year
Email	167	284
Telephone	42	79
Face to face	20	32

Cases raised anonymously

This Month	This Year
0	0

Detriment

This Month	This Year
0	0

The Guardian Service
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Date produced 06 Feb 2026 8:29

Produced by NATALIE MORGAN

Title	**GUARDIAN ACTIVITY REPORT**
Guardians	**Adam Howe**
Period	**January - 2026**
Trust	**Tees, Esk and Wear Valleys NHS Foundation Trust**

Think before you print. Protect our environment.

The Guardian Service
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Tees, Esk and Wear Valleys NHS Foundation Trust

January - 2026

Cases

New cases this month	16
Cases closed this month	8
Open cases year to date	24
Closed cases year to date	15
Total cases year to date	39

RAG status

	Open Cases This Month	Total Cases This Year
Red	4	7
Amber	3	6
Green	9	26
White	0	0
	16	39

Outcomes

	This Month	This Year
Written / Verbal	6	13
Chose not to pursue	1	1
No further contact	1	1
	8	15

Themes

	Primary only		All themes inc. primary	
	Month	Year	Month	Year
Patient safety / quality	5	8	5	8
Worker safety / wellbeing	0	0	1	2
Bullying / harassment	3	5	3	5
Other inappropriate behaviour or attitudes				
Behaviour / relationship	1	4	2	9
Discrimination / inequality	0	1	1	3
Management issue	2	9	12	29
Sexual misconduct	0	0	0	1
Additional Themes				
System / process	5	12	7	20
Other	0	0	0	0
Totals	16	39	31	77

Activity / Visits

	This Month	This Year
Promotion	26	90
Site briefing	4	6
Online briefing	2	12
Site meeting	0	0
Online meeting	0	3

Case-related activity

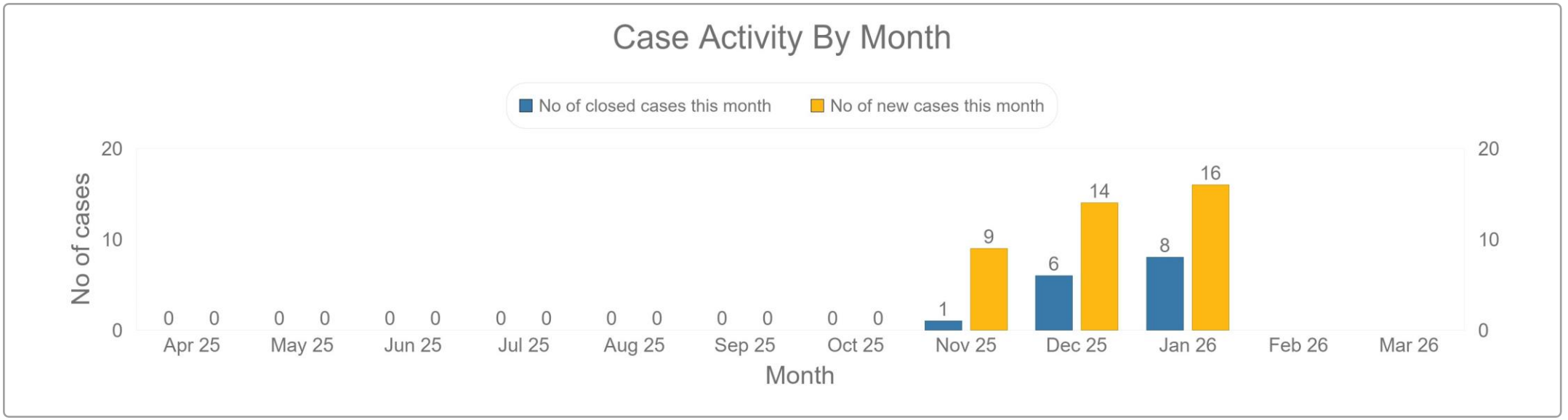
	This Month	This Year
Email	167	284
Telephone	42	79
Face to face	20	32

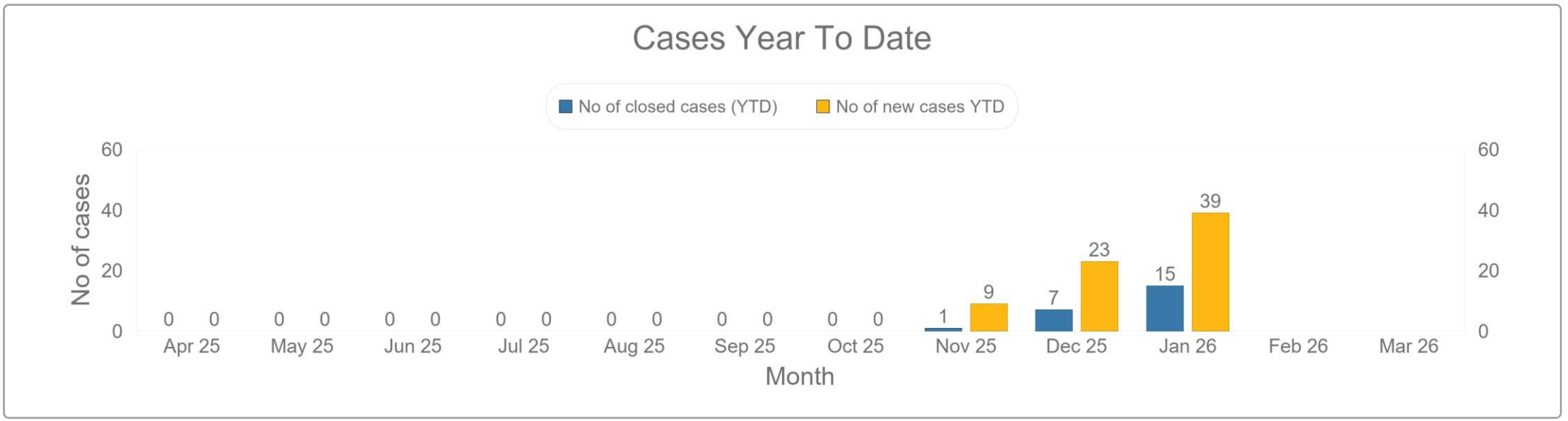
Cases raised anonymously

This Month	This Year
0	0

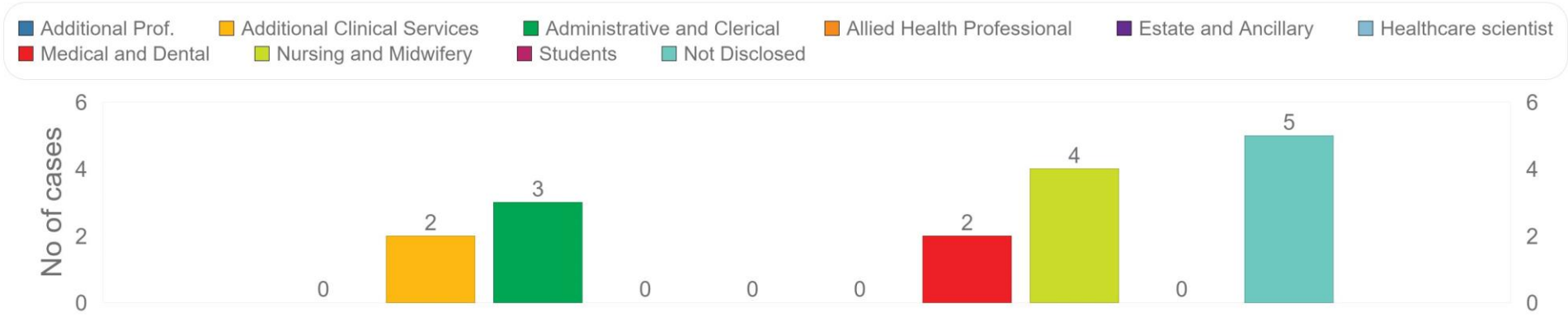
Detriment

This Month	This Year
0	0

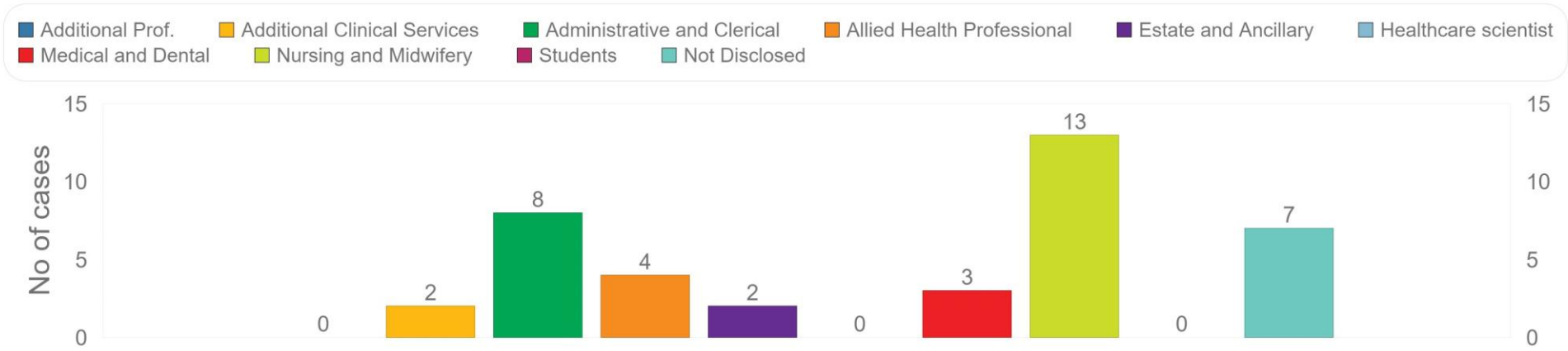

Case Activity By Month
No of closed cases this month
No of new cases this month
No of cases
Month
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26
Mar 26
0 0 0 0 0 0 0 0 0 0 0 0 1 9 6 14 8 16


Cases Year To Date
No of closed cases (YTD)
No of new cases YTD
No of cases
Month
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26
Mar 26
0 0 0 0 0 0 0 0 0 0 0 0 1 9 7 23 15 39

Cases by Job Group This Month



Cases by Job Group YTD



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Tees, Esk and Wear Valleys NHS Foundation Trust

January - 2026

Case Status by Job Group

Case No	Start Month	Open	Closed	Add. Prof. Scientific Technical	Add. Clinical Services	Administrative & Clerical	Allied Health Professional	Estates & Ancillary	Heatlhcare Scientist	Medical & Dental	Nursing & Midwifery	Students	Not Disclosed
TEWV-25-01	Nov		✓				✓						
TEWV-25-02	Nov	✓				✓							
TEWV-25-03	Nov		✓								✓		
TEWV-25-04	Nov		✓								✓		
TEWV-25-05	Nov		✓								✓		
TEWV-25-06	Nov		✓										✓
TEWV-25-07	Nov		✓				✓						
TEWV-25-08	Nov		✓			✓							
TEWV-25-09	Nov		✓				✓						
TEWV-25-10	Dec		✓								✓		
TEWV-25-11	Dec		✓								✓		
TEWV-25-12	Dec	✓									✓		
TEWV-25-13	Dec		✓								✓		
TEWV-25-14	Dec		✓							✓			
TEWV-25-15	Dec	✓						✓					
TEWV-25-16	Dec		✓			✓							
TEWV-25-17	Dec		✓			✓							
TEWV-25-18	Dec		✓								✓		

The Guardian Service
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Tees, Esk and Wear Valleys NHS Foundation Trust

January - 2026

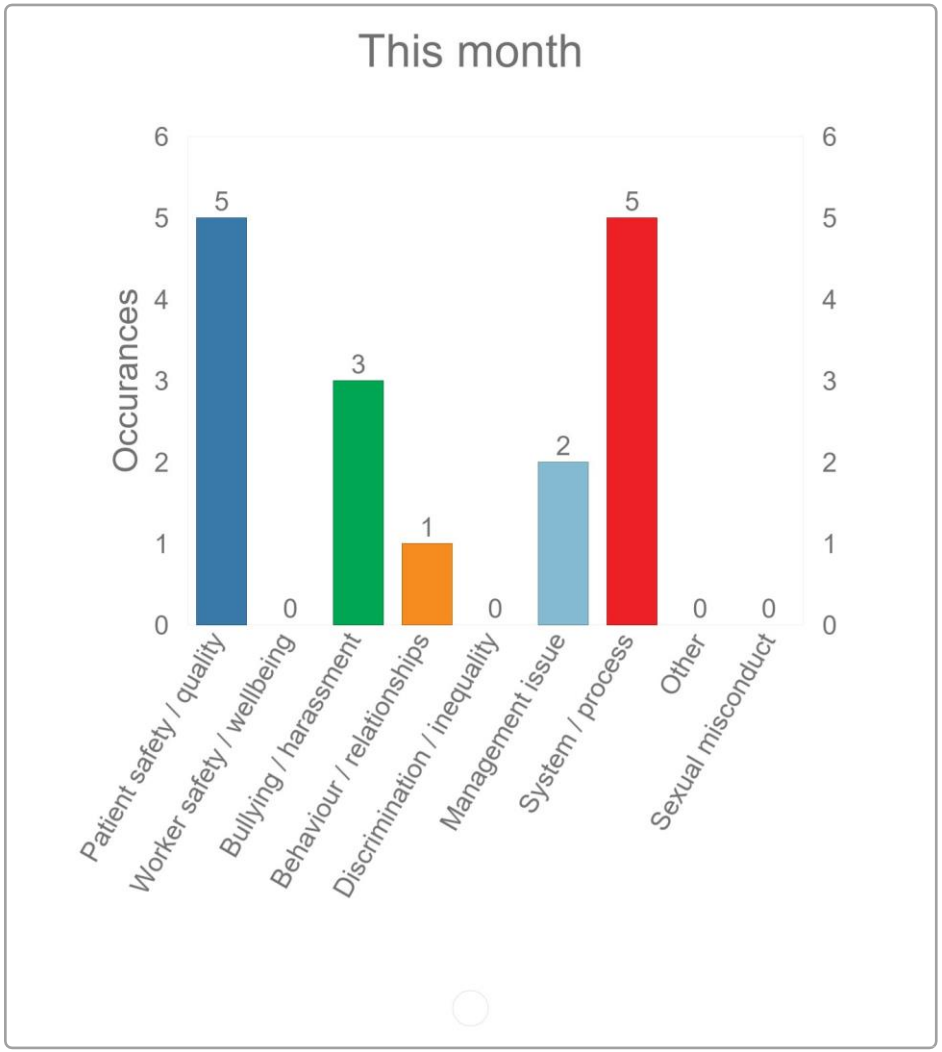
Case Status by Job Group

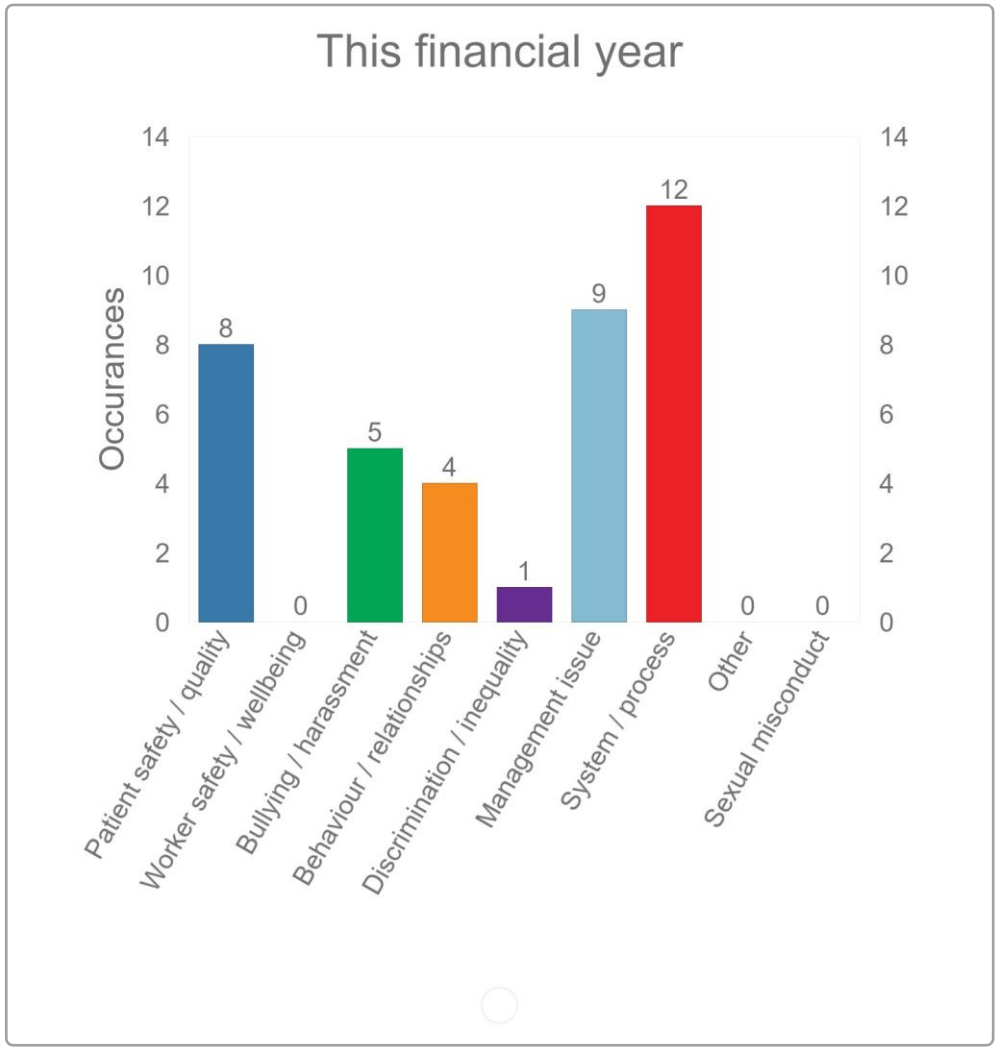
Case No	Start Month	Open	Closed	Add. Prof. Scientific Technical	Add. Clinical Services	Administrative & Clerical	Allied Health Professional	Estates & Ancillary	Heatlhcare Scientist	Medical & Dental	Nursing & Midwifery	Students	Not Disclosed
TEWV-25-19	Dec	✓					✓						
TEWV-25-20	Dec	✓									✓		
TEWV-25-21	Dec	✓						✓					
TEWV-25-22	Dec	✓											✓
TEWV-25-23	Dec	✓				✓							
TEWV-25-24	Jan	✓									✓		
TEWV-25-25	Jan	✓											✓
TEWV-25-26	Jan	✓								✓			
TEWV-25-27	Jan	✓											✓
TEWV-25-28	Jan	✓			✓								
TEWV-25-29	Jan	✓								✓			
TEWV-25-30	Jan	✓									✓		
TEWV-25-31	Jan	✓									✓		
TEWV-25-32	Jan	✓			✓								
TEWV-25-33	Jan	✓									✓		
TEWV-25-34	Jan	✓											✓
TEWV-25-35	Jan	✓											✓
TEWV-25-36	Jan	✓				✓							

Case Status by Job Group

Case No	Start Month	Open	Closed	Add. Prof. Scientific Technical	Add. Clinical Services	Administrative & Clerical	Allied Health Professional	Estates & Ancillary	Heatlhcare Scientist	Medical & Dental	Nursing & Midwifery	Students	Not Disclosed
TEWV-25-37	Jan	✓				✓							
TEWV-25-38	Jan	✓				✓							
TEWV-25-39	Jan	✓											✓
	Totals	24	15		2	8	4	2		3	13		7

Primary Themes





Cases by Primary Theme

Case Number	Start Month	Open	Closed	Patient Safety/Qlty	Management Issue	System / Process	Bullying / Harassment	Discrimination / Inequality	Behaviour / Relationship	Worker Safety	Other	Sexual Misconduct	Other Detail
TEWV-25-01	Nov		✓		✓								
TEWV-25-02	Nov	✓				✓							
TEWV-25-03	Nov		✓		✓								
TEWV-25-04	Nov		✓	✓									
TEWV-25-05	Nov		✓			✓							
TEWV-25-06	Nov		✓						✓				
TEWV-25-07	Nov		✓						✓				
TEWV-25-08	Nov		✓			✓							
TEWV-25-09	Nov		✓	✓									
TEWV-25-10	Dec		✓		✓								
TEWV-25-11	Dec		✓	✓									
TEWV-25-12	Dec	✓			✓								
TEWV-25-13	Dec		✓			✓							
TEWV-25-14	Dec		✓				✓						
TEWV-25-15	Dec	✓				✓							
TEWV-25-16	Dec		✓			✓							
TEWV-25-17	Dec		✓			✓							
TEWV-25-18	Dec		✓		✓								

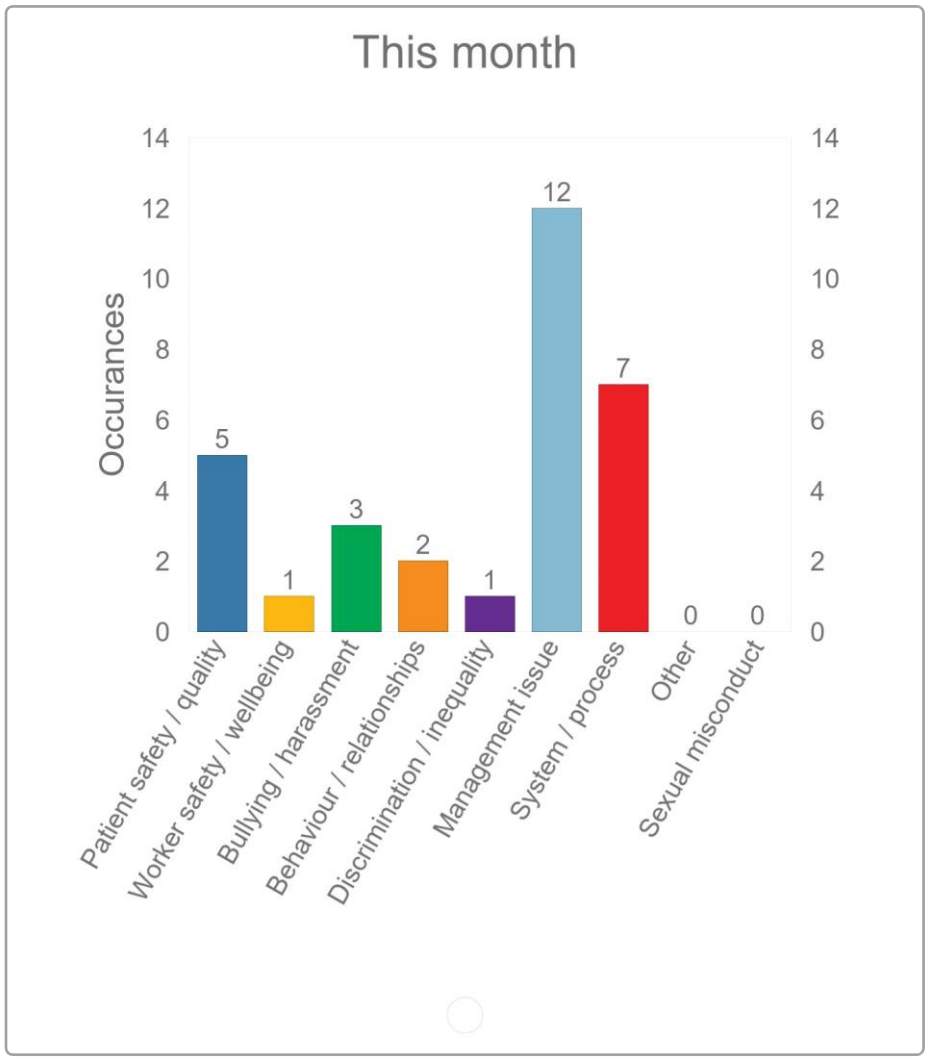
Cases by Primary Theme

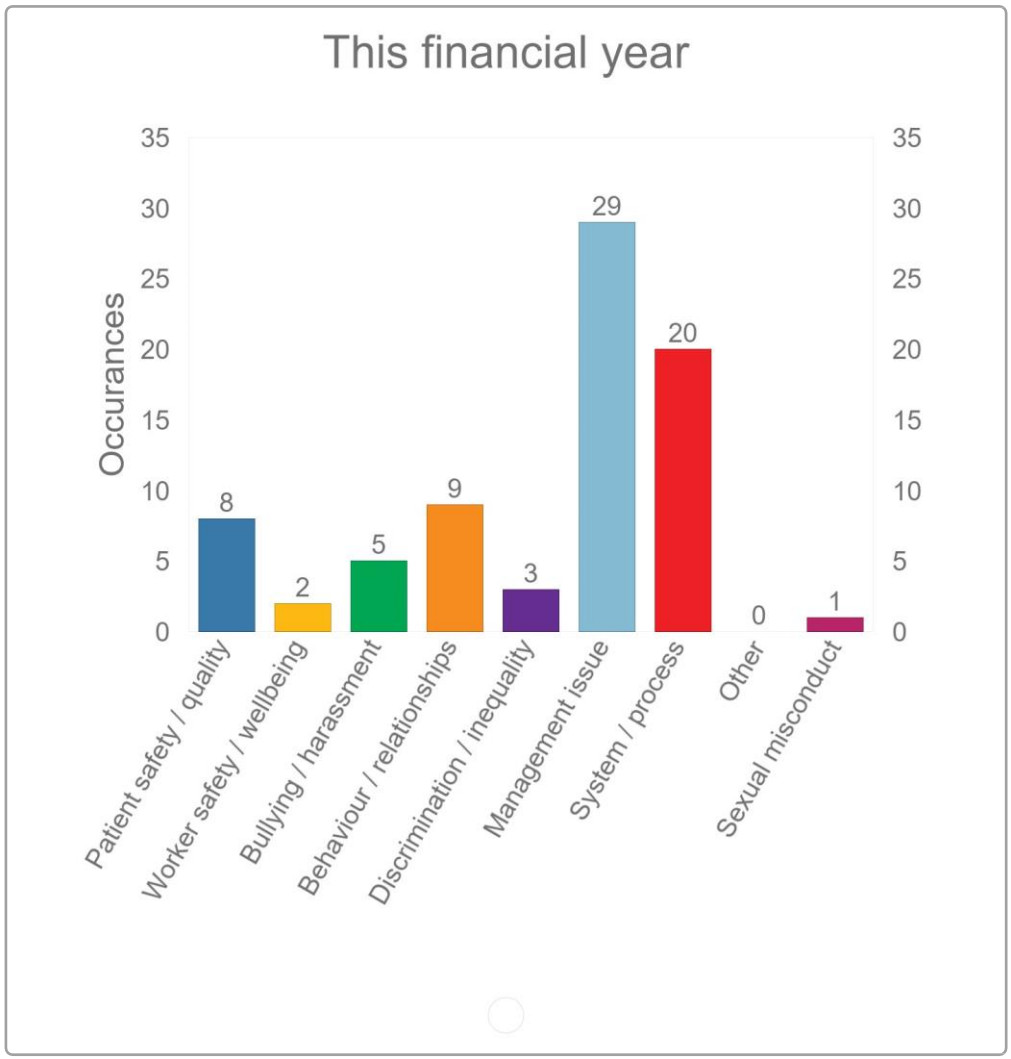
Case Number	Start Month	Open	Closed	Patient Safety/Qlty	Management Issue	System / Process	Bullying / Harassment	Discrimination / Inequality	Behaviour / Relationship	Worker Safety	Other	Sexual Misconduct	Other Detail
TEWV-25-19	Dec	✓						✓					
TEWV-25-20	Dec	✓							✓				
TEWV-25-21	Dec	✓			✓								
TEWV-25-22	Dec	✓					✓						
TEWV-25-23	Dec	✓			✓								
TEWV-25-24	Jan	✓		✓									
TEWV-25-25	Jan	✓					✓						
TEWV-25-26	Jan	✓					✓						
TEWV-25-27	Jan	✓					✓						
TEWV-25-28	Jan	✓		✓									
TEWV-25-29	Jan	✓							✓				
TEWV-25-30	Jan	✓		✓									
TEWV-25-31	Jan	✓		✓									
TEWV-25-32	Jan	✓			✓								
TEWV-25-33	Jan	✓			✓								
TEWV-25-34	Jan	✓		✓									
TEWV-25-35	Jan	✓				✓							
TEWV-25-36	Jan	✓				✓							

Cases by Primary Theme

Case Number	Start Month	Open	Closed	Patient Safety/Qlty	Management Issue	System / Process	Bullying / Harassment	Discrimination / Inequality	Behaviour / Relationship	Worker Safety	Other	Sexual Misconduct	Other Detail
TEWV-25-37	Jan	✓				✓							
TEWV-25-38	Jan	✓				✓							
TEWV-25-39	Jan	✓				✓							
Totals		24	15	8	9	12	5	1	4				

Multi-theme Occurences





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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th February 2026**
Title:	**Quarterly Report of the Guardian of Safe Working Hours for Postgraduate Doctors**
Executive Sponsor(s):	**Dr Kedar Kale**
Author:	**Dr Sharon Beattie, Guardian of Safe Working**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

Purpose:

This report aims to provide assurance that 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 Q3 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 (4/15) and South (5/25) care groups. Most delays were due to additional information being needed to process these.

- All fines have been levied due to breach of the 5 hours overnight rest requirement on NROC rotas. There was 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 but such reports wouldn't result in fines unless rest requirements were not met.

- 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 15 exception reports in Q2, which is similar to the numbers from Q3 (17) and Q4 (17) from the previous year and Q2 (20) of this year. Q1 from this year remains an outlier with only 4 exception reports. Seven of the exceptions were due to breach of rest requirements or claiming additional NROC hours on the middle tier rota (an increase from last quarter when it was only 2). Eight exceptions were from different doctors staying late due to level of workload. None of these raised a concern about a pattern in a specific department.

- In the South Care Group there were 25 exception reports which is similar to Q2 (24) of this year and Q2 (39) and Q3 (20) of the previous year. It is an increase from Q1 (11) of this year and Q4 (7) of the previous year. Similar to Q2 of this year there has been a shift with a higher proportion of these exceptions being educational exceptions (14) related to the change in the tier 1 rota and missing psychotherapy/teaching. There were 18 educational exceptions 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, 1 for additional hours related to NROC and 8 due to not receiving 5 hours continuous rest on the NROC roster.

- 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 thirteen of the fines this quarter have been levied for breach of the requirement for 5 hours of continuous overnight rest on NROC rotas. Six of the fines were from the North Care Group and seven of the fines were from the South Care Group. One of the fines related to this quarter (from the North Care Group) was from a breach in Q2 which hadn't been processed in that 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. Two of the 1st tier doctors have exceeded 56 weekly hours through picking up 1st tier resident shifts. I have spoken to medical staffing who will monitor the shifts picked up by these doctors to keep these within safe working hours. For some of the second tier doctors the locums increases the weekly hour worked substantially, however 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 may 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): 137

Number of doctors / dentists in training on 2016 TCS (total): 137

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	1	1	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2/GP - Teesside & Forensic Services	0	1	1	0
CT1-2/GP –North Durham	0	3	3	0
CT1-2/GP – South Durham	0	0	0	0
CT3 – Teesside & Forensic Services	0	1	1	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 – Teesside & Forensic Services Seniors	0	3	3	0
ST4-6 –North & South Durham Seniors	0	5	5	0
Trust Doctors - Teesside	0	1	1	0
Trust Doctors - North	0	0	0	0

Durham				
Trust Doctors - South Durham	0	0	0	0
Total	**0**	**15**	**15**	**0**

Exception reports were due to:

- *F2 stayed late (first day) x1*
- *CT stayed late (due to work level or lone doctor on resident shift) x5*
- *ST didn't achieve 5 hours continuous rest/claiming additional NROC hours x7*
- *ST stayed late x1*
- *Trust doctor being lone doctor whilst on resident shift x1*

Exception reports by Rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services (F2/CT1-3/ GP/ trust doctor)	0	4	4	0
North Durham (F2/ CT1-3/GP/trust)	0	3	3	0
South Durham (F2/ CT1-3/GP/trust)	0	0	0	0
Teesside & Forensic Senior Registrars	0	3	3	0
South Durham Senior Registrars	0	2	2	0
North Durham Senior Registrars	0	2	2	0
DTV CYPS Senior Registrars	0	1	1	0
Total	**0**	**15**	**15**	**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	1	1	2	0
Teesside & Forensic Senior Registrars	1	1	1	0
North Durham Juniors	1	2	0	0
South Durham Juniors	0	0	0	0
South Durham	2	0	0	0

Senior Registrars				
North Durham Senior Registrars	0	2	1	0
Total	**5**	**6**	**4**	**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					
	CT1/2/GP	86	41		844.5	444.5
	CT3		7			45
	Trust Doctor		17			194.5
	Middle Tier (SR/SAS)	15	13		272	232
North Durham	F2					
	CT1/2/GP	29	15		314	147.5
	CT3		7			87.5
	Trust Doctor		6			66.5
	Middle Tier (SR/SAS)	9	5		184	96
South Durham	F2					
	CT1/2/GP	45	27		401	252.5

	CT3		4			50
	Trust Doctor		6			58
	Middle Tier (SR/SAS)	8	6		152	120
CAMHS	Middle Tier (SR/SAS)	20	20		384	384
Total		**212**	**174**		**2551.5**	**2178**

The discrepancies in the figures are due to:

- *On Teesside & Forensic rota, 19 shifts (152.5 hours) were taken by SAS doctors who don't have section 12.*
- *On Teesside & Forensic rota, 2 shifts (8 hours) were taken by SRs who acted down due to short notice sickness.*
- *On North Durham rota, 1 shift (12.5 hours) was taken by a SAS doctor who doesn't have section 12.*
- *On South Durham rota, 8 shifts (40.5 hours) were taken by SAS doctors who don't have section 12.*
- *On North Durham Middle Tier, 4 shifts (88 hours) were taken by SAS doctors.*
- *On South Durham Middle Tier, 2 shifts (32 hours) were taken by SAS doctors.*
- *On Teesside Middle Tier, 2 shifts (40 hours) were taken by SAS doctors.*

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	33	33		459.5	459.5
Sickness	48	38		494	411.5
Paternity/maternity leave	9	6		157.5	93.5
On call restrictions	45	35		483.5	391.5
Industrial Action	64	49		808	673
Special leave	10	10		120	120
Annual Leave	3	3		29	29
Total	**212**	**174**		**2551.5**	**2178**

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 (TD)	Teesside & Forensic	11	136.5	43.75	54.25	Y
B (TD) *	Teesside & Forensic	1	12.5	43.75	45.75	Y
	NYY	1	12.5			

C (TD)	North Durham	2	25	43.75	45.75	Y
D (TD)	South Durham	2	16.5	43.75	45	Y
E (TD)	Teesside & Forensic	2	25	43.75	46.75	Y
	South Durham	1	12.5			
F (TD) *	Teesside & Forensic	3	20.5	43.75	48.75	Y
	North Durham	4	41.5			
	South Durham	1	4			
G (TD)	South Durham	2	25	43.75	45.75	Y
H (CT)	North Durham	5	61.5	43.75	47	Y
I (CT)	Teesside & Forensic	3	37.5	43.75	52.25	Y
	South Durham	4	41.5			
	NYY	2	16.5			
	Scarborough	1	16			
J (CT)	North Durham	1	4	34	34.25	Y
K (CT)	Teesside & Forensic	2	16.5	43.75	45	Y
L (CT)	Teesside & Forensic	1	12.5	43.75	45.75	Y
	South Durham	1	12.5			
M (CT)	Teesside & Forensic	1	12.5	43.75	44.75	Y
N (CT)	Teesside & Forensic	1	4	43.75	48.25	Y
	South Durham	6	41			
	NYY	1	12.5			
O (CT)	Teesside & Forensic	9	104	43.75	63.5	Y
	South Durham	8	74.5			
	NYY	6	77			
P (CT)	North Durham	3	37.5	43.75	49.5	Y
	South Durham	3	37.5			
Q (CT)	Teesside & Forensic	15	162	43.75	65.75	Y
	North Durham	1	12.5			
	South Durham	4	50			
	NYY	5	62.5			

R (CT)	Teesside & Forensic	1	12.5	43.75	44.75	Y
S (CT)	Teesside & Forensic	5	20	43.75	47.25	Y
	South Durham	1	12.5			
	NYY	1	12.5			
T (CT)	North Durham	2	28.5	43.75	47.75	Y
	NYY	2	24.5			
U (CT)	North Durham	3	37.5	43.75	46.75	Y
V (CT)	South Durham	4	33	43.75	46.25	Y
W (CT)	North Durham	2	8	43.75	44.25	Y
X (CT)	Teesside & Forensic	1	12.5	43.75	47.75	Y
	North Durham	1	12.5			
	NYY	2	25			
Y (CT)	North Durham	1	12.5	43.75	44.75	Y
Z (CT)	Teesside & Forensic	2	25	43.75	45.75	Y
AA (CT)	Teesside & Forensic	2	8	43.75	44.25	Y
AB (CT)	NYY	5	62.5	43.75	48.75	Y
AC (CT)	Teesside & Forensic	5	62.5	43.75	50.25	Y
	North Durham	3	20.5			
AD (SR)	Teesside & Forensic	1	4	43.25	45.5	Y
	North CYPS MT	1	24			
AE (SR)	North Durham MT	4	72	32	72	Y
	South Durham MT	1	24			
	North CYPS MT	7	128			
	NYY MT	1	16			
	Scarborough MT	15	280			
AF (SR)	South Durham MT	1	16	32	33.25	Y
AG (SR)	Teesside MT	4	72	43.25	60	Y
	North CYPS MT	7	144			
AH (SR)	Teesside MT	1	16	43	48	Y
	Scarborough MT	2	32			

	South CYPS MT	1	16			
AI (SR)	North CYPS MT	5	88	42	48.75	Y
AJ (SR)	Teesside MT	3	56	43.25	68	Y
	South Durham MT	1	16			
	NYY MT	1	16			
	Scarborough MT	11	232			
AK (SR)	North Durham MT	1	24	43	46.75	Y
	South Durham MT	1	24			
AL (SR)	Scarborough MT	1	24	43	45	Y
AM (SR)	South Durham MT	2	40	43	46	Y
AN (SR) **	Teesside MT	4	72		8	Y
	Scarborough MT	2	32			
AO (SR)	Teesside & Forensic	1	4	43.25	43.5	Y

The discrepancies in the figures are due to:

- ** These doctors have since become specialty doctors*
- *** This doctor works for CNTW so regular working hours are unknown*
- *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	2	2	2	2	99.5
	GP	3 (ITP)	3 (ITP)	3 (ITP)	3 (ITP)	149.25
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	1	1	1	49.75

South 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	0	0	0	0	0
Total		**6**	**6**	**6**	**6**	**298.5**

The higher trainee (ST4-6) 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 GP vacancy in quarter 3.

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	1	£75.57
North Durham	3	£1755.14
South Durham	2	£320.80
Total	**6**	**£2151.51**

All breaches were for not receiving 5 hours continuous rest.

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 October to 31st December 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

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - Scarborough	0	1	1	0
F2 - York	0	1	1	0
CT1-3 / GP - Northallerton	0	0	0	0
CT1-3 / GP – Harrogate	0	4	4	0
CT1-3 / GP - Scarborough	0	2	2	0
CT1-3 / GP - York	0	11	11	0
ST4-6 - Northallerton	0	0	0	0
ST4-6 - Harrogate	0	1	1	0
ST4-6 - Scarborough	0	2	2	0
ST4-6 - York	0	2	2	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	1	1	0
Trust Doctors - York	0	0	0	0
Total	**0**	**25**	**25**	**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	16	16	0
Scarborough (F2/CT1-3/ GP/trust doctor)	0	4	4	0
NYY middle tier	0	3	3	0
Scarborough middle tier	0	2	2	0
South CYPS middle tier	0	0	0	0
Total	**0**	**25**	**25**	**0**

Exception reports were for:

- *F2 – did not receive 5 hours continuous rest during NROC x1*
- *F2 – stayed late after long days x1*
- *CT – unable to participate in psychotherapy/teaching due to long days x12*
- *CT – did not receive 5 hours continuous rest during NROC x2*
- *CT – Worked on zero hour day (CBT session) x2*
- *CT – Stayed late after long days x1*
- *Trust Doctor – claiming additional hours during NROC x1*
- *ST – Did not receive 5 hours continuous rest during NROC x5*

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
NYY Resident doctors	7	4	5	0
NYY Middle tier	1	2	0	0
Scarborough Resident doctors	2	2	0	0
Scarborough Middle tier	2	0	0	0
Total	**12**	**8**	**5**	**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					
	CT1/CT2/GP	87	19		855	214
	CT3		41			415.5

	Trust Doctor		10			73.5
	Middle Tier (SR/SAS)	14	7		244	108
Scarborough	F2					
	CT1/CT2/GP	21	9		311.5	130
	CT3		3			37.5
	Trust Doctor		9			144
	Middle Tier (SR/SAS)	83	42		1544	816
South CYPS Middle Tier	Middle Tier (SR/SAS)	57	57		1056	1056
Total		**262**	**197**		**4010.5**	**2994.5**

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

- *In NYY, 13 shifts were picked up by SAS doctors without S12 (127.5 hours) and 4 shifts picked up by middle tier (SR/SAS) acting down (24.5 hours)*
- *In NYY Middle Tier, 6 shifts were picked up by SAS doctors (120 hours) and 1 shift (16 hours) was picked up by a consultant choosing to work on the middle tier rota*
- *In Scarborough Middle Tier, 32 shifts (560 hours) were picked up by SAS doctors and 9 shifts (168 hours) were picked up by consultants choosing to work on the middle tier rota*

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	148	106		2589	1853
Sickness	72	55		894	690.5
OH restrictions	4	4		64	64
Special leave	2	1		28.5	12.5
Industrial action	36	31		435	374.5
Total	**262**	**197**		**4010.5**	**2994.5**

Locum work carried out by trainees						
Grade	**Rota**	**Number of shifts**	**Number of hours worked**	**Rostered weekly hours**	**Actual weekly hours**	**Opted out of WTR**
A (TD)	NYY	3	20.5	44.75	46.25	Y
B (TD)	NYY	6	40.5	44.75	47.75	Y
C (TD)	Scarborough	4	64	44	49	Y
D (TD)	Scarborough	3	48	44	47.75	Y

E (TD)	Scarborough	2	32	44	46.5	Y
F (CT)	Scarborough	4	53.5	44	48.25	Y
G (CT)	NYY	11	103.5	35.75	43.75	Y
H (CT)	NYY	12	123	44.75	54.25	Y
I (CT)	NYY	2	16.5	44.75	46	Y
J (CT)	Scarborough	4	60.5	44	48.75	Y
K (CT)	NYY	2	25	44.75	46.75	Y
L (CT)	NYY	1	4	44.75	45	Y
M (CT)	NYY	5	52.5	44.75	48.75	Y
N (CT)	NYY	3	12	44.75	48.5	Y
	Scarborough	3	37.5			
O (SR)**	South CYPS MT	12	232		18	Y
P (SR)	NYY MT	1	12.5	43	44	Y
Q (SR)	NYY	1	4	34.25	35.75	Y
	NYY MT	1	16			
R (SR)	Scarborough MT	8	152	43	56	Y
	Teesside MT	1	16			
S (SR)**	South CYPS MT	9	144		10.25	Y
T (SR)**	South CYPS MT	23	424		32.6	Y
U (SR)*	South CYPS MT	3	56		4.5	Y
V (SR)	NYY MT	4	60	34.25	39	Y
W (SR)**	NYY	1	4		0.25	Y
X (SR)**	Scarborough MT	3	64		5	Y
Y (SR)**	South CYPS MT	9	184		14.25	Y

The discrepancies in the figures are due to:

- *NYY And Scarborough shifts carried out by trainees working in the north care group have been included in the DTVF report*
- ** This doctor is no longer a trainee*
- ***These doctors work in a different trust*
- *All middle tier shifts and week days in Scarborough 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	0	0	0	0	0
Harrogate	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	1	1	1	1	49.75
	GP	0	0	0	0	0
Scarborough	F1	1	1	1	1	49.75
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	1	1	1	1	49.75
York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	4	4	4	4	199
	GP	1 (ITP)	1 (ITP)	1 (ITP)	1	49.75
Total		**8**	**8**	**8**	**8**	**398**

The higher trainee and ITP GP vacancies are due to there being more trainers than posts available, therefore some posts are classed as fallow. The only true vacancies are F1 and GP in Scarborough.

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	4	£1368.94
Harrogate, Northallerton & York	3	£1435.84
Total	**7**	**£2804.78**

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

Meeting of:	**Board of Directors**
Date:	**12 February 2026**
Title:	**Getting the basics right for resident doctors**
Executive Sponsor(s):	**Dr Kedar Kale**
Report Author(s):	**Dr Aqsa Ghazanfar; Bryan O'Leary** **Dr Hany El Sayeh**

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	
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**	Failure to ensure a good working environment for resident doctors will have an impact on the future recruitment of resident doctors into career grade roles in the Trust. This would subsequently correlate to high locum and agency costs and poor morale of those colleagues remaining who cover recruitment gaps

EXECUTIVE SUMMARY:

Purpose:

This paper has been written to provide assurance to the Trust Board that the organisation has considered the NHS England mandate that sets out clear expectations in the form of a ten-point plan to improve the working lives of resident doctors and this is progressing well.

Proposal:

A good level of assurance is being proposed based on the progress made since last Board report in October 2025.

Overview:

In early September 2025, NHS England wrote to all NHS Trusts setting out a ten-point plan to improve resident doctors' working lives and to fix unacceptable working practices to help ensure that organisations got the basics right for resident doctors. The Medical Education Leadership team (MELT) is responsible for tracking progress against the 10-point plan. The

newly appointed Resident Doctor Peer Lead, Dr Aqsa Ghazanfar will update the Board on a regular basis.

Following the introduction of the 10-point plan in 2025, all trusts have now responded to an initial survey and a follow-up survey, the latter completed in December 2025. This report is an update on the progress, highlights current areas undergoing change and those that are outside the trust's scope of influence.

The improvements since the last board update include:

1) Appointment of a Resident Doctor Peer Lead: This was done following an interview process, led by Senior Medical Management, and various grades of resident doctors.

2) Improvements in facilities include provision of lockers at all trust sites, provision of food onsite in most areas with the remainder pending discussions with local reps to preference their choices.

Work in progress includes:

1) Development of an annual leave policy is underway and may take some time as this would need agreement from local deaneries since we expect to have a policy which allows residents to request leave for the future, when their placement may be within another trust, but this pre-agreed leave would be respected. A few neighbouring trusts are draughting their policies and one such trust's peer lead has shared this with us, which may help in getting approval if all local trusts were to have a similar policy, especially in areas covered by LET.

2) Work is underway to reduce the amount of mandatory training, wherever possible, and the trust is accepting training from accredited sources/ providers.

3) For Exception reporting, the Trust is now providing webinars to understand this process, alongside incorporating this into induction. There is additional policy change expected in this area from February, on a national level, and we are therefore likely to see this area of compliance fluctuate.

Areas we may show as noncompliant in but not within the Trust's remit:

1) Study leave approvals and reimbursement remains in issue only in the NYY care group. For trainees employed by the YH Deanery- Study leave is either not approved or reimbursement of course fees is done sometime after attendance at the courses. The YH Deanery is aware of this and there is a plan by the RD Peer lead to make the regional Dean aware of this.

2) Reducing the impact of rotations isn't always within the Trust's remit. Difficulties are reported in the YH Deanery, especially by higher trainees, who are only being given 6 monthly placements, which can make planning ahead both in terms of personal and professional lives difficult.

3) With both the Deanery and the Trust covering a large area, this can have an impact on both wellbeing and long-term career progression. This has been escalated to the Head of School (their response attached in #9 in the detailed 10-point plan progress report), and the Resident Doctor Peer Lead will also be raising this with the regional Dean.

To summarise, we are largely compliant with most of the 10 points. Most of the noncompliance is in areas not directly within our control and influenced by the Deaneries locally. We have escalated these issues with the Deanery and NHSE.

For further details of the plan and actions see appendix.

Prior Consideration and Feedback:

The Faculty of Medical Education meet with resident doctor representatives on a regular basis. The group review the plan and agree a position of compliance and outline further actions for improvement. (Appendix)

Implications:

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

Recommendations:

The Trust Board is to note the progress made thus far since October 2025 and confirm good level of assurance.

Appendix: Summary of 10 Point Plan

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Ten Point Plan		Current positions Trust position / LET / NHSE	Status ✓/✗ Partial	Supporting documentation	Actions including lead	Progress
1.	**Improve workplace wellbeing for our resident doctors** Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so trusts can adapt implementation to reflect local needs and operational realities in these and other areas:	The Trust has developed a strong Faculty of Medical Education to oversee the delivery of both undergraduate and postgraduate placements and has created its own standard operating framework for GMC compliance. The faculty monitor compliance and satisfaction through the annual GMC survey, forums, feedback at organised clinics, end of placement job review forms and the annual internal audit event. In 2025, the Trust was ranked 6th best placement provider for overall satisfaction in the whole UK by resident doctors in the GMC Survey. The Trust has quarterly Postgraduate Forums during the year where junior doctors representatives attend and provide updates on their placements. The Forum receives an update on wellbeing as a standing agenda item and the group discuss issues affecting resident doctors working and rest environments. In attendance at the forum is the Director of Medical Education (DME), Guardian of Safe Working, Training Programme Director, representatives from the Faculty of Medical Education and colleagues from medical development. In addition, there are bi-monthly meetings held with junior doctor representatives and the Medical Staffing Manager to pick up more local matters associated with placements. During the past year five task and finish groups (Race / IMG, Disability, Gender, LGBTQ+ and Religious Practice) have been created with regular meetings taking place to formulate plans to address any negative feedback / outliers received from both internal and external quality visits and surveys. The Medical Education Leadership	Status disc for next Forum	 Medical Education Annual Board Report  Medical Education Annual Board Report  Task Finish Focus Group Actions - 202	Medical Education Board Report to be written and submitted in November 2025. Lead: Head of Medical Education	**Action Complete** The board report has been written and shared. Reports have been attached.

		Team (MELT) continues to work closely with the Trust Strategic Lead for Equality, Diversity, Inclusion (EDI) and Engagement and the Director of People and Culture.				
		Whilst the Trust provides ongoing assurance to relevant governing bodies, the Faculty identified that findings and actions from external quality visits did not always align to the internal feedback collected from resident doctor clinics, end of placements review meetings and Trust rankings in the GMC Trainee survey and so implemented its own internal audit framework to enhance the quality monitoring systems and receive genuine feedback first hand. These events now run annually with colleagues from one Care Group visiting the other to undertake an assessment and are a source of rich feedback, from which actions are set. This was described as exemplar at the Quality Management Visit.		 TEWV Internal Educational Audit F		
		The Faculty has developed a buddy support system to ensure that early year Registrars, Trust Doctors, Foundation Doctors and GP Registrars feel appropriately supported. It helps rotating doctors to understand the systems in place and points of contact.		 August 2025 - Buddy allocations.d	Dr Jordan Williams outlined a SOP used by the Yorkshire and Humber School of Psychiatry to offer support to SpR's. MELT agreed to consider using a system like this or lobby the School of Psychiatry. Lead: Director of Medical Education	**Action Complete** Dr Jordan Williams has sent Bryan O'Leary the SOP and this will be shared with MELT on Friday 16th January 2026.
		The faculty has a well-established Resident Doctor Wellbeing Team which is accessible to all doctors and physician associates within the Trust. The Wellbeing Team includes the Associate Director of Medical Development, Nurse Specialist, a doctor and physician associate representatives. The team follow guidance from the GMC, HEE and BMA around wellbeing initiatives, work closely with the Trust wide Health and Wellbeing Team to share new initiatives and training to		 Clinical Teams - Wellbeing Poster DRA  Health & Wellbeing Support Booklet - DR		

		improve staff wellbeing, and focus on changes which can be made to facilities within the Trust to improve wellbeing. They also arrange Annual Wellbeing Away Days open to all doctors and physician associates in the Trust.			
		The Faculty has recently introduced VASCO. This initiative is essentially access to middle tier and consultant level advice out of hours. It is proactive support by providing Vertical Advice and Support for Colleagues On-call.	 VASCO Guidance - September 2023.pdf	Audit the effectiveness and feedback from the lengthened conversation in August 2025. Lead: MELT	**Action ongoing** A protocol has been developed and this will be getting shared with MELT on Friday 16th January 2026
		At the start of each OOH shift, a senior doctor makes contact with the resident doctor to 'check in' and discuss likely complex cases. Colleagues are also encouraged to have a lengthened conversation when it is the resident doctors first OOH shift in psychiatry (Aug 25') and are reminded by medical staffing when this is the case.			
		In 2025, MELT developed a Charter for resident doctor in TEWV. Some of those measures relate directly with improving the wellbeing and working environment and include: • Effective and tailored individuals work schedules. • Paid opportunities available to shadow colleagues out of hours before undertaking the first shift • Access and use of a personal laptop and mobile phone within two weeks of starting. • Opportunities to receive face-to-face or virtual coaching sessions with qualified coaches. • Access to free Royal College CPD learning and BAP modules. • Access to free, high quality internal CPD and professional development, including modules that	 Resident Doctor Charter v3 - October	The Faculty plan to survey resident doctors in 2026 to understand if it meets the standards outlined. Lead: Head of Medical Education	**Action Ongoing** Hayley to plan to survey the resident doctors in late February 2026

		complement the weekly teaching programme and MRCPsych. • Access to senior advice out of hours and proactive support through VASCO at the start of each shift. • Support from resident doctor representatives in each rota area with additional support from a Dignity at Work Champion and Wellbeing representatives, both roles being developed by the Trust. • Support to take a zero-tolerance stance on issues of any kind in relation to discrimination. • Opportunity to attend face to face wellbeing symposia focussed on doctors in training, developed by reps.				
	Where possible, [provide designated on-call parking spaces]	No designated spaces are granted on Trust sites. However, it has been agreed that resident doctors can park in designated disabled spaces whilst on-call. This is shared with doctors at induction.			Check with resident doctors that this approach is acceptable. Make this more prominent in the induction information so that it is understood by all. Lead: Medical Staffing Manager	**Action complete** A slide regarding car parking spaces has been added in the induction booklet.
	The autonomy to complete portfolio and self-directed learning from an appropriate location for them	Every doctor has an individualised laptop and has access to a workspace they can use.				
	Access to mess facilities, rest areas and lockers in all hospitals, including new builds	Every doctor has access to a junior doctor room on each main site. The Trust has rest rooms and facilities at each main hospital site and lockers are available as below: RPH – yes WPH – no lockers but metal draws are available LRH – no lockers available FPH – yes CLH – yes				**Action ongoing** Lockers for LRH have been ordered. Awaiting feedback from reps regarding the safety of using lockers at FPH

		At FPH the lockers have codes on and don't require keys. The reps will have a look at FPH to ensure the use of lockers are safe to use.				
	A 24/7 out-of-hours menu offering hot meals and cold snacks for staff	There are no cafeterias that operate out of hours on Trust sites. However, we have worked with local resident doctors to determine a choice of free ready meals and snack. This includes microwave hot meals, pot noodles, porridge, soup, as well as savoury snacks and biscuits. There is access to hot water and microwave on all sites. NHSE Y&H have confirmed that there is no strict definition about what and how these are provided. The key is for Trusts to have resident doctor reps involved in discussions and action plans to look at the art of the possible (as part of the wellbeing discussions in general) The result may well be a vending machine / microwave.		Standing agenda item at rep meeting with medical staffing manager. Lead: Medical Staffing Manager	Issues with lack of provisions raised at the rep meeting on 7/11 and these have been escalated to Catering. They confirmed that the trust is changing suppliers hence the delay. **Action complete** NHS England has confirmed that as long as the food can be heated in a microwave, it can be considered hot food.
	Within the next 12 weeks every trust should: Conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plans must be approved by the trust's people committee or equivalent body. Trusts will be expected to provide updates for national reporting on progress.	An annual survey will be created to understand the quality and facilities provided by the Trust. The group also discussed the BMA Fatigue and Facilities charter and this will be shared with the working group.	Resident Doctors Survey 12.11.2025.do	It was agreed to set up a working group to design a survey that will be shared amongst doctors. This will include the standards of the ten-point plan and more aspirational standards to consider. Members include Dr Heba Saeed, Dr Aqsa Ghazanfar, Dr Sharon Kwagiri and Dr Oluwadara Akintunde. Lead: Chair of Working Group	**Action ongoing** Survey has been completed circulated an action plan will be shared with the group w/c 30th March 2026.

		A discussion was held to consider how progress against the plan could be reported back to the Trust and whether it was more appropriate for the Medical Education Committee or People and Culture Group to oversee, and this will be discussed further with colleagues in the Trust. To consider response from estates around installation of A/C unit in the Resident Dr Room at FPH. This was requested following feedback received from resident doctors around the temperature in the room (gets very hot during the summer months). Following request from medical staffing, estates confirmed that the trust no longer installs A/C in offices due to the cost incurred with running and maintaining them.				
2.	**Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice (COP)** **From now,** and for all rotations going forward NHS England must provide at least 90% of trainee information to trusts 12 weeks prior to rotations commencing. **From now,** Trusts must use this information to ensure that resident doctors receive their work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are not met corrective action must be taken. Performance data must be submitted	This is delivered by the Lead Employer Trust (LET) for colleagues in DTV Care Group • The LET maintains establishment reports of training placements and notifies each Lead Employer Placement (LEP) of expected trainees 12 weeks in advance of the rotational start date to comply with COP • The LET works to ensure compliance with COP by ensuring Work Schedules are issued to the trainee 8 weeks prior to commencement of an individual trainee's work schedule. • Overall, NE compliance rate with COP typically exceeds 90% with regards to the LET notifying the Lead Employer Trust (LEP)12 weeks in advance. • Some non-compliance is not locally driven, and the result of nationally implemented recruitment timelines. The Medical Staffing team is responsible for issuing work schedules to resident doctors in NYY Care Group.				**Action ongoing** Delays in receiving the Core Trainee

	by trusts, and NHS England will monitor and report on national compliance across all stages of the process **Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing** It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery. **Within 12 weeks, NHS England will:** conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts.	Overall compliance with COP (August 2025 rotation): • 100% compliance as rotas were compiled and distributed providing the required 6 week notice (it was noted that the NYY resident doctor rota had to be amended in Aug 25' and some changes made to Work Schedules. • 95% compliance with issuing all work schedules with 8 weeks' notice. The delay of the remaining work schedules was caused as we waited confirmation of non-work days of LTFT resident doctors. • Compliance with the COP will be monitored via the Resident Doctor Forums and data will be presented in future forums.				Rotational Information for February 2026 from Yorkshire & Humber. Information has been chased with the deanery and the TPD but the 12 week deadline has not been met
3.	**Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing** It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery.	As a Mental Health Trust, it is important to differentiate between resident doctors who remain on placement within the organisation (core and higher training) and resident doctors who rotate and join the organisation for a fixed period of time (FP and GP). The Trust still finds some Foundation doctors seek pre-approval for annual leave whilst in a previous placement. It can also find that the distribution of leave is not consistent so this can negatively impact on the amount of			Consider whether a formal policy for annual leave is required for resident doctors. Action: Medical Staffing Manager	

	Within 12 weeks, NHS England will: conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts. **All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board** Within 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board. **In Sept 2025, NHS England will:** publish a national role specification for the board lead. The senior lead will formally take on this responsibility within an existing role, supported by a national role specification to be published by NHS England in September. The resident doctor lead will act as a peer representative and enable trust boards to hear directly from resident	time on leave when on placement in the MH Trust. This is a matter discussed with the Foundation School. Annual leave is discussed and agreed within the service and where possible leave requested is agreed, whilst ensuring that patient care is maintained. A minimum of six weeks' notice is generally provided by the resident doctors. Following a discussion, it was agreed that resident doctors should be able to seek approval for annual leave out with their current rota cycle as this would support 'life planning'. Additionally, annual leave requests should consider how the medical role impacts staff differently across the various tiers of medical cover and not solely granting approval for the resident doctor. Before the rotas are compiled, resident doctors are asked by the medical staffing team to indicate specific dates (using MS Forms) to be avoided for on-call purposes. This system, where residents give notice of dates they wish to avoid, helps to create a fair and more balanced rota for resident doctors and it is appreciated. The medical staffing team are currently considering an e-rostering solution that could allow doctors to indicate the dates to be avoided and ensure a fair and transparent scheduling process for all.			Once approval is granted a confirmation letter will be sent by Medical Staffing and they will take this into consideration when planning rota cycles. Lead: Associate Director of Medical Development Medical managers will be asked to consider a process to capture this. Action: Director of Medical Education Medical Staffing Manager to oversee and report back when pilot rota site agreed. Rostering, Facilities & Fatigue Policy to be updated Lead: Medical Staffing Manager	**Action ongoing** Teesside Resident Doctor Rota to pilot DRS E Rostering solution from Feb to Aug 2026

	doctors themselves. They should be invited to attend board level discussions on issues which specifically relate to improving doctors' working lives. Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses					
4.	**All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board** Within 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board. **In Sept 2025, NHS England will:** publish a national role specification for the board lead. The senior lead will formally take on this responsibility within an existing role, supported by a national role	Dr Kedar Kale, Executive Medical Director is appointed as the Board Lead. Dr Hany El Sayeh and Bryan O'Leary are appointed as the Senior Leaders. During the meeting held 23/09/25, the process to appoint a peer representative from the resident doctor body was discussed and agreed. It was agreed that Bryan O'Leary would send communication to resident doctors about the appointment process and ask for expressions of interest to form a panel, made up of resident doctors and a member of MELT. This group would shortlist, interview and appoint a representative.			The Trust will seek to understand the national profiles and consider as necessary. Lead: Associate Director of Medical Development A letter was sent 24/09/25 Lead: Associate Director of Medical Development	Raised at the SpR Forum 25/09/25

	specification to be published by NHS England in September. The resident doctor lead will act as a peer representative and enable trust boards to hear directly from resident doctors themselves. They should be invited to attend board level discussions on issues which specifically relate to improving doctors' working lives. Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses **Resident doctors should never experience payroll errors due to rotations**	It was also agreed that the application to apply for this role would be open for all resident doctors, mindful that colleagues with more experience and at the end of core training or in higher training would and in representative roles would be more likely to succeed in this role. The faculty produce a Medical Education Annual Board Report that outlines performance over the last year, challenges and risk and this provides assurance of placement activity.		Provided in Point 1	Closing date 10/10/25 Lead: Associate Director of Medical Development To be tabled November 2025 Lead: MELT	
5.	Following a successful pilot that has reduced errors by half, we are extending the learning from this work to all NHS trusts. **Within the next 12 weeks, every trust should:** Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All	This is delivered as part of existing Lead Employer arrangement for resident doctors in DTV Care Group: With effect from 1/5/2025, the LET's Payroll Service is outsourced to NHS Payroll Services (provided by Northumbria NHS Foundation Trust) and is managed through an SLA by the LET. This element of the LET contract specification remains outsourced meaning that, irrespective of any change to the host organisation in the future, the LET continues to			The Trust Financial Controller has been approached to be the finance lead that oversees payroll matters	

	organisations are required to establish a board-level governance framework to monitor and report payroll accuracy and begin national reporting as required.	liaise with NHS Payroll Services to ensure onward delivery of these services. The LET continues to work with LEPs to ensure timely and accurate work schedules are received and the decision to outsource was to ensure a robust and consistent delivery of payroll services could be achieved as being part of a large payroll-specific team of experts. Performance standards are agreed by the LET and NHS Payroll Services along with specific KPIs the Payroll Services are performance managed against. These are in areas including accuracy and timeliness of payments (salary and approved expenses), overpayments, correspondence response times and meeting statutory deadlines. In terms of the resident doctors employed by TEWV, we work closely with payroll in order to ensure that any payroll errors are minimised and we have agreed that going forward a quarterly report will be produced and presented to LNC and the Resident Doctor Forums that would detail any issues in relation to accuracy and timeliness of payments as well as any errors resulting in overpayments or underpayments.				**Action ongoing** Finance will be sharing a payroll error report on a quarterly basis.
6.	**No resident doctor will unnecessarily repeat statutory and mandatory training** **Within the next 12 weeks if they are not already doing so, every trust should:** Comply with agreements set out in the MoU signed by all trusts in	This is delivered as part of existing Lead Employer arrangements for resident doctors in DTV Care Group: The LET oversees compliance of Statutory and Mandatory training (via ESR). Given the LET model, this irradicates duplication of training as all employees managed as per annual cycle of requirements only irrespective of rotations.				

	May 2025 by ensuring acceptance of prior training. **By April 2026, NHS England will:** reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England. **Within the next 12 weeks if they are not already doing so, every trust should:** Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of prior training. **By April 2026, NHS England will:** reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England. **Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours**	As part of the MOU, the Trust accept prior learning from all Core Skills Training Framework except Safeguarding. (The Trust will accept Safeguarding if the individual has completed both adult and children at the same level as TEWV deliver it combined and the CSTF has it separate). The Trust only accepts these from another NHS Organisation as per the MOU. Currently, resident doctors undertaking locum shifts are required to complete outstanding mandatory and statutory training prior to booking a shift - even if similar training has been completed under another organisation. This is because the locum bank is a separate employment contract with the Trust. TEWV accept prior learning for other National e-learning programmes: • Patient Safety Level 1 and 2 • Speak Up • Listen Up • Follow Up • Mental Capacity Act modules TEWV adheres to the People Policy Framework for Mandatory Learning agreed on 1 May 2025. The Workforce Development Lead is part of the national group and TEWV are with all Trust working towards the end goal. The TEWV document is not yet finalised, but it will go to the next Governance Oversight Group identified in the policy for agreement		 Mandatory Training Needs Analysis (Inc I	The Medical Staffing Manager will meet with colleagues in the Trust to understand whether we can make this simpler. Lead: Medical Staffing Manager	
7.	A new national Framework Agreement for Exception Reporting	Awaiting roll-out of new national Framework Agreement for Exception Reporting (agreed March 2025).				

	was agreed on 31 March 2025 and will be rolled out for implementation in due course. The changes agreed simplify the reporting process for resident doctors, ensure they are being fairly compensated for the additional hours they are required to work, and will support the safety of their working hours. We are committed to implementing these reforms as soon as practicable.	The LET is a key player given the new approach within the Framework which indicates Trainees will be obliged to submit Exception Reports to the Employer. TEWV has recently upgraded to DRS5 as exception reporting platform and in preparation for the roll-out of the national framework agreement. The Trust provides written guidance and a step by step guide on how to submit exception reports as well as an overview of the system at each Resident Doctor Induction. We ensure that all exception reports are responded to in a timely manner and all data are presented in the Resident Doctor Forums as well as the Quarterly Guardian Reports. Exception reporting was highlighted at the Trust Annual Audit event. It was agreed that there would be an additional session put on by medical staffing to practically illustrate how to use the system.			In place for December 2025. Lead: Medical Staffing Manager	Exception Reporting Reform implementation February 2025 Action complete
8.	**Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims** We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a resident doctor has attended a course/activity, to one where reimbursement is provided as	This is delivered as part of existing Lead Employer arrangement for resident doctors in DTV Care Group : Specifically for Study Leave, the LET already has a long-standing process to ensure early re-imbursement of approved activity for trainees opting to apply this way (i.e. approved Study Leave costs can be submitted for re-		 Guidance for early reimbursement.pdf	NHSE Y&H have confirmed that from Wednesday 8th October all approved study leave activity taking place on or after this date will be eligible for early reimbursement for which an	

	soon as possible after the expense is incurred. **Within the next 12 weeks every trust should:** Review their current processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsistence. **We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery** A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority. **Within 12 weeks, NHS England will:** develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.	imbursement at the time of booking rather than after the event). During the meeting, resident doctors raised concerns that they are unable to book study or training in NYY Care Group due to stricter course booking processed by the School of Psychiatry. This creates a system within the Trust that is inequitable, unfair and inconsistent. For resident doctors in NYY • Trainees submit their study leave on Accent (electronic study leave system), including expected expenses for approval as normal • Once the trainee has attended the training, they then have to submit a TEWV expenses form to us for approval (see attached) along with any receipts. • The medical Development team then check the claim form against Accent to check the study leave / expenses were approved • If matches the expenses form is signed off, added to our monitoring spreadsheet and then sent to finance for payment • Expenses are signed off on Accent as approved / claimed (this is what has replaced the old "returns" system we used to have so HEYH know what has been claimed back by the trainee)		NHSE North East local Study Leave Po NHSE YH Study Leave Guidance.doc	expenses receipt can be provided are eligible, except for mileage and subsistence. TEWV Medical Education team are aware of the updated process introduced to support resident doctors This is a longstanding issue and had been raised with the Dean. The DME will again highlight this disparity and provide challenge on behalf of the doctors, using this framework. Lead: Director of Medical Education	

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

10.	**We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model**	This is not a matter for the Trust. This is a matter for NHS England to work with partners.				

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 12 February 2026		
Date of last meeting: 22 December 2025		**Report from the Quality Assurance Committee (quoracy met)**
		Related Board Assurance Framework (BAF) Risks: **1: Safe staffing** **4: Quality of Care** **8: Quality Governance** **10: Regulatory Compliance** **14. Health inequalities**
1	**Agenda -** The Committee considered the following matters: • Minutes of meeting held on 27 November 2025 • Board Assurance Framework • Corporate Risk Register • Summary of the Executive Review of Quality Group meeting, held on 25 November 2025 • Quality Governance Reports: highlights from the Quality Dashboard and the Quality Assurance Risks CQC Activity and delivery of the Oversight Improvement actions Quality Assurance and NICE guidance Implementation • Quality Priorities • Waiting Times • Learning from Deaths • Positive and Safe • Community Transformation • Organisational Learning Group • Compliance with Clinical Supervision • Quality Impact of Services requiring additional support • Section 17 leave and time away from the ward • Safeguarding • Infection, Prevention and Control • Research and Development Annual Report • Committee Workplan - noted	
2a	**Alert**	The Committee alerts the Board on the following matters: From the matters discussed at the Executive Director's Group meeting on 25 November 2025, the key alerts are: • The previously reported unexpected inpatient death: Board of Directors were notified, three people in long term segregation, one of whom has been re-patriated back to his home area. • EPR data quality issues continue. Improvement actions are in place. • There is *reasonable assurance* of the quality of care in the care groups, based on the Integrated Performance Dashboard, Quality Dashboard, reports and data provided by services and corporate colleagues. However, there is currently *limited assurance* of the impact of improvement actions in some services. • There has been an incident where the search policy was not properly adhered. S Dexter-Smith attended Committee to talk through the limited assurance on the ability to report consistent levels of supervision being reported and the ongoing work across all services to address concerns. A small oversight group is monitoring the implementation

		of the audit actions. Manual reporting of supervision until TEWVision is fully embedded provides a degree of assurance.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **Board Assurance Framework:** There is good assurance that the relative strategic risks in the BAF aligned to the Committee were being managed appropriately following review of the risks assigned to Committee (as at Quarter 2, 2025/26) and it is proposed that BAF risk 4 and 8 should be considered for closure with the Board review of BAF risks. **Corporate Risk Register:** Good assurance is confirmed relating to the oversight and management of the organisation's corporate risks (as at 1 December 2025) and reasonable assurance relating to the management of the 11 risks in the register. **Quality Governance Reports** From Quality Governance, a triple A report now provides members with the specific matters from across a suite of papers including: a. Quality Governance Summary (including the Quality Dashboard Report, and Quality Assurance Risks). b. CQC Activity and Integrated Oversight Plan where there is one overdue action with the searching of patients' policy being finalised. ➢ Good assurance is confirmed relating to the systems and processes for oversight, monitoring and progress with the Integrated Oversight Plan. c. Quality Assurance Improvement Programme and NICE Guidance Implementation quarterly report. ➢ Good assurance is confirmed relating to the operational and strategic oversight of quality assurance and clinical effectiveness activities. There are no new gaps in assurance or mitigating actions escalated. **Learning from Deaths** The dashboard and points from learning from deaths gives good assurance of the required reporting and learning in line with national guidance. During Q2 there were 508 deaths reported on Inpase of patients who had been in contact with services in the six months preceding the data of death (309 were open to a Trust service at their time of death). Figures include natural expected and unexpected /unnatural deaths. **Positive and Safe** Good assurance is confirmed for the period July to September 2025 (Quarter 2) through progress demonstrated with the implementation of the Positive and Safe strategy. There continues to be high level use of high frequency/low duration seclusion, with one specific person in ALD services, which results in TEWV being a national outlier. If the data for the single person (who is in control of their seclusion, it is self-imposed) was removed from the data, TEWV would be reporting a very low use of seclusion against the nationally reported data. There is good assurance from the outputs of the three **Organisational Learning Group** meetings held between September and November 2025. Since the group had been established for two years now there is an opportunity to review the impact of the themes of learning. For those teams who require additional support, good assurance is confirmed on the care group board governance and oversight, however limited assurance relating to the overall quality of care and patient experience. There is vigilant oversight of the position and triangulation of information across teams from performance, outcomes, waiting times, freedom to speak up and complaints.

		Section 17 leave: Good assurance is confirmed on the oversight and monitoring of quality assurance schedule results, demonstrating a sustained improvement in compliance with S 17 leave safety planning with improvement plans being managed by Assoc. Directors of Nursing to monitor monthly trends and ensure recovery is sustained. **Safeguarding:** There is good assurance relating to the six-monthly position for safeguarding activity that demonstrates that we are proactively applying safeguarding across services. **Infection, Prevention and Control:** There is good assurance relating to the six-monthly position demonstrated through the proactive management of infection incidents with full alignment of all policies and procedures in line with national guidance. **Research and Development:** The annual report was received for information, which gives good assurance on the positive developments in research and development for 2024/25. **Quality Priorities 2025/26** were received with good assurance on progress so far on delivery of the priorities and there was a request that future reports focus more on impact.
	Advise	The Committee wishes to advise the Board on the following matters: At the December 2025 meeting it was recognised that there is hesitancy amongst staff to take up the flu vaccination (43%), however the 5% increased uptake is not far off. Robust assurance was described on the monitoring of restrictive interventions, which includes the monthly positive and safe meeting, individual review of RI's to ensure they are clinically appropriate, benchmarking and on occasion independent review. The recording of local resolution complaints has reverted to the complaints team to be managed centrally to ensure consistency of logging complaints and outcomes. **Waiting Times** A report describing the position for patients waiting for an assessment in core services within Adult Mental Health, Mental Health Services for Older People, Children and Young People's Services and Adult Learning Disabilities gives good assurance linked to the oversight and management of waiting times to access services, however, there is limited assurance and sustained challenges with timely access to both Adults and Children's Neurodevelopmental Assessments, the actions being taken to address and mitigate any gaps in service and further actions being developed in support of quality improvement. Actions are underway within specialties to improve the oversight and management of waiting times and the impacts on quality and experience that include, improved reporting, resolving data quality issues and patient tracker lists. **Community Transformation** Progress over the last six months demonstrates there is reasonable assurance that the impact of community transformation is positive for patients, colleagues and partners across the system. Challenges remain linked to funding uncertainty, however there is strong integration and partnership working, strong governance and shared learning. Next steps are being worked through, which include expanding hub models already commissioned in NYYS.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that the risks to quality are understood and are being managed appropriately.

3	**Actions to be considered by the Board**	*i) that the report be noted, confirming there is good assurance with regards to the governance, oversight and management of risks to quality of care and that the areas of reasonable and limited assurance are understood.*
4	**Report compiled by**	Jules Preston, Acting Chair of the Quality Assurance Committee, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manager

Committee Key Issues Report		
Report Date to Board of Directors – 12 February 2026		
Date of last meeting: 05 February 2026	**Report from the Quality Assurance Committee (quoracy met)**	
1	**Agenda -** The Committee considered the following matters: • Minutes of meeting held on 22 December 2025 • Board Assurance Framework (summary) • Corporate Risk Register • Summary of the Executive Review of Quality Group meetings, held on 23 December 2025 and 27 January 2026. • Triple A Quality Governance Report covering: CQC Activity and Integrated Oversight Plan Quality Assurance Dashboard Quality Risks QAI Programme • Environmental Risk Group Annual Report • Verbal position statement on implementation of Lio (Oxehealth) • Rehabilitation Services • Quality and Performance of Specialist Services • Responding to National Guidance (Oct 2025) on identifying restrictive practice • Compliance with Duty of Candour • Physical Health • Patient Flow across AMH Acute Wards • Safe Staffing • Complaints and Patient Experience • Activity associated with the Patient Carer Race Equality Framework (PCREF) • Committee Workplan - noted	
2a	**Alert**	The Committee alerts the Board on the following matters: **Reports of the Executive Directors Group, 23 December 2025 and 27 January 2026.** Good assurance is confirmed on the review, monitoring and oversight of the provision of quality care, noting there is limited assurance relating to the impact of improvement actions in some services. Steps are being taken to focus on those teams requiring additional support, to look at what can be done differently with EDG having robust oversight of the impact of improvement actions. From the matters discussed, the key alerts are: • Waiting times in community services in Harrogate and Ripon. Impact of the improvement plans are being monitored carefully by EDG. • The service level agreement (SLA) with Co Durham for a gastroenterologist to support people on Birch Ward has fallen through. Other options are being considered. • Compliance with the required follow-up of people who are treated with rapid tranquilisation has seen an in-month deterioration which has led to closer oversight.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: There are lots of positive achievements, evidence of learning and good practice reported into Committee from various reports/ the EDG meetings, particularly the quality reports from the care groups. Committee welcomes the balance of matters of exception and escalation with the positive work being carried out every day by staff. **Board Assurance Framework:** There is good assurance that the

		Regarding progress on managing the BAF risks (as at Quarter 3, 2025/26): (1) The present scores of the following risks have been reduced in year and achieved target: BAF 4 (Quality of Care) BAF 8 (Quality Governance). BAF risk 4: Quality of Care: The overall indicative controls assurance rating has increased from 75% (good) to 85% (substantial). BAF risk 8: Quality Governance: The assurance rating for the control "Executive and Operational Organisational Leadership and Governance Structure" has been increased from good to substantial with the integration of quality governance across both care groups from December 2025. **Corporate Risk Register (CRR):** Good assurance is confirmed relating to the risk management processes in place, the consideration of risks for addition to the CRR and the ongoing management of these risks. Compliance for reviewing risks remains at 100%. **Quality Governance Reports** From Quality Governance, a triple A report covered the specific matters from across a suite of papers including: CQC Activity and Integrated oversight Plan, Quality Dashboard and Quality Risks in the QAI Programme. The Quality and Controls Assurance Framework demonstrates 29 measures (85%) with good or substantial assurance, providing an overall substantial level of quality assurance for the Quality Assurance Dashboard. Outcomes measures continue to demonstrate sustained improvement in child and adolescent services. There is good assurance evidenced from the **Annual Environmental Risk Group Report**. Significant strides have been made across the Trust estate to remove ligature anchor points. **Rehabilitation Service Model.** At present there is **limited assurance** relating to the adult mental health rehabilitation services due to variation in the models and absence of a Trust wide evidence-based assurance framework for rehabilitation services. Standardising and strengthening Adult Mental Health Rehabilitation services across the Trust will be achieved by: • Implementing consistent metrics and assurance frameworks to monitor quality and equity. • Reducing variation by replicating effective community models in areas with gaps, using resources released from service transformation. • Ensuring services are needs-led and inclusive, guided by comprehensive needs assessments. • Establishing a task and finish group to drive data collection, quality improvement, and integrated care pathways. These actions will align the Trust's rehabilitation services with national guidance, improve outcomes, and ensure equitable access for all service users. **Responding to National Guidance (Oct 2025) on identifying restrictive practice** A multidisciplinary task and finish group, including Experts by Experience reviewed guidance published in October 2025 by NHS England on identifying and reducing restrictive practice, alongside the Trust current 3 year positive and safe care strategy. Identification of some areas for further development include: • Supporting services to implement/adapt the Trust 3-year strategy for community services. • Recording and reporting of blanket restrictions and surveillance via Trust systems • Updated training aligned to the new guidance specifically for use of language • Reflection and support systems for staff, patients and services

		• Alignment with existing Trust initiatives/work around trauma informed, autism-informed, culture of care to support implementation of reducing restrictive practices. Committee can confirm there is reasonable assurance on the current position compared to the review and publication by NHS England. **Specialist Services** Committee monitors progress across specialist services every six months and a review of the governance, performance, and strategic priorities of AMH Specialist Services provides a good level of assurance on the delivery of quality and safe care within specialist services in DTV, however limited level of assurance within specialist services in NYY. Continued challenges relate to sickness, appraisals and Adult Eating Disorders workforce gaps. Improvement workstreams are underway. There is good assurance linked to reduced waiting lists within several services, notably Persistent Physical Symptoms (PPS), Perinatal NYY and ADHD/Autism PTL validation work, strong compliance with quality standards, enhanced leadership arrangements and improved monitoring through revised governance dashboards. **Duty of Candour** From the cases that identified **Statutory** Duty of Candour, in Quarter 2, full compliance with statutory obligations can be evidenced in 30% (3/10) of the cases. The is good evidence of patient/family involvement during the After-Action Reviews through telephone conversations and/or face to face conversations. Similar to previous learning identified, the main area for improvement relates to follow-up letters being sent, that these contain an apology and that they are sent in a timely manner following statutory Duty of Candour being agreed (as a Trust we aim for within 10 working days). Committee confirms that there is reasonable assurance on compliance. The committee discussed duty of candour more generally with a view that we adhere to the principle and it is in the small number of issues where statutory DoC apply where we have work to do to ensure letters are sent in good time and filed appropriately. **Physical Health Plan** There is reasonable assurance that the Trust is making continuous, demonstrable progress in delivering the physical health delivery plan. Clinical Advisory Groups (CAGs) and Specialist Interest Groups (SIGs) continue to meet and advance objectives relating to physical healthcare and the Trust-wide Physical Health Group meets every two months, receiving progress reports and escalating risks as needed. **Safe Staffing** There is good assurance that safe staffing continues to be monitored and governed through established processes. Controls demonstrate positive impact and effective governance; however, continued focus and further development is required, particularly within community services. Improvements seen in reduced use of agency staff, reduced overtime and improved quality of rosters. **Complaints and Patient Experience** Overall, there is good assurance in Quarter 3 that complaints are responded to in a timely way. Reasonable assurance for patient and carer experience has been determined taking into consideration the transition of systems from IQVIA/Meridian to iWantGreatCare. As predicted the change in system has resulted in an initial reduction in our response numbers, due to initially using QR codes only and embedding of the new system Reasonable assurance is confirmed that the Trust is delivering a range of activities that aim to address inequalities identified via the data collected as required by the **PCREF**.

	Advise	The Committee wishes to advise the Board on the following matters: At the December 2025 meeting it was recognised that there is hesitancy amongst staff to take up the flu vaccination (43%), however the 5% increased uptake for the organisation's **flu campaign** has been achieved.
2d	**Review of Risks**	**Related (BAF) Risks and controls assurance rating** **2: Demand - Good** **3: Co-creation - Good** **4: Quality of Care - Good** **8: Quality Governance – Good** **14. Health inequalities - Limited** The Committee held a **developmental session** on 2 February 2026 where the primary focus was to consider how we further strengthen floor to board quality governance and the risks to quality of care out of which a refreshed work plan for the committee will be proposed to the Board. Discussions centered around the need for a workplan for 2026/27 that will be driven by the strategic risks of the organisation, (also to be re-considered and re-stated), a rag rated workplan to allow at a glance, review of increasing/decreasing levels of assurance, revised agendas framed around the fundamental standards of care. Key themes were discussed including Access and demand, Outcomes, Patient Experience and Health Inequalities. A full report will be presented to Board on 9 April 2026 proposing the focus of the QAC for 2026 – 27 and to make formal recommendations on the strategic risks linked to quality. Some other improvements Committee will pursue include: • Revised report templates to allow links to be made to the key controls set out in the Board Assurance Framework. This will demonstrate that Committee is giving attention to the important matters relating to the strategic risks. • Quarterly full review of the workplan to ensure areas with sustained substantial/good assurance are not being reported unnecessarily and areas of limited assurance are brought to the fore. • BAF training to be provided at Care Group level and for General Managers/authors of reports. • Reports to include, "*What does this tell the Committee that it did not know before?* • Reduced length of reports/packs with detailed information held separately allowing NEDs to focus on assurance, not volume, which will encourage better quality narratives rather than data dumps. Source information to be made available in a library. From the reports presented at the February 2026 meeting, Committee considers that there is good assurance that the risks to quality are understood and being managed appropriately. That where there is limited focus, future reports will include a trajectory for making improvements.
3	**Actions to be considered by the Board**	*i) that the report be noted.* *ii) that there were no new risks identified.* *iii) that the direction of travel for the improvements to the Committee's governance and effectiveness be supported.*
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
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th February 2026**
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 October to December 2025 (Quarter 3). The Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

All NHS Trusts must publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy and have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all

the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) are in Appendix 2.

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

Overview:
In line with National Guidance the Learning from Deaths Dashboard at appendix 1 details Q3 information for the Trust and includes 2024/25 data for comparison.

- During Q3 514 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, 386 patients were still open to a Trust service at the time of their death, of which 16 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).
- 13 inpatient deaths were reported. 7 of these deaths were expected and occurred in Mental Health Services for Older People (MHSOP) wards. There were 4 unexpected physical health related deaths that occurred in MHSOP wards; 2 have been subject to part 1 reviews and 2 have been reported on national Strategic Executive Information System (StEIS) and are subject to a Patient Safety Incident Investigation (PSII).
- Of the remaining 2 deaths, 1 occurred in a Care Home which related to a patient who was on leave from a MHSOP ward and 1 occurred in an Adult Mental Health (AMH) ward and was reported as a suspected suicide. Both have been reported on StEIS and are subject to a PSII.
- 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.
- 10 Part 2 Structured Judgement Reviews (SJRs) were requested.
- 91 Part 1 reviews and 16 SJRs were completed.
- 4 Patient Safety Incident Investigations for unexpected deaths were completed.
- 26 patient deaths were reported to LeDER during Q3. 25 of the 26 patient deaths occurred in Q3 and 1 in Q2. 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 is assumed by the TEWV clinical team that the team providing 24-hour care has 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.

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

- 2 in relation to environmental risks and issues (ligature risk of doors and staff hostage situation)
- 1 in relation CITO recording and alerts (saving patient information outside of the Electronic Patient Record)

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

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

Prior Consideration and Feedback

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

Implications:

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

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

Recommendations:

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

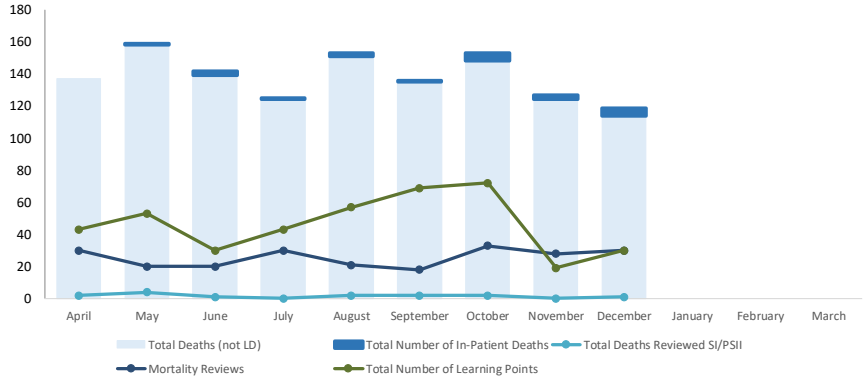
Appendix 1: Learning from Deaths Dashboard Q3 2025/26

Learning from Deaths Dashboard - Data Taken from Cito
Reporting Period - Q3 2025-26

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

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

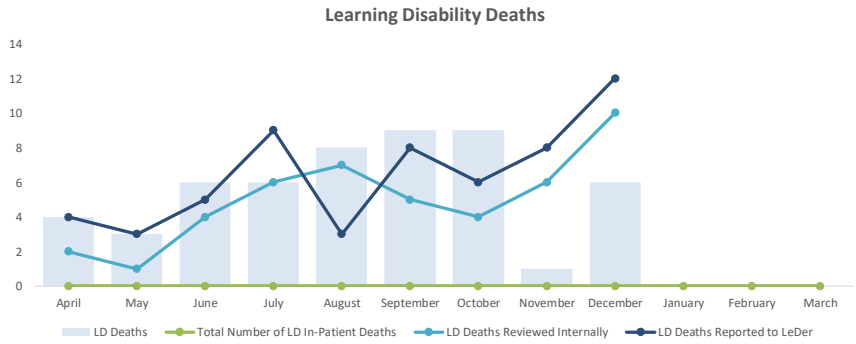
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths reviewed by PSII		Mortality Reviews		Total Number of Learning Points	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2024/25	2024/25
Q1	434	↘ 453	4	↘ 5	7	↘ 32	70	↗ 52	126	↗ 123
Q2	410	↘ 445	4	↘ 7	4	↘ 28	69	↗ 55	169	↗ 125
Q3	386	↘ 483	13	↗ 8	3	↘ 14	91	↗ 43	121	↗ 75
Q4	0	↘ 475	0	↘ 6						
YTD	1230	↘ 1856	21	↘ 26	14	↘ 74	230	↗ 150	416	↗ 323



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

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

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25
Q1	13	↘ 25	0	↘ 1	7	↗ 6	12	↗ 9
Q2	23	↗ 20	0	↔ 0	18	↗ 9	20	↗ 14
Q3	16	↘ 26	0	↔ 0	20	↗ 13	26	↗ 20
Q4	0	↘ 27	0	↔ 0				
YTD	52	↘ 98	0	↘ 1	45	↗ 28	58	↗ 43



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

7 structured judgement reviews were discussed and reviewed by the Mortality Review Panel during Q3.

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

- Clinical Effectiveness Personalised Care (consideration of Dual Diagnosis needs)

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 3 there were a total of 121 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 Clinical Effectiveness/ Personalised Care all sub themes were team specific. The subtheme dual diagnosis, drug and alcohol misuse and addiction highlighted learning focusing on the use of the dual diagnosis clip. Record Keeping was the second most frequent learning theme identified with subthemes being team specific and individual focused.

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 clinical webinars take place which are designed to encourage collaboration and share valuable insights across our clinical communities. Topics that have been explored during Quarter 3 have included 'What their stories teach us: Reflecting on Dual Diagnosis and Mortality'

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).

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
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 February 2026**
Title:	**Leadership Walkabout Feedback – January 2026**
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 walkabout that took place in January 2026.

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 26 January 2026 across various service areas. Common themes across the visits are summarised below, with more detailed breakdown in further information.

Summary of feedback:
Across all six services, teams are highly committed and demonstrate strong values, collaboration, and innovation. However, recurring challenges - primarily workforce pressures, operational constraints, and the need for clearer strategic alignment - continue to affect service delivery and staff wellbeing.

Teams are proactive in identifying and implementing improvements but require sustained organisational support, clearer communication, and more robust infrastructure to maximise impact and maintain service quality. Leadership visibility remains valued and continues to provide helpful assurance and insight. Common themes across the groups include:

1. **Strong, values-led teams:** Teams consistently demonstrate commitment, compassion, and effective MDT working, with good learning cultures and focus on person-centred care.
2. **Workforce pressures:** Staffing shortages, retention issues, sickness gaps, and administrative workload are affecting capacity, morale, and service consistency.
3. **Operational and infrastructure constraints:** Environmental pressures such as limited clinical space, parking, IT issues, and remote locations hinder efficient working.
4. **High demand and complex caseloads:** Rising complexity, unclear service interfaces, and variable referral pathways are creating pressure across services.
5. **Need for clearer leadership and strategic alignment:** Teams request more consistent communication, clearer transformation plans, aligned leadership structures, and better integration across services.
6. **Partnership and system interface challenges:** Working with external partners (e.g., social care, medical staffing, research partners) remains variable and sometimes restrictive.
7. **Quality and safety improvement 0pportunities:** Teams are proactively identifying improvement needs (e.g., environment upgrades, staffing models, crisis response, better record systems) and have actions underway.
8. **Strong use of outcome measures v's limited by capacity:** Teams collect and use outcome measures, however operational pressures limit their ability to fully embed learning and continuous improvement.

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 – January 2026

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 26 January 2026 across the following service areas. These are summarised as follows:

Group 1 – Durham and Darlington, North Durham CAMHS

The D&D North Durham CAMHS service offer support to children and adolescent mental health services in the community out of North End House.

- **Service strengths:** The team were proud of keeping young people and families central to care, having strong internal support networks, and delivering quality care.
- **Service challenges:** Main challenges include high demand and complex referrals versus capacity, environmental constraints such as parking and clinical room availability, and unclear core offer and inclusion criteria between services. The lack of clarity in service offerings leads to many young people being referred to more intensive support teams.
- **Measuring impact:** Success is gauged through CROMS, PROMS, participation groups, Friends and Family Test (FFT) surveys / feedback tools through"I Want Great Care," regular care plan and goal reviews, and tracking transitions and discharges.
- **Agreed actions:** Improvements planned include making the environment more child- and family-friendly, exploring parking support options, seeking additional clinical rooms, and reviewing the interface between Getting Help and Getting More Help teams to better manage caseloads and reduce pressure.

Group 2 – Research and Development Team, Foss Park, York

The research and development team works trust-wide, working closely with clinical teams and service users and offer a variety of local, national and international research studies and opportunities.

- **Collaborative research strengths**: The service excels in partnerships with universities for applied mental health research, supports staff development including PhD studentships, and hosts a dedicated research space enabling innovative studies such as early Alzheimer's interventions, positioning the Trust as a leader in this field. Large grants have funded new roles and projects.
- **Opportunities to enhance strengths:** Strengthening university partnerships by aligning research priorities, supporting emerging research leaders through targeted recruitment and development, addressing variations in research time allocation, and improving dissemination and implementation of research outcomes via Board sessions and learning groups were identified as ways to maximise strengths.
- **Key challenges faced**: Financial reliance on external funding and the critical need for large NIHR grants pose stability risks, alongside uncertainty about future research leadership. Balancing the Research Delivery Network budget requires careful

management due to annual spending and reporting demands. Clinical team engagement is difficult due to staff release challenges despite funding, and the innovation service faces sustainability issues with limited staff and research as a TEWV priority.

- **Support needs and priorities:** Priorities include ongoing financial support for income management and 'at risk' posts, enhancing clinical team engagement through job planning and appraisal integration, and reviewing the innovation service's alignment with Trust strategy. The visit was welcomed for raising the profile of research activities and highlighting leadership risks affecting funding continuity.

Group 3 – MHSOP Hambleton and Richmond CMHT

The Hambleton and Richmondshire community mental health team offer services to people aged 65 and over with severe or acute mental health in Hambleton and Richmondshire.

- **Team strengths and service offerings:** The service were passionate about its strong team culture, development of patient groups offering non-pharmacological interventions, and provision of a 7-day intensive in-reach service with a full multidisciplinary team including physio, OT, psychology, dietetics, and social work.
- **Plans to maximise service strengths**: Plans include expanding patient groups to new locations, developing Compassion Focused Therapy groups, implementing Structured Clinical Management as a core intervention requiring team training, enhancing health promotion through MDT collaboration, supporting trauma-informed care, and better supporting carers of organic patients through START and PAC guidance.
- **Impact measurement and challenges**: Success is measured using HONOS and SWEMWBS outcome measures, Friends and Family Tests, and feedback from staff, students, and external partners. Key challenges include burdensome electronic patient records and administrative tasks causing staff anxiety, strained relationships with social services impacting care provision, and out-of-hours crisis response for organic care patients.
- **Support needs and actions**: Support requested includes improved record systems, better collaboration with social services, and enhanced safety planning for out-of-hours organic crisis response. An action was taken to escalate concerns regarding potential exclusion criteria by tier 3 weight management services for mental health patients, with escalation to South Tees Dietetics completed.

Group 4 – Danby Ward, Cross Lane Hospital, Scarborough

Danby Ward is a male ward at Cross Lane Hospital in Scarborough offering adult mental health inpatient services.

- **Team strengths and culture:** The ward team works cohesively with shared responsibilities, fostering camaraderie and morale. There is a strong learning culture benefiting both students and permanent staff, with positive student feedback. The team upholds person-centred values, applying positive risk-taking and least restrictive principles, and has maintained the seclusion room closure for over a year. The multidisciplinary team (MDT) morning meetings are valued and effective.
- **Challenges and priorities**: The main challenges include staffing levels impacting patient care time, stopping overtime, and limited bank shifts for substantive staff. Prioritisation focuses on staffing issues and their impact on care quality.
- **Actions and support needed**: Recruitment of nursing staff is now managed in-house, with ward teams working within budget except when acuity demands exceed staffing levels. There is a need to review the overall budget to facilitate escorted leave and appointments, clarify overtime approval rationale for safety and retention, and address potential loss of the Trust doctor. Leadership discussions are ongoing to address these points.

Group 5 – South Durham LD Acley Centre, Newton Aycliffe

Acley Centre is a base for specialist mental health services for children and young people living in the South Durham area, providing support, information and advice for parents and carers.

- **Team strengths and pride:** The service is proud of advocating for young people, ensuring their voices are heard, making reasonable adjustments for access, and supporting each other amid limited resources while promoting staff wellbeing.
- **Primary challenges faced:** Staffing shortages and poor retention are the top concerns, alongside resource allocation pulling staff outside their roles, transformation uncertainties, communication issues, and complex caseloads.
- **Support needed to address challenges:** The service requests clear transformation plans, consistent senior leadership direction, and enhanced efforts to retain staff to improve service stability and consistency.
- **Actions and observations:** Actions include reviewing communication on transformation, incorporating CAMHS into LD workforce reviews, addressing IT hardware issues, and standardising referral processes amongst staffing and caseload pressures, with efforts to support staff wellbeing ongoing.

Group 6 – Harrogate Crisis Service, The Orchards, Ripon

The Orchards provides inpatient mental health recovery (rehabilitation) support, and base for some of our community adult mental health and crisis services which were visited on this occasion.

- **Committed and resilient staff:** The team is described as supportive, committed, and providing good care, with interventions like flash-lite available during crises due to higher assistant psychologists in the team. An audit led to improved management of high-risk community patients.
- **Enhancing communication and leadership:** Suggestions include improving communication and integration of transformation work across neighbourhood services, ensuring up-to-date operational policies, and having a full collective leadership group rather than just a service manager. Clear medical involvement in monthly meetings is also emphasised.
- **Challenges of location and staffing:** The team's location in Ripon versus patients in Harrogate causes isolation and limits hot desking. Inter-team relationships, delays in care coordinator allocation, and staffing gaps due to long-term sickness are noted challenges, with recent recruitment efforts underway.
- **Action plans for improvement:** Upcoming meetings will address quality issues, safe staffing, and roster reviews to inform staffing models. The team will be updated on options appraisals, and follow-up with medical leads is planned to link discussions and improve communication.

4 Conclusion:

Board is invited to take this report and feedback and actions contained as good assurance.

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Tees, Esk and Wear Valleys
NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report to the Board of Directors		
Report Date:		3 February 2026
Date of last meeting:		19 January 2026 – Committee was quorate
1	**Agenda: The Committee considered the following agenda items during the meeting** • Mental Health Legislation Combined Assurance Report, including Mental Health Capacity Act/DoLS • Multi-Agency and Internal Mental Health Legislation Operational Group Updates (DTVF and NYY) • Section 17 Leave and Time Away from the Ward • Positive and Safe: Quarter 2 Update • Progress of CQC MHA Monitoring Activity – 1 August 2025 to 31 December 2025 • Individual Case Study • Advocacy and Patient Rights Network • Policies and Procedures for approval (CLIN-0001-v5.4 – Consent to examination or treatment; MHA-0002-v4.4 - Death of a patient subject to the MHA; MHA-0003-002-v2.5 – S135(2) Procedure; MHA-0003-v10.3 - Section 136 Policy) • MHLC Workplan – noted • Any Other Business	
2a	**Alert: The Committee alerts members of the Board to the following:** **-**	
2b	**Assurance: The Committee confirms assurance to the Board on the following:** **Mental Health Legislation (MHL) Combined Assurance Report, including Mental Capacity Act/DOLS** • In striving towards improving governance further, the report had been extended to include matters concerning Mental Capacity Act/DOLS which had previously been set out in a separate report. In future the combined report will be supported by the MHL dashboard for all measures; • Accordingly, the matters covered in the report included: detained patients discharged without being read their rights; lapsed Section 5s; CQC AWOL notifications; Discharges by the Hospital Managers; Discharges by the Mental Health Tribunal; S136s that reached 24 hours; S136s that were extended; Failed Scrutiny and Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS); • The report was approved with good assurance on the robustness of data provided, that there has been appropriate scrutiny and consideration of the matters by the care groups at operational level and that the legislation has been correctly applied; and • Further consideration to be given to firstly, how Crisis Teams are enabled to undertake capacity assessments prior to admission and, secondly, the quality of such assessments, with an Audit to be completed by Care Groups. **Multi-Agency and Internal Mental Health Legislation Operational Group Updates (DTVF and NYY)** • Overall Committee confirms there is reasonable assurance that the external and internal Mental Health Legislation Operational Groups have identified key issues and themes relating to the application of Mental Health Legislation and appropriate workstreams. The Mental Health Legislation (MHL) Committee will be provided with progress on the current workstreams for monitoring and oversight, and the internal groups (DTVF and NYY) will work closely with the external MHL Operational groups in actioning some of the workstreams. The Group will also be a good forum for implementing changes to the Mental Health Act; • Attendance at the internal Mental Health Operational Groups (DTVF and NYY) to be made a priority for future meetings in order to improve the narrative provided and increase assurance levels; and	

- Noted good level of attendance by external partners at those meetings and a request had been received for an escalation process for any issues requiring such consideration. In addition, information regarding governance structures was to be shared between organisations.

Positive and Safe: Quarter 2 Update

- The Committee confirms there is good assurance demonstrated of progress implementing the Trust wide Positive and Safe Strategy, noting the current improvement activity which has been undertaken:
    - There were 1,518 reported restrictive intervention incidents via the Trust positive and safe systems in Quarter 2, this was a decrease from 1529 in Quarter 1 for 2025/2026. Overall, the Trust remains within normal parameters for restrictive intervention use for the Quarter;
    - DTVF accounted for 1311 of these incidents and NYYS 207. The restrictive interventions that are most frequently used within Quarter 2 were standing restraint, supine restraint and seclusion;
    - There has been continued high level use of high frequency, low duration seclusion across ALD services which results in TEWV being a national outlier for the use of seclusion. However, should the data for a single person (who is in control of their 'self-imposed' seclusion) be removed from the data, TEWV would be reporting a very low use of seclusion against the nationally reported data; and
- Services across the Trust continue to implement a range of interventions aimed at reducing the use of restrictive interventions as part of the Trust's co-produced 3-year Positive and Safe Care Strategy.

Section 17 Leave and Time Away from the Ward

- The Committee confirms good assurance of oversight and monitoring of quality assurance schedule results and notes that improvements have been made in line with Time Away from the Ward and Section 17 Leave compliance;
- The Committee notes that where variation with compliance to the Inpatient Quality Standards occurs, the Care Groups have improvement plans in place and are monitoring monthly trends to ensure continued recovery. There is good oversight of 'outliers' on a month-by-month basis and actions are taken to rectify any specific issues which are identified; and
- Recent Quality Assurance schedule work has identified similarities between questions 37 and 45 in the audit and this will be addressed for future audits.

Progress of CQC MHA Monitoring Activity – 1 August 2025 to 31 December 2025

- The Committee confirms good assurance regarding the system oversight and delivery of actions resulting from CQC MHA Inspection activity, with no new gaps in assurance or systems as a result of this report;
- During the reporting period (August to December 2025), there were 9 site based CQC MHA inspections (including 7 informal visits) undertaken as follows:
    - Informal Monitoring Visits (DTVF) - Cedar Ward, AMH, West Park Hospital/Elm Ward, AMH, West Park Hospital/Farnham Ward, AMH, Lanchester Road Hospital/Tunstall Ward, AMH Lanchester Hospital/Bransdale Ward, AMH, Roseberry Park Hospital/Bilsdale Ward, AMH, Roseberry Park Hospital/Overdale Ward, AMH, Roseberry Park Hospital;
    - Hamsterley Ward, MHSOP, Auckland Park Hospital (DTV&F);
    - Newtondale Ward, SIS, Roseberry Park Hospital (DTV&F);
- Three key issues have continued to be highlighted from these inspections as follows:
    - Access to technology - concerns were raised regarding challenges with Wi-Fi and phone signal which affected both patient and staff access to systems due to poor connectivity. Concerns regarding the electronic records systems were also raised by staff on 3 wards and included staff feeling that the system was not user friendly and was difficult to use. Concerns around a ward computer not working were raised on another ward;
    - Care plans/Documentation - concerns regarding patients not having or being offered copies of their care plans and not feeling involved in the care planning process;

	○ Staffing issues - Patients told the CQC that they felt there were not always enough staff available to support with timely access to section 17 leave from the ward. Staff numbers for registered nurses remained problematic on Tunstall ward; • As at 19 December 2025, there were 23 actions outstanding (>31 days) from the MHA inspections involving 10 inpatient wards within the DTV&F Care Group and 2 inpatient wards within the NYY&S Care Group. Work is in progress via Care Groups to ensure completion and submission of relevant assurance evidence; • Noted that food quality standards remained an ongoing, although not as significant an issue, for Cedar and Elm Wards. This was being addressed through feedback from patients and monitoring meetings with the new supplier; • Noted regarding the PAS action in respect of the reconfiguration of Rehabilitation Services and the plan for the closure of Primrose Lodge, this was estimated to take place in February or March 2026, with 2 patients only to leave. Following that, this action will then be closed; and • Noted regarding the concerns identified by the CQC regarding the seclusion room on Cedar ward that the temporary work to the walls within the Cedar seclusion suite has been completed as an interim measure, however, formal approval of a Business Case was required to provide a longer-term solution. There would be consideration of a request for capital work on 23 January 2026.
	Advise: The Committee advises the Board on the following: **Individual Case Study** • Discussion was held regarding how individuals were admitted under the Mental Health Act who presented with behavioural disturbance and were also on the end-of-life care pathway. The challenges faced by clinicians in terms of discharge were highlighted due to limited spaces available in care homes and hospices in HNY. A further meeting is to take place involving Consultant Psychiatrists from MHSOP, the Clinical Network, Head of Clinical Strategy for MHSOP, plus the Associate Director of Mental Health Legislation to discuss current practice and clarify the guidance. **Advocacy and Patient Rights Network** • A presentation was provided on the Advocacy and Patient Rights Network by representatives from Teesside Mind, Darlington Association on Disability and 'We are People First' who were all providers of advocacy services, supported by an Associate Director of Nursing, NYY; • The Network aims to improve the communication and collaboration between patients, advocates, and healthcare providers, ensuring that patient rights are promoted in all interactions and aspects of their care; • Noted that it was planned to hold Network meetings on a monthly basis; • The launch event for the Network on 9 December 2025, identified the following: ○ 'Barriers to Advocacy' - participants identified many barriers which prevented patients from fully accessing advocacy support. For example, referral processes were often inconsistent – not every eligible patient was informed about or referred to an advocate. Communication gaps meant some advocates found out too late about patient discharges or meetings, missing critical opportunities to help. There were also practical obstacles like lack of private space for advocates to speak with patients confidentially on Wards. Additionally, cultural issues were noted - a few staff held paternalistic attitudes (acting as if they knew best for the patient without considering the patient's wishes or rights), and some teams had a defensive culture which made it hard for advocates to raise concerns. Such barriers led to variation in how well patients' rights were supported. ○ Variation in Practice**:** The event highlighted that advocacy involvement varied widely across the Trust. In some services and wards, staff routinely involved advocates and upheld patients' rights, while in others advocacy was an afterthought or inconsistently used. This variation meant patients had unequal experiences – a patient's access to advocacy support could depend on which team or unit was caring for them. Attendees agreed that every patient, in every service, should get the same high standard of support for their rights and that whilst different specialties may face

unique challenges, the underlying principles of good advocacy practice should be consistent Trust-wide;
    - Strengths to Build On: There were “pockets of good practice” where staff and advocates worked together effectively. For instance, a few teams proactively referred every eligible patient and welcomed advocates as part of the care team, showing that a better culture was achievable through enthusiastic staff champions and strong advocate relationships. NICE guidance and a National Advocacy Charter was available to support.
- The representatives asked how advocacy could be embedded within both governance and Culture of Care work to ensure successful collaboration;
- Noted that an Advocacy pilot had been commissioned by the Mental Health Legislation Team on several wards at Roseberry Park Hospital to strengthen relationships. Information on the pilot was reported to the internal MHL Operational Group and the Advocacy Leads will be invited to regular meetings to share information. It was also noted the MHL Department hold regular monitoring meetings with all providers. It was acknowledged that whilst a representative from ‘We are People First’ was invited to attend those meetings, wider Advocacy provider representation was required. It was acknowledged that there was further learning to be done in respect of the experience of Advocacy at Lanchester Road Hospital and further development work on the reporting of all data across the Network in the future in order to improve outcomes for patients;
- The Committee endorses the ongoing work of the Advocacy & Patient Rights Network – acknowledging the issues identified and the importance of the actions planned to address them. By championing this work, MHLC reinforces to all levels of the Trust that patient rights and advocacy must be a priority;
- Noted that there were very low numbers of Safeguarding referrals (in relation to the Care Act) and these referrals would be discussed with the Safeguarding Team to ensure that there were no barriers. In addition, further consideration would be given to ways in which the data might be reviewed from the Trust and other parts of the system;
- The Committee agrees to receive a regular report, either as a separate report or incorporated into the current reporting structure, for example, quarterly reports/presentations from the Network on what has been achieved, issues resolved, and any further challenges are to be submitted to the External MHL Operational groups in future to ensure the Committee has continued oversight and enable accountability of the Network for delivering improvements. It also provides a route for escalating any serious or persistent barriers requiring higher-level attention; and
- An invitation was extended to the voluntary sector representatives to attend a future Committee Development session to consider the wider issues, including Mental Health Act changes.
- It was noted by the MHL team that detained patients now receive a questionnaire as part of “I want Great care” and will be able to share feedback and their experiences about being a detained patient and having access to an IMHA.

Policies and Procedures for approval

- The following policies/procedures were approved: CLIN-0001-v5.4 – Consent to examination or treatment; MHA-0002-v4.4 - Death of a patient subject to the MHA; MHA-0003-002-v2.5 – S135(2) Procedure; MHA-0003-v10.3 - Section 136 Policy.

Any Other Business – Mental Health Act 2025

- The Mental Health Act 2025 (formerly the Mental Health Bill 2024-2025) received Royal Assent on 18 December 2025 and will have a phased implementation in England and Wales over the following decade. This legislation amends and aims to modernise the Mental Health Act 1983 to better reflect 21st-century standards of care, autonomy, and human rights;
- Key Reforms and Changes to note include the following:
    - Conditional Discharge: This change will begin on 18 February 2026 in response to the decision of the Supreme Court in November 2018. It is likely to only apply to a small number of patients;
    - Detention: The bar for detention will be higher as under both section 2 and section 3 there must be evidence that ‘serious harm may be caused to the health or safety of

	the patient or of another person'. However, the Code of Practice is awaited for a definition of "serious harm". Under section 3, a patient must be suffering from a "psychiatric disorder", there must be a clear therapeutic benefit from the treatment and detention must be necessary; o Community treatment orders (CTOs): will also have stricter criteria and require the input of the community clinician. Whilst the Government has committed to a review of CTOs, the timelines and how the review of CTOs will impact on these changes is currently unclear; o Nearest relative: provisions will be updated to provide for a nominated person ("NP"). Patients will be able to choose their NP, with safeguards in place. The NP will be able to exercise some additional rights compared to the current nearest relative role, such as the right to object to a patient being placed on a CTO or the right to be consulted about renewals; o Definitions: Four new definitions feature in the Act for "autism", "learning disability", "psychiatric disorder" and "Appropriate Medical Treatment"; o Consultation: Before discharging a patient, the responsible clinician (RC) must consult a person who has been professionally concerned with the patient's medical treatment and who belongs to a profession other than that to which the RC belongs; o Section 3: ▪ Changes to renewals, frequency of tribunals and changes to second opinion appointed doctor (SOAD) roles; ▪ The initial period of section 3 detention for treatment will be three months followed by renewals of three months, followed by six months and then a year; ▪ People with a learning disability and autistic people without a co-occurring mental health issue will no longer be detained under section 3. However, this will only be enacted when the government is confident sufficient community services are in place; • Noted that the Act will be phased in over the next 8 to 10 years to allow for service expansion and staff training. A Business Manager has been identified to support the implementation, develop an Action Plan and monitor progress; and • Noted that relevant issues have been raised by the Executive Medical Director with the ICB, for example, the potential for those currently in Locked Rehabilitation Wards to be sent out of area. Further consideration to be given to the potential impact on demand for beds in view of the changes to conditional discharges.	
2d	**Review of Risks**	The following risks were identified: • WiFi – to remain on the Risk Register; and • Implementation risks regarding the Mental Health Act 2025 – availability of resources to meet the requirements
Recommendation: The Committee requests that the Board of Directors: • *Note the report and confirm the levels of assurance set out above.*		
3	**Actions to be considered by the Board:** There are no actions for the Board to consider.	
4	**Report prepared by***: Roberta Barker, Chair of Committee/Non-Executive Director, Kedar Kale, Executive Medical Director and Deborah Miller, Corporate Governance Manager*	

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 February 2026**
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 December 2025 and January 2026.

Proposal:
This update is presented as good assurance in terms of delivery of the communications strategy and related targets.

Overview:
Our 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.

Strategy and planning:
We're currently refreshing the trust-wide communications strategy in line with the shifts in the Government's 10-year health plan and the priorities outlined in the medium-term plan. We're also preparing a specific public inquiry communications strategy, outlining an initial broad approach which will be updated once details such as chair, scope and timings are confirmed.

Press coverage and campaigns:

- 12 proactive media releases were issued in this period (7 in December and 5 in January) which exceeds our KPI. We secured coverage on winter wellbeing and mental health support over Christmas. We successfully pitched in an interview on BBC Radio Tees with Dr. James Olvanhill, who had a long segment discussing brain health and dementia. We also supported our North Yorkshire and York adult and young people's crisis services with their walk-in recruitment event in York, by creating a social media advertising campaign.

- We managed 21 media enquiries (13 in December and 8 in January). The majority of those enquiries related to the confirmation of a public inquiry into our trust.

- In total there were 196 pieces of coverage across online news, TV, and radio (121 in December and 75 in January), which was substantially higher than previous months and due primarily to the coverage of the public inquiry. Understandably, the media coverage related to this had an impact on media sentiment. Media sentiment was 93% negative in December. There was further media coverage related to the public inquiry in January. Our proactive focus on good news ensured that positive sentiment remained balanced at 48% - 51% of coverage was negative in January.

- We continue to have regular contact and strengthen our links with journalists, media outlets and partners. In February we are meeting with the editor of Northern Echo.

Social media engagement:

- Our social media content continued to gain followers across the month. Overall, our social media engagement during December and January remains strong and successful in reaching a wide-ranging audience, generating positive interactions.

- One of our top performing posts on social media was a story about colleague Sarah Price, completing the World Marathon Majors and receiving her six-star medal. With over 18,000 views and 52 comments on Facebook alone, it is already the highest performing post for the year. Teesside Live also posted about Sarah's achievement and had very high engagement on their post, compared to other content they'd posted across the month. NHS England also shared the story on their channels.

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.

Further information
(For exceptional use only)

Report Title:

1 Proposal

- *Restatement of the proposal*

2 Prior Consideration and Feedback:

- *Further information to be provided on prior consideration and feedback.*
- *Reasons should be provided if the proposal is different to feedback received*

3 Commentary:

- *Supporting arguments to enhance (but not repeat) the summary*
- *Maximum of three arguments (unless special circumstances apply)*
- *All arguments to be supported by data (additional data to be provided (if required) in an appendix)*
- *Costings and source of funds to be clear*

4 Risks and Mitigations:

- *Impacts on existing BAF risks should be highlighted*
- *Any new strategic risks should be identified together with the approach to be taken to mitigating and managing them*

5 Conclusions:

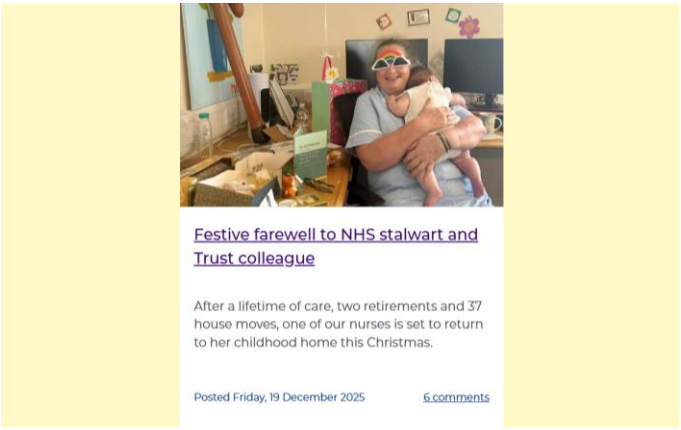
- *In relation to the proposal – why is it reasonable and appropriate*

Communications Dashboard

December 2025

Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights

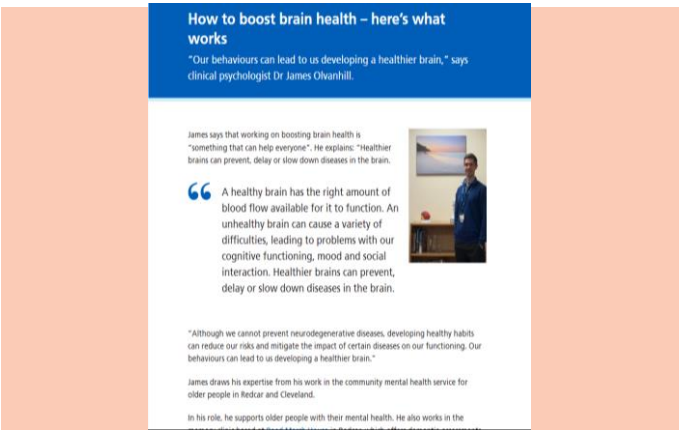


Marked the retirement of a devoted mental health nurse, returning home to Scotland after over 30 years of working within the NHS

Celebrated our first Multi-Professional Conference that took place in Middlesbrough on Tuesday 16 December

Gained coverage around a new virtual reality mindfulness treatment available at North Yorkshire Talking Therapies

Announced a new exhibition showcasing patients' artwork at Foss Park Hospital



Publicised how adopting six healthy habits can strengthen brain health and help reduce cognitive decline

Shared the news of our Tees Crisis Hub winning the prestigious 2025 Seni Lewis Award

Communications Objectives

Tees, Esk and Wear Valleys NHS Foundation Trust

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

Objectives	Key pieces of our work that support our objectives
Increase public confidence	• Responded to the announcement of the public inquiry into our trust • Continued good news stories released to the media, including a media call with Talking Therapies • Filmed at the 24/7 hub in York with NHS England • Promoting a range of mental health support in the winter on our social media channels
Enhance staff engagement	• Unwrapping our values Christmas campaign on Team TEWV • Shared a Christmas thank you message from Alison Smith • Working on two staff personas to improve staff engagement • Continued to promote our 2025 staff flu vaccination campaign
Strengthen partnerships	• Working with partners on the Tees Valley CAMHS getting help service • Prepared briefings for MP meetings to support senior colleagues • Sent our monthly partner newsletter and Christmas card • Provided response to announcement of the public inquiry into our trust to key partners
Support a culture of co-creation	• Developed a communications plan and briefings to support the new CAMHS Tees Valley Getting Help service • Taking a collaborative approach to the development of new self-help guides, which will replace the versions we use from CNTW
Provide accessible and timely information	• Website accessibility audit planned for January 2026 • Planned the communications around the public inquiry announcement • Freedom of Information requests • Policy updates

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

13
Media enquiries handled by the team

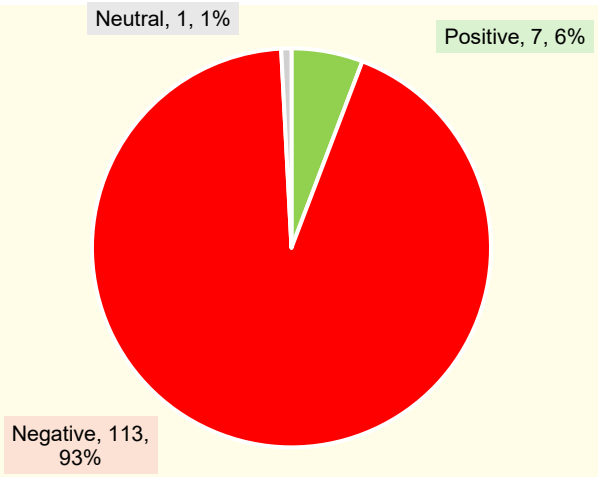
7
Media releases issued

121
Total pieces of coverage across online news, TV and radio

Some of our news stories

- West Park Hospital Darlington patient found dead in bedroom – *Northern Echo*
- Inquiry to be held into north-east England NHS trust after patient deaths – *The Guardian*
- Family carers celebrated in Ripon – *The Stray Ferret*
- Streeting confirms public inquiry into NHS trust – *BBC News*
- Free mental health and wellbeing support available at Christmas – *Northern Echo*
- Foss Park Hospital in York exhibits patient's artwork – *York Press*
- 'Virtual reality mindfulness transformed my life' – *BBC News*
- Leah Bedford inquest concludes as family pays tribute – *Gazette & Herald*

Media sentiment



Our website

33,771
page views

Top three visited pages

1. Careers
2. Services
3. Locations

315

Staff intranet

106,452
page views

Top staff intranet news stories

1. Tees crisis hub wins 2025 Seni Lewis Award
2. Our two lucky winners: £500 Virgin Experience Day voucher
3. Festive farewell to NHS stalwart and Trust colleague

Our ongoing work

Communications:

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

Corporate affairs and stakeholder engagement:

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

Intranet news
17
stories posted

Email enquiries
591
email requests

Team TEWV
staff Facebook group
230 posts
812 comments
2,634 total members
0 new members

All staff emails
7
sent

Patient information
0
updated

Policies
106 total policies
279 total procedures and guidelines
2 consultations open
8 revised and published

Freedom of Information requests
37 received
50 responded to

Partner newsletter
2
stories shared

MP briefings
3

What we're working on

Tees Valley Getting Help service

We developed a communications plan that sets out a strategic approach to promote and support the launch and ongoing delivery of a new children and young people's mental health service in Teesside.

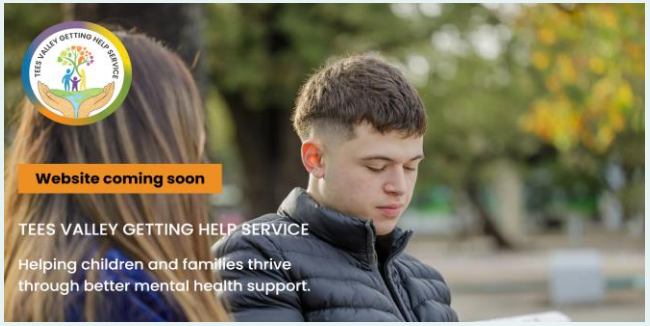
The plan ensures clear messaging, stakeholder engagement, and effective information sharing to maximise awareness, understanding, and usage of the service.

Objectives

- Provide accurate and accessible information about the mental health advice and support available for children and young people in Tees Valley.
- Promote the website and app as a 'front door' for mental health advice and support for children, young people and their families/carers in Tees Valley.
- Provide assurance to young people and families currently within our children and young people's service.
- Build trust and confidence in the service through transparent, consistent communication.
- Encourage early support and reduce stigma around mental health.
- Strengthen partnerships within our communities.
- Ensure information is communicated as part of an i-Thrive system of support

Briefings have been shared with partners including schools and GPs.

We will continue to work with the service and partners to make sure young people, their families and those who work with them know how to access the right support.



Social media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

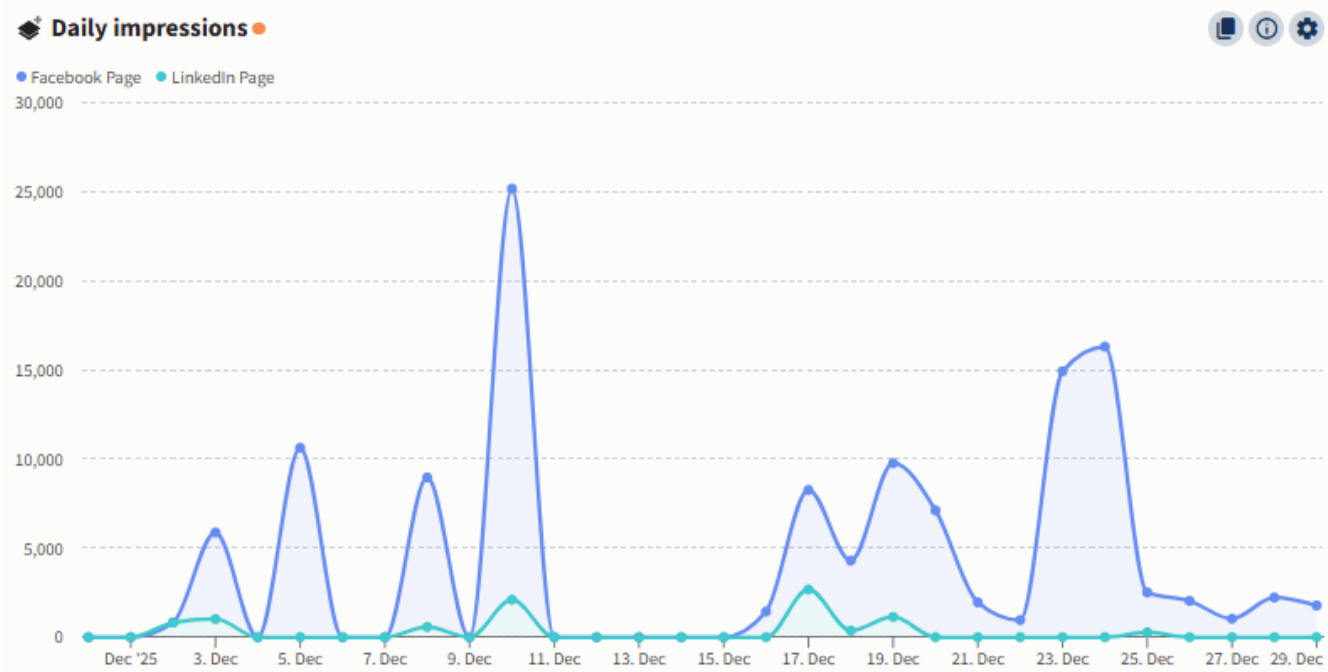
Our audience

29,401 ↑
Total followers

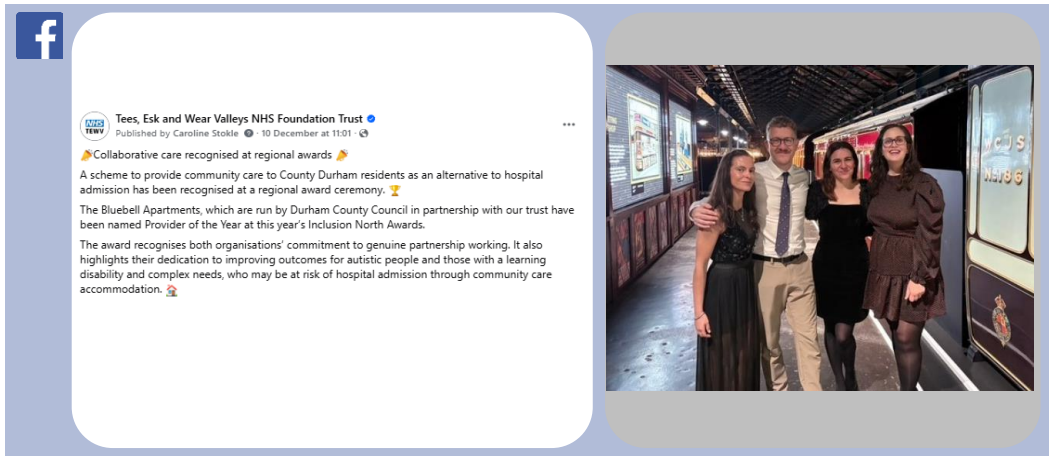
124 ↑
New followers

126,092
People who saw our content - impressions

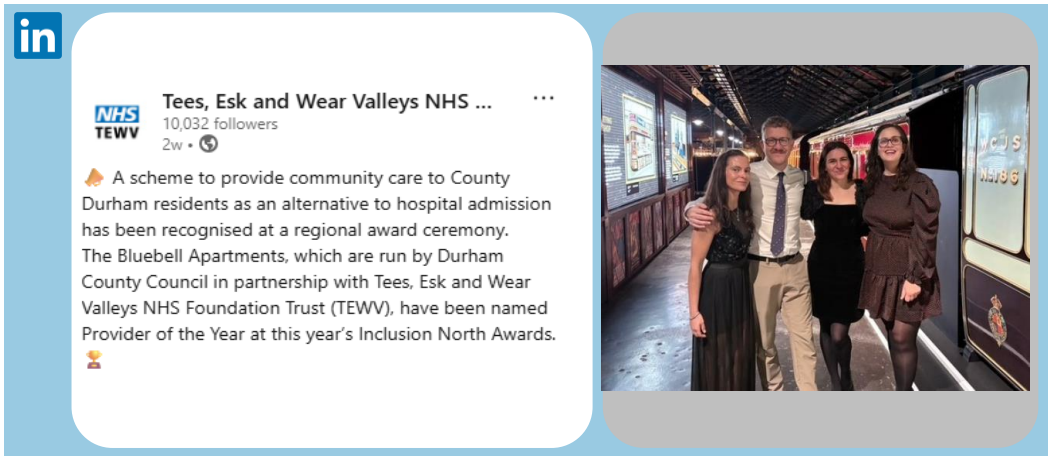
33 ↑
Total posts



Top posts



Impressions 14,933 - Engagement 110



Impressions 2,107 - Engagement 124

Insights

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

This month's focus

Star Awards 2025

Our trust's annual award ceremony is a chance to celebrate colleagues, volunteers and teams going the extra mile in everything they do. This year we introduced new categories and updated the criteria for nominations to be more inclusive and reflective of our trust values. We also refreshed the Star Awards look and feel to generate excitement around its campaign and to make it more engaging and relevant for audiences following feedback from last year. The ceremony was held at Ramside Hall Hotel in County Durham on Thursday 6 November.

Objectives

Encourage staff and stakeholders to enter nominations into the Star Awards 2025

Increase the number of nominations by 5% YonY

Increase nominations in categories that received only 30 or less such as: volunteer of the year (18) and excellence in learning (25)

Build staff, volunteer, involvement member and team morale by celebrating the good work around our trust

Enhance the reputation of our trust by promoting and celebrating our achievements and successes

Quantitative outcomes

Total nominations 2025: 661 (+34.4% YonY)

Top three categories:
1. Living our values – 143 nominations
2. Team of the year – 127 nominations
3. People's star – 110 nominations

Top nominators:
579 – staff member
23 – other
19 – carer
17 – partner
11 – patient
7 – volunteer
5 – involvement member
0 – governor

Event enjoyment rate:
2025: 9.31/10
2024: 9.14/10

Social media

LinkedIn:
Winner's round up post –
Second overall popular post
- 1.8K reach
- 65 engagement

Facebook:
Winner's round up post –
Second overall popular post
- 21,694 views
- 11,230 reach
- 164 interactions

Qualitative outcomes

"Feels like it has evolved and improved so much since last attending."

"The new categories and criteria are a great addition."

"This was my first time attending the star awards and I thought it was a fabulous evening, really good feeling in the room and great to see individuals and teams celebrating.

"This morning, I thought about quitting or pulling away but that was my sign to not give up and continue to strive for what we are and believe in. I needed to hear this today and I appreciate and echo the thoughts for my team."

"This was my first time attending the star awards and I thought it was a fabulous evening, really good feeling in the room and great to see individuals and teams celebrating. The comms team did a wonderful job of organising and also running the evening."

"Honoured, proud of my achievements and thankful to the trust and colleagues for their kindness and support!"

Future considerations

- Specific corporate categories i.e. behind the scenes/unsung hero award
- York location
- Move event to early 2027
- QR code to online feedback form

Communications Dashboard

January 2026

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Highlights

TEWV 10k will return in 2026. Entries are open now!

The TEWV 10k returns to York for a third year on Sunday 26 April 2026.

Continued to promote entries to our own running event, the TEWV 10k

[Demystifying dementia on local radio](#)

Dr James Olvanhill, one of our clinical psychologists, was featured on BBC Radio Tees. He shared information about dementia and boosting brain health

[Flu isn't "on the way" – it's already here.](#)

We've made it as easy as possible to access your flu jab. Find out how to contact your local vaccinator and reach out to them to book a time and place to get your vaccine.

Continued to share messages with staff about our flu campaign, encouraging all staff to book a vaccination

Highlighted artwork at our new Hummingbird House site, which was created by local students from Harrogate College


TeessideLive

NEWS MIDDLESBROUGH FC WHAT'S ON MORE

BUY A PAPER FUNERAL NOTICES JOBS MARKETPLACE PUBLIC NOTICES DIRECTORY ADVERTISE WITH US NEWSLETTER SIGNUP

T > News > Teesside News > NHS

'Six-star' runner Sarah Price completes all world marathon majors scooping clutch of medals

Mum-of-two Sarah Price, 42, completed the prestigious challenge at the end of last year

NEWS By Felicity Collinson Head of News

00:01, 17 Jan 2026

Our news story about a colleague who has completed all the World Marathon Majors gained coverage in the Teesside Gazette

£250,000 funding awarded to charitable organisations in York for community-led mental health and wellbeing support

Seven charitable organisations in York have been awarded a share of £250k over two years to further extend and build on the achievements of earlier transformation work, which has reshaped how local people access mental health support close to home.

January 2026

Seven charitable organisations in York have been awarded a share of £250,000 over two years to further extend and build on the achievements of earlier transformation work, which has reshaped how local people access mental health support close to home.

The grant is part of the NHS Community Mental Health Transformation programme, delivered locally by the York Mental Health Partnership and the 'Connecting Our City' Partnership, of which the trust is a part of. Local voluntary, community and social enterprise (VCSE) support and development charity York CVS has been commissioned to manage the grant distribution.

This is the second phase of the grant programme. It follows earlier funding in 2023 to deliver new ways of supporting adults experiencing serious mental ill-health in York.

Supporting long-term ambitions

This additional funding strengthens York's long-term ambition to create a city where mental health support is local, accessible, co-designed with communities, and rooted in trusted relationships. It sits alongside wider developments across the city, including co-designed mental health hubs and multi-agency support models. These have been influenced by successful international approaches, such as those built into York's transformation learning programmes. This renewed investment ensures York remains at the forefront of community-focused mental health innovation.

Publicised the details of £250,000 funding for Community Mental Health Transformation projects in York

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	• Continuing to deliver the communications plan around the public inquiry, including responding to ongoing media enquiries • Good news stories released to the media, including a story about a colleague who has completed all the World Marathon Majors, which was covered in the Teesside Gazette • Promoting a range of mental health support in the winter on our social media channels
Enhance staff engagement	• Launched the quarterly pulse survey to our colleagues • Continued to promote our 2025 staff flu vaccination campaign • Continued to promote entries to our own running event, the TEWV 10k • Working on two staff personas to improve staff engagement
Strengthen partnerships	• Prepared briefings for MP meetings to support senior colleagues • Sent our monthly partner newsletter which included an update on the public inquiry from our chief executive • Planning meetings with journalists from key media outlets in our region • Welcomed colleagues from NHS England to Hartlepool to showcase our work in community mental health
Support a culture of co-creation	• Promoted a new artwork collaboration in Harrogate with college students with resulted in local media coverage • Taking a collaborative approach to the development of new self-help guides, which will replace the versions we use from CNTW
Provide accessible and timely information	• Supported senior colleagues with briefings ahead of the Tees joint overview and scrutiny committee and the York wellbeing board • Website accessibility audit taking place this month • Freedom of Information requests and ongoing planning to streamline the process in anticipation of increased demand around the public inquiry • Policy updates

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

8 ↓
Media enquiries handled by the team

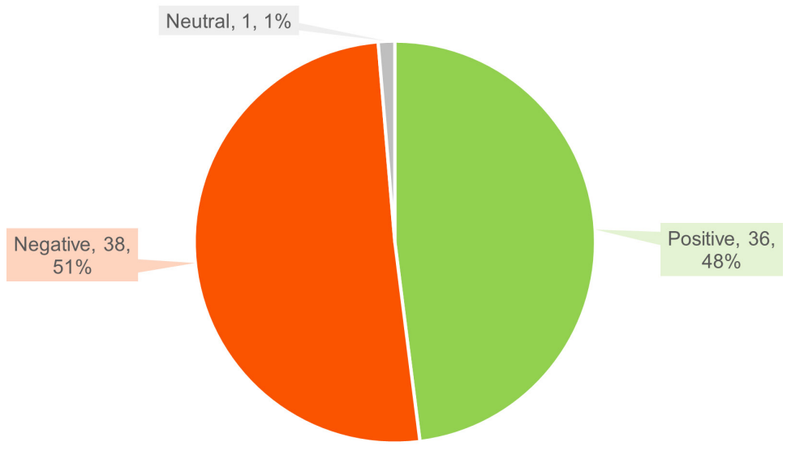
5 ↑
Media releases issued

75 ↓
Total pieces of coverage across online news, TV, and radio

Some of our news stories

- **Free NHS recruitment event to take place in York** – *The Star*
- **Harrogate College students celebrate artwork at new mental health building** – *Your Harrogate*
- **New mothers' mental health support group to launch in Thirsk** – *Darlington and Stockton Times*
- **'Six-star' runner Sarah Price completes all world marathon majors scooping clutch of medals** – *Teesside Live*
- **TEWV NHS trust vows to support public inquiry into it** – *Northern Echo*
- **Teesside mental health trust supports inquiry after girls' deaths** – *BBC News*
- **Mental health pop-up event to support Scarborough residents this January** – *York Press*

Media sentiment



Our website

49,163 ↑
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

105,725 ↓
page views

Top staff intranet news stories

1. Policy updates from October and November
2. Our quarterly pulse survey
3. Public inquiry update on document management

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

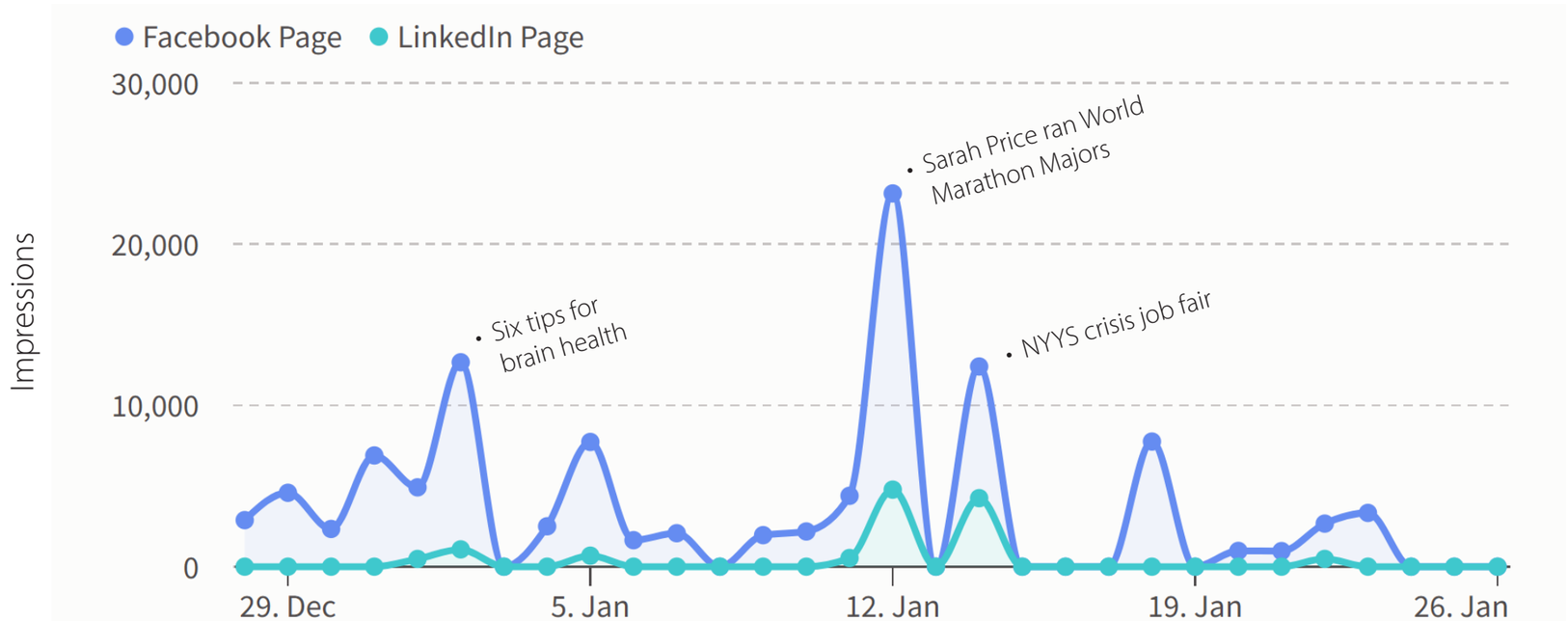
29,466 ↑
Total followers

114 ↓
New followers

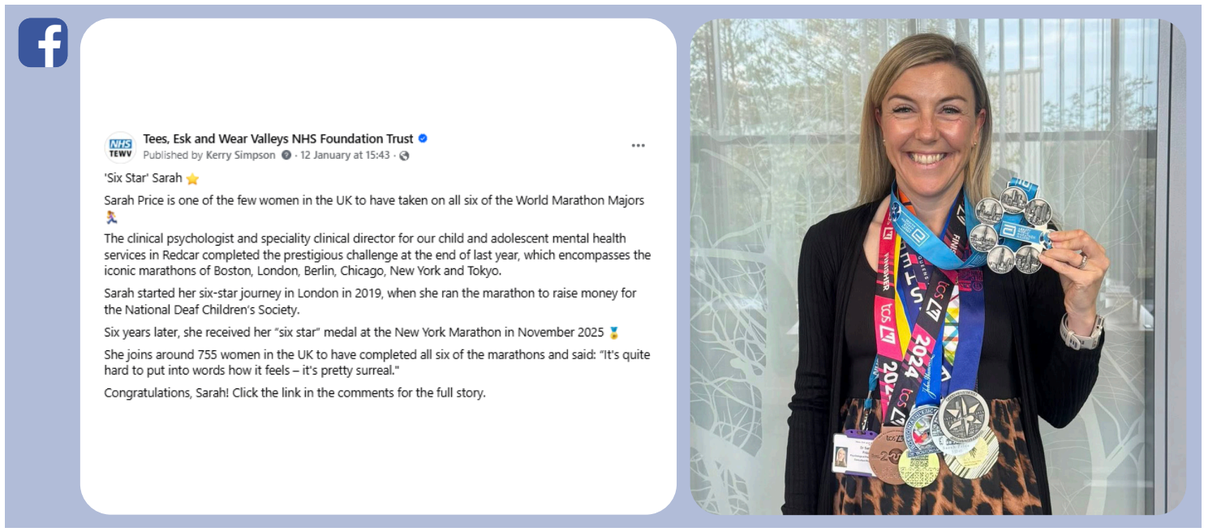
108,057 ↓
People who saw our content - impressions

32 ↓
Total posts

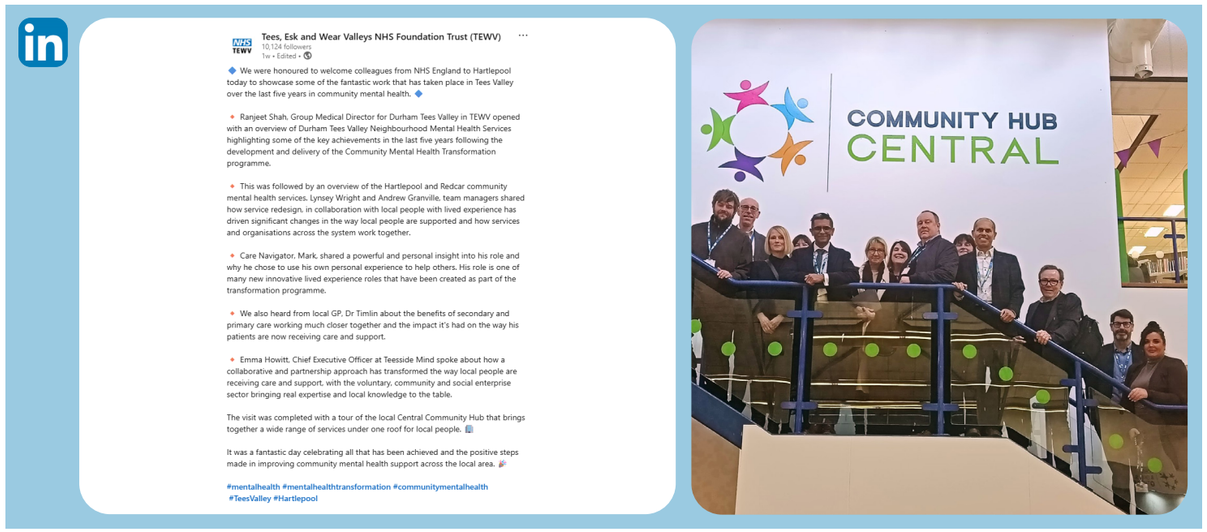
Daily impressions



Top posts



Views 18,383 - Engagement 239



Impressions 3,739 - Engagement 204

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
- Responding to emails into the communications, governor and enquiries inboxes

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
11
stories posted

Email enquires
512
email requests

Team TEWV
staff Facebook group
197 posts
535 comments
2,390
total members
14 new members

All staff emails
11
sent

Patient information
2
updated

Policies
105
total policies
280
total procedures and guidelines
3
consultations open
16
revised and published

Freedom of Information requests
28
received
35
responded to

Partner newsletter
8
stories shared

MP briefings
1

What we're working on

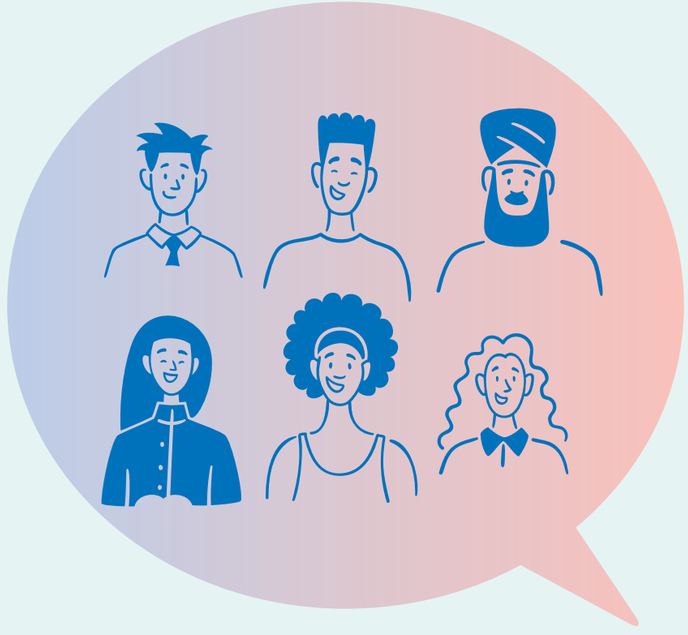
Improving how we share information with staff – creating personas

We are working on a project to create staff personas that will make it easier for us to design better internal communications. A staff persona is a made up character that represents a real group of staff.

We are starting with two personas: one for inpatient staff and one for community staff. The personas focus on how people get information, what they need from it, and what they prioritise.

To develop these, we spent time across the trust speaking with colleagues. Clear themes have emerged: many staff receive too many emails and too much information, making it difficult to spot what's important. Staff told us they use their time looking at team updates and seeking out information relevant to their role.

We are now finalising the personas. Our next steps are to share them more widely. We would like to work with you as trust leaders, as well as care group boards, and people and culture, to improve our internal communications. Our aim is for all staff to receive the right information at the right time, supporting safe and kind patient care.



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

North Yorkshire and York crisis recruitment event

Our adult and young people's crisis services in North Yorkshire and York held a walk-in recruitment event on Friday 16 January. Anyone could attend to find out more about available roles, with an opportunity to interview on the day.

Objectives

- Inform people about the event in the most cost-effective way
- Encourage people to attend by highlighting the benefits of working in crisis care and the impact they can make
- Fill existing vacancies that are traditionally hard to recruit into

Our outputs

Social media advertising campaign
The team had limited budget, so we advised that this was the most cost-effective and targeted way to reach their audience. We set the ad demographics to cover 'York' and '30 miles from Selby'. This helped us reach people as far as Doncaster, Wakefield and Leeds.

Video-first
Created a social media video advert, as video is known to get more engagement. It clearly displayed our key messages that it was a free recruitment event that anyone can attend, and even interview on the day. Towards the end of the campaign, we changed the ad to a video of a crisis clinician saying how rewarding it is working in crisis care.

Facebook event
Included full information so we could link our advert to a dedicated page.

Word of mouth
Promoted the event internally to our colleagues through the weekly briefing, Team TEWV staff Facebook group and posters, encouraging people to tell their friends.

Media
Sent a press release to North and South Yorkshire press to widen our reach.

Organic social media posts
Utilised Facebook, Linkedin and Instagram to spread the word, sharing the videos we created.

Outtakes

Social media advertising campaign
£44 spent on ads from 2 to 13 January (Facebook and Instagram)
14,737 views (number of times the ad was displayed on Facebook and Instagram)
9,621 reach (number of accounts that saw the ad at least once on Facebook and Instagram)
300 landing page views

Facebook event
64 people responded to say they were 'interested' or 'going'.

Word of mouth
Received a small number of emails from people who were interested in the event and heard about it from people who work at our trust.

Organic social media posts
9.7k video views on Facebook
1.6k video views on Instagram
21 shares on Facebook
17 reposts on Linkedin

Impact

124 people attended the event in York, which surpassed team expectations. They were interested in the following roles:

- 25 nurse
- 84 support worker
- 15 admin

2 email enquiries from people that couldn't attend on the day.

People attended from as far as Glasgow, Northampton and Essex.