Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS
9 April 2026
at 10.30am

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

AGENDA

NOTE: there will be a confidential session at 10.00am for the Board of Directors to receive a patient/staff story.

No.	Agenda item	BAF Risk*	Lead	Timing
Standard Items				
1.	Chair's welcome and introduction (verbal)	-	Chair	10.30am
2.	Apologies for absence (verbal)	-	Chair	
3.	Declarations of interest (verbal)	-	All	
4.	Minutes of the last Board of Directors meeting held on 12 February 2026	-	Chair	
5.	Board Action Log	-	Chair	
6.	Chair's Report *(verbal)*	-	Chair	10.40am
7.	Questions raised by Governors in relation to matters on the agenda *(verbal)* *To be received by 10am on Tuesday 7 April 2026.*	-	Co-Sec	10.50am
Strategic Items				
8.	Board Assurance Framework Summary Report	All	Co Sec	10.55am
9	Chief Executive's Report	-	CEO	11.00am
10	Medium Term Plan	All	Int. EDS&T EDFE&F	11.10am
11	Integrated Performance Report	1, 2, 4, 5, 6, 7, 8, 10, 12, 13	Int. EDS&T Int. CG MD	11.20am
12	Corporate Risk Register	-	CN	12.00pm

BREAK (12.10pm to 12.20pm)

No.	Agenda item	BAF Risk*	Lead	Timing
13.	Report of the Chair of the Quality Assurance Committee, which includes the following report to Board:	-	Cmt Chair	12.20pm
	a. Clinically Ready for Discharge	2	Int. CG MD	12.30pm
	b. Patient and Carer Race Equality Framework – data publication	3, 4, 14	EMD	12.45pm

Matters for Information

14	Register of Sealing	10	Co Sec	-

Exclusion of the Public:

15	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	12.55pm

M Burnham
Trust Chair
1 April 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.

*Further information on the strategic risks included in the Board Assurance Framework (BAF) can be found in the summary report, which is item 8 on the Board agendda.

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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 12 FEBRUARY 2026 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS

Present
B Reilly, Interim Chair
B Murphy, Chief Nurse/Deputy Chief Executive
N Adethuberu, 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
J Preston, Non-Executive 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)
H Crawford, Executive Director for 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
N Black, Chief Information Officer
K Christon, Deputy Company Secretary (minutes)
A Howe, Freedom to Speak up Guardian (agenda item 11c)
S Paxton, Head of Communications (on behalf of Ann Bridges)

214. CHAIRS WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting.

215. APOLOGIES FOR ABSENCE

Apologies for absence were received from Alison Smith, Chief Executive, Ann Bridges, Executive Director for Corporate Affairs and Involvement and Jane Robinson, Non-Executive Director.

216. DECLARATIONS OF INTEREST

None.

217. MINUTES OF THE BOARD MEETING HELD ON 11 DECEMBER 2025

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

It was agreed that the action for N Lonergan [para 173 (8)] should be reflected in the Board Action Log and an update would be provided at the next meeting

Action: N Lonergan

218. BOARD ACTION LOG

Agreed: *the action log is received and noted.*

219. INTERIM CHAIR REPORT

The Chair presented her report, which outlined areas of focus and internal and external meetings she had attended since the last Board meeting.

She drew attention to the announcement by the Secretary of State that there would be a statutory public inquiry and that the Trust had indicated its intention to fully cooperate. She also noted the significant focus given to the Medium Term Plan and Medium Term Financial Plan, Board activity during the period and reflected on the value of engagement with staff and services through leadership walkabouts and Living Our Values awards.

In discussion:

1. J Preston welcomed the recent leadership walkabout to the Research and Development Team and he proposed that interest in research activity be more explicitly considered in recruitment panels, particularly for newly promoted consultants.

   K Kale acknowledged the point raised and noted that, as interview questions were often limited, questions on audit, clinical effectiveness and research were often combined. H Crawford also welcomed a focus for therapies roles, to ensure there was a multidisciplinary contribution to research.
2. Reference was made to discussion at Audit and Risk Committee on the Board's approach to strengthening assurance beyond Internal Audit to other independent sources of assurance, for example through independent quality reviews and peer reviews.

   It was agreed that this had been a challenge and it was noted that Internal Audit days had been reduced to provide capacity to support broader assurance activity.

   K Ellis also noted work was underway to review previous external assurance and past reviews, which would support the Board to take a consolidated view

   The Chair confirmed that Audit and Risk Committee would lead on this work and proposed to return to a query on the timeline for an independent quality review once the Chief Nurse had joined to the meeting.

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

P Bellas advised that the following questions had been received from a Governor:

- What's our realistic trajectory for discharge delays in 12 months?
- Where do the next £x million savings come from without quality impact?
- Why do staff feel short when numbers say we're not?
- Which risks are we reframing v actually reducing?

The Chair noted there was limited time for Executive Directors to prepare a response and proposed that more detail be provided to the Governor following the meeting, if required. However, initial responses were provided.

In response to the first question, N Lonergan advised that work was underway to review admission and discharge data, alongside the position on patients clinically ready for discharge, to provide a robust forecast.

Short term improvements were expected through tighter operational grip and new models of working, which included the transfer of care hubs in Durham and Tees Valley. Whilst initial work to improve patient flow may help to reduce overall delays, there was a risk that pressures would increase for a cohort of patients who were clinically ready for discharge and required significant or bespoke packages of care in the future. In parallel, longer-term strategic work was underway with directors of adult social care and the ICB to progress longer-term system level solutions.

The Chair acknowledged that this was a complex national challenge, rather than an issue unique to the Trust.

In response to the second question, B Murphy noted that all public organisations were expected to generate cash releasing efficiency savings (CRES) that would be reinvested in services. She advised that decisions would be informed by the Trust's equality and quality impact assessment process, where proposed changes would be reviewed by senior clinical leaders to assess their potential impact and mitigation before they were agreed. She proposed that it was difficult to define any saving that would have no clinical impact, as even non-clinical changes had potential to affect clinical capacity or flow.

She confirmed that the Board was well sighted on the issue and had considered the CRES position, in its approval of the Medium Term Plan and the Medium Term Financial Plan. K Kale also observed that reduced occupancy levels over the past year had allowed staffing levels to flex and contributed to improved quality outcomes.

In response to the third question, B Murphy advised that services had been asked to work to staffing levels determined through the Mental Health Optimisation Tool, which considered a number of factors including patient numbers and their acuity and dependency, the environment and physical healthcare needs. This reflected a shift back from higher resource levels during the Covid period to staffing levels that would be considered efficient and appropriate for current service need.

S Dexter-Smith advised that executive directors were aware of services that had struggled to achieve optimal staffing levels and the associated risks. She suggested that staff perception may also be driven by factors such as unclear workloads, demand and use of agency staff and commented on work underway on areas such as accountability, training and rostering to support more consistent and productive ways of working.

In response to the fourth question, P Bellas highlighted that four strategic risks set out in the Board Assurance Framework had reduced over the past year - quality of care, quality governance, partnerships and system working and regulatory compliance. The drivers for reframing risks included scheduled annual reviews, instances where the Board had identified a new risk and to reflect the dynamic nature of risks as circumstances change. By way of example, reference was made to the estates and physical infrastructure risk where scores had increased in response to the new capital regime and to reflect a higher risk environment.

220. BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

P Bellas presented the report, which provided information on risks included in the Board Assurance Framework (BAF) to support discussion at the meeting. He noted that the full BAF was provided in the confidential Board papers.

Agreed: *Board notes the report and agrees to take the strategic risks into account during its discussions at the meeting.*

221. CHIEF EXECUTIVE'S PUBLIC REPORT

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

She drew attention to the announcement of a statutory public inquiry and confirmation provided that the Trust would engage in an open and honest way. She also referenced the intensive work undertaken to finalise the medium term financial plan and placed on record her thanks to colleagues for delivery of the plan, which had been done at pace and in challenging circumstances. This was echoed by the Chair.

K Kale commented on the reported implementation of the Mental Health Act and preparatory work undertaken with progress to be overseen by Mental Health Legislation Committee. He proposed to hold a related workshop for committee members and other Non-Executive Directors.

In discussion:

1. A query was raised about the timescale for the independent quality review, as discussed earlier in the meeting and B Murphy advised that preparatory work was underway and a draft scope had been prepared. She proposed that, while the Trust wished to proceed quickly, time would be taken to ensure the process was robust. Timescales would be confirmed following discussion with the Chief Executive and the progress would be overseen by Quality Assurance Committee.

   Action: B Murphy
2. P Bellas confirmed that proposals for the 2026/27 Board seminar programme would be discussed at the Board seminar on 25 February 2026 and would follow a discussion on the Trust's strategic risks.
3. K Kale advised that the implications of the Mental Health Act reforms included a potential increase in the number of responsible clinicians, increased demand for independent mental health advocacy and implications within the administrative team.

   C Wood indicated that she was reassured by the preparedness of the Mental Health Legislation team.

222. INTEGRATED PERFORMANCE REPORT (IPR)

K Ellis introduced 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 improved performance in respect of bed occupancy and the dip in performance in out of area placements and noted that the Trust had been cited at a recent NHS Providers Improvement Network Conference in respect of the positive work undertaken to improve length of stay, out of area placements and bed occupancy. She also noted that neurodevelopmental assessments remained a challenge and advised that both ICBs had set out their intentions in relation to those waiting and improvements in the pathways. She then referenced ongoing improvement work around safety incidents and analysis of the latest national Mental Health Act data, which may suggest some areas of inequity in detention rates.

N Lonergan then drew the Board's attention to ongoing risks related to clinically ready for discharge, the reduction achieved in commissioned levels of occupancy, and reference in the report to the relationship between patient flow and clinically ready for discharge, with

pilots now in place to test and evaluate new approaches to determine if they delivered further improvements.

In respect of Neurodevelopmental services, she advised the Trust had submitted a joint clinically led proposal with CNTW on a future model and clinical protocol to support those waiting for services. Progress in Humber and North Yorkshire had stalled but there remained confidence in the direction of travel set out in their commissioning intentions.

She also drew attention to ongoing challenges within Talking Therapies, where the trust-wide action plan had led to improvements in waiting times, but where a sustained improvement in the reliable improvement and reliable recovery indicators had yet to be achieved, particularly in Co Durham and Tees Valley. A performance improvement plan would be developed, which would set a clear trajectory and investigate the disparities seen between deprived communities and other populations.

Finally, she noted challenges related to access to perinatal mental health services and the related increased capacity in County Durham. Work would also be completed to understand if there was a discrepancy in data.

In discussion:

1. B Murphy acknowledged that whilst the report showed the Trust met the standard for mandatory training, there would be teams and courses where compliance was below standard. She provided assurance that there was good governance and plans in place to understand where that was the case and to address underperformance.

   The Chair queried what action had been taken nationally in response to concerns about the overall burden of mandatory and statutory training and in response S Dexter-Smith confirmed that a national review was underway, with an expectation that requirements would reduce over time. She reflected that challenges were increased by training mandated by the Trust and commented on work underway to address the volume of training and to review all new training proposals.

   K Kale noted the added burden of intensive life support training when doctors joined the Trust, as this was not provided by acute trusts.

   H Crawford also referenced the impact of health and safety requirements on clinicians and proposed that by articulating their professional responsibilities and why training was required, staff would understand the purpose and value.
2. It was noted that Quality Assurance Committee had commended the team for work to reduce bed occupancy levels in line with commissioning and Board welcomed that this had been recognised nationally.
3. It was noted that the report indicated there was limited assurance in relation to the quality impact on patients waiting for services and a query raised about the action would be taken to improve confidence.

   In response, N Lonergan outlined current keep-in-touch processes and use of patient tracker lists to provide oversight and acknowledged that those approaches worked better for some, than others. She discussed the longer-term focus on service transformation and system wide working to provide more open access services to enable people to receive support when they needed it. Examples included the development of 24/7 centres and Getting Help and Getting More Help for children and young people.

As neurodevelopmental services was a shared system issue, work was underway to clarify the appropriate NHS mental health response alongside broader system solutions for those whose needs may be met through alternative routes. While a range of mitigations were in development, it was recognised that some level of risk remained.

Board reflected that, despite the significant amount of work underway, families may not perceive and indeed understand this activity or its impact.

B Murphy confirmed that under the Patient Safety Incident Response Framework, when investigating an incident, the Trust responsibility for a patient began once a referral was received. In the context of patients waiting to access services, it was important to ensure effective screening and early decision-making to understand if an immediate response was required from specialist services or if the person would be appropriately supported through alternative community services, recognising that some people may be known to other parts of the system.

Board sought assurance that the Trust was confident in its ability to identify those that required specialist support and N Lonergan acknowledged that this varied by specialty and pathway and that neurodevelopmental services remained an area where visibility was more limited while work toward a broader system-wide solution continued.

K Kale added that for the neurodevelopmental waiting list, a clinical prioritisation approach had been proposed, which recognised the risk of misdiagnosis and diagnostic overlap for those already known to Trust services.

B Murphy highlighted that levels of risk tolerance varied significantly across services and by way of example, noted that there would be a lower risk tolerance for eating disorder services, which had a higher mortality risk compared to other mental health services.

K Ellis noted that both ICBs had set out clear commissioning intentions and recognised these were complex system-wide challenges that required joint action to ensure the right level of response to meet population need and clarity on who was best placed to deliver services. Alongside these intentions, the Trust worked with each ICB to agree next steps, sequencing and priorities to aim to enter 2026/27 with a clear and deliverable plan.

Board sought clarity on reference in the IPR to Quality Assurance Committee actively monitoring the quality impact of those patients who were waiting to access services and B Murphy acknowledged this was inconsistent with the committee report to Board.

The Chair proposed that Quality Assurance Committee maintain oversight to provide assurance to the Board and B Murphy advised that this aligned with a recent committee development session, where committee had agreed an area of strategic focus in relation to access to services and waiting times.

4. Board noted that, despite sustained effort and focus, rates of sickness absence were high and that this appeared to be an upward trend, which would impact on staff perception about staffing levels and resources. A query was raised on whether there were any factors unique to the Trust and if external benchmarking had been undertaken to consider learning from others.

In response, S Dexter-Smith acknowledged sickness absence was a longstanding challenge and noted that work was due to start in March 2026 to strengthen team level accountability, reduce processes and apply greater rigour to sickness absence

management. Data would be reviewed to understand those interventions that were effective, recognising that there was no consistency in the reasons of sickness absence between different teams and there was an opportunity to learn from those with low sickness levels.

L Romaniak noted that as the NHS was the largest employer in the region, there would be a correlation between NHS sickness absence and sickness levels in the broader population and proposed that alongside benchmarking it would be important to recognise this local context. She went on to note that sickness absence was largely driven by long-term sickness, and whilst health and wellbeing interventions may support some from entering long-term sickness, it would be unlikely to resolve underlying long-term health conditions.

S Dexter-Smith advised that training was available to managers to help them to manage long-term sickness in a more rigorous way. Responding to a query, she advised that sickness absence also varied across HNY Care Group and she emphasised the need to understand what sat beneath the headline figures, such as pockets of deprivation and challenges linked to the rurality of the area.

5. B Murphy drew the Board's attention to the small increase in out-of-area placements in December 2025 due to the temporarily closure of a ward following concerns about the quality and safety of care and she provided assurance that this had been a deliberate decision to prioritise quality over performance.

   A concern was raised about Board visibility of the closure and B Murphy confirmed that the matter had been reported into Quality Assurance Committee and was referenced in the committee report to Board. The Chair asked that the matter be discussed further in the private session of the Board meeting.

Agreed: *Board confirms there is –*

i. Good controls assurance on the operation of the Performance Management Framework.
ii. Good performance assurance on the Integrated Performance Dashboard.
iii. 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.
iv. That the strategic risks are being managed effectively.

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

R Barker, Chair of People, Culture and Diversity Committee (PCDC), presented the report and summarised the key areas of discussion at the committee meeting held on 12 January 2026.

In discussion:

1. R Barker confirmed that both Mental Health Legislation Committee and PCDC received patient or staff stories at their meetings and this was seen as valuable in illustrating how legislation was applied in practice, to improve committee understanding of impact and allowed committee the opportunity to engage directly with staff.

   S Dexter-Smith also noted that as Board-level staff stories had reduced, the provision of staff stories at committee level had become increasingly beneficial.

2. S Dexter-Smith confirmed that the new ESR system was a national solution and expected to be more user-friendly than the current system. The Trust had not offered to be in the first wave of roll out and would take learning from those that had. In the meantime, preparatory work was underway to ensure data quality.

   Commenting further L Romaniak noted the Trust had been disappointed about the functionality of the new system and acknowledged that this may be expected given the scale of roll out and variance in existing systems. S Dexter-Smith added that NENC would explore potential digital enhancements.

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

224. PAY GAPS

S Dexter-Smith presented the report, which demonstrated adherence to gender pay gap reporting legislation alongside further context to explain why there were gender pay differences with a view to demonstrating the Trust's commitment to equality.

In discussion:

1. S Dexter-Smith clarified that gender and ethnicity pay gap figures did not indicate unequal pay for the same work. Instead, the data indicated there were differences in opportunity and progression for staff from BAME backgrounds in middle tier pay bands. She also noted themes arising through other reporting, for example progression following maternity leave and higher instances of salary sacrifice among female staff, which indicated areas where support could be provided.

   The complexity of the issue was acknowledged, and it was noted that the report had been explored in detail by the committee.
2. S Dexter-Smith acknowledged that the level of effort involved in reporting was not proportionate to the return and consideration had been given to providing assurance through other routes. However, the pay gaps report was a statutory requirement.
3. A query was raised about the action that would be taken in response to the data and S Dexter-Smith confirmed that the data would inform ongoing work in the Trust to help change beliefs about what people could aspire to do. By way of example, she commented on anti-racism work to address cultural barriers, work undertaken with the staff networks to improve experience, training and influence and work to increase the visibility of diverse role models, which included sharing staff experience at Board level.
4. B Murphy acknowledged that the data highlighted disproportionate experiences and outcomes for staff from global majority backgrounds and reflected that staff may reasonably expect the Board to act on this information. She proposed that, while some progress had been made this was slower than expected and further attention may be needed to understand any underlying causes.

   S Dexter-Smith reiterated the intention to develop a more integrated approach to reporting, to enable the committee to better understand the overall narrative, rather than consider issues in isolation.
5. L Romaniak commented on the breadth of activity underway to address inequality and support progression as a large employer and anchor organisation. This included through the Leadership and Management Academy to support career progression, use of the apprenticeship levy, development of staff networks to give people a voice and support in individual professions through structured mentoring and training. She reflected that the outcomes of this work would take time and welcomed the report as an opportunity to consider if meaningful progress had been made.

6. As a public document caution was expressed about interpretation of the data, which on face value may suggested there were issues due to the statutory definitions used, rather than actual inequity. Reference was made to the consultant merit awards and the impact of salary sacrifice arrangements, which reflected personal choice.

   S Dexter-Smith concurred with the point raised and advised that whilst the statutory information would be published to the Trust website, it would be accompanied by clear narrative to avoid misinterpretation.
7. A query was raised about the main factor that had influenced the change in the pay gap median from 0 to 2% and it was proposed that this supporting narrative be included in future reports. S Dexter-Smith agreed to clarify following the meeting.

Action: S Dexter-Smith

Agreed:

i. There is substantial assurance that the Trust can demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation, ethnicity and disability pay gap reporting along with further context to demonstrate the Trust's commitment to equality.

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

iii. Board 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 may therefore not necessarily reflect improvements for BAME staff or fairer pay across pay bands.

iv. Board 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 still being how has resulted in a limited picture for the Trust to consider this year.

v. Publication of the Gender Pay Gap data on the Trust and government website by 30 March 2026.

225. EQUALITY DELIVERY SYSTEM 22

S Dexter-Smith presented the report, which provided assurance that the Trust had met its obligations under the NHS Contract, to complete EDS 22.

She advised that this would be the last report to Board, as agreement had been reached with the integrated care board to integrate the report with other reporting. She also noted the limited value of the scoring, due to the requirement to select different teams each year.

Agreed:

i. There is good assurance that a robust process has been undertaken when completing the proposed scoring and evidence for EDS 22 for 2025.

ii. Board takes 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.

iii. Board ratifies the scores of EDS 22 and agrees to the publication of EDS 22 on the Trust website, as required.

226. REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN

S Dexter-Smith introduced the report which outlined the transition to the new Freedom to Speak up (FTSU) service and provided data on how the service had been used.
She welcomed the proactive response to visit services where concerns may have been identified and advised that, whilst an initial drop in usage had been anticipated following the change in service, uptake had been strong and the Guardian had met with over 1,000 staff on site visits since he started in mid-November 2025. This included areas where engagement had previously been limited.

A Howe reported a positive start to the service and concurred that there had been strong staff engagement and recognition of its independence. He noted the benefit of 24/7 access, with early use of the service and direct outreach which had helped to build confidence and raise awareness. He noted progress in engagement with previously hard-to-reach areas, that staff felt confident to pass on his contact details to others and the overall increase in staff contacts, some of which had been anonymous, which may be expected until staff gained confidence service.

In discussion:

1. J Preston advised that he had met with A Howe and was confident about early implementation of the service. He noted the increase in anonymised contact, which would make follow-up with individuals more challenging and agreed that this may decrease as staff gained confidence in the service. He also reminded Board that the service sat alongside other routes to raise a concern, which included direct contact with directors
2. K Ellis welcomed the report and the level of assurance provided and noted it was a final item to be closed within the provider capability assessment. She went on to propose that the intentional commissioning of the service had established a strong core offer that would support cultural improvements.

   S Dexter-Smith also noted the Guardian's attendance at the BAME network, to further raise visibility.
3. Board welcomed the added value of the 24/7 service, particularly in relation specialist or restricted settings and out of hours services, where there was an opportunity to observe team culture.
4. Board welcomed the rich data provided in the report and queried how the service would be used to encourage staff to raise concerns related to patient safety and quality. In response, S Dexter-Smith advised that while the service was a valuable route, it was not the sole mechanism for staff to raise concerns. She commented the role of the speak up group and wider staff engagement to join up intelligence to identify issues at an earlier stage and acknowledged the need to maintain a balance between provision of an open Freedom to Speak Up service and its focus on patient safety and staff wellbeing.

   Commenting further, B Murphy emphasised that understanding team culture was directly linked to patient safety. She added that executive directors regularly shared and triangulated concerns and used multiple data sources to build curiosity, understand culture and support patient safety.
5. Clarification was sought on the nature of the systems and processes theme and A Howe explained that the theme brought together a range of issues related to organisational systems and ways of working, such as policies not followed, rather than only IT system issues.

Agreed: *Board receives the report with good assurance from the new FTSU provision.*

227. QUARTERLY REPORT OF THE GUARDIAN OF SAFE WORKING HOURS FOR POSTGRADUATE DOCTORS, QUARTER 3 2025/26

S Beattie 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 advised that there were no overall concerns about the volume of exception reporting. Service changes in CAMHS may lead to an increase in exception reporting in the next quarter, with a further rota review to be completed, if required. There were rota pressures in North Yorkshire, with middle tier doctors acting down to cover sickness absence and an increase in education exception reports.

She also commented on preparatory work undertaken by medical staffing to prepare for the new contractual reforms and communications to support a clearer understanding of the purpose of exception reporting and new processes in place to ensure that exception reports would be processed within seven days.

In discussion:

1. A query was raised about the risk associated with shifts undertaken by SAS doctors who did not have a Section 12 and K Kale advised that it did not present a risk, as a consult would attend if called out. He acknowledged it would be preferable for doctors to hold a Section 12 and work was underway to progress this.
2. A query was raised about the financial impact of the reforms and S Beattie advised that exception reporting for work completed beyond contracted hours had been infrequent and the financial risk was therefore low. She acknowledged that the position may have been underreported and there was a risk that reporting would increase once a payment was available.

   She went on to emphasise that exception reporting should only arise where a doctor had worked beyond their scheduled hours to maintain patient safety, not through choice, and that recurrent issues should be addressed through clinical supervision. She also noted challenges arising from the reforms, which required the Guardian to seek the consent of the resident doctor before contact with the clinical supervisor, which would limit her ability to intervene early.
3. K Kale highlighted that exception reports may also reflect the impact of strike action.

Agreed: *Board receives the report with assurance that resident doctors are safely rostered and that their working hours are safe and in compliance with their terms and conditions of service.*

228. GETTING THE BASICS RIGHT FOR RESIDENT DOCTORS

A Ghanzanfar presented the report, which provided assurance that the organisation had considered the NHS England mandate that set out clear expectations in the form of a ten-point plan to improve the working lives of resident doctors.

In discussion:

1. Board welcomed the broadly compliant position and queried how resident doctors may perceive the position. In response, A Ghanzanfar explained that views would differ between the north and south, largely due to resource variation between each deanery, with doctors in the south more likely to express concerns about lack of influence over placements and the impact on their wellbeing.

2. A query was raised about the implications of a reduction in mandatory training requirements and in response, K Kale explained that there were no national requirements as trainees would be placed in different settings. He noted the example of Leeds, where doctors had 12 items of training compared to 31 in TEWV, plus an additional 7 for forensic services. Work was underway to achieve a more proportionate multi-professional approach.

   S Dexter-Smith confirmed that the Trust had held a workshop to review all resident doctor mandatory training and work was underway to consider what could safely be removed.
3. A Chair raised an issue about what action NHS England had taken in respect of issues outside the Trust's control and in response, K Kale advised that discussions had taken place with the Regional Medical Director and each deanery and the Trust Chair had escalated concerns through other channels. The position was not expected to be resolved quickly.

Agreed: *there is good assurance on progress since the last Board report in October 2025.*

229. REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

J Preston, Chair of Quality Assurance Committee (QAC), presented the report and summarised the key areas of discussion at the committee meetings held on 22 December 2025 and 5 February 2026.

He advised that committee had concluded there was reasonable assurance of the quality of care within care groups and this assessment had informed developed of the committee's workplan, where there was agreement to move away from process monitoring to a stronger focus on impact, outcomes and risk. The February meeting reflected this change and attention was drawn to the complaints and patient experience report, which highlighted an increase in AI-generated complaints that were more complex and time-consuming to investigate and impacted on response times.

B Murphy returned to a point raised earlier in the meeting on the closure of a ward and acknowledged that, as a public report, it did not sufficiently explain the underlying issue and she would provide further detail in the confidential session.

In addition to that reported, she then noted:
- A recent Regulation 28 notice from a coroner who, whilst recognising the progress made on safety planning for section 17 leave, had indicated that further improvement was possible.
- The intensive approach taken to quality concerns in Harrogate and Ripon Community Team, which had arisen despite previous assurances.
- Consideration of a report on rehabilitation services, which had not been sufficiently aspirational in relation to support to enable people to live in the community.
- Committee had acknowledged the progress made to reduce restrictive practice and agreed there was reasonable assurance on progress to reduce restrictive practice compared to the review and publication by NHS England.

In discussion:

1. N Black concurred with the Committee Chair's comments that increased use of artificial intelligence had led to more detailed complaints and potential to base complaints on non-factual information.
2. Board expressed disappointment that despite the recognition of progress by the coroner on Section 17, this had not been sufficient. J Preston considered that

significant progress had been made over the past two years and it was agreed that committee would report back to Board via the 3A report.

Action: B Reilly/B Murphy

3. Board noted a service level agreement for a Gastroenterologist for Birch Ward remained outstanding and K Kale explained that CDDFT had pulled out of the previous SLA due to capacity and that alternative support had been explored with other regional Trusts. The Chair offered to support those discussions, if needed.

   Commenting further, B Murphy advised that the Provider Collaborative Quality Group had agreed that the Trust would move out of enhanced oversight, as sustained improvement in this area had been demonstrated.
4. B Murphy confirmed that an action plan was in place to address challenges related to evidencing statutory duty of candour. H Crawford added that this had been considered at the Organisational Learning Group and nine teams would take part in a pilot that aimed to embed duty of candour consideration and actions into after action reviews, to strengthen evidence and learning. The pilot would run through to June 2026 or until there was sufficient data from after action reviews that had taken place.

Agreed:

i. Board receives the report with good assurance of the governance, oversight and management of risks to quality of care and that the areas of reasonable and limited assurance are understood.

ii. The direction of travel for improvements to the committee's governance and effectiveness is supported.

230. QUARTERLY LEARNING FROM DEATHS REPORT, QUARTER 3 2025/26

K Kale presented the report, which provided assurance that the Trust's approach to reporting and learning was in line with national guidance.

He drew attention to the increase in patient deaths reported to LeDER and analysis, where there had been a seasonal rise in deaths during November and December due to physical health causes. This was consistent with national findings. He also noted the national report indicated that 40% of deaths were avoidable and that people with a learning disability and autism tended to die 19.5 years earlier than the general population.

He went on to note one inpatient death had been reported as a suspected suicide, and the Trust had taken learning in relation to potential anchor points in ward environments and a briefing had been circulated.

In discussion:

1. A query was raised on how learning from deaths was considered by the Organisational Learning Group (OLG) and H Crawford explained that, whilst data was not automatically fed into OLG, overarching themes from mortality reviews were considered by the group. Quality Improvement work would be undertaken to improve the flow of information.
2. Board noted there were a number of recurring themes and queried whether the Trust was able to demonstrate that it genuinely had learnt from deaths over time. In response, K Kale proposed that recurrent themes, such as record keeping, would continue to appear, which reflected the central role that they played.

   H Crawford proposed that learning could be demonstrated and explained that themes would be considered by the OLG and progress tracked through quality improvement work. She noted that there were some issues that were also reflected nationally, which

required a multi-agency response and were therefore difficult to influence. B Murphy added that she considered there was clear evidence of significant improvement in practices over time, which included a consistent approach to physical healthcare for people with a learning disability and the quality of risk assessments.

3. A query was raised on how non-executive directors would take assurance beyond data quality and examples of learning, to demonstrate there was a tangible impact, particularly whether learning had reduced harm or death.

   K Kale acknowledged the challenge and noted that the report met the statutory requirement to share themes, rather than evidence what had been prevented or avoided, which would require a more discussion on learning from individual cases.

   It was noted that Quality Assurance Committee had discussed how the Trust demonstrated that learning was embedded and had made a difference, which spoke to organisational culture around continuous improvement. It was noted that committee would focus not only on process but also on outcomes and impact and proposed that reports be structured to draw this out more clearly.

Agreed: *Board notes the report, with good assurance of reporting and learning in line with national guidance.*

231. LEADERSHIP WALKABOUT FEEDBACK – JANUARY 2026

S Dexter-Smith presented the report, which summarised feedback from leadership walkabouts that took place in January 2026.

In discussion:

1. A query was raised about the work of the Leadership and Management Academy to address workforce and leadership capability concerns. In response, S Dexter-Smith acknowledged there was a lag between the programme and frontline impact and she explained that the academy had begun with senior managers and was now extended to team managers.
2. The Chair reflected positively on the leadership walkabouts and queried how the level of assurance recommended to Board was measured. In response, S Dexter-Smith indicated that there was good assurance that the report reflected the visits undertaken.

   B Murphy also noted the report also demonstrated that the Board and Governors were visible across all Trust sites.

Agreed: *Report is received with good assurance that it reflects feedback from the leadership walkabouts held in January 2026.*

232. REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

R Barker, Chair of Mental Health Legislation Committee, presented the report and summarised feedback from the committee meeting held on 19 January 2026.

She highlighted changes in committee support, the regular attendance of C Morton, Lived Experience Director to support committee discussion, and reflected on the value of individual case studies to deepen committee understanding of Mental Health Act issues.

In discussion:

1. A query was raised about committee oversight of Section 17 leave and R Barker advised that statistical data would be reported to MHLC and risks related to quality would be reported to Quality Assurance Committee. She noted that MHLC had good assurance that data was collated and reported correctly and satisfied the Mental Health Act.
2. N Black advised that work to improve access to Wi-Fi technology had progressed to plan and work on inpatient sites would conclude the following week, subject to verification that coverage was acceptable. Recent reports suggested that Wi-Fi was no longer an issue in those sites. Work would then roll out to remaining sites through to May 2026.

   B Murphy confirmed that planned Wi-Fi improvements had been shared with the CQC.

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

233. COMMUNICATIONS UPDATE

S Paxton presented the report, which provided an update on the progress made on delivery of the Trust's communications strategy in December 2025 and January 2026.

She noted the report included the period following the announcement of the public inquiry, which had shaped some of the sentiment and media activity.

In discussion, a query was raised about the effectiveness of communications with Council of Governors' and S Paxton advised that Governors received a monthly newsletter and a communications report was presented to each Council of Governors' meeting. This would be reviewed to ensure it reflected the breadth of activity and impact. She offered to follow up on concerns outside of the meeting. **Action: S Paxton**

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

234. BOARD ASSURANCE FRAMEWORK (VERBAL)

Agreed: *there have been no matters discussed during the meeting that needed to be reflected in the Board Assurance Framework.*

P Bellas confirmed that the Trust's strategic risks would be considered in the Board seminar on 25 February 2026.

235. EXCLUSION OF THE PUBLIC

Agreed: *that representatives of the press and other members of the public be excluded from the remainder of the meeting on the ground 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.*

On conclusion of confidential business, the meeting ended at 3.37pm.

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Board of Directors
Public Action Log

RAG Ratings:

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

Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
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	**See agenda item 13a**	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 (see board minutes 173 (8)).
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	**Propose action be closed**	**Update provided to Board Feb26** **Regular 6 month updates have been scheduled on the Board Workplan for 2026/27.**
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	**See agenda item 10 (confidential session)**	**April update: Board annual risk seminar held on 25 February 2026 and the outcome from this is included on the Board agenda. Trust Risk Manager has worked with Nursing and Governance leaders to restate the risks for consideration within the overall review of the 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	**Propose action be closed**	**Completed**
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	**See agenda item 11 (confidential session)**	
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	**In progress**	**April update: meeting arranged for 23-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		
12-Feb-25	**221 (1)**	**Independent Quality Review**	**Timescales for the independent quality review to be confirmed and progress to be overseen by Quality Assurance Committee**	**B Murphy**	**Jun-26**		**B Murphy to proivde progress report to Board in June 2026.**

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
12/02/2026	**224 (7)**	**Pay Gaps report**	**S Dexter-Smith to clarify the main factor that had influenced the change in the gender pay gap median from 0 to 2%.**	**S Dexter-Smith**	**Apr-26**		**Verbal update to be provided at the April Board meeting**
12/02/2026	**229 (2)**	**Section 17 leave**	**Quality Assurance Committeee to monitor continued progress on safety planning for Section 17 leave and provide assurance to Board**	**B Reilly B Murphy**	**Apr-26**	**Propose action be closed**	**April update: considered by the QAC as part of the escalated risks in the work plan. Overall improved performance is demonstrated however QAC will continue to have oversight in the standard of safety planning is regularly delivered and has been sustained.**
12/02/2025	**230 (3)**	**Learning from Deaths**	**Quality Assurance Committeee to consider how the Trust demonstrated that learning was embedded and had made a difference.**	**K Kale**	**Apr-26**	**Propose action be closed**	**April update: examples of impact of learning from national/regional and local learning were provided. There was also a discussion on how themes from learning were discussed in Organisational Learning Group and disseminated via learning webinars and various other methods.**
12/02/2026	**233**	**Communications with Governors**	**Review to be completed of the monthly newsletter to Governors and the communications report presented to Council of Governors.**	**S Paxton**	**Jun-26**	**In progress**	**April update: a revised communications report is in development. The first report in this updated format will cover activity and impact starting from April. This will be shared with the Executive Team and we will review where else this report is shared, including how we can update Governors on progress.**

Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9 April 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

The Board is asked to note that the Quarter 4, 2025/26 position will be reported to its meeting to be held on 11 June 2026.

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
	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
2	✓			**Demand** **There is a risk** that people will experience unacceptable waits to access services in the community and for an inpatient bed **caused by** increasing demand for services, commissioning issues and a lack of flow through services **resulting in** a poor experience and potential avoidable harm.	**Mng Dir**	**QuAC**	**High 16** (C4 xL4)	**Moderate 12** (C4 xL3) Q4 25/26	**Q4 25/26** Implement transformational developments (-1L)	**Good**	Partnership Arrangements Demand Modelling Operational Escalation Arrangements Integrated Performance Reporting Establishment Reviews Strengthen voice of Lived Experience
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
4	✓	✓	✓	**Quality of Care** **There is a risk** that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; **caused** by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions **resulting** in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.	**CN**	**QuAC**	**Moderate 9** (C3 x L3)	**Moderate 9** (C3 x L3) (Target Achieved)	Target Achieved	**Substantial** ↑	Complaints Policy ↑ 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

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
	1	2	3								Organisational Learning Group
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
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
7	✓	✓	✓	**Data Security and Protection** There is a risk of data breach or loss of access to systems, caused by successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and information integrity, reputational damage and loss of confidence in the organisation.	**CEO (CIO)**	**RPC**	**High 20** (C5 x L4)	**Moderate 10** (C5xL2) **2025/26 Q4**	**30/06/2026** Internal Audit assurance on 2024/25 DSPT with submission of Meets Standards; and control moves to substantial assurance (-1 L)	**Good**	Digital, Data & Technology (DDAT) Skills and Knowledge 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

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
	1	2	3								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
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
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 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
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**	**DoFE**	**Board**	**High 16 (C4xL4)**	**Moderate (12) (-1L)**	TBC Rectification date for works – subject to access to national capital (uncertain) and	**Good**	Roseberry Park Rectification Programme

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
	1	2	3								
				our service quality, safety, financial, and regulatory standing.					Trust cash position / scope of works		Capital Programme
											External Audit
12	✓	✓	✓	**Financial Sustainability** **There is a risk that** constraints in real terms funding growth **caused by** government budget constraints and underlying financial pressures **could adversely impact** on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing	DoFE	RPC	**High 20** (C5 x L4)	**High 20** (C5 x L4) -	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
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
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

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
	1	2	3								
15			✓	**Transformation** There is a risk that failure to ensure we have the capacity and capability to scope and deliver a Trust-wide programme of transformation, realise and evidence anticipated benefits, will mean we do not deliver on the Trust ambition to impact positively on the mental health and wellbeing of our local populations	EDTS	RPC	**High 16** **(C4 x L4)**	**Moderate 12** **(C=4 x L=3)** ~~**Dec 25**~~ **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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9 April 2026**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**Alison Smith, Chief Executive**
Author(s):	**Alison Smith**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***

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.

Winter Preparation
Winter preparation enabled TEWV to maintain its operational flow over a period of high demand, the impact of Flu and over the festive season. Our Care Board leadership teams ensured a consistent approach that enabled both our community and inpatient services to remain within our resources, the out of hours support and on call facilitation was robust and provided the level of oversight that maintained our care and bed oversight and I would like to thank all for their efforts during this time.

Public Inquiry
On the 11th December 2025 the Secretary of State shared that he had met with families from our community, who had requested a public inquiry into the deaths of those in the care of Tees, Esk and Wear Valleys NHS Foundation Trust, and that their request has been granted.
The public inquiry will enable the parents and family to have transparency and truth, and we are committed to responding to the PI with humility, grace and respect. It is 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.

Electronic Patient Record System
Following completion of a competitive procurement process, the Trust has selected Rio by The Access Group as its preferred supplier for the new Electronic Patient Record system. This system is widely used across 26 Mental Health Trusts across the country, operationally supporting their day-to-day service delivery. The new contract is expected to be signed before Easter, with implementation commencing immediately thereafter. The programme is planning for a go-live date of 15 April 2027, ahead of the expiry of the Trust's existing EPR contract in June 2027.

Board Assurance Framework
The TEWV BAF will be transitioning onto the InPhase programme which provides a serviced online BAF system and we will be ceasing the manual BAF process. The Board of Directors will receive the first InPhase update in June 2026.

Medium Term Plan
The TEWV MTP submission supported and authorised by the BoD was received well and our NHSE NEY colleagues accepted our compliant plan. NHSE NEY colleagues called for a greater ask from those in the NENC ICB, within a rapid time frame due to a regional/national deficit. TEWV EFO and CEO supported the ask and this will be reported within the Finance report.

IPQR
TEWV executives are in the process of reviewing and updating the IQPR data, the reports today remain as is, however we anticipate demonstrating the improvements planned over the next two months.

Industrial Action
The recent announcement of a Resident Doctors Industrial Action due to start on 7th April, initiated a series of planning sessions and we will be working to ensure service provision is in maintained over the IA period, as previously our rigorous planning and support. has mitigated impacts

National Priorities programme
The newly appointed NHSE Director for Mental Health, Learning Disabilities and Neurodiversity as part of the National Priorities Programme met with all MH/LD CEOs on the 10th March. Dr Nick Broughton shared his priorities and focus for MH, LDA and ND for the communities we serve and the improvements needed. The focus of working together, collating experience, expertise, energy and passion – which all CEO's supported.

NHS Operating Model
The NHSE Northeast and Yorkshire region, alongside all NHSE regions are to become the key part of the new NHS Operating Model in England, providing clarity on the organisational responsibilities, help improve operational performance and devolve decision-making. The new regional Blueprint comes ahead of the abolition of NHSE as the NHS merge into the Department of Health and Social Care The blueprint demonstrates the core functions of the regional team which will maintain their geographical footprints, emphasize their performance management role and emphasise the enhanced and expanded roles for the regional team. Which will be supported by new governance structures with an executive team, chief executive and non-executive chair in each region. Recent appointments have been made Bill Mc Carthy has been appointed as the NEY Chair and Fiona Edwards remains the CEO.

Board Development
As part of our ongoing development the executives have begun work on exploring and developing their own cultural competence with Mevish Shaffi-Ajibola from Socially Inspired. This is due to continue in Q1 as part of our wider executive development programme and forms part of our broader commitment to ensuring that leaders are well equipped to support inclusive services that serve our communities effectively and safely.

International events in Iran
Due to the ongoing fuel, diesel availability risks due to international events in Iran, TEWV colleagues are considering approaches to maintain business as usual prioritising clinical should the situation escalate. Whilst this will be managed within our operational delivery agenda, it is worth noting this is being addressed following national statements regarding the intention to prioritise public services.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	Trust Board
Date:	9th April 2026
Title:	Medium Term Plan
Executive Sponsor(s):	Kathryn Ellis, Interim Director of Transformation and Strategy, Liz Romaniak, Director of Finance, Estates and Facilities
Author(s):	Kathryn Ellis and Liz Romaniak

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

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

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

Relevant BAF risk/s (name and number)	***Relevant control***
All BAF risks with additional emphasis on: **12 Financial Sustainability** **15 Transformation**	This paper relates most notably to Board Assurance Framework risks concerning **financial sustainability** and **delivery of transformation**. The Medium Term Plan (MTP) sets out the Trust's five year strategic and financial direction and therefore underpins all strategic risks. This paper strengthens Board assurance by: • confirming the robustness of Board and Committee oversight throughout the planning process and NHSE mandated MTP phases; • updating on the outcome from contract negotiations with Humber and North Yorkshire • setting out how risks and dependencies identified at the point of approval are being managed as the Trust moves into delivery; and • clarifying the focus of ongoing Board oversight including linkage to management of the regional financial position being managed through NHS England arrangements.

Executive Summary

This paper provides the Trust Board (in public) with assurance following submission of the Trust's Medium Term Plan and associated Medium Term Financial Plam to NHS England on 12 February 2026, and sets out the Trust's transition from planning into delivery. It provides summary level financial plan details against which performance will be monitored by the Board.

The Trust Board approved submission of the Medium Term Plan in February 2026 on the basis of **good assurance** on the robustness of the planning process, governance and triangulation. This assurance was informed by extensive Board and Committee scrutiny, including review of assumptions, risks, mitigations and the NHS England Board Assurance

Statements. The Chair of Resources and Planning Committee reported that the Committee had taken good assurance on process and between reasonable to good assurance on progress and triangulation.

Following submission, NHS England's regional team has confirmed that the Trust's plan is **compliant on headline planning requirements**, providing independent external validation of the adequacy of the Board's assurance approach.

As the Trust moves from planning into implementation, the Board is asked to take **reasonable assurance** at this stage on progress in establishing delivery arrangements. While there has been movement in some contextual risks and improvement in controls (notably the establishment of programme level transformation governance), it is too early in April (month 1) to evidence good assurance on delivery. Some material dependencies remain, including confirmation of national capital allocations.

A further update will be brought to the Board in June 2026, providing more detailed assurance on delivery, progress against areas assessed as "maturing" at the point of February submission, and updated risk and dependency management.

Purpose of the report

The purpose of this report is to:

- provide assurance to the Trust Board on the governance and oversight of the Medium Term Plan following submission;
- summarise external feedback from NHS England;
- clarify the current assurance position as the Trust transitions into delivery; and
- set expectations for further Board oversight and assurance.

Overview

<u>What the Medium Term Plan was designed to achieve</u>

The Trust's Medium Term Plan was designed to set a clear and realistic direction for how the Trust will continue to deliver high quality mental health care over the next five years, while responding to rising demand, workforce pressures and financial constraints.

The Plan brings together priorities for quality, access, workforce and sustainability and sets out how the Trust will contribute to delivery of the NHS 10-Year Plan. In particular, it focuses on the three national shifts in care:

- moving more care from hospital into community settings;
- strengthening prevention and earlier intervention to improve long term outcomes; and
- making better use of digital technology to improve access, experience and productivity.

Alongside these shifts in care, the Plan also addresses '**how the Trust works'**. This includes strengthening clinical leadership, reducing unwarranted variation, improving productivity, supporting the workforce, and ensuring that governance, systems and ways of working enable staff to spend more time delivering care. This aligns closely to national expectations about improving Productivity, adopting 'Getting it Right First Time' (GIRFT) principles, and improving value and outcomes measurement.

The Medium Term Plan was developed to ensure the Trust is well prepared for the future, aligned with national NHS priorities and local system plans, and able to continue providing safe, effective and sustainable services that meet the needs of its communities.

How the Board discharged its role

In line with the NHS Medium Term Planning Framework, the Trust Board discharged its responsibilities for the development of the Medium Term Plan through active leadership, scrutiny and challenge, spanning all plan phases as set out by NHSE rather than by simply endorsing a final document. A key responsibility was to ensure that there was strong clinical, service user and partner engagement throughout Plan development which was evidenced.

Setting direction and expectations

The Board set clear expectations that the Plan should align with the Trust's purpose and strategic framework (*Our Journey to Change*), support national NHS ambitions, and remain realistic and deliverable within known financial, workforce and system constraints.

Reviewing drafts and challenging assumptions

The Board was engaged throughout the planning cycle, including through a series of scheduled Board seminars and formal Board and Resources and Planning Committee papers and discussion. It reviewed draft iterations of the Plan and the Board Assurance Statements and provided constructive challenge on financial sustainability, workforce assumptions, capital constraints, productivity, quality and equality impacts, and the phasing of transformation.

Supporting national ambitions and the three shifts

The Board explicitly considered how the Plan supports delivery of the three national shifts and how these are enabled by changes in productivity, workforce models, clinical leadership and governance, rather than treating transformation as a standalone activity.

Setting the conditions for continuous improvement

The Board focused not only on the content of the Plan, but on whether the Trust has the conditions in place to deliver it. This included assurance on data driven, clinically led improvement approaches, development of improvement capability and capacity, and governance and reporting arrangements that support learning and course correction. In March 2026 Resources and Planning Committee received a detailed report on progress and transformation governance structure established to ensure strong Executive sponsorship of each of the Trust's transformational shifts. This included a commitment to regular reporting through Executive Directors Group to Board Committee and Board on progress, and importantly impact of the work.

Working collaboratively across the system

The Board sought assurance that the Trust engaged early and consistently with ICBs and system partners through operational planning channels, shared assumptions and risks, participated in peer review and system challenge, and ensured the Trust's Plan both stands alone and contributes to wider system priorities. It also reflects that there are key transformational changes that require effective system partner support; e.g. collaborative working, support for engagement and consultation – and therefore has been developed jointly to ensure full partner engagement.

Formal approval and ongoing oversight

The Board formally approved the Medium Term Plan and supporting Medium Term Financial Plan appended at high level to this report for submission once satisfied that appropriate challenge had taken place and risks and constraints were clearly understood. The Board was explicit that approval did not represent the end of assurance and that delivery would remain subject to ongoing oversight.

Key delivery concerns related to:

- Efficiency plans; both the value targeted and delivery assurance
- Capital funding following application of a revised capital funding formula for providers given the context of an assessed £2m shortfall for 2026/27 and ongoing costs for works at Roseberry Park Hospital

External feedback and assurance position

NHS England's regional feedback confirms that the Trust's 12 February submission and break-even financial plan are **compliant on headline planning requirements**. The feedback also highlights areas for continued attention, including refinements in workforce alignment, data quality, and contract and capital dependencies, and sets the parameters for further updates as the planning round closes.

This external confirmation strengthens the Board's assurance position on the planning process and provides a clear framework for ongoing improvement as the Trust moves into delivery.

Residual risks, maturity and forward look

At the point of Board approval in February, the Board Assurance Statements (NHS England issued statements which invite Boards to assess Plan maturity) identified several areas assessed as **fully embedded**, including Board engagement and challenge, clinical leadership involvement, system partnership structures, and contract alignment and sign-off processes.

A number of areas were assessed as **maturing**, including:

- consideration of population needs and inequalities;
- Scheme level Quality and Equality Impact Assessment (QEIA) maturity;
- continuous improvement capability;
- deliverability and phasing;
- triangulation across finance, workforce and performance;
- productivity opportunities;
- risk management;
- contract reporting timetables;
- workforce implications of the three shifts; and
- alignment of narrative and numerical plans.

Executives are overseeing further progress to strengthen delivery of the above, having received, or having scheduled for assurance, updates in areas such as Health Inequalities oversight, Continuous Improvement and Productivity capability building and further confirmation of ICBs financial requirements of the Trust. Further detail will be included in the June update to Trust Board.

In addition, specific residual risks and dependencies were explicitly recorded at the point of approval, including significant capital constraints, QEIA development, unidentified CRES and transformation dependencies, contract alignment issues with some ICBs, and potential impacts arising from the public inquiry. These areas also form the focus of continued Executive and Committee scrutiny, risk and dependency management, and will be the basis of the further assurance report to the Board in June 2026.

Recommendations

The Trust Board is asked to:

1. **Note** NHS England's confirmation that the Trust's Medium Term Plan submission is compliant on headline requirements.
2. **Note** the improved financial plan assurance resulting from conclusion of contract discussions, including for Humber and North Yorkshire Commissioners, where engagement was ongoing at the point of the February plan submission.
3. **Confirm** good assurance on the governance and process underpinning development and approval of the Medium Term Plan.
4. **Take reasonable assurance** at this stage on progress in transitioning from planning into delivery, recognising remaining dependencies and early stage delivery maturity.
5. **Note** that a further update will be brought to the Board in June 2026, focusing on delivery governance, progress against "maturing" assurance areas, and updated risk and dependency management.

Appendix 1

Statement of Combined Income and Expenditure	Plan 2026/27 £'000	Plan 2027/28 £'000	Plan 2028/29 £'000
Operating income from patient care activities	516,959	519,253	524,917
Other operating income	29,902	32,206	32,764
Employee expenses	(456,802)	(458,278)	(460,345)
Operating expenses excluding employee expenses	(86,521)	(88,327)	(92,389)
OPERATING SURPLUS/(DEFICIT)	**3,538**	**4,854**	**4,947**
FINANCE COSTS			
Finance income and expense	(320)	(314)	(254)
PDC dividend expense	(2,658)	(3,413)	(3,481)
NET FINANCE COSTS	(2,978)	(3,727)	(3,735)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**560**	**560**	**560**
PFI revenue adjustments	(560)	(1,127)	(1,212)
Adjusted financial performance surplus/(deficit)	**0**	**0**	**0**

Appendix 2

Statement of Financial Position	Forecast Outturn	M01 2026/27	M02 2026/27	M03 2026/27	M04 2026/27	M05 2026/27	M06 2026/27	M07 2026/27	M08 2026/27	M09 2026/27	M10 2026/27	M11 2026/27	M12 2026/27
Non-current assets													
Intangible assets	2,294	2,213	2,132	2,052	1,971	1,890	1,810	1,729	1,648	1,568	1,487	1,406	1,326
On-SoFP IFRIC 12 assets	6,510	6,528	6,547	6,566	6,585	6,603	6,623	6,641	6,660	6,679	6,698	6,716	6,735
Other property, plant and equipment (excludes leases)	134,984	139,474	140,542	141,488	142,435	143,383	144,284	145,434	145,487	145,231	144,977	144,723	144,466
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	7,609	6,902	6,823	6,745	6,667	6,589	6,510	6,433	6,354	6,276	6,198	6,120	8,555
Receivables: due from NHS and DHSC group bodies	381	381	381	381	381	381	381	381	381	381	381	381	381
Receivables: due from non-NHS/DHSC group bodies	20	19	19	19	19	18	18	18	18	17	17	17	17
Total non-current assets	151,798	155,517	156,444	157,251	158,058	158,864	159,626	160,636	160,548	160,152	159,758	159,363	161,480
Current assets													
Inventories	1,286	1,286	1,286	1,286	1,286	1,286	1,286	1,286	1,286	1,286	1,286	1,286	1,286
Receivables: due from NHS and DHSC group bodies	2,525	2,525	2,525	2,525	2,525	2,525	2,525	2,525	2,525	2,525	2,525	2,525	2,525
Receivables: due from non-NHS/DHSC group bodies	12,983	12,983	12,983	12,983	12,983	12,983	12,983	12,983	12,983	12,983	12,983	12,983	12,983
Credit Loss Allowances	(373)	(373)	(373)	(373)	(373)	(373)	(373)	(373)	(373)	(373)	(373)	(373)	(373)
Non-current assets held for sale and assets in disposal groups	0	1,180	1,180	750	750	750	750	750	750	0	0	0	0
Cash and cash equivalents: GBS/NLF	36,450	51,987	47,393	45,454	49,424	46,264	42,800	45,100	41,082	38,916	42,483	40,153	36,550
Cash and cash equivalents: commercial / in hand / other	94	103	103	103	103	103	103	103	103	103	103	103	103
Total current assets	52,965	69,691	65,097	62,728	66,698	63,538	60,074	62,374	58,356	55,440	59,007	56,677	53,074
Current liabilities													
Trade and other payables: capital	(1,962)	(3,549)	(1,550)	(1,428)	(1,429)	(1,429)	(1,384)	(1,631)	(535)	(226)	(228)	(227)	(226)
Trade and other payables: non-capital	(34,898)	(50,742)	(50,742)	(50,742)	(50,742)	(49,542)	(48,210)	(47,210)	(46,210)	(45,210)	(44,210)	(43,210)	(40,884)
Borrowings	(3,209)	(3,581)	(3,581)	(3,581)	(3,581)	(3,581)	(3,581)	(3,581)	(3,581)	(3,581)	(3,581)	(3,581)	(3,581)
Provisions	(151)	(151)	(151)	(151)	(151)	(151)	(151)	(151)	(151)	(151)	(151)	(151)	(151)
Other liabilities: deferred income including contract liabilities	(519)	(4,519)	(2,519)	(519)	(4,519)	(2,519)	(519)	(4,519)	(2,519)	(519)	(4,519)	(2,519)	(519)
Total current liabilities	(40,739)	(62,542)	(58,543)	(56,421)	(60,422)	(57,222)	(53,845)	(57,092)	(52,996)	(49,687)	(52,689)	(49,688)	(45,361)
Total assets less current liabilities	164,024	162,666	162,998	163,558	164,334	165,180	165,855	165,918	165,908	165,905	166,076	166,352	169,193
Non-current liabilities													
Borrowings	(32,939)	(32,581)	(32,282)	(31,983)	(31,684)	(31,385)	(31,086)	(30,787)	(30,488)	(30,189)	(29,890)	(29,591)	(31,807)
Provisions	(3,123)	(3,123)	(3,123)	(3,086)	(3,086)	(3,086)	(3,049)	(3,049)	(3,049)	(3,012)	(3,012)	(3,012)	(2,975)
Total non-current liabilities	(36,062)	(35,704)	(35,405)	(35,069)	(34,770)	(34,471)	(34,135)	(33,836)	(33,537)	(33,201)	(32,902)	(32,603)	(34,782)
Total net assets employed	**127,962**	**126,962**	**127,593**	**128,489**	**129,564**	**130,709**	**131,720**	**132,082**	**132,371**	**132,704**	**133,174**	**133,749**	**134,411**
Financed by													
Public dividend capital	171,784	172,269	173,371	174,473	175,575	176,677	177,673	177,673	177,673	177,673	177,673	177,673	177,673
Revaluation reserve	5,628	5,628	5,628	5,628	5,628	5,628	5,628	5,628	5,628	5,628	5,628	5,628	5,628
Income and expenditure reserve	(49,450)	(50,935)	(51,406)	(51,612)	(51,639)	(51,596)	(51,581)	(51,219)	(50,930)	(50,597)	(50,127)	(49,552)	(48,890)
Total taxpayers' and others' equity	**127,962**	**126,962**	**127,593**	**128,489**	**129,564**	**130,709**	**131,720**	**132,082**	**132,371**	**132,704**	**133,174**	**133,749**	**134,411**

Appendix 3

Cash Flow	Forecast Outturn	M01 2026/27	M02 2026/27	M03 2026/27	M04 2026/27	M05 2026/27	M06 2026/27	M07 2026/27	M08 2026/27	M09 2026/27	M10 2026/27	M11 2026/27	M12 2026/27	Outturn 2026/27
Cash flows from operating activities														
Operating surplus/(deficit)	2,648	(373)	(301)	(37)	143	212	186	531	459	502	640	744	832	3,538
Depreciation and amortisation	6,028	621	623	621	622	622	622	621	623	621	622	622	623	7,463
(Increase)/decrease in receivables	5,155	1	0	0	0	1	0	0	0	1	0	0	0	3
(Increase)/decrease in inventories	(63)	0	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(decrease) in trade and other payables	(14,231)	12,829	(1,999)	(122)	1	(1,200)	(1,377)	(753)	(2,096)	(1,309)	(998)	(1,001)	(2,327)	(352)
Increase/(decrease) in other liabilities	(240)	4,000	(2,000)	(2,000)	4,000	(2,000)	(2,000)	4,000	(2,000)	(2,000)	4,000	(2,000)	(2,000)	0
Increase/(decrease) in provisions	(322)	0	0	(37)	0	0	(37)	0	0	(37)	0	0	(37)	(148)
All other movements in operating cash flows (including working capital movements)	0	(222)	(222)	(222)	(222)	(222)	1,110	(222)	(222)	(222)	(222)	(222)	1,110	0
Net cash generated from / (used in) operations	(1,025)	16,856	(3,899)	(1,797)	4,544	(2,587)	(1,496)	4,177	(3,236)	(2,444)	4,042	(1,857)	(1,799)	10,504
Interest received	2,306	155	155	155	155	155	155	155	155	155	155	155	150	1,855
Purchase of property, plant and equipment and investment property	(15,668)	(1,549)	(1,550)	(1,428)	(1,429)	(1,429)	(1,384)	(1,631)	(535)	(226)	(228)	(227)	(226)	(11,842)
Proceeds from sales of property, plant and equipment and investment property	430	0	0	430	0	0	0	0	0	750	0	0	0	1,180
Net cash generated from/(used in) investing activities	(12,932)	(1,394)	(1,395)	(843)	(1,274)	(1,274)	(1,229)	(1,476)	(380)	679	(73)	(72)	(76)	(8,807)
Cash flows from financing activities														
Public dividend capital received	5,862	485	1,102	1,102	1,102	1,102	996	0	0	0	0	0	0	5,889
Capital element of lease liability repayments	(2,256)	(199)	(199)	(199)	(199)	(199)	(199)	(199)	(199)	(199)	(199)	(199)	(199)	(2,388)
Capital element of PFI, LIFT and other service concession payments	(954)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(99)	(1,199)
Interest element of lease liability repayments	(255)	(27)	(27)	(27)	(27)	(27)	(28)	(27)	(27)	(27)	(27)	(27)	(28)	(326)
Interest element of PFI, LIFT and other service concession obligations	(909)	(75)	(76)	(75)	(76)	(75)	(76)	(75)	(76)	(75)	(76)	(75)	(76)	(906)
PDC dividend (paid)/refunded	(2,355)	0	0	0	0	0	(1,332)	0	0	0	0	0	(1,326)	(2,658)
Net cash generated from/(used in) financing activities	(867)	84	700	701	700	701	(739)	(401)	(402)	(401)	(402)	(401)	(1,728)	(1,588)
Increase/(decrease) in cash and cash equivalents	**(14,824)**	**15,546**	**(4,594)**	**(1,939)**	**3,970**	**(3,160)**	**(3,464)**	**2,300**	**(4,018)**	**(2,166)**	**3,567**	**(2,330)**	**(3,603)**	**109**
Restated cash and cash equivalents at start of period	51,368	36,544	52,090	47,496	45,557	49,527	46,367	42,903	45,203	41,185	39,019	42,586	40,256	36,544
Cash and cash equivalents at end of period	**36,544**	**52,090**	**47,496**	**45,557**	**49,527**	**46,367**	**42,903**	**45,203**	**41,185**	**39,019**	**42,586**	**40,256**	**36,653**	**36,653**

Appendix 4

Workforce Plan	Forecast Out-turn 2025/6 Year Ending WTE	Plan 2026/27 Month 3 WTE	Plan 2026/27 Month 6 WTE	Plan 2026/27 Month 9 WTE	Plan 2026/27 Month 12 WTE	Plan 2027/28 Month 3 WTE	Plan 2027/28 Month 6 WTE	Plan 2027/28 Month 9 WTE	Plan 2027/28 Month 12 WTE	Plan 2028/29 Month 3 WTE	Plan 2028/29 Month 6 WTE	Plan 2028/29 Month 9 WTE	Plan 2028/29 Month 12 WTE
Non-medical - clinical staff													
Registered nursing, midwifery and health visiting staff	2,572.2	2,577.6	2,552.3	2,541.2	2,539.1	2,522.7	2,509.4	2,503.5	2,502.8	2,494.6	2,492.6	2,491.7	2,491.6
Allied health professionals (excluding paramedics)	362.1	367.9	364.9	363.6	363.4	360.0	358.3	357.6	357.5	357.5	357.5	357.5	357.5
Other scientific, therapeutic and technical staff	799.8	816.3	811.0	808.7	805.7	802.2	799.3	798.0	795.2	797.9	797.9	797.9	795.2
Healthcare scientists and scientific, therapeutic and technical staff	1,161.9	1,184.2	1,175.9	1,172.3	1,169.1	1,162.1	1,157.6	1,155.6	1,152.8	1,155.4	1,155.4	1,155.4	1,152.8
Qualified ambulance service staff	2.7	0.0	0.0	0.0	2.7	0.0	0.0	0.0	2.6	0.0	0.0	0.0	2.6
Support to nursing staff	1,665.0	1,653.7	1,632.9	1,623.8	1,620.7	1,595.6	1,583.2	1,577.7	1,577.0	1,562.7	1,556.3	1,553.5	1,553.1
Support to allied health professionals	105.9	105.3	104.5	104.1	104.0	103.0	102.6	102.4	102.4	102.4	102.4	102.4	102.4
Support to other clinical staff	496.8	509.9	505.8	504.0	488.0	499.0	496.7	495.7	495.6	495.6	495.6	495.6	495.6
Support to clinical staff	2,267.8	2,268.9	2,243.2	2,231.9	2,212.7	2,197.6	2,182.5	2,175.8	2,175.0	2,160.7	2,154.3	2,151.4	2,151.1
Total non-medical - clinical staff	6,004.5	6,030.7	5,971.4	5,945.3	5,923.6	5,882.4	5,849.5	5,835.0	5,833.2	5,810.7	5,802.3	5,798.6	5,798.1
Medical and dental staff													
Consultants	171.6	169.8	168.0	167.2	167.1	163.8	163.1	162.9	162.8	160.0	159.6	159.4	159.4
Career/staff grades	67.2	64.5	63.8	63.5	63.4	62.6	62.3	62.1	62.1	61.9	61.9	61.9	61.8
Resident grades	223.5	226.4	224.6	223.8	223.7	221.6	220.6	220.1	220.1	220.1	220.1	220.1	220.1
Total medical and dental staff	462.3	460.7	456.4	454.5	454.2	448.0	446.0	445.1	445.0	442.0	441.5	441.3	441.3
Non medical - non-clinical staff													
NHS infrastructure support	1,864.9	1,858.0	1,843.9	1,837.7	1,852.7	1,836.8	1,828.9	1,825.4	1,825.0	1,824.9	1,824.9	1,824.9	1,824.9
Any others	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total non medical - non-clinical staff	1,864.9	1,858.0	1,843.9	1,837.7	1,852.7	1,836.8	1,828.9	1,825.4	1,825.0	1,824.9	1,824.9	1,824.9	1,824.9
Total Staff WTE	8,331.7	8,349.4	8,271.6	8,237.4	8,230.5	8,167.2	8,124.4	8,105.5	8,103.2	8,077.6	8,068.7	8,064.8	8,064.3

Appendix 5

Multi Year Capital Summary	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000
Total CDEL (net of intra-DHSC group eliminations)	12,750	7,366	7,475	7,586	6,811
Provider Operational Capital Allocation	6,513	6,123	6,226	6,330	6,438
Central estates safety fund allocation	5,889	889	889	889	889
Total Capital Allocation	**12,402**	**7,012**	**7,115**	**7,219**	**7,327**

Capital Schemes	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	2030/31 £'000
PFI Lifecycle	352	425	407	150	153
Phase 2 Tees safety works	10,519	0	0	0	0
RPH future phases	0	3,723	5,541	4,590	9,503
RPH Programme mgmt	200	0	0	0	0
WPH Lifecycle	453	465	352	400	400
CHP maintenance contract	182	128	131	210	138
Seclusion room minimum safety improvements	240	0	0	0	0
Salaries	620	410	420	431	442
Patient safety doors	555	0	0	0	0
Digital network infrastructure	454	0	1,000	0	6,900
Trust lifecycle	450	450	450	450	450
Digital infrastructure	0	2,000	1,000	1,500	1,500
IFRS16 additions (NHS providers / ICB)	0	0	0	0	100
IFRS16 additions (NHS property services)	0	0	440	55	2,950
IFRS16 additions (non NHS)	1,350	180	167	1,274	1,467
IFRS inflation (NHS providers / ICB)	4	4	4	4	4
IFRS16 inflation (NHS property services)	406	406	406	406	406
IFRS16 inflation (non NHS)	754	694	694	694	694
Dragon Parade sale	(750)	0	0	0	0
Jubilee House sale	(430)	0	0	0	0
Total capital expenditure	**15,359**	**8,885**	**11,012**	**10,163**	**25,107**
Total charge against allocation (less PFI lifecycle and intra NHS lease)	**14,597**	**8,050**	**9,755**	**9,548**	**21,494**
Variance to allocation (including over programming)	**(2,195)**	**(1,038)**	**(2,640)**	**(2,329)**	**(14,167)**

Capital plans can only be submitted on a compliant basis i.e. within allocated resources, since templates do not allow 'over programming'. The plan therefore needed to assume that either or a combination of:
- access to £2.2m additional 2026/27 allocation in secured in-year, from ongoing NENC partner discussion to reallocated CDEL (following net losers / beneficiaries from 2026/27 allocations) and/or access to wider 2026/27 slippage.
- programme costs can be reduced or slip in-year.
- IFRS16 lease changes or disposals generate additional headroom.

Executives and R&P Committee to oversee and ensure plans are developed

Appendix 6

Efficiency Savings Planned	2026/7		2027/28		2028/29	
	£'000	WTE	£'000	WTE	£'000	WTE
Pay - Recurrent	16,765	282	12,092	203	10,427	171
Non-pay - Recurrent	3,092		2,783		2,130	
Income - Recurrent	738		760		560	
Total recurrent efficiencies	**20,595**	**282**	**15,635**	**203**	**13,117**	**171**
Pay - Non-recurrent	4,744	11	4,691	0	2,850	0
Non-pay - Non-recurrent	2,147		1,800		1,600	
Income - Non-recurrent	204		180		120	
Total non-recurrent efficiencies	**7,095**	**11**	**6,671**	**0**	**4,570**	**0**
Total Efficiencies	**27,690**	**293**	**22,306**	**203**	**17,687**	**171**

Efficiency Savings Planned	2026/7		2027/28		2028/29	
	£'000	WTE	£'000	WTE	£'000	WTE
FYE CRES (Previous Year)	4,239		3,519		1,627	
Additional CRES (Current Year)	23,451	293	18,787	203	16,060	171
Total CRES	27,690	293	22,306	203	17,687	171

Efficiency Savings	2026/27		2027/28		2028/29	
	%	£ '000's	%	£ '000's	%	£ '000's
Target 2026/27 (February Board Paper)	**4.79%**	**25,378**	**4.17%**	**22,304**	**3.28%**	**17,762**
Additional Contract Income Notified	0.35%	1,927				
Rounding Adjustments future years				2		75
Targets 2026/27 Submitted	**4.29%**	**23,451**	**4.04%**	**22,302**	**3.17%**	**17,687**

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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9th April 2026**
Title:	**Board Integrated Performance Report as 28th February 2026**
Executive Sponsor(s):	**Kathryn Ellis, Interim Executive Director of Strategy & Transformation** **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

There has been no change to the performance assurance level for the IPD this month.

Overview:

Controls Assurance

Our Integrated Performance Approach (IPA) enables us to have **good** oversight (i.e. controls assurance) of performance, by monitoring and reporting key measures that demonstrate the delivery of the quality of services we provide. The IPR is discussed and approved each month at 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. The contents of this report have been subject to Executive review on 24th March, and assurance sought that where performance standards are not being met there are robust remedial actions and appropriate oversight in place.

Performance Assurance

Update:

Rectification work has been completed on the previously identified cost centre issue which affected all patient and carer experience measures below Trust level. In terms of the inconsistent response options for the carer experience and inpatient feeling safe measures following the implementation of I Want Great Care (new system), which has impacted the validity of the data from September 2025, a KPI change has been approved to address this and the revised data back to September will be included in the next report.

We have now addressed the previously identified issue regarding the flow of indirect contact information. Our internal data has been refreshed, and this is now reflected in the measures that were affected.

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 **24** measures (77%) with good or substantial assurance.

Key changes this month:

Increased performance assurance (from good to substantial)	• Patient Experience
Decreased performance assurance (from substantial to good)	• Bed Occupancy

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

- Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for
- Percentage of inpatients reporting that they feel safe whilst in our care
- Percentage of CYP showing measurable improvement following treatment - 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 had 11 open actions, 8 of which have been closed at this stage with EDG and Resources & Planning Committee approval, reflecting the planned transition from Cito to a new electronic patient record system. Of the 3 open actions, 2 are on track for delivery and the remaining action has been placed on hold, pending the receipt of outstanding information from partner organisations. One action has been completed since last month; to implement training in the pilot teams for the new outcome measures linked to community transformation.

- **Bed Occupancy** – Sustained special cause improvement is being demonstrated; however, we are above the commissioned and funded level of 85%. The main areas of concern remain linked to patients that are clinically ready for discharge (*see overleaf*) in all services.

- **Mandatory & Statutory Training –** We are continuing to achieve the standard and have made progress in reducing the number of mandatory training courses below the 85% standard (9 courses below this month, compared to 8 the previous month). A focused discussion on the courses below 85% was held in the March Quality & Performance EDG. With the exception of Estates & Facilities Management and Medical (due to contextual factors), the Executive Directors for all corporate directorates are to ensure 85% compliance for all courses by the end of June 2026, and all Executive Directors are to establish trajectories with their services to reduce the number of DNAs by the end of quarter 1 2026/27.

- **Agency Price Cap Compliance** - The Trust has made significant strides to reduce the value and number of shifts breaching price cap. 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 and nursing vacancy cover in prisons. The Temporary Staffing Sub-Group has leadership and oversight of this work. Medical leaders have considered wider options during the year to date to plan to reduce reliance and to develop CRES plans to achieve further reductions in 2026/27. It is expected that breaches relating to prison nurse 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. The Trust has established the Hospital to Community Programme Board and one of the workstreams will be focused on the Clinically Ready for Discharge Programme. A Trust-wide 12-month delivery plan was reviewed at Quality & Performance EDG in March 2026, outlining a structured and phased approach to reducing clinically ready for discharge delays, supporting improved patient flow, operational efficiency and organisational performance. The final plan will be presented to Board of Directors in April 2026.

  At Trust level, patients classified as clinically ready for discharge in February equated to an average of 76.2 beds (47.6 Adult and 28.5 Older Adult beds), with an associated direct cost of c.£1.45m. Of the cost, c.£0.88m relates to Adult and c.£0.58m relates to Older Adult. The annualised impact of patients classified as clinically ready for discharge is £17.4m.

  The pilot hub in Durham was implemented in November 2025, and the first 3-month evaluation demonstrated an improvement in the total number of people from Durham residing in hospital beds and those clinically ready for discharge. The next phase of the hub development is being progressed by the Project Leadership Team, with the revised plan to be presented to the Hospital Community Board in April 2026. Planning meetings for piloting the new ways of working within the Tees Valley transfer of care hub with South Tees Local Authorities have completed, and the service will commence mid-March. Recruitment for the Clinically Ready for Discharge pilot role supporting this work, is progressing.

  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. Following the cancellation of the event in January, the Trust had approached the council with a view to hosting; however, a new project lead/manager has recently been appointed whose role will be to review and improve Section 117 aftercare and discharge processes, alongside working closely with older people's teams and acute hospital discharge hubs. The lead is currently making contact across the system to understand current processes and challenges, and a new date will be confirmed in discussion with them. In North Yorkshire recruitment continues 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

The Deputy Director of People & Culture & Associate Director of Performance facilitated a deep dive on sickness absence at the Quality & Performance EDG in February 2026. Since the last report, several actions have now been completed which are detailed in the IPR and further actions are being progressed. Whilst we are not yet seeing any impact on our overall sickness absence rate, we believe the actions identified should support improvement once they have been completed and are fully embedded. Based on past seasonal trends we believe we should start to see a reduction in sickness absence from March (data ending February), coupled with the improvement actions we would forecast actual improvement during Quarter 1 26/27.

- **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 those associated with reducing temporary staffing and managing overall 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. 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 agreed additional controls for overtime and the expansion of staff banks, and further restrictions on agency usage in recent months. Additional Overtime approval processes have been implemented. 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 have been 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 **68%** of measures are achieving standard (compared to 63% 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
- Talking Therapies waiting times (6 and 18 weeks)

- Active Inappropriate Out of Area Placements
- Average Length of Stay for Adult Acute Beds

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 all Place level plans this financial year. 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 EIP Waiting Times** (York)**:** Capacity within the York & Selby EIP team is currently impacted by vacancies and maternity leave, for which recruitment is currently underway. In addition, the Adult Mental Health General Manager is to host a meeting between CAMHS and EIP by the end of April 2026, with a view to improving timely access to joint assessments for patients under 18.

- **Talking Therapies Reliable Improvement and Reliable Recovery** (County Durham & Tees Valley): The completed Trustwide action plan was presented to the Quality & Performance EDG in February 2026. An outcomes-focused Performance Improvement Plan developed specifically for County Durham & Tees Valley was approved at the Quality & Performance EDG in March 2026.

- **Perinatal Mental Health Access – within a 12-month period** (County Durham): Investigations have confirmed that the Perinatal KPI for the Durham & Darlington team is affected by underlying data quality issues. The measure will be redeveloped and the source system corrected to ensure alignment with NHS England definitions and accurate reporting by the end of March 2026.

- **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 will be completed by the end of March 2026. In January 2026 we launched the new CYP Tees Valley Getting Help Service, whose data is recorded on IAPTUs. Whilst this data will be incorporated into our MHSDS it is currently reported separately in the new service report. We are exploring how to match national and local data for assurance and reporting and identify any possible mitigating actions for risks identified.

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 has worked closely with the ICB and Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust to develop a framework for clinical prioritisation and an aligned regional process for the management and assessment of referrals. A paper was submitted to the ICB MH Subcommittee in January 2026 and an outcome is awaited. 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. A paper was to be taken to the March 2026 Mental Health, Learning Disabilities & Autism Assurance Meeting; however, this will now be presented to the County Durham Care Partnership Executive and then to the MHLDA meeting in April.

  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 May 2026 to agree a plan for full roll out. 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. Recruitment of a medic to support the transformed model for local triage has now been completed and the successful candidate will start in February 2026.

  <u>North Yorkshire & York</u>

  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 currently has a recovery plan in place which is impacted by sickness absence; however, it is under regular review. A review of the process and use of resources will be undertaken with a view to meeting demand; however, this is contingent on vacancies being filled and absence levels, and there remains a backlog of assessments that will require additional resources to address to return to sustainable position based on current referral rates. A progress report will be completed and presented through Integrated Care Group Governance and then go to EDG for assurance. A Stop the Line Day was held in January 2026 to review progress with the Team and the CAMHS Leadership Cell. The outcome of the day was a focus on maintaining a stable position until new staff commence in post, and ensuring the team were supported pending the appointment of a new Team Manager, recruitment for which is now underway.

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

  Durham and Tees Valley

  There are several actions identified to support improvements in waiting times. This includes a proposal to approve the implementation of Koa Step 3 Digital Therapy for post-traumatic stress disorder and a review of the suitability criteria with internal services and ICB colleagues.

  North Yorkshire and York

  Following the work to convert treatment capacity to assessment capacity to address the backlog of patients waiting for 1st treatment appointment, the Service Manager has developed a plan for the recovery of wait time between 1st and 2nd appointment; the impact is expected to be seen by end of April 26.

NHS Oversight Framework – Quarter 3 Performance:

The NHS Oversight Framework, introduced for 2025/26, outlines a consistent and transparent approach to assessing Integrated Care Boards (ICBs), NHS Trusts, and Foundation Trusts. It ensures public accountability for performance and is a foundation for how NHS England will work with systems and providers to support improvement. It is a 1-year framework and will be reviewed at the end of 2025/26. The Trust's Medical Director and Interim Director of Strategy & Transformation have been engaged in developmental sessions with NHS England and NHS Confederation to inform measures for 2026/27.

A range of agreed metrics are used to assess performance. These reflect the 2025/26 NHS priorities and operational planning guidance. Not all metrics will be used to formulate the segmentation; some metrics are contextual and will be used for consideration in NHS England's oversight response. All metrics are split into domains: access to services, effectiveness and experience of care, patient safety, people and workforce, finance and productivity, improving health and reducing inequalities.

Segmentation scores will have different weightings across domains. An additional segment (5) will be used if the organisation is one of most challenged providers in the country, with poor

performance across a range of domains and low capability to improve, or an organisation is a challenged provider where NHS England has identified significant concerns. All organisations in deficit, or in receipt of deficit support, will be limited to an organisational delivery score of no greater than 3. Promotion of improvement and identification of support needs. Segmentation data will be reviewed at least quarterly as part of a review meeting and segments may be updated at any time based on emerging information.

Data on Trust performance for quarters 1, 2 and 3 can be seen in the table below and are also publicly available via NHS.co.uk. The majority of these metrics are already included in the IPR and performance is monitored monthly, where available. For the period Quarter 3 the Trust's position reflects **an improvement in overall segmentation to Segment 2.** Although performance rankings span a relatively wide range, suggesting some volatility, the underlying pattern remains one of relative stability. TEWV's comparative position among non-acute trusts has strengthened and is at its highest point to date (19 out of 61 non-acute Trusts).

	Quarter 1 2025/26			Quarter 2 2025/26			Quarter 3 2025/26		
	Q1 peformance	Q1 score	Q1 rank	Q2 peformance	Q2 score	Q2 rank	Q3 peformance	Q3 score	Q3 rank
Annual change in number of children and young people accessing NHS-funded MH services (rolling 12 months)	0.44%	3.37	36 out of 46	-2.28%	3.35	40 out of 49	3.63%	2.91	
Percentage increase in Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	2.16			5.89%					
Proportion of patients with an open suspected autism referral in the month that has been open for at least 13 weeks that have not had a care contact appointment recorded				84.00%					
DOMAIN SCORE - Access to Services		**3.37**			**3.35**			**2.91**	
Percentage of inpatients with >60 day length of stay (rolling 3-month average)	11.78%	1.13	3 out of 47	9.18%	1.06	2 out of 47	11.07%	1.06	2 out of 47
Community mental health survey satisfaction rate (annual)		2			2			2	
DOMAIN SCORE - Effectiveness and experience of care		**1.57**			**1.53**			**1.53**	
NHS Staff Survey – raising concerns sub-score (annual)	6.6	3.15	44 out of 61	6.6	3.15	44 out of 61	6.6	3.15	44 out of 61
CQC safe inspection score (if awarded within the preceding 2 years)		3			3				
Percentage of patients in crisis to receive face-to-face contact within 24 hours (rolling 3 months)	97.70%	1.07	2 out of 45	98.40%	1.18	3 out of 48	94.19%	1.06	2 out of 48
Rate of restrictive interventions use	26			33					
DOMAIN SCORE - Patient Safety		**2.41**			**2.44**			**2.11**	
Sickness absence rate (rolling 3 months)	6.06%	3.32	41 out of 61	5.98%	3.63	49 out of 61	6.94%	3.81	54 out of 61
NHS staff survey engagement theme score (annual)	6.86	3.55	52 out of 61	6.86	3.55	52 out of 61	6.86	3.55	52 out of 61
National Education & Training Survey "Overall Experience" survey score	83.45%			83.45%			83.45%		
DOMAIN SCORE - People and Workforce		**3.44**			**3.59**			**3.68**	
Planned surplus/deficit (annual)	0%	1	15 out of 61	0%	1	16 out of 61	0%	1	16 out of 61
Variance year-to-date to financial plan	0.68%	1	3 out of 61	0.39%	1	8 out of 61	0.44%	1	10 out of 61
Relative difference in costs (annual)	79.03%	1.22	5 out of 60	96.24%	1.9	17 out of 61		1.9	17 out of 61
DOMAIN SCORE - Finance and productivity		**1.11**			**1.45**			**1.45**	
Percentage of inpatients aged 65 years and over with a length of stay at discharge exceeding 90 days	38.88%			26.57%					
DOMAIN SCORE - Improving health & reducing inequality (non-scoring)		**N/A**			**N/A**			**N/A**	
OVERALL AVERAGE SCORE		2.28			2.38			2.27	
FINAL SEGMENTATION	2		24 out of 61	3		34 out of 61	2		19 out of 61

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

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
- Appropriate and effective management of risks to delivery

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

For the period ending 28th February 2026

Report produced by: Laura Wheater, Performance Lead, and Ashleigh Lyons, Head of Performance
Date the report was produced: 19th March 2026

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

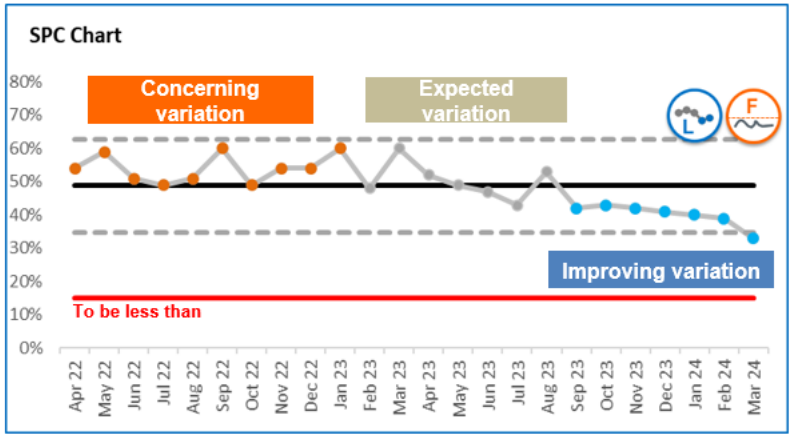
CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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



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

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

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

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

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

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

Our Approach to Data Quality

Tees, Esk and Wear Valleys NHS Foundation Trust

Data Quality

On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The last assessment was completed in quarter 1 2025/26 and scores are included in this report. The most recent assessment has been completed in quarter 4 2025/26 and the results were approved at the March 2026 Resources & Planning Committee. The results will be incorporated within the next report.

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

Our Approach to Performance and Controls Assurance

Tees, Esk and Wear Valleys NHS Foundation Trust

Our Performance Assurance

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

	Substantial	Good	Reasonable	Limited
	The control is operating effectively in meeting its objective (and managing the associated risk). It is being applied consistently. No remedial action required.	The control is operating effectively in meeting its objective. It is generally being applied consistently. Minor remedial action is required.	The effectiveness of the control in meeting its objective is uncertain. Compliance is variable/inconsistent. Some moderate remedial action is required.	The control is not operatively effectively in meeting its objective. There are low levels of/wide variation in compliance. Immediate and fundamental remedial action is required
Positive	We have Positive Assurance AND we are achieving the standard agreed (where relevant)	We have Positive Assurance; HOWEVER, we have 1 (or more) underlying areas of concern OR We are not achieving standard		
Neutral	We are achieving standard (where relevant) **AND** we have no underlying areas of concern	We are achieving the standard (where relevant) with only 1 area of concern; **OR** There is consistent performance	We have more than 1 underlying area of concern **OR** There is consistent underperformance below the standard	
Negative		We have no underlying areas of concern **AND** there is an improving position visible in the data	We have a small number of areas of underlying concern **OR** There is a deteriorating position visible in the data **OR** Performance continues below the mean **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
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
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STS	Short Team Sickness
STEIS	Strategic Executive Information System
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
UoRR	Use of Resources Rating
WTE	Whole time equivalent

Integrated Performance Dashboard

Board Integrated Performance Dashboard – for the period ending February 2026

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%	93.46%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC	H	?	75.00%	82.45%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	H	?	75.00%	86.97%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	H	P	35.00%	53.51%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC	H	F	55.00%	47.27%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	?	50.00%	59.16%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC	H	F	30.00%	25.75%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	L	F	85.00%	90.31%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L	F	0	130
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				12
11)	The number of Incidents of moderate or severe harm	QAC				216
12)	The number of Restrictive Interventions Used	QAC				11,134
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				4
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				3
15)	The number of uses of the Mental Health Act	MHLC				3,620

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%	53.95% (Jan-2026)
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D		?	65.00%	60.71% (Jan-2026)
18)	Staff Leaver Rate	PC&D	L	?	11.00%	9.81%
19)	Percentage Sickness Absence Rate (month behind)	PC&D	H	?	5.50%	6.71%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	P	85.00%	92.14%
21)	Percentage of staff in post with a current appraisal	PC&D	H	?	85.00%	87.28%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				88,104
23)	Unique Caseload (snapshot)	S&RC	L			62,455

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	845,000	-946,035
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	6,245,000	5,514,955
25b)	Agency price cap compliance	S&RC	67.00%	48.87%
26)	Use of Resources Rating - overall score	S&RC	2	2
27)	CRES Performance - Recurrent	S&RC	15,181,000	12,108,175
28)	CRES Performance - Non-Recurrent	S&RC	9,477,778	12,613,756
29)	Capital Expenditure (CDEL)	S&RC	12,319,000	10,384,291
30)	Cash against plan	S&RC	39,265,000	50,218,023

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

- **Patient and Carer Experience:** there is no significant change for the patient experience measure and we are achieving standard. However, there is one outstanding issue affecting the carer experience and inpatients feeling safe measures in relation to the consistency of response options following the implementation of I Want Great Care (new system). A KPI change has been approved to address the inconsistency of response options, and the revised data back to September will be included in the next report.

- **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. Whilst there is no significant change in the number of timely paired outcomes recorded for both CYP measures and special cause concern in the number of timely paired outcomes recorded for both AMH/MHSOP measures, the overall rate of paired measures remains consistent.

- **Bed Pressures:** there is special cause improvement; however, we are above standard for bed occupancy. There is special cause improvement for out of area bed days and whilst we are not achieving the rolling 3-month standard there were no new out of area placements in February. There is special cause concern for patients clinically ready for discharge (supporting measure).

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

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

- **People:** there is no significant change and we are not achieving standard for the staff survey measures. 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 9 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 28th February 2026 is a surplus of £0.946m, which is £1.791m better than planned for the year to date. The in-month position in February was a surplus of £951k, incorporating receipt of non-recurrent NHSE income to support industrial action and pressures in-year. Favourable year to date performance is helping to support non-recurrent invest to save costs. CRES delivered £24.72m for the first 11 months against a target of £24.66m, 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 the patient experience measure and we have achieved the standard. However, there is one outstanding issue affecting the carer experience and inpatients feeling safe measures in relation to the consistency of response options following the implementation of I Want Great Care (new system). A KPI change has been approved to address the inconsistency of response options and revised data back to September 2025 will be included in the next report.

- **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. Whilst there is no significant change in the number of timely paired outcomes recorded for the CYP CROM and PROM; there is an increase in the rate of paired measures for the CROM. Whilst there is special cause concern in the number of timely paired outcomes recorded for the AMH/MHSOP PROM and CROM, the overall rate of paired measures remains consistent.

- **Bed Pressures**: there is special cause improvement; however, we are above the standard for bed occupancy. There is special cause improvement for out of area bed days and whilst we are not achieving the rolling 3-month standard there were no new out of area placements in February. There is special cause concern for patients clinically ready for discharge (supporting measure).

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

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

- **People –** there is no significant change and we are not achieving standard for the staff survey measures. 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 9 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 £256.9m as at February, and actual spend was £261.5m, which is £4.7m more than planned with CRES delivery £1.2m behind plan.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Outcomes
- Bed Measures (Occupancy and OAP days)
- Patient Safety (PSII and Incidents)
- People (Leaver rate, Appraisals, Training)
- Unique Caseload

Risks / Issues

- Sickness Absence
- Financial Plan

Mitigations

Sickness: 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.

The Deputy Director of People & Culture & Associate Director of Performance facilitated a deep dive on sickness absence at the Quality & Performance EDG in February 2026. Since the last report, several actions have now been completed which are detailed in the IPR and further actions are being progressed. Whilst we are not yet seeing any impact on our overall sickness absence rate, we believe the actions identified should support improvement once they have been completed and are fully embedded. Based on past seasonal trends we believe we should start to see a reduction in sickness absence from March (data ending February), coupled with the improvement actions we would forecast actual improvement during Quarter 1 26/27.

Finance - Financial plan

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

- Identified unfunded posts with care groups, with roadmaps for recovery
- Previously approved non recurrent roster changes for AMH and for MHSOP and ALD ward staffing aimed to reduce reliance on premia rate flexible staffing as safe staffing requirements are reviewed
- Use of Agency and bank for both Medical and Nursing (more notably premia rates for medics and prisons, albeit with reducing trajectories)

The Care Group General Managers' focus is to reduce over establishments and continue to deliver reductions in bank, overtime and agency spend whilst maintaining recurrent CRES delivery.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** There is no significant change for that patient experience measure and we are achieving standard. However, there is one outstanding issue affecting the carer experience and inpatients feeling safe measures in relation to the consistency of response options following the implementation of I Want Great Care (new system). A KPI change has been approved to address the inconsistency of response options, and the revised data back to September will be included in the next report.

- **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. Whilst there is no significant change in the number of timely paired outcomes recorded for the CYP PROM, CYPS CROM and AMH/MHSOP PROM, there is special cause improvement for the AMH/MHSOP CROM. However, the overall rate of paired measures remains consistent.

- **Bed Pressures:** whilst there is special cause improvement for bed occupancy and no significant change for inappropriate out of area bed days, there is special cause concern for patients clinically ready for discharge (supporting measure). There were 0 out of area placements during February.

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

- **Uses of Mental Health Act:** there is an unexpected low shift at Care Group level.

- **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. There is no significant change in sickness levels and 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 Care Group** as at 28th February 26 the has reported an overspend to plan of £1.4m and an overspend to budget of £1.9m. The CRES delivery is behind plan by £1.2m.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

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

Risks / Issues

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

Mitigations

Outcomes

The **Trust-wide Clinical Outcomes improvement Plan** currently has 11 open actions, 8 of which are dependant on CITO development. Of the 3 ongoing actions, 2 are on track for delivery following EDG approval to extend the deadlines:

- Undertake quarterly webinars to organisation
- To use data meaningfully at all levels (e.g. clinical supervision, team meetings, care group meetings, board meetings)

The remaining action is included on the CYP PROM slide. One action has been completed since last month, to implement training in the pilot teams for the new outcome measures linked to community transformation (Dialog, ReQoL 10, Goal-Based Outcomes GBO). The Improvement Plan continues to progress,

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 as at 28th February 26 the has reported an overspend to plan of £1.4m and an overspend to budget of £1.9m. The CRES delivery is behind plan by £1.2m. 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 • CYP showing measurable improvement following treatment - clinician reported	• Adults and Older Persons showing measurable improvement following treatment - patient reported • Adults and Older Persons showing measurable improvement following treatment - clinician reported • Bed Occupancy (AMH & MHSOP A & T Wards) ***reduced performance assurance*** • Inappropriate OAP bed days for adults that are 'external' to the sending provider • Staff Leaver Rate • Compliance with ALL mandatory and statutory training • Staff in post with a current appraisal • Unique Caseload		
Neutral	• Patients surveyed reporting their recent experience as very good or good ***improved performance assurance*** • PSII reported on STEIS • 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	• New unique patients referred • Financial Plan: SOCI - Final Accounts - Surplus/Deficit • Financial Plan: Agency expenditure compared to agency • CRES Performance – Non-Recurrent	• Restrictive Intervention Incidents Used • Staff recommending the Trust as a place to work • Staff feeling they are able to make improvements happen in their area of work	
Negative		• Use of Resources Rating – overall • Cash balances (actual compared to plan)	• Agency price cap compliance • 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

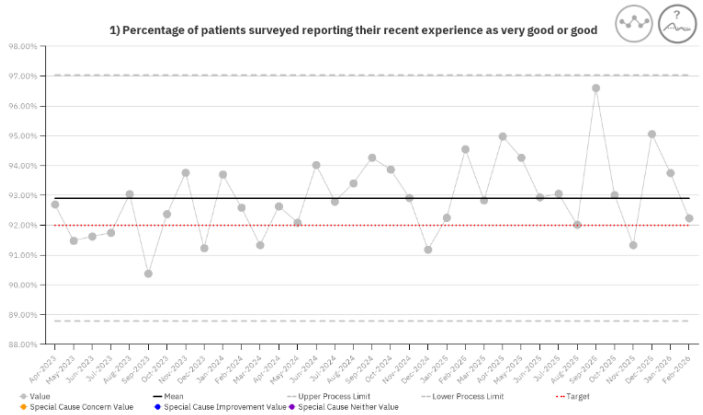
What does the chart show/context:
During February, **1069** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent contact overall, how was your experience of our service?". Of those, **986 (92.24%)** scored "very good" or "good".

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

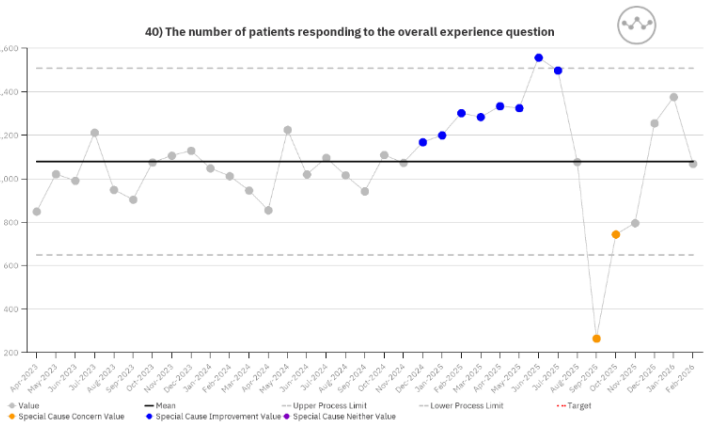
The latest National Benchmarking data (December 2025) shows the England average (including Independent Sector Providers) was **89.42%** and we were ranked **12** (previously 14th) out of 66 trusts (1 being the best with the highest ratings), we were also ranked 2nd (previously 5th) for total number of responses received.

Underlying issues:
There are no underlying issues to report.

Actions:
- Rectification work has been undertaken on the previously identified cost centre issue which affected all levels below Trust. **(Complete)**
- From January 2026, the Patient & Carer Experience Team have introduced support visits initially focusing on teams with zero responses with a view to improving response rates which is anticipated to have a positive impact.



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



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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

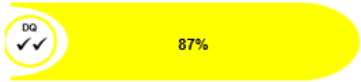
Background / standard description:
We are aiming for 75% of carers reporting they feel they are actively involved in decisions about the care and treatment of the person they care for.

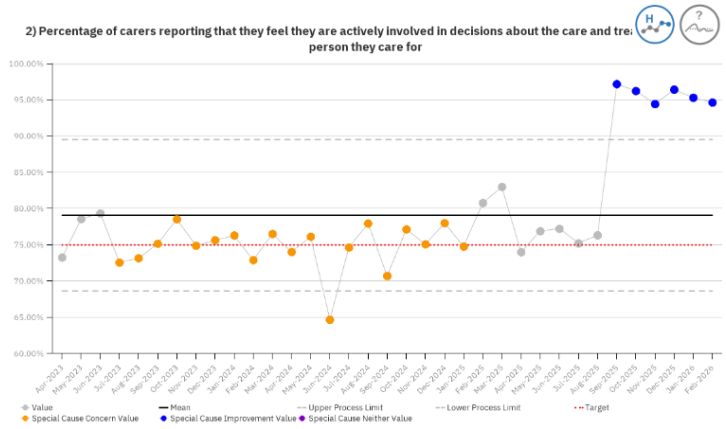
What does the chart show/context:
During February, **242** carers responded to the question in the carer survey: Question: "Are you offered choices about the care being provided?". Of those, **229 (94.63%)** scored "yes" or "sometimes"*.

Investigations have confirmed there is an issue in relation to the consistency of response options following the implementation of I Want Great Care (new system), which has impacted the validity of the data from September 2025.

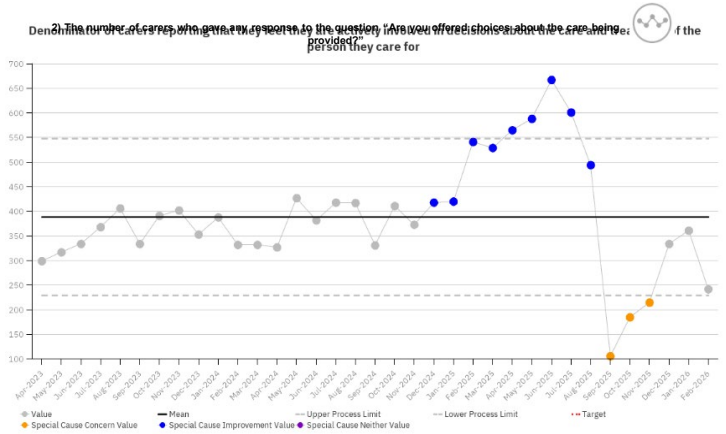
Underlying issues:
There are no underlying issues to report.

Actions:
- Rectification work has been undertaken on the previously identified cost centre issue which affected all levels below Trust. **(Complete)**
- A KPI change has been approved to address the inconsistency of response options, and the revised data back to September will be included in the next report.
- From January 2026, the Patient & Carer Experience Team have introduced support visits initially focusing on teams with zero responses with a view to improving response rates which is anticipated to have a positive impact.





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.

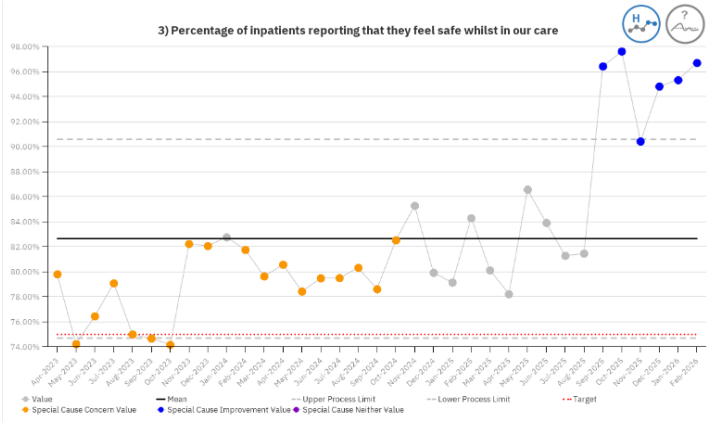
What does the chart show/context:
During February, **91** patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **88 (96.70%)** scored “yes “ or “sometimes”*.

Investigations have confirmed there is an issue in relation to the consistency of response options following the implementation of I Want Great Care (new system), which has impacted the validity of the data from September 2025.

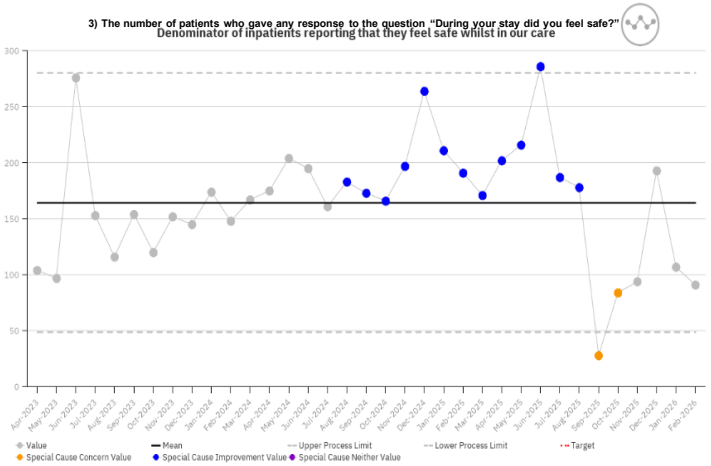
Underlying issues:
There are no underlying issues to report.

Actions:
- Rectification work has been undertaken on the previously identified cost centre issue which affected all levels below Trust. **(Complete)**
- A KPI change has been approved to address the inconsistency of response options, and the revised data back to September will be included in the next report.
- From January 2026, the Patient & Carer Experience Team have introduced support visits initially focusing on teams with zero responses with a view to improving response rates which is anticipated to have a positive impact.

DQ
87%

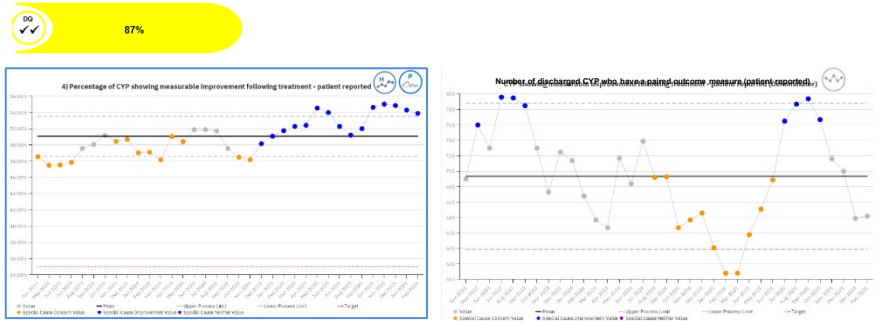


The below chart represents the number of patients that responded to the safety question.



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

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



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

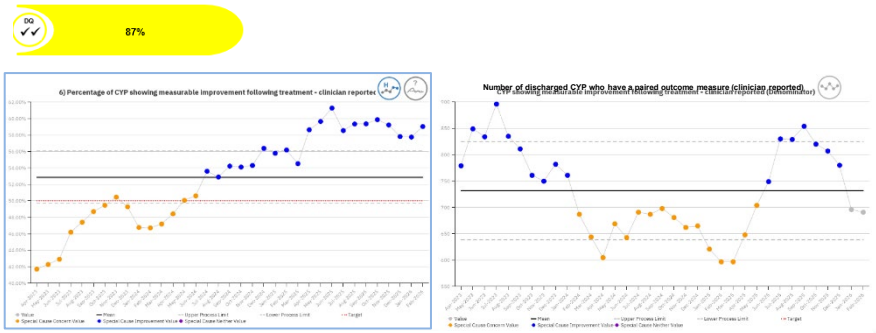
What does the chart show/context:
For the 3-month rolling period ending February, **641** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **346 (53.98%)** made a measurable improvement.

There is special cause improvement at Trust and Care Group level in the reporting period and performance is above standard at all levels.

Whilst there is no significant change for the number of patients discharged with a paired outcome measure at Trust level and for Durham, Tees Valley & Forensic Care Group and special cause concern for North Yorkshire, York & Selby Care Group, the overall rate of paired measures remains consistent.

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

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



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

What does the chart show/context:
For the 3-month rolling period ending February, **690** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **407 (58.99%)** 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.

Whilst there is no significant change in the number of patients discharged with a paired outcome measure at Trust level and special cause concern for North Yorkshire, York & Selby Care Group, the overall rate of paired measures remains consistent. There is special cause improvement for Durham Tees Valley & Forensic Care Group and the overall rate of paired measures reports an increase.

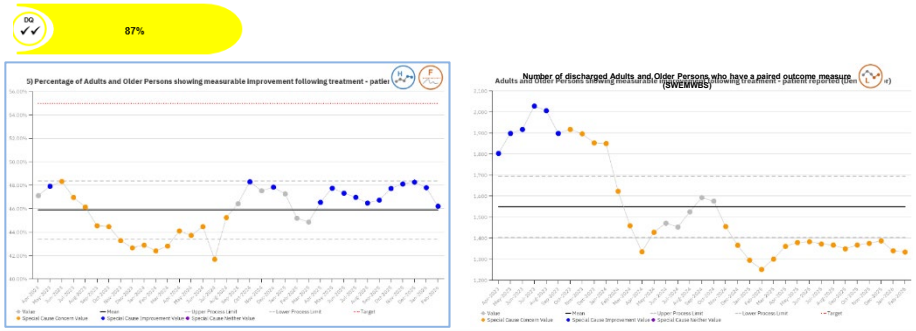
The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

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) **(On Hold)** 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. This work is to be complete by the end of April 26.
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

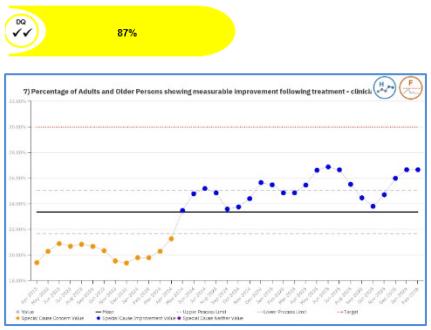
What does the chart show/context:
For the 3-month rolling period ending February, **1335** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 617 (46.22%)** made a measurable improvement.

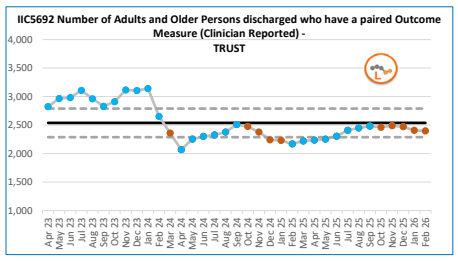
There is special cause improvement at Trust level, for Durham, Tees Valley & Forensic Care Group, for Adult Mental Health in that Care Group and for Mental Health Services for Older People in North Yorkshire, York & Selby Care Group; there is no significant change for North Yorkshire & York Care Group. Performance is below standard at all levels.

Whilst there is special cause concern in the number of patients discharged with a paired outcome measure at Trust level and Care Group level, the overall rate of paired measures remains consistent.

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 February, **2397** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 639 (26.66%)** 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.

Whilst there is special cause concern in the number of patients discharged with a paired outcome measure at Trust level and for Durham, Tees Valley & Forensic Care Group and special cause improvement for North Yorkshire, York & Selby Care Group, the overall rate of paired measures remains consistent.

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** had 11 open actions, 8 of which are dependent on Cito development. Following an Equality Quality Impact Assessment, both EDG and the Resources & Planning Committee accepted the recommendation not to undertake any further developments on Cito unless deemed critical to patient safety, thereby closing all Cito related outcomes improvement actions. This decision was supported on the grounds that all completed actions within the plan, and those currently in progress, continue to deliver the desired impact and there will be no negative impact to the completion of outcomes within the services. All actions will be taken forward into the requirements for the new electronic patient record.

Of the 3 open actions, 2 are on track for delivery following EDG approval to extend the deadlines:

1. Undertake quarterly webinars to organisation
2. To use data meaningfully at all levels (e.g. clinical supervision, team meetings, care group meetings, board meetings)

The remaining action is included on the CYP PROM slide with an update.

One action has been completed since last month; to implement training in the pilot teams for the new outcome measures linked to community transformation (Dialog, ReQoL 10, Goal-Based Outcomes GBO).

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

NHS
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.

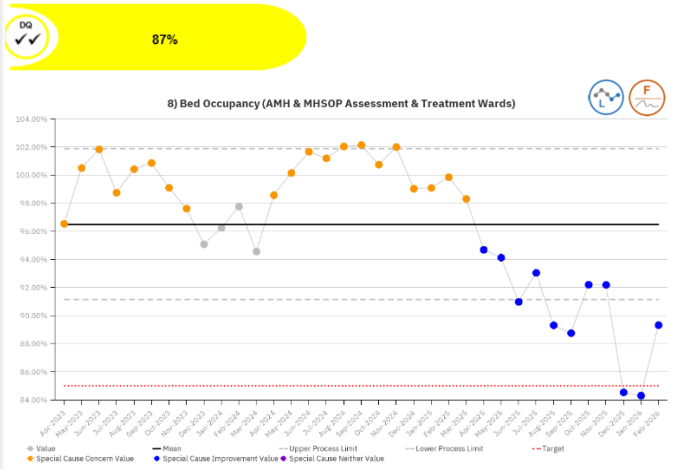
What does the chart show/context:
During February, **9856** daily beds were available for patients; of those, **8804 (89.33%)** were occupied. There were no patients admitted to independent sector beds during February.

There is special cause improvement at Trust and Care Group level in the reporting period, for Adult Mental Health in both Care Groups and for Mental Health Services for Older People in North Yorkshire, York & Selby Care Group. Performance is above standard at all levels.

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:
- Following the presentation of a strategic outline business case for a crisis assessment centre in Durham, aimed at preventing/reducing unnecessary admissions to assessment & treatment wards, the DTVFCG AMH General Manager will present the full business case to the Integrated Care Group Board in March 2026 and subsequently the Quality & Performance EDG in April (previously March).
- 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 are continuing.
- 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, was approved at the January 2026 Care Group Board. An outline business case is to be developed for Executive Directors Group with full business case development and engagement from end of April 26.
- A KPI change has been approved to amend the scope of the Bed Occupancy measure to include PICU wards. This will align the measure with those for out of area placements and clinically ready for discharge. **Timescale to be confirmed**



To Note:
The Integrated Care Group has received a report on the impact of restricted patients within our Assessment and Treatment wards as part of its programme to improve and reduce long lengths of stay. Actions will be developed and taken forward as part of the Hospital to Community Transformation Programme work.

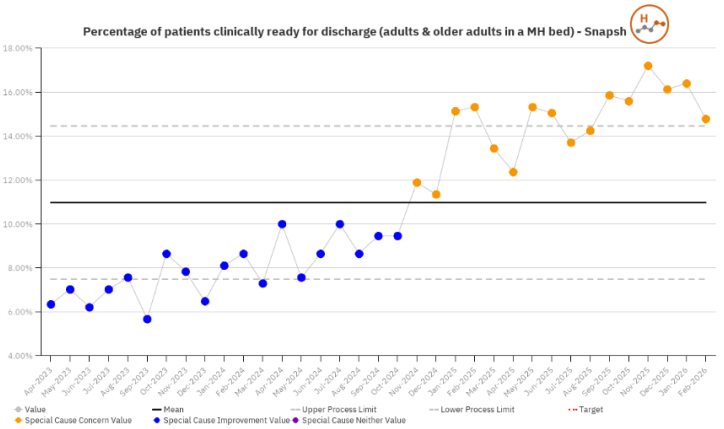
Additional Information - Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed) (Snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
At the end of February 2026, there were **57** adults clinically ready for discharge occupying adult MH, older adult MH or PICU beds, accounting for **15.32%** of our **372** acute beds open to admission.

There is special cause concern in the percentage of patients clinically ready for discharge at Trust and Care Group level, and Adult Mental Health in both Care Groups and Mental Health Services for Older People in North Yorkshire, York & Selby Care Group.

At Trust level, patients classified as clinically ready for discharge in February equated to an average of 76.2 beds (47.6 Adult and 28.5 Older Adult beds), with an associated direct cost of c.£1.45m. Of the cost, c.£0.88m relates to Adult and c.£0.58m relates to Older Adult. The annualised impact of patients classified as clinically ready for discharge is £17.4m.



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:
- The pilot hub in Durham was implemented in November 2025 and will be evaluated by the end of February 2026. **(Complete)** The first 3-month evaluation demonstrated an improvement in the total number of people from Durham residing in hospital beds and those clinically ready for discharge. The next phase of the hub development is being progressed by the Project Leadership Team, with the revised plan to be presented to the Hospital Community Board in April 2026.
- Piloting of the new ways of working for the Tees Valley transfer of care hub will be undertaken with South Tees Local Authorities from February 2026. **(Not Complete)** The service will commence mid March 2026.
- The recruitment for the Clinically Ready for Discharge pilot role in DTVFCG, aimed at reducing delays within Adults and Older Peoples services is in progress and the pilot will commence mid March 2026.
- The Trust has established the Hospital to Community Programme Board and one of the workstreams will be focused on the Clinically Ready for Discharge Programme. An outline for a Trust-wide 12-month delivery plan was shared with Quality & Performance EDG in March 2026 for comment, which outlines a structured and phased approach to reducing clinically ready for discharge delays, supporting improved patient flow, operational efficiency and organisational performance. The final plan will be presented to Board of Directors in April 2026.

Actions continued:
- In North Yorkshire recruitment continues for a discharge liaison officer to support patient discharge within adult beds at Cross Lane Hospital.
- 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 planned for January 2026 was cancelled by City of York Council due to sickness absence. **(Not Complete)** Director of Operations has approached the council with a view to hosting the event to enable this work to progress.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

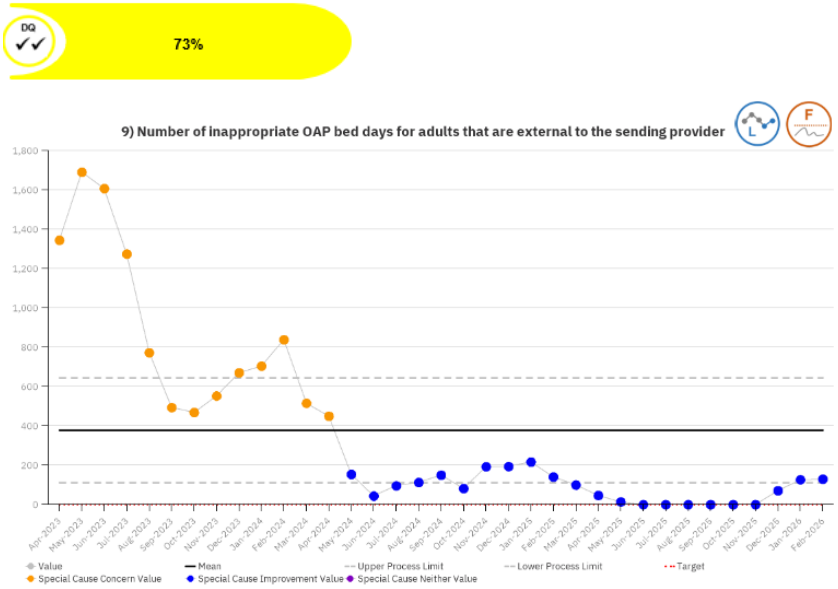
What does the chart show/context:
For the 3-month rolling period ending February, **130** days were spent by patients in beds away from their closest hospital.

There is special cause improvement at Trust level, for Durham, Tees Valley & Forensic Care Group and for Adult Mental Health within that Care Group in the reporting period; there is no significant change for North Yorkshire, York & Selby.

There were no active OAP placements as at 28th February 2026.

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	1	0	

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

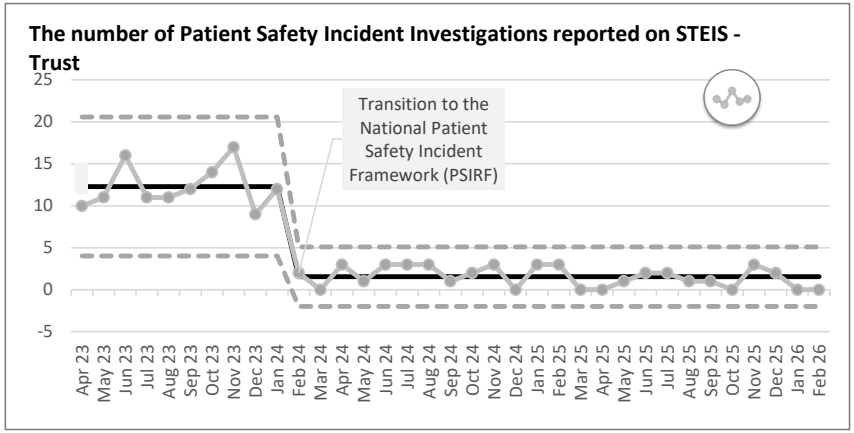
Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

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

Actions:
- 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 during which a redesigned process was finalised. Trust-wide and pilot specific communication has been issued, and formal testing of the new process began early February 2026 for an expected period of up to four months across nine AMH planned care teams following which the process will be evaluated and data re-measured before wider roll-out.



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 February.

There is common cause at Trust and Care Group level. There is special cause improvement in Adult Learning Disabilities and Children and Young Peoples Services in both Durham, Tees Valley & Forensic Care Group.

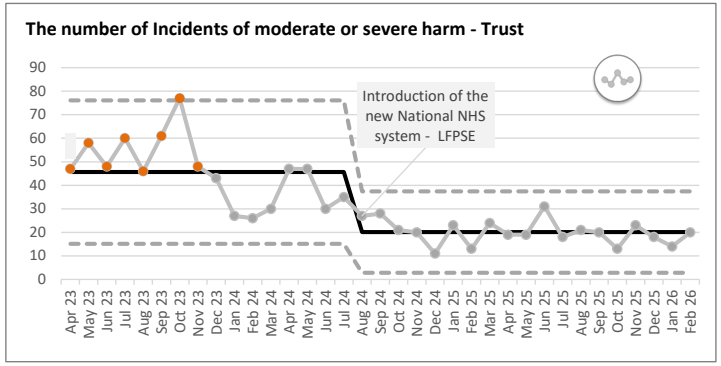
Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

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

Underlying issues:
There are no risks relating to incidents to raise.

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

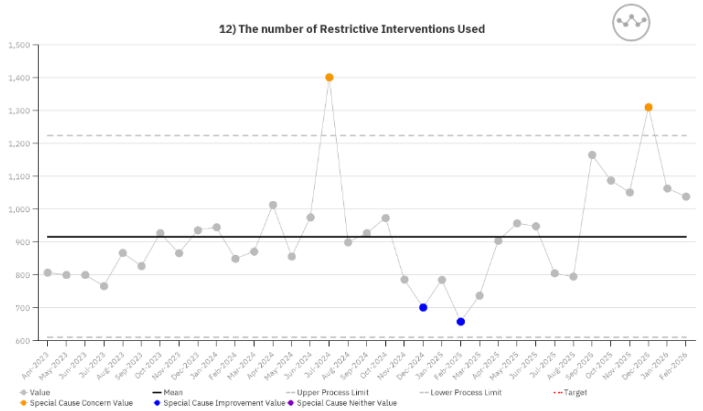
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
1,039 types of Restrictive Interventions were used during February.

There is no significant change at Trust level and Care Group level in the reporting period. There is special cause concern in Adult Learning Disabilities. Whilst there is also special cause concern for Children & Young Peoples Services in Durham, Tees Valley & Forensic Care Group, the service are well-sighted on the underlying reasons and have confirmed there is no actual concern at this stage.

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

Actions:
- Monthly clinics are being provided by the Positive & Safe Clinical Skills Team to support ongoing confidence-building for teams on physical clinical skills. Additional training was provided in February by the Positive & Safe Lead.
- The Positive & Safe Lead is undertaking observations to support the correct use of interventions.
- The ALD service has been identified as a Service Requiring Support due to the acute nature of the clinical needs and the associated impacts.



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

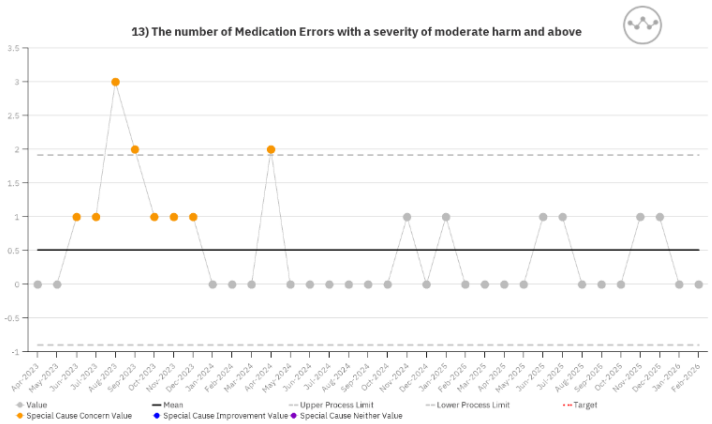
What does the chart show/context:
0 medication errors were recorded during February.

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

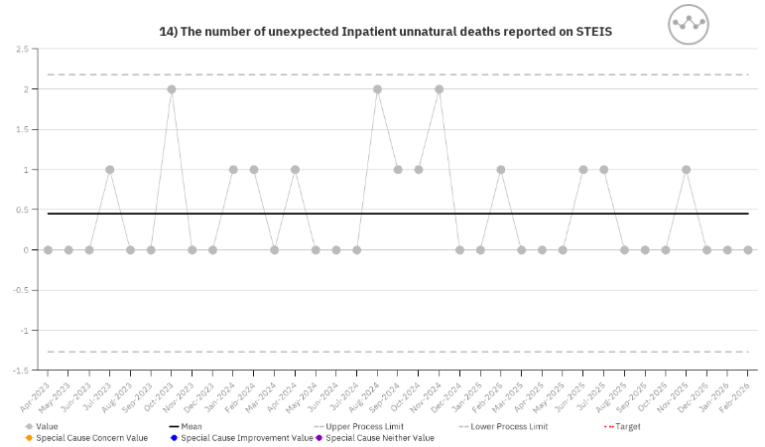
Tees, Esk and Wear Valleys NHS Foundation Trust

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 February.

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 **314** uses of the Mental Health Act during February.

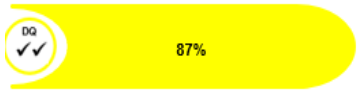
There is no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; there is an unexpected low shift in uses in North Yorkshire, York & Selby Care Group and within Adult Mental Health in that Care Group; however, the services have confirmed this is not an actual concern.

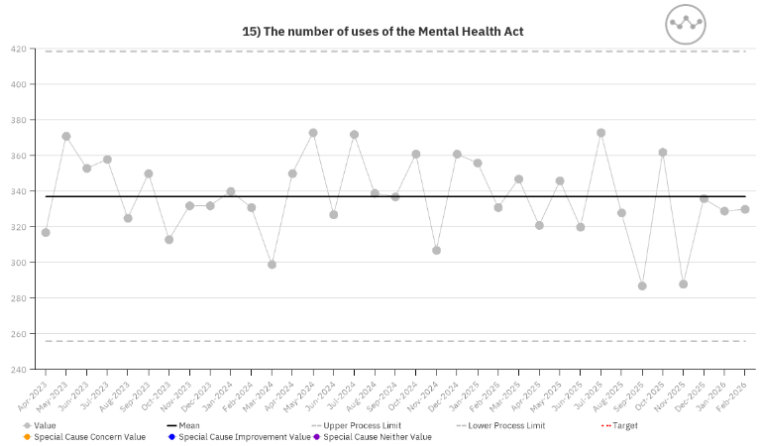
The latest national Mental Health Act data (2023/24) produced by NHS Digital has been analysed by Business Intelligence. Expected rates of detention by gender and ethnicity showed that Trust followed the same trend as the national rate of the higher the level of deprivation, the higher the rate of detention.

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.

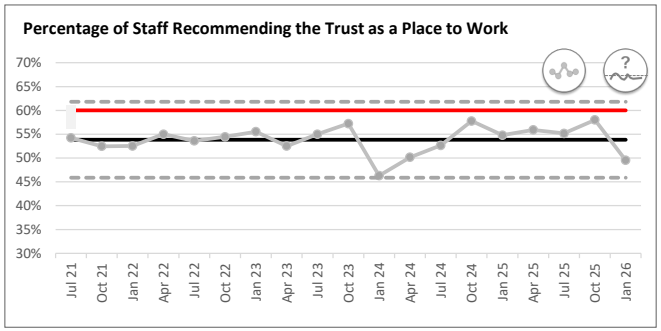
Underlying issues:
Analysis of the latest national Mental Health Act data (2023/24) shows some areas of inequality in our detention rates.

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. Clinical capacity has been secured to lead inpatient special interest sessions, and these will commence in August 2026. In the interim the Consultant in Public Health Medicine will support this work to ensure it remains on track.
- 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.





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



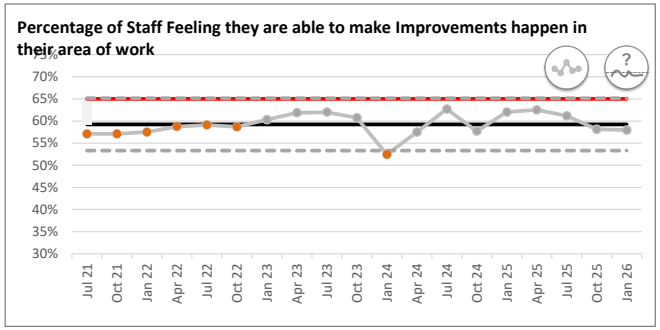
** Please note the survey is only undertaken once a quarter . The National Staff Survey (annual) is October each year; the National Quarterly Pulse Survey is the months of January, April and July*

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:
4239 staff responded to the 2025 Annual Staff Survey; **58.13%** of staff responded that they would recommend the Trust as a place to work. The NHS Staff Survey Benchmarking report 2025, shows the "best result" was 76% and the "average result" was 62% for similar organisations.

1805 staff responded to the January Pulse Survey. In relation to the question "I would recommend my organisation as a place to work", **894 (49.53%)** responded either "Strongly Agree" or "Agree".

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:
4239 staff responded to the 2025 Staff Survey; **57.91%** of staff responded that they are able to make improvements happen in their area of work. The NHS Staff Survey Benchmarking report 2025, shows the "best result" was 66% and the "average result" was 59% for similar organisations.

1805 staff responded to the January Pulse Survey. In relation to the question "I am able to make improvements happen in my area of work", **1046 (57.95%)** responded either "Strongly Agree" or "Agree".

Underlying issues:
- Whilst there is a growing trend in the Trust response rates for the Annual Staff Survey, they remain below the national average (51.85% compared 54.60%). Responses to the January Pulse Survey equate to approximately 22% of staff, which is positive when compared to an estimated national response rate of 8%, noting that this estimate includes responses from non-substantive NHS staff.
- Emerging themes suggest that we need to make improvements in our flexible working and management practices.

See overleaf for actions

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.
- The main areas of concern from the staff surveys continue to be 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 is now running, which will strengthen leadership capability and people management skills to improve staff experience, engagement and development conversations. 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, to ensure flexible working is fair to all staff while maintaining service delivery.
- A Staff Survey session was held at the March 2026 People & Culture & Diversity Committee time-out to align the strategic plans with the latest dataset in order to reduce the risk rating within the Board Assurance Framework. **(Complete)**

18) Staff Leaver Rate

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

What does the chart show/context:
From a total of **7,397.89** staff in post, **725.72 (9.81%)** had left the Trust in the 12-month period ending February 2026.

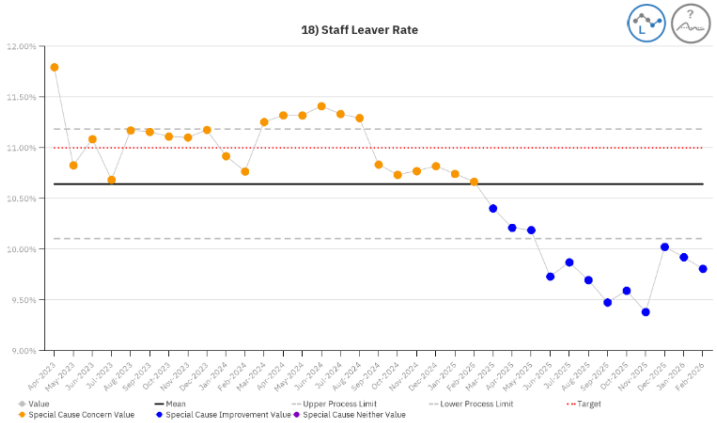
There is special cause improvement at Trust level and for a number of Directorates in the reporting period; however, there is special cause concern for Children & Young Peoples Services within Durham, Tees Valley & Forensic Care Group. There is also special cause concern for Corporate Affairs & Involvement, Estates & Facilities Management, and Management in Durham, Tees Valley & Forensic Care Group. These areas have confirmed there is no actual concern at this stage.

To Note:
In July 2025 the Trust ran its first mutually agreed resignation scheme and was able to support 56 staff to leave under this scheme. The notice periods of the staff ended in either November or December and therefore have impacted on the leaver rate in those months.

Underlying issues:
Within DTVFCG Children & Young Peoples Services, there has been a high number of staff leaving.

Actions:
General Manager to schedule a number of communication and engagement sessions for the team to understand and discuss their concerns, with a view to informing identifying actions. **Timescales to be confirmed**

DQ
87%



19) Percentage Sickness Absence Rate

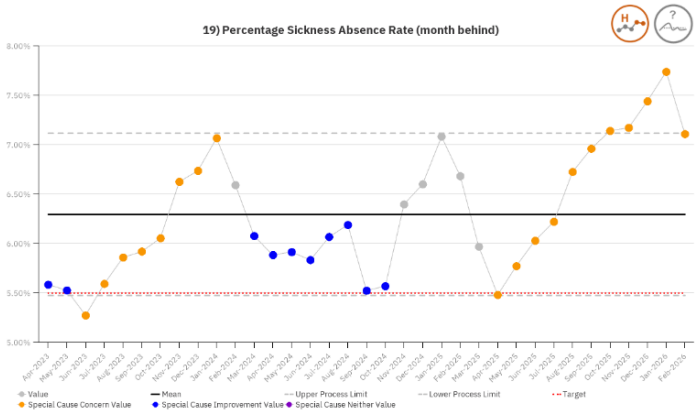
Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
There were **233,842.71** working days available for all staff during February 2026 (reported month behind); of those, **16,626.87 (7.11%)** days were lost due to sickness.

There is special cause concern at Trust level in the reporting period and for Assistant Chief Executive, Corporate Affairs & Involvement, Digital & Data Services, Durham, Tees Valley and Forensic Care Group, People & Culture, Adult Learning Disabilities, Adult Mental Health and Mental Health Services for Older People within Durham, Tees Valley and Forensic Care Group, and Children & Young Peoples Services within both Care Groups.

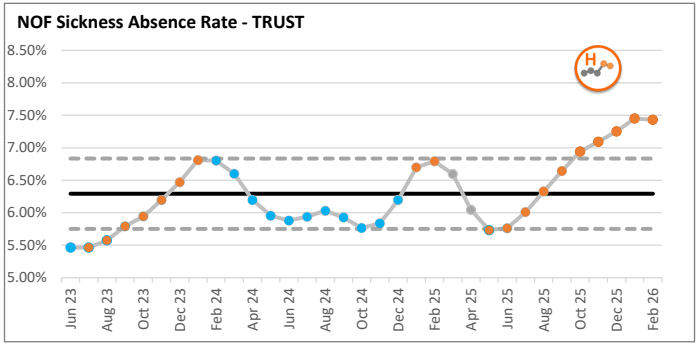
National Benchmarking for NHS Sickness Absence Rates published 26th February 2026 (data ending November 2025) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.59%** compared to the Trust mean of **6.20%**, with the Trust ranked 42 of 47 Mental health Trusts (compared to 37 previously) (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 **696,567.74** working days available for all staff in the 3-month period ending February 2026 (reported month behind); of those, **51,761.56 (7.43%)** days were lost due to sickness.

There is special cause concern at Trust level, for both Care Groups and for several directorates: Assistant Chief Executive, Corporate Affairs & Involvement, Digital & Data Service, Estates & Facilities Management, People & Culture.



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).

Original Actions:

The following actions were due for completion by the **end of December 25/January 26:**

1. 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). Research completed and briefing will be provided by end of January 26. **(Complete)** Confirmation being sought as to forums this is to be shared in.

2. 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. **(Complete)** Trust technology would enable the development of a bot but wider discussions and approval to develop is required from NHSE.

3. 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)** This action has been superseded by the Director-led deep dives, which will be expanded to corporate services, and all actions identified to date will be fed into that work.

4. 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 **(Complete)**

Additional Actions:

5. 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) One People Partner has completed training; all remaining People Partners are on the waiting list.

6. Director led deep dives to be undertaken monthly supported initially by Heads of People & Resourcing; to commence by end of March 2026 (previously January) **(In Progress)** Deep dives commenced in March.

7. 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) **(In Progress)** Training commenced in March.

8. To review the existing Attendance Management policy (by end of January 26) **(Complete)** Review completed and a minor amendment has been identified. The ratification process is currently being confirmed; however, is anticipated by the end of March 2026.

9. Head of Inclusive Culture to explore how socio-deprivation indicators can be used to influence our plan. This will be completed by the end of June 2026.

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:
157,411 training courses were due to be completed for all staff in post by the end of February. Of those, **145,039 (92.14%)** were completed.

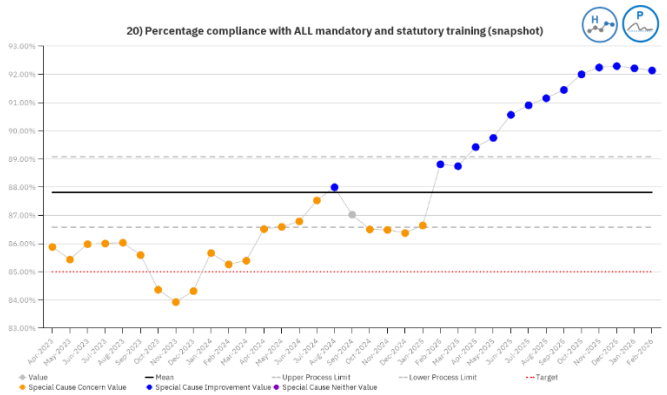
There is special cause improvement at Trust level and for most Directorates in the reporting period. There is special cause concern in Estates and Facilities Management.

As at the 28th February 2026, the below directorates are below 85%:

Directorate	Number compliant	Total Number	% Compliance
CHIEF EXECUTIVE OFFICE	128	152	84.21%
ESTATES AND FACILITIES MANAGEMENT	4540	5377	84.43%
TRUST FINANCING (BANK STAFF)	457	539	84.79%

Underlying issues:
- There are a number of roles that still require their competencies reviewing to ensure they are aligned correctly.
- Approximately 80 colleagues have been TUPE-transferred into EFM and are becoming familiar with Trust systems, processes and expectations. In addition, a reduction in overtime within the directorate has impacted on staff availability for training.

Actions:
- Executive Director of People & Culture to review membership of the Chief Executive Office and reallocate executive oversight by the end of March 2026.
- EFM have a plan in place to improve the position, including:
  - Targeted support sessions to help new staff use laptops and access ESR and other training systems.
  - Prioritised training lists to ensure essential and overdue modules are completed first.
  - Local monitoring on a weekly basis to track progress and address any emerging issues early.
- Outstanding training within Trust Financing (Bank Staff) to be completed by the end of March 2026.
- Workforce Development Lead has reviewed 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 has been completed and is with the Chief Nurse & Interim Care Group Director for approval.



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 **9** courses that are currently below the standard (compared to 8 in the previous month); 7 of which are face to face. Follow Up is now reported below standard.

Underlying issues:
- Staff unable to be released to attend training (high DNA rate and wasted spaces). During February 2026 there has been an average of 34% wasted spaces (including 13% DNAs) across the mandatory face to face training courses.
- There is currently an issue with the availability of spaces to deliver Resuscitation Level 3.
- Resident doctors have significant variability in their prior placements / training and join in a group causing potential bottlenecks for face-to-face training.

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 has developed a guide for managers to know where to go (and to who) if issues with accuracy of training data. This was to be published on the staff Intranet by the end of February 2026. **(Not Completed)** This will be shared with executive leads for input and confirmation of the publication route by the end of March 2026.
- Workforce Development Lead to scope training for 6 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 July 2026 (previously December 2025). One trainer has trained to provide Resuscitation Level 3 from April 2026 and 5 further trainers have been booked onto the course in April 2026, with a view to providing courses from June.
- Workforce Development Lead to scope the potential for purchasing additional North East Ambulance Service and acute hospital spaces in North Yorkshire and York to provide Resuscitation Level 3 training. **(Complete)** Additional spaces will be purchased from NEAS as required; there is no additional scope within the NYY acute hospitals.
- Executive Director of People & Culture and Associate Director of Performance to repeat the mandatory & statutory training deep dive, for a focused discussion at the Quality & Performance EDG in March 2026.
- Workforce Development to review and contact all staff that have completed Resuscitation level 3 but have not completed the test by the end of March 2026.

	Number Compliant	Total Number	% Compliance
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	744	1011	73.59%
Annual Medicines Optimisation Module	524	678	77.29%
Positive and Safe Care Level 2 Update*	1286	1650	77.94%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1618	1999	80.94%
Resuscitation - Level 1 - 1 Year*	2080	2568	81.00%
Moving and Handling - Level 2 - 2 Years*	661	813	81.30%
Positive & Safe Care Level 1*	3697	4524	81.72%
Resuscitation - Level 3 - Adult Immediate Life Support - Test*	812	989	82.10%
Follow Up.	14	17	82.35%

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

Actions continued:
- With the exception of Estates & Facilities Management and Medical, the Executive Directors for all corporate directorates are to ensure 85% compliance for all courses by the end of June 2026.
- All Executive Directors to establish trajectories with their services to reduce the number of DNAs by the end of quarter 1 2026/27

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
Of the **7,082** eligible staff in post at the end of February; **6,181 (87.28%)** had an up-to-date appraisal.

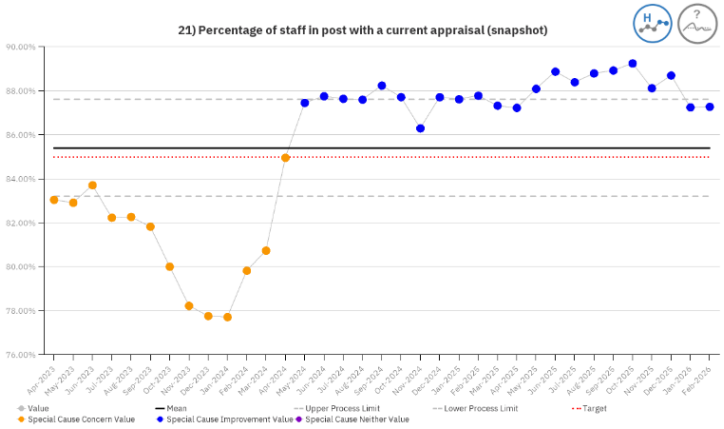
There is special cause improvement at Trust level and for a number of directorates in the reporting period. There is special cause concern in Digital & Data Services.

As at the 28th February 2026, by exception compliance levels below 85% are as follows:

	Number Compliant	Total Number	% Compliance
CORPORATE AFFAIRS AND INVOLVEMENT	29	40	72.50%
DIGITAL AND DATA SERVICES	127	170	74.71%

Underlying issues:
- In a small number of areas staff are incorrectly allocated to the wrong cost centre.
- Corporate Affairs & Involvement appraisals are currently impacted by staff sickness.

Actions:
- Sickness absence within Corporate Affairs & Involvement is being managed in line with Trust policy and as staff return to work, appraisals will be undertaken.
- Outstanding appraisals to be completed within Digital & Data Services by the end of March 2026.
- 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. **(Not Complete)** The paper will now be presented to the April meeting.



22) Number of new unique patients referred

Tees, Esk and Wear Valleys
NHS Foundation Trust

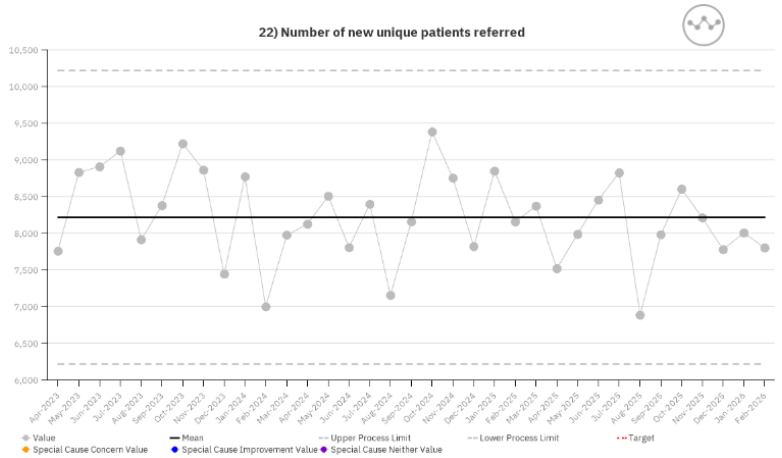
What does the chart show/context:
7,806 patients referred in February that are not currently open to an existing Trust service.

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. 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

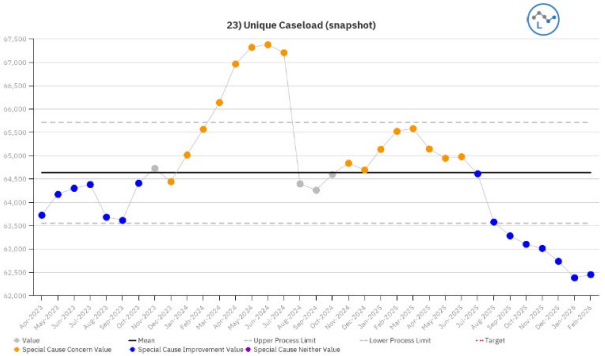
What does the chart show/context:
62,455 cases were open, including those waiting to be seen, as at the end of February 2026; **53,430** were active.

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.

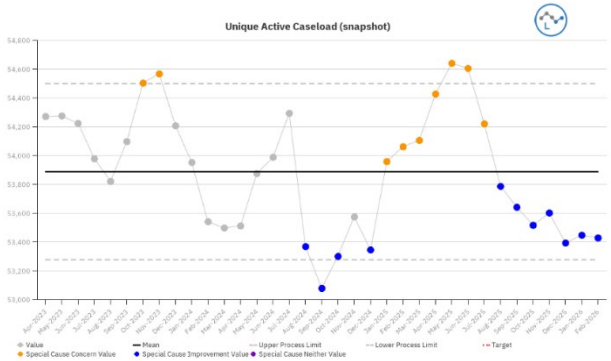
The **additional** SPC chart representing **Active Caseload** (excluding patients waiting for first contact) shows special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group; there is no significant change for North Yorkshire, York & Selby Care Group. There is special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

Underlying issues:
- The active caseload measure includes patients that have received a Keeping in Touch contact but have not had an assessment and are, therefore still on the waiting list.
- A number of data quality issues have been identified in the SIS caseload data.

Actions:
- Following approval at the at the People & Resources EDG in November 2025, the proposal for a new option for the Unique Caseload measure has been shared with Resources & Planning Committee for approval prior to development.
- SIS Service Manager to work with Business Intelligence to resolve the data quality issues by the end of March (previously 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 28th February 2026 against which Trust performance is assessed was a surplus **of £0.946m which was £1.79m better than planned**. The Trust's breakeven plan for 2025/26 assumes delivery of challenging £27.41m Cash Releasing Efficiency Schemes (CRES).

- **Temporary Staffing Costs** are monitored to support delivery of the nationally required reductions of 40% on Agency (outturn spend 2024/25 £10.2m, target spend 2025/26 £6.5m) 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) adversely 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 £1.33m in April 2025 and had slightly decreased to £1.30m in February 2026 (the plan required a £119k p/m reduction to average run rate). Bank costs were £14.80m to date and £1.16m more than planned.
- **Overtime costs** reduced from £430k in April to £74k in February, against a target of £323k in month. Total costs to date of £2.2m reduced from £4.4m in the same period last year and were £1.2m less than planned.
- **Agency expenditure** was **£5.52m** for the year to date and **£0.73m 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 increased. 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 (due to back end loading of plan, but with actual savings delivering ahead of plan). 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 £0.19m** decreasing by £0.17m compared to prior month and representing **1.36% of paybill (**which is **1.20 percentage points or 46.9%** lower than the 2024/25 average of 2.56%). Delivering further expenditure run rate reductions will require ongoing rigour. Costs in February would represent an annualised £5.7m agency cost, compared to a straight-line projection £6.0m, and 2025/26 target cost of £6.5m. The probable case is achievement of target, with some forward risk.
- Residual agency costs include (reducing) high premia rate cover for 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 have developed trajectories and savings plans for medical agency staffing reductions, to minimise run rates looking ahead to 2026/27 and considering alternatives to like for like agency medical cover.
- The Trust had **no off-framework agency assignments**.
- **Independent sector beds** - the Trust used **34 non-Trust bed days in February** (86 in January). **Year to date costs of £504k** included estimates for unvalidated periods of occupancy and average observation levels pending billing and were **£34k above plan**. This remains a key area of volatility with ongoing bed pressures needing sustained clinical and management focus. Flow pressures, including from unprecedented average levels of adults and older adults who are clinically ready for discharge, mean that sustaining low (and delivering nil targeted) independent sector bed utilisation is 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

Tees, Esk and Wear Valleys NHS Foundation Trust

- 2025/26 plans assumed delivery of **£27.41m Cash Releasing Efficiency Savings (CRES)** for the year, with £16.8m plans being recurrent and £10.6m non–recurrent.
- Year to date CRES are £0.06m ahead of plan, but with **recurrent schemes delivering £3.1m below plan**, and **non-recurrent schemes delivering £3.1m above plan**.
- Full delivery of planned savings is forecast, but with **an in-year shortfall of £2.8m on recurrent schemes**, currently more than fully mitigated by non recurrent mitigations. The **Full Year Effect of recurrent schemes is currently forecast at £3.4m**, which would equate to a **total recurrent Full Year Impact of CRES of £17.4m** (£0.6m 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 51% 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 both 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, was carried out in December, with Full Year Effects reduced to £17.4m, with some reduced assessments being mitigated by transfer of non recurrent schemes 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 provides 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

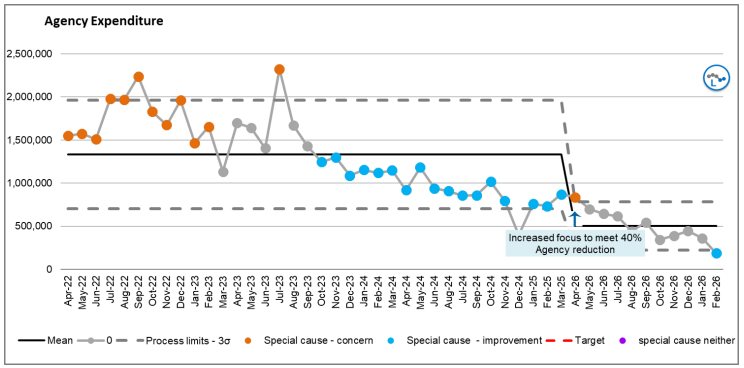
87%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Year to date agency costs of £5.5m to Month 11 (February 2026) were £0.7m below plan.

Agency expenditure compared to plan £000's	Annual Plan £000's	Current Month Plan £000's	Current Month Actual £000's	Current Month Variance to Plan £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance to Plan £000's	Prior Month WTE Actual	Current Month WTE Actual
Nursing and Other	2,984	48	5	- 43	2,985	2,229	- 756	27.39	23.11
Medical	3,555	296	183	- 113	3,259	3,286	27	12.31	10.05
Total	**6,539**	**344**	**188**	**- 156**	**6,244**	**5,515**	**- 729**	**39.70**	**33.16**
Total Pay Bill £000's	**433,961**	**35,444**	**36,500**		**398,619**	**405,596**			
% agency	**1.51%**	**0.97%**	**0.51%**		**1.57%**	**1.36%**			



Underlying issues:

We need to continue to ensure a sustainable permanent workforce, including in key shortage professions including medical and nursing (the latter notably to continue successful actions to tackle price cap breaches in Health and Justice), 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. Ongoing 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 and a Performance Improvement Plan was approved at the March Quality & Performance EDG, the progress on which will be monitored through the Safe Staffing Group and EDG. 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 40 in November, 48 in December, 62 in January and 59 in February (all NYYS). Trusts were required to stop all shifts by January 2026, unless an allowed exception is identified. Further work is required to ensure Trust compliance within the NYYS care group.

25b) Agency price cap compliance

93%

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
622 agency shifts were worked in February 2026 (729 shifts prior month), with 304 or 49% of shifts compliant and 318 or 51% non-compliant with national price caps.

Price Cap Compliance	January Shifts	January Shifts %	February Shifts	February Shifts %	Increase / (reduction)
Compliant	344	47%	304	49%	-40
Non-Compliant	385	53%	318	51%	-67
Total Shifts	**729**		**622**		**-107**

Staffing Group	Jan-26			Feb-26			Feb-25			12 month non-compliant shift change	12 month non-compliant shift change %
	Shifts	Non-Compliant	% Compliant	Shifts	Non-Compliant	% Compliant	Shifts	Non-Compliant	% Compliant		
Healthcare Assistant & Other Support	62	0	0%	59	0	0%	414	0	0%	0	0%
Medical and Dental	254	254	100%	191	191	100%	338	338	100%	-147	-43%
Nursing, Midwifery & Health Visiting	413	131	32%	372	127	34%	605	80	13%	47	59%
Scientific, Therapeutic & Technical (AHPs)	0	0	0%	0	0	0%	57	34	60%	-34	-100%
Total Shifts	**729**	**385**	**53%**	**622**	**318**	**51%**	**1414**	**452**	**32%**	**-134**	**-30%**

Annualised Premia £m (exc Capital)	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Medical & Dental	1.67	1.93	2.37	2.33	2.36	2.19	1.71	2.15	2.07	1.74	1.57	1.49	1.12
Nursing, Midwifery & Health Visiting	0.09	0.23	0.15	0.11	0.10	0.10	0.07	0.08	0.19	0.15	0.17	0.14	0.14
Administration & Estates	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Scientific, Therapeutic & Technical (AHPs)	0.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Healthcare Assistant & Other Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	1.78	**2.16**	**2.52**	**2.44**	**2.47**	**2.29**	**1.78**	**2.23**	**2.26**	**1.90**	**1.74**	**1.63**	**1.26**

Underlying issues:
Particularly persistent challenges relate to levels of medical staffing and prison mental health nursing vacancies (including for recently tendered services) 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:

- Medical assignments attract the highest value and percentage premia rates, and medical colleagues in both Care Groups have developed medical staff recruitment and locum trajectories looking ahead to 2026/27 CRES planning and following a NENC system reforecast of flexible staffing costs.
- 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 was a 1 for the period ending 28th February 2026 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 had a capital service capacity **rating of 2**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric was **rated as 1.**
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust had an I&E margin of 0.32% which was a **rating of 2**.
- The Income and Expenditure **(I&E)** margin distance from plan was 0.35% (favourable) which was 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 £5.52m to date were £730k 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 resulted in an **overall UoRR** of **1** for the period ending 28th February 2026 compared to a planned UoRR of 2.

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 has considered wider options to achieve further agency cost reductions beyond 2025/26, through its Medium-Term Plan, as a significant proportion of cost (and most price cap breaches by value) relate to medical vacancy cover.

Whilst a reduction in forward operational capital allocations is of concern for the Trust's capital programme, it will have a positive impact on cash balances, capping the amount of capital the Trust is able to expend using accumulated cash balances. This will favourably impact liquidity.

Actions:
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 28th February was **£12.11m and £3.10m 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.

Whilst Bank staffing reductions were £0.38m behind plan, actions were targeted to reduce premia rate Agency shift reductions, plans being £0.16m ahead of plan, and overtime also over-achieving by £0.25m in February.

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 applied additional controls on use of agency and overtime shifts, with additional authorisation now required for Overtime. 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 2026/27, including their EQIA before 1st March 2026.
- New overtime controls piloted January, and now implemented..
- 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 £3.14m** for the period ending 28th February, with £12.61m 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, with one QEIA for Trust wide temporary staffing reductions being progressed to include 2026/27 actions. A number of schemes were planned for later in the year, creating a risk to delivery, reducing options for mitigation if performance is lower than planned.

The £3.14m over achievement year to date on non-recurrent schemes includes, £0.66m reduction on cost of capital, £2.12m other actions, £0.64m management of cash to achieve maximum interest, offset by under achievement of planned learning disability savings £0.28m.

Underlying issues:
It was necessary to target non-recurrent CRES to deliver a break-even plan, however higher than planned reliance on non-recurrent schemes would leave an unmitigated financial challenge moving into future years unless further recurrent schemes are identified.

Actions:
Work is ongoing:

- To develop plans and finalise full year effect impacts 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 **£10.38m to the end of February**, which was £0.95m less than the revised Board approved programme (£0.62m less 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 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) to give a composite £13.80m capital allocation and £16.16m capital programme (including PFI). Mid-Year, following the 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 additional funding to support Solar panel installation on more Trust sites, but due to timing constraints and/or structural works needed this funding could not be fully progressed to active schemes in 2025/26. Achievable works are being completed, and funding has not been drawn down from NHSE for schemes that it was not possible to complete in year.

An additional £0.68m of funding was awarded for decarbonisation works (LED Lighting), with a further £4.70m awarded in January to fund other capital scheme costs in year.

There is potential that fast tracked capital works will outturn below currently approved spending for 2025/26 (with costs carried into 2026/27). Planned disposals have been deferred into 2026/27 to mitigate impacts from reduced future year allocations. The Trust is communicating with system partners to aim to ensure full commitment of allocated expenditure.

Underlying issues:

Due to reduced Trust operational capital allocations from 2026/27 and increasingly constrained national and regional capital allocations relative to need, access to capital funding is 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 has been submitted to NHS England, aligned to medium term financial planning. Strategic Capital has not been allocated beyond 2026/27, with action now needed to enable regional NEY NHSE prioritisation of all provider requirements.

30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£51.1m** at the end of February 2026 which was **£11.8m above planned cash balances of £39.3.m**. Balances reflect higher than planned opening cash, income received in advance of the period it relates to, and capital funding received not anticipated in plan (with no matching year to date cash outflow).

- **Prompt Payment of Suppliers:** The Trust achieved a combined Better Payment Practice Code (BPPC) compliance of **95.7%** to date for the prompt payment suppliers, which was 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 28th February 2026 was £3.9m, with **debts exceeding 90 days amounting to £0.46m** (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. If the Trust can secure access to additional operational capital (non-cash-backed) to progress the significant works programmed at Roseberry Park Hospital it will deplete accumulated cash balances. If the Trust can secure access to additional regional Strategic Capital to progress works, this should be expected to be cash-backed, preserving significantly more Trust cash reserves over the medium term. The Trust's medium term financial plan includes a capital programme, however regional capital allocations to providers for Return to Constitutional Standards and Strategic Capital have not been confirmed for the full planning horizon, with processes ongoing/developing.

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%	93.65%
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%	80.64%
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%	89.58%
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)	L	F	95.00%	95.00%	86.40%
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%	79.31%

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	0
IIC6600	Average length of stay for Adult Acute Beds (Rolling Quarter)		?	42.0	42.1	40.0
IIC6490	Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48.00%	48.00%	47.57%
IIC6480	Talking Therapies - Reliable improvement rate for those completing a course of treatment		?	67.00%	67.00%	66.83%
IIC5370	Number of women accessing (1+ contact) specialist community PMH services in the previous 12 months	H	N/A	N/A	N/A	1,599
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	31,779
IIC6610	Number of people accessing IPS services (rolling 12 month)	H	N/A	N/A	N/A	1,084

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 with the exception of York.
- **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 County Durham and York. For the month of February there was 1 patient 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 County Durham and Tees Valley. There is special cause concern for North Yorkshire. For the month of February there were 2 patients that did not receive treatment within the 1-week standard.

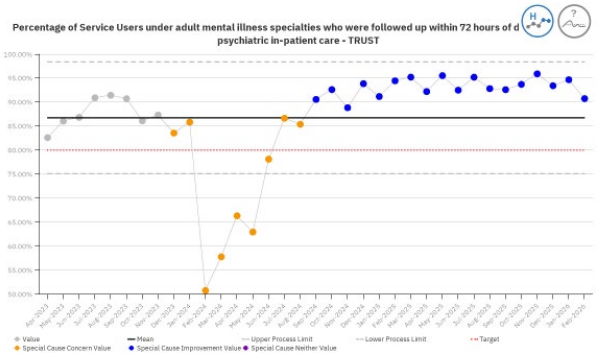
Mental Health Priorities

- **Active OAP (inappropriate):** Plan achieved at Trust level for February.
- **Average Length of stay for Adult acute beds:** Plan achieved at Trust level for February.
- **Talking Therapies Reliable Recovery:** National Standard not achieved at Trust and commissioned place level, with the exception of Tees Valley and North Yorkshire, noting that we have achieved the standard for the month of February in Tees Valley and North Yorkshire.
- **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 February in North Yorkshire and York.
- **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:** Plans not achieved at ICB level; however, there is special cause improvement in both ICBs.

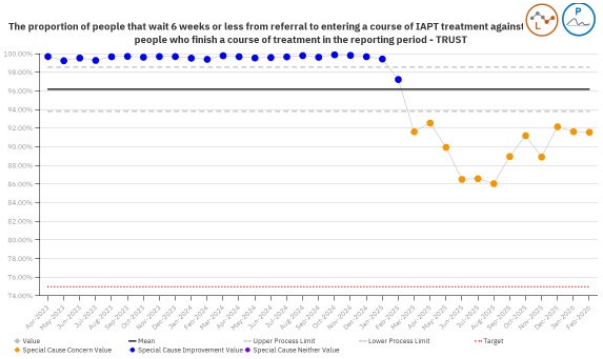
*All headlines are based on financial year to date unless otherwise stated.

National Quality Requirements

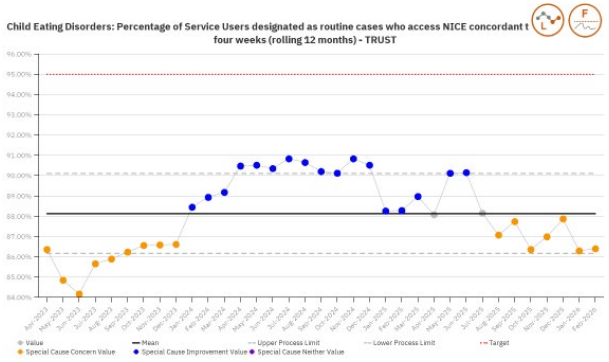
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



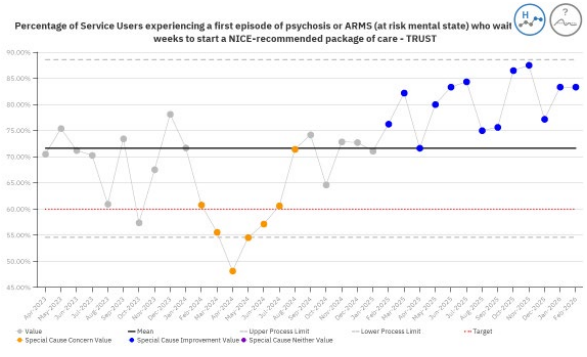
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	80%	93.65%			✓
COUNTY DURHAM	80%	95.12%			✓
TEES VALLEY	80%	93.29%			✓
NORTH YORKSHIRE	80%	95.85%			✓
YORK	80%	94.06%			✓



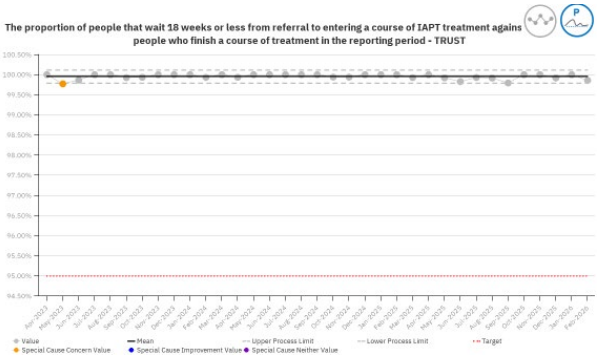
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	75%	89.58%			✓
COUNTY DURHAM	75%	82.69%			✓
TEES VALLEY	75%	84.07%			✓
NORTH YORKSHIRE	75%	97.86%			✓
YORK	75%	91.44%			✓



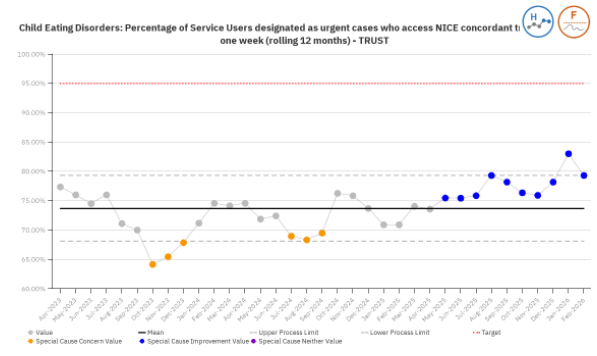
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	86.40%			✗
COUNTY DURHAM	95%	79.78%			✗
TEES VALLEY	95%	96.34%			✓
NORTH YORKSHIRE	95%	92.31%			✗
YORK	95%	65.52%			✗



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	60%	80.64%			✓
COUNTY DURHAM	60%	74.44%			✓
TEES VALLEY	60%	84.05%			✓
NORTH YORKSHIRE	60%	86.41%			✓
YORK	60%	69.23%			✗



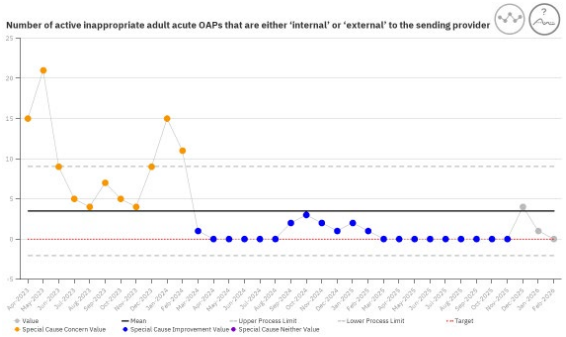
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	99.92%			✓
COUNTY DURHAM	95%	99.90%			✓
TEES VALLEY	95%	99.83%			✓
NORTH YORKSHIRE	95%	99.98%			✓
YORK	95%	99.92%			✓



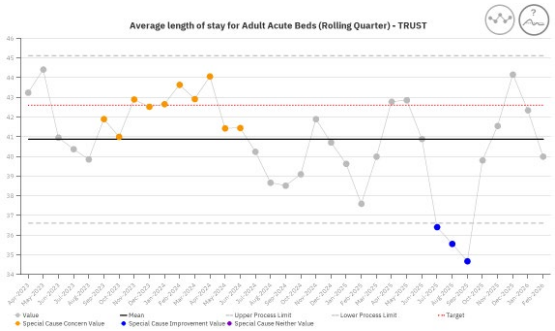
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	79.31%			✗
COUNTY DURHAM	95%	95.00%			✓
TEES VALLEY	95%	100.00%			✓
NORTH YORKSHIRE	95%	50.00%			✗
YORK	95%	66.67%			✗

Mental Health Priorities

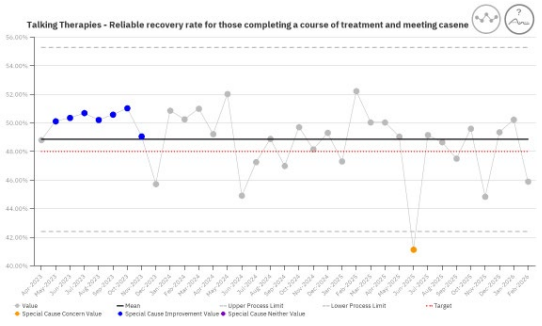
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



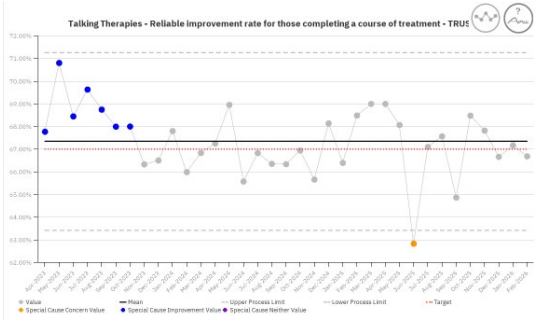
Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	0	0			



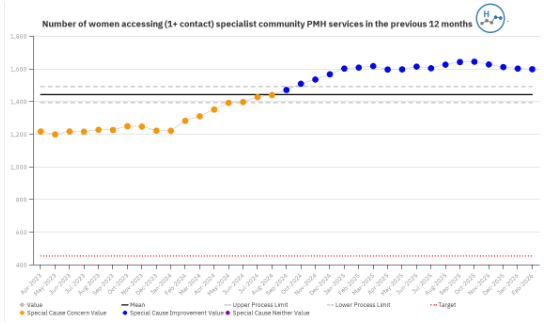
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	42.1	39.99			



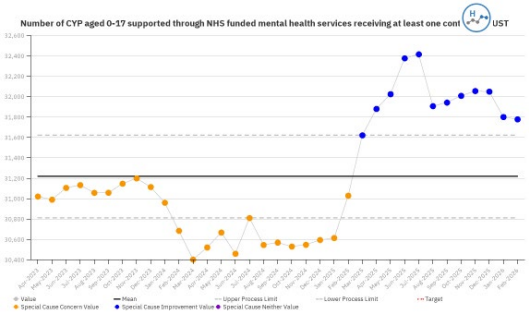
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	48%	47.57%			
COUNTY DURHAM	48%	43.65%			
TEES VALLEY	48%	46.53%			
NORTH YORKSHIRE	48%	51.10%			
YORK	48%	49.95%			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	67%	66.83%			
COUNTY DURHAM	67%	64.15%			
TEES VALLEY	67%	63.30%			
NORTH YORKSHIRE	67%	70.02%			
YORK	67%	68.46%			



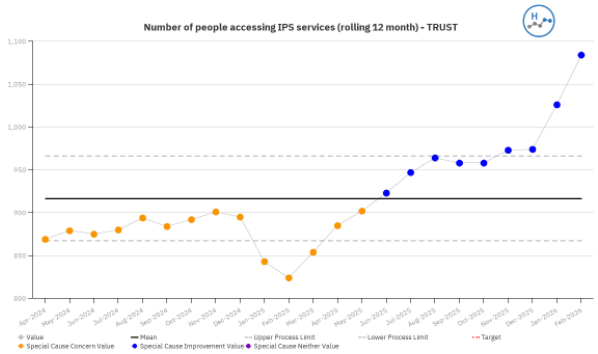
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,599			
COUNTY DURHAM	456	411			
TEES VALLEY	447	522			
NORTH YORKSHIRE	368	460			
YORK	156	178			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		31,779			
COUNTY DURHAM		11,189			
TEES VALLEY		10,980			
NORTH YORKSHIRE		5,577			
YORK		3,454			

Mental Health Priorities

Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Standard	Actual	Variation	Assurance	Plan Met
Trust	N/A	1084			
County Durham	745	316			
Tees Valley		429			
North Yorkshire	323	211			
York		112			

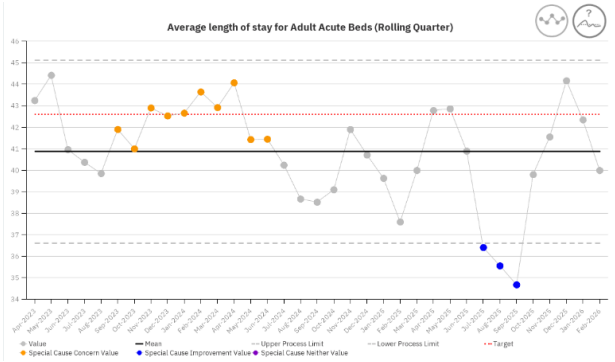
Average length of stay for Adult Acute Beds

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 February we are aiming to have an average length of stay of **42.1** days.

What does the chart show/context:
During the 3-month period ending February 2026, there were **694** discharged hospital spells from adult acute beds for patients aged 18+, accounting for a total of **27,753** bed days which equates to an average length of stay of 40.0 days.

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 North Yorkshire, York & Selby 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	42.4	40.0	

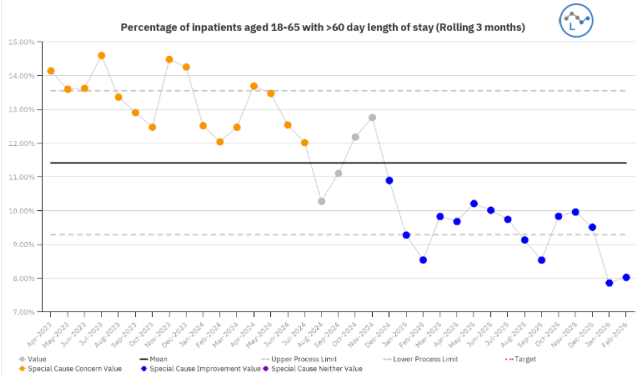
Underlying issues:
No concerns have been identified at this stage as long lengths of stay are largely impacted by the discharge of patients that are clinically ready for discharge; however, this remains under review.

Actions:
See *Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed)* on page 24 for action.

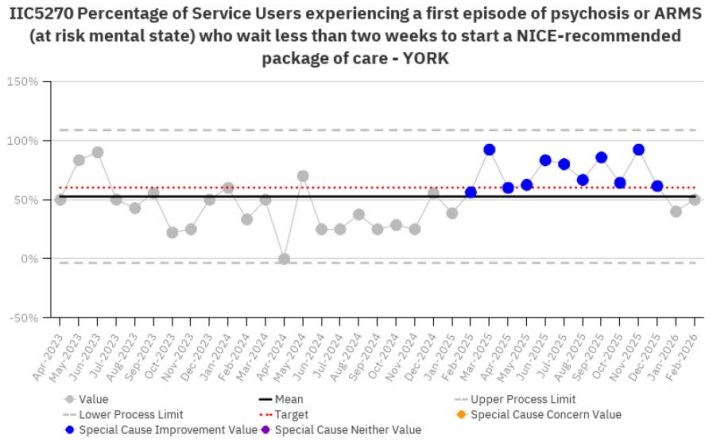
Percentage of adult inpatients with a length of stay over 60 days at discharge - rolling 3 months (National Oversight Framework measure)

What does the chart show/context:
Over the 3-month period ending February 2026 there were **523** adult patients discharged from an adult acute (assessment & treatment) bed, of which **42** (**8.03%**) had a length of stay exceeding 60 days.

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



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 - *by exception*



Background / standard description:
We are aiming to have 60% of services users experiencing a first episode of psychosis or ARMS (at risk mental state) wait less than two weeks to start a NICE recommended package of care.

What does the chart show/context:
2 service users experienced a first episode of psychosis or ARMS within February 2026. Of those, **1 (50.00%)** commenced a NICE-recommended package of care within 2 weeks of referral.

There is no significant change noted at Care Group level in **York** in the reporting period.

Underlying issues:
- Capacity within the York & Selby EIP team is currently impacted by vacancies and maternity leave
- Timeliness of joint assessments with CAMHS within York services

Actions:
- Recruitment is underway for 10 posts, all of which have been advertised with closing dates between March and April 2026.
- AMH General Manager host a meeting between CAMHS and EIP by the end of April 2026, with a view to improving timely access to joint assessments for patients under 18.

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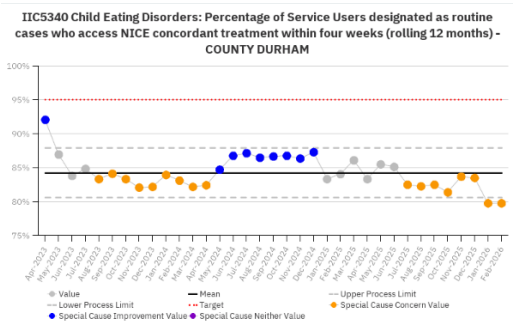
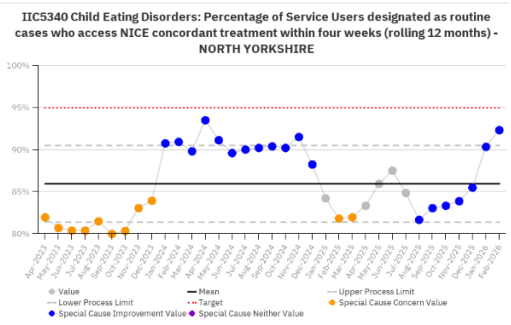
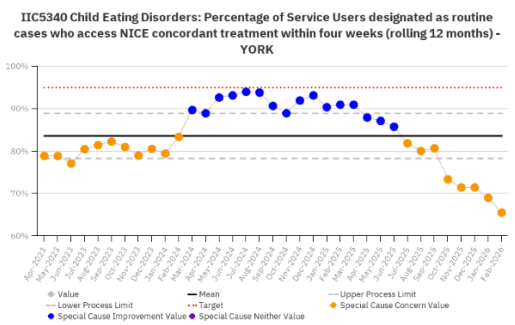
The proportion of CYP with ED (routine cases) that wait 4 weeks, from referral to start of NICE-approved treatment (rolling 12 months) - *by exception*

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 February 2026, there were **89** children and young people with a routine referral, of which **71 (79.78%)** started treatment within 4 weeks in **County Durham**.

In February, there were **8** children and young people with a routine referral; **all (100.00%)** started treatment within 4 weeks.

Underlying issues:
There are no underlying issues

Actions:
There are no specific improvement actions required.

What does the chart show/context:
In the rolling 12 months ending February 2026, there were **65** children and young people with a routine referral, of which **60 (92.31%)** started treatment within 4 weeks in **North Yorkshire**.

In February, there were **6** children and young people with a routine referral; **all (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 February 2026, there were **29** children and young people with a routine referral, of which **19 (65.52%)** started treatment within 4 weeks in **York**.

In February, there were **2** children and young people with a routine referral, **1 (50.00%)** of which started treatment within 4 weeks.

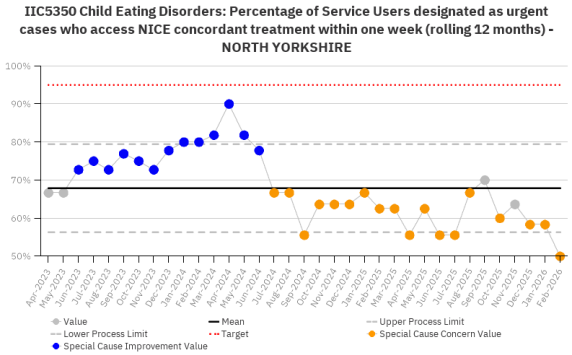
Of the **1** patient not seen within 4 weeks due to patient choice; they commenced treatment on day 58.

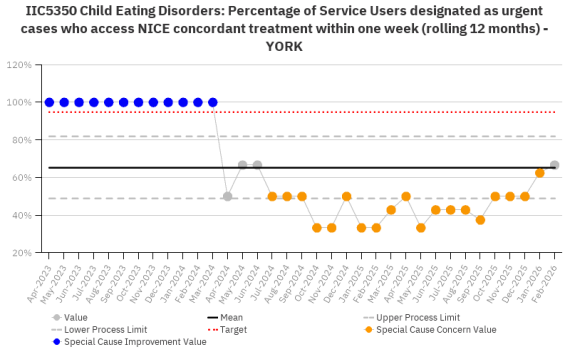
Underlying issues:
There are no underlying issues to report.

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 February 2026 there were **16** child or young people with an urgent referral, of which **8 (50.00%)** started treatment within 1 week in **North Yorkshire**.

In February, there were **4** children and young people with an urgent referral, of these, **2** started treatment within 1 week **(50.00%).**

Of the **2** patients not seen within 4 weeks:

- 1 patient was impacted by a delay in receiving information from their GP. They were seen on day 8 (day 4 after receiving outstanding information).
- A November 2025 referral was delayed due to a known system workflow issue that initially made it invisible to the service; once identified, it was prioritised and treatment commenced within eight days. An after-action review is underway, and a revised referral form has been implemented to prevent recurrence.

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 February 2026, there were **9** child or young people with an urgent referral, of which **6 (66.67%)** started treatment within 1 week in **York**.

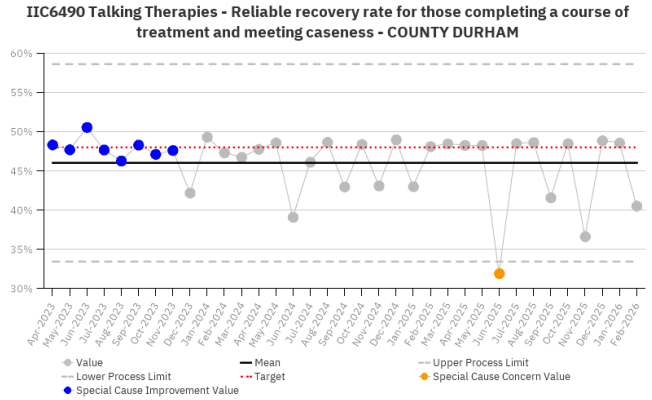
In February, there was **1** child or young person with an urgent referral who started treatment within 1 week (**100.00**%).

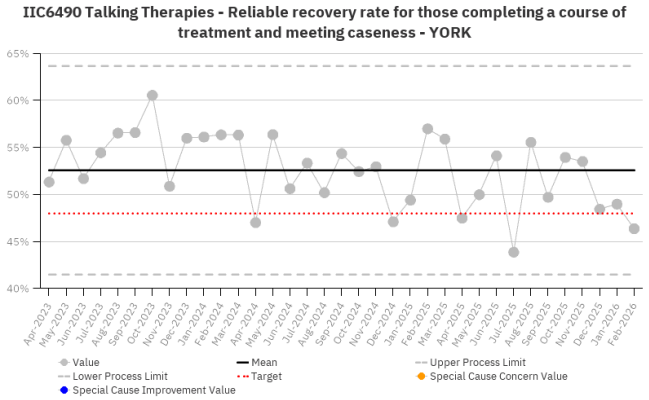
Underlying issues:
There are no underlying issues to report.

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.

What does the chart show/context:
During February, **40.54%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**.

There is no significant change as indicated in the chart above.

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

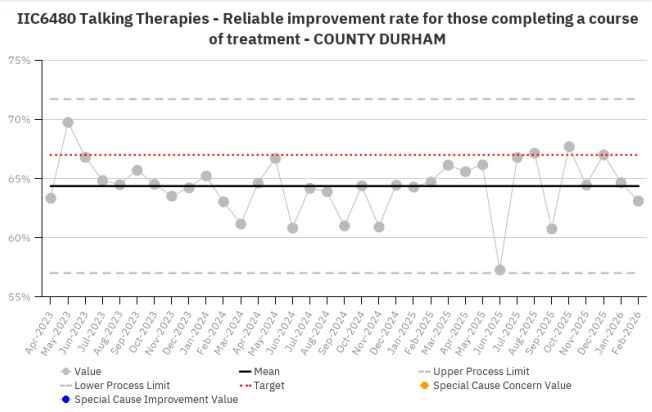
What does the chart show/context:
During February, **46.38%** of patients demonstrated reliable improvement following completion of a course of treatment within **York**.

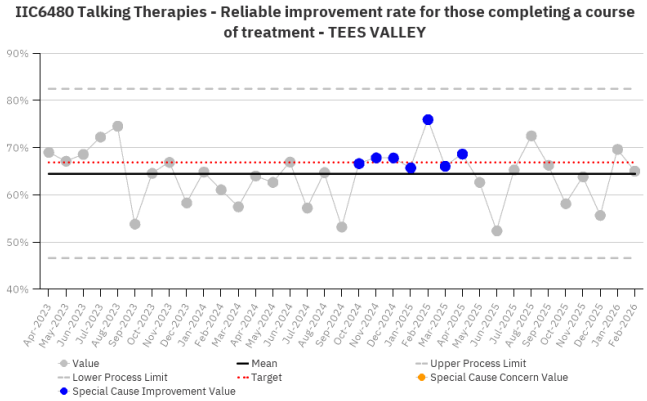
There is no significant change as indicated in the chart above.

For underlying issues and action, please page 65

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 February, **63.12%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**.

There is no significant change as indicated in the chart above.

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 February, **65.05%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**.

There is no significant change as indicated in the chart above.

For underlying issues and action, please page 65

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Underlying issues (County Durham & Tees Valley):

- 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 financial gap between capacity and demand is potentially impacting outcomes as under current capacity we are providing fewer than the prescribed number of treatment sessions per patient for Step 3 treatment.
- Reliable Improvement is impacted by the inclusion of Step 1 counselling, as this includes patients that do not meet caseness on referral and therefore are unable to demonstrate sufficient improvement to reflect reliable improvement.
- High levels of complex patients are showing reliable improvement on two outcome measures; however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the other scores.

Actions (Trust-wide):

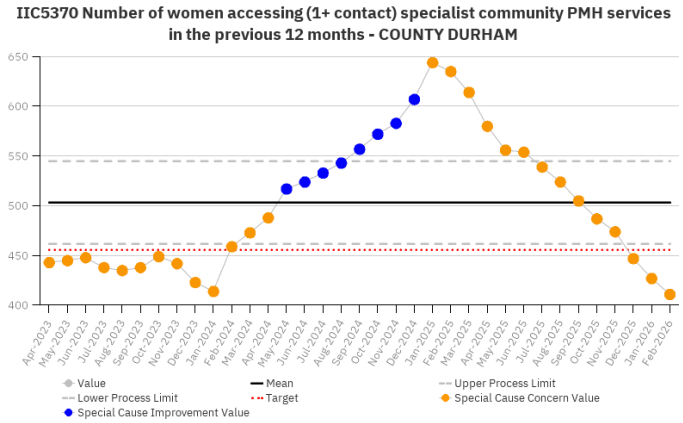
- The completed Trustwide action plan was presented to the Quality & Performance EDG in February 2026. **(Complete)** A Performance Improvement Plan is being developed specifically for County Durhan & Tees Valley (*see action below*).

Actions (County Durham & Tees Valley):

- Recruitment is ongoing for 3 High Intensity workers and 3 Psychological Wellbeing Practitioner to cover maternity leave. One HIW has started in post; 1 further HIW will start in April. One PWP is progressing through employment checks.
- The General Manager has developed a Performance Improvement Plan aimed at improving outcomes, including a proposal for the introduction of Koa Step 3 Digital Therapy for PTSD, options for the management of Step 1 counselling, and a review of suitability criteria. This was approved at the Quality & Performance EDG in March 2024.

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.

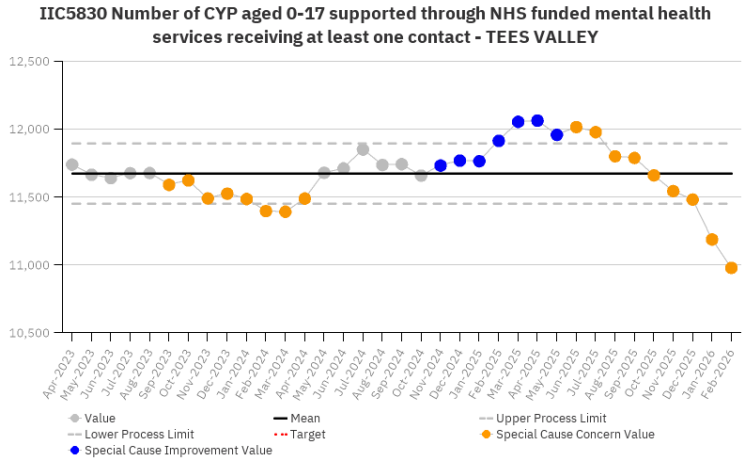
What does the chart show/context:
In the 12-month period ending February 2026, **411** women accessed our specialist community PMH services within **County Durham**.

Underlying issues:
Investigations have confirmed that the Perinatal KPI for the Durham & Darlington team is affected by underlying data quality issues.

Actions:
The metric will require redevelopment and some source-system data correction to ensure alignment with NHS England definitions and accurate future reporting. This will be completed for the March 2026 report and all historic data refreshed.

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.

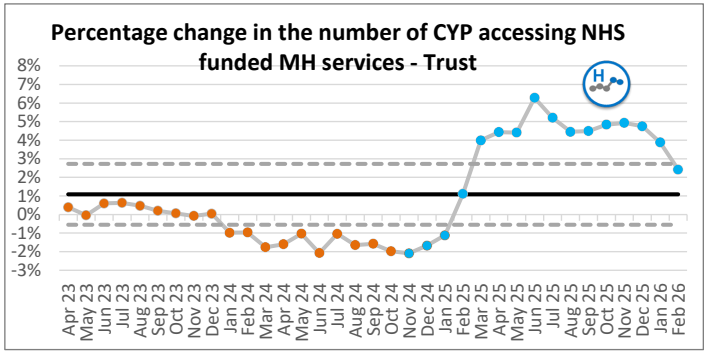
What does the chart show/context:
In the 12-month period ending February 2026, **10,980** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **Tees Valley**.

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 **31,777** CYP aged under 18 supported through NHS funded mental health with at least one contact in the 12-month period ending February 2026, compared to **31027** in the 12-month period ending February 2025; a growth factor of **2.42%.**

There is special cause improvement at Trust level and for North Yorkshire, York & Selby Care Group; however, there is special cause concern for Durham, Tees Valley & Forensic Care Group.



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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

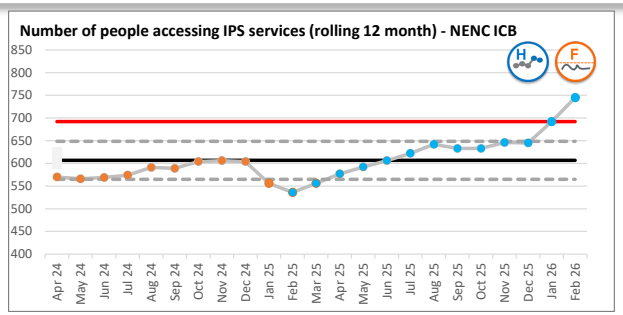
Measure/Area	Underlying issue	Action
MHP measure - Tees Valley	Whilst there is a decreasing trend, further work is required to understand whether there is an underlying issue.	Business Intelligence to review the numbers accessing services to better understand the position. This work will be completed by the end of January 2026 (previously December 2025). **(Not Complete)** This will now be completed by the end of March 26
	In January 2026 we launched the new CYP Tees Valley Getting Help Service, whose data is recorded on IAPTUs. Whilst this data will be incorporated into our MHSDS it is currently reported separately in the new service report. We can see from the new service report that there are approximately 300 CYP contacts.	The Associate Director of Performance is to work with Business Intelligence to explore how to match national and local data for assurance and reporting and identify any possible mitigating actions for risks identified. Exploration will be completed by the end of March 2026.
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 was to be completed by the end of February (previously November 2025). **(Not Complete)** It is anticipated this will now be completed by the end of March 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)** Two peer Trusts have been contacted; one meeting has been arranged for March 2026.
Both measures	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.	We have now addressed the previously identified issue regarding the flow of indirect contact information. Our internal data has been refreshed and this is now reflected in the measures that were affected.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

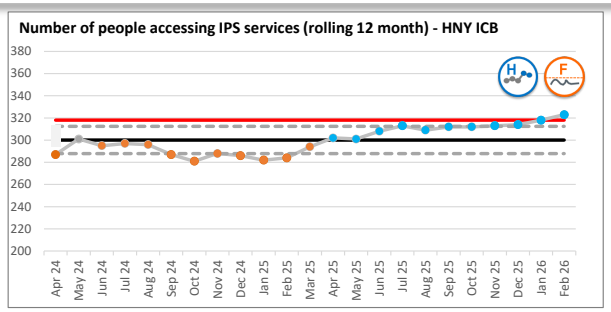
Background / standard description:
In the 12 months ending February 2026, we are aiming for 1,009 people across **North East & North Cumbria ICB** to access individual placement & support services.

What does the table show/context:
In the 12 months ending February 2026, **745** people accessed IPS services.



Background / standard description:
In the 12 months ending February 2026, we are aiming for 578 people across **Humber & North Yorkshire ICB** to access individual placement & support services.

What does the table show/context:
In the 12 months ending February 2026, **323** people accessed IPS services.

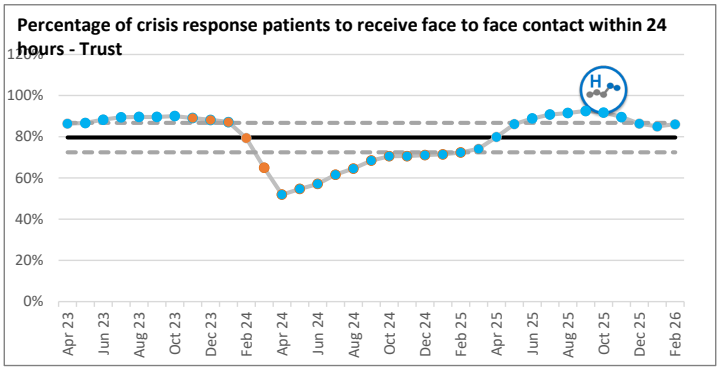


NENC	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TEWV- Ambition	752	752	752	752	789	825	862	899	936	972	1,009	1,046
TEWV- Actual	576	592	605	622	641	633	633	646	645	692	745	
HNY	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
TEWV- Ambition	230	230	230	347	347	347	545	553	562	570	578	586
TEWV- Actual	302	301	308	313	309	312	312	313	314	318	323	

Underlying issues:
- **Trust-wide:** Calculation of ambition
- **NENC**: Time to recruit following confirmation of funding to achieve ambition
- **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.

Actions:
- **Trust-wide:** 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. **(Complete)** It has been established that the calculation of the ambition was based on IPS workers having a full caseload from start date when it should be within their first year. Future ambitions will need to take this into account.
- **NENC:** 1 Employment Specialist started in March and the interviews for 2 Employment Specialist and 1 Employment Assistant posts are scheduled for March 26.
- **HNY**: 1.0 Employment Specialist is in pre-employment checks.

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



What does the chart show/context:
There were **1048** new urgent referrals to crisis services with a first face to face contact in the 3-month period ending February 2026, of which **902** (**86.07%**) were seen within 24 hours of referral were seen within that timeframe.

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

To Note:
Analysis undertaken by Business Intelligence identified several issues impacting the data following the implementation of Cito. Work has now been completed by Digital & Data Services to rectify the **historic** data.

Underlying issues:
There are no underlying issues to report.

Actions:
Whilst there are no specific improvement actions required, Business Intelligence have worked with NHS England to understand differences between the published data and the Trust assessment to ensure Trust calculations are correct. This work was completed in February 2026 (previously December 2025). **(Complete)**
Investigations identified that internal data incorrectly included a cohort of referrals received prior to each reporting month. Work has been undertaken to rectify this and refresh historic data, and the data has been validated against the national position.

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		2608	1149	521	290	416	194	36	1	1	0	9	155*
Adults with a learning disability Waiting for an Assessment		85	71	10	2	2	0	0	0	0	0	3	24*
Adults in Health and Justice services Waiting for an Assessment		45	25	14	2	4	0	0	0	0	0	5	20*
Older People Waiting for Assessment		2750	947	688	398	515	154	46	2	0	0	10	57
Children and Young People Waiting for an Assessment		1249	628	343	108	82	17	7	38	25	1	10	161*

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		5285	191	113	81	222	224	287	1802	2009	356	92	208*
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		1854	11	42	37	99	143	94	592	231	605	104	200
Adults waiting for an ADHD Assessment		4955	182	109	107	327	178	349	1052	1449	1198	107	333
Children and young people waiting for an ADHD Assessment		4467	184	115	35	287	335	482	1848	1063	118	78	258*
Adults waiting for an Autism Assessment		4107	63	72	82	190	184	321	678	1251	1266	119	333

Waiting Times Dashboard (National Waiting Times)	Variation	Actual Number Waiting	0-1 Week	1-2 Weeks	2-4 Weeks	4-6 Weeks	6-8 Weeks	8-12 Weeks	Over 12 Weeks	Average Wait (weeks)	Longest Wait (weeks)
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		3	1	1	1	0	0	0	0	3	5
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		45	12	8	21	3	0	0	1	3	12*
Adults Waiting for EIP Treatment (2 week standard)		78	23	29	20	3	1	1	1	2	29*

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		4735	684	681	1262	561	979	568	14	69

NOTES:

- *An asterisk denotes a data quality issue*

Waiting Times Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

Waiting Times Assessment & Treatment

- **AMH** There is special cause improvement (a reduction) in the numbers waiting for an assessment. Our longest genuine wait time is **47 weeks** in NYYSCG. The majority (**64**%) of adults are waiting less than 2 months for an assessment.
- **ALD** There is no significant change in the numbers waiting for an assessment. Our longest wait time is **15 weeks** in DTVFCG. The majority (**84**%) of adults are waiting less than 1 month for an assessment. **H&J** There is no significant change in the numbers waiting for an assessment. Our longest wait time is **20 weeks** in DTVFCG. The majority (**87**%) of adults are waiting less than 2 months for an assessment.
- **MHSOP** There is no significant change in the numbers waiting for an assessment. Our longest wait time is **57 weeks** in NYYSCG. The majority (**60**%) of older adults are waiting less than 2 months for an assessment.
- **CYP** There is no significant change in the number of children and young people waiting for an assessment. Our longest genuine wait time is **156 weeks** in DTVFCG. The majority (**78**%) of children and young people are waiting less than 2 months for an assessment.

Waiting Times Neuro Services

- **CYP Autism** There is special cause improvement (a reduction) in the numbers waiting for an autism assessment. Our longest genuine wait time is **207** weeks (4 years) in DTVFCG. The majority (**72%**) of children and young people are waiting between 1-3 years for an autism 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 **200 weeks** (3.8 years) in DTVFCG. The majority (**77%**) 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 **333** weeks (6.4 years) in DTVFCG. The majority (**75%**) of adults are waiting over 1 year for an assessment.
- **CYP ADHD** There is special cause concern (an increase) in the numbers waiting for an ADHD assessment. Our longest wait time is **198** weeks (5 years) in DTVFCG. The majority (**65%**) of children and young people are waiting between 1 and 3 years 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 **333 weeks** (6.4 years) in DTVFCG. The majority (**61**%) of adults are waiting over 2 years for an assessment.

National Waiting Times

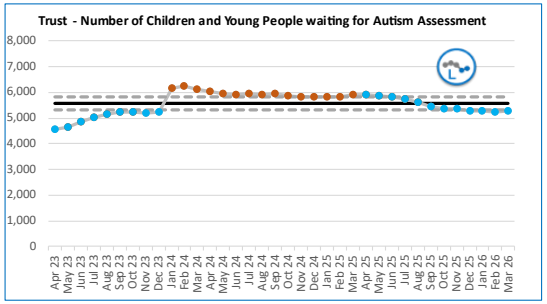
- **CED Urgent** There is no significant change in the number waiting from an urgent referral within our Eating Disorder Service. There are no patients waiting over 1 week to start treatment.
- **CED Routine** There is no significant change in the number waiting from a routine referral within our Eating Disorder Service. Our longest genuine wait time is **5 weeks** in NYYSCG. The majority (**91%)** of children and young people are waiting less than 4 weeks for treatment.
- **EIP** There is no significant change in the number of waiting for EIP Treatment. Our longest genuine wait time is **5 weeks** in DTVFCG. The majority (**67%**) of adults are waiting less than 2 weeks for treatment

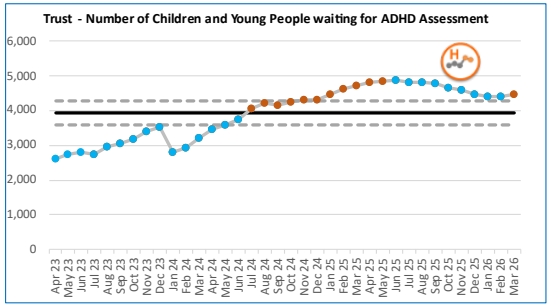
Waiting Times Talking Therapies

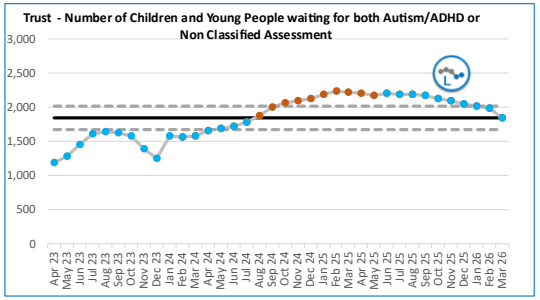
- There is special cause concern (an increase) in the number of adults waiting for their second contact with Talking Therapies. Our longest wait time is **69 weeks** in NYYSCG. The majority (**55%**) of adults are waiting less than 12 weeks for their second appointment.

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	5285	92	208	
DTVF Care Group	4255	100	208	
NYY&S Care Group	1030	59	138	

Commentary on Longest waits

DTVF: Data quality, assessment commenced (longest wait is 1448 days)
NYY&S: Genuine Waiter - Specialist Assessment Required

Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4467	78	258	
DTVF Care Group	3860	83	206	
NYY&S Care Group	609	47	258	

Commentary on Longest waits

DTVF: Data Quality - Specialist Assessment Complete (longest genuine wait - 1386 days - specialist assessment booked).
NYY&S: Genuine waiter, Specialist Assessment Required

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

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	1854	104	200	
DTVF Care Group	1188	134	200	
NYY&S Care Group	666	50	116	

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 has worked closely with the ICB and Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust to develop a framework for clinical prioritisation and an aligned regional process for the management and assessment of referrals. A paper was submitted to the ICB MH Subcommittee in January 2026 and an outcome is awaited.
- 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. The ICB paper was to be taken to the March 2026 Mental Health, Learning Disabilities & Autism Assurance (MHLDA) Meeting. **(Not Complete)** This will now be submitted to the County Durham Care Partnership Executive and then to the MHLDA meeting in April with some recommendations.
- 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.

Actions (Trust):

- DTVFCG have a recovery plan in place with Phase 2 testing on dual assessments complete. All remaining actions within the recovery plan are progressing, while demand currently continues to outweigh capacity, the service continues to deliver favourably delivering against the trajectory we set out. A service away day is planned for May 2026 (previously March) to agree a plan to roll out the clinical protocol work and further streamline processes around transformation.
- The General Manager to provide an update on the current position in respect of the patients on the under-5 pathway. Proposals were submitted to the Care Group Board in December 2025 and concerns were shared with the ICB. **(Complete)** (*See action on the previous page*)
- The Team Manager in Durham and Darlington is leading a recruitment exercise to recruit 8 Band 6 posts (5 permanent/3 to cover maternity leave). Interviews are scheduled for February 2026. **(Complete)** 3 permanent posts were recruited to; the remaining posts will be readvertised.
- The Scarborough ADHD team currently has a recovery plan in place which is impacted by sickness absence; however, it is under regular review. A review of the process and use of resources will be undertaken with a view to meeting demand; however, this is contingent on vacancies being filled and absence levels, and there remains a backlog of assessments that will require additional resources to address to return to sustainable position based on current referral rates. A progress report will be completed and presented through Integrated Care Group Governance and then go to EDG for assurance.
- The Service Manager has completed 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. **(Complete)** **(***See below* action**)**
- A Stop the Line Day was held in January 2026 to review progress with the Team and the CAMHS Leadership Cell. **(Complete)** The outcome of the day was a focus on maintaining a stable position until new staff commence in post, and ensuring the team were supported pending the appointment of a new Team Manager. **(***See below* action**)**
- The Service Manager to progress recruitment for one team manager for neuro services. An updated position is to be shared at the Service Improvement Development Group in April 26.

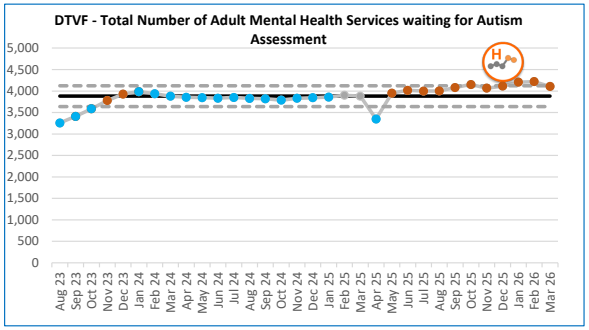
To I

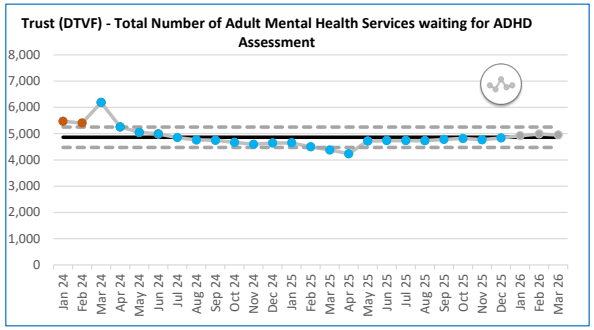
Total number of Children and Young People waiting for Neurodevelopmental Assessment (DTVF Care Group)

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 m		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	9594	9446	9303	
Change		99	10	-43	10	-149	-138	-216	-209	-104	-145	-71	-148	-143	

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
·ust (DTVF Care Group)	4107	119	333	

Commentary on Longest waits

DTVF: Genuine Wait - Assessment Required

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
·ust (DTVF Care Group)	4955	107	333	

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 has worked closely with the ICB and Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust to develop a framework for clinical prioritisation and an aligned regional process for the management and assessment of referrals. A paper was submitted to the ICB MH Subcommittee in January 2026 and an outcome is awaited.

Actions (Trust):

- Monies were identified to fund a medic to support the transformed model for local triage; the recruited candidate commenced in post in February 2026. **(Complete)**

Waiting Times Neuro Services: Adult Services

Tees, Esk and Wear Valleys NHS Foundation Trust

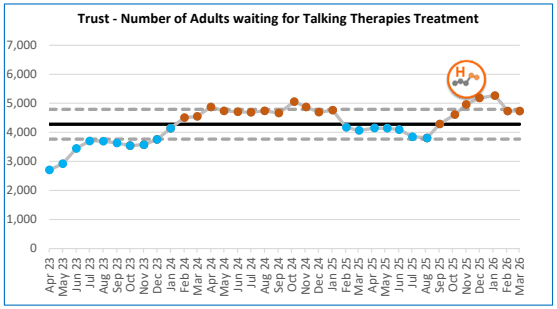
To Note: The trajectory submitted to NENC ICB is not on track.

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 m		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	4922	4985	4955	
Change		-117	-143	475	24	-2	-2	46	40	-50	69	86	63	-30	

Waiting Times Talking Therapies

Tees, Esk and Wear Valleys NHS Foundation Trust



Talking Therapies - adults waiting for their second treatment contact

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4735	14	69	
DTVF Care Group	2073	13	41	
NYY&S Care Group	2662	15	69	

Commentary on Longest waits

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

Underlying issues (DTVFCG):

- A financial gap between capacity and demand is impacting on waiting times.
- Team capacity is currently impacted by sickness/absence.

Underlying issues (NYYSCG):

- 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. An update on the progress and impact of the plan will be submitted to the Quality & Performance EDG in February 2026. **(Complete)**

Actions (DTVFCG)

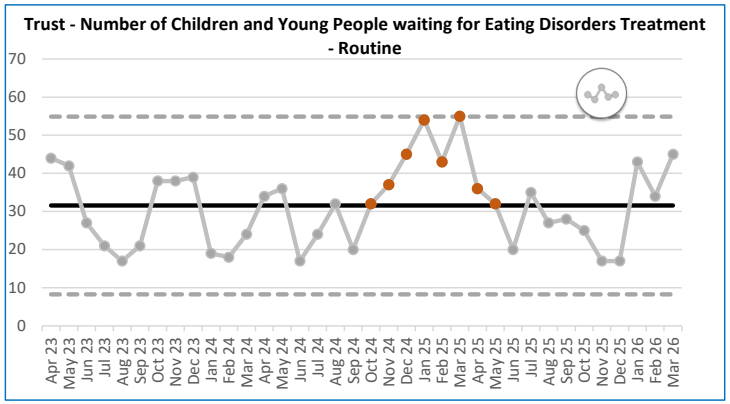
- General Manager to submit a paper to Integrated Care Group Board in February 2026 for approval of the implementation of Koa Step 3 Digital Therapy for PTSD. This will support the drive to reduce wait times. **(Complete)** Awaiting confirmation of funding.
- General Manager to submit a paper outlining the current financial gap and workforce challenges for the service to Integrated Care Group Board by the end of April 26, with a view to securing additional staff.

Actions (NYYSCG)

- Service Manager has developed a Keeping in Touch plan and the impact is expected to be seen by end of April 26.

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

Tees, Esk and Wear Valleys NHS Foundation Trust



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

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	45	18	87	
DTVF Care Group	25	15	28	
NYY&S Care Group	20	22	87	

DTVF: Genuine Wait - Treatment appointment booked.
NYY&S: Data quality - longest wait is 33 days, assessment booked.

Summary:
There are 4 children or young people reported as waiting more than 4 weeks of which 3 are genuine waits:

- 1 patient had an appointment offered in March (outside 4 weeks) delay due to difficulties contacting patient.
- 1 patient offered an appointment (within 4 weeks) however, the appointment was rescheduled for March due to family requesting appointment with dietician.
- 1 patient had an appointment offered in March (outside 4 weeks) delay due to requiring a joint appointment with the community team.

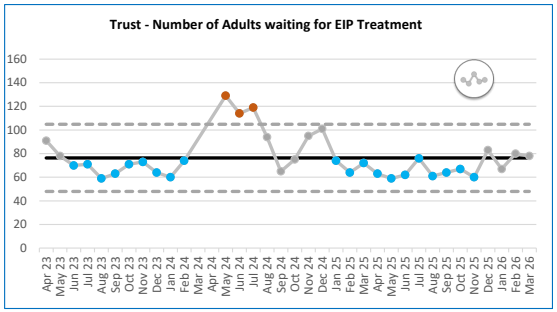
The remaining child or young person is not a genuine wait. They have been assessed, and treatment is not suitable to their presentation. The service are in the process of referring patient to Autism Spectrum Condition diagnostic pathway.

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	78	2	29	
DTVF Care Group	34	2	29	
NYY&S Care Group	44	2	11	

Commentary on Longest waits

DTVF: Data Quality, assessment complete (Longest wait 33 days, assessment booked)
NYY&S: Genuine Wait - Appointment required

Summary:
There are **26** adults **reported** as waiting more than 2 weeks of which **10** are genuine waits:

- 1 patient (11 weeks) was offered their first appointment (outside 2 weeks) due to the Christmas period; however, these were cancelled by the patient. Assessment booked in March.
- 5 patients have been offered appointments in March (outside 2 weeks) due to team capacity.
- 2 patients have been offered appointments in March (outside 2 weeks) as they require a joint appointment with CAMHS.
- 2 patients failed to attend/engage with appointments (within 2 weeks); assessments booked in March

Of the remaining **16** patients:
- 7 patients have been assessed, and treatment is not suitable for their presentation. The service has subsequently closed 5 referrals and are in the processing of discharging/transferring the remaining 2 patients.
- 1 patient did not engage with the service, and the referral has been closed.
- **8** are attributable to data quality; 6 have been subsequently resolved and 2 are logged with the Service Desk for resolution.

Underlying issues:
- Failed Appointments
- Data Quality
- Capacity within the York & Selby EIP team is currently impacted by vacancies and maternity leave
- Timeliness of joint assessments with CAMHS within York services

Actions:
- Recruitment is underway for 10 posts, all of which have been advertised with closing dates between March and April 2026.
- AMH General Manager to host a meeting between CAMHS and EIP by the end of April 2026, with a view to improving timely access to joint assessments for patients under 18.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

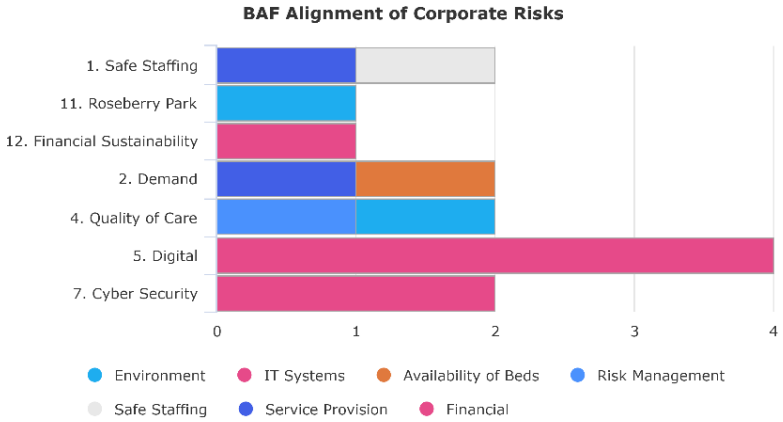
Meeting of:	**Board of Directors**
Date:	**9th April 2026**
Title:	**Corporate Risk Register**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Kendra Marley, Head of Risk Management**

Report for:				
	Assurance	✓	Decision	
	Consultation		Information	

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

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

Strategic Risks relating to this report:



EXECUTIVE SUMMARY:

Purpose:

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

Proposal:

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

Overview:

This paper presents to the Board the risks on the Corporate Risk Register as of 2nd March 2026, reflecting any movement and changes since 20th November 2025.

There are currently 14 risks on the Corporate Risk Register, which represents no change, although there have been some movements in current risk ratings, and there is clear evidence that all risk have been reviewed.

1 current risk rating was reduced in December, risk 1632, aligned to the Resources and Planning Committee:

> Risk 1632 – Digital and Data - There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.
>
> The rationale reflected a reduction in risk likelihood rating now that R3.1 is live and the focused training programme complete. (further information requested by Executive Risk Group and oversight on CRR remains in place)

2 current risk ratings were increased during January.

One risk with an increased risk rating is aligned to the Quality Assurance Committee. This risk was discussed in Executive Risk Group and the increased score agreed:

> Risk 1529 – DTVF-AMH – Risk of delayed discharged continuing to impact on inpatient length of stay for AMH acute wards.(increased from 12 to 15)
>
> Rationale: Following discussion at the Jan-26 DTV AMH Urgent Care IDG, the group agreed that current risk rating should be increased in likelihood given the current number of patients reported as CRFD.

The second risk with an increased current risk rating is aligned to People, Culture and Diversity Committee. This risk was increased after papers to Executive Risk Group were submitted and it will be formally approved at the next meeting in April.

> Risk 1137 – PCD – There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. (increased from 12 to 15)
>
> Rationale: Risk rating has been increased due to the limited assurance audit report and gaps identified. Gaps in assurance and associated actions (policy and changes to TEWVision) have been added to the BAF. Actions to address the audit are on track. The audit has been discussed at EDG, QuAC, PCDC and Board.

Following planned review, risk 811 – Nursing & Governance, has been fully revised and restated. The original risk, added in 2020, focussed on ligatures using anchor points and the plans to address these across the estate. As this work has progressed, the risk has been widened to encompass all inpatient ligatures, whether an anchor point is used or not. Clear controls, assurances and actions have been added. While we cannot eliminate this risk, we can improve our assurance sources to ensure controls are working effectively and look to strengthen these.

Compliance with reviews/targets

This Risk review compliance for corporate risks is 93% (previously 100%). 1 risk was overdue, risk 1137, PCD, relating to supervision compliance and assurance. (this has now been addressed.)

40 (was 44) actions are open across 14 risks (decrease of 4). 7 actions were overdue (17%, previously 9%) and have been followed up and addressed. Additional focussed work on the impact of actions and follow up on risks reaching target date is underway.

The Risk Quality Assurance reporting improvement work is underway and improvements are already being demonstrated.

Prior Consideration and Feedback:

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

Implications:

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

Recommendations:

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

Further Information

Report Title: Corporate Risk Register

1. Proposal

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

2. Prior Consideration and Feedback

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

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

3. Commentary

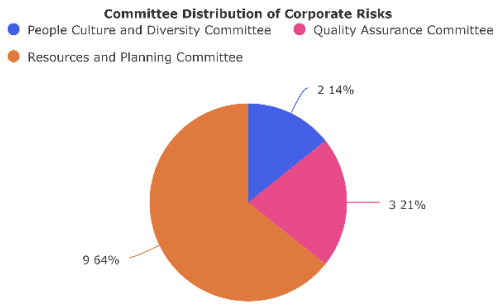
This paper presents to the Group the risks on the Corporate Risk Register as of 2nd March 2026, reflecting any movement and changes since 20th November 2026.

3.1 Corporate Risk Register

There are currently 14 risks on the Corporate Risk Register, and although no change in number, 2 risks have increased in current risk rating back to 15+ and 1 current risk rating has decreased to below 15. 5 risks are now at a risk rating of 12 or below (previously 6). All continue to be monitored on the Corporate Risk Register.

3.2 Committee & Care Group Alignment

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

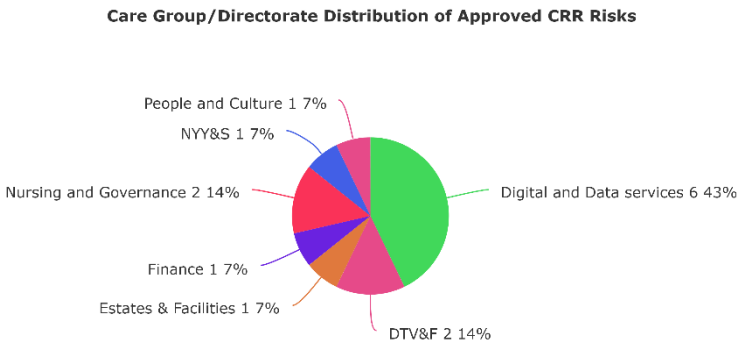


This shows that there are now

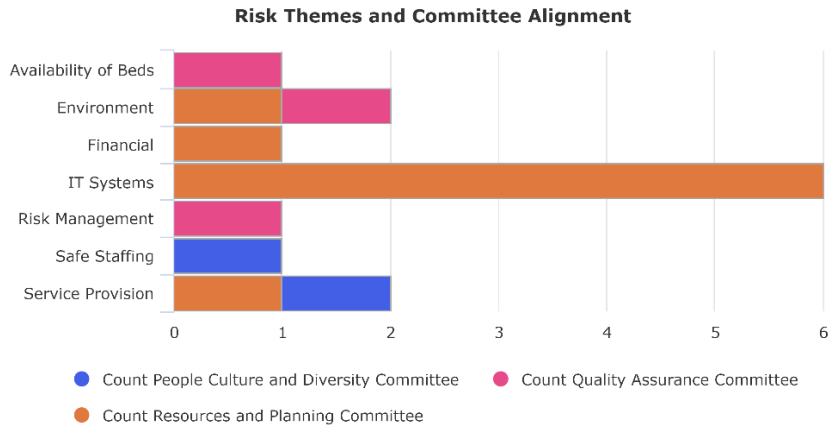
- 3 risks aligning to the Quality Assurance Committee
- 9 risks aligning to the Resources and Planning Committee
- 2 risks aligning to the People, Culture and Diversity Committee

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

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



3.3 Risk Themes



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

3.4 Risk Movements

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

The following key indicates the movement and Committee alignment.

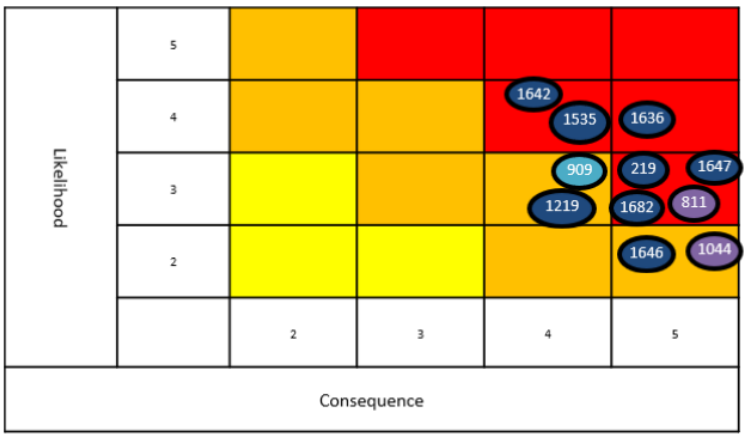
Outline – movement in period
- Black – static
- Green – reduced
- Red – increased

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

Risks with no movement in the period

The 11 risks on the register remain static and are shown on the following matrix.

Corporate risks at ≥15 remaining static in period

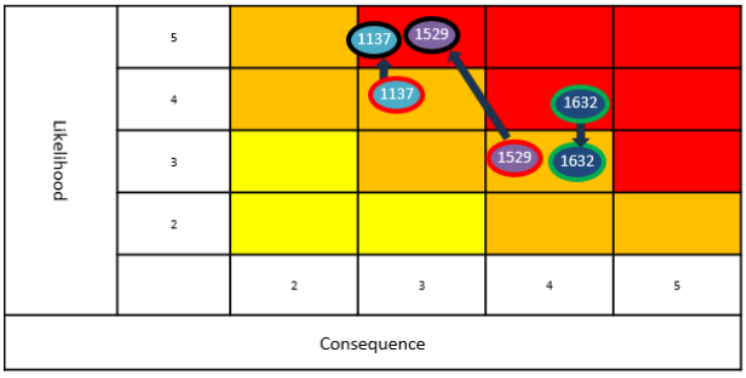


Risks are shown based on current risk rating

Risks with movement in the period

The 2 risks with increased current risk ratings and 1 decreased current risk rating are shown on the following matrix.

Risks increased or reduced in the period



1 risk with a reduced current risk rating was reduced in December, risk 1632, aligned to the Resources and Planning Committee:

> Risk 1632 – Digital and Data - There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers.
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> The rationale reflected a reduction in risk likelihood rating now that R3.1 is live and the focused training programme complete. (further information requested and oversight on CRR remains in place)

2 risks has the current risk rating increased during January

One risk with an increased current risk rating is aligned to the Quality Assurance Committee. This risk was discussed in Executive Risk Group and the increased risk rating agreed:

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The second risk with an increased current risk rating is aligned to People, Culture and Diversity Committee. This risk was increased after papers to Executive Risk Group were submitted and while discussed and supported, it will be formally approved at the next meeting in April.

> Risk 1137 – PCD – There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. (increased from 12 to 15)
>
> Rationale: Risk rating has been increased due to limited assurance audit report and gaps identified. Gaps in assurance and associated actions (policy and changes to TEWVision) have been added to the BAF. Actions to address the audit are on track. The audit has been discussed at EDG, QuAC, PCDC and Board.

5 risks with current risk ratings at below 15 now remain on the register for oversight (previously 6):

- NYY risk relating to consultant recruitment. (909)
- Nursing & Governance risk re Incident management. (1044)
- CAMHS Neurodevelopmental pathway (1219)
- Digital risk on Cyber. (1646), and
- Benefits of CITO not delivered (1632) which required further information for the group to agree, and will be followed up in next meeting..

Restated Risk

A planned review of risk 811 has been undertaken, with the risk not residing within Nursing & Governance, with the Chef Nurse as the executive lead. This risk has been fully revised and restated.

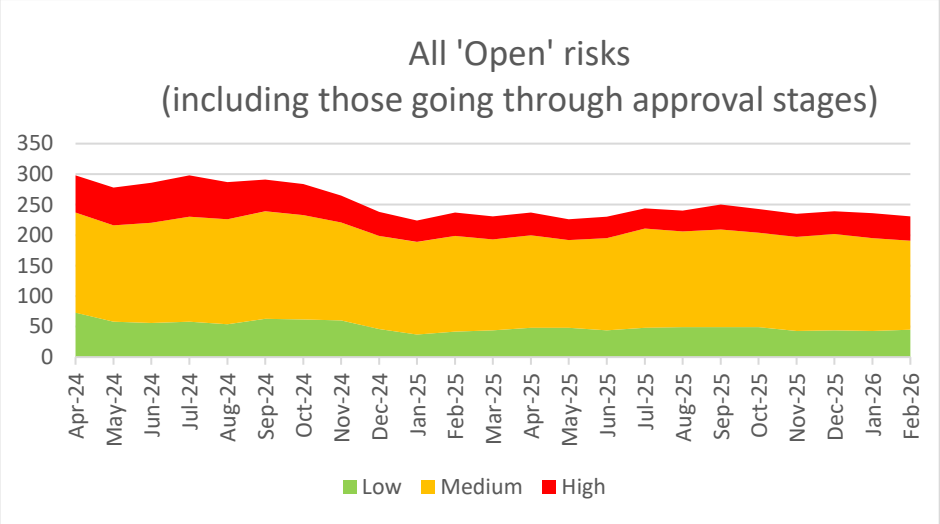
The original risk, added in 2020, focussed on ligatures using anchor points and the plans to address these across the estate. As the work across the estate has progressed, the risk has now been widened to encompass all inpatient ligatures, whether an anchor point is used or not. Clear controls, assurances and actions have been added. While we cannot eliminate this risk, we can improve our assurance sources to ensure controls are working effectively and look to strengthen these.

Since the introduction of new sub categorisation within the self harm category when reporting incidents, we can see that ligature incidents with no anchor point across TEWV sites account for approximately 45% of all self harm incidents recorded, which is the highest category reported at approximately 25% of all incidents per month.

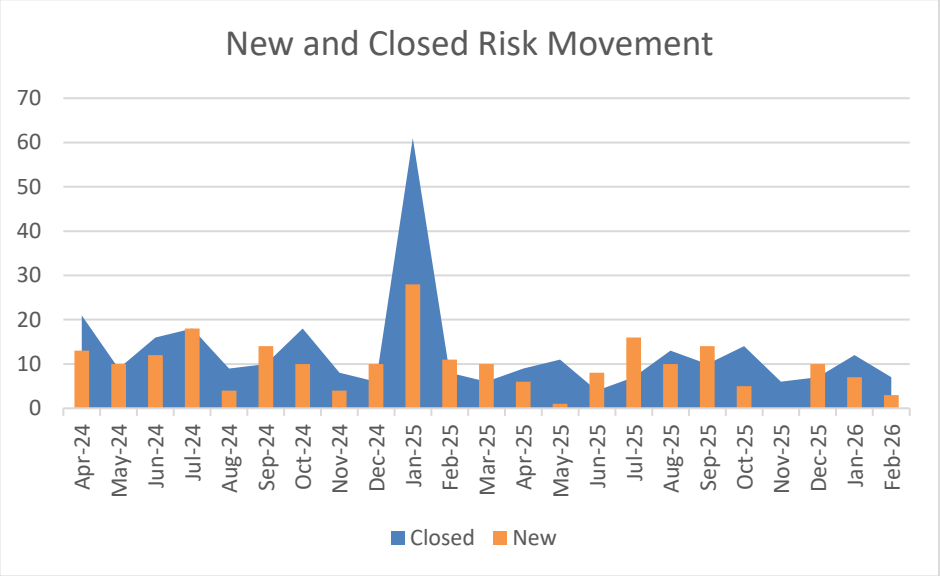
3.5 Risk Profile

3.5.1 Risk Profile

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



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



Risk Quality Assurance

A number of key performance indicators have been identified and are now being reported on, highlighting compliance with policy and process and enabling demonstration of regular and robust risk review and monitoring and progression of actions. These include gaps in risk entries, including where there is a lack of controls or actions, as well as review and delivery compliance and monthly rating application.

These help to:

- Ensure decisions are based on complete and reliable information.
- Enable active management by keeping accurate, up-to-date records that support better risk control.

- Safeguard patients and staff by making sure controls work effectively and risks are well managed.
- Promote improvement, accountability, and good governance by showing progress and highlighting areas that need attention.
- Improve business performance and service planning with dependable risk data for annual strategies and regulatory obligations.
- Encourage organisational learning by identifying needs for training or process updates, fostering transparency and ongoing safety enhancements.

Work has commenced to begin to address gaps, with improvements already being evidenced and this will continue over the coming months.

For the Corporate Risk Register, the metrics highlight:

- No gaps in the main risk entry
- No risks with no controls – Risk 811 has been revised and restated with clear controls.
- 1 risk with no current actions – this is risk 909 – relating to consultant recruitment. The controls in place and 'business as usual' actions around recruitment and alternate solutions to address gaps in the workforce do not have any gaps requiring specific action to add new controls or new assurance. The risk record has been updated to reflect that additional actions are not required.
- 61 controls over 14 risks, 44% (27/61) of which were rated for effectiveness in February.
- 40 actions over 14 risks, 41% of which were rag rated for progress status in February, 7 were overdue.

Control effectiveness and action progress ratings are being used more frequently and will continue to be promoted for better understanding and application. However, as the metrics are being reviewed for all risks, we are undertaking focussed targeting to address gaps in risk entry, lack of controls or lack of actions, before we target the monthly update of ratings.

3.6 Risk and Action Review Compliance

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

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

At the time of writing the paper the compliance of timely risk review for the Corporate Risk Register is 93% (previously 100%). 1 risk is overdue, risk 1137, PCD, relating to supervision compliance and assurance. (this has subsequently been addressed)

Actions across corporate risks are in place, with a total of 40 current open actions across 14 risks (decrease of 4), 7 of the actions are overdue (17%, previously 9%). (these have subsequently been addressed)

Further information

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

4. Conclusions

Governance meetings are being undertaken in line with policy and risks at or above 15 reviewed in the Executive Risk Group for consideration of inclusion on the Corporate Risk Register.

Risk 811 has been transferred back to Nursing and Governance where it has been fully reviewed, revised and restated, with a wider focus on all inpatient ligature and not just those with anchor points.

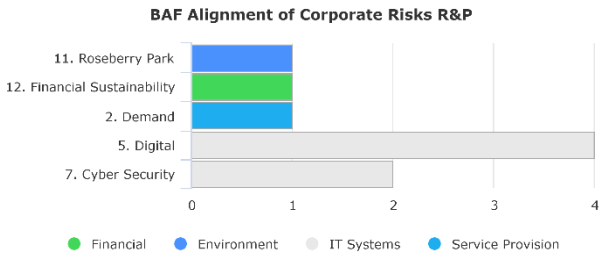
The Quality Assurance reporting across all risks is enabling a targeted approach to address gaps, and while the initial gaps for the Corporate Risk Register risks have been addressed, there remain timing issues with updating actions before they go overdue and applying ratings for effectiveness and action status. As wider target work continues and then moves its focus to the regular rating of effectiveness and actions, we will hopefully see this drive improvement in this area.

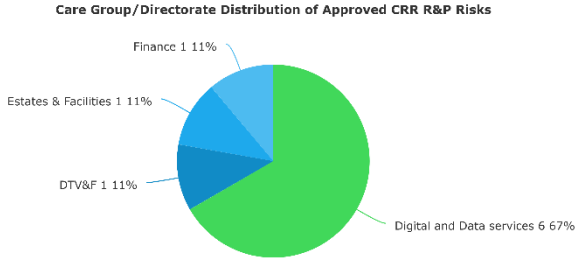
Compliance with review of corporate risks has marginally dropped, and the number of overdue actions had increased. These were however addressed quickly.

5. Recommendations

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

Resources and Planning Aligned Risks





There are 9 risks aligned to Resources and Planning. 1 risk, risk 1632, risk that Cito benefits are not realised, had the current risk rating reduced from 16 to 12, however further information has been asked for by the Executive Risk Group before formally agreeing.

Current Risk Rating Movements

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

The 2 other risks remaining below 15 are 1646, Digital, cyber response (10), and 1219, DTVF CAMHS Neurodevelopmental pathway (12) This risk is in the process of being replaced by a trust wide risk for Neurodevelopmental pathways to fully capture the wider risk.

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025	31 Aug 2025	30 Sep 2025	31 Oct 2025	30 Nov 2025	31 Dec 2025	31 Jan 2026	28 Feb 2026
Resources and Planning Committee	Risk 00000219	Risk of a H&S incident at Roseberry park Hospital	Actual	15	15	15	15	15	15		15	15	15	15	15	
	Risk 00001219	CAMHS Neurodevelopmental assessment pathway	Actual	15	15	15	15	15	15	15	15	12	12	12	12	12
	Risk 00001535	Risk of escalation due to inability to provide appropriate information to external bodies	Actual	16	12	12	16	16	16	16	16	16	16	16	16	
	Risk 00001632	Risk that intended benefits to be delivered with implementation of CITO are not being delivered	Actual			16	16		16	16		16	16	12	12	12
	Risk 00001636	Incomplete or inaccurate patient record displayed on Cito	Actual	20		20	20	20	20	20	20	20	20	20	20	20
	Risk 00001642	TEWV Critical digital network infrastructure failure	Actual	12	12	12	16	16	16	16	16	16	16	16	16	
	Risk 00001646	Cyber and operational incident response gaps	Actual	10	10	10	10		10			10	10			
	Risk 00001647	Cyber security vulnerbilities	Actual	15	10	10	15		15		15	15	15	15		15
	Risk 00001682	Delivery of financial plan	Actual	n/r	n/r	n/r	15		15	15		15	15	15	15	15

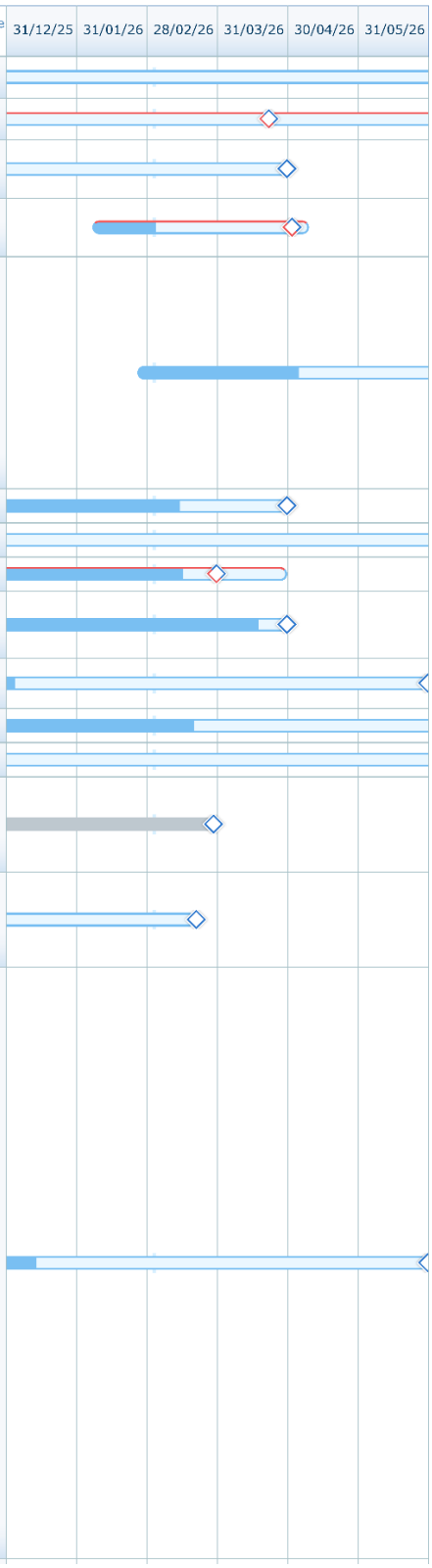
The current summary of the register is shown in the following table and reflects the 3 risks below 15. The control effectiveness now reflects the last rated, so will show for the period, although does not reflect that it is a current assessment. As we improve routine capture this will be more timely.

sk CRR summary

	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	28 Feb 2026 Control Effectiveness Current	Control Effectiveness Target	RM03 Risk Rating Current	RM03 Risk Rating Target
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	08 Sep 2016	02/03/2026	Simon Adamson	15	Roseberry Park Rectification Programme	▪ Phase 2 rectification works ▪ Review of Phase 2 rectification works programme	Reasonable	Good	15	10
Risk 00001219	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	01 Apr 2021	02/03/2026	Jamie Todd	16	▪ Activity levels and outputs ▪ Capacity and demand ▪ Clinical prioritisation ▪ PTLs ▪ Recovery and Improvement Plan ▪ Right to choose ▪ Support whilst waiting and signposting	▪ ICB independent sector capacity for longest waiters across the region ▪ Rollout of Clinical Protocols to Improve Assessment Efficiency and Throughput	Reasonable		12	6
Risk 00001535	Since the implementation of Cito, the organisation has been unable to provide all of the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO). There is a risk that this could escalate to a level which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations including CQC regulatory frameworks.	25 Mar 2024	02/03/2026	Nick Black	16	▪ Development of Action Plan for EDG Review ▪ R1535 - Monitoring of Data Quality Maturity Index (DQMI) score for datasets ▪ R1535 - Validation prior to submission of MHSDS	Create simple user guide for service managers	Good		16	4
Risk 00001632	There is a risk that the benefits of CITO are not realised for example, improved workforce efficiency, staff experience, patient and carer experience, improved quality of records and released time to care.	13 Jan 2025	02/03/2026	Nick Black	20	▪ Cito Simplification and Stablisation and Project active ▪ Service desk ▪ Shared issue resolution plan ▪ Staff usability survey completed ▪ System speed issues addressed	▪ R1632 - Data Retention/Saving Requirements ▪ R1632 - Cito benefits realisation ▪ R1632 - Performance/stability management	Good		12	8
Risk 00001636	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	15 Jan 2025	19/02/2026	Lorraine Sellers	25	▪ Access to Great North Care Record and Yorkshire Care Record ▪ Cito training mandated for new starters from 1 Jan 2025 ▪ Data migration (documents) completed ▪ Robust test scripts developed ▪ Speed issues with the system resolved ▪ Stabilisation programme in place for release management ▪ Standard Operating Procedures in place ▪ User confidence training ▪ User guides updated	▪ R1636 Complete data rectification for 4 issues ▪ R1636 Enhance automated testing ▪ R1636 Cito Improvement Programme - wifi/infrastructure ▪ Cito Practice Leads Audit - undertake baseline and post training audit to evidence improvements	Good	Substantia	20	16
Risk 00001642	There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. Including UPS, Network, Servers Links to KPIs that will be reported through DPAG	16 Jan 2025	02/03/2026	Steven Forster	20	▪ Network infrastructure lifecycle ▪ Network Infrastructure Maintenance and Support - in hours ▪ Network infrastructure patching ▪ Network resilience and operational function	▪ Complete installation of Wi-Fi at all priority sites. ▪ High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks) ▪ Crisis and Professional Telephone lines replacement for PSTN Switchoff ▪ End-to-end connection monitoring to support essential services (Thousandeyes)	Good		16	6
Risk 00001646	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	17 Jan 2025	02/03/2026	Nick Black	25	▪ Cyber awareness training for all staff ▪ DSPT 2025/26 submission ▪ Incident Response Framework ▪ MDE secure score ▪ Privileged Access Controls	▪ SIEM delivery ▪ Incident response excercise in conjunction with services. ▪ Incident response follow up Audit November 2025	Reasonable		10	5
Risk 00001647	There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	17 Jan 2025	02/03/2026	Steven Forster	25	▪ Continuous patching ▪ Data Security & Protection Toolkit ▪ Independent Penetration test ▪ Multi Factor Access (MFA) ▪ Network & Perimeter security ▪ NHS Cyber Alert ▪ Regular scanning	▪ TEWV secure boundary tenant utilised for all internet traffic ▪ Vulnerability scanning of non-MDE hosts ▪ SIEM delivery ▪ Extend the use of MFA ▪ High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks)	Good		15	5
Risk 00001682	There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs.	01 May 2025	19/02/2026	Liz Romaniak	15	▪ Financial reporting ▪ Roster approvals and reviews	▪ Improve level loading of headroom and all rosters to be approved on time ▪ Flexible staffing group overtime reduction ▪ Health Roster reason codes standardisation ▪ Level loading of headroom on Health Roster ▪ Progressing schemes identified at Sustainability and Transformation events ▪ Capital charge review following changes to guidance. ▪ Discretionary spend control increases ▪ Plans on a Page and EQIA of CRES schemes	Reasonable	Good	15	8

The following table shows all current actions related to these risks. There are currently 3 actions which are overdue on risk 1682, Finance, relating to the delivery of financial plan, although the action leads are within Care Group/ PCD. These have been addressed following report extraction.

Risk ID	Risk Description	Action Name	Due Date	Planned Completion Date	Owner	Percentage Complete
Risk 00000219	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	Phase 2 rectification works	18 Sep 2026	18 Sep 2026	Simon Adamson	5%
		Review of Phase 2 rectification works programme	23 Mar 2026	05 Mar 2027	Steven Boon	0%
Risk 00001219	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	ICB independent sector capacity for longest waiters across the region	31 Mar 2026	31 Mar 2026	Claire Farley	30%
		Rollout of Clinical Protocols to Improve Assessment Efficiency and Throughput	02 Apr 2026	09 Apr 2026	Claire Farley	30%
Risk 00001535	Since the implementation of Cito, the organisation has been unable to provide all of the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO). There is a risk that this could escalate to a level which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations including CQC regulatory frameworks.	Create simple user guide for service managers	31 Dec 2026	31 Dec 2026	Paula Hay	20%
Risk 00001632	There is a risk that the benefits of CITO are not realised for example, improved workforce efficiency, staff experience, patient and carer experience, improved quality of records and released time to care.	R1632 - Cito benefits realisation	31 Mar 2026	31 Mar 2026	Jo Turner	75%
		R1632 - Data Retention/Saving Requirements	30 Jun 2026	30 Jun 2026	Beverley Smith	20%
		R1632 - Performance/stability management	28 Feb 2026	31 Mar 2026	Vianne Chapman	90%
Risk 00001636	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	Cito Practice Leads Audit - undertake baseline and post training audit to evidence improvements	31 Mar 2026	31 Mar 2026	Gemma Pickering	95%
		R1636 Cito Improvement Programme - wifi/infrastructure	31 May 2026	31 May 2026	Steven Forster	40%
		R1636 Complete data rectification for 4 issues	30 Jun 2026	30 Jun 2026	Gemma Pickering	75%
		R1636 Enhance automated testing	30 Jul 2027	30 Jul 2027	Vianne Chapman	25%
Risk 00001642	▪ There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG	Crisis and Professional Telephone lines replacement for PSTN Switchoff	27 Feb 2026	27 Feb 2026	Dale Hopper	0%
		End-to-end connection monitoring to support essential services (Thousandeyes)	20 Feb 2026	20 Feb 2026	Dale Hopper	10%
▪ Risk 00001642 ▪ Risk 00001512 ▪ Risk 00001413	▪ Risk 00001413: There is a risk that IT systems will be less accessible when it is critical to patient safety due to the problems with wifi provision on the Ridgeway site. It is a concern that this will impact on operational delivery further. ▪ Risk 00001512: Due to poor wifi connections across RPH, LRH and WPH hospital sites there is a risk to patient and staff safety and experience due to the delays being experienced when using Trust systems such as EMPA, CITO, Health Roster, MS teams and also when attempting to make contact with colleagues and family members. This results in lack of timely availability of accurate and concise patient information to support clinical decision making and does not support positive experience for staff or patients. ▪ Risk 00001642: There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG	Complete installation of Wi-Fi at all priority sites.	31 May 2026	31 May 2026	Dale Hopper	48.77%



Risk 00001646	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	Incident response excercise in conjunction with services.	23 Feb 2026	23 Feb 2026	Steven Forster	0%
		Incident response follow up Audit November 2025	31 Mar 2026	31 Mar 2026	Fayraz Hussain	65%
Risk 00001647	▪ There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ ▪ Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	Extend the use of MFA	01 Oct 2027	01 Oct 2027	Steven Forster	5%
		TEWV secure boundary tenant utilised for all internet traffic	31 Mar 2026	31 Mar 2026	Fayraz Hussain	60%
		Vulnerability scanning of non-MDE hosts	31 Mar 2026	31 Mar 2026	Michael Fincken	97%
▪ Risk 00001647 ▪ Risk 00001642	▪ Risk 00001642: There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. ▪ ▪ Including UPS, Network, Servers ▪ Links to KPIs that will be reported through DPAG ▪ Risk 00001647: There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ ▪ Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks)	31 Mar 2026	20 Mar 2026	Steven Forster	56%
▪ Risk 00001647 ▪ Risk 00001646	▪ Risk 00001646: There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ Risk 00001647: There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. ▪ ▪ Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	SIEM delivery	31 Mar 2027	30 Oct 2026	Steven Forster	0%
Risk 00001682	There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs.	Capital charge review following changes to guidance.	30 Nov 2025	31 Mar 2026	John Chapman	75%
		Discretionary spend control increases	30 Sep 2025	31 Mar 2026	John Chapman	75%
		Flexible staffing group overtime reduction	28 Aug 2025	30 Nov 2025	Lesley Hodge	90%
		Health Roster reason codes standardisation	30 Sep 2025	30 Sep 2025	Elspeth Devanney	0%
		Improve level loading of headroom and all rosters to be approved on time	30 Sep 2025	31 Mar 2026	Beverley Murphy	90%
		Level loading of headroom on Health Roster	30 Sep 2025	30 Sep 2025	Elspeth Devanney	0%
		Plans on a Page and EQIA of CRES schemes	30 Sep 2025	24 Apr 2026	Richard Mellor.	95%
		Progressing schemes identified at Sustainability and Transformation events	31 Mar 2026	31 Mar 2026	Chris Lanigan	25%

Summary of risks

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

Owner – Simon Adamson

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

Risk Review – in date, Action Delivery – 2 action ongoing – in date.

Assurance – Good Assurance – The current updates reflects that plans are on track.

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

Owner – Jamie Todd

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

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

Assurance – Good Assurance – the risk has been reviewed and controls are reflected in the risk, with good assurance levels reflected on all. The service continues to meet NHSE trajectory..

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

Owner – Nick Black

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

Risk Review – In date, Action Delivery – 1 current actions, in date.

Assurance – Good Assurance – the entry has been strengthened with sources of assurance and effectiveness of controls.

Risk 1632 – Digital and Data - There is a risk that the benefits of CITO are not realised due to poor performance/stability and a limitation of functionality of the system resulting in a reduced ability to effect clinical change, leading to reduced: efficiencies, staff engagement, poor record keeping, patient safety, reputation, confidence in the system and increased: staff absence, leavers. (current rating 12)

Owner – Lorraine Sellers

Initial rating 20 (C4, L5), Current Rating 12 (C4, L3 risk rating reduced in December 25), Target Rating 8 (C4, L2), Date to reduce risk 22 October 2026.

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

Assurance – Good Assurance – the entry has all controls reflected and all now reflect good assurance.

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

Owner – Nick Black

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

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

Assurance – Reasonable Assurance – controls effectiveness reflected with a number of substantial assurances.

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

Owner – Steven Forster

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

Risk Review – in date, Action Delivery – 4 current actions, 2 just overdue..

Assurance – Good Assurance – the entry has been strengthened with sources of assurance, and now include effectiveness of controls which all indicate good assurances.

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

Owner – Nick Black

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

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

Assurance – Good Assurance – this risk has been updated to reflect controls in place and assurance sources, and control effectiveness is now reflected.

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

Owner – Steven Forster

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

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

Assurance – Good Assurance – the entry has been strengthened with sources of assurance, and effectiveness of controls is being reflected.

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

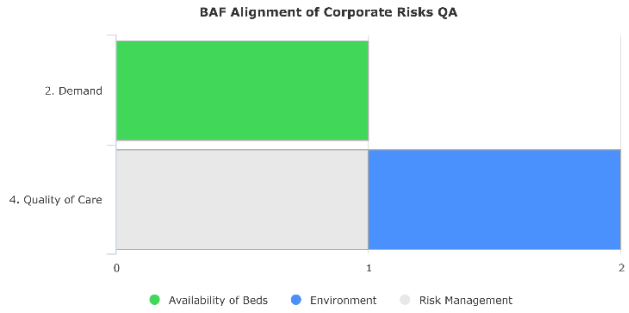
Owner – Liz Romaniak

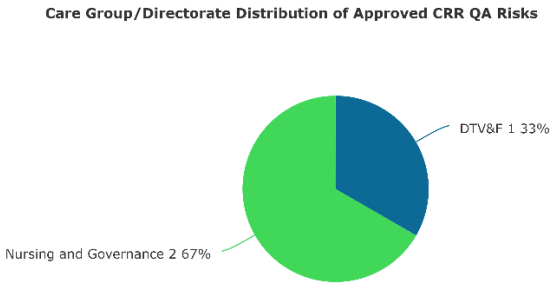
Initial rating 15 (C5, L3), Current Rating 15 (C5, L3), Target Rating 8 (C4, L2), Date to reduce risk 31 March 2026

Risk Review – in date, Action Delivery – 8 actions ongoing, 3 overdue, although leads all sit outside of finance.

Assurance – Good Assurance – the entry has been strengthened with sources of assurance, and effectiveness of controls is being reflected.

Quality Assurance Aligned Risks





Current Risk Rating Movements

The following table below shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. Risk 1529 had the current risk rating increased from 12 to 15 in the period. 1 risk remains at below 15, risk 1044.

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025	31 Aug 2025	30 Sep 2025	31 Oct 2025	30 Nov 2025	31 Dec 2025	31 Jan 2026	28 Feb 2026
Quality Assurance Committee	Risk 00000811	Risk of patient using a ligature while on an inpatient ward leading to harm or death	Actual	15	15	15	15		15	15	15		15	15	15	15
	Risk 00001044	Incidents that are more serious than initially reported are not identified within appropriate timescales	Actual	15	15	15	10	10	10		10		10			10
	Risk 00001529	Risk if increased length of stay across AMH acute wards	Actual	16	16	16	12		12	12	12	12	12	12	15	15

The current summary of the register is shown below. The control effectiveness now reflects the last rated, so will show for the period, although does not reflect that it is a current assessment. As we improve routine capture this will be more timely.

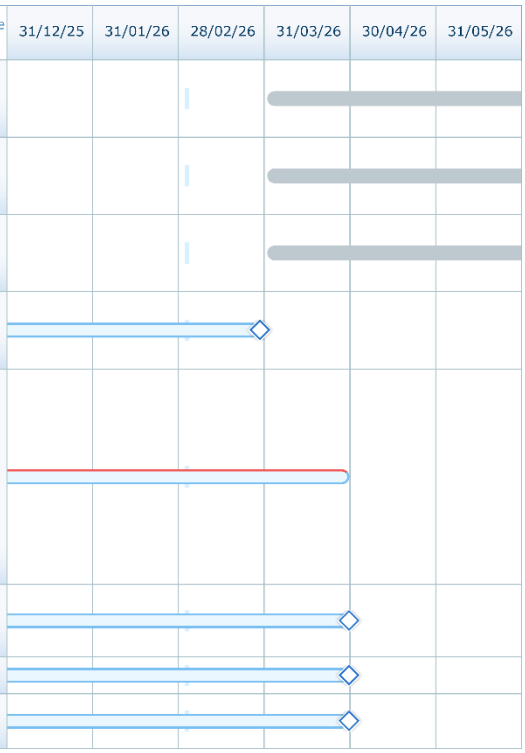
Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	28 Feb 2026			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000811	There is a risk that a patient may use a ligature while on an inpatient ward, due to individual patient behaviours (including using ligatures with or without suicidal intent) and environmental limitations such as the presence of unavoidable anchor points, which could lead to death, significant harm, and trauma for families and staff, along with regulatory and reputational consequences.	01 Jun 2020	02/03/2026	Beverley Murphy	20	▪ R811 - Environment Ligature Poir Survey ▪ R811 - Individual Ris Assessment Care Plannin ▪ R811 - Removal / Mitigation of Anchor Point ▪ R811 - Restricting Access to Ligature Materials ▪ R811 - Staff Training & Competence ▪ R811 - Staffir levels ▪ R811 - Therapeutic Engagement & Observatic	▪ R903 - Phase 3 delivery ▪ R811 - Improve Assurance ▪ R811 - Handover Quality ▪ 811 - Staff Skill Mix Review	Reasonabl		15	10
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	08 Aug 2022	03/02/2026	Rachel Weddle	20	▪ INC - Patient Safety Huddle Daily - reviews moderate and above incidents ▪ Staff understand the initial review process and timelines	R1044 - QI work on operational management and governance of incidents from ward to board	Good		10	5
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	29 May 2024	03/02/2026	Shaun McKenna	20	▪ Incident Data ▪ Patient Flow Work ▪ Performance reporting	▪ Develop Patient Flow Transformation workstream ▪ Develop an electronic live visual bed state in conjunction with IT and our digital journey to change ▪ Develop the "Transforming Mental Health Discharge" workstream	Good		15	9

The below table shows the actions ongoing in relation to the risks, all in date, although some reflecting extensions.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completion Date	Owner	Percentage Complete
Risk 00000811	▪ There is a risk that a patient may use a ligature while on an inpatient ward, due to individual patient behaviours (including using ligatures with or without suicidal intent) and environmental limitations such as the presence of unavoidable anchor points, which could lead to death, significant harm, and trauma for families and staff, along with regulatory and reputational consequences. ▪	811 - Staff Skill Mix Review	31 Mar 2027	31 Mar 2027	Rachel Weddle	0%
		R811 - Improve Assurance	30 Sep 2026	30 Sep 2026	Rachel Weddle	0%
		R811 - Handover Quality	31 Dec 2026	31 Dec 2026	Rachel Weddle	0%
		R903 - Phase 3 delivery	27 Feb 2026	27 Feb 2026	Simon Adamson	50%
Risk 00001044	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	R1044 - QI work on operational management and governance of incidents from ward to board	30 Sep 2025	31 Mar 2026	Kendra Marley	80%
Risk 00001529	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	Develop an electronic live visual bed state in conjunction with IT and our digital journey to change	31 Mar 2026	31 Mar 2026	Shaun McKenna	50%
		Develop Patient Flow Transformation workstream	31 Mar 2026	31 Mar 2026	Shaun McKenna	0%
		Develop the "Transforming Mental Health Discharge" workstream	31 Mar 2026	31 Mar 2026	Shaun McKenna	0%



Summary of risks

Risk 811 – N&G - There is a risk that a patient may use a ligature while on an inpatient ward, due to individual patient behaviours (including using ligatures with or without suicidal intent) and environmental limitations such as the presence of unavoidable anchor points, which could lead to death, significant harm, and trauma for families and staff, along with regulatory and reputational consequences.

Owner – Beverley Murphy

Initial rating 20 (C5, L4), Current Rating 15 (C5, L3), Target Rating 10 (C5, L2), Date to reduce risk extended to 30 April 2027.

Risk Review – in date, Action Delivery – 4 action ongoing, 1 overdue relating to the Phase 3 delivery.

Assurance – Reasonable Assurance – Following planned review, risk 811 has been fully revised and restated. The original risk, added in 2020 focussed on ligatures using anchor points and the plans to address anchor points across the estate. As this work has progressed the risk has been widened to encompass all inpatient ligatures, whether an anchor point is used or not. Clear controls, assurances and actions have been added, reflecting the need to strengthen assurance to ensure controls are effective. While we cannot eliminate this risk we can improve our assurance sources to ensure controls are working effectively and look to strengthen these.

Since the introduction of new sub categorisation within the self harm category when reporting incidents, we can see that ligature incidents with no anchor point across TEWV sites account for approximately 45% of all self harm incidents recorded, which is the highest category reported at approximately 25% of all incidents per month.

Risk 1044 – N&G Quality Governance - There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review

resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.
Owner – Rachel Weddle

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

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

Assurance – Good Assurance – the risk has been updated and includes detail of progress made. While central controls are effective with good assurance, quality Improvement work undertaken is highlighting further areas for improvement.

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

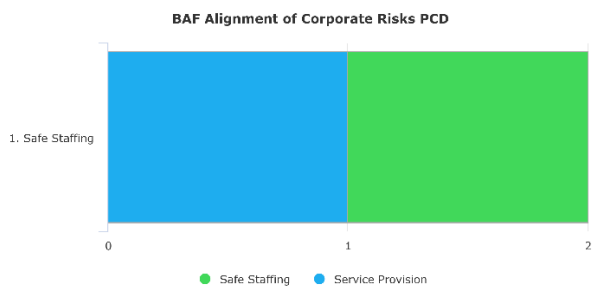
Owner – Shaun McKenna

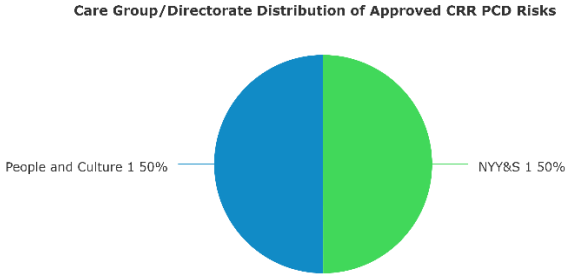
Initial rating 20 (C4, L5), Current Rating 15 (C3, L5), Target Rating 9 (C3, L3), Date to reduce risk – 31 March 2026. Date revised from June 2025, reduced in May 2025 to 12, but not yet to target, and further work ongoing with partners. Subsequently risk rating increased again from 12 to 15 in January 2026.

Risk Review – in date, Action Delivery – 3 actions now identified and ongoing, in date.

Assurance – Good Assurance – There has been considerable work to update the risk to reflect controls and assurances in place as well as identify all actions to be undertaken. Controls effectiveness assurance is rated as good, reflecting the processes in place. Notwithstanding this the risk rating was increased the group agreed that current scoring of risk should be increased in likelihood given the current number of patients reported as CRFD (26 patients as at 31st Dec-25).

People, Culture & Diversity Aligned Risks





Current Risk Rating Movements

The table below shows the current risk rating at each month across the last year. Where there is no rating shown, this means a review was not undertaken in the period. Risk 1137 has had the current risk rating increased in the period, so only risk 909 remains below 15.

CRR risks - monthly current rating

	Risk Number	Risk Title	Current Risk Rating	28 Feb 2025	31 Mar 2025	30 Apr 2025	31 May 2025	30 Jun 2025	31 Jul 2025	31 Aug 2025	30 Sep 2025	31 Oct 2025	30 Nov 2025	31 Dec 2025	31 Jan 2026	28 Feb 2026
People Culture and Diversity Committee	Risk 00000909	Inability to recruit to vacant consultant posts	Actual	16	12	12	12	12		12	12		12			12
	Risk 00001137	Supervision Compliance and Assurance	Actual	15		15	15	15	12	12	12		12		15	

The current summary of the register is shown below. The control effectiveness now reflects the last rated, so will show for the period, although does not reflect that it is a current assessment. As we improve routine capture this will be timelier.

Risk CRR summary

Id	Risk Description	Opened Date	Last Review Date	Owner	Initial Score	Control(s)	Open Actions	28 Feb 2026			
								Control Effectiveness		RM03 Risk Rating	
								Actual	Target	Actual	Target
Risk 00000909	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20 Oct 2020	05/02/2026	Himanshu Garg	20	▪ Employment of international fellowship Doctors to fil gaps and reduce locun mind the gap ▪ Mind the Gap arrangement ▪ Retention of Existing Consultant workforce ▪ Substantive recruitment to vacant consultant posts		Reasonabl	Substantia	12	9
Risk 00001137	There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care.	22 Mar 2022	29/01/2026	Sarah Dexter-Smith	15	▪ Manual Recording Systems ▪ TEWVision	▪ All ward team managers to be using the same clinical supervision recording system TEWVision ▪ Routine performance monitoring of clinical supervision compliance with TEWVision in specialties	Limited		15	6

The following table shows current actions for the risks, all are in date.

Current Actions

Risk ID	Risk Description	Action Name	Due Date	Planned Completio Date	Owner	Percentage Complete	31/12/25	31/01/26	28/02/26	31/03/26	30/04/26	31/05/26
Risk 00001137	▪ There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care. ▪ ▪ ▪ ▪	All ward team managers to be using the same clinical supervision recording system TEWVision	01 Apr 2026	01 Apr 2026	Sarah Dexter-Smith	61%						
		Routine performance monitoring of clinical supervision compliance with TEWVision in specialties	31 Oct 2025	01 Apr 2026	Sarah Dexter-Smith	85%						

Summary of risks

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

Owner – Himanshu Garg

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

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

Assurance – Good Assurance – The risk is expected to persist with subtle variations due to financial constraints and NHS workforce challenges, particularly affecting team composition and consultant retention. While the risk remains above tolerance, no new actions are reflected as recruitment activity is part of business as usual controls.

Recent update reflect the successful recruitment of a substantive consultant at Whitby, which will reduce 1 WTE agency Locum with a Trust Locum moving into that post, leaving 2 WTE Locums in Care Groups.

Risk 1137 – PCD - There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care.

Owner – Sarah Dexter-Smith

Initial rating 15 (C3, L5), Current Rating 15 (C3, L5), Target Rating 6 (C3, L2), Date to reduce risk changed to 31 March 2026. (note this risk rating was increased from 12 to 15)

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

Assurance – Reasonable Assurance – this risk has now transferred to People, Culture and Diversity under the management of the Director. Controls effectiveness is being assessed and reflected, and actions progressed. A limited assurance internal audit report has further highlighted the work to do in this area and is reflected in the existing actions and increased risk rating.

Corporate Risk Register

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00000219 **BAF Risk Alignment :** 11. Roseberry Park **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Estates & Facilities **Specialty/ Department :** EFM - Estates **Ward/Team :** Estates Department	30 Mar 2026 **Opened Date :** 08 Sep 2016 **Last Review Date :** 02 Mar 2026	Simon Adamson **Risk Manager :** Steven Boon	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	15	Roseberry Park Rectification Programme **First line of Assurance :** Works completed to Blocks 5 and 10 in first phase of rectification programme, additional facility constructed (block 16) for decanting patients within Forensic services during future works phases. **Second Line of Assurance :** Lessons learned from phase 1 have directly influenced our approach to rectifying known defects via approved standard rectification detail. **Third Line of Assurance :** Works have commenced on phase 2, blocks 1 and 9, with future design phase workshops held to influence decision making processes as to which blocks are contained within defined phases of activity.	15.00		2 **Actions :** Phase 2 rectification works Review of Phase 2 rectification works programme	10	06 Jan 2032

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00000811 **BAF Risk Alignment :** 4. Quality of Care **Committee Alignment :** Quality Assurance Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Nursing and Governance **Specialty/ Department :** N&G - Management **Ward/Team :** Director Management Team	03 Apr 2026 **Opened Date :** 01 Jun 2020 **Last Review Date :** 02 Mar 2026	Beverley Murphy **Risk Manager :** Rachel Weddle	There is a risk that a patient may use a ligature while on an inpatient ward, due to individual patient behaviours (including using ligatures with or without suicidal intent) and environmental limitations such as the presence of unavoidable anchor points, which could lead to death, significant harm, and trauma for families and staff, along with regulatory and reputational consequences.	20	R811 - Environmental Ligature Point Survey **First line of Assurance :** Ward leadership completing and reviewing surveys. Updated as new ligature risks are identified. **Second Line of Assurance :** Environmental Risk Group oversight **Third Line of Assurance :** CQC inspections / external review processes R811 - Individual Risk Assessment & Care Planning **First line of Assurance :** Named nurse & MDT, Matron/Care Group oversight **Second Line of Assurance :** Quality governance audits **Third Line of Assurance :** CQC inspections / external review processes R811 - Removal / Mitigation of Anchor Points **First line of Assurance :** Estates completing works **Second Line of Assurance :** Estates governance reporting, Capital programme oversight **Third Line of Assurance :** CQC inspections / external review processes R811 - Restricting Access to Ligature Materials **First line of Assurance :** Ward staff record searches undertaken, Matron audits **Second Line of Assurance :** Incident trend review, Do we have information on searches undertaken? **Third Line of Assurance :** CQC inspections / external review processes R811 - Staff Training & Competence **First line of Assurance :** Staff training compliance **Second Line of Assurance :** Workforce/Training oversight **Third Line of Assurance :** CQC inspections / Internal Audit R811 - Staffing levels **First line of Assurance :** Staffing rotas, Matron Oversight, Escalation Processes **Second Line of Assurance :** Safe Staffing reports to Committee **Third Line of Assurance :** CQC inspections / external review processes R811 - Therapeutic Engagement & Observation **First line of Assurance :** Clinical staff follow agreed process and clinical practice **Second Line of Assurance :** Ward managers auditing observation practice, incident reviews **Third Line of Assurance :** CQC inspections / external review processes	15.00	➡	4 **Actions :** R903 - Phase 3 delivery R811 - Improve Assurance R811 - Handover Quality 811 - Staff Skill Mix Review	10	30 Apr 2027

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00000909 **BAF Risk Alignment :** 1. Safe Staffing **Committee Alignment :** People Culture and Diversity Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** NYY&S **Specialty/ Department :** NYY&S Management **Ward/Team :** North Yorkshire And York Management	03 Apr 2026 **Opened Date :** 20 Oct 2020 **Last Review Date :** 05 Feb 2026	Himanshu Garg **Risk Manager :** Himanshu Garg	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20	Employment of international fellowship Doctors to fill gaps and reduce locum mind the gap **First line of Assurance :** Successful recruitment of these posts has substantially reduced our locum reliance in MHSOP South. other specialty updates will follow. **Second Line of Assurance :** **Third Line of Assurance :** Mind the Gap arrangements **First line of Assurance :** Lead Psychiatrists report that the locum doctors are present at work. **Second Line of Assurance :** Finance reports confirming payments to locum doctors **Third Line of Assurance :** Retention of Existing Consultant workforce **First line of Assurance :** Quarterly meeting with all career grade doctors within the care group Monthly meeting with individual specialty career grade doctors **Second Line of Assurance :** Sickness absence is below the Trustwide percentages. Increasing numbers of approved flexible working requests Increase in LTFT colleagues. **Third Line of Assurance :** Substantive recruitment to vacant consultant posts **First line of Assurance :** Posts are regularly re-advertised where needed and appropriate incentives financial or developmental are added to make them more attractive **Second Line of Assurance :** **Third Line of Assurance :**	12.00	?	0 **Actions :**	9	30 Sep 2025
Risk 00001044 **BAF Risk Alignment :** 4. Quality of Care **Committee Alignment :** Quality Assurance Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Nursing and Governance **Specialty/ Department :** N&G - Quality governance **Ward/Team :** Patient Safety Management	02 Apr 2026 **Opened Date :** 08 Aug 2022 **Last Review Date :** 03 Feb 2026	Rachel Weddle **Risk Manager :**	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	20	INC - Patient Safety Huddle Daily - reviews moderate and above incidents **First line of Assurance :** Daily Huddle undertaken. Incidents looked at have the record updated in InPhase to reflect the review and discussion and any outcome/ action needed. Senior leaders report is generated post huddle every day. Report query's extended to pick up deaths (via clinical outcome box) that are low/no harm **Second Line of Assurance :** **Third Line of Assurance :** Staff understand the initial review process and timelines **First line of Assurance :** Numbers of staff who have been trained in the process and use of the system (against those given access to undertake this role). Staff undertaking incident reviews Requests for support Number of Incidents awaiting 4 day review (reported into CG and EROQG) Numbers of incidents overdue 4 day review and age of these Number of incidents in stages of process and length of time in the process. **Second Line of Assurance :** New e-learning training compliance **Third Line of Assurance :**	10.00	?	1 **Actions :** R1044 - QI work on operational management and governance of incidents from ward to board	5	31 Mar 2026

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001137 **BAF Risk Alignment :** 1. Safe Staffing **Committee Alignment :** People Culture and Diversity Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** People and Culture **Specialty/ Department :** PCD - Director **Ward/Team :**	28 Feb 2026 **Opened Date :** 22 Mar 2022 **Last Review Date :** 29 Jan 2026	Sarah Dexter-Smith **Risk Manager :**	There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care.	15	Manual Recording Systems **First line of Assurance :** Locally updated Reported through specialty governance **Second Line of Assurance :** **Third Line of Assurance :** Audit one clinical supervision Audit TEWVVision **First line of Assurance :** Individuals record supervision Line managers monitor **Second Line of Assurance :** Form July 25 able to report out from TEWV Vision in terms of compliance for each specialty. Reporting from TEWVVision to CG Specialty and CG Board **Third Line of Assurance :**	15.00		2 **Actions :** All ward team managers to be using the same clinical supervision recording system TEWVision Routine performance monitoring of clinical supervision compliance with TEWVision in specialties	6	31 Mar 2026

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001219 **BAF Risk Alignment :** 2. Demand **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** DTV&F **Specialty/ Department :** DTV&F - CAMHS **Ward/Team :**	02 Apr 2026 **Opened Date :** 01 Apr 2021 **Last Review Date :** 02 Mar 2026	Jamie Todd **Risk Manager :** James Graham	Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	16	Activity levels and outputs **First line of Assurance :** SM Q&P huddle **Second Line of Assurance :** GM Q&P huddle **Third Line of Assurance :** DoOps Q&P huddle Capacity and demand **First line of Assurance :** Q&P huddle at SM level on a weekly basis **Second Line of Assurance :** Q&P huddle at GM level on a weekly basis **Third Line of Assurance :** Q&P huddle at DoOps level on a weekly basis Clinical prioritisation **First line of Assurance :** TMs and SM to ensure waiters are reviewed in an effective and timely manner to be assured around risk management and patient safety. **Second Line of Assurance :** Once identified these waiters will be prioritised for an assessment. In order to identify needs and offer support required. **Third Line of Assurance :** PTLs **First line of Assurance :** TMs and SMs to have a robust and timely process for management of PTLs **Second Line of Assurance :** Provides oversight of the people waiting, there assessment dates and assurance KIT letters have been sent. **Third Line of Assurance :** Robust and effective KiT processes are in place to ensure timely and clear communication with young people and families, offering advice, signposting, and contact details to enable escalation if risks increase Recovery and Improvement Plan **First line of Assurance :** The Recovery plan provides assurance and oversight of the current improvement work been undertaken by the service **Second Line of Assurance :** Reviews of the recovery plan allow sight of the progress against the milestones **Third Line of Assurance :** Right to choose **First line of Assurance :** RTC process can be assessed via GP. PTL monitoring who has opted for RTC , removed from waiting list **Second Line of Assurance :** Waiting time reduction due to uptake through RTC **Third Line of Assurance :** Support whilst waiting and signposting **First line of Assurance :** KIT letters offer local signposting support and inform families of who to contact if mental health or risk changes **Second Line of Assurance :** **Third Line of Assurance :**	12.00	➡	2 **Actions :** ICB independent sector capacity for longest waiters across the region Rollout of Clinical Protocols to Improve Assessment Efficiency and Throughput	6	31 Mar 2026

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001529 **BAF Risk Alignment :** 2. Demand **Committee Alignment :** Quality Assurance Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** DTV&F **Specialty/ Department :** DTV&F - AMH **Ward/Team :**	02 Mar 2026 **Opened Date :** 29 May 2024 **Last Review Date :** 03 Feb 2026	Shaun McKenna **Risk Manager :** Polly Mennell	Risk of delayed discharges continuing to impact on inpatient length of stay for AMH acute wards.	20	Incident Data **First line of Assurance :** Number of incidents reported via InPhase linked to delays **Second Line of Assurance :** **Third Line of Assurance :** Patient Flow Work **First line of Assurance :** Total number of DTV AMH patients reported as clinically ready for discharge **Second Line of Assurance :** Monitoring of key inpatient bed performance data including length of stay, bed occupancy and number of discharges **Third Line of Assurance :** Performance reporting **First line of Assurance :** Weekly CRFD report from corporate reporting team **Second Line of Assurance :** Weekly Q&P dashboard reporting total patients who are CRFD **Third Line of Assurance :** Use of OPTICA for reporting of CRFD patients	15.00	➡	3 **Actions :** Develop Patient Flow Transformation workstream Develop an electronic live visual bed state in conjunction with IT and our digital journey to change Develop the "Transforming Mental Health Discharge" workstream	9	31 Mar 2026
Risk 00001535 **BAF Risk Alignment :** 5. Digital **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - Business intelligence, clinical outcomes **Ward/Team :** Bi And Co Management	02 Apr 2026 **Opened Date :** 25 Mar 2024 **Last Review Date :** 02 Mar 2026	Nick Black **Risk Manager :** Paula Hay	Since the implementation of Cito, the organisation has been unable to provide all of the appropriate information to commissioning bodies such as Integrated Care Boards due to the current performance levels of the electronic patient recording system (CITO). There is a risk that this could escalate to a level which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations including CQC regulatory frameworks.	16	Development of Action Plan for EDG Review **First line of Assurance :** Review by BICO Management Group Meeting **Second Line of Assurance :** Review by Cito Improvement Group **Third Line of Assurance :** Review by Executive Directors Group and on-going monitoring of progress R1535 - Monitoring of Data Quality Maturity Index (DQMI) score for datasets **First line of Assurance :** MHSDS Team review of National DQMI publication for TEWV (monthly monitoring) **Second Line of Assurance :** BICO Management Group monthly review **Third Line of Assurance :** Monthly reporting via Digital Performance and Assurance Group (DPAG) R1535 - Validation prior to submission of MHSDS **First line of Assurance :** Step 1 – Self-validation of submission Review table counts against previous months and investigate any changes over 5%. Apply the same check to selected DQMI indicators **Second Line of Assurance :** A Band 7 or above reviews table counts, DQMI checks, and the submission portal to confirm record totals match and the submission is not marked as a test. **Third Line of Assurance :** NHSE emails monthly summary statistics on submissions, which we review. Any ad hoc queries from NHSE require us to provide a narrative response.	16.00		1 **Actions :** Create simple user guide for service managers	4	30 Sep 2027

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001632 **BAF Risk Alignment :** 5. Digital **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - It & systems **Ward/Team :** Patient Systems	02 Apr 2026 **Opened Date :** 13 Jan 2025 **Last Review Date :** 02 Mar 2026	Nick Black **Risk Manager :** Gemma Pickering	There is a risk that the benefits of CITO are not realised for example, improved workforce efficiency, staff experience, patient and carer experience, improved quality of records and released time to care.	20	Cito Simplification and Stablisation and Project active **First line of Assurance :** workstream leads are assigned for all actions on the plan and this is reviewed weekly in the simplification and stabilisation project meeting. **Second Line of Assurance :** oversight and monitoring with weekly reporting to EDG and monthly CIG. **Third Line of Assurance :** AUDIT for clinical change element measuring quality and safety of record keeping compliance. NHSE involvement and reviews on progress. Service desk **First line of Assurance :** **Second Line of Assurance :** **Third Line of Assurance :** Shared issue resolution plan **First line of Assurance :** Performance is monitored and fully supported operationally by patient Systems team and supplier, and any issues encountered managed through the formal issue management process in place **Second Line of Assurance :** oversight and monitoring, governance groups etc - Performance monitored at service review meetings, DPAG and CIG **Third Line of Assurance :** External audits undertaken periodically with plans in place for outstanding actions and key functionality included in ongoing audit plans with clinical effectiveness team Staff usability survey completed **First line of Assurance :** User support calls monitored by patient systems team **Second Line of Assurance :** Training effectiveness action plan tabled quarterly at CIG Training compliance tabled monthly at CIG **Third Line of Assurance :** Information on training compliance included in EDG monthly report System speed issues addressed **First line of Assurance :** system is fully supported operationally with performance and functionality continuously monitored by patient Systems team and supplier, and any issues encountered managed through the formal issue management process in place **Second Line of Assurance :** Performance monitored at service review meetings DPAG and CIG **Third Line of Assurance :** External audits undertaken periodically with plans in place for outstanding actions.	12.00	➡	3 **Actions :** R1632 - Data Retention/Saving Requirements R1632 - Cito benefits realisation R1632 - Performance/stabilit management	8	22 Oct 2026

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001636 **BAF Risk Alignment :** 5. Digital **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :** Quality Assurance Committee	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - Quality governance **Ward/Team :** Information Governance	19 Mar 2026 **Opened Date :** 15 Jan 2025 **Last Review Date :** 19 Feb 2026	Lorraine Sellers **Risk Manager :** Vianne Chapman	There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	25	Access to Great North Care Record and Yorkshire Care Record **First line of Assurance :** Report loss of service to Information service desk and second line patient systems team **Second Line of Assurance :** Availability of systems and outage reports taken to DPAG for assurance and approval **Third Line of Assurance :** Cito Improvement group system report Cito training mandated for new starters from 1 Jan 2025 **First line of Assurance :** Cito training reports available to line managers via ESR **Second Line of Assurance :** Cito Improvement group receives regular training compliance reports alongside the Education and Training governance group **Third Line of Assurance :** Information shared within EDG monthly CITO report for training compliance and also on BAF 7 bi-monthly risk report Data migration (documents) completed **First line of Assurance :** Identification of data issues via Data Quality Working Group **Second Line of Assurance :** Issues articulated within system report to CIG on monthly basis **Third Line of Assurance :** Any significant issues would be raised via EDG monthly CITO report and at DPB Robust test scripts developed **First line of Assurance :** Identification of bugs/issues within the test system **Second Line of Assurance :** Error trapping **Third Line of Assurance :** Regular weekly meetings with system supplier to identify resolutions to bugs and issues, alongside monthly system supplier performance meeting. Speed issues with the system resolved **First line of Assurance :** Call logging via IT help desk for affected users **Second Line of Assurance :** Patient systems escalation processes to system supplier via their helpdesk procedures **Third Line of Assurance :** Monthly reports to CIG Supplier monthly service performance review meeting Stabilisation programme in place for release management **First line of Assurance :** Reported progress on weekly stabilisation meeting calls **Second Line of Assurance :** Reported progress via CIG monthly **Third Line of Assurance :** Progress reported as part of the monthly CITO report to EDG Standard Operating Procedures in place **First line of Assurance :** Continual monitoring of effectiveness of SOPs via fault/problem logging **Second Line of Assurance :** KPI's provided to monthly DPAG meeting **Third Line of Assurance :** Monthly supplier review performance meeting	20.00	➡	4 **Actions :** R1636 Complete data rectification for 4 issues R1636 Enhance automated testing R1636 Cito Improvement Programme - wifi/infrastructure Cito Practice Leads Audit - undertake baseline and post training audit to evidence improvements	16	30 Apr 2026

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

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001642 **BAF Risk Alignment :** 5. Digital **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - It & systems **Ward/Team :** Technology Networks	02 Apr 2026 **Opened Date :** 16 Jan 2025 **Last Review Date :** 02 Mar 2026	Steven Forster **Risk Manager :** Dale Hopper	There is a risk that critical infrastructure fails to deliver the required service levels due to failure in maintenance or management; resulting in failure to accesses records and impacting on services. Including UPS, Network, Servers Links to KPIs that will be reported through DPAG	20	Network infrastructure lifecycle **First line of Assurance :** Network team patch network infrastructure on a continual basis inline with the release of vendor patches. Network segmentation in place to provide mitigation while patches are applied to vulnerable devices. Multiple firewalls in place to prevent direct access to network infrastructure. **Second Line of Assurance :** Reporting compliance levels to cyber security group and DPAG. **Third Line of Assurance :** DSPT annual submission and associated annual audit. Network Infrastructure Maintenance and Support - in hours **First line of Assurance :** This includes frontline IT teams and service delivery functions. They are responsible for identifying, owning, and managing risks directly. For example, your IT-NTWK-SOP-0065-v1 Digital and Data Network Configuration procedure outlines how network leads and system owners monitor systems, raise incidents, and maintain documentation to mitigate operational risks. **Second Line of Assurance :** Cyber Security Team, Information Governance, and Digital Programme Assurance Group. These teams ensure that controls are effective, policies are followed, and risks are escalated appropriately. The Resource and Planning - BAF 7 update report - Sep 25 and IT-0010-v7 Information Security and Risk Policy draft both detail how second-line functions support assurance through structured governance and compliance frameworks. Root cause analysis reports are created after major incidents and reflected upon as a lessons learnt exercise and communicated across relevant teams **Third Line of Assurance :** DSPT annual response provide assurance that controls are effective. In addition these controls are audited. Internal audit and external reviews provide independent assurance that risk management and internal controls are functioning as intended. Annual penetration tests validate that controls are effective and highlight any additional risk for remediation. Network infrastructure patching **First line of Assurance :** Operational teams patch devices inline with release of CVE's associated with devices inline with IT-NTWK-SOP-0065-V1 & NHS England Cyber alerts. **Second Line of Assurance :** Patching compliance measured by IThealth platform and Microsoft Defender for endpoint. Results summarised monthly and shared with Head of Technology and Chief Information Officer. Compliance of any High severity vulnerabilities reported formally to NHS England through the cyber alert dashboard. **Third Line of Assurance :** DSPT annual response provide assurance that control is effective. In addition these controls are audited. Internal audit and external reviews provide independent assurance that risk management and internal controls are functioning as intended. Annual penetration tests validate that patching remains compliant, effective and highlight any further remediation required,	16		4 **Actions :** Complete installation of Wi-Fi at all priority sites. High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks) Crisis and Professional Telephone lines replacement for PSTN Switchoff End-to-end connection monitoring to support essential services (Thousandeyes)	6	01 Mar 2027

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
						Network resilience and operational function **First line of Assurance :** Operational teams to identify single points of failure and through Architecture board implement methods of best practice. **Second Line of Assurance :** **Third Line of Assurance :**					
Risk 00001646 **BAF Risk Alignment :** 7. Cyber Security **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - It & systems **Ward/Team :** Technology Services	02 Jun 2026 **Opened Date :** 17 Jan 2025 **Last Review Date :** 02 Mar 2026	Nick Black **Risk Manager :** Steven Forster	There is a risk that cyber and operational incident response is inadequate due to insufficient cyber security resources, skills and enforced cyber security policies and procedures, along with technical audit and assurance; resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery.	25	Cyber awareness training for all staff **First line of Assurance :** Uptake measured via metacompliance monthly **Second Line of Assurance :** Uptake summary taken to cyber security group **Third Line of Assurance :** Metrics presented for review at DPAG bi-monthly.	10.00		3 **Actions :** SIEM delivery Incident response excercise in conjunction with services. Incident response follow up Audit November 2025	5	30 Nov 2028
						DSPT 2025/26 submission **First line of Assurance :** Operational teams evidence DSPT toolkit annually **Second Line of Assurance :** Oversight of Information governance team with at least annual reporting to SIRO/CIO through DPAG on current risk position and gap analysis. **Third Line of Assurance :** DSPT interim annual annual audit, outcome and any associated actions presented to service and oversight through Audit & Risk Committee					
						Incident Response Framework **First line of Assurance :** Cyber incident response plan in place and reviewed annually in addition to desktop exercise. **Second Line of Assurance :** Incident response plan ratified at DPAG. Supporting evidence submitted as part of annual DSPT submission. **Third Line of Assurance :** Incident response audited 23-25 by independent audit.					
						MDE secure score **First line of Assurance :** Secure score is provided in the national MDE platform dynamically and is monitored via operational teams **Second Line of Assurance :** Monthly position report within Cyber security Group **Third Line of Assurance :** Data is reported nationally against all organisations registered on the MDE platform and provided monthly. The Trust score within the top 20 each month. Data presented b-monthly to DPAG					
						Privileged Access Controls **First line of Assurance :** MFA monitored inline with essential function requirements (DSPT) **Second Line of Assurance :** MFA mandated across NHSmail via national policy. An exclusions are by exception and must be agreed by SIRO. **Third Line of Assurance :** Annual DSPT submission and supporting report to SIRO/CIO through DPAG would highlight any residual risk.					

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00001647 **BAF Risk Alignment :** 7. Cyber Security **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Digital and Data services **Specialty/ Department :** DADS - It & systems **Ward/Team :** Technology Services	02 Apr 2026 **Opened Date :** 17 Jan 2025 **Last Review Date :** 02 Mar 2026	Steven Forster **Risk Manager :** Steven Forster	There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	25	Continuous patching **First line of Assurance :** Patch triage meeting bi-weekly to ensure low level compliance. **Second Line of Assurance :** Updates provided to cyber security group with escalation to DPAG. Reporting via IT health monthly to CIO/SIRO and head of technology **Third Line of Assurance :** DSPT annual submission along with annual report to SIRO via DPAG with any gaps in remediation. Data Security & Protection Toolkit **First line of Assurance :** Annual DSPT submission to plan within operational teams. **Second Line of Assurance :** Any gaps highlighted and submitted as part of DSPT reports with SIRO review via DPAG. **Third Line of Assurance :** Annual DSPT interim audit. Independent Penetration test **First line of Assurance :** Independent Penetration test performed annually by Dionach on behalf of NHS england (CREST approved) **Second Line of Assurance :** Operational team review and interim updates on progress via cyber security group and team management huddles. **Third Line of Assurance :** Cyber security Group update and DPAG update with progress against annual test. Multi Factor Access (MFA) **First line of Assurance :** The Trust complies with the MFA national policy and DSPT standards by applying computer based certificates for all corporate devices interacting with the Trusts always on VPN service. The MyDesktop remote access service which is a web based system for use with staff and 3rd parties has a dedicated MFA software token to provide secure access. **Second Line of Assurance :** **Third Line of Assurance :** Network & Perimeter security **First line of Assurance :** Web applications firewalls deployed at edge and within critical network segments. Client firewalls deployed on all endpoints. **Second Line of Assurance :** Uptime of firewalls monitored through PRTG monitoring platform and any non-compliance with client firewalls monitored through national defender for endpoint tenant and through IT health dashboard. **Third Line of Assurance :** NHS Cyber Alert **First line of Assurance :** National mandate which is underpinned by the National Cyber Security Centre. **Second Line of Assurance :** Follow up with Regional cyber security consultant as part of Trust Cyber reviewed (Quarterly). **Third Line of Assurance :** Annual DSPT submission and associated interim audit	15.00	?	5 **Actions :** TEWV secure boundary tenant utilised for all internet traffic Vulnerability scanning of non-MDE hosts SIEM delivery Extend the use of MFA High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks)	5	30 Nov 2028

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
						Regular scanning **First line of Assurance :** National reporting as part of Microsoft MDE endpoints enrolled on the national tenant. The Trust perform well nationally and demonstrate a high level of compliance each month. **Second Line of Assurance :** Nessus scans monthly against non-windows assets and reported into operational teams and by exception at cyber security group monthly. **Third Line of Assurance :**					
Risk 00001682 **BAF Risk Alignment :** 12. Financial Sustainability **Committee Alignment :** Resources and Planning Committee **Secondary Committee Alignment (Impact) :**	**Care Group/Directorate :** Finance **Specialty/ Department :** FIN - Financial management **Ward/Team :** Director Of Finance	31 Mar 2026 **Opened Date :** 01 May 2025 **Last Review Date :** 19 Feb 2026	Liz Romaniak **Risk Manager :** John Chapman	There is a risk that, if we do not deliver our annual 2025/26 financial plan (or project being off plan) caused by a deterioration in income and expenditure rates, this may result in a statutory breach of our financial duties leading to regulatory intervention, reduced autonomy and / or adverse unintended consequences from short term actions to control costs.	15	Financial reporting **First line of Assurance :** Finance team preparing monthly reports; budget holders reviewing financial positions; principal finance business partners validating figures. **Second Line of Assurance :** Executive Directors reviewing reports; Planning & Resources Committee scrutinising financial performance; internal performance dashboards, non executive members reviewing reports and adding constructive challenge. **Third Line of Assurance :** Internal audit of financial reporting processes; external audit of financial statements; NHSE financial oversight; Board-level scrutiny of financial risks. Roster approvals and reviews **First line of Assurance :** Ward managers, service leads, and roster support team ensuring rosters are approved on time and aligned to staffing requirements. **Second Line of Assurance :** Safe Staffing Group reviewing compliance with roster timelines, benchmarking against agreed targets, and escalating issues. May include HR or workforce planning teams. **Third Line of Assurance :** Internal audit of rostering processes; external reviews (e.g. NHSE workforce efficiency assessments / benchmarking of roster efficiency against peers); Board-level scrutiny of staffing KPIs and financial impact.	15.00	➡	8 **Actions :** Improve level loading of headroom and all rosters to be approved on time Flexible staffing group overtime reduction Health Roster reason codes standardisation Level loading of headroom on Health Roster Progressing schemes identified at Sustainability and Transformation events Capital charge review following changes to guidance. Discretionary spend control increases Plans on a Page and EQIA of CRES schemes	8	31 Mar 2026

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Committee Key Issues Report		
Report Date to Board of Directors – 9April 2026		
Date of last meeting: 05 March 2026	**Report from the Quality Assurance Committee (quoracy met)**	
1	**Agenda -** The Committee considered the following matters: • Minutes of meeting held on 5 February 2026 • Board Assurance Framework • Summary of Executive Directors Group Quality and Performance meeting, 24 February 2026 • Quality Governance Triple A Report including: Quality Dashboard, Quality Risks and QAI Programme • Draft 2026/27 Quality Assurance and Improvement Programme • Progress with Quality Priorities • Review of Implementation of Lio (Oxehealth) • Roll out of Complex Care Boards across adult mental health • Learning from Deaths • Equality and Quality Impact Assessments • Statutory/mandatory compliance – areas of risk • Organisational Learning Group • Positive and Safe • Drug and Therapeutics • Crisis Line Performance • Core Services Waiting Times • Compliance with Clinical Supervision • Outcome of Committee Developmental session, 2 February 2026 – item deferred to April • Quality Oversight of PIPs and subcontracts	
2a	**Alert**	**Matters of alert (areas requiring escalation or heightened awareness)** **Harrogate & Ripon AMH Services – Ongoing Quality Concerns** • Weekly oversight continues due to waiting times and a range of quality issues. • Enhanced oversight will continue for six months or until there is indication of sustained improvements. **Sexual Safety** • Ten isolated incidents in NYY MHSOP linked to one service user. All incident were directed towards staff. All managed appropriately. **Increase in Restrictive Interventions (Q3)** • Rise from 1,516 to 1,966 incidents, largely due to one service user in ALD services and a change in reporting of incidents following a QI event in MHSOP. Whilst the rise in acuity and behavioural risk in Dec 2025 showed special cause for concern, overall the rise remained within normal variance for the quarter. • Nine patients accounted for 48% of interventions; one ALD patient accounted for 93% of seclusion episodes and 12% of all restrictive interventions Trust wide. Discussion took place as to the trust's diligence and good practice in recording every episode and all types of use of seclusion in ALD. • Prone restraint increased to 16 episodes related to how we exit seclusion safely. Work with Merseycare continues to establish alternative practice which is safe for staff and safer and more dignified for patients.. • Monitoring of physical health following rapid tranquilisation requires continued vigilance and clinical scrutiny. **Incidents of people falling on Rowan Lea and Moor Croft** • Special cause concern for number of falls per 1000 OBD in NYY MHSOP. Review of falls has not identified any themes, which are across different wards.

		Allied Health Professionals looking for potential solutions including testing alternative bedding. **Delays to Five Clinical Audits** • Requests to delayed audits due to capacity issues. • Committee concerned about risks associated with delaying physical health assessment audit to June 2026. Further discussion between B Murphy is planned with audit leads. **Complex Care Boards – Limited Assurance** • Full implementation across AMH community and EIP teams scheduled for the end of March 2026. A small number of teams were reporting delays in implementation hence limited assurance. • No dedicated resource for this piece of nationally mandated work. Challenges with EPR means that it is not easy to specifically identify patients with assertive and intensive needs and therefore daily huddles and caseload supervision is relied upon. • Assurance limited until full rollout by March 2026. **Crisis Line Performance – Variation and Workforce Gaps** • Reasonable assurance overall, but NYYS workforce pressures and reduced capacity remain. • Committee concerned that it is difficult to quantify any potential harm to callers who cannot get through. **Governance and Oversight of PIPS (Positive Individual Proactive Support Ltd.)** • Committee agreed **limited assurance** at the present time due to the need for a deeper understanding on the role of the commissioners of the service (non TEWV commissioned), quality oversight and governance flows.
2b	**Assurance**	**Matters of assurance (Positive Assurance and areas of strength)** **Executive Oversight and Monitoring** • Good assurance received for EDG performance and quality oversight, with enhanced scrutiny across several risk areas. **Learning from Deaths** • Good assurance with strong alignment to national guidance. • Benchmarking work progressing with comparator Trusts. **Quality Assurance & Improvement Programme 2026/27** • Good assurance received and revised programme approved. **Oxehealth (Lio) Review of TEWV implementation** • Good assurance regarding oversight, policy compliance and monthly auditing. • System implementation improving with strengthened governance. Consent model being further strengthened. **Organisational Learning Group** • Good assurance on thematic learning and improved engagement. • A shift to fewer, more focused themes per meeting seen as beneficial. **Positive and Safe Strategy** • Despite a recognition that restrictive interventions in ALD have risen within normal variance in this quarter, Committee received good assurance that improvement activity and governance remains strong with close monitoring to continue. **Drug and Therapeutics** • Good assurance and progress against agreed priorities from the Medicines Optimisation & Pharmacy Framework (MO&PF).and Committee support the additional submission of the new Medicines Optimisation & Pharmacy Framework for 2026-2030. **Waiting Times – Improved Oversight** • Good assurance on oversight of people waiting for treatment • Good assurance on compliance with 72-hour follow up safety standard. • Committee concluded:

		○ **Good assurance** on oversight ○ **Limited assurance** on quality and access ○ **Therefore, overall reasonable assurance** **Clinical Supervision** • Good assurance on progress with recording supervision; significant improvement in compliance (DTVF 34% → 53%, NYY 31% → 44%).
	Advise	**Matters of Advice (Points for Consideration or Ongoing Development)** **Section 17 Leave Safety Planning** • Whilst data indicated overall improvement there remains a long-standing challenge with inconsistent compliance. • Policy is under review, which will address overly complex processes; implementation expected Autumn 2026. **Improvements in Data Capture Systems** • Delay in notification of the death of one community patient due to human error. System and process improvements made. • Patient-reported experience data is being reviewed following a change to #IWantGreatCare to map across the previous reporting sets to improve consistency over time. **Quality Priorities – Measuring Demonstrable Change** • Committee advised that assurance cannot progress to "good" until impact measures demonstrate tangible change. • Co-creation approach positively received and to be emphasised through Committee workplan development over 2026/27. **Equality and Quality Impact Assessments (QEIA)** • Committee confirms that significant progress has been made over the recent year and recommended additional focus on measuring outcomes and demonstrating how changes may impact inequalities. **Workforce and Capacity Pressures** • Capacity challenges across Quality Governance, IPC, and Clinical Audit teams continue to affect delivery, but plans in place to address • Recruitment underway for the Quality Governance team, which will take approximately three months to return to full capacity. No concern with delivery of audits due to skill mix of current team. **Statutory and mandatory training compliance** • Trajectories improving and provide good assurance overall, though only **reasonable assurance demonstrated on the impact of actions to date**, with further monitoring required. **Non-Executive falls lead** • Company Secretary to be advised on the need to move with national guidance to have a NED lead for falls.
2d	**Review of Risks**	**Committee emphasised the importance of:** Maintaining a clear line of sight between risks, mitigations and assurance. • Strengthening evidence of impact and outcomes, particularly where assurance is assessed as reasonable or limited. • Continuing regular review and escalation of material risks through Executive Directors' Group and onward to Board where required. Overall, the Committee was assured that risks are being actively identified and managed, whilst recognising that further work is required to strengthen assurance on the effectiveness and sustainability of mitigating actions in several key risk areas.
3	**Actions to be considered by the Board**	**Items for Escalation to the Board** • Committee agreed no formal escalations or amendments to the BAF were required at this meeting. • However, the following items should be highlighted for awareness, not escalation:

		○ Delayed clinical audits and associated capacity risks. ○ Rising restrictive interventions observed in the quarter (within normal variance). This is due to the support required by one individual in ALD and the impact of a QI event in MHSOP. Prone restraint increased to 16 episodes related to how we exit seclusion safely. Work with Merseycare continues. ○ Limited assurance regarding Complex Care Boards implementation. ○ Limited assurance on PIPS governance arrangements.
4	**Report compiled by**	Bev Reilly, Interim Chair of the Committee, Deputy Chair of Trust/Hannah Crawford, Executive Director of Therapies/Donna Keeping, Corporate Governance Manager

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For General Release

Meeting of:	Board of Directors
Date:	9th April 2026
Title:	Clinically Ready for Discharge
Executive Sponsor(s):	Naomi Lonergan – Interim Managing Director
Author(s):	Naomi Lonergan – Interim Managing Director Liz Romaniak – Director of finance and Estates Kathryn Ellis – Interim Executive director of Strategy & Transformation

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

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

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

Relevant BAF risk/s (name and number)	***Relevant control***
Quality and Safety **2**	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/or contraction of the provider market and a lack of flow through services resulting in a poor experience and potential avoidable harm.

Executive Summary

Purpose

This paper builds on the initial review of Clinically Ready for Discharge (CRFD) delays presented to Executive Directors Group in November 2025 and, more latterly this plan, in March 2026.

This paper was developed through discussion to agree the scope at the Trust's Resource and Planning Committee and following discussion at Trust Board. It builds on work previously discussed at Executive Directors Group (EDG) and system forums and it was verbally discussed and agreed at the NENC ICB Mental Health Sub-Committee in March 2026.

The paper proposes a Trust-wide 12-month operational and strategic programme to reduce CRFD delays and strengthen the safety, quality and experience of inpatient care with the scope including Acute Mental Health, Mental Health Services for Older People, Rehabilitation, and Learning Disability and Autism services across Durham Tees Valley and Forensic (DTVF) and North Yorkshire and York (NYY).

Delays for patients who are clinically ready to leave hospital continue to affect outcomes and experience, restrict flow, increase length of stay and create sustained pressure on bed

capacity. The proposed plan sets out a coordinated approach that standardises operational practice, improves the use of data in decision making, strengthens system alignment with partners and supports the development of community alternatives.

Overview

CRFD remains a material quality, safety and system risk. While many drivers of CRFD sit outside the Trust's direct control, including housing availability, social care capacity and commissioning decisions, the Trust must demonstrate strong grip over what it can influence. This includes consistency of clinical and operational practice, early identification of discharge risk, timely escalation, robust governance and visible system leadership.

Persistent CRFD delays restrict access to inpatient beds, prolong length of stay, increase reliance on out-of-area placements and expose patients to avoidable iatrogenic harm through delayed recovery, deconditioning, institutionalization and avoidable incidents associated with extended inpatient stays. This programme is therefore a harm-reduction opportunity as well as a flow and capacity intervention.

CRFD pressure is significant but unevenly distributed, with particular concentration in Adult Mental Health, Adult Learning Disability and Older People's pathways. Additional complexity in North Yorkshire and York geographically presents due to dementia prevalence, frailty and limited nursing home provision.

In October 2025, the DTV Care Group in AMH experienced 1,163 delayed bed days (approximately 37.5 beds) and MHSOP experienced 265 delayed bed days (approximately 8.5 beds). The NYYS Care Group in AMH experienced 461 delayed bed days (approximately 14.9 beds) and MHSOP experienced 536 delayed bed days (approximately 17.3 beds) The indicative annualised full (not avoidable) cost for those specialties across the Trust is estimated at circa £19m, with additional impact in Adult Learning Disabilities (at points in time 100% of Adult LD admissions have experienced delays, some patients being in hospital for many months awaiting bespoke packages and/or accommodation being constructed. Current average Adult LD admissions costs are between £1.4 and £1.6 million reflecting complex needs that require additional support, therefore delayed transfers have significant secondary financial implications (primary concerns relating to appropriateness of clinical care and outcomes). These figures are contextual indicators only and should not be treated as delivery commitments or trajectories.

CRFD is first and foremost a patient experience, quality and safety issue, with financial consequences as a secondary effect. In spite of this, the Trust has continued to demonstrate credible progress in enhancing patient flow management, implementing the OPEL framework, progressing toward sustained commissioned targets for bed occupancy and supporting the elimination of out-of-area placements. Continued success will require ongoing system emphasis on mental health discharge in conjunction with opportunities whereby admission can be safely avoided, particularly in groups with the most complex needs or where there isn't a clear purpose of admission. Progress will also be required at system level to develop parity to acute physical health priorities, through access to dedicated discharge support funds (such as the BCF), as well as collaborative efforts with local authorities who are also impacted by discharge delays.

Proposal

CRFD delays arise from a combination of system-level constraints and internal variation.

System constraints include care home and nursing capacity, housing availability and adaptations, social care workforce capacity and funding decisions and commissioning gaps for complex, dementia and autism-specific provision. These require system-level solutions and joint ownership through ICB, local authority and Mental Health Sub-Committee governance.

Internal variation within Trust control includes inconsistent MDT practice and Estimated Date of Discharge setting, variable escalation thresholds, differing discharge processes by geography and specialty, and limited early identification of patients at high risk of delayed discharge. The programme therefore focuses on reducing unwarranted internal variation while escalating system constraints through agreed governance routes.

Strategic Approach

A phased approach has been adopted. Publishing delivery trajectories without a robust baseline would undermine credibility and assurance. The approach prioritises establishing a baseline, evaluating existing initiatives, and understanding variation by cohort, geography and pathway. This enables informed decision-making and proportionate ambition. It also ensures alignment with ICBs' ambitions to further Inpatient Quality Transformation, effect reductions in length of stay and improved system partnership working to support more effective alternatives to admission in the community.

By the end of the 12-month period the Trust should be able to evidence standardised discharge processes, earlier identification and escalation of CRFD risk, clear system ownership of external barriers and reduced variation in length of stay for priority cohorts. There has been progress in practice and there are current pilots in operation (Transfer of Care Hubs, in both Durham and south Tees) where we have an opportunity to learn and share best practice. However, there remains variance in process and approach by geography and specialty. Learning and evaluation of local authority discharge leads (North Yorkshire and York) is also part of the plan in 2026/2027 and provide an opportunity to compare different approaches and practice. This learning and future evaluation offers an opportunity to standardise processes, eliminate inconsistencies in multidisciplinary team (MDT) practices, delivering a reliable, streamlined pathway from admission to discharge. This consistency offers an opportunity to accelerate decision-making and ensures that every patient receives equitable, timely care wherever possible.

Delivery Plan (Appendix 1)

Quarter 1: Focuses on baseline and stabilisation, establishing a clear baseline, mapping internal variation and formally distinguishing Trust-controlled actions from system dependencies. Outputs include an agreed Trust-wide CRFD definition, escalation routes, and a baseline dataset for assurance.

Quarter 2: Focuses on alignment and standardisation through adoption of a Trust-wide CRFD SOP, defined escalation triggers and agreement on cohorts requiring commissioning solutions. Consideration of current patient flow / discharge facilitation roles will also be a core outcome within Q2; with recommendation for ongoing resource / roles to enable the future model.

Quarter 3: Focuses on implementation and spread, demonstrating reduced variation and early benefits for patients and flow.

Quarter 4: Consolidates learning, evaluates interventions, and informs recommendations for system investment, commissioning and future digital enablement.

Current limitation: the Optica pilot remains restricted to the DTVF Care Group at present, so learning will be evaluated before any Trust-wide scaling decisions are taken.

Data and reporting: there are plans to strengthen CRFD data quality, consistency and routine reporting through the Integrated Quality and Performance Report (IQPR) during 2026–2027, to improve assurance, triangulation and the ability to track variation and improvement over time.

Risks and Mitigations

Digital Enablement and Delivery Risk-_ The programme recognises reliance on limited current tools, dependency on future EPR functionality and transition risks. While there are digital risks to delivery, a patient flow / discharge module within the new EPR may be available in 2027–2028 (potentially 6–12 months from the go-live position), and this will be explored as part of Quarter 4 recommendations for future digital enablement. These risks will be actively monitored and reported.

Table 1 – Delivery risks

Key risk	Potential impact	Mitigation / management approach
Harm to Patients arising from prolonged hospital delays	Iatrogenic harm, increased levels of restriction and human rights, decompensation or deterioration of mental and physical health	Enhance oversight of quality impact of those clinically ready but delayed. Quality and safety assurance process, internal escalation processes, external system escalation
System capacity constraints (housing, social care, commissioning) and lack of parity of focus with acute physical health priorities	Prolonged delays for clinically ready patients, constrained bed availability and increased pressure and impact on local authorities from delayed discharge	Position CRFD as a system risk, maintain escalation through ICB and Mental Health Sub-Committee, agree priority cohorts and commissioning solutions, and use integrated programme governance to sustain focus and pace
Variation in internal clinical and operational practice	Inconsistent identification and escalation of CRFD risk, undermining impact of improvement actions	Implement Trust-wide CRFD SOP, standardise MDT practice and escalation triggers, monitor variation through routine reporting
Insufficient baseline data to support credible trajectories	Risk of over- or under-committing to delivery expectations	Use Quarter 1 to establish robust baseline and evaluate existing initiatives before setting trajectories
Digital enablement and transition risk (including timing of EPR flow module)	Reduced visibility of patient flow and delays during transition, with some functionality potentially not available until 2027–2028 (6–12 months post go-live)	Explicitly manage digital dependency as a delivery risk, maintain interim manual/operational controls, and report progress and issues through governance while planning for future enablement
Workforce capacity and competing operational pressures	Reduced ability to sustain focus on CRFD improvement alongside other priorities	Embed CRFD into existing governance and operational reviews to avoid reliance on additional parallel structures

Governance and Accountability

Operational delivery and oversight will be managed through the Care Group Board (CGB) through integration into the Inpatient Quality Transformation Programme (IQPT) escalation into the Executive Directors Group, with alignment to Mental Health Sub-Committee priorities and escalation beyond the Trust where required. This approach will be discussed with Humber North Yorkshire ICB colleagues and agreement sought to adopt through IQPT.

Key Roles:

- **Director of Operations (DoO):** Provides unified leadership, ensures accountability, and drives performance across all quarters.
- **Care Group Board:** Monitors progress, reviews outcomes, conducts quarterly reviews and escalates issues as needed.
- **EDG:** Reviews quarterly assurance updates and delivery plans, endorses strategic direction, and approves resource allocations (as required).

Prior Consideration and Feedback

This paper builds on the initial review of Clinically Ready for Discharge (CRFD) delays presented to Executive Directors Group in November 2025 and, more latterly this plan, in March 2026.

This paper was developed through discussion to agree the scope at the Trust's Resource and Planning Committee and following discussion at Trust Board. It builds on work previously discussed at Executive Directors Group (EDG) and system forums and it was verbally discussed and agreed at the NENC ICB Mental Health Sub-Committee in March 2026.

Implications

Patient Care - CRFD delays prolong institutionalisation, delay recovery, increase risk of deconditioning, medication-related harm, hospital-acquired complications and distress, and disrupt continuity of care. Improving CRFD is therefore a clinical quality priority aligned to Trust quality and safety objectives, with a clear opportunity to reduce avoidable iatrogenic harm through earlier, safer discharge and better system coordination.

Access to services – Maintaining access and provision to local inpatient services is a key objective and NHS plan operating plan commitment. Inability to effectively reduce delays caused by those CRFD could increase the likelihood of both out of locality or inappropriate out of area placements.

Financial sustainability – In additional to quality and access risk, prolonged care in excess of commissioned capacity could result in financial implications if additional capacity, or workforce, is required to maintain safety.

Recommendations

The Executive Directors Group (EDG) supported a recommendation to Board to endorse the phased delivery plan, note CRFD as a shared system risk,

support standardisation of discharge practice and note that operational delivery and oversight will be integrated into the Inpatient Quality Transformation Programme. Care Group Board and EDG. The Board is also asked to agree that trajectories will follow Quarter 1 baseline work and to note the identified risks, dependencies and digital constraints (including timing of future EPR functionality).

Appendix 1 – Delivery Plan
Q1 – Establish Baseline and Stabilisation

- **Milestones:**
- Quality Improvement approach – mapping existing processes cross specialty.
- Comprehensive resource scoping to identify gaps and needs
- *Launch of operational dashboards for real-time monitoring (subject to digital and data capacity*
- Learning workshop with DASS / ICB leads to identify capability gaps (Apr/ May / June 2026)
- North Yorkshire focused workshop re CRFD challenge and opportunities (May 2026)
- **Expected Outputs:**
- Baseline assessment of current CRFD delays and process variability
- Resource allocation reports and gap analysis
- *Dashboard analytics highlighting key performance metrics (subject to digital and data capacity)*
- **Impacts:**
- Improved consistency in discharge processes
- Early identification and mitigation of resource constraints
- Greater transparency in patient flow
- Enhanced collaboration across agencies
- **Roles and Functions:**
- **Director of Operations (DoO):** Intelligence gathering, insight and oversight of data and process incorporating review and reporting into monthly governance cycles.
- **Care Group Operational and Clinical Leads:** Facilitate specialty adoption and compliance

Q2 – Alignment

- **Milestones:**
- Transfer of Care Hub Evaluation (DTVF)
- Discharge lead evaluation (NYY)
- Data informed trajectories agreed (DoOs)
- Standard Operating Procedure (SOP) development
- Deployment of SOP's and multi-agency huddles
- Consistent application of SOPs resulting in early operational grip
- Initiation of regular multi-agency huddles to promote early engagement
- Strengthening partnerships with local authorities and ICB's
- Engagement with Regional DASS / ICB leads to share learning and approach
- **Expected Outputs:**
- Reduced friction in multi-agency working
- Enhanced clarity and consistency in patient referrals
- Clear senior system escalation process
- **Impacts:**
- Smoother transitions and faster discharge planning
- Equitable and timely care for patients with complex needs
- Strengthened inter-organisational trust and cooperation

- **Roles and Functions:**
- **Referral Coordinators:** Implement and monitor template usage
- **Clinical Pathway Leads:** Develop autism pathway, oversee protocol adherence
- **Partnership Managers:** Foster relationships with NY&Y agencies, negotiate agreements
- **Multi-Agency Working Group:** Address barriers, facilitate alignment

Q3 – Spread and Implementation

- **Milestones:**
- Extension of Transfer of Care Hubs (ToCH) practice / principles subject to further evaluation
- Review opportunities to strengthen Patient Flow Team leadership (IQTP)
- **Expected Outputs:**
- Expanded capacity for timely discharges
- Operational pilots with documented outcomes
- Reduction in length of stay (LoS) for target cohorts
- Best practice guidelines based on pilot evaluations
- **Impacts:**
- Broader adoption of effective discharge models
- Improved patient recovery and reduced bed occupancy
- Enhanced crisis response and community support options
- **Roles and Functions:**
- **ToCH Managers:** Oversee hub operations, coordinate extension
- **Crisis Response / Intensive Support Teams:** Deliver and monitor alternative discharge pathways
- **Quality Improvement Leads:** Capture lessons learned, disseminate best practices

Q4 – Consolidation

- **Milestones:**
- Comprehensive evaluation of all initiatives and data outputs
- *Development of a digital roadmap for sustained improvements*
- Submission of community capacity proposals
- **Expected Outputs:**
- Final evaluation reports with actionable recommendations
- *Strategic digital investment plan*
- Business cases for enhanced community capacity (*transformation plans linked to Hospital to Community Workstream*)
- Framework for ongoing performance monitoring
- **Impacts:**
- Long-term sustainability of discharge improvements
- Digital enablement of patient flow processes
- Strengthened community support infrastructure
- Positioning the organization for continued leadership in patient flow innovation
- Roles and Functions:
- Evaluation Leads: Conduct assessments, synthesise findings
- Digital Transformation Managers: Develop and propose digital solutions

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9 April 2026**
Title:	**Data publication – Patient Carer Race Equality Framework (PCREF)**
Executive Sponsor(s):	**Kedar Kale - Executive Medical Director**
Report Author(s):	**Rachel Nye, Section Head of Research and Analytics** **Danielle Rome, Lead Information Analyst** **Catherine Parker, Consultant in Public Health**

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

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

1: We will co-create high quality care	**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*
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
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
14	**Health Inequalities**	There is a risk that health inequalities are exacerbated / opportunities to reduce health inequalities are not realised. Caused by differential opportunities for equitable access, excellent experience and optimal outcomes. In particular for people living in areas of high deprivation, those from Black, Asian and minority ethnic communities and those from inclusion health groups. Resulting in lack of service reach into underserved communities, increased risk of late/crisis presentation, higher acuity, disengagement, suboptimal outcomes and experience in health inclusion groups.

EXECUTIVE SUMMARY:

Purpose:

This paper provides assurance that the Trust is meeting its obligations under the Patient Carer Race Equality Framework (PCREF) data collection and publication.

Proposal:

Board of Directors is asked to:

- Confirm that it has reasonable assurance that the Trust has followed a robust process in producing and analysing the quantitative data required for the PCREF.
- To approve the proposed publication of the PCREF prior to publication on the Trust website.

Overview:

The data is for the period 1st April 2024 to 31st March 2025. The PCREF requirements 2 – 8 were reported on in January 2025 and an update provided on them in January 2026. The PCREF for 2025/26 will go through the governance process again in November 2026 together with our public sector equality duty report for patients so that all the data will be for the same period. The PCREF requirements 2 – 8 will be reported on in detail in the November report.

This paper should be viewed in addition to the paper February 2025, the data published on the trust website in October 2025, and the update provided to Quality Assurance Committee in January 2026 which provided a narrative account of the trust's response to date in relation to the PCREF domains.

NHS England (NHSE) has developed the PCREF to support Mental Health Trusts to become anti- racist organisations by ensuring they co-produce and implement actions to reduce racial inequalities within their services. It is now part of the CQC inspections. The ICBs are monitoring Trust's progress with the PCREF.

As a minimum Trusts must publish:

- The number of cases of detention under the Mental Health Act and the cause (section) and duration of these detentions by ethnicity
- Restraint including the type of restraint by ethnicity, age and gender.
- Physical health checks for those adults with Severe Mental Illness by ethnicity. (This data is held by primary care, and we do not currently have access to this data segmented for our trust footprint)
- Improved access rates to Children and Young People's mental health services for 0 – 17-year-olds
- A sample of locally agreed access, experience and outcome metrics. Information which previously formed part of the patient publication of information has been included under this heading.
- The Trust will report on any deaths in mental health inpatient units to the CQC by protected characteristics. The Trust is complaint with this and currently reports to the CQC on all deaths of patients detained under the Mental Health Act by gender, ethnicity, disability, religion/ belief, sexual orientation and age. This data is not collated centrally, but the Mental Health Legislation office save a copy of the death notification once it is sent to CQC.

The Trust is required to publish the PCREF data annually. The proposal for assurance is based on the information contained in this report and the data in appendix 1.

PCREF data (Data in Appendix 1)

Detention data (Fig 3)
Information has been produced by calculating the expected rates of detention by gender and ethnicity for the Trust based on standardised rates of detention per 100,000 population. The Trust's anticipated rates are based on the 2021 census for ethnicity, sex, age and gender. These have been compared to the Trust's detention rates and NHS Digital rates for 2024/25.

- Compared to the national rates of detention per 100,000 population the Trust detains more White, Asian/ Asian British and Other Ethnicities than the national rates, fewer Mixed people and the same number of Black/ Black British people.(Fig 3) It should be noted that national rates of detention have fallen and that the Trust's rates of detention have also decreased but are still higher than national rates for some groups of people as described above.
- The table in fig 4 which shows that per 100, 000 population those who identify as Black/ Black British are detained 2.03 times more than White People, compared to 2.61 times in 2023/24 and Other Ethnicities are detained 2.33 times more than White people, compared to 1.32 times in 2023/24. Asian/ Asian British, which is the same as 2023/24, and Mixed people are less likely to be detained than White people compared to 1.32 times more likely to be detained in 2023/24.
- Further analysis of relative rates of detention by ethnicity and gender per 100,000 population (Fig 5) show that compared to White women, Black/ Black British women are detained 2.24 times more, compared to 3.39 times more in 2023/24, and are detained at higher rates than any other female ethnic group. Black/ Black British men are 1.65 times more likely to be detained than White men, compared to 1.94 times in 2023/24. Women from other ethnicities are 1.85 times more likely to be detained compared to White women, compared to 0.85 times less likely in 2023/24. Men from other ethnicities are 2.36 times more likely to be detained compared to White men, compared to 1.77 in 2023/24.

Restrictive Practice (Figs 6-12)

- Initial analysis (figures 6 -9) suggests that women are more likely to physically restrained, chemically restrained and be in seclusion compared to men, whereas in 2023/24 men were more likely to be in seclusion. Men are more likely to be mechanically restrained compared to women, but the numbers are very small so caution must be shown in drawing any conclusions from this. Physical interventions are significantly higher for those aged 18 – 29 than for any other age group as was the case in 2023/24. Mechanical restraint is low across the board but there appears to be an outlier in the 30 – 44 age group as there was in 2023/24.
- Analysis was done which included comparing restrictive intervention data to the number of ward stays (figures 10 – 12). For this, patients were only counted once in the numerator (number of restrictive interventions) and once in the denominator (number of ward stays within the time frame) regardless of how many ward stays or restrictive interventions they may have had.
  The analysis showed the following
  - Women are slightly more likely (22.7%) to be subject to restrictive interventions compared to men (19.4%).
  - Restrictive interventions were used on 23.3% of 18-29 year olds who had a ward stay. The two numerators (the number of interventions) added together divided by the two denominators (the number of ward stays) have been used to reach this figure.
  - All ethnicities, except for Mixed, experienced higher levels of restrictive interventions

compared to White people. However, it needs to be noted that for 45.3% of restrictive interventions ethnicity is unknown and therefore the figures need to be treated with caution.

CYP Access
Data on CYP access is included at fig 13. The PCREF requires us to report on rates of access, and this has been compared to the 2021 census figures for the under 18s in the local authority areas covered by the Trust. This shows that compared to White people all other ethnicities access CYP services at lower rates with Asian/ Asian British and Black/ Black British having the lowest access rates.

PROMS and CROMS (fig 14 – 17)
For each outcome measure there are two table. The first showing the percentage of patients with a paired outcome measure and the second showing the percentage with measurable improvement.
For adults and older people (figures 14 – 15) as in 2023/24 the percentages of patients with a paired outcome measure are not significantly different. The percentage of discharged patients showing measurable improvement on the CROM tool is higher for all ethnicities than it is for White people.

For CYP (16 – 17) the percentage of Black/ Black British patients with a paired CROM is 15% which is significantly different to the percentage for other ethnicities. The percentage with a paired PROM is 35% for White patients as compared to 18% for Asian/ Asian British patients and 12% for Black/ Black British patients. The percentage showing measurable improvement in CROMS for Other Ethnicities is significantly lower, but for PROMS the greatest level of improvement is shown for those of Other Ethnicities. 0% of Black/ Black British patients report measurable improvement, however the number of responses is <5 caution needs to be applied to this as it does for all ethnicities compared to White due to the significantly lower number of patients.

Access Rates and Admissions (fig 18)
This data compares access rates to services in general per 100,000 population with admissions to hospital per 100 people who accessed services in general. The figures show that all ethnicities access services in general at lower rates than White people and with the exception of Mixed race people all ethnicities have higher levels of hospital admissions compared to White people.

PCREF requirements 2 – 8
These were reported on in January 2025 and an update provided in January 2026. The PCREF for 2025/26 will go through the governance process again in November 2026 together with our public sector equality duty report for patients so that all the data will be for the same period. The PCREF requirements 2 – 8 will be reported on in detail in the November report.

Areas of future focus
While this report details data to support the trust on its journey to become an anti-racist organisation and to address inequalities identified via the data collected as required by the PCREF, we have more to do in response. Areas of focus for the coming year will be as follows:

- National data quality for ethnicity recording is inconsistent with missing, unknown or our dated codes with lack of alignment of systems further reducing overall data reliability. We still have work to do to increase recording of ethnicity data at TEWV. Our current recording (68.2%) is below national average (74.6%) for mental health settings and has fallen. Consultation is taking place as to how best to improve the recording of ethnicity data.

- The Health Inequalities plan sets out the following actions in relation to the PCREF: establish relationships with our community sector partners to grow insights from racialised communities; undertake a detailed exploration into the drivers of mental health act use for ethnically minoritised and racialised communities; use these insights to model service adaptations, increase community reach and improve accessibility and responsiveness of services. Work is currently undergoing to identify specific focuses for this work within clinical services.

Prior Consideration and Feedback:
This paper was approved by Executive Clinical Leaders Subgroup on 18th March 2026. To note this version additionally includes data on the % of matched pairings for clinician and patient reported outcomes which is a discretionary data set and numbers less than 5 have been suppressed in readiness for publication. This paper was subsequently approved by Executive Directors Group on 24th March 2026 and was received by Quality assurance committee on 2nd April 2026.

Implications:
Failure to understand the differences in outcomes and experiences of our ethnically minoritised and racialised communities in accordance with the requirements of the PCREF, and more broadly those with protected characteristics in accordance with our public sector equality duties may have regulatory and reputational consequences. Failure to act to reduce differences in outcomes and experiences of our service users with protected characteristics may impact on their outcomes and experiences.

Recommendations:

Board of Directors is asked to:

- Confirm that it has reasonable assurance that the Trust has followed a robust process in producing and analysing the quantitative data required for the PCREF
- To approve the proposed publication of the PCREF prior to publication on the Trust website.

Appendix 1 – Data required for PCREF Publication

Number of Detentions under the Mental Health Act by cause and duration by ethnicity (1.4.24 – 31.3.25)

Figure 1: Number of Detentions by Ethnicity and Section Type

Number of Detentions by Ethnicity & Section Type							
Ethnicity x Section Type	White	Asian/Asian British	Black/Black British	Mixed	Other Ethnicities	Unknown	Grand Total
2	1477	43	13	15	26	208	**1782**
3	806	18	15	6	13	86	**944**
37	10	0	0	*<5*	0	0	**11**
37/41	6	0	*<5*	0	0	0	**7**
37N	*<5*	0	*<5*	0	0	0	**5**
4	8	0	0	*<5*	0	0	**9**
47/49	*<5*	0	0	0	0	0	**<5**
48/49	*<5*	0	0	0	0	0	**<5**
5(2)	271	*<5*	*<5*	*<5*	5	23	**304**
5(4)	100	*<5*	0	0	*<5*	5	**107**
Grand Total	**2686**	**65**	**31**	**24**	**45**	**322**	**3173**

Figure 2: Average Duration of Detention by Ethnicity and Section Type (1.4.23 – 31.3.25)

Average Duration in Days by Ethnicity & Section Type							
Ethnicity x Section Type	White	Asian/Asian British	Black/Black British	Mixed	Other Ethnicities	Unknown	Grand Total
2	19	18	18	17	20	19	**19**
3	69	85	53	19	55	67	**69**
37	120	*n/a*	*n/a*	46	*n/a*	*n/a*	**113**
37/41	184	*n/a*	116	*n/a*	*n/a*	*n/a*	**161**
37N	165	*n/a*	183	*n/a*	*n/a*	*n/a*	**169**
4	*<5*	*n/a*	*n/a*	*<5*	*n/a*	*n/a*	**<5**
47/49	256	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	**256**
48/49	96	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	**96**
5(2)	*<5*	*<5*	*<5*	0	*<5*	*<5*	**<5**
5(4)	0	0	*n/a*	*n/a*	0	0	**0**
Grand Total	**32**	**35**	**43**	**17**	**28**	**30**	**32**

Figure 3: Actual Detention rates per 100,000 population compared with anticipated detention rates and compared with national rates (2024)

COMPARISON TO NATIONAL RATES OF DETENTION					
Ethnicity	**National rates of detention per 100,000 population**	**Anticipated numbers of detentions in TEWV based on national rates**	**Actual numbers of detentions in TEWV**	**TEWV rates of detention per 100,000 population**	**Relative rate between TEWV detention figures and National Figures**
White	66.9	1278	2405	125.8	1.88
Mixed	122	30	22	89.9	0.74
Asian/Asian British	85.7	46	63	117.4	1.37
Black/Black British	256.7	33	33	254.7	0.99
Other Ethnicities	140.8	20	41	292.4	2.08
Unknown	-	-	309	-	-

Figure 4: Relative Ratios of TEWV detention rates by ethnicity (1.4.24 – 31.3.25)

The rates are calculated against the row labels so if the figure is greater than 1 the characteristic in the row label shows a higher detention rate than the comparator in the column label, if the figure is less than 1 they show a lower rate of detention.
An example of interpretation would be 'per 100,000 population Black/ Black British people are detained 2.03 times more than White people.'

Ethnicity	**White**	**Mixed**	**Asian/Asian British**	**Black/Black British**	**Other Ethnicities**
White		1.40	1.07	0.49	0.43
Mixed	0.71		0.77	0.35	0.31
Asian/ Asian British	0.93	1.31		0.46	0.40
Black/ Black British	2.03	2.83	2.17		0.87
Other Ethnicities	2.33	3.25	2.49	1.15	

Figure 5: Comparisons of TEWV detention rates by ethnicity and gender (1.4.24 – 31.3.25)

The table below shows the highest relative ratios when assessing cross- sectional data between ethnicity and gender.

Ethnicity x Gender	Asian/ Asian British - Female	Asian/ Asian British - Male	Black/ Black British - Female	Black/ Black British - Male	Mixed - Female	Mixed - Male	Other Ethnicities - Female	Other Ethnicities - Male	White - Female	White - Male
Asian/ Asian British - Female		1.13	0.43	0.60	1.14	1.64	0.51	0.42	0.95	0.99
Asian/ Asian British - Male	0.88		0.38	0.53	1.00	1.45	0.45	0.37	0.84	0.87
Black/ Black British - Female	2.35	2.67		1.41	2.68	3.85	1.21	0.98	2.24	2.32
Black/ Black British - Male	1.67	1.89	0.71		1.90	2.73	0.86	0.70	1.59	1.65
Mixed - Female	0.88	1.00	0.37	0.53		1.44	0.45	0.37	0.84	0.87
Mixed - Male	0.61	0.69	0.26	0.37	0.69		0.31	0.26	0.58	0.60
Other Ethnicities - Female	1.94	2.20	0.83	1.16	2.21	3.18		0.81	1.85	1.92
Other Ethnicities - Male	2.39	2.71	1.02	1.43	2.72	3.92	1.23		2.28	2.36
White - Female	1.05	1.19	0.45	0.63	1.20	1.72	0.54	0.44		1.04
White - Male	1.01	1.15	0.43	0.61	1.15	1.66	0.52	0.42	0.96	

Number of Cases of restrictive practice, including type of restrictive practice by ethnicity, age and gender

Figure 6: Total Number of Restrictive practice interventions by type (1.4.24 – 31.3.25)

Total Number of Interventions	No. Physical Interventions	No. Mechanical Interventions	No. Chemical Interventions	No. Isolation Interventions
	5449	31	1775	570

Figure 7: Number of Restrictive interventions by gender (1.4.24 – 31.3.25)

Number of Interventions by Gender				
Gender	No. Physical Interventions	No. Mechanical Interventions	No. Chemical Interventions	No. Isolation Interventions
Female (Including Trans Woman)	3439	<5	1197	349
Male (Including Trans Man)	1745	29	513	218
Non-Binary	13	0	<5	<5
Unknown	252	<5	62	<5

Figure 8: Number of Restrictive interventions by ethnicity (1.4.24 – 31.3.25)

Number of Interventions by Ethnicity				
Ethnicity	No. Physical Interventions	No. Mechanical Interventions	No. Chemical Interventions	No. Isolation Interventions
Asian/Asian British	265	0	195	<5
Black/Black British	27	<5	11	<5
Mixed	43	0	18	0
White	4644	27	1360	564
Other Ethnicities	43	0	35	0
Unknown	427	<5	156	<5

Figure 9: Number of Restrictive interventions by age (1.4.24 – 31.3.25)

Number of Interventions by Age				
Age Groupings	**No. Physical Interventions**	**No. Mechanical Interventions**	**No. Chemical Interventions**	**No. Isolation Interventions**
<20	1003	<5	251	<5
20-29	1662	<5	512	182
30-44	1082	17	375	358
45-64	788	7	351	25
65+	664	0	225	<5
Unknown	250	<5	61	<5

Figures 10 – 12 show the number of Restrictive Interventions used as a percentage of any open ward stays for the period 1.4.24 – 31.3.25. This only counts patients once in the numerator (number of restrictive interventions) and once in the denominator (open ward stays within the time frame being looked at) regardless of how many restrictive interventions or ward stays they may have had.

Figure 10. Percentage of people with a restrictive intervention by gender (1.4.24 – 31.3.25)

Gender			
Gender	Number of ward stays	Number of restrictive interventions used	%
FEMALE (INCLUDING TRANS WOMAN)	1475	335	22.7%
MALE (INCLUDING TRANS MAN)	1750	339	19.4%
NON-BINARY	6	<5	50.0%

Figure 11: Percentage of people with a restrictive intervention by age (1.4.24 – 31.3.25)

Age			
Age	Number of ward stays	Number of restrictive interventions used	%
<20	230	36	15.7%
20 - 29 years old	538	143	26.6%
30 - 44 years old	927	189	20.4%
45 - 64 years old	854	157	18.4%
65+	719	153	21.3%

Figure 12: Percentage of people with a restrictive intervention by ethnicity (1.4.24 – 31.3.25)

Ethnicity			
Ethnicity	Number of ward stays	Number of restrictive interventions used	%
Asian/Asian British	67	23	34.3%
Black/Black British	36	12	33.3%
Mixed	23	<5	17.4%
White	2419	563	23.3%
Other Ethnicities	28	14	50.0%
Unknown	695	315	45.3%

Improved Access to Children and Young People Services (CYPS) for ages 0 – 17 (1.4.14 – 31.3.25)

Figure 13: CYPS access compared to the 2021 census figures for the under 18 population in the local authority areas covered by the Trust. (1.4.24 – 31.3.25)

Ethnicity	Number of Patients	Population	Access rate per 100,000 population
Asian/Asian British	190	13019	1459.41
Black/Black British	77	3706	2077.71
Mixed	356	11643	3057.63
White	24656	361283	6824.57
Other Ethnicities	140	3988	3510.53
Unknown	4470		

Sample of locally agreed outcome metrics (1.4.24 – 31.3.25)

Clinical Outcome Measures for Adult and Older People's services by ethnicity
The first tables show the percentage of patients with a paired outcome measure and the second shows the percentage reporting measurable improvement.

Figure 14: Clinician Reported Outcome Measures

AMH / MHSOP - CROM			
Ethnicity	Number of patients discharged in the reporting period (based on the logic mentioned above)	Number who have a paired outcome measure	% who have a paired outcome measure
Asian/Asian British	133	67	50%
Black/Black British	48	26	54%
Mixed	88	43	49%
Other Ethnicities	79	43	54%
White	13180	6882	52%

AMH / MHSOP - CROM			
Ethnicity	Number of patients discharged in the reporting period (based on the logic mentioned above)	Number showing measurable improvement	% showing measurable improvement
Asian/Asian British	82	25	30%
Black/Black British	34	12	35%
Mixed	56	21	38%
Other Ethnicities	56	23	41%
White	8131	1968	24%

Figure 15:

AMH / MHSOP - PROM			
Ethnicity	Number of patients discharged in the reporting period (based on the logic mentioned above)	Number who have a paired outcome measure	% who have a paired outcome measure
Asian/Asian British	147	49	33%
Black/Black British	51	16	31%
Mixed	95	31	33%
Other Ethnicities	94	21	22%
White	13976	4072	29%

AMH / MHSOP - PROM			
Ethnicity	Number of patients discharged in the reporting period (based on the logic mentioned above)	Number showing measurable improvement	% showing measurable improvement
Asian/Asian British	59	22	37%
Black/Black British	22	9	41%
Mixed	41	20	49%
Other Ethnicities	28	10	36%
White	5103	2312	45%

Clinical Outcome measures for Children and Young People by ethnicity
Patient Reported Outcome Measures and the second shows the percentage reporting measurable improvement and the second shows the percentage reporting measurable improvement.

Figure 16: Clinician Reported Outcome Measures

CYP - CROM			
Ethnicity	Number of patients discharged in the reporting period (based on the logic mentioned above)	Number who have a paired outcome measure	% who have a paired outcome measure
Asian/Asian British	36	12	33%
Black/Black British	13	<5	15%
Mixed	88	21	24%
Other Ethnicities	29	8	28%
White	5075	1793	35%

CYP - CROM			
Ethnicity	Number of patients discharged in the reporting period (based on the logic mentioned above)	Number showing measurable improvement	% showing measurable improvement
Asian/Asian British	12	7	58%
Black/Black British	6	<5	50%
Mixed	27	14	52%
Other Ethnicities	10	<5	20%
White	2340	1267	54%

Figure 17: Patient Reported Outcome Measures

CYP - PROM			
Ethnicity	Number of patients discharged in the reporting period (based on the logic mentioned above)	Number who have a paired outcome measure	% who have a paired outcome measure
Asian/Asian British	39	7	18%
Black/Black British	17	<5	12%
Mixed	95	28	29%
Other Ethnicities	32	8	25%
White	5551	1945	35%

CYP - PROM			
Ethnicity	Number of patients discharged in the reporting period (based on the logic mentioned above)	Number showing measurable improvement	% showing measurable improvement
Asian/Asian British	8	5	63%
Black/Black British	<5	0	0%
Mixed	30	14	47%
Other Ethnicities	9	7	78%
White	2331	1181	51%

Figure 18: Access Rates to services in general per 100,000 population (compared to the 2021 census figures) and access rates to hospital per 100 people accessing services.

Ethnicity	Number accessing services	Census data	Crude rate per 100,000	Number who occupied an inpatient bed	Rates of people who spent time in hospital per 100 people accessing services
Asian/Asian British	462	53656	861.0	59	12.8
Black/Black British	193	12954	1489.9	30	15.5
Mixed	530	24478	2165.2	23	4.3
Other Ethnicities	327	14020	2332.4	29	8.9
White	49072	1911131	2567.7	2298	4.7

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9 April 2026**
Title:	**Register of Sealing**
Executive Sponsor(s):	**Alison Smith, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

Report for:

Assurance		***Decision***	
Consultation		***Information***	✓

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

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

Strategic Risks relating to this report:

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

Executive Summary:

Purpose:

To advise the Board of the use of the Trust's seal in accordance with Standing Order 15.2.

Proposal:

The Board is asked to receive and note this report.

Overview

The Trust's seal has been used as follows:

Ref	Document	Sealing Officers
455	Settlement deed relating to Windsor House, Harrogate	Naomi Lonergan, Interim Managing Director Phil Bellas, Company Secretary

Prior Consideration and Feedback

None relating to this report.

Implications:

None relating to this report.

Recommendations:

The Board is asked to note this report.