BOARD OF DIRECTORS
11 June 2026
at 10.00am

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

AGENDA

No.	Report Title	BAF Risk*	Lead	Timing
Standing Items				
1.	Chair's welcome and introduction (verbal)	-	Chair	10.00am
2.	Board of Directors to receive a patient story (verbal)	-	CN	10.01am
3.	Apologies for absence (verbal)	-	Chair	10.30am
4.	Declarations of interest (verbal)	-	All	10.31am
5.	Questions from members of the public (verbal)	-	Co-Sec	10.32am
6.	Minutes of the last Board of Directors meeting held on 9 April 2026	-	Chair	10.40am
7.	Board Action Log	-	Chair	10.45am
8.	Chair's Remarks (verbal)	-	Chair	10.50am
9.	Chief Executive's Public Report	-	CEO	11.00am
Strategic Items				
10.	Board Assurance Framework Summary Report	All	Co Sec	11.15am
11.	Medium Term Plan	All	Int EDS&T EDFE&F	11.20am
BREAK (11.40pm to 11.50pm)				
12.	Integrated Quality & Performance Report	1, 2, 9, 12	Int EDS&T Int CG MD	11.50am
	a. Supporting Mental Health Demand in Acute Care Services	2, 4	Int CG MD	

No.	Report Title	BAF Risk	Lead	Timing
13.	Report of the Chair of People, Culture and Diversity Committee, which includes the following report to Board:	-	Cmt Chair	12.30pm
	a. Report of the Freedom to Speak up Service	1, 4	EDP&C	12.40pm
14.	Report of the Chair of the Quality Assurance Committee, which includes the following statutory report to Board:	-	Cmt Chair	12.50pm
	a. Learning from Deaths, quarterly report	8, 10	EMD	1.00pm
15.	Report of the Chair of Mental Health Legislation Committee	-	Cmt Chair	1.10pm
16.	Report of the Chair of Audit & Risk Committee	-	Cmt Chair	1.20pm

Matters for Information

No.	Report Title	BAF Risk	Lead	Timing
17.	Register of Sealing	10	Co Sec	-

* further information on the strategic risks in the Board Assurance Framework (BAF) can be found in the summary report, which is item 10 on the agenda.

M Burnham
Trust Chair
5 June 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.

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD AT 10AM ON 9 APRIL 2026 AT WEST PARK HOSPITAL DARLINGTON AND VIA MSTEAMS

Present:
M Burnham, Trust Chair (Chair)
N Adetuberu, Non-Executive Director
K Kale, Executive Medical Director
N Lonergan, Interim Care Group Managing Director
J Maddison, Non-Executive Director
B Murphy, Chief Nurse/Deputy Chief Executive
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)
H Crawford, Executive Director of Therapies (non-voting)
K Ellis, Interim Executive Director of Strategy and Transformation (non-voting)
E Gorringe, Associate Non-Executive Director (non-voting)

In attendance
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)

01. CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting.

02. APOLOGIES FOR ABSENCE

Apologies for absence were received from A Bridges, Executive Director for Corporate Affairs and Involvement and N Black, Chief Information Officer.

The Chair confirmed the meeting was quorate and able to proceed.

03. DECLARATIONS OF INTEREST

No declarations of interest were raised.

04. MINUTES OF THE LAST BOARD OF DIRECTORS MEETING HELD ON 12 FEBRUARY 2026

Agreed: *the minutes are a true and accurate record of the meeting.*

Matters arising

In response to a query, B Reilly confirmed that she had offered to escalate concerns about the experience of resident doctors in the south, if that was required [para 229 (3) refers].

05. BOARD ACTION LOG

Action 171 (1) [review of BAF risks]: B Murphy advised that Executive Risk Group had agreed that the risks related to quality of care and quality governance would be restated and P Bellas indicated that changes would be presented to Board in June 2026.

Action 183 (4) [leadership walkabouts]: A Smith proposed that the action owner be amended to S Dexter-Smith and linked to an action raised at Council of Governors.

Action 224 (7) [pay gaps report]: S Dexter-Smith confirmed that she had provided a detailed written response by email to the Board and proposed the action be closed.

Action 233 [communications with Governors]: In response to a query, A Smith confirmed that communications with Governors were under review and proposed to confirm to J Preston following the meeting the timeline for a report to Council of Governors.

A Smith proposed that the action log be updated for future meetings to provide a progress update on those actions due for completion at a later date. **Action: action owners**

Agreed: *that the updates to the action log are noted and actions proposed as complete are closed.*

06. CHAIR'S REPORT

The Chair advised that her report to future meetings would highlight those matters included on the private Board agenda. Other matters would be reported via the Chief Executive's report.

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

No questions were received from Governors for the meeting.

B Reilly noted that she had previously raised a concern about the short timescale to respond to detailed questions and the significant burden this placed on executive directors.

In response, P Bellas advised that there was no legal requirement to allow questions from the public at a Board meeting. The purpose was to allow governors the opportunity to ask questions related to matters on the agenda and the timescale was linked to the publication of Board papers. If the ability to ask questions was extended beyond this, an alternative timeline may be determined.

The Chair indicated that in future, the agenda item would be questions from the public and questions from Governors would be raised through the Council of Governors

08. 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.

In discussion:

1. Board acknowledged the significant work undertaken to strengthen the BAF and improve clarity.
2. A query was raised about a disconnect between the substantial level of assurance for quality risks outlined in the BAF and the assurances included in the Integrated Performance Report (IPR) and other documents on the agenda.

   B Murphy acknowledged the point raised and noted that Board had agreed to restate the two quality risks to provide greater clarity.

P Bellas then explained that the reports provided different but complementary forms of assurance. The BAF focused on assurance over key controls that supported the management of strategic risks, while the performance report provided assurance on progress to achieve the intended outcomes and targets, with performance information a key indicator of the effectiveness of controls. He noted it was important to ensure controls related to strategic risks were correct, that variations in performance were underwood and within agreed tolerances, and that assurance ratings were robustly evidenced.

J Preston confirmed he was assured by the response provided and would be further assured when the information was able to be fully triangulated.

3. It was noted that the Board had previously discussed the potential to place greater emphasis on outcomes assurance rather than process assurance, and reference was made to the focus on outcomes included in the BAF developed by Co Durham and Darlington FT.

4. A query was raised about the timeline for previously agreed amendments to the BAF and A Smith confirmed that strategic risks would be reviewed by Executive Directors Group and a report would be considered by Board in June 2026.

5. A query was raised about the identification of strategic annual objectives to support delivery of the Trust's vision and key goals, with risks to delivery reflected in the BAF.

J Maddison concurred that the Board had previously discussed the need for clear annual objectives and alignment between strategic and corporate risks. By way of example, he noted a potential disconnect between BAF risk 1 [safe staffing], which carried a risk score of 20, and the Corporate Risk Register (CRR), which included one related risk at a score of 12.

The Chair indicated that organisations would usually have annual strategic objectives linked to the BAF and the Corporate Risk Register and that the Trust's current position was less clearly defined. She proposed that further work be undertaken by executive directors to identify objectives, as the Trust entered a new financial year.

Action: A Smith

A Smith also proposed that executive directors consider whether existing processes provided sufficient intelligence to support effective triangulation of data and if the BAF enabled to the Board to see all necessary assurances. She noted that risks were mitigated through operational delivery and whilst the BAF and CRR remained distinct, they were interdependent and she welcomed the guidance provided by P Bellas.

Action: A Smith

P Bellas confirmed the Board had previously discussed the need for annual objectives and outcomes-based assurance. He confirmed that this would be addressed once annual objectives had been established, as their absence limited the ability to articulate outcomes.

K Ellis added that objectives would be developed through work undertaken on the medium-term and Integrated Performance Report, as part of a clear governance framework.

6. The Chair outlined how strategic and operational objectives would flow through the organisation, to inform executive, non-executive and committee objectives and

associated outcomes. She acknowledged that, whilst an overall framework was in place, it was important to articulate it clearly, as clarity and consistency would demonstrate that the Trust was well-led.

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

09. CHIEF EXECUTIVE'S REPORT

A Smith presented the report, which briefed the Board on important topical issues that were of concern to the Chief Executive. She noted:

- The significant efforts of staff over the winter period to keep patients safe, maintain effective bed flow and to ensure patients were cared for in the right place.
- The Trust was cognisant of the impact of recent challenges related to fuel costs and availability and internal processes were in place to consider options, should he position worsen.

In discussion:

1. A Smith confirmed that reference to IPQR related to the development of the Integrated Quality Performance Report and the first draft would be presented to Board in June 2026.

2. Assurance was sought on the data that underpinned the Integrated Performance Report, as several data quality issues had been highlighted at Quality Assurance Committee, and A Smith proposed to discuss in detail following the Board meeting.
Action: A Smith

3. K Kale provided an update on the impact of industrial action by resident doctors and confirmed that all services had managed well. Some staff had been redeployed to inpatient services; however, attendance had been higher than anticipated and where doctors had attended work, their clinics had continued as planned. All out-of-hours on-call shifts had been covered and cover for the weekend would be in place within the next two days.

   A Smith thanked K Kale for his leadership and support to medical staff and the focus on continued planning, which enabled a positive update to be provided to Board.

Agreed: *the report is received and noted.*

10. MEDIUM TERM PLAN

K Ellis introduced the report, which provided assurance to the Board following submission of the Trust's Medium Term Plan (MTP) and associated Medium Term Financial Plan to NHS England in February 2025, set out the Trust's transition from planning into delivery and provided summary level financial plan details against which performance would be monitored by the Board.

L Romaniak provided an update on the Humber and North Yorkshire position. She reminded Board of the significant financial challenges faced by colleagues in those systems in 2025/26 and 2026/27 and welcomed the constructive engagement of the Integrated Care Board's (ICB) Chief Financial Officer, which had resulted in a more favourable contract outcome than anticipated. This included a 1% uplift in 2026/27 to support bottom line pressures and bracketed risk and risk share with commissioners, related to commissioning responsibility on

the contract, that would otherwise be open ended in relation to adult learning disability admissions and related staffing and a small number of complex packages of care.

In discussion:

1. The Chair queried the timeline for assessment of delivery of the 2025/26 strategic and operational objectives and development of objectives for 2026/27.

   L Romaniak confirmed that the Trust measured progress against financial breakeven, compliance and national indicators, such as NHS business rules and the mental health performance trajectory.

   K Ellis noted that Trust defined year one objectives were set out in the MTP and the transformation programme had been scrutinised by Resources and Planning Committee and considered by Board in a series of workshops over the previous six-month period.

2. Chair emphasised that, as the Trust moved into 2025/26 following submission of the plan and confirmed compliance, there should be an assessment of the delivery of 2025/26 strategic and operational objectives and, by June, clarity on objectives for 2026/27 and agreement on related committee, executive and non-executive objectives, to support meaningful outcome-based performance monitoring.

   A Smith confirmed that executive objectives would reflect the MTP and wider strategic challenges, which would be discussed by the Board in June 2026. She noted there had been a delay in sequencing due to in-year challenges linked to the national timeline for the MTP and delivery of additional requests from the centre and suggested that 2026/27 would operate as a transition year.

   The Chair accepted the need for transitional arrangements and noted that some elements, such as individual objectives, should still be progressed in May.

   S Dexter-Smith advised that non-executive directors typically had oversight of executive objectives through the Nomination and Remuneration Committee, where objectives were brought together through the appraisal process to provide a coherent narrative. She acknowledged that this had not been as expected this year, due to recent senior leadership changes, and provided assurance that must-do requirements had been reflected in executive objectives over the preceding six months.

   The Chair discussed how objectives would be set at Board level and reflected in committee, non-executive and executive director aligned objectives. Assurance on delivery would be triangulated through committee reports, which would provide line of sight from committees to Board and allow Board to triangulate related evidence.

3. J Maddison observed that, whilst objectives were implicit in the MTP, non-financial objectives had been less clearly defined than financial objectives, which continued to be explicit and measurable.

   The Chair concurred and proposed that, while financial objectives were subject to strong governance and management, greater clarify was needed on non-financial objectives, which included patient safety objectives and related objectives for Quality Assurance Committee.

4. B Murphy highlighted recent developmental work by Quality Assurance Committee, where committee had identified priority areas that would make a meaningful difference

to patient experience and safety. Four priority areas had been identified, subject to Board approval, which included the experience and safety of those while waiting to access services.

5. The Chair indicated that a key objective for the Board was the establishment of a clear Trust-wide accountability framework. She emphasised the importance of alignment between Board objectives, committees, executives and non-executives and staff to ensure there was shared ownership of the Trust's strategic objectives at all levels. It was acknowledged that this would take time to embed and, if achieved, would support an organisation's progression from good to outstanding.

6. N Adetuberu highlighted the importance of a clear golden thread between strategic objectives, risks to delivery and committee oversight. She proposed that the four themes proposed for the Quality Assurance Committee workplan be reviewed to ensure that they were aligned to quality-related strategic objectives.

   B Reilly noted that the proposed workplan for Quality Assurance Committee would be considered by the Board in June 2026.

7. The Chair queried the assurance levels used in the Board reports and noted that reports did not consistently specify which committee had previously reviewed the report or the nature of the assurance provided.

   L Romaniak explained that assurance ratings were based on the internal audit assurance model. She advised that the paper under discussion had been considered by Resources and Planning Committee, which had confirmed good assurance regarding processes and reasonable assurance in relation to the development of the detailed plan.

   J Maddison added that assurance ratings were informed by the NHS England framework, and used criteria such as maturing and embedded, and confirmed that Resources and Planning Committee had used this framework to form its assurance judgement. He also highlighted that assurance definitions had been included with the Board papers.

   N Adetuberu welcomed the explanation provided and observed that individual Board members may interpret terms such as good assurance differently, where the underlying criteria was not clearly defined.

   A Smith invited Board to consider if it was content to rely on assurance ratings provided by committees, whether further definition and shared understanding was required at Board level, or whether the Board wished to apply additional check and challenge to committee-provided assurance.

   In response, the Chair noted that the cover reports did not provide Board with a sufficient level of information on prior consideration and proposed the template be reviewed and revised.

   Action: A Smith

   S Dexter-Smith referenced work undertaken with the Company Secretary to provide additional guidance on the completion of the report template and use of assurance levels and P Bellas confirmed that the report template included reference to prior committee discussions, which had been omitted from this report.

Agreed: *that Board -*

i. Notes NHS England's confirmation that the Trust's Medium Term Plan submission is compliant on headline requirements.
ii. Notes 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.
iii. Confirms there is good assurance on the governance and process underpinning development and approval of the Medium Term Plan.
iv. Takes reasonable assurance at this stage on progress in transitioning from planning into delivery, recognising remaining dependencies and early stage delivery maturity.
v. Notes that a further update will be brought to Board in June 2026, focusing on delivery governance, making progress against maturing assurance areas, and updated risk and dependency management.

11. INTEGRATED PERFORMANCE REPORT

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

She drew attention to:
- The marginal improvement in performance assurance during the period, with 24 measures assessed as good or substantial. Mandatory and statutory training, clinically ready for discharge and sickness absence continued to be subject to oversight by executive and Board committees, with actions agreed to address performance.
- An update to the NHS Oversight Framework data for quarter 3 and noted that, whilst the Trust had moved from 19 to 24, it remained at an improved segment 2 rating. The Trust was engaged with NHS England on the development of mental health metrics for the coming year and expected a broader set of provider and system-level measures.

N Lonergan commented on operational delivery challenges in relation to:
- Patients clinically ready for discharge and the related paper included on the Board agenda.
- Continued access challenges within neurodevelopmental pathways where, despite some evidence of special-cause improvement due to operational efficiencies and transformation activity, there remained broader strategic challenges related to demand and capacity. The Trust continued to work with the Integrated Care Board (ICB) and had developed a joint protocol with Cumbria, Northumberland, Tyne and Wear NHS FT.
- Performance within the clinical and young people's eating disorders service, which remained below standard. Each breach was subject to scrutiny and a further deep dive would be undertaken to inform a targeted quality improvement approach.
- Early signs of improvement for adult waiting times, particularly in North Yorkshire, due to the impact of community hubs and transformation activity, with performance trajectories expected to continue to improve over the coming months.

In discussion:

1. B Murphy welcomed the level of compliance with statutory and mandatory training at 85% and stressed that continued focus was required on areas of non-compliance and the associated risks. She advised that work was underway to understand the underlying causes of non-compliance, with feedback to be reported to Quality Assurance Committee.

H Crawford outlined work in progress to ensure effective use of training headroom and noted that a planned session would take place in June to consider how training headroom could be protected to ensure staff had time to complete mandatory and statutory training requirements.

2. B Murphy reported that the Safer Staffing Group had identified agency usage within HMP services as a specific area of focus. She noted that Executive Directors Group had recognised the inherent delays associated with recruitment into prison settings and that an alternative approach may be required to reduce reliance on agency staffing.

3. B Murphy highlighted the risks and impact on experience for patients who were clinically ready for discharge and advised that the North East North Cumbria Integrated Care Board Quality Management Group had agreed that this would be an area of focus for future meetings.

4. S Dexter-Smith acknowledged that sickness absence levels remained high and were consistent with those reported by other Trusts in the region. She noted that feedback from the regional health and wellbeing hub strengthened assurance as it included intelligence related to non-work related absence, which would inform further areas to explore, for example earlier intervention by the long-term sickness team.

5. A concern was raised about the impact of sickness absence at Bankfields at 10% and S Dexter-Smith acknowledged the specific challenges that affected that service. She noted variation in short- and long-term sickness absence across Trust services and that not all sickness absence was work related. She further advised that, although significant support arrangements were in place for staff, these had not delivered the intended impact and some interventions had therefore been stood down while further analysis took place. Director panels continued to review the local impact and consider alternative options.

6. K Kale noted that, whilst medical agency usage continued to breach the price cap, there had been a significant reduction in agency expenditure over the previous three years. He advised that objectives for Care Group Medical Directors included a target to achieve a further 30% reduction by the end of 2026/27.

   In relation to clinical outcomes, he provided assurance there had been a gradual improvement over the previous two years and that performance remained on a positive trajectory, whilst further work continued. The position had been reported to the most recent Quality Assurance Committee.

7. A concern was raised about the quality and reliability of data and whether current data was sufficiently robust to support effective decision-making.

8. A concern was raised about the level of agency usage in HMP services in the context of reported deaths in custody and it was noted that Quality Assurance Committee had requested additional quality information.

   N Lonergan acknowledged that the percentage of agency staffing in HMP services was high and explained that this reflected challenges within two specific prisons. She advised that, while recruitment had taken place, progress had been delayed by prison security clearance requirements. She provided assurance that robust mitigations were in place for agency staff, who were supported in line with Trust processes and received

induction, training, supervision and clinical oversight through Modern Matrons and Associate Directors of Nursing, and that there was good operational oversight of these arrangements.

The Chair proposed that the Board maintain oversight of the position.

9. Board queried the absence of a response from the HNY MHLDA Collaborative Executive to the recommended redesign of autism and ADHD services, submitted in August 2025.

   A Smith advised that the Trust was well represented in relevant system-level discussions and reported that both Integrated Care Boards had set out commissioning intentions to address challenges over the coming year. Tangible progress had been made in the North East North Cumbria system, in partnership with CNTW, to review waiting lists and implement clinical pathways. In Humber and North Yorkshire there was provider-level agreement that a different approach was required, and discussions had taken place on financial allocations.

   She acknowledged variation in the pace of progress across system and provided assurance that there was a shared commitment to resolve the issues. She expressed confidence that a resolution would be achieved in NENC in 2026/27, which offered an opportunity to test the approach prior to wider implementation and undertook to keep Board updated as proposals developed.

   In response to a query, she confirmed that block contracts remained in place.

10. Caution was expressed about the ability to determine performance assurance or reassurance where the underlying methodology and sample size were not always clear and where assurance was, in some cases, based on relatively small sample sizes.

11. In response to feedback received from leadership walkabouts, Board queried whether the Vacancy Control Board operated a process similar to that of the Quality Equality Impact Assessment process.

    L Romaniak advised that, whilst there could be a delay while proposals were considered by the panel, a break glass process was in place where a vacancy related to a clinical or safety issue.

12. Clarification was sought on the reported negative controls assurance ratings for use of resources and cash balances. L Romaniak explained that the ratings rated to the underlying resources metrics and the longer-term position of BAF risks. She advised that the position reflected current challenges with price-cap compliance and reliance on higher-cost agency, alongside the broader strategic outlook on liquidity and cash, linked to capital constraints and organisational sustainability. She noted the quarter 4 refresh of the BAF was expected to demonstrate that a tighter capital regime was likely to result in a strengthened cash position, albeit counter-intuitively.

13. Board queried the reported average waiting times for adult and children and young people, where data included a small number of patients recorded as waiting over one or two years. In response, N Lonergan explained that, when reviewed on an individual basis, those cases were typically attributable to data quality issues or to patients recorded on alternative pathways. She added that while work had been undertaken to

address data quality issues within neurodevelopmental services, challenges remained and confirmed that such patients were routinely excluded from the reported data.

14. Board proposed that the actions within the IPR related to the workforce be presented more clearly to distinguish between actions that were complete, in progress or no longer taken forward, and that status descriptions be updated to demonstrate whether actions had led to a material improvement. In response, K Ellis advised that the revised version of the IPR would provide this clarity.

15. The Chair welcomed the new report format, noting that the current report was retrospective and did not include heat maps or forward-looking information, such as forecast trajectories, to support executive accountability and provide an early warning system. She also emphasised the importance of clear analysis and interpretation for both executive and non-executive directors.

    She went on to highlight that the Trust was ranked 24th nationally out of 61 and placed within segment 2 of the National Oversight Framework, which indicated strong overall performance. She noted this reflected the collective contribution of staff and demonstrated effective leadership and financial management, and she congratulated the executive directors on this achievement.

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.*
- *iv. Appropriate and effective management of risks to delivery.*

12. CORPORATE RISK REGISTER

B Murphy presented the report, which provided assurance on the management of risk and oversight of organisational wide risks rated as high risk in the Corporate Risk Register (CRR).

In discussion:

1. Board noted the report highlighted a risk with a target date of September 2025, despite a subsequent risk review and identified further risks with target dates of 31 March 2026 where no commentary had been provided on the likelihood that the target would be achieved. Board queried whether this affected the level of assurance.

   In response, B Murphy explained that target dates were not revised where slippage had occurred, to ensure visibility to the Board and committees. She acknowledged that the inclusion of information on trajectory and likelihood would be helpful and advised this would be considered for the next iteration of the report.

   A Smith suggested that greater clarity on trajectories to target, alongside improved alignment between the timing of risk reviews and reporting to Executive Risk Group, committees and Board would strengthen assurance.

   J Maddison supported the points raised and cited the example of delayed discharges [risk 1529] where triangulation with the report on the Board agenda did not indicate the

target date would be met. He acknowledged the progress made to develop the report and proposed that the issues raised would support further refinement.

2. A query was raised about the rationale for the reduction in risk score from 15 to 12 for the risk related to the CAMHS neurodevelopmental pathway [risk 1219]. In response, N Lonergan advised that the reduction reflected improvements in overall waiting times and continued delivery against the trajectory agreed with the ICB.

3. A Smith confirmed that the CRR was reviewed by executives on a monthly basis.

4. Board queried how the number and nature of risks on the CRR compared with those of other Mental Health and Learning Disability Trusts. A Smith advised that most Trusts would hold similar risks, for example risks related to neurodevelopmental waiting lists and delayed transfers of care and proposed that benchmarking be undertaken and shared informally with the Board.

   Action: B Murphy

   L Romaniak also highlighted internal benchmarking undertaken through the bi-monthly Executive Risk Group, which reviewed active and static risks on the CRR, identified potential gaps, and undertook comparative analysis across care groups and services. She noted that the group also carried out thematic reviews of risk type and grading and moderated risks to support a consistent understanding of risk and the appropriate response.

5. K Kale advised that, although there had been an intention to reduce the rating for risk 909 [consultant recruitment in North Yorkshire], subsequent staff departures had meant the risk had been retained at a score of 12. He acknowledged that related discussions at Executive Risk Group and Quality Assurance Committee had not been reflected in the report.

6. B Reilly advised that the CRR had been reviewed by Quality Assurance Committee the previous week and expressed concern about the volume of information included. She noted that future reports would place greater emphasis on static risks.

   The Chair reflected, that while the report was detailed and helpful for executive directors, it was overly detailed for Board consideration and more suited to committee level scrutiny. She proposed that the Board focus on assurance and risk movement, with detailed analysis reported through the 3A report from each committee. She further proposed that future Board meetings alternate between risk and assurance focused discussions and performance focused discussions, as to cover both at each meeting limited the depth of meaningful debate.

Agreed: *Board takes 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 risks.*

13. REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee (QAC), presented the report and summarised the key areas of discussion at the committee meetings held on 5 March 2026 and 2 April 2026.

She drew attention to:

- The significant level of positive assurance reported through Executive Directors Group.

- Continued quality concerns related to Harrogate and Ripon Adult Mental Health Services, where the position remained unchanged over several months.
- An increase in sexual safety incidents within North Yorkshire and York Mental Health Services for Older People related to a single service user, where committee had received an explanation of the underlying drivers and assurance that the issues were appropriately managed.
- An increase in restrictive interventions during March and April 2026, largely attributed to a single service user within Adult Learning Disability Services and that supporting narrative indicated there were no broader concerns.
- Consideration of a paper on Positive Individual Proactive Support Ltd, which generated further questions and follow-up work with the ICB on the role of the commissioner.
- An exception report related to Bankfields, which highlighted increased sickness levels and RIDDOR-reportable incidents, linked to the admission of a patient from an independent sector assessment and treatment unit.
- Receipt of a Regulation 28 notice in relation to a death of a patient whilst on leave.
- A recent positive visit by a number of Coroners and their staff to Roseberry Park Hospital.
- A well-received paper on clinical outcomes that demonstrated positive progress over the past year.

Given the earlier circulation of Board papers, a written report from most recent committee meeting would be provided to the next Board meeting.

In discussion:

1. N Adetuberu advised that committee had been informed of a CQC whistleblowing concern related to patient and staff safety at Bankfields following the RIDDOR-reportable incident. She noted this may link to the CQC improvement plan and the outstanding action related to implementation of the harm-minimisation policy, and that committee had asked executive directors to consider a revised target date for completion.

   She also acknowledged the significant improvements made at Bankfields and highlighted that the Trust had requested a CQC inspection, which was expected in quarter 1 2026/27.

   B Murphy stated that the Trust was very proud of work undertaken at Bankfields and the improvements delivered by staff. She explained that the service supported a small number of individuals whose needs were particularly complex and that transitions from assessment and treatment units into a new environment would be destabilising. This had been reflected in the incident profile, where recent changes had been observed.

   For transparency, she noted that whistleblowing incidents were routinely reported to the CQC and this issue had been highlighted to committee in the context of the historic position at Bankfields. She advised that the matter had been considered alongside a wider range of data and invited Board to note the position, particularly given the focus on restrictive interventions and welcomed continued scrutiny of the service. She added that, if Bankfields data was excluded from the Trust-wide position, the Trust would be amongst the lowest users of restrictive interventions nationally.

   In response to a query, she clarified that there were a limited number of assessment and treatment units nationally for those with a learning disability and/or autism who required a period of intensive assessment prior to treatment.

A Smith proposed that staff at Bankfields be invited to a future Board meeting, either to discuss the service or to present a patient story. While she acknowledged the need for continued oversight and scrutiny, she reflected that the service was exceptional and noted that, in many other parts of the country, patients would remain in their existing environments and would not be successfully supported to return to the community.

2. S Dexter-Smith explained how People and Culture Directorate worked closely with small specialist services, such as Bankfields and also advised that where concerns were identified, visits by the Freedom to Speak up Guardian would be undertaken.

3. The Chair queried why the Trust had not adopted a zero-tolerance approach to prone restraint. B Murphy agreed that its use was considered unacceptable and noted that this position had been supported by Quality Assurance Committee. She advised that prone restraint was used only in very limited circumstances and that staff had received training on alternative approaches, with future data expected to demonstrate the impact.

   K Kale added that the Trust had maintained a period of zero use of prone restraint for a sustained period and that the incidents reported were recent occurrences. B Murphy provided assurance that all incidents of prone restraint were fully investigated and that appropriate action was taken in response.

   The Chair emphasised the importance of clear communications on the Trust's position and invited committee to consider the matter further.

ACTION: B Reilly/B Murphy

14. CLINICALLY READY FOR DISCHARGE

N Lonergan presented the report, which proposed a Trust wide 12 month operational and strategic programme to reduce delays and strengthen the safety, quality and experience of inpatient care within the scope of acute Adult Mental Health Services, Mental Health Services for Older People, Rehabilitation and Learning Disability and Autism services.

In discussion:

1. A query was raised on how the Trust would maintain focus on patients clinically ready for discharge, while it continued to operate productively and efficiently, addressing service variation and sustaining reductions in length of stay for those able to be discharged.

   In response, N Lonergan referred to a recent sustainability workshop on delivery of the Medium Term Plan and transformation programme, which focused on the development of alternatives to admission and improved access models. She advised there was robust daily operational grip on patient flow and confirmed that a minimal out-of-area placement position had been sustained.

2. It was proposed that the paper did not clearly set out the respective responsibilities of partners or the impact of their actions. In response, A Smith advised that, while the Trust's formal levers were limited, she had received positive feedback from local authorities on shared responsibilities and would continue to build on trusted professional relationships. She explained that the Trust had initially focused on a consistent internal approach, as a foundation from which greater consistency could reasonably be expected from partners.

3. L Romaniak reported that patient flow had been maintained, with over 125 internal beds created from the Trust's total adult and older adult bed base of 370. She acknowledged the significant clinical achievement that, even when clinically ready for discharge patients were included, the Trust benchmarked 4th best nationally for adult services and 10th best nationally for older adult services.

4. K Ellis added that inpatient quality transformation was a key priority for the Integrated Care Boards and noted that discussions through their Mental Health and Learning Disability Sub-Group would provide visibility of partner actions. She also highlighted the intention to strengthen the granularity of data within the Integrated Performance Report, to support more focused and informed system-level discussions.

5. B Murphy noted that, while the report referenced harm to patients, it did not articulate the nature of that harm and proposed that explicit articulation would be important to demonstrate impact and secure system-wide engagement. N Adetuberu also suggested that the report reference the additional patient outcomes the Trust sought to achieve.

   N Lonergan acknowledged the points raised and advised that the Care Group Board had received a report on harm within adult mental health services, which would be extended to all specialties. K Kale added that the Integrated Care Board had requested the Trust to consider how harm would be assessed and evidenced, to support feedback and drive system-level change.

6. K Kale noted the limitations of the NOF length of stay metric, where the appropriate discharge of patients could adversely impact reported performance. The Chair agreed that the metric did not incentivise timely discharge and noted that it was expected to be revised.

7. A query was raised about the incentives available to encourage partners to respond to the challenges, which had persisted for some time.

   In response, A Smith reflected on the changed system landscape and noted that the Trust would need to work closely with the ICB, to ensure challenges were understood and commissioned services delivered a positive impact. She also highlighted the importance of engagement with regional performance oversight arrangements to clarify underlying pressures and their implications for sustained strong performance. She further noted the potential consequences of poor bed flow, which included the risk of increased use of out-of-area placements, higher costs and a deterioration in quality of care and patient and family experience.

8. The Chair highlighted an opportunity for the Board to take a strategic view of the Trust's future role and operating model, which included whether it should move towards a lead or place-based commissioning role, a health-managed organisation or enhanced Foundation Trust status. She noted this could provide greater control over commissioning resources, facilitate a shift towards community-based care and improve pathways into the most appropriate settings. She also advised that this required the establishment of a Commissioning Committee, independent of the Board.

9. K Ellis noted that discussions with local authority partners had recognised a shared quality and financial challenge in the provision of appropriate support and highlighted the potential for creative and collaborative commissioning solutions where there was mutual benefit.

10. L Romaniak advised that the Trust had used a number of national forums to challenge and explain anomalies in national productivity metrics, particularly to distinguish between provider performance and wider system-level issues. She also noted a recent mental health productivity visit to the Trust by NHS England's Productivity and Efficiency Team and that a national meeting attended by NHS England's Chief Executive and Director of Finance had provided an opportunity for her to highlight specific challenges within mental health services, which included issues related to the clinically ready for discharge metric emerging post-covid and opportunities for Better Care Fund allocation.

11. Responding to a query, N Lonergan advised the Trust did not have a system that was able to provide real-time performance information, due to limitations in digital capability. The Chair recognised a system was important to support effective operational leadership oversight and proposed that it be given consideration.

12. L Romaniak advised that the reported estimated £19m cost related to bed days for all clinically optimised individuals in inpatient care. The Chair emphasised the importance of avoiding in appropriate occupancy of inpatient beds and proposed that there may be future circumstances where the Trust may wish to recharge associated costs if bed flow challenges impacted on patient care, safety and experience and led to out of area placements.

Agreed: *Board –*

i. Endorses the phased delivery plan.
ii. Notes clinically ready for discharge as a shared system risk.
iii. Supports standardisation of discharge practice.
iv. Notes that operational delivery and oversight will be integrated into the Inpatient Quality Transformation Programme, Care Group Board and Executive Directors Group.
v. Agrees that trajectories will follow quarter 1 baseline work.
vi. Notes that the identified risks, dependencies and digital constraints (including the timing of future Electronic Patient Record functionality).

15. PATIENT AND CARER RACE EQUALITY FRAMEWORK

K Kale presented the report, which provided assurance that the Trust continued to meet its obligations under the Patient Carer Equality Framework (PCREF) for data collection and publication. He highlighted the level of staff engagement and noted the intention to align future PCREF and EDI reporting into a single annual reporting cycle from September 2026.

He cautioned against over-interpretation of the data as ethnicity was not recorded for approximately one third of patients. He also highlighted an increase in use of the other ethnicity category due to reporting challenges and the reluctance of some patients to disclose their ethnicity. Ethnicity was also unknown in 45.3% of restrictive intervention cases.

He went on to highlight that:

- Black people were twice as likely as white people to be detained; compared with four times nationally.
- Black women were disproportionally more likely to be detained than men.
- Access to services by ethnically racialised communities was poor overall.
- Hospital admission rates were higher across all ethnicities when compared with white people.

He proposed the Trust should continue to focus on its direction of travel, to better understand the reported position and to strengthen engagement with underserved communities.

He also advised that Quality Assurance Committee had considered the report and proposed minor amendments prior to publication.

In discussion:

1. J Preston advised that previous consideration by Mental Health Legislation Committee had provided assurance that all detentions were appropriate and emphasised that attention should be directed towards addressing wider health inequalities, which included the impact of social factors such as housing and deprivation.

2. B Murphy proposed that clinical executives consider women's experience within services, which included length of stay, use of restrictive interventions, rapid tranquilisation and seclusion, as areas within the Trust's control. She also welcomed the opportunity for stronger engagement between the Trust and community and representative groups, to better understand and respond to the experiences of racialised communities and to adapt services in order to improve access.

   H Crawford noted a link worker in Middlesbrough worked with communities and the community and voluntary sector to understand experiences of access to services. She also advised that work was underway to improve understanding of data related to women's experience of services and how that could be used to inform service improvements.

3. B Murphy noted that use of mechanical restraint related almost exclusively to Ministry of Justice requirements, where alternative practice was not permissible.

4. A Smith suggested that awareness and understanding of PCREF may not be consistent across the Trust and proposed that future reports include actions taken to improve awareness, to reinforce the importance of the data and support more complete recording.

5. The Chair observed that the level of data captured was low and suggested this may reflect wider cultural or contextual factors.

   S Dexter-Smith advised that a similar position was evident in staff data and noted that the wider community context included historical community unrest. She also provided reassurance that, while PCREF was led by the Executive Medical Director, there was close working with the EDI function and dedicated support had been identified to strengthen data collection and support strategic engagement.

6. The Board noted that data recording at the Trust was 64%, compared with the national average of 75% and queried when national levels were expected to be achieved. It was also observed that data quality had been a recurring theme across Board papers and at Quality Assurance Committee, and the Board queried whether there were actions it could take to support an improvement.

   H Crawford acknowledged there were several contributory factors to the current level of data quality, which included the cultural competency of staff to feel confident to ask questions, work required with patients to support confidence that it was safe to disclose their ethnicity, and limitations in the functionality of the current Electronic Patient Record system (EPR), which would be addressed in the new EPR.

She also noted that a range of awareness raising activity was underway and advised that the paper was intended as an interim report and would be aligned to other reporting cycles to support comparison across health inequalities and related indicators.

Agreed: *Board -*

i. *Confirms that it has reasonable assurance that the Trust has followed a robust process in producing and analysing the quantitative data required for PCREF.*
ii. *Approves the proposed publication of the PCREF, prior to publication on the Trust website.*

16. REGISTER OF SEALING

Board received and noted the report, which advised the Board of the use of the Trust's seal, in accordance with Standing order 15.2.

17. 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 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.*

The meeting concluded at 12.50pm.

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Board of Directors
Public Action Log

RAG Ratings:

Colour	Meaning
Green	Action completed
Amber	Action due/Matter due for consideration at the meeting.
Pink	Action outstanding but no timescale set by the Board.
Red	Action outstanding and the timescale set by the Board having passed.
Grey	Action superseded
Peach	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	**Action Closed**	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)). **Apr26: Board received and endorsed the phased delivery plan**
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**	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. Executive Risk Group has agreed that the risks should be restated and Board will receive a report in June 2026 **June update: for discussion at the meeting (see confidential agenda, item 14) - propose that the action be subsequently closed.**
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.	M Burnham	Mar-26	**Action Closed**	**Apr26: interim arrangements approved - action closed.**
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	**Propose action is closed**	**June-26 update: N Lonergan and H Crawford propose closing the action on the basis that understanding community resources and opportunities, and the therapies establishment and demand is a longer term piece of work. We will address and report on this through the productivity workstream, and work we're leading on nationally regarding AHP job planning.**
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	**Propose action is closed**	April update: meeting arranged for 23-Apr-26 **June update: the meeting has taken place and plans are being progressed within the executive restructure. Proposed that the action be closed.**
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	**Propose action is closed**	**Propose that the action be closed and monitored through Quality Assurance Committee**
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	S Dexter-Smith	~~Jun-26~~ **August-26**		Feb26: Action owner amended to S Dexter-Smith. Action to be linked to an action raised at Council of Governors. **Jun26: Revised completion date of August-26 to reflect the link to engagement with governors.**

Board of Directors
Public Action Log

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Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
12/02/2026	221 (1)	Independent Quality Review	Timescales for the independent quality review to be confirmed and progress to be overseen by Quality Assurance Committee	A Smith	~~Jun-26~~ Jul-26		B Murphy to provide a progress report to Board in June 2026. **June update: the proposed terms of reference to be shared with Quality Assurance Committee in July 2026**
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 Dexter-Smith	~~Jun-26~~ **Sept-26**		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. S Dexter-Smith to confirm to J Preston the timeline for a report to Council of Governors **Jun26 update: Report to be provided to Council of Governors at the meeting on 30 Sept 26**
09/04/2026	**5**	**Action Log**	**All action owners to provide progress updates on actions due for completion at a later date.**	**All action owners**	**Jun-26**	**Propose action is closed**	**June update: Actions updated - proose action closed**
09/04/2026	**8 (5)**	**Strategic Objectives**	**Strategic objectives to be developed for 2026/27**	**A Smith**	**Aug-26**		**June update: initial conversation took place in the Board development seminar in May 2026 and will be continued to identify Board agreed strategic objectives, aligned to the revsied strategy for the Trust.**
09/04/2026	**8 (5)**	**Triangulation of data**	**CEO proposed that executive directors consider whether existing processes provided sufficient intelligence to support effective triangulation of data and if the BAF enabled the Board to see all necessary assurances**	**K Ellis**	**Aug-26**		**June update: On the finalisation of the reviewed BAF, agreement on the data set availability both internally, regionally and nationally will be reviewed and shared with Board.**
09/04/2026	**9 (2)**	**Data quality**	**A Smith/K Ellis To investigate concerns about the quality of data that underpinned the IPR (as highlighted at Quality Assurance Committee)**	**A Smith K Ellis**	**Jun-26**	**Propose action is closed**	**June update: Review of Quality Assurance Committee (QAC) discussion referenced at April Board has taken place with the Executive lead for QAC. Concerns raised at April Board did not relate to the Integrated Performance Report, but rather systems reporting issues which have impacted particular measures reported via the Quality Dashboard and Ward/Team level Dashboard at QAC. Further work is scheduled to review and resolve these, with progress updates to QAC**
09/04/2026	**10 (7)**	**Report Template**	**CEO to review and revise the Trust's report template**	**A Smith**	**linked to governance improvement plan**	**Propose action is closed**	**June update: This action is included within the Governance Improvement Plan and will be progressed as the plan is progressed. CEO proposes to close the action as it will be included in the overarching plan oversight via Audit and Risk Committee and Board, as updates are provided.**
09/04/2026	**12 (4)**	**Corporate Risk Report**	**In response to a query on the number and nature of risks compared with other MHLD Trusts, benchmarking to be undertaken and shared informally with the Board**	**B Murphy**	**Jul-26**		**June update: this will be a manual process, we are considering a cross section of siminar sized Trusts. A briefing note will be shared with the Board member July 2026.**

Board of Directors
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Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
09/04/2026	**13 (3)**	**Prone restraint**	**Quality Assurance Committee to consider the Trust's approach to a zero-tolerance of prone restraint**	**B Murphy**	**Jun-26**	**Action Closed**	**June update: The annual Positive and Safe report was presented at June QAC, within this assurances were given to the approach to prone restraint and further improvement plans. Prone will continue to be reported into QAC and always noted in the triple A report to the Board, the Board will therefore have an opportunity to review the impact of the proposed interventions.**

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For General Release

Meeting of:	**Board of Directors**
Date:	**11th June 2026**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**N/A**
Report Author(s):	**Alison Smith, Chief Executive**

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

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

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

Strategic risks relating to this report:

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

EXECUTIVE SUMMARY:

Purpose: To brief the Board on a number of important current issues of relevance to the Chief Executive.

Proposal: For the Board to receive and note the contents of this report.

Overview: A range of current topics is presented to update the Board.

Prior Consideration and Feedback: N/A

Implications: No additional implications.

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

Registration of Therapists

Within TEWV, we have Psychological Practitioners in adult services, including Psychological Wellbeing Practitioners (PWPs) and Mental Health and Wellbeing Practitioners (MHWPs). We also have Psychological Practitioners in CAMHS, including Children's Wellbeing Practitioners (CWPs) and Educational Mental Health Practitioners (EMHPs). These practitioners are trained to deliver low-intensity interventions safely and effectively to support people experiencing anxiety and depression without other complicating co-morbidities. Staff delivering these interventions within TEWV are either qualified to do so or are undertaking appropriate training that will lead to qualification.

Over the last two years, Psychological Practitioner staff have been required to join a professional register. This register is overseen by the Professional Standards Authority, which provides a regulatory function equivalent to that of the NMC and HCPC. The relevant registers are held by the British Association for Behavioural and Cognitive Psychotherapies and the British Psychological Society. The registers for PWPs opened in 2021, and those for EMHPs and CWPs opened in April 2023. All of our PWP, EMHP and CWP staff are now registered. The MHWP register opened in June 2025, and all 29 of our MHWP staff have submitted applications. Around a third have received confirmation of registration to date. We are monitoring progress closely and are committed to continuing employment beyond the registration deadline where staff have submitted an application and are awaiting a response. Appropriate clinical oversight remains in place while registration is being confirmed.

Band 5 National Review

In February 2026, the Secretary of State for Health and Social Care set out a commitment to deliver a fairer deal for nursing, including ensuring that nurses are paid correctly for the work they are asked to do. The Secretary of State also confirmed an employer-led review of all Band 5 nursing roles employed directly by NHS trusts. This builds on existing job evaluation (JE) commitments agreed through the Agenda for Change (AfC) non-pay deal. On 2 June, we were informed of the requirement to submit a nursing Band 5 job evaluation delivery plan to the region for review by 31 July 2026. The plan must be realistic and deliverable, setting out how all Agenda for Change Band 5 nursing roles will be reviewed by October 2028. The Trust has already made significant progress in partnership with staff side through a job description standardisation project. Updated Band 5–7 nursing job descriptions, matched to the new nursing profiles, were implemented and issued to staff earlier in 2026. During this process, staff were given the opportunity to raise concerns, and no formal issues were identified in relation to roles and job descriptions.

The proposed approach to reviewing whether job descriptions accurately reflect the work staff are asked to do includes a structured process led by line managers, assessing each Band 5 nurse against the standardised job description and a Band 6 comparison checklist. Reviews will be discussed with staff, with clear escalation routes where there is disagreement. Where individuals are found to be undertaking Band 6 responsibilities, this may lead to consideration of regrading or further justification of duties. The plan sets out a phased implementation timeline, with the aim of completing this process by March 2027, well ahead of schedule.

The Online NHS Trust

The Online NHS Trust has been formally established, and its Chair appointed. From late 2027, NHS Online will give patients the choice to connect with clinicians across England, no matter where they are, providing faster care.

Find out more ➡️ https://onlinetrust.nhs.uk

Public Inquiry
The appointment of a Chair to the Public Inquiry is still awaited. We share the view of patients, families, staff and communities that appointing a Chair as soon as possible is essential so that the Inquiry can begin its important work. The Trust remains fully committed to supporting the Inquiry and ensuring it has all the information it needs to complete its work successfully.

NHS Modernisation Bill 2026 — structural reform
The 2026 King's Speech announced plans for an NHS Modernisation Bill. Key proposals include the abolition of NHS England, with functions pulled directly into the Department of Health and Social Care; reconfiguration of integrated care board duties; changes to the single patient record; and abolition of Healthwatch, replaced by a new DHSC patient voice function. ￼

The Health Bill had its second reading in the House of Commons on 1 June 2026 and has been committed to a Public Bill Committee concluding 16 July. Opposition raised concerns about loss of patient voice, centralisation of power, and risks around data security.

Introduction with the SoS
James Murray, the new Secretary of State for Health and Social Care, was appointed on 14 May 2026 following Wes Streeting's departure and met with all NHS Chief Executives on 2 June.

James Murray is the MP for Ealing North and has served since the 2019 General Election. After Labour's 2024 election victory, he was appointed Exchequer Secretary to the Treasury, then Chief Secretary to the Treasury following a 2025 reshuffle. He previously served as Deputy Mayor of London for Housing.

James Murray comes from a Treasury background rather than a health background. This experience may influence how he approaches the resourcing of Mental Health Act reform, which remains a significant concern given that the Spending Review committed no additional funding.

He immediately inherits the Health Bill, currently at committee stage, the rollout of the Mental Health Act 2025, and ongoing NHS restructuring. Importantly, James Murray remains committed to the 10-year plan and the three shifts, and has indicated a particular interest in technology.

2025 National NHS Staff Survey Results - Recognition
I am delighted to share that TEWV has received a Certificate of Recognition from Dr Ronke Akerele, Director of Staff Experience and Engagement at NHS England, following publication of the 2025 NHS Staff Survey results. These results show TEWV improving across all seven elements of the People Promise, as well as the themes of Staff Engagement and Morale. This is a significant achievement. This was the fifth year in which the NHS Staff Survey provided insight aligned to the People Promise framework. The framework offers a consistent and standardised way to measure staff experience, benchmark performance across NHS organisations, and support the shared ambition to improve the experience of working in the NHS for everyone.

Meeting our people and patients
I have been privileged to continue visiting many of our sites, teams, services, families and patients, in some cases more than once, and I have been warmly welcomed on every occasion. During these visits, I have seen empathy, compassion, genuine connection, and a real commitment to improving the care we provide. The skill, values-driven approach, person-centred care, and commitment to patients and families have been both humbling and inspiring, and I would like to thank everyone for their generosity and warmth as my familiarisation with the Trust continues.

For General Release

Meeting of:	Board of Directors
Date:	11 June 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 provide 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 4, 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 the controls effectiveness of the following risks has increased:
BAF 1 (Safe Staffing)
BAF 4 (Quality of Care)
BAF 10 (Regulatory Compliance)

(3) The controls effectiveness rating of BAF 3 (Cocreation) has deteriorated from good to reasonable.

(4) Only one risk, BAF 14 (Health Inequalities) has a limited controls effectiveness rating.

(5) 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
BAF 13 (Public Confidence) – 10 point difference

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

Prior Consideration and Feedback:
Not applicable to this report

Implications:
None relating to this report

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

Board Assurance Framework Summary

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
▪ 02 -Be a Great Employer ▪ 01 - Co-create High Quality Care	01 - Safe Staffing **Risk Description :** 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 **Date to achieve target :** 31 Dec 2025	People Culture and Diversity Committee **Executive Lead :** Director of People, Culture & Diversity	20	10	9	Good	31 Mar 2026			1.1 Knowing which staff we need and where **Object End Date :** not set	Daily operational processes in care groups and corporate services Monthly e-roster reviews and new dashboard re fill rates, roster rules level loading of leave Safe staffing reports re shifts over 13 hours, missing RN, missed breaks
										1.2 Ensuring that staff are recruited to and safely deployed to the right places **Object End Date :** not set	Rosters for inpatient services Daily management huddles/ staffing calls Daily safety huddles on wards Recruitment processes to ensure safe employment
										1.3 - Staff are appropriately trained to support people using our services **Object End Date :** not set	Recruitment processes ensure fundamental qualifications are in place. Trust welcome ensures basic introduction to the way we work Local induction Daily safety huddles on wards Increasing number of development JDs in place to ensure people are safely developed into more senior roles. Individual and manager compliance reports available weekly. Individual appraisals to ensure skills are maintained
										1.4 - Staff are supported to maintain their wellbeing, feel they belong and choose to stay and **Object End Date :** not set	Quarterly reviews and annual appraisals support staff Supervision – managerial and clinical OH provision Multiple H&W interventions including comprehensive support and psychological services – all with outcome measures reported to EDG Trust wide self assessments against violence reduction, sexual safety and H&WB EDI champions – grown in number and receive regular training to be effective allies Staff networks, Schwartz rounds enable stories to be told and concerns heard
										1.5 - Ensuring that local leaders and managers are equipped to lead and maintain safe staffing **Object End Date :** not set	Recruitment processes inc LE panel members Establishment and oversight of Leadership and Management Academy for all L&M training 3 year L&M programme Quarterly leadership and management events for service management level and above New people manager programme
										1.6 - Early understanding of when things go wrong (BAF 1) **Object End Date :** not set	Operational escalation processes Links from services to EDG Thinking about leaving interviews 'Working in TEWV' monthly online meetings

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
01 - Co-create High Quality Care	02 - Demand **Risk Description :** 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. **Date to achieve target :** 31 Mar 2026	Quality Assurance Committee **Executive Lead :** Managing Director	16	12	9	Reasonable	31 Mar 2026			2.1 Partnership Arrangements **Object End Date :** not set	Weekly operational interface meetings with Local Authority partners to support flow within inpatient services.
										2.2 Demand Modelling **Object End Date :** not set	Associate Director of Strategic Planning and Programmes – Lead for demand modelling in the Trust
										2.3 Operational Escalation **Object End Date :** not set	Inpatient wards – Management of admissions through PIPA process and the operational daily escalation calls. Bed Management Team – Responsible for the oversight and management of the use of beds On-call arrangements – Agreement of actions in response escalations. Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand Daily Lean Management Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services. Stop the Line arrangements for community services
										2.4 Integrated Performance Reporting **Object End Date :** not set	Operational delivery of performance standards by wards and teams Performance Department – Management of the IPR including validation of data, oversight of data quality and reporting to the various tiers of the governance structure
										2.5 Establishment Reviews **Object End Date :** not set	Safe Nursing Workforce Staffing Standards Team – Responsible for managing and delivering the establishment review process. This is based on: Acuity dependency assessments for each ward using the MHOST tool and professional judgements General Management reviews, including discussions with Matrons, on the ward assessments Assessments of a range of data including benchmarking, patient outcomes, staffing information e.g. use of temp staff and overtime Care Group Boards – Review the outcomes of the establishment reviews and development of proposals (included in the Establishment Review reports to the BoD) Finance Department – Reviews of affordability of the outcome of establishment reviews (Reports to the FSB/EDG)
										2.6 Strengthen voice of Lived Experience **Object End Date :** not set	Role of peer workers. Expanding opportunities of lived experience roles, including lived experience facilitators and senior lived experience roles/peers Service level service user and carer user groups Triangle of care Patient Experience reporting Understanding our complaints themes and impact on services. Patient Safety Partners – PSIRF Partnership with clinicals networks – cocreation of clinical care initiatives and models. Commissioning VCS lived in core services to meet identified needs.
01 - Co-create High Quality Care	03 - Co-Creation **Risk Description :** 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, which will result in fragmented approaches to involvement and a missed opportunity to fully achieve OJTC. **Date to achieve target :** 31 Dec 2025	Quality Assurance Committee **Executive Lead :** Director of Corporate Affairs & Involvement	8	4	9	Reasonable	31 Mar 2026			3.1 Co-creation Journey - Further develop the co-creation infrastructure **Object End Date :** not set	Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan Head of Co-creation Lived Experience Directors Involvement & Engagement (I&E) team Patient Experience team Peer Support team Clinical Leaders Service Managers

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
01 - Co-create High Quality Care	04 - Quality of Care **Risk Description :** 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. **Date to achieve target :** 01 Apr 2025	Quality Assurance Committee **Executive Lead :** Chief Nurse	9	9	9	Good	31 Mar 2026			4.1 Our Quality and Safety Strategic Journey **Object End Date :** not set	Chief Nurse – Responsible for the development of Our Quality and Safety Journey Workstreams and key performance indicators have been developed for each of the Journey's four priorities. The professional structure with the care groups have day to day oversight of the quality and safety of care. Integrated Performance Dashboard is utilised to identify variance in care delivery. Learning from serious incidents and near misses.
										4.2 Incident management policies and procedures **Object End Date :** not set	Chief Nurse Responsible for ensuring the systems for incident reporting, identification of patient safety issues and reporting appropriate incidents through correct procedures is in place. Clinical and operational Managers,, medical Staff, modern matrons - Responsible for the operational implementation of the policy and associated guidelines. MDT in teams ensure effective after action reviews.
										4.3 Governance arrangements at corporate, directorate and specialty levels **Object End Date :** not set	Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolios including: ? ERQ (CN)) – Responsibilities include oversight of Serious Untoward Incident/Never Event management processes and receive lessons learnt for sharing across the Trust as appropriate ? CGBs (Mgt Dirs) – Responsibilities include Oversight of the day to day management of an effective system of integrated governance, risk management and internal control across the whole Care Group's activities
										4.4 Performance Management of Serious Incident Review **Object End Date :** not set	Patient Safety Team - Responsible for ensuring all reportable serious incidents are reviewed within the agreed timescales following an internal governance process Daily patient safety huddles to review incidents of moderate harm and above to identify areas of immediate action and learning and support timely dissemination of information to mitigate risks Implementation of PSIRF Jan 24
										4.5 Organisational Learning Group (OLG) **Object End Date :** not set	PSIRF Policy PSIRF Implementation plan
										4.6 Friends and Family / Patient Experience Survey **Object End Date :** not set	Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements Head of Patient Experience Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
										4.7 Co-creation Journey - capture accurate patient experience data - Complaints **Object End Date :** not set	Chief Executive – Overall accountability for ensuring that the Complaints Policy meets the statutory requirements. Director of Corporate Affairs and Involvement – Responsible for the development, implementation and monitoring of the complaints policy Head of Patient Experience - Responsible for facilitating the effective reporting, investigation, and communication of all complaint activity Complaints Team Manager – Responsible for managing the complaints' function including the central database for complaints and producing statistical data. Trust Organisational Learning Group – triangulation between all sources of intelligence to identify and act on service improvements. General Managers/Service Managers – • Responding to concerns and complaints within their areas of responsibility. • Ensuring timely approval of complaints. • Ensuring learning and actions from complaints are identified and reported upon. Ward/Team Managers/Modern Matrons – • Ensuring information is available on how to raise concerns and complaints. • Responding to concerns raised locally (Local Issue Resolution). • Capturing Local Issue Resolution (LIR) and monitoring using the InPhase solution. • Providing feedback to complaints upon request. • Implementation of actions/learning Complaints Team - Responsible for • Managing complaints • Ensuring complaints are investigated in line with the complaints policy. • Ensuring the accurate and timely recording of data using the InPhase Solution. • Ensuring written responses include any identified learning/actions. • Ensuring that responses are compassionate and have a restorative approach. • Obtain feedback from those that have experience of the service to inform future service improvement.
▪ 01 - Co-create High Quality Care ▪ 02 -Be a Great Employer ▪ 03 - Be a Trusted Partner	05 - Digital - Supporting Change **Risk Description :** 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. **Date to achieve target :** 31 Aug 2027	Resources and Planning Committee **Executive Lead :** Chief Information Officer	20	10	12	Reasonable	31 Mar 2026			5.1 Embedded Digital Strategy **Object End Date :** not set	Digital Management Meeting Digital Programme Board (DPB) Digital Programme Assurance Group (DPAG)
										5.2 EPR Deployment and Optimisation Programme **Object End Date :** not set	Digital Programme Board (DPB) Digital Programme Assurance Group (DPAG)
										5.3 Integrated Information Centre Optimisation Programme **Object End Date :** not set	Digital Programme Board (DPB) Digital Programme Assurance Group (DPAG)
										5.4 Digital and Data Delivery Plan **Object End Date :** not set	Digital Management Meeting Digital Programme Board (DPB) Digital Programme Assurance Group (DPAG)

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
▪ 01 - Co-create High Quality Care ▪ 02 -Be a Great Employer ▪ 03 - Be a Trusted Partner	06 - Estate/Physical Infrastructure **Risk Description :** 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. [Note this risk specifically excludes the separate BAF risk incorporating estate rectification works for Roseberry Park Hospital] **Date to achieve target :** 31 Mar 2029	Resources and Planning Committee **Executive Lead :** Director of Finance & Estates	12	12	12	Reasonable	31 Mar 2026			6.1 NENC Infrastructure board supported by Provider Collaborative Estates Directors Group and Di **Object End Date :** not set	Executive Director of Finance and Estates/Facilities and Director of Estates, Facilities & Capital (or their deputies) represent the Trust at NENC meetings
										6.2 Estates Master Plan (EMP) **Object End Date :** not set	EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework. Finance Department – Responsible for the preparation of the annual capital and revenue financial plans for Board approval
										6.3 CIG & CPSG **Object End Date :** not set	Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements
										6.4 Estates, Facilities & Capital Directorate Management Team Meeting (DMT) **Object End Date :** not set	All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital.
										6.5 ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring **Object End Date :** not set	EFM Directorate responsible for: PLACE - Organising PLACE assessment visits, compiling and submitting information to NHSE - Preparation of the Action Plan ERIC - Compiling and submitting ERIC information to NHSE - Considering and delivering improvement and CRES plans in light of benchmarked outputs PAM - Completing self-assessment with processes to ensure timely submission - Developing and delivering action plans to ensure continuous improvement
										6.6 Green Plan submission and monitoring **Object End Date :** not set	EFM Directorate responsible for: Green Plan ? Compiling and submitting Green Plan submission to NHSE / ensuring progress to deliver milestones
										6.7 Environmental Risk Group (ERG) **Object End Date :** not set	Director of Estates, Facilities and Capital ensures aligned CPSG and ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs Directors of Operations / Operational teams support identification of environmental issues Servicedesk tracks levels of maintenance issues

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
▪ 01 - Co-create High Quality Care ▪ 02 -Be a Great Employer ▪ 03 - Be a Trusted Partner	07 - Data Security and Protection **Risk Description :** 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. **Date to achieve target :** 31 Mar 2026	Resources and Planning Committee **Executive Lead :** Chief Information Officer	20	10	12	Reasonable	31 Mar 2026			7.1 Digital, Data & Technology (DDAT) Skills and Knowledge **Object End Date :** not set	Digital and Data Management Meeting (DDMM) Digital Programme Assurance Group (DPAG) Digital Programme Board (DPB)
										7.2 Secure IT Infrastructure and Asset Management **Object End Date :** not set	DPAG
										7.3 Cyber Security and Incident Management **Object End Date :** not set	DPAG
										7.4 Data Security and Protection Toolkit (DSPT) and Information Risk Management fully operational **Object End Date :** not set	DPAG
										7.5 Robust Clinical Safety and Change Control **Object End Date :** not set	DPAG DPB Digital Change Assurance Board
										7.6 Digital Service Delivery Monitoring **Object End Date :** not set	Digital Programme Assurance Group (DPAG
▪ 01 - Co-create High Quality Care ▪ 02 -Be a Great Employer ▪ 03 - Be a Trusted Partner	08 - Quality Governance **Risk Description :** There is a risk that 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 the standard of care people receive. **Date to achieve target :** 01 Jan 2025	Quality Assurance Committee **Executive Lead :** Chief Nurse	9	9	9	Good	31 Mar 2026			8.1 Open and transparent culture working to organisational values steered by Our Journey to Chan **Object End Date :** not set	Cohesive Board Engaged and visible Executive High Quality Care Group Directors Substantive recruitment of service leadership and clinical teams. Executive Directors' Quality & Performance Review summaries presented to QAC
										8.2 Executive and Operational Organisational Leadership and Governance Structure **Object End Date :** not set	Chief Executive – Responsible for the Operational Leadership and Governance Structure Executive Directors – Responsible for the delivery of key elements of the Leadership and Governance Structure within their portfolios Co Sec – Responsible for the provision of secretariat services within the governance structure Care group clinical leaders responsible for the oversight of care delivery
										8.3 Quality Management System **Object End Date :** not set	The QI team is well established and embedded into services. There is an operational, clinical and professional leadership structure. There are Improvement plans for incidents, complaints and inspections. The IPD tracks performance monthly. The Care Group Board oversees delivery of services
										8.4 Oversight / Insight / Foresight **Object End Date :** not set	Performance team are responsible for measuring and reporting performance Chief Nurse leads the nursing and quality directorate who have responsibility to measure and repott out on-patient safety - quality governance -audit - infection, prevention and control - safeguarding - risk -Use of Force Chief Nurse lead the executive review of quality reporting to QuAC Medical Director leads on a number of patient safety priorities including Mortality review and Sexual Safety. Care groups have dedicated clinical leaders at director delivery levels with a role to assess delivery of care standards.

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
03 - Be a Trusted Partner	09 - Partnerships and System Working **Risk Description :** 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. **Date to achieve target :** 31 Dec 2025	Resources and Planning Committee **Executive Lead :** Executive Director of Transformation and Strategy	16	12	12	Good	31 Mar 2026			9.1 DTV Commissioning Groups **Object End Date :** 31 Mar 2024	Care Group Board members and Associate Directors within ACE team all core members
										9.2 Active engagement in Collaborative forum at regional, ICB and local level to help shape system **Object End Date :** not set	Engagement in a wide range of partnership functions and committees/ groups across each place, in line with individual place governance structures Joint work / operational processes with local authorities and other partners including PCNs Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future
										9.3 Supporting North East and North Cumbria Mental Health and Learning Disabilities Specialised Serv **Object End Date :** 30 Sep 2025	Operational service leads from DTVF Care Group are members of the different groups in the Partnership Governance structure
										9.4 Supporting Humber North Yorkshire Provider Collaboratives **Object End Date :** 30 Sep 2024	Attendance at specialist provider collaborative governance groups.
										9.5 Placing AD Strategy into NENC ICB MHLDA Transformation Team **Object End Date :** 30 Sep 2024	AD Strategic Planning and Programs placed into NENC ICB MHLDA Transformation Team for one day per week. Asked to lead on Inpatient Quality Transformation (including bed census)
										9.6 Attending HNY ICB Operations Group **Object End Date :** 30 Sep 2025	AD Strategic Planning and Programs and Finance Business Partner attend
										9.7 Strategic Framework **Object End Date :** not set	Visibility of Strategic Framework through internal / external comms (so that it is widely known what our strategic Goals and Objectives are).

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
03 - Be a Trusted Partner	10 - Regulatory Compliance **Risk Description :** There is a risk that failure to comply with our regulatory duties and obligations, at all times, caused by weaknesses in our controls or processes, or human error could result in enforcement action and financial penalties and damage our reputation **Date to achieve target :** 31 Mar 2025	Board of Directors **Executive Lead :** Chief Executive	8	8	5	Reasonable	31 Mar 2026			10.01 Statutory Reporting including compliance with accounting standards and the GAM **Object End Date :** not set	Reporting requirements and timetables developed by the Company Secretary. Information provided by designated leads. Reports produced by Corporate Affairs and Communications based on submissions received. Annual Accounts timetable drafted by Associate Director of Finance (Accounting and Governance). Annual Accounts (and related TAC submissions) undertaken by the Finance Staff. Associate Director of Finance (Accounting and Governance) considers and coordinates annual training needs for annual accounts team. Accounting ledger and accounts payable entries reviewed including toensure accurate coding to support reporting as well as VAT recovery. Associate Director of Finance (Accounting and Governance) is member of national Technical Issues Group where implications of accounting policy, accounting standard and HMRC legislation changes are discussed. Associate Director of Finance (Accounting and Governance) is member of NENC provider network who meet quarterly to discuss technical accounting issues and share learning / best practice.
										10.02 Provider Licence **Object End Date :** not set	Board certification processes undertaken by the Company Secretary. Delivery of related by policies by operational and corporate departments. Commissioning of external governance reviews, preparation of evidence for and support by the ACE and Co Sec. Delivery of improvement plans by designated leads.
										10.03 Environmental Sustainability **Object End Date :** not set	EFM Teams maintain day to day BAU with Directorate Management Team (DMT) maintaining routine operational oversight, including at their formal monthly DMT meeting
										10.04 Statutory Financial Duties and NHS Oversight Framework (Health and Care Act 2022) **Object End Date :** not set	Annual plan prepared through arrangements under the responsibility of the DoFEF and with EDG oversight and to agree plan parameters / integrated planning processes to recommend to Board / Committee Processes overseen by the Associate Director of Finance (Financial Management) for detailed bottom up annual planning / budget setting and for financial reporting / forecasting, including for related budget holder processes and Care Group / Directorate sign off The Trust's financial plans set our planned performance relative to statutory break even duty, with performance against plan monitoried and reported monthly to ensure responsive mitigations and performance within agreed Trust plan parameters - delivery of quarter end positions relates to NOF metrics. Standing Orders and SFIs set out respective controls and delegated financial responsibilities
										10.05 Compliance with the CQCs Fundamental Standards of Quality and Safety **Object End Date :** not set	Day to day delivery of the fundamental standards by ward and team staff. Responsibility for delivery of each element of the CQC Action Plan. designated to lead Directors. Chief Nurse is the lead Executive for relationship management with the CQC.
										10.06 Compliance with Mental Health Legislation (MHL) **Object End Date :** not set	Delivery of the requirements of MHL by clinicians, admin and managers. Operational meetings established from April 24 to identify any issues with external partner organisations.

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
										10.07 Equality, Diversity, Inclusion and Human Rights **Object End Date :** not set	The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery. EDIHR Lead and officers: ? Provision of support for inclusion networks. ? Compilation of Equality Act 2010 data. ? Compilation of evidence and consultation on the EDS. ? Support for the development of the Trust's equality objectives Designated managers/leads: ? Completion of equality analyses ? Delivery of actions under the EDS All staff are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision. Public Health Consultant engaged to develop the Trust's approach to tackling health inequalities.
										10.08 Risk Management Arrangements **Object End Date :** not set	Care Group Managing Directors, General Management Tier and Service Management Tier – ? Consider capture and maintain risks raised by staff in local risk registers, ? Develop and implement action plans to ensure risks identified are appropriately treated,. ? Ensure that appropriate and effective risk management processes are in place and that all staff are made aware of the risks within their work environment. Other Executive Directors - Responsible for ensuring effective systems for risk management, are in place within their directorate. Head of Risk Management – Day to day management of the Trust Risk Register.
										10.09 Health Safety and Security (HSS) **Object End Date :** not set	The Trust has a Health, Safety and Security Team who manage the day-to-day Health and Safety requirements in line with all relevant parliamentary acts. Reporting system is in place for the reporting of incidents which fall under the requirements of Reporting of Incidents of Disease and Dangerous Occurrences regulation (RIDDOR). Provision of HSS information for new employees at Trust induction. HSS awareness training forming part of all staff mandatory package. HSS online tool kit available for all services, wards and departments across the trust. Regular workplace audits undertaken by the HSS team. Incidents recorded on 'InPhase' are shared with relevant service leads, including HSS. This enables investigation of incidents to identify trends and flag any remedial actions.
										10.10 Executive and Care Group Leadership, management and governance arrangements **Object End Date :** not set	Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolio. Individual staff compliance with the range of policies relating to regulatory compliance e.g health and safety.
										10.11 Inquests and Coroners **Object End Date :** not set	Inquest Team - Management of the Inquest process from a Trust perspective including: ? Arranging and compiling witness statements and submission to Coroner ? Instruction of Solicitors ? Co-ordination and compilation of information ? Provision of support for staff Preparation of responses to Regulation 28 Reports by staff nominated by the CEO
▪ 01 - Co-create High Quality Care ▪ 02 -Be a Great Employer ▪ 03 - Be a Trusted Partner	11 - Roseberry Park **Risk Description :** There is a risk that the necessary Programme of rectification works at Roseberry Park and impacted by limited Trust access to capital and cash funding could adversely affect our service quality, safety, financial, and regulatory standing **Date to achieve target :** 31 Mar 2032	Board of Directors **Executive Lead :** Director of Finance & Estates	16	12	12	Reasonable	31 Mar 2026			11.1 Roseberry Park Rectification Programme **Object End Date :** not set	Programme Director and Programme Manager – Responsible for managing the RPRP including key risks and issues log (Assurance to weekly huddle)
										11.2 Capital Programme **Object End Date :** not set	Trust CPSG overseeing agreement of priorities for capital investment / impact assessment. DMT overseeing detailed milestone capital project planning. RPH huddle to ensure regular project and performance reporting for scheme via Programme leadership and supported by Drivers cost advisers.
										11.3 External Audit **Object End Date :** not set	DoFEF and Associate DoF (Accounting and Governance) meetings with external auditor to brief ahead of audit and as any significant transactions / changes identified.

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
▪ 01 - Co-create High Quality Care ▪ 02 -Be a Great Employer ▪ 03 - Be a Trusted Partner	12 - Financial Sustainability **Risk Description :** 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 **Date to achieve target :** 31 Mar 2029	Resources and Planning Committee **Executive Lead :** Director of Finance & Estates	20	20	12	Reasonable	31 Mar 2026			12.1 ICB Financial Governance **Object End Date :** not set	DoFEF member of ICS DoF/CFO group. DoFEF member of ICS Resource Allocation Steering Group seeking to optimise system allocations (incoming) and equitable distribution of new allocations (outgoing) CEO member of NENC provider leadership board (CEOs). CEO member of HNY provider collaborative work for MHLDA. TEWV Director of Strategy and Transformation (and CNTW DoF) leading Provider Collaborative work to ensure robust alliance arrangements / ensure escalation of provider resourcing issues to PC Board
										12.2 Executive Directors Group **Object End Date :** not set	Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of underlying financial position
										12.3 Business Planning and Budget Setting Framework and in year financial forecasting & recovery arr **Object End Date :** not set	DS&T is responsible for the delivery of the Business Planning Framework. DoFEF and EDG are responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers. Interim Managing Director (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. (Reporting into EDG with assurances into R&PC and Board).
▪ 01 - Co-create High Quality Care ▪ 02 -Be a Great Employer ▪ 03 - Be a Trusted Partner	13 - Public Confidence **Risk Description :** There is a risk that external scrutiny and /or adverse publicity (as a result of, for example, legal action, a serious incident, coroners' investigations or regulatory action) may lead to a loss in public confidence in our trust. **Date to achieve target :** 30 Jun 2024	Board of Directors **Executive Lead :** Director of Corporate Affairs & Involvement	20	10	9	Reasonable	30 Sep 2025			13.1 Communications strategy **Object End Date :** not set	Director of Corporate Affairs and Involvement Head of Communications Communications team
										13.2 Stakeholder communications and engagement strategy **Object End Date :** not set	Trust Board Director of Corporate Affairs and Involvement Care Group Board Directors Head of communications Corporate Affairs and Stakeholder Engagement Lead Communications team
										13.3 The social media policy **Object End Date :** not set	Director of Corporate Affairs and Involvement – responsible for the development, implementation and monitoring of the social media policy Head of communications Comms team – responsible for ongoing monitoring of social media General Managers/Service Managers – Ward/Team Managers/Modern Matrons – as above Complaints team Patient experience team Clinical leaders Service managers People and Culture

Strategic Goal	Object Name	Oversight Committee	Current Risk Rating	Target Risk Rating	Risk Tolerance	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
▪ 01 - Co-create High Quality Care ▪ 02 -Be a Great Employer ▪ 03 - Be a Trusted Partner	14 - Healthcare Inequalities **Risk Description :** 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. **Date to achieve target :** 31 Mar 2027	Quality Assurance Committee **Executive Lead :** Medical Director	16	12	9	Limited	31 Mar 2026			14.1 Public health capability and capacity **Object End Date :** not set	Reporting to Executive Clinical leaders and trust wide physical health group and equality, diversity and human rights group.
										14.2 Use of Data, Insight evidence and evaluation **Object End Date :** not set	EDI dashboard
										14.3 Strategic leadership & accountability **Object End Date :** not set	Annual Executive/ PH Consultant appraisal reflecting on objectives and delivery.
										14.4 System Partnerships **Object End Date :** not set	Involvement in wide range of networks and relevant groups.
03 - Be a Trusted Partner	15 - Transformation **Risk Description :** 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. **Date to achieve target :** 31 Dec 2025	Resources and Planning Committee **Executive Lead :** Executive Director of Transformation and Strategy	16	12	12	Good	31 Mar 2026			15.1 Review of Trust-wide transformation portfolio (content, governance, delivery/impact). **Object End Date :** not set	Engagement with Operational and Corporate teams to review Transformation workstream delivery.
										15.2 Development of future Trust-wide transformation portfolio: **Object End Date :** not set	Engagement and horizon scanning activities of national policy, guidance and transformation expectations. Assessment of capacity and capability to deliver necessary transformation alongside development of the above.
									?	15.3 Delivery of Transformation Portfolio **Object End Date :** not set	Transformation governance established (Programme Boards for each Transformation shift, Oversight Group, reporting to EDG)

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	11th June 2026
Title:	Medium Term Plan – Conditions, Assurance and Mobilisation Update
Executive Sponsor(s):	Kathryn Ellis, Interim Director of Strategy and Transformation Liz Romaniak, Director of Finance Estates and Facilities
Author(s):	Kathryn Ellis, Interim Director of Strategy and Transformation Liz Romaniak, Director of Finance Estates and Facilities

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	X
2: To be a great employer	X
3: To be a trusted partner	X

Relevant BAF risk/s (name and number)	***Relevant control***
All BAF risks with particular emphasis on:	This paper relates most notably to Board Assurance Framework risks concerning financial sustainability and delivery of transformation. The Medium Term Plan (MTP) set out the Trust's five year strategic and financial direction and therefore underpins all strategic risks.
12 Financial Sustainability 15 Transformation	This paper strengthens assurance by demonstrating progress to address MTP conditions and that Board assurance statements have further matured since February submission, supported by clear Executive ownership, strengthened delivery plans and robust governance arrangements.

Executive Summary

Purpose

As reported to the Board in April 2026, NHS England has assessed the Trust's Medium Term Plan (MTP) as *"Compliant with Conditions"* and, in the letter from the Regional Director NHS England – North East & Yorkshire, set out specific requirements to be addressed prior to the end of June 2026. These requirements relate to the delivery of a fully developed Board-approved sickness reduction plan, a fully developed Board-approved bank cost reduction plan, and the expectation that levels of unidentified Cash Releasing Efficiency Savings (CRES) should be minimal from month 1. NHS England also re-emphasised the importance of maintaining and improving quality through robust Executive-led Equality and Quality Impact Assessment (EQIA/QEIA) processes as the plan moves into delivery.

This paper:

- provides the Board with assurance on how these requirements are being addressed and seeks confirmation that the Board is satisfied that the Trust has met, or has credible and deliverable arrangements in place to meet, the conditions within the required timescale to support final confirmation to NHS England by the end of June 2026
- updates the Board on how assurance on the Medium Term Plan has strengthened since the February submission and the April Board update, as the organisation has moved from plan development into delivery.

Proposal

At the point of reporting, the Trust can demonstrate that:

- The CRES condition is met, with no unidentified value reported at Month 1
- The sickness reduction condition is met, supported by a fully developed improvement plan
- The bank reduction condition remains the final element in progress, with a clear and controlled route to completion, although the full recurrent value is not supported by detailed plans at the point of reporting (weekly updates scheduled to end of June).

In addition, the Trust has strengthened its QEIA approach and transformation governance arrangements, providing increased assurance of plan integrity and delivery control.

Taken together, this provides a basis for good assurance that the Trust has met, or has credible and deliverable arrangements in place to meet, all MTP conditions within the required timeframe.

Whilst this paper proposes good assurance on plan conditions compliance, reasonable assurance is noted at this stage on delivery, in particular in relation to Bank cost and Sickness Absence reductions in light of operational and workforce pressures. Delivery risks and mitigations are an explicit part of improvement plans, and will be monitored closely through Executive Directors Group, Board Committees and Trust Board during 2026/27.

The proposal is therefore that the Board:

1. confirms the level of assurance of Plan conditions compliance as good, with delivery assurance at this stage as reasonable
2. confirms that it is satisfied that the Trust has met, or has credible plans in place to meet, the MTP conditions within the required timeframe;
3. considers overall financial and CRES performance context at Month 1;
4. approves delegation to the Chief Executive and Executive team to confirm final sign-off of the conditions by the end of June; and
5. notes the commitment for ongoing oversight of Medium Term Plan delivery via Resources and Planning Committee, with consideration of Condition areas as appropriate at People and Culture Committee and Quality Assurance Committee

Overview

The April 2026 Board update confirmed that the Trust's plan was compliant with headline requirements and took reasonable assurance at an early stage of transition into delivery. At that point, a number of areas were identified as continuing to mature, particularly workforce productivity, QEIA at scale and delivery governance.

Since that point, the Trust has strengthened assurance through the development of defined delivery plans, clearer alignment between workforce and financial assumptions, and the establishment of programme governance and delivery oversight arrangements.

This paper therefore focuses on the Trust's current position against the MTP conditions and the extent to which delivery arrangements now provide sufficient assurance for final confirmation.

Medium Term Plan Conditions

1. Sickness Absence Reductions

Executive Sponsor: Sarah Dexter-Smith, Director of People and Culture

Sickness absence remains a material workforce challenge for the Trust and a direct driver of temporary staffing demand. The Trust-wide sickness absence baseline for May 2025 to April 2026 is 6.92%, with a trajectory in the Performance Improvement Plan to reduce this to 5.5% by March 2027. The diagnostic work underpinning the plan shows that the challenge is not just the overall absence rate, but the combination of variation in local management practice, delays in early intervention, and the contribution of mental health-related absence in more challenged service areas.

The Sickness Absence Performance Improvement Plan has been designed around the specific drivers identified through audit and review and includes strengthened Director-led case management, a more proactive approach to long-term and mental health-related absence, and a systematic programme to improve managerial capability and consistency in managing sickness absence. It also builds on existing organisational strengths, including established long-term sickness support and wider wellbeing provision, but places more emphasis on using those resources consistently and with stronger assurance of impact. This indicates increased assurance that the Trust is effectively targeting the underlying factors contributing to avoidable absence.

The Board should note that delivery risk is not uniform across the organisation. The highest risk sits in those parts of the Trust where complexity of service, patient need and workforce pressures combine. This includes secure and specialist inpatient settings and areas where acuity, staffing pressure and case complexity make it more challenging to achieve a rapid reduction in absence. The plan targets areas with the greatest risk and importance, rather than assuming uniform improvement. That is important, because it is those same areas which also experience a disproportionate level of bank usage and therefore influence both workforce availability and financial sustainability.

There is a direct link between sickness absence and bank staffing demand. The more effectively the Trust reduces sickness absence, particularly in high-use areas, the greater the benefit to both workforce resilience and financial delivery. The bank reduction work has explicitly identified sickness as one of the major drivers of temporary staffing use, and the bank plan quantifies a further savings opportunity associated with achieving the sickness target. Therefore, reducing sickness is considered not just a separate staff concern but a key factor in improving both MTP workforce productivity and overall CIP outcomes. Oversight is provided through Executive Directors Group and the People and Culture Committee, giving a clear route for review, challenge and escalation.

2. Bank Cost Reductions

Executive Sponsor: Naomi Lonergan, Interim Managing Director

The Trust's work on bank cost reductions has been informed by detailed analysis of the nature of bank expenditure and usage. The detailed review of bank staffing expenditure demonstrates that bank usage is driven by a combination of vacancy gaps, sickness

absence, high patient acuity, enhanced observations, service pressures and operational practices such as rostering and training backfill. This is of note, as it identifies that bank spend is not solely a matter of local practice, but is heavily influenced by demand-led and structural pressures across the delivery system.

The analysis shows that bank expenditure rose to approximately £16.16m in 2025/26, and ‘intentionally’ from a value for money perspective, as the Trust prioritised reductions in premia rate Agency and Overtime shift reductions. The most significant bank pressures were consequently in inpatient and specialist settings.

Several areas presently face significant challenges, notably services requiring additional support such as Bankfields Court (due to support being provided to an especially vulnerable patient) and widespread pressure within Secure Inpatient Services (factors contributing to workforce volatility include high patient acuity, staff absences, maternity leave, and ongoing HR cases). These service pressures mean that the Trust cannot assume a uniform rate of reduction across the organisation and must instead manage the overall target across the portfolio, taking account of those areas where short-term reduction is especially challenging.

The Trust has formulated a comprehensive response that addresses multiple factors and is consistent with the previously identified drivers. It includes strengthening workforce supply through recruitment and substantive staffing approaches, improving operational grip on rostering and forward workforce planning, reducing avoidable demand where possible through clinical model and acuity management, and tightening control over bank approval and challenge. Some delivery confidence comes from the Trust's shift to an evidence-based approach that connects operational, workforce, and financial actions, rather than simply a generic "reduce bank" usage goal.

However, Trust Board should also note that at the point of writing, the Trust does not yet have a fully compliant bank reduction plan, with additional work continuing to the end of June to identify actions to deliver the full recurrent value of required bank cost reduction (which includes recovering 2025/26 growth). This means **the bank condition is not yet fully met** at the time of writing. We do, however, now have a clear route to resolving that position: the key drivers are known, priority actions are being quantified and refined, and the remaining work is progressing through Executive review during June. Governance for this sits through Executive Directors Group, with onward performance scrutiny through People and Culture Committee, and with explicit recognition that the bank trajectory is dependent on delivery of sickness reduction, review of inpatient mandatory and statutory training, recruitment, inpatient rostering, and operational, discipline.

The Board’s assurance therefore needs to be balanced. The bank challenge remains the most material of the individual MTP conditions and is not fully resolved at the point of reporting. It should be noted that achieving the bank cost reduction NHSE target may (worst case) increase, (probable case) maintain, or (best case) partially reduce overall costs unless overall WTE reductions are achieved. This brings a significant dependency on sickness and bed occupancy variables (including levels of patients presently clinically ready for discharge).

Equally, it is now a well-understood and actively managed delivery issue, with clear Executive ownership and a credible route to closure by the end of June.

3. Unidentified CRES

Executive Sponsor: Liz Romaniak, Director of Finance and Estates

The Trust has no unidentified CRES and confirmed compliance to NHSE of the 2026/27 plan condition through the Month 1 Provider Finance Return. This reflects strengthened planning discipline, improved financial grip and greater visibility of the savings pipeline than was available earlier in the planning cycle.

However, it should be noted that although the condition itself is met, delivery of the financial plan remains dependent on the successful execution of the wider productivity and workforce assumptions within the MTP, particularly the interdependent assumptions around sickness reduction and bank usage. Trust Board should note that whilst the planning condition is met, financial sustainability remains linked to the delivery of the wider MTP controls and trajectories. A significant risk is respect of CRES delivery relates to inpatient staffing costs for clinically optimised patients, this being the main strategic driver of flexible staffing.

The Trust maintains clear governance and oversight of this position. CRES delivery and underlying financial performance are monitored through Executive Directors Group and the Resources and Planning Committee, ensuring that changes in workforce productivity performance or pressures in bank usage are visible in the financial reporting. This strengthens the triangulation between workforce, operational and financial delivery and provides a more robust basis for in-year financial assurance.

The Trust has an excellent track record of in-year delivery, mitigation and escalation, and will use approaches developed in recent years to significantly reduce reliance on premia rate agency and overtime staffing and adapt these to respond to 2026/27 cost reduction challenges.

4. Quality and Equality Impact Assessment (QEIA) and Plan Integrity

Executive Sponsor: Hannah Crawford, Director of Therapies

Robust QEIA oversight is required to ensure effective quality oversight of the delivery of the Trust's Medium Term Plan, and was specifically emphasised in NHS England's letter. Since the February submission, the Trust has strengthened its approach to QEIA oversight. This includes updated policy and process, introduction of proportionate triage and "Early Sighter" stages, clearer sign-off arrangements, and increased QEIA panel capacity and scheduling discipline. This ensures that the Trust's process is sufficiently robust and scalable to support a large and varied portfolio of transformation and efficiency schemes in moving through planning and assurance governance.

The QEIA process is an integral part of the critical path for development and delivery of Medium Term Plan schemes, with engagement early on in idea generation and development. Executive oversight has highlighted QEIA sequencing as a dependency for programme delivery, and the strengthened process is intended to ensure that quality and equality issues are identified early enough to influence scheme design, not just recorded at the point of approval. This is particularly important given the scale of change and the need to maintain quality through operational and financial challenge.

There remains a risk that the volume and sequencing of schemes could create pressure if QEIA capacity is not actively managed. This risk is known, and the process changes already made are specifically designed to mitigate it through earlier submission, prioritisation and increased panel capacity. QEIA also now supports broader assurance in areas such as clinical leadership, health inequalities and the cumulative impact of plan changes across the Trust. The Trust's QEIA approach is overseen by the Quality Assurance Committee (QAC).

Scheduling indicates the Trust will have completed QEIA of 94% by value of the total CRES plans of £27,690k by the end of Quarter 1 (some schemes commencing beyond Quarter 1).

Transformation Governance, Mobilisation and Delivery Control

Executive Sponsor: Kathryn Ellis, Interim Director of Strategy and Transformation

An important factor in increased assurance since April is the improving maturity and visibility of the Trust's transformation governance. Governance arrangements are established and functioning, including programme boards aligned to the strategic shifts, a 5-Year Plan

Oversight Group chaired by the Interim Executive Director of Strategy and Transformation, identified Executive sponsors for each condition area and transformation programme, and clear reporting into Executive Directors Group. These arrangements provide line of sight from plan priorities to programme delivery, and from programme delivery to Executive oversight, and will provide Resources and Planning Committee and Board assurance.

The Oversight Group's role extends beyond monitoring progress, providing executive direction on sequencing, interdependencies, risk management, and change control. A 'critical path' of activities has been established, facilitating the identification of delivery dependencies, risks to capital, programme phasing, and the effects of QEIA sequencing and programme management capacity on overall deliverability. This represents clear progress since earlier in the year, when governance was developing and the plan shifted from proposal to implementation.

Nonetheless, the Board should recognise that enhanced governance maturity does not eliminate delivery risk. The principal concern has shifted from the existence of governance frameworks to ensuring their sustained alignment, discipline, and simplicity as the programme develops. Executive oversight has already highlighted the necessity for more integrated governance, stronger programme management capacity alignment, proactive change control, and continued management of cumulative impacts across schemes. Addressing these matters at this stage demonstrates that governance is being applied actively and critically, thereby reinforcing confidence in its effectiveness.

Board Assurance Statements – Strengthening Since February

The Board previously reviewed and approved the Medium Term Plan assurance statements and associated maturity assessments in February as part of the formal submission. Since that point, a number of key areas have been further strengthened, reflecting the transition from plan development to delivery readiness.

In particular, assurance has been enhanced through increased Board and Executive oversight of plan development and delivery, including the establishment of formal programme governance and the 5-Year Plan Oversight Group. Clinical leadership and Lived Experience engagement has continued to be embedded throughout programme design and delivery, strengthening the clinical credibility of the plan.

There has also been meaningful progression in health inequalities and prevention, with clearer articulation of priorities, strengthened governance arrangements and the establishment of programme oversight, approved by Executive Directors Group, to support delivery and monitoring of impact. In parallel, QEIA processes have been strengthened and more consistently applied across the transformation portfolio, supported by clearer Executive clinical oversight.

Further assurance has been gained through improvements in data-driven performance management and delivery oversight, including enhanced dashboards, pipeline tracking and integrated reporting, alongside strengthened triangulation of finance, workforce and activity assumptions.

Collectively, these developments provide the Board with increased confidence in the maturity, integrity and deliverability of the plan.

<u>Prior Consideration and Feedback</u>

This paper builds on the Board's previous consideration of the MTP in February and April, and on subsequent review through Executive Directors Group and ongoing programme governance structures. The detailed sickness, and bank reduction plans, CIP identification, QEIA strengthening actions and wider MTP assurance position have all been considered

through Executive processes prior to Board consideration and will continue to the end of June (plan condition compliance) and beyond (delivery).

Implications

The principal implications are as follows.

- In relation to quality and safety, the strengthened QEIA process and transformation governance provide greater confidence that delivery of the plan will not proceed without proper consideration of impact.
- In relation to the workforce, successful implementation of the sickness and bank plans is critical to productivity, resilience and sustainability.
- In relation to finance, whilst the identified CRES condition is met, schemes reflect a combination of RAG-rated deliverables and will require ongoing oversight, rigour and mitigation in-year, with success depending on successful implementation of the linked workforce and operational actions.
- In relation to risk, the Board should recognise that delivery challenge remains, particularly in workforce productivity, but that the key risks are known and are being actively managed through established governance arrangements.

Recommendations

The Board is asked to:

1. Confirm the level of assurance of Plan conditions compliance as good, with delivery assurance at this stage as reasonable
2. Confirm that it is satisfied that the Trust has met, or has credible plans in place to meet, all MTP conditions within the required timeframe, noting that the bank reduction condition is the final element still progressing through Executive governance.
3. Take assurance on the strength of the sickness reduction plan, the identified CRES position, the strengthened QEIA framework, and the transformation governance and mobilisation arrangements now in place.
4. Consider overall financial performance assurance from Month 1, but noting caveats as outlined above in respect of bank cost challenges, drivers, opportunities and next steps.
5. Approve delegation to the Chief Executive and Executive team to confirm final sign-off of the MTP conditions by the end of June 2026.
6. Note the commitment for ongoing oversight of Medium Term Plan delivery via Resources and Planning Committee, with consideration of Condition areas as appropriate at People and Culture Committee and Quality Assurance Committee.

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For General Release

Meeting of:	Board of Directors
Date:	11th June 2026
Title:	Board Integrated Quality & Performance Report as 30th April 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
Author(s):	Kathryn Ellis, Interim Executive Director of Strategy & Transformation 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: 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***
Whilst the IQPR relates to all BAF risks, the contents of this report pertain particularly to: 1 Safe Staffing 2 Demand 9 Partnerships & System Working 12 Financial Sustainability	Our Integrated Performance Approach (IPA) provides the Board with robust oversight of performance through the systematic monitoring and reporting of key measures, which demonstrate the delivery of the quality of services we provide. The Trust level IQPR was reported into Executive Directors Group on 26th May 2026. The Trust level IQPR is supported by two care group IPRs, oversight of which was maintained by Integrated Combined Governance, comprising clinical and corporate leaders.

Executive Summary

Purpose

The Board IQPR 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.

This paper presents the first iteration of the Trust's new Integrated Quality and Performance Report (IQPR). Revisions are designed to improve the presentation and content of the report, the analysis, and therefore the assurance to Board of Directors. The new IQPR will complement broader developments underway within the Trust's oversight of accountability and performance, through its planned new Accountability Framework. Amendments and additions in this report, drawing on best practice exemplars and continuing alignment with Making Data Count principles, have included:

- Revised structure (Alert, Advise, Assure) and IQPR format
- Improved visual presentation of included charts, icon and narrative
- Circle 'heatmap' diagrams at report outset within the Executive Summary at Trust and Care Group level
- Data on population health, ethnicity and deprivation indicators
- Revised presentation of Trust and ICB system measures
- Revised structure of the Waiting Times section to distinguish the national waiting times standards, including the new 104-week meaningful help requirements, and local monitoring
- Addition of the Care Group Integrated Performance Dashboards

The Trust IQPR report in August will see incorporation of further benchmarking data, and an increased focus on reporting of detailed narratives and remedial actions by exception.

Proposal

The Executive Directors Group are proposing that Board of Directors receives this report with:

- **Good assurance** on the oversight of performance through the systematic and robust reporting of key measures for the purposes of demonstrating high quality, safe and effective care.
- **Reasonable assurance** that we have identified and understood the improvement actions and that these are consistently implemented and effective where performance standards are not being met. Forthcoming implementations of the Accountability and Performance framework should improve this assurance level over 2026/27.
- **Reasonable performance assurance** on the Integrated Performance Dashboard (IPD), National Quality requirements/Mental Health Priorities and on Waiting Times. Overall performance assurance for the IPD, as measured through the Performance & Controls Assurance Framework, shows 66% of measures achieving good or substantial assurance, reduced from 77% last month. Overall performance assurance for the National Quality Requirements and Mental Health Priorities, based on Statistical Process Control (SPC) analysis, shows 63% of measures are meeting standard (previously 75%). Waiting times assurance is similarly informed by SPC, combined with detailed analysis to identify areas of strength and concern. Quality Assurance Committee actively monitor the quality impact for those patients who are waiting to access our services.

There has been a change to the performance assurance level for the IPD this month (from good to reasonable). Key changes to the IPD this month are:

Increased performance assurance (good to substantial)	• The number of uses of the Mental Health Act • Percentage compliance with ALL mandatory and statutory training • Percentage of staff in post with a current appraisal
Decreased performance assurance (from substantial to reasonable)	• Percentage of inpatients reporting that they feel safe whilst in our care
Decreased performance assurance (good to reasonable)	• Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported • Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

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 IQPR is discussed and approved each month at Integrated Care Group Governance and then at Trust level by the Executive Directors Group and bi-monthly, and is reported to the Board of Directors to provide assurance that the Trust is continuing to deliver operationally. Further assurance is being sought for any measures where performance is not in line with standard, and where remedial actions and oversight is not yet considered sufficiently robust.

Performance Assurance

ALERT

Quality - *Clinically Ready for Discharge and bed occupancy* - an average of 73 inpatient beds in April were occupied by patients who were clinically ready for discharge but unable to leave due to delays in external care placements and packages. These patients comprised 14% of all adult and older adult acute beds in use, reducing available capacity and contributing to longer lengths of stay. This flow constraint is the Trust's most significant performance and quality risk, driving an estimated direct cost pressure of circa £18 million annually. Adult mental health bed occupancy, whilst improved, remains at 88%, above the commissioned level of 85%.

- **Action / Mitigation (Trust-Wide):** System-wide interventions are in place to reduce pressure on patient flow. The Trust established a 'Hospital to Community' Programme Board with a 12-month delivery plan (presented to the Board in April 2026) that sets out a phased approach to reducing delayed discharges, improving flow, and restoring performance. Both Care Groups are closely collaborating with local authority and NHS partners to expedite complex discharges. Recognising the link between acute admissions and community services, an outline business case for a new Crisis Assessment Centre in Durham has been approved in principle to divert demand from acute wards; a full business case is in development for July. In NYYSCG, two new 24/7 community mental health 'Neighbourhood Centres' in Harrogate and Scarborough have been approved for 2026/27 and a Mental Health Emergency Department in York for 2029/30 to strengthen alternatives to admission. Despite these concerted efforts, this remains a key area of focus for the Trust, and

the level of assurance remains partial pending implementation of the delivery plan and improved performance.

Quality - *Waiting times for Community services -* Trust-Wide): Demand exceeds capacity across specific key care pathways - neurodevelopmental services, Early Intervention in Psychosis (EIP), children's eating disorders, and talking therapies.

- **Action / Mitigation**: Active waiting list management and service-specific plans are being deployed across affected specialties to mitigate capacity issues. Teams have been scheduling extra clinics, prioritising urgent cases, and closely monitoring waiting lists daily to prevent significant target breaches. The Trust has commissioned targeted improvement plans (e.g. for children's eating disorder waits; a '104-week wait recovery plan for CAMHS) and resources to reduce neurodevelopmental assessment backlogs are being negotiated with the Integrated Care Boards. Longer-term service transformations – such as crisis alternatives and assessment centres– are expected to expand capacity and improve access over time. The Quality Assurance Committee will continue to monitor the potential quality impact on patients waiting to access services.

Quality - *Restrictive interventions -* Trust-wide, 1058 instances of restraint or seclusion were recorded in April – a special cause concern. This outlier trend is largely attributable to the Adult Learning Disability (ALD) inpatient service in the Durham, Tees Valley & Forensic Care Group (DTVFCG), where a small number of patients with particularly complex needs have required repeated physical interventions

- **Action / Mitigation:** The Trust has escalated this issue through enhanced governance and support. DTVFCG's ALD service has been formally designated a "Service Requiring Additional Support", with a comprehensive Recovery Plan and heightened Care Group Board oversight now in place. The Positive & Safe clinical skills team is providing monthly specialist clinics to reinforce de-escalation techniques and reduce restraint use. Additional measures include the development of detailed Positive Behavioural Support plans for the individuals concerned, efforts to secure extra specialist staff, and enhanced staff wellbeing support to maintain resilience. The Trust has also commissioned an independent peer review by Mersey Care NHS FT to advise on any further improvement actions that could be taken.

People - *Sickness absence rates* - Sickness absence stands at circa 6.5%, above the Trust's 5.5% target and higher than the national 5.6% average for mental health trusts.

- **Action / Mitigation:** Strengthening workforce resilience and management is an organisational priority. Under the new "How We Work" programme the Trust is implementing a range of initiatives to improve culture, flexibility, and staff wellbeing. Enhanced attendance management procedures are being embedded; monthly Director-led sickness review meetings in adult mental health services (as a pilot across both Care Groups) have begun to show improved handling of short-term absences and more timely progression of long-term cases. Additionally, 35 dedicated training sessions for all line managers on Attendance Management are scheduled through 2026, to ensure Trust policies are consistently applied and staff off sick receive timely support. The Executive Directors Group are closely monitoring this issue as a Medium Term Plan 'condition', and a Trust-wide Performance Improvement Plan is in place.

Finance & Resources – *Cash Releasing Efficiency Savings (CRES) recurrent* - The Trust's financial performance, while currently on track, is conditional on delivering ambitious future efficiencies, presenting delivery risk. As of month 1, the Trust's deficit of £0.23 m is £0.43 m better than planned, demonstrating strong early financial controls. However, the full-year break-even plan is heavily reliant on a £27.7 m Cash Releasing Efficiency Savings (CRES) programme and on further reductions in temporary staffing costs. Without

operational improvements – particularly in patient flow and workforce availability – there is a risk that cost pressures (such as delays in discharging patients clinically ready for discharge and temporary staffing) will accumulate, presenting risk to financial targets later in the year.

- **Action / Mitigation:** The Trust has robust financial governance and efficiency plans in place. A dedicated Temporary Staffing Group is rigorously controlling agency use – requiring executive pre-approvals for agency shifts and maximizing use of the internal staff bank. These measures have already shown impact: the number of agency shifts worked has fallen by over 60% in the past 12 months and agency expenditure in April was £0.09 m below budget. At the same time, an Efficiency Delivery Hub is driving a range of CRES projects and supporting Care Groups to achieve savings. The Executive Directors Group are closely monitoring Bank usage and expenditure, as a condition of the Medium Term Plan, and a Trust-wide Performance Improvement Plan is in place. The Trust's transformational programmes (aligned to national priorities of "hospital to community", "treatment to prevention", and "analogue to digital") are targeted to yield significant efficiencies from 2027 onward; transformation governance and engagement work continues to strengthen delivery assurance. Combined, these actions indicate that financial risks are being managed with a high degree of control. Board of Directors should remain alert to slippage risks but can take reasonable assurance that the Trust is proactively mitigating financial challenges.

ADVISE

People & Workforce – *Mandatory Training compliance* - Training compliance, although above target overall, is compromised by non-attendance: in April, 28% of booked face-to-face mandatory training slots were unfilled (including 12% DNAs) due to challenges releasing staff.

- **Action / Mitigation:** The Trust has established a Training & Education Task Group which has already implemented measures to improve attendance and course capacity – for example, expanding resuscitation training slots by upskilling six additional trainers (with all in place by August 2026). Furthermore, a new guide for managers to resolve training data issues will be rolled out in May.

Data Quality & Reporting Integrity *for specific metrics* – 3 out of 21 waiting time measures (Child Eating Disorders, Early Intervention in Psychosis, CYP Neuro), service access (caseload), and clinical outcomes have been impacted by data definition or recording issues 'in period' and are under active investigation and resolution. Given the measures affected and numbers involved, they do not present a material risk to overall accuracy of reporting.

- **Action / Mitigation:** The Performance & Business Intelligence teams are working together with Operational Leaders to address data quality issues. Remedial actions are underway, such as technical fixes, operational follow up with data inputters and updating of procedures. While these steps are building confidence that data integrity is improving – indeed the IPR overall is underpinned by generally robust data – the Trust acknowledges only partial assurance in some areas until all known issues are resolved. Board of Directors is advised to note these limitations when interpreting performance in the affected metrics, but also to take reassurance that active data quality management is in place.

Inequalities & Population Health – *access and data capture* - Disparities in service access and outcomes across different population groups are apparent, and not yet fully quantified or controlled. A recent analysis of Mental Health Act detention data found detention rates in the Trust above national benchmarks: White patients are 1.79 times more

likely to be detained than the national average, and Black/Black British female patients are detained at roughly twice the expected rate, indicating potential racial and socio-economic inequalities in crisis care and risk management. Additionally, core population data capture is declining; rates of ethnicity recording are falling and now below national average, reducing our ability to monitor equity of access.

- **Action / Mitigation:** The Trust has initiated targeted work to understand and address inequalities, working through both clinical and governance channels. Findings from the national Mental Health Act data have been escalated to the Mental Health Legislation Committee for further examination, and a deeper analysis of 2024/25 data is underway, with updates planned for the May 2026 IPR. To build our response, specialist capacity is being added: new inpatient consultant sessions focused on inequalities will begin in August 2026, and an Equality, Diversity & Inclusion (EDI) Officer post is being established (temporarily filled by an interim analyst) to support the Patient & Carer Race Equality Framework work. The EDI work will include comprehensive community engagement and improved governance of these metrics. While these efforts are in early stages, Board of Directors is advised that addressing inequality is recognised as a strategic priority, with tangible actions in development to ensure all population groups receive equitable, effective care.

ASSURE

Quality – *patient and carer experience* - Core quality and safety metrics remain stable or improving, indicating a strong foundation of safe, patient-centred care. Patient experience levels are high; in April, 93.5% of patients rated their service experience as "very good" or "good", a result above our 92% standard and well above the 89.6% national average, placing us among the top performers nationally (13th of 66 trusts). Similarly, carer-reported involvement has shown special cause improvement 86.8% of carers felt actively involved in care decisions, surpassing the 75% target. On the safety front, no unexpected inpatient deaths occurred in April, and only one serious incident (PSII) was reported, both within normal variation. The number of moderate or severe harm incidents (17 in April) was also within expected range, with a downward trend in older adult services (special cause improvement).

- **Action / Ongoing Assurance:** The Quality & Assurance Committee and care group governance forums continue to track these metrics to ensure any emerging issues are promptly identified. The consistently high patient and carer satisfaction reflects the positive outcomes of ongoing quality improvement and patient engagement work, such as the "Triangle of Care" initiatives to support carer involvement. Quality of care is monitored daily across wards to ensure patients receive appropriate, needs-led interventions. The Enhanced Therapeutic Observation & Care (ETOC) initiative continues to progress, supporting patient safety, recovery, and dignity while reducing reliance on restrictive practices such as seclusion. Recent data shows a reduction in agency use for ETOC, with increased delivery by substantive staff and a concurrent decline in nurse leaver rates. These improvements are expected to contribute to further reductions in restrictive practices and length of stay.

Quality – *72 hr follow up, EIP and out of area placements* - key national access standards are being met, providing confidence in critical areas of patient care. The Trust has reliably delivered on its 72-hour follow-up after inpatient mental health discharge and on the two-week access to Early Intervention in Psychosis (EIP) services, maintaining full compliance with these national requirements. Furthermore, the Trust's use of out-of-area beds is near zero – only 3 external bed-days were used in the last quarter (late winter to April), meaning we have almost entirely eliminated inappropriate external placements. Meeting these targets indicates that, despite the pressures noted earlier, the organisation is ensuring patients receive timely, local care for urgent needs.

- **Action / Ongoing Assurance:** The above standards will continue to be monitored through our performance management framework to ensure they remain on track. The sustained avoidance of out-of-area placements, in particular, shows that our capacity and escalation processes are effective in maintaining local provision and reducing patient travel. Achieving these benchmarks contributes to strong assurance that core access pathways are functioning as intended, even as we work to improve areas of delay.

People – *Turnover* - the Trust's annualised staff turnover has fallen below the target 11%, with recent data indicating a 9.9% leaver rate (special cause improvement) – a sign that retention is improving after focused efforts last year. Additionally, the Trust's mandatory training compliance stands at 93%, exceeding the 85% standard in every directorate. No service area currently falls below this critical training threshold, reflecting a workforce largely compliant with required skills and safety competencies.

- **Action / Ongoing Assurance:** The People & Culture Committee continues to oversee these metrics as part of its remit. Strong compliance with training and positive retention trends provides the Board of Directors with assurance that foundational workforce capabilities and stability are being strengthened through our People strategy. Maintaining these trends – and extending them to areas like sickness absence and staff engagement – is a key focus of the People Management Skills Programme and "How We Work" transformation, which aim to further enhance our capacity and resilience.

Finance & Resources – *April performance* - The Trust's financial position at the start of 2026/27 provides assurance of positive performance. At the end of April 2026 (month 1), the Trust's revenue performance was £0.43 m better than plan, reflecting effective cost control from the outset of the year. Notably, agency staff expenditure is on a clear downward trajectory; April's agency spend was £93k below budget, continuing a trend that has seen the number of agency shifts reduce by 62.5% over the last 12 months. These improvements are the result of deliberate measures (e.g., enhanced bank staffing and strict approval for agency use) and underscore the Trust's ability to manage resources efficiently.

- **Action / Ongoing Assurance:** The Resources & Planning Committee has clear line of sight on financial performance and efficiency programmes and will ensure that savings plans are delivered with minimal impact on services. The progress in curtailing agency use and maintaining discipline on budgets yields good assurance of financial control in the near term, with our internal governance (e.g., the Efficiency Delivery Hub and Temporary Staffing Group) continuing to drive further improvements. Board of Directors can take assurance on the robustness of current financial controls, providing a stable platform for future efficiency delivery.

Data Quality & Reporting Integrity – *overall* - Overall data quality is strong across the vast majority of our performance measures, providing confidence that the Board is receiving an accurate picture of the Trust's performance. The Integrated Performance Report is compiled under a proven, nationally aligned methodology ("Making Data Count") and undergoes multiple layers of review (Care Group governance, Executive Directors Group, Board committees) to assure accuracy. With only a small number of metrics are affected by known issues (as detailed above), Board of Directors can take assurance that data quality is robust. Where specific data issues do exist, they are explicitly flagged in the report alongside active resolution plans, providing further assurance of reporting improvement.

- **Action / Ongoing Assurance:** The Quarter 4 IPR Data Quality Assessment confirmed that all measures continue to report Good or Substantial assurance, with no indicators assessed as Reasonable or Limited. The Trust's Performance & Business Intelligence teams are maintaining a continuous focus on data quality improvement as part of routine performance management approach. The few metrics currently subject to data quality concern will be updated in subsequent reports as

corrections are implemented. Given the transparent identification of issues and the actions in train, the Board can take assurance that reported performance is a reliable basis for oversight and decision-making, notwithstanding the specific caveats noted.

For Approval – Executive Directors Group seek Board of Directors approval to replace the current *Use of Resources Rating* within the Integrated Performance Dashboard with a new *Bank Costs Compared to Plan* measure. This will provide Board of Directors with increased oversight of bank costs, which have proved challenging to reduce, with initial priority being given to reducing premium rate Agency and Overtime shifts in 2025/26.

Prior Consideration and Feedback

The Trust IQPR has been discussed with Care Group leaders, Care Group Combined Governance and Executive Directors Group prior to submission to the Board of Directors. The Care Group IPRs were discussed at Integrated Care Group governance.

Implications

The Integrated Quality and Performance Report (IQPR) 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 and 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 assurance** on the oversight of performance through the systematic and robust reporting of key measures for the purposes of demonstrating high quality, safe and effective care.
- **Reasonable assurance** that improvement actions are consistently implemented and effective where performance standards are not being met
- **Reasonable performance assurance** on the Integrated Performance Dashboard (IPD), National Quality requirements/Mental Health Priorities and on Waiting Times. Quality Assurance Committee actively monitor the quality impact for those patients who are waiting to access our services.
- Appropriate and effective management of risks to delivery.

Board of Directors is also asked to approve the replacement of the *Use of Resources Rating* measure with a new *Bank Costs Compared to Plan* measure.

Integrated Quality and Performance report

For the period ending April 2026

Contents

Section Number	Section	Sub-Section	Page Number
1	**Executive Summary**		**3**
		• Summary Headlines	4
		• Board Integrated Performance Dashboard	5
		• Board Integrated Performance Dashboard – Performance Assurance Ratings	7
		• Board Integrated Performance Dashboard – Performance & Controls Assurance Framework	8
2	**Quality**		**10**
3	**People**		**26**
4	**Activity**		**35**
5	**Finance**		**38**
6	**Access to Services**		**51**
		• Waiting Times Dashboard – National Waiting Times Measures	52
		• Waiting Times Dashboard - Local Waiting Times Measures	53
		• Waiting Times *by Exception*	54
7	**Population health, prevention and reducing inequality**		**60**
8	**Care Group**		**65**
		• Durham, Tees Valley & Forensic Care Group – Overview	66
		• North Yorkshire, York & Selby Care Group - Overview	68
9	**National metrics**		**70**
		• NHS Oversight Framework	71
		• National Quality Requirements	72
		• Mental Health Priorities – Provider and System-wide Plans	78
		• Mental Health Priorities – System-Wide Plans	81
10	**Appendices**		**90**
		• Our Guide To Our Statistical Process Control Charts	91
		• Our Guide To Our Statistical Process Control Charts: Interpreting summary icons	92
		• Our Approach to Data Quality	93
		• Our Approach to Performance and Controls Assurance	94
		• Glossary	95

1. Executive Summary

Governance forum responsible: Executive Directors Group
Executive lead: Alison Smith, Chief Executive

Summary Headlines

- **Overall assurance** remains positive, with good controls assurance and performance oversight in place through the Integrated Performance Approach and revised Integrated Quality and Performance Report (IQPR) format ; however, performance assurance is mixed, with some areas (as below) reported with reasonable assurance.

- **Patient flow** continues to be the Trust's most significant operational and financial pressure, with high numbers of patients clinically ready for discharge impacting on bed occupancy levels and length of stay, contributing to an estimated c.£18m annual cost pressure.

- **Sustained demand and capacity challenges** are impacting access to care, particularly across neurodevelopmental services, EIP, CAMHS and talking therapies; waiting time pressures are noted despite active management and remedial actions, with longer-term improvement dependent on workforce, commissioning and service transformation.

- **Workforce** remains a key enabler and constraint, with sickness absence above target, although retention, training compliance and management processes are improving, indicating early impact of workforce interventions.

- The **financial position** is better than planned at this early stage of the financial year and forecast to deliver to plan. However, this is not without risk, and delivery depends on achievement of ambitious efficiency schemes (including meeting NHSE stretch requirements to continue actions to reduce bank and agency costs) and on mitigation of emerging in-year pressures (including in respect of nationally negotiated pay award where funded through tariff).

- **Inequalities** and data quality represent areas of partial assurance, with emerging evidence of variation in access and outcomes across population groups and some limitations in data completeness (e.g. ethnicity recording); both part of targeted improvement actions

- **Core quality, safety and key national standards** remain strong, with high levels of positive patient and carer experience, low levels of harm, delivery of 72-hour follow-up and EIP standards, and near elimination of out-of-area placements

Executive Summary - Board Integrated Performance Dashboard

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC			92.00%	93.54%	93.54%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	86.79%	86.79%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	70.83%	70.83%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	51.79%	51.79%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	46.39%	46.39%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	62.38%	62.38%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC			30.00%	28.65%	28.65%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	87.83%	87.83%

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
9)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC				14.25%	14.25%
10)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC			0	3	3
11)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				1	1
12)	The number of Incidents of moderate or severe harm	QAC				17	17
13)	The number of Restrictive Interventions Used	QAC				1,058	1,058
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	0
15)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	0
16)	The number of uses of the Mental Health Act	MHLC				304	304

Executive Summary - Board Integrated Performance Dashboard

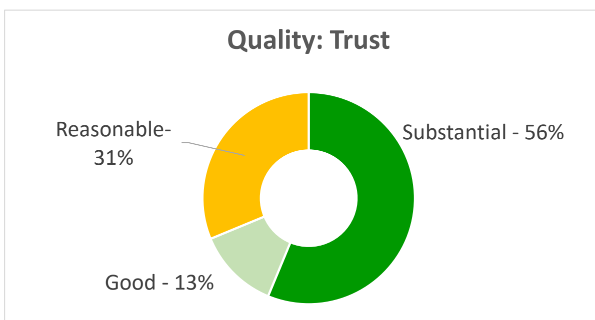
Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
17)	Percentage of staff recommending the Trust as a place to work	PC&D		?	60.00%	52.38%	52.38%
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D		?	65.00%	59.78%	59.78%
19)	Staff Leaver Rate	PC&D	L	P	11.00%	9.88%	9.88%
20)	Percentage Sickness Absence Rate (month behind)	PC&D	H	F	5.50%	6.49%	6.49%
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	P	85.00%	92.86%	92.86%
22)	Percentage of staff in post with a current appraisal	PC&D		P	85.00%	89.10%	89.10%

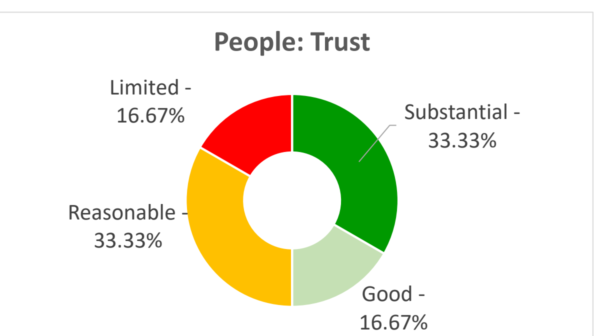
Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
23)	Number of new unique patients referred	RPC				7,578	7,578
24)	Unique Caseload (snapshot)	RPC	L			62,550	62,550

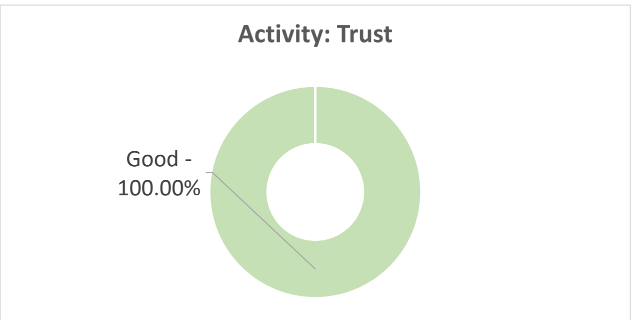
Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
25)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	666,998	229,781
26)	Financial Plan: Agency expenditure compared to agency target	RPC	397,876	305,263
27)	Agency price cap compliance	RPC	67.00%	43.63%
28)	Use of Resources Rating - overall score	RPC	3	3
29)	CRES Performance - Recurrent	RPC	1,204,000	1,105,677
30)	CRES Performance - Non-Recurrent	RPC	401,000	499,553
31)	Capital Expenditure (CDEL)	RPC	1,549,000	1,355,000
32)	Cash against plan	RPC		

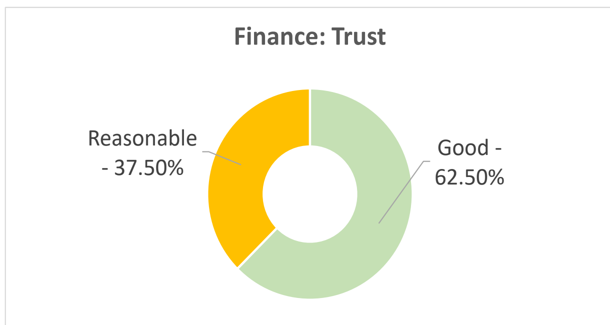
Executive Summary - Board Integrated Performance Dashboard – Performance Assurance Ratings

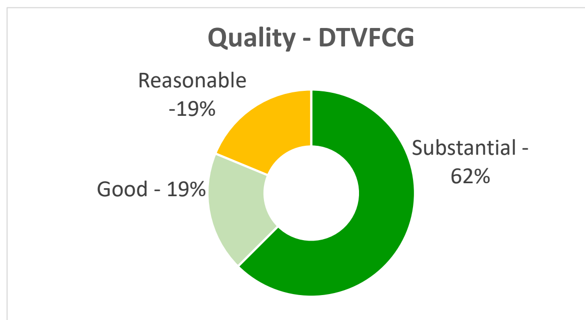
The visuals below depict performance assurance ratings for all measures part of the Integrated Performance Dashboard (IPD) – shown on the previous slides (5-6). Each measure is assigned a Performance Assurance rating based on SPC variation, performance against standard, trend, and wider intelligence. The assessment begins with a Controls Assurance rating (informed by SPC variance or, where necessary, forecast outturn or benchmarking), and is then refined by considering delivery against standards, underlying variation, and the direction of trend. This methodology is in line with the Performance & Controls Framework which is shown on the following slide, and further detailed in the Appendix.

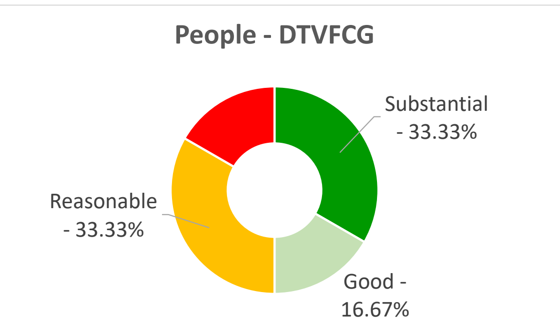


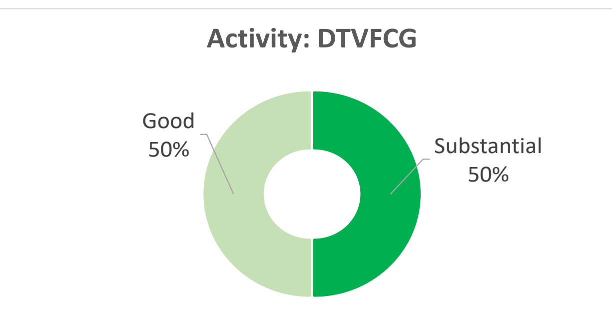


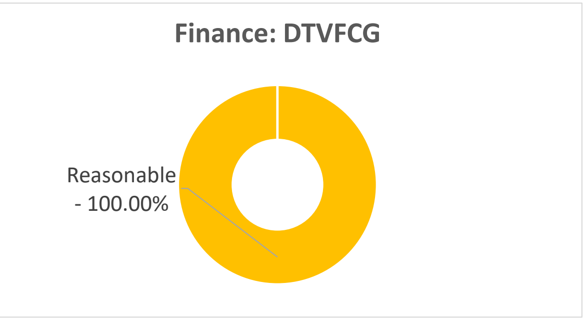


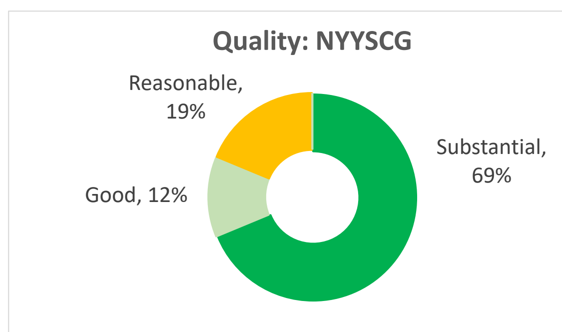


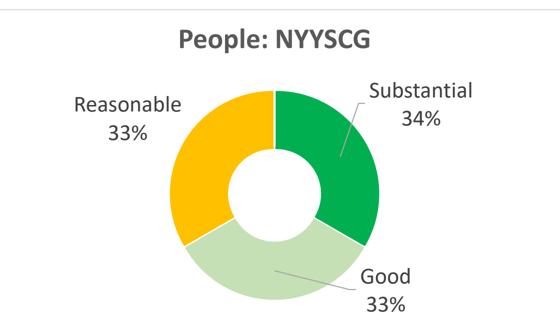


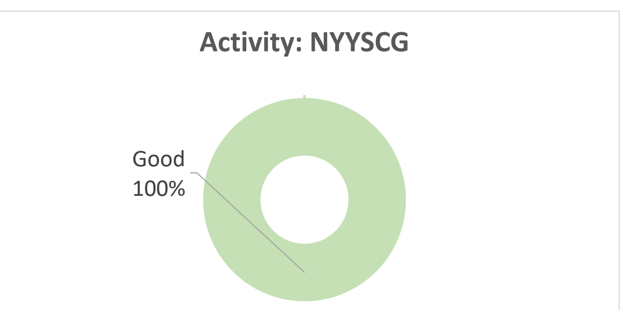


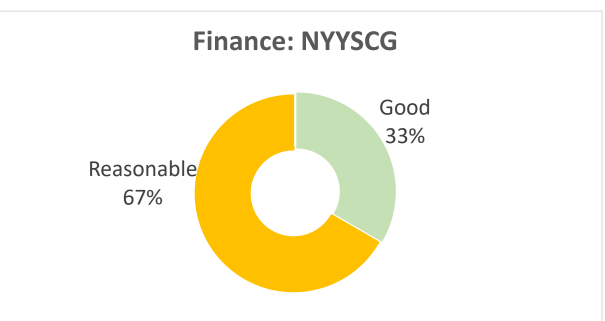












Glossary

DTVFCG	Durham, Tees Valley & Forensic Care Group
NYYSCG	North Yorkshire, York & Selby Care Group

Key

- Substantial
- Reasonable
- Good
- Limited

Executive Summary - Board Integrated Performance Dashboard – Performance & Controls Assurance Framework

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 • CYP showing measurable improvement following treatment - clinician reported • Compliance with ALL mandatory and statutory training ***increased performance assurance***	• Adults and Older Persons showing measurable improvement following treatment - clinician reported • Bed Occupancy (AMH & MHSOP A & T Wards) • Staff Leaver Rate • Unique Caseload		
Neutral	• Patients surveyed reporting their recent experience as very good or good • CYP showing measurable improvement following treatment - patient reported ***reduced controls 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 ***increased performance assurance*** • Staff in post with a current appraisal ***increased performance assurance; reduced controls assurance.***	• New unique patients referred • Financial Plan: SOCI - Final Accounts - Surplus/Deficit • Financial Plan: Agency expenditure compared to agency • CRES Performance – Non-Recurrent	• Inpatients reporting that they feel safe whilst in our care ***reduced performance assurance*** • Adults and Older Persons showing measurable improvement following treatment - patient reported ***reduced performance and controls assurance*** • Inappropriate OAP bed days for adults that are 'external' to the sending provider ***reduced performance and controls assurance*** • Staff recommending the Trust as a place to work • Staff feeling they are able to make improvements happen in their area of work	• Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed) ***new***
Negative		• Use of Resources Rating – overall • Cash balances (actual compared to plan)	• Restrictive Intervention Incidents Used • Agency price cap compliance • CRES Performance – Recurrent • Capital Expenditure (Capital Allocation)	• Percentage Sickness Absence Rate

2. Quality

Governance forum responsible:	Quality and Assurance Committee
Non-Executive Chair:	Marie Burnham (Interim Chair QAC)
Executive Lead:	Beverley Murphy

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

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 April, **1239** 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, **1159 (93.54%)** scored "very good" or "good".

There is no significant change at Trust and Care Group level in the reporting period; there is special cause improvement for Children & Young Peoples Services in Durham, Tees Valley & Forensic Care Group.

There is no significant change in the number of patients who have responded to this question at Trust and Care Group level. There is special cause concern for Children & Young Peoples Services in Durham, Tees Valley & Forensic Care Group.

National Benchmarking data
The latest National Benchmarking data (February 2026) shows the England average (including Independent Sector Providers) was **89.63%** and we were ranked **13** out of 66 trusts (1 being the best with the highest ratings), we were also ranked 3rd for total number of responses received.

Underlying issues:
Low response rates within DTVFCG CYPS, with ongoing issues identified regarding the functionality of the QR code.

Actions:
DTVFCG CYPS are meeting regularly with the Patient Experience Team through both support and quality visits to teams within the service. Collaborative work is underway to understand current barriers and identify opportunities to improve response rates within the service since the implementation of iWGC. Work is ongoing to address QR code functionality issues. The team are also exploring alternative approaches to help increase response rates, including the potential use of a volunteer to contact patients post-appointment.

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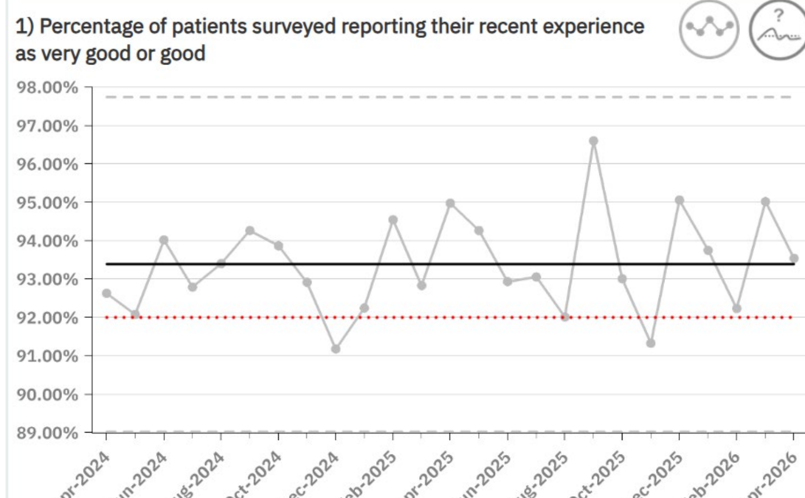
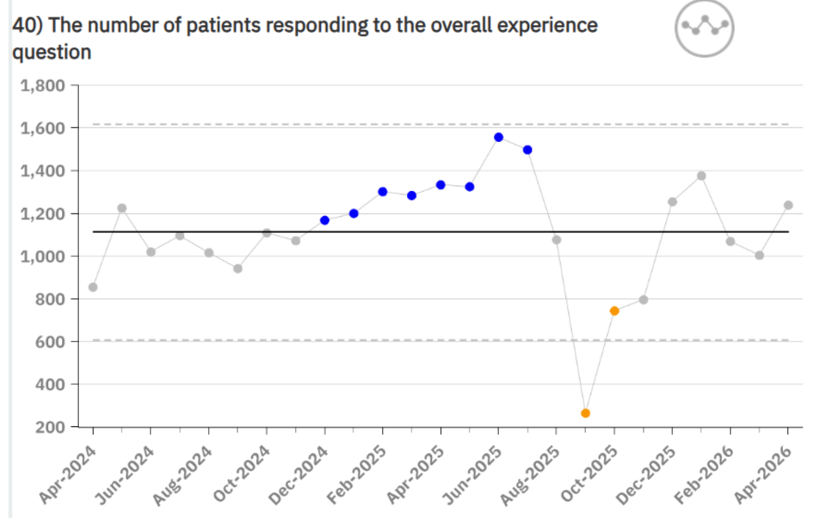


80%

Updated March 2026

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

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.

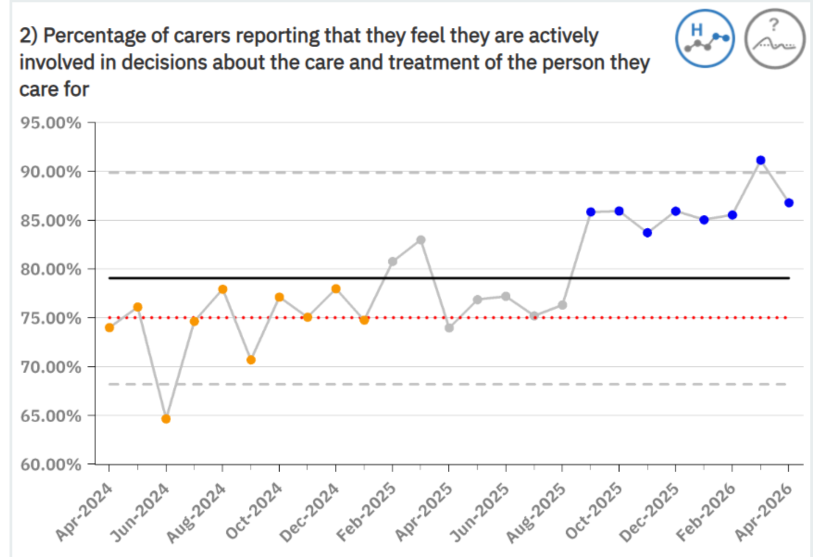
What does the chart show/context:
During April, **280** carers responded to the question in the carer survey: Question: “Are you offered choices about the care being provided?”. Of those, **243 (86.79%)** scored “yes”.

There is special cause improvement at Trust and Care Group level in the reporting period, and for Children & Young Peoples Services and Adult Mental Health in Durham, Tees Valley & Forensic Care Group and Adult Learning Disabilities in North Yorkshire & York Care Group.

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

Underlying issues:
The number of carer responses remain a concern.

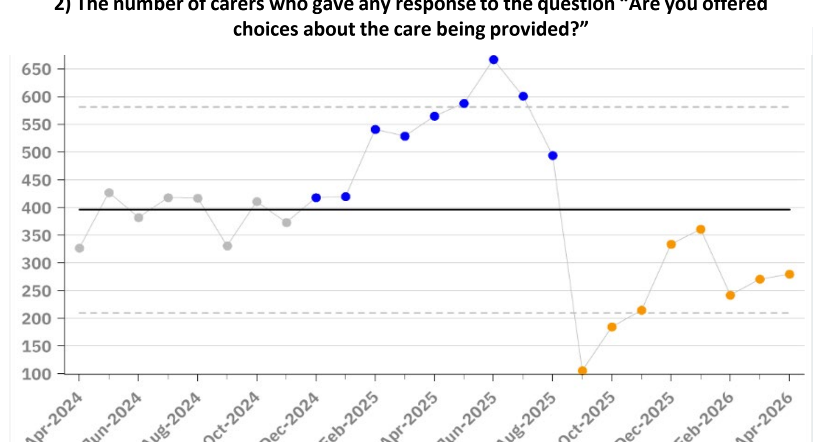
Actions:
Self-assessment action plans have been developed across all areas to support the annual Triangle of Care report to the Carers Trust, each including actions aimed at increasing carer feedback.



73%

Updated March 2026

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

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

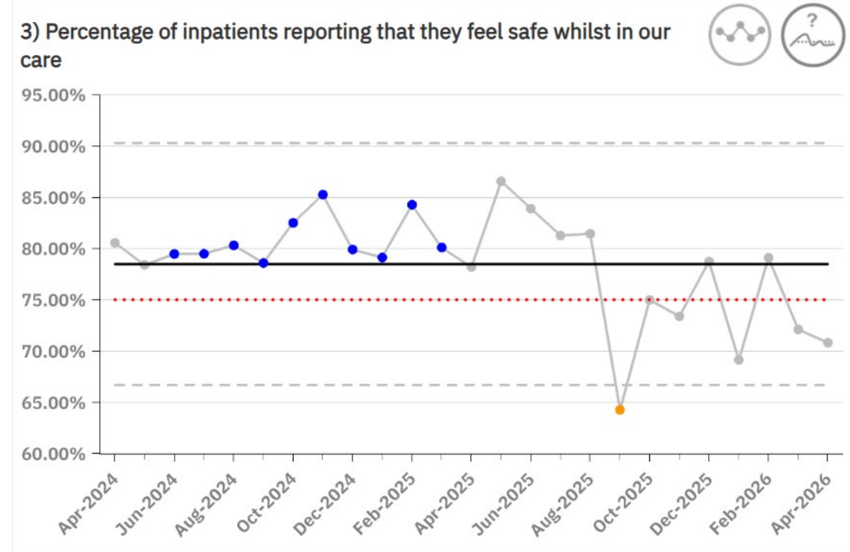
What does the chart show/context:
During April, **48** patients responded to the overall experience question in the patient survey: "During your stay, did you feel safe?". Of those, **34 (70.83%)** scored "yes ".

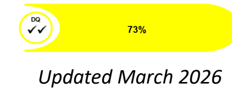
There is no significant change at Trust and Care Group level in the reporting period; however, there is special cause concern for Adult Mental Health Services in North Yorkshire, York & Selby Care Group.

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

Underlying issues:
Within inpatient services the survey is currently only available for completion by using the QR code or using the standard paper-based surveys; the easy-read versions have not been developed.

Actions:
- The Patient & Carer Experience Team are working with Learning Disabilities Services and I Want Great Care to develop and roll out the easy-read paper-based surveys to inpatient services; it is anticipated we will have a timescale for development by the end of July 2026.
- We have noted that there are areas of special cause concerns in AMH and MHSOP in DTVFCG that we need to understand further. This has been raised with Care Group Leads and will be discussed in Integrated governance forum this month with appropriate actions agreed and implemented.

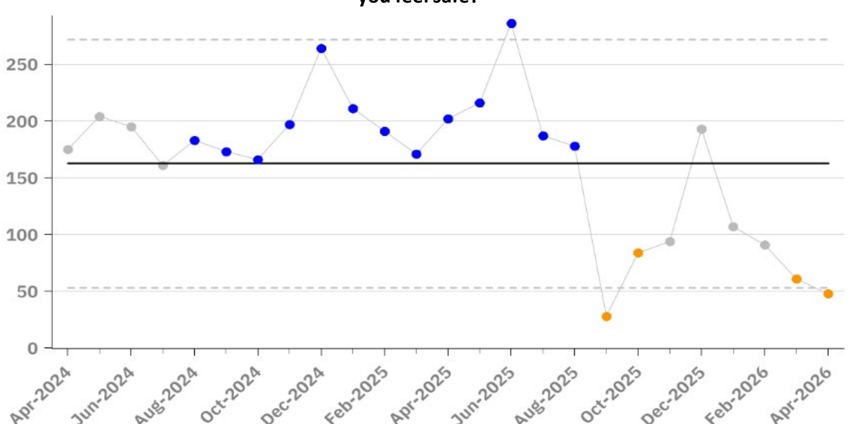




Updated March 2026

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

3) The number of patients who gave any response to the question "During your stay did you feel safe?"



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 April, **616** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **319 (51.79%)** made a measurable improvement.

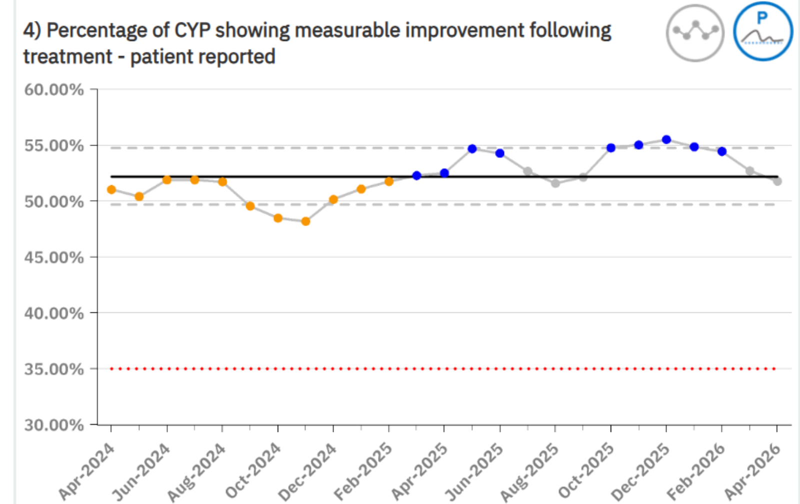
There is no significant change at Trust level and for North Yorkshire, York & Selby Care Group in the reporting period; there is special cause improvement for Durham, Tees Valley & Forensic Care Group. Performance is above standard at all levels.

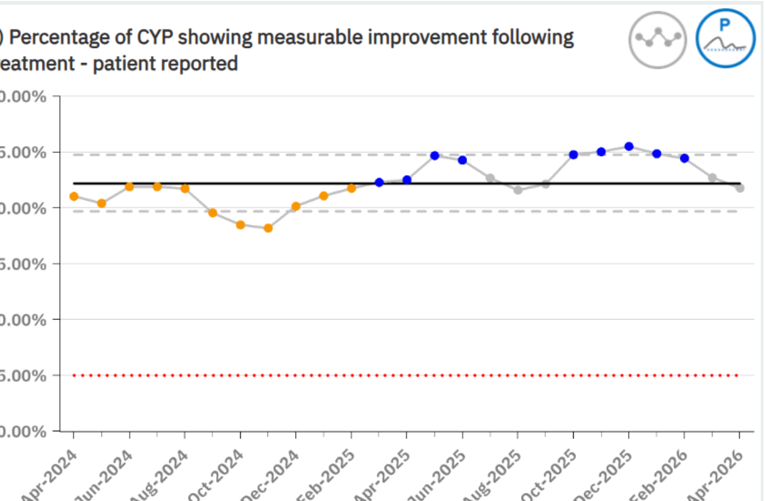
There is special cause concern in the rate of paired outcomes for patients discharged at Trust level and for North Yorkshire, York & Selby Care Group; there is no significant change for Durham, Tees Valley & Forensic Care Group.

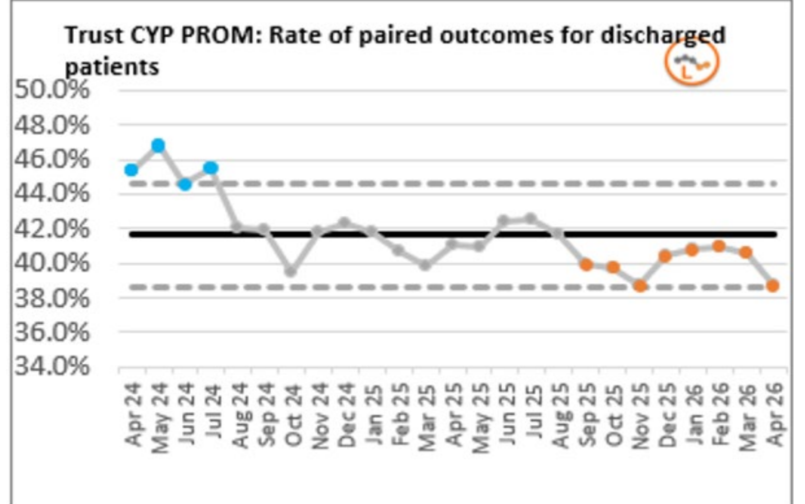
The accepted Patient Rated Outcome Measures are CORS/ ORS/ GBO (goal-based outcomes)/ RCADS/ SDQ/ SCORE-15/ PHQ-9/ GAD-7/CORE-10.

Underlying issues:
- 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)*
- Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV
- There are a number of outcome measures that are not currently included in the rate of paired outcomes for discharged patients linked to CITO.

Actions:
- 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.
- Business Intelligence to effect the changes required to enable the flow of GBO from Cito into the measure by the end of June 2026 (previously May).
- Business Intelligence to effect the changes required to include those patients that transition between CYP and AMH within the measure by the end of September 2026.







Actions continued:
- Work is underway to remediate historical gaps in clinical documentation and to enable previously unsigned documents, including some clinical outcome measures, to complete an automated sign-off process and be incorporated into the IIC. This is anticipated to be completed for the May 2026 report (produced in June).

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 April, **1317** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 611 (46.39%)** made a measurable improvement.

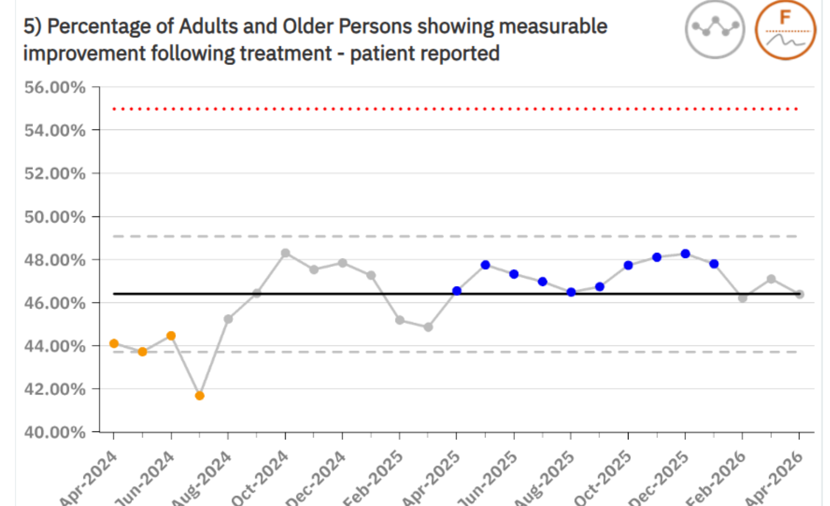
There is no significant change at Trust level, for North Yorkshire, York & Selby Care Group and for Mental Health Services for Older People within that Care Group in the reporting period; there is special cause improvement for Durham, Tees Valley & Forensic Care Group. Performance is below standard at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

There is special cause concern in the rate of paired outcomes for patients discharged at Trust and Care Group level, and for MHSOP in DTVFCG and AMH in both Care Groups.

The accepted Patient Rated Outcome Measure is Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS).

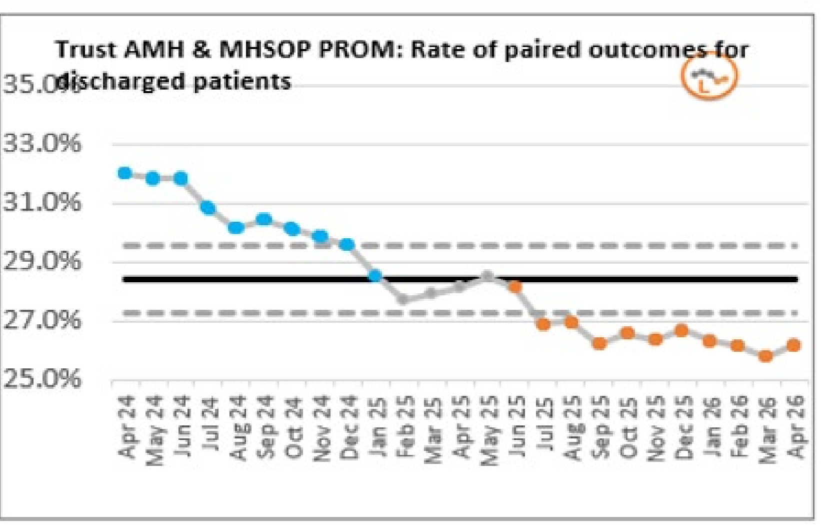
Underlying issues:
- There may have been some confusion regarding use of SWEMWBS following the implementation of new PROMs.
- Within MHSOP, around 30% of discharges currently have a clinically inappropriate or declined PROM status.
- There are a number of outcome measures that are not currently included in the rate of paired outcomes for discharged patients linked to CITO.

Actions:
- A piece of work is underway to develop a new PROM for organic MHSOP services, recognising that SWEMWBS is not always an appropriate measure, noting that pending completion of this work, there can be limited improvement in the measure for these patients.
- Work is underway to remediate historical gaps in clinical documentation and to enable previously unsigned documents, including some clinical outcome measures, to complete an automated sign-off process and be incorporated into the IIC. This is anticipated to be completed for the May 2026 report (produced in June).



73%

Updated March 2026



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 April, **715** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **446 (62.38%)** made a measurable improvement.

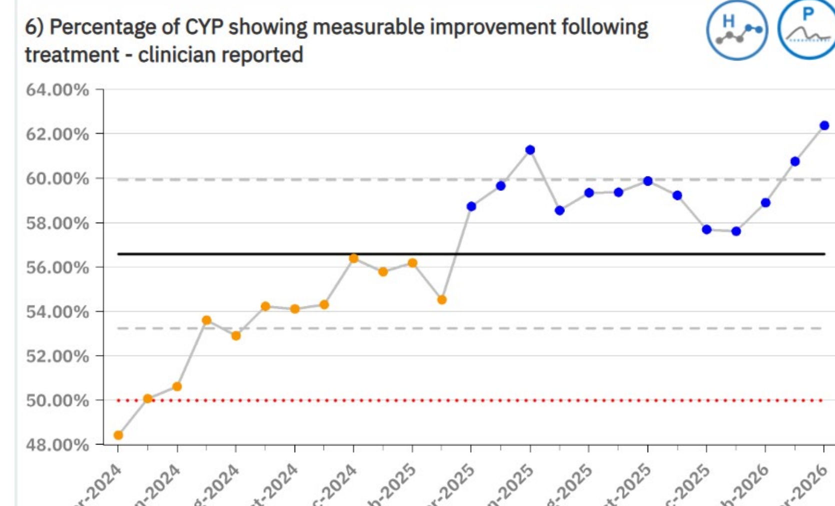
There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; there is no significant change for North Yorkshire, York & Selby Care Group. Performance is above standard at all levels.

There is no significant change in the rate of paired outcomes for patients discharged at Trust level. Whilst there is special cause improvement for Durham, Tees Valley & Forensic Care Group, there is special cause concern for North Yorkshire, York & Selby Care Group.

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

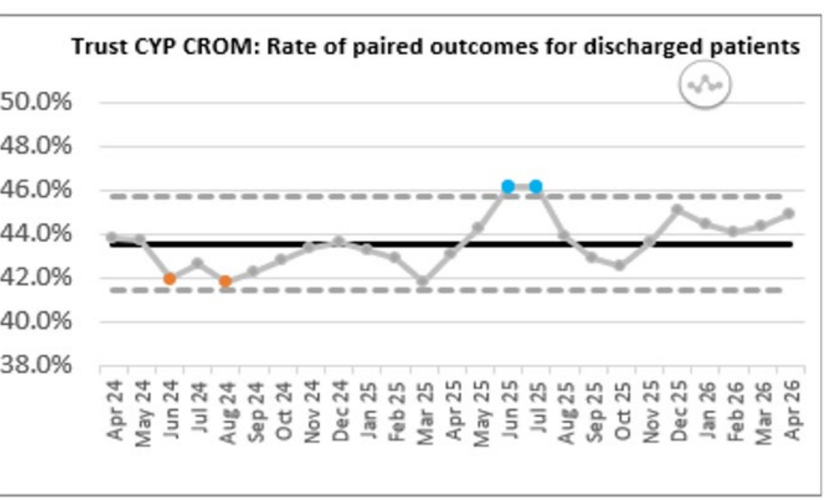
Underlying issues:
- Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV
- There are a number of outcome measures that are not currently included in the rate of paired outcomes for discharged patients linked to CITO.

Actions:
- Business Intelligence to effect the changes required to include those patients that transition between CYP and AMH within the measure by the end of September 2026.
- Work is underway to remediate historical gaps in clinical documentation and to enable previously unsigned documents, including some clinical outcome measures, to complete an automated sign-off process and be incorporated into the IIC. This is anticipated to be completed for the May 2026 report (produced in June).



73%

Updated March 2026



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 April, **2419** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 693 (28.65%)** made a measurable improvement.

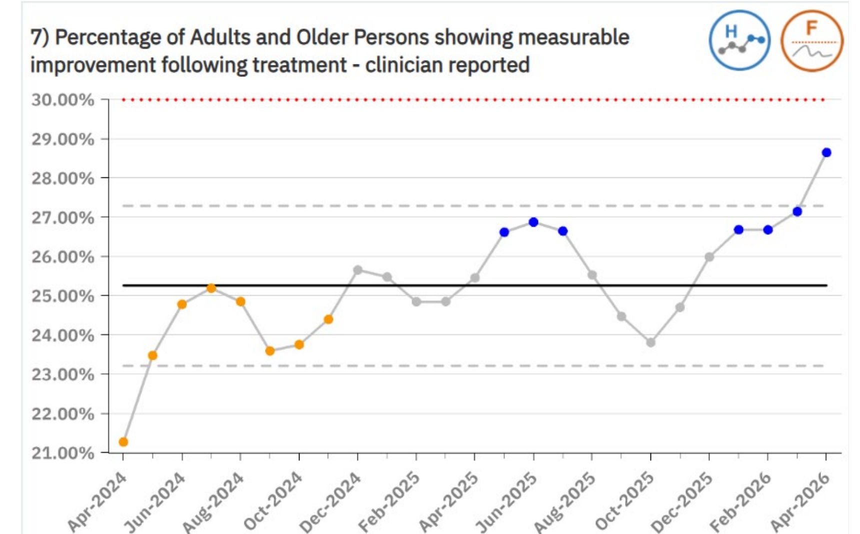
There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; there is no significant change for North Yorkshire, York & Selby Care Group. There is special cause improvement for Mental Health Services for Older People in DTVFCG and Adult Mental Health in both Care Groups. Performance is above standard for Adult Mental Health in both Care Groups. The low performance in MHSOP continues to be a concern.

There is no significant change in the rate of paired outcomes for patients discharged at Trust level and for DTVFCG. There is special cause improvement for NYYSCG and for MHSOP in both Care Groups. There is special cause concern for AMH in NYYSCG.

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

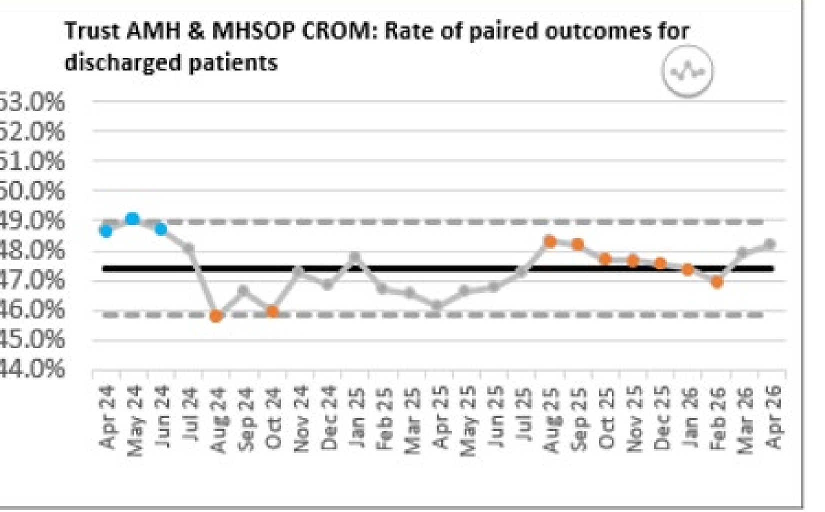
Underlying issues:
- There are a number of outcome measures that are not currently included in the rate of paired outcomes for discharged patients linked to CITO.

Actions:
- Work is underway to remediate historical gaps in clinical documentation and to enable previously unsigned documents, including some clinical outcome measures, to complete an automated sign-off process and be incorporated into the IIC. This is anticipated to be completed for the May 2026 report (produced in June).



73%

Updated March 2026



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

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

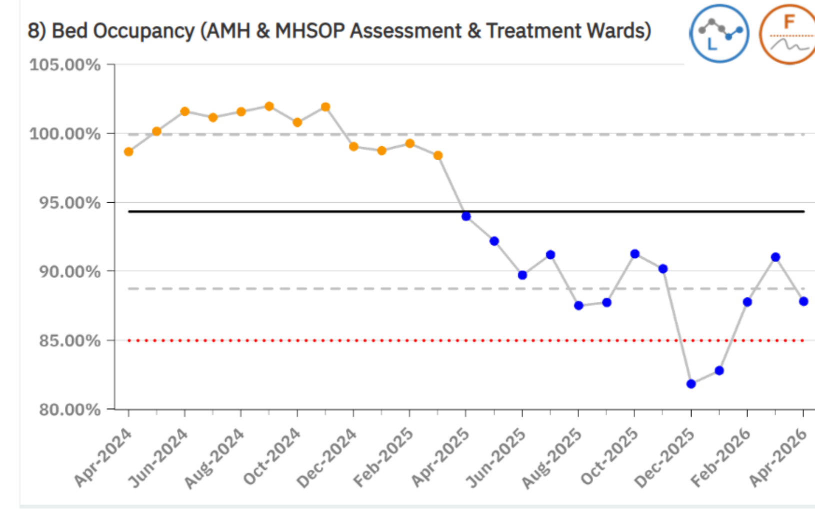
What does the chart show/context:
During April, **11,160** daily beds were available for patients; of those, **9,802 (87.83%)** were occupied.

There is special cause improvement at Trust and Care Group level in the reporting period and for Adult Mental Health in both Care Groups. Performance is below standard for Adult Mental Health in both Care Groups.

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 experiencing longer lengths of stay due to MoJ restrictions and timescales for decisions to be made.

Actions:
- In May 2026, the Director of Operations presented an outline business case (previously referenced as a full business case) for a crisis assessment centre in Durham to the People & Resources EDG. The proposal aims to reduce unnecessary admissions to assessment and treatment wards, and work is now underway to develop the full business case, which will be presented to the Partnerships & Governance EDG in July 2026.
- In NYYSCG the ICB have approved bids for two 24/7 Neighbourhood Centres in Harrogate and Scarborough (to open 2026/27). Business cases for the neighbourhood centres to be developed and shared within the Trust by end of July 26. The ICB has also approved a bid for a Mental Health Emergency department in York, which is now anticipated to open in 2029/30.
- The outline business case for the closure of MHSOP organic beds on Springwood and the development of a 24/7 crisis and care home in-reach/outreach service for the Scarborough, Whitby and Ryedale area was not presented to the Partnership & Governance EDG as planned in May (previously April). **(Not Complete)** A joint business case will now be developed in partnership with the DTVFCG organic bed provision. Submission to the Partnership & Governance EDG will follow on completion; **revised timescale to be confirmed**.
- A KPI change was completed in April 2026 to amend the scope of the Bed Occupancy measure to include PICU wards and align the measure with those for out of area placements and clinically ready for discharge. **(Complete)** This is reflected in this month's report.



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

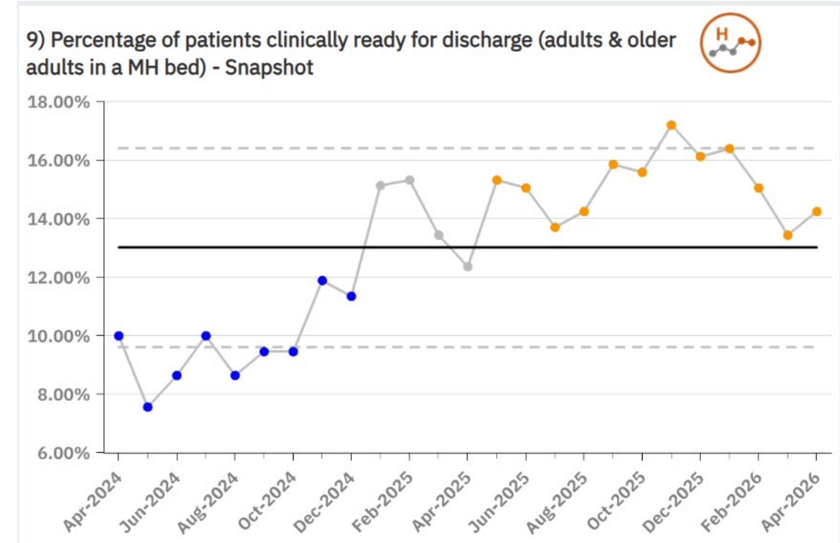
What does the chart show/context:
At the end of April 2026, there were **53** adults clinically ready for discharge occupying adult MH, older adult MH or PICU beds, accounting for **14.25%** of our **372** acute beds open to admission.

There is special cause concern in the percentage of patients clinically ready for discharge at Trust level, for Durham, Tees Valley & Forensic Care Group and for Adult Mental Health in that Care Group in the reporting period; there is no significant change for North Yorkshire, York & Selby Care Group.

At Trust level, patients classified as clinically ready for discharge in April equated to an average of 73.0 beds (44.2 Adult and 28.8 Older Adult beds), with an associated direct cost of c.£1.51m. Of the cost, c.£0.88m relates to Adult and c.£0.63m relates to Older Adult. The annualised impact of patients classified as clinically ready for discharge is £18.07m.

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 next phase of the Durham hub development is being progressed by the Project Leadership Team, with the revised Clinically Ready for Discharge Programme work plan to be presented to the Hospital Community Board in May 2026 (previously April).
- Piloting of the new ways of working for the Tees Valley transfer of care hub commenced in March 2026; the first evaluation will be completed at month 3 (June 2026).
- 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 post is anticipated to be advertised by the end of April. **(Not Complete)** Work is underway to refine the job description, after which it will be resubmitted for evaluation.
- In North Yorkshire recruitment continues for a discharge liaison officer to support patient discharge within adult beds at Cross Lane Hospital; interviews are scheduled for June 2026.



Actions continued:
- Within York, the Trust is to participate 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. 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.

10) Number of inappropriate OAP bed days for adults that are ‘external’ to the sending provider

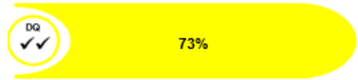
Background / standard description:
We are aiming to have no out of area bed days.

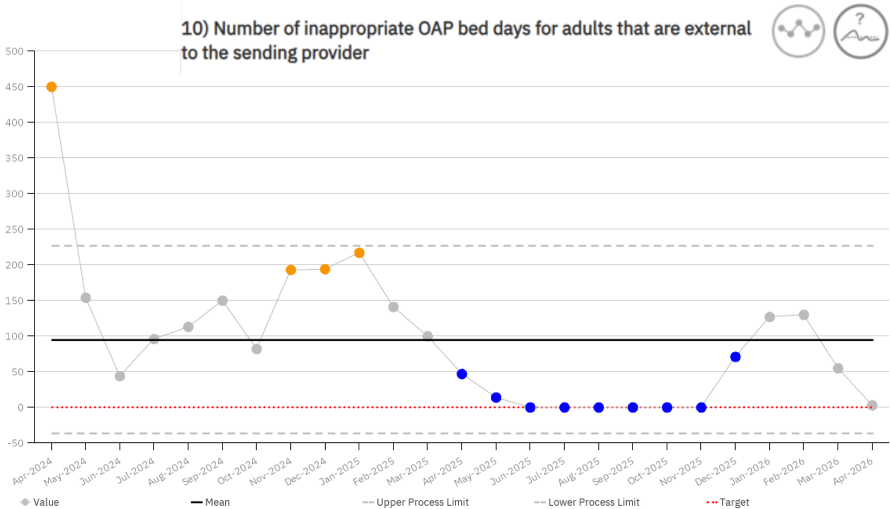
What does the chart show/context:
For the 3-month rolling period ending April, **3** days were spent by a patient in a bed away from their closest hospital.

There is no significant change at Trust, Care Group level and specialty level in the reporting period. Performance is above standard for Adult Mental Health Services in both Care Groups.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.





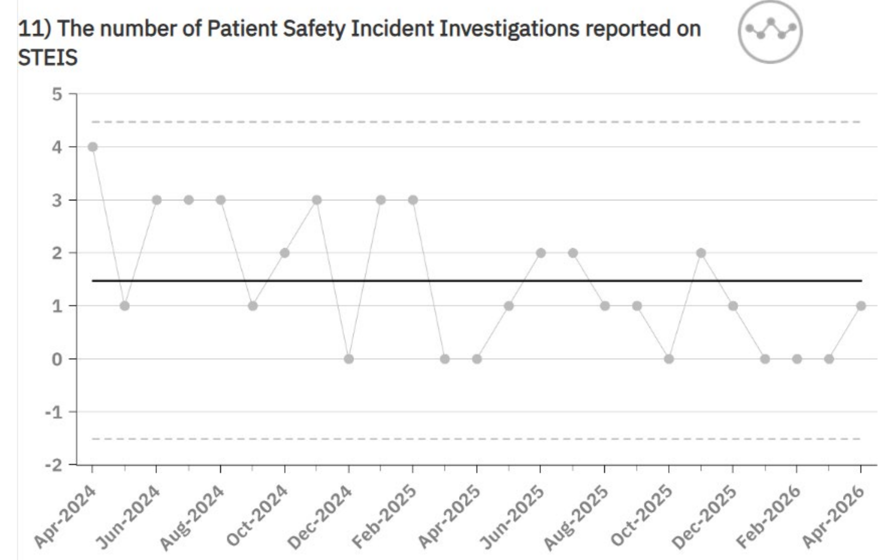
11) The number of Patient Safety Incident Investigations reported on STEIS

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

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 against locally set timeframes 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 commenced formal testing of a new AAR process with the aim of reducing the lead time for completing AARs in early February 2026 for a four-month period across nine AMH planned care teams. During April, early testing of the revised AAR processes demonstrated clear value. **(Complete)** *See following actions*
- Preparation has been completed to expand testing across
    - all NYYS AMH community and specialist teams from May 2026
    - all DTVF AMH Planned Care teams from July 2026.
- A structured regroup is planned for September 2026 to ensure learning is captured consistently and refinements are coordinated during the testing phase.



12) The number of Incidents of moderate or severe harm

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

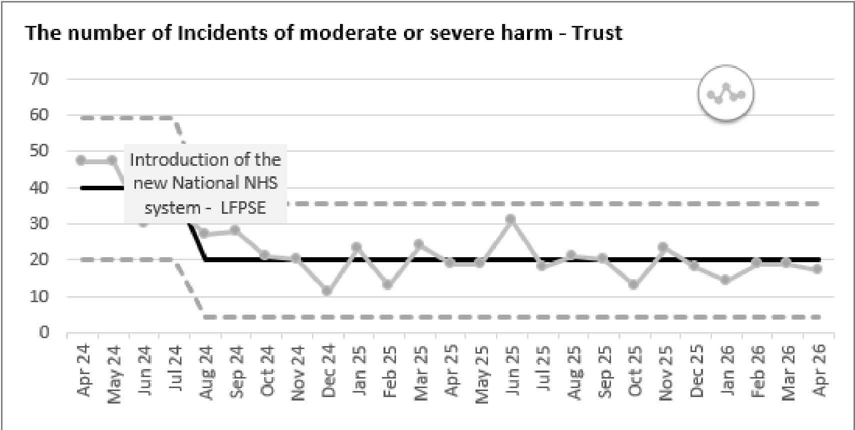
There is no significant change at Trust and Care Group level. There is special cause improvement in Mental Health Services for Older People in North Yorkshire Care Group.

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.



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.

What does the chart show/context:
1058 types of Restrictive Interventions were used during April.

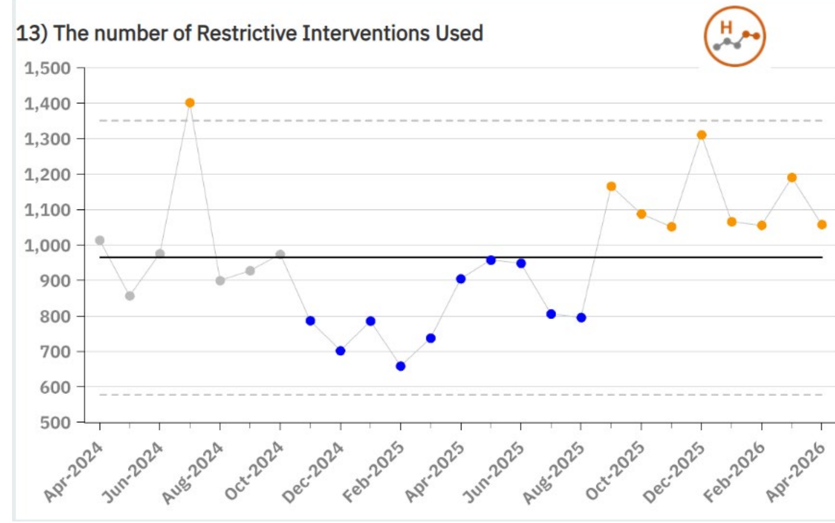
There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period and for Adult Learning Disabilities within that Care Group; there is no significant change for North Yorkshire, York & Selby. There is special cause improvement for Health & Justice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

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 and support is continuing.
- The Positive & Safe Lead, Specialist Practitioner for Positive & Safe and clinical skills trainers have completed observations within the environment and following the provision of feedback, an options appraisal has been completed with the team to consider best-fit reactive strategies. Observations will continue to monitor the implementation of these.
- The ALD service has been identified as a Service Requiring Additional Support due to the acute nature of the clinical needs and the associated impacts. A Recovery Plan is in place, including supportive oversight from the Care Group Board, enhanced support from the senior leadership team, the development of detailed Positive Behavioural Support plans, the exploration of options for securing additional staff, and staff wellbeing offers to provide support and maintain attendance.
- A request for an independent review by Mersey Care has been submitted.



Note: The high use noted in July 2024 relates to one patient within Adult Eating Disorders Inpatients.

14) The number of Medication Errors with a severity of moderate harm and above

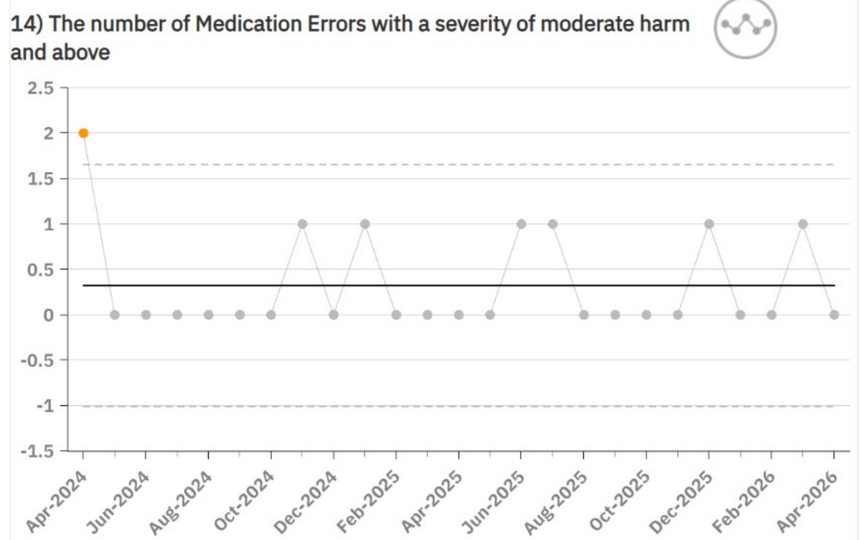
What does the chart show/context:
0 medication error was recorded during April.

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

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.



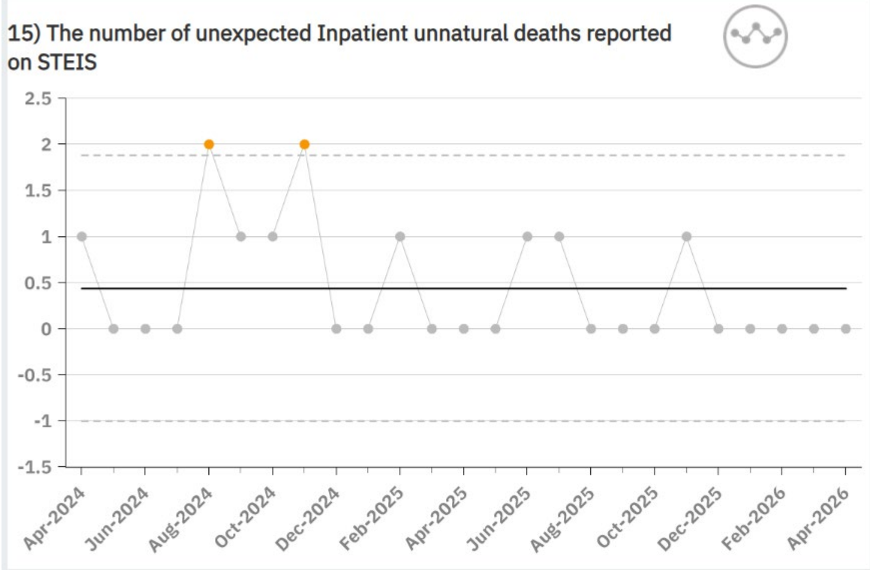
15) The number of unexpected Inpatient unnatural deaths reported on STEIS

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 April.

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.



16) The number of uses of the Mental Health Act

What does the chart show/context:
There were **304** uses of the Mental Health Act during April.

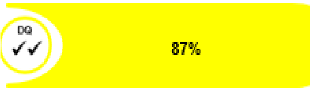
There is no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; however, there is an unexpected low shift in uses in North Yorkshire, York & Selby Care Group.

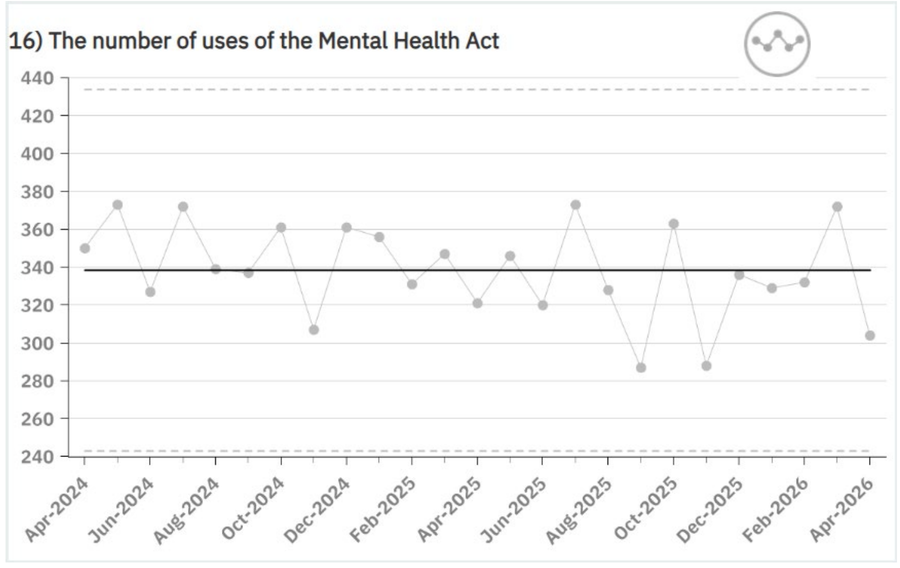
Analysis of the 2023/24 NHS Digital Mental Health Act data showed that while the Trust reflected the national pattern of higher detention rates in more deprived populations, overall detention rates were above expected levels compared to national benchmarks. Patients recorded within the White group were 1.79 times more likely to be detained than the national average, while Black/Black British patients experienced the highest detention rates of all ethnic groups, with the number of Black/Black British females detained around double that expected.

Initial findings on the national Mental Health Act data 2024/25 were shared with the Mental Health Legislation Committee in May 2026 and further discussions are being progressed. An update will be provided in the May 2026 IQPR (produced in June).

Underlying issues:
- Analysis of the 2023/24 national Mental Health Act data shows some areas of inequality in our detention rates.
- Within DTVFCG CYP increased demand for inpatient services and a high volume of complex cases in the community requiring intensive support, had previously resulted in an increase in uses of the Mental Health Act.

Actions:
- 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.
- The job description for the EDI officer to support Patient & Carer Race Equality Framework delivery is currently progressing through job evaluation. Pending recruitment, bank staff has been appointed to enable analysis and governance of the latest dataset and the drafting of the initial community engagement plans. Comprehensive plans will be developed, and all aspects of the framework will be operational by March 2027.





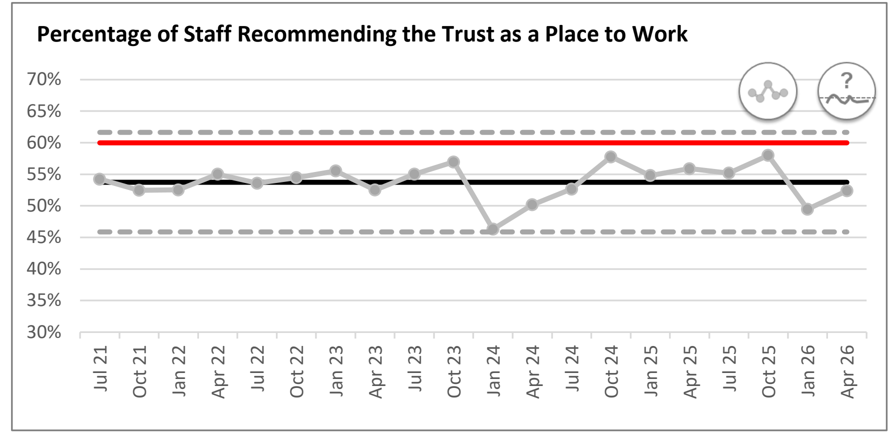
Actions continued:
- Within DTVFCG, the CYP Service Manager is leading a review with Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust, to understand the reasons for admission and to identify whether there was any learning to be taken forward. (**Complete)** No underlying themes were identified.
- The CYP Associate Director of Nursing to work with Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust in April 2026 to clinically review all current inpatients, with a view to improving patient flow. (**Complete)** No underlying themes or further actions were identified.

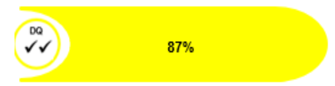
3. People

Governance forum responsible:	People and Culture Committee
Non-Executive Chair:	Roberta Barker
Executive Lead:	Sarah Dexter-Smith

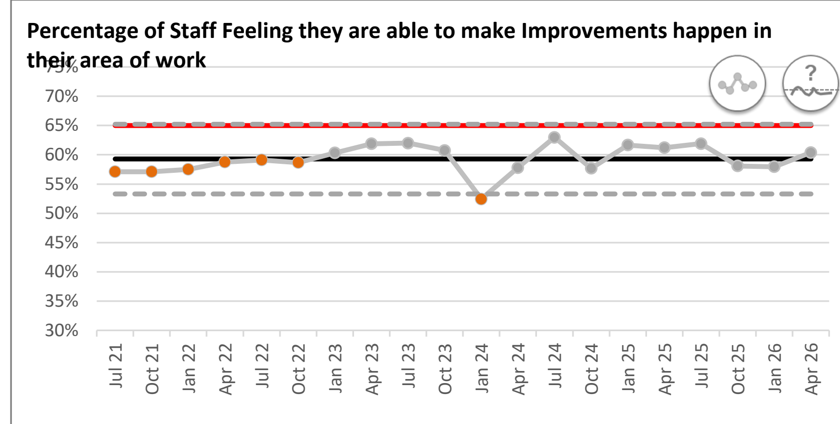
17) Percentage of staff recommending the Trust as a place to work

18) Percentage of staff feeling they are able to make improvements happen in their area of 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:
2,231 staff responded to the April Pulse Survey. In relation to the question "I would recommend my organisation as a place to work", **1,177 (52.76%)** responded either "Strongly Agree" or "Agree".

There is no significant change at Trust and Care Group level in the reporting period. We are currently reviewing the corporate directorate positions.

The NHS Staff Survey Benchmarking report 2025, shows the "best result" was 76% and the "average result" was 62% for similar organisations.

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:
2,231 staff responded to the April Pulse Survey. In relation to the question "I am able to make improvements happen in my area of work", **1347 (60.38%)** responded either "Strongly Agree" or "Agree".

There is no significant change at Trust and Care Group level in the reporting period. We are currently reviewing the corporate directorate positions.

The NHS Staff Survey Benchmarking report 2025, shows the "best result" was 66% and the "average result" was 59% for similar organisations.

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 April Pulse Survey equate to approximately 26% of staff, which is positive when compared to an estimated national response rate of 8% for the January 2026 Pulse Survey, noting that this estimate includes responses from non-substantive NHS staff. Benchmarking against the national response rate for the April Pulse Survey will be completed, once that data is released in June 2026.
- Emerging themes suggest that we need to make improvements in our flexible working and management practices.

See overleaf for actions

17) Percentage of staff recommending the Trust as a place to work
18) Percentage of staff feeling they are able to make improvements happen in their area of work

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. Members of the How We Work Programme Board have been agreed, and the Board will meet in May 2026. The mandate covers a conceptual shift in culture building on the foundations that we have laid in the last 4 years.
- 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 People Management Skills Programme 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. New programme dates are planned for 2026 and 2027, with the latest cohort starting in May 2026. Periodic reviews will be undertaken.
  - 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.

19) Staff Leaver Rate

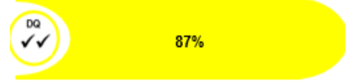
Background / standard description:
We are aiming for our staff leaver rate to be no more than 11%.

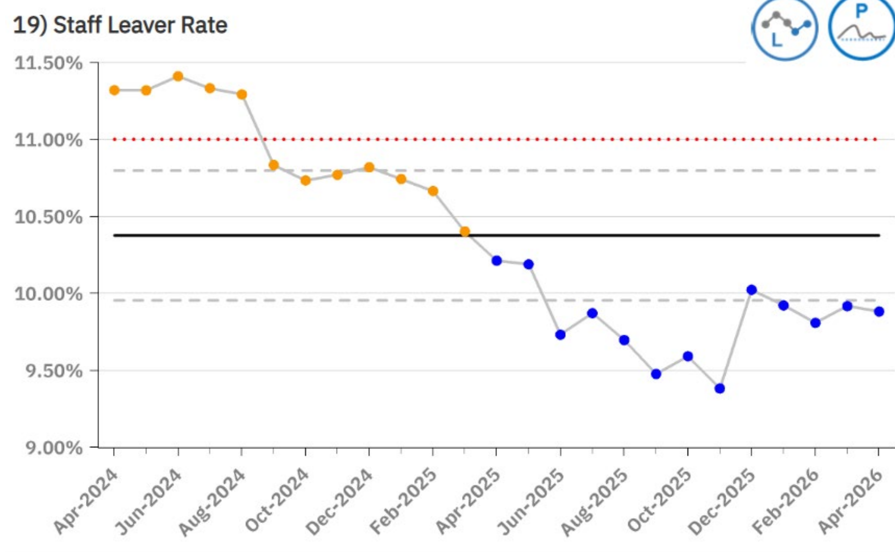
What does the chart show/context:
From a total of **7,421.39** staff in post 733.48 **(9.88%)** had left the Trust in the 12-month period ending April 2026.

There is special cause improvement at Trust level and for a small number of Directorates in the reporting period. There is special cause concern for Corporate Affairs & Involvement and Adult Learning Disabilities and Management in Durham, Tees Valley & Forensic Care Group. These areas have confirmed there is no actual concern at this stage. There is also special cause concern for Estates & Facilities Management, which is currently being reviewed by the service.

Underlying issues:
- Whilst no longer showing statistical concern, 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 identifying actions if required. **(Complete)**





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.

20) Percentage Sickness Absence Rate

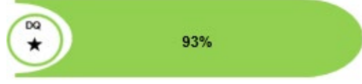
Background / standard description:
We are aiming for sickness absence to be no more than 5.5%

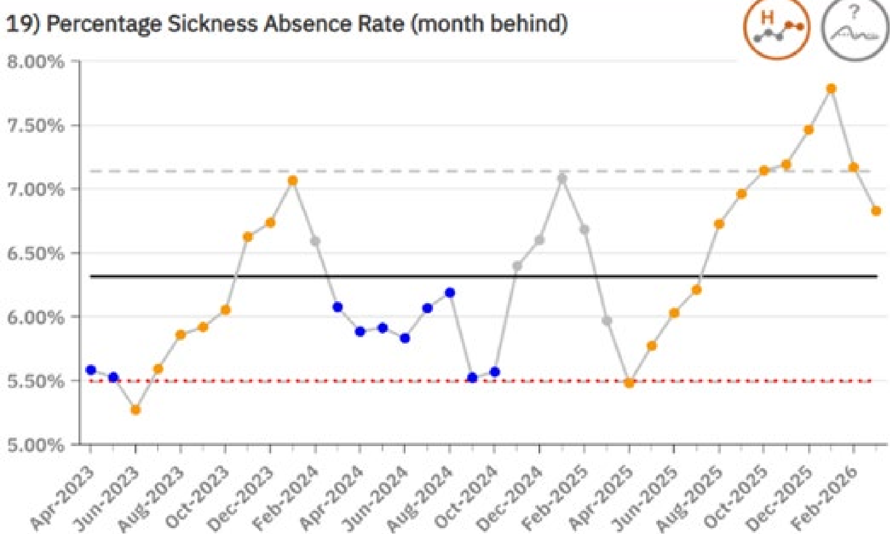
What does the chart show/context:
There were **233,284.94** working days available for all staff during April 2026 (reported month behind); of those, **15,133.45 (6.49%)** days were lost due to sickness.

There is special cause concern at Trust level in the reporting period and for Corporate Affairs & Involvement, Durham, Tees Valley & Forensic Care Group, Children & Young Peoples Services, Health & Justice and Mental Health Services for Older People within that Care Group, and North Yorkshire, York & Selby Care Group.

National Benchmarking for NHS Sickness Absence Rates published 30th April 2026 (data ending January 2026) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.63%** compared to the Trust mean of **6.27%**, with the Trust ranked 36 of 47 Mental health Trusts (1 being the best with the lowest sickness rate).

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





20) Percentage Sickness Absence Rate *continued*

Actions:

1. Strategic Leads for Health & Wellbeing have developed a briefing on what interventions are generally evidence based for LTS and STS (or if not evidence based, available and good face value). This will be shared with the People & Culture Senior Leads Meeting in April 2026 for approval. **(Complete)** *See below action*

2. ***NEW** The Strategic Lead for Health & Wellbeing will complete a scoping exercise to explore whether it is feasible to reduce the LTS initial contact timeframe for staff absent due to mental health issues from 28 days to 14 days by 31 May 2026.

3. 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) **(Not Complete)** One People Partner has completed training; bespoke training sessions for the remaining People Partners will be completed by the end of June 2026.

4. Director led sickness absence management meetings are being undertaken monthly supported initially by Heads of People & Resourcing within Adult Mental Health Services across both Care Groups as the pilot service. Initial feedback indicates that short-term sickness is being managed effectively, and long-term sickness is being appropriately progressed. The pilot will continue with existing teams for a six-month period to enable robust monitoring and evaluation. Expansion to additional teams is planned, and People & Culture are currently undertaking a review to identify the next cohort.

5. People Partners/Officers to provide training to all managers who have direct line management responsibility on Attendance Management (to commence from May (previously February 26 – December 2026) **(In Progress)** Formal training commenced in May 2026; 35 sessions have been booked between now and December 2026 and emails have been sent to all managers with responsibility for managing staff absence requesting they book on the training.

6. To review the existing Attendance Management policy (by end of January 26) **(Partially Complete)** It has been agreed with staff side to pause a full review of the procedure, pending the piloting of the approaches noted above.

7. 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.

21) Percentage compliance with ALL mandatory and statutory training

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

What does the chart show/context:
157,134 training courses were due to be completed for all staff in post by the end of April. Of those, **145,913 (92.86%)** were completed.

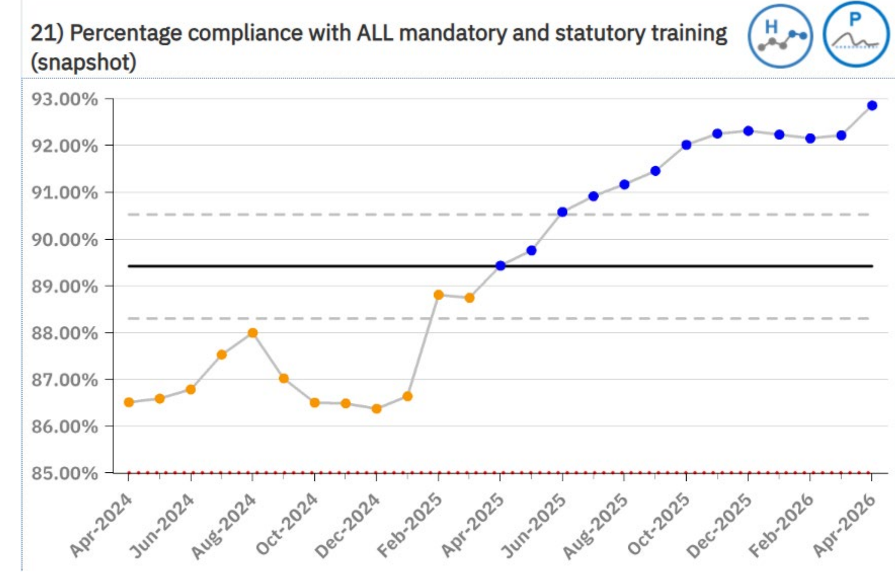
There is special cause improvement at Trust level and for most Directorates in the reporting period.

As at the 30th April 2026, no directorates are below 85%.

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

Actions:
- Executive Director of People & Culture to review membership of the Chief Executive Office and reallocate executive oversight by the end of March 2026. **(Complete)**
- 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. **(Partially Complete)** The training matrices have been approved for General Managers and Service Managers. Those for the Associate Director of Nursing and Modern Matron are with the Chief Nurse/Nursing & Governance Directorate for approval.
- Executive Director of Therapies to hold a workshop in June 2026 to review the essential training, which will include a further review of all mandatory and statutory training profiles.

93%



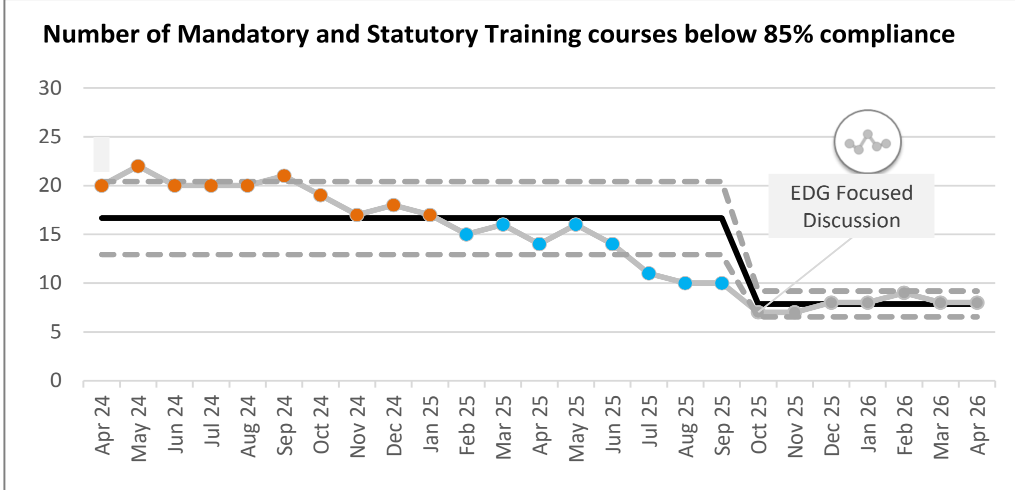
Courses below standard

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

What does the table show/context:
There is no significant change in the number of courses below 85%. We have **8** courses that are currently below the standard (same as the previous month); 7 of which are face to face.

Underlying issues:
- Staff unable to be released to attend training (high DNA rate and wasted spaces). During April 2026 there has been an average of 28% wasted spaces (including 12% DNAs) across the mandatory face to face training courses.
- There is currently an issue with the availability of spaces to deliver Resuscitation Level 3.

Actions:
- The Training and Education Task Group have identified several actions that run through to April 2026 which will support staff to complete mandatory and wider training. **(Complete)** *See action at foot of previous page*
- 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 the Training & Education Governance Group in May 2026.
- Workforce Development Lead has scoped training for 6 Positive & Safe Care trainers to provide Resus training. One trainer has completed their training and additional courses are now being provided. One trainer is completing their training and will be in a position to provide Resus training by the end of June 2026; 4 further trainers are completing training with a view to providing courses from August 2026 (previously June)
- 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 June 2026.



	Number Compliant	Number of courses	% Compliance
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	785	1029	76.29%
Positive & Safe Care Level 1*	3655	4580	79.80%
Positive and Safe Care Level 2 Update*	1320	1642	80.39%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1665	1981	84.05%
Resuscitation - Level 1 - 1 Year*	2150	2558	84.05%
Moving and Handling - Level 2 - 2 Years*	658	779	84.47%
Resuscitation - Level 3 - Adult Immediate Life Support - Test*	849	1003	84.65%
Incident Management-Corporate	190	224	84.82%

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

22) Percentage of staff in post with a current appraisal

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

What does the chart show/context:
Of the **7,074** eligible staff in post at the end of April; **6,303 (89.10%)** had an up-to-date appraisal.

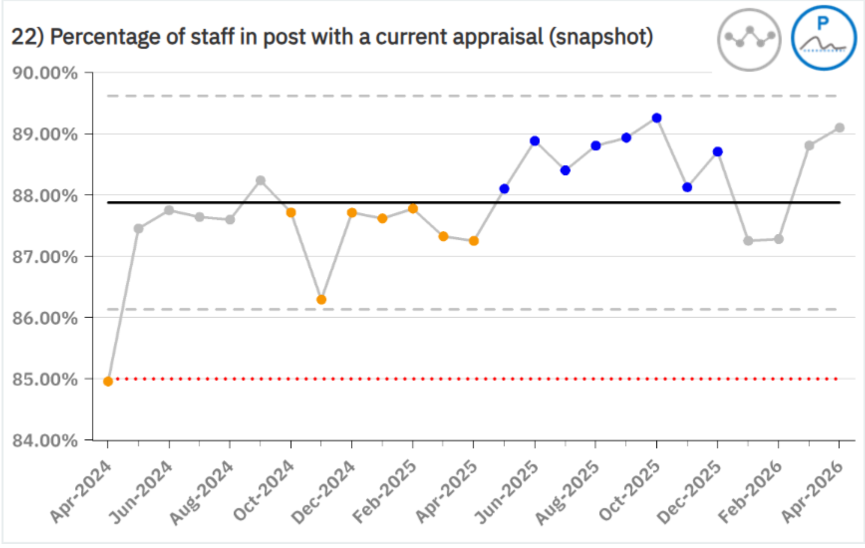
There is no significant change at Trust level and for most directorates in the reporting period.

As at the 30th April 2026, by exception compliance levels below 85% are as follows:

	Number Complaint	Total Number	% Compliance
CORPORATE AFFAIRS AND INVOLVEMENT	30	40	75.00%
PEOPLE AND CULTURE	107	129	82.95%
THERAPIES	30	36	83.33%

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:
- Outstanding appraisals to be completed within:
  - Capital Planning by the end of April 2026. **(Complete)**
  - Digital & Data Services by the end of March 2026. **(Complete)**
  - People & Culture – by the end of April 2026 **(Not Complete)** Noting at time of reporting the directorate is achieving standard
  - Therapies is attributable to data quality and action has been taken to resolve on ESR; at time of reporting the directorate is achieving standard.
- Sickness absence within Corporate Affairs & Involvement is being managed in line with Trust policy and as staff return to work, appraisals will be undertaken.
- 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 June meeting as part of the Inclusive Cultures Report.



4. Activity

Governance forum responsible:	Resources and Planning Committee
Non-Executive Chair:	John Maddison
Executive Lead:	Liz Romaniak

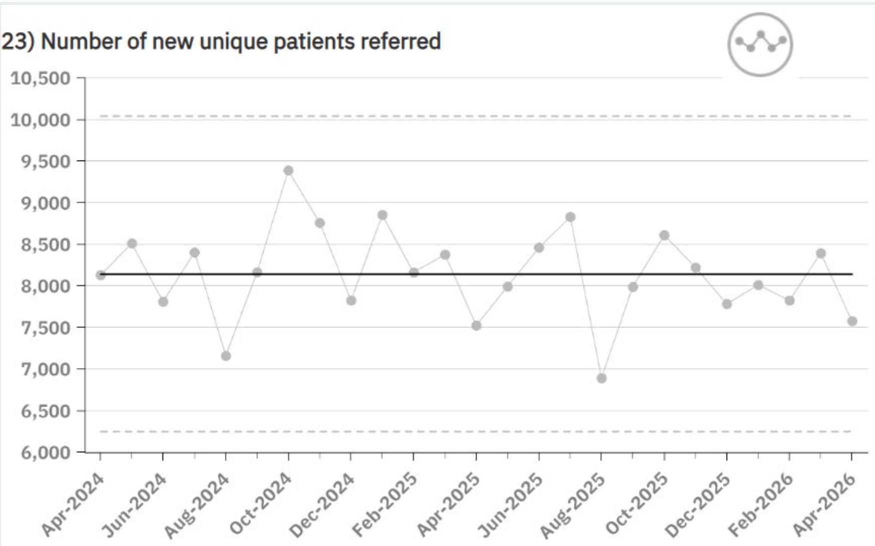
23) Number of new unique patients referred

What does the chart show/context:
7,578 patients referred in April that are not currently open to an existing Trust service.

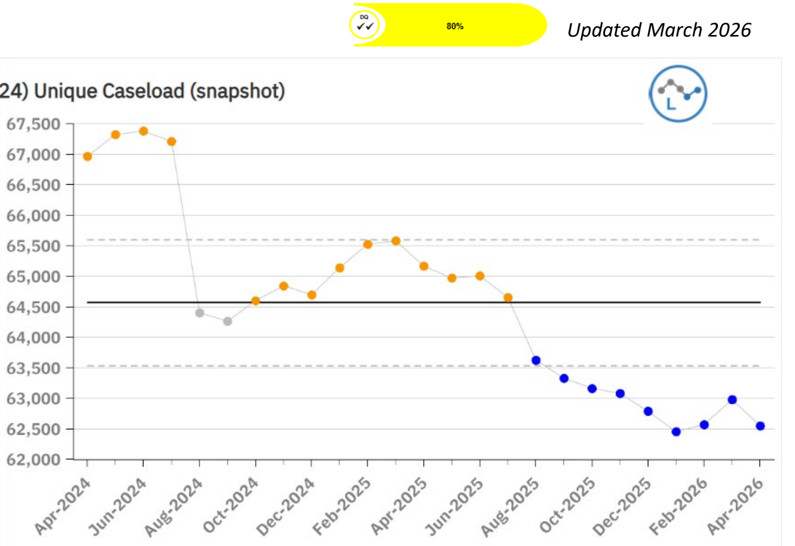
There is no significant change at Trust and Care Group level in the reporting period. However, there are a number of unexpected shifts of referrals. There is a low shift in referrals for Children & Young Peoples Services and Health & Justice within Durham, Tees Valley & Forensic Care Group; the Care Group has confirmed there are no underlying issues. There is a high shift in referrals for Adult Mental Health in North Yorkshire, York & Selby Care Group *(please see below*).

Underlying issues:
A breakdown in the administrative process within the Harrogate and Ripon Community teams, has resulted in a number of duplicate referrals being logged in Cito.

Actions:
Work has been undertaken to correct the standard process within the Harrogate and Ripon Community teams to ensure further duplicate referrals are not logged, and action is being taken to investigate whether the historic data can be corrected.



24) Unique Caseload (snapshot)



What does the chart show/context:
62,550 cases were open, including those waiting to be seen, as at the end of April 2026; **53,644** were active.

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

Underlying issues:
- The measure includes patients currently on our waiting lists and does not accurately reflect the active caseloads within our services.
- A number of data quality issues had been identified in the SIS caseload data.

Actions:
- Following approval from the Resources & Planning Committee in March 2026, the Head of Performance is to oversee completion of the specification for the new Unique Caseload measure by the end of April 2026. **(Not Complete)** Refinement work will be completed by the end of May 2026.
- SIS Service Manager to work with Business Intelligence to resolve the data quality issues by the end of March (previously February 2026). **(Partially Complete)** Two issues remain outstanding, and work is underway to resolve; these will be reflected in the next report. **(Complete)**

5. Finance

Governance forum responsible:	Resources and Planning Committee
Non-Executive Chair:	John Maddison
Executive Lead:	Liz Romaniak

Key Financial Indicators for the period ending 30 April 26 - Revenue

Revenue Performance - Trust	Year to date			RAG
	Plan	Actual	Variance	
Revenue Performance (Surplus) / Deficit £m	0.67	0.23	0.44	
Income & Expenditure Margin (Surplus) / Deficit %	(3.26%)	(1.73%)	1.52%	
Income £m	(44.60)	(44.60)	0.00	
Pay Expenditure £m	37.90	37.30	0.60	
Non Pay Expenditure £m	8.00	8.00	0.00	
Non Operating Expenditure £m	(0.70)	(0.40)	(0.30)	

Revenue Performance - Group	Year to date £m			RAG
	Plan	Actual	Variance	
Durham, Tees Valley & Forensic	24.03	24.34	(0.31)	
North Yorkshire & York	9.81	9.95	(0.14)	
Estates & Facilities	2.82	2.92	(0.10)	
Corporate	4.92	5.07	(0.15)	
Income	(42.34)	(42.34)	0.00	
Central and Reserves	1.43	0.29	1.14	
	0.67	**0.23**	**0.44**	

Variances - Better / (Worse) than plan

Key Messages:

- Early in the financial year key areas of focus include:
    - Developing robust plans to reduce reliance on bank staffing to manage within required financial envelopes (A proposal for new Integrated Quality & Performance Report (IQPR) metric for 2026/27 to be considered at June Board).
    - Managing any implications of nationally negotiated pay awards where funded via national tariff uplift
    - Ensuring delivery of required actions to achieve progressively stepped cost reductions in-year
    - Working with ICB and Local Authority colleagues to address current high levels of inpatients who are clinically optimised for discharge

What does the data show/context:

Financial performance of a £0.23m deficit was £0.43m better than plan for the year to date.

Underlying issues:

- Planned delivery of £27.7m Cash Releasing Efficiencies underpins achievement of our 2026/27 break-even plan. Specific priorities include:
    - Further temporary staffing reductions (Agency, Bank and Overtime)
    - Substantive staff reductions, including from 2025/26 Mutually Agreed Resignations
    - Non pay reductions, including contracting and estate management, and
    - Service redesign.
- We need to reduce bed occupancy, including by tackling system delays preventing the discharge of sustained high numbers of adult and older adult patients who are clinically optimised. This will enable average length of stay reductions (following short-term increase on discharge) and support nil reliance on independent sector beds. Wider system support is needed to address this challenge.

For actions see following page

Underlying issues continued:

- Due to high ward occupancy, we used **55 non-Trust bed days in April** (31 in March) costing **£0.09m to date** including estimated occupancy and observations, which was **£0.08m worse than plan**. Flow pressures mean sustaining low independent sector bed utilisation is challenging. Occupancy also impact temporary staffing costs, and delivery of our plan, and ward staffing are above funded levels.
- Despite success reducing overall Agency use and shifts breaching price caps, premia rate price cap breaches are an ongoing challenge. 56% of (a continuously reducing number of overall) agency shifts remained above price cap and impact overall value for money.
- To achieve premia rate Agency and Overtime cost reductions the Trust needed to enhance Bank staffing arrangements during 2025/26. Having achieved this objective new actions are now necessary to reduce Bank costs and meet 2026/27 plan requirements.
- Information on workforce costs and Whole Time Equivalents (WTE) is being continually enhanced and is shared to support a renewed efficiency focus.

Key Areas for Action:

- A Temporary Staffing sub-group oversees actions to reduce all temporary staffing, and reports progress into Executive Directors. Task and Finish Groups are developing detailed plans to reduce levels of staff sickness absence and bank staff reliance to support the delivery of national targets.
- An Efficiency Hub oversees delivery of schemes and provides support to Care Groups and Directorates.
- Executive-led Transformation Programmes are progressing to support the NHS 10 Year Health Plan and, by effecting the 3 national 'left-shifts' (from hospital to community, treatment to prevention, and analogue to digital) aim to transform services to improve outcomes and value for money, with efficiencies targeted to commence at scale from 2027/28.

26) Financial Plan: Agency expenditure compared to agency target

Key Financial Indicators for the period ending 30 April 26 - Agency costs compared to plan by category

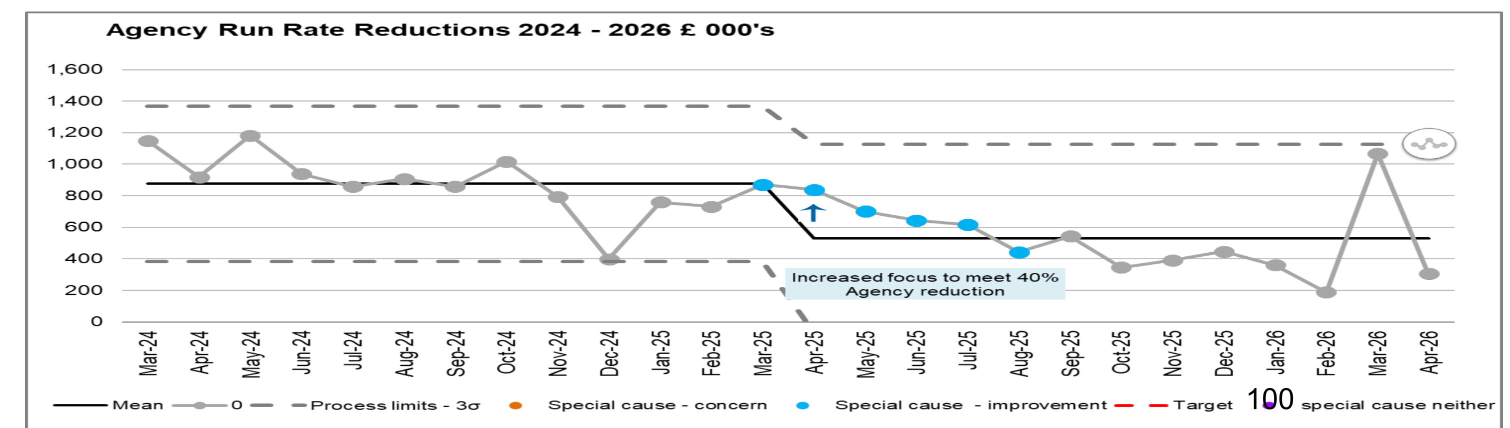
Agency Usage	Expenditure £ 000's							WTE		
	Annual	Current Month			Year to Date			Current Month		
Category	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Nursing and Other	1,810	172	118	54	172	118	54	24.02	17.92	6.10
Medical	1,975	226	187	39	226	187	39	12.06	11.06	1.00
Grand Total	**3,785**	**398**	**305**	**93**	**398**	**305**	**93**	**36.08**	**28.98**	**7.10**

Agency Quarterly Cost Profile	Q1	Q2	Q3	Q4	Total
Agency Plan £ 000	1390	1144	1146	898	**4578**
Agency Plan %	30%	25%	25%	20%	**100%**

Key Financial Indicators for the period ending 30 April 26 - Agency costs compared to plan by area

Agency Usage	Expenditure £ 000's							WTE		
	Annual	Current Month			Year to Date			Current Month		
Area	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Durham Tees Valley & Forensic	1,839	201	155	46	201	155	46	17.12	12.64	4.48
North Yorkshire & York	1,558	144	150	(6)	144	150	(6)	18.96	16.34	2.62
Medical and Central	388	53	0	53	53	0	53	0.00	0.00	0.00
Gross Total	**3,785**	**398**	**305**	**93**	**398**	**305**	**93**	**36.08**	**28.98**	**7.10**

Variances - Better / (Worse) than plan



87%

What does the data show/context:

- Year to date agency **costs of £0.305m were £0.093m and 7.10 WTE better than planned**; this builds on success in the last several years
- The SPC chart shows sustained gradual reductions in monthly cost as compared to March 2024 when agency costs were c£150k per month.
- Whilst planned Medical agency costs are £1.975m (52% plan) this represents just 33% planned agency WTE due to high premia rates.

Underlying issues:

- Temporary staffing are currently needed to provide essential vacancy cover. We need to ensure a sustainable permanent workforce, including in key shortage professions e.g. medical and registered nursing in prisons.
- Trust Nursing Agency usage was previously high in inpatient wards linked to high occupancy. This has reduced more recently in Durham, Tees Valley and Forensic, including from sustained action to improve rostering and regularly review safer staffing levels relative to clinical need. North Yorkshire and York Care Group is targeting further inpatient cost reductions in 2026/27.

For actions see following page

26) Financial Plan: Agency expenditure compared to agency target

Actions:
A Temporary Staffing Group oversees actions to reduce Agency costs:

- Controls operate to ensure prior approval, with consideration of alternatives before Agency shifts are agreed. Performance is now being considered alongside the level loading of e rosters for inpatient wards.
- Enhanced staff banks were established in 2025/26 to aim to provide an alternative staffing resource and better value for money than Agency and Overtime options. Task and Finish Groups are working to develop detailed plans to reduce levels of staff sickness absence and bank staff reliance to ensure the delivery of national targets.
- Providers were asked in late 2025 to cease all Band 2 and 3 HCA agency shifts with a longstop effective from February 2026. Actions are progressing to cease use via the Care Groups (subject to usual break glass exceptions). Further actions are in train to ensure Trust compliance within the North Yorkshire and York Care Group.

Key Financial Indicators for the period ending 30 April 26 - Agency Staff Price Cap Compliance

Price Cap Compliance	Mar - 26		Apr - 26		In-Month Movement	
	Shifts	Shifts %	Shifts	Shifts %	No.	%
Compliant	278	41%	209	44%	(69)	(25%)
Non-Compliant	395	59%	270	56%	(125)	(32%)
Total Shifts	**673**	**100%**	**479**	**100%**	**(194)**	**(29%)**

12-Month Compliance Change by Staffing Group	Apr-25			Mar-26			Apr-26			12-Month Movement	
	Shifts	Non-Compliant		Shifts	Non-Compliant		Shifts	Non-Compliant		Non-Compliant	
	No.	No.	%	No.	No.	%	No.	No.	%	No.	%
Healthcare Assistant & Support	272	0	0%	42	0	0%	39	0	0%	0	0%
Medical	441	441	100%	255	255	100%	187	187	100%	(254)	(58%)
Nursing	553	133	24%	376	140	37%	253	83	33%	(50)	(38%)
Allied Health Professionals	13	0	0%	0	0	0%	0	0	0%	0	0%
Total Shifts	**1279**	**574**	**45%**	**673**	**395**	**59%**	**479**	**270**	**56%**	**(304)**	**(53%)**

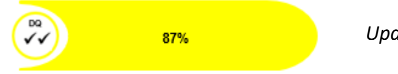
Annualised Premia £m	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Medical	2.33	2.36	2.19	1.71	2.15	2.07	1.74	1.57	1.49	1.12	1.48	1.20
Nursing	0.11	0.10	0.10	0.07	0.08	0.19	0.15	0.17	0.14	0.14	0.16	0.10
Total	**2.44**	**2.47**	**2.29**	**1.78**	**2.23**	**2.26**	**1.90**	**1.74**	**1.63**	**1.26**	**1.64**	**1.30**

Movement - Increase / (Reduction)

Key Financial Indicators for the period ending 30 April 26 - Band 3 Agency Support Worker Breaches

Care Group Band 3 Breaches	Band 3 Agency Breach - No. Shifts Worked					
	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Durham Tees Valley & Forensic	3	1	6	0	0	0
North Yorkshire & York	40	47	57	59	42	39
Total Shifts Worked	**43**	**48**	**63**	**59**	**42**	**39**

Memorandum: Current Month Top 3 Shift Users (and Recent Trend)						
Team	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**
Minster (York) Adult	5	0	7	5	7	13
Wold View (York) Older Adult	12	14	7	7	13	11
Ebor (York) Adult	5	5	9	10	6	9



Updated March 2026

What does the data show/context:

- The total number of agency shifts worked reduced by 800 (62.5%) in the 12 months ending April 2026 falling from 1,279 to 479 shifts.
- Whilst numbers of non compliant shifts also reduced over the same period, by 304 (53.0%), the fall from 574 to 270 was at a lower rate proportionately, giving a higher percentage non-compliant.
- Of all agency shifts in month, 209 (44%) shifts were compliant and 270 (56%) non-compliant with national price caps.
- Whilst a national requirement prevents Band 2 / 3 Support Worker Agency shifts (except in ‘break glass’ circumstances) 39 Bank 3 Support Worker shifts were used in April 2026. This was 3 shifts less than last month and represented 8% of all 479 shifts worked in the period. All breaches were in North Yorkshire and York, 33 in 3 wards shows below (bottom left).

Underlying issues:

Persistent challenges relate to levels of medic and prison mental health registered nurse vacancies (including for newly tendered provision) necessitating cover from premia rate locum assignments and which have consistently breached price caps. Prison service recruitment is impacted by additional, longer recruitment checks.

For actions see following page

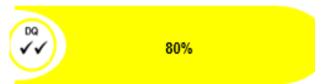
27) Financial Plan: Agency price cap compliance

Actions:

In addition to actions from **26) Financial Plan: Agency expenditure compared to agency target** supporting improved compliance:

- Care Group Medical colleagues have developed medical staff recruitment and locum plans and savings trajectories to aim to fill substantive medic vacancies and reduce reliance on Medical assignments that attract the highest cost and premia rates.
- Social media and other targeted recruitment activities are seeking to attract new colleagues to registered nurse vacancies in prisons (Health and Justice teams).

28) Use of Resources Rating - overall score



What does the data show/context:
The overall rating for the trust was a **3** for the period ending 30th April 2026 and better than plan. This excludes any impact from PIPS.
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 3**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric 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 0.70% which was a **rating of 4**.
- The Income and Expenditure **(I&E)** margin distance from plan was 0.54% (favourable) which was a **rating of 1.**
- The agency expenditure metric assesses costs compared to planned levels that target delivery of a 30% reduction against 2025/26 forecasts. Costs of £0.31m to date were £0.09m under plan and therefore **rated as a 1.**

Specifically for agency please refer to **26) Financial Plan: Agency expenditure compared to agency target & 27) Financial Plan: Agency price cap compliance**

The Trust's financial performance resulted in an **overall UoRR** of **3** for the period ending 30th April 2026 compared to a planned UoRR of 3.

Underlying issues:
The Trust's forward liquidity position is of concern, including as cash balances are deployed to progress capital programmes. Recovery actions need to be identified and progressed to target future year breakeven and to continue to reduce agency costs and prices cap breaches. These will support achievement of the associated individual UoRR metrics and overall UoRR rating. The Trust 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.

Key Financial Indicators for the period ending 30 April 26 - CRES savings compared to plan

Updated March 2026

Type	2026/27 CRES performance compared to plan							2026/27 CRES plans phasing £ 000				
	Year to date £ 000			Annual £ 000			Full Year Effect	Q1	Q2	Q3	Q4	2026/27
	Plan	Actual	Variance	Plan	Forecast	Variance		Plan	Plan	Plan	Plan	Plan
Recurrent:												
Pay	962	971	9	17,076	16,767	(309)	16,767	2940	4108	4842	4875	**16765**
Non Pay	218	131	(87)	2,795	3,012	217	3,012	657	723	851	861	**3092**
Income	24	4	(20)	724	717	(8)	717	75	75	294	294	**738**
Sub Total	**1,204**	**1,106**	**(98)**	**20,596**	**20,496**	**(100)**	**20,496**	**3,672**	**4,906**	**5,987**	**6,030**	**20,595**
								18%	**24%**	**29%**	**29%**	**100%**
Non Recurrent:												
Pay	220	360	140	4,744	2,511	(2,234)	0	786	1586	1149	1223	**4744**
Non Pay	164	140	(25)	2,150	4,497	2,347	0	1040	369	369	369	**2147**
Income	17	0	(17)	200	187	(13)	0	51	51	51	51	**204**
Sub Total	**401**	**500**	**98**	**7,094**	**7,195**	**101**	**0**	**1,877**	**2,006**	**1,569**	**1,643**	**7,095**
								26%	**28%**	**22%**	**23%**	**100%**
Total	**1,605**	**1,605**	**0**	**27,690**	**27,690**	**1**	**20,496**	**5,549**	**6,912**	**7,556**	**7,673**	**27,690**
								20%	**25%**	**27%**	**28%**	**100%**

Variances - Better / (Worse) than plan

Year to Date CRES Delivery

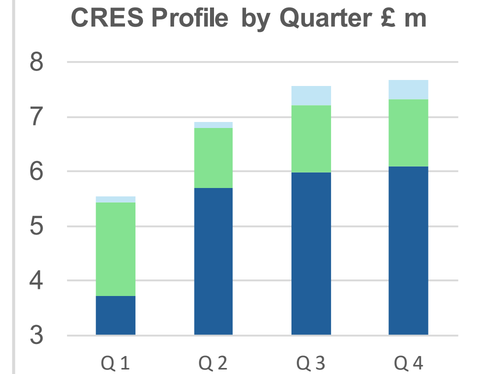
% CRES to Date by Type

17%

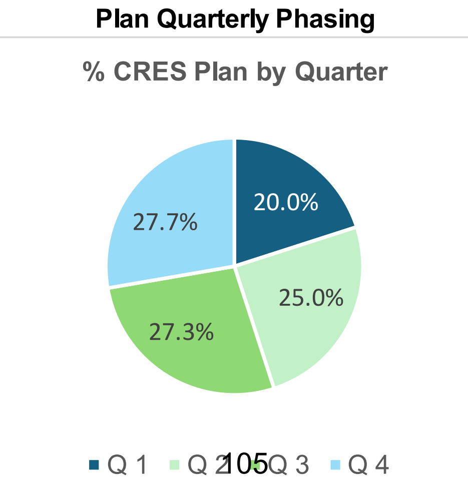
83%

Pay Non Pay Income

Plan Quarterly Profile by Type



Plan Quarterly Phasing



What does the data show/context:

Whilst **overall CRES delivery of £1.605m was on plan** for the year to date, plans assume marked stepped increases from quarter two:

- £1.11m Recurrent CRES delivery was £0.10m below plan
- £0.50m Non Recurrent CRES delivery was £0.10m above plan

Agency and Overtime delivery was above plan (£0.10m and £0.03m respectively to date).

Areas of under-delivery included for overtime including Secure Inpatient Services and Hotel Services and for bank Ridgeway, Mental Health Services for Older Adults in Durham and Tees Valley, Trust Adult Mental Health Services and schemes linked to establishment reviews.

Underlying issues:

- CRES schemes underpin achievement of our 2026/27 plan and recurrent schemes are necessary to improve our underlying financial sustainability.
- Higher than planned non-recurrent achievement would increase, whereas higher than planned recurrent achievement would decrease, planned CRES required in 2027/28.

Controls operate to support continued Agency and Overtime cost reductions including through Healthroster for inpatient wards, and from enhanced staff bank arrangements. Care Groups have applied additional agency and overtime controls, with additional authorisation required for Overtime. The Trust targeted those two premia rate sources initially, but must now implement actions to reduce bank shifts to meet nationally mandated bank cost caps for 2026/27 (and beyond).

For actions see following page

29) CRES Performance – Recurrent and
30) CRES Performance – Non-Recurrent

Actions:

Please see measures - 25) Financial Plan: SOCI - Final Accounts - Surplus/Deficit, 26) Financial Plan: Agency expenditure compared to agency target, 27) Financial Plan: Agency price cap compliance

The Clinical Executive has scheduled panels to ensure QEIA's of all schemes in Quarter 1.

- To mitigate year to date and projected under achievement and ensure recurrent schemes deliver planned levels of savings.

Key Financial Indicators for the period ending 30 April 26 - Capital programme performance

Capital Programme:	Year to Date £ 000			Annual £ 000		
	Plan	Actual	Variance	Plan	Forecast	Variance
Total expenditure plan	1,549	1,355	194	13,176	15,384	(2,208)
Performance against capital allocation	1,519	1,325	194	12,402	14,610	(2,208)

Variances - Lower / (Higher) than plan

Key Financial Indicators for the period ending 30 April 26 - Capital Plan Profile

Capital Plan	Plan Phasing £ 000				
Category	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Capital Programme inc IFRS16	4,436	4,151	2,301	2,694	**13,582**
Planned Disposals	(430)		(750)		**(1,180)**
Plan Performance Against Allocation	**4,006** **32%**	**4,151** **33%**	**1,551** **13%**	**2,694** **22%**	**12,402** **100%**
PFI Lifecycle	91	91	91	91	**364**
NHS Lease Additions				410	**410**
Items outside Capital Performance	**91**	**91**	**91**	**501**	**774**
Capital Programme	**4,097**	**4,242**	**1,642**	**3,195**	**13,176**

What does the data show/context:
£1.33m Capital expenditure for the year to date was **£0.19m lower than planned** costs charged against the Trust's capital allocation.

a) Capital Charged to allocation: £12.40m 2026/27 capital allocation comprised:
- £5.90m operational capital allocation (derived national using a formula)
- £5.00m cash backed Estates Safety Fund (2026/27 only)
- £0.89m cash backed Estates Safety Fund (Medium Term Plan 4-year allocation)
- £0.62m non recurrent allocation (revenue surplus bonus 2024/25)

b) Not Charged to allocation: £0.77m further planned capital costs comprised:
- £0.36m PFI lifecycle £0.36m
- £0.41m NHS Lease additions

Total 2026/27 planned capital expenditure (a + b) was £13.18m.

Whilst the capital programme forecast is a £2.2m overspend actions are being taken to aim to mitigate this in year (without impacting clinically), including accessing national funding streams or capital and fast tracking estate consolidation.

For underlying issues and actions see following page

31) Capital Expenditure (Capital Allocation)

Underlying issues:
The Trust was impacted by low operational capital allocations from 2026/27. Additional NHSE capital allocations are subject to separate application or bid processes. Access to capital is of significant concern going forward, especially given the significant capital requirement for Roseberry Park Hospital works.

Capital investments have needed to be prioritised and risk-assessed to manage costs to within Trust and system limits for capital. Multi-year capital plans were submitted to NHS England in February 2026 aligned to medium term financial plans and confirmed funding. Strategic Capital had not been allocated beyond 2026/27, with actions emerging in relation to NHSE assessment and agreement of relative provider priorities.

Actions:
- The Trust is bidding to optimise access to national Return to Constitutional Standards, Digital Productivity, Net Zero, and Estates Safety Funding.
- The Trust’s Estate Masterplan is seeking to fast track consolidation plans to reduce IFRS16 lease charges and to generate asset disposals.
- The Trust needs to revisit phasing of plans for works at Roseberry Park Hospital.

32) Cash Balances (actual compared to plan)

Key Financial Indicators for the period ending 30 April 26 - Cash, Supplier Payment and Receivables

	Year to Date			Annual		
Receivable & Payables Metric:	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Cash (£000s)	52,090	56,492	4,402	36,653	36,653	0
Better Payment Practice Code (%)	95.0%	96.8%	1.8%	95.0%	95.0%	0.0%
Aged Debt > 90 days overdue (%)	5%	11%	(6%)	5%	5%	0%

Variances - Better / (Worse) than plan

Key Financial Indicators for the period ending 30 April 26 - Planned Closing Cash Balances 2026/27

	2026/27 Monthly Cash Plan £ 000											
Plan	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Closing Cash	52,090	47,496	45,557	49,527	46,367	42,903	45,203	41,185	39,019	42,586	40,256	36,653

What does the data show/context:
Cash balances of **£56.49m were £4.40m more than planned** and reflect higher than planned trade payables, which are expected to reduce in the first quarter.

- **Prompt Payment of Suppliers:** The Trust achieved a combined Better Payment Practice Code (BPPC) compliance of **96.8%** 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**: Debt outstanding at the period end was £3.71m, with **£0.42m debts exceeding 90 days (**excluding amounts being paid in 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 **25) Financial Plan: Revenue Performance:**
- We need to expend more via our annual capital programme and debt servicing (PFI and lease contracts) than is generated internally from depreciation. If we secure access to additional operational capital (non-cash-backed) to progress works, including at Roseberry Park Hospital, it will deplete accumulated cash balances. We need to secure access to regional or national cash-backed capital, e.g. Estates Safety / Strategic Capital to progress works and preserve cash reserves over the medium term.
- Our medium term financial plan includes a capital programme, however NHSE allocations to providers for Return to Constitutional Standards, Estates Safety Funding and Strategic Capital have not been confirmed for the full planning horizon, with processes ongoing/developing.

- ***For actions see measure 25) Financial Plan: SOCI - Final Accounts - Surplus/Deficit and 31) Capital Expenditure (Capital Allocation)***

6. Access to Services

Governance forum responsible:	Resources and Planning Committee
Non-Executive Chair:	John Maddison
Executive Lead:	Naomi Lonergan

Waiting Times Dashboard – National Waiting Times Measures

Patients waiting for Meaningful Help	Actual Number Waiting (Snapshot)	0-4 weeks	Over 4 weeks	Over 26 weeks	Over 52 weeks	Over 78 weeks	Over 104 weeks
Children & Young People Waiting to receive Meaningful Help (Provider)	11014	633	10381	8682	7404	5850	4209
Children & Young People Pathway A - Spells with at least one referral with a primary reason for referral - Gender Discomfort Issues	2	0	2	2	2	2	2
Children & Young People Pathway B - Spells with at least one referral with primary reason for referral - Neurodevelopmental Conditions, excluding Autism or a referral to a Neurodevelopmental Team	6672	184	6488	5759	7407	3915	2837
Children & Young People Pathway C - Spells with at least one referral with a primary reason for referral - Suspected Autism or Diagnosed Autism or a referral to an Autism Service	5016	101	4915	4415	3967	3149	2302
Children & Young People Pathway D - Spells with at least one 'other' referral not identified as related to autism, neurodevelopmental or gender identity	**2518**	**424**	**2094**	**1264**	**1043**	**894**	**728**
Children & Young People Pathway E - Spells with at least one referral identified as related to autism, neurodevelopmental or gender identity; and at least one 'other' referral not identified as related to autism, neurodevelopmental or gender identity	1245	5	1240	1165	1019	886	725
Adults Waiting to receive Meaningful Help	4721	1206	3515	901	231	116	52

"Meaningful Help" for **children/young people** involves a successful contact with a SNOMED-coded intervention (Advice, Signposting, Formulation, Care Plan, Consultation, or an Evidence Based Intervention) and a recorded outcome measure.

Note: *Children & Young People Pathway D - Spells with at least one 'other' referral not identified as related to autism, neurodevelopmental or gender identity* (emboldened) is the national standard

For **adults**, it involves a direct contact with a SNOMED-coded intervention, a meaningful assessment, a baseline outcome measure, and the start of a clinical/social intervention or a co-produced care plan.

Patients waiting for Eating Disorders Services	Variation	Actual Number Waiting (Snapshot)	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)		2	2	0	0	0	0	0	0	1	1
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		28	7	6	11	2	1	0	1	3	**13** *

Patients waiting for EIP Treatment	Variation	Actual Number Waiting (Snapshot)	0-1 Week	1-2 Weeks	2-4 Weeks	4-6 Weeks	6-8 Weeks	8-12 Weeks	Over 12 Weeks	Average Wait (weeks)	Longest Wait (weeks)
Adults Waiting for EIP Treatment (2 week standard)		75	35	19	13	4	4	0	0	2	8

Waiting Times Dashboard - Local Waiting Times Measures

Waiting Times Dashboard (Assessment)	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 Assessment		1097	461	242	185	130	21	2	30	24	2	12	168	*
Adults Waiting for an Assessment		2563	995	562	404	381	166	48	5	0	2	10	252	*
Adults with a learning disability Waiting for an Assessment		104	87	12	5	0	0	0	0	0	0	3	11	*
Adults in Health and Justice services Waiting for an Assessment		29	22	5	2	0	0	0	0	0	0	3	11	
Older People Waiting for Assessment		2737	846	644	498	542	178	27	2	0	0	10	56	

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		4700	127	163	168	236	188	277	1634	1486	421	90	215
Children and young people waiting for an ADHD Assessment		4483	124	158	160	195	241	418	1717	1268	202	82	207
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2388	10	4	9	102	109	170	589	767	628	112	207
Adults waiting for an Autism Assessment		4222	49	66	74	220	191	183	802	1150	1487	124	343
Adults waiting for an ADHD Assessment		5078	110	118	160	323	254	188	1110	1384	1431	112	343

WPatients waiting for 2nd contact in 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		4146	280	296	1488	713	554	815	16	62

NOTES:

- *Asterisk* denotes a data quality issue*

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

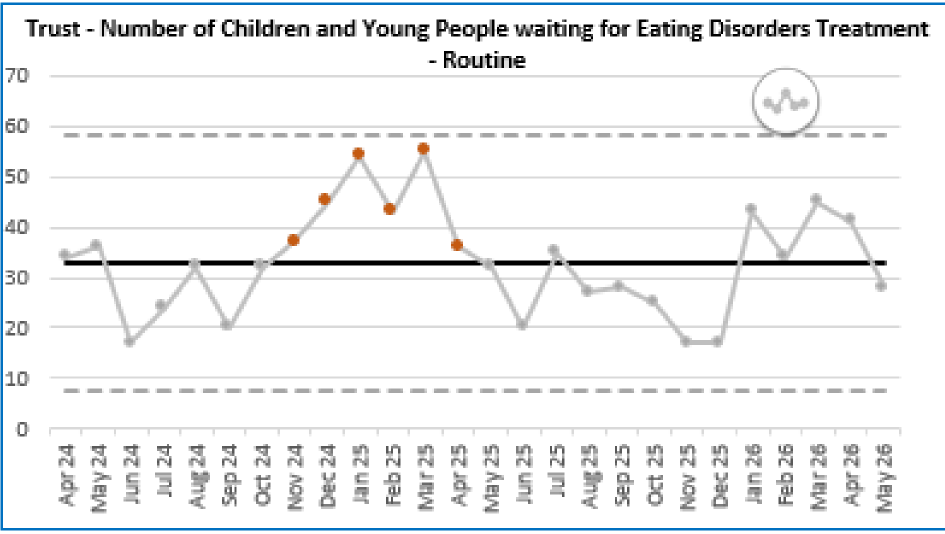
Summary:
There are 4 children or young people reported as waiting more than 4 weeks, of which 2 are genuine waits.

- 1 patient cancelled appointments (first within 4 weeks); a further appointment has been rescheduled for May.
- 1 patient was offered an appointment (within 4 weeks); however, this was cancelled by the service and rescheduled for May (outside of 4 weeks) due to staff capacity issues.

The remaining 2 waits are attributable to data quality and steps are being taken to resolve them.

Underlying issues:
- We are continuing to flow inaccurate information in our internal reporting and out Mental Health Services Dataset, as outlined above.
- Capacity within the Durham & Darlington Eating Disorders team is impacted by maternity leave and sickness.

Actions:
- Operational leads, overseen by the Directors of Operations, to undertake a Trust-wide deep dive and develop an improvement plan by the end of May 2026.
- From the July 2026 the Durham & Darlington Eating Disorders team rota will be amended to increase the number of assessment appointments to meet demand



Children & Young People Eating Disorders Services - 4 week standard for Routine referral				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	28	3	13	
DTVF Care Group	19	3	7	
NYY&S Care Group	9	4	13	

DTVF: Data quality. Genuine longest wait is 36 days, apt booked.
NYY&S: Data quality - longest wait is 28 days, assessment required

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

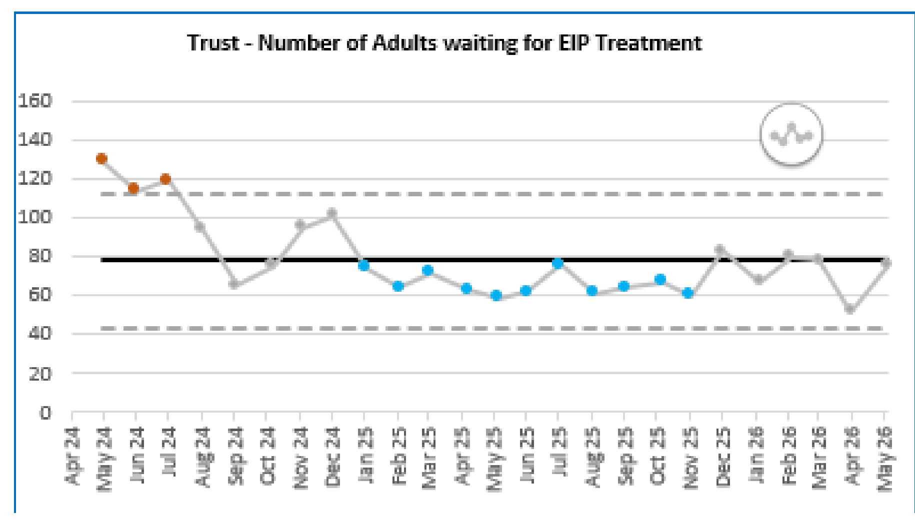
Summary:
There are **21** adults **reported** as waiting more than 2 weeks of which **11** are genuine waits:

- 4 patients have been offered appointments (outside 2 weeks) due to team capacity; appointments are booked in May.
- 1 patient has been offered an appointment (outside 2 weeks) due to patient choice; assessment booked in May.
- 6 patients have been offered appointments (within 2 weeks) but did not attend; further appointments are offered in May.

Of the remaining 10 waits:
- 2 patients have been assessed, and treatment is not suitable for their presentation, and the service is in the processing of discharging them.
- 8 are attributable to data quality and steps have been taken to resolved them.

Underlying issues:
- We are continuing to flow in accurate information in our internal reporting and out Mental Health Services Dataset, as outlined above.
- Capacity within the York & Selby EIP team is currently impacted by vacancies and maternity leave

Actions:
- Performance leads to review the DNAs with the services to identify whether there are any trends or underlying issues. This work will be completed by the end of May 2026.
- The York & Selby EIP team have now been placed in Services Requiring Additional Support and an action plan is in place. Additional assessment slots are now being made available and where appropriate mutual support is being given from the Harrogate EIP Team, and we are anticipating an improvement from the end of May 2026. Six staff are now in post and 2 are to be readvertised.
- Whilst there are no new specific issues, the Head of Performance is to meet with NHS England, commissioners and EIP leads in May 2026 to discuss the management of patients within secure services.
- Whilst there are no new specific issues, the AMH General Manager hosted a meeting between CAMHS and EIP in April 2026, with a view to improving timely access to joint assessments for patients under 18. **(Complete)** An agreed process has been implemented to provide additional oversight of under 18 patients referred to EIP to ensure timely joint assessments.
- Directors of Operations to ensure standard work is in place for all staff to ensure EIP contacts are recording timely and accurately.



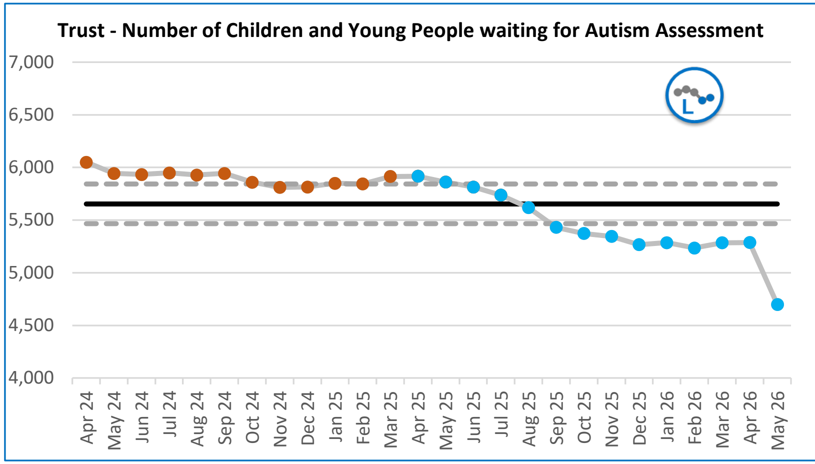
Adults Waiting for EIP Treatment - 2 week standard

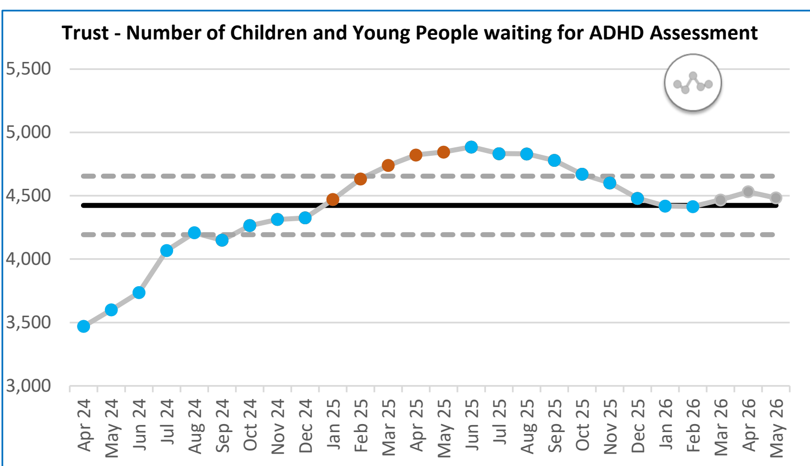
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	75	2	8	
DTVF Care Group	45	1	5	
NYY&S Care Group	30	3	8	

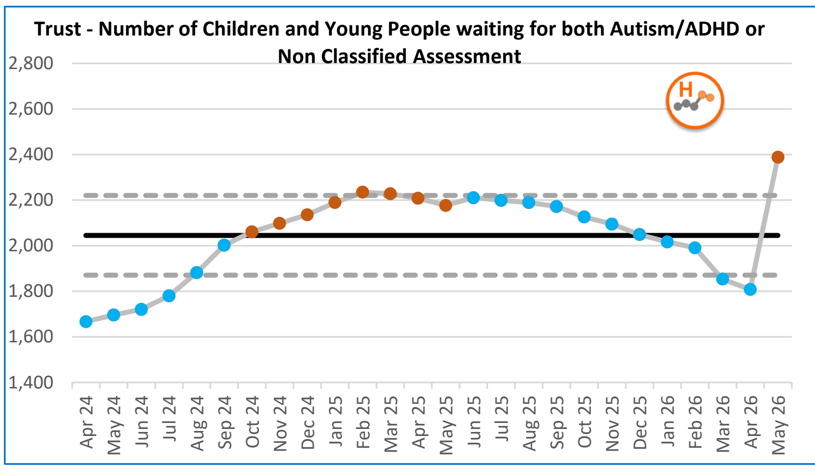
Commentary on Longest waits

DTVF: Data quality, assessment complete. Longest genuine wait is 22 days, assessment booked
NYY&S: Genuine Wait - Appointment Booked

Waiting Times Neuro Services: Children & Young People







Children and young people waiting for an Autism Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4700	90	215	
DTVF Care Group	3628	98	215	
NYY&S Care Group	1072	61	142	

Commentary on Longest waits

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

Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4483	82	207	
DTVF Care Group	3763	90	207	
NYY&S Care Group	720	42	129	

Commentary on Longest waits

DTVF: Data Quality - Specialist Assessment Complete (longest genuine wait - 1439 days - specialist assessment booked).
NYY&S: Genuine wait - Specialist Assessment booked.

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

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2388	112	207	
DTVF Care Group	1753	131	207	
NYY&S Care Group	635	57	124	

Commentary on Longest waits

DTVF: Genuine wait - Specialist Assessment Required (on hold due to consent). Longest genuine wait 1372, assessment booked.
NYY&S: Genuine wait - Specialist Assessment Required

To Note:
A review undertaken by Business Intelligence identified a number of patients with dual autism/ADHD diagnosis were recorded against the incorrect referral reason. Work has been undertaken to correct this issue and whilst the total number of people waiting has not changed, more people are now recorded as waiting for a combined Autism and ADHD assessment, with fewer recorded as waiting for Autism or ADHD alone. This has primarily impacted services within Durham, Tees Valley & Forensic Care Group.

For underlying issues and action, please see page 58

Country Durham & Tees Valley

Underlying issues:
- High levels of demand outweighing capacity
- Long wait times and projected waiting times in the County Durham areas
- High levels of vacancies within Durham & Darlington
- Long wait times and projected waiting times for children on the under 5s pathway (South Durham)

Actions (Partnership-wide):
- System-wide work is continuing within North East & North Cumbria ICB and Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust.

Actions (Trust):
- A DTVFCG 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 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. **(Partially Complete)** The 3 permanent posts have been recruited to; interviews for the remaining posts will be completed by the end of May 2026.
- The Durham CYP Leadership Team has scheduled an away day in July 2026 to explore the complex challenges facing services, including recruitment, capacity, and demand. The aim is to understand the impact of these challenges and agree a plan for moving forward.

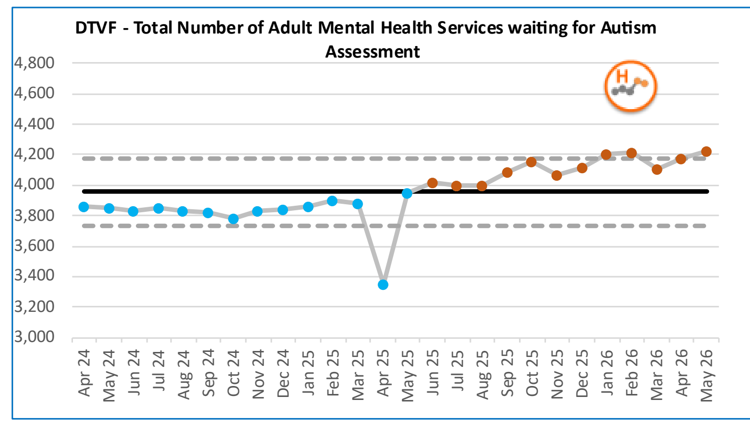
North Yorkshire & York

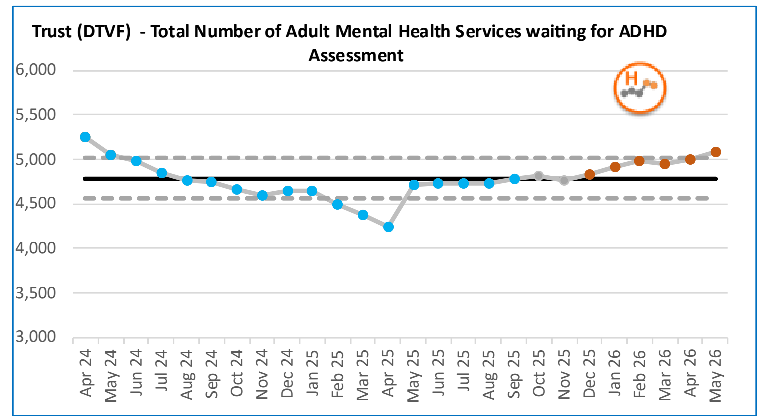
Underlying Issues:
- Long-term sickness absences within the Scarborough ADHD team

Actions (Partnership-wide):
- HNY ICB have concluded their exploration of a system approach to addressing the current challenges across all providers around the assessment of ASD and ADHD across children, young people and adults. Discussions are ongoing between ICB colleagues and the Chief Executive Officers of the four local providers.

Actions (Trust):
- 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. The first progress report will be completed and presented to the Integrated Care Group Governance in May 2026 and then go to EDG for assurance.
- The Service Manager to progress recruitment for one team manager for neuro services. An updated position was shared at the Service Improvement Development Group in April 26. **(Complete)** Interviews are scheduled in May 2026.

Waiting Times Neuro Services: Adult Services





Adults waiting for an Autism Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	4222	124	343	
Commentary on Longest waits				
DTVF: Genuine Wait - Assessment Required				

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	5078	112	343	
Commentary on Longest waits				
DTVF: Genuine Wait - Assessment Required				

Underlying issues:

- High levels of demand outweighing commissioned capacity

Actions (Partnership-wide):

- The Trust are working with the ICB on a proposal to introduce regional referral management processes; the initial pilot area will be within Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust.

Actions (Trust):

- The Trust are in the process of responding to a formal letter from NENC ICB in relation to Adult ADHD and Autism Waiting List Validation, Backlog Recovery and Funding Approach. This will be shared with Executive Directors Group and the Integrated Care Board by end of April 26. **(Complete)** The Trust is currently working with CNTW and the ICB to agree allocation of resource to improve the waiting list position and a paper will go to People & Resources EDG in June 2026.

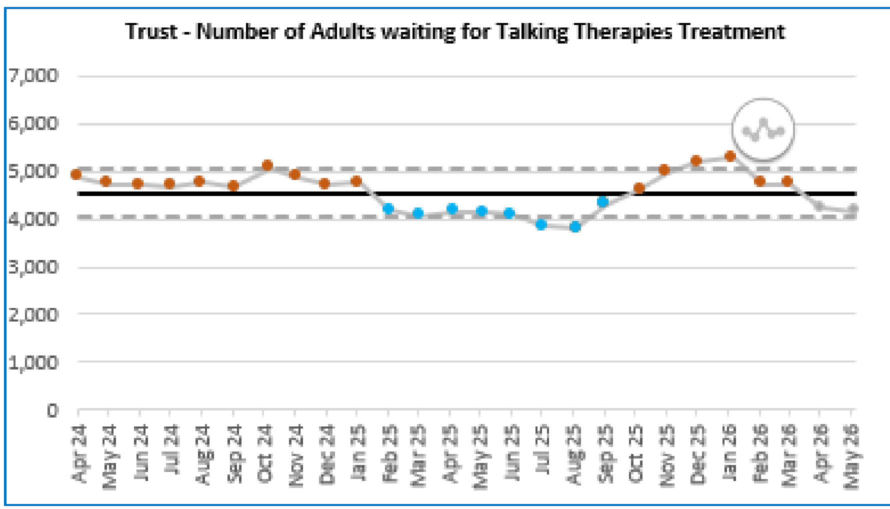
Waiting Times Talking Therapies

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 was temporarily converted to assessment capacity from the middle of October 25, which is continuing to impact on the waiting time for 2nd treatment appointments.

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) –** Pending 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 June 2026 (previously April), with a view to securing additional staff.

Actions (NYYSCG)
- Service Manager has implemented a Keeping in Touch plan some positive impact has been seen within the York team and following positive receipt of the pilot, this is now being progressed as business as usual. **(Complete)**
- The Service Manager is to develop an improvement plan to reduce the waiting time between 1st and 2nd appointments in North Yorkshire and York by the end of May 2026; progress will be monitored monthly through the Service Improvement & Delivery Group.



Talking Therapies - adults waiting for their second treatment contact

Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4146	16	62	
DTVF Care Group	1667	14	50	
NYY&S Care Group	2479	18	62	

Commentary on Longest waits

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

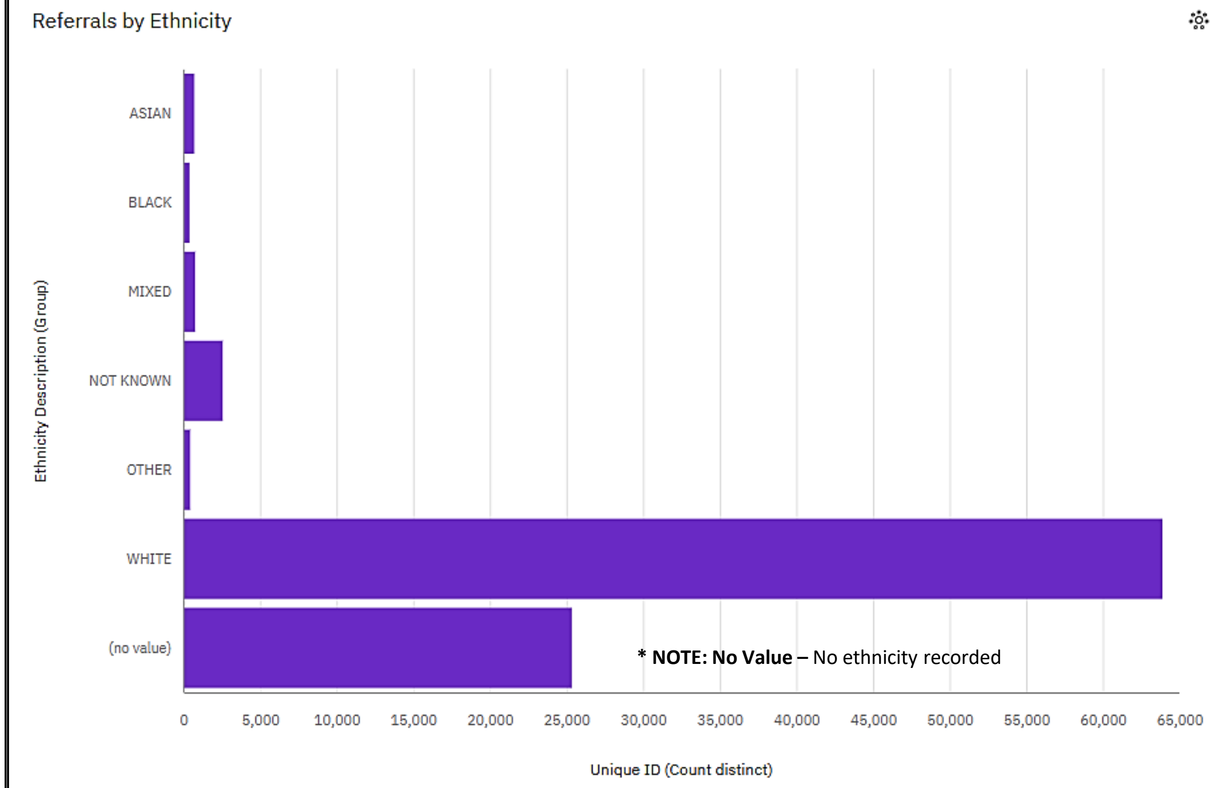
7. Population health, prevention and reducing inequality

Governance forum responsible:	Quality and Assurance Committee
Non-Executive Chair:	Marie Burnham (Interim Chair QAC)
Executive Lead:	Beverley Murphy

Ethnicity – Referrals and Admissions

Referrals: Ethnicity recorded for any patients which were admitted within the given period (distinct count). The data represents a count of referrals from 01/04/2025 to 30/04/2026.

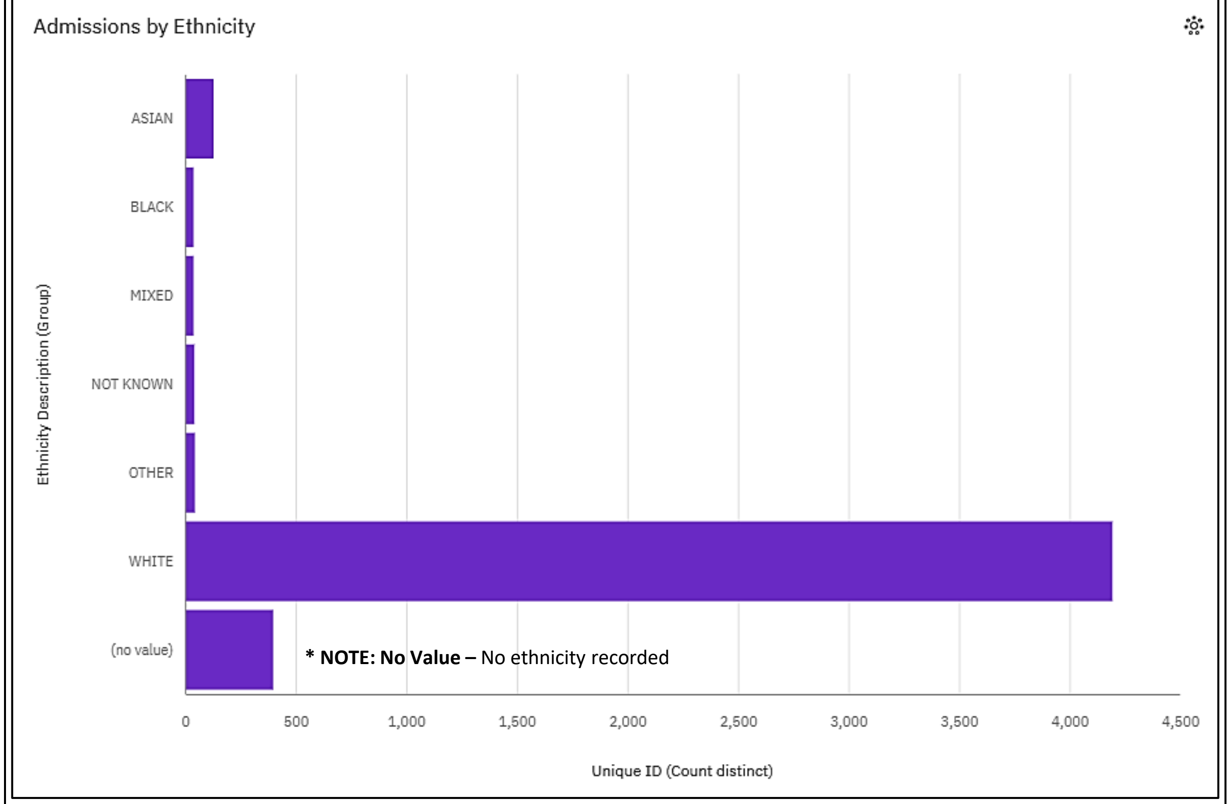
- Ethnicity recording has declined and is below the national mental health trust average, which limits how confidently we can understand and address inequalities.
- When viewed as a population rate, annual access data shows that many racialised communities are underrepresented in services overall.



- Future data sets to include referrals by population rate and will be reported quarterly to track improvements in ethnicity recording.
- A Patient and Carer Race Equality Framework team action plan template has been cascaded to teams for completion. This includes the importance of accurate ethnicity recording and is being monitored through quality standards.

Admissions: Ethnicity recorded for the first Referral within the Patient Journey within the given period. The data represents a count of admissions from 01/04/2025 to 30/04/2026.

- Ethnicity recording is higher in inpatient settings.
- Although in numerical terms admissions for ethnically minoritised and racialised communities are lower than for white communities, the population rate is higher with annual data indicating admission rates per 100 population over 3 times higher for Asian/ Asian British and Black/Black British communities than for white communities.

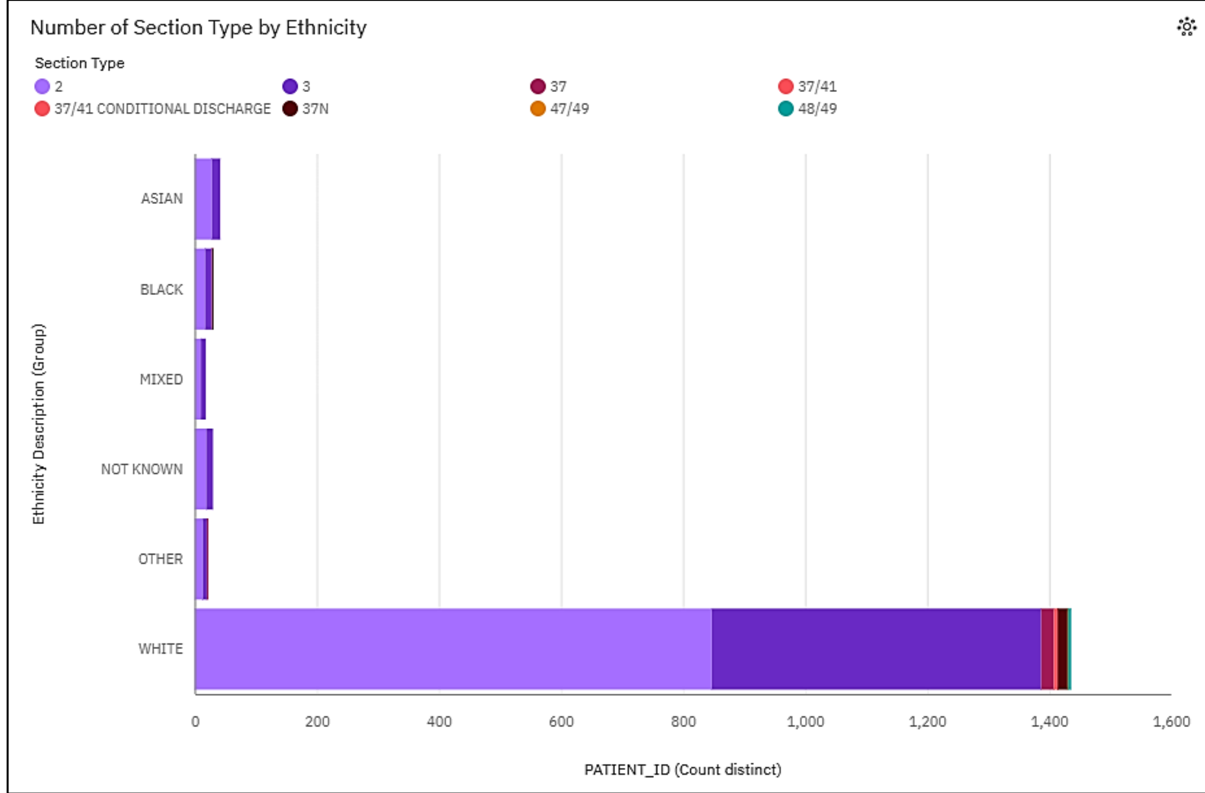


- Future data sets to be reported inclusive of population rate and will be reported quarterly to track any chances.
- A Community engagement plan to be developed to improve access, outcomes, experience, trust and early engagement for racialised communities.

Ethnicity – Mental Health Act

Mental Health Act: Ethnicity recorded once per patient per section type in given period (distinct count). The data shows the numbers of detentions and reflects the high proportion of white people in the population served by TEWV over the period from 01/09/2025 to 30/04/2026.

- Annual data analysis identifies that when viewed as a population rate that Black/ Black British people were detained 2.03 times more than White People, in 2024/25 compared to 2.61 times more in 2023/24

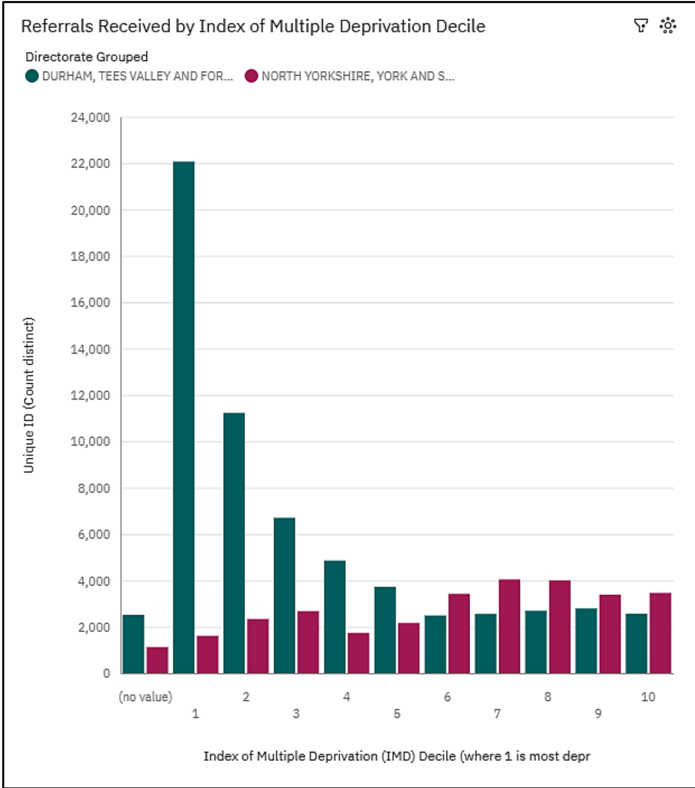


- Future data sets to include detention by population rate and will be reported quarterly to track any changes.
- A Patient & Carer Race Equality Framework team action plan template has been cascaded to teams for completion.

Deprivation Decile (Code) – Referrals and Admissions

Referrals: Deprivation Decile (associated with the earliest recorded postcode) recorded for the first Referral within the Patient Journey within the given period. 1 = Most Deprived 10 = Least Deprived. The data represents a count of referrals from 01/04/2025 to 30/04/2026.

- The interconnectedness of poverty and mental ill health means that those using our services are disproportionally impacted by financial hardship.
- The Trust serves some of the most deprived communities in the country. This is reflected in referrals with significantly higher numbers of referrals in Durham Tees Valley coming from the 10% most deprived communities. This pattern cannot be seen in North Yorkshire, York and Selby reflecting overall population differences.

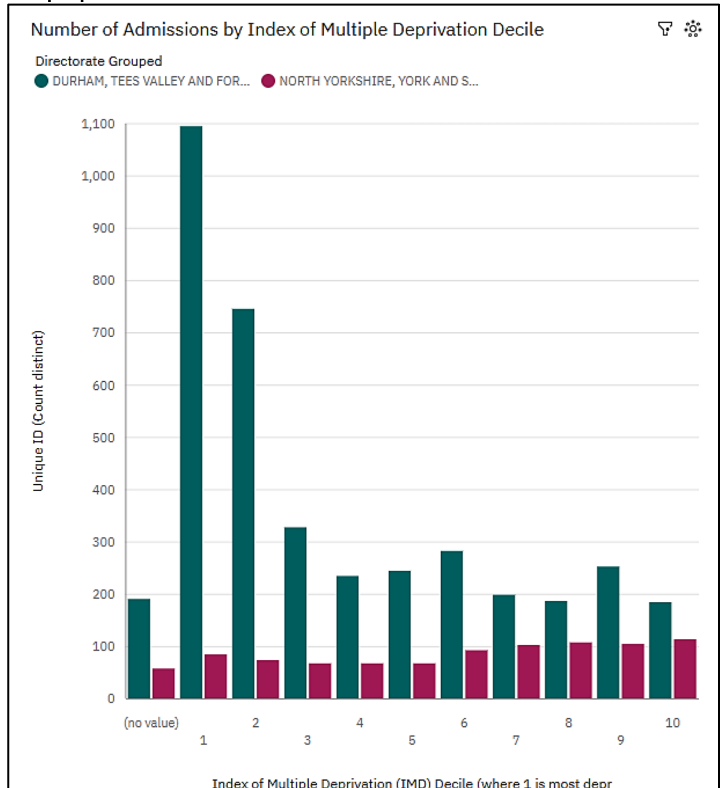


*** NOTE: No Value –** No corresponding deprivation decile available for the given postcode

Within the personalising care agenda we are considering accessibility for people experiencing multiple disadvantage; "Poverty Proof" © our service pathways.

Admissions: Deprivation Decile (associated with the earliest recorded postcode) recorded for any patients which were admitted within the given period (distinct count). 1 = Most Deprived 10 = Least Deprived. The data represents a count of admissions from 01/04/2025 to 30/04/2026.

- The interconnectedness of poverty and mental ill health means that those using our services are disproportionally impacted by financial hardship.
- The Trust serves some of the most deprived communities in the country. This is reflected in admission rates which show significantly higher number of admissions in Durham Tees Valley from the most deprived 20% of communities nationally. This pattern cannot be seen in North Yorkshire, York and Selby reflecting overall population differences.

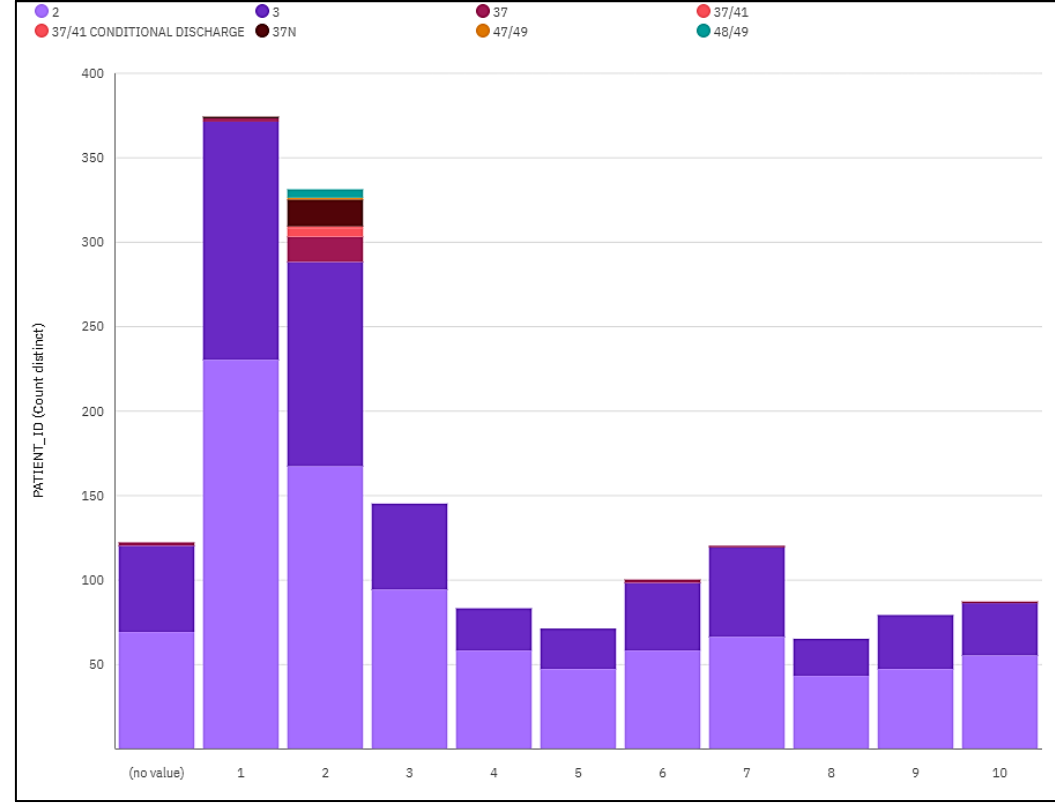


*** NOTE: No Value –** No corresponding deprivation decile available for the given postcode

Roll out of the Standard 5 of Culture of Care programmes and "Equality" informed by local drivers of inequality, including deprivation.

Mental Health Act: Deprivation Decile (associated with the earliest recorded postcode) recorded once per patient per section type in given period (distinct count). 1 = Most Deprived, 10 = Least Deprived. The data represents a count of detentions from 01/09/2025 to 30/04/2026.

- Numbers of detentions for the most deprived deciles are significantly higher at Trust Level in our most deprived communities. Annual data indicates more than twice the rate of detention in our most derived decile than our least deprived decile overall.
- Within the care groups there are significant differences, which reflect the makeup of the population. Annual data indicates that in numerical terms this results in 7 times as many detentions in the most deprived decile in Durham & Tees Valley than in the least deprived decile. Within North Yorkshire, York & Selby the actual number detentions are not socially profiled with slightly more detentions from the least deprived deciles than the most deprived deciles. This is a reflection of the different population make up in the two care groups and demonstrates the need to interrogate this data at place level and in the context of the communities served.



*** NOTE: No Value –** No corresponding deprivation decile available for the given postcode

Roll out of the Standard 5 of Culture of Care programmes and "Equality" informed by local drivers of inequality, including deprivation.

8. Care Group

124

Durham, Tees Valley & Forensic Care Group - Overview

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC			92.00%	92.08%	92.08%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	88.46%	88.46%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	69.05%	69.05%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	52.54%	52.54%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	46.83%	46.83%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	62.24%	62.24%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC			30.00%	29.78%	29.78%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	89.27%	89.27%

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
9)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC				13.78%	13.78%
10)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC			0	0	0
11)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				1	1
12)	The number of Incidents of moderate or severe harm	QAC				14	14
13)	The number of Restrictive Interventions Used	QAC				982	982
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	0
15)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	0
16)	The number of uses of the Mental Health Act	MHLC				190	190

Durham, Tees Valley & Forensic Care Group - Overview

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
17)	Percentage of staff recommending the Trust as a place to work	P&C			60.00%	54.70%	54.70%
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	P&C			65.00%	58.31%	58.31%
19)	Staff Leaver Rate	P&C			11.00%	8.91%	8.91%
20)	Percentage Sickness Absence Rate (month behind)	P&C			5.50%	7.25%	7.25%
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	P&C			85.00%	93.32%	93.32%
22)	Percentage of staff in post with a current appraisal	P&C			85.00%	89.09%	89.09%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
23)	Number of new unique patients referred	RPC				5,026	5,026
24)	Unique Caseload (snapshot)	RPC				47,270	47,270

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
25)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	0	24,341,316
26)	Financial Plan: Agency expenditure compared to agency target	RPC	745,000	154,889
27)	Agency price cap compliance	RPC	67.00%	1.46%

North Yorkshire, York & Selby Care Group - Overview

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC			92.00%	95.75%	95.75%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	83.67%	83.67%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	83.33%	83.33%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	50.50%	50.50%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	45.56%	45.56%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	62.57%	62.57%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC			30.00%	26.32%	26.32%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	84.75%	84.75%

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
9)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC				15.25%	15.25%
10)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC			0	3	3
11)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				0	0
12)	The number of Incidents of moderate or severe harm	QAC				3	3
13)	The number of Restrictive Interventions Used	QAC				76	76
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	0
15)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	0
16)	The number of uses of the Mental Health Act	MHLC				98	98

North Yorkshire, York & Selby Care Group - Overview

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
17)	Percentage of staff recommending the Trust as a place to work	P&C		?	60.00%	41.67%	41.67%
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	P&C		?	65.00%	53.12%	53.12%
19)	Staff Leaver Rate	P&C	L	F	11.00%	11.42%	11.42%
20)	Percentage Sickness Absence Rate (month behind)	P&C	H	?	5.50%	5.50%	5.50%
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	P&C	H	P	85.00%	92.09%	92.09%
22)	Percentage of staff in post with a current appraisal	P&C	H	?	85.00%	89.02%	89.02%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)
23)	Number of new unique patients referred	RPC				2,552	2,552
24)	Unique Caseload (snapshot)	RPC	L			15,272	15,272

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
25)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	0	9,947,712
26)	Financial Plan: Agency expenditure compared to agency target	RPC	745,000	150,374
27)	Agency price cap compliance	RPC	67.00%	75.46%

9. National metrics

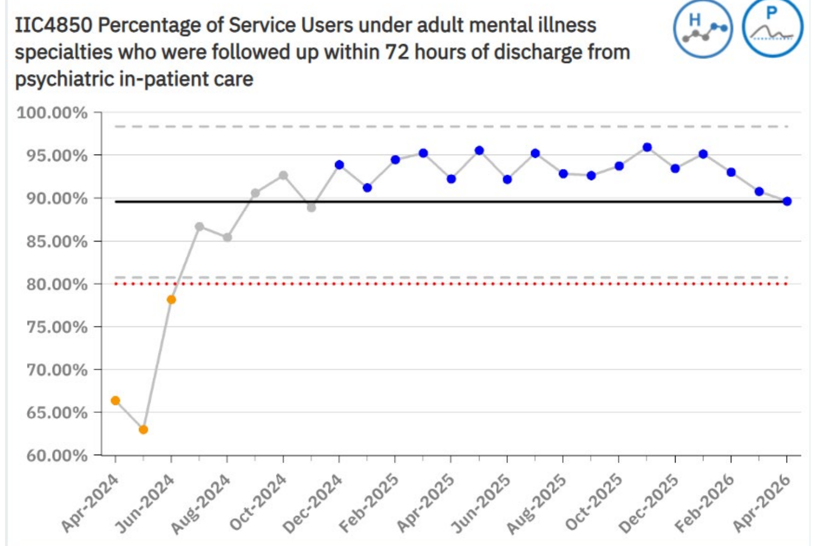
NHS Oversight Framework

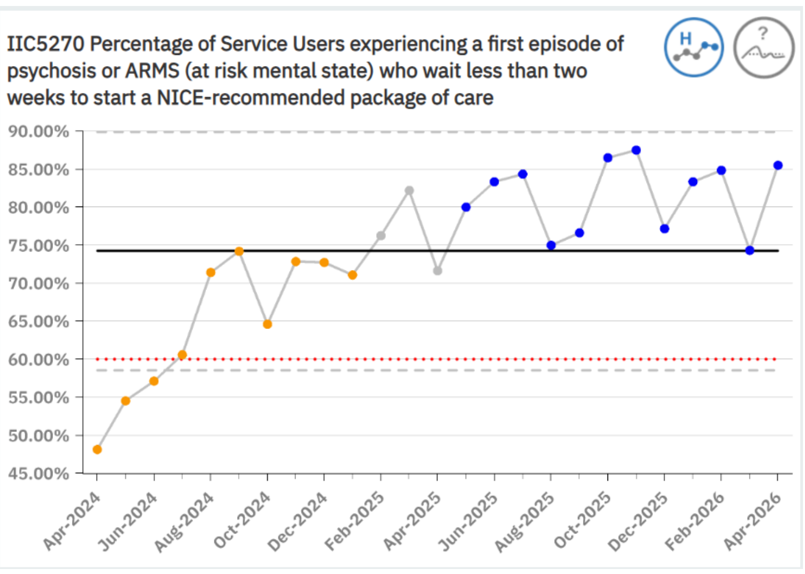
NHS Oversight Framework	Quarter 1 2025/26			Quarter 2 2025/26			Quarter 3 2025/26		
	Q1 peformance	Q1 score	Q1 rank	Q2 peformance	Q2 score	Q2 rank	Q3 peformance	Q3 score	Q3 rank
Annual change in number of children and young people accessing NHS-funded MH services (rolling 12 months)	0.44%	3.37	36 out of 46	-2.28%	3.35	40 out of 49	3.63	2.91	34 out of 50
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)		2.00			2.00			2.00	
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)		3.00			3.00				
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%					
DOMAIN SCORE - People and Workforce		3.44			3.59			3.68	
Planned surplus/deficit (annual)	0%	1.00	15 out of 61	0%	1.00	16 out of 61	0%	1.00	16 out of 61
Variance year-to-date to financial plan	0.68%	1.00	3 out of 61	0.39%	1.00	8 out of 61	0.44%	1.00	10 out of 61
Relative difference in costs (annual)	79.03%	1.22	5 out of 60	96.24%	1.90	17 out of 61	96.24%	1.90	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%					
OVERALL AVERAGE SCORE		2.28			2.38			2.27	
FINAL SEGMENTATION	2		24 out of 61	3		34 out of 61	2		24 out of 61

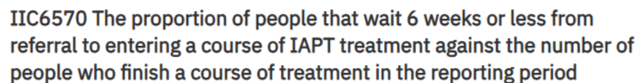
National Quality Requirements

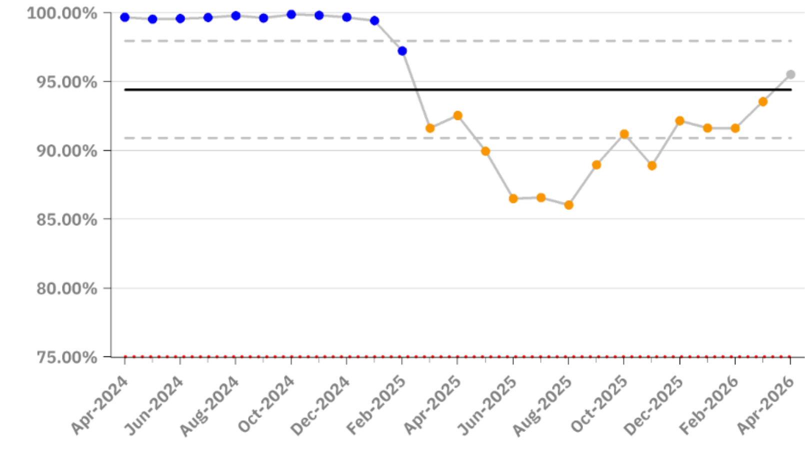
Rep Ref	National Quality Requirements	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26
IIC4850	Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	H	P	80.00%	80.00%	89.64%	89.64%
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%	85.51%	85.51%
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		P	75.00%	75.00%	95.53%	95.53%
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%	99.86%	99.86%
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%	86.69%	86.69%
IIC5350	Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)	H	F	95.00%	95.00%	78.69%	78.69%

National Quality Requirements









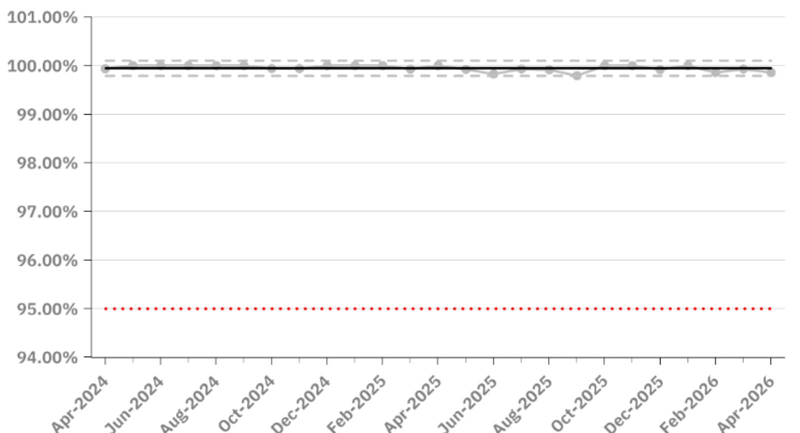
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	80%	89.64%			
COUNTY DURHAM	80%	90.00%			
TEES VALLEY	80%	94.37%			
NORTH YORKSHIRE	80%	92.42%			
YORK	80%	92.00%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	60%	85.51%			
COUNTY DURHAM	60%	84.62%			
TEES VALLEY	60%	94.12%			
NORTH YORKSHIRE	60%	85.71%			
YORK	60%	75.00%			

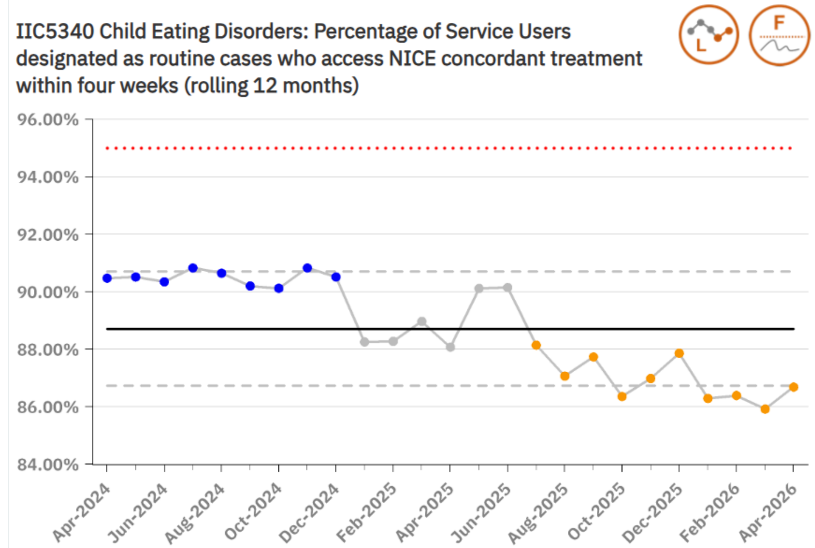
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	75%	95.53%			
COUNTY DURHAM	75%	94.00%			
TEES VALLEY	75%	94.85%			
NORTH YORKSHIRE	75%	97.36%			
YORK	75%	95.41%			

National Quality Requirements

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



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	99.86%			✓
COUNTY DURHAM	95%	99.80%			✓
TEES VALLEY	95%	98.97%			✓
NORTH YORKSHIRE	95%	100.00%			✓
YORK	95%	100.00%			✓

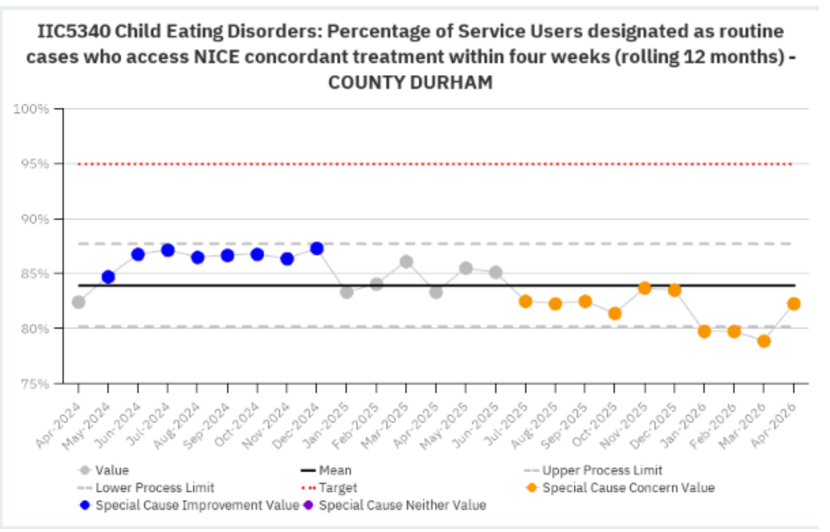


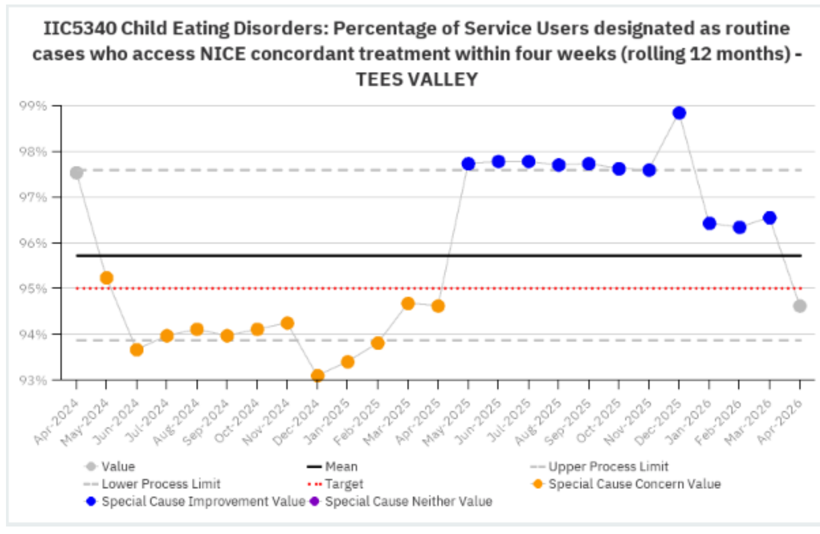
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	86.69%			✗
COUNTY DURHAM	95%	82.29%			✗
TEES VALLEY	95%	94.62%			✗
NORTH YORKSHIRE	95%	91.23%			✗
YORK	95%	66.67%			✗

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

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	78.69%			✗
COUNTY DURHAM	95%	95.45%			✓
TEES VALLEY	95%	100.00%			✓
NORTH YORKSHIRE	95%	55.00%			✗
YORK	95%	62.50%			✗

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*





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 **April** 2026, there were **96** children and young people with a routine referral, of which **79 (82.29%)** started treatment within 4 weeks in **County Durham**.

In April **t**here were **10** children and young people with a routine referral; **all (100%)** started treatment within 4 weeks.

What does the chart show/context:
In the rolling 12 months ending **April** 2026, there were **93** children and young people with a routine referral, of which 88 **(94.62%)** started treatment within 4 weeks in **Tees Valley**.

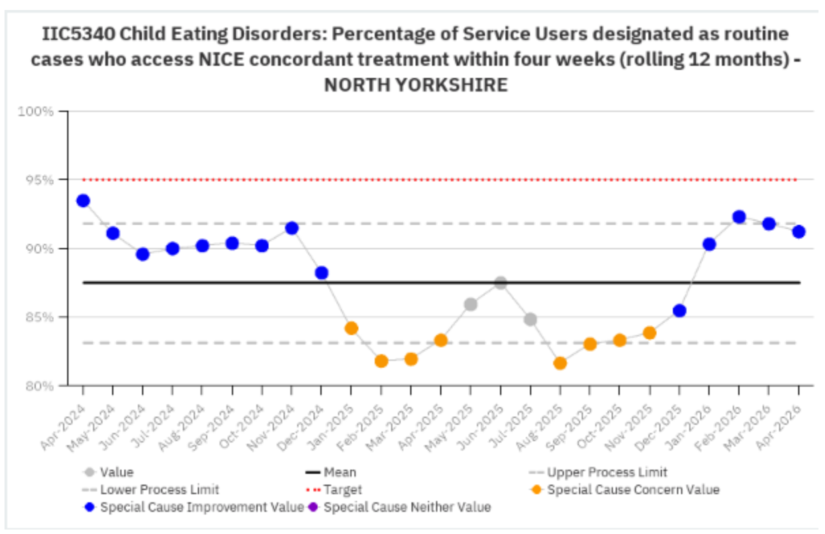
In April, there were **11** children and young people with a routine referral; **9 (81.82%)** started treatment within 4 weeks.

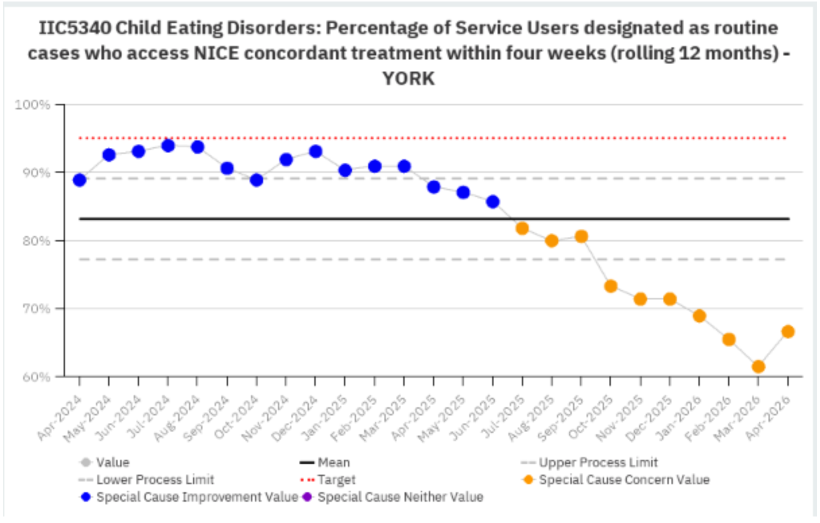
Of the 2 patients that did not meet the standard, **both** were offered appointments within 4 weeks; however, the families requested later appointments outside the standard. One patient cancelled a further appointment and commenced treatment on day 49; the remaining patient was assessed, and as the service was not appropriate for their needs they have been discharged.

Underlying Issues:
We are continuing to flow in accurate information in our internal reporting and out Mental Health Services Dataset, as outlined above.

Trust-wide Actions:
Operational leads, overseen by the Directors of Operations, to undertake a deep dive and develop an improvement plan by the end of May 2026.

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*





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 **April** 2026, there were **57** children and young people with a routine referral, of which **52 (91.23%)** started treatment within 4 weeks in **North Yorkshire**.

In April, there were **1** children and young people with a routine referral; the patient 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 April 2026, there were **27** children and young people with a routine referral, of which **18 (66.67%)** started treatment within 4 weeks in **York**.

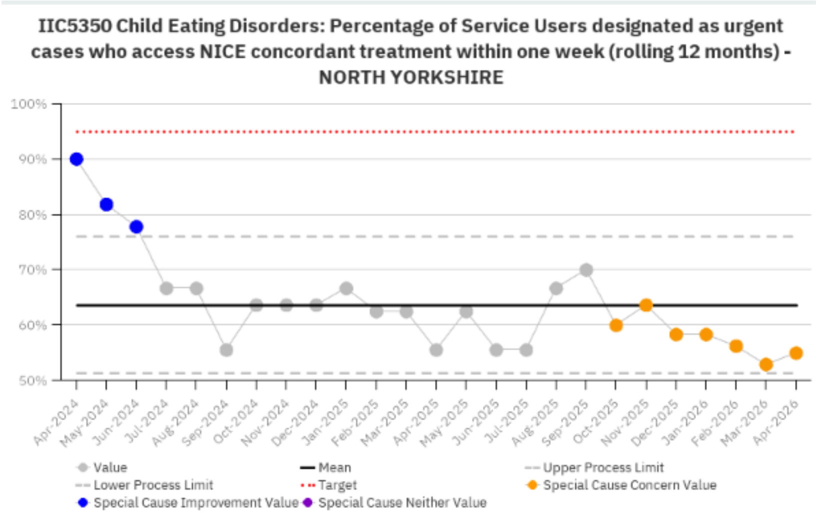
In April, there were **2** children and young people with a routine referral; both started treatment within 4 weeks

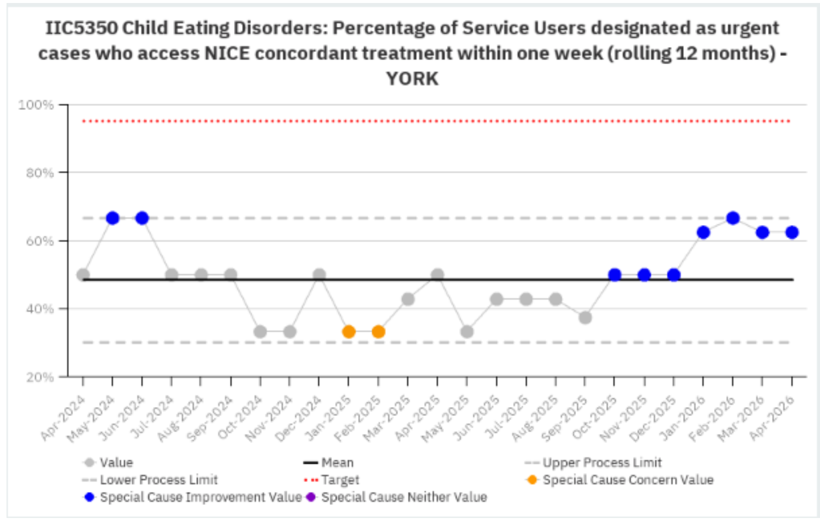
Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

Trust-wide Actions:
Operational leads, overseen by the Directors of Operations, to undertake a deep dive and develop an improvement plan by the end of May 2026.

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*





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 April 2026 there were **20** child or young people with an urgent referral, of which **11 (55.00%)** started treatment within 1 week in **North Yorkshire**.

In April, there were **3** children and young people with an urgent referral, of these, **2** started treatment within 1 week **(66.67%).**

One patient was booked an appointment within 1 week; however, the service were unable to contact the family. The patient commenced treatment on day 8.

What does the chart show/context:
In the rolling 12 months ending April 2026, there were **8** child or young people with an urgent referral, of which **5 (62.50%)** started treatment within 1 week in **York**.

In April, there were **no** children or young people with an urgent referral.

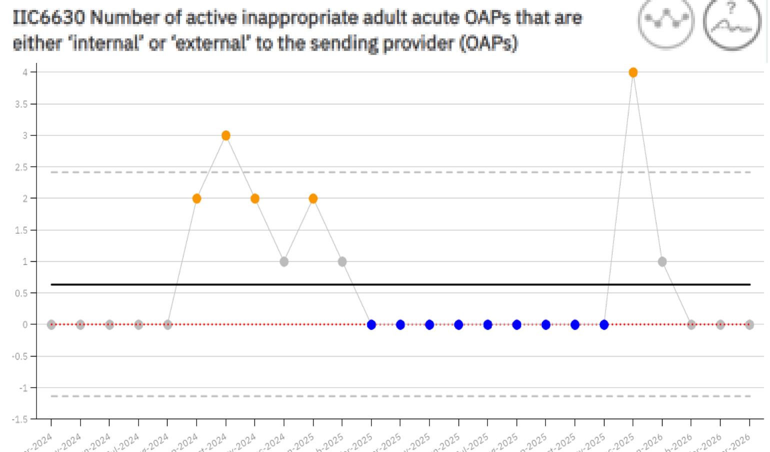
Underlying Issues:
There are no underlying issues to report.

Trust-wide Actions:
There are no specific improvement actions required.

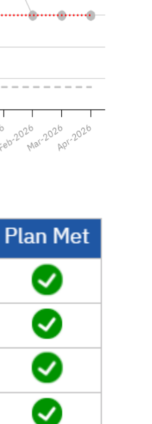
Mental Health Priorities – Provider and System-wide Plans

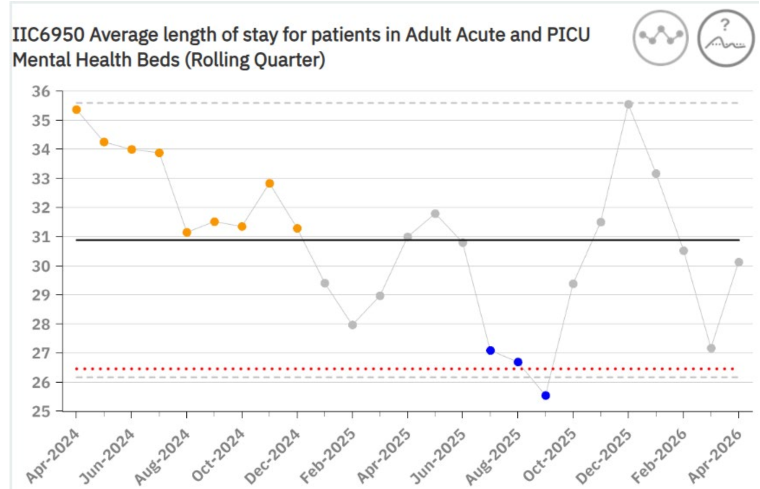
Rep Ref	Mental Health Priorities - Provider and System-wide Plans	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26
IIC6630	Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider (OAPs)			0	0	0	0
IIC6950	Average length of stay for patients in Adult Acute and PICU Mental Health Beds (Rolling Quarter)			26.40	26.47	30.13	30.13
IIC6960	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (Rolling Quarter)			70.00	70.16	70.12	70.12
IIC7010	Number of CYP referral-spells waiting more than 104 weeks for a full clock stop that were still open at the end of the reporting period. Referrals are limited to the 'other' (pathway 'd') group within the referral-spell breakdowns	N/A	N/A	0	1,420	725	725

Mental Health Priorities – Provider and System-wide plans

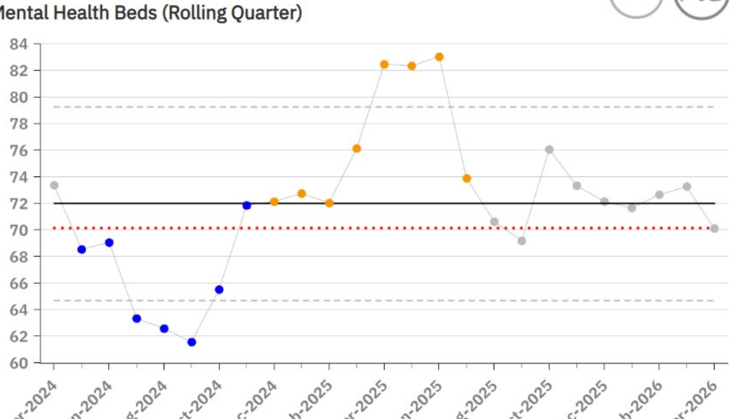


Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	0	0			✓
COUNTY DURHAM	0	0			✓
TEES VALLEY	0	0			✓
NORTH YORKSHIRE	0	0			✓
YORK	0	0			✓



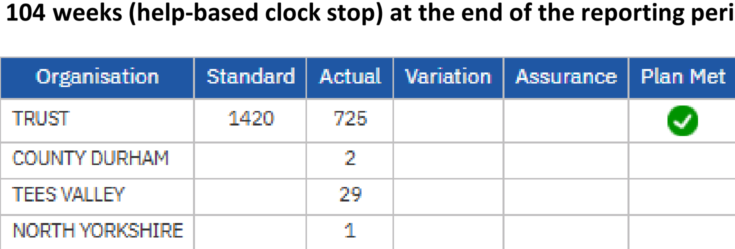


Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	26.47	30.13			✗
COUNTY DURHAM		26.31			
TEES VALLEY		30.31			
NORTH YORKSHIRE		31.65			
YORK		36.22			



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	70.16	70.12			✓
COUNTY DURHAM		63.65			
TEES VALLEY		78.36			
NORTH YORKSHIRE		64.40			
YORK		55.75			

Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	1420	725			✓
COUNTY DURHAM		2			
TEES VALLEY		29			
NORTH YORKSHIRE		1			
YORK		2			

Average length of stay for patients in Adult Acute and PICU Mental Health Beds (rolling quarter)

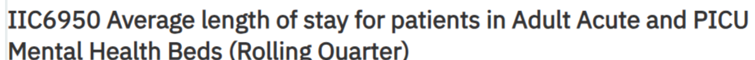
Background / standard description:
We are aiming to reduce our average length of stay within our adult acute and PICU inpatient beds to 26.47 days by the end of April 2026.

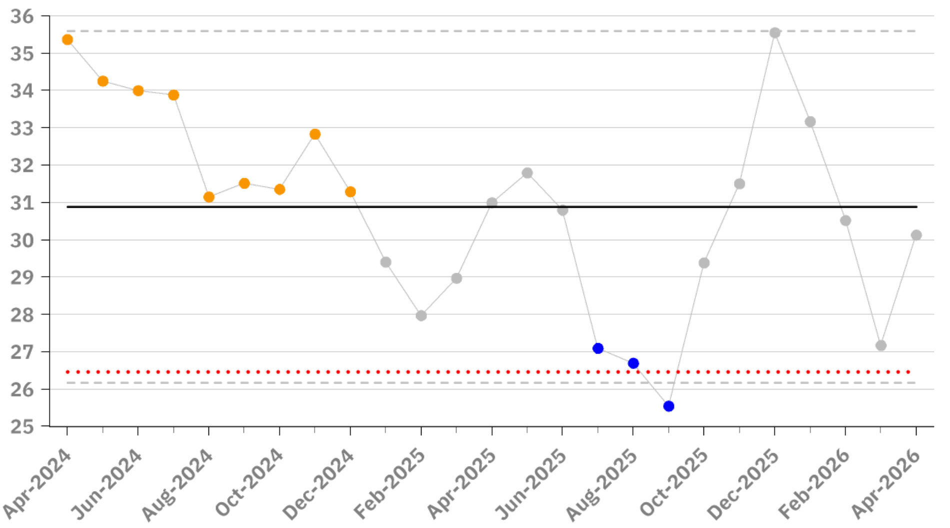
What does the chart show/context:
During the 3-month period ending April 2026, there were **548** discharged hospital spells from adult acute or PICU beds for patients aged 18+, accounting for a total of **16,509** bed days which equates to an average length of stay of **30.13** days.

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

Underlying issues:
Long lengths of stay are largely impacted by the discharge of patients that are clinically ready for discharge. In the 3 months ending April 2026 there were 8 patients with lengths of stay exceeding 300 days were discharged.

Actions:
See *Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed)* on page 21 for actions.



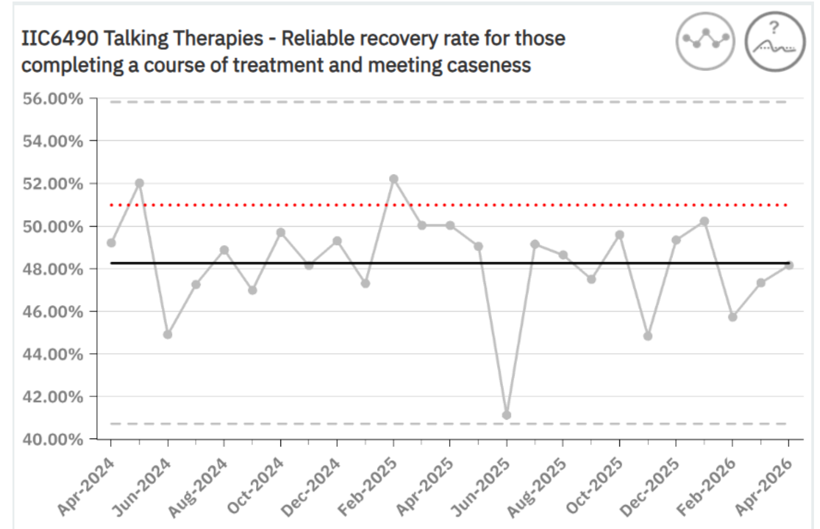


Average Length of Stay in Adult Acute MH Beds (rolling 3 months)	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Plan	26.47	26.47	26.46	26.46	26.46	26.44	26.44	26.44	26.42	26.42	26.42	26.40
Actual	30.13											

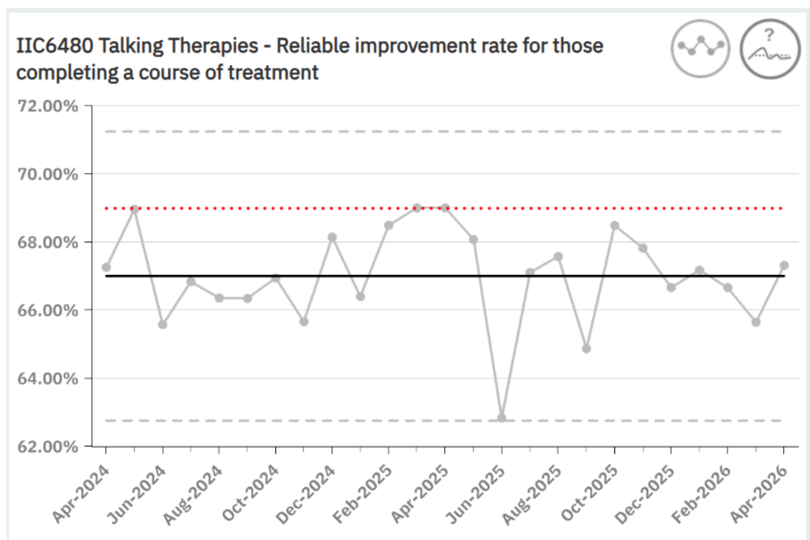
Mental Health Priorities – System-Wide Plans

Rep Ref	Mental Health Priorities - System-wide Plans	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26
IIC6490	Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness			51.00%	51.00%	48.16%	48.16%
IIC6480	Talking Therapies - Reliable improvement rate for those completing a course of treatment			69.00%	69.00%	67.32%	67.32%
IIC6640	Talking Therapies: Number of people who are discharged having received at least 2 treatment appointments in the reporting period	L	N/A	Data Only	Data Only	1,386	1,386
IIC5371	Number of women accessing (1+ contact) specialist community PMH services in the previous 12 months	L	N/A	Data Only	Data Only	1,501	1,501
IIC6610	Number of people accessing IPS services (rolling 12 month)	H	N/A	Data Only	Data Only	1,100	1,100
IIC5830	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact		N/A	Data Only	Data Only	31,225	31,225
IIC7000	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact with an MHST (Rolling 12 Month)	H	N/A	Data Only	Data Only	1,987	1,987

Mental Health Priorities – System Wide Plans



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	51%	48.16%			
COUNTY DURHAM	51%	48.16%			
TEES VALLEY	51%	47.19%			
NORTH YORKSHIRE	51%	48.06%			
YORK	51%	48.54%			

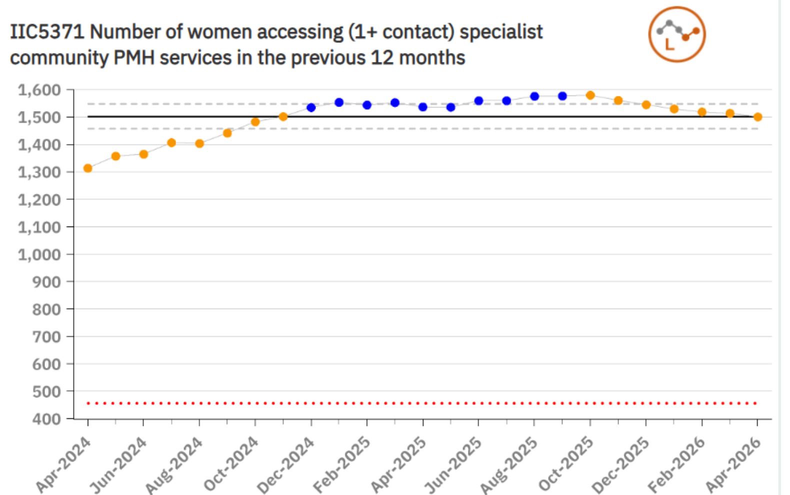


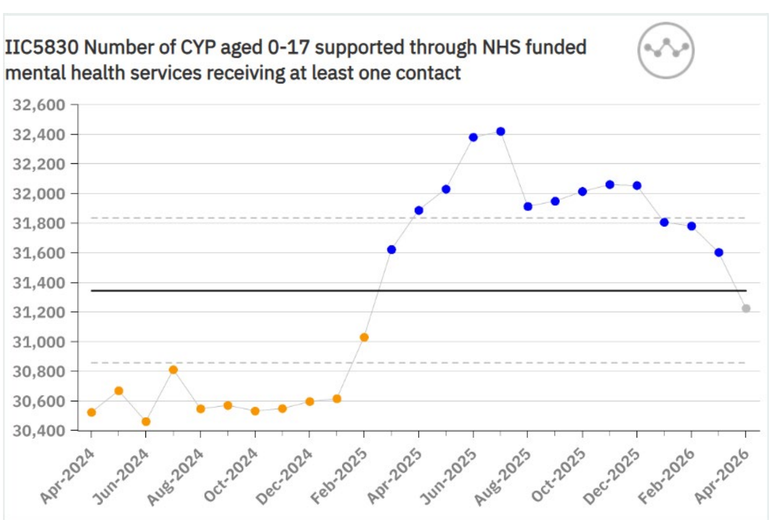
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	69%	67.32%			
COUNTY DURHAM	69%	68.40%			
TEES VALLEY	69%	65.98%			
NORTH YORKSHIRE	69%	68.57%			
YORK	69%	64.83%			

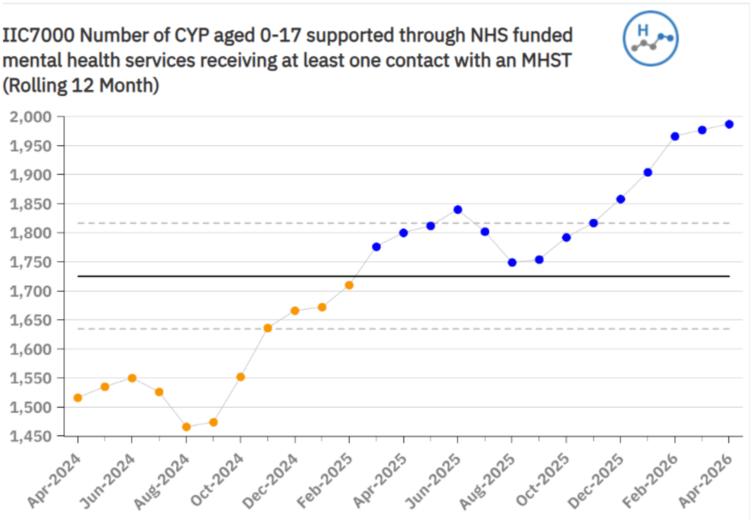
IIC6640 Talking Therapies: Number of people who are discharged having received at least 2 treatment appointments in the reporting period

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,386			
COUNTY DURHAM		500			
TEES VALLEY		97			
NORTH YORKSHIRE		455			
YORK		327			

Mental Health Priorities – System-Wide Plans







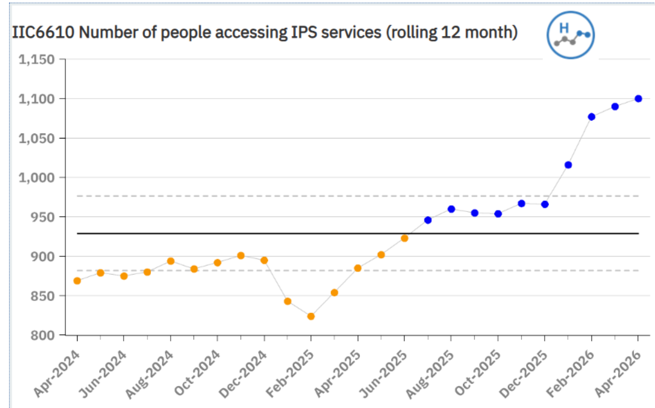
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,501			
COUNTY DURHAM	456	382			
TEES VALLEY	447	495			✓
NORTH YORKSHIRE	368	433			✓
YORK	156	167			✓

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		31,225			
COUNTY DURHAM		10,944			
TEES VALLEY		10,485			
NORTH YORKSHIRE		5,709			
YORK		3,511			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,987			
COUNTY DURHAM		850			
TEES VALLEY		327			
NORTH YORKSHIRE		511			
YORK		233			

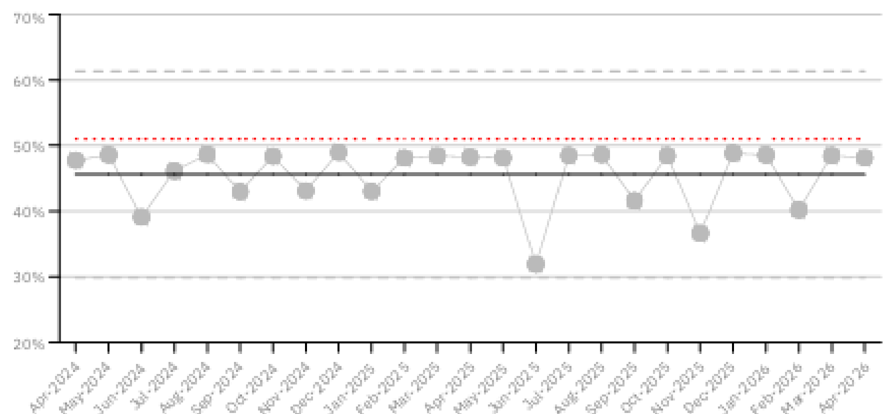
Please note that the data for County Durham place has been removed due to several issues that we have identified. Remedial work is underway, and an action plan with resolution timescales will be completed by the end of May 2026.

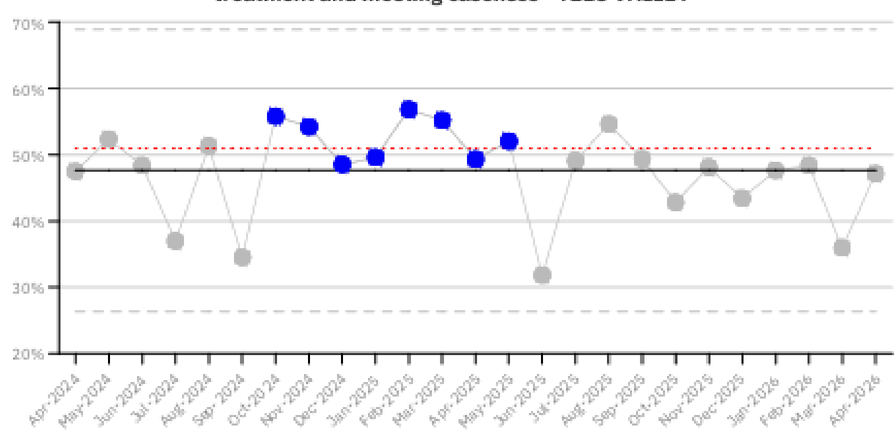
Mental Health Priorities – System-Wide Plans



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,100			
COUNTY DURHAM		321			
TEES VALLEY		446			
NORTH YORKSHIRE		218			
YORK		101			

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





Background / standard description:
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:
During **April**, 48.16**%** 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.

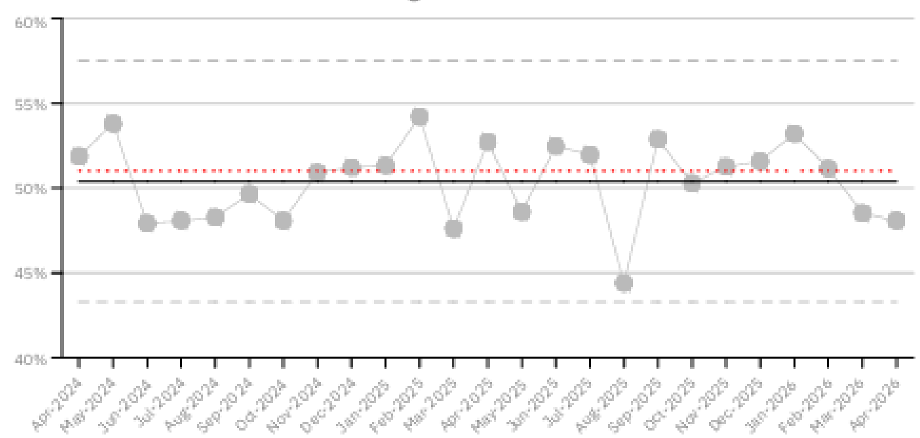
Background / standard description:
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:
During April, 47.19**%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees**.

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

For underlying issues and action, please see page 90

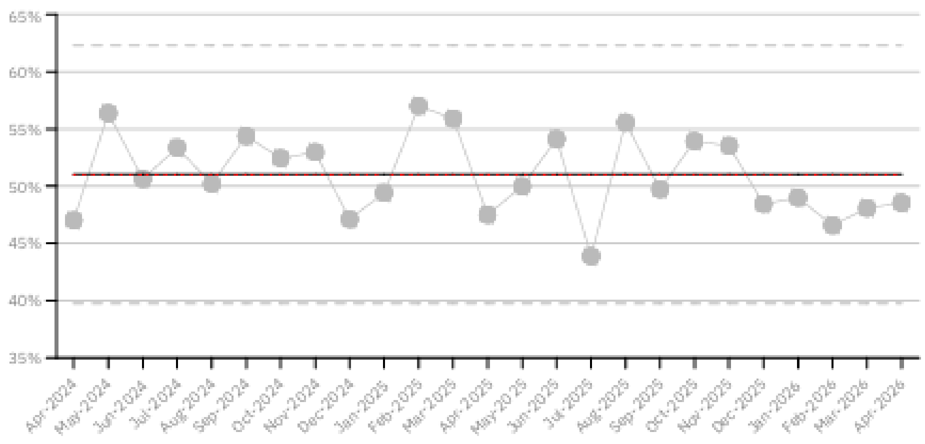
Talking Therapies: Reliable recovery rate for those completing a course of treatment – *by exception*



Background / standard description:
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:
During **April**, 48.06**%** of patients demonstrated reliable improvement following completion of a course of treatment within **North Yorkshire.**

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



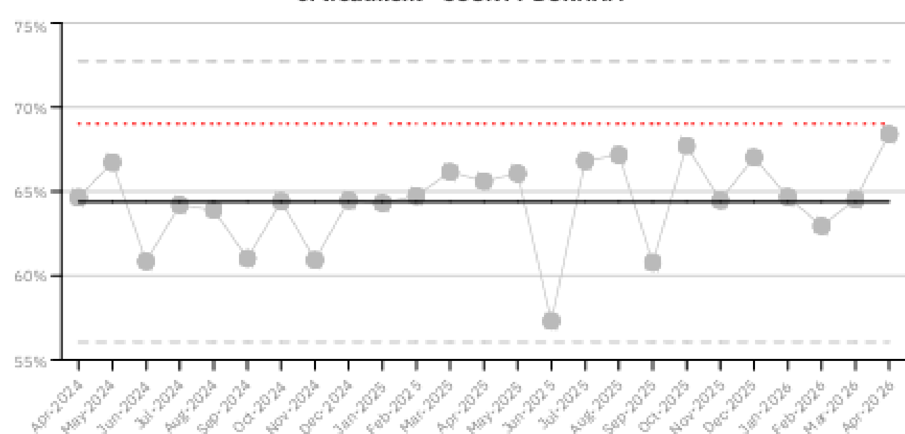
Background / standard description:
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

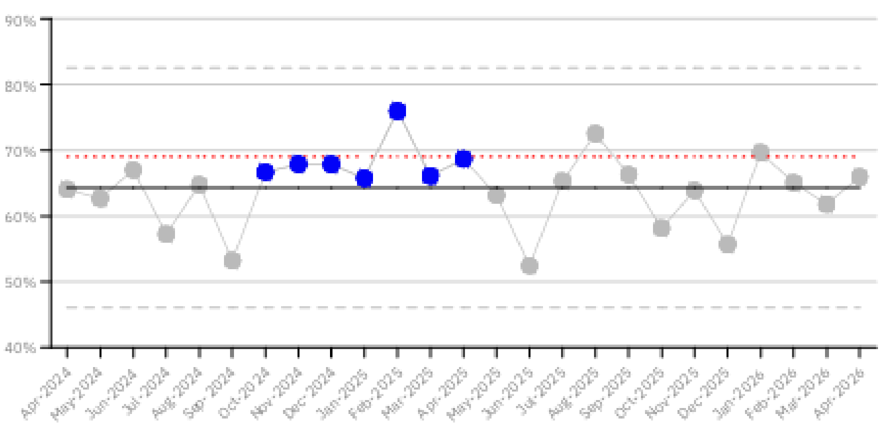
What does the chart show/context:
During April, 48.54**%** of patients demonstrated reliable improvement following completion of a course of treatment within **York**.

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

For underlying issues and action, please see page 90

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





Background / standard description:
We are aiming for 69% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
During **April, 68.40%** 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.

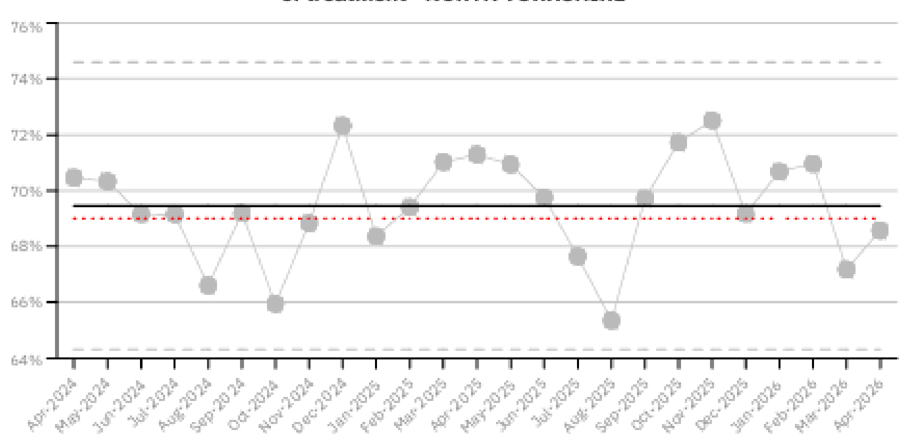
Background / standard description:
We are aiming for 69% of patients to demonstrate reliable improvement following completion of a course of treatment.

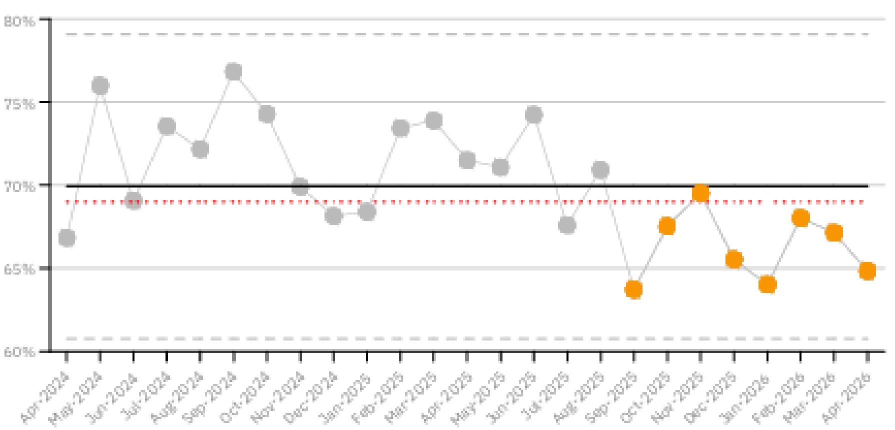
What does the chart show/context:
During **April, 65.98%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**.

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

For underlying issues and action, please see page 90

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





Background / standard description:
We are aiming for 69% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
During **April, 68.57%** of patients demonstrated reliable improvement following completion of a course of treatment within **North Yorkshire**.

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

Background / standard description:
We are aiming for 69% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
During **April, 64.83%** of patients demonstrated reliable improvement following completion of a course of treatment within **York**.

There is cause for concern indicated in the chart above.

For underlying issues and action, please see page 90

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*

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.

Underlying issues North Yorkshire & York:

This is the first month reporting below standard and there are no underlying issues to report at this stage.

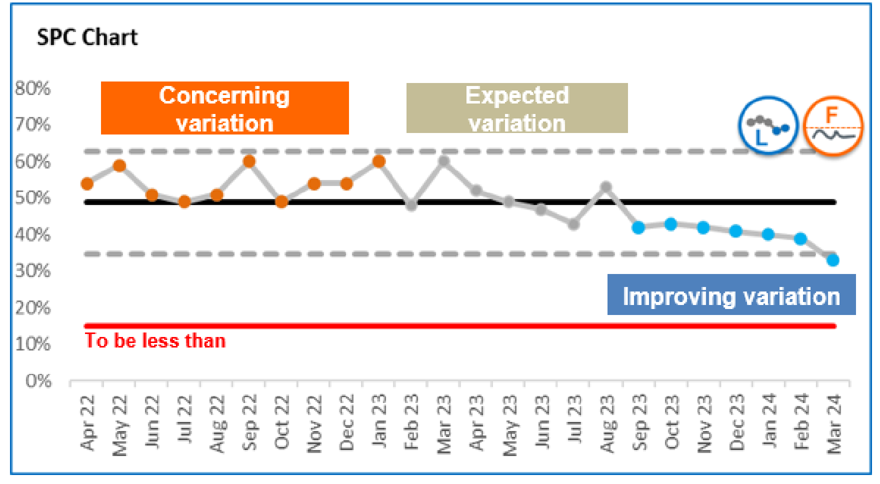
Actions County Durham & Tees Valley:

- Recruitment is underway for 3.7 WTE permanent PWPs; interviews are schedule with 2 applicants in May 2026.
- The DTVFCG Performance Improvement Plan has 7 open actions, which are due to be completed by July 2026; all are on track for delivery.

10. Appendices

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

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

Icon	Technical Description	What does this mean?	What should we do?
	Variation/Performance Icons		
	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.	

Icon	Technical Description	What does this mean?	What should we do?
	Assurance Icons		
	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.

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 was completed in quarter 4 2025/26 and the results incorporated within this report.

	Data Quality Assessment		
Icon	***Description***	***What does this mean?***	***What should we do?***
DQ ★	SUBSTANTIAL assurance; a data quality score of **93% or over**	The measure is reliable.	There is no specific action to take.
DQ ✓✓	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.
DQ ✓	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.
DQ ×	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

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

Glossary of Terms

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
ESR	Electronic Staff Record
GBO	Goal-Based Outcomes
HNY	Humber & North Yorkshire
ICB	Integrated Care Board
IPD	Integrated Performance Dashboard
IPS	Individual Placement Support
LTS	Long Term Sickness
MHLDA	Mental Health, Learning Disabilities & Autism Collaborative

MHSDS	Mental Health Services Dataset
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
SIS	Secure Inpatient Services
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STS	Short Team Sickness
STEIS	Strategic Executive Information System
UoRR	Use of Resources Rating
WTE	Whole time equivalent

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For General Release

Meeting of:	Board of Directors
Date:	11th June 2026
Title:	Supporting Mental Health demand in Acute Care Services
Executive Sponsor(s):	Naomi Lonergan, Interim Managing Director
Author(s):	Jamie Todd, Director of Operations & Transformation, Jo Salvin, DTV AMH Urgent Care Business Manager

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

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	X
3: To be a trusted partner	X

Strategic risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
2	***Demand***	Timely access to acute inpatient treatment and assessment beds is impacted due to current patient flow challenges across adult mental health acute inpatient services. Delays in access to adult mental health acute inpatient beds can lead to people waiting for acute inpatient care within the community, Emergency Departments (ED) and Health Based Place of Safety (HBPOS). In addition, these delays can also impact the wider system, particularly ED. Such delays can lead to poor experience for the people we serve and could potentially result in avoidable harm.
4	***Quality of Care***	Pressure to maintain flow within acute inpatient services can affect quality of care, including the timeliness of admission and discharge processes. People may not be discharged to a less restrictive setting as soon as their purpose of admission is met, sometimes due to a lack of effective discharge planning from the point of admission and sometimes due to a lack of a range of available community support and supported living options that meet the needs of the people we serve.

Executive Summary

Purpose

This paper sets out the Trust's strategic response to the NHS England (NHSE) priority to reduce avoidable mental health presentations in Accident & Emergency (A&E) departments and to ensure that individuals in crisis receive timely, appropriate, and therapeutic care in the right setting.

This paper provides assurance on the actions underway within the Trust to support this ambition, including internal service improvements and alignment with national best practice. It outlines planned service developments to enhance crisis response and reduce reliance on A&E settings and summarises progress to date, including engagement with the Getting It Right First Time (GIRFT) programme and broader system transformation work.

Proposal

Recognising both the scale of demand and the system-wide implications, the Chief Executive has initiated direct engagement with acute and ambulance sector partners to develop a shared understanding of current challenges and opportunities. This collaborative approach is focused on:

- **Improving response and access to services for patients**, ensuring timely clinical assessment and reducing delays in care within emergency pathways
- **Understanding the scale and shape of demand** experienced by acute and ambulance colleagues, including pressures arising from mental health-related attendances
- **Jointly identifying and delivering improvement opportunities**, with a focus on pathway redesign, alternative models of care, and strengthening community-based responses

Trust Board are asked to accept this report with **good assurance** in relation to reduced Emergency Department (ED) delays, improved patient flow, increased bed availability and enhanced system co-ordination, enabling Acute Trust hospitals to transfer and manage mental health patients more efficiently, improve patient experience and reduce operational pressures across urgent and emergency care pathways.

Inconsistent data collection and models is a limitation to full understanding however it is proposed that the Trust continues to build on the demonstrable improvements achieved to date through a series of planned meetings with partners to agree consistent data collection and to work towards improved models of delivery. This will include the following:

- Maintaining and embedding effective operational oversight through the consistent application of OPEL and RAIDR frameworks, supported by enhanced use of real-time digital intelligence via OPTICA to inform timely decision-making.
- Progressing targeted corrective actions to address identified process inefficiencies at the acute interface, particularly in relation to documentation, referral pathways, and handover arrangements, ensuring a standardised and streamlined end-to-end patient journey.
- Scaling and embedding best practice models emerging from Liaison Psychiatry services and local improvement initiatives to reduce unwarranted variation and strengthen consistency of delivery across all localities.

- Continuing to reduce length of stay and optimise bed utilisation through strengthened discharge planning, improved multi-agency coordination, and sustained focus on timely patient flow.
- Working with Acute and ambulance partners to further develop credible alternatives to admission and routine conveyance, including joint work with NEAS, to better manage demand across 111 and 999 pathways and support delivery of care closer to home.
- Strengthening workforce models, including sustained senior clinical decision-making capacity, to enhance service responsiveness, reduce operational pressures, and improve patient outcomes.

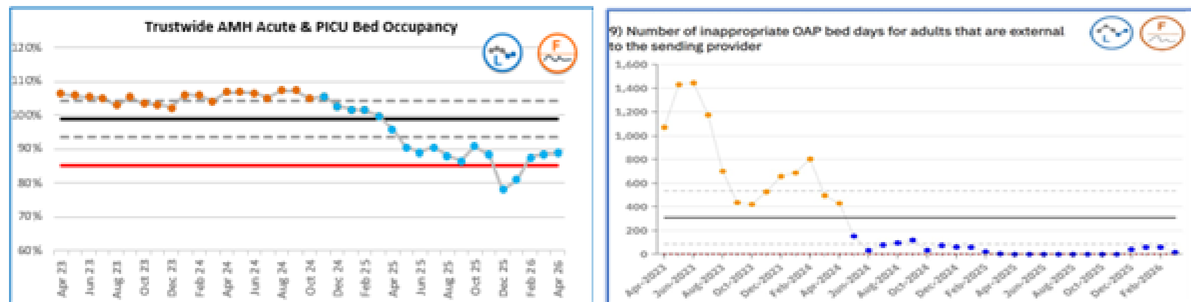
Overview

The level of assurance has been determined through a triangulated approach drawing on multiple sources of evidence, including Key Performance Indicators (KPI) relating to bed occupancy, length of stay, and independent sector bed usage, the implementation of operational oversight frameworks OPEL and RAIDR, digital system intelligence through use of OPTICA, and targeted service-level reviews in the form of Liaison Psychiatry Deep Dives and local improvement work. This has been complemented by established governance structures within the AMH (Planned and Urgent) Clinical Transformation Programmes, incorporating regular reporting through Care Group and Trust-level forums, and engagement with system partners and frontline teams. Collectively, this provides a robust and continuous assessment of delivery against BAF risks, strategic objectives relating to patient flow and safety, and statutory requirements.

Across Adult Mental Health (AMH) urgent care services, a comprehensive programme of transformation and improvement has been delivered in response to sustained and complex system pressures. Historically, significant challenges across patient flow pathways including high admission rates, limited alternatives to hospital, delays within discharge processes, and persistently elevated bed occupancy levels, resulting in system inefficiencies and periods of special cause concern. These pressures at times directly impacted access to beds, particularly for patients waiting within Acute Trust settings.

In recognition of these challenges, a coordinated and multi-faceted programme of work has been undertaken, focusing on improving flow, strengthening operational oversight, and enhancing patient experience and safety. This has resulted in a demonstrable shift in bed occupancy levels. Since April 2025, AMH Assessment and Treatment and Psychiatric Intensive Care Unit (PICU) wards have achieved sustained special cause improvement over a 13-month period. This reflects a marked improvement in throughput, underpinned by more effective processes, strengthened governance, and a clearer focus on timely admission and discharge.

A key indicator of this improvement has been the reduction in bed occupancy levels alongside a more efficient utilisation of existing capacity. Importantly, this has enabled the elimination of £2 million of independent sector bed usage, with the Trust now consistently able to accommodate patients within its own bed base. This not only represents a significant financial efficiency but also supports continuity of care and improved patient outcomes.



Further evidence of improved patient flow is demonstrated through reductions in total admitted patients and reduced patient length of stay (rolling quarter) over a 12-month period, balanced with no material change in the number of those readmitted into hospital. Collectively, these improvements highlight a more resilient and responsive urgent care system. This has been achieved through focussed improvement within crisis pathways and gatekeeping to reduce reliance upon hospital care and consistent improvements in crisis assessment standards.

Urgent Care Clinical Transformation Programme

These operational improvements are underpinned by the continued maturation of the AMH Urgent Care Clinical Transformation Programme throughout 2025/26. Whilst this work has seen accelerated development within the Durham and Tees Valley Care Group, recent changes to leadership within urgent care services at Specialty and Director level, will see improvements to the alignment and consistency of approach and future priority development. The programme has maintained a strong strategic focus on shifting care closer to home, reducing unnecessary admissions, and strengthening pathways into and out of inpatient services. Progress across A visual representation of the work completed (within Durham Tees Valley) to date along with impact seen can be found in **Appendix 1** of the report.

Key areas of focus have included:

- The development of credible alternatives to admission including improving our own crisis and liaison assessment and responses processes
- Embedding purposeful admission and discharge practices
- Strengthening day to day ownership and operational accountability of patient flow and clear escalation processes.

Central to these improvements has been the implementation of strengthened operational frameworks and digital solutions. The introduction of the OPTICA electronic bed management system in early 2025 has been transformational, providing real-time visibility of patient journeys, bed status, and discharge-related tasks. This enhanced transparency has enabled more timely and informed decision-making, reduced previously ‘hidden’ delays, and improved the overall productivity of both clinical and patient flow teams.

Complementing this, the embedding of the Operational Pressures Escalation Levels (OPEL) framework has significantly improved the Trust’s approach to managing daily operational pressures. Through revised escalation processes, clearer roles and responsibilities, and enhanced meeting structures, there is now a more proactive and coordinated response to flow challenges.

Focused improvement work within Liaison Psychiatry Services has provided further insight into patient flow challenges at the acute interface. A detailed review of 12-hour delays within Emergency Departments across Durham and Darlington identified that delays were not attributable to a lack of mental health bed availability. Instead, issues related to documentation timeliness, referral processes, and handover consistency were highlighted as contributory factors.

Parallel work within Teesside Liaison Services is underway, however, the service has also recently delivered tangible operational improvements through the introduction of 24/7 Band 7 Clinical Nurse Specialist cover, which has strengthened clinical decision-making, improved discharge planning, and reduced reliance on Crisis Services. Staff feedback indicates enhanced support and reduced out-of-hours pressures. Additional improvements include the implementation of structured shift handovers via Microsoft Teams, enabling consistent communication, better oversight of outstanding actions, and real-time visibility of patient flow risks. Enhanced collaboration with acute site teams has been supported through dedicated communication channels and physical presence on acute hospital sites has further improved responsiveness and issue resolution.

In addition to the work outlined above, we have enhanced diversionary pathways for NEAS into our CAS at Roseberry Park Hospital and further collaboration is underway between the Trust and both NEAS and YAS to identify and progress practical, jointly deliverable solutions aimed at improving outcomes and experience for individuals presenting with mental health needs via the 111 and 999 pathways.

Recognition and review

The impact of this transformation work has been recognised regionally and nationally. The Trust has routinely welcomed visitors and colleagues from across the mental health sector to share ways of working and celebrate the areas whereby the Trust is 'leading the way' within Urgent Care Improvement.

In May 2026, the organisation was invited to contribute to a Getting it Right First Time (GIRFT) webinar, following a visit by the GIRFT team to identify best practice in improving patient flow across urgent and emergency care pathways in mental health earlier in the year. This invitation reflects external validation of the progress made and positions the Trust as a contributor to the development of future clinical operational standards and used as the pilot site for testing of the 12 hour breach tool.

Areas of future focus

- Work with Acute Partners across the Trust to improve shared visibility of data and recording.
- Strengthen end-to-end pathway standardisation by addressing identified inconsistencies in documentation, referral processes, and handovers across acute interfaces to ensure timely, seamless transitions of care and reduce avoidable delays within Emergency Departments.
- Expansion of CAS model into both Lanchester Road and Foss Park Hospitals
- Embed and sustain operational discipline through continued reinforcement of the consistent application of OPEL and RAIDR frameworks across all services, ensuring proactive escalation, clear accountability, and timely system-wide responses to emerging pressures.
- Enhance data quality and utilisation through development of a digital patient flow dashboard highlighting real-time usage to support operational decision-making, identify bottlenecks earlier, and track performance against flow metrics more effectively.
- Expand alternatives to admission and conveyance with further development of credible community-based alternatives and crisis response pathways, including continued joint working with NEAS, to reduce reliance on hospital admission and routine conveyance via 111 and 999 services.
- Address residual variation across localities and services ensuring learning from Liaison Psychiatry deep dives and Teesside Liaison service improvements is consistently applied across all areas to minimise unwarranted variation and embed best practice.

- Continue to maintain targeted interventions to reduce length of stay, with particular focus on discharge planning, multi-agency coordination, and removal of downstream barriers to timely discharge and those CRFD.
- Continue to deepen engagement with system partners, ensuring shared ownership of patient flow challenges, aligned priorities, and coordinated delivery of improvement actions, enhancing system-wide collaboration.

Prior Consideration and Feedback

Patient Flow, including elements directly impacting patient flow, is discussed regularly as part of each Care Group Board's performance agenda and Boards are well sighted on areas of concern.

Implications

Patient Safety, Quality of Care and Experience – potential of compromised safety, quality and experience for those patients and carers who are waiting for an AMH acute inpatient bed, non-compliance with key indicators of Liaison (1 hour and 24 hour) and Crisis (4 hour and 24 hour) access metrics.

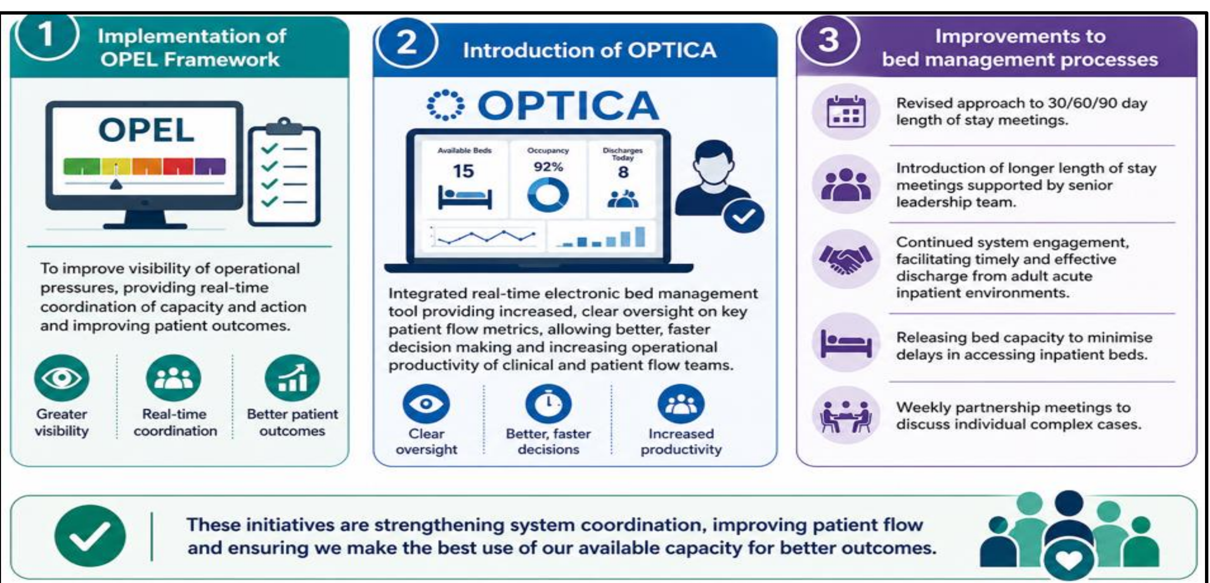
Staff Experience – Challenges associated with caring for people in inappropriate settings when a need for an inpatient bed has been identified.

Partnership/System working – due to impacts of delays upon the broader system; we are also reliant upon broader system partners to support resolution of challenges.

Recommendations

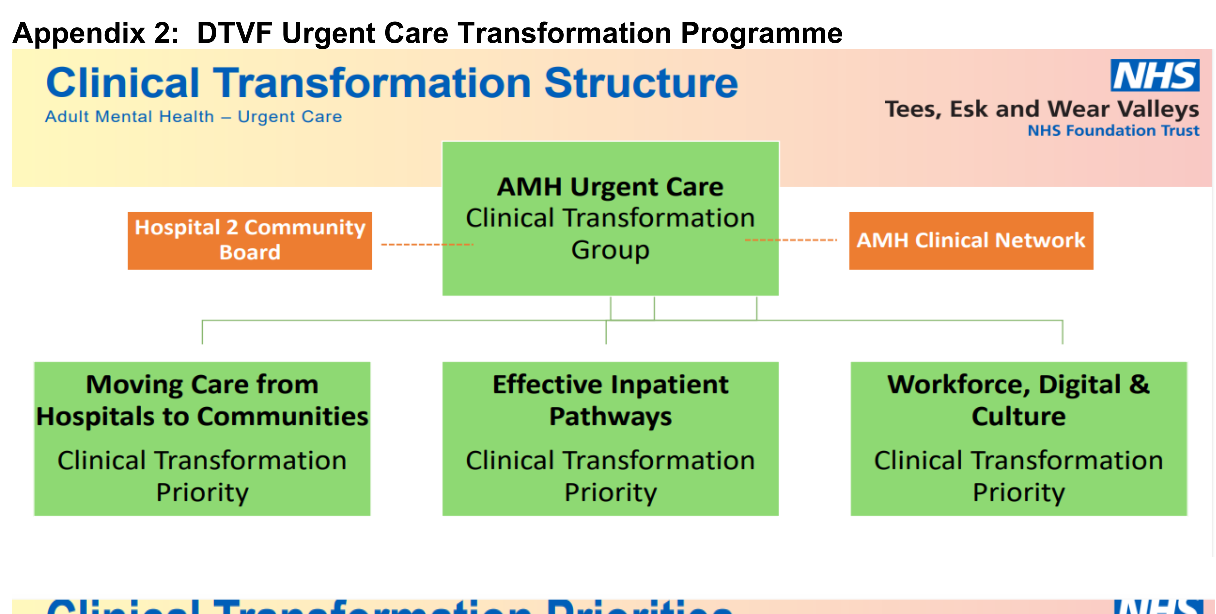
Trust Board are asked to accept the report with good assurance and to Note the progress made within urgent care pathways, in support of wider system partners, their impact on patient care and the regional and national recognition of those improvements and the influence within national best practice.

Appendix 1: Transformation work to date – DTVF Urgent Care and Planned Care



Planned Care Services – Transformation work to date

Appendix 2: DTVF Urgent Care Transformation Programme



Clinical Transformation Priorities

Adult Mental Health – Urgent Care

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

We will provide timely, effective assessment, intervention, and treatment in the least restrictive and safest setting, as close to your home community as possible. Where more restrictive care is needed, we are committed to keeping this to the shortest possible time and ensuring care remains as close to home as it can be.

Moving Care from Hospitals to Communities Clinical Transformation Priority	**Effective Inpatient Pathways** Clinical Transformation Priority	**Workforce, Digital & Culture** Clinical Transformation Priority
Working across boundaries to develop seamless and appropriate access to services across Adult Mental Health.	Having the right beds in the right place to facilitate care closer to home.	Developing and embedding a fully multidisciplinary, skilled & supported workforce across services.
Creating suitable step-up capacity to facilitate care delivery in the community.	Optimising inpatient processes	Development of dashboards and access to data, to drive and inform clinical transformation across services.
Managing the threshold for inpatient assessment and treatment.	Managing the threshold for Discharge "why not home, why not today?"	Culture of Care

Clinical Transformation Priorities

Adult Mental Health – Urgent Care

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Moving Care from Hospitals to Communities

Clinical Transformation Priority

- Working across boundaries to develop seamless and appropriate access to services across Adult Mental Health.
- Creating suitable step-up capacity to facilitate care delivery in the community.
- Managing the threshold for inpatient assessment and treatment.

Develop seamless & appropriate access to services across AMH - ***between community & crisis & community/crisis and inpatient.***

Create step-up capacity to facilitate care delivery in the community – through the development of a

- ***Safe haven model***
- ***24/7 virtual crisis cafes***
- ***18-25 transition service supporting care close to home***
- ***standardised IHT model***
- ***24/7 intermediate care for patients requiring more intense nursing/observations***
- ***Develop crisis houses with 24/7 bedded capacity as a step up for immediate care***
- ***Crash pad for complex/severe Autism***

Managing the threshold for inpatient assessment & treatment.

To **standardised Psychiatric Liaison model** across DTV to provide timely access & reduce reliance on Emergency Dept.

Develop **clarity on purpose & function of** inpatient settings

Develop **guidance** on purpose of admission and shared understanding across the system

Develop an **acute referrals centre** for pre-admission checks & appropriate admissions

Timely and consistent input from crisis to explore intermediate care ahead of MHA for patients who become difficult or risky in the community

Effective Inpatient Pathways

Clinical Transformation Priority

- Having the right beds in the right place to facilitate care closer to home.
- Optimising inpatient processes
- Managing the threshold for Discharge "why not home, why not today?"

Having the **right beds** in the **right place** to facilitate care **closer to home**. – to complete **Bed modelling** to understand baseline of bed requirement including the admissions to independent sector.

To **Future proof bed requirements** for next 3 years based on improvements and alternatives to admission provision in place

Develop an Admission ward function

To Review Adult PICU provision (single sex)

Optimising inpatient processes - review & embed **PIPA & formulation model.**

Dedicated specialist resource for patients with complex autism.
To Improve /streamline S37/41 admissions to reduce delays
To Streamline Greenlight admissions and optimise the long LOS review (30/60/90/265)

Managing the threshold for Discharge "why not home, why not today?"

Development of a standardised approach to **homelessness** (in the absence of care needs) across the system

Development of a **'Transfer of Care' hub** within each hospital with a focus on partnership working to get the best timely outcome for patients

Roll out **OPTICA** to all inpatient areas for discharge tracking.

Implement **discharge team** across inpatient services

Create dedicated **step-down capacity** in the form of a discharge to assess model linked to the needs of the community.

Create a **virtual ward** for early supported discharge.

Create a **'Same Day Urgent Care' model** for patients who are transitioning out of inpatient services.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

<table>
<tr><td colspan="2">People, Culture and Diversity Committee: Key Issues Report</td></tr>
<tr><td>Report Date: 11 June 2026</td><td>Report of: People, Culture and Diversity Committee</td></tr>
<tr><td>Date of last meeting: 6 May 2026</td><td>The meeting was quorate.</td></tr>
<tr><td>1</td><td>Agenda: The following agenda items were considered during the meeting:
• Colleague Story
• Key Issue Reports
    o Board Report - 12 January 2026 PCDC meeting
    o 'Time Out' Report – 4 March 2026 meeting
• Corporate Risk Register – Risks to PCD
• Board Assurance Framework
• Workforce Strategy Delivery Report
• Workforce Data
• Inclusive Cultures Progress Update Report
• Health and Wellbeing Update
• Freedom to Speak Up Guardian Update Report
• Partnership Agreement with Staff-side
• Annual Review of Committee Performance/Committee Evaluation
• Committee Terms of Reference
• Workplan - noted the potential changes to the dates of future meetings</td></tr>
<tr><td>2a</td><td>Alert: The Committee wishes to alert the Board on the following matters:
-</td></tr>
<tr><td>2b</td><td>Assurance: The Committee can confirm assurance on the following matters:

Corporate Risk Register – Risks to PCD
The Committee confirms good assurance in respect of the risk management processes in place, the consideration of risks for inclusion in the Corporate Risk Register and the ongoing management of these risks. The Committee notes there are 14 risks on the Corporate Risk Register, with no change in the total number from the previous period. Among these, 2 risks have had their current risk ratings reduced during March 2026, reflecting successful mitigation efforts. All risks show evidence of review, ensuring ongoing monitoring and control effectiveness. With regard to Risk 909 (Consultant Recruitment Difficulties in NYY) the score remains below 15 at a rating of 12. Further discussions to take place with a view to reducing the risk. Risk 1137 (Supervision Compliance and Assurance) remains at 15 with an extended target date to the end of August 2026. Actions are ongoing, and reasonable assurance is reported, with internal audit highlighting areas for improvement. The Committee notes that in future, Risk Register reports will be specifically Committee focussed rather than generic.

Board Assurance Framework (BAF)
The Committee confirms it has good assurance on the management of BAF risk 1 (safe staffing) as at Quarter 4, 2025/26 and agrees that the risk score should be reduced from 20 to 15 following the delivery of the key action to develop a "specific workforce plan for each clinical and corporate service". The Committee notes that in future the BAF will be presented in a new format following the transfer of all data to the 'InPhase' system. The Committee recognises that the context for the organisation has changed and that the wording of the BAF Safe Staffing risk requires altering to reflect this. This would be addressed in forthcoming reports to the Committee.

Workforce Strategy Delivery Report
The Committee confirms that ongoing work offers good assurance that the correct activities are being carried out which effectively impacts on the Performance Metrics and the progress of the BAF, with key exception to this being sickness levels across the Trust. This would be the subject of further reports. There was strong and growing assurance that workforce risks such as safe staffing, training, supply, and governance are effectively managed with improved controls and oversight. Other positive performance indicators included: average time to hire, local induction compliance, staff leaver rate,</td></tr>
</table>

mandatory and statutory training compliance (over 90% compliance), and appraisal completion rates. However, alongside sickness absence, Immediate Life Support (ILS) training also requires monitoring compliance with standards and clear actions.

The Trust demonstrates strong assurance in medical education governance, supported by high participation in national surveys and positive GMC survey outcomes validating a robust training environment. Consultant and SAS job planning targets have been met with 95% sign-off, positioning the Trust well for national expectations on service planning and workforce sustainability. Recruitment processes have improved with enhanced reporting and remain within key performance indicators despite pressures. A new approach to recruitment beyond interviews is being developed. The second MARS scheme approved 29 staff departures with notice periods extending to June 2026. The Trust manages 389 apprenticeships with good assurance and is adapting to the national changes in apprenticeship funding and mitigating risks.

The Committee acknowledges that the absence of a Workforce Strategy/Strategy Refresh report as a 'formal' successor to the People Journey Delivery Report has implications for the development of the leadership and cultural focus of a refreshed 'Safe Staffing' risk for the Board Assurance Framework. No further updates were available at the current time on the National NHS Leadership Programme or the regulation of managers.

Workforce Data
The Committee notes the overall workforce position as at March 2026 and takes reasonable assurance on the monitoring of the Trust's workforce data. The Trust's workforce headcount is 8,290 with 7,478.96 WTE, a reduction due to fewer starters and the MARS scheme. Recruitment KPIs for 'Time to Hire' are met consistently, though pre-employment checks need improvement. Internal transfers continue to aid workforce mobility. Disciplinary cases numbered 30 from December 2025 to February 2026, with low grievance activity. The Committee notes that whilst the Trust was benchmarking 'high' for disciplinaries, recent benchmarking information indicated that the Trust was not an outlier in respect of Tribunals. Freedom to Speak Up cases total 52 since November 2025, showing strong engagement. The Committee notes that the Trust would be hosting a Regional Reasonable Adjustments Team in the future.

Inclusive Cultures Update Report
The Committee confirms good assurance of the link between the indicators and the interventions, and the data provided, but only reasonable assurance that the impact is as expected. Staff participation in leadership initiatives remains strong, with improvements noted in leadership development and staff mood, though achieving management consistency remains as a concern. Accordingly, the Trust is implementing a Management and Leadership Framework, ongoing leadership programs, and team development modules to address this and promote good practice.

Staff survey data shows improvements in experiences of ethnic minority staff and those with disabilities, with reductions in harassment and bullying and increased confidence in reporting. Despite progress, disparities persist for staff with long-term health conditions and ethnic minorities regarding career progression, discrimination, and feeling valued, requiring targeted interventions. Accordingly, the Trust is undertaking surveys, developing action plans, analysing workforce data, and has committed to regional anti-racism pledges and policy reviews to address discrimination and increase support for affected staff, for example, the Reasonable Adjustments Team facilitates access to funding and promotes inclusivity. The Committee notes the good oversight of the Anti-Racist Steering Group and the positive work with Cleveland Police in relation to reporting processes and restorative practices.

While appraisal completion rates are high, audits reveal inconsistent appraisal quality, documentation, and alignment with staff development needs. This is being addressed through workshops, additional guidance, and integration of information into management training to improve appraisal quality and staff experience.

Health and Wellbeing Update
The Committee confirms reasonable assurance acknowledging that assurance varies across the themes. There is good assurance for the impact of health and well-being staff support services and an

overall score of 'improving' for staff health and safety as there is a good understanding of staff sickness absence and several related interventions are in place or due to be piloted. Reasonable assurance is proposed in respect of work concerning violence and aggression, impact of burnout, and health and safety climate.

Staff survey results show a steady improvement in the overall health and safety climate score, now slightly above the NHS similar organisation average, though burnout and health and safety climate remain areas of concern. A new dashboard and audit of sexual safety incidents provide oversight of violence and aggression towards staff, with training compliance near targets and plans for an operational group to oversee actions. Gaps include incomplete understanding of incident prevalence and outcomes, and inconsistent responses. Both short and long-term sickness absence rates have decreased since January 2026, with detailed reporting and completed actions such as policy reviews and planned coaching training for managers to support absence management. The Employee Psychology Service shows effectiveness while the Employee Support Service maintains stable referral levels and positive user feedback. The Mindfulness programme courses report positive feedback and referrals to the regional Wellbeing Hub are increasing, though outcome effectiveness data is lacking at the current time. The Committee notes that the Staff Experience Group have identified flexible working as a priority area for further consideration.

Freedom to Speak Up (FTSU) Guardian Update Report
The Committee takes substantial assurance in respect of the implementation and impact of the FTSU service. Since mid-November, the FTSU Guardian Service has engaged with approximately 2,000 staff members, maintaining and even increasing contact levels, particularly in previously underrepresented areas. Visits to services by the FTSU Guardian are well targeted based on emerging concerns and intelligence, supported by robust oversight including monthly updates and immediate escalation of urgent issues to relevant Directors. The Committee notes that the FTSU Guardian has been attending Leadership events and suggests that a formal workplan could be developed to build on this approach. The strengthening and expanded reach of the FTSU service contributes positively to service safety and cultural change within the Trust, supporting the Committee's responsibilities. The Committee notes that NHS England (NHSE) plan to close the National Guardian office and the future reporting lines will be direct to NHSE. As a contracted service, the Trust's Guardian will continue to receive support from the organisation's national team.

2c **Advise: The Committee would like to advise the Board on the following matters:**

Colleague Story
A member of staff who is the parent of a 16 year-old trans son provided a presentation to the meeting, with the consent of her son, to share her reflections on her experience whilst working as a Psychologist in the NHS. Her aims were to influence training provision, highlight the lack of local services to meet her son's needs and to draw attention to the issues in relation to the quality of Trust services. In 2021 he had presented with increased anxiety and became withdrawn, developing patterns of excessive exercise and eating difficulties. In 2022, he began receiving support from CAMHS Eating Disorder Service and CAMHS. In February 2023, he started transitioning from female to male, changing his name in June 2023. Whilst on the waiting list for the Gender Identity Service, he had periods of suicidal ideation and required considerable emotional support. Local CAMHS services were responsive, helpful and kind but did not provide the specialist Trans focused support which was needed for the family. Whilst the CAMHS support focused on the anxiety, low mood or eating difficulties there was a clear message that being Trans could not be a focus of the work. Whilst the family was not in the catchment for Hart Gables, they had some contact with the charity, although the offer of a peer support group did not meet the need for specialist support. The Rainbow Staff Network, Trans Reference Group and Abigail Holder, Inclusive Community Engagement Lead have provided support and a point of contact for the member of staff and this has been valuable. The Committee notes the challenges in respect of accessing appropriate services and the gaps in care. It suggests that the presentation be considered by the Quality Assurance Committee.

'Time Out' Report – 4 March 2026 meeting
The Committee notes the report from the 'Time Out' highlighting key workforce, culture and organisational development issues. Staff Survey results show improvement in overall engagement, with response rates increasing from 44% to 52% and the Trust identified as the second most improved Mental Health/Learning Disability Trust, alongside above national average access to

	supervision and improved scores for advocacy, work–life balance and morale; however, areas of concern remain, including experiences of racial discrimination, support for staff with long-term conditions, access to reasonable adjustments, and a lack of improvement in violence at work and post-incident feedback. A 'Deep Dive' is planned into violence and aggression reporting to assess potential underreporting. The Committee notes that a Trust-wide three-year workforce plan is in development, focused on reducing agency and bank usage, supporting new staffing models aligned to clinical transformation to enable the hospital to community shift and the delivery of evidence-based care, and embedding a service-led approach to workforce planning, supported by training and lived experience input. There is also a need for further consideration to be given to future changes to corporate roles and the requirement for additional commissioning/contract management expertise/skills. The Committee also notes the position regarding the transformation of People Services through a national programme, including development of a digital-first Target Operating Model with automated processes and 24/7 access, alongside regional 'Scaling Up' workforce initiatives. The Committee highlights the need to consider organisational culture more broadly within the Board Assurance Framework, strengthen triangulation of workforce and quality risks, and confirms actions including further analysis of workforce challenges and to hold future 'Time Out' sessions on a face-to-face basis **Partnership Agreement with Staff-side** The Committee notes that the Partnership Agreement is under review at the current time. This sets out the framework for effective joint working, consultation and information sharing between the Trust and Staff-side, with the aim of supporting positive employee relations, meaningful staff involvement and constructive engagement on matters affecting the workforce and service delivery. It establishes shared principles of openness, early consultation and mutual respect, and defines the respective roles of the Trust, managers and staff-side representatives, alongside the operation of Joint Consultative Committee (JCC) and Local Consultative Committee (LCC) arrangements. As part of the current review, a number of practical and governance-related areas have been identified for discussion with staff-side. The outcome of these discussions will inform any proposed amendments, which will be considered through partnership governance arrangements, in line with the agreement. **Annual Review of Committee Performance/Committee Evaluation** The Committee notes that the frequency of meetings is likely to change in future, perhaps with the introduction of shorter meetings which have a more themed approach. Some concerns were expressed in respect of the limited attendance from some members which was to be discussed with the Chief Executive out with the meeting, along with clarification in respect of links with other Committees. **Committee Terms of Reference** The Committee approves a minor change of wording to the Terms of Reference and notes that decisions in respect of membership are within the remit of the Board of Directors.	
2d	**Risks**	• No new risks • Potential risk to 'Well-led' from the lack of a successor 'People Journey' strategy

Recommendation: The Board is asked to note the contents of the report.

3	**Any Items to be escalated to another Board Sub-Committee/Board of Directors**	• BAF risk 1 (safe staffing) risk reduction (score reduced from 20 to 15) at Quarter 4, 2025/26 following the delivery of the key action to develop a specific workforce plan for each clinical and corporate service • Sickness Absence levels, not reducing as expected • Attendance of members at meetings • Colleague Story as a potential Quality item for Quality Assurance Committee
4	**Report compiled by:** Deborah Miller, Corporate Governance Manager, Roberta Barker, Non-Executive Director (Committee Chair), Sarah Dexter-Smith, Executive Director of People and Culture	

DM/28/05/2026

For General Release

Meeting of:	Trust Board
Date:	11 June 2026
Title:	Report of the Freedom to Speak up Service
Executive Sponsor(s):	Sarah Dexter-Smith, Executive Director of People and Culture
Author(s):	Sarah Dexter-Smith and Adam Howe (Freedom to Speak Up Guardian)

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	x
2: To be a great employer	x
3: To be a trusted partner	x

Relevant BAF risk/s (name and number)	***Relevant control***
All risks relating to patient safety, quality of care and staffing	Having a strong and independent Freedom to Speak Up Guardian (FTSUG) is a fundamental requirement of NHS provision and ensure that there is a safe route for colleagues to raise concerns about patient and staff safety even when they do not feel safe to raise this within their local service.

Executive Summary

Purpose

This paper is presented to board to provide an update on the relatively new FTSU service provided by The Guardian Service, including assurance on process, reach and uptake across the trust.

Proposal

Board is invited to take substantial assurance from the new service that is in place.

Overview

The new independent Guardian service began in mid-November 2025. The FTSUG Adam Howe meets regularly with the Executive Director of People and Culture, the CEO and Chair. And when the contract began, he met with key service leads and those corporate teams (eg Organisational development, people partners, employee support) who colleagues turn to at times of distress, or who are key to staff engagement (eg communications).

The Guardian has used the time to not only respond to concerns that he receives but has put considerable time into visiting services across the Trust footprint and meeting staff. The reach of the FTSUG is impressive with approximately 2000 staff meeting the new FTSUG since mid-November. He has also joined numerous staff events, attended meetings, and been part of our informal Speak Up Group. During these visits the Guardian distributes

promotional material to all staff. Further promotional briefings happen with teams, networks and services happening both in person and virtually across many trust directorates.

Communications are regularly provided to colleagues in addition to the Guardian's personal visits. Posters are up around sites (an initial glitch on one main site is resolved) and the communications team have ensured that the new service has been prominent on splash screens, bulletins, and the staff facebook page).

Feedback indicates that staff contact the Guardian following promotional activity, recommendations from colleagues, and briefings delivered by the Guardian, accounting for the route for the majority of concerns raised. Early in the new service, this was done via internal communications or seeing the new promotional posters around their locations of work.

Visits that the FTSUG makes to services are well aligned with concerns that are arising within services e.g. those highlighted in the Speak Up group as early indicators of challenges developing. In addition, he has the freedom to visit those areas that he has his own intelligence about and would like to visit.

Oversight

Oversight processes are strong. Monthly meetings with the Executive Director of People and Culture are held to talk through monthly reports which include themes, outcomes of cases and delays in resolving concerns. No individual can be identified through these meetings and reports therefore this always maintains staff members' confidentiality.

The Freedom to Speak Up Guardian attends monthly speak up meetings with others from the trust to triangulate data and ensure services/teams/wards within the trust have the support they need and are aware of the guardian should they need to speak up.

Quarterly meetings are held with the CEO, Chair and Non-Executive Director to discuss emerging themes and learning points.

The following timescales have been agreed and form part of the Service Level Agreement and the Guardian reports these are working well. Any deviation from this is escalated to the relevant executive but this has been minimal.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours

Impact

As a result of this work from the Guardian and others, contact with the FTSU service has not dipped as is often the case when a new FTSU service begins and has in fact increased in areas that we have previously struggled to hear from. Details of services represented in contact to the service are outlined in the Appendix. The only area of note that we are keeping an eye on is adult services in NYY which is featuring at a higher rate than is proportional to the service size.

There has been no reported detriment in this period. If any cases of detriment are raised there is an established process through the deputy director of People and Culture and the NED champion to investigate and bring to a resolution.

Themes and Trends

People, Culture and Diversity Committee have received a detailed report on the first 6 months of the service (17th November 2025 to 31 March 2026).

During the reporting period, 68 concerns were raised, demonstrating strong early engagement with the service and growing staff confidence in speaking up. Of these, 35 cases have been closed, with the remainder ongoing and subject to continued support.

A notable feature of the reporting period is the high level of confidentiality requested by staff. Half of all concerns (50%) remain confidential within the Guardian Service, with a further 32.5% escalated without staff names being shared with the Trust. Their trust in the process has increased because of the role of the Guardian being independent to the organisation. This can be evidenced from the feedback and conversations mentioned to the Guardian when highlighting this independence. The Guardian and the Executive Director of People and Culture have this as a standing item to track in their monthly meetings.

The most common themes raised relate to system and process issues (34%; note this relates to all systems and processes eg trust policies and processes, recruitment processes, service structures, bandings and responsibilities), management issues (19%), and behavioural, relationship, bullying and harassment concerns (22% combined).

Patient safety and worker safety concerns continue to feature and are escalated in line with agreed timescales where appropriate. An example of these concerns are around staffing levels, sickness and injuries being a contributing factor. 20% of concerns raised have either patient safety or staff safety as the primary theme.

Issues relating to policies and the way they are implemented by their manager/management team are often brought to the Freedom to Speak Up Guardian. A significant proportion of concerns raised relate to systems and processes, particularly in relation to organisational change, recruitment, restructuring, and the application of policies. Concerns relating to management behaviour and practice highlight variability in staff experience across teams and services.

This aligns with the data in the national Staff Survey and the focus on the people skills management programme that has been implemented. The independent status of the Guardian, in clarifying points that staff may not comprehend, understand or want to raise internally, in many instances satisfied the staff member who was raising the concern and prevented an escalation.

Overall, the findings suggest that the introduction of an independent Freedom to Speak Up service has increased access, trust and engagement.

Prior Consideration and Feedback

The FTSUG regularly engages with groups across the trust and previous reports have been provided to the Executive Directors Group, as well as more informal meetings with staff networks, teams, and leadership groups to triangulate the themes and areas of concern.

Implications

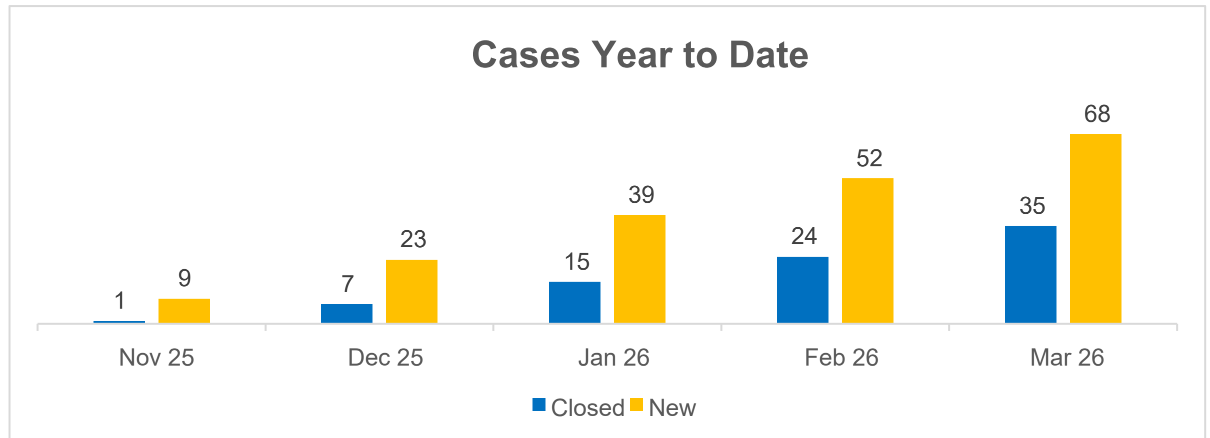
The strengthening of the FTSU service and the increased reach/ uptake of the service from all parts of the Trust is a positive contribution to the safety of services and the cultural

change that People Culture and Diversity committee is tasked with overseeing on behalf of the Board.

Recommendations

That board take substantial assurance from the report this paper on the implementation and impact of the FTSU service.

Appendix: Further detailed information from the Guardian's report



The chart presents cumulative year-to-date figures rather than individual monthly totals. The data shows a steady increase in both new cases received and cases closed since The Guardian Service began in mid November 2025, reaching a cumulative total of 68 new cases and 35 closed cases by the end of March 2026.

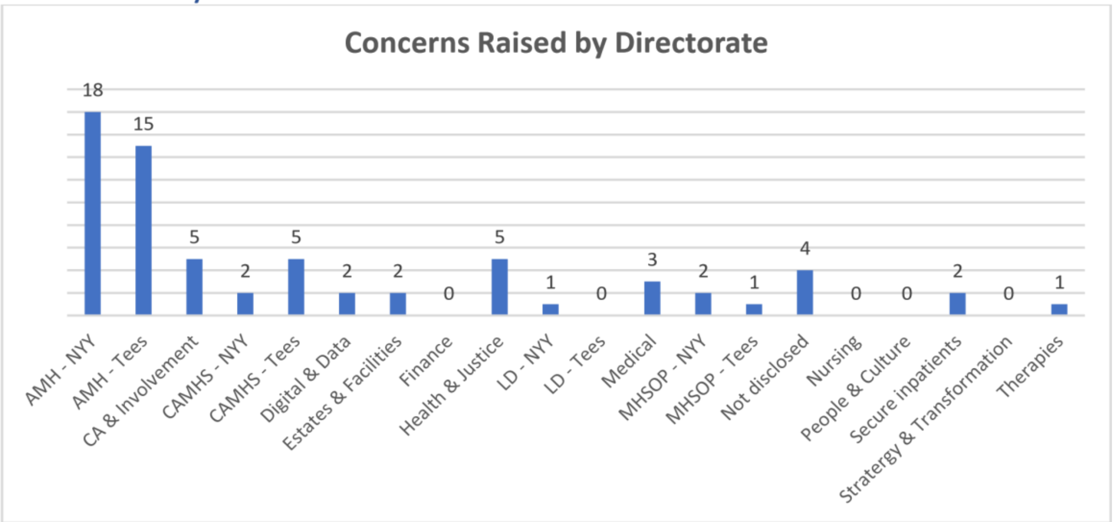
While progress in closing cases is evident, it is expected that closures will trail new cases, as some matters require sustained support for staff over a number of months before they can be appropriately and safely concluded. This reflects the nature of the work, which prioritises thorough, person-centred resolution.

All concerns raised have a primary theme.
The primary themes are broken down into the following categories;

Theme	Total	Percentage
A Patient and Service User Safety / Quality	9	13%
B Management Issue	13	19%
C System Process	23	34%
D Bullying and Harassment	7	10%
E Discrimination / Inequality	3	4%
F Behavioural / Relationship	8	12%
G Other (Describe)	0	0%
H Worker Safety	5	7%
I Sexual Misconduct	0	0%
Total	**68**	

11. Statistical Graphs

Concerns raised by Directorate



<u>Feedback</u>

When a concern is closed, the staff member raising the concern receives a voluntary Guardian Service feedback form. Five members of staff completed the survey, which is 14% of those it was sent to. The following are some of the comments received from this feedback form and emails received directly to the Guardian:

- *"Thank you for all your support. You have been very understanding and you have given me more updates than I expected so all is positive there."*
- *"Thank you for your support, I am pleased I now have someone I can make contact with if the situation arises again. Many thanks for your time and knowledge."*
- *"Thank you for your assistance earlier in the year it was good to feel that there was support if needed"*
- *"If I need to speak up again then I will, as I had a really positive experience using my speak up guardian. He was amazing and helped me so much just to feel heard and to have my feeling feel validated."*
- *"The initial appointment was arranged very quickly, The Guardian Service representative sat very patiently for over two hours listening to the historic events that had been escalating for over one year and asked appropriate questions to ensure they had a full understanding of the case which was resolved very quickly after the initial meeting."*
- *"I would definitely use again, the whole process was quick and communication was excellent."*
- *"Based on my experience, I have recommended the Guardian Service Representative by name and provided their contact details to the other colleagues."*

Agenda Item 14

<table>
<tr><td colspan="3">Committee Key Issues Report</td></tr>
<tr><td colspan="3">Report Date to Board of Directors – 11 June 2026</td></tr>
<tr><td colspan="2" rowspan="2">Date of last meeting:
02 April 2026</td><td>Report from the Quality Assurance Committee (quoracy met)</td></tr>
<tr><td>A verbal update was given at the April 2026 Board of Directors meeting.</td></tr>
<tr><td>1</td><td colspan="2">Agenda - The Committee considered the following matters:
• Minutes of meeting held on 05 March 2026
• Board Assurance Framework
• Corporate Risk Register
• Summary of Executive Directors Group Quality and Performance meeting, 24 March 2026
• Quality Governance Triple A Report including: CQC Activity and Integrated Oversight Plan, Quality Assurance and NICE, Quality Dashboard and Quality Risks Programme
• Annual Quality Account Timeline
• Safter staffing, focus on risks and level loading of leave
• Clinical Outcomes
• Sexual Safety, Annual Statement of compliance/mixed sex accommodation breaches
• Patient and Carer Race Equality Framework and Publication of Information
• Quality monitoring of Services that are Sub-Contracted
• Quality Impact of Teams in Recovery
• Bankfields Court escalated risk report
• Safety planning for Section 17 leave – compliance report
• Outcome of Committee Developmental session, 02 February 2026.</td></tr>
<tr><td>2a</td><td>Alert</td><td>Matters of alert (areas requiring escalation or heightened awareness)

Services Requiring Additional Support (SRAS): Some services have exited SRAS with others entering. Overall pressure and variable stability continue with implications for safe staffing, quality, and patient experience.

Harrogate & Ripon: Returned to SRAS due to specific complex local circumstances (ongoing challenges rather than new issues).

Entered SRAS: HMP Full Sutton, HMP Deerbolt, AMH Ripon/Harrogate Community Mental Health Team, NYY Perinatal Mental Health Services, NYY All Age Crisis Line, NYY CAMHS Crisis, NYY CAMHS Scarborough, Whitby and Ryedale ADHD Team, SIS Ivy/Clover, ALD Bankfield's court, DTVF CAMHS Single Point of Contact Durham, Getting More Help South Durham, DTVF CAMHS Crisis and DTVF AMH Planned Care Darlington CMHT.

Exited SRAS: MHSOP R&C CMHT on 20 February 2026.

Bankfields Court: One person admitted who is very distressed leading to Increased incidents including a RIDDOR-reportable incident; staff support in place and a comprehensive care plan is in place.
Regulation 28 (Prevention of Future Deaths): Issued regarding communication with carers and planning leave from hospital, with a formal response sent on 5 April 2026.The Coroner did recognise progress had been made
Planned care in Durham: Raw data indicates a potential increase in unexpected deaths in the community; A thematic review is underway.
Restrictive Interventions (RIs): The increase in mechanical restraint was noted and understood as a Ministry of Justice requirement.   After many months of sustained</td></tr>
</table>

		improvement in prone restraint there has been an increase in prone related restraint to two patients. This is not in line with our standards and is being closely considered.
2b	**Assurance**	**Matters of assurance (Positive Assurance and areas of strength)** **Annual Quality Account timeline (2025/26):** Committee received the proposed consultation, internal review/approval and publication timetable for the Quality Account 2025/26, noted the Quality Governance Team had drafted the outline (including mandated statements and progress against Quality Priorities), and approved the timeline, taking good assurance that the processes for consultation, review/approval and publication are in place. **Corporate Risk Register governance:** Good assurance on the risk management processes in place and management of risks on the Corporate Risk Register (despite tolerance of some significant risks). Risk review compliance is at 93% with one overdue corporate risk. (risk 1137, supervision compliance/assurance). The restated inpatient ligature risk (risk 811) may need further review due to discussed risk of plastic bags in inpatient areas. **Executive Directors' Group (Performance & Quality):** Good assurance on monitoring and oversight on performance and quality; reasonable assurance on the impact of improvement actions in some services. **Quality Governance Reports / Dashboard:** Overall substantial assurance — 30 measures (85.71%) showing good/substantial assurance. **CQC Activity & Integrated Oversight Plan:** Good assurance on systems and processes for oversight, monitoring and progress with one overdue improvement action: embedding harm minimisation policy. **NICE / Clinical Effectiveness oversight:** Good assurance; no new gaps in assurance or new mitigating actions escalated. **Safe staffing / e-rostering:** Good assurance linked to continued improvements in oversight of staffing and e-rostering metrics with some continued high agency usage in HMP noted for follow-up. **Clinical Outcomes:** Reasonable assurance that actions to improve outcome measures, reporting, and impact monitoring are progressing. **Sexual Safety (Mixed Sex Accommodation compliance):** Good assurance regarding MSA position and robust monitoring/review processes; reasonable assurance overall because the Trust is not yet fully compliant with the ambition for single sex accommodation across all sites. **PCREF publication/data:** Good assurance that robust processes were followed to produce/analyse the required PCREF data, and publication was approved. **SRAS oversight:** Good assurance regarding Care Group Board oversight and governance processes for SRAS (but limited assurance noted for overall quality of care/patient experience in SRAS services as referred to in alerts).
	Advise	**Matters of Advice (Points for Consideration or Ongoing Development)** **Celebratory / good news items:** Many good news stories and celebratory matters were noted. The recommendations following the Committee developmental session held in February 2026 were considered and approved. The workplan for 2026/27 will be driven by the strategic risks of the organisation, a rag rated workplan will allow at a glance, review of increasing/decreasing levels of assurance and agendas will be revised and framed around key themes - access and demand, outcomes, patient experience and health inequalities. Other improvements will include reducing the in-meeting paper volume

		(move to a smaller pack + library) with shorter reports to focus on drawing out key risks and assurance.
2d	**Review of Risks**	Overall, the Committee is 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 the meeting. • However, the following items are highlighted for awareness, not escalation: • **Bankfields Court** (adult learning disabilities), ongoing service pressures driven by highly distressed patient, sustained restrictive interventions, staff injuries/sickness and a RIDDOR-reportable incident. • **Section 17 leave / Time Away from the Ward:** • **Regulation 28 Prevention of Future Deaths** issues about communication with carers/families and leave processes/policy expectations (with oversight and policy renewal actions underway). • **Services Requiring Additional Support (SRAS):** Continued system pressure with services moving in/out of SRAS and limited assurance regarding overall quality of care and patient experience, despite good governance oversight.
4	**Report compiled by**	Bev Reilly, Chair of the Committee, Deputy Chair of Trust/Beverley Murphy, Chief Nurse/Donna Keeping, Corporate Governance Manager

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For General Release

Meeting of:	Board of Directors
Date:	11th June 2026
Title:	Learning from Deaths
Executive Sponsor(s):	Kedar Kale, Executive Medical Director
Author(s):	Amy Taylor, Head of Patient Safety

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

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

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

Relevant BAF risk/s (name and number)	***Relevant control***
8 Quality Governance **10 Regulatory Compliance**	The national guidance on learning from deaths requires each Trust to collect and publish specific information. Quarterly reports are presented to Executive Directors Group, the Quality Assurance Committee and Board of Directors detailing relevant data and learning in relation to deaths that have occurred during the reporting period.

Executive Summary

Purpose

The national guidance on learning from deaths requires each Trust to collect and publish specific information. This report covers the period from January to April 2026 (Quarter 4). The Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

All NHS Trusts must publish a dashboard (appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy and have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) are detailed in appendix 2.

Proposal

We would like to propose a **good level of assurance** for reporting and learning in line with national guidance.

The ongoing incident management improvement programme supported by the QI team is now being extended to cover the Trusts mortality review process, including how learning is identified and shared. The first mapping workshop is planned for July 2026, to identify opportunities to improve quality, consistency and learning. The Executive Medical Director has met with their counterpart from Sheffield and a proposal for joint working to develop the Mortality dashboard is being considered. The Executive Medical Director has also been in touch with their counterpart in SWYFT and they have shared their learning from deaths report, which will also be considered as part of the overall process review.

Overview

In line with National Guidance, the Learning from Deaths Dashboard at appendix 1 details quarter four (Q4) information for the Trust and includes 2024/25 data for comparison.

- During Q4, 408 deaths were reported on Inphase of patients who had been in contact with our services in the 6 months preceding the date of death. Of these, 327 patients were still open to a Trust service at the time of their death, of which 9 patients were open to an Adult Learning Disability service. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were open to the Trust's caseload which is largely community and includes older people and memory services (>60,000).
- 2 inpatient deaths were reported. Both deaths were expected physical health and occurred in Mental Health Services for Older People (MHSOP) wards and have been subject to Part 1 reviews.
- There were 0 unexpected deaths reported on StEIS during the reporting period.
- 21 Part 2 Structured Judgement Reviews (SJRs) were requested.
- 64 Part 1 reviews were completed and 13 SJRs were reviewed at a Mortality Panel.
- 2 Patient Safety Incident Investigations for unexpected deaths were completed.
- 17 patient deaths were reported to LeDER during quarter 4. 14 of the 17 patient deaths occurred in quarter 4 and 3 in quarter 3. All deaths of people with either a learning disability or a diagnosis of autism require reporting to LeDER in line with national requirements over the reporting period. Deaths are reported to LeDER via the clinical teams and the Patient Safety Team have added a prompt to all After Action Review and Mortality Review documents. It has also been built into the InPhase reporting system since 30th October 2023. Any discrepancies in reporting are being followed up by the Patient Safety team. Reasons given for not reporting have been identified as deaths occurring in the Acute Trust or a Care home and it is assumed by the TEWV clinical team that the team providing 24-hour care has submitted the referral. Teams are being asked to confirm this with those providers.

Appendix 3 sets out in detail the specific areas of learning, Trust themes, progress within the Quality Assurance programme and structures to support and embed learning from incident investigations.

6 Patient Safety Briefings were circulated Trust wide during this reporting period:

- 1 in relation to physical health recording in CITO
- 1 related to printed EPMA prescriptions
- 1 in relation to environmental risks (potential ligature anchor points)
- 1 related to national medicines recall
- 2 related to equipment/devices (suction devices and braking mechanisms on empressa profiling bed frames)

Prior Consideration and Feedback
Updates and assurance aligned to improvement work relating to learning from deaths is reported to the Quality Assurance Committee. This includes regular updates on the Quality Assurance schedule (providing assurance of compliance against key patient safety policies such as leave, clinical record keeping, risk assessment and management, observation and engagement) as well as updates on key areas that sit within our Quality and Clinical journeys that relate to themes from patient safety incidents such as progress following implementation of the patient safety incident response framework (PSIRF). Themes of learning are reported into the Trust wide Organisational learning group to support organisation wide learning.

Implications
There is a risk that the data published is utilised or interpreted without context as there is no current national benchmarking or methodology within mental health and learning disability services for mortality data.

There are financial and reputational implications associated with poor standards of care. A focus on learning helps the Trust to improve the quality and safety of our care services.

Recommendations
The Board of Directors is requested to note the content of this report, the dashboard and the learning points as **good assurance** of reporting and learning in line with national guidance and consider any additional actions to be taken.

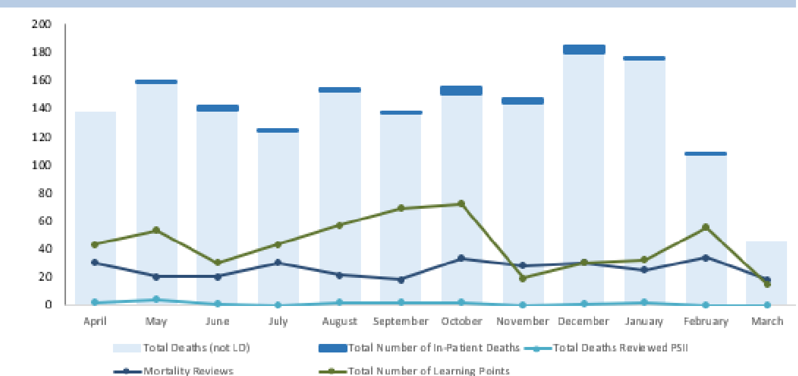
Appendix 1: Learning from Deaths Dashboard Q4 2025/26

Learning from Deaths Dashboard - Data Taken from Cito
Reporting Period - Q4 2025-26

Summary of total number of deaths and total number of cases reviewed under the Patient Safety Incident Response Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

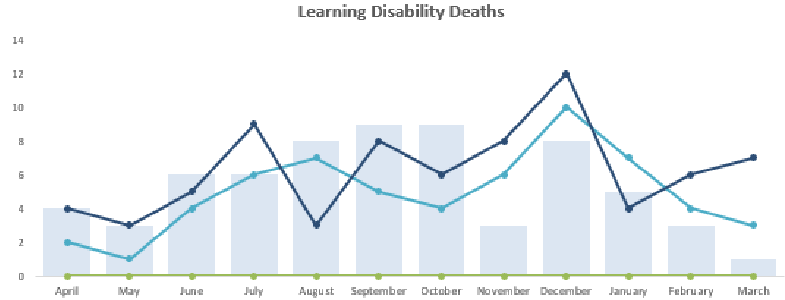
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed PSII		Mortality Reviews		Total Number of Learning Points	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2024/25	2024/25
Q1	434	↘ 453	4	↘ 5	7	↘ 32	70	↗ 52	126	↗ 123
Q2	412	↘ 445	4	↘ 7	4	↘ 28	69	↗ 55	169	↗ 125
Q3	473	↘ 484	14	↗ 8	3	↘ 14	91	↗ 43	121	↗ 75
Q4	327	↘ 476	2	↘ 6	2	↘ 5	77	↗ 62	102	↗ 43
YTD	1646	↘ 1858	24	↘ 26	16	↘ 79	307	↗ 212	518	↗ 366



Summary of total number of Learning Disability deaths and total number of cases reviewed under the Patient Safety Incident Response Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25
Q1	13	↘ 25	0	↘ 1	7	↗ 6	12	↗ 9
Q2	23	↗ 20	0	⇔ 0	18	↗ 9	20	↗ 14
Q3	20	↘ 26	0	⇔ 0	20	↗ 13	26	↗ 20
Q4	9	↘ 27	0	⇔ 0	14	↘ 40	17	↘ 24
YTD	65	↘ 98	0	↘ 1	59	↘ 68	75	↗ 67



Appendix 2

Mortality Reviews 2025/2026

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatrist and peer organisations across the region.
The mortality review tool used consists of a Part 1 and Part 2 review.
Part 1 is a review of the care records, if any red flags or concerns are noted a Part 2 (Structured Judgement Review) will be considered and completed if required.

The “red flags” to be considered during the Part 1 review are as follows:

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Random Selection
- Specific area of interest to the Trust (e.g., Clozapine)

This criterion allows for greater learning from a more suitable selection of cases reviewed. To prioritise the most significant cases for learning from unexpected and expected physical health deaths, the following actions have been taken for those deaths reported via Inphase.

- All in-patient deaths, not subject to a Patient Safety Incident Investigation (PSII) have either had a Part 1 completed or are in the process of having one completed.
- All LD deaths of those open to TEWV have either been reviewed or are being reviewed under Part 1 of the mortality review process. Where any concerns are identified, a Structured Judgement Review has been or will be requested. All these cases are to be reported to LeDER for review. The LeDER referral will not necessarily be completed by TEWV if the individual is receiving their main care from another provider.
- All community deaths for patients aged 64 and under have been or are being reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested.
- 20% of community deaths for patients aged between 65 and 74 have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.
- 10% of community deaths for patients aged 75 onwards have been reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review has been requested. This 10% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2025/2026

13 Structured Judgement Reviews (SJRs) were discussed and reviewed by the Mortality Review Panel during Q4.

A number of actionable learning points identified remain the same as previous quarter under the theme of Clinical Effectiveness/Personalised Care; although this remains the same theme, the panel discussed the progression on an organisational level on specifics being put in place to address the reoccurring dual diagnosis learning points.

Learning from actions/assurance

- Findings from SJRs are fed back to the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel. These are fed into the re-established Organisational Learning Group for future quarters.
- Where the learning identified is related to the work of a specific professional group, for example Pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trust-wide.
- Learning for individuals is shared with operational teams where appropriate and addressed via supervision and local governance processes.

Learning from mortality reviews often demonstrate similar themes identified during After Action Reviews (AARs) or Patient Safety Incident Investigations (PSIIs). The themes from mortality reviews are triangulated with learning from AARs/PSIIs to establish any new themes occurring.

1.2 Learning from deaths and patient safety incidents

Within Quarter 4 there were a total of 102 learning points identified through Patient Safety Incident Investigations, After Action Reviews and Mortality Reviews following patient deaths. The most frequent actionable learning Trust theme identified related to Record Keeping/Care Documents. Specifically, with regards to Care Planning/ CPA/ Interventions Plans with learning focused on risk information being documented in case notes but not in safety summary/safety plans.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Fundamental Standards meetings where wider learning and good practice can be shared to facilitate improvements Trust-wide.

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Any significant issues identified by the OLG are escalated to the Executive Directors Group – Quality and Performance for further discussion

and or actions. The OLG now has a 12-month workplan based on the recurring themes identified.

Regular clinical webinars are facilitated to share learning from the Organisational Group and/or lunch and learn sessions are undertaken to encourage collaboration and share valuable insights across our clinical communities. Examples of lunch and learn sessions have included financial wellbeing and celebrating LGBTQ+ History Month.

1.3.3 Patient Safety Incident Management/Investigation

The Trust has a continued focus on improving the quality of incident reporting, investigation, and identification of key actionable learning. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF).

1.3.4 The Environmental Risk Group

This group receives information where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is distributed Trust-wide via Patient Safety Briefings. The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures.

1.3.5 Recruitment and Retention/staffing establishment reviews

When looking at patient safety incidents through a systems and human factors lens, it can be seen that workforce pressures and capacity including community caseloads can impact on the quality of care delivered. Significant work is being undertaken to ensure that we have a suitably skilled and resourced workforce who can carry out their duties in a safe and compassionate way. Further details can be seen within the safe staffing and establishment review papers.

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<table>
<tr><td colspan="3">Mental Health Legislation Committee (MHLC): Key Issues Report to the Board of Directors</td></tr>
<tr><td colspan="2">Report Date:</td><td>11 June 2026</td></tr>
<tr><td colspan="2">Date of last meeting:</td><td>6 May 2026 – Committee was quorate</td></tr>
<tr><td>1</td><td colspan="2">Agenda: The Committee considered the following agenda items during the meeting
• Mental Health Legislation Combined Assurance Report, including Mental Health Capacity Act/DoLS
• Multi-Agency and Internal Mental Health Legislation Operational Group Update (DTVF)
• Multi-Agency and Internal Mental Health Legislation Operational Group Update (NYY)
• Data publication – Patient Carer Race Equality Framework (PCREF) including Mental Health Act Detention Rates Report
• Section 17 Leave and Time Away from the Ward
• Positive and Safe: Quarter 3 Update
• Progress of CQC MHA Monitoring Activity – 1 January 2026 to 30 April December 2026
• Individual Case Study
• Patient Advocacy – Assurance Update Report and Presentation
• Policies and Procedures for approval
• Scheme of Delegation
• Committee Evaluation
• MHLC Workplan – noted
• Any Other Business - Feedback from the Development meeting on 13 April 2026</td></tr>
<tr><td>2a</td><td colspan="2">Alert: The Committee alerts members of the Board to the following:

Patient Advocacy - Assurance Update Report
The Committee confirms a limited assurance rating for an initial assurance report on how services are engaging with statutory advocacy provision, including Independent Mental Health Act, Independent Mental Capacity Act and Care Act advocacy, drawing on the first round of service-level returns submitted in response to the February 2026 assurance request. The report identifies variation in the quality and completeness of returns, while also highlighting examples of good practice, particularly where services built on the work of the Mental Health Legislation Team and shared learning across teams. The approaches within Adult Mental Health had been strengthened. Members note ongoing work with Wards to improve equity of access, including recognition of postcode variation in informal advocacy provision, with Durham and Middlesbrough having established services while gaps remain in York, North Yorkshire and Darlington. It also recognises that detention-specific information currently available to patients is too generic and is under review by services.

In discussion, the Committee explored the need for culturally appropriate advocacy, including support for asylum seekers and refugees, and learned that commissioned advocacy provision is more developed in some areas than others, particularly in Teesside and the City of York compared with rural parts of North Yorkshire. Overall, the Committee concludes that the advocacy landscape across the Trust is complex and that further data, provider mapping and continued focus on embedding advocacy are needed to improve oversight, promote advocacy rights and strengthen assurance. Proposals for corrective actions include: chasing outstanding returns; escalating non-responses where needed; continuing provider mapping; progressing strategic advocacy work through Integrated Care Governance Group (ICGG); and submitting further assurance on service-level learning at the next reporting cycle.</td></tr>
<tr><td>2b</td><td colspan="2">Assurance: The Committee confirms assurance to the Board on the following:

Mental Health Legislation (MHL) Combined Assurance Report, including Mental Capacity Act/Deprivation of Liberty (DOLS)
The Committee approves a good level of assurance in respect of the robustness of data provided and confirms that the legislation, Mental Health Act and Mental Capacity Act/DoLS, has been applied correctly, noting evidence of overall compliance and improvement across key measures. It is</td></tr>
</table>

reported that 5 patients were discharged without being read their rights (July–October 2025), showing improvement, alongside a reduction in escalations to 88 (from 95 previously). There were 4 lapsed Section 5 episodes across four wards, and approximately 35% of Section 5s are applied within 24 hours of admission, with a delayed deep-dive review planned. AWOL episodes total 93 for the reporting period (November 2025–February 2026), including 2 requiring CQC notification, while 8 discharges from 182 Tribunal hearings and 3 from 151 Hospital Managers' hearings are recorded. Of 202 Section 136 cases, 2 are extended and 2 reach 24 hours, with all discharged to the community. The Committee notes one failure of administrative scrutiny and none for medical scrutiny, alongside strong demand for training across clinical staff groups. A significant reduction in DoLS activity is observed, from 63 to 5 authorisations for residents in 365 Thornaby Road and 1 for MHSOP at Foss Park, reflecting changes in service provision and continued application of least restrictive principles.

Multi-Agency and Internal Mental Health Legislation Operational Group Updates (DTVF)
The Committee notes that the DTVF Multi-Agency and Internal Mental Health Legislation Operational Groups are established with a good level of assurance and provide oversight of the application of the Mental Health Act and Mental Capacity Act, supporting both internal practice and partnership working. It recognises good partner engagement, although attendance from some agencies remains inconsistent, and notes that a Behavioural Disturbance workstream is being established with multi-agency involvement. It highlights the need to strengthen partnership working, particularly with ambulance services, where mental health-related demand is increasing and agreed actions to improve engagement and contact arrangements. Demand for Mental Health Legislation training is high, with approximately 200 staff requesting sessions, and commissioning of targeted training is underway. The Committee also notes ongoing work to improve recording of Section 17 leave through an external audit, alongside identified issues in patient feedback mechanisms.

Multi-Agency and Internal Mental Health Legislation Operational Group Updates (NYY)
The Committee notes that the NYY Multi-Agency and Internal Mental Health Legislation Operational Groups are established and provide oversight of the application of the Mental Health Act and Mental Capacity Act, supporting both internal practice and partnership working. It notes good engagement with partners, including plans for a joint Away Day, and confirms that the Right Care Right Person approach is embedded, supported by local guidance. The Committee recognises ongoing work to improve secure transport arrangements and identifies variation in practice regarding the use and transfer of sections when patients attend Acute Trusts, with a lack of a consistent pathway. It is noted that a working group is being established to develop a clear Trust-wide approach, alongside emerging learning from patient safety investigations relating to transfers and environmental risks. The Committee agrees actions to progress pathway development and standardised reporting and concludes that there is a good level of assurance that the groups are identifying key issues and supporting coordinated improvement activity across services.

Section 17 Leave and Time Away from the Ward
The Committee confirms good assurance in respect of oversight and monitoring of Section 17 Leave and Time Away from the Ward, supported by continued quality assurance activity and monthly performance review. The Committee notes that the report has been considered by the Quality Assurance Committee and that the policy is due for renewal with a review event scheduled for June 2026. Whilst no Regulation 28 order had been issued and Coroners have acknowledged improvement; it had been recognised that informing carers of Section 17 leave arrangements was not explicitly mentioned in Trust Policy. This was to be considered as part of the day event and policy review.

Overall improvement in compliance is recognised, although variation persists, with February performance in one service (DTVF MHSOP) declining to 69.57% due to a lack of audit returns following three months above 85%. The Committee notes areas of strong compliance, including 100% achievement regarding Informal Time Away From the Ward (TAFW), in ensuring patients and carers receive relevant contact information, and in accompanied leave standards. Compliance with discussing the TAFW plan at the last use was 0%, indicating a clear area for improvement. Accompanied leave measures, standards related to accompanied leave achieved 100% compliance, with the exception of the requirement to offer a copy of the Section 17 form to the accompanying

person, which was met in 50% of cases. Ongoing improvement actions include a Trust-wide audit, strengthened staff awareness, targeted ward-level action plans, and future system support through the implementation of the Rio EPR.

Positive and Safe: Quarter 3 Update
The Committee confirms there is good assurance demonstrated of progress implementing the Positive and Safe Strategy. The update on the implementation of the three-year Positive and Safe Strategy and a review of restrictive practice for Quarter 3 (2025/26), reported 1,966 restrictive interventions, an increase from 1,518 in Quarter 2, primarily attributed to patient acuity, while remaining within expected parameters. It is highlighted that 239 patients experienced restrictive interventions, with 9 patients accounting for 48% of all interventions, including one patient responsible for 93% of seclusion and 12% of interventions Trust-wide, indicating areas of significant unmet clinical need. The Committee notes an increase in prone restraint to 16 confirmed episodes, alongside data quality issues, with 10% of incidents missing patient identifiers, limiting statutory reporting and analysis of equity and repeat use. Disproportionality in the use of restrictive interventions across some ethnic groups is also recognised, although completeness of ethnicity data is impacted by unknown recording. The Committee recognises the need for continued focus on data quality, culturally informed practice and embedding the Positive and Safe Strategy across services.

Progress of CQC MHA Monitoring Activity – 1 January 2026 to 30 - April 2026
The Committee confirms a good level of assurance in respect of the oversight systems and processes and notes the progress made in relation to CQC Mental Health Act inspection activity across Trust inpatient wards, including thematic learning. During the reporting period (January to April 2026), 11 inspections, including informal visits, were undertaken. No new systemic themes were identified; however, recurring issues continue to relate to environmental factors such as access to therapeutic outdoor space, nutrition, staffing pressures, and the quality and storage of Mental Health Act documentation. The Committee notes that 75 actions have been completed since April 2025, with a small number of outstanding actions subject to ongoing monitoring and receives assurance regarding the effectiveness of oversight arrangements. It also recognises that wider themes identified in the CQC's Monitoring the Mental Health Act 2024/2025 one-page summary of key points report, including demand pressures, workforce challenges and inequalities in access, are consistent with those observed within the Trust.

Advise: The Committee advises the Board on the following:

Data publication – Patient Carer Race Equality Framework (PCREF) including Mental Health Act Detention Rates Report
The Committee notes the position regarding detention rates under the Mental Health Act which have been analysed by gender, ethnicity and age using 2024/2025 data benchmarked against national and expected rates. Significant data quality limitations are identified, including ethnicity being unknown for almost one-third of individuals and approximately 50% of restrictive intervention data missing ethnicity, which impacts the reliability of conclusions. Available data indicates that detention rates for Black/Black British people are similar to national averages and are around twice those of White people locally, with Black/Black British women disproportionately affected. The Committee also recognises a consistent pattern of under-representation of ethnically minoritised and racialised communities in services alongside higher rates of admission and detention, highlighting the need to improve access, cultural humility and workforce capability. A targeted engagement plan is also in development to address these issues through community partnership, co-design and improved learning, and the Committee supports further work to strengthen ethnicity data recording, develop a Performance Improvement Plan and enhance organisational oversight.

Individual Case Study
The Committee reviewed an individual clinical case study regarding the circumstances of a young adult woman with bipolar disorder and polysubstance misuse, focusing on the challenges encountered during the expiry and attempted extension of her Community Treatment Order (CTO). The discussion highlighted that the AMHP does not need to see the patient in person to extend a Community Treatment Order (CTO), provided the Responsible Clinician had seen them, given that a phone conversation could suffice for the Part 2 signature. The patient experienced no harm or relapse following a CTO lapse, with satisfactory clinical outcomes and minimal carer involvement.

Key actions include sharing case study learning with the AMHP Lead and supporting wider dissemination via external groups. The Committee stresses the importance of early collaboration between clinical teams and AMHPs, recognising the impact of varying statutory interpretations, and calling for clear processes to resolve or escalate disagreements to ensure effective and equitable application of the Mental Health Act for CTOs.

Policies and Procedures for approval
The Committee receives a report reviewing policies and procedures relevant to its remit to ensure ongoing compliance with regulatory and statutory requirements. It is noted that a number of policies previously approved in January 2026 have been subject to minor amendments following further review by the Equality and Diversity team and, in the case of the Section 17 Leave Policy, in response to a Regulation 28 Coroner's report. The updates include strengthening equality impact wording to emphasise time-limited and least restrictive approaches to patient rights, the introduction of gender-neutral language, minor typographical corrections, and enhancements to guidance within the Section 17 policy, including clearer expectations around contingencies, family involvement and alignment with electronic patient records. The Committee notes that these changes have been approved by the Executive Medical Director and formally approves the updated policies and associated procedures: (i) 'CLIN-0001-v5.4 - Consent to examination or treatment' and associated forms; (ii) MHA-0003-002-v2.5 – S135(2) Procedure; (iii) MHA-0003-v10.3 - Section 136 Policy; and (iv) MHA-0003-001 v3.5 S17 - Leave for detained patients' Policy.

Scheme of Delegation
The Committee approves the Scheme of Delegation which sets out the key responsibilities and functions placed on the Hospital Managers of the detaining authority.

Committee Evaluation
The Committee notes the results of the Committee Evaluation tool circulated in April 2026, which identifies key themes in relation to membership, representation and engagement. It notes that consistent nursing representation from Care Groups is to be strengthened and that a review of arrangements for lived experience representation is currently in place with proposals to enhance the patient voice being in development. The Lived Experience Director is to progress these through the appropriate governance routes prior to consideration by the Committee in September 2026.

Committee Terms of Reference
The Committee approves the revised Terms of Reference in respect of minor changes to update the reference to the Mental Health Act 1983 to state 'as amended by the Mental Health Acts 2007 and 2025'. No further changes to the Terms of Reference are proposed at this stage, pending future review of involvement and engagement proposals.

Any Other Business - Feedback from the Development meeting on 13 April 2026
The Committee notes the report which summarises the Committee Development Meeting held on 13 April 2026, focusing on the review of the Committee's work during the 2025/2026 period and plans for 2026/2027. A dashboard was scoped during 2025/2026 for use by the Committee; however, implementation is overdue and requires urgent action in 2026/2027. Whilst a review is undertaken to identify proposals for the Patient Voice/Lived Experience, the Committee will gather lived experience through multiple routes such as a Lived Experience Director, case studies, advocacy services, and patient feedback platforms, rather than an individual patient representative. In addition, there was a presentation on the implementation and implications of the Mental Health Act 2025. The Act will be introduced in phases over 8-10 years, with stricter criteria for detention and community treatment orders, new conditional discharge forms from February 2026, and increased workforce needs including approved clinicians and tribunal members. Patient rights and safeguards will change, including the introduction of nominated persons and encouragement of advanced choice documents. The following key risks were identified: limited resources for Mental Health Act implementation, training, workforce gaps, and support for minority ethnic communities. Identified actions included: progressing the dashboard, exploring patient voice methods, reviewing support for ethnic minorities and non-medical prescribers, and benchmarking against similar Mental Health Legislation Committees.

<table>
<tr><td>2d</td><td>Review of Risks</td><td>There were no new risks.</td></tr>
<tr><td colspan="3">Recommendation: The Committee requests that the Board of Directors:
• Note the report and confirm the levels of assurance set out above.</td></tr>
<tr><td>3</td><td colspan="2">Actions to be considered by the Board: The following matters for escalation are for the Board to note/consider:
• Individual Case Study (to be considered by the Operational Groups);
• Section 17 – ongoing work in progress;
• Performance Improvement Plan for ethnicity recording – recommendation; and
• Patient Advocacy.</td></tr>
<tr><td>4</td><td colspan="2">Report prepared by: Roberta Barker, Chair of Committee/Non-Executive Director, Kedar Kale, Executive Medical Director and Deborah Miller, Corporate Governance Manager</td></tr>
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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

<table>
<tr><td colspan="3">Committee Key Issues Report</td></tr>
<tr><td colspan="2">Report Date:
5 June 2026</td><td>Report of: Audit and Risk Committee
Quorum was met – all members were in attendance</td></tr>
<tr><td colspan="2">Date of last meeting:</td><td>21 May 2026</td></tr>
<tr><td>1</td><td>Agenda</td><td>The agenda included:
• Counter Fraud Progress Report
• Internal Audit Progress Report 2025/26
• Internal Audit Plan 2026/27, update
• Internal Audit Charter and Protocol Annual Review
• Briefing on the Global Internal Audit Standards
• External Audit Progress
• External Audit Engagement Packs
• External Audit Strategy Memorandum for 2025-26
• Summary report from Executive Risk Group meeting on 2 April 2026
• Tender Waivers Approved (2025-26)
• Briefing on the draft accounts and accounting treatment of significant items
• Registration of interests
• Draft Annual Report 2025/26
• NICE Assurance and Improvement Programme and NICE Implementation – 2025/26 Annual Report
• Annual Committee Performance Evaluation 2025/26
• Annual Review of Committee Terms of Reference
• Cross cutting issues from Board Committees
• Committee Workplan 2025/26</td></tr>
<tr><td>2a</td><td>Alert</td><td>Head of Internal Audit Opinion
AuditOne advised that, based on work completed to date, it is likely that the Head of Internal Audit Opinion (HOIAO) will be reasonable assurance. This reflects the balance overall of fewer good and substantial assurance reports proportionately, with fewer substantial assurance reports having been returned during 2025/26 and two limited assurance reports (for EPRR and clinical supervision), which the Board is already aware of. An adverse outcome from the Data Security and Protection Toolkit Assessment advisory audit, which is an independent review conducted annually prior to the national submission in June, was also considered. It is unlikely that further work before the HOIAO is finalised will change the assurance due to the reduction in ‘substantial’ ratings (down from 7 to 3 currently).

Executive Risk Group (ERG)
Committee was alerted to reported incidents (including RIDDOR) at Bankfields Court, relating to staff injury arising from the care of one patient. The issues and responses were briefly outlined and Committee received assurance on enhanced executive oversight, additional support in place to ensure the appropriate ongoing care of the patient and staff safety and input from the Challenging Behaviour Foundation and MerseyCare. An Ethics Committee had been stood up and had considered implications and next steps to mitigate dual workforce and patient safety risks. Quality of care matters will be considered by Quality Assurance Committee, workforce matters by People Culture and Diversity Committee and finance matters by Resources and Planning Committee.
ERG also considered ongoing concerns on risks related to smoking incidents on inpatient sites and a task and finish group will report to a future ERG meeting. Committee heard that, due to proactive external networking by the health and safety lead, the Trust had secured an immediate alert to action being taken by the HSE in one NHS organisation. This had led to a requirement for them to develop</td></tr>
</table>

		an organisation stress risk assessment. Health & Safety and People & Culture leads were responding proactively to develop a Trust stress risk assessment.
2b	**Assurance**	**Internal Audit Plan 2026/27** Committee received assurance on the structured approach to development of a prioritised 2026/27 plan shortlist and supported the proposed move to develop an indicative strategic, rolling three-year plan using the same risk-based approach. This considered an AuditOne 'audit universe' of potential organisational risks, their generic risk ratings (non Trust specific) across several domains, whether/when previously audited and the outcomes and areas of highest risk. It was agreed that executives would consider an alternative, e.g. peer review or other, as absence management, whilst only recently audited, remained a key risk area (above target). Plan proposals including audit scopes will be discussed with Committee Chairs before a final plan is approved at the next committee meeting. **Global Internal Audit Standards** Committee received a briefing on the new standards, which strengthen expectations for Audit Committee and senior management, including responsibilities relating to governance, independence, oversight and adequate resourcing of the internal audit function. Assurance was provided that no gaps have been identified in current arrangements. **External Audit Progress and Audit Strategy Memorandum for 2025/26** Committee received a report on the planned scope and timing of the 2025/26 audit. The audit approach is largely unchanged from the previous year with a focus on the financial statements and value for money. The audit will consider presumed risks in relation to fraud in revenue recognition, management override of controls and valuation of land, buildings and right-of-use assets due to the materiality and complexity of these balances. The audit will also include a review of material income and expenditure balances within the Trust's subsidiary PIPs (as completed for the first time the previous year). Committee received assurance on work underway and that there were currently no identified risks to completion by the end of June, in line with NHSE audited accounts submission deadlines. **Tender Waivers** Committee received assurance that the overall number of waivers remain low, with 25 waivers approved in 2025/26 totaling £3.7m. Assurance was provided that waivers are used appropriately, where specialist systems or expertise is required or where the continuity of suppliers is necessary. Assurance was also provided in relation to the use of national framework agreements where tenders had not been used. **Draft 2025/26 Accounts and the accounting treatment of significant items** Committee received prior assurance that the Trust had processes to ensure the accounts were prepared in line with accounting standards, accurately reflected transactions during the year and submitted on time. Members had welcomed the opportunity for Non-Executive Directors to be briefed in advance to consider the report in detail, prior to the meeting and for the detailed briefing provided. It was noted that the Lead Governor had also attended this meeting and all Governors had been offered the opportunity to be briefed on the draft accounts at an alternative, later, date. **Registration of Interests** Committee received the report with reasonable assurance that conflicts of interest were being registered in accordance with the policy, with compliance at approx.70% following the change to recording on ESR. There was increased confidence in the accuracy of the relevant senior staff cohort and the policy and processes were in place to support compliance, including the escalation of non-

		responders. Advice had been sought from People and Culture Directorate on the use of sanctions for those who continually fail to declare and the potential to report breaches to Executive Directors Group was also proposed. Committee discussed the importance of accurate and up to date information, especially for outlying medics, in the context of the Aubrey Report and members queried potential to link compliance to the appraisal process. **Quality Assurance and Improvement Programme and NICE Implementation – 2025/26 Annual Report** Committee received the report with good overall assurance regarding the operational and strategic oversight of quality assurance and clinical effectiveness activities and that no new gaps in assurance or mitigating actions had been escalated or proposed by management. Committee also received assurance that programme carry-over forms part of a planned cyclical approach, rather than being indicative of non-delivery or specific capacity shortcomings. Committee queried the impact of oversight through the Clinical Effectiveness Group and received assurance that the revised governance structure provides a more effective link to operational delivery without reducing oversight. Clarification was provided that National Clinical audits were focused on compliance with defined core national standards, with the Prescribing Observatory programmes being supported by the Pharmacy Team.
2c	**Advise**	**Counter Fraud** Committee discussed planned opportunities to strengthen the reach of counter fraud awareness across the Trust, including those working across dispersed sites and 24/7 services and supported the opportunity to explore increasing visibility through information sharing (only) at visits conducted by the Freedom to Speak up Guardian, whilst acknowledging his independence should be maintained. **Internal Audit** Committee welcomed the positive progress in management oversight, including low levels of overdue actions and no actions outstanding beyond revised agreed dates, or 12 months. Committee supported a proposed amendment to the audit plan – the removal of the Overtime Audit due to the availability of data through new processes. The audit was deemed to be of reduced priority due to significant progress made to reduce overtime and had not therefore been retained as a 2026/27 plan priority. The audit will be replaced by an advisory review of the NHS Provider Capability Self-Assessment, to strengthen assurance on governance and regulatory readiness. Committee also proposed that benchmarking information be included in audits and sought continued mutual improvement against audit KPIs. **Internal Audit Charter** Committee approved the charter, which sets out the mandate, independence, scope and responsibilities of the internal audit function. The charter is largely unchanged from the previous year, except for the inclusion of the new Chief Executive within the escalation protocol. **Executive Risk Group (ERG)** It was noted that ERG had conducted a deep dive into risk relating to ligatures, to ensure risks considered self-harm more broadly and reflected a dynamic environment where the Trust needs to remain vigilant. ERG had agreed to an extension to enable clinical engagement on proposed revisions to the supervision policy, and in response a limited assurance internal audit. It received assurance that, in the meantime, there had been a significant increase in compliance and supervision rates had doubled in the last year.

		In response to a query at a Board seminar, executives had agreed that digital risks should not be incorporated within Transformation risk, to ensure Board visibility is maintained and this had been fed back to Board. **Annual Report** Committee received an update on the compilation of the Annual Report for 2025/26 and was invited to provide comment following the meeting on whether the report presented a fair, balanced and understandable view of the Trust's position. Outstanding sections included the Annual Governance Statement, which would be completed following receipt of the Head of Internal Audit Opinion, and performance which will be rewritten to provide a more cohesive summary. Committee discussed the presentation and accessibility of the report, the final version of which would not be submitted to NHSE but was needed prior to the Annual Members Meeting. It was acknowledged that the revised internal reporting timetable and process had been a significant improvement to the previous cycle. Committee will receive a final draft report for submission to NHSE for consideration prior to Board on 25 June 2026. **Annual Committee Performance Evaluation 2025/26** Committee received the report with good assurance on the effectiveness of its governance and on internal and external audit arrangements. Feedback highlighted some gaps in understanding about several items the Committee only considered annually due to recent membership changes. Committee agreed to hold a dedicated development session following completion of the annual accounts cycle to explore the feedback in more detail and to support understanding. It was also agreed that a session for Governors would be delivered by the Committee Chair and Associate Director of Finance separately to maintain clarity of roles and responsibilities. **Annual Review of Committee Terms of Reference** Committee agreed minor changes to the terms of reference and these will be presented to a future Board meeting for approval.
2d	**Review of risks**	No additional risks identified at the meeting.
3	**Actions/ escalations**	No additional actions or matters to escalate.
4	**Report compiled by**	John Maddison, Chair of Audit and Risk Committee/Non-Executive Director, Liz Romaniak, Executive Director of Finance, Estates and Facilities and Karen Christon, Deputy Company Secretary

For General Release

Meeting of:	**Board of Directors**
Date:	**11 June 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.

REPORT:

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**
456	Renewal lease relating to Dover House, 1-3 Lynn Street, Hartlepool	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.