

BOARD OF DIRECTORS
13 August 2026
at 10.00am

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

AGENDA

No.	Report Title	Lead	Timing
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Standing Items

1.	Chair's welcome and introduction (verbal)	Chair	10.00am
2.	Board of Directors to receive a staff story (verbal)	Executive Director for People & Culture	10.01am
3.	Apologies for absence (verbal)	Chair	10.30am
4.	Declarations of interest	All	10.31am
5.	Questions from members of the public (verbal)	Int. Company Secretary & Director of Governance	10.32am
6.	Minutes of Board of Directors meetings held on: a. 11 June 2026 b. 25 June 2026	Chair	10.35am
7.	Board Action Log	Chair	10.40am
8.	Chair's Remarks (verbal)	Chair	10.45am
9.	Chief Executive's Public Report	Chief Executive	10.55am

Risk and assurance

10.	Report of the Chair of Audit and Risk Committee (note: verbal update provided at the Board meeting on 25 June 2026)	Committee Chair	11.10am
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BREAK (11.20pm to 11.30pm)

No.	Report Title	Lead	Timing
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Assurance

11.	Integrated Quality and Performance Report	Int. Executive Director for Strategy & Transformation Int. Care Group Managing Director	11.30am
12.	Guardian of Safe Working Hours, Quarter 4 and 2025/26 Annual Report and Q1 2026/27 Report	Guardian of Safe Working Hours	12.15pm
13.	Getting the basics right for resident doctors	Resident Doctor Peer Lead	12.30pm
14.	Report of the Chair of Quality Assurance Committee	Committee Chair	12.45pm
15.	Learning from Deaths Report Quarter 1 2025/26 (Statutory Report to Board)	Executive Medical Director	12.55pm
16.	Report of the Chair of Resources and Planning Committee	Committee Chair	1.05pm

For General Release

Meeting of:	Board of Directors
Date:	13 August 2026
Title:	Board of Directors Register of Interests
Executive Sponsor(s):	A Smith, Chief Executive
Report Author(s):	A Pridmore, Interim Company Secretary and Director of Governance

Report for:	Assurance	☒	Decision	☐
	Consultation	☐	Information	☐

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

1: We will co-create high quality care

2: We will be a great employer

3: We will be a trusted partner

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Strategic risks relating to this report:

BAF ref no.	Risk Title	Context
10	Regulatory Compliance	The Register of Interests forms part of the Trust's governance and compliance framework and provides assurance that actual, potential and perceived conflicts of interest are identified and managed appropriately. This contributes to the mitigation of BAF Risk 10 (Regulatory Compliance) by supporting compliance with the Trust's regulatory and governance obligations.

EXECUTIVE SUMMARY:

Purpose:

This report provides the Register of Interest of the Board of Directors at 6 August 2026.

Proposal:

To receive and note the Register of Interests and identify any amendments required, and to declare any interests which may be relevant to matters on the agenda.

Overview:

The Trust is required to maintain a register of interests of directors in accordance with para. 20(1)(d) of Sch.7 of the NHS Act 2006.

The format of the register and the definitions of types of interest reflect the requirements of policy HR-0020-v4.3. This policy is based on NHSE guidance.

The Register of Interests of the Board of Directors of Tees, Esk and Wear Valleys NHS Foundation Trust, at 6 August 2026, is attached to this report. It has been updated based on information submitted by individual Directors.

The Register is published on the Trust website to ensure compliance with the relevant provision in the Annual Governance Statement.

Prior Consideration and Feedback:

n/a

Implications:

The Trust is required to establish and implement processes and systems to identify risks and guard against their occurrence. Failure to do so would be a breach of the provider licence.

Recommendations:

Board is asked to:

- i. To receive and note the Register of Interests and identify any amendments required.
- ii. Declare any interests which may be relevant to matters on the agenda.

Employee Name	Role	Position Title	Interest Category	Interest Situation	Interest Description
Niniola Adetuberu	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	Non Executive Director of North East Ambulance Service Trust.
Roberta Barker	Non-Executive Director	Non Executive Director	I have no interests to declare		
Marie Burnham	Chair	Chair of the Trust	Financial interests	Outside employment	Chair, NICE Committee - Fatty Liver Disease - remunerated
Marie Burnham	Chair	Chair of the Trust	Non-Financial Professional Interest	Outside employment	Chair, Apex Collaborative Trust - unremunerated; Advisor to Why Not I Board - unremunerated; Coach and Mentor for NHS Alliance - unremunerated
David Butcher	Non-Executive Director	Associate Non Executive Director	Non-financial professional interest	Outside employment	Board member at Bradford and Craven MIND (mental health charity) - unremunerated
David Butcher	Non-Executive Director	Associate Non Executive Director	Financial interests	Outside employment	Board member at North Star Housing Group (social housing provider) - remunerated
Philomena Corrigan	Non-Executive Director	Non Executive Director	Financial interests	Outside employment	Strategic Advisor and Lead for Mental Health Liaison Group; Director of Corrigan Consultancy
Philomena Corrigan	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	Chair of Thank You Healthcare Staff; Trustee of Liaison Charity
Hannah Crawford	Other Executive Director	Director of Therapies	Non-financial personal interests	Loyalty interests	My sister is a Legal Director at DAC Beachcroft in Leeds. She does not undertake any work for our organisation
Sarah Dexter-Smith	Chief People Officer	Director of People and Culture	Financial interests	Shareholdings and other ownership interests	I occasionally receive a small payment for royalties for a book I co wrote and which some of our teams use. I gift any royalties to the Trust charitable funds.
Kathryn Ellis	Other Executive Director	Interim Executive Director of Transformation and	Indirect interests	Shareholdings and other ownership interests	I am sole director of a company which provides organisational coaching/consultancy. Whilst employed full time at TEWV I may provide occasional, adhoc work with clients out of work hours. None of this work is directly to TEWV as an organisation, nor to employees of the organisation. Nor is it for services that would otherwise represent a direct commercial conflict of interest for TEWV
Edward Gorringe	Non-Executive Director	Associate Non Executive Director	Non-financial professional interest	Outside employment	I am a Trustee of a national mental health charity, Rethink Mental Illness, Rethink has a number of contracts with TEWV for the provision of services within prisons.
Kedar Kale	Medical Director	Medical Director	Indirect interests	Clinical private practice	My spouse currently carries out pvt clinical practice. I do not carry out private practice. However I am a co-director with her on a private ltd company.
Naomi Lonergan	Senior Manager	Managing Director	I have no interests to declare		
John Maddison	Non-Executive Director	Non Executive Director	I have no interests to declare		
Beverley Murphy	Director of Nursing	Chief Nurse	Financial interests	Outside employment	Consulting into organisations and coaching individuals outside of NHS employment as a sole trader. The business name is Practice Partnership.
Beverley Murphy	Director of Nursing	Chief Nurse	Non-financial professional interest	Outside employment	Unpaid member of the Council of the national forum of Mental Health and Learning Disability Directors of Nursing. As a part of this role I serve as the Company Secretary.
Jules Preston	Non-Executive Director	Non Executive Director	I have no interests to declare		
Len Richards	Non-Executive Director	Non Executive Director	Financial interests	Outside employment	Non Executive Director of Life Sciences Hub in Wales; Luminary Advisor fo St Vincents Consulting Ltd (St Vincents have been commissioned to provide external assurance on the EPR Programme; however, I was not aware or involved in identifying, promoting or commissioning their support. It was in place when I joined TEWV); Group Strategic Advisor for Liaison Group; Advisor and Subject Matter Expert for Health Spaces; Advisor on Health Practice for Q5 Partners; Advisor for Health Pathways UK subsidiary of Streamliners NZ.
Len Richards	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	Chair of the Regional Spinal Cord Injury Network, North East & Yorkshire Region - voluntary position.

Employee Name	Role	Position Title	Interest Category	Interest Situation	Interest Description
Liz Romaniak	Finance Director	Director of Finance	I have no interests to declare		
Alison Smith	Chief Executive	Chief Executive	I have no interests to declare		
Catherine Wood	Non-Executive Director	Non Executive Director	Non-financial professional interest	Outside employment	From November 2025 I hold a second Non Executive Director post for Care Housing Association in addition to my NED role at TEWV. Care Housing provide housing for people with learning disabilities and autistic people across the North and are a Community Benefit Society and therefore not for profit.

MINUTES OF THE BOARD OF DIRECTORS HELD 10.00AM ON 11 JUNE 2026 AT WEST PARK HOSPITAL, DARLINGTON AND MSTEAMS

Present:

Marie Burnham, Trust Chair (Chair)
Nini Adebentu, Non-Executive Director
Roberta Barker, Non-Executive Director
Kedar Kale, Executive Medical Director
John Maddison, Non-Executive Director
Beverley Murphy, Chief Nurse/Deputy Chief Executive
Jules Preston, Non-Executive Director
Liz Romaniak, Executive Director for Finance, Estates and Facilities
Alison Smith, Chief Executive
Catherine Wood, Non-Executive Director
David Butcher, Non-Executive Director (non-voting)
Hannah Crawford, Executive Director for Therapies (non-voting)
Sarah Dexter-Smith, Executive Director for People and Culture (non-voting)
Kathryn Ellis, Interim Executive Director for Strategy and Transformation (non-voting)
Edward Gorringer, Non-Executive Director (non-voting)

In attendance:

Phil Bellas, Company Secretary
Nick Black, Chief Information Officer
Karen Christon, Deputy Company Secretary (minutes)
Adam Howe, Freedom to Speak Up Guardian
Vicky, service user (patient story)
Vanessa, Community Nurse (patient story)

Observers:

Jawharia Amin, Trainee Clinical Psychologist
Emma Robinson, Trainee Clinical Psychologist

36. CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting.

37. APOLOGIES FOR ABSENCE

Apologies for absence were received from Ann Bridges, Executive Director for Corporate Affairs and Involvement (non-voting).

38. BOARD OF DIRECTORS TO RECEIVE A PATIENT STORY

The Board received a patient story from Vicky, who shared her experience of support from Trust services. Vicky described the positive impact of the therapeutic relationship she had developed with her Psychologist Becky and Community Nurse, Vanessa, and spoke about the non-judgemental and supportive care she had received. She explained that the support had helped her to manage the effects of trauma, rebuild trust and achieve substantial progress in her recovery. Vicky advised that she had received excellent support throughout her care, which included between formal appointments and she highlighted the flexibility of community services to provide timely support in response to changes in her needs. She encouraged others who may experience difficulties to seek help early and emphasised the positive difference that support from the Trust had made to her life.

Board acknowledged the importance of continuity of support and the positive impact of compassionate, person-centred care and how that could be measured and recognised.

Vicky was thanked for sharing her experience and Board acknowledged the courage required to do so.

39. DECLARATIONS OF INTEREST

No declarations of interest were noted.

40. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions were received from the public.

41. MINUTES OF LAST BOARD OF DIRECTORS MEETING HELD ON 9 APRIL 2026

Agreed: *The minutes are an accurate record of the meeting, subject to the following amendments and amendments to be provided by N Lonergan following the meeting:*

- i. The inclusion of B Reilly, Non-Executive Director and S Dexter-Smith, Executive Director for People and Culture in the list of attendees.*
- ii. Minute item 15, para 6 be amended to ‘ The Board noted that data recording at the Trust was 68%, compared with the national average of 75%....’*

42. BOARD ACTION LOG

The Chair proposed that the action log template be amended to differentiate between actions closed by the Board at the last meeting and actions completed recommended for closure at the meeting.

Agreed: *Board notes the updates to the action log and closes the actions recorded as complete.*

43. CHAIR’S REMARKS (VERBAL)

The Chair provided an update on activities undertaken since the previous meeting, which included:

- A visit to Roseberry Park Hospital, where she met members of the team and toured the site. She thanked colleagues for the warm welcome and recognised the significant work undertaken at the site.
- Productive introductory meetings with senior colleagues and the NHS England Regional Director.
- Ongoing work to strengthen governance arrangements, which included the completion of Non-Executive Director appraisals, and she thanked colleagues for their engagement with the process.

Looking forward, she highlighted that interviews for Non-Executive Directors with clinical and digital expertise were scheduled the following week and advised that she would shortly begin to meet with local Members of Parliament and would keep Board colleagues informed of any points raised.

44. CHIEF EXECUTIVE'S PUBLIC REPORT

A Smith, Chief Executive presented the report, which briefed the Board on important current issues relevant to the Chief Executive and drew attention to: the registration of therapists; preparations for the band 5 review by March 2027, which were well advanced; the delay to the appointment of Chair for the public inquiry; key national developments; staff survey results; and her continued programme of visits to Trust sites and meetings with staff, patients and families, which reflected the value of maintaining visibility and engagement.

In discussion:

1. S Dexter-Smith advised that robust job evaluation and regrading processes were in place to ensure that staff did not work beyond their agreed role and confirmed if any instances arose, staff would be appropriately recompensed.
2. Board reflected on the role of leadership walkabouts and it was agreed that visits should be purposeful, appropriately coordinated and supported by clear governance arrangements to ensure there was clarity on the purpose and to capture feedback, themes and actions.

Non-Executive Directors who wished to organise a visit outside of leadership walkabouts were advised to contact Wendy Johnson in the first instance.

Agreed: Board receives and notes the report.

45. BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

P Bellas introduced the report, which summarised the strategic risks, controls and control ratings within the Board Assurance Framework (BAF) and was intended to support discussion and triangulation with other Board reports at the meeting.

He noted the proposed reduction in the score for BAF risk 1 [safer staffing], as recommended by People, Culture and Diversity Committee, which would be discussed during the confidential meeting.

In discussion:

1. Members queried missing target dates and formatting issues within the report and P Bellas advised that omissions related to the configuration of the system and formatting errors and did not indicate missing information. The report was the first iteration from InPhase and would continue to be developed and refined.
2. The new format was welcomed and it was proposed that a glossary be included to support its interpretation.
3. Board discussed the need to distinguish between assurance regarding the content of the BAF and assurance on process. It was recognised that there had been an improvement to the process and consistency of reporting and further work was needed to strengthen assurance over the content.
4. A Smith confirmed that future iterations of the BAF would be aligned to the Trust's planning cycle and strategic and annual objectives and welcomed patience from the Board while this work was undertaken.

5. The Chair noted the importance of committee ownership of BAF risks and confirmed that committees would continue to undertake detailed scrutiny, with the Board focused on triangulation, assurance and identification of areas that required further attention. K Ellis noted the role of Resources and Planning Committee to support strategic planning and proposed that sequencing work be undertaken now in preparation for the next planning cycle.
6. It was proposed and agreed that narrative to explain changes and the development of the BAF would be included within the BAF confidential report.

Action: P Bellas

7. The Board took assurance that development of an appropriate framework and reporting process was underway and recognised that the strategic risks would continue to evolve.

Agreed: *Board receives and notes the report.*

46. MEDIUM TERM PLAN

K Ellis presented the report, which provided assurance on how plan conditions would be addressed and updated on how assurance on the Medium Term Plan (MTP) had strengthened since the February 2026 submission and the April Board update.

Liz Romaniak drew attention to the challenge associated with the development of a plan to reduce bank staffing and the previous increased use of bank as the most cost-effective alternative to agency and overtime. The Trust was behind plan at month one in relation to the bank staff target and £900k of the target remained unidentified. She also noted that that should the Trust achieve a reduction in bank that may not reduce overall costs where bank staff were replaced by substantive staff, unless overall workforce numbers also reduced.

In discussion:

1. L Romaniak confirmed that it was important to determine the permanent staffing establishment level aligned to funded bed occupancy, with headroom to respond to variable inpatient occupancy and complex packages of care. However, current clinically ready for discharge levels contributed to occupancy levels beyond that funded through commissioning arrangements.
2. Board agreed that the Trust would not compromise on patient safety and there may need to be flexibility on the bank target until the establishment could be aligned with patient demand, acuity and commissioning levels.
3. L Romaniak advised that the Trust performed strongly on reductions in agency and overtime when benchmarked with other mental health trusts. She reiterated that Bank staff had increased the previous year as part of a deliberate value for money approach, in order to replace more expensive temporary staffing options.
4. K Ellis reminded Board that the MTP was based on assumptions related to activity, workforce and finance, and that ongoing oversight was required to ensure those assumptions remained valid as delivery progressed. She proposed that oversight through Resources and Planning Committee and Quality Assurance Committee, together with the EQIA process, would support the management of risks and enable the Board to monitor how operational, quality and financial considerations were balanced throughout delivery.

5. Board discussed the challenges to delivery of the sickness absence target and noted the interdependency between sickness absence, temporary staffing and delivery of efficiency savings. K Ellis provided reassurance that interdependencies were well understood and there would be regular oversight through the People, Culture and Diversity Committee.

S Dexter-Smith also acknowledged the complexity of the issue and indicated that the sickness absence improvement plan provided assurance through its focus on areas with the highest sickness absence and bank use, with local audits and case study reviews planned to assess whether the actions implemented had delivered the intended impact.

L Romaniak cautioned that reductions in sickness absence would only deliver a financial benefit where rostered shifts had been backfilled; therefore, whilst the Trust might achieve an improvement in sickness absence there would not be a corresponding reduction in expenditure.

6. L Romanak confirmed that agency staffing remained subject to national reduction targets and Trust performance was ahead of plan through a sustained focus.

7. Board discussed a concern that the plan predominantly described measures to manage and reduce current staffing pressures, and that it would be important to articulate a future operating model that set out how services would change to deliver longer-term workforce and financial sustainability.

N Lonergan explained that the transformation programme set out the shift from hospital-based to community-based care and would support the reduction in reliance on inpatient services, as a driver of bank expenditure. The programme was underpinned by transformation plans across all specialties.

8. A Smith reflected on national drivers related to workforce productivity and temporary staffing. She noted the Trust's operating context, with inpatient services at 95% - significantly above the commissioned level of 85% - and proposed that if the Trust was able to evidence that national requirements had been met, it would be in a strong position to justify higher bank staffing levels to support patient safety.
9. L Romaniak advised that the 2026/27 medium term plan, as a foundational plan, would be unlikely to realise the benefit from proposed transformation schemes and that if the Trust was able to address challenges around clinically ready for discharge – a cost of £10m, equivalent to 5 inpatient wards per year - that would lead to a significant reduction in the level of flexible staffing required.

Agreed: Board -

- i. *Confirms the level of assurance of Plan conditions compliance as good, with delivery assurance at this stage as reasonable.*
- ii. *Confirms 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.*
- iii. *Takes 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.*

- iv. *Notes overall financial performance assurance from month 1 and notes the caveats in respect of bank cost challenges, drivers, opportunities and next steps.*
- v. *Approves delegation to the Chief Executive and executive team to confirm final sign-off of the MTP conditions by the end of June 2026.*
- vi. *Notes the commitment for ongoing oversight of MTP delivery via Resources and Planning Committee, with consideration of condition areas as appropriate at People, Culture and Diversity Committee and Quality Assurance Committee.*

The Chair varied the order of the agenda.

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

R Barker, Chair of People, Culture and Diversity Committee, presented the report and summarised the key areas of discussion at the committee meeting held on 6 May 2026.

In discussion, the Chair indicated a colour-coded approach to committee reporting would be introduced from September 2026 to track issues across different committees, to support the triangulation of information and provide visibility of cross-committee matters.

Action: P Bellas

48. REPORT OF THE FREEDOM TO SPEAK UP SERVICE

S Dexter-Smith introduced the report, which provided an update on the relatively new Freedom to Speak up service, including assurance on process, reach and uptake.

In discussion,

1. J Preston, as Non-Executive Director Champion for Freedom to Speak Up, confirmed that he was regularly informed of progress and was assured on the transition to the new service.
2. Board noted the high proportion of concerns related to organisational systems, processes and management practice, which although not the original intention for a Freedom to Speak Up service, may impact on patient care and agreed that it was important to triangulate data with other sources of intelligence on patient experience, culture and safety. A Smith also noted that themes arising through the service may reflect organisational and financial challenges facing the NHS more broadly.
3. Board noted the proportion of concerns raised confidentially and queried whether anonymity limited the ability to address issues effectively and if the Trust's position was similar to that of other Trusts.

In response, A Howe explained that confidential concerns would change throughout the course of a case, as staff gained confidence in the process and, in most cases, staff shared their identity with him, which enabled dialogue, clarification and feedback. He acknowledged that fully anonymous concerns were more difficult to investigate as there was no opportunity to seek further information or provide feedback. He also advised that the Trust's level of anonymity was similar to that of other mental health trusts.

A Smith proposed that anonymity levels would reduce as staff became more confident in the service and S Dexter-Smith added that confidence in the independent nature of the service had grown, and the Guardian helped to mediate concerns, provide feedback and encourage staff to engage directly with the organisation where appropriate.

4. Board welcomed the sustained level of referrals following the introduction of the new provider, and agreed this reflected increased openness, transparency and confidence in speaking up.
5. A Howe confirmed that all staff had the opportunity to provide feedback on the service, of which a sample had been included in the report, and he recognised the importance of learning from positive and negative feedback.
6. Board welcomed the Guardian's experience across multiple organisations and agreed that it was important to identify and escalate recurring themes or wider learning through the appropriate governance routes, including through People, Culture and Diversity Committee.
7. The Chair welcomed the progress made by the new service and proposed that clarity be provided to the network of local Speak Up Champions on their role to support the Guardian.

Action: S Dexter-Smith

Agreed: Board receives the report with substantial assurance on the implementation and impact of the Freedom to Speak Up Service.

49. INTEGRATED QUALITY AND PERFORMANCE REPORT

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

In discussion:

1. A Smith highlighted work underway on neurodevelopmental pathways across both integrated care systems and welcomed the collaborative approach they had taken.
2. Board welcomed the inclusion of population health and inequality data and discussed the low proportion of patients with ethnicity recorded and the impact of that on the Trust's ability to draw meaningful conclusions about access, outcomes and inequalities. Members suggested that ethnicity recording should be included in the report as a performance metric to strengthen oversight.

In response, K Kale advised that ethnicity data was now available through the live dashboard and would be coordinated through the sickness to prevention workstream. N Lonergan also noted work underway by the care groups to develop a performance improvement plan and N Black reflected on the need to consider how staff used the existing electronic patient record (EPR) system and to ensure data capture was embedded in the design of the new EPR system.

B Murphy discussed evidence, which indicated that ethnic minority communities may be more likely to contact services at a point of crisis and that the Trust should seek to understand barriers to access and engagement, alongside the collection of data. She went on to outline progress to embed the Patient Carer Race Equality Framework, as an important step to improve data quality and address inequalities in care and outcomes.

3. Board welcomed the continued development of the report and noted that the latest revisions further strengthened the quality and usability of the report. It was suggested

that additional benchmarking information be included to help provide further context to support interpretation of performance.

4. Board noted the continued use of restrictive interventions and queried whether care environments met patient needs and if that led to an impact on staff.

In response, B Murphy advised that restrictive intervention data was closely monitored, to understand the factors and opportunities for earlier therapeutic engagement to prevent escalation. She confirmed the Trust had developed an approach to reduce restrictive practice and Quality Assurance Committee had agreed that the Trust should work to eradicate all prone restraint.

A Smith highlighted broader national discussions regarding least restrictive practice, risk management and inpatient care.

5. Board sought clarification on the new waiting times table and N Lonergan explained that the report reflected the new Meaningful Help metric, which included a new approach and terminology. She commented on the complexity of the underlying data and instances where some waiting times appeared long due to how pathways and referral dates were recorded.

Board agreed that it was important to ensure the presentation of data was clear and able to be easily understood and emphasised the need to resolve issues that impacted on data, to avoid the potential for misleading conclusions.

N Black advised that the bi-annual external review of all metrics was reported to Resources and Planning Committee.

6. Board sought clarification on governance and oversight arrangements for the How We Work Programme and proposed that this be outlined in the report. In response, S Dexter-Smith advised that she was the SRO for the programme and oversight would be through People, Culture and Diversity Committee with specific areas reviewed by other relevant committees.
7. Board discussed whether the level of detail provided in the report was appropriate and the Chair proposed that performance oversight remained a collective Board responsibility. She welcomed the revised format of the report, which gave a focus to key issues, with supporting detail where required and outlined plans to further develop Board governance arrangements, to provide an opportunity for an alternating focus on the BAF and performance at monthly Board meetings.

A Smith also advised that executive performance reviews would be established once the revised IQPR was in place, to provide additional scrutiny and matters would be reported to Board by exception.

L Romaniak reminded Board that committee-level performance dashboards had previously been developed to support performance oversight through Board committees and the proposed changes formed part of the continued evolution of the Trust's performance and accountability framework, to build on existing governance arrangements rather than to address any gap in oversight.

Kathryn advised that future iterations of the report would focus less on descriptive narrative and place greater emphasis on a concise articulation of the 'so what', with a clearer focus on delivery, improvement actions and links to relevant Board Assurance Framework risks

8. Board queried the change in children and young people's neurodevelopmental waiting list data and N Lonergan advised that the data had been corrected after a Business Intelligence review and did not represent an increase in the overall number of patients waiting.

A Smith reflected on the significant challenges associated with children's neurodevelopmental waiting times, which remained a national issue. She recognised that, while work had progressed on adult pathways, further development was required for children's services. Board welcomed the continued focus, as a hugely important area for children and young people

9. Board queried patient experience response rates and H Crawford outlined work underway to improve participation through enhanced use of QR codes, accessible survey formats and targeted support to teams. In respect of feeling safe response rates, she advised that volumes were small and did not align with the consistently positive patient and carer experience results reported elsewhere. Further work would be undertaken to understand the position and monitor trends and Board agreed to receive an update on the findings.

Action: H Crawford

Agreed:

Board confirms there is –

- i. 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.*
- ii. Reasonable assurance that improvement actions are consistently implemented and effective where performance standards are not being met.*
- iii. 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.*
- iv. Appropriate and effective management of risks to delivery.*

Board approves the replacement of the Use of Resources Rating measure with a new Bank Costs Compared to Plan measure.

50. SUPPORTING MENTAL HEALTH DEMAND IN ACUTE CARE SERVICES

N Lonergan presented the report, which set out the Trust's strategic response to the NHS England priority to reduce avoidable mental health admissions in Accident and Emergency Departments and to ensure individuals in crisis received timely, appropriate and therapeutic care in the right setting.

In discussion:

1. A Smith noted that Board would receive a future report on Trust arrangements and performance to support mental health demand in acute care settings.
2. The Chair welcomed the progress made and noted the Trust was ahead of many others in this area.
3. N Lonergan advised that no additional funding was available to support this work and improvements would need to be delivered within existing resources. Future

opportunities to secure investment may arise as service models develop and the evidence base was strengthened.

L Romaniak reminded Board that national planning assumptions expected delivery of left shifts largely within existing resources. She noted that, while some resources had been identified within the Medium-Term Plan and through capital schemes, there were multiple competing priorities and a key challenge would be to repurpose existing resources more effectively and maximise the contribution of system partners to support service transformation and improved outcomes.

4. A Smith recognised the financial pressures faced by acute providers and emphasised that, while the Trust would seek to lobby for a fair share of available resources, it was important to sustain effective partnerships to deliver improvements across urgent and emergency care pathways. By way of example, noted the Trust's liaison psychiatry services were well integrated within emergency departments and benefited from positive working relationships and appropriate clinical space.
5. K Ellis discussed the need to establish a shared understanding of the impact of mental health interventions on the wider system, to build a stronger evidence base to support future discussions on investment.
6. Board also emphasised the importance of strengthening relationships across the wider system, which included primary care, to support a shared ambition of care closer to home and to deliver service transformation collaboratively.

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

51. REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Murphy, Chief Nurse, presented the reports from the committee meetings held on 2 April 2026, 7 May 2026 and 4 June 2026.

Board discussed whether the Trust was able to meet the needs of a gentleman at Bankfields and reflected on challenges to support those with highly complex needs where an appropriate onward placement was not available.

B Murphy advised that the Trust had initially challenged the appropriateness of the placement and had subsequently accepted the referral following a change in circumstances. Executive engagement with the ICB and local authority was ongoing to secure an appropriate longer-term solution.

Board acknowledged the compassionate and ethically rigorous approach taken by staff to support the individual and protect their wellbeing.

52. LEARNING FROM DEATHS QUARTERLY REPORT

K Kale presented the report which, provided assurance of reporting and learning in line with national guidance.

In discussion:

1. K Kale clarified that of the 408 deaths reported in the quarter, 327 people were open to Trust services at the time and of those, 2 were inpatients.
2. Board queried how learning from incidents was translated into practice and how the impact of communications was evaluated. In response, K Kale noted that learning was shared through a range of channels, such as briefings, webinars and learning sessions, to reach different audiences. B Murphy advised that patient safety briefings were used selectively for significant issues, reviewed for clarity, and supported by a formal process that required teams to consider the learning and confirm it had been shared locally.

H Crawford indicated that the impact of safety briefings could be tracked through the Quality Assurance Schedule to understand if there had been sustained changes to practice; however, the measurement of learning on behaviour and practice remained complex. She noted a link to the How We Work Programme and accountability framework to strengthen individual responsibility to understand and act on relevant changes.

[N Loneragan left the meeting]

3. B Murphy proposed the Trust had seen demonstrable improvements over time in areas previously identified through the Quality Assurance Schedule, such as risk assessments and safety summaries, with processes put in place to drive and monitor improvement. She explained that assurance work had evolved from assessment of whether documentation was completed, to consideration of its quality.
4. Board noted the recurrence of themes identified through mortality reviews and patient safety investigations and K Kale advised that some themes related to routine clinical tasks and, while improvement could be demonstrated over time, it was not realistic to expect such issues to be entirely eliminated.
5. The Chair proposed that the discussion had provided reassurance that learning and improvement had taken place, supported by ongoing oversight through the Quality Assurance Committee.

Agreed: Board notes the content of the report, the dashboard and the learning points as good assurance of reporting and learning in line with national guidance.

53. REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

R Barker, Chair of Mental Health Legislation Committee, presented the report and summarised the key areas of discussion at the committee meeting held on 6 May 2026. She also reflected on her two years as Chair of the Committee and the positive development of the Committee during that period, and thanked members and staff for their support and contribution.

In discussion:

1. B Murphy expressed surprise that patient advocacy had emerged as an area with limited assurance, as advocacy access and provision had not previously been identified as a significant concern through CQC Mental Health Act monitoring activity or inspection feedback.
2. K Kale clarified that the reported variation in Section 17 leave primarily related to elements of safety planning, rather than the authorisation of leave itself. He advised

that the policy would be reviewed to simplify expectations and support more consistent practice. B Murphy reminded the Board that the Trust had previously received two Regulation 28 Orders related to safety planning and that committee focus was on work to improve consistency with safety planning, rather than Section 17 leave per se.

3. K Kale noted a correction to the report, that a Regulation 28 order had been issued [report para 'section 17 Leave and Time Away from the Ward'].
4. A Smith proposed to discuss the limited assurance on advocacy at Executive Directors Group and to consider what support could be provided to committee to provide clarity on the position with safety planning.

Agreed: Board receives and notes the report.

54. REPORT OF THE CHAIR OF AUDIT AND RISK COMMITTEE

J Maddison, Chair of Audit and Risk Committee, presented the report and summarised the key areas of discussion at the committee meeting held on 21 May 2026. He concluded by thanking L Romaniak and colleagues for their support to the Committee throughout the year

Agreed: Board receives and notes the report.

55. REGISTR OF SEALING

P Bellas presented the report, which advised on use of the Trust's seal in accordance with Standing Order 15.2.

Agreed: Board receives and notes the report.

56. ANY OTHER BUSINESS

On behalf of the Board, the Chair presented a gift to J Preston in recognition of his significant contribution to the Trust, the NHS and a range of charitable organisations over many years and noted that it had been a privilege to work alongside him.

J Maddison paid tribute to his dedication, generosity and commitment to both the Trust and the wider community and placed on record his thanks for his ongoing support, wisdom and service.

The meeting closed at 1.24pm

**MINUTES OF A MEETING OF THE BOARD OF DIRECTORS HELD AT 1PM ON
25 JUNE 2026 VIA MSTEAMS**

Present

Marie Burnham, Trust Chair (Chair)
Alison Smith, Chief Executive
Nini Adetuberu, Non-Executive Director
Roberta Barker, Non-Executive Director
Kedar Kale, Executive Medical Director
Naomi Lonergan, Interim Care Group Managing Director
John Maddison, Non-Executive Director
Jules Preston, Non-Executive Director
Liz Romaniak, Executive Director of Finance, Estates and Facilities
Catherine Wood, Non-Executive Director
David Butcher, Associate Non-Executive Director (non-voting)
Kathryn Ellis, Interim Executive Director of Strategy and Transformation (non-voting)
Hannah Crawford, Executive Director of Therapies (non-voting)
Sarah Dexter-Smith, Executive Director for People and Culture (non-voting)

In attendance

Phil Bellas, Company Secretary
Nick Black, Chief Information Officer
Karen Christon, Deputy Company Secretary (minutes)

Observers

E Henderson, member of the public

76. CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting and noted the intention to align Board meetings to statutory decision points during the year, to avoid the need for additional meetings.

77. APOLOGIES FOR ABSENCE

Apologies for absence were received from Beverley Murphy, Chief Nurse/Deputy Chief Executive.

DECLARATIONS OF INTEREST

None.

78. REGISTER OF INTERESTS OF THE BOARD OF DIRECTORS

Board received the report, which provided the Register of Interests of the Board of Directors as at 31 March 2026, based on information drawn from ESR.

In discussion:

1. The following amendments were highlighted:
 - N Adetuberu – reference to the Associate Non-Executive Director at Newcastle Upon Tyne Hospitals NHS Trust, to be removed.

- M Burnham – interests to be added: Chair of APEX Collaborative Trust (voluntary role); Chair of NICE Committee on fatty liver disease (remunerated); and Advisor to the Why Not I Board (voluntary role).
2. H Crawford undertook to provide amendments following the meeting.
 3. J Preston noted there would be a change to his interests at the end of July 2026.

Agreed: Board receives and notes the Register of Interests of the Board of Directors as at 31 March 2026.

79. REPORT OF THE CHAIR OF AUDIT AND RISK COMMITTEE

J Maddison provided a verbal update from the special meeting of Audit and Risk Committee held on 22 June, to review the year-end reports prior to Board consideration. He advised:

- The Internal Audit Annual Report for 2025/26 by AuditOne included a reasonable Head of Internal Audit Opinion, a reduction from good the previous year. This reflected there had been two limited assurance reports related to clinical supervision and emergency preparedness, resilience and response, alongside findings from the independent assessment of the Trust's self-assessment against the Data Security and Protection Toolkit. AuditOne had focused on high risk areas and delivered 14 reports of which two provided substantial assurance, five good assurance, four reasonable assurance and two limited assurance. AuditOne had indicated that the reduction in opinion was marginal and had commended management's response to audit recommendations during the year.
- The 2025/26 External Audit Completion Report by Forvis Mazars LLP on the Trust's Annual Accounts 2025/26 had identified no significant control deficiencies and no significant weaknesses related to financial sustainability, governance, efficiency and effectiveness. One classification adjustment and two minor unadjusted items had been reported, none of which were considered significant. The auditor had indicated they would provide an unqualified audit opinion for 2025/26 and their final Annual Report would be available that week and would be presented to the Annual General and Members' Meeting later in the year.
- Committee had considered the final 2025/26 Annual Report and Accounts and had taken into account the assurances provided by the internal and external audit processes, previous committee scrutiny and information on the annual accounts and key transactions provided at a seminar for Non-Executive Directors. Committee had identified opportunities to enhance the format and accessibility of future reports and supported the recommendation that Board approve the 2025/26 Annual Report and Accounts, for submission to NHS England and Parliament.

He placed on record his thanks to L Romaniak and her team, P Bellas and his team and executive directors for all their work to prepare the Annual Report and Accounts and noted that the process had improved significantly compared to the previous year. The Chair also thanked staff for their efforts.

- Committee had reviewed the draft Quality Account 2025/26 to provide assurance on process, rather than content, which was the remit of Quality Assurance Committee. Opportunities to improve the format, accessibility and transparency of the document and to strengthen the description of the assurance process in future years, had been

highlighted. Committee recommended that Board approve the Quality Account for submission and publication.

- In respect of the Data Protection and Security Toolkit (DSPT) committee had considered a detailed report and supporting audit report from AuditOne, who had assigned a high level of confidence in the Trust's assessment. The submission would be 'approaching standards', principally due to issues related to emergency preparedness, resilience and response and committee discussed opportunities to accelerate improvement actions prior to the next submission. Committee recommended that Board approve the recommendations of the report.

80. ANNUAL REPORT AND ACCOUNTS 2025/26

Board received the report, which sought approval of the Annual Report and Accounts 2025/26, as recommended by Audit and Risk Committee.

P Bellas drew the Board's attention to the Forvis Mazars follow up letter to the Audit Completion Report 2025/26, circulated prior to the meeting. He also advised:

- The CQC disclosure on Page 42, would be amended to 'During 2025/26, the Trust has delivered the internal audit actions in relation to the CQC improvement plan, following the Trust-wide inspection in 2023'.
- The attendance of B Murphy at Mental Health Legislation Committee would be amended to 0 with the report to include a footnote that E Newbury, Associate Director of Nursing had attended on her behalf, as permitted under the terms of reference of the committee.
- A minor amendment to note 26.5 in the report related to the value of financial liabilities at the 30 March 2026 and other minor amendments to reflect final changes to the annual accounts, for consistency.

In discussion:

1. D Butcher recognised the significant work involved in preparation of the Annual Report and Accounts and noted that only minor amendments had been identified through the audit process, which reflected the quality of work undertaken.
2. A Smith also recognised the work undertaken alongside business-as-usual activity and indicated that early consideration would be given to the format, accessibility and presentation of future reports to ensure they were meaningful and accessible to service users and staff.

J Maddison welcomed the suggestion and noted that Audit and Risk Committee had proposed that the 2025/26 report be used to help inform the development in-year of a more accessible and effective format, rather than delay until preparation of the 2026/27 report.

Agreed: on the recommendation of Audit and Risk Committee, and subject to changes outlined and further matters being raised by the External Auditors, Board agrees to:

- i. Approve the Annual Report and Annual Accounts 2025/26*
- ii. Approve the Letter of Representation*
- iii. Authorise the signing off of:*
 - The Annual Report*

- *The Performance Report*
 - *The Accountability Report*
 - *The Remuneration Report*
 - *The Annual Governance Statement*
 - *The Statement on the Accounting Officer's Responsibilities*
 - *The Foreword to the Accounts*
 - *The Statement of the Financial Position*
 - *The Letter of Representation*
 - *Any certificates relating to the above as required by NHS England*
- iv. *Authorise the submission of the signed Annual Report and Accounts, and related documentation, to NHS England and Parliament.*

81. THE QUALITY ACCOUNT 2025/26

Board received the report, which sought approval to the Quality Account 2025/26, submission to the Department of Health and Social Care and publication.

Agreed: *Board approves the Quality Account 2025/26 and authorises its submission to the Department of Health and Social Care and approves its publication.*

82. DATA SECURITY AND PROTECTION TOOLKIT

Board received the report, which provided the outcome of the Data Security and Protection Toolkit (DSPT) CAF internal audit report that a 'standards met' submission would not be achieved for 30 June 2026 and proposed that a 'approaching standards' position supported by an action plan be submitted.

In discussion, assurance was sought on the proposed move to the national cyber security monitoring solution and any financial savings. In response, N Black indicated that the change would provide access to a national service for Security Information and Event Management (SIEM) with enhanced monitoring and incident response capabilities and would not result in a reduction in costs. It was anticipated that implementation would be completed in October 2026.

Agreed: *Board considers the report a suitable level of assurance in relation to the DSPT-CAF submission and agrees that –*

- i. *The Trust will submit the DSPT-CAF return by 30 June 2026 at 'Approaching Standards'.*
- ii. *The Trust will submit, as per the NHS England guidance, a time bound action plan to support movement towards a 'Standards Met' return.*
- iii. *The proposed monitoring of the action plan is sufficient to provide confidence:*
 - *External monitoring by AuditOne*
 - *Quarterly Monitoring by NHS England*
- iv. *Progress will be monitored via the Digital Performance Assurance Group, with formal reporting to Executive Directors Group in the bi-month Board Assurance Framework report.*

Meeting ended at 1.28pm

Board of Directors Public Action Log

RAG Ratings:

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

Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
12/06/2025	51 (3)	IPR - clinically ready for discharge	Resources and Planning Committee (RPC) and Quality Assurance Committee (QAC) to discuss delayed transfers of care and report into the Board	N Lonergan	Oct25 Apr26	Action closed June 26	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 attendance 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	Action closed	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. Aug26 update: BAF risks agreed by Board in June 2026 - action to be 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 June 26	Apr26 update: 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	Action closed June 26	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	Action closed June 26	April26 update: meeting arranged for 23-Apr-26 June26 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)	Clinical 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	Action closed June 26	Jun26 update: Propose that the action be closed and monitored through Quality Assurance Committee

**Board of Directors
Public Action Log**

**RAG
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Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
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	in progress	Feb26 update: Action owner amended to S Dexter-Smith. Action to be linked to an action raised at Council of Governors. Jun26 update: Revised completion date of August-26 to reflect the link to engagement with governors. Aug26 update: In progress - a three year cycle is proposed covering approx 90 sites, bringing in themes from service types across the visits and any other sources of information.
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. June26 update: the proposed terms of reference to be shared with Quality Assurance Committee in July 2026 Verbal update to be provided 13 August 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	Action closed	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 Aug26 update: The communications report has been reviewed and the Executive Directors Group report is now regularly shared with Governors
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	Action closed June 26	June update: Actions updated - propose action closed
09/04/2026	8 (5)	Strategic Objectives	Strategic objectives to be developed for 2026/27	A Smith	Aug-26	in progress	June26 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 revised 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 Board Assurance Framework (BAF) enabled the Board to see all necessary assurances	K Ellis A Pridmore	Aug-26 Oct-26	in progress	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. Aug update: Governance arrangements and BAF under review by the Interim Company Secretary; new processes will ensure that there are sufficient mechanisms to enable Board triangulation of data, assurance and risk, drawing from a range of sources (IQPR, Committee reporting). This will be in place from 1st October.

**Board of Directors
Public Action Log**

**RAG
Ratings:**

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	Action outstanding but no timescale set by the Board.
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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	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	Action closed June 26	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	Action closed June 26	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 MHL Trusts, benchmarking to be undertaken and shared informally with the Board	B Murphy	Jul-26	In progress	June update: this will be a manual process, we are considering a cross section of similar sized Trusts. A briefing note will be shared with the Board member July 2026. August update: Task in hand - board briefing will be provided once information is available
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 26	June update: The annual Positive and Safe report was presented at June QAC, within this assurance 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.
11/06/2026	47	Board Reporting	Report templates to be revised to ensure Board is able to track issues that require action or escalation across Board committees.	A Pridmore	Sep-26	In progress	August update: revised templates have been agreed and will be rolled out for use from Autumn 2026.
11/06/2026	49	Patient experience response rates	Board noted low 'feeling safe' response rates and agreed to receive an update on the findings of work that would be undertaken to understand the position and monitor trends.	H Crawford	Aug-26	Action closed	August update: On further exploration of the response numbers for the feeling safe measure, while response rates have shown a slightly falling trajectory in recent months, this is as measured against our own response rates. In May 2026 we received 1837 responses to our friends and family test with 94% rated as positive, and only 2% rated as negative. In terms of comparison against other NHS Mental Health Trusts we received the most number of responses nationally followed by 1775 responses and then 1308 responses. The percentage of those who report feeling safe is lower. We are working to understand the narrative that sits behind this and develop a performance improvement plan (PIP). The Board will be able to view high level detail of the PIP and track progress through the Integrated Quality Performance Report.

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For General Release

Meeting of:	Board of Directors
Date:	13th August 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:

<i>BAF ref no.</i>	<i>Risk Title</i>	<i>Context</i>
<i>N/A</i>		

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.

Clinical records communications

We have shared communications with colleagues about viewing clinical records through the all-staff briefing, intranet, staff Facebook group and desktop messaging. This reinforces the importance of appropriate access to clinical information and supports consistent understanding across the workforce.

Recognition and external profile

The latest edition of the Royal College of Psychiatrists General Adult Faculty magazine, iMind, includes three articles involving TEWV colleagues. These showcase co-creation, community mental health transformation and the integration of public mental health and sustainability interventions.

The edition also includes a GIRFT interview with Dr Neeraj Berry, which highlights positive developments and examples of good practice within TEWV.

Kedar Kale and colleagues presented at the National Medical Director's Roadshow in York on 23 July 2026. The presentation covered improvements in job planning, appraisal, medical education, agency reduction and medical workforce development, alongside community mental health transformation in Durham Tees Valley and North Yorkshire and York. The presentation was very well received, with requests from neighbouring organisations for TEWV to share learning with their teams.

TEWV has received the SAS Excellence in Development Recognition Silver Award. This recognises the Trust's commitment to the development, support and retention of Specialist, Associate Specialist and Specialty doctors, and reflects the leadership and culture of support that enables SAS doctors to thrive and contribute to patient care. The award was celebrated at a national ceremony attended by senior leaders from the Department of Health and Social Care, recognising innovation, commitment and good practice across the NHS.

CQC Inspection of CAMHS Community Services

CQC commenced an unannounced inspection of our CAMHS Community Services 14-16th April 2026, and we received the report on the 7th August 2026 sharing the Trust wide services received an overall rating of good. This reflects the

improvements made since the previous inspection in 2022, where we were rated requires improvement, and the commitment of colleagues to provide kind, compassionate and person-centred care for young people and their families.

The report shows the determination of our teams to improve care and make sure young people can access help more quickly, closer to home and in ways that support them to thrive in their families and communities. Inspectors recognised positive feedback from young people and carers, who described staff as kind, respectful, compassionate and supportive. The report also highlights improvements in staffing, responsiveness, multidisciplinary working and access to local support. We also recognise there is more to do. The report is clear we must strengthen the consistency of risk assessments, safety summaries and safety plans. We accept this and will act, with a continued focus on learning, improvement and providing safe, kind and person-centred care.

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 the information it needs to carry out its work effectively.

Executive Restructure

I am delighted to share that the review of our Executive Portfolio's, roles and responsibilities has been completed and have been agreed, there are some notable changes with the inclusion of Patient Experience and an Executive Director of Delivery, please find the revised structure:

1. Executive Medical Director
2. Director of Finance, Estates and Facilities
3. Chief Nurse/ Deputy CEO
4. Chief Operating Officer
5. Executive Director of Therapies and Patient Experience
6. Executive Director of People and Culture
7. Executive Director of Delivery

Lord Mann Review

The Lord Mann Review, published on 4 June 2026, examines antisemitism and other forms of racism across the NHS and healthcare regulatory system. The review makes recommendations to strengthen leadership and accountability, improve reporting and investigation processes, support staff and patients who experience racism, and embed anti-racist practice across the health system.

The government has accepted the recommendations, and NHS England has confirmed immediate actions including adoption of the NHS Race and Health Observatory's Seven Anti-Racism Principles, clearer staff standards, strengthened accountability, and anti-racism training for Boards and system leaders.

Digital transformation

Digital transformation continues to make good progress in supporting safer and more effective care. The Rio EPR implementation remains on track through mobilisation and planning, laying the foundations for a modern clinical record that will improve information sharing, productivity and the experience of patients and staff. Phase 1 of the Trust's Wi-Fi upgrade has been completed and verified across inpatient sites. Phase 2 has commenced and will extend improvements to Trust-owned community sites. The Trust has also strengthened information retention arrangements to support the Public Inquiry, ensuring records remain preserved and accessible.

Rio roadshows are planned across Trust sites and start in August to support engagement and readiness.

Community Mental Health Centres and Mental Health Emergency Departments (CAS)

I am delighted to share that we have been successful in our business case submissions for Darlington, Co Durham, Hartlepool and Roseberry Park

Regional leadership changes

Fiona Edwards has decided to leave NHS England for personal reasons following a period of ill health and after a 32-year career in the NHS. Her contribution to the region has been significant, including work with ICBs and providers on performance and strategic challenges, support to colleagues and development of the regional team structure. Sam Allen, Chief Executive of the Northeast and North Cumbria ICB, will join NHS England as interim regional director. She is well known across the region and has played a key leadership role since taking on the ICB role in 2022.

Triangle of Care

The Triangle of Care Annual Report confirms that the Trust has retained Star 1 and 2 Accreditation for 2026–27. The report recognises substantial progress in embedding a carer-centred culture and commends the scale and quality of the Trust's self-assessment process, which involved 195 wards and teams across all care groups. The report highlights strong organisational commitment to recognising carers as partners in care, with governance embedded within patient experience and quality structures. Following submission of the report, the Trust has been invited to showcase its annual report and achievements nationally at the Triangle of Care conference in London this October.

National leadership visit

NHS Confederation Chief Executive Sir Ciarán Devane and NHS England Chief Executive Sir Jim Mackey visited Roseberry Park Hospital to hear about the positive impact of service transformation in supporting our communities.

Introduction with the SoS

Yvette Cooper the new Secretary of State for Health and Social Care, was appointed on 20th July 2026 following James Murray's departure as Andy Burnham Prime Minister developed his new team.

Yvette Cooper is the MP for Pontefract, Castleford and Knottingley and was previously the Secretary of State for Foreign, Commonwealth and Development Affairs between 5 September 2025 and 20 July 2026. She was previously Secretary of State for the Home Department from 5 July 2024 to 5 September 2025.

She immediately inherits the Health Bill, currently at committee stage, the rollout of the Mental Health Act 2025, and ongoing NHS restructuring. Importantly, Yvette Cooper remains committed to the 10-year plan and the three shifts and is a supporter of devolvement to locality Health and Social Care and has recently announced the plans for community mental health centres and Mental health A&Es.

Committee Key Issues Report

Report Date: 13 August 2026

Report of: Audit and Risk Committee (ARC)

Date of last meeting:
22 June 2026

Membership Numbers: Quoracy met

This report provides a written summary of matters considered at the ARC special meeting held on 22 June 2026. Board received a verbal update at the meeting held on 25 June 2026.

Agenda: The Committee considered the following matters:

- Internal Audit Annual Report 2025/26 (including Head of Internal Audit Opinion)
- 2026/27 Internal Audit Plan
- External Auditors' draft Audit Completion Report 2025/26 including the draft Opinion and Letter of Representation
- In light of the above to make recommendations to the Board of Directors with regard to the approval of the Annual Report and adoption of the Annual Accounts for 2025/26.
- To recommend the Quality Account 2025/26 for approval by the Board of Directors
- Cyber Assessment Framework (CAF) – Aligned Data Security and Protection Toolkit (DSPT)

2a **Alert**

The Committee alerts the Board to the following matters:

- The Internal Audit Annual Report 2025/26 gave a 'reasonable' Head of Internal Audit Opinion, reduced from 'good' in the previous year, reflecting two limited assurance reports for clinical supervision and emergency preparedness, resilience and response (EPRR), alongside findings from the Data Security and Protection Toolkit (DSPT) assessment, and a reduction in substantial assurance audits compared to prior year.
- The Trust would submit the DSPT-CAF return as 'Approaching Standards', rather than 'Standards Met', with key gaps remaining around Essential Functions, Security Information and Event Management (SIEM) capability, and Information Asset Registers (IARs).
- The DSPT-CAF position was principally impacted by issues relating to EPRR. External Audit work was substantially complete; however any additional findings would be reported in a follow-up letter to the report considered by ARC.

2b **Assurance:**

The Committee draws the following positive assurances to the attention of the Board:

- External Audit identified no significant or material issues or control deficiencies and no significant weaknesses in relation to financial sustainability, governance, efficiency or effectiveness. They indicated that work was on track to meet the required deadline of 26th June 2026 and anticipated that an unqualified audit opinion would be issued.
- Committee reviewed and supported the Annual Report and Accounts 2025/26, taking account of internal and external audit assurances, previous committee scrutiny and a detailed accounts briefing and seminar discussion with Non-Executive Directors (and the lead Governor).
- Committee recommended for Board approval the Annual Report and Accounts 2025/26, Letter of Representation and related documentation for submission to NHS England and Parliament.
- Committee recommended for Board approval the Quality Account 2025/26 for submission to the Department of Health and Social Care prior to publication taking into account feedback from the Quality Assurance Committee which had reviewed the draft Quality Account 2025/26, considered the feedback received

		from Stakeholders, and provided assurance that it provided a fair, accurate and understandable description of the quality of the Trust's service quality with a robust preparation process. • AuditOne assigned a high level of confidence in the Trust's DSPT-CAF assessment of 'standards met'. • The Head of Internal Audit Opinion reflected that 90% of all audit recommendations, and 100% of 'high' risk rated recommendations due for implementation in-year had been implemented, with revised dates agreed for others. Internal Auditor independence, objectivity and effectiveness were considered to have been maintained. • The 2026/27 Internal Audit Plan was approved and aligned to strategic objectives, principal risks, regulatory requirements and the Board Assurance Framework.
2c	Advise:	The Committee wishes to advise Members of the Board that: • Committee requested some minor amendments to the Annual Report and Accounts, including to clarify specific wording on CQC improvement plan actions, Mental Health Legislation Committee attendance, and a minor adjustment relating to financial liabilities. • Committee requested that the versions of the Annual Report and Quality Accounts made available to the public be improved in terms of format, accessibility, transparency and usefulness for service users, staff and other stakeholders. It requested that actions commence earlier for 2026/27 to enact this for subsequent years. • Monitoring of progress on the DSPT-CAF action plan, which would be submitted to NHSE, would be through the Digital Performance Assurance Group reporting into Executive Directors Group via the Board Assurance Framework digital risk reporting process, and with assurances provided into Resources and Planning Committee for all digital BAF risks and ultimately to ARC in respect of CAF-DSPT. AuditOne would consider progress to implement agree actions through their annual cycle of work. • Committee emphasised the importance of maintaining close partnership working with AuditOne to keep the audit cycle on track. • Committee advised that the clinical supervision audit should not be delayed given its significance and link to quality assurance oversight.
2d	Review of Risks – Committee did not consider there were any new risks to add to the BAF.	
3	Actions to be considered by the Board: Following the receipt of satisfactory assurances, there are no specific actions to be considered by the Board. Recommendation: <i>i) That the report be received and noted</i>	
4	Report compiled by	John Maddison, Chair of Committee/Non-Executive Director, Liz Romaniak, Executive Director of Finance, Estates & Facilities and Donna Keeping, Corporate Governance Manager

For General Release

Meeting of:	Board of Directors
Date:	13 th August 2026
Title:	Board Integrated Quality & Performance Report as 30 th June 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 of Directors 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 is supported by two care group IQPRs, 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 next iteration of the Trust's new Integrated Quality and Performance Report (IQPR). This report incorporates a new section on national benchmarking data as previously agreed.

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, a reduction from 72% last month. Overall performance assurance for the National Quality Requirements and Mental Health Priorities, based on Statistical Process Control (SPC) analysis, shows **55%** of measures are meeting standard (previously 56%). 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)	• Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for • Compliance with ALL mandatory and statutory training • New unique patients referred
Decreased performance assurance (substantial to reasonable)	• Inpatients reporting that they feel safe whilst in our care

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 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 - At the end of June, 63 patients were clinically ready for discharge but unable to leave due to delays in external care placements and packages. These patients comprised 16.9% of all adult and older adult acute beds, reducing available capacity and contributing to longer lengths of stay. This equated to an average of 72 beds and an estimated £21.5m annual cost pressure. This continues to represent the Trust's most significant performance, quality and financial risk, impacting flow, length of stay and access, as sustained improvement remains dependent on wider system capacity and delivery of the Trust-wide improvement plan. Bed occupancy remains above the commissioned 85% level at c.91%, reflecting ongoing system constraints and average lengths of stay remain above planned levels in both adult acute/PICU beds (30.15 days) and older adult acute beds (74.27 days), demonstrating the continuing consequence of delayed discharge across inpatient pathways.

- **Action / Mitigation (Trust-Wide):** A focused 12-month improvement plan to reduce the number of patients clinically ready for discharge has been developed and received by Board of Directors with good assurance. Work is on track to deliver the actions for quarter 1, after which a meaningful set of targets to support continued improvement will be developed. The Trust has established a 'Hospital to Community' Programme Board to oversee transformation of inpatient provision and a reduction in hospital admissions. 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 October. 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 continues to exceed capacity across neurodevelopmental services and talking therapies resulting in sustained waiting time pressures. Within Early Intervention in Psychosis (EIP) and children's eating disorders the commencement of treatment is often delayed due to patient choice and delays in receiving information from referrers.

- **Action / Mitigation:** Active waiting list management and service-specific plans are being deployed across affected specialties to mitigate capacity issues, including the Services Requiring Additional Support process where required. Teams have been scheduling extra clinics, prioritising urgent cases, and closely monitoring waiting lists daily to prevent significant target breaches. The Trust has commissioned a 104-week wait recovery plan for CAMHS, which is exceeding plan, and a Performance Improvement Plan for children's eating disorder waits, which will be shared with Care Group Governance Group in July. In addition, monies over 3 years to reduce neurodevelopmental assessment backlogs have been negotiated with the North East & North Cumbria Integrated Care Board; a plan has been agreed and we are moving to the implementation of the plan in quarter 2 2026/26. We have also commenced early discussions with Humber & North Yorkshire ICB in developing a draft service specification and understanding the direction of travel the ICB would like providers to take. 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 - There were 1,189 restrictive interventions recorded in June, with special cause concern driven by a small number of patients with complex needs within DTVFCG ALD inpatient services. Whilst the number of interventions remain high, the type of intervention required has seen some positive change.

- **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, the provision of extra specialist staff to support the unit, and enhanced staff wellbeing support to maintain resilience including an agreed organisational development programme. The Trust commissioned an independent peer review by Mersey Care NHS FT to advise on any further improvement actions that could be taken. Executive oversight is in place, escalated plans have been agreed, and the ICBs and local authority are actively engaged. A more suitable placement has been identified. Early indications following reviews of the individualised care package have shown a change in the incident profile with reduced supine and increased arm holds showing that the level of restrictive intervention is reducing. Periods of leave are also being achieved.

People - Sickness absence rates - Sickness absence remains above target at 6.64%, and higher than the national 5.8% average for mental health trusts, contributing to workforce pressure and impacting service delivery.

- **Action / Mitigation:** A focused improvement plan to reduce Trust sickness levels has been developed. Work is on track to deliver the actions for quarter 1. 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, whilst currently better than planned, is conditional on delivering higher levels of recurrent efficiencies than are presently being achieved, which presents delivery risk. As of month 3, the Trust’s surplus of £0.3m is £1.90m better than planned. 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, most notably in respect of bank staffing. 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. A small number of inpatient packages present immediate financial risk; two patients are accommodated in Independent Sector PICU provision (£8k per day combined) pending the identification of available NHS inpatient accommodation; one further patient admitted for Assessment to our Adult Learning Disability unit requires additional staffing support, with discharge now pending identification of suitable ICB-commissioned community or Independent Sector provision. The Trust is working closely with partners to achieve the right patient outcomes and mitigate attendant financial risks.

- **Action / Mitigation:** The Trust has robust financial governance and efficiency plans in place. A dedicated Temporary Staffing and Overtime Group has overseen the rigorous control of agency staffing and overtime – requiring executive pre-approvals for agency shifts, implementing additional overtime approvals 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 May 2026 was £167k below budget. The patient package at our Adult Learning Disability unit has necessitated approval of significant additional day and night shift support from a specialist agency, with shifts representing significant price cap breaches. The Board has been briefed privately on related issues and actions. The Executive Directors Group has recently approved plans to target delivery of Bank cost reductions which represent an NHS England 2026/27 plan condition. 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 2027/28 onward; transformation governance and engagement work continues to strengthen delivery assurance. Combined, these actions indicate that most financial risks are being managed with a high degree of

control where driven by internal factors. External factors and pathway flow challenges represent significant financial risk and require continued weekly Executive oversight. 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 remains above standard overall; however, delivery is impacted by non-attendance and challenges in releasing staff, with a high proportion of unused training capacity. Performance assurance this month has increased from good to substantial, as we have no underlying areas of concern.

- **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 five (previously six) additional trainers (with all in place by August 2026). Furthermore, a new guide for managers to resolve training data issues has been published.

People & Workforce - *Staff experience and engagement* - Staff survey metrics remain below benchmark in some areas, with themes relating to flexibility and management practices.

- **Action / Mitigation:** “How We Work” and People Management programmes are underway to improve culture, engagement and leadership capability; benefits are emerging but not yet embedded.

Data Quality & Reporting Integrity for specific metrics – A detailed impact assessment is underway to determine the extent, implications and required actions associated with three data quality issues affecting contact activity reporting, the outcome of which will be incorporated within future reports. In addition, Board of Directors is advised that partial assurance remains in relation to inequalities and population health intelligence, with gaps in ethnicity recording continuing to limit full understanding of our data. Improvement actions remain in place to strengthen data quality and support more robust insight into health inequalities. Any further data quality issues impacting specific measures are limited and addressed within the body of the report.

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. Gaps in ethnicity recording and evidence of variation in access and outcomes limit the Trust’s ability to fully understand and address inequalities.

- **Action / Mitigation:** The Trust has initiated targeted work to understand and address inequalities, working through both clinical and governance channels. A working group identified via the sickness to prevention programme has been formed and will deliver webinars for staff engagement on ethnicity recording. New inpatient consultant

sessions focused on inequalities will begin in August 2026. A performance improvement plan is being developed to improve ethnicity recording by the care groups and a part time 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, and a Performance Improvement Plan has been commissioned to support the improvement of ethnicity recording. 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 June, 94% of patients rated their service experience as “very good” or “good”, a result above our 92% standard and well above the 87.8% national average, placing us among the top performers nationally (12th of 66 trusts). We aim to focus on increasing the number of people who are giving us feedback about their care. Similarly, carer-reported involvement has shown special cause improvement 80.4% of carers felt actively involved in care decisions, surpassing the 75% target. In July 2026 we were advised we were reaccruited with the 2 star award for the Triangle of Care, from the Carers Trust. On the safety front, no unexpected inpatient deaths or serious incidents (PSII) occurred in June. The number of moderate or severe harm incidents (25 in June) was also within expected range.

- 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 – safety and harm - Safety metrics remain within expected variation, with low levels of harm, 0 PSII reported, 1 medication-related moderate or severe harm incidents, and no unexpected inpatient deaths in June.

- Action / Ongoing Assurance:** Established governance processes continue to ensure timely review and learning from incidents, supporting safe care delivery.

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 zero, 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 Trust ambition is that all patients discharged from our services will receive a timely follow-up, and we review every patient to ensure safety. 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 – Retention, training and appraisal - Staff turnover remains below target at 9.8%, with sustained compliance in mandatory training (93.0%) and appraisals (90.3%), indicating improving workforce stability and capability. We are continuing to achieve the standard and have made significant progress in reducing the number of mandatory training courses below the 85% standard (6 courses below this month, compared to 5 the previous month).

- **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. Targeted support is in place for key face to face courses within the Care Group to reduce DNAs and improve compliance, with trajectories agreed at specialty and service level. 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 – June performance - The Trust's end of quarter one financial position provides generally positive performance assurance including in respect of delivering planned efficiency savings. At the end of quarter one the Trust's revenue performance was £1.90 m better than plan, reflecting effective financial management from the outset of the year. Whilst underlying agency staff expenditure is on a clear downward trajectory, specific care requirements at the Trust's Assessment and Treatment unit for Adults with a Learning Disability have necessitated the approval of non-compliant Band 3, price cap breaching agency shifts from Month 3. Whilst agency expenditure was £167k below budget at month 2, continuing a trend that has seen the number of agency shifts reduce by 57% over the last 12 months, costs at the end of the quarter are higher than planned and reflect £87k Bankfields Court and £458k subsidiary agency costs. The underlying position shows continued improvements resulting from 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:** Executive Directors have clear line of sight on financial performance and efficiency programmes to ensure delivery of savings with minimal impact on services. Resources and Planning Committee and the Trust Board in private receive finance reports at each meeting. Resources and Planning

Committee received good assurance from their review of performance and on progress to approve plans that target additional bank staff cost reductions from Quarter 2.

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. In addition, the Trust continues to perform positively against the Data Quality Maturity Index as shown within the Benchmarking section of the IQPR, providing further assurance that data quality governance, controls and improvement arrangements are embedded and effective across the organisation. 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.

National Oversight Framework - Q4 25/26 position – The Trust's NHS Oversight Framework position remains stable at Segment 2 for Q4 (ranked 15 out of 61 Trusts), with improvements across key domains resulting in a strengthened overall ranking and demonstrating continued progress against national expectations.

- **Action / Ongoing Assurance:** The NHS Oversight Framework will transition for 2026/27 to include an expanded and revised set of metrics. The Trust is aligning its Integrated Performance Approach and reporting arrangements to this updated framework to ensure continued oversight, early identification of risk, and sustained delivery against national expectations and we have commenced early work as an Executive team to consider the metrics and anticipated performance; this will be brought back to Board in September.

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.

Integrated Quality and Performance Report

For the period ending June 2026

Contents

Section Number	Section	Sub-Section	Page Number
1	Executive Summary	- Summary Headlines - Board Integrated Performance Dashboard - Board Integrated Performance Dashboard – Performance Assurance Ratings - Board Integrated Performance Dashboard – Performance & Controls Assurance Framework	3 4 5 7 8
2	Quality		9
3	People		27
4	Activity		36
5	Finance		39
6	Access to Services	- Waiting Times Dashboard – National Waiting Times Measures - Waiting Times Dashboard - Local Waiting Times Measures - Waiting Times <i>by Exception</i>	48 49 50 51
7	Population health, prevention and reducing inequality		57
8	Care Group	- Durham, Tees Valley & Forensic Care Group – Overview - North Yorkshire, York & Selby Care Group - Overview	62 63 65
9	National metrics	- NHS Oversight Framework - National Quality Requirements - Mental Health Priorities – Provider and System-wide Plans - Mental Health Priorities – System-Wide Plans	67 68 69 75 79
10	Benchmarking		92
11	Appendices	- Our Guide To Our Statistical Process Control Charts - Our Guide To Our Statistical Process Control Charts: Interpreting summary icons - Our Approach to Data Quality - Our Approach to Performance and Controls Assurance - Glossary	94 95 96 97 98 99

1. Executive Summary

Governance forum responsible:
Executive lead:

Executive Directors Group
Alison Smith, Chief Executive

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 remains mixed, with a number of measures rated as reasonable assurance due to continuing pressures relating to patient flow, workforce capacity, waiting times and restrictive interventions. Improvement plans are established and monitored through existing governance arrangements.

Patient flow: continues to be the Trust's most significant operational and financial pressure, with sustained high numbers of patients clinically ready for discharge impacting bed occupancy, length of stay, and service capacity, contributing to an estimated c.£21m annual cost pressure. Progress is being made with system partners; however, sustainable improvement remains dependent on wider health and social care capacity.

Sustained demand: continues to outstrip capacity, particularly across neurodevelopmental services, EIP, CAMHS and talking therapies; resulting in ongoing waiting time pressures despite active recovery plans and recruitment activity.

Workforce: remains a key enabler and constraint: sickness absence continues above target (6.56%) and impacts operational delivery in some services; however, positive improvements are evident in retention, mandatory training compliance and appraisal rates, demonstrating progress from workforce improvement initiatives.

Financial position: The Trust is ahead of plan at month 3, delivering a surplus £1.9m better than plan. Financial sustainability remains reliant on delivery of the £27.7m efficiency programme, reduced temporary staffing costs and improvements in patient flow, with discharge delays continuing to drive cost pressures.

Core quality and safety standards: remain strong, with high levels of patient (93.63%) and carer satisfaction (83.79%), improving clinical outcomes in Children and Young People's Services, no out-of-area placements and no unexpected inpatient unnatural deaths. However, Adult and Older People's patient-reported outcome measures remain below expected levels and require continued focus, and restrictive interventions within Adult Learning Disability services continue to require enhanced oversight.

Inequalities and data quality: partial assurance remains with gaps in ethnicity recording limit insight; there is evidence of variation in access and outcomes across population groups. Improvement actions are progressing, although measurable impact is not yet evident.

Service transformation and improvement: recovery plans remain in place across key pressure areas, including discharge delays, neurodevelopmental services, talking therapies and workforce, with several actions now delivering early signs of improvement.

NHS Oversight Framework: the Q4 position remains consistent (segment 2) with improvements in the domain scores for Access to Services and Patient Safety resulting in our highest ranking (15 out of 61) in the financial year 25/26.

Executive Summary - Board Integrated Performance Dashboard

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC			92.00%	93.95%	93.63%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	80.37%	83.79%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	73.66%	75.24%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	67.69%	67.29%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	44.99%	45.86%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	61.86%	61.52%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician	QAC			30.00%	28.02%	28.39%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	91.40%	88.71%	

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
9)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC				16.94%	16.94%	
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				0	2	
12)	The number of Incidents of moderate or severe harm	QAC				25	61	
13)	The number of Restrictive Interventions Used	QAC				1,189	3,311	
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				1	1	
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				360	986	

Please Note: 09 Clinically Ready for Discharge does not have a Data Quality Assessment rating as this is a new measure. The assessment has been completed and will be shared with Resources & Planning Committee for approval in July 2026.

Executive Summary - Board Integrated Performance Dashboard

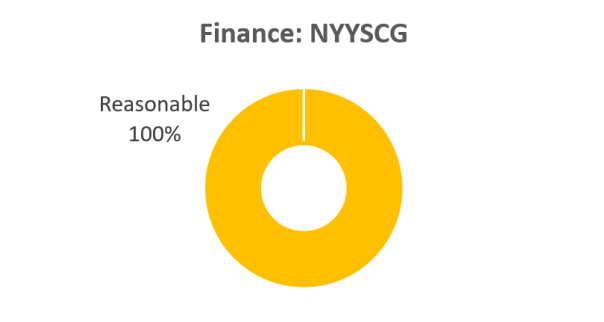
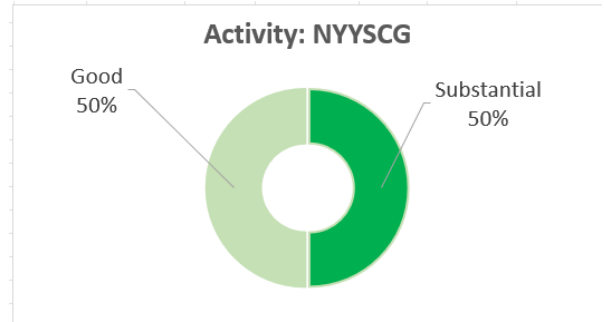
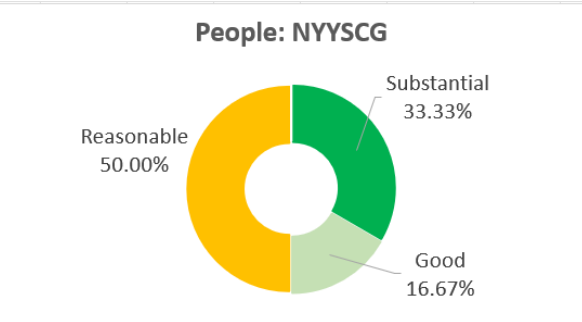
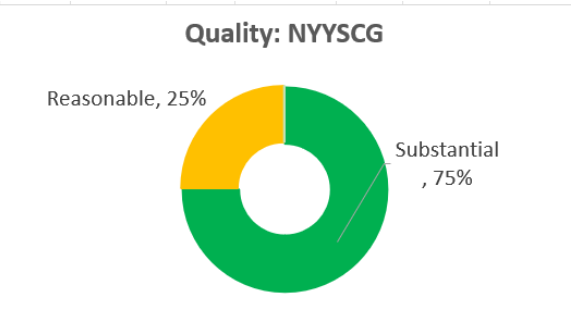
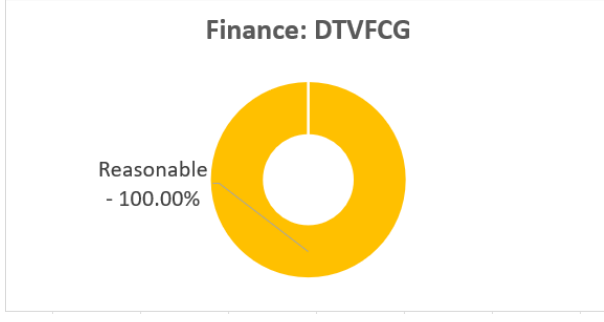
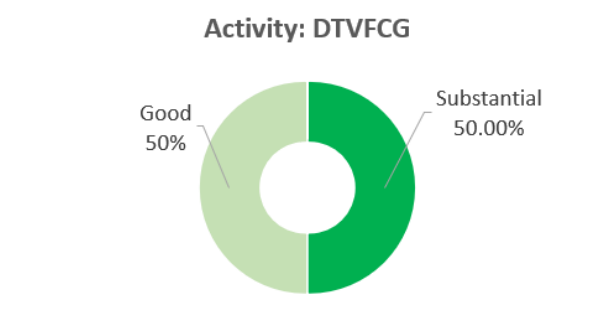
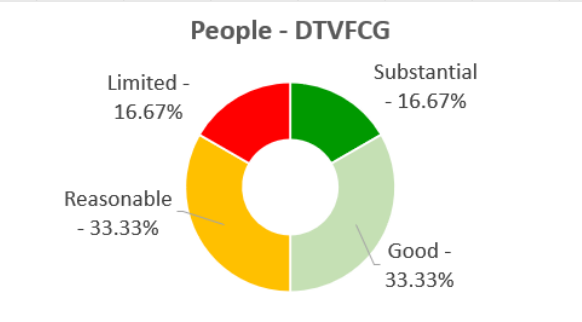
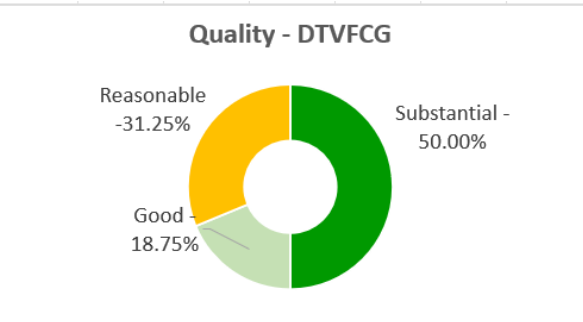
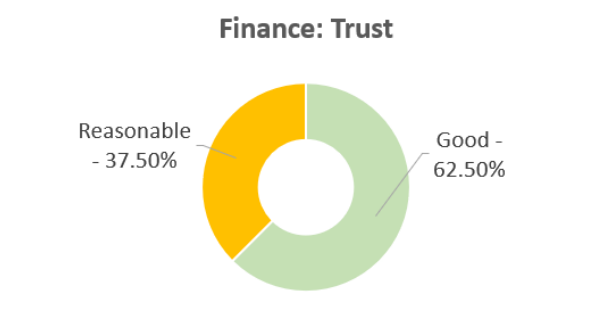
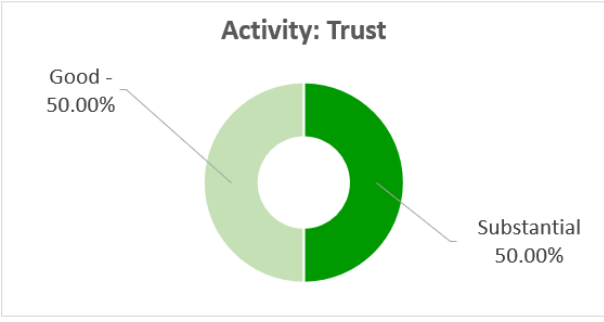
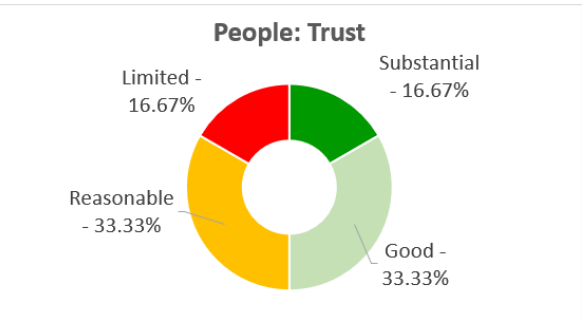
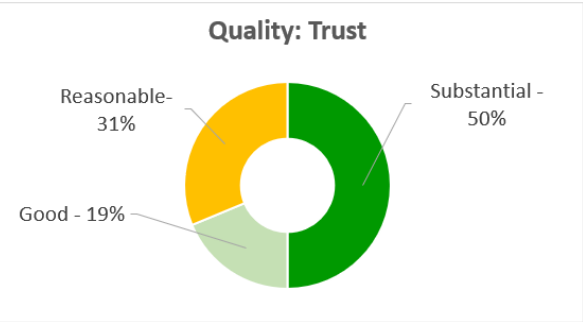
Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
17)	Percentage of staff recommending the Trust as a place to work	PCDC			60.00%	52.38%	52.38% (Apr-2026)	
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	59.78%	59.78% (Apr-2026)	
19)	Staff Leaver Rate	PCDC			11.00%	9.82%	9.82%	
20)	Percentage Sickness Absence Rate (month behind)	PCDC			5.50%	6.64%	6.56%	
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC			85.00%	93.01%	93.01%	
22)	Percentage of staff in post with a current appraisal	PCDC			85.00%	90.31%	90.31%	

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
23)	Number of new unique patients referred	RPC				8,659	24,049	
24)	Unique Caseload (snapshot)	RPC				62,619	62,619	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)	DQA Metric Rating
25)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	1,594,994	-258,815	
26)	Agency Expenditure	RPC	1,390,000	1,447,839	
27)	Agency price cap compliance	RPC	67.00%	29.59%	
28)	Bank Expenditure	RPC	3,464,000	4,111,051	
29)	CRES Performance - Recurrent	RPC	3,922,904	3,668,746	
30)	CRES Performance - Non-Recurrent	RPC	1,626,005	2,817,483	
31)	Capital Expenditure (CDEL)	RPC	4,006,000	2,971,551	
32)	Cash against plan	RPC	45,557,000	52,951,825	

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.



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

		Performance Assurance Rating			
Controls 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 <u>increased performance assurance</u> - CYP showing measurable improvement following treatment - patient reported <u>increased controls assurance</u> - CYP showing measurable improvement following treatment - clinician reported - Inappropriate OAP bed days for adults that are 'external' to the sending provider - PSII reported on STEIS - Unexpected Inpatient unnatural deaths reported on STEIS - Compliance with ALL mandatory and statutory training <u>increased performance assurance</u>	- Adults and Older Persons showing measurable improvement following treatment - clinician reported - Bed Occupancy (AMH & MHSOP A & T Wards) - Staff Leaver Rate - Staff in post with a current appraisal - Unique Caseload		
	Neutral	- Patients surveyed reporting their recent experience as very good or good - Uses of the Mental Health Act - New unique patients referred <u>increased performance assurance</u>	- Medication Errors with a severity of moderate harm and above - 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 <u>reduced performance assurance</u> - Adults and Older Persons showing measurable improvement following treatment - patient reported - Incidents of moderate or severe harm** - Staff recommending the Trust as a place to work - Staff feeling they are able to make improvements happen in their area of work	
	Negative		- Use of Resources Rating – overall - Cash balances (actual compared to plan)	- Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed) - Restrictive Intervention Incidents Used - Agency price cap compliance - CRES Performance – Recurrent - Capital Expenditure (Capital Allocation)	Percentage Sickness Absence Rate

2. Quality

Governance forum responsible:

Non-Executive Chair:

Executive Lead:

Quality and Assurance Committee

Marie Burnham (Interim Chair QAC)

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 June, **1256** 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, **1,180 (93.95%)** scored "very good" or "good".

There is no significant change at Trust and Care Group level; 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 level and Durham Tess Valley and Forensic Care Group. There is special cause improvement in North Yorkshire York and Selby Care Group and in Health and Justice within Durham, Tees Valley & Forensic Care Group.

National Benchmarking data

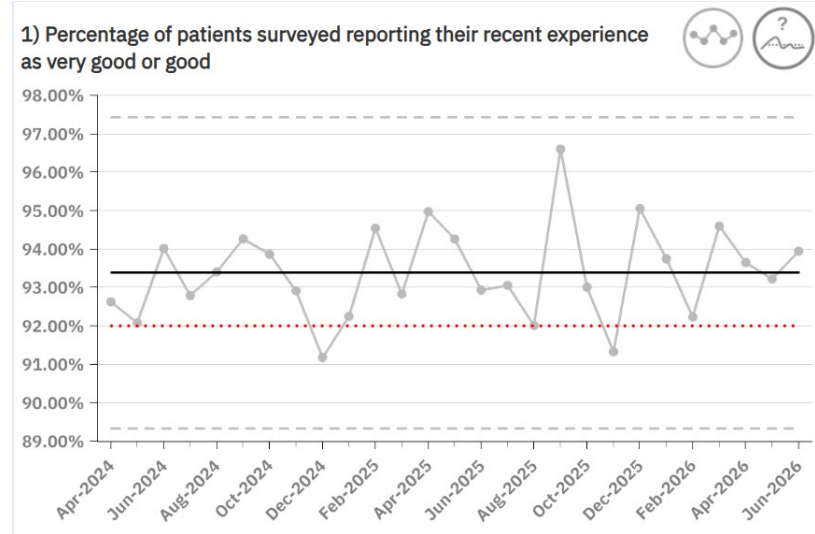
The latest National Benchmarking data (April 2026) shows the England average (including Independent Sector Providers) was **87.83%** and we were ranked **12** out of 66 trusts (1 being the best with the highest ratings), we were also ranked **1st** for total number of responses received.

Underlying issues:

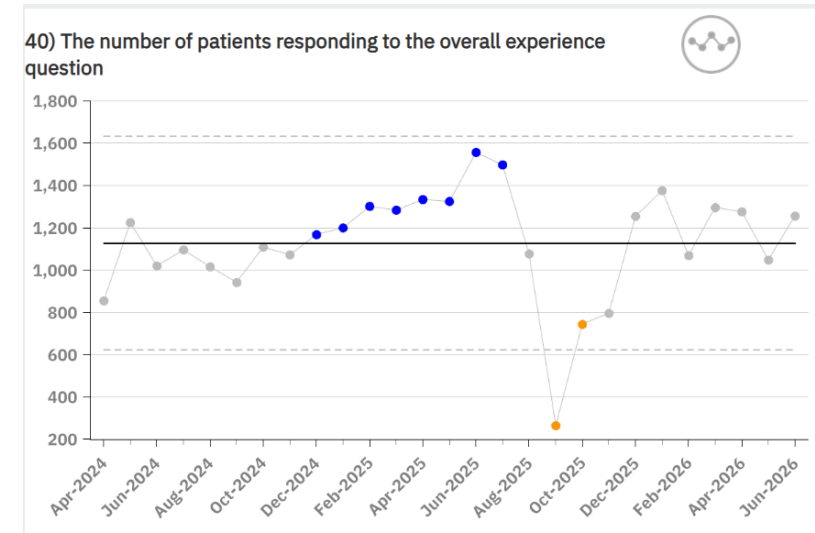
There are no underlying issues to report.

Actions:

- ALD General Manager (DTVFCG & NYYSCG) and ADON have undertaken a review to understand the reasons for the reduction in responses provided. This was completed by the end of June. **(Complete)** Whilst the reduction in responses may be impacted by the non-availability of an easy read version, investigations did not identify any specific issues, and the services are no longer reporting a concern.



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 June, **321** carers responded to the question in the carer survey: Question: "Are you offered choices about the care being provided?". Of those, **258 (80.37%)** scored "yes".

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

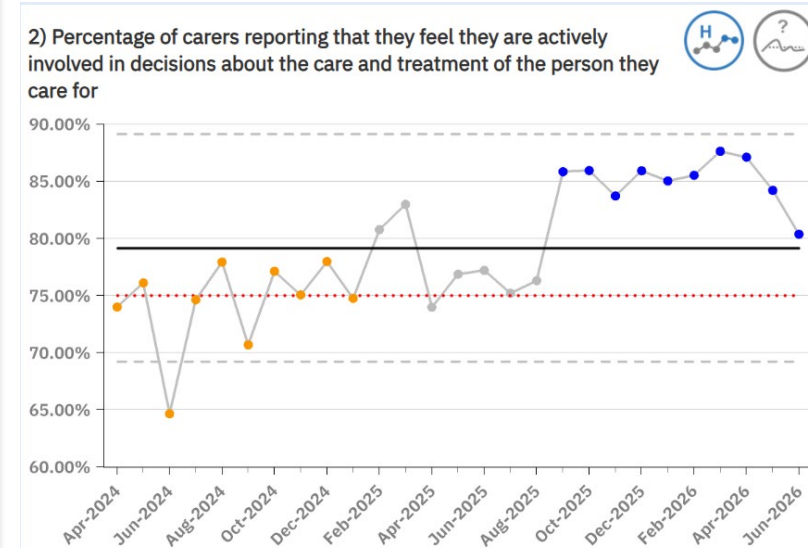
There is special cause concern in the number of patients who have responded to this question at Trust level, for Durham, Tees Valley & Forensic Care Group and for Children & Young Peoples Services in that Care Group. There is no significant change for North Yorkshire, York & Selby.

Underlying issues:

The number of carer responses remain a concern within CYP in DTVF.

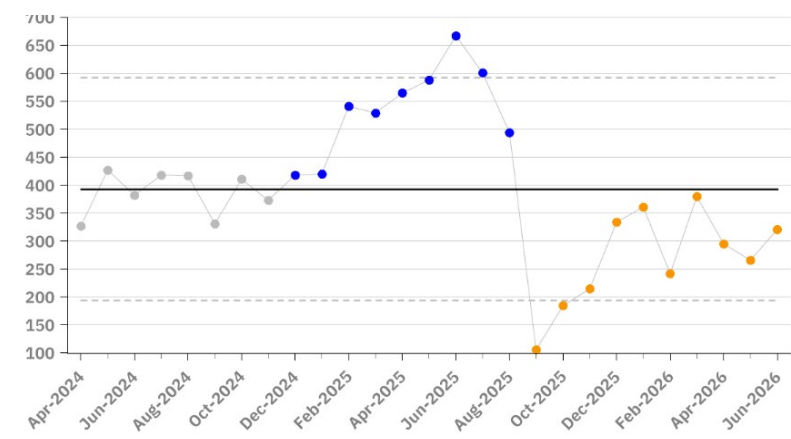
Actions:

- 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. The report was submitted on the 1st June 2026; feedback including recommendations is anticipated by the end of July 2026.
- DTVFCG CYPS were exploring alternative approaches to help increase response rates, including the potential use of a volunteers to contact patients post-appointment and actions were to be formalised by end of June 26. **(Not Complete)** This will be complete by the end of September.
- Work is underway by the Acting MHSOP General Manager in NYYCG to understand the reasons for the reduction in the responses provided. This will be completed by the end of June 26. **(Complete)** The service is no longer reporting a concern.
- DTVFCG MHSOP have developed an 'I Want Great Care' poster detailing a series of actions to improve response rates. The actions have been piloted in 1 area with positive results. Findings have been presented at team and service level meetings and response rates are being monitored through monthly quality and performance meetings. This was rolled out across all MHSOP services by end of June. **(Complete)**



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

2) The number of carers who gave any response to the question "Are you offered choices about the care being provided?"



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 June, **243** patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **179 (73.66%)** scored “yes”.

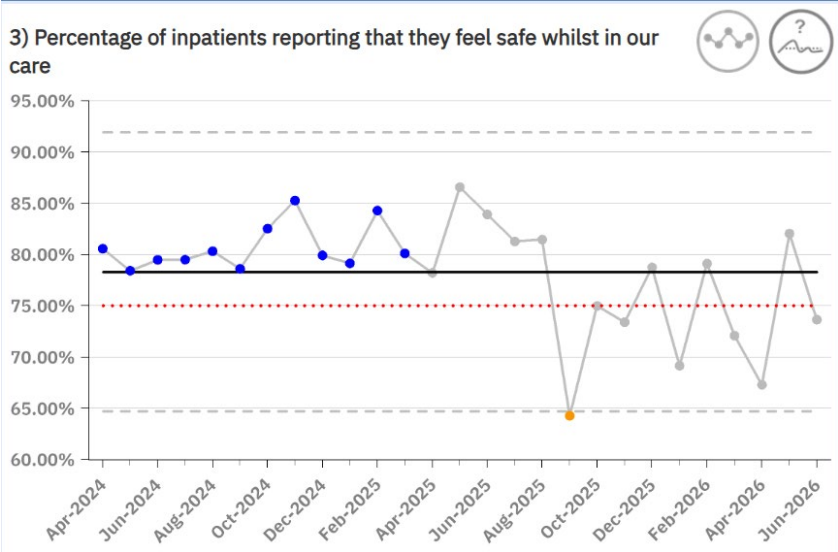
There is no significant change at Trust and Care Group level.

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

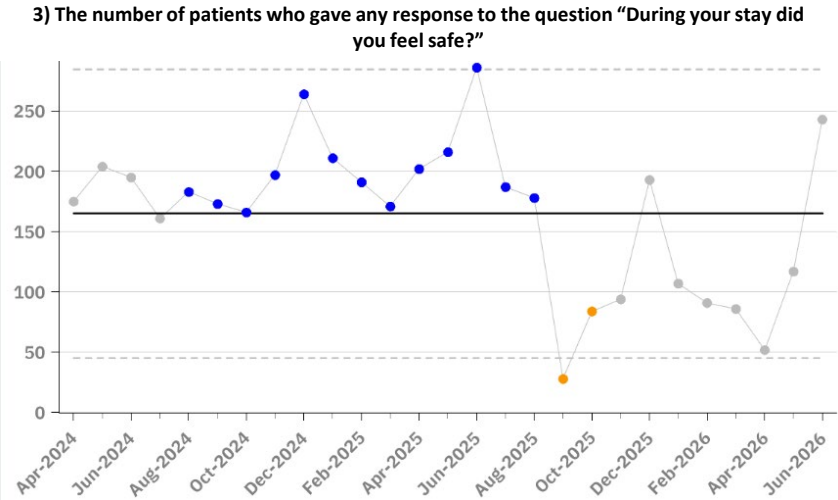
Underlying issues:
Within inpatient services the survey is currently only available for completion by using the QR code or using the standard paper-based surveys; the easy-read versions have not been developed.

Actions:

- The Patient & Carer Experience Team have worked with Learning Disabilities Services and I Want Great Care to develop easy-read paper-based surveys for rollout to inpatient services; iWGG are currently completing the final technical requirements, after which rollout can commence.
- AMH Modern Matrons were to outline plans to improve the number of responses to the June Integrated Care Group Governance meeting. **(Not complete)** This will now be shared with the AMH Urgent Care Specialty Governance in July 26.
- DTVFCG MHSOP have rolled out an ‘I Want Great Care’ poster detailing a series of actions to improve response rates across all MHSOP services by end of June. **(Complete)**



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



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

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

Background / standard description:

We are aiming for 35% of CYP showing measurable improvement following treatment - patient reported

What does the chart show/context:

For the 3-month rolling period ending June **882** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **597 (67.69%)** made a measurable improvement.

There is special cause improvement at Trust and Care Group level. Performance is above standard at all levels.

There is special cause improvement in the rate of paired outcomes for patients discharged at Trust and Care Group Level.

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

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 PHQ-9, GAD-7 and CORE-10.
- Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV

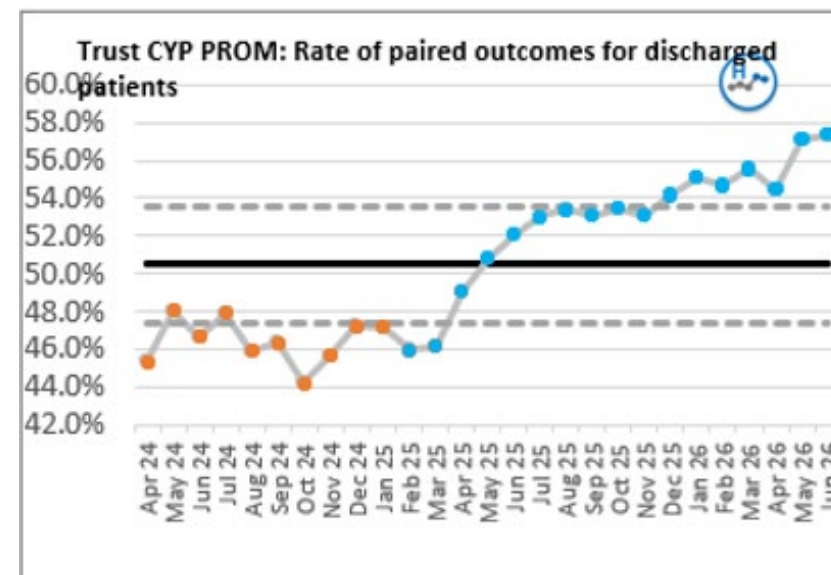
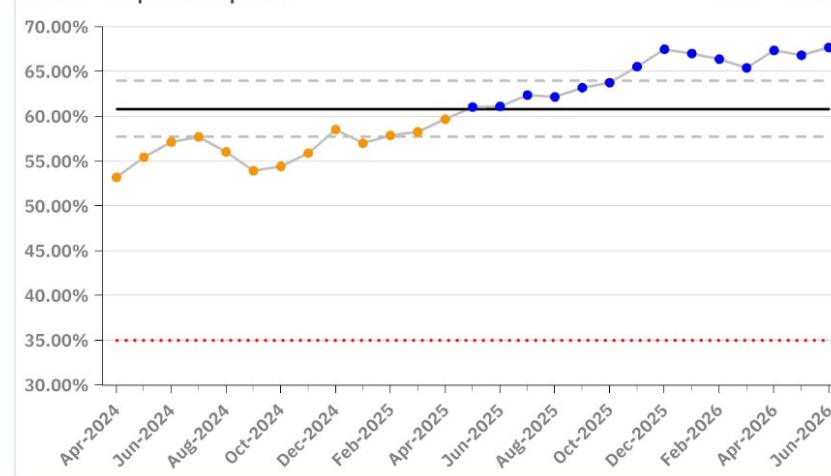
Actions:

- 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 include those patients that transition between CYP and AMH within the measure by the end of September 2026.
- Business Intelligence has effected the changes required to enable the flow of GBO from Cito into the measure in June 2026 (previously May). **(Complete)**
- Work has been undertaken 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 has been completed for the June 2026 report. **(Complete)**

To Note:

Following completion of the work to enable the flow of GBO (action above), the measure and rate of paired outcomes both reflect the improvements made by clinical services.

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



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 June **1407** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those, **633 (44.99%)** made a measurable improvement.

There is no significant change at Trust and Care Group Level. 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 and AMH in DTVFCG and AMH in NYYS CG.

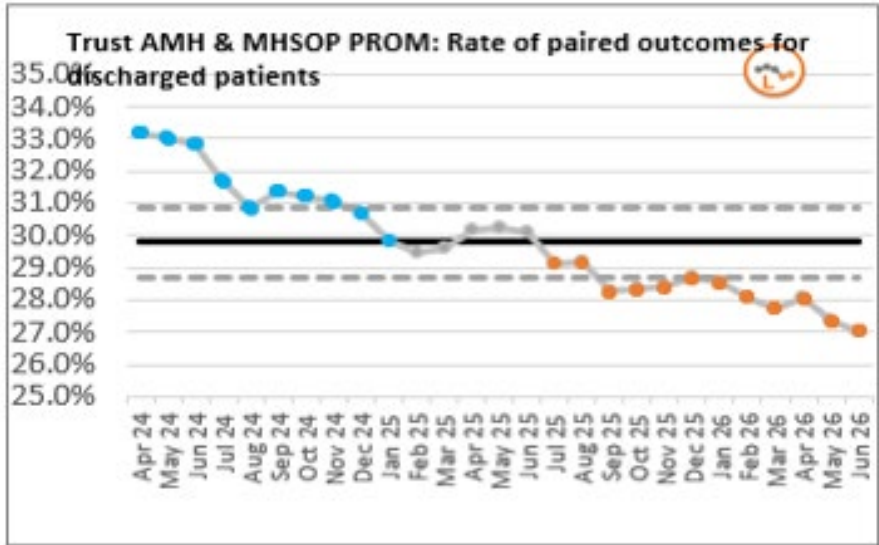
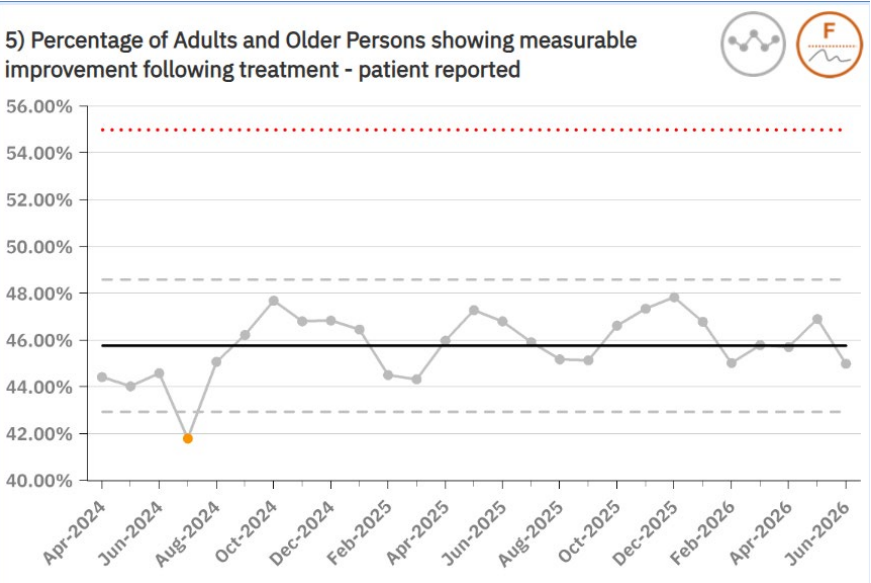
The accepted Patient Rated Outcome Measure is Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS).

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. The Data Protection Impact Assessment (DPIA) was discussed and approved at the Information Governance Group on the 17th June 2026. **(Complete)** See below action
- The pilot will commence on the 1st August (previously 1st July) and run for 6 months.
- Work has been undertaken 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 has been completed for the June 2026 report. **(Complete)** No material impact on the measure or rate of paired outcomes.



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 June **742** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **459 (61.86%)** made a measurable improvement.

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

There is special cause improvement in the rate of paired outcomes for patients discharged at Trust level and for Durham, Tees Valley & Forensic Care Group. There is no significant change within NYYSCG.

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

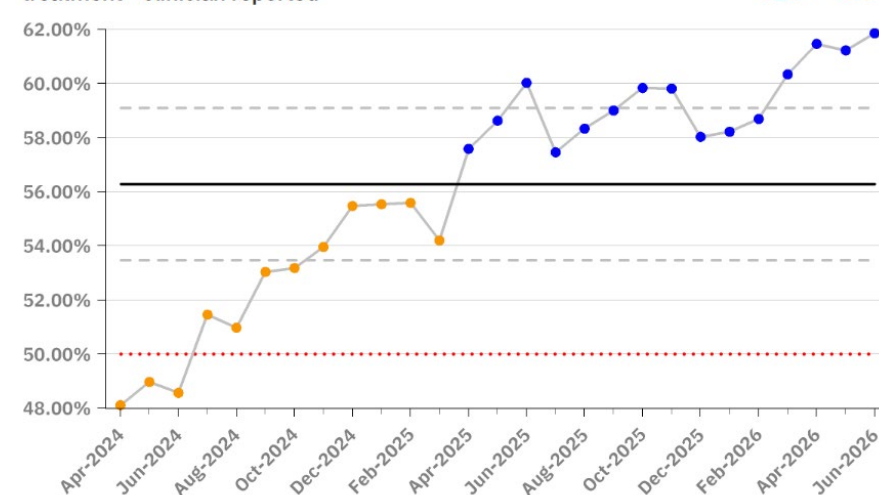
Underlying issues:

- Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV

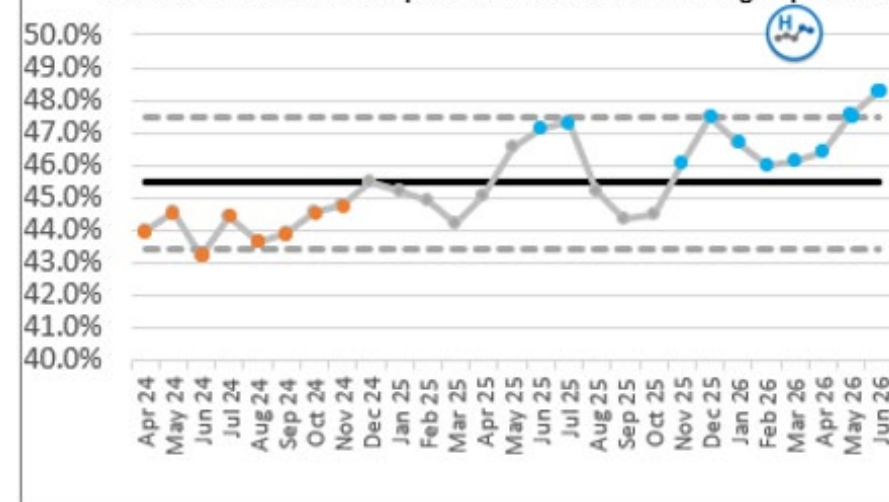
Actions:

- 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 has been undertaken 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 has been completed for the June 2026 report. **(Complete)** No material impact on the measure or rate of paired outcomes.

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



Trust CYP CROM: Rate of paired outcomes for discharged patients



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 June **2541** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those, **712 (28.02%)** made a measurable improvement.

There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group and speciality level. There is no significant change for North Yorkshire, York & Selby Care Group. There is special cause improvement within Adult Mental Health in NYSCG. Performance is above standard for Adult Mental Health in both Care Groups.

There is no significant change in the rate of paired outcomes for patients discharged at Trust level and within DTVFCG; however, there is special cause improvement for NYSCG. There is special cause concern for Adult Mental Health Services within NYSCG; however, special cause improvement for MHSOP within that Care Group.

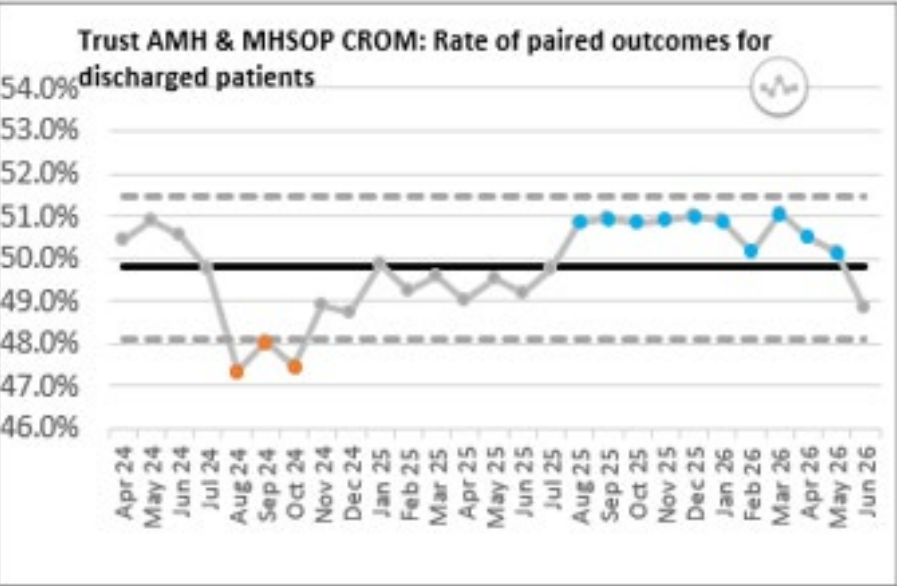
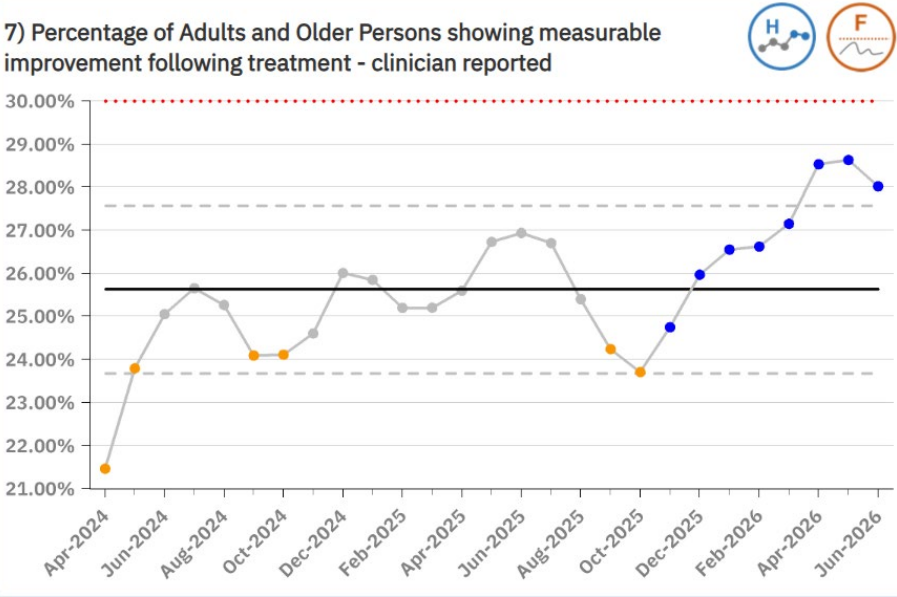
The accepted Clinician Rated Outcome Measure is Health of the Nation Outcome Scales (HoNOS).

Underlying issues:

There are no underlying issues to report.

Actions:

- Work has been undertaken 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 has been completed for the June 2026 report. **(Complete)** No material impact on the measure or rate of paired outcomes.



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 June, **11,160** daily beds were available for patients; of those, **10,200 (91.40%)** were occupied.

There is special cause improvement at Trust level and in Durham Tees Valley & Forensic Care Group and for Adult Mental Health in both Care Groups. There is no significant change within North Yorkshire York & Selby Care Group. Performance is above standard in both Care Groups across both AMH & MHSOP.

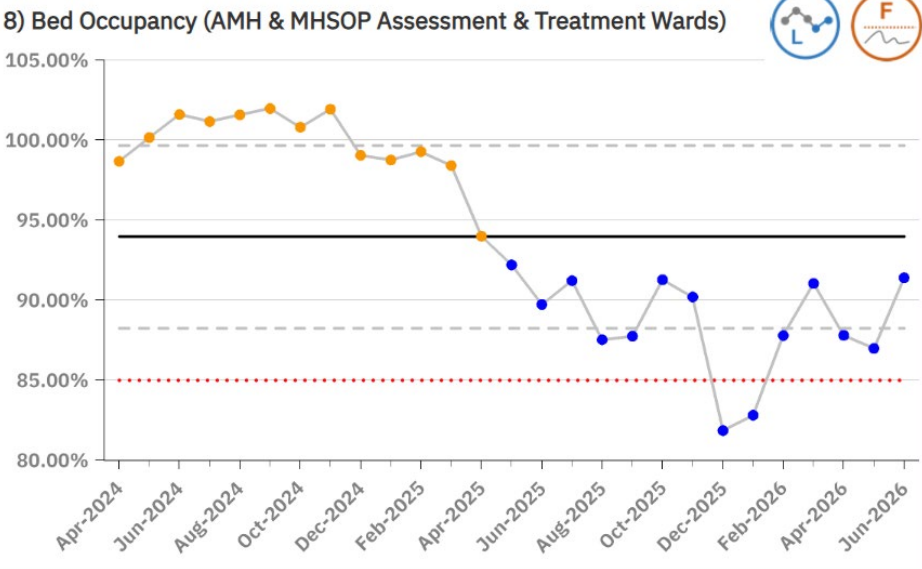
Quality Assurance Committee are fully sighted on bed occupancy and focussed on the potential impact on quality.

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 was to be presented to the Partnerships & Governance EDG in July 2026. **(Not Complete)** The full business base is in design phase with full costings to be developed by end of September. This will be shared with EDG by the end of October 2026.
- In NYYSO 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 for Harrogate and Ripon was developed and shared with the Combined Governance group in May **(Complete)**. For Scarborough neighbourhood centres, the business case to be developed and shared within the Trust by end of July 26.
- 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 and submitted to the Combined Care Group Governance group in July 26. Submission to the Partnership & Governance EDG will follow on completion.



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

What does the chart show/context:

As at the 30th June 2026, there were **63** adults clinically ready for discharge occupying adult MH, older adult MH or PICU beds, accounting for **16.94%** of our **372** acute beds open to admission.

There is special cause concern at Trust level and within Durham, Tees Valley & Forensic Care Group; there is no significant change in North Yorkshire, York & Selby Care Group.

At Trust level, patients classified as Clinically Ready for Discharge equated to an average of 72.3 beds (34.2 Adult, 4.9 PICU and 33.2 Older Adult beds) across the whole of June, with an associated cost of c£1.74m. Of the cost, c£0.72m relates to Adult, £0.25m relates to PICU and c£0.77m relates to Older Adult. The estimated full cost (not all releasable) of patients classified as Clinically Ready for Discharge over the last 12 months is £21.53m

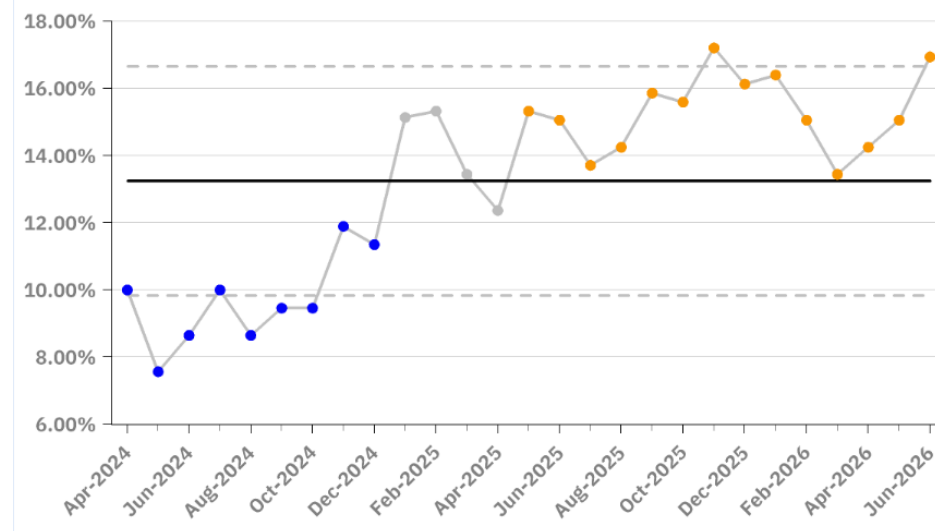
Underlying issues:

- Availability of specialist packages of care and specialist placements.

Actions:

- Interim Care Group Managing Director to present the Trust-wide Clinically Ready for Discharge Improvement Plan to the Quality & Performance EDG in July 2026.
- Both care groups are working closely with system partners to strengthen a system wide approach to supporting those clinically ready for discharge:
 - The CRFD baseline assessment was presented to the June Hospital Community Board. **(Complete)**
 - Piloting of the new ways of working for the Tees Valley transfer of care hub commenced in March 2026 and the first evaluation was completed at month 3 (June 2026). **(Complete)** This will be presented to the Combined Care Group Governance in September (previously July 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)** It is anticipated the job description will have been completed and evaluated by the end of August 2026.
 - In North Yorkshire recruitment continues for a discharge liaison officer to support patient discharge within adult beds at Cross Lane Hospital following unsuccessful interviews in June 2026. The post will be readvertised by the end of June. **(Not complete)** The job description will be reviewed by the job evaluation panel in July, following which the post will be readvertised in August.
 - Within York, the Trust participated 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. **(Complete)** See following actions

9) Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot



Actions continued:

- By the end of July, Acting General Manager will establish an enhanced service manager level joint escalation process with the Local Authority Service Manager to strengthen discharge processes and support patients clinically ready for discharge flow.
- MHSOP Modern Matrons with Social Care and ICB colleagues to develop a standardised Section 117 checklist to improve structure, accountability, and oversight within weekly patients' clinically ready for discharge meetings, supporting more effective and timely discharges. This will be developed by end of July 2026.
- By the end of July 2026, Acting General Manager to initiate a Social Care Link Worker pilot within Rowan Lea. The link workers will be integrated from the point of admission to support early identification of social care needs, facilitate timely assessment and interventions and reduce delay in transfer of care and discharge planning. The pilot will be expanded to Foss Park MHSOP wards by end of October.

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 June 0 days were spent by a patient in a bed away from their closest hospital.

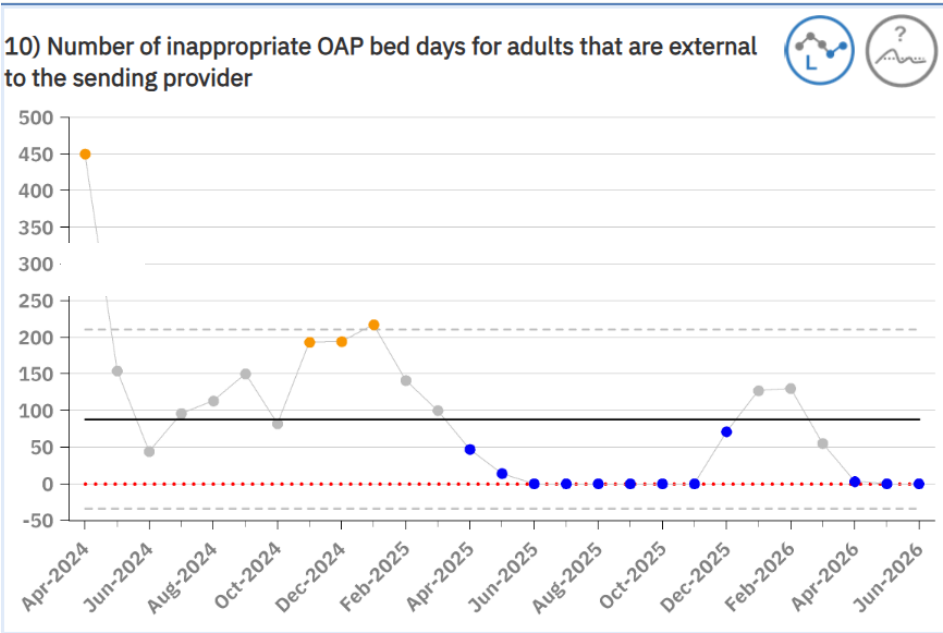
There is special cause improvement at Trust level and for North Yorkshire York & Selby Care Group level; there is no significant change for Durham, Tees Valley & Forensic Care Group.

Underlying issues:

There are no underlying issues to report.

Actions:

There are no specific improvement actions required.



The following table provides more detailed analysis by speciality for the four key bed related metrics.

- Within Adult Mental health, there is little variation for bed occupancy and ALOS across the two Care Groups; however, there is significant variation for CRfD.
- Within Mental Health Services for Older Persons, there is significant variation in bed occupancy and CrfD and some variation in ALOS across the two Care Groups

Adult Mental Health Services - June 2026

	Bed Occupancy	CRfD	OAPs	ALOS
Trust	85.96%	13.78%	0	30.15
DTVf	85.64%	15.34%	0	30.69
NYYS	86.77%	9.68%	0	29.04

Mental Health Services for Older People - June 2026

	Bed Occupancy	CRfD	OAPs	ALOS
Trust	99.73%	21.77%	0	74.27
DTVf	101.50%	12.09%	0	73.30
NYYS	96.85%	37.50%	0	76.41

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

What does the chart show/context:

0 Patient Safety Incident Investigations (PSII) was reported on the Strategic Executive Information System (STEIS) during June.

There is special cause improvement at Trust level, indicating a sustained reduction in Patient Safety Incident Investigations reported on STEIS. Whilst positive, the measure is characterised by very low numbers, meaning relatively small movement in the data can result in changes to variation. No significant change is observed within either Care Group.

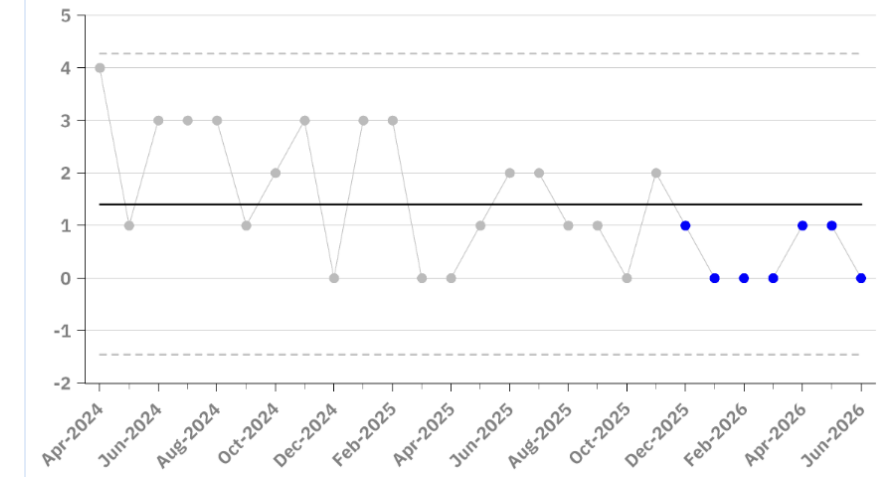
Underlying issues:

- 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 PSII.

Actions:

- Testing of the new AAR process was expanded across all NYYS AMH community and specialist teams from May 2026 **(Complete)**.
- Testing of the new AAR process will be expanded to all DTVF AMH Planned Care teams from the end of July 2026.
- A structured regroup is planned for September 2026 to ensure learning is captured consistently and refinements are coordinated during the testing phase.

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



12) The number of Incidents of moderate or severe harm

What does the chart show/context:

25 incidents of moderate or severe harm were reported during June.

There is no significant change at Trust and Care Group level.

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

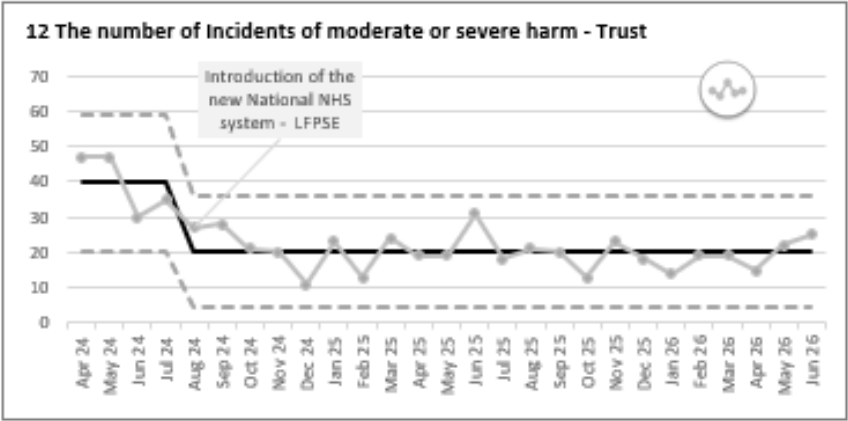
As incidents are reviewed, the severity could be reduced or increased (severity is usually reduced).

Underlying issues:

There are no 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.

13) The number of Restrictive Intervention Used

What does the chart show/context:

1189 types of Restrictive Interventions were used during June.

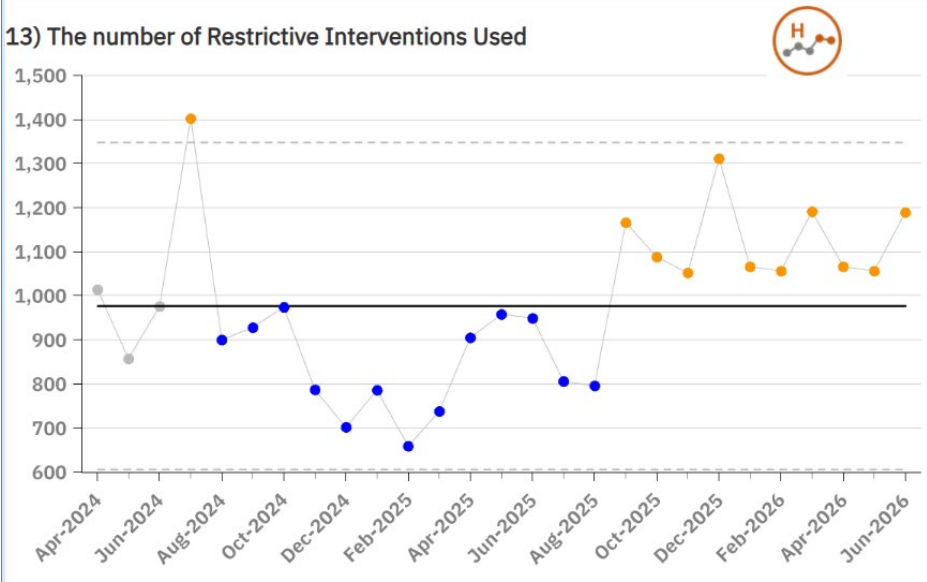
There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group and for Adult Learning Disabilities within that Care Group; there is no significant change for North Yorkshire, York & Selby. There is special cause improvement for Health & Justice within Durham, Tees Valley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

Underlying issues:

- In DTVFCG ALD there are a high number of interventions used for a small number of patients presenting with complex needs.

Actions:

- The Positive and Safe Lead & Specialist Practitioners continue to provide intensive support to one patient in terms of implementing the Positive Behavioural Support plan. An options appraisal has been completed, and the service are currently exploring options for a rapid and safe transfer to another hospital or alternative provision.
- 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. Actions are progressing and weekly oversight from the Executive Board has been implemented.
- The ward is receiving additional support from the national HOPE(s) team from Mersey Care NHS Foundation Trust. **(Complete)**



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:

1 medication error was recorded during June.

There is no significant change at Trust and Care Group level.

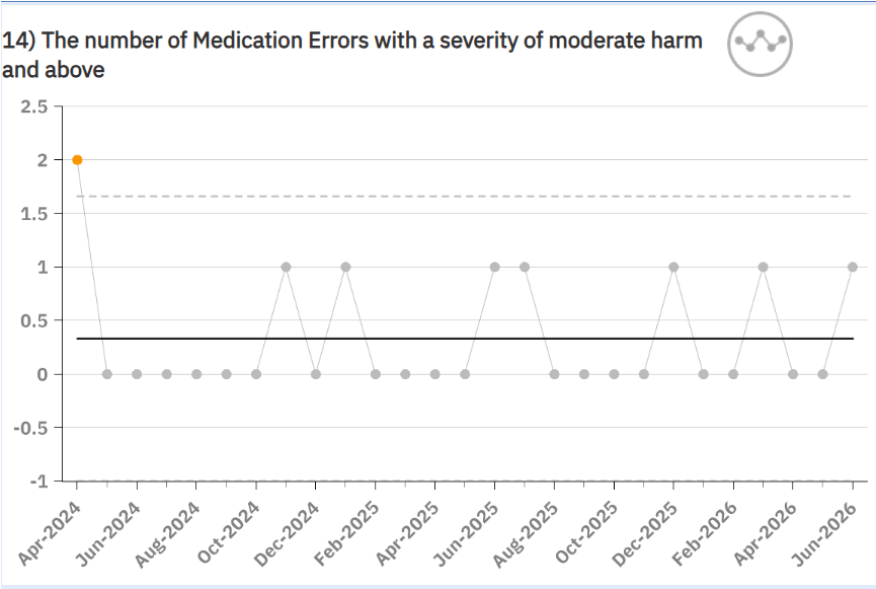
As incidents are reviewed the severity could be reduced or increased (usually reduced), which would then be refreshed in future reports.

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 June.

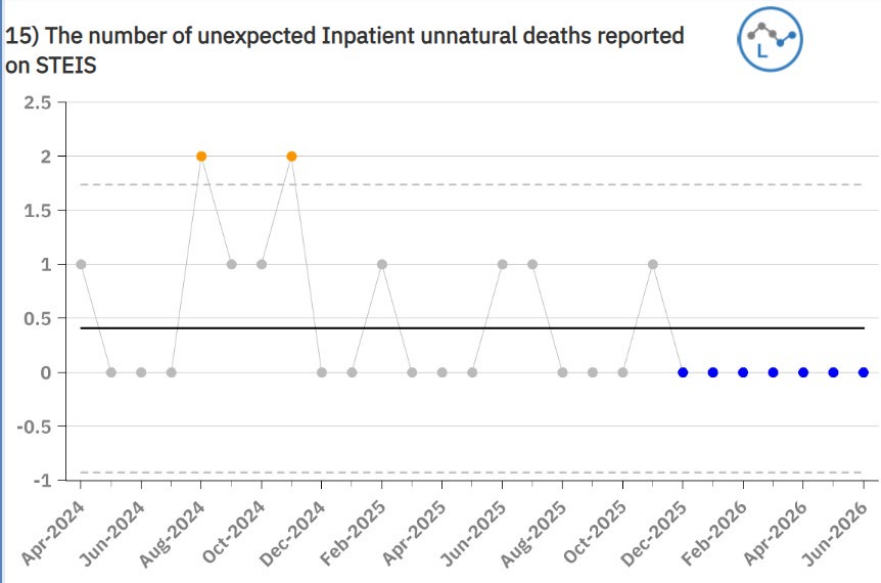
All unexpected and unnatural deaths in inpatient wards are immediately reported in this data. Once the cause of death is confirmed, where necessary the data is refreshed. Therefore, on occasion we might be over reporting the number of unexpected, unnatural deaths.

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 **360** uses of the Mental Health Act during June.

There is no significant change at Trust and Care Group level and within for Durham, Tees Valley & Forensic Care Group. There is an unexpected low shift in uses in ALD in North Yorkshire, York & Selby Care Group, the service has confirmed this is not an actual concern.

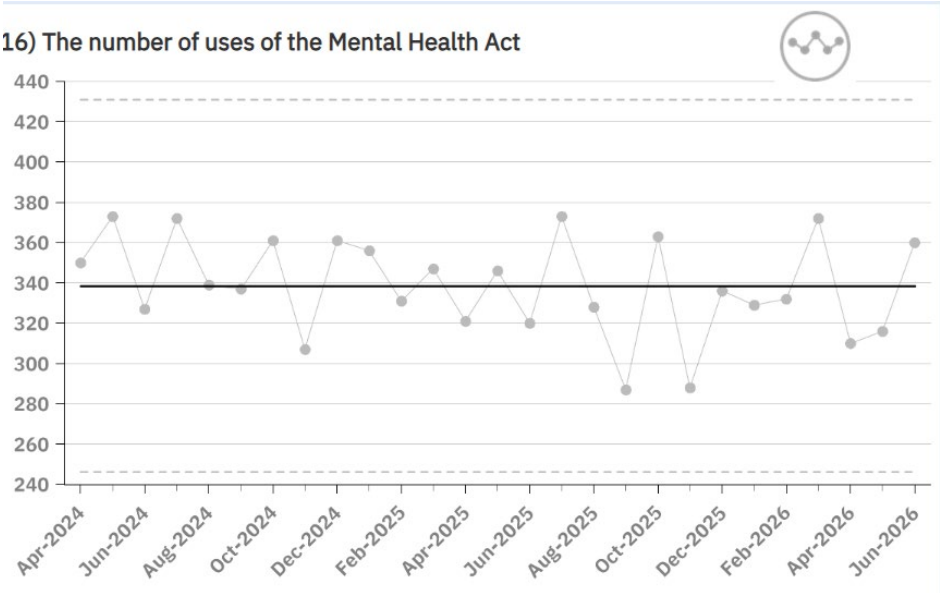
Initial findings on the national Mental Health Act data 2024/25 were shared with the Mental Health Legislation Committee in May 2026. Data indicates that detention rates for Black/Black British people are similar to national averages and are around twice those of White people locally, with Black/Black British women disproportionately affected. The Committee 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.

Underlying issues:

- Analysis of the national Mental Health Act data 2024/25 identified significant data quality limitations, 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.
- Analysis of the 2024/25 national Mental Health Act data shows some areas of inequality in our detention rates.

Actions:

- The EDI officer vacancy to support Patient & Carer Race Equality Framework delivery was advertised in July (**Complete**). Interviews scheduled for early August 2026.
- The Sickness to Prevention programme board will lead some staff engagement work to support and strengthen ethnicity data recording. A task and finish group has been established, and webinars will be in place by the end of September 2026.



3. People

Governance forum responsible:

Non-Executive Chair:

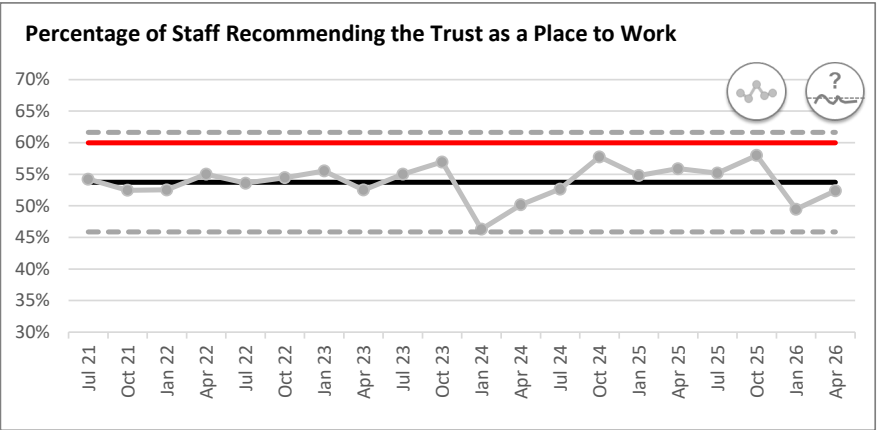
Executive Lead:

People and Culture Committee

Roberta Barker

Sarah Dexter-Smith

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



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

Background / standard description:

We are aiming for 60% of staff to recommend the Trust as a place to work

What does the chart show/context:

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. The latest data at Care Group and Corporate Directorate level are shown on the following slide.

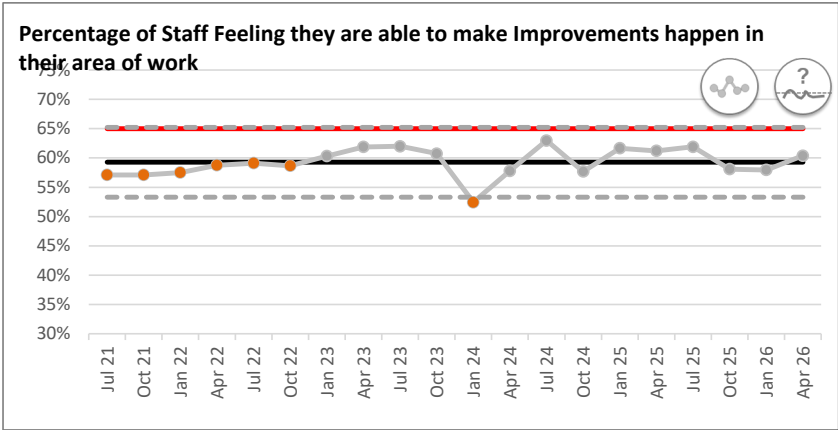
The NHS Staff Survey Benchmarking report 2025, shows the “best result” was 76% and the “average result” was 62% for similar organisations.

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

18) Percentage of staff feeling they are able to make improvements happen in their area of work



Background / standard description:

We are aiming for 65% of staff to feel they are able to make improvements happen in their area of work

What does the chart show/context:

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. The latest data at Care Group and Corporate Directorate level are shown on the following slide.

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

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 latest meeting took place on 8 July 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; the next cohort will start in July 2026. The annual review of the programme will be undertaken in August 2026. The remaining elements of the NHS England Expectations of Managers Programme will be introduced as bitesize sessions later in the year.
 - 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. The first Trust-wide meeting to review how we capture flexible working centrally; explore all types of flexible working; and to ensure that services are not negatively impacted by agreed flexible working was held on the 7th July 2026. The next meeting is scheduled for August 2026.
- The Staff Experience Group triangulates soft intelligence and staff experience data across the organisation to support a compassionate, inclusive working culture. The group is focussing on 3 areas: meaningful use of staff survey information, application of flexible working, hybrid working and reasonable adjustments and finally an understanding of violence and aggression towards staff.
- All operational services Trust-wide have a Staff Survey Improvement Plan and are working toward the Culture of Care Local Change Programme.

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 7,416.63 staff in post 728.03 (9.82%) had left the Trust in the 12-month period ending June 2026.

There is special cause improvement at Trust level and for a number of Directorates. There is special cause concern for Corporate Affairs and Involvement, Estates & Facilities Management, People and Culture, Therapies, 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. (please see below action).

Underlying issues:

- A team within Corporate Affairs & Involvement is undergoing organisational change, which has impacted staff leaver rate.

Actions:

- Corporate Affairs & Involvement has been identified as a Service Requiring Additional Support. A Recovery Plan is in place, including supportive oversight at Executive level.



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 **232,706.27** working days available for all staff during June 2026 (reported month behind); of those, **15,446.19 (6.64%)** days were lost due to sickness.

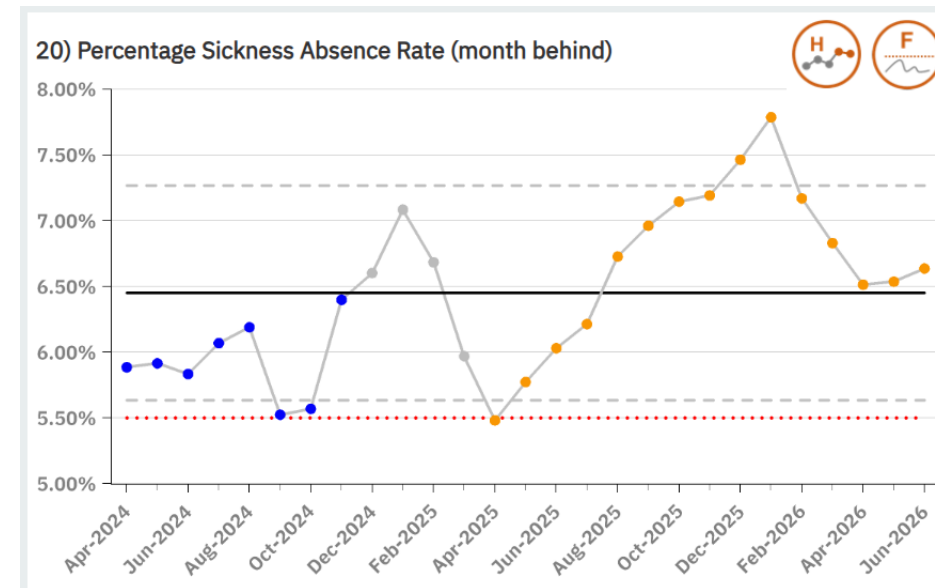
There is special cause concern at Trust level, and for both Care Groups, Corporate Affairs & Involvement, Children & Young Peoples Services, Health & Justice, Management and Mental Health Services for Older People within Durham Tees Valley & Forensic Care Group. There is also special cause concern for North Yorkshire, York & Selby Care Group and Children & Young Peoples Services within NYYCG; however, the directorate continues to report below standard.

National Benchmarking for NHS Sickness Absence Rates published 25th June 2026 (data ending March 2026) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.75%** compared to the Trust mean of **6.45%**, with the Trust ranked 37 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).
- There is a high level of sickness within Health & Justice Services due to stress and anxiety.
- Whilst statistically not a concern, there is a continual increase in sickness and work-related injuries in DTVFCG ALD service.

Improvement actions are detailed in the following slide



20) Percentage Sickness Absence Rate *continued*

Actions:

1. The Strategic Lead for Health & Wellbeing completed 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. The pilot will now start in August (previously July 2026) in Secure Inpatient Services, Children & Young Peoples Services and NYYS CG Mental Health Services for Older People.
2. All People Partners undertook Coaching Training to support managers in regular reviews of sickness absence by the end of June 2026 **(Complete)**
3. 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. To date 48 meetings have taken place; 31 in DTVFCG and 17 in NYYS CG. The pilot will continue with existing teams for a six-month period to enable robust monitoring and evaluation and meetings will be expanded to a number of additional NYYS Adult Mental Health teams and Secure Inpatient Services wards from July. In addition, meetings are underway within People & Culture. Review activity has strengthened organisational oversight of sickness management, with repeat reviews providing assurance that managers are implementing agreed actions and embedding consistent attendance management practices.
4. 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. 40% of line managers have been trained to date.
5. To review the existing Attendance Management policy (by end of January 26) **(On Hold)** The review has been undertaken; however, it has been agreed with staff side to pause a full review of the procedure, pending the piloting of the approaches noted above.
6. Head of Inclusive Culture has explored how socio-deprivation indicators can be used to influence our plan by the end of June 2026. **(Complete)** The findings did not provide any clear correlation; therefore, the exercise will be repeated in 6 months time.
7. The bereavement and compassionate leave provisions have been reviewed and will be submitted for full consultation in July 2026. Revision is expected by the end of September 2026
8. Health & Justice Services have developed a service improvement plan, which is managed through the Service Improvement & Development Group and Combined Governance. Of the 14 identified actions, 8 have been completed; the remaining 6 actions will be completed by 30th September 2026.
9. **NEW** The DTVFCG ALD service has been identified as a Service Requiring Additional Support and a Recovery Plan is in place, including 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. Actions are progressing and weekly oversight from the Executive Board has been implemented. Agency staff are being utilised to support substantive staff.

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:

158,500 training courses were due to be completed for all staff in post by the end of June. Of those, **147,424 (93.01%)** were completed.

There is special cause improvement at Trust level and for most Directorates.

As at the 30th June 2026, the Medical directorate and Trust Financing (Bank Staff) are currently below 85%.

	Number Compliant	Total Number	% Compliant
MEDICAL	2704	3251	83.17%
TRUST FINANCING (Bank Staff)	455	540	84.26%

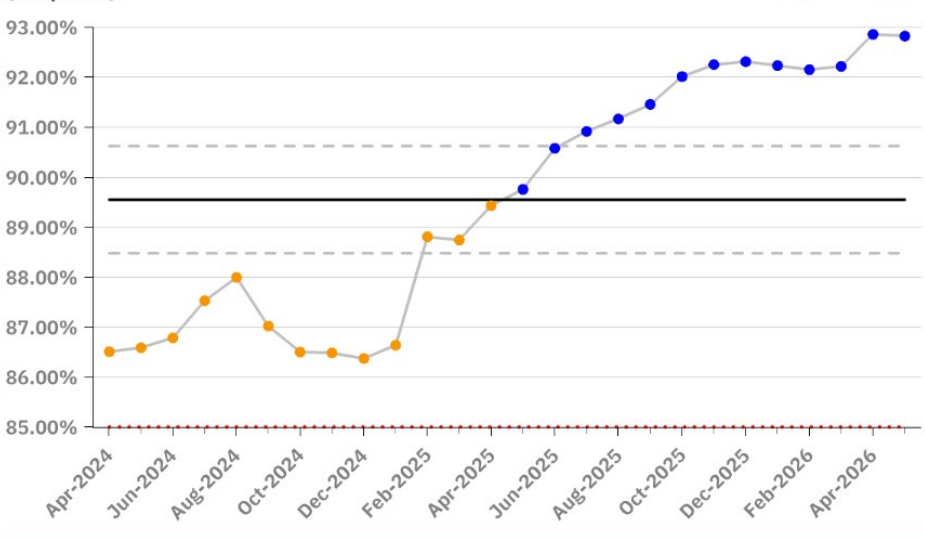
Underlying issues:

- There are a number of roles that still require their competencies reviewing to ensure they are aligned correctly.
- Within Medical directorate, a recent review identified inconsistencies in training across pharmacy roles, following which training profiles have been standardised in late May. This has resulted in a significant increase in training requirements for most pharmacy staff, with expected short-term impacts on capacity as teams work towards compliance.
- Within Trust Financing (Bank Staff) a number of data quality issues have been identified that are impacting on the compliance rate.

Actions:

- Workforce Development Lead has reviewed the training matrix for the Associate Directors of Nursing and Modern Matron to ensure the competencies align to their management and clinical roles where appropriate, which 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. **(Complete)** Feedback is currently being reviewed and will be presented to the Training Education Governance Group in July.
- In Medical directorate, the leadership team within Pharmacy, are working to ensure compliance by the end of August 2026.
- The Temporary Staffing Service Manager for Bank Staff has taken action to address a number of data quality issues and is linking in with Workforce to ensure the remaining issues are addressed on ESR.

21) Percentage compliance with ALL mandatory and statutory training (snapshot)



21) Percentage compliance with ALL mandatory and statutory training

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 **6** courses that are currently below the standard (compared to 5 the previous month); all of which are face to face.

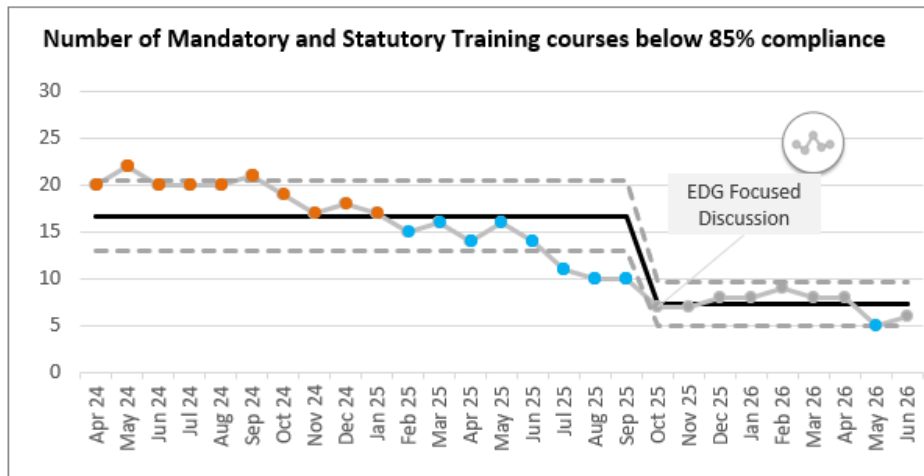
Underlying issues:

- Staff unable to be released to attend training (high DNA rate and wasted spaces).

Actions:

- 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 published on the staff Intranet by the end of June 2026 (previously February). **(Complete)**
- Workforce Development Lead has scoped training for 5 (previously 6) Positive & Safe Care trainers to provide Resus training. Two trainers have completed their training and additional courses are now being provided. Three 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 were to ensure 85% compliance for all courses by the end of June 2026. **(Partially Complete)** The majority of corporate directorates have either achieved the required 85% compliance standard or have plans in place to do so. Strategy & Transformation, Finance, and People & Culture are currently compliant. Compliance trajectories for the remaining directorates are:
 - Nursing & Governance and the Chief Executive - August 2026
 - Therapies - September 2026
 - Corporate Affairs & Involvement – October 2026

Trust Financing (Bank) to be confirmed and will be reported in next month's report.



	Number Compliant	Total Number	% Compliant
ACCT Training.	0	1	0.00%
Positive & Safe Care Level 1*	3436	4344	79.10%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	785	991	79.21%
Resuscitation - Level 1 - 1 Year*	2069	2535	81.62%
Positive and Safe Care Level 2 Update*	1289	1575	81.84%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1555	1887	82.41%

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

Actions continued:

- All Executive Directors to establish trajectories with their services to reduce the number of DNAs by the end of June 2026 **(Partially Complete)** The Integrated Care Group has a robust improvement plan in place for key face to face courses to reduce DNAs and improve compliance, with trajectories agreed at specialty and service level, and Therapies has a trajectory for September 2026. Trajectories for Digital & Data Services, Estates & Facilities Management, Medical and Trust Financing (Bank) to be confirmed and will be reported in next month's report. It has been confirmed that DNA rates are not an issue for the remaining directorates.

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 **7021** eligible staff in post at the end of June; **6341 (90.31%)** had an up-to-date appraisal.

There is special cause improvement at Trust level, and for Estates and Facilities Management, Finance, North Yorkshire, York & Selby and AMH within Durham Tees Valley Care Group. There is special cause concern for Corporate Affairs & Involvement. There is also special cause concern in Children & Young Peoples Services with Durham Tees Valley & Forensics Care Group; however, they remain above standard.

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

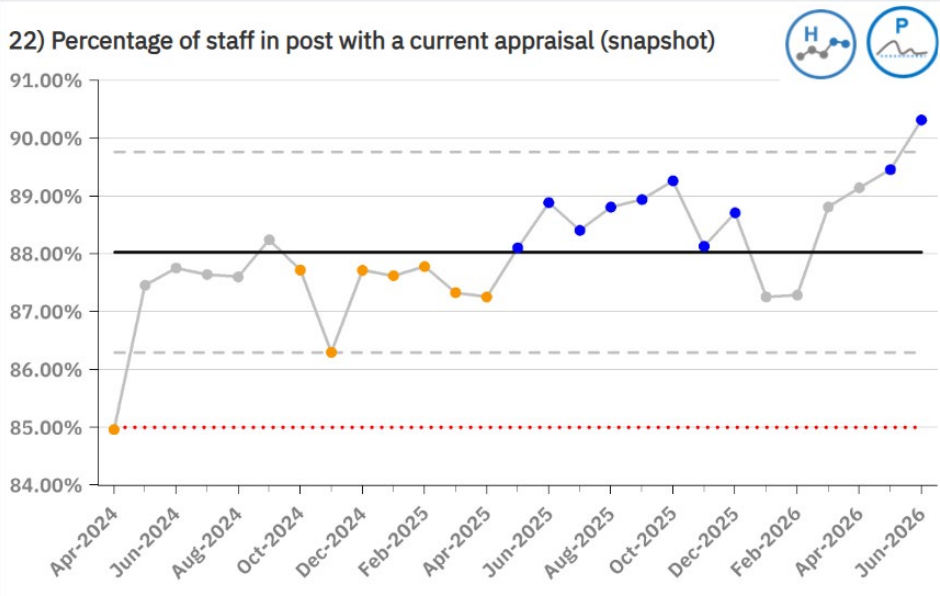
	Number Compliant	Total Number	% Compliance
CORPORATE AFFAIRS AND INVOLVEMENT	28	38	73.68%

Underlying issues:

- Corporate Affairs & Involvement appraisals has been impacted by staff sickness and uncertainties during a period of organisational change.

Actions:

- Corporate Affairs & Involvement has been identified as a Service Requiring Additional Support. A Recovery Plan is in place, including supportive oversight at Executive level and appraisals will be addressed as part of the plan.



4. Activity

Governance forum responsible:

Non-Executive Chair:

Executive Lead:

Resources and Planning Committee

John Maddison

Liz Romaniak

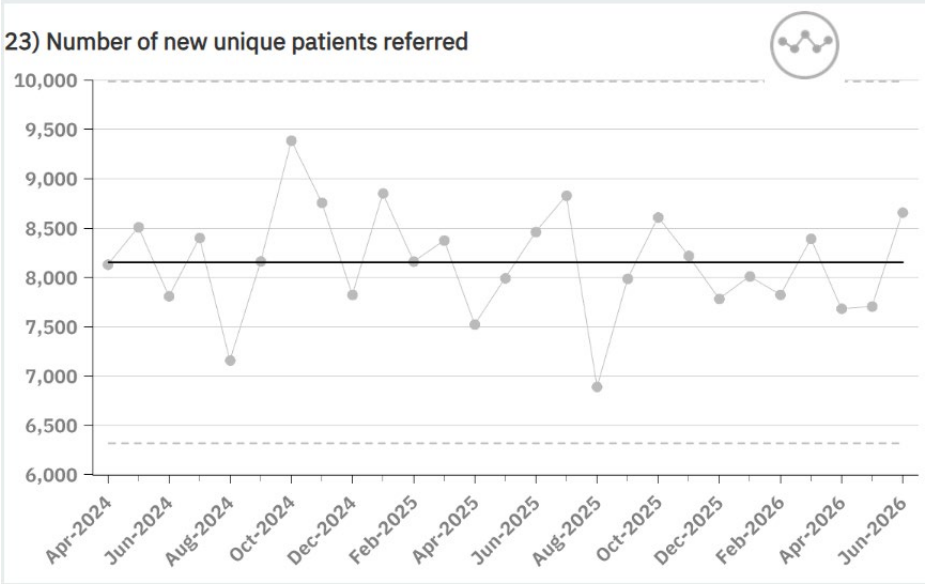
23) Number of new unique patients referred

What does the chart show/context:
8,659 patients referred in June that are not currently open to an existing Trust service.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



24) Unique Caseload (snapshot)

What does the chart show/context:

62,619 cases were open, including those waiting to be seen, as at the end of June 2026; **53,632** were active.

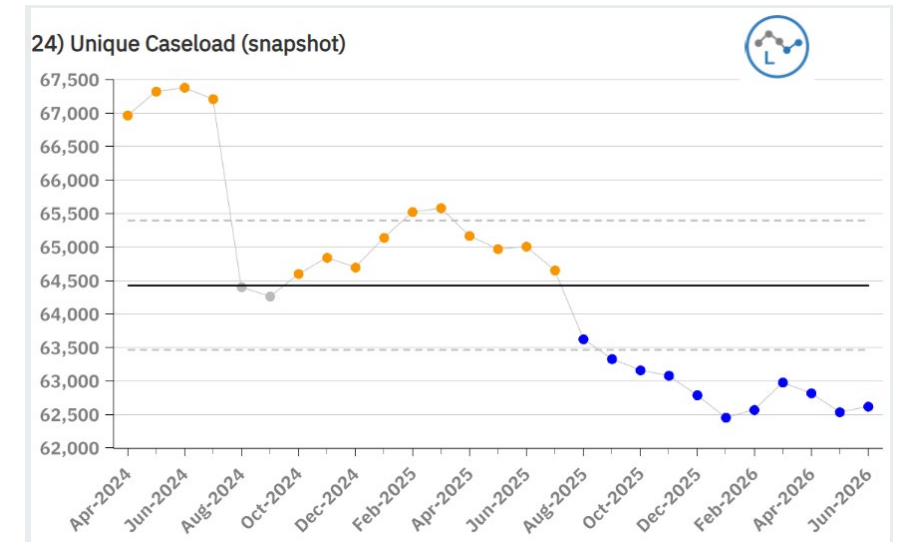
There is special cause improvement at Trust and Care Group level. There is special cause concern for Mental Health Services for Older People and Secure Inpatient Services in Durham, Tees Valley & Forensic Care Group and Children & Young Peoples Services in North Yorkshire and York Care Group; however, the services have confirmed that this is not an actual area of concern. There is special cause improvement for Adult Learning Disabilities both Care Groups, Children & Young Peoples Services and Health and Justice in Durham, Tees Valley & Forensic Care Group.

Underlying issues:

- The measure includes patients currently on our waiting lists and does not accurately reflect the active caseloads within our services.

Actions:

- Following approval from the Resources & Planning Committee in March 2026, the Head of Performance has overseen completion of the specification for the new Unique Caseload measure by the end of June (previously April and May 2026). **(Complete)** See *below action*
- Business Intelligence to develop the new caseload measure for the July 2026 IQPR (reported in August).



5. Finance

Governance forum responsible:

Non-Executive Chair:

Executive Lead:

Resources and Planning Committee

John Maddison

Liz Romaniak

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

Revenue Performance - Group	Year to date			RAG
	Plan	Actual	Variance	
Revenue Performance (Surplus) / Deficit £m	1.60	(0.26)	1.86	●
Income & Expenditure Margin (Surplus) / Deficit %	(1.58%)	(0.03%)	1.55%	●
Income £m	(134.30)	(136.10)	1.80	●
Pay Expenditure £m	114.00	112.30	1.70	●
Non Pay Expenditure £m	21.00	22.80	(1.80)	◆
Non Operating Expenditure £m	0.90	0.70	0.20	●

Revenue Performance - Group	Year to date £m			RAG
	Plan	Actual	Variance	
Durham, Tees Valley & Forensic	72.29	73.30	(1.01)	◆
North Yorkshire & York	29.86	30.10	(0.24)	◆
Estates & Facilities	8.57	8.69	(0.12)	◆
Corporate	15.08	15.29	(0.21)	◆
Income	(127.89)	(127.70)	(0.19)	◆
Central and Reserves	3.68	0.06	3.62	●
PIPS	0.01	0.00	0.01	●
	1.60	(0.26)	1.86	●

Variances - Better / (Worse) than plan

For actions see following page

Key Messages:

Early in the financial year key areas of focus include:

- Approval in quarter one of detailed plans to reduce bank costs to within NHSE expenditure caps (Board approved a new Bank IQPR metric when it met in June 2026).
- Managing implications of national pay awards where under-funded via national tariff uplift.
- Ensuring delivery of progressively stepped cost reductions in-year.
- Work with system partners to reduce high levels of patients who are clinically optimised for discharge.

What does the data show/context:

Financial performance of a £0.3m surplus was £1.9m better than planned but included £1.3m unplanned contract receipt.

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.
- Service redesign.

We need to reduce bed occupancy, including through Board approved actions to reduce high numbers of patients who are clinically optimised, but who have not been discharged. This will support lower ward occupancy and average lengths of stay and reduce related unfunded temporary staffing costs as well as supporting nil reliance on independent sector beds. Wider system support is needed to address this challenge.

We used **74 non-Trust bed days in June** (68 in May) costing **£0.3m to date** including estimated occupancy and observations, which was **£0.3m worse than plan**. Bed pressures mean sustaining low independent sector bed utilisation is challenging. 100% non-Trust bed days related to Psychiatric Intensive Care Unit usage (3 beds presently) in June. Further independent sector bed usage arose in June relating to 2 Adult Learning Disability Patients and reflects i) capacity pressures in medium secure and ii) Bankfields Court care package implications.

Despite success reducing Agency expenditure and price cap breaches, nursing and medical breaches are an ongoing challenge. Initially prioritised actions to 'swap out' agency and overtime to lower cost Bank staff arrangements have adversely impacted Bank expenditure reductions. Information on workforce usage is being continually enhanced to support a renewed efficiency focus and ensure visibility of impacts from bank reductions plans that have now been approved.

25) Financial Plan: Financial Performance – Revenue (Surplus)/Deficit

Key Areas for Action:

- A Temporary Staffing and Overtime sub-group oversees actions to reduce all temporary staffing, and reports progress into Executive Directors. Task and Finish Groups have developed detailed plans to reduce levels of staff sickness absence and bank staff reliance to support the delivery of national targets. The sub-group remit is being enhanced to ensure oversight of overall staffing resource deployed (including all substantive and flexible staffing sources).
- An Efficiency Hub oversees delivery of schemes and provides support to Care Groups and Directorates.
- Executives agreed detailed plans to optimise Bank expenditure and Sickness Absence reductions in response to NHS England plan conditions, providing assurance on these to Resources and Planning Committee at the beginning of July 2026. (These will be complemented by new IQPR Bank Expenditure metric reporting from the August 2026 Board Meeting).
- 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

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

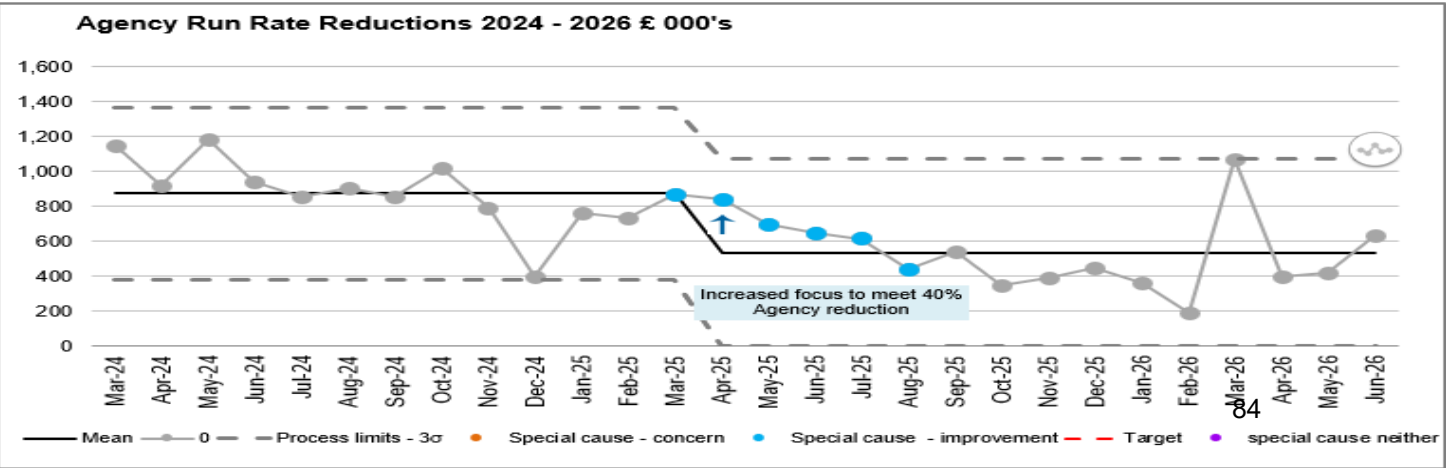
Agency Usage	Expenditure £ 000's							WTE		
	Annual Plan	Current Month			Year to Date			Current Month		
Category		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Nursing and Other	2,603	291	424	(133)	821	844	(23)	34.85	59.19	(24.34)
Medical	1,975	172	208	(36)	569	604	(35)	13.30	10.25	3.05
Grand Total	4,578	463	632	(169)	1,390	1,448	(58)	48.15	69.44	(21.29)

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 June 26 - Agency costs compared to plan by area

Agency Usage	Expenditure £ 000's							WTE		
	Annual Plan	Current Month			Year to Date			Current Month		
Area		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Durham Tees Valley & Forensic	1,839	155	238	(83)	512	589	(77)	15.39	23.47	(8.08)
North Yorkshire & York	1,558	135	123	12	413	401	12	10.76	11.67	(0.91)
Medical and Central	388	107	2	105	267	0	267	8.00	0.00	8.00
Trust Total	3,785	397	363	34	1,192	990	202	34.15	35.14	(0.99)
PIPS	793	66	269	(203)	198	458	(260)	14.00	34.30	(20.30)
Group Total	4,578	463	632	(169)	1,390	1,448	(58)	48.15	69.44	(21.29)

Variances - Better / (Worse) than plan



What does the data show/context:

- Year to date **Group agency costs of £1.4m were £58k and 21.29 WTE worse than planned**; The Trust position (excluding PIPS) was £202k and 0.99 WTE better than planned and builds on success in the last several years.
- The bottom SPC chart shows a recent uptick in quarter one. This follows a general reduction in monthly 'run rates' since March 2024 when agency costs were c £1.2m per month and includes premia rate Band 3 agency shifts supporting a package at Bankfields Court.
- Whilst planned Medical agency costs are £2.0m (43% plan) this represents just 28% planned agency WTE due to high premia rates.

Underlying issues:

- Since temporary staff currently provide essential vacancy cover, we need sustainable substantive staff in shortage (medical and nursing) professions and services (including Secure Inpatient Services).
- Whilst inpatient ward Agency Nurse expenditure has reduced markedly in Durham, Tees Valley and Forensic, including from actions to optimise rostering and review staffing relative to clinical need, North Yorkshire and York saw slower impacts, albeit favourable in the current month.

Actions:

- A Temporary Staffing and Overtime Group oversees related actions:
- Controls operate to ensure prior approval, with consideration of alternatives before Agency shifts are agreed. Performance is considered alongside the assessed level loading of inpatient rosters.
 - North Yorkshire and York Care Group is targeting further inpatient cost reductions in 2026/27.
 - Enhanced staff banks were developed in 2025/26 as an alternative to premia rate Agency and Overtime options. Task and Finish Groups have developed detailed plans in Quarter 1 to reduce sickness absence and bank expenditure and deliver our plans and NHSE plan conditions.
 - Providers were asked in late 2025 to cease Band 2-3 clinical agency shifts with a February 2026 longstop date. Actions are progressing via the Care Groups (subject to usual break glass exceptions) to respond to breaches that:
 - were largely within York inpatient wards (April 2026), but
 - are now needed to support care at Bankfields Court.

27) Financial Plan: Agency price cap compliance

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

Price Cap Compliance	Jun - 25		May - 26		Jun - 26		In-Month Movement		12-Month Movement	
	Shifts	Shifts %	Shifts	Shifts %	Shifts	Shifts %	No.	%	No.	%
Compliant	642	54%	253	46%	187	30%	(66)	(26%)	(455)	(71%)
Non-Compliant	536	46%	293	54%	445	70%	152	52%	(91)	(17%)
Total Shifts	1178	100%	546	100%	632	100%	86	16%	(546)	(46%)

Compliance Change by Staffing Group	Jun - 25			May - 26			Jun - 26			In-Month Movement		12-Month Movement	
	Shifts	Non-Compliant		Shifts	Non-Compliant		Shifts	Non-Compliant		Non-Compliant		Non-Compliant	
	No.	No.	%	No.	No.	%	No.	No.	%	No.	%	No.	%
HCA & Support	150	0	0%	93	0	0%	223	156	70%	156	156%	156	156%
Medical	446	446	100%	198	198	100%	222	222	100%	24	12%	(224)	(113%)
Nursing	579	90	16%	255	95	37%	187	67	36%	(28)	(29%)	(23)	(9%)
Allied Health Professionals	3	0	0%	0	0	0%	0	0	0%	0	0%	0	0%
Total Shifts	1178	536	46%	546	293	54%	632	445	70%	152	52%	(91)	(17%)

Movement - Increase / (Reduction)

Key Financial Indicators for the period ending 30 June 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	May-26	Jun-26
Durham Tees Valley & Forensic	3	1	6	0	0	0	73	173
North Yorkshire & York	40	47	57	59	42	39	20	50
Total Shifts Worked	43	48	63	59	42	39	93	223

Memorandum: Current Month Top 3 Shift Users (and Recent Trend)								
Team	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Bankfields Court (Tees) ALD	0	0	0	0	0	0	73	173
Wold View (York) Older Adult	12	14	7	7	13	11	5	15
Rowan Lea (S'Bro) Older Adult	2	4	15	17	5	1	3	13

What does the data show/context:

- Agency usage reduced by 546 shifts (46%) over 12 months ending June 2026 but has increased by 86 shifts in-month.
- Non-compliant shifts reduced by 91 shifts (17%) over the same period but at a lower rate; driving a higher non-compliance rate.
- Of 632 current month shifts, 187 or 30% were compliant with national price caps.
- 223 Band 3 shifts breached an NHSE requirement to cease Band 2-3 Support Worker usage in June 2026; up by 130 shifts in-month and being 35% of all 632 shifts worked in the period. This included support approved for Adult Learning Disability care at Bankfields Court commencing in May in response to an agreed care package and with appropriate approvals for all 246 shifts worked to date. Board has been briefed on the circumstances and next steps.

Underlying issues:

Persistent challenges relate to levels of medic and prison registered nurse vacancies necessitating premia rate agency cover with persistent price cap breaches. Prison service recruitment is impacted by additional, longer recruitment checks.

An emerging pressure relates to enhanced support at Bankfields Court, with Commissioners supporting future care options.

Actions:

In addition to actions from 26) Financial Plan: Agency expenditure supporting improved compliance:

- Care Group Medical colleagues have developed medical staff recruitment and locum plans and savings trajectories, aiming 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).
- Humber and North Yorkshire Commissioners are supporting consideration of the enhanced package and workforce impacts at Bankfields Court.

28) Financial Plan: Bank Expenditure

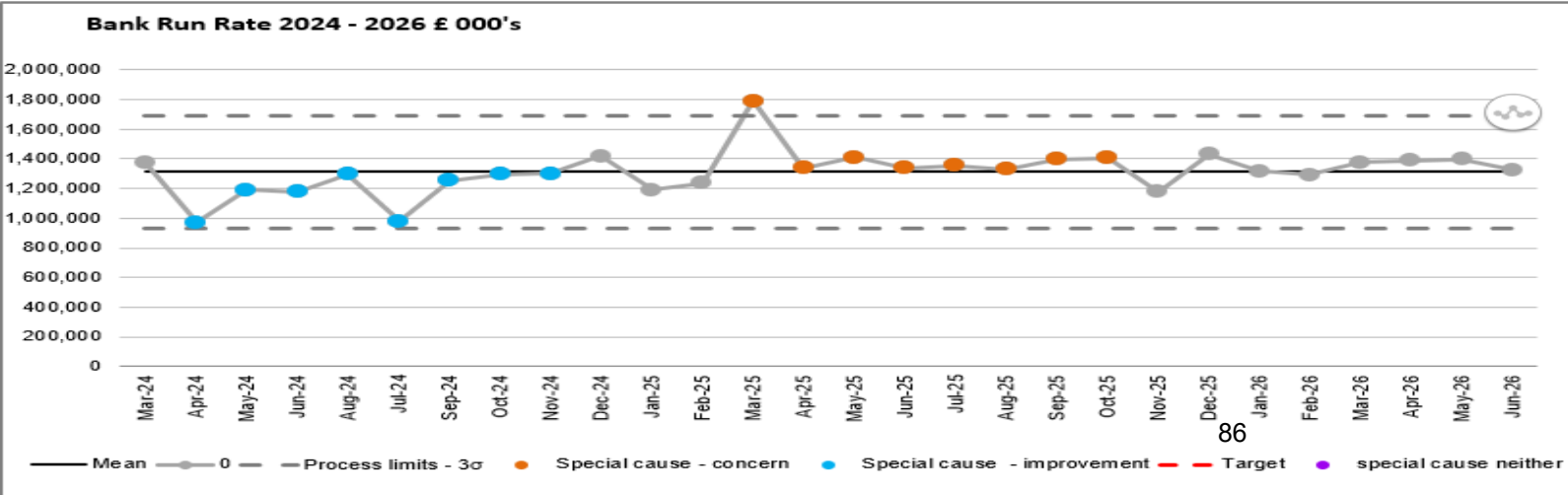
Key Financial Indicators for the period ending 30 June 26 - Bank Expenditure

Bank Usage	Expenditure £ 000's							WTE		
	Annual Plan	Current Month			Year to Date			Current Month		
Category		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Qualified Nursing	2,315	193	318	(125)	579	995	(416)	45.99	61.99	(16.00)
Unqualified Nursing	10,722	961	1,004	(43)	2,882	3,102	(220)	273.66	274.24	(0.58)
Other	15	1	3	(2)	3	14	(11)	2.08	1.26	0.82
Grand Total	13,052	1,155	1,325	(170)	3,464	4,111	(647)	321.73	337.49	(15.76)

Variances - Better / (Worse) than plan

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

Bank Usage	Expenditure £ 000's							WTE		
	Annual Plan	Current Month			Year to Date			Current Month		
Area		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Durham Tees Valley & Forensic	13,226	1,102	1,070	32	3,307	3,363	(56)	317.44	275.94	41.50
North Yorkshire & York	1,732	144	254	(110)	433	741	(308)	60.35	61.15	(0.80)
Estates & Facilities	29	2	1	1	7	3	4	0.34	0.19	0.15
Corporate	-0	1	0	1	0	4	(4)	1.09	0.21	0.88
Central and Reserves	-1,935	-94	0	(94)	-283	0	(283)	-57.49	0.00	(57.49)
Grand Total	13,052	1,155	1,325	(170)	3464	4111	(647)	321.73	337.49	(15.76)



What does the data show/context:

- Year to Date Bank costs of £4.1m were £647k worse than planned. Whilst expenditure plans pre-date the finalisation of recent, more detailed bank reductions plans during quarter 1, the adverse variance illustrates the stretch those actions need to deliver to meet national plan requirements.
- Most plan variation related to qualified nursing roles, which include hard to fill vacancies. The largest users in June were Bankfields Court (single care package), Secure Inpatient Wards (Kestrel Kite, Sandpiper and Clover/Ivy) and one Older Adult Ward in Durham and Tees Valley (Westerdale North).

Underlying issues:

Challenges in reducing Bank costs reflect actions to initially prioritise reducing premium rate Agency and Overtime shifts during 2025/26, including by growing bank resources to 'swap out' higher cost Agency and Overtime, at the expense of increased total Bank shifts at lower hourly rates.

The Trust now needs to tackle overall levels of flexible staffing and to reduce bank through addressing sickness, rostering and substantive recruitment.

Actions:

A Task and Finish Group finalised detailed plans to reduce reliance on bank staffing and target delivery of planned performance by March 2027. Enhanced governance will be provided by oversight from the Temporary Staffing and Overtime group, which reports into the Executive Directors Group. Actions include analysis of drivers of use, e.g. vacancy cover and targeted recruitment, optimal rostering of / site-based responses to replace flexible staffing requirements.

A Task and Finish Group also developed actions to target sickness absence reductions, by targeting areas a small number of areas that have most impact on Trust performance. It is expected that this will also help to reduce reliance on bank staff.

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

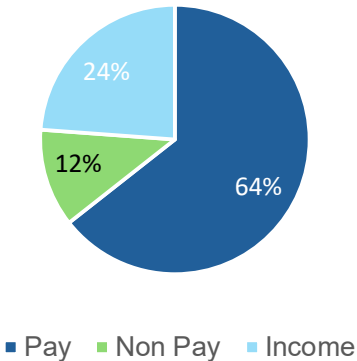
Key Financial Indicators for the period ending 30 June 26 - CRES savings compared to plan

	2026/27 CRES performance compared to plan							2026/27 CRES plans phasing £ 000				
Type	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	3,150	3,089	(61)	16,763	16,268	(496)	16,453	2940	4108	4842	4875	16765
Non Pay	701	512	(189)	3,108	2,852	(256)	3,283	657	723	851	861	3092
Income	72	67	(5)	724	883	159	1,039	75	75	294	294	738
Sub Total	3,923	3,669	(254)	20,595	20,002	(593)	20,775	3,672	4,906	5,987	6,030	20,595
								18%	24%	29%	29%	100%
Non Recurrent:												
Pay	729	1,087	358	4,745	4,321	(424)	0	786	1586	1149	1223	4744
Non Pay	847	251	(596)	2,150	1,639	(511)	0	1040	369	369	369	2147
Income	50	1,479	1,429	200	1,728	1,528	0	51	51	51	51	204
Sub Total	1,626	2,817	1,191	7,095	7,689	594	0	1,877	2,006	1,569	1,643	7,095
								26%	28%	22%	23%	100%
Total	5,549	6,486	937	27,690	27,691	0	20,775	5,549	6,912	7,556	7,673	27,690
								20%	25%	27%	28%	100%

Variances - Better / (Worse) than plan

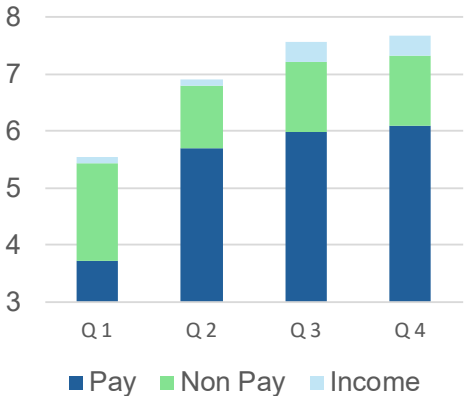
Year to Date CRES Delivery

% CRES to Date by Type



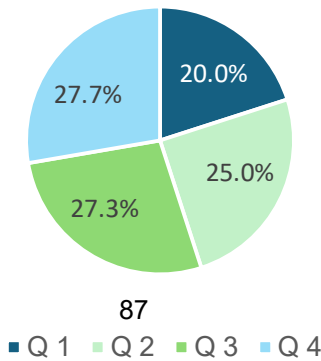
Plan Quarterly Profile by Type

CRES Profile by Quarter £ m



Plan Quarterly Phasing

% CRES Plan by Quarter



What does the data show/context:

Whilst **CRES delivery of £6.5m was £0.9m above plan** at the end of the quarter, plans assume marked stepped increases from quarter two. Performance reflects that:

- £3.7m Recurrent CRES delivery was £0.3m below plan
- £2.8m Non-Recurrent CRES delivery was £1.2m above plan

Agency and Overtime delivery was above plan (£0.05m and £0.1m respectively to date).

Areas of under-delivery included overtime reductions in Secure Inpatient Services and Hotel Services; Bank staff reductions in Ridgeway, Older Adult Mental Health Services in Durham and Tees Valley, Trust Adult Mental Health Services; and schemes linked to establishment reviews.

Underlying issues:

- CRES schemes underpin 2026/27 plan delivery, and recurrent schemes importantly improve our underlying financial sustainability.
- Not all actions to reduce bank expenditure reductions and fulfil NHSE plan requirements will deliver cost reductions. We need to meet NHSE plan conditions and deliver planned cost reductions.
- Higher than planned non-recurrent achievement would increase, whereas higher than planned recurrent achievement would decrease, planned CRES required in 2027/28.

Recently approved bank and sickness absence reduction plans will be overseen through bolstered Temporary Staffing and Overtime Group arrangements and report into Executive Directors Group.

Actions:

Please see Financial Plan measures - 25) SOCI - Surplus/Deficit, 26) Agency expenditure target, 27) Agency price cap compliance

- Additional Quality and Equality Impact Assessment panels operated and ensures 96% schemes (by value) due to commence in Quarter One had been assessed by the end of June. Of schemes starting July or later, 30% had been assessed by the end of June.
- Oversight and escalation for action by the Efficiency Hub, to forecast and ensure mitigation of under achievement and ensure recurrent schemes deliver planned levels of savings.

31) Capital Expenditure (Capital Allocation)

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

Capital Programme:	Year to Date £ 000			Annual £ 000		
	Plan	Actual	Variance	Plan	Forecast	Variance
Total expenditure plan	4,097	3,061	1,036	13,176	19,773	(6,597)
Performance against capital allocation	4,006	2,972	1,034	12,402	15,124	(2,722)
Performance against revised capital allocation	4,006	2,972	1,034	12,889	15,124	(2,235)

Variances - Lower / (Higher) than plan

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

Capital Plan	Plan Phasing £ 000				
Category	Q1	Q2	Q3	Q4	Total
Capital Programme inc IFRS16 Planned Disposals	4,436 (430)	4,151	2,301 (750)	2,694	13,582 (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

Explanatory Note:

£3,450k left shift Mental Health Emergency Department and Neighbourhood Health Centre scheme cost is included in the forecast total expenditure plan. This was agreed after the submission of capital plans and is funded in full by NHS England Public Dividend Capital drawdown. It therefore shows as an adverse plan variation but no forecast variation against allocation(s).

What does the data show/context:

£2,972k Capital expenditure for the year to date was **£1,034k lower than planned** costs charged against the Trust's capital allocation.

a) Capital Charged to allocation: £12,402k 2026/27 allocation comprised:

- £5,900k operational capital allocation (derived nationally using a formula)
- £5,000k cash-backed Estates Safety Fund (2026/27 only)
- £890k cash-backed Estates Safety Fund (4-year allocation)
- £620k non recurrent allocation (revenue performance bonus 2024/25)

b) Revised Allocation: includes £487k notified allocation linked to revenue performance bonus for 2025/26.

c) Not Charged to allocation: £774k further planned costs comprised:

- £364k PFI lifecycle
- £410k NHS Lease additions

Total 2026/27 planned capital expenditure (a + c) was £13,176k. Revised planned capital expenditure is now £13,663k (a + b + c).

Whilst forecast performance against our revised allocation is a £2,235k pressure, actions are being taken to aim to mitigate this in year.

Underlying issues:

We have been impacted by reduced operational capital allocations from 2026/27. Additional NHSE capital allocations are subject to separate application or bid processes. Future access to capital is of concern, especially given the significant capital requirement for Roseberry Park Hospital works.

Capital plan priorities have needed to be risk-assessed to manage costs to within Trust capital allocations. Multi-year plans were submitted to NHS England in February 2026 aligned to medium term financial plans and confirmed funding. Strategic Capital was not allocated beyond 2026/27, with NHSE assessing relative provider priorities post submission.

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 and work with the contractor to review current cashflow forecasts.

32) Cash Balances (actual compared to plan)

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

Receivable & Payables Metric:	Year to Date			Annual		
	Plan	Actual	Variance	Plan	Actual	Variance
Cash (£000s)	45,557	52,952	7,395	36,653	40,653	4,000
Better Payment Practice Code (%)	95.0%	96.1%	1.1%	95.0%	95.0%	0.0%
Aged Debt > 90 days overdue (%)	5.0%	27.0%	(22.0%)	5.0%	5.0%	0.0%

Variances - Better / (Worse) than plan

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

Plan	2026/27 Monthly Cash Plan £ 000											
	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 **£52,952k were £7,395k more than planned** and reflect higher than planned trade payables projected to reduce during the financial year.

- **Prompt Payment of Suppliers:** The Trust achieved a combined Better Payment Practice Code (BPPC) compliance of **96.1%** 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:** Total debt outstanding at the period end was £3,250k, with **£722k 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 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:

Non-Executive Chair:

Executive Lead:

Resources and Planning Committee

John Maddison

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)	9830	694	9136	7767	6746	5333	3934
Children & Young People Pathway A - Spells with at least one referral with a primary reason for referral - Gender Discomfort Issues	4	2	2	1	1	1	1
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	5714	125	5589	4975	4371	3444	2535
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	4597	40	4557	4050	3712	3020	2266
Children & Young People Pathway D - Spells with at least one 'other' referral not identified as related to autism, neurodevelopmental or gender identity	1781	547	1234	527	369	312	257
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	465	3	462	435	356	308	256
Adults Waiting to receive Meaningful Help	4594	1313	3281	714	184	80	51

"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.

For this methodology, waiting time bands are cumulative. Patients waiting more than 104 weeks are included within all preceding waiting-time categories (over 104, over 78, over 52, over 26 and over 4 weeks). As a result, the figures presented within each waiting-time band should not be summed, and the total actual number waiting is represented by the combined 0-4 weeks and over 4 weeks categories.

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)		0	0	0	0	0	0	0	0	0	0
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		31	7	13	9	0	1	0	1	2	12

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)		95	36	29	21	5	3	0	1	2	12

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		1177	553	167	147	166	27	12	51	48	6	16	177	*
Adults Waiting for an Assessment		2680	1150	502	343	530	140	12	3	0	0	9	66	
Adults with a learning disability Waiting for an Assessment		82	65	14	2	1	0	0	0	0	0	3	20	*
Adults in Health and Justice services Waiting for an Assessment		38	34	4	0	0	0	0	0	0	0	2	7	
Older People Waiting for Assessment		2662	922	529	445	562	154	49	1	0	0	10	55	

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		4614	93	79	135	422	177	203	1460	1487	568	92	223	*
Children and young people waiting for an ADHD Assessment		4512	132	79	97	338	211	262	1601	1350	443	87	209	*
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2180	10	5	5	49	87	160	565	787	536	117	215	
Adults waiting for an Autism Assessment		4337	36	53	32	188	181	180	792	1079	1796	130	353	
Adults waiting for an ADHD Assessment		5586	124	168	97	337	288	222	1103	1330	1917	120	396	

Patients 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		4356	450	379	1213	842	723	749	16	71

- NOTES:**
- Asterisk* denotes a data quality issue
 - The Children and Young People neurodevelopmental waiting times dashboards are referral-based; therefore, patients may appear more than once within the underlying waiting time bands but are counted only once in the total waiting list.

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

Summary:

There are 2 children or young people reported as waiting more than 4 weeks, of which 0 are actually waiting to commence treatment.

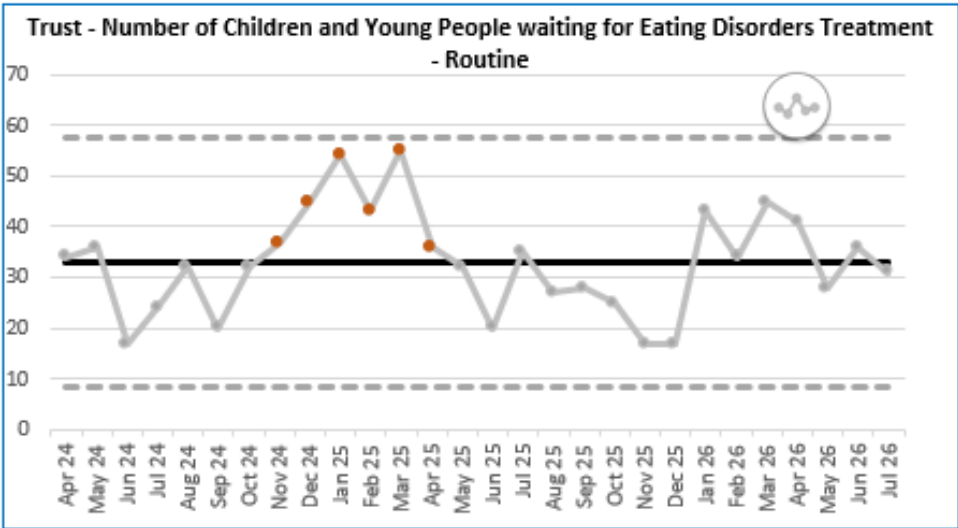
- Both patients were assessed (1 within 4 weeks and 1 outside 4 weeks due to a delaying in receiving physical health information from the GP) however Eating Disorders is not suitable for their needs; both have been transferred to the Adult Community Team.

Underlying issues:

- We are continuing to flow inaccurate information in our internal reporting and our Mental Health Services Dataset, as outlined above.
- Whilst there were no patients waiting more than 4 weeks in the Durham & Darlington Eating Disorders team, capacity continues to be impacted by maternity leave and sickness.

Actions:

- Operational Leads, overseen by Directors of Operations, will complete a service deep dive and develop a measurable improvement plan by 31 May 2026. The plan will set out actions and improvement trajectories and will be presented to Combined Care Group Governance in June **(Not Complete)** The plan will now be presented to Combined Care Group Board in July 2026 and then Executive Directors Group in August for oversight and assurance.
- From July 2026 the Durham & Darlington Eating Disorders team rota will be amended to increase the number of assessment appointments to meet demand. **(Complete)**



Children & Young People Eating Disorders Services - 4 week standard for Routine referral				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	31	2	12	
DTVF Care Group	20	2	4	
NY&S Care Group	11	3	12	
DTVF: Genuine wait - longest wait is 26 days, assessment booked				
NY&S: Genuine wait - longest wait is 85 days due to team capacity				

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

Summary:

There are **30** adults **reported** as waiting more than 2 weeks of which 24 are actually waiting to commence treatment:

- 13 patients were offered appointments (within 2 weeks) but did not attend/cancelled; further appointments are offered in July.
- 10 patients have been offered appointments (outside 2 weeks) due to team capacity; appointments are booked in July.
- 1 patient is currently in prison, awaiting admission to a Trust Medium Secure Unit. Admission date is yet to be confirmed.

Of the remaining 6 waits:

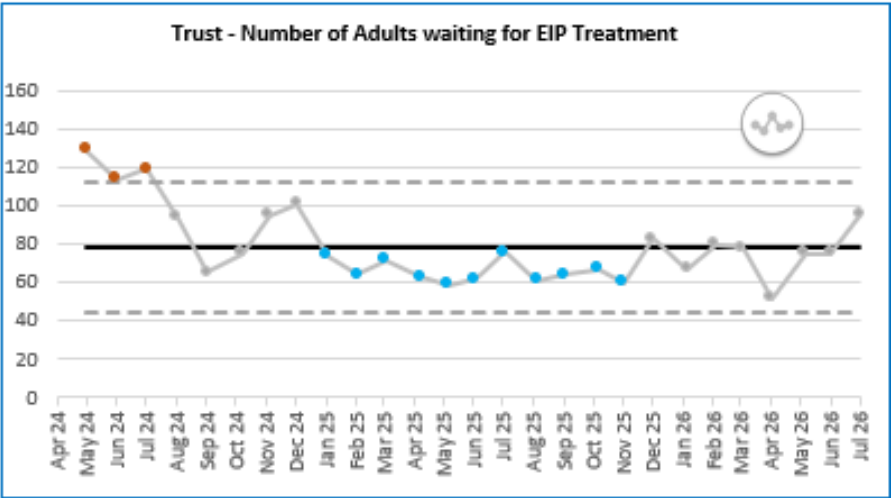
- 4 patients have been assessed, and treatment is not suitable for their presentation; the service is in the processing of discharging them.
- 2 are attributable to data quality (pathway not completed in CITO and incorrect referral reason added), and steps have been taken to resolve them.

Underlying issues:

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

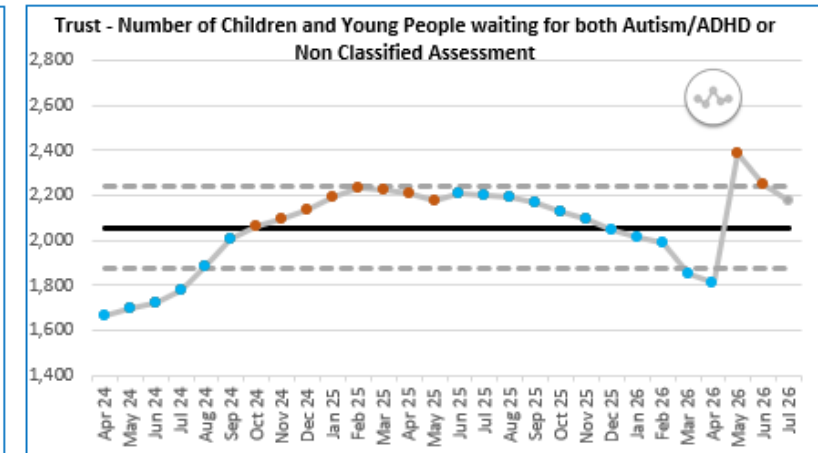
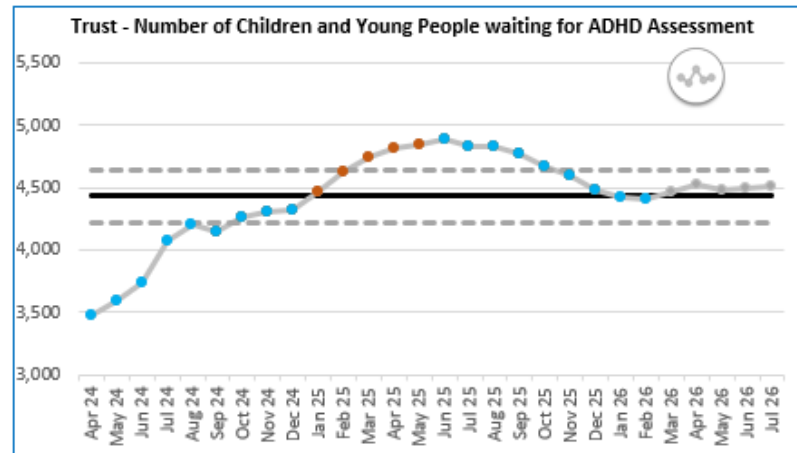
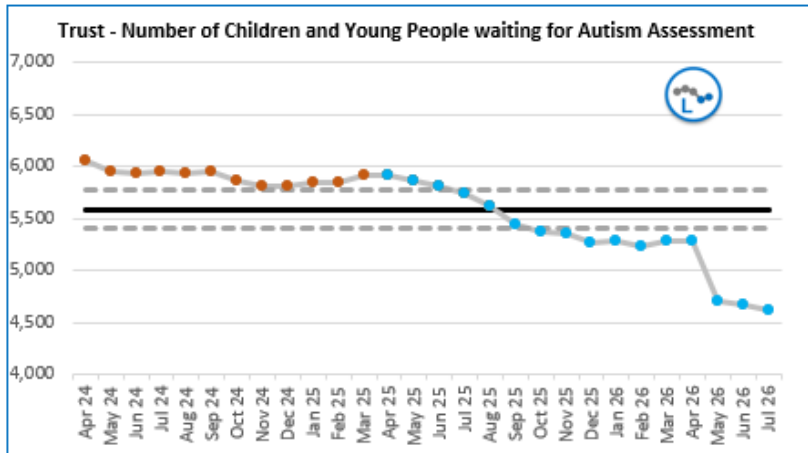
Actions:

- 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 June (previously May 2026). **(Complete)** Initial investigations have identified an increase in DNAs since April 2025; however, data could not be sourced at Care Group level to enable the identification of any specific trends or themes. Steps have been established to enable enhanced oversight from April 2026.
- The York & Selby EIP team remains in Services Requiring Additional Support and an action plan is in place. Recruitment is complete following successful interviews. Two staff commenced in July 26 and the successful candidates for the remaining vacancies will be in post by the end of September 2026. Following the delay to recruitment, care coordination capacity to improve treatment commencement is anticipated to improve from July 26 (previously May).



Adults Waiting for EIP Treatment - 2 week standard				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	95	2	12	
DTVF Care Group	62	2	6	
NYY&S Care Group	33	2	12	
Commentary on Longest waits				
DTVF: Genuine Wait - Appointment Booked				
NYY&S: Genuine Wait - Appointment Booked				

Waiting Times Neuro Services: Children & Young People



To Note: Correction work has led to more people being recorded as waiting for a combined autism/ADHD assessment, with no change to overall numbers (May 26).

Children and young people waiting for an Autism Assessment				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4614	92	223	
DTVF Care Group	3524	101	223	
NYY&S Care Group	1090	64	146	
Commentary on Longest waits				
DTVF: Data Quality - Assessment completed (longest genuine wait 1554 days - 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	4512	87	209	
DTVF Care Group	3776	96	209	
NYY&S Care Group	736	41	144	
Commentary on Longest waits				
DTVF: No information present for longest waiter				
NYY&S: No information present for longest waiter				

Children and young people waiting for both Autism/ADHD Assessment or Not Categorised				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2180	117	215	
DTVF Care Group	1609	136	215	
NYY&S Care Group	571	64	126	
Commentary on Longest waits				
DTVF: Genuine wait - Specialist Assessment Required (on hold due to consent).				
NYY&S: Genuine wait				

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:

- In Durham and Darlington plans have been formalised for the rollout of the clinical protocol and within Tees some amendments to the original clinical pathway have been highlighted. Both elements will be complete by the end of August 2026.
- A recruitment exercise is being led by the Team Manager in Durham & Darlington to fill a mix of permanent and fixed-term posts. A meeting is scheduled in July 2026 to confirm available funding for vacant posts.
- 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. **(On hold)** Pending induction of new team manager who commenced in June.

North Yorkshire & York

Underlying Issues:

- Long-term sickness absences within the Scarborough ADHD team

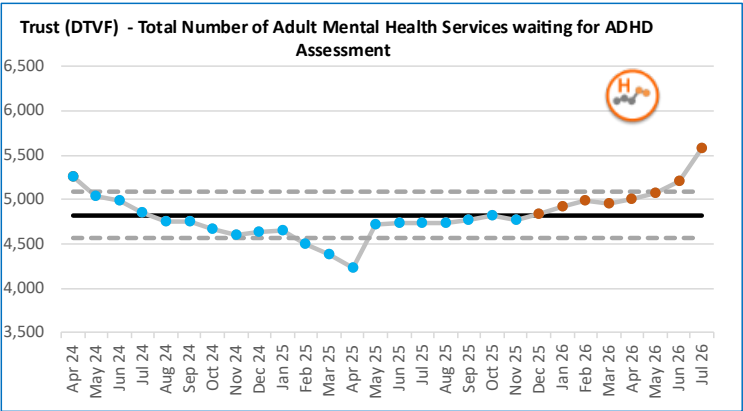
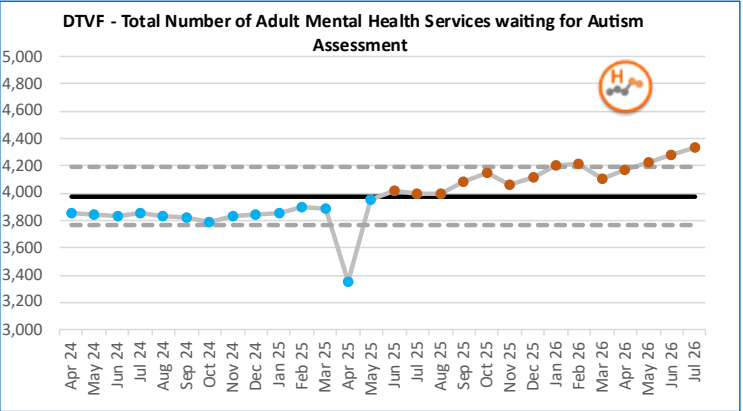
Actions (Partnership-wide):

- 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:

- The Scarborough ADHD team has a recovery plan in place; however, delivery is currently constrained by sickness absence and vacancies. A review of capacity and resource utilisation is underway, but a backlog of assessments remains, requiring additional resource to achieve a sustainable position against current demand. The first progress report was completed and presented to the Combined Care Group Governance in June (previously May 2026) **(Complete)** Next steps for internal approval via Executive Directors Group to be confirmed and updated next month.
- The Service Manager has progressed recruitment for one team manager for neuro services. The post will be filled internally for 12 months from July/August. **(Complete).**

Waiting Times Neuro Services: Adult Services



Adults waiting for an Autism Assessment				
Organisation	Actual	Average wait	Longest wait	Assurance
(DTVF Care Group)	4337	130	353	
Commentary on Longest waits				
DTVF: Data quality, longest genuine wait is 2089 days (298 weeks). Apt required				

Adults waiting for an ADHD Assessment				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	5586	120	396	
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):

- Following a formal NENC ICB letter on Adult ADHD/Autism waiting lists validation the Trust is currently working with CNTW and the ICB to agree resource allocation to improve the waiting list position, with a paper due to People & Resources EDG in June 2026. **(Complete)**. A full mobilisation plan including procurement plan will be complete by the end of July and shared with the ICB.

DTVFCG

Underlying issues:

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

Actions:

- Following approval to implement Koa Step 3 Digital Therapy for PTSD funding is anticipated to be signed off by the end of July 2026 which will support a reduction in waiting times.
- General Manager submitted a paper outlining the current financial gap and workforce challenges for the service to Integrated Care Group Board in June 2026 (previously April), with a view to securing additional staff. **(Complete)** This will be presented to the EDG progress development day in August.

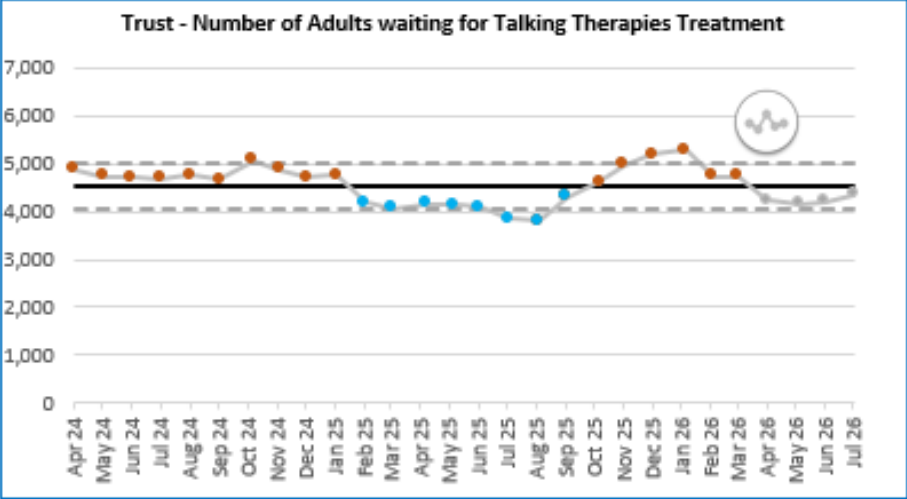
NYYSCG

Underlying issues:

- Within North Yorkshire Talking Therapy team, 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.
- There is insufficient capacity to deliver Step 2 and Step 3 treatments within the York & Selby Talking Therapy team.

Actions:

- The Service Manager was 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. **(Not complete)** A further meeting took place on the 17th June to explore actions for an improvement plan. See following actions
- Within the North Yorkshire Talking Therapies team, treatment capacity will continue to be converted to assessment capacity to reduce waiting time for assessment to 4 weeks; this work will be completed by the end of September 2026.
- Within the York & Selby Talking Therapies team, the Service Manager will expand the keeping touch pilot to other treatment pathways, over a period of 6 weeks from June 26 with improvement to waiting times expected from August 2026.



Talking Therapies - adults waiting for their second treatment contact				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4356	16	71	
DTVf Care Group	1780	14	53	
NYy&S Care Group	2576	18	71	
Commentary on Longest waits				
DTVf: Genuine Wait - Appointment booked				
NYy&S: Genuine Wait - DNAd 2 x apts, appt required				

7. Population health, prevention and reducing inequality

Governance forum responsible:

Non-Executive Chair:

Executive Lead:

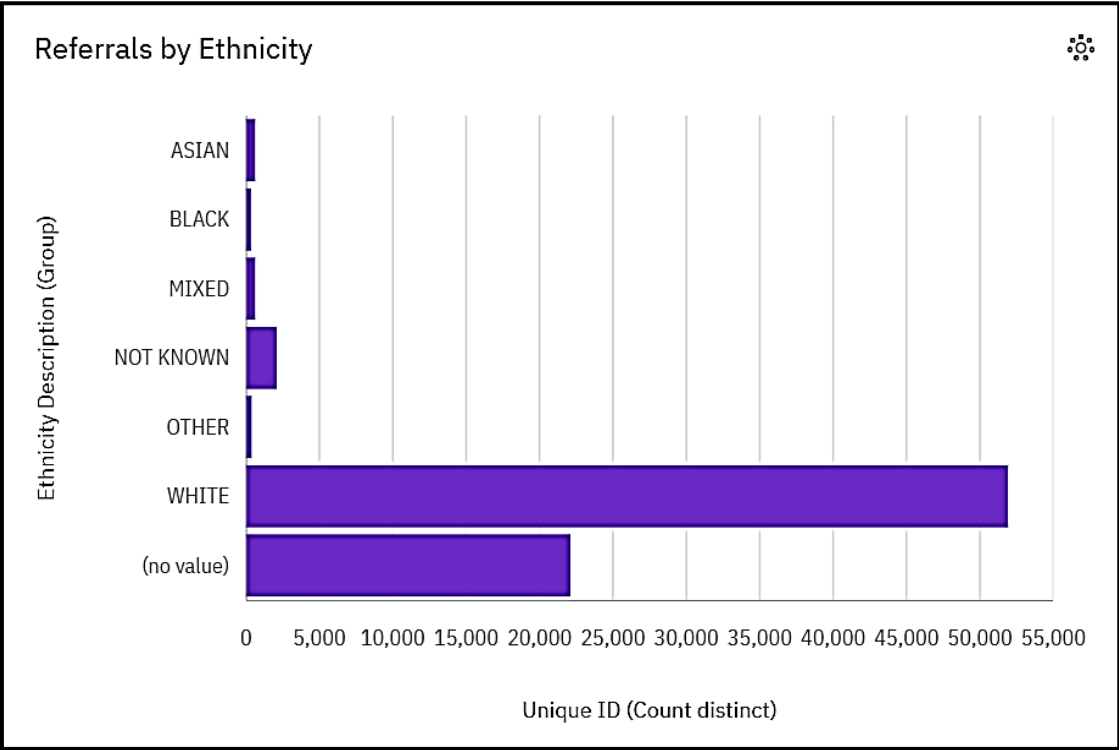
Quality and Assurance Committee

Marie Burnham (Interim Chair QAC)

Beverley Murphy

Referrals: Ethnicity recorded for any patients which were admitted within the given period (distinct count). Data is included from 01/09/2025 onwards.

- 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.

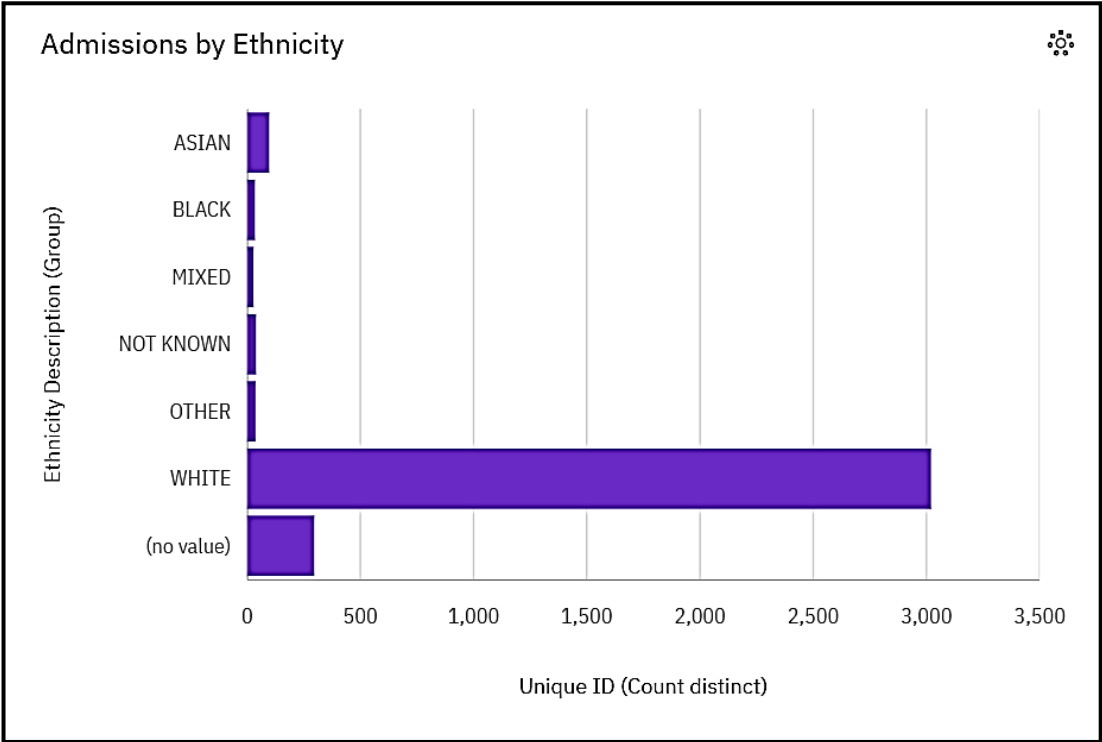


* NOTE: No Value – No ethnicity recorded

- 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. Data is included from 01/09/2025 onwards

- 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.

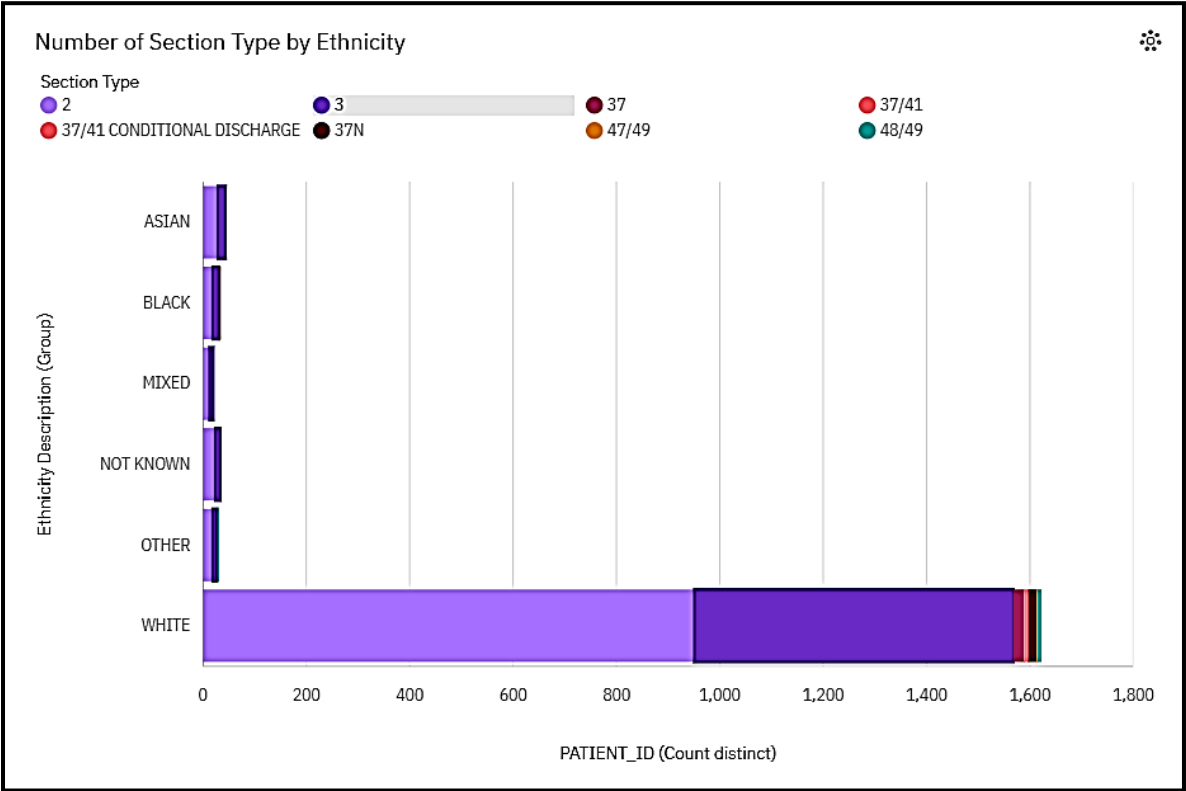


* NOTE: No Value – No ethnicity recorded

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

Mental Health Act: Ethnicity recorded once per patient per section type in given period (distinct count). Data is included from 01/10/2025 onwards. The table shows numbers of detentions and reflects the high proportion of white people in the population served by TEWV.

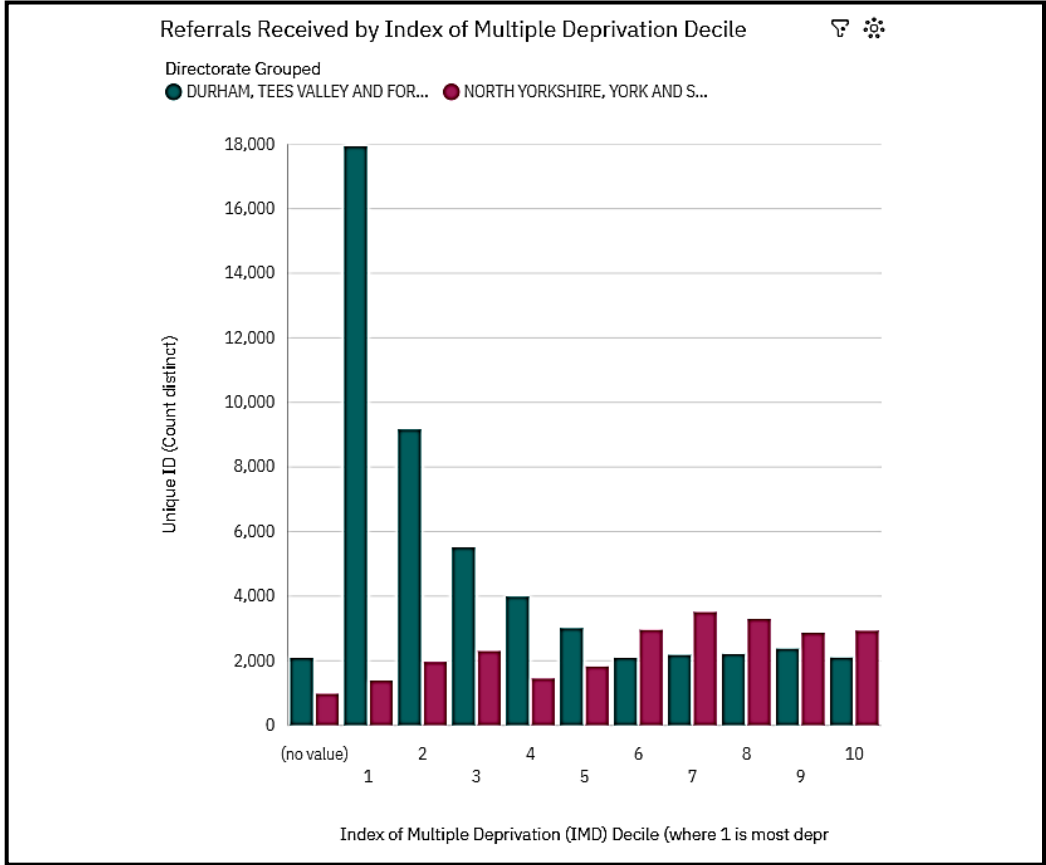
- Annual data analysis identifies that when viewed as a population rate that Black/ Black British people were detained 2.03 times more than White People, in 2024/25 compared to 2.61 times more in 2023/24



- 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.

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. Data is included from 01/09/2025 onwards

- The interconnectedness of poverty and mental ill health means that those using our services are disproportionately 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.

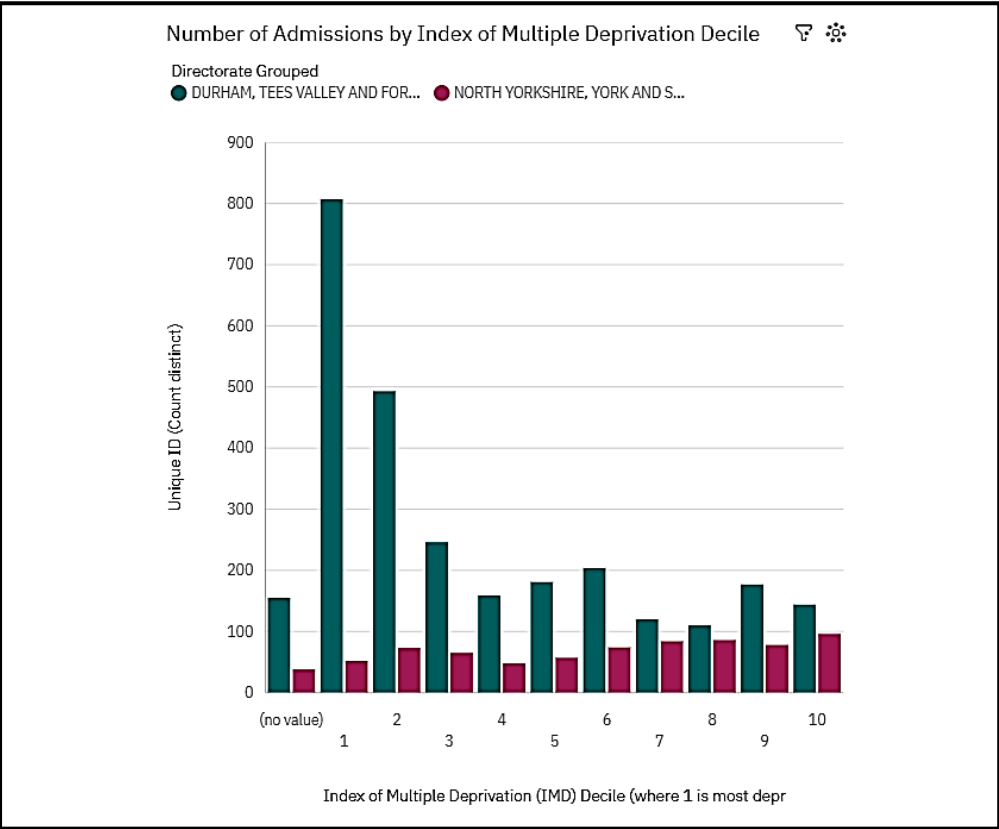


* NOTE: No Value – No corresponding deprivation decile available for the given postcode

Within the personalising care agenda we are considering accessibility for people experiencing multiple disadvantage including how to “Poverty Proof”[®] our 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. Data is included from 01/09/2025 onwards

- The interconnectedness of poverty and mental ill health means that those using our services are disproportionately 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.

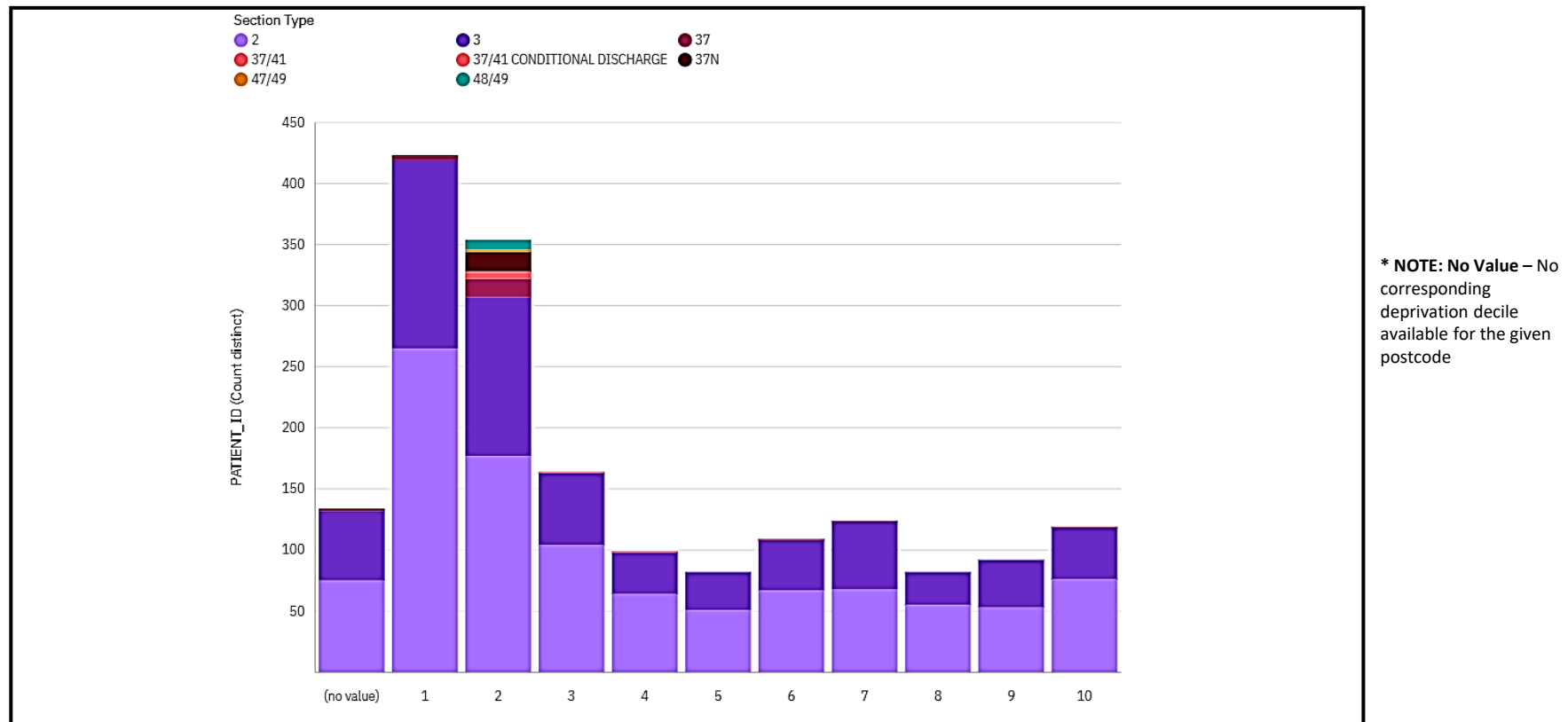


* NOTE: No Value – No corresponding deprivation decile available for the given postcode

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. Data is included from 01/10/2025 onwards

- 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.



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

8. Care Group

Durham, Tees Valley & Forensic Care Group - Overview

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC			92.00%	93.24%	92.89%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	80.10%	84.18%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	71.22%	74.02%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	64.36%	64.14%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	45.85%	46.83%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	61.32%	61.57%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician	QAC			30.00%	28.98%	29.36%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	91.33%	89.83%	

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
9)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC				14.17%	14.17%	
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				0	2	
12)	The number of Incidents of moderate or severe harm	QAC				22	49	
13)	The number of Restrictive Interventions Used	QAC				1,049	2,975	
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				1	1	
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				229	638	

Please Note: 09 Clinically Ready for Discharge does not have a Data Quality Assessment rating as this is a new measure. The assessment has been completed and will be shared with Resources & Planning Committee for approval in July 2026.

DTVF Integrated Performance Dashboard – for the period ending June 2026

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
17)	Percentage of staff recommending the Trust as a place to work	PCDC			60.00%	54.70%	54.70% (Apr-2026)	
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	58.31%	58.31% (Apr-2026)	
19)	Staff Leaver Rate	PCDC			11.00%	8.87%	8.87%	
20)	Percentage Sickness Absence Rate (month behind)	PCDC			5.50%	7.57%	7.37%	
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC			85.00%	93.35%	93.35%	
22)	Percentage of staff in post with a current appraisal	PCDC			85.00%	89.78%	89.78%	

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
23)	Number of new unique patients referred	RPC				5,812	16,050	
24)	Unique Caseload (snapshot)	RPC				47,524	47,524	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)	DQA Metric Rating
25)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	25,580,877	73,297,310	
26)	Agency Expenditure	RPC	511,874	588,852	
27)	Agency price cap compliance	RPC	67.00%	4.58%	
28)	Bank Expenditure	RPC	3,306,603	2,139,446	

North Yorkshire, York & Selby Care Group - Overview

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC			92.00%	95.02%	94.68%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	80.83%	83.07%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	86.84%	80.25%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	72.15%	72.02%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	43.25%	43.97%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	62.89%	61.35%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician	QAC			30.00%	26.18%	26.46%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	91.55%	86.30%	

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
9)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC				22.88%	22.88%	
10)	Number of inappropriate QAP 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				0	0	
12)	The number of Incidents of moderate or severe harm	QAC				3	12	
13)	The number of Restrictive Interventions Used	QAC				140	336	
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				120	315	

Please Note: 09 Clinically Ready for Discharge does not have a Data Quality Assessment rating as this is a new measure. The assessment has been completed and will be shared with Resources & Planning Committee for approval in July 2026.

NYY Integrated Performance Dashboard – for the period ending June 2026

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
17)	Percentage of staff recommending the Trust as a place to work	PCDC			60.00%	41.67%	41.67% (Apr-2026)	
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	53.12%	53.12% (Apr-2026)	
19)	Staff Leaver Rate	PCDC			11.00%	11.25%	11.25%	
20)	Percentage Sickness Absence Rate (month behind)	PCDC			5.50%	5.32%	5.41%	
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC			85.00%	92.83%	92.83%	
22)	Percentage of staff in post with a current appraisal	PCDC			85.00%	90.94%	90.94%	
Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
23)	Number of new unique patients referred	RPC				2,847	7,999	
24)	Unique Caseload (snapshot)	RPC				15,090	15,090	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)	DQA Metric Rating
25)	Financial Plan: SOC1 - Final Accounts - (Surplus)/Deficit	RPC	29,434,973	30,100,603	
26)	Agency Expenditure	RPC	413,144	400,726	
27)	Agency price cap compliance	RPC	67.00%	70.71%	
28)	Bank Expenditure	RPC	432,873	508,097	

9. National metrics

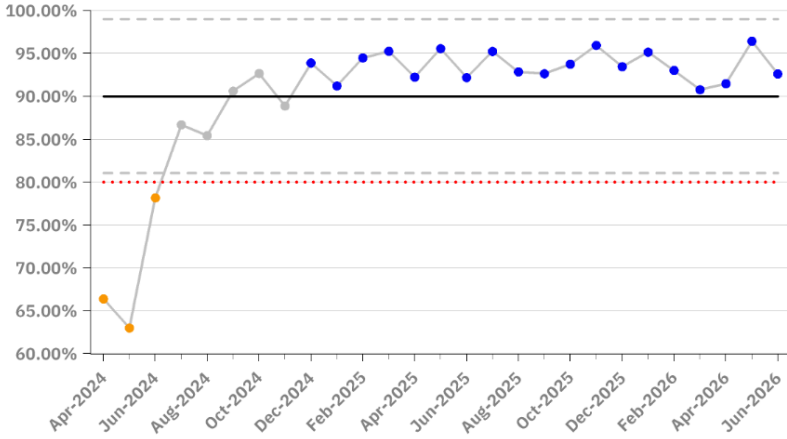
NHS Oversight Framework 25/26		Quarter 1 2025/26			Quarter 2 2025/26			Quarter 3 2025/26			Quarter 4 2025/26		
		Q1 performance	Q1 score	Q1 rank	Q2 performance	Q2 score	Q2 rank	Q3 performance	Q3 score	Q3 rank	Q4 performance	Q4 score	Q4 rank
DOMAIN SCORE - Access to Services		4 - Low performing			4 - Low performing			4 - Low performing			3 - Below average		
		3.37		49 out of 58	3.35		52 out of 58	2.91		41 out of 59	2.57		35 out of 59
Annual change in number of children and young people accessing NHS-funded MH services (rolling 12 months)	Scored	0.44%	3.37	36 out of 46	-2.28%	3.35	40 out of 49	3.63%	2.91	34 out of 50	5.86%	2.57	29 out of 50
Percentage increase in Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Contextual	2.16%	Mid-Low 25% (Blue)		5.89%	Mid-High 25% (Blue)		11.15%	Mid-High 25% (Blue)				
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	Contextual				84.00%	Lowest 25% (Blue)		86.00%	Lowest 25% (Blue)				
DOMAIN SCORE - Effectiveness and experience of care		1 - High performing			1 - High performing			1 - High performing			1 - High performing		
		1.57		6 out of 59	1.53		3 out of 60	1.53		3 out of 60	1.50		5 out of 60
Percentage of inpatients with >60 day length of stay (rolling 3-month average)	Scored	11.78%	1.13	3 out of 47	9.18%	1.06	2 out of 47	11.07%	1.06	2 out of 47	8.94%	1.00	1 out of 47
Community mental health survey satisfaction rate (annual)	Scored		2.00			2.00			2.00			2.00	
DOMAIN SCORE - Patient Safety		2 - Above average			2 - Above average			2 - Above average			1 - High performing		
		2.41		33 out of 61	2.44		32 out of 61	2.11		20 out of 61	1.81		17 out of 61
NHS Staff Survey – raising concerns sub-score (annual)	Scored	6.60	3.15	44 out of 61	6.60	3.15	44 out of 61	6.60	3.15	44 out of 61	6.65	2.55	32 out of 61
CQC safe inspection score (if awarded within the preceding 2 years)	Scored		3.00			3.00		No NOF score was generated for Q3 2025/26 as the CQC Safe key question rating was over two years old					
Percentage of patients in crisis to receive face-to-face contact within 24 hours (rolling 3 months)	Scored	97.70%	1.07	2 out of 45	98.40%	1.18	3 out of 48	94.19%	1.06	2 out of 48	88.66%	1.07	2 out of 45
Rate of restrictive interventions use	Contextual	28	Mid-High 25% (amber/red)		42	Highest 25% (red)		53	Highest 25% (red)		46	Highest 25% (red)	
DOMAIN SCORE - People and Workforce		4 - Low performing			4 - Low performing			4 - Low performing			4 - Low performing		
		3.44		54 out of 61	3.59		56 out of 61	3.68		57 out of 61	3.44		50 out of 61
Sickness absence rate (rolling 3 months)	Scored	6.06%	3.32	41 out of 61	5.98%	3.63	49 out of 61	6.94%	3.81	54 out of 61	7.44%	3.74	51 out of 61
NHS staff survey engagement theme score (annual)	Scored	6.86	3.55	52 out of 61	6.86	3.55	52 out of 61	6.86	3.55	52 out of 61	6.87	3.15	44 out of 61
National Education & Training Survey "Overall Experience" survey score (annual)	Contextual	84.68%	Highest 25% (Green)		84.68%	Highest 25% (Green)		84.68%	Highest 25% (Green)		84.68%	Highest 25% (Green)	
DOMAIN SCORE - Finance and productivity		1 - High performing			1 - High performing			1 - High performing			1 - High performing		
		1.11		5 out of 61	1.45		12 out of 61	1.45		12 out of 61	1.45		14 out of 61
Planned surplus/deficit (annual)	Scored	0%	1.00	15 out of 61	0%	1.00	16 out of 61	0%	1.00	16 out of 61	0%	1.00	16 out of 61
Variance year-to-date to financial plan	Scored	0.68%	1.00	3 out of 61	0.39%	1.00	8 out of 61	0.44%	1.00	10 out of 61	0.64%	1.00	20 out of 61
Combined finance <i>*only the combined finance score contributes to the domain score</i>	See *		1.00			1.00			1.00			1.00	
Relative difference in costs (annual)	Scored	79.03%	1.22	5 out of 60	96.24%	1.90	17 out of 61	96.24%	1.90	17 out of 61	96.24%	1.90	17 out of 61
Improving health and reducing inequality (non-scoring)													
Percentage of inpatients aged 65 years and over with a length of stay at discharge exceeding 90 days	Contextual	38.88%	Mid-Low 25% (Amber/Green)		26.57%	Lowest 25% (Green)		31.95%	Lowest 25% (Green)				
OVERALL AVERAGE METRIC SCORE		2.28		30 out of 61	1102.38		34 out of 61	2.27		28 out of 61	2.11		15 out of 61
FINAL SEGMENTATION		2		24 out of 61	3		34 out of 61	2		24 out of 61	2		15 out of 61

National Quality Requirements

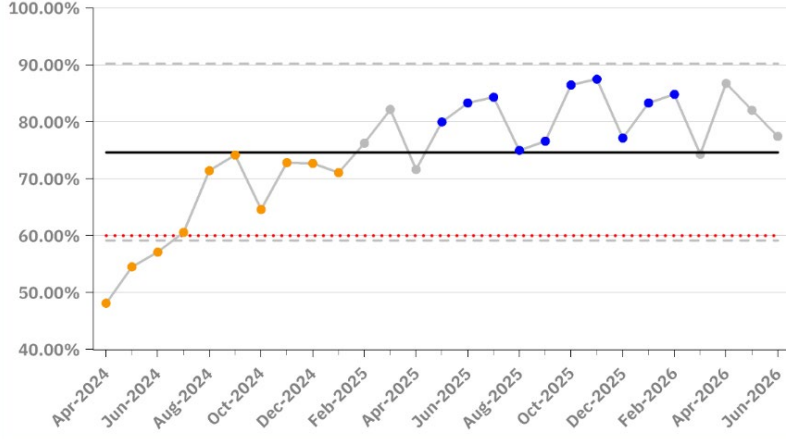
Rep Ref	National Quality Requirements	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26	May-26	Jun-26
IIC4850	Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care			80.00%	80.00%	93.45%	91.48%	96.43%	92.62%
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			60.00%	60.00%	82.03%	86.76%	82.05%	77.46%
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			75.00%	75.00%	93.11%	95.53%	93.78%	90.12%
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			95.00%	95.00%	99.93%	99.86%	99.92%	100.00%
IIC5340	Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)			95.00%	95.00%	87.15%	86.74%	86.48%	87.15%
IIC5350	Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)			95.00%	95.00%	80.70%	78.69%	80.33%	80.70%

National Quality Requirements

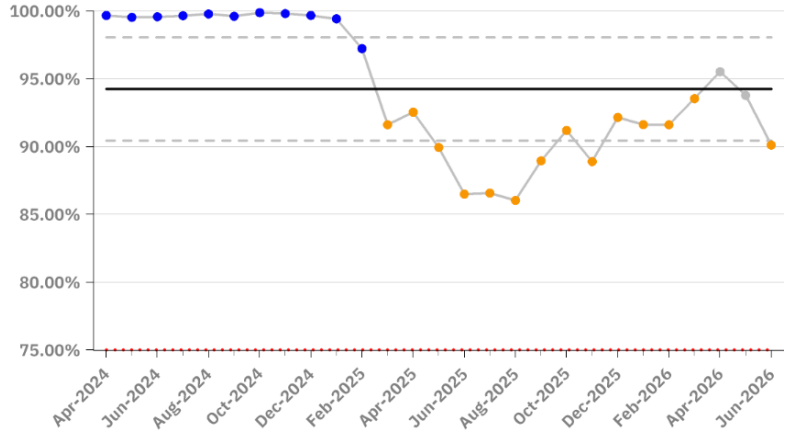
IIC4850 Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care



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



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



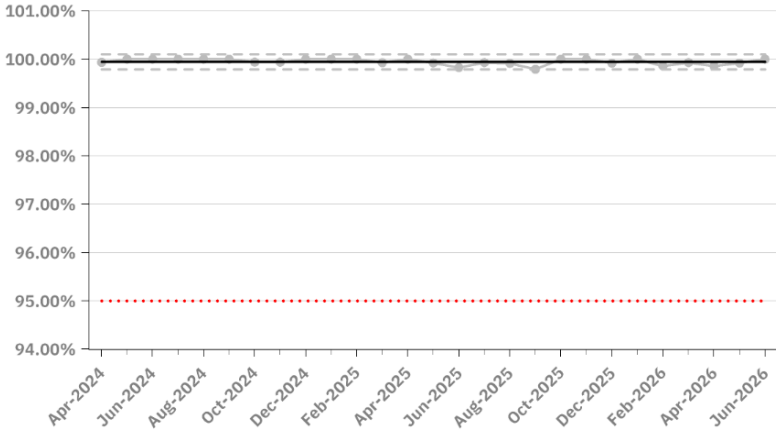
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	80%	93.45%			
COUNTY DURHAM	80%	94.24%			
TEES VALLEY	80%	95.80%			
NORTH YORKSHIRE	80%	95.24%			
YORK	80%	95.71%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	60%	82.03%			
COUNTY DURHAM	60%	80.00%			
TEES VALLEY	60%	86.49%			
NORTH YORKSHIRE	60%	88.41%			
YORK	60%	50.00%			

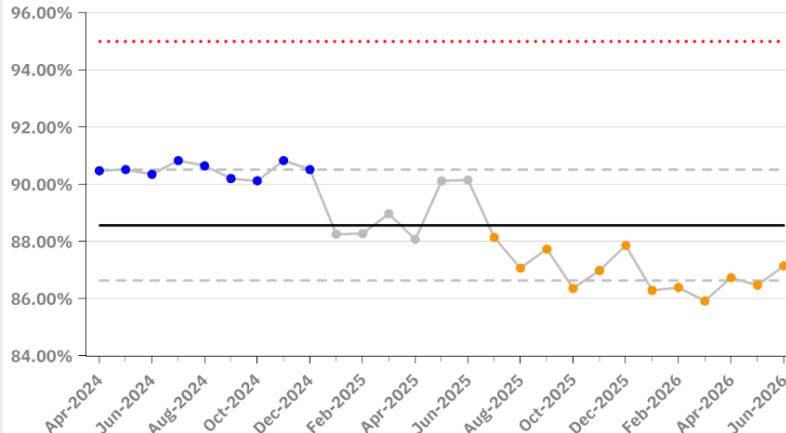
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	75%	93.11%			
COUNTY DURHAM	75%	94.39%			
TEES VALLEY	75%	94.48%			
NORTH YORKSHIRE	75%	89.43%			
YORK	75%	95.87%			

National Quality Requirements

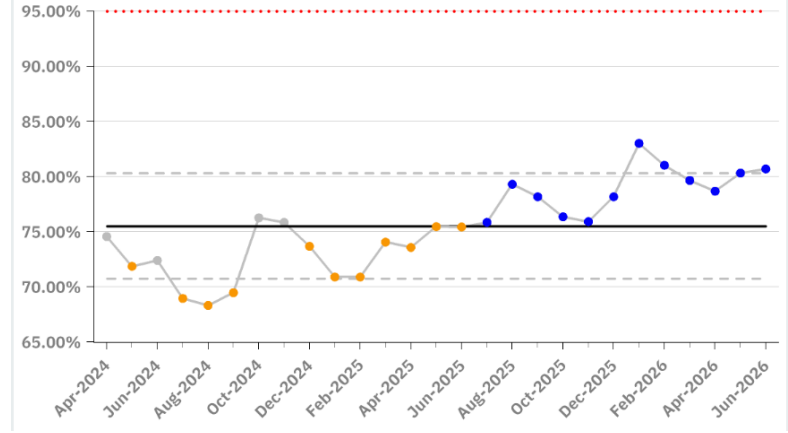
IIC6560 The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period



IIC5340 Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)



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



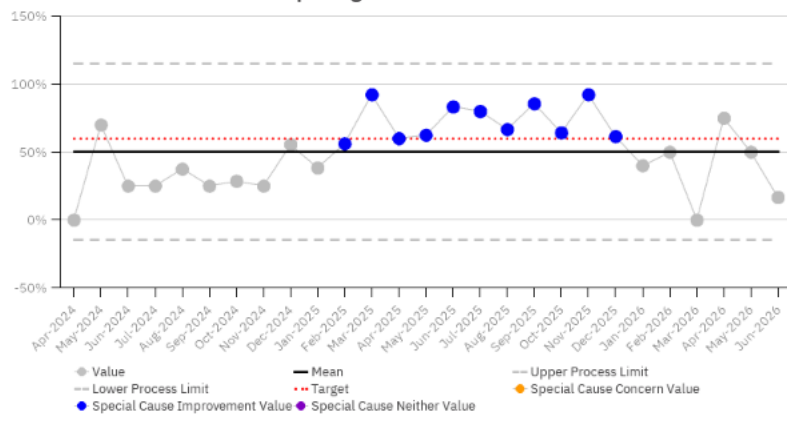
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	99.93%			
COUNTY DURHAM	95%	99.93%			
TEES VALLEY	95%	99.39%			
NORTH YORKSHIRE	95%	100.00%			
YORK	95%	100.00%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	87.15%			
COUNTY DURHAM	95%	84.26%			
TEES VALLEY	95%	95.74%			
NORTH YORKSHIRE	95%	89.29%			
YORK	95%	64.00%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	80.70%			
COUNTY DURHAM	95%	100.00%			
TEES VALLEY	95%	90.91%			
NORTH YORKSHIRE	95%	60.00%			
YORK	95%	66.67%			

Percentage of people experiencing First Episode Psychosis with a NICE approved care package within 2 weeks of referral

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 - YORK



Background / standard description:

We are aiming to have 60% of people experiencing First Episode Psychosis with a NICE approved care package within 2 weeks of referral

What does the chart show/context:

In June 2026, there were 6 patients referred in experiencing First Episode Psychosis, of which 1 (**16.67%**) received an approved care package within 2 weeks in **York**.

Of the 5 patients that did not receive treatment within the standard:

- 1 patient was offered an appointment (outside 2 weeks) due to patient choice. Patient commenced treatment on day 28.
- 1 patient was offered an appointment (outside 2 weeks) as additional information was needed prior to appointment. Patient commenced treatment on day 23.
- 3 patients were offered appointments (outside 2 weeks) due to team capacity. 2 patients commenced treatment on day 21; the remaining patient on day 33.

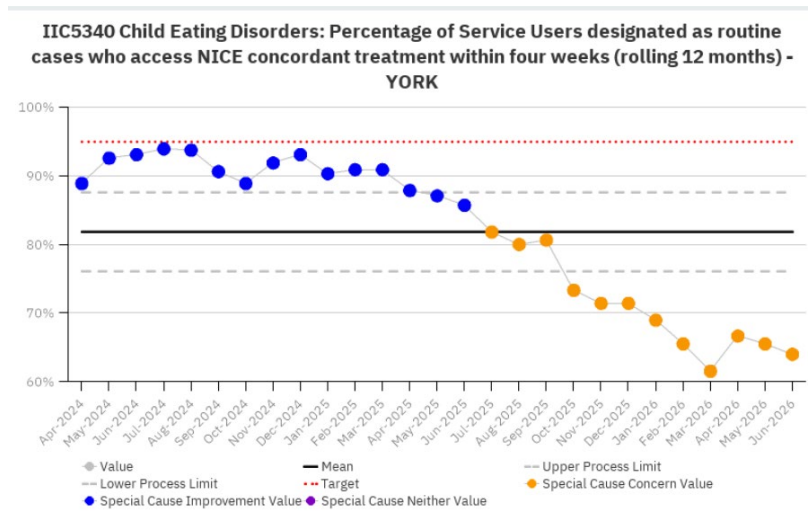
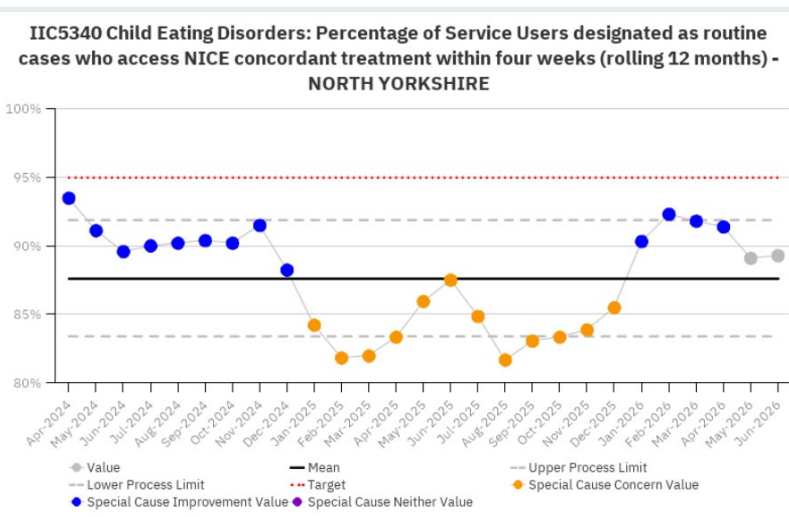
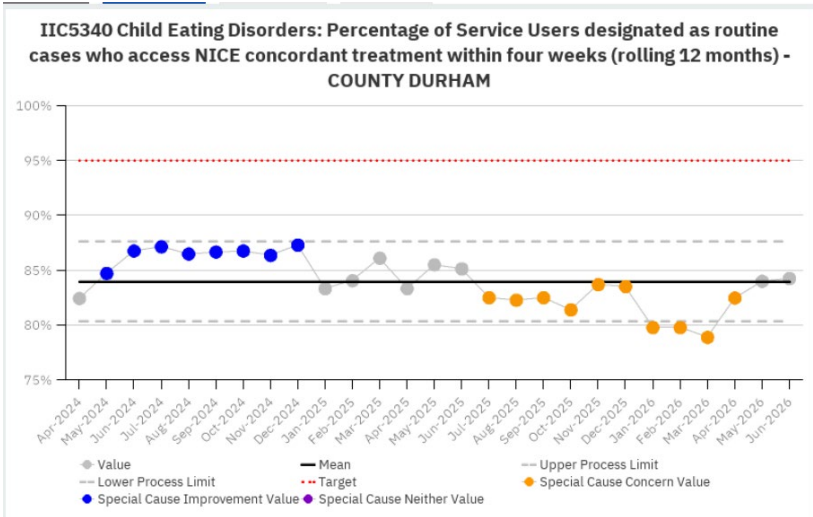
Underlying issues:

- Capacity within the York & Selby EIP team is currently impacted by vacancies and maternity leave

Actions:

- The York & Selby EIP team is in Services Requiring Additional Support and an action plan is in place. Recruitment is complete following successful interviews. Two staff commenced in July 26 and the successful candidates for the remaining vacancies will be in post by the end of September 2026. Following the delay to recruitment, care coordination capacity to improve treatment commencement is anticipated to improve from July 26 (previously May).

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 June 2026, there were **108** children and young people with a routine referral, of which 91 **(84.26%)** started treatment within 4 weeks in **County Durham**.

In June there were 16 children and young people with a routine referral; 14 **(87.50%)** started treatment within 4 weeks.

The 2 patients that did not receive treatment within the standard were offered appointments within 4 weeks, however, did not attend/cancelled. They commenced treatment on days 35 and 36.

What does the chart show/context:

In the rolling 12 months ending June 2026, there were **56** children and young people with a routine referral, of which **50 (89.29%)** started treatment within 4 weeks in **North Yorkshire**.

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

What does the chart show/context:

In the rolling 12 months ending June 2026, there were **25** children and young people with a routine referral, of which **16 (64.00%)** started treatment within 4 weeks in **York**.

In June, there were 2 children and young people with a routine referral; all 2 (100%) started treatment within 4 weeks.

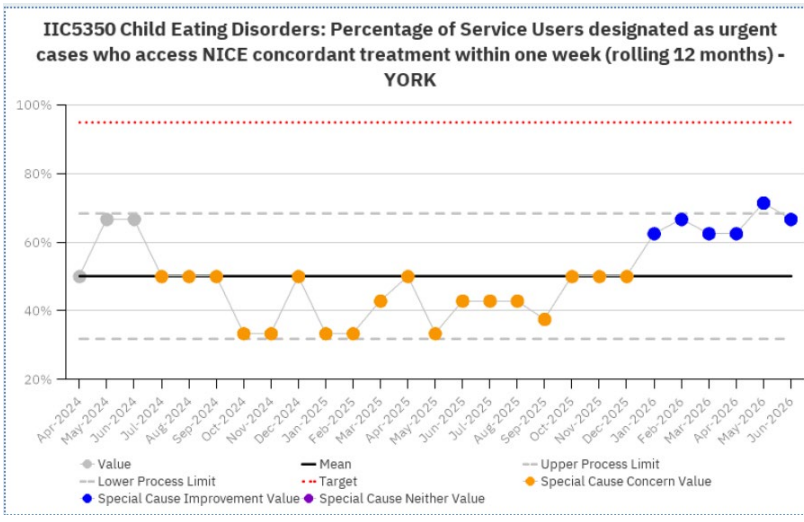
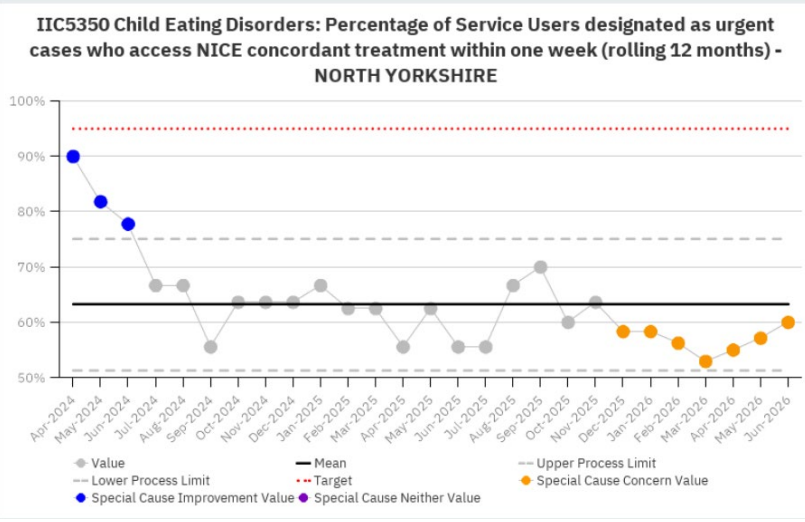
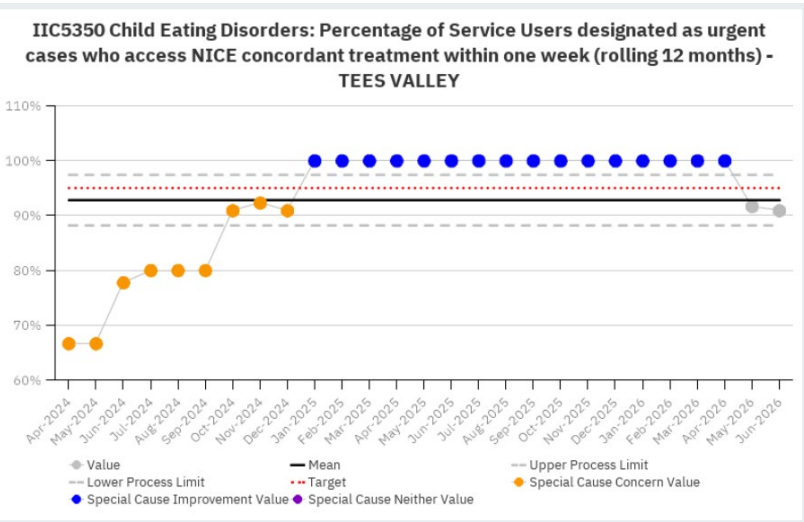
Underlying Issues:

There are no underlying issues to report.

Trust-wide Actions:

Operational Leads, overseen by Directors of Operations, will complete a service deep dive and develop a measurable improvement plan by 31 May 2026. The plan will set out actions and improvement trajectories and will be presented to Combined Care Group Governance in June **(Not Complete)** The plan will now be presented to Combined Care Group Board in July 2026 and then Executive Directors Group in August for oversight and assurance.

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 June 2026 there were **11** children or young people with an urgent referral, of which **10 (90.91%)** started treatment within 1 week in **Tess Valley**.

In June, there were no children and young people with an urgent referral.

What does the chart show/context:
In the rolling 12 months ending June 2026 there were **20** child or young people with an urgent referral, of which **12 (60%)** started treatment within 1 week in **North Yorkshire**.

In June, there were no children and young people with an urgent referral.

What does the chart show/context:
In the rolling 12 months ending June 2026, there were **6** child or young people with an urgent referral, of which **4 (66.67%)** started treatment within 1 week in **York**.

In June, there were no children and young people with an urgent referral.

Underlying Issues:
There are no underlying issues to report.

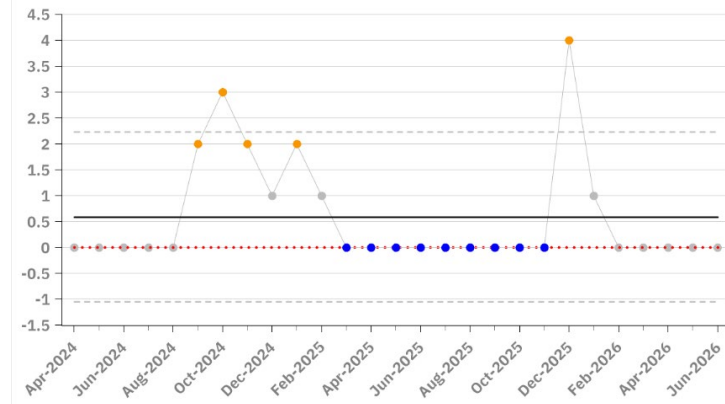
Actions:
There are no specific improvement actions required.

Mental Health Priorities – Provider and System-wide Plans

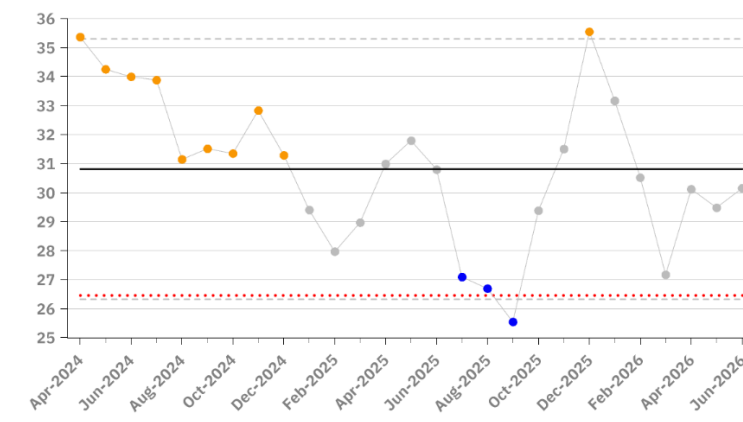
Rep Ref	Mental Health Priorities - Provider and System-wide Plans	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26	May-26	Jun-26
IIC6630	Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider (OAPs)			0	0	0	0	0	0
IIC6950	Average length of stay for patients in Adult Acute and PICU Mental Health Beds (Rolling Quarter)			26.40	26.46	30.15	30.12	29.48	30.15
IIC6960	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (Rolling Quarter)			70.00	70.12	74.27	70.12	72.30	74.27
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	257	725	340	257

Mental Health Priorities – Provider and System-wide plans

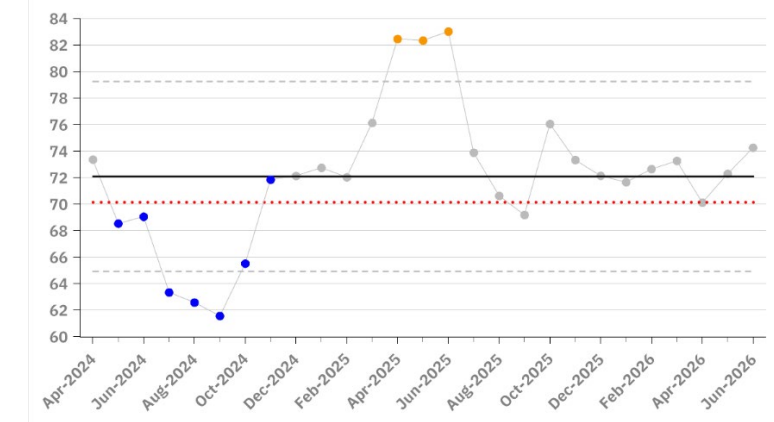
IIC6630 Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider (OAPs)



IIC6950 Average length of stay for patients in Adult Acute and PICU Mental Health Beds (Rolling Quarter)



IIC6960 Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (Rolling Quarter)



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	26.46	30.15			
COUNTY DURHAM		26.94			
TEES VALLEY		35.08			
NORTH YORKSHIRE		29.06			
YORK		33.33			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	70.12	74.27			
COUNTY DURHAM		66.90			
TEES VALLEY		77.80			
NORTH YORKSHIRE		88.61			
YORK		47.00			

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	257			
COUNTY DURHAM		52			
TEES VALLEY		204			
NORTH YORKSHIRE		0			
YORK		0			

To Note: There is one patient not included in the table as they are from Chorley and South Ribble Place.

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 26.46 days by the end of June 2026.

What does the chart show/context:

During the 3-month period ending June 2026, there were **546** discharged hospital spells from adult acute or PICU beds for patients aged 18+, accounting for a total of **16,642** bed days which equates to an average length of stay of **30.15** days.

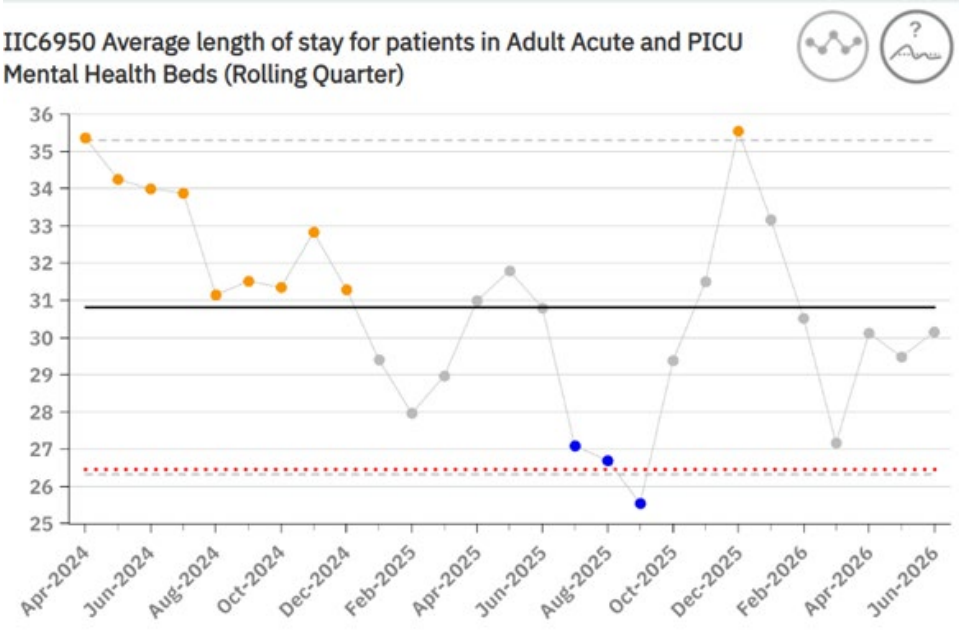
We are not achieving plan at Trust and Care Group level and there is no significant change in the reporting period.

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 June 2026 there were 172 (out of 546) patients with a length of stay exceeding plan; 27 patients with lengths of stay exceeding 100 days were discharged.

Actions:

See measure 09 within the IPD *Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed)* 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	30.12	29.48	30.15									

Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (rolling quarter)

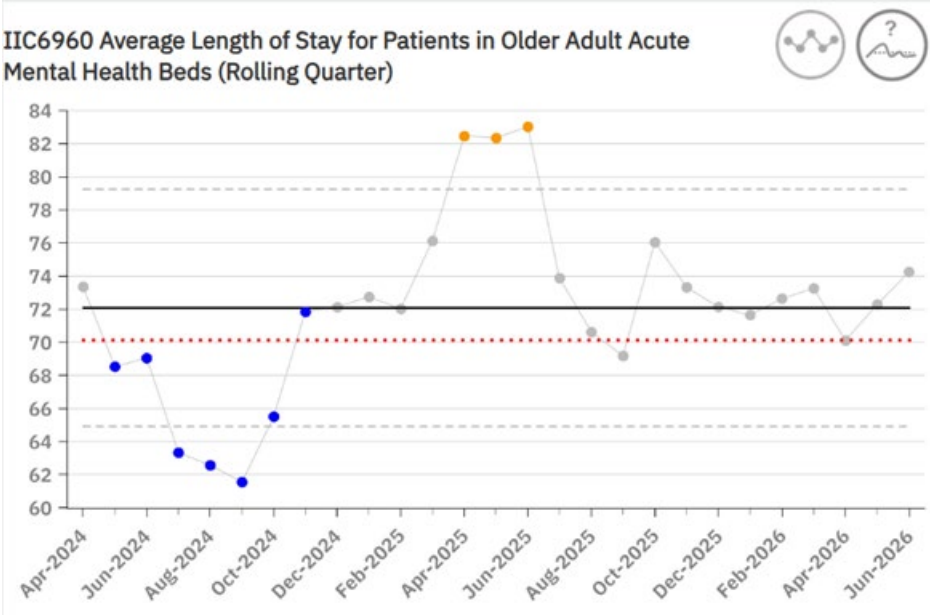
Background / standard description:
We are aiming to reduce our average length of stay within our older adult acute inpatient beds to 70.12 days by the end of June 2026.

What does the chart show/context:
During the 3-month period ending June 2026, there were **157** discharged hospital spells from older adult acute beds, accounting for a total of **11,660** bed days which equates to an average length of stay of **74.27** days.

We are not achieving plan at Trust and Care Group level and there is no significant change 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 June 2026 there were 74 (out of 157) patients with a length of stay exceeding plan; 42 patients with lengths of stay exceeding 100 days were discharged.

Actions:
See measure 09 *Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed)* for actions.



Average Length of Stay for Patients in Older Adult Acute Mental Health 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	70.16	70.15	70.12	70.12	70.12	70.08	70.08	70.08	70.04	70.04	70.04	70.00
Actual	70.12	72.30	74.27									

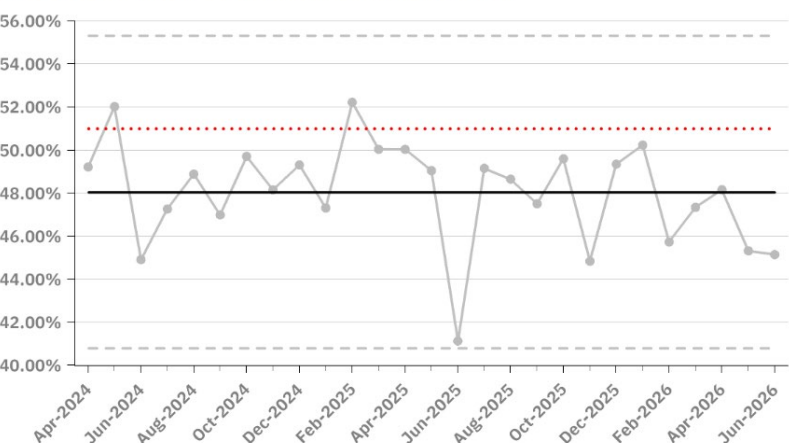
Mental Health Priorities – System-Wide Plans

Rep Ref	Mental Health Priorities - System-wide Plans	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26	May-26	Jun-26
IIC6490	Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness			51.00%	51.00%	46.22%	48.16%	45.32%	45.15%
IIC6480	Talking Therapies - Reliable improvement rate for those completing a course of treatment			69.00%	69.00%	66.23%	67.41%	65.71%	65.53%
IIC6640	Talking Therapies: Number of people who are discharged having received at least 2 treatment appointments in the reporting period		N/A	Data Only	Data Only	4,080	1,387	1,286	1,407
IIC5371	Number of women accessing (1+ contact) specialist community PMH services in the previous 12 months		N/A	Data Only	Data Only	1,494	1,503	1,493	1,494
IIC6610	Number of people accessing IPS services (rolling 12 month)		N/A	Data Only	Data Only	1,326	1,196	1,240	1,326
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	30,432	31,247	30,845	30,432
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)		N/A	Data Only	Data Only	2,057	1,990	2,014	2,057

Please note that the variation for the number of women accessing specialist community PMH services has been removed due to several issues that we have identified. Remedial work is underway, and an action plan has been developed which is being overseen by the Associate Director of Performance.

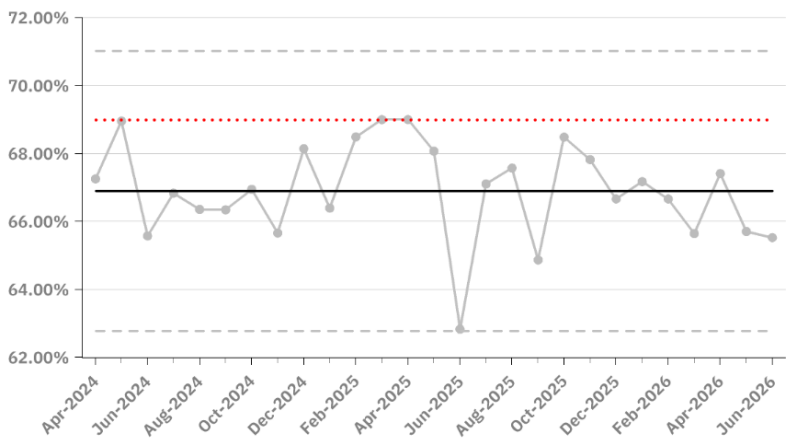
Mental Health Priorities – System Wide Plans

IIC6490 Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness



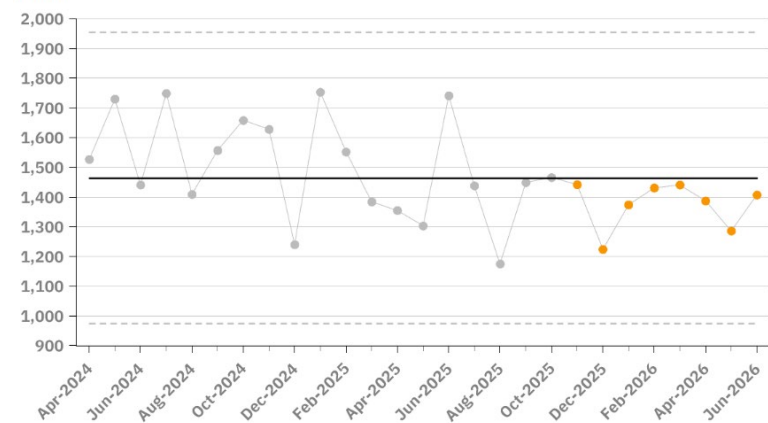
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	51%	46.22%			
COUNTY DURHAM	51%	42.91%			
TEES VALLEY	51%	44.11%			
NORTH YORKSHIRE	51%	48.28%			
YORK	51%	49.58%			

IIC6480 Talking Therapies - Reliable improvement rate for those completing a course of treatment



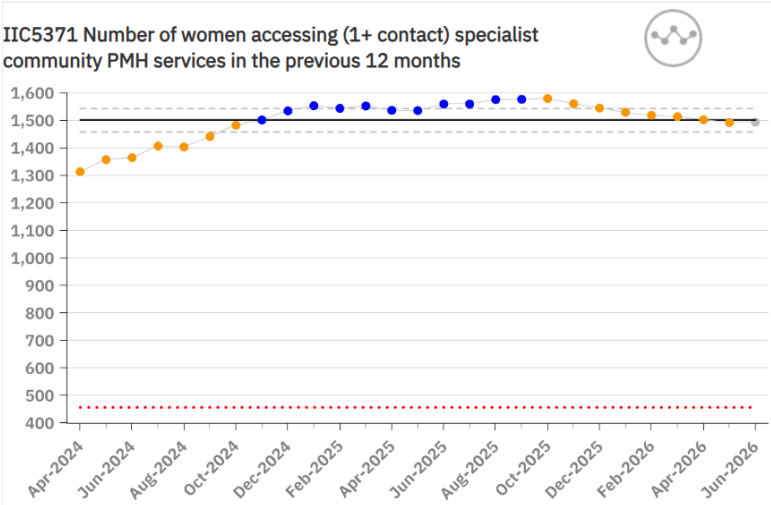
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	69%	66.23%			
COUNTY DURHAM	69%	63.93%			
TEES VALLEY	69%	63.80%			
NORTH YORKSHIRE	69%	68.20%			
YORK	69%	68.23%			

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



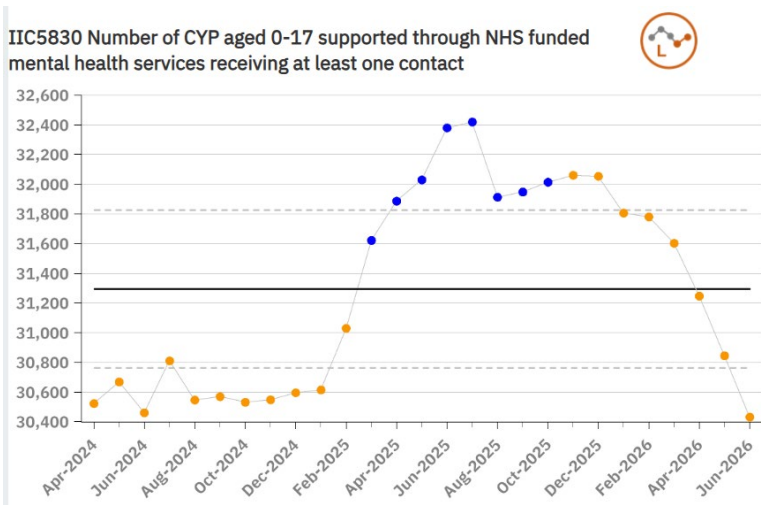
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		4,080			
COUNTY DURHAM		1,533			
TEES VALLEY		326			
NORTH YORKSHIRE		1,324			
YORK		872			

Mental Health Priorities – System-Wide Plans

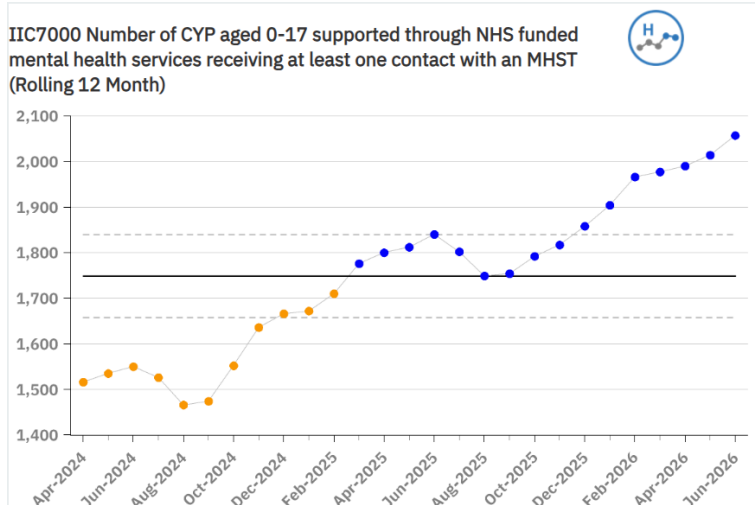


Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,494			
COUNTY DURHAM	456	389			
TEES VALLEY	447	499			
NORTH YORKSHIRE	368	420			
YORK	156	161			

Please note that the variation for Trust and County Durham place has been removed due to several issues that we have identified. Remedial work is underway, and an action plan has been developed which is being overseen by the Associate Director of Performance.



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		30,432			
COUNTY DURHAM		10,688			
TEES VALLEY		9,913			
NORTH YORKSHIRE		5,744			
YORK		3,525			

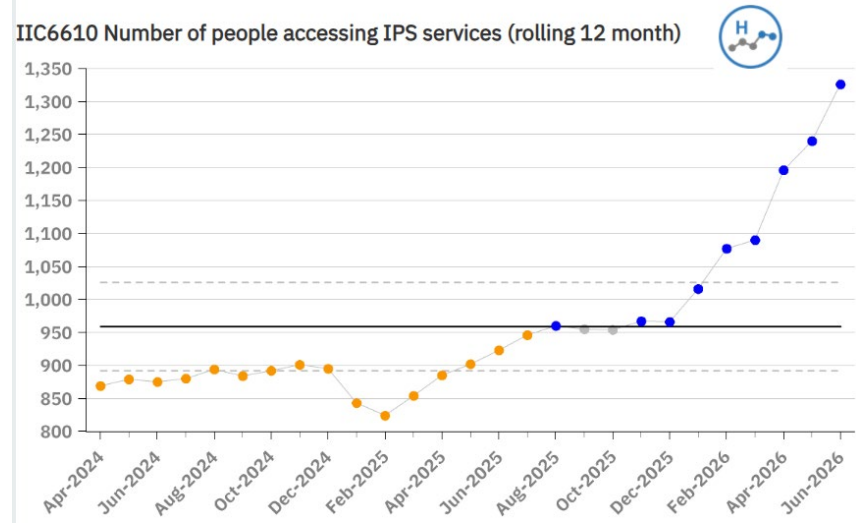


Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		2,057			
COUNTY DURHAM		901			
TEES VALLEY		350			
NORTH YORKSHIRE		504			
YORK		238			

Mental Health Priorities – System-Wide Plans

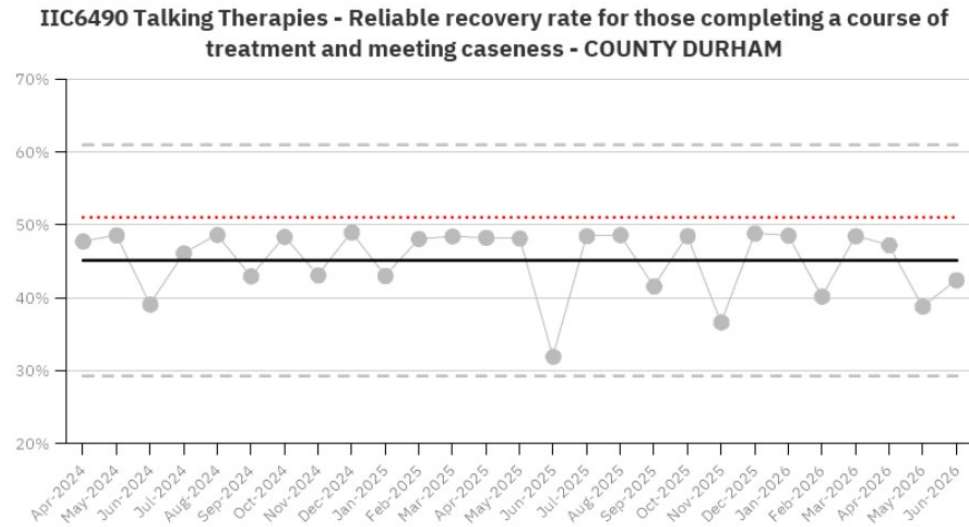
IIC6610 Number of people accessing IPS services (rolling 12 month)

Month	Number of people accessing IPS services (rolling 12 month)
Apr-2024	875
May-2024	880
Jun-2024	875
Jul-2024	880
Aug-2024	895
Sep-2024	885
Oct-2024	895
Nov-2024	905
Dec-2024	895
Jan-2025	845
Feb-2025	825
Mar-2025	855
Apr-2025	885
May-2025	905
Jun-2025	925
Jul-2025	950
Aug-2025	965
Sep-2025	955
Oct-2025	955
Nov-2025	970
Dec-2025	965
Jan-2026	1015
Feb-2026	1080
Mar-2026	1090
Apr-2026	1195
May-2026	1240
Jun-2026	1330



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,326			
COUNTY DURHAM		433			
TEES VALLEY		509			
NORTH YORKSHIRE	380	241			
YORK		109			

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



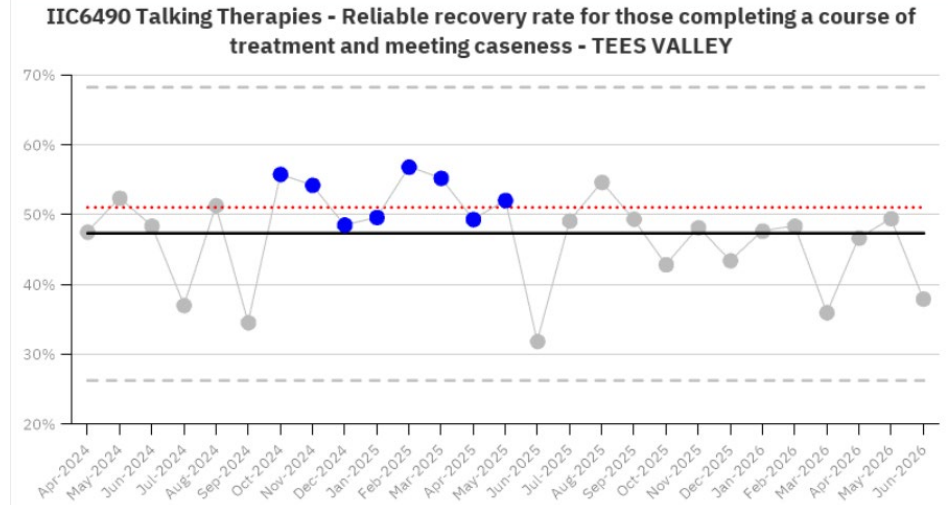
Background / standard description:

We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:

Financial year to date 42.91% of patients demonstrated reliable recovery rate following completion of a course of treatment within **County Durham**. During June, 42.44% demonstrated reliable recovery.

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.

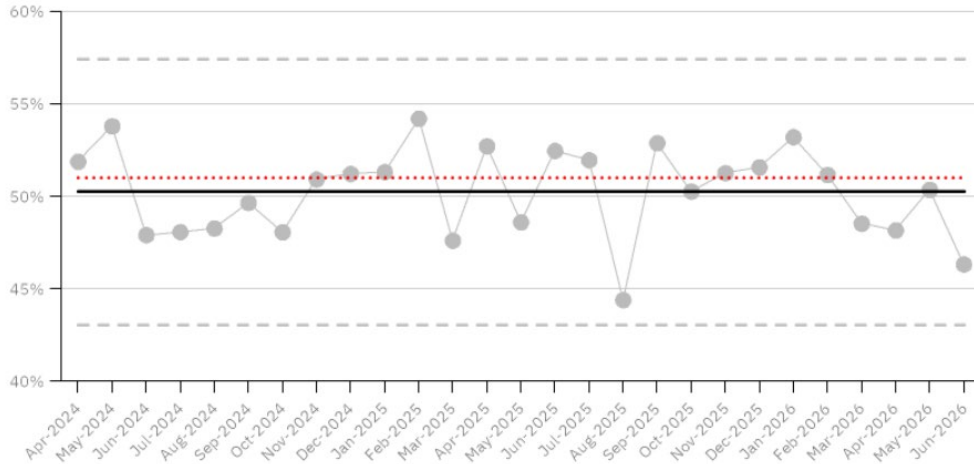
What does the chart show/context:

Financial year to date 44.11% of patients demonstrated reliable recovery rate following completion of a course of treatment within **Tees Valley**. During June, 37.93% demonstrated reliable recovery.

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

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

IIC6490 Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness - NORTH YORKSHIRE



Background / standard description:

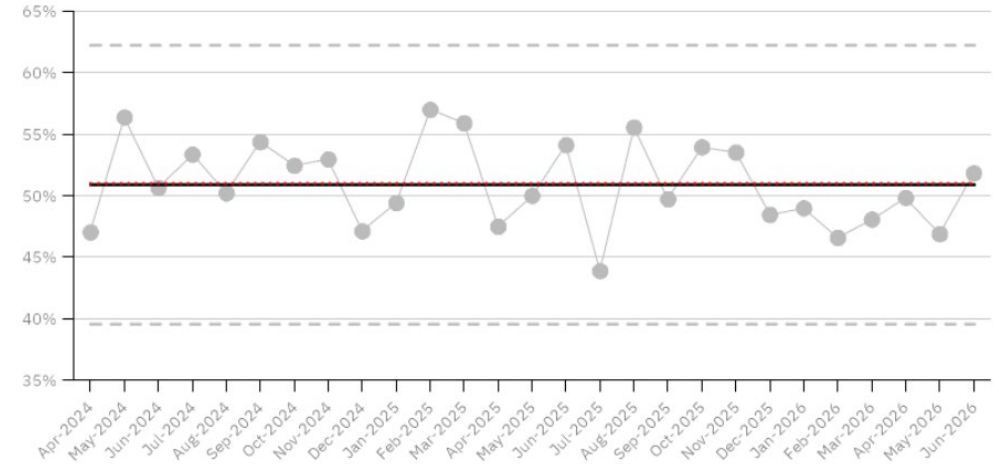
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:

Financial year to date **48.28%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **North Yorkshire**. During June, **46.32%** demonstrated reliable recovery.

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

IIC6490 Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness - YORK



Background / standard description:

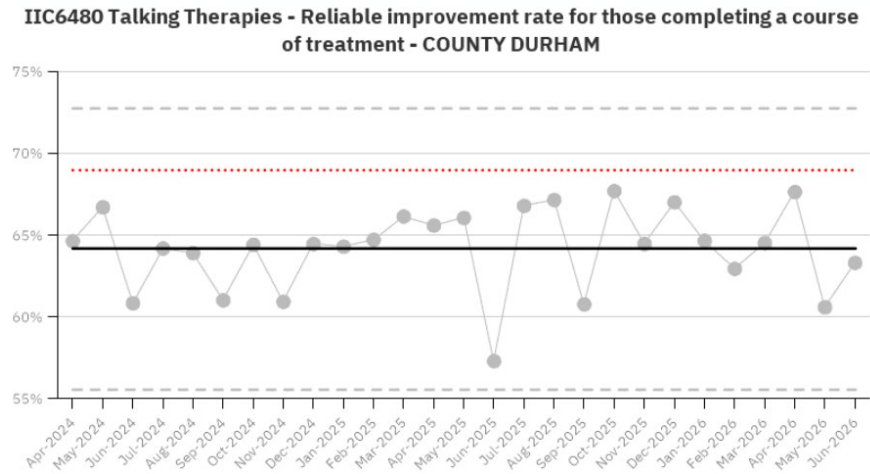
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:

Financial year to date **49.58%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **York**. During June, **51.84%** demonstrated reliable recovery.

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

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



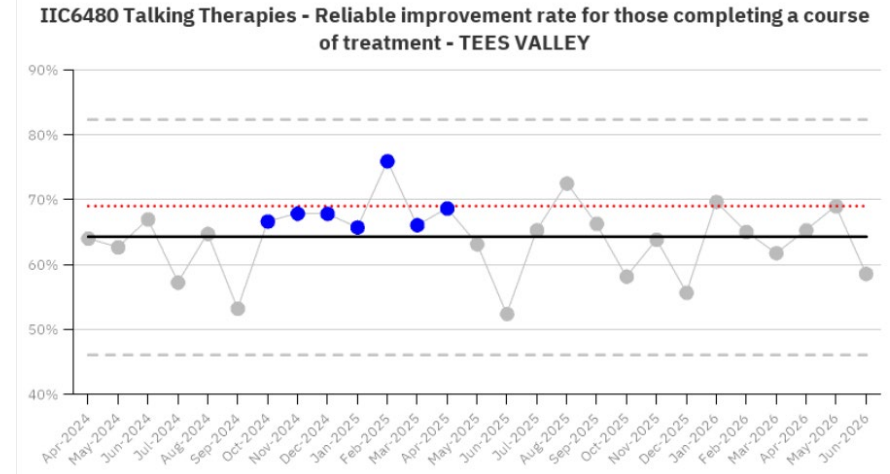
Background / standard description:

We are aiming for 69% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:

Financial year to date **63.93%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**. During June, **63.31%** demonstrated reliable improvement.

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.

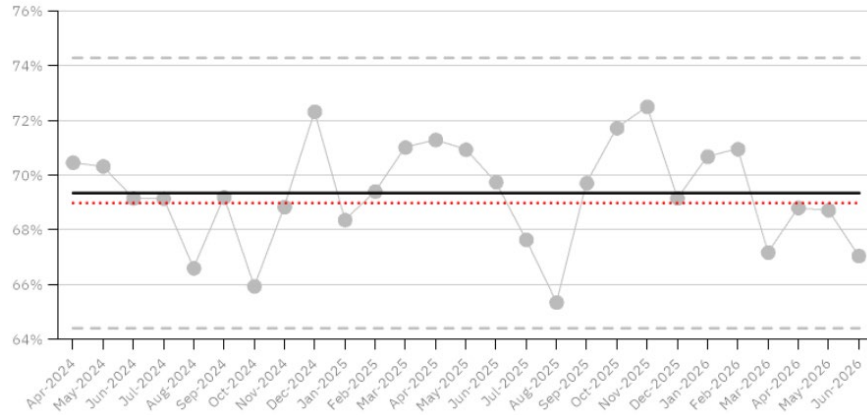
What does the chart show/context:

Financial year to date **63.80%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**. During June, **58.59%** demonstrated reliable improvement.

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

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

IIC6480 Talking Therapies - Reliable improvement rate for those completing a course of treatment - NORTH YORKSHIRE



Background / standard description:

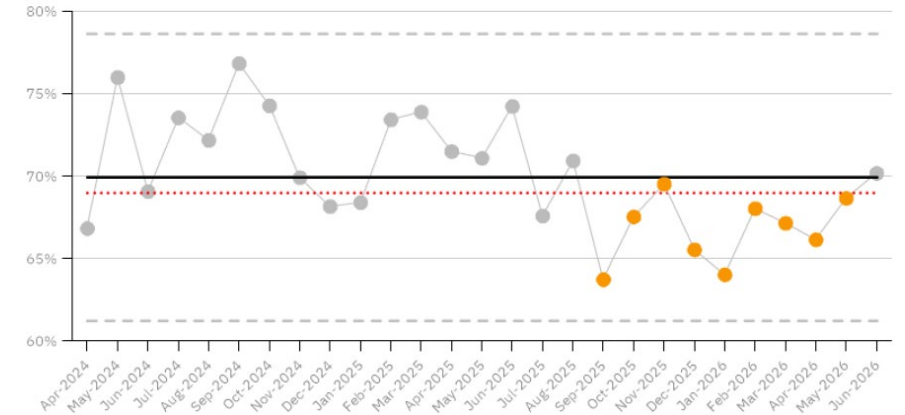
We are aiming for 69% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:

Financial year to date **68.20%** of patients demonstrated reliable improvement following completion of a course of treatment within **North Yorkshire**. During June, **67.05%** demonstrated reliable improvement.

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

IIC6480 Talking Therapies - Reliable improvement rate for those completing a course of treatment - YORK



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:

Financial year to date **68.23%** of patients demonstrated reliable improvement following completion of a course of treatment within **York**. During June, **70.18%** demonstrated reliable improvement.

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

County Durham & Tees Valley

Underlying issues:

- Increase in complexity and severity of patient's presentation, which makes it more challenging to see a 6-point (Patient health questionnaire - PHQ9) or a 4-point (Generalised anxiety disorder - GAD) shift.
- A financial gap between capacity and demand is potentially impacting outcomes as under current capacity we are providing fewer than the prescribed number of treatment sessions per patient for Step 3 treatment.
- Reliable Improvement is impacted by the inclusion of Step 1 counselling, as this includes patients that do not meet caseness on referral and therefore are unable to demonstrate sufficient improvement to reflect reliable improvement.
- High levels of complex patients are showing reliable improvement on two outcome measures; however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the other scores.

Actions:

- Recruitment is underway for 3.7 WTE permanent PWPs; interviews held in May 2026 were unsuccessful, therefore the posts will be held until later in the year to align with college intake processes in September 2026.
- The DTVFCG Performance Improvement Plan has 6 open actions due to be completed by July 2026. Two actions have been completed - possibility thinking sessions and completion of the options appraisal to remove Step 1 activity; the remaining 4 are on track for delivery. Testing of the trial separation of the Step 1 data is now complete, and this will now be subject to a next steps paper.

North Yorkshire & York

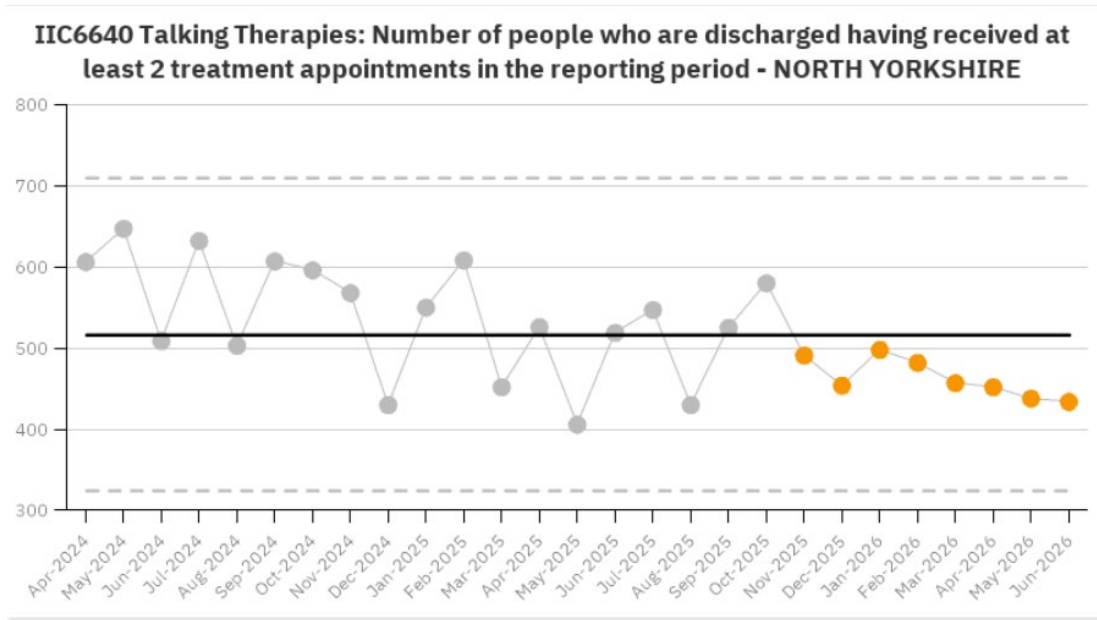
Underlying issues:

The complexity and severity of patients within the North Yorkshire Talking Therapies teams

Actions:

- North Yorkshire Talking Therapies team manager to re-share referral and suitability criteria with all GP practices within North Yorkshire to support early identification and improve understanding of appropriate referral thresholds and alternative pathways for patients with high complexity and severity. This will be completed by September 26.
- North Yorkshire Talking Therapies to commence sharing patient-level specific reliable recovery and reliable improvement outcomes with GP practices, through targeted engagement to improve reliable recovery and reliable improvement rates for these patients and improve understanding on the benefits of early referral and appropriate service selection. This will commence from July 2026.
- Scarborough Talking Therapies team manager to set up Leadership Review panel pilot to provide additional clinical oversight for patients who are at risk of poor outcomes, ensuring that treatment plans remain appropriate, timely and effective. This will be completed by the end of September 2026.

Talking Therapies: Number of discharges having received at least 2 treatment appointments in the reporting period – *by exception*



Background / standard description:

Whilst we are contributing to the system-wide plan there is no agreed standard at place level.

What does the chart show/context:

Financial year to date **1324** patients discharged having received at least 2 treatment appointments in the report period within **North Yorkshire**. During June, 434 patients received at least 2 treatment appointments.

There is special cause concern within North Yorkshire as indicated in the chart above.

Underlying issues:

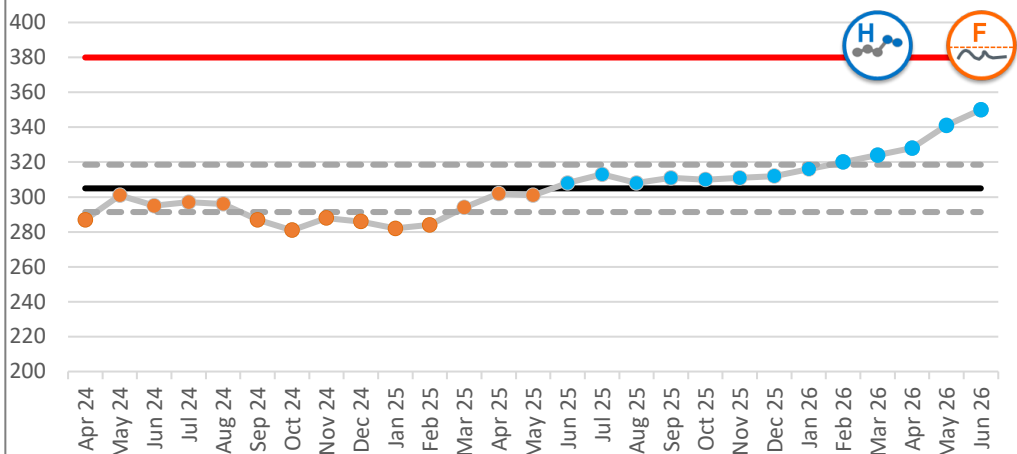
Within North Yorkshire Talking Therapy service, from middle of October 2025, treatment capacity has been converted to assessment capacity to address a backlog of patients waiting for 1st treatment appointment, reducing the number of people receiving psychological therapies and impacting the number of patients discharged having received at least 2 treatment appointments.

Actions:

- There are no specific improvement actions at present; however, this was discussed at the Care Group Board Quality & Performance Group in June 2026 (**Complete**). The Group agreed that further work is required to understand the underlying cause of the issue and to identify appropriate improvement actions. The current priority is to continue converting treatment capacity into assessment capacity to reduce assessment waiting times to four weeks. This work is expected to be completed by the end of September 2026.

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

Number of people accessing IPS services (rolling 12 month) - HNY ICB



Background / standard description:

In the 12 months ending June 2026, we are aiming for **380** people across **Humber & North Yorkshire ICB** to access individual placement & support services.

What does the table show/context:

In the 12 months ending June 2026, **350** people accessed IPS services.

HNY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TEWV- Ambition	380	380	380	380	380	380	384	385	434	466	501	536
TEWV- Actual	319	339	350									

Underlying issues:

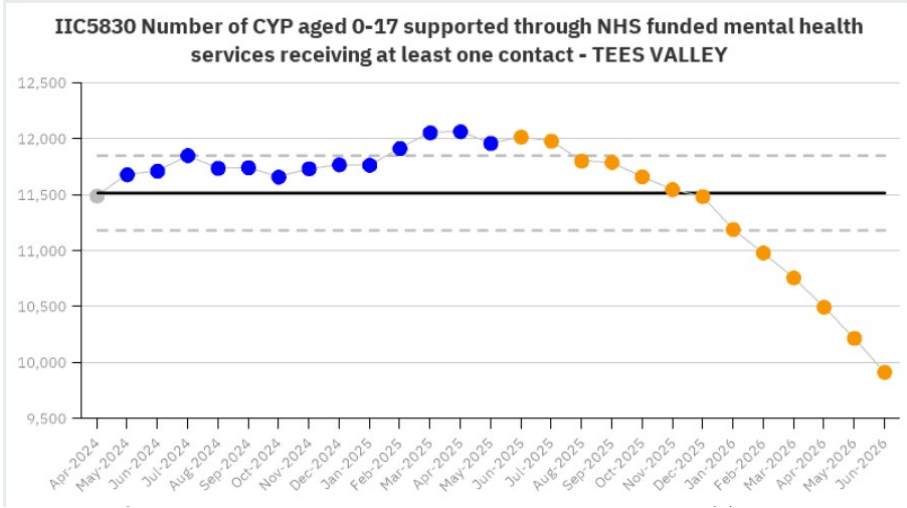
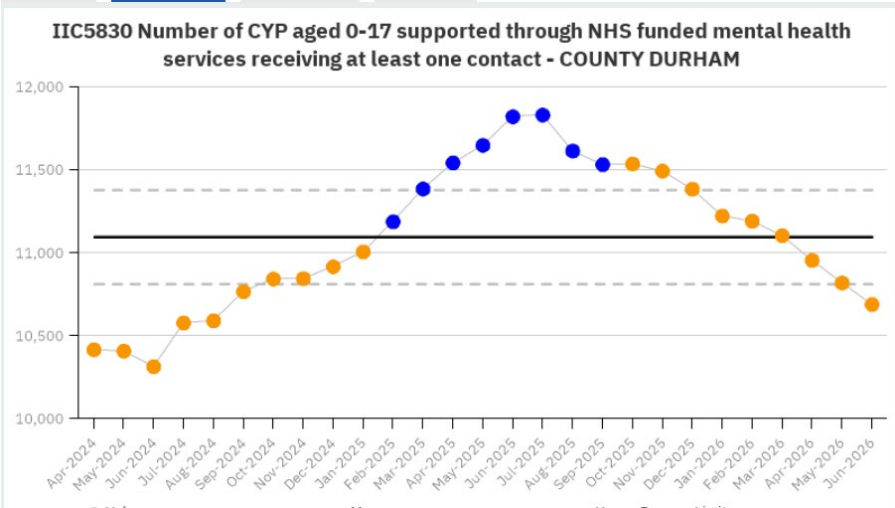
Vacancy (1 wte Senior Employment Specialist) and maternity leave (0.4 Employment Specialist)

Actions:

Recruitment for the Senior Employment Specialist has been successful, and the individual is currently in pre-employment checks. Employment Specialist returns from maternity leave in July 2026.

To note: funding has been agreed to expand this service which aligns to the increased ambition in the trajectory shown above. 3.5 wte Employment Specialist and 1 wte Employment Assistant have been recruited and are anticipated to commence by the end of August 2026. Recruitment is underway for 2 wte Employment Specialists (closing date July 2026) and 3.8wte Employment Specialists (in vacancy control).

Number of CYP aged under 18 supported through NHS funded mental health with at least one contact



Background / standard description:

Whilst we are contributing to the system-wide plan there is no agreed standard at place level.

What does the chart show/context:

In the rolling 12 months ending June, **10,688** children and young people received at least one contact within **County Durham**.

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

What does the chart show/context:

In the rolling 12 months ending June, **9,913** children and young people received at least one contact within **Tees Valley**.

There is special cause concern as indicated in the chart above; however, this does not include the additional data (see underlying issue below)

Underlying Issues:

- For County Durham place we do not fully understand the underlying reasons for the reduction.
- In January 2026 we launched the new CYP Tees Valley Getting Help Service, whose data is recorded on IAPTUs. Whilst this data is incorporated into our MHSDS, it is reported separately in the new service report. Based on latest figures, this would show the overall position at approximately 12,000 children and young people therefore not a concern.

Actions:

- The Performance Lead in collaboration with the General Manager was to undertaken a review to understand the reasons for the reduction within County Durham Place, by the end of June 2026. **(Not Complete)**. The review will now be completed by the end of August.
- The Associate Director of Performance has worked with Business Intelligence to explore how to match national and local data for assurance and reporting and identify any possible mitigating actions for risks identified. An options appraisal was shared with collaborators by the end of June 2026 (previously April and May 26). **(Complete)** See below actions.
- The Associate Director of Performance is exploring an interim solution pending the implementation of the new Electronic Patient Record, RIO, Business Intelligence to explore a permanent option. This will be completed by the end of July.

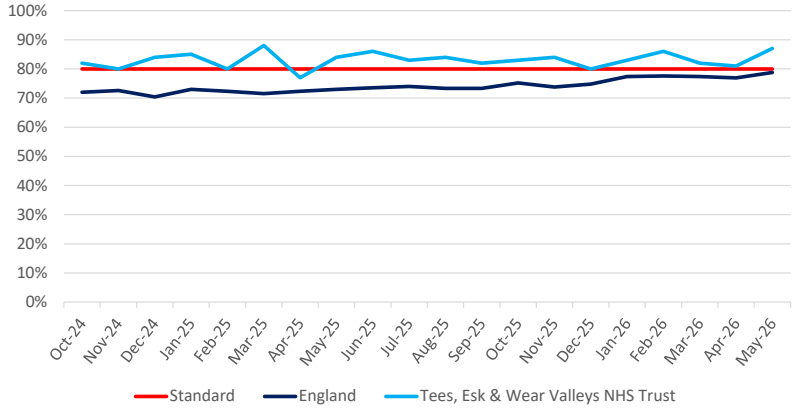
Number of CYP aged under 18 supported through NHS funded mental health with at least one contact

To Note:
Following validation of local reporting methodology against national MHSDS definitions, administrative contacts have been removed from the CYP Access measure, which has resulted in a small reduction in reported activity. The change improves alignment with national reporting requirements and provides greater assurance regarding the accuracy of reported access performance.

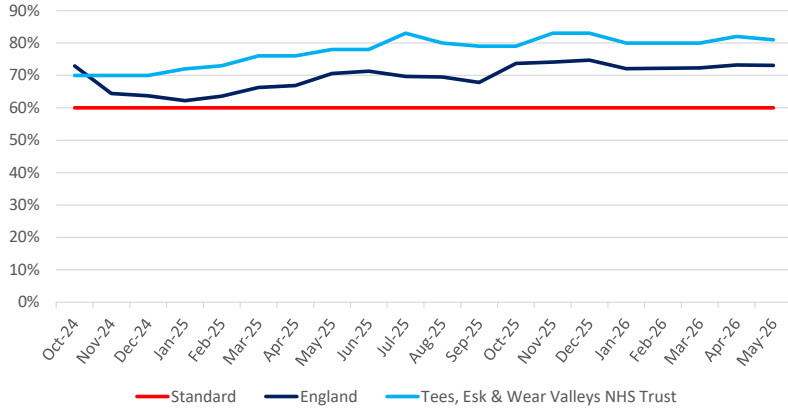
10. Benchmarking

National Quality Requirements

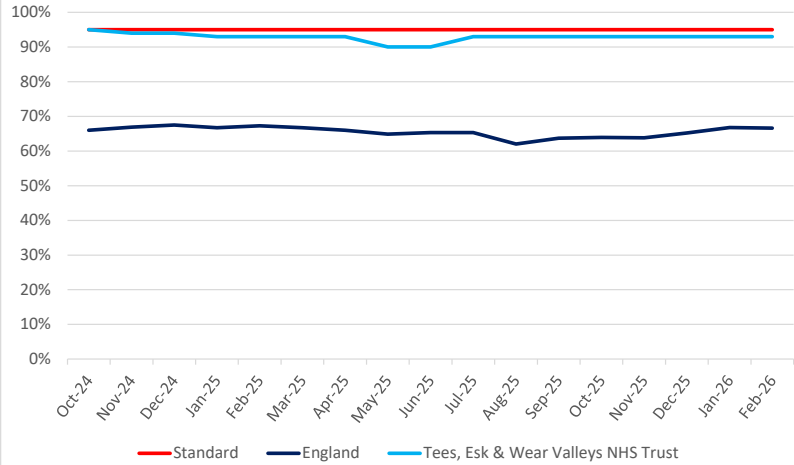
Percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care



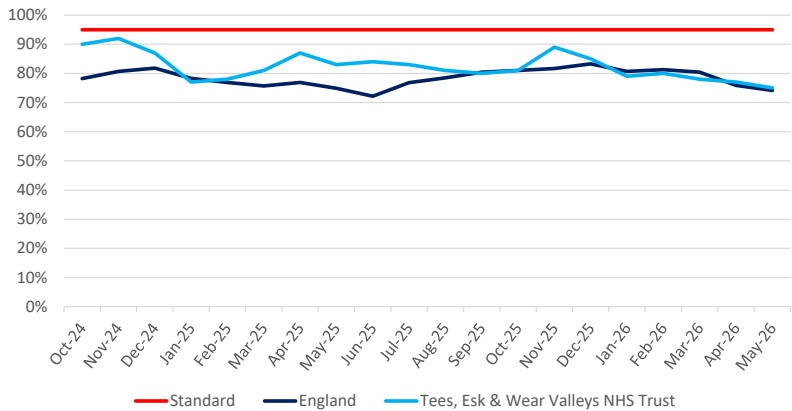
Percentage of service users experiencing a first episode psychosis of ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care



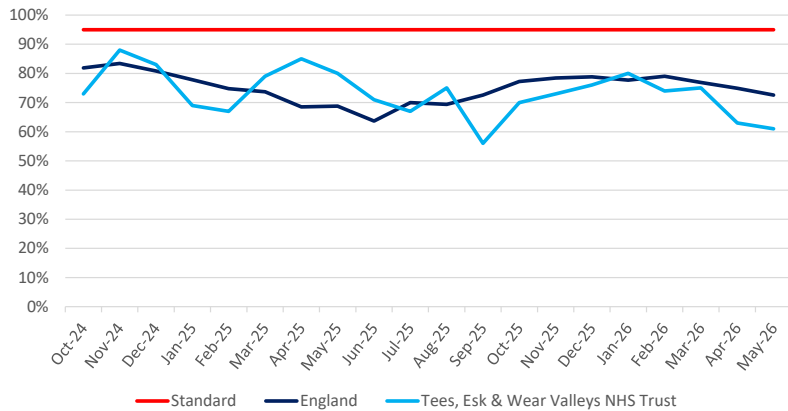
Data Quality Maturity Index



Child Eating Disorders: Percentage of service users designated as routine cases who access NICE concordant treatment within 4 weeks



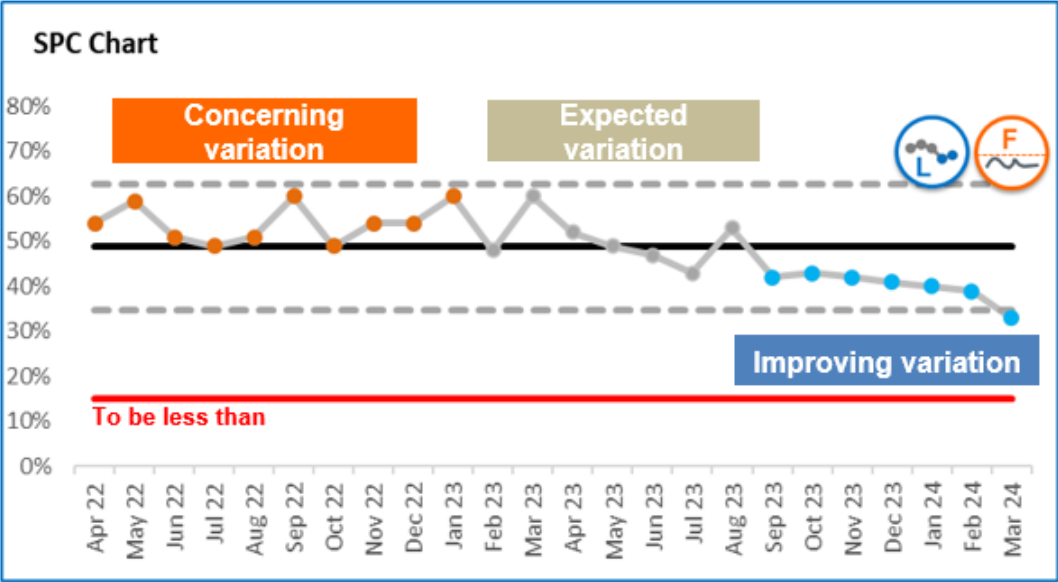
Child Eating Disorders: Percentage of service users designated as routine cases who access NICE concordant treatment within 4 weeks



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.

Variation/Performance Icons			
Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.	Consider if the level/range of variation is acceptable. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	Something's going on! Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	Investigate to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	Something's going on! Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	Something good is happening! Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. Celebrate the improvement or success. Is there learning that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	Something good is happening! Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	Investigate to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	
Assurance Icons			
Icon	Technical Description	What does this mean?	What should we do?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.	You need to change something in the system or process if you want to meet the target. The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.	Celebrate the achievement. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Data Quality

On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The most recent assessment was completed in quarter 4 2025/26 and the results incorporated within this report. The next assessment will be completed in quarter 2 2026/27.

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

Our Approach to Performance and Controls Assurance

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 <u>OR</u> We are not achieving standard		
Neutral	We are achieving standard (where relevant) <u>AND</u> we have no underlying areas of concern	We are achieving the standard (where relevant) with only 1 area of concern; <u>OR</u> There is consistent performance	We have more than 1 underlying area of concern <u>OR</u> There is consistent underperformance below the standard	
Negative		We have no underlying areas of concern <u>AND</u> there is an improving position visible in the data	We have a small number of areas of underlying concern <u>OR</u> There is a deteriorating position visible in the data <u>OR</u> Performance continues below the mean <u>OR</u> We are achieving the standard <u>HOWEVER</u> 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 <u>OR</u> There is a clear deterioration visible in the data <u>AND</u> 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; <u>OR</u> - the SPC chart indicates an unexpected upward or downward shift, which is confirmed by the service as a positive shift; <u>OR</u> - Forecast position is positive; <u>OR</u> - National benchmarking data indicates we are in the lowest (most positive) quartile	We have Neutral controls assurance when: - the SPC chart indicates Common Cause; <u>OR</u> - 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; <u>OR</u> - the SPC chart indicates an unexpected upward or downward shift, which is confirmed by the service as a negative shift; <u>OR</u> - Forecast position is negative; <u>OR</u> - National benchmarking data indicates we are in the highest (least positive) quartile

AAR	After Action Review
ADHD	Attention deficit hyperactivity disorder
ALD	Adult Learning Disabilities
ALOS	Average Length of Stay
AMH	Adult Mental Health
CAMHS	Child and Adolescent Mental Health Services
CRES	Cash Release Efficiency Savings
CROM	Clinician Reported Outcome Measure
CrFD	Clinically Ready for Discharge
CYP	Children & Young People
DNA	Did Not Attend
DTVFCG	Durham Tees Valley & Forensic Care Group
EDG	Executive Directors Group
EIP	Early Intervention in Psychosis
ESR	Electronic Staff Record
GBO	Goal-Based Outcomes
HCY	Humber & North Yorkshire
ICB	Integrated Care Board
IPD	Integrated Performance Dashboard
IPS	Individual Placement Support
IQPR	Integrated Quality & Performance Report

LTS	Long Term Sickness
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
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NOF	NHS Oversight Framework
NYSCG	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
STEIS	Strategic Executive Information System
WTE	Whole time equivalent

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For General Release

Meeting of:	Board of Directors
Date:	13 August 2026
Title:	Quarterly (Q4) and Annual Report of the Guardian of Safe Working Hours for Resident Doctors
Executive Sponsor(s):	Dr Kedar Kale, Executive Medical Director
Author:	Dr Sharon Beattie, Guardian of Safe Working

Report for:	<i>Assurance</i>	☒	<i>Decision</i>	☐
	<i>Consultation</i>	☐	<i>Information</i>	☒

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*

X

Strategic Risks relating to this report:

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

Executive Summary:

Purpose:

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

The Board receives annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for resident doctors. This is the annual report for 2025-2026, and there is also quarterly data relating to Q4. The appendices have been provided to me by Medical Staffing, and they include aggregated data on exception reports, details of fines levied against departments, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting, when needed, good practice and/or persistent concern. Reports and appendices are shared with the corresponding NHS England body for the different sectors.

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

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

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

Overview:

- The majority of fines, in Quarter 4, that have been levied are due to breach of the 5 hours overnight rest requirement on NROC rotas. There was a rota intensity exercise for the middle tier rotas throughout the Trust in 2025. The data collected from this suggested that the NROC rotas are significantly quieter than was previously predicted. This has resulted in a reduction in the payments for on-call work on these rotas. There is the risk that this could lead to increased exception reports but such reports wouldn't result in fines unless rest requirements were not met.
- The internal system for covering out of hours rota gaps appears to generally continue to function well in that there is no reported use of agency locums on out of hours postgraduate doctors' rotas. There have been occasions when doctors on the higher tiers have had to 'act down' for periods of time when internal locums cannot be appointed at short notice.
- There is a well-functioning Resident Doctors' Training Forum (RDTF) in each of the Care Groups with good attendance by resident doctor representatives from localities across the Trust. In January 2026 the decision on how the monies, from the existing guardian fine pot would be spent, was agreed. It has been challenging to find a fair use of the money raised through

the fines which must be used to benefit the education, training and working environment of trainees but must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEE as fundamental requirement for doctors in training and which should be provided as standard. The RDTF agreed that as a one off (given that the fund pot was linked to breaches on 1st and 2nd tier rotas) all resident doctors would be given book tokens to invest in resources that may personally benefit them in their working life. We are aware many have exams with significant associated costs and that a contribution towards resources that will support preparation for these may be helpful. Although the organisation provides access to electronic resources such as the Maudsley prescribing guidelines, we also know that many trainees prefer a hard copy of these and often purchase these themselves and so we hoped that these vouchers can be used towards such resources which are not fundamental requirements but may enhance the training experience.

- **Appendix 1** gives details of both Care Groups respectively for the quarter January to March 2026.
- In the North Care Group there were 22 exception reports in Q4, which is a little higher than Q3 (15) and Q2(20) of this year and Q4 of the previous year (17). Q1 from this year (2025) remains an outlier with only 4 exception reports. Six of the exception reports included in Q4 were for confirmation of access to the system and so in reality the number of exceptions related to issues with working late or breaching rest requirements were only 16. Only 2 of the exceptions were due to breach of rest requirements on the middle tier rota. One was a first tier doctor who worked over 13 hours on an out of hours shift. The remaining 13 exceptions were related to working late and over and above scheduled hours. One doctor made 6 exceptions for staying late but when contacted by the GOSW this seemed related to an isolated staffing issue which had been resolved. None of the exception reports raised a concern about a pattern in a specific department.
- In the South Care Group there were 32 exception reports in Q4 which is higher than Q3 (25) and Q2 (24) of this year. It is an increase from Q1 (11) of this year and Q4 (7) of the previous year. The figure is a little inflated as it includes 7 access to the system exceptions but there is still a higher proportion of exceptions made for working beyond the hours in work schedule (18 for working late, 1 for coming early, 1 for missed breaks) and, unlike Q3 and Q2, there was only 1 educational exception. This is a substantial increase for these reasons compared to the previous quarters. Although there were increased numbers of exceptions for working late, when I looked into these there were no concerns about a pattern in a specific department.

- Additional information about reasons for the exception reports are given within the appendices.
- With exception report reforms being implemented in February 2026 we had been expecting an increase in exception reporting related to working late due to the increased communication/awareness in resident doctors about the use of exception reporting and the change in choice of remuneration for these.
- There were only five fines in this quarter which have been levied for breach of the requirement for 5 hours of continuous overnight rest on the middle tier NROC rotas. Two of the fines were from the North Care Group and three of the fines were from the South Care Group.
- Vacancies for normal working day posts are given within the appendices along with the number of shifts remaining uncovered after use of the Trust Doctor Scheme or, where necessary, agency locums. The remaining uncovered normal working day shifts, after accounting for annual leave, have been presented. It is important to note that the Trust does not cover GP ITP and ST4-7 resident doctor vacancies as these posts are considered to be primarily for training. Also, not all posts can be filled at any one time as there are more available training posts than trainees.
- With the implementation of exception report reforms there is now a requirement to do a regular detriment survey. Unfortunately on our first attempt of this, using a very short Microsoft teams survey, we had an incredibly poor response rate with 5 out of 242 doctors completing it. This has since been discussed at the resident doctor forum meeting and future surveys will be done within the postgraduate teaching programme to maximise participation.

Annual Position

- **Appendix 2** gives annual data relating to Trustwide postgraduate doctor vacancies (normal working day positions), as well as the number and value of Guardian fines.
- Across the year for the whole Trust, vacancies have varied from averaged at 17.71 WTE per quarter, which is a reduction on the previous year where it was 21.5 WTE per quarter. ST 4-7 and GP ITP posts are not always filled and there is an expectation these may be fallow. For other unexpected training vacancies, I am advised by the Medical Staffing Manager, that any training vacancies are filled with Trust Doctor when we are made aware of the vacancy in advance. Recruitment rounds for Trust Grade doctors will run as and when these are required and will be to cover the specific training vacancies.

- It is important to note that the Trust does not cover GP ITP and ST4-7 resident doctor vacancies as these posts are considered to be primarily for training. Also, not all posts can be filled at any one time as there are more available training posts than trainees.
- Over the year the majority of fines have been generated in relation to the middle tier rotas for breach of rest requirements for NROC shifts. The workload these shifts is unpredictable and occasional breaches are to be expected.
- Details about Guardian fines, and disbursements, are given in **appendix 2**.

Implications:

- **Compliance with the CQC Fundamental Standards:**
The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour.
- **Financial/Value for Money:**
The new contract is underpinned by the principle that resident doctors are paid for the work they do. It is necessary that the Board understands that extra costs will be incurred for breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to postgraduate doctors is necessary and appropriate.

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

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

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

- **Other Implications:**

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

With the implementation of exception report reforms there will be the risk of addition fines in the following circumstances:

- Failing to provide system access to a doctor within seven days of them starting a new post.
- Breaching confidentiality of exception reporting data
- Failing to process reports within the specified timeframes (initially 10 days, reducing to 7 days from August 2026).

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

Background Papers: **Appendix 1:** detailed information on numbers, exception reports and locum usage - North and South Care Groups respectively.
Appendix 2: information of training vacancies and exception report fines.
These appendices have been written and provided by the Medical Staffing Manager.

Appendix 1

Quarterly report 4 (1st January 2026 to 31st March 2026)

a) Number of exception reports submitted per rota

Rota	Number of exception reports submitted over the last quarter
1 st Tier – Teesside	12
Middle Tier – Teesside	0
1 st Tier – North Durham	5
Middle Tier – North Durham	2
1 st Tier – South Durham	2
Middle Tier – South Durham	1
Middle Tier – North CAMHS	0
1 st Tier - NYY	8
Middle Tier – NYY & Scarborough	5
1 st Tier - Scarborough	19
Middle Tier – South CAMHS	0
Total	54

b) Categories of exception reports submitted per rota

North & South Durham 1st Tier, Teesside 1st Tier - Resident Doctors

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					
Additional hours an unscheduled late finish		13.25			13
Breaches of non-resident on-call patterns					
The inability to take contractual breaks					
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat of detriment related to exception reporting					
Information breach					
Access and					

completion resolved in time					
Access and completion breaches					
Access and completion test				5	5
Other: optional free text box					1
Total					19

Teesside 1st Tier

There were 9 exception reports received from resident doctors working in Teesside this quarter. 6 exception reports were submitted from the same doctor and the remaining 2 were from 2 different doctors. 1 exception report for a fine was due to a resident doctor exceeding the 13 hr maximum shift duration whilst on resident shift.

North and South Durham 1st Tier

There were 5 exception reports received this quarter from Resident Doctors in the North and South Durham localities. 4 exceptions reported late finishes in North Durham (2 doctors reported 2 exceptions each). 1 exception report was made from a South Durham resident doctor and it was also for a late finish.

North & South Durham, Teesside & NORTH CAMHS - Middle Tier

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					
Additional hours an unscheduled late finish					
Breaches of non-resident on-call patterns	£72.59		£120.96		2
The inability to take contractual					

breaks					
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat of detriment related to exception reporting					
Information breach					
Access and completion resolved in time					
Access and completion breaches					
Access and completion test				1	1
Other: optional free text box					
Total					3

In this quarter, there were 2 exception reports received from the NORTH Senior Registrars.

Both exception reports were to report breaches of the 5 hours continuous rest whilst on-call.

North Yorkshire & York, Scarborough Resident Doctors – 1st Tier

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	

Additional hours an unscheduled early start	0.5				1
Additional hours an unscheduled late finish	29	6			18
Breaches of non-resident on-call patterns					
The inability to take contractual breaks					1
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat of detriment related to exception reporting					
Information breach					
Access and completion resolved in time					
Access and completion breaches					
Access and completion test				6	6
Other: Missed teaching	0.75				1
Total					27

North Yorkshire & York Resident Doctors – 1st Tier

A total of 3 exception reports were submitted in Quarter 4, reflecting a reduction from the previous quarter. Out of these, there were 2 reports for late finishes, and 1 report for early

start. There was 1 payment for additional hours because the doctor opted for payment while others opted for TOIL. There were no additional hours paid in the previous quarters in the year.

Scarborough Resident Doctors – 1st Tier

A total of 18 exception reports were submitted in Quarter 4, representing an increase from the previous quarter in which 3 exceptions were reported. One of these exceptions reported was due to missed breaks, another one was for missed teaching and the remaining 16 exceptions reported were for late finish.

North Yorkshire & York, Scarborough Resident Doctors – Middle Tier

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					
Additional hours an unscheduled late finish					
Breaches of non-resident on-call patterns	£328.51		£548.87		3
The inability to take contractual breaks					
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat of detriment related to exception reporting					
Information breach					
Access and					

completion resolved in time					
Access and completion breaches					
Access and completion test				1	1
Other: Difference in work pattern					1
Total					5

North Yorkshire & York, Scarborough Resident Doctors – Middle Tier

During this quarter, senior registrars submitted 4 exception reports, 3 of these exception reports relate to a breach of the requirement for five hours of uninterrupted rest between 22:00 and 07:00. The remaining one was for a difference in work schedule - the middle tier acted down as resident doctor between 14:00 and 20:00 because there was no cover for resident doctor 2 in Foss Park Hospital.

The recorded reason for the breach recorded was Mental Health Assessment and associated durations were for 3 hours, 2 hours and 5 hours completed by different doctors.

There was no additional payment for senior registrars this quarter, which is consistent with all previous quarters this year.

c) Experiences of actual or threatened detriment – per rota

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

Quarterly survey response rate	2%
Doctors experiencing actual detriment as a result of exception reporting	20%
Doctors feeling that they are not discouraged from exception reporting	80%

d) Withdrawals (overall)

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	0
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e) Access to individual doctors' exception reporting data

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	0
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f) Work schedule reviews related to exception reporting pattern/instances (overall – education or hours)

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances	0
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g) Rota gaps on all shifts

NORTH

Locum bookings by Locality & Grade						
Locality	Grade	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Teesside & Forensics	F2					
	CT1/2/GP	43	22		418.5	215.5
	CT3	16	16		140.5	140.5
	Trust Doctor					
	Middle Tier (SR/SAS)	6	27		96	299
North Durham	F2					
	CT1/2/GP	10	9		108	95.5
	CT3					
	Trust Doctor					
	Middle Tier (SR/SAS)	6	7		112	124.5
South Durham	F2	1			12.5	0
	CT1/2/GP	29	12		274.5	90
	CT3		10			114.5
	Trust Doctor					
	Middle Tier (SR/SAS)	12	20		217	299.5

CAMHS	Middle Tier (SR/SAS)	55	55		904	904
Total		178	178	0	2283	2283

- 30 1st tier shifts in total (21 in Teesside, 1 in North Durham and 8 in South Durham) were worked by SAS doctors who do not hold S12 approval and do not participate in the middle tier rotas.

Locum bookings by reason					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	46	46		473	473
Sickness	47	47		568.5	568.5
Paternity/maternity leave	9	9		141	141
On call restrictions	60	60		945.5	945.5
Industrial Action					
Special leave	8	8		94	94
Annual Leave	1	1		16	16

Incomplete Mand & Stat	7	7		45	45
Total	178	178	0	2283	2283

Vacancies by month						
Locality	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered
Teesside & Forensics	F1	0			0	0
	F2	0			0	0
	CT1	0	1	1	0.6	45.9
	CT2					
	CT3					
	ST4 -6	2	1	1	1.3	102
	GP	3	5	5	4.3	331.5
North Durham	F1	0			0	0
	F2	0			0	0
	CT1	0				0
	CT2				0	
	CT3					
	ST4 -6	0	0	0	0	

	GP	1	0	0	0.3	25.5
South Durham	F1	0	0	0	0	0
	F2	0	1	1	0.6	51
	CT1	0			0	0
	CT2					
	CT3					
	ST4 -6	0	3	3	2	153
	GP	0	1	1	0.6	51
Total		6	12	12	10	759.9

The higher trainee and ITP GP vacancies are due to there being more trainers than posts available, therefore some posts are classed as fallow.

SOUTH

Locum bookings by Locality & Grade						
Locality	Grade	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Harrogate, Northallerton, Selby & York (NYY)	F2					
	CT1/CT2/GP	40	13		385.5	154
	CT3		19			135.5
	Trust Doctor					
	Middle Tier (SR/SAS)	16	23		288	372

Scarborough	F2					
	CT1/CT2/GP	2			32	
	CT3		1			16
	Trust Doctor		1			16
	Middle Tier (SR/SAS)	89	85		1095	1079
South CYPS Middle Tier	Middle Tier (SR/SAS)	66	65		1215	1191
Total		213	207	0	3015.5	2963.5

- *NYN 1st tier - 1 shift remained vacant*
- *Scarborough Middle Tier - 1 shift remained vacant & 3 shifts were covered by consultants*
- *South CYPS Middle Tier - 1 shift was covered by a consultant*

Locum bookings by reason					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	165	159		2445.5	2393.5

Sickness	38	38		432	432
Paternity/maternity leave					
On call restrictions	4	4		53.5	53.5
Industrial Action					
Special leave	3	3		64	64
Annual Leave					
Incomplete Mand & Stat	3	3		20.5	20.5
Total	213	207	0	3015.5	2963.5

Vacancies

Locality	Grade	Month 1	Month 2	Month 3	Average no of vacancies	Number of shifts uncovered (days)
Northallerton	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	0	0	0	0	0

	GP	0	0	0	0	0
Harrogate	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	1	1	1	1	76.5
	GP	1	1	1	1	76.5
Scarborough	F1	1	1	1	1	76.5
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	1	1	1	1	76.5
	GP	1	0	0	0	0
York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	4	2	2	2.6	204
	GP	1	2	2	1.6	127.5
Total		10	8	8	8.3	637.5

The higher trainee and ITP GP vacancies are due to there being more trainers than posts available, therefore some posts are classed as fallow.

Appendix 2

Annual reporting requirements

a) Disbursement of fines

The details of the GoSWH fines will be published in the organisation's annual financial report (accounts), which are subject to independent audit. The GoSWH annual report will include clear detail on how the money has been spent. (Schedule 5 paragraph 31)

Annual financial report requirements

Fine	Number of fines applied	Value of fines applied
Additional hours worked breach (breach of rest requirements)	29	£8766.22
Information breach	0	0
Access and completion breach	0	0
Missed breaks breach	0	0
Total	29	£8766.22

Details of disbursement of the fines (provided by finance):

Spend	Q1	Q2	Q4	Total
Catering	153			153
Hot Drinks		90		90
Vouchers			6300	6300
Total	153	90	6300	6543

b) Work schedule reviews relating to education and training (overall)

The DME shall report annually to the board on all work schedule reviews relating to education and training.

Number of work schedule reviews related to education and training	0
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c) Rota gaps

A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the trust's quality account, which must be signed off by the trust's chief executive.

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)

North Durham	F1	0	0	0	0	0	0
	F2	0	0	0	0	0	0
	CT1						
	CT2	0	0	0	0	0	0
	CT3						
	ST4 -6	1	0	0	0	0.25	49.5
	GP	1	1	1	0.3	0.825	277
	Trust Doctor	0	0	0	0	0	0
South Durham	F1	0	0	0	0	0	0
	F2	1			0.6	0.4	100.5
	CT1						
	CT2	0	0	0	0	0	0
	CT3						
	ST4 -6	3	1	0	2	1.5	453.75
	GP	2	0.6	0	0.6	0.8	251.5
	Trust Doctor	0	0	0	0	0	0
Teesside & Forensics	F1	0	0	0	0	0	0
	F2	0	0	0	0	0	0
	CT1						
	CT2	0	0	0	0.6	0.15	45.9
	CT3						

	ST4 -6	3	2.3	2	1.3	2.15	705.25
	GP	4	3.3	3	4.3	3.65	1186.25
	Trust Doctor	0	0	0	0	0	0
Scarborough	F1	0	0	1	1	0.5	126.25
	F2	0	0	0	0	0	0
	CT1						
	CT2	1	0	0	0	0.25	49.5
	CT3						
	ST4 -6	0.99	0	0	1	0.4975	92.83
	GP	2	1.3	1	0	1.075	351.75
	Trust Doctor	0	0	0	0	0	0
NYY	F1	0	1.3	0	0	0.325	203
	F2	1	0	0	0	0.25	49.5
	CT1						
	CT2	2	0	0	0	0.5	99
	CT3						
	ST4 -6	1	2.6	5	3.6	3.05	984.25
	GP	1	1.6	1	2.6	1.55	557
	Trust Doctor	0	0	0	0	0	0
Total		23.99	15	14	17.9	17.7225	5582.73

1. Recipients of board reports

All quarterly reports must be publicly accessible online within one month after the report has been created.

Information to be shared	Recipient(s) of board reports	Frequency
Quarterly reports	This report must be sent directly to: the Joint Local Negotiating Committee (JLNC) the Local Negotiating Committee (LNC) chair at least one nominated LNC resident doctor, and relevant RDF representatives upon completion. DHSC/NHS England NHS England (Local office), Care Quality Commission, General Medical Council and General Dental Council. In addition, all quarterly reports must be publicly accessible online within one month after the report has been created.	Quarterly
Issues identified as a result of exception reporting that cannot be remedied locally and require a system-wide solution	LNC The board will raise the system-wide issue with partner organisations (eg NHS England) to find a solution.	Ad hoc
Annual reports	DHSC/NHS England local offices of NHS England, the Care Quality Commission, the General Medical Council and the General Dental Council.	Annual

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For General Release

Meeting of:	Board of Directors
Date:	13 August 2026
Title:	Quarterly (Q1) Report of the Guardian of Safe Working Hours for Resident Doctors
Executive Sponsor(s):	Dr Kedar Kale, Executive Medical Director
Author:	Dr Sharon Beattie, Guardian of Safe Working

Report for:	<i>Assurance</i>	☒	<i>Decision</i>	☐
	<i>Consultation</i>	☐	<i>Information</i>	☒

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

1: *We will co-create high quality care*

2: *We will be a great employer*

3: *We will be a trusted partner*

☐
☒
☐

Strategic Risks relating to this report:

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

Executive Summary:

Purpose:

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

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

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

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

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

Overview:

- In Quarter 1 the majority of fines that were levied were due to breach of the 5 hours overnight rest requirement on NROC rotas. Particularly on the middle tier rotas, the intensity of on-call work varies between NROC shifts considerably. There is always a risk of breach of rest and subsequent fines on such rotas due to the unpredictable nature of the work. Based on the exception reports submitted, the frequency of breaches remains low overall.
- There has been no instance where the GOSW has felt the need to request a work schedule review due to concerns of exception reporting within specific departments.
- The internal system for covering out of hours rota gaps appears to continue to function well in that there is no reported use of agency locums on out of hours postgraduate doctors' rotas. There have been occasions when doctors on the higher tiers have had to 'act down' for periods of time when internal locums cannot be appointed at short notice.
- There is a well-functioning Resident Doctors' Training Forum in each of the Care Groups with good attendance by resident doctor representatives from localities across the Trust. In July 2026 there was a decision on how the monies from existing

guardian fine pot would be spent. There will be a social/educational face to face event in September 2026 for the higher trainees Trustwide to promote connectivity, peer interaction and to meet educational requirements outside the higher training curriculum. The money raised through the fines must be used to benefit the education, training and working environment of trainees but must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEE as fundamental requirement for doctors in training and which should be provided as standard.

- **Appendix 1** gives details of both Care Groups respectively for the quarter April to June 2026.
- In the North Care Group there were 20 exception reports in Q2, which is similar to Q4 (22), Q3 (15) and Q2 (20) of last year. Q1 from last year (2025) remains an outlier with only 4 exception reports. In Q1 this year only one of the exception reports was for confirmation of access to the system and so in reality the number of exceptions related to issues with working late or breaching rest requirements was higher than the previous quarter. Only 2 of the exceptions were due to breach of rest requirements on the middle tier rota. Sixteen exceptions were related to working late, over and above scheduled hours. One doctor submitted 10 exception reports for staying late but when contacted by the GOSW this seemed related to a temporary increase in acuity in the clinical workplace and isolated staffing issues which had been resolved. At present none of the exception reports raised a concern about a pattern in a specific department, and so there has not been the need to request a work schedule review.
- In the South Care Group there were 20 exception reports in Q1, which is lower than Q4 (32) Q3 (25) and Q2 (24) of last year. It is an increase from Q1 (11) of last year. The figure from Q1 is a little inflated as it includes 7 access to the system exceptions. Unlike the previous quarter, the remaining (13) exception reports were due to breaches of rest/work undertaken above the schedule related to the NROC rotas. There were no exception reports for working late/missing breaks, nor were there any educational exception reports.
- Additional information about reasons for the exception reports are given within the appendices.
- With exception report reforms being implemented in February 2026 we had been expecting an increase in exception reporting related to working late due to the increased communication/awareness in resident doctors about the use of exception reporting and the change in choice of remuneration for these. In this quarter this seems to be reflected in the North Care group (albeit majority were submitted by one doctor) but

not in the South Care Group. At present we have not had enough of a response rate to the detriment survey to know whether this could be a contributing factor.

- There were thirteen fines in this quarter which have been levied for breach of the requirement for 5 hours of continuous overnight rest on the NROC rotas (an increase from 5 in the previous quarter). Two of the fines were from the North Care Group and eleven of the fines were from the South Care Group. The cost of these were £1917.47 in additional payment to the doctors and £3195.83 in Guardian fines.
- The number of vacancies for normal working day posts are given within the appendices along with the number of shifts remaining uncovered after use of the Trust Doctor Scheme. The remaining uncovered normal working day shifts, after accounting for annual leave, have been presented. It is important to note that the Trust does not cover GP ITP and ST4-7 resident doctor vacancies as these posts are considered to be primarily for training. Also, not all posts can be filled at any one time as there are more available training posts than trainees. The data presented raises no concerns about vacancies.
- With the implementation of exception report reforms there is now a requirement to do a regular detriment survey. Unfortunately on our first attempt of this, using a very short Microsoft teams survey, we had an incredibly poor response rate with 5 out of 242 doctors completing it. This has since been discussed at the most recent resident doctor forum meeting and future surveys will be done within the postgraduate teaching programme to maximise participation.

Implications:

- **Compliance with the CQC Fundamental Standards:**
The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour.
- **Financial/Value for Money:**
The new contract is underpinned by the principle that resident doctors are paid for the work they do. It is necessary that the Board understands that extra costs will be incurred for breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to postgraduate doctors is necessary and appropriate.

From February 2026, following the implementation of exception report reforms, all resident doctors must receive their choice of either payment or time off in lieu (TOIL) for all time worked above contracted hours following exception, except when a breach of safe working hours mandates the award of TOIL. All resulting payments and TOIL must be facilitated by responsible parties and must not be substituted without residents'

consent. Historically TOIL has been the standard for additional hours worked and so there may be a change in the cost to the Trust with this reform. At present there is not a high level of exception reporting for working late but this can vary depending on cohorts, and it is difficult to predict whether there will be an increase in reporting with the option of payment. The contract mandates that TOIL is mandated when there is a breach of safe working, and so this may limit the financial impact.

- **Legal and Constitutional (including the NHS Constitution):**
The Learning Agreement signed by the Trust with NHS England sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow resident doctors to fulfil their curriculum needs within a sound learning environment.
- **Equality and Diversity:**
The Champion of Less Than Full-time (LTFT) Working is a core member of the Resident Doctors' Training Forums.
- **Other Implications:**

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

With the implementation of exception report reforms there will be the risk of addition fines in the following circumstances:

- Failing to provide system access to a doctor within seven days of them starting a new post.
- Breaching confidentiality of exception reporting data
- Failing to process reports within the specified timeframes (initially 10 days, reducing to 7 days from August 2026).

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

Background Papers: **Appendix 1:** detailed information on numbers, exception reports and locum usage - North and South Care Groups respectively. This appendix has been written and provided by the Medical Staffing Manager.

Appendix 1

Quarterly report 1 (1st April 2026 to 30th June 2026)

a) Number of exception reports submitted per rota

Rota	Number of exception reports submitted over the last quarter
1 st Tier – Teesside	3
Middle Tier – Teesside	1
1 st Tier – North Durham	4
Middle Tier – North Durham	1
1 st Tier – South Durham	11
Middle Tier – South Durham	0
Middle Tier – North CAMHS	1 – but rejected as it was outside NROC period
1 st Tier - NYY	5
Middle Tier – NYY & Scarborough	11
1 st Tier - Scarborough	3
Middle Tier – South CAMHS	1
Total	41

b) Categories of exception reports submitted per rota
North Yorkshire & York, Scarborough Resident Doctors – 1st Tier

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					
Additional hours an unscheduled late finish					
Breaches of non-resident on-call patterns	£44.72		£74.53		1
The inability to take contractual breaks					
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat of detriment related to exception reporting					
Information breach					
Access and completion resolved in time					
Access and completion					

breaches					
Access and completion test					7
Other: optional free text box					
Total					8

One exception report was submitted by a Scarborough resident doctor via the Non-Resident On-Call (NROC) monitoring form, representing a substantial reduction compared with Quarter 4. The report related to a breach of the requirement for five hours of uninterrupted rest between 22:00 and 07:00, with administrative duties recorded as the reason for the breach.

7 exception reports were submitted as TEST from the Foundation doctors that commenced in April.

North Yorkshire & York, Scarborough & South CYPs Resident Doctors – Middle Tier

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					
Additional hours an unscheduled late finish					
Breaches of non-resident on-call patterns	£855		£1425.14		10
The inability to take contractual breaks					
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat					

of detriment related to exception reporting					
Information breach					
Access and completion resolved in time					
Access and completion breaches					
Access and completion test					
Other: Difference in work pattern	55 hrs				2
Total					12

Senior registrars submitted 12 exception reports during Quarter 1, all recorded through Non-Resident On-Call (NROC) monitoring forms. This was a slight increase on the previous quarter. Where a difference in work pattern was identified, it was recorded on the same exception report as the breach.

All exception reports also related to work undertaken above the work schedule. Of these, 10 were breaches of the requirement for five hours of uninterrupted rest between 22:00 and 07:00. The reasons recorded were mental health assessments, travel, and administrative duties.

North & South Durham, Teesside Resident Doctors - 1st Tier

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					
Additional hours an unscheduled late finish		8 hrs & 33 mins			16
Breaches of non-resident on-call patterns					
The inability to				1.5 hrs -	1

take contractual breaks				payment taken	
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat of detriment related to exception reporting					
Information breach					
Access and completion resolved in time					
Access and completion breaches					
Access and completion test					1
Other: optional free text box					
Total					18

North and South Durham 1st Tier

There were 15 exception reports received this quarter from Resident doctors in the North and South localities. 4 Exceptions reported late finishes in North Durham (2 doctors reported these exceptions).

There were 11 exceptions reports made from South Durham resident doctor, and they were also for late finishes.

Teesside 1st Tier

There were 2 exceptions reported this quarter, 1 for a late finish and the other for missed break. Both exceptions were from different doctors and they both requested for payment. Additionally, there was 1 TEST exception report submitted from a Foundation doctor that commenced in April.

North & South Durham, Teesside & NORTH CAMHS - Middle Tier

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start					
Additional hours an unscheduled late finish					
Breaches of non-resident on-call patterns	£1017.75		£1696.16		2
The inability to take contractual breaks					
Inadequacy of clinical support					
Inadequacy of rostered skills mix					
Raising concerns of a suspected non-compliant rota pattern					
Detriment or threat of detriment related to exception reporting					
Information breach					
Access and completion resolved in time					
Access and completion					

breaches					
Access and completion test					
Other: optional free text box					
Total					2

In this quarter there were 3 exception reports received from NORTH senior registrars, although one exception report was rejected from CYPS as it was outside the NROC period for Submission.

Both exception reports were received for work done about schedule (1 reported in North Durham and 1 in Teesside).

c) Fines

Rota	Value of fines levied
1 st Tier – Teesside	
Middle Tier – Teesside	£1194.91
1 st Tier – North Durham	
Middle Tier – North Durham	
1 st Tier – South Durham	
Middle Tier – South Durham	
Middle Tier – North CAMHS	£501.25
1 st Tier - NYY	
Middle Tier – NYY & Scarborough	£1425.14
1 st Tier - Scarborough	£74.53
Middle Tier – South CAMHS	
TOTAL	£3195.83

d) Experiences of actual or threatened detriment – per rota

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

Quarterly survey response rate	2%
Doctors experiencing actual detriment as a result of exception reporting	20%
Doctors feeling that they are not discouraged from exception reporting	80%

e) Withdrawals (overall)

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	0
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f) Access to individual doctors' exception reporting data (overall)

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	0
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g) Work schedule reviews related to exception reporting pattern/instances (overall – education or hours)

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances	0
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h) Rota gaps on all shifts (per rota) – split into day gaps and OOH gaps (how many filled by locums and how many filled by someone acting down). To add narrative around what the gaps were for

NORTH

Locum bookings by Locality & Grade						
Locality	Grade	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Teesside & Forensics	F2					
	CT1/2/GP	60	29		579.5	243
	CT3		14			141
	Trust Doctor					
	Middle Tier (SR/SAS)	10	27	0	139	334.5
North Durham	F2					
	CT1/2/GP	27	15		285.5	145
	CT3		4			50
	Trust Doctor					
	Middle Tier (SR/SAS)	9	16	0	160	234.5
South Durham	F2					
	CT1/2/GP	20	7		190.5	62
	CT3		7			70.5
	Trust					

	Doctor					
	Middle Tier (SR/SAS)	18	24	0	280	338
CAMHS	Middle Tier (SR/SAS)	51	51	0	952	952
Total		195	194	0	2586.5	2570.5

- 1 N Durham MT shift was covered by a Consultant
- 8 N Durham 1st Tier shifts were covered by SAS doctors
- 6 S Durham 1st Tier shifts were covered by SAS doctors
- 17 Teesside 1st Tier shifts were covered by SAS doctors

Locum bookings by reason					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	56	56		802	802
Sickness	42	42		550	550
Paternity/maternity leave	6	6		90	90
On call restrictions	57	57		719.5	719.5
Industrial Action	25	24		338	322
Special leave					
Annual Leave					
Incomplete Mand & Stat	9	9		87	87
Total	195	194	0	2586.5	2570.5

Vacancies by month						
Locality	Grade	Month 1	Month 2	Month 3	Total gaps (average)	Number of shifts uncovered
Teesside & Forensics	F1				0	0
	F2	1	1	1	1	76.75

	CT1	1	1	1	1	76.75
	CT2					
	CT3					
	ST4 -6	1	1	1	1	75.5
	GP	4	4	4	4	307
North Durham	F1				0	0
	F2				0	0
	CT1					0
	CT2				0	
	CT3					
	ST4 -6				0	
	GP				0	0
South Durham	F1				0	0
	F2				0	0
	CT1				0	0
	CT2					
	CT3					
	ST4 -6	2	2	2	2	153.5
	GP	1	1	1	1	76.75
Total		10	10	10	10	766.25

The higher trainee and ITP GP vacancies are due to there being more trainers than posts available, therefore some posts are classed as fallow.

SOUTH

Locum bookings by Locality & Grade						
Locality	Grade	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Harrogate, Northallerton, Selby & York (NYY)	F2		3			37.5
	CT1/CT2/GP	35	16		314.5	155.5
	CT3		13			86

	Trust Doctor					
	Middle Tier (SR/SAS)	17	20		298.5	334
Scarborough	F2					
	CT1/CT2/GP	7	7		101.5	101.5
	CT3					
	Trust Doctor					
	Middle Tier (SR/SAS)	85	82		1600	1536
South CYPS Middle Tier	Middle Tier (SR/SAS)	45	44		848	832
Total		189	185	0	3162.5	3082.5

- NYY 1st tier - 3 shifts were covered by SAS doctors
- Scarborough Middle Tier - 3 shifts were covered by consultants
- South CYPS Middle Tier - 1 shift was covered by a consultant

Locum bookings by reason					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy	123	120		2288	2224
Sickness	24	24		327	327
Paternity/maternity leave	3	3		29	29
On call restrictions	9	8		148.5	132.5

Industrial Action	23	23		251.5	251.5
Special leave	4	4		69.5	69.5
Annual Leave					
Incomplete Mand & Stat	3	3		49	49
Total	189	185	0	3162.5	3082.5

Vacancies

Locality	Grade	Month 1	Month 2	Month 3	Average no of vacancies	Number of shifts uncovered (days)
Northallerton	F1				0	0
	F2				0	0
	CT1-3				0	0
	ST4 -6				0	0
	GP				0	0
Harrogate	F1				0	0
	F2				0	0
	CT1-3				0	0
	ST4 -6				0	0

	GP	1	1	1	1	76.75
Scarborough	F1				0	0
	F2				0	0
	CT1-3				0	0
	ST4 -6	1	1	1	1	75.5
	GP				0	0
York	F1				0	0
	F2				0	0
	CT1-3				0	0
	ST4 -6	4	4	4	4	302
	GP	2	2	2	2	153.5
Total		8	8	8	8	607.75

The higher trainee and ITP GP vacancies are due to there being more trainers than posts available, therefore some posts are classed as fallow.

Meeting of:	Board of Directors
Date:	Thursday 13 th August 2026
Title:	Getting the basics right for resident doctors
Executive Sponsor(s):	Dr Kedar Kale, Executive Medical Director (EMD) / Resident Doctor Senior Board Lead
Report Author(s):	Hayley Lonsdale, Head of Medical Education, Dimitra Papakosta, Medical Staffing Manager & Dr Aqsa Ghazanfar, Resident Doctor Peer Lead

Report for:

Assurance

✓

Decision

Consultation

Information

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

1: We will co-create high quality care

2: We will be a great employer

3: We will be a trusted partner

Strategic risks relating to this report:

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

EXECUTIVE SUMMARY:

Purpose:

This paper provides the Trust Board with assurance that the Faculty of Medical Education has considered the NHS England (NHSE) mandate, which sets out clear expectations through a 10-point plan to improve the working lives of resident doctors. It also confirms that progress continues to be made towards full compliance with the mandate.

Proposal:

A good level of assurance is proposed, based on the progress made since the previous Board report in February 2026.

Overview:

In early September 2025, NHS England wrote to all NHS Trusts setting out a 10-point plan (*Appendix 1*) to improve resident doctors' working lives and address unacceptable working practices. The plan aims to ensure that organisations get the basics right for resident doctors.

The Medical Education Leadership Team (MELT) remains responsible for tracking progress against the 10-point plan and continues to report formally through the Medical Education Committee. The nominated Trust Leads — Dr Aqsa Ghazanfar, Resident Doctor Peer Lead (RDPL), Hayley Lonsdale, Head of Medical Education, and Dimitra Papakosta, Medical Staffing Manager, will continue to update the Board on a bi-annual basis.

In April 2026, NHSE confirmed that all Trusts must complete a Board Assurance Framework (BAF) (*Appendix 2*) to provide assurance to Trust Boards. This report provides an update on key areas completed, work in progress, and areas of non-compliance that sit outside the Trust's sphere of influence.

Key areas completed:

1. *Workplace wellbeing* – A baseline audit has been completed, and an approved improvement plan is in place.
2. *Rota transparency* - Processes are in place to support compliance with the 8-week work schedule and 6-week rota publication standards, ensuring resident doctors receive timely information to support workforce planning, work-life balance and educational commitments.
3. *Board-level leadership* – Dr Kedar Kale, Executive Medical Director is the nominated Resident Doctor Senior Board Lead. Jules Preston has been nominated as the Non-Executive Director for the 10 Point Plan. The RDPL, Dr. Aqsa Ghazanfar, has been appointed and is engaged in line with national guidance.
4. *Payroll accuracy* – Monthly monitoring and reporting arrangements are in place to review payroll performance, identify themes and provide assurance that payroll errors are being addressed promptly and effectively. This work supports the Trust's commitment to ensuring resident doctors receive accurate and timely remuneration.
5. *Mandatory training* – The Trust has signed the Memorandum of Understanding (MoU), and monitoring processes are in place to ensure that unnecessary training is not repeated. A Mandatory Training Local Oversight Group (MLOG) is in place. Within the Trust this is titled the Training and Education Governance Group (TEGG). Approval has recently been granted by the Chair of TEGG for a resident doctor representative to join the group. This will help ensure that mandatory and statutory training requirements are necessary and proportionate. A small pool of resident doctor representatives have now been identified to attend the group.
6. *Exception reporting* - The Trust has communicated the exception reporting reform process and associated local arrangements to resident doctors through induction, relevant meetings (RDTF – Resident Doctors Training Forum) and ongoing communication. Resident doctors are encouraged to utilise exception reporting to raise concerns relating to working hours, training opportunities and service pressures, ensuring issues can be addressed promptly and appropriately. Local processes align with national requirements and data relating to exception reports is monitored and reported through established governance mechanisms (Quarterly Board Reports).
7. *Expense reimbursement* – The Trust has adopted the fast-track course costs guidance issued by NHSE.

Work in progress:

1. *Annual leave reform* - The Trust has adopted the minimum standards for annual leave management for resident doctors, with the aim of improving access to leave, reducing administrative burden and enhancing the overall trainee experience. To further support implementation, an annual leave procedure has been drafted (pending clarification of some points from NHSE) to ensure consistent application of annual leave processes and compliance with national guidance.

2. *Expense reimbursement* - Issues have been raised by TEWV employed resident doctors working in NHSE Y&H in relation to payments that are still being reimbursed outside of the 6 weeks' timeframe. Work is ongoing with the resident doctor representative to gain further information regarding non-compliance so this can be explored further.
3. *Payroll Errors / Mileage Claims* - There are ongoing discussions around S12 on-call payments for Middle Tier doctors, which is a contractual part of their role. There is lack of clarity around whether the trust is responsible for this and how to process mileage claims for on-call doctors working from home. This is, however, a national issue due to the complexity of S12 payments. The RDPL has raised this with the Regional 10-point plan Lead, who is beginning work with local ICBs to understand this process better. This is likely to be a long term piece of work.

Areas of non-compliance outside of the Trust's range of influence:

1. *Expense reimbursement* - The Trust cannot yet confirm whether it is meeting the ≥80% satisfaction target for resident doctors. This standard was set up by NHSE in April 2026, with the roll out of the Board Assurance Framework, and is meant to be measured using the PSAR (Provider Self Assessment Report). The Education Quality Provider self-assessment (PSAR) will launch in August for completion by October. The PSAR will have a dedicated Resident Doctor (RD) section which ensures that the outcomes and benefits of the 10-point plan continue to be realised.

In summary, the Trust is primarily compliant with most areas of the 10-point plan. The majority of non-compliance relates to areas not directly within the Trust's control and is influenced by NHSE regional offices. These issues have been escalated to the relevant NHSE regional offices.

Prior Consideration and Feedback:

The Faculty of Medical Education continues to meet regularly with resident doctor representatives. The BAF is reviewed routinely, and the agreed position on compliance and further improvement actions is updated accordingly.

Implications:

Failure to meet the standards set out in the plan, alongside other quality indicators for medical education, would directly affect the future recruitment of resident doctors into career-grade roles within the Trust. This could subsequently contribute to increased locum and agency costs and affect morale among colleagues who are required to cover recruitment gaps.

The Trust is also required to report compliance with the 10-point plan to NHSE, with any shortcomings clearly communicated alongside relevant rationale and supporting evidence.

Recommendations:

1. The Trust Board is asked to note the progress made since the previous report presented in February 2026.
2. The Trust Board is asked to confirm the proposed good level of assurance.

Appendices:

Appendix 1: NHSE 10-Point Plan to improve resident doctors' working lives

Appendix 2: Board Assurance Framework

10 Point Plan to improve resident doctors' working lives

Fixing unacceptable working practices: getting the basics right for resident doctors

The 75,000 resident doctors working across the NHS are the backbone of the service – but too often they are let down on basic issues like payroll errors, poor rota management, lack of access to rest facilities and hot food, and unnecessarily repeating training.

While some progress has been made, it has been too slow, and many still face unfair and inconsistent working conditions.

Supported by our commitment to staff under the recently published 10 Year Health Plan for England, NHS England is setting out 10 ways in which we are improving resident doctors working conditions over the next 12 weeks.

This plan sets out actions for NHS England and individual trusts. To ensure meaningful progress, it will be formally incorporated into the new NHS Oversight Framework. However, trusts should proceed on the basis that it is already in effect and take appropriate action without delay.

Trusts are also expected to develop a Board Assurance Framework to provide oversight of this work. The outcomes should be included in their annual reports to demonstrate accountability and progress.

Every NHS organisation is required to act across all 10 areas within the next 12 weeks. Progress must be reported to their boards and, where actions are not met, a formal explanation and corrective measures should be provided.

Summary of the 10 Point Plan

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

1. Improve workplace wellbeing for our resident doctors

Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so trusts can adapt implementation to reflect local needs and operational realities in these and other areas:

- where possible, [provide designated on-call parking spaces]
- the autonomy to complete portfolio and self-directed learning from an appropriate location for them
- access to mess facilities, rest areas and lockers in all hospitals, including new builds
- a 24/7 out-of-hours menu offering hot meals and cold snacks for staff

Within the next 12 weeks every trust should: Conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plans must be approved by the trust's people committee or

equivalent body. Trusts will be expected to provide updates for national reporting on progress.
2. Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice From now, and for all rotations going forward NHS England must provide at least 90% of trainee information to trusts 12 weeks prior to rotations commencing. From now, Trusts must use this information to ensure that resident doctors receive their work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are not met corrective action must be taken. Performance data must be submitted by trusts, and NHS England will monitor and report on national compliance across all stages of the process.
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery. Within 12 weeks, NHS England will: conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts.
4. All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board Within 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board. In September 2025, NHS England will: publish a national role specification for the board lead. The senior lead will formally take on this responsibility within an existing role, supported by a national role specification to be published by NHS England in September. The resident doctor lead will act as a peer representative and enable trust boards to hear directly from resident doctors themselves. They should be invited to attend board level discussions on issues which specifically relate to improving doctors' working lives. Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses.
5. Resident doctors should never experience payroll errors due to rotations

Following a successful pilot that has reduced errors by half, we are extending the learning from this work to all NHS trusts. Within the next 12 weeks, every trust should: Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All organisations are required to establish a board-level governance framework to monitor and report payroll accuracy and begin national reporting as required.
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating Within the next 12 weeks if they are not already doing so, every trust should: Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of prior training. By April 2026, NHS England will: reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England.
7. Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours A new national Framework Agreement for Exception Reporting was agreed on 31 March 2025 and will be rolled out for implementation in due course. The changes agreed simplify the reporting process for resident doctors, ensure they are being fairly compensated for the additional hours they are required to work, and will support the safety of their working hours. We are committed to implementing these reforms as soon as practicable.
8. Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a resident doctor has attended a course/activity, to one where reimbursement is provided as soon as possible after the expense is incurred. Within the next 12 weeks every trust should: Review their current processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsistence.
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority. Within 12 weeks, NHS England will: develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model

NHS England is committed to extending the Lead Employer model to cover all resident doctors and dentists in training. This change will eliminate the need for trainees to change employers with each rotation, reducing duplication and administrative errors while improving continuity, efficiency, and the overall training experience.

By October 2025, NHS England will: develop a comprehensive and financially sustainable roadmap, underpinned by a robust business case. This will include detailed recommendations on costing and funding, service catalogue requirements, and pricing models for national implementation. The roadmap will provide a clear framework for expanding Lead Employer arrangements across the system.

Why are we doing this?

- Supporting resident doctors improves the quality of care offered to patients. Many of these steps will also improve the lives of other staff groups across the NHS.
- Our educators work hard to ensure that resident doctors' education and training is world class, but too often they have been let down on basic issues. The 10 Point Plan will help us respond to what resident doctors have been telling us.
- We have long recognised the need to improve the working lives of resident doctors, but we know we need to go further, faster to build on what we have already done.

Why the focus on resident doctors?

- Resident doctors are different from other staff because they provide care while training in different parts of the NHS, which means they move employer regularly for several years.
- All NHS staff are important, and we will continue to support improvements in working conditions, retention, health and wellbeing and facilities through the 10 Year Health Plan and the forthcoming NHS Workforce Plan.

What have we already done?

We have piloted a payroll improvement programme with 31 trusts to tackle the root causes of payroll errors leading to a 48% reduction in errors.	90% of trusts who responded to a recent survey have a named senior resident doctor lead responsible for improving doctors working lives issues and who report directly to trust boards on this issue.
Started a national review of the current system of resident doctor medical rotations to reduce administrative and bureaucratic burdens.	Learned from the best local initiatives such as an enhanced focus on sexual safety, health and wellbeing, improved local facilities such as doctors' mess, on-call facilities and car parking, and enhancements to HR medical staffing teams particularly around reviewing processes to inform these further national plans.

We have agreed a new national framework to improve exception reporting.	Established a new national project to explore extending Lead Employer arrangements, allowing resident doctors to have a single employer throughout their rotations.
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What happens next?

We will immediately:

- include this work within the NHS Oversight Framework and work with all trusts to deliver these 10 actions
- ask NHS regions to support and oversee trusts in their delivery
- require trust boards to take clear ownership of local improvements to resident doctors' working lives by developing and implementing action plans informed by staff feedback and national survey results
- share these actions with all resident doctors via their educators, medical directors and deans, including with the new resident doctors who rotated in August, and expect them to hold us to account

From the autumn we will publish new data and information on:

- trusts delivering access to the basics – lockers, rest facilities, hot meals, on-call parking spaces
- delivery of 8 week work schedules and 6 week rota notice on rotations
- number of payroll errors
- self/preferential e-rostering
- percentage of trusts delivering board level reporting of issues
- changes to the way in which annual leave can be taken



Resident Doctors Board Assurance Framework

Version 1.0 March 2026

Publication approval reference:

Introduction



The 10 point plan to improve the working lives of Resident Doctors Board Assurance Framework ("the framework") is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to ensure the working lives of Resident Doctors maintain improvement. The framework is for use for all trusts with Resident Doctors and can be used to provide assurance in NHS settings or settings where NHS services are delivered.

This framework is compulsory and should be used by organisations to ensure compliance with the 10 Point Plan to improve resident doctors' working lives which aims to fix unacceptable working practices by getting the basics right for Resident Doctors.

The purpose of this framework is to provide assurance for boards against which the system can effectively self-assess compliance with the measures set out in the 10 Point Plan to improve resident doctors' working lives.

The aim of this document is to identify areas for improvement and outline a systematic framework to ensure improvements are implemented and maintained. Ensuring provider and regional teams collaborate to implement improvements and continued engagement with Resident Doctors.

The framework should be used to assure the executive board or equivalent of the assessment of the improvements. The outcomes can be used to provide evidence to support improvement to the working lives of Resident Doctors. The adoption and implementation of this framework remain the responsibility of the organisation and requires demonstration of compliance with the criteria outlined.

If the criterion is not applicable within the organisation or setting, then select not applicable option.

Links

[NHS England » 10 Point Plan to improve resident doctors' working lives](#)

Legislative Framework

[Doctors and dentists in training terms and conditions \(England\) 2016 | NHS Employers](#)

Instructions for use

The adoption and implementation of the 10 point plan to improve the working lives of Resident Doctors Board Assurance Framework ("the framework") remains the responsibility of the organisation and must demonstrate compliance with the 10 Point Plan to improve resident doctors' working lives.

The framework worksheet is ordered by the criteria of the 10 point plan principles and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Once options have been selected a summary plot for each criterion is generated automatically, which are displaced in the corresponding worksheet. The overall RAG status for an organisation across all criteria outlined in the framework will be relevant and applicable to all organisations with Resident Doctors'.

To note: use of the framework is compulsory and should be used by organisations through collaboration with their Resident Doctor Peer Leads, Resident Doctor Board Lead and Non-Executive Directors for Resident Doctors.

Resident Doctor Board Assurance Framework v1.0						
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
1. Workplace wellbeing – Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead.						
Organisational or board systems and process should be in place to ensure that:						
1.1	Completed baseline audit	Baseline audit completed	See cell 6C for action plan	See cell 6C for action plan	See cell 6C for action plan	3. Compliant
1.2	Approved improvement plan in place	 Summary of 10 Point Plan V8.pdf	See cell 6C for action plan	See cell 6C for action plan	See cell 6C for action plan	3. Compliant
2. Rota transparency – Compliance with 8-week schedules, 6-week rotas with improvement plans in place where performance needs to improve.						
System and process are in place to ensure that:						
2.1	Compliant with 6- and 8-week rota standards	Feb 2026 data - 97.3% compliance in the South Care Group for both work schedules and rotas issued and 93.61% compliance for the work schedules and 100% compliance for the rotas being issued in the North Care Group Aug 2026 data - 100% compliance in the South Care Group for both work schedules and rotas issued and 100% compliance for the rotas being issued in the North Care Group	None	None	Processes are in place to support compliance with the 8-week work schedule and 6-week rota publication standards, ensuring resident doctors receive timely information to support workforce planning, work-life balance and educational commitments.	2. Partially compliant
2.2	Clear monitoring of compliance and reported at Board sub-committee level	NHS England Reporting around Code of Practise Compliance	None	None	Ongoing	3. Compliant
3. Annual leave reform – Adoption of minimum standards for annual leave for resident doctors.						
NHS England » Minimum standards for annual leave for resident doctors						
System and process are in place to ensure that:						

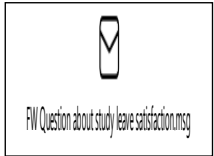
Resident Doctor Board Assurance Framework v1.0

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
3.1	Adopted the minimum standards for annual leave for resident doctors	The Trust has adopted the minimum standards for annual leave management for resident doctors, with the aim of improving access to leave, reducing administrative burden and enhancing the overall trainee experience. To further support implementation, an annual leave procedure has been drafted (pending clarification of some points) to ensure consistent application of annual leave processes and compliance with national guidance.	Annual leave procedure has been drafted pending clarification of some points	Awaiting clarification of some points (from NHSE) before the procedure can be finalised	Awaiting clarification of some points before the procedure can be finalised	2. Partially compliant
3.2	Provision of rota coordination training	Ongoing. Pending NHSE update for clarity around annual leave policy. The Trust is looking at providing rota coordination training to resident doctor reps.	Pending clarification of some points as above	Pending clarification of some points as above	Rota co ordination training to be provided to trainee reps from September 2026	2. Partially compliant
4. Board-level leadership – Senior leads and peer representatives are in place						
System and process are in place to ensure that:						
4.1	Appointed Resident Doctor Senior Board Lead and a Non-Executive Director for Resident Doctors'	Dr Kedar Kale, Executive Medical Director, has been appointed as Resident Doctor Senior Board Lead. Jules Preston has been appointed as the Non-Executive Director for Resident Doctors.	None	None	Compliant	3. Compliant
4.2	Appointed Resident Doctor Peer Lead and they are engaged in line with national guidance	RDPL is fully engaged with national guidance	None	None	Compliant	3. Compliant
4.3	Robust progress updates in place which involve Resident Doctor	• North RDTF • South RDTF • 10 Point plan working group meetings • Senior Registrar Business meetings • Internal Audit	None	None	Compliant	3. Compliant

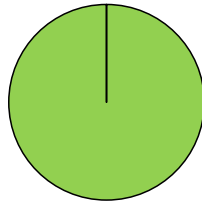
Resident Doctor Board Assurance Framework v1.0						
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
4.4	Clear support plan in place to assist the RDPL	Support plan in situ and has access to speak to all senior leaders	None	None	Compliant	3. Compliant
5. Payroll accuracy – Trusts have commenced payroll improvement activity and are monitoring						
System and process are in place to ensure that:						
5.1	Implementing payroll improvement methodology	Medical staffing and TEWV Payroll team continue to work collaboratively to improve payroll methodology. Payroll drop in clinics are to be piloted from August 2026. The clinics will be hosted by the medical staffing team and Payroll manager and will provide a platform for resident doctors to raise any queries in relation to pay and travel expenses.	None	None	Ongoing	2. Partially compliant
5.2	Reduction in payroll errors	Ongoing - Monthly monitoring and reporting arrangements are in place to review payroll performance, identify themes and provide assurance that payroll errors are being addressed promptly and effectively. This work supports the Trust's commitment to ensuring resident doctors receive accurate and timely remuneration.	None	None	Ongoing	2. Partially compliant
5.3	Monthly error reporting compliance undertaken	Ongoing - Monthly monitoring and reporting arrangements are in place to review payroll performance, identify themes and provide assurance that payroll errors are being addressed promptly and effectively. This work supports the Trust's commitment to ensuring resident doctors receive accurate and timely remuneration.	None	None	Ongoing - Section 12 payment issues for SR's is being investigated through Regional 10 point plan lead (Dr. Ostrowski) and has also been escalated to EMD.	2. Partially compliant
6. Mandatory Training – no unnecessary duplication and MLOGs in place and working with RDs						

Resident Doctor Board Assurance Framework v1.0						
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
System and process are in place to ensure that:						
6.1	Signed MoU and processes in place for monitoring that no unnecessary training is being repeated	The Trust has signed up to national mandate.	None	None	Compliant	3. Compliant
6.2	Mandatory Training Local Oversight Group (MLOG) in place	A Mandatory Training Local Oversight Group (MLOG) is in place. Within the Trust, this is titled the Training and Education Governance Group (TEGG).	None	None	Compliant	3. Compliant
6.3	The MLOG involves Resident Doctors in ensuring that local STATMAN requirements are necessarily and proportionate	The chair of TEGG has agreed that a resident doctor representative can attend the meeting and a small group of resident doctors have been identified to attend TEGG.	None	None	Compliant	3. Compliant
7. Exception reporting – Adoption of new national framework						
System and process are in place to ensure that:						
7.1	Clearly communicated new approach and local processes to all Resident Doctors	The Trust has communicated the exception reporting reform process and associated local arrangements to resident doctors through induction, relevant meetings (RDF) and ongoing communication. Resident doctors are encouraged to utilise exception reporting to raise concerns relating to working hours, training opportunities and service pressures, ensuring issues can be addressed promptly and appropriately.	None	None	Compliant	3. Compliant
7.2	Implemented local and national data reporting requirements	Local processes align with national requirements and data relating to exception reports is monitored and reported through established governance mechanisms (Quarterly Board Reports).	None	None	Compliant	3. Compliant
8. Expense reimbursement – Adoption of fast-track course costs						
System and process are in place to ensure that:						
8.1	Adopted new reimbursement process	The Trust has adopted the fast-track course costs guidance issued by NHSE.	None	None	Compliant	3. Compliant

Resident Doctor Board Assurance Framework v1.0

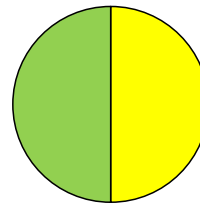
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
8.2	Meeting target reimbursement time of 6 weeks.	Confirmation received from NHSE NE that LET employed resident doctors are receiving reimbursement of course costs within the 6 weeks time scale. 	Issues have recently been raised by TEWV employed resident doctors working in NHSE Y&H that payments are still being reimbursed outside of the 6 weeks timeframe. Work is ongoing with the resident doctor representative to gain further information regarding non-compliance so this can be explored further.	It is not yet clear whether the non-compliance is a Trust or NHSE Y&H issue.	Work is ongoing with the resident doctor representative to gain further information regarding non-compliance for reimbursement of course costs within six weeks so this can be explored further.	2. Partially compliant
8.3	Doctor satisfaction meeting ≥80% target	RDPL has contacted the Head of Improvement at NHSE to gain clarity regarding the 80% satisfaction rate and how Trusts are going to measure the satisfaction rate amongst resident doctors.	The Trust cannot provide assurance on the 80% satisfaction rate until NHSE have provided the Trust with the Education Quality Provider self assessment (PSAR).	None	RDPL has received confirmation from NHSE that the PSAR will be provided to Trusts in August for completion and return by the end of October. Completion of the PSAR will result in compliance. 	2. Partially compliant

1. Workplace wellbeing – Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead.



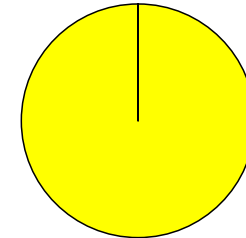
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2. Rota transparency – Compliance with 8-week schedules, 6-week rotas with improvement plans in place where performance needs to improve.



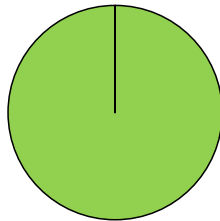
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3. Annual leave reform – Adoption of national best practice initiatives



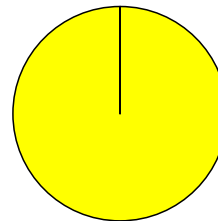
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4. Board-level leadership – Senior leads and peer representatives are in place



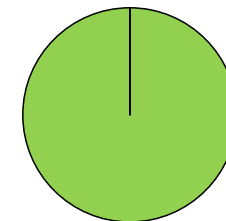
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5. Payroll accuracy – Trusts have commenced payroll improvement activity and are monitoring



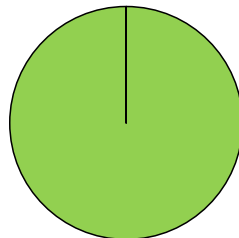
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6. Mandatory Training – no unnecessary duplication and MLOGs in place and working with RDs



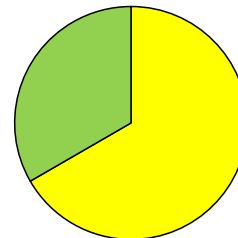
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7. Exception reporting – Adoption of new national framework

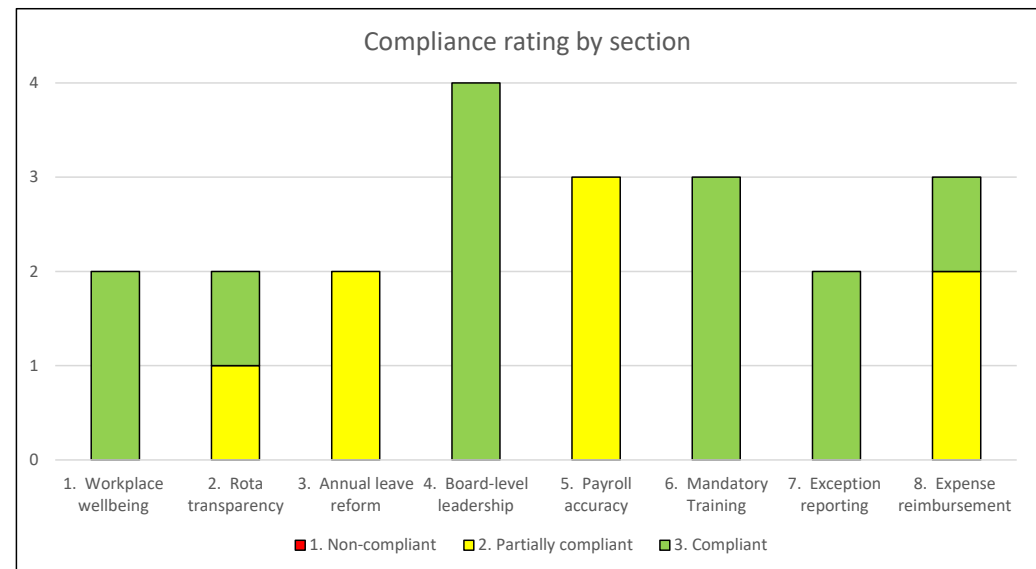
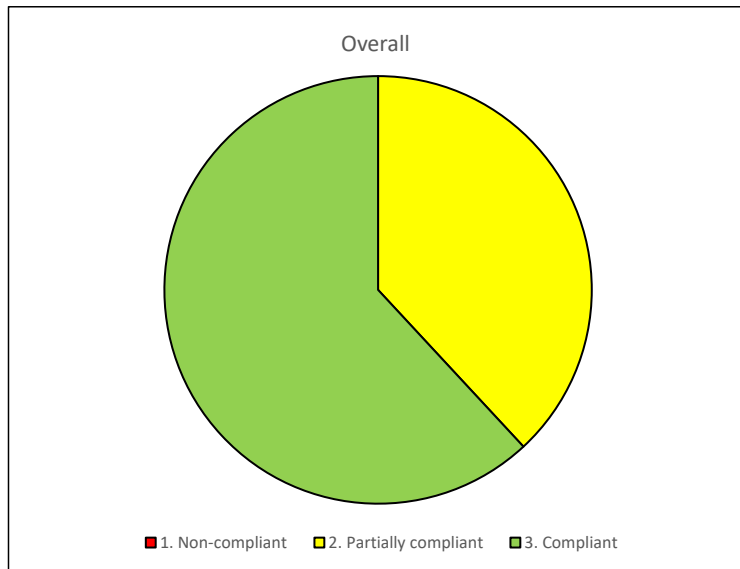


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8. Expense reimbursement – Adoption of fast-track course costs



■ 1. Non-compliant ■ 2. Partially compliant ■ 3. Compliant



TEWV Response to NHS England Ten Point Plan for Resident Doctors

<u>Ten Point Plan</u>	<u>Current positions</u> <u>Trust position / LET / NHSE</u>	<u>Status</u> <u>✓/X</u> <u>Partial</u>	<u>Supporting</u> <u>documentatio</u> <u>n</u>	<u>Actions including lead</u>	<u>Progress</u>
1. Improve workplace wellbeing for our resident doctors Trusts are expected to take meaningful steps to improve the working environment for resident doctors. Issues will vary by location, so trusts can adapt implementation to reflect local needs and operational realities in these and other areas:	The Trust has developed a strong Faculty of Medical Education to oversee the delivery of both undergraduate and postgraduate placements and has created its own standard operating framework for GMC compliance. The faculty monitor compliance and satisfaction through the annual GMC survey, forums, feedback at organised clinics, end of placement job review forms and the annual internal audit event. In 2025, the Trust was ranked 6th best placement provider for overall satisfaction in the whole UK by resident doctors in the GMC Survey. The Trust has quarterly Postgraduate Forums during the year where junior doctors representatives attend and provide updates on their placements. The Forum receives an update on wellbeing as a standing agenda item and the group discuss issues affecting resident doctors working and rest environments. In attendance at the forum is the Director of Medical Education (DME), Guardian of Safe Working, Training Programme Director, representatives from the Faculty of Medical Education and colleagues from medical development. In addition, there are bi-monthly meetings held with junior doctor representatives and the Medical Staffing Manager to pick up more local matters associated with placements. During the past year five task and finish groups (Race / IMG, Disability, Gender, LGBTQ+ and Religious Practice) have been created with regular meetings taking place to formulate plans to address any negative feedback / outliers received from both internal and external quality	Status disc for next Forum	 Medical Education Annual Board Report  Medical Education Annual Board Report  Task Finish Focus Group Actions - 202	Medical Education Board Report to be written and submitted in November 2025. Lead: Head of Medical Education	Action Complete The board report has been written and shared. Reports have been attached.

TEWV Response to NHS England Ten Point Plan for Resident Doctors

	visits and surveys. The Medical Education Leadership Team (MELT) continues to work closely with the Trust Strategic Lead for Equality, Diversity, Inclusion (EDI) and Engagement and the Director of People and Culture. Whilst the Trust provides ongoing assurance to relevant governing bodies, the Faculty identified that findings and actions from external quality visits did not always align to the internal feedback collected from resident doctor clinics, end of placements review meetings and Trust rankings in the GMC Trainee survey and so implemented its own internal audit framework to enhance the quality monitoring systems and receive genuine feedback first hand. These events now run annually with colleagues from one Care Group visiting the other to undertake an assessment and are a source of rich feedback, from which actions are set. This was described as exemplar at the Quality Management Visit. The Faculty has developed a buddy support system to ensure that early year Registrars, Trust Doctors, Foundation Doctors and GP Registrars feel appropriately supported. It helps rotating doctors to understand the systems in place and points of contact. The faculty has a well-established Resident Doctor Wellbeing Team which is accessible to all doctors and physician associates within the Trust. The Wellbeing Team includes the Associate Director of Medical Development, Nurse Specialist, a doctor and physician associate representatives. The team follow guidance from the GMC, HEE and BMA around wellbeing initiatives, work closely with the Trust wide Health and	 TEWV Internal Educational Audit F  August 2025 - Buddy allocations.d  Clinical Teams - Wellbeing Poster DRA  Health & Wellbeing Support Booklet - DR,	Dr Jordan Williams outlined a SOP used by the Yorkshire and Humber School of Psychiatry to offer support to SpR's. MELT agreed to consider using a system like this or lobby the School of Psychiatry. Lead: Director of Medical Education	Action Complete Dr Jordan Williams has sent Bryan O'Leary the SOP and this will be shared with MELT on Friday 16th January 2026.
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TEWV Response to NHS England Ten Point Plan for Resident Doctors

	Wellbeing Team to share new initiatives and training to improve staff wellbeing, and focus on changes which can be made to facilities within the Trust to improve wellbeing. They also arrange Annual Wellbeing Away Days open to all doctors and physician associates in the Trust. The Faculty has recently introduced VASCO. This initiative is essentially access to middle tier and consultant level advice out of hours. It is proactive support by providing Vertical Advice and Support for Colleagues On-call. At the start of each OOH shift, a senior doctor makes contact with the resident doctor to 'check in' and discuss likely complex cases. Colleagues are also encouraged to have a lengthened conversation when it is the resident doctors first OOH shift in psychiatry (Aug 25') and are reminded by medical staffing when this is the case. In 2025, MELT developed a Charter for resident doctor in TEWV. Some of those measures relate directly with improving the wellbeing and working environment and include: • Effective and tailored individuals work schedules. • Paid opportunities available to shadow colleagues out of hours before undertaking the first shift • Access and use of a personal laptop and mobile phone within two weeks of starting. • Opportunities to receive face-to-face or virtual coaching sessions with qualified coaches. • Access to free Royal College CPD learning and BAP modules.	 VASCO Guidance - September 2023.pdf	Audit the effectiveness and feedback from the lengthened conversation in August 2025. Lead: MELT The Faculty plan to survey resident doctors in 2026 to understand if it meets the standards outlined. Lead: Head of Medical Education	Action ongoing A protocol has been developed and this will be getting shared with MELT on Friday 16th January 2026 Action Complete
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TEWV Response to NHS England Ten Point Plan for Resident Doctors

	• Access to free, high quality internal CPD and professional development, including modules that complement the weekly teaching programme and MRCPsych. • Access to senior advice out of hours and proactive support through VASCO at the start of each shift. • Support from resident doctor representatives in each rota area with additional support from a Dignity at Work Champion and Wellbeing representatives, both roles being developed by the Trust. • Support to take a zero-tolerance stance on issues of any kind in relation to discrimination. • Opportunity to attend face to face wellbeing symposia focussed on doctors in training, developed by reps.				
Where possible, [provide designated on-call parking spaces]	No designated spaces are granted on Trust sites. However, it has been agreed that resident doctors can park in designated disabled spaces whilst on-call. This is shared with doctors at induction.			Check with resident doctors that this approach is acceptable. Make this more prominent in the induction information so that it is understood by all. Lead: Medical Staffing Manager	Action complete A slide regarding car parking spaces has been added in the induction booklet.
The autonomy to complete portfolio and self-directed learning from an appropriate location for them	Every doctor has an individualised laptop and has access to a workspace they can use.				
Access to mess facilities, rest areas and lockers in all hospitals, including new builds	Every doctor has access to a junior doctor room on each main site. The Trust has rest rooms and facilities at each main hospital site and lockers are available as below: RPH – yes WPH – no lockers but metal draws are available LRH – no lockers available				Action ongoing Lockers for LRH have been ordered. Awaiting feedback from reps regarding the safety of using lockers at FPH.

TEWV Response to NHS England Ten Point Plan for Resident Doctors

A 24/7 out-of-hours menu offering hot meals and cold snacks for staff Within the next 12 weeks every trust should: Conduct a self-assessment of the feasibility of improving priority areas and develop action plans to address any gaps. This audit and subsequent plans must be approved by the trust's people committee or equivalent body. Trusts will be expected to provide updates for national reporting on progress.	FPH – yes CLH – yes At FPH the lockers have codes on and don't require keys. The reps will have a look at FPH to ensure the use of lockers are safe to use. There are no cafeterias that operate out of hours on Trust sites. However, we have worked with local resident doctors to determine a choice of free ready meals and snack. This includes microwave hot meals, pot noodles, porridge, soup, as well as savoury snacks and biscuits. There is access to hot water and microwave on all sites. NHSE Y&H have confirmed that there is no strict definition about what and how these are provided. The key is for Trusts to have resident doctor reps involved in discussions and action plans to look at the art of the possible (as part of the wellbeing discussions in general) The result may well be a vending machine / microwave. An annual survey will be created to understand the quality and facilities provided by the Trust. The group also discussed the BMA Fatigue and Facilities charter and this will be shared with the working group.	 Resident Doctors Survey 12.11.2025.docx	Standing agenda item at rep meeting with medical staffing manager. Lead: Medical Staffing Manager It was agreed to set up a working group to design a survey that will be shared amongst doctors. This will include the standards of the ten-point plan and more aspirational standards to consider. Members include Dr Heba Saeed, Dr Aqsa Ghazanfar, Dr Sharon Kwagiri and Dr Oluwadara Akintunde.	Dr Aqsa Ghazanfar mentioned the junior doctors won't be aware of how to use the Lockers. Dimitra to ask the reps to include this information in the local induction booklet Issues with lack of provisions raised at the rep meeting on 7/11 and these have been escalated to Catering. They confirmed that the trust is changing suppliers hence the delay. Action complete NHS England has confirmed that as long as the food can be heated in a microwave, it can be considered hot food. Action ongoing Survey has been completed circulated an action plan will be shared with the group w/c 30th March 2026.
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TEWV Response to NHS England Ten Point Plan for Resident Doctors

		A discussion was held to consider how progress against the plan could be reported back to the Trust and whether it was more appropriate for the Medical Education Committee or People and Culture Group to oversee, and this will be discussed further with colleagues in the Trust. To consider response from estates around installation of A/C unit in the Resident Dr Room at FPH. This was requested following feedback received from resident doctors around the temperature in the room (gets very hot during the summer months). Following request from medical staffing, estates confirmed that the trust no longer installs A/C in offices due to the cost incurred with running and maintaining them.			Lead: Chair of Working Group	
2.	Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice (COP) From now, and for all rotations going forward NHS England must provide at least 90% of trainee information to trusts 12 weeks prior to rotations commencing. From now, Trusts must use this information to ensure that resident doctors receive their work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before the rotation begins. Where these standards are	This is delivered by the Lead Employer Trust (LET) for colleagues in DTV Care Group • The LET maintains establishment reports of training placements and notifies each Lead Employer Placement (LEP) of expected trainees 12 weeks in advance of the rotational start date to comply with COP • The LET works to ensure compliance with COP by ensuring Work Schedules are issued to the trainee 8 weeks prior to commencement of an individual trainee's work schedule. • Overall, NE compliance rate with COP typically exceeds 90% with regards to the LET notifying the Lead Employer Trust (LEP) 12 weeks in advance. • Some non-compliance is not locally driven, and the result of nationally implemented recruitment timelines.				

TEWV Response to NHS England Ten Point Plan for Resident Doctors

	not met corrective action must be taken. Performance data must be submitted by trusts, and NHS England will monitor and report on national compliance across all stages of the process Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery. Within 12 weeks, NHS England will: conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts.	The Medical Staffing team is responsible for issuing work schedules to resident doctors in NYY Care Group. Overall compliance with COP (August 2025 rotation): • 100% compliance as rotas were compiled and distributed providing the required 6 week notice (it was noted that the NYY resident doctor rota had to be amended in Aug 25' and some changes made to Work Schedules. • 95% compliance with issuing all work schedules with 8 weeks' notice. The delay of the remaining work schedules was caused as we waited confirmation of non-work days of LTFT resident doctors. • Compliance with the COP will be monitored via the Resident Doctor Forums and data will be presented in future forums.				Action ongoing Delays in receiving the Core Trainee Rotational Information for February 2026 from Yorkshire & Humber. Information has been chased with the deanery and the TPD but the 12 week deadline has not been met
3.	Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing It is vital that leave is allocated in a way that meets individual needs while maintaining service delivery.	As a Mental Health Trust, it is important to differentiate between resident doctors who remain on placement within the organisation (core and higher training) and resident doctors who rotate and join the organisation for a fixed period of time (FP and GP). The Trust still finds some Foundation doctors seek pre-approval for annual leave whilst in a previous placement. It can also find that the distribution of leave is not consistent so this can negatively impact on the amount			Consider whether a formal policy for annual leave is required for resident doctors. Action: Medical Staffing Manager	

TEWV Response to NHS England Ten Point Plan for Resident Doctors

Within 12 weeks, NHS England will: conduct a review of how annual leave is currently agreed and managed for our resident doctors. This review will identify areas for improvement and lead to clear recommendations to ensure a more consistent, transparent and supportive approach across all trusts. All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board Within 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board. In Sept 2025, NHS England will: publish a national role specification for the board lead. The senior lead will formally take on this responsibility within an existing role, supported by a national role specification to be published by NHS England in September. The resident doctor	of time on leave when on placement in the MH Trust. This is a matter discussed with the Foundation School. Annual leave is discussed and agreed within the service and where possible leave requested is agreed, whilst ensuring that patient care is maintained. A minimum of six weeks' notice is generally provided by the resident doctors. Following a discussion, it was agreed that resident doctors should be able to seek approval for annual leave out with their current rota cycle as this would support 'life planning'. Additionally, annual leave requests should consider how the medical role impacts staff differently across the various tiers of medical cover and not solely granting approval for the resident doctor. Before the rotas are compiled, resident doctors are asked by the medical staffing team to indicate specific dates (using MS Forms) to be avoided for on-call purposes. This system, where residents give notice of dates they wish to avoid, helps to create a fair and more balanced rota for resident doctors and it is appreciated. The medical staffing team are currently considering an e-rostering solution that could allow doctors to indicate the dates to be avoided and ensure a fair and transparent scheduling process for all.			Once approval is granted a confirmation letter will be sent by Medical Staffing and they will take this into consideration when planning rota cycles. Lead: Associate Director of Medical Development Medical managers will be asked to consider a process to capture this. Action: Director of Medical Education Medical Staffing Manager to oversee and report back when pilot rota site agreed. Rostering, Facilities & Fatigue Policy to be updated Lead: Medical Staffing Manager	Action ongoing Teesside Resident Doctor Rota to pilot DRS E Rostering solution from Feb to Aug 2026
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TEWV Response to NHS England Ten Point Plan for Resident Doctors

	lead will act as a peer representative and enable trust boards to hear directly from resident doctors themselves. They should be invited to attend board level discussions on issues which specifically relate to improving doctors' working lives. Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses					
4.	All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board Within 6 weeks, trusts should: appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board.	Dr Kedar Kale, Executive Medical Director is appointed as the Board Lead. Dr Hany El Sayeh and Bryan O'Leary are appointed as the Senior Leaders. During the meeting held 23/09/25, the process to appoint a peer representative from the resident doctor body was discussed and agreed. It was agreed that Bryan O'Leary would send communication to resident doctors about the appointment process and ask for expressions of interest			The Trust will seek to understand the national profiles and consider as necessary. Lead: Associate Director of Medical Development A letter was sent 24/09/25 Lead: Associate Director of Medical Development	Action Complete

TEWV Response to NHS England Ten Point Plan for Resident Doctors

	In Sept 2025, NHS England will: publish a national role specification for the board lead. The senior lead will formally take on this responsibility within an existing role, supported by a national role specification to be published by NHS England in September. The resident doctor lead will act as a peer representative and enable trust boards to hear directly from resident doctors themselves. They should be invited to attend board level discussions on issues which specifically relate to improving doctors' working lives. Boards should also ensure their executive teams engage directly with resident doctors to understand local working conditions and priorities. This should be supported by national and local data sources (for example, GMC/NET Survey), with improvement plans developed with the same rigour as staff survey responses Resident doctors should never experience payroll errors due to rotations	to form a panel, made up of resident doctors and a member of MELT. This group would shortlist, interview and appoint a representative. It was also agreed that the application to apply for this role would be open for all resident doctors, mindful that colleagues with more experience and at the end of core training or in higher training would and in representative roles would be more likely to succeed in this role. The faculty produce a Medical Education Annual Board Report that outlines performance over the last year, challenges and risk and this provides assurance of placement activity.			Closing date 10/10/25 Lead: Associate Director of Medical Development	Action Complete
5.	Following a successful pilot that has reduced errors by half, we are	This is delivered as part of existing Lead Employer arrangement for resident doctors in DTV Care Group:			The Trust Financial Controller has been approached to be the	Action ongoing Dimitra to send formal communication to the LET

TEWV Response to NHS England Ten Point Plan for Resident Doctors

	extending the learning from this work to all NHS trusts. Within the next 12 weeks, every trust should: Participate in the current roll out of the national payroll improvement programme and ensure that payroll errors as a result of rotations are reduced by a minimum of 90% by March 2026. All organisations are required to establish a board-level governance framework to monitor and report payroll accuracy and begin national reporting as required.	With effect from 1/5/2025, the LET's Payroll Service is outsourced to NHS Payroll Services (provided by Northumbria NHS Foundation Trust) and is managed through an SLA by the LET. This element of the LET contract specification remains outsourced meaning that, irrespective of any change to the host organisation in the future, the LET continues to liaise with NHS Payroll Services to ensure onward delivery of these services. The LET continues to work with LEPs to ensure timely and accurate work schedules are received and the decision to outsource was to ensure a robust and consistent delivery of payroll services could be achieved as being part of a large payroll-specific team of experts. Performance standards are agreed by the LET and NHS Payroll Services along with specific KPIs the Payroll Services are performance managed against. These are in areas including accuracy and timeliness of payments (salary and approved expenses), overpayments, correspondence response times and meeting statutory deadlines. In terms of the resident doctors employed by TEWV, we work closely with payroll in order to ensure that any payroll errors are minimised and we have agreed that going forward a quarterly report will be produced and presented to LNC and the Resident Doctor Forums that would detail any issues in relation to accuracy and timeliness of payments as well as any errors resulting in overpayments or underpayments.			finance lead that oversees payroll matters	for the reports to be shared in time Action ongoing Finance will be sharing a payroll error report on a quarterly basis.
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TEWV Response to NHS England Ten Point Plan for Resident Doctors

6.	No resident doctor will unnecessarily repeat statutory and mandatory training Within the next 12 weeks if they are not already doing so, every trust should: Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of prior training. By April 2026, NHS England will: reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England. Within the next 12 weeks if they are not already doing so, every trust should: Comply with agreements set out in the MoU signed by all trusts in May 2025 by ensuring acceptance of prior training. By April 2026, NHS England will: reform the entire approach to statutory and mandatory training with a revised framework as outlined in the 10 Year Health Plan for England. Resident doctors should be enabled and encouraged to Exception Report to better support	This is delivered as part of existing Lead Employer arrangements for resident doctors in DTV Care Group: The LET oversees compliance of Statutory and Mandatory training (via ESR). Given the LET model, this irradiates duplication of training as all employees managed as per annual cycle of requirements only irrespective of rotations. As part of the MOU, the Trust accept prior learning from all Core Skills Training Framework except Safeguarding. (The Trust will accept Safeguarding if the individual has completed both adult and children at the same level as TEWV deliver it combined and the CSTF has it separate). The Trust only accepts these from another NHS Organisation as per the MOU. Currently, resident doctors undertaking locum shifts are required to complete outstanding mandatory and statutory training prior to booking a shift - even if similar training has been completed under another organisation. This is because the locum bank is a separate employment contract with the Trust. TEWV accept prior learning for other National e-learning programmes: • Patient Safety Level 1 and 2 • Speak Up • Listen Up • Follow Up • Mental Capacity Act modules		 Mandatory Training Needs Analysis (Inc	The Medical Staffing Manager will meet with colleagues in the Trust to understand whether we can make this simpler. Lead: Medical Staffing Manager	Action ongoing Mandatory and Statutory training has been reviewed and some modules have been removed to streamline training for permanent and locum staff. Stephen Parry will review the interface and will contact Dimitra for further discussion.
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TEWV Response to NHS England Ten Point Plan for Resident Doctors

	doctors working beyond their contracted hours	TEWV adheres to the People Policy Framework for Mandatory Learning agreed on 1 May 2025. The Workforce Development Lead is part of the national group and TEWV are with all Trust working towards the end goal. The TEWV document is not yet finalised, but it will go to the next Governance Oversight Group identified in the policy for agreement				
7.	A new national Framework Agreement for Exception Reporting was agreed on 31 March 2025 and will be rolled out for implementation in due course. The changes agreed simplify the reporting process for resident doctors, ensure they are being fairly compensated for the additional hours they are required to work, and will support the safety of their working hours. We are committed to implementing these reforms as soon as practicable.	Awaiting roll-out of new national Framework Agreement for Exception Reporting (agreed March 2025). The LET is a key player given the new approach within the Framework which indicates Trainees will be obliged to submit Exception Reports to the Employer. TEWV has recently upgraded to DRSS as exception reporting platform and in preparation for the roll-out of the national framework agreement. The Trust provides written guidance and a step by step guide on how to submit exception reports as well as an overview of the system at each Resident Doctor Induction. We ensure that all exception reports are responded to in a timely manner and all data are presented in the Resident Doctor Forums as well as the Quarterly Guardian Reports. Exception reporting was highlighted at the Trust Annual Audit event. It was agreed that there would be an			In place for December 2025. Lead: Medical Staffing Manager	Exception Reporting Reform implementation February 2025 Action complete

TEWV Response to NHS England Ten Point Plan for Resident Doctors

		additional session put on by medical staffing to practically illustrate how to use the system.				
8.	Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims We will transition nationally from an approach where expenses for approved study leave are reimbursed only after a resident doctor has attended a course/activity, to one where reimbursement is provided as soon as possible after the expense is incurred. Within the next 12 weeks every trust should: Review their current processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsistence. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the	This is delivered as part of existing Lead Employer arrangement for resident doctors in DTV Care Group : Specifically for Study Leave, the LET already has a long-standing process to ensure early re-imbursement of approved activity for trainees opting to apply this way (i.e. approved Study Leave costs can be submitted for re-imbursement at the time of booking rather than after the event).		 Guidance for early reimbursement.pdf	NHSE have been working nationally to support Trusts with the implementation of early reimbursement of study leave expenses as set out in the attached 10-point plan. NHSE Y&H have confirmed that from <u>Wednesday 8th October</u> all approved activity taking place on or after this date will be eligible for reimbursement. In summary all approved study leave activity for which an expenses receipt can be provided are eligible. Accent Leave Manager has been configured to allow all expenses to be recorded as claimed and authorised by Medical Education in advance of the activity date, except for mileage and subsistence. Early reimbursement guidance has been created and is intended to support employers, approvers and applicants	Action Complete

TEWV Response to NHS England Ten Point Plan for Resident Doctors

	BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority. Within 12 weeks, NHS England will: develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.	During the meeting, resident doctors raised concerns that they are unable to book study or training in NYY Care Group due to stricter course booking processed by the School of Psychiatry. This creates a system within the Trust that is inequitable, unfair and inconsistent. For resident doctors in NYY		 NHSE North East local Study Leave Po  NHSE YH Study Leave Guidance.doc	understand study leave expenses which can be claimed early, the process for obtaining reimbursement of expenses and what happens in the event of cancellation or non-attendance. This is a high trust guidance reliant on applicants notifying their employers at the earliest if they are unable to attend study leave activity for which they have already been remunerated. Whilst NHSE Y&H acknowledge concerns that this could contribute to a rise in study leave costs they are driven by improving the experience for resident doctors. Furthermore, evidence from regions already offering early reimbursement provides assurances that this has not notably contributed to an increase. This is a longstanding issue and had been raised with the Dean. The DME will again highlight this disparity and provide challenge on behalf of the doctors, using this framework. Lead: Director of Medical Education	Action ongoing Dr Aqsa Ghazanfar to add this in the Trust report and feedback
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TEWV Response to NHS England Ten Point Plan for Resident Doctors

		• Trainees submit their study leave on Accent (electronic study leave system), including expected expenses for approval as normal • Once the trainee has attended the training, they then have to submit a TEWV expenses form to us for approval (see attached) along with any receipts. • The medical Development team then check the claim form against Accent to check the study leave / expenses were approved • If matches the expenses form is signed off, added to our monitoring spreadsheet and then sent to finance for payment • Expenses are signed off on Accent as approved / claimed (this is what has replaced the old “returns” system we used to have so HEYH know what has been claimed back by the trainee)				
9.	We will reduce the impact of rotations upon resident doctors’ lives while maintaining service delivery A review of how rotations are managed is now underway and is being led by the Department for Health and Social Care (DHSC) in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees’ concerns and to find constructive and workable solutions to address their needs as a matter of priority.	This is not a matter for the Trust. The NE LET shared their position: FP: National competitive recruitment, overseen by UKFPO, dictates that all applicants are matched to two-year Foundation Programmes with a specific LEP at the outset with all 6 x 4-month placements (specialty and location) also confirmed at that point. The Northern Foundation School (NFS) have limited flexibility to change their ‘offer’. All Foundation Programmes are quality assured and checked to ensure that they provide a good balance of specialties and that each LEP is compliant with the requirement to offer exposure to Psychiatry.			The Medical Education Lead has written to Head of School to seek clarity on how they would support this action. Lead: Head of Medical Education	Action Complete Response from Y&H  RE 10 point plan issue for higher trainee

TEWV Response to NHS England Ten Point Plan for Resident Doctors

	Within 12 weeks, NHS England will: develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.	NFS offer Specialised FP pre-matching for 1/3rd of our programmes (7/21). NFS considers the personal circumstances of all applicants allocated to our School under pre-allocation on a case-by-case basis to facilitate a match to their first choice of LEP and Programme in the locality closest to their home address. What the Specialty Training team does at present is: Core psychiatry: doctors are either placed in the North (with CNTW) or South (with TEWV) for the whole 3 years. IMT: around half of their doctors spend 2 of their 3 years in a single trust. Head of School looked at the data which shows: 2023 - 53% of doctors had 2 years in the same trust • 2024 - 44% of doctors had 2 years in the same trust • 2025 - 49% of doctors had 2 years in the same trust				
10.	We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model	This is not a matter for the Trust. This is a matter for NHS England to work with partners.				

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Committee Key Issues Report		
Report date to Board of Directors – 13 August 2026		
Date of last meeting: 02 July 2026	Report from the Quality Assurance Committee (quoracy met)	
	Chaired by Marie Burnham, Chair of the Trust	
1	Agenda - The Committee considered the following matters: • Minutes of meeting held on 7 May 2026 and 4 June 2026 • Action Log • Patient Story – Hilary Nozedar • Summary of Executive Directors Group Quality and Performance meeting, 26 May 2026 • Quality Governance Triple A Report including: CQC Improvement Plan, Quality Dashboard (Appendix 1), Quality Risks QAI Programme (Appendix 2), Quality Assurance and Improvement Programme and NICE Guidance Implementation Update (Appendix 3) • Safe Staffing • Impact of Statutory/mandatory compliance on regulation – verbal update • Clinical Outcomes Improvement Plan • Equality/Quality Impact Assessments • Health and Justice Services • Compliance with Clinical Supervision • Services requiring additional support (SRAS) • Q4 2025/26 data for Learning from Patient Safety Incidents	
2a	Alert	The Committee wishes to alert the Board to the following matters: There is limited controls assurance linked to actions/mitigations in place for services requiring additional support (SRAS) in: NYYS - Ebor & Minster Wards, Ripon and Harrogate Integrated Community Team (additional Executive oversight), DTVF Services/SIS inpatients - Ridgeway (Ivy Clover, Sandpiper and Kestrel Kite), and CAMHS Crisis and Getting More Help South Durham. There are reasonable controls assurance for the remaining services across the care group. There is close monitoring of all services in SRAS with regular reporting to Executive Directors. A review of organic beds across the Trust including Springwood is underway. Fourth month of high use of prone restraint reported. The incidents relate to the complex care of two people, one person in Adult Learning Disability services (ALD) Bankfields and one in SIS. With regards the person in ALD services, liaison with the ICB and LA's continues to source suitable placements. Increase in prone restraint in SIS is in relation to seclusion exits. A range of approaches have been put in place to address the issues including Mersey Care NHSFT to provide some training to adopt an alternative method for seclusion entry and exit. Safe Staffing: SIS - use of Safe Care is in place. Daily oversight is in place to manage overtime, shifts over 13 hours and missed breaks. There are a high number of staff on alternative duties, including Registered Nurses. DTVf Adult Learning Disabilities: Bankfields have started to use HCA agency staff with Executive approval, to manage the impact of short- and long-term sickness.
2b	Assurance	The Committee received the following positive assurances:

		Good assurance in relation to the delivery and oversight of Health and Justice services, Committee has requested a further paper to the September meeting to describe assurances linked specifically to quality. There has been no use of tear proof clothing since January 2026. No regulation 28 notifications received from Coroners.
	Advise	The Committee wishes to advise the Board that: Patient Story - Committee listened to a mother of an adult with profound and multiple learning disabilities. The Chair has requested a training session for Board members/Committee members on the BAF and the risk register and how they link. Two change requests were approved to the Quality Assurance and Improvement Programme (1) to include a 'Did Not Attend/ Was Not Brought' clinical audit project within the 2026/2027 Programme and (2) to extend the completion timeframe from the end May 2026 to 31 July 2026, for the NICE225: Self-harm clinical audit project within the 2026/2027 Programme to allow collection of sufficient data. Statutory/Mandatory compliance training and the impact on regulation: It has been approved that the renewal period for Oliver McGowan Mandatory E-learning will be removed and become a one- off training module. This is a positive step. E-learning currently sits at 96%. Compliance for tier 1 and 2 autism remains on track for compliance to be reached by end 2026/27. Observation & Engagement E-learning – This has been unavailable on ESR since 6 May as is being reviewed and new e-learning is being developed, which will be available by the end of July. This has resulted in people not being able to complete the e-learning, although it remains over 85%. Mental Capacity Act training is not available at a national level due to changes in legislation. NHS England national safeguarding leads are currently reviewing content and plan to release updated sessions by August 2026. Most teams are over 85% compliance, however there are some which are below this and a list of teams is being gathered for local support where necessary from the Mental Health Legislation team. Reasonable assurance is provided in relation to: The effective oversight and monitoring of arrangements for section 17 leave and time away from the ward. There is ongoing variation in compliance evidenced from the inpatient quality audit tool. A policy refresh following an event in June 2026 has supported overall improvements. Improvement plans are in place where there is variation this is monitored through the governance structures. The Trust-wide Clinical Outcomes Improvement Plan remains on track, with routine governance oversight, closure of relevant actions, and continued monitoring of the remaining actions. Of the 12 actions previously reported, one has been completed and eight CITO-related actions have been closed, leaving three actions under continued monitoring. Of these, two are complete but remain on the plan to monitor impact in July 2026. These relate to the implementation of quarterly webinars to support clinical engagement and the meaningful use of outcomes data at all levels. The remaining open action is paused due to external factors outside the Trust's control, relating to the requirement for a Reliable Change Index for a small number of CYP PROM measures. There is good assurance on the awareness of the QEIA pipeline, however, for the period from mid-May 2026 to present day there is only reasonable/limited assurance on the QEIA pipeline, which primarily focuses on Cash Releasing Efficiency Savings

		(CRES) schemes that require a QEIA assessment. Proposed changes to the QEIA policy and process will shortly go out to all staff for a six week consultation period, including recommendations and comments from lived experience leaders. There is reasonable assurance linked to progress to improve compliance for clinical supervision; however, improvement is variable and there are inconsistencies across the care groups. Overall compliance has increased to 57% for Q1 compared with 47% in Q1 2025/26. (DTVF 59% and NYY 46%). Data for Learning from Patient Safety Incidents from Quarter 4 25/26 has revealed that the Trust has demonstrated a strong reporting culture, with high levels of data completeness, timely reporting, and a high proportion of no-harm incidents. Nationally, the Trust compares favorably for reporting quality (ie completeness of data), with only 2.0% of incidents recorded without a specified harm level, compared with 8.0% nationally. The denominator used is incident rates per 1,000 bed days and does not allow for other comparators such as type of services included and weighted population.
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 and to demonstrate the scrutiny and consideration of reports before being presented to the committee. The Committee paid particular attention to the following risks: ▪ Secure Inpatient Services – Ridgeway, the three wards managing challenging behaviours, reported high acuity, as well as staffing issues. (Sandpiper, Kestrel/Kite and Ivy/Clover). ▪ Teams with increased executive oversight - Bankfields Court and Ripon/Harrogate ICT. ▪ The increase in restrictive interventions related to 2 specific areas, noting the plans with Merseycare to introduce new methods of training for exiting and entering seclusion in SIS. ▪ The challenges with the Electronic Patient Record. ▪ That training is required for Board and Committee members on the Board Assurance Framework, scoring of risks and controls assurance.
3	Actions to be considered by the Board	Items for Escalation to the Board ▪ No matters were identified for escalation to the Board. ▪ No formal escalations or amendments to the BAF risks were noted at the meeting.
4	Report compiled by	Marie Burnham Interim Chair of the Committee, Chair of Trust, Hannah Crawford, Executive Director of Therapies, Donna Keeping, Corporate Governance Manager

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For General Release

Meeting of:	Board of Directors
Date:	13 August 2026
Title:	Learning from Deaths Report - Quarter 1 (2026/27)
Executive Sponsor(s):	Kedar Kale, Executive Medical Director
Author:	Kayleigh Parris, Associate Director of Safeguarding & Patient Safety

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
8 Quality Governance	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.
10 Regulatory Compliance	

Executive Summary

Purpose

The National Quality Board (NQB) guidance on Learning from Deaths requires each Trust to collect and publish specific information; the Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

All 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.

As part of the ongoing incident management improvement programme, a collaborative review of the Trusts mortality process, including how learning is identified and shared was commenced 1st July 2026. The first mapping workshop successfully identified opportunities to improve quality, consistency and learning; and two QI events are planned throughout Q2.

Proposal

The dashboard and the learning points are provided as **good** assurance of reporting and learning in line with national guidance.

During quarter 1 (Q1) 2026/27, the trust was fully compliant with the 2017 National Quality Board (NQB) standards for learning from deaths.

Overview

In line with National Guidance the Learning from Deaths Dashboard, appendix 1 details Quarter 1 2026/27 information for the Trust and includes 2024/25 data for comparison.

- During Q1, 402 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, 338 patients were still open to a Trust service at the time of their death, of which 17 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 (>62,000).
- 4 inpatient deaths were reported. 3 of the 4 deaths were expected physical health that occurred in Mental Health Services for Older People (MHSOP) wards and have been subject to Part 1 reviews. The remaining inpatient death was an unexpected physical health death of a patient who was transferred from Secure Inpatient Services to an Acute Hospital, and has been subject to an After Action Review.
- There were 2 unexpected deaths reported on StEIS during the reporting period; 1 death occurred in Q1 and 1 death occurred in previous reporting period.
- 50 Part 1 reviews were completed and 8 Structured Judgement Reviews (SJR)s were completed and discussed at a mortality review panel.
- 13 Part 2 SJRs were requested.
- 5 Patient Safety Incident Investigations for unexpected deaths were completed.
- 22 patient deaths were reported to LeDER during Q1. All deaths of people with either a learning disability or a diagnosis of autism require reporting to LeDER in line with national requirements over the reporting period. Deaths are reported to LeDER via the clinical teams and the Patient Safety Team have added a prompt to all After Action Review and Mortality Review documents. It has also been built into the InPhase reporting system since 30th October 2023. Any discrepancies in reporting are being followed up by the Patient Safety team. Reasons given for not reporting have been identified as deaths occurring in the Acute Trust or a Care home and it 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.

5 Patient Safety Briefings were circulated Trust wide during this reporting period:

- E-form completion on CITO
- Correct choice of needles
- Frequent attender triage function
- Suspected suicides of Hartlepool residents
- Death module

Prior Consideration and Feedback

Updates and assurance aligned to improvement work relating to learning from deaths is reported to the Executive Directors Group and 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.

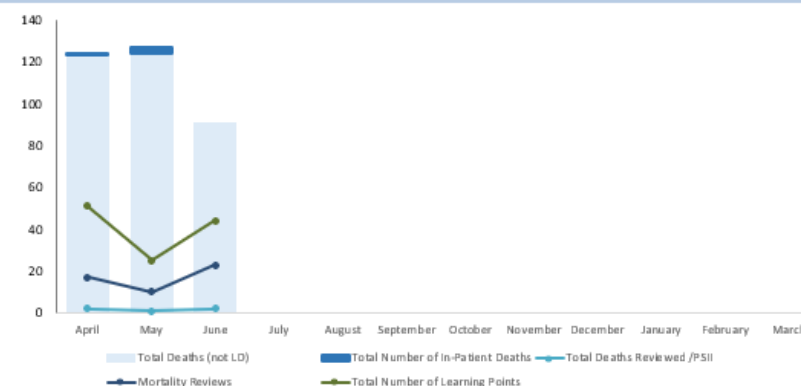
Appendix 1: Learning from Deaths Dashboard Q1 2026/27

Learning from Deaths Dashboard - Data Taken from Cito Reporting Period - Q1 2026-27

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	
	2026/27	2025/26	2026/27	2025/26	2026/27	2025/26	2026/27	2025/26	2024/25	2025/26
Q1	338	↘ 434	4	↔ 4	5	↘ 7	50	↘ 70	120	↘ 126
Q2	0	↘ 412	0	↘ 4						
Q3	0	↘ 474	0	↘ 14						
Q4	0	↘ 491	0	↘ 3						
YTD	338	↘ 1811	4	↘ 25	5	↘ 7	50	↘ 70	120	↘ 126

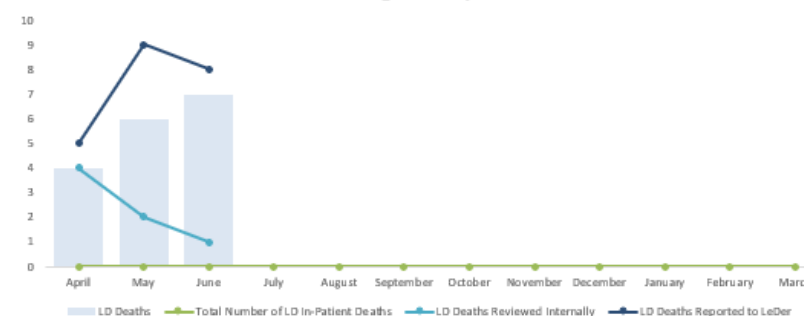


Summary of total number of Learning Disability deaths and total number of cases reviewed under the Patient Safety Incident Response Framework or Mortality Review

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	
	2026/27	2025/26	2026/27	2025/26	2026/27	2025/26	2026/27	2025/26
Q1	17	↗ 13	0	↔ 0	7	↔ 7	22	↗ 12
Q2	0	↘ 23	0	↔ 0				
Q3	0	↘ 24	0	↔ 0				
Q4	0	↘ 15	0	↔ 0				
YTD	17	↘ 75	0	↔ 0	7	↔ 7	22	↗ 12

Learning Disability Deaths



Appendix 2

Mortality Reviews

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

8 Structured Judgement Reviews (SJRs) were discussed and reviewed by the Mortality Review Panel during Q1.

Learning themes included:

- Patient/Carer/Family involvement specifically with regards to improving access to carers assessment and improving consistency during patient engagement.
- Medicines management – Lithium blood monitoring did not take place as per Trust guidance and lack of communication with the patient with regards to bloods results and changes to medication.

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 1 there were a total of 120 learning points identified through Patient Safety Incident Investigations, After Action Reviews and Mortality Reviews following patient deaths. The most frequent actionable learning Trust themes included:

- Record keeping – records not always up to date and/or had gaps (e.g. missing progress notes), Next of Kin details not recorded.
- Communication – learning related to liaison between services (internal) and liaison with external services such as GPs and Drug and Alcohol services.
- Safeguarding – relating to 'Think Family' approach and the use of PAMIC tool
- Risk assessment/safety information – not always updated when expected therefore not reflective of current needs and risk

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Quality 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), and the Patient Safety, Learning and Experience Group (PSLEG). 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 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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Key Issues Report	
Report Date: 7 August 2026	Report of: Resources and Planning Committee
Date of last meeting: 8 July 2026	Membership Numbers: Quoracy: met Apologies: Roberta Barker, Non-Executive Director, Alison Smith (Chief Executive), Anna Pridmore (Interim Company Secretary and Director of Corporate Governance)
1	Agenda: Committee considered the following: • Corporate Risk Register • Strategic Environment Review • Emergency Preparedness, Resilience and Response (EPRR) • Partnerships and strategy update • Medium Term Plan update • Data Security and Protection/BAF 7 • Electronic Patient Record (EPR) Update • Finance Update: in-year financial performance • Clinical sub-contracts • National Cost Collection Submission • Corporate Benchmarking Submission • Premises Assurance Model (PAM) Report and Action Plan • Green Plan – assurance on delivery • PIPs update • Internal Audit findings • Annual review of committee performance • Committee forward workplan • Meeting review and consideration of BAF Risks
2a	Alert: The Committee alerts members of the Board to the following: EPRR: the Trust has received an assurance outcome of ‘partial compliance (77%)’ reflecting the position for governance, business continuity documentation, training, assurance processes and risk management arrangements. On behalf of Audit and Risk Committee, which will not meet until September, Committee received a positive update on urgent actions about which ARC had requested more immediate updates. It noted concerns regarding actions to address the internal audit limited assurance opinion due to the senior EPRR lead vacancy, which presents a risk to the pace of delivery of the improvement programme, although recruitment is underway and mitigation is in place. It was noted that some of the current action plan timescales may compromise improvements required in support of the 2026/27 Data Security protection Toolkit and committee requested that these be revisited and reported back. Medium Term Plan (MTP): delivery of the MTP remains dependent on delivering planned bank cost reduction plans. Continued scrutiny is required to ensure planned benefits are realised. Committee supported a refreshed (internal only) Board Assurance Self-Assessment and noted that People, Culture and Diversity Committee would need to oversee sickness absence reductions. It would expect to receive more detail on delivery of planned bank expenditure reductions, if expected outcomes were not delivered. Committee noted the significance of Bank and Agency reductions in the context of revised draft National Oversight Framework metrics, which reference both delivery of planned reductions and proportion of pay bill, with rankings from performance compared to peers. In-Year Financial Performance: delivery remains dependent on achieving planned efficiency savings, with bank expenditure currently above plan (on plans phased per original plan)

	submission, rather than plans considered by committee under MTP agenda item). There are significant financial risks associated with a small number of complex care packages and the Trust will continue system discussions regarding funding where care needs create significant financial, safety, workforce or operational pressures. Data Security & Protection – BAF Risk 7: there is limited assurance in relation to Information Asset Register (IAR) and Subject Access Requests (SARs). Despite progress, as demonstrated by dynamic review of the live IAR at Executive Directors Group (EDG), IAR completion and quality remains below standard and SAR performance is challenged by increasing demand. The Trust's Data Security and Protection Toolkit (DSPT) was published with a 'standards not met' status, pending review by NHSE of the submitted improvement plan. There will be active executive oversight of improvement actions through EDG and Digital Programme Assurance Group. PIPS: recruitment and retention of suitably skilled staff remain a principal operational risk for PIPS, with increased reliance on agency in some areas, including newly commissioned support for individuals with highly complex care needs. Committee requested PIPS develop trajectories to forecast and reduce agency costs to ensure alignment with the Group target. Securing suitable accommodation and developing new commissioned schemes continues to present a challenge to future growth. National Cost Collection: the anticipated reduction in inpatient activity linked to reduced occupancy means inpatient unit costs have increased, which may adversely impact the Trust's relative position in national benchmarking for inpatient currencies and on the overall cost index. Internal Audit Findings: no new committee-related internal audit reports had been issued since March 2026. However, Committee noted that the Trust's overall 2025/26 Head of Internal Audit Opinion was confirmed as reduced from good to reasonable assurance, with limited assurance findings previously reported for EPRR contributing to this position.
2b	Assurance: The Committee assures members of the Board about the following: Corporate Risk Register: Committee took good assurance that governance and oversight arrangements for corporate risks remained effective, with 100% compliance for risk reviews across all risks aligned to the Committee, and 88% action compliance. Positive changes were noted in relation to: reduction in risk score and closure of risk for delivery of the 2025/26 financial plan, following submission of the audited annual accounts and related clean audit opinion; reduction in risk score for external reporting reflecting strengthened mitigation; and reduction in risk score for critical infrastructure, following network improvements. EDG has agreed the need to tolerate residual risk relating to patient records in Cito, while migration to the new Electronic Patient Record System progresses. Strategic Environment Review: committee was assured that environmental intelligence is being actively used to assess emerging national and system developments and to inform strategic decision-making, transformation planning and delivery of the Trust's 5 Year Plan; and that robust governance arrangements are in place to identify, assess and respond to significant external changes. Committee was unable to assign an assurance rating at this stage and agreed to review this in future as the approach becomes further embedded and evidence of impact develops. EPRR: Committee was assured that the Trust retains effective operational, tactical and strategic arrangements and is able to respond to incidents and maintain service continuity, supported by established command structure, on-call arrangements and business continuity processes. Two significant business continuity incidents have been successfully managed using these arrangements. Committee was assured that a structured improvement programme, governance arrangements and clear milestones were in place to address compliance gaps. Committee was unable to provide an assurance rating at this stage and requested continued oversight of delivery against milestones and progress through the agreed governance route. MTP: committee received good assurance that strengthened governance arrangements for the MTP are now embedded and that NHSE plan conditions had been satisfied, considering a detailed review of the related bank reduction plan which reflected more granular analysis and the alignment of the bank reduction and sickness absence plans. Committee noted that delivering bank

reductions remained challenging and took reasonable assurance on bank reduction delivery at this stage and that risks related to the delivery of the wider MTP were being effectively managed.

Data Security & Protection – BAF Risk 7: committee received assurance that significant progress had been made to strengthen data security and protection arrangements, deliver improvements to the IAR programme and reduce the SARs backlog. Committee endorsed the good assurance rating for digital skills and knowledge, digital infrastructure, asset management and cyber security.

Electronic Patient Record: Committee took assurance that overall programme delivery remained on track and supported the 'Amber' programme rating. Progress was reported in data migration, system configuration and programme planning, supported by governance and oversight arrangements. Two programme workstreams relating to reporting capacity and a Business Change Manager vacancy were highlighted as areas that may impact programme delivery.

In-Year Financial Performance: Committee received good assurance from strong year-to-date performance that the Trust expects to deliver its approved 2026/27 break-even plan, with a favourable month 2 position, and on completion of NHSE plan conditions. Positive progress has been made on cash-releasing efficiency schemes, although a proportion of schemes remain high risk. Committee received reasonable assurance regarding the delivery of NHSE plan conditions, particularly in relation to bank cost reductions, where expenditure is currently above plan and where meeting the plan condition may initially require recruitment (non-cash-releasing), meaning over-achievement will be required to deliver planned efficiencies.

Clinical Sub-Contracts: Committee received good assurance regarding baseline clinical sub-contract controls, with evidence of effective contract management arrangements and no red-rated risks across the portfolio. Committee received reasonable assurance regarding formal clinical oversight, with known risks actively managed through established mitigation and escalation processes and oversight at Quality Assurance Committee. Committee endorsed the continued rollout of the enhanced tiered governance model to strengthen clinical, quality and financial oversight.

PIPS: Committee received good assurance that PIPS continues to operate effectively and remains financially viable. The subsidiary delivered a stronger-than-expected financial outturn in 2025/26, generated a profit and has repaid half of the Trust loan, with the remainder expected to be repaid in 2026/27. Progress has been made in expanding provision, including development of a three-place children's home in partnership with Durham County Council. Committee recognised the positive contribution made by PIPs to support alternatives to inpatient admission and delayed discharge pathways, supporting Trust objectives.

National Cost Collection: Committee received good assurance regarding the integrity of the 2025/26 National Cost Collection submission, with costs reconciled to the audited accounts and activity reconciled to national data sets, compliance with NHSE guidance confirmed and no material validation issues identified. Committee noted that, using inflation-adjusted prior year comparators, it was estimated that, all other things being equal, the Trust's overall cost position was anticipated to remain broadly favourable, with improvements in the Trust's community cost and activity inputs offsetting some deterioration in inpatient unit costs arising from reduced bed occupancy.

Corporate Benchmarking Submission: Committee received good assurance that the Trust complied with national benchmarking requirements and had met national submission deadlines. The submission demonstrated continued delivery against NHSE expectations for reducing corporate costs, with the Trust significantly ahead of the national target. Committee received assurance that the benchmarking information is being used to support planning and value for money assessments, which supports Board Assurance Statements accompanying annual plan submissions. Committee received reasonable assurance that benchmark performance may improve in a number of areas, although final rankings are not confirmed and reflect peers' relative performance. Continued benchmarking with peers, through mechanisms previously established for inpatient ward-level benchmarking, would be used to identify further efficiency opportunities and support financial sustainability.

Internal Audit Findings: Committee received good assurance that no internal audit or counter fraud recommendations were overdue against either their original or revised implementation dates.

	Assurance was received that processes for monitoring and implementing audit recommendations remained significantly improved, supported by regular oversight through executive and audit governance arrangements. The status of audit recommendations remained consistent with that reported to the Audit and Risk Committee in June 2026.
2c	Advise: The Committee advises members of the Board that: Medium Term Plan (MTP): Board/committee may need to consider delegated authority arrangements or a special meeting in October to support the time-critical approval of the Durham Crisis Assessment Suite Full Business Case, in order to meet NHSE submission timescales. Annual Review of committee performance: Committee received a report on the outcome of its annual evaluation, which considered if the committee had discharged its functions effectively. It was agreed that the report would be deferred to the next development session alongside a number of other matters for consideration. Board Assurance Framework: No new risks were identified during the meeting.
Recommendations: <i>That Board:</i> i) <i>Receives the report and notes the assurances provided.</i> ii) <i>Notes that a special Board/Committee meeting may be required in October to approve the Crisis Assessment Suite Full Business Case.</i>	
3	Report compiled by: John Maddison, Interim Chair, Liz Romaniak, Executive Director of Finance, Estates & Facilities, Karen Christon, Deputy Company Secretary