

Board of Directors meeting held on 23 September 2026

Chair's Introduction to Board Papers

Dear Colleagues,

Please find attached the papers for the forthcoming meeting of the Board of Directors. The agenda has been designed to support the Board in discharging its responsibilities for strategic leadership, assurance, performance oversight and good governance. In particular, I would encourage members to review the papers in advance and to focus their contributions on the areas where Board challenge, scrutiny and decision-making will add greatest value. Key items for consideration at this meeting include:

- Strategic developments and progress against the Trust's objectives;
- Board Assurance Framework and principal risks;
- Quality, safety, workforce and performance assurance;
- Financial performance and sustainability; and
- Matters requiring Board approval or endorsement.

As always, I would ask members to consider whether the information presented provides sufficient assurance regarding the delivery of the Trust's objectives, the effectiveness of controls in place, and the actions being taken to address areas of risk or concern.

Please ensure that any significant questions which may require a detailed response are shared with the relevant Executive Lead in advance wherever possible. This will help facilitate a focused and productive discussion at the meeting.

I look forward to seeing you all and thank you for your continued commitment and contribution to the work of the Board.

Kind regards

Marie Burnham
Trust Chair

Board of Directors meeting held in public

The meeting will be held from 10.00am – 1.00pm in the Boardroom at West Park Hospital Edward Pease Way, Darlington, DL2 2TS and via MS Teams

The Board of Directors resolved that representatives of the press and other members of the public be excluded from the meeting for the remaining items of business on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.

Lunch 1pm-1.45pm

Board of Directors meeting held in private

The meeting will be held from 1.45pm – 3.20pm in the Boardroom at West Park Hospital Edward Pease Way, Darlington, DL2 2TS and via MS Teams

BOARD OF DIRECTORS
23 September 2026
at 10.00am -1.00pm

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

AGENDA

No.	Report Title	Lead	Timing
Standing Items			
1.	Chair's welcome and introduction (verbal)	Chair	10.00am
2.	Apologies for absence (verbal)	Chair	10.01am
3.	Declarations of interest	All	10.02am
4.	Board of Directors to receive a patient story (verbal)	Chief Nurse/Dep. Chief Executive	10.03am
5.	Questions from members of the public (verbal)	Int. Company Secretary & Director of Governance	10.20am
6.	Minutes of the Board of Directors meeting held on 13 August 2026	Chair	10.25am
7.	Board Action Log	Chair	10.30am
8.	Chair's Remarks (verbal)	Chair	10.35am
9.	Chief Executive's Report (to follow) including • Update on the public Inquiry • Update on the Terms of Reference	Chief Executive	10.40am
10.	Listening Report (to follow)	Chief Executive	10.55am

Risk and assurance

11.	Board Assurance Framework and Corporate Risk Register	Int. Company Secretary & Director of Governance	11.05am
12.	Report of the Chair of Audit and Risk Committee (verbal report from the committee meeting held on 21 September 2026)	Committee Chair	11.10am

No.	Report Title	Lead	Timing
13.	Report of the Chair of Quality Assurance Committee	Committee Chair	11.25pm
14.	Integrated Quality Performance Report	Int. Executive Director for Strategy & Transformation Int. Care Group Managing Director	11.30am
15.	Utilising Population Health Intelligence: Locality and Neighbourhood Profiles	Executive Medical Director	12.00pm
16.	Spotlight – Health & Justice Services (presentation)	Int. Care Group Managing Director	12.10pm
17.	Winter Resilience Plan 2026/27 and Board Assurance Statement Readiness	Int. Care Group Managing Director	12.20pm
18.	Revalidation, Appraisal and Job Planning Report	Executive Medical Director	12.25pm

Governance

19.	Provider Capability Assessment 2026/27	Int. Executive Director for Strategy & Transformation	12.30pm
20.	Introduction of the revised governance system, committee terms of reference and work programmes	Int Company Secretary and Director of Governance	12.40pm
21.	Improvement Governance Action Plan	Int Company Secretary and Director of Governance	12.50
22.	Any Other Business	Chair	12.55pm
23.	Date and time of next meeting 9.30am on Thursday 28 October 2026 at West Park Hospital, Darlington.	Chair	-
	<i>Exclusion of Press and Public</i> <i>The Board of Directors to resolve that representatives of the press and other members of the public be excluded from the meeting for the remaining items of business on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.</i>	Chair	1.00pm

For General Release

Meeting of:	Board of Directors
Date:	23 September 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

x

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 17 September 2026. Amendments since the previous meeting are highlighted in red.

Proposal:

Board are invited 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 invited 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.

Board of Directors, Register of Interests
17 September 2026

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 Strategy	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 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.

Employee Name	Role	Position Title	Interest Category	Interest Situation	Interest Description
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.
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 personal interests	Outside employment	From September 2026 I am Co-chair of the British Institute of Learning Disabilities (BILD) Growing Older with Learning Disabilities (GOLD) steering group.
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 AT 10AM ON 13 AUGUST 2026 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS

Present:

M Burnham, Trust Chair (Chair)
 R Barker, Non-Executive Director
 P Corrigan, Non-Executive Director
 S Dexter-Smith, Executive Director for People and Culture
 K Kale, Executive Medical Director
 J Maddison, Non-Executive Director
 B Murphy, Chief Nursing Officer/Deputy Chief Executive
 J Preston, Non-Executive Director
 L Richards, Non-Executive Director
 L Romaniak, Executive Director of Finance, Estates and Facilities
 A Smith, Chief Executive
 C Wood, Non-Executive Director
 D Butcher, Associate Non-Executive Director (non-voting)
 H Crawford, Executive Director of Therapies and Patient Experience (non-voting)
 K Ellis, Interim Executive Director of Strategy and Transformation (non-voting)
 E Gorrington, Associate Non-Executive Director (non-voting)

In attendance:

S Beattie, Guardian of Safe Working
 N Black, Chief Information Officer
 K Christon, Deputy Company Secretary (minutes)
 A Ghazanfar, Resident Doctor Peer Lead
 A Pridmore, Interim Company Secretary and Director of Governance
 L Taylor, Care Group Director of Operations and Transformation (on behalf of N Lonergan)

Observers:

K Hasell, Programme Director
 L Hodge, Deputy Director for People and Culture
 S Richardson, Co-Creation member

83. CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed Board members and observers to the meeting. Introductions were made for Cathy Hassell, Director of Programmes and Lesley Hodge, Deputy Director for People and Culture who would become Interim Director when S Dexter-Smith left the Trust.

84. APOLOGIES FOR ABSENCE

Apologies for absence were received from N Adetuberu, Non-Executive Director and N Lonergan, Interim Chief Operating Officer.

85. DECLARATIONS OF INTEREST

Board received the report, which provided the Register of Interests for the Board of Directors.

The Chair advised that the report would be provided for each meeting and reminded members to notify the Company Secretary of any changes.

No declarations of interest were made in relation to the business of the meeting.

Agreed: Board received and noted the report.

86. BOARD OF DIRECTORS TO RECEIVE A STAFF STORY (VERBAL)

Tami, a Community Nurse, shared her experience of receiving a late diagnosis of dyslexia two years after qualification. She described the significant challenges this created in her early career, which were compounded by limited support and understanding. Following her diagnosis, access to appropriate supervision, reasonable adjustments, coaching and supportive management had enabled her to thrive in her role and continue her nursing career. She highlighted the importance of early recognition, confidential and empathetic support, effective reasonable adjustments, and time allowed for individuals to develop new ways of working. She emphasised that neurodiverse staff were highly capable and would bring valuable strengths, if they received the understanding and support they needed.

The Board thanked Tami for sharing her personal experiences and reflected on the impact that neurodiversity can have on staff experience, development and progression within the organisation.

Members discussed the importance of creating an inclusive culture in which staff felt safe to disclose their needs, raise concerns and seek support without fear of judgement. Members also recognised it was important to view neurodiversity as a strength within the workforce and to ensure staff were given every opportunity to succeed and thrive within the Trust. The discussion highlighted the need for managers to understand individual strengths, barriers and preferred ways of working, and recognise that timely support and reasonable adjustments would significantly improve staff experience and outcomes.

The Board was advised on work underway to strengthen support for neurodivergent staff, which included reasonable adjustments, manager training and peer support. The potential role of technology to support staff to work effectively was also highlighted.

The Chair thanked Tami for sharing her experiences and insights with the Board.

87. QUESTIONS FROM MEMBERS OF THE PUBLIC (VERBAL)

No questions received.

88. MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 11 JUNE 2026

A query was raised about reference to individuals within the patient story by name and B Murphy advised that staff and patients who attended were made aware in advance that the meeting was held in public.

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

89. MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 26 JUNE 2026

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

90. BOARD ACTION LOG

In discussion:

1. Action 12 (4) [Corporate Risk Register] - B Murphy advised that a briefing had been circulated to the Board. This compared the Trust's approach with three other Trusts and highlighted the Trust had a higher number of risks captured on the Board Assurance Framework (BAF) and differences in how Trusts captured corporate risks as a service level and as overarching risks.

Board agreed it would be beneficial to ensure there was a shared understanding of the purpose and application of both, in the context of transition to the revised BAF, and it was agreed this would be included on a future Board development session.

Action: A Pridmore

2. Clarification was sought regarding the closure of action 178 (3) [Medical Education] and S Dexter-Smith advised the action had been closed as a timeline had been confirmed and would be provided to Board in autumn. It was agreed that the action log would be updated accordingly.
Action: S Dexter-Smith
3. Board sought an update on the development of Trust strategic objectives [action 8 (5)] and A Smith advised that work to refresh the Trust's strategy was underway, informed by the review of public/community messaging, Medium Term Plan and stakeholder feedback through the strategic review. The strategic review feedback would be presented to the Board in October 2026, with a further road map report scheduled for November 2026.
Action: A Smith

It was agreed that the organisation would continue to progress its agreed priorities while the strategy refresh was completed, and that the current year should be regarded as a transitional phase. The terminology 'interim objectives' would be avoided.

Members confirmed they were clear on the objectives and priorities for the current year and the Chair emphasised the importance of alignment between Board, committee and Board member objectives. She noted that further discussions would be held with newly appointed Non-Executive Directors.

Agreed: Board notes the updates to the action log and, subject to amendments discussed, closes the actions recorded as complete.

91. CHAIR'S REMARKS (VERBAL)

The Chair updated the Board on a range of activities she had undertaken since the previous meeting, which included briefing for Non-Executive Directors on revised governance arrangements and committee structures, engagement with Governors and external stakeholders, visits to Trust services across the organisation, and meetings with local Members of Parliament. The Chair also reflected on a recent visit by Sir Jim Mackey to Roseberry Park Hospital, which showcased the Trust's transformation and improvement work and attracted positive feedback regarding the passion and commitment of staff. She placed on record her thanks to Board colleagues, staff and former Governors for their support and contribution to the Trust.

The Chair concluded by reflecting positively on the month and noted that these activities had provided valuable insight into the Trust's services, staff and wider strategic priorities.

92. CHIEF EXECUTIVE'S PUBLIC REPORT

A Smith presented the report, which briefed the Board on important current issues relevant to the Chief Executive. She reflected on the balance between areas of further improvement and areas of excellent care and innovation across the Trust and acknowledged the impact of the delay to the public inquiry on patients, families and communities.

In discussion:

1. B Murphy advised the Trust had been shortlisted as a finalist in two HSJ categories for its community mental health transformation work and she recognised the contribution of Dr R Shah and D Gardner who had commenced this work.

The Chair welcomed the reported increased national profile for the Trust, which recognised the contribution of staff to work of national importance.

2. Board sought assurance on arrangements to prevent inappropriate access by staff to clinical records and A Smith outlined renewed communications with staff, supported by leadership briefings. S Dexter-Smith advised that a small number of potential cases had been identified and would be investigated, and she acknowledged the importance of maintaining public confidence and trust in the organisation's handling of confidential information.

H Crawford advised that the electronic patient record system included access controls where staff were not directly involved in a patient's care and B Murphy also noted that staff awareness was supported by mandatory induction and professional training programmes.

The Chair acknowledged that, whilst incidents would not be eliminated, the Board had received reassurance that processes were in place to identify, investigate and respond appropriately to any concerns.

3. Board queried the role of Non-Executive Directors in stakeholder engagement and in raising awareness of the Trust's work and A Smith proposed that a structured approach would be developed, informed by stakeholder feedback through the strategic review.

Agreed: Board receives and notes the report.

93. 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 22 June 2026.

In discussion:

1. A Pridmore confirmed there was an opportunity to improve the presentation of the Trust's Annual Report and initial work had been undertaken on the timeline to enable earlier completion of key elements and to expedite the external audit process.
2. A query was raised in relation to contradictory references in the report to the Data Security Protection Toolkit Self-assessment and J Maddison clarified that both references should be 'approaching standards'. L Romaniak clarified that the 'high confidence' referenced, was from the assurance provided by an independent AuditOne review, which provided a high level of confidence in the accuracy and robustness of the self-assessment outcome of 'approaching standards'.
3. The Chair highlighted the importance of strengthening the ability of the Board to triangulate assurance and evidence across committees and noted future committee reports would be cross-referenced to support clearer oversight of interdependencies, risks and assurances.

Agreed: Board receives and notes the report.

94. INTEGRATED QUALITY 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 referenced changes to governance arrangements to strengthen organisational oversight and accountability for performance. This included the introduction of a monthly Executive Performance Review meeting; to provide greater rigour in performance management, assurance and delivery and which would strengthen assurance over time.
2. Board queried Trust performance relating to patients who were clinically ready for discharge and how the Trust benchmarked against other organisations. A Smith advised that national NHS data indicated overall performance was broadly comparable to other providers; however, the position was influenced by a small number of patients who experienced exceptionally long lengths of stay. There was no established national benchmark methodology for mental health providers.

L Romaniak discussed the impact of delays on patient flow, bed occupancy, quality of care and financial performance. She noted, for example, that the Trust had experienced periods in which 100% of beds in Adult Learning Disability Services had been occupied by patients clinically ready for discharge, with beds costing on average £1.5m per annum. She advised the deterioration in performance, from around 2 to more than 70 beds on average per month, had developed over several years due to wider system challenges, which included pressures on local authority social care funding and reduced provider capacity.

B Murphy also noted that flow through secure care pathways had been affected by specialist bed availability across the region and nationally and advised that the North East North Cumbria (NENC) Integrated Care Board had re-established quality oversight arrangements, where the Trust would continue to escalate concerns about delays and potential impact on harm.

3. Board noted that it had previously received a 12 month improvement plan in relation to Clinically Ready for Discharge and had taken good assurance and queried the extent to which the plan would deliver the intended outcomes, given the dependency on system partners.

L Romaniak advised that improvement plan projections had been incorporated into workforce and bank staff assumptions within the Plan conditions work. K Ellis also noted that wider transformation work would help to inform future bed and capacity modelling.

K Kale confirmed that length of stay continued to be monitored and advised that as long-stay patients were discharged, the overall average length of stay would increase in the short term.

The Board requested a quarterly update on progress against key milestones in the improvement plan be provided to Finance and Performance Committee.

Action: N Lonergan

4. L Taylor highlighted Trust learning that inpatient care provided to some individuals could be delivered in the community and she proposed that the introduction of a Learning Disability and Autism Crisis Facility would support more timely transition into community-based care and help prevent unnecessary admissions.

5. L Romaniak advised that the Trust had been categorised in the lowest risk based 'light touch' category under the new North East and Yorkshire NHS England financial performance approach. This category provided retained autonomy and did not entail additional monitoring and reporting. She noted performance at quarter 1 remained on track but recognised challenges related to delivery of Medium Term Plan conditions, which would be reported to Resources and Planning Committee.
6. Board discussed inequalities in detention rates and emphasised it was important to understand the underlying causes and maintain oversight. K Kale provided reassurance that relevant data was regularly monitored and would remain a key area of focus. A Pridmore also noted that oversight of data on inequalities had been reflected in the revised terms of reference for Mental Health Legislation Committee to support ongoing scrutiny.
7. H Crawford welcomed the strong response rates on patient experience metrics and the level of patients who rated their experience as good or very good. She noted a concern about the patients feeling safe metric and advised that an urgent care feeling safe task and finish group would be established to understand the detail and develop bespoke work to support improvement. Progress would be reported into Quality Assurance Committee.
8. With reference to the patient story earlier in the meeting and the impact of a late diagnosis, Board queried the potential for a focused piece of work to understand the action required to reduce waiting times.

K Kale commented on additional funding from NENC Integrated Care Board to support a reduction in neurodiverse waiting lists, alongside the implementation of clinical prioritisation to ensure that those who already received a Trust service had access to a timely assessment where a diagnosis would inform their care, and to consider alternative pathways and support options for others who did not need an NHS service.

A Smith confirmed that the children and young people's waiting list was a Trust priority and advised of a pilot underway in Tees Valley to respond to current challenges. She went on to discuss national challenges that impact on neurodiverse waiting lists, system recognition that the position was unsustainable, and work underway with partners in NENC to respond to the backlog, to prioritise those currently in services and to provide waiting well support. Initial discussions on a new model were also underway in Humber and North Yorkshire. Work underway was not expected to clear the waiting list completely. She proposed that a progress update be provided to Board in October 2026.

Action: ?

K Kale also noted that in addition to the waiting well offer the Trust had secured 500 licences to provide online support.

9. B Murphy provided reassurance regarding productivity improvement work in community Adult Mental Health Services, which had begun to ease pressures and – whilst no firm conclusions could be made – indicated that the hub established in York had begun to reduce demand on services.

She went on to advise that any incidents where a patient came to harm while waiting for a Trust service and not in receipt of support elsewhere, would be subject to a Patient Safety Incident Review.

10. L Romaniak reflected on the role of deprivation, population diversity and socio-economic factors in local communities, and notably in Middlesbrough, in driving

variation in service use and outcomes. A Smith provided reassurance on work underway to strengthen analysis of demographic data and incorporate reporting into the IQPR to provide ongoing assurance. She proposed that a report be presented to the next Board meeting.

Action: C Parker

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, National Quality requirements/Mental Health Priorities and on Waiting Times.*
- iv. *Appropriate and effective management of risks to delivery.*

The Chair varied the order of the agenda.

95. GETTING THE BASICS RIGHT FOR RESIDENT DOCTORS

A Ghazanfar presented the report, which provided assurance that the Faculty of Medical Education had considered the NHS England mandate, which set out clear expectations through a 10-point plan to improve the working lives of resident doctors, and confirmed that progress continued to be made towards full compliance with the mandate.

In addition to that reported, she highlighted: differences in lead employer arrangements between the north and south, which created additional bureaucracy in Humber and North Yorkshire around payroll and study leave processes; and development of the framework to include further requirements, such as the introduction of a Board Assurance Framework.

In discussion:

1. L Romaniak advised that finance team had worked collaboratively with the Medical Staffing team and Resident Doctors lead to ensure that any outstanding issues did not arise from internal Trust processes and A Ghazanfar noted that some elements of expense reimbursement remained outside of the Trust's control.
2. J Preston confirmed that he would link into the work, as the Board's representative. He welcomed progress made to date and noted that several outstanding issues remained dependent on NHS England action.

A Ghazanfar confirmed that national work was underway and proposed to reflect that in the next report. By way of example, she highlighted the introduction of pilot schemes that aimed to reduce travel to placements and the expansion of the Lead Employer Model to reduce bureaucracy where multiple organisations were involved.

Agreed: Board receives and notes the report.

96. GUARDIAN OF SAFE WORKING HOURS

S Beattie presented the reports for quarter 4 2025/26 and Annual Report of the Guardian of Safe Working Hours for Resident Doctors, and quarter 1 2026/27 and confirmed there were no patterns of concern to raise.

In discussion:

1. Board queried the low response rates to the detriment survey and sought assurance that concerns related to exception reporting were identified and addressed. S Beattie advised that the current dataset was too small to draw a meaningful conclusion and discussed plans to increase participation. She also noted work she undertaken to promote the confidentiality and importance of exception reporting and indicated she remained alert to any indication that doctors felt discouraged from reporting concerns.
2. Board queried the reduction in exception reports within the south from quarter 1 to quarter 4 and S Beattie advised that reporting levels typically fluctuated between quarters and this was not an indication of any emerging concerns. She noted there had been a higher proportion of exception reports in the prior period related to education issues and this had since reduced.

Agreed: Board receives and notes the reports.

97. REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

Board received the report, which summarised the key areas of discussion at the committee meeting held on 2 July 2026.

In discussion:

1. Board noted the limited controls assurance in relating to continued use of prone restraint and B Murphy advised that training on alternative approaches to seclusion entry and exit had been completed and incorporated into the training curriculum and a reduction in use in Secure Inpatient Services had been noted. Progress would continue to be presented to Quality Assurance Committee.
2. The Chair noted that committee had considered members' understanding of the Board Assurance Framework (BAF) and had proposed that further organisational training be undertaken to strengthen understanding of the BAF, risk scoring and controls assurance.
3. The Chair noted that committee had discussed the extent of statutory and mandatory training requirements and S Dexter-Smith advised that a report on training requirements and headroom would be prepared for People, Culture and Diversity Committee. Any proposed training changes would be reported to Quality Assurance Committee. L Romaniak also noted a link between a workstream led by the Director of Therapies and Patient Experience to review and reduce levels of mandatory training and bank staff; the reduction of which was a Medium Term Plan condition.
4. Board queried the inclusion of a patient name in the report and H Crawford confirmed prior to the end of the meeting that the patient was happy for her name to be shown in the report.
5. A query was raised regarding the number of staff on alternative duties and B Murphy advised that nursing or healthcare staff may work in alternative roles where they were unable to undertake direct patient-facing duties for reasons such as pregnancy or workforce related considerations.

Agreed: Board receives and notes the report.

98. LEARNING FROM DEATHS REPORT

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

In addition to that reported, he referred to collaborative work with mental health Trusts in South West Yorkshire and Sheffield to improve mortality dashboards and reporting and noted the re-emergence of family/carer involvement as a learning theme.

In discussion:

1. K Kale advised that the report would ordinarily be considered by Quality Assurance Committee prior to Board; however, the committee had not met in August. He confirmed that prior consideration would be referenced in the report.
2. Board sought assurance regarding arrangements to ensure that identified learning had been translated into sustained changes in practice and queried whether recurring themes indicated that learning had not yet been fully embedded.

K Kale outlined examples where learning had resulted in changes in practice and referenced the Quality Assurance Scheme, which included regular audit activity to test whether improvements had been embedded and if they had the intended impact. He also advised that record keeping and communications were recurring national themes and noted the Trust would also compare itself against themes arising through the LeDeR reports.

B Murphy also explained that the Trust's established Quality Assurance Schedule included extensive data that enabled the Trust to demonstrate measurable improvements in the quality of care and regulatory compliance. The framework was regularly reviewed and refined to ensure it continued to assess the effectiveness, not just the completion, of improvement actions, and work was underway to strengthen this as part of the Trust's overall quality management system.

3. Board queried whether staff would consider the Trust to be a learning organisation and B Murphy proposed that staff experience may vary, and she acknowledged the importance of ensuring that learning was translated into practice in a consistent way.

S Dexter-Smith highlighted that 'how we learn' was a theme within the How We Work Programme and K Ellis also acknowledged the importance of assurance on system learning.

4. H Crawford offered to brief new Non-Executive Directors on the Organisational Learning Group, who undertook work to understand the impact of learning through a broad range of intelligence, and it was agreed that the date would be shared with other Non-Executive Directors should they wish to attend. **Action: H Crawford**
5. N Black discussed how learning had been incorporated into the design of the Trust's new electronic patient record system, to support staff to use it effectively and to follow best practice.

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

99. REPORT OF THE CHAIR OF RESOURCES AND PLANNING COMMITTEE

J Maddison, Interim Chair of Resources and Planning Committee, presented the report, which summarised the key areas of discussion at the committee meeting held on 8 July 2026. He placed on record his thanks to L Romaniak who had supported the Committee during his time as Interim Chair.

In discussion:

1. L Romaniak highlighted the importance of bank and agency reductions to delivery of the Trust's financial plan and the National Oversight Framework metrics. She noted that the Trust's position was assessed on a group basis and therefore included Positive Individual Placement Support (PIPS) who were significantly above plan on use of agency, including due to newly commissioned packages of care pending recruitment. Regular progress updates would be provided to committee.
2. Board queried the extent of Trust influence over PIPS performance, given the impact on group level metrics and L Romaniak advised that a Trust director sat on the Board of PIPS and their Managing Director reported regularly into Resources and Planning Committee. She proposed there may be an opportunity for closer collaboration on recruitment and indicated that staff had different terms and conditions, which reflected that it operated in a challenging sector and with difficult commissioning arrangements.
3. K Ellis noted that, whilst the committee had not taken assurance from the Environmental Report, it had recognised that it would be important to do so. She referenced work by the executive to review the intelligence, the 'so what' and how that translated into action, and she expressed confidence that committee would in future be able to take assurance as the process became embedded.

Agreed: Board receives and notes the report.

The Chair thanked everyone for attending and, there being no further business, closed the meeting.

Meeting concluded at 12.53pm.

M Burnham
Chair
23 September 2026

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
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 Aug 26	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 closed.
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	Apr26 Autumn 26	Action closed Aug 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. Aug26 update: S Dexter-Smith advised that the action had been closed as the timeline had been confirmed and would be provided to Board in autumn.
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. Sep26 update: Chief Nurse to present a paper to Quality Assurance Committee and a verbal update to be provided to the next Council of Governors meeting.
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

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
12/02/2026	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 Aug 26	April update: a revised communications report is in development. The first report in this updated format will cover activity and impact starting from April. This will be shared with the Executive Team and we will review where else this report is shared, including how we can update Governors on progress. S Dexter-Smith to confirm to J Preston the timeline for a report to Council of Governors Jun26 update: Report to be provided to Council of Governors at the meeting on 30 Sept 26 Aug26 update: The communications report has been reviewed and the Executive Directors Group report is now regularly shared with Governors
09/04/2026	8 (5)	Strategic Objectives	Strategic objectives to be developed for 2026/27	A Smith	Aug-26 Nov-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. Aug26 update: work to refresh the Trust's strategy is underway, informed by the review of public/community messaging, Medium Term Plan and stakeholder feedback through the strategic review. The strategic review feedback will be presented to the Board in October 2026, with a further road map report scheduled for November 2026.
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. Aug26 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. Sept26 update: the Board Assurance Framework and Corporate Risk Register will be reviewed together in the organisation. The review of the BAF by Executive Directors is being considered and proposals being made to strengthen the approach.
09/04/2026	12 (4)	Corporate Risk Report	In response to a query on the number and nature of risks compared with other MHLTD Trusts, benchmarking to be undertaken and shared informally with the Board	B Murphy	Jul-26	Action closed Aug26	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. Aug26 update: Briefing circulated to the Board, which compared the Trust's approach to that of other Trusts.
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.

**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
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 Aug26	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.
13/08/2026	90 (2)	Strategic and Corporate Risks	A future Board development session to include a session on the purpose and application of the Board Assurance Framework and the Corporate Risk Register	A Pridmore	tba	in progress	Sept26 update: the proposal currently is that AQUA provide training at one of their development sessions. Timing to be agreed.
13/08/2026	94 (3)	Clinically Ready for Discharge	Quarterly update on progress against key milestones in the improvement plan to be provided to Finance and Performance Committee	N Lonergan	tbc	in progress	Report scheduled on the new Finance & Performance Committee workplan - date to be confirmed
13/08/2026	94 (8)	Neurodiverse Waiting lists	Progress update to be provided to Board in October 2026 on actions to reduce waiting times in NENC and HNY ICB areas	N Lonergan	Oct-26	in progress	Item scheduled for Board meeting in October 2026
13/08/2026	94 (10)	Inequalities	Report to be provided to Board in September on work underway to strengthen analysis of demographic data and incorporate reporting into the IQPR to provide ongoing assurance.	C Parker	Sep-26		Action complete - see Board agenda
13/08/2026	98 (4)	Organisational Learning Group	Briefing to be held with new Non-Executive Directors (and offered to all NEDs) on the Organisational Learning Group, who undertook work to understand the impact of learning through a broad range of intelligence.	H Crawford	Sep-26		Action complete - briefing scheduled for 28 September 2026

This page is intentionally blank

For General Release

Meeting of:	Board of Directors
Date:	23 September 2026
Title:	Chief Executive's Public Report
Executive Sponsor(s):	N/A
Report Author(s):	Alison Smith, Chief Executive

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
N/A	BAF 01 – Safe Staffing:	Relevant, though more indirectly, to leadership and management capacity, operational resilience, staff engagement, executive development and sustainable leadership arrangements.
	BAF 03 – Patient Experience:	Applies to engagement with patients, carers and bereaved families, the Listening Report, Hub of Hope and the strengthened patient-experience executive portfolio.
	BAF 08 – Partnerships and System Working	Strongly linked to the strategic partnership review, locality arrangements and the multi-agency suicide-prevention and 48-hour follow-up work.
	BAF 09: Regulatory Compliance	Relevant to regional assurance, the Provider Capability Assessment, the National Operating Framework position, governance effectiveness and compliance with external oversight requirements.

	BAF 13 – Public Inquiry:	The report covers the Inquiry's commencement, organisational preparedness, executive capacity, service delivery, stakeholder confidence and the Trust's commitment to openness and learning.
--	---------------------------------	--

Regional assurance arrangements

In line with the new Department of Health and Social Care and NHS England operating model, the North East and Yorkshire region is implementing a more integrated approach to oversight and assurance. This brings together intelligence on quality, performance, workforce, finance and organisational capability within a single framework. A revised quarterly segmentation approach has been introduced, under which organisations receive light-touch assurance, targeted oversight and support, or active intervention, according to delivery risk and organisational performance. Under these arrangements, TEWV is currently rated Green within the regional financial segmentation framework, meaning that it is on track and retains organisational autonomy. The Trust has also been identified as a Tier 2 provider for the forthcoming Mid-Year Review process, reflecting a requirement for targeted, time-limited regional oversight and support. The September Mid-Year Review and Provider Capability Assessment will provide important opportunities to demonstrate the Board's oversight of delivery against the Trust Plan, the management of key risks and mitigations, organisational capability, and the effectiveness of the Trust's governance and assurance arrangements.

Temporary changes to Director of Operations portfolios

During quarters 1 and 2 of 2026/27, a series of temporary changes were made to the Directors of Operations' portfolios and associated leadership arrangements. These will remain in place until the end of the financial year. The first phase followed concerns regarding quality, service delivery and operational performance within Adult Mental Health Community Services in Harrogate. A review of leadership and management capacity across Director, General Manager and Service Manager roles identified an opportunity to strengthen oversight, increase leadership focus and create additional capacity to support improvement. Temporary portfolio adjustments were therefore introduced to provide focused executive attention, accelerate improvement, reduce variation and strengthen operational resilience.

A second phase was implemented during quarter 2 to align the Trust's Mental Health Services for Older People and Adult Learning Disability portfolios under consistent operational arrangements across all localities. This was intended to improve consistency in service delivery, quality governance and performance management, while providing clearer executive oversight of transformation programmes and service redesign proposals linked to the Medium-Term Financial Plan. Throughout these changes, locality-based relationships and partnership working have continued to be led through General Manager and Service Manager arrangements, supported by appropriate clinical leadership and continued senior representation at Health and

Wellbeing Boards, Overview and Scrutiny Committees, and other key partnership forums.

The temporary arrangements have strengthened organisational capacity, improved the alignment of operational priorities and enhanced oversight of quality, performance and transformation. Following the successful appointment of the Chief Operating Officer, the arrangements will be reviewed to determine the most effective and sustainable leadership structure for future delivery.

These temporary changes sit alongside the Trust's locality focus and provide a matrix approach to service and locality-based oversight.

National Operating Framework

On 7 September 2026, we were advised of the revised National Operating Framework rating for quarter 1 of 2026/27. The assessment takes account of a series of newly introduced metrics. TEWV remains in Segment 2, with an average organisational metric score of 2.25; on a scale of 1 to 4, a lower score indicates stronger performance. The Trust is ranked 27th of 58 non-acute NHS providers nationally, compared with 15th of 61 in quarter 4 of 2025/26. We have not yet received the detailed assessment and will provide a further update once it has been received and analysed.

Reflections on the past year

It is now a year since I formally joined TEWV. In truth, my connection with the Trust began earlier, through the conversations and introductions I had with colleagues and partners during the recruitment process. Those early encounters gave me a sense of the commitment, compassion and honesty that exist across our organisation—and of the responsibility we share to build on what is strong while facing openly the areas where we must do better.

I began with a clear intention: to listen carefully, understand deeply and resist the temptation to reach conclusions too quickly. My first months were therefore shaped by listening and diagnosis, building relationships, clarifying priorities and creating the stability from which lasting change could grow.

Although I arrived with some initial priorities in mind, I wanted observation to come before action. As my involvement deepened, however, it became clear that a small number of issues could not wait. That balance—taking time to understand while acting promptly where people needed us to—has guided much of the year.

My first priority was to make meaningful connections with families, patients and carers. In July 2025, I met with a number of families and listened as they spoke about the tragic loss of loved ones, the poor and harmful liaison and communication they had experienced with TEWV, and the enduring impact on their lives. I remain deeply grateful for the courage, honesty and generosity with which they shared their experiences. Those conversations have continued, and they have influenced how I think, how I lead and how we approach improvement. The Listening Report on

today's Board agenda offers examples of the learning and progress that have grown from this investment of time and trust.

The announcement of the Public Inquiry on 11 December 2025 was a significant moment. It reflected, in no small part, the resilience and determination of families and patients who continued to seek truth, accountability and learning. On 17 September 2026, we were advised that the inquiry would commence on 21 September. We recognise the importance of this process and the Secretary of State's emphasis on learning and establishing the truth. We will engage fully and approach the inquiry with openness, transparency and humanity.

I had made a commitment not to take action during my first three months, and I honoured it. Once that period of listening and discovery had concluded, we moved with purpose to establish several focused reviews: corporate governance, strategic partnerships, public and community perceptions, and the design of the executive team.

These connected pieces of work helped us to see the organisation more clearly: to value what colleagues already do well, to be candid about where improvement is needed, and to begin shaping a future that reflects the hopes of staff, the Board, people who use our services and the communities we serve. Where additional capacity or specialist insight was needed, we created focused programmes to take the work forward.

Public and community perceptions

We began by looking outward—at how TEWV is understood and experienced by the communities and partners around us, and at whether our strategic position, operational resilience and statutory engagement give colleagues the strongest possible foundation from which to focus on patient care.

We invited external colleagues to bring a fresh pair of eyes to our communications and to challenge us constructively. Their assessment has now been completed and shared with the Board. Alongside this, we have begun refreshing our strategy so that we can tell a clearer, more authentic story about who we are, what matters to us and where we are heading.

Strategic partnership review

We have also made time to listen carefully to our key stakeholders. Through a bespoke programme of semi-structured conversations, partners have been able to speak openly about TEWV's presence, impact and potential. I appreciate the candour with which colleagues have contributed. Their insight will help us strengthen integration, deepen partnership working and shape services that are sustainable and responsive to local needs.

The Board will hear more about these programmes in October and November. Their findings, together with the transformation work within the Medium-Term Financial

Plan, will come together at a Board seminar in December and inform the refreshed draft strategy planned for launch in 2027/28.

Corporate governance

At the same time, we looked closely at our own governance. We drew on learning shared generously by peer organisations following their external assessments and used it to develop a practical improvement plan. That plan is now being implemented. With bespoke support and expertise, we have added a committee to the Board's governance framework, improved Board and sub-Board arrangements, and strengthened the line of sight from committees to the Board. I am grateful to colleagues who have embraced this work and helped turn reflection into more confident and effective oversight.

Connection with our staff has been equally important. Our quarterly leadership sessions have grown into full-day events that bring leaders and managers together to share ideas, ask questions and build a common understanding of our direction. The early feedback has been extremely positive, and I value the energy and openness colleagues bring to these sessions. We will keep improving how key messages are shared afterwards so that leadership is not held at the centre, but distributed confidently throughout the organisation.

During 2027/28, the Board will support a wider programme of monthly engagement with teams and individuals. This will give us more opportunities to hear directly from colleagues, recognise what has gone well, help teams build on good practice and ensure that achievements across the Trust are seen, shared and celebrated.

Perhaps the most encouraging part of the year has been seeing the scale and quality of transformation across children's community services, adult community services and specialist services. This work has been recognised by system and regional colleagues and, nationally, through awards celebrating TEWV's improvement, transformation and best practice. I am proud of the care our services provide and appreciative of every colleague who has contributed. That includes the clinical teams closest to patients and families, and the many people across our corporate functions whose expertise, care and persistence provide the statutory and non-statutory infrastructure that makes high-quality care possible. Their contribution is sometimes less visible, but it is absolutely essential, and I offer my sincere thanks.

Executive restructure

Our recently agreed executive restructure and portfolio realignment mark the next chapter in this story. By bringing Patient Experience explicitly into the title and portfolio of the Executive Director of Therapies, we are giving involvement and engagement a stronger voice at Board level. The new Executive Director of Delivery role will provide dedicated leadership for our organisation-wide transformation portfolio, helping us connect strategy to delivery and maintain a clear focus on measurable improvements in outcomes, quality, productivity, experience and sustainability, supported by robust communication and engagement.

As this new team comes together, we have begun an executive development programme. I am pleased that this support has also been extended to the Trust Board as we welcome new non-executive directors. Investing in relationships, shared learning and collective leadership will help us meet the next phase with confidence and unity.

North East suicide prevention

I have been pleased to host and facilitate a pilot programme bringing partners and colleagues together to explore a system-wide approach to suicide prevention. Progress continues on the development of Suicide Prevention Strategy Priority 2, which aims to establish a consistent, trauma-informed, multi-agency 48-hour follow-up offer for people following self-harm or a suicidal crisis. The work is aligned with NICE guideline NG225 and seeks to strengthen early aftercare, reduce gaps between services and ensure that people receive timely support during periods of heightened vulnerability.

Following a multi-agency suicide prevention roundtable convened by myself in February 2026, a further partnership event was held in July 2026 with representatives from health, local authority, acute, community and voluntary, community and social enterprise organisations. Discussion focused on opportunities to implement a system-wide 48-hour follow-up standard, clarify organisational responsibilities and improve coordination across care pathways. There was broad support for a consistent approach to reduce the risk of people falling through gaps in provision and to strengthen collaborative suicide prevention across the region. A further partnership meeting is being planned to agree next steps, governance arrangements and wider stakeholder engagement. While TEWV has facilitated these discussions by providing leadership support, chairing and meeting space, the development and delivery of this priority remain a shared system-wide responsibility requiring collective ownership across partner organisations.

Hub of Hope

The Hub of Hope is the UK's largest mental health support directory, providing free access to local and national mental health, wellbeing and support services through an online platform and mobile application.

TEWV began discussions with Chasing the Stigma regarding a commissioned partnership during 2025, with internal funding for the directory and basic analytics explored and subsequently approved through the Trust's business case process. By 2026, TEWV was actively working with Chasing the Stigma to promote and implement Hub of Hope across Trust services.

The purpose of commissioning Hub of Hope is to improve awareness and accessibility of support for our community, service users, carers and staff, making it easier for people to find timely and appropriate help before reaching crisis point. The Trust also aims to strengthen links with community and voluntary sector services, support social prescribing opportunities, and utilise available analytics to better understand the types of support people are seeking and identify emerging population health needs.

Current activity is focused on increasing awareness and uptake across Trust services and partner organisations, integrating Hub of Hope into relevant Trust resources and pathways, and ensuring local support services are accurately represented within the directory. This work complements the wider Suicide Prevention Strategy by improving access to support, strengthening community connectivity and helping people identify appropriate sources of help at an earlier stage.

The Board can be assured that positive progress is being made in bringing partners together to develop a consistent, system-wide approach to 48-hour follow-up after presentations involving self-harm or suicidal crisis. Early engagement has demonstrated strong partner commitment to improving continuity of support, reducing variation and strengthening collaborative suicide prevention arrangements across the region. In parallel, implementation of the Hub of Hope continues to support wider prevention objectives by improving access to support and strengthening links between statutory, community and voluntary sector services.

There is much to look forward to in the years ahead, and we should be honest that there will also be challenges. What gives me confidence is that we will meet them together—with our communities and localities, our staff, patients, people who contribute their lived experience, families, carers and partners. I am grateful for everything people have given during my first year and for the trust they have placed in us. The next part of our story will be shaped by how well we continue to listen, learn and act together, and ultimately building trust.

Meeting of:	Board of Directors
Date:	23 September 2026
Title:	TEWV Public Inquiry Decision-Making Group Terms of Reference Update
Executive Sponsor(s):	Alison Smith, Chief Executive
Report Author(s):	Cathy Hassell, Public Inquiry Programme Director

Report for:

Assurance

Decision

x

Consultation

Information

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

1: We will co-create high quality care

x

2: We will be a great employer

x

3: We will be a trusted partner

x

Strategic risks relating to this report:

BAF ref no.	Risk Title	Context
13	Public Inquiry	There is a risk that the Public Inquiry, as announced on 11th December 2025, may affect capacity to maintain effective organisational and service levels at the current rate and impact on the confidence of patients which may cause them to delay accessing care, support and/or treatment.

EXECUTIVE SUMMARY:

The Terms of Reference for the Trust's Public Inquiry Decision-Making Group were approved by the Board of Directors on 12 March 2026.

Now the Chair to the Public Inquiry, His Honour Judge John Potter, has been appointed minor amendments are proposed to the Decision-Making Group Terms of Reference to enable the Trust to meet the needs of the public inquiry.

Purpose:

To request approval for minor amendments to the Trust's Public-Inquiry Decision-Making Group Terms of Reference. The original Terms of Reference agreed in March are attached for reference.

Proposal:

Section 5.1 Membership to be updated to include the Executive Director of Finance, Estates & Facilities as agreed at the March Board meeting, and Public Inquiry Programme Director.

Section 6.3 Clarification that deputies can attend to cover absence as agreed by the Chair.

Section 6.5 The secretariat will be provided by the Public Inquiry Response Team rather than the Company Secretary's office.

Section 7.1 Meeting frequency to be increased from fortnightly to weekly.

Section 8.2 Quoracy clarified so that at least one director with statutory responsibilities will be present.

Implications:

The implications remain materially unchanged from those identified at the time of the Terms of Reference approval decision in March 2026.

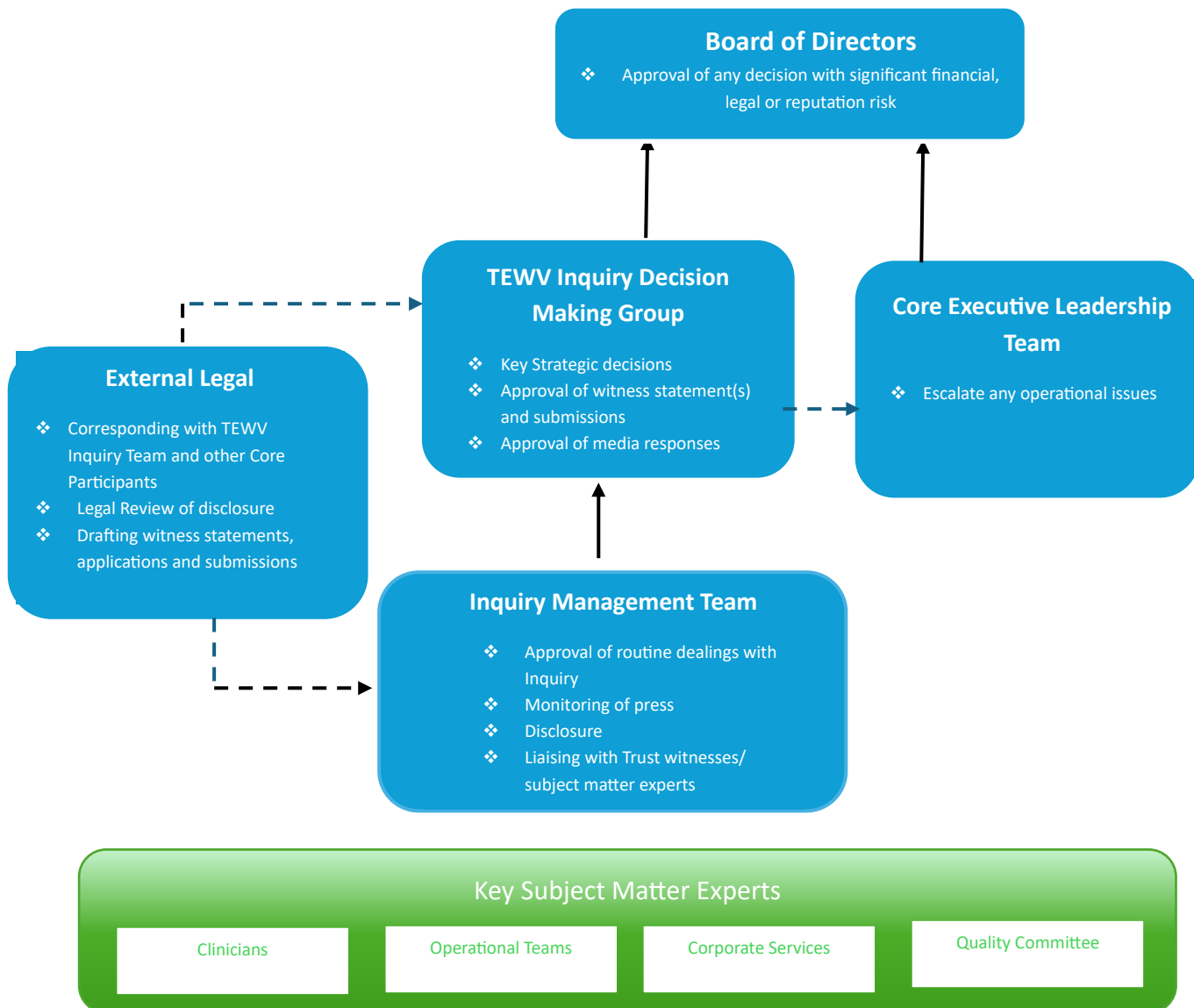
Recommendations:

The Board is asked to approve the minor amendments to the Public Inquiry Decision-Making Group.

Tees Esk and Wear Valley (TEWV) Inquiry Decision Making Group

Terms of Reference

Structure and relationship



1 Constitution

- 1.1 The Statutory TEWV Inquiry Decision Making Group (The Group) is appointed by the Board of Directors.
- 1.2 The Group is an executive strategy group of the Board of Directors with powers specifically delegated in these terms of reference.

2 Authority

- 2.1 The Board of Directors authorises the Group to fulfil its terms of reference.
- 2.2 The Group is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Group. To note, under the Inquiries Act 2005, the Chair of the TEWV Inquiry has a wide range of powers, including the power to compel the production of documents and to summon witnesses to give evidence on oath.
- 2.3 The Group is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of external parties with relevant experience and expertise if it considers this necessary.
- 2.4 The group is authorised by the Board of Directors to create sub-groups as it deems necessary in the fulfilment of these terms of reference.

3 Purpose

TBA once ToRs of the Inquiry are available and the Chair has been confirmed

- 3.1 Provide assurance to the Board of Directors that the Trust complies with its legal obligations and the TEWV Inquiry policies, protocols and guidance. The Group will have in place structures, processes and controls to ensure that the TEWV Inquiry has access to Trust information in the timescale that it requires it, unless agreed reasonable cause.
- 3.2 Provide assurance to the Board of Directors that the Trust has in place an effective system of integrated governance and risk management to manage the Trust's activities that will respond to the TEWV Inquiry requirements plus prepare for and respond to internal Trust related activities.

4 Roles and Responsibilities

To provide the Board of Directors with assurance, the Group will receive regular reports (as a minimum monthly) on key issues and clear decision points in line with the TEWV Inquiry requirements, in respect of each of the following, including:

4.1 Governance and Internal Control

- 4.1.1 To receive information and recommendations from the Inquiry Management Team on issues and risks related to Trust activities then provide direction, in order to meet the request from the TEWV Inquiry.

- 4.1.2 To scrutinise and assure the Board of Directors on the Trust's control and risk related to delivery of the Rule 9s received from the TEWV Inquiry.
- 4.1.3 To make recommendations into the Board of Directors on any decisions with significant financial, legal or reputation risk.
- 4.1.4 To approve witness statement(s) and submissions to the TEWV Inquiry.
- 4.1.5 To approve media responses.
- 4.1.6 To identify any areas of escalation to receive and report to the committees of the Board such as to the People and Culture Committee, Quality Assurance Committee, Resources Committee. This is done via the core Executive Leadership Team.
- 4.1.7 To anticipate the next requests from and stages of the TEWV Inquiry to meet the requirements of the TEWV Inquiry and prepare the Trust.
- 4.1.8 To receive and advise on a learning log for the Trust.

4.2 Financial Reporting and Financial Stewardship

- 4.2.1 To approve outside legal or other independent professional advice and to secure the attendance of external parties with relevant experience and expertise.
- 4.2.2 To scrutinise the Trust's Inquiry spend including those of budgetary control for the completeness and accuracy of the information provided to the Board of Directors.

4.3 Information Governance

- 4.3.1 All members and those in attendance will sign a confidential undertaking to the TEWV Inquiry.
- 4.3.2 To ensure that all Trust staff involved in responding to the requests from the TEWV Inquiry sign and adhere to the above TEWV Inquiry Undertaking.

5 Membership

- 5.1 The membership of the Group will be confined to Executive Directors only.
 - Chief Executive
 - Deputy Chief Executive/ Chief Nurse
 - Executive Medical Director

- Director of People and Culture
- Director of Therapies

5.2 The Chair of the Group is the Chief Executive, and the Vice- Chair is the Deputy Chief Executive.

6 Attendance

6.1 The following roles will be regular attendees and will be recorded as being in attendance and as being present in the minutes.

- DAC Beechcroft Legal Advisors
- Independent Specialist Advisor to be confirmed
- Trust Inquiry Programme Director

6.2 Other Executive Directors/Officers should be invited to attend, particularly when the Group is discussing areas of risk, internal limited assurance reports or operation that are the responsibility of that Director. No other party may attend without the specific approval of the Group Chair.

6.3 Attendance at the Group is essential. There are no nominated deputies.

6.4 The Group may ask any or all of those who normally attend by are not members to withdraw, in order to facilitate open and frank discussion of particular matters.

6.5 The secretariat will be provided by the Company Secretaries office.

6.6 A register of attendance will be maintained

7 Frequency of meeting

7.1 The Group will meet every two weeks until the Hearings are complete (tbc) with additional adhoc meetings as required. These can be held in person or virtually.

7.2 Agenda and papers will be circulated five calendar days prior to monthly meetings.

7.3 Reports to the Group must be completed on the agreed template and following the expected Trust Committee report writing protocols.

- 7.4 The frequency of the meetings will be reviewed once the Hearings are complete.

8 Quorum

- 8.1 A quorum shall be no less than three Executive Director members.
- 8.2 Either the Chief Executive or Deputy Chief Executive will be present to be quorate

9 Reporting

- 9.1 The Chair will provide an update to the Board of Directors' meeting that informs the Board of its assurances, decision, and any areas of concern.
- 9.2 The Chair of the Group shall draw to the attention of the Board of Directors any issues that require disclosure to the Board of Directors or require executive action.

10 Accountability and Governance

- 10.1 The Group will hold the Inquiry Management Team to account for the routine dealings with the TEWV Inquiry.

11 Review

- 11.1 The Group will review the effectiveness and, where appropriate, revise the Group membership and terms of reference, subject to the approval of the Board of Directors

Signed as approved

Chair of the Board of Directors

Date of approval by the Board of Directors

NHS Trust Board Report: Trauma-Informed Response, Accountability and Support Following Harm

Phase One

Purpose

This report provides the Board with a consolidated summary of the key themes, findings, risks, recommendations and proposed actions learned through the Chief Executive's direct engagement since June 2025 with parents, patients, carers and families individually, as well as with family groups, patient representative groups and forums, and service user groups. It is intended to support Board oversight of compassionate, trauma-informed improvement, accountability and assurance.

Executive summary

I want to thank the parents, families, carers and patients who have taken part in deeply personal conversations with courage, openness and honesty, sharing their experiences of care, loss, distress and loss of trust in TEWV services. Across the responses, there is a consistent emphasis on listening with compassion, acknowledging harm, apologising where care or communication fell short, and identifying practical steps to support individuals while also strengthening organisational learning. The material relates to both recent and previous experiences that have been reviewed and highlights a consistent and significant concern that people harmed by, bereaved following, or distressed by contact with Trust services may experience existing complaints, claims, records, assessment, inquest and post-incident processes as adversarial, retraumatising and unsafe. A recurring theme is that loss of trust should not be viewed simply as disengagement; for some people, it represents trauma-related avoidance linked to previous experiences of care, communication, documentation and follow-up.

Key issues include the need for safe alternatives where trust has broken down, clearer routes to independent and trauma-informed support, improved transparency and timeliness in information governance processes, careful handling of clinical records, and proportionate approaches to claims, complaints and expert assessment. People want compassionate listening, but also visible accountability, practical support and evidence that learning is leading to change.

The findings should therefore be understood as direct learning from lived experience and from sustained engagement with people and groups who have continued to offer their insight, often while carrying significant distress, to help improve care, accountability and organisational learning.

It is important to recognise that this report reflects the experiences and perceptions shared by parents, families, carers and patients. Some may not yet have been informed about the changes that have been initiated, reviewed or embedded, and this reinforces the need for

clearer communication, visible follow-through and compassionate feedback on the impact of learning.

To protect confidentiality and avoid identifying individuals, this report does not set out the specific clinical care experiences shared during these conversations. These matters have been, or will be, considered through the appropriate established NHS review processes following incidents of harm or loss of life.

I also want to reiterate my sincere apologies to everyone who has experienced harm and to those whose loved ones have died. We cannot begin to imagine how difficult it has been to share these deeply personal experiences. Your accounts have had a profound impact on me and on the colleagues who joined me in listening, and we are grateful for the courage and openness with which they were shared.

Recommendations

The Board is asked to:

1. Note the key findings and the emotional, relational and safety impact described by individuals, families and carers.
2. Endorse the development of a single coordinated thematic action plan, with named owners, timescales, milestones and escalation routes.
3. Request assurance that themes are triangulated with complaints, claims, incidents, patient safety investigations, inquests, patient experience feedback, safeguarding, equality considerations and Public Inquiry learning.
4. Ask the Executive Team to identify which actions require Trust-level ownership and which require escalation to ICBs, partner providers or other external bodies.
5. Receive a further progress report setting out completed actions, evidence of impact, outstanding risks and any barriers to delivery.

Background and context

The report draws on learning from the Chief Executive's meetings and conversations since June 2025 with parents, patients, carers and families individually, alongside discussions with family groups, patient representative groups and forums, and service user groups. These conversations, together with written material shared by those affected, describe experiences of care, bereavement, distress, loss of confidence, difficulty accessing support, and the impact of organisational processes following incidents, complaints, claims, inquests and the Public Inquiry. Many people shared their experiences with the explicit intention of helping the organisation learn and prevent others experiencing similar harm or distress.

Key findings

1. **Processes may compound harm:** Current complaints, claims, inquest, records and assessment processes are experienced by some people as adversarial, destabilising and retraumatising.
2. **Trust and confidence have been seriously damaged:** Some individuals and families feel unable to engage safely with Trust services because services are associated with previous trauma, poor communication or unresolved harm.
3. **Alternative support is fragmented:** There is no single clear, reliable and accessible pathway for people who cannot safely access Trust services or who need independent support.
4. **Standard processes may be unsuitable for complex mental health harm:** Legal, clinical and administrative approaches may need to be adapted for trauma, fluctuating capacity, psychiatric injury, cognitive impairment or physical illness.
5. **Records accuracy and transparency are central concerns:** Incomplete, disputed or poorly contextualised records can undermine trust, fairness, future care and resolution.
6. **SAR handling has raised fairness concerns:** Delays, partial disclosures, unclear communication and withholding of information have increased distress and mistrust.
7. **Bereaved families describe ongoing harm:** Post-incident processes, reports, inquests and communication can either support healing or compound trauma.
8. **People want visible accountability:** Listening is valued, but people want evidence that concerns are owned, acted on and converted into measurable improvement.

Detailed key themes and responses provided

Theme identified	What people told us	Response provided or required
Loss of trust and fear of re-engagement	Some people described being unable to re-engage with Trust services because previous experiences had become associated with trauma, fear, distress or unresolved harm. For some, avoidance of services appeared to be a protective response rather than a simple choice not to engage.	Responses need to recognise loss of trust as a safety issue. This includes offering compassionate contact, acknowledging previous distress and providing clear, supportive next steps.
Need for alternative and independent support	People described uncertainty about where to go when Trust services did not feel safe or when they needed support that felt independent of the organisation they were raising concerns about.	The response should include mapping existing alternatives, identifying gaps, working with commissioners and partners, and developing clear information for people about independent advocacy, specialist support and escalation routes.

Complaints, claims and legal processes felt adversarial	Concerns were raised that formal processes can feel defensive, slow, legalistic and difficult to navigate, particularly for people experiencing trauma, bereavement, psychiatric injury or cognitive and physical health difficulties.	The response should review internal processes against trauma-informed principles, reduce avoidable delay, improve plain English communication, and ensure reasonable adjustments and support are available throughout, while enabling due process to be applied.
Records accuracy, disclosure and transparency	People described distress where records were felt to be inaccurate, incomplete, poorly contextualised or difficult to challenge. Concerns were also raised about delays or partial disclosure in Subject Access Request processes.	The response should include clearer communication about records processes, timely SAR handling, support to understand disclosures, and a fair route for considering disputed records where accuracy affects dignity, trust or future care.
Bereavement, post-incident and inquest experience	Families described that communication after serious incidents, during investigations and in preparation for inquests can either support understanding and healing or compound grief and trauma.	The response should strengthen family liaison, bereavement support, communication standards and preparation for inquests, ensuring families are treated with compassion, honesty and respect throughout.
Need for visible accountability and learning	People wanted assurance that their experiences would not simply be heard, but would lead to specific changes, named accountability and evidence of impact.	The response should include a single action tracker, clear executive ownership, regular reporting to the Board, and feedback to people where possible on what has changed as a result of their contribution.
Communication, tone and relational repair	Some people described communication that felt impersonal, defensive or insufficiently compassionate. Others highlighted the importance of being listened to by senior leaders and having their experience acknowledged without qualification.	Responses should consistently acknowledge harm and distress, avoid defensive language, be clear about what can and cannot be done, and ensure that senior contact is followed by practical action and ongoing support.

Across the themes, the response required is both relational and practical. A compassionate response means acknowledging distress, recognising the impact of past harm, and offering contact that feels safe and respectful. A practical response means creating clear routes for

support, adapting processes where they may compound trauma, assigning ownership, and providing the Board with assurance that learning is being translated into measurable change.

Principal risks and implications

Risk area	Implication for the Board
Patient and family safety	People may avoid services despite continuing need if those services are associated with previous trauma or harm.
Trust and confidence	Perceived defensiveness, delay or lack of transparency may further damage confidence in the Trust and partner processes.
Governance and assurance	Without clear ownership and follow-through, themes may be heard but not converted into measurable improvement.
Legal, regulatory and information governance	Poorly adapted claims, disclosure, records or SAR processes may increase distress, prolong resolution and undermine procedural fairness.
Culture and learning	If people do not see evidence of change, engagement may be experienced as tokenistic rather than restorative.

Proposed actions

Action	Lead	Expected outcome
Review existing improvement plans, identify areas of learning that align with the themes identified, and document impact, sustainability and monitoring arrangements.	Executive Team	Clear ownership, progress reporting, sustainability, monitoring and assurance of actions.
Map current alternative support options and identify gaps for people who cannot safely access Trust services.	Operations, Nursing and Partnerships	A clear pathway for independent, trauma-informed or alternative support.
Review claims, complaints, inquest, SAR and records processes against trauma-informed principles. Train and support people to use clear and compassionate language	Corporate Governance, Legal, Patient Safety and Information Governance	Processes that are more proportionate, transparent, compassionate and person-centred. Training
Develop a supported records review offer where records are disputed and review may support future care, dignity or resolution.	Clinical Leadership and Information Governance	Improved fairness, transparency and confidence in records handling.
Strengthen bereavement and family support before, during and after	Nursing, Patient Safety and Experience	More consistent, compassionate and

serious incident, inquest and inquiry-related processes.		accessible support for families and carers.
--	--	---

Assurance required

- A clear governance route is agreed for oversight of the thematic action plan and escalation of barriers.
- Themes are triangulated with complaints, incidents, patient safety investigations, inquests, claims, patient experience feedback, safeguarding, equality data and Public Inquiry learning.
- There is evidence that compassionate practice, respectful communication and trauma-informed care are being reinforced through leadership, supervision, training and feedback.
- There is evidence that compassionate listening and understanding are embedded in all engagement with people affected by harm, with staff supported to respond with empathy, openness and practical follow-through.
- Families, carers and people with lived experience are meaningfully involved in improvement work and co-production of support materials.
- There are clear routes for supporting people who have lost trust in Trust services, including escalation to commissioners and partner providers where alternative provision is required.
- Processes for SARs, disputed records and record accuracy are timely, transparent and person-centred.

Conclusion

The material reviewed presents a clear message: compassionate listening is necessary, but it is not sufficient on its own. People affected by harm need processes that do not compound trauma, routes to support that feel safe, and visible evidence that concerns are being translated into action. A clear, trauma-informed and accountable response will be essential to rebuilding trust, improving safety and demonstrating that learning is leading to meaningful change.

We should also note that the announcement of the Public Inquiry start of the 21st September 2026 should not prevent or delay the improvements outlined,

Recommendations

The Board is asked to receive this Phase One report and support the actions identified, led by the Executive Director of Therapies and Patient Experience.

The Board is asked to receive ongoing reports through the Quality and Assurance Committee and quarterly updates to the Trust Board of Directors.

This report will be shared openly with those individuals, forums and key partner stakeholders who have contributed to this work.

The Board is asked to support the Chief Executive Officer in continuing engagement with communities, parents, patients, families and carers on progress, and to encourage involvement from Trust Board colleagues.

Meeting of:	Board of Directors
Date:	23 September 2026
Title:	Board Assurance Framework and Corporate Risk Register
Executive Sponsor(s):	Alison Smith, Chief Executive
Report Author(s):	Anna Pridmore, Interim Company Secretary and Director of Corporate Governance

Report for:	Assurance	☒	Decision	☐
	Consultation	☐	Information	☐
		☐		☐

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

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

✓
✓
✓

Strategic risks relating to this report:

BAF ref no.	Risk Title	Context
9	Regulatory Compliance	There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation

EXECUTIVE SUMMARY:

1. Purpose:

The refreshed 2026/27 Board Assurance Framework contains 13 strategic risks. As of 14 September 2026, nine of these risks are above our risk tolerance levels, representing material exposure across digital infrastructure, cyber security, financial sustainability, workforce capacity and clinical quality.

Three risks are rated at 20 (our highest rating):

BAF 05: Digital – Supporting Change

BAF 07: Data Security and Protection

BAF 11: Financial Sustainability

The Corporate Risk Register contains 10 risks aligned to relevant BAF risks. The highest-rated corporate risk is Risk 1636 (CITO patient record completeness), also rated 20.

The principal assurance the Board can take from the documents is that the Trust has an established BAF and CRR, defined Executive and committee oversight, identified controls, and a developing approach to linking strategic and corporate risks. However, the evidence also shows that quality and maturity of assurance is inconsistent. Several BAF controls have no stated control-effectiveness assessment, several CRR entries have incomplete second- or third-line assurance, and some source dates and references require validation. Accordingly, the overall conclusion is reasonable assurance over the framework and visibility of risk, with further work required to strengthen evidence of control effectiveness and delivery of mitigating actions.

2. Overview:

Current BAF position

The table below summarises the current BAF position.

BAF	Risk	Score	Tolerance	Position / Board significance
01	Safe Staffing	16	12	Above tolerance; supervision assurance risk rated 15.
02	Access	1	9	Within tolerance at BAF level, aligned corporate risks are rated 12 and 15, requiring reconciliation.
03	Patient Experience	9	9	At tolerance; control effectiveness recorded as limited.
04	Quality and Outcomes	15	9	Above tolerance; aligned inpatient self-harm/suicide risk rated 15.
05	Digital - Supporting Change	20	12	Above tolerance; highest-rated strategic risk.
06	Estates / Physical Infrastructure	12	12	At tolerance.
07	Data Security and Protection	20	12	Above tolerance; aligned cyber risk remains rated 15.
08	Partnerships and System Working	16	12	Above tolerance; no aligned CRR recorded.
09	Regulatory Compliance	8	5	Above tolerance under minimal appetite; direct Board oversight.
10	Roseberry Park	16	12	Above tolerance; aligned CRR risk rated 15.
11	Financial Sustainability	20	12	Above tolerance; aligned CRR risk remains rated 15.
12	Transformation	16	12	Above tolerance; no aligned CRR recorded.
13	Public Inquiry	4	5	Within tolerance but strategically significant.

There are several key assurances the report provides to the Board which are summarised below:

Assurance theme	Assurance available
Framework and governance	A refreshed BAF is in place for 2026/27, with 13 strategic risks, identified Executive leads and oversight committees. The CRR provides the operational and corporate detail beneath relevant strategic risks.
Strategic risk review	The annual review has refreshed the profile: the former co-creation risk has been removed, Patient Experience has been created as a separate strategic risk, quality risks have been consolidated, and Public Inquiry has been added for explicit Board oversight.
Internal audit	Internal Audit provided substantial assurance over management of the BAF in 2025/26, with no recommendations.
Risk visibility	The strategic risk map makes the position against tolerance explicit and links BAF risks to aligned corporate risks, supporting more focused committee and Board scrutiny.
Established operational controls	The BAF and CRR identify a broad range of first-line controls and management oversight, including governance forums, performance reporting, workforce and service review processes, incident and quality systems, financial monitoring, programme governance, cyber controls and external reporting.
External and independent sources	The CRR identifies external or independent assurance for a number of risks, including CQC inspection and review, Internal Audit, External Audit, NHS England oversight, DSPT audit, external penetration testing and national reporting.
Active mitigating work	Open actions are recorded across the significant corporate risks, including Roseberry Park rectification, inpatient harm minimisation, supervision policy and reporting, waiting list and discharge improvement, cyber remediation, and delivery of the financial plan.

It is also recognised at this stage that there are some gaps in assurance and limitations that need to be addressed over the next few months including:

- Control effectiveness at present is not as consistent as it should be when assessed across the BAF. There are some challenges to overcome around updating the BAF on the Inphase system which will help in getting a more consistent approach. Several risks show a blank or uncertain effectiveness position; this does have the effect of limiting the Board's ability to determine whether controls are operating as intended.
- The CRR contains many controls for which second- or third-line assurance is blank. In some cases, activity or reporting is described, but an evidenced conclusion on effectiveness is not clear.
- BAF 02 Access is scored within tolerance at 1, while aligned corporate access risks are rated 12 and 15. This difference may be valid, but the rationale and aggregation methodology need to be explicitly evidenced.
- Risk 1636 is rated 20 with a target rating of 20 and a target date of 16 April 2026. At the reporting date, this does not demonstrate a planned reduction in exposure and the target date appears to have passed.
- Risk 1535 is at its target rating of 12 but has no open actions and several assurance fields are blank. Work should be undertaken to determine if this risk is addressed and accepted or continued monitoring is required or there are other actions that should be identified.

- Some review dates in the CRR appear to have passed by 14 September 2026, including Risks 1137, 1529 and 1647. This maybe as a result of delays in meeting risk owners to update their risks.
- BAF 09 shows a target date of March 2025 in the BAF summary, which requires validation or correction.

There are three issues requiring the board’s attention:

Access Risk Reconciliation (BAF 02) – Finance and Performance Committee

BAF 02 (Access) is scored at 1 (within tolerance), but two aligned corporate risks are rated 12 and 15. This difference may be valid, reflecting that the strategic risk is lower than operational implementation challenges. However, the rationale requires explicit Board clarity. Action 8 will reconcile this position and provide measurable access, safety and experience outcomes by the next BAF update.

Digital and Estates Committee

This is rated 20 with a target date that has now passed (16 April 2026) and a target rating that remains 20—indicating no planned reduction in exposure. This requires immediate clarification. Action 3 (Priority – 30 October 2026) will confirm the treatment plan, revised target date, and measurable improvement outcomes with independent assurance.

Nine Strategic Risks Above Tolerance – Various Board Committees

Beyond the three risks rated 20, a further six risks are above tolerance (scores 15–16). These span safe staffing, quality and outcomes, partnerships, Roseberry Park rectification, and transformation. Action 2 will establish measurable recovery trajectories for each risk with expected score movement and completion confidence by the routine committee cycle.

It is proposed that a number of actions are implemented to develop and improve the effectiveness of the BAF and the CRR, these include:

#	Priority	Required work / evidence of completion	Lead oversight	Timing
1	Complete the assurance architecture	For every BAF control, identify the first, second and third lines of assurance, the evidence source, frequency, owner and latest conclusion. Remove question marks and blank effectiveness fields.	All Executive leads, coordinated by Corporate Governance and Risk Management	Next full BAF refresh
2	Agree recovery trajectories for above-tolerance risks	Identify measurable milestones, expected score movement and delivery confidence for each of the nine BAF risks above tolerance. Future exception reporting to the Committees should explain slippage and whether further escalation is required.	Executive leads and oversight committees	Routine committee cycle

#	Priority	Required work / evidence of completion	Lead oversight	Timing
3	Resolve the Digital and CITO risk position	Clarify the treatment plan for Risk 1636, including why the target remains 20, the status of the elapsed target date, measurable improvement outcomes, supplier actions and independent assurance over record completeness. Complete missing assurance fields for Risk 1535.	Chief Information Officer / Planning Digital and Estate Committee	Priority Board oversight
4	Strengthen cyber assurance	Track the five open cyber actions, including secure boundary, vulnerability scanning, SIEM, MFA and the Cisco alert; provide evidence of risk reduction and independent testing against the planned target.	Chief Information Officer / SIRO / Planning, Digital and Estates Committee	Through the agreed cyber reporting cycle
5	Evidence delivery of the financial plan	Report forecast outturn, financial risks, mitigations, equality impacts, unfunded pay-award exposure and assurance over delivery of the plan to NHS England and the Board.	Director of Finance and Estates / Finance and Performance Committee	Routine committee work programme committee cycle
6	Improve quality and safety assurance	For Risk 811, complete the five actions and strengthen evidence across incident learning, observation practice, training, staffing, environmental controls and use of technology. Ensure third-line gaps are addressed or explicitly accepted.	Chief Nurse / Quality Assurance Committee	To support target by 30 April 2027
7	Close safe staffing assurance gaps	Complete the revised supervision policy and TEWV Vision reporting; establish reliable central compliance data. Continue consultant recruitment controls and confirm performance against the September 2026 target.	Director of Workforce and Culture / People and Culture Committee	Routine committee work programme committee cycle
8	Reconcile access risks	Explain the relationship between the low BAF 02 score and higher-rated corporate risks. Track neurodevelopmental waiting-list capacity and adult mental health discharge actions through measurable access, safety and experience outcomes.	Interim MD for Care Groups / Finance and Performance Committee	Next BAF and CRR update
9	Maintain Roseberry Park oversight	Continue phase 2 rectification and review the programme, with clear reporting of milestones, safety assurance, capital exposure and changes to the residual risk.	Director of Finance and Estates / Board of Directors	Programme reporting cycle
10	Improve data quality and document control	Reconcile risk identifiers, confirm all review and target dates, standardise terminology and ensure one controlled monthly version of the BAF, CRR and strategic risk map is used throughout the Trust.	Corporate Governance and Risk Management	Before next reporting cycle

3. Board Assurance

Board-level assurance conclusion

I propose that the Board should take reasonable assurance from the information provided. This conclusion rests on:

- (a) a refreshed strategic risk framework in place;
- (b) clearly defined Executive and committee oversight;
- (c) documented first-line controls for all BAF risks; and

(d) consistent visibility of risks above tolerance.

However, assurance cannot yet be considered comprehensive because evidence of control effectiveness and independent assurance is incomplete in parts of the BAF and CRR. Board oversight should therefore concentrate on the nine above-tolerance risks and the actions required to bring them within tolerance.

4. Recommendations

The Board of Directors is asked to:

- Confirm the view that there is reasonable assurance that the refreshed 2026/27 BAF and the CRR provide a consolidated view of the principal strategic and corporate risks at 14 September 2026.
- Note that nine of the 13 BAF risks are above tolerance, with particular Board attention required for Digital, Data Security and Protection, Financial Sustainability, Safe Staffing, Quality and Outcomes, Partnerships and System Working, Regulatory Compliance, Roseberry Park and Transformation.
- Note the key assurances and limitations set out in the report including gaps in independent assurance and incomplete evidence of control effectiveness.
- Note the proposed actions to develop the effectiveness of the BAF and CRR as part of the assurance mechanisms.

5. Attachments

Attachment A – Corporate Risk Register 14 September 2026

Attachment B – Board Assurance Framework 14 September 2026

Attachment C – Strategic Map 14 September 2026

Corporate Risk Register

Risk Details	Impact/ Location	Next Review Date	Risk Owner	Risk Description	Initial Risk Rating	Control & Assurances	Current Risk Rating	Movement	Open Actions	Target Risk Rating	Date to achieve target
Risk 00000219 BAF Risk Alignment : 26-27 BAF 10 - Roseberry park Committee Alignment : Finance and Performance Committee Secondary Committee Alignment (Impact) :	Care Group/Directorate : Estates & Facilities Specialty/ Department : EFM - Estates Ward/Team : Estates Department	01 Oct 2026 Opened Date : 08 Sep 2016 Last Review Date : 01 Sep 2026	Simon Adamson Risk Manager : John Adamson	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	15	Roseberry Park Rectification Programme First line of Assurance : Works completed to Blocks 5 and 10 in first phase of rectification programme, additional facility constructed (block 16) for decanting patients within Forensic services during future works phases. Second Line of Assurance : Lessons learned from phase 1 have directly influenced our approach to rectifying known defects via approved standard rectification detail. Third Line of Assurance : Works have commenced on phase 2, blocks 1 and 9, with future design phase workshops held to influence decision making processes as to which blocks are contained within defined phases of activity.	15.00	➡	2 Actions : Phase 2 rectification works Review of Phase 2 rectification works programme	8	06 Jan 2032

Risk 00000811 BAF Risk Alignment : Care 26-27 BAF 4 - Quality & Outcomes Committee Alignment : Quality Assurance Committee Secondary Committee Alignment (Impact) : Group/Directorate : Nursing and Governance Specialty/Department : N&G - Management Ward/Team : Director Management Team 01 Oct 2026 Opened Date : 01 Jun 2020 Last Review Date : 01 Sep 2026 Beverley Murphy Risk Manager : Rachel Weddle There is a risk that patients receiving inpatient mental health care may engage in self-harm, suicide attempts or suicide, due to the complex interaction of individual patient factors, fluctuating mental state, environmental risks, accessibility of means, and variability in the delivery of therapeutic interventions and observation practices, which could result in serious injury or death, trauma for families and staff, regulatory scrutiny, reputational damage, and disruption to services.	20	R811 - Environmental Ligature Point Survey First line of Assurance : Ward leadership completing and reviewing surveys. Updated as new ligature risks are identified. Second Line of Assurance : Environmental Risk Group oversight Third Line of Assurance : CQC inspections / external review processes R811 - Individual Risk Assessment & Care Planning First line of Assurance : Named nurse & MDT, Matron/Care Group oversight Second Line of Assurance : Quality governance audits Third Line of Assurance : CQC inspections / external review processes R811 - Learning from Self Harm incidents First line of Assurance : Ward level review of all incidents of self harm and consideration of learning. Second Line of Assurance : AAR and PSII completed involving central overview. Suicide prevention leads Third Line of Assurance : R811 - Removal / Mitigation of Anchor Points First line of Assurance : Estates completing works Second Line of Assurance : Estates governance reporting, Capital programme oversight Third Line of Assurance : CQC inspections / external review processes R811 - Restricting Access to Means of Self-Harm First line of Assurance : Ward staff record searches undertaken, Matron audits Second Line of Assurance : Incident trend review, Do we have information on searches undertaken? Third Line of Assurance : CQC inspections / external review processes R811 - Staff Training & Competence First line of Assurance : Staff training compliance Second Line of Assurance : Workforce/Training oversight Third Line of Assurance : CQC inspections / Internal Audit R811 - Staffing levels First line of Assurance : Staffing rotas, Matron Oversight, Escalation Processes Second Line of Assurance : Safe Staffing reports to Committee Third Line of Assurance : CQC inspections / external review processes	15.00 ➡	5	Actions : R811 - Improve Assurance - QA schedule results, incidents R811 - Handover Quality 811 - Staff Skill Mix Review R811 - Central oversight of door and LIO (Oxehealth) checks (and others) R811 - Improve harm minimisations training adding additional components 10 30 Apr 2027
--	----	---	---------	---	---

R811 - Technology enabled patient safety
First line of Assurance : Ward level use in environment - reflected in incident reports where this has assisted in identifying incident Audits undertaken to check operationally fit for purpose
Second Line of Assurance : Matron Validation of checks
Third Line of Assurance :

R811 - Therapeutic Engagement & Observation
First line of Assurance : Clinical staff follow agreed process and clinical practice
Second Line of Assurance : Ward managers auditing observation practice, incident reviews
Third Line of Assurance : CQC inspections / external review processes

Risk 00000909 BAF Risk Alignment : Care 26-27 BAF 1 – Safe Staffing Committee Alignment : People Culture and Diversity Committee Secondary Committee Alignment (Impact) : Quality Assurance Committee	Care Group/Directorate : NYY&S Specialty/Department : Management Ward/Team : North Yorkshire And York	29 Oct 2026 Opened Date : 20 Oct 2020 Last Review Date : 27 Aug 2026	Himanshu Garg Risk Manager : Himanshu Garg There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYY&S due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20	Employment of international fellowship Doctors to fill gaps and reduce locum mind the gap First line of Assurance : Successful recruitment of these posts has substantially reduced our locum reliance in MHSOP South. other specialty updates will follow. Second Line of Assurance : Third Line of Assurance : Mind the Gap arrangements First line of Assurance : Lead Psychiatrists report that the locum doctors are present at work. Second Line of Assurance : Finance reports confirming payments to locum doctors Third Line of Assurance : Retention of Existing Consultant workforce First line of Assurance : Quarterly meeting with all career grade doctors within the care group Monthly meeting with individual specialty career grade doctors Second Line of Assurance : Sickness absence is below the Trustwide percentages. Increasing numbers of approved flexible working requests Increase in LTFT colleagues. Third Line of Assurance : Rolling recruitment activity First line of Assurance : AMDs within specialties giving regular updates in recruitment meetings which involves DMD recruitment and medical staffing Second Line of Assurance : Six monthly update to Care Group Board and EDG Third Line of Assurance : Substantive recruitment to vacant consultant posts First line of Assurance : Posts are regularly re-advertised where needed and appropriate incentives financial or developmental are added to make them more attractive Second Line of Assurance : Third Line of Assurance :	12.00 ➡	1 Actions : 909 Regular recruitment meetings	9	30 Sep 2026
---	---	---	--	----	---	---------	---	---	-------------

Risk 00001137		29 Aug 2026	Sarah Dexter-Smith	There is a risk of lack of oversight and assurance in relation to supervision due to inconsistent recording processes and inability to provide central data, resulting in limited assurance that staff and team are receiving appropriate levels of clinical and line management supervision to support their wellbeing and quality of care.	15	Manual Recording Systems First line of Assurance : Locally updated Reported through specialty governance Second Line of Assurance : Third Line of Assurance : Audit one clinical supervision Audit	15.00 ➡	2 Actions : New supervision policy to be drafted TEWVision reporting to be updated in line with revised policy	6	31 Mar 2027
BAF Risk Alignment : Care 26-27 BAF 1 – Safe Staffing Committee Alignment : People Culture and Diversity Committee Secondary Committee Alignment (Impact) : Quality Assurance Committee		Group/Directorate : Mar 2022 Specialty/Department : PCD – Director Ward/Team :	Risk Manager :			TEWVision First line of Assurance : Individuals record supervision Line managers monitor Second Line of Assurance : Form July 25 able to report out from TEWV Vision in terms of compliance for each specialty. Reporting from TEWVision to CG Specialty and CG Board Third Line of Assurance :				

Risk 00001219 BAF Risk Alignment : Care 26-27 BAF 2 - Access Committee Alignment : Finance and Performance Committee Secondary Committee Alignment (Impact) : Quality Assurance Committee Group/Directorate : DTV&F Specialty/Department : DTV&F - CAMHS Ward/Team : 06 Nov 2026 Opened Date : 01 Apr 2021 Last Review Date : 07 Sep 2026 Jamie Todd Risk Manager : James Graham Children and young people may experience deterioration in mental health due to excessive waiting times for neurodevelopmental assessments, leading to increased demand on specialist and urgent care services and poor patient experience.	16	Activity levels and outputs First line of Assurance : SM Q&P huddle Second Line of Assurance : GM Q&P huddle Third Line of Assurance : DoOps Q&P huddle Capacity and demand First line of Assurance : Q&P huddle at SM level on a weekly basis Second Line of Assurance : Q&P huddle at GM level on a weekly basis Third Line of Assurance : Q&P huddle at DoOps level on a weekly basis Clinical prioritisation First line of Assurance : TMs and SM to ensure waiters are reviewed in an effective and timely manner to be assured around risk management and patient safety. Second Line of Assurance : Once identified these waiters will be prioritised for an assessment. In order to identify needs and offer support required. Third Line of Assurance : Clinical Risk Management of Waiting List First line of Assurance : Clinical triage processes, incident reporting and safeguarding reviews. Second Line of Assurance : Governance meetings and Quality Assurance structures. Third Line of Assurance : Over 5 Pathway Capacity and Demand Review First line of Assurance : Performance reports reviewed by Service Managers, Team Managers and Operational Managers. Second Line of Assurance : Review through Speciality governance meetings, Quality & Performance meetings, Care Group governance. Third Line of Assurance : Pathway Review and Improvement First line of Assurance : Service-led pathway reviews and improvement planning. Second Line of Assurance : Care Group Governance, Neurodiversity Steering Group and ICB oversight. Third Line of Assurance :	12.00 ➡	1 Actions : Workforce Capacity Review- Teesside Organisation change	6	31 Dec 2026
--	----	---	---------	---	---	-------------

PTLs

First line of Assurance : TMs and SMs to have a robust and timely process for management of PTLs

Second Line of Assurance : Provides oversight of the people waiting, there assessment dates and assurance KIT letters have been sent.

Third Line of Assurance : Robust and effective KIT processes are in place to ensure timely and clear communication with young people and families, offering advice, signposting, and contact details to enable escalation if risks increase

Recovery and Improvement Plan

First line of Assurance : The Recovery plan provides assurance and oversight of the current improvement work been undertaken by the service

Second Line of Assurance : Reviews of the recovery plan allow sight of the progress against the milestones

Third Line of Assurance :

Right to choose

First line of Assurance : RTC process can be assessed via GP. PTL monitoring who has opted for RTC , removed from waiting list

Second Line of Assurance : Waiting time reduction due to uptake through RTC

Third Line of Assurance :

Support whilst waiting and signposting

First line of Assurance : KIT letters offer local signposting support and inform families of who to contact if mental health or risk changes

Second Line of Assurance :

Third Line of Assurance :

Under 5 to Over 5 Transition Oversight

First line of Assurance : Waiting list reviews and pathway transition reporting.

Second Line of Assurance : Quality and Performance Meetings, Specialty governance and Care Group Governance

Third Line of Assurance :

Workforce Capacity and CRES Oversight

First line of Assurance : Service workforce reports and establishment reviews.

Second Line of Assurance : Leadership team and Care group governance oversight

Third Line of Assurance :

Risk 00001529		11 Sep 2026	Shaun McKenna	There is a risk that delayed discharges from Adult Mental Health (AMH) acute inpatient wards will continue to contribute to extended lengths of stay, due to challenges in securing timely and appropriate onward care, community support arrangements, or accommodation solutions. This may result in reduced bed availability, increased pressure on inpatient services, delayed access to care for individuals requiring admission, and a poorer experience for patients awaiting discharge and those requiring urgent inpatient treatment.	20	Incident Data First line of Assurance : Number of incidents reported via InPhase linked to delays Second Line of Assurance : Third Line of Assurance :	15.00 ➡	4 Actions : Develop Patient Flow Transformation workstream Develop an electronic live visual bed state in conjunction with IT and our digital journey to change Develop the "Transforming Mental Health Discharge" workstream Trust-wide CRFD programme	9	31 Dec 2026
BAF Risk Alignment : Care		Opened Date : 29	Risk Manager :							
26-27 BAF 2 - Access		Group/Directorate :								
Committee		May 2024								
Alignment : Quality		Specialty/								
Assurance Committee		Department :								
Secondary		DTV&F - AMH								
Committee		Ward/Team :								
Alignment (Impact) :		12 Aug 2026								
						Patient Flow Work First line of Assurance : Total number of DTV AMH patients reported as clinically ready for discharge Second Line of Assurance : Monitoring of key inpatient bed performance data including length of stay, bed occupancy and number of discharges Third Line of Assurance :				
						Performance reporting First line of Assurance : Weekly CRFD report from corporate reporting team Second Line of Assurance : Weekly Q&P dashboard reporting total patients who are CRFD Third Line of Assurance : Use of OPTICA for reporting of CRFD patients				
						Q&P reporting First line of Assurance : OPTICA data Second Line of Assurance : Quality & Performance Dashboard Third Line of Assurance : Monthly Governance Reporting				

Risk 00001535		01 Oct 2026	Nick Black	16	Formal data quality error review process	12.00 ➡	0	12	30 Sep 2027							
BAF Risk Alignment : Care		Opened Date : 25	Risk Manager : Nick Black													
26-27 BAF 5 - Digital		Mar 2024	Paula Hay													
- Supporting Change		Last Review Date :														
Committee		01 Sep 2026														
Alignment : Finance		Specialty/	There is a risk the Trust will be unable to provide accurate contract information to commissioning bodies and NHS England due to performance and stability issues with Cito which could lead to legal, compliance or financial action against the Trust through the inability to meet contractual obligations.		First line of Assurance : Second Line of Assurance : Third Line of Assurance :		Actions :									
and Performance		Department : DADS														
Committee		- Business														
Secondary		intelligence, clinical														
Committee		outcomes														
Alignment (Impact) :		Ward/Team : Bi And			First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
		Co Management														
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
					First line of Assurance : Second Line of Assurance : Third Line of Assurance :											
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													
			First line of Assurance : Second Line of Assurance : Third Line of Assurance :													

Risk 00001636 BAF Risk Alignment : Care 26-27 BAF 5 - Digital - Supporting Change Committee Alignment : Finance and Performance Committee Secondary Committee Alignment (Impact) : Quality Assurance Committee	Group/Directorate : Digital and Data services Specialty/ Department : DADS - Quality governance Ward/Team : Information Governance	03 Oct 2026 Opened Date : 15 Jan 2025 Last Review Date : 03 Aug 2026	Lorraine Sellers Risk Manager : Vianne Chapman There is a risk that the CITO system does not display a complete or accurate patient record to TEWV staff and partners, due to system performance and/or corruption of existing data, or data not saving, resulting patient care decisions being misinformed, quality of care being impacted, or requiring additional manual mitigations to be put in place and limiting clinical capacity.	25	Access to Great North Care Record and Yorkshire Care Record First line of Assurance : Report loss of service to Information service desk and second line patient systems team Second Line of Assurance : Availability of systems and outage reports taken to DPAG for assurance and approval Third Line of Assurance : Cito Improvement group system report Active monitoring of Service Desk Calls to identify issues First line of Assurance : Service Desk reporting Second Line of Assurance : DPAG Systems Report Third Line of Assurance : DSPT report to EDG through BAF7 Cito training mandated for new starters from 1 Jan 2025 First line of Assurance : Cito training reports available to line managers via ESR Second Line of Assurance : Cito Improvement group receives regular training compliance reports alongside the Education and Training governance group Third Line of Assurance : Information shared within EDG monthly CITO report for training compliance and also on BAF 7 bi-monthly risk report Data migration (documents) completed First line of Assurance : Identification of data issues via Data Quality Working Group Second Line of Assurance : Issues articulated within system report to CIG on monthly basis Third Line of Assurance : Any significant issues would be raised via EDG monthly CITO report and at DPB Review Quality Audit data to monitor record keeping quality First line of Assurance : Quality Audits Second Line of Assurance : Strategic Quality Standard Group EDG Quality reports Third Line of Assurance : Robust test scripts developed First line of Assurance : Identification of bugs/issues within the test system Second Line of Assurance : Error trapping Third Line of Assurance : Regular weekly meetings with system supplier to identify resolutions to bugs and issues, alongside monthly system supplier performance meeting.	20.00 ➡	0 Actions :	20	16 Apr 2026
--	--	---	---	---------------	--	--------------------	--------------------------------------	---------------	--------------------

Speed issues with the system resolved
First line of Assurance : Call logging via IT help desk for affected users
Second Line of Assurance : Patient systems escalation processes to system supplier via their helpdesk procedures
Third Line of Assurance : Monthly reports to CIG
Supplier monthly service performance review meeting

Stabilisation programme in place for release management
First line of Assurance : Reported progress on weekly stabilisation meeting calls
Second Line of Assurance : Reported progress via CIG monthly
Third Line of Assurance : Progress reported as part of the monthly CITO report to EDG

Standard Operating Procedures in place
First line of Assurance : Continual monitoring of effectiveness of SOPs via fault/problem logging
Second Line of Assurance : KPI's provided to monthly DPAG meeting
Third Line of Assurance : Monthly supplier review performance meeting

User confidence training
First line of Assurance : Pre and post training measurement ongoing via audit and training feedback
Second Line of Assurance : Reported to CIG monthly Liaison with operational business managers Shared intelligence via Practice leads Community of Practice
Third Line of Assurance : Reported to EDG via monthly CITO report

User guides updated
First line of Assurance : KPI monitoring - reduction in help requests via patient systems and digital learning teams
Second Line of Assurance : CITO practice leads community of practice discussions, messages and requests for support
Third Line of Assurance : Monitored via DPAG in relation to KPI's Team output reported to Education and Training governance group

Risk 00001647 BAF Risk Alignment : Care 26-27 BAF 7 - Data Security and Protection Committee Alignment : Finance and Performance Committee Secondary Committee Committee Alignment (Impact) :	Care Group/Directorate : Digital and Data services Specialty/Department : DADS - It & systems Ward/Team : Technology Services	29 Aug 2026 Opened Date : 17 Jan 2025 Last Review Date : 31 Jul 2026	Steven Forster Risk Manager : Steven Forster There is a risk of exposure to published critical cyber vulnerabilities due to the failure to maintain all digital assets resulting in loss of digital services and systems, and loss of records; leading to potential patient harm, data leaks, regulatory action, impacting on service delivery. Includes: Unpatched endpoints, servers, and equipment; Unsupported operating systems, software and hardware; AV coverage and patching	25	Continuous patching First line of Assurance : Patch triage meeting bi-weekly to ensure low level compliance. Second Line of Assurance : Updates provided to cyber security group with escalation to DPAG. Reporting via IT health monthly to CIO/SIRO and head of technology Third Line of Assurance : DSPT annual submission along with annual report to SIRO via DPAG with any gaps in remediation.	15.00 ➡	5	Actions : TEWV secure boundary tenant utilised for all internet traffic Vulnerability scanning of non-MDE hosts SIEM delivery Extend the use of MFA High Severity Alert (CC4702) Cisco IOS operating system exploitation (190x Switch stacks)	5	30 Nov 2028
					Data Security & Protection Toolkit First line of Assurance : Annual DSPT submission to plan within operational teams. Second Line of Assurance : Any gaps highlighted and submitted as part of DSPT reports with SIRO review via DPAG. Third Line of Assurance : Annual DSPT interim audit.					
					Independent Penetration test First line of Assurance : Independent Penetration test performed annually by Dionach on behalf of NHS england (CREST approved) Second Line of Assurance : Operational team review and interim updates on progress via cyber security group and team management huddles. Third Line of Assurance : Cyber security Group update and DPAG update with progress against annual test.					
					Multi Factor Access (MFA) First line of Assurance : The Trust complies with the MFA national policy and DSPT standards by applying computer based certificates for all corporate devices interacting with the Trusts always on VPN service. The MyDesktop remote access service which is a web based system for use with staff and 3rd parties has a dedicated MFA software token to provide secure access. Second Line of Assurance : Third Line of Assurance :					
					Network & Perimeter security First line of Assurance : Web applications firewalls deployed at edge and within critical network segments. Client firewalls deployed on all endpoints. Second Line of Assurance : Uptime of firewalls monitored through PRTG monitoring platform and any non-compliance with client firewalls monitored through national defender for endpoint tenant and through IT health dashboard. Third Line of Assurance :					

					</				

Board Assurance Framework Summary

BAF 01 – Safe Staffing												
Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance	
There is a risk that variability in leadership and management capability caused by leadership maturity, skills and management practice could result in reduced assurance on our ability to create, sustain and assure safe staffing and wellbeing, and therefore service safety and quality	People Culture and Diversity Committee Executive Lead : Director of People, Culture & Diversity Strategic Goal(s) : 01 - Co-create High Quality Care 02 - Be a Great Employer	16	12 Date to achieve target : Mar 2027	12	People Risk Appetite : 4 – Seek Risk Tolerance : 12		Jun 2026		?	1.01 Leadership and management capability	LaMA in place provides clarity on what is expected of L&Ms and free access – workshops, 360s, insights. Modules mapped onto new national framework Executive restructure ensures capability and strategic alignment of organisation (from Q2)	
										?	1.02 Processes supporting daily rigour, safety and accountability	Daily rosters Daily operational processes in care groups and corporate services Ward dashboards E-roster reviews/ dashboard (fill rates, level loading) Recruitment processes P&C dashboard available to all colleagues
										?	1.03 Early identification of concerns	Monthly speak up group P&C dashboards working in TEWV monthly online sessions enable
										?	1.04 Workforce health and wellbeing	Comprehensive offer of support services HR processes are regularly reviewed with staffside TNA for CPD monies is coordinated through Therapies and Nursing leads alongside training and OD Significant increase in number of PDPs in services to support nursing and wider workforce Job descriptions are standardised and as accessible as possible Active health and wellbeing champion network and robust use of charitable funds
										?	1.05 Sustainable workforce planning and future workforce	Clinical models give direction to the workforce that is needed Strong and growing volunteer group, provides alternative routes into employment (routes to recruit) EQIA for any service change Strong partnership working with unions and partnership agreement in place. Recruited to two new workforce officers to support services with workforce planning and strategy* Transformation models require detail of workforce implications to be articulated All staff networks have an executive sponsor.
										?	1.06 People & Culture Directorate effectiveness	

BAF 02 – Access

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk that patients will experience prolonged waiting times for community and specialist services (notably neurodevelopmental and talking therapies) and do not receive timely access to assessment, treatment or admission, resulting in avoidable harm, due to flow constraints, variation in and impacts of historical commissioning, system and workforce capacity.	Finance and Performance Committee Executive Lead : Managing Director Strategic Goal(s) : 01 - Co-create High Quality Care 03 - Be a Trusted Partner	1	1 Date to achieve target : Mar 2028	9	Quality and Safety (including innovation) Risk Appetite : 2 - Cautious Risk Tolerance : 9	Limited	Jun 2026	.		2.01 Partnership Arrangements	Weekly operational interface meetings with Local Authority partners to support flow within inpatient services.
										 2.02 Demand Modelling	Associate Director of Strategic Planning and Programmes – Lead for demand modelling in the Trust. IQPR.
										 2.03 Operational Process and Escalation	Inpatient wards – Management of admissions through PIPA process and the operational daily escalation calls. Bed Management Team – Responsible for the oversight and management of the use of beds On-call arrangements – Agreement of actions in response escalations. Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand Daily Lean Management Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services. Stop the Line arrangements for community services PTL's.
										 2.04 Integrated Performance Reporting	Operational delivery of performance standards by wards and teams Performance Department – Management of the IPR including validation of data, oversight of data quality and reporting to the various tiers of the governance structure

BAF 03 - Patient Experience

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk that limited insight into patient experience is hindering consistent delivery of high-quality outcomes. Current data lacks diversity, depth and breadth, and does not reliably capture impact, constraining understanding of how experience influences effectiveness, safety and recovery. This risks services being insufficiently informed by patient priorities, leading to variable outcomes and missed opportunities to improve quality.	Quality Assurance Committee Executive Lead : Director of Therapies Strategic Goal(s) : 01 - Co-create High Quality Care	9	6 Date to achieve target : Mar 2028	9	Quality and Safety (including innovation) Risk Appetite : 2 - Cautious Risk Tolerance : 9	Limited	Jun 2026	.		3.01 - Patient experience insight and triangulated survey intelligence	Patient and Carer Experience Team – oversight of FFT and survey processes and reporting Care Group Patient Experience Networks and ward/team-level monitoring of returns and themes Clinical and operational leaders – ownership of local response rates and action plans Routine operational dashboards (FFT, experience metrics, narrative themes)
										 3.02 Complaints, local issue resolution (LIR) and learning from concerns	Service managers, ward managers and teams responsible for local resolution and LIR capture Complaints Team managing investigations, responses and data recording Operational services implementing actions and learning from complaints InPhase system capturing complaints and LIR activity
										 3.03 Co-creation, diversity and lived experience involvement	Involvement and Engagement Team delivering co-creation activity Co-creation boards and networks involving service users and carers Clinical leaders and service managers embedding co-creation in service development Patient Experience and Peer Support teams contributing to lived experience insight [25-26 BAF...ed actions PDF]

BAF 04 - Quality and Outcomes

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk of variable quality of care and clinical outcomes due to inconsistent service models, clinical practice, and use of intelligence to manage emerging risks, resulting in avoidable harm, compounding health inequities, and reduced confidence in the Trust.	Quality Assurance Committee Executive Lead : Chief Nurse Strategic Goal(s) : 01 - Co-create High Quality Care	15	10 Date to achieve target : Dec 2027	9	Quality and Safety (including innovation) Risk Appetite : 2 - Cautious Risk Tolerance : 9	Reasonable	Jun 2026	.		4.01 Trust wide Quality, Safety and Improvement Framework	Delivery against Trust-wide quality priorities through Care Group governance and performance reviews, including monitoring of quality, safety, access and experience indicators.
										 4.02 Standardised Governance and Escalation Framework (Floor to Board)	Risk identification, management and escalation through Care Group governance structures in line with Trust policy
										 4.03 Integrated Performance and Quality Intelligence	Use of Trust-wide performance and quality intelligence within Care Groups to monitor access, outcomes and variation, and to inform improvement activity
										 4.04 Patient Experience, Engagement and Quality intelligence	Collection and use of patient experience, complaints and engagement insight within Care Groups to inform service improvement
										 4.05 Incident, Learning and Improvement System	Incident reporting, review and local learning processes embedded within services and Care Groups.

BAF 05 - Digital - Supporting Change

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk to the delivery of safety, productivity and transformational improvements due to failure to fully deploy, utilise, and adopt digital and data systems resulting in financial and regulatory failures	Finance and Performance Committee Executive Lead : Chief Information Officer Strategic Goal(s) : 01 - Co-create High Quality Care 02 - Be a Great Employer 03 - Be a Trusted Partner	20	10 Date to achieve target : Mar 2028	12	Financial and Business Risk Appetite : 2 - Cautious Risk Tolerance : 12		Jun 2026		?	5.01 Well led Digital Governance	Analogue to Digital Board Operational governance monitoring of delivery Digital Programme Assurance Group (DPAG)
										5.02 Digital Demand Management and Prioritisation	New work request process Digital & Data Leadership Meeting
										5.03 Digital Programme Delivery and Control	Project and programme steering groups / reporting
										5.04 Digital Capability, Adoption and Inclusion	Training and education governance group Digital and data senior leadership
										5.05 EPR Deployment Programme	Clinical Advisory Group (CAG) Operational Readiness group Technical Design Authority
										5.06 Business Intelligence	Digital & Data Leadership Group Business Intelligence Development Strategic Oversight Group (BIDSOG) Digital Programme Assurance Group (DPAG)

BAF 06 - Estates/ Physical Infrastructure

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk of delayed or reduced essential investment caused by increasingly constrained capital resources following changes from 2026/27 in capital allocation processes resulting in an inability to adequately maintain, enhance or transform our inpatient and community estate / infrastructure, adversely impacting patient and colleague outcomes/experience.	Finance and Performance Committee Executive Lead : Director of Finance & Estates Strategic Goal(s) : 01 - Co-create High Quality Care 02 - Be a Great Employer 03 - Be a Trusted Partner	12	12 Date to achieve target : Mar 2029	12	Financial and Business Risk Appetite : 2 - Cautious Risk Tolerance : 12		Jun 2026		?	6.01 NENC Infrastructure board supported by Provider Collaborative Estates Directors Group	Executive Director of Finance and Estates/Facilities and Director of Estates, Facilities & Capital (or their deputies) represent the Trust at NENC meetings
										6.02 Estates Master Plan (EMP)	EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework. Finance Department – Responsible for the preparation of the annual capital and revenue financial plans for Board approval
										6.03 CIG & CPSG	Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements
										6.04 Estates, Facilities & Capital Directorate Management Team Meeting (DMT)	All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital.
										6.05 ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring	EFM Directorate responsible for: PLACE - Organising PLACE assessment visits, compiling and submitting information to NHSE - Preparation of the Action Plan ERIC - Compiling and submitting ERIC information to NHSE - Considering and delivering improvement and CRES plans in light of benchmarked outputs PAM - Completing self-assessment with processes to ensure timely submission - Developing and delivering action plans to ensure continuous improvement
										6.06 Green Plan submission and monitoring	EFM Directorate responsible for: Green Plan ? Compiling and submitting Green Plan submission to NHSE / ensuring progress to deliver milestones
										6.07 Environmental Risk Group (ERG)	Director of Estates, Facilities and Capital ensures aligned CPSG and ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs Directors of Operations / Operational teams support identification of environmental issues Servicedesk tracks levels of maintenance issues

BAF 07 - Data Security & Protection											
Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk of data breach or loss of access to systems, due to successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and information integrity, reputational damage and loss of confidence in the organisation.	Finance and Performance Committee Executive Lead : Chief Information Officer Strategic Goal(s) : 01 - Co-create High Quality Care 02 - Be a Great Employer 03 - Be a Trusted Partner	20	10 Date to achieve target : Mar 2028	12	Financial and Business Risk Appetite : 2 - Cautious Risk Tolerance : 12	Reasonable	Jun 2026	.		7.01 Objective A - Managing Security Risk (Governance & Supply Chain)	Risk register updates; supplier reviews via panarays; service owner risk ownership
										7.02 Objective B - Protecting against cyber attack (Identity, Device, Resilience)	System configs, MFA enforcement, device compliance checks Bi-Monthly Cyber security focused training
										7.03 Objective C - Detecting events (Monitoring & Logging)	Log collection and alert generation with supporting processes
										7.04 Objective D - Minimising impact (Response & Recovery)	Playbooks, Disaster Recovery tests, backup recovery validation. Server monitoring through local delivery teams.
										7.05 Objective E - Information governance (Use & Sharing)	IG processes, access control, records management

BAF 08 - Partnerships and System Working

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk that failure to engage effectively in partnerships across our Integrated Care Systems, Provider Collaboratives, 'places' and 'neighbourhoods' will compromise our ability to effect service improvement, transformation and population health of the communities we serve	Finance and Performance Committee Executive Lead : Executive Director of Transformation and Strategy Strategic Goal(s) : 03 - Be a Trusted Partner	16	12 Date to achieve target : Mar 2028	12	Financial and Business Risk Appetite : 2 - Cautious Risk Tolerance : 12		Jun 2026		?	8.01 Active engagement in Collaborative forum at regional, ICB and local level to help shape system 8.02 Strategic Framework	Engagement in a wide range of partnership functions and committees/ groups across each place, in line with individual place governance structures Joint work / operational processes with local authorities and other partners including PCNs Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future Visibility of Strategic Framework through internal / external comms (so that it is widely known what our strategic Goals and Objectives are).

BAF 09 - Regulatory Compliance

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation	Board of Directors Executive Lead : Chief Executive Strategic Goal(s) : 03 - Be a Trusted Partner	8	8 Date to achieve target : Mar 2025	5	Regulation Risk Appetite : 1 - Minimal Risk Tolerance : 5		Jun 2026		?	9.01 Statutory Reporting including compliance with accounting standards	Reporting requirements and timetables developed by the Company Secretary. Information provided by designated leads. Reports produced by Corporate Affairs and Communications based on submissions received. Annual Accounts timetable drafted by Associate Director of Finance (Accounting and Governance). Annual Accounts (and related TAC submissions) undertaken by the Finance Staff. Associate Director of Finance (Accounting and Governance) considers and coordinates annual training needs for annual accounts team. Accounting ledger and accounts payable entries reviewed including to ensure accurate coding to support reporting as well as VAT recovery. Associate Director of Finance (Accounting and Governance) is member of national Technical Issues Group where implications of accounting policy, accounting standard and HMRC legislation changes are discussed. Associate Director of Finance (Accounting and Governance) is member of NENC provider network who meet quarterly to discuss technical accounting issues and share learning / best practice.
									?	9.02 Provider Licence	Board certification processes undertaken by the Company Secretary. Delivery of related by policies by operational and corporate departments. Commissioning of external governance reviews, preparation of evidence for and support by the ACE and Co Sec. Delivery of improvement plans by designated leads.
									?	9.03 Environmental Sustainability	EFM Teams maintain day to day BAU with Directorate Management Team (DMT) maintaining routine operational oversight, including at their formal monthly DMT meeting



? 9.04 Statutory Financial Duties and NHS Oversight Framework (Health and Care Act 2022)	Annual plan prepared through arrangements under the responsibility of the DoFEF and with EDG oversight and to agree plan parameters / integrated planning processes to recommend to Board / Committee Processes overseen by the Associate Director of Finance (Financial Management) for detailed bottom up annual planning / budget setting and for financial reporting / forecasting, including for related budget holder processes and Care Group / Directorate sign off The Trust's financial plans set our planned performance relative to statutory break even duty, with performance against plan monitored and reported monthly to ensure responsive mitigations and performance within agreed Trust plan parameters - delivery of quarter end positions relates to NOF metrics. Standing Orders and SFIs set out respective controls and delegated financial responsibilities
? 9.05 Compliance with the CQCs Fundamental Standards of Quality and Safety	Day to day delivery of the fundamental standards by ward and team staff. Responsibility for delivery of each element of the CQC Action Plan. designated to lead Directors. Chief Nurse is the lead Executive for relationship management with the CQC.
? 9.06 Compliance with Mental Health Legislation (MHL)	Delivery of the requirements of MHL by clinicians, admin and managers. Operational meetings established from April 24 to identify any issues with external partner organisations.
? 9.07 Equality, Diversity, Inclusion and Human Rights	The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery. EDIHR Lead and officers: ? Provision of support for inclusion networks. ? Compilation of Equality Act 2010 data. ? Compilation of evidence and consultation on the EDS. ? Support for the development of the Trust's equality objectives Designated managers/leads: ? Completion of equality analyses ? Delivery of actions under the EDS All staff are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision. Public Health Consultant engaged to develop the Trust's approach to tackling health inequalities.



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

BAF 10 - Roseberry Park

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk that the necessary Programme of rectification works at Roseberry Park and impacted by limited access to capital funding could adversely affect our service quality, safety, financial, and regulatory standing.	Board of Directors Executive Lead : Director of Finance & Estates Strategic Goal(s) : 01 - Co-create High Quality Care 02 - Be a Great Employer 03 - Be a Trusted Partner	16	12 Date to achieve target : Mar 2032	12	Financial and Business Risk Appetite : 2 - Cautious Risk Tolerance : 12		Jun 2026		?	10.01 Roseberry Park Rectification Programme	Programme Director and Programme Manager – Responsible for managing the RPRP including key risks and issues log (Assurance to weekly huddle)
									?	10.02 Capital Programme	Trust CPSG overseeing agreement of priorities for capital investment / impact assessment. DMT overseeing detailed milestone capital project planning. RPH huddle to ensure regular project and performance reporting for scheme via Programme leadership and supported by Drivers cost advisers.
									?	10.03 External Audit	DoFEF and Associate DoF (Accounting and Governance) meetings with external auditor to brief ahead of audit and as any significant transactions / changes identified.

BAF 11 – Financial Sustainability

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk that constraints in real terms funding growth caused by government budget constraints and underlying financial pressures could adversely impact on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing	Finance and Performance Committee Executive Lead : Director of Finance & Estates Strategic Goal(s) : 01 - Co-create High Quality Care 02 - Be a Great Employer 03 - Be a Trusted Partner	20	20 Date to achieve target : Mar 2029	12	Financial and Business Risk Appetite : 2 - Cautious Risk Tolerance : 12		Jun 2026		?	11.01 ICB Financial Governance	DoFEF member of ICS DoF/CFO group. DoFEF member of ICS Resource Allocation Steering Group seeking to optimise system allocations (incoming) and equitable distribution of new allocations (outgoing) CEO member of NENC provider leadership board (CEOs). CEO member of HNY provider collaborative work for MHLDA. TEWW Director of Strategy and Transformation (and CNTW DoF) leading Provider Collaborative work to ensure robust alliance arrangements / ensure escalation of provider resourcing issues to PC Board
									?	11.02 Executive Directors Group	Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of underlying financial position
									?	11.03 Business Planning and Budget Setting Framework and in year financial forecasting & recovery	DS&T is responsible for the delivery of the Business Planning Framework. DoFEF and EDG are responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers. Interim Managing Director (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. (Reporting into EDG with assurances into R&PC and Board).

BAF 12 - Transformation

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk that failure to ensure we have the capacity and capability to scope and deliver a Trust-wide programme of transformation, realise and evidence anticipated benefits, will mean we do not deliver on the Trust ambition to impact positively on the mental health and wellbeing of our local populations	Finance and Performance Committee Executive Lead : Executive Director of Transformation and Strategy Strategic Goal(s) : 03 - Be a Trusted Partner	16	12 Date to achieve target : Mar 2028	12	Financial and Business Risk Appetite : 2 - Cautious Risk Tolerance : 12		Jun 2026		?	12.01 Review of Trust-wide transformation portfolio (content, governance, delivery/impact).	Engagement with Operational and Corporate teams to review Transformation workstream delivery.
										12.02 Development of future Trust-wide transformation portfolio:	Engagement and horizon scanning activities of national policy, guidance and transformation expectations. Assessment of capacity and capability to deliver necessary transformation alongside development of the above.
										12.03 Delivery of Transformation Portfolio	Transformation governance established (Programme Boards for each Transformation shift, Oversight Group, reporting to EDG)

BAF 13 - Public Inquiry

Risk Description	Oversight Committee	Current Risk Rating	Target Risk Rating ↓	Risk Tolerance	Risk Appetite Category	Overall Control Effectiveness	Control Effectiveness Date	Control Effectiveness Trend	Ind CE	Control & Assurances	First line of Assurance
There is a risk that the Public Inquiry, as announcement on 11th December 2025, may affect capacity to maintain effective organisational and service levels at the current rate and impact on the confidence of patients which may cause them to delay accessing care, support and/or treatment.	Board of Directors Executive Lead : Chief Executive Strategic Goal(s) : 01 - Co-create High Quality Care 02 - Be a Great Employer 03 - Be a Trusted Partner	4	4 Date to achieve target : Mar 2028	5	Regulation Risk Appetite : 1 - Minimal Risk Tolerance : 5	Reasonable	Jun 2026		●	13.01 Maintenance of organisational and service performance oversight	Monthly Performance Review reports; IQPR metrics; Directorate performance reviews; Waiting time, quality and operational KPI reporting
										13.02 Executive capacity and organisational resilience	Executive workload monitoring; Public Inquiry programme reports; Executive action logs; Business continuity arrangements
										13.03 Workforce engagement and wellbeing arrangements	FTSU reports; Staff turnover reports; Sickness absence data; Staff grievance reports; Uptake of wellbeing services; Internal staff engagement feedback
										13.04 Stakeholder, partner and patient confidence	Monthly referral trends; Complaints and PALS data; Patient feedback; Community engagement activity reports; Communications metrics

Strategic Risk Map (Including Corporate Risk Tolerance Alignment)

Strategic Risk (BAF)	BAF Score	Appetite	Tol.	BAF Position	Aligned Corporate Risks
BAF 01 - Safe Staffing	16	People (Seek)	12	Above	12 909 Consultant workforce recruitment shortages ● At tolerance 15 1137 Supervision assurance / TEWVision reporting ● Above tolerance
BAF 02 - Access	1	Quality (Cautious)	9	Within	12 1219 CAMHS neurodevelopmental assessment pathway delays ● Above tolerance 15 1259 Neurodevelopmental and ADHD waiting times ● Above tolerance
BAF 03 - Patient Experience	9	Quality (Cautious)	9	At tolerance	-
BAF 04 - Quality and Outcomes	15	Quality (Cautious)	9	Above	15 811 Self-harm, suicide and ligature risks within inpatient services ● Above tolerance
BAF 05 - Digital - Supporting Change	20	Finance (Cautious)	12	Above	12 1535 Inability to provide accurate contract information (CITO issues) ● At tolerance 20 1636 Inaccurate or incomplete patient record displayed on CITO ● Above tolerance
BAF 06 - Estates / Physical Infrastructure	12	Finance (Cautious)	12	At tolerance	-
BAF 07 - Data Security & Protection	20	Finance (Cautious)	12	Above	15 1647 Cyber security vulnerabilities ● Above tolerance
BAF 08 - Partnerships and System Working	16	Finance (Cautious)	12	Above	-
BAF 09 - Regulatory Compliance	8	Regulation (Minimal)	5	Above	-
BAF 10 - Roseberry Park	16	Finance (Cautious)	12	Above	15 219 Roseberry Park design and construction defects ● Above tolerance
BAF 11 - Financial Sustainability	20	Finance (Cautious)	12	Above	15 1792 Delivery of the 2026/27 financial plan ● Above tolerance
BAF 12 - Transformation	16	Finance (Cautious)	12	Above	-
BAF 13 - Public Inquiry	4	Regulation (Minimal)	5	Within	-

RAG Key

Risk Score	Rating
15-25	● Red
8-12	● Amber
4-6	● Yellow
1-3	● Green

Tolerance key

Position Against Tolerance	Rating
Above tolerance	
At tolerance	
Within tolerance	

Summary Tolerance Count

Measure	Count
BAF Risks Above Tolerance	9
BAF Risks At Tolerance	2
BAF Risks Within Tolerance	2
Corporate Risks Above BAF Tolerance	8
Corporate Risks At BAF Tolerance	2

Committee Key Issues Report		
Report date to Board of Directors – 23 September 2026		
Date of last meeting: 03 September 2026	Report from the Quality Assurance Committee (quoracy met)	
	Chaired by Phil Corrigan, Chair of Committee/Non-Executive Director	
1	Agenda - The Committee considered the following matters: • Minutes of meeting held on 02 July 2026 • Action Log • Executive Directors Group Quality and Performance meetings, 28 July and 25 August 2026 • Quality Governance Triple A Report including: CQC Improvement Plan, Quality Dashboard, Quality Risks QAI Programme, Quality Assurance and Improvement Programme and NICE Baseline Assessment Change Requests • Annual Safe Staffing Establishment Review • Patient Safety and Coroners Report • Complaints and Patient/Carer Experience • Learning from Deaths Quarter 1 2026/27 • Positive and Safe Care, Quarter 1 • Medicines Optimisation and Pharmacy (including Drug and Therapeutics Committee) • Health and Justice Services • Quality Visits • Workplan • Outcome of Annual Committee Performance Evaluation	
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, DTVF Services/SIS inpatients - Ridgeway (Ivy Clover, Sandpiper and Kestrel Kite), and CAMHS Crisis and Getting More Help South Durham. Care Group leaders will set timeframes for services exiting SRAS with oversight of impact. There is assurance that wards are sufficiently staffed with no immediate patient safety issues. NorthEast and North Cumbria Provider Collaborative has placed Secure Inpatient Services in enhanced surveillance. This is an area where there is good assurance with regards to systems, processes and oversight. Workforce pressures remain an issue with sickness absence above the Trust target and the national MH Trust average. Workforce improvement plans are in place, which is critical to maintaining service quality, patient experience and timely access to care. Patient flow and delayed discharges continue to represent a pressure impacting on length of stay and service capacity, with sustainable improvement dependent on the wider health and social care system.

		Restrictive interventions within Adult Learning Disability Services continue to require enhanced oversight, although improvement actions are in place. Adult and Older People's Services patient-reported outcome measures remain below expected levels, requiring continued performance improvement and oversight. There is limited assurance on the timelines of final completion of After-Action Reviews and Mortality Part 1 reviews. Limited assurance on the timeliness of the immediate review (within 4 days) of non-patient safety incidents. Reasonable assurance on the timeliness of the immediate review (within 4 days) of patient safety incidents. Actions are in place to improve these positions.
2b	Assurance	The Committee received the following positive assurances: In summary the Committee received assurance that the Trust continues to deliver strong performance across several key quality and safety indicators. Patient and carer satisfaction remain high, clinical outcomes within Children and Young People's Services continue to improve, there were no out-of-area placements and no unexpected inpatient unnatural deaths reported during the period. Robust governance arrangements and improvement plans are in place to address identified performance challenges, including patient flow, sickness absence and workforce pressures. Progress is being made through focused workforce improvement initiatives, enhanced attendance management arrangements and director-led oversight. There is substantial assurance of the timeliness of reporting and allocation of Patient Safety Incident Investigations (PSIIs). Data demonstrates this is actioned within 24 hours of reporting. There is good assurance demonstrated through continued improvements with oversight of staffing and e-rostering metrics. There is good assurance that the Trust is fully compliant with the National Quality Board (NQB) Learning from Deaths requirements during Quarter 1 and continues to maintain arrangements for mortality review, investigation and organisational learning. 93.63% of patients reported a positive experience of care and 83.79% of carers reported a positive experience, indicating that most people using Trust services continue to report good experiences of care and support. Patients also reported strong perceptions of safety whilst receiving inpatient care, and outcomes within Children and Young People's Services continue to demonstrate significant improvement. There is substantial assurance of progress against the Medicines Optimisation & Pharmacy Framework and of the responsibilities of the Drug and Therapeutics committee being appropriately discharged in line with the terms of reference.

		Committee has received evidence of improving compliance, with reported supervision compliance increasing compared to the previous year. Staff survey results also indicate that most staff report having opportunities for clinical supervision. Committee noted new and ongoing improvements within prison services, with quality assurance reporting identifying further improvement against established quality standards. Health & Justice Services are also contributing to the Trust's wider co-production and lived experience priorities through joint work with partner organisations and the development of lived experience networks. There has been no use of tear proof clothing since January 2026.
	Advise	The Committee wishes to advise the Board that: The gentleman at Bankfields with complex needs is awaiting discharge. Ebor Ward continues to participate in the Trust's Culture of Care improvement programme, with improvement and coaching activity underway to strengthen patient and staff experience. The ward remains an area of focus due to the level of restrictive interventions reported and ongoing workforce pressures, although assurance was provided that improvement work is progressing and restrictive practice activity is largely associated with a small number of individuals with complex care needs. Following review of other models across the healthcare sector, the organisation will move to an 'opt in' process for the use of Lio on the wards, which will be supported by clear signage, training and briefings. Compliance with post rapid tranquilisation (RT) monitoring requirements remains a focus, particularly physical health observations. Committee reviewed the use of RT and notes that its use is not inherently inappropriate, provided there is clear indication and it is used in line with Trust policy and the importance of understanding the circumstances surrounding individual RT incidents. Significant progress has been made with safety planning, however this needs to be consistently embedded across all services and progress will be monitored by Committee. A multi-professional task and finish group will consider the future positioning of the Board Quality visits. The group will report recommendations to the November 2026 Quality Assurance Committee.
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.
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	Phil Corrigan, Non-Executive Director, Rachel Weddle, Director of Nursing (Care Delivery) Donna Keeping, Corporate Governance Manager

This page is intentionally blank

For General Release

Meeting of:	Board of Directors
Date:	23 rd September 2026
Title:	Board Integrated Quality & Performance Report as 31 st July 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 **62%** of measures achieving good or substantial assurance, a reduction from 66% 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 (the same as last month). 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 no change to the performance assurance levels this month. Key changes to the IPD this month are:

Increased performance assurance (reasonable to substantial)	• Inpatients reporting that they feel safe whilst in our care
Decreased performance assurance (substantial to good)	• Compliance with ALL mandatory and statutory training
Decreased performance assurance (good to reasonable)	• Staff Leaver Rate

Further narrative on the above areas is included in the body of the report.

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

Update:

Following the introduction of the new Bank Expenditure measure in June, which replaced the Use of Resources Rating, this month's report introduces the **Unique Active Caseload** measure. This replaces the previous **Unique Caseload** and supporting **Active Caseload** measures and provides a count of patients on active caseloads who have received a successful direct contact, including face-to-face, telephone, or video consultations. The measure is intended to provide a more accurate reflection of the active caseload within Trust services.

A monthly Performance Review Meeting has been established with operational services to strengthen performance assurance arrangements. The meetings are attended by Executive Directors and Care Group Leads, providing enhanced oversight and challenge for services. They will also provide targeted support for those services identified as requiring additional support. We anticipate the benefits of this approach to become embedded over the next 6 to 9 months.

The NHS Oversight Framework section has been removed from this report and will now be presented to Executive Directors Group as a separate report.

ALERT

Quality - Clinically Ready for Discharge and bed occupancy - At the end of July, 59 patients were clinically ready for discharge but unable to leave due to delays in external care placements and packages. These patients comprised 15.86% of all adult and older adult acute beds, reducing available capacity and contributing to longer lengths of stay. 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.90%, reflecting ongoing system constraints and average lengths of stay remain above planned levels in both adult acute/PICU beds (30.59 days) and older adult acute beds (76.71 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; progress will be shared with Executive Directors Group in August. Actions identified for quarter 1 have been completed, and

work is now underway to identify a meaningful set of metrics and associated targets to support continued improvement. 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 the Performance Improvement Plan for children's eating disorder waits will be shared with Executive Directors Group in August. 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 1,056 restrictive interventions recorded in July, 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 individual 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 for the team. The Trust

commissioned an independent peer review by Mersey Care NHS FT to advise on any further improvement actions that could be taken. In addition, we have sought support from CNTW around positive and safe support. Executive oversight is in place, escalated plans have been agreed, and the ICBs and local authority are 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 6.90%, and higher than the national 5.7% average for mental health trusts, contributing to workforce pressure and impacting service delivery. The planned decrease in North East Yorkshire for sickness absence (12-month rolling) is to reach 5.1% by March 2027 and 4.8% by March 2029; The sickness absence national average rate Mental Health & Learning Disabilities Trusts for July is 6%. The director-led sickness review process has continued across identified services, with repeat reviews taking place in a number of teams. Some reviews have provided evidence that managers are actively managing both short and long-term absence, including completing extended return-to-work discussions, issuing formal warnings where appropriate, obtaining occupational health input and supporting planned returns to work. Several teams have reported no current sickness or reductions in absence, although it is too early to attribute changes in sickness levels directly to the review process. Other reviews are identifying areas requiring further support and follow-up. These include inconsistent completion of return-to-work discussions, missed opportunities to progress cases, delays or difficulties accessing staff support, and the need to maintain accurate management information. Actions are being followed up with individual managers, with repeat reviews providing a mechanism to check progress and strengthen the consistency of sickness management across services.

- **Action / Mitigation:** A focused improvement plan to reduce Trust sickness levels has been developed and all actions for quarter 1 have been completed.
 - 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 oversight and support processes are being embedded
 - Monthly Director-led sickness review meetings in adult mental health services and in People & Culture (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 and have given early indications of much better assurance eg notable increases in post panel audit.
 - 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; 60% (476 of 799) of line managers have undertaken the training to date.
 - The Bereavement and Compassionate Leave provisions have been reviewed and are currently under consultation requirements.

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) - Whilst financial performance remains favourable plans assume delivery of higher levels of recurrent efficiencies than are presently being achieved, which presents delivery risk. The Trust’s £27.7m Cash Releasing Efficiency Savings (CRES) programme needs to deliver (and recover year to date recurrent under delivery) stepped reductions in temporary staffing costs, most

notably in respect of bank staffing. Group agency expenditure was £213k over plan at month 4, this incorporates:

- £589k subsidiary agency costs, which were £325k above plan.
- £178k costs relating to specific care requirements at Bankfields Court, our Assessment and Treatment unit for Adults with a Learning Disability, which necessitated 'break glass' approvals of non-compliant Band 3, price cap and framework breaching agency shifts from Month 3 onwards (ongoing). The Board has been briefed privately on related issues and actions.

Trust bank costs were £902k above plan. Plans to achieve stepped cost reductions were approved at the beginning of July.

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) with year to date costs for those two patients exceeding £610k, 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 achievement of transition to an ICB-commissioned 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 Group has overseen the rigorous control of agency staffing and overtime. Its remit has expanded to incorporate oversight of recently approved bank reduction plans, with a revised Terms of Reference, and renamed the Reduction of Flexible Staffing Group.
 - A Subsidiary agency reduction plan has been requested, noting that costs to date reflect a period of recruitment for a newly commissioned package, and are not expected to continue to the same extent.
 - Collaboration with ICB Commissioners and across clinical teams and Executives is ongoing to secure the safe transition of an Adult Learning Disability patient to alternative care provision. On transition agency staffing will be stepped down.
 - 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.
 - On 10 July an informal sustainability and transformation event was held which discussed the opportunities for examining service configuration, including "left shift" opportunities. There will be further STP workshops on 8 October and 2 December. The latter will include presentation and discussion of CRES plans for 2027/28 and also broader financial sustainability plans.

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.

Finance & Resources – Capital Allocation – The Trust's capital expenditure for the year to date was £4,718k, which is £687k lower than the Trust's capital allocation plan to date.

Forecast annual expenditure of £15,146k is £2,251k higher than revised allocation (allocation was increased linked to last financial year's better than planned revenue position). Changes in the timing of expenditure relating to Phase 2 works at Roseberry Park Hospital account for the year-to-date underspend, the contractor cashflow reflects increasing costs from Month 5.

The forecast overspend against revised allocation reflects the overcommitment at plan exacerbated by in-year pressures, despite confirmation of additional funding in-year.

- **Action / Ongoing Assurance:** Capital Steering Group is informed and aware of the current risk in the 2026/27 capital programme and the necessity to take corrective actions in year. Trust lifecycle works and elective works have been tightly controlled to date however further savings or capital receipts are required to ensure the Trust stays within allocation, or is able to attract additional funding.

National Priorities – Average lengths of stay, Talking Therapies outcomes and Child Eating Disorders – Performance against several national priorities remains below expected standards at Trust level. Average length of stay for both Adult Acute/PICU (30.59 days) and Older Adult Acute services (76.71 days) continues above plan, primarily due to delays in discharging patients who are clinically ready for discharge. In Talking Therapies, Reliable Improvement and Reliable Recovery remain below national standards, reflecting ongoing capacity pressures and increasing patient complexity. Performance against Children and Young People's Eating Disorder waiting time standards (rolling 12-month position) remains below the 95% standard, despite improved performance during July.

- **Action / Ongoing Assurance:** Recovery plans remain in place across all areas, with a revised Talking Therapies Outcomes Improvement Plan being presented to Care Group Board in August; however, it is important to note, that whilst a number of improvement actions have been completed, we may not see the positive impact until April 2027. The CEDs Improvement Plan being presented to EDG in August and the Improvement Plan for Clinically Ready for Discharge should support improvements in average length of stay with actions focused on reducing discharge delays particularly within MHSOP.

ADVISE

Quality – Adult & Older Persons Outcomes - The Outcomes paper presented to the Executive Directors Group (EDG) in June proposed the transition from the two existing outcome measures to four service-specific measures. Business Intelligence has subsequently confirmed that the necessary system and reporting developments can be completed by the end of September 2026 and EDG have approved the progression of this work to support implementation of the revised measures and associated reporting arrangements.

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 but reducing proportion of unused training capacity for some courses. Performance assurance this month has decreased from substantial to good, as we have one underlying area 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. However, this is the national annual survey. In the quarterly Pulse Surveys, we are well above national average in engagement levels and scores on the pulse factors

- **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 patients are detained at roughly twice the rate as white people which is similar to the national picture, indicating potential racial and socio-economic inequalities in health risk, timely access to support, 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. A performance improvement approach 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 a bank EDI officer) to support the Patient & Carer Race Equality Framework (PCREF) work. The EDI work will include comprehensive community engagement and improved governance of these metrics. While these efforts are in early stages, Board of Directors is advised that addressing inequality is recognised as a strategic priority, with tangible actions in development to ensure all population groups receive equitable, effective care.

A sickness to prevention programme board has been established and is overseeing the delivery of the trust inequalities and prevention plan which includes workstreams on data use and improvement, PCREF, addressing non-attendance and disengagement, expansion of mental health in schools teams. It also includes development of prevention priorities in partnership across dementia, neighbourhood health and suicide prevention. As part of this work locality profiles are in development to improve understanding and use of population health data to inform service planning and response and to increase understanding of the drivers of inequality and of the context in which services are delivered. These will be presented to Board in September and developed further at neighbourhood level commencing with areas where neighbourhood mental health approaches are being developed. The Sickness to prevention Programme Board reports on progress via the Five-Year Plan Oversight Group through to Executive Directors Group and Resources & Planning Committee.

ASSURE

Clinical Outcomes - CYP Measurable Improvement - CYP clinical outcomes continue to provide strong assurance, with both patient-reported and clinician-reported measures remaining significantly above target and demonstrating sustained improvement. Both measures show special cause improvement at Trust and Care Group level, demonstrating the improvement work that has been undertaken within services and indicating that improvements are being sustained.

- **Action / Ongoing Assurance:** Sustained performance above target, alongside evidence of special cause improvement, provides the Board of Directors with assurance that CYP services are delivering positive and measurable clinical outcomes for children and young people. Work is continuing to strengthen the outcomes framework through the inclusion of patients transitioning between CYP and Adult Mental Health Services, ensuring that future reporting provides a more comprehensive assessment of treatment effectiveness.

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 July, 94% of patients rated their service experience as “very good” or “good”, a result above our 92% standard and above the 89.8% national average, placing us among the top performers nationally (16th 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 82.9% of carers felt actively involved in care decisions, surpassing the 75% target, and we are focussing on the percentage of people who report they feel safe in our care, which reports 75.3% in line with the 75% standard, with the development of a Trust-wide feeling safe programme. The number of moderate or severe harm incidents (30 in July) was also within expected range. In addition, clinical outcomes remain particularly strong for CYP services with both the patient-reported outcomes (68.8%) and clinician-reported outcomes (62%) reporting above standard, and a sustained improvement in the rate of paired outcomes.

- **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 Care Groups have agreed an Urgent Care Feeling Safe Task and Finish group to focus on improving patients' experiences of feeling safe across Adult Mental Health inpatient services, with a multidisciplinary Feeling Safe working Group overseeing delivery. Improvement priorities will be agreed collaboratively following review of baseline information. 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; 5 PSIs reported on Steis and 1 medication-related moderate or severe harm incidents. There was 1 unexpected inpatient death in July, for which a comprehensive multi-disciplinary after-action review is underway and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation will be completed.

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

Quality – 72 hr follow up, and out of area placements - key national access standards are being met, providing confidence in critical areas of patient care. The Trust continues to reliably deliver on its 72-hour follow-up after inpatient mental health discharge and 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. 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 10.5%. Although there was an increase in the number of leavers during July, this is currently understood to reflect the latest phase of the Mutually Agreed Resignation Scheme (MARS). The position will continue to be monitored closely to determine whether this increase represents an emerging trend; however, there is no initial evidence at this stage to suggest that the rise has continued. There is sustained compliance in appraisals (90.3%) and mandatory training (92.5%) indicating improving workforce stability and capability, noting that the Medical Directorate is reporting special cause concern for training, for which targeted actions are underway to achieve compliance by the end of September 2026. We are continuing to achieve the standard and have made maintained the number of mandatory training courses below the 85% standard (6 courses).

- **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 – July performance – The Trust’s financial position to July provides generally positive performance assurance including in respect of delivering planned aggregate efficiency savings. Group revenue performance was £2.0m better than plan, which incorporates an unplanned £1.3m income flow supplemented by continued robust financial management. With the exception of a care package at Bankfields Court, underlying Trust agency staff expenditure has maintained a clear downward trajectory, the number of agency shifts having reduced by 48% over the last 12 months. The improvements result from deliberate measures (e.g. enhanced bank staffing and strict approval for agency and overtime premium rate shifts) 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 planning activities to target additional bank staff cost reductions from Quarter two (reasonable assurance on delivery).

Finance & Resources – July Cash Balances - Cash balances of £56,885k were £7,358k higher than planned in July and reflect higher than planned trade payables, and the receipt, in late 2025/26, of nationally unearned deficit support funding which was allocated to the Trust in March. Whilst we forecast maintaining higher than planned cash balances in 2026/27, we project reducing balances over the medium term since capital requirements exceed annually self-financed capital cash funding from depreciation, with reducing cash detrimentally impacting liquidity. Even if the Trust achieves revenue breakeven over that period, capital requirements would deplete cash balances (subject to the Trust securing access to CDEL (capital allocation) to service its requirements). If Strategic Capital is allocated (e.g. Estates Safety Fund), the impact on cash would be mitigated to an equivalent extent. Allocations beyond 2026/27 remain unclear for strategic regionally allocated capital.

- **Action / Ongoing Assurance:** Favourable cash balances reflect higher than planned trade creditors which are expected to reduce during the year, and receipt of nationally unearned 2025/26 deficit support funding in March 2026. Cash balances are projected to remain above plan.

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. The report uses a formal Data Quality Assessment framework, which assesses robustness, source, reliability and audit arrangements for Board measures, and data quality assessments are undertaken routinely and refreshed through formal committee governance. 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.

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 July 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		37
5	Finance		40
6	Access to Services	- Waiting Times Dashboard – National Waiting Times Measures - Waiting Times Dashboard - Local Waiting Times Measures - Waiting Times <i>by Exception</i>	49 50 51 52
7	Population health, prevention and reducing inequality		58
8	Care Group	- Durham, Tees Valley & Forensic Care Group – Overview - North Yorkshire, York & Selby Care Group - Overview	63 64 66
9	National metrics	- National Quality Requirements - Mental Health Priorities – Provider and System-wide Plans - Mental Health Priorities – System-Wide Plans	68 69 75 79
10	Benchmarking		91
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	93 94 95 96 97 98

1. Executive Summary

Governance forum responsible:
Executive lead:

Executive Directors Group
Alison Smith, Chief Executive

Overall assurance

remains positive, with strong controls assurance across the majority of quality, activity and financial metrics. 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. Performance improvements are evident in a number of quality indicators, particularly patient safety, patient experience and outcomes for children and young people.

Patient flow: continues to represent the Trust's most significant operational and financial challenge. There were 59 patients clinically ready for discharge at the end of July, accounting for 15.86% of acute mental health bed capacity and contributing to an estimated annual cost pressure of £21.5m. Whilst system-wide improvement work is progressing, sustainable improvement remains dependent on wider health and social care capacity.

Workforce: remains a key enabler and constraint. Sickness absence increased to 6.90% and continues above target, impacting operational delivery across a number of services. However, mandatory and statutory training compliance remains strong at 92.54%, appraisal compliance remains above 90%, and staff turnover remains below the Trust threshold at 10.5%.

Patient quality & safety: remain strong overall, with patient experience (93.58%), carer involvement (82.89%) and inpatients feeling safe measures (75.26%) all above target. There continues to be no out-of-area placements. However, July saw 5 PSIs reported on STEIS, 1 unexpected inpatient unnatural death, and continued high levels of restrictive interventions within Adult Learning Disability services, requiring ongoing executive oversight.

Service transformation and improvement: progress continues across key recovery programmes, including clinically ready for discharge, workforce, neurodevelopmental services, talking therapies and patient safety. A number of actions are now evidencing early improvement, including reductions in bed occupancy, improvements in patient safety and stronger clinical outcomes within children's services.

Clinical outcomes: remain positive for CYP Services, with both PROM (68.75%) and CROM (61.97%) measures remaining well above target and demonstrating sustained improvement. Adult and Older People's PROM remain significantly below target (43.57%) and continue to require focused improvement through implementation of the new outcomes framework.

Access & demand: demand continues to exceed available capacity across several services, particularly neuro pathways, Talking Therapies and EIP. Waiting time recovery plans are in place; however, workforce availability, vacancies and increasing complexity continue to affect service performance. The York & Selby EIP service remains an area of particular focus despite recent recruitment progress.

Inequalities and data quality: partial assurance remains due to limitations in ethnicity recording and wider data quality challenges, which restrict understanding of variation in access, experience and outcomes. Analysis continues to demonstrate inequalities relating to deprivation, ethnicity and Mental Health Act use, with improvement plans progressing through the PCREF and wider population health programmes.

Financial position: remains positive, with the Trust reporting a year-to-date surplus position £2.0m better than plan and continuing to outperform planned efficiency delivery. Financial sustainability remains dependent on delivery of the £27.7m efficiency programme, reducing bank expenditure, and addressing ongoing cost pressures associated with independent sector beds and patients clinically ready for discharge.

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%	93.58%	93.62%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	82.89%	83.52%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	75.26%	75.25%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	68.75%	67.79%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	43.57%	45.23%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	61.97%	61.66%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician	QAC			30.00%	26.93%	28.01%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	88.95%	88.77%	

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				15.86%	15.86%	
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				5	7	
12)	The number of Incidents of moderate or severe harm	QAC				30	85	
13)	The number of Restrictive Interventions Used	QAC				1,056	4,387	
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				1	2	
15)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				1	1	
16)	The number of uses of the Mental Health Act	MHLC				363	1,352	

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 is being shared with Resources & Planning Committee for approval.

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%	52.58%	52.49%	
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	60.24%	60.03%	
19)	Staff Leaver Rate	PCDC			11.00%	10.50%	10.50%	
20)	Percentage Sickness Absence Rate (month behind)	PCDC			5.50%	6.90%	6.66%	
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC			85.00%	92.54%	92.54%	
22)	Percentage of staff in post with a current appraisal	PCDC			85.00%	90.35%	90.35%	

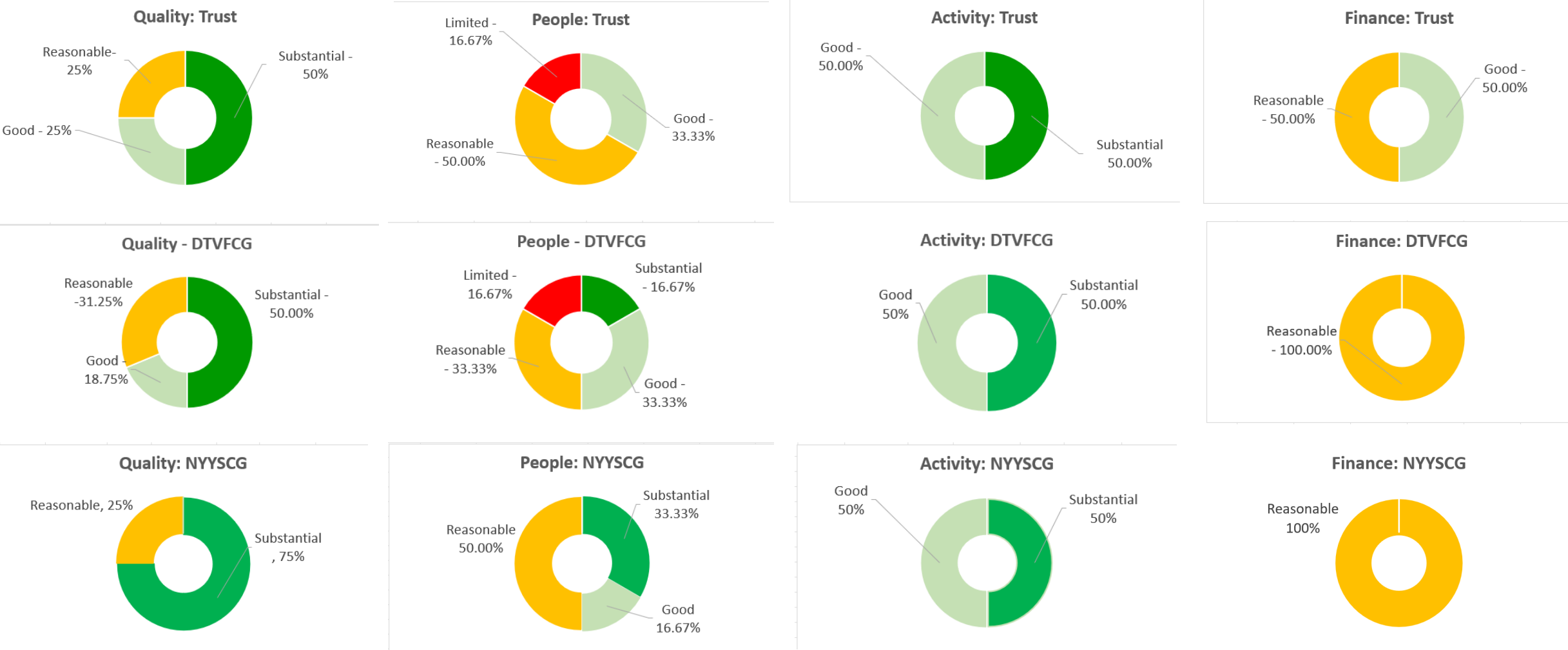
Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
23)	Number of new unique patients referred	RPC				8,431	32,615	
24)	Unique Active Caseload (Snapshot)	RPC				47,917	47,917	

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	1,746,992	-285,815	
26)	Agency Expenditure	RPC	1,771,000	1,984,349	
27)	Agency price cap compliance	RPC	67.00%	26.50%	
28)	Bank Expenditure	RPC	4,552,000	5,453,739	
29)	CRES Performance - Recurrent	RPC	5,299,998	4,955,635	
30)	CRES Performance - Non-Recurrent	RPC	2,535,999	3,776,198	
31)	Capital Expenditure (CDEL)	RPC	5,405,000	4,718,000	
32)	Cash against plan	RPC	49,527,000	56,885,057	

Please Note: 24 Unique Active Caseload and 28 Bank Expenditure do not have a Data Quality Assessment rating as they new measures. These will be completed as part of the updated Data Quality Assessment ,which is underway and will be presented to Resources & Planning Committee for approval in September 2026.

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

** These can be very low numbers for some services, meaning relatively small movement in the data can result in changes to variation.

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 July, 1231 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, 1,152 (93.58%) 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

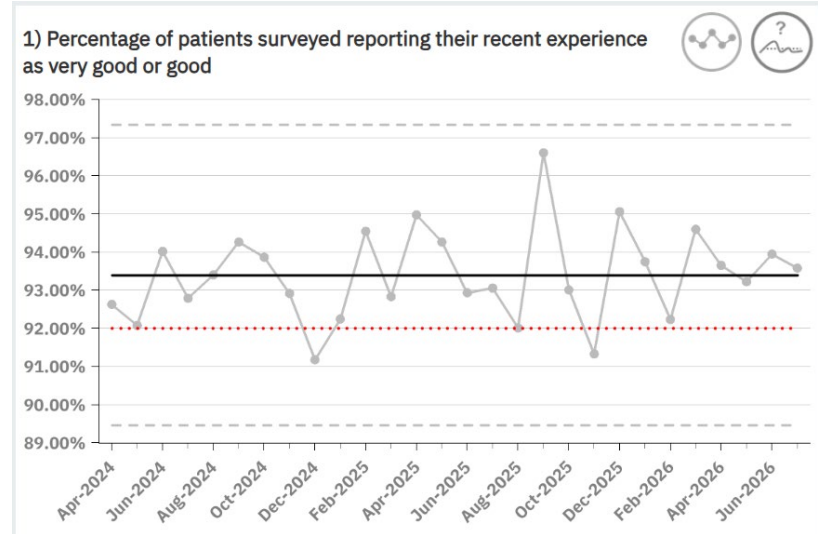
The latest National Benchmarking data (May 2026) shows the England average (including Independent Sector Providers) was 89.76% and we were ranked 16 out of 66 trusts (1 being the best with the highest ratings). We were also ranked 2nd for total number of responses received.

Underlying issues:

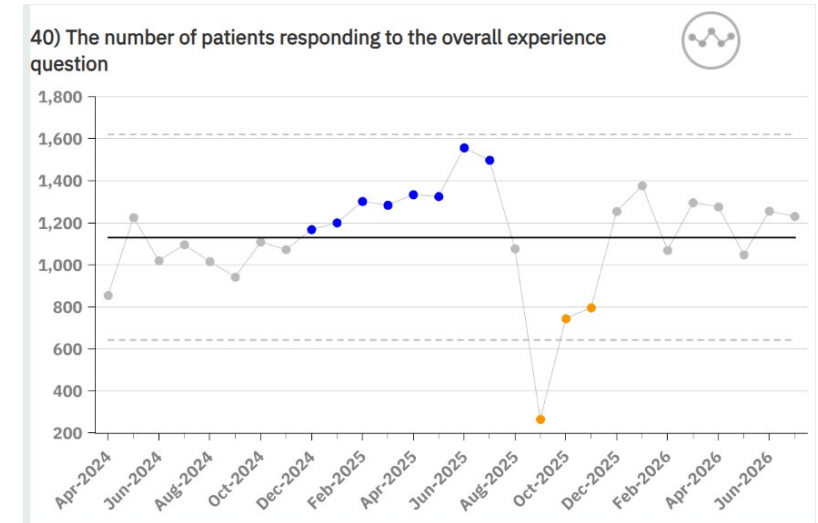
There are no underlying issues to report.

Actions:

There are no specific improvement actions required.



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 July, 380 carers responded to the question in the carer survey: Question: “Are you offered choices about the care being provided?”. Of those, 315 (82.89%) scored “yes”.

There is special cause improvement at Trust and Care Group level and for Adult Learning Disabilities and Adult Mental Health in both care groups.

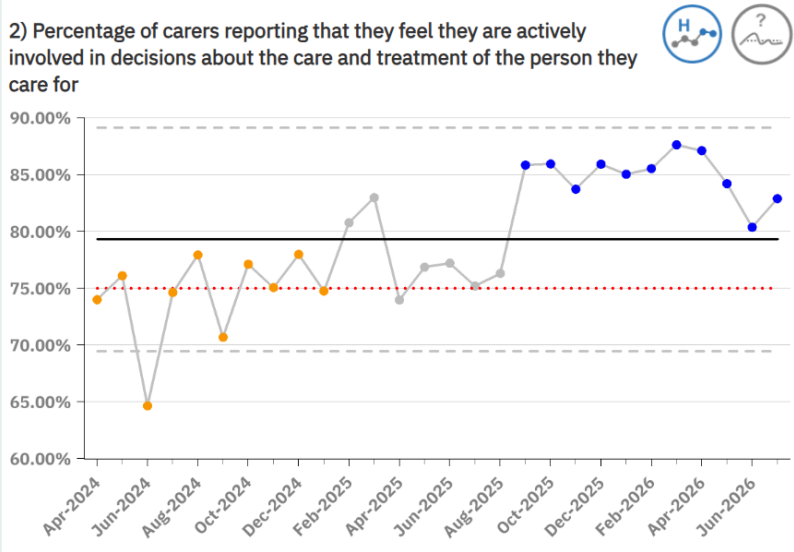
There is special cause concern in the number of patients who have responded to this question at Trust level, for North Yorkshire, York & Selby Care Group, and for Children & Young People in DTVFCG. There is no significant change for Durham, Tees Valley & Forensic Care Group. There is special cause improvement for Adult Mental Health in DTVFCG and for Adult Learning Disabilities within NYSCG.

Underlying issues:

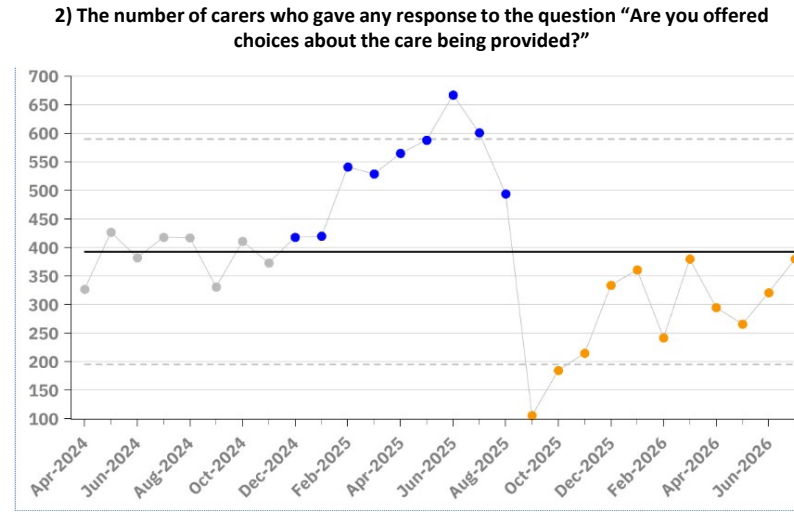
The number of carer responses remain a concern within CYP in DTVF.

Actions:

- Following circulation of the Triangle of Care action plan, Associate Directors of Nursing will ensure recommendations from the Carers Trust feedback report are aligned to specialty-specific workstreams and provide an initial progress update by the end of October 2026, with quarterly reporting thereafter to demonstrate implementation of all agreed actions by the end of June 2027.
- DTVFCG CYPS were exploring alternative approaches to help increase response rates, including the potential use of volunteers to contact patients post-appointment and actions are to be formalised by end of September (previously June 26).



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



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 July, **190** patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **143 (75.26%)** scored “yes”.

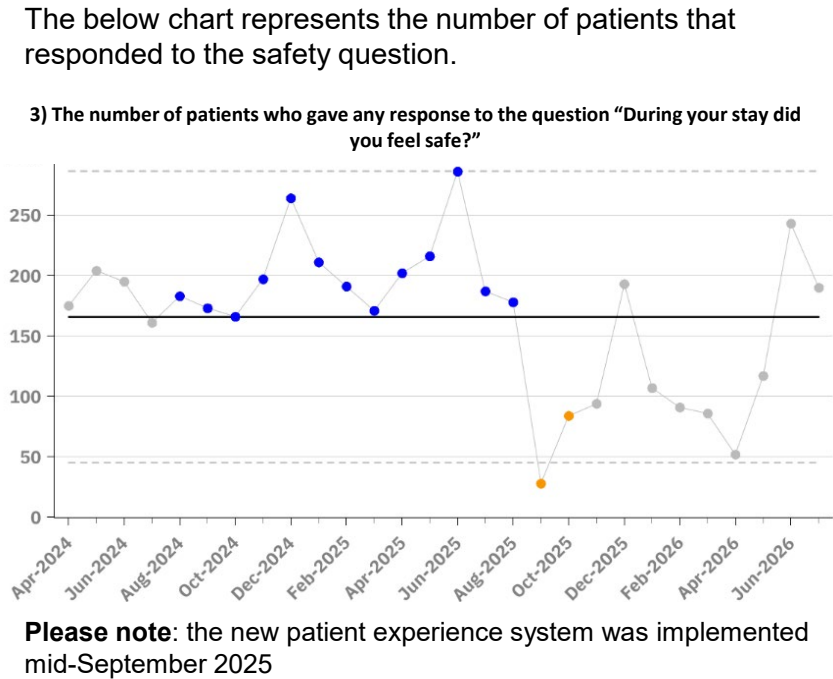
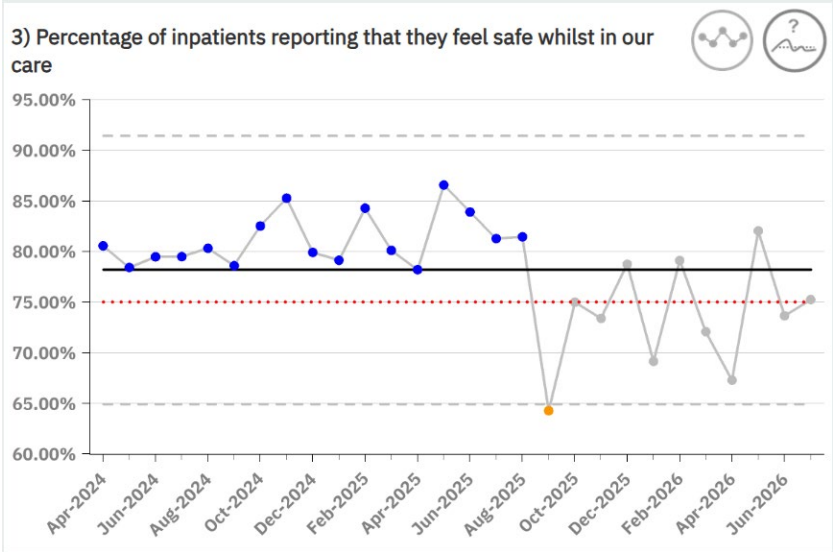
There is no significant change at Trust and Care Group level.

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:

- Draft easy-read paper-based surveys for rollout to inpatient services have been developed by I Want Great Care, with support from the Patient & Carer Experience Team and Learning Disabilities Services; however, further work is required to ensure these are fit for Trust purpose. Timescale to be confirmed.
- AMH Modern Matrons have shared plans to improve the number of responses with the AMH Urgent Care Specialty Governance in July 26. **(Complete)** See action below
- The AMH Urgent Care Governance Group has developed a Trust-wide feeling safe programme, which includes a target of 10 patient surveys to be completed by each ward by end of September 2026.



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 July **960** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **660 (68.75%)** 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.

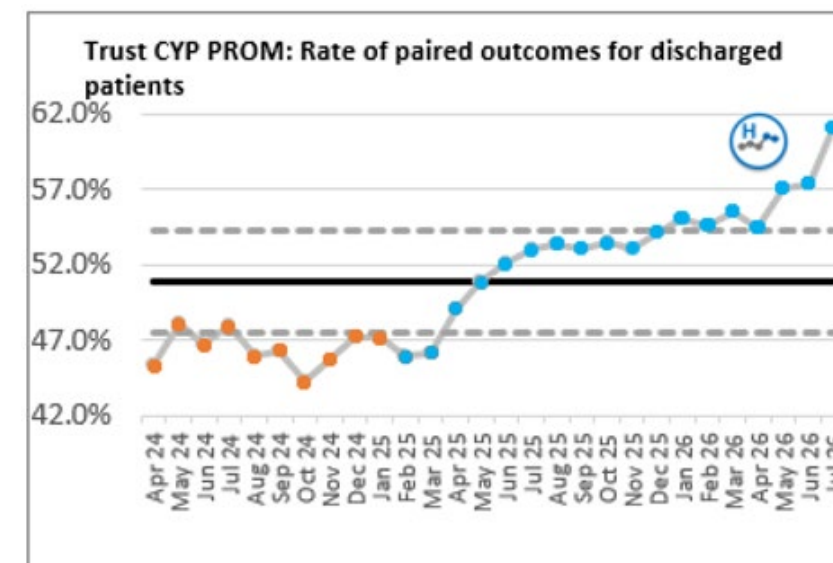
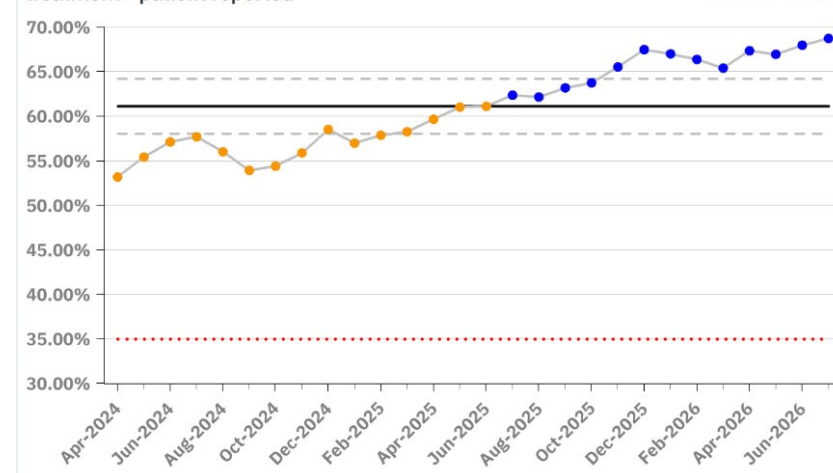
Underlying issues:

- 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. (**This is included within the Trust-wide Improvement Plan*)
- Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV

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. Alternative options will be considered by the end of August 2026.
- 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.

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 July **1508** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those, **657 (43.75%)** made a measurable improvement.

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

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

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

Underlying issues:

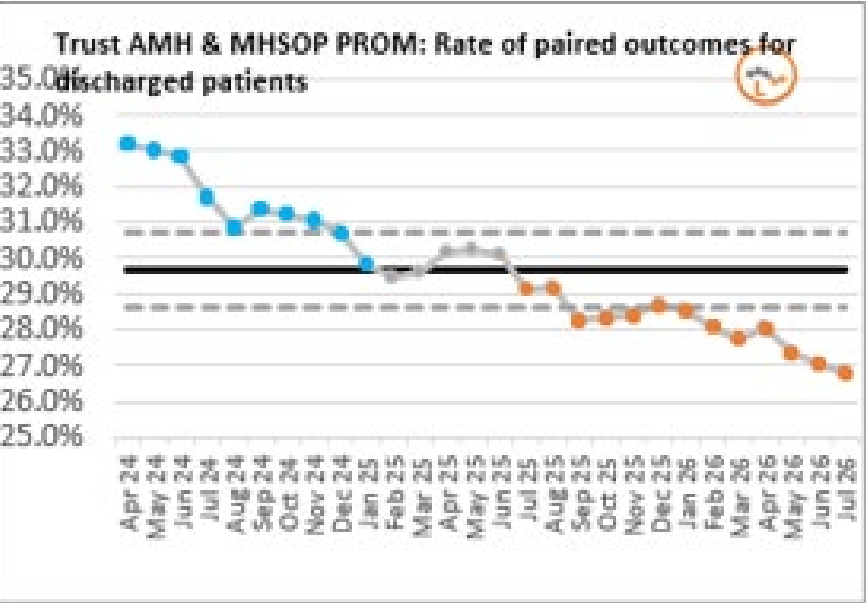
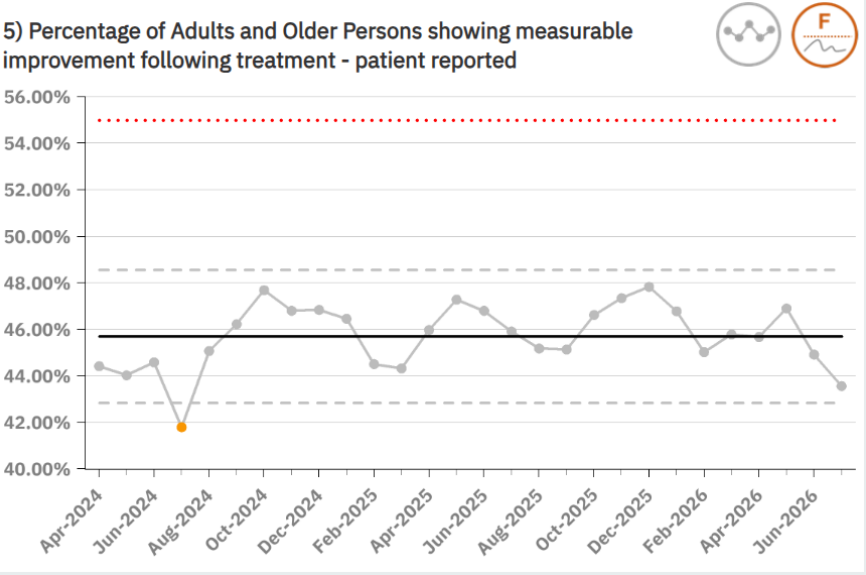
- Within MHSOP, around 30% of discharges currently have a clinically inappropriate or declined PROM status.
- A continued reduction in SWEMWBS based paired outcomes is anticipated as teams transition to piloting GBO, ReQoL-10 and DIALOG with new patients, ahead of planned Trust-wide rollout in September 2026.

Actions:

- A new PROM for organic MHSOP services was approved at the Information Governance Group in June and the pilot will commence on the 1st August (previously 1st July) and run for 6 months.
- Work is planned to update the measure to reflect the new outcomes (GBO, ReQoL-10 and DIALOG), with implementation expected during Q3 2026/27.

To Note:

It has been proposed to split this measure into two new metrics, one for adults and one for older persons, with an anticipated timescale of October 2026 pending EDG approval, noting that the measures will continue to report both functional and organic patients.



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 July **752** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **466 (61.97%)** made a measurable improvement.

There is special cause improvement at Trust level and at 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 level and for DTVFCG. There is no significant change within NYYS CG.

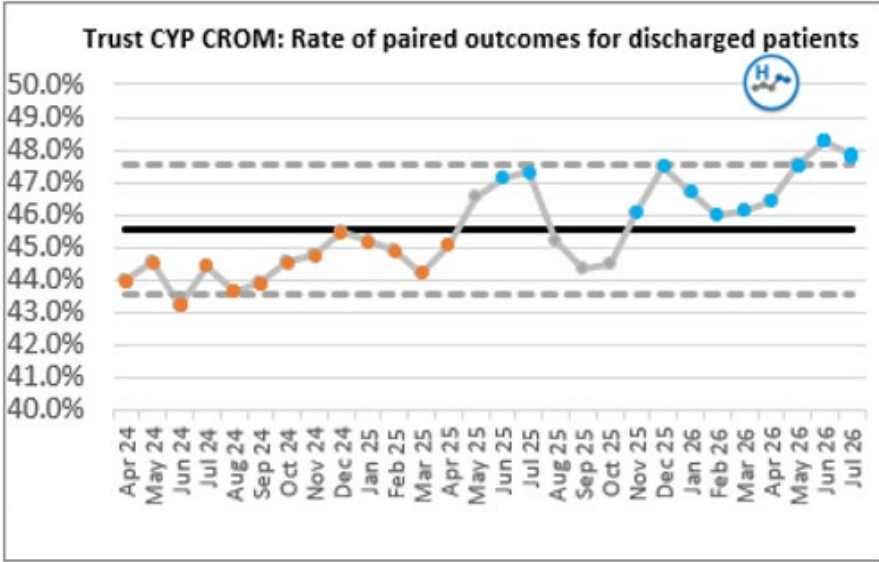
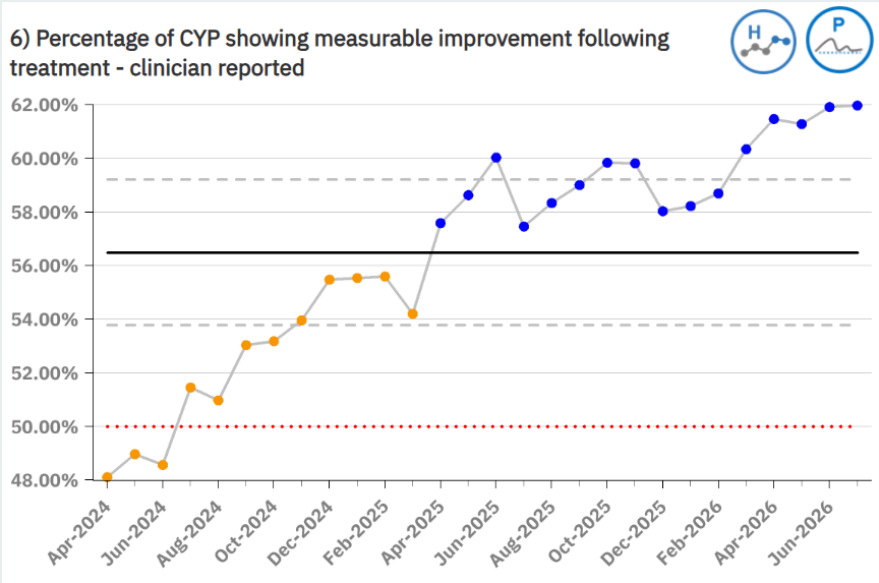
The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

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.



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 July 2,726 patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those, 734 (26.93%) 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, there is cause for concern 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:

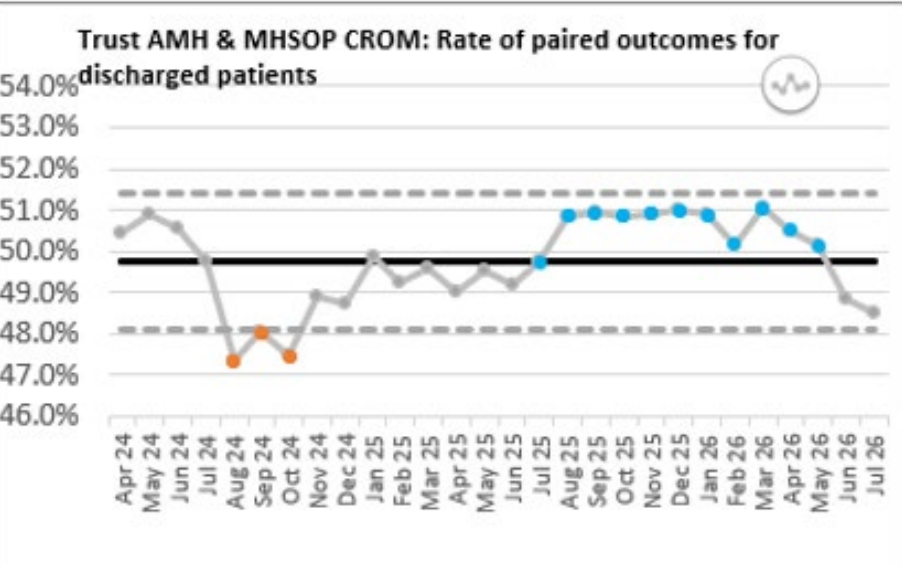
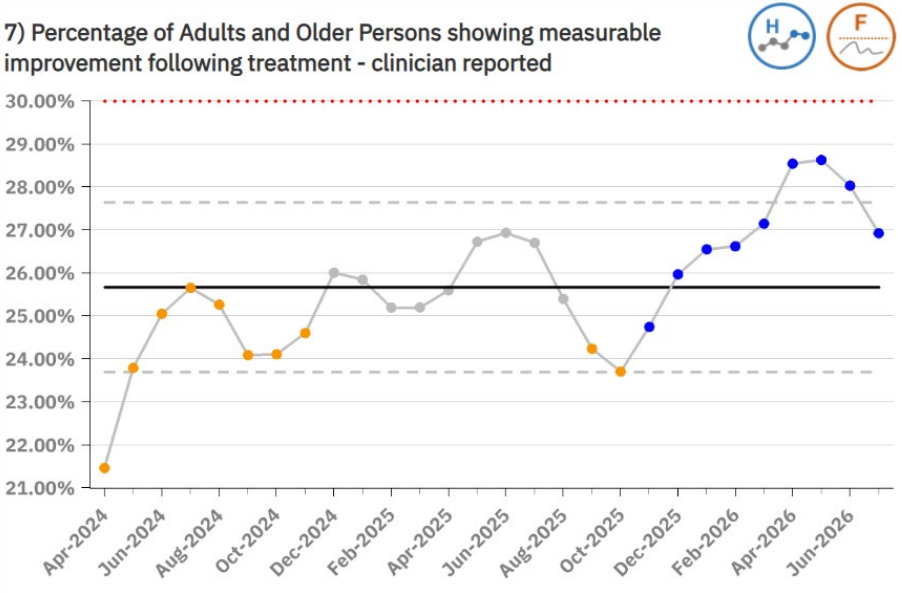
The root causes of the reported performance position have not yet been fully established. A review is in progress to understand the underlying factors and determine whether any mitigating actions are required.

Actions:

Please see underlying issue above

To Note:

It has been proposed to split this measure into two new metrics, one for adults and one for older persons, with an anticipated timescale of October 2026 pending EDG approval, noting that the measures will continue to report both functional and organic patients.



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 July, 11,532 daily beds were available for patients; of those, 10,258 (89.95%) were occupied.

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

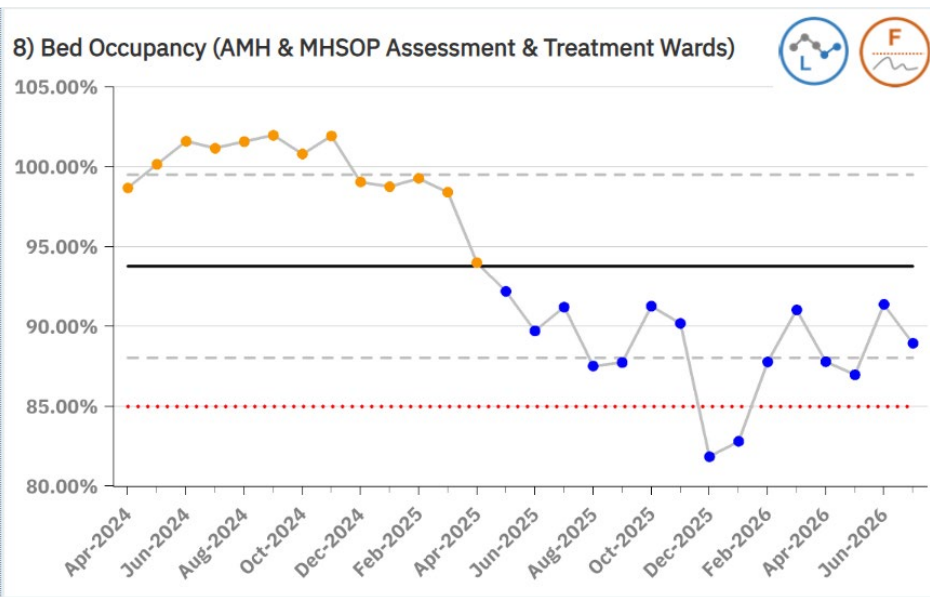
Quality Assurance Committee are fully sighted on bed occupancy and focussed on the potential impact on quality.

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:

- The Director of Operations will complete the design and costing of the Durham Crisis Assessment Centre full business case and present it to EDG by 30 September 2026 to support submission to the NHS England scheme approval panel.
- The Director of Operations will complete the design and site identification requirements for the Scarborough 24/7 Neighbourhood Centre and submit a business case light to EDG by January 2027, with the full business case completed by March 2027.
- The Director of Operations will review and update the draft business case for MHSOP organic beds at Springwood and the development of a 24/7 crisis and care home in-reach/outreach service for the Scarborough, Whitby and Ryedale area, incorporating the implications of the Springwood fire, and submit the revised business case to the Partnerships & Governance EDG once complete. (Closed) MHSOP are looking at what the future model of care will look like for both functional and organic patients Trust-wide and this will be picked up within that piece of work.



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 31st July 2026, there were **59** adults clinically ready for discharge occupying adult MH, older adult MH or PICU beds, accounting for **15.86%** 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.

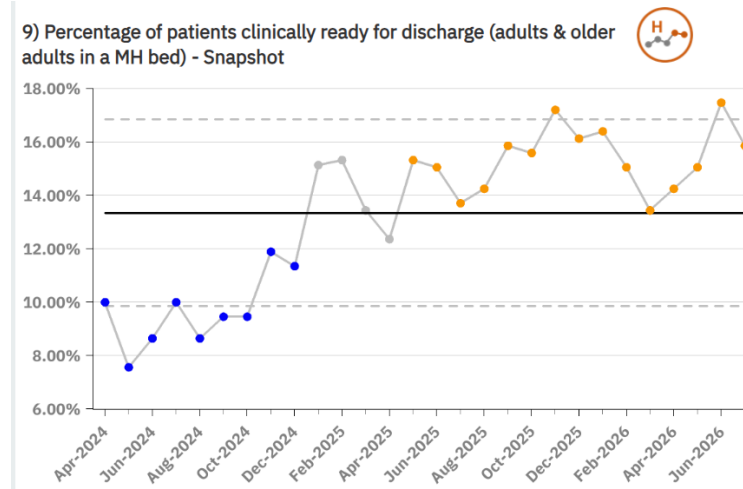
At Trust level, patients classified as Clinically Ready for Discharge during July equated to an average of 74.5 beds across all AMH and MHSOP beds including rehab (37.6 Adult, 4.6 PICU and 32.3 Older Adult beds), with an associated in-month cost of c£1.82m. Of the cost, c£0.82m relates to Adult, £0.24m to PICU and c£0.75m to Older Adult beds. The estimated full cost (not all releasable) of patients classified as Clinically Ready for Discharge in the two specialities over the last 12 months is £21.49m.

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. **(Complete)**
- General Manager for Trust-wide Urgent Care is undertaking a review of the Patient Flow team structure, and a proposal will be shared with Care Group Board in October 2026.
- Both care groups are working closely with system partners to strengthen a system wide approach to supporting those clinically ready for discharge:
 - The first evaluation of the Tees Valley transfer of care hub 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 was delayed. The job description will be completed and evaluated by the end of August 2026.
 - In North Yorkshire recruitment has been delayed for a discharge liaison officer to support patient discharge within adult beds at Cross Lane Hospital. The job description will be reviewed by the job evaluation panel in August (previously July).



Actions (contd.):

- 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. **(Not Complete)** This is being refined following the learning from DTVF Care Group Quality Improvement work and will now be completed by the end of August 2026.
- MHSOP Modern Matrons with Social Care and ICB colleagues were 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 by end of July 2026. **(Not Complete)** Further refinement is underway to ensure consistency across both care groups, with completion due by the end of August 2026.
- Acting General Manager has initiated 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 July 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.

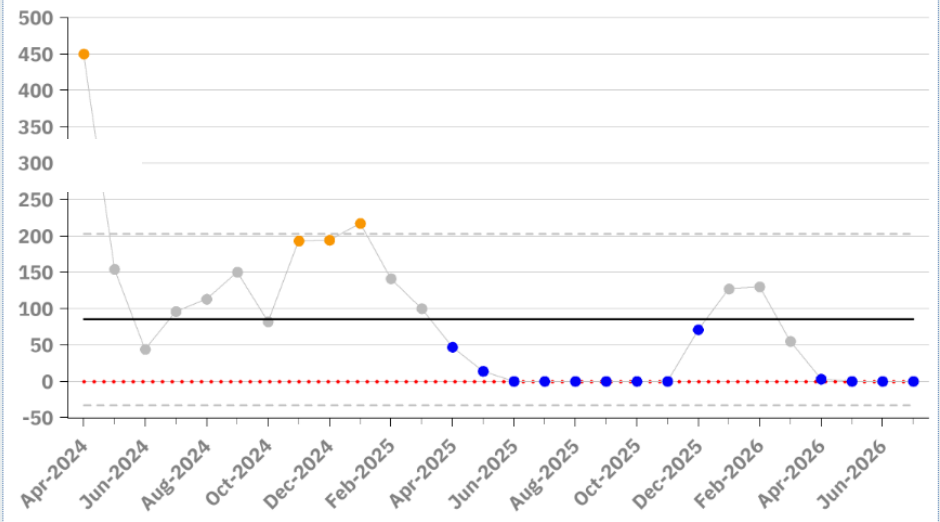
Underlying issues:

There are no underlying issues to report.

Actions:

There are no specific improvement actions required.

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



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

- Within Adult Mental Health, there is some variation across the two Care Groups.
- 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 - July 2026

	Bed Occupancy	CRfD	OAPs	ALOS
Trust	83.86%	12.89%	0	30.59
DTVf	81.48%	13.50%	0	32.66
NYYS	90.11%	11.29%	0	25.85

Mental Health Services for Older People - July 2026

	Bed Occupancy	CRfD	OAPs	ALOS
Trust	96.75%	20.41%	0	76.71
DTVf	97.98%	13.19%	0	74.04
NYYS	94.76%	32.14%	0	82.94

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

What does the chart show/context:

5 Patient Safety Incident Investigations (PSII) was reported on the Strategic Executive Information System (STEIS) during July; 2 occurred in July. The remaining 3 occurred in November, January and May; however, due to a number of unique circumstances they were escalated to PSII based on information gathered through review.

Whilst there is special cause concern at Trust level, 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.

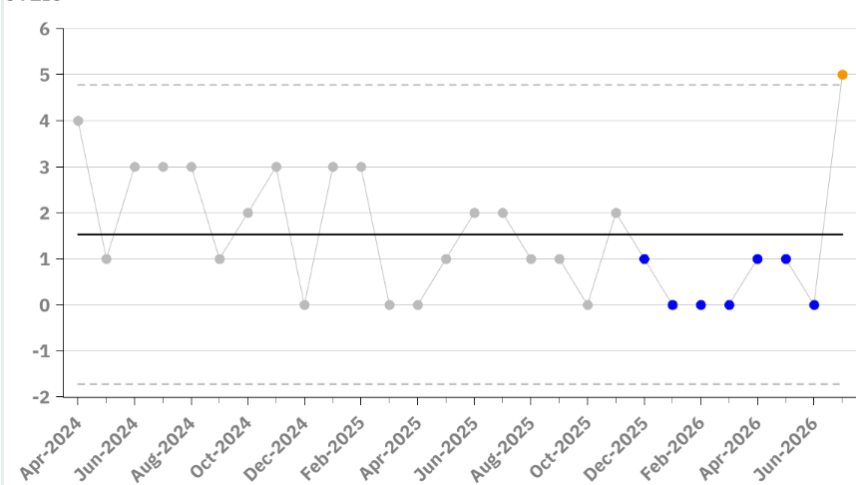
Underlying issues:

- 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 PSIIs.

Actions:

- Testing of the new AAR process will be expanded to all DTVF AMH Planned Care teams from the end of July 2026. **(Complete)**
- A structured regroup following the expansion of testing is planned for September 2026 to ensure learning is captured consistently and refinements are coordinated during the testing phase.
- All 5 PSII's have been allocated to a Patient Safety Incident Investigator and investigations are underway.

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:

30 incidents of moderate or severe harm were reported during July.

There is no significant change at Trust and both Care Group Levels.

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.

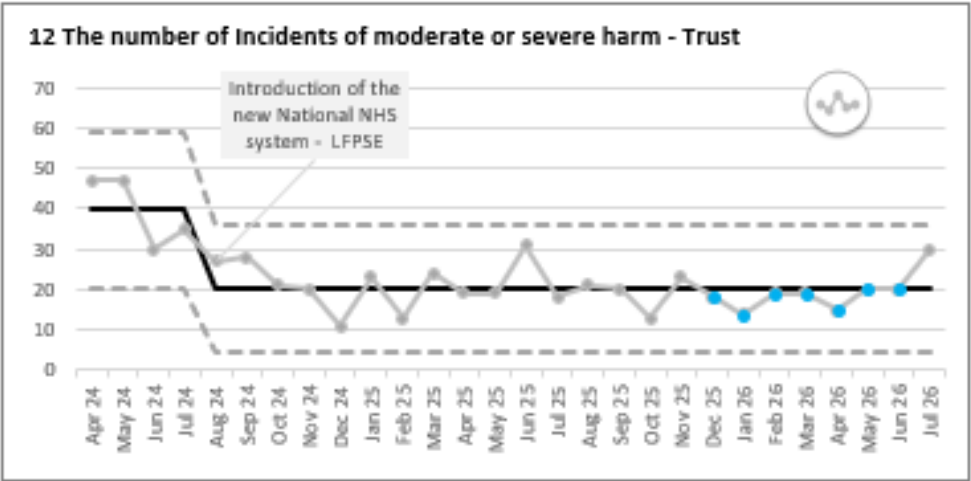
As incidents are reviewed, the severity could be reduced or increased (severity is usually reduced).

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:

1056 types of Restrictive Interventions were used during July.

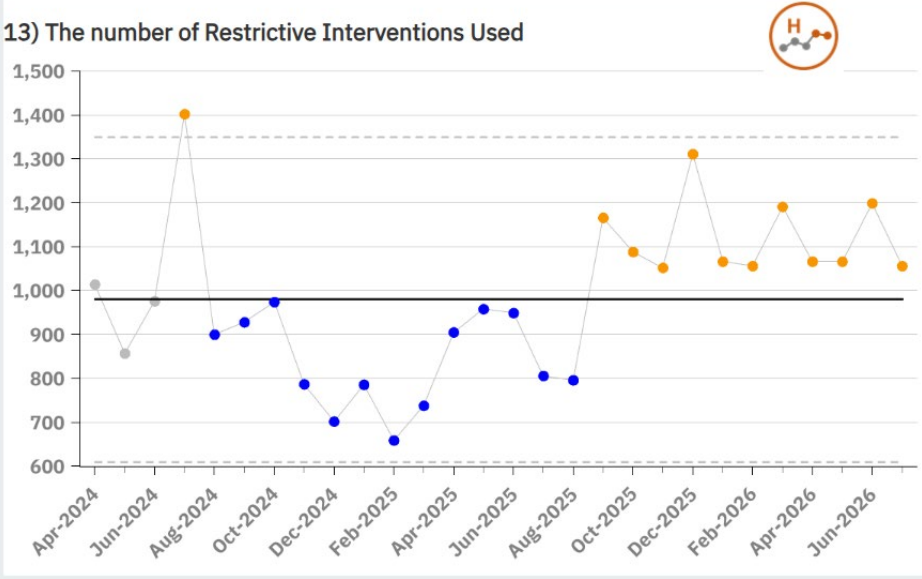
There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group and for Adult Learning Disabilities within that Care Group; there is no significant change for North Yorkshire, York & Selby. There is special cause improvement for Adult Mental Health and Health & Justice 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. The service continue to explore 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 and actions are progressing, with weekly oversight from the Executive Board. It is currently anticipated the service will step down enhanced support from the end of September.
- The ward continues to receive additional support from the national HOPE(s) team.



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 July.

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

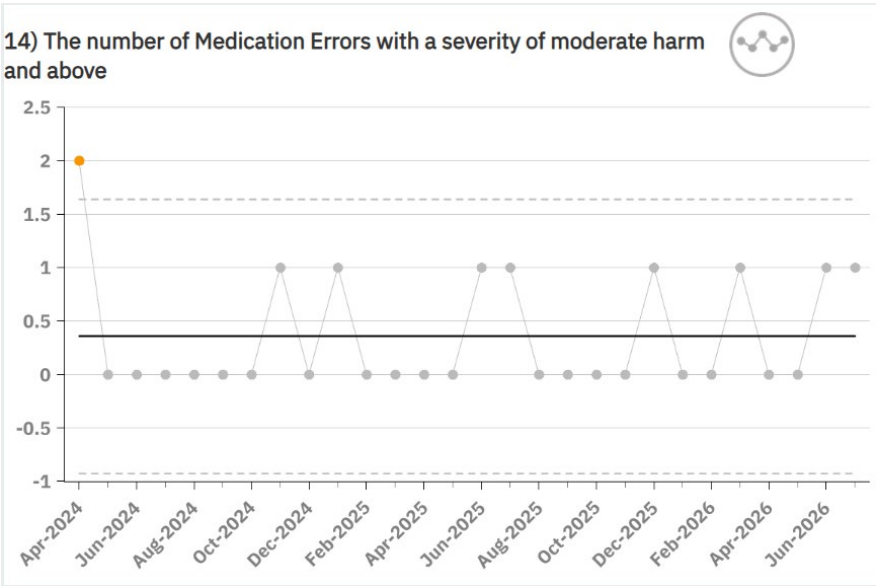
As incidents are reviewed the severity could be reduced or increased (usually reduced), which would then be refreshed in future reports.

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:

1 unexpected inpatient unnatural death on an inpatient ward was reported on the Strategic Executive Information System (STEIS) during July.

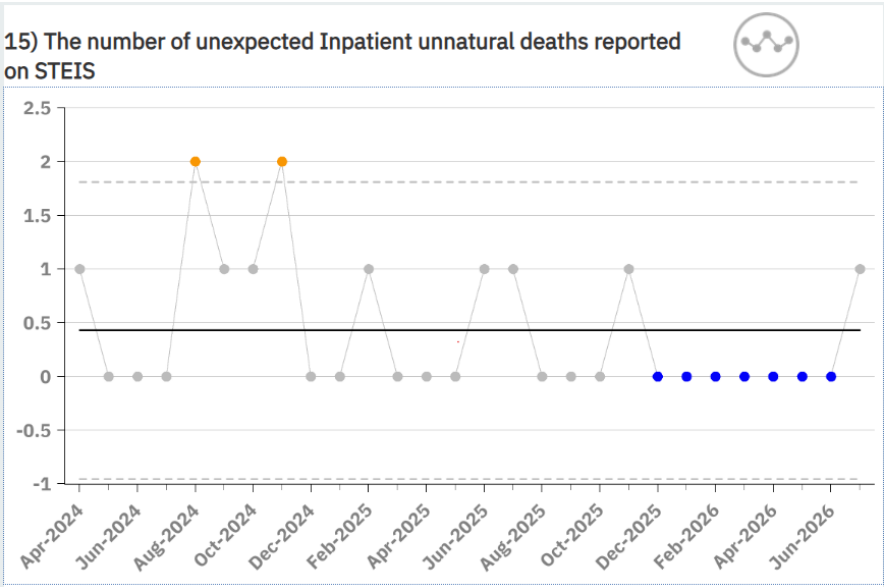
All unexpected and unnatural deaths in inpatient wards are immediately reported in this data. Once the cause of death is confirmed, where necessary the data is refreshed. Therefore, on occasion we might be over reporting the number of unexpected, unnatural deaths.

Underlying issues:

There are no underlying issues to report.

Actions:

A comprehensive multi-disciplinary after-action review is underway and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation will be completed.



16) The number of uses of the Mental Health Act

What does the chart show/context:

There were **363** uses of the Mental Health Act during July.

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

Analysis of the national Mental Health Act data 2024/25 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 Mental Health Legislation 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.

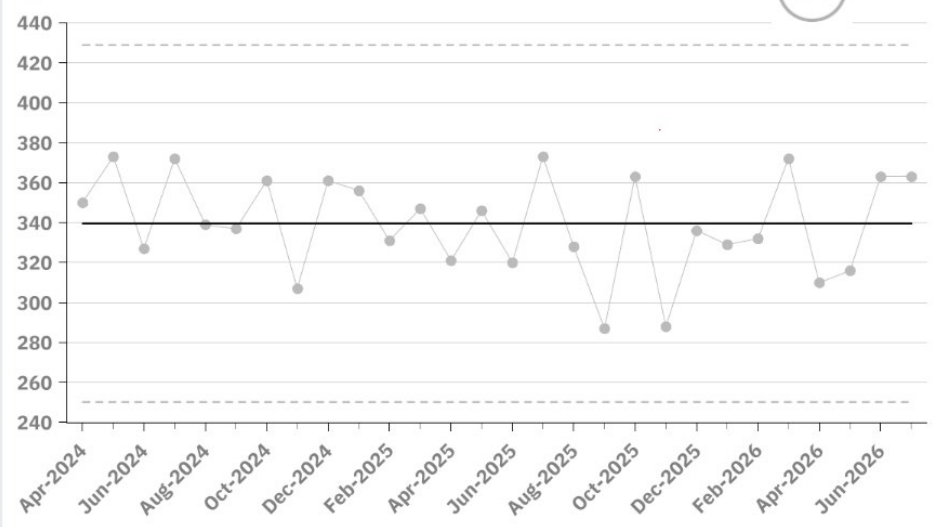
Underlying issues:

- Analysis of the 2024/25 data 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 also showed some areas of inequality in our detention rates.

Actions:

- A Sickness to Prevention Programme Board has been established and is overseeing the delivery of the Trust inequalities and prevention plan which includes workstreams on data use and improvement, Patient and Carer Race Equality Framework, addressing non-attendance and disengagement, expansion of mental health in schools teams. It also includes development of prevention priorities in partnership across dementia, neighbourhood health and suicide prevention.
- The EDI officer vacancy to support Patient & Carer Race Equality Framework delivery was advertised in July (**Complete**). Interviews were held in August, and whilst a conditional offer was made, the candidate has now withdrawn. An interim plan will be considered by the Sickness to Prevention Board in September.
- 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.

16) The number of uses of the Mental Health Act



3. People

Governance forum responsible:

Non-Executive Chair:

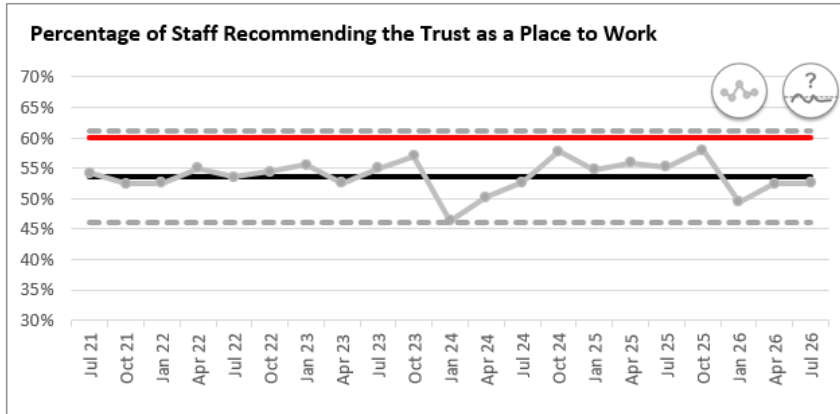
Executive Lead:

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:

1,396 staff responded to the July Pulse Survey. In relation to the question “I would recommend my organisation as a place to work”, **734 (52.58%)** 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.

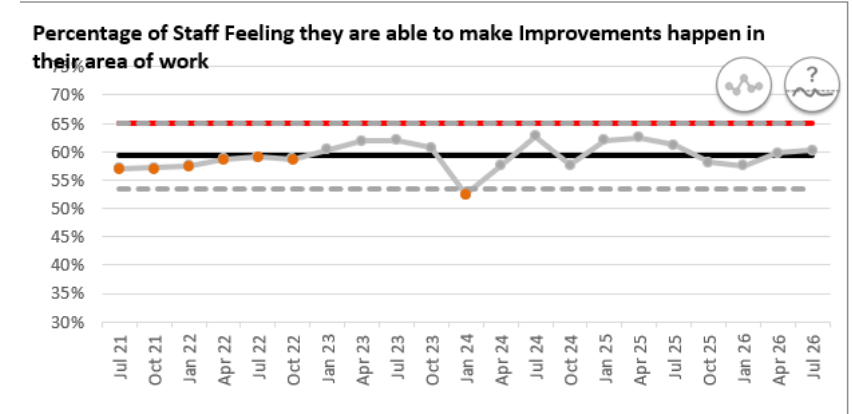
The NHS Staff Survey Benchmarking report 2025, shows the “best result” was 76% and the “average result” was 62% for similar organisations.

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.
- Within Digital & Data Services an increase in workload/pressure/risk linked to the preparatory and enabling work required to ensure organisational readiness for the new Electronic Patient Record implementation, is potentially impacting on staff responses.

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:

1,396 staff responded to the July Pulse Survey. In relation to the question “I am able to make improvements happen in my area of work”, **841 (60.24%)** 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:

- The 'How We Work' programme will develop and agree an organisational framework with headings such as How We Lead, How We Care, How We Govern and Assure, How We Improve, and How We Work Together, to support the Trust's strategic transformation priorities and provide a consistent approach to service delivery.
- Implement the agreed improvements identified through the August 2026 review of the People Management Skills Programme and deliver the July 2026 to 2027 cohorts, with the remaining NHS England Expectations of Managers modules introduced through e-learning and bite-size sessions by March 2027 to strengthen leadership capability and improve staff experience.
- The Flexible Working Group will review and standardise the Trust's approach to flexible working by the end of Quarter 2 2026/27, including piloting ESR functionality to capture flexible working arrangements and making recommendations to ensure equitable access for staff while maintaining safe and effective service delivery.
- The Staff Experience Group will analyse staff experience data and soft intelligence and implement improvement initiatives focused on staff survey outcomes, flexible and hybrid working, reasonable adjustments, and violence and aggression towards staff, with progress monitored through regular reporting and governance processes.
- Estates & Facilities Management will implement the Feedback-to-Fix initiative in September 2026 and undertake face-to-face staff survey completion sessions in October 2026 to increase staff engagement, gather feedback, and identify practical improvements across the service
- Nursing & Governance will hold a staff survey engagement session at the September 2026 Directorate Day to review survey results, discuss key areas of concern, and agree improvement actions to enhance staff experience.
- Digital & Data Services will review the data to identify any underlying themes and trends. **Timescale to be confirmed.**

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

17) Percentage of staff recommending the Trust as a place to work Trust Standard 60%/Best Result - 76%			18) Percentage of staff feeling they are able to make improvements happen in their area of work Trust Standard 65%/Best Result 66%		
	Actual (Latest data)	RAG (*against Trust Standard)		Actual (Latest data)	RAG (*against Trust Standard)
Trust	52.58%		Trust	60.24%	
PEOPLE AND CULTURE	86.08%		PEOPLE AND CULTURE	91.14%	
MEDICAL	69.35%		FINANCE	80.00%	
FINANCE	68.00%		ASSISTANT CHIEF EXEC	71.43%	
CORPORATE AFFAIRS AND INVOLVEMENT	61.90%		DIGITAL AND DATA SERVICES	65.22%	
THERAPIES	59.09%		THERAPIES	63.64%	
DIGITAL AND DATA SERVICES	53.62%		MEDICAL	62.90%	
DURHAM, TEES VALLEY AND FORENSIC	52.01%		CORPORATE AFFAIRS AND INVOLVEMENT	61.90%	
NURSING AND GOVERNANCE	51.33%		NORTH YORKSHIRE, YORK AND SELBY	60.53%	
ASSISTANT CHIEF EXEC	50.00%		ESTATES AND FACILITIES MANAGEMENT	58.57%	
NORTH YORKSHIRE, YORK AND SELBY	44.74%		DURHAM, TEES VALLEY AND FORENSIC	56.63%	
ESTATES AND FACILITIES MANAGEMENT	44.29%		NURSING AND GOVERNANCE	55.75%	

RAG rating has been applied based on the Trust standards shown.



Is achieving /Exceeding standard



Within 5% of standard



Below 5% of standard

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 7,482.17 staff in post 785.93 (10.50%) had left the Trust in the 12-month period ending July 2026.

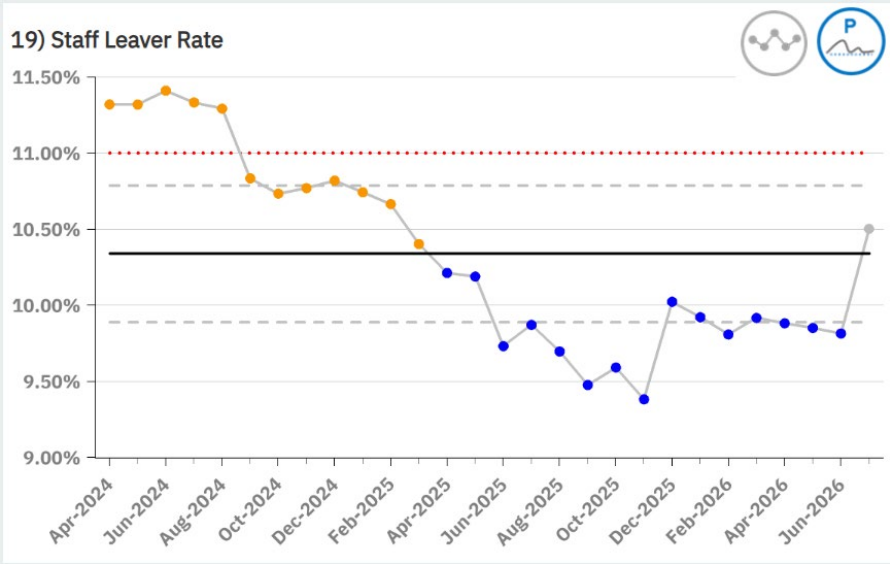
There is no significant change at Trust level. There is special cause concern for Corporate Affairs & Involvement (please see below action), People & Culture, Therapies, Estates & Facilities Management and Management in DTVFCG (these areas have confirmed there is no actual concern at this stage and Adult Learning Disabilities in DTVFCG (investigations will be undertaken to review whether there is an actual concern).

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. The second scheme was ran in January 2026, supporting 30 further staff to leave. The notice periods for this cohort have impacted the leaver rate between April and June.

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 **225,500.62** working days available for all staff during July 2026 (reported month behind); of those, **15,564.62 (6.90%)** days were lost due to sickness.

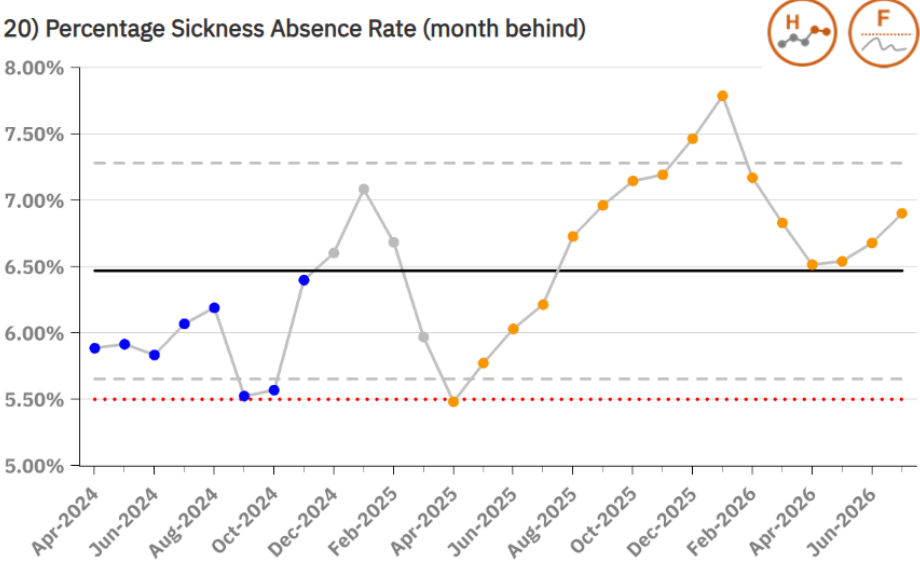
There is special cause concern at Trust level, and for both Care Groups, Corporate Affairs & Involvement, Finance, Medical, Children & Young Peoples Services, Health & Justice, Management and Durham Tees Valley & Forensic Care Group. There is also special cause concern for North Yorkshire, York & Selby Care Group and Children & Young Peoples Services within NYYCG.

National Benchmarking for NHS Sickness Absence Rates published 30th July 2026 (data ending April 2026) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.74%** compared to the Trust mean of **6.45%**, with the Trust ranked 40 of 46 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*

1. The Strategic Lead for Health & Wellbeing will evaluate the pilot to reduce initial contact for staff absent due to mental health reasons from 28 to 14 days within Children & Young People's Services and make recommendations for wider implementation by March 2027.
2. Director-led sickness absence management reviews will continue monthly across DTVFCG and NYYS CG, with services demonstrating sustained improvement stepped down from enhanced oversight and additional teams identified for targeted support, to improve attendance management and reduce sickness absence.
3. People Partners and People Officers will deliver Attendance Management training to all line managers with responsibility for managing staff absence by 31 December 2026, building on the 53% completion achieved to date.
4. Following evaluation of current sickness absence management pilots, the Attendance Management Policy review will be recommenced in partnership with Staff Side, with a revised implementation timetable agreed by March 2027.
5. Complete consultation and implement revised Bereavement and Compassionate Leave provisions by 30 September 2026, subject to agreement on consultation requirements.
6. Health & Justice Services will complete the remaining four actions within the Service Improvement Plan by 30 September 2026, with progress monitored through the Service Improvement & Development Group and Combined Governance.
7. The DTVFCG ALD Service will deliver the remaining actions within the Recovery Plan, including workforce, wellbeing and Positive Behavioural Support initiatives, to achieve exit from Service Requiring Additional Support status by 3 September 2026.

21) Percentage compliance with ALL mandatory and statutory training

Background / standard description:

We are aiming for 85% compliance with mandatory and statutory training

What does the chart show/context:

158,454 training courses were due to be completed for all staff in post by the end of July. Of those, 146,635 (92.54%) were completed.

There is special cause improvement at Trust level and for most Directorates. The Medical directorate is showing as a cause for concern.

As at the 31st July 2026, the Medical directorate and Trust Financing (Bank Staff) are currently below 85%.

	Total Compliant	Total Number	% Compliant
TRUST FINANCING (Bank Staff)	491	584	84.08%
MEDICAL	2840	3440	82.56%

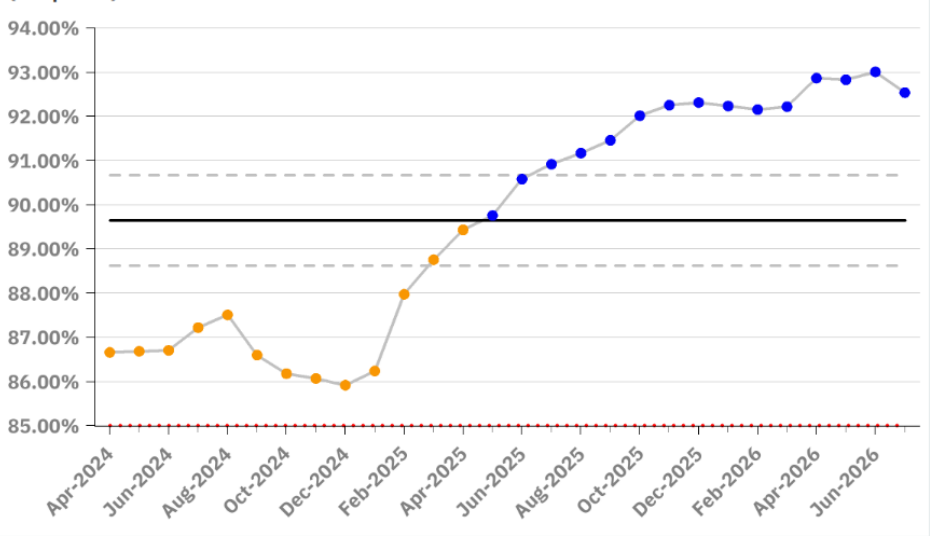
Underlying issues:

- Competencies for Associate Directors of Nursing and Modern Matrons are under review 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:

- The Deputy Chief Nurse will finalise approval of the revised training matrix for Associate Directors of Nursing and Modern Matrons and oversee implementation to ensure competency requirements are aligned to management and clinical role expectations.
- The Executive Director of Therapies will establish a working group to complete the outstanding review of feedback from the June 2026 essential training workshop, agree improvement actions, and report recommendations through the Training Education Governance Group.

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



Actions continued:

- The Pharmacy Leadership Team will continue monthly compliance monitoring and implement targeted actions to achieve compliance by 30 September 2026, following delays associated with peak summer service pressures.
- The Temporary Staffing Service Manager for Bank Staff will continue working with Workforce colleagues to resolve outstanding ESR issues and improve the accuracy and effectiveness of bank workforce management processes.

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 (the same as 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).
- A number of unexpected staff absences within the Education & Training Team have significantly affected delivery capacity for Resuscitation Level 3 and are impacting the team's ability to achieve forecast trajectories.
- Following a recent case law the national team have switched off the training for Mental Capacity Act whilst the content is reviewed, which is impacting a number of teams. A timescale is yet to be confirmed.

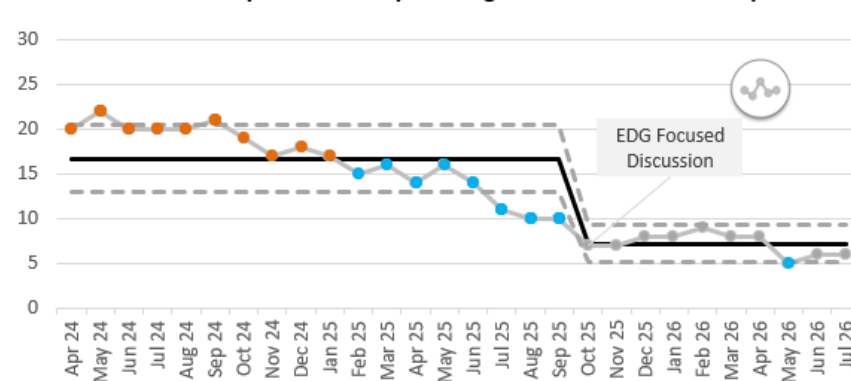
Actions:

- Following delays caused by sickness within the training team, the Workforce Development Lead will complete the training of the remaining two Positive & Safe Care Resuscitation trainers and increase course provision by October 2026 to strengthen training capacity.
- The following directorates will ensure 85% compliance for all courses by the timescales outlined:
 - Nursing & Governance and the Chief Executive - August 2026
 - Therapies - September 2026
 - Corporate Affairs & Involvement – October 2026

Please note issue and ongoing action on previous page in relation to Trust Financing (Bank).

- The Executive Directors for Estates & Facilities and Medical Directorates will complete the outstanding action to agree and implement service-level DNA reduction trajectories (as per EDG action log).
- The Education & Training Team will re-align resources to support priority areas experiencing capacity constraints, specifically Resuscitation Level 3 and Positive and Safe Care Training.

Number of Mandatory and Statutory Training courses below 85% compliance



	Total Compliant	Total Number	% Compliant
Positive & Safe Care Level 1*	3719	4615	80.59%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1610	1989	80.95%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	845	1042	81.09%
Resuscitation - Level 1 - 1 Year*	2162	2659	81.31%
Positive and Safe Care Level 2 Update*	1345	1638	82.11%
ACCT Training*	124	146	84.93%

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

22) Percentage of staff in post with a current appraisal

Background / standard description:

We are aiming for 85% of staff in post with a current appraisal

What does the chart show/context:

Of the 6,993 eligible staff in post at the end of July; 6,318 (90.35%) 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 & MHSOP 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 31st July 2026, by exception compliance levels below 85% are as follows:

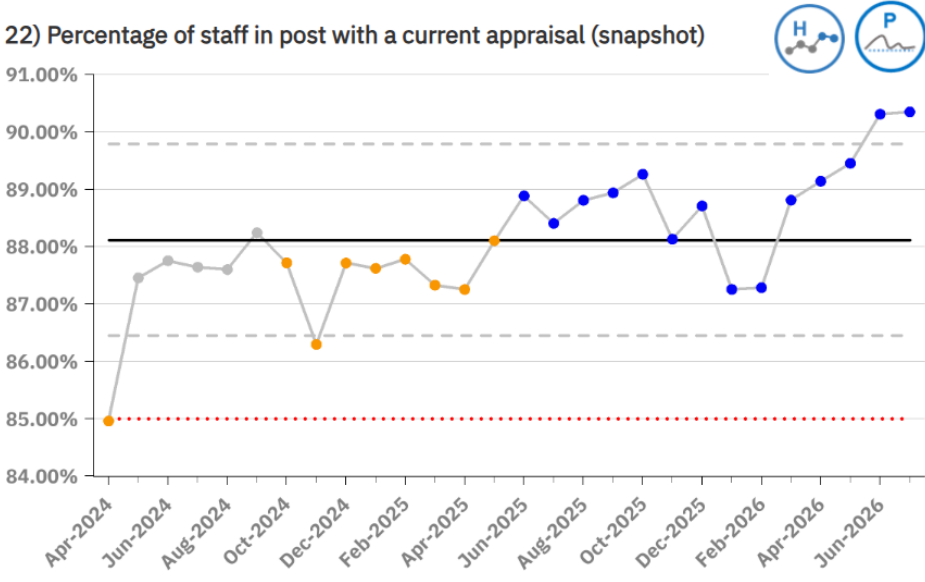
	Total Compliant	Total Number	% Compliant
CORPORATE AFFAIRS AND INVOLVEMENT	28	37	75.68%

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

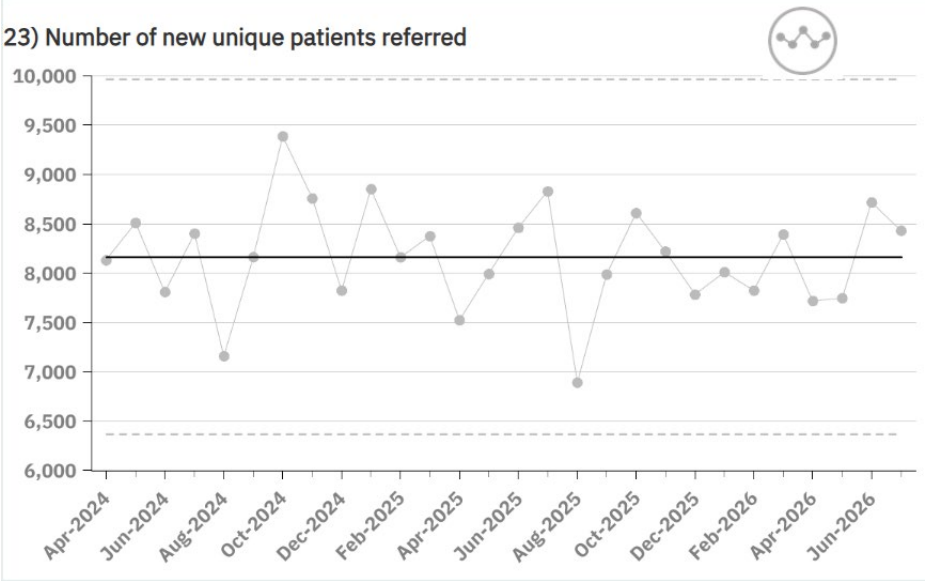
23) Number of new unique patients referred

What does the chart show/context:
8,431 patients referred in July that are not currently open to an existing Trust service.

There is no significant change at Trust and Durham, Tees Valley & Forensic Care Group. There is a high shift in referrals for North Yorkshire, York & Selby Care Group and for Adult Mental Health in that Care Group. There are low shifts in referrals for Children & Young Peoples Services and Health & Justice within Durham, Tees Valley & Forensic 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 Active Caseload (snapshot)

To Note:

This month’s dashboard includes the new Unique Active Caseload measure. This replaces the previous Unique Caseload and supporting Active Caseload measures.

What does the chart show/context:

47,917 unique active cases were open as at the end of July 2026.

There is special cause improvement at Trust and Durham, Tees Valley & Forensic Care Group, there is no significant change shown within North Yorkshire and York Care Group .There is special cause concern for Secure Inpatient Services in DTVFCG and in Children & Young Peoples Services for NYYCG. There is special cause improvement shown in ALD & CYP within DTVFCG and ALD, AMH & MHSOP within NYYCG.

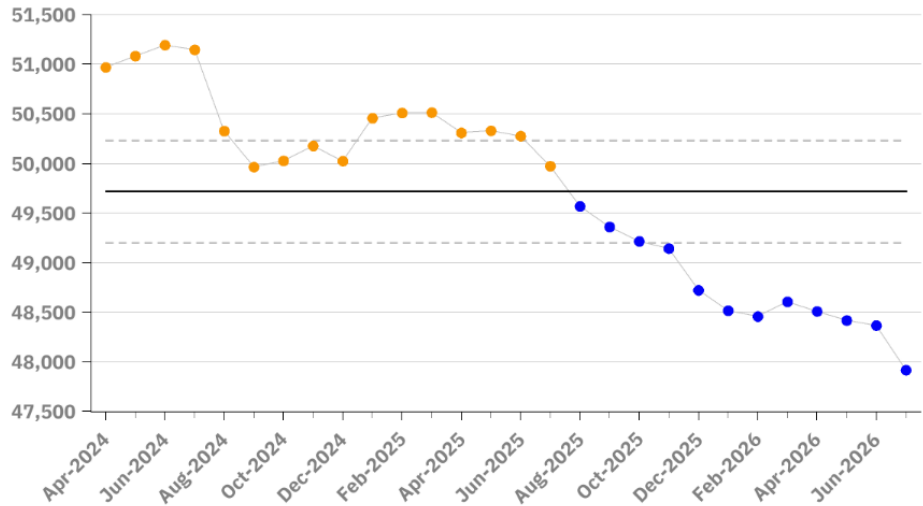
Underlying issues:

The root causes of the reported performance position have not yet been fully established. A review is in progress to understand the teams impacted, underlying factors and determine whether any mitigating actions are required.

Actions:

- Please see underlying issue above
- Business Intelligence to develop the new caseload measure for the July 2026 IQPR (reported in August). **(Complete)** Reflected in this dashboard

24) Unique Active Caseload (Snapshot) – Includes only patients with a successful contact, a valid assessment code, and a contact duration exceeding the minimum threshold



5. Finance

Governance forum responsible:

Non-Executive Chair:

Executive Lead:

Resources and Planning Committee

John Maddison

Liz Romaniak

25) Financial Plan: SOCI - Final Accounts - Surplus/Deficit

Key Financial Indicators for the period ending 31 July 26 - Revenue

Revenue Performance - Group	Year to date			RAG
	Plan	Actual	Variance	
Revenue Performance (Surplus) / Deficit £m	1.75	(0.29)	2.04	●
Income & Expenditure Margin (Surplus) / Deficit %	1.20%	(0.06%)	1.26%	●
Income £m	183.72	186.50	2.78	●
Pay Expenditure £m	156.02	154.57	1.45	●
Non Pay Expenditure £m	28.29	30.53	(2.24)	◆
Non Operating Expenditure £m	1.16	1.12	0.04	●

Revenue Performance - Group	Year to date £m			RAG
	Plan	Actual	Variance	
Durham, Tees Valley & Forensic	96.34	97.97	(1.63)	◆
North Yorkshire & York	39.88	40.33	(0.45)	◆
Estates & Facilities	11.39	11.08	0.31	●
Corporate	20.13	20.32	(0.19)	◆
Income	(170.75)	(170.35)	(0.40)	◆
Central and Reserves	4.76	0.36	4.40	●
PIPS	0.00	0.00	0.00	●
	1.75	(0.29)	2.04	●

Variances - Better / (Worse) than plan

For actions see following page

Key Messages:

Moving into quarter two key areas of focus include:

- Implementing actions developed in response to NHSE plan conditions seeking to reduce bank costs to within NHSE expenditure caps (new metric from August 2026 Board IQPR).
- Managing implications of national pay awards where under-funded via national tariff uplift.
- Ensuring delivery of progressively stepped cost reductions in-year.
- System partnership work to reduce high levels of patients clinically optimised for discharge.

What does the data show/context:

Financial performance of a £0.3m surplus was £2.0m better than planned but included £1.3m unplanned contract receipt (in-month broadly break-even).

Underlying issues:

Planned delivery of £27.7m Cash Releasing Efficiencies Savings (CRES) underpins achievement of our 2026/27 break-even plan. Specific priorities include:

- Further temporary staffing reductions (Bank, Agency, and Overtime).
- Substantive staff reductions, including Mutually Agreed Resignations from late 2025/26.
- 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 not yet discharged. This will support lower ward occupancy and average lengths of stay, reduce unfunded temporary staffing costs and support nil reliance on independent sector beds. Critical system support is central to those plans.

We used **99 non-Trust bed days in July** (74 in June) costing **£0.5m to date** including estimated occupancy and observations, which was **£0.5m worse than plan**. Bed pressures mean achieving nil independent sector bed utilisation is challenging. 100% non-Trust bed days related to Psychiatric Intensive Care Unit usage (3 beds presently) in July. Further independent sector bed usage arose in June (and ongoing) relating to 2 Adult Learning Disability Patients and reflects i) capacity pressures in female medium secure pathways, and ii) impacts on bed availability arising from Bankfields Court care package implications (**£0.6m to date**)

Despite Trust wide success in reducing Agency expenditure and price cap breaches, nursing and medical breaches are an ongoing challenge. Previously prioritised actions to 'swap out' agency and overtime to lower cost Bank staff arrangements proved effective. That approach will now be applied to deliver Bank expenditure reductions. Workforce Information is being continually enhanced to ensure an efficiency focus and vital visibility of impacts from approved bank reduction plans.

Key Areas for Action:

- 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 and to August Trust Board.
- Board approved reporting against a new IQPR Bank Expenditure metric from the August 2026 Board Meeting.
- A Temporary Staffing and Overtime sub-group oversaw actions to reduce all temporary staffing, and reports progress into Executive Directors. Detailed approved plans to reduce levels of staff sickness absence and bank staff will be overseen by the Reduction of Flexible Staffing sub-group, replacing the Temporary staffing and Overtime Group, and whose remit is being enhanced to ensure oversight of, and reductions in, overall staffing resource deployed (including all substantive and flexible staffing sources).
- 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 31 July 26 - Agency costs compared to plan by category

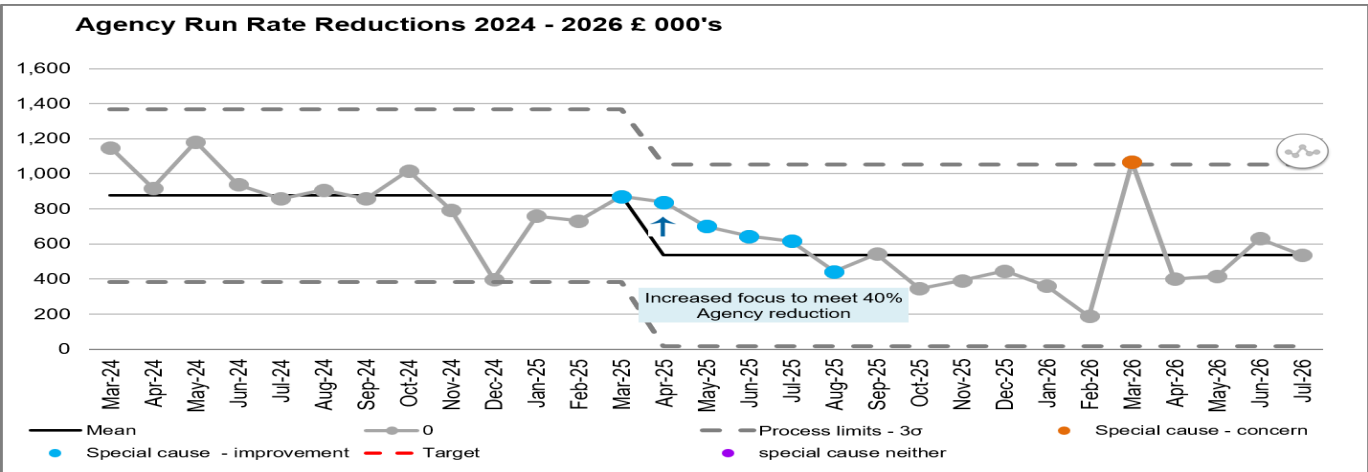
Agency Usage	Expenditure £ 000's							WTE		
	Annual	Current Month			Year to Date			Current Month		
Category	Plan	Plan	Actual		Plan	Actual		Plan	Actual	
Nursing and Other	2,603	209	299	(90)	1,030	1,143	(113)	29.85	62.63	(32.78)
Medical	1,975	172	238	(66)	741	841	(100)	13.30	10.67	2.63
Grand Total	4,578	381	537	(156)	1,771	1,984	(213)	43.15	73.30	(30.15)

Agency Quarterly Cost Profile	Q1	Q2	Q3	Q4	Total
Agency Plan £ 000	1,390	1,144	1,146	898	4,578
Agency Plan %	30%	25%	25%	20%	100%

Key Financial Indicators for the period ending 31 July 26 - Agency costs compared to plan by area

Agency Usage	Expenditure £ 000's							WTE		
	Annual	Current Month			Year to Date			Current Month		
Area	Plan	Plan	Actual		Plan	Actual		Plan	Actual	
Durham Tees Valley & Forensic	1,840	155	286	(131)	667	875	(208)	15.39	28.90	(13.51)
North Yorkshire & York	1,558	135	119	16	548	519	29	10.76	10.10	0.66
Medical and Central	387	25	0	25	291	0	291	3.00	0.00	3.00
Trust Total	3,785	315	405	(90)	1,506	1,394	112	29.15	39.00	(9.85)
PIPS	793	66	132	(66)	265	590	(325)	14.00	34.30	(20.30)
Group Total	4,578	381	537	(156)	1,771	1,984	(213)	43.15	73.30	(30.15)

Variances - Better / (Worse) than plan



What does the data show/context:

- Year to date **Group agency costs of £2.0m were £213k and 30.15 WTE above plan:** The Trust position (excluding £590k subsidiary; £325k above plan) was £112k below plan; building on success in the last several years. In-month Trust costs for Nursing and Other were £90k and 9.85 WTE worse than planned, including £91k Bankfields Court 'break glass' shifts approved by Directors.
- The bottom SPC chart shows an uptick in Quarter 1, following consistent general reductions in monthly 'run rates' since March 2024 (c £1.2m monthly). Increases reflect premia rate Band 3 shifts supporting the Bankfields Court 'break glass' package and a recently commissioned PIPS care package.
- Medical agency costs of £238k (44.3%) represent just 14.6% 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 nursing 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 recent months.

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 reductions in 2026/27.
- Enhanced staff banks were developed in 2025/26 as an alternative to premia rate Agency and Overtime options.
- 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 31 July 26 - Agency Staff Price Cap Compliance

Price Cap Compliance	Jul - 25		Jun - 26		Jul - 26		In-Month Movement		12-Month Movement	
	Shifts	Shifts %	Shifts	Shifts %	Shifts	Shifts %	No.	%	No.	%
Compliant	809	63%	187	30%	177	26%	(10)	(5%)	(632)	(78%)
Non-Compliant	473	37%	445	70%	491	74%	46	10%	18	4%
Total Shifts	1282	100%	632	100%	668	100%	36	6%	(614)	(48%)

Compliance Change by Staffing Group	Jul - 25			Jun - 26			Jul - 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	223	0	0%	223	156	70%	278	186	67%	30	30%	186	186%
Medical	390	390	100%	222	222	100%	228	228	100%	6	3%	(162)	(73%)
Nursing	669	83	12%	187	67	36%	162	77	48%	10	15%	(6)	(3%)
Allied Health Professionals	0	0	0%	0	0	0%	0	0	0%	0	0%	0	0%
Total Shifts	1282	473	37%	632	445	70%	668	491	74%	46	34%	18	4%

Movement - Increase / (Reduction)

Key Financial Indicators for the period ending 31 July 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	Jul-26
Durham Tees Valley & Forensic	3	1	6	0	0	0	73	173	239
North Yorkshire & York	40	47	57	59	42	39	20	50	39
Total Shifts Worked	43	48	63	59	42	39	93	223	278

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	Jul-26
Bankfields Court (Tees) ALD	0	0	0	0	0	0	73	173	186
Wold View (York) Older Adult	12	14	7	7	13	11	5	15	7
Moor Croft (York) Older Adult	2	4	15	17	5	1	3	13	10

Information on this slide is Trust only. No data is included from PIPS on Price Cap Compliance

What does the data show/context:

- Agency usage reduced by 614 shifts (48%) over 12 months ending July 2026 but increased by 36 shifts in-month.
- Non-compliant shifts increased by 18 shifts (4%) over the same period, driving a higher non-compliance rate, accounted for by Bankfields Court 'break glass' approvals.
- Of 668 shifts in July, 177 or 26% complied with price caps.
- 278 Band 3 shifts breached an NHSE requirement to cease Band 2-3 Support Worker usage in July 2026; up by 55 shifts in-month (prior month 130 shifts increase). This included 239 shifts from 'break glass' approvals at Bankfields Court commencing in May (73 shifts, 173 in June) in response to an agreed care package and with appropriate approvals for all 432 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. A significant challenge relates to break glass approvals 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 agreement of plans for a patient at Bankfields Court.

28) Financial Plan: Bank Expenditure

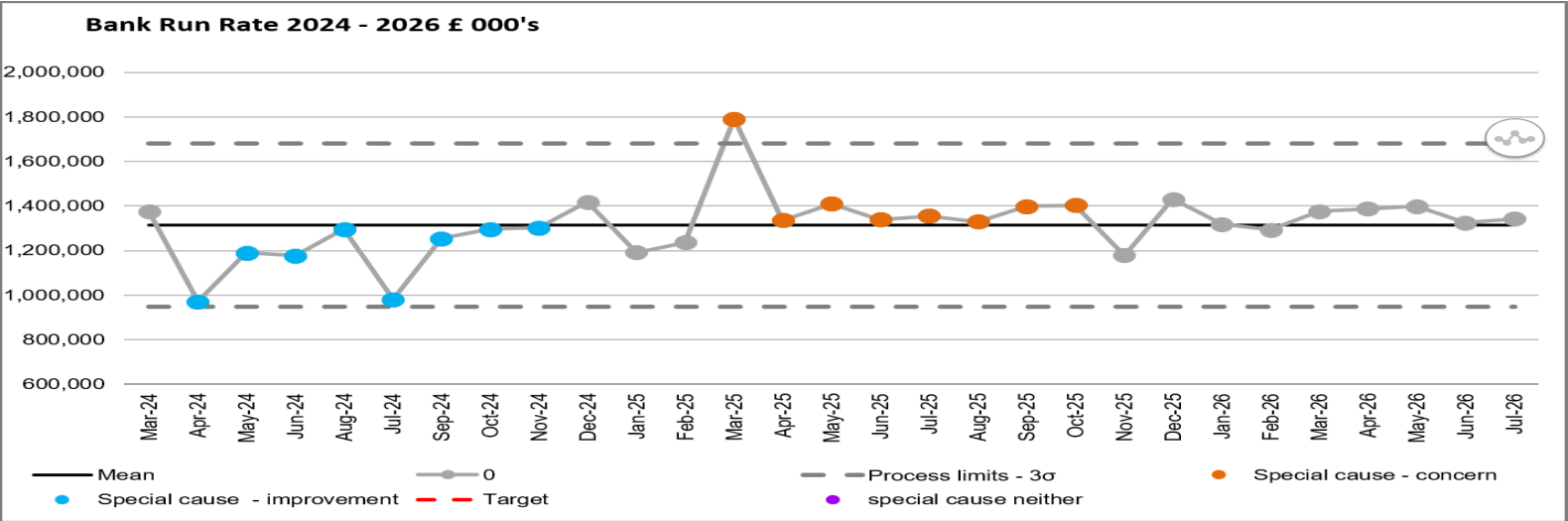
Key Financial Indicators for the period ending 31 July 26 - Bank Expenditure

Bank Usage	Expenditure £ 000's							WTE		
	Annual	Current Month			Year to Date			Current Month		
Category	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Qualified Nursing	2,315	193	310	(117)	772	1,305	(533)	45.99	59.31	(13.32)
Unqualified Nursing	10,722	894	1,031	(137)	3,775	4,133	(358)	261.66	275.41	(13.75)
Other	15	1	1	0	5	16	(11)	14.08	0.83	13.25
Initial Plan Variance	13,052	1,088	1,342	(254)	4,552	5,454	(902)	321.73	335.55	(13.82)
Plan Condition Variance	13,052	1,345	1,342	3	5,026	5,454	(428)	325.99	335.55	(9.56)

Variances - Better / (Worse) than plan

Key Financial Indicators for the period ending 31 July 26 - Bank costs compared to revised plan by area

Bank Usage	Expenditure £ 000's							WTE		
	Annual	Current Month			Year to Date			Current Month		
Area	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Durham Tees Valley & Forensic	11,291	1,184	1,073	111	4,413	4,436	(23)	264.21	270.32	(6.11)
North Yorkshire & York	1,732	158	266	(108)	603	1,008	(405)	60.35	64.19	(3.84)
Estates & Facilities	29	2	1	1	10	4	6	0.34	0.23	0.11
Corporate	-0	1	2	(1)	0	6	(6)	1.09	0.81	0.28
Grand Total	13,052	1,345	1,342	3	5026	5454	(428)	325.99	335.55	(9.56)



What does the data show/context:

- Year to date Bank costs of £5.5m were £902k above plan. Plan profiling pre-dates approval of detailed bank reduction plans. Whilst comparison against this reduces the adverse variance to date by £474k (to £428k), the variance illustrates the additional 'stretch' those actions now need to deliver.
- Most plan variation related to qualified nursing roles, including hard to fill vacancies. Largest users in July were Bankfields Court (single care package), Secure Inpatient Wards (Kestrel Kite, Sandpiper and Clover/Ivy) and two Adult Mental Health wards at Lanchester Road Hospital (Tunstall and Farnham).

Underlying issues:

Previously prioritised actions to 'swap out' agency and overtime to lower cost Bank staff arrangements proved effective but mean bank arrangements were enhanced, and utilisation grew, as a lower cost alternative, in the short term.

Actions:

Enhanced governance will be provided by oversight from the Reduction of Flexible Staffing group, which reports into the Executive Directors Group. The approach taken to reduce agency and overtime will now be used to target stepped bank reductions and to ensure no unintended consequences. Actions reflect analysis of key drivers e.g. reducing bank by reducing sickness, optimising rostering and from substantive recruitment, as well as work with partners to addressing high levels of clinically optimised patients and site-based substantive responses to replace flexible staffing requirements. Substantive recruitment will transfer costs from bank but not save money overall. This equates to £560k (16%) of the total plans of £3.6m.

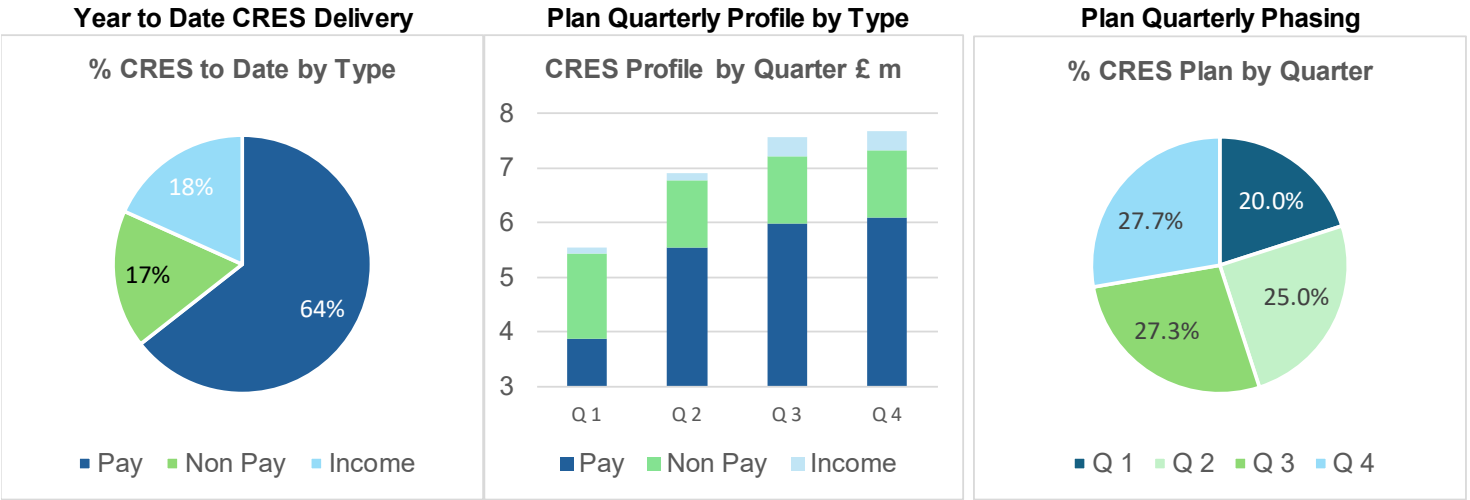
Actions to target sickness absence reductions across a small number of areas that have most impact on Trust performance are progressing. It is expected that this will also help to reduce reliance on bank staff.

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

Key Financial Indicators for the period ending 31 July 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	4,302	4,139	(163)	16,765	16,280	(485)	17,136	3150	3898	4842	4875	16765
Non Pay	898	727	(171)	3,092	2,922	(170)	3,164	701	679	851	861	3092
Income	100	90	(10)	738	333	(405)	294	72	78	294	294	738
Sub Total	5,300	4,956	(344)	20,595	19,535	(1,060)	20,594	3,923	4,655	5,987	6,030	20,595
								19%	23%	29%	29%	100%
Non Recurrent:												
Pay	1,305	1,486	181	4,744	4,261	(483)	0	729	1643	1149	1223	4744
Non Pay	1,163	785	(378)	2,147	1,657	(490)	0	847	562	369	369	2147
Income	68	1,505	1,437	204	2,237	2,033	0	50	52	51	51	204
Sub Total	2,536	3,776	1,240	7,095	8,155	1,060	0	1,626	2,257	1,569	1,643	7,095
								23%	32%	22%	23%	100%
Total	7,836	8,732	896	27,690	27,690	0	20,594	5,549	6,912	7,556	7,673	27,690
								20%	25%	27%	28%	100%

Variances - Better / (Worse) than plan



What does the data show/context:

Whilst **CRES delivery of £8.7m was £0.9m above plan** year to date, plans assume marked stepped increases from quarter two. Performance reflects **delivery if 31.5% annual savings** required, with:

- **£5.0m Recurrent** CRES delivery; being £0.3m below plan
- **£3.8m Non-Recurrent** CRES delivery was £1.2m above plan

Agency was above plan by £50k but Overtime was £30k above plan to date. Bank staff savings to date are £405k, although our overall bank expenditure is increased by additional expenditure in other areas..

Areas of under-delivery included:

- Overtime reductions (Secure Inpatient 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 Reduction of Flexible Staffing Group arrangements and report into Executive Directors Group. Temporary bed closures in MHSOP will support delivery of £1.7m (54WTE) of savings.

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 ensured 97% schemes (by value) due to commence in Quarter One had been assessed by the end of July 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 31 July 26 - Capital programme performance

Capital Programme:	Year to Date £ 000			Annual £ 000		
	Plan	Actual	Variance	Plan	Forecast	Variance
Total expenditure plan	5,526	4,837	689	13,176	19,795	(6,619)
Performance against capital allocation	5,405	4,718	687	12,402	15,146	(2,744)
Performance against revised capital allocation	5,405	4,718	687	12,895	15,146	(2,251)

Variances - Lower / (Higher) than plan

Key Financial Indicators for the period ending 31 July 26 - Capital Plan Profile

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

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 will be 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:

£4,718k Capital expenditure for the year to date was **£687k 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 £493k 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 £13,669k (a + b + c).

Whilst forecast performance against our revised allocation is a £2,251k 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 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 to capital 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 31 July 26 - Cash, Supplier Payment and Receivables

Receivable & Payables Metric:	Year to Date			Annual		
	Plan	Actual	Variance	Plan	Actual	Variance
Cash (£000s)	49,527	56,885	7,358	36,653	40,653	4,000
Better Payment Practice Code (%)	95.0%	95.6%	0.6%	95.0%	95.0%	0.0%
Aged Debt > 90 days overdue (%)	5.0%	51.6%	(46.6%)	5.0%	5.0%	0.0%

Variances - Better / (Worse) than plan

Key Financial Indicators for the period ending 31 July 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 **£56,885k** were **£7,358k more than planned** and reflect higher than planned trade payables projected to reduce slightly during the year but expect the year end cash position to outturn above plan.

- **Prompt Payment of Suppliers:** The Trust achieved a combined Better Payment Practice Code (BPPC) compliance of **95.6%** to date for the prompt payment suppliers, which remains 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 £2,129k, with **£934k 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)	9343	577	8766	7331	6584	5256	3924
Children & Young People Pathway A - Spells with at least one referral with a primary reason for referral - Gender Discomfort Issues	6	3	3	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	5698	128	5570	4871	4389	3485	2630
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	4540	82	4458	3842	3514	2959	2185
Children & Young People Pathway D - Spells with at least one 'other' referral not identified as related to autism, neurodevelopmental or gender identity	1280	396	884	281	159	103	71
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	233	1	232	216	150	100	70
Adults Waiting to receive Meaningful Help	4474	1201	2582	506	109	26	50

"**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)		4	4	0	0	0	0	0	0	1	1
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		30	9	8	11	1	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)		90	34	23	19	9	1	3	1	2	13

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		1003	448	193	114	124	19	13	35	48	9	17	182
Adults Waiting for an Assessment		2697	1130	606	341	493	105	20	2	0	0	9	71
Adults with a learning disability Waiting for an Assessment		71	62	7	1	1	0	0	0	0	0	2	15
Adults in Health and Justice services Waiting for an Assessment		49	35	13	1	0	0	0	0	0	0	3	11
Older People Waiting for Assessment		2761	948	677	414	523	163	35	1	0	0	10	60

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		4748	137	93	135	533	219	170	1372	1441	656	91	228
Children and young people waiting for an ADHD Assessment		4544	142	109	88	333	168	236	1496	1375	597	90	213
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		2069	7	6	4	9	87	100	564	837	483	120	220
Adults waiting for an Autism Assessment		4342	30	38	48	159	204	182	768	1055	1853	133	356
Adults waiting for an ADHD Assessment		5583	85	103	159	314	301	250	1064	1303	2000	123	399

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		4054	288	367	1361	588	789	661	17	75

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)

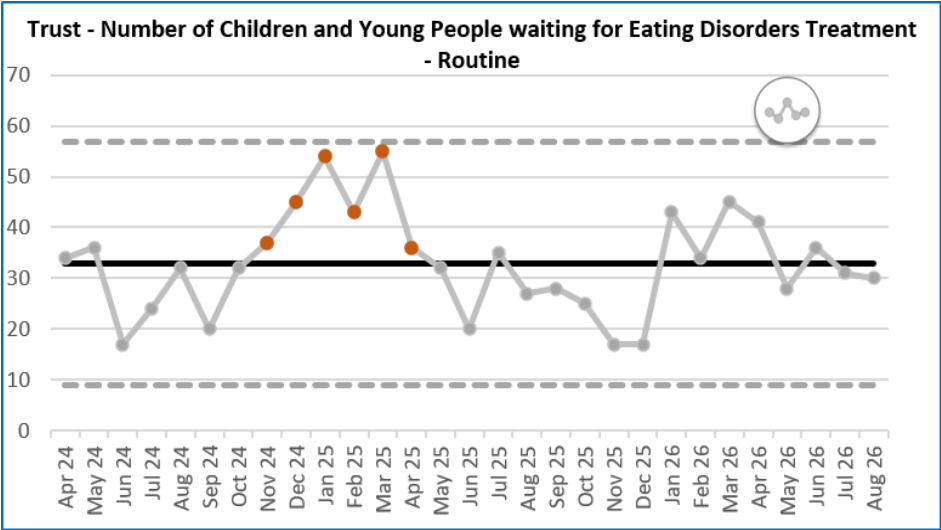
Summary:
There are **2** children or young people reported as waiting more than 4 weeks; however, validation confirms that only **1** patient is currently waiting beyond 4 weeks:

- Patient was offered appointment (within 4 weeks) however, they presented at the wrong location and declined a virtual assessment on the same day; a further appointment is offered in August.

The remaining patient was assessed (within 4 weeks) however; Eating Disorders is not suitable for their needs, and they have been transferred to the Adult Community Team.

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

Actions:
Following agreement at the Combined Care Group Board in July 2026, Directors of Operations will submit the service improvement plan, including agreed actions and improvement trajectories from the service deep dive, to the Executive Directors Group in August 2026 for approval.



Children & Young People Eating Disorders Services - 4 week standard for Routine referrals				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	30	16	85	
DTVF Care Group	16	11	21	
NYY&S Care Group	14	21	85	
Commentary on Longest waits				
DTVF: Genuine wait - assessment moved to accommodate an urgent referral				
NYY&S: Genuine wait - longest wait is 85 days due to team capacity				

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

Summary:

There are **33** adults **reported** as waiting more than 2 weeks; however, validation confirms that **26** patients are currently waiting beyond 2 weeks.

- 11 patients were offered appointments (within 2 weeks); 9 did not attend/cancelled, 1 is awaiting FEP pathway allocation due to team capacity, and 1 was cancelled due to staff sickness. Further appointments were offered in August for 10 patients, and the remaining patient is placed on the KIT waiting list.
- 11 patients were offered appointments (outside 2 weeks); 7 due to team capacity, 2 due to requiring joint assessments with CAMHS, 1 due to difficulties in contacting them and the remaining patient required 2 assessors due to the complexity of presentation. All patients were offered appointments in August.
- 1 patient has not yet received an offer of appointment due to difficulties in contacting them; the service has now sent an offer of service letter.
- 3 patients are currently in prison, awaiting admission to Trust Medium Secure Unit. Admission dates are yet to be confirmed.

Of the remaining 7 waits:

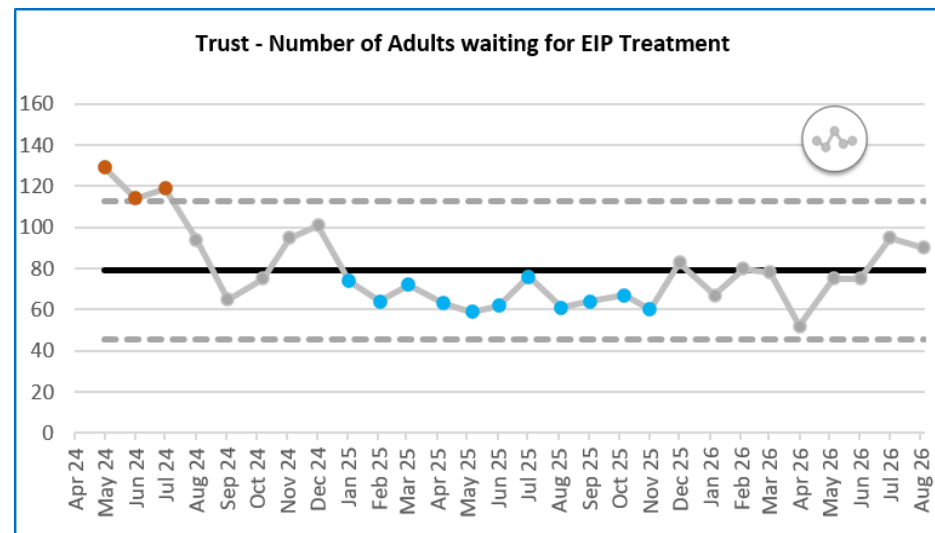
- 4 patients have been assessed, and treatment is not suitable for their presentation; the service is in the process of discharging them.
- 3 are attributable to data quality (pathway not completed in CITO and incorrect referral reason added), and steps have been taken to resolve them.

Underlying issues:

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

Actions:

As a Service Requiring Additional Support, the York & Selby EIP Team will implement its recovery plan by filling all substantive vacancies by 30 September 2026 and utilising increased care coordination capacity to address the backlog of patients awaiting treatment. Following delays to recruitment, improvements in waiting list performance are anticipated from August 2026, with further gains expected as additional staff come into post.



Adults Waiting for EIP Treatment - 2 week standard

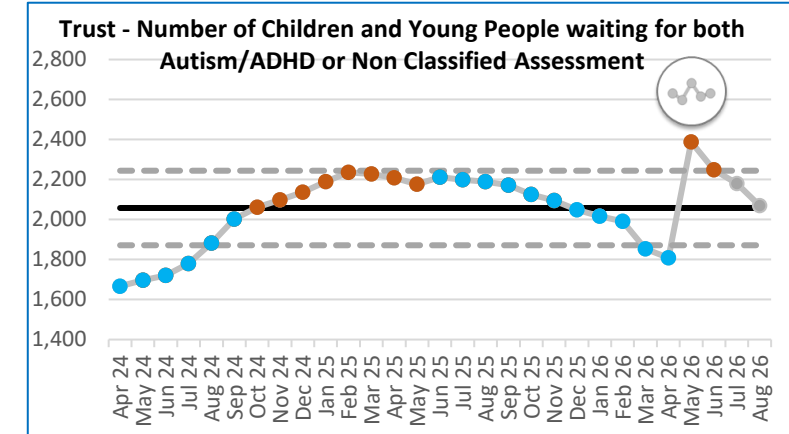
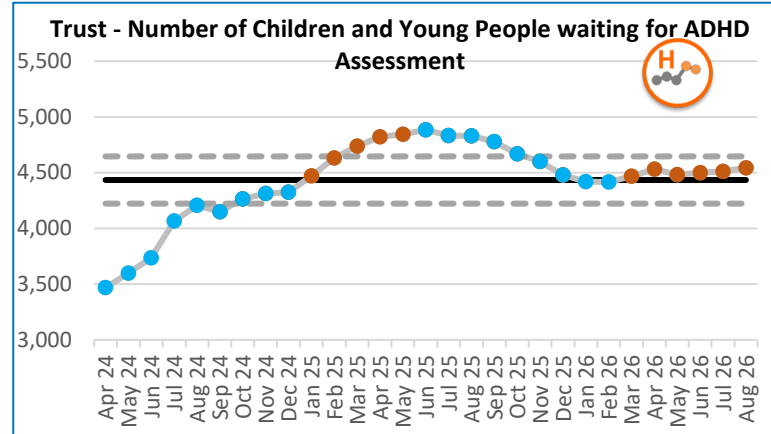
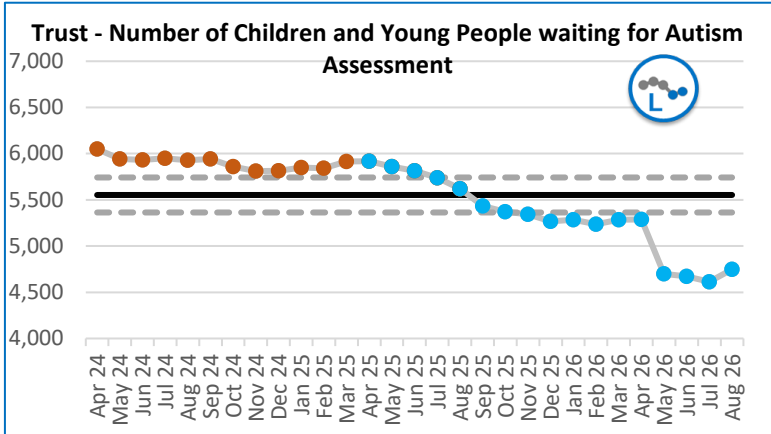
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	90	17	91	
DTVF Care Group	55	14	70	
NYY&S Care Group	35	20	91	

Commentary on Longest waits

DTVF: Genuine Wait - Pt in prison

NYY&S: Genuine Wait - Pt choice

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	4748	635	1596	
DTVF Care Group	3633	690	1596	
NY&S Care Group	1115	457	1001	
Commentary on Longest waits				
DTVF: Data Quality - Assessment completed (longest genuine wait 1588 days - MAAT meeting booked)				
NY&S: Genuine Waiter - Assessment booked				

Children and young people waiting for an ADHD Assessment				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4544	630	1488	
DTVF Care Group	3826	693	1488	
NY&S Care Group	718	294	967	
Commentary on Longest waits				
DTVF: Genuine wait - on hold further information required				
NY&S: Genuine wait - waiting for assessment, no date yet				

Children and young people waiting for both Autism/ADHD Assessment or Not Categorised				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2069	840	1542	
DTVF Care Group	1524	973	1542	
NY&S Care Group	545	480	918	
Commentary on Longest waits				
DTVF: Genuine wait - on hold due to consent				
NY&S: Genuine wait - no date yet				

Country Durham & Tees Valley

Underlying issues:

- High levels of demand outweighing capacity
- Long wait times and projected waiting times in the County Durham areas
- 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. Following the confirmation of available funding, 1 permanent band 5 CAMHS clinician will commence in September, and 1 fixed term will commence in October for 12 months. **(Complete)**
- The Durham & Darlington Neurodevelopment 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. **(Not Complete)** *See action below which supersedes this action*
- Durham & Darlington Neurodevelopment Leadership Team will facilitate an away day with the full team in September to improve induction processes, develop and embed new assessment processes and improve wellbeing.

North Yorkshire & York

Underlying Issues:

- Long-term sickness absences within the Scarborough ADHD team

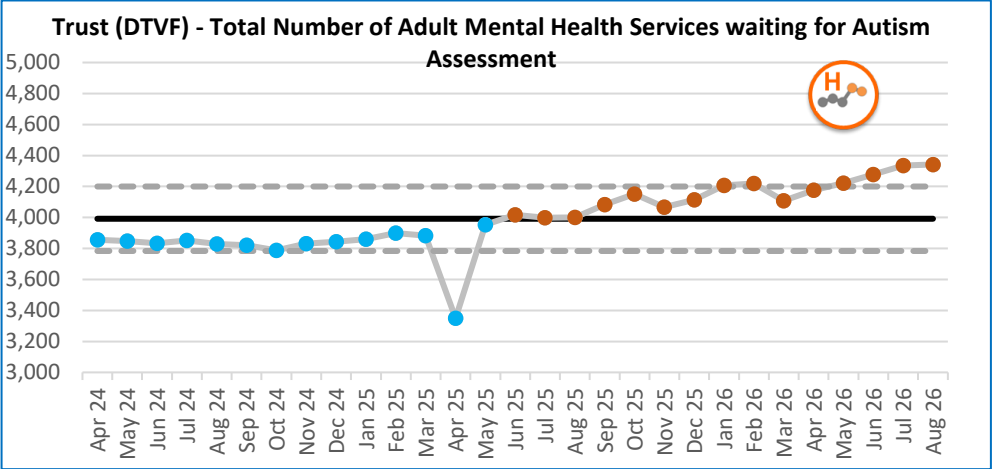
Actions (Partnership-wide):

- 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.

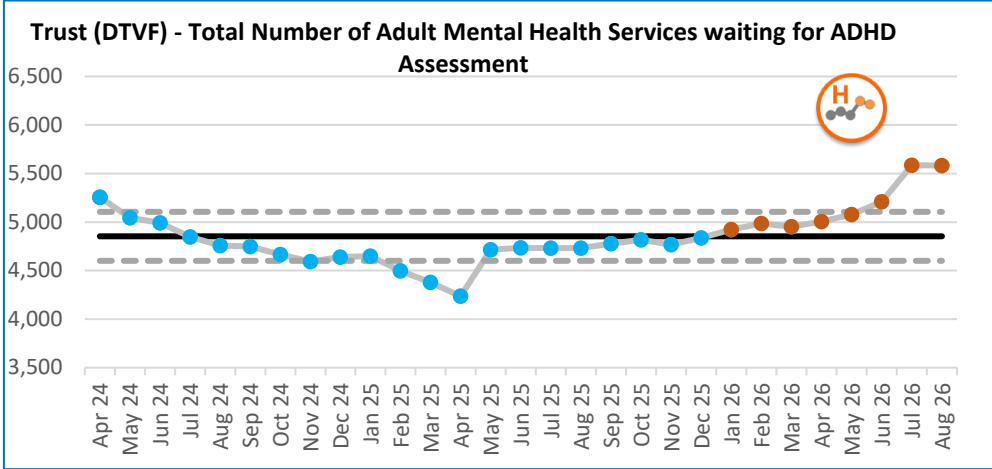
Actions:

- 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)** This will be presented to Executive Directors Group in August.

Waiting Times Neuro Services: Adult Services



Adults waiting for an Autism Assessment				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	4342	928	2495	
Commentary on Longest waits				
DTVF: Data quality - new wait date agreed. longest genuine wait is 2190 days (313 weeks). Apt required				



Adults waiting for an ADHD Assessment				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	5583	858	2794	
Commentary on Longest waits				
DTVF: No information on status of wait				

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. A full mobilisation plan including procurement plan has been completed and will be shared with the ICB in August 2026.

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 now anticipated to be signed off by the end of August 2026 which will support a reduction in waiting times.
- The General Manager submitted a workforce and financial gap analysis paper to EDG in July 2026, seeking additional staffing investment. EDG will revisit the proposal and confirm required actions by 30 September 2026.
- The General Manager will recruit 3.7 WTE PWP's. 2 Trust-qualified PWP posts will go to Vacancy Control by the end of August 2026, and Mental Health Matters will look to recruit 2 trainee PWP's from the January 2027 intake (increased from 1.7 WTE due to slippage in management costs).

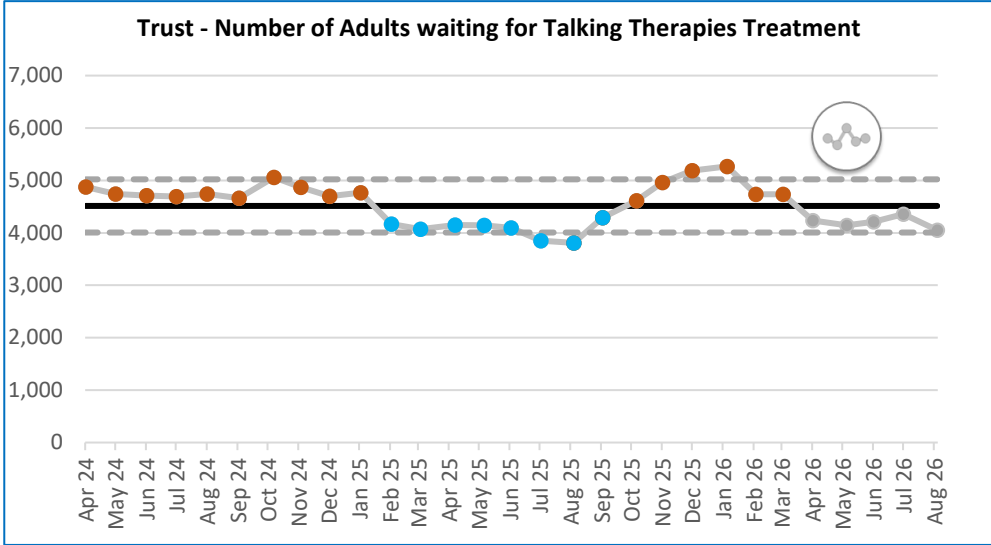
NYYS CG

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:

- North Yorkshire Talking Therapies: Treatment capacity will continue to be converted to assessment capacity, with the aim of reducing routine assessment waiting times to 4 weeks by 30 September 2026. Progress will be monitored through monthly waiting time reports.
- The York & Selby Talking Therapies Service Manager will expand the Keeping in Touch pilot across additional treatment pathways by 31 July 2026 to improve treatment waiting times from August 2026.



Talking Therapies - adults waiting for their second treatment contact				
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4054	118	524	
DTVF Care Group	1557	93	350	
NYYS&S Care Group	2497	134	524	
Commentary on Longest waits				
DTVF: Genuine Wait - no appt booked due to limited capacity				
NYYS&S: Genuine Wait - DNAd waiting for specific appt time and location				

7. Population health, prevention and reducing inequality

Governance forum responsible:

Non-Executive Chair:

Executive Lead:

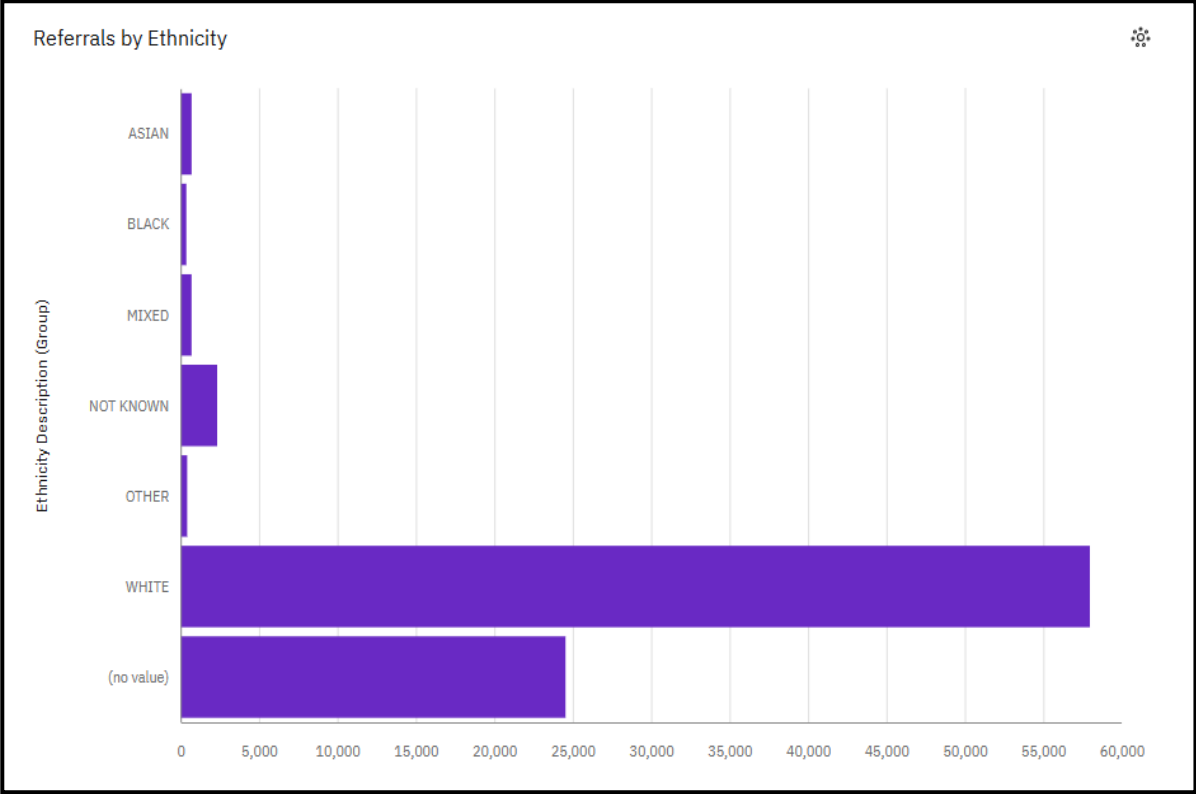
Quality and Assurance Committee

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.

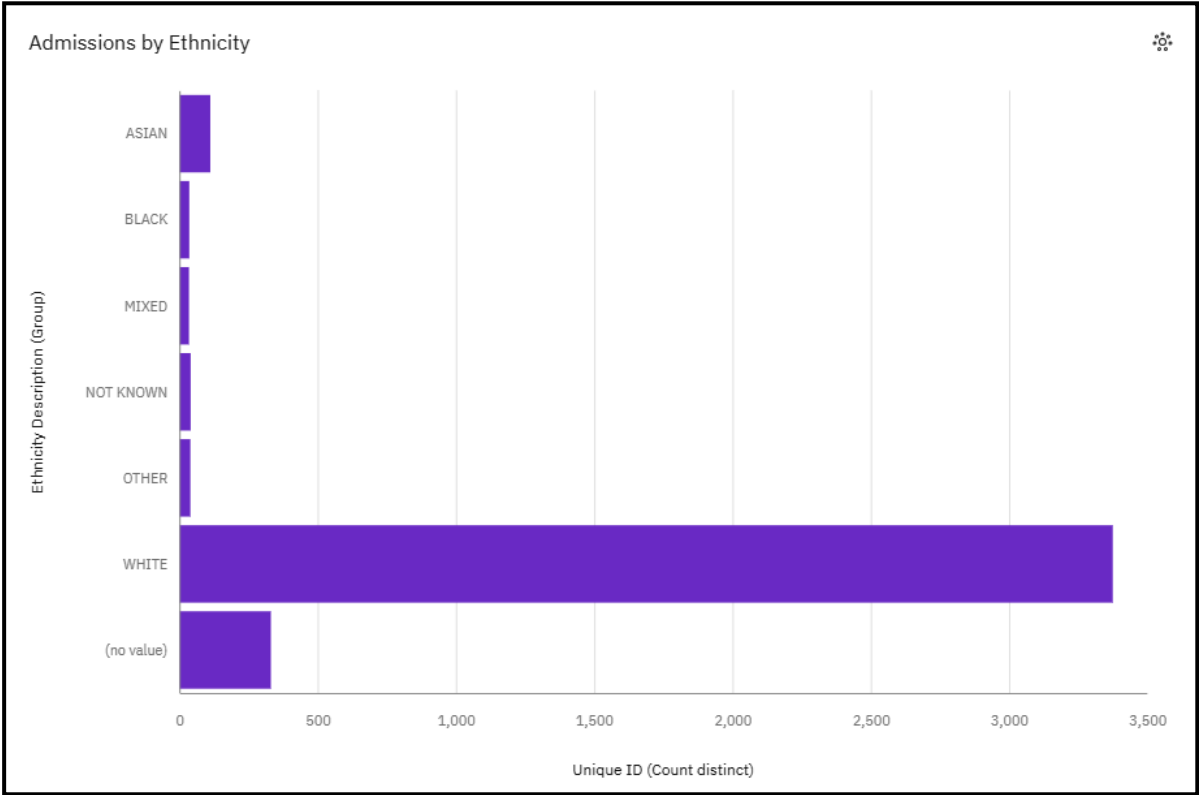


* NOTE: No Value – No ethnicity recorded

- 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.

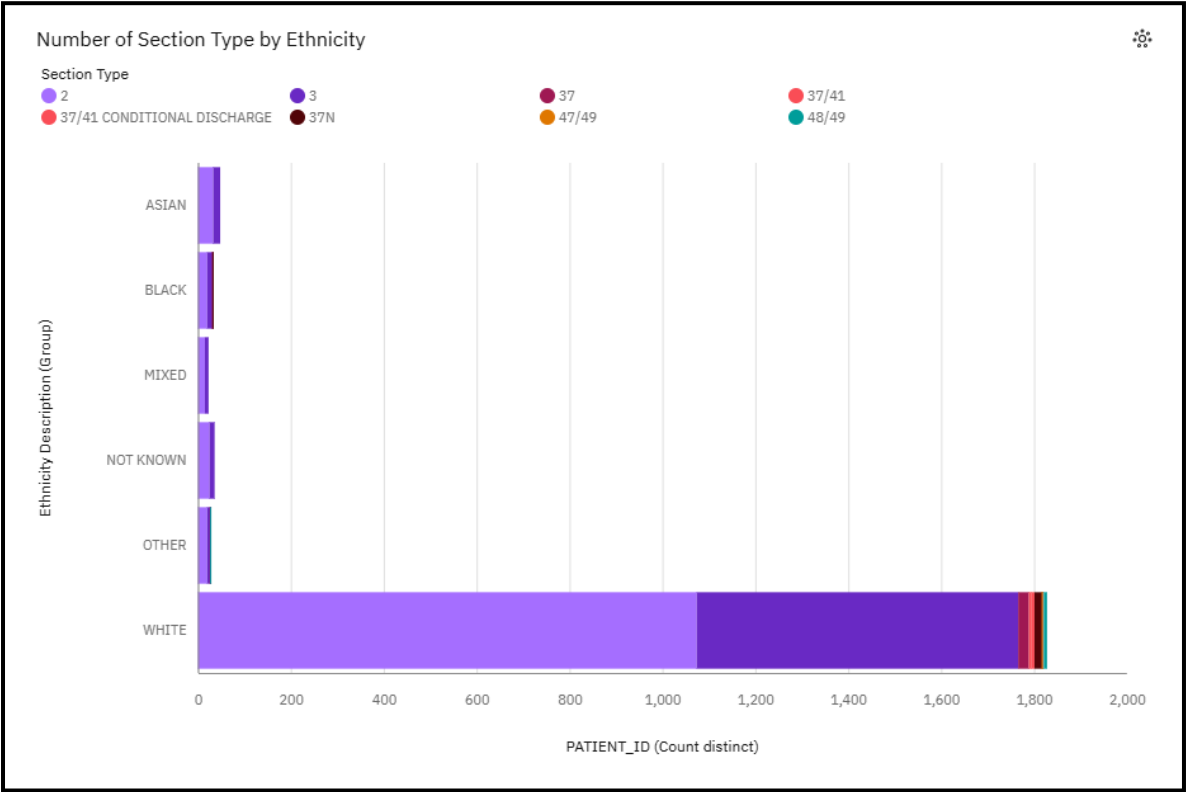


* NOTE: No Value – No ethnicity recorded

- 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 approved 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.

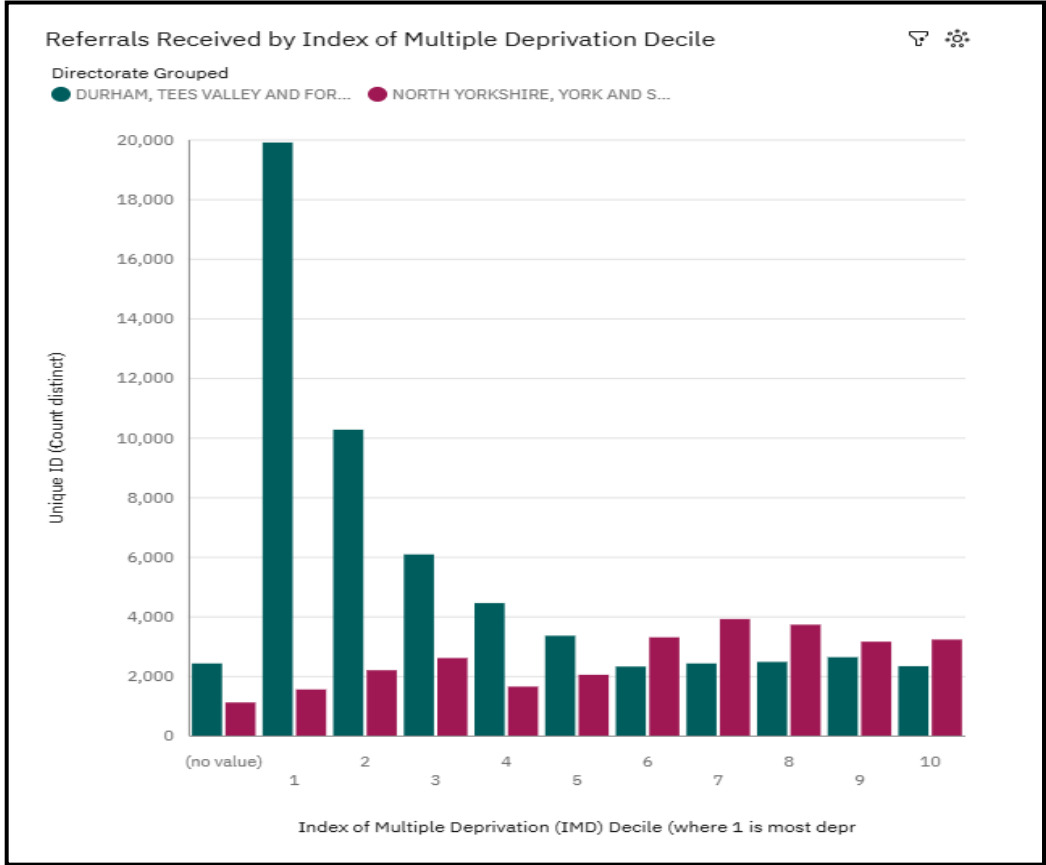
- Annual data analysis identifies that when viewed as a population rate that Black/ Black British people were detained 2.03 times more than White People, in 2024/25 compared to 2.61 times more in 2023/24



- 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.

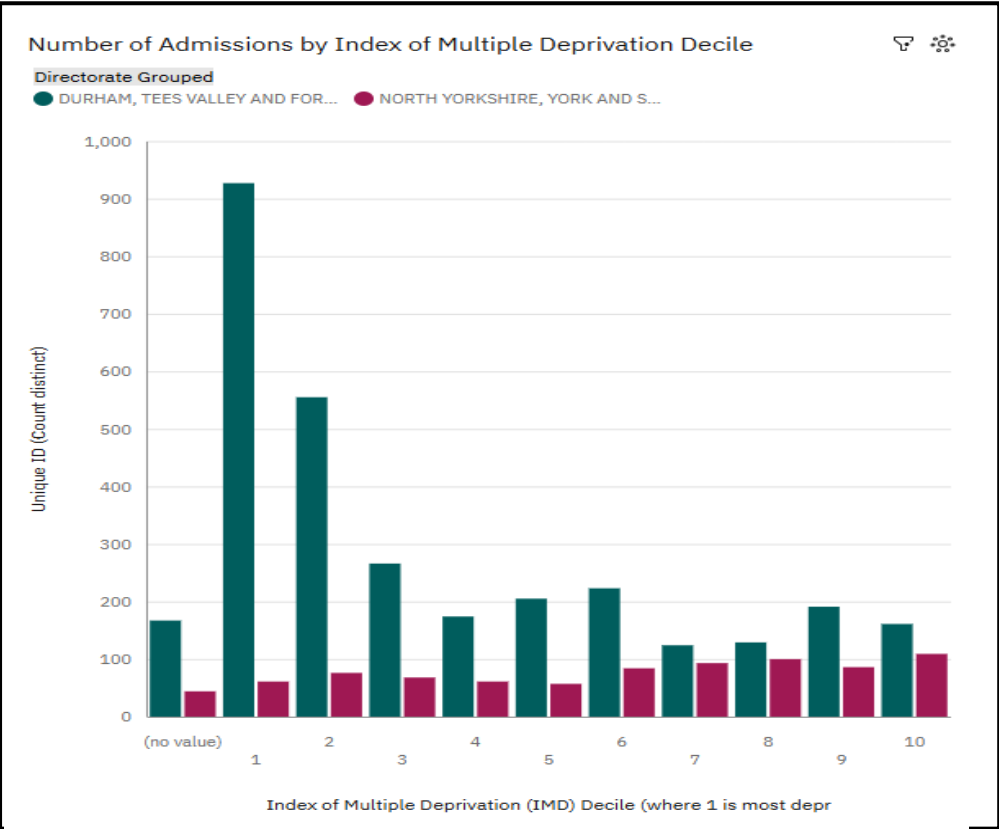


* NOTE: No Value – No corresponding deprivation decile available for the given postcode

2 additional service pathway will be “Poverty Proofed”[®] this financial year with learning shared across specialities .

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

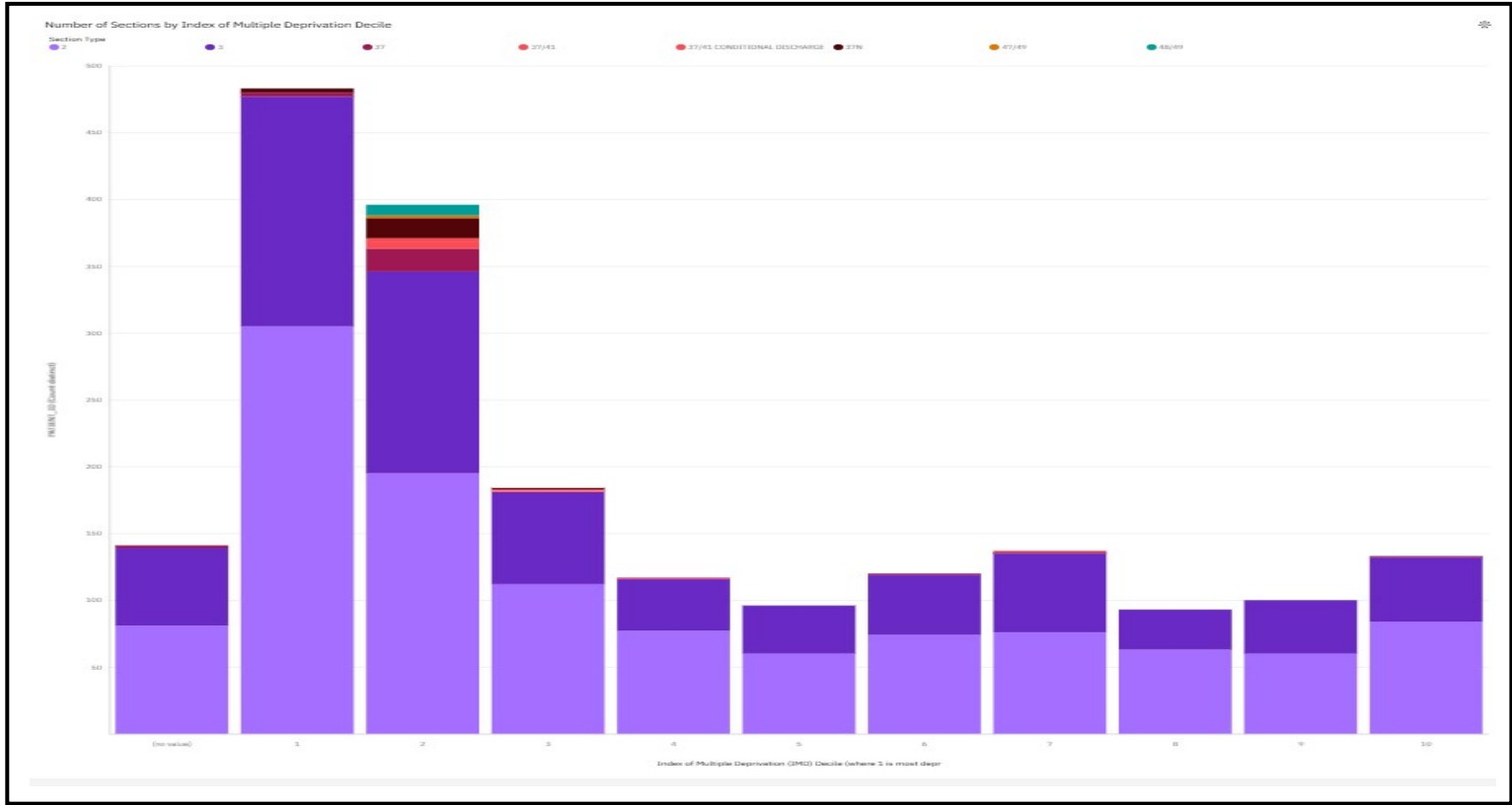
- The interconnectedness of poverty and mental ill health means that those using our services are disproportionately impacted by financial hardship.
- The Trust serves some of the most deprived communities in the country. This is reflected in admission rates which show significantly higher number of 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 within annual data. This is a reflection of the different population make up in the two care groups and demonstrates the need to interrogate this data at place level and in the context of the communities served.



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

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

8. Care Group

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%	94.29%	93.25%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	80.49%	82.94%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	78.67%	75.47%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	64.91%	64.53%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	45.47%	46.45%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	60.22%	61.29%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC			30.00%	27.23%	28.81%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	87.39%	89.21%	

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				13.39%	13.39%	
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				3	5	
12)	The number of Incidents of moderate or severe harm	QAC				22	65	
13)	The number of Restrictive Interventions Used	QAC				878	3,871	
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				1	2	
15)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				1	1	
16)	The number of uses of the Mental Health Act	MHLC				247	889	

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 is being shared with Resources & Planning Committee for approval.

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%	52.01%	53.23%	
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	56.63%	57.39%	
19)	Staff Leaver Rate	PCDC			11.00%	9.46%	9.46%	
20)	Percentage Sickness Absence Rate (month behind)	PCDC			5.50%	7.42%	7.38%	
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC			85.00%	92.88%	92.88%	
22)	Percentage of staff in post with a current appraisal	PCDC			85.00%	90.03%	90.03%	

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				5,577	21,753	
24)	Unique Active Caseload (Snapshot)	RPC				36,052	36,052	

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	96,336,670	97,947,924	
26)	Agency Expenditure	RPC	667,337	875,134	
27)	Agency price cap compliance	RPC	67.00%	11.39%	
28)	Bank Expenditure	RPC	4,408,804	4,436,555	

Please Note: 24 Unique Active Caseload and 28 Bank Expenditure do not have a Data Quality Assessment rating as they new measures. These will be completed as part of the updated Data Quality Assessment ,which is underway and will be presented to Resources & Planning Committee for approval in September 2026.

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%	92.59%	94.14%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	90.32%	84.73%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	62.50%	74.38%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC			35.00%	73.49%	72.40%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC			55.00%	39.88%	42.86%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC			50.00%	64.81%	62.41%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician	QAC			30.00%	26.36%	26.44%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	92.32%	87.83%	

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				21.19%	21.19%	
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				2	2	
12)	The number of Incidents of moderate or severe harm	QAC				8	20	
13)	The number of Restrictive Interventions Used	QAC				178	516	
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				102	416	

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 is being shared with Resources & Planning Committee for approval.

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%	44.74%	43.33%	
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	60.53%	57.14%	
19)	Staff Leaver Rate	PCDC			11.00%	11.72%	11.72%	
20)	Percentage Sickness Absence Rate (month behind)	PCDC			5.50%	6.32%	5.65%	
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC			85.00%	92.42%	92.42%	
22)	Percentage of staff in post with a current appraisal	PCDC			85.00%	90.58%	90.58%	

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				2,854	10,862	
24)	Unique Active Caseload (Snapshot)	RPC				11,862	11,862	

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	39,883,422	40,333,055	
26)	Agency Expenditure	RPC	547,822	519,375	
27)	Agency price cap compliance	RPC	67.00%	63.40%	
28)	Bank Expenditure	RPC	577,328	1,007,457	

Please Note: 24 Unique Active Caseload and 28 Bank Expenditure do not have a Data Quality Assessment rating as they new measures. These will be completed as part of the updated Data Quality Assessment ,which is underway and will be presented to Resources & Planning Committee for approval in September 2026.

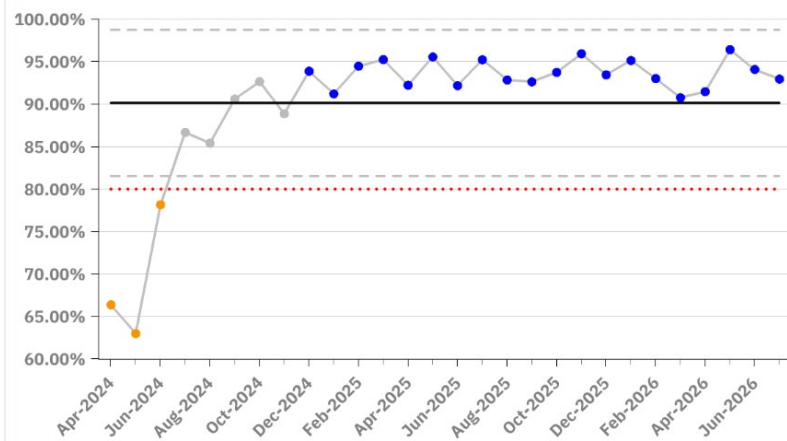
9. National metrics

National Quality Requirements

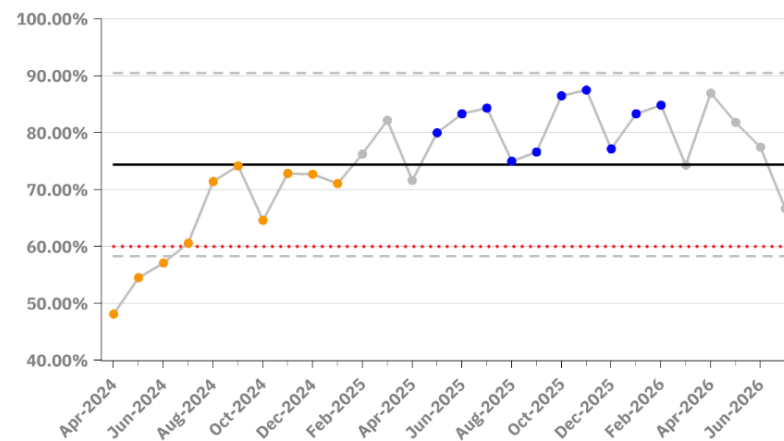
Rep Ref	National Quality Requirements	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26	May-26	Jun-26	Jul-26
IIC4850	Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care			80.00%	80.00%	93.72%	91.48%	96.43%	94.10%	92.96%
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%	77.74%	86.96%	81.82%	77.46%	66.67%
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%	92.39%	95.67%	93.78%	90.09%	90.06%
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%	99.92%
IIC5340	Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)			95.00%	95.00%	89.08%	86.74%	86.48%	87.20%	89.08%
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%	83.93%	78.69%	80.33%	80.70%	83.93%

National Quality Requirements

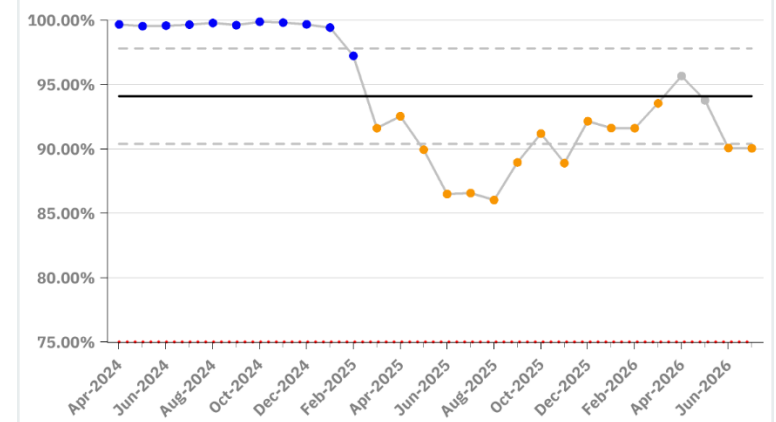
IIC4850 Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care - TRUST



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 - TRUST



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 - TRUST



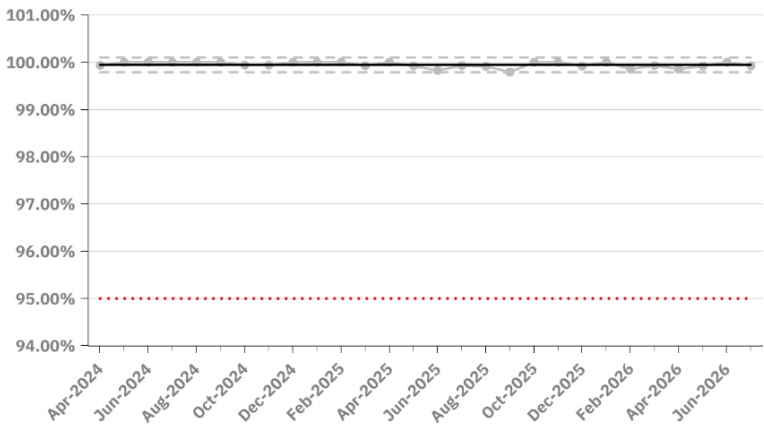
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	80%	93.72%			
COUNTY DURHAM	80%	95.65%			
TEES VALLEY	80%	94.77%			
NORTH YORKSHIRE	80%	96.00%			
YORK	80%	95.79%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	60%	77.74%			
COUNTY DURHAM	60%	79.10%			
TEES VALLEY	60%	82.52%			
NORTH YORKSHIRE	60%	84.21%			
YORK	60%	38.46%			

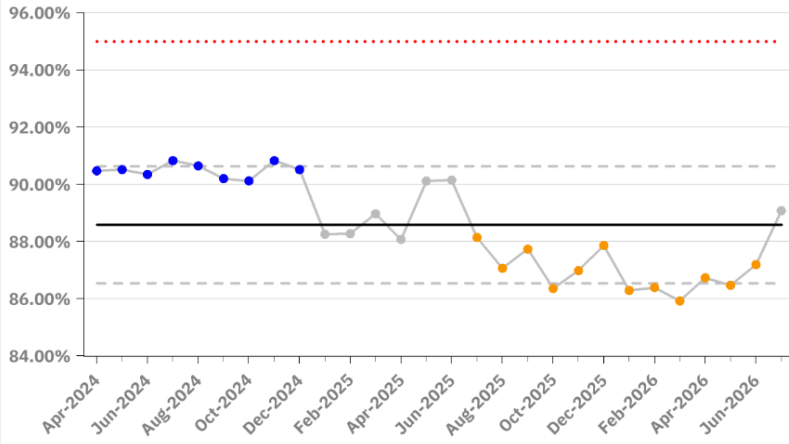
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	75%	92.39%			
COUNTY DURHAM	75%	94.38%			
TEES VALLEY	75%	94.94%			
NORTH YORKSHIRE	75%	87.48%			
YORK	75%	95.25%			

National Quality Requirements

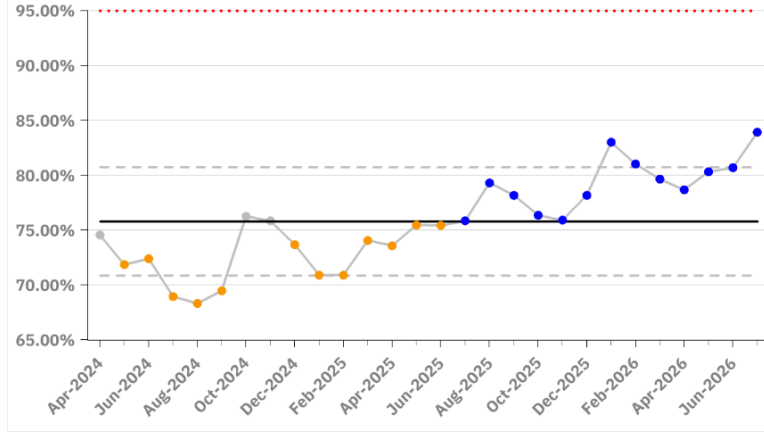
IIC6560 The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - TRUST



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



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



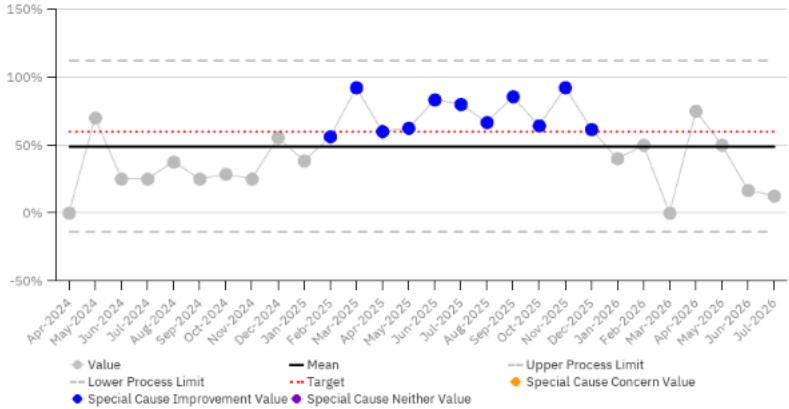
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	99.93%			
COUNTY DURHAM	95%	99.90%			
TEES VALLEY	95%	99.52%			
NORTH YORKSHIRE	95%	100.00%			
YORK	95%	100.00%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	89.08%			
COUNTY DURHAM	95%	86.79%			
TEES VALLEY	95%	95.79%			
NORTH YORKSHIRE	95%	92.59%			
YORK	95%	65.22%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	83.93%			
COUNTY DURHAM	95%	100.00%			
TEES VALLEY	95%	90.91%			
NORTH YORKSHIRE	95%	63.16%			
YORK	95%	83.33%			

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 July 2026, there were 8 patients referred experiencing First Episode Psychosis, of which 1 (12.50%) received an approved care package within 2 weeks in York.

Of the 7 patients that did not receive treatment within the standard, 6 patients were offered appointments (outside 2 weeks) due to team capacity. Patients commenced treatment between days 16 and 27.

The remaining wait was due to data quality and steps have been taken to resolve this on Cito.

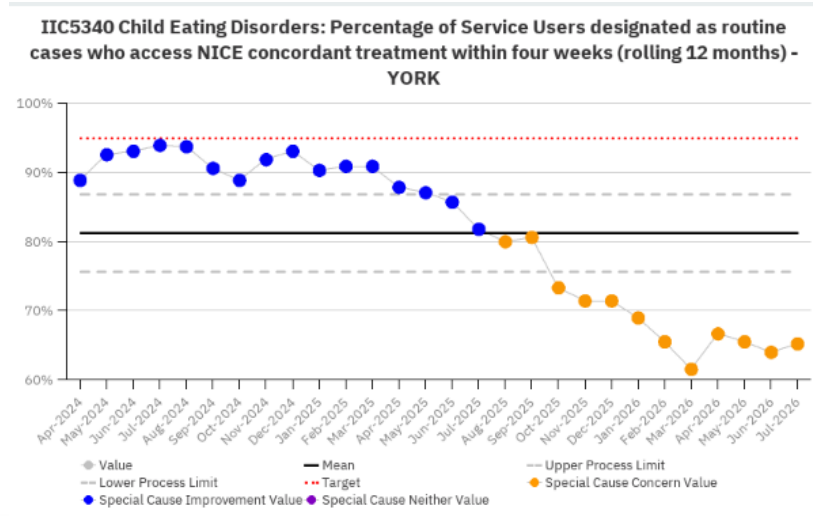
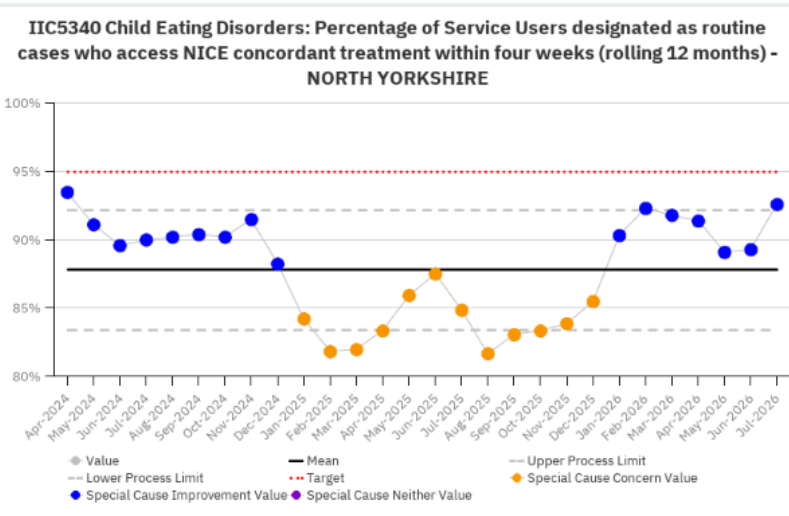
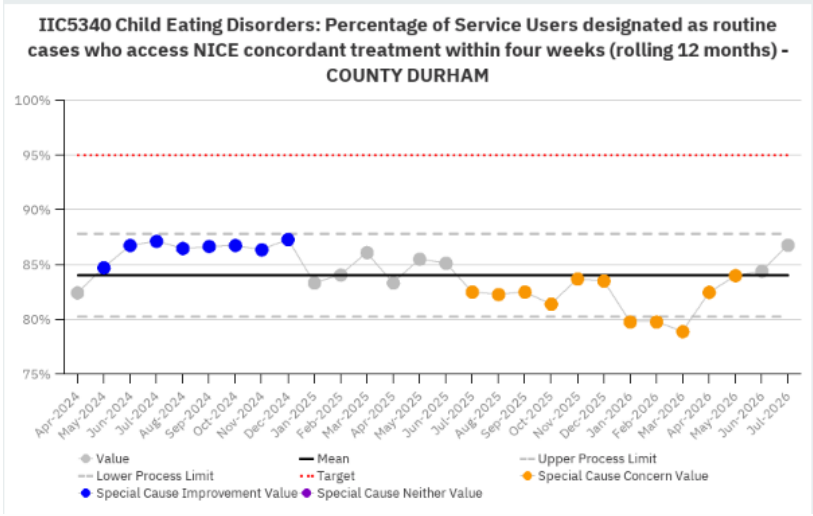
Underlying issues:

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

Actions:

As a Service Requiring Additional Support, the York & Selby EIP Team will implement its recovery plan by filling all substantive vacancies by 30 September 2026 and utilising increased care coordination capacity to address the backlog of patients awaiting treatment. Following delays to recruitment, improvements in waiting list performance are anticipated from August 2026, with further gains expected as additional staff come into post.

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 July 2026, there were **106** children and young people with a routine referral, of which **92 (86.79%)** started treatment within 4 weeks in **County Durham**.

In July there were 9 children and young people with a routine referral; all **(100%)** started treatment within 4 weeks.

What does the chart show/context:

In the rolling 12 months ending July 2026, there were **54** children and young people with a routine referral, of which **50 (92.59%)** started treatment within 4 weeks in **North Yorkshire**.

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

What does the chart show/context:

In the rolling 12 months ending July 2026, there were **23** children and young people with a routine referral, of which **15 (65.22%)** started treatment within 4 weeks in **York**.

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

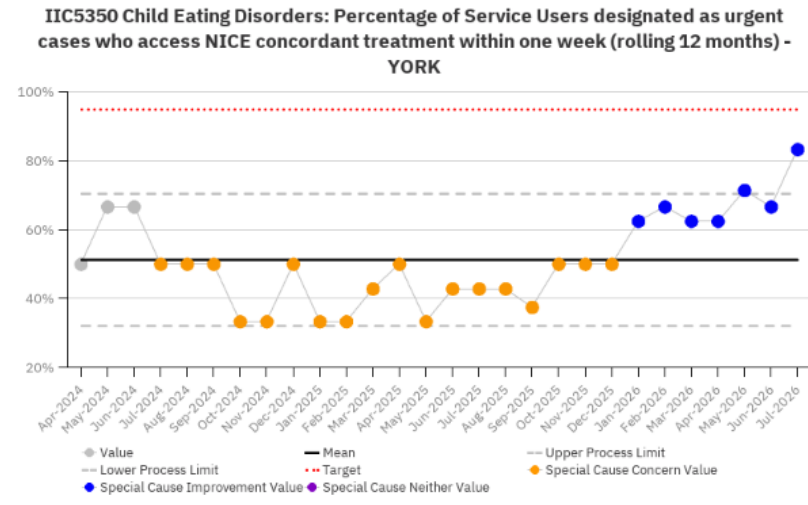
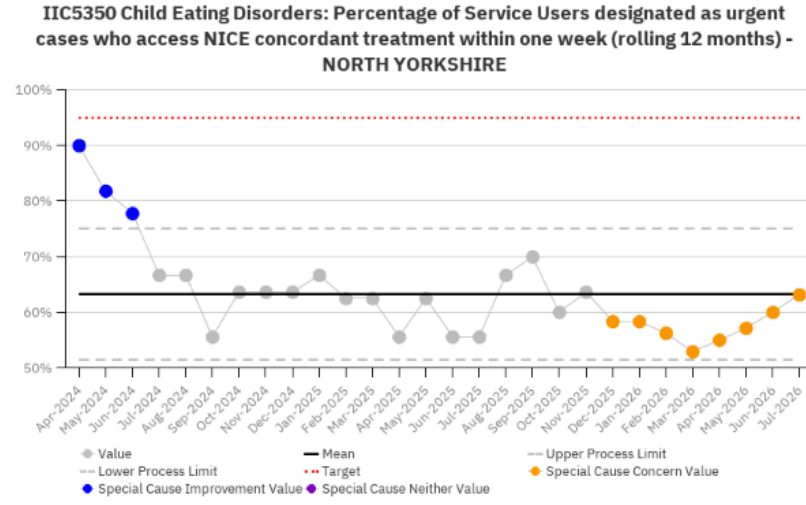
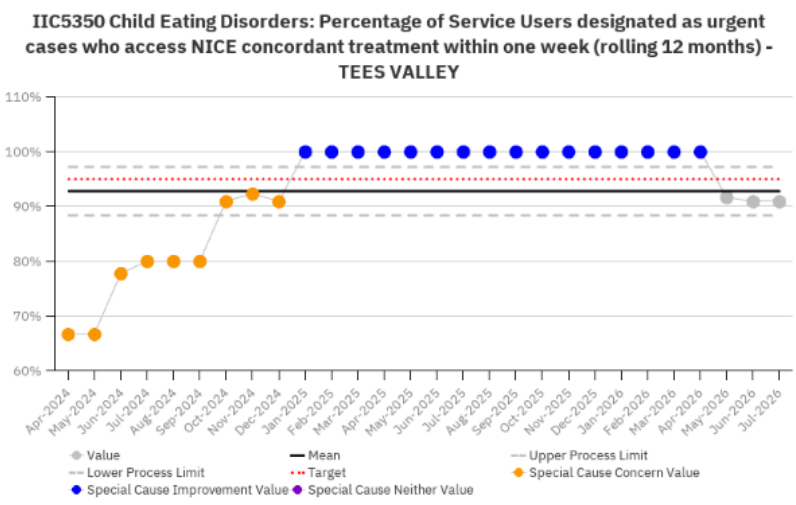
Underlying Issues:

There are no underlying issues to report.

Trust-wide Actions:

Following agreement at the Combined Care Group Board in July 2026, Directors of Operations will submit the service improvement plan, including agreed actions and improvement trajectories from the service deep dive, to the Executive Directors Group in August 2026 for approval.

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

In July, there was **1** child or young person with an urgent referral. They started treatment within 1 week

What does the chart show/context:
In the rolling 12 months ending July 2026 there were **19** child or young people with an urgent referral, of which **12 (63.16%)** started treatment within 1 week in **North Yorkshire**.

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

What does the chart show/context:
In the rolling 12 months ending July 2026, there were **6** child or young people with an urgent referral, of which **5 (83.33%)** started treatment within 1 week in **York**.

In July, there was **1** child or young person with an urgent referral. They started treatment within 1 week

Underlying Issues:
There are no underlying issues to report.

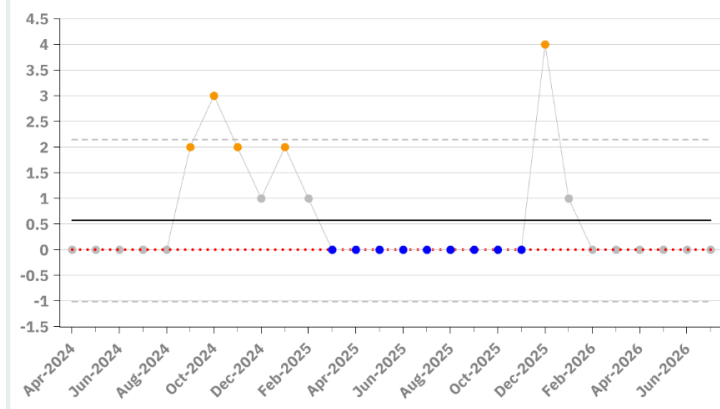
Actions:
There are no specific improvement actions required.

Mental Health Priorities – Provider and System-wide Plans

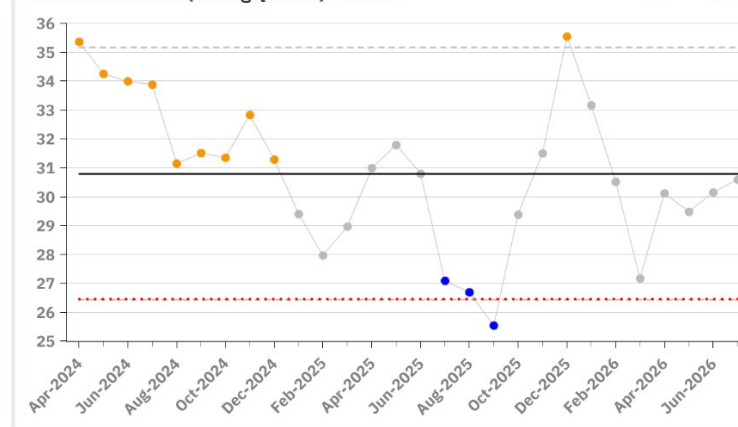
Rep Ref	Mental Health Priorities - Provider and System-wide Plans	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26	May-26	Jun-26	Jul-26
IIC6630	Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider (OAPs)			0	0	0	0	0	0	0
IIC6950	Average length of stay for patients in Adult Acute and PICU Mental Health Beds (Rolling Quarter)			26.40	26.46	30.59	30.12	29.48	30.15	30.59
IIC6960	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (Rolling Quarter)			70.00	70.12	76.71	70.12	72.30	74.27	76.71
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	73	725	340	257	73

Mental Health Priorities – Provider and System-wide plans

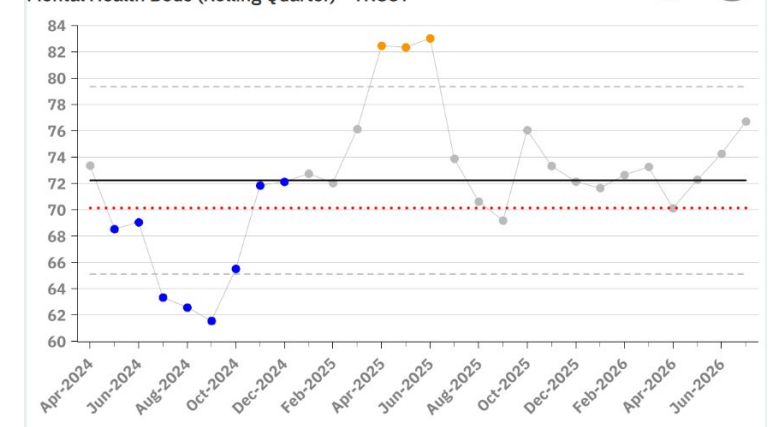
IIC6630 Number of active inappropriate adult acute OAPs that are either 'internal' or 'external' to the sending provider (OAPs) - TRUST



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



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



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	30.59			
COUNTY DURHAM		33.03			
TEES VALLEY		33.77			
NORTH YORKSHIRE		26.98			
YORK		26.97			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	70.12	76.71			
COUNTY DURHAM		57.14			
TEES VALLEY		89.78			
NORTH YORKSHIRE		88.44			
YORK		42.00			

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	73			
COUNTY DURHAM		45			
TEES VALLEY		27			
NORTH YORKSHIRE		0			
YORK		1			

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 by the end of July 2026.

What does the chart show/context:

During the 3-month period ending July 2026, there were **589** discharged hospital spells from adult acute or PICU beds for patients aged 18+, accounting for a total of **18,019** bed days which equates to an average length of stay of **30.59** days.

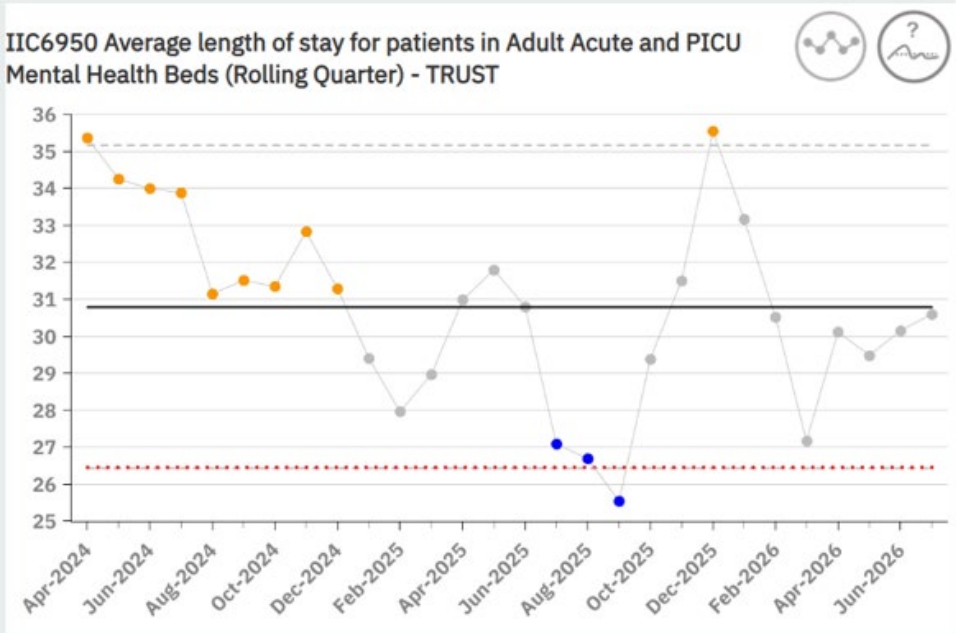
We are not achieving plan at Trust and Care Group level and there is no significant change in the reporting period.

Underlying issues:

- Long lengths of stay are largely impacted by the discharge of patients that are clinically ready for discharge.
- It should be noted that this measure is influenced by patients who require longer lengths of stay to meet their clinical needs.
- In the 3 months ending July 2026 there were 179 (out of 589) patients with a length of stay exceeding plan; 28 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	30.59								

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 July 2026.

What does the chart show/context:

During the 3-month period ending July 2026, there were 163 discharged hospital spells from older adult acute beds, accounting for a total of 12,504 bed days which equates to an average length of stay of 76.71 days.

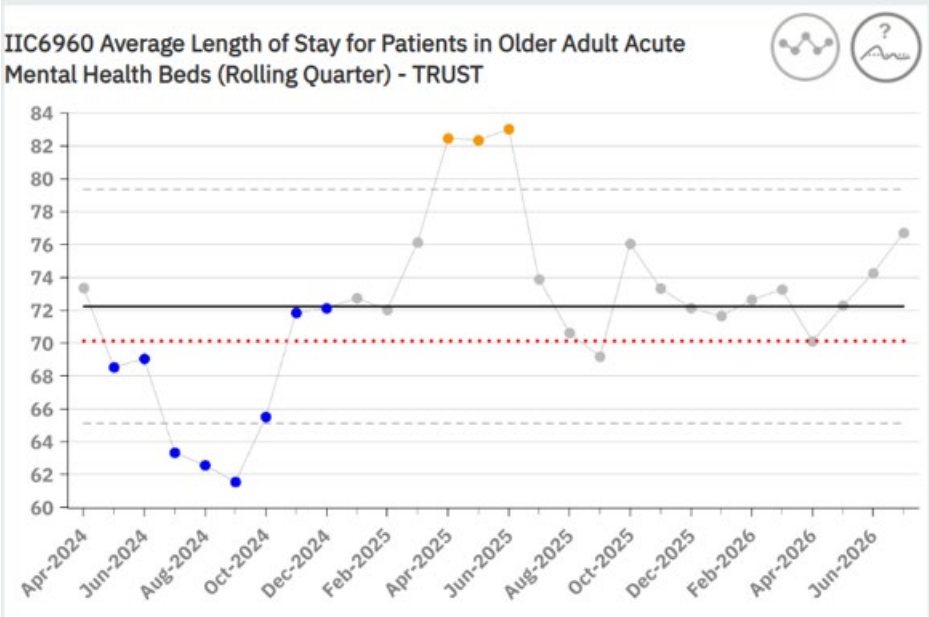
We are not achieving plan at Trust and Care Group level and there is no significant change in the reporting period.

Underlying issues:

- Long lengths of stay are largely impacted by the discharge of patients that are clinically ready for discharge.
- It should be noted that this measure is influenced by patients who require longer lengths of stay to meet their clinical needs.
- In the 3 months ending July 2026 there were 70 (out of 163) patients with a length of stay exceeding plan; 41 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 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	76.71								

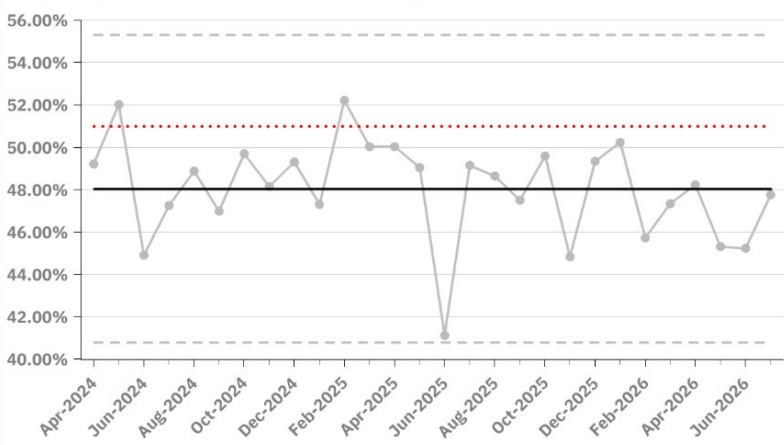
Mental Health Priorities – System-Wide Plans

Rep Ref	Mental Health Priorities - System-wide Plans	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26	May-26	Jun-26	Jul-26
IIC6490	Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness			51.00%	51.00%	46.65%	48.24%	45.32%	45.24%	47.77%
IIC6480	Talking Therapies - Reliable improvement rate for those completing a course of treatment			69.00%	69.00%	66.36%	67.51%	65.71%	65.69%	66.49%
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	5,401	1,385	1,286	1,402	1,328
IIC5371	Number of women accessing (1+ contact) specialist community PMH services in the previous 12 months		N/A	Data Only	Data Only	1,490	1,504	1,494	1,495	1,490
IIC6610	Number of people accessing IPS services (rolling 12 month)		N/A	Data Only	Data Only	1,381	1,199	1,244	1,328	1,381
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	29,909	31,249	30,847	30,439	29,909
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	2,108	1,990	2,014	2,057	2,108

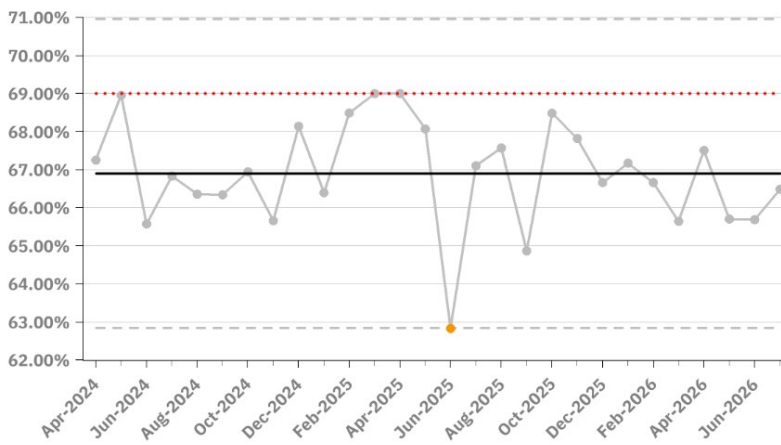
Please note that the variation for the number of women accessing specialist community PMH services has been removed due to several issues that we have identified. Remedial work is underway, and an action plan has been developed which is being overseen by the Associate Director of Performance.

Mental Health Priorities – System Wide Plans

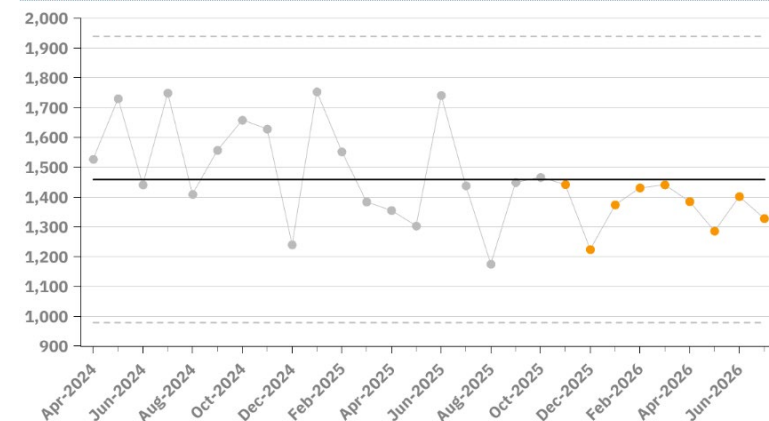
IIC6490 Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness - TRUST



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



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



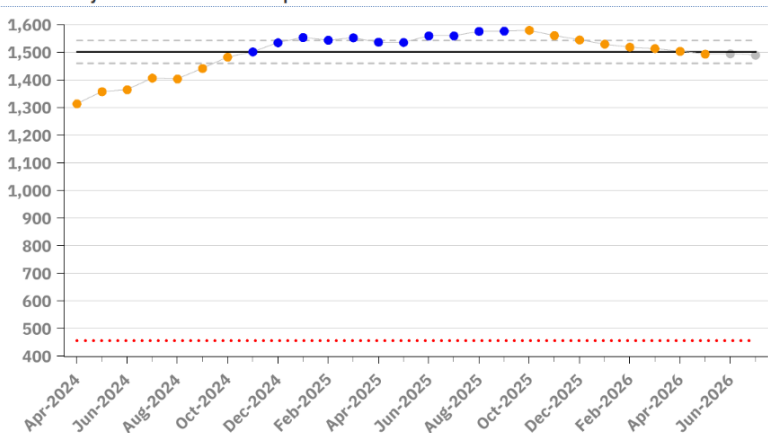
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	51%	46.65%			
COUNTY DURHAM	51%	42.69%			
TEES VALLEY	51%	45.65%			
NORTH YORKSHIRE	51%	49.28%			
YORK	51%	50.05%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	69%	66.36%			
COUNTY DURHAM	69%	64.30%			
TEES VALLEY	69%	65.78%			
NORTH YORKSHIRE	69%	67.92%			
YORK	69%	68.10%			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		5,401			
COUNTY DURHAM		2,101			
TEES VALLEY		415			
NORTH YORKSHIRE		1,733			
YORK		1,116			

Mental Health Priorities – System-Wide Plans

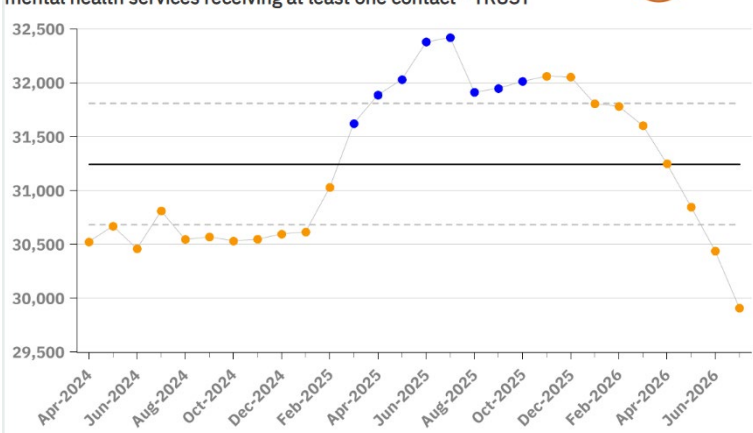
IIC5371 Number of women accessing (1+ contact) specialist community PMH services in the previous 12 months - TRUST



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,490			
COUNTY DURHAM	456	392			
TEES VALLEY	447	501			
NORTH YORKSHIRE	368	415			
YORK	156	160			

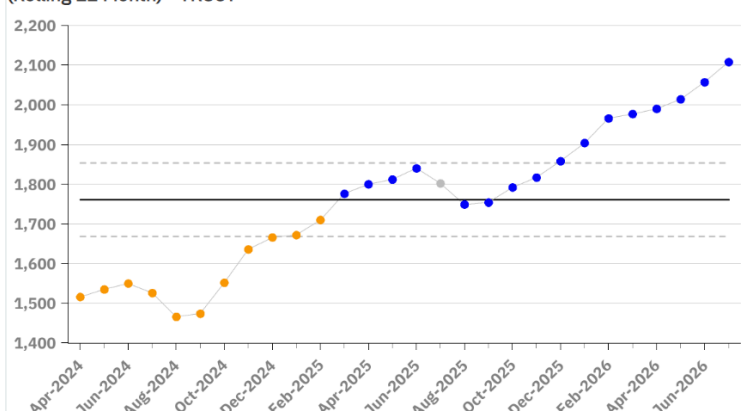
Please note that the variation for Trust and County Durham place has been removed due to several issues that we have identified. All practicable actions have been undertaken. A briefing note is in development to support understanding of the issues identified, the implications for the rolling metric, and the expected trajectory for achieving a fully accurate reported position.

IIC5830 Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact - TRUST



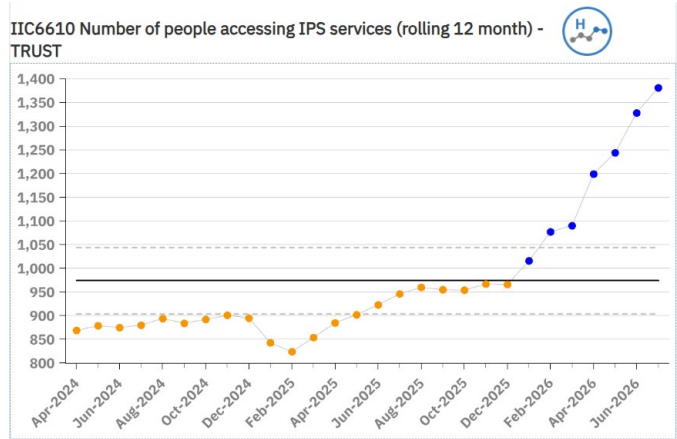
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		29,909			
COUNTY DURHAM		10,612			
TEES VALLEY		9,509			
NORTH YORKSHIRE		5,703			
YORK		3,488			

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) - TRUST



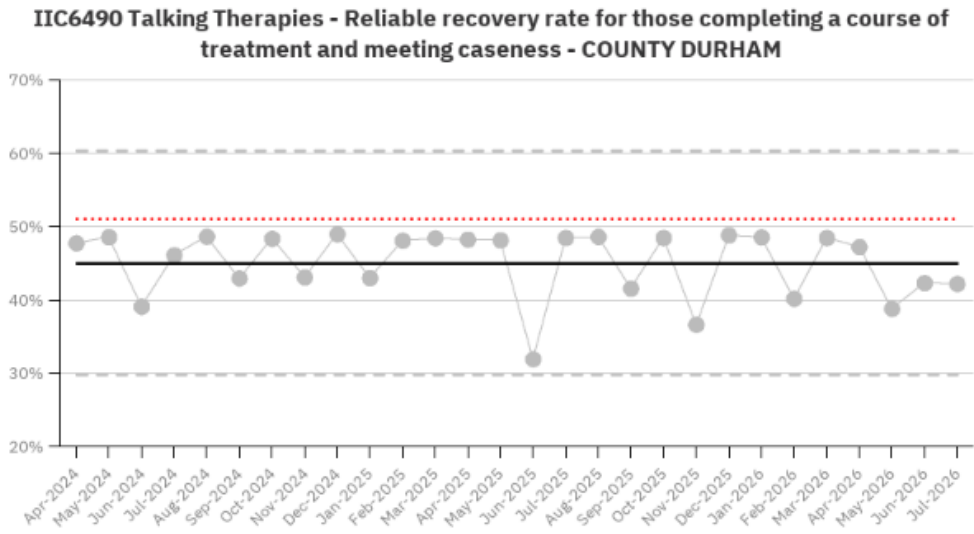
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		2,108			
COUNTY DURHAM		977			
TEES VALLEY		363			
NORTH YORKSHIRE		480			
YORK		224			

Mental Health Priorities – System-Wide Plans



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,381			
COUNTY DURHAM		443			
TEES VALLEY		534			
NORTH YORKSHIRE	380	244			
YORK		115			

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



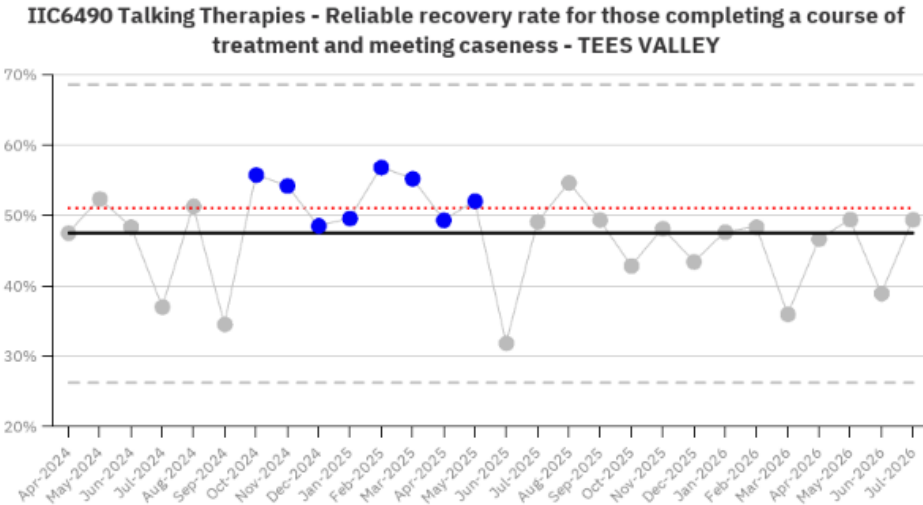
Background / standard description:

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 **42.69%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **County Durham**. During July, **42.21%** 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.

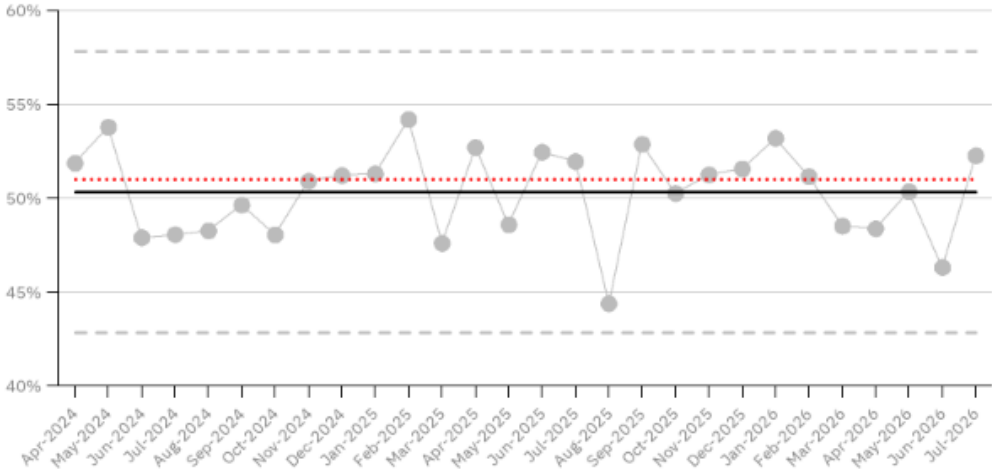
What does the chart show/context:

Financial year to date **45.65%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **Tees Valley**. During July, **49.41%** 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:

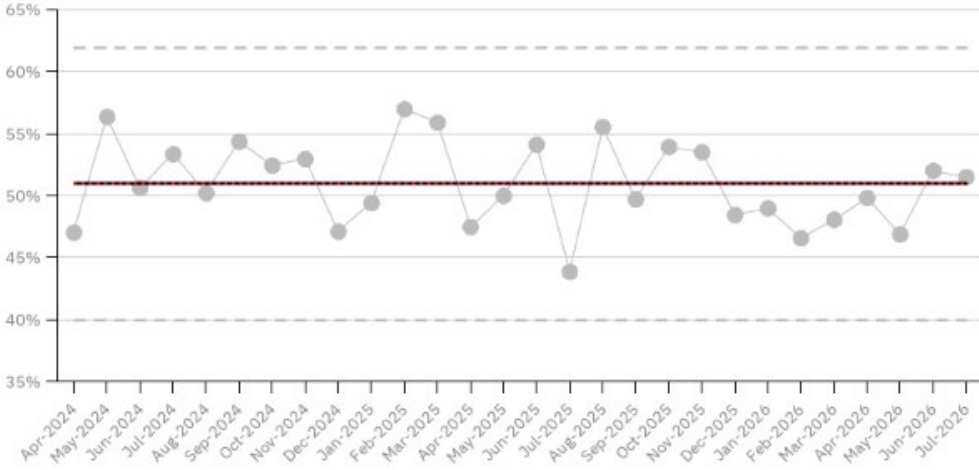
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:

Financial year to date **49.28%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **North Yorkshire**. During July, **52.27%** 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:

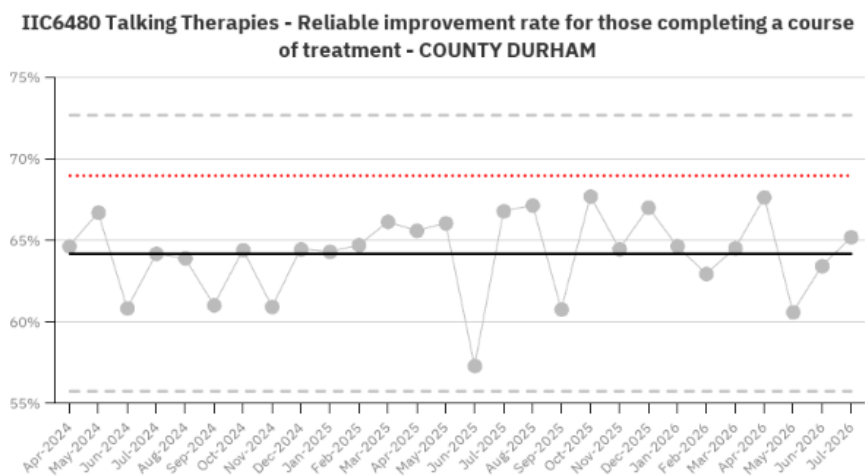
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:

Financial year to date **50.05%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **York**. During July, **51.52%** 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*



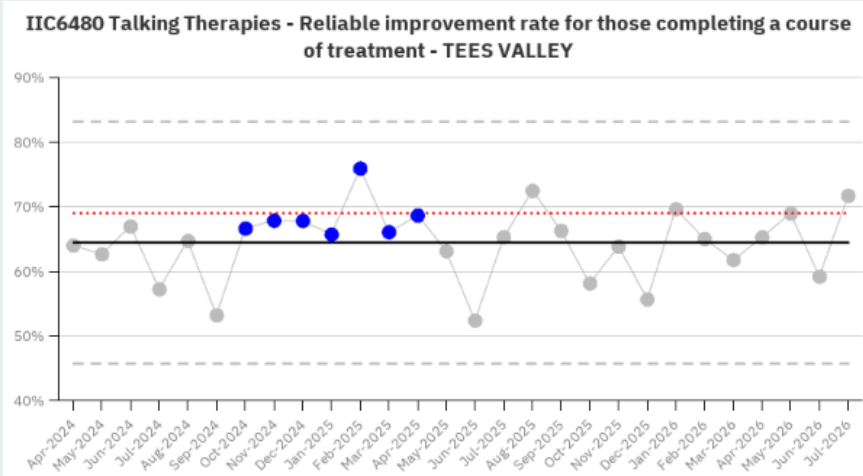
Background / standard description:

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 **64.30%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**. During July, **65.20%** demonstrated reliable improvement.

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



Background / standard description:

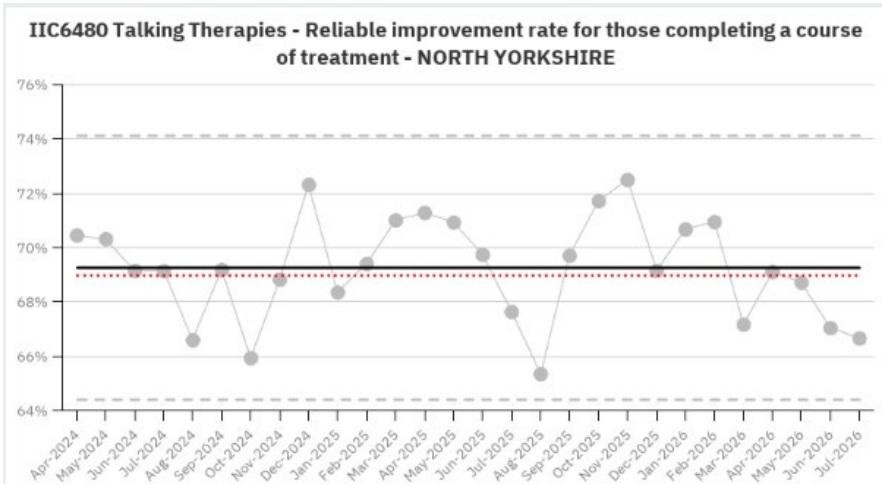
We are aiming for 69% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:

Financial year to date **65.78%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**. During July, **71.74%** 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*



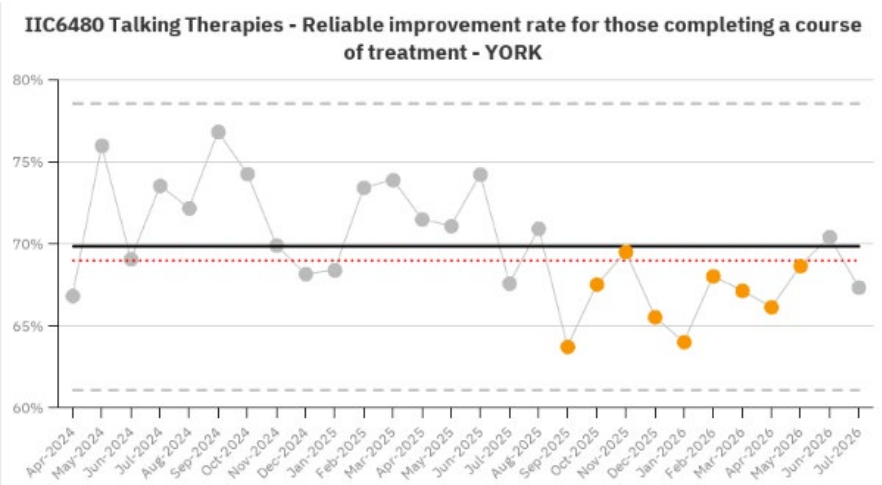
Background / standard description:

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 **67.92%** of patients demonstrated reliable improvement following completion of a course of treatment within **North Yorkshire**. During July, **66.67%** 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 **68.10%** of patients demonstrated reliable improvement following completion of a course of treatment within **York**. During July, **67.35%** 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:

- The General Manager will recruit 3.7 WTE PWP. 2 Trust-qualified PWP posts will go to Vacancy Control by the end of August 2026, and Mental Health Matters will look to recruit 2 trainee PWPs from the January 2027 intake (increased from 1.7 WTE due to slippage in management costs).
- The DTVFCG Performance Improvement Plan had 6 actions due for completion by July 2026, of which 5 have been completed. The remaining action is to implement KOA Step 3 Therapy; funding is now anticipated to be signed off by the end of August 2026. Testing of the trial separation of the Step 1 data is subject to a next steps paper.
- The General Manager submitted a workforce and financial gap analysis paper to EDG in July 2026, seeking additional staffing investment. EDG will revisit the proposal and confirm required actions by 30 September 2026.

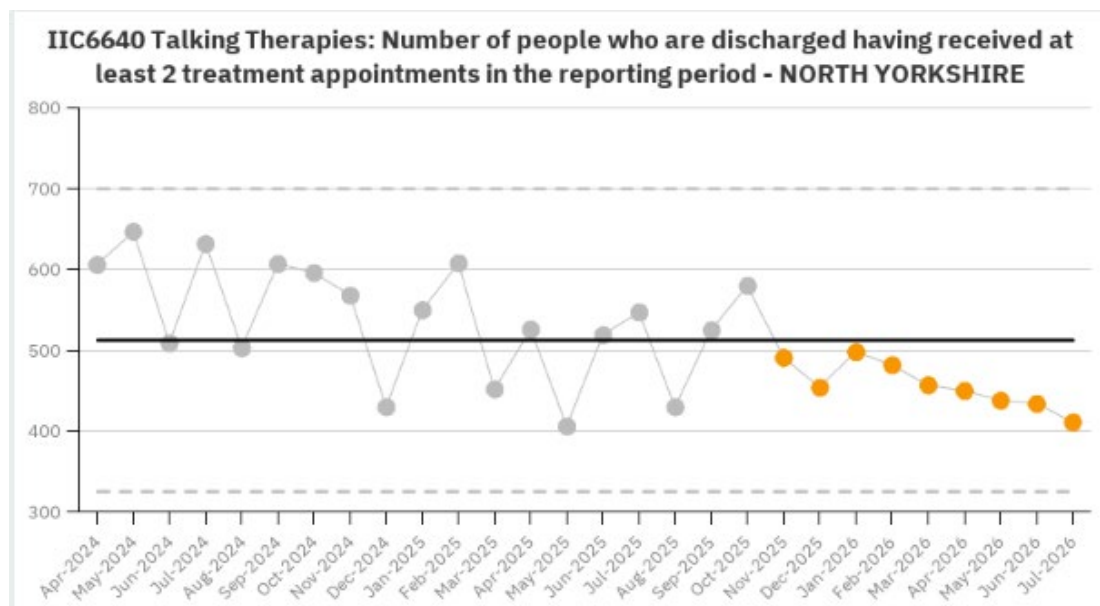
North Yorkshire & York

Underlying issues:

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

Actions:

- North Yorkshire Talking Therapies team manager will 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 will 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 commenced in July 2026 and will be embedded in service process by the end of September.
- Scarborough Talking Therapies team manager will 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.



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 **1,733** patients discharged having received at least 2 treatment appointments in the report period within **North Yorkshire**. During July, 411 patients received at least 2 treatment appointments.

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

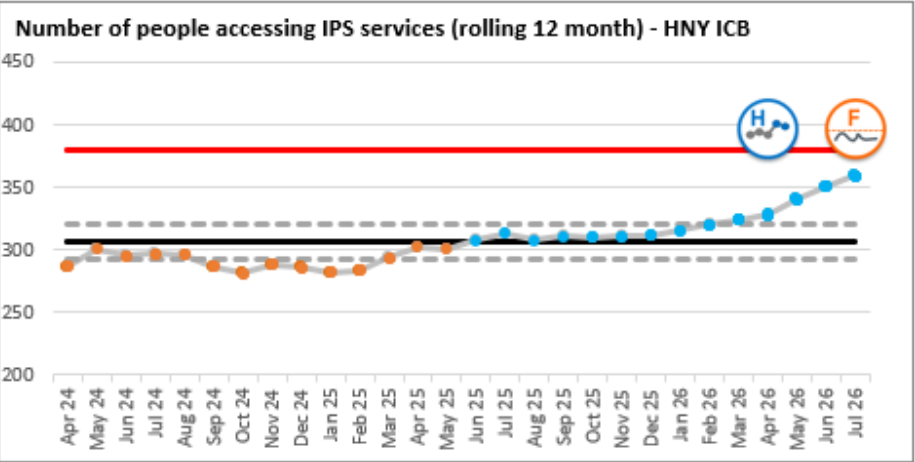
Underlying issues:

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:

- Care Group Board Quality & Performance Group have 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



Background / standard description:
In the 12 months ending July 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 July 2026, **350** people accessed IPS services.

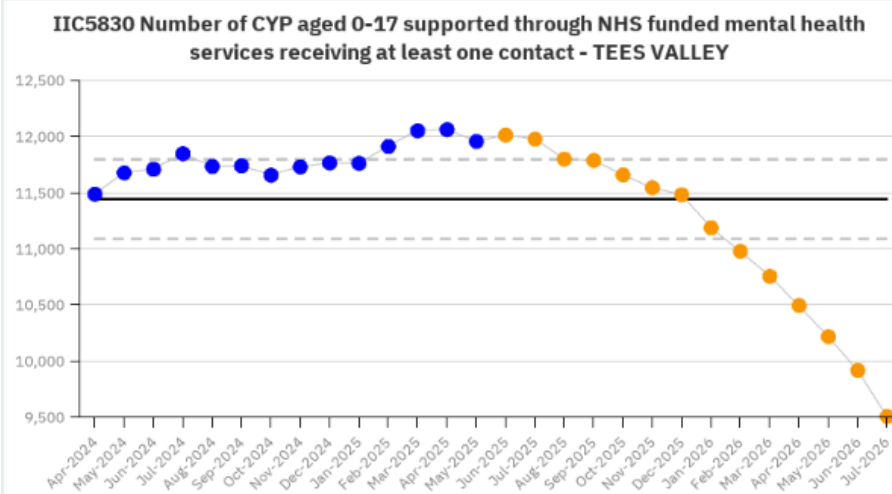
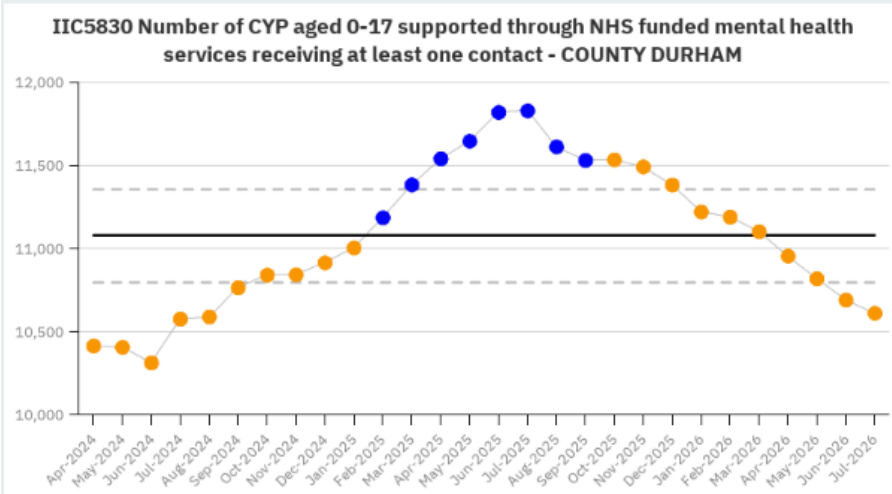
HNY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TEWV- Ambition	380	380	380	380	380	380	384	385	434	466	501	536
TEWV- Actual	328	341	351	359								

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

Actions:
The Senior Employment Specialist commenced in post on the 1st August 2026 and the Employment Specialist returned from maternity leave at the end of 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/early September 2026. Two wte Employment Specialists have been appointed and are progressing through pre-employment processes and recruitment for 3.8wte Employment Specialists is now underway.

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 July, **10,612** children and young people received at least one contact within **County Durham**.

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

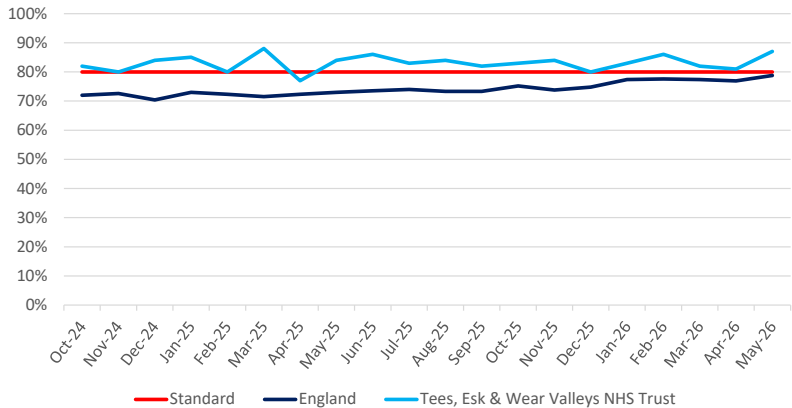
- Underlying Issues:**
- The root causes of the reported performance position for County Durham place have not yet been fully established.
 - In January 2026 we launched the new CYP Tees Valley Getting Help Service, whose data is recorded on IAPTUs. Whilst this data is incorporated into our MHSDS, it 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 has completed the data collation and analysis required to inform the review of reduced performance within County Durham Place. The Performance Lead and General Manager are now working together to complete service-level discussions and investigation to understand the factors contributing to the reduction. Due to the additional engagement and analysis required, this will be completed by 31 August 2026.
 - 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. **(Complete)** The review concluded that no robust interim solution is currently available. Whilst manual aggregation of data sources could provide an indicative position, the inability to de-duplicate patients across datasets would result in an overestimated figure. Consequently, the reported position cannot be assured as sufficiently accurate pending implementation of RiO

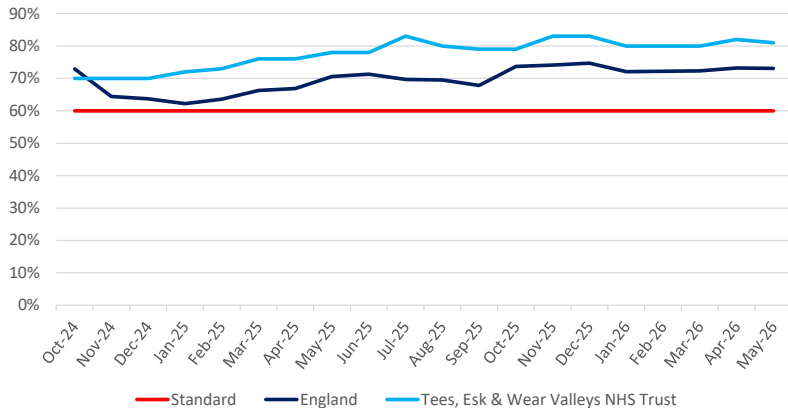
10. Benchmarking

National Quality Requirements

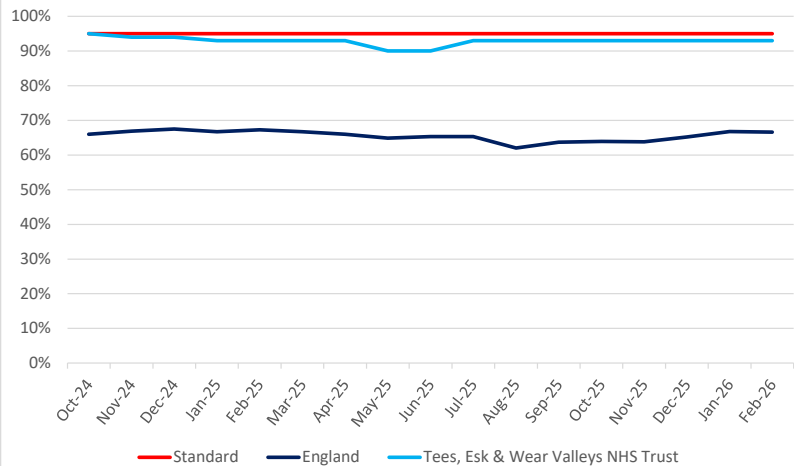
Percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care



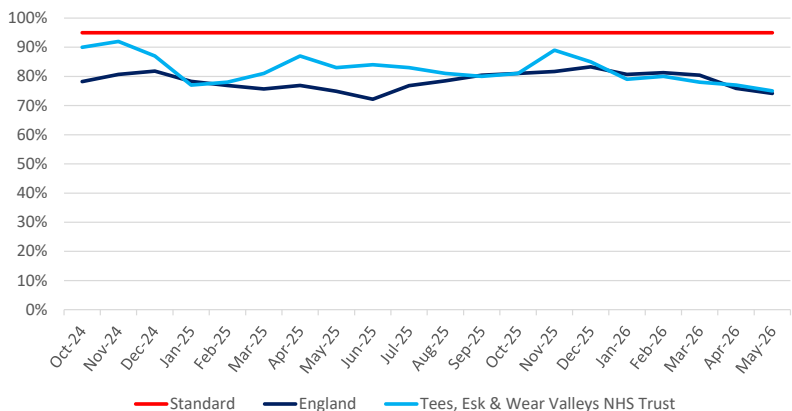
Percentage of service users experiencing a first episode psychosis of ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care



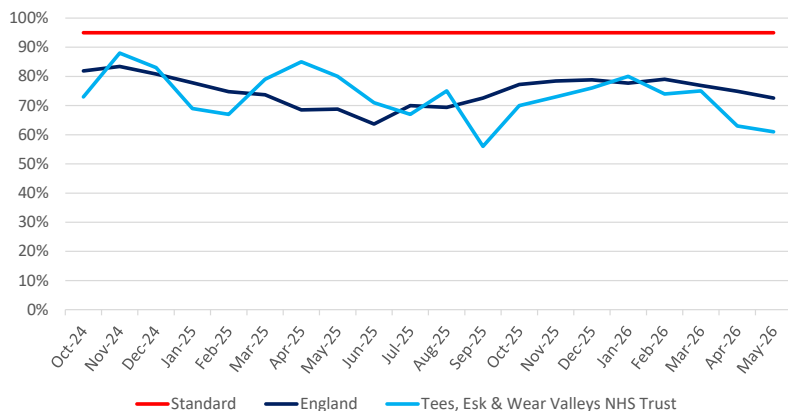
Data Quality Maturity Index



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



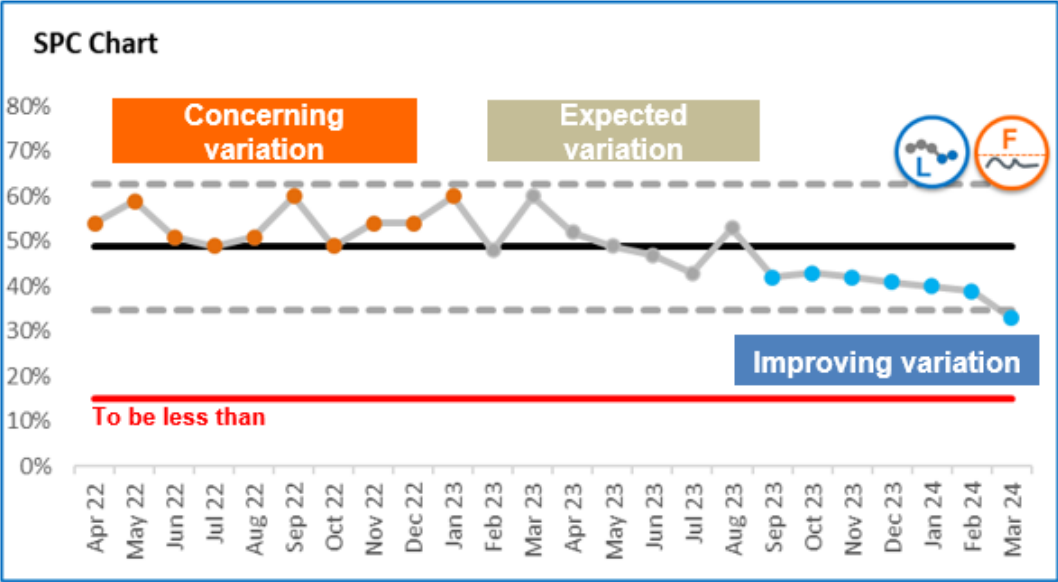
Child Eating Disorders: Percentage of service users designated as routine cases who access NICE concordant treatment within 4 weeks



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.

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 is underway and will be presented to Resources & Planning Committee for approval in September 2026.

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
HNy	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
NYYS CG	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

For General Release

Meeting of:	Board of Directors
Date:	23 rd September 2026
Title:	Utilising Population Health Intelligence: Locality and Neighbourhood profiles
Executive Sponsor(s):	Kedar Kale – Executive Medical Director Naomi Lonergan- Interim Care Group Managing Director Kathryn Ellis - Interim Executive Director of Transformation and Strategy
Author(s):	Catherine Parker, Consultant in Public Health Abi Neasham, Public Health Speciality Registrar Jo Murray, Associate Director - MH/LD Partnerships and Strategy

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	☒

BAF ref no.	Risk Title	Context
2	Demand	It is proposed that neighbourhood and locality profiles will provide intelligence on population need, inequalities and drivers of demand supporting more effective service planning. The proposed work supports better decisions, more equitable allocation of resources, and improved patient flow across the system.
4	Quality of Care	Neighbourhood and locality profiles may help identify variation in need, outcomes and access to care, enabling targeted quality improvement, service planning and resource allocation. This could support more equitable, consistent care, reduce unwarranted variation, and help mitigate risks to quality, safety and patient experience.
9	Partnership and Systems Working	The profiles are based on public health system intelligence. Neighbourhood and locality profiles will provide a mechanism for engagement with system partners through their development and use of a shared evidence base. Utilising partner intelligence, local strategies and community insight, the profiles support shared understanding and alignment of priorities. This strengthens partnership working and our ability to collectively influence and improve population health outcomes at scale.
10	Regulatory Compliance	The Trust is expected to demonstrate action through the Patient and Carer Race Equality Framework, the Public Sector Equality Duty, the National Oversight Framework assurance process and Care Quality Commission requirements. Without further targeted delivery, there is a risk that the inequalities identified in the data are not translated into sufficient action and assurance.

14	Health Inequalities	Neighbourhood and locality profiles will provide further information on inequalities in need, access and outcomes, informed by partner intelligence and community insight. They can support targeted action to improve service reach, address barriers to access and focus resources on underserved communities, helping to reduce health inequalities and improve outcomes.
----	----------------------------	--

Executive Summary

Purpose

This paper presents the draft locality profiles (Appendix 1), which provide an accessible summary of population health need across the communities served by TEWV and align with the emerging locality-based model for clinical and operational delivery. The profiles are intended to give the Board routine access to clear, accessible information on local population health need, supporting informed strategic oversight and decision-making.

The profiles bring together publicly available data, Joint Strategic Needs Assessments, Director of Public Health Annual Reports, local strategies and partner intelligence to provide a place-based understanding of population characteristics, mental health need, inequalities, drivers of demand and community assets across TEWV localities. Their development, and the needs reflected within them, support delivery of the existing Medium-Term Plan and are intended to directly inform the forthcoming strategic plan refresh.

The profiles are intended to complement, rather than duplicate, existing local intelligence and form part of a wider programme of work with our partners. This work will strengthen shared understanding of population health need at locality level and ensure that this intelligence informs emerging locality and neighbourhood approaches, service planning, transformation and governance. The profiles are not intended to be comprehensive assessments of need; they provide a strategic overview that can be supplemented by more detailed neighbourhood-level intelligence available through a range of existing and developing public health data sources.

Proposal

It is proposed that the Trust begins to utilise the profiles to inform the organisational strategic plan refresh and the development of the locality and neighbourhood working models. Alongside this, further work will be undertaken to validate the locality profiles with Care Groups and system partners.

The Board of Directors is asked to:

1. Note the content of the profiles and support their ongoing development with our partners.
2. Note the intention to align this insight with the development of our forthcoming refresh of the Trust Strategy, of a refreshed communications strategy with locally focused messaging, and our anticipated feedback from PA Consulting on stakeholder perceptions
3. Note the alignment of these profiles with the emerging locality-based model for clinical and operational delivery.
4. Support their use alongside the development of locality-based internal data within the IPQR.
5. Draw on the data to inform interactions with services, partners and communities

Together, the above will strengthen the Trust's focus on deepening understanding of our local communities and developing partnerships, supporting the Trust's strategic ambition

Overview

Population health intelligence can support strategic planning in TEWV by improving understanding of how mental health need, inequalities, access, outcomes, drivers of demand and community assets vary between places. The development of locality and neighbourhood profiles is intended to bring together relevant intelligence in a format that is accessible and applicable to Trust planning and decision-making.

The draft locality profiles provide a high-level strategic overview of the populations TEWV serve. They have been developed using publicly available data, Joint Strategic Needs Assessments, Director of Public Health Annual Reports, local strategies and partner intelligence. They are designed to signpost users to more detailed sources and should not be treated as comprehensive assessments of need. They are not intended to create a standalone or duplicative dataset.

The profiles highlight variation in population characteristics, deprivation, rurality, mental health need, health outcomes and community assets. This reinforces the need to consider place and population when planning services. In the proposed approach locality profiles will provide a strategic overview across each TEWV locality and neighbourhood profiles will be developed to provide more granular intelligence for defined local communities, where this adds value to planning or transformation.

Draft locality profiles have been shared with Directors of Public Health and analytical colleagues for feedback on accuracy, currency, data sources and local priorities. Further engagement with Care Groups, system partners and communities is needed to ensure the profiles meet needs and test their practical application. Further work is also required to develop the neighbourhood level profiles, define their intended use, and demonstrate how the intelligence can inform decision-making.

Strategic alignment

The locality and neighbourhood profiles represent the next stage in the Trust's understanding of the communities it serves. Building on the strategic analysis undertaken through the Trust's Medium Term Plan and earlier strategy development work, they provide a strengthened evidence base on population need, inequalities and place. Together with forthcoming Board sessions in October on stakeholder perceptions and organisational communication, they will help the Board consider not only what our communities need from TEWV, but how we are experienced by those communities and our partners. The October Board discussion will bring these strands together and support the development of a forward plan for the Trust's response. This will provide a foundation for the Board's December strategy seminar and the subsequent refresh of the Trust Strategy during the second half of the financial year, ensuring that future priorities are informed by both external insight and a deepening understanding of our local populations and community need.

Operational alignment

The profiles will support both future service development and current operational and clinical delivery. Care Groups will use them alongside internal intelligence on demand, access, waiting times, caseloads, capacity, workforce, quality, outcomes and patient experience. This will support identification of gaps between population need and current provision, inform operational priorities and recovery plans, and test whether resources are directed towards communities with the greatest need or poorest outcomes.

Care Group leadership teams will jointly own the application of the profiles as part of an emerging locality operating model (2027/2028), with named operational and clinical leads. They will support validation of the intelligence, identify priority issues, agree actions and

monitor impact through existing quality, performance, planning and governance arrangements. Trust public health and neighbourhood leads will maintain a consistent methodology, support interpretation and help connect external population intelligence with internal service data.

The approach will not create a separate governance structure. Material findings, delivery risks and actions requiring cross-Trust or system intervention will be escalated through established executive arrangements and reflected in the IPQR where appropriate. Board assurance will focus on decisions made, actions delivered and measurable changes in access, quality, outcomes and inequalities.

Prior Consideration and Feedback

The profiles are being presented to the Board at the earliest opportunity to support strategic oversight and inform their ongoing development. They have been shared with Directors of Public Health and their teams and amended in response to their feedback. They remain in development with partners, with ongoing feedback being used to strengthen their accuracy, relevance and practical application.

The development of the locality and neighbourhood profiles was undertaken in partnership with clinical network leads and representatives from the North East and North Cumbria Integrated Care board and local authority analyst. The work has been noted through the Sickness to Prevention Programme Board and the Neighbourhood Working Sub-group.

Implementation opportunities

Implementation provides opportunities to use a stronger understanding of our communities, their needs and assets to inform planning, action, partnership working and locally relevant communications. Accountability and assurance can be strengthened by embedding this intelligence in established Care Group performance and governance arrangements and viewing alongside strengthened internal locality data within the IPQR. Making this data accessible to teams and services through, for example, the inequalities intranet page will also support its routine use, in day-to-day planning and decision making.

TEWV and local mental health systems would equally be able to use this intelligence to strengthen engagement and outcomes from the wider neighbourhood health agenda. For example to support:

- Earlier identification of, and intervention for, emerging mental health needs;
- Improved coordination of support for people with complex or multiple needs;
- Stronger integration between physical and mental healthcare;
- A greater focus on prevention, early intervention and population outcomes;
- Clearer shared accountability across organisations for addressing the impact of mental ill health; and
- More coordinated and consistent use of data, workforce and estate resources.

Over time, improved use of population health intelligence may support more effective targeting of resources, inform commissioning and transformation activity, and help ensure investment is aligned to population need and inequalities.

Implications

Risk

The ability to deliver the ambitions of the Medium Term Plan and achieve its intended impact is dependent on the Trust being responsive to community need and to the context at place.

The locality and neighbourhood profiles have the potential to mitigate strategic risks relating to health inequalities, demand, quality of care and partnership working by improving understanding of population need, inequalities, drivers of demand and community assets. This intelligence provides an evidence base for more informed planning, prioritisation and service transformation.

There are risks that the profiles are limited by inconsistent data availability, duplicate existing intelligence or are not routinely used within decision-making processes, limiting their impact on service planning and improvement. This will be mitigated through ongoing engagement with Care Groups and system partners to test their use, and embedding within existing governance, performance and planning arrangements.

Financial

There are no requests for additional funding arising from this paper. It is expected that the proposed work can be delivered within existing staff capacity from public health, project management office, analysts and Care Groups. However, this approach could create opportunity costs or reveal material investment requirements to achieve outcomes and impact the reduction of health inequalities.

Any future resource requirements arising from implementation of recommendations will be considered through established business planning and governance processes.

Equalities and human rights

The Trust has been aware for some time of the inequalities in access and outcomes. A key purpose of the locality and neighbourhood profiles is to improve understanding of inequalities in health need, access, experience and outcomes across the populations served by TEWV.

The approach is consistent with the Trust's commitment to addressing health inequalities, improving equitable access to services and meeting its responsibilities under the Equality Act and Human Rights Act. Further development of neighbourhood profiles and engagement with local partners and communities will strengthen understanding of the needs of protected and underserved groups and support the design of more equitable services.

Recommendations

The Board of Directors is asked to:

1. Note the content of the profiles and support their ongoing development with our partners.
2. Note the intention to align this insight with the development of our forthcoming refresh of the Trust Strategy, of a refreshed communications strategy with locally focused messaging, and our anticipated feedback from PA Consulting on stakeholder perceptions
3. Note the alignment of these profiles with the emerging locality-based model for clinical and operational delivery.
4. Support their use alongside the development of locality-based internal data within the IPQR.
5. Draw on the data to inform interactions with services, partners and communities

Together, the above will strengthen the Trust's focus on deepening understanding of our local communities and developing partnerships, supporting the Trust's strategic ambition

Appendices

- 1) Draft Locality Profiles

This page is intentionally blank

County Durham: Locality profile summary for TEWV

Key local references. This profile should be read alongside County Durham's Joint Strategic Needs Assessment and the latest Director of Public Health Annual Report:

- County Durham Joint Strategic Needs Assessment:
<https://www.durhaminsight.info/health-and-social-care/jsna/>
- County Durham Director of Public Health Annual Report:
<https://www.durham.gov.uk/article/22392/Public-health-annual-report>

Overview and demographics.

Place: County Durham is a large and varied locality with a strong sense of place, including former coalfield communities, rural villages, market towns, natural landscapes and a significant university population.

Population: Census 2021 data shows the population increased modestly to around 522,100, with a median age of 43 (older than the England average). The population profile by broad ethnic group is: White 95.5%, Asian 2.3%, Mixed 1.1%, Black 0.6% and Other ethnic groups 0.6%. Projection data shows a predicted decline in 5–19-year-olds from 91,198 in 2025 to 81,297 in 2047, an 11% reduction, while the population aged 65 and over is projected to increase from 119,463 to 149,049, a 25% rise.

Future demand may be driven more by complexity of need than by population growth alone. Planning therefore needs to support children, young people and families while responding to growing needs associated with ageing including, dementia, frailty, loneliness, carers and co-occurring long-term conditions.

Building blocks of mental health. County Durham's mental health needs are influenced by poverty, housing, employment, physical health, transport access and rurality. Former coalfield communities and dispersed rural populations experience different but overlapping challenges relating to poverty, access to services, transport and social isolation. Despite strong social networks and community assets, these wider determinants influence mental wellbeing, resilience, access to support and recovery.

Poverty can be both a cause and a consequence of poor mental health, 29.2% of children in County Durham live in relative poverty. Housing insecurity and poor-quality housing can contribute to poor mental health, while stable, good quality housing supports wellbeing and recovery. Employment is also linked to mental health and wellbeing; 23.3% of the population in County Durham are economically inactive, higher than the national average.

These wider determinants do not affect all groups equally. People experiencing multiple disadvantage are more likely to face a combination of poverty, poor physical health, unemployment, unstable housing, substance use and social isolation, contributing to worse outcomes and barriers to accessing support. This can disproportionately affect inclusion health groups, including Gypsy and Traveller communities, vulnerable migrants and people in contact with the criminal justice system, as well as looked after children and care-experienced adults. People living with SMI, learning disability or neurodivergence can also experience health inequalities. In 23/24, 4,316 people (0.76%) in County Durham were registered with a learning disability, higher than the England average, and the number registered has increased by over 15% in the last five years. In County Durham, these challenges may be amplified by longstanding deprivation, rurality and transport barriers.

Prevalence of severe mental illness (SMI). Modelled estimates suggest that 5,910 people, or 1.33% of the population, are expected to have a SMI, defined as bipolar disorder,

schizophrenia or other psychosis. This estimate is important for planning community mental health services, physical health checks for people with SMI, prevention activity, early intervention, crisis response and support for people with multiple and intersecting needs. County Durham also has higher than average rates of suicide at 16.0 per 100,000 (2022-24). Source: Fingertips adult mental health profile.

Ward-level insight and implications for TEWV. Ward and neighbourhood data are particularly important in County Durham because need and assets are not evenly distributed. Around 17% of County Durham's lower super output areas are in the 10% most deprived nationally, with around 81,000 residents living in these neighbourhoods. Higher disadvantage is concentrated in parts of east Durham and former coalfield areas, including Easington, Horden, Peterlee and surrounding villages, as well as parts of Shildon, Ferryhill, Bishop Auckland and Woodhouse Close. Some neighbourhoods in and around Durham City, including parts of Belmont and Gilesgate, also show higher levels of disadvantage alongside areas of relative affluence. These communities have strong local identities and assets, alongside challenges relating to employment, income, housing, transport, physical health and access to support.

Health inequalities are reflected in outcomes. Life expectancy is 11.5 years lower for men and 9.4 years lower for women living in the most deprived areas compared with the least deprived. People living in more deprived communities are also more likely to experience severe mental illness and poorer health outcomes.

Rural and more dispersed communities have different strengths and challenges, including close community ties, access to green space, isolation, transport barriers and hidden poverty. For TEWV, this means that service planning should combine county-level information with ward-level insight, community intelligence, lived experience and local partnership knowledge to target outreach, prevention, early intervention and access improvement work where it is likely have the greatest impact.

Examples of work to improve mental health and reduce inequalities:

- Partnership with Public health and specialist services to deliver a substance use in-reach offer at Lanchester Road hospital through a dedicated drug and alcohol care team seeing over 620 people since its inception across Durham and Darlington sites alongside wider work to address drug and alcohol related harm
- Programme to reduce DNAs and WNBs in disadvantaged communities, including Children's North East poverty-proofing of targeted older people's mental health pathways to help services understand practical barriers to attendance and reduce avoidable gaps in care.
- Partnership work with public health, specialist health visiting and University of York to understand and address mental health services access barriers for Gypsy and Traveller communities.
- Lived experience research to improve access, pathways and outcomes for rural and farming communities.
- Delivery of local mental health, wellbeing, and resilience set out in the County Durham Joint Local Health and Wellbeing Strategy, including the development of a mental health gateway across primary care, launch of a refreshed Suicide Prevention Alliance Action Plan and funding to support VCSE support.
- Durham County Council's Health and Wellbeing insights profile "Durham Insight"

Darlington: Locality profile summary for TEWV

Key local references. This profile should be read alongside Darlington's Joint Strategic Needs Assessment and the latest Director of Public Health Annual Report:

- Darlington Joint Strategic Needs Assessment: <https://www.darlington.gov.uk/the-council/council-information/documents/darlington-joint-strategic-needs-assessment/>
- Darlington Director of Public Health Annual Reports: <https://www.darlington.gov.uk/public-health/health-annual-reports/>

Overview and demographics.

Place: Darlington is a compact borough with a strong town identity, surrounding villages, established transport links and a growing role as an employment and service centre for the wider Tees Valley and south Durham area. The borough includes areas of relative affluence alongside communities experiencing greater social and economic challenge.

Population: Census 2021 data recorded around 107,800 residents, an increase of 2.1% since 2011. The median age increased from 41 to 43, slightly older than the England average. The population is ageing with the largest growth in people aged 50–64 and 65–74, and a fall in residents aged 35–49. Population projections suggest growth to around 115,436 residents by 2032, up by 5.5% which exceeds the predicted North East increase of 4.8%. The median age is expected to rise to 44. The population profile by broad ethnic group is: White 94.4%, Asian 1.6%, Mixed 0.9%, Black 0.5% and Other ethnic groups 0.5%.

Planning should consider children and young people, working-age adults, older people, carers, families and people living alone, recognising that patterns of mental health need and access to support vary across these groups.

Building blocks of mental health and inequalities. Darlington's mental health needs are shaped by poverty, employment, housing, education, transport, physical health and access to services. The borough has strong community, voluntary and public sector assets, but some neighbourhoods experience higher levels of deprivation and poorer health outcomes. These wider determinants can increase stress, affect family wellbeing and create barriers to early help.

Poverty can be both a cause and consequence of poor mental health, with around 28% of children in Darlington living in poverty. Housing insecurity, poor-quality housing and financial pressures can contribute to poor mental health, while stable housing supports wellbeing and recovery. 27.6 per 1,000 households are owed a duty under the Homelessness Reduction Act, the highest in the North East. Employment is also closely linked to mental health and wellbeing. Darlington's employment rate is higher than regional and national averages, inequalities remain between population groups and there have been significant changes in employees by industry. Darlington also has a higher proportion of one- and two-person households than the Tees Valley, North East and England, which may increase the risk of social isolation for some residents.

These wider determinants do not affect all groups equally. People experiencing multiple disadvantage, including those experiencing homelessness, drug and alcohol related harm, vulnerable migrants and people in contact with the criminal justice system, are more likely to experience poorer mental and physical health outcomes and barriers to accessing support. Deprivation is unequal and concentrated in urban areas. Service planning should recognise the needs of people experiencing poverty, housing insecurity, social isolation, physical health problems, caring responsibilities and complex or multiple disadvantage.

Prevalence of severe mental illness (SMI). Modelled prevalence estimates suggest that 1138 people (1.26%), are expected to have a SMI, defined as bipolar disorder, schizophrenia or other psychosis. This estimate is important for planning community mental health services, physical health checks for people with SMI, prevention activity, early intervention, crisis response and support for people with multiple and intersecting needs. Darlington also has higher than average suicide rates at 18.0 per 100,000, with rates among men four times higher. Source: Fingertips adult mental health profile.

Ward-level insight and implications for TEWV. Ward and neighbourhood data are important because need and assets vary across the borough. Darlington includes communities with strong local networks, schools, faith groups, community organisations and public services, alongside areas where residents may face greater challenges linked to income, housing, employment, physical health, substance use, loneliness and access to support. Around 14% of Darlington's LSOAs fall within the 10% most deprived nationally. Higher disadvantage is concentrated in urban areas, such as Bank Top and Lascelles, Northgate, North Road, Eastbourne, Park East, Red Hall and Lingfield, and parts of Stephenson, where some small areas fall within the most deprived national deciles. These areas sit geographically close to more affluent wards such as Hummersknott, Mowden, College, Park West, Cockerton and parts of Heighington and Coniscliffe, meaning that marked differences in income, housing, health and life chances can exist over relatively short distances.

Health inequalities are reflected in outcomes, with life expectancy reported to be around 16 years lower for men and 11 years lower for women in the most deprived parts of Darlington compared with the least deprived. Communities experiencing greater disadvantage often face overlapping challenges relating to poverty, housing, employment, physical health, substance use, loneliness and access to support.

Darlington's villages and more rural communities, including Hurworth, Heighington, Coniscliffe, Sadberge and Middleton St George, have different assets and challenges. They have strong community identity, green space and local networks, alongside challenges linked to transport, ageing, hidden poverty, social isolation and access to timely services.

For TEWV, this means combining borough-level information with ward-level insight, lived experience and local partnership knowledge to identify where outreach, prevention, early intervention and access improvement work may have the greatest impact, particularly in communities experiencing disadvantage, multiple disadvantage and barriers to access.

Examples of work to improve mental health and reduce inequalities:

- Building health inequalities considerations into the development of the new neighbourhood mental health centre at Hundens Lane
- Partnership with Public health and specialist services to deliver a substance use in-reach offer at West Park Hospital
- Partnership working with acute partners on diabetes care for people with an SMI
- Mental health and wellbeing identified as a priority in Darlington's Joint Health and Wellbeing Strategy
- Darlington's Mental Health Network works to enable greater collaboration and partnership working, generating learning to strengthen preventative approaches and inform future commissioning and delivery.

Teesside

Key local references. This profile should be read alongside the Joint Strategic Needs Assessments and Director of Public Health Annual Reports for Stockton-on-Tees, Hartlepool, Redcar and Cleveland, and Middlesbrough:

- Stockton-on-Tees JSNA: <https://stocktonjsna.org.uk/>
- Stockton-on-Tees public health and DPH annual report: <https://www.stockton.gov.uk/public-health-and-wellbeing>
- Hartlepool JSNA and DPH annual report: <https://www.hartlepool.gov.uk/joint-strategic-needs-assessment>
- South Tees JSNA for Middlesbrough and Redcar and Cleveland: <https://www.middlesbrough.gov.uk/health-and-wellbeing/public-health-information/south-tees-joint-strategic-needs-assessment-jsna/>
- [PHST Director of Public Health Annual Report 2026 5.pdf](#)

Overview and demographics.

Place: Teesside covers Stockton-on-Tees, Hartlepool, Redcar and Cleveland, and Middlesbrough. It includes coastal communities, former industrial areas, town centres, rural fringes, universities, ports, major employers and strong community, cultural and voluntary sector assets.

Population: Census 2021 shows clear variation across Teesside. Stockton-on-Tees has the largest population (196,600), followed by Middlesbrough (143,900), Redcar and Cleveland (136,500) and Hartlepool (92,300). Ethnic diversity varies across the locality and is greatest in Middlesbrough, where the population profile by broad ethnic group is: White 82.4%, Asian 9.6%, Mixed 3.2%, Black 2.6% and Other ethnic groups 2.1%. Middlesbrough's Central ward has a larger proportion of residents recorded in Asian, Black, Mixed and Other ethnic groups than the Middlesbrough average, reflecting the town-centre population, migration patterns and student communities (Source: Office for National Statistics, Census 2021 ethnic group dataset). Stockton-on-Tees, Hartlepool and Redcar and Cleveland have higher proportions of residents in the White ethnic group overall, but local averages can mask smaller communities and neighbourhood concentrations. For example, in Stockton-on-Tees Asian, Black and mixed ethnic groups have a significantly younger age profile compared to the general population in

Age profiles also differ. Redcar and Cleveland has the oldest population (median age 46), while Middlesbrough has the youngest (median age 36). Middlesbrough has experienced rapid recent population growth driven largely by international migration and is home to Teesside University, with around 25,000 students. This brings important assets, cultural diversity and economic activity, but also means service planning should consider student mental health, transitions, accommodation, language and cultural access, and the different needs of local, regional and international students. Hartlepool is also among the 10% fastest growing local authorities, but this is largely driven by net internal migration. Stockton-on-Tees and Redcar and Cleveland have ageing populations, with the proportion of older residents expected to increase further over the coming decade.

Planning should reflect both shared Teesside-wide challenges and the distinct demographic, cultural and health needs of each area, including the needs of ethnically diverse communities, students, older people and populations experiencing rapid change.

Building blocks of mental health and inequalities. Health need across Teesside is shaped by income, employment, housing, education, transport, industrial legacy, physical health, substance use, community safety and access to services. Many communities have strong local identity, community assets and social networks, but some neighbourhoods experience deep and persistent inequalities. These wider determinants influence mental wellbeing, resilience, access to support and recovery.

Poverty can be both a cause and consequence of poor mental health. The proportion of children living in low-income families is higher than the national average across Teesside ranging from 22.3% in Stockton-on-Tees to 34.4% in Middlesbrough, the highest rate in the North East. Housing insecurity can also contribute to poor mental health and create barriers to recovery. Rates of households owed a duty under the Homelessness Reduction Act are higher than the England average in Middlesbrough (26.2 per 1,000), Stockton-on-Tees (23.7 per 1,000) and Hartlepool (14.7 per 1,000). Employment is closely linked to health and wellbeing, although employment rates vary considerably across Teesside, from 65.4% in Hartlepool and 66.8% in Middlesbrough to 75.2% in Stockton-on-Tees.

These wider determinants do not affect all groups equally. People experiencing multiple disadvantage, including those affected by homelessness, drug and alcohol related harm, vulnerable migrants and people in contact with the criminal justice system, are more likely to experience poorer mental and physical health outcomes and barriers to accessing support. High levels of substance use, often linked to deprivation, trauma and poor mental health, further contribute to health inequalities across parts of Teesside. Service planning should recognise the needs of people experiencing poverty, housing insecurity, substance use, social isolation, co-existing physical health problems and complex or multiple disadvantage.

Prevalence of severe mental health illness (SMI). Modelled estimates suggests that 6,200 people across Teesside are living with SMI, defined as bipolar disorder, schizophrenia or other psychosis. Estimated prevalence ranges from 1.22% of the population in Stockton-on-Tees (1,996 people) to 1.4% in Hartlepool (1,082 people), with estimates of 1.36% in Middlesbrough (1,599 people) and 1.35% in Redcar and Cleveland (1,555 people). These estimates are important for planning community mental health services, physical health checks for people with SMI, prevention, early intervention, crisis response and support for people with multiple and intersecting needs.

Suicide rates are also higher than the England average (10.9 per 100,000) across all four local authority areas. Rates are highest in Redcar and Cleveland and Middlesbrough (both 20.2 per 100,000), followed by Hartlepool (17.6 per 100,000) and Stockton-on-Tees (14.6 per 100,000).

Ward-level insight and implications for TEWV. Ward and neighbourhood data are essential because need and assets vary significantly across Teesside and borough-level averages can mask concentrated inequalities.

In Stockton-on-Tees, affluent areas sit alongside neighbourhoods experiencing greater disadvantage. Nine of 27 wards are in the 10% most deprived wards nationally and the gap in life expectancy between the least and most deprived areas is 13.9 years for women and 14.5 years for men, one of the widest in the country.

In Hartlepool, healthy life expectancy is the second lowest in England at 52.1 years. While the borough is among the 20% most deprived areas in England there are also inequalities within the area with life expectancy 12.5 years lower for men and 10.4 years lower for women in the most deprived areas compared with the least deprived areas. Ward and JSNA

dashboard information should be used to understand variation across communities such as Headland and Harbour, Victoria, Manor House, Foggy Furze, Rossmere and rural or coastal areas.

Middlesbrough is the 2nd most deprived local authority in England based on average score. Half of the LSOAs are in the most deprived 10% nationally and 14% are among the most deprived 1%. In Middlesbrough, there is also concentrated deprivation, with Newport, North Ormesby, Brambles and Thortree, and Berwick Hills and Pallister in the most deprived 1% nationally, and Park End and Beckfield, Central, Longlands and Beechwood, and Hemlington also among the most 3% deprived wards. Life expectancy is 17.4 years lower for men and 14.9 years lower for women in the most deprived areas compared with the least deprived, the widest in England.

Redcar and Cleveland has a mixed geography of coastal, rural and industrial communities, with inequalities shaped by employment, health and disability, transport, housing, ageing and access to services. Ward and neighbourhood analysis should consider areas such as South Bank, Grangetown, Eston, Dormanstown, Brotton, Loftus, Skelton, Redcar and more rural communities alongside areas of relative advantage. Life expectancy is 14.3 years lower for men and 9.5 years lower for women in the most deprived communities compared with the least deprived.

These inequalities are reflected in differences in mental health need, physical health outcomes and access to services. For TEWV, ward-level insight should be combined with lived experience, VCSE intelligence, primary care data and local partnership knowledge to identify where outreach, prevention, early intervention and access improvement work may have the greatest impact, particularly in communities experiencing poverty, housing insecurity, substance use, poorer physical health, multiple disadvantage, rural or coastal isolation, and barriers to accessing support. Sources: Stockton-on-Tees JSNA and deprivation summary; Hartlepool JSNA and local health profile; Middlesbrough Council ward deprivation data; Redcar and Cleveland local statistics and South Tees JSNA; English Indices of Deprivation.

Examples of work to improve mental health and reduce inequalities:

- A programme of community engagement in partnership local authorities and community sector partners to address differences in access, outcome and experience for ethnically minoritised and racialised communities in Stockton and Middlesbrough
- Poverty Proofing © Child and Adolescent mental health services (CAMHS) in partnership with Children's North East and A "CAMHS closet" to provide essential items to families the Ridings Redcar
- Work to address to root causes of "did not attend" and "was not brought" in adult mental health services in Middlesbrough for those experiencing disadvantage
- In partnership with the local authorities and specialist commissioned providers provision of specialist substance use in-reach to Roseberry Park and dedicated "dual diagnosis" roles to support community joint working across mental health and substance use services which in Hartlepool has resulted in 270 referrals to date and in South Tees is projected to reach over 450 this year alongside enhanced harm minimisation and much improved partnerships
- Partnering to support "Changing Futures" programmes to address multiple disadvantage in Middlesbrough, Hartlepool and previously in Redcar including a

partnership with the ICB and local authorities to embed a social determinants key worker in the crisis suite resulting in significant reduction in repeat attendance by focussing on route causes with very high levels of service satisfaction.

- Tees Suicide Prevention Strategic Plan 2024-29 aims to reduce local suicide and ensure those affected by suicide receive the best available support.

North Yorkshire

Key local references. This profile should be read alongside North Yorkshire's Joint Strategic Needs Assessment and Director of Public Health Annual Reports:

- North Yorkshire JSNA: <https://www.datanorthyorkshire.org/JSNA/JSNA>

Overview and demographics.

Place: North Yorkshire is a large and geographically diverse county, including market towns, rural villages, coastal communities, national parks, farming communities and areas linked to tourism, the military and key transport corridors. Most of the county is sparsely populated with Harrogate and Scarborough as the largest towns.

Population: Census 2021 recorded around 615,500 residents. The population is older than the England average and dispersed across a wide geography, which can create challenges in access. The median age is 48.7, and one in four residents are aged 65 and over (up from 20.6% in 2011). Population growth is expected to be modest with the largest increase in the over 65's. The population profile by broad ethnic group is: White 96.7%, Asian 1.4%, Mixed 1.1%, Black 0.4% and Other ethnic groups 0.5%.

Most residents report good or very good health, but a significant minority experience some limitations in daily activities. County-wide averages may mask the needs of smaller communities including farming communities, migrant communities, Gypsy and Traveller communities, military-linked populations and seasonal or rural workforces. Planning needs to respond to ageing, long-term conditions, disability, rural isolation, caring responsibilities, transport barriers and the needs of people across dispersed communities.

Building blocks of mental health and inequalities. North Yorkshire's mental health needs are shaped by rurality, ageing, transport access, housing, employment, farming pressures, digital access, social isolation and physical health. Many communities have strong networks and community assets, but need and deprivation can be hidden in rural and more affluent areas where barriers to support may be hidden by county wide averages. These wider determinants influence mental wellbeing, resilience, access to support and recovery.

Poverty can be both a cause and consequence of poor mental health. Although the proportion of children living in relative low-income families (14.7%) is below the national average, deprivation and financial insecurity are not experienced equally across the county. In 2020, 15.1% of households were classified as fuel poor, reflecting income and the challenges associated with housing type and access to affordable energy. Employment rates are high overall (78.9%), but averages can mask variation. Homelessness is lower than the national average, but access to affordable housing remains a challenge in some areas.

These wider determinants do not affect all groups equally. People experiencing multiple disadvantage, including those experiencing homelessness, drug and alcohol related harm, Gypsy and Traveller communities, vulnerable migrants and people in contact with the

criminal justice system, are more likely to experience barriers to accessing support and poorer mental and physical health outcomes. In North Yorkshire, these challenges may be compounded by rurality, transport barriers, social isolation and the hidden nature of need in some communities. Service planning should therefore consider geographic access, digital exclusion, outreach and community-based approaches to ensure support reaches those most at risk.

Prevalence of severe mental health illness (SMI). Modelled estimates suggest that 5564 people (1.05%), are expected to have a SMI, defined as bipolar disorder, schizophrenia or other psychosis. This estimate is important for planning community mental health services, physical health checks for people with SMI, prevention activity, early intervention, crisis response and support for people with multiple and intersecting needs. The suicide rate is higher than the England average at 14.1 per 100,000.

Ward-level insight and implications for TEWV. Ward, primary care network and locality data are particularly important in North Yorkshire because county-level averages can mask rural poverty, isolation and pockets of deprivation. Twenty of the 24 LSOAs that fall within the most deprived 20% are concentrated in Scarborough and Whitby, with Eastfield, Castle and Woodlands the three most deprived in the county.

Health inequalities are reflected in outcomes. Life expectancy is 6.8 years lower for men and 4.0 years lower for women in the most deprived communities compared with the least deprived, with variation also seen in healthy life expectancy across the county.

Coastal deprivation is a particular challenge in the east of the county. Communities around Scarborough, Filey and Whitby experience a greater concentration of deprivation than elsewhere in North Yorkshire, reflecting the “coastal effect” where lower incomes, insecure or seasonal employment, housing pressures, ageing populations, transport barriers and poorer physical health can combine to increase need. However, these communities benefit from strong local identity, tourism, green space community networks and voluntary sector assets.

Elsewhere, patterns of need vary across the county. In Selby, former industrial communities, housing affordability and financial pressures remain important considerations. In Harrogate, relative affluence can mask hidden poverty, housing pressures, loneliness and need among older people, carers and more isolated residents. Across Craven, Hambleton, Richmondshire and Ryedale, rurality, car ownership, farming pressures, military-linked populations and long travel distances can influence both need and access to services.

For TEWV, planning should combine county-wide data with neighbourhood, PCN and ward-level insight, lived experience, VCSE knowledge and local partnership knowledge to identify where outreach, prevention, early intervention and access improvement work may be most needed, particularly in communities experiencing rural isolation, deprivation, poorer physical health, multiple disadvantage and barriers to accessing support.

Examples of work to improve mental health and reduce inequalities

- REACH (Reducing Exclusion for Adults with Complex Housing Needs) is a multiagency Housing First service that provides support to those with complex needs who are homeless or likely to be made homeless due to a range of social and long-term health needs across Scarborough and Whitby. An evaluation demonstrated a 91% tenancy sustainment rate, 30 people supported through

REACH, with 23 moving into their own tenancies and 21 securing permanent housing. Alongside Substance-related harm reduced improved health outcomes, and a Strong return on investment, generating £1.40 to £3.32 savings for every £1 invested, with estimated public sector savings of £469,328 per year

- A network of professionals who work collaboratively on mental health need and drug and alcohol related harm underpinned by The North Yorkshire and York Dual Diagnosis Pledge and a multiagency network with 209 members across Mental health, acute care, police, social care, council (housing, tenancy support), drug and alcohol services, Voluntary sector and probation.
- A programme of community engagement work to commence to address differences in access, outcome and experience for asylum seeking communities in North Yorkshire
- TEWV and North Yorkshire Council co-chair the NY Mental Health, Learning Disabilities, Autism and Neurodiversity Partnership board. This connects partners strategically and provides a shared space for oversight and assurance.

York

Key local references. This profile should be read alongside York's Joint Strategic Needs Assessment and latest Director of Public Health Annual Report:

- York JSNA: <https://www.healthyyork.org/> and [Our City Health Narrative V4](#)
- City of York Director of Public Health Annual Reports: <https://www.york.gov.uk/health-wellbeing/director-public-healths-annual-report>
- York Profile 2025-26: <https://data.yorkopendata.org/dataset/york-profile>
- Ward Profile 2025-26: <https://data.yorkopendata.org/dataset/york-ward-profiles-2025-26>
- Neighbourhood profile 2025-26: <https://data.yorkopendata.org/dataset/locality-profiles-2025-26>

Overview and demographics.

Place: York is a historic city with a strong civic identity, major universities, tourism, cultural assets, neighbourhood communities alongside rural edges.

Population: Census 2021 recorded around 202,800 residents, including a significant full-time student population. The median age increased from 38 to 39, younger than the England and Yorkshire and the Humber average. York has distinctive age profile with growth in both young adult and older people. Between 2014 and 2024, the population increased by 3.5%, including a 14% increase among people aged 10-24 and a 19% increase among those aged 70 and over. Dementia prevalence among people aged 65+ is projected to increase by 24%.

York's population is increasingly diverse. The population profile by broad ethnic group is: White 88.4%, Asian 5.6%, Mixed 3.1%, Black 1.4% and Other ethnic groups 1.5%. The 2021 Census reported 267 ethnicities, with China the most common country of birth outside the UK and Polish the most common language other than English or Welsh.

Overall, 83.6% of residents report being in good health, while 17.1% state that they have some limitation in day-to-day activities. TEWV Planning should consider the needs of students, families, working-age adults, older people, carers and people living alone, alongside the impact of housing affordability, cost of living, student population flows, loneliness and the differing needs of both city-centre and outer communities.

Building blocks of mental health and inequalities York has significant community assets and many positive health and wellbeing indicators, but inequalities remain. Health need is shaped by housing affordability, income, employment, social isolation, student populations, substance use, long-term conditions and access to services. Some people may experience hidden poverty or barriers to support despite living in a city often seen as relatively affluent.

Poverty can be both a cause and consequence of poor mental health. Although the proportion of children living in relative low-income families (13.9%) is below the regional and national average, financial pressures remain significant for some residents. Employment levels are high overall (77.9%), but inequalities persist between communities. Housing affordability is a particular challenge with average house prices increasing by 39.1% between 2015 and 2025 and York has the highest private rental costs in the region.

These wider determinants do not affect all groups equally. York Council has identified a number of local PLUS groups who experience poorer access, experience or outcomes, including people affected by drug and alcohol dependency, Gypsy, Roma and Traveller communities, people experiencing homelessness, minoritised ethnic communities, people leaving care, people with learning disabilities, vulnerable migrants and asylum seekers, sex workers, and transgender and non-binary people. The number of people from PLUS groups varies considerably across neighbourhoods, with the highest numbers recorded in East and Central York. Service planning should therefore use neighbourhood-level insight, lived experience and partnership intelligence to understand who is most affected and how access and outcomes can be improved.

Prevalence of severe mental health illness (SMI). Modelled mental health prevalence estimates suggest that 1567 people (0.89%), are expected to have a SMI, defined as bipolar disorder, schizophrenia or other psychosis. This estimate is important for planning community mental health services, physical health checks for people with SMI, prevention activity, early intervention, crisis response and support for people with multiple and intersecting needs.

Ward-level insight and implications for TEWV. Ward and neighbourhood data are important because city-wide averages can mask different experiences by area and population group. An estimated 6.23% of people live in the most deprived 20%, an increase from 4.6% in 2019, with deprivation present across all four neighbourhoods.

York includes areas of relative affluence alongside communities facing greater challenges linked to income, housing costs, employment, domestic abuse, isolation, student transitions and access to support. Health inequalities are reflected in outcomes. Life expectancy is around 11 years lower for both men and women in Westfield, which has the lowest life expectancy compared to Copmanthorpe, which has the highest. Westfield experiences the highest levels of relative and deep poverty, although deprivation is present across all wards. Neighbourhood planning should consider areas such as Westfield, Clifton, Heworth, Hull Road, Guildhall and other wards where indicators suggest greater financial pressure, housing stress, health need or barriers to access. At the same time York benefits from significant local assets including schools, community organisations, faith groups, universities, local businesses, neighbourhood networks and VCSE partners.

For TEWV, planning should combine city-wide data with ward-level insight, lived experience, university and student support intelligence, VCSE knowledge and local partnership information to identify where outreach, prevention, early intervention, access improvement work and crisis support may have the greatest impact.

Examples of health inequalities work delivered or planned include:

- Consideration of health inequalities in the development and assessment of impact of the York Community Wellbeing Hub, emerging neighbourhood models and impact of Community Mental Health Transformation grant.
- A network of professionals who work collaboratively on mental health need and drug and alcohol related harm underpinned by The North Yorkshire and York Dual Diagnosis Pledge and multiagency network with 209 members across Mental health, acute care, police, social care, council (housing, tenancy support), drug and alcohol services, Voluntary sector and probation.
- A programme of community engagement work to commence to address differences in access outcome and experience for Gypsy and Traveller communities in York
- A mental health support team offer to electively home educated children in partnership with York Traveller's Trust with excellent community feedback.
- Mental health and wellbeing is a priority within York's Health and Wellbeing Strategy, including action to reduce inequalities, suicide and self-harm, and embed trauma-informed approaches.
- York Mental Health Partnership provides strategic oversight.

Health & Justice Services

Board Presentation

The Health & Justice Service provides mental health assessment, treatment and support to those individuals who come into contact with the criminal justice system. We are the largest provider of specialist mental health services across the prison estate.

We work with partners across the offender pathway and have gained vast experience in the delivery of care within these environments.

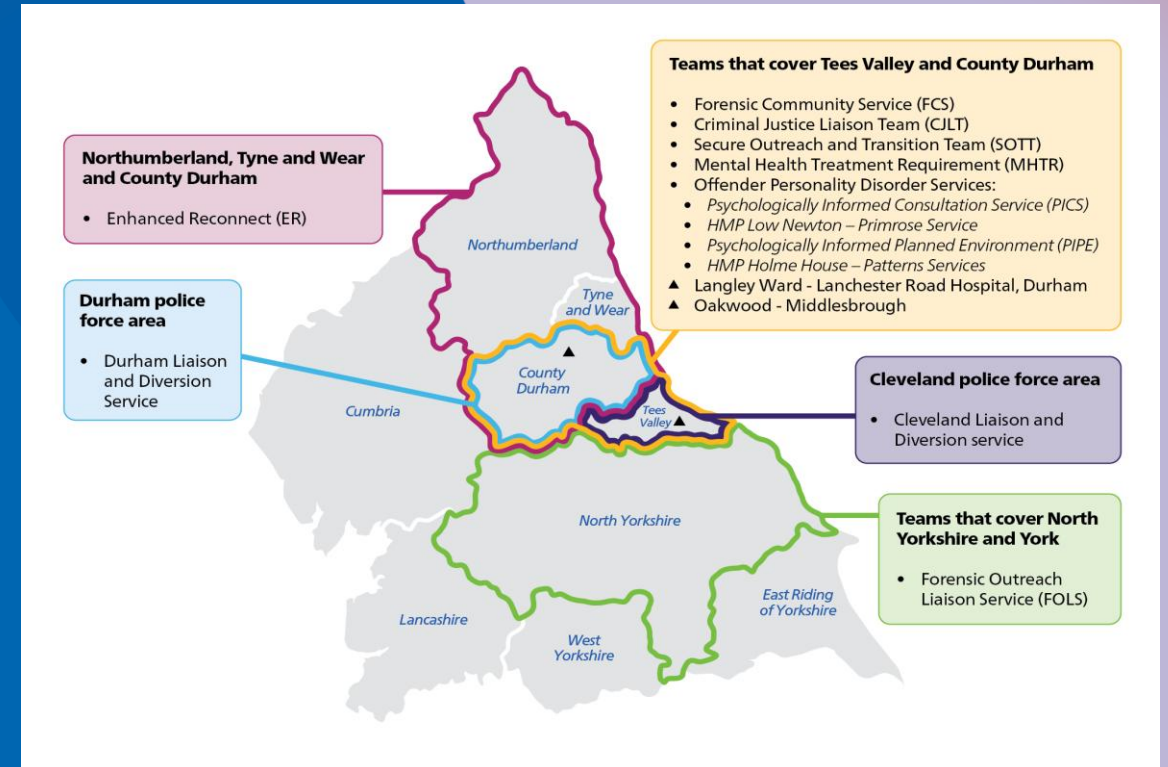
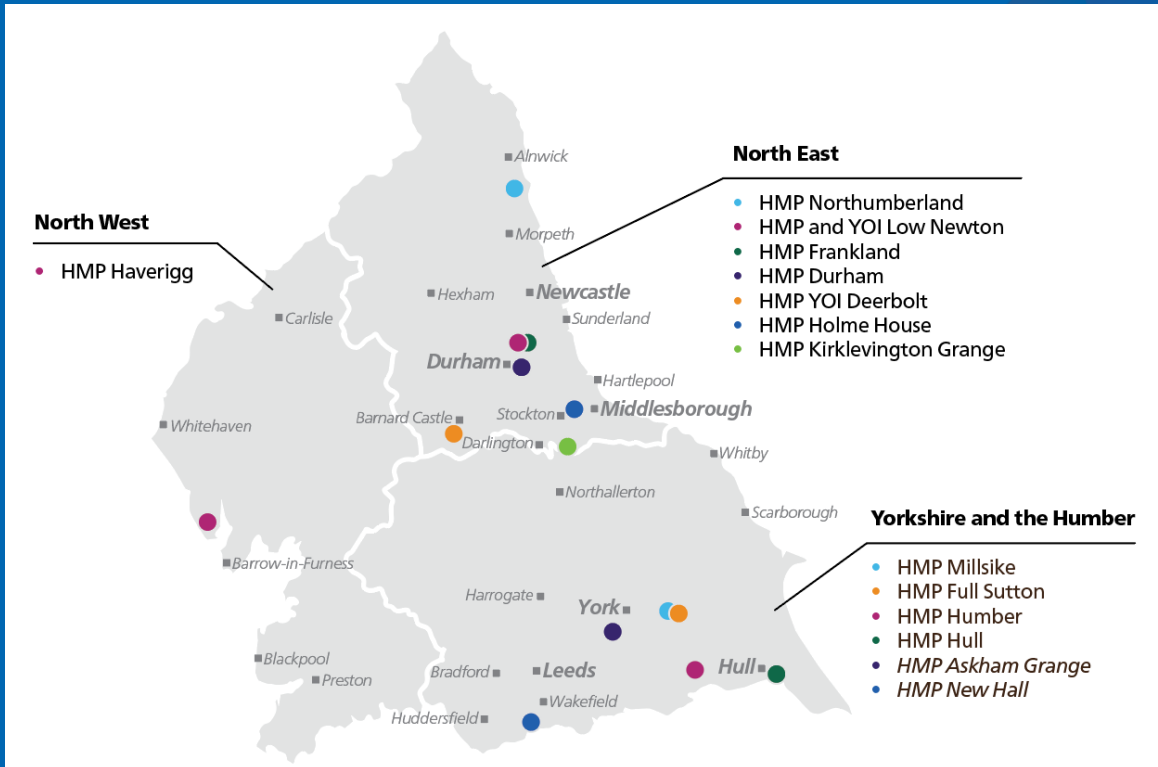
Within the contract for delivery of the mental health care package this includes – MH, LD, Autism and Neurodiversity (within L & D services also vulnerabilities).

Lisa Taylor

Care Group Director

September 2026

H&J Services and Partners



H&J - Community Services



Referral Demand Across Our Pathways

High-volume access across prison mental health and Liaison & Diversion services

PRISON SERVICES

3,047

referrals reported April–June 2026

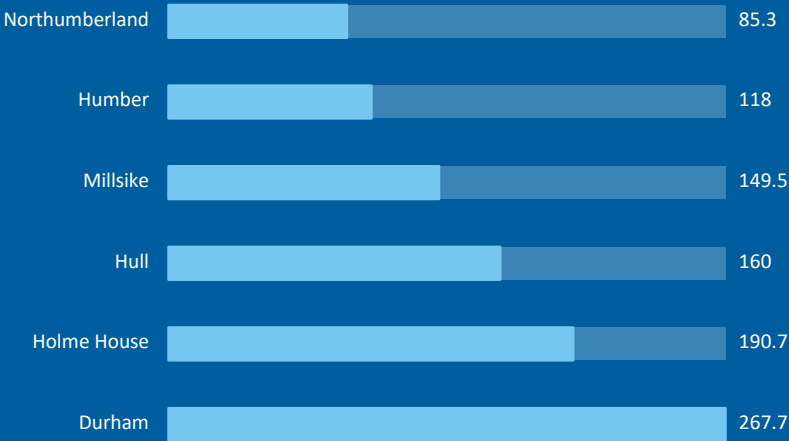
LIAISON & DIVERSION

1,443

referrals reported April–June 2026

Highest prison referral volumes

Average monthly referrals, April–June 2026



Community referrals by service

April–June 2026



BOARD INSIGHT

4,490 referrals were reported across prison and community pathways between April and June 2026.

*Prison total reflects reported activity, unreported monthly cells are excluded.

Governance

Internal Trust/H&J Governance	Justice, Commissioner & External Assurance
Care Group Board – oversight and decision making.	Clinical Partnership Assurance Group (CPAG) (bi-monthly)
Integrated Care Governance Group (ICGG) (monthly) - senior leadership looking at standards and delivery.	Local Delivery Boards (LDBs) (monthly across each prison)
Improvement Delivery Group (monthly) – looking at transformation and quality improvements.	Commissioner Quality Visits – (quarterly across commissioned services)
Operational Oversight	Contract Reports & Meetings (quarterly)
Leadership Visits – Service and Director Level (monthly) op	North Provider Forum (quarterly)
Leadership Huddles (weekly)	Northern Region Partnership Board (quarterly)
	HMPPS Partnership Boards – North-East & Yorkshire & Humber (quarterly)
	Quality Network for Prison Mental Health Services (QNPMHS) (annually)
	Quality Network for Locked Rehab Services (annually)
Health & Justice Service work within a matrix model of governance and assurance with partners.	

Priorities

People & Culture	Service Development
Staff Wellbeing Wellbeing Lead in post to support staff wellbeing and improve workplace environments across the services.	Womens' Pathways Review and development of four priority pathways: Perinatal, Safe to Secure Transition, Leaving Custody and Trauma.
Lived Experience Strategy Implementation commencing at HMP Deerbolt, including recruitment of a Senior Peer Worker.	Prison–Ridgeway Transitions Enhancing continuity of care and treatment during transfers between prison and Ridgeway services.
H&J People Plan Further embed the people plan across all H&J services.	Quality Improvement Ongoing reviews of services providing opportunities to improve quality and services e.g. ADHD pathway and appropriate outcomes for people within H&J services.
Innovation & Transformation	Growth & Future Opportunities
Digital Transformation SystmOne development and analysis programme alongside an 18-month Extended Reality pilot at HMP Low Newton.	2026 Business Opportunities Tender opportunities at HMPPS Newhall and Askham Grange, and development of the Offender Personality Disorder Service at HMP Holme House.
POLIT (Paedophile Online Investigation Team) Partnership Working Multi-agency workshops involving Liaison & Diversion, Police, Safeguarding, ICB and CAMHS partners.	Oakwood & Langley Exploration of future commissioning and service development opportunities.
Service Pathway Review Review of CJLT, MHTR and Liaison & Diversion services to identify overlaps and opportunities for integration.	Primrose Establishment of a contracted service rather than a project. 6

Wellbeing Offer

A comprehensive wellbeing programme is in place to support staff health and wellbeing, strengthen organisational culture, and improve staff experience across Health and Justice Services..

Capability & Learning

- Monthly training offer
- Reflective practice
- Shared learning across teams

Leadership & Strategy

- Designated wellbeing lead
- Wellbeing plan and strategy
- H&J People Plan embedded in practice

Staff Survey Results

59 of 101 measures were green

Nearly 6 in 10 results were at least 3 percentage points above the Trust benchmark



Listening & Insight

- Staff survey
- Pulse survey
- Culture Census
- Feedback loops for local action

Everyday Wellbeing Culture

- Tune in Tuesday wellbeing email sharing information and resources
- Focus Friday - meeting-free afternoons
- Walking for Wellbeing sessions – bi-monthly wellbeing time to encourage physical activity, team connection and partnership engagement
- White Ribbon accreditation in progress – to support a culture of respect and prevention of violence against women and girls

59

GREEN | 58%

35

AMBER | 35%

7

RED | 7%

Strong evidence of performance above the Trust benchmark

H&J n=166 | Trust overall n=4,239

Achievements

A year of progress across specialist provision, clinical pathways, partnerships and workplace foundations.

01 Awards - Mollie Urwin, finalist in the Nursing Times Workforce Awards – Preceptee of the Year (and special commendation) (HMP Northumberland) - HMP Durham ISU Sensory Garden – Koestler Bronze Award - Primrose – Accredited as Enabling Environment 10 yrs - Our Health Heroes Awards – National Winner for Reconnect - Primrose – National prison award for partnership working	02 Pathway innovation - Sensory suitcases rolled out to all teams. - Speech and Language model developed and delivered across the pathway. - ADHD pathway developed. - The National Lead from the Royal College of OT is visiting H&J in October to discuss development of OT in the service.	03 Partnerships, people & estate - York University links strengthened. - Voices Within Premier – co-produced lived experience film promoting co-creation and person- centred practice. Being adopted nationally within NHS H&J and HMPPS induction. - People Plan developed for induction. - Office-space improvements across prisons and Liaison & Diversion.	04 Care Quality Commission - Health and Justice has an integrated CQC inspection regime with police and prison service inspectorates. - Positive feedback received across services following all CQC visits, identifying good areas of practice.
--	--	---	---

National Specialist Provision

THREE DISTINCTIVE SERVICES • ONE RECOVERY-FOCUSED SYSTEM

Primrose

HMP Low Newton •
National

The Primrose Service is a flagship example of psychologically informed practice. The service has up to 12 places plus outreach for high and very high-risk women in the offender personality disorder pathway. Phased, individually formulated therapy supports recovery and reduction of risk.

Specialist Enhanced Support Units

HMP Hull Wellbeing Unit
and HMP Durham ISU
(Integrated Support Unit)

The HMP Durham Integrated Support Unit and HMP Hull Wellbeing Unit are innovative, collaborative services designed to support prisoners experiencing significant mental health difficulties who are unable to cope safely on standard prison locations. Delivered jointly by Health & Justice and prison staff, these specialist environments provide enhanced support, structured activities, and therapeutic interventions focused on recovery and wellbeing. The units offer a level of care and engagement that cannot be achieved through traditional mental health outreach services alone, helping individuals to stabilise, develop coping strategies, and improve their overall wellbeing. By providing intensive, person-centred support within the prison setting, the services aim to reduce deterioration in mental health and, where appropriate, prevent the need for admission to secure hospital care.

NATIONAL VISITORS

HMP Deerbolt

Dame Carol Black
Independent Advisor to the
Government on Drugs

HMP Low Newton

Dame Lesley Regan
England's Women's Health
Ambassador

Speech & Language Therapy

Karen Bryan
Vice Chancellor,
York University

The European Committee
for the Prevention of
Torture and Inhuman or
Degrading Treatment or
Punishment (CPT)

NATIONAL LEARNING INTO ACTION

The Challenge of Synthetic Substances

Opened by Lord Timpson, Justice
Minister • 8–9 Oct 2025

200+ delegates **29** speakers

95% confident about the risks

86% able to translate learning into local
plans

"Perfectly timed and perfectly pitched." —
Police and Crime Commissioner

NEXT 12–13 Nov 2026 • Harrogate

North East conference requested by Police
and Crime Commissioner for 2027

Any Questions?

For General Release

Meeting of:	Board of Directors
Date:	23 September 2026
Title:	Winter Resilience Plan 2026/27 and Board Assurance Statement (BAS) Readiness
Executive Sponsor	Naomi Lonergan – Interim Managing Director
Report Author(s):	Andrea Jaworski, Business Manager

Report for:	Assurance	☒	Decision	☒
	Consultation	☐	Information	☒

Strategic Goal(s) in Our Journey to Change relating to this report:
1: To co-create high-quality care
2: To be a great employer
3: To be a trusted partner

☒
☒
☒

Strategic risks relating to this report:

BAF ref no.	Risk Title	Context
1	Safe Staffing	There is a risk that variability in leadership and management capability caused by leadership maturity, skills and management practice could result in reduced assurance on our ability to create, sustain and assure safe staffing and wellbeing, and therefore service safety and quality
2	Access	There is a risk that patients will experience prolonged waiting times for community and specialist services (notably neurodevelopmental and talking therapies) and do not receive timely access to assessment, treatment or admission, resulting in avoidable harm, due to flow constraints, variation in and impacts of historical commissioning, system and workforce capacity.
4	Quality and Outcomes	There is a risk of variable quality of care and clinical outcomes due to inconsistent service models, clinical practice, and use of intelligence to manage emerging risks, resulting in avoidable harm, compounding health inequities, and reduced confidence in the Trust.
8	Partnerships and System Working	There is a risk that failure to engage effectively in partnerships across our Integrated Care Systems, Provider Collaboratives, 'places' and 'neighbourhoods' will compromise our ability to effect service improvement, transformation and population health of the communities we serve
9	Regulatory Compliance	There is a risk that failure to comply with our regulatory duties and obligations, at all times, could result in enforcement action and financial penalties and damage our reputation.

1. EXECUTIVE SUMMARY

The attached Winter Resilience Plan and BAS assurance slides provide an overview of the Trust's preparedness for winter 2026/27, together with an assessment of current assurance against the NHS England Board Assurance Statement requirements. The review identifies a number of areas where robust arrangements are already in place, together with a small number of residual risks and evidence gaps requiring ongoing executive oversight following Board submission.

A detailed review of the NHS England Board Assurance Statement (BAS) requirements has been completed. The review demonstrates that the majority of governance, operational, IPC, patient flow and winter preparedness arrangements are established. However, a number of evidence-based assurance gaps remain in relation to QEIA completion, winter exercise learning, festive staffing arrangements, Section 136 resilience, mutual aid arrangements, severe weather/business continuity contingencies and completion of IPC fit-testing assurance. These areas are reflected within the Board Assurance evidence deck and have informed the current Reasonable Assurance assessment.

Purpose:

To provide the Board of Directors with:

- An overview of the Trust's Winter Resilience Plan 2026/27.
- An assessment of current BAS assurance.
- Key risks and dependencies requiring oversight.
- Recommended actions prior to Board approval and BAS submission.

Outstanding Evidence:

Area	RAG	Key Executive Consideration
Governance & Leadership	Reasonable	Final approval route, QEIA and evidence closure
Prevention	Reasonable	Delivery of vaccination trajectory towards 60% uptake and EDG approval of vaccination plan
Occupancy & Discharge	Reasonable	Delivery of CRFD reduction trajectory
Capacity	Reasonable	Workforce resilience and festive rosters
Flow	Good	Liaison, Crisis and Section 136 assurance evidence
IPC	Reasonable	Completion of fit-testing programme and confirmation of operational ownership for PPE escalation.
Mental Health Specific Requirements	Reasonable	Home Treatment Team resilience, senior cover and Section 136 assurance remain outstanding.

2. CURRENT POSITION

The review demonstrates that several core winter resilience arrangements are established, including:

- Daily operational flow meetings and OPEL escalation arrangements and oversight.
- Senior on-call and executive escalation processes.
- Established Infection Prevention and Control governance through the Infection Prevention and Control Committee and Outbreak Control Team arrangements.
- A planned seasonal vaccination programme with established governance arrangements.
- Sustained reduction in inappropriate out-of-area placements.
- Defined oversight of occupancy, discharge and clinically ready for discharge (CRFD) performance.
- Business continuity and winter escalation planning.
- Participation in the North East and Yorkshire Winter Test Event 17th September 2026.
- Planned internal winter resilience exercise November 2026 (TBC).
- Board Assurance Statement evidence review completed 23rd September 2026.

3. BOARD ASSURANCE STATEMENT READINESS

BAS Domain	Current Position
Governance & Leadership	Reasonable assurance. Executive Director Group approval complete 10 th September 2026 with agreed review of progress November 2026, January 2027 and March 2027. EQIA has been completed and is currently progressing through the Trust's governance and approval process prior to being submitted for panel review. Partner engagement evidence and testing exercise learning remain outstanding at the time of this report (17 th September North East Yorkshire Winter Test Event).
Prevention	Reasonable assurance. Vaccination programme established but trajectory and final approval evidence required. Vaccination clinics start on the 1 October 2026 and will run until 31 March 2027.
Occupancy & Discharge	Reasonable assurance. CRFD improvement trajectory in place; festive discharge arrangements to be completed.
Capacity	Reasonable assurance. Workforce resilience arrangements established; festive staffing assurance required.
Flow	Good assurance. OPEL and escalation processes established; Section 136 and handover assurance to be strengthened.

IPC	Reasonable assurance. Governance arrangements established; fit-testing and PPE escalation assurance outstanding. Fit- testing training in Urgent Care teams commenced in September 2026. By November 2026, any staff fit tested need to have this entered on ESR.
Mental Health Specific Requirements	Reasonable assurance. Further evidence required regarding Home Treatment Team resilience and sustained capacity to support Section 136 arrangements.

Overall, the Trust's position is assessed as Reasonable Assurance, reflecting that the majority of BAS requirements are either fully or substantially met, with a limited number of evidence gaps remaining that do not currently prevent Board approval of the Winter Resilience Plan but require ongoing executive oversight.

4. KEY AREAS OF ASSURANCE

Occupancy and Patient Flow

Current bed occupancy is reported at 89.95%, remaining above the Trust target of 85%. There are currently 59 patients identified as clinically ready for discharge, representing 15.86% of the inpatient population. A reduction trajectory to 15% by December 2026 has been established. The principal assurance risk remains delivery of discharge improvements and completion of the Christmas and holiday-period discharge arrangements.

Prevention and Vaccination

A comprehensive staff vaccination programme is in place, supported by mandatory RAVS recording, dedicated administrative support, peer vaccinators, roving vaccinators and planned vaccination clinics between October 2026 and March 2027. The Trust achieved 46% staff flu vaccination uptake in 2025/26 against the NHS England ambition of 60%, with weekly monitoring and reporting arrangements expected through EDG and wider Trust governance channels. High-risk patient groups are actively identified through pharmacy and nursing teams.

Infection Prevention and Control

IPC governance arrangements are well established, with formal oversight through the Infection Prevention and Control Committee and Outbreak Control Team meetings. Annual audit processes are in place and responsibilities for action plans are clearly defined. Fit-testing activity is progressing, with approximately 60 staff already fit tested and priority given to Crisis and Liaison services as key front-door areas.

5. Prior Consideration and Feedback

The Winter Plan was reported to and agreed by the Executive Directors Group on 10 September 2026 and presented at the Audit and risk Committee on 21 September 2026.

6. RISKS

1. Delivery of the CRFD reduction trajectory and associated discharge plans.
2. Bed occupancy remaining above the Trust target.
3. Achievement of the NHS England workforce flu vaccination ambition of 60%.
4. Completion of fit-testing activity and associated assurance reporting.
5. Outstanding evidence requirements relating to Home Treatment Team resilience, senior cover and Section 136 capacity and contingency arrangements.
6. Confirmation and sign-off of the seasonal vaccination plan through EDG.

Risk Assurance Outstanding:

1. EQIA completion and Board evidence requirements.
2. Temporary Changes to Director of Operations Portfolios.
 - During Q1 and Q2 of 2026/27, a series of temporary changes were implemented to Director of Operations portfolios and associated leadership arrangements, which will remain in place until the end of the financial year. The first phase of changes followed concerns regarding quality, service delivery and operational performance within Adult Mental Health (AMH) Community Services in Harrogate. A review of leadership and management capacity across Director, General Manager and Service Manager roles identified an opportunity to strengthen oversight, increase leadership focus and create additional capacity to support improvement activity. Temporary portfolio adjustments were therefore introduced to ensure focused executive attention, accelerate improvement activity and provide greater operational resilience.
 - A second phase of changes was implemented during Q2 to align the Trust's Mental Health Services for Older People (MHSOP) and Adult Learning Disability (ALD) portfolios under consistent operational arrangements across all localities. This was designed to support greater consistency in service delivery, quality governance and performance management, while also providing clearer executive oversight of transformation programmes and service redesign proposals linked to the Medium-Term Financial Plan. Throughout these changes, locality-based relationships and partnership working have continued to be led through General Manager and Service Manager arrangements, supported by appropriate clinical leadership and maintained senior representation at Health and Wellbeing Boards, Overview and Scrutiny Committees, and other key partnership forums. The temporary arrangements have strengthened organisational capacity, improved alignment of operational priorities and provided enhanced oversight of quality, performance and transformation activity. Following the successful appointment of the Chief Operating Officer, these arrangements will be reviewed to determine the most effective and sustainable leadership structure for future delivery.
3. BAS evidence gaps relating to mutual aid arrangements.
4. Completion of winter testing and action closure.
5. Severe weather contingency assurance.
6. Confirmation of partner engagement evidence.

7. RECOMMENDATIONS

The Board of Directors are asked to:

1. Approve the Winter Resilience Plan 2026/27.
2. Note the detailed Board Assurance Statement assessment.
3. Endorse the current Reasonable Assurance position.
4. Support continued executive oversight and completion of the identified assurance actions prior to BAS submission on 30 September 2026.

Winter Resilience Plan

2026/27

Board Assurance Statement Structure

Executive summary

Our plan

The Trust will support system-wide winter resilience through local community care, timely transfer from acute hospitals, OPEL, system calls, contingency planning and business continuity arrangements.

Board Assurance Position

- Zero inappropriate out-of-area placement bed days
- Occupancy 89.95% at end July 2026
- 59 CRFD patients, 15.86% of acute capacity

Principal Risks

- Patient flow remains the Trust's most significant operational challenge
- Workforce resilience and 6.90% sickness
- Vaccination, IPC and urgent care interface

Board Decision Required

Recommendation

Approve the plan subject to closure of evidence actions.

Current Assurance

Reasonable assurance with several areas still requiring evidence.

Board Ask

Agree assurance, owners, deadlines and escalation.

Residual Risks

- Occupancy and CRFD
- Workforce and festive rotas
- NHS 111, liaison and Section 136
- Vaccination plan approval date
- IPC fit-testing evidence and operational dependencies

BAS Assurance Dashboard

Reasonable

Section	RAG	Current assurance	Owner
Governance		Sponsor, QEIA, exercise learning and route require evidence	Interim Managing Director
Prevention		Campaign controls established: 46% baseline, 60% NHSE ambition, mandatory RAVS recording and weekly EDG reporting	Chief Nurse
Occupancy and discharge		CRFD trajectory added; annual leave plan outstanding	Director of Operations
Capacity		Combined contracted staffing is 208.43 WTE below plan across DTVF and NYYS; safe staffing, temporary staffing and festive rota assurance required	Director of Operations
Flow		NHS 111 screening, crisis triage/professional-line and liaison metrics evidenced; S136, handover and winter contingency evidence remain open.	Director of Operations
IPC		Governance defined; fit testing and operational limitations require explicit assurance	Associate Director of IPC
Mental health specific		NHS 111 and urgent-care metrics evidenced; HTT resilience, senior cover, S136 and contingency assurance remain outstanding.	Director of Operations / General Manager (UC)

Governance and Executive Leadership

In Place

Daily staffing and flow meetings, OPEL, system escalation and senior on-call. IPC documents, plans and assurance are signed off through the Infection Prevention and Control Committee.

Vaccination Governance

The seasonal vaccination plan is normally submitted to EDG for sign-off. The 2026/27 campaign runs from 1 October to 31 March; the EDG approval date is awaiting confirmation.

Evidence Action

Confirm EDG date, record approval and retain the final plan as BAS evidence.

Trust representatives are scheduled to participate in the North East and Yorkshire (NEY) Winter Test Event on 17 September 2026. Learning and actions arising from the event will be reviewed through winter governance arrangements and incorporated into the Winter Resilience Plan and supporting contingency arrangements as appropriate.

An internal winter resilience test exercise will also be undertaken to test local operational arrangements, business continuity plans, escalation processes and winter surge responses. Learning and actions will be reviewed through winter governance arrangements and incorporated into the final BAS submission.

Service winter huddles → Care Group review → Trust winter cell → Executive oversight → Board assurance

Prevention

Reasonable

Component	Current Assurance	Further Assurance / Action	Owner	Completion Date	Escalation
Performance and trajectory	2025/26 uptake was 46%; NHSE ambition is 60%. Uptake is monitored through the internal vaccination system	Agree weekly trajectory to 60%; report weekly to EDG and across the Trust, with exception reporting	Associate Director of IPC	March 2027	Health, Safety and Security
Campaign delivery	Campaign runs 1 October to 31 March. Fixed and additional clinics, 98+ peer vaccinators and a roving model support delivery	Monitor uptake by locality and workforce group and target additional clinics where required	Associate Director of IPC	March 2027	Health, Safety and Security
RAVS and data quality	Every vaccination is mandatorily entered on RAVS. Two dedicated administrators support records and staff additions	Maintain RAVS completeness and coding assurance; vaccination activity is not reported through ESR	Associate Director of IPC	March 2027	Health, Safety and Security
Inpatient vaccination	Mixed model: fixed clinics, additional clinics based on uptake, peer vaccinators and roving provision	Monitor inpatient uptake and deploy additional capacity where required	Associate Director of IPC	March 2027	Health, Safety and Security
High-risk cohorts	Pharmacy and nursing teams identify older adults, long-stay inpatients, people with SMI and physical comorbidities, people with LD/autism and people in supported accommodation	Monitor uptake across identified cohorts and target vaccination where gaps are identified	Associate Director of IPC	March 2027	Health, Safety and Security

Occupancy and Discharge

Reasonable

Metric	Current Position	Target / Evidence Required	Owner	Completion Date	Escalation
Bed occupancy	Trust: 89.95%. AMH locality position: DTV 81.48%; NYYS 90.17% in July 2026.	Reduce Trust occupancy towards <=85%; maintain DTV improvement and address NYYS pressure. July activity: 232 admissions and 208 discharges.	Director of Operations	March 2027	Care oversight Group
CRFD	Trust: 59 patients, 15.86% of acute capacity. AMH urgent care: 22 DTV patients, with delays of 3 to 1,024 days.	Deliver the Trust-wide CRFD Improvement Plan. DTVF mitigations include Transfer of Care Hub evaluation, Patient Flow Team review and a CRFD pilot role; estimated 12-month cost £21.49m.	Interim Managing Director	Reduce to 15% by December 2026 Reduce to 12% by March 2027	Care oversight Group
Long LoS	Adult acute/PICU ALOS: 30.59 days; older adult acute ALOS: 76.71 days. 28 adult/PICU and 41 older adult discharges exceeded 100 days.	Reduce >100-day discharges through the CRFD plan, strengthened discharge pathways and system escalation.	Director of Operations	December 2026	Care oversight Group
Annual Leave Plan	Awaiting completion and sign-off	Confirm daily discharge and senior cover.	General Managers	November 2026	Care oversight Group
OOA placements	Zero inappropriate OOA bed days in the 3-month period ending July 2026	Maintain zero inappropriate OOA bed days	Director of Operations	Maintain Position	Care oversight Group

Capacity

Reasonable

Area	Current Evidence	Further Evidence Required	Owner	Completion Date	Escalation
Workforce establishment	Month 4 combined contracted staffing: 6,374.59 WTE against 6,583.02 WTE plan, a 208.43 WTE gap.	Monitor vacancies, safe staffing, sickness, deployment, temporary staffing and festive rota coverage. Christmas ward and team staffing rosters will be published on 19 October 2026 and New Year ward and team staffing rosters will be published on 16 November 2026, providing early assurance of winter staffing arrangements.	General Managers	November 2026	Integrated Care Group Board / IQPR
Priority service pressures	AMH safe-staffing controls include weekly monitoring of shifts over 13 hours and missed meal breaks; missed meal breaks were <1% of shifts. DTV safe staffing depends on £1.4m allocation and temporary staffing for ETOC.	Confirm winter service-level mitigations, funding dependencies, festive rotas, skill mix, medical cover and escalation.	General Managers	November 2026	Integrated Care Group Board / IQPR
Professional groups	Actual gaps include consultants 29.62 WTE, medical and dental 26.69 WTE, AHPs 36.12 WTE and qualified nurses/nurse managers 38.82 WTE.	Provide recruitment, skill-mix, medical cover and escalation assurance for priority services.	Associate Medical Directors / Professional Leads / General Managers	November 2026	Integrated Care Group Board / IQPR
Temporary staffing	Actual staffing includes 39.00 WTE agency staff, 59.31 WTE qualified bank nurses and 274.60 WTE unqualified bank nurses. Temporary staffing controls require consideration of alternatives before agency use.	Reduction of Flexible Staffing Group oversight covers sickness reduction, roster optimisation, substantive recruitment and bank/agency reduction; confirm festive fallback routes.	General Managers	November 2026	Integrated Care Group Board / IQPR

Flow and Crisis Assurance

Good

Area	Current assurance / control	Further assurance required	Owner	Completion Date	Escalation
Liaison psychiatry and ED waits	Liaison: 93.30% assessed within 60 minutes in ED and 98.70% within 24 hours in July. Weekly 12-hour mental-health ED breach meetings operate across acute hospitals.	Continue site-level oversight of demand surges, response standards, staffing resilience, breaches and improvement actions.	AMH Urgent Care General Manager / Director of Operations	November 2026	Care Oversight Group
NHS 111, triage and professional lines	DTV NHS 111 screening achieved 95%; NYYS CAMHS screening 92%. D&D professional line: 1,086 calls, 68% within 7 minutes (73% incl. callbacks). Tees: 1,222 calls, 93% within 7 minutes.	Complete standardised KPI review; retain call volume, answer, callback, abandonment, wait and escalation reporting. NYYS professional-line data is not currently available from its landline.	AMH Urgent Care General Manager / Director of Operations	November 2026	Care Oversight Group
Ambulance, police and Section 136	Diversionary pathways are established with ambulance services and police forces through CAS and Section 136 arrangements, supporting appropriate access and reducing avoidable ED demand.	Report pathway activity, outcomes, handover arrangements, demand, capacity, contingency and senior escalation.	AMH Urgent Care General Manager / Director of Operations	November 2026	Care Oversight Group
Crisis alternatives	Durham Crisis Assessment Centre has progressed to design and costing. Scarborough 24/7 Neighbourhood Centre development is progressing, alongside existing crisis cafes, hubs and support services.	Provide delivery milestones, utilisation, opening arrangements, locality coverage, capacity and identified gaps.	AMH Urgent Care General Manager / Director of Operations	November 2026	Care Oversight Group
Daily operational oversight	Daily OPEL oversight is supplemented by monthly contract meetings for NYYS screening, bimonthly quality meetings and an Intensive Support Plan for NYYS crisis triage.	Confirm dashboard measures, unresolved risks, decisions, action tracking and winter escalation thresholds.	AMH Urgent Care General Manager / Director of Operations	November 2026	Care Oversight Group

Infection Prevention and Control

Reasonable

Assurance Area	Current Position for EDG Assurance	Residual Gap / Action	Owner	Completion Date	Escalation
DIPC / IPC sign-off	Documents, plans and associated assurance are signed off through the Infection Prevention and Control Committee	Evidence committee approval and record any exceptions	Associate Director of IPC	November 2026	Infection Prevention and Control Committee
Fit testing	IPC is developing local fit-test capability; approximately 60 staff are fit tested, prioritising crisis and liaison teams	Complete local testing and ensure relevant records are entered on ESR by November; Scott Rogers and Stephen Parry are supporting	Associate Director of IPC	November 2026	Infection Prevention and Control Committee / Health, Safety and Security
PPE stock and escalation	IPC reminds services through routine communications to check masks are in date	Ward stock levels and escalation are outside IPC remit; identify the operational owner and escalation route	Associate Director of IPC	November 2026	Infection Prevention and Control Committee
Outbreak governance	Managed through the Infection Prevention and Control Committee and Outbreak Control Team meetings	Evidence meeting route, decisions and actions	Associate Director of IPC	November 2026	Infection Prevention and Control Committee / Health, Safety and Security
Cohorting and isolation	Managed through OCT meetings during outbreaks; procedures are available on the IPC intranet page	Confirm staff awareness and use of current procedures	Associate Director of IPC	November 2026	Infection Prevention and Control Committee / Health, Safety and Security
Estates risks	IPC-related estates issues are managed through ward/team managers and included in IPC audit where relevant	Confirm local ownership and escalation for material risks	Associate Director of IPC	November 2026	Infection Prevention and Control Committee
Audit compliance	IPC undertakes annual audits; ward/team managers own and update action logs	Report compliance, overdue actions and exceptions through IPC governance	Associate Director of IPC	November 2026	Infection Prevention and Control Committee

Leadership and Operational Grip

Reasonable

Clear routes for escalation and evidence ownership

Area	Assurance Position	Action for EDG
IPC governance	IPCC provides formal sign-off; OCT provides outbreak-specific operational governance	Receive approval/exception evidence through winter governance
Operational ownership	Ward/team managers own IPC audit action logs and relevant estates issues	Escalate overdue or material actions through management routes
PPE dependency	IPC does not manage ward PPE stock or escalation levels	Confirm accountable operational/estates/supplies owner and escalation route
Fit testing	Priority rollout to crisis and liaison teams; ESR recording required by November	Monitor coverage, exceptions and ESR completion
Vaccination programme	46% achieved in 2025/26 against a 60% NHSE ambition; weekly EDG reporting is expected	Confirm EDG approval date, weekly trajectory and exception thresholds

Specific Actions for Mental Health Teams

Reasonable

Measurable evidence required

BAS Ask	Current Position	Evidence Required	Owner	Completion Date	Escalation
NHS 111 option 2	July screening answer-rate compliance: DTV 95%; NYYS CAMHS 92%. Governance includes contract and quality meetings; an approved business case will bring NYYS screening in-house by March 2027.	Confirm NHS 111 Option 2 scope and retain demand, abandonment, wait, capacity and escalation reporting; transition meetings begin September 2026.	AMH Urgent Care General Manager / Director of Operations	November 2026	Care Oversight Group
Crisis / HTT	Crisis 4-hour response: DTV 90.75%, NYYS 92.98%; Tees 94.27%, Durham 83.33%, Darlington 70%. D&D resource does not support both HTT and triage; recruitment and data-quality work continue.	Provide HTT capacity, workforce, medical/senior cover, mutual aid, winter escalation and improvement trajectory.	AMH Urgent Care General Manager / Director of Operations	November 2026	Care Oversight Group
CYP crisis 4 hours	July performance was 78.57% in County Durham and 76.19% in Tees Valley against the 90% standard. Capacity, sickness, vacancies and acuity affected delivery; recruitment and overtime mitigations are in place.	Report winter capacity, staffing resilience, escalation arrangements and improvement trajectory.	CAMHS General Manager / Director of Operations	November 2026	Care Oversight Group
High-risk attenders	Frequent attender management arrangements are routinely in place across services, including established care and safety planning.	OPEL escalation triggers are communicated to senior operational and clinical colleagues; monitor the defined cohort and plan completion.	AMH Urgent Care General Manager / Director of Operations	N/A	Care Oversight Group
Liaison / S136	Liaison response is evidenced. In July, four patients waited over 4 hours for a bed in a Health Based Place of Safety, including waits of 6, 18, 19.5 and 22 hours.	Provide complete Section 136 demand, capacity, outcomes, transport/handover, contingency and escalation evidence.	AMH Urgent Care General Manager / Director of Operations	November 2026	Care Oversight Group

Escalation Level	Welfare Action	Controls and Actions
Business as usual	Trust sickness: 6.90% against 5.5% aim. DTVF sickness: 7.42%, with long-term absence the main driver.	Wellbeing, supervision, return-to-work and consistent attendance management; monthly Director-led reviews and targeted service improvement plans.
OPEL 3	Hotspot review, breaks, redeployment and visible leadership	Director-led monthly sickness reviews, hotspot review, breaks, redeployment and visible leadership
OPEL 4	Executive oversight of fatigue, staffing and communications	Executive oversight of fatigue, staffing and communications; targeted support for services with sustained absence pressures
Recovery	Debrief, learning, absence support and recovery plan	Debrief, learning, absence support, recovery planning and evaluation of sickness reduction initiatives

Top Residual Risks and Mitigations

Risk	Current Control	Further Action	Escalation
CRFD / discharge	Trust-wide CRFD Improvement Plan, daily flow oversight, system escalation, Transfer of Care Hub and Patient Flow Team review.	Reduce 59 CRFD patients (15.86% of acute capacity), complete holiday discharge plan and deliver locality actions; £21.49m estimated 12-month cost.	Interim Managing Director
Workforce	208.43 WTE contracted gap; 6.90% sickness; rota/on-call controls and Reduction of Flexible Staffing Group oversight.	Target recruitment and skill mix; monitor bank/agency use, safe staffing, redeployment and festive rota coverage. Christmas ward and team staffing rosters will be published on 19 October 2026 and New Year staffing rosters on 16 November 2026 to support proactive workforce planning and escalation management.	Director of operations / General Managers
Vaccination uptake	46% achieved in 2025/26; mixed delivery model and mandatory RAVS recording	Weekly trajectory to 60% and targeted action by locality/workforce group	Associate Director of IPC
Fit testing	Local rollout; crisis/liaison prioritised	Coverage and ESR completion by November	Associate Director of IPC
PPE stock ownership	IPC communications on mask expiry	Name operational owner and escalation route	Associate Director of IPC
IPC outbreaks	IPCC and OCT governance	Evidence decisions, actions and exceptions	Associate Director of IPC

Immediate Action Plan

Action	Owner	Output
Confirm EDG date for seasonal vaccination plan	Interim Managing Director/ Associate Director of IPC	EDG approval recorded
Agree weekly vaccination trajectory to 60% and exception thresholds	Associate Director of IPC	Weekly EDG and Trust-wide report
Confirm accountable owner for ward PPE stock and escalation	Associate Director of IPC	Named route and thresholds
Report fit-testing coverage and ESR recording plan	Associate Director of IPC	Coverage, exceptions and November milestone
Confirm IPCC/OCT governance evidence	Associate Director of IPC	Committee approvals and action records
Report IPC audit exceptions and overdue actions	Associate Director of IPC	Exception report
Retain CRFD trajectory and add annual leave plan	Interim Managing Director / General Managers	Completed occupancy assurance
Internal winter resilience test exercise to be organised and completed during autumn 2026.	Director of Operations	Assurance that Winter Plan, Business Continuity Plans and escalation arrangements are effective in responding to periods of increased system pressure and maintaining service delivery.
External stress testing of Winter Plan, Contingency and Business Continuity plans at regional level.	Interim Managing Director / Director of Operations	Plans are effective in responding to increased system pressure and maintaining service delivery.

Evidence Collection Tracker

Reasonable

Evidence Required	Lead Area	Status
Vaccination plan EDG date and sign-off	Vaccination Lead / MD office	Awaiting date
Weekly trajectory from 46% baseline to 60% ambition	Vaccination Lead / Operational	To be agreed
RAVS completeness and staff coding assurance	RAVS Administrators	Controls in place
Fit-test coverage and ESR completion	IPC	In progress
PPE stock owner and escalation route	Operations / Supplies / Estates	Owner to confirm
IPCC and OCT governance evidence	DIPC / IPC	In place; evidence to attach
IPC audit compliance and action exceptions	Ward/Team Managers / IPC	Annual process in place
Cohorting, isolation and intranet procedures	IPC	In place

Board Approval Statement

Proposed Wording

The Board is asked to approve the Trust Winter Resilience Plan 2026/27 and note the current reasonable assurance position. IPC governance is established through the Infection Prevention and Control Committee, with outbreak management, cohorting and isolation decisions supported through Outbreak Control Team arrangements. Annual IPC audits are undertaken, with ward and team managers responsible for action logs.

The seasonal vaccination programme achieved 46% staff flu uptake in 2025/26 against a 60% NHS England ambition for 2026/27. The campaign runs from 1 October to 31 March, using fixed and targeted clinics, more than 98 peer vaccinators and roving provision. All vaccinations are mandatorily recorded on RAVS, supported by two dedicated administrators, and weekly performance reporting is expected through EDG and Trust-wide communications. Pharmacy and nursing teams identify high-risk patient cohorts for targeted vaccination. Residual assurance is required regarding the agreed weekly trajectory to 60%, the confirmed EDG sign-off date, fit-testing coverage and named operational ownership of ward PPE stock and escalation arrangements.

Board Decision

Approve the plan and agree owners, deadlines and escalation routes.

Conditions before BAS submission

Close evidence actions or agree controlled residual risks and exception reporting.

BAS Readiness Assessment

Reasonable

BAS section	Current position	Outstanding Requirement	RAG
Governance	Governance routes described. The Trust is participating in the North East and Yorkshire Winter Test Event on 17 September 2026. The event will provide assurance regarding the effectiveness of winter escalation, business continuity and contingency arrangements. Any actions identified will be reviewed through winter governance structures and incorporated into the final BAS submission.	Confirm Winter Plan QEIA, attach evidence of Executive Sponsor and partner engagement, complete the planned internal winter resilience test exercise, and incorporate learning arising from the NEY Winter Test Event and local testing activities.	
Prevention	Campaign model, RAVS and high-risk cohorts	Plan approval, weekly trajectory, FHCW ESR flag and inpatient offer	
Occupancy & discharge	Occupancy, CRFD and OOA evidence available	Annual leave plan, seven-day discharge and tested escalation	
Capacity	Vacancy, sickness and temporary staffing analysis	Safe staffing, festive rosters, skill mix and senior cover. Christmas staffing rosters are due 19 October 2026 and New Year staffing rosters are due 16 November 2026. Residual assurance required regarding final staffing resilience and escalation arrangements.	
Flow	OPEL, NHS 111 screening, crisis triage/professional-line, liaison response and DTVF GIRFT oversight evidenced.	S136 capacity, demand, contingency arrangements and Trust-wide oversight.	
IPC	Governance, outbreak arrangements and fit-test rollout	Cohorting activation, PPE owner, environmental and space assurance	
Leadership & grip	OPEL and on-call arrangements described	Mutual aid, tested BCPs, and severe weather.	
MH-specific	NHS 111 screening, crisis triage/professional-line activity, liaison metrics and improvement controls evidenced.	HTT capacity, senior cover, S136 demand/outcomes, mutual aid, winter surge and contingency evidence.	

Board position: Reasonable assurance. Approve the plan subject to closure of the actions above, or formal agreement of controlled residual risks before BAS submission.

Board Assurance Statement

Section A and Section B evidence deck

Prepared for Board review and update

Trust: Tees, Esk and Wear Valleys NHS Foundation Trust
Meeting date: 23 September 2026
Executive Winter Sponsor: Naomi Lonergan, Interim Managing Director



BOARD ASSURANCE

Section A | Governance and executive leadership

Assurance requirement	Board evidence and position
A1.1 The Board has assured the Trust Winter Plan for 2026/27.	REASONABLE Plan recommends approval subject to closure of evidence actions.
A1.2 A robust quality and equality impact assessment informed development of the plan and has been reviewed by the Board.	LIMITED The QEIA has been completed and is currently progressing through the Trust's governance and approval process prior to being submitted for panel review.
A1.3 The plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	LIMITED Learning will follow attending the Winter Planning event on 17 September 2026.
A1.4 The plan was tested through a regionally led winter exercise; the outcome was reviewed and lessons incorporated.	REASONABLE NEY Winter Test Event is scheduled for 17 September 2026; an internal exercise is planned for autumn. Learning is not yet available.
A1.5 A named Executive Winter Sponsor is accountable for preparedness, including vaccinations, escalation and operational delivery.	REASONABLE Interim Managing Director is identified as sponsor; retain evidence of formal designation.
A1.6 Clear governance, escalation processes and operational leadership arrangements are in place throughout winter.	GOOD Daily staffing and flow meetings, OPEL, system escalation, senior on-call and an executive-to-Board governance route are described.

Section B | Prevention

Vaccination, respiratory virus prevention and identification of vulnerable cohorts

Assurance requirement	Board evidence and position
B1.1 FHCW flu programme delivers Trust uptake ambitions: accessible 1 October to 31 March; majority by 30 November; walk-in and bookable routes; activity recorded on RAVS; FHCW flag applied accurately in ESR.	REASONABLE 46% 2025/26 baseline; 60% ambition. Campaign runs 1 October to 31 March, with fixed/targeted clinics, 98+ peer vaccinators and RAVS recording.
B1.2 Targeted operational plans support frontline staff vaccination, respiratory virus prevention and staff health measures.	REASONABLE Locality and workforce-group monitoring, targeted clinics and roving provision are planned.
B1.3 Plans offer flu and COVID-19 vaccination to long-stay inpatients (21 days or more) and those discharged to a care home.	REASONABLE A mixed inpatient vaccination model is described.
B1.4 Population health intelligence and risk stratification are used with system partners to identify and support vulnerable and high-risk cohorts.	GOOD Pharmacy and nursing teams identify older adults, long-stay inpatients, people with SMI, comorbidities, LD/autism and supported accommodation.

Board self-assessment:  Full  GOOD  REASONABLE  LIMITED  Limited

Section B | Occupancy and discharge

Joint discharge planning, seven-day optimisation and holiday-period resilience

Assurance requirement	Board evidence and position
B2.1 Discharge pathways required to manage bed demand and occupancy have been reviewed with local authority, community health and system partners, including holiday-period arrangements.	REASONABLE Pilot CRFD and Transfer of Care Hub evaluation..
B2.2a Seven-day model discharge requirements include coordinated escalation, surge and extreme-surge arrangements that are tested and capable of safe activation.	GOOD Daily flow oversight, OPEL and escalation are in place. Pilot CRFD plan and Transfer of Care Hub evaluation.
B2.2b Executive-led governance oversees occupancy, required and delivered discharges.	REASONABLE Executive and Care Oversight Group monitoring of occupancy is reasonable. Control effectiveness is limited.
B2.2c Targeted operational actions reduce long discharge delays.	LIMITED Trust-wide CRFD plan, Transfer of Care Hub evaluation and Patient Flow Team review support delay reduction.

Section B | Occupancy and discharge

Occupancy reduction and admission avoidance

Assurance requirement	Board evidence and position
B2.3 Pre-Christmas and holiday-period occupancy reduction plans will be implemented.	REASONABLE Patient flow daily OPEL and Safe Staffing will remain in place. Senior on-call arrangements will be confirmed by end of October.
B2.4 Same Day Emergency Care and ambulatory emergency care pathways are optimised to support admission avoidance.	REASONABLE Crisis alternatives, NHS 111 screening and diversionary pathways support admission avoidance. Further evidence required regarding Home Treatment Team resilience and sustained capacity to support Section 136 arrangements.
B2.5 Frailty pathways have been reviewed and operate effectively to avoid unnecessary admission.	REASONABLE Consistent delivery of patient flow and crisis alternatives.

Section B | Capacity

Workforce resilience, senior decision-making and delivery headroom

Assurance requirement	Board evidence and position
B3.1 Workforce assumptions evidence safe staffing, skill mix, redeployment models and staff wellbeing, with mitigations for sustained increased demand.	REASONABLE 6,374.59 WTE against 6,583.02 WTE plan, a 208.43 WTE gap; sickness is 6.90%. Safe-staffing and flexible staffing controls are described. Christmas roster will be finalised on 19 October 2026 and New year roster will be finalised on 16 November 2026.
B3.2 Rotas support consistent senior clinical decision-making at peak times, including weekends, with clear escalation and supervision.	REASONABLE Senior on-call and escalation arrangements are described.
B3.3 Elective and cancer plans create sufficient headroom in Quarters 2 and 3, including diagnostics.	Liaison psychiatry crisis alternatives and crisis response ams will continue to support partners with delivery
B3.4 The Board has reviewed 4-hour, 12-hour and RTT trajectories and is assured the winter plan mitigates risks to delivery.	Liaison psychiatry crisis alternatives and crisis response will continue to support partners with delivery
B3.5 Operational actions ensure urgent community capacity is prioritised for the sickest patients.	REASONABLE Liaison Psychiatry Crisis, crisis response and home team response

Section B | Flow

Patient safety, ambulance handover and system transfer of care

Assurance requirement	Board evidence and position
B4.1 ED crowding mitigations actively eliminate corridor care, implement relevant GIRFT recommendations, define safety thresholds and escalation triggers, and support routine Board oversight of dignity, privacy and clinical harm.	REASONABLE Weekly 12-hour mental-health ED breach meetings and DTVF GIRFT oversight are described.
B4.2 Ambulance handover plans are deliverable and supported by operational arrangements and escalation processes.	
B4.3 Escalation arrangements with system partners support timely transfer of care and patient flow.	REASONABLE Daily OPEL, system calls and escalation arrangements support timely transfer and flow.
B4.4 Plans are in place to implement Model ED and Model Discharge requirements ahead of winter.	

Section B | Infection Prevention and Control

Safe reconfiguration, IPC leadership, PPE and patient cohorting

Assurance requirement	Board evidence and position
B5.1 Plans, infrastructure, estates, IPC governance and operational capability support safe rapid reconfiguration, additional capacity and cohorting, with environmental risk assessment and code compliance.	REASONABLE IPCC/OCT governance, outbreak controls and local procedures are described.
B5.2 The DIPIC or nominated IPC Lead was engaged in the winter plan and is confident in mitigations and actions.	GOOD Plans and assurance are signed off through the Infection Prevention and Control Committee.
B5.3 Fit testing is recorded, monitored and scalable; PPE supply, stock management and escalation support increased respiratory and gastrointestinal transmission.	REASONABLE Approximately 60 staff are fit tested, prioritising crisis and liaison teams; ESR completion is planned by November.
B5.4 A risk-based patient cohorting plan is understood by staff and ready for activation by site management teams.	REASONABLE Cohorting and isolation are managed through OCT meetings and IPC procedures.

Section B | Leadership and operational grip

On-call readiness, real-time oversight and contingency arrangements

Assurance requirement		Board evidence and position	
B6.1	Tested on-call arrangements include access to medical and nursing leaders and oversight to prioritise urgent community capacity.	GOOD	Senior on-call arrangements and access routes are described.
B6.2	Real-time pressures are monitored and reported through OPEL, with clear escalation triggers and timely response.	GOOD	Daily OPEL oversight, system calls and escalation routes are established.
B6.3	Mutual aid arrangements have been reviewed and can be activated if required.	LIMITED	Mutual aid evidence remains outstanding.
B6.4	Business continuity plans have been reviewed and tested where appropriate.	REASONABLE	An internal winter resilience exercise is planned for November 2026.
B6.5	Severe weather and infrastructure disruption contingencies have been reviewed.	REASONABLE	Summer and winter plan currently being reviewed and transferred to an Adverse Weather Plan with completion by end of October. .
B6.6	Industrial action contingencies have been reviewed where relevant.	GOOD	Industrial action contingency has been demonstrated and evidence is available.
B6.7	Plans support staff welfare during periods of high demand.	GOOD	Wellbeing, supervision, return-to-work, redeployment and executive oversight are described; sickness is 6.90%.

Section B | Mental health specific actions

Operational resilience across urgent mental health pathways

Assurance requirement	Board evidence and position
B7.1 Plans ensure resilience of all-age urgent mental health helplines via NHS 111, local crisis alternatives, crisis and home treatment teams, liaison psychiatry and senior decision-makers.	REASONABLE NHS 111 screening, professional lines, crisis response, liaison and crisis alternatives are evidenced.
B7.2 People who frequently access urgent care and all high-risk patients have a tailored crisis and relapse plan ahead of winter.	REASONABLE Frequent-attender care and safety planning is routinely in place.
B7.3 Liaison psychiatry pathways and Section 136 arrangements remain resilient during peak demand.	REASONABLE Further evidence will be sought through the internal winter test.

Board assurance dashboard

A	Governance and executive leadership	REASONABLE
B1	Prevention	REASONABLE
B2	Occupancy and discharge	REASONABLE
B3	Capacity	REASONABLE
B4	Flow	GOOD
B5	Infection Prevention and Control	REASONABLE
B6	Leadership and operational grip	REASONABLE
B7	Mental health specific actions	REASONABLE

Overall assurance

REASONABLE

Rationale: Core governance, OPEL, vaccination delivery, CRFD controls, urgent-care metrics and IPC arrangements are established. Material evidence gaps remain across QEIA, testing, festive staffing, S136, mutual aid and contingency arrangements.

Priority Actions

1. Complete QEIA, confirm Executive Sponsor and capture learning from regional/local testing.
2. Finalise festive staffing and holiday plans, including senior cover and escalation.
3. Complete fit-testing, PPE ownership, mutual-aid and contingency evidence gaps.
4. Test 136 and Home Treatment Team resilience.

Board conclusion and approvals

Capture the final assurance judgement and the decision required.

Board conclusion

The Board is REASONABLY assured that the 2026/27 Winter Resilience Plan addresses the BAS requirements, subject to closure of the identified evidence actions and formal acceptance of any residual risks.

Material qualifications

Qualifications relate to the outstanding QEIA and sponsor evidence; regional and internal exercise learning; festive staffing and discharge plans; S136 and HTT resilience; fit-testing and PPE ownership; and mutual-aid, severe-weather and industrial-action contingencies.

Decision requested

Approve the Winter Resilience Plan and the current REASONABLE assurance position, subject to completion of the recorded actions, agreed owners and deadlines, and exception reporting to the Board.

Accountable Officer: Naomi Lonergan Date: 23 September 2026

Chair: Marie Burnham Date: 23 September 2026

For General Release

Meeting of:	Board of Directors
Date:	23rd September 2026
Title:	Revalidation, Appraisal & Job Planning Report
Executive Sponsor(s):	Dr Kedar Kale, Executive Medical Director
Report Author(s):	Dr Kedar Kale, Dr Lenny Cornwall, Elaine Corbyn, Chloe Casson and Jenny Miller

Report for:

Assurance

x

Decision

Consultation

Information

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

1: We will co-create high quality care

x

2: We will be a great employer

x

3: We will be a trusted partner

x

Strategic risks relating to this report:

BAF ref no.	Risk Title	Context
4.	Quality and Outcomes	<i>Governance and assurance - the absence of a clear line of sight from ward to board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risk to patients.</i>

EXECUTIVE SUMMARY:

Purpose:

The Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) is requested by NHS England each year and has been designed to assist responsible officers in providing assurance to their organisations Board that the doctors working in their organisations remain up to date and fit to practice.

It highlights compliance rates for appraisal and revalidation amongst our doctors for the previous appraisal year (2025-26) and the supporting narrative explains the processes we have in place. The report also shows the number of doctors who were managed under 'Responding to Concerns' and demographic information relating to such concerns during the reporting period. It also details Job Planning information regarding compliance and disputes for the Job Planning Season 2026.

Proposal:

All Responsible Officers are asked to present an annual report to their Board or equivalent management team along with the Statement of Compliance (Annex A) in order to provide a substantial level of assurance that our doctors are fit to practice. The statement of

compliance should be signed off by the Chief Executive or Chairman of the Designated Body's Board or management team and submitted to NHS England by 31st October 2026.

Overview:

The purpose of revalidation is to provide **assurance** to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise. This aim will be achieved through annual appraisal and processes supporting revalidation. By presenting our appraisal and revalidation data within this report which shows we have strong compliance in these areas, it is hoped this will give **good assurance** that we uphold a strong system for appraising and revalidating our doctors.

Prior Consideration and Feedback:

This updated report is brought to the attention of the Board annually for assurance, this has provided the assurance that all doctors are up to date and fit to practice.

Implications:

Failure to submit a signed version of the Board report and Statement of Compliance to NHS England by the required date means our appraisal and revalidation data will not be recognised and compared to that of other NHS organisations.

Recommendations:

The Board are required to confirm a level of assurance as proposed within the report. If assurance is met, the Statement of Compliance should be signed off by the Chief Executive or Chairman of the designated body's Board or management team and then the report can be submitted to NHS England.

ANNUAL REPORT REVALIDATION / APPRAISAL, RESPONDING TO CONCERNS AND JOB PLANNING

1st April 2025 – 31st March 2026

Management of Appraisal and Revalidation

Responsible Officer: Dr Kedar Kale
Associate Responsible Officer: Dr Lenny Cornwall
Lead Psychiatrist for Appraisal and Revalidation: Dr Kirsty Passmore
Medical Development and Medical Management: Mr Bryan O'Leary
Mrs Elaine Corbyn
Mrs Chloe Casson/Miss Jenny Miller
Dr Himanshu Garg (GMD – NYY Care Group)
Dr Ranjeet Shah (GMD – DTVF Care Group)
Dr Hany El Sayeh (Director of Medical Education)

Activity Levels

Number of doctors that TEWV are responsible body for (264)	Consultant		SAS includes IFD Doctors		Trust Doctors	
	2024–25	2025–26	2024–25	2025–26	2024–25	2025–26
Adult Mental Health	60	63	46	51	17	11
Mental Health Services for Older People	30	32	24	18	7	10
Child and Young Person's Services	35	39	6	6	0	0
Learning Disabilities	12	11	3	3	0	0
Forensic Services	16	15	4	5	2	0
Total:	153	160	84	83	26	21
Comments: A total of 264 doctors had a prescribed connection with TEWV as at 31 st March 2026.						

Number of doctors who were due for an appraisal (239)	Consultant		SAS includes IFD Doctors		Trust Doctors	
	2024–25	2025–26	2024–25	2025–26	2024–25	2025–26
Adult Mental Health	56	59	39	43	17	10
Mental Health Services for Older People	28	30	22	16	5	10
Child and Young Person's Services	31	35	5	5	0	0
Learning Disabilities	12	10	2	2	0	0
Forensic Services	13	15	4	4	2	0
Total	140	149	72	70	24	20
Comments: The table above illustrates the number of doctors that were due an appraisal in the last appraisal year between 1 st April 2025 - 31 st March 2026.						

You will see that there is a difference of 11 in the consultant figure of prescribed GMC connections and those due for appraisal. This is due to 11 new consultants commencing employment with the trust within the last year and therefore were not due an appraisal as of 31st March 2026. They had either already undertaken an appraisal with their previous organisation before joining TEWV or may not have worked with the trust for the minimum time period (one year) required to have a Trust appraisal.

There were also 13 new SAS doctors who were not due an appraisal at this time for the same reasons as above, this included 1 International Fellowship Doctors (IFDs) who are counted as SAS doctors. We also had 1 Trust doctor who was not due a 'priming appraisal' as at 31st March 2026. A 'priming appraisal' is a pre-appraisal that introduces the doctor to the appraisal process and allows the doctor to set a PDP for the coming year, which can help the doctor to prepare for their formal appraisal later in the year.

Number of doctors who have had an appraisal in the appraisal year (233) (97%)	Consultant		SAS includes IFD Doctors		Trust Doctors	
	2024–25	2025–26	2024–25	2025–26	2024–25	2025–26
Adult Mental Health	54	58	39	43	17	10
Mental Health Services for Older People	28	29	20	15	5	9
Child and Young Person's Services	30	33	5	5	0	0
Learning Disabilities	12	10	2	2	0	0
Forensic Services	13	15	4	4	2	0
Total	137 (98%)	145 (97%)	70 (97%)	69 (99%)	24 (100%)	19 (95%)

Comments:

The figures in the table above show the number of doctors that have had an appraisal between 1st April 2025 - 31st March 2026. The figures include ARCP's undertaken whilst in training for any new consultants who have started in post within the last year as well as priming appraisals with TEWV.

The reasons that a doctor may have missed their annual appraisal is detailed in the next section under exceptions.

Exceptions

The table below illustrates the approved missed or incomplete appraisals. This cohort are doctors that could not complete their appraisal in the appraisal year for a reason that was accepted and signed off by the Associate Responsible Officer on behalf of the Responsible Officer.

For an appraisal to be an 'approved missed or incomplete', the Trust needs to produce documentation to demonstrate that they have agreed the postponement as reasonable. These requirements are set out by NHS England.

Number of 'approved missed or incomplete appraisals'	Consultant	SAS including IFD Doctors	Trust Doctors
Adult Mental Health	1	0	0
Mental Health Services for Older People	1	1	1
Child and Young Person's Services	2	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	4	1	1

Comment:

The Consultant exceptions are due to:

- 2 Consultants being on long term sick
- 2 Consultants on maternity leave.

The SAS doctor exception is due to:

- 1 SAS doctor on long term sick.

The Trust doctor exception is due to:

- 1 Trust doctor on maternity leave

This resulted in the above doctors not being able to complete an appraisal before 31st March 2026.

The table below illustrates the 'unapproved missed or incomplete appraisals'. This group of doctors have not completed their appraisal in the appraisal year, neither have they sought any agreement of this from the Associate Responsible Officer.

Number of 'unapproved missed or incomplete appraisals'	Consultant	SAS includes IFD Doctors	Trust Doctors
Adult Mental Health	0	0	0
Mental Health Services for Older People	0	0	0
Child and Young Person's Services	0	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	0	0	0
Comments: There are no unapproved, missed or incomplete appraisals in this appraisal year.			

Number of doctors completing revalidation cycle (18)	Consultant		SAS includes IFD Doctors		Trust Doctors	
	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26
Adult Mental Health	19	2	10	6	1	1
Mental Health Services for Older People	7	1	3	2	0	0
Child and Young Person's Services	13	3	0	1	0	0
Learning Disabilities	4	0	0	2	0	0
Forensic Services	1	0	0	0	0	0
Other	0	0	0	0	0	0
Total	44	6	13	11	1	1

Revalidation

Number of doctors receiving revalidation recommendations (18)	Consultant		SAS including IFD's		Trust Doctors	
	2024-25	2025-26	2024-25	2025-26	2024-25	2025-26
Adult Mental Health	19	2	10	6	1	1
Mental Health Services for Older People	7	1	3	2	0	0
Child and Young Person's Services	13	3	0	1	0	0
Learning Disabilities	4	0	0	2	0	0
Forensic Services	1	0	0	0	0	0
Other	0	0	0	0	0	0
Total	44	6	13	11	1	1
Comments: Between 1 April 2025 – 31 March 2026, there were 18 doctors who were due to be revalidated. 18 doctors were revalidated during the timescales allowed. 1 of the 18 doctors initially were deferred but were revalidated thereafter. The reason for deferment was due to an appraisal not taking place due to sick leave and so the doctor has insufficient evidence, therefore it was agreed to defer their revalidation to give them time to complete their appraisal and gather the required evidence.						

Performance Review, Support and Development of Appraisers

Training of Appraisers

	Consultant		SAS	
	2024-25	2025-26	2024-25	2025-26
Number of enhanced appraisers - 48	43	42	5	6
Number of enhanced appraisers carrying out appraisals in appraisal year - 47	43	41	5	6
The Trust trained 2 new appraisers in February 2025; they were ready to start the role in April 2025. One of these new appraisers became a 'Super appraiser'. We introduced 'Super appraisers' in 2025, to help with the low uptake of new appraisers and several appraisers wishing to step down from the role that year. We call them 'Super appraisers' as they undertake 12 appraisals each, rather than the usual 5 or 6 appraisals that our appraisers normally do. The doctors undertaking the super appraiser role are either retire and return doctors or who work less than 4 PAs clinically. We agreed they could do this for a maximum of 3 years if not undertaking clinical work. We had 3 appraisers step down or leave the Trust before 1st April 2025. One appraiser did not undertake any appraisals and then stepped down from the appraiser role in 2026 which is why we had 47 appraisers carrying our appraisals, rather than 48.				

Support and Development of Appraisers

Update/Support Sessions	
4 th June 2025	12 th November 2025
17 th September 2025	11 th February 2026
Comment: There are four sessions held each year, providing greater opportunity for colleagues to attend. The sessions in June and February were face to face, whilst September and November operated on MS Teams virtually. This provides appraisers with options of how they wish to attend. As part of the session, the Trust provides appraisers with an opportunity to share feedback and/or issues that they may have experienced.	

Performance Review of Appraisers

Each appraiser's performance is reviewed by their appraisee after every appraisal that they complete. A set of standardised questions are sent to each appraisee of which they answer them on a scale from 'strongly agree' to 'strongly disagree'. On a yearly basis the feedback is anonymised, collated and fed back to the appraisers in a report. Part of this report allows the appraiser to reflect on the information fed back to them and include it in their own appraisal to contribute to any development discussions and/or PDP objectives. If any trends are identified from the feedback received, this is then discussed with the Associate Responsible Officer who then incorporates this into the quarterly Appraiser Update Sessions and the Annual Trustwide Appraisal Session, which is held each year before the start of the new appraisal year.

Quality Assurance of Appraisals

On an annual basis we undertake an internal peer review of appraisal summaries. Due to an update to SARD Appraisal version 7.1 in April 2025, we paused our annual peer review of appraisals, so that we could make sure all medics were familiar with using the new SARD version before we looked at reviewing the appraisal summaries. We have also been having conversations with our appraisers at our update sessions around whether it would be beneficial to implement a standard template for writing the appraisal summaries, which has led to some appraisers sharing their own templates with us. We are reviewing these templates and as such, won't be carrying out the appraisal summary peer review until the end of 2026.

Responding to Concerns about doctors in TEWV

Total Number of All doctors who were managed under 'Responding to Concerns' (10) (includes 'Low Level' and 'Investigations')	Consultant				SAS/IFD				Trust Doctors			
	2024/25		2025/26		2024/25		2025/26		2024/25		2025/26	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
<i>Teesside</i>	0	0	0	0	0	1	1	0	0	0	0	0
<i>Durham & Darlington</i>	1	1	3	0	0	0	1	0	0	0	0	0
<i>North Yorkshire & York</i>	0	0	0	0	0	0	0	1	0	0	0	0

Total Number of All doctors who were managed under 'Responding to Concerns' (10) (includes 'Low Level' and 'Investigations')	Consultant				SAS/IFD				Trust Doctors			
	2024/25		2025/26		2024/25		2025/26		2024/25		2025/26	
	M	F	M	F	M	F	M	F	M	F	M	F
Mental Health Services for Older People:												
Teesside	1	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	1	0	0	0	0	0	0	0	0	0	0	1
North Yorkshire & York	0	1	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	1	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	1	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	1	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	3	2	5	1	0	1	2	1	0	0	0	1

The total issues dealt with in Medical Development in terms of investigations and low level concerns this year was ten. This consisted of one investigation and nine low level concerns.

The investigation was completed and concluded in line with our 'Dealing with Concerns Affecting Medical Staff' policy.

The low level concerns have increased from three last year to nine this year, however, we have been having more medical manager training sessions where we explain when managers should be completing low level concerns and this could explain the increase. We believe this is a positive move forward as we want any issues and concerns to be dealt with immediately in order to avoid future problems.

In addition to the details documented in this report, Medical Development also deal with other issues and concerns in relation to our doctors, but these do not specifically fall into the categories stated such as, agency doctors or those employed by the Lead Employer Trust (LET).

Total Number of doctors spoken to under 'Low Level Concerns'	Consultant				SAS/IFD				Trust Doctors			
	2024/25		2025/26		2024/25		2025/26		2024/25		2025/26	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	1	1	0	0	0	0	0
Durham & Darlington	1	1	2	0	0	0	1	0	0	0	0	0

Total Number of doctors spoken to under 'Low Level Concerns'	Consultant				SAS/IFD				Trust Doctors			
	2024/25		2025/26		2024/25		2025/26		2024/25		2025/26	
	M	F	M	F	M	F	M	F	M	F	M	F
North Yorkshire & York	0	0	0	0	0	0	0	1	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	1
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	1	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	1	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	1	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	1	1	4	1	0	1	2	1	0	0	0	1

Comments:

Low level concerns are dealt with by a medical manager or another relevant manager. They will organise a meeting with the individual to discuss the issues that have been raised or that might be causing some concern and which they would like to address before those issues become more serious. We have a low-level concern form that managers complete and a copy is given to the doctor and Medical Development for recording purposes.

The purpose of the low-level concern form is to allow concerns to be documented and monitored so that should there be any future concerns raised, there are records to show that actions had already been taken before making the matter more formal. An example of concerns raised may be comments made by colleagues in relation to a doctor's behaviour or how they communicate with others etc.

This year there were nine low level concerns raised. Medical Development work closely with managers at a very early stage to support the doctors and managers, thus reducing the need to progress to a formal investigate.

Total Number of doctors spoken to under 'Low Level Concerns'	Consultant				SAS/IFD				Trust Doctors			
	2024/25		2025/26		2024/25		2025/26		2024/25		2025/26	
	M	F	M	F	M	F	M	F	M	F	M	F
Total Number of doctors where investigation was necessary 'More Serious Concerns'	Consultant				SAS/IFD				Trust Doctors			
	2024/25		2025/26		2024/25		2025/26		2024/25		2025/26	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	1	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	1	0	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	1	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	1	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	2	1	1	0	0	0	0	0	0	0	0	0
Comments: In 2025/26 there was one investigation, which resulted in an action plan being put in place and a 12 month's written warning being given. The doctor concerned will also discuss and reflect on this at their appraisal meeting.												

JOB PLAN COMPLIANCE 2026

Number of doctors who were due for a Job Plan between 1 st January – 31 st March 2026. (Data taken on 31 March 2026)	Consultant		SAS/IFD	
	2025	2026	2025	2026
Total	157	162	73	75

NORTH CARE GROUP JOB PLANS				
SPECIALITY	% Completed	% Not Completed	% Disputed	No. of Job Plans 12 PA's & Above
AMH	100%	0%	0%	18
CAMHS	96%	4%	0%	3
FORENSIC	100%	0%	0%	4
LD	100%	0%	0%	3
MHSOP	96%	4%	0%	4

Comments: Reasons for Non-Completion – x2 Doctors on Sick Leave.

SOUTH CARE GROUP JOB PLANS				
SPECIALITY	% Completed	% Not Completed	% Disputed	No. of Job Plans 12 PA's & Above
AMH	68%	32%	0%	8
CAMHS	44%	56%	0%	1
LD	100%	0%	0%	1
MHSOP	93%	7%	0%	3

Comments: Reasons for Non-Completion: x1 Doctor had just started with the Trust in February. X1 Doctor was on extended Special Leave, x2 Doctors on Long Term Sick Leave and x1 Doctor on Maternity Leave.

TRUSTWIDE JOB PLANS				
SPECIALITY	% Completed	% Not Completed	% Disputed	No. of Job Plans above 12 PAs
AMH	87%	13%	0%	26
CAMHS	77%	23%	0%	4
FORENSIC	100%	0%	0%	4
LD	100%	0%	0%	4
MHSOP	94%	6%	0%	7

OVERALL TOTAL:	89%	11%	0%	45
-----------------------	------------	------------	-----------	-----------

Job Planning Consistency Panels

28 th May 2025 – LD	2 nd October 2025 – MHSOP
5 th June 2025 - CYPS	9 th October 2025 - Forensics
3 rd July 2025 - AMH	

Comment:

The Trust held five job plan consistency panels for each specialty which began in May 2025 and these meetings helped to identify areas where further training was required. The Job Planning training was subsequently delivered in December 2025 before the 2026 Job planning round began.

Executive Medical Director or Group Medical Directors Chair these meetings, and all Associate Medical Directors and Lead Psychiatrists are invited to attend the meeting for their speciality along with the Associate Responsible Officer, Medical Development colleagues and LNC Rep.

Training/Support Sessions

1 st April 2025	20 th August 2025
2 nd November 2025	17 th December 2025

Comment:

Dr Cornwall runs an annual Job Planning Training Session for all doctors in December ahead of the Job Planning season. This training session includes updates from any issues picked up in the Job Planning Consistency Panels.

Dr Cornwall also runs Job Plan Training sessions throughout the year for any new consultants and SAS Doctors that start with the Trust.

Ongoing Actions

Appraisal & Revalidation

The challenge we currently face is retaining and recruiting appraisers, as every year we lose appraisers either due to doctors leaving the Trust or wanting to relinquish the appraiser role because they have other commitments and very few (if any) new doctors wish to take up the appraiser role. Our current number of appraisers is insufficient and so as of April 2025 we are relying on what we are calling 'super appraisers' who are 3 retired consultants doing minimal work for TEWV that have agreed to each undertake 12 appraisals within the year. We have agreed they should only undertake the role for a maximum of 3 years if they are not doing clinical work alongside this, so that they are not too far removed from clinical practice.

In December 2025, there was a Higher Level (Responsible Officer) Quality Review visit from the NHSE regional team, chaired by Dr Yasmin Khan. The included a review of the appraisal system and the management of doctors where concerns had been reported. Actions were agreed for minor modifications to our processes.

Learning from Revalidation

The Trust continues to have a robust electronic system and team in place to help manage revalidation and this ensures the process runs efficiently.

Our medical Appraisal Policy and Procedure was last updated and published in December 2022 and has since been updated in 2025/26. This is currently awaiting approval before being published. Our Job Planning Policy was last updated and published in March 2023 and has also undergone updates in 2025/26, this is currently awaiting approval before being published.

Responding to Concerns – Remediation/Disciplinary

Our Responsible Officer (Executive Medical Director), Associate Responsible Officer and Associate Director of Medical Development attend regular sessions with the GMC representative throughout the year. These sessions allow for any concerns to be raised and advice to be given from a GMC perspective – additional to these sessions the representative from the GMC is always available to be contacted with queries throughout the year.

In addition our Responsible Officer also attends the Responsible officer Network meeting organised by Regional NHSE.

The Policy followed in relation to Career Grade Medical Staff doctors is called 'Dealing with Concerns affecting Medical Staff Policy'. In 2025, Medical Development colleagues along with a small handful of doctors (including Local Negotiating Committee reps) formed a subgroup to review the new 'Fairness and Proportionality Framework' that was published by NHSE and NHS resolution in relation to investigations. This framework has now been incorporated into our policy. Following the updates to the policy, we are awaiting a response from Local Negotiating Committee (LNC) colleagues.

Job Planning

The information/data in relation to job planning, detailed above in the report, is the second year we have had to provide information relating to our job plan sign off rates following a letter from the National Medical Director. The letter from Professor Meghana Pandit, Mark Brassington and Professor Stella Vig, highlighted the key points related to job planning and the ASK from NHS England.

- The need for Job Planning Data Submissions
- Visibility of data at Board Level
- Achieving 95% sign-off of job plans by the next financial year
- In the future to achieve 98% delivery of sessional direct clinical care activity, delivered in the most productive way possible.

There are ongoing meetings and information being released by NHS England and this will continue to be actioned over the coming months and year.

Our Executive Medical Director chairs the Mental Health job planning task and finish group for NEY region to help improve the rate of completion of job plans across the region and focus on improving quality of job planning in line with the ask from NHSE. As a region, NEY is ranked first nationally for mental health job planning. He is also a member of the regional job planning steering group chaired by the Regional Medical Director.

Electronic IT System

SARD JV continues to be used as the electronic system for appraisals, revalidation and Job Planning. The Associate Responsible Officer continues to deliver training sessions to support the use of SARD for the purpose of appraisal and job planning for all new Consultant and SAS doctors that join TEWV, with sessions ran every 4 months.

From 1st April 2025 we have moved to a new version of SARD appraisal v7.1 in line with Good Medical Practice standards 2024 and Dr Lenny Cornwall has worked with SARD to adapt the appraisal portfolio on SARD to make it more streamlined for our medics.

We have also altered the process of appraisal for our Trust doctors, by designing a separate appraisal portfolio that is specific to Trust doctors. Trust doctors previously used the same portfolio as consultant and SAS doctors. In doing so they no longer need to upload their HORUS training E-portfolio to SARD as SARD is now much more catered to their appraisal needs.

Trust doctors have a priming appraisal in the first three months of joining the Trust, where they agree a PDP with their appraiser for the year ahead. They have a full appraisal around month 10 if they remain in post.

The Trust continues to use the 360 MSF module on SARD JV for the production of patient and colleague feedback for medics in AMH & MHSOP services. The format of the feedback forms mimics the GMC questionnaire. Medics in CYPS, LD and Forensic services may use the ACP 360 (which is from RCPsych) as this has a slightly different patient questionnaire which is more 'user friendly'.

The Trust also continues to use the e-leave function on SARD, which allows our doctors to request annual leave via SARD and to have that signed off by managers in a more streamlined process. We continue to provide training and advice where needed and we will be looking to gain feedback on how this has been going over the next 12 months.

Furthermore, the Trust continues to use SARD e-job planning for medical staff to complete an annual job plan. The form aims to consider job planning as a process, taking stock of commitments in each year and their appropriateness, alongside developing continuity between years ensuring amendments to work practices and financial impact are accurately captured and can be reviewed when needed. The system will have a key role in ensuring all quality improvement requirements of NHSE can be achieved for job planning.

Our contract with SARD is due to expire in October 2026 after all extensions have been granted. We began working with IT in 2025 to explore other electronic systems to see if there were any better systems on the market and to ensure SARD is cost effective and can continue to meet our needs going forward. We did engage in some informal demos from other suppliers to see what is on the market. However, following advice from NHS England around Job Planning we have been advised not to make changes to our supplier, therefore we felt it made sense to renew our contract with SARD until we have further guidance from NHSE on what the future may look like for Job Planning. We are currently working closely with our IT department to direct award a new contract with SARD, this is how the current contract was awarded (ensuring we comply with the framework process).

SARD Guidance has been updated to reflect new system layout following the implementation of the appraisal portfolio. The Associate Responsible Officer has developed local guidance for doctors to help them when using the new system for the first time which helps with adapting to the new layout.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Tees, Esk and Wear Valleys NHS Foundation Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	No change expected
Comments:	Dr Kedar Kale, Executive Medical Director was appointed Responsible Officer on 27th June 2022 and remains in post to date.
Action for next year:	No change expected

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	No change was expected.
Comments:	The Trust ensures we have the funds and staffing to support the role of Responsible Officer. TEWV as the designated body hosts the Medical Development team with dedicated members of admin and an Associate Responsible Officer & Lead Psychiatrist for Medical Appraisal and Revalidation to support the Responsible Officer.
Action for next year:	No change expected.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	We continue to use our current process of maintaining a prescribed connection with GMC Connect.
Comments:	Medical Development Team under the management of Dr Kedar Kale ensures that all our medical practitioners have a prescribed connection to GMC Connect, this is also linked to our electronic system SARD for appraisals.
Action for next year:	The process will remain in place as described above.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Continue to update our Appraisal Policy & Procedure.
Comments:	We have updated our Appraisal Policy & Procedure and are currently waiting for this to be ratified by the relevant Trust groups.
Action for next year:	To ensure the updated Policy & Procedure are published once ratified.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No for 2025/26 due to changing our SARD appraisal form in April 2025, we agreed to pause our annual peer review until the new appraisal form was established amongst our medics.
-----	--

Action from last year:	To work on the recommendations listed in the comments.
Comments:	For our internal peer review we use the appraisal summaries for those doctors who were revalidated in the last year and ask a pool of our appraisers to score them using our own Trust rating tool. Our focus for the next year is to explore other tools such as ASPAT and see if this would be better suited to us or perhaps look at amending our own rating tool. We have seen an improvement in the quality of our appraisal summaries in the previous years, we know this because we have seen an improvement in the scores from reviewing our appraisal summaries. We provide feedback of the results of this exercise at our appraiser networks which we run 4 times a year. This is an internal peer review process. As mentioned in last year's report, in 2024/25 appraisal year we worked alongside Harrogate and Calderdale NHS Trusts to carry out a Trust to Trust peer review which was successful.
Action for next year:	Explore other peer review tools such as ASPAT and agree the best tool for future use.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Continue with the process below
Comments:	We provide exit reports for agency locum doctors that have worked with us for a minimum of 3 months upon leaving the Trust, which states details of any leave / sickness / complaints / investigations and comments from line managers. Longer term locums are provided with time to complete CPD. We provide supporting info to all our doctors (including those not prescribed to us) to enable them to input into their appraisal. For TEWV employed locums they are provided with software to access appraisals, coaching, CPD etc.
Action for next year	Continue with the process above.

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Implementation of Appraisal 2022 model template.

Comments:	All appropriate information in relation to serious incidents, complaints, sickness etc is provided centrally for each individual's appraisal.
Action for next year:	Continue with the process above

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	No action identified.
Comments:	We have an appraisal policy and procedure in place which is followed in this instance.
Action for next year:	Continue with the process above.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Update policy & procedure by 31 st January 2026 then it will be 3 years until the next review is due.
Comments:	Our Trust appraisal policy and procedure were last updated and ratified in August 2022. In 2025 we began updating our policy and procedure and this is still going through the necessary process for ratification.
Action for next year:	To ensure the updated Appraisal policy and procedure are ratified and published Trust wide.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Y/N	Yes
Action from last year:	Continue looking at how we can attract more appraisers to take up the role.
Comments:	There were 48 trained appraisers for 264 doctors in 2025 – 2026 (of which 258 actually had an appraisal). The Trust trained 2 new appraisers in February 2025; they were ready to start the role in April 2025. One of these new appraisers became a 'Super appraiser'. We introduced 'Super appraisers' in 2025, to help with the low uptake of new appraisers and several appraisers wishing to step down from the role or not undertake as many appraisals. We call them 'super appraisers' as they undertake 12 appraisals each, rather than the usual 6 appraisals that our appraisers normally do. The doctors undertaking the super appraiser role are either retire and return doctors or who work less than 4 PAs clinically. We agreed they could do this for a maximum of 3 years if not undertaking clinical work. We had 3 appraisers step down or leave the Trust before 1 st April 2025. One appraiser did not end up undertaking any appraisals and then stepped down from the appraiser role in 2026 which resulted in only 47 appraisers carrying our appraisals, rather than 48.
Action for next year:	Continue looking at how we can attract more appraisers to take up the role. We usually send out application forms for new appraisers in October time each year.

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	To continue providing training sessions.
Comments:	We normally hold four training sessions a year, of which appraisers must attend at least two. These are held in June, September, November and February. We also provide feedback reports to all appraisers which contain anonymous feedback from their appraises and these are discussed at the appraiser's own appraisal. The Associate Responsible Officer & Lead Psychiatrist for Medical Appraisal and Revalidation will also meet with any new appraisers once they have been in the role for 12 months or earlier if felt necessary.
Action for next year:	To introduce a scoring system as part of the appraiser reports to see how appraisers rate alongside other appraisers.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Due to the implementation of the new appraisal form on SARD in 2025/26 we will not be undertaking the peer review of appraisal summaries but will continue to provide feedback for individual appraisers.
Comments:	Our appraisal process is quality assured through the use of feedback questionnaires following appraisal and then a report is collated for each appraiser at the end of the appraisal year. As mentioned in question '1A(v)' we would also usually follow an annual process whereby a group of appraisers undertake a peer review of appraisal summaries from the previous revalidation year and the findings are then fed back to our appraiser group (this was paused for 2025/26).
Action for next year:	To undertake a peer review of appraisal summaries in 2026/27 once we have agreed on the tool to use.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	We ensure that all fitness to practice recommendations are undertaken in a timely manner and where this is not possible we record the reasons and actions taken. Good communications exist with no concerns raised from either side. In addition regular meetings occur between the Responsible Officer and the GMC's ELA which are minuted – these allow for ongoing concerns and low level concerns to be regularly reviewed.
Action for next year:	To continue with the process above.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	Doctors are informed following the Revalidation Meeting of the recommendation, this is confirmed in a letter from the Responsible Officer. In terms of any deferrals or non-engagement these would have been discussed in advance of a revalidation meeting and communicated with the Doctor.
Action for next year:	To continue with process above.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	There are effective and well established processes in place for pre-employment checks, medical appraisal and revalidation, and responding to concerns. Within this, roles and responsibilities are clearly defined. The medical directorate has dedicated expertise and is adequately resourced to carry out its function.
Action for next year:	To continue with process above.

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	To review and update the Dealing with Concerns affecting Medical Staff Policy in 2025, looking at the Framework for fairness and proportionality that was published by NHSE in 2025.
Comments:	There is a disciplinary policy for maintaining high professional standards called 'Dealing with Concerns affecting Medical Staff'. Issues around conduct and performance can be identified from multiple sources, including formal complaints, SIs, Guardian of Safe Working, and the Freedom to Speak up Guardian, Monitoring of any conduct and performance issue is undertaken within the medical development team. Processes are in place to allow this to be done under a variety of different formats, depending on the seriousness of the concern e.g. low level concerns and disciplinary investigations. The department receives Complaints and SI reports each month and this is documented on the supporting information which is sent to doctors ahead of their appraisal. All doctors have a line manager who monitors performance. We also email Line Managers to ask for comments on the supporting information in regards to the doctors performance or if there are any concerns. A new framework was

	shared by NHSE in 2025 for ensuring 'Fairness and Proportionality' when dealing with Concerns so we have incorporated this into our Policy.
Action for next year:	The Dealing with Concerns affecting Medical Staff Policy has been updated however has not yet been ratified due to on-going discussions with our LNC. We hope this will be ratified ASAP.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	We continue to update the Supporting Information template as and when necessary.
Comments:	Supporting Information template is populated 1-2 months in advance of the appraisal and uploaded into the SARD Portfolio. Supporting Information includes; Sickness, SI's, & Complaints, Low Level Concerns, Grievances, if the Section 12 or AC Status is due for renewal and Appraiser Details where appropriate.
Action for next year:	We continue to update the Supporting Information template as and when necessary.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	To continue to follow the below.
Comments:	In our annual report to the Board, we include an analysis of the number of disciplinary cases/low level concerns, type and outcome. In addition we provide information through the trust MWRES which includes analysis of the protected characteristics of the doctors concerned. Medical Education also produce a differential attainment report which includes an analysis of medical management roles.
Action for next year:	To continue to follow the above.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	To continue to follow the below.

Comments:	In our annual report to the Board, we include an analysis of the number of disciplinary cases/low level concerns, those that to progress to more informal investigations as well as the type and outcome. In addition, we provide information through the trust MWRES which includes analysis of the protected characteristics of the doctors concerned.
Action for next year:	To continue to follow the above.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	To continue to follow the below.
Comments:	We complete an MPIT form for doctors who work for us and are connected to us to pass to a doctor's new organisation. The medical development team inform the RO of any concerns, who would then directly contact the doctor's new Designated Body. If there are issues concerning agency doctors, we would contact the agency, completing an event form, this is then shared with their with their RO. If they wanted to discuss with our RO we would arrange this.
Action for next year:	To continue to follow the above.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	To follow the below.
Comments:	All doctors have clinical and managerial supervision, annual appraisal and annual job planning. Quality assurance systems are in place checking our processes. The medical revalidation team are part of the medical directorate which meets weekly for huddles and quarterly to discuss and agree issues in relation to appraisals and revalidation. All doctors are treated equally and any issues would be dealt with following our procedures. We have a complaints team and a dedicated medical development team that deal with all issues/concerns as they arise.
Action for next year:	To continue to follow the above.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and

enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	We will continue to ensure our processes remain fit for purpose.
Comments:	Our governance arrangements and assurance processes for doctors employed by TEWV remain robust and fit for purpose. We receive updates from RO networks and from regional Appraiser meetings, GMC etc.
Action for next year:	To continue to follow the above.

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	To follow the below.
Comments:	Our appraisals are now more nuanced to reflect each profession's standards and development needs. Professional input is requested for disciplinary processes where professional standards are being queried.
Action for next year:	To continue to follow the above.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	To ensure all pre-employment check standards are completed.
Comments:	Yes, we ensure that all six NHS pre-employment check standards are completed. This is done by medical staffing.
Action for next year:	To continue with the above. We will be audited in autumn 2026 on this.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	To continue with the below. All new clinical leaders will now take part in the new managers programme to ensure that all senior staff have the same understanding of how the 'national expectations of senior managers' resources can support all our development.

Comments:	Yes, there are quarterly Leadership Timeout Sessions which explore quality, safety, learning from other organisations, Freedom to Speak Up. The Trust has undertaken a Culture Audit. Weekly bulletin and monthly Medical Directors Webinar support this agenda. The Trust has launched Show Racism the Red Card from September 2024. The restructure set up a formal expectation that our decision making would be clinically led, with clinical networks for each specialty to support. Our nursing and governance team jointly with our lived experience directors developed and led the culture of care tool. This links to our culture on a page oversight and our speak up group where representatives from teams come together to highlight any low level concerns they have about any teams. We engage with clinical leaders and managers in the same way that we engage with operational leaders – through quarterly events (recently covering organisational learning, quality, safety, learning from other organisations), and a core three year leadership and management development programme. The Freedom to Speak Up Guardian speaks at Senior Medical Staff Committee as well as Trust Board and our People Committee. Our recently completed medical engagement scale report indicates very high and high levels of engagement as benchmarked across 175 organisations worldwide.
Action for next year:	To continue to follow the above.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue with the below.
Comments:	Work is underway to look into why some groups are over-represented in our disciplinary processes. All staff undertake necessary mandatory training and follow Trust Values and Behaviours as part of Our Journey to Change. We launched work with Show Racism the Red Card from September 2024, and invited clinical leaders from our BAME staff network to introduce this work and speak to board. We report all our statutory data but add extra monitoring to ensure we track all the experiences of our staff including through our employee relations processes which are reported to board. Staff networks are discussed at trust welcome session so that all staff know the opportunities for being part of the networks. Anti discriminatory training, upstander training and EDI champions are a key part of our work this year, with involvement in developing that work with clinicians from our staff networks. Staff and patients share stories of the organisation at committees and board on a regular basis. All staff networks have an exec sponsor and chairs meet with the director of people and culture every other month. The mandatory leadership and management programme includes work on understanding our impact on others, who we in/exclude, the way we behave in line with values and any access to wider development programmes requires evidence of paying it forward to colleagues and doing something to tackle health and social inequality.

	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 lead by our DME to formulate plans to address any negative feedback / outliers received from both internal and external quality visits and surveys. Previous to the creation of the task and finish groups the Medical Education Leadership Team (MELT) attended the Medical Workforce Equality Group that met on a quarterly basis to oversee equality for both resident doctors and career grade colleagues. MELT continues to work closely with the Trust Strategic Lead for Equality, Diversity, Inclusion (EDI) and Engagement and the Director of People and Culture.
Action for next year:	To continue to follow the above.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	To continue with the below.
Comments:	In addition to comments above, we have a transparent process in place including the deputy director of People and Culture and the NED champion for any individual who believes they have experienced detriment as a result of speaking up. All senior staff undertake a values and a knowing yourself workshop. The organisational learning group is chaired by one of our clinical executives. The clinical executive triumvirate lead on multiple forums to ensure clinical and professional standards are consistent and embedded. We also now have VASCO in place which is primarily a pastoral / wellbeing intervention for doctors following on-calls so ensure they feel supported and to encourage communication between peers. The content of the call include: - General enquiry of wellbeing -rest-breaks, nutrition, fatigue, transport etc - Any clinical concerns that the doctors may be aware of - An appreciation of the supervisees experience, and need for supervision - Offer of completion of a Workplace Based Assessment if appropriate
Action for next year:	To continue to follow the above.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	To continue with the below.
Comments:	Yes. Connected Doctors are able to provide feedback directly about their individual appraisal and also the general process for appraisals. In relation to Job Plans, doctors are able to escalate issues to the Job Planning Lead / Associate RO. All doctors can make complaints through the formal process or raise concerns through their team structures. The deputy director of people and culture and the associate director of medical development meet regularly to ensure our processes are consistent. The Associate Director of Medical Development is a member of the Freedom to Speak up group to ensure that professional work is joined up across the organisation.
Action for next year:	To continue with the above.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	To continue with the process below.
Comments:	We monitor information on all our Doctors involved in any concerns and quality information is provided as part of our MWRES return.
Action for next year:	To continue with the process above.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	To continue to attend Regional Appraiser Network meetings and RO meetings and continue to share best practice.
Comments:	Attendance at Regional Appraiser Networks and RO meetings, contacts made with other Trust colleagues to share information and best practice.
Action for next year:	To continue to attend Regional Appraiser Network meetings and RO meetings and continue to share best practice.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	264
Total number of appraisals completed	258
Total number of appraisals approved missed	6
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	18
Total number of late recommendations	0
Total number of positive recommendations	18
Total number of deferrals made	1 (Revalidated further along the appraisal year)
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	3
Total number of trained case managers	5
Total number of concerns received by the Responsible Officer ²	1
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March 2026 (working days)	0
Median duration of concerns processes closed (working days) ³	28
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	45
Total number of new employment checks completed before commencement of employment	45
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

Section 3 – Summary and overall commentary

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
To review and update the Dealing with Concerns affecting Medical Staff Policy in 2025-26. Plan to undertake quality assurance of appraisals in 2026-27. To continue working on recommendations from the external peer review. To review and update the Medical Revalidation Policy and Procedure by January 2026. A peer review of appraisal summaries was put on hold for 2025 due to the appraisal form on SARD being updated from April 2025 in line with Good Medical Practice 2024. We wanted to focus on embedding the new form this year and then undertake a peer review in 2026.
Actions still outstanding
Both of the above policies have been updated, however they are still awaiting approval by the relevant Trust groups before publication. We plan to undertake a quality assurance of appraisals in 2026-27.
Current issues
We have had issues recruiting new appraisers despite promoting and seeking support from medical colleagues, this is an ongoing issue. Introducing the 'super appraisers' has helped however this isn't a long term fix due to these medics taking on the role for a maximum of three years.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
To continue to attend Regional Appraiser Network meetings and RO meetings and continue to share best practice. Consider use of ASPAT tool, for peer review of appraisal summaries. Update and publish the relevant Policies as mentioned above.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Our governance arrangements and assurance processes for doctors employed within TEWV remain robust and fit for purpose. We have successfully completed and learnt from an external peer review. We had a higher level (Responsible Officer) quality review in December 2025 with positive outcomes and recommendations which we are now implementing.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists))]

Official name of the designated body:	Tees, Esk and Wear Valleys NHS Foundation Trust
---------------------------------------	---

Name:	Alison Smith
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Kedar Kale
Email address:	kedar.kale2@nhs.net

Meeting of:	Trust Board
Date:	23 September 2026
Title:	Provider Capability Assessment 2026/27
Executive Sponsor(s):	Kathryn Ellis, Interim Executive Director of Strategy and Transformation
Author(s):	Kathryn Ellis, Interim Executive Director of Strategy and Transformation

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	☒

Relevant BAF risk/s (name and number)	Relevant control
All BAF risks	The Provider Capability Assessment requires Boards to assure themselves against all six domains of 'The Insightful Provider Board', and therefore applies to all strategic risks on the Board Assurance Framework.

Executive summary

Purpose

This report enables the Board to consider and approve the Trust's 2026/27 NHS England Provider Capability Self-Assessment. It provides assurance on:

- the robustness of the assessment process;
- progress since the 2025/26 assessment;
- the evidence supporting the proposed 2026/27 ratings;
- the Executive calibration and challenge applied; and
- the additional external perspective provided through the Trust-commissioned Internal Audit advisory review.

A version of this report has also been prepared for consideration by the Audit and Risk Committee (ARC) on 21 September. As the deadline for submitting Board papers falls before the ARC meeting, this paper does not include the Committee's assurance update. The ARC Chair and report author will provide that update verbally at the Board meeting.

Proposal

The Board is recommended to take assurance that the proposed assessment has been developed through a structured, evidence-based and proportionate process. This included two additional assurance measures chosen by the Trust: a first-, second- and third-line

evidence methodology to strengthen triangulation and traceability, and an Internal Audit advisory review to provide independent challenge and an external lens. Internal Audit concluded that the assessment was “Substantially Evidenced”, supported the proposed Amber-Green rating across all six domains, and identified no material weaknesses that would warrant a reduction in the proposed ratings.

The Board is asked to approve an Amber-Green rating for each of the six Provider Capability domains and authorise submission of the completed assessment to NHS England, with supporting domain statements (Appendix 1), subject to any final amendments agreed by the Board.

Overview

Background and context

The NHS England Provider Capability Self-Assessment forms part of the 2026/27 NHS Oversight Framework. It is intended to support Board reflection on organisational capability, promote transparency about strengths and challenges, and support continued improvement. The assessment covers six domains aligned with The Insightful Provider Board:

- Strategy, Leadership and Planning
- Quality of Care
- People and Culture
- Access and Delivery of Services
- Productivity and Value for Money
- Financial Performance and Oversight

NHS England requires providers to assess themselves against prescribed capability statements and indicative descriptors, explain the basis for each rating, reference supporting evidence and describe improvement since the 2025 submission. The national guidance is not designed as an automatic or algorithmic scoring exercise. Instead, it requires the Board to reach an informed judgement based on the full range of evidence, taking account of organisational context, performance trajectory and residual risk.

The capability questions therefore offer a structured basis for the Board to reflect on whether the Trust understands its strengths and challenges, has effective governance and management grip, and can demonstrate that improvement is translating into measurable and sustained outcomes.

Assessment and assurance approach

Enhanced evidence methodology

A detailed Excel evidence workbook provided the audit trail for the assessment and evidence-gathering process (provided to ARC members). For each assessment line, it recorded the relevant NHS England capability statement and lines of enquiry, the ‘comply or explain’ judgement, supporting evidence, narrative commentary and the rationale for the proposed domain rating.

The Trust deliberately applied a first-, second- and third-line lens to the collection and collation of evidence. This additional internal discipline strengthened the rigour, triangulation and traceability of the assessment by bringing together:

- **First line:** management and operational evidence;
- **Second line:** formal governance and oversight evidence; and
- **Third line:** independent or external evidence, where available.

This structured approach enabled evidence from different sources and perspectives to be considered together. It tested not only whether a process, plan or control existed, but whether it had been implemented and was operating effectively, whether it was delivering demonstrable impact, and whether improvements were embedded and sustained.

Evidence base and outcome

The evidence base drew on operational, clinical and corporate information from across the Trust, including:

- **Governance and assurance:** Board, Committee and Executive reports; the Board Assurance Framework; corporate risks; and internal and external audit work.
- **Performance and improvement:** the Integrated Quality and Performance Report; performance, workforce and benchmarking information; and improvement and recovery programmes.
- **External and stakeholder intelligence:** regulatory and inspection findings; patient, staff and stakeholder intelligence; and system and partnership evidence.

The completed working position covered all 60 assessment lines contained in the six domains, and referenced more than 300 individual pieces of first-, second- and third-line evidence. Of the 60 lines, 55 were assessed as compliant, two as “explain” and three as correctly “not applicable” (relating to regulatory matters and acute trusts). The two “explain” judgements related to the presence of a Board Succession Plan (in development in line with recruitment) and bank and agency usage (a current Trust improvement plan). Descriptor-level calibration derived from NHS England guidance identified eleven Green, eleven Amber-Green and two Amber-Red signals, with no Red signals. The two Amber-Red signals related to the wider CQC Well-Led context (Requires Improvement) within Strategy, Leadership and Planning, and unplanned bank or agency reliance within Financial Performance and Oversight. Taking the evidence in the round, an Amber-Green rating is proposed for all six domains.

Executive review and challenge

On 1 September 2026, the Executive Directors Group reviewed the methodology, evidence and proposed ratings through a structured calibration exercise. The challenge considered:

- whether the evidence demonstrated outcomes and effectiveness, as well as robust process
- recent trajectories and management track record
- external and third-party intelligence
- evidence of Board and management grip
- contrary evidence and residual risk
- the closest national descriptor
- what further evidence or delivery would be required to move each rating

The Executive review confirmed the proposed Amber-Green position across all six domains. It also confirmed the proposed narrative in line with NHS England guidance (Appendix 1). The Executive identified a consistent cross-cutting theme: that governance and active management were generally well evidenced, while developmental work continues to demonstrate consistently the sustained impact and outcomes arising from those arrangements.

Internal Audit review

Whilst an Internal Audit review was not mandated by NHS England, it was commissioned by the Trust to add independent scrutiny and an external lens to its self-assessment, and to test whether the proposed judgements were reasonable and supported by sufficient and appropriate evidence. The Internal Audit advisory review considered the robustness and proportionality of the process; the strength, relevance and sufficiency of the evidence; linkage between evidence and assessment criteria; progress against previous development areas; material changes since the prior assessment; governance of further actions; and Board and ARC engagement and sign-off.

Internal Audit assessed the return as “Substantially Evidenced”. It concluded that the proposed ratings were substantially supported by evidence; all six domains demonstrated effective governance arrangements; the Trust showed organisational self-awareness and active management of its main challenges; the process was robust, proportionate and aligned with the principles of the NHS England framework; and no material weaknesses were identified that would warrant reducing any proposed rating. Internal Audit supported the proposed Amber-Green rating in all six domains.

The Board should note that the Internal Audit review was an advisory review based on document review and challenge of management’s assessment. It did not undertake detailed testing of systems and controls or reperform the full baseline work completed in the previous year (on which this reassessment was built).

Progress since the Trust’s 2025/26 assessment

The 2026/27 assessment explicitly considered what has changed since the Trust’s previous review. Internal Audit identified evidence of implementation and improved organisational capability in the following areas:

- increased maturity in strategic review and planning
- enhanced stakeholder engagement and Board challenge
- strengthened organisational learning arrangements
- development of leadership and management programmes
- stronger clinical supervision and appraisal oversight
- structured recovery arrangements for areas of access pressure
- greater use of benchmarking and productivity intelligence
- strengthened financial governance and Quality and Equality Impact Assessment arrangements

The assessment indicates positive organisational development and stronger evidence of governance and grip. It also noted, as identified by the Executive, that the principal next step is to ensure the Trust can continue to evidence the impact of those arrangements on sustainability and wider organisational outcomes.

Proposed ratings and basis for assurance

Domain	Proposed rating	Principal basis for assurance	Principal factors constraining a Green rating
Strategy, Leadership and Planning	Amber-Green	Coherent strategic framework; approved Medium-Term Plan; established Board and Committee oversight; strengthened strategic-risk, digital and cyber assurance; active system engagement.	Leadership succession and substantive appointments remain in development; Trust Strategy refresh planned Q3-4 26/27; the impact of partnership working and digital investment to be further evidenced
Quality of Care	Amber-Green	Established quality governance; use of regulatory, safety, complaints and patient-experience intelligence; Board and Executive engagement; Quality Assurance and Improvement Programme.	The wider regulatory and quality context remains relevant, and sustained and consistently evidenced impact from learning and improvement is not yet demonstrated across all services.
People and Culture	Amber-Green	Improved staff experience indicators; use of staff, trainee, equality and workforce intelligence; independent Freedom to Speak Up arrangements; established development and appraisal infrastructure.	Embedding of new FTSU arrangements; strengthened evidence linking workforce interventions and staff feedback to measurable outcomes.
Access and Delivery	Amber-Green	Established performance oversight; improvement and recovery plans; use of benchmarking and variation analysis; greater visibility of population health and inequalities.	Performance remains challenged in a few areas against some standards with recovery plans in place; reductions in access inequalities to be further evidenced
Productivity and Value for Money	Amber-Green	Increased use of benchmarking; productivity approach incorporated within How We Work; toolkit and self-assessment developed; evidence of individual productivity improvements.	The Productivity plan requires further, Trust-wide embedding; a consolidated view of planned and realised benefits, peer position and sustainability to be developed
Financial Performance and Oversight	Amber-Green	Strong financial governance and reporting; independent assurance over financial controls; delivery track record; QEIA safeguards; system planning engagement.	Recurrent CRES delivery and bank expenditure remain challenging; continued evidence is required that workforce cost reductions and the underlying financial position are sustainable.

Development and continuous improvement

Internal Audit did not identify material capability or governance gaps requiring formal audit recommendations. Its observations were framed as opportunities to support continued maturity. These include:

- consolidating thematic evidence of outcomes and sustained benefit
- completing and implementing the Trust Strategy refresh
- improving visibility of succession planning, leadership pipeline and development actions
- strengthening the link between quality and workforce interventions and their impact on staff and service user outcomes

- maintaining oversight of recovery trajectories where performance improvement is required
- consolidating oversight of productivity opportunities and realised benefits
- evidencing delivery against recurrent CRES requirements and the bank-spend reduction plan

The Trust will use the assessment as a continuing developmental tool rather than solely as an annual regulatory submission. Future Trust work will extend the level of challenge beyond demonstrating alignment with the current capability statements, with greater emphasis on outcomes, sustainability, comparative performance, organisational learning and the evidence associated with higher levels of capability. The development areas will be incorporated into existing governance arrangements rather than managed through a separate parallel process. This will include clear Executive ownership, incorporation into relevant Board Committee workplans, alignment with the Board Assurance Framework where appropriate, use of the IQPR and other established reporting to monitor outcomes, periodic Executive review, and an interim mid-year update to the Board.

Prior consideration and feedback

The assessment has been considered twice by the Executive Directors Group during evidence gathering and calibration and builds on the Trust's 2025/26 assessment and associated review work. ARC is scheduled on 21 September to consider the process and supporting assurance (after publication of the Board papers). Any subsequent ARC conclusion or recommendation will be conveyed to the Board by the Chair of Committee and report author. Following Board approval, the assessment requires sign-off by the Chair and Chief Executive and submission to NHS England by 5 pm on Friday 2 October 2026.

Implications

The Provider Capability Assessment informs NHS England's oversight of provider capability and consideration of any actions or support appropriate to individual organisations. The assessment also provides an integrated view across the Trust's strategic risks and therefore has relevance to all risks within the Board Assurance Framework.

Recommendations

The Board is asked to:

- Note the NHS England requirements and the process followed to complete the 2026/27 Provider Capability Self-Assessment.
- Take assurance from the structured assessment process, including the enhanced first-, second- and third-line evidence methodology chosen by the Trust, Executive calibration and challenge, and the Internal Audit advisory review commissioned to provide independent challenge and an external lens.
- Note Internal Audit's conclusion that the assessment was "Substantially Evidenced", that the proposed Amber-Green ratings across all six domains were supported, and that no material gaps were identified that would warrant reducing a proposed rating.
- Consider the assessment as a reflection of the Trust's current organisational capability, including progress since 2025/26 and the areas in which further evidence of measurable and sustained impact is required.
- Consider feedback from ARC review on 21 September.
- Approve an Amber-Green rating for each of the six Provider Capability domains and authorise submission of the assessment to NHS England, including the

proposed domain statements in Appendix 1, subject to any final amendments agreed by the Board.

- Support integration of the identified development areas into existing Executive, Board Committee, Board Assurance Framework and performance-reporting arrangements, with an interim mid-year update to the Board.

Appendix 1: Provider capability self-assessment template 2026

Provider name:	Tees Esk and Wear Valleys NHS Foundation Trust
-----------------------	--

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to england.neyoversightregulation@nhs.net by **5pm Friday 2 October 2026**.

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Amber-Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	The Trust considers its rating to be Amber-Green, based on its judgement against the NHS England guidance and informed by independent review and challenge through the Internal Audit advisory review. Capability statements: - The Trust's Strategy and the Medium-Term Plan provide a coherent strategic framework informed by benchmarking, SWOT and PESTLE analysis, staff and partner feedback and engagement with both ICBs. The Trust is planning a Strategy refresh during Q3 and 4 2026/27, to ensure the Board's ambition for the future is articulated and embedded throughout the organisation. Delivery is supported through four transformation programmes: Hospital to Community, Sickness to Prevention, Analogue to Digital and How We Work. Operating, financial and transformation plans have been triangulated with system partners, and the Trust is an active participant in the Mental Health Specialised Provider Collaborative and wider neighbourhood, place and system arrangements. Governance and effectiveness: - Strategy and Medium-Term Plan delivery are overseen through Executive Group, Resources and Planning Committee, Trust Board and the Board Assurance Framework, supported by Executive Risk Group review, environmental and partnership intelligence and an enhanced IQPR incorporating Trust and system priorities. The Trust reviews strategic risks periodically and annually, including through the February 2026 BAF review. Digital and cyber oversight has also strengthened through the Digital Roadmap, specialist Board development, appointment of a
2. If in breach of licence: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	

5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	Non-Executive Director with digital expertise, BAF risk reporting and independent DSPT and Internal Audit assurance. Concerns, development needs and actions: ○ The Trust has identified further planned work to ensure leadership resilience, with a renewed succession programme being developed and recruitment under way for substantive Executive and governance appointments. Revised accountability and operating arrangements are also being implemented. Although partnership working and joint planning are well evidenced, the Trust will continue to evidence shared outcomes delivered through these arrangements. Digital governance is established, with further work planned to further embed benefits across quality, access, productivity and safety. These factors mean that the full Green descriptor is not yet met. Developments since 2025: ○ Since 2025 the Trust has developed and approved the Medium-Term Plan, established four transformation programmes and strengthened integrated reporting, strategic-risk oversight and system alignment. It has commissioned stakeholder-perception work to inform a further Strategy refresh for implementation from 1 April 2027. Board and Executive digital capability has also been strengthened through the Digital and Data Strategy, Digital Maturity Analysis, enhanced cyber assurance and revised governance arrangements. These developments evidence positive direction and organisational grip; however, succession arrangements, substantive appointments and consistent evidence of system and digital outcomes remain in development, supporting an Amber–Green rather than Green rating.
--	--

II. Quality of care

Capability statements	Proposed domain rating Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	The Trust considers its rating to be Amber-Green, based on its judgement against the NHS England guidance and informed by independent review and challenge through the Internal Audit advisory review. Domain capability statements Quality governance arrangements ensure that national guidance, regulatory requirements, patient safety intelligence, complaints, organisational learning and quality metrics are routinely reviewed and used to drive improvement. The Trust can demonstrate the systematic use of internal and external intelligence, including CQC findings, Regulation 28 reports, patient safety learning and benchmarking information, to identify risks, implement improvement actions and monitor progress. Patient experience, co-creation and lived experience are embedded within quality oversight and service improvement arrangements.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	Governance arrangements and their effectiveness Quality is overseen through the Integrated Care Governance Group, Executive Directors Group, Quality Assurance Committee and Trust Board, supported by the IQPR, Quality Assurance Dashboard, Triple A reporting and the Quality Assurance and Improvement Programme. The Trust can evidence active Board engagement in quality improvement, regulatory oversight and organisational learning, with both quantitative and qualitative information used to inform decision-making. External assurance from Quality Management Group discussions and the recent CAMHS CQC inspection provides additional confidence in the effectiveness of governance arrangements.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	Concerns, development needs and actions Whilst quality governance arrangements are well established, the Trust recognises the need to continue strengthening the consistency of learning, escalation and improvement across all services. Current actions include delivery of CQC improvement plans, continued development of organisational learning arrangements, embedding learning from patient safety incidents and

	Regulation 28 reviews, and strengthening the use of patient experience, complaints and co-production intelligence to demonstrate measurable impact on outcomes. There is also the broader context of the forthcoming Public Inquiry. These factors have led to the Amber-Green rating. Developments since the 2025 assessment ○ Since 2025, the Trust has strengthened quality governance through enhanced quality reporting, development of the Quality Assurance and Improvement Programme, expansion of organisational learning arrangements and greater integration of patient experience, complaints and co-creation within governance processes. The Trust has also enhanced oversight of regulatory improvement activity, quality risks and benchmarking through the IQPR and Quality Assurance Committee. These developments provide stronger assurance and organisational insight; however, further work is required to demonstrate consistently evidenced impact of learning and improvement activity across the organisation, supporting an Amber–Green rather than Green rating."
--	--

III. People and culture

Capability statements	Proposed domain rating Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Trust considers its rating to be Amber-Green, based on its judgement against the NHS England guidance and informed by independent review and challenge through the Internal Audit advisory review.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	Domain capability statements ○ The Trust considers its position to be Amber–Green. Staff experience and culture are monitored through the NHS Staff Survey, National Quarterly Pulse Survey, GMC trainee and trainer surveys, WRES, WDES, SOWES, staff networks and local workforce information. The 2025 NHS Staff Survey showed significant improvement, with the Trust the second most improved mental health and learning disability trust in its sector; engagement in the NQPS is above national averages and trainee feedback is strong. Staff have access to established training, appraisal and leadership-development arrangements, alongside an independent Freedom to Speak Up service with clear escalation routes.
11. Staff can express concerns in an open and constructive environment	Governance arrangements and their effectiveness ○ People and culture are overseen through Care Group governance, Executive Directors Group, People, Culture and Diversity Committee and Trust Board, supported by the IQPR, workforce assurance reports, inclusive-culture reporting and Committee Chair assurance. The Training and Education Governance Group oversees mandatory, statutory and continuing professional development, while the Leadership and Management Academy aligns management development with national frameworks. FTSU intelligence is reported through the independent Guardian Service, the monthly Speak Up Group, Executive oversight and regular Committee and Board reporting. AuditOne’s appraisal review provided Good Assurance, confirming that key controls were operating, while also identifying improvement opportunities. Concerns, development needs and actions ○ Management and leadership measures remain below sector averages in some areas, inequalities persist in recruitment, progression and staff experience, and further work is required to provide consistent assurance on management and clinical supervision. Although appraisal compliance is strong, AuditOne identified variability in

	documentation, appraiser training and qualitative assurance. Actions include implementation of the NHS Leadership and Management Framework, delivery of WRES, WDES and SOWES plans, strengthening appraisal quality assurance and demonstrating clearer links between staff feedback, management action and measurable improvement. Developments since the 2025 assessment ○ Since 2025, the Trust has introduced an independent FTSU service, strengthened escalation and reporting through the Speak Up Group, expanded staff-network and inclusive-culture assurance, and achieved improved Staff Survey and NQPS results. The Leadership and Management Academy, People Management Skills Programme and implementation of the national Leadership and Management Framework have strengthened development arrangements, while workforce equality action plans are now co-produced with staff networks. These developments demonstrate positive progress and organisational grip; however, leadership experience, workforce inequalities, supervision and appraisal quality mean that Green is not yet fully evidenced, supporting an Amber–Green rating.
--	--

IV. Access and delivery of services

Capability statements	Proposed domain rating
12. Plans are in place to improve performance against the relevant access and waiting times standards	Amber-Green The Trust considers its rating to be Amber-Green, based on its judgement against the NHS England guidance and informed by independent review and challenge through the Internal Audit advisory review.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	Capability statements: - Performance against many national standards and quality requirements is strong, with favourable benchmarking in areas such as length of stay and out-of-area placements. Where standards are not being met, including Children and Young People's Eating Disorder Services (CEDS), the Trust has identified the underlying causes and has recovery plans in place, supported by Executive and Board scrutiny. The Trust can demonstrate alignment between operational delivery, population health priorities and system plans through the Medium-Term Plan and agreed trajectories with both ICBs. Governance arrangements and their effectiveness: - Access and performance are overseen through Care Group governance, Executive Group, Quality Assurance Committee and Trust Board, supported by routine IQPR reporting. These arrangements provide visibility of performance, waiting times, inequalities and variation, with improvement plans reviewed where standards are off trajectory. The recently established Performance Review Group further strengthens oversight by providing focused Executive-level review of performance and recovery actions. Concerns/development needs: - Whilst governance and planning arrangements are well established, performance remains inconsistent against some access standards. The Trust continues to focus on recovery of CEDS performance, reduction of ADHD and autism backlogs, and improvement in other areas where trajectories are not yet being achieved. The Trust has identified variation in access and outcomes across geography and population groups and is strengthening its approach to reducing unwarranted variation through benchmarking, performance review and targeted improvement activity. Further work is planned to demonstrate measurable improvement in inequalities and the impact of joint system plans on outcomes - and will be scrutinised via the EDI dashboard and IQPR
14. Appropriate population health targets have been agreed with the ICB	

	Developments since 2025 ○ Since 2025, the Trust has strengthened the integration of access, inequalities and population-health information within performance and planning arrangements. Benchmarking and variation analysis are now more explicitly used to inform both operational recovery and strategic planning. Population-health measures have been embedded within operational delivery plans and the Medium-Term Plan, supported by PCREF, health inequalities and prevention work, enhanced IQPR reporting and the introduction of the Performance Review Group. These developments provide greater organisational insight and stronger governance, although sustained improvement across all access standards and demonstrable reduction in inequalities remain areas for continued focus."
--	--

V. Productivity and value for money

Capability statements	Proposed domain rating
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Amber-Green The Trust considers its rating to be Amber-Green, based on its judgement against the NHS England guidance and informed by independent review and challenge through the Internal Audit advisory review. Capability statements: ○ The Trust has good insight into productivity drivers and uses national benchmarking (included in IQPR), the NHS productivity pack, peer comparisons, CRES reporting and internal improvement data. Productivity has been incorporated within How We Work transformation programme, linking effectiveness and efficiency to activity, quality, workforce, finance and outcomes. A Trust productivity approach now comprises a self-assessment, toolkit and developing measurement framework - in development with partners at the University of York. Pilot teams report that the approach improves clarity about responsibility and supports collective action planning. Examples of effective productivity improvement include reductions in length of stay and Culture of Care work. However, the approach is not yet systematic or consistently embedded across the organisation, nor is the Trust consistently in the upper quartile for productivity measures (hence amber-green) Governance arrangements and their effectiveness: ○ Productivity work is overseen via Executive Directors Group and Resources & Planning Committee, with engagement and discussion at Care Group level. The impact of productivity work is also seen via the IQPR - and referred to explicitly where this is a contributor to improved performance. The developing measurement framework is explicitly designed to use governed measures (e.g. NOF) and triangulated quality, workforce, activity, finance and outcomes. This represents stronger governance than in 2025, although the measurements and benefits realisation arrangements are not yet fully mature Concerns/development needs: ○ Further development work will include a developed and utilised measurement framework, consistent upper quartile productivity performance, and consistently

	embedded productivity method across the organisation (via toolkit, utilisation of approach). Alignment between productivity gains and QEIA assessment will continue. Developments since 2025 ○ Since 2025 the Trust has moved from developing a productivity plan, to piloting and rollout of an integrated productivity approach, with a manager toolkit, self-assessment, positive pilot feedback and alignment to the Trust's IQPR and 'How We Work' transformation programme. Amber-Green has been determined because of the direction, insight and governance arrangements in place and examples of productivity; with further work planned to systematise and embed this organisation-wide.
--	--

VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Amber-Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements	The Trust considers its rating to be Amber-Green, based on its judgement against the NHS England guidance and informed by independent review and challenge through the Internal Audit advisory review.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	Capability statements: the Trust can evidence reporting to Board Committees and Board on its finances, and oversight of subcontracts (from both a finance and quality lens). The Trust has a track record of delivery, with Board Committee and Board well-sighted on plan delivery, forecast position and mitigations. The Trust can evidence it is a proactive partner in both system, Region and national forum - evidenced via leadership roles, to lobby on behalf of the Trust and wider mental health matters
18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	Governance arrangements and their effectiveness: - the Trust has a strong track record, endorsed via substantial Audit assurance, on the robustness of its finance and payroll reporting. Established arrangements are in place for detailed oversight and assurance of financial plans, forecasting, risk, efficiencies delivery, contract management and system alignment - at Care Group Board, Performance Review meeting, Executive Directors Group, Resources and Planning and Trust Board. Variance to plans are highlighted, trajectories agreed to return to plan and mitigations proposed - which has led to visible substantial assurance noted at Resources and Planning and Board Concerns/development needs: - the Board are well sighted on financial risks to delivery - via financial risk on BAF, Board and Resources and Planning Committee reporting highlighting key risks to delivery - e.g. recurrent CRES, bank expenditure, high-cost care packages, system-dependent discharge delays and capital constraints. Reporting includes consideration of mitigations and follow up actions Developments since 2025

	○ Since the 2025 assessment the Trust has delivered its prior-year financial plan and CRES requirement, obtained further Audit assurance (substantial) of financial reporting, materially reduced agency use, strengthened QEIA and integrated Medium Term Planning, and completed all NHS England MTP conditions. Whilst the Trust's position on financial governance and delivery overall is strong, the rating of Amber-Green reflects the unplanned reliance on agency/bank staff (and noted MTP condition), and challenges to CRES delivery, The Trust's Regional assessment of 'On track' for finances (green) provides positive context.
--	---

Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____

Annex: Using a RAG-rating approach to derive the rating – guidance for providers

The table below sets out the approach providers should take to assess themselves across the six domains. Providers should set out, in their return template, a commentary covering the rationale behind each domain's rating, the evidence referenced in their return and improvements made since the last submission in 2025. Note that regions will take their own views of capability across the board and will not have the level of detail that providers have – while the evidence here supports the rating it should not be considered automatic or algorithmic in every instance, rather it sets a general benchmark around different levels of capability taking account of the statements.

Leadership and strategy	
<i>Overarching expectation: the trust's board is working well as a unit to oversee the provider and has effective relationships with system partners and stakeholders. The board demonstrates the skills to oversee the delivery of safe, sustainable services, plans effectively and receives the right information to oversee performance and plan delivery as well as monitoring internal and external risk factors.</i>	
Capability statements	Indicative evidence
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners 2. If in breach: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE 3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan. 4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served 5. The trust has an effective cyber security strategy	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green • Strategy is coherent, measurable, aligned with provider's objectives and system priorities. • If in breach: all undertakings being delivered; regulatory confidence restored and trust on track to compliance • Board has requisite range of skills; development plans active; succession plans in place; no vacancies > 3 months; no interims > 6 months. • Strong collaboration with local partners; joint planning; shared outcomes delivered. • Regular board reporting on cybersecurity matters, cyber built into Board Assurance Frameworks; digital strategy embedded. Amber-Green • Strategy mostly aligned with the provider's objectives but lacks depth or consistent delivery. • If in breach: On track to compliance with credible plans; minor slippage only. • Skills mostly adequate; some gaps recognised and being addressed. • Good relationships with system partners but inconsistent joint delivery. • Cybersecurity is mostly well-managed, but some areas lack maturity or consistency.

and uses digital technology to support improvement	- Concerns from independent board governance reviews or CQC well-led findings in past 6 months that are in hand Amber-Red - Strategy unclear, outdated, or inconsistently applied. If in breach: Behind trajectory on return to compliance; repeated slippage; weak assurance. - Significant capability gaps at board level; weak development; over-reliance on individuals. - CQC well-led 'requires improvement' - Patchy collaboration; strained relationships; siloed behaviour. - Outdated systems; weak cyber assurance; limited digital use. Red - No credible strategy; board direction fragmented. If in breach: persistent non-compliance; enforcement actions escalating; board grip absent. - Board lacks a number of core skills; no development; unsafe capability. - CQC well-led 'Inadequate' - Board isolated; system relationships dysfunctional. - No credible cyber strategy; repeated material incidents.
Quality oversight	
<i>Overarching expectation: the trust's board is set up for effective oversight of the quality of care it provides, monitoring safety, patient experience and using insights from third parties as appropriate. This is evidenced by robust information going to boards, a track record of high-quality care and an open, curious and enquiring approach on quality issues from executives and non-executives alike.</i>	
Capability statements	Indicative evidence
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green - Guidance is used effectively to drive improvements in quality of care. - Established quality governance arrangements in place; confidence in early warning systems; systems of triangulation identify issues before they become critical - Patient experience embedded in discussions around quality; concerns reach board quickly. Amber-Green - Mostly compliant with guidance and it is generally used to improve care;

arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	- Some gaps in the effectiveness of quality oversight e.g. escalation approaches or learning from close calls. Triangulation is used in places. - Systems in place to monitor patient experience but aren't always used consistently to escalate. Amber-Red - Guidance applied inconsistently - Board tends to be reactive to quality issues and actions to address issues are not consistently effective. - Limited insight into patient experience; slow escalation; weak or non-existent triangulation. Red - No regard for guidance; blind spots in safety and complaints. - Quality governance failing; evidence from third parties that serious risks are unmanaged. - No reliable patient experience monitoring.
People and culture	
<i>Overarching expectation: the board has an accurate, evidence-based view of the trust's culture and improves the organisation as a place to work. This is evidenced by: staff input being collected, valued and used in board decisions; staff being able to speak up where they have concerns; and staff have access to training and other opportunities to carry out their roles as well as possible.</i>	
Capability statements	Indicative evidence
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green: - Evidence that staff feedback drives improvement; strong culture indicated by high scores in staff survey, and Staff Standards measures. - Workforce plans credible; training embedded across the organisation; safe staffing levels in place and reviewed regularly. - Strong speaking-up culture. Amber-Green - Feedback collected but not consistently acted on. - Staff skills are mostly adequate but there may be gaps/insufficient depth in key areas. - Generally open culture; some pockets of concern in specific areas of the staff survey. Amber-Red - Feedback intermittently collected or when reported is out of date; limited impact on care or management actions.

	• Persistent gaps in skill levels in key areas; weak/ineffective training; • Evidence that staff groups indicate fear of speaking up; insufficient insights at board level. • Persistently lowest quartile in NHS staff survey Red • Persistent lowest 10% in NHS staff survey • Staff feedback ignored; culture deteriorating. • Unsafe staffing; no development in staff. • Evidence of a toxic culture; concerns suppressed.
Access and delivery of services	
<i>Overarching expectation: the board understands the drivers of delivery of core national access standards and uses this to optimise the trust's performance. The Board has extracted the maximum reasonable performance from the resources, workforce and authority available to it, and does all it can to mitigate the impact of external factors.</i>	
Capability statements	Indicative evidence
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green • Generally delivering on trajectory vs plans. • Clear knowledge/awareness of access and care levels across local geography and demographics in order to identify and address inequalities; can demonstrate measurable improvement. • Targets aligned with system partners; joint delivery plans in place where necessary (e.g. with provider collaborative partners). Amber-Green • Plans credible but inconsistent delivery. • Inequalities in access/care identified; actions underway but not yet fully addressing issues. • Targets aligned with system partners; joint delivery plans in place as necessary (e.g. provider collaborative) but not fully implemented or delivering desired outcomes. Amber-Red • Under-delivery or deterioration in performance but board cannot demonstrate a credible plan to address it; • Underperforming local peers with no evidence of mitigating factors

	- Known variation in the quality of and access to services but little or no evidence of addressing them. - Limited engagement across system partners to deliver access standards. Red - Behind trajectory on multiple access measures with no credible plan to address. - No insights into inequalities by demographic. - No engagement with rest of system
Productivity and value for money	
<i>Overarching expectation: the board understands how workforce, estate, asset utilisation, activity and provision of care interact at the trust to drive productivity. This is evidenced by a track record of improvements in productivity that are delivered within the wider context of quality of care and patient experience.</i>	
Capability statement	Indicative evidence
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green - Board understands drivers of productivity and can use them to improve use of resources; provider in top 25% vs peers - Productivity improvements are discussed in the context of quality of care, patient experience and staff wellbeing Amber-green - Board has good insights and credible plans but has not fully extracted efficiencies - Performance vs peers flat/declining <12 months Amber-red - Board is aware of poor productivity and associated symptoms but has been unable to address them - Declining productivity vs peers >12 months Red - Board cannot explain the drivers behind poor productivity, quantify the upside or deliver improvement - Persistent bottom quartile in benchmarks vs peers
Financial performance and oversight	
<i>Overarching expectation: the trust's board demonstrates a good financial understanding and literacy, leads the forecasting and risk management process and</i>	

has a track record of overseeing the delivery of financial plans and efficiencies and offers strong challenge and insight. There is effective triangulation of workforce, activity and finance in both forward planning and in-year oversight.

Capability statements	Indicative evidence
16. The trust has a robust financial governance framework and appropriate contract management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive:</i> Green • Track record of delivering financial plans ‘without surprises’; cost improvement programmes are generally delivered • Executives and Non-Executives understand the drivers of the trust’s financial position and the board links finance discussions to quality of care, operational demand and workforce • Financial risks are reviewed regularly at board level; • Strong links between trust and system planning functions; supports system outturn. Impact of external factors outside the board’s control are minimised Amber-Green • Occasionally off-plan, but generally returns to plan over time and by year-end • Cost improvement programs are delivered, but below forecast • Minimal reliance on one-off mitigations to hit plans Amber-Red • Understands headline numbers but struggles to explain or control how underlying drivers affect financial performance. • Unplanned reliance on agency/bank staff • Has recurring forecasting inaccuracies and missing planned performance – may rely on one-off mitigations to ameliorate under-performance • Shows weak linkage between workforce, activity levels, quality of care and financial performance. Red • Persistent plan under-delivery, with frequent unexpected in-year deterioration in performance vs plan, and little confidence in forecasts. Consistently misses savings targets. • Unplanned reliance on agency/bank staff

	• Board cannot clearly articulate factors behind the organisation's financial position; weak board-level financial governance, poor scrutiny of financial information and the factors behind performance • Track record of reliance on external support, regulatory intervention or year-end bailouts; little connection with system partners on financial planning and investment
--	--

Agenda Item 20

For General Release

Meeting of:	Board of Directors
Date:	23 September 2026
Title:	Introduction of the revised governance system, committee terms of reference and work programmes
Executive Sponsor(s):	Alison Smith, Chief Executive
Author(s):	Anna Pridmore, Interim Company Secretary and Director of Corporate Governance

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
BAF 9	A strengthened, standardised governance framework is a key control for BAF 9, supporting clear accountability, effective risk escalation, consistent committee assurance and demonstrable Board oversight of statutory and regulatory obligations.

Executive Summary

Purpose

This report seeks Board approval to introduce the Trust's revised governance system from 1 October 2026 and to approve in principle the accompanying committee terms of reference and annual work programmes. The revised arrangements establish a consistent end-to-end framework for planning business, receiving evidence, recording decisions and actions, escalating material issues and providing assurance to the Board.

Proposal

The Board is asked to approve the revised governance system, the updated terms of reference for Board committees and the aligned 2026/27 work programmes; note the associated implementation, training and review arrangements; and delegate authority to the Chief Executive and Interim Company Secretary and Director of Corporate Governance to make minor presentational or non-material amendments before issue.

Key points

- A new set of templates have been developed that includes an assurance mapping document.
- The revised arrangements will go live on 1 October 2026 and include monthly Board meetings, two Board seminar sessions each year and a standard suite of governance templates.

- Each committee's terms of reference have been reviewed by the Chairs and Lead Executive's.
- Each work programme translates the committee's duties into a scheduled cycle of assurance, decision and information items, with named leads and explicit links to the relevant terms of reference.
- Committees reporting to the Board will focus on assurance received, gaps, risks, decisions and matters requiring escalation, strengthening the Board's line of sight from services to committees and onward to strategic risks.
- The arrangements will be monitored after implementation, with an initial review in February 2027 and annual effectiveness reviews thereafter.

Overview

The revised governance brings the Board and committee timetable, committee mandates, work programmes, reporting flows, core expectations and a common reporting architecture along with a refresh of the role of board committees. The system is designed to ensure that responsibilities delegated by the Board are translated into planned committee activity and supported by a complete audit trail: terms of reference define duties; work programmes that are fully scheduled; agendas and reports provide evidence; minutes, action and decision logs record outcomes; committee reports escalate significant assurance; and assurance mapping demonstrates coverage of Board Assurance Framework risks.

1. Case for change

The changes respond to the need for a clearer and more consistent governance framework, stronger scrutiny of both hard and soft intelligence, improved alignment between committee activity and strategic risk, and a demonstrable line of sight from ward and service information to executive oversight, Board committees and the Board. Previous arrangements contained variation in committee documentation, reporting formats and the way assurance, decisions and escalation were recorded. This increased the risk of duplication, gaps in coverage, unclear accountability and papers that described activity without clearly stating the assurance provided.

The case for change also includes changing some of the board committees. The most significant change is the introduction of the Planning, Digital and Estates Committee and the changing the Resources and Planning Committee to the Finance and Performance Committee. Both these changes support the Board to understand key agendas more clearly. Historically the Board has not included a performance element in its assurance so the addition of it into a committee is significant.

Any actions remaining in the Resources and Planning Committee will be reviewed and shared between the Planning, Digital and Estates Committee and the Finance and Performance Committee.

The other significant change is the closing down of Roseberry Park Committee. This was a committee that specifically addressed a number of financial and legal issues. All of these issues have now been concluded, and work is underway to close the committee down, report that through the Audit and Risk Committee and ensure any remaining outstanding issues are addressed, for example there is an entry on the Board Assurance Framework around Roseberry Park and a risk included on the Corporate Risk Register that will be reviewed. This will be picked up by the Planning Digital and Estates Committee as the entry in the Board Assurance Framework and Corporate Risk Register relates directly to the resulting estates elements.

Other changes include the revision of the title of the People and Culture Committee, it was called the People, Culture and Diversity Committee previously, it has been agreed that diversity is automatically picked up as part of culture and therefore it was agreed between the Lead Executive and Chair of the committee that the meeting should be called the People and Culture Committee.

2. Revised governance system

The revised system establishes a single governance operating cycle across the Executive Directors Groups, Board committees and the Board. The cycle is: terms of reference; work programme; agenda and reports; meeting consideration; minutes; action and decision logs; committee report to the Board; and assurance mapping.

Standard templates will be used for agendas, minutes, action logs, decision logs, Board and committee reports, committee assurance reports, terms of reference, work programmes and Board assurance mapping.

The Diligent platform will support secure circulation, document control and access to the approved governance library.

3. Revised terms of reference

The terms of reference have been reviewed to create a consistent framework while retaining the distinct statutory and delegated responsibilities of each committee. They specify the committee's purpose, authority, duties, membership, attendance, quoracy, frequency, reporting routes, administration and annual review requirements. The language has been strengthened so that Board committees are clearly positioned as assurance and scrutiny bodies rather than operational management groups. Each committee must review relevant strategic and corporate risks, identify gaps in control or assurance, and escalate matters outside tolerance or requiring Board attention.

4. Committee work programmes

The revised work programmes operationalise the terms of reference. Each duty is mapped to a report or assurance activity, a frequency, a responsible lead and scheduled meeting dates.

5. Remaining work

Although all the Board Committees have been included in the work so far the one element of the corporate governance that has not been properly addressed as yet are the Terms of Reference for the Board of Directors and the associated Work Programme. This work has started and will be completed over the next few weeks. To finalise the work, there is also an historic document that outlines the division of responsibility between the Chair and the Chief Executive that sits with the Board suite of documents. This document should be updated and presented to Board with the terms of reference and work programme as a complete set of governance for the Board.

Although significant time has been allocated to training colleagues during August, further training will be available over the coming months to support the system implementation and imbedding. This training is available to teams at all levels.

6. Roles and accountability

- **The Board** retains collective responsibility for strategy, risk, internal control and the quality and safety of services, and approves committee mandates.
- **Committee Chairs** ensure effective scrutiny, conclude on the assurance available and report material issues to the Board.

- **Executive Leads** ensure that timely, evidence-based reports are provided and that agreed actions are implemented.
- **Report authors** must distinguish assurance from reassurance, state limitations and gaps, link evidence to risk and make clear recommendations.
- **Corporate Governance** maintains the approved framework, supports agenda planning, monitors compliance and coordinates effectiveness reviews.

7. Consultation and engagement

The revised arrangements have been developed through engagement with the Chair, Chief Executive, Non-Executive Director, Executive Leads, governance secretariat. Draft terms of reference and work programmes have been reviewed with relevant Chairs and Executive Leads. Training and briefing sessions on the revised templates and assurance approach were delivered during August 2026, with further targeted support available during implementation.

8. Implementation and transition

Milestone	Timing	Responsibility
Board approval of governance system, terms of reference and work programmes	23 September 2026	Board of Directors
Publication of the final documents will be on the intranet. A page on governance is being developed	By 30 September 2026	Corporate Governance
New arrangements and templates go live	1 October 2026	All committees and Executive Leads
Initial compliance and user feedback review	February 2027	Corporate Governance and Committee Chairs
Annual committee effectiveness and terms of reference review	April 2027/28 cycle	Committee Chairs and Board

9. Assurance and monitoring

Implementation assurance will be based on evidence rather than completion of documents alone. Monitoring will include: use of approved templates; delivery of scheduled work programme items; timeliness and quality of papers; explicit assurance conclusions; completeness of action and decision logs; quality of committee escalation to the Board; alignment of committee business to the Board Assurance Framework and Corporate Risk Register; and feedback from Chairs, members, Executive Leads and secretariats.

Exceptions and persistent non-compliance will be reported to the Executive Directors and, where material, to the Audit and Risk Committee and Board.

10. Risks and mitigations

Risk	Mitigation
Inconsistent adoption across committees	Mandatory templates, briefing, targeted support and compliance monitoring.
Work programmes become static schedules rather than active assurance tools	Review at every meeting, named leads, status tracking and documented re-phasing.
Volume of reporting obscures material issues	Purpose-led papers, concise executive summaries, exception reporting and explicit assurance conclusions.

Gaps or duplication between committees	Annual mandate review, assurance mapping and cross-committee coordination by Corporate Governance.
Transition creates short-term administrative pressure	Phased support, clear ownership, Diligent document library and early post-implementation review.

11. Implications for areas:

- **Quality and safety:** clearer committee responsibilities, planned assurance and escalation should strengthen oversight of service quality and safety.
- **Workforce:** members, Executive Leads, authors and secretariats will require continued support to embed the approach.
- **Finance:** implementation will be managed within existing resources, including the commissioned Diligent platform.
- **Legal and regulatory:** the framework supports compliance with the Trust's statutory duties, Provider Licence, constitution, standing orders and the NHS Code of Governance.
- **Equality and health inequalities:** report templates require relevant impacts to be considered and committees remain responsible for appropriate scrutiny within their remit.
- **Information governance:** controlled templates, secure circulation and clear document ownership strengthen version control and information handling.

12. Conclusion

The revised governance system provides a coherent framework through which the Board can delegate clearly, receive focused assurance and maintain oversight of strategic objectives, risks and statutory responsibilities. Approval will allow the Trust to move from variable committee practice to a consistent governance cycle with clearer accountability, documented evidence and routine review. The effectiveness of the system will depend on disciplined use, active ownership by Chairs and Executive Leads, and transparent escalation where assurance is limited or incomplete.

13. Attachments

Appendix A Terms of reference and work programmes for the following committees:

- Quality Assurance Committee
- Audit and Risk Committee
- Finance and Performance Committee
- Planning, Digital and Estates Committee
- People and Culture Committee
- Mental Health Legislation Committee

Board and Committee structure:

<https://tevv.boardeffect-uk.diligentoneplatform.com/downloads/vfile/60671>

Committee Membership:

<https://tevv.boardeffect-uk.diligentoneplatform.com/downloads/vfile/60672>

14. Recommendations

The Board of Directors is asked to:

1. **Approve** the revised governance system for implementation from 1 October 2026.
2. **Approve** the revised terms of reference and 2026/27 work programmes for the Board committees.
3. **Note** the implementation, training, monitoring and February 2027 review arrangements.
4. **Delegate** authority to the Chief Executive and Interim Company Secretary and Director of Corporate Governance to make minor presentational or non-material amendments before final publication.
5. **Require** a post-implementation assurance report to the Board following the February 2027 review.

TERMS OF REFERENCE

1. Document Control

Committee / Group Name	Audit and Risk Committee
Reports To	Board of Directors
Sub-Groups Reporting In	Executive Risk Group
Chair	John Maddison Non-Executive Director
Executive Lead	Liz Romaniak
Secretariat	Donna Keeping, Corporate Governance Manager
Version	V1
Approved By	Board of Directors
Review Date	Annually from date of approval

2. Purpose

The Audit and Risk Committee is established to provide assurance to the Board of Directors that the Trust is meeting its statutory, regulatory and quality obligations in relation to finance, corporate governance, organisational risk management, internal control and assurance.

The Committee provides the Board of Directors with independent and objective reviews of the key areas under its responsibility and works with the other Board Committees to ensure assurance, internal control, risk management, corporate governance are effective across the Trust.

3. Authority

The Audit and Risk Committee is established under Standing Order 6 of the Board of Directors.

The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain external legal or other independent professional advice, and to secure the attendance of individuals with relevant experience and expertise, if it considers this necessary.

The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee.

Meetings of the Committee shall be held in private.

4. Duties

4.1 Governance, Risk Management and Internal Control

- To review the establishment and maintenance of an effective system of integrated governance, organisational risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's Strategic Objectives.

In particular, the Committee will review the adequacy of:

- all organisational risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with national standards/regulatory requirements), together with

any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

- the Trust's policies, processes and procedures to manage organisational risk and the internal control framework, including the design, implementation and effectiveness of those systems;
- the Board Assurance Framework (BAF) and the underlying processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal organisational risks; and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and
- the policies and procedures for all work related to fraud and corruption as set out in section 24 of the NHS Standard Contract and as required by NHS Counter Fraud Authority.
- To advise the Board on the Trust's overall risk appetite, tolerance and strategy and the principal and emerging risks the Trust is willing to take in order to achieve its strategic objectives.
- To review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care Arm's Length Bodies or Regulators/Inspectors (e.g. NHS England, the Care Quality Commission, NHS Resolution Authority, Health and Safety Executive etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

- To review the Trust's systems and processes for the prevention of bribery and receive reports on non-compliance.
- To request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. (eg. Conflicts of interest, Declarations of interest)
- Receive an assurance map of the organisation's assurance during the previous quarter
- To commission and review value for money studies of the Trust's services and functions and to make recommendations to the Board accordingly

4.2 Counter Fraud

- Approve the annual counter fraud work programme
- Approve the self-assessment statement against the Counter Fraud Standards
- update from the local counter fraud specialist including progress on the approved annual counter fraud work plan

4.3 Internal Audit

- To consider the Internal Audit Strategy and Operational Plan ensuring it is consistent with the needs of the organisation as identified in the Assurance Framework.
- To oversee, on an ongoing basis, the effective operation of Internal Audit in respect of:
 - Adequate resourcing
 - Its co-ordination with External Audit
 - Meeting mandatory NHS Internal Audit Standards
 - Providing adequate and appropriate independent assurances
 - Having appropriate standing within the organisation
 - Meeting the internal audit needs of the Trust
- To consider the major findings of Internal Audit investigations and management's responses and their implications and monitor progress on the implementation of agreed recommendations.
- To consider the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

- To conduct an annual review of the effectiveness of the Internal Audit function.

4.4 External Audit

- To make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditor.

(Note: Where the Council of Governors does not approve the recommendation, the Audit and Risk Committee shall prepare a statement for consideration by the Board of Directors explaining its recommendation, for inclusion in the Annual Report.)

- To oversee the conduct of a market testing exercise for the appointment of an External Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors in respect to the appointment of the External Auditor.
- To discuss with the External Auditor, before the audit commences, the nature and scope of the audit and to ensure coordination, as appropriate, with other External Auditors in the local health economy.
- To review the work and findings of the External Auditor and to consider implications and management's responses to their work. This will be achieved by:
 - consideration of the appointment and performance of the External Auditor;
 - discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and
 - reviewing all External Audit reports, including agreement of the annual audit letter (if required) before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.
- To review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements and compliance with the Code of Audit Practice.
- To develop and implement a policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the External Audit firm.

4.5 Annual Accounts Review

- To review whether the Trust remains a "going concern" and to assure the Board accordingly.
- To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:
 - The meaning and significance of the figures, notes and significant changes.
 - Areas where judgment has been exercised
 - Adherence to accounting policies and practices
 - Explanation of estimates or provisions having a material effect
 - The schedule of losses and special payments
 - Any adjusted misstatements
 - Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved
- To review the Annual Report and Annual Governance Statement prior to submission to the Board of Directors to determine their completeness, objectivity, integrity, accuracy and compliance with directions received from NHS England.
- To review the Trust's Quality Account/Report prior to inclusion in the Annual Report and submission to the Board of Directors to determine its completeness, integrity and accuracy. This review will include but is not limited to:
 - Compliance with directions received from the Department of Health and Social Care and NHS England.
 - The accuracy of mandatory and local performance indicators

- Any issues raised by stakeholders
- To review all systems of accounting and financial reporting, including those of budgetary control, in order to provide assurance on the completeness and accuracy of information provided to the Board.

4.6 Other

- To review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care Arm's Length Bodies or Regulators/Inspectors (e.g. NHS England, the Care Quality Commission, NHS Resolution Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

- To review the work of other committees within the organisation whose work can provide relevant assurance to the Committee's own scope of work on the appropriateness, robustness and operation of the Trust's governance arrangements. This will particularly include the Quality Assurance Committee and the Executive Risk Group.

In reviewing the work of the Quality Assurance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

- To review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ("The Whistle Blowing Policy").

In undertaking the review, the Committee's objective will be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

- To review the Trust's systems and processes for the prevention of bribery and receive reports on non-compliance.
- To request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- To request and review specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

4.7 Delegated Authority

- Approval of any administrative actions as may be necessary to facilitate the delivery of the Committee's purpose and functions.
- Approval of the Internal Audit Strategy and Operational Plan.
- Approval of the annual Counter Fraud Plan.
- Appointment and dismissal of the Internal Audit provider.
- Approval of the External Audit Strategy.
- Authority to write off losses within the limits set by HM Treasury and NHS England/Improvement.

5. Membership

Role / Job Title	Voting rights
John Maddison Chair —Non-executive Director	Voting
Jules Preston – Non-executive Director	Voting
Phil Corrigan – Non-executive Director	Voting
David Butcher – Associate Non-executive Director	Non-voting
Edward Gorringe – Associate Non-executive Director	Non-voting

Members are expected to attend a minimum of [80%] of meetings in any 12-month period. Persistent non-attendance will be raised with the Chair and may result in a request to nominate an alternative representative.

6. Quorum

The meeting shall be quorate when a minimum of three members are present, to include at least one Executive Director and the Chair (or their nominated deputy). No decision may be ratified at a meeting that is not quorate.

7. Frequency and Notice

The Committee shall meet quarterly in line with the standard requirements for an Audit and Risk Committee in the NHS. Additional meetings may be convened by the Chair where urgent business requires consideration. The agenda and supporting papers shall be circulated to all members no later than [5 working days] prior to the meeting.

The Committee will additionally have a standard year end meeting included in the diary to allow for the Annual Report and Accounts to be considered prior to approval by the Board of Directors.

External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

The Committee shall meet privately at least once a year with the Internal and External Auditors.

8. Conduct of Meetings

- All members will declare any conflicts of interest at the start of each meeting and as they arise during discussion.
- Meetings will be conducted in accordance with the Trust's Standing Orders and Standards of Business Conduct Policy.
- Discussions involving identifiable patient information will be conducted with due regard to confidentiality and information governance requirements.
- Minutes will be taken by the Secretariat and approved by the Chair prior to circulation as a true and accurate record.

9. Reporting Arrangements

The Committee will provide a written report, including a summary of key decisions, risks and assurances, to the Board of Directors following each meeting. An annual report summarising the Committee's effectiveness against its Terms of Reference will be submitted to the Board of Directors each year.

10. Administration

The Secretariat will be responsible for agenda planning, minute-taking, maintenance of the action log and decision log, and circulation of papers.

A rolling Work Programme will be maintained alongside these Terms of Reference to ensure all duties are discharged within the appropriate reporting cycle.

11. Review

These Terms of Reference will be reviewed annually, or sooner if required by changes in legislation, regulatory guidance, or Trust governance structures, and approved by the Board of Directors.

12. Approval

Approved By	Date Approved
Next Review Due	Version

WORK PROGRAMME

*This Work Programme operationalises the Committee's Terms of Reference, ensuring every duty in Section 4 is discharged within the appropriate reporting cycle.
ToR Ref values correspond directly to the duty sub-sections in the Terms of Reference.*

1. Programme Details

Committee / Group	Audit and Risk Committee
Linked Terms of Reference	Terms of Reference V1 — Approved duty references below correspond to ToR Section 4
Programme Year	2026/27
Owner	Chair: ARC Chair, Non-Executive Director / Secretariat –
Secretariat	Donna Keeping Governance Manager
Last Updated	17/09/2026

2. Standing Agenda Items

Ref	Standing Item (every meeting)
1	Welcome, apologies and confirmation of quoracy
2	Declarations of interest
3	Minutes of previous meeting and matters arising / action log review
4	Review of relevant risks on the Board Assurance Framework / risk register
5	Items per Work Programme (see Section 3)
6	Any other business
7	Summary of key decisions and items for escalation

3. Annual Forward Planner

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.1	Governance, Risk Management and Internal Control To review the establishment and maintenance of an effective system of integrated governance, organisational risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's Strategic Objectives. In particular, the Committee will review the adequacy of:				
	all organisational risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with national standards/regulatory requirements), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board;	Annual	Company Secretary	March	On Track
	- the Trust's policies, processes and procedures to manage organisational risk and the internal control framework, including the design, implementation and effectiveness of those systems; - Report on Trust policy systems	Twice a year	Company Secretary	December, May	On Track
	the Board Assurance Framework (BAF) and the underlying processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal				

	organisational risks; and the appropriateness of the above disclosure statements; • Board Assurance Framework and Corporate Risk Register Report	Each meeting	Company Secretary	Each meeting	On Track
	• the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;	Annual	Executive Director of Finance, Estates and Facilities / Company secretary	May	
	the policies and procedures for all work related to fraud and corruption as set out in section 24 of the NHS Standard Contract and as required by NHS Counter Fraud Authority	Each meeting	Executive Director of Finance, Estates and FM / Counter Fraud Specialist	Each meeting	On Track
4.2	Counter Fraud				
	• Approve the annual counter fraud work programme	Annual	Counterfraud – Audit one	????	On Track
	• Approve the self-assessment statement against the Counter Fraud Standards	Annual	Exec D F AC Chair	June	On Track
	• Approve the Annual Report for Counter Fraud	Annual	Counter Fraud – Audit One	September	On Track
	• Update from the local counter fraud specialist including progress on the approved annual counter fraud work plan	Each meeting	Executive Director of Finance, Estates and FM / Counter Fraud Specialist	Each meeting	On Track
	• To advise the Board on the Trust's overall risk appetite, tolerance and strategy and the principal and emerging risks the Trust is willing to take in order to achieve its strategic objectives. • Report and proposal on risk appetite	Annual	Company Secretary	August	On Track
4.3	Internal Audit				
	• To consider the Internal Audit Strategy and Operational Plan ensuring it is consistent with the needs of the organisation as identified in the	Annual		March	On Track

	Assurance Framework including the adequacy around the internal audit provision in the context of the risks requiring audit oversight.		Executive Director of Finance, Estates and FM / AuditOne		
	- To oversee, on an ongoing basis, the effective operation of Internal Audit in respect of: - Adequate resourcing - Its co-ordination with External Audit - Meeting mandatory Global Internal Audit Standards (GIAS) - Providing adequate and appropriate independent assurances - Having appropriate standing within the organisation - Agreed KPIs - Meeting the internal audit needs of the Trust	Internal Audit progress report to each meeting. Head of Internal Audit Opinion received annually (draft prior meeting) Internal Auditors strategic plan received annually (with update on progress in annual report)	Executive Director of Finance, Estates and Facilities AuditOne Executive Director of Finance, Estates and Facilities AuditOne Executive Director of Finance, Estates and Facilities AuditOne	Each meeting May (draft in March) March	On Track On Track On Track
	To consider the major findings of Internal Audit investigations and management's responses and their implications and monitor progress on the implementation of agreed recommendations.	Internal Audit progress report to each meeting. Internal Auditors strategic plan annual progress update.	Executive Director of Finance, Estates and Facilities AuditOne Executive Director of Finance, Estates and Facilities AuditOne	Each meeting March	On Track On Track
	To consider the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	Internal Audit plan document supported by outputs from Corporate benchmarking submission. Internal Auditors strategic plan	Executive Director of Finance, Estates and Facilities	December March	On Track On Track

		received annually (with update on progress in annual report)	Executive Director of Finance, Estates and Facilities AuditOne		
	To conduct an annual review of the effectiveness of the Internal Audit function	Annual	Executive Director of Finance, Estates and FM	March	On Track
4.4	External Audit				
	To make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditor. <i>(Note: Where the Council of Governors does not approve the recommendation, the Audit and Risk Committee shall prepare a statement for consideration by the Board of Directors explaining its recommendation, for inclusion in the Annual Report.)</i>	As required (current contract required annual consideration)	Executive Director of Finance, Estates and Facilities ARC Chair	September	On Track
	To oversee the conduct of a market testing exercise for the appointment of an External Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors in respect to the appointment of the External Auditor.	Every 5 years (year preceding contract expiry – 2026 in current contract)	Executive Director of Finance, Estates and Facilities ARC Chair	December	On Track
	To discuss with the External Auditor, before the audit commences, the nature and scope of the audit and to ensure coordination, as appropriate, with other External Auditors in the local health economy.	Annual meeting	Executive Director of Finance, Estates and Facilities	December	On Track

	- To review the work and findings of the External Auditor and to consider implications and management's responses to their work. This will be achieved by: - consideration of the appointment and performance of the External Auditor; - discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee; and	Annual Annual meeting (see 4.5)	Executive Director of Finance, Estates and Facilities ARC Chair Executive Director of Finance, Estates and Facilities	December December	On Track On Track
	Review all External Audit reports, including agreement of the annual audit letter (if required) before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.	Annually, during the audit review	Executive Director of Finance, Estates and Facilities	1 st May to 30 th June	On Track
	- To review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements and compliance with the Code of Audit Practice. - Survey of External Audit services	Annual – when considering appointment / extension to contract.	ARC Chair	December	On Track
4.5	Annual Accounts Review				
	To review whether the Trust remains a "going concern" and to assure the Board accordingly.	Annual	Executive Director of Finance, Estates and Facilities	March	On Track
	- To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to: - The meaning and significance of the figures, notes and significant changes.	Annual	Executive Director of Finance, Estates and Facilities	May (meeting with ARC members (NEDs and CoG representatives) to be arranged prior to May meeting to go through in detail.	On Track

	- Areas where judgment has been exercised - Adherence to accounting policies and practices - Explanation of estimates or provisions having a material effect - The schedule of losses and special payments - Any adjusted misstatements Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved				
	• To review the Annual Report and Annual Governance Statement prior to submission to the Board of Directors to determine their completeness, objectivity, integrity, accuracy and compliance with directions received from NHS England.	Annually	Company Secretary	March	On Track
	• To review the Trust's Quality Account/Report prior to inclusion in the Annual Report and submission to the Board of Directors to determine its completeness, integrity and accuracy. This review will include but is not limited to: - Compliance with directions received from the Department of Health and Social Care and NHS England. - The accuracy of mandatory and local performance indicators • Any issues raised by stakeholders	Annually	Company Secretary	March	On Track
	• To review all systems of accounting and financial reporting, including those of budgetary control, in order to provide assurance on the completeness and accuracy of information provided to the Board	Annually	Executive Director of Finance, Estates and Facilities	March	On Track

4.6	Other				
	To review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health and Social Care Arm's Length Bodies or Regulators/Inspectors (e.g. NHS England, the Care Quality Commission, NHS Resolution Authority, Health and Safety Executive etc.) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)	Adhoc	Executive Director of Finance, Estates and Facilities	Adhoc	On Track
	To review the work of other committees within the organisation whose work can provide relevant assurance to the Committee's own scope of work on the appropriateness, robustness and operation of the Trust's governance arrangements. This will particularly include the Quality Assurance Committee and the Executive Risk Group. In reviewing the work of the Quality Assurance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.	Annually	Company Secretary	May	On Track
	- To review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ("The Whistle Blowing Policy"). - In undertaking the review, the Committee's objective will be to ensure that arrangements are in place for the proportionate and independent	Annually	Executive Director of People and Culture	June	On Track

	investigation of such matters and for appropriate follow-up action.				
	To review the Trust's systems and processes for the prevention of bribery and receive reports on non-compliance.	Annually	Executive Director of Finance, Estates and Facilities	March	On Track
	To request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. (eg. Conflicts of interest, Declarations of interest)	Adhoc	Executive Director of Finance, Estates and Facilities Company Secretary	Adhoc	On Track
	Receive an assurance map of the organisation's assurance during the previous quarter	Each meeting	Co Sec	Each meeting	On Track
	To request and review specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. Including receiving the annual clinical audit programme	Adhoc	Executive Director of Finance, Estates and Facilities Co Sec		On Track
	- To commission and review value for money studies of the Trust's services and functions and to make recommendations to the Board accordingly	Annual reviews linked to national submissions	Executive Director of Finance, Estates and Facilities	September / December – reliant on timely receipt of output files from NHSE.	On Track

On Track	Due	Overdue	Not Started
----------	-----	---------	-------------

4. Notes for Use

This Work Programme should be reviewed by the Chair and Secretariat at the start of each Programme Year and revisited at each meeting to confirm forthcoming items remain on track.

Each item should map to a specific duty in Section 4 of the Terms of Reference (ToR Ref). Items with no direct duty reference should be marked '—' and reviewed at the annual Committee effectiveness review to confirm they remain within remit.

Where an item is rated Overdue, the Lead should provide a written update to the Chair in advance of the next meeting, and the item should be escalated via the action log if it remains outstanding for more than one cycle.

5. Document Control

Version	Date	Author	Summary of Changes
V1	17/09/2026	Anna Pridmore	Initial draft, aligned to Terms of Reference Section 4

TERMS OF REFERENCE

1. Document Control

Committee / Group Name	Charitable Funds Committee
Reports To	Corporate Trustee
Sub-Groups Reporting In	None
Chair	Catherine Wood -Non-Executive Director
Executive Lead	Hannah Crawford, Executive Director of Therapies and Patient Experience
Secretariat	[Job Title responsible for agenda, minutes and action log]
Version	1
Approved By	Corporate Trustee
Review Date	Annually from date of approval

2. Purpose

The Charitable Funds Committee is established by the Board of Directors acting as Corporate Trustee of the Trust's charitable funds. The Committee provides assurance to the Corporate Trustee that charitable funds are managed, invested and applied in accordance with charity law, the Charity Commission's guidance, NHS Charitable Funds requirements, donor intentions and the objectives of the charity.

The Committee oversees the stewardship, investment, fundraising strategy, financial performance and governance of the charitable funds and ensures that charitable assets are used effectively for public benefit and in furtherance of the charity's objects.

3. Authority

The Committee exercises delegated authority from the Board of Directors acting in its capacity as Corporate Trustee. The Committee may approve expenditure, investment decisions and policies within limits delegated by the Board and in accordance with the Scheme of Delegation.

The Committee shall ensure compliance with the requirements of the Charity Commission, Charities Act 2011, Trustee Act 2000, NHS Charitable Funds guidance and applicable accounting standards.

The Committee is authorised to obtain external legal or other independent professional advice, and to secure the attendance of individuals with relevant experience and expertise, if it considers this necessary.

4. Duties

- 4.1 Ensure the Trust's Charitable activities comply with current legislation and review new legislation and its impact (i.e. Trustees Act 2000, SORP 2005 & The Charities Act 2006, Charities Act 2011).
- 4.2 Set and review an investment policy for the charity and annually review and recommend a Charity Reserves Policy
- 4.3 Appoint brokers to manage the charitable funds (if deemed appropriate). If a broker is appointed, receive at least annual assurance from investment managers regarding performance, ethical considerations and compliance with the Investment Policy and link to the investment policy.
- 4.4 Review the performance of the charities investments (as managed by its brokers, if appropriate).

- 4.5 Review individual fund balances and income and expenditure transactions within the overall charity at each meeting
- 4.6 Seek expenditure plans from individual fund holders where funds are currently not being used.
- 4.7 Agree guidance and procedures for fund holders to apply to access fund balances (within new delegated approval limits established as up to £1k for Fund Managers, up to £10k for Director of Finance, Estates and Facilities, and over £10k the Charitable Funds Committee itself) and oversee the appropriate use of all funds including Trustee Funds.
- 4.8 Review relevant audit recommendations including consideration of Independent Review by external auditors. Review actions from recommendations made by Internal Audit reports.
- 4.9 Review the Annual Report and Accounts for the Charity prior to their submission for approval by the Trust Board and ensuring their production in accordance with the latest accountancy practice and policy as laid down by the Charity Commission for England and Wales.
- 4.10 Oversee the development of the strategy and objectives for the Charity (including any fundraising plans).
- 4.11 Ensure the funds are administered in an efficient and effective method that supports use of the funds.
- 4.12 Ensure the funds are utilised in accordance with the objects of the charity and where stipulated, purposes for which they are given by the donors.
- 4.13 Establish a process for the periodic review to rationalize funds within the powers granted by the Charity Commission where the original objectives have failed or are no longer relevant.
- 4.14 Encourage a culture of income generation and raise the profile of the Charity within the trust and local population to promote fundraising plans.
- 4.15 Approve promotional material of the Charity on behalf of the Trustees to ensure that material used will not place the Charity's reputation at undue risk.
- 4.16 Agree the basis for allocating interest received from investments and applying management and administrative charges.

5. Membership

Role / Job Title	Voting / Non-Voting
Catherine Wood -Chair — Non-executive Director	Voting
Roberta Barker – Non-executive Director	Voting
Jules Preston – Non-executive Director	Voting
Edward Gorringe – Associate Non-executive Director	Non-voting
Hannah Crawford, Lead Executive	Non-voting
Sarah Dexter-Smith	Voting
Kathryn Ellis	Non-Voting
Regular in attendance	
John Chapman	Not applicable

Members are expected to attend a minimum of [80%] of meetings in any 12-month period. Persistent non-attendance will be raised with the Chair and may result in a request to nominate an alternative representative.

6. Quorum

The meeting shall be quorate when a minimum of 3 voting members are present, to include at least one Executive Director and the Chair (or their nominated deputy). No decision may be ratified at a meeting that is not quorate.

7. Frequency and Notice

The Committee shall meet quarterly. Additional meetings may be convened by the Chair where urgent business requires consideration. The agenda and supporting papers shall be circulated to all members no later than 5 working days prior to the meeting.

8. Conduct of Meetings

- All members will declare any conflicts of interest at the start of each meeting and as they arise during discussion.
- Meetings will be conducted in accordance with the Trust's Standing Orders and Standards of Business Conduct Policy.
- Discussions involving identifiable patient information will be conducted with due regard to confidentiality and information governance requirements.
- Minutes will be taken by the Secretariat and approved by the Chair prior to circulation as a true and accurate record.

9. Reporting Arrangements

The Committee will provide a written report, including a summary of key decisions, risks and assurances, to the Corporate Trustee following each meeting. An annual report summarising the Committee's effectiveness against its Terms of Reference will be submitted to the Corporate Trustee each year.

10. Administration

- The Secretariat will be responsible for agenda planning, minute-taking, maintenance of the action log and decision log, and circulation of papers.
- A rolling Work Programme will be maintained alongside these Terms of Reference to ensure all duties are discharged within the appropriate reporting cycle.

11. Review

These Terms of Reference will be reviewed annually, or sooner if required by changes in legislation, regulatory guidance, or Trust governance structures, and approved by the Corporate Trustee.

12. Approval

Approved By	Date Approved
Corporate Trustee	
Next Review Due	Version

WORK PROGRAMME

This Work Programme operationalises the Committee's Terms of Reference, ensuring every duty in Section 4 is discharged within the appropriate reporting cycle. ToR Ref values correspond directly to the duty sub-sections in the Terms of Reference.

1. Programme Details

Committee / Group	Charitable Funds Committee
Linked Terms of Reference	Terms of Reference v 1, approved — duty references below correspond to ToR Section 4
Programme Year	2025/26
Owner	Chair: Catherine Wood, Non-Executive Director / Secretariat: Karen Christon, Deputy Company Secretary
Last Updated	17/09/2026

2. Standing Agenda Items

Ref	Standing Item (every meeting)
1	Welcome, apologies and confirmation of quoracy
2	Declarations of interest
3	Minutes of previous meeting and matters arising / action log review
4	Review of relevant risks on the Board Assurance Framework / risk register
5	Items per Work Programme (see Section 3)
6	Any other business
7	Summary of key decisions and items for escalation

3. Annual Forward Planner

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.1	Ensure the Trust's Charitable activities comply with current legislation and review new legislation and its impact (i.e. Trustees Act 2000, SORP 2005 & The Charities Act 2006, Charities Act 2011).	Annual	Executive Director for Therapies and Patient Experience		On Track
4.2	Set and review an investment policy for the charity.	Annual	Executive Director for Therapies and Patient Experience		On Track
4.3	Appoint brokers to manage the charitable funds (if deemed appropriate). If a broker is appointed, receive at least annual assurance from investment managers regarding performance, ethical considerations and compliance with the Investment Policy and link to the investment policy.	Ad hoc	Executive Director for Therapies and Patient Experience		On Track
4.4	Review the performance of the charities investments (as managed by its brokers, if appropriate).	Six monthly	Associate Director of Finance		On Track
4.5	Review individual fund balances and income and expenditure transactions within the overall charity at each meeting. - Charitable Funds Transaction Report (to provide assurance on use of the funds)	Every meeting	Associate Director of Finance		On Track

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.6	Seek expenditure plans from individual fund holders where funds are not currently being used.	Annual	Associate Director of Finance		On Track
4.7	Agree guidance and procedures for fund holders to apply to access fund balances (within new delegated approval limits established as up to £1k for Fund Managers, up to £10k for Director of Finance, Estates and Facilities and over £10k the Charitable Funds Committee itself) and oversee the appropriate use of all funds including Trustee Funds.	Annual	Associate Director of Finance		On Track
4.8	Review relevant audit recommendations including consideration of Independent Review by External Auditors Review actions from recommendations made by Internal Audit reports.	Ad hoc	Associate Director of Finance		On Track
4.9	Review the Annual Report and Accounts for the charity prior to their submission for approval by the Trust Board and ensuring their production in accordance with the latest accountancy practice and policy as laid down by the Charity Commission for England and Wales. - Charitable Funds draft annual report (to be assured on the robustness of the preparation of the annual report, for consideration by ARC and Board prior to submission to the Charities Commission by 31 January 2027).	Annual	Associate Director of Finance	September 2026	On Track

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
	- External Audit Report and Management Letter				
4.10	Oversee the development of the strategy and objectives for the charity (including any fundraising plans)	Ad hoc	Executive Director for Therapies and Patient Experience		On Track
4.11	Ensure the funds are administered in an efficient and effective method that supports use of the funds.	Six monthly	Associate Director of Finance		On Track
4.12	Ensure the funds are utilised in accordance with the objects of the charity and where stipulated, purposes for which they are given by the donors.	Six monthly	Associate Director of Finance		On Track
4.13	Establish a process for the periodic review to rationalise funds within the powers granted by the Charity Commission where the original objectives have failed or are no longer relevant.	Annual	Associate Director of Finance		On Track
4.14	Encourage a culture of income generation and raise the profile of the charity within the Trust and local population to promote fundraising plans.	Six monthly	Executive Director for Therapies and Patient Experience		On Track
4.15	Approve promotional material of the charity on behalf of the Trustees to ensure that material used will not place the Charity's reputation at undue risk.	Ad hoc	Executive Director for Therapies and Patient Experience		On Track
4.16	Agree the basis for allocating interest from investments and applying management and administration charges.	Ad hoc	Executive Director for Therapies and Patient Experience		On Track

On Track

Due

Overdue

Not Started

4. Notes for Use

This Work Programme should be reviewed by the Chair and Secretariat at the start of each Programme Year, and revisited at each meeting to confirm forthcoming items remain on track.

Each item should map to a specific duty in Section 4 of the Terms of Reference (ToR Ref). Items with no direct duty reference should be marked '—' and reviewed at the annual Committee effectiveness review to confirm they remain within remit.

Where an item is rated Overdue, the Lead should provide a written update to the Chair in advance of the next meeting, and the item should be escalated via the action log if it remains outstanding for more than one cycle.

5. Document Control

Version	Date	Author	Summary of Changes
Version 1	17/09/2026	Anna Pridmore	Initial draft, aligned to Terms of Reference Section 4

TERMS OF REFERENCE

1. Document Control

Committee / Group Name	Finance and Performance Committee
Reports To	Board of Directors
Sub-Groups Reporting In	None
Chair	Jules Preston Chair/Non-Executive Director
Executive Lead	Liz Romaniak, Executive Director of Finance, Estates and Facilities
Secretariat	Sharon Ross, Corporate Governance Manager
Version	V1
Approved By	Board of Directors
Review Date	Annually from date of approval

2. Purpose

The Finance and Performance Committee is established to provide assurance to Board of Directors on the stewardship of the Trust's finances, investments, sustainability, reputation, and operational performance and will provide assurance on the achievement Trust's strategic goal

The Finance and Performance Committee is established under Standing orders 6 of the Board of Directors

3. Authority

The Committee is authorised by Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain external legal or other independent professional advice, and to secure the attendance of individuals with relevant experience and expertise, if it considers this necessary.

4. Duties

4.1 Performance Management

Receive assurance on the following:

- Operational performance against the Trust's operational objectives, annual plan and key performance indicators.
- performance trends, benchmarking information and emerging issues.
- areas of underperformance and seek assurance that robust improvement plans are in place.
- operational performance supports the delivery of safe, effective and patient-centred care.

Receive assurance and understand the work related to:

- Monitoring compliance with national and local mental health access and waiting time standards.
- Reviewing performance relating to:
 - AMH
 - MHSOP

- CYPs
- ALD
- Health and Justice
- Ridgeway (Secure Inpatients Services)
- Receive assurance on performance against response times and service access standards.
- Receive assurance on Performance Improvement Plans where services are failing to meet agreed standards.
- Receive assurance on the Monitoring of progress against performance improvement trajectories.
- Seek assurance of evidence that lessons learned from performance challenges are identified and embedded.
- Seek assurance that performance objectives are being achieved where they interface with acute providers, local authorities, primary care and voluntary sector partners.
- Seek assurance that the Trust is contributing effectively to system-wide mental health performance objectives.

4.2 Operational activity

- Seek assurance regarding waiting list management and reductions in health inequalities affecting access to services.
- Receive assurance on the oversight of demand and capacity planning across inpatient, community and specialist services.
- Seek assurance on the process and impact of Monitoring inpatient bed occupancy, out-of-area placements and delayed discharges.
- Receive assurance on the effectiveness of patient flow through acute, community and crisis pathways and assurance on actions being taken to improve flow and reduce unnecessary admissions and lengths of stay.
- Receive assurance on the monitoring of the responsiveness and effectiveness of urgent and crisis care pathways.
- Seek assurance regarding the availability and resilience of crisis services, including liaison psychiatry and crisis resolution and home treatment teams.
- Seek Assurance that delivery of operational objectives that are dependent upon Integrated Care System (ICS) partners are in place.

4.3 Performance efficiency and Regulators

- Seek assurance on the financial, efficiency and delivery plans linked to operational performance.
- Seek assurance on the NHS Oversight Framework (NOF) quarterly information.
- Receive assurance on the provisions agreed in the winter plan and any financial implications the plan might have for the Trust.

4.4 Finance

- Receive assurance on the development and monitoring of strategic plans as related to the committee's purpose including but not limited to the Medium-Term Financial Plan (MTFP) including analysis of the underlying position and drivers of deficit for the Trust.
- Receive assurance that the Trust understands contractual Income and Expenditure by Commissioner and that MTFPs use data-driven analysis to seek to secure appropriate funding, having regard to:
 - national cost collection outputs by commissioner and
 - emerging deconstructing block contract processes.
- To receive assurance on the development and monitoring of annual financial plans as related to the committee's purpose including but not limited to:
 - The annual financial plan encompassing revenue and capital plans, cashflow, statement of financial position, overall financial risk assessment, scenarios and mitigations, efficiencies and ensuring plans are within overall agreed allocations and/or meet regulatory requirements

- Financial revenue and capital performance oversight including financial run rate assurance, forecasting, efficiencies, assessment of key risks and mitigations, and focus on in-year financial mitigation and/or recovery as appropriate.
- Seek assurance on the NHS Oversight Framework (NOF) quarterly Finance Metrics
- To seek assurance on investments and business cases for strategic projects, gaining assurance on their affordability (both capital and revenue) and seek assurance that they meet due diligence requirements.
- To seek and provide assurance to the Board on the performance of the Trust's subsidiaries and other trading vehicles, including drawing the Board's attention to any risks relating to the regulatory position, financial standing and public confidence in the group.
- To gain assurance on, processes for the robust management of clinical service sub-contracts.
- Receive assurance on the adequacy of the level of performance on contracts and commissioning.
- To identify and escalate any significant risks related to the Committee's purpose and functions to the Board, taking into account agreed risk appetite and tolerances. To review the scope, impact and management of risks contained within the Board Assurance Framework and the Corporate Risk Register, as relevant to the committee's purpose and functions, and to gain assurance on the delivery and effectiveness of mitigation plans.
- To seek assurance that the Trust has appropriate processes for ensuring timely and accurate national cost collection submissions annually.
- To seek assurance on the output from the national cost collection submission and index, corporate services benchmarking submission and other peer benchmarking returns including any insights to inform
 - Review of the annual national cost collection inputs and indexed outputs, corporate services benchmarking submission and other peer benchmarking returns including any insights to inform Commissioning and Financial Planning
 - Commissioner contracting discussions on funding, including linked to national financial frameworks (Deconstructing the Block) and other
 - Internal cost efficiency programme including from internal team level benchmarking and productivity measurement
- Committee has delegated authority to:
 - Approve business cases and investments within the delegated limits set out in the Constitution and Standing Financial Instructions.
 - Approve changes to the business plan priorities subject to them not impacting on the overall delivery of the Trust strategy.
 - Approve the submission of national cost collection information to the Department of Health and Social Care and/or NHS England on its behalf.
 - Provide guidance on any matter related to the Trust's interest in a subsidiary to:
 - The nominee(s) on the Board or equivalent of that subsidiary.
 - If relevant, a person or persons appointed under Section 323 of the Companies Act 2006 to act as the Trust's representative or representatives at any meeting of the subsidiary.
 - Approve metrics to support the monitoring of the committee's purpose and functions.

4.5 Risk Management

- To identify and escalate any significant risks related to the Committee's purpose and functions to the Board, taking into account agreed risk appetite and tolerances.
- To review the scope, impact and management of risks contained within the Board Assurance Framework and the Corporate Risk Register, as relevant to the committee's purpose and functions, and to gain assurance on the delivery and effectiveness of mitigation plans.
- Internal Audit findings, recommendations and management response (assurance that controls are being

- strengthened in accordance with agreed Internal Audit recommendations)
- Annual review of committee's terms of reference and performance (assurance that the functions of the committee are effectively discharged and reflect changing internal and external and BAF context)

5. Membership

Role / Job Title	Voting / Non-Voting
Jules Preston , Non-Executive Director	Voting
John Maddison, Non-executive Director	Voting
Roberta Barker, Non-executive Director	Voting
Liz Romaniak, Executive Director of Finance, Estates and Facilities	Voting
Kedar Kale, Medical Director	Voting
Naomi Lonergan Interim MD for Care Services	Voting

Members are expected to attend a minimum of [80%] of meetings in any 12-month period. Persistent non-attendance will be raised with the Chair and may result in a request to nominate an alternative representative.

- 5.1 The Chair of the committee shall be appointed by the Board of Directors.
- 5.2 Deputy or substitute members may be appointed by members of the committee to attend particular meetings on their behalf, where their absence is unavoidable. Notice of the appointment of a deputy/substitute member must be provided to the Chair of the committee and Company Secretary, in writing, before the meeting commences.
- 5.3 All other Board members all be invited to attend and participate in meetings of the committee (but not to vote). To facilitate this, copies of all agendas and papers for meetings will be provided to them.
- 5.4 Officers of the Trust shall be invited to attend meetings of the Committee to deliver reports and to support the committee's discussions on them.

6. Quorum

The meeting shall be quorate when a minimum of three voting members are present, to include at least one Executive Director and the Chair (or their nominated deputy). No decision may be ratified at a meeting that is not quorate.

7. Frequency and Notice

The Committee shall meet monthly. Additional meetings may be convened by the Chair where urgent business requires consideration. The agenda and supporting papers shall be circulated to all members no later than 5 working days prior to the meeting.

8. Conduct of Meetings

- 8.1 All members will declare any conflicts of interest at the start of each meeting and as they arise during discussion.
- 8.2 Meetings will be conducted in accordance with the Trust's Standing Orders and Standards of Business Conduct Policy.
- 8.3 Discussions involving identifiable patient information will be conducted with due regard to confidentiality and information governance requirements.

- 8.4 Minutes will be taken by the Secretariat and approved by the Chair prior to circulation as a true and accurate record.

9. Reporting Arrangements

The Committee will provide a written report, including a summary of key decisions, risks and assurances to the Board of Directors, following each meeting. An annual report summarising the Committee's effectiveness against its Terms of Reference will be submitted to the Board of Directors each year.

10. Administration

- 10.1 The company secretary, or an officer appointed by them, shall be the secretary of the committee.
- 10.2 The Secretariat will be responsible for agenda planning, minute-taking, maintenance of the action log and decision log, and circulation of papers.
- 10.3 A rolling work programme will be maintained alongside these Terms of Reference to ensure all duties are discharged within the appropriate reporting cycle.

11. Review

These Terms of Reference will be reviewed annually, or sooner if required by changes in legislation, regulatory guidance, or Trust governance structures, and approved by the Board of Directors

12. Approval

Approved By	Date Approved
Next Review Due	Version

WORK PROGRAMME

This Work Programme operationalises the Committee's Terms of Reference, ensuring every duty in Section 4 is discharged within the appropriate reporting cycle.
 ToR Ref values correspond directly to the duty sub-sections in the Terms of Reference.

1. Programme Details

Committee / Group	Finance and Performance Committee
Linked Terms of Reference	Terms of Reference V1, approved — duty references below correspond to ToR Section 4
Programme Year	2026/27
Owner	Chair: Jules Preston Non-Executive Director / Secretariat – S Ross, Corporate Governance Manager
Last Updated	13/9/2026

2. Standing Agenda Items

Ref	Standing Item (every meeting)
1	Welcome, apologies and confirmation of quoracy
2	Declarations of interest
3	Minutes of previous meeting and matters arising / action log review
4	Review of relevant risks on the Board Assurance Framework / risk register
5	Items per Work Programme (see Section 3)
6	Any other business
7	Summary of key decisions and items for escalation

3. Annual Forward Planner

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.1	Operational / Care Group Performance Management				
	Receive assurance on the following: - Operational performance against the Trust's operational objectives, annual plan and key performance indicators. - performance trends, benchmarking information and emerging issues. - areas of underperformance and seek assurance that robust improvement plans are in place. - operational performance supports the delivery of safe, effective and patient-centred care. - IQPR	Monthly	Chief Operating Officer	Monthly	On Track
	Receive assurance and understand the work related to: - Monitoring compliance with national and local mental health access and waiting time standards. - Reviewing performance relating to: - AMH - MHSOP - CYPS - ALD - Health and Justice - Ridgeway (Secure Inpatients Services) - IQPR	Monthly	Chief Operating Officer	Monthly	On Track
	Receive assurance on performance against response times and service access standards. - IQPR	Monthly	Chief Operating Officer		On Track

	• Receive assurance on Performance Improvement Plans where services are failing to meet agreed standards. - IQPR	Monthly	Chief Operating Officer		On Track
	• Receive assurance on the Monitoring of progress against performance improvement trajectories. - IQPR	Monthly	Chief Operating Officer		On Track
	• Seek assurance of evidence that lessons learned from performance challenges are identified and embedded. - IQPR	Monthly	Chief Operating Officer		On Track
	• Seek assurance that performance objectives are being achieved where they interface with acute providers, local authorities, primary care and voluntary sector partners. -	Monthly	Chief Operating Officer		On Track
	• Seek assurance that the Trust is contributing effectively to system-wide mental health performance objectives. -	Monthly	Chief Operating Officer		On Track
4.2	Operational Activity				
	• Seek assurance regarding waiting list management and reductions in health inequalities affecting access to services. -	Quarterly	Chief Operating Officer		On Track
	• Receive assurance on the oversight of demand and capacity planning across inpatient, community and specialist services. -	Six monthly	Chief Operating Officer/ Chief Delivery Officer		On Track
	• Seek assurance on the process and impact of Monitoring inpatient bed occupancy, out-of-area placements and delayed discharges. - Reports that address this duty will be included in 4.1		Chief Operating Officer		On Track
	• Receive assurance on the effectiveness of patient flow through acute, community and crisis pathways and assurance on actions being taken to improve flow and reduce unnecessary admissions and lengths of stay.		Chief Operating Officer		On Track

	-				
	• Receive assurance on the monitoring of the responsiveness and effectiveness of urgent and crisis care pathways.	Quarterly	Chief Operating Officer		On Track
	-				
	• Seek assurance regarding the availability and resilience of crisis services, including liaison psychiatry and crisis resolution and home treatment teams.	Quarterly	Chief Operating Officer		On Track
	-				
	• Seek Assurance that delivery of operational objectives that are dependent upon Integrated Care System (ICS) partners are in place		Chief Operating Officer		On Track
	-				
4.3	Performance efficiency and Regulators				
	• Seek assurance on the financial, efficiency and delivery plans linked to operational performance.		Chief Operating Officer		On Track
	-				
	• Seek assurance on the NHS Oversight Framework (NOF) quarterly Performance information.	Monthly	Chief Operating Officer/ Chief Delivery Officer	Every meeting	On Track
	- IQPR				
	• Receive assurance on the provisions agreed in the winter plan and any financial implications the plan might have for the Trust	Six monthly	Chief Operating Officer		On Track
	-				
4.4	Finance				
	• Receive assurance on the development and monitoring of strategic plans as related to the committee's purpose including but not limited to the Medium-Term Financial Plan (MTFP) including analysis of the underlying position and drivers of deficit for the Trust.	Six-Monthly	Executive Director for Finance, Estates and Facilities		On Track
	-				

	- Receive assurance that the Trust understands contractual Income and Expenditure by Commissioner and that MTFPs use data-driven analysis to seek to secure appropriate funding, having regard to: - national cost collection outputs by commissioner and - emerging deconstructing block contract processes. -		Executive Director for Finance, Estates and Facilities		On Track
	- To receive assurance on the development and monitoring of annual financial plans as related to the committee's purpose including but not limited to: -				On Track
	- The annual financial plan encompassing revenue and capital plans, cashflow, statement of financial position, overall financial risk assessment, scenarios and mitigations, efficiencies and ensuring plans are within overall agreed allocations and/or meet regulatory requirements. - Annual Financial Plan	Annual, or as necessary ahead of Board Approval and submission to regulator	Executive Director for Finance, Estates and Facilities		On Track
	- Financial revenue and capital performance oversight including financial run rate assurance, forecasting, efficiencies, assessment of key risks and mitigations, and focus on in-year financial mitigation and/or recovery as appropriate. - In year Financial Report	At Least Quarterly	Executive Director for Finance, Estates and Facilities		On Track
	- Seek assurance on the NHS Oversight Framework (NOF) quarterly Finance Metrics. - In year Financial Report	At Least Quarterly	Executive Director for Finance, Estates and Facilities		On Track
	To seek assurance on investments and business cases for strategic projects, gaining assurance on their affordability (both capital and revenue) and seek assurance that they meet due diligence	As required	Executive Director for Finance, Estates and Facilities		On Track

	requirements.				
	- Business cases				
	To seek and provide assurance to the Board on the performance of the Trust's subsidiaries and other trading vehicles, including drawing the Board's attention to any risks relating to the regulatory position, financial standing and public confidence in the group.	Six monthly	Executive Director for Finance, Estates and Facilities PIPS Ltd Managing Director		On Track
	- PIPS Ltd Performance reports				
	To gain assurance on, processes for the robust management of clinical service sub-contracts.	Six monthly	Executive Director for Finance, Estates and Facilities		On Track
	- Service contract report				
	To receive assurance that the Trust has appropriate processes for ensuring timely and accurate National Cost Collection submissions annually.	Annual	Executive Director of Finance, Estates and Facilities	June	On Track
	- Costing Transformation Plan and National Cost Collection (formerly Reference Costs) Process assurance				
	To receive assurance that outputs from cost and other benchmarking returns / sources are being used to improve value for money and productivity, including:	Annual			On Track
	- Review of the annual national cost collection inputs and indexed outputs, corporate services benchmarking submission and other peer benchmarking returns including any insights to inform Commissioning and Financial Planning - Commissioner contracting discussions on funding, including linked to national financial frameworks (Deconstructing the Block) and other - Internal cost efficiency programme including from internal team level benchmarking and productivity measurement	Annual	Executive Director of Finance, Estates and Facilities		

	• Committee has delegated authority to:				
	• Approve business cases and investments within the delegated limits set out in the Constitution and Standing Financial Instructions.	Ad hoc	Executive Director of Finance, Estates and Facilities		On Track
	• Approve the processes to ensure timely submission of national cost collection information to the Department of Health and Social Care and/or NHS England on its behalf.	Annual	Executive Director of Finance, Estates and Facilities		On Track
	• Provide guidance on any matter related to the Trust's interest in a subsidiary to: - The nominee(s) on the Board or equivalent of that subsidiary. - If relevant, a person or persons appointed under Section 323 of the Companies Act 2006 to act as the Trust's representative or representatives at any meeting of the subsidiary.	Ad hoc	Executive Director of Finance, Estates and Facilities		On Track
	• Approve metrics to support the monitoring of the committee's purpose and functions.	Ad hoc	Chair		On Track
4.5	Risk Management				
	• To review the scope, impact and management of risks contained within the Board Assurance Framework and the Corporate Risk Register, as relevant to the committee's purpose and functions, and to gain assurance on the delivery and effectiveness of mitigation plans.	Monthly	Company Secretary	Monthly	On Track
	• To identify and escalate any significant risks related to the Committee's purpose and functions to the Board, taking into account agreed risk appetite and tolerances	Ad hoc	Chair	Adhoc	On Track
	• Internal Audit findings, recommendations and management response (assurance that controls are being strengthened in	Quarterly	Executive Director for Finance, Estates and Facilities		On Track

	accordance with agreed Internal Audit recommendations)		Associate Director of Finance		
	Annual review of committee's terms of reference and performance (assurance that the functions of the committee are effectively discharged and reflect changing internal and external and BAF context)	Annual	Chair		On Track

On Track	Due	Overdue	Not Started
----------	-----	---------	-------------

4. Notes for Use

This Work Programme should be reviewed by the Chair and Secretariat at the start of each Programme Year, and revisited at each meeting to confirm forthcoming items remain on track.

Each item should map to a specific duty in Section 4 of the Terms of Reference (ToR Ref). Items with no direct duty reference should be marked '—' and reviewed at the annual Committee effectiveness review to confirm they remain within remit.

Where an item is rated Overdue, the Lead should provide a written update to the Chair in advance of the next meeting, and the item should be escalated via the action log if it remains outstanding for more than one cycle.

5. Document Control

Version	Date	Author	Summary of Changes
1.0	13/09/2026	Anna Pridmore	Initial draft, aligned to Terms of Reference Section 4

TERMS OF REFERENCE

1. Document Control

Committee / Group Name	Mental Health Legislation Committee
Reports To	Board of Directors
Sub-Groups Reporting In	None
Chair	Nini Adetuberu Non-Executive Director
Executive Lead	K Kale, Executive Medical Director
Secretariat	D Keeping, Corporate Governance Manager
Version	[0.1]
Approved By	Board of Directors
Review Date	Annually from date of approval

2. Purpose

The Mental Health Legislation Committee is established to provide assurance to the Board of Directors that the Trust is meeting its statutory, regulatory and quality obligations in relation to the Mental Health Act 1983 as amended by the Mental Health Act 2007 and 2025; Mental Capacity Act 2005 and associated statutory Codes of Practice.

The Mental Health Legislation Committee is established under Standing Orders 6 of the Board of Directors

The Committee contributes to the oversight of the safety, quality, effectiveness and experience of care provided to people who use mental health, learning disability and/or community services, ensuring that risks to patients, staff and the organisation are identified, escalated and mitigated appropriately.

3. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain external legal or other independent professional advice, and to secure the attendance of individuals with relevant experience and expertise, if it considers this necessary.

4. Duties

4.1 Quality, Safety and Clinical Governance

- Monitor compliance with the Mental Health Act 1983 (as amended) and its Code of Practice, including use of detention powers, Community Treatment Orders and Section 17 leave.
- Monitor compliance with the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS)
- Receive assurance on the reduction of restrictive practices, including seclusion, segregation, rapid tranquillisation and physical restraint, in line with national reduction programmes.
- Identify themes arising from the findings of the Care Quality Commission (CQC) following visits to Trust services and to gain assurance that appropriate learning and action is being undertaken in relation to them. The monitoring of the delivery of actions arising from CQC visits will be undertaken by the Quality Assurance Committee (QAC).

- To gain assurance that the Trust actively listens to, and learns from, the experiences of service users, families and carers in the application of mental health legislation
 - To receive assurance where the application of the mental health legislation is a contributory factor to learning arising from serious incidents, deaths, complaints, claims, coronial processes, Ombudsman investigations and external reviews.
 - To gain assurance that the Trust is acting in accordance with the Mental Health Act Scheme of Delegation.
 - To undertake an annual review of the Scheme of Delegation, prepared in accordance with the Mental Health Act Code of Practice, and to make recommendations relating to its confirmation to the Board of Directors.
 - To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to advise the Board accordingly.
 - To review national reports on mental health legislation as appropriate.
 - To receive assurance on the implementation of any policies and procedures relating to mental health legislation.
- To assess compliance with mental health legislation through the establishment and monitoring of a range of appropriate metrics.
- To receive assurance regarding the operation and effectiveness of application of the Mental Health Act for example number of Hospital Managers' or Tribunal discharges, Independent Mental Health Advocacy, consent to treatment provisions and patients' rights.

4.2 Workforce and Culture

- To ensure appropriate arrangements are in place for the appointment and appraisal of associate managers and to oversee managers' hearings.
- To receive assurance that mental health legislation is applied in a manner that promotes equality, human rights and least restrictive practice, including oversight of any disproportionality in the use of detention, Community Treatment Orders and restrictive interventions.

4.3 Risk Management

- Taking into account agreed risk appetite and tolerances, to identify and escalate any significant risks to the delivery of its purpose and functions to the Board and to provide guidance on appropriate mitigations.
- Maintain oversight of the relevant sections of the Board Assurance Framework and Corporate Risk Register.

5. Membership

Role / Job Title	Voting / Non-Voting
Nini Adetuberu Chair— Non-executive Director	Voting
Cathrine Wood Non-executive Directors	Voting
Jules Preston – Non-executive Director	Voting
Kedar Kale Executive Medical Director - Lead Executive Director	Voting
Beverley Murphy Chief Nursing Office / Deputy Chief Executive	Voting
Kathryn Ellis Interim Director of Strategy and Transformation	Voting

Members are expected to attend a minimum of [75%] of meetings in any 12-month period. Persistent non-attendance will be raised with the Chair

5.1 Attendance at meetings

- All other Board members shall be invited to attend and participate in meetings of the Committee (but not to vote).
- To facilitate this, copies of all agendas and papers for meetings will be provided to them.
- Officers of the Trust shall be invited to attend meetings of the Committee to deliver reports and to support the Committee's discussions on them.
- Subject to the agreement of the Board, to invite a specified number of service users or carers to attend and participate in meetings of the Committee (but not to vote) in order to gain their perspectives on the matters under consideration.

6. Quorum

- The meeting shall be quorate when a minimum of three members are present, to include at least one Executive Director and the Chair (or their nominated deputy). No decision may be ratified at a meeting that is not quorate.

7. Frequency and Notice

- The Committee shall meet quarterly. Additional meetings may be convened by the Chair where urgent business requires consideration. The agenda and supporting papers shall be circulated to all members no later than 5 working days prior to the meeting.

8. Conduct of Meetings

- All members will declare any conflicts of interest at the start of each meeting and as they arise during discussion.
- Meetings will be conducted in accordance with the Trust's Standing Orders and Standards of Business Conduct Policy.
- Discussions involving identifiable patient information will be conducted with due regard to confidentiality and information governance requirements.
- Minutes will be taken by the Secretariat and approved by the Chair prior to circulation as a true and accurate record.

9. Reporting Arrangements

- The Committee will provide a written report, including a summary of key decisions, risks and assurances, to the Board of Directors following each meeting. An annual report summarising the Committee's effectiveness against its Terms of Reference will be submitted to the Board of Directors each year.

10. Administration

- The Secretariat will be responsible for agenda planning, minute-taking, maintenance of the action log and decision log, and circulation of papers.
- A rolling Work Programme will be maintained alongside these Terms of Reference to ensure all duties are discharged within the appropriate reporting cycle.
- The Company Secretary, or an officer appointed by him/her, shall be the Secretary of the Committee.

11. Review

- These Terms of Reference will be reviewed annually, or sooner if required by changes in legislation, regulatory guidance, or Trust governance structures, and approved by the Board of Directors

12. Approval

Approved By	Date Approved
Next Review Due	Version

WORK PROGRAMME

This Work Programme operationalises the Committee's Terms of Reference, ensuring every duty in Section 4 is discharged within the appropriate reporting cycle. ToR Ref values correspond directly to the duty sub-sections in the Terms of Reference.

1. Programme Details

Committee / Group	Mental Health Legislation Committee
Linked Terms of Reference	Terms of Reference V1 , approved — duty references below correspond to ToR Section 4
Programme Year	2026/27
Owner	Chair – N Adetuberu / Secretariat – D Keeping, Corporate Governance Manager
Last Updated	13/09/2026

2. Standing Agenda Items

Ref	Standing Item (every meeting)
1	Welcome, apologies and confirmation of quoracy
2	Declarations of interest
3	Minutes of previous meeting and matters arising / action log review
4	Review of relevant risks on the Board Assurance Framework / risk register
5	Items per Work Programme (see Section 3)
6	Any other business
7	Summary of key decisions and items for escalation

3. Annual Forward Planner

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.1	Monitor compliance with the Mental Health Act 1983 (as amended) and its Code of Practice, including use of detention powers, Community Treatment Orders and Section 17 leave - MH Legislation Combined Assurance Report - Report from multi-agency and Internal MH Ops Groups - Human Rights, Equality & Diversity Report - PCREF - MHA Detention Rates - Section 17 Leave Audit and Improvement Plan - Section 5 - MHL combined Assurance Report	Quarterly (every meeting)	Executive Medical Director	Every meeting	On Track
4.1	Monitor compliance with the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) - MH Legislation Combined Assurance Report - Response to the Consultation on MHA Reforms	Quarterly (every meeting) as appropriate Six monthly	Executive Medical Director Executive Medical Director	Every meeting October, May	On Track
4.1	Receive assurance on the reduction of restrictive practices, including seclusion, segregation, rapid tranquillisation and physical restraint, in line with national reduction programmes.	Quarterly (every meeting)	Executive Chief Nurse	Every meeting	On Track

	Positive and Safe Report, including Use of Forces Act				
4.1	Identify themes arising from the findings of the Care Quality Commission (CQC) following visits to Trust services and to gain assurance that appropriate learning and action is being undertaken in relation to them. The monitoring of the delivery of actions arising from CQC visits will be undertaken by the Quality Assurance Committee (QAC). - Progress of CQC MHA Monitoring Activity (for information) - Section 17 Leave and time away from the ward (for information) - Positive and Safe Report (for information)	Quarterly (every meeting) Quarterly (every meeting) Quarterly (Every meeting)	Executive Chief Nurse Executive Medical Director Executive Chief Nurse	Every meeting	On Track
4.1	Gain assurance that the Trust actively listens to, and learns from, the experiences of service users, families and carers in the application of mental health legislation. - Individual Case Study including staff voice (rotating basis) - Advocacy and Patient Rights Network (rotating basis) - Patient Advocacy Assurance Report (rotating basis) - Patient Voice Report (title tbc). (rotating basis) - MHL assurance report	Quarterly (every meeting)	Executive Medical Director	Each meeting	On Track
4.1	To receive assurance where the application of the mental health legislation is a contributory factor to learning arising from serious incidents, deaths,	Six monthly	Executive Medical Director	Every other meeting	On Track

	complaints, claims, coronial processes, Ombudsman investigations and external reviews. - Oversight of all other reports				
4.1	Gain assurance that the Trust is acting in accordance with the Mental Health Act Scheme of Delegation. - Oversight of all other reports included in the agenda at each meeting				On Track
4.1	To undertake an annual review of the Scheme of Delegation, prepared in accordance with the Mental Health Act Code of Practice, and to make recommendations relating to its confirmation to the Board of Directors. Annual scheme of delegation	Annual	Executive Medical Director		On Track
	To consider the implications of any changes to statute, including statutory Codes of Practice, or case law relating to the Trust's responsibilities as a provider of mental health services and to advise the Board accordingly. Supreme Court Judgement (Deprivation of Liberty)	Ad hoc	Executive Medical Director		On Track
	Review national reports on mental health legislation Reports from CQC (for information)	Ad hoc	Executive Medical Director/ Executive Chief Nurse	Ad hoc	On Track
	To receive assurance on the implementation of any policies and procedures relating to mental health legislation. - Annual audit of policy and list of policy updates	May	Executive Medical Director	May	On Track
4.1	To receive assurance regarding the operation and effectiveness of application of the Mental Health Act for example number of Hospital Managers' or	Quarterly (every meeting)	Executive Medical Director	Each meeting	On Track

	Tribunal discharges, Independent Mental Health Advocacy, consent to treatment provisions and patients' rights. • Combined ML assurance report • consent to treatment (do we need a report)				
4.1	Assess compliance with mental health legislation through the establishment and monitoring of a range of appropriate metrics. • Progress of CQC MHA Monitoring Activity • Integrated Quality Performance Report	Dashboard (quarterly)	Executive Medical Director	Each meeting	On Track
4.2	To receive assurance that mental health legislation is applied in a manner that promotes equality, human rights and least restrictive practice, including oversight of any disproportionality in the use of detention, Community Treatment Orders and restrictive interventions. • Equality and Diversity report • PCREF	Annually	Executive Medical Director		On Track
4.3 Risk management	Taking into account agreed risk appetite and tolerances, to identify and escalate any significant risks to the delivery of its purpose and functions to the Board and to provide guidance on appropriate mitigations. • Issues to escalate to Board	Quarterly	Executive Medical Director	Each meeting	On Track
4.3	Maintain oversight of the relevant sections of the Board Assurance Framework and Corporate Risk Register. • Board Assurance Framework/Corporate Risk Register	Quarterly	Company Secretary	Each meeting	On Track

—	Annual Committee effectiveness review & ToR review - Annual Developmental meeting - Review of terms of reference - Assurance tracker	Annual	Chair	March	On Track
On Track	Due	Overdue	Not Started		

4. Notes for Use

This Work Programme should be reviewed by the Chair and Secretariat at the start of each Programme Year, and revisited at each meeting to confirm forthcoming items remain on track.

Each item should map to a specific duty in Section 4 of the Terms of Reference (ToR Ref). Items with no direct duty reference should be marked '—' and reviewed at the annual Committee effectiveness review to confirm they remain within remit.

Where an item is rated Overdue, the Lead should provide a written update to the Chair in advance of the next meeting, and the item should be escalated via the action log if it remains outstanding for more than one cycle.

5. Document Control

Version	Date	Author	Summary of Changes
0.1 DRAFT	[DD Month YYYY]	[Name]	Initial draft, aligned to Terms of Reference Section 4

TERMS OF REFERENCE

1. Document Control

Committee / Group Name	Nomination and Remuneration Committee
Reports To	Board of Directors
Sub-Groups Reporting In	[List any sub-committees or working groups, or state 'None']
Chair	Marie Burnham Chair
Executive Lead	Alison Smith
Secretariat	A Pridmore, Interim Company Secretary
Version	V1
Approved By	Board of Directors
Review Date	Annually from date of approval

2. Purpose

The Nomination and Remuneration Committee is established under Standing Order 6 of the Board of Directors. The Standing Orders of the Board of Directors, as far as they are applicable and with any appropriate alterations, shall apply to meetings of the Committee. To contribute to the delivery of Our Journey to Change by ensuring that the Executive Leadership Team has the required skills, expertise and experience.

To ensure compliance with relevant provisions of the Foundation Trust Code of Governance.

The Committee provides oversight of the safety, quality, effectiveness and experience of care provided to people who use mental health, learning disability and/or community services, ensuring that risks to patients, staff and the organisation are identified, escalated and mitigated appropriately.

3. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain external legal or other independent professional advice, and to secure the attendance of individuals with relevant experience and expertise, if it considers this necessary.

4. Duties

4.1 Appointments

To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and to make recommendations to the Board with regard to any changes.

- To gain assurance on the maintenance of an effective succession plan for Executive Director and Very Senior Manager roles which promotes diversity in accordance with the Equality Act 2010, Equality Delivery Systems and Workforce Equality Standards and takes account of future challenges, risks, opportunities and skills required within the Board of Directors.
 - Promotes diversity in accordance with the Equality Act 2010, NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Equality Standards and which describes how senior managers will in percentage terms at least mirror our overall workforce and local communities.

- Takes into account the future challenges, risks and opportunities facing the Trust, and the skills and expertise required within the Board of Directors to meet them.
- To be responsible for appointing the Chief Executive subject to the approval of the Council of Governors.
- To be responsible for appointing Executive Directors.
- To confirm any matter relating to the continuation in office of any Executive Director (including the Chief Executive) or Directors covered by Very Senior Manager contracts including suspension or termination.

4.2 Remuneration

To be responsible for reviewing and determining the terms and conditions of office of the Chief Executive, the Medical Director and Directors covered by VSM contracts (except where these are determined nationally) including:

- a. Salary including any performance related pay or bonus
 - b. Provisions for other benefits including pensions
 - c. Allowances
 - d. Pay Award for VSM colleagues
- To gain assurance through benchmarking information that the terms and conditions of employment, including levels of remuneration are sufficient to attract, retain and motivate the Chief Executive, the Medical Director and Directors covered by VSM contracts (except where these are determined nationally).
 - To receive reports on the performance of the Chief Executive, the Medical Director and Directors covered by VSM contracts, as required, to support the consideration of any decisions affecting their remuneration.
 - To receive reports on the performance of the Chief Executive, the Medical Director and Directors covered by VSM contracts, as required, to support the consideration of any decisions affecting their remuneration.
 - To advise upon and oversee contractual arrangements for the Chief Executive, the Medical Director and Directors covered by VSM contracts (except where these are determined nationally) including but not limited to termination payments.

4.3 Miscellaneous

To be responsible for authorising applications to NHS England and HM Treasury for permission to make a special severance payment.

- To consider the engagement or involvement of any suitably qualified adviser to assist with any aspect of its responsibilities.
- Monitor staff safety incidents, including violence and aggression towards staff, and the effectiveness of mitigation plans.
- Receive reports from the Freedom to Speak Up Guardian relevant to mental health services.

4.4 Risk Management

- Maintain oversight of the relevant sections of the Board Assurance Framework and Corporate Risk Register.
- Escalate any risk rated [15 or above / as defined by Trust risk matrix] to [Trust Board / parent committee] without delay.

5. Membership

Role / Job Title	Voting / Non-Voting
Chair — [Non-Executive Director / Executive Director]	Voting
Director of Nursing & Quality (or deputy)	Voting
Medical Director (or deputy)	Voting
Director of Operations (or deputy)	Voting
Approved Clinician / Responsible Clinician representative	Voting
Head of Mental Health Act Office	Non-Voting
Lead for Safeguarding (Adults & Children)	Non-Voting
Patient / Carer Experience Representative	Non-Voting
Freedom to Speak Up Guardian (by invitation)	Non-Voting
[Additional member]	[Voting / Non-Voting]

Members are expected to attend a minimum of [80%] of meetings in any 12-month period. Persistent non-attendance will be raised with the Chair and may result in a request to nominate an alternative representative.

6. Quorum

The meeting shall be quorate when at least three Committee members are present. No decision may be ratified at a meeting that is not quorate.

7. Frequency and Notice

The Committee shall meet as and when required on dates and times agreed by the Chair. The agenda and supporting papers shall be circulated to all members no later than 3 working days prior to the meeting.

8. Conduct of Meetings

- All members will declare any conflicts of interest at the start of each meeting and as they arise during discussion.
- Meetings will be conducted in accordance with the Trust's Standing Orders and Standards of Business Conduct Policy.
- Discussions involving identifiable patient information will be conducted with due regard to confidentiality and information governance requirements.
- Minutes will be taken by the Secretariat and approved by the Chair prior to circulation as a true and accurate record.

9. Reporting Arrangements

The Committee will provide a written report, including a summary of key decisions, risks and assurances, to the Board of Directors following each meeting. An annual report summarising the Committee's effectiveness against its Terms of Reference will be submitted to [Trust Board] by [month] each year.

10. Administration

- The Secretariat will be responsible for agenda planning, minute-taking, maintenance of the action log and decision log, and circulation of papers.

- A rolling Work Programme will be maintained alongside these Terms of Reference to ensure all duties are discharged within the appropriate reporting cycle.

11. Review

These Terms of Reference will be reviewed annually, or sooner if required by changes in legislation, regulatory guidance, or Trust governance structures, and approved by Board of Directors.

12. Approval

Approved By	Date Approved
Next Review Due	Version

WORK PROGRAMME

This Work Programme operationalises the Committee's Terms of Reference, ensuring every duty in Section 4 is discharged within the appropriate reporting cycle. ToR Ref values correspond directly to the duty sub-sections in the Terms of Reference.

1. Programme Details

Committee / Group	Nomination and Remuneration Committee of the Board of Directors
Linked Terms of Reference	Terms of Reference V1 approved:, — duty references below correspond to ToR Section 4
Programme Year	[2025/26]
Owner	Chair: M Burnham, Trust Chair / Secretariat: A Pridmore, Interim Company Secretary and Director of Governance
Last Updated	17/09/2026

2. Standing Agenda Items

Ref	Standing Item (every meeting)
1	Welcome, apologies and confirmation of quoracy
2	Declarations of interest
3	Minutes of previous meeting and matters arising / action log review
4	Review of relevant risks on the Board Assurance Framework / risk register
5	Items per Work Programme (see Section 4)
6	Any other business
7	Summary of key decisions and items for escalation

3. Annual Forward Planner

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.1	Appointment To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and to make recommendations to the Board with regard to any changes.				
	Executive restructure proposals	Ad-hoc	Chief Executive Executive Director for People and Culture		
	To gain assurance on the maintenance of an effective succession plan for Executive Director and Very Senior Manager roles which: - Promotes diversity in accordance with the Equality Act 2010, NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Equality Standards and which describes how senior managers will in percentage terms at least mirror our overall workforce and local communities. - Takes into account the future challenges, risks and opportunities facing the Trust, and the skills and expertise required within the Board of Directors to meet them.	Ad hoc			
	To be responsible for appointing the Chief Executive subject to the approval of the Council of Governors.	Ad-hoc			
	To be responsible for appointing Executive Directors.				

	To confirm any matter relating to the continuation in office of any Executive Director (including the Chief Executive) or Directors covered by the Very Senior Manager (VSM) contracts at any time including suspension or termination of an individual as an employee of the Trust.				
4.2	Remunerations To be responsible for reviewing and determining the terms and conditions of office of the Chief Executive, the Medical Director and Directors covered by VSM contracts (except where these are determined nationally) including: a. Salary including any performance related pay or bonus b. Provisions for other benefits including pensions c. Allowances d. Pay Award for VSM colleagues	Annual	Executive Director for People and Culture		
	To gain assurance, through the consideration of benchmarking information, that the terms and conditions of employment, including levels of remuneration are sufficient to attract, retain and motivate the Chief Executive, the Medical Director and Directors covered by VSM contracts (except where these are determined nationally).	Ad hoc			
	To receive reports on the performance of the Chief Executive, the Medical Director and Directors covered by VSM contracts, as required, to support the consideration of any decisions affecting their remuneration.	Adhoc			
	To advise upon and oversee contractual arrangements for the Chief Executive, the Medical Director and Directors covered by	Ad hoc			

	VSM contracts (except where these are determined nationally) including but not limited to termination payments.				
	To be responsible for reviewing and deciding locally determined terms and conditions of service for all Trust staff.	Ad hoc			
4.3	To receive reports on the outcome of the annual appraisals of the Chief Executive, and the Executive Directors who sit on the board including assurance that they remain fit and proper persons to be directors of an NHS Foundation Trust as required by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	Ad hoc			
	Executive Appraisals approach (proposals to strengthen the executive appraisal process and provide a consistent approach to engagement of NED colleagues in the process)	Ad-hoc	Chief Executive Executive Director for People and Culture	April 2026	
	Executive appraisals (to provide assurance that a robust process has been completed for annual appraisals and objective setting and to summarise the outcome)	Annual	Chief Executive Executive Director for People and Culture		
4.3	Miscellaneous To be responsible for authorising applications to NHS England and HM Treasury for permission to make a special severance payment. - To consider the engagement or involvement of any suitably qualified adviser to assist with any aspect of its responsibilities. - Monitor staff safety incidents, including violence and aggression towards staff, and the effectiveness of mitigation plans.	Ad hoc			

	Receive reports from the Freedom to Speak Up Guardian relevant to mental health services.				
4.4	Risk Management - Maintain oversight of the relevant sections of the Board Assurance Framework and Corporate Risk Register. - Escalate any risk rated [15 or above / as defined by Trust risk matrix] to [Trust Board / parent committee] without delay.	Ad hoc	Chief Executive		

On Track	Due	Overdue	Not Started
-----------------	------------	----------------	--------------------

4. Notes for Use

This Work Programme should be reviewed by the Chair and Secretariat at the start of each Programme Year, and revisited at each meeting to confirm forthcoming items remain on track.

Each item should map to a specific duty in Section 4 of the Terms of Reference (ToR Ref). Items with no direct duty reference should be marked '—' and reviewed at the annual Committee effectiveness review to confirm they remain within remit.

Where an item is rated Overdue, the Lead should provide a written update to the Chair in advance of the next meeting, and the item should be escalated via the action log if it remains outstanding for more than one cycle.

5. Document Control

Version	Date	Author	Summary of Changes
Version 1	[17/09/2026	Anna Pridmore	Initial draft, aligned to Terms of Reference Section 4



--	--	--	--

TERMS OF REFERENCE

1. Document Control

Committee / Group Name	People & Culture Committee
Reports To	Board of Directors
Sub-Groups Reporting In	[List any sub-committees or working groups, or state 'None']
Chair	Roberta Barker, Non-Executive Director
Executive Lead	S Dexter-Smith, Executive Director, People and Culture
Secretariat	S Ross, Corporate Governance Manager
Version	V1
Approved By	Boar of Directors
Review Date	Annually from date of approval

2. Purpose

The People and Culture Committee is established under Standing Order 6 of the Board of Directors. The Committee operates in accordance with the Standing Orders of the Board of Directors. The Committee is the lead provider of oversight and assurance, on behalf of the Board of Directors, regarding delivery of the Trust's Strategic Goal "To co-create a great experience for our colleagues" through the Trust's People Journey.

The Committee provides oversight of the Trust's strategic workforce needs (including wellbeing, culture, recruitment, retention, development of people, and organisational capacity) and plans to progress their delivery, against organisational regional and national drivers as well as regulatory and legal frameworks. Workforce refers to substantive, temporary student, volunteer and apprenticeship groups.

3. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain external legal or other independent professional advice, and to secure the attendance of individuals with relevant experience and expertise, if it considers this necessary.

4. Duties

- 4.1. To receive assurance on and make recommendations to the Board in relation to whether:
 - The Trust understands its strategic workforce needs including wellbeing, culture, recruitment, retention, development of people and organisational capacity) and to oversee the development and monitoring of plans to progress their delivery. Using the Workforce Strategy Delivery Report (including metrics and information on apprenticeships
 - To provide assurance that agreed performance standards are being met, or reasonable remedial action is being taken. Metrics being used include the People and Culture dashboard, national staff

survey, national quarterly pulse survey, NHS staff standards, and national oversight framework and any other appropriate metrics.

- To provide assurance the Trust is meeting its responsibilities for monitoring apprenticeship provision; safeguarding apprenticeships and making the best use of apprenticeship opportunities.
- To receive assurance using the Inclusive Cultures Report including compliance with the Equality Act 2010 including the Public Sector Equality Duty and Accessibility of Trust buildings. With specific reference to NHS staff standards

4.2 To receive assurance that:

- the Trust's values are being practiced within all services and at all levels of the organisation through the behaviour of all colleagues.
- The Trust is compliant with its statutory, regulatory and contractual obligations as an employer including but not limited to the Equality Act 2010 including the Public Sector Equality Duty. That the trust understands the workforce it has and the triangulation of trends across different data sources.
- The health and wellbeing of staff is being effectively promoted and supported.
- appropriate action is taken to support the transformation of services and teams where issues are identified.
- Arrangements for raising concerns, including the functions of the Freedom to Speak up Guardian, meet national expectations and have the confidence of staff.
- The leaders and managers of the organisation are appropriately recruited and trained, reflecting an inclusive and evidence-based approach to the development of these roles.
- Appropriate arrangements are in place to support and maintain good relations with employees including through their recognised trade unions and professional bodies.
- That appropriate training and supervision is in place for all staff.

4.3 To receive assurance that the Trust is keeping abreast of changes in employment law and regulation; to draw the Board's attention to any significant risks and implications arising from them; and to obtain assurance on the appropriateness of mitigating actions proposed by management.

4.4 To assess the delivery of its purpose through the People and Culture Dashboard, plus any other appropriate metrics as detailed in the ToR.

4.5 Receive assurance on the risks and BAF elements and Corporate Risk Register allocated to the Committee and identify and escalate any significant risks related to the Committee's purpose and functions to the Board of Directors.

4.6 To review and make recommendations to the Board on:

- Changes to the staffing establishment and workforce planning, including financial and staffing implications, arising from strategic staffing reviews, major service changes or where quality or workforce concerns are identified which could impact on the delivery of 'Our Journey to Change' or the Trust's statutory and regulatory obligations.
- The appropriateness of the findings of external staffing reviews, including culture reviews, and the management's response to them. In doing so the Committee shall take advice from the Quality Assurance Committee where quality issues/concerns are identified.

- Internal Audit findings, recommendations and management response (assurance that controls are being strengthened in accordance with agreed Internal Audit recommendations)
 - Appraisal, revalidation, disciplinary and job plans (To highlight compliance rates for appraisal and revalidation amongst doctors and explain the processes in place to support this. To highlight doctors who were managed under 'responding concerns' for the reporting period. To detail compliance and disputes for job planning.
 - The progress against actions undertaken by management to tackle NHS workforce equality and diversity issues including, but not limited to, the delivery of improvements on:
 - Pay gaps
 - National equality and diversity standards (including WRES, WDES, SOWES)
- 4.7 Review of the committee's terms of reference to ensure its functions are effectively discharged/ reflect changing internal, external and BAF context.
- 4.8 Review of the committee's performance to consider the committee's effectiveness in delivering its terms of reference and to identify any improvements required.

5. Membership

Role / Job Title	Voting / Non-Voting
Roberta Barker, Chair, Non-Executive Director	Voting
Phil Corrigan, Non-Executive Director	Voting
Edward Gorringe, Associate Non-Executive Director	Non-Voting
Beverley Murphy, Chief Nurse / Deputy CEO	Voting
Sarah Dexter Smith, Executive Director of People and Culture and Executive Lead	Voting
Hannah Crawford, Executive Director of Therapies and Patient Experience	Non-Voting

Members are expected to attend a minimum of [75 %] of meetings in any 12-month period. Persistent non-attendance will be raised with the Chair and may result in a request to nominate an alternative representative.

6. Quorum

The meeting shall be quorate when a minimum of three voting members are present, to include at least one Executive Director. No decision may be ratified at a meeting that is not quorate.

7. Frequency and Notice

The Committee shall meet bimonthly. The arrangements for these meetings shall be set to support the timely provision of assurance to the Board. The agenda and supporting papers shall be circulated to all members no later than 3 working days prior to the meeting.

8. Conduct of Meetings

- All members will declare any conflicts of interest at the start of each meeting and as they arise during discussion.

- Meetings will be conducted in accordance with the Trust's Standing Orders and Standards of Business Conduct Policy.
- Discussions involving identifiable patient information will be conducted with due regard to confidentiality and information governance requirements.
- Minutes will be taken by the Secretariat and approved by the Chair prior to circulation as a true and accurate record.

9. Reporting Arrangements

The Committee will provide a written report, including a summary of key decisions, risks and assurances, to the Board of Directors following each meeting. An annual report summarising the Committee's effectiveness against its Terms of Reference will be submitted to the Board of Directors annually.

10. Administration

- The Secretariat will be responsible for agenda planning, minute-taking, maintenance of the action log and decision log, and circulation of papers.
- A rolling Work Programme will be maintained alongside these Terms of Reference to ensure all duties are discharged within the appropriate reporting cycle.

11. Review

These Terms of Reference will be reviewed annually, or sooner if required by changes in legislation, regulatory guidance, or Trust governance structures, and approved by the Board of Directors

12. Approval

Approved By	Date Approved
Next Review Due	Version

WORK PROGRAMME

This Work Programme operationalises the Committee's Terms of Reference, ensuring every duty in Section 4 is discharged within the appropriate reporting cycle. ToR Ref values correspond directly to the duty sub-sections in the Terms of Reference.

1. Programme Details

Committee / Group	People and Culture Committee
Linked Terms of Reference	Terms of Reference v1 approved — duty references below correspond to ToR Section 4
Programme Year	2025/2026
Owner	Chair: Roberta Barker, Non-Executive / Secretariat: Sharon Ross, Corporate Governance Manager
Last Updated	17/09/2026

2. Standing Agenda Items

Ref	Standing Item (every meeting)
1	Welcome, apologies and confirmation of quoracy
2	Declarations of interest
3	Minutes of previous meeting and matters arising / action log review
4	Review of relevant risks on the Board Assurance Framework / risk register
5	Items per Work Programme (see Section 3)
6	Any other business
7	Summary of key decisions and items for escalation
8	Review of the Committee Work Programme

3. Annual Forward Planner

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.1	To receive assurance that the Trust understands its strategic workforce needs (including wellbeing, culture, recruitment, retention, development of people and organisational capacity) and to oversee the development and monitoring of plans to progress their delivery. Using the Workforce Strategy Delivery Report (including metrics and information on apprenticeships				
	To provide assurance that agreed performance standards are being met, or reasonable remedial action is being taken. Metrics being used include the People and Culture dashboard, national staff survey, national quarterly pulse survey, NHS staff standards, and national oversight framework and any other appropriate metrics.	Each meeting	Executive Director for People and Culture	Each meeting	On track
	To provide assurance the Trust is meeting its responsibilities for monitoring apprenticeship provision; safeguarding apprenticeships and making the best use of apprenticeship opportunities	biannually	Head of Workforce Strategy & Systems		On track
	To receive assurance using the Inclusive Cultures Report including compliance with the Equality Act 2010 including the Public Sector Equality Duty and Accessibility of Trust buildings. With specific reference to NHS staff standards	Quarterly	Executive Director for People and Culture Head of Inclusive Cultures		On track

4.2	To receive assurance that:				
	the Trust's values are being practiced within all services and at all levels of the organisation through the behaviour of all colleagues - Colleague story (to enable committee to have benefits of lived experience/ co-creation)	Each meeting	Executive Director for People and Culture		On track
	The Trust is compliant with its statutory, regulatory and contractual obligations as an employer including but not limited to the Equality Act 2010 including the Public Sector Equality Duty. And that the trust understands the workforce it has and the triangulation of trends across different data sources - Workforce data (provide update on activities which maintain compliance with workforce returns and audits)	Quarterly	Executive Director for People and Culture Head of Workforce Strategy & Systems		On track
	The health and wellbeing of staff is being effectively promoted and supported. - Health and Wellbeing Report with specific reference to NHS staff standards To provide assurance on activities that support staff to maintain their wellbeing)	Quarterly	Executive Director for People and Culture Strategic Lead for Health and Wellbeing		On track
	Appropriate action is taken to support the transformation of services and teams where issues are identified.				On track
	Arrangements for raising concerns, including the functions of the Freedom to Speak up Guardian, meet national expectations and have the confidence of staff.	Quarterly	Freedom to Speak up Guardian		On track

	- Freedom to Speak Up Guardian Report (To inform about FTSU activity and demonstrate the impact the service makes through joint working with services to share lessons learnt and develop action plans which help those who spoke up feel listened to and valued)				
	- Voluntary Services' Annual Update (part of the Inclusive Cultures report – provide assurance that volunteer recruitment processes are robust and to report volunteer training and induction compliance levels)	Annual	Executive Director for People and Culture Head of Inclusive Cultures		On track
	The leaders and managers of the organisation are appropriately recruited and trained, reflecting an inclusive and evidence-based approach to the development of these roles.	Biannual	Executive Director of People and Culture		On track
	Appropriate arrangements are in place to support and maintain good relations with employees including through their recognised trade unions and professional bodies. - Partnership agreement with Staff Side (review of the partnership agreement to provide assurance that the Trust operates within a well-established and formally ratified framework for partnership working with recognised Trade Unions and Professional Organisations)	Biennial	Executive Director for People and Culture Acting Deputy Director for People and Culture		On track
	That appropriate training and supervision is in place for all staff.				
4.7	To receive assurance that the Trust is keeping abreast of changes in employment law and regulation; to draw the Board's attention to any significant risks and implications arising from them; and to obtain assurance on the appropriateness of mitigating actions proposed by management.	through workforce assurance and governance reports – ad hoc	Head of People and Resourcing		On track

	- Employment Rights Act 2025 update (briefing on impending changes to the act and the impact these changes will have on the Trust)				
4.4	To assess the delivery of its purpose through the People and Culture Dashboard, plus any other appropriate metrics as detailed in the ToR.	biannual			On track
4.5	Receive assurance on the risks and BAF elements and Corporate Risk Register allocated to the Committee and identify and escalate any significant risks related to the Committee's purpose and functions to the Board of Directors - Board Assurance Framework and Corporate Risk Register Summary report (to support the committee's focus on strategic risks during discussion at the meeting and to identify where action is necessary to strengthen controls)	Every meeting	Company Secretary		On track
4.6	To review and make recommendations to the Board on:				
(a)	Changes to the staffing establishment and workforce planning, including financial and staffing implications, arising from strategic staffing reviews, major service changes or where quality or workforce concerns are identified which could impact on the delivery of 'Our Journey to Change' or the Trust's statutory and regulatory obligations. - Deep dive on a topic of the chair's choosing, determined by key strategic or performance issues	Ad-hoc	Executive Director for People and Culture		On track

(b)	The appropriateness of the findings of external staffing reviews, including culture reviews, and the management's response to them. In doing so the Committee shall take advice from the Quality Assurance Committee where quality issues/concerns are identified.				On track
(c)	Internal Audit findings, recommendations and management response (assurance that controls are being strengthened in accordance with agreed Internal Audit recommendations)				On track
	Appraisal, revalidation, disciplinary and job plans (To highlight compliance rates for appraisal and revalidation amongst doctors and explain the processes in place to support this. To highlight doctors who were managed under 'responding concerns' for the reporting period. To detail compliance and disputes for job planning.	Scheduled as needed. Annual	Director of Finance, Estates and Facilities Head of Accounting and Governance Executive Medical Director	Scheduled as needed.	On track
4.7	Review of the committee's terms of reference to ensure its functions are effectively discharged/ reflect changing internal, external and BAF context.	Annual	Chair Executive Director for People and Culture		On track
4.8	Review of the committee's performance to consider the committee's effectiveness in delivering its terms of reference and to identify any improvements required.	Annual	Chair Executive Director for People and Culture		On track

On Track	Due	Overdue	Not Started
----------	-----	---------	-------------

4. Notes for Use

This Work Programme should be reviewed by the Chair and Secretariat at the start of each Programme Year, and revisited at each meeting to confirm forthcoming items remain on track.

Each item should map to a specific duty in Section 4 of the Terms of Reference (ToR Ref). Items with no direct duty reference should be marked '—' and reviewed at the annual Committee effectiveness review to confirm they remain within remit.

Where an item is rated Overdue, the Lead should provide a written update to the Chair in advance of the next meeting, and the item should be escalated via the action log if it remains outstanding for more than one cycle.

5. Document Control

Version	Date	Author	Summary of Changes
Version 1	17/09/2026	Anna Pridmore	Initial draft, aligned to Terms of Reference Section 4

TERMS OF REFERENCE

1. Document Control

Committee / Group Name	Planning, Digital and Estates Committee
Reports To	Board of Directors
Sub-Groups Reporting In	Assurance Briefing
Chair	Len Richards- Non-Executive Director
Executive Lead	Kathryn Ellis – Interim Director of Strategy and Transformation
Secretariat	Donna Keeping, Corporate Governance Manager
Version	V1
Approved By	Board of Directors
Review Date	Annually from date of approval

2. Purpose

The Planning, Digital and Estates Committee is established to provide assurance to Board of Directors. The Committee provides assurance about the strategic planning, transformation and delivery responsibilities of the Trust, with particular focus on delivery of the Trust's Strategy and strategic plans, digital and estates transformation and digital and estates statutory/core delivery requirements.

The purpose of the Committee is to provide assurance to the Board that:

- Appropriate arrangements are in place to develop, implement and monitor the Trust's strategic plans.
- Digital services, technology infrastructure and information systems are secure, resilient, compliant and support delivery of the Trust's strategic objectives.

- The Trust's estate is safe, compliant, effective, sustainable and supports the delivery of high-quality patient care and staff wellbeing.
- The Trust maintains compliance with all relevant statutory, regulatory and NHS requirements relating to digital, cyber security, estates, infrastructure and planning.
- Significant risks within the Committee's remit are appropriately identified, managed and mitigated.
- Capital investments, digital programmes and estates strategies are governed effectively and are delivering intended benefits.

In overseeing the Trust's portfolio of strategic planning, transformation, and infrastructure delivery activities, including digital and estates, the Committee will ensure that these interdependent elements collectively enable high-quality clinical services and support the coordinated delivery of transformation programmes required to achieve the Trust's strategic objectives.

3. Authority

The Committee is authorised by Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain external legal or other independent professional advice, and to secure the attendance of individuals with relevant experience and expertise, if it considers this necessary.

4. Duties

4.1 Strategic Planning

The Committee will:

- Receive assurance regarding the development and delivery of the Trust Strategy.
- Receive assurance on the progress against strategic objectives and long-term plans.
- Receive assurance regarding annual operational planning processes and alignment to NHS national and regional planning guidance.
- Receive assurance that the TEWV strategic context is understood and informs future strategic plans (drawing on information such as population health data, benchmarking, environmental and market analysis) .
- Consider demographic, population health, service transformation and infrastructure implications of future planning.

- Receive assurance on progress against the risks associated with delivery of strategic objectives.
- Receive assurance regarding system-wide planning activities involving Integrated Care Systems and partner organisations.
- Receive assurance on the Trust's engagement with strategic partners, in support of Trust strategic objectives and statutory duties to collaborate

4.2 Digital Strategy and Transformation

The Committee will:

- Receive assurance regarding delivery of the Trust's Digital Strategy.
- Receive assurance regarding implementation of digital transformation programmes, including electronic patient records, clinical systems, digital productivity initiatives and emerging technologies.
- Receive assurance on the monitoring of the delivery of digital benefits, outcomes and value for money.
- Receive assurance on the digital maturity assessments and progress against national digital requirements made in the Trust.

4.3 Information Governance, Data Protection and Cyber Security

The Committee will receive assurance that robust arrangements are in place to comply with statutory and regulatory requirements including:

- UK General Data Protection Regulation (UK GDPR).
- Data Protection Act 2018.
- Common Law Duty of Confidentiality.
- NHS Information Governance requirements.
- NHS Digital and NHS England cyber security requirements.
- Data Security and Protection Toolkit (DSPT).
- Network and Information Systems regulations, where applicable.
- Relevant standards including Cyber Assessment Framework requirements.

The Committee will:

- Receive reports for assurance on information governance compliance.
- Review assurance on significant information governance incidents and associated actions.
- Receive assurance regarding cyber security arrangements, cyber resilience, security controls and business continuity.
- Receive assurance on progress against cyber risks and mitigations.

- Receive assurance regarding third-party digital and information security risks.
- Receive assurance regarding supplier management and critical ICT contracts

4.4 Digital Infrastructure and Technology

The Committee will:

- Review assurance regarding digital infrastructure resilience, reliability and performance.
- Receive assurance on the monitoring of risks relating to technology obsolescence and infrastructure capacity.
- Receive assurance regarding disaster recovery arrangements and digital business continuity.
- Receive assurance on performance of digital management including skills across the digital team and across the organisation

4.5 Estates Strategy and Infrastructure

The Committee will:

- Receive assurance regarding delivery of the Estates Strategy.
- Receive assurance that the estate supports service delivery, patient safety and workforce requirements.
- Receive assurance on the estate utilisation, condition, backlog maintenance and infrastructure risks.
- Receive assurance on the monitoring of the long-term sustainability and fitness for purpose of Trust assets.
- Receive assurance regarding major estate developments and infrastructure programmes.

4.6 Statutory Estates Compliance

The Committee will receive assurance regarding compliance with statutory and regulatory obligations relating to the estate, including:

- Health and Safety at Work etc. Act 1974.
- Regulatory Reform (Fire Safety) Order 2005.
- NHS Premises Assurance Model requirements.
- Building Regulations.
- Construction (Design and Management) Regulations 2015.
- Control of Asbestos Regulations.
- Control of Legionella requirements.

- Electricity at Work Regulations.
- Pressure Systems Safety Regulations.
- Lifting Operations and Lifting Equipment Regulations.
- Provision and Use of Work Equipment Regulations.
- Relevant Health Technical Memoranda (HTMs).
- Relevant Health Building Notes (HBNs).
- Environmental and waste management legislation.
- Requirements of the Care Quality Commission.

The Committee will:

- Receive periodic reports on statutory compliance performance.
- Receive assurance on the management of significant compliance breaches and remedial actions.
- Receive assurance regarding fire safety, building safety and engineering infrastructure.
- Receive assurance on the processes for managing high-risk estate-related issues.

4.7 Sustainability and Net Zero

The Committee will:

- Receive assurance on the delivery of the Trust's Green Plan and sustainability objectives.
- Receive assurance on the monitoring of progress against NHS Net Zero commitments.
- Receive assurance regarding environmental compliance and climate resilience.
- Receive assurance on the management and considerations being given to sustainability implications of estates and digital programmes.

4.8 Risk Management

- Maintain oversight of the relevant sections of the Board Assurance Framework and Corporate Risk Register.
- Escalate any areas of concern to the Board of Directors

5. Membership

Role / Job Title	Voting / non-voting
Len Richards— [Non-Executive Director / Executive Director]	Voting
Nini Adetuberu	Voting

David Butcher	Non-Voting
Edward Gorringe	Non-Voting
Liz Romaniak	Voting
Kathryn Ellis	Non-Voting
Naomi Lonergan	Voting
Standard - in attendance	
Nick Black, Chief Information Officer	Not applicable
Simon Adamson, Director of Estates	Not applicable

Members are expected to attend a minimum of [80%] of meetings in any 12-month period. Persistent non-attendance will be raised with the Chair and may result in a request to nominate an alternative representative. The voting / non-voting option does not need to be in place for all Committees

6. Quorum

The meeting shall be quorate when a minimum of 3 voting members are present, to include at least one Executive Director and the Chair (or their nominated deputy). No decision may be ratified at a meeting that is not quorate.

7. Frequency and Notice

The Committee shall meet monthly. Additional meetings may be convened by the Chair where urgent business requires consideration. The agenda and supporting papers shall be circulated to all members no later than [5 working days] prior to the meeting.

8. Conduct of Meetings

- All members will declare any conflicts of interest at the start of each meeting and as they arise during discussion.
- Meetings will be conducted in accordance with the Trust's Standing Orders and Standards of Business Conduct Policy.
- Discussions involving identifiable patient information will be conducted with due regard to confidentiality and information governance requirements.
- Minutes will be taken by the Secretariat and approved by the Chair prior to circulation as a true and accurate record.

9. Reporting Arrangements

The Committee will provide a written report, including a summary of key decisions, risks and assurances, to the Board of Directors following each meeting. An annual report summarising the Committee's effectiveness against its Terms of Reference will be submitted to Board of Directors each year.

10. Administration

- The Secretariat will be responsible for agenda planning, minute-taking, maintenance of the action log and decision log, and circulation of papers.
- A rolling Work Programme will be maintained alongside these Terms of Reference to ensure all duties are discharged within the appropriate reporting cycle.

11. Review

These Terms of Reference will be reviewed annually, or sooner if required by changes in legislation, regulatory guidance, or Trust governance structures, and approved by Board of Directors.

12. Approval

Approved By	Date Approved
Next Review Due	Version

WORK PROGRAMME

This Work Programme operationalises the Committee's Terms of Reference, ensuring every duty in Section 4 is discharged within the appropriate reporting cycle. ToR Ref values correspond directly to the duty sub-sections in the Terms of Reference.

1. Programme Details

Committee / Group	Planning Digital and Estates Committee
Linked Terms of Reference	Terms of Reference v1 approved— duty references below correspond to ToR Section 4
Programme Year	2026/27
Owner	Len Richards Non-executive Director, Donna Keeping, Corporate Governance Manager
Last Updated	17/09/2026

2. Standing Agenda Items

Ref	Standing Item (every meeting)
1	Welcome, apologies and confirmation of quoracy
2	Declarations of interest
3	Minutes of previous meeting and matters arising / action log review

4	Review of relevant risks on the Board Assurance Framework / risk register
5	Items per Work Programme (see Section 4)
6	Any other business
7	Summary of key decisions and items for escalation

3. Annual Forward Planner

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.1	Strategic Planning Receive assurance regarding the development and delivery of the Trust Strategy				
	Receive assurance on the progress against strategic objectives and long-term plans. - Strategic Environment Review - consider demographic, population health, service transformation and infrastructure implications of future planning - Productivity and benchmarking report. (NB – scheduling in line with	Annual Annual	Interim Director of Strategy and Transformation Interim Director of Strategy and Transformation		

	publication dates, with headlines reported as part of the above) - Trust Strategy Refresh 26/27 - Timeline and approach - Strategic insight pre-Board seminar - Draft Strategy review and recommendation to Board	Periodic exercise Annual	Interim Director of Strategy and Transformation Interim Director of Strategy and Transformation		
	Receive assurance regarding annual operational planning processes and alignment to NHS national and regional planning guidance.	Annual			
	Receive assurance that the TEWV strategic context is understood and informs future strategic plans (drawing on information such as population health data, benchmarking, environmental and market analysis) . - Operational plan development in line with NHS national and regional planning guidance. Receive assurance regarding system-wide planning activities involving Integrated Care Systems and partner organisations. - Annual delivery plan and objectives	Quarterly	Interim Director of Strategy and Transformation	Approval Feb ahead of Board and Feb submission Approval Mar ahead of Board Mar approval	On track On track

		Annual	Interim Director of Strategy and Transformation		
	Consider demographic, population health, service transformation and infrastructure implications of future planning.				
	Receive assurance on progress against the risks associated with delivery of strategic objectives. - Receive assurance on the progress against strategic objectives and long-term plans, including Strategy, MTP, annual plan. Receive assurance on progress against the risks associated with delivery of strategic objectives	Quarterly	Interim Director of Strategy and Transformation	June 27/28, Sep, Dec, Mar	On track
	Receive assurance regarding system-wide planning activities involving Integrated Care Systems and partner organisations.				
	Receive assurance on the Trust's engagement with strategic partners, in support of Trust strategic objectives and statutory duties to collaborate Provider collaborative/Strategic Partnership update report Strategic report on activities against Partnership plan, key strategic relationships (Collaborative, Place, Neighbourhood)	Quarterly	Interim Director of Strategy and Transformation	Nov, Feb, May, Aug Timing query; informed by outcomes of PA Consulting work and 'account' approach; propose update in Q4, reporting from Q1	On track

4.2	Digital Strategy and Transformation Receive assurance regarding delivery of the Trust's Digital Strategy. Receive assurance regarding implementation of digital transformation programmes, including electronic patient records, clinical systems, digital productivity initiatives and emerging technologies. - Assurance briefing from the EPR project Board Receive assurance on the monitoring of the delivery of digital benefits, outcomes and value for money. - A2D programme update report Receive assurance on the digital maturity assessments and progress against national digital requirements made in the Trust. - Benchmark report on digital maturity	Monthly	Interim Director of Strategy and Transformation /Chief Information Officer	Every Month	On Track
		Monthly		Every month	
		Annual	Interim Director of Strategy and Transformation /Chief Information Officer	January	
			Interim Director of Strategy and Transformation /Chief Information Officer		
4.3	Information Governance, Data Protection and Cyber Security				

	Receive reports for assurance on information governance compliance.	Annual		June	
	- DSPT- CAF toolkit report	Six monthly		December	
	- Action plan				
		Six monthly		March, August	
	Review assurance on significant information governance incidents and associated actions.				
	- Highlight report on significant information governance incidents	Quarterly		April, July, October, January	
	Receive assurance regarding cyber security arrangements, cyber resilience, security controls and business continuity.	annual		April	
	Receive assurance on progress against cyber risks and mitigations.				
	- Benchmarking against national standards	Six monthly		February, August	
	Receive assurance on data quality including coding				

	- Report on data quality Receive assurance regarding third-party digital and information security risks. Receive assurance regarding supplier management and critical ICT contracts. - DTAC, Clinical safety and Supplier contract report				
4.4	Digital Infrastructure and Technology Review assurance regarding digital infrastructure resilience, reliability and performance. - Current service provision report - Operation of associated systems across the organisation managed by services Receive assurance on the monitoring of risks relating to technology obsolescence and infrastructure capacity. - Legacy IT and risk report Receive assurance regarding disaster recovery arrangements and digital business continuity.	Six monthly Six monthly Annual Annual Six monthly		March, September December, June April May April, October	

	- Audit Report - Testing programme Performance for Digital management - IQPR - Mandatory training - Sickness - vacancy - Digital skills across the organisation and in the digital team	Monthly		Every month	
4.5	Estates Strategy and Infrastructure Receive assurance regarding delivery of the Estates Strategy. - Estates Master Plan Receive assurance that the estate supports service delivery, patient safety and workforce requirements. - PLACE reports and action plans	6 monthly Annual 6 monthly	Director of Estates, Facilities and Capital Director of Estates, Facilities and Capital	April, October March, September	

	Receive assurance on the estate utilisation, condition, backlog maintenance and infrastructure risks. - ERIC return	Annual 6 monthly	Director of Estates, Facilities and Capital	November, May	
	Receive assurance on the monitoring of the long-term sustainability and fitness for purpose of Trust assets. - PAM report and action plan	Annual 6 monthly	Director of Estates, Facilities and Capital	July January	
	Receive assurance regarding major estate developments and infrastructure programmes. - NE and N Cumbria Infrastructure Strategy	Annual	Director of Estates, Facilities and Capital	Quarter 4 (may vary within the quarter dependent on the commissioners)	
4.6	Statutory Estates Compliance Receive periodic reports on statutory compliance performance. Review significant compliance breaches and remedial actions.	Quarterly	Director of Estates, Facilities and Capital	Mid quarter at each quarter (May, August, November, February)	

	Receive assurance regarding fire safety, building safety and engineering infrastructure. Review processes for managing high-risk estate-related issues. Performance standards for Estates management				
4.7	Sustainability and Net Zero Receive assurance on the delivery of the Trust's Green Plan and sustainability objectives. Receive assurance on the monitoring of progress against NHS Net Zero commitments. Receive assurance regarding environmental compliance and climate resilience. Receive assurance on the management and considerations being given to sustainability implications of estates and digital programmes. - Green Plan	6 monthly	Director of Estates, Facilities and Capital	July, February	
4.8	Risk Management				

	Maintain oversight of the relevant sections of the Board Assurance Framework and Corporate Risk Register. - Board Assurance Framework - Corporate Risk Register	Monthly Monthly	Company Secretary	Each meeting	On track
--	--	--------------------	-------------------	--------------	-----------------

On track	Due	Overdue	Not Started
-----------------	------------	----------------	--------------------

4. Notes for Use

This Work Programme should be reviewed by the Chair and Secretariat at the start of each Programme Year, and revisited at each meeting to confirm forthcoming items remain on track.

Each item should map to a specific duty in Section 4 of the Terms of Reference (ToR Ref). Items with no direct duty reference should be marked '—' and reviewed at the annual Committee effectiveness review to confirm they remain within remit.

Where an item is rated Overdue, the Lead should provide a written update to the Chair in advance of the next meeting, and the item should be escalated via the action log if it remains outstanding for more than one cycle.

5. Document Control

Version	Date	Author	Summary of Changes
---------	------	--------	--------------------

0.1 DRAFT	20/08/2026	Anna Pridmore	Initial draft, aligned to Terms of Reference Section 4
0.1 DRAFT	09/09/2026	Kathryn Ellis	Updated with report information

TERMS OF REFERENCE

1. Document Control

Committee / Group Name	Quality Assurance Committee
Reports To	Board of Directors
Sub-Groups Reporting In	None
Chair	Phil Corrigan, Non-Executive Director
Executive Lead	Beverley Murphy, Chief Nurse
Secretariat	Donna Keeping, Corporate Governance Manager
Version	1.0
Approved By	Board of Directors
Review Date	Annually from date of approval

2. Purpose

The Quality Assurance Committee is established to provide assurance to the Board of Directors that the Trust is meeting its statutory, regulatory and quality obligations in relation to:

- 2.1 The provision of assurance on the quality, safety and effectiveness of the Trust's clinical and operational services.

3. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain external legal or other independent professional advice, and to secure the attendance of individuals with relevant experience and expertise, if it considers this necessary.

4. Duties

- 4.1 To provide assurance to the Board that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008.

- 4.2 To provide assurance to the Board on compliance with:

- (a) Regulatory requirements enabling the Trust to maintain registration with the Care Quality Commission to undertake regulated activities at each location;
- (b) Standards of quality and safety as set out in the Fundamental Standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014;
- (c) Other statutory and regulatory requirements and national guidance relating to quality and safety including but not limited to:
 - Safe Staffing
 - Infection Prevention and Control
 - Safeguarding
 - Annual EMSA report
 - Mortality Reviews including Learning Disabilities Mortality Review (LeDeR)
 - Patient Experience

- Patient Safety report
- Use of Force and reducing Restrictive Practice

- 4.3 To receive assurance on behalf of the Board that effective structures, systems and processes are put in place, maintained and continually improved to:
- (a) Co-create and deliver a high-quality experience and outcomes for all patients and their carers and families both individually and collectively.
 - (b) Identify and manage risks to quality and safety.
 - (c) Investigate, review, and report on complaints, adverse events and serious incidents.
 - (d) Learn and ensure that best practice is shared, implemented and embedded across the Trust.
 - (e) Deliver clinical care with other providers including transfers of care.
- 4.4 To support the Trust's approach to having a consistent quality of care that identifies risks related to variance in quality, access and demand to services, patient experience, health inequalities and patient harm as well as clinical outcomes:
- 4.5 To seek assurance on the findings of reviews and investigations into the delivery of healthcare services by the Trust (including those undertaken or commissioned by the Care Quality Commission or NHS England) and management's responses to them, and to monitor progress on the implementation of agreed actions.
- 4.6 To be assured on compliance with national clinical standards including NICE guidelines/guidance and any rationale for non or partial compliance.
- To receive the draft clinical audit programme for information. During the year receive completed audit reports for assurance. Share assurance with the Audit and Risk Committee following discussion at the Quality Assurance Committee.
- 4.7 To review and seek assurance that recommendations about priorities in the Trust's Annual Quality Account for the following year have been made and are appropriate.
- 4.8 To receive assurance on the governance of research and development.
- 4.10 To receive assurance on the work of the Drugs and Therapeutics Committee including the safety of medication management.
- 4.11 To be provided with assurance about the commissioning and monitoring of projects/programmes of work to assist the Trust to maintain CQC registration and/or discharge its duty of quality and safety.
- 4.13 To seek assurance on the range of quality and safety metrics and the metrics in the Quality Dashboard and the Quality Assurance Schedule.
- 4.14 To identify and escalate any significant risks related to the Committee's purpose and functions to the Board, taking into account agreed risk appetite and tolerances.
- To review the scope, impact and management of risks contained within the Board Assurance Framework and the Corporate Risk Register, as relevant to the committee's purpose and functions, and to gain assurance on the delivery and effectiveness of mitigation plans.
- 4.16 To gain assurance on the quality of services commissioned by the Trust.
- 4.17 To conduct an annual review of effectiveness of the Committee.

5. Membership

Role / Job Title	Voting / Non-Voting
Philomena Corrigan – Chair, Non-executive Director	Voting
Nini Adetuberu - Non-executive Director	Voting
Cathrine Wood Non-executive Directors	Voting
Edward Gorringer – Associate Non-executive Director	Non-voting

Beverley Murphy Chief Nursing Office / Deputy Chief Executive	Voting
Kedar Kale Executive Medical Director - Lead Executive Director	Voting
Hannah Crawford, Executive Director of Therapies and Patient Experience	Non-voting
Naomi Lonergan, Interim MD of Care Group	Voting

Other regular attendees of the Committee include the following and are not member of the Board of Directors.

The Chair of the Committee shall be appointed by the Board of Directors.

Regular deputy or substitute members (with voting rights) may be appointed by Members of the Committee to attend meetings, on their behalf, where their absence is unavoidable. Notice of the appointment of a deputy/substitute member must be provided to the Chair of the Committee and the Corporate Governance Manager, in writing, before the meeting commences.

Members are expected to attend a minimum of [80%] of meetings in any 12-month period. Persistent non-attendance will be raised with the Chair and may result in a request to nominate an alternative representative.

6. Quorum

- 6.1 The meeting shall be quorate when a minimum of three voting members are present, to include at least two Executive Director and the Chair (or their nominated deputy). No decision may be ratified at a meeting that is not quorate.
- 6.2 All other Board Members, the Lived Experience Directors, subject matter experts and Care Group Clinical Leaders shall be invited to attend and participate in meetings of the Committee (but not to vote). To facilitate this, copies of all agendas and papers for meetings will be provided to them.
- 6.2 Assurance will be generally provided by the Executive Directors present at the meeting, but on occasions officers of the Trust shall be invited to attend a meeting of the Committee to provide additional understanding to support the Committee's discussions.
- 6.3 External independent experts may be invited to attend meetings where their advice would be beneficial in the consideration of matters within the purpose and functions of the Committee.
- 6.4 Subject to the agreement of the Board, a specified number of service users or carers may be invited to attend and participate in meetings of the Committee (but not to vote) in order to gain their perspectives on the matters under consideration. In addition, patients/service users may be invited to attend meetings of the Committee to share their experience of the care they received.

7. Frequency and Notice

- 7.1 The Committee shall meet monthly with the exception of August and January. Additional meetings may be convened by the Chair where urgent business requires consideration. The agenda and supporting papers shall be circulated to all members no later than [5 working days] prior to the meeting.
- 7.2 The Committee shall also hold at least one developmental session per year to consider and discuss topics agreed by the Chair of the Committee.

8. Conduct of Meetings

- All members will declare any conflicts of interest at the start of each meeting and as they arise during discussion.
- Meetings will be conducted in accordance with the Trust's Standing Orders and Standards of Business Conduct Policy.

- Discussions involving identifiable patient information will be conducted with due regard to confidentiality and information governance requirements.
- Minutes will be taken by the Secretariat and approved by the Chair prior to circulation as a true and accurate record.

9. Reporting Arrangements

The Committee will provide a written report, including a summary of key decisions, risks and assurances, to [parent committee / Trust Board] following each meeting. An annual report summarising the Committee's effectiveness against its Terms of Reference will be submitted to [Trust Board] by [month] each year.

Following every meeting the Chair of the Committee shall report to the next meeting of the Board of Directors:

- To advise of the business transacted.
- To escalate any material matters of concern which may require a response from the Board or which might impact on the functions of another Board Committee.
- To provide assurance on the progress being made on the delivery of strategic plans related to its principal purpose.
- To provide a commentary on the assurances it has received, drawing the Board's attention to any positive assurances and gaps in assurance (including actions being taken to address them).
- To provide assurance on the management of strategic and operational risks which relate to its principal purpose and functions and to advise the Board of any new risks identified and actions being taken to address them.
- To seek the Board's approval of any recommendations made by the Committee.
- To inform the Board of any other matters that the Committee considers important to bring to its attention.
- To provide the Board with a summary of risks to quality as an outcome from the consideration of the Integrated Performance Dashboard (IQPD).

10. Administration

- The Secretariat will be responsible for agenda planning, minute-taking, maintenance of the action log and decision log, and circulation of papers.
- A rolling Work Programme will be maintained alongside these Terms of Reference to ensure all duties are discharged within the appropriate reporting cycle.

11. Review

These Terms of Reference will be reviewed annually, or sooner if required by changes in legislation, regulatory guidance, or Trust governance structures, and approved by [parent committee / Trust Board].

12. Approval

Approved By	Date Approved
Next Review Due	Version

WORK PROGRAMME

This Work Programme operationalises the Committee's Terms of Reference, ensuring every duty in Section 4 is discharged within the appropriate reporting cycle. ToR Ref values correspond directly to the duty sub-sections in the Terms of Reference.

1. Programme Details

Committee / Group	Quality Assurance Committee
Linked Terms of Reference	Terms of Reference v1 2026, approved — duty references below correspond to ToR Section 4
Programme Year	2026/27
Owner	Phil Corrigan, Chair – Non-executive Director, Karen Christon, Deputy Company Secretary
Last Updated	15/09/2026

2. Standing Agenda Items

Ref	Standing Item (every meeting)
1	Welcome, apologies and confirmation of quoracy
2	Declarations of interest
3	Minutes of previous meeting and matters arising / action log review
4	Review of relevant risks on the Board Assurance Framework / risk register
5	Items per Work Programme (see Section 3)
6	Any other business
7	Summary of key decisions and items for escalation

3. Annual Forward Planner

ToR Ref	Agenda Item / Duty	Frequency	Lead	Scheduled Months	Status
4.1	To provide assurance to the Board that the Trust is discharging its duty of quality and safety in compliance with the Health and Social Care Act 2008.	Every meeting	Chair		On Track
4.2	To provide assurance to the Board on compliance with				
	(a) Regulatory requirements enabling the Trust to maintain registration with the Care Quality Commission to undertake regulated activities at each location;				
	- Regulatory activity: delivery of CQC integrated plan and HMC notices and requirements	Bi-monthly	Executive Chief Nurse	September, November, January, March, May, July	On Track
	- Annual Review of the CQC statement of purpose	Annual	Executive Chief Nurse	May	On Track
	(b) Standards of quality and safety as set out in the Fundamental Standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014;				
	(c) Other statutory and regulatory requirements and national guidance relating to quality and safety including but not limited to: • Safe Staffing • Infection Prevention and Control • Safeguarding • Annual EMSA report • Mortality Reviews including Learning Disabilities • Mortality Review (LeDeR) • Patient Experience • Patient Safety Report • Duty of Candour				

	• Use of Force and Reducing Restrictive Practice				
	- Safe staffing	Quarterly	Executive Chief Nurse	January, March, May, July	On Track
	- Infection Prevention and Control	Six monthly	Executive Chief Nurse	November, May	On Track
	- Safeguarding	Bi Monthly	Executive Chief Nurse	September, November, March, June	On Track
	- Annual EMSA report	Annual	Executive Chief Nurse	June	On Track
	- Mortality Reviews including Learning Disabilities Mortality Review (LeDeR)	Quarterly	Executive Chief Nurse	September, November, February, May	On Track
	- Patient Experience	Quarterly	Executive Director of Therapies and Patient Safety	October, January, April, July	On Track
	- Patient Safety Report	Annual	Executive Director of Therapies and Patient Safety	May	On Track
	- Duty of Candour	Six monthly	Executive Chief Nurse	November, May	On Track
	- Use of Force and Reducing Restrictive Practice	Quarterly	Executive Chief Nurse	September, November, February, May	On Track
4.3	To receive assurance on behalf of the Board that effective structures, systems and processes are put in place, maintained and continually improved to: • Co-create and deliver a high-quality experience and outcomes for all patients and their carers and families both individually and collectively. • Identify and manage risks to quality and safety. • Investigate, review, and report on complaints, adverse events and serious incidents. • Learn and ensure that best practice is shared, implemented and embedded across the Trust. • Deliver clinical care with other providers including transfers of care.				
4.4	To support the Trust's approach to having a consistent quality of care that identifies risks related to variance in quality, access and demand to services,				

	patient experience, health inequalities and patient harm as well as clinical outcomes:				
	- Adult Acute and Planned	Annual	Chief Operating Officer	February	On Track
	- Adult Crisis Care	Annual	Chief Operating Officer	May	On Track
	- Adult Community MH	Annual	Chief Operating Officer	October	On Track
	- Older Adults Inpatient Care	Annual	Chief Operating Officer	November	On Track
	- Older Adults Community Care	Annual	Chief Operating Officer	???	On Track
	- Learning Disability Care	Annual	Chief Operating Officer	July	On Track
	- Child and Adolescent services	Annual	Chief Operating Officer	September	On Track
	- Secure Inpatient Services	Annual	Chief Operating Officer	April	On Track
	- Health & Justice	Annual	Chief Operating Officer	September	On Track
	- Specialist Eating Disorders	Annual	Chief Operating Officer	December	On Track
	- Rehabilitation	Annual	Chief Operating Officer	December	On Track
	- Perinatal	Annual	Chief Operating Officer	June	On Track
	To seek assurance of the approach and impact of: • Organisational learning • Supervision • Care Quality governance • Patient and Carer Race Equality • Board Quality Visits • Ethics Committee • Culture of Care Improvements				
	- Organisational learning	Quarterly	Executive Director of Therapies and Patient Safety	July, October, January, April	On Track

	- Supervision	Quarterly	Director of People and Culture	October, January, April, July	On Track
	- Care Group Quality Governance Triple A report	Monthly	Chief Operating Officer	Every Month	On Track
	- Patient and Carer Race Equality Framework	Six monthly	Executive Medical Director	May, November	On Track
	- Board Quality visits (leadership walk rounds)	3 x yearly	Executive Chief Nurse	January, April, September	On Track
	- Ethics Committee	Six monthly	Executive Chief Nurse	September, February	On Track
4.5	To seek assurance on the findings of reviews and investigations into the delivery of healthcare services by the Trust (including those undertaken or commissioned by the Care Quality Commission or NHS England) and management's responses to them, and to monitor progress on the implementation of agreed actions. Picked up as part of the regulatory arrangements at 4.2.				
4.6	To be assured on compliance with national clinical standards including NICE guidelines/guidance and any rationale for non or partial compliance. To receive the draft clinical audit programme for information. During the year receive completed audit reports for assurance. Share assurance with the Audit and Risk Committee following discussion at the Quality Assurance Committee.				
	- Clinical Effectiveness including Audit and NICE	Quarterly	Executive Chief Nurse	September, December, March, June	On Track
	- Annual Quality Assurance and Improvement Programme activity including NICE	Annual	Executive Chief Nurse	May	On Track
	- Approval of the annual quality assurance and improvement programme	Annual	Executive Chief Nurse	March	On Track

	- Clinical Audit Annual Report				
4.8	To seek assurance that recommendations about priorities in the Trust's Annual Quality Account for the following year have been made and are appropriate.				
	- Quality priorities for the Quality Account	Quarterly	Executive Chief Nurse	December, March June (annual), October	On Track
4.9	To receive assurance on the governance of research and development.				
	- Summary Report on R&D including the Annual Report	Six monthly	Executive Medical Director	December, June	On Track
4.10	To receive assurance on the work of the Drugs and Therapeutics Committee including the safety of medication management.				
	- Drugs and Therapeutics including the CD Accountable Officer Annual Report	Six monthly	Executive Medical Director	September, March	On Track
	- Medical Devices Annual Report	Annual	Executive Chief Nurse	December	On Track
4.11	To be provided with assurance about the commissioning and monitoring of projects/programmes of work to assist the Trust to maintain CQC registration and/or discharge its duty of quality and safety. Picked up as part of 4.1 and 4.2				
4.13	To seek assurance on the range of quality and safety metrics and the metrics in the Quality Dashboard.				
	- Quality Report: Quality Assurance, risk and Quality Dashboard	Monthly	Executive Chief Nurse	Every month	On Track
	- Quality Review of Clinical Contracts	Six monthly	Executive Chief Nurse	November, May	On Track
	- Equality and Quality Impact assessment	Six monthly	Executive Medical Director	December, June	On Track

	- Safer Staffing	Quarterly	Executive Chief Nurse	November, February, May, July	On Track
	- Infection Prevention and Control	Six monthly	Executive Chief Nurse	October, May	On Track
	- Environmental Risk	Six monthly	Executive Chief Nurse	December, June	On Track
4.14	To identify and escalate any significant risks related to the Committee's purpose and functions to the Board, taking into account agreed risk appetite and tolerances. To review the scope, impact and management of risks contained within the Board Assurance Framework and the Corporate Risk Register, as relevant to the committee's purpose and functions, and to gain assurance on the delivery and effectiveness of mitigation plans.				
	- Board Assurance Framework and Corporate Risk Register	Monthly	Company Secretary	Every month	On Track
	- Service requiring additional support	Quarterly	Chief Operating officer	October, January, April, July	On Track
	- Safety Planning for Section 17 Leave -	Quarterly	Executive Medical Director	October, January, April, July	On Track
4.16	To gain assurance on the quality of services commissioned by the Trust.				
	- Patient safety and Quality Strategy	Six monthly	Executive Chief Nurse	December, June	On Track
	- Physical healthcare / quality of care				On Track
	- Issues raised with other Board Committees	Monthly	Chair	Every month	On Track
	- Issue to escalate to Trust Regulators	Monthly	Chair	Every month	On Track
4.17	To conduct an annual review of effectiveness of the Committee.				On Track

	- ToRs	Annual	Chair	TBA	On Track
	- Annual Report and performance evaluation	Annual	Chair	TBA	On Track
	- Outcome for annual development session	Annual	Executive Chief Nurse	TBA	On Track
	- Quality Matters report	Monthly	Executive Chief Nurse	Every month	On Track

On Track	Due	Overdue	Not Started
----------	-----	---------	-------------

4. Notes for Use

This Work Programme should be reviewed by the Chair and Secretariat at the start of each Programme Year, and revisited at each meeting to confirm forthcoming items remain on track.

Each item should map to a specific duty in Section 4 of the Terms of Reference (ToR Ref). Items with no direct duty reference should be marked '—' and reviewed at the annual Committee effectiveness review to confirm they remain within remit.

Where an item is rated Overdue, the Lead should provide a written update to the Chair in advance of the next meeting, and the item should be escalated via the action log if it remains outstanding for more than one cycle.

5. Document Control

Version	Date	Author	Summary of Changes
Version 1	17/09/2026	Anna Pridmore	Initial draft, aligned to Terms of Reference Section 4

This page is intentionally blank

For General Release

Agenda Item 21

Meeting of:	Board of Directors
Date:	23 September 2026
Title:	Governance Improvement Action Plan
Executive Sponsor(s):	Alison Smith, Chief Executive
Author(s):	Anna Pridmore, Governance Consultant

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
BAF 9	

Executive Summary

Purpose

In 2025, the Chief Executive requested a review of the governance actions arising from the Deloitte report published in March 2024. The scope was subsequently extended following a request from the Integrated Care Board to provide assurance statements concerning the Trust's governance arrangements in response to the Aubery report, published in February 2026. The resulting work was consolidated, and a thematic approach was adopted to set out the outstanding actions.

The seven themes, established by the Chief Executive in June 2026, were as follows:

- Leadership, corporate governance, accountability and oversight;
- Clinical leadership, clinical governance and patient safety;
- External reviews, NHS Oversight Framework (NOF) assessment, audits and independent assurance;
- Workforce, culture, and patient and staff experience;
- Financial governance, business cases and contracts;
- Information, digital and documentation governance; and
- Operational governance, performance and risk.

An action plan was developed around the seven themes to support Executive Directors in overseeing completion of the outstanding actions and in maintaining collective and individual accountability for delivery. The version of the action plan completed in August 2026 was version 7.

This report has been prepared for the Audit and Risk Committee to provide assurance on the governance, monitoring and escalation process only. It does not provide assurance that individual actions are complete, effective or delivering their intended outcomes.

Overview

Within the actions plan there are 90 detailed actions split into seven themes. The plan uses a Brag rating system as follows to keep track of the progress against the various actions.

The rating system used in the plan is BRAG as follows:

Blue – completed

Red – Challenges to complete the action

Amber- on track, but some current challenges

Green – on track to complete on time

Whole plan position

Theme	Total	Blue	Green	Amber	Red	Amber/Red
Leadership, corporate governance, accountability and oversight	47	18	23	5	1	13%
Clinical leadership, clinical governance and patient safety	13	6	5	2	0	15%
External reviews, NOF assessment, audits and independent assurance	6	3	1	2	0	33%
Workforce, culture and patient, staff experience	4	1	3	0	0	0%
Financial governance, business cases and contracts	6	2	4	0	0	0%
Information, digital and documentation governance	5	1	0	3	1	80%
Operational governance, performance and risk	9	1	3	5	0	56%
Total	90	32	39	17	2	21%

The plan contains 90 rated actions. Of these, 32 (36%) are complete, 39 (43%) are on track, 17 (19%) are on track with challenges and 2 (2%) are facing challenges to completion.

Read by volume, the plan appears strongly weighted towards the Leadership theme, which carries 47 of the 90 actions.

Read by risk, the picture is different. The two themes with the weakest profiles, Information, digital and documentation governance and Operational governance, performance and risk, together carry 14 actions, of which 9 are Amber or Red.

Conversely, Workforce, culture and patient, staff experience carries no Amber or Red actions but has only four actions for the whole of its objective.

The Board should therefore be cautious about reading a low Amber and Red count as assurance.

In the next section of the report the tables provide details looking from an assurance grouping perspective.

3. Leadership, corporate governance, accountability and oversight

Objective: demonstrate that Board assurance and strategic risks are actively managed and improve the quality and timeliness of Board assurance; demonstrate visible leadership impact and delivery of agreed actions, clear accountability from Board to services, and an effective, well-functioning Board and committees.

Executive ownership: Chief Executive.

Assurance grouping	Actions	Blue	Green	Amber	Red
A. Active management of strategic risk	7	3	4	0	0
B. Quality of Board assurance	5	0	5	0	0
C. Timeliness and flow of assurance	10	5	4	0	1
D. Accountability from Board to services	9	2	5	2	0
E. Effective, well-functioning Board and committees	8	3	3	2	0
F. Strategy and priority setting	8	5	2	1	0
Total	47	18	23	5	1

In place:

- the 26/27 Board Assurance Framework has been integrated into InPhase with risks agreed by the Board;

- The committee terms of reference and work programmes have been reviewed and updated into the new governance framework. There are a few final steps in terms of elements on the work programmes to complete, but all committees have updated terms of reference and work programmes. There is a new action added separately to the plan for the Board terms of reference and work programme to be updated in line with the revised governance arrangements.
- Executive portfolios were discussed and agreed by the Nomination and Remuneration Committee and started to be effective from August 2026
- the meeting timetable, Board and seminar frequency, decision log and diligent platform are all in place. There is a further piece of work to complete around the Executive meetings and the operational meetings. That work is underway.
- Non-executive arrangements for induction are complete, and the full induction is near completion for both new non-executive directors. The induction for the new is complete for the Governors.

Not yet assured:

- the quality of Board assurance elements of the action plan are still to complete and remain in development.
- Although the new governance system has been designed and people have received training, the system does not start until October 2026 so the system has not been tested. The next three months will be used to identify any issues and approaches to resolve them.
- The Executive Directors Group work programme is the only, Red-rated action in the theme. Work is being undertaken to agree how the current business discussed through the Executive Directors weekly group should be re organised to fit with the revised arrangements for the Executive Directors meetings.
- The Accountability Framework, IQPR and Performance Framework has not yet been received by the Board and has yet to be approved.

The assurance level for the Leadership, corporate Governance, accountability and oversight is proposed as reasonable assurance on design and limited assurance on operating effectiveness.

It is anticipated that the remainder of the actions would be completed by the end of the current financial year.

4. Clinical leadership, clinical governance and patient safety

Objective: clarify and formalise the clinical leadership quadrate and portfolio responsibilities; improved Board level assurance on quality and risk; robust learning and Duty of Candour assurance.

Executive ownership: Medical Director, Chief Nursing Officer, Chief Therapies and Patient Experience Officer.

Assurance grouping	Actions	Blue	Green	Amber	Red
A. Clinical leadership and portfolio responsibilities	2	1	1	0	0
B. Board level assurance on quality and risk	4	1	2	1	0
C. Learning, complaints and patient experience	7	4	2	1	0
Total	13	6	5	2	0

In place:

- the Executive clinical leadership quadrate has been clarified and formalised following approval of Executive portfolios.
- The Quality Assurance Committee work programme has been reviewed and approved by the Committee and by its new Chair, and the QAC work plan and terms of reference will be presented to the Board in September for approval.
- Complaints have been embedded into Care Groups, complaint responses improved, research governance established through the quarterly Research Governance Group, and peer to peer support systems confirmed.
-

In progress:

- quality triggers are on the Quality Assurance Committee agenda for 3 September; clinical audit is to sit within the emerging Quality Management System;
- the complaints quality improvement event runs from 30 September to 2 October.
- Benchmarking remains Amber, with engagement events being developed to link benchmarking into quality management.

The assurance level for the clinical leadership, clinical governance and patient safety is proposed as reasonable assurance.

5. External reviews, NOF assessment, audits and independent assurance

Objective: provide clear and transparent assurance within all levels of the Trust and independent validation of improvement and learning.

Executive ownership: Chief Executive.

Assurance grouping	Actions	Blue	Green	Amber	Red
A. Visibility and transparency of external review activity	2	1	0	1	0
B. Independent validation of improvement	2	1	1	0	0
C. Integration of internal and external assurance sources	2	1	0	1	0
Total	6	3	1	2	0

In place:

- a mechanism for external review ratings shared with Executive Directors and supported by policy.
- an Internal Audit Plan based on the BAF and Trust risk profile; and benchmarking now included in the IQPR from the August Board.

Not assured:

- the register of external reviews, action 2, has not been created. A register does exist; it does need to be reviewed and updated and has not been prioritised over other work.
- The link between clinical audit and Internal Audit, action 6, is also Amber, pending discussion with the Chair of the Audit and Risk Committee.
- Action 3, commissioning an independent Quality Review following the CQC and NHSE Niche reviews, is rated Green. Terms of reference have been reviewed by QAC, and a person has been identified to undertake the work.

The assurance level for the External reviews, NOF assessment, audits and independent assurance is currently limited assurance due to the key outstanding action.

6. Workforce, culture and patient, staff experience

Objective: supports patient experience and informs Board decision making; supports a safer culture and clearer escalation.

Executive ownership: Chief People and Culture Officer.

Assurance grouping	Actions	Blue	Green	Amber	Red
A. Staff voice and escalation into Board decision making	1	0	1	0	0
B. Comparative and benchmarking information	1	0	1	0	0
C. Professional assurance and workforce compliance	2	1	1	0	0
Total	4	1	3	0	0

In place:

- the medical revalidation process has been reviewed and provides clear assurance, with all career grade doctors expected to have an annual Trust appraisal ahead of revalidation.
- The nursing revalidation action now carries a BRAG rating, it was reported to Executive Directors in July.

In progress:

- the paper on integration of staff listening, staff satisfaction and Freedom to Speak Up learning will be routed through the People and Culture leads meeting and the Executive Directors Group to the People and Culture Committee.
- Benchmarking has begun to be integrated into reporting across the governance structure.

The assurance level for the Workforce, culture, patient and staff experience is proposed as reasonable assurance.

7. Financial governance, business cases and contracts

Objective: better informed, higher quality investment decisions, integrated system oversight and assurance, maximising learning opportunities.

Executive ownership: Chief Finance Officer.

Assurance grouping	Actions	Blue	Green	Amber	Red
A. Quality of investment decisions	2	1	1	0	0
B. Governance route and traceability of decisions	2	0	2	0	0
C. System oversight and contracts	1	1	0	0	0
D. Learning from investment	1	0	1	0	0
Total	6	2	4	0	0

In place:

- the business case template and supporting guidance are complete, and the review of service contract information provided to the Executive Directors Group has concluded.
- Contract documents route through the Resources and Planning Committee (now Finance and Performance) and the Quality Assurance Committee, with an internal audit of subcontracting included in the 26/27 plan.

In progress:

- the revised business case process is expected to be in place as a full system by the end of September; a kite mark process for lived experience in business cases is planned for Q3;
- quarterly meetings with clinical networks on business case development are established;
- the Scheme of Delegation has been confirmed as providing the governance route for business cases and will be reviewed. This review will take place at the beginning of the next financial year.

The assurance level for the finance governance, business cases and contracts is proposed as reasonable assurance on design and limited assurance on traceability and learning.

8. Information, digital and documentation governance

Objective: clear, integrated performance reporting, stronger documentation and compliance assurance, and improved information quality and coding.

Executive ownership: Chief Information Officer.

Assurance grouping	Actions	Blue	Green	Amber	Red
A. Integrated performance reporting	1	1	0	0	0
B. Information quality and coding	2	0	0	2	0
C. Documentation and compliance assurance	2	0	0	1	1
Total	5	1	0	3	1

This is the weakest theme profile in the plan. It contains no Green-rated actions, and four of its five actions are Amber or Red.

- strengthening operational and quality benchmarking through the improved IQPR is complete following the August Board, which delivers the integrated performance reporting element of the objective.

Areas of challenge:

- the DSPT action is Red. The 25/26 submission was agreed at Trust Board and the Audit and Risk Committee as approaching standards with a supporting action plan, but delivery is constrained by EPRR capacity following the departure of the post holder. Recruitment for a replacement is underway. An update is due to the Executive Directors Group and a progress report, with a separate EPRR update, to the Audit and Risk Committee in September.
- The RIO EPR programme remains Amber, with strengthened governance from September. The Chief Executive takes the Chair role of the EPR Board from 2 September, and the new Planning, Digital and Estates Committee will meet monthly from 1 October and will seek assurance from the EPR Board.
- IIC remains Amber; IBM has improved the upload process but the Trust records that it cannot currently hold the supplier to account under the existing licensing arrangement, and options work continues. The digital strategy is Amber, and its timescale has moved to 26/27 Q4, with a final draft digital, data and technology strategy now due by 31 March 2027.

On the evidence provided the assurance level for the Information, digital and documentation governance the proposed assurance rating is limited. At present there are still significant issues to resolve that could impact across the organisation.

9. Operational governance, performance and risk

Objective: embed executive performance reviews across quality, workforce, finance and risk.

Executive ownership: Interim Managing Director.

Assurance grouping	Actions	Blue	Green	Amber	Red
A. Framework for operational governance	2	0	1	1	0
B. Reporting and assurance from Care Groups to Board	3	0	1	2	0
C. Service and risk baseline	2	0	1	1	0
D. Workforce and resource assurance in operations	2	1	0	1	0
Total	9	1	3	5	0

In place

- assurance around job planning is complete and is recorded as an area of strength, with the Trust the highest achiever in the Northeast and Yorkshire region for mental health job planning.

In progress

- the Operating Framework is being finalised, with work on ambassador roles across the five localities being undertaken;
- the register of services will cross-reference all services on the intranet against CQC registration and the external website;
- the Company Secretary will discuss the revised governance arrangements with Care Group senior management, which will inform the format, template and timing of Care Oversight Group reporting.
-

Areas of challenge

- five of the nine actions are Amber, the highest proportion in the plan.
- Finalising management structures for the Care Oversight Group is delayed pending the permanent appointment of the Chief Operating Officer.
- The annual governance statement from Care Groups remains under consideration rather than in delivery.
- EPRR is rated Green on the basis that the job description has been progressed and the post advertised in August, but the same capacity gap is the driver of the Red-rated DSPT action in the Information, digital and documentation governance theme.

On the evidence provided the assurance level for the operational governance, performance and risk proposed assurance rating is limited – there are significant issues to resolve that could impact across the organisation.

10. Cross-cutting findings

There are two significant area where the plan as a whole is more significant than any individual action rating.

Assurance on design, not on effectiveness.

The improvement in the plan's profile during August is substantial, but it reflects the conclusion of design work rather than evidence of improved outcomes. The revised governance arrangements, templates, terms of reference, work programmes, business case process and new committee structure all take effect from 1 October 2026.

Nothing has yet been produced under any of them. The first meaningful test will be the October to December reporting cycle.

Delivery concentrated on a small number of posts and individuals.

Three vacancies now sit on the critical path for actions across several themes: the Chief Operating Officer, which blocks Care Oversight Group management structures; the Director of People and Culture and the Director of Delivery, which is the final Board appointment;

The EPRR post, which is the driver of the only, Red-rated action outside the Leadership theme.

Separately, a high proportion of the Leadership theme actions are owned by the Company Secretary, which concentrates delivery risk in the corporate governance function ahead of the 1 October go-live.

11. Assurance judgement by theme

Theme	Assurance judgement	Principal basis
Leadership, corporate governance, accountability and oversight	Reasonable on design, limited on effectiveness	Architecture substantially agreed; nothing yet produced under the new arrangements, which start on 1 October 2026.
Clinical leadership, clinical governance and patient safety	Reasonable	Clinical leadership quadrate formalised, QAC work plan and terms of reference agreed, complaints and research governance concluded. Duty of Candour is not covered by any action.
External reviews, NOF assessment, audits and independent assurance	Limited	Register of external reviews not progressed and deprioritised; three of four open actions carry no update since July or earlier.
Workforce, culture and patient, staff experience	Limited	Four actions only for the whole objective; no updates recorded in the August round; benchmarking recorded as not sustainable.
Financial governance, business cases and contracts	Reasonable on design, limited on effectiveness	Template and guidance complete and process due to be fully in place by end September; register, decision log and post-project evaluation least developed.
Information, digital and documentation governance	Limited	No Green-rated actions; four of five Amber or Red; DSPT constrained by EPRR vacancy and outstanding Business Continuity Plans.
Operational governance, performance and risk	Limited	Five of nine actions Amber; Care Oversight Group structures blocked by the COO vacancy; the stated objective is not directly covered by the actions in the theme.

12. Recommendations

The Board is asked to:

- Note the position and the assurance judgement for each theme.
- Note that assurance across the plan is currently available on the design of the revised arrangements and not on their operating effectiveness, and that the first test will be the October to December 2026 reporting cycle.