Board of Directors held on 28 October 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:

- A patient story;
- The Chief Executive's updates, including matters related to the public inquiry and strategic developments;
- Assurances provided through Board Committees
- Quality, safety and operational performance, including safer staffing, the Integrated Quality Performance Report and a spotlight report on Adult Mental Health Planned Care; and
- Finance, workforce and equality performance, including approval of the annual workforce equality reports

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 9.30am – 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 1.00pm

As part of this year's flu vaccination campaign, Board members are encouraged to take the opportunity to receive their flu vaccination during the lunch break. Vaccination helps to protect you and those around you, including patients, colleagues and others who may be particularly vulnerable to flu. It only takes a few minutes, and every vaccination makes a difference.

Board of Directors meeting held in private

The meeting will be held from 2.45pm – 5pm in the Boardroom at West Park Hospital Edward Pease Way, Darlington, DL2 2TS and via MS Teams

AGENDA

1. Meeting Details

Meeting	Board of Directors
Date	Wednesday 28 October 2026
Time	9.30am to 1.00pm
Venue	Boardroom at West Park Hospital, Edward Pease Way, Darlington, DL2 2TS and via MS Teams
Chair	Marie Burnham, Trust Chair
Secretariat	Anna Pridmore, Company Secretary & Director of Governance

2. Agenda

Ref	Agenda Item	BAF reference	Purpose	Lead	Paper Ref	Time
1	Welcome, introductions and confirmation of quoracy	-	-	Chair	Verbal	09:30
2	Apologies for absence	-	-	Chair	Verbal	
3	Declarations of interest	10. Regulatory Compliance	-	Chair	Paper A	
4.	Questions from members of the public	-	**Information**	Int. Company Secretary & Director of Governance	Verbal	09:35
5.	Minutes of the previous meeting held on 23 September 2026	-	**Decision**	Chair	Paper B	09:40
5.1	Matters arising / review of action log	-	**Assurance**	Chair	Paper C	
6.	Chair's Remarks	-	**Information**	Chair	Verbal	09:45
7.	Chief Executives Report, including an update on the public inquiry	13. Public inquiry	**Assurance**	Chief Executive	Paper D	09:50

Risk and Assurance						
8.	Report of the Chair of Audit and Risk Committee *(for information – verbal report provided at the last meeting)*	09. Regulatory compliance	**Assurance**	Committee Chair	Paper E	-
Performance Oversight and Assurance						
9.	Report of the Chair of Quality Assurance Committee	03. Patient Experience, 04. Quality & Outcomes	**Assurance**	Committee Chair	Paper F	10:05
10.	Report of the Chair of Mental Health Legislation Committee	-	**Assurance**	Committee Chair	Paper G	10:15
11.	Report of the Chair of People, Culture and Diversity Committee	01. Safe Staffing	**Assurance**	Committee Chair	Paper H	10:25
11.1	Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard & publication of staff equality information Annual Reports	01. Safe Staffing	**Decision**	Int. Executive Director for People & Culture	Paper I	
12.	Report of the Chair of Finance and Performance Committee	02. Access, 08.Partnerships & system working 11. Financial sustainability 12. Transformation	**Assurance**	Committee Chair	Paper J	10:40
13.	Report of the Chair of Planning, Digital and Estates Committee	05. Digital – supporting change, 06. Estates/ Physical infrastructure 07. Data security & protection, 10. RPH	**Assurance**	Committee Chair	Paper K	10:50

Break						11:00
14.	Board of Directors to receive a patient story	-	**Assurance**	Int. Executive Director for People & Culture	Verbal	11:10
15.	Spotlight Report on Adult Mental Health Planned Care: Core Community Offer	02. Access 04. Quality & outcomes 05. Financial sustainability	**Assurance**	Int. Care Group Managing Director	Paper L	11:40
16.	Integrated Quality Performance Report	All	**Assurance**	Int. Executive Director for Strategy & Transformation Int. Care Group Managing Director	Paper M	11:55
17.	Safer Staffing	01. Safe Staffing	**Assurance**	Chief Nursing Officer/Dep, Chief Executive	Paper N	12:30
Exceptional items						
18.	Any other business *Board members are reminded of the opportunity to receive their flu vaccination during the lunch break.*	-	**Discussion**	Chair	Verbal	12:40
19.	Summary of key decisions and items for escalation	-	**Assurance**	Chair	Verbal	12:50
20.	Date and time of next meeting *9:30am on Thursday 26 November 2026*	-	**Information**	Chair	Verbal	-
21.	Exclusion of the Press and Public		**Decision**	Chair	Verbal	13:00
For information						
22.	Board Assurance Framework and Corporate Risk Register	All	**Information**	Int. Company Secretary & Director of Governance	***See library***	-

3. Distribution List

Members	In Attendance / Copy
Marie Burnham, Trust Chair (Chair)	A Pridmore, Int. Company Secretary & Director of Governance
Alison Smith, Chief Executive	K Christon, Deputy Company Secretary
Nini Adetubery, Non-Executive Director	
Roberta Barker, Non-Executive Director	
David Butcher, Associate Non-Executive Director (non-voting)	
Phil Corrigan, Non-Executive Director	
Hannah Crawford, Executive Director for Therapies and Patient Experience (non-voting)	
Kathryn Ellis, Int. Executive Director of Strategy and Transformation (non-voting)	
Edward Gorringe, Associate Non-Executive Director (non-voting)	
Lesley Hodge, Int. Executive Director for People and Culture	
Kedar Kale, Executive Medical Director	
Naomi Lonergan, Int. Care Group Managing Director	
John Maddison, Non-Executive Director	
Beverley Murphy, Chief Nursing Officer/ Deputy Chief Executive	
Jules Preston, Non-Executive Director	
Len Richards, Non-Executive Director	
Liz Romaniak, Executive Director for Finance, Estates and Facilities	
Catherine Wood, Non-Executive Director	

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BOARD REPORT

1. Cover Sheet

Report Title	Board of Directors Register of Interests
Meeting	Board of Directors
Date of Meeting	28 October 2026
Paper	A
Sponsoring Director / Author	A Smith, Chief Executive
Report Author	A Pridmore, Interim Company Secretary and Director of Governance
Purpose of Paper	Assurance
Previously Considered By	n/a
Financial Implications	None.

2. Recommendation

The Board is asked to:
The Board is invited to receive and note the Register of Interests, identify any amendments required and declare any interests which may be relevant to matters on the agenda.

3. Executive Summary

This report presents the Board of Directors Register of Interests as at 22 October 2026. The Trust is required to maintain a register of directors' interests in accordance with paragraph 20(1)(d) of Schedule 7 to the NHS Act 2006. The register supports the Trust's governance and compliance framework by ensuring that actual, potential and perceived conflicts of interest are identified and managed appropriately. It has been updated using information submitted by individual Directors and is published on the Trust's website in support of the Annual Governance Statement requirements.

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	Strategic Goal 3: We will be a trusted partner.
Board Assurance Framework	BAF Risk 10 — Regulatory Compliance.
Corporate Risk Register	Not applicable.
Committee / Work Programme Ref	Board of Directors standing governance requirement.
Regulatory / Legal Reference (if applicable)	NHS Act 2006, Schedule 7, paragraph 20(1)(d); Trust policy HR-0020-v4.3; NHS England guidance.

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BOARD REPORT

Report Title	Board of Directors Register of Interests
Meeting	Board of Directors — Public
Date of Meeting	28 October 2026
Item number	Linked to the agenda

1. Background

The Trust is required to maintain a register of directors' interests in accordance with paragraph 20(1)(d) of Schedule 7 to the NHS Act 2006. The format of the register and definitions of interests reflect Trust policy HR-0020-v4.3, which is based on NHS England guidance. The register has been updated from information submitted by individual Directors and is published on the Trust website.

2. Key Issues and Findings

The attached register records the interests declared by members of the Board of Directors as at 22 October 2026. There are no amendments since the previous Board meeting in September 2026. The register enables the Board to identify any actual, potential or perceived conflicts requiring management.

2.1 Assurance

- Assurance is provided that the Trust maintains and publishes a Register of Interests in accordance with its statutory and governance obligations.
- The register has been updated using declarations submitted by individual Directors; the Board is invited to identify any further amendments required.

2.2 Risks

- Failure to maintain effective processes for identifying and managing conflicts of interest could result in non-compliance with statutory, regulatory and provider licence requirements.
- This risk is mitigated through regular review of declarations, Board member confirmation of relevant interests and publication of the register.

3. Options Considered

Not applicable. This report is presented for assurance.

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	No direct impact.
Safeguarding	No direct impact.
Equality, Diversity & Inclusion	No direct impact.
Workforce	No direct impact.
Financial / Resource	No direct financial or resource impact.
Legal	Supports compliance with paragraph 20(1)(d) of Schedule 7 to the NHS Act 2006.
Protected characteristics	No direct impact.

5. Appendices

Appendix	Title
A	Board of Directors Register of Interests

6. Document Control

Version	Date	Author	Summary of Changes
0.1 Draft	22 October 2026	K Christon	Draft report for review
1.0 Final	22 October 2026	A Pridmore	Final report for consideration by Board

Board of Directors, Register of Interests
22 October 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 Consultng 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 MEETING

1. Meeting Details

Meeting	Board of Directors meeting held in public
Date	Wednesday 23 September 2026
Time	10.00am – 1.00pm
Venue	Boardroom, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS and via Microsoft Teams
Chair	Marie Burnham, Trust Chair
Minute Taker	Donna Keeping, Corporate Governance Manager
Status	DRAFT – Pending ratification

2. Present and in attendance

Marie Burnham, Trust Chair (voting)
Nini Adetuberu, Non-Executive Director (voting)
David Butcher, Associate Non-Executive Director (non-voting)
Phil Corrigan, Non-Executive Director (voting)
Edward Gorringe, Associate Non-Executive Director (non-voting)
Jules Preston, Non-Executive Director (voting)
Len Richards, Non-Executive Director (voting)
Catherine Wood, Non-Executive Director (voting)
Alison Smith, Chief Executive (voting)
Hannah Crawford, Executive Director of Therapies and Patient Experience (non-voting)
Sarah Dexter-Smith, Executive Director for People and Culture (voting)
Kathryn Ellis, Interim Executive Director of Strategy and Transformation (non-voting)
Kedar Kale, Executive Medical Director (voting)
Naomi Lonergan, Interim Care Group Managing Director (voting)
John Maddison, Non-Executive Director (voting)
Beverley Murphy, Chief Nurse/Deputy Chief Executive (voting)
Liz Romaniak, Executive Director of Finance, Estates and Facilities (voting)
In attendance
Cathy Hassell, Public Inquiry Programme Director
Lisa Taylor, Care Group Director Health and Justice
Anna Pridmore, Interim Company Secretary and Director of Corporate Governance
Catherine Parker, Consultant in Public Health
Abigail Neasham, Public Health Specialty Registrar
Donna Keeping, Corporate Governance Manager

3. Apologies for Absence

Roberta Barker, Non-Executive Director

4. Declarations of Interest

Name	Agenda Item	Nature of Interest
Catherine Wood	4	The Board noted the Register of Interests and Catherine Wood's declaration that, from September 2026, she would be Co-chair of the British Institute of Learning Disabilities (BILD) Growing Older with Learning Disabilities (GOLD) steering group.

5. Minutes

Ref	Agenda Item	Discussion / Decision / Action
26/09/100	**Chair's welcome and introduction**	The Chair welcomed members and attendees and confirmed the revised order of business, with the Health and Justice Services presentation to be considered first. The Board was quorate. The Chair noted that this was Sarah Dexter-Smith's final Board meeting, thanked her for her contribution to the Trust and wished her well in her new role.
26/09/101	**Patient story**	The Board was advised that the planned patient story could not be presented as the patient was not available.
26/09/102	**Public questions**	No questions were received from members of the public.
26/09/103	**Minutes of the meeting held on 13 August 2026**	The minutes of the meeting held on 13 August 2026 were approved as a true and accurate record of the meeting.
26/09/104	**Spotlight – Health and Justice Services**	The Chair welcomed Lisa Taylor, who presented an overview of the scale, geographical reach, governance and performance of Health and Justice Services. The Board noted the scale of the service, including 4,490 referrals across prison and community pathways between April and June 2026; the mixed commissioning and partnership model; the focus on staff wellbeing, lived experience, pathway development, innovation and specialist provision; and the positive external recognition received. The Chief Executive emphasised the value of the service, its national recognition and the confidence expressed by commissioners. Members welcomed the quality and innovation demonstrated and noted risks relating to recruitment, sickness absence, agency use, remote working

		environments and estate issues. The Board also recognised the need to strengthen links with therapies provision and received assurance that the Quality Assurance Committee maintained oversight of quality standards and Care Quality Commission outcomes. The Board thanked Lisa Taylor and the teams for their work.
26/09/105	**Board Action Log**	The Board noted the action log. Clarification was provided regarding action 19(4). In relation to leadership walkabouts, the Board noted that Quality Assurance Committee had supported the proposed approach and requested a progress briefing to the private Board meeting in October 2026, with the full report to follow. A final report would be provided to the January 2027 Board from the QAC. The Council of Governors would also receive an update at the September meeting. **ACTION:** Provide a progress briefing on leadership walkabouts to the private Board meetings going forward. A final report will be provided to the January 2027 Board from the Quality Assurance Committee. *Owner: Chief Nurse | Due: Progress briefing: 28 October 2026; final report: January 2027 Board*
26/09/106	**Chair's remarks**	The Chair reported extensive engagement with staff, services, Governors and external stakeholders, including visits to Bishop Auckland, Darlington, York, Ripon and other localities, and attendance at the Annual General Meeting. She highlighted positive staff engagement and service quality. Issues raised during the visit to the Orchards had been escalated to the Chief Executive, who confirmed that the Interim Care Group Managing Director was following these up. The Chair also reported a constructive meeting with Sir Julian Smith, MP for Skipton and Ripon. The Chair welcomed the commencement of the Public Inquiry and the appointment of His Honour Judge John Potter. The Board noted the update.
26/09/107	**Chief Executive's Report and Public Inquiry**	The Board received the Chief Executive's report, including reflections on her first year, regional assurance, the National Operating Framework, strategy development, suicide prevention and the Hub of Hope. The Board noted that the Trust remained in Segment 2 and that the new metrics had altered relative rankings.

		Cathy Hassell, Public Inquiry Programme Director, presented an update on Public Inquiry preparedness, including document preservation, organisational readiness, emerging risks, staff support, communications and monthly Board reporting. The Board discussed whether a Non-Executive Director should be included in the Decision-Making Group. It was agreed that the Chair and Chief Executive would consider arrangements for independent assurance and appropriate Non-Executive Director involvement, reflecting the Board's unitary responsibilities. The Chief Executive emphasised the arrangements established to separate the Trust's response to the Public Inquiry from the continued delivery of business-as-usual activities. The Board discussed communications and noted that, as the Trust was a subject of the Public Inquiry, it would not lead communications on the Inquiry itself. The Trust would, however, maintain an internal plan to coordinate with key stakeholders and agencies, ensure clear and consistent messages, and provide appropriate web and email contact routes. The plan would be reported to the Board through the regular updates. Resource requirements and the anticipated work profile would be considered in private session. The Board noted the appointment of His Honour Judge John Potter, endorsed the approach to organisational readiness and approved the amended Terms of Reference for the Public Inquiry Decision-Making Group, subject to minor drafting corrections. **ACTION:** Review the Public Inquiry Decision-Making Group arrangements to consider assurance and appropriate Non-Executive Director involvement and correct the minor drafting points identified. *Owner: Trust Chair / Chief Executive / Public Inquiry Programme Director | Due: To be confirmed*
26/09/108	**Listening Report**	The Chief Executive presented the Phase One Listening Report, based on engagement with patients, families and carers. Themes included loss of trust, fear of re-engagement, the need for independent support, the impact of processes and communication, records accuracy, bereavement support, visible accountability and feedback on learning. The Board welcomed the compassionate approach and emphasised that listening must lead to accessible evidence

		of action and impact. The Board received the report, endorsed the development of a coordinated thematic action plan and agreed that oversight would be through Quality Assurance Committee, with quarterly updates to the Board. The Chief Executive would maintain established relationships where appropriate; new cases would be led by the Executive Director of Therapies and Patient Experience. **ACTION:** Develop the thematic action plan, triangulate the themes with existing intelligence and provide progress through Quality Assurance Committee and quarterly to the Board. *Owner: Executive Director of Therapies and Patient Experience | Due: To be confirmed; quarterly reporting to the Board*
26/09/109	**Board Assurance Framework and Corporate Risk Register**	The Board received the first combined report on the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) and noted the improved presentation and linkage between strategic and corporate risks. The Board noted that the Audit and Risk Committee meeting had not been quorate and had therefore made no formal decision. However, the members present had supported reasonable assurance from the report on the processes adopted to manage and update the BAF and CRR. The Board noted that nine of 13 strategic risks were above tolerance and that further work was required to strengthen control-effectiveness evidence, assurance mapping and risk trajectories. The Board took reasonable assurance from the report with regards to the risk management process and noted that scores relating to financial sustainability and the Public Inquiry would be revisited as part of the private-session discussions. The continuing development of the BAF, including greater consistency of updates and executive review, was supported.
26/09/110	**Audit and Risk Committee report**	John Maddison, Chair of the Audit and Risk Committee, provided a verbal summary from the meeting held on 21 September 2026. It was noted that the meeting was not quorate and had therefore made no formal decisions. The Committee had generally received good or reasonable assurance across governance, counter fraud, internal control, financial governance, the BAF and provider capability.

		Areas requiring continued focus included capacity and resilience, delivery of the internal audit programme, outstanding recommendations, clinical supervision, waiting-list management and the Winter Resilience Plan. The Board noted the update and emphasised the importance of robust clinical and professional supervision.
26/09/111	**Quality Assurance Committee report**	Phil Corrigan, Chair of the Quality Assurance Committee, presented the Committee report. The Board received and noted the report, which contained different assurance levels by topic: • Limited assurance — controls for services requiring additional support; timeliness of completed After-Action Reviews and mortality reviews. • Reasonable assurance — timeliness of immediate reviews following patient-safety incidents. • Substantial assurance — timely allocation and reporting of patient-safety incident investigations. • Good assurance — compliance with Learning from Deaths requirements and associated review, investigation and learning arrangements. Alerts included limited controls assurance for services requiring additional support; enhanced surveillance of Secure Inpatient Services; workforce pressures; patient flow; restrictive interventions in Adult Learning Disability Services; outcome measures in Adult and Older People's Services; and timeliness of After-Action Reviews and mortality reviews. Positive assurance included strong patient and carer experience, improving children and young people's outcomes, no out-of-area placements, compliance with Learning from Deaths requirements and strong medicines governance. The Board noted the move to an opt-in approach for use of Oxehealth/Lio technology. Members requested a full clinical, ethical, financial and contractual review of the technology, taking account of national developments, with findings to return via Quality Assurance Committee. The Chair concluded that the report had been well received, recognising the varying levels of assurance reported across individual areas. **ACTION:** Complete the review of Oxehealth/Lio technology and report through Quality Assurance Committee to the Board. *Owner: Chief Nurse | Due: To be confirmed; report through the Quality Assurance Committee to the Board*

26/09/112	**Integrated Quality and Performance Report**	The Board received the report and noted the mid-year regional review had provided positive feedback on organisational grip, control and shared ownership of challenges. Key matters included clinically ready for discharge, waiting times, sickness absence, bank expenditure, restrictive interventions and outcome measures. Positive assurance included improved inpatient safety feedback, elimination of inappropriate out-of-area placements, strong children and young people's outcomes and delivery of the 104-week recovery trajectory. The Board noted that clinically ready for discharge remained a significant system-dependent challenge, particularly in North Yorkshire and York, but that patient flow had been maintained through significant operational effort. Work would continue through the Hospital to Community Programme Board, locality plans and system escalation. The Board confirmed good controls assurance and reasonable performance and improvement assurance.
26/09/113	**Population Health Intelligence**	Catherine Parker, Consultant in Public Health, was welcomed to the Board. She presented the draft locality profiles, which drew together population need, inequalities, drivers of demand and community assets. The Board supported their use in the strategy refresh, locality and neighbourhood models, clinical planning, workforce design, investment and the IQPR. Members emphasised the need for granular neighbourhood-level information to avoid masking deprivation, rurality and hidden need within broader geographic areas. The Board noted the profiles and supported their ongoing development with partners. Prototype neighbourhood profiles would be developed for consideration through the Executive Directors and the December Board strategy seminar. The Board thanked Catherine for her work and presentation. **ACTION:** Develop neighbourhood-level profiles for consideration by the Executive Directors Group and inclusion in the December 2026 Board strategy work. *Owner: Consultant in Public Health / Interim Executive Director of Strategy and Transformation | Due: December 2026*

26/09/114	**Winter Resilience Plan 2026/27**	The Interim Care Group Managing Director presented the report. The Board considered the Winter Resilience Plan 2026/27 and the associated Board Assurance Statement, including the assessment of the Trust's readiness for winter. The readiness assessment provided moderate/reasonable assurance. The Board noted the established arrangements for operational flow, escalation, infection prevention and vaccination. Residual risks remained in relation to patients who were clinically ready for discharge, occupancy, workforce resilience, flu vaccination, fit testing, Section 136 capacity, severe weather and wider socioeconomic pressures. The Board approved both the Winter Resilience Plan 2026/27 and the associated Board Assurance Statement for submission to the Integrated Care Board. It endorsed the reasonable-assurance assessment, recognising the residual risks, and supported continued executive oversight at the agreed review points.
26/09/115	**Revalidation, Appraisal and Job Planning**	The Executive Medical Director presented the annual report and provided good assurance that doctors were appropriately appraised, revalidated and supported. The Board noted 97% appraisal completion, 100% revalidation for doctors due in the period and job-plan completion reaching 96% shortly after year-end. The Board welcomed the external assurance received and discussed appraiser capacity, appraisal quality, productivity, capacity and demand. The Board approved the report and associated statement for signature by the Chief Executive and Executive Medical Director.
26/09/116	**Provider Capability Assessment 2026/27**	The Interim Executive Director of Strategy and Transformation presented the report. The Board reviewed the evidence-based self-assessment, which had been considered by the Executive Directors Group and Audit and Risk Committee and independently reviewed by Internal Audit. Members noted that the assessment tested both governance arrangements and evidence of impact, and that over 300 items of evidence supported the ratings. The Board approved the Provider Capability Assessment for submission by 2 October 2026.

26/09/117	**Revised governance system**	The Interim Company Secretary presented the revised governance system, committee terms of reference and work programmes. The Board noted that implementation had been completed at pace and that work programmes would continue to develop as the organisation transitioned to monthly committee cycles. Subject to the minor membership amendments identified, the Board approved the revised governance system and Terms of Reference for implementation from 1 October 2026. The Board noted the implementation, training, monitoring and February 2027 review arrangements. The Board approved the delegated authority to the Chief Executive and Interim Company Secretary to make non-material final amendments and requested a post-implementation report following the February review. **ACTION:** Undertake the post-implementation review in February 2027 and report the outcome to the Board via the Audit and Risk Committee by June 2027. *Owner: Interim Company Secretary and Director of Corporate Governance | Due: June 2027*
26/09/118	**Improvement Governance Action Plan**	The Interim Company Secretary presented the report. The Board received the update on actions arising from the Deloitte review and the Trust's self-assessment against the Albury report. The Board noted that, although the Audit and Risk Committee had not been quorate and had therefore made no formal decision, the members present had supported reasonable assurance from the process adopted. The Board noted the report and the requirement for further evidence of implementation and impact, with most actions expected to be completed by March 2027.
26/09/119	**Any Other Business and next meeting**	No further business was raised. The next meeting was scheduled for 9.30am on Wednesday 28 October 2026 at West Park Hospital, Darlington. The public meeting concluded and the Board resolved to exclude representatives of the press and public from the remaining business because of its confidential nature.

6. Ratification

These minutes are agreed as a true and accurate record of the meeting.

Chair Signature	Date
Printed Name:	

7. Document Control

Version	Date	Author	Summary of Changes
Draft v1.0	26 September 2026	Donna Keeping	Initial draft for Chair review
Draft v1.1	2 October 2026	Anna Pridmore	Review of draft
Draft v1.2	26 October 2026	Alison Smith	Minor amendments

Tees, Esk and Wear Valleys
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ACTION LOG

1. Log Details

Committee / Group	Board of Directors
Log Maintained By	Karen Christon, Deputy Company Secretary
Last Updated	22 October 2026

2. Outstanding Actions

Date of meeting and Min. Ref	Action	Owner	Raised	Due	Status	Progress
12-Feb-26 221 (1)	Timescales for the independent quality review to be confirmed, with progress to be overseen by Quality Assurance Committee	Chief Nursing Officer	12-Feb-26	Jul-26	**Completed**	Oct26 update: Reported to Quality Assurance Committee in October 2026 – see committee report to Board. **Propose action is closed.**
09-Apr-26 8 (5)	Strategic objectives to be developed for 2026/27	Chief Executive	09-Apr-26	~~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. Oct26 update: scheduled for discussion at the private Board meeting.
09-Apr-26 8 (5)	Executive directors to consider whether existing processes provide sufficient intelligence to support effective triangulation of	Int. Executive Director of Strategy & Transformation	09-Apr-26	~~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.

Date of meeting and Min. Ref	Action	Owner	Raised	Due	Status	Progress
	data and if the BAF enables the Board to see all necessary assurances.	Int. Company Secretary & Director of Corporate Governance				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. Oct 26: New governance arrangements in place and currently being embedded. This will be part of the assessment undertaken at the end of the first period of running the new governance system. Enhanced governance arrangements in place for the triangulation between the BAF and the CRR and rolled out to all committees.
11-Jun-26 47	Board report templates to be revised to ensure Board is able to track issues that require action or escalation across Board committees	Int. Company Secretary & Director of Corporate Governance	11-Jun-26	Sept-26	**Completed**	Oct26 update: New Board report templates in place. **Propose action is closed.**
13-Aug-26 90 (2)	Future Board development session to be held on the purpose and application of the Board Assurance Framework and the Corporate Risk Register	Int. Company Secretary & Director of Corporate Governance	13-Aug-26	tbc	**In Progress**	Sept26 update: the proposal currently is that AQUA provide training at one of their development sessions. Timing to be agreed. Oct 26 update: Timing to be confirmed with the Chair and AQUA.
13-Aug-26 94 (3)	Quarterly update on progress against key milestones in the clinically ready for discharge improvement plan to be provided to Finance and Performance Committee	Int. Care Group Managing Director	13-Aug-26	tbc	**In Progress**	Sept26 update: report scheduled on the new Finance and Performance Committee work plan – date to be confirmed. Oct26 update: Finance & Performance Committee to hold a development session in November to finalise its work programme.
23-Sept-26 26/09/105	Provide a progress briefing on Quality Visits to the private Board meeting in October 2026. A final report will be provided to the	Chief Nurse	23-Sept-26	28-Oct-26 Final report:	**In Progress**	Oct26 update: Proposals to be discussed by Quality Assurance Committee on 11 November 2026 and then reported to Board.

Date of meeting and Min. Ref	Action	Owner	Raised	Due	Status	Progress
	January Board from the Quality Assurance Committee.			January 2027		
23-Sept-26 26/09/107	Review the Public Inquiry decision-making group arrangements to consider independent assurance and appropriate Non-Executive Director involvement and correct the minor drafting points identified.	Trust Chair / Chief Executive / Programme Director	23-Sept-26	Nov-26	In Progress	Oct26 update: in discussion with the Chair we are progressing with a monthly review cycle of the PI decision making group – entitled PI Assurance Briefing and plans are progressing to initiate this approach from November 2026.
23-Sept-26 26/09/108	Listening Report - develop the thematic action plan, triangulate the themes with existing intelligence and provide progress through the Quality Assurance Committee and quarterly to the Board.	Executive Director of Therapies and Patient Experience	23-Sept-26	November 2026	In Progress	Oct26 update: initial response to the listening report to be provided to Quality Assurance Committee and reported to Board via the committee report. Future reports to be provided quarterly thereafter.
23-Sept-26 26/09/111	Complete the review of Oxehealth/Lio technology and report through the Quality Assurance Committee to the Board.	Chief Nurse	23-Sept-26	January 2027	Not Started	Update26 update: Scheduled for discussion at Quality Assurance Committee in December 2026
23-Sept-26 26/09/113	Develop neighbourhood-level profiles for consideration by the Executive Directors Group and inclusion in the December 2026 Board strategy work.	Consultant in Public Health / Interim Executive Director of Strategy and Transformation	23-Sept-23	December 2026	In Progress	Oct26 update: Public health analysis will form part of the strategy analysis work to contribute to the December Board seminar. There will be consideration of the synthesis of this at December Planning, Digital and Estates Committee, ahead of the December Board seminar.
23/09/2026 26/09/118	Undertake the post-implementation review in February 2027 and report the outcome to the Board via the	Interim Company Secretary and Director of Corporate Governance	23-Sept-23	June 2027	Not Started	Review to be undertaken in February 2027.

Date of meeting and Min. Ref	Action	Owner	Raised	Due	Status	Progress
	Audit and Risk Committee by June 2027.					

Completed	In Progress	Overdue	Not Started

3. Completed actions

Date of meeting and Min. Ref	Action	Owner	Raised	Due	Status	Progress
9-Apr-26 5	All action owners to provide progress updates on actions due to completion at a later date	All action owners	April 2026	Jun-26	**Completed (closed June26)**	June update: Actions updated - action closed
9-Apr-26 9 (2)	A Smith/K Ellis to investigate concerns about the quality of data that underpinned the IPR (as highlighted at Quality Assurance Committee)	A Smith K Ellis	April 2026	Jun-26	**Completed (closed June26)**	June update: Review of Quality Assurance Committee (QAC) discussion referenced at April Board has taken place with the Executive lead for QAC. Concerns raised at April Board did not relate to the Integrated Performance Report, but rather systems reporting issues which have impacted particular measures reported via the Quality Dashboard and Ward/Team level Dashboard at QAC. Further work is scheduled to review and resolve these, with progress updates to QAC. Action Closed
9-Apr-26 10 (7)	Trust's report template to be reviewed/revised	A Smith A Pridmore	April 2026	Linked to governance improvement plan	**Completed (closed June26)**	June update: This action is included within the Governance Improvement Plan and will be progressed as the plan is progressed. CEO proposes to close the action as it will be included in the overarching plan oversight via Audit and Risk Committee and Board, as updates are provided. Action Closed.

Date of meeting and Min. Ref	Action	Owner	Raised	Due	Status	Progress
9-Apr-26 12(4)	In response to a query on the number and nature of risks on the Corporate Risk Register compared with other MHLD Trusts, benchmarking to be undertaken and shared informally with Board.	B Murphy, Chief Nurse	9-Apr-26	Jul-26	**Completed (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.
9-Apr-26 13 (3)	Quality Assurance Committee to consider the Trust's zero tolerance approach to use of prone restraint	B Murphy, Chief Nursing Officer	April 2026	Jun-26	**Completed (closed June26)**	June update: The annual Positive and Safe report was presented at June QAC, within this report assurances were given to the approach to prone restraint and further improvement plans. Prone will continue to be reported into QAC and always noted in the triple A report to the Board, the Board will therefore have an opportunity to review the impact of the proposed interventions.
11-Jun-26 49	Board noted low 'feeling safe' patient response rates and agreed to receive an update on the finding of work that would be undertaken to understand the position and monitor trends.	Executive Director for Therapies and Patient Experience	11-Jun-26	Aug-26	**Completed (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-Aug-26 94 (10)	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, Public Health Consultant.	13-Aug-26	Sept-26	**Completed (closed Sept26)**	Completed – report considered at Board on 23 September 2026.

Date of meeting and Min. Ref	Action	Owner	Raised	Due	Status	Progress
13-Aug-26 98 (4)	Briefing to be held for new Non-Executive Directors (and offered to all NEDS) on the Organisational Learning Group, who undertake work to understand the impact of learning through a broad range of intelligence.	Executive Director for Therapies and Patient Experience	13-Aug-26	Sept-26	**Completed (closed Sept26)**	Completed – briefing scheduled for 28 September 2026

4. Notes for Use

This log should be reviewed and updated at the start of each meeting under the 'Matters Arising' agenda item, with completed actions retained for audit trail purposes rather than deleted.

Minute Ref values must match the Ref column used in the corresponding Minutes document exactly including the date of the meeting (e.g. an action arising from minute 5 is logged as 5; a sub-item from matters arising is logged as 4.1).

Actions overdue by more than one reporting cycle should be flagged to the Chair for escalation.

5. Document Control

Version	Date	Author	Summary of Changes
0.1	23 September 2026	D Keeping	Actions from Board meeting added.
0.2	22 October 2026	K Christon	Updated for Board of Directors meeting on 28 October 2026.

Tees, Esk and Wear Valleys NHS Foundation Trust

BOARD REPORT

1. Cover Sheet

Report Title	CEO Public Board Report
Meeting	Trust Board Public
Date of Meeting	28/10/2026
Paper	D
Sponsoring Director / Author	Alison Smith - CEO
Report Author	Alison Smith - CEO
Purpose of Paper	**Information**
Previously Considered By	N/A
Financial Implications	

2. Recommendation

The Board is asked to:
Note the report for information.

3. Executive Summary

To brief the Board on key issues relevant to the Chief Executive.

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	N/A
Board Assurance Framework	N/A
Corporate Risk Register	Not applicable
Committee / Work Programme Ref	N/A
Regulatory / Legal Reference (if applicable)	N/A

BOARD REPORT

Report Title	CEO Public Board Report
Meeting	Trust Board Public
Date of Meeting	20/10/2026
Paper	D

Key updates

Structure update – Following approval of the revised executive structure, associated corporate portfolio changes have been implemented in phases, with updates reported through Corporate LCC. Patient Experience, Involvement and Engagement, and Lived Experience have transferred to the Therapies and Patient Experience portfolio. Communications has moved to the Director of Transformation and Strategy in preparation for the new Delivery Directorate. Digital and Data will also join the Delivery portfolio but have not yet transferred. Further changes, including to the Corporate Governance structure, are progressing through the appropriate organisational change processes, with implementation expected by the end of February 2027.

Consultant strike – The BMA has confirmed two days of strike action by consultant doctors in England on 25 and 26 November 2026, following the failure to reach agreement with the Government over pay, workload, wellbeing and the sustainability of the consultant role. The action follows a mandate secured in July and discussions involving the Department of Health and Social Care, NHS Employers and trade unions. Consultants are expected to provide emergency, Christmas Day-level cover. The BMA has stated that the strikes could be avoided if the Government commits to adequately funded formal negotiations on pay and working conditions.

Public Inquiry – The Trust welcomes the appointment of His Honour Judge John Potter as Chair, an important step for the patients, families and loved ones involved, and awaits publication of the Terms of Reference. The Trust has begun responding to information requests to support the Chair's preparations and has established governance arrangements to coordinate its response.

The Public Inquiry Management Team continues to establish the systems and processes required for the Trust to comply fully, honestly and efficiently. This includes secure arrangements to preserve, retrieve and disclose documentary evidence, and to record information-search methods. A network of departmental leads and heads of service will coordinate responses, identify relevant records, subject-matter experts and key staff, and support timely communication and information-sharing. The Trust is also providing enhanced wellbeing support for current and former staff who may be affected by the Inquiry.

A Privacy Notice has been published in accordance with the Trust's data protection obligations, explaining how personal data is collected, used and protected. Preparatory work continues to strengthen organisational readiness ahead of publication of the Terms of Reference and the start of formal Inquiry proceedings.

The Thirlwall Inquiry report and recommendations on events at the Countess of Chester Hospital were published in September 2026. They will be reviewed through the Quality Assurance Committee and corporate governance arrangements, with findings reported to the Trust Board in November.

Independent review of mental health conditions, autism and ADHD – Professor Peter Fonagy's independent review was published in October 2026. The key findings from the extensive 600-page report are summarised below.

The review found a genuine rise in distress, particularly among children, young people, girls and young women. Greater awareness alone does not explain this increase, which is affecting participation in education, employment, relationships and community life. It also identified a mismatch between rising referrals for ADHD and autism and evidence on underlying prevalence. The central recommendation is to move from a diagnosis-led system to a needs-led model that offers earlier support while protecting specialist assessment and treatment for those who need it.

Key findings

- **Rising distress:** Population data, service activity and referral patterns indicate increased anxiety, depression, eating disorders and self-harm, particularly among younger people.

- **Wider drivers:** Financial and housing insecurity, harmful online environments, loneliness, reduced belonging, limited opportunities for connection and physical activity, and insufficient recovery from stress are significant contributors.

- **ADHD and autism:** Referrals and waiting lists have risen substantially, while evidence suggests that population prevalence is broadly stable or increasing only modestly. Better population-level data are needed before firm conclusions can be drawn.

- **Greater awareness:** Increased awareness has enabled many people, particularly women with previously unmet neurodevelopmental needs, to seek support. However, demand has outpaced access to trusted information, practical help and timely services.

- **Diagnosis-led support:** Diagnosis has too often become the gateway to support, leaving people waiting months or years for assessment, while some people with severe, complex and enduring needs do not receive the specialist care they require.

- **Co-occurring needs:** Many people's needs span more than one diagnostic category, and fragmented, diagnosis-specific pathways can limit effective support.

Recommended actions

- Move from a diagnosis-led to a needs-led system, making support available earlier and according to individual need.
- Protect and strengthen diagnostic assessment and specialist services for people who need them.
- Increase the focus on prevention, public mental health and the social and environmental causes of distress.
- Integrate mental health and neurodevelopmental support to reduce fragmentation between services.
- Improve access to evidence-based treatment and support, particularly for severe, complex and enduring needs.
- Reduce treatment gaps and long waits while strengthening specialist provision.
- Reform commissioning, regulation, workforce planning, digital infrastructure and data collection, with stronger oversight of neurodevelopmental assessment pathways.

The Executive Team will consider the report in more detail over the coming weeks, while awaiting the national mental health strategy and further guidance on the required response.

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	No direct impact
Safeguarding	No direct impact
Equality, Diversity & Inclusion	EIA not required
Workforce	No direct impact
Financial / Resource	No direct impact
Legal	No direct impact
Protected characteristics	No direct impact

5. Appendices

Appendix	Title
n/a	

6. Document Control

Version	Date	Author	Summary of Changes
1.0	26 October 2026	A Smith, Chief Executive	Final report

Tees, Esk and Wear Valleys
NHS Foundation Trust

Report to the Board of Directors

Committee Chair's 3A Report

Committee:	Audit and Risk Committee
Report to:	Board of Directors (Public)
Date of Committee meeting:	21 September 2026
Date of Board meeting:	28 October 2026
Committee Chair:	John Maddison, Non-Executive Director
Report author:	Donna Keeping, Corporate Governance Manager
Quorate:	No
Attendance:	Two of three voting members required for quoracy were present. Apologies were received from Nini Adetuberu, Non-Executive Director; the meeting proceeded on an advisory basis and no formal decisions were made.

1. Purpose of this report

This report provides the Board of Directors with a written summary of the business considered at the Audit and Risk Committee (ARC) meeting held on 21 September 2026. The Committee Chair provided a verbal update to the Board of Directors on 23 September 2026, and this written report is presented to the Board meeting on 28 October 2026. It highlights matters requiring the Board's attention and sets out the Committee's assurance across its areas of oversight, in line with its Terms of Reference and the Board Assurance Framework.

2. Key items considered at the meeting

Agenda item	Lead	Summary of discussion	Outcome
Governance System Update (Matters Arising)	Interim Company Secretary	The revised governance processes, including the Work Programme and Terms of Reference, were considered prior to being approved by the Board on 23 September 2026. A decision log and assurance map arising from the Board committees would be presented to ARC quarterly before being signed off by the Board. A new “strategic map” was positively received.	Members received good assurance.
Board Assurance Framework (BAF) and Corporate Risk Register (CRR)	Interim Company Secretary	This was the first report to consider the BAF and CRR together, with ARC focusing primarily on the robustness of the supporting risk and assurance processes. Digital, data security and protection, and financial sustainability were the highest-rated strategic risks. Several risks were above tolerance, and inconsistencies between strategic and corporate risk scores, together with gaps in controls and assurance, required further work.	Members received reasonable assurance on the risk and assurance process.

Agenda item	Lead	Summary of discussion	Outcome
		Members received reasonable assurance on the process, with the potential to move to substantial assurance once the identified improvements had been embedded.	
Executive Risk Group	Executive Director of Finance, Estates and Facilities	Members received reasonable assurance from the Executive Risk Group reports covering the June and August meetings. They noted continuing pressures in crisis services and secure pathways, including the related Services Requiring Additional Support (SRAS) processes and actions, together with responses to concerns about lone-working arrangements and the management of associated devices. Members requested further work to strengthen risk-register alignment, escalation of cross-cutting themes and the timeliness of risk and action reviews, which had dipped over the summer period.	Members received reasonable assurance.
Internal Audit Progress and Internal Audit Plan 2026/27	AuditOne / Executive Director of Finance, Estates and Facilities	Members noted continued pressure on delivery of the Internal Audit Plan, with outstanding 2025/26 work nearing completion alongside the 2026/27 programme. Recruitment was under way to increase AuditOne capacity, and further work was to be undertaken by AuditOne with Committee chairs to ensure the plan remained aligned to the Trust's principal risks. Substantial assurance had been provided on the NHS England provider capability self-assessment completed by the Trust and audited to gain third line assurance prior to submission. Reasonable assurance was reported for IAPT; however, fundamental control weaknesses remained. The Data Security and Protection Toolkit audit identified three mandated outcomes that had not been met, relating to resilience, back-up and response planning, and the mapping of essential functions and dependencies. An 'Approaching Standards' improvement plan was in place, with detailed oversight to be provided through the new Planning, Digital and Estates Committee (PDEC), executive decision-making and Board triangulation. Members received assurance on progress relating to one longstanding high-rated clinical supervision action and sought assurance on a further revised target date for a low-rated waiting-list management action. Members expressed advisory support for deferring the IT Supplier Management audit to January 2027, owing to capacity constraints	Members noted the position and expressed advisory support for the audit deferral.

Agenda item	Lead	Summary of discussion	Outcome
		within the Trust team, and requested a further update for December 2026.	
Provider Capability Assessment	Interim Executive Director of Strategy and Transformation	The assessment had undergone detailed executive challenge, and the report included an independent Internal Audit review. Substantial assurance was provided that conclusions across all six capability domains were supported by evidence. The Internal Audit advisory review supported Amber-Green ratings across all six domains and concluded that the assessment was substantially evidenced, while further work was required to demonstrate sustained outcomes and benefits. Members expressed advisory support for the seven recommendations and agreed that the findings should inform Committee work programmes, the Governance Improvement Programme and the Trust strategy refresh. As the Committee was not quorate, it could not make a formal recommendation; however, its advisory support was to be reported to the September Board when the assessment was submitted for formal approval.	Members expressed advisory support for Board approval.
EPRR and Winter Resilience	Interim Care Group Managing Director	Emergency Preparedness, Resilience and Response (EPRR) remained at limited but improving assurance, with progress across the four priority areas and recovery action plan at approximately 75% complete. Loss of specialist EPRR leadership and continuing capacity constraints represented the most significant risk; recruitment was under way, supported by interim operational resource and external NHS expertise. Members noted continuing concern and requested a review of the EPRR risk rating, capacity and capability. The Winter Resilience Plan provided moderate assurance, with principal residual risks relating to occupancy and clinically ready for discharge, staffing and Christmas rotas (including vacancies, sickness levels and agency control), vaccinations, crisis pathways and Section 136 arrangements. Submission to the ICB was due by 30 September. Positive performance in community transformation and access, together with reductions in out-of-area placements and improvements in discharge, provided some mitigation. As the Committee was not quorate, it could not formally recommend approval; however, the September Board would be informed that ARC had expressed advisory support for the submission.	Members received limited assurance for EPRR and moderate assurance for Winter Resilience.

Agenda item	Lead	Summary of discussion	Outcome
Counter Fraud and internal case management and Counter Fraud Annual Report	Counter Fraud Specialist / Director of Finance, Estates and Facilities Exec. Director of People and Culture/People Partner	Counter fraud delivery was progressing, with one legacy activity remaining and six completed. Assurance was received that outcome reporting had improved in response to revised NHS Counter Fraud Authority requirements. Members had received a separate email briefing on the outcome of a criminal prosecution in a case overseen by the Committee. The case was being used to raise awareness of, and help prevent, qualifications-related fraud. The Director of Finance, Estates and Facilities had approved the Counter Fraud Annual Report as the accountable Board member. Two functional standard areas remained amber: one reflected an in-year change to the national fraud-risk assessment methodology, meaning compliance could not be achieved; the other required further work to embed improvements relating to conflicts of interest. Members received good assurance that cases not meeting the criminal threshold were monitored and managed through internal processes, with a target timescale of 12 weeks from allegation to conclusion.	Members noted the position and received good assurance on internal case management.
Governance Improvement Action Plan	Interim Company Secretary	The governance plan comprised 90 actions: 32 were complete, 39 on track, 18 on track with challenges and one faced challenges to complete. Members received reasonable assurance on the monitoring and escalation process and requested routine progress updates, including commentary on any red actions.	Members received reasonable assurance on monitoring and escalation arrangements.

3. Key alerts — matters requiring Board attention

The following issues are escalated to the Board for awareness and oversight:

EPRR: assurance remained limited despite progress. Specialist leadership capacity had reduced to one substantive coordinator, four priority milestones remained open and formal evidence of approval, implementation and sustained operation was incomplete. Recruitment, operational resourcing contingencies and interim Executive oversight were in place.

Internal Audit delivery: the 2026/27 plan was behind profile and three audits expected for the September meeting had not reached final report. Capacity mitigations were underway, but timely delivery remained important to secure risk-based assurance.

Digital and information governance: the IAPTUS audit, relating to the clinical information system used by Talking Therapies services, received reasonable assurance. Auditors identified fundamental weaknesses in access controls, supplier oversight and business continuity. The Data Security and Protection Toolkit assessment remained high risk, with three mandated outcomes not achieved. The deferred IT Supplier Management audit, rescheduled for January 2027, needed to be completed, while the related BAF and CRR risk ratings required close oversight in the interim.

4. Assurance summary

The assurance position identified by members for each area of oversight, based on the evidence reviewed at this meeting, is set out below.

Area of oversight	Assurance level	Commentary
Risk management and BAF	Some concerns	The refreshed framework and strategic-link reporting strengthened visibility, but inconsistencies between BAF and corporate risk scores, gaps in controls and assurance, and summer deterioration in review compliance required further action.
Counter fraud	Positive	Core arrangements and internal case-management processes were effective. Further work was required to respond to national changes in fraud-risk assessment requirements and to embed the revised conflicts-of-interest arrangements.
Internal audit	Some concerns	Useful risk-based assurance continued to be provided, but delivery was behind profile. Capacity mitigations and clearer reporting against Committee dates were being introduced.
Provider capability and governance improvement	Positive	The Provider Capability Assessment was substantially evidenced and the Governance Improvement Action Plan had structured oversight. Further evidence of sustained outcomes remained necessary.
Winter resilience	Some concerns	Established operational controls supported moderate assurance, with residual risks in patient flow, staffing, vaccination, fit testing, crisis pathways and Section 136 arrangements.
EPRR	Limited assurance	Limited assurance remained appropriate while specialist capacity was constrained and priority controls had not yet been fully approved, implemented and tested. Recovery work and interim mitigations were progressing.

Key: Positive assurance — controls are effective | Some concerns — controls are partially effective and action is under way | Limited assurance — significant weaknesses remain and improvement is required | No assurance — controls are ineffective and immediate action is required

5. Advisory support and requested follow-up

As the meeting was not quorate, no formal decisions, approvals or recommendations were made. Members expressed advisory support for the Provider Capability Assessment and Winter Resilience Plan. The Board subsequently approved the Amber-Green assessment across all six Provider Capability domains for submission to NHS England and approved the Winter Resilience Plan 2026/27 for submission to the ICB at its meeting on 23 September 2026.

Members expressed advisory support for deferring the start of the IT Supplier Management audit to 11 January 2027, subject to continued oversight of the associated digital risks.

Members requested continuing updates on EPRR recovery, Governance Improvement Action Plan delivery and completion of the high-risk Internal Audit action relating to clinical supervision, which remained within its revised target date but had been open for more than one year.

6. Links to the Board Assurance Framework (BAF) and risk register

The Committee reviewed the refreshed BAF and Corporate Risk Register together. The principal linkages and required follow-up were:
BAF 05 Digital, BAF 07 Data Security and Protection and BAF 11 Financial Sustainability each remained scored at 20. BAF 09 Regulatory Compliance was scored at 8 against a tolerance of 5. Members also noted the need to reassess BAF 13 Public Inquiry following recent developments.

The Corporate Risk Register comprised 10 risks, with Cito patient-record completeness rated 20. Members requested a review of the corporate risk position for EPRR and DSPT, stronger alignment between operational and strategic risks, and clearer identification of gaps in control and assurance.

7. Recommendations to the Board

No.	Recommendation / action requested of the Board	Owner	Timescale
1	Note the contents of this report, including that the Committee was not quorate and therefore that advice was provided, rather than formal recommendations to the September Board through the verbal update.	Board	28 October 2026
2	Consider the limited assurance and material capacity risk relating to EPRR, and seek confirmation of Executive accountability, revised delivery dates and evidence required to close the four priority milestones. An update on EPRR recovery will return to the Audit and Risk Committee on 10 December 2026.	Board / Accountable Emergency Officer	10 December 2026
3	Note the Board approved the proposed Amber-Green assessment across all six Provider Capability domains and authorised submission to NHS England, at the meeting held on 23 September 2026.	Board	28 October 2026
4	Note that, at its meeting on 23 September 2026, the Board approved the Winter Resilience Plan 2026/27 for submission to the ICB, noting the moderate assurance position.	Board	28 October 2026
5	Note the need for continued oversight of internal audit delivery, digital and data-security control weaknesses, and revised risk ratings for EPRR, DSPT and the Public Inquiry.	Board / relevant Executive leads	Ongoing

8. Forward look

At its next meeting, the Committee will review progress on EPRR recovery and recruitment, digital and DSPT improvement actions, internal audit delivery and overdue recommendations, the Governance Improvement Action Plan, updated risk ratings and the developing three-year Internal Audit Plan. The deferred Integrated Oversight Plan report will also return with updated information. A cross-committee Chair forum will be re-established to strengthen triangulation of shared risks and assurance.

9. Next meeting

The next meeting of the Audit and Risk Committee is scheduled for 10 December 2026.

Report prepared by: Donna Keeping, Corporate Governance Manager | On behalf of: John Maddison, Committee Chair | Date: 20 October 2026

Tees, Esk and Wear Valleys
NHS Foundation Trust

Report to the Board of Directors

Committee Chair's 3 A Report

Committee:	Quality Assurance Committee
Report to:	Board of Directors (Public)
Date of committee meeting:	7 October 2026
Date of Board meeting:	28 October 2026
Committee Chair:	P Corrigan, Non-Executive Director
Report author:	B Murphy, Chief Nursing Officer/Deputy Chief Executive K Christon, Deputy Company Secretary
Quorate:	Yes
Attendance:	All members present

1. Purpose of this report

This report provides the Board of Directors with a summary of the business considered at the meeting of the Quality Assurance Committee held on Wednesday 7 October 2026, highlights any matters requiring the Board's attention, and sets out the Committee's assurance rating across its areas of oversight, in line with the Committee's Terms of Reference and the Trust's Board Assurance Framework (BAF).

2. Key items considered at the meeting

Agenda item	Lead	Summary of discussion	Outcome
BAF and Corporate Risk Register	A Pridmore, Int. Company Secretary & Director of Governance	The Committee reviewed the revised exception-based report and the risks within its remit. BAF 03 Patient Experience was at tolerance (not aligned corporate risks), while BAF 04 Quality and Outcomes was above tolerance. Members discussed the need for more representative and timely patient-experience intelligence, clearer evidence that feedback, co-creation and organisational learning were improving care, and greater service-level visibility of variation in quality and clinical practice. Committee requested a clear improvement trajectory for	Committee agreed reasonable assurance on governance and oversight, recognising that evidence of control effectiveness and sustained impact is mixed.

Agenda item	Lead	Summary of discussion	Outcome
		patient experience, aligned with the developing quality strategy and quality management system, with progress to be reviewed in six months. The need to resolve the outstanding Accessible Information Standard position was also highlighted.	
Adult Community Mental Health Care	N Lonergan, Int. Care Group Managing Director	Committee considered the quality and safety of adult community mental health services, including variation in access, waiting times, clinical outcomes, patient experience and health inequalities. Members considered that the aggregated data alone did not yet provide sufficient assurance on where the greatest risks existed or the impact of waiting on patient harm. Members emphasised the importance of triangulating waiting data with incidents, complaints, any clinical deterioration, admissions and patient experience and sought more granular service-level analysis, greater use of benchmarking and clearer evidence of the impact of waiting on quality. Committee requires the analysis of data to provide good quality information to the committee. Committee agreed that the report should return in six months with strengthened evidence and analysis.	Committee agreed limited assurance (rather than the reasonable assurance proposed) reflecting gaps in understanding and evidencing patient harm, and the need for further triangulation.
Quality Reports: Executive Directors Group Quality Report Quality Assurance, Risk and Quality Dashboard	B Murphy, Chief Nursing Officer/Dep. Chief Executive	Committee received an integrated view of quality and safety, noting positive trends in self-harm, deaths, seclusion and patient experience, together with strong patient safety investigation oversight. Members noted continuing areas requiring oversight, including use of restrictive practice, complaints, safety planning, DIALOG completion and care planning, and workforce pressures impacting	Committee agreed good assurance overall, recognising there are areas requiring continued oversight and improvement *Note: MHLC received a report on Positive and Safe Care – to provide assurance on arrangements to monitor restrictive practice.*

Agenda item	Lead	Summary of discussion	Outcome
Quality Report – Triple A summary		on services requiring additional support. Committee sought clarity on whether the same services are consistently falling below standards within the Quality Assurance Programme. Committee was briefed on an emerging risk to access to specialist children and young people's inpatient beds following the temporary suspension of six beds by CNTW and briefed on the potential use of an intervention that would be classed as a mechanical restraint, within eating disorder inpatient care at an acute Trust. The intervention would be use of a rolled-up towel to support the patients neck. The CQC have been made aware.	
Patient Safety Report	B Murphy, Chief Nursing Officer/Dep. Chief Executive	Members considered whether delays in completing reviews could affect the timely identification and embedding of learning and were assured that immediate learning and safety actions were identified and shared prior to completion of formal reviews. Improvement work is underway to improve review processes and reconsider the current After Action Review completion standard and further benchmarking and assurance has been sought to help inform that. Members supported an appropriate balance between timeliness and ensuring multidisciplinary reviews were sufficiently thorough to identify underlying causes and effective actions.	Committee agreed substantial assurance in relation to Patient Safety Incident Investigations and limited assurance regarding the timeliness of initial incident reviews, After Action Reviews and Mortality Part 1 Reviews.
Organisational Learning Group Quarterly Report	H Crawford, Executive Director for Therapies and Patient Experience	Committee noted progress in developing a more systematic approach to organisational learning, with clearer accountability, escalation and feedback arrangements, and	Committee agreed reasonable assurance regarding the oversight and implementation of organisational learning.

Agenda item	Lead	Summary of discussion	Outcome
		recognised that learning was not solely an activity of the Organisational Learning Group. Members requested that future reporting provide stronger evidence-based assurance of the impact of learning, drawing on a wider range of organisational intelligence.	
Independent Quality Review	B Murphy, Chief Nursing Officer/Dep. Chief Executive	Committee considered the proposed Terms of Reference for an independent review to assess whether the recommendations and learning arising from previous external scrutiny, investigations and reviews had resulted in effective and sustained improvement. Committee received assurance that legal advice had confirmed the review could proceed in the context of the ongoing public inquiry. Committee will receive a progress report in December 2026.	Terms of Reference approved, with a revised completion date of January 2027
Infection Prevention and Control	B Murphy, Chief Nursing Officer/Dep. Chief Executive	The Committee received the six-month Infection Prevention and Control report and noted that Bare Below the Elbows compliance remained an area for improvement at 54%, with implementation of the new national uniform and revised dress code providing an opportunity to reinforce standards. The increased flu vaccination target and arrangements to support uptake were also noted.	Committee agreed good assurance regarding the management and governance of the Infection Prevention and Control service
The Quality Impact of services requiring additional support (SRAS)	N Lonergan, Int. Care Group Managing Director	The Committee received an update on the 15 services within SRAS and noted that the majority were demonstrating sustained improvement or stable performance, with some services progressing towards exit. Committee requested clearer evidence of the impact on quality, challenged the length of time some services had remained within SRAS and	Committee agreed reasonable assurance that governance, oversight and recovery arrangements remain effective.

Agenda item	Lead	Summary of discussion	Outcome
		sought assurance that recovery interventions remained appropriate and sufficiently focused to support sustainable improvement and exit.	
Safety Planning for Section 17 leave and time away from the ward	K Kale, Executive Medical Director	The Committee noted the improving position in relation to safety planning for Section 17 leave and time away from the ward, with overall compliance at 84.97% (85% standard). Members noted continuing variation across services and was advised that variation was not consistently attributable to the same wards, with targeted action taken where concerns were identified. Policy changes, training and improved electronic recording arrangements are expected to support further improvement.	Committee agreed reasonable assurance, recognising the improving position and the continued work required to reduce variation and strengthen compliance. *Note: MHLC received a report on Section 17 leave and time away from the ward, to allow it to consider oversight, monitoring and legislative aspects*
Supervision	L Hodge, Int. Executive Director for People and Culture	Committee noted improvement in the recording and oversight of supervision, with clinical supervision compliance increasing from 22% in 2023/24 to 63% in Q2 2026/27, although this remains below the Trust target of 85%. Committee challenged how the Trust could demonstrate the impact of supervision on patient safety, staff wellbeing and service quality and was advised that supervision intelligence was triangulated with other quality and workforce information where concerns were identified. A trajectory to achieve compliance by the end of Q4 2026/27 was agreed.	Committee agreed reasonable assurance, recognising the improving position but that compliance remains below target and the associated risk is not yet fully mitigated.

3. Key alerts — matters requiring Board attention

The following issues are escalated to the Board for awareness, discussion, or decision:

- Adult Community Mental Health Care: the Committee agreed limited assurance because evidence did not yet sufficiently demonstrate the quality impact or potential harm associated with waiting, including marked variation between localities.
- BAF 04 Quality and Outcomes and corporate risk 811 remained above tolerance; assurance on sustained control effectiveness and impact was mixed.

- Continued oversight is required in relation to restrictive practice, persistent non-compliance with some clinical standards, review timeliness, complaints, safety planning and workforce pressures in services requiring additional support.

The Board is asked to note these matters and the further assurance work commissioned by the Committee.

4. Assurance summary

The Committee's overall assurance rating for each area of oversight, based on the evidence reviewed at this meeting, is set out below.

Area of oversight	Assurance level	Commentary
Quality governance and patient safety	**Positive**	Good overall assurance from quality reporting and substantial assurance for investigation oversight, with continued monitoring of identified exceptions.
Adult community mental health care	**Some concerns**	Limited assurance due to variation in waits and insufficient evidence of quality impact or potential harm while waiting.
Organisational learning	**Some concerns**	Reasonable assurance; further evidence was requested to demonstrate that learning was consistently embedded and producing measurable, sustained impact.
Infection prevention and control	**Positive**	Good assurance on management and governance, with action to reinforce Bare Below the Elbows compliance.
SRAS, safety planning for Section 17 leave and supervision	**Some concerns**	Reasonable assurance with improvement required on quality impact, persistent variation, documentation and communication, and achievement of the supervision compliance trajectory.

Key: Positive assurance — controls are effective | Some concerns — controls are partially effective, action underway | No assurance — controls are not effective, immediate action required

5. Decisions made, and papers approved

Committee:

- Accepted the assurance levels presented, except for Adult Community Mental Health Care, where limited assurance was agreed.
- Approved the Independent Quality Review Terms of Reference for onward reporting to the Board, subject to amendment of the review timescale.
- Agreed an ambition of 85% supervision compliance by the end of March 2027
- Commissioned further assurance reporting on quality visits, organisational learning, SRAS and community care.

6. Links to the Board Assurance Framework (BAF) and risk register

The Committee reviewed the following strategic risks and corporate/principal risks relevant to its remit:

- **BAF 03 – Patient Experience:** score 9, at tolerance, with limited assurance. Further work is required to improve the representativeness of patient insight and evidence the impact of co-creation and improvement activity.

- **BAF 04 – Quality and Outcomes:** score 15 against tolerance 9, above tolerance, with reasonable assurance. Variation in service models and practice, and evidence that learning is consistently embedded, remain principal gaps.
- **Corporate risk 811 – Inpatient self-harm and suicidal behaviour:** score 15 and above tolerance. Five actions remained open and in progress; the target score of 10 remained above the BAF tolerance of 9 and required correction or formal exception.

7. Recommendations to the Board

No.	Recommendation / action requested of the Board	Owner	Timescale
1	Note the business considered, assurance received and matters highlighted for continued oversight.	Board	28 October 2026
2	Note the limited assurance agreed for Adult Community Mental Health Care and the further report commissioned for April 2027.	Board	28 October 2026
3	Approve the Independent Quality Review Terms of Reference, subject to the revised completion timescale.	Board	28 October 2026

8. Forward look

The Committee's November 2026 forward work programme will focus on quality, safety and risk assurance, including patient safety and experience, restrictive practice, safer staffing, safeguarding, learning from deaths and regulatory compliance. It will also consider older adults inpatient care and the Culture of Care Quality Improvement Programme, alongside learning from the Thirlwall Inquiry, proposed trigger reporting and the future approach to quality visits.

9. Next meeting

The next meeting of the Quality Assurance Committee is scheduled for 9.30am on Wednesday 11 November 2026.

Report prepared by: Beverley Murphy, Chief Nursing Officer and Karen Christon, Deputy Company Secretary on behalf of: P Corrigan, Committee Chair. Date: 14 October 2026

Tees, Esk and Wear Valleys
NHS Foundation Trust

Report to the Board of Directors

Committee Chair's 3A Report

Committee:	Mental Health Legislation Committee
Report to:	Board of Directors (Public)
Date of committee meeting:	8 October 2026
Date of Board meeting:	28 October 2026
Committee Chair:	Nini Adetuberu, Non-Executive Director
Report author:	Donna Keeping, Corporate Governance Manager
Quorate:	Yes
Attendance:	6 of 6 members present; no apologies received

1. Purpose of this report

This report provides the Board of Directors with a summary of the business considered by the Mental Health Legislation Committee on 8 October 2026, the assurance received in relation to the Trust's statutory and regulatory duties, and the matters requiring Board attention. It is presented in accordance with the Committee's Terms of Reference and its oversight of relevant Board Assurance Framework and risk register themes.

2. Key items considered at the meeting

Agenda item	Lead	Summary of discussion	Outcome
Terms of Reference and Work Programme	Interim Company Secretary	The Committee reviewed its Terms of Reference and work programme following their approval by the Board as part of the revised governance arrangements. Members agreed that the remit should more explicitly reflect assurance on the application of mental health legislation in the context of health inequalities and protected characteristics, including ethnicity recording. Further clarification was requested on the respective roles of MHLC and the Quality Assurance Committee where oversight overlaps, particularly for restrictive practice, Section 17 leave and long-term segregation; MHLC's focus should remain statutory compliance and the Mental Health Act Code of Practice, with broader quality and service outcomes considered through QAC. The quorum wording was considered open to interpretation and will be checked against the Trust constitution and governance	**No assurance level proposed.** Further refinement agreed, with amendments to be checked against the constitution and progressed through the appropriate approval route.

Agenda item	Lead	Summary of discussion	Outcome
		advice. The work programme will be updated to include the annual review alongside the Scheme of Delegation, align patient voice reporting with the current agenda, include the January PCREF item and ensure future papers clearly state the assurance required and its link to the Committee's remit. Formal amendments will follow the appropriate approval route, with a focused discussion to agree the detailed changes before submission.	
Policies and procedures	Executive Medical Director	The Committee reviewed revisions to the Section 17 leave, Associate Hospital Managers, Mental Capacity Act Policy, Deprivation of Liberty and Section 135 procedure. Discussion focused on the responsibilities placed on accompanying persons, Responsible Clinician accountability and patient involvement. Future policy approval will transfer to Executive Directors, with implementation assurance reported to the Committee.	**Decision: Approved.**
BAF and risk register	Head of Risk Management	The Committee received a verbal update on the Board Assurance Framework and risk register. The update highlighted that, although the Committee is not currently the lead for a specific BAF risk, its work contributes assurance relevant to regulatory compliance (BAF 9), access (BAF 2), quality and outcomes (BAF 4), partnership working (BAF 8) and staffing (BAF 1). The verbal update noted that the Committee's contribution could be articulated more clearly within the BAF as relevant controls, sources of assurance or assurance gaps. A written follow-up was requested to clarify cross-committee ownership, strengthen the mapping of MHLC assurance to relevant strategic risks and identify any matters requiring escalation. The Committee noted the verbal update and requested clearer written visibility of its contribution to controls and assurance across risks owned elsewhere.	**No assurance level proposed.** Verbal update received; written follow-up due at the next Committee meeting.
Mental Health Legislation assurance and operational groups	Executive Medical Director	Positive assurance was received on the overall application of mental health legislation, with low levels of statutory exceptions and follow-up action in place. Some concerns were identified in relation to operational and partnership arrangements because Section 12 doctor availability, limited internal attendance and inconsistent	**Proposed assurance agreed: Good assurance** for the Mental Health Legislation Combined

Agenda item	Lead	Summary of discussion	Outcome
		partner engagement may affect assessment timeliness and patient experience. Key data included 4 patients discharged without recorded rights from approximately 1,000 detained patients; 3 lapsed Section 5 powers out of 75; 86 AWOL episodes with 1 CQC notification; 8 discharges from 197 tribunals; 0 discharges from 156 Hospital Managers' hearings; 0 Section 136 extensions over 24 hours from 219 episodes; and 1 failed administrative scrutiny out of approximately 1,000 detentions. Section 12 doctor availability, particularly out of hours, remained the principal system constraint. The Committee requested continued monitoring of statutory exceptions and escalation of the system constraints through ICB and partnership governance routes.	Assurance Report and the DTVF operational groups; **Good assurance, with limited assurance on internal group attendance** for the North Yorkshire and York operational groups. Continued monitoring and escalation are required.
Supreme Court judgment on deprivation of liberty	Executive Medical Director	The Committee considered the immediate and evolving implications of the Supreme Court judgment, including application of the new multifactorial test and the requirements for valid consent. It received positive assurance on the Trust's initial response, including revised policies, legal training, guidance, a flowchart and checklist. Members nevertheless identified continuing risks relating to inconsistent interpretation, potential loss of safeguards for some patients, variation in partner practice, and unclear governance arrangements for community, commissioned and subsidiary provision. The Committee agreed that implementation and emerging legal interpretation should remain under review and that the associated risks should be escalated to the Board.	**Proposed assurance agreed: Positive assurance.** Continuing legal and operational uncertainty requires Board oversight.
Capacity assessments in crisis services	Interim Chief Operating Officer	The Committee identified some concerns: capacity was generally considered before informal admission, but assessments using the MCA1 form were not consistently completed and evidenced to the required quality standard. A review of 85 records identified regional variation in recorded MCA1 completion: 71% in North Yorkshire and York, 64.2% in Teesside and 56% in Durham and Darlington. This creates legal, regulatory and patient-safeguarding risk where the Trust cannot clearly evidence informal admission decisions as part of their record. Trust-wide huddle checks, targeted training, monthly	**Proposed assurance agreed: Reasonable assurance** that the Mental Capacity Act is considered before informal admission; **Limited assurance** that capacity assessments

Agenda item	Lead	Summary of discussion	Outcome
		sampling and governance oversight are being implemented. The next report should compare performance with this baseline, confirm the agreed Trust standard, report assessment quality as well as completion, and demonstrate that the new checklist has a stable and auditable electronic record. Sustained improvement should be evidenced before the action is closed.	are consistently documented in line with statutory requirements.
Patient voice and advocacy	Executive Director of Therapies and Patient Experience	The Committee identified some issues in the first integrated patient voice and advocacy report, which brought together quantitative and qualitative evidence on patients' experience of mental health legislation. Assurance was constrained by small response numbers, incomplete advocacy data and limited evidence that identified themes had resulted in completed improvement actions. Of particular concern was low reported patient involvement in Section 17 leave decisions. While these decisions must remain risk-based, patients should be involved as fully as possible. The Committee requested that future reports improve response rates and advocacy data, demonstrate how patient feedback has informed action, and provide evidence of improvement in involvement, communication and the closure of identified issues.	**Proposed assurance agreed: Reasonable assurance.** Improved evidence, action tracking and patient involvement are required; a positive finding was the high proportion of patients, from a comparatively large cohort, who reported feeling safe.
CQC monitoring	Chief Nursing Officer/Deputy Chief Executive	The Committee identified some issues regarding the governance, monitoring and closure of CQC Mental Health Act inspection actions. Members noted recurring themes relating to staffing, food and meaningful leave, alongside improvement in environmental concerns. Assurance was constrained by nine overdue actions. The next report should identify the accountable operational owner, reason for delay, revised completion date and residual risk for each overdue action, and demonstrate a reduction from the current baseline of nine. Any further slippage, increasing risk or inability to agree a credible completion date should be escalated.	**Proposed assurance agreed: Good assurance** for the oversight systems and processes. Nine overdue actions require strengthened tracking and timely completion.

Agenda item	Lead	Summary of discussion	Outcome
Section 17 leave	Executive Medical Director	Section 17 leave compliance was 84.97%, marginally below the 85% threshold. The Committee identified some issues: record-keeping concerns persisted and appeared likely to be linked to CiTO. Governance arrangements were in place, but continuing improvement was required in patient involvement in leave decisions, communication of responsibilities to accompanying persons and the completeness of documentation. The final audit should confirm whether compliance has exceeded the threshold, set out the quality of documentation and patient involvement, identify accountable owners and completion dates, and provide evidence that improvement is sustained before actions are closed. Deterioration below the current level or repeated failure to meet the threshold should be escalated.	**Proposed assurance agreed: Reasonable assurance, with improvement required.** Improvement action and evidence of sustained compliance are required.
Restrictive practice	Chief Nursing Officer/Deputy Chief Executive	The Committee reviewed restrictive-practice governance and improvement arrangements. Some concerns remained in relation to data quality and the concentration of interventions among a small number of high-risk patients. Continued oversight was required to improve the completeness and reliability of reporting; understand the factors contributing to repeated interventions and provide evidence that improvement actions are reducing restrictive practice in line with least-restrictive care principles.	**Proposed assurance agreed: Reasonable assurance.** Improved data quality and evidence of sustained reduction are required.

3. Key alerts — matters requiring Board attention

The following issues are escalated for Board oversight. The Board is asked to distinguish matters requiring acknowledgement from those requiring executive action and further assurance:

- The Supreme Court judgment on deprivation of liberty creates a legal and operational risk. The Committee received positive assurance on the Trust's initial response, including revised policies, legal training, guidance and decision-support tools. Residual risk remains in relation to variable interpretation of deprivation, agreement and valid consent; reduced safeguards for some patients; differing partner practice; and commissioned or subsidiary provision. Further escalation will be required if legal advice materially changes, inconsistent practice is identified, or evidence indicates that patient safeguards are not operating effectively.
- Mental capacity assessments for informal admissions were not consistently completed and documented to the required standard. Recorded MCA1 completion varied from 56% to 71% across the three areas reviewed, reducing the Trust's ability to evidence compliance with capacity-assessment recording requirements and informed decision-making. Executive assurance should demonstrate improvement from this baseline, compliance with an agreed Trust standard, consistent audit quality and a stable, auditable location for the new legal checklist within the future electronic patient record. Inability to improve, or deterioration in audit findings, should trigger further escalation.
- The availability of independent Section 12 doctors, particularly out of hours, remains a significant system constraint affecting assessment timeliness and patient experience. The Committee requested escalation through ICB contractual and partnership routes.

- The verbal update highlighted that the Committee's contribution to BAF controls and assurance could be articulated more clearly. A written follow-up will clarify how MHLC assurance informs risks led by other committees, including regulatory compliance, access, quality and outcomes, partnerships and staffing.

Board attention is requested on the linked legal, capacity-assessment, digital-recording and system-partnership risks. The Board is asked to note the controls and committee-led oversight arrangements and to receive further escalation where the specified triggers are met.

4. Assurance summary

The Committee's overall assurance rating for each area of oversight, based on the evidence reviewed at this meeting, is set out below.

Overall Committee conclusion: The evidence reviewed provided reasonable assurance that the principal arrangements supporting compliance with mental health legislation were operating. This judgement was supported by low levels of reported statutory exceptions and evidence of follow-up action; however, it was moderated by weaknesses in the consistent completion and recording of capacity assessments, nine overdue CQC actions, Section 17 leave documentation and patient involvement, continuing legal and operational uncertainty following the Supreme Court judgment, Section 12 doctor availability and variable partner engagement. The Committee did not identify evidence requiring immediate Board intervention. Time-bound executive action and continued Committee oversight are required, with escalation to the Board if agreed improvement measures are not delivered, statutory exceptions increase, legal advice identifies a material change in exposure, or the identified risks worsen.

Area of oversight	Assurance level	Commentary
Mental Health Act implementation	**Positive assurance**	Core statutory indicators were positive and exceptions were low, with further enquiry and operational follow-up in place.
Operational and partnership arrangements	**Some concerns**	Groups are established and active, but assurance was constrained by attendance in North Yorkshire and York, gaps in ICB participation and the ongoing Section 12 doctor issue.
Supreme Court judgment response	**Positive assurance**	Policies, training, guidance and decision-support tools were in place. The emerging legal interpretation and impact on safeguards require continued oversight.
Capacity assessments for informal admission	**Some concerns**	Capacity is generally considered, but assessments are not consistently completed or evidenced to the required standard.
Patient voice and advocacy	**Some concerns**	Useful mixed-method evidence is emerging, but small denominators, incomplete returns and limited evidence of issue closure constrain assurance.
CQC MHA monitoring	**Some concerns**	Oversight and closure processes were evidenced, but nine overdue actions constrain assurance. Future reports will explain operational barriers, progress and expected completion dates.
Section 17 leave	**Some concerns**	Compliance was 84.97%, with improvement required in documentation, patient involvement and communication with accompanying persons.
Restrictive practice	**Some concerns**	Governance and improvement arrangements remain in place, with continued focus required on data quality and interventions concentrated among a small number of high-risk patients.

Key: Positive assurance — controls are effective | Some concerns — controls are partially effective, action underway | No assurance — controls are not effective, immediate action required

5. Decisions made, and papers approved

- **Policies approved:** Section 17 Leave; Associate Hospital Managers; Mental Capacity Act; Deprivation of Liberty Policy and Procedure; and Section 135(2) Procedure. Future policy approvals will be undertaken by Executive Directors, with implementation assurance reported to MHLC.
- **Assurance levels agreed:** good assurance for the combined legislation report, DTVF operational groups and CQC oversight; good assurance for North Yorkshire and York operational groups, with limited assurance on internal attendance; positive assurance for the Supreme Court response; reasonable assurance for patient voice, Section 17 leave and restrictive practice; and reasonable assurance that capacity is considered before informal admission, with limited assurance on consistent statutory documentation.
- **Escalation and follow-up:** the Supreme Court judgment and associated capacity-assessment and electronic-record risks will be escalated through this report. Future CQC reporting will explain barriers to overdue-action completion, and patient voice and advocacy will remain a regular assurance item with stronger data and clearer evidence of action and closure.

6. Links to the Board Assurance Framework (BAF) and risk register

The Committee received a verbal update on the Board Assurance Framework and risk register. BAF 9 — Regulatory Compliance was identified as the principal alignment, with the Committee's work also contributing assurance relevant to access, quality and outcomes, partnership working and staffing. The update referenced risks 1206 and 1208 concerning the DoLS backlog, unlawful deprivation and Mental Capacity Act compliance, together with Section 17 leave risk R1661. A written follow-up was requested to clarify the Committee's contribution to controls, sources of assurance and assurance gaps, confirm cross-committee ownership and identify any matters requiring amendment to the BAF or escalation to the Board.

7. Recommendations to the Board

No.	Recommendation to the Board	Owner	Timescale
1	Receive and discuss the report, noting the Committee's overall reasonable-assurance judgement, agreed assurance levels, material limitations and escalation triggers.	Board	At this meeting
2	Note that MHLC will oversee the agreed assurance updates on the Supreme Court response, capacity-assessment documentation, Section 12 doctor availability and BAF assurance mapping, with prompt escalation to the Board if legal exposure, statutory compliance, patient safeguards or delivery risks materially worsen.	Executive Medical Director; Interim Chief Operating Officer; Head of Risk Management	On or before 14 January 2027

8. Forward look

At its January 2027 meeting, the Committee will review progress on BAF assurance mapping, capacity-assessment compliance, Section 17 leave, patient voice and advocacy, CQC overdue actions, benchmarking, partner attendance and Section 12 doctor availability. Updates will report performance against agreed baselines, accountable owners, delivery dates, residual risks and evidence of improvement, with any material deterioration escalated to the Board. The Committee will also progress targeted amendments to its Terms of Reference to clarify health inequalities, quoracy and areas of overlap with the Quality Assurance Committee.

9. Next meeting

The next meeting of the Mental Health Legislation Committee is scheduled for 14 January 2027 at 9.30 am.

Report prepared by: Donna Keeping, Corporate Governance Manager | On behalf of: Nini Adetuberu, Committee Chair | Date: 20 October 2026

Tees, Esk and Wear Valleys
NHS Foundation Trust

Report to the Board of Directors

Committee Chair's 3 A Report

Committee:	People, Culture and Diversity Committee
Report to:	Board of Directors (Public)
Date of committee meeting:	25 September 2026
Date of Board meeting:	28 October 2026
Committee Chair:	Roberta Barker, Non-Executive Director
Report author:	Donna Keeping, Corporate Governance Manager
Quorate:	Yes
Attendance:	5 of 6 members present; apologies were received from Beverley Murphy, Chief Nurse, Lesley Hodge, Deputy Executive Director of People and Culture and J Keenan, Staff Side Chair.

1. Purpose of this report

This report provides the Board of Directors with a summary of the business considered at the meeting of the People, Culture and Diversity Committee held on 25 September 2026, highlights matters requiring the Board's attention and sets out the Committee's assurance across its areas of oversight, in line with its Terms of Reference and the Board Assurance Framework.

2. Key items considered at the meeting

Agenda item	Lead	Summary of discussion	Outcome
Transforming People Services	Executive Director for People, Culture and Diversity	The Committee considered the national digital-first programme, regional and ICB alignment, shared services, ESR readiness, workforce capacity, employment terms, entry-level opportunities and career pathways. The Trust was not in the early implementation waves and would learn from initial delivery.	Noted; milestone updates and an extended discussion to be scheduled if required.
Workforce Strategy Delivery Report	Executive Director for People, Culture and Diversity	The Committee received good assurance on workforce activity and strengthened governance, and reasonable assurance on improvement across priorities. Sickness absence remained a negative assurance despite improved policy compliance and manager training. Further focused oversight and psychologically informed support were proposed.	Assurance accepted; continuing oversight agreed.
Anti-discrimination definitions	Executive Director for People,	The Committee considered the nationally proposed standalone definitions of antisemitism and anti-Muslim hatred and	Recommendation to the Board not to adopt the definitions as

Agenda item	Lead	Summary of discussion	Outcome
	Culture and Diversity	preferred the Trust's consistent approach based on belonging, safety, respect and fair treatment for all.	standalone Trust definitions.
Statutory staff equality information	Executive Director for People, Culture and Diversity	The Committee reviewed WRES, WDES, SOWES and related staff equality information, noting positive progress alongside continuing variation in recruitment, disciplinary outcomes and staff experience.	Publication approved and onward submission to the Board agreed.

3. Key alerts — matters requiring Board attention

The following issues are escalated to the Board for awareness, discussion, or decision:

- Sickness absence remained the principal area of negative assurance. Although policy compliance and manager training had improved, this had not yet translated into reduced absence levels; targeted interventions and focused Committee oversight would continue.
- Transforming People Services represented significant cultural and organisational change, with potential pressure on People and Culture capacity, uncertainty over implementation timescales and implications for employment arrangements and career pathways.
- The Committee asked the Board to consider its recommendation not to adopt the nationally proposed antisemitism and anti-Muslim hatred definitions as standalone Trust definitions, while continuing a comprehensive Trust-wide anti-discrimination approach.

4. Assurance summary

The Committee's overall assurance rating for each area of oversight, based on the evidence reviewed at this meeting, is set out below.

Area of oversight	Assurance level	Commentary
Workforce strategy delivery and governance	**Positive**	Correct workforce activities were being undertaken and governance of workforce risk had strengthened. Reasonable assurance was received on delivery across priority areas, with some initiatives still subject to further evaluation or national guidance.
Sickness absence	**Some concerns**	Compliance with policy and manager training had improved, but absence levels had not reduced. Targeted interventions, early contact and focused Committee scrutiny would continue.
Transforming People Services	**Some concerns**	The programme remained at an early stage, with uncertainty over timescales, delivery footprint and capacity implications. The Trust was actively preparing and would monitor implementation through programme milestones.
Staff equality information and inclusive culture	**Positive**	Positive progress was noted in workforce representation and aspects of staff experience. Continued monitoring was required to sustain improvement and address variation in recruitment, disciplinary processes and experience.
Risk and BAF alignment	**Positive**	Sickness absence and Transforming People Services were recognised within the new BAF. The Committee requested explicit mapping of workforce assurances to the relevant people risk.

Key: Positive assurance — controls are effective | Some concerns — controls are partially effective, action underway | Limited assurance — controls are not effective, immediate action required

5. Decisions made, and papers approved

- Approved the minutes of 6 May 2026 and closure of completed actions, with revised actions retained for outstanding matters.
- Accepted the workforce strategy assurance statements and agreed continued oversight of sickness absence and other priority workforce trajectories.
- Agreed not to adopt the nationally proposed antisemitism and anti-Muslim hatred definitions as standalone Trust definitions, recommending continuation of the Trust-wide inclusive anti-discrimination approach.
- Approved publication of the statutory staff equality information reports and their submission to the Board.

6. Links to the Board Assurance Framework (BAF) and risk register

The Committee considered the workforce-related strategic and corporate risks within its remit. The evidence reviewed provided assurance on workforce governance and planned mitigating activity; however, further work is required to complete explicit mapping to the new BAF and to clarify the consultant recruitment risk. Risk reference numbers, current scores and risk appetite positions were not available in the papers considered and will need to be confirmed through the next reporting cycle.

Risk and status	Committee assurance and evidence	Gaps and follow-up	Board implication
People BAF risk — sickness absence Reference, score and risk appetite position to be confirmed.	The Committee received positive assurance on strengthened workforce governance, improved policy compliance and manager training. It nevertheless concluded that controls were only partially effective because these improvements had not yet reduced absence levels.	Workforce assurance reporting is to be mapped explicitly to the new BAF. Targeted interventions, early contact, psychologically informed support and focused Committee scrutiny will continue, with the trajectory reviewed through future reporting.	The Board is asked to note continuing negative assurance on the outcome measure and the Committee's ongoing oversight. Escalation should be reconsidered if the trajectory does not improve.
People BAF risk — Transforming People Services Reference, score and risk appetite position to be confirmed.	The Committee received early-stage assurance that the Trust was preparing for the national digital-first programme and would learn from initial implementation waves. The programme was recognised as a significant cultural and organisational change.	Uncertainty remained regarding implementation timescales, delivery footprint, People and Culture capacity, employment arrangements and career pathways. Milestone reporting and an extended Committee discussion will be scheduled if required.	The Board is asked to note the emerging strategic and organisational implications and that assurance remains developing while the programme is at an early stage.
Corporate risk register — consultant recruitment Reference and current score to be confirmed.	The Committee noted the risk but did not receive sufficient information to determine whether the existing controls and mitigating actions were effective.	Further analysis of the underlying causes, the scale and impact of the recruitment position, current controls, mitigating actions and the expected trajectory is required for the Committee's next review.	The Board is asked to note the current assurance gap pending a fuller risk assessment and updated position.

7. Recommendations to the Board

No.	Recommendation / action requested of the Board	Owner	Timescale
1	Note the contents of this report and the assurance received by the Committee.	Board of Directors	28 October 2026
2	Receive the statutory staff equality information reports approved by the Committee and support publication within the required timetable.	Board of Directors / Executive Lead	28 October 2026
3	Endorse the Committee's recommendation not to adopt the proposed antisemitism and anti-Muslim hatred definitions as standalone Trust definitions, and to continue the Trust-wide inclusive anti-discrimination approach.	Board of Directors	28 October 2026

8. Forward look

The Committee would receive the new Board Assurance Framework and confirmation of workforce assurance mapping at its next meeting. Its workplan would include regular focused oversight of sickness absence, milestone updates on Transforming People Services, an annual programme of deep dives and follow-up on consultant recruitment and targeted training for the long-term sickness team.

9. Next meeting

The date of the next meeting of the People, Culture and Diversity Committee was not recorded in the source documents and should be inserted when confirmed.

Report prepared by: Donna Keeping Corporate Governance Manager, on behalf of Roberta Barker, Chair of Committee, Date: 25 September 2026

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

1. Cover Sheet

Report Title	Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Sexual Orientation Workforce Equality Standard (SOWES) & Publication of Staff Equality Information
Meeting	Board of Directors
Date of Meeting	28 October 2026
Paper	I
Sponsoring Director / Author	Lesley Hodge, Int. Executive Director of People and Culture
Report Author	Lisa Cole, Head of Inclusive Cultures
Purpose of Paper	**Decision**
Previously Considered By	People, Culture and Diversity Committee, 25 September 2026 Outcome: recommended for approval
Financial Implications	

2. Recommendation

The Board is asked to:
• Note the assurance provided by People, Culture and Diversity Committee that a robust process has been undertaken when developing the data and actions for the WRES, WDES, SOWES and the Publication of Staff Information • Approve the data for publication on the Trust website.

3. Executive Summary

This paper is presented to provide assurance that the Trust is meeting the requirements of the NHS Standard Contract by gathering data for the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) and requests approval to publish the results and associated action plans on the Trust website by 31st October 2026. The Trust also undertakes and publishes a Sexual Orientation Workforce Equality Standard

(SOWES). Publishing staff equality data also helps to meet the obligations under the Public Sector Equality Duty of the Equality Act 2010.

The paper proposes that there is good assurance that the Trust has followed a robust process in analysing its staff data by protected group and that the actions provide a clear response to the concerns raised. In doing so it is meeting its NHS Standard Contract requirements and Equality Act duties. The paper asks PCDC to confirm that they support the publication of the information onto the external website.

The report has been considered by People, Culture and Diversity Committee who have recommended Board approve publication on the Trust website.

The development of the data has been undertaken by the Trust's Business Analytics and Clinical Outcomes Information Department and the Equality, Diversity, Inclusion and Human Rights Team. Staff networks have been involved in the development of the WRES, WDES and SOWES actions plans, through consultation events.

This paper has been considered by Executive Directors Group in August 26, JCC in Sept 26 and a version of this information has been to the Equality, Diversity, Inclusion and Human Rights Steering Group in July 26.

4.. Strategic Context

Linkage	Detail
Strategic Objective(s)	To be a great employer.
Board Assurance Framework	Safe staffing - The feedback from the WRES, WDES, SOWES and publication of staff information allow the Trust to better understand the experiences and outcomes for staff from protected groups, to act where necessary and in doing so to improve employee experience and retention.
Corporate Risk Register	Not applicable
Committee / Work Programme Ref	People & Culture Committee, Terms of Ref
Regulatory / Legal Reference (if applicable)	Publishing staff equality data will also to meet the obligations under the Public Sector Equality Duty of the Equality Act 2010.

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

Report Title	WRES, WDES, SOWES & Publication of Staff Equality Information
Meeting	Trust Board [Public / Private]
Date of Meeting	28 October 2026
Item number	Linked to the agenda

1. Background

This paper is presented to provide assurance that the Trust is meeting the requirements of the NHS Standard Contract by gathering data for the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) and requests approval to publish the results and associated action plans on the Trust website by 31st October 2026.

2. Key Issues and Findings

Areas of progress

The Trust continues to demonstrate positive progress across the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Sexual Orientation Workforce Equality Standard (SOWES). Workforce representation is strong, with an increase of 11.1% of staff identifying as Black, Asian and Minority Ethnic (BAME), an increase to 12.8% identifying as having a disability, and 5% identifying as Lesbian, Gay or Bisexual (LGB). Representation at Board level is proportionate for ethnicity and exceeds workforce representation for disability, although there remains no declared LGB representation at Board level. Disability declaration has increased to 90% in 2026. Sexual orientation declaration is also high at 92%, providing a stronger evidence base for monitoring inequalities.

Within WRES, disciplinary disproportionality has improved from 2.46 in 2025 to 1.87 in 2026, while reported discrimination among BAME staff has reduced from 19% to 13%. Harassment, bullying or abuse from patients, relatives and the public has also reduced from 40% to 34% and from staff its reduced from 22% to 18%.

WDES data shows reductions in bullying and harassment over time. Harassment from patients/public for staff with a LTHC has reduced from 34% in 2019 to 25% in 2025, whilst harassment from managers has reduced from 15% to 9%. Disabled staff are also less likely to enter capability processes than non-disabled staff. The percentage of staff that require reasonable adjustments and have had them in place has increased from 77% to 78%.

SOWES demonstrates improvements, recruitment outcomes remain close to parity, with heterosexual applicants only 1.06 times more likely to be appointed from shortlisting than LGB applicants. Disciplinary disproportionality has reduced substantially, from 2.5 in 2019 to 0.3 in 2026, meaning LGB staff are now less likely to enter disciplinary processes than heterosexual staff. Experiences of harassment from patients, relatives and the public have also reduced significantly since 2019 for both gay/lesbian and bisexual staff.

Areas of concern

All three standards continue to demonstrate inequalities in workplace experience between protected characteristic groups and their peers.

BAME staff remain 2.46 times less likely to be appointed from shortlisting than White applicants and 1.87 times more likely to enter disciplinary processes. BAME staff are also more likely to report harassment, bullying or abuse from patients, relatives and the public (34% compared with 21%), discrimination (13% compared with 6%) and lower confidence in fair career progression (52% compared with 62%). BAME staff are less represented within Agenda for Change Bands 7 and above, with representation generally decreasing at more senior banding levels compared to their overall workforce

Staff with a LTHC continue to report poorer experiences than staff without a LTHC. They are more likely to experience harassment from patients/public (25% versus 20%), colleagues (18% versus 10%) and managers (9% versus 5%). They are less likely to feel valued (43% versus 52%), less likely to believe career progression is fair (54% versus 65%) and more likely to report pressure from managers to attend work when unwell (19% versus 13%).

LGB staff continue to report higher levels of harassment from colleagues and lower engagement scores than heterosexual staff. Bisexual staff consistently report the least positive experiences. Whilst based on a small sample size, staff whose sex is not the same as assigned at birth report substantially higher levels of harassment from colleagues (36% compared with 12%) and lower confidence in fair career progression (50% compared with 62%).

Comparison to sector averages

TEWV performs favourably against comparable Mental Health and Learning Disability Trusts across many Staff Survey measures.

Within WRES, Staff Survey outcomes are broadly in line with sector averages. TEWV performs better than average in relation to harassment from colleagues (18% of BAME staff compared with 20% nationally). However, levels of discrimination and perceptions of career progression remain broadly aligned with national findings.

Within WDES, TEWV reports lower levels of harassment, bullying and abuse than sector averages. Harassment from patients, relatives and the public is reported by 25% of staff with a long-term health condition (LTHC) compared with a sector average of 27%, whilst harassment from managers is reported by 9% compared with 12% nationally. Career progression perceptions are also more positive, with 54% of staff with a LTHC believing the Trust acts fairly regarding career progression compared with 52% nationally.

Within SOWES, TEWV performs better than sector averages on several indicators. Harassment from patients, relatives and the public is lower across all groups, particularly for bisexual staff (19% compared with 30% nationally). Experiences of discrimination are also lower than the sector average for gay and lesbian staff (5% compared with 9%).

Key areas from Publication of staff information

This year, the Publication of Staff Information has been redesigned to align with the format used for the WRES, WDES and SOWES reports. Previously, the information was presented in a large Excel workbook, which made it difficult to identify key findings and trends. The revised format provides a clearer and more accessible analysis of the data (see Appendix 5, 6 & 7).

Gender **-** Higher representation of men at higher pay bands, the higher likelihood of men entering disciplinary processes (2.85 times more likely), men are more likely to report harassment, bullying abuse from patients, relatives or the public (26% compared to 21%)

Age - Staff aged 21–30 have the lowest engagement score and declining confidence in fair career progression, and discrimination has gradually increased amongst staff aged 21–40.

Religion **-** Recruitment data shows that Hindu and Muslim applicants had the lowest likelihood of being offered a role. Staff survey data also shows higher reported levels of harassment, bullying, abuse and discrimination for some groups, particularly Buddhist staff, Muslim staff, staff recorded as any other religion, and staff who prefer not to disclose their religion or belief. Board religious diversity is broadly aligned for Christian representation, but there is higher non-disclosure

Assurance

The Trust can take assurance that workforce representation, declaration rates and several key equality indicators continue to improve, and that TEWV performs at or above the benchmark for comparable Mental Health and Learning Disability Trusts across many staff experience measures. Whilst progress is evident across WRES, WDES and SOWES, particularly in relation to representation, disciplinary disproportionality and reductions in some forms of harassment and discrimination, the data continues to identify persistent inequalities in recruitment, progression, workplace experience and inclusion for racially minoritised staff, disabled staff and LGBTQ+ staff. The Trust has a clear understanding of these areas and targeted action plans have been co-created with staff and staff networks to address them (Appendix 1).

Additional assurance can be taken from the revised approach to the Publication of Staff Information. By aligning the analysis of age, religion and gender data with the WRES, WDES and SOWES reporting format, the Trust has strengthened its ability to identify trends, understand staff experience and target action where inequalities exist.

3. Options Considered

n/a

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	No direct impact. However, improving staff experience, inclusion and retention may contribute indirectly to workforce stability and the delivery of safe, high-quality care.
Safeguarding	No direct impact.
Equality, Diversity & Inclusion	Positive impact. The report identifies differences in representation, recruitment, progression and workplace experience across protected characteristic groups and supports targeted action to reduce these inequalities. Failure to collect, publish and act on the findings may result in continued inequalities and regulatory or reputational consequences.
Workforce	Positive workforce impact. The findings and associated action plans will inform work to improve recruitment, retention, career progression, staff experience and inclusion.

Impact Area	Assessment
Financial / Resource	No direct impact.
Legal	The report supports the Trust in meeting its obligations under the Public Sector Equality Duty of the Equality Act 2010 and the workforce equality requirements of the NHS Standard Contract.
Protected characteristics	The report directly considers differences in workforce representation, recruitment, progression and staff experience relating to race, disability, sexual orientation, sex, age, religion or belief, and gender reassignment. The associated action plans are intended to reduce identified inequalities and advance equality of opportunity.

5. Appendices (refer to the library for appendices B to G)

Appendix	Title
A	Equality Action Plans 2026/27 (attached)
B	WRES data
C	WDES data
D	SOWES data
E	Gender data
F	Age data
G	Religion data

6. Document Control

Version	Date	Author	Summary of Changes
1 Final	22 October 2026	L Hodge, Int. Executive Director for People and Culture	Report for Board following consideration by PCDC

Appendix 1 Equality Action Plans 2026/27

WRES Action Plan 2026/2027

1. Strengthen our anti-racist culture and improve staff experience
   - Deliver a Trust-wide anti-racism campaign, including anti-racism poster campaigns, awareness events and communications.
   - Update hate crime, abuse and aggression intranet page providing guidance, support, reporting routes and resources for staff.
   - Produce a staff video highlighting the impact of racism from patients, service users, visitors and the public, to support organisational learning and training and to share with partner organisations e.g. Police.
   - Continue work with Safer Communities to embed restorative justice approaches following incidents of racism and discrimination, review impact by repeating survey on confidence in the reporting process.

2. Improve leadership accountability and capability
   - Ensure all Board members and senior leaders have explicit, measurable equality, diversity and inclusion objectives, including actions to tackle racism (linked to Mann Report and NHS staff standards recommendations).
   - Deliver anti-racism development opportunities for managers and leaders, including bitesize learning on racial bias including the NHS Race & Health Observatory's Seven Anti-Racism Principles.
   - Deliver leadership and management development taster sessions for members of the Race Equality Network and promote access to wider leadership programmes.
   - Provide an annual Board report on incidents of racial discrimination, themes, learning and actions (Mann Report).
   - Review the six High Level Impact Actions action plan (NHS Staff Standards).

3. Develop anti-racist policies, procedures and guidance
   - Develop and implement an Anti-Racist Policy and Managers' Guide aligned to the NHS Race & Health Observatory Seven Anti-Racism Principles (Mann Report).
   - Review relevant workforce policies to ensure clear definitions, reporting arrangements and investigation processes relating to racism and discrimination (Mann Report).
   - Review conduct and disciplinary policies to ensure expected standards of behaviour and consequences of racist conduct are explicit (NHS Staff Standards).
   - Develop a clear flowchart and guidance for staff and managers outlining the actions, support and procedures available following incidents of discrimination and racism.
   - Develop Equality Impact Assessment guidance to strengthen consideration of race equality within policy development and organisational change.

4. Improve inclusive recruitment and career progression
   - Develop and implement an Inclusive Recruitment and Career Progression Plan to address ethnic disparities in recruitment, development and promotion opportunities (NHS Staff Standards).

- Review recruitment processes to ensure equitable selection and progression opportunities for candidates from ethnically diverse backgrounds (NHS Staff Standards).
- Promote anti-racist commitments through recruitment materials, job advertisements, induction and Trust Welcome programmes, reinforcing expectations that TEWV is an anti-racist organisation.

5. Strengthen reporting, investigation and response to racism

- Review grievance, disciplinary and investigation processes to ensure they are responsive to experiences of racism and discrimination and promote fair, robust and unbiased investigations (NHS Staff Standards).

WDES Action Plan 2026/27

1. Improve disability inclusion awareness and reporting
   - Promote Freedom to Speak Up, Respectful Resolution and other reporting routes through the Long-Term Health Condition and Disability (LTHC&D) Staff Network, communications campaigns and manager engagement activities.
   - Work alongside Executive Sponsors of the networks to raise awareness of the LTHC&D and Neurodiversity Staff Networks through regular communications and staff engagement opportunities throughout the year.
   - Share lived experience stories, including a Board-level staff story, to increase understanding of the experiences of disabled staff and those with long-term health conditions.

2. Strengthen manager capability to support disabled staff
   - Develop and deliver bitesize training for managers and leaders on disability inclusion, including disability-related harassment, ableism, microaggressions, psychological safety and inclusive leadership.
   - Develop manager guidance on common workplace adjustments, supporting staff with long-term health conditions and creating inclusive working environments.

3. Improve career development and progression opportunities
   - Collect and analyse demographic data relating to participation in leadership programmes, management development, coaching, mentoring and career development activities to identify and address any inequalities in access.
   - Deliver leadership and management development taster sessions for members of the LTHC&D and Neurodiversity Networks and promote wider leadership development opportunities.

4. Strengthen inclusive policy development and workforce processes
   - Develop a checklist to be included in the Equality Impact Assessment (EIA) guidance to support policy owners to assess and mitigate potential impacts on disabled staff and staff with long-term health conditions.
   - LTHC&D and Neurodiversity staff networks link with work from NHS Staff Standards on the Flexible Working Standard.

5. Increase disability confidence, staff engagement and declaration rates
   - Deliver a "Why Declare?" communications campaign to increase staff confidence in disclosing disability and long-term health conditions on ESR and improve workforce data quality.

- Develop resources and awareness campaigns to address disability-related bullying, harassment and microaggressions and to promote psychological safety, Respectful Resolution and Freedom to Speak Up routes.

SOWES Action Plan 2026/27

1. Increase awareness, visibility and allyship for LGBTQ+ staff
   - Deliver a programme of LGBTQ+ awareness campaigns throughout the year, including Pride activities, bisexual awareness, trans awareness and the impact of microaggressions.
   - Incorporate LGBTQ+ allyship resources into communications, campaigns and training.
   - Work alongside the Executive Sponsor of the network to raise awareness of the LGBTQ+ staff network through regular communications and staff engagement activities.
   - Share LGBTQ+ lived experience stories, including Board-level staff stories, to improve understanding of LGBTQ+ experiences in the workplace.

2. Improve manager capability to create inclusive workplaces
   - Review and update sexual orientation and gender identity training to reflect current Trust policies, procedures and guidance.
   - Develop bitesize learning for managers on creating psychologically safe and inclusive workplaces, including recognising and addressing homophobia, transphobia, microaggressions and inappropriate behaviours.
   - Develop a Managers' Guide covering:
     - Supporting staff who come out at work.
     - Supporting trans staff during transition.
     - Challenging inappropriate language and behaviours.
     - Having inclusive conversations about wellbeing, support needs and reasonable adjustments.
   - Promote Respectful Resolution resources and guidance to support early intervention and positive workplace behaviours.

3. Strengthen support and resources for LGBTQ+ staff
   - Develop and maintain a dedicated LGBTQ+ intranet resource page containing guidance, support services, reporting routes and educational materials.
   - Create a confidential point of contact for trans staff seeking advice, information or support.
   - Develop a clear flowchart outlining relevant policies, procedures and support available following incidents of discrimination, harassment or bullying.
   - Develop record-keeping guidance to ensure staff records are maintained appropriately and consistently, including guidance relating to trans staff.
   - Increase awareness of Freedom to Speak Up routes through partnership working with the LGBTQ+ Network.

4. Improve workforce data, representation and career development
   - Explore reasons for non-disclosure of sexual orientation data, particularly within Very Senior Manager (VSM) groups, and implement actions to improve confidence in declaration.
   - Deliver leadership and management development taster sessions for members of the LGBTQ+ Network and promote wider leadership development opportunities.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Report to the Board of Directors

Committee Chair's 3 A Report

Committee:	Finance and Performance Committee
Report to:	Board of Directors (Public)
Date of committee meeting:	8 October 2026
Date of Board meeting:	28 October 2026
Committee Chair:	Jules Preston, Non-Executive Director
Report author:	Liz Romaniak, Executive Director for Finance, Estates and Facilities Karen Christon, Deputy Company Secretary
Quorate:	Yes
Attendance:	All members in attendance

1. Purpose of this report

This report provides the Board of Directors with a summary of the business considered at the meeting of the Finance and Performance Committee held on 8 October 2026, highlights any matters requiring the Board's attention, and sets out the Committee's assurance rating across its areas of oversight, in line with the Committee's Terms of Reference and the Trust's Board Assurance Framework (BAF).

2. Key items considered at the meeting

Agenda item	Lead	Summary of discussion	Outcome
Closing Resources and Planning Committee	A Pridmore, Int. Company Secretary and Director of Governance	Committee reviewed transfer and closure arrangements for Resources and Planning Committee, noting updates to actions recorded as outstanding.	Committee agreed the transfer of actions to the relevant successor committee and authorised the Corporate Governance Team to validate the status of, close or redirect the remaining legacy actions.
Committee Terms of Reference and Work Programme	A Pridmore Int. Company Secretary and Director of Governance	Committee identified the risk of duplication or gaps in assurance where its responsibilities intersect with planning, workforce and quality. Board is advised that effective coordination between committee chairs and proportionate, integrated	Terms of reference to be reviewed to confirm quoracy. Further development of the work programme to be completed.

Agenda item	Lead	Summary of discussion	Outcome
		reporting will be important to ensure cross-cutting matters are considered comprehensively without creating duplicate scrutiny. Committee agreed to hold a workshop to clarify its priorities, interfaces and assurance requirements, including the use of thematic reviews and focused deep dives for complex or persistent performance issues.	
Access and waits	K Ellis Int. Executive Director of Strategy and Transformation	Committee reviewed how it would take assurance on access and waiting times. It supported a proportionate approach combining routine oversight of key metrics and trajectories with thematic reviews and focused deep dives into complex or persistent areas of underperformance. Committee's principal lens will be performance, demand and capacity, sustainability, and the credibility and impact of improvement plans; with quality and patient experience considered principally through the Quality Assurance Committee.	Further work to be completed to develop the committee work programme.
Board assurance Framework and Corporate Risk Register	A Pridmore Int. Company Secretary and Director of Governance	BAF 02 (access), BAF 08 (partnerships and system working) and BAF 11 (financial sustainability) remain above tolerance. Members considered that risks above tolerance should clearly articulate the expected trajectory, actions required to reduce exposure and, where further reduction is not achievable, the basis for the residual position, which was discussed for Committee-owned risks. Reporting to also distinguish matters within the Trust's control from those reliant on other external factors, e.g. commissioning or partners.	Committee agreed reasonable assurance from governance and oversight arrangements and limited assurance on current risk reduction and delivery.

Agenda item	Lead	Summary of discussion	Outcome
		Committee agreed a deep dive into waiting list management to strengthen assurance on underlying causes, actions, impact and expected improvement trajectories.	
Internal Audit findings and progress against Internal Audit recommendations	L Romaniak, Executive Director for Finance, Estates and Facilities	No internal audit or counter-fraud recommendations are beyond their original or agreed revised implementation dates, and no new audit reports (within the committee's remit) have been issued during the reporting period	Committee accepted good assurance on the implementation of Internal Audit recommendations.
Integrated Quality and Performance Report	N Lonergan Int. Care Group Managing Director	Committee was advised of a mixed assurance position, with continued pressures relating to patient flow and clinically ready for discharge, access, workforce and financial recovery. Members agreed a focus on areas of significant variation and persistent challenge, to gain an understanding of root causes, improvement activity and transformational change required for sustained improvement. Committee also highlighted the need to better understand the implications of health inequalities for access, performance and resource requirements and agreed to incorporate this into its future work programme.	Committee accepted the mixed assurance levels presented.
Finance Report for 2026/27 month 5, including plan conditions	L Romaniak Executive Director for Finance, Estates and Facilities	Committee noted challenges to achieve planned reductions in bank expenditure and related recurrent CRES, with current overall CRES delivery supported by non-recurrent savings. Committee also noted continued capital pressures, with forecast expenditure above the current allocation. Members recognised the interdependency between financial recovery and wider operational pressures, particularly patient flow,	Committee accepted good assurance on overall financial performance and delivery of the break-even plan, with limited assurance in relation to bank reductions, recurrent CRES and delivery of the capital programme within allocated resources.

Agenda item	Lead	Summary of discussion	Outcome
		clinically ready for discharge and flexible staffing. Committee was briefed on a newly reported issue in relation to the classification of bank expenditure – *please refer to key alerts section 3 below.*	
Deconstructing the block	L Romaniak	Committee noted compliance with national guidance, analysis of the potential financial implications and regional and national escalation of significant methodological concerns by the Executive Director. Limited assurance was taken from the methodology and resulting outputs, which could materially disadvantage the Trust despite its relative cost efficiency. Committee noted the risk should the methodology be incorporated into future national financial arrangements without amendment and commended the executive director and colleagues for continued work to evidence and challenge areas of concern.	Committee accepted good assurance on the Trust's submission and limited assurance regarding the methodology and resulting potential financial opportunity.

3. Key alerts — matters requiring Board attention

The following issues are escalated to the Board for awareness, discussion, or decision:

- **Bank staffing reporting and delivery:** an expenditure classification anomaly remains subject to review but has potential to increase the bank reduction challenge. Validation, control review and consideration of internal audit input are underway and will be reported at the next meeting.
- **Financial plan risks:** the Trust continues to forecast break-even, but delivery remains dependent on management of the exit run rate, including for recurrent CRES (notably bank), capital pressures and other emerging liabilities. Full delivery of the £3.6m in-year bank expenditure reduction was considered unlikely, with the challenge exacerbated by the misclassification of cost.
- **Cross-committee assurance:** the revised committee structure creates a risk of gaps or duplication across finance, performance, planning, workforce and quality. Periodic coordination between committee chairs and integrated reporting should be used to maintain clear ownership and a complete assurance picture.
- **Deconstructing the block:** it is understood that the current methodology will not be implemented from 2027/28, reducing immediate downside methodological risk but deferring a potential financial opportunity should this be corrected. Material concerns remain regarding the methodology and proposed productivity deflator; a further Board report is recommended when the national position is clearer.

4. Assurance summary

The Committee's overall assurance rating for each area of oversight, based on the evidence reviewed at this meeting, is set out below.

Area of oversight	Assurance level	Commentary
Risk governance and oversight	**Some concerns**	Reasonable assurance on governance and oversight, but limited assurance on current risk reduction and delivery. BAF 02, BAF 08 and BAF 11 remain above tolerance and require clearer trajectories, completed assurance assessments and action follow-up, with rationale where risks remain above tolerance.
Operational performance, access and flow	**Some concerns**	Mixed assurance. Positive performance was offset by sustained pressures in access, long waits, flow, clinically ready for discharge, bed occupancy, sickness and temporary staffing. A waiting-list management deep dive will test root causes, actions and trajectories.
Financial performance	**Positive**	Good assurance on year-to-date performance and arrangements to deliver break-even, while recognising that forecast delivery remains dependent on effective management of identified risks.
Financial plan conditions and capital	**Some concerns**	Limited assurance on bank reductions, related recurrent CRES and managing capital expenditure within available resources. The bank classification issue further increases the delivery challenge.
Internal audit actions	**Positive**	Good assurance: no committee-related internal audit or counter-fraud recommendations were overdue against original or revised dates.
Deconstructing the block	**Some concerns**	Good assurance on the Trust's submission and engagement, but limited assurance on the national methodology and realisation of any financial opportunity.

Key: Positive assurance — controls are effective | Some concerns — controls are partially effective, action underway | No assurance — controls are not effective, immediate action required

5. Decisions made, and papers approved

- Approved the transfer of relevant Resources and Planning Committee actions to successor committees and authorised validation, closure or redirection of remaining legacy actions, subject to the amendments recorded.
- Agreed that the quorum requirement should specify at least two Non-Executive Directors and one Executive Director.
- Agreed the committee work programme be developed to incorporate access and waiting-times assurance, waiting-list management deep dive, and health inequalities intelligence relevant to access, performance and finance.
- Accepted the assurance levels presented for the BAF/CRR, internal audit, Integrated Quality and Performance, 2026/27 month 5 finance and deconstructing the block reports.
- Agreed to replace the November substantive meeting with a workshop to develop the Committee's priorities, work programme and related committee interfaces.

6. Links to the Board Assurance Framework (BAF) and risk register

The Committee reviewed the following strategic risks and corporate/principal risks relevant to its remit:

- **BAF 02 – Access:** current score 16 against tolerance 9. Assurance on delivery remains limited, reflecting prolonged waits, demand/capacity pressures, variation and dependency on system action. Corporate risks include the CAMHS neurodevelopmental pathway and flow/clinically ready for discharge.
- **BAF 08 – Partnerships and system working:** current score 16 against tolerance 12. The Committee sought clearer articulation of the impact of ineffective partnership arrangements and of performance constraints outside the Trust's direct control. It considered the previous focus on 'being' a good partner, and the need to better articulate necessary partner contributions from those relationships. No aligned corporate risk was identified in the report, and this requires further consideration.
- **BAF 11 – Financial sustainability:** current score 20 against tolerance 12. The position reflects the challenging medium-term funding context (expected to continue beyond the current Spending Review due to public finances) and risks to recurrent in-year CRES delivery, including bank reductions, capital affordability and emerging workforce costs. The Committee considered the score above tolerance credible, provided the intended trajectory and limits of mitigation remain explicit.

7. Recommendations to the Board

No.	Recommendation / action requested of the Board	Owner	Timescale
1	Note the assurances, concerns, decisions and planned follow-up set out in this report.	-	-
2	Support periodic coordination between Board committee chairs to identify cross-cutting matters and avoid gaps or duplication in assurance.	Board / Committee Chairs	From October 2026
3	That a further report on deconstructing the block will be presented to Board when the national methodology and proposed deflator are clearer.	L Romaniak, Executive Director for Finance, Estates & Facilities	To be confirmed (subject to national next steps being confirmed)

8. Forward look

Committee has proposed a workshop will be held in late November to agree its priorities, work programme and interfaces with other committees. The work programme will be developed to include the access and waiting-times assurance model; a focused deep dive on waiting-list management, root causes and improvement trajectories; health inequalities intelligence relevant to finance and performance; and continued scrutiny of bank reduction, recurrent savings and financial forecasts.

9. Next meeting

The November meeting will be replaced by a committee workshop. The next substantive meeting is scheduled for 1.30pm on 9 December 2026.

Report prepared by: Liz Romaniak, Executive Director for Finance, Estates and Facilities and Karen Christon, Deputy Company Secretary | On behalf of: Jules Preston, Committee Chair | Date: 21 October 2026

Tees, Esk and Wear Valleys
NHS Foundation Trust

Report to the Board of Directors

Committee Chair's Report

Committee:	Planning, Digital and Estates Committee
Report to:	Board of Directors
Date of committee meeting:	9 October 2026
Date of Board meeting:	28 October 2026
Committee Chair:	Len Richards, Non-Executive Director (Nini Adetuberu chaired the meeting as the Chair's nominated deputy)
Report author:	Donna Keeping, Corporate Governance Manager
Quorate:	Yes
Attendance:	All seven members; with the substantive Chair joining the meeting at 10.29 am. There were no apologies. Nini Adetuberu, Non-Executive Director, chaired the meeting throughout as the substantive Chair's nominated deputy.

1. Purpose of this report

This report provides the Board of Directors with a summary of the business considered at the first meeting of the Planning, Digital and Estates Committee held on 9 October 2026. It highlights matters requiring the Board's attention and sets out the Committee's assurance across its remit, aligned to the Terms of Reference and Board Assurance Framework.

2. Key items considered at the meeting

Agenda item	Lead	Summary of discussion	Outcome
Terms of Reference and work programme	Chair / Executive Lead	The Committee reviewed its Terms of Reference and work programme and identified potential gaps and duplication across the wider committee architecture, involving the Planning, Digital and Estates Committee, Finance and Performance Committee and Audit and Risk Committee, particularly in relation to EPRR, cyber security, incident response and business continuity. The Committee agreed that the work programme would be revised to clarify accountability and assurance routes, remove unnecessary operational detail and ensure balanced oversight across the Committee's remit.	Agreed — the Committee endorsed the scope of the proposed revisions to the Terms of Reference and work programme. Revised documents will be developed in consultation with the Interim Company Secretary and returned through the appropriate

		A Committee workshop would be planned. Separately, the Chairs and Executive Leads of the Planning, Digital and Estates Committee and the Finance and Performance Committee would discuss shared responsibilities and assurance routes. Any wider implications for the Audit and Risk Committee would be addressed through the appropriate governance route.	approval route. A Committee workshop will be arranged, together with a separate discussion between the Chairs and Executive Leads of the Planning, Digital and Estates Committee and the Finance and Performance Committee to clarify shared responsibilities and assurance routes. Any implications for the Audit and Risk Committee will be addressed through the appropriate governance route.
BAF and Corporate Risk Register	Head of Risk Management	The Committee reviewed the five BAF risks within its remit: BAF 05 Digital, BAF 07 Data Security and Protection, BAF 10 Roseberry Park and BAF 12 Transformation remained above tolerance; BAF 06 Estates and Physical Infrastructure was at tolerance. The Committee took reasonable assurance from the governance and oversight arrangements. The Committee noted that assurance over delivery and demonstrable risk reduction remained mixed given gaps in reported information linked to the transition to a new risk reporting system. Gaps included incomplete quarterly and control-level assurance, overdue actions, BAF risks without aligned corporate risks and insufficiently evidenced recovery trajectories, which Executive leads had agreed timescales to update risk	Reasonable assurance over governance and oversight; further assurance required on delivery, demonstrable risk reduction, completion of overdue actions and recovery trajectories.

		records before the next Board meeting on 28 October 2026 with the Head of Risk Management. For Roseberry Park, the required rectification works were understood, although insufficient and uncertain capital funding meant that a fully deliverable programme had not yet been secured. A £6 million one-off allocation had been received for estates safety and further regional funding was being pursued. The programme would therefore be brought forward in stages, with the Phase 3 business case and strategic outline case developed incrementally to support Board consideration of scope, sequencing, affordability and alignment with the Trust's risk tolerance. The Committee also noted the established governance, legal advice and early rectification work already in place.	
Electronic Patient Record (EPR) Programme assurance	Director of Finance, Estates and Facilities / Chief Information Officer	The EPR Programme remained rated amber, with the internal programme assessment and independent assurance providing a consistent view. The planned go-live date of 12 April 2027 remained unchanged. Three significant matters remained unresolved: the reporting solution and confirmation of reporting capability from day one; training capacity and organisational readiness; and the risks and mitigations associated with Civica's proposed re-platforming of the existing systems. The Committee took reasonable assurance that the three matters were subject to active governance, consistent internal and independent assurance, and appropriate escalation. In relation to Civica, the Trust was assessing the end-of-life and cyber risks, seeking mitigations from the	Reasonable assurance over governance and active management; three material risks remained unresolved and required continued Committee and Board oversight.

		supplier to support continued operation of the existing platform through to the end of the contract, and considering additional temporary specialist support if required. The independent assurer confirmed that the position was not unusual and was being explored at an appropriate level of detail and pace. However, the assurance related to the effectiveness of the governance and mitigation arrangements and did not indicate that the underlying risks had been resolved. Based on the evidence available to the Committee at its meeting on 9 October 2026, none of the three unresolved risks was forecast to affect go-live. Failure to agree and implement the required mitigations within programme timescales could, however, place delivery at risk and would require escalation. The governance and assurance layers comprised: weekly review of the programme RAID log; oversight through the Clinical Assurance Group, Technical Design Authority and Organisational Readiness Board; monthly review and decision-making by the EPR Programme Board; executive oversight through the Executive Directors Group and a monthly EPR Programme Assurance Briefing.	
Strategic partnerships	Executive Lead	The Committee considered how it would test the effectiveness and local impact of strategic partnerships, initially focusing on the provider collaborative.	Update requested for future Committee meeting

3. Key alerts — matters requiring Board attention

The following matters are escalated to the Board for assurance, awareness and discussion. No Board decision or approval is requested at this stage:

- **EPR Programme — assurance and continued oversight:** The programme remained amber and the 12 April 2027 go-live date was unchanged. Reporting capability, training capacity and Civica re-platforming remained unresolved, although none was forecast to affect go-live based

on the evidence available to the Committee on 9 October 2026. The Board is asked to take reasonable assurance from the governance and active management arrangements and note the Committee's monthly oversight, the independent assurance due in December 2026 and the requirement for earlier escalation if mitigations are delayed or delivery is forecast to be affected.

- **Strategic risks — awareness and challenge:** BAF 05, BAF 07, BAF 10 and BAF 12 remained above tolerance. Quarterly and control-level assurance records were incomplete during the transition to the new risk reporting system, and overdue actions remained within estates, Roseberry Park and cyber security. The Board is asked to note the position and seek assurance that missing evidence, overdue actions and measurable recovery trajectories are completed within agreed timescales and reported through the established assurance routes.
- **Roseberry Park — awareness of capital dependency:** The required rectification works were understood, but insufficient and uncertain capital funding meant that a fully deliverable end-to-end programme had not yet been secured. The Board is asked to note the continuing dependency and the need for oversight of programme scope, sequencing, affordability and alignment with the Trust's risk tolerance through the established Committee and Board assurance routes.
- **Governance interfaces — note the agreed discussion:** The Committee identified areas of overlap with the Finance and Performance Committee. The Board is asked to note that the Chairs and Executive Leads of the two committees will discuss and clarify responsibilities, accountability and assurance routes for shared matters, including EPRR and Roseberry Park oversight. Any proposed changes will be returned through the appropriate governance route.

The Board is asked to take assurance from the governance and oversight of the EPR Programme, note the incomplete BAF assurance and Roseberry Park capital dependency, and note the agreed discussion between the Planning, Digital and Estates Committee and the Finance and Performance Committee. No Board decision or approval is requested at this stage.

4. Assurance summary

The Committee's overall assurance rating for each area of oversight, based on the evidence reviewed at this meeting, is set out below. In this report, "reasonable assurance" describes confidence in the governance and oversight arrangements operating in each area, while the summary rating of "Some concerns" reflects the unresolved risks, gaps in evidence or delivery issues that require further action and continued oversight.

Area of oversight	Assurance level	Commentary
EPR Programme	**Some concerns**	Reasonable assurance was taken that the programme's assurance lines were operating consistently. The programme remained amber, with three unresolved risks under active management and independent review.
BAF and risk management	**Some concerns**	Governance and oversight arrangements supported reasonable assurance, but delivery and risk reduction were mixed. Four of five aligned BAF risks were above tolerance and assurance records and actions required completion.
Estates and Roseberry Park	**Some concerns**	Established governance and early rectification work provided assurance, but capital uncertainty prevented confirmation of a fully deliverable end-to-end programme. Scope, affordability and residual risk require continued oversight.

Committee governance and remit	**Some concerns**	The Committee was quorate and established clear initial oversight. Further work is required to refine its Terms of Reference, work programme, EPRR coverage and interface with Finance and Performance Committee.

Key: Positive assurance — governance, controls and delivery evidence are adequate and effective |Some concerns — governance, controls or delivery evidence are only partially adequate or effective, with further action required | No assurance — governance, controls or delivery evidence are inadequate or ineffective, requiring immediate action

5. Decisions and agreements

- Agreed the scope of revisions to the Terms of Reference and work programme, including EPRR coverage, overlapping digital and cyber responsibilities, incident response and business continuity assurance, quoracy wording and balance across the Committee's remit. Revised documents will be developed with the Interim Company Secretary and returned through the appropriate approval route.
- Agreed a Committee workshop within one-month, monthly agenda-planning meetings and a separate discussion between the Chairs and Executive Leads of the Planning, Digital and Estates Committee and the Finance and Performance Committee to clarify shared responsibilities and assurance routes.
- Agreed that EPRR risks would be incorporated into Committee oversight and that the Board report would reflect reasonable assurance over EPR governance, while identifying the three unresolved risks and confirming that none was forecast to affect go-live at the time of the meeting.

6. Links to the Board Assurance Framework (BAF) and risk register

The Committee reviewed the following strategic risks and corporate/principal risks relevant to its remit:

- **BAF 05 – Digital: Supporting Change:** score 20 against tolerance 12; above tolerance. Reasonable assurance was recorded for Q1 and Q2. Corporate risks 1535 and 1636 remained above tolerance.
- **BAF 06 – Estates / Physical Infrastructure:** score 12 against tolerance 12; at tolerance. Quarter 2 assurance had been submitted but was not visible in the extract; later-quarter and some control-level assurance remained unrecorded.
- **BAF 07 – Data Security and Protection:** score 20 against tolerance 12; above tolerance. Corporate risk 1647 remained above tolerance with four open actions, including an overdue vulnerability-scanning action.
- **BAF 10 – Roseberry Park:** score 16 against tolerance 12; above tolerance. Positive assurance was recorded for Q1 and Q2, but programme scope, affordability and end-to-end delivery remained uncertain. Corporate risk 219 remained above tolerance.
- **BAF 12 – Transformation:** score 16 against tolerance 12; above tolerance. Quarterly assurance had not yet been reflected in the risk reporting extract, and no aligned corporate risk had been identified.

7. Recommendations to the Board

No.	Recommendation / action requested of the Board	Owner	Timescale
1	Take reasonable assurance from the governance and active management of the EPR Programme, noting that three material risks remain unresolved but, based on the evidence available to the Committee on 9 October 2026, were not forecast to	Director of Finance, Estates and Facilities /	Monthly, with independent assurance in December 2026

	affect the 12 April 2027 go-live date. The Board is asked to note the Committee's continued monthly oversight, the further independent assurance due in December 2026 and the requirement for earlier escalation should mitigations not be agreed or implemented within programme timescales, or should any risk be forecast to affect go-live.	Chief Information Officer	
2	Note that four of the five BAF risks within the Committee's remit remained above tolerance and that assurance over demonstrable risk reduction was incomplete. The Board is asked to seek assurance that missing quarterly and control-level evidence, overdue actions and measurable recovery trajectories are completed within agreed timescales and reported through the established Committee and Board assurance routes.	Board	Ongoing
3	Note the planned Committee workshop and the agreed discussion between the Chairs and Executive Leads of the Planning, Digital and Estates Committee and the Finance and Performance Committee. The discussion will clarify responsibilities, accountability and assurance routes for shared matters, including EPRR and Roseberry Park oversight, with any proposed changes returned through the appropriate governance route. No Board decision or approval is requested at this stage.	Committee Chair / Executive Lead	By 13 November 2026

8. Forward look

The Committee will review the revised Terms of Reference and work programme, the agreed approach to EPRR risk reporting and an update on strategic partnerships, including the provider collaborative. It will continue monthly oversight of the EPR Programme, including the reporting proof of concept, training readiness, Civica mitigations and preparations for the December independent assurance assessment. The Committee will also maintain oversight of BAF and corporate risks, including Roseberry Park programme development and capital dependencies.

9. Next meeting

The next meeting of the Planning, Digital and Estates Committee is scheduled for 13 November 2026 at 9.30 am.

Report prepared by: Donna Keeping, Corporate Governance Manager | On behalf of: Nini Adetuberu, Chair's nominated deputy | Date: 9 October 2026

BOARD REPORT

1. Cover Sheet

Report Title	**Adult Mental Health Planned Care: Core Community Offer**
Meeting	Trust Board - Public
Date of Meeting	28 October 2026
Paper	L
Sponsoring Director / Author	Naomi Lonergan – Interim Care Group Managing Director
Report Author	Ranjeet Shah – Group Medical Director (DTVF) Jamie Todd – Director of Operations & Transformation Shaun Mayo – General Manager (Adult Planned Care DTVF) Paul Swalwell – Business Manager (Adult Planned Care DTVF)
Purpose of Paper	Assurance
Previously Considered By	Quality Assurance Committee
Financial Implications	No decision on additional expenditure is requested. The report identifies workforce and financial pressures affecting capacity and the pace of transformation.

2. Recommendation

The Board is asked to:

- Note the scope, current performance and quality position of the AMH Planned Care core community offer.
- Receive assurance on the governance, audit and improvement arrangements in place.
- Note the material risks relating to access waits, service variation, workforce capacity and delivery of the neighbourhood mental health model.

3. Executive Summary

This report provides the Board with a concise overview of the Adult Mental Health Planned Care core community offer across the Trust. Services support adults with moderate to severe or complex mental health needs across eight local authority areas, with locally configured teams delivering access, assessment, treatment, review and safe transition or discharge.

Trustwide AMH core community services holds a unique caseload of 12,084 people. There are 1,986 people waiting for an initial assessment and the mean wait is 62 days, against an internal indicator of less than 28 days. Four community teams are receiving additional support. Assurance is provided through weekly care group oversight, monthly quality and performance reporting, audit, incident and complaint review, and escalation to the Quality Assurance Committee.

Positive indicators include high reported experience, stable incident rates, achievement of the 72-hour follow-up standard, improving community quality audit compliance and clinician-reported outcomes above standard. However, access waits, local variation, workforce capacity, inequalities and system and financial dependencies remain material risks. The Board is asked to note the position, receive assurance on current controls and support continued improvement and development of a more consistent neighbourhood-based model.

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	Deliver safe, effective, person-centred community mental health care; improve access, outcomes and experience; support the shift from hospital to community and neighbourhood working.
Board Assurance Framework	BAF 02 – Access BAF 04 – Quality and Outcomes BAF 11 – Financial sustainability
Corporate Risk Register	None
Committee / Work Programme Ref	Quality Assurance Committee
Regulatory / Legal Reference (if applicable)	CQC Fundamental Standards; NHS England Community Mental Health Framework and Mental Health Personalised Care Framework; relevant NICE guidance and Royal College of Psychiatrists community standards.

5. Appendices

Appendix	Title
A	AMH Planned Care - Community Health Care - Trust Board presentation, 28 October 2026

6. Document Control

Version	Date	Author	Summary of Changes
1. Final	21 October 2026	Jamie Todd	Initial draft completed from the AMH Planned Care Trust Board presentation

Tees, Esk and Wear Valleys
NHS Foundation Trust

Adult Mental Health (AMH) Planned Care

Core Community Offer

28th October 2026

What and where the services are

Tees, Esk and Wear Valleys
NHS Foundation Trust

Footprint

8 Local Authorities across North Yorkshire, City of York, County Durham, Darlington and the Tees Valley.

Most services: 09:00–17:00
New hubs extend access

More than 2 million people live within the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) footprint

Population & Access

Adults aged 18 and over with moderate to severe or complex needs requiring secondary mental health services

In North Yorkshire and York, this includes adults with mild to moderate needs

Majority of referrals via primary care, hubs/access teams.

What we provide

Tees, Esk and Wear Valleys
NHS Foundation Trust

1 **Access**

Referral, assessment, triage

2 **Assess**

Biopsychosocial formulation + safety planning

3 **Treat**

Co-produced care plan

4 **Next Steps**

Review, step up/down or discharge

Front Door

- Daily multidisciplinary team (MDT) huddle
- High-risk escalation
- Patient tracking list (PTL) until assessed
- Keeping in touch process mitigates areas of longer waits

Core Offer

- Formulation and safety plan
- Clinical and social interventions and treatments
- Health of the Nation Outcome Scales (HoNOS) and Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) capture outcomes

Continuity / Endings

- Regular MDT review
- Step between services
- Shared care with Primary Care
- Safe discharge

Key Stats:

Our core community service hold a unique caseload (IIC 5571) of **12,084** across the trust (DTVF: 8,504, NYY: 3,577).

1,986 patients are currently waiting for an initial assessment. The average wait for meaningful help across the trust is **104 days**.

Community Provision - Core functions

Tees, Esk and Wear Valleys NHS Foundation Trust

TEWV's core community offer is delivered through locally configured teams.

Core Function	Local Team Name and Location
Access, triage and brief intervention Referral, triage and assessment; navigation; brief support; step up or down.	**Community Hubs**: DTVF locality-based access offer, York 2 Hubs (North & Central) **Access and Wellbeing Team**: York & Selby **Integrated Community Teams:** Harrogate and Rural; Hambleton and Richmondshire; Scarborough, Whitby and Ryedale **Durham Gateway**: County Durham – service integrated with Social Care.
Ongoing treatment, intervention and recovery Expert assessment and formulation; co-produced care planning; clinical and social interventions; review and safety management.	**Treatment and Intervention Teams**: Durham, Darlington and Tees Valley **Integrated Community Teams:** Harrogate and Rural; Hambleton and Richmondshire; Scarborough, Whitby and Ryedale **Community Mental Health Teams**: York & Selby (4 teams)
Complex needs and assertive engagement Proactive engagement, multidisciplinary oversight, and coordinated risk and safety planning.	**Assertive Outreach Team**: York & Selby **Complex and assertive care processes within core teams**: Everywhere else.

The core function is the constant. Team names and configuration reflect historical local operating models and partnerships.

For example, in York & Selby, Access Team: Assessment & low-level need, CMHT: mild/moderate and severe. For North Yorkshire, the functions are integrated and provided within the Integrated Community Teams.

What do we work to?

Tees, Esk and Wear Valleys NHS Foundation Trust

Community Mental Health Teams operate within a combined national framework:

- **National Institute for Health and Care Excellence (NICE) clinical guidelines and quality standards** guide evidence-based assessment, treatment and management of conditions e.g. Psychosis and schizophrenia **NG222 / QS80**; bipolar disorder **CG185**; depression **NG222 / QS8**; self-harm **NG225 & QS34**; and coexisting severe mental illness and substance misuse **NG58 & QS188**.
- **National Health Service (NHS) England's Community Mental Health Framework** promotes integrated, neighbourhood-based and person-centred care, delivered in partnership with primary care, local authorities and the voluntary sector.
- **The Mental Health Personalised Care Framework** expects every person to have a personalised care and support plan, a named responsible professional, regular reviews and measured outcomes.
- **Care Quality Commission Fundamental Standards** provide the regulatory framework across the domains of Safe, Effective, Caring, Responsive and Well-led.
- **Royal College of Psychiatrists** standards provide practical benchmarks for access, assessment, treatment, physical healthcare, risk management, staffing and patient experience
- **Role specific standards** and frameworks that contribute to the wider care of our patients. E.g. Nursing and Midwifery Council, Health and Care Professions Council, Social Work England, Royal College of Occupational Therapists and Royal College of Psychiatrists requirements relevant to each practitioner's role.

Key References: NICE guidance and standards | NHS England Community Mental Health Services | Mental Health Personalised Care Framework | CQC Fundamental Standards| Royal College Community Standards

Access and demand to services

Tees, Esk and Wear Valleys
NHS Foundation Trust

Demand

Sustained referrals across trust and backlog across community teams.

1,986 patients waiting for an initial assessment
DTVF: 1,069 NYY: 917

466 patients waiting ≥3 months
DTVF:151 NYY: 315

No. of new unique patients referred in August (IIC 5710)
DTVF: 799 NYY: 515

Capacity

While we have seen a reduction in caseloads as a result of community transformation, more work is required to progress left shift further.

Workforce and financial pressures

Unique Caseload (IIC 5571):
DTVF: 8,504 NYY: 3,577

Access Waits

Variation in lengths of wait for new patients awaiting an assessment.

Wait for assessment varies.

Mean length of wait for an assessment is 62 days.

Impact

Potential deterioration, poor experience and avoidable harm.

Mitigations include local incident data monitored for harm and feedback analysed.

Mitigations

Patients who Did Not Attend (DNA) risk reviewed; longest and urgent prioritisation for people waiting; Keeping in Touch (KIT) processes; Service Requiring Additional Support processes.

Identified Risk

Unacceptable waits may cause deterioration and avoidable harm.

In the national 2025 CMH survey, respondents reporting that their mental health got worse the longer they waited. A quarter (25%) of people who waited less than 2 weeks said their mental health got worse while they waited, compared to 67% of those who waited more than 6 months.

Evidence Gap

Hard to correlate within existing reporting incidents, complaints and clinical deterioration with PTL. Only 4 complaints have been submitted in rolling 12-month period to date relating to Waiting Times in AMH services.

Governance

Weekly quality and performance oversight supports operational delivery and challenge, embedding early identification of issues and escalations.

Access - Key performance Indicators

Tees, Esk and Wear Valleys NHS Foundation Trust

Measure	Expected	Current	Trend	What the gap means
Access to Assessment	Internal Indicator < 4 weeks (28 days)	Median length of wait for assessment DTVF: 33 days NYY:61 days Trust: 42	Sustained	While some teams are hitting the internal indicator for access to an assessment within 28 days for patients who externally referred into the trust, some people are waiting longer and the 4 teams within 'service requiring additional support' are a factor in the average length of wait for patients. The average length of wait across the trust is 62 days. DTVF: 47 days, NYY:79 days.
72-hour follow-up	≥80%	DTVF: 87.79% NYY: 91.43% Trust: 89.05%	Sustained	Standard achieved; breaches reviewed weekly. Year to date average: 92.44% (942/1,019)
Second contact	No specific standard	Median for open CMH referral spells waiting for 2nd Contact DTVF: 32 days NYY: 52 days Trust: 38 days	Improving	Only 8 people waiting over 1 year for second contact. Improvements in front end access and delivery of intervention supporting improving picture.
Meaningful help beyond 104 weeks	Reduce to zero	DTVF: 3 Patients NYY: 1 Patient	Improving	Trajectories introduced to move towards a reduction in long waits for meaningful help.

Assurance obtained from: standards > key controls > evidence reviewed > management oversight > escalation > action

Quality & Safety – Key Performance Indicators

Tees, Esk and Wear Valleys NHS Foundation Trust

At a Glance

Quality Domain	Measure	DTVF	NYYS
Experience	Good/Excellent Experience	96.94%	92.79%
Effectiveness	CROM Improvement	37.3% vs 30% standard	41.21% vs 30% standard
Safety	Incidents per 1,000 caseload	3.87 (stable)	3.57 (stable)
Assurance Audit	Community Quality Audit Compliance	78.9% and improving position	78.06% Improving position
Experience	Complaints via the Complaints Manager Pathway	7 (5 CMHTs) (stable)	4 (4 CMHTs)
Safety	Declared PSIIs	1 FYTD	0 FYTD
Safety	No. of incidents of moderate or severe harm	5 (31 FYTD)	4 (13 YTD)
Effectiveness	No. of Services Requiring Additional Support	1 (Darlington CMHT)	Harrogate & Ripon ICTs (joint SRAS) Scarborough ICT

Quality & Safety

Tees, Esk and Wear Valleys NHS Foundation Trust

Quality standards actively monitored and reported monthly through Care Group Governance and reports. Learning is shared monthly via operational (speciality governance and director meetings) and clinical routes (Patient Safety and Learning Meetings) with any identifiable learning shared trust wide with Quality Standards meetings. Where trends have been discovered interventions and performance improvement plans may be issued with support from senior leadership.

Quality Assurance Audits

In DTVF, community quality audit compliance has improved from 72.9% in January 2026 to 78.9% in August 2026.

In NYY, community quality audit compliance has improved from 72.09% in January 2026 to 78.06% in August 2026.

Example: A recent audit assurance review of patient records across Planned Care services found that the majority of records contained Safety Summaries, Safety Plans and Care Plans that were in place, relevant and reflective of current patient needs. Risks were generally well identified and aligned to the individual's presentation, with many records demonstrating strong evidence of co-production, clear patient involvement, and detailed risk management strategies. The review identified numerous examples of high-quality, person-centred documentation and concluded that overall documentation standards and safety planning practices had improved across services. Importantly, no widespread patient safety concerns were identified during the audit.

Services Requiring Additional Support

4 AMH Community Teams across the trust are in SRAS with enhanced support available to them (Ripon and Harrogate are in a linked SRAS). They are detailed within regular updates to the Quality Assurance Committee and monitored weekly within the care group.

Risk, response and assurance

Where the risks are:

- The immediate quality and access risk is most visible in four Adult Mental Health Community Teams currently in SRAS.
- Wider exposure sits in delivery of the Neighbourhood Mental Health Centre (NMHC) left shift, particularly system dependencies and financial constraints.
- Workforce capacity and resilience.

How we will improve:

- Use targeted improvement plans and enhanced senior support for services below standard;
- Phase NMHC delivery with system partners and utilisation of existing and available resources;
- Strengthen workforce capacity, deployment and skill mix.

How Board will be assured:

- Review progress through weekly Care Group monitoring, monthly quality and performance reporting, audit and trend analysis, with off-track areas escalated to the Quality Assurance Committee and supported through formal performance improvement plans.

Clinical outcomes

Tees, Esk and Wear Valleys NHS Foundation Trust

Outcome Measure Discharged patients who have made Measurable Improvement	IIC5692 - Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported (HoNOS) **Standard – 30%**		IIC5681 - Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported (SWEMWBS) **Standard – 55%**	
DTVF	August – **37.31%**	Financial year to date (FYTD) average – **37.46%**	August – **42.38%**	FYTD average – **42.39%**
NYY	August – **41.21%**	FYTD average - **41.44%**	August – **46.12%**	FYTD average - **48.59%**
So what…	**DTVF -** We have **good assurance** with our clinician reported outcome measure for which has been above standard since November 2024. **NYY -** We have **good assurance** with our clinician reported outcome measure for which has been above standard since July 2024.		**DTVF -** Review of patient reported outcome measures underway with planned introduction of new patient reported outcome measure, pilot underway in Redcar and Cleveland Community Mental Health Team (CMHT). **NYY –** We are aware of a backlog in assessments and baseline outcomes. Teams are working through the PTL to complete outstanding work and ensure data quality. Also implementing a reset aligned to combined pathway work, to ensure all teams are aware of expectations.	

What we are doing to Improve

A programme of work is underway to implement NHS England's recommended Community Transformation **PROMs** (DIALOG, ReQoL-10 and Goal Based Outcomes) across Adult and Older People's Community Mental Health Services during **Q3 2026/27**. The approach has been informed by a pilot involving five teams across Adult Mental Health and MHSOP services within DTVF and NYY, enabling lessons learned and practical feedback to shape the Trust-wide roll-out. The new measures are intended to strengthen person-centred care, support shared decision-making and provide a broader understanding of outcomes that matter to patients.

Key risk - Impact of Inequalities

Tees, Esk and Wear Valleys NHS Foundation Trust

Deprivation and place

Stark contrast in deprivation across place

Index of Multiple Deprivation ranks (measured by Local Authority area) range from Middlesbrough 21 and Hartlepool 30 to North Yorkshire 189 and York 261 out of 269.

Lower rank indicates greater deprivation.

Experience

3 groups

Younger, autistic and disabled people reported worse-than-average experience nationally in the 2025 community mental health survey.

Access barriers

Rural and digital

Transport, connectivity and workforce availability can reduce access and continuity. Cultural and language barriers may also affect referral and engagement.

Outcomes

Earlier mortality

Severe mental illness (SMI) is associated with multimorbidity and increased premature mortality, varying by socioeconomic group and geography.

Measure

Improve our data capture and stratify referrals, length of wait, People who Did Not Attend, intervention access, outcomes and experience by deprivation, ethnicity, age, sex, disability and locality.

Act

Use the Patient and Carer Race Equality Framework, neighbourhood planning and voluntary-sector partnerships to target identified gaps.

What we are doing to improve

- Dual Diagnosis teams completing specific work regarding patients in Middlesbrough as to the root cause of patients not attending appointments, specifically around drug and alcohol addiction etc.
- Working alongside colleagues in local authorities to support development of new approaches to homelessness and mental health.
- Services widely accessing the trust wide autism team which is utilised to support individuals.
- Ongoing work with BAME communities addressing access and understanding in some of our hard-to-reach communities.

Key Risk – Variation across services

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Variation	What varies?	Likely explanation	Next Steps	So what does this mean for the quality of care provided?
Quality	Length of wait	Capacity and demand	Ongoing improvement work to support effective diary management, caseload management and effective use of PTLs supporting right-sizing.	Improvements will mean unwarranted variation reduced and best practice shared across core community services. This is happening now with learning from the new Durham 'Gateway' model.
Commissioning	Funding & Commissioned Services	Working across two integrated care boards (ICBs) with differing legacy arrangements.	Acknowledge variation and understand impact on trust's ability to deliver services and how commissioned services vary place-to-place.	The services will engage with commissioners to work towards consistent commissioning and that services are responsive to demand.
Health Inequalities	Prevalence and acuity	Deprivation. Detailed through related indices such as: Income, Education, Health, Employment, crime, Housing and Services, Living Environment etc.	Better engagement with Patient and Carer Race Equality Framework (PCREF) Sickness to prevention board oversight. Work with system to enhance neighbourhood offer recognising unique communities we serve. Ongoing Public Health engagement through Catherine Parker.	We will continue to tailor our work on inequalities providing specific interventions with system partners to tackle some of the biggest societal challenges. We will measure the impact of our work and share learning across the system. This is exemplified by our dual diagnosis work.
Structural	Ways of working and service functionality by Care Group	Previous disaggregated leaderships and governance	Integrated model and governance restructure has helped bring services closer together. Approval of trust wide AMH Planned Care Operational policy will consolidate this removing unwarranted variation across teams.	Patients will benefit from the closer working relationships, better understanding of learning and a reduction in unwarranted variation.

My Story

Sharing good practice & Model Development

Tees, Esk and Wear Valleys NHS Foundation Trust

Improved working across CG's reducing unwarranted variation

Through our clinical network and Neighbourhood health programme, AMH teams are working together to identify and reduce unwarranted variation in models of care, share best practice and develop more standardised approaches to delivery across community services.

Community transformation models have been tried and tested with learning shared operationally and clinically; helping shape the next phase of Neighbourhood Health ambitions.

FUTURE DIRECTION

- **Access begins wherever the person presents**
- **Initial contact identifies need and coordinates help**
- **Expertise is distributed through neighbourhood systems**
- **Crisis prevention and response connect to neighbourhood support**
- **Care is physical, virtual, home-based and outreach-enabled**
- **Information follows the person and supports population decisions**
- **Access, continuity, outcomes and avoided escalation define success**

Celebrating

Our Progress So Far

Building neighbourhood mental health together across TEWV

TEWV Tees, Esk and Wear Valleys NHS Foundation Trust

TEES VALLEY

NORTH YORKSHIRE & YORK

DURHAM

COMMUNITY MENTAL HEALTH TRANSFORMATION

Bringing care closer to home through neighbourhood models and integrated primary care partnerships.

PRIMARY CARE

COMMUNITY SUPPORT

VOLUNTARY & COMMUNITY SECTOR

SOCIAL CARE & HOUSING SUPPORT

EARLY HELP & PREVENTION

TEWV NEIGHBOURHOOD MENTAL HEALTH CENTRE

PLANNED CARE & SPECIALIST SERVICES

PEER SUPPORT & LIVED EXPERIENCE

DIGITAL & VIRTUAL SUPPORT

OUR VISION

The right support, at the right time, close to home, for everyone in our communities.

CRISIS RESPONSE 24/7

HOME TREATMENT & RAPID RESPONSE

RECOVERY, WELLBEING & SOCIAL CONNECTION

EMPLOYMENT, EDUCATION & SKILLS

NATIONAL PILOT

24/7 NEIGHBOURHOOD MENTAL HEALTH CENTRE IN YORK

Proud to be one of the national pilot sites at our Acomb Neighbourhood Mental Health Centre.

OUR ACHIEVEMENTS

- New community models
- Improved access and experience
- Stronger partnerships
- Earlier help and prevention
- Better outcomes for people
- Supporting people to live well in their communities

PROUD TO BE SHORTLISTED

HSJ AWARDS 2026 FINALIST
Mental Health Innovation of the Year

HSJ AWARDS 2026 FINALIST
Neighbourhood & Community Care Innovation of the Year

Thank you to our staff, partners and communities

TOGETHER, WE ARE BUILDING A BETTER FUTURE FOR MENTAL HEALTH

People at the heart

Stronger together

Compassionate and inclusive

Excellence in all we do

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

1. Cover Sheet

Report Title	Board Integrated Quality & Performance Report as 31st August 2026
Meeting	Trust Board [Public]
Date of Meeting	28th October 2026
Paper	M
Sponsoring Director / Author	Kathryn Ellis, Interim Executive Director of Strategy & Transformation Naomi Lonergan, Interim Managing Director, Durham, Tees Valley & Forensic Care and North Yorkshire & York Care Groups
Report Author	Kathryn Ellis, Interim Executive Director of Strategy & Transformation Sarah Theobald, Associate Director of Performance Ashleigh Lyons, Head of Performance
Purpose of Paper	**Assurance**
Previously Considered By	Executive Directors Group, 22 September 2026 — Outcome: Approved
Financial Implications	

2. Recommendation

The Board 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.

3. Executive Summary

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 **56%** of measures achieving good or substantial assurance, a reduction from **62%** 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 (good to substantial)	• Compliance with ALL mandatory and statutory training
Decreased performance assurance (substantial to reasonable)	• Inpatients reporting that they feel safe whilst in our care
Decreased performance assurance (good to limited)	• Agency expenditure
Decreased performance assurance (reasonable to limited)	• Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed) (Snapshot) • The number of Restrictive Intervention Incidents • Agency price cap compliance • Bank Expenditure • CRES Performance - Recurrent

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	All three strategic goals: co-create high-quality care; be a great employer; and be a trusted partner.
Board Assurance Framework	The IQPR relates to all BAF risks, but particularly BAF 01 – Safe Staffing; BAF 02 – Access; BAF 03 – Patient Experience; BAF 04 – Quality and Outcomes; BAF 08 – Partnerships and System Working; BAF 09 – Regulatory Compliance; BAF 11 – Financial Sustainability; and BAF 12 – Transformation.

Linkage	Detail
Corporate Risk Register	The report provides performance intelligence relevant to a range of risks recorded on the Corporate Risk Register. Specific risks and mitigating actions are managed and reported through the established risk management and committee assurance arrangements.
Committee / Work Programme Ref	Board and Executive performance oversight through the monthly IQPR. Relevant assurance routes include the Finance and Performance Committee, Quality Assurance Committee, People and Culture Committee, and Planning, Digital and Estates Committee, in accordance with their approved terms of reference and work programmes.
Regulatory / Legal Reference (if applicable)	CQC Fundamental Standards; NHS England National Oversight Framework; national and local mental health access, waiting-time and quality requirements; Mental Health Act 1983; and 2026/27 NHS planning and financial requirements, where relevant to the measures reported.

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

Report Title	Board Integrated Quality & Performance Report as 31st August 2026
Meeting	Trust Board [Public]
Date of Meeting	28th October 2026
Item number	

1. Background

The Board IQPR aims to provide oversight of the quality and performance of Trust delivery, providing assurance to the Executive Directors Group (and subsequently 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.

2. Key Issues and Findings

2.1 What the data / evidence shows

What is working well

- Patient and carer experience and children and young people's clinical outcomes remain strong.
- The overall financial position remains better than plan, although recurrent efficiencies and temporary staffing require continued focus.

Principal exceptions requiring Board attention

- Delayed discharge remains the most significant operational, quality and financial pressure, affecting bed occupancy, length of stay and access.
- Waiting-time pressures continue across several community pathways, particularly neurodevelopmental services, Talking Therapies, older people's services, Early Intervention in Psychosis and children's eating disorder services.
- Sickness absence remains above target and the national benchmark.

- Recurrent CRES delivery, bank and agency expenditure, and the capital allocation position require continued close oversight.

2.2 Assurance

Controls Assurance

Our Integrated Performance Approach (IPA) enables us to have good oversight (i.e. controls assurance) of performance, by monitoring and reporting key measures that demonstrate the delivery of the quality of services we provide. The IQPR is discussed and approved each month at Integrated Care Group Governance and then at Trust level by the Executive Directors Group, and bi-monthly is reported to the Board of Directors to provide assurance that the Trust is continuing to deliver operationally. Further assurance is being sought for any measures where performance is not in line with standard, and where remedial actions and oversight is not yet considered sufficiently robust.

Performance Assurance

ALERT

Quality - *Clinically Ready for Discharge and bed occupancy* - At the end of August, 68 patients were clinically ready for discharge but unable to leave due to delays in external care placements and packages. These patients comprised 18.28% 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.89%, reflecting ongoing system constraints and average lengths of stay remain above planned levels in both adult acute/PICU beds (39.8 days) and older adult acute beds (32.3 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 was shared with Executive Directors Group in September. Both Care Groups and the Executive have undertaken a mid-year review with the local authority and NHS partners to expedite complex discharges, and there has been executive escalation with partners of the top 25 patients clinically ready for discharge. Executive Directors noted this escalation. The current ambition is to reduce the number of patients clinically ready for discharge to 15% by the end of December and 12% by the end of March 2027. The Trust's Hospital to Community Programme Board continues to oversee the transformation of services through a shift from inpatient provision to community-based alternatives, aligned with

neighbourhood development priorities. 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. In addition, demand continues to exceed capacity for our Mental Health Services for Older People and there has been an executive ask to develop a local ambition for our older peoples services, noting there are distinct challenges for memory services. 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 was shared with Executive Directors Group in September. In addition, monies over 3 years to reduce neurodevelopmental assessment backlogs have been negotiated with the North East & North Cumbria Integrated Care Board and a proposal for implementing this has been agreed in principle. An update will be brought to Board in November. Humber & North Yorkshire have opened a consultation on the draft commissioning policy and future service specification, which we have responded to. 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 1486 restrictive interventions recorded in August, with special cause concern linked to a small number of patients with complex needs within DTVFCG ALD inpatient services.

- **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. The ALD team have actively sought external scrutiny and advice to reduce restrictions in a challenging situation. The risks are of concern and the team, the Executive and the external system are working together to find a resolution. In the interim there is close and consistent oversight of the risks to all.

People - *Sickness absence rates* - Sickness absence remains above target at 7.60%, 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 and/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 have agreed to establish a more robust Executive-led approval process to the use of Bank staff.

A Trust-wide Performance Improvement Plan is in place, and further actions are being established; timescale to be confirmed. The Executive Directors Group are closely monitoring this issue as a Medium Term Plan 'condition'.

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 from) stepped reductions in temporary staffing costs, most notably in respect of bank staffing.

Group agency expenditure was £354k above plan at month 5, this incorporates:

- £701k subsidiary agency costs, which were £370k above plan.
- Whilst Trust costs were £16k below plan; this included £337k 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 and increased in August to reflect patient and safety risk management). The Board has been briefed separately on related issues and actions.

Trust bank costs were £1.3m above levels planned (in February 2026) and £578k above recently approved trajectories and stepped cost reductions.

Without operational improvements – particularly in patient flow and workforce availability – there is a risk that cost pressures (such as delays in discharging patients clinically ready for discharge and temporary staffing) will accumulate, presenting risk to financial targets later in the year

- **Action / Mitigation**: The Trust has robust financial governance and efficiency plans in place.
    - A dedicated Temporary Staffing Group has overseen the rigorous control of Trust 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 PIPS (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. Following a period of 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.
- A Bank Reduction Plan is in place, and further actions are being established; timescale to be confirmed.

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 £6,123k, which is £681k lower than the Trust's capital allocation plan to date.

Forecast annual expenditure of £15,016k is £2,121k 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, although the Programme remains broadly on track, with the contractor cashflow reflects increasing costs from Month 6.

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

- **Action / Mitigation**: Capital Programme 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 (28.75 days) continues above plan, primarily due to delays in discharging patients who are clinically ready for discharge. An increasing trend is emerging for the average length of stay within Older Adult Acute Services (77.1 days) and analysis is underway to identify the key drivers, including any outlier cases, and support the development of targeted improvement actions. 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 August.

- **Action / Ongoing Assurance:** Recovery plans remain in place across all areas, and a revised Talking Therapies Outcomes Improvement Plan was supported by Care Group Board in September, noting that work continues to identify targeted actions to drive further improvements within reliable recovery and improvement. It is important to note, however, that whilst a number of improvement actions have been completed, we may not see the positive impact until April 2027. The CEDs Improvement Plan was approved by EDG in September, and the Improvement Plan for Clinically Ready for Discharge should support improvements to reduce the percentage of patients that are delayed within our acute and PICU services whilst clinically ready for discharge.

ADVISE

People & Workforce – *Mandatory Training compliance* - Training compliance remains above standard overall with all directorates achieving standard; 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.

- **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 has been completed to determine the extent, implications and required actions associated with three data quality issues affecting contact activity reporting. The findings have informed a programme of remediation actions, which are now being implemented. Updates on implementation and any impact on reported performance 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 continuous 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:** Continued improvement provides the Board of Directors with assurance that CYP services are delivering positive and measurable clinical outcomes for children and young people. Whilst work is continuing to strengthen the outcomes framework through the inclusion of patients transitioning between CYP and Adult Mental Health Services, further review of RIO implementation has identified a risk that development work to include patients transitioning between CYP and AMH would need to be repeated post-migration. To avoid duplication and ensure alignment with the final RIO design and business rules, **Executive Directors are asked to support pausing this work pending completion of the RIO configuration**.

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 August, 93.2% of patients rated their service experience as "very good" or "good", a result above our 92% standard and above the 88.9% national average, placing us among the top performers nationally (15th 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 81.5% of carers felt actively involved in care decisions, surpassing the 75% target. In addition, clinical outcomes remain particularly strong for CYP services with both the patient-reported outcomes (68.1%) and clinician-reported outcomes (63.7%) 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; 1 PSII was reported on Steis and there were no medication-related moderate or severe harm incidents or unexpected inpatient deaths in August.

- **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. 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%. The increase in the number of leavers over July and August 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 evidence at this stage to suggest that the rise will continue. There is sustained compliance in appraisals (89.1%) and mandatory training (93.2%) indicating improving workforce stability and capability, noting we have 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 – *August performance* – The Trust's financial position to August 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 (and would otherwise be below targeted Trust

costs to date). 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.

A small number of Independent Sector placements present immediate financial risk; two patients are accommodated in non Trust PICU provision (£8k per day combined) with year to date costs for those two patients exceeding £676k, pending the identification of available NHS inpatient accommodation; one patient requiring admission to our Adult Learning Disability unit and another to a medium secure pathway. The Trust is working closely with partners to achieve the right patient outcomes and mitigate attendant financial risks.

- **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 financial performance and on planning activities to develop bank staff cost reduction trajectories from Quarter two (reasonable assurance on delivery). Bank staff costs in August are maintaining at a high level, and new pressures are outweighing the impacts from actions, with limited assurance on delivery of bank expenditure reductions. PIPS Subsidiary agency costs are above plan and driving adverse agency plan performance at Group level. Consequently both bank and agency NOF metrics are adversely impacted, with costs exceeding planned level indicators.

Finance & Resources – August Cash Balances - Cash balances of £53,511k were £7,411k higher than planned in August 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 if we are able to access operational capital allocation sufficient to self-finance our capital requirements, notably at Roseberry Park Hospital. If Regional Strategic Capital is allocated (e.g. Estates Safety Fund), the adverse 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.

2.3 Risks

- 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 relate particularly to Safe Staffing, Demand, Quality of Care, Quality Governance, Regulatory Compliance, 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. The Trust's Board Committees and risk governance forum ensure appropriate risk oversight.

3. Options Considered

Not applicable

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	The report identifies quality and patient safety risks relating to restrictive interventions, delayed discharges, inpatient safety, waiting times and patient safety incidents. It provides assurance regarding patient experience, clinical outcomes, patient safety investigations and mortality measures, together with actions to address areas of concern. All of the above are overseen at Quality Assurance Committee.
Safeguarding	No specific safeguarding concerns requiring Board action are identified within this report.
Equality, Diversity & Inclusion	The report highlights inequalities relating to ethnicity, deprivation and access to services, together with the impact of variable ethnicity data quality. Ongoing work through the Patient & Carer Race Equality Framework, Sickness to Prevention Programme and wider inequalities initiatives is supporting improved understanding and reduction of health inequalities. This is overseen at Quality Assurance Committee.
Workforce	The report identifies workforce challenges including sickness absence, vacancies and reliance on flexible staffing arrangements. Continued delivery of workforce improvement plans, attendance management initiatives, recruitment activity and leadership development programmes is required to support operational resilience and performance recovery. This is overseen at People and Culture Committee.
Financial / Resource	Delayed discharges, independent sector placements, bank and agency expenditure and delivery of the £27.7m efficiency programme continue to present significant resource implications. The report provides assurance regarding the Trust's financial position and identifies actions to mitigate financial pressures and support long-term sustainability. This is overseen at Finance and Performance Committee.
Legal	No direct impact

Impact Area	Assessment
Protected characteristics	The report identifies differential experiences and outcomes for some protected groups, particularly in relation to ethnicity and Mental Health Act use. Improvement work is underway to strengthen data quality, improve understanding of inequalities and support equitable access, experience and outcomes. This is overseen via Mental Health Act Legislation, and Quality Assurance Committees.

5. Appendices

Appendix	Title
A	Integrated Quality and Performance Report August 2026

6. Document Control

Version	Date	Author	Summary of Changes
0.1 DRAFT	07 October 2026	Ashleigh Lyons	Initial draft for Sponsoring Director review
1.0 Final	21 October 2026	Sarah Theobald	Final document following review

Tees, Esk and Wear Valleys
NHS Foundation Trust

Integrated Quality and Performance Report

For the period ending August 2026

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1. Executive Summary

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

Summary Headlines

Overall assurance
remains positive, with strong controls assurance across patient experience, clinical outcomes for children and young people, workforce compliance measures and financial performance. Performance assurance remains mixed, with ongoing challenges relating to clinically ready for discharge patients, sickness absence, restrictive interventions, waiting times and selected workforce metrics. Several measures have demonstrated improvement during the month, including mandatory training compliance, patient safety investigations and inpatient unnatural deaths.

Patient flow: remains a significant operational challenge. Delayed discharges increased during August, with 68 patients clinically ready for discharge occupying 18.3% of acute mental health bed capacity and contributing to an estimated annual cost pressure of £21.5m. This continues to affect bed occupancy and length of stay performance, reinforcing the need for strengthened system-wide discharge arrangements and improved access to community-based support and placements.

Clinical outcomes: remain a key area of strength, with Children and Young People's patient-reported and clinician-reported outcomes continuing to perform well above target. Adult and older people's outcomes present a more mixed picture, with patient-reported measures remaining below target despite improving clinician-reported outcomes. Ongoing analysis and service-level improvement work are focused on understanding variation and strengthening outcomes across adult services.

Workforce: continues to present a mixed picture. Sickness absence rose to 7.6%, remaining above both Trust and national benchmarks and continuing to affect operational resilience in several services. Encouragingly, mandatory and statutory training compliance improved to 93.2%, appraisal compliance remains above target at 89.1%, and staff turnover is stable at 10.5%, below the Trust threshold. Delivery of planned attendance management and wellbeing initiatives will be critical to achieving sustained improvement.

Access & demand: remains challenging, with demand continuing to exceed capacity across several key services, including neurodevelopmental pathways, Talking Therapies, Older People's Services and Early Intervention in Psychosis within York and Selby. Recovery plans are in place and improvement work is underway; however, workforce pressures and rising demand continue to affect waiting time performance. Delivery of agreed recovery actions and capacity improvements will be critical to achieving sustainable improvement.

Patient quality & safety: remains strong overall, with positive patient and carer experience, low levels of serious patient safety incidents, and no unexpected inpatient unnatural deaths during August. Whilst one Patient Safety Incident Investigation was reported, increases in moderate and severe harm incidents and restrictive interventions, particularly within Adult Learning Disability Services, remain areas of focus and continue to receive enhanced oversight.

Inequalities and data quality: continue to present challenges, with limitations in ethnicity recording impacting the quality of inequalities analysis and insight. Improvement work is progressing through the Patient and Carer Race Equality Framework, Sickness to Prevention Programme and wider population health initiatives, with a focus on strengthening data quality, improving intelligence and supporting targeted action to reduce health inequalities.

Financial position: remains strong overall, with a year-to-date surplus position ahead of plan and efficiency delivery exceeding expectations. Continued focus is required to deliver the full £27.7m efficiency programme, reduce expenditure on flexible staffing, and mitigate ongoing cost pressures associated with independent sector placements and delayed discharges to ensure financial sustainability.

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%	93.15%	93.54%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC	H		75.00%	81.48%	83.16%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	70.06%	74.18%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	H	P	35.00%	68.09%	67.81%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC	L	F	55.00%	43.29%	44.83%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	P	50.00%	63.66%	62.03%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC	H	F	30.00%	26.74%	27.75%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC	L	F	85.00%	89.42%	88.90%	

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	H			18.28%	18.28%	
10)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC	L		0	0	0	
11)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				1	8	
12)	The number of Incidents of moderate or severe harm	QAC				36	122	
13)	The number of Restrictive Interventions Used	QAC	H			1,486	5,877	
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	2	
15)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	1	
16)	The number of uses of the Mental Health Act	MHLC				336	1,695	

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 has been 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% (Jul-2026)	✓
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	60.24%	60.03% (Jul-2026)	✓
19)	Staff Leaver Rate	PCDC		P	11.00%	10.51%	10.51%	✓
20)	Percentage Sickness Absence Rate (month behind)	PCDC	H	F	5.50%	7.60%	6.86%	✓✓
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC	H	P	85.00%	93.15%	93.15%	✓✓
22)	Percentage of staff in post with a current appraisal	PCDC		P	85.00%	89.14%	89.14%	✓✓

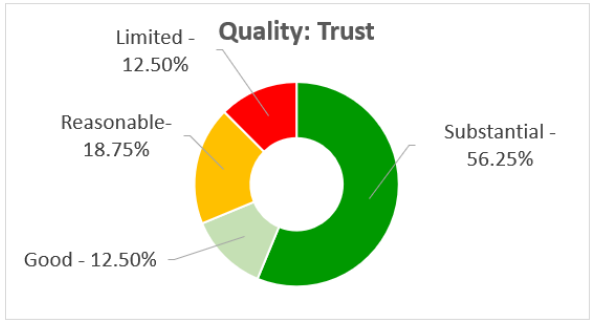
Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
23)	Number of new unique patients referred	RPC				7,371	40,064	✓
24)	Unique Active Caseload (Snapshot)	RPC	L			50,493	50,493	

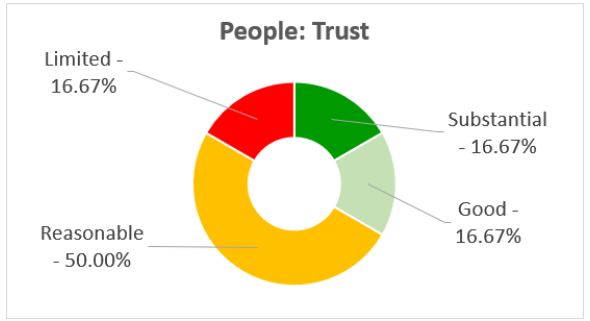
Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)	DQA Metric Rating
25)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	1,828,990	-346,841	✓✓
26)	Agency Expenditure	RPC	2,152,000	2,506,060	✓
27)	Agency price cap compliance	RPC	67.00%	32.29%	✓
28)	Bank Expenditure	RPC	5,641,000	6,898,013	
29)	CRES Performance - Recurrent	RPC	6,931,998	6,184,737	✓
30)	CRES Performance - Non-Recurrent	RPC	3,194,999	4,917,173	✓
31)	Capital Expenditure (CDEL)	RPC	6,804,000	6,122,316	✓✓
32)	Cash against plan	RPC	46,367,000	53,510,723	✓✓

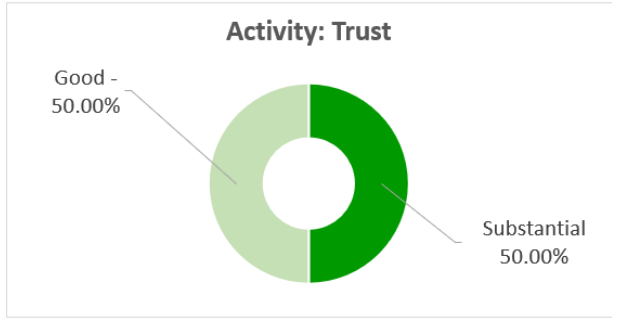
Please Note: *24 Unique Active Caseload and 28 Bank Expenditure do not have a Data Quality Assessment rating as they new measures. These will be completed as part of the updated Data Quality Assessment ,which is underway and will be presented to Resources & Planning Committee for approval in September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

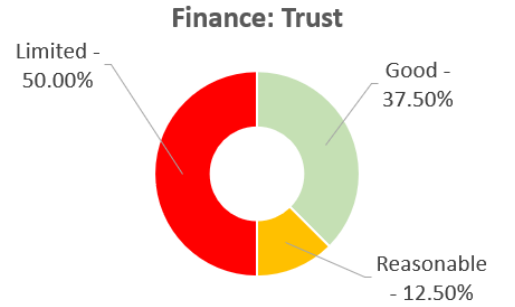
Executive Summary - Board Integrated Performance Dashboard – Performance Assurance Ratings

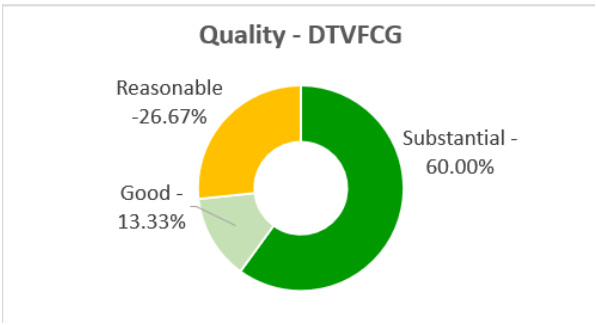
The visuals below depict performance assurance ratings for all measures part of the Integrated Performance Dashboard (IPD) – shown on the previous slides (5-6). Each measure is assigned a Performance Assurance rating based on SPC variation, performance against standard, trend, and wider intelligence. 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.

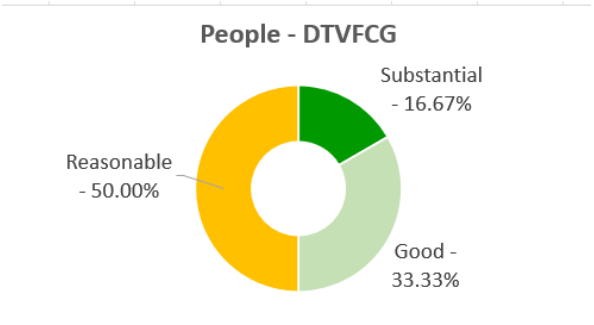


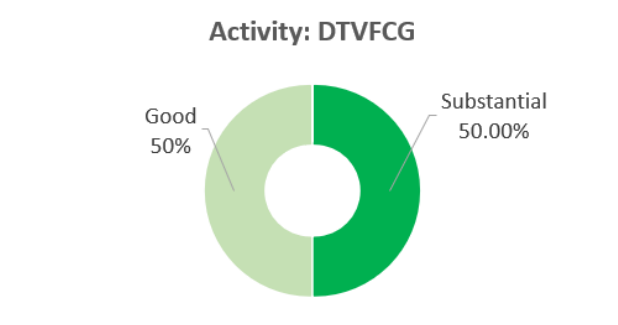


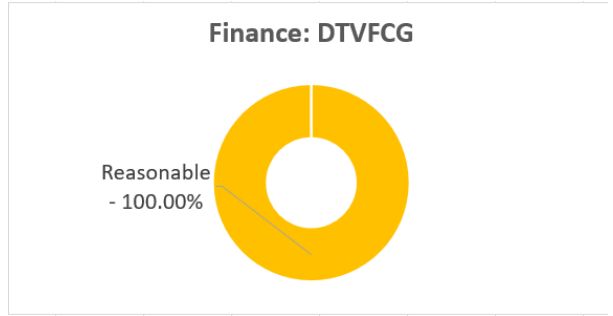


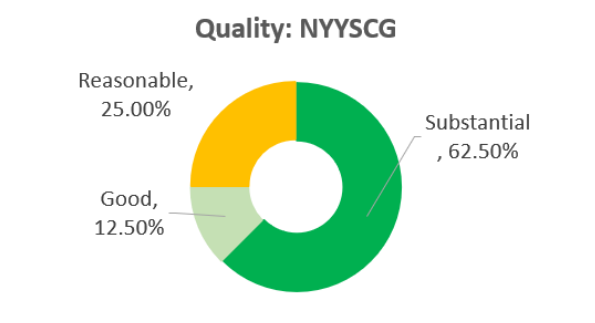


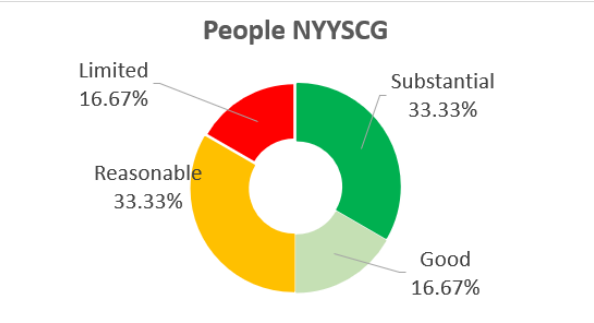


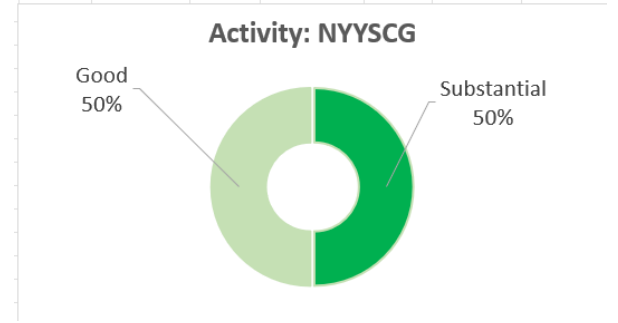


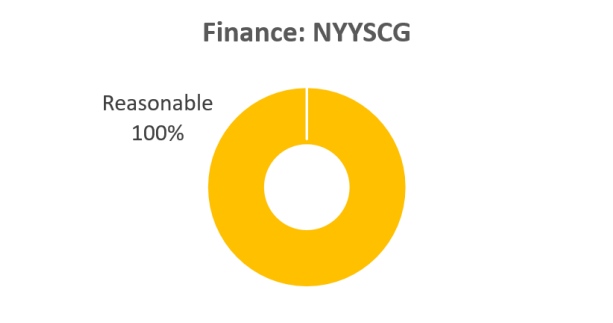












Glossary

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

Key

Substantial
Reasonable
Good
Limited

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

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

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

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

Background / Standard description:
We are aiming for 92% of patients surveyed, reporting their recent experience as very good or good

What does the chart show/context:
During August, **992** 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, **924 (93.15%)** scored "very good" or "good".

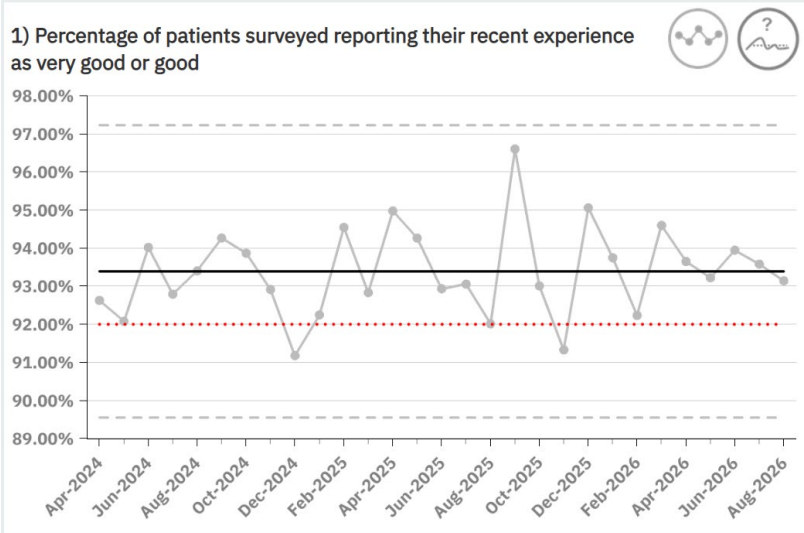
There is no significant change at Trust and Care Group level; there is special cause improvement for Children & Young Peoples Services in Durham, Tees Valley & Forensic Care Group.

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

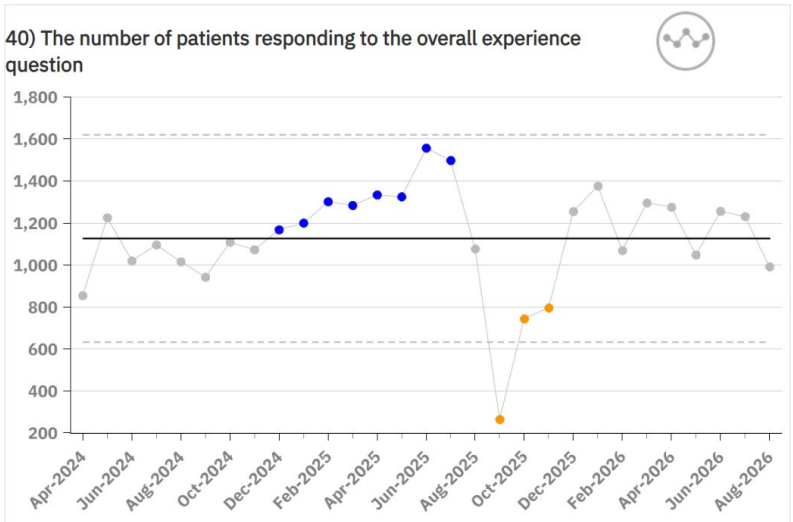
National Benchmarking data
The latest National Benchmarking data (June 2026) shows the England average (including Independent Sector Providers) was **88.94%** and we were ranked **15** out of 66 trusts (1 being the best with the highest ratings). We were also ranked 2nd for total number of responses received.

Underlying issues:
- The number of patients responding to the question varies significantly across services and specialities.
- It has been identified that paper-based survey responses have not been provided from the source system to feed this measures This has impacted the data reported for July and August 2026.

Actions:
- By 31 December 2026, the Care Group Director for Lived Experience will complete a Trust-wide review of low and variable patient feedback response rates, implement agreed interventions with identified services, and report recommendations and improvement trajectories to the appropriate governance forum.
- Business Intelligence have worked with the system supplier to refresh the data, and updated data will be reflected in next month's report (data ending September 2026). Our system supplier is investigating the cause and will take appropriate steps to implement a permanent solution to prevent recurrence.



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.

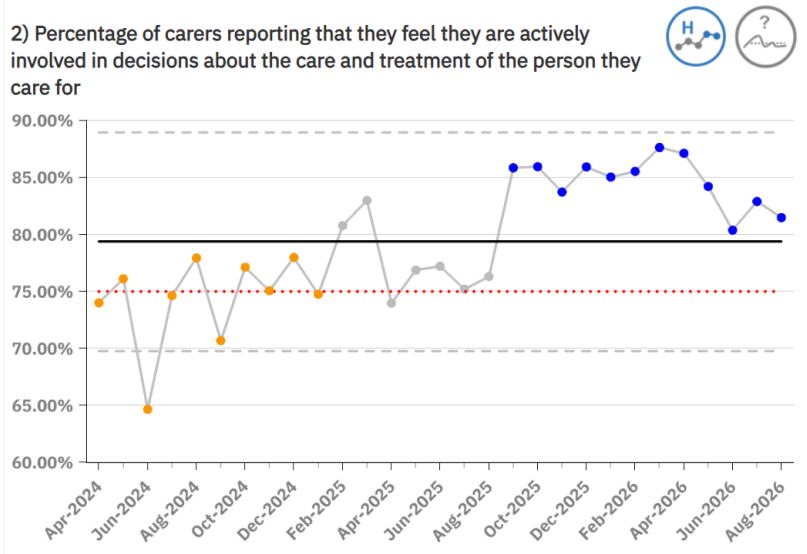
What does the chart show/context:
During August, **270** carers responded to the question in the carer survey: Question: "Are you offered choices about the care being provided?". Of those, **220 (81.48%)** scored "yes".

There is special cause improvement at Trust level, Durham Tees Valley & Forensic Care Group, for Adult Mental Health within that Care Group and for Adult Learning Disabilities within North Yorkshire, York & Selby Care Group. There is no significant change within North Yorkshire, York & Selby Care Group.

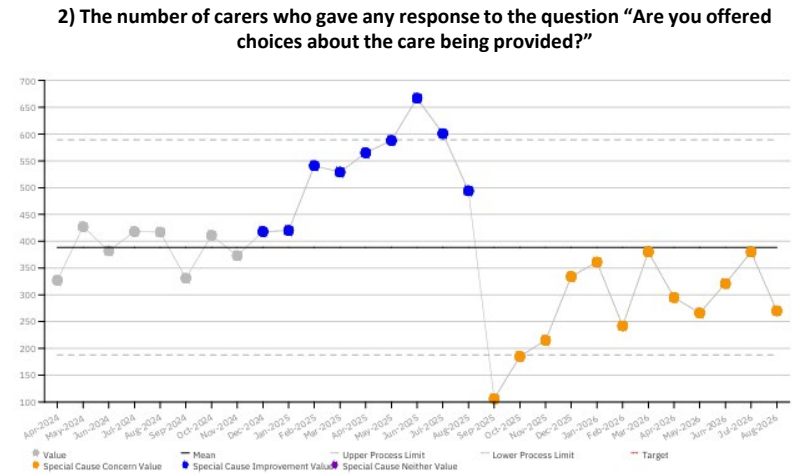
There is special cause concern in the number of patients who have responded to this question at Trust level, for North Yorkshire, York & Selby Care Group and MHSOP within the care group, and for Children & Young People in Durham, Tees Valley & Forensic Care Group. There is no significant change for Durham,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

Underlying issues:
- The number of carer responses remain a concern within CYP in DTVF.
- It has been identified that paper-based survey responses have not been provided from the source system to feed this measures This has impacted the data reported for July and August 2026.

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).
- Business Intelligence have worked with the system supplier to refresh the data, and updated data will be reflected in next month's report (data ending September 2026). Our system supplier is investigating the cause and will take appropriate steps to implement a permanent solution to prevent recurrence.



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



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

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

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

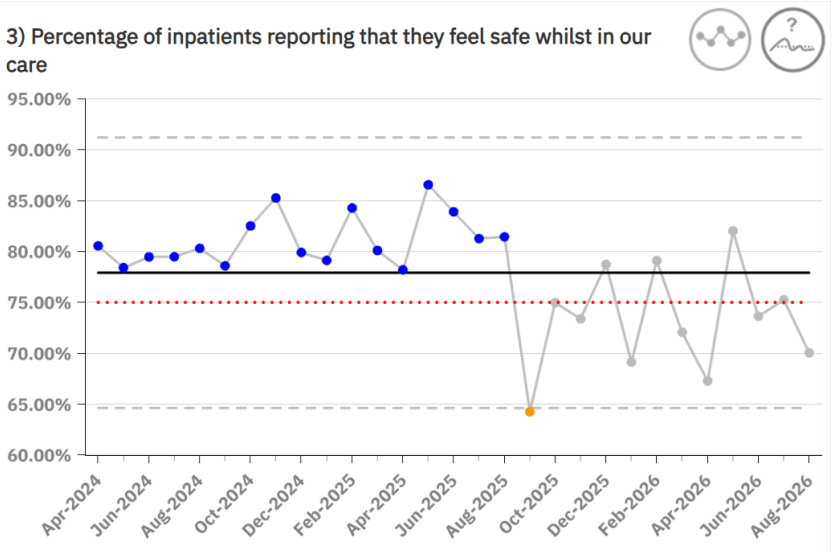
What does the chart show/context:
During August, **157** patients responded to the overall experience question in the patient survey: "During your stay, did you feel safe?". Of those, **110 (70.06%)** scored "yes ".

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

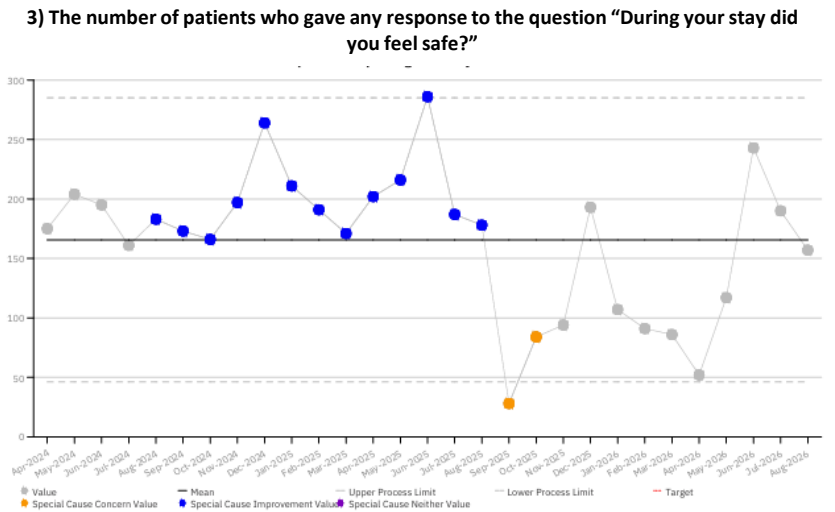
There is no significant change at Trust and Care Group level in the number of patients who have responded to this question.

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.
- It has been identified that paper-based survey responses have not been provided from the source system to feed this measures This has impacted the data reported for July and August 2026.

Actions:
- Patient & Carer Experience Team to present the easy-read paper-based surveys for rollout to inpatient services to the Service User Reference Group for those with Learning Disabilities in September for final approval. Subject to approval, implementation is scheduled for completion by 30 September.
- 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.
- Business Intelligence have worked with the system supplier to refresh the data, and updated data will be reflected in next month's report (data ending September 2026). Our system supplier is investigating the cause and will take appropriate steps to implement a permanent solution to prevent recurrence.



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



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

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

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

What does the chart show/context:
For the 3-month rolling period ending August **940** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **640 (68.09%)** made a measurable improvement.

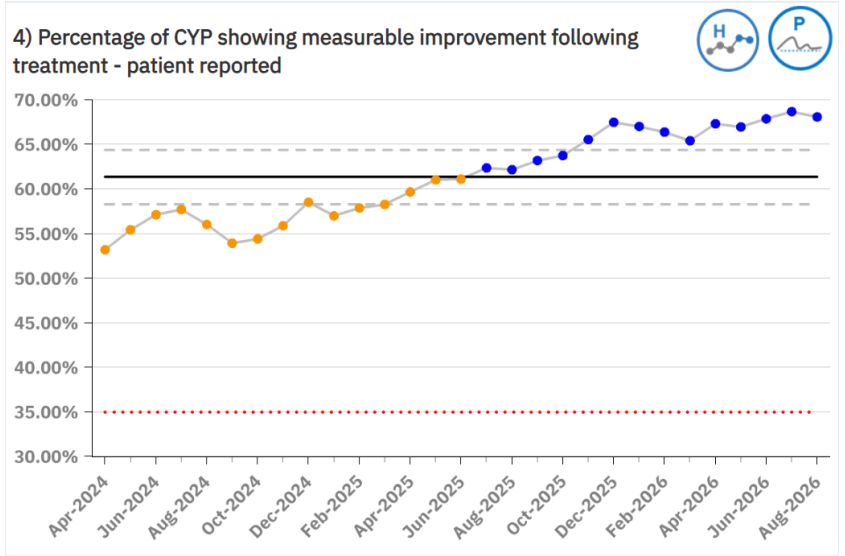
There is special cause improvement at Trust and Care Group level. Performance is above standard at all levels.

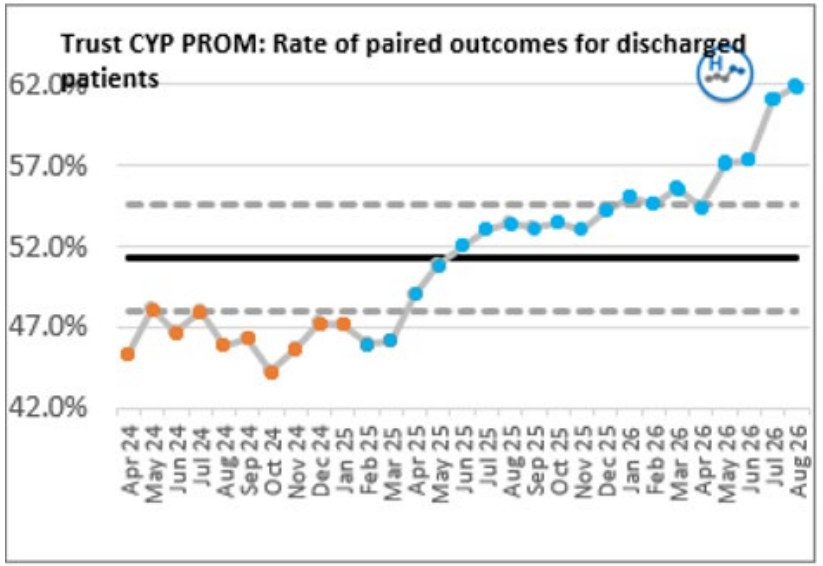
There is special cause improvement in the rate of paired outcomes for patients discharged at Trust and Care Group Level.

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

Underlying issues:
- This measure currently does not report the full suite of patient-related outcomes as a number of measures do not have a reliable change index, which includes PHQ-9, GAD-7 and CORE-10.
- Patients who transition from CYP to AMH are not counted in these measures until they are discharged from TEWV

Actions:
- Head of Business Intelligence & Clinical Outcomes to oversee the development of a local Reliable Change Index for EDEQ, EDEA and Gaslight measures by the end of March 2027.
- 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. Further review of RIO implementation has identified a risk that development work to include patients transitioning between CYP and AMH would need to be repeated post-migration. To avoid duplication and ensure alignment with the final RIO design and business rules, **Executive Directors are asked to support pausing this work pending completion of the RIO configuration.**





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 August **1506** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 652 (43.29%)** made a measurable improvement.

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

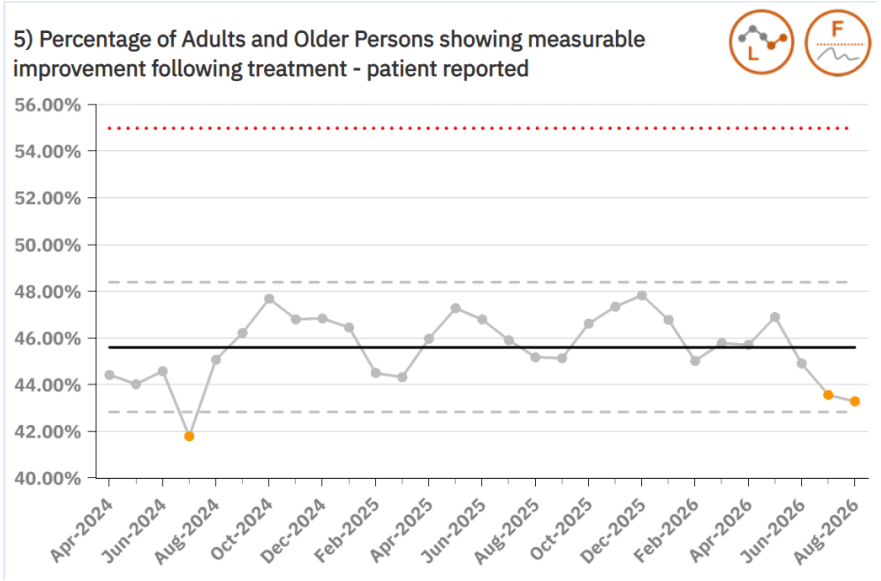
There is special cause concern in the rate of paired outcomes for patients discharged at Trust and Care Group level, and AMH in both Care Groups and MHSP in DTVFCG.

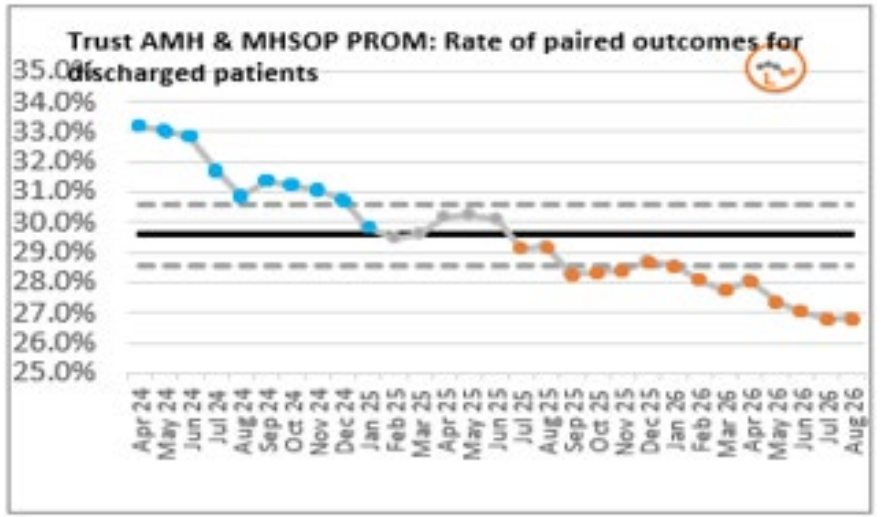
The accepted Patient Rated Outcome Measure is Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS).

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:
- The pilot for the new PROM for organic MHSOP services commenced on the 1st August and will 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:
In August, Executive Directors Group approved progressing the split of this measure into two new metrics, one for adults and one for older persons; this work will be completed for the October report (data ending September).





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 August **732** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **466 (63.66%)** made a measurable improvement.

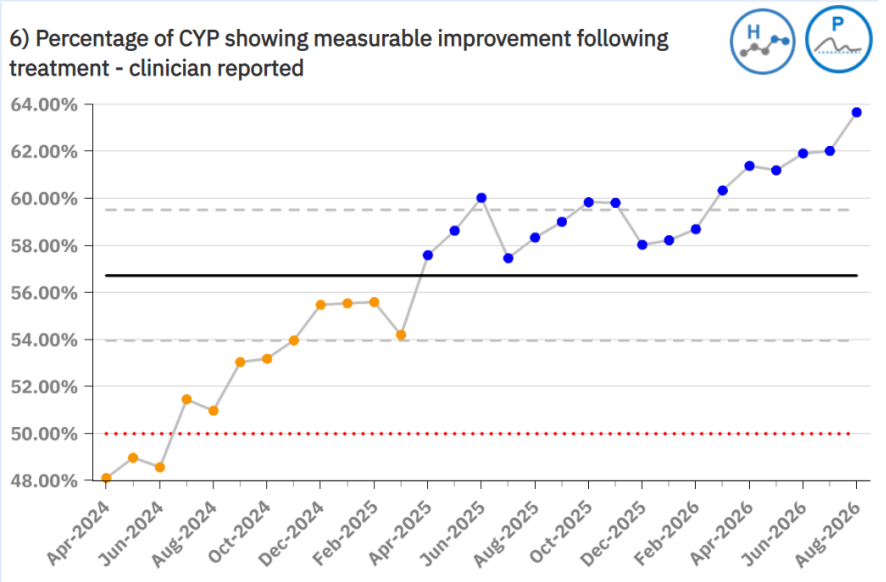
There is special cause improvement at Trust level and at Care Group Level. Performance is above standard at all levels.

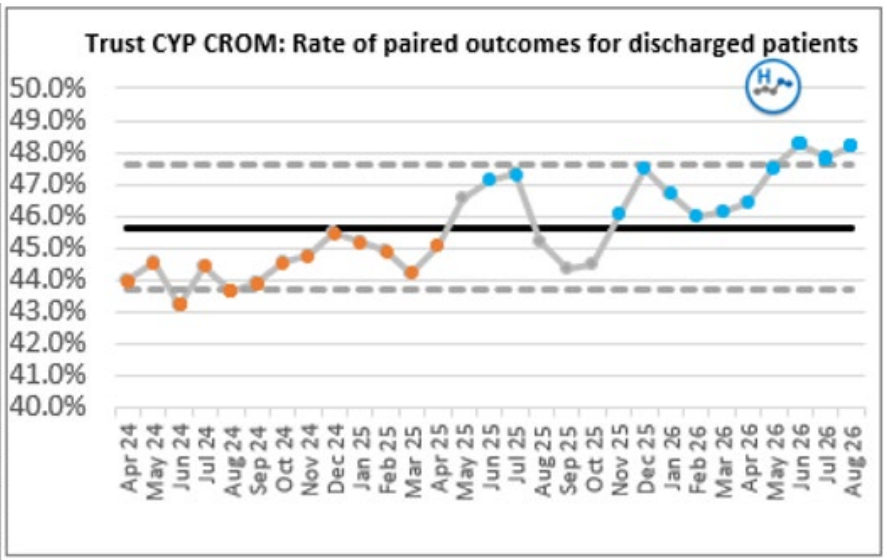
There is special cause improvement in the rate of paired outcomes for patients discharged at Trust level and for DTVFCG. There is no significant change within NYYSCG.

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

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

Actions:
Business Intelligence to effect the changes required to include those patients that transition between CYP and AMH within the measure by the end of September 2026. Further review of RIO implementation has identified a risk that development work to include patients transitioning between CYP and AMH would need to be repeated post-migration. To avoid duplication and ensure alignment with the final RIO design and business rules, **Executive Directors are asked to support pausing this work pending completion of the RIO configuration.**





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 August **2,618** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 700 (26. 74%)** made a measurable improvement.

There is special cause improvement at Trust, Care Group and specialty level. Performance is above standard for Adult Mental Health in both Care Groups.

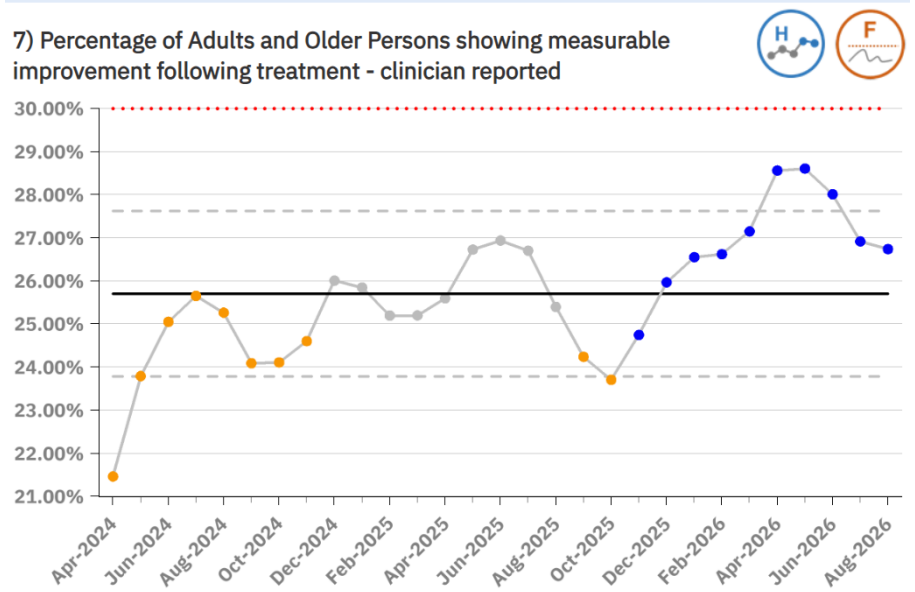
There is special cause concern in the rate of paired outcomes for patients discharged at Trust and Care Group level and for Adult Mental Health Services within DTVFCG, there is special cause improvement MHSOP within both care groups.

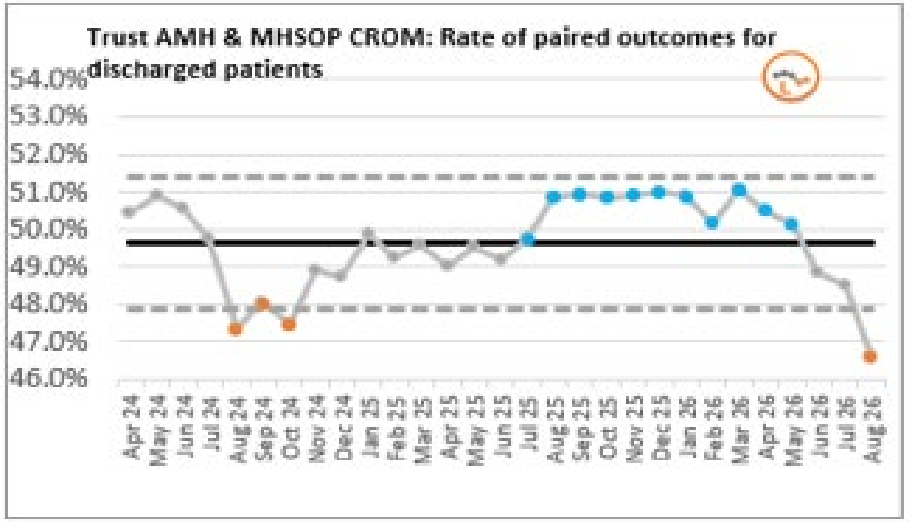
The accepted Clinician Rated Outcome Measure is Health of the Nation Outcome Scales (HoNOS).

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.
- There is a decreasing rate of paired outcomes for discharged patients within AMH, the root causes of which have not yet been fully established. A review is required to understand the teams impacted, underlying factors and determine whether any mitigating actions are required.

Actions:
- By 30 September 2026, the Directors of Therapies and relevant General Managers will review the findings of the performance analysis, identify the underlying causes of the reported position, and agree targeted improvement actions and timescales through the appropriate governance arrangements.
- The Directors of Therapies will continue to deliver the programme of Trust-wide webinars, monitoring attendance and engagement, to support consistent communication of clinical outcomes priorities and improvement requirements across all services.

To Note:
In August, Executive Directors Group approved progressing the split of this measure into two new metrics, one for adults and one for older persons; this work will be completed for the October report (data ending September).





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.

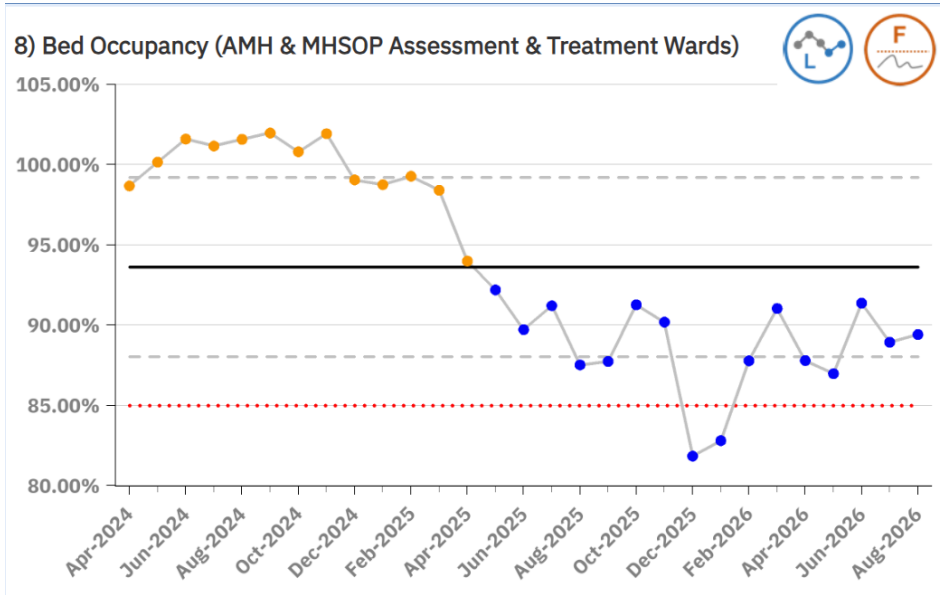
What does the chart show/context:
During August, **11,532** daily beds were available for patients; of those, **10,312 (89.42%)** were occupied.

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 full business case to EDG by March 2027.



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

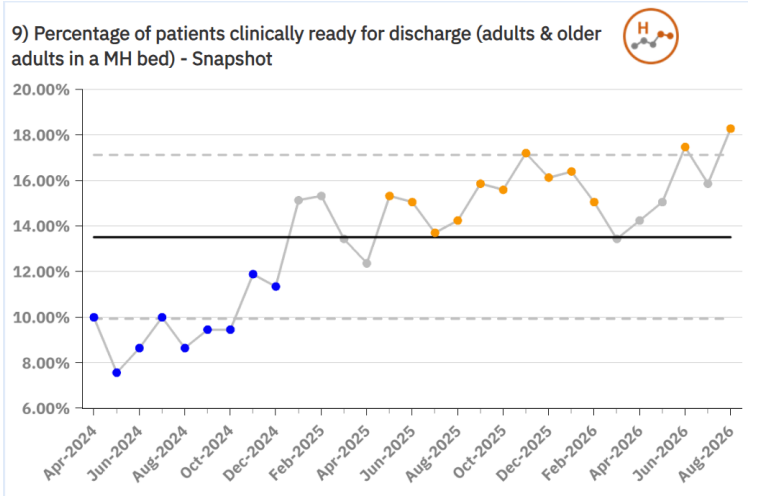
What does the chart show/context:
As at the 31st August 2026, there were **68** adults clinically ready for discharge occupying adult MH, older adult MH or PICU beds, accounting for **18.28%** of our **372** acute beds open to admission.

There is special cause concern at Trust level and Care Group Level.

At Trust level, patients classified as Clinically Ready for Discharge during the whole month of August equated to an average of 72.0 beds across all AMH and MHSOP beds including rehab (36.4 Adult, 3.4 PICU and 32.3 Older Adult beds), with an associated in-month cost of c£1.74m. Of the cost, c£0.80m relates to Adult, £0.18m to PICU and c£0.76m 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 £21.55m.

Underlying issues:
- Availability of specialist packages of care and specialist placements.

Actions:
- General Manger 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 now be presented to the Combined Care Group Governance in October.
  - The job description for the Clinically Ready for Discharge pilot roles in DTVFCG has been evaluated and the post will be advertised by end of September.
  - The job description for the AMH Discharge Liaison role in NYYSCG has been evaluated and the post will be advertised by end of September.
  - 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 September 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; completion will now be by the end of September 2026.



Actions (contd.):
- 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

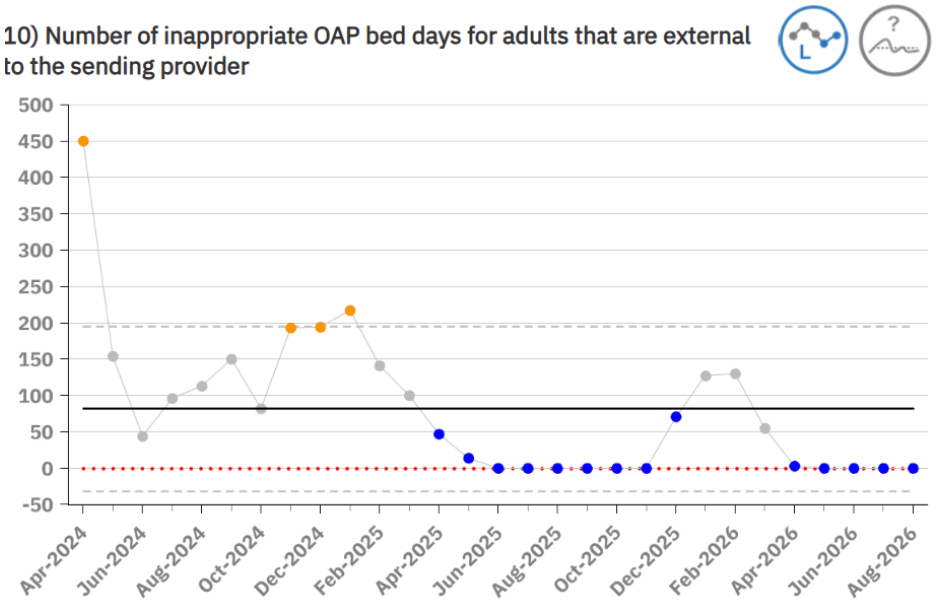
Background / standard description:
We are aiming to have no out of area bed days.

What does the chart show/context:
For the 3-month rolling period ending August 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.



Bed Pressures – Additional Information

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

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

Adult Mental Health Services - August 2026

	Bed Occupancy	CRfD	OAPs	ALOS
Trust	84.95%	14.67%	0	28.75
DTVF	84.13%	13.50%	0	31.06
NYYS	87.10%	17.74%	0	23.90

Mental Health Services for Older People - August 2026

	Bed Occupancy	CRfD	OAPs	ALOS
Trust	96.27%	23.81%	0	77.10
DTVF	97.13%	15.38%	0	74.29
NYYS	94.87%	37.50%	0	82.05

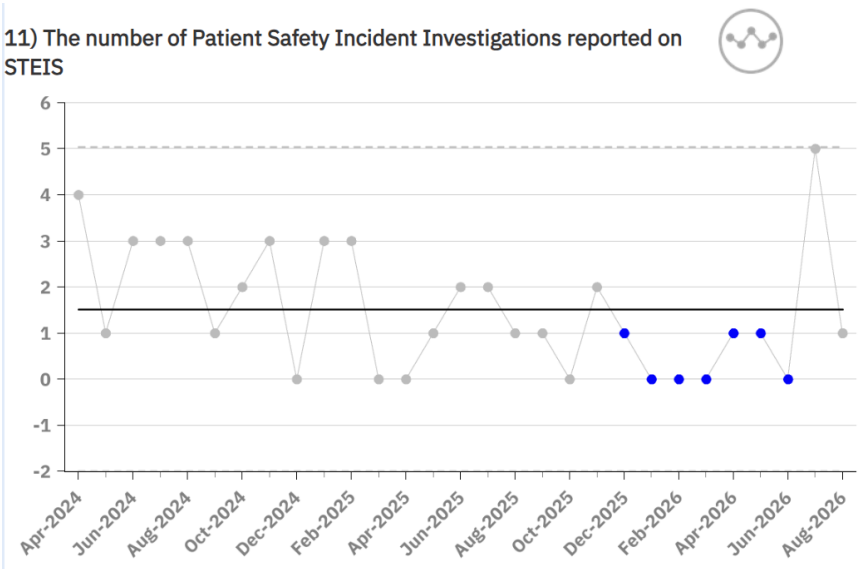
11) The number of Patient Safety Incident Investigations reported on STEIS

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

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

Underlying issues:
This PSII was identified, recorded on STEIS and allocated for investigation within 1 working day. This is a community death which is also considered for an After-Action review (AAR) which is underway and a detailed Patient Safety Incident Investigation (PSII) which is undertaken by an independent patient safety investigator. An immediate review (referred to as a hot debrief) has occurred to identify any immediate learning and actions required. Learning identified during the investigation processes is actioned without necessarily awaiting the conclusion of the investigations.

Actions:
- A structured regroup following the expansion of testing of the new AAR process is planned for September 2026 to ensure learning is captured consistently and refinements are coordinated during the testing phase. Rollout of the new process will be managed through the Quality Assurance Committee. **Confirming this action**



12) The number of Incidents of moderate or severe harm

What does the chart show/context:

36 incidents of moderate or severe harm were reported during August. Of the 36 incidents reviewed 11 were subsequently determined not to meet the criteria for moderate or severe harm.

There is no significant change at Trust and North Yorkshire, York & Selby Care Group, whilst there is special cause concern indicated for Durham, Tees Valley and Forensic Care Group Level; the Director of Nursing (Care Delivery) has confirmed this is not an actual concern.

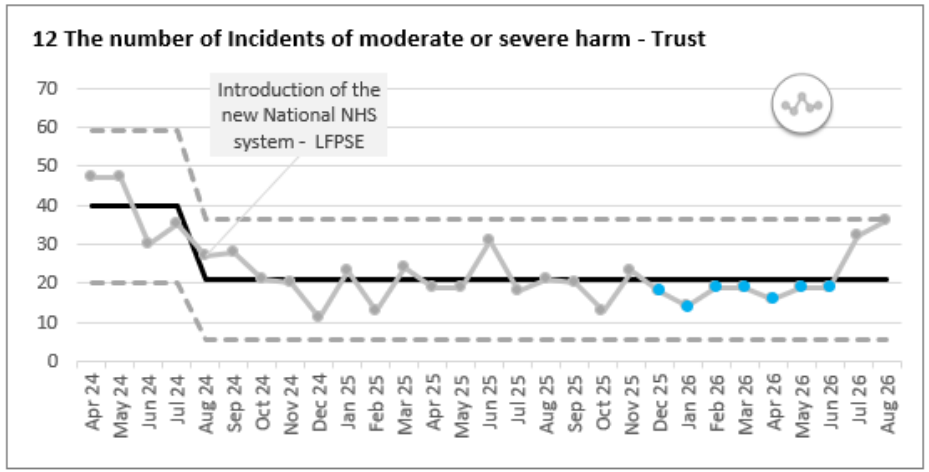
All moderate and severe harm incidents are reviewed through the Patient Safety Huddle within one working day to validate the reported severity. Each incident that remains at moderate/severe is then considered for a multi-disciplinary after-action review (AAR) by services to identify learning. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

Underlying issues:

We use a nationally recommended systems-based learning approach and our internal quality improvement has identified for a comprehensive review, it requires up to 36 working days. Our procedure currently has a timeframe of 15 days and a number of AARs are currently overdue against this timescale.

Actions:

By 30 September 2026, Patient Safety and Care Group leads to ensure all overdue AARs will be completed and closed, or have an agreed extension supported by a documented rationale.



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.

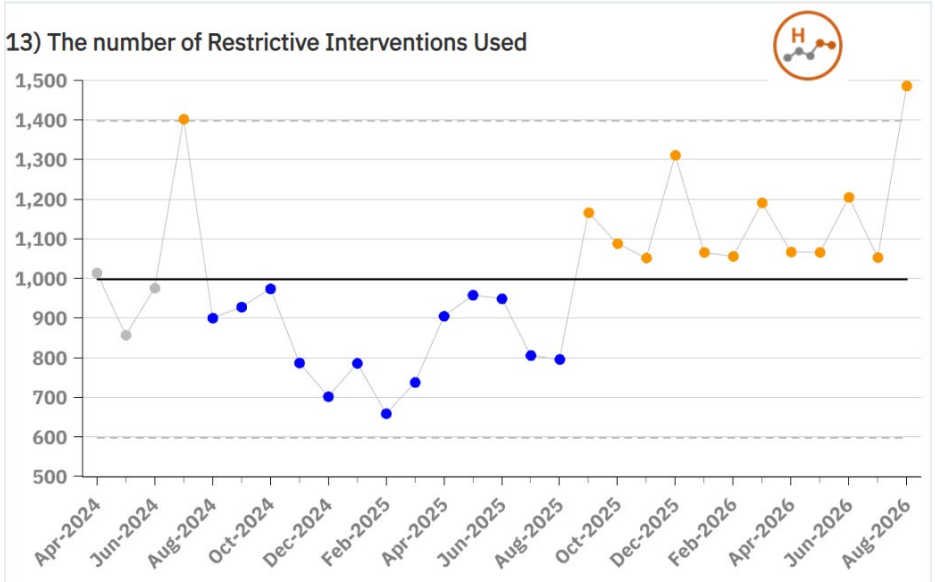
13) The number of Restrictive Intervention Used

What does the chart show/context:
1486 types of Restrictive Interventions were used during August. These interventions occurred within a total of 816 incidents, as multiple interventions can occur within 1 incident.

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 and Adult Learning Disabilities 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 continue to provide intensive support to one patient within ALD in terms of implementing the Positive Behavioural Support plan.
- 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, weekly oversight from Executives and weekly transitions meetings to support the move of the patient.



Note: where data points are high, detailed case by case reviews are undertaken through speciality governance.

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

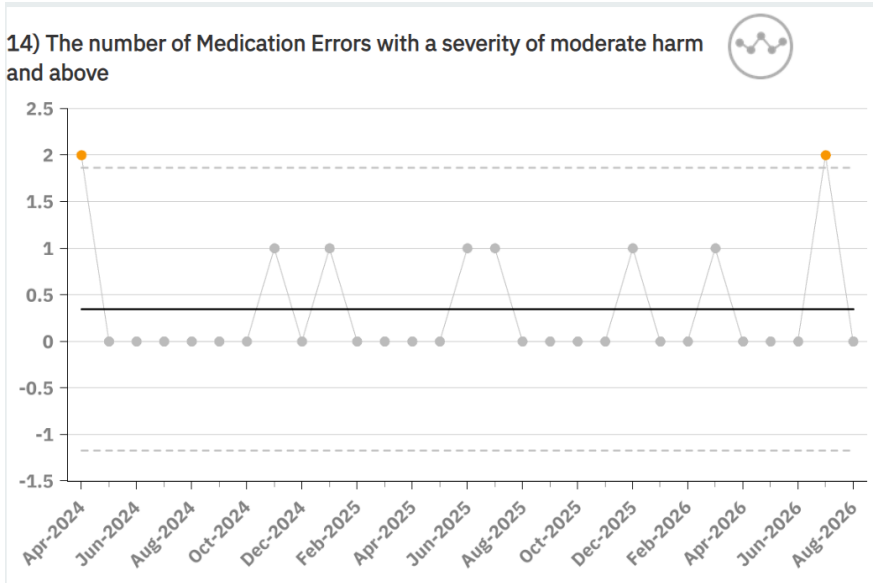
What does the chart show/context:
0 medication error was recorded during August.

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

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



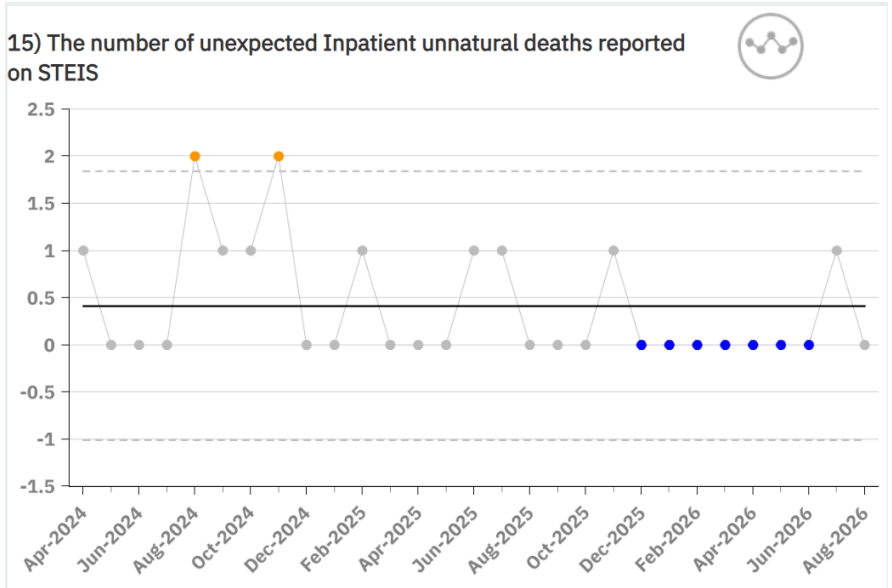
15) The number of unexpected Inpatient unnatural deaths reported on STEIS

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

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



16) The number of uses of the Mental Health Act

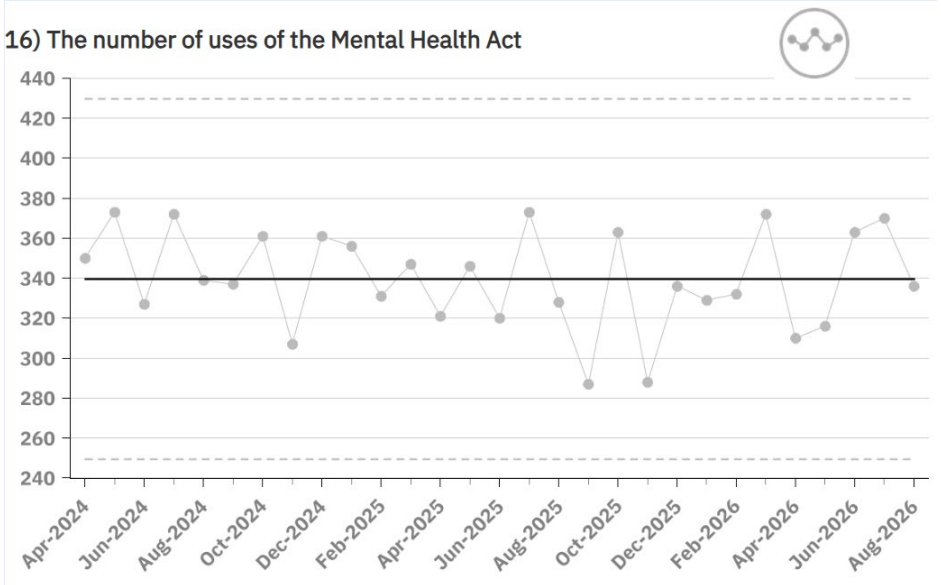
What does the chart show/context:
There were **370** uses of the Mental Health Act during August.

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.

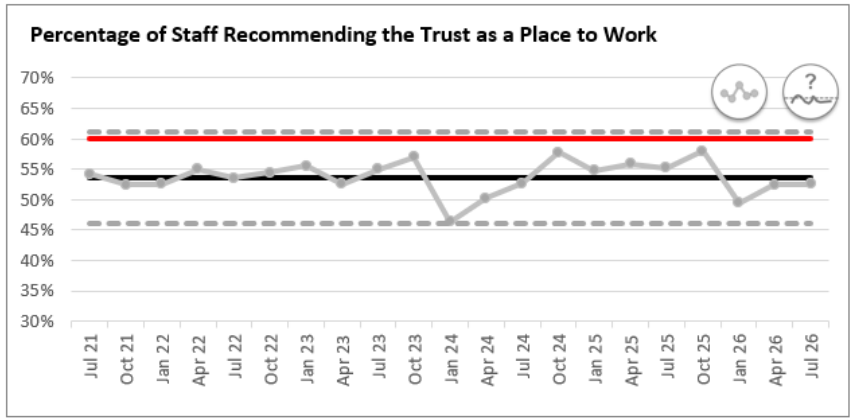
Actions:
- Interviews for the EDI officer vacancy to support Patient & Carer Race Equality Framework delivery were held in August, and whilst a conditional offer was made, the candidate has now withdrawn. An interim plan will be considered by the Sickness to Prevention Board in September.
- The Sickness 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.
- The Sickness to Prevention Programme Board will meet monthly and review progress against the Trust Inequalities and Prevention Plan, ensuring delivery of agreed milestones across data improvement, Patient and Carer Race Equality Framework (PCREF) implementation, reducing non-attendance and disengagement.



3. People

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

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



** 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*

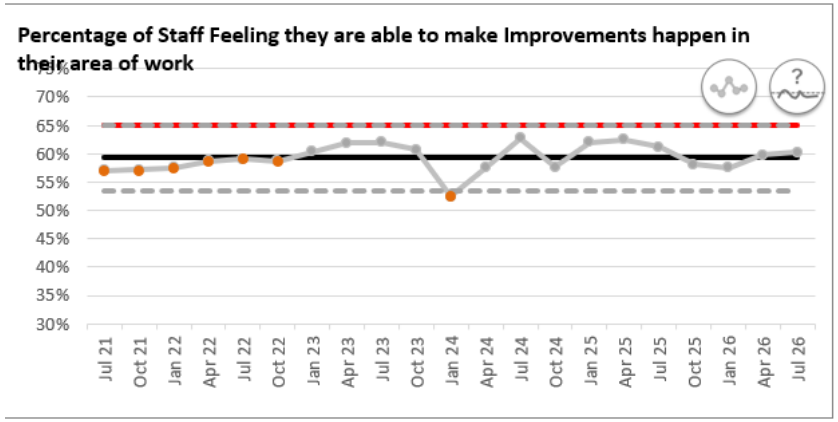
Background / standard description:
We are aiming for 60% of staff to recommend the Trust as a place to work

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.

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.

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

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:

- 'How we learn and improve' and 'How we lead and manage', are the two key areas of focus for this year. This will ensure that the core work being undertaken on accountability, productivity, employee wellbeing/ attendance are bought together into one strategic oversight forum.
- 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, with a view to standardising, the Trust's approach to flexible working by the end of Quarter 2 2026/27 **(Complete).** *See new action below*
- Standardisation work including implementing a manager toolkit and piloting ESR functionality to capture flexible working arrangements will be complete by the end of December 2026.
- 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 progress their Staff Survey Improvement Plan, which addresses themes of change management, staff wellbeing, and communication by the Pulse Survey in January 2027.

19) Staff Leaver Rate

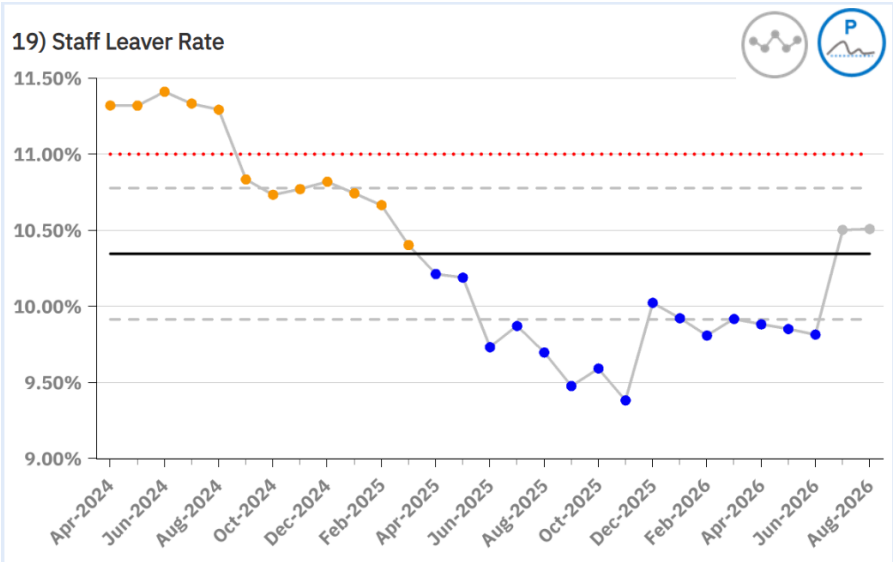
Background / standard description:
We are aiming for our staff leaver rate to be no more than 11%.

What does the chart show/context:
From a total of **7,478.97** staff in post **785.97 (10.51%)** had left the Trust in the 12-month period ending August 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, Management and Adult Learning Disabilities in DTVFCG and MHSOP within NYYSCG (these areas have confirmed there is no actual concern at this stage). There is special cause improvement for Durham Tees Valley & Forensic Care Group and Health & Justice, MHSOP & SIS within the Care Group, there is also special cause improvement for North Yorkshire, York & Selby and CYPS within the Care Group.

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%

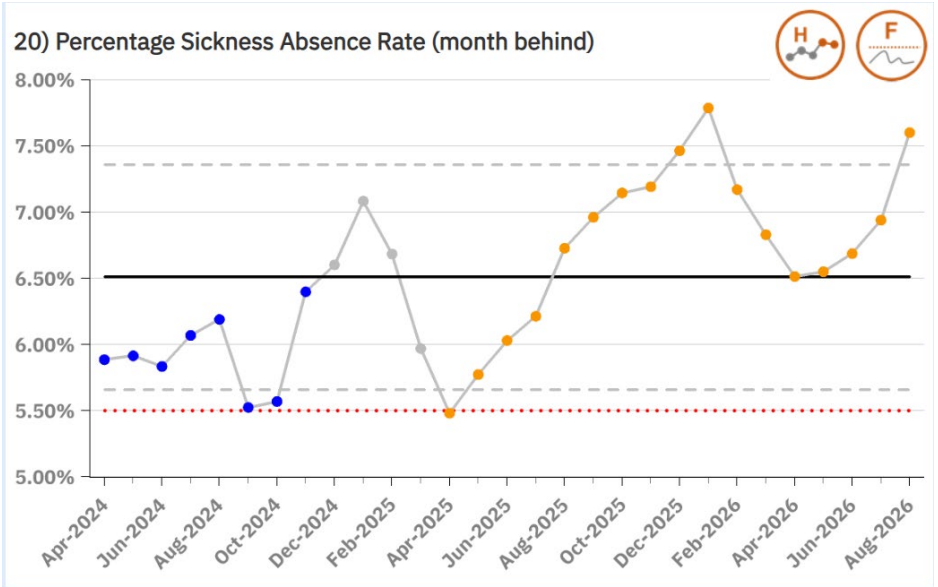
What does the chart show/context:
There were **233,156.42** working days available for all staff during August 2026 (reported month behind); of those, **17,723.47 (7.60%)** days were lost due to sickness.

There is special cause concern at Trust level, and for both Care Groups, Corporate Affairs & Involvement, Finance, Medical, Health & Justice and SIS within DTVFCG, MHSOP within NYYCG and Children & Young Peoples Services within both Care Groups. There is special cause improvement within Management for NYYSCG.

National Benchmarking for NHS Sickness Absence Rates published 27th August 2026 (data ending May 2026) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.73%** compared to the Trust mean of **6.46%**, with the Trust ranked 41 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, particularly stress, anxiety or mental health-related conditions, 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.
- There is a high level of sickness within Secure Inpatient Services for a range of reasons.

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 NYYSCG MHSOP and make recommendations for wider implementation by March 2027.
2. Director-led sickness absence management reviews will continue monthly across DTVFCG and NYYSCG, 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 the end of December 2026, building on the 64.18% 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 a review of the Bereavement and Compassionate Leave provisions by the end of September 2026 **(Complete)** Formal consultation to follow from September for 6 weeks.
6. Health & Justice Services will now complete the remaining four actions within the Service Improvement Plan by the end of October 2026, with progress monitored through the Service Improvement & Development Group and Combined Governance. An additional action relating to the management of long-term sickness (LTS) has recently been added to the plan and is due to be completed by the end of September.
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 the end of September 2026.
8. SIS have been identified as a Service Requiring Additional Support and have a recovery plan in place, including workforce and sickness management initiatives, to achieve exit from SRAS status by the end of October 2026.

21) Percentage compliance with ALL mandatory and statutory training

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

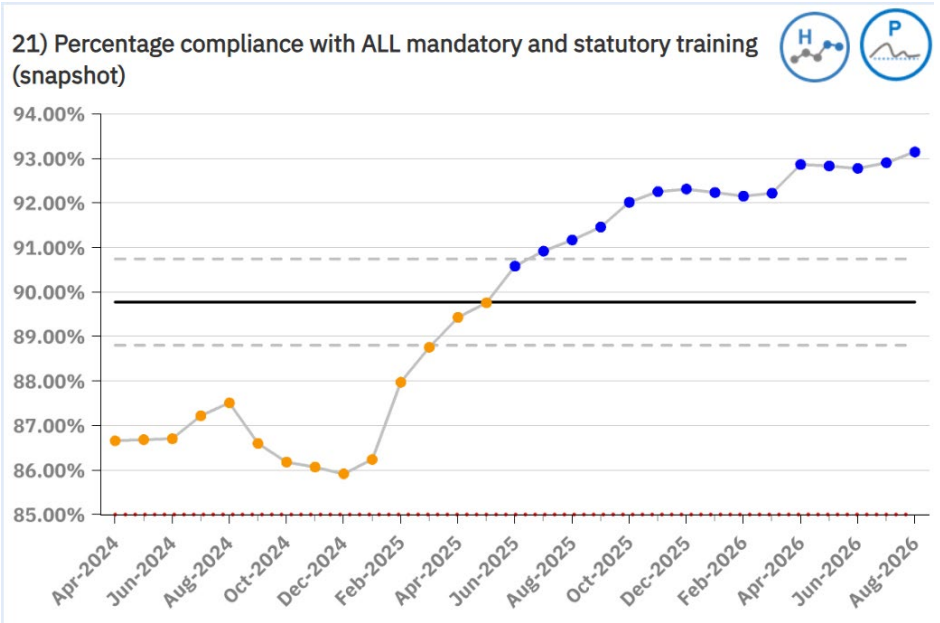
What does the chart show/context:
157,008 training courses were due to be completed for all staff in post by the end of August. Of those, **146,249 (93.15%)** were completed.

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

As at the 31st August 2026, All directorates are currently above 85%.

Underlying issues:
- Competencies for Associate Directors of Nursing and Modern Matrons are under review to ensure they are aligned correctly.
- The growing increase in mandatory and statutory training is reducing workforce capacity and headroom, necessitating tighter governance to ensure training requirements remain essential, proportionate, safe, and compliant.

Actions:
- The Deputy Chief Nurse will finalise approval of the revised training matrix for Associate Directors of Nursing and Modern Matrons by the end of September 2026 and oversee implementation to ensure competency requirements are aligned to management and clinical role expectations.
- By 31 October 2026, the working group established by the Executive Director of Therapies will commence a review of all outstanding feedback from the June 2026 Essential Training Workshop. Improvement actions and recommendations will be submitted to the Training Education Governance Group for consideration.
- 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 has worked with Workforce colleagues to resolve outstanding ESR issues and improve the accuracy and effectiveness of bank workforce management processes. **(Complete)**



21) Percentage compliance with ALL mandatory and statutory training

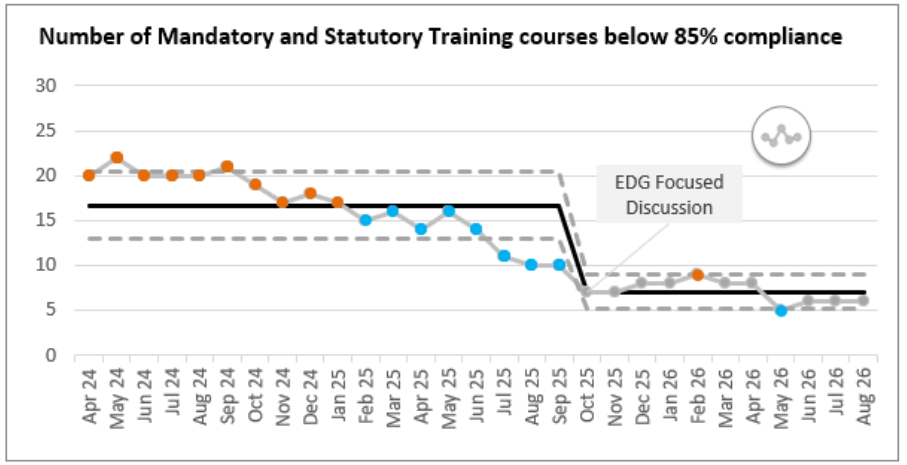
Courses below standard

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 and long-term sickness 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: Deprivation of Liberty whilst the content is reviewed, which is impacting a number of teams. A timescale is yet to be confirmed.
- The Observation & Engagement module is currently offline.

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 - August 2026 **(Complete)**
  - Therapies - September 2026
  - Corporate Affairs & Involvement – October 2026
  - Chief Executive – now November 26
- 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). **(Complete)**
- The Education & Training Team have realigned resources to support Resuscitation Level 3; the team is at capacity for Positive and Safe Care Training. **(Complete)**
- Active recruitment is underway for clinical skills trainers to meet the demand required.
- The Observation & Engagement module has been approved, and the Education & Training Team are agreeing the detail on the transfer of compliance from the previous training to the new model, and the timescales for staff to update the training.



	Total Complaint	Total Number	% Complaint
Positive & Safe Care Level 1*	3683	4583	80.36%
Resuscitation - Level 1 - 1 Year*	2131	2634	80.90%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1642	2020	81.29%
Observation & Engagement	1211	1484	81.60%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	800	980	81.63%
Positive and Safe Care Level 2 Update*	1340	1618	82.82%

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

22) Percentage of staff in post with a current appraisal

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

What does the chart show/context:
Of the **7,026** eligible staff in post at the end of August; **6,263 (89.14%)** had an up-to-date appraisal.

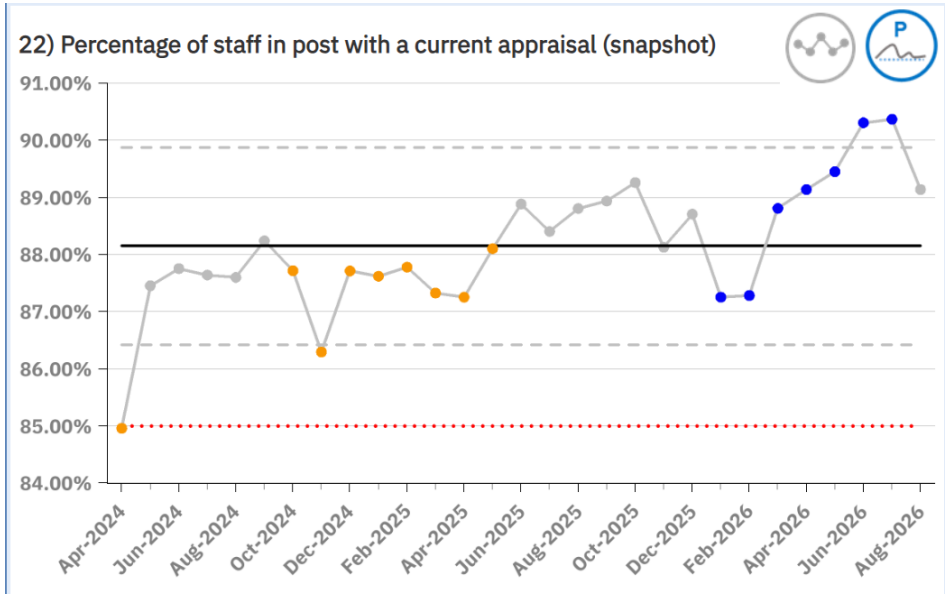
There is no significant change at Trust level and for most Directorates, there is special cause improvement for North Yorkshire, York & Selby, Assistant Chief Executive and AMH within Durham Tees Valley Care Group. There is special cause concern for Corporate Affairs & Involvement. There is also special cause concern in Children & Young Peoples Services with Durham Tees Valley & Forensics Care Group; however, they remain above standard.

As at the 31st August 2026, by exception compliance levels below 85% are as follows:

	Total Compliant	Total Number	% Compliance
CORPORATE AFFAIRS AND INVOLVEMENT	28	37	75.68%
FINANCE	44	55	80.00%
PEOPLE AND CULTURE	103	124	83.06%
CHIEF EXECUTIVE OFFICE	5	6	83.33%

Underlying issues:
- Corporate Affairs & Involvement appraisals has been impacted by staff sickness and uncertainties during a period of organisational change.
- People and Culture appraisals are impacted by one appraisal which has been completed but not yet recorded.
- Chief Executive office are impacted by one appraisal which has been incorrectly recorded.
- Finance appraisals have been impacted by staff on long term sick and a number of staff where appraisals were due at the same time.

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.
- People and Culture will ensure the recording of the outstanding appraisal before the end of September 2026
- The Chief Executive Office and Finance will have completed outstanding appraisals by the end of September 26.



4. Activity

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

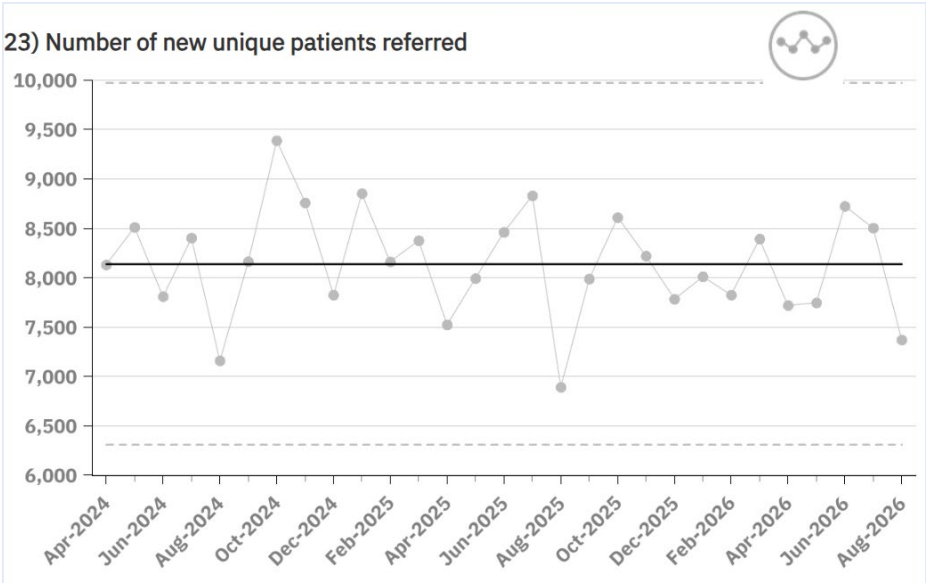
23) Number of new unique patients referred

What does the chart show/context:
7,371 patients referred in August that are not currently open to an existing Trust service.

There is no significant change at Trust and both Care Group Level. There is a high shift in referrals for Adult Mental Health in NYYSCG. 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.



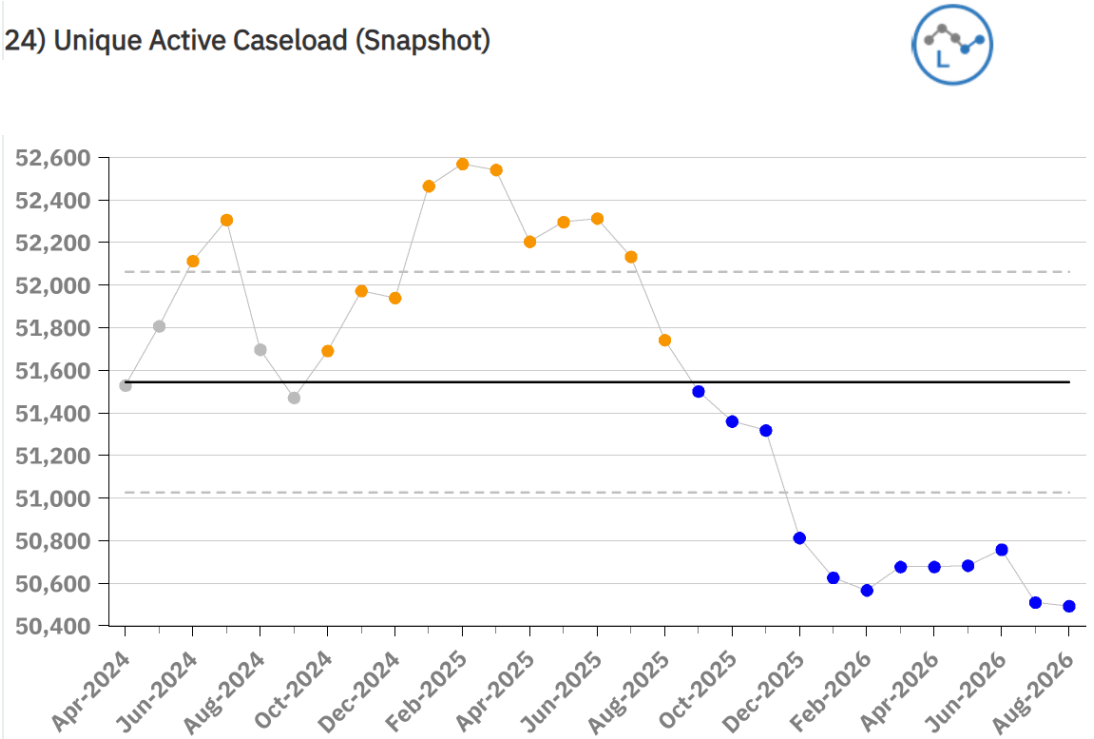
24) Unique Active Caseload (snapshot)

What does the chart show/context:
50,493 unique active cases were open as at the end of August 2026.

There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group. However, there continues to be special cause concern for Secure Inpatient Services (*see issue and action below*). There is special cause concern for North Yorkshire, York & Selby Care Group, Adult Mental Health and Children & Young Peoples Services with that Care Group *(see issues and actions below*). There is special cause improvement for Children & Young Peoples Services in DTVFCG, Mental Health Services for Older People in NYYSCG and Adult Learning Disabilities in both care groups.

Underlying issues:
- The caseload for Secure Inpatient Services reflects the Trust bed base, which can be impacted by discharges and new admissions.
- The root causes of the reported performance position for AMH and CYP within NYYSCG 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:
- By 30 September 2026, Performance, Business Intelligence and clinical service leads will complete a review of the appropriateness of including Secure Inpatient Services (SIS) within this measure and agree any required amendments to the metric definition.
- *Please see underlying issue above for NYYSCG AMH and CYP*



5. Finance

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

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

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

Revenue Performance - Group	Year to date			RAG
	Plan	Actual	Variance	
Revenue Performance (Surplus) / Deficit £m	1.83	(0.35)	2.18	
Income & Expenditure Margin (Surplus) / Deficit %	0.94%	(0.12%)	1.06%	
Income £m	229.74	233.24	3.50	
Pay Expenditure £m	194.75	193.12	1.64	
Non Pay Expenditure £m	35.35	38.71	(3.35)	
Non Operating Expenditure £m	1.46	1.07	0.39	

Revenue Performance - Group	Year to date £m			RAG
	Plan	Actual	Variance	
Durham, Tees Valley & Forensic	120.82	122.55	(1.73)	
North Yorkshire & York	49.96	50.57	(0.61)	
Estates & Facilities	14.20	13.97	0.23	
Corporate	25.35	25.52	(0.17)	
Income	(213.52)	(213.04)	(0.48)	
Central and Reserves	5.01	0.07	4.94	
PIPS	0.01	0.01	0.00	
	1.83	**(0.35)**	**2.18**	

For actions see following page

Key Messages:

Key areas of focus include:

- Implementing actions developed in response to NHSE plan conditions seeking to reduce bank costs to within NHSE caps, but noting additional approvals for areas of high bank utilisation were agreed at Executive Directors Group (EDG) in September
- 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 to date of a £0.35m surplus was £2.18m better than planned but included £1.3m unplanned contract receipt (in-month broadly break-even) in quarter one.

Underlying issues:

Planned delivery of £27.7m Cash Releasing Efficiencies Savings (CRES) underpins achievement of our 2026/27 break-even plan with details provided at indicator 28 and 29 and a key forward focus on reducing reliance on flexible staffing WTE.

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 **93 Independent Sector bed days in August** (102 in July) generating **£0.6m cost to date (£ nil planned)** including estimated occupancy and observations. 100% bed days related to Psychiatric Intensive Care requirements (3 beds presently) in August. Increases in June (and ongoing) related to 2 Adult Learning Disability Patients linked to female medium secure pathway challenges and Bankfields Court care package implications (**£0.7m** to date)

Focus is needed to tackle ongoing 'knotty' nursing and medical price cap breaches. Success in 'swapping out' premia rate for Bank staffing options is now being applied to support Bank reductions, informed by continually enhanced WTE and Financial Information by source.

Key Areas for Action:

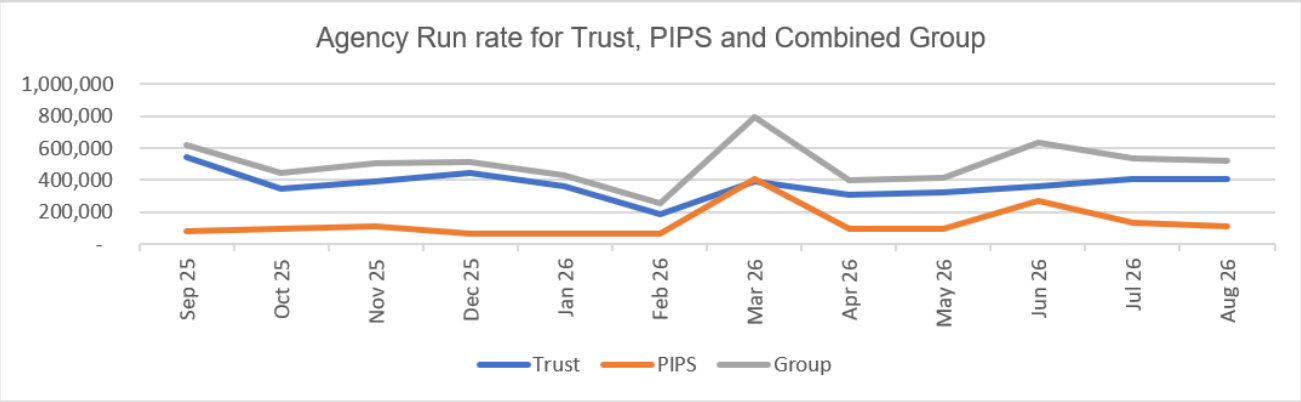
- An Efficiency Hub oversees delivery of CRES and supports Care Groups and Directorates.
- Delivering approved bank and sickness reduction plans with oversight at the Reduction of Flexible Staffing sub-group (reporting into EDG).
- Executive-led Transformation Programmes are progressing to support the NHS 10 Year Health Plan and, by effecting the 3 national 'left-shifts' aim to improve outcomes and value, with efficiencies targeted to commence at scale from 2027/28.

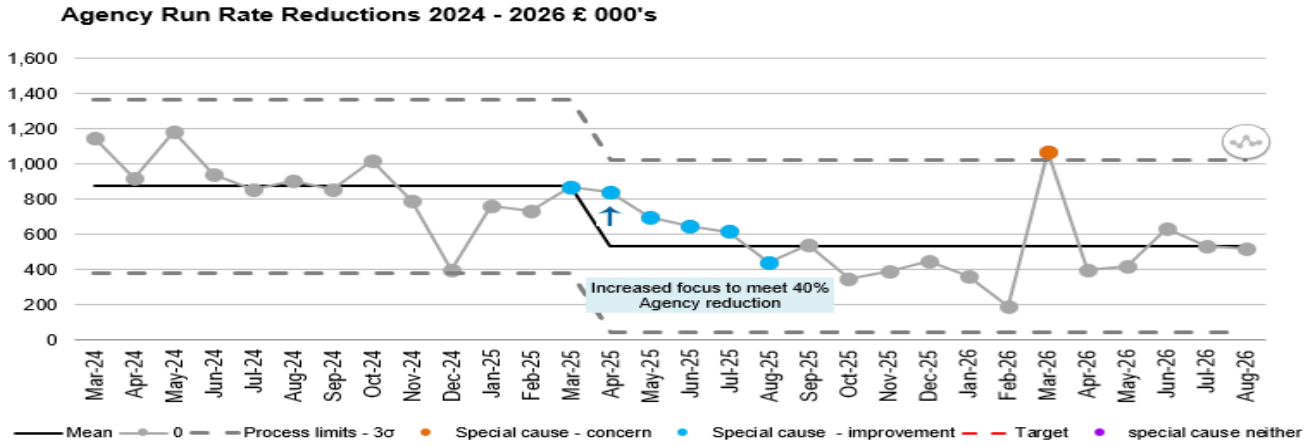
26) Financial Plan: Agency expenditure

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

Agency Usage	Expenditure £ 000's							WTE		
	Annual Plan	Current Month			Year to Date			Current Month		
Category		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Nursing and Other	2,603	223	371	(148)	899	992	(93)	13.30	9.52	3.78
Medical	1,975	158	151	7	899	992	(93)	13.30	9.52	3.78
Grand Total	**4,578**	**381**	**522**	**(141)**	**1,798**	**1,984**	**(186)**	**26.60**	**19.04**	**7.56**
Agency expenditure YTD as a proportion of total Pay expenditure (NOF Metric)						1.03%				

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%**





What does the data show/context:

- Year to date **Group agency costs of £2.5m were £354k and 40.51 WTE above plan:** The Trust position (excluding £701k subsidiary; £370k above plan) was £16k below plan; building on successful reduction in the last several years. In-month Trust costs for Nursing and Other were £102k and 24 WTE worse than planned, including £159k Bankfields Court 'break glass' shifts (£337k to date) 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 a Bankfields Court 'break glass' package and a recently commissioned PIPS care package.
- Medical agency represents 28.9% (£151k) in-month cost, but just 11.4% (9.52 WTE) in-month WTE due to high premia rates and price cap breaches.

Underlying issues:

- With agency WTE providing essential vacancy cover, we need sustainable solutions in shortage (medical and nursing) professions and services (including Secure Inpatient Services).
- Whilst inpatient ward Agency nursing expenditure reduced markedly in Durham, Tees Valley and Forensic, including from actions to optimise rostering and review staffing relative to clinical need, costs since quarter one have been impacted by the 'break glass' Bankfields Court package. North Yorkshire and York saw slower impacts, albeit favourable in recent months.

Actions:

A Reduction of Flexible Staffing 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 is targeting further 2026/27 inpatient cost reductions.
- Enhanced staff banks were developed in 2025/26 as an alternative to premia rate Agency and Overtime options.
- Band 2-3 clinical agency shifts can only take place with Director level approval. Actions are progressing via the Care Groups to address 'Break Glass' approvals 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 August 26 - Agency Staff Price Cap Compliance

Price Cap Compliance	Aug - 25		Jul - 26		Aug - 26		In-Month Movement		12-Month Movement	
	Shifts	Shifts %	Shifts	Shifts %	Shifts	Shifts %	No.	%	No.	%
Compliant	641	64%	177	26%	248	32%	71	40%	(393)	(61%)
Non-Compliant	360	36%	491	74%	520	68%	29	6%	160	44%
Total Shifts	**1001**	**100%**	**668**	**100%**	**768**	**100%**	**100**	**15%**	**(233)**	**(23%)**

Compliance Change by Staffing Group	Aug - 25			Jul - 26			Aug - 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	155	0	0%	278	186	67%	455	290	64%	104	104%	290	290%
Medical	304	304	100%	228	228	100%	164	164	100%	(64)	(28%)	(140)	(61%)
Nursing	542	56	10%	162	77	48%	149	66	44%	(11)	(14%)	10	6%
Allied Health Professionals	0	0	0%	0	0	0%	0	0	0%	0	0%	0	0%
Total Shifts	**1001**	**360**	**36%**	**668**	**491**	**74%**	**768**	**520**	**68%**	**29**	**32%**	**160**	**44%**

Movement - Increase / (Reduction)

Run Rate of Agency Expenditure

	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26
Prisons	41	61	50	54	48	53	58	35	42	29	32	27
Bankfields Court	0	0	0	0	0	0	0	0	20	85	96	150
Other Nursing	170	153	132	138	122	103	94	75	59	54	52	76
Other Medical	405	392	331	304	284	214	278	206	221	246	253	186
Other Staff Groups	0	0	0	0	0	0	0	0	0	0	0	0
Total Expenditure	**616**	**606**	**513**	**496**	**454**	**370**	**430**	**316**	**342**	**414**	**433**	**439**

Key Financial Indicators for the period ending 31 August 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	Aug-26
Durham Tees Valley & Forensic	1	1	7	0	0	0	73	173	239	451
North Yorkshire & York	40	941	1040	59	42	39.52	20	50	39	4
Total Shifts Worked	**41**	**942**	**1047**	**59**	**42**	**39.52**	**93**	**223**	**278**	**455**

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**	**Aug-26**
Bankfields Court (Tees) ALD	0	0	0	0	0	0	73	173	186	290
SIS RPH Clover/Ivy Ward	0	0	0	0	0	0	0	0	15	36
SIS RPH Jay Ward Low Secure Male	0	0	0	0	0	0	0	0	6	19

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 233 shifts (12%) over the 12 months ending August 2026 but increased by 100 shifts in-month.
- Non-compliant shifts increased by 29 shifts (6%) over the same period, driving a higher non-compliance rate, accounted for by Bankfields Court 'break glass' approvals.
- Of 768 shifts in August, 248 or 32% complied with price caps.
- 455 Band 3 shifts in August 2026 breached an NHSE requirement to cease Band 2-3 Support Worker usage; up by 177 shifts in-month (prior month 55 shifts increase). This included 290 shifts worked in August from 'break glass' approvals at Bankfields Court commencing in May in response to an agreed care package and with appropriate approvals for all 722 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 for Bankfields Court.

Actions:

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

- Care Group Medical colleagues are revising 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

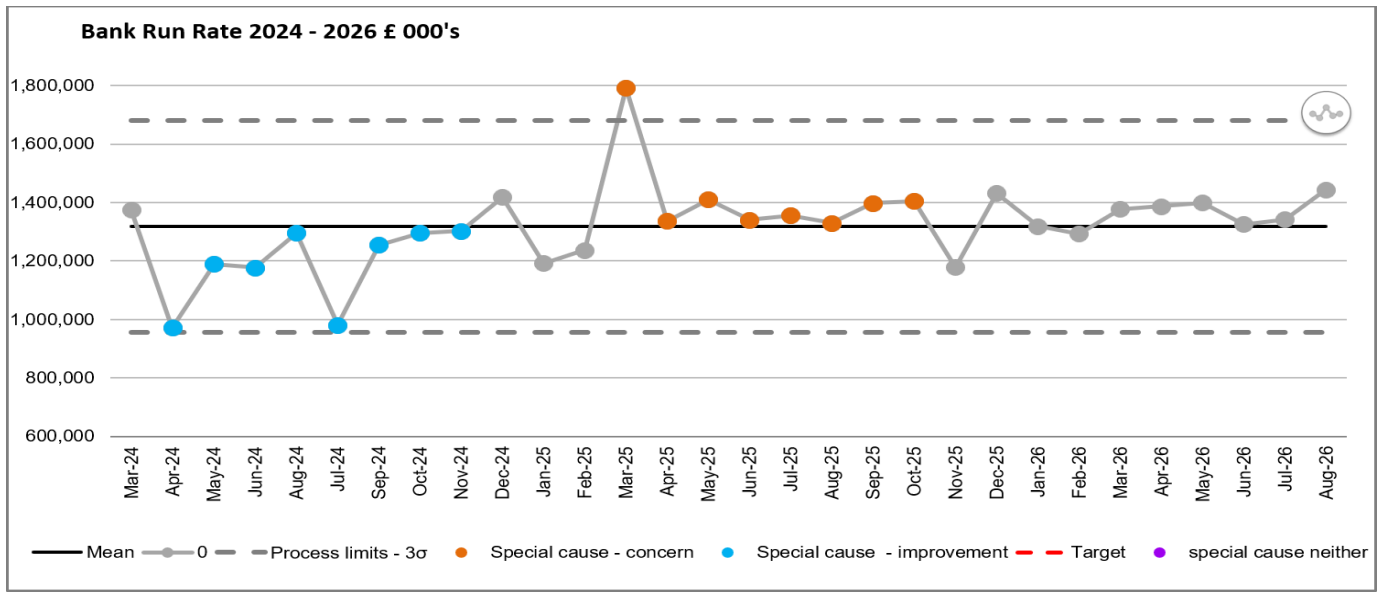
Key Financial Indicators for the period ending 31 August 26 - Bank Expenditure

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	356	(163)	965	1,662	(697)	40.90	65.22	(24.32)
Unqualified Nursing	10,722	895	1,087	(192)	4,670	5219	(549)	222.18	281.36	(59.18)
Other	15	1	1	0	6	17	(11)	0.36	0.60	(0.24)
Initial Plan Variance	**13,052**	**1,089**	**1,444**	**(355)**	**5,641**	**6,898**	**(1,257)**	**263.44**	**347.18**	**(83.74)**
Plan Condition Variance	**13,052**	**1,287**	**1,444**	**(157)**	**6,313**	**6,898**	**(585)**	**277.20**	**347.18**	**(69.98)**
Agency expenditure YTD as a proportion of total Pay expenditure (NOF Metric)						3.57%				

Variances - Better / (Worse) than plan

Key Financial Indicators for the period ending 31 August 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		Plan	Actual	Variance
Durham Tees Valley & Forensic	11,311	305	1,183	(878)	4,713	5,619	(906)	211.77	286.14	(74.37)
North Yorkshire & York	1,732	144	261	(117)	722	1,268	(546)	49.71	60.64	(10.93)
Estates & Facilities	29	2	0	2	13	4	9	0.95	0.23	0.72
Corporate	(20)	638	0	638	193	7	186	1.01	0.17	0.84
Grand Total	**13,052**	**1,089**	**1,444**	**(355)**	**5,641**	**6,898**	**(1,257)**	**263.44**	**9.53**	**(83.74)**



What does the data show/context:

- Year to date Bank **costs of £6.9m were £1.3m above original plan (February NHSE submission) but** £585k worse than plans finalised at the end of quarter one. Both metrics illustrate the 'stretch' those actions need to deliver.
- Most plan variation related to qualified nursing roles, including hard to fill vacancies. Largest users in August were Bankfields Court (single care package), Secure Inpatient Wards (Kestrel Kite, Sandpiper and Clover/Ivy) and two Adult Mental Health wards (Lanchester Road; Tunstall and Foss Park; Minster).

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 is being provided by oversight from the Reduction of Flexible Staffing 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 being targeted 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 address 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.

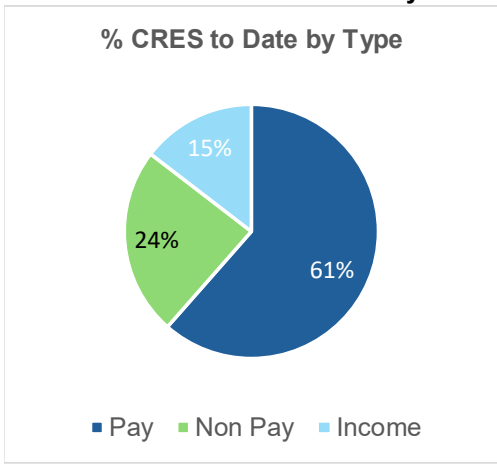
29) CRES Performance – Recurrent and 30) CRES Performance – Non-Recurrent

Key Financial Indicators for the period ending 31 August 26 - CRES savings compared to plan

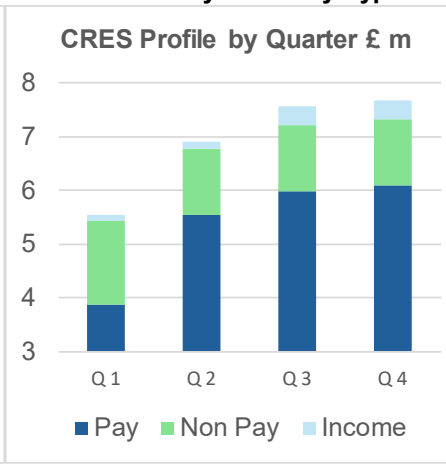
Type	2026/27 CRES performance compared to plan							2026/27 CRES plans phasing £ 000				
	Year to date £ 000			Annual £ 000			Full Year Effect	Q1	Q2	Q3	Q4	2026/27
	Plan	Actual	Variance	Plan	Forecast	Variance		Plan	Plan	Plan	Plan	Plan
Recurrent:												
Pay	5,668	4,949	(719)	16,765	16,342	(423)	17,034	3,150	3,898	4,842	4,875	**16,765**
Non Pay	1,139	1,124	(15)	3,092	3,123	31	3,367	701	679	851	861	**3,092**
Income	125	112	(13)	738	315	(423)	194	72	78	294	294	**738**
Sub Total	**6,932**	**6,185**	**(747)**	**20,595**	**19,780**	**(815)**	**20,595**	**3,923**	**4,655**	**5,987**	**6,030**	**20,595**
								19%	**23%**	**29%**	**29%**	**100%**
Non Recurrent:												
Pay	1,824	1,877	53	4,744	4,189	(555)	0	729	1,643	1,149	1,223	**4,744**
Non Pay	1,286	1,535	249	2,147	1,707	(440)	0	847	562	369	369	**2,147**
Income	85	1,505	1,420	204	2,014	1,810	0	50	52	51	51	**204**
Sub Total	**3,195**	**4,917**	**1,722**	**7,095**	**7,910**	**815**	**0**	**1,626**	**2,257**	**1,569**	**1,643**	**7,095**
								23%	**32%**	**22%**	**23%**	**100%**
Total	**10,127**	**11,102**	**975**	**27,690**	**27,690**	**0**	**20,595**	**5,549**	**6,912**	**7,556**	**7,673**	**27,690**
								20%	**25%**	**27%**	**28%**	**100%**

Variances - Better / (Worse) than plan

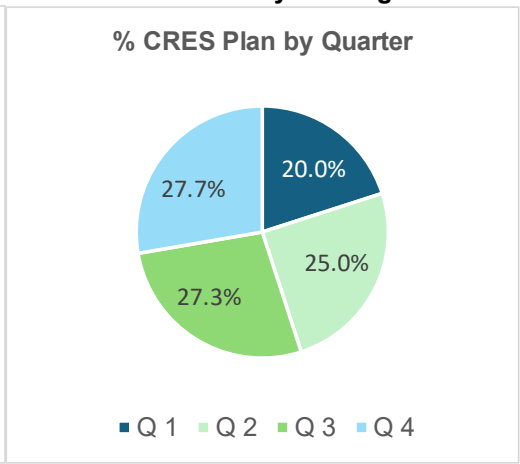
Year to Date CRES Delivery



Plan Quarterly Profile by Type



Plan Quarterly Phasing



What does the data show/context:

Whilst **CRES delivery of £11.1m was £1m above plan** year to date, plans assume marked stepped increases from quarter two. Performance reflects **delivery of 40.1% annual savings** required (36.6% planned), with**:**

- **£6.2m Recurrent** CRES delivery; being £0.8m below plan
- **£4.9m Non-Recurrent** CRES delivery was £1.7m above plan

Agency CRES were £16k and Overtime £203k better than plan to date, but Bank CRES were below the (February NHSE submission) plan by £1.3m.

Areas of under-delivery included:

- Overtime reductions (Secure Inpatients and Hotel Services);
- Bank staff reductions and growth in Secure Inpatients and in Older Adult Mental Health Services in Durham and Tees Valley, Trust Adult Mental Health Services;
- 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.

Approved bank and sickness absence reduction plans are being overseen through bolstered Reduction of Flexible Staffing Group arrangements. Temporary Older Adult bed changes will contribute to reducing bank costs. Additional controls have been put in place to approve rosters in high expenditure areas.

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 98% schemes (by value) had been assessed by the end of August. 3 schemes are awaiting assessment, and 16 schemes (including 7 for Secure Inpatients awaiting exit from additional support status) need to provide additional information to panel. Oversight and escalation for action is by the Efficiency Hub, to project 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 August 26 - Capital programme performance

Capital Programme:	Year to Date £ 000			Annual £ 000		
	Plan	Actual	Variance	Plan	Forecast	Variance
Total expenditure plan	6,955	6,273	682	13,176	19,763	(6,587)
Performance against capital allocation	6,804	6,123	681	12,402	15,016	(2,614)
Performance against revised capital allocation	6,804	6,123	681	12,895	15,016	(2,121)

Variances - Lower / (Higher) than plan

Key Financial Indicators for the period ending 31 August 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**	**4,151**	**1,551**	**2,694**	**12,402**
	32%	**33%**	**13%**	**22%**	**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).

Additional funding to install solar panels on Trust sites of £1,600k has been approved by NHSE during September – this will not impact on performance against the Trust's capital allocation or Trust cashflow as it is also cash backed.

What does the data show/context:
£6,123k Capital expenditure for the year to date was **£681k lower than planned** costs charged against the Trust's capital allocation.

a) Capital Charged to allocation: £12,402k 2026/27 allocation comprised:
- £5,896k operational capital allocation (derived nationally using a formula)
- £5,000k cash-backed Estates Safety Fund (2026/27 only)
- £889k cash-backed Estates Safety Fund (4-year allocation)
- £617k 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 permitted capital expenditure (a + c) was £13,176k. Revised permitted capital expenditure is now £13,669k (a + b + c).

Whilst forecast performance against our revised allocation is a £2,121k 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 will bid 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 August 26 - Cash, Supplier Payment and Receivables

	Year to Date			Annual		
Receivable & Payables Metric:	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Cash (£000s)	46,367	53,511	7,144	36,653	48,535	11,882
Better Payment Practice Code (%)	95.0%	95.6%	0.6%	95.0%	95.0%	0.0%
Aged Debt > 90 days overdue (%)	5.0%	49.8%	(44.8%)	5.0%	5.0%	0.0%

Variances - Better / (Worse) than plan

Key Financial Indicators for the period ending 31 August 26 - Planned Closing Cash Balances 2026/27

	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

	2026/27 Monthly Cash Actual / Forecast £ 000											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Closing Cash	56,492	58,915	52,952	56,885	53,511	53,355	56,395	52,645	48,165	51,912	51,580	46,424

What does the data show/context:

Cash balances of **£53,511k were £7,144k 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 £2,298k, with **£984k 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:	**Resources and Planning Committee**
Non-Executive Chair:	**John Maddison**
Executive Lead:	**Naomi Lonergan**

Waiting Times Dashboard – National Waiting Times Measures

Patients waiting for Meaningful Help	Actual Number Waiting (Snapshot)	0-4 weeks	Over 4 weeks	Over 26 weeks	Over 52 weeks	Over 78 weeks	Over 104 weeks
Children & Young People Waiting to receive Meaningful Help (Provider)	8925	389	8536	7263	6464	5329	**3886**
Children & Young People Pathway A - Spells with at least one referral with a primary reason for referral - Gender Discomfort Issues	3	0	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	5555	90	5465	4853	4327	3531	**2611**
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	4494	56	4438	3835	3428	3002	**2168**
Children & Young People Pathway D - Spells with at least one 'other' referral not identified as related to autism, neurodevelopmental or gender identity	991	286	705	204	107	71	**60**
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	141	1	140	131	97	69	**60**
Adults Waiting to receive Meaningful Help	4180	1076	3104	663	190	81	**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)		1	0	0	1	0	0	0	0	2	**2**
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		40	10	9	14	4	2	1	0	3	**10**

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)		78	25	26	16	5	5	1	0	2	**9**

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		805	335	154	85	108	21	19	34	44	8	19	**186**	
Adults Waiting for an Assessment		2713	1140	566	376	489	125	14	3	0	0	9	**76**	
Adults with a learning disability Waiting for an Assessment		98	80	11	3	2	1	0	0	0	1	6	**309**	*
Adults in Health and Justice services Waiting for an Assessment		49	38	5	5	1	0	0	0	0	0	3	**15**	
Older People Waiting for Assessment		2889	915	678	532	542	165	57	0	0	0	10	**46**	

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		4745	95	141	95	494	322	201	1306	1451	647	92	**242**
Children and young people waiting for an ADHD Assessment		4565	83	147	106	283	207	271	1501	1253	714	92	**217**
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		1972	3	5	4	8	60	84	515	878	437	123	**224**
Adults waiting for an Autism Assessment		4346	42	30	37	149	190	190	781	983	1944	135	**365**
Adults waiting for an ADHD Assessment		5571	89	72	121	311	308	299	1054	1223	2094	124	**372**

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		3950	232	362	1342	665	676	673	17	**79**

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.*

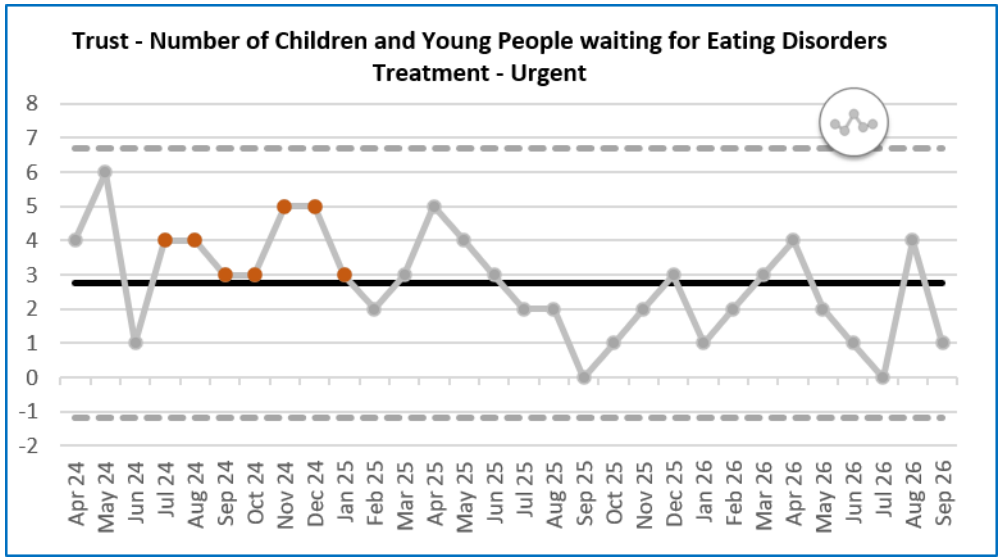
Waiting Times Children's Eating Disorders – Urgent Referrals (1 week National Standard)

Summary:
There is **1** child or young person reported as waiting more than 1 week and validation confirms that they are waiting beyond 1 week.

The patient was offered an appointment within one week but did not attend. A joint assessment with the York North Community Team and Adult Eating Disorders Service is scheduled for mid September.

Underlying issues:
There is a consistent break in process between the adult access team and the adult eating disorder team.

Actions:
By the end of October 2026, Adult Mental Health General Managers to develop a dedicated triage pathway for eating disorder referrals for young people aged 18-19, ensuring timely treatment and adherence to the national 7-day urgent and 28-day routine access standards.



Children & Young People Eating Disorders Services - 1 week standard for Urgent referrals

Organisation	Actual	Average wait (days)	Longest wait (days)	Assurance
Trust	1	16	16	
DTVF Care Group	0	0	0	
NYY&S Care Group	1	16	16	

Commentary on Longest waits

DTVF: No waiters
NYY&S: Genuine wait - awaiting joint assessment with community team, estimated further 2 weeks wait due to capacity of community team

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

Summary:
There are **7** children or young people reported as waiting more than 4 weeks; however, validation confirms that only **4** patients are currently waiting beyond 4 weeks:

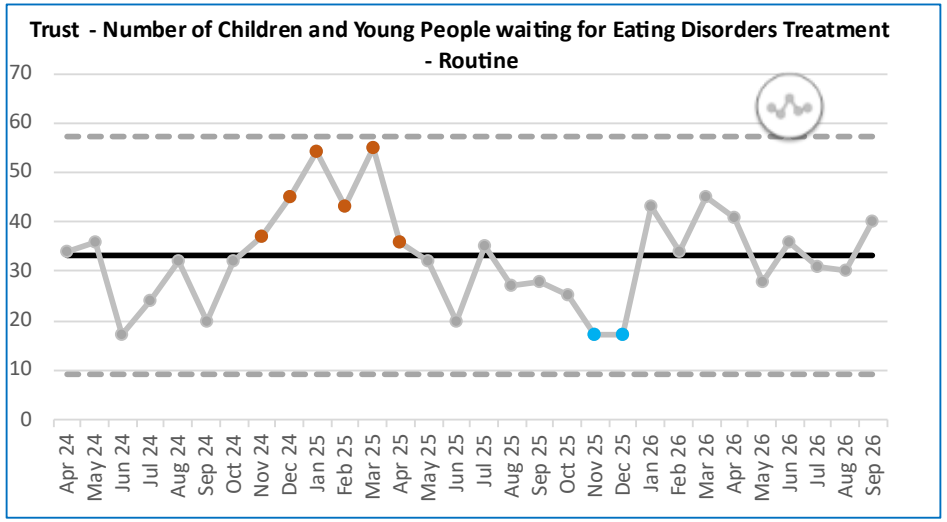
All 4 patients were offered appointments (within 4 weeks):

- 2 patients did not attend; one patient has a further appointment is offered in September and the second patient has failed to attend two subsequent appointments, and an offer of service letter has now been sent.
- 1 patient presented at the wrong location; they have subsequently been assessed, and an extended assessment is to be undertaken.
- 1 patient's appointment was cancelled by the family; the patient has subsequently commenced treatment.

The 3 remaining waits are attributable to data quality issues; 2 have subsequently been resolved and steps are being taken to resolve the outstanding issue in Cito.

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

Actions:
Directors of Operations submitted the service improvement plan, including agreed actions and improvement trajectories to the Executive Directors Group in September 2026, which was approved. **(Complete)**



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

Organisation	Actual	Average wait (days)	Longest wait (days)	Assurance
Trust	40	18	68	
DTVF Care Group	28	14	40	
NYY&S Care Group	12	27	68	

Commentary on Longest waits

DTVF: Genuine wait - assessment booked
NYY&S: Genuine wait - patient undergoing extended assessment, dietetics appointment 11th September to be followed by review with consultant psychiatrist

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

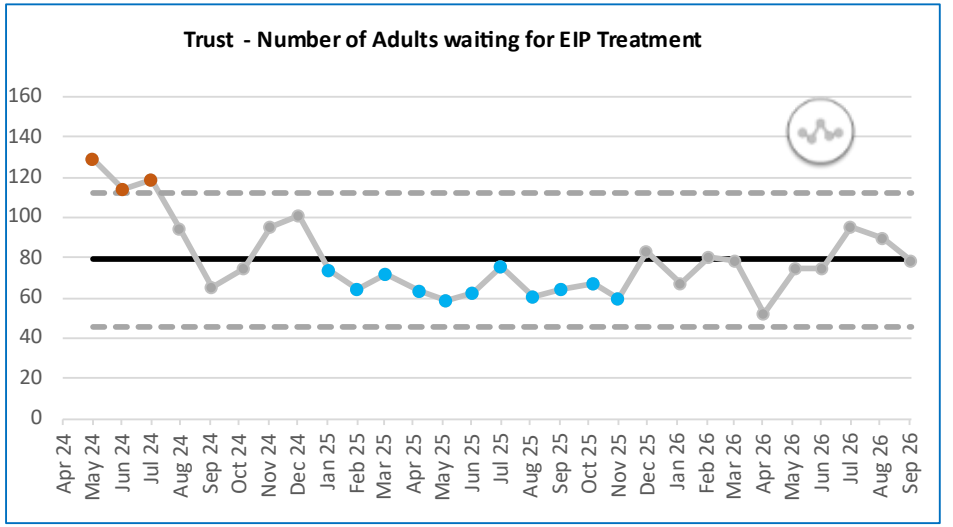
Summary:
There are **27** adults **reported** as waiting more than 2 weeks; however, validation confirms that **19** patients are currently waiting beyond 2 weeks.

- 12 patients were offered appointments (within 2 weeks); all either did not attend or cancelled. Further appointments have been offered in September.
- 7 patients were offered appointments (outside 2 weeks) due to team capacity within the York & Selby EIP Team. Of these, 5 have been assessed; one has been allocated to the EIP pathway and 4 are awaiting key worker allocation. The remaining 2 patients did not attend their allocated appointments, and further appointments have been offered in September.

Of the remaining 8 waits:
- 5 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
- 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 has implemented its recovery plan and successfully filled all substantive vacancies. Progress in reducing the backlog of patients awaiting treatment has been delayed as newly recruited care coordinators are awaiting professional registration PINs before they can hold caseloads. PINs are expected to be received in September 2026, with improvements in waiting list performance anticipated from the end of September 2026.



Adults Waiting for EIP Treatment - 2 week standard

Organisation	Actual	Average wait (days)	Longest wait (days)	Assurance
Trust	78	16	61	
DTVF Care Group	42	13	57	
NYY&S Care Group	36	19	61	

Commentary on Longest waits

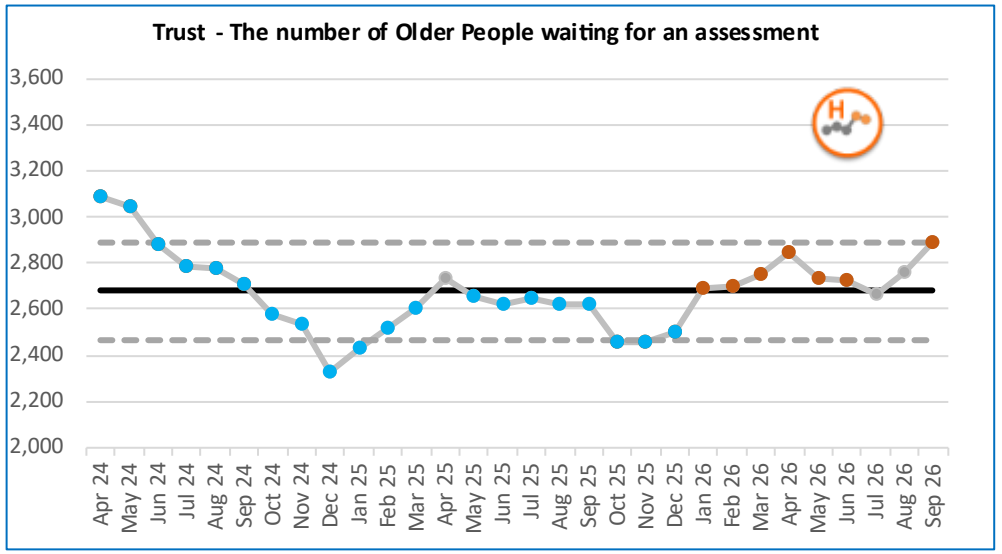
DTVF: Genuine Wait - Assessment booked 15/9, patient choice
NYY&S: Genuine Wait - Attended assessment 26/8, awaiting allocation, predicted wait 2 - 4 weeks

Waiting Times – Older People Waiting for Assessment

Summary:
As at **2nd September**, we have **1889** older people waiting for an assessment within Mental Health Services for Older People. There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group. There is special cause improvement for North Yorkshire, York & Selby Care Group.

Underlying issues:
- High levels of sickness and vacancies in the Durham & Tees Valley community teams is impacting capacity, together with an increase in referral numbers
- High levels of sickness and vacancies in Harrogate Memory Service is impacting capacity.

Actions:
- In DTVFCG, weekly performance meetings are taking place with senior leadership to review the waiting list position and to ensure those patients with the longest waits are prioritised where appropriate.
- Senior Leadership will review workforce capacity weekly and reallocate peripatetic resource to those areas with the greatest need.
- Harrogate Memory Service Manager has been unable to increase assessments following recruitment to a number of vacant posts, due to long-term sickness absence and a further Band 5 clinician vacancy. Assessments will increase to 17 per week from December and, subject to successful recruitment, assessments are expected to increase to 21 per week thereafter.



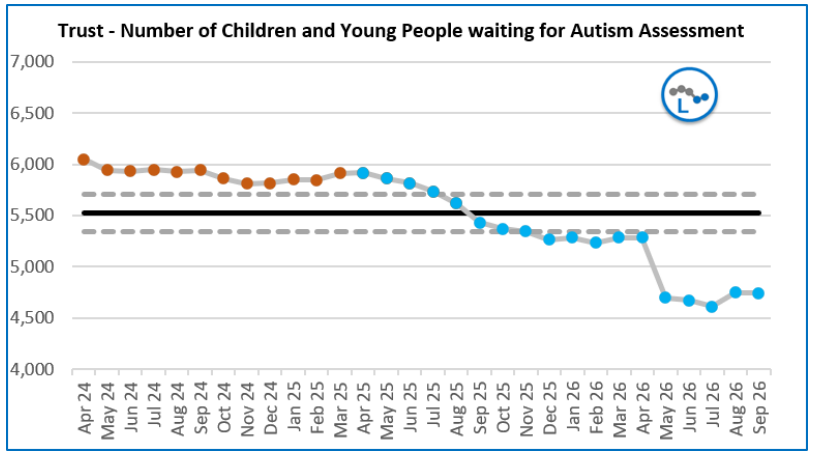
Older People Waiting for Assessment

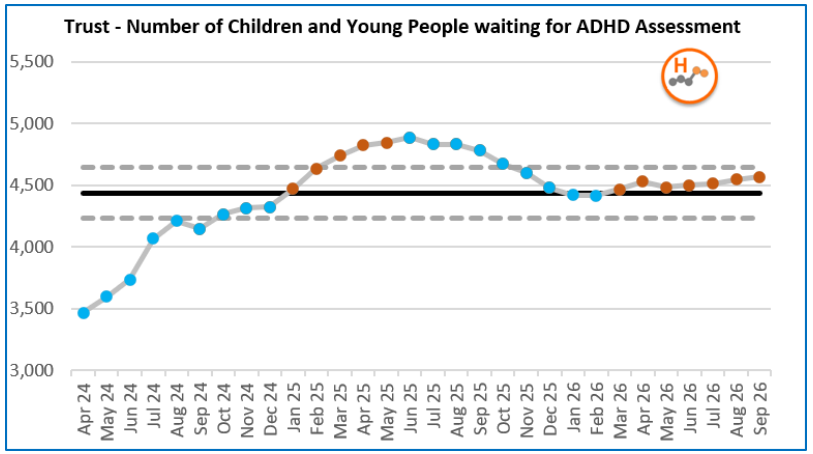
Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust	2889	10	46	
DTVF Care Group	1451	7	30	
NYY&S Care Group	1438	14	46	

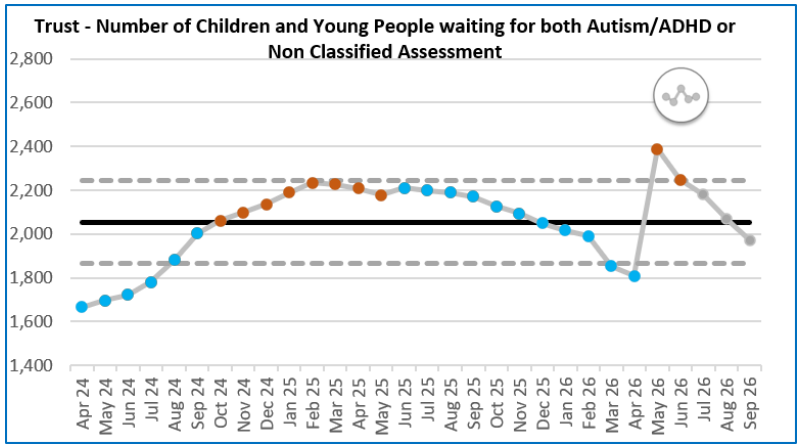
Commentary on Longest waits

DTVF: Data Quality - has now been discharged. Longest genuine wait is 173 days, appointment booked 16/9/26
NYY&S: Genuine Wait - assessment required, patient choice, appointment booked 29/6/26

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 (weeks)	Longest wait (weeks)	Assurance
Trust	4745	92	242	
DTVF Care Group	3640	100	242	
NYY&S Care Group	1105	67	147	

Commentary on Longest waits

DTVF: Genuine wait - no appointment booked
NYY&S: Genuine wait - DNA'd, appointment rebooked for 30/9/26

Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust	4565	92	217	
DTVF Care Group	3821	102	217	
NYY&S Care Group	744	42	142	

Commentary on Longest waits

DTVF: Genuine wait - DNA's appointment and serivce letter sent. Still wanting assessment, consultant psychiatrist to offer appointment in November due to LD and previous CAMHS involvement
NYY&S: Genuine wait - Appointment booked 14/9/26

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

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust	1972	123	224	
DTVF Care Group	1455	141	224	
NYY&S Care Group	517	73	135	

Commentary on Longest waits

DTVF: Genuine wait - offered appointment on 25/9 after declining to return consent forms. Service letter to be sent if DNA later in the month
NYY&S: Genuine wait - awaiting further information from patient and school before scheduling appointment

For underlying issues and action, please see overleaf

Waiting Times Neuro Services: Children & Young People

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:
- Tees service have implemented the identified amendments to the clinical pathway arising from the rollout of the clinical protocol, with all changes approved and embedded in practice by 31 August 2026. **(Complete)**
- Durham and Darlington Service will roll out the clinical protocol by the end of August 2026. **(Not Complete)** *See below revised action*
- Durham & Darlington Neurodevelopment Leadership Team will facilitate an away day with the full team on the 30th September to improve induction processes, develop and embed new assessment processes, roll out the clinical protocol and improve wellbeing.

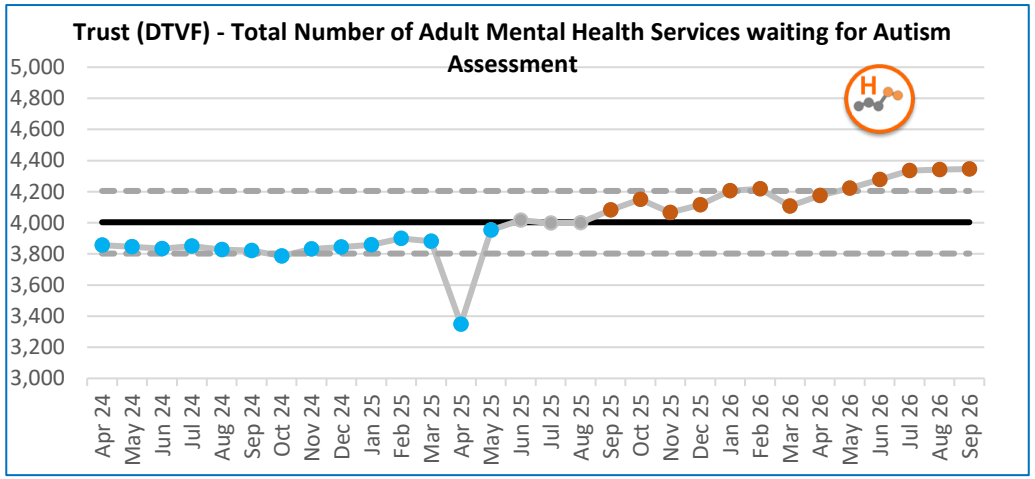
North Yorkshire & York

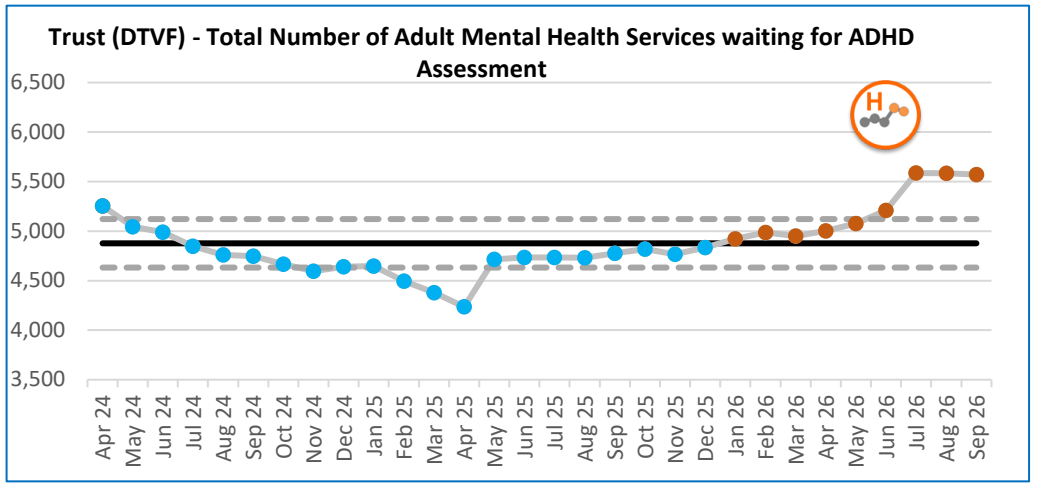
Underlying Issues:
- Long-term sickness absences within the Scarborough ADHD team
- High levels of demand outweighing capacity in the Scarborough ADHD and York & Selby ADHD teams

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, and an ICB-level service specification was shared with providers with comments returned during August. Providers are currently waiting for confirmation of the next steps from the ICB.

Actions:
- The Scarborough ADHD team has a recovery plan in place; however, delivery is currently constrained by sickness absence and vacancies. The first progress report on capacity and resource utilisation was presented to the Combined Care Group Governance in June; however, was not presented to Executive Directors Group in August. **(Not Complete)** The current position is being reviewed, and an updated report will be presented to Care Group Governance in October 2026 and then to EDG.

Waiting Times Neuro Services: Adult Services





Adults waiting for an Autism Assessment

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust (DTVF Care Group)	4346	135	365	

Commentary on Longest waits

DTVF: Genuine wait - appointment booked 24th August 2026

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust (DTVF Care Group)	5571	124	372	

Commentary on Longest waits

DTVF: Longest wait no longer showing in data. Longest genuine wait is 2994

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 a contracting plan will now be completed and shared with the ICB in September 2026.

To Note: *the above tables reflect waiting periods in weeks rather than days*

Waiting Times Talking Therapies

DTVFCG

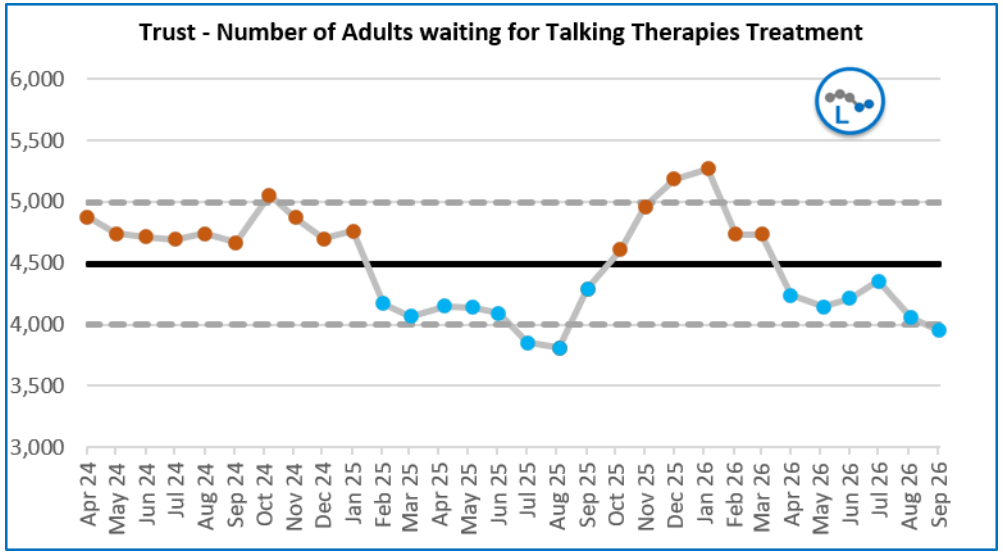
Underlying issues:

- 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 was anticipated to be signed off by the end of August 2026. **(On Hold)** *See below action*
- Following ICB commissioning the implementation of Dr Julian, a digital therapy offer, the Talking Therapies Service will meet with the ICB and Dr Julian representatives in September to explore the offer, with implementation scheduled for completion by 31 October 2026.
- The General Manager submitted a workforce and financial gap analysis paper to EDG in July 2026, seeking additional staffing investment. EDG will now revisit the proposal and confirm required actions by the end of October 2026.
- The Service Manager will recruit to 4.1 PWP staffing vacancies by the end of December 2026; 2 will be appointed as soon as possible following vacancy control approval, the remaining 2.1 will be filled by trainees who complete their training in December.
- Mental Health Matters will recruit to 1.7 PWP staffing vacancies by the end of September 2026. In addition, the service has been allocated 2 trainee PWP places for 2027/28.
- By the end of September, the Clinical Lead and Service Manager will develop an options appraisal paper which will identify further actions aimed at improving the current position for those waiting for treatment.

- *See following page for NYYSCG*



Talking Therapies - adults waiting for their second treatment contact

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust	3950	17	79	
DTVF Care Group	1458	13	54	
NYY&S Care Group	2492	19	79	

Commentary on Longest waits

DTVF: Genuine Wait - no appointment booked due to limited capacity
NYY&S: Genuine Wait - DNA'd waiting for specific appointment time and location

Waiting Times Talking Therapies

NYYSCG

Underlying issues:

- Within North Yorkshire Talking Therapy team, treatment capacity was temporarily converted to assessment capacity from the middle of October 25, which is continuing to impact on the waiting time for 2nd treatment appointments.
- There is insufficient capacity to deliver Step 2 and Step 3 treatments within the York & Selby Talking Therapy team.

Actions:

- 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.
- From the 1st October, assessment capacity will be converted back to treatment capacity as a stepped approached, initially focusing on Guided Self Help & Step 3 treatments. (*See following action*)
- The York & Selby Talking Therapies Service Manager will embed the Keeping in Touch pilot as part of standard practice from October 2026 following maintenance of the waiting list.

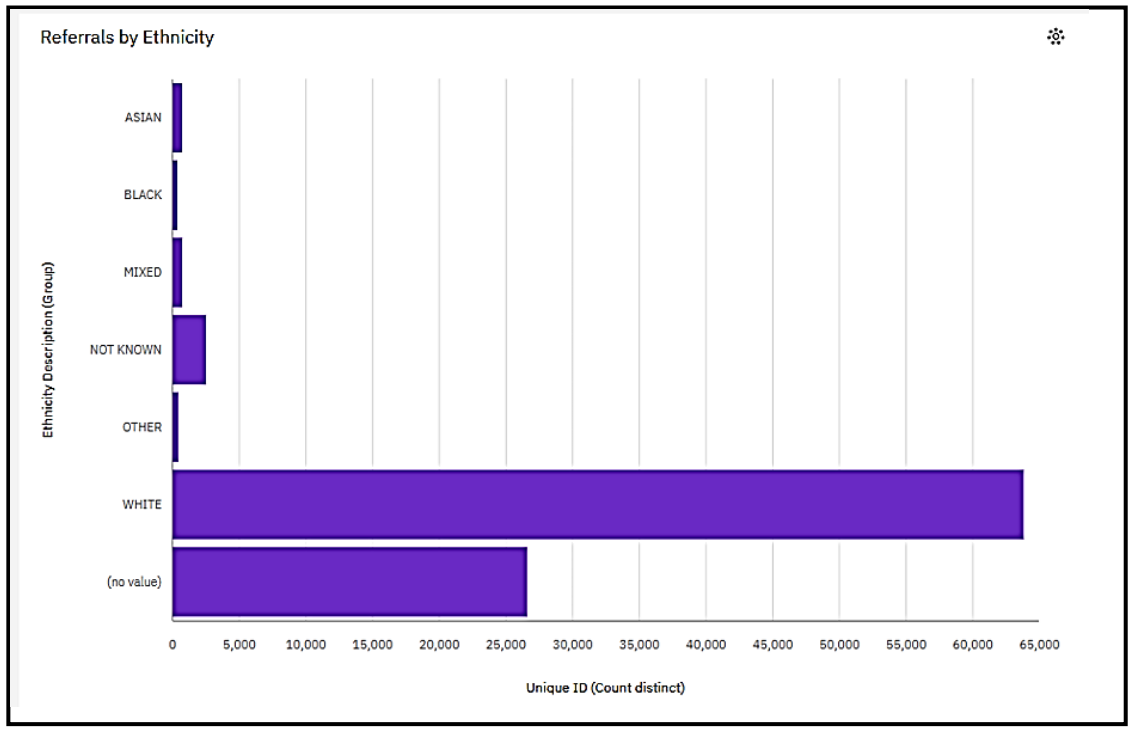
7. Population health, prevention and reducing inequality

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

Ethnicity – Referrals and Admissions (TRUST)

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.

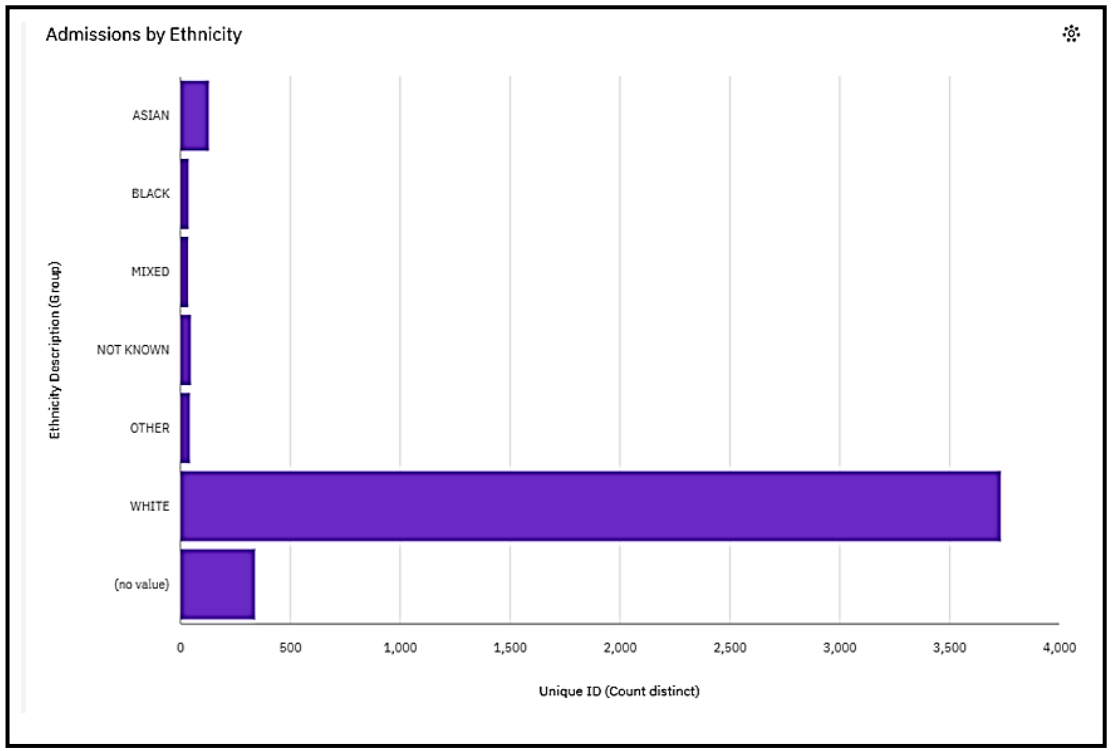


*** NOTE: No Value –** No ethnicity recorded

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

Admissions: Ethnicity recorded for the first Referral within the Patient Journey within the given period. Data is included from 01/09/2025 onwards

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



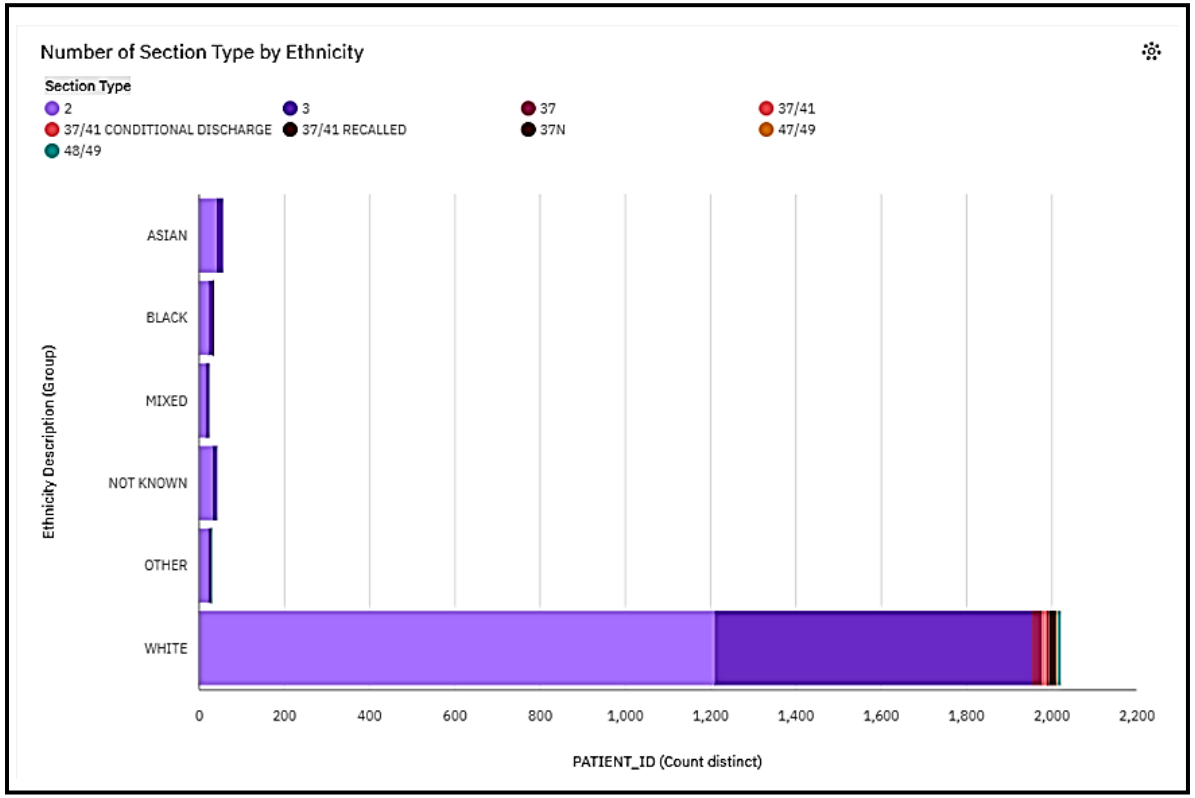
*** NOTE: No Value –** No ethnicity recorded

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

Ethnicity – Mental Health Act (TRUST)

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

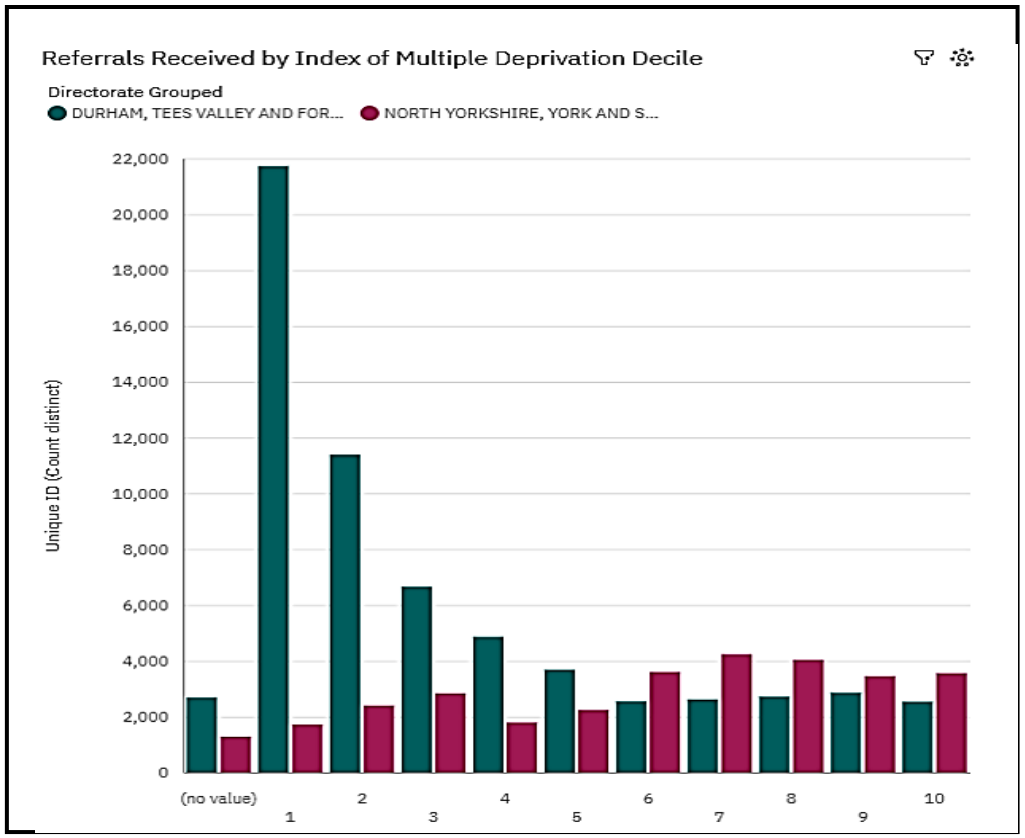


- Future data sets to include detention by population rate and will be reported quarterly to track any changes.
- A Patient & Carer Race Equality Framework team action plan template has been cascaded to teams for completion.

Deprivation Decile (Code) – Referrals and Admissions (TRUST)

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 disproportionally impacted by financial hardship.
- The Trust serves some of the most deprived communities in the country. This is reflected in referrals with significantly higher numbers of referrals in Durham Tees Valley coming from the 10% most deprived communities. This pattern cannot be seen in North Yorkshire, York and Selby reflecting overall population differences.

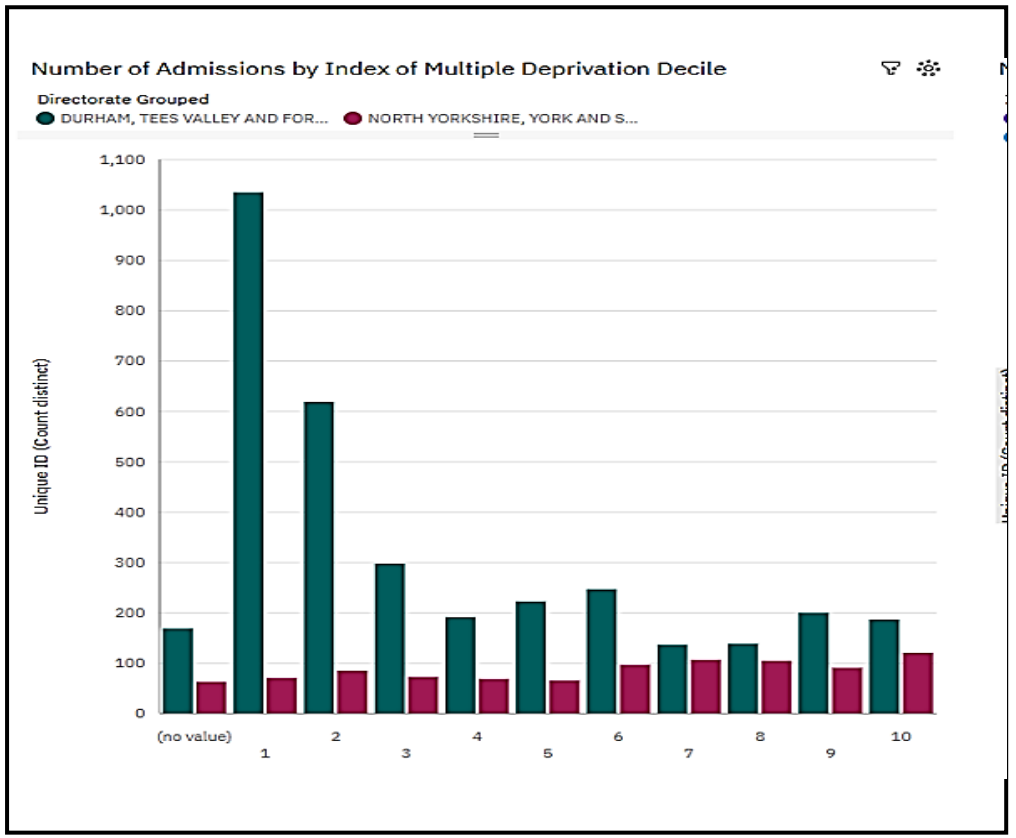


*** NOTE: No Value –** No corresponding deprivation decile available for the given postcode

Within the personalising care agenda we are considering accessibility for people experiencing multiple disadvantage including how to "Poverty Proof" © our service pathways overseen by the sickness to prevention programme board.

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



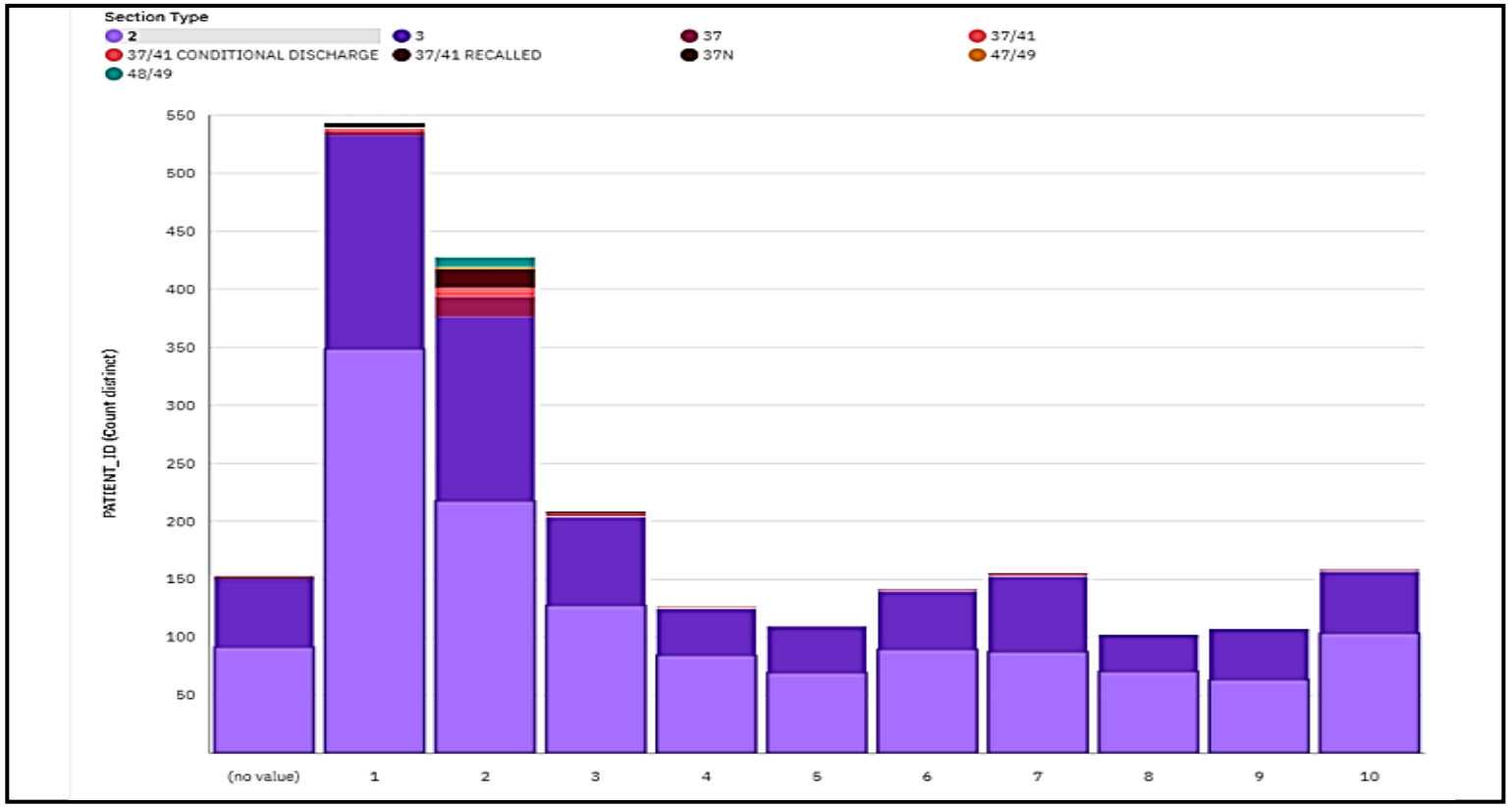
*** NOTE: No Value –** No correspondin g deprivation decile available for the given postcode

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

Deprivation Decile (Code) – Mental Health Act (TRUST)

Mental Health Act: Deprivation Decile (associated with the earliest recorded postcode) recorded once per patient per section type in given period (distinct count). 1 = Most Deprived, 10 = Least Deprived. Data is included from 01/10/2025 onwards

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



*** 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%	93.49%	93.29%	✓
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC	H	?	75.00%	82.42%	82.86%	✓
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	73.11%	75.00%	✓
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	H	P	35.00%	64.99%	64.56%	✓
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC		F	55.00%	45.13%	46.18%	✓
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	P	50.00%	63.12%	61.65%	✓
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC	H	F	30.00%	27.22%	28.49%	✓
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC	L	F	85.00%	88.79%	89.12%	✓

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	H			14.17%	14.17%	
10)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC		?	0	0	0	✓
11)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				1	6	✓✓
12)	The number of Incidents of moderate or severe harm	QAC	H			24	91	✓
13)	The number of Restrictive Interventions Used	QAC	H			1,386	5,266	✓✓
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	1	✓✓
15)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC	L			0	0	✓✓
16)	The number of uses of the Mental Health Act	MHLC				207	1,100	✓

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 August 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% (Jul-2026)	
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	56.63%	57.39% (Jul-2026)	
19)	Staff Leaver Rate	PCDC	L	P	11.00%	9.35%	9.35%	
20)	Percentage Sickness Absence Rate (month behind)	PCDC	H	F	5.50%	8.27%	7.57%	
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC	H	P	85.00%	93.34%	93.34%	
22)	Percentage of staff in post with a current appraisal	PCDC		P	85.00%	88.71%	88.71%	

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				5,010	26,813	
24)	Unique Active Caseload (Snapshot)	RPC	L			37,912	37,912	

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	120,820,988	122,549,335	
26)	Agency Expenditure	RPC	817,988	1,182,328	
27)	Agency price cap compliance	RPC	67.00%	26.32%	
28)	Bank Expenditure	RPC	4,713,337	5,619,085	

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%	92.69%	93.89%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	80.00%	83.76%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	60.53%	71.07%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	H	P	35.00%	71.87%	72.27%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient	QAC	L	F	55.00%	39.60%	42.19%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	P	50.00%	64.58%	62.78%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinicia	QAC	H	F	30.00%	25.76%	26.29%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	90.79%	88.42%	

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	H			27.12%	27.12%	
10)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC	L		0	0	0	
11)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				0	2	
12)	The number of Incidents of moderate or severe harm	QAC				12	31	
13)	The number of Restrictive Interventions Used	QAC				100	611	
14)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	1	
15)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	1	
16)	The number of uses of the Mental Health Act	MHLC				118	536	

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 August 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% (Jul-2026)	✓
18)	Percentage of staff feeling they are able to make improvements happen in their area of work	PCDC			65.00%	60.53%	57.14% (Jul-2026)	✓
19)	Staff Leaver Rate	PCDC	L	F	11.00%	11.92%	11.92%	✓
20)	Percentage Sickness Absence Rate (month behind)	PCDC	H		5.50%	6.64%	5.87%	✓✓
21)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC	H	P	85.00%	92.96%	92.96%	✓✓
22)	Percentage of staff in post with a current appraisal	PCDC	H		85.00%	89.55%	89.55%	✓✓

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				2,361	13,251	✓
24)	Unique Active Caseload (Snapshot)	RPC	H			12,579	12,579	

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	49,961,952	50,565,482	✓✓
26)	Agency Expenditure	RPC	674,069	622,780	✓
27)	Agency price cap compliance	RPC	67.00%	57.93%	✓
28)	Bank Expenditure	RPC	721,660	1,268,245	

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.*

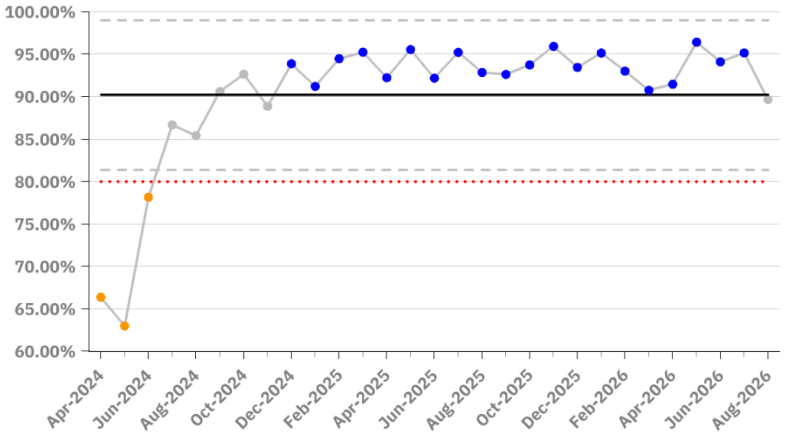
9. National metrics

National Quality Requirements

Rep Ref	National Quality Requirements	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26	May-26	Jun-26	Jul-26	Aug-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		P	80.00%	80.00%	93.41%	91.48%	96.43%	94.12%	95.17%	89.67%
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%	77.17%	86.96%	82.05%	78.57%	67.44%	73.08%
IIC6570	The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	L	P	75.00%	75.00%	91.51%	95.53%	93.77%	90.08%	89.93%	88.17%
IIC6560	The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period		P	95.00%	95.00%	99.94%	99.86%	99.92%	100.00%	99.92%	100.00%
IIC5340	Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)		F	95.00%	95.00%	90.24%	86.74%	86.48%	87.20%	89.08%	90.24%
IIC5350	Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)	H	F	95.00%	95.00%	84.21%	78.69%	80.33%	80.70%	83.93%	84.21%

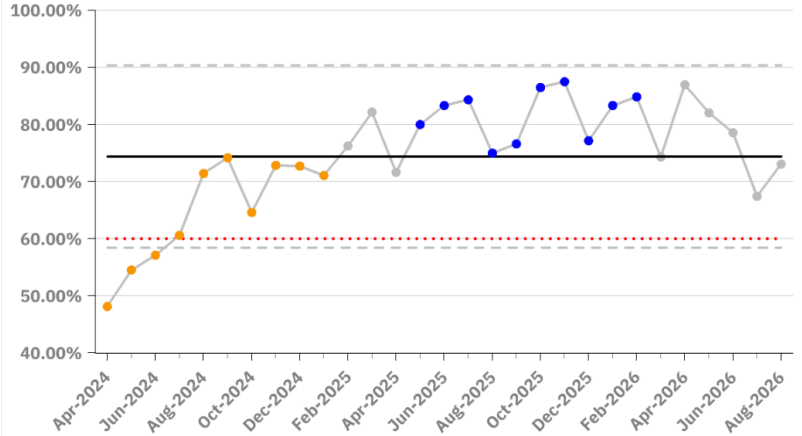
National Quality Requirements

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



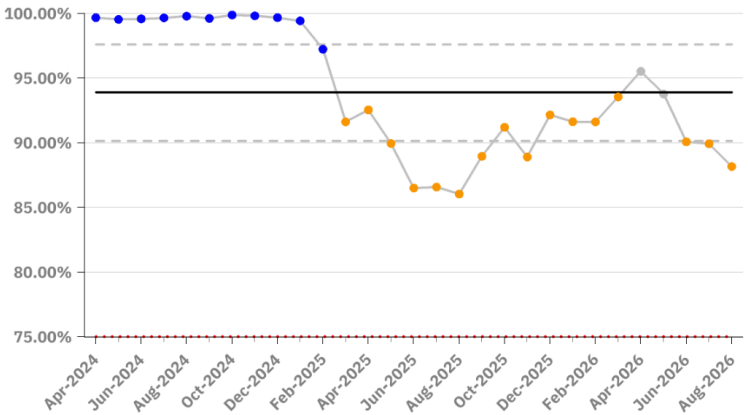
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	80%	93.41%			
COUNTY DURHAM	80%	96.04%			
TEES VALLEY	80%	93.81%			
NORTH YORKSHIRE	80%	95.13%			
YORK	80%	93.33%			

IIC5270 Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care - TRUST



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	60%	77.17%			
COUNTY DURHAM	60%	81.40%			
TEES VALLEY	60%	81.95%			
NORTH YORKSHIRE	60%	83.93%			
YORK	60%	34.21%			

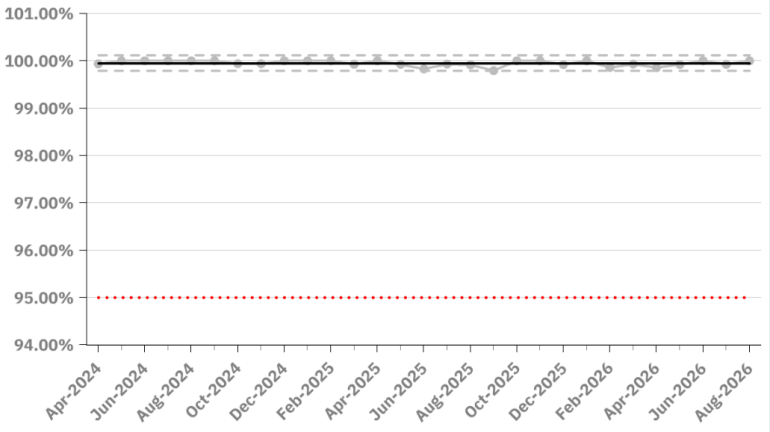
IIC6570 The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - TRUST



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	75%	91.51%			
COUNTY DURHAM	75%	94.95%			
TEES VALLEY	75%	95.23%			
NORTH YORKSHIRE	75%	84.87%			
YORK	75%	94.58%			

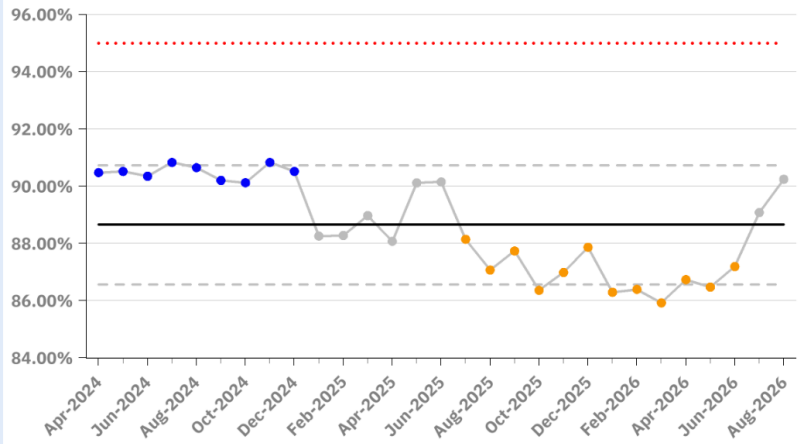
National Quality Requirements

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



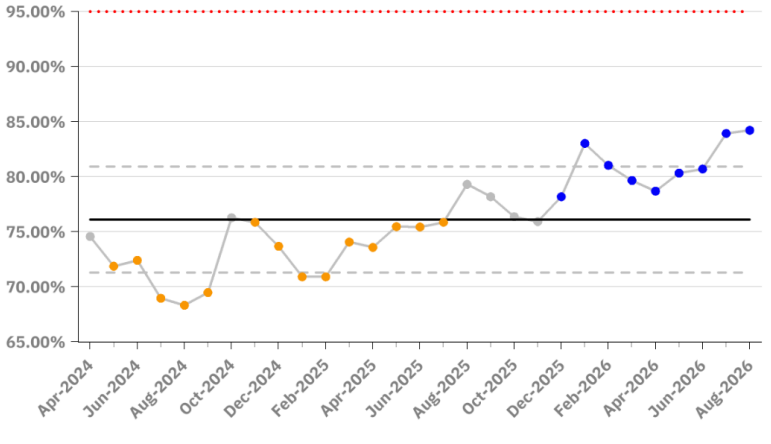
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	99.94%			
COUNTY DURHAM	95%	99.92%			
TEES VALLEY	95%	99.60%			
NORTH YORKSHIRE	95%	100.00%			
YORK	95%	100.00%			

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



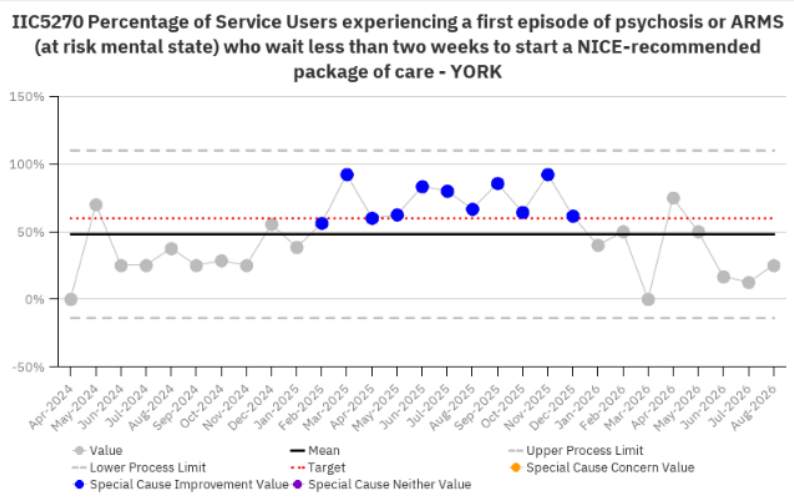
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	90.24%			
COUNTY DURHAM	95%	87.74%			
TEES VALLEY	95%	95.92%			
NORTH YORKSHIRE	95%	94.83%			
YORK	95%	66.67%			

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



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	84.21%			
COUNTY DURHAM	95%	100.00%			
TEES VALLEY	95%	91.67%			
NORTH YORKSHIRE	95%	58.82%			
YORK	95%	83.33%			

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



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

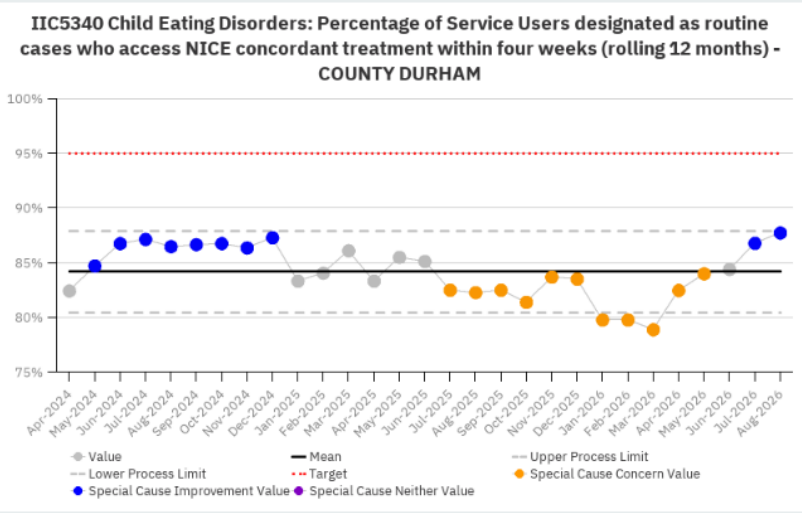
What does the chart show/context:
In August 2026, there were 12 patients referred experiencing First Episode Psychosis, of which **3 (25.00%)** received an approved care package within 2 weeks in **York**.

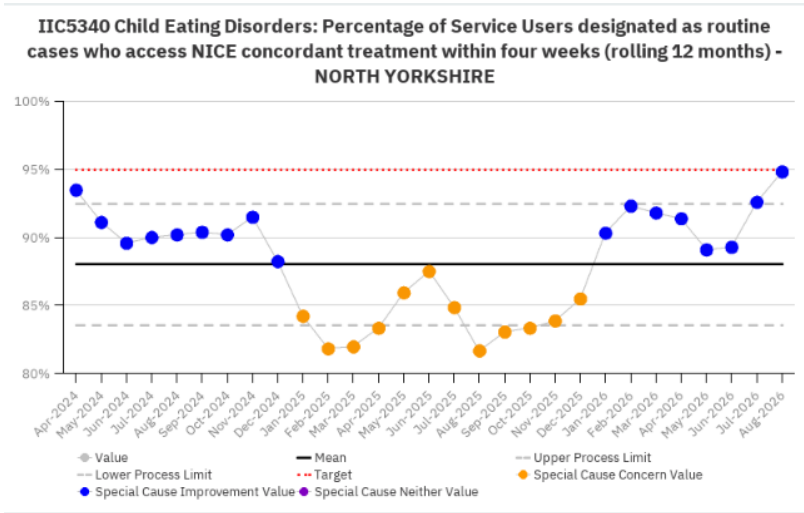
Of the 9 patients that did not receive treatment within the standard:
- 7 patients were offered appointments (outside 2 weeks) due to team capacity
- 1 patient was offered appointment (outside 2 weeks) due to a joint assessment required with CAMHS
- 1 patient was offered assessment (outside 2 weeks) due to patient choice.

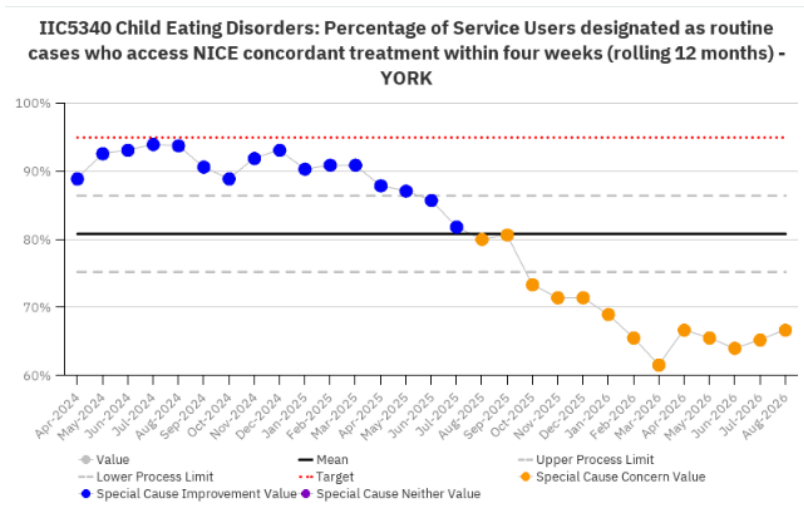
Underlying issues:
- Capacity within the York & Selby EIP team is currently impacted by vacancies and maternity leave

Actions:
As a Service Requiring Additional Support, the York & Selby EIP Team has implemented its recovery plan and successfully filled all substantive vacancies. Progress in reducing the backlog of patients awaiting treatment has been delayed as newly recruited care coordinators are awaiting professional registration PINs before they can hold caseloads. PINs are expected to be received in September 2026, with improvements in waiting list performance anticipated from the end of September 2026.

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







Background / standard description:
We are aiming to have 95% of suspected eating disorder cases for routine referrals seen within 4 weeks from referral to start of NICE approved treatment.

What does the chart show/context:
In the rolling 12 months ending August 2026, there were **106** children and young people with a routine referral, of which **93 (87.74%)** started treatment within 4 weeks in **County Durham**.

In August 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 August 2026, there were **58** children and young people with a routine referral, of which **55 (94.83%)** started treatment within 4 weeks in **North Yorkshire**.

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

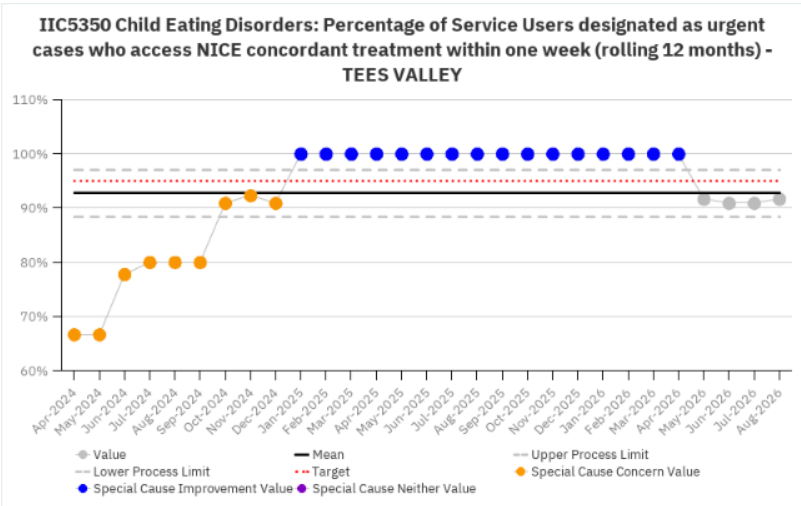
What does the chart show/context:
In the rolling 12 months ending August 2026, there were **21** children and young people with a routine referral, of which **14 (66.67%)** started treatment within 4 weeks in **York**.

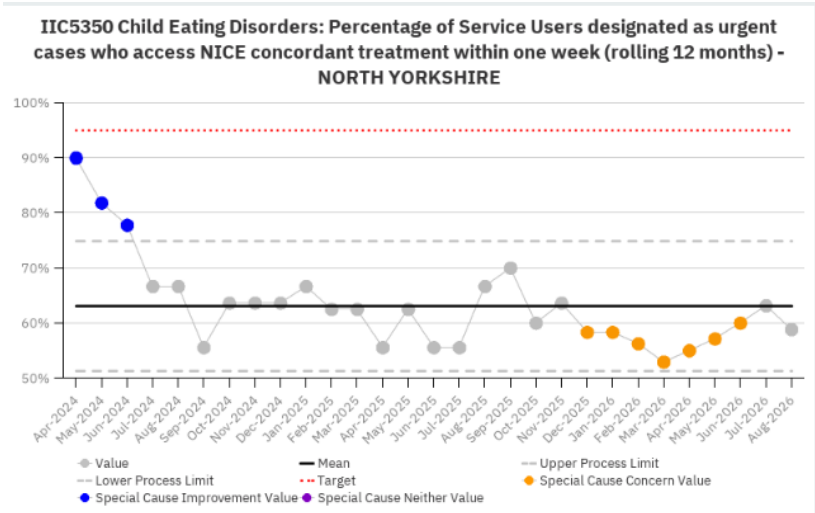
In August, there were **2** children and young people with a routine referral; both (100%) started treatment within 4 weeks.

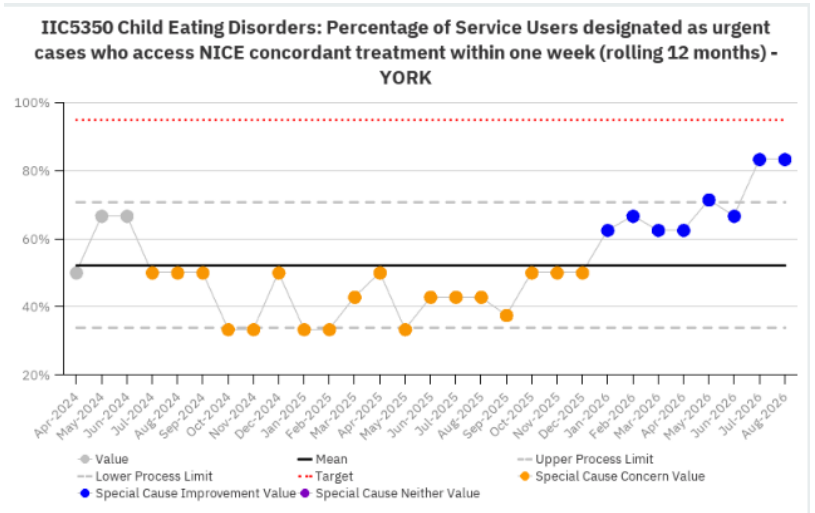
Underlying Issues:
There are no underlying issues to report.

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. **(Complete)**

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 August 2026 there were **12** children or young people with an urgent referral, of which **11 (91.67%)** started treatment within 1 week in **Tees Valley.**

In August, 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 August 2026 there were **17** child or young people with an urgent referral, of which **10 (58.82%)** started treatment within 1 week in **North Yorkshire**.

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

Underlying Issues:
There are no underlying issues to report.

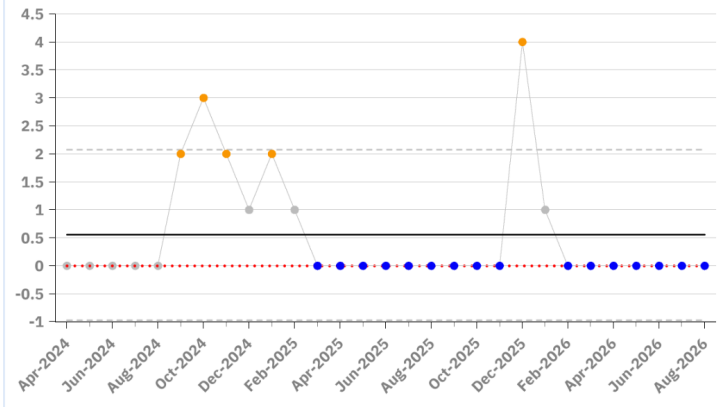
Trust-wide Actions:
Following agreement at the Combined Care Group Board in July 2026, Directors of Operations will submit the service improvement plan, including agreed actions and improvement trajectories from the service deep dive, to the Executive Directors Group in August 2026 for approval. **(Complete)**

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	Aug-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	0
IIC6950	Average length of stay for patients in Adult Acute and PICU Mental Health Beds (Rolling Quarter)			26.40	26.46	28.75	30.12	29.48	30.11	30.59	28.75
IIC6960	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (Rolling Quarter)			70.00	70.12	77.10	70.12	72.30	74.27	76.71	77.10
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	61	725	340	257	73	61

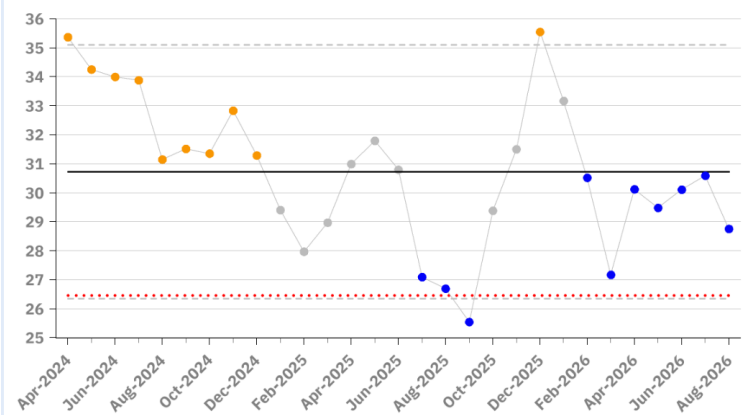
Mental Health Priorities – Provider and System-wide plans

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



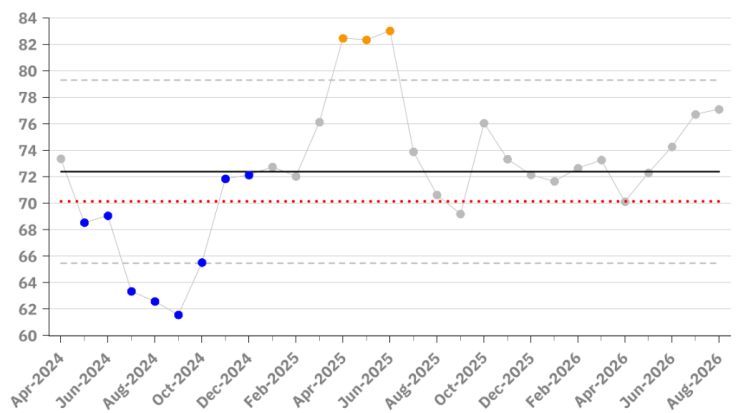
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	0	0			✓
COUNTY DURHAM	0	0			✓
TEES VALLEY	0	0			✓
NORTH YORKSHIRE	0	0			✓
YORK	0	0			✓

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



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	26.46	28.75			✗
COUNTY DURHAM		33.31			
TEES VALLEY		31.97			
NORTH YORKSHIRE		23.40			
YORK		25.67			

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	70.12	77.10			✗
COUNTY DURHAM		55.48			
TEES VALLEY		93.51			
NORTH YORKSHIRE		82.49			
YORK		79.00			

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	61			✓
COUNTY DURHAM		46			
TEES VALLEY		14			
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)

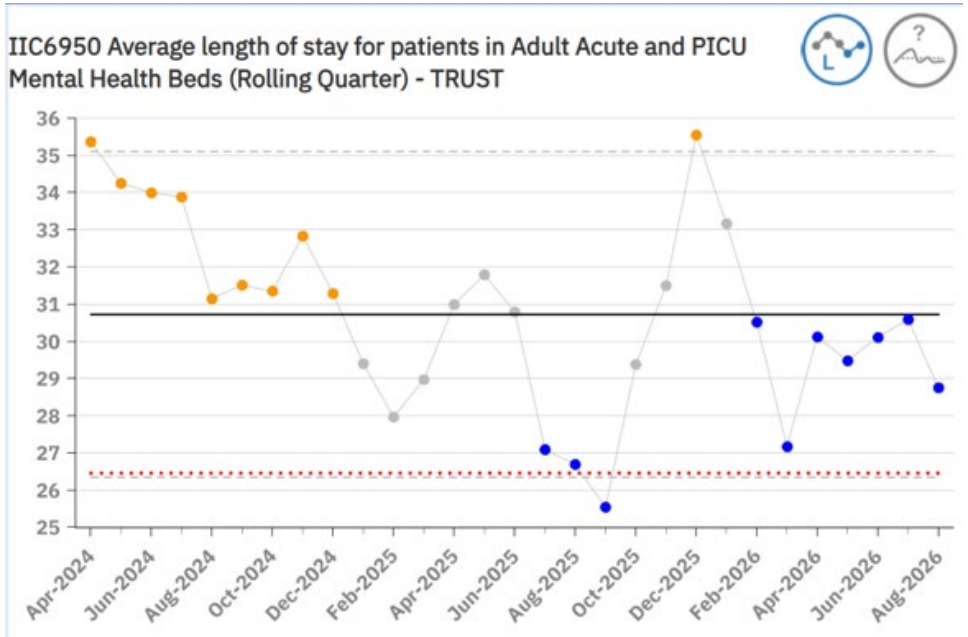
Background / standard description:
We are aiming to reduce our average length of stay within our adult acute and PICU inpatient beds to 26.46 by the end of August 2026.

What does the chart show/context:
During the 3-month period ending August 2026, there were **605** discharged hospital spells from adult acute or PICU beds for patients aged 18+, accounting for a total of **17,396** bed days which equates to an average length of stay of **28.75** days.

We are not achieving plan at Trust and Care Group level; however, there is special cause improvement 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 August 2026 there were 170 (out of 605) patients with a length of stay exceeding plan; 23 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	28.75							

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

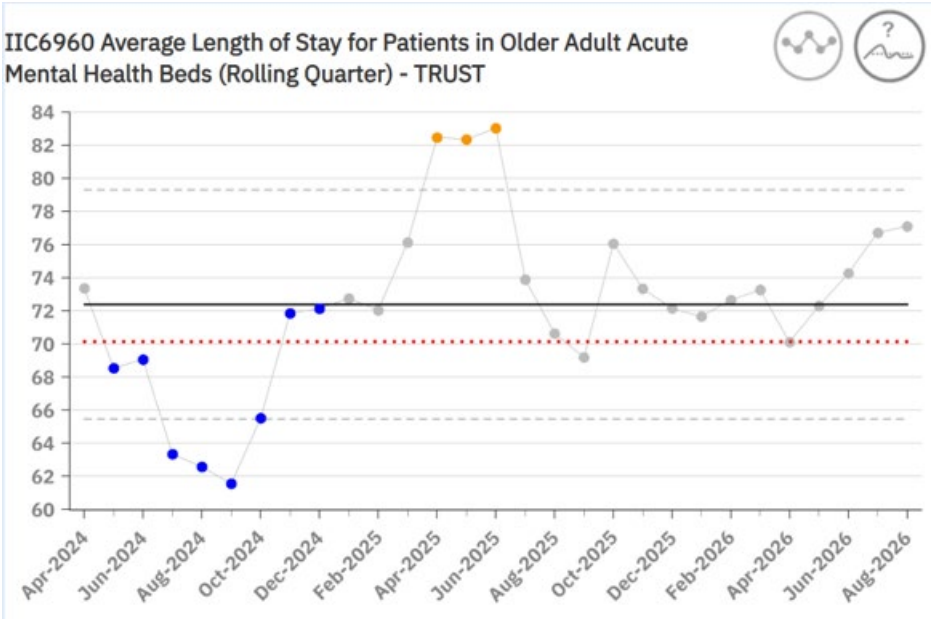
Background / standard description:
We are aiming to reduce our average length of stay within our older adult acute inpatient beds to 70.12 days by the end of August 2026.

What does the chart show/context:
During the 3-month period ending August 2026, there were **163** discharged hospital spells from older adult acute beds, accounting for a total of **12,567** bed days which equates to an average length of stay of **77.10** 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 August 2026 there were 69 (out of 163) patients with a length of stay exceeding plan; 44 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	77.10							

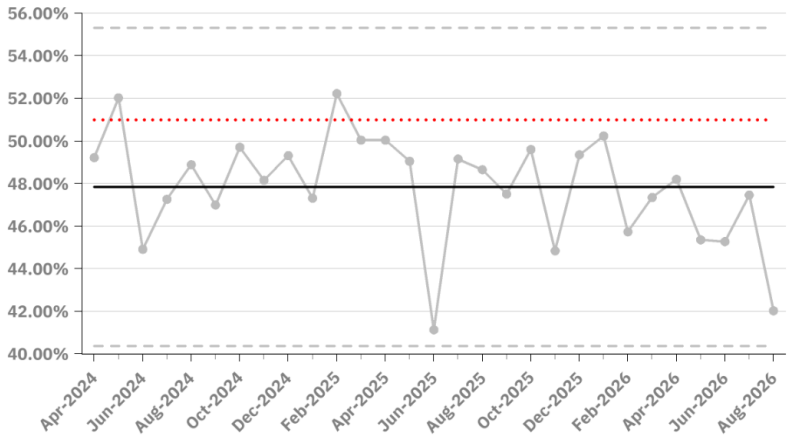
Mental Health Priorities – System-Wide Plans

Rep Ref	Mental Health Priorities - System-wide Plans	Variation	Assurance	Annual Standard	Standard (FYTD)	Actual (FYTD)	Apr-26	May-26	Jun-26	Jul-26	Aug-26
IIC6490	Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness			51.00%	51.00%	45.69%	48.20%	45.36%	45.28%	47.46%	42.03%
IIC6480	Talking Therapies - Reliable improvement rate for those completing a course of treatment			69.00%	69.00%	65.72%	67.46%	65.76%	65.67%	66.49%	63.13%
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	6,713	1,386	1,285	1,401	1,331	1,310
IIC5371	Number of women accessing (1+ contact) specialist community PMH services in the previous 12 months		N/A	Data Only	Data Only	1,480	1,504	1,494	1,496	1,491	1,480
IIC6610	Number of people accessing IPS services (rolling 12 month)		N/A	Data Only	Data Only	1,460	1,199	1,245	1,329	1,387	1,460
IIC5831	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact		N/A	Data Only	Data Only	28,787	30,102	29,775	29,409	29,009	28,787
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	2,144	1,990	2,014	2,057	2,109	2,144

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. 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.

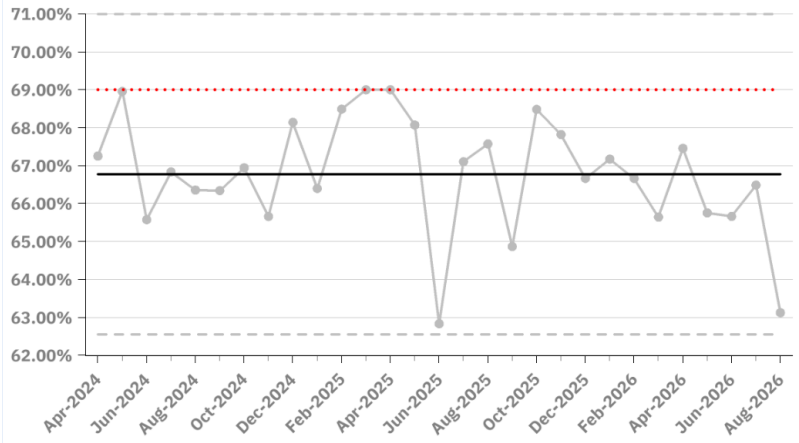
Mental Health Priorities – System Wide Plans

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



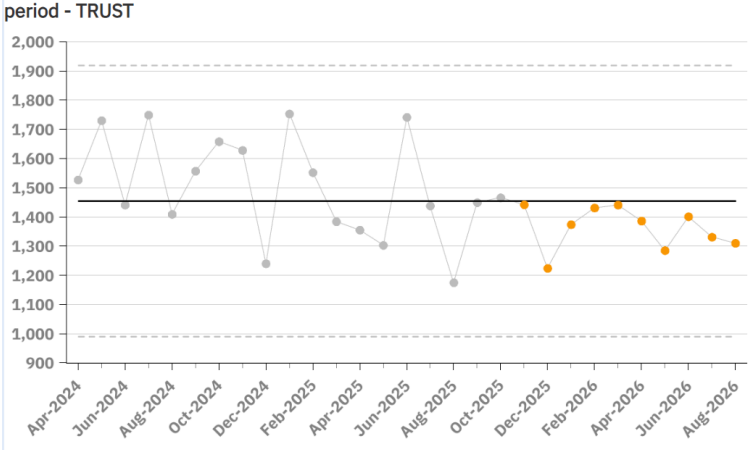
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	51%	45.69%			
COUNTY DURHAM	51%	42.37%			
TEES VALLEY	51%	45.22%			
NORTH YORKSHIRE	51%	46.90%			
YORK	51%	50.04%			

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



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	69%	65.72%			
COUNTY DURHAM	69%	63.56%			
TEES VALLEY	69%	65.01%			
NORTH YORKSHIRE	69%	66.97%			
YORK	69%	68.13%			

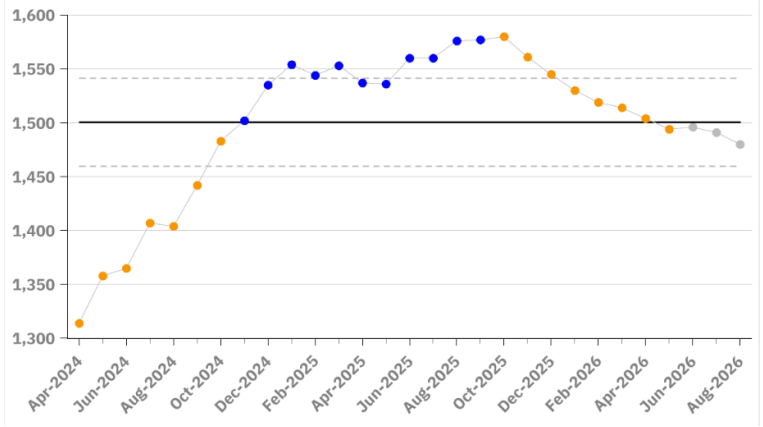
IIC6640 Talking Therapies: Number of people who are discharged having received at least 2 treatment appointments in the reporting period - TRUST



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		6,713			
COUNTY DURHAM		2,574			
TEES VALLEY		503			
NORTH YORKSHIRE		2,228			
YORK		1,365			

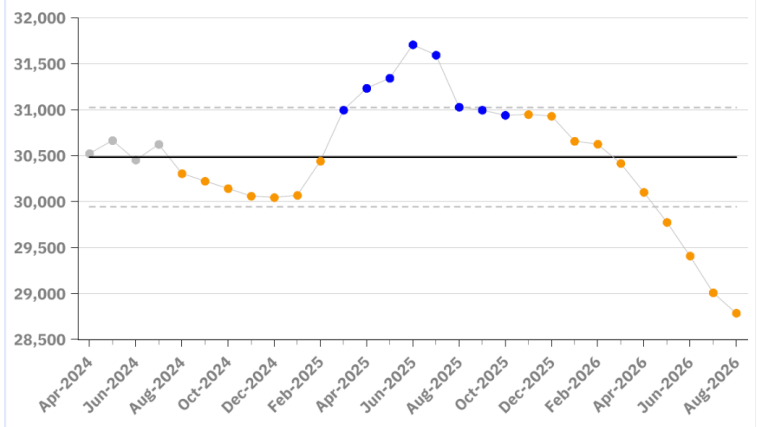
Mental Health Priorities – System-Wide Plans

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



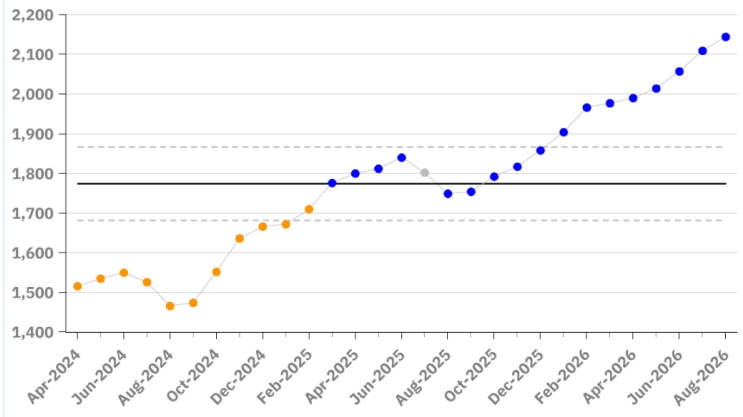
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,480			
COUNTY DURHAM	456	396			
TEES VALLEY	447	501			
NORTH YORKSHIRE	368	405			
YORK	156	156			

IIC5831 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		28,787			
COUNTY DURHAM		9,920			
TEES VALLEY		9,151			
NORTH YORKSHIRE		5,663			
YORK		3,471			

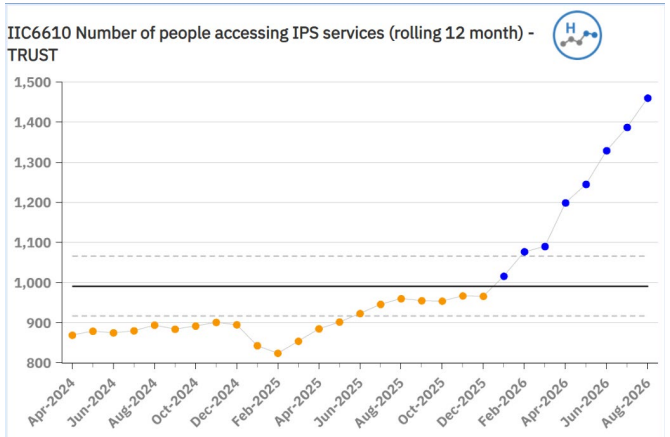
IIC7000 Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact with an MHST (Rolling 12 Month) - TRUST



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		2,144			
COUNTY DURHAM		1,024			
TEES VALLEY		363			
NORTH YORKSHIRE		473			
YORK		223			

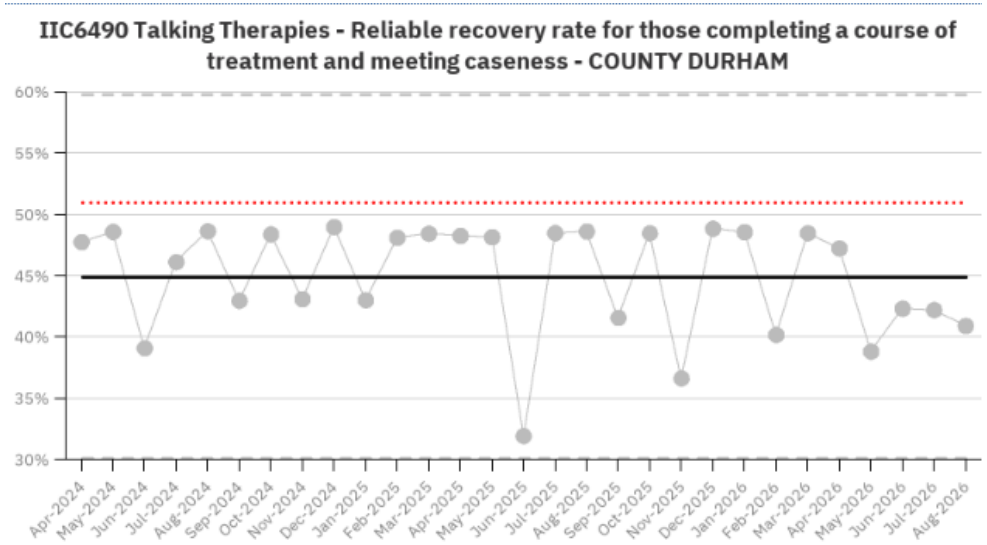
Please note that the variation for Trust and County Durham place has been removed due to several issues that we have identified. All practicable actions have been undertaken. A briefing note is in development to support understanding of the issues identified, the implications for the rolling metric,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

Mental Health Priorities – System-Wide Plans



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,460			
COUNTY DURHAM		469			
TEES VALLEY		566			
NORTH YORKSHIRE	380	257			
YORK		116			

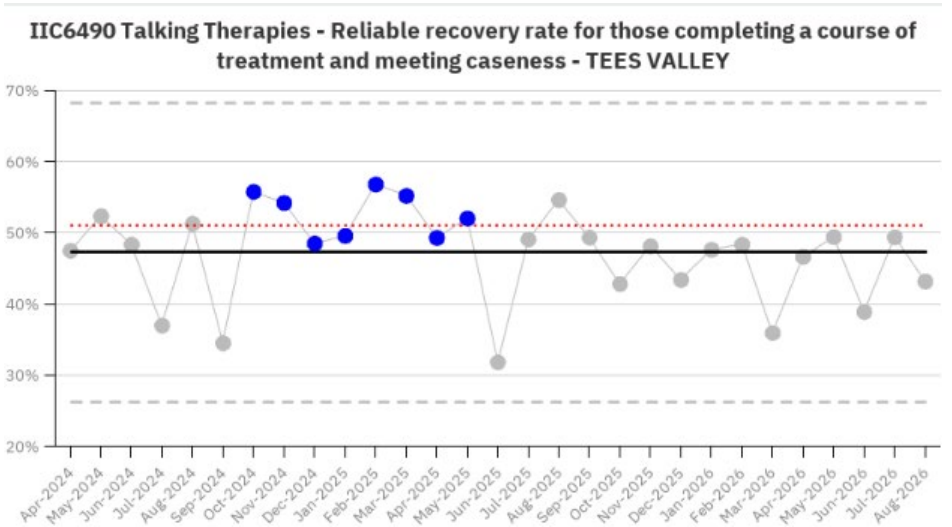
Talking Therapies: Reliable recovery rate for those completing a course of treatment – *by exception*



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 **42.37%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **County Durham**. During August, **40.92%** demonstrated reliable recovery.

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



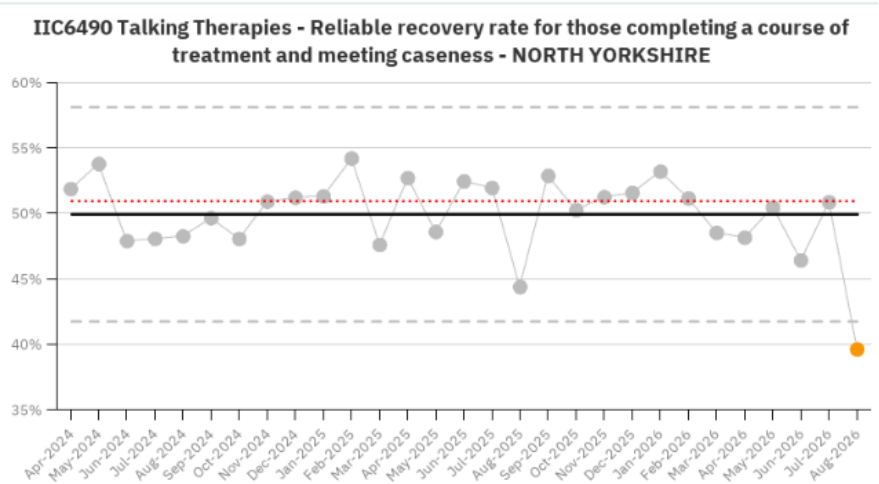
Background / standard description:
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:
Financial year to date **45.22%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **Tees Valley**. During August, **43.21%** demonstrated reliable recovery.

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

For underlying issues and action, please see page 88

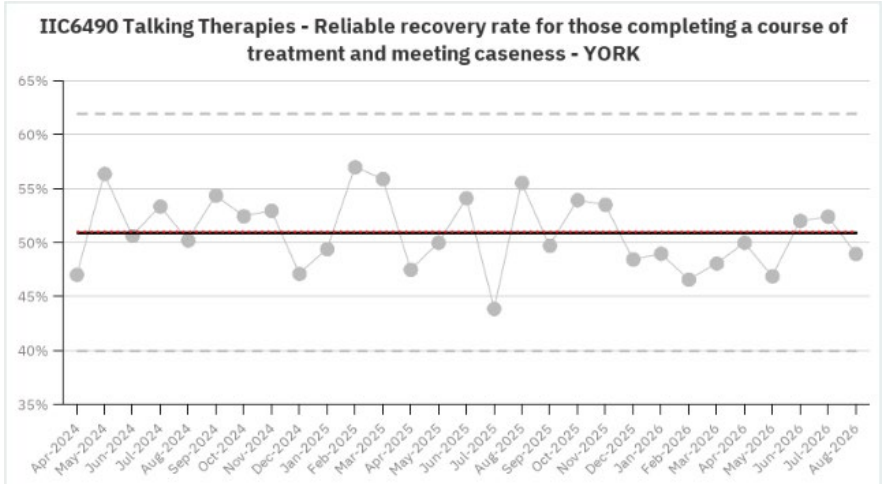
Talking Therapies: Reliable recovery rate for those completing a course of treatment – *by exception*



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 **46.90%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **North Yorkshire**. During August, **39.62%** demonstrated reliable recovery.

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



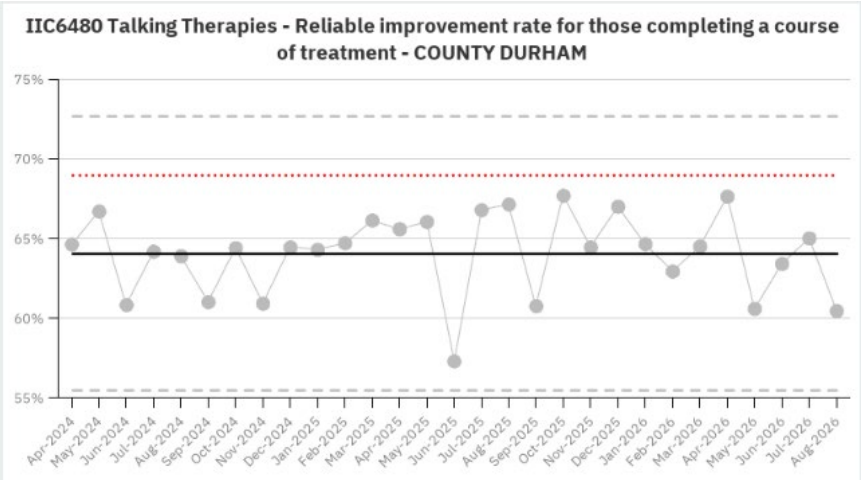
Background / standard description:
We are aiming for 51% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:
Financial year to date **50.04%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **York**. During August, **48.97%** demonstrated reliable recovery.

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

For underlying issues and action, please see page 88

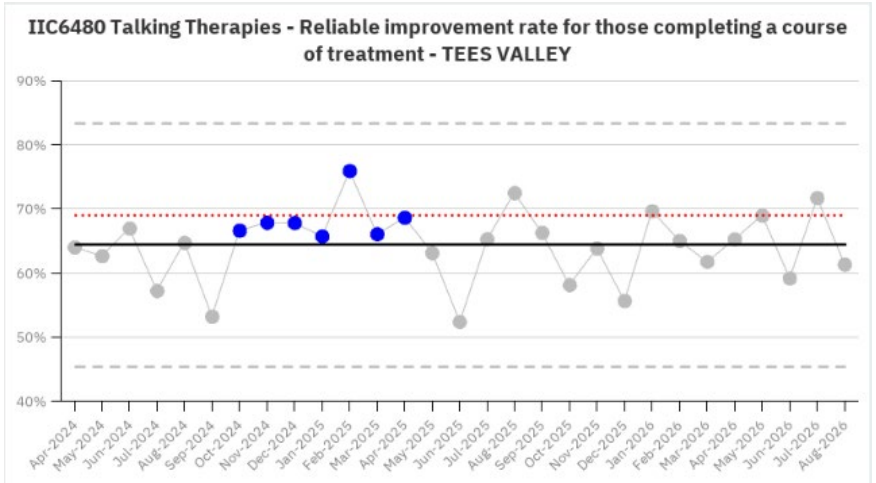
Talking Therapies: Reliable improvement rate for those completing a course of treatment – *by exception*



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

What does the chart show/context:
Financial year to date **63.56%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**. During August, **60.47%** demonstrated reliable improvement.

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



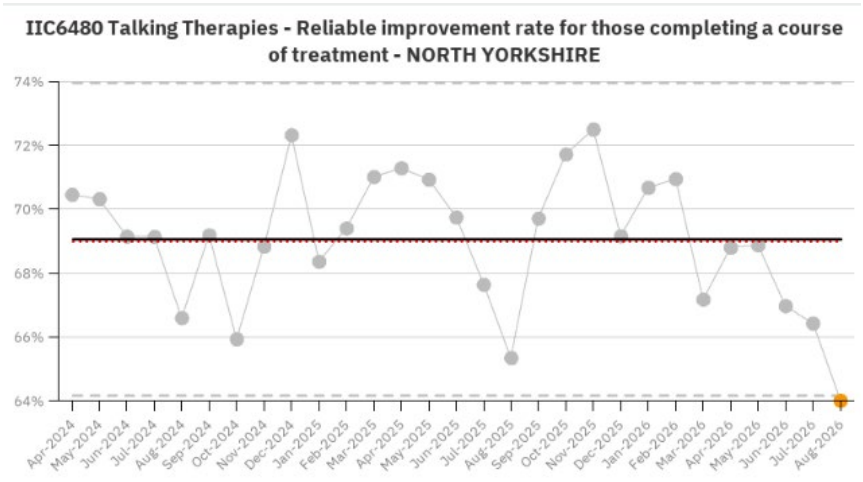
Background / standard description:
We are aiming for 69% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
Financial year to date **65.01%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**. During August, **61.36%** demonstrated reliable improvement.

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

For underlying issues and action, please see page 88

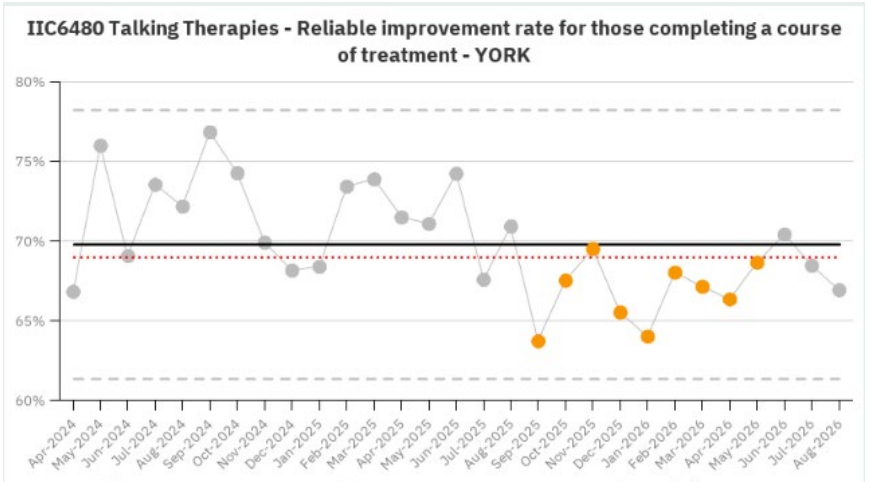
Talking Therapies: Reliable improvement rate for those completing a course of treatment – *by exception*



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 **66.97%** of patients demonstrated reliable improvement following completion of a course of treatment within **North Yorkshire**. During August**, 64.01%** 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 **68.13%** of patients demonstrated reliable improvement following completion of a course of treatment within **York**. During August, **66.93%** demonstrated reliable improvement.

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

For underlying issues and action, please see page 88

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

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 Service Manager will recruit to 4.1 PWP staffing vacancies by the end of December 2026; 2 will be appointed as soon as possible following vacancy control approval, the remaining 2.1 will be filled by trainees who complete their training in December.
- Mental Health Matters will recruit to 1.7 PWP staffing vacancies by the end of September 2026. In addition, the service has been allocated 2 trainee PWP places for 2027/28.
- The DTVFCG Performance Improvement Plan had 6 actions due for completion by July 2026, of which 5 have been completed. The remaining action was to implement KOA Step 3 Therapy. **(On Hold)** *See below*
- Following the ICB commissioning the implementation of Dr Julian, a digital therapy offer, the Talking Therapies service will meet with the ICB and Dr Julian representatives in September to explore the offer, with implementation scheduled for completion by the 31st October.
- The General Manager submitted a workforce and financial gap analysis paper to EDG in July 2026, seeking additional staffing investment. EDG will now revisit the proposal and confirm required actions by the end of October 2026.
- By the end of September, the Clinical Lead and Service Manager will develop an options appraisal paper which will identify improvement actions in relation to reliable recovery and reliable improvement.

North Yorkshire & York

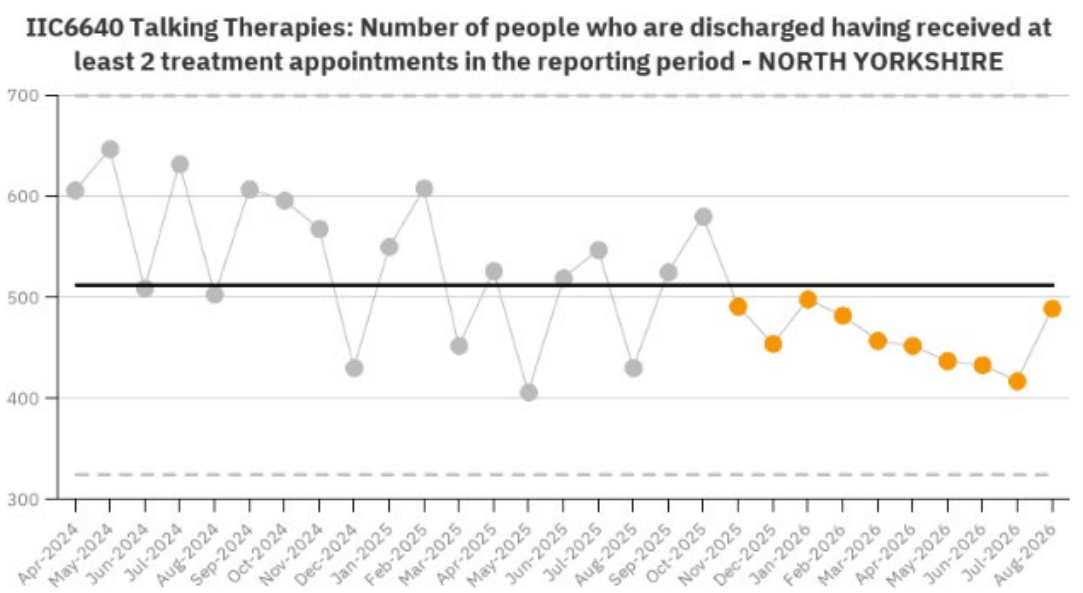
Underlying issues:

- The complexity and severity of patients within the North Yorkshire Talking Therapies teams
- Additional root causes of the reported performance positions 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:

- 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.

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



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

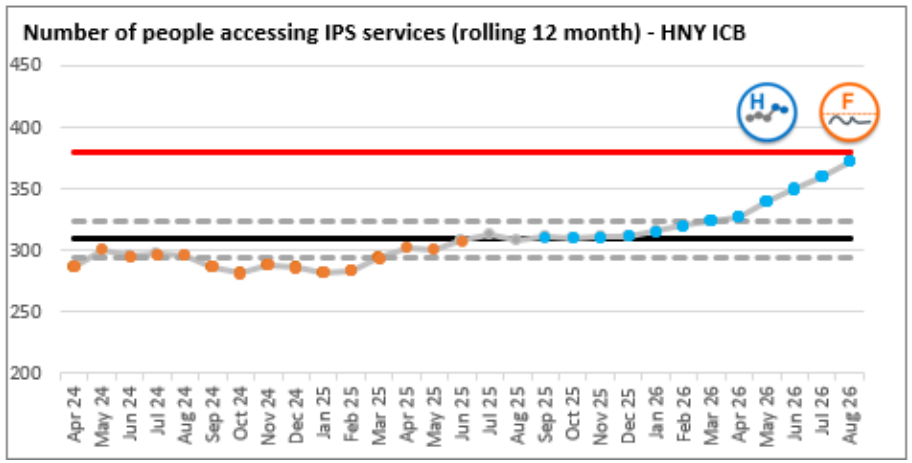
What does the chart show/context:
Financial year to date **2,228** patients discharged having received at least 2 treatment appointments in the report period within **North Yorkshire**. During August, **489** patients received at least 2 treatment appointments.

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. (*See following action)*
- From the 1st October, assessment capacity will be converted back to treatment capacity as a stepped approached, initially focusing on Guided Self Help & Step 3 treatments.

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



Background / standard description:
In the 12 months ending August 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 August 2026, **373** people accessed IPS services.

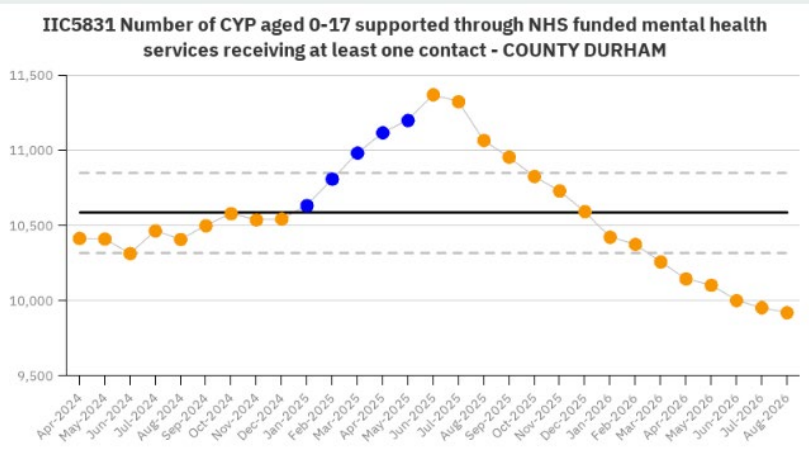
HNY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TEWV- Ambition	380	380	380	380	380	380	384	385	434	466	501	536
TEWV- Actual	327	340	350	360	373							

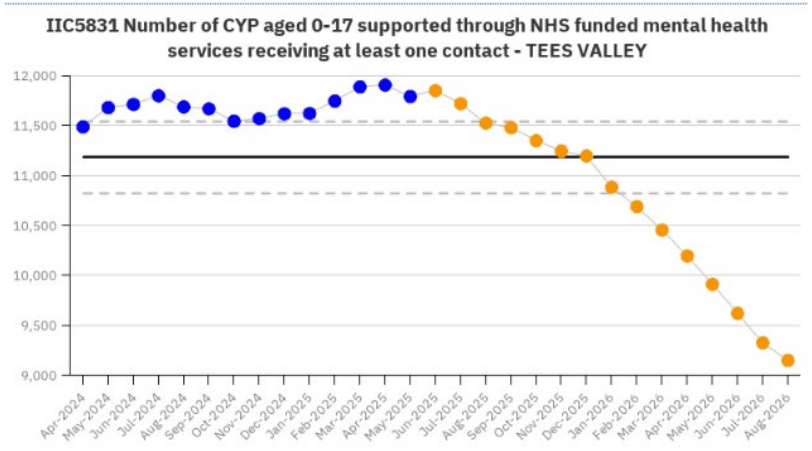
Underlying issues:
A short-term reasonable adjustment package is in place, reducing the workforce by 0.4 Employment Specialist.

Actions:
The Employment Specialist hours will be filled following review of the reasonable adjustment package.

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 will commence by the end of 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 August, **9,920** children and young people received at least one contact within **County Durham**.

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

What does the chart show/context:
In the rolling 12 months ending August **9,151** children and young people received at least one contact within **Tees Valley**.

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

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

Country Durham

Underlying issues:

- High levels of sickness and vacancies for sustained periods in teams that have been identified as Services Requiring Additional Support
- The root causes of the reported position for several teams has not yet been fully established

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 **(Complete)**
- Single Point of Access, South Durham Community and the Crisis Team have been identified as Services Requiring Additional Support due to capacity and demand concerns. A recovery plan is in place and actions are progressing.
- The General Manager has submitted an information request to Business Intelligence to try and better understand the underlying issues for several teams.

Tees Valley

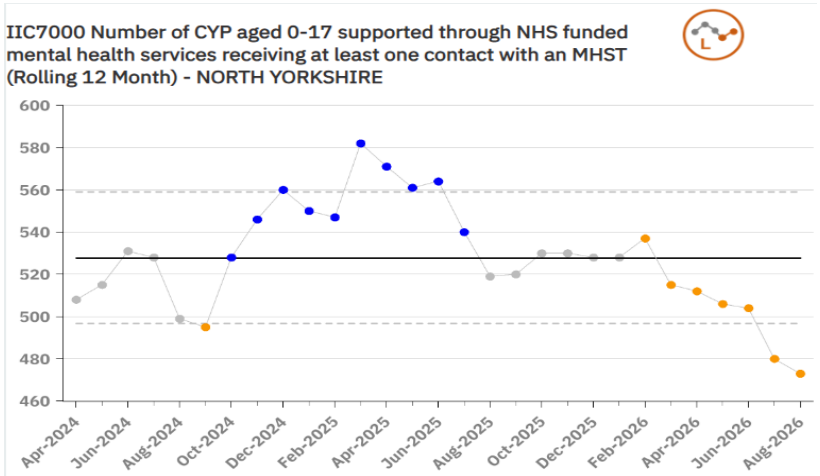
Underlying issues:

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:

There are no specific improvement actions required.

Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact with an MHST (Rolling 12 Month)



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 **August 2026**, there were **473** children with at least one contact with an MHST in **North Yorkshire.**

There is special cause concern within in this reporting period in **North Yorkshire.**

Underlying issues:
The reduction in children receiving at least one contact is due to vacancies within the Hambleton and Richmondshire (H&R) MHST team and reduced capacity in Harrogate, where staff are supporting Hambleton and Richmondshire services.

Actions:
By September 2026, the MHST Service Manager will advertise Senior EMHP and Psychologist posts, with 5 EMHP trainees already in post within the H&R team to strengthen capacity and support service improvement.

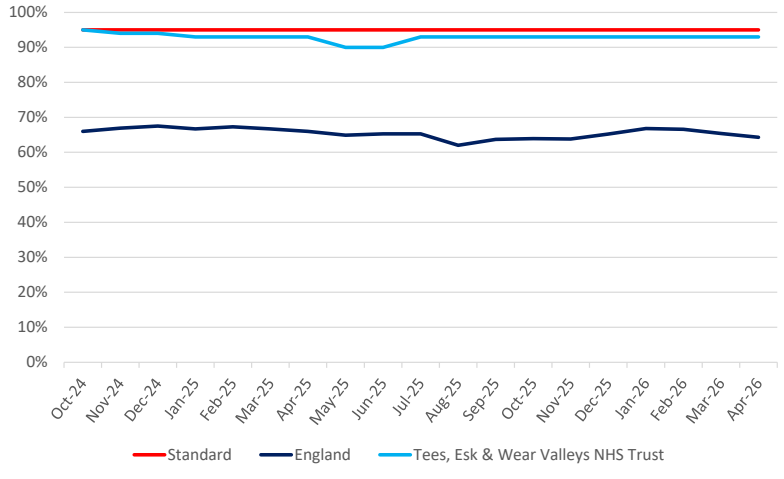
10. Benchmarking

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

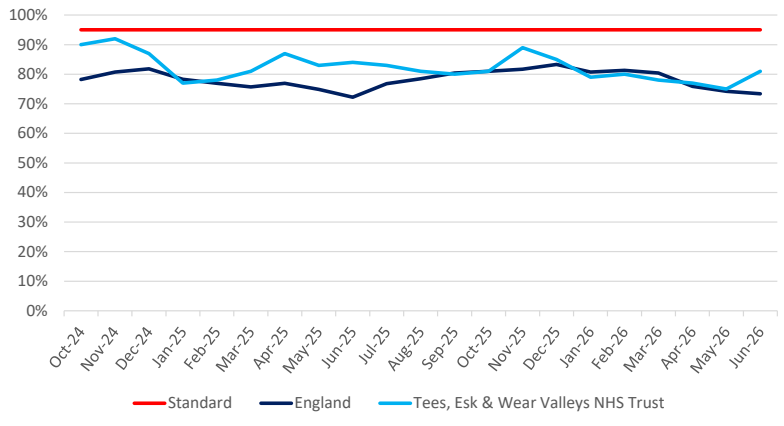
Percentage of service users experiencing a first episode psychosis of ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care

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

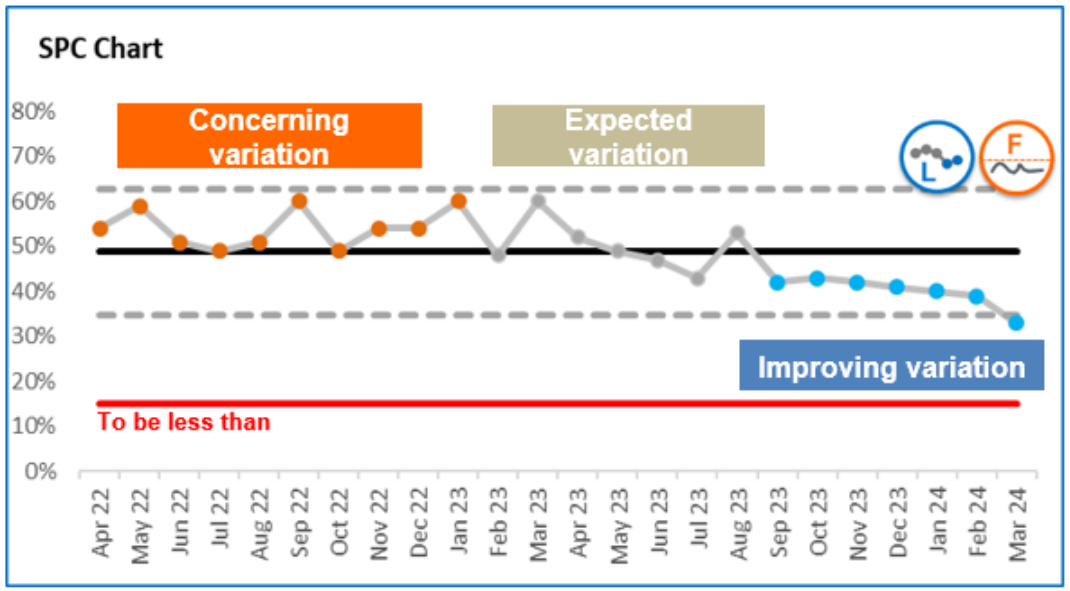


Appendices

Our Guide To Our Statistical Process Control Charts

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

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



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

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

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

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

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

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

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

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what 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 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 has been completed and will be presented to Executive Directors Group 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 **OR** We are not achieving standard		
Neutral	We are achieving standard (where relevant) **AND** we have no underlying areas of concern	We are achieving the standard (where relevant) with only 1 area of concern; **OR** There is consistent performance	We have more than 1 underlying area of concern **OR** There is consistent underperformance below the standard	
Negative		We have no underlying areas of concern **AND** there is an improving position visible in the data	We have a small number of areas of underlying concern **OR** There is a deteriorating position visible in the data **OR** Performance continues below the mean **OR** We are achieving the standard **HOWEVER** we have the Trust and both Care Group/several directorates all showing a concern	We have the Trust and both Care Group/several directorates all showing a concern **OR** There is a clear deterioration visible in the data **AND** outside the control limits

Our Controls Assurance

Our Controls Assurance is determined based on SPC variance or, where this is not appropriate, using forecast position or national benchmarking data.

Controls Assurance Rating		
Positive	**Neutral**	**Negative**
We have Positive controls assurance when: • the SPC chart indicates Special Cause Improvement; **OR** • the SPC chart indicates an unexpected upward or downward shift, which is **confirmed by the service** as a positive shift; **OR** • Forecast position is positive; **OR** • National benchmarking data indicates we are in the lowest (most positive) quartile	We have Neutral controls assurance when: • the SPC chart indicates Common Cause; **OR** • the SPC chart indicates an unexpected upward or downward shift, which is **confirmed by the service** as a neutral shift	We have Negative controls assurance when: • the SPC chart indicates Special Cause Concern; **OR** • the SPC chart indicates an unexpected upward or downward shift, which is **confirmed by the service** as a negative shift; **OR** • Forecast position is negative; **OR** • National benchmarking data indicates we are in the highest (least positive) quartile

Glossary of Terms

AAR	After Action Review
ADHD	Attention deficit hyperactivity disorder
ALD	Adult Learning Disabilities
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
NYYSCG	North Yorkshire, York & Selby Care Group
OAP	Out of Area Placement
PICU	Psychiatric Intensive Care Unit
PMH	Specialist Community Perinatal Mental Health
PROM	Patient Reported Outcome Measure
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Framework
SIS	Secure Inpatient Services
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STEIS	Strategic Executive Information System
WTE	Whole time equivalent

Tees, Esk and Wear Valleys NHS Foundation Trust

BOARD REPORT

1. Cover Sheet

Report Title	Annual Safer Staffing Establishment Review 2025/26
Meeting	Trust Board [Public]
Date of Meeting	28 October 2026
Paper	N
Sponsoring Director / Author	Beverley Murphy, Chief Nurse and Deputy CEO
Report Author	Joe Bergin, Nurse Consultant and Stephen Parry, Head of Workforce Strategy
Purpose of Paper	**Assurance**
Previously Considered By	Quality Assurance Committee 3rd September 2026, chaired by Phil Corrigan, Non-Executive Director.
Financial Implications	Although the use of overtime and agency has consistent improved, some inpatient teams continue to utilise resources beyond their budget.

2. Recommendation

The Board is asked to:

- Be assured that the Quality Assurance Committee, chaired by Phil Corrigan, considered the detailed findings of the Annual Safer Staffing Establishment Review and that the committee reached a conclusion that there is good assurance demonstrated through continued improvements with oversight of staffing and e-rostering metrics.
- Be assured that the annual establishment review 2025 /2026 was conducted in line with national regulatory requirements.

3. Executive Summary

The Annual Staffing Establishment review for 2025/26 was completed in line with NQB requirements, using the Mental Health Optimal Staffing Tool (MHOST) and triangulated with SafeCare, Care Hours Per Patient Day (CHPPD), and professional judgement. Findings were reviewed through established governance routes. The Quality Assurance Committee received a paper summarising the key findings, risks and actions and the outputs and learning from the safer staffing meetings.

The Quality Assurance Committee reached a conclusion that there is good assurance demonstrated through continued improvements with oversight of staffing and e-rostering metrics.

There are continued risks that there is unwarranted variance across inpatient services about the use of staffing resources that is not fully understood and, there is a risk that the level of sickness absence will continue to challenge our ability to work within agreed budgets.

To improve our consistency in the application of the Annual Safer Staffing Establishment review, the Chief Nurse, Directors of Nursing and the Associate Directors of Nursing will undertake MHOST training to enable them to lead the 2026/27 annual staffing reviews.

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	We will co create high-quality care. We will be a great employer.
Board Assurance Framework	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. 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 inequalities and reduced confidence in the Trust.
Corporate Risk Register	There are relationship between staffing and multiple risks in the corporate risk register. It is recognised that substantive, well trained staff who are engaged is pivotal in us delivering safe, high-quality care.
Committee / Work Programme Ref	Quality Assurance Committee Work Programme Ref: 4.13 (to seek assurance on the range of quality and safety metrics and the metrics in the Quality Dashboard).
Regulatory / Legal Reference (if applicable)	CQC fundamental standards, NHSE requirement in line with the National Quality Board standards.

BOARD REPORT

Report Title	Annual Safer Staffing Establishment Review 2025/26
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Paper	N

1. Background

Evidence based decision making on safe staffing and effective staffing is a requirement for all NHS organisations. The National Quality Board sets out the expectations in the document: https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf - July 2016 following the findings of Sir Robert Francis QC in his report of the inquiry into the failings at Mid Staffordshire FT 2013. The expectations of the Quality Board include three clear principles that we have the right staff, with the right skills in the right place and time.

Relevant to this report is the requirement that the Board is required to seek assurance that evidence-based guidance is used to determine if staffing is safe. The Board is also required to seem assurance that the organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.

2. Key Issues and Findings

2.1 What the data / evidence shows

The Trust has met the requirements of the National Quality Board by conducting an annual safer staffing establishment review using the Mental Health Optimal Staffing Tool (MHOST) and triangulated the outcomes with Safe care and Care Hours Per Patient Day as well as applying professional judgement.

2.2 Assurance

The Board can be assured that the Quality Assurance Committee received a detailed paper and accepted the following recommendations:

- There is good assurance that we have met the National Quality Board (NQB) requirements to complete and report out the annual Safer Staffing Review.
- Acknowledged the concerns and further actions in relation to those wards specifically requiring additional support including Secure Inpatient Services (SIS) and Adult Mental Health (AMH) Acute and Psychiatric Intensive Care Unit (PICU) services.
- Were assured that we understand where focus is needed to further improve the use of staffing resources to enable consistently high-quality care.
- Took good assurance that we continue to make improvements in the oversight of staffing and e-rostering metrics.
- Agreed that a summary version of the paper would be presented to Board confirming that QAC have received detailed findings.

2.3 Risks

- There is an ongoing risk that some wards are operating beyond their budgeted establishment.
- There is a risk that we do not fully understand the variance in the use of staff.
- There is a risk that we do not have a consistent approach to MHOST.
- Despite meeting the NQB requirements there is an ongoing risk that services at times fall short of the required staff, at the required skills et in the right place and time and that this impacts the quality of care. This risk takes daily management with a clear operational approach and governance.

3. Options Considered

Not applicable

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	A lack of the right staff, in the right place with the right skills can quickly impact the quality of care. A sustained use of temporary staff can also have a direct impact on the quality of care.
Safeguarding	If we are unable to deploy the right number of staff with the right skills, we may not be able to safeguard people in our care from avoidable harm
Equality, Diversity & Inclusion	Not required.
Workforce	A lack of suitably qualified and experienced staff can impact the morale and experience of staff.
Financial / Resource	Sustained use of temporary staffing either within establishment numbers or beyond can cause a significant financial burden.
Legal	A failure to staff clinical teams to meet service user needs risks a breach in the Health and Social Care Act Fundamental Standards which we are regulated against by the CQC.
Protected characteristics	None recognised in this paper.

5. Appendices

None

6. Document Control

Version	Date	Author	Summary of Changes
1 Final	23.10.26	Beverley Murphy	This paper is a summary of the full paper presented at the QAC on 3 September 2026