Tees, Esk and Wear Valleys
NHS Foundation Trust

Board of Directors held on 26 November 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:

- The staff story and related service spotlight report, providing an opportunity to consider staff experience alongside service delivery.
- The Chief Executive's report and update on the Potter Inquiry, highlighting developments relevant to the Trust and the Board.
- Reports from the Quality Assurance, Planning, Digital and Estates, and People and Culture Committees, highlighting key assurances and matters requiring Board attention.
- The Learning from Deaths report for Quarter 2 2026/27, with consideration of the learning identified and its implications for improving care.
- The Freedom to Speak Up Service and Guardian of Safe Working Hours reports, supporting scrutiny of speaking up arrangements and safe working for postgraduate doctors.
- The Integrated Quality Performance Report, focusing on the Trust's performance, areas of concern and progress in addressing them.
- The Medical Education and Research annual reports, providing assurance on these areas of the Trust's work.

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
John Maddison
Interim Trust Chair

Board of Directors meeting held in public

The meeting will be held from 9.30am – 1.15pm in the Boardroom at Foss Park Hospital, Haxby Road, York, YO31 8TA and via MS Teams.

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

Lunch 1.15pm

Board of Directors meeting held in private

The meeting will be held from 1.45pm – 3.20pm in the Boardroom at Foss Park Hospital, Haxby Road, York, YO31 8TA and via MS Teams.

Tees, Esk and Wear Valleys
NHS Foundation Trust

AGENDA

1. Meeting Details

Meeting	Board of Directors
Date	Thursday 26 November 2026
Time	9.30am to 1.15pm
Venue	Boardroom at Foss Park Hospital, Haxby Road, York, YO31 8TA and via MS Teams.
Chair	John Maddison, Interim 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	9.30am
2	Apologies for absence	-	-	Chair	Verbal	
3	Declarations of interest	-	-	Chair	Paper A	
4.	Board of Directors to receive a staff story	-	**Assurance**	Int. Executive Director for People & Culture	Verbal	9.32am
5.	Spotlight Report	-	**Assurance**	Chief Operating Officer	Paper B	10.00am
6.	Questions from members of the public	-	**Information**	Int. Company Secretary & Director of Governance	Verbal	10.15am
7.	Minutes of the previous meeting held on 28 October 2026	-	**Decision**	Chair	Paper C	10.20am
7.1	Matters arising / review of action log	-	**Assurance**	Chair	Paper D	
8.	Chair's Remarks	-	**Information**	Chair	Verbal	10.25am

Ref	Agenda item	BAF reference	Purpose	Lead	Paper Ref	Time
9.	Chief Executives Report	-	**Information**	Chief Executive	Paper E	10.30am
10.	TEWV Public Inquiry, update	BAF 13	**Assurance**	Chief Executive Programme Director	Paper F	10.45am
Performance Oversight and Assurance						
11.	Report of the Chair of Quality Assurance Committee	BAF 3 BAF 4	**Assurance**	Committee Chair	Paper G	11.00am
12.	Learning from Deaths Report Q2 2026/27	BAF 4 BAF 9	**Assurance**	Executive Medical Director	Paper H	11.10am
13.	Report of the Chair of Planning, Digital and Estates Committee	BAF 5 BAF 6	**Assurance**	Committee Chair	Paper I	11.20am
Break						11.30am
14.	Report of the Chair of People and Culture Committee	BAF 1	**Assurance**	Committee Chair	Paper J	11.40am
15.	Freedom to Speak Up Guardian Service, Half-Year Report Apr-Sep 2026 *(FTSU Guardian in attendance)*	BAF 1 BAF 9	**Assurance**	Int. Executive Director for People and Culture	Paper K	11.50am
16.	Guardian of Safe Working Quarterly Report	BAF 1	**Assurance**	Guardian of Safe Working Hours	Paper L	12.05pm
17.	Integrated Quality Performance Report at 30 September 2026	All	**Assurance**	Int. Executive Director for Strategy & Transformation Chief Operating Officer	Paper M	12.15pm

Ref	Agenda item	BAF reference	Purpose	Lead	Paper Ref	Time
			Exceptional items			
18.	Medical Education Annual Report 2026	BAF 1 BAF 8	**Assurance**	Executive Medical Director	Paper N	12.45pm
19.	Any other business	-	**Discussion**	Chair	Verbal	12.55pm
20.	Summary of key decisions and items for escalation	-	**Assurance**	Chair	Verbal	1.05pm
21.	Exclusion of the Press and Public	-	**Decision**	Chair	Verbal	1.10pm
			For information			
22.	Board Assurance Framework and Corporate Risk Register	All	**Information**	Int. Company Secretary & Director of Governance	*Available in the Library*	-
23.	Date and time of next meeting *9:30am on Thursday 28 January 2027*	-	**Information**	Chair	Verbal	-

3. Distribution List

Members	In Attendance / Copy
John Maddison, Non-Executive Director (Interim Trust Chair)	A Pridmore, Int. Company Secretary & Director of Governance
Alison Smith, Chief Executive	K Christon, Deputy Company Secretary
Nini Adetubery, Non-Executive Director	Adam Howe, Freedom to Speak up Guardian Service
Roberta Barker, Non-Executive Director	Derek McIlroy, Freedom to Speak up Guardian Service
David Butcher, Associate Non-Executive Director (non-voting)	Sharon Beattie, Guardian of Safe Working Hours for Postgraduate Doctors
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	
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	

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

1. Cover Sheet

Report Title	Board of Directors Register of Interests
Meeting	Board of Directors
Date of Meeting	26 November 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 20 November 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.

Linkage	Detail
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.

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

Report Title	**Board of Directors Register of Interests**
Meeting	Board of Directors [Public]
Date of Meeting	26 November 2026
Item number	A

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.

Impact Area	Assessment
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	20 November 2026	K Christon	Draft report for review
1.0 Final	20 November 2026	A Pridmore	Final report for consideration by Board

Board of Directors, Register of Interests
20 November 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.

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	27/11/2026
Item number	E
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)	Not applicable
Board Assurance Framework	Not applicable
Corporate Risk Register	Not applicable
Committee / Work Programme Ref	Not applicable
Regulatory / Legal Reference (if applicable)	Not applicable

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

Report Title	CEO Public Board Report
Meeting	Trust Board Public
Date of Meeting	27/11/2026
Item number	E

Key updates

Consultant strike – The BMA has suspended the planned two days of strike action by consultant doctors in England on 25 and 26 November 2026, as negotiations are underway with NHSE.

Fuel Poverty - A recent report within the Health Foundation recognised that fuel poverty is associated with a higher prevalence of poor mental health. After accounting for differences in age and income, areas in England at the highest risk of fuel poverty had a 24% higher prevalence of poor mental health recorded in primary care than the lowest-risk areas. This is an association rather than evidence that fuel poverty alone causes poorer mental health.

Fuel poverty risk is more widespread in Wales and Scotland than in England. The highest concentrations are in the North West of England, Eastern and Southern Scotland, and North and South East Wales, where more than 30% of neighbourhoods fall within Great Britain's highest-risk fifth. In England, the West Midlands (29%) and Yorkshire and the Humber (27%) also have substantial concentrations, compared with 7% in the South West. Remote rural Scotland is particularly affected, with almost 60% of areas in the highest-risk fifth. The findings highlight the value of targeting support where fuel poverty risk and poor mental health overlap. These figures describe the proportion of neighbourhoods at high risk, not the percentage of households experiencing fuel poverty. With Winter now with us and likely to be particularly cold this year, we should consider potential impacts on staff, patients and families and I have asked Catherine Parker and team to consider how best we do this.

The Thirlwall Inquiry report and recommendations on events at the Countess of Chester Hospital were published in September 2026. This was reviewed through the Quality Assurance Committee and elements will be reviewed within corporate governance arrangements and will be progressed through Audit and Risk Committee and Quality Assurance Committee.

The Senior managers pay award has been published by NHS England for 2026/27 confirming the eligibility criteria that apply. The award is a 3% pay rise for VSM's. This award is lower than most other NHS staff who received a 3.3% consolidated uplift given to Agenda for Change staff in the same year. A report will be provided to a yet to be planned, Board Nomination and Renumeration Committee.

Heart disease in severe mental illness A recent report from the Royal College of Psychiatrists, the British Foundation and others found that people with severe mental illness are around four times more likely to die prematurely from cardiovascular disease. It also found they are 15% less likely to have a recent prescription for statins, and up to 66% with serious mental illness have undetected Cardio Vascular Disease prior to Cardio Vascular death. We should continue the opportunity to offer support for earlier detection, in partnership with our health partners and will raise awareness of this report with our commissioning partners.

Winter preparedness our winter plans remain a key focus both in terms of flu vaccination promotion and delivery and supporting the flow of patients in a timely way to ensure safe access to all health services. Our ICB colleagues remain focused on the flow through emergency departments and for us, how we ensure delays in care and assessment are prevented.

Young People who are NEET recent publication by Alan Milburn shares the national concerns regarding the number of young people not in in work, training or education with 1 in 6 never having a job. Alongside the rising spending on the Health and Disability benefit spending and the 10 year plan to reduce the NEET rate. The report shares that poor mental and physical health are cited as significant drivers of youth economic inactivity with 24% citing depression or anxiety as the main limiting condition in the May interim report.

With the planned changes in benefit support, colleagues at the Royal College of Psychiatrists and Charitable organisations supporting Mental Health and Learning Disabilities are advocating for continued support and to not unfairly disadvantage those with fluctuating or life long severe mental illness and/or complex needs through learning disabilities.

As an Anchor institution and one of the largest employers in the region NHS organisations like us are in a unique position to support employment and to reduce inequalities and we will work with partners regionally and nationally to seek opportunities to support training and employment for younger people, specifically in those localities with the highest need and impacts.

Regional and ICB oversight in terms of performance is under renewed focus and executive colleagues are continuing to respond to regular requests of review by our regulators. While responding to planning requests, though currently the guidance has not yet been provided, however work continues.

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
-	Not applicable

6. Document Control

Version	Date	Author	Summary of Changes
1.0 Final	19 Nov 26	Report Author	Final version submitted to Board

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

1. Cover Sheet

Report Title	TEWV Public Inquiry Update
Meeting	Trust Board
Date of Meeting	26 November 2026
Item number	F
Sponsoring Director / Author	Alison Smith, Chief Executive
Report Author	Cathy Hassell, Public Inquiry Programme Director
Purpose of Paper	**Assurance**
Previously Considered By	
Financial Implications	

2. Recommendation

The Board is asked to:
The Board is asked to note ongoing work and endorse the Trust's approach to supporting the inquiry to ensure organisational readiness, transparency and learning.

3. Executive Summary

The purpose of this paper is to provide an update on the Potter Inquiry, for which a Chair was announced on 17 September. It includes a summary of the work underway to ensure the Trust can fully and effectively participate in the inquiry with transparency, openness and humility.

The Potter Inquiry into mental health services at Tees, Esk and Wear Valleys NHS Foundation Trust, chaired by His Honour Judge John Potter, has begun its work.

The Trust has welcomed this important step and, above all, recognises the significance of the Inquiry for the families, survivors and others affected. Our thoughts remain with everyone whose lives have been impacted by the matters under investigation.

We are committed to supporting the Inquiry fully and engaging with it in an open, honest and constructive way.

This paper provides an update on the work underway to ensure that TEWV can fully support the public inquiry, fulfilling its legal, regulatory and moral obligations in line with the Inquiry Terms of Reference. This will be delivered in a way which also supports staff to continue to provide care to our communities and progress our transformation work.

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	
Board Assurance Framework	BAF Risk 13 – Public Inquiry
Corporate Risk Register	Not applicable.
Committee / Work Programme Ref	Not applicable.
Regulatory / Legal Reference (if applicable)	Inquiries Act 2005; Inquiry Rules 2006; Inquiry Terms of Reference, once finalised; associated statutory, regulatory and information governance obligations

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

Report Title	TEWV Public Inquiry Update
Meeting	Trust Board
Date of Meeting	26 November 2026
Item number	F

1. Background

Since the Chair, His Honour Judge John Potter was announced on 21 September, the Trust has been providing information to support his preparatory work.

The Trust will keep uppermost in mind the purpose of public inquiries which is to provide those affected with an opportunity to be heard, prevent recurrence of similar failings in the future, improve accountability, strengthen learning and system improvement and improve public confidence in services.

The Inquiry is currently developing its Terms of Reference and is engaging with families, individuals and organisations before these are finalised and published. As a statutory public inquiry, it is independent of the Trust and operates under the Inquiries Act 2005 and the Inquiry Rules 2006.

We will continue to support the process and, where appropriate, provide updates through the usual communication channels, including Board meetings. We will also signpost information published by the Inquiry, including details of its website and future opportunities for engagement as these become available.

Over the past year, since the original announcement in December 2025, the Trust has taken action to ensure it is ready to comply with its statutory, regulatory and moral responsibilities effectively through:

1. Ongoing engagement and open dialogue with families who are central to the matters being examined by the public inquiry.

2. Issuing regular guidance on document preservation between January to May 2026 (via email, staff briefings and team briefings) to ensure all records are retained securely as potential evidence, information assets are comprehensively updated and that all colleagues are clear on the policy regarding inappropriate access of patient records.

3. Record retention instructions are given at all new staff inductions and referred to in mandatory information governance training for all staff.

4. Recruitment of a team to ensure the Trust is able to respond effectively.

2. Proposal

2.1 Organisational readiness

The Trust is now establishing resources, structures, policies, protocols and guidance to enable participation in a comprehensive, timely and responsive way. These will enable the provision of assurance to the Board on the effective management of TEWV's response. This work includes:

1. Scoping of a management team to ensure TEWV, learning from other inquiries, has sufficient operational resources to service the inquiry.
2. A comprehensive assessment of organisational readiness and implementation of the following is being carried out:
    - Record preservation and disclosure systems
    - Identification of corporate records
    - Identification of clinical and patient safety records
    - Identification of past and present staff records
    - Public inquiry resources and financial oversight
    - Legal and regulatory provisions
    - Governance and assurance framework
    - 'PI architecture' support for witnesses
    - Staff wellbeing and psychological support
    - Identifying and engaging with key stakeholders
    - Learning and improvement feedback and implementation
    - Support for inquiry related service-user issues

2.2 Governance, Oversight and Assurance

The Terms of Reference for the Trust's Public Inquiry Decision-Making Group, responsible for operational delivery of the Trust's response to the PI were approved at the 12 March 2026 Board meeting, with minor amendments finalised at the Board meeting on 23 September 2026.

The Public Inquiry Decision-Making Group, made up of executive directors, the Chief Information Officer and the Programme Director and chaired by the Chief Executive has been meeting to oversee organisational readiness since the Chair was announced.

The Board will be provided with a monthly update on assurances, decisions, and any areas of concern and additional assurance arrangements are being put in place.

2.3 Risk and Issue Management

An initial risk assessment has been conducted to evaluate TEWV's capacity to support the public inquiry whilst maintaining strong operational performance and high-quality patient care. The risk register will align to the Board Assurance Framework (BAF) and Corporate Risk Register where appropriate. BAF Risk 13-Public Inquiry will be monitored monthly throughout.

A quality and equality impact assessment of the business plan has been conducted and approved by the QEIA Panel.

2.4 Resourcing and Financial Management

Recruitment is ongoing against the planned team structure and finances are being managed within budget. Estimates in November suggest the budget is within the financial allocation.

2.5 Implications

The appointment of the Inquiry Chair marks an important milestone in the establishment of the public inquiry. For the Trust, this will require continued focus on cooperation, transparency, evidence management and organisational learning. The appointment also presents an opportunity for the Trust to demonstrate its commitment to openness and continuous improvement while supporting the inquiry in its work to establish the facts and identify lessons for the future.

3. Options Considered

Not applicable.

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	No direct impact. The Trust will respond to the findings of the inquiry to support learning, prevent recurrence of failings and strengthen patient safety.
Safeguarding	No direct impact.
Equality, Diversity & Inclusion	No advise equality impact identified in the update.
Workforce	Additional programme resources are being recruited.
Financial / Resource	Resources are required for the Public Inquiry team, legal and regulatory support, witness support and staff wellbeing.
Legal	The Trust must comply with statutory obligations under the Inquiries Act 2005 and the Inquiry Rules 2026.
Protected characteristics	No direct impact.

5. Appendices

Appendix	Title
	Not applicable

6. Document Control

Version	Date	Author	Summary of Changes
1.0 FINAL	20-Nov026	C Hassell	Final draft submitted for Trust Board

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:	11 November 2026
Date of Board meeting:	26 November 2026
Committee Chair:	P Corrigan, Non-Executive Director
Report author:	B Murphy, Chief Nurse/Deputy Chief Executive K Christon, Deputy Company Secretary
Quorate:	Yes
Attendance:	Apologies for absence received from N Adetuberu, Non-Executive Director, K Kale, Executive Medical Director and E Gorringe, Associate Non-Executive Director

1. Purpose of this report

This report provides the Board of Directors with a summary of the business considered at the meeting of Quality Assurance Committee held on Wednesday 11 November 2026. It highlights 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
Board Assurance Framework and Corporate Risk Register	K Marley, Head of Risk Management	Committee reviewed the exception-based report on risks within its remit and secondary risks, where they have potential to materially affect quality, patient safety or experience. Committee agreed the need for stronger evidence that improvement activity is delivering measurable and sustained impact against BAF risks, recognising that reports often focused on process assurance. It was agreed that N Lonergan will clarify in the BAF when access improvement plans are expected to deliver measurable impact.	Committee agreed the assurance levels presented, including reasonable assurance on overall governance and oversight arrangements, recognising that evidence of control effectiveness and sustained improvement remained mixed.

Agenda item	Lead	Summary of discussion	Outcome
		The EPRR risk score of 20 against a tolerance of 5 reflects limited audit assurance, partial compliance and team capacity and leadership gaps. Further assurance will be considered by Audit and Risk Committee in December 2026.	
Older Adults Inpatient Care	H Garg, NYYS Care Group Medical Director and R Weddle, Care Group Director of Nursing	Committee considered an overview of the quality, safety and performance of inpatient Mental Health Services for Older People. Early improvements in patient flow were reported from weekly ICB meetings, although limited placement availability in North Yorkshire remained a significant constraint. Committee agreed the need for stronger triangulation of quality, performance, workforce, patient experience and outcomes data to provide assurance on service variation and impact. Committee received reassurance on strengthened care group governance arrangements to identify and explore service concerns. A further update was requested for March 2027, including stronger triangulation of data and clearer understanding of variation across services.	Committee agreed to receive the report with reasonable assurance regarding quality and safety, noting there continue to be ongoing risks associated with demand, access and service variation.
Quality Reports: Executive Directors Group Quality Report Quality Assurance, Risk and Quality Dashboard Quality Report – Triple A summary	B Murphy, Chief Nurse / Deputy Chief Executive and L McCrindle, Associate Director of Quality Governance Compliance and Quality Data	The Quality Report provided good overall assurance, with 29 measures (82.8%) offering good or substantial assurance and improvement across a number of measures. The EDG discussion emphasised that patient safety reviews must move beyond procedural non-compliance to understanding and embedding learning. Areas for continued monitoring included self-harm in DTVF ALD services, mechanical restraint at Ridgeway and complaints in DTVF AMH. The increase in mechanical restraint largely reflected transfers for health or court appointments, and	Committee received the Quality Report with good assurance, recognising areas requiring continued monitoring and improvement. The EDG Quality Report was stood down, with escalation of matters through Any Other Business as appropriate.

Agenda item	Lead	Summary of discussion	Outcome
		procedures will be reviewed for potential improvement within MOJ requirements. Quality Assurance Programme standards had improved but were not consistently achieved. The use of restrictive intervention in Adult Learning Disability services was expected to reduce with recent changes in the patient population. Committee agreed the Executive Directors Group Quality Report could be stood down, given the introduction of speciality reporting and allowing for the escalation of matters, as required.	
Patient Safety Report	B Murphy, Chief Nurse/ Dep. Chief Executive	Committee considered the report, which presented a mixed assurance position on patient safety incident management. Improvement work was having a positive impact on the backlog and timeliness of After Action Reviews against the revised 36-day standard. Limited assurance remained on the timeliness of initial incident reviews, After Action Reviews and Mortality Part 1 reviews. 13 Inquests had concluded in September 2026, with no Regulation 28 Reports or Letters of Concern. Committee expected evidence of improvement by March 2027, with each area of limited assurance to be considered separately against its expected timescales and improvement impact.	Committee received the report with substantial assurance on Patient Safety Incident Investigations and limited assurance on initial incident, After Action Review and Mortality Part 1 review timeliness.
Complaints and Patient & Carer Experience Q2 2026/27	H Crawford, Executive Director for Therapies and Patient Experience	Committee considered the report, which provided an overview of complaints, local issue resolution, patient carer feedback, associated learning and the developing complaints improvement programme. Over 93% of patients and carers rated their experience as good or very good, and the Trust retained its two-star Triangle of Care accreditation.	Committee agreed to receive the report with reasonable assurance.

Agenda item	Lead	Summary of discussion	Outcome
		Overdue local issue resolutions and complaint action plans, recurring themes and evidence that learning is delivering sustained improvement require continued focus. Committee noted the proportion of inpatients who reported feeling safe was broadly similar to the previous quarter and discussed factors that influence a perception of safety. Recognising that there continues to be a number of recurring themes, committee agreed to seek evidence of improvement in the next report.	
Listening Report	H Crawford, Executive Director for Therapies and Patient Experience	Committee received this new report, which provided an initial response to the CEO Listening Report considered by Board in September 2026. Early progress was identified, but evidence of sustained impact was not yet sufficiently developed. A coordinated thematic action plan was proposed by the end of November 2026. Committee agreed its role would be to receive assurance rather than consider the detailed plan. The importance of being transparent with patients, families and communities about improvements made in response to patient experience or feedback was recognised. Members also discussed the opportunity to strengthen the Board's ongoing connection with, and opportunity to listen to, lived experience. Members discussed the purpose of the report and agreed there was significant overlap with other areas of learning and an opportunity to consolidate these and demonstrate improvement.	It was agreed that the Chief Nurse and Executive Director for Therapies and Patient Experience would clarify the purpose, scope and reporting arrangements, including how the report could consolidate learning and impact highlighted through a number of different reports. Committee propose that the Lived Experience Director be supported to use the patient story session at Board to increase the impact of lived experience stories at Board.
Use of Force and Reducing Restrictive Practice Q2 2026/27	B Murphy, Chief Nurse/ Dep. Chief Executive	Committee discussed the overall increase in restrictive practice, positive movement towards less restrictive interventions, including reduced prone and supine restraint and increased standing	Committee agreed to vary the assurances proposed to: good assurance regarding the monitoring and oversight of restrictive

Agenda item	Lead	Summary of discussion	Outcome
		restraint, Trust oversight within ALD services, and variation across services. Committee received reassurance that cases of rapid tranquilisation were reviewed, and the reported increase of 41% was clinically appropriate. B Murphy agreed to clarify the reasons for the increase in patients requiring restrictive interventions in Adult Learning Disability Services for this reporting period	practice across all inpatient sites, and reasonable assurance that restrictive interventions showed a move towards safer, less restrictive interventions.
Culture of Care Quality Improvement Programme	C Morton, Lived Experience Director	Committee considered an update on the rollout, sustainability and benefits realisation of the Culture of Care Programme. Members sought assurance on the consistency of governance arrangements and discussed the need to strengthen multidisciplinary and senior clinical leadership engagement to support sustainability. Committee agreed to receive a further update in six months time.	Committee agreed to accept the report with reasonable assurance overall; acknowledging there is reasonable assurance on delivery and implementation, partial assurance on governance and sustainability, and limited assurance on longer-term benefits realisation.
Regulatory activity: delivery of CQC Integrated Plan and HMC notices and requirements	L McCrindle, Associate Director of Quality Governance Compliance and Quality Data	Committee considered the report, which outlined progress on the Integrated Oversight Plan and regulatory activity. Four improvement actions remained open, with two behind target. These related to completion of LIO rollout and achievement of the 85% supervision target, where changes to TEWVision at the end of November 2026 were expected to improve reported supervision. The Trust has responded to a significant CQC information request relating to an inpatient death in 2024 and submitted provider action statements and responses to NHS inspection reports.	Committee agreed to receive the report with good assurance regarding the system and processes for oversight, monitoring and delivery of the integrated oversight plan.
Learning from Deaths Report Q2 2026/27	R Shah, DTVF Care Group Medical Director, on	Committee considered the Q2 report, which identified 198 learning points with recurring themes related to record keeping, communication and information	Committee agreed to receive the report with good assurance of reporting and learning in line with the national

Agenda item	Lead	Summary of discussion	Outcome
	behalf of K Kale, Executive Medical Director	sharing, and risk assessment and safety planning. It was acknowledged that while mechanisms were in place to share and embed learning, further work was required to demonstrate impact. Reassurance was provided on progress of the mortality improvement programme, including testing of a revised review process.	guidance and endorsed the report for submission to the Board.
Safer Staffing	B Murphy, Chief Nurse/ Dep. Chief Executive	Committee received the report which provided an update on safer staffing oversight and the approach to the next safer staffing establishment review. Establishment reviews will commence following NHSE staff training on the revised MHOST methodology, in January 2027. NHSE has proposed good assurance on day-to-day staffing oversight and limited assurance on Board-level oversight because reporting had been annual rather than six-monthly. The reporting gap will be addressed.	Committee agreed to receive the report with good assurance that the oversight of staffing and e-rostering continues to improve and supported the sequencing of staffing establishment reviews following the introduction of MHOST.
Duty of Candour Q1 and Q2 2026/27	B Murphy, Chief Nurse/ Dep. Chief Executive	Committee considered the report on compliance with statutory Duty of Candour requirements. Committee noted there was continued improvement in oversight and the involvement of families where a PSII is required, and further improvements related to staff understanding of when statutory requirements need to be applied.	Committee agreed to receive the report with reasonable assurance that there is compliance with statutory Duty of Candour requirements, substantial assurance of the oversight of compliance, and reasonable assurance of the understanding of compliance requirements.
The Thirlwall Inquiry Response	B Murphy, Chief Nurse/ Dep. Chief Executive	Committee considered the report, which outlined the Trust's initial response to the recommendations arising from the inquiry. It was agreed that the proposal would be amended to include perinatal services within the assessment of arrangements for Board-level monitoring of child and baby deaths.	Committee approved the approach, with the addition of Perinatal Services.

Agenda item	Lead	Summary of discussion	Outcome
		Committee agreed to receive a further report in March 2027.	
Trigger Report	B Murphy, Chief Nurse/ Dep. Chief Executive	Committee approved a systematic approach to identifying quality and safety issues that require a prompt Board briefing or escalation to Committee outside routine reporting. The trigger list was not exhaustive and professional judgement would continue to apply.	Committee approved the list of issues that would trigger either a briefing to Board or Quality Assurance Committee.

3. Key alerts — matters requiring Board attention

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

- **Emerging patient safety concern:** Committee was briefed on emerging concerns about arrangements for a proposed transfer into Ridgeway, where senior-level discussions with system partners continue.
- **Patient safety review timeliness:** There is limited assurance on the timeliness of initial incident reviews, After Action Reviews and Mortality Part 1 reviews. Committee expect evidence of improvement by March 2027.
- **Evidence of sustained improvement:** there is a recurring assurance gap concerning the ability to demonstrate the impact of improvement and learning, rather than improvements in processes alone. This arose across the BAF, complaints and patient experience, Learning from Deaths and Culture of Care.
- **Board oversight of safer staffing:** NHS England have proposed limited assurance on Board-level oversight, where reporting to Board has been annual rather than six-monthly. This gap will be addressed. Good assurance was reported on day-to-day staffing oversight.

4. Assurance summary

The summary below provides one entry for each item in section 2, in the same order. It records the assurance levels agreed by Committee and distinguishes items where no assurance rating was recorded or consideration was deferred.

Area of oversight	Assurance level	Commentary
Older Adults Inpatient Care	Reasonable assurance	Reasonable assurance on current quality and safety arrangements, with continuing demand, access and service variation risks.
Quality Reports: Executive Directors Group Quality Report; Quality Assurance, Risk and Quality Dashboard; Quality Report – Triple A summary	Good assurance	Good overall assurance on the Quality Report, with 29 measures (82.8%) providing good or substantial assurance.
Patient Safety Report	Substantial / limited assurance	Substantial assurance on Patient Safety Incident Investigations; limited assurance on initial incident, After Action Review and Mortality Part 1 review timeliness.

Area of oversight	Assurance level	Commentary
Complaints and Patient & Carer Experience Q2 2026/27	Reasonable assurance	Reasonable assurance for complaints and local issue resolution and patient and carer experience.
Use of Force and Reducing Restrictive Practice Q2 2026/27	Good / reasonable assurance	Good assurance on monitoring and oversight of restrictive practice; reasonable assurance on progress towards safer, less restrictive interventions.
Culture of Care Quality Improvement Programme	Reasonable assurance overall	Reasonable assurance on delivery and implementation; partial assurance on governance and sustainability; limited assurance on longer-term benefits realisation.
Regulatory activity: delivery of CQC Integrated Plan and HMC notices and requirements	Good assurance	Good assurance on systems and processes for oversight, monitoring and delivery of the integrated oversight plan.
Learning from Deaths Report Q2 2026/27	Good assurance	Good assurance on reporting and learning in line with national guidance.
Safer Staffing	Good assurance	Good assurance that staffing and e-rostering oversight continues to improve. NHSE propose limited assurance on Board-level oversight reflecting the annual rather than six-monthly reporting to Board.
Duty of Candour Q1 and Q2 2026/27	Substantial / reasonable assurance	Substantial assurance on compliance oversight; reasonable assurance on statutory compliance and understanding of requirements.

5. Decisions made, and papers approved

Committee:

- Endorsed the Q2 2026/27 Learning from Deaths report for submission to the Board.
- Approved the proposed approach to the Thirlwall Inquiry recommendations, with perinatal services included in the assessment of Board-level monitoring of child and baby deaths.
- Approved the issues that would trigger a briefing to Board members or escalation to Committee, recognising that the list was not exhaustive and professional judgement would continue to apply.
- Supported the sequencing of safer staffing establishment reviews following training on the revised MHOST methodology.
- Agreed to stand down the Executive Directors Group Quality Report following the introduction of more detailed specialty reporting, with matters escalated through Any Other Business as appropriate.

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

Committee considered an exception-based report on BAF and CRR risks within its remit, including secondary BAF risks led by other committees where these could materially affect quality, patient safety or experience.:

- **BAF 03 Access to services:** It was agreed that N Lonergan will clarify in the BAF when access improvement plans are expected to deliver measurable impact.
- **Control effectiveness:** Committee agreed reasonable assurance overall from governance and oversight arrangements, while recognising that evidence of control effectiveness and sustained improvement remained mixed.
- **Sustainable improvement:** Committee agreed the need for stronger evidence that improvement activity is delivering measurable and sustained impact against BAF risks, recognising that reports often focused on process assurance

7. Recommendations to the Board

No.	Recommendation / action requested of the Board	Owner	Timescale
1	Receive the Q2 2026/27 Learning from Deaths report, endorsed by Committee with good assurance on reporting and learning in line with national guidance.	Executive Medical Director	26 November 2026
2	Note changes will be made to the Board work programme to address the safer staffing reporting frequency gap so that the Board receives six-monthly rather than annual reports.	Chief Nurse / Deputy Chief Executive	Date will be confirmed in line with availability of the revised MHOST training from NHSE
3	Committee proposes that the Lived Experience Director be supported to use the patient story session at Board meetings to increase the impact of lived experience stories at Board.	Chief Operating Officer	tbc

8. Forward look

The December 2026 meeting will consider service-level assurance reports on Specialist Eating Disorders and Rehabilitation, alongside a broad range of quality, safety and compliance matters. These will include patient safety, physical healthcare, clinical effectiveness, the Quality Management Strategy, equality, safeguarding, medical devices, research and development, quality priorities and progress arising from the Independent Quality Assurance Review. The Committee will also consider the future approach to Quality Visits.

9. Next meeting

The next meeting of the Quality Assurance Committee is scheduled for Wednesday 9 December 2026.

Report prepared by: Karen Christon, Deputy Company Secretary on behalf of: P Corrigan, Committee Chair.
Date: 13 November 2026

BOARD REPORT

1. Cover Sheet

Report Title	Learning from Deaths – Quarter 2 (2026/27)
Meeting	Board of Directors
Date of Meeting	26th November 2026
Item number	H
Sponsoring Director / Author	Dr Kedar Kale, Executive Medical Director
Report Author	Amy Taylor, Head of Patient Safety
Purpose of Paper	**Assurance** and **Information**
Previously Considered By	All deaths reported on Inphase are reviewed within 1 working day by the Patient Safety Team. All mortality reviews, After Action Reviews and Patient Safety Incident Investigations are reviewed and finalised through patient safety quality assurance processes. This report was considered by the Quality Assurance Committee on 11th November 2026.
Financial Implications	No specific financial implications identified.

2. Recommendation

The Board is asked to:
Receive and note the content of this report, the dashboard and the learning points as **good** assurance of reporting and learning in line with the national guidance.

3. Executive Summary

In line with National Guidance the Learning from Deaths Dashboard, appendix 1 details Quarter 2 2026/27 information for the Trust and includes 2025/26 data for comparison.

During Q2, 353 deaths were reported on InPhase relating to people who had been in contact with Trust services during the preceding six months. Of these, 303 people were open to Trust services at the time of death, including eight people open to Adult Learning Disability services.

Four deaths occurred in inpatient settings: 1 was an expected physical health death and 3 were unexpected deaths, all of which were subject to the appropriate review and/or investigation processes.

99 Part 1 Mortality Reviews and 21 Part 2 Structured Judgement Reviews (SJRs) were completed, alongside two Patient Safety Incident Investigations relating to unexpected deaths. 7 unexpected deaths were reported on StEIS during the reporting period, 3 of which occurred during Q2.

21 deaths were reported to LeDER. The Patient Safety Team continues to strengthen assurance around LeDER reporting, with prompts incorporated into After Action Review and Mortality Review documentation and any identified discrepancies followed up with clinical teams. This includes reinforcing the need for teams to confirm that a LeDER referral has been made where a death occurs within an acute hospital or care home, rather than assuming this has been completed by the 24-hour care provider.

During Q2, 198 learning points were identified through Patient Safety Incident Investigations, After Action Reviews and Mortality Reviews following patient deaths. The most frequently identified actionable Trust themes related to record keeping, communication and information sharing, and risk assessment and safety planning. Recurring learning highlighted the importance of clear documentation of clinical decision-making, effective information sharing and joint working across services and organisations, and ensuring risk assessments, safety summaries and contingency plans are current, comprehensive and clearly communicated

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	Our Journey to Change goals
Board Assurance Framework	BAF Risk 4: Quality and outcomes BAF Risk 9: Regulatory Compliance
Corporate Risk Register	N/A
Committee / Work Programme Ref	N/A
Regulatory / Legal Reference (if applicable)	N/A

BOARD REPORT

Report Title	Learning from Deaths - Quarter 2 (2026/27)
Meeting	Board of Directors
Date of Meeting	26th November 2026
Item number	H

1. Background

The National Quality Board (NQB) guidance on Learning from Deaths requires each Trust to collect and publish specific information; the Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

All Trusts must publish a dashboard (appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy and have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) are detailed in appendix 2.

As part of the ongoing incident management improvement programme, a collaborative review of the Trusts mortality process, including how learning is identified and shared was commenced 1st July 2026. The first mapping workshop successfully identified opportunities to improve quality, consistency and learning. A QI event focusing on Part 1 of the mortality review process took place in October 2026 with planned roll-out across all specialities to test the new process planned for November 2026. Planning is under way for further QI event in Q3 to review Part 2/SJR process.

2. Key Issues and Findings

In line with National Guidance the Learning from Deaths Dashboard, appendix 1 details Quarter 2 2026/27 information for the Trust and includes 2025/26 data for comparison.

- During Q2, 353 deaths were reported on Inphase of patients who had been in contact with our services in the 6 months preceding the date of death. Of these, 303 patients were still open to a Trust service at the time of their death, of which 8 patients were open to an Adult Learning Disability service. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were open to the Trust's caseload which is largely community and includes older people and memory services (>62,000).
- 4 inpatient deaths were reported. 1 of the 4 deaths was a expected physical health related death that occurred in Mental Health Services for Older People (MHSOP) wards and has been subject to a Part 1 review.
- Of the remaining 3 inpatient deaths; 2 were unexpected physical health related deaths; 1 of which was on an Adult Mental Health (AMH) Ward and the other on Secure Inpatient Services (subject to After Action Reviews). The remaining inpatient death was an unexpected unnatural death on an Adult Mental Health ward (subject to an After Action Review and a Patient Safety Incident Investigation).
- There were 7 unexpected deaths reported on StEIS during the reporting period; 3 deaths occurred in Q2 and 4 deaths occurred in previous reporting periods.

- 99 Mortality Review Part 1 reviews were completed and 21 Part 2 Structured Judgement Reviews (SJR) were completed and discussed at a mortality review panel.
- 18 Part 2 SJRs were requested.
- 2 Patient Safety Incident Investigations for unexpected deaths were completed.
- 21 patient deaths were reported to LeDER during Q2. All deaths of people with either a learning disability or a diagnosis of autism require reporting to LeDER in line with national requirements over the reporting period. Deaths are reported to LeDER via the clinical teams and the Patient Safety Team have added a prompt to all After Action Review and Mortality Review documents. Any discrepancies in reporting are being followed up by the Patient Safety team. Reasons given for not reporting have been identified as deaths occurring in the Acute Trust or a Care home and it is assumed by the TEWV clinical team that the team providing 24-hour care has submitted the referral. Teams are being asked to confirm this with those providers.

Appendix 3 sets out in detail the specific areas of learning, Trust themes, progress within the Quality Assurance programme and structures to support and embed learning from incident investigations.

2 Patient Safety Briefings were circulated Trust wide during this reporting period:

- Social media and presenting at mental health services
- Safe working in our communities and work settings

3. Options Considered

This report is presented for assurance and information.

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	Direct relevance relating to timely reporting, review, investigation and learning from deaths are central to patient safety and quality.
Safeguarding	No specific adult or child safeguarding impact assessments were included.
Equality, Diversity & Inclusion	No Equality Impact Assessments were included.
Workforce	Staff are required to support incident reviews, investigation and mortality review processes.
Financial / Resource	No specific financial or resource implications are identified.
Legal	No specific legal implications are identified.
Protected characteristics	No specific impact on protected characteristics was identified.
Data quality / limitations	Some deaths that occurred in quarter 2 may not yet have been reported.

5. Appendices

Appendix	Title
1	Learning from Deaths Dashboard Q2 2026/27
2	Overview of morality review criterion
3	Overview of mortality reviews and learning

6. Document Control

Version	Date	Author	Summary of Changes
0.1 DRAFT	23 October 2026	Amy Taylor	Report created
1.0 FINAL	23 October 2026	Amy Taylor/Dr Kedar Kale	Report amended and updated

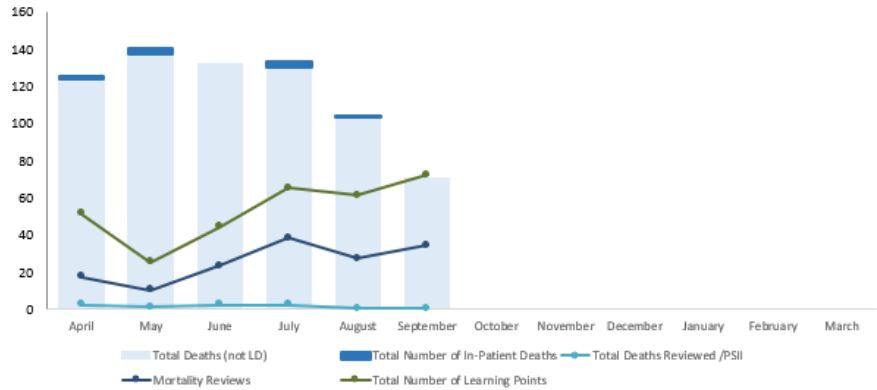
Appendix 1: Learning from Deaths Dashboard Q2 2026/27

Learning from Deaths Dashboard - Data Taken from Cito
Reporting Period - Q2 2026-27

Summary of total number of deaths and total number of cases reviewed under the Patient Safety Incident Response Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

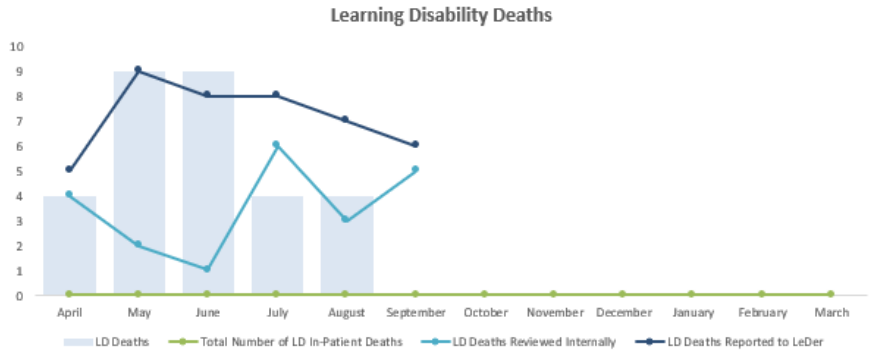
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed /PSII		Mortality Reviews		Total Number of Learning Points	
	2026/27	2025/26	2026/27	2025/26	2026/27	2025/26	2026/27	2025/26	2024/25	2025/26
Q1	393	↘ 434	4	↔ 4	5	↘ 7	50	↘ 70	120	↘ 126
Q2	303	↘ 412	4	↔ 4	2	↘ 4	99	↗ 69	198	↗ 169
Q3	0	↘ 474	0	↘ 14						
Q4	0	↘ 499	0	↘ 3						
YTD	696	↘ 1819	8	↘ 25	7	↘ 11	149	↗ 139	318	↗ 295



Summary of total number of Learning Disability deaths and total number of cases reviewed under the Patient Safety Incident Response Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2026/27	2025/26	2026/27	2025/26	2026/27	2025/26	2026/27	2025/26
Q1	22	↗ 13	0	↔ 0	7	↔ 7	22	↗ 12
Q2	8	↘ 23	0	↔ 0	14	↘ 18	21	↗ 20
Q3	0	↘ 24	0	↔ 0				
Q4	0	↘ 15	0	↔ 0				
YTD	30	↘ 75	0	↔ 0	21	↘ 25	43	↗ 32



Appendix 2

Mortality Reviews

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatrist and peer organisations across the region.
The mortality review tool used consists of a Part 1 and Part 2 review.
Part 1 is a review of the care records, if any red flags or concerns are noted a Part 2 (Structured Judgement Review) will be considered and completed if required.

The “red flags” to be considered during the Part 1 review are as follows:

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Random Selection
- Specific area of interest to the Trust (e.g., Clozapine)

This criterion allows for greater learning from a more suitable selection of cases reviewed. To prioritise the most significant cases for learning from unexpected and expected physical health deaths, the following actions have been taken for those deaths reported via Inphase.

- All in-patient deaths, not subject to a Patient Safety Incident Investigation (PSII) have either had a Part 1 completed or are in the process of having one completed.
- All LD deaths of those open to TEWV have either been reviewed or are being reviewed under Part 1 of the mortality review process. Where any concerns are identified, a Structured Judgement Review has been or will be requested. All these cases are to be reported to LeDER for review. The LeDER referral will not necessarily be completed by TEWV if the individual is receiving their main care from another provider.
- All community deaths for patients aged 64 and under have been or are being reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested.
- 20% of community deaths for patients aged between 65 and 74 have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.
- 10% of community deaths for patients aged 75 onwards have been reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review has been requested. This 10% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2026/2027

21 Structured Judgement Reviews (SJRs) were discussed and reviewed by the Mortality Review Panel during Q2.

Learning themes included:

- Record Keeping
- Communications, although communication was noted as a learning point in several cases; Communication and involving multiple agencies in patient's care accounted for good practice in several other cases.

No new learning themes were noted throughout the quarter all learning points were addressed with appropriate action plans and fed through relevant clinical networks.

Learning from actions/assurance

- Findings from SJRs are fed back to the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel. These are fed into the re-established Organisational Learning Group for future quarters.
- Where the learning identified is related to the work of a specific professional group, for example Pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trust-wide.
- Learning for individuals is shared with operational teams where appropriate and addressed via supervision and local governance processes.

Learning from mortality reviews often demonstrate similar themes identified during After Action Reviews (AARs) or Patient Safety Incident Investigations (PSIIs). The themes from mortality reviews are triangulated with learning from AARs/PSIIs to establish any new themes occurring.

1.2 Learning from deaths and patient safety incidents

Within Quarter 2 there were a total of 198 learning points identified through Patient Safety Incident Investigations, After Action Reviews and Mortality Reviews following patient deaths. The most frequent actionable learning Trust themes included:

- **Record keeping–**incomplete clinical recording including recording of clinical decision making.
- **Communication**–Ineffective communication and information sharing across teams, services, agencies, and carers. Issues included poor handover processes, delays in sharing critical information, lack of joint working arrangements, unclear responsibilities, and communication barriers between organisations. These factors contributed to missed opportunities for escalation, follow-up, continuity of care, and effective risk management.
- **Risk Assessment/ Management/ Safety summaries/ contingency planning** - Multiple cases identified incomplete, outdated, or undocumented safety planning, resulting in risks not being clearly recorded, communicated, or mitigated. The associated learning focuses on improving risk assessment practices, ensuring safety plans are current and comprehensive, strengthening documentation standards, and increasing staff competency through supervision, training, and audit.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Quality Standards meetings where wider learning and good practice can be shared to facilitate improvements Trust-wide.

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG), and the Patient Safety, Learning and Experience Group (PSLEG). Any significant issues identified by the OLG are escalated to the Executive Directors Group – Quality and Performance for further discussion and or actions. The OLG has a 12-month workplan based on the recurring themes identified.

1.3.3 Patient Safety Incident Management/Investigation

The Trust has a continued focus on improving the quality of incident reporting, investigation, and identification of key actionable learning. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF).

1.3.4 The Environmental Risk Group

This group receives information where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is distributed Trust-wide via Patient Safety Briefings. The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures.

1.3.5 Recruitment and Retention/staffing establishment reviews

When looking at patient safety incidents through a systems and human factors lens, it can be seen that workforce pressures and capacity including community caseloads can impact on the quality of care delivered. Significant work is being undertaken to ensure that we have a suitably skilled and resourced workforce who can carry out their duties in a safe and compassionate way. Further details can be seen within the safe staffing and establishment review papers.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Report to the Board of Directors

Committee Chair's report — Alert, Assure and Advise

Committee:	Planning, Digital and Estates Committee (PDEC)
Report to:	Board of Directors — Public
Date of committee meeting:	13 November 2026
Date of Board meeting:	26 November 2026
Committee Chair:	Len Richards, Non-Executive Director
Report author:	Donna Keeping, Corporate Governance Manager
Quorate:	The meeting was quorate, with three voting members: Len Richards (Chair), Liz Romaniak and Jamie Todd (attending on behalf of Naomi Lonergan).
Attendance:	Lorraine Sellers on behalf of Nick Black, Chief Operating Officer, Simon Adamson, Director of Facilities and Estates, Kendra Marley, Head of Risk Management. David Butcher, Associate Non-Executive Director, left at 11.37 am.

1. Purpose of this report

To inform the Board of PDEC's principal alerts, assurance conclusions and decisions from 13 November 2026, and the matters requiring Board consideration. The report reflects the draft minutes pending ratification and the action log updated on 16 November 2026; it does not include subsequent programme or risk updates. Reports were presented by Kendra Marley, Head of Risk Management; Kathryn Ellis, Interim Executive Director of Strategy and Transformation; Liz Romaniak, Executive Director of Finance, Estates and Facilities; Lorraine Sellers, Head of Digital Delivery; and Simon Adamson, Director of Estates, Facilities and Capital.

2. Key items considered at the meeting

Agenda item	Lead	Summary of discussion	Outcome
Matters Arising and Action Log	Committee Chair	Reviewed actions, cross-Committee working and EPRR reporting through InPhase, CRR and BAF.	Progress noted; EPRR tracking completed. Meeting: 30 November; workshop: January 2027.
Terms of Reference and Work Programme	Committee Chair / Anna Pridmore	Refinement to clarify remit, EPRR responsibilities and Committee interfaces, prioritising strategic scrutiny over operational detail.	Further development agreed through the Q3/4 governance review.

Board Assurance Framework and Corporate Risk Register	Kendra Marley	All five primary risks remained above tolerance. Capital constraints drove the estates reassessment; members challenged control effectiveness and BAF/CRR alignment.	Reasonable assurance; estates escalated. Alignment by 11 December.
Trust Strategy Refresh Approach	Kathryn Ellis	Refresh to build on Our Journey to Change and the Medium-Term Plan, informed by evidence, engagement and the PA review. Capacity, affordability and health inequalities remain central.	Supported. PDEC material by 11 December; Board seminar: 17 December.
Partnership and System Working	Kathryn Ellis	Governance was established. Further work to strengthen demonstration of strategic impact of partnership working on Trust objectives.	Reasonable assurance. Framework/reporting cycle recorded as agreed.
EPR Assurance Briefing	Liz Romaniak	Programme amber; Reporting and Integration red. Supplier arrangements, authentication, migration, training and Rio Rep support remained under scrutiny; day-one mitigations in testing and NHS England's written report awaited.	Reasonable; no go-live approval. CEO: Chair update after 19 November/before Board. QAC/PCC engagement before finalisation.
Analogue to Digital Programme Report	Lorraine Sellers	Approved projects were on track, but EPR demands constrained capacity. Non-quoracy and inconsistent operational participation were escalated; roadmap and benefits reporting were developing.	Reasonable assurance. Stronger ownership supported; adoption, sustained benefits and risk reduction not yet demonstrated.
Digital Management Performance Report	Lorraine Sellers	Cyber controls supported assurance, but SAR/rectification pressures, inconsistent recovery maturity and safety-case gaps remained. DSPT plan acceptance did not establish full compliance.	Reasonable overall; limited for SARs. To return December EDG findings on demand, capacity, resources and trajectory.
ERIC 2025/26 Benchmarking and Assurance Report	Simon Adamson	Validated return supported planning. Occupancy costs were favourable; cleaning, waste, water costs and utilisation required scrutiny alongside future service needs.	Good assurance received. Further review in February 2027.
Estates and Facilities Performance and Compliance	Simon Adamson	Stable services, cleanliness and improved oversight were recognised. Water, maintenance, workforce, CRES and investment pressures remained despite favourable finances.	Upgraded to good assurance for performance/oversight, not all estate risks. Simon Adamson to relay positive feedback to staff.

3. Alert — matters requiring Board attention

- **Estates capital exposure:** The Committee escalated constrained capital availability: must-do requirements exceed resources, future allocations are uncertain and Roseberry Park Phase 2 commitments restrict other investment. BAF 06 was re-rated at 16 against tolerance 12 through reassessment of both initial and current exposure, not deterioration from the revised initial position. The Board is asked to request further Executive assurance through PDEC on the funding gap, investment priorities, implications of deferring works, mitigation options and residual risks, and agree the reporting timetable (recommendation 2). Risk-register alignment alone will not resolve the capital constraint.
- **Electronic Patient Record (EPR) readiness:** The programme remained amber overall. Reporting and Integration were red, day-one reporting mitigations unproven and licensing/cost negotiations unresolved. Further assurance was required on authentication replacement, migration load times, training capacity and arrangements to cover the clinical duties of Rio representatives (staff supporting colleagues with the new electronic patient record system around go-live); NHS England's written report was awaited. Implementation remained planned for April 2027, potentially one week later than 12 April for staffing reasons. The exceptional Programme Board on 19 November is scheduled to test go-live criteria and readiness. An update for the Chair is to follow before the Trust Board, covering unresolved risks and matters beyond the Programme Board's remit. Go-live approval remains with the Trust Board.
- **Limited assurance on Subject Access Requests (SARs):** October reporting recorded 28 overdue SARs and 40 open non-SAR information requests. Rectification complexity, resource constraints and anticipated Public Inquiry demand prevent a sustainable position being reported at this point. December Executive Directors Group (EDG) scrutiny of demand, capacity, resources and trajectory will inform PDEC's next assessment. Statutory obligations remain unchanged; the Information Commissioner's Office (ICO) will review progress in March 2027.

> Estates is the explicit risk escalation; EPR and SARs require Board oversight. No new above-tolerance risk acceptance or EPR go-live approval is sought.

4. Assure — Committee assurance conclusions

The Committee recorded the following assurance conclusions; no single overall grade was agreed.

Area of oversight	Assurance level	Commentary
BAF and Corporate Risk Register (CRR) governance	**Reasonable**	Established oversight supported assurance; evidence of effective controls and sustained risk reduction remained mixed. Risk ratings and alignment actions are set out in section 6.
Partnership and system working	**Reasonable**	Relationships and governance were established; measurable impact on commissioning, pathways, resources and population outcomes needs strengthening.
EPR programme	**Reasonable**	Programme, independent and audit assurance were broadly consistent: Gateway 4 approval was conditional at amber and AuditOne's good governance opinion was draft. Readiness exceptions in section 2 prevent higher assurance.

Analogue to Digital programme Digital Management overall	**Reasonable**	Approved digital projects were on track, but capacity, non-quoracy, inconsistent operational participation and incomplete adoption/benefits evidence limited assurance. Cyber controls and sampled recovery testing supported Digital Management assurance; continuity/recovery maturity was inconsistent and seven clinical-system safety cases incomplete, although the highest-risk cases were complete. NHS England accepted the Data Security and Protection Toolkit (DSPT) improvement plan, not compliance with all standards; planned completion is 31 May 2027.
Subject Access Requests	**Limited**	Backlog improvement had not yet established sustainability; see section 2 for exceptions and Executive follow-up.
Estates and Facilities performance and compliance	**Good**	Upgraded from reasonable to good for stable services, cleanliness, oversight and improvement. Fire Risk Assessments were compliant with no outstanding fire actions. Water actions awaited Water Safety Plan ratification; maintenance, workforce, cost improvement (CRES) and investment pressures remained despite a favourable financial position.
Estates Returns Information Collection (ERIC) and estates planning	**Good**	Validated return supported planning. Occupancy costs were favourable; cleaning, waste and water benchmarks and utilisation require scrutiny alongside future service needs. Proposed substantial submission assurance and good improvement assurance were agreed. Overall good assurance agreed.

Key: Green: good; amber: reasonable; red: limited. Governance, performance and favourable cost benchmarks do not establish that strategic risks are resolved or within tolerance.

5. Advise — decisions and strategic direction

- Approved the 9 October minutes and agreed continued Terms of Reference/work programme refinement through the governance review. Emergency preparedness, resilience and response (EPRR) risk-tracking arrangements were agreed.
- Supported the Strategy Refresh approach - building on Our Journey to Change and the Medium-Term Plan, informed by delivery evidence, engagement and population insight, alongside the independent Strategic Review undertaken by PA Consulting to inform the Trust's longer-term ambition, priorities and strategic choices. Capacity, affordability and health inequalities evidence remain key considerations.
- Agreed purposeful, influential, impactful and controlled partnership assurance, with quarterly synthesis, an annual strategic view and exception reporting. Confirmed the boundary between Executive management and PDEC strategic assurance.

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

The following Board Assurance Framework (BAF) and Corporate Risk Register (CRR) ratings and risk-action position are those reported at 14 October 2026, not a refreshed position at the date of this report.

- **Primary BAF risks:** All five remained above tolerance 12: BAF 05 Digital – Supporting Change and BAF 07 Data Security and Protection at 20; BAF 06 Estates/Physical Infrastructure, BAF 10 Roseberry Park and BAF 12 Transformation at 16. Some scores were unlikely to reduce materially until 2027/28.
- **Corporate risks:** New aligned risks were CRR 1827 Electronic Patient Record – Rio (15) and CRR 1637 Information Asset Management Compliance (16); CRR 1647 Cyber security vulnerabilities was 15, all against tolerance 12. CRR 1636 Incomplete or inaccurate Cito patient record was already formally accepted above tolerance.
- **Secondary lens:** BAF 08 Partnerships and System Working (16) and BAF 11 Financial Sustainability (20) exceeded tolerance 12; BAF 11 was already formally accepted above tolerance. BAF 13 Public Inquiry (4 against tolerance 5) remained within tolerance under Board oversight.
- **Follow-up:** BAF 06/12 corporate-risk alignment, or a rationale for none, is due on 11 December; BAF 06/10 Committee alignment will be corrected in the next report. Quarter 2 controls were updated and no risk actions were overdue at 14 October, although dates had been extended.

7. Recommendations to the Board

No.	Recommendation / action requested of the Board	Owner	Timescale
1	Note the recorded assurance conclusions and decisions.	Board of Directors	26 November 2026
2	Note the escalated estates capital exposure and request further Executive assurance, through PDEC, on the quantified gap between must-do requirements and available capital, investment priorities, the implications of deferring works, mitigation options and residual risks. Separately, note the risk-alignment follow-up in section 6, due on 11 December 2026; this will clarify risk reporting but will not resolve the capital constraint. No additional capital expenditure approval or formal acceptance of above-tolerance estates risk is sought through this report.	Board; follow-up: Kathryn Ellis, Interim Executive Director of Strategy and Transformation / Liz Romaniak, Executive Director of Finance, Estates and Facilities	26 November 2026: Board consideration and agreement of the further-assurance timetable; risk-alignment follow-up: 11 December 2026.
3	Receive the Committee Chair's verbal EPR update at the Board meeting on 26 November 2026, including the implementation recommendation, unresolved risks and matters requiring Board attention. This report does not seek go-live approval.	Board / Committee Chair; update arranged by Chief Executive	At the Board meeting on 26 November 2026
4	Note the Strategy Refresh sequencing towards the Board seminar and the December Executive scrutiny of SAR sustainability, with the outcome returning to PDEC.	Board of Directors	Note on 26 November; seminar 17 December; SAR scrutiny in December 2026

8. Forward look

PDEC will review emerging strategic analysis and Board seminar material on 11 December, ahead of the 17 December seminar. The EPR interim assurance report is expected on 7 December; a clinical-safety recovery update is due in December. The SAR outcome will return after December EDG scrutiny, with timing dependent on that consideration. Cross-Committee discussion is arranged for 30 November, followed by a PDEC workshop in January 2027 and planned bi-monthly Chair meetings during 2027 alongside the governance review. The cleaning-service review is expected to conclude in February 2027.

9. Next meeting

The next meeting of the Planning, Digital and Estates Committee is scheduled for Friday 11 December 2026 at the revised time of 10.00 am.

Prepared by: Donna Keeping, Corporate Governance Manager | On behalf of: Len Richards, Non-Executive Director and Committee Chair | Reporting date: 16 November 2026 | Version 1.1 - prepared for Board submission. Source minutes remain draft pending ratification.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Report to the Board of Directors

Committee Chair's 3 A Report

Committee:	People and Culture Committee
Report to:	Board of Directors (Public)
Date of Committee meeting:	Thursday 12 November 2026
Date of Board meeting:	Thursday 26 November 2026
Committee Chair:	Roberta Barker, Non-Executive Director
Report author:	Sharon Ross, Corporate Governance Manager
Quorate:	Yes
Attendance:	6 of 6 present; no apologies for absence

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 and Culture Committee held on 12 November 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
Committee Terms of Reference and Work Programme	Chair/ Secretariat	The Terms of Reference and draft Work Programme were considered. The Committee agreed to a proposal put forward that Sharon Ross and Lesley Hodge would meet with the Chair to populate gaps and identify dates for reports.	Agreed to amend and return updated Work Programme to Committee in January 2027
Board Assurance Framework and Corporate Risk Register	K Marley Head of Risk Management	The Committee received reasonable assurance on risk management, noting improved risk and action reporting, two completed actions and additional control evidence.	Reasonable assurance

Agenda item	Lead	Summary of discussion	Outcome
People and Culture Performance Dashboard and Workforce Strategy Delivery Report	L Hodge Interim Director of People and Culture	The Committee received good assurance on workforce risk understanding and reasonable assurance on improvement. During Quarter 2, it noted improvement in long-term sickness cases concluding within six months and the introduction of specialist early intervention support for mental health cases. Bank scrutiny and weekly Executive reporting were being strengthened. Further focus was required on training capacity, flexible working and employee relations.	Good assurance on risk understanding; reasonable assurance on improvement
Inclusive Cultures Quarterly Report	Lisa Cole, Head of Inclusive Cultures	The Committee received reasonable assurance on development activity and staff networks, noting progress. Further focus was required on six- and twelve-month tracking of staff network development outcomes and unmet development requests.	Reasonable assurance
Workforce Data Report Quarter 2	L Hodge Interim Director of People and Culture	The Committee received reasonable assurance on workforce data. Staffing remained broadly stable at approximately 8,305 staff and 7,498 whole-time equivalents. Of 106 active employee relations cases, those exceeding four months fell from 54 to 32. Further focus was required on exit information to strengthen understanding of retention.	Reasonable assurance
Health and Wellbeing Report	H Cooke, Strategic lead for Health & Wellbeing	The Committee received reasonable assurance on health and wellbeing, noting pulse survey scores above national comparators and positive outcomes from Employee Psychology, Professional Nurse Advocate and regional support. Occupational Health arrangements were under review ahead of contract expiry in March 2027. Further focus was required on contextual activity and experience data, violence and aggression controls and future funding.	Reasonable assurance

3. Key alerts — matters requiring Board attention

The following matters are highlighted for Board awareness and continued oversight:

- **Safe staffing and workforce capacity:** Long-term sickness case resolution and oversight had improved, but absence remained above target; mental health accounted for over half of long-term absence. Sustained improvement and stronger safe staffing assurance required further focus on deployment, supervision, safety-critical training, consultant recruitment and planning gaps.

- **Culture, participation and development:** Development and staff networks progressed, but staff survey and leadership self-assessment uptake remained low. Further focus was required on targeted development, active talent management and clearer career progression for bands 6–9, with monitoring of access and outcomes required.
- **Speaking up and organisational learning:** The service was well used and operating effectively, but one third of Guardian concerns had been raised internally without reported feedback or visible action. Demonstrating improvement required impact tracking, clearer 'You Said, We Did' feedback, triangulated reporting and benchmarking.

4. Assurance summary

The table below summarises the Committee's assurance assessments based on the evidence reviewed. Definitions and qualifications are provided in the key.

Area of oversight	Assurance level	Commentary
Understanding workforce risks	Good	The Committee received good assurance on workforce risk understanding, supported by reporting and strengthened executive oversight. This did not represent complete assurance on delivery.
Workforce strategy and improvement	Reasonable	The Committee received reasonable assurance on workforce improvement, noting progress in recruitment and long-term sickness case resolution. Further focus was required on sustained improvement in retention, temporary staffing use and data quality.
Leadership development and inclusive culture	Reasonable	The Committee received reasonable assurance, with risks understood and actions progressing. Further focus was required on targeted development, talent management and career progression for bands 6–9; monitoring access and outcomes; six- and twelve-month staff network outcome tracking; and unmet development requests. Mediation capacity remained under Committee oversight.
BAF and risk management	Reasonable	The Committee received reasonable assurance overall. Controls generally provided good assurance, with further focus required on material gaps limiting the BAF assessment.
Health and wellbeing	Reasonable	The Committee received reasonable assurance, noting positive wellbeing outcomes. Further focus was required on contextual activity and experience data, Occupational Health arrangements, violence and aggression controls and future funding.
Freedom to Speak Up	No formal rating recorded	The Committee recognised that the service was well used and operating effectively. Further focus was required on evidence of impact and organisational learning to support a fuller Trust-wide assurance assessment. No formal rating was recorded.

Key: Good — assurance that workforce risks were understood, not complete assurance on delivery | Reasonable — progress and oversight arrangements provided assurance, but unresolved risks or evidence gaps required further action | No formal rating recorded — no formal assurance rating was attributed by the Committee; this is not a rating of "No assurance".

5. Decisions and agreements

- Agreed a regularly reviewed Work Programme balancing routine assurance, annual reports and scheduled deep dives, aligned with Care Group reporting and Trust decisions. Amendments would use tracked changes and member feedback.
- Requested Board members' support to encourage staff survey completion.
- Requested consideration of staff rotation to support flexibility and retention, and clearer workforce trend reporting with thematic analysis of grievances, disciplinary investigations and tribunal links.
- Agreed to consider promoting Cavell and evidence-based digital wellbeing support alongside existing SilverCloud provision.
- Agreed to include Occupational Health referral reasons and non-attendance in quarterly workforce reporting.

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 01 Safe Staffing:** score 16 against target and tolerance of 12; above tolerance. Corporate risks 909 (Consultant recruitment) and 1137 (supervision compliance) were also above tolerance.
- **Shared oversight:** BAF 03 Patient Experience, BAF 09 Regulatory Compliance and BAF 13 Public Inquiry were considered through a people and culture lens. Overall assurance responsibility remained with the relevant lead Committees or Board.

7. Recommendations to the Board

The Board is asked to note the Committee's assurances, outstanding risks and agreed actions, and support encouragement of staff survey completion.

8. Forward look

The Committee will receive the updated Work Programme and review leadership and management training, including workforce impact and staff release for mandatory and statutory training.

9. Next meeting

The next meeting of the People and Culture Committee is scheduled for 14 January 2027.

Report prepared by: Sharon Ross, Corporate Governance Manager | On behalf of: Roberta Barker, Committee Chair | Date: 18 November 2026

BOARD REPORT

1. Cover Sheet

Report Title	Freedom to Speak Up Guardian Service Half-Year Report April – Sept 2026
Meeting	Trust Board of Directors
Date of Meeting	26 November 2026
Item number	K
Sponsoring Director/ Author	Lesley Hodge, Interim Director of People & Culture
Report Author	Thomas Vickers, Associate Director of People governance, performance & quality
Purpose of Paper	**Discussion** / **Assurance**
Previously Considered By	People & Culture Committee
Financial Implications	No direct financial implications arise from receipt of the report. Any actions requiring additional resource will be considered through existing governance and business planning arrangements.

2. Recommendation

The Board is asked to:
• receive the independent Guardian Service report for the period 1 April to 30 September 2026; • note the activity, themes, positive indicators and limitations set out in this cover report

3. Executive Summary

This paper presents the Guardian Service report covering the period 1 April to 30 September 2026. The report records 71 new concerns and 44 case closures. The most frequently recorded primary themes were management issues, with 28 cases (40%); system/process issues, with 15 cases (21%); and behaviour/relationship issues, with 10 cases (14%). The report records that no detriment arising from speaking up was reported to the Guardian Service during the period.

The report also provides information on confidentiality preferences, reasons for contacting the service, contact activity and feedback from staff who used the service. Of the 71 concerns, 23 were escalated with names, 16 without names, 3 anonymously, and 29 were retained within the Guardian Service remit.

The report relates only to concerns raised through the Guardian Service and does not include concerns raised through internal Trust routes. The information should therefore be considered alongside other relevant Trust information where appropriate.

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	A safe, healthy and inclusive workplace; high-quality care supported by an open learning culture
Board Assurance Framework	BAF 01 – Safe Staffing: control 1.03, Early identification of concerns, explicitly identifies Freedom to Speak Up as a source of assurance supporting timely identification and response. The report also informs control 1.04, Workforce health and wellbeing. Secondary linkage: BAF 09 – Regulatory Compliance, particularly control 9.07, Equality, Diversity, Inclusion and Human Rights. Guardian Service information is one source of assurance and does not provide a complete Trust-wide speaking-up position.
Corporate Risk Register	No directly aligned Freedom to Speak Up corporate risk is identified in the supplied BAF and CRR report (reporting position: 14 October 2026). CRR 909 – Consultant recruitment and CRR 1137 – Supervision Compliance and Assurance are aligned to BAF 01 and provide wider workforce context; this Guardian Service report does not provide specific assurance on either risk.
Committee / Work Programme Ref	People & Culture Committee Terms of Reference, section 4.2: assurance that arrangements for raising concerns, including the Freedom to Speak Up Guardian, meet national expectations and have the confidence of staff. Work Programme v1, section 3, ToR ref 4.2: Freedom to Speak Up Guardian Report (quarterly).
Regulatory / Legal Reference (if applicable)	Freedom to Speak Up; CQC Well-led; National Guardian's Office Guidance

BOARD REPORT

Report Title	Freedom to Speak Up Guardian Service Half-Year Report April – Sept 2026
Meeting	Trust Board
Date of Meeting	26 November 2026
Item number	K

1. Background

The Freedom to Speak Up (FTSU) Guardian Service provides an independent and confidential route for staff to raise concerns about patient safety, workplace culture, behaviours and organisational practices.

2. Key Issues and Findings

2.1 What the data / evidence shows

During the first six months of 2026/27, 71 new concerns were raised, with 44 cases closed by the end of September. The level of activity demonstrates continued engagement with the independent service and suggests staff are increasingly confident in accessing support.

Primary themes included: management issues 28 (40%), system/process 15 (21%), behaviour/relationship 10 (14%), discrimination/inequality 7 (10%), worker safety/wellbeing 6 (8%), bullying/harassment 4 (6%), and patient safety/quality of care 1 (1%).

The report records 1,006 emails, 248 calls and 195 face-to-face meetings during the period and also includes feedback from staff who used the service.

The report identifies encouraging developments in staff willingness to speak up, alongside areas requiring further organisational attention, particularly management culture, communication, responsiveness to concerns and the handling of organisational change.

Importantly, no incidents of detriment arising from speaking up were reported during this period There are positive indications of growing confidence in the independent Guardian Service.

Of the 71 concerns:

- 41% were retained confidentially within the Guardian Service.
- 32% were escalated with the individual's identity disclosed.
- 23% were escalated without disclosing the individual's identity.
- 4% were raised anonymously.

2.2 Oversight

The Trust has established arrangements to provide oversight of the Guardian Service. These include:

- Monthly meetings with the Director of People and Culture to review emerging themes, case outcomes and any delays.

- Monthly speaking up meetings to triangulate information and identify services or teams requiring additional support.
- Quarterly meetings with the Chief Executive, Chair and Non-Executive Director to consider emerging concerns and organisational learning.
- Continued Guardian engagement through ward visits, team briefings, staff networks and awareness activities.

These arrangements provide mechanisms for identifying emerging risks, supporting timely escalation and promoting organisational learning.

Staff feedback about the independent service has been positive, particularly regarding impartiality, confidentiality, emotional support and feeling listened to.

2.3 Assurance

The report provides positive evidence of staff engagement with the Freedom to Speak Up Guardian Service, including increased willingness to disclose identities when escalating concerns and no reported detriment during the reporting period, with further work to be concentrated on local listening and resolution with meaningful action and feedback.

3. Options Considered

N/A. The paper presents the Guardian Service report for consideration by the Board.

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	The report includes concerns relating to patient safety and quality of care.
Safeguarding	No specific implications identified within this report.
Equality, Diversity & Inclusion	The report includes concerns relating to discrimination and inequality.
Workforce	The report provides information about staff experience and concerns raised through the Guardian Service.
Financial / Resource	No direct financial implications arising from receipt of the report.
Legal	Existing Freedom to Speak Up and employment processes apply as appropriate
Protected characteristics	No specific assessment has been undertaken as part of this report.

5. Appendices

Appendix	Title
A	Guardian Service Report: Tees, Esk and Wear Valleys NHS Foundation Trust, November 2026

6. Document Control

Version	Date	Author	Summary of Changes
0.1	5 November 2026	Thomas Vickers	First Draft
1.0 FINAL	18 November 2026	Lesley Hodge	Final version submitted to Trust Board

Annual Report

1st April – 30th September 2026

Tees, Esk and Wear Valleys NHS Foundation Trust

Distribution: Public Board

Main Point of Contact:

Lesley Hodge

Executive Lead for FTSU

Prepared by:

Adam Howe

Freedom to Speak Up Guardian

The Guardian Service Ltd.

Date:

23rd October 2026

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Contents

1. **Executive summary** 3
2. **Purpose of the paper** 3
3. **Background to Freedom to Speak Up** 4
4. **The Guardian Service** 4
5. **Access and Independence** 4
6. **Categorisation of Calls and Agreed Escalation Timescales** 5
7. **Number of concerns raised** 6
8. **Confidentiality** 7
9. **Themes** 8
10. **Assessment of Cases** 10
11. **Statistical Graphs** 11
12. **Why do staff use The Guardian Service?** 12
13. **Detriment** 13
14. **Action taken to improve the Freedom to Speak Up Culture** 13
15. **Learning and Improvements** 14
16. **Comments & Recommendations** 14
17. **Staff Feedback** 16

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1. Executive summary

During the period 1 April to 30 September 2026, 71 new concerns were raised with the independent Freedom to Speak Up Guardian Service. This level of activity reflects continued awareness of the service and suggests that staff remain willing to use an independent route to raise concerns. During the same period, 44 cases were closed, with the remaining cases continuing to receive support and oversight.

Management-related issues remained the most common theme, accounting for 40% of all concerns raised. Staff frequently described feeling unheard when raising concerns, receiving limited feedback after speaking to managers, and experiencing poor communication. Concerns about management culture and the handling of confidential information also featured regularly.

System and process issues accounted for 21% of cases and were often linked to organisational change, recruitment processes, and uncertainty around evolving ways of working. Concerns relating to behaviours and working relationships also remained a significant theme, demonstrating the impact that workplace interactions can have on staff wellbeing, morale and team functioning.

Encouragingly, there has been an increase in the number of staff who were comfortable having concerns escalated with their identity known. This suggests growing confidence in the speaking up process and greater trust that concerns will be handled appropriately and fairly by trust managers who are responding well and promptly to concerns escalated to them.

No reports of detriment as a result of speaking up were received during this reporting period.

The themes identified highlight the ongoing importance of an independent Freedom to Speak Up service in providing staff with impartial advice and support. They also point to opportunities for improvement, particularly around management communication, feedback to staff following the raising of concerns, and understanding of key organisational processes such as recruitment and service change. Continuing to strengthen these areas will help support a culture where staff feel listened to, valued and confident to speak up when something does not feel right.

2. Purpose of the paper

The purpose of this paper is to give an overview of the cases raised at Tees, Esk and Wear Valleys NHS Foundation Trust to the Freedom to Speak Up Guardian employed by The Guardian Service Limited (GSL) during the first half of reporting year of 2026/27. This reporting period begins on 1st April 2026 and ends on 30th September 2026.

This paper does not include any data relating to cases raised internally and only those raised with the Guardian. This paper will not contain any identifiable information to ensure that confidentiality of those raising concerns is respected in line with national guidelines.

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3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work-related concerns. We work closely with the NHSE and attend relevant FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent service. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in 2025 on Monday 17th November.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

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6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

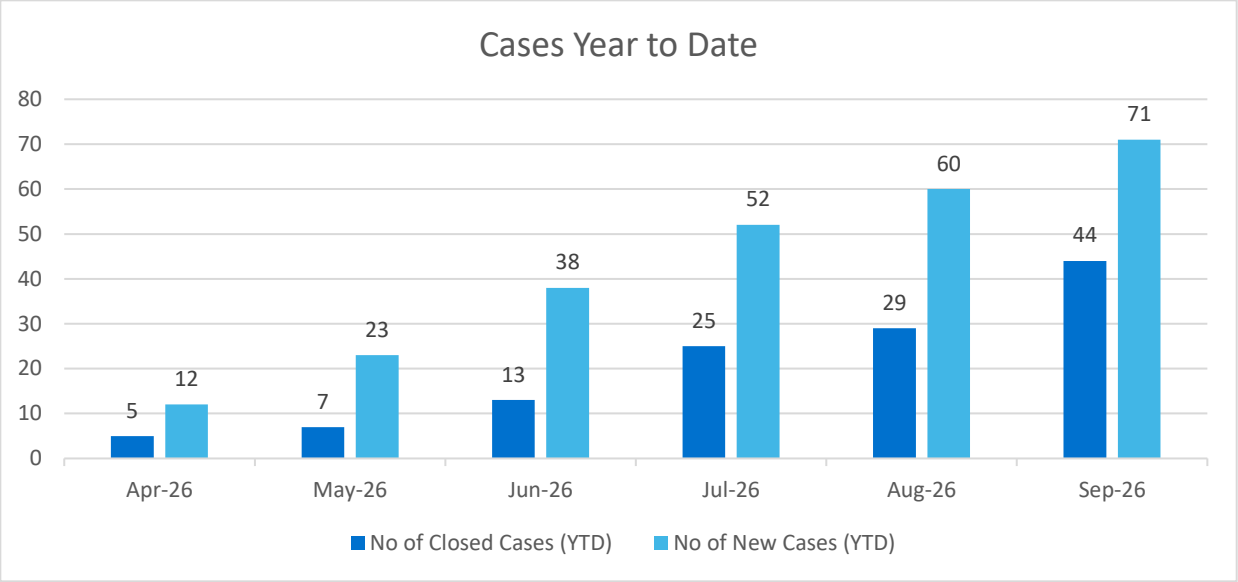
Call Type	Description	Agreed Escalation Timescales
Red	Relates to patient safety/quality, safeguarding and care, staff safety /wellbeing, issues of potential danger to any individual including self-harm. Fraud.	Response required within 12 hours
Amber	Includes bullying, harassment, discrimination, inequality staff safety. Patient safety/quality, staff safety /wellbeing, and fraud can be considered in this category if there is no immediate threat.	Response required within 48 hours
Green	All other themes e.g. change in work conditions etc.	Response required within 72 hours
White	Matters with no discernible risk or cases that highlight opportunities for improvement.	No organisational response required

Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

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7. Number of concerns raised



The above graph shows the number of cases cumulatively year to date. The data shows a steady increase of concerns being brought to the Freedom to Speak up Guardian and cases closed since 1st April 2026, reaching a cumulative total of 71 new cases and 44 closed cases by the end of September 2026. While progress in closing cases is evident, it is expected that closures will trail new cases, as some matters require sustained support for staff over a number of months before they can be appropriately and safely concluded. This reflects the nature of the work, which prioritises thorough, person-centred resolution.

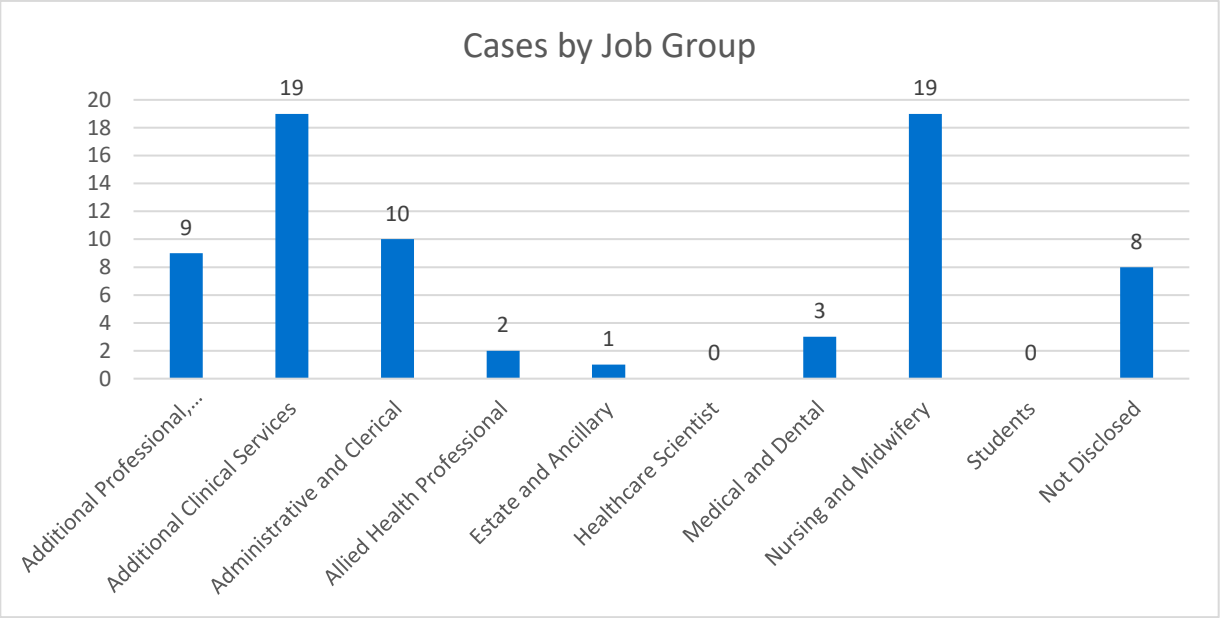
Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff. Guardians will maintain contact until the situation is resolved or the staff member is satisfied that no further action or support is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the Trust's Executive lead for Speaking up at regular monthly meetings.

Cases can remain ongoing for a period, where staff require either ongoing support and guidance from the Freedom to Speak Up Guardian in tackling situations informally or emotional support in situations where they have not built up the resilience to act for themselves.

The number of emails, telephone calls and face to face visits in responding to these concerns during the reporting period are as follows:

Emails - 1006	Calls - 248	Face to Face Meetings - 195

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Cases by Job Group highlight that even though a large majority of concerns raised haven't been directly related to patient safety, the majority of concerns taken have come from job groups that have direct contact and care for patients. Removing the concerns that staff have enable staff to give the best care possible to the patients.

Open cases are continually monitored and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff. Guardians will maintain contact until the situation is resolved or the staff member is satisfied that no further action or support is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the trust's organisational lead for the Freedom to Speak Up Service at regular monthly meetings.

8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	29	41%
Permission to escalate with names	23	32%
Permission to escalate without name	16	23%
Permission to escalate anonymously	3	4%
Total	**71**	**100%**

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The number of concerns being raised without their name being has reduced significantly compared to the first 6 months of the Guardian Service taking over the service. The number of concerns being raised with names has increased dramatically as those raising concerns have faith and trust in the process without fear of facing detriment as a result of speaking up.

For clarification, “Permission to escalate anonymously” means the Guardian does not know the name of the staff member raising the concerns. “Permission to escalate without name” means the Guardian knows the staff members name but they have chosen to withhold that information from the Trust.

The monthly reports that a received by the trust are working documents and the figures around permission to escalate can change month to month as the Freedom to Speak Up Guardian works with staff raising concerns.

9. Themes

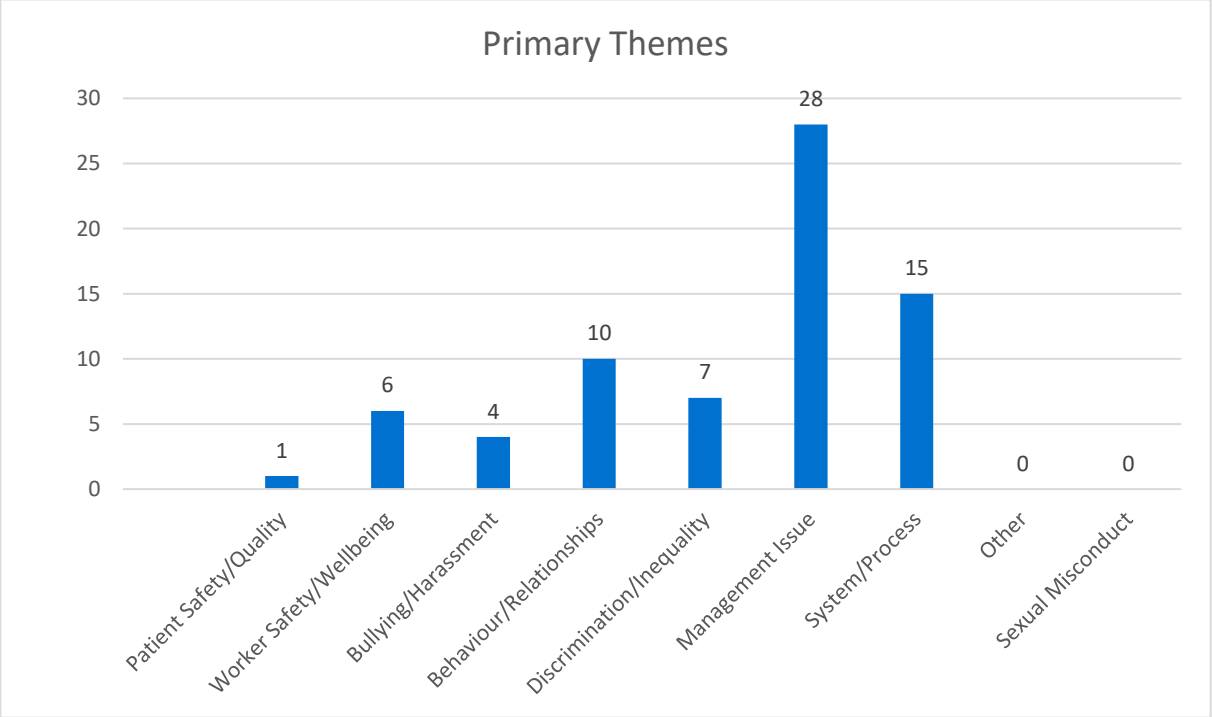
Each case is recorded under a primary theme, with any additional themes logged as multi-theme occurrences. Quarterly national reporting is based on multi-theme occurrences, which reflect cases involving elements of more than one theme.

Concerns raised are broken down into the following categories; Patient Safety/Quality of Care, Worker Safety/Wellbeing, Bullying/Harassment, Behaviour/Relationship, Discrimination/Inequality, Management Issue, Sexual Misconduct, System/Process and Other.

The following table and graph display the breakdowns of the primary themes for the 71 concerns raised from 1st April to 30th September 2026:

Primary Theme	Total	Percentage
Patient Safety / Quality of Care	1	1%
Worker Safety / Wellbeing	6	8%
Bullying / Harassment	4	6%
Behaviour / Relationship	10	14%
Discrimination / Inequality	7	10%
Management Issue	28	40%
Sexual Misconduct	0	0%
System / Process	15	21%
Other (Describe)	0	0%
Total	**71**	**100%**

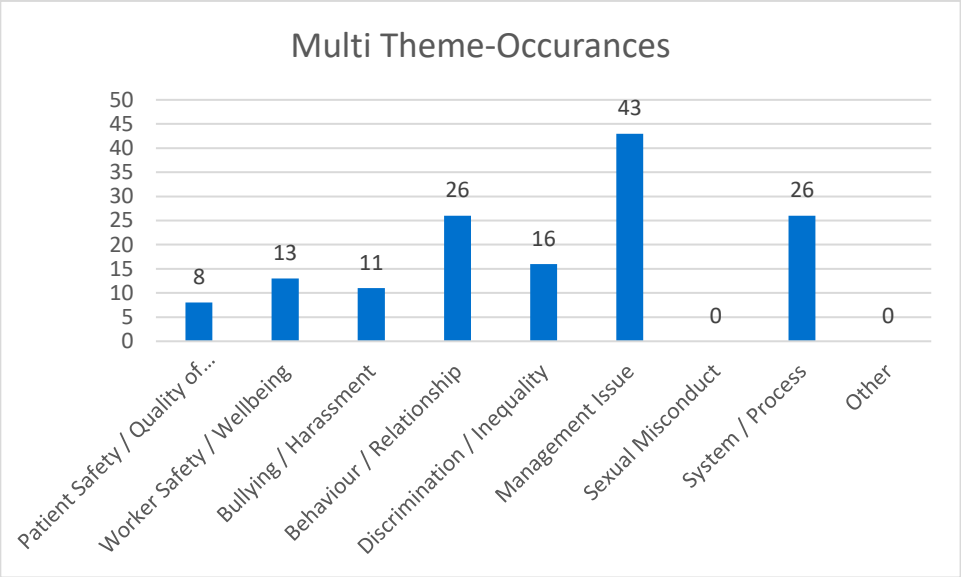
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Some concerns raised may also have a secondary theme attributed to them with secondary/multi-themes broken down as below in the table and graph:

Multi Theme-Occurances	Total	Percentage
Patient Safety / Quality of Care	8	6%
Worker Safety / Wellbeing	13	9%
Bullying / Harassment	11	8%
Behaviour / Relationship	26	18%
Discrimination / Inequality	16	11%
Management Issue	43	30%
Sexual Misconduct	0	0%
System / Process	26	18%
Other (Describe)	0	0%
Total	143	100%

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10. Assessment of Cases

The top three themes recorded during the reporting period have been assessed as follows:

Management Issue

During this reporting period 28 concerns (40%) of all concerns raised related to a management issue. This is quite a significant increase compared to the previous reporting period. Within these cases the most prominent experiences reported were perceptions of the following:

- Poor leadership and culture
- Staff not feeling listened to when raising concerns to management
- Staff reaching out to management for extra support for the team when staffing levels are low and getting no further support continues to be a common theme within management issue concerns.
- Managers not respecting confidentiality and having confidential conversations in open offices/locations.

System/Process

For clarification, System/Process refers to concerns that are around, for example, Trust policies and processes, recruitment processes, service structures, bandings and responsibilities and similar kinds of concerns.

15 concerns were raised under system/process accounting for 21% of all concerns raised to the Freedom to Speak up Guardian. Some of the recurring themes raised by staff members are as follows:

- Insecurity around the handling of change and change management.
- Lack of clarity on new ways of working

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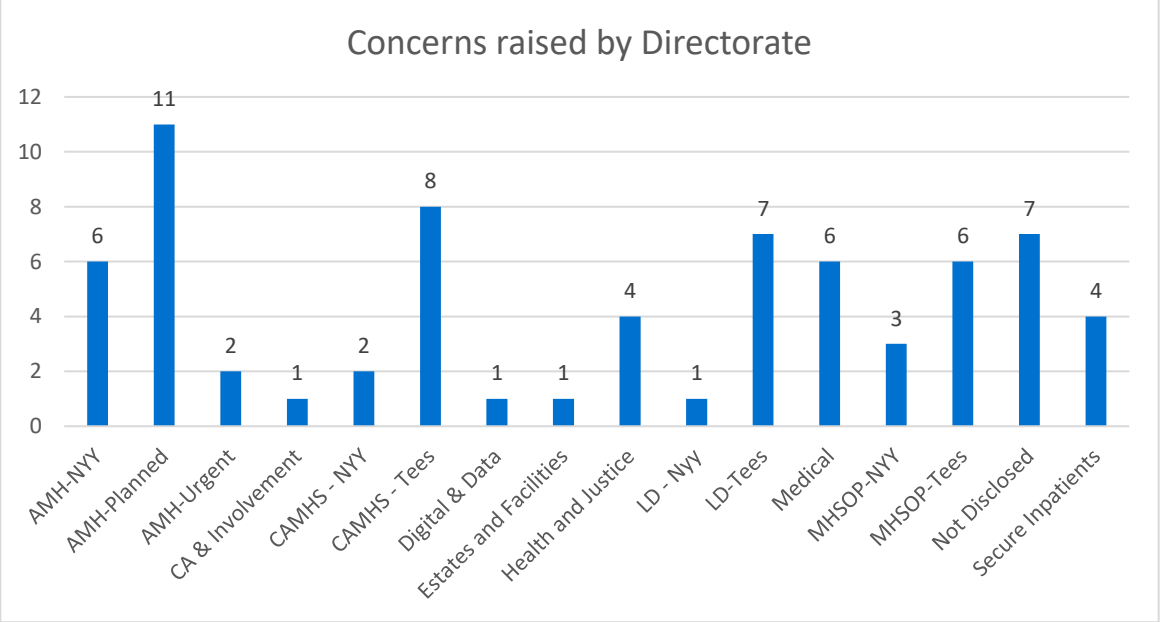
Behaviour/Relationships and Bullying/Harassment

Even though Behavioural/Relationship and Bullying and Harassment are 2 separate themes, I have combined them as there are similarities between with common themes. 20% of concerns raised have either Behavioural/Relationship or Bullying and Harassment as the primary theme. This equates to 14 concerns raised during this reporting period. Some of the recurring themes raised by staff members are as follows:

- Colleagues taking clinical questions personally which results in staff being treated differently
- Staff being rude or inappropriate to colleagues in front of patients, patient families or other colleagues

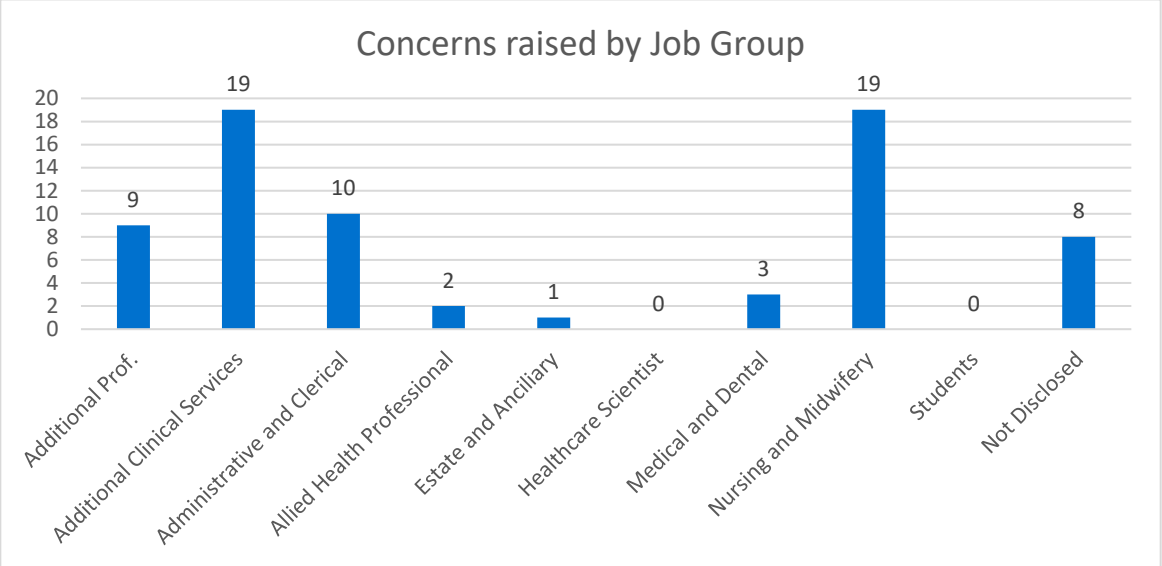
11. Statistical Graphs

Concerns raised by Directorate



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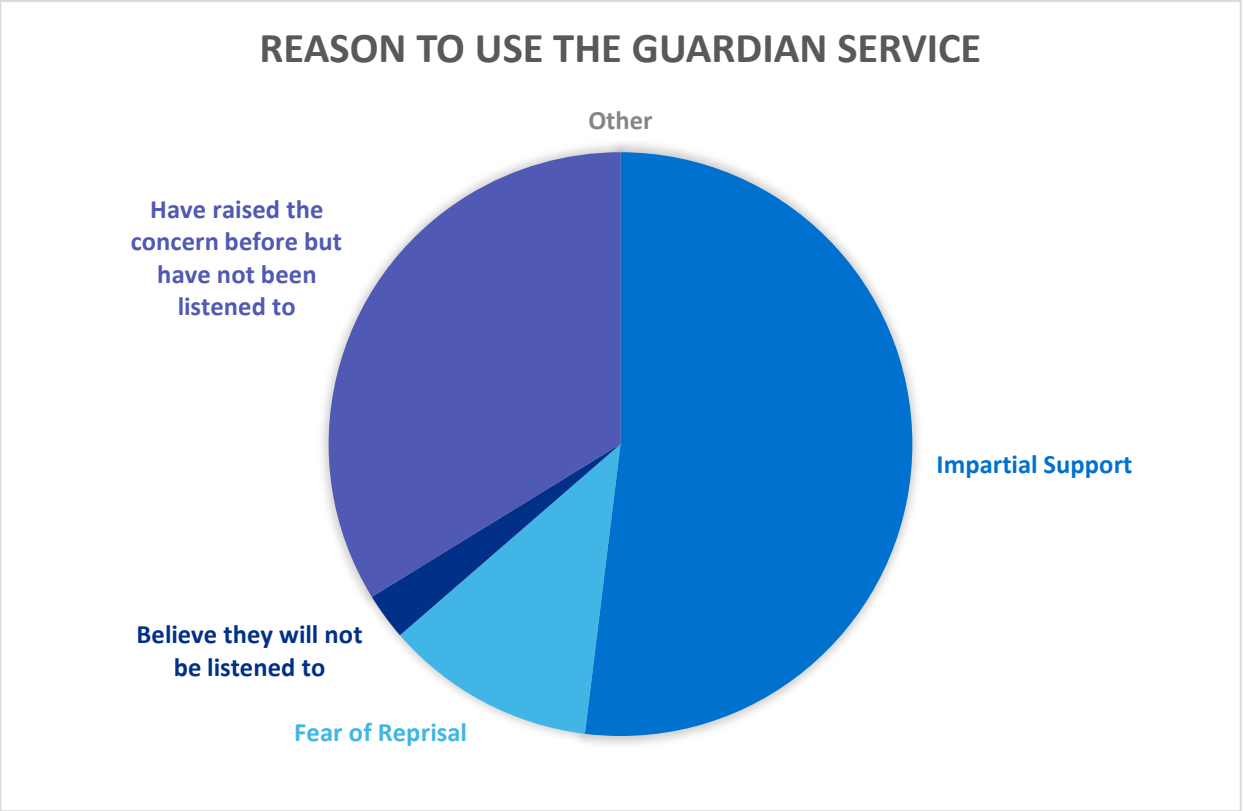
Concerns raised by Job Group



12. Why do staff use The Guardian Service?

Reason to Use the Guardian Service	Total	Percentage
Impartial Support	40	52%
Fear of Reprisal	9	12%
Believe they will not be listened to	2	3%
Have raised the concern before but have not been listened to	26	33%
Other	0	0%
Total	77	100%

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As can be seen above 33% of all cases raised to the Freedom to Speak up Guardian have already been raised to the trust. In these cases, managers/management have had the opportunity to listen and give feedback and updates on potential changes that are being explored. Unfortunately, these opportunities have been missed by managers, and managers haven't been giving updates, listening or making staff feel listened to pushing the staff member to feel like they need to speak to the Freedom to Speak Up Guardian.

13. Detriment

There has been no reported detriment in this period. The Guardian Service encourages staff to speak up whilst maintaining that they will not suffer any detriment. The Freedom to Speak Up Guardian spends a great deal of time with staff members creating a psychologically safe space for them to be able to share their experiences openly, reassuring them that if they do feel they have suffered detriment, they must report this to the Freedom to Speak Up Guardian immediately. This is part of the process and gives staff confidence they will continue to be supported. Detriment is a major concern that is associated with speaking up and has a huge influence on Freedom to Speak Up culture.

14. Action taken to improve the Freedom to Speak Up Culture

The Freedom to Speak Up Guardian supports staff to resolve their concerns and worries informally. This avoids concerns that can lead to more formal processes to resolve these concerns such as grievances which can be long, costly and damaging to all those involved.

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

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

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

The Guardian conducts walkabouts, ward visits and offices to speak about The Guardian Service and raising awareness. During these visits the Guardian distributes promotional material too all staff. Further promotional briefings happen with teams, networks and services happening both in person and virtually across many trust directorates.

Feedback indicates that staff contacted the Guardian following promotional activity, recommendations from colleagues, and briefings delivered by the Guardian, which accounted for the majority of concerns raised. Early in the new service, staff would also see internal communications or seeing the new promotional posters around their locations of work.

15. Learning and Improvements

Issues relating to policies/procedures and the way they are implemented are often brought to the Freedom to Speak Up Guardian. The independent status of the Guardian, in clarifying points that staff may not comprehend, understand or want to raise internally, in many instances satisfied the staff member who was raising the concern and prevented an escalation.

16. Comments & Recommendations

Improve feedback to staff who raise concerns (Management Issue)

Concerns relating to management behaviour and practice highlight variability in staff experience across teams, services and departments.

Recommendation:

Concerns continue to highlight that some staff do not receive feedback after raising issues and are therefore unclear about outcomes and if any actions have been taken. To improve confidence in local resolution processes, managers should be supported to provide timely feedback and effectively close the loop on concerns raised. The Trust may wish to consider

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implementing a "You Said, We Did" approach to strengthen transparency, promote learning, and demonstrate the positive impact of speaking up.

Focus on management capability (Management Issue)

Recommendation:

With management issues representing the most frequently raised theme in this reporting period. This suggests there is the opportunity to further strengthen leadership capability across the trust, particularly in relation to active listening, conflict resolution, compassionate leadership and the effective handling of concerns. The trust may want to review the existing Leadership Academy and speed up the rolling out to even more management.

Recommendation:

To further strengthen a positive speaking up culture, leaders need to routinely discuss speaking up within team meetings, one to ones and other staff engagement forums. These conversations must reinforce that raising concerns is welcomed, valued and won't be subjected to negative responses. As part of this, management promoting staff surveys, listening events and inviting the Freedom to Speak up Guardian to team meetings. These surveys, engagement with the Freedom to Speak up Guardian and conversations with staff will enable the Trust to assess whether staff feel psychologically safe to challenge decisions, share concerns and contribute around service improvements.

System/Process

A significant proportion of concerns raised relate to systems and processes, particularly in relation to organisational change, recruitment, restructuring, and the application of policies. Staff have described uncertainty, prolonged timeframes, and a lack of clarity, which in turn has increased anxiety and reduced confidence in internal escalation routes.

Recommendation:

Concerns raised within the System/Process have highlighted opportunities to improve recruitment processes, particularly in relation to the communication between hiring managers and internal candidates. Also the improvements in hiring managers' knowledge around the recruitment processes and policies need to be improved to remove the issues that have arisen within this reporting period.

Behaviour/Relationship and Bullying and Harassment

A combined theme of behavioural, relationship, bullying and harassment concerns represents a notable proportion of cases continues to be found within the data. Staff describe repeated inappropriate behaviours, unprofessional interactions, and breakdowns in working relationships that negatively impact both wellbeing and team functioning.

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Recommendation:

Themes identified through concerns raised suggest an opportunity to further strengthen people management practices across the Trust. Focus needs to be given in promoting respectful and professional behaviours, maintaining appropriate confidentiality, and ensuring concerns are acknowledged and addressed in a timely and supportive manner by managers at all levels throughout the trust. Continued development of managers in these areas will help foster a more open and responsive culture.

17. Staff Feedback

I did feel the service was helpful and offered a non-biased, non-judgmental conversation which was both supportive and enabled me to reflect. This was very much appreciated- when I was feeling "hard done by"

I felt very supported and listened to in a non-judgmental manner. I felt confident to speak up knowing that my confidentiality was respected. I also felt empowered and was given options to deal with my issue.

If I felt unable to speak up within my own service as was the case in my scenario then I wouldn't hesitate to contact FTSU

Thanks for all your support in this, you really made all the difference

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Tees, Esk and Wear Valleys
NHS Foundation Trust

LBOARD REPORT

1. Cover Sheet

Report Title	Guardian of Safe Working Quarterly Report
Meeting	Trust Board of Directors
Date of Meeting	26th November 2026
Item number	L
Sponsoring Director / Author	Dr Kedar Kale, Executive Medical Director
Report Author	Dr Sharon Beattie, Guardian of Safe Working
Purpose of Paper	**Assurance** / **Information**
Previously Considered By	n/a
Financial Implications	

2. Recommendation

The Board is asked to:
Note and receive assurance on safe working hours for resident doctors.

3. Executive Summary

The Board receives annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for resident doctors.
The Board are asked to read and note this quarterly report from the Guardian of Safe Working.

At present the data from Exception Reporting raises no significant concerns about safe working for Resident Doctors. There is a potential pattern arising related to late working when there are periods of leave/rest days within a department. This needs further monitoring.

There has been a poor response rate from the detriment survey but from these few responses there is a signalling that some doctors feel they are discouraged from exception reporting. These issues will be explored further within the Resident Doctor Training Forum.

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	We will be a great employer – the report supports a safe and positive working environment for resident doctors, including compliance with contractual working-hours and rest requirements.
Board Assurance Framework	BAF 01: Safe Staffing - safe rostering,, the management of rota gaps and compliance with resident doctors' terms and conditions contribute to maintaining viable training positions and attracting and retaining the medical workforce.
Corporate Risk Register	Not applicable.
Committee / Work Programme Ref	The report provides Board with quarterly assurance on compliance with resident doctors' contractual safe-working requirements.
Regulatory / Legal Reference (if applicable)	2016 Terms and Conditions of Service; Guardian of Safe Woking Hours requirements; CQC Fundamental Standards relating to safe care and treatment, staffing and good governance.

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

Report Title	Guardian of Safe Working Quarter 2 report
Meeting	Trust Board Public
Date of Meeting	26th November 2026
Item number	L

1. Background

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

The Board receives annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for resident doctors.

This is the quarterly report for July to September 2026. The appendix has been provided to me by Medical Staffing, and includes aggregated data on number of exception reports, details of associated payments, time of in lieu and fines levied, and data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting, when needed, good practice and/or persistent concern. Reports and appendices are shared with the corresponding NHS England body for the different sectors

2. Key Issues and Findings

2.1 What the data / evidence shows

Exception reporting data for Quarter 2 has been prepared by medical staffing and details are included in Appendix 1.

In the North Care Group there were 29 exception reports in Quarter 2. If you exclude the access and completion exceptions, which are in place to confirm access to the system rather than an exception to the working schedule, this number falls to 21. This is a similar figure to Q1 (19 when access and completion excluded). Five of the exceptions were from NROC breaches on the middle roster. Fifteen of the remaining exceptions were for working late, over and above scheduled hours. This is similar to the figure from Q1 (16) but did not occur in the same locality as the Quarter 1 exceptions. Although one doctor did not achieve scheduled breaks this did not incur a fine as this did not go over the guidance outlined in the terms and conditions (missed breaks for more than 25% of occasions across 4 week reference period). At present, based on this data, none of the exception reports raise a concern about a pattern in a specific department, and so there has not been the need to request a work schedule review.

In the South Care Group there were 19 exception reports in Quarter 2. This remains lower than last year's figures, and is also over inflated by the access and completion exceptions. If these are excluded the number of exception reports is 13. This is the same as the number of exceptions made in Quarter 1 (13 once the access and completion exceptions excluded). Eleven of the exceptions in this quarter were from the middle tier roster and Scarborough NROC roster. This rate of exception reporting on the NROC roster is not unexpected. Only 2 exception reports in this region were related to working late.

With exception report reforms being implemented in February 2026 we had been expecting an increase in exception reporting related to working late due to the increased communication/awareness in resident doctors about the use of exception reporting and the change in choice of renumeration for these. In this quarter this again seems to be reflected in the North Care group but not in the South Care Group. At present we have not had enough of a response rate to the detriment survey to know whether this could be a contributing factor.

Unfortunately, the detriment survey response rate remains low despite targeted efforts to optimise this. One doctor has reported that they have experienced detriment from making an exception report, which of course is of concern. Another two feel they have been discouraged from making exception reports. Information from the regional Guardian of Safe Working groups suggest there are similar issue in other Trusts, with poor responses to the detriment survey. Similarly, the access and completion rates are incredibly low. The purpose of these are to confirm that doctors have access to the system however the majority of resident doctors are electing not to do complete these, with only 14 out of 232 doctors doing this. As Guardian of Safe Working, I have not been contacted by any resident doctors expressing concern that they cannot access the system to make an exception report. The detriment survey and access and completion exception reports were introduced following exception report reforms. The issue of low response rates and any further actions to try and address these will be discussed in the next Resident Doctor Training Forum meetings in January 2027. Similarly the recent results from the detriment survey will also be explored further within this Forum. I continue to encourage the resident doctors to exception report when necessary.

There has been no instance where the GOSW has felt the need to request a work schedule review due to concerns of exception reporting within specific departments. Particularly since the change to exception report reforms came into place in February 2026 there have been short lived pockets of late working throughout the Trust and when this has been explored, to ensure that there are no issues with safe working, this is usually related to urgent clinical work often alongside a temporary overall increased intensity of work due to resident doctor staffing levels (peer resident doctors being on rest days, annual or study leave). The Guardian of Safe Working will continue to monitor this to see if this is a persistent pattern that needs addressed.

On the data tables presented in Appendix 1, it outlines there were twelve exception reports in this quarter which levied a fine due to breach of NROC working patterns. The cost of these were £2,633.92 in additional payments to doctors and £3,641.81 in Guardian fines.

In Quarter 2 the fines that were levied were due to breach of the 5 hours overnight rest requirement on Non-Residential On-Call (NROC) rotas. For the first time over the last 12 months there were some breaches in rest on the 1st Tier Scarborough NROC roster. There continue to be breaches on the middle tier NROC rosters in both the North and South Care Groups. The intensity of on-call work varies between NROC shifts considerably. There is always a risk of breach of rest and subsequent fines on such rotas due to the unpredictable nature of the work. Based on the exception reports submitted, the frequency of breaches on all NROC rosters remain low overall.

There is a well-functioning Resident Doctors' Training Forum in each of the Care Groups with good attendance by resident doctor representatives from localities across the Trust. In November 2026 there was a decision on how the monies from existing guardian fine pot would be spent. This will be spent on an educational resource (1 year subscription to the

British Association for Psychopharmacology for all senior registrars on the middle tier roster) to enhance the training experience. The money raised through the fines must be used to benefit the education, training and working environment of trainees but must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEE as fundamental requirement for doctors in training and which should be provided as standard.

The number of vacancies for normal working day posts are given within the Appendix. Medical Staffing assure me they always liaise with the services and Associate Medical Directors and Trust Doctor cover is sourced when requested. It is important to note that the Trust does not cover GP ITP and ST4-7 resident doctor vacancies as these posts are considered to be primarily for training. Also, not all posts can be filled at any one time as there are more available training posts than trainees. The data presented raises no concerns about vacancies.

The internal system for covering out of hours rota gaps appear to continue to function well in that there is no reported use of agency locums on out of hours postgraduate doctors' rotas. First tier resident doctors and SAS doctors stepped in to do these locums and on only one occasion was it was necessary to ask a senior registrar to 'act down' due to an internal locum not being appointed. Although the data presented in the appendix suggests that some shifts were unfilled, I am assured this was not the case by Medical Staffing and these figures are linked with an admin issue related to Patchwork.

3. Options Considered

This report is for information and assurance only.

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	**Positive impact.** Monitoring exception reports, working hours, rest requirements and rota gaps supports the safe rostering of resident doctors and helps identify potential risks arising from excessive hours or insufficient rest.
Safeguarding	No direct impact identified
Equality, Diversity & Inclusion	No adverse impact identified
Workforce	**Positive workforce impact.** The report provides assurance on resident doctors' working hours, rest, rota coverage and compliance with their terms and conditions.
Financial / Resource	12 exception reports, resulted in additional payments to resident doctors and Guardian fines.
Legal	No direct impact identified
Protected characteristics	No adverse impact identified

5. Appendices

Appendix	Title
1	Quarterly report 2 (1st July 2026 to 30th September 2026)

6. Document Control

Version	Date	Author	Summary of Changes
1.0 FINAL		Report author	Final version submitted to Trust Board

Appendix 1

Quarterly reporting requirements

Quarterly report 2 (1st July 2026 to 30th September 2026)

a) Number of exception reports submitted per rota

Rota	Number of exception reports submitted over the last quarter
1st Tier – Teesside	11
Middle Tier – Teesside	3
1st Tier – North Durham	10
Middle Tier – North Durham	1
1st Tier – South Durham	3
Middle Tier – South Durham	0
Middle Tier – North CAMHS	1
1st Tier - NYY	4
Middle Tier – NYY & Scarborough	9
1st Tier - Scarborough	6
Middle Tier – South CAMHS	0
Total	**48**

b) Categories of exception reports submitted per rota

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

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	0	0	0		0
Additional hours an unscheduled late finish	7.75hrs / £263.50	0	0		3
Breaches of non-resident on-call patterns	£245.96	0	£409.92		4
The inability to take contractual breaks			0	2hrs	1
Inadequacy of clinical support				0	0
Inadequacy of rostered skills mix				0	0
Raising concerns of a suspected non-compliant rota pattern				0	0
Detriment or threat of detriment related to exception reporting				0	0
Information breach			0		0
Access and completion resolved in time				0	0
Access and completion breaches			0		0
Access and completion test					2
Other: Difference in work pattern	0	0	0	0	0
Total					10

Two exception reports were submitted by North Yorkshire and York resident doctors in Quarter 2. Both reports were submitted by the same doctor and were related to late finishes. There were 2 access and completion tests.

Scarborough resident doctors submitted 6 exception reports in Quarter 2. The exception reports were submitted by 3 doctors; 4 were due to breach of the requirement for five hours of uninterrupted rest between 22:00 and 07:00, 1 for a late finish and 1 for a missed break.

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

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	0	0	0		0
Additional hours an unscheduled late finish	0	0	0		0
Breaches of non-resident on-call patterns	£1045.20	0	£1367.67		3
The inability to take contractual breaks			0	0	0
Inadequacy of clinical support				0	0
Inadequacy of rostered skills mix				0	0
Raising concerns of a suspected non-compliant rota pattern				0	0
Detriment or threat of detriment related to exception reporting				0	0
Information breach			0		0
Access and completion resolved in time				0	0
Access and completion breaches			0		0
Access and completion test				0	4
Other: Difference in work pattern	21.5 hours / £700.90	0	0	0	3
					9

Senior registrars submitted 5 exception reports in Quarter 2, all through Non-Resident On-Call (NROC) monitoring forms. These reports were submitted by 5 doctors and some of the reports had multiple description as detailed below:

	Plain Hours	Enhanced Hours	Breach
SpR 1	**0.5**		
SpR 2	**3.75**		
SpR 3	**0.75**	**5.25**	
SpR 4		**7**	**1**
SpR 5	**2.25**	**2.5**	**2.75**
Total	**7.25**	**14.25**	

All 5 exception reports related to work undertaken beyond the scheduled hours. 2 exception reports involved breaches of the requirement for five hours of uninterrupted rest between 22:00 and 07:00. There were 4 access and completion tests.

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

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	0	0	0		0
Additional hours an unscheduled late finish	15.25hrs / £404.74	0.5	0		15
Breaches of non-resident on-call patterns	0	0	0		0
The inability to take contractual breaks			0	1.25hr	1*
Inadequacy of clinical support				0	0
Inadequacy of rostered skills mix				0	0
Raising concerns of a suspected non-compliant rota pattern				0	0
Detriment or threat of detriment related to exception reporting				0	0
Information breach			0		0
Access and completion resolved in time				0	0
Access and completion breaches			0		0
Access and completion test				0	8
Other: Difference in Work Pattern	0	0	0	0	0
Total					**24**

North and South Durham 1st Tier

There were 11 exception reports received this quarter from Resident Doctors in the North and South Durham localities. 10 exceptions were reported late finishes in North Durham, *1 of these also included a missed break. There was 1 report made from a South Durham resident doctor, and this was also due for a late finish. There were 2 access and completion tests by South Durham resident doctors.

Teesside 1st Tier

There were 4 exception reports received from resident doctors working in Teesside this quarter. All 4 exception reports were for a late finish and 3 of these exception reports were from the same doctor. There were 6 access and completion tests by Teesside resident doctors.

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

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	0	0	0		0
Additional hours an unscheduled late finish	0	0	0		0
Breaches of non-resident on-call patterns	£1342.76		£1,864.22		5
The inability to take contractual breaks			0	0	0
Inadequacy of clinical support				0	0
Inadequacy of rostered skills mix				0	0
Raising concerns of a suspected non-compliant rota pattern				0	0
Detriment or threat of detriment related to exception reporting				0	0
Information breach			0		0
Access and completion resolved in time				0	0
Access and completion breaches			0		0
Access and completion test				0	0

Other: Difference in Work Pattern	10.25 hours (£439.70) paid to resident doctor	0	0	0	4*
Total					5

In this quarter, there were 5 exception reports received from the NORTH Senior Registrars, (please note that this includes all middle tier rotas in the North Care Group; North Durham, South Durham, Teesside and NORTH CYPS).

5 exception reports were received for a breach of 5 hours continuous rest (3 reported in Teesside, 1 reported in North Durham and 1 reported in North CYPS). 4* of these were also for work done above schedule.

c) Fines

Rota	Value of fines levied
1st Tier – Teesside & North Durham & South Durham	£0
Middle Tier – Teesside & North Durham & South Durham & North CAMHS	£1,864.22
1st Tier – NYY & Scarbrough	£409.92
Middle Tier – NYY & Scarborough & South CAMHS	£1,367.67
TOTAL	**£3,641.81**

d) Experiences of actual or threatened detriment – per rota

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

Quarterly survey response rate	14/225 (6.22% completion)
Doctors experiencing actual detriment as a result of exception reporting	1
Doctors feeling that they are not discouraged from exception reporting	12

e) Withdrawals (overall)

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

Number of exception reports withdrawn over the last quarter	0

f) Access to individual doctors' exception reporting data (overall)

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.
The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	0

g) Work schedule reviews related to exception reporting pattern/instances (overall – education or hours)

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

Number work schedules reviews related to exception reporting patterns or instances	0

h) Rota gaps on all shifts (per rota) – split into day gaps and OOH gaps (how many filled by locums and how many filled by someone acting down). To add narrative around what the gaps were for

NORTH

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	0	2	0	0	8
	CT1/2/GP	60	17	0	592	127.5
	CT3	0	10	0	0	99.5
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	17	45	0	316	640.5
North Durham	F2	0	0	0	0	0
	CT1/2/GP	27	12	0	261	90.5
	CT3	0	5	0	0	54
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	30	36	0	560	596.5
South Durham	F2	0	0	0	0	0
	CT1/2/GP	22	6	0	232.5	49.5
	CT3	0	6	0	0	58
	Trust Doctor	0	0	0	0	0

Locum bookings by Locality & Grade						
	Middle Tier (SR/SAS)	11	17	0	208	253
CAMHS	Middle Tier (SR/SAS)	47	47	0	864	864
Total		**214**	**203** (plus x7 consultant cover)	**0**	**3033.5**	**2841** (plus x124hr consultant cover)

30 shifts in Teesside Res Dr Rota were picked up by SpR/ SAS doctors
10 shifts in ND Res Dr Rota were picked up by SpR/ SAS doctors
10 shifts in SD Res Dr Rota were picked up by SpR/ SAS doctors
3 shifts in ND Middle Tier rota were picked up by consultant rota cover (64hr)
2 shift in SD middle tier were picked up by consultant rota cover (40hr)
2 shifts in Teesside Middle Tier rota were picked up by consultant rota cover (20hr)
1 shift in ND middle tier rota remained vacant
2 shifts in SD middle tier remained vacant
1 shift in Teesside Res Dr Rota remained vacant

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	67	66	0	1110.5	1094.5
Sickness	49	46	0	611	575
Paternity/maternity leave	0	0	0	0	0
On call restrictions	80	74	0	1078.5	950.5
Industrial Action	0	0	0	0	0
Special leave	7	7	0	98	98
Annual Leave	0	0	0	0	0
Incomplete Mand & Stat	11	10	0	135.5	123
Total	**214**	**203**	**0**	**3033.5**	**2841**

NORTH

Vacancies by month						
Locality	**Grade**	**Month 1**	**Month 2**	**Month 3**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	1	0	0	0	50.75
	CT1-3	2	0	0	1	101.5
	ST4 -6	2	1	1	1	203
	GP	4	1	1	2	304.5
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	2	0	0	1	101.5
	ST4 -6	0	0	0	0	0
	GP	0	1	1	1	101.5
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	2	1	1	1	203
	GP	1	1	1	1	152.25
Total		**14**	**5**	**5**	8	**1218**

SOUTH

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Harrogate, Northallerton, Selby & York (NYY)	F2	0	0	0	0	0
	CT1/CT2/GP	41	19	0	414	173
	CT3	0	10	0	0	108
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	6	17	0	87.5	211
Scarborough	F2	0	0	0	0	0
	CT1/CT2/GP	13	4	0	187	61
	CT3	0	8	0	0	114
	Trust Doctor	0	0	0	0	0

Locum bookings by Locality & Grade						
	Middle Tier (SR/SAS)	80	61	0	1486	1124
South CYPS Middle Tier	Middle Tier (SR/SAS)	48	36	0	888	664
Total		**188**	**155** (plus x23 consultant cover)	**0**	**3062.5**	**2455** (plus 424hrs consultant cover**)**

12 shifts in the NYY Res Dr rota were covered by SpR/SAS doctors
1 shift in the Scarborough Res Dr rota was covered by SpR / SAS doctor
11 shifts in the Scarborough middle tier rota were covered by consultants 200hr)
12 shifts in the South CAMHS Middle Tier rota were covered by consultants (224hr)
1 shift in the NYY Middle Tier rota was vacant
9 shifts in the Scarborough middle tier rota remained vacant

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	131	100	0	2400	1817
Sickness	47	45	0	563	538
Paternity/maternity leave	4	4	0	33	33
On call restrictions	1	1	0	12.5	12.5
Industrial Action	0	0	0	0	0
Special leave	3	3	0	29	29
Annual Leave	0	0	0	0	0
Incomplete Mand & Stat	2	2	0	25	25
Total	**188**	**155**	**0**	**3062.5**	**2455**

Vacancies

Locality	Grade	Month 1	Month 2	Month 3	Average no of vacancies	Number of shifts uncovered (days)
Northallerton	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	1	0	0	0	
	ST4 -6	0	0	0	0	0
	GP	0	4	4	3	406
Harrogate	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	1	1	1	1	152.25
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	0	0	0	0
	ST4 -6	1	0	0	0	50.75
	GP	0	2	2	1	203
York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	0	1	1	1	101.5
	ST4 -6	4	1	1	2	304.5
	GP	2	0	0	1	101.5
Total		**9**	**9**	**9**	**9**	**1319.5**

i) Additional information on an ad hoc basis (GoSW to populate)

The GoSWH is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.

No issues have been escalated. The content of this report and current context has been discussed with the deputy medical director

The GoSWH is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

n/a

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	[Implications for patient safety, clinical outcomes, MHA compliance, restrictive practice, or 'No direct impact']
Safeguarding	[Implications for adult or child safeguarding, or 'No direct impact']
Equality, Diversity & Inclusion	[Summary of Equality Impact Assessment findings, including impact on protected characteristics and health inequalities, or confirm EIA not required]
Workforce	[Staffing, training or organisational development implications, or 'No direct impact']
Financial / Resource	[Cost, savings or resource implications, confirmed with Finance, or 'No direct impact']
Legal	[Legal advice obtained / required, or 'No direct impact']
Protected characteristics	Impact on any protected characteristics

5. Appendices

Appendix	Title
A	[Title of supporting document]
B	[Title of supporting document]

6. Document Control

Version	Date	Author	Summary of Changes
0.1 DRAFT	[DD Month YYYY]	[Name]	Initial draft for Sponsoring Director review

Tees, Esk and Wear Valleys
NHS Foundation Trust

BOARD REPORT

1. Cover Sheet

Report Title	Board Integrated Quality & Performance Report as 30th September 2026
Meeting	Trust Board [Public]
Date of Meeting	26th November 2026
Item number	M
Sponsoring Director / Author	Kathryn Ellis, Interim Executive Director of Strategy & Transformation Naomi Lonergan, Chief Operating Officer
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, 27th October 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 **59%** of measures achieving good or substantial assurance, an increase on **56%** last month. Overall performance assurance for the National Quality Requirements and Mental Health Priorities, based on Statistical Process Control (SPC) analysis, shows **58%** of measures are meeting standard (an increase on 55% 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 overall assurance position this month. However, the assurance ratings for a small number of individual measures have changed, as set out below.

Increased performance assurance (reasonable to substantial)	• Incidents of moderate or severe harm
Increased performance assurance (limited to reasonable)	• Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed) • Restrictive Intervention Incidents Used • Percentage Sickness Absence Rate

Following EDG approval, the previously combined adult and older adult outcome measures have been separated and are reflected in this report.

For information: EDG also approved the amendment to the Unique Active Caseload measure to exclude inpatient activity across all services, so that it reflects community caseloads only. No further Board approval is sought.

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 30th September 2026
Meeting	Trust Board [Public]
Date of Meeting	26th November 2026
Item number	M

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.

2. Key Issues and Findings

2.1 What the data / evidence shows

What is working well

Overall performance has improved modestly this month. The proportion of Integrated Performance Dashboard measures achieving good or substantial assurance has increased from 56% to 59%, while 58% of National Quality Requirements and Mental Health Priorities are meeting standard, compared with 55% last month.

Performance remains strong or is improving across a number of important areas, particularly patient and carer experience, children and young people's clinical outcomes, safety and harm, 72-hour follow-up, avoidance of out-of-area placements, retention, appraisal and overall mandatory training compliance. The overall year-to-date financial position also remains favourable to plan.

There has, however, been no change to the overall assurance position. The improvement across the aggregate measures is not yet sufficiently broad or sustained to offset the areas in which significant performance pressures remain.

The published Q1 National Oversight Framework assessment provides further context to the Trust's overall position. The Trust is placed in Segment 2, with an average score of 2.25 and an Amber/Red capability rating, broadly in line with peers. Patient safety is in the highest-performing quartile, with access to services, finance, productivity and innovation, and experience of care in the second quartile. People, effectiveness of care and population health are in the third quartile; the two red-rated metrics relate to supported quit attempts for acute inpatients and clinical trials set up within 90 days.

Principal exceptions requiring Board attention

The principal areas requiring Board attention remain delayed discharge and inpatient flow, community waiting times, restrictive interventions, sickness absence and the underlying financial risks associated with recurrent CRES delivery, flexible staffing expenditure and capital affordability.

The causes of underperformance are generally understood and improvement arrangements are in place. The key assurance question is now whether those actions are delivering sufficient and sustained impact and whether there is a credible trajectory back to the required level of performance.

2.2 Assurance

Controls Assurance

The Integrated Performance Approach continues to provide **good assurance over the identification, reporting and oversight of performance**. Care Group IQPRs were scrutinised at the Executive Review of Performance, followed by EDG review of the Board IQPR in light of the earlier discussion. Executive challenge focused on recovery plans, evidence of impact and matters requiring executive or system escalation.

- **Recovery and delivery:** Executives challenged medium-term plan delivery, financial recovery, bank expenditure and workforce pressures. With adult and older adult outcome measures now separated, further work was requested to establish credible improvement trajectories, milestones and accountability. Additional analysis of Talking Therapies deterioration was also commissioned.

- **Quality and safety:** Further triangulation of Feeling Safe results and analysis of restrictive interventions were requested. As part of this discussion a concern about the interpretation and application of mechanical restraint requirements was raised and will be picked up by the Quality Assurance Committee. A 36-working-day standard for After Action Reviews was agreed, with continued scrutiny of timeliness and family engagement.

- **Capacity and system dependencies:** EDG requested clear evidence distinguishing commissioned activity levels alongside demand, particularly in ADHD, to ensure understanding of potential impact of commissioning gaps. Continued system and local authority engagement, targeted support for complex discharge cases and clearer reporting of patient impact and system-wide flow pressures were requested. Further analysis of demand and complexity in older people's services will inform planning and commissioning discussions.

Further work was commissioned to sharpen organisational narratives and strengthen reporting for Board and regional stakeholders.

These reviews demonstrate **active executive scrutiny, challenge and escalation**, supporting good assurance on performance oversight. **Reasonable assurance on improvement remains appropriate**, as sustained recovery is not yet consistently evidenced. Strengthened assurance will depend on delivery against credible trajectories and demonstrable improvement in outcomes.

Performance Assurance

ALERT

Performance remains off trajectory across a number of connected areas. The causes are generally understood and improvement arrangements are in place, but sustained recovery is not yet evident.
Delayed discharge and inpatient flow remain the most significant Trust-wide pressure. At the end of September, 62 patients were clinically ready for discharge, representing 16.67% of adult and older adult acute beds. Bed occupancy remained at approximately 89%, with average length of stay above plan in adult acute/PICU services at 29.04 days and older adult acute services at 87.39 days. The relationship between delayed discharge, occupancy, length of stay, access and financial pressure is understood. A Trust-wide improvement plan, executive oversight and system escalation are in place, with an ambition to reduce the clinically ready for discharge position to 15% by December and 12% by March 2027.

However, delivery remains partly dependent on wider system capacity and the required improvement has not yet been sustained. Assurance therefore remains partial pending measurable delivery against trajectory.

Community waiting-time performance remains challenged across neurodevelopmental services, Talking Therapies, older people's services, Early Intervention in Psychosis and children's eating disorder services. Demand and capacity pressures and pathway-specific causes are under active review by operational and clinical leaders. Recovery arrangements are in place, with progress evident in the reduction of CYP waits exceeding 104 weeks and delivery of the commissioned recovery plan currently exceeding plan. However, reconciliation and validation continue, and improvement is not yet consistent across pathways. The anticipated impact of recovery actions varies across pathways. Clear actions and expected benefits have been identified for areas such as neurodevelopmental services.

Further work is planned to clarify improvement opportunities in other areas, where recovery may depend on additional capacity, commissioning decisions or wider pathway transformation.

Restrictive interventions deteriorated to 1,090 incidents in September, with the adverse variation predominantly attributable to a small number of patients with complex needs within Adult Learning Disability inpatient services. The cause is understood, the service is receiving additional support, and enhanced internal and external oversight is in place. However, sustained improvement in the outcome has not yet been demonstrated. Assurance is therefore stronger regarding the management of risk than the effectiveness of actions in reducing restrictive interventions.

Sickness absence remains above target at 6.95%, compared with the reported national average of 5.7%, and continues to affect workforce resilience. Director-led reviews are providing greater visibility of the drivers and the consistency of management practice, with early improvement in case management in some services. However, it is too early to evidence a sustained reduction in the overall absence rate. Assurance has therefore improved regarding grip and oversight, but not yet regarding impact.

The year-to-date financial position remains favourable, with Group revenue performance £2.0m better than plan. However, material underlying risks remain in recurrent CRES delivery, bank expenditure and capital affordability. Bank costs were £2.3m above the levels originally planned and £1.4m above recently approved trajectories, while forecast capital expenditure is £2.326m above currently allocated resources. The principal drivers are understood and strengthened controls are in place, including weekly oversight of flexible

staffing. Agency usage is improving in most areas, but confidence in the recurrent position remains dependent on further reductions in bank costs and improvement in the operational pressures driving expenditure.

ADVISE

A number of areas require continued oversight because performance is below expectation or evidence of improvement is not yet sufficiently mature, although they do not currently represent the same level of material risk as the Alert areas.

At the reporting point, 41 After-Action Reviews were overdue, including 30 exceeding 36 working days. Inpatient perceptions of safety were also below standard, with 71.69% of respondents reporting that they felt safe against the 75% standard. The issues are recognised and established governance and improvement arrangements are in place, but stronger assurance will require evidence that reviews are completed promptly, learning is acted upon and the experience of safety improves.

Adult and older adult outcomes remain mixed, with improvement in some clinician-reported measures but patient-reported outcomes and paired outcome completion requiring further attention. The measures have been separated; stronger assurance now requires credible trajectories, clear milestones and accountability, and evidence of sustained improvement. Staff experience, inequalities and ethnicity recording also require continued oversight. The direction of travel and effectiveness of current actions are not yet sufficiently established to provide stronger assurance.

Mandatory training remains above standard overall at 93.16%, although eight individual courses are below the 85% standard and non-attendance and staff release remain areas for targeted action. Three identified data-quality issues affecting contact activity reporting are subject to remediation. Overall controls remain strong, but future assurance should focus on whether targeted actions improve the affected measures rather than on completion of actions alone.

ASSURE

There continues to be strong and sustained performance across a number of core quality, access, workforce and financial measures, supported by established controls and oversight. Patient and carer experience remain strong. In September, 93.34% of patients rated their experience as good or very good against the 92% standard, while 85.17% of carers reported feeling actively involved in care decisions against the 75% target. CYP patient- and clinician-reported outcomes remain significantly above target and demonstrate sustained improvement. Safety and harm measures also remain within expected variation with low levels of harm.

The Trust continues to deliver the 72-hour follow-up standard and maintain zero use of out-of-area beds. These measures provide assurance that key access and continuity standards are being maintained despite the wider pressures on flow and community waiting times. Workforce retention remains within target at 10.5%, with appraisal compliance at 88.9% and overall mandatory training compliance at 93.16%. These measures provide assurance regarding core workforce stability and capability, notwithstanding the separate pressures relating to sickness absence and individual training courses.

The year-to-date financial and cash positions remain favourable against plan, and underlying Trust agency shifts have reduced by 48% over the last 12 months. Established financial governance provides clear oversight of the underlying risks; however, this assurance should

be considered alongside the Alert position on recurrent savings, bank expenditure and capital affordability.

Overall data-quality controls for established Board measures remain strong. Specific limitations have been transparently identified and are being addressed. Subject to the caveats set out in the report, the reported performance remains a reliable basis for Board oversight and decision-making.

2.3 Risks

The principal risks arising from the current performance position continue to relate to access and patient flow, quality of care, workforce resilience, regulatory compliance and financial sustainability.

While there is good assurance that these risks and associated performance issues are identified and subject to appropriate oversight, reasonable assurance remains appropriate in relation to improvement, reflecting that the impact of actions is not yet consistently evidenced and confidence in return to trajectory varies across the areas of greatest challenge.

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

Impact Area	Assessment
	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
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 September 2026

6. Document Control

Version	Date	Author	Summary of Changes
0.1 DRAFT	29 October 2026	Sarah Theobald	Initial draft for Sponsoring Director review
1 FINAL	16 November 2026	Sarah Theobald	Final version submitted for Trust Board

Tees, Esk and Wear Valleys
NHS Foundation Trust

Integrated Quality and Performance Report

For the period ending September 2026

Contents

Section Number	Section	Sub-Section	Page Number
1	**Executive Summary**		**3**
		• Summary Headlines	4
		• Board Integrated Performance Dashboard	5
		• Board Integrated Performance Dashboard – Performance Assurance Ratings	7
		• Board Integrated Performance Dashboard – Performance & Controls Assurance Framework	8
2	**Quality**		**9**
3	**People**		**29**
4	**Activity**		**38**
5	**Finance**		**41**
6	**Care Group**		**49**
		• Durham, Tees Valley & Forensic Care Group – Overview	50
		• North Yorkshire, York & Selby Care Group - Overview	52
7	**Population health, prevention and reducing inequality**		**54**
8	**National metrics**		**59**
		• NHS Oversight Framework	60
		• National Quality Requirements	62
		• Mental Health Priorities – Provider and System-wide Plans	69
		• Mental Health Priorities – System-Wide Plans	73
9	**Benchmarking**		**88**
10	**Access to Services**		**90**
		• Waiting Times Dashboard – National Waiting Times Measures	91
		• Waiting Times Dashboard - Local Waiting Times Measures	92
		• Waiting Times *by Exception*	93
11	**Appendices**		**102**
		• Our Guide To Our Statistical Process Control Charts	103
		• Our Guide To Our Statistical Process Control Charts: Interpreting summary icons	104
		• Our Approach to Data Quality	105
		• Our Approach to Performance and Controls Assurance	106
		• Glossary	107

1. Executive Summary

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

Summary Headlines

Overall assurance
remains positive, with strong controls and evidence of improvement across several key areas, including patient safety, clinical outcomes, workforce compliance and financial performance. Whilst a number of significant operational challenges remain, most notably patient flow, access, workforce absence and flexible staffing expenditure, appropriate recovery and improvement arrangements are in place and continue to receive focused executive oversight.

Patient flow: remains the Trust's most significant operational risk. Delayed discharges continue to affect bed occupancy, ALOS and capacity across acute mental health services, with 62 patients clinically ready for discharge occupying 16.7% of acute bed capacity at the end of September. Whilst extensive improvement work is underway with system partners, with heightened escalation processes in place, the ongoing shortage of specialist placements and care packages continues to constrain flow and create significant operational and financial pressures.

Workforce: remains broadly positive, with strong compliance against the mandatory training and appraisal standards and a stable staff turnover. Whilst sickness absence continues to exceed target and remains a challenge for some services, improvement work is progressing. Sustained delivery of attendance management, wellbeing and leadership initiatives will remain key to improving workforce resilience.

Inequalities and data quality: remain areas requiring continued focus. Work to strengthen the Trust's understanding of population health needs and inequalities is progressing through the PCREF, the Trust Inequalities & Prevention Plan, and targeted improvement initiatives. However, limitations in ethnicity recording and data completeness continue to affect the reliability of some inequalities analysis and insight. Programmes to improve data quality, strengthen intelligence and support more consistent recording practices provide assurance are ongoing to address these challenges and improve our ability to identify and respond to health inequalities.

Clinical outcomes: remain positive overall, with strong performance across CYP where both patient and clinician-reported outcomes remain well above target and continue to improve. Adult and older people's services demonstrate a more varied position, with positive clinician-reported outcomes but patient-reported measures remaining below expectation. Work is underway to understand underlying variation; strengthen outcome measurement and ensure improvement actions are targeted appropriately across adult pathways.

Access & demand: continue to present challenges across several services, with demand in a number of pathways, including neuro, Talking Therapies, Older People's Services and EIP in York and Selby. Whilst performance pressures remain, a range of recovery plans, service redesign initiatives, recruitment programmes and system-wide interventions are in place to improve access and reduce waiting times. Sustained progress will depend on addressing underlying workforce and capacity constraints and delivering planned improvements.

Patient quality & safety: remain positive overall, with strong patient and carer experience, low levels of serious patient safety incidents and no unexpected inpatient unnatural deaths reported during September. Patient safety processes continue to demonstrate timely identification, investigation and learning. Areas requiring ongoing focus include restrictive interventions, particularly within ALD and female acute pathways, alongside ensuring the timely completion of After-Action Reviews to maximise organisational learning and improvement.

Financial position: remains strong overall, with a year-to-date surplus position ahead of plan, efficiency delivery exceeding expectations and healthy cash reserves. Whilst underlying challenges remain in relation to flexible staffing expenditure, recurrent efficiency delivery and cost pressures associated with delayed discharge and specialist placements, robust governance arrangements and targeted improvement plans are in place to support delivery of the Trust's financial objectives.

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%	93.34%	93.66%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC	H		75.00%	85.17%	83.88%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	71.69%	73.19%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	H	P	35.00%	66.81%	66.81%	
5)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	P	50.00%	65.81%	65.81%	
6)	Percentage of Adults showing measurable improvement following treatment - patient reported	QAC				49.08%	49.08%	
7)	Percentage of Adults showing measurable improvement following treatment - clinician reported	QAC	H			39.45%	39.45%	
8)	Percentage of Older Persons showing measurable improvement following treatment - patient reported	QAC				32.71%	32.71%	
9)	Percentage of Older Persons showing measurable improvement following treatment - clinician reported	QAC	H			18.46%	18.46%	

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
10)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC	L	F	85.00%	89.84%	89.05%	
11)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC	H			16.67%	16.67%	
12)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC	L		0	0	0	
13)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				1	9	
14)	The number of Incidents of moderate or severe harm	QAC				16	128	
15)	The number of Restrictive Interventions Used	QAC	H			1,090	7,010	
16)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	2	
17)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	1	
18)	The number of uses of the Mental Health Act	MHLC				356	2,053	

Please Note: *11 Clinically Ready for Discharge does not have a Data Quality Assessment rating as this is a new measure. The assessment has been completed and will now be shared with the Planning, Digital, & Estates 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
19)	Percentage of staff recommending the Trust as a place to work	PCDC			60.00%	52.58%	52.49% (Jul-2026)	
20)	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)	
21)	Staff Leaver Rate	PCDC		P	11.00%	10.51%	10.51%	
22)	Percentage Sickness Absence Rate (month behind)	PCDC		F	5.50%	7.05%	6.89%	
23)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC	H	P	85.00%	93.16%	93.16%	
24)	Percentage of staff in post with a current appraisal	PCDC	H	P	85.00%	88.90%	88.90%	

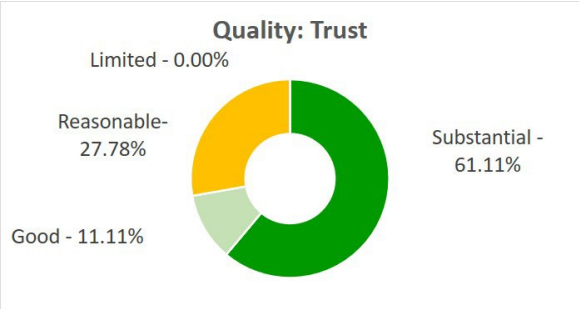
Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
23)	Number of new unique patients referred	RPC				7,371	40,064	
24)	Unique Active Caseload (Snapshot)	RPC	L			50,493	50,493	

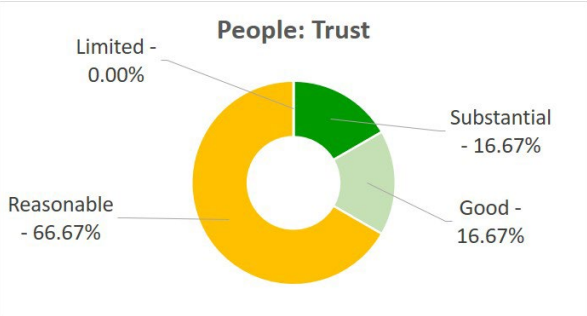
Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)	DQA Metric Rating
27)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	1,939,988	-31,396	
28)	Agency Expenditure	RPC	2,534,000	3,034,950	
29)	Agency price cap compliance	RPC	67.00%	18.34%	
30)	Bank Expenditure	RPC	6,730,000	9,033,928	
31)	CRES Performance - Recurrent	RPC	8,577,998	7,527,504	
32)	CRES Performance - Non-Recurrent	RPC	3,882,999	5,793,539	
33)	Capital Expenditure (CDEL)	RPC	8,157,000	7,946,600	
34)	Cash against plan	RPC	42,903,000	56,698,270	

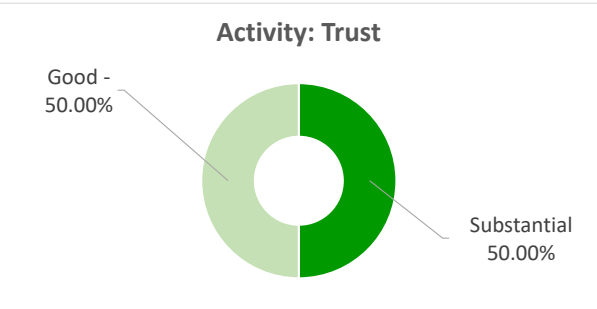
Please Note: *26 Unique Active Caseload and 30 Bank Expenditure do not have a Data Quality Assessment rating as they new measures. The assessments have been completed and will now be shared with the Planning, Digital, & Estates Committee for approval.*

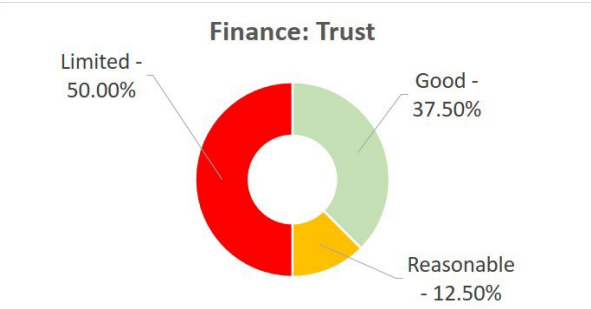
Executive Summary - Board Integrated Performance Dashboard – Performance Assurance Ratings

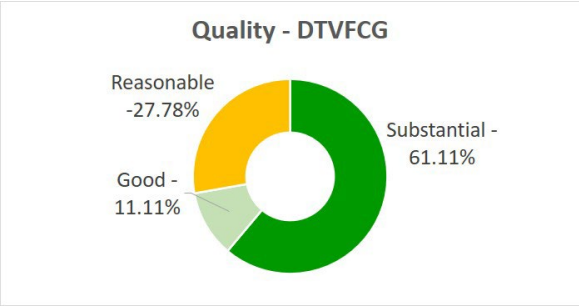
The visuals below depict performance assurance ratings for all measures part of the Integrated Performance Dashboard (IPD) – shown on the previous slides (5-6). Each measure is assigned a Performance Assurance rating based on SPC variation, performance against standard, trend, and wider intelligence.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

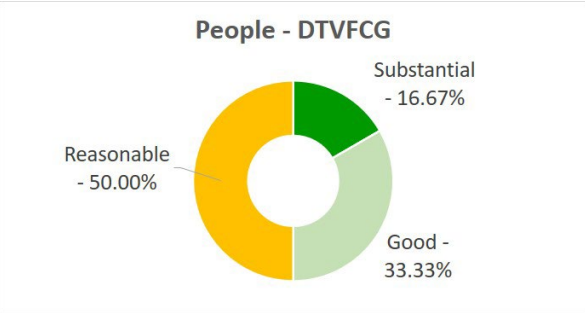


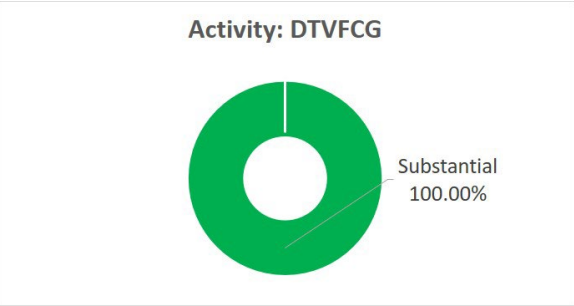


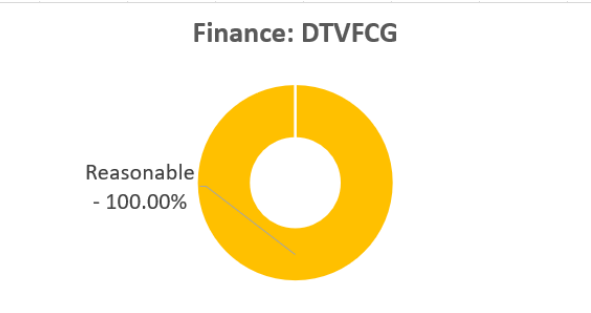


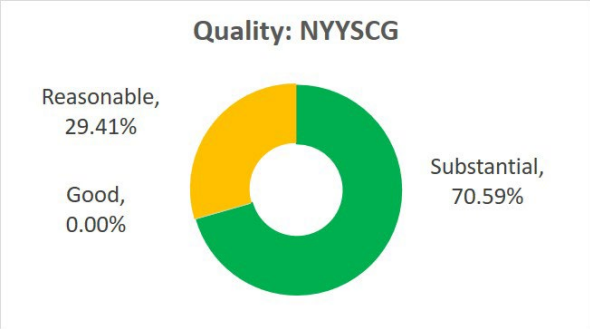


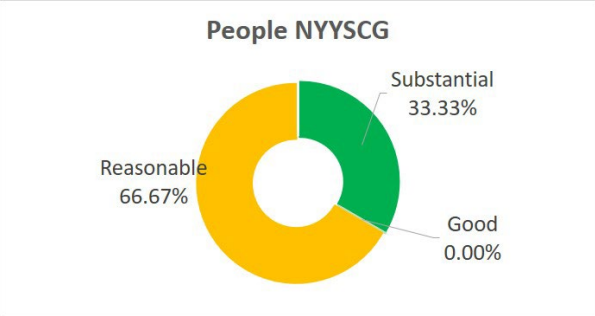


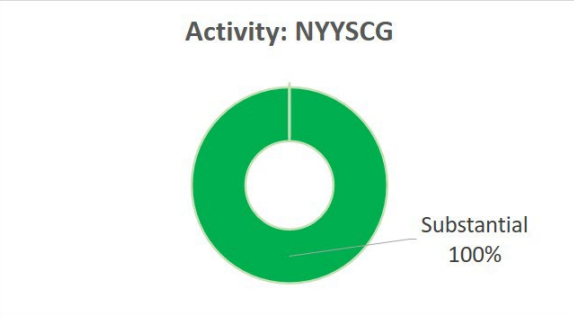


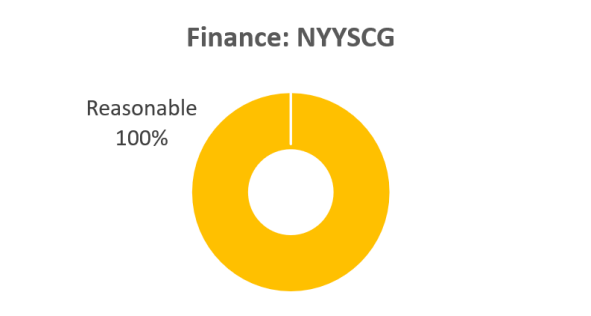












Glossary

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

** 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 September, **1,441** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent contact overall, how was your experience of our service?". Of those, **1,345 (93.34%)** 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 within Durham, Tees Valley & Forensic Care Group and for Adult Learning Disabilities within North Yorkshire, York & Selby Care Group.

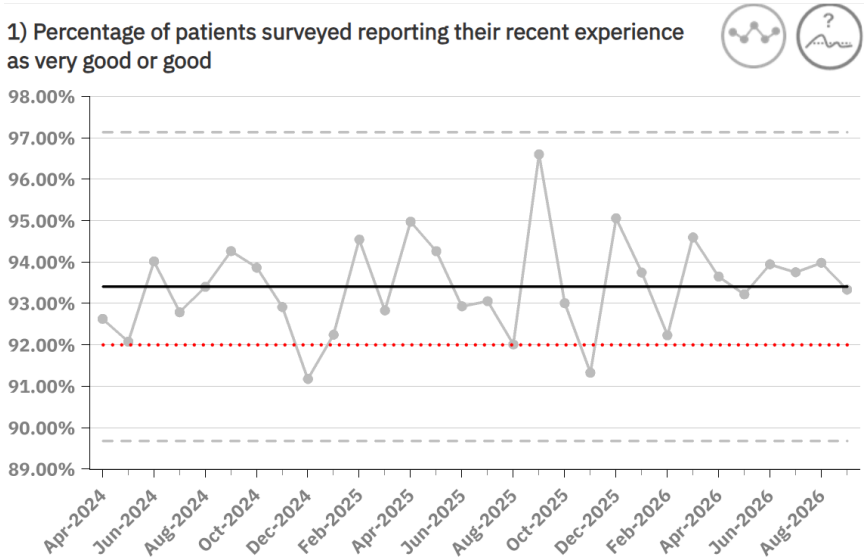
There is no significant change in the number of patients who have responded to this question at Trust level and for Durham, Tees Valley & Forensic Care Group. There is special cause improvement for North Yorkshire, York & Selby Care Group in Adult Mental Health within that Care Group and in Children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

National Benchmarking data
The latest National Benchmarking data (July 2026) shows the England average (including Independent Sector Providers) was **87.03%** and we were ranked **11** out of 64 trusts (1 being the best with the highest ratings). We were also ranked 1st for total number of responses received.

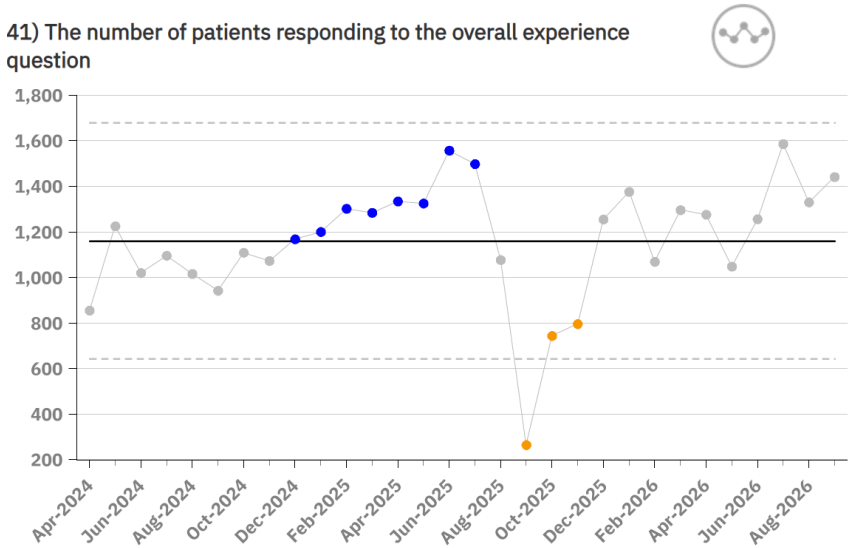
Underlying issues:
- The number of patients responding to the question varies significantly across services and specialities.

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.

To Note:
Work has now been completed with the system supplier and all paper-based survey responses have been included within the measure and reflected in this report.



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 September, **445** carers responded to the question in the carer survey: Question: "Are you offered choices about the care being provided?". Of those, **379 (85.17%)** scored "yes".

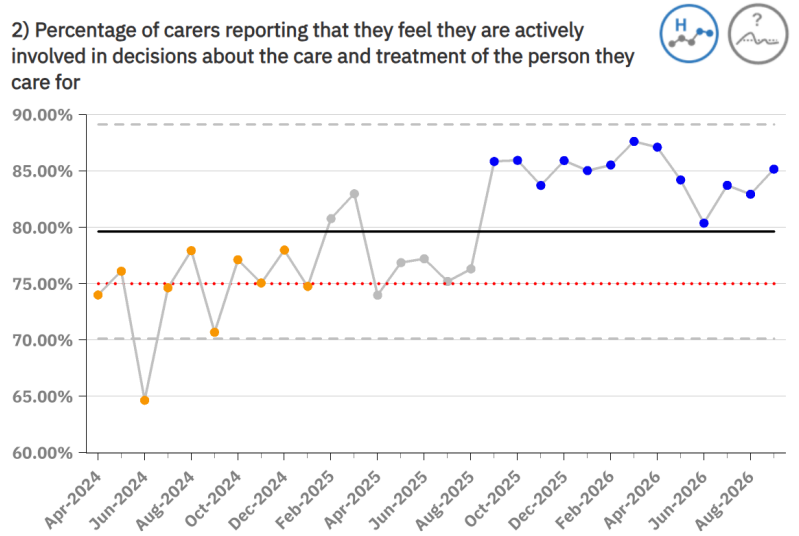
There is special cause improvement at Trust level, Durham Tees Valley & Forensic Care Group, for Adult Mental Health within that Care Group. There is no significant change within North Yorkshire, York & Selby Care Group.

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 for Adult Mental Health within North Yorkshire, York & Selby Care Group.

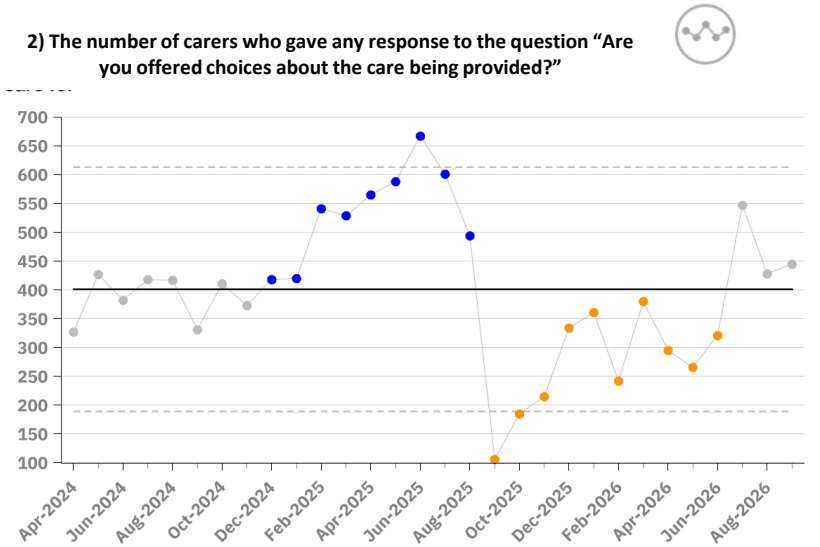
Underlying issues:
- Whilst no underlying issues have been identified, the section below outlines the actions currently being progressed to maintain performance and mitigate future risk.

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 have explored alternative approaches to help increase response rates, including the potential use of volunteers to contact carers post-appointment; however, no formal actions have been agreed. **(Partially Complete)** The service were unable to source/employ volunteers; however, carer responses continue to be monitored through governance and team business meetings, offering performance monitoring, direction and support.

To Note:
Work has now been completed with the system supplier and all paper-based survey responses have been included within the measure and reflected in this report.



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 September, **166** patients responded to the overall experience question in the patient survey: "During your stay, did you feel safe?". Of those, **119 (71.69%)** scored "yes ".

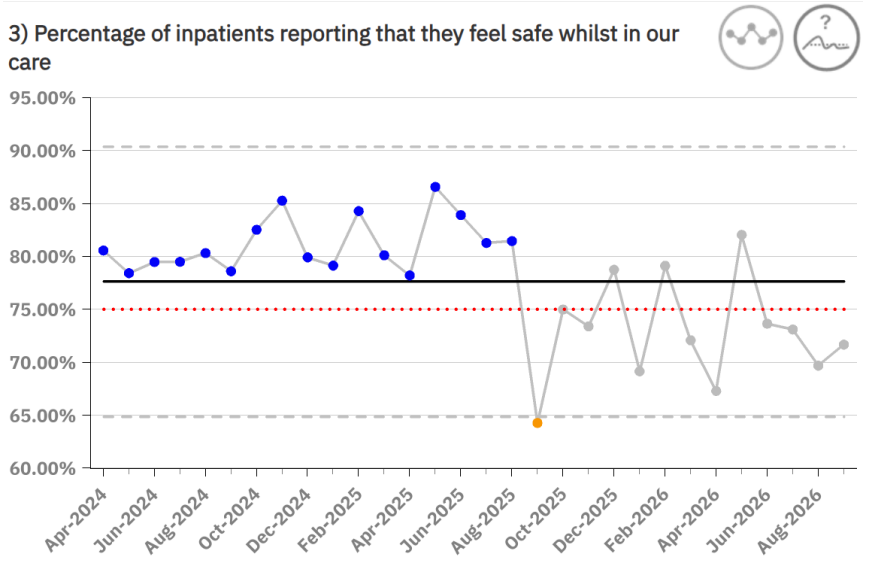
There is no significant change at Trust, Care Group and specialty level.

There is no significant change in the number of patients how have responded to the question at Trust level and for Durham, Tees Valley & Forensic Care Group. There is special cause improvement for North Yorkshire, York & Selby Care Group.

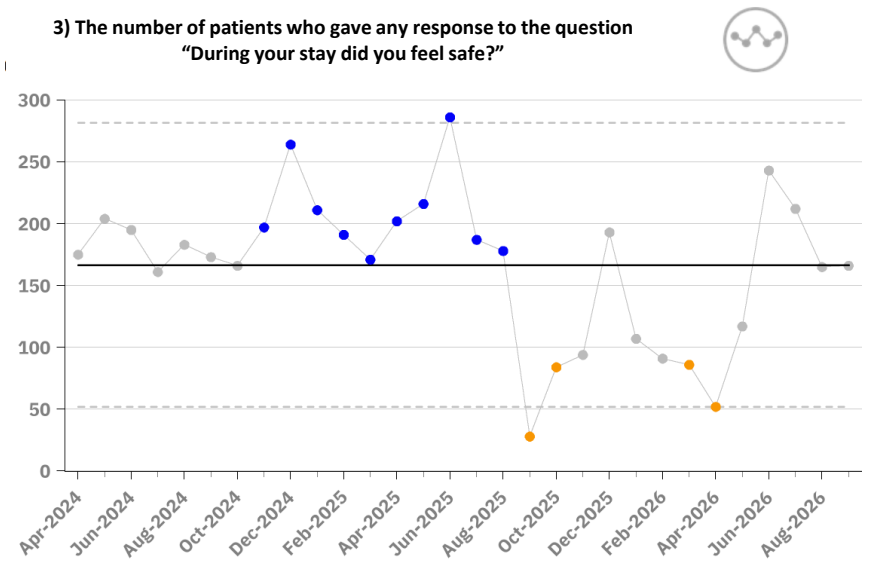
Underlying issues:
- Within inpatient services the survey is currently only available for completion by using the QR code or using the standard paper-based surveys; the easy-read versions have not been developed.

Actions:
- Patient & Carer Experience Team to address feedback received from the Service User Reference Group for people with Learning Disabilities on the easy-read paper-based inpatient survey and re-submit the survey for approval in October 2026.
- 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. Review of progress and next steps underway.

To Note:
Work has now been completed with the system supplier and all paper-based survey responses have been included within the measure and reflected in this report.



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

To Note current performance indicates scope to increase the existing standard. The Heads of Clinical Strategy are leading a review to establish a more stretching level of expectation, with recommendations to be completed by December 2026.

What does the chart show/context:
For the 3-month rolling period ending September **940** patients were discharged from our CYP service with a patient rated paired outcome score. Of those, **628 (66.81%)** made a measurable improvement.

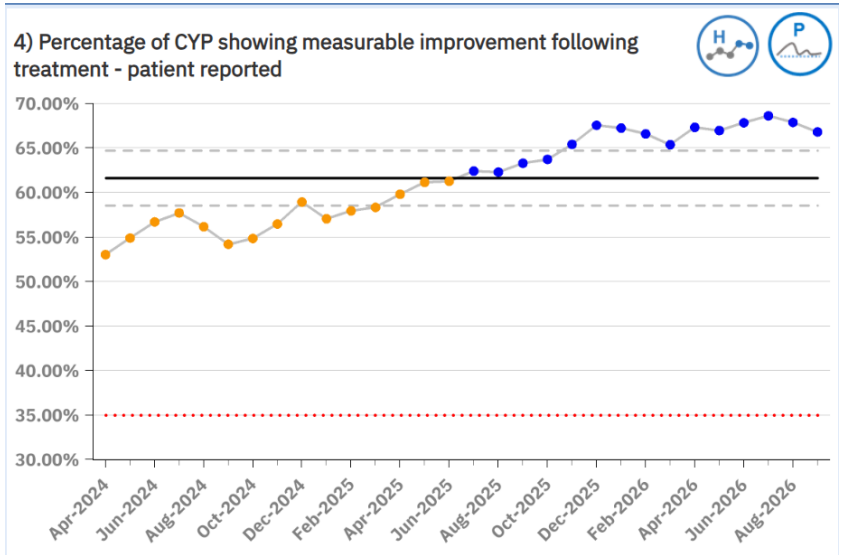
There is special cause improvement at Trust and Care Group level. Performance is above standard at all levels.

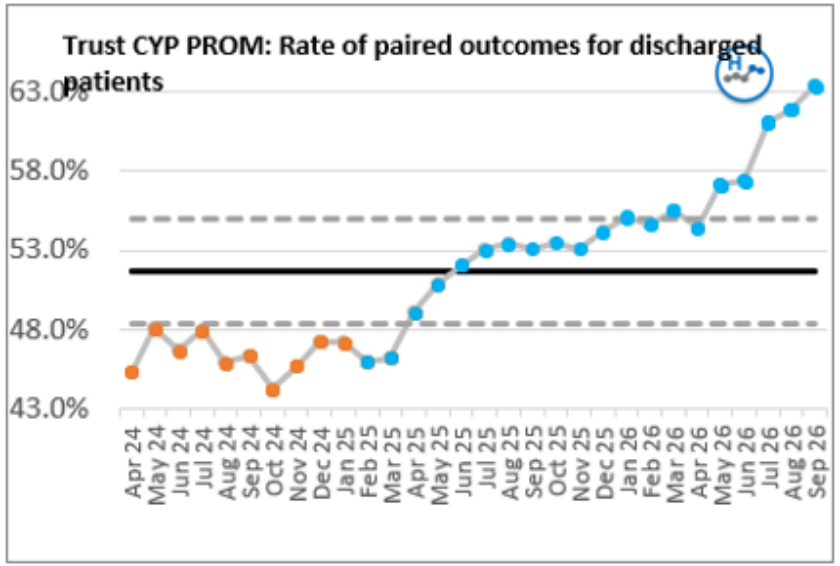
There is special cause improvement in the rate of paired outcomes for patients discharged at Trust and Care Group Level.

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.
- **To Note.** In September, Executive Directors Group agreed to pause the work to include those patients that transition between CYP and AMH within this measure to avoid duplication of effort and ensure alignment with the final RIO design and business rules. The work will be resumed upon implementation of RIO.





05) 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

To Note current performance indicates scope to increase the existing standard. The Heads of Clinical Strategy are leading a review to establish a more stretching level of expectation, with recommendations to be completed by December 2026.

What does the chart show/context:
For the 3-month rolling period ending September **702** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those, **462 (65.81%)** made a measurable improvement.

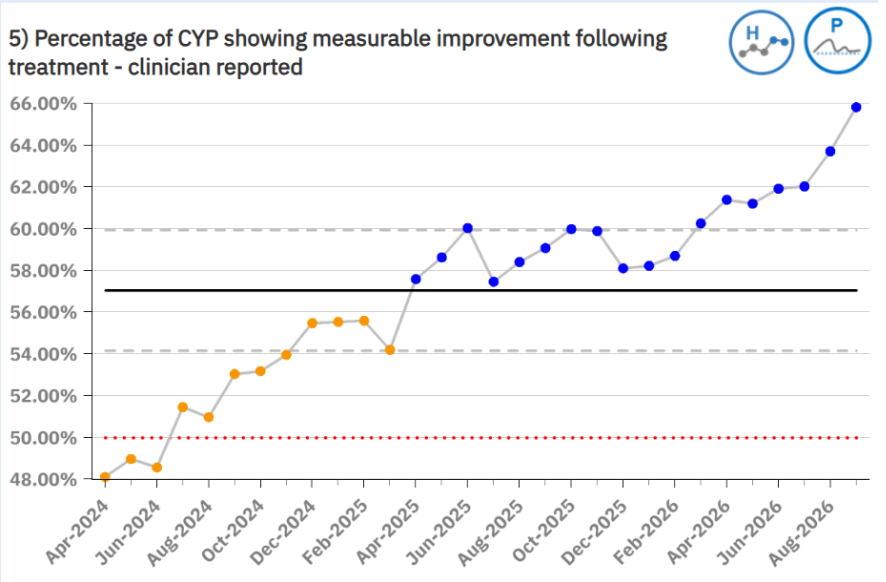
There is special cause improvement at Trust level and at Care Group Level. Performance is above standard at all levels.

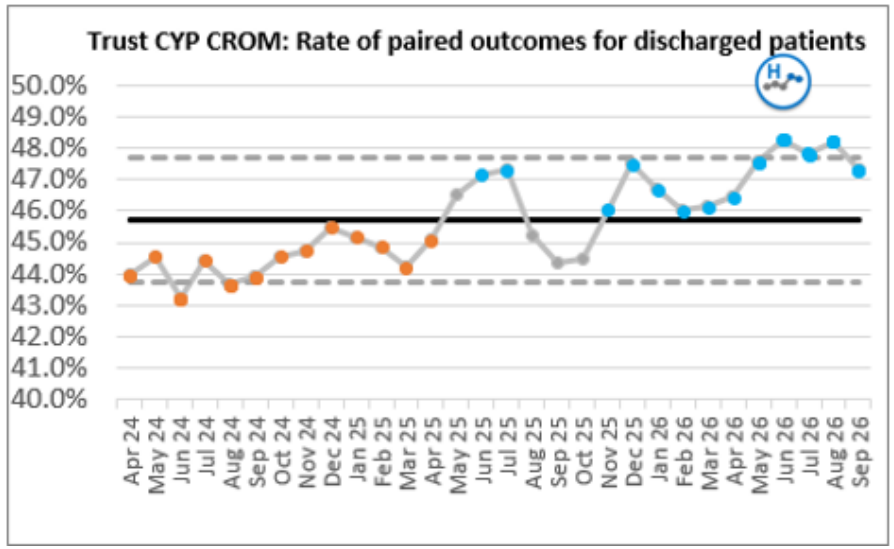
There is special cause improvement in the rate of paired outcomes for patients discharged at Trust level and for DTVFCG. There is no significant change within NYYSCG.

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:
- **To Note.** In September, Executive Directors Group agreed to pause the work to include those patients that transition between CYP and AMH within this measure to avoid duplication of effort and ensure alignment with the final RIO design and business rules. The work will be resumed upon implementation of RIO.





06) Percentage of Adults 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.

To Note following the separation of the metric into adult and older adult measures, the Heads of Clinical Strategy are leading a review to establish appropriate specialty-level standards, with proposals to be completed by December 2026.

What does the chart show/context:
For the 3-month rolling period ending September **982** patients were discharged from our Adults services with a patient rated paired outcome score. Of those**, 482 (49.08%)** made a measurable improvement.

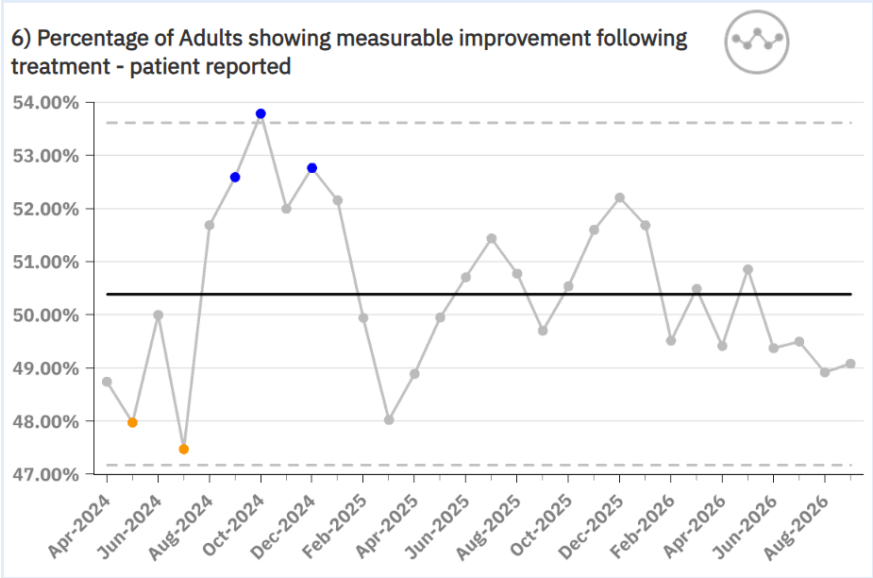
There is no significant change at Trust and Care Group level.

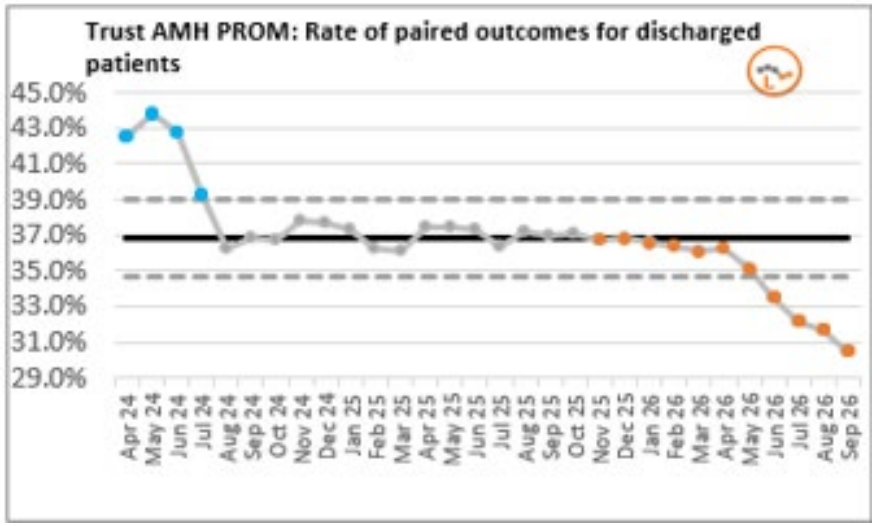
There is special cause concern in the rate of paired outcomes for patients discharged at Trust and Care Group level.

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

Underlying issues:
- 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:
- By the end of October 2026, the Head of Business Intelligence & Clinical Outcomes will assess the feasibility of incorporating GBO, ReQoL-10 and DIALOG outcomes measures within this metric and the options available, pending the implementation of the new Electronic Patient Record (RIO).





07) Percentage of Adults 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

To Note following the separation of the metric into adult and older adult measures, the Heads of Clinical Strategy are leading a review to establish appropriate specialty-level standards, with proposals to be completed by December 2026.

What does the chart show/context:
For the 3-month rolling period ending September **1,014** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 400 (39.45%)** made a measurable improvement.

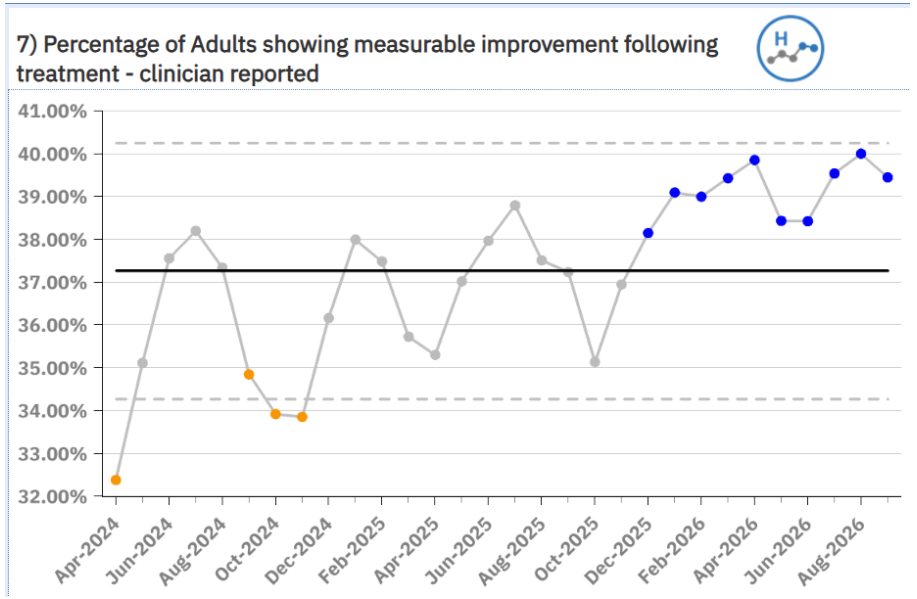
There is special cause improvement at Trust and Care Group level.

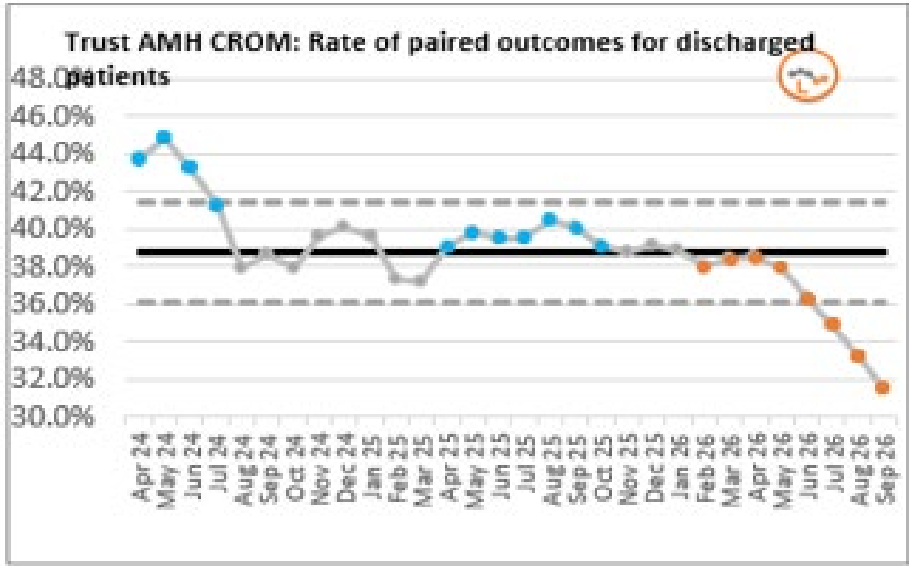
There is special cause concern in the rate of paired outcomes for patients discharged at Trust and Care Group level.

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

Underlying issues:
- 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 end of Q3, Corporate Performance and Business Intelligence to undertake analysis with the Directors of Therapies and relevant General Managers to identify the underlying causes of the reported rate of paired outcomes for discharged patients, underlying factors and determine whether any mitigating actions are required.





08) Percentage of Older Adults 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

To Note following the separation of the metric into adult and older adult measures, the Heads of Clinical Strategy are leading a review to establish appropriate specialty-level standards, with proposals to be completed by December 2026.

What does the chart show/context:
For the 3-month rolling period ending September **425** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 139 (32.71%)** made a measurable improvement.

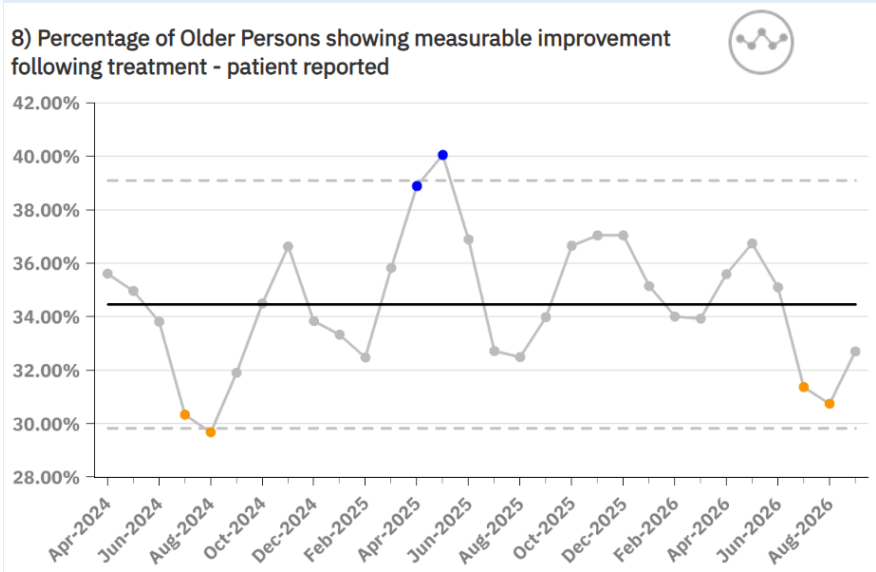
There is no significant change at Trust and Care Group level.

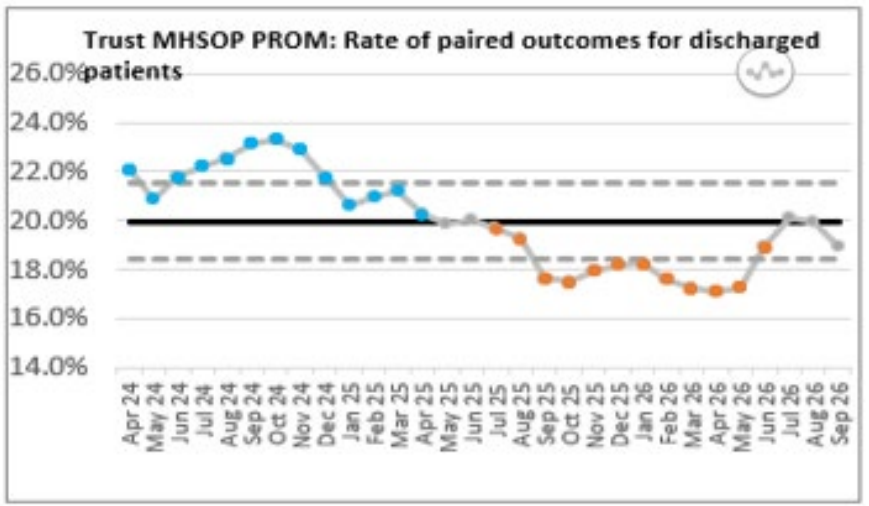
There is no significant change in the rate of paired outcomes for patients discharged at Trust level, however there is special cause concern in Durham Tees Valley & Forensic Care Group and special cause improvement in North Yorkshire, York & Selby Care Group.

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.
- By the end of October 2026, the Head of Business Intelligence & Clinical Outcomes will assess the feasibility of incorporating GBO, ReQoL-10 and DIALOG outcomes measures within this metric and the options available, pending the implementation of the new Electronic Patient Record (RIO).





09) Percentage of Older Adults 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

To Note following the separation of the metric into adult and older adult measures, the Heads of Clinical Strategy are leading a review to establish appropriate specialty-level standards, with proposals to be completed by December 2026.

What does the chart show/context:
For the 3-month rolling period ending September **1,479** patients were discharged from our Older Persons services with a clinician rated paired outcome score. Of those**, 273 (18.46%)** made a measurable improvement.

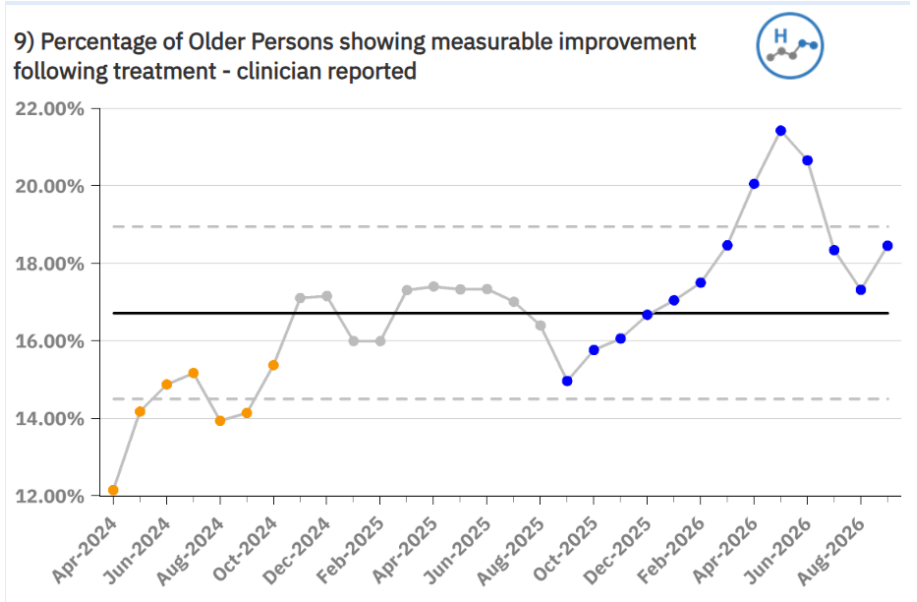
There is special cause improvement at Trust and Durham Tees Valley & Forensic Care Group level, whilst there is no significant change in North Yorkshire, York & Selby Care Group.

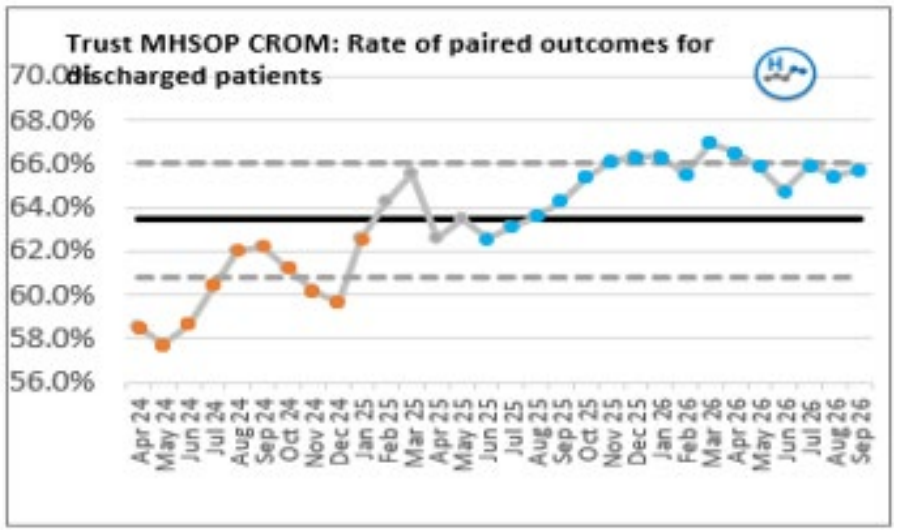
There is special cause improvement in the rate of paired outcomes for patients discharged at Trust and Care Group level.

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

Underlying issues:
Although the measure demonstrates sustained special cause improvement, the proportion of older people showing measurable improvement following treatment remains low overall and continued focus is required to understand and address the underlying factors affecting clinical outcomes.

Actions:
By end of Q3, Corporate Performance and Business Intelligence to undertake analysis with the Directors of Therapies and relevant General Managers to understand performance, underlying factors and determine whether any mitigating actions are required.





10) 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.

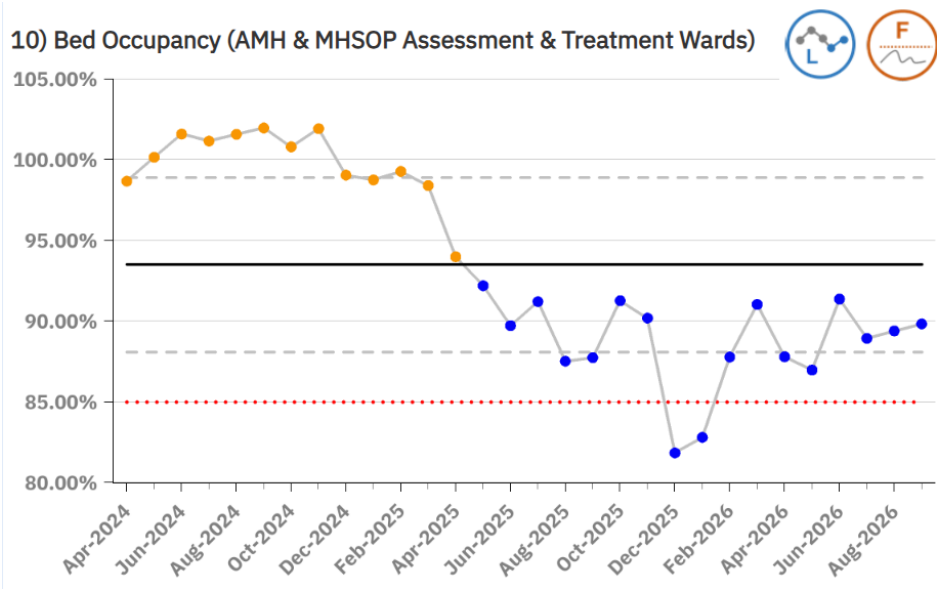
What does the chart show/context:
During September, **11,160** daily beds were available for patients; of those, **10,026 (89.84%)** were occupied.

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; however, there is special cause improvement in Adult Mental Health Services within that Care Group. Performance is above standard in both specialties in North Yorkshire, York & Selby Care Group and MHSOP in Durham, Tees Valley & Forensic Care Group.

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. **(Complete)**
- 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.



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

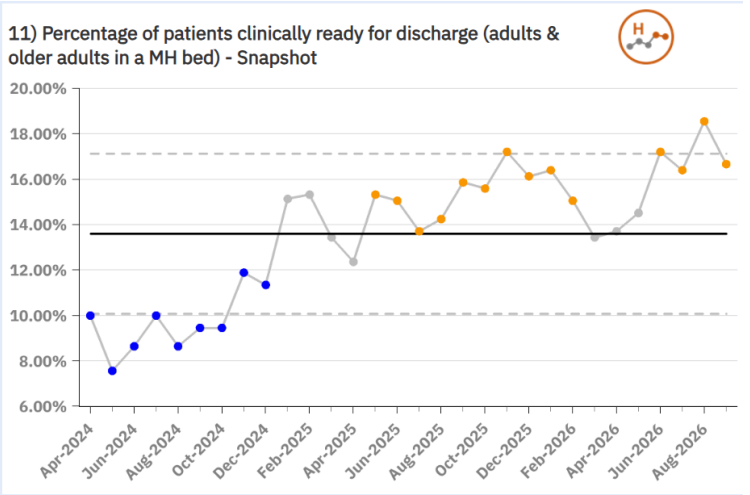
What does the chart show/context:
As at the 30th September 2026, there were **62** adults clinically ready for discharge occupying adult MH, older adult MH or PICU beds, accounting for **16.67%** of our **372** acute beds open to admission.

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

At Trust level, patients classified as Clinically Ready for Discharge during the whole month of September equated to an average of 74.0 beds across all Adult and Older Adult beds including rehab (38.0 Adult, 2.2 PICU and 33.9 Older Adult beds), with an associated in-month estimated full cost of c£1.68m. Of the cost, c£0.81m relates to Adult, £0.11m 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 £21.52m.

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.
- By the end of Quarter 3 2026/27, enabling work to support delivery of the Clinically Ready for Discharge Steering Group priorities will be completed, including mobilisation of workstreams focused on process alignment, clinical escalation, oversight of extended lengths of stay, and system-wide management of discharge delays.
- 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 has been completed and will be presented to the Integrated Performance & Assurance Group in October 2026.
  - Interviews for the Clinically Ready for Discharge pilot roles in DTVFCG and NYYSCG will take place in October.
  - The General Manager will now implement the enhanced service manager-level joint escalation process with Local Authority partners from 1 November 2026 to strengthen discharge processes and support the flow of patients clinically ready for discharge.
  - MHSOP Modern Matrons will now implement the standardised Section 117 checklist across both care groups from 1 November 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.

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

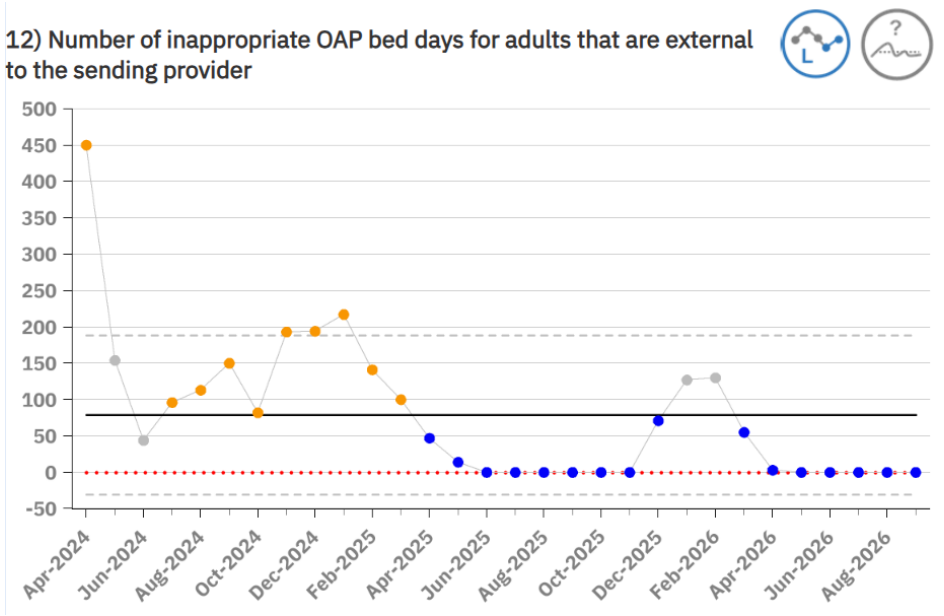
Background / standard description:
We are aiming to have no out of area bed days.

What does the chart show/context:
For the 3-month rolling period ending September, **0** days were spent by a patient in a bed away from their closest hospital.

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

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 bed occupancy and CRfD and consistent in terms of ALOS across the two Care Groups

Adult Mental Health Services - September 2026

	Bed Occupancy		CRfD		OAPs		ALOS	
Trust		83.72%		15.11%		0		29.04
DTVF	L	82.56%		14.11%	L	0		32.90
NYYS	L	86.77%		17.74%	L	0	L	20.55

Mental Health Services for Older People - September 2026

	Bed Occupancy		CRfD		OAPs		ALOS	
Trust		99.21%		19.05%		0		87.39
DTVF	H	101.47%	H	13.19%		0	H	87.22
NYYS		95.54%		28.57%		0	H	87.64

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

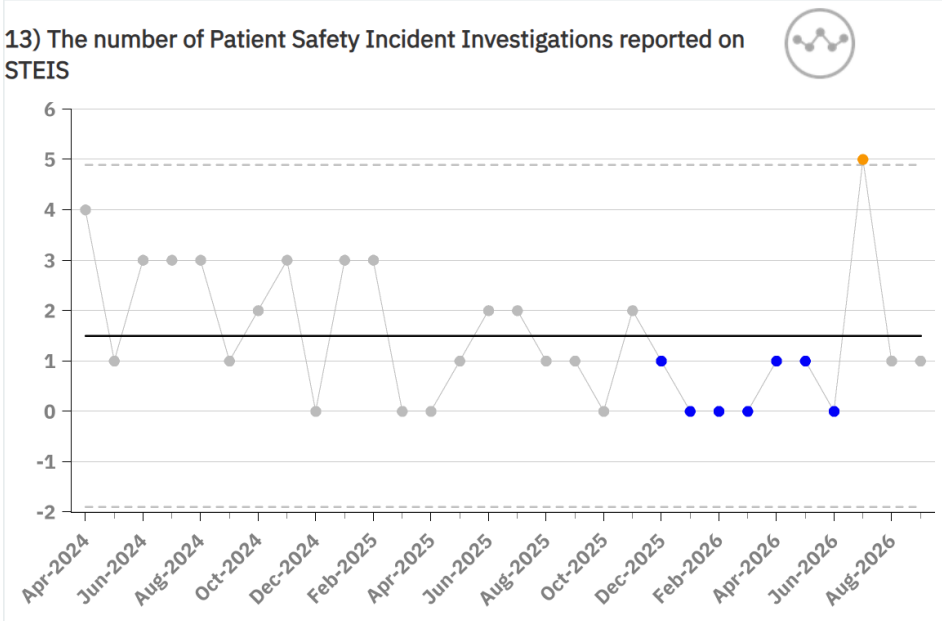
What does the chart show/context:
1 Patient Safety Incident Investigation (PSII) was reported on the Strategic Executive Information System (STEIS) during September.

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

To Note:
This PSII was identified, recorded on STEIS and allocated for investigation within 1 working day. This is a community death that occurred in June 2026 following which an After Action Review (AAR) was completed. The AAR was reviewed with Patient Safety in September at which point escalation to a Patient Safety Incident Investigation (PSII) was agreed to provide further opportunity to identify learning. A detailed Patient Safety Incident Investigation (PSII) is being undertaken by an independent patient safety investigator. An immediate review (referred to as a hot debrief) occurred alongside the AAR to identify any immediate learning and actions required. Learning identified during the investigation processes is actioned without necessarily awaiting the conclusion of the investigations.

Underlying Issues:
There are no underlying issues to report.

Actions:
Whilst there are no specific improvement actions required, a structured regroup following the expansion of testing of the new AAR process within AMH Planned Care services took place in September 2026, and rollout will now be overseen by the Patient Safety Team. **(Complete)**



14) The number of Incidents of moderate or severe harm

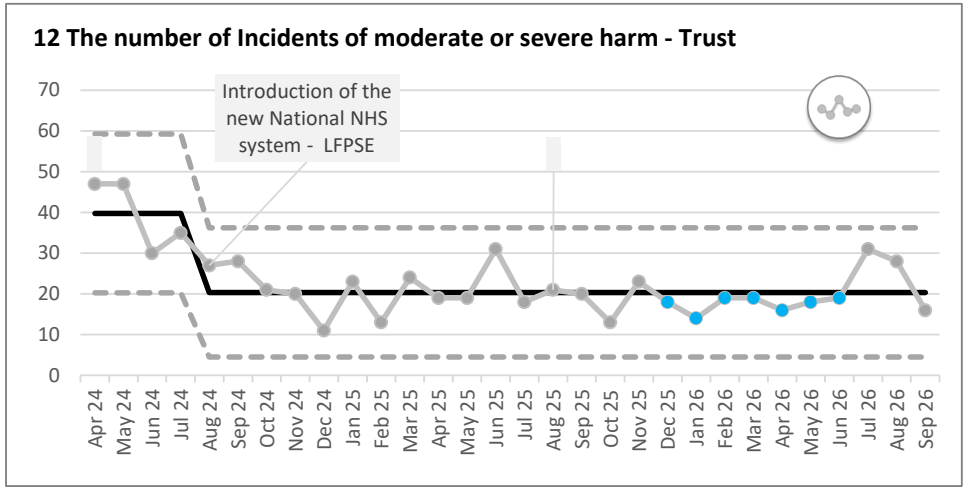
What does the chart show/context:
16 incidents of moderate or severe harm were reported during September. Of the 16 incidents reviewed 4 were subsequently determined not to meet the criteria for moderate or severe harm.

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

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. **(Not Complete)** Currently there are 41 cases that are overdue against the 15-36 day timescale; 30 cases currently exceed 36 days and are in the final stages of completion.



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.

15) The number of Restrictive Intervention Used

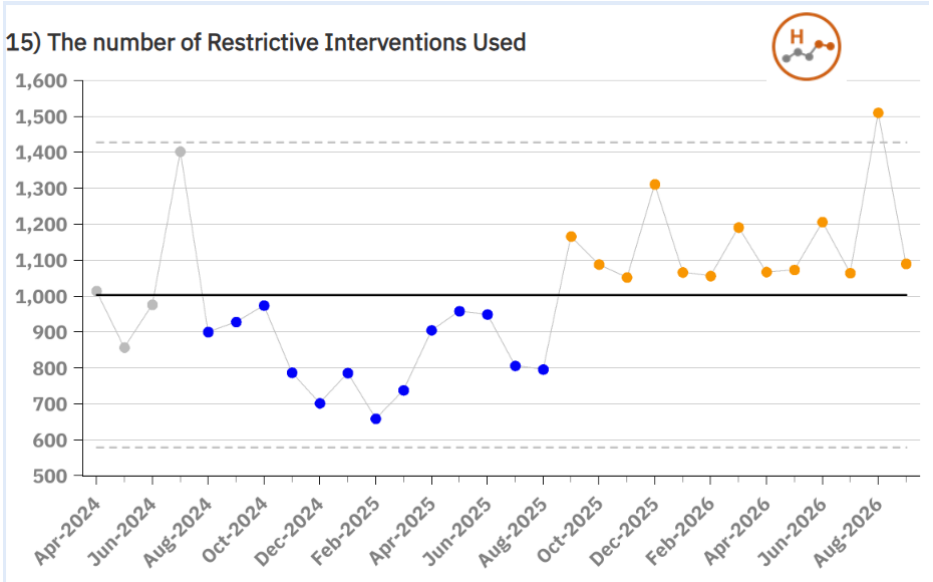
What does the chart show/context:
1,090 types of Restrictive Interventions were used during September. These interventions occurred within a total of 566 incidents, as multiple interventions can occur within 1 incident.

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

To note: The Positive and Safe Care update, Quarter 1 2026/27 to Quality Assurance Committee in September 2026, identifies restrictive practice activity within Adult Learning Disability (ALD) services has a significant influence on the Trust-wide position. Three patients in ALD accounted for 43.4% of all restrictive practices during the quarter, significantly influencing the Trust-wide position. The report indicates that, excluding ALD activity, the Trust compares favourably with peer organisations across several key restrictive practice measures. This provides context for the special cause concern but does not diminish the need for continued oversight and reduction of restrictive practices across all services.

Underlying issues:
- In DTVFCG ALD there are a high number of interventions used for a small number of patients presenting with complex needs.
- Trust-wide there are a high number of interventions used within our AMH female pathway .

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 (SRAS) 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. The service currently remains in SRAS.
- 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.
- By 31 December 2026, the Trust-wide Positive and Safe Group will support an AMH review of restrictive practice in female pathways, identifying themes, trends, and improvement opportunities.



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

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

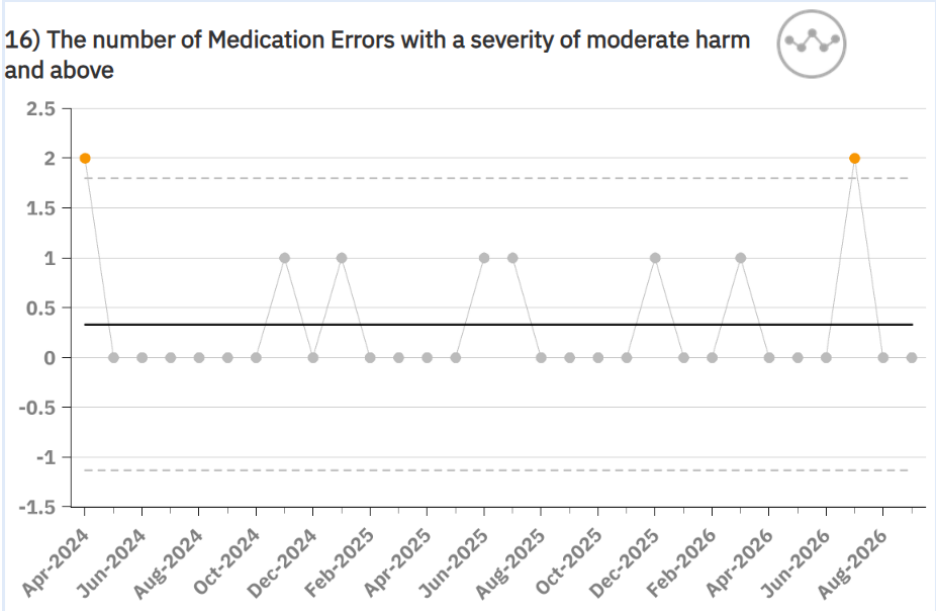
What does the chart show/context:
0 medication error was recorded during September.

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.



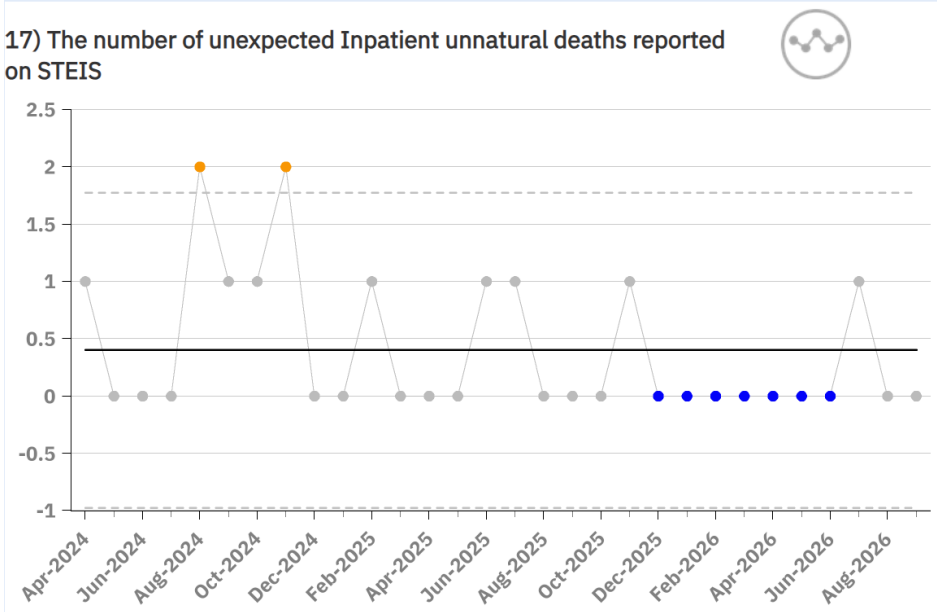
17) The number of unexpected Inpatient unnatural deaths reported on STEIS

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 September.

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.



18) The number of uses of the Mental Health Act

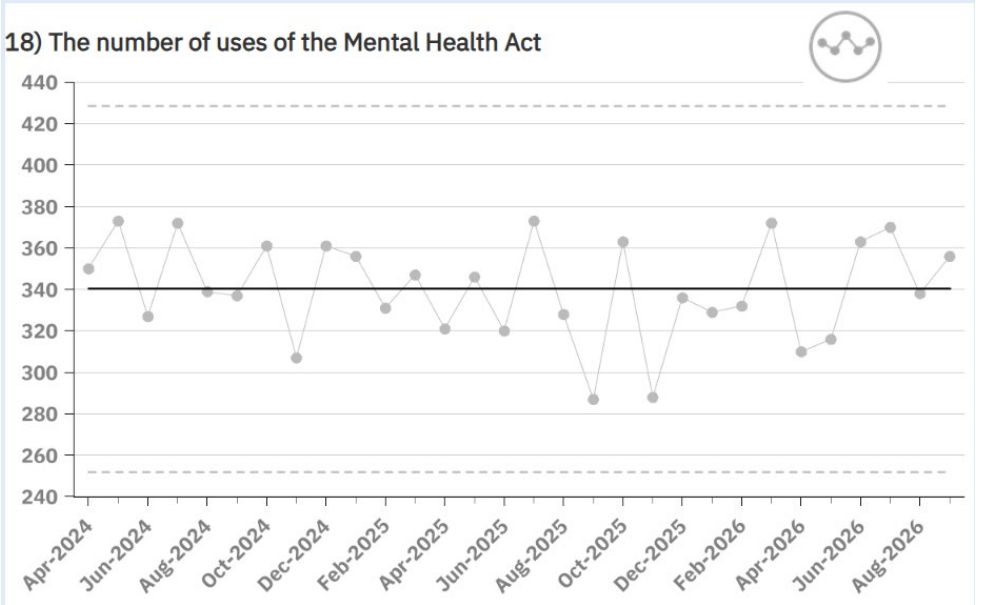
What does the chart show/context:
There were **356** uses of the Mental Health Act during September.

There is no significant change at Trust and Care Group level. Whilst there is an upward shift for Children & Young People's Services in North Yorkshire, York & Selby Care Group the numbers are minimal, and the service has confirmed this is not a cause for concern.

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.

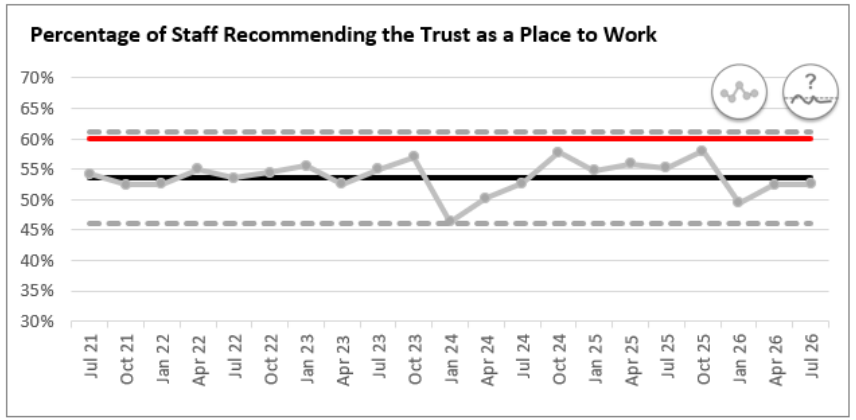
Actions:
- The EDI officer vacancy to support Patient & Carer Race Equality Framework has been readvertised with a plan to move from bank use to a substantive appointment by end of November 2026.
- The Sickness to Prevention programme board in partnership with the race equality staff network is leading work to support and strengthen ethnicity data recording. Staff webinars have commenced as per plan with 40 attending an EDI lunch and learning in September, initial actions have been identified and further conversations are planned.
- The Sickness to Prevention Programme Board meets monthly to 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 by March 2028.



3. People

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

19) 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*
- *The next data release will be the Q4 Pulse Survey in January 2027*

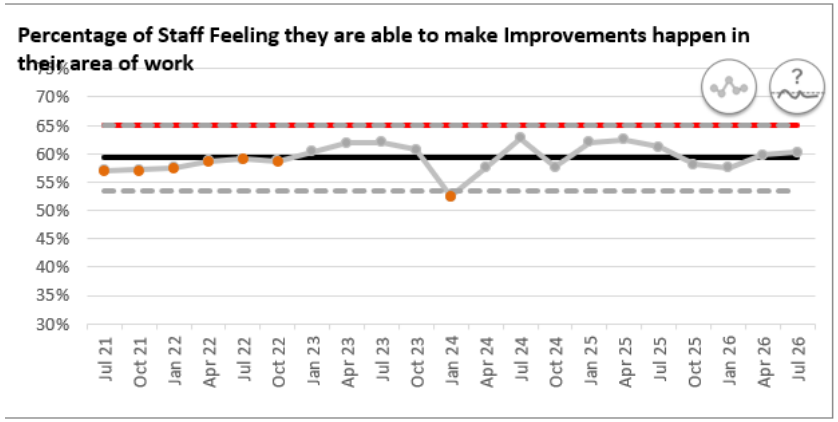
Background / standard description:
We are aiming for 60% of staff to recommend the Trust as a place to work

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.

20) 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

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

Actions:

- Implement the revised How We Work governance structure by the end of December 2026, with the Health & Wellbeing Strategic Group, Training & Education Governance Group, Reduction of Violence & Aggression Group, and Leadership & Management Academy reporting through a single oversight framework. Delivery will be aligned to the Leadership & Management Framework and Staff Standards to provide coordinated oversight of workforce development, wellbeing, attendance and culture improvement activity.
- 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.
- Standardisation of flexible working practices 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 have commenced their Feedback-to-Fix initiative. This will be a continued programme, and the action plan will be developed by the end of December 2026. In addition, face-to-face staff survey completion sessions will be undertaken 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.
- The Interim Care Group Managing Director has completed a leadership engagement session with care group leaders to promote the 2026 Staff Survey, reinforcing leadership accountability for encouraging staff participation and preparing leaders to review and act upon survey findings when results are released.

21) Staff Leaver Rate

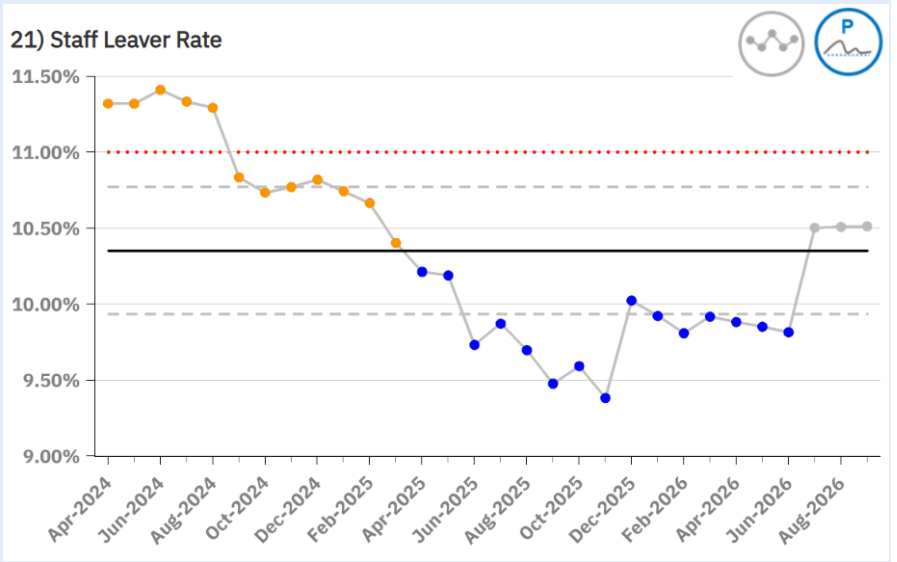
Background / standard description:
We are aiming for our staff leaver rate to be no more than 11%.

What does the chart show/context:
From a total of **7,485.13** staff in post **786.91 (10.51%)** had left the Trust in the 12-month period ending September 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, Medical, 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 CYPS within North Yorkshire, York & Selby 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:
The Trust's mutually agreed resignation schemes in July 2025 and January 2026 supported 86 staff to leave. Their notice periods ended November-December 2025 and April–June 2026, affecting leaver rates in those months.

22) Percentage Sickness Absence Rate

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

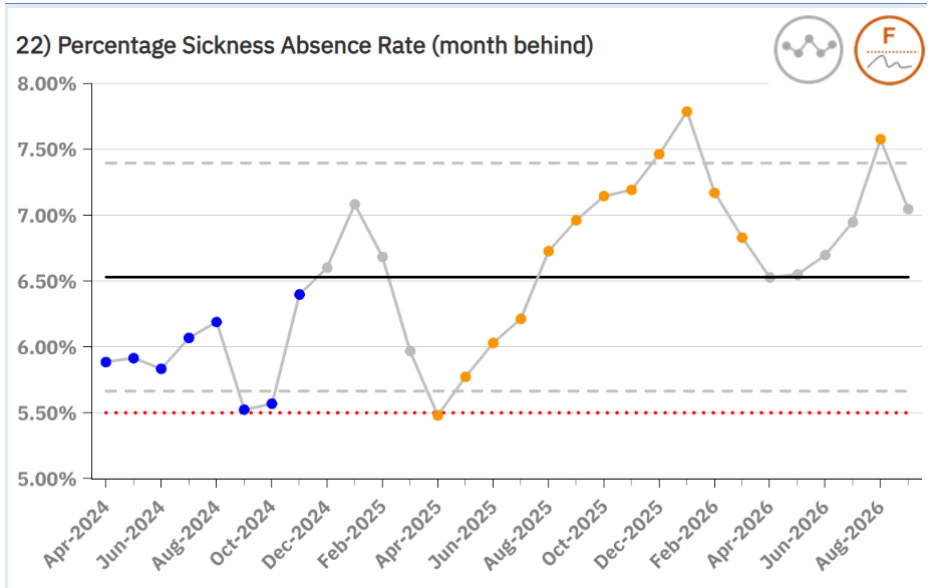
What does the chart show/context:
There were **225,429.77** working days available for all staff during September 2026 (reported month behind); of those, **15,663.76 (6.95%)** days were lost due to sickness.

There is no significant change at Trust level, however there is special cause concern for Corporate Affairs & Involvement, Finance, Medical, North Yorkshire, York & Selby Care Group, CYP and SIS within DTVF, and AMH and MHSOP within NYYSCG. There is special cause improvement for Nursing & Governance, Therapies and Management within NYYSCG.

National Benchmarking for NHS Sickness Absence Rates published 24th September 2026 (data ending June 2026) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.74%** compared to the Trust mean of **6.48%**, 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
- There is a high level of sickness within Health & Justice Services due to stress and anxiety.
- There is a high level of sickness within Secure Inpatient Services for a range of reasons.

Improvement actions are detailed in the following slide



22) 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. Following low intake, the proposal has been refined. (*See below action*).
2. **NEW** The Workforce Directorate will implement and communicate by the 1st November 2026 an interim prioritisation approach for Long-Term Sickness support, focusing available specialist capacity on mental health cases, while ensuring early intervention advice and signposting are provided through the Employee Support Service to mitigate the impact of current demand pressures.
3. 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.
4. 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 68.2% completion achieved to date.
5. 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 now to be agreed by June 2028.
6. 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.
7. Building on completion of 3 of the 5 actions, Health & Justice Services will implement the remaining 2 actions by 31 October 2026, with ongoing oversight through the Service Improvement & Development Group to support improvement in sickness absence performance.
8. Whilst there is no longer an issue, the ALD service has been identified as a Service Requiring Additional Support (SRAS) due to the acute nature of the clinical needs and the associated impacts, which include workforce health and wellbeing. A recovery plan is in place and actions are progressing, with weekly oversight from the Executive Board. The service currently remains in SRAS.
9. 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.
10. **NEW** The Workforce Directorate will complete a review of all Final Sickness Hearings concluded within the previous 12 months by the end of October 2026, analysing the timeliness of case progression from absence commencement to outcome, including the impact of deferred or rearranged hearings, to identify barriers to timely resolution and inform improvement actions.
11. **NEW** By the end of October 2026, the Workforce Directorate will analyse long-term sickness absence trends, causes and duration, including the increase in new cases identified during July 2026, to identify recurring themes and inform targeted actions to improve attendance and reduce long-term sickness absence.

23) Percentage compliance with ALL mandatory and statutory training

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

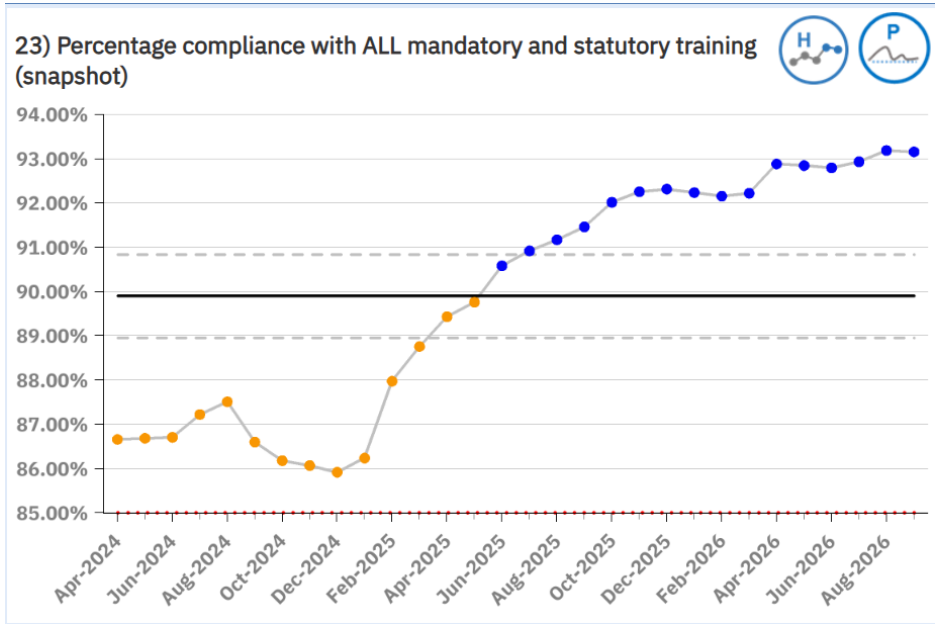
What does the chart show/context:
156,673 training courses were due to be completed for all staff in post by the end of September. Of those, **145,950 (93.16%)** were completed.

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

As at the 30th September 2026, all directorates are currently above 85%.

Underlying issues:
- 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 has approved the revised training matrix for Associate Directors of Nursing and Modern Matrons and will now oversee implementation to ensure competency requirements are aligned to management and clinical role expectations. **(Complete)**
- 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. **(Complete)**



23) Percentage compliance with ALL mandatory and statutory training

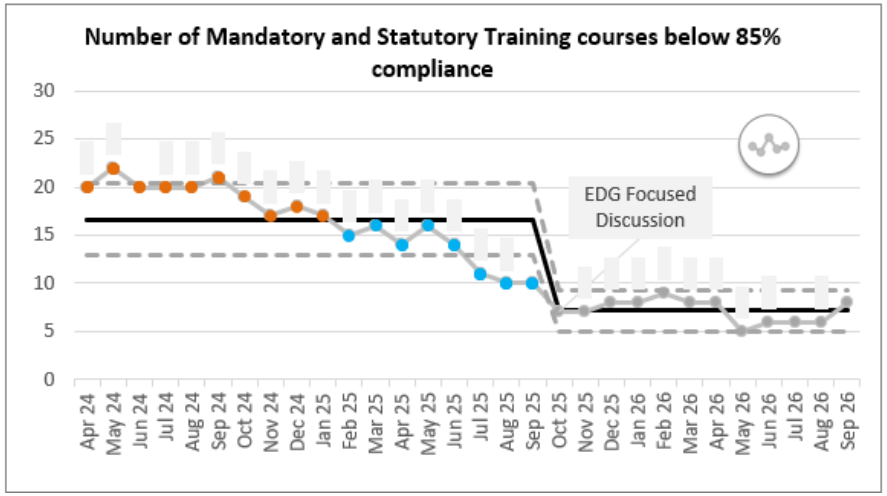
Courses below standard

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 **8** courses that are currently below the standard (an increase to the 6 reported in the previous month); **6** 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 are now anticipated to increase course provision by December 2026.
- The following directorates will ensure 85% compliance for all courses by the timescales outlined:
  - Therapies - now November 2026
  - Corporate Affairs & Involvement – October 2026
  - Chief Executive – now November 26
- Active recruitment is underway for clinical skills trainers to meet the demand required. One post has been successfully recruited to, and the candidate is progressing through pre-employment checks; recruitment continues for 2 further posts.
- Ensure all relevant staff complete mandatory retraining on the approved Observation & Engagement module by 1 December 2026, with compliance monitored and escalated through the appropriate governance arrangements.



	Total Compliant	Total Number	% Compliant
Observation & Engagement	1148	1487	77.20%
Positive & Safe Care Level 1 *	3654	4514	80.95%
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	787	965	81.55%
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1672	2049	81.60%
Resuscitation - Level 1 - 1 Year*	2139	2606	82.08%
Follow Up.	14	17	82.35%
Positive and Safe Care Level 2 Update*	1348	1625	82.95%
Moving and Handling - Level 2 - 2 Years*	678	799	84.86%

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

24) 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 **7,012** eligible staff in post at the end of September; **6,234 (88.90%)** had an up-to-date appraisal.

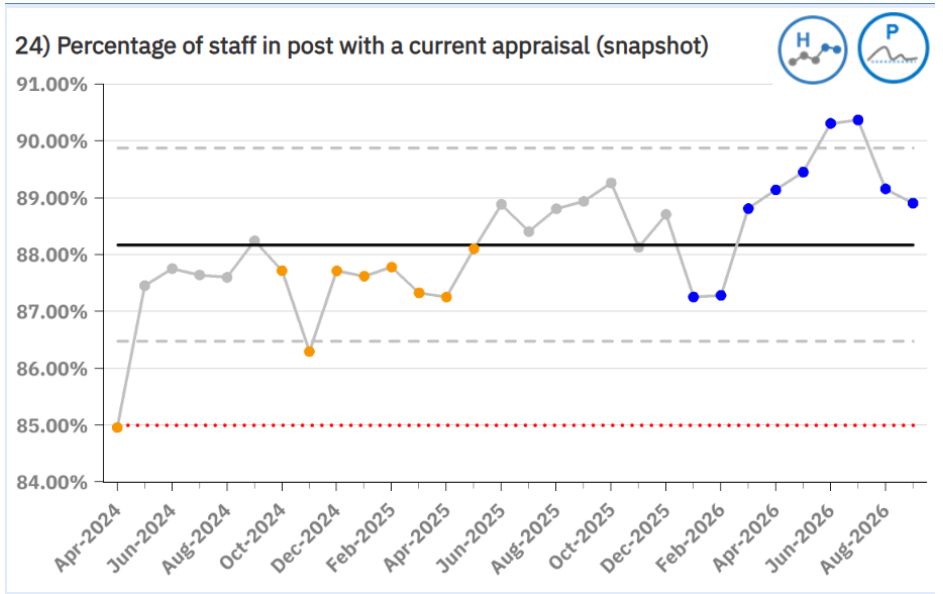
There is special cause improvement at Trust level and for Assistant Chief Executive, Durham Tees Valley & Forensic Care Group, North Yorkshire, York & Selby Care Group, CYPS, MHSOP and Management within that Care Group and AMH within both Care Groups. There is special cause concern for Corporate Affairs & Involvement. There is also special cause concern in CYP and SIS within Durham Tees Valley & Forensics Care Group; however, they remain above standard.

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

	Total Compliant	Total Number	% Compliance
CORPORATE AFFAIRS AND INVOLVEMENT	27	36	75.00%
FINANCE	42	54	77.78%
THERAPIES	37	45	82.22%
PEOPLE AND CULTURE	107	126	84.92%

Underlying issues:
- Corporate Affairs & Involvement appraisals has been impacted by staff sickness and uncertainties during a period of organisational change.
- People & Culture compliance is impacted by two services that have recently moved as part of the organisational change.
- Finance appraisals have been impacted by staff on long term sick and a number of staff where appraisals were due at the same time.
- Therapies appraisal compliance has been affected by a small number of isolated factors that are being actively addressed.

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 **(Complete)**



Actions continued:
- Head of Performance to oversee the completion of a Notification of Service Change form by the end of November 2026 to ensure all corporate services are aligned to the correct directorates.
- The Chief Executive Office will have completed outstanding appraisals by the end of September 2026. **(Complete)**
- The Finance will have completed outstanding appraisals by the end of September 2026.
- Therapies will have completed outstanding appraisals by the end of November 2026.

4. Activity

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

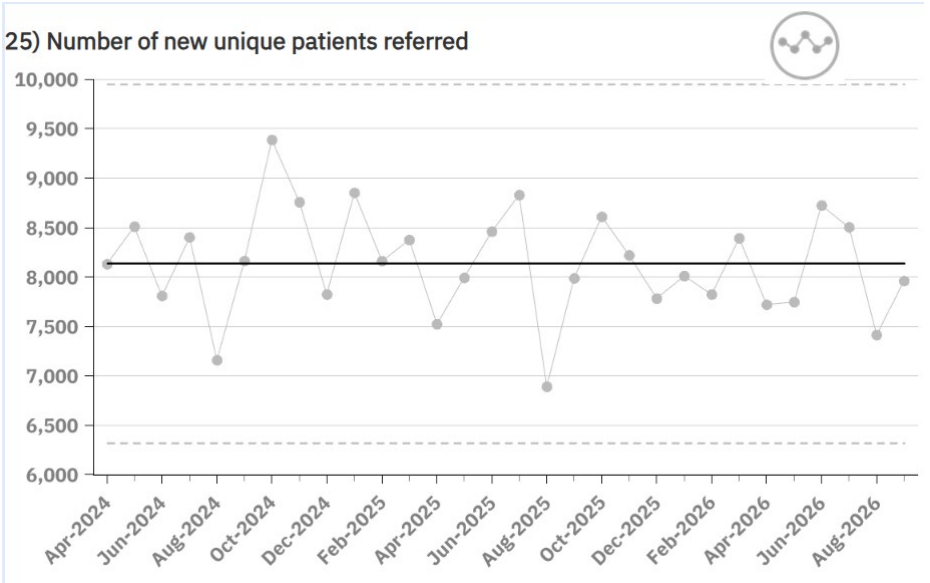
25) Number of new unique patients referred

What does the chart show/context:
7,961 patients referred in September that are not currently open to an existing Trust service.

There is no significant change at Trust and 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 DTVFCG. 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.



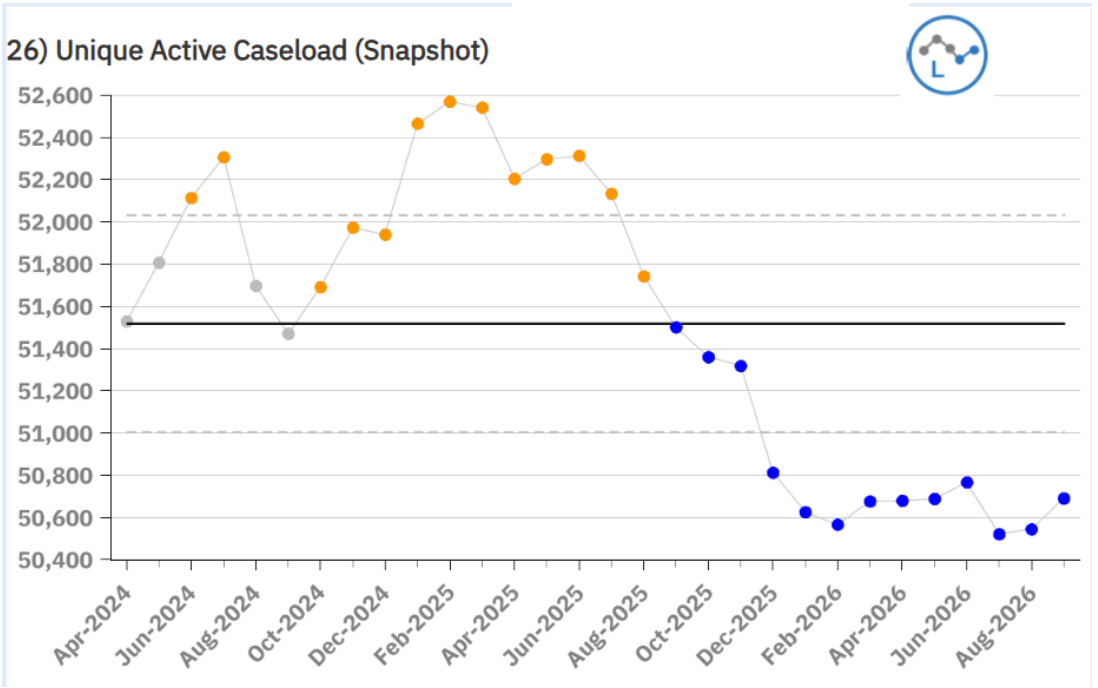
26) Unique Active Caseload (snapshot)

What does the chart show/context:
50,691 unique active cases were open as at the end of September 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.

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. **(Complete)** Review of the methodology has confirmed that inpatient admissions are included within the reported active caseload. **Executive Directors Group approval is sought to amend the measure to exclude inpatient activity across all services, ensuring the measure reflects community caseloads only.**
- Analysis to be reviewed by the AMH and CYP General Managers within NYYSCG by the end of October 2026 to understand the teams identified, underlying factors and determine whether any mitigating actions are required.



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 30 September 26 - Revenue

Revenue Performance - Group	Year to date			RAG
	Plan	Actual	Variance	
Revenue Performance (Surplus) / Deficit £m	1.94	(0.03)	1.97	
Income & Expenditure Margin (Surplus) / Deficit %	0.78%	(0.03%)	0.81%	
Income £m	275.67	279.71	4.04	
Pay Expenditure £m	233.43	231.80	1.63	
Non Pay Expenditure £m	42.43	46.60	(4.17)	
Non Operating Expenditure £m	1.75	1.28	0.47	

Revenue Performance - Group	Year to date £m			RAG
	Plan	Actual	Variance	
Durham, Tees Valley & Forensic (DTVF)	145.01	147.74	(2.74)	
North Yorkshire & York (NYY)	60.06	60.65	(0.59)	
Estates & Facilities	17.07	16.70	0.37	
Corporate	30.39	30.68	(0.29)	
Income	(256.20)	(255.59)	(0.61)	
Central and Reserves	5.61	(0.22)	5.83	
PIPS	0.00	0.00	(0.00)	
	1.94	**(0.03)**	**1.97**	

Variances - Better / (Worse) than plan

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 significant present delivery challenges.
- Managing implications of national pay awards where under-funded via national tariff uplift.
- Ensuring delivery of progressively stepped planned 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 £0.03m surplus was £1.97m better than planned.
Income reflects £1.3m unplanned contract receipt in May, growth in subsidiary income £1.2m for the period, final pay award tariff income and other cumulative income changes of £0.5m net.
Pay performance masks pressures from PIPS £1.0m (related to their increased income), Bank overspending £2.3m (see Indicator 28) mitigated by vacancies across a range of services, and delivery of other pay savings.
Non Pay overspending is driven by purchase of healthcare £2.5m and under-delivery of non-pay non recurrent savings £0.9m (mitigated by non recurrent pay savings), growth in lease cars £0.7m, with offsetting reductions in expenditure on general supplies and services £0.5m,
Adverse Care Group performance reflects pressures relating to Humber and North Yorkshire ICB commissioned activity which benefit from helpful risk share arrangements. These cap annual Trust liabilities and would equate to an income offset of £0.6m year to date pressure for services located in DTVF £0.6m and £0.5m for NYY if pressures persist.

Underlying issues:
- Slippage on delivery of recurrent Cash Releasing Efficiencies Savings (CRES) has the risk of carrying forward a larger underlying pressure into 2027/28 (Indicators 29 and 30).
- Bank costs significantly exceed plan and reflect increased in-year costs and undelivered savings. Focus to reduce flexible staffing WTE is essential. (See Indicators 28 to 30).
- High numbers of patients who are clinically optimised, but not discharged, are adversely impacting bed occupancy and average lengths of stay, temporary staffing costs and reliance on independent sector beds. Critical system support is central to those plans.

Key Areas for Action:
- Delivering approved bank and sickness reduction plans (see indicator 28).
- Progressing Executive-led Transformation Programmes to support the NHS 10 Year Health Plan and, by effecting the 3 national 'left-shifts', target efficiencies to commence at scale from 2027/28.

26) Financial Plan: Agency expenditure

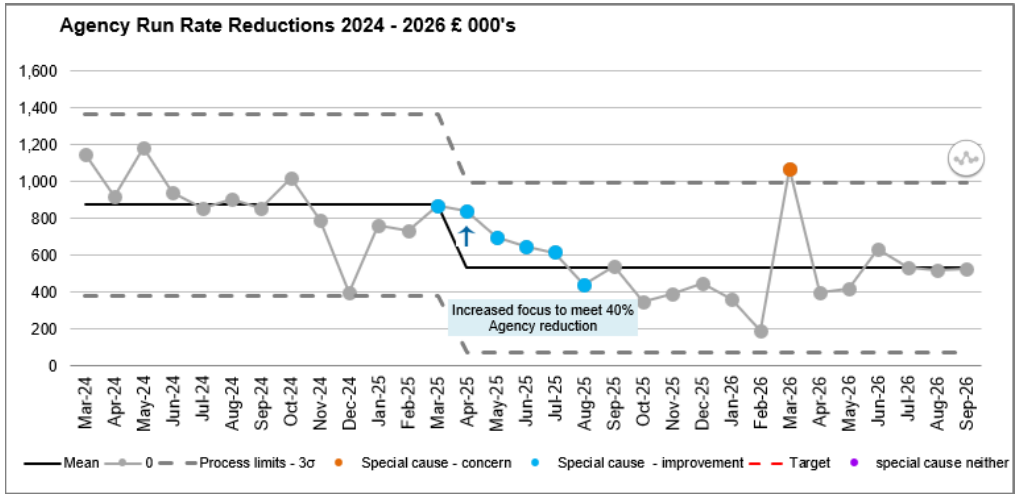
Key Financial Indicators for the period ending 30 September 26 - Agency costs compared to plan by category

Agency Usage	Expenditure £ 000's							WTE		
	Annual	Current Month			Year to Date			Current Month		
Category	Cost Cap	Cost Cap	Actual	Variance	Cost Cap	Actual	Variance	Cost Cap	Actual	Variance
Nursing and Other*	3,050	261	304	(43)	1,700	1,817	(117)	33.62	59.60	(25.98)
Medical	1,975	158	225	(67)	1,058	1,218	(160)	13.30	13.50	(0.20)
Grand Total	**5,025**	**419**	**529**	**(110)**	**2,758**	**3,035**	**(277)**	**46.92**	**73.10**	**(26.18)**
Agency expenditure YTD as a proportion of total Pay expenditure (NOF Metric)						1.31%				

* Agency Plan has been increased by £477k following notification from NHSE of an amendment to be made to our cap value for PIPS.

Agency Quarterly Cost Profile	Q1	Q2	Q3	Q4	Total
Agency Plan £ 000	1,502	1,256	1,258	1,010	**5,026**
Agency Plan %	30%	25%	25%	20%	**100%**

Agency Run Rate	Annual Cost Cap	Year to Date			Expenditure £ 000's					
		Cost Cap	Actual	Variance	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26
Trust	4,226	2,361	2,226	135	305	323	362	405	410	421
Subsidiary	799	397	809	(412)	94	94	269	132	112	108
Group Total	5,025	2,758	3,035	(277)	399	417	631	537	522	529



The Agency cost cap of £5.03m is an adjustment to the annual plan, as NHSE have agreed to an increase relating to our subsidiary, and that this will be included for calculation of our Q2 NOF scores. It was not actioned in time for inclusion in PFR reporting templates, which showed £501k variance to our Annual plan.

- Year to date **Group agency costs of £3.0m were £501k and 30.95 WTE above initial plan, but improved against our anticipated revised cost cap:**
- NHSE have agreed to adjust the Trust agency cost cap by £447k (£224k year to date) as PIPS was not included in Trust agency reporting when targets were set. The variance to the revised agency cost cap is £277k above plan. These tables reflect performance against the revised Group Agency cap which NHSE have advised will be adjusted for Quarter 2 National Outcomes Framework metrics (although not yet corrected in NHSE financial returns).
- **Trust costs** were £2.2m and £135k below the revised cost cap to date.
- **Subsidiary costs** were £809k and £412k above cost cap to date.
- Nursing and Other costs were £117k above the revised cost cap, including £126k Bankfields Court 'break glass' shifts (£464k to date) approved by Directors.
- The lower SPC chart shows a rise in Quarter 4 2025/26 (including Subsidiary cost adjustments). An uptick in Trust Quarter 1 costs follows consistent monthly 'run rate' reductions since March 2024 (c £1.2m monthly). Recent increases reflect premia rate Band 3 shifts supporting one 'break glass' Trust patient care package, Secure Inpatient Service staffing pressures, and an additional PIPS Subsidiary care package.
- Medical costs are 42.5% (£225k) of in-month cost, but 18.5% (13.50 WTE) of in-month WTE due to high premia rates and price cap breaches.

Underlying issues:

- Agency WTE provide essential vacancy cover so we need sustainable solutions in shortage (medical and nursing) professions and services.
- Whilst inpatient Agency nursing expenditure reduced markedly in Durham, Tees Valley and Forensic, reflecting actions to optimise rostering and review staffing relative to clinical need, costs since Quarter 1 have been impacted by the 'break glass' Bankfields Court package and Secure staffing pressures. North Yorkshire and York saw slower impacts, albeit favourable recently.

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.
- Band 2-3 clinical agency shifts require Director level approval. Actions are progressing via the Care Groups to address 'Break Glass' approvals that: are needed to support care at Bankfields Court.

27) Financial Plan: Agency price cap compliance

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

Price Cap Compliance	Sep - 25		Aug - 26		Sep - 26		In-Month Movement		12-Month Movement	
	Shifts	Shifts %	Shifts	Shifts %	Shifts	Shifts %	No.	%	No.	%
Compliant	595	58%	248	32%	108	18%	(140)	(56%)	(487)	(82%)
Non-Compliant	437	42%	520	68%	481	82%	(39)	(8%)	44	10%
Total Shifts	**1032**	**100%**	**768**	**100%**	**589**	**100%**	**(179)**	**(23%)**	**(443)**	**(43%)**

Compliance Change by Staffing Group	Sep - 25			Aug - 26			Sep - 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	137	0	0%	455	290	64%	260	229	88%	(61)	(61%)	229	229%
Medical	370	370	100%	164	164	100%	194	194	100%	30	18%	(176)	(107%)
Nursing	525	67	13%	149	66	44%	135	58	43%	(8)	(12%)	(9)	(6%)
Total Shifts	**1032**	**437**	**42%**	**768**	**520**	**68%**	**589**	**481**	**82%**	**(39)**	**15%**	**44**	**10%**

Movement - Increase / (Reduction)

Run Rate of Agency Expenditure

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Year to Date
Adult Mental Health	293	267	350	234	173	187	172	159	156	161	102	143	893
Bankfields Court	0	1	-1	0	0	0	0	16	71	91	159	126	464
CYPS Community	121	1	13	53	44	72	64	64	55	82	58	72	394
Secure Inpatient Services	25	17	16	17	-10	1	-3	0	0	2	45	19	64
Other Services	1	122	137	128	115	128	72	84	80	69	45	62	412
Total Expenditure	**440**	**409**	**515**	**432**	**321**	**388**	**305**	**323**	**362**	**405**	**410**	**421**	**2226**

Key Financial Indicators for the period ending 30 September 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	Sep-26
Durham Tees Valley & Forensic	1	1	7	0	0	0	73	173	239	451	259
North Yorkshire & York	40	941	1040	59	42	40	20	50	39	4	1
Total Shifts Worked	**41**	**942**	**1047**	**59**	**42**	**39.52**	**93**	**223**	**278**	**455**	**260**

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**	**Sep-26**
Bankfields Court (Tees) ALD	0	0	0	0	0	0	73	173	186	290	229
SIS RPH Clover/Ivy Ward	0	0	0	0	0	0	0	0	15	36	6
SIS RPH Jay Ward Low Secure Mal	0	0	0	0	0	0	0	0	6	19	8

Information on this slide is Trust only. No data is included from PIPS on Price Cap or Band 3 Agency Compliance or Run Rates.

What does the data show/context:

- Agency usage reduced by 443 shifts (43%) over the 12 months ending September 2026 and decreased by 179 shifts in-month.
- Non-compliant shifts reduced by 39 (15%) over the same period, a slower proportionate reduction; driving a higher non-compliance rate, accounted for by an uptick in Medical shifts offset by a reduction in Band 3 Support Worker usage at ALD Bankfields Court due to observation step down.
- Of 589 shifts in September, 108 (18%) complied with price cap.
- 260 Band 3 shifts in September 2026 breached an NHSE requirement to cease Support Worker usage; down by 195 shifts in-month (prior month 177 shifts increase). This included 259 shifts worked in September from 'break glass' approvals at Bankfields Court commencing in May in response to an agreed care package and with appropriate approvals for all 951 shifts worked to date.

Underlying issues:

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

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

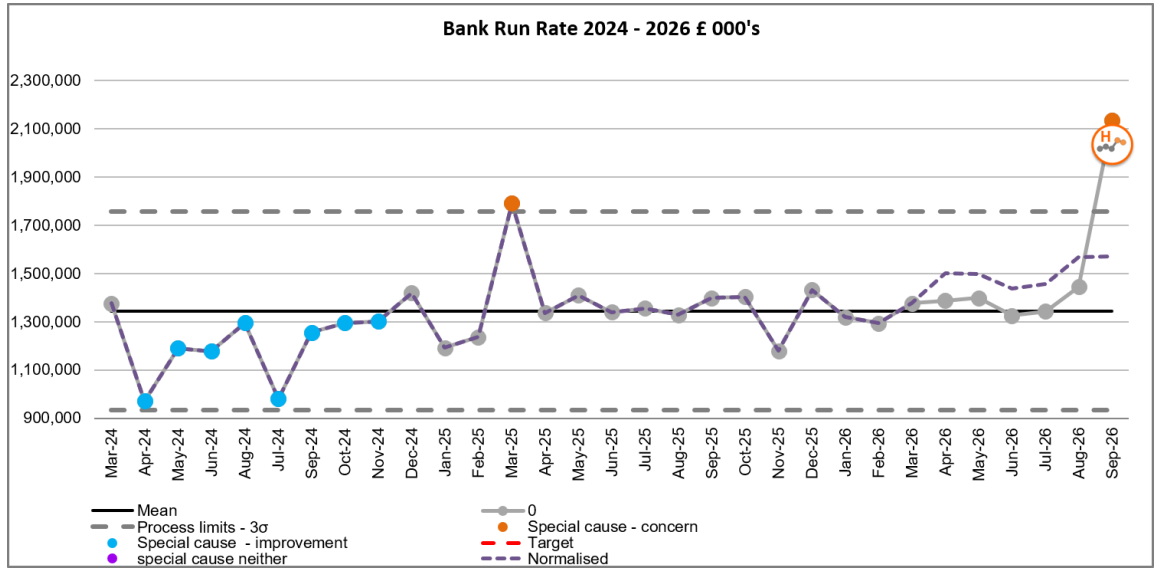
Key Financial Indicators for the period ending 30 September 26 - Bank Expenditure

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	623	(430)	1,158	2,285	(1,127)	40.90	81.44	(40.54)
Unqualified Nursing	10,722	895	1,084	(189)	5,565	6,303	(738)	221.68	292.9	(71.22)
Other	15	1	429	(428)	7	446	(439)	0.36	17.06	(16.70)
Initial Plan Variance	**13,052**	**1,089**	**2,136**	**(1,047)**	**6,730**	**9,034**	**(2,304)**	**262.94**	**391.40**	**(128.46)**
Plan Condition Variance	**13,052**	**1,310**	**2,136**	**(826)**	**7,623**	**9,034**	**(1,411)**	**278.35**	**391.40**	**(113.05)**
Agency expenditure YTD as a proportion of total Pay expenditure (NOF Metric)						4.03%				

Variances - Better / (Worse) than plan

Key Financial Indicators for the period ending 30 September 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	943	1,419	(476)	5,656	7,038	(1,382)	299.78	308.63	(8.85)
North Yorkshire & York	1,732	144	453	(309)	866	1,722	(856)	49.71	72.73	(23.02)
Estates & Facilities	30	3	126	(123)	15	131	(116)	0.95	6.32	(5.37)
Corporate	(20)	-1	138	(139)	193	143	50	1.01	3.72	(2.71)
Grand Total	**13,053**	**1,089**	**2,136**	**(1,047)**	**6,730**	**9,034**	**(2,304)**	**351.45**	**391.40**	**(39.95)**



What does the data show/context:

- Year to date Bank **costs of £9.0m were £2.3m above original plan (February NHSE submission)** but £1.4m worse than plans finalised at the end of quarter one. Both metrics illustrate the material 'stretch' those actions need to deliver.
- Most plan variation related to qualified nursing roles, including hard to fill vacancies.
- During September, additional bank staff assignments recorded as substantive posts were identified and corrected, with a catch up of expenditure recorded in month. Further assurance and control measures are being implemented, with a report on the issue and follow up actions due to be considered by Executives on the 27 October. The normalised position for 2026/27 is shown on the chart

Underlying issues:

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

Actions:

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.

There is a risk that substantive recruitment transfers costs from bank but does not deliver targeted CRES. Substantive recruitment equates to £560k (16%) of the total bank reduction plans approved by Board 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.

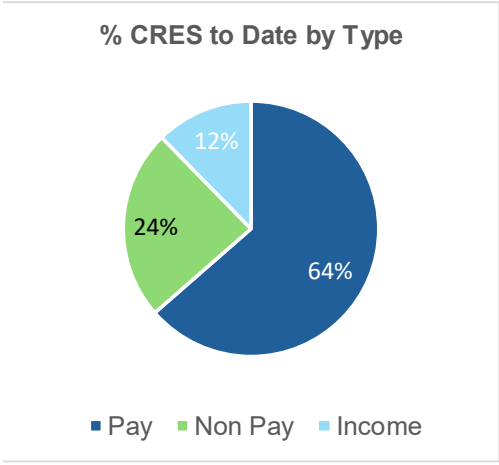
29) CRES Performance – Recurrent and 30) CRES Performance – Non-Recurrent

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

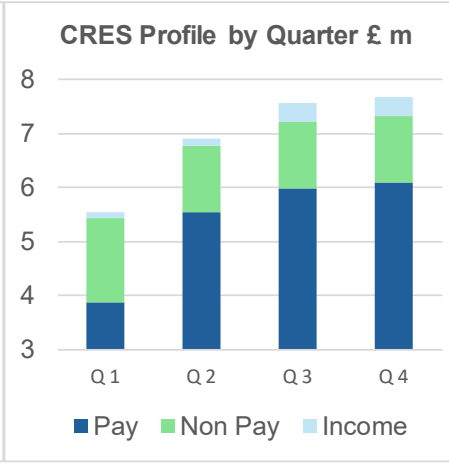
Type	2026/27 CRES performance compared to plan							2026/27 CRES plans phasing £ 000				
	Year to date £ 000			Annual £ 000			Full Year Effect	Q1	Q2	Q3	Q4	2026/27
	Plan	Actual	Variance	Plan	Forecast	Variance		Plan	Plan	Plan	Plan	Plan
Recurrent:												
Pay	7,048	6,047	(1,001)	16,765	16,343	(422)	18,600	3,150	3,898	4,842	4,875	**16,765**
Non Pay	1,380	1,344	(36)	3,092	3,103	11	3,612	701	679	851	861	**3,092**
Income	150	136	(14)	738	334	(404)	151	72	78	294	294	**738**
Sub Total	**8,578**	**7,527**	**(1,051)**	**20,595**	**19,780**	**(815)**	**22,363**	**3,923**	**4,655**	**5,987**	**6,030**	**20,595**
								19%	**23%**	**29%**	**29%**	**100%**
Non Recurrent:												
Pay	2,372	2,422	50	4,744	4,258	(486)	0	729	1,643	1,149	1,223	**4,744**
Non Pay	1,409	1,866	457	2,147	1,678	(469)	0	847	562	369	369	**2,147**
Income	102	1,506	1,404	204	1,974	1,770	0	50	52	51	51	**204**
Sub Total	**3,883**	**5,794**	**1,911**	**7,095**	**7,910**	**815**	**0**	**1,626**	**2,257**	**1,569**	**1,643**	**7,095**
								23%	**32%**	**22%**	**23%**	**100%**
Total	**12,461**	**13,321**	**860**	**27,690**	**27,690**	**0**	**22,363**	**5,549**	**6,912**	**7,556**	**7,673**	**27,690**
								20%	**25%**	**27%**	**28%**	**100%**

Variances - Better / (Worse) than plan

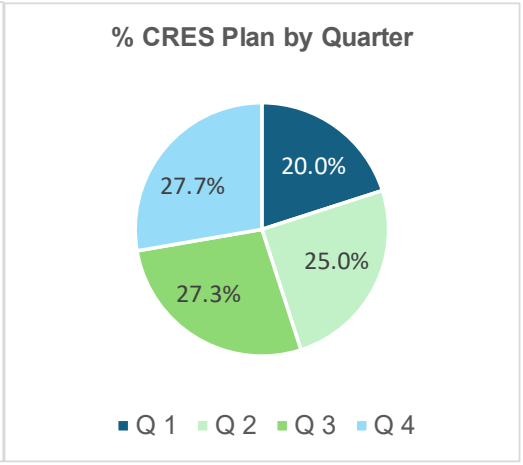
Year to Date CRES Delivery



Plan Quarterly Profile by Type



Plan Quarterly Phasing



What does the data show/context:

Whilst **CRES delivery of £13.3m was £0.9m better than plan** year to date, plans assume marked stepped increases from quarter three. Performance reflects **delivery of 48.1% annual savings** required (45% planned), with:

- **£7.5m Recurrent** CRES delivery; being £1.1m below plan
- **£5.8m Non-Recurrent** CRES delivery was £1.9m above plan

Adverse year to date performance reflects **recurrent pay under delivery**:

- Non delivery of **Bank staff reductions (£1.8m worse than plan).** Under-delivery includes growth in Secure Inpatient Wards (where staffing challenges have required additional support), Older Adult Mental Health Services in Durham and Tees Valley and Trustwide Adult Mental Health Services.
- Whilst **Overtime was £242k better, Agency was £89k worse, than plan**. The Forecast Outturn assumes full recovery of the bank savings plan and delivery of an increased full year effect into 2027/28, however current performance highlights the level of risk associated. Forecast slippage on recurrent Secure service income (reflecting staffing pressures) and other pay schemes are being offset in-year by non recurrent income over-achievement.

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 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 delivery would increase, whereas higher than planned recurrent delivery would decrease, CRES required in 2027/28.

Temporary Older Adult bed changes will contribute to reducing bank costs. Additional weekly controls have been introduced to ensure appropriate oversight and approvals but with plan delivery being seen as high risk.

Actions:

Please see Financial Plan measures - 25) SOCI - Surplus/Deficit, 26) Agency expenditure target, 27) Agency price cap compliance, 28) Bank Expenditure

- Focus is on reduction in bank expenditure to aim to recover the under-delivery on schemes to date, with additional weekly oversight introduced.
- 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. New Schemes to reduce the shortfall in recurrent delivery are being pursued.

31) Capital Expenditure (Capital Allocation)

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

Capital Programme:	Year to Date £ 000			Annual £ 000		
	Plan	Actual	Variance	Plan	Forecast	Variance
Total expenditure plan	8,339	8,162	177	13,176	21,058	(7,882)
Performance against capital allocation (a)	8,157	7,947	210	12,402	15,221	(2,819)
Performance against revised capital allocation (b)	8,157	7,947	210	12,895	15,221	(2,326)

Variances - Lower / (Higher) than plan

Key Financial Indicators for the period ending 30 September 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:

Total Expenditure Plan includes the following unplanned variations against plan, but where costs are fully funded and do not therefore show as variation above allocated resources**:**

- **£2,978k projected left shift Mental Health Emergency Department and Neighbourhood Health Centre scheme cost** is included in forecast expenditure. Access to funding was confirmed after capital plan submission and will be fully funded via NHS England Public Dividend Capital drawdown. It therefore shows as an adverse plan variation but no forecast variation against allocation (i.e. unplanned cash draw offsetting unplanned expenditure).
- **£1,600k projected cost for installation of solar panels** on Trust sites approved by NHS England during September – this is also fully funded and will not impact on performance against the allocation.

What does the data show/context:

£7,947k Capital expenditure for the year to date was **£210k 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: Current allocation of **£12,895k** 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).

Forecast performance against our revised allocation is a **£2,326k pressure**, with actions being taken to aim to mitigate this in year including from expressions of interest for access to Estates Safety Scheme funding.

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 were risk-assessed to aim to manage costs to within Trust capital allocations, however we forecast risk to delivery within plan this year. Multi-year plans were submitted to NHSE in February 2026 aligned to medium term financial plans and confirmed funding. Strategic Capital was not allocated beyond 2026/27, with NHSE assessing 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.
- Our 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 30 September 26 - Cash, Supplier Payment and Receivables

	Year to Date			Annual		
Receivable & Payables Metric:	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Cash (£000s)	42,903	56,698	13,795	36,653	46,424	9,771
Better Payment Practice Code (%)	95.0%	95.6%	0.6%	95.0%	95.0%	0.0%
Better Payment Practice Code (count)	27,741	27,916	175	55,832	55,832	0
Aged Debt > 90 days overdue (%)	5.0%	46.8%	(41.8%)	5.0%	5.0%	0.0%
Aged Debt > 90 days overdue (% of annual income)	0.0%	0.1%	(0.1%)	0.0%	0.0%	0.0%

Variances - Better / (Worse) than plan

Key Financial Indicators for the period ending 30 September 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	56,698	53,052	52,645	48,165	51,912	51,580	46,424

What does the data show/context:

Cash balances of **£56,698k were £13,795k 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 £2,051k, with **£808k 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. 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%	92.53%	93.34%	✓
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC	H		75.00%	86.41%	84.28%	✓
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	70.37%	74.27%	✓
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	H	P	35.00%	64.00%	64.00%	✓
5)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	P	50.00%	66.01%	66.01%	✓
6)	Percentage of Adults showing measurable improvement following treatment - patient reported	QAC				49.20%	49.20%	
7)	Percentage of Adults showing measurable improvement following treatment - clinician reported	QAC	H			39.24%	39.24%	
8)	Percentage of Older Persons showing measurable improvement following treatment - patient reported	QAC				34.47%	34.47%	
9)	Percentage of Older Persons showing measurable improvement following treatment - clinician reported	QAC	H			17.97%	17.97%	
10)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC	L	F	85.00%	89.33%	89.15%	✓
11)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC	H			13.78%	13.78%	
12)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC	L		0	0	0	✓
13)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				0	6	✓✓
14)	The number of Incidents of moderate or severe harm	QAC				13	94	✓
15)	The number of Restrictive Interventions Used	QAC	H			952	6,260	✓✓
16)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	1	✓✓
17)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC	L			0	0	✓✓
18)	The number of uses of the Mental Health Act	MHLC				223	1,323	✓

Please Note: *11 Clinically Ready for Discharge does not have a Data Quality Assessment rating as this is a new measure. The assessment has been completed and will now be shared with the Planning, Digital, & Estates 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
19)	Percentage of staff recommending the Trust as a place to work	PCDC		?	60.00%	52.01%	53.23% (Jul-2026)	✓
20)	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)	✓
21)	Staff Leaver Rate	PCDC	L	P	11.00%	9.18%	9.18%	✓
22)	Percentage Sickness Absence Rate (month behind)	PCDC		F	5.50%	7.74%	7.61%	✓✓
23)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC	H	P	85.00%	93.48%	93.48%	✓✓
24)	Percentage of staff in post with a current appraisal	PCDC	H	P	85.00%	88.99%	88.99%	✓✓

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
25)	Number of new unique patients referred	RPC				5,381	32,227	✓
26)	Unique Active Caseload (Snapshot)	RPC	L			38,160	38,160	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)	DQA Metric Rating
27)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	145,005,098	147,743,988	✓✓
28)	Agency Expenditure	RPC	968,639	1,488,329	✓
29)	Agency price cap compliance	RPC	67.00%	7.06%	✓
30)	Bank Expenditure	RPC	5,656,005	7,037,712	

Please Note: *26 Unique Active Caseload and 30 Bank Expenditure do not have a Data Quality Assessment rating as they new measures. The assessments have been completed and will now be shared with the Planning, Digital, & Estates Committee for approval.*

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%	94.52%	94.14%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care	QAC			75.00%	82.91%	83.04%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC			75.00%	74.14%	69.92%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	H	P	35.00%	70.36%	70.36%	
5)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	P	50.00%	65.43%	65.43%	
6)	Percentage of Adults showing measurable improvement following treatment - patient reported	QAC				48.80%	48.80%	
7)	Percentage of Adults showing measurable improvement following treatment - clinician reported	QAC	H			40.08%	40.08%	
8)	Percentage of Older Persons showing measurable improvement following treatment - patient reported	QAC				30.53%	30.53%	
9)	Percentage of Older Persons showing measurable improvement following treatment - clinician reported	QAC				19.28%	19.28%	

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
10)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	RPC			85.00%	90.93%	88.83%	
11)	Percentage of patients clinically ready for discharge (adults & older adults in a MH bed) - Snapshot	RPC				22.88%	22.88%	
12)	Number of inappropriate OAP bed days for adults that are external to the sending provider	RPC	L		0	0	0	
13)	The number of Patient Safety Incident Investigations reported on STEIS	QAC				1	3	
14)	The number of Incidents of moderate or severe harm	QAC				3	34	
15)	The number of Restrictive Interventions Used	QAC				138	750	
16)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	1	
17)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	1	
18)	The number of uses of the Mental Health Act	MHLC				117	655	

Please Note: *11 Clinically Ready for Discharge does not have a Data Quality Assessment rating as this is a new measure. The assessment has been completed and will now be shared with the Planning, Digital, & Estates 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
19)	Percentage of staff recommending the Trust as a place to work	PCDC		?	60.00%	44.74%	43.33% (Jul-2026)	✓
20)	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)	✓
21)	Staff Leaver Rate	PCDC		F	11.00%	12.21%	12.21%	✓
22)	Percentage Sickness Absence Rate (month behind)	PCDC	H	?	5.50%	6.05%	5.87%	✓✓
23)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PCDC	H	P	85.00%	92.59%	92.59%	✓✓
24)	Percentage of staff in post with a current appraisal	PCDC	H	P	85.00%	89.62%	89.62%	✓✓

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard	Actual (Latest Month)	Actual (FYTD)	DQA Metric Rating
25)	Number of new unique patients referred	RPC				2,580	15,846	✓
26)	Unique Active Caseload (Snapshot)	RPC	H			12,530	12,530	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)	DQA Metric Rating
27)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	RPC	60,061,042	60,654,210	✓✓
28)	Agency Expenditure	RPC	800,316	737,709	✓
29)	Agency price cap compliance	RPC	67.00%	55.88%	✓
30)	Bank Expenditure	RPC	865,992	1,721,622	

Please Note: *26 Unique Active Caseload and 30 Bank Expenditure do not have a Data Quality Assessment rating as they new measures. The assessments have been completed and will now be shared with the Planning, Digital, & Estates Committee for approval.*

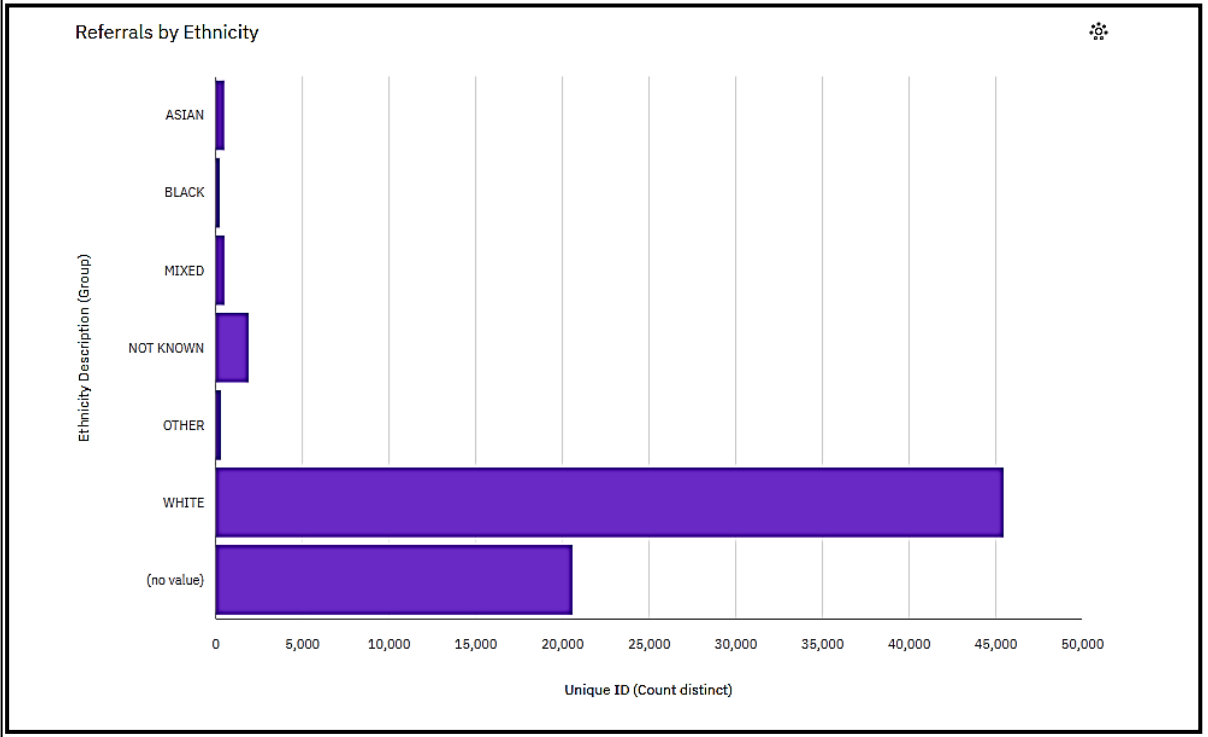
7. Population health, prevention and reducing inequality

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 but more likely to have an inpatient admission than white communities

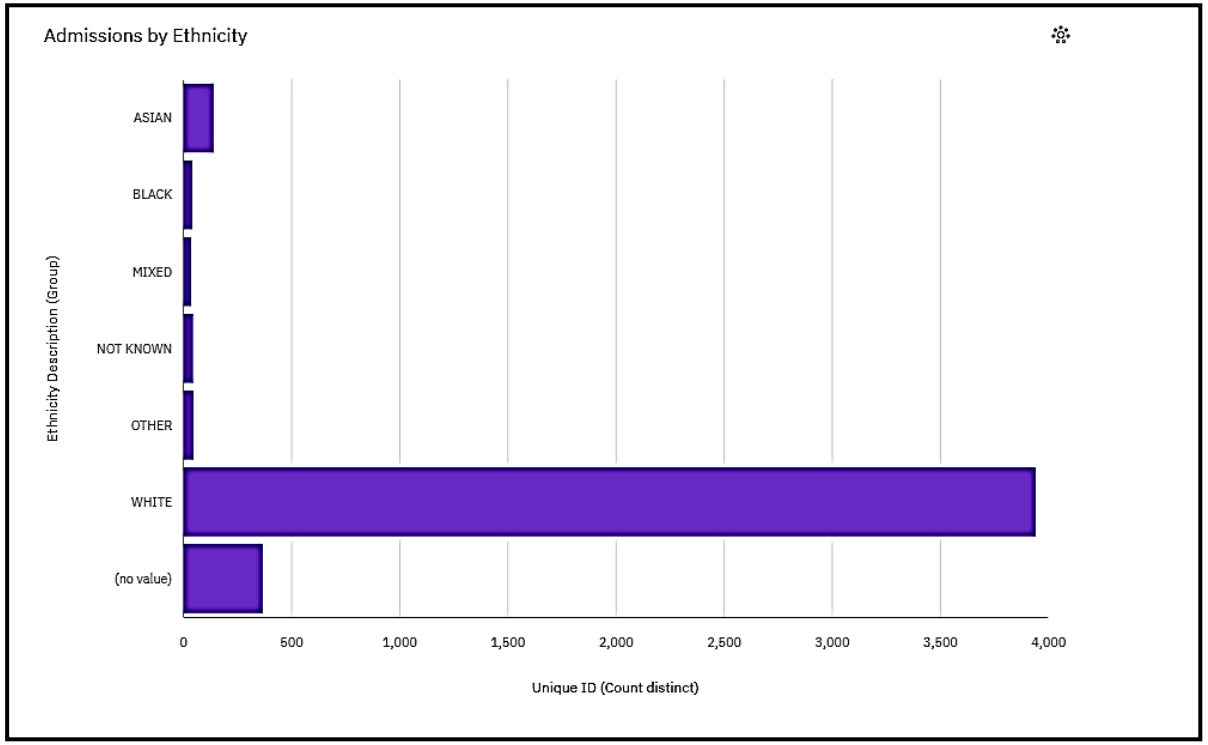


*** NOTE: No Value –** No ethnicity recorded

- Staff engagement webinar on ethnicity recording held and initial actions identified
- New IIC dashboard launched to enable identification of individuals without ethnicity recorded and available at team level
- 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.



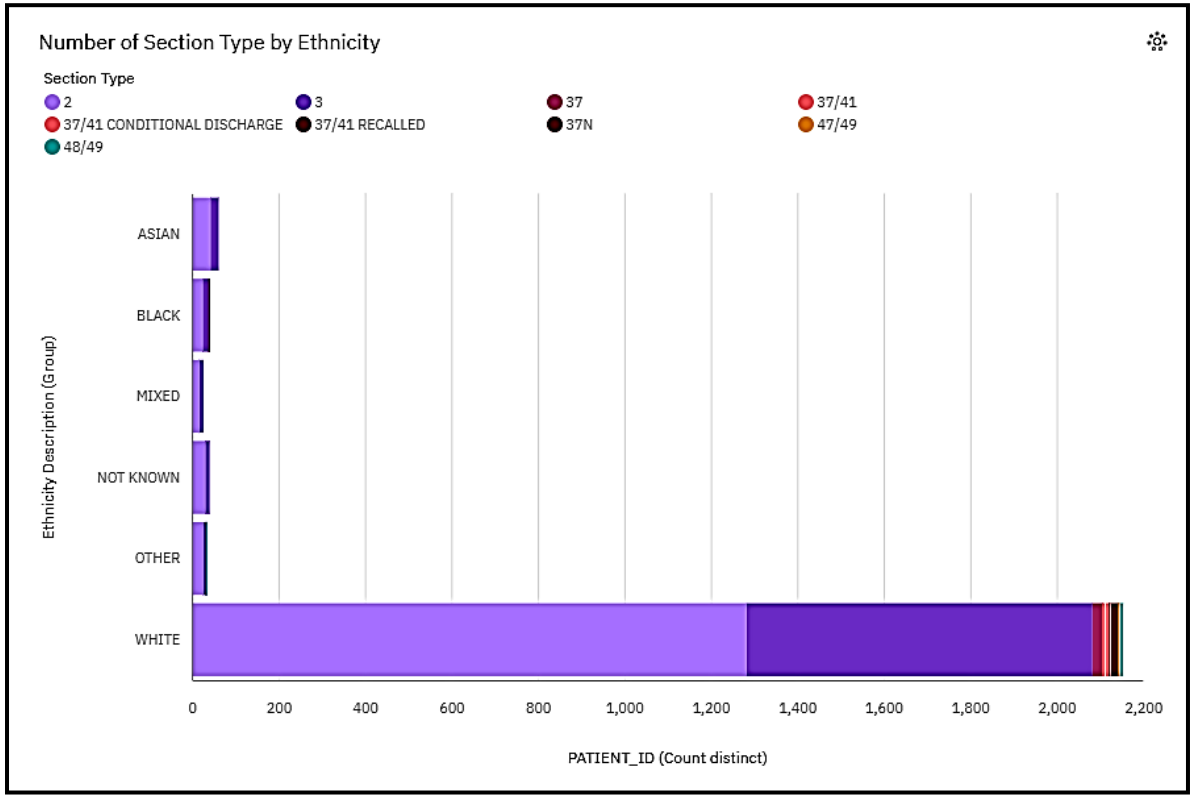
*** NOTE: No Value –** No ethnicity recorded

- Future data sets to be reported inclusive of population rate and will be reported quarterly to track any chances.
- A Community engagement plan to be developed 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 refreshed data will be presented in q3/4

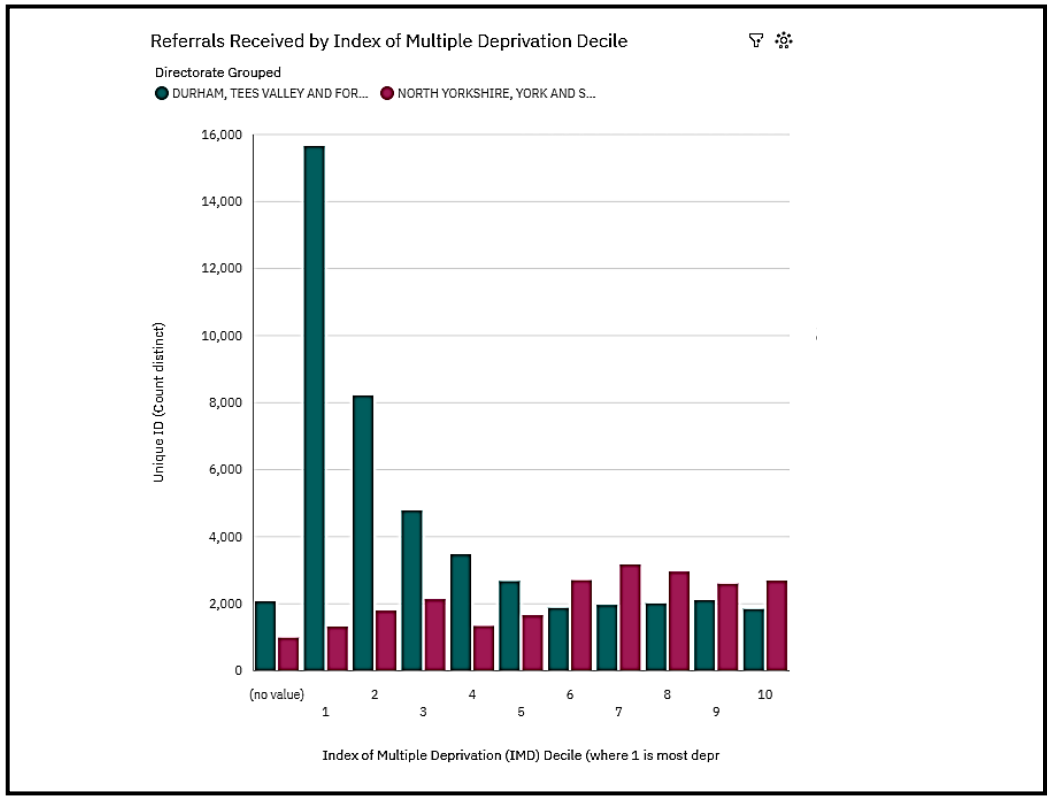


- Future data sets to include detention by population rate and will be reported quarterly to track any changes.
- A Patient & Carer Race Equality Framework team action plan template has been cascaded to teams for completion.

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.

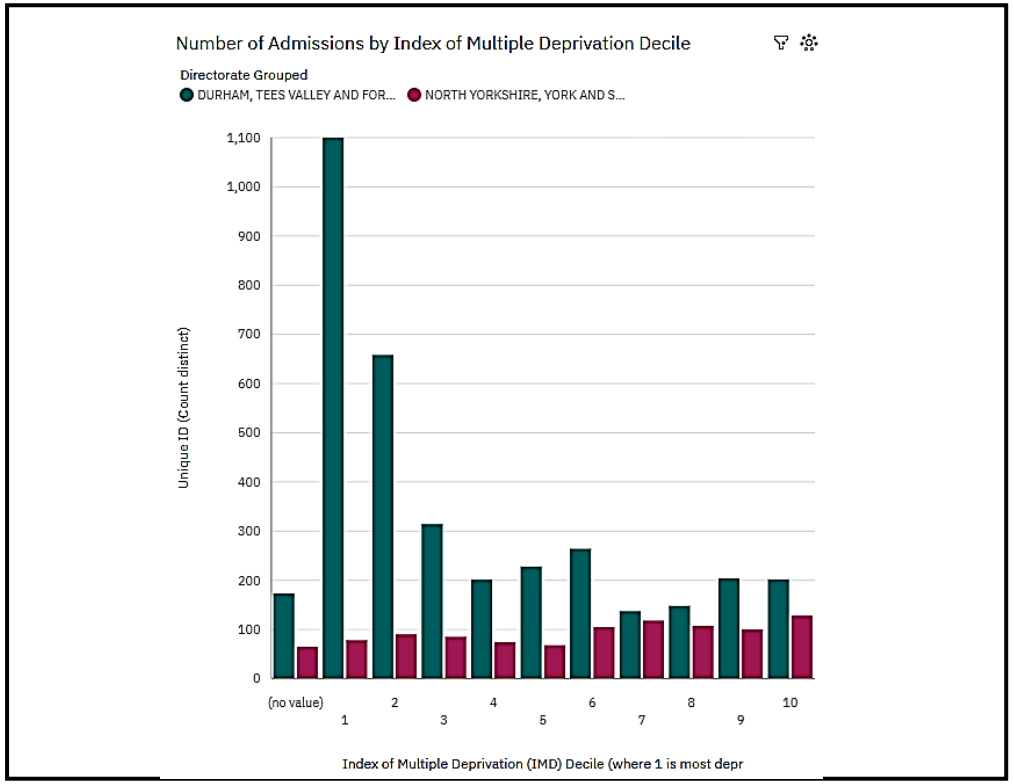


*** NOTE: No Value –** No corresponding deprivation decile available for the given postcode

Within the personalising care agenda we are considering accessibility for people experiencing multiple disadvantage including how to "Poverty Proof" © our pathways with pilot sites identified in AMH (Middlesbrough) and MSHOP (Hartlepool) CAMS site completed .

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.



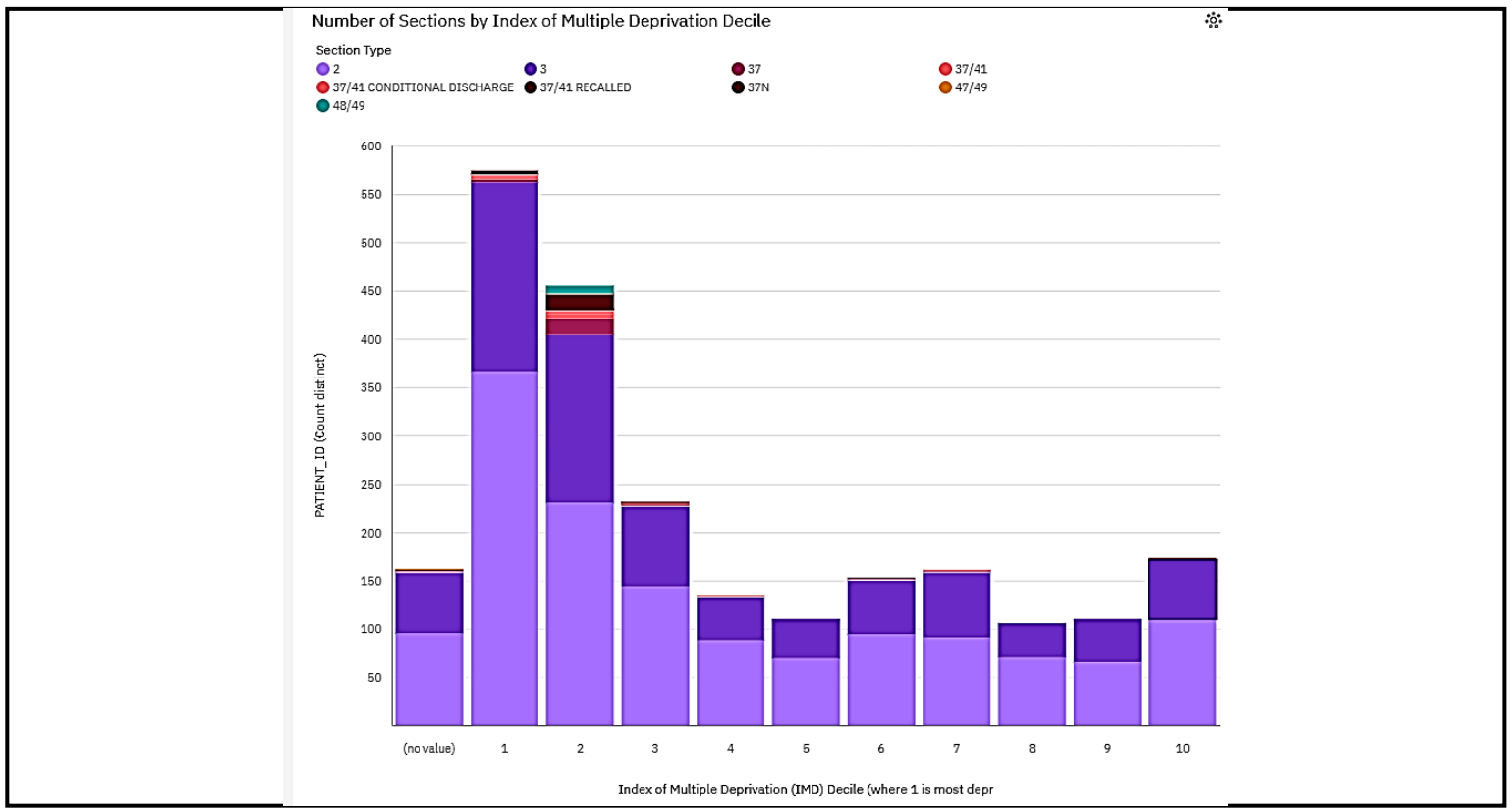
*** NOTE: No Value –** No correspondin g deprivation decile available for the given postcode

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. National metrics

PUBLISHED Q1 POSITION

OVERALL POSITION

A balanced Q1 position, broadly in line with peers

The published assessment places the Trust in Segment 2, with an average score of 2.25 and an Amber/Red capability rating.

STRENGTHS

Patient safety is in the highest-performing quartile. Access to services, finance, productivity and innovation, and experience of care are in the second quartile.

PRIORITY AREAS

People and effectiveness of care and population health are in the third quartile. The two red-rated metrics are supported quit attempts for acute inpatients and clinical trials set up within 90 days.

NHS Oversight Framework 26/27	Quarter 1 2026/27		
	Published Peformance	Score	
Access to services			
Percentage of total Children and Young People's mental health waits for help that are over 104 weeks	16.14%	3	Amber/Red
Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages)		2	Amber/Green
Percentage of people discharged from community mental health services with a paired outcome score recorded (adult and older adult)	16.16%		
Percentage of people discharged from community mental health services with a paired outcome score recorded (children and young people)	21.04%		
Experience of care			
CQC community mental health survey satisfaction rate		2	Amber/Green
NHS staff survey advocacy rate	6.68	3.32	Amber/Red
Mean length of stay for adult acute and psychiatric intensive care unit patients (Days)	30	1	Green
Mean length of stay for older adult acute discharges (Days)	74	2	Amber/Green
Effectiveness of care and population health			
Percentage of acute inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	0%	4	Red
Percentage of acute and rehabilitation adult discharges followed up within 72 hours	84.72%	1	Green
Mental health 14-day readmission rate	6.97%	2	Amber/Green

NHS Oversight Framework

NHS Oversight Framework 26/27	Quarter 1 2026/27		
	Published Peformance	Score	
Patient safety			
Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours	85.53%	1	Green
NHS staff survey raising concerns sub-score	6.65	2.58	Amber/Green
Crude rate of restrictive interventions per 1000 bed days	Not Published on public gateway	Not Scored	
Percentage of all patient safety incidents defined as resulting in harm	Not Published on public gateway	Not Scored	
Finance, productivity and innovation			
Combined finance score		1	Green
Planned surplus/deficit	0%	1	Green
Variance to plan year-to-date	1.32%	1	Green
Relative cost difference (National Cost Collection Index)	96.24	1	Green
Percentage of clinical trials set up within 90 days	75%	4	Red
Data Quality Maturity Index score	94.40%	2	Amber/Green
Rate of implied productivity growth	Not Published on public gateway	Not Scored	

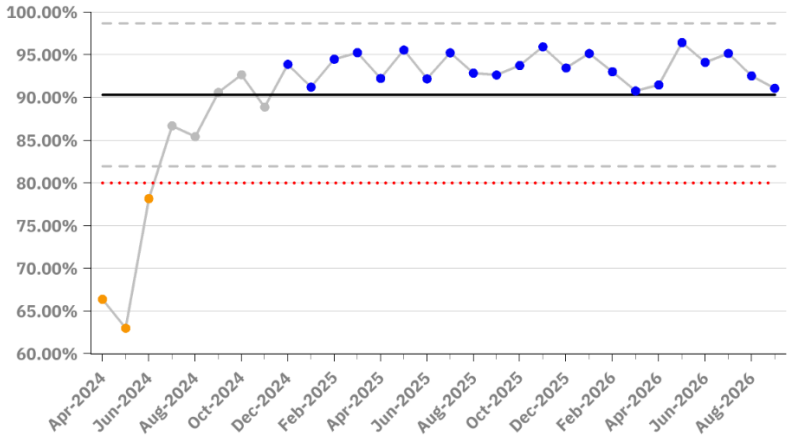
NHS Oversight Framework 26/27	Quarter 1 2026/27		
	Published Peformance	Score	
People			
Sickness absence rate (previous quarter)	6.86%	3.66	Amber/Red
NHS staff survey engagement theme score	6.87	3.21	Amber/Red
National Education and Training Survey satisfaction rate	85%	1.22	Green
NHS staff standards sub-score	7.69	3.37	Amber/Red
Healthcare Worker Flu Vaccination Rate	46.2%	2.84	Amber/Green
Temporary staffing cost relative band		1	Green
Temporary staffing agency	2		
Temporary staffing bank	1		

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	Sep-26
IIC4850	Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care			80.00%	80.00%	93.48%	91.48%	96.43%	94.12%	95.17%	92.53%	91.09%
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%	77.06%	86.96%	82.05%	78.57%	67.44%	73.68%	75.71%
IIC6570	The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period			75.00%	75.00%	90.54%	95.53%	93.77%	90.08%	89.92%	88.09%	86.07%
IIC6560	The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period			95.00%	95.00%	99.93%	99.86%	99.92%	100.00%	99.92%	100.00%	99.86%
IIC5340	Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)			95.00%	95.00%	89.53%	86.74%	86.48%	87.20%	89.08%	90.24%	89.53%
IIC5350	Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)			95.00%	95.00%	86.44%	78.69%	80.33%	80.70%	83.93%	84.21%	86.44%

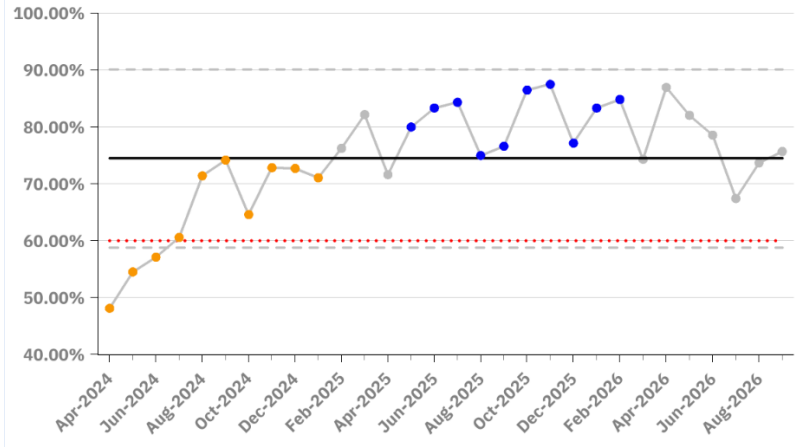
National Quality Requirements

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



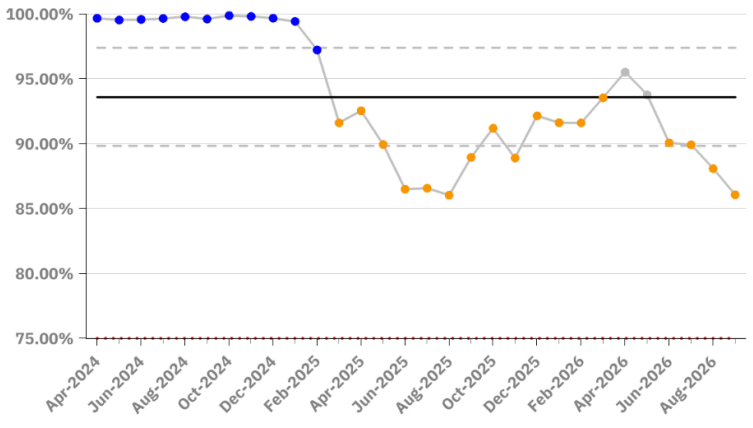
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	80%	93.48%			✓
COUNTY DURHAM	80%	96.71%			✓
TEES VALLEY	80%	94.29%			✓
NORTH YORKSHIRE	80%	95.14%			✓
YORK	80%	93.17%			✓

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%	77.06%			✓
COUNTY DURHAM	60%	80.39%			✓
TEES VALLEY	60%	83.54%			✓
NORTH YORKSHIRE	60%	83.61%			✓
YORK	60%	35.29%			✗

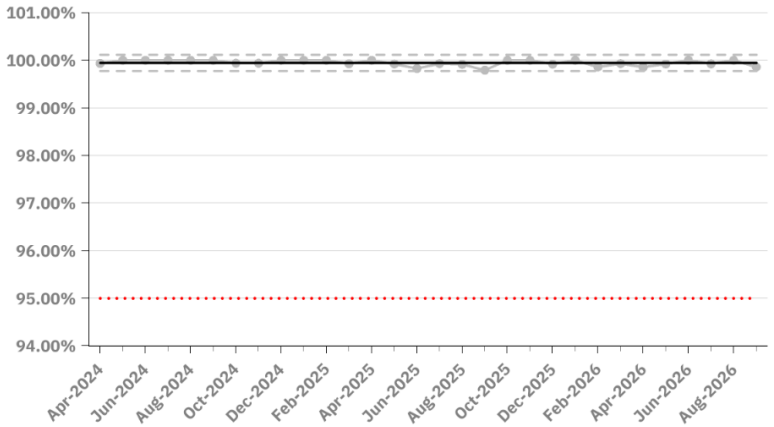
IIC6570 The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period - TRUST



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	75%	90.54%			✓
COUNTY DURHAM	75%	95.27%			✓
TEES VALLEY	75%	95.50%			✓
NORTH YORKSHIRE	75%	82.34%			✓
YORK	75%	93.34%			✓

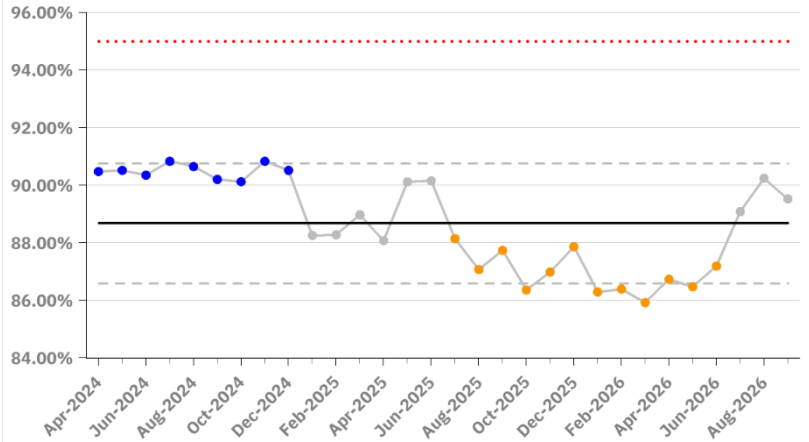
National Quality Requirements

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



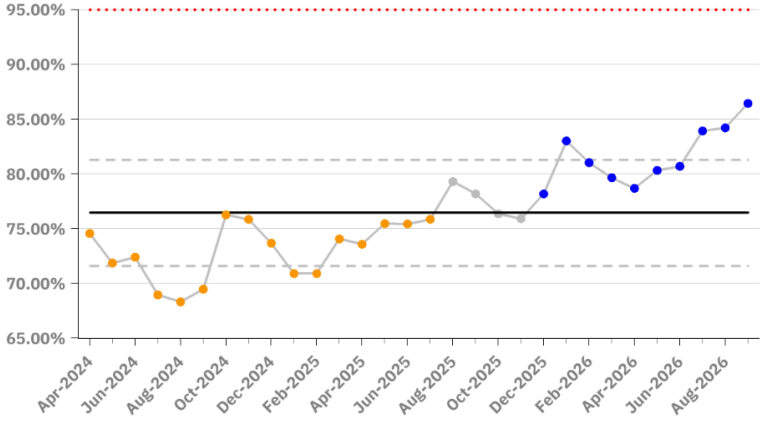
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	99.93%			
COUNTY DURHAM	95%	99.90%			
TEES VALLEY	95%	99.68%			
NORTH YORKSHIRE	95%	99.96%			
YORK	95%	100.00%			

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



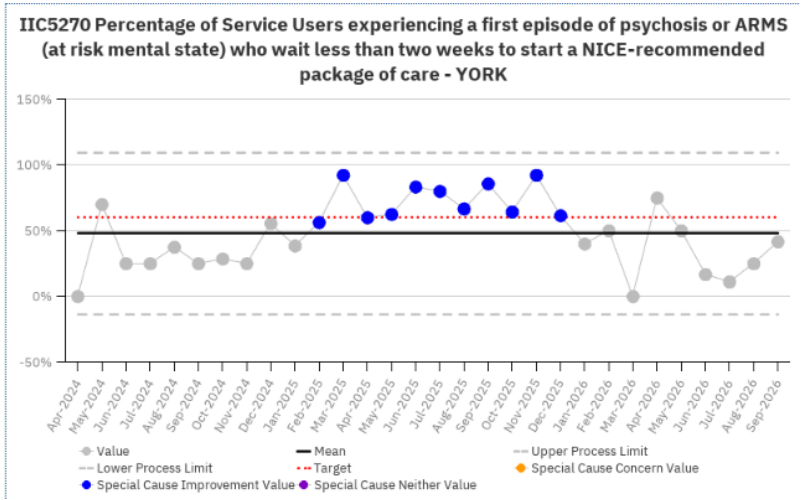
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	95%	89.53%			
COUNTY DURHAM	95%	87.74%			
TEES VALLEY	95%	94.23%			
NORTH YORKSHIRE	95%	94.74%			
YORK	95%	66.67%			

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%	86.44%			
COUNTY DURHAM	95%	100.00%			
TEES VALLEY	95%	92.31%			
NORTH YORKSHIRE	95%	61.11%			
YORK	95%	100.00%			

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

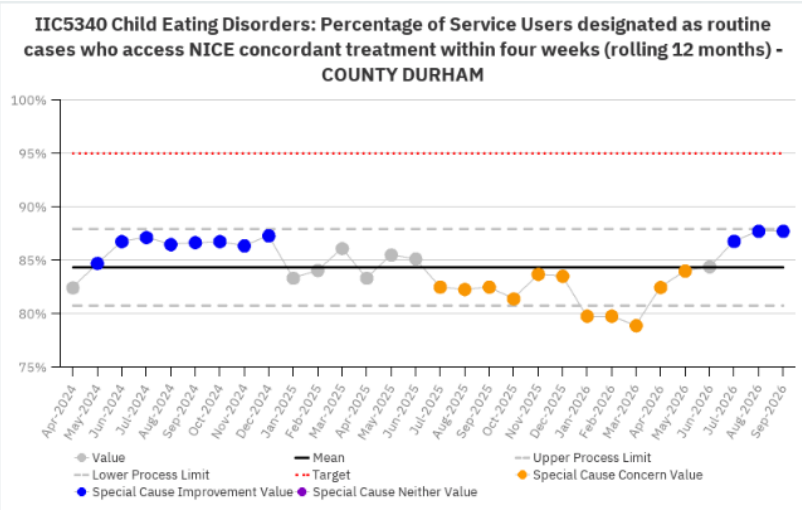
What does the chart show/context:
In September 2026, there were 12 patients referred experiencing First Episode Psychosis, of which **5 (41.67%)** received an approved care package within 2 weeks in **York**.

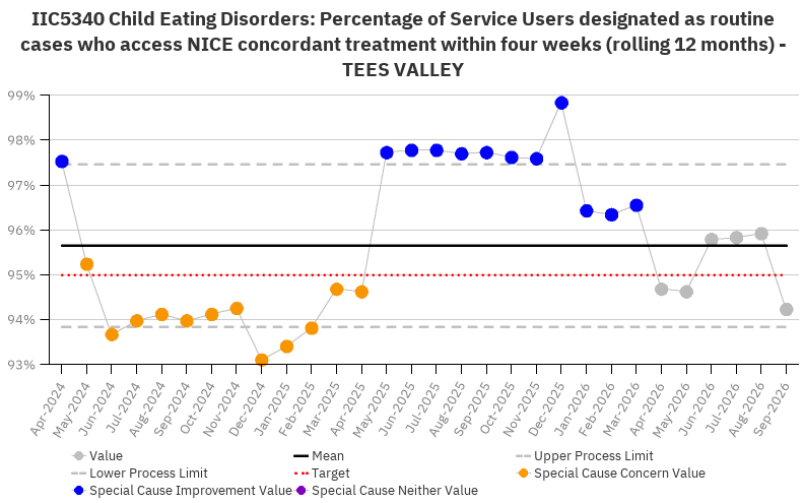
Of the **7** patients that did not receive treatment within the standard:
- 5 patients were offered an appointment (outside 2 weeks) due to team capacity.
- 1 patient was offered an appointment (outside 2 weeks) due to patient choice.
- 1 patient was offered an appointment (outside 2 weeks) as a joint assessment with CAMHS was required followed by a further delay due to clinical complexity.

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 was delayed as newly recruited care coordinators were awaiting professional registration PINs before they can hold caseloads. All PINs have now been received, and the team anticipate delivery against the 2-week treatment standard from the end of October 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 September 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 September there were **8** children and young people with a routine referral; **7 (87.50%)** started treatment within 4 weeks.

The 1 patient that did not receive treatment within the standard was offered 2 appointments within 4 weeks; the first was cancelled due to service capacity, the second was not attended. The patient commenced treatment on day 52.

What does the chart show/context:
In the rolling 12 months ending September 2026, there were **104** children and young people with a routine referral, of which **98 (94.23%)** started treatment within 4 weeks in **Tees Valley**.

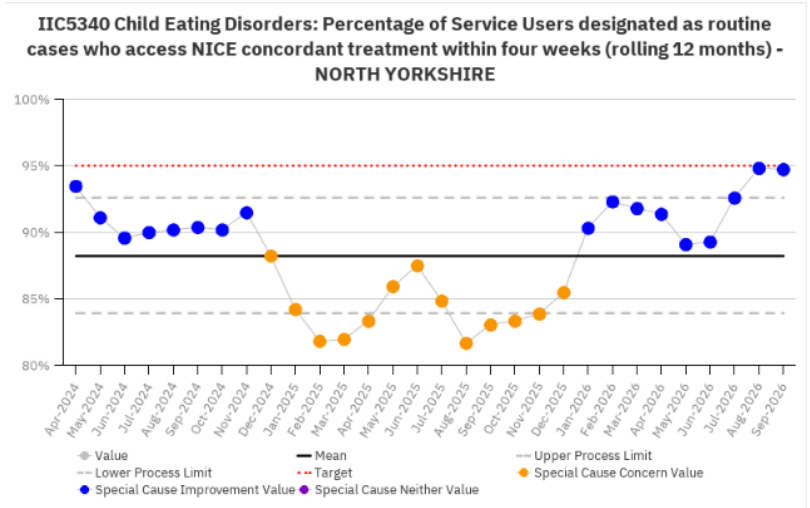
In September there were **10** children and young people with a routine referral; **8 (80.00%)** started treatment within 4 weeks.

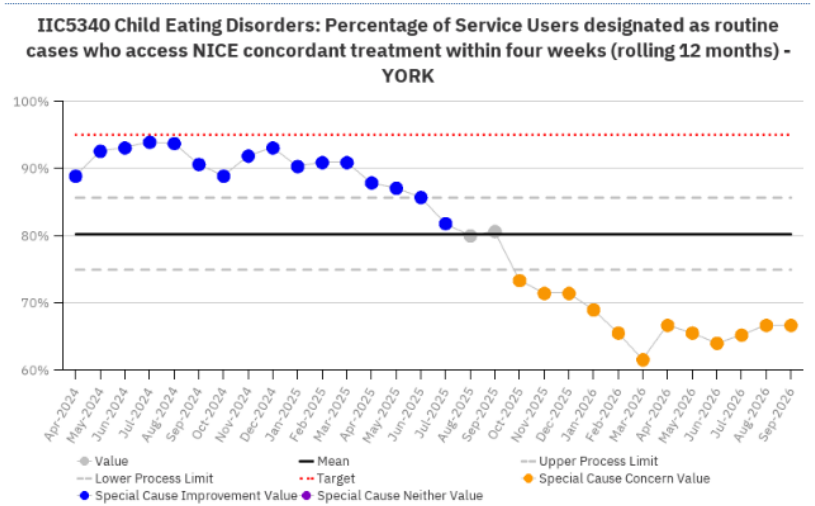
The 2 patients that did not receive treatment within the standard were offered appointments within 4 weeks, which the patients failed to attend. The patients commenced treatment on days 33 and 59 respectively.

Underlying Issues:
There are no underlying issues to report.

Trust-wide Actions:
Building on completion of 6 of the 8 actions, the Directors of Operations will oversee completion of the two outstanding service improvement plan actions and secure governance approval of the access and choice options paper by January 2027.

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 September 2026, there were **57** children and young people with a routine referral, of which **54 (94.74%)** started treatment within 4 weeks in **North Yorkshire**.

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

What does the chart show/context:
In the rolling 12 months ending September 2026, there were **24** children and young people with a routine referral, of which **16 (66.67%)** started treatment within 4 weeks in **York**.

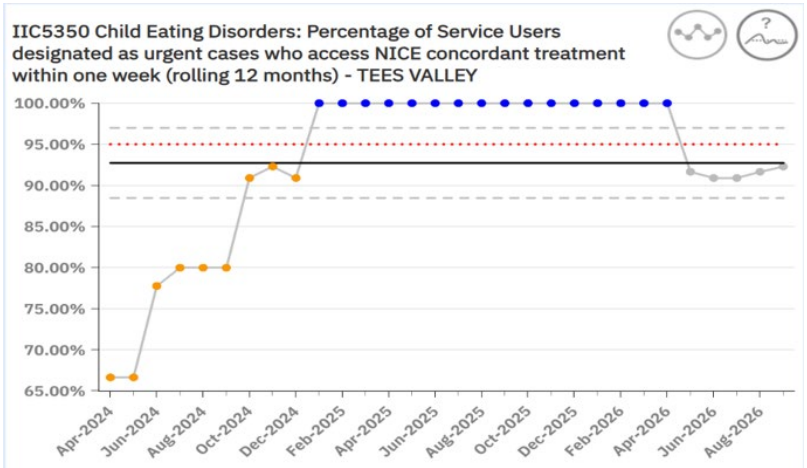
In September, there were **3** children and young people with a routine referral; **2 (66.7%)** started treatment within 4 weeks.

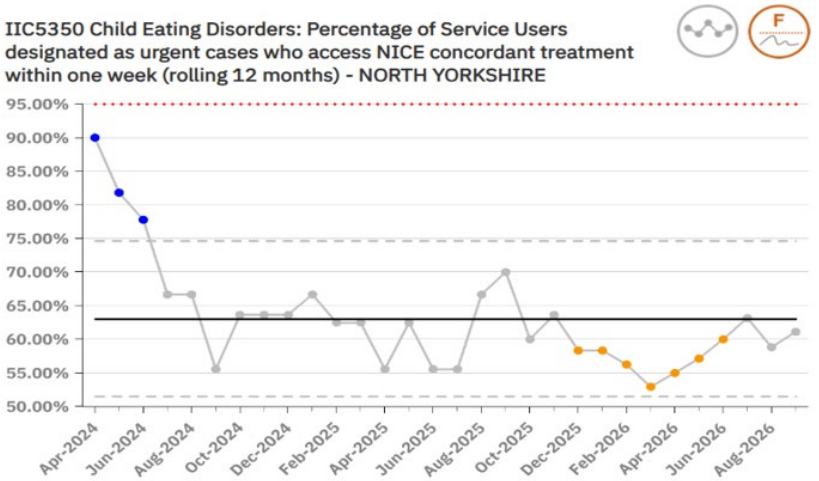
1 patient was offered treatment within 4 weeks; however, the standard was not met due to patient choice. Treatment commenced on day 60.

Underlying Issues:
There are no underlying issues to report.

Trust-wide Actions:
Building on completion of 6 of the 8 actions, the Directors of Operations will oversee completion of the two outstanding service improvement plan actions and secure governance approval of the access and choice options paper by January 2027.

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 September 2026 there were **13** children or young people with an urgent referral, of which **12 (92.31%)** started treatment within 1 week in **Tees Valley.**

In September, 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 September 2026 there were **18** child or young people with an urgent referral, of which **11 (61.11%)** started treatment within 1 week in **North Yorkshire**.

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

Underlying Issues:
There are no underlying issues to report.

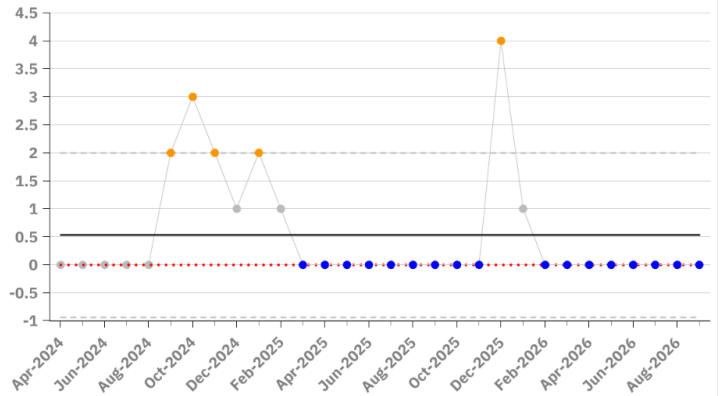
Trust-wide Actions:
Building on completion of 6 of the 8 actions, the Directors of Operations will oversee completion of the two outstanding service improvement plan actions and secure governance approval of the access and choice options paper by January 2027.

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	Sep-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	0
IIC6950	Average length of stay for patients in Adult Acute and PICU Mental Health Beds (3-month rolling)			26.40	26.44	29.04	30.12	29.48	30.11	30.59	28.75	29.04
IIC6960	Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3-month rolling)			70.00	70.08	87.39	70.12	72.30	74.27	76.71	77.10	87.39
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	58	725	340	257	73	61	58

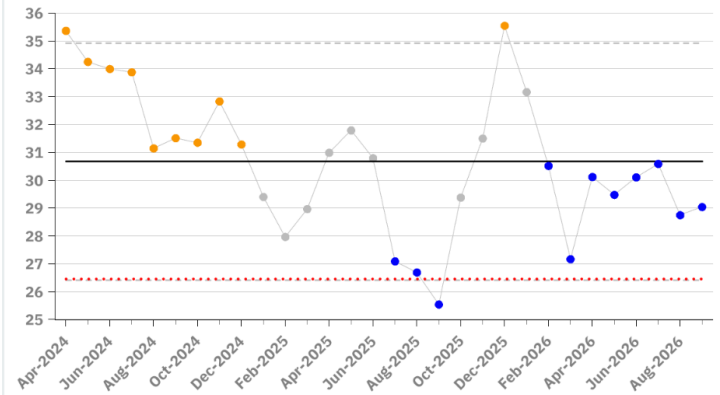
Mental Health Priorities – Provider and System-wide plans

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



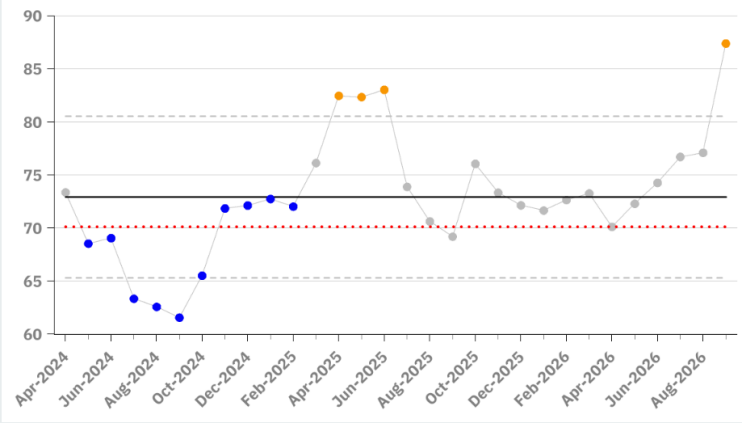
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	0	0			✓
COUNTY DURHAM	0	0			✓
TEES VALLEY	0	0			✓
NORTH YORKSHIRE	0	0			✓
YORK	0	0			✓

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	26.44	29.04			✗
COUNTY DURHAM		32.79			
TEES VALLEY		29.14			
NORTH YORKSHIRE		26.71			
YORK		23.72			

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	70.08	87.39			✗
COUNTY DURHAM		52.61			
TEES VALLEY		121.15			
NORTH YORKSHIRE		90.06			
YORK		86.29			

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	58			✓
COUNTY DURHAM		47			
TEES VALLEY		9			
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 26.44 by the end of September 2026.

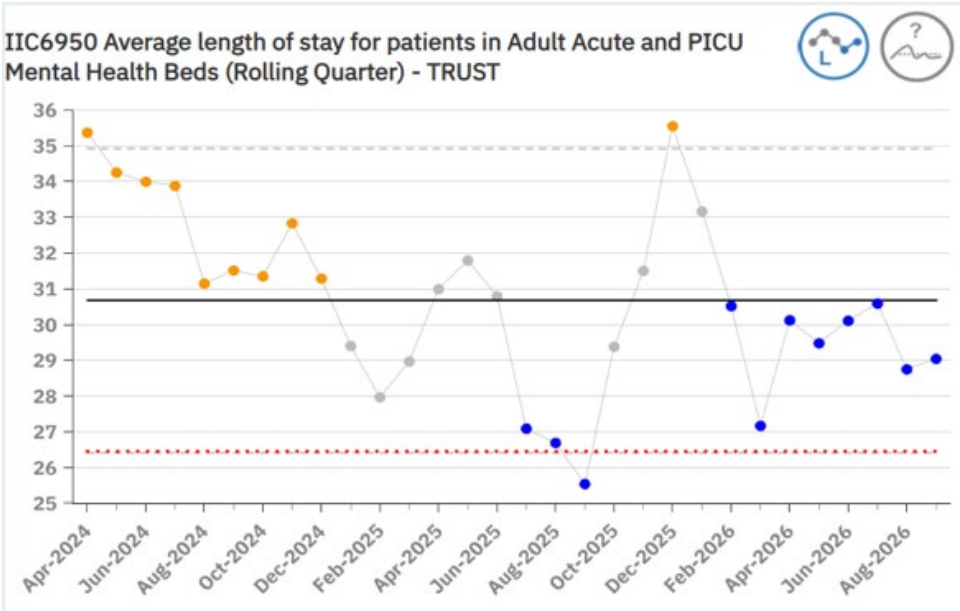
What does the chart show/context:
During the 3-month period ending September 2026, there were **599** discharged hospital spells from adult acute or PICU beds for patients aged 18+, accounting for a total of **17,396** bed days which equates to an average length of stay of **29.04** days.

We are not achieving plan at Trust and Care Group level; however, there is special cause improvement in the reporting period.

In the 3 months ending September 2026 there were 174 (out of 599) patients with a length of stay exceeding plan; 23 patients with lengths of stay exceeding 100 days were discharged.

Underlying issues:
- Long lengths of stay are impacted by the discharge of patients that are clinically ready for discharge.
- There are some patients who require longer lengths of stay to meet their clinical needs.

Actions:
- See measure 11 within the IPD *Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed)* for actions.
- Corporate Performance and Business Intelligence to undertake analysis with the relevant General Managers to understand performance, underlying factors and determine whether any mitigating actions are required.



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**	**30.11**	**30.59**	**28.75**	**29.04**						

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 70.08 days by the end of September 2026.

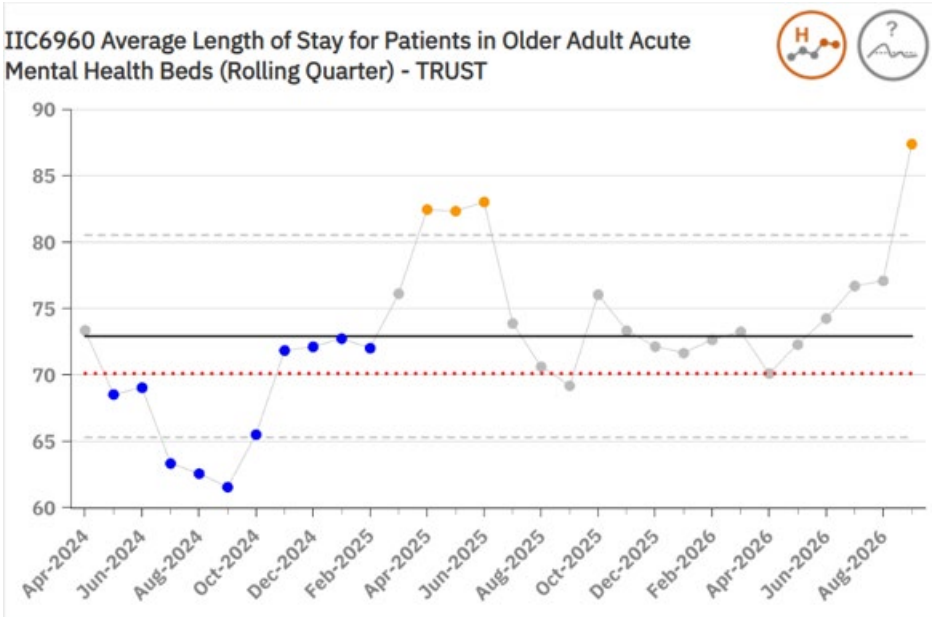
What does the chart show/context:
During the 3-month period ending September 2026, there were **156** discharged hospital spells from older adult acute beds, accounting for a total of **13,633** bed days which equates to an average length of stay of **87.39** days.

We are not achieving plan at Trust and Care Group level and there is special cause concern in the reporting period.

In the 3 months ending September 2026 there were 70 (out of 156) patients with a length of stay exceeding plan; 47 patients with lengths of stay exceeding 100 days were discharged.

Underlying issues:
- Long lengths of stay are impacted by the discharge of patients that are clinically ready for discharge.
- There are some patients who require longer lengths of stay to meet their clinical needs.

Actions:
- See measure 11 within the IPD *Percentage of Patients Clinically Ready for Discharge (adults & older adults in a MH Bed)* for actions.
- Corporate Performance and Business Intelligence to undertake analysis with the relevant General Managers to understand performance, underlying factors and determine whether any mitigating actions are required.



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	87.39						

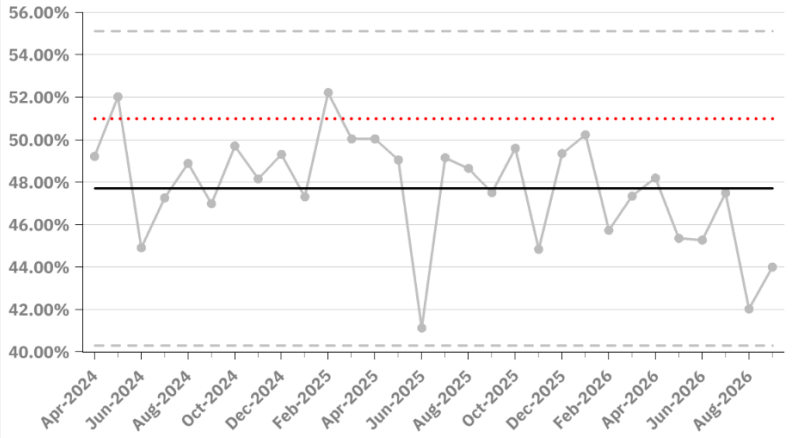
Mental Health Priorities – System-Wide Plans

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	Sep-26
IIC6490	Talking Therapies - Reliable recovery rate for those completing a course of treatment and meeting caseness		?	51.00%	51.00%	45.40%	48.20%	45.36%	45.28%	47.50%	42.03%	44.00%
IIC6480	Talking Therapies - Reliable improvement rate for those completing a course of treatment	L	?	69.00%	69.00%	65.10%	67.46%	65.76%	65.67%	66.47%	63.21%	62.14%
IIC6640	Talking Therapies: Number of people who are discharged having received at least 2 treatment appointments in the reporting period	L	N/A	Data Only	Data Only	8,141	1,386	1,285	1,401	1,330	1,310	1,429
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	1,480
IIC6610	Number of people accessing IPS services (rolling 12 month)	H	N/A	Data Only	Data Only	1,538	1,199	1,245	1,329	1,388	1,467	1,538
IIC5831	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact	L	N/A	Data Only	Data Only	28,411	30,102	29,775	29,411	29,010	28,789	28,411
IIC7000	Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact with an MHST (Rolling 12 Month)	H	N/A	Data Only	Data Only	2,201	1,990	2,014	2,058	2,109	2,144	2,201

Please note The variation reported for women accessing specialist community perinatal mental health services has been removed due to identified historic data quality issues. As this is a 12-month rolling measure, local reporting is expected to be accurate from November 2026 onwards, with alignment between local and national datasets anticipated by April 2027, after which SPC charts will be reprofiled.

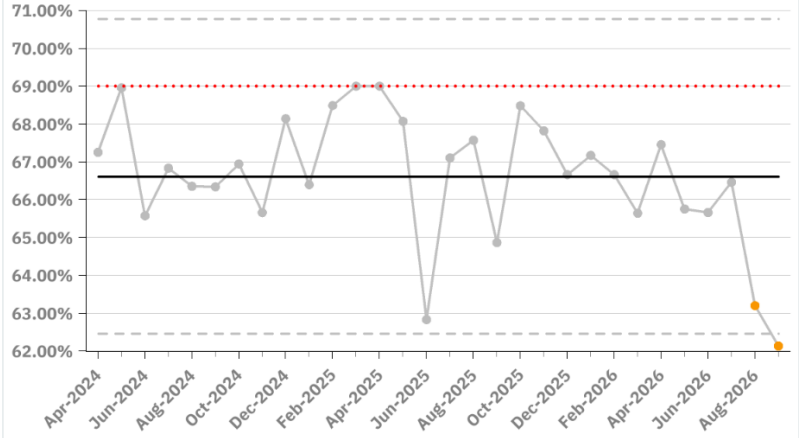
Mental Health Priorities – System Wide Plans

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



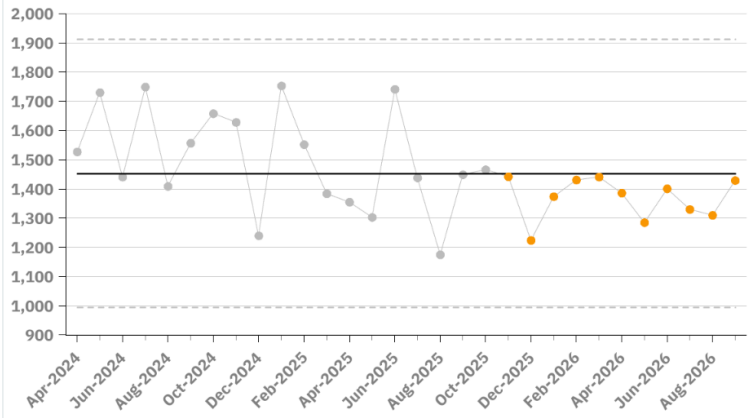
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	51%	45.40%			
COUNTY DURHAM	51%	41.68%			
TEES VALLEY	51%	44.06%			
NORTH YORKSHIRE	51%	48.15%			
YORK	51%	48.49%			

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



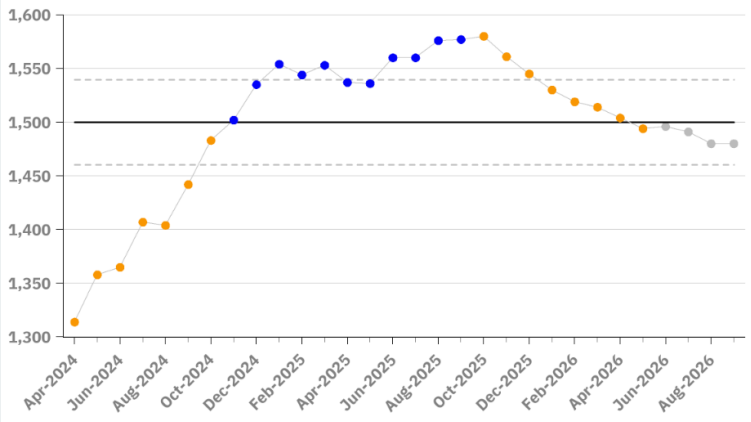
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST	69%	65.10%			
COUNTY DURHAM	69%	62.58%			
TEES VALLEY	69%	63.83%			
NORTH YORKSHIRE	69%	67.18%			
YORK	69%	67.14%			

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

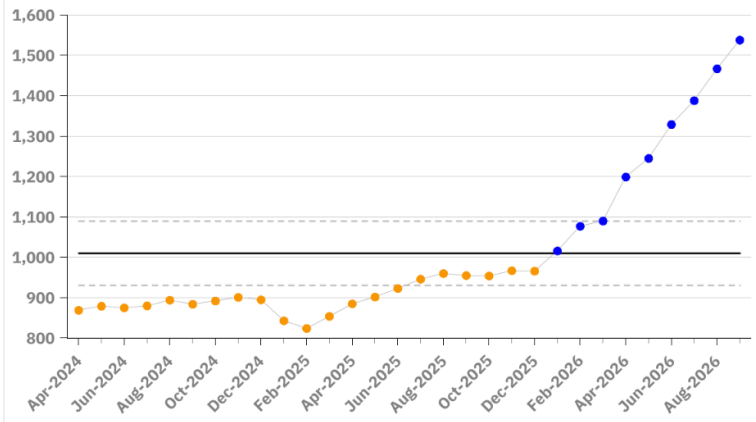


Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		8,141			
COUNTY DURHAM		3,153			
TEES VALLEY		622			
NORTH YORKSHIRE		2,706			
YORK		1,607			

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



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



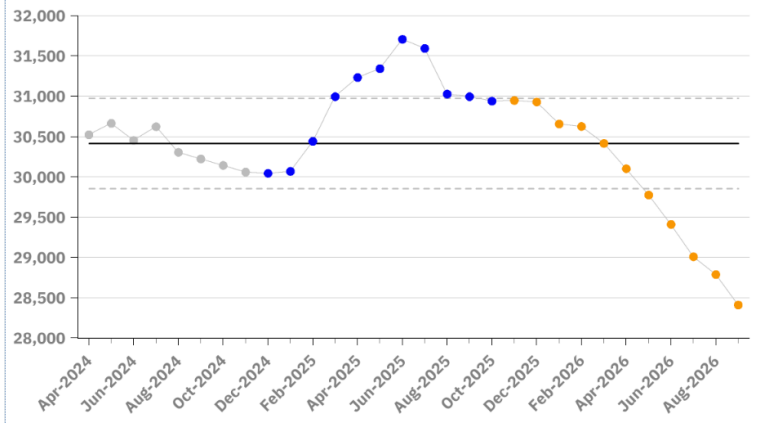
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,480			
COUNTY DURHAM	456	391			
TEES VALLEY	447	518			
NORTH YORKSHIRE	368	394			
YORK	156	158			

Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		1,538			
COUNTY DURHAM		495			
TEES VALLEY		597			
NORTH YORKSHIRE	380	272			
YORK		109			

Please note The variation reported for women accessing specialist community perinatal mental health services has been removed due to identified historic data quality issues. As this is a 12-month rolling measure, local reporting is expected to be accurate from November 2026 onwards, with alignment between local and national datasets anticipated by April 2027, after which SPC charts will be reprofiled.

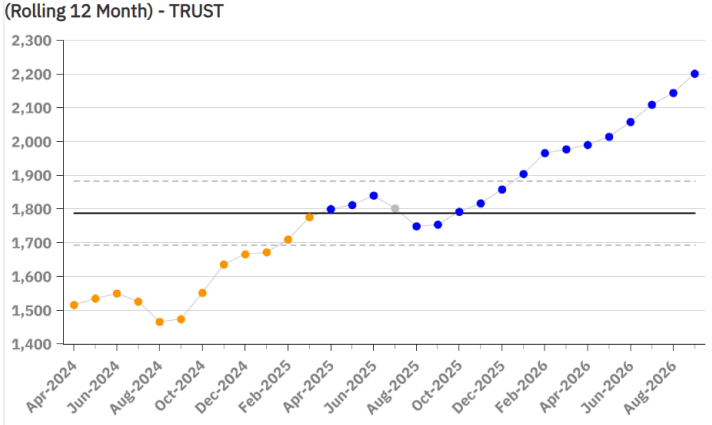
Mental Health Priorities – System-Wide Plans

IIC5831 Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact - TRUST



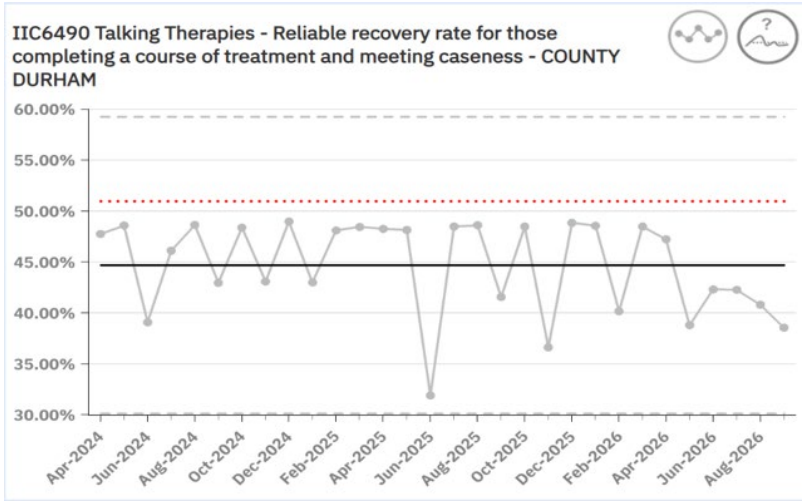
Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		28,411			
COUNTY DURHAM		9,873			
TEES VALLEY		8,826			
NORTH YORKSHIRE		5,664			
YORK		3,458			

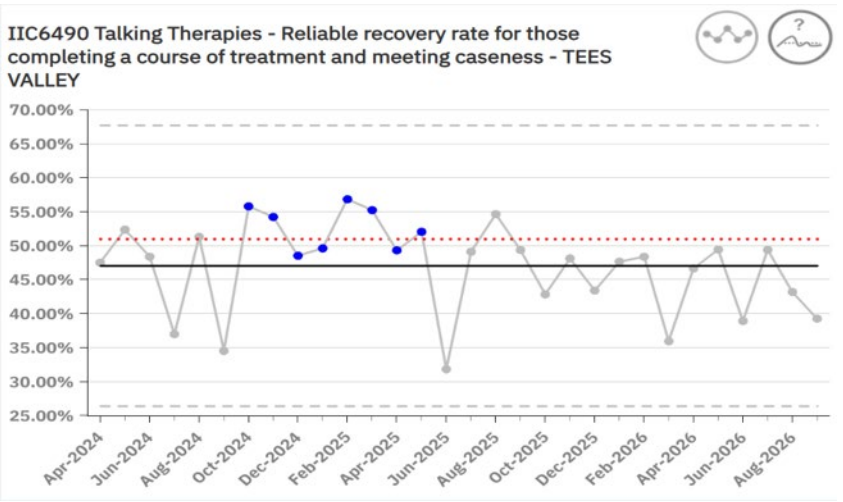
IIC7000 Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact with an MHST (Rolling 12 Month) - TRUST



Organisation	Standard	Actual	Variation	Assurance	Plan Met
TRUST		2,201			
COUNTY DURHAM		1,072			
TEES VALLEY		372			
NORTH YORKSHIRE		477			
YORK		220			

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 **41.68%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **County Durham**. During September, **38.58%** demonstrated reliable recovery.

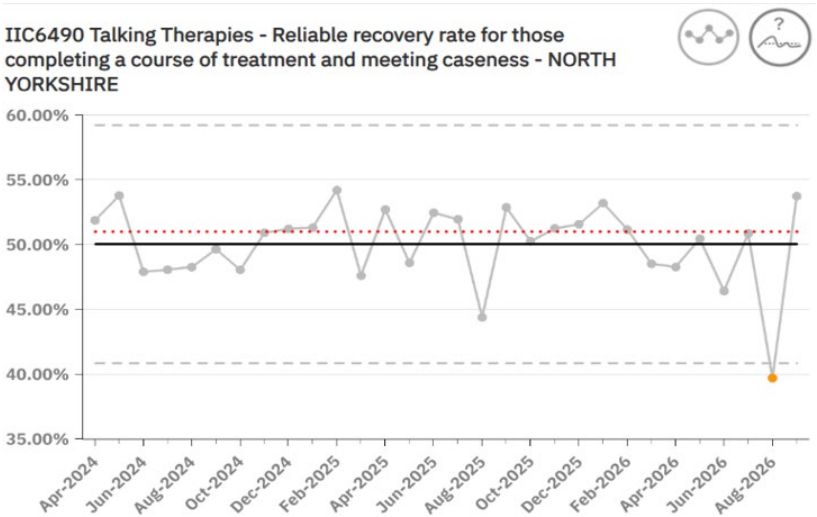
There is no significant change as indicated in the chart above.

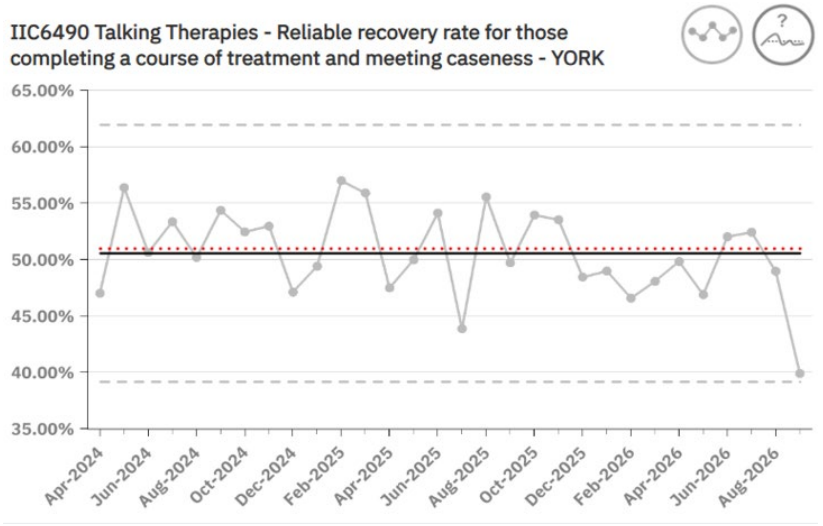
What does the chart show/context:
Financial year to date **44.06%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **Tees Valley**. During September, **39.29%** demonstrated reliable recovery.

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

For underlying issues and action, please see page 81

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 **48.15%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **North Yorkshire**. During September, **53.75%** demonstrated reliable recovery.

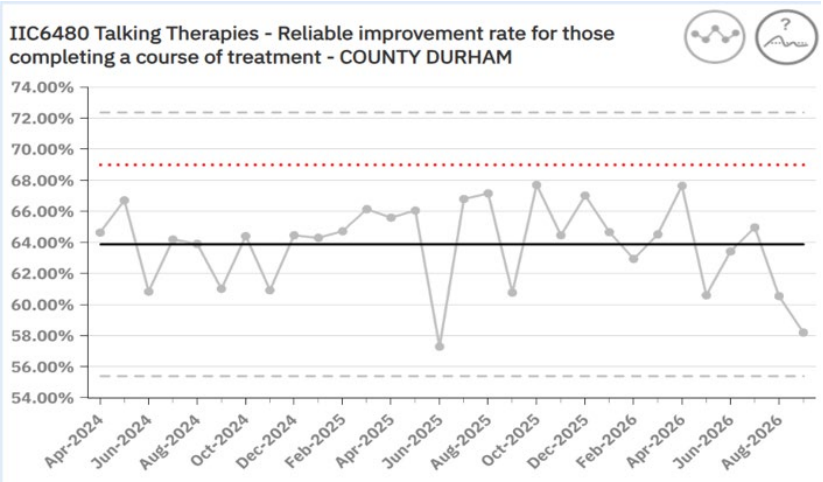
There is no significant change as indicated in the chart above.

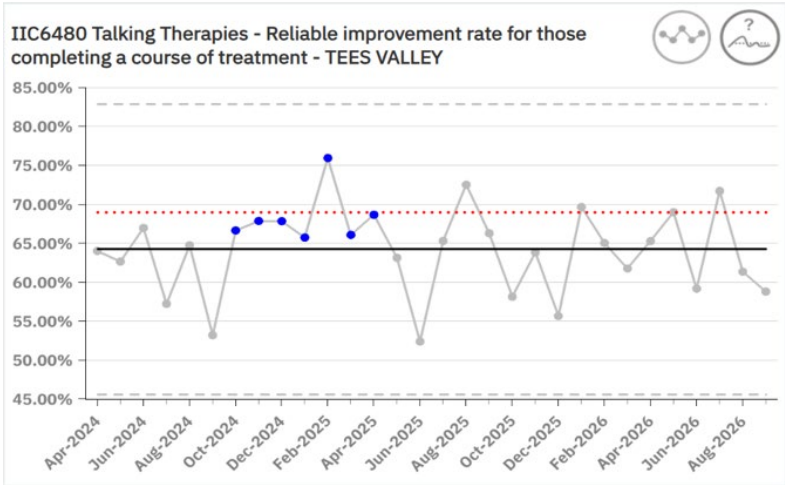
What does the chart show/context:
Financial year to date **48.49%** of patients demonstrated reliable recovery rate following completion of a course of treatment within **York**. During September, **39.91%** demonstrated reliable recovery.

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

For underlying issues and action, please see page 82

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 **62.58%** of patients demonstrated reliable improvement following completion of a course of treatment within **County Durham**. During September, **58.20%** demonstrated reliable improvement.

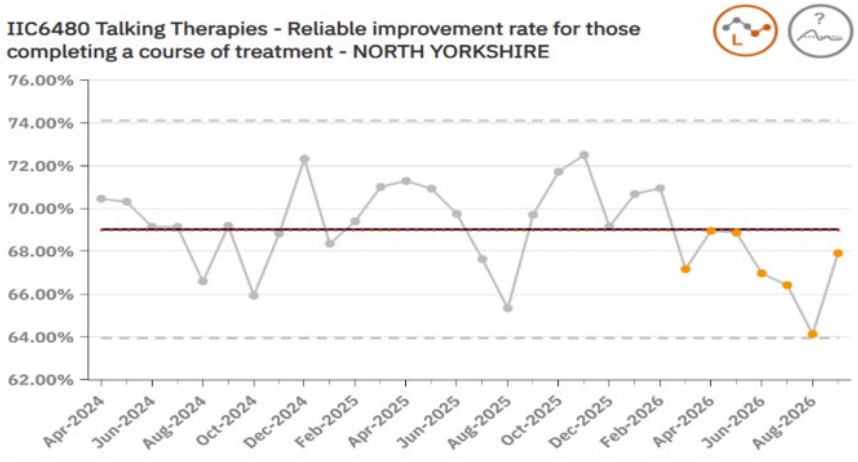
There is no significant change as indicated in the chart above.

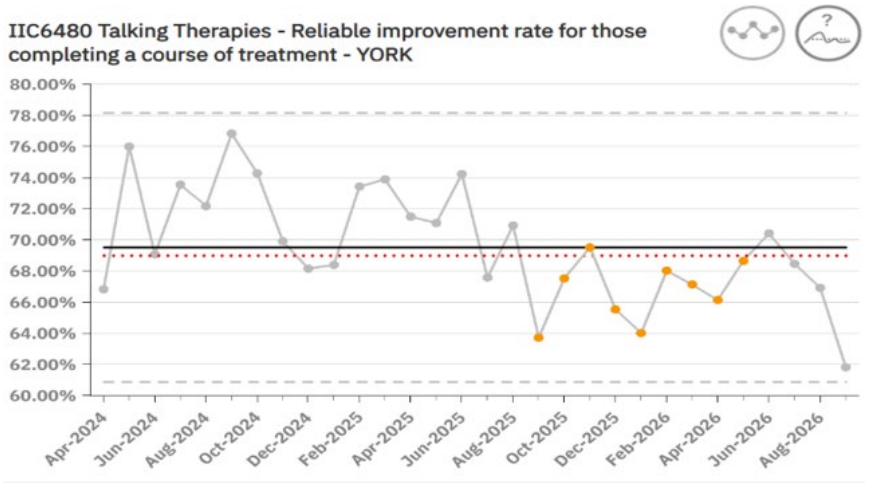
What does the chart show/context:
Financial year to date **63.83%** of patients demonstrated reliable improvement following completion of a course of treatment within **Tees Valley**. During September, **58.82%** demonstrated reliable improvement.

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

For underlying issues and action, please see page 81

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





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

What does the chart show/context:
Financial year to date **67.18%** of patients demonstrated reliable improvement following completion of a course of treatment within **North Yorkshire**. During September**, 67.92%** demonstrated reliable improvement.

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

What does the chart show/context:
Financial year to date **67.14%** of patients demonstrated reliable improvement following completion of a course of treatment within **York**. During September, **61.83%** demonstrated reliable improvement.

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

For underlying issues and action, please see page 82

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; shortlisting for 2 will be undertaken in October, 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, interviews for which will be held in October 2026.
- By the end of September, the Clinical Lead and Service Manager will develop improvement actions in relation to reliable recovery and reliable improvement. ***(Complete)*** *See below action.*
- In October 2026, the DTVFCG service will present a revised Performance Improvement Plan, for approval, to the Integrated Performance Assurance Group, which includes new actions including the deferred implementation of KOA Step 3 Therapy, recovery and relapse prevention processes, wellbeing support for those awaiting Step 3 therapy, and an Eye Movement Desensitisation & Reprocessing (EMDR) therapy gatekeeping process. If approved this will then be shared with EDG in November 26.
- Implementation of the Dr Julian digital therapy offer within Talking Therapies is subject to ICB confirmation of TEWV's fair-share allocation, data-sharing arrangements and associated funding arrangements.
- 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 peer model review work in their executive development session in November 26.

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*

North Yorkshire & York

Underlying issues:

- North Yorkshire Talking Therapies team: Variation in the application of the attendance policy for patients who disengage from treatment or do not attend appointments is contributing to earlier discharge in some cases, limiting opportunities to achieve optimal treatment outcomes and impacting recovery performance measures.
- York and Selby Talking Therapies team: The psycho-education programme introduced in York in June 2026 is not currently delivering the expected clinical outcomes. Initial review suggests variation in patient selection and course allocation may be contributing to reduced effectiveness.

Actions:

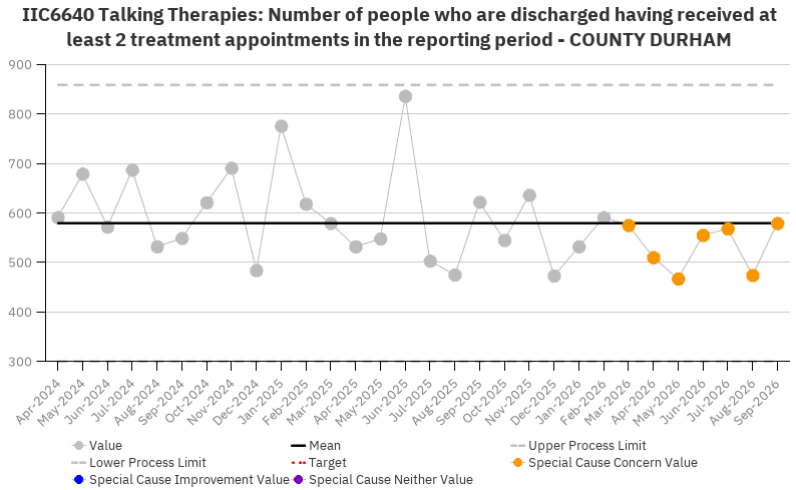
North Yorkshire Talking Therapies teams:

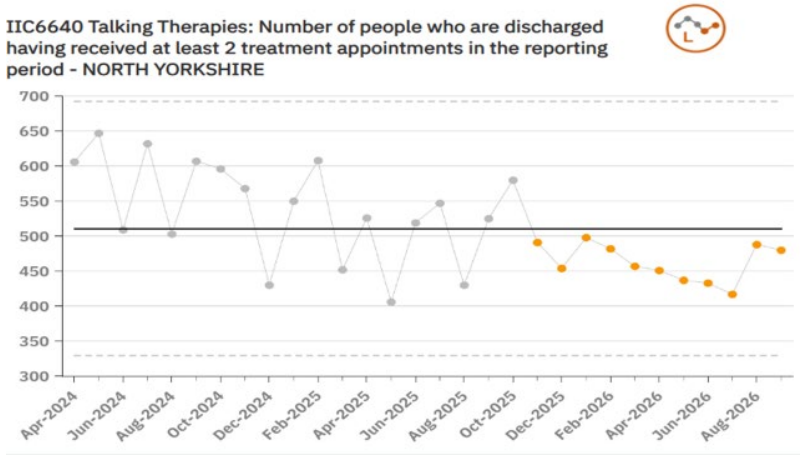
- North Yorkshire Talking Therapies team manager has re-shared referral and suitability criteria with all GP practices within North Yorkshire to support early identification and improve understanding of appropriate referral thresholds and alternative pathways for patients with high complexity and severity. **(Complete)**
- North Yorkshire Talking Therapies have embedded the sharing of 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 to improve understanding on the benefits of early referral and appropriate service selection. **(Complete)**
- Scarborough Talking Therapies team manager has set up a 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. **(Complete)**
- By November 2026, Clinical Leads will circulate attendance policy guidance to all staff to ensure consistent application of the policy, support timely discharge of recovered patients, and improve compliance with treatment pathway and recovery targets.

York and Selby Talking Therapies team:

- By October 2026, Senior PWPs will review the suitability of patients allocated to the psycho-education course through clinical skills supervision.
- By November 2026, Senior PWPs will deliver a refresher session to clinicians on appropriate course allocation to improve clinical outcomes following treatment.

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 **3,153** patients discharged having received at least 2 treatment appointments in the report period within **County Durham**. During September, **579** patients received at least 2 treatment appointments.

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

Underlying issues:
- The root causes of the reported performance position have not yet been fully established. Analysis will be undertaken to understand the teams impacting, underlying factors and determine whether any mitigating actions are required.

Actions:
- *Please see underlying issue above*

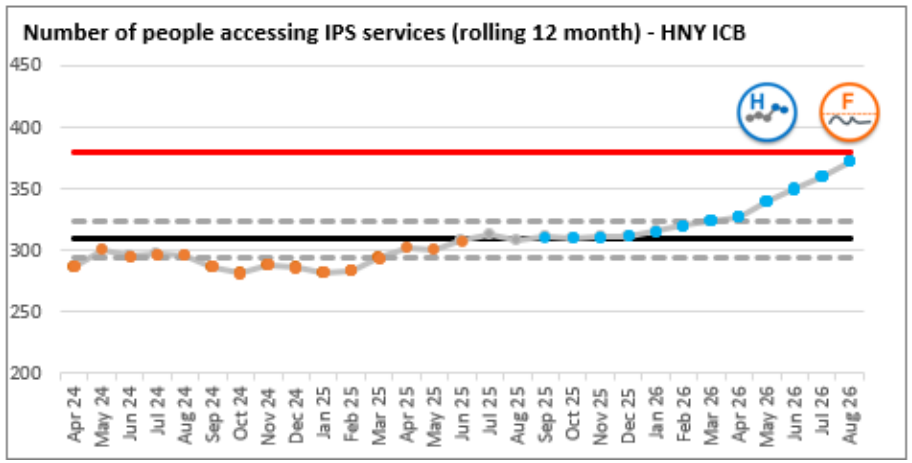
What does the chart show/context:
Financial year to date **2,706** patients discharged having received at least 2 treatment appointments in the report period within **North Yorkshire**. During September, **480** patients received at least 2 treatment appointments.

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:
- The current priority remains the conversion of treatment capacity into assessment capacity to reduce assessment waiting times to four weeks. This work is now expected to be completed by the end of October 2026.
- From the 1st November 2026, 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 September 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 September 2026, **381** people accessed IPS services.

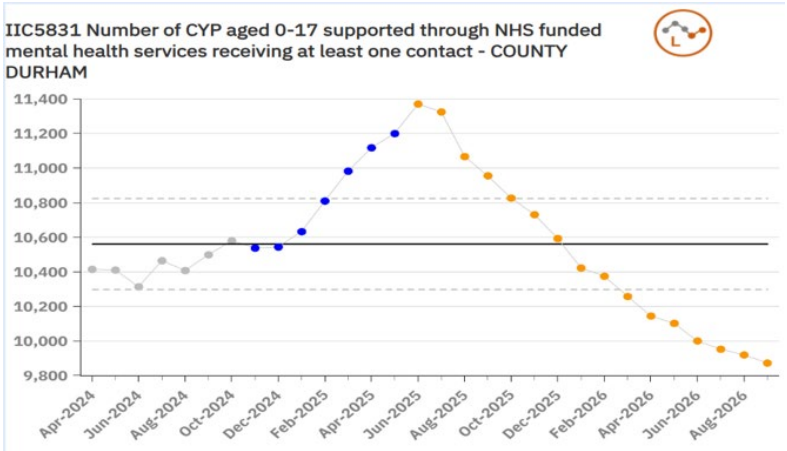
HNY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TEWV- Ambition	380	380	380	380	380	380	384	385	434	466	501	536
TEWV- Actual	328	341	351	359	373	381						
Variance	-52	-39	-29	-21	-7	1						

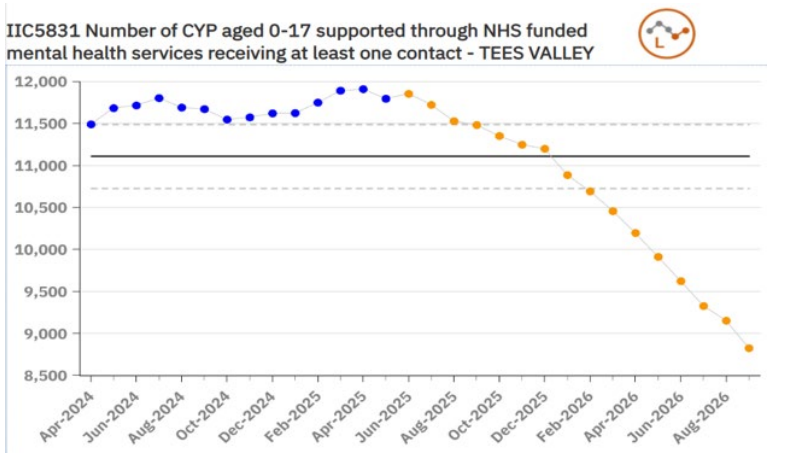
Underlying issues:
A short-term reasonable adjustment package is in place, reducing the workforce by 0.4 Employment Specialist.

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 commenced in September 2026. Two wte Employment Specialists are anticipated to commence in post in October and interviews for 3.8 wte Employment Specialists will take place in October.

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 September, **9,873** 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 September **8,826** 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

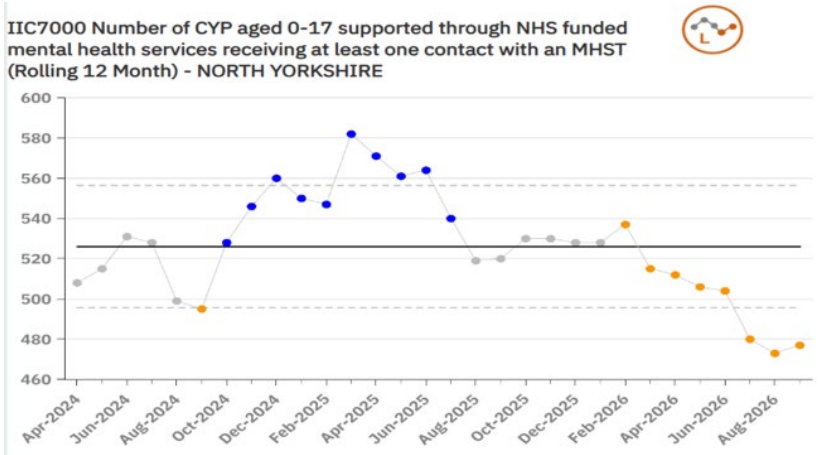
Actions:
- Single Point of Access, South Durham Community and the Crisis Team have been identified as Services Requiring Additional Support due to capacity and demand concerns. A recovery plan is in place and actions are progressing.
- The CYPS General Manager, supported by Performance and Business Intelligence, will complete analysis to identify the root causes of the decline in performance data and develop an action plan informed by triangulated data by the end of November 2026.

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 September 2026, there were **477** 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:
The MHST Service Manager has completed recruitment for the team. The Team Manager, Clinical Specialist, Band 6 Practitioner and 5 EMHP trainees commenced in post in September 2026. A Senior EMHP is due to start in October 2026, and the Psychology post is awaiting a confirmed start date.

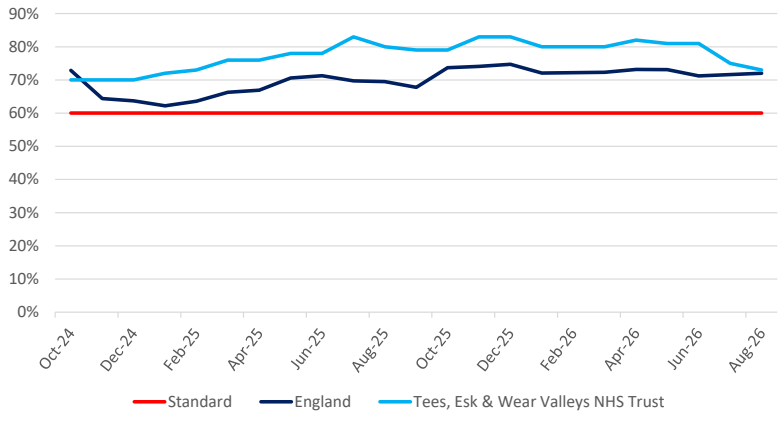
9. Benchmarking

National Quality Requirements

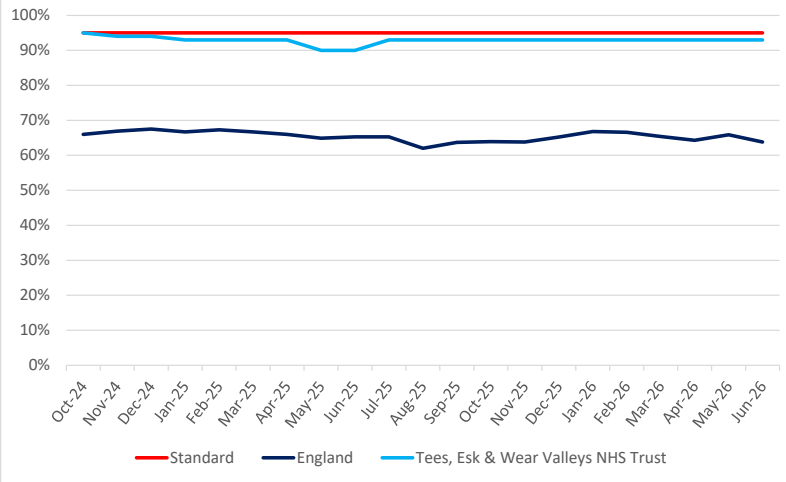
Percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care



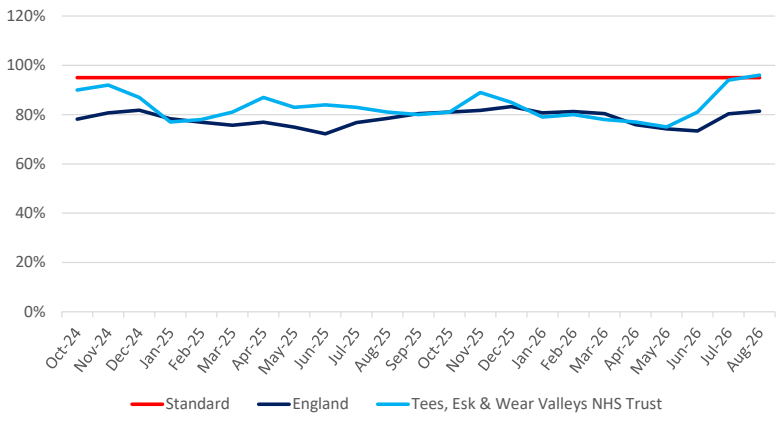
Percentage of service users experiencing a first episode psychosis of ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care



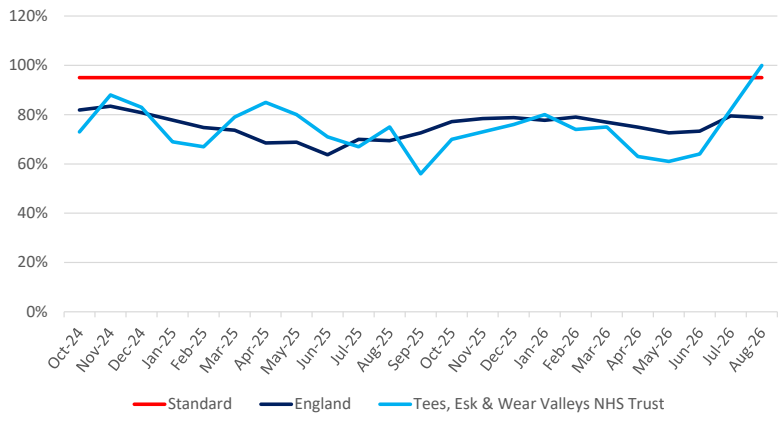
Data Quality Maturity Index



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



10. 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)	Less than 4 weeks	Over 4 weeks	Over 26 weeks	Over 52 weeks	Over 78 weeks	Over 104 weeks
Children & Young People Pathway D - Spells with at least one 'other' referral not identified as related to autism, neurodevelopmental or gender identity	916	462	456	176	105	67	**58**
Adults Waiting to receive Meaningful Help	4130	1175	2955	631	168	54	37

"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. Pathway-level breakdowns have been removed to simplify the Board IQPR and avoid potential misinterpretation. While they provided context on neurodevelopmental waits within CYP referral spells, they do not represent standalone neurodevelopmental waiting lists and are therefore not considered appropriate measures for Board-level reporting.

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)		3	2	0	1	0	0	0	0	1	**2**
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		44	18	9	11	2	3	0	1	2	**14**

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)		83	42	26	12	0	0	1	2	1	**12**

To note: * Denotes data quality

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		719	468	87	45	61	18	8	16	7	9	11	**190**	*
Adults Waiting for an Assessment		2354	1008	552	279	383	118	8	5	1	0	8	**127**	
Adults with a learning disability Waiting for an Assessment		72	60	6	2	2	0	0	1	0	1	9	**420**	*
Adults in Health and Justice services Waiting for an Assessment		48	38	7	1	2	0	0	0	0	0	3	**14**	*
Older People Waiting for Assessment		2899	921	616	508	618	188	48	0	0	0	11	**49**	*

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		4694	89	93	133	382	431	180	1274	1461	651	94	**224**	
Children and young people waiting for an ADHD Assessment		4510	90	81	120	227	301	198	1440	1344	709	96	**250**	
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised		1901	7	4	3	4	33	83	474	835	458	126	**229**	*
Adults waiting for an Autism Assessment		4379	53	42	29	122	181	188	811	863	2090	141	**365**	*
Adults waiting for an ADHD Assessment		5640	130	86	69	321	326	281	1032	1177	2218	126	**376**	

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		3862	184	304	1341	637	712	684	17	**71**

NOTES:

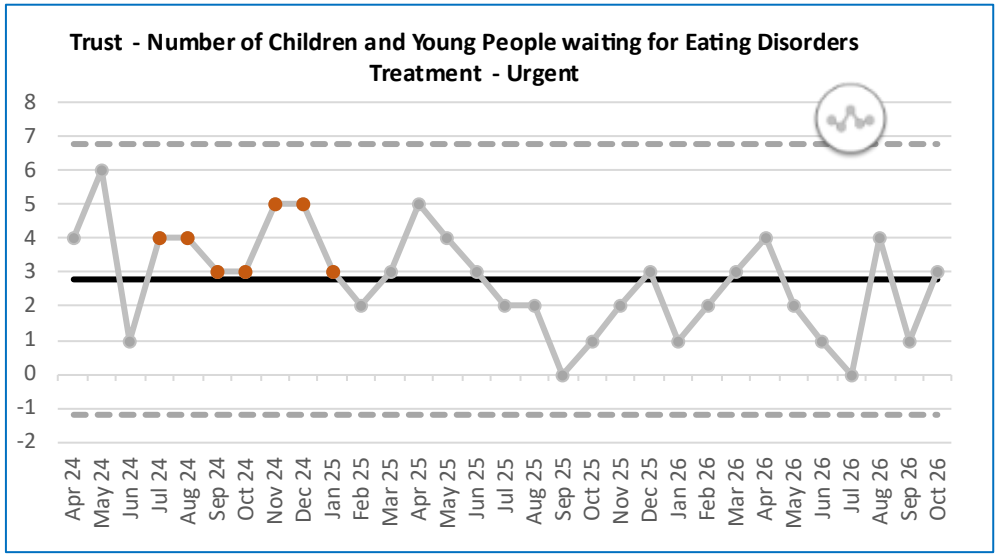
- *Asterisk* denotes a data quality issue*
- *The Children and Young People neurodevelopmental waiting times dashboards are referral-based; therefore, patients may appear more than once within the underlying waiting time bands but are counted only once in the total waiting list.*

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

Summary:
The **1** child or young person reported as waiting more than 1 week was offered an appointment within one week but did not attend. They have subsequently been assessed, and the service is not appropriate for their needs.

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

Actions:
Adult Mental Health General Managers have developed 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. **(Complete)**



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

Organisation	Actual	Average wait (days)	Longest wait (days)	Assurance
Trust	3	8	17	
DTVF Care Group	2	3	4	
NYY&S Care Group	1	17	17	

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

Summary:
There are **6** children or young people reported as waiting more than 4 weeks; however, validation confirms that **3** patients are currently waiting beyond 4 weeks.

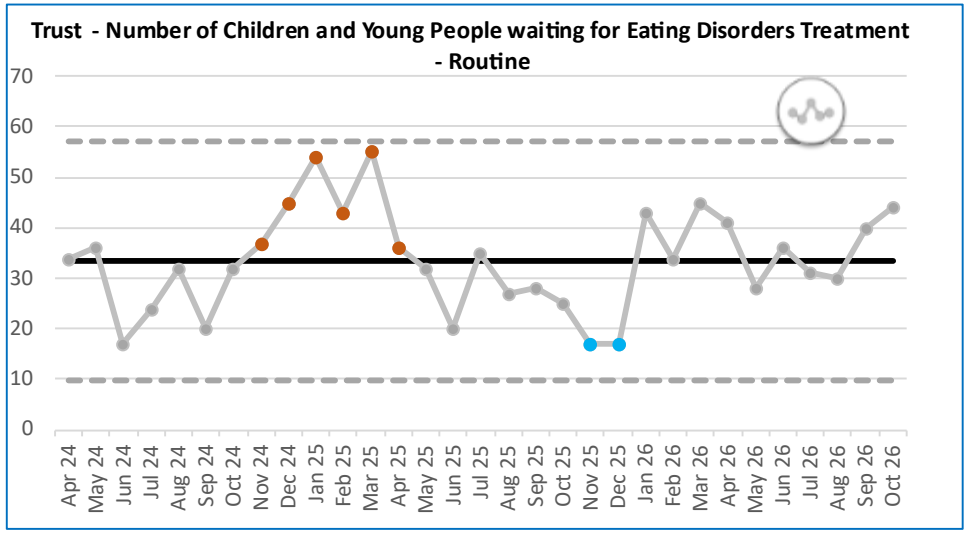
Of the 3 patients waiting:

- 1 patient was offered an appointment (within 4 weeks); however, the family cancelled the appointment, and next available appointment was outside 4 weeks. Treatment has subsequently commenced.
- 2 patients were offered appointments (outside 4 weeks) as they required Transfer of Care meetings to take place prior to an assessment, which were delayed. These are now complete and treatment has commenced

The 3 remaining waits are attributable to data quality issues 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:
Building on completion of 6 of the 8 actions, the Directors of Operations will oversee completion of the two outstanding service improvement plan actions and secure governance approval of the access and choice options paper by January 2027.



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

Organisation	Actual	Average wait (days)	Longest wait (days)	Assurance
Trust	44	15	98	
DTVF Care Group	30	13	45	
NYY&S Care Group	14	20	98	

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

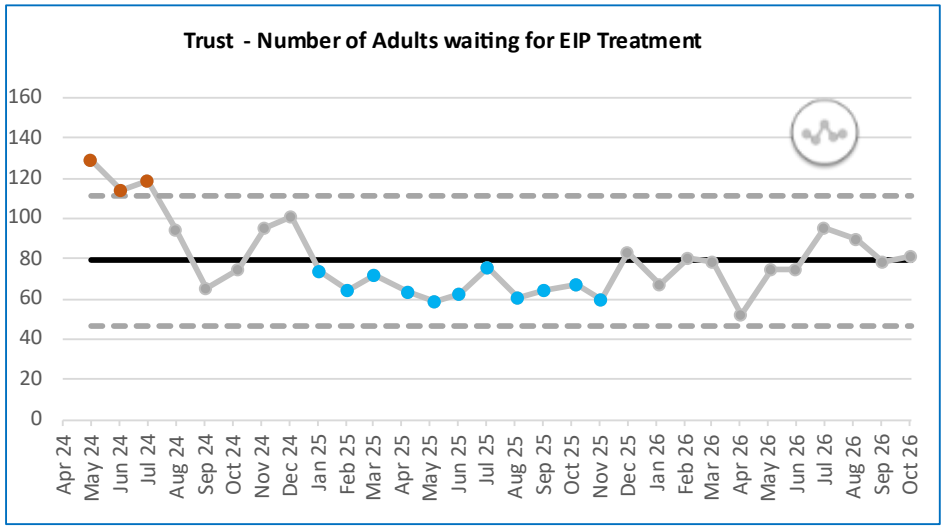
Summary:
There are **15** adults **reported** as waiting more than 2 weeks; however, validation confirms that **9** patients are currently waiting beyond 2 weeks.

- 9 patients were offered appointments (within 2 weeks); 8 either did not attend or cancelled their allocated appointments. Four have been assessed; 1 has been allocated to the EIP pathway, and 3 are awaiting MDT discussion to establish whether the EIP pathway is suitable for their needs. The remaining 4 have appointments in October. The final patient was delayed due to patient choice; an appointment has been arranged for October.

Of the remaining 6 waits:
- 2 patients have been assessed, and treatment is not suitable for their presentation; the service have now discharged them.
- 4 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 was delayed as newly recruited care coordinators were awaiting professional registration PINs before they can hold caseloads. All PINs have now been received, and the team anticipate delivery against the 2-week treatment standard from the end of October 2026.



Adults Waiting for EIP Treatment - 2 week standard

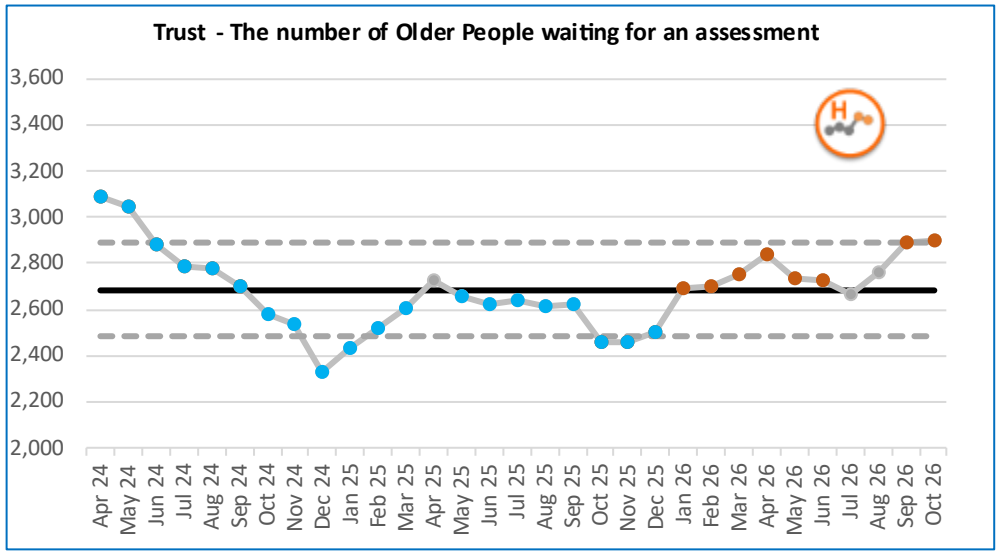
Organisation	Actual	Average wait (days)	Longest wait (days)	Assurance
Trust	83	10	87	
DTVF Care Group	56	10	87	
NYY&S Care Group	27	10	86	

Waiting Times – Older People Waiting for Assessment

Summary:
As at **2nd October**, we have **2899** 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.
- High levels of sickness in York & Selby Memory Service is impacting capacity.

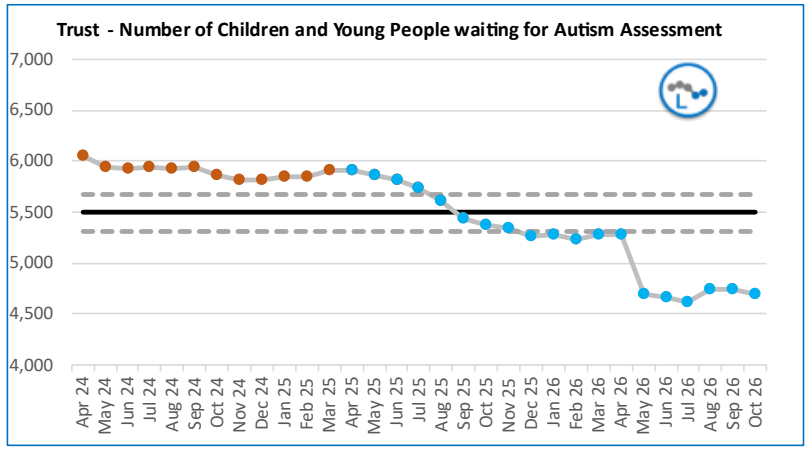
Actions:
- In DTVFCG:
    - Weekly performance meetings are taking place with senior leadership to review the waiting list position and to ensure those patients with the longest waits are prioritised where appropriate.
    - Senior Leadership continue to review workforce capacity weekly and reallocate peripatetic resource to those areas with the greatest need.
    - Secure Care Group Board approval of the Business Case reviewing team size and capacity across Teesside and Darlington and commence delivery of agreed staffing and capacity changes following approval.
- 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 following successful recruitment, assessments are expected to increase to 21 per week thereafter.
- York & Selby Memory Service to be supported by a band 4 clinician from the North East York Community Mental Health Team.

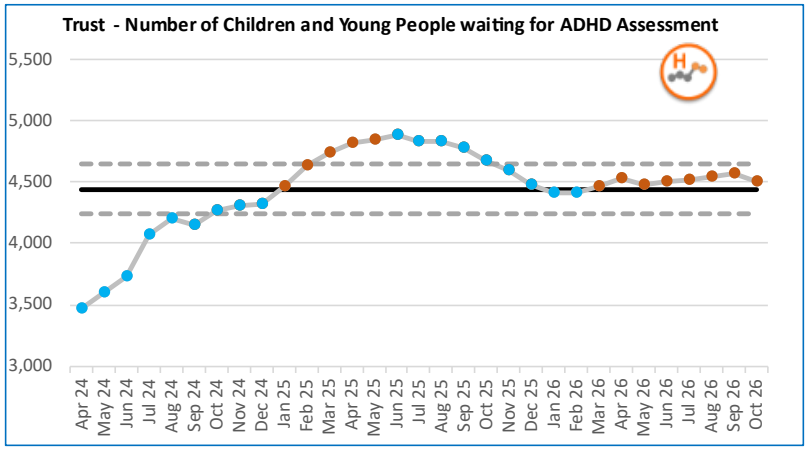


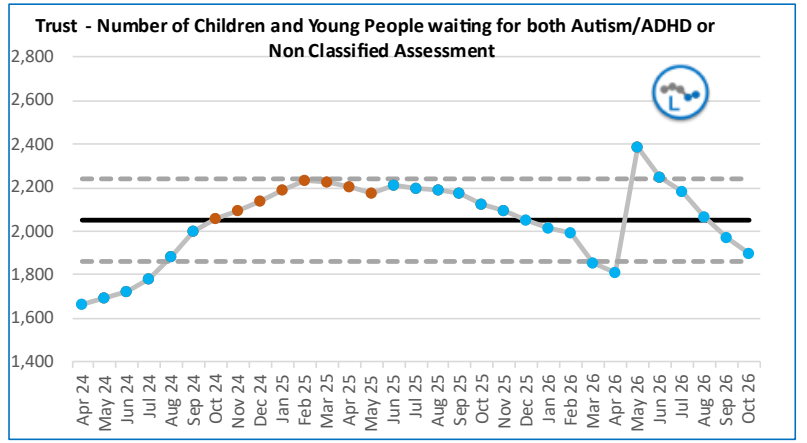
Older People Waiting for Assessment

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust	2899	11	49	
DTVF Care Group	1481	7	27	
NYY&S Care Group	1418	14	49	

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	4694	94	224	
DTVF Care Group	3607	101	224	
NYY&S Care Group	1087	69	151	

Children and young people waiting for an ADHD Assessment

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust	4510	96	250	
DTVF Care Group	3782	106	250	
NYY&S Care Group	728	42	147	

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

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust	1901	126	229	
DTVF Care Group	1401	144	229	
NYY&S Care Group	500	77	140	

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)
- There is limited resource for ADHD assessment in the Tees Valley area

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

Actions:
- 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. **(Complete)** See below action
- The Durham & Darlington Neurodevelopment Leadership Team will complete job planning and diary mapping to establish sufficient Diagnostic Decision-Making capacity and support the safe implementation of the clinical protocol from January 2027.
- The service will review all children on the under 5's pathway to ensure those who are waiting and are now of school age are transitioned onto the correct pathway by the end of December 2026, where appropriate. Once this work is complete, group work with the under 5 cohort will commence in January 2027.

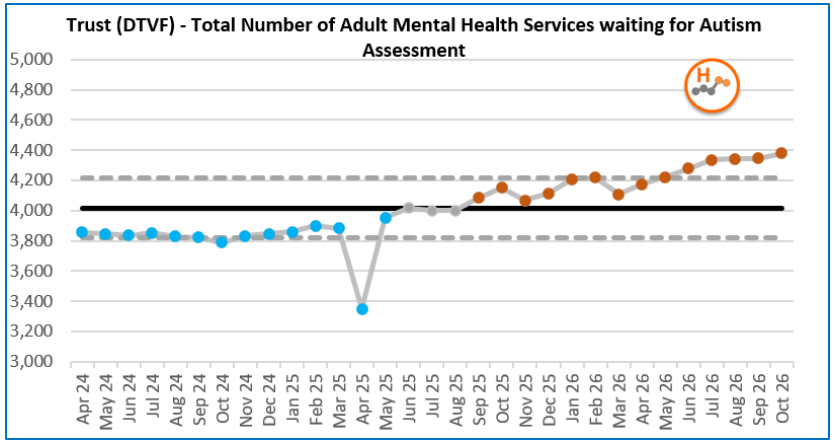
North Yorkshire & York

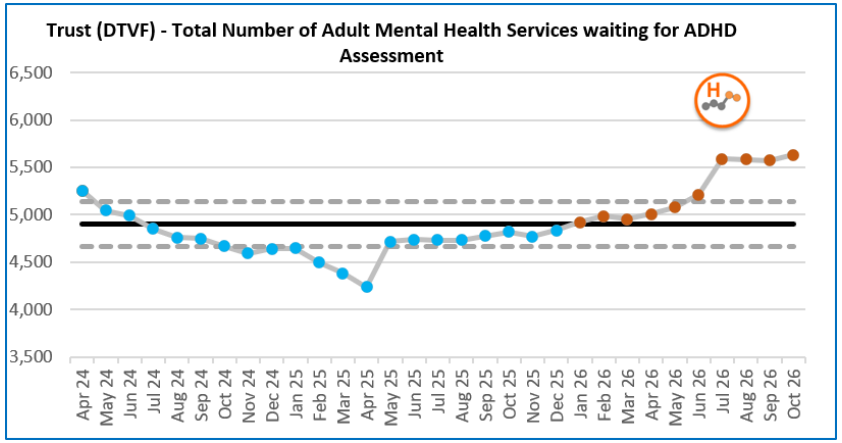
Underlying Issues:
- Long-term sickness absences within the Scarborough ADHD team
- High levels of demand outweighing capacity in the Scarborough ADHD and York & Selby ADHD teams

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)	4379	141	365	

Adults waiting for an ADHD Assessment

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust (DTVF Care Group)	5640	126	376	

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.
- 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. **(Complete)**
- The Trust has supported a proposal for additional capacity from external providers to support existing patients; this has been submitted to the ICB for approval in October 2026, with the anticipated transfer of patients to accredited providers to commence in November.

Actions (Trust):

- A referral management process for ADHD is commencing in Tees Valley in October and County Durham in December, which will ensure that only patients requiring secondary mental health care are referred to the Trust. This is anticipated to be approximately 2% of current ADHD referral rates.

Waiting Times Talking Therapies

DTVFCG

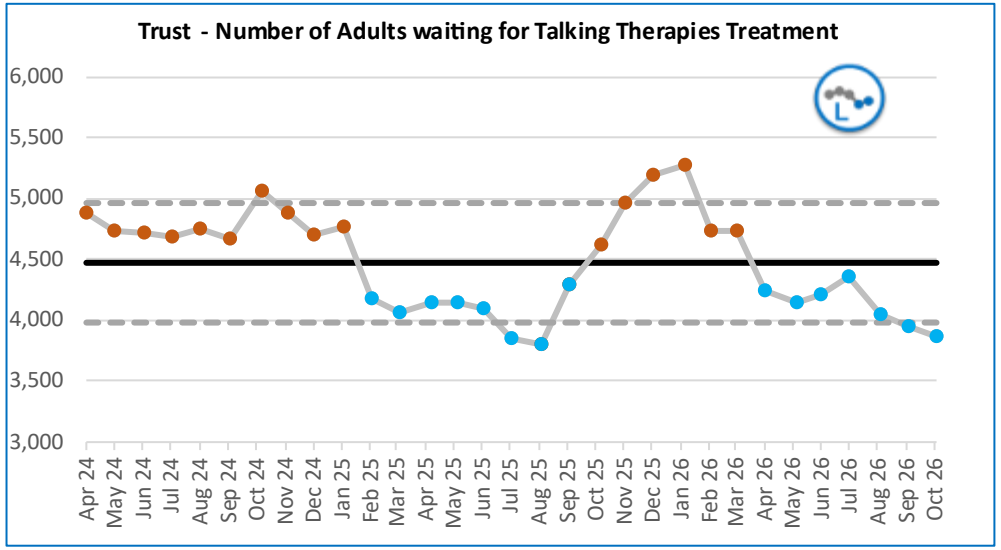
Underlying issues:

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

Actions:

- 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. *(See below action)*
- In October 2026, the DTVFCG service will present a revised Performance Improvement Plan to the Integrated Performance Assurance Group, which includes new actions including the deferred implementation of KOA Step 3 Therapy, recovery and relapse prevention processes, wellbeing support for those awaiting Step 3 therapy, and an Eye Movement Desensitisation & Reprocessing (EMDR) therapy gatekeeping process.
- Implementation of the Dr Julian digital therapy offer within Talking Therapies is subject to ICB confirmation of TEWV's fair-share allocation, data-sharing arrangements and associated funding arrangements.
- 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 peer model review work in their executive development session in November 26.
- The Service Manager will recruit to 4.1 PWP staffing vacancies by the end of December 2026; shortlisting for 2 will be undertaken in October, 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, interviews for which will be held in October 2026.

- *See following page for NYYSCG*



Talking Therapies - adults waiting for their second treatment contact

Organisation	Actual	Average wait (weeks)	Longest wait (weeks)	Assurance
Trust	3862	17	71	
DTVF Care Group	1406	13	58	
NYY&S Care Group	2456	20	71	

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:

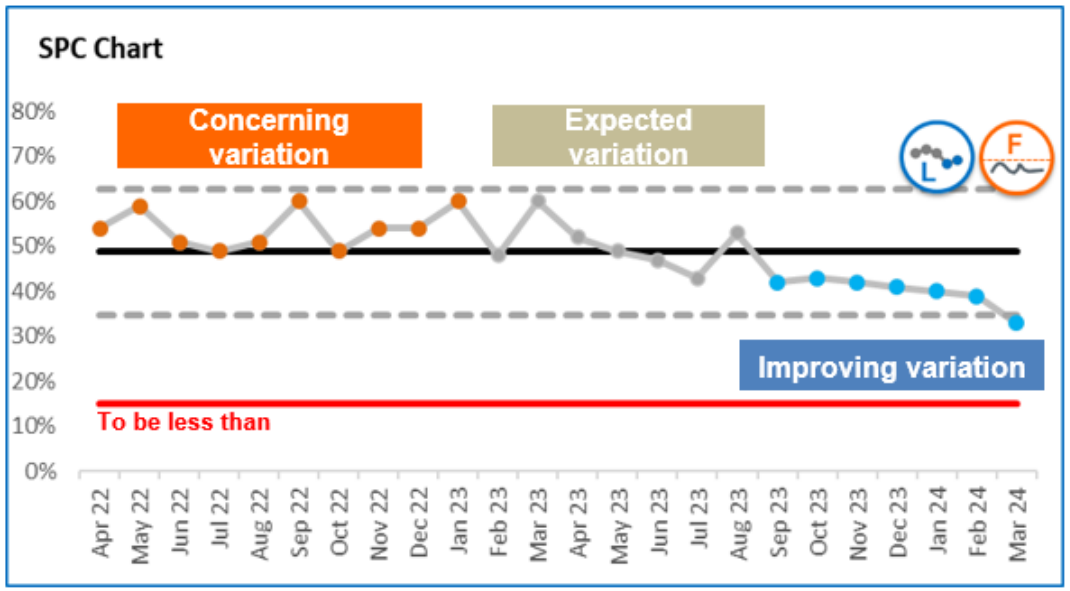
- The current priority remains the conversion of treatment capacity into assessment capacity to reduce assessment waiting times to four weeks. This work is now expected to be completed by the end of October 2026.
- From the 1st November 2026, assessment capacity will be converted back to treatment capacity as a stepped approached, initially focusing on Guided Self Help & Step 3 treatments.
- 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. **(Complete)**

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 results incorporated within this report reflect the assessment completed in quarter 4 2025/26. The quarter 2 2026/27 assessment has been completed and will now be presented to the Planning, Digital & Estates Committee for approval.

	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
EHMP	Education Mental Health Practitioners
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

BOARD REPORT

1. Cover Sheet

Report Title	**Medical Education Annual Report 2026**
Meeting	Board of Directors Meeting [Public]
Date of Meeting	26.11.2026
Item number	N
Sponsoring Director / Author	Dr Kedar Kale, Executive Medical Director
Report Author	Hayley Lonsdale, Head of Medical Education & Medical Education Leadership Team
Purpose of Paper	**Assurance**
Previously Considered By	Executive Board on 03.11.2026
Financial Implications	NHS England (NHSE) Education Funding Agreement (EFA)

2. Recommendation

The Board is asked to:
Receive good assurance on the utilisation of funding received via the Education Funding Agreement (EFA) to provide high quality medical education placements for both postgraduate and undergraduate learners.

3. Executive Summary

This annual report provides the Board with year-end assurance on the delivery of medical education during the 2025–2026 academic year (September 2025 to August 2026). It covers compliance with the NHS Education Funding Agreement (EFA), General Medical Council (GMC) standards and NHSE Workforce Training Education (WTE) annual quality monitoring cycle; progress against NHS England's ten-point plan to improve resident doctors' working lives; and performance in the GMC National Training Survey (NTS) and National Education and Training Survey (NETS).

TEWV supported almost 500 resident doctors across 226 approved training posts, 448 medical student placements, 20 Physician Associate student placements and provided educational opportunities for 90 Specialty, Associate Specialists and Specialist (SAS) doctors, supported by more than £9.6 million of education funding. Quality indicators are strong: in the 2026 GMC National Training Survey, TEWV ranked 17th nationally for trainees and 14th for trainers from 226 active Trusts. The Medical Education Leadership Team therefore offers good assurance that medical education is being delivered to a high standard.

Alongside the good assurance described, some risks remain relating to persistent consultant and accredited trainer vacancies, limited substantive supervision capacity and inadequate training

facilities at some sites, which may affect sustained compliance. The Board is asked to note the assurance provided, the achievements and outstanding risks, and to maintain oversight of the actions required to strengthen workforce and estate capacity.

4. Strategic Context

Linkage	Detail
Strategic Objective(s)	01 - Co-create High-Quality Care; 02 - Be a Great Employer; 03 - Be a Trusted Partner
Board Assurance Framework	01 Safe Staffing & 08 Partnerships and System Working
Corporate Risk Register	Not applicable
Committee / Work Programme Ref	Not applicable
Regulatory / Legal Reference (if applicable)	Not applicable

BOARD REPORT

Report Title	Medical Education Annual Report 2026
Meeting	Board of Directors Meeting [Public]
Date of Meeting	26.11.2026
Item number	N

1. Background

This annual report provides the Trust Board with assurance regarding the quality, governance, performance and strategic direction of undergraduate and postgraduate medical education across TEWV. It reviews activity undertaken during 2025 / 2026, progress against the objectives set out in the 2025 Medical Education Annual Board Report, the principal risks requiring oversight, and priorities for 2026 / 2027.

Since the previous report, the Faculty of Medical Education has made significant progress in advancing the simulation agenda. It has also introduced an inquest support process for resident doctors, a medical student placement Quality Recognition Framework (QRF), a Senior Registrar teaching and feedback framework, and guidance on Self-Directed Time. Feedback for undergraduate placements has continued to improve, and the clinical induction materials for resident doctors have been comprehensively reviewed.

Although the 2026 General Medical Council (GMC) National Training Survey (NTS) indicated a slight decline in rankings, TEWV ranked 17th nationally for trainees and 14th for trainers among 226 active Trusts.

Key national and regulatory drivers include the GMC standards for medical education and training; the NHS Education Funding Agreement (EFA) 2024–2027 and associated education and training tariff requirements; NHS England's Safe Learning Environment Charter and maturity assessment; and NHS England's 10 Point Plan to improve resident doctors' working lives, which continues to require Board-level oversight. Local drivers include medical school expansion; increasing placement demand; the need for sufficient educational facilities and trainer capacity; the correct allocation of protected educational time within job plans; the effective use and assurance of education funding; and delivery of the Trust's Medical Education Quality Improvement Plan, self-assessment process and 2026 MELT objectives.

2. Key Issues and Findings

2.1 What the data / evidence shows

The evidence provides strong overall assurance that TEWV delivers high-quality medical education, with national survey performance above average and substantial improvements in undergraduate placement satisfaction. However, the report also identifies capacity, workload, consistency and infrastructure risks that could constrain future growth.

Theme	What the evidence shows	Key message	Implication
Scale and investment	226 approved resident doctor placements; 448 medical student placements; 20 Physician Associate placements; 213 additional Stage 1–2 teaching-day participants; over £9.6 million education funding in 2025 / 2026.	TEWV is a major education provider with substantial activity and investment.	Sustaining quality requires workforce, estate, simulation and administrative capacity to keep pace.
National training survey	GMC 2026: 17th of 226 Trusts for trainee experience and 14th nationally for trainer experience. All 18 trainee and all 9 trainer indicators were above the national average, with no overall red or pink outliers.	Strong national assurance across trainee and trainer experience.	Maintain strengths while addressing the decline in rankings and identified strengths compared with 2025.
Wider learner experience	NETS: 141 responses, including 83 resident doctors. TEWV scored above the national average in every domain and exceeded regional comparators in most areas.	Supervision, team support, multidisciplinary working, wellbeing and routes for raising concerns are clear strengths.	Continue targeted work on bullying and undermining (for multi-professional trainees), discrimination, sexual safety, facilities, learning resources, simulation access and workload variation.
Undergraduate improvement	Newcastle Medical School Integrated Core Clinical Placements (ICCP) satisfaction rose from 53.9% to 71.4% (+17.5 points). Assistantship satisfaction rose from 58.0% to 86.4% (+28.4 points). Sunderland learning outcomes and supervision reached 100% positive responses.	The clearest gains were in Newcastle Assistantship programmes and Newcastle ICCP placements (Teesside locality).	Embed successful improvements and address remaining variation in patient contact, clinical involvement and placement consistency.

Theme	What the evidence shows	Key message	Implication
Quality assurance	The May 2026 North care group audit was positive overall and generated two actions now included in the Quality Improvement Plan. A Quality Recognition Framework will use placement evidence to recognise high-performing teams.	Assurance processes are identifying and responding to focused improvement needs.	Monitor delivery and evaluate whether recognition improves engagement and placement quality.
Trainer capacity and workload	Clinical Supervisors increased to 128; Educational Supervisors remained at approximately 85–88. Only 36 of 128 Clinical Supervisors (28.13%) had correct supervision time recorded; 16.41% exceeded recommended trainee limits (mainly within inpatient settings).	Capacity has improved but protected-time recording and workload distribution remain weak.	Correct job-plan records and rebalance allocations to protect quality, posts and associated funding.
Strategic risks	Evidence highlights placement saturation, mandatory training burden, variable facilities and learning access, limited supervisory capacity, and approval processes that delay action.	Current quality is strong, but future growth may exceed available capacity and infrastructure.	Link expansion decisions to confirmed workforce, funding, placement and governance capacity.
Overall assurance	**Performance is consistently above national benchmarks, and undergraduate satisfaction has improved markedly.**	**Good assurance, with targeted risks requiring active management.**	**Board focus should be on sustainability, consistency and capacity for planned growth.**

2.2 Assurance

It is expected this report will provide good assurance to Board members regarding the placements of medical students and resident doctors in the Trust.

2.3 Risks

The central risk is sustainability rather than current quality. Performance remains strong, but planned growth may outpace available supervision, staffing, infrastructure and decision-making capacity.

3. Options Considered

Not applicable.

4. Impact Assessment

Impact Area	Assessment
Quality & Patient Safety	No direct impact
Safeguarding	No direct impact
Equality, Diversity & Inclusion	EIA not required
Workforce	If the Faculty of Medical Education (FoME) is unable to identify additional supervisors to provide high quality supervision this could lead to a decrease in resident doctor training posts. This could result in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.
Financial / Resource	There is a risk that failure to provide high quality placements for medical students and resident doctors may result in the removal of funding via the EFA which in turn would increase agency locum costs.
Legal	The Trust has a legal responsibility through the EFA to quality assure the delivery of medical education.
Protected characteristics	No direct impact

5. Appendices

Appendix	Title
A	Summary of Medical Education Activity (2025 – 2026) – Provided as a separate Appendices.

6. Document Control

Version	Date	Author	Summary of Changes
0.1 DRAFT	09 October 2026	Hayley Lonsdale, Head of Medical Education	Initial draft for MELT review
0.2 DRAFT	23 October 2026	Hayley Lonsdale, Head of Medical Education	MELT approved draft for Sponsoring Director review
1.0 FINAL	26 October 2026	Hayley Lonsdale, Head of Medical Education	Approved version following Sponsoring Director review

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Summary of Medical Education Activity
September 2025 – August 2026

Faculty of Medical Education
Tees, Esk and Wear Valleys NHS Foundation Trust

Prepared by Hayley Lonsdale, Head of Medical Education &
Medical Education Leadership Team (MELT)

CONTENTS

1. **INTRODUCTION & PURPOSE** 3
2. **BACKGROUND INFORMATION** 3
3. **KEY ACHIEVEMENTS IN MEDICAL EDUCATION** 4
4. **IMPLICATIONS / RISKS** 16
5. **HORIZON SCANNING** 19
6. **ACTIONS** 21
7. **CONCLUSIONS** 22
8. **RECOMMENDATIONS** 22

1. INTRODUCTION & PURPOSE

This report summarises medical education activity in 2025 / 2026 (academic year) and priorities for 2026 / 2027.

2. BACKGROUND INFORMATION

2.1 The Trust currently hosts 226 approved resident doctor placements in Foundation, GP, core, and higher training.

During the 2025–2026 academic year, the Trust hosted 448 medical student placements from four universities and 20 Physician Associate placements from three universities. Detailed below is the breakdown by medical school / university, placement stage and locality.

Medical Schools (Medical students)	Stage	Number of students
Newcastle AST (Durham, Darlington and Teesside localities)	5	113
Newcastle ICCP (Durham, Darlington and Teesside localities)	3	120
Sunderland (Durham & Darlington & localities)	3	100
Leeds (Harrogate locality)	4	24
Hull and York (York locality)	3	46
Hull and York (Scarborough locality)	3	32
Hull and York (South Tees locality)	3	13

Universities (Physician Associates)	Stage	Number of students
Newcastle University (Durham, Darlington and Teesside localities)	2	6
University of Bradford (York locality)	2	6
Hull and York (York & Scarborough locality)	2	8

In addition to the above the Trust also provided teaching days for Stage 1 and Stage 2 medical students as follows:

Medical Schools (Medical students)	Stage	Number of students
Sunderland (Durham & Darlington & localities)	1	50
Sunderland (Durham & Darlington & localities)	2	50
Hull and York (York, Scarborough and South Tees localities)	1	113

2.2 Postgraduate medical education is governed through Resident Doctor Training Forums (RDTFs) for the Trust's two care groups, overseeing registrar and senior registrar training and placement satisfaction. Separate committees oversee Foundation doctor and GP registrar training. Local undergraduate groups report to

the Trustwide Undergraduate Governance Board (UGB), while the Medical Education Committee (MEC) oversees all groups and sets the strategic direction.

2.3 The NHS Education (NHSE) Funding Agreement (EFA) covers education and placement providers until 31 March 2027. https://www.england.nhs.uk/terms-and-conditions-2/new-nhs-education-contract/ The 2024–2027 agreement supports eligible non-competitive, equitable activities under annual Department of Health and Social Care (DHSC) tariff and NHSE funding guidance, including placement funding, salary support not otherwise commissioned or covered by a host / lead contract, and NHSE programme grants. Placement providers must work with NHSE and partners to support learners' career transitions and maintain and improve placement capacity and capability.

2.4 Medical education quality is monitored through a self-assessment report (SAR) and quality improvement plan (QIP), shared with NHSE to demonstrate compliance with GMC training domains: https://www.gmc-uk.org/education From November 2026, the Provider Self-Assessment (PSA) will replace the SAR. Redesigned to reduce burden, duplication and strengthen assurance, it cuts questions from 116 in 2025 to 96 in 2026 and uses more structured, exception-based reporting.

2.5 The Faculty of Medical Education (FoME) conducts annual Internal Educational Audits of Trust postgraduate activity. The April 2026 audit of the North care group identified areas for improvement and informed action plans.

2.6 The Medical Education Operating Framework (MEOF) outlines the FoME's role and the Trust's governance of undergraduate and postgraduate education and continues to be reviewed annually.

2.7 Published by NHSE in February 2024 the Safe Learning Environment Charter (SLEC) defined supportive environments that equip learners to deliver safe, compassionate, high-quality care. Aligned with the NHS People Promise, SLEC supports learners and placement educators across all professions and settings, recognising learners as vital to the NHS workforce.

The Head of Medical Education (HME) is a member of the Trust working group and coordinated multidisciplinary, Trust-wide completion of NHSE's Maturity Matrix (1, 2, 3). Submitted to NHSE with the annual SAR, the maturity matrix informed the Trust's SLEC plan. The working group meets monthly and has set three objectives for each professional group to address areas scoring below 3 (optimal).

3. KEY ACHIEVEMENTS IN MEDICAL EDUCATION

Detailed below are key achievements in the last 12 months.

3.1 General Medical Council (GMC) Survey

The GMC national training survey (NTS) captures resident doctor and trainer satisfaction and benchmarks the Trust against similar organisations.

The Trust performed strongly across all programmes. In 2026, TEWV ranked **17th nationally** among 226 active Trusts in the trainee survey (6th in 2025) and **14th nationally** in the trainer survey (9th in 2025).

In the **trainee survey**, **all 18 indicators exceeded the national average**. There were **9 overall green outliers** (17 in 2025), no overall red or pink outliers, and a further **40 strengths by site** and **30 by specialty and post specialty**.

In the **trainer survey**, **all 9 indicators exceeded the national average**. There were **3 overall green outliers**, no overall red or pink outliers, and **36 further strengths**, compared with 3 green outliers and 53 further strengths in 2025.

3.2 National Education and Training (NETS) Survey

NHSE conducted the NETS survey in autumn 2025. TEWV received 141 responses, including 83 from resident doctors (97 in 2024), with increased participation from Nursing and Allied Health Professionals.

TEWV scored above the national average in every domain and surpassed regional comparators Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) and Leeds and York Partnership Foundation Trust (LYPFT) in most.

Strengths included supportive teams, effective supervision, multidisciplinary working, clear routes for raising concerns and accessible wellbeing support. Old Age Psychiatry improved notably in wellbeing, supervision and overall experience. Learning Disabilities Psychiatry also improved markedly, achieving 100% positive scores in several domains, including bullying and undermining, discrimination, sexual safety, wellbeing and workload.

Continued attention is needed on bullying and undermining, discrimination and sexual safety; a small number of negative experiences mainly involved patient behaviour. Satisfaction with facilities, learning resources, simulation and immersive learning varied by specialty and site and was lower in General Psychiatry. Workload also varied, and some Foundation doctors and General Psychiatry trainees reported a neutral or negative impact on learning.

MELT reviewed the findings, agreed QiP priorities and are monitoring local actions, with progress reported to NHSE. A separate nursing-only report was produced by the Medical Education Business Lead (MEBL) for the first time and shared with the Director of People and Culture and Chief Nurse for action.

3.3 Internal Educational Audit Visits

The Trust provides ongoing assurance to relevant governing bodies, but previous findings show that some formal visit outcomes do not align with internal feedback from resident doctor clinics, end-of-placement reviews or GMC NTS rankings. The FoME therefore conducts annual internal educational audit visits to strengthen quality monitoring and, where necessary, shares findings with governing bodies.

The visit gathers first-hand feedback from trainees and trainers, provides constructive challenge and improvement support, and reviews the FoME's approach to delivering high-quality educational programmes across the Trust.

The developmental visit offers panel members, resident doctors and trainers a supportive setting for feedback. The May 2026 audit of the North care group was positive overall and identified two outliers requiring address, now included in the QiP.

3.4 Undergraduate placement feedback

Newcastle Medical School, Year 3 ICCP Comparison

Undergraduate placement feedback demonstrated several improvements during the 2025 / 2026 academic year. Students increasingly reported feeling welcomed by clinical teams, receiving appropriate supervision, and benefiting from structured teaching opportunities. Feedback indicated improvements in placement organisation, communication with students prior to placement, clarity of induction materials, and consistency of learning opportunities. Actions taken in response to earlier feedback regarding supervision, orientation to inpatient settings, variability in teaching quality, and placement timetabling contributed to a more positive student experience across the academic year.

The following table summarises the change in satisfaction between the 2024 / 2025 and 2025 / 2026 academic years:

Measure	2024 / 2025	2025 / 2026	Change
Indicative overall satisfaction	53.9%	71.4%	+17.5% points
North Tees average	39.6%	62.4%	+22.8% points
South Tees average	45.8%	76.8%	+31.0% points
Durham & Darlington average	76.2%	75.0%	−1.2% points

The clearest improvement was across Teesside, particularly South Tees. Durham and Darlington remained broadly stable overall, although satisfaction declined slightly in Rotations 1 and 3.

Newcastle Medical School, Year 5 Assistantship Comparison

Assistantship satisfaction improved substantially across all three localities. Excluding Rotation 1 (as the evaluation system did not collect the data correctly in 2024 / 2025 so not comparable), eight of the nine comparable site / rotation results improved. The

only decline was South Tees Rotation 3, which reduced from 77.78% to 55.56%. Rotation 4 achieved 100% satisfaction across North Tees, South Tees and Durham and Darlington.

The following table highlights the % improvement over the last 2 academic years:

Measure	2024 / 2025	2025 / 2026	Change
Indicative overall satisfaction, R2 to R4	58.0%	86.4%	+28.4% points
North Tees average	50.0%	87.5%	+37.5% points
South Tees average	67.2%	82.2%	+15.0% points
Durham & Darlington average	56.9%	89.6%	+32.8% points

Sunderland Medical School, Year 3 Placement Comparison

Overview

Feedback for Sunderland Medical School is collected through university semester surveys alongside local teaching and placement evaluations. As the sources, questions and response numbers are not fully consistent between academic years, the findings below represent indicative trends rather than a direct whole-cohort statistical comparison.

Overall, feedback demonstrates a positive and improving placement experience during 2025 / 2026, with teaching quality, organisation, supervision and staff support remaining key strengths.

Evidence of improvement - Comparison of the formal Semester 1 surveys shows:

- The proportion of students who strongly agreed that they were satisfied increased from 32% in 2024 / 2025 to 62% in 2025 / 2026. Overall positive satisfaction remained high, although it reduced from 100% to 93%, with one respondent disagreeing in 2025 / 2026.
- Positive responses for achieving the expected learning outcomes increased from 94% to 100%.
- Positive ratings for adequate clinical learning opportunities increased from 84% to 92%.
- Positive responses regarding the balance between teaching and patient contact increased from 89% to 100%.
- Positive ratings for appropriate clinical supervision increased from 94% to 100%.
- Organisation, access to learning resources and the relevance of teaching remained consistently strong, achieving 100% positive responses in both years.

The 2025 / 2026 Semester 2 survey provides further positive assurance. All 11 respondents agreed or strongly agreed that they were satisfied with their placement,

achieved their learning outcomes, had adequate learning opportunities and received appropriate supervision. All respondents also confirmed that taught sessions supported their learning objectives and that there was an appropriate balance between teaching and patient contact.

Hull and York Medical School (HYMS) - Year 3 Comparison

Undergraduate placement feedback for 2025 / 2026 identified a number of positive developments in the student experience, particularly in relation to placement organisation, supervision and pastoral support. Feedback indicated that students felt welcomed by clinical teams, experienced appropriate supervision and benefited from structured teaching opportunities. Improvements were also noted in placement organisation, including the timely provision of timetables and effective communication prior to placement commencement. Students reported positive experiences of teaching and highlighted the value of continuity in pastoral support and supervision.

Feedback further highlighted the positive contribution of dedicated learning space and access to patient records via laptops in supporting the learning environment. Increased engagement with clinical teams resulted in an expansion of placement opportunities for HYMS students, enabling a greater proportion of placements to be delivered closer to students' base locations and reducing travel requirements. Improved communication from clinical teams regarding student absences also supported more effective partnership working with medical schools and facilitated timely intervention where required.

Opportunities for further improvement were identified in relation to student attendance during examination periods and consistent access to suitable patients for learning opportunities.

The table below summarises the change in student satisfaction between the 2024 / 2025 and 2025 / 2026 academic years.

Measure	2024 / 2025	2025 / 2026	Change
Indicative overall satisfaction	97%	91%	−6% points
Rotation 1	86%	94.4%	+8.4% points
Rotation 2	100%	90%	-10% points
Rotation 3	95%	78.6%	-16.4% points
Rotation 4	100%	100%	Equal value

Whilst overall satisfaction remains high, year-on-year results demonstrate variation across individual rotations. The most significant reduction in satisfaction was observed in Rotation 3, which coincides with the period in which students transition between university base locations. Qualitative feedback suggests that adjustment to a new placement environment, alongside examination pressures, may have influenced student experience during this period. Continued monitoring and engagement with students and clinical teams will support ongoing quality improvement.

It should also be noted that the overall survey response rate declined from 74% in 2024 / 2025 to 52.6% in 2025 / 2026. This reduction in response rate should be considered when interpreting year-on-year comparisons.

Leeds Medical School - Year 4 PICU Comparison

Student satisfaction improved across all comparable rotations during the 2025 / 2026 academic year. Comparisons exclude Rotations 2 and 4 due to insufficient evaluation returns resulting from data collection issues.

Review of midpoint feedback and end of placement evaluation data indicates a consistently positive student experience. Students reported well-organised placements, timely communication and valued access to dedicated study facilities, IT accounts and laptops. Simulation-based learning, including role-play with actors and Experts by Experience, continued to receive exceptionally positive feedback, with students highlighting benefits to history-taking skills, clinical reasoning, OSCE preparation and understanding of patient perspectives.

Some students reported variable access to patients, attributed in part to high rates of non-attendance within certain clinical services. During 2025 / 2026, Leeds students were introduced to inpatient placements. This enhancement was positively received, with students welcoming the additional learning opportunities despite increased travel requirements.

Feedback identified opportunities to further strengthen the student experience through increased exposure to medical staff and clearer signposting of available learning opportunities.

In response, ongoing engagement has taken place with clinical teams to reinforce placement expectations, improve placement readiness and support the delivery of high-quality learning experiences. Students are also encouraged to maximise learning opportunities through active engagement with the wider multidisciplinary team.

Overall, student feedback remains positive and provides assurance regarding the quality of the Trust's placement programme and the effectiveness of ongoing improvement initiatives. The findings also identify opportunities for continued development and enhancement.

The table below summarises the change in satisfaction scores between the 2024 / 2025 and 2025 / 2026 academic years.

Measure	2024 / 2025	2025 / 2026	Change
Indicative overall satisfaction	83%	86.4%	+3.4% points
Rotation 1	100%	Nil returns	N/a
Rotation 2	83%	100%	+17.0% points
Rotation 3	83%	100%	+17.0% points
Rotation 4	50%	100%	+50.0% points
Rotation 5	100%	Nil returns	N/a

Completion of feedback questionnaires declined in 2025 / 2026 compared with the previous academic year, with response rates reducing from 87% to 32%. One rotation experienced technical issues that may have affected the successful submission of evaluation forms. Consequently, the lower response rate reduces the volume of available data available for analysis and should be considered when interpreting year-on-year comparisons.

Overall assurance and priorities

Newcastle and Sunderland placement feedback improved in 2025 / 2026. Teaching, organisation, supervision and staff support remained strong, with notable gains in Newcastle Assistantships and Teesside ICCP placements.

Priorities are to improve patient contact and clinical involvement, prepare teams for students, reduce placement variation, and address travel, service pressures and supervisory capacity. These findings will inform capacity reviews, clinical engagement and expansion planning.

Leeds and Hull York feedback was positive, particularly for organisation, supervision, communication and simulation-based learning. Variation in satisfaction has prompted targeted improvements and continued clinical engagement, while overall placement quality remains assured.

3.5 Simulation progress

Since opening the medical education simulation suite, the FoME has expanded simulation-based learning across the Trust. The New IMG Psychiatric Simulation (NIPS) programme is now delivered twice yearly within the in-house programme, while the quarterly Physical Health Emergencies in Psychiatric Settings course continues with Bishop Auckland Simulation Centre, receiving positive feedback and improved attendance. Reserved places for Supported Return to Training (SuppoRTT) returners have also widened access and supported workforce development.

Simulation is also being embedded in postgraduate communication skills teaching, undergraduate psychiatry teaching with Hull and York Medical School, and new projects such as a dual diagnosis simulation programme.

Simulation capacity and sustainability have been strengthened through recruitment of a dedicated simulation nurse and an administration/technician post. Regular training days are also developing Clinical Teaching Fellows' and educators' skills in simulation design, facilitation and debriefing, broadening faculty expertise.

The Simulation Oversight Group now provides strategic governance, aligns activity with the Trust's Simulation Strategy, supports quality assurance, and improves Trust-wide data collection and evaluation. Together, these developments support further expansion of safe, scalable simulation that enhances learning and patient safety while meeting growing training demand without adding pressure to clinical services.

3.6 Ambitious Continuing Professional Development (CPD) Programme

The medical in-house training programme supports the professional development of our medical community and continues to evolve. FoME members and associates deliver workshops and educational sessions vetted for relevance and quality. The prospectus outlines each session's content, intended audience and objectives, while participant feedback informs ongoing improvements.

Clinical expertise does not automatically translate into effective training or teaching. This programme develops trainers' educational skills and knowledge. The brochure groups requirements by frequency—annual (three hours of education), three-yearly (EDI training) and five-yearly (CS / ES updates)—and aligns learning with recognised Academy of Medical Educators (AoME) standards, making trainers' annual appraisals easier to navigate.

As part of the GP Education and Liaison portfolio, the FoME continues to deliver dedicated educational events that enhance understanding of contemporary mental health topics relevant to primary care and general practice. These events are available to general practitioners working in practices linked to our organisation across the North East and North Yorkshire footprint. The FoME also continues to provide sessions that support psychiatrists to develop confidence in physical health-related topics, which consistently receive excellent feedback.

Investment in the development of the SAS workforce remains a key priority. SAS Educational Away Days and business meetings are held on alternate months. In addition, the FoME supports the national #SASWeek campaign each October by delivering bite-sized teaching sessions throughout the week, alongside a full-day wellbeing event for the SAS workforce. The SAS doctors' "Experience and Development" survey continues to be conducted annually, with action plans developed in response to feedback to inform and enhance the future CPD offer.

In June 2025, the CPD Tutor and colleagues developed a Rapid Tranquilisation eLearning module for all medics which is now available via the Electronic Staff Record (ESR). Previously, medics completed two-yearly training through the Royal College of Psychiatrists (RCPsych) eLearning Hub, requiring annual licences. Bringing the training in-house has saved the Trust almost £30,000 a year.

The development of a CPD Academy remains a key aspiration for the FoME and a strategic priority. The Academy would create opportunities for interprofessional collaboration across the Trust and with independent and third-sector organisations, while also offering potential income generation for the Trust. A paper setting out the proposals is currently being developed and will be presented to the Trust Board once finalised.

3.7 Self-Development Time (SDT)

NHSE introduced protected Self-Development Time (SDT) for resident doctors in 2020 to support educational and professional development. Recommended weekly allocations are around 2 hours for foundation doctors (F1 / F2), up to 4 hours for registrars, and 8 hours for senior registrars, including research and special interest sessions.

In August 2026, MELT developed SDT guidance in response to queries from resident doctors and supervisors. It clarifies appropriate SDT activities, emphasises that SDT should support rather than compromise placement competencies, and encourages discussion at the start of each rotation.

3.8 Inquest Support Process

Resident doctors are more transient than other medical colleagues due to rotating of posts. If a resident doctor were to be involved in an inquest they could have moved away from the Trust by the court date. NHS England guidance, Supporting doctors in training attending a Coroners' Inquest, sets out the support responsibilities of the local employer, Medical Defence Organisation, NHSE local teams and Postgraduate Dean.

The HME and Associate Director of Medical Education (ADME) – South worked with the Trust Legal and Patient Safety teams to agree a process to support any resident doctor involved in an inquest and to establish a small pool of volunteer Inquest Mentors experienced in preparing for and attending coroner's court. Inquest Mentors meet regularly, develop shared resources and provide ongoing advice, signposting and support to mentees. It was agreed that Inquest Mentors would attend RCPsych 'Supervising Resident Doctors through Inquests' training.

Clearer reporting, identification and contact points have been agreed to ensure FoME involvement as soon as a coroner's request is received. The Legal Team will contact the Head of Service, who appoints statement providers; if a resident doctor is identified, the inquest mentoring team will be notified.

3.9 Medical Student Placement Quality Recognition Framework (QRF)

The medical student placement Quality Recognition Framework (QRF) was developed in 2026 to recognise, incentivise and support clinical teams delivering high-quality medical student placements across the Trust. The framework aims to strengthen the student learning experience, promote continuous improvement and reinforce TEWV's commitment to medical education and future workforce development.

The framework introduces clear standards for high-quality placements, including effective induction, accessible clinical supervision, meaningful clinical participation, teaching opportunities and constructive feedback. Clinical teams are recognised through a bronze, silver and gold award system based on student feedback, placement evaluation data and evidence of educational engagement and improvement.

Recognition includes annual team awards, departmental certification, acknowledgement through Trust communications and support for professional development and appraisal activities. The framework is intended to promote a culture where education is valued alongside clinical service delivery and to highlight excellence in clinical teaching.

The QRF has been implemented as a 12-month pilot, which will be evaluated against student experience, placement quality data, clinical team engagement and evidence of improvement before any decision is made regarding permanent annual implementation.

3.10 Peer-Peer Review Meeting

A Peer-Peer Review meeting held in March brought together Medical Education Managers (MEM) and HME's from neighbouring mental health Trusts to share and compare approaches to resident doctor induction, mandatory and statutory training monitoring, and wider medical education governance.

Chaired by the TEWV HME, participants discussed different induction models, highlighted common challenges around making doctors "work ready," managing out of rotation starters, and balancing engagement with information overload, alongside practical issues such as IT access and laptop provision.

There was shared learning around mandatory and statutory training compliance monitoring and escalation processes, including difficulties with Inter Authority Transfers (IATs) and resident doctor responses to reminder communications. Trusts also provided updates on progress against the NHS England 10 Point Plan, noting similar stages of implementation and shared challenges such as parking and access to meals.

Overall, discussions were reassuring in demonstrating common practice and challenges across organisations, with agreement to share documentation, templates, and tools and to reconvene the group in March 2027 to continue peer learning.

3.11 Review of Clinical Induction

Following the Peer-Peer Review meeting and the sharing of induction documentation it was agreed that the resident doctor clinical induction delivered on the first day of each rotation would be reviewed to make the content more interactive with a focus on ensuring resident doctors felt "work ready" as opposed to "governance ready".

A small working group chaired by the ADME – South was formed which included members of the medical education team, clinical teaching fellows and resident doctor representatives. Current material was shared and underwent a full overhaul to ensure content was current and relevant. The didactic teaching on the afternoon of the induction day was replaced with more participative workshops covering the same

material. Positive feedback from the August induction continues to inform ongoing improvement.

3.12 Technology Enhanced Learning Tutor (TELT)

The FoME and RCPsych recognise digital literacy as essential for resident doctors, as set out in the 2023 Digital Literacy Framework Digital Literacy Framework. Digital technologies can support effective and efficient medical education whilst the use of digital technologies may also help medics better understand their benefits and limitations.

Medical education combines clinical and theoretical learning through placements and protected teaching. Whereas trainers provide formative assessment to help resident doctors and medical students achieve required competencies on time, digital technologies can provide objective assessment and feedback, freeing up supervisors' and educators' time while enabling them to act as allies in resident doctors' clinical development.

Following the 2025 Medical Education Conference, developing a TELT role became a key 2026 MELT objective with the role being recruited to in May 2026 following competitive interview. Recent work undertaken by the post holder has included:

- Exploring digital skills literacy across medical colleagues and promoting opportunities for learning.
- Developing links with regional and national networks, including engagement with the RCPsych, to strengthen opportunities for shared learning and innovation and examples of best practice in this area.
- Drafting a regular technology-focused contribution for inclusion in the medical education newsletter, highlighting developments relevant to medical education, digital innovation, and clinical practice.
- Exploring the use of artificial intelligence (AI) to support audit activity and quality improvement projects.
- Assisting with the establishment of RIO task-and-finish groups involving resident doctors.

3.13 Senior Registrar Teaching and Feedback Framework

The framework introduces a structured, progressive approach to developing the educational capabilities of senior registrars from the 2026 / 2027 intake. It was developed from an existing framework that was created and shared by colleagues in CNTW, where they had seen success since it was introduced. It supports senior registrars to contribute consistently to undergraduate and postgraduate education while building evidence of teaching, assessment and feedback within their professional portfolios.

At ST4, the emphasis is on developing teaching skills. Senior registrars will set personal educational objectives, participate in peer support and review, undertake relevant continuing professional development, complete an Assessment of Teaching (AoT) and deliver at least one formal undergraduate teaching session in each semester. Teaching opportunities include simulation, case-based discussion, interview skills and a range of core psychiatric topics.

At ST5 and above, the focus progresses to giving effective feedback and supporting student assessment. Senior registrars will continue formal teaching and educational CPD while facilitating at least one end-of-placement assessment, completing a written reflection on feedback and discussing this through structured peer review.

Initial and end-of-year peer meetings provide opportunities to establish objectives, review learning and develop the next stage of each senior registrar's personal development plan. Standardised records and participation certificates support portfolio evidence and recognition of educational activity.

Overall, the framework will provide a consistent pathway for strengthening teaching, assessment and feedback skills across the registrar workforce, while increasing structured educational input for medical students and supporting the development of future clinical educators. A range of internal and external CPD opportunities is identified, with senior registrars expected to undertake at least one relevant activity each year.

3.14 Specialty, associate specialists and specialist (SAS) collective

The #SASsix campaign is a grassroots initiative founded by the SAS Collective to improve the careers, recognition, and retention of Specialist, Associate Specialist, and Specialty (SAS) doctors along with Locally Employed Doctors (LEDs) within the UK NHS. Ongoing work has been taking place to support TEWV's endorsement of the #SASsix commitments and discussions have included engagement with Trust Communications regarding endorsement requirements, promotion of the commitments and use of the SAS Collective logo.

The commitments focus on educational supervision, professional development, specialist progression, educator opportunities, leadership roles and access to SAS contracts. The endorsement was discussed as part of wider work to improve development, retention and career progression opportunities for SAS doctors within TEWV.

3.15 Aspiring Specialist Psychiatrist programme

The SAS governance group have discussed developing a structured pathway to support progression from Specialty Doctor to Specialist Psychiatrist and Approved Clinician roles. This included considering whether elements of the Trust's Portfolio Pathway Programme could be adapted to help SAS doctors gain the competencies and experience needed to progress.

Agreed actions included reviewing relevant RCPsych guidance, competency frameworks and development pathways, and exploring how a programme could be implemented within TEWV. The work remains at an early stage and is linked to the SAS Excellence in Development (SEiD) "What Gold Looks Like" initiative under the specialist progression pillar, following TEWV's recent silver award in the SEiD Recognition Awards.

3.16 Open Medical Education Leadership Team (MELT) meetings

Earlier this year, the Medical Education Leadership Team (MELT) agreed to invite senior registrars, wider FoME members, and Clinical Supervisors with an interest in medical education to attend designated "Open" MELT meetings.

MELT meetings bring together the FoME's senior leadership team to consider strategic and operational matters relating to postgraduate and undergraduate medical education across the Trust. Although many discussions are necessarily confidential, MELT recognised the value of offering colleagues greater insight into senior-level educational governance.

To balance accessibility with the need to maintain confidentiality, MELT now holds an "Open" meeting every two months, which colleagues are welcome to attend as observers for the full duration.

4. IMPLICATIONS / RISKS

4.1 Quality:

4.1.1 The QiP outlines the quality objectives to be delivered in the next reporting period.

4.2 Financial:

4.2.1 The Trust received over £9.6 million in 2025 / 2026 to support SAS doctor development, medical education placement salaries and infrastructure. Following discussions between the FoME, Newcastle Medical School and the Trust's Associate Director for Financial Management, the University supported the Trust's request to retain any underspend.

A member of the Undergraduate Leadership Team in in the progress of preparing a paper for Executive Directors outlining the scale and duration of potential underspends, proposed use of savings, and seeking in-principle support for small-scale plans that could use year-end underspends.

4.3 Legal and Constitutional:

4.3.1 The Trust has a legal responsibility through the EFA to quality assure the delivery of medical education.

4.4 Equality and Diversity:

4.4.1 There are no implications to consider.

4.5 Other Risks:

4.5.1 Mandatory and statutory training for resident doctors

The NHSE 10 Point Plan requires every organisation to address all actions, including preventing resident doctors from unnecessarily repeating mandatory and statutory training when rotating between posts or Local Education Providers (LEPs).

When the 10 Point Plan was introduced, TEWV's Workforce Development Lead confirmed through a national group that the Trust had signed the Memorandum of Understanding (MoU), recognised prior learning under the Core Skills Training Framework (except Safeguarding), and followed the People Policy Framework for Mandatory Learning agreed on 1 May 2025.

Feedback gathered from resident doctors during post review meetings and internal audit visits indicated that the number of training modules TEWV asks resident doctors to complete is excessive and continually increasing. Neighbouring Mental Health (MH) Trusts were approached to request their training requirements for resident doctors to enable the FoME to gain a greater understanding of the issue. Data provided confirmed that resident doctors undertaking a placement in TEWV were completing considerably more training modules than their peers working in neighbouring MH Trusts.

Following this exercise a request was made to the Chair of the Training and Education Governance Group (TEGG) for a resident doctor representative to become a member of TEGG to help ensure that mandatory and statutory training requirements are necessary and proportionate. The request was approved and a small pool of resident doctor representatives have now been identified to attend the group.

4.5.2 Trainer capacity and protected time in job plans

Maintaining enough substantive trainers to provide high quality supervision to resident doctors remains challenging due to medical vacancies, rising clinical demand, and Mind the Gap (MTG) arrangements. Effective job planning underpins high-quality clinical services, service development, training, education, and research.

A re-audit undertaken in April 2025 found discrepancies across specialties and care groups in the accurate recording of Supporting Professional Activities (SPA) SPA time in Clinical and Educational Supervisors' job plans.

Exact SPA allocation for supervising resident doctors could not be determined because most supervision time was aggregated with supervision of SAS doctors and multi-professional colleagues. Only 36 of 128 Clinical Supervisors (28.13%) had the correct supervision SPA time recorded.

The re-audit showed progress across the 2024–2026 cycles in workforce capacity and SPA allocation. Clinical Supervisors increased to 128, while Educational Supervisors remained stable at 85–88, expanding training capacity. SPA deficits have fallen substantially across both care groups. However, the main issue in 2026 is now inconsistent and inaccurate recording rather than insufficient allocation.

Educational Supervisors achieved full compliance with trainee allocation limits in both audit cycles. However, 16.41% of Clinical Supervisors exceeded recommended limits, indicating continued workload imbalance.

In recent years, the percentage of locally trained senior registrars recruited to Consultant Psychiatrist roles within TEWV has declined, from 52.3% in 2020 to 38.4% in 2024. The FoME continues to work with medical management colleagues to better understand the factors contributing to reduced retention and to agree targeted strategies to address this trend.

Without remedial action to address trainer capacity, the Trust could risk losing resident doctor training posts and associated funding, increasing agency locum costs.

4.5.3 Undergraduate workforce capacity and educational infrastructure

Undergraduate medical education is supported by a small specialist workforce, comprising Clinical Teaching Fellows (CTF's), Nurse Specialists and administrative staff, who coordinate placements, deliver teaching, support students and maintain educational quality.

The Trust currently employs five CTF's, who provide induction, teaching and pastoral support to medical students. These roles have reduced reliance on frontline clinicians for teaching delivery, thereby minimising disruption to clinical services. All planned teaching sessions were delivered during the reporting period.

Recruitment to CTF's posts has remained challenging throughout 2026. Despite several recruitment rounds, one vacancy remains in the South locality, reflecting wider national workforce pressures and challenges in postgraduate training recruitment. The anticipated growth in student numbers will require sufficient staffing, supervision, teaching space and simulation resources to safeguard placement quality and the student experience.

4.5.4 Undergraduate clinical placement capacity

Providing enough high-quality placements remains a significant strategic risk. The North currently supports about 240 Newcastle University and 100 Sunderland University medical students annually, but capacity varies by team and depends on staffing, supervision, service pressures, other learner commitments and accommodation. Some teams struggle to accommodate medical students alongside other learners where space and supervision are limited, risking placement saturation in a small number of services without continued support for hosts.

4.5.5 Simulation provision (South)

Whilst highlighted as key achievement, there remains limited infrastructure within the South care group to support dedicated simulation-based teaching. To address this, mobile simulation equipment has been introduced to provide a degree of simulation-based learning. Whilst this does not offer the same breadth or quality of provision as a purpose-designed simulation suite, it represents an important step towards improving access for students and reducing geographical disparities.

The long-term ambition remains the development of appropriate facilities within the South care group to enable the delivery of high-quality simulation-based education equivalent to that available elsewhere in the Trust. Until such facilities are available, mobile simulation will continue to provide an important interim solution to support student learning and experience. The FoME remains committed to reducing inequity in educational opportunities across the Trust.

4.5.6 Limited decision-making agility

The FoME has encountered challenges in responding to emerging developments with the necessary agility and autonomy, independently of care group approval processes and timelines.

While the FoME recognises the Trust's current financial position, the growing requirement to produce business case papers for CTF roles, new FoME posts, approval of new post developments, and protected time within job plans has increased the administrative burden on the FoME. This has constrained the FoME's ability to progress essential priorities in a timely manner even though funding received from the EFA should be ring-fenced for such activities and initiatives.

5. HORIZON SCANNING

To ensure the FoME remains proactive in its approach to continual improvement, several initiatives are planned for the next academic year.

5.1 Succession planning

Succession planning is a core component of effective talent management, enabling the organisation to identify and develop future leaders and individuals capable of stepping into business-critical roles. A key priority for MELT in 2027 will be to initiate succession-planning discussions across the FoME, particularly as several key postholders are expected to reach retirement age within the next few years.

The objective will be to identify individuals with the potential, capability and willingness to assume key roles when current postholders leave. This work will also ensure that the FoME identifies, develops and supports a sufficiently diverse and high-quality leadership pipeline to meet future organisational needs.

MELT will ensure that those responsible for succession planning have a thorough understanding of how the FoME is expected to evolve, its future strategic direction and the capabilities likely to be required.

5.2 NHSE 10 Point Plan to improve resident doctors' working lives

In August the Board of Directors and Executive Directors Group were presented a report by the Resident Doctor Senior Board Lead and Resident Doctor Peer Lead to provide assurance that the FoME had considered the NHSE 10 Point Plan mandate.

The report provided an overview of the key areas completed, work in progress and areas of non-compliance outside of the Trust's range of influence. An update was also shared relating to the resident doctors Board Assurance Framework (BAF) which was issued to all NHS organisations to enable them to respond using an evidence-based approach. The purpose of the BAF is to provide assurance for Trust Board's against which the system can effectively self-assess compliance with the measures set out in the plan.

The report confirmed that the Trust is primarily compliant with most areas of the 10 Point Plan. The majority of non-compliance relates to areas not directly within the Trust's control and is influenced by NHSE regional offices. These issues have been escalated to the relevant NHSE regional offices. Failure to meet the standards set out in the plan, alongside other quality indicators for medical education, may directly affect the future recruitment of resident doctors into career-grade roles within the Trust.

5.3 Teesside Medical School

Progress continues toward the establishment of Teesside Medical School, with a target of welcoming the proposed first cohort of students in September 2027. Provisional feedback from the General Medical Council (GMC) following its recent visit (August 2026) was positive, recognising the quality of the university facilities, the multidisciplinary approach being developed, and the strong collaborative partnership across regional education providers.

The GMC identified two key areas requiring continued focus:

- Ensuring sufficient capacity, expertise and leadership to develop and deliver the curriculum and assessment framework.
- Delivering the curriculum within the required timescales, with consideration being given to whether this should be initially aligned very closely with the established Newcastle University model to support governance and quality assurance arrangements.

Work is now progressing across regional NHS partners to assess current placement capacity and capability, with planning assumptions of approximately 50 students per year across a five-year programme. Discussions are underway to explore opportunities

for joint delivery of elements of the Newcastle and Teesside curricula, which could provide efficiencies in teaching, staffing and educational resources.

Further work is being undertaken to determine the additional academic, administrative and clinical education resource required to support curriculum delivery, assessment processes and quality assurance. Plans are also being developed to establish a Partnership Liaison Group to provide oversight of curriculum delivery and educational quality across partner organisations.

Overall, the programme remains ambitious but is progressing well, with positive early GMC feedback and strong collaboration across partner organisations as preparations continue for programme launch in 2027.

5.4 Expectation / experience management for Gen Z learners and practitioners

The FoME recognises that Generation Z (Gen Z) learners and practitioners are becoming an increasingly important part of the workforce. Having grown up with smartphones, social media and readily available digital technology, many Gen Z learners bring different expectations of workplace communication and technology.

A key area of work will be for the FoME to review the clinical and educational supervisor refresher training within the medical in-house training programme to ensure it meets Gen Z learners' needs. Areas to consider for inclusion are:

- Provide context – explain the rationale for clinical decisions, administrative rules and shift changes rather than expecting compliance without explanation.
- Give transparent feedback – use frequent, actionable, two-way feedback that balances constructive critique with recognition of strengths.
- Embrace digital tools – integrate mobile-friendly clinical references, quick-access software and AI-assisted workflows to reduce friction from outdated technology.
- Expand interactive and simulation-based learning – prioritise case-based discussions, simulations and rapid-cycle deliberate practice over prolonged passive teaching.
- Increase bite-sized teaching – support rapid information retrieval and microlearning.

6. ACTIONS

6.1 To address the risks outlined in this report, MELT agreed high level objectives for 2026 which are detailed below.

- With input from an identified Senior Registrar review the role of resident doctors within an inpatient setting – ADME North / ADMD
- Implementation and monitoring of Faculty developmental review structure – HME
- Introduction of a CPD Academy – ADMD / HME

- Enhance quality assurance processes to ensure resident doctor inductions are effective – ADME South
- Explore the effectiveness, motivation and impact on providing UG Clinical placements by incentivisation – ADME UG
- Utilising Out Of Hours provision for medical students on placement – ADME UG
- Developing a practical approach to increase opportunities for the use of artificial intelligence in medical education - DME

7. CONCLUSIONS

7.1 The Trust continues to have a pro-active and strong FoME. Feedback demonstrates more than ever that despite ongoing challenges; the Trust continues to achieve exceptionally high results in relation to the delivery of all medical education programmes.

8. RECOMMENDATIONS

8.1 It is recommended that the Trust Board note the content of this paper and take good assurance from it.

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