Healthier Greenwich Partnership (in public)

Date: Wednesday 23 April 2025
Time: 12.30 – 14.30
Venue: MS Teams Click here to join meeting
Chair: Iain Dimond

AGENDA

	Item	Page no.	Presented by	Time
Opening Business				
1.	Welcome, introductions and apologies.	Verbal	Chair	12.30
2.	Questions from the public related to today's agenda – to be submitted in advance	Verbal	Chair	12:35
3.	Declarations of interest	Verbal	Chair	12:45
4.	Minutes of the meeting held 22 January 2025	2	Chair	
5.	Action Log and Matters Arising	13	Chair	
6.	Chair rotation	Verbal	Iain Dimond	12:50
Public Engagement: Delivering our Healthier Greenwich Plan				
7.	HGP refresh and Joint Forward Plan	14	Chris Dance/Imogen Setter	13:00
8.	Neighbourhood Next steps	16	Gabi Darby	13:20
9.	Positive Partnership Story – Partnership working to improve acute flow during Super March	Verbal	Lisa Wilson/Erica Bond/Jo Sutcliffe	13:45
10.	Healthier Greenwich Charitable Funds update – Funding Awards and Funding Themes	24	Daniella Finch	13:55
Items for Noting				
11.	Healthier Greenwich Partnership – Chief Operating Officer Report	Appendix A – to be circulated separately	Gabi Darby	14:15
12.	Performance Report	26	Chair	
13.	Risk update	48	Chair	
Closing Administration				
14.	HGP Forward Planner	51	Chair	14:20
15.	Any Other Business	Verbal	Chair	14:25
16.	Next Meeting in public: 23 July 2025		Chair	
Meeting closes at 14:30				

Healthier Greenwich Partnership
Held in Public
Minutes of the meeting held on 22 January 2025
MS Teams

Members		**Voting member**	**Apologies**
Iain Dimond (Chair)	Chief Operating Officer, Oxleas NHS Foundation Trust (ID) (Chair)	Yes	
Nayan Patel	PCN Clinical Director (NaP)	Yes	
Niraj Patel	PCN Clinical Director (NiP)	Yes	
Gabi Darby	Chief Operating Officer, SEL ICB Greenwich (GD)	No	
Tuan Tran	Greenwich LMC (Local Medical Committees) Chair (TT)	No	
Florence Kroll	Director of Children's Services (FK)	Yes	Yes
Kate Heaps	Chief Executive, Greenwich, and Bexley Community Hospice (KH)	Yes	
Kate Anderson	Director of Corporate Affairs, LGT (KA)	Yes	
Jose Garcia-Lobera	Clinical and Care Professional Lead for Greenwich (JG)	Yes	
David James	Chief Executive, Greenwich Health (DJ)	No	
Steve Whiteman	Director of Public Health, RBG (SW)	Yes	
Nick Davies	Acting Director of Health and Social Care, Roya Borough of Greenwich (ND)	Yes	
Lisa Thompson	Director of Children & Young People's Services, Oxleas NHS Foundation Trust (LT)	No	
Mark Delacour	Metro GAVS (MD)	Yes	
Joy Beishon	Chief Executive Officer, Healthwatch Greenwich (JB)	No	
	Adult Social Care Provider	No	
Lisa Wilson	Integrated Director of Commissioning, Adults, RBG (LW)	No	
Dave Borland	Integrated Director of Commissioning, Children, RBG (DB)	No	
Jessica Arnold	Director of Primary Care & Neighbourhoods, SEL ICB, Greenwich (JA)	No	

In attendance	
Julie Mann	Business Support (Minutes) (JM)
Russell Cartwright	AD Comms and Engagement (RC)
Jane Thurston	Strategic Change Programme Lead, Integrated Commissioning Adults (JT)
Daniella Finch	Programmes Officer (Grants), Groundwork London (DF)
Imogen Setter	Senior Consultant, PPL (IS)
Maria Howdon	Assistant Director of Primary Care (MH)
Clare Simpson	Programme Director, Connecting Greenwich (CS)
Georgina Fekete	Non-Executive Director, SEL ICB (GF)
Chris Dance	Assistant Director of Finance, SEL ICB (CD)
Kelly-Ann Ibrahim	Senior Public Health Manager (Health Inequalities & Neighbourhood Development), Public Health Well-being/Royal Borough of Greenwich (KI)
Rebekah Middleton	SEL ICS People Programmes (observing by invitation from Kate Heaps) (RM)
Nupur Yogarajah	Clinical Care and Professional Lead (NY)
Samantha Bennett	Assistant Director Public Health, Health & Adult Services, Royal Borough of Greenwich (SB)
Johnson D'Souza	PCN Clinical Director (JdS)
Members of the public	**12**

Apologies	
Eugenia Lee	Clinical Care and Professional Lead (EL)
Florence Kroll	Director of Children's Services, RBG (FK) – voting member

1	**Welcome, introduction and apologies**
1.1	• The Chair welcomed the attendees and noted the attendance of Georgina Fekete, Non-Executive Director, SEL ICB who had joined to observe the meeting. • Noted that Rebekah Middleton, SEL ICS People Programmes, observing the meeting at the invitation of Kate Heaps
1.2	• Apologies as noted above
2.	**Questions from the public related to today's agenda**
2.1	Chair noted that a question had been submitted but did not relate to any agenda items. The question related to a sickle cell disease project, and connecting with local partners and gaining support for a coordinated approach. A response is being managed outside of the meeting.
2.2	Chair invited attendees to note any questions relating to the agenda items in the meeting chat function
3	**Conflicts of Interest - relating to agenda items**
3.1	The following potential conflicts of interest were noted relating to agenda item 10: Live Well: MSK Procurement Update: • Iain Dimond and Lisa Thompson - Oxleas NHS Foundation Trust • Johnson D'Souza – Valentine Health PCN • David James – Greenwich Health
3.2	The Chair advised that due to the COI, he would hand over Chairing for agenda item 10 to Gabi Darby, Chief Operating Officer, Greenwich
3.3	The committee noted that agenda item 10 is an update only and no decision making will be required at this meeting, therefore the potential conflicts are noted, but do not affect the agenda item
4	**Minutes of the meeting held 24 July and 11 December 2024**
4.1	The minutes of the meeting held on 24 July and 11 December 2024 were accepted and approved as a true record of the meeting
5	**Action Log and Matters Arising**
5.1	Chair requested that updates are emailed to JM
5.2	No matters arising
5.3	**Actions:** **Action Log updates to be emailed to JM**
6.	**Positive Partnership Story – Connecting Greenwich**
6.1	CS shared presentation Connecting Greenwich is creating environments that encourage people to connect & lead change to enable neighbourhood health in Greenwich by: • Changing the way we are doing things, not what we are doing • Building trusting relationships across all parts of the system and with our communities • Challenging the structures that limit us and focusing on people The following questions were posed to the committee:

	• How effective is the work, and how connected do people feel
	• Consider to what extent you are already connected and working in partnership across Greenwich
	
	Noted that:
	• 68% of practices are participating in the programme with more expressing interest
	• Linking in with existing neighbourhood programmes where we've already done lots of engagement through the public health teams
	• Plumstead and Glyndon delivery team of community leaders, system partners and residents have been working together since 2023 on needs and challenges in the neighbourhood and setting priorities.
	  ○ There is now an action plan for Plumstead and Glyndon with several working groups on young people and mental health, food and nutrition, digital inclusion, employability and a community garden
	  ○ The community is engaging with a variety of community groups, including the Nepalese community and faith groups
	• Abbeyslade and Thamesmead had identified under- diagnosed and poorly managed hypertension in a specific cohort
	  ○ Asked them how they would like to receive services and how to better connect with established communities
	  ○ Considering approaching via a local football team
	  ○ With a large Nepalese community, and Nepalese being the most spoken language, many experience language and cultural barriers accessing services - working with a local Nepalese social prescriber to overcome this
	  ○ There is a specific project working on communication channels
	• Work in communities must be tailored to each community

6.2	The Chair thanked CS for the positive story The following observations and queries were noted: • Good information on projects shared • All relates/links into neighbourhood working • Good to see the work and include community development work at the Community Hospice. CS and KH to discuss. • Hospice would like to be involved in discussions about how their estate can be utilised. CS and KH to discuss • How does cultural humility feed into this – training available from Shola Oladipo Cultural humility for services working with local communities - shola.oladipo@foodforpurpose.org • Suggestion to connect with Jude Emmanuel in relation to African men in Thamesmead • How does the connecting Greenwich work (noting it is organic) – how is this translated and moved across all areas of partnership and borough – how do you give different groups a platform • What is the structure to bring this work together with how we bring services closer to people where they live • How are connections between different areas of the borough being made .

6.3	JA responded:
	• Currently neighbourhood work is taking place in an accelerated fashion
	• Grouping into two categories
	  ○ A consistent offer across South East London looking at frailty, long term conditions, how we manage children and young people, etc.
	  ○ Neighbourhood geographies that are consistent in their population

	CS added: • Connecting Greenwich – will work across all cohorts/geography building relationships with communities • Needs to involve all partners to set the foundation for the future • Evaluations are helping to identify how to connect effectively • Evaluations are then used to develop a systematic approach • Human interaction can be difficult to measure, so DG Cities are helping with that element • Allows people to continue to apply learnings into local context • Need to encourage and enable ownership and adaption of what is in communities and what makes each community different • Important to note and be aware of cultural differences
6.4	**Actions:** • **CS and KH to discuss community work at Hospice and estate availability** • **CS to contact Jude Emmanuel re African men in Thamesmead**
7	**Update on process of HGP refresh**
7.1	**Note that agenda item 8 – 'Feedback from public forums' was integrated with this agenda item**
7.2	GD introduced the item and advised that papers were shared and relate to the established priorities, some of the slides were presented by IS • This is part of the Health and Wellbeing Strategy that was published in 2023 • Refreshing and identifying priorities for the next year • Identifying a shortlist of activities for next year • Yellow brick road shows the roadmap • Reviewed progress of last year, identified any challenges • Have met with SROs and delivery teams from each 'well' • At development workshop in November 2024 agreed on priorities for a partnership approach • Identified high impact activities • All items are important, but some are high priority that require all partners to be involved
7.3	**Feedback from public forums (originally item 8 on the agenda)**
	Comprehensive report from the public forum was circulated in advance Highlights: • Focussed on refresh – testing emerging priorities with local residents • Go into the community, somewhere local residents go • Had two events – one was face-to-face at Mycenae House, and one was online • Format worked well – allowed for better engagement • Tone was more positive, and solution focused • Had a good attendance with a total of 32 attendees at both events • There was a good balance of diversity at the events, with some new participants noticed as well • Feedback included: o Need to focus on the whole person and the whole family for support rather than individual conditions o There are wider needs than just ADHD and ASD o Schools and funding for children with special needs o Delays in funding cause issues for schools o Agreement that the priorities are important for helping people live happy, healthy lives

	○ Discussions about food accessibility and being able to access healthy, nutritious food ○ The role of food and exercise creating community cohesion ○ Cost of living crisis means that paying for healthy food and exercise is unaffordable ○ Council licenses being awarded to fast food outlets ○ Understanding barriers to people's health ○ What can be done to enable people to live well ○ Community spirit and signposting to community assets ○ Staff training to enable better communication and correspondence ○ Access to services can be difficult especially for those with disabilities ○ Language barriers ○ Digital communication, should be part of what is available but not the only solution ○ Support and advice to increase digital skills ○ Better support for the voluntary sector ○ Support for carers ○ Rich insights from local residents about how to implement some of the priorities • Will be using the feedback about future public forums, focussing on the individual wells to allow for more detailed discussions • Knowledge of Healthier Greenwich Partnership has increased from 3.2 to 4.3
7.4	GD advised: • Forum feedback has been shared with SROs • Good feedback from the teams, helping their planning on final version of priorities for next year • Plan finalisation should be able to be shared at the next meeting in public – April 2025
7.5	Comments and observations • More feedback and updates will be provided at the April meeting • Recognise that these events take a lot of effort and input • Resonates and reflected in feedback from residents and HealthWatch • How is this all being triangulated across the partnership – into an 'intelligence bank' • Lack of awareness of the Greenwich Community directory – not easy to navigate and not very useful – work needs to be done on that • How diverse was the attendance at the forums – is there data to support Some residents are not aware that they do have a voice • Must ensure voices of children and young people are included – adults and children's priorities do not always align • Need to pull feedback across all areas • Important to engage with people in an open and frank way • Do we provide context of what is needed to be achieved – so expectations can be managed • Do they know what support is available – need to be transparent about what can be done
7.6	The following responses were made: • Engagement triangulation – a lot of insight does come in – looking to set up a HGP engagement professionals' group which will involve partners to help plan strategically • Community directory – there is a contact address on the website that can be used to address issues • Representation – did collect data, there was a mixture of all groups – working age, disabled, all ethnicities – agree that more could potentially be done • Agree that those without a voice – do actually meet with those groups to create connections before meetings

	The Chair thanked RC and his team for all their work on the forums which ran smoothly and there was good engagement
8	**Feedback from Public Forums**
8.1	• This item was incorporated and addressed under agenda item 7
9	**Update on Greenwich Neighbourhood planning**
9.1	Papers were circulated in advance GD and ND advised: • Discussions about neighbourhoods have been taking place both nationally and locally, looking at the trajectory of how demand will change due to demographic changes in the future • Robust way of joining up services, including partnering with the voluntary sector • Aligning with what is happening across London, South East London and Greenwich • Delivering more care and support to people outside of residential settings, supporting people in their own homes • Progress to date o Good sign up and engagement with Connecting Greenwich o Also engaging with different partners – to identify neighbourhood deliverables o Core integrated neighbourhood team o There will be operational consistencies o Recognise that this is about removing fragmentations and not shoehorning everyone into specific areas o Helping to tackle health inequalities o Identifying those with multiple risk factors o Proactive approach o Can reduce referrals etc. o Holistic person-centred approach to care o Will need to evaluate and adjust • Operationally organise services • There are two main options o One with three groupings o One with four groupings o Currently testing the options and ensuring they work well with primary care groups • Currently in scope and design phase, moving into set up phase from February – to align and coordinate • Phase Three will be from April onwards – will be a test and learn approach – systemise what works, and evolve the approach • Conversations are also taking place across the council to ensure alignment • In the future there will be opportunities to examine the neighbourhood work in context and some other services e.g.: housing, safer communities, social care and home care • Do not want to lose focus on outcomes for residents • Also need to remember the role of key partners such as the voluntary sector
9.2	The following comments and observations were made: • Suggestion that the terminology should be Integrated Neighbourhood Working as Integrated Working Teams could create boundaries • Integrated Neighbourhood Working will have the patient at its heart • Important to recognise the power of terminology and the language that is used • Must bear in mind that some services (JET, District Nursing, COPD etc.) are borough wide, so may be hard to create divisions within those

	• Need to be careful that useful resources are not 'carved up' • Make use of current resources making sure to fragment less and communicate better • Will there be any additional resources for this

9.3	GD responded to the comments and observations:
	• Comments have been noted
	• Financial context:
	  ○ The partnership will need to consider what resources are available and how they can be used effectively
	  ○ It is doubtful that any additional funds will be made available

10	**Live Well: MSK Procurement update** **NOTE: The Chair handed over chairing of this item to Gabi Darby, Chief Operating Officer, Greenwich, due to potential conflict of interest as the Chair is also representative of a provider who might tender for MSK**
10.1	Papers were circulated in advance LW advised: • There have been several discussions at HGP about re-commissioning the MSK service • Had to ensure that there was good local engagement, including from patients, the workforce and our partners to inform what the model should be before going to procurement • The timeline has changed JT added: • Updated timeline is noted in the papers • Timeline was changed to ensure that local engagement concluded before the procurement process started • Service specification document has been updated • It is now a comprehensive multi-disciplinary service model which includes first contact practitioners, MSK podiatry, hand therapy and ultrasound with and without injections • The new service model addresses concerns about the service being disjointed • There was feedback about long waiting times on diagnostics – and this has now been included in the contract LW finalised: • Formal launch of the procurement has a revised date, which is noted in the pack • There will be an opportunity during the formal procurement process for potential partners or providers to ask clarification questions • It is important that we enter the formal procurement process so that it is fair to all potential partners
10.2	The following queries were raised: • Recognising that there was a meeting with clinical leaders, etc., will there be another meeting before the tender is issued
10.2i	Response: • Formal procurement process is noted in the circulated pack and includes when questions can be raised. Specific questions need be via the clarification process
10.3	**Gabi Darby returned Chairing of the meeting to the Chair**
11	**Healthier Greenwich charity**
11.1	A detailed paper was circulated in advance.

	DF advised:
	• Groundwork are working with HGP, ICB and borough public health teams to deliver the Greenwich Healthier Communities Fund
	• The programme aims to fund work that prevents and responds to health inequalities in Greenwich
	• Programme launched in April 2024
	• There are two main funding strands:
	  o Enabling – focussing on capacity building
	  o Delivery – focussing on new and existing work
	• 54 organisations have received funding
	• The success rate of getting funding is increasing
	• Receiving good feedback from those who apply but are unsuccessful
	• 73 applications for next delivery strand – currently being evaluated
	• Do want to increase engagement with the south of the borough
	• The fund will be re-launched in April 2025

11.2	The following comments and observations were noted: • Good achievements • This relates back to several discussion items on today's agenda items – all play into each other. • Connections and triangulations are being made, fitting in to other strategies • The fund is an incredible opportunity for funding until 2029 • Fits well with the Healthier Greenwich Partnership priorities • Need to align with the Health and Wellbeing strategy • Need to link into existing work on food, CYP, learning disabilities and other community resources • Communities fund can be applied to for additional resource • Can play into priority themes • What is being done about sustainability – multiyear funding • Are any metrics being measured
11.3	DF responded: • Sustainability – recognise this, hoping that with multiyear funding, organisations can apply throughout the five-year period • Looking into appointing an independent evaluator including after programme to help and check on organisations that have received funding, and ensure that their work can continue
11.4	**Actions:** **Updates to be provided at each quarterly public meeting** **Update to be noted on forwards planner by JM**
12	**Healthier Greenwich Partnership – Quarterly Partner Update**
12.1	This item is for noting
12.2	The Chair noted: • This is the second time using the new report format, if anyone has any comments on the report and format, they can contact the Chair
12.3	**Actions** **Any feedback on the quarterly partner updates to be advised to the Chair**
13	**Performance report**

13.1	• This item is for noting
13.2	The Chair noted: • Slides 96 and 97 detail current mitigations to improve some of the current lower performing areas
14	**Risk update**
14.1	• This item is for noting
14.2	The Chair advised: • Risks are being updated monthly • Eight risks have been reviewed and mitigations updated • If the committee would like a more detailed focus on risks, they should advise ID/GD or JM
14.3	**Actions:** **ALL to advise ID/GD/JM if there should be a more detailed focus on risks at a future meeting**
15	Forward planner
15.1	• This item is for noting
15.2	• The Chair advised that if any members have items for future agendas, these should be sent to JM
15.3	**Action:** **Future agenda item requests to be sent to JM**
16	**AOB**
16.1	JB noted: • Meetings in Public in Lambeth are operated differently • It is more supportive and facilitating for members of the public to be involved • Open questions are accepted, and these don't need to be submitted in advance
16.1i	RC responded: • Lambeth holds their public forums directly before the Meetings in Public, and some of the members of the public then stay for the rest of the meeting • Greenwich made a conscious decision to separate forums from meetings in public, enabling more meaningful conversations which are then reported back at the meetings • Acknowledge that there could be some learnings from the Lambeth approach
16.2	KH advised on the Assisted dying bill: • Second reading of the private members bill on Assisted Dying went through parliament in December 2024 • There is now a bill committee examining the bill to improve it before applying it in law • This is a very important conversation • Guidance from NHSE is that organisations cannot respond • Individuals are able to respond • Everyone encouraged to look at the bill and respond if they feel it is appropriate • Consultation hasn't been well publicised • Link to the consultation provide in the chat https://www.parliament.uk/business/news/2025/january/terminally-ill-adults-end-of-life-bill-call-for-evidence/
	Next meeting in public: 23 April 2025

Action Log - Open

Date of meeting	Minute reference	Action and updates	Lead	Deadline	Date closed
22/01/2025	15.3	All to advise JM of future agenda item requests	ALL	Ongoing	
22/01/2025	14.3	All to advise ID/GD/JM if there should be more detailed focus on risk at a future meeting	ALL		
22/01/2025	5.3	Members to email JM with updates on their items on the action log	ALL	Ongoing	
11/12/2024	3.8	NS to provide written confirmation to JM to notify the board that the bidder has been notified of their appointment	NS	12/12/2024	

AGENDA ITEM: 7

Healthier Greenwich Partnership

Date: 23rd April 2025

Title	LCP & Joint Forward View Refresh	
This paper is for **noting/approval**		
Executive Summary	SELICB have recently finalised a 'light touch' refresh of the Joint Forward View with a focus on streamlining content to support wider public engagement. The JFV has been developed following an in-depth re-fresh of the Local Care Plan over the past 6 months. Feedback received from HGP members during the consultation phase have been reflected within the final plans as appropriate. This is scheduled to be published in April.	
Recommended action for the Committee	HGP are asked to note the update.	
Potential Conflicts of Interest	None directly arise from this report	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	None arise directly from the report
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	For the JFV, ongoing Internal engagement with SROs, and commissioning leads to ensure the streamlined refresh of the Joint Forward View encapsulates the key priorities

Author:	Imogen Setter	
Clinical lead:	SROs: David Borland, Jessica Arnold, Lisa Wilson, Steve Whiteman	
Executive sponsor:	Gabi Darby	

AGENDA ITEM: 8

Healthier Greenwich Partnership

Date: 23 April 2025

Title	Neighbourhoods Next Steps
This paper is for **approval**	
Executive Summary	**Next steps on a Greenwich 'Integrator'** The Healthier Greenwich Partnership (HGP) has previously discussed the South East London ICB Neighbourhood framework. This framework includes a proposition for an 'integrator' that delivers a number of functions on behalf of health and care partners within a Place. **Wider context:** Since this work began there have been announcements in relation to corporate costs for the NHS – including proposed 50% reductions in ICB spend and a 50% reduction in the growth to provider corporate costs since the pandemic. This will create significant pressure the system. There have been long-standing ideas about how the NHS could move towards a model of more strategic, outcomes based commissioning and in turn enable and empower integrated providers to innovate care to delivery against population outcomes. There have been significant changes in both procurement legislation and maturity of outcomes data over recent years as well as greater flexibility in how commissioners and providers can work together in an ICS.
Recommended action for the Committee	The committee is asked: • To consider the options for evolving the partnership and delivery of the integrator functions, reducing reliance on the ICB. • Agree to undertake a 3-month project to develop and assess options for evolving and integrator/place-based function in Greenwich • To support the initiation of this work, provide input and agree to review the output in July 2025.
Potential Conflicts of Interest	Not applicable

Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	• Not required for the direct purposes of the report • It is likely that this proposal will have a positive impact of improving inequalities in Greenwich
	Financial impact	Not applicable
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	Not Applicable
Author:	Gabi Darby, Chief Operating Officer, Greenwich	
Clinical lead:	Not applicable	
Executive sponsor:	Not applicable	

Next Steps on Greenwich 'Integrator'

1. Introduction

The Healthier Greenwich Partnership (HGP) has previously discussed the South East London ICB Neighbourhood framework. This framework includes a proposition for an 'integrator' that delivers a number of functions on behalf of health and care partners within a Place.

2. The Integrator Concept

The functions of an integrator have been further defined since the framework was developed and the current draft stands as follows:

Support operational coordination between sectors and partners across the borough and between INTs, bridging the gap across the current reality of fragmented pathways and services by addressing the practicalities of collaboration (e.g., building interfaces and relationships, supporting workforce planning, and business intelligence).

Facilitate population health management (PHM) by promoting the sharing and effective use of data and real-time information across organisations, enabling holistic care for residents and improving population health outcomes. Integrators will need to provide access to real-time population health data, drawing down on regional and place infrastructure, to enable INTs to target interventions in proactively and preventatively addressing health inequalities and needs.

Address interface issues and share learning through coordinating discussions at Place level (e.g., sharing resources and managing care transitions) and escalating issues affecting multiple neighbourhoods to ensure system-wide alignment. They will need to facilitate cross-borough collaboration, spread and scaling of successful practice, ensuring continuous improvement and increasing alignment to the most efficient and effective models of local care.

Drive equity in access and outcomes across system, INT and Place levels using PHM data and working closely with partners (including VCSFEs) to identify and address disparities in access and care delivery, supporting INTs to meet local needs and reduce inequalities.

Lead the delivery of INTs, driving the test and learn approach: The integrator will work within system and place leadership structures, including with primary care and local government, and in partnership with all local providers to ensure that agreed local strategies and priorities for improving health and wellbeing are being translated into day-to-day delivery of services and care, and that the integrators are supporting the continuous improvement approach.

Support system sustainability and resilience supporting to identify and strategically manage where there might be issues and risks (e.g., alignment with CareTaker Arrangement)

Provide essential infrastructure for INTs, supporting people, finance, governance and risk management in a way which is consistent and cost-effective so that neighbourhood delivery becomes business-as-usual. This will include:

- Enabling shared use of estates from across the public, private and VCSE sector to enable co-location of services and public access where applicable
- Maintaining an up to date view of local assets, including the VCFSE sector, to ensure continual seamless delivery of Neighbourhood Health Services

3. Wider Context

Since this work began there have also been announcements in relation to corporate costs for the NHS – these include proposed 50% reductions in ICB spend and a 50% reduction in the growth to provider corporate costs since the pandemic. This will put significant pressure on us, as a system, to achieve efficiencies within our organisations, deliver 'the 3 shifts' and establish integrated neighbourhood working.

There is a risk that if all organisations dig down into their own cost saving plans, that we effectively maximise the productivity within organisations, but miss out on the opportunity to maximise productivity across organisations. For example, missing out on opportunities to

optimise workforce deployment across district nursing, reablement, homecare and practice nursing. The result would be bottlenecks in care pathways and a rise in unmet needs that could lead to worse outcomes and increase costs overall.

There have been long-standing ideas about how the NHS could move towards a model of more strategic, outcomes based commissioning and in turn enable and empower integrated providers to innovate care to delivery against population outcomes. For a range of reasons, this vision has proved hard to realise – with separate funding flows, procurement regulations and lack of maturity in outcomes frameworks and data analytics being amongst them. However, there have been significant changes in both procurement legislation and maturity of outcomes data over recent years as well as greater flexibility in how commissioners and providers can work together in an ICS. In Jim Mackay's recent letter to NHS Trust and ICBs he described 'the need to commission and develop neighbourhood health, with the delivery being a provider function over time.'

4. Greenwich Context

The 6 boroughs across South East London all have different eco-systems, as well as some commonality and commitment to consistency. In boroughs with a shared acute and community provider (LGT in Lewisham, GSTT for Lambeth and Southwark) these organisations seem likely to play a key role as an integrator, complimented with a wider partnership agreement. The Bexley integrator is being built out of the existing Bexley Care partnership between the Council and Oxleas, with work ongoing to include primary care. In Bromley, the ICB place team sees itself as the 'integrator' and they are seeking to further formalise the wider partnership through an alliance arrangement that will replace a long-standing MOU.

In Greenwich, we have strong relationships across partners but we have little in the way of formalised arrangements between them, beyond a shared membership of the Healthier Greenwich Partnership.

We have pockets of transformation capacity across the partnership – with capacity within the Royal Borough of Greenwich, ICB, Oxleas and LGT each with slightly differing skills and expertise. At times we also rely on third party transformation resource – which is occasionally necessary but as a principle we should seek to minimise.

5. Proposal

In Greenwich, we need to consider the options for evolving our partnership and delivery of the integrator functions, with reduced reliance on the ICB.

Each partner will have different success -criteria for such a model which needs to be understood in order to inform the options development. Overall, we collectively need to reduce to a minimum any duplication in roles and responsibilities, enable co-ordination of multiple professionals working within neighbourhoods, and ensure that we maintain a critical mass of system support and transformation capacity collectively to get stuff done. This would enable us to continue to improve our collective services for residents.

The proposed next step is to undertake a 3-month project to develop and assess options for evolving an integrator/ place-based provider function in Greenwich. From a legal perspective, there are multiple potential routes that could be utilised alone, or in combination, to combine

budgets, formalise shared governance and form integrated vehicles. Therefore, it proposed to engage specialist legal advice to support this work. The 3 main phases of the work would be:

1) Establish partner goals and success criteria for future arrangements
2) Develop options to achieve these
3) Assess option amongst the partnership – proposed for the July HGP

Does the HGP support the initiation of this work, to input into this work and agree to review the output in July 2025?

Greenwich Neighbourhoods – approach for 25/26

The 4 neighbourhoods

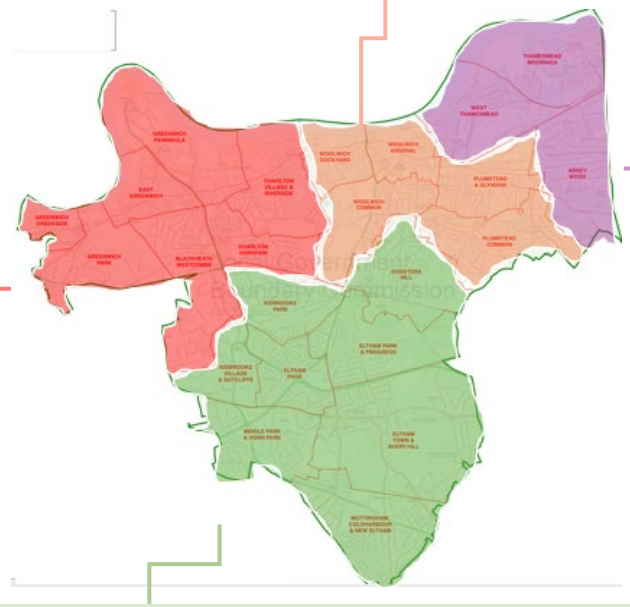
Overview of key social and health indicators across four "neighbourhoods" within Greenwich: **Central, East, West, and South Greenwich.**

Central-East Greenwich

- Severe socioeconomic and health disparities, with elevated hospital admission and mortality rates.
- Concerns: **highest income deprivation (18.8%)** and older people in poverty (36.3%), indicating significant socioeconomic struggles. **Worst hospital admission rates for COPD (SAR 157.0) and coronary heart disease (SAR 112.4)** in the borough. **Highest mortality rates across multiple categories, including all-cause mortality (SMR 111.2) and under-75 mortality (SMR 120.3).**

West Greenwich

- Faces lower health burden but challenges **in social isolation and overcrowding.**
- **Strengths: lowest emergency hospital admissions for all causes** (SAR 92.6), **fewer hospital admissions for coronary heart disease** (SAR 79.2) and myocardial infarction (SAR 63.3), **lower overall mortality** (SMR 100.7) and **all-cancer mortality** (SMR 96.0).
- **Health Concerns: stroke mortality rates (SMR 107.6) are higher than the borough average**. Lung cancer incidence (SIR 120.4) remains a concern. **Older people living alone (38.7%) is the highest among all areas**, raising social isolation concerns. **Overcrowded housing (19.4%)**, slightly exceeding the borough average (19.3%).



East Greenwich:

- **Concerns: high income deprivation** (18.5%) and older people in poverty (26.9%), **exceeding borough averages. Highest emergency hospital admissions for stroke (SAR 138.7) and COPD (SAR 129.3),** indicating poor respiratory and cardiovascular health. Severe **lung cancer incidence (SIR 142.1) and prostate cancer incidence (SIR 137.5), far exceeding borough averages. High all-cause mortality (SMR 120.2) and respiratory disease mortality (SMR 124.9),** the worst in Greenwich.

South Greenwich

- Mixed health trends with **rising cancer rates and mental health challenges**.
- **Strengths: lowest mortality from all causes** (SMR 92.3) in the borough, suggesting better health outcomes. **Lower emergency hospital admissions for stroke** (SAR 85.2) and myocardial infarction (SAR 68.9) than Greenwich overall. Mortality from circulatory diseases (SMR 91.8) is the lowest among all areas.
- **Concerns:** breast cancer incidence (SIR 111.3) and prostate cancer incidence (SIR 111.5) **exceed borough averages.** Hospital admissions for intentional self-harm **(SAR 41.9) are above the borough average.**

Goals for Year 1

Universal goals (for all neighbourhoods)

- All provider orgs to consider alignment to 4x footprints
- Support 4 x neighbourhood linkage into communities via:
  - Working with PH on community activation
  - GHCF encouraging VCSE collaboration within neighbourhoods for bigger bids
- Revision of incentives for all GPs to engage in risk strat, case finding and MDT approach within each neighbourhood (in both national contract and PMS premium)
- Clarification of target cohort and methodology for identification
- Expansion of proactive care approach (for multiple LTC, frail and EoL) for all neighbourhoods – ideally building (a)co-ordination function (b) VCSE input (c)consultant input. This is subject to ongoing workshops and planning.
- Mapping of core members of each neighbourhood and facilitating neighbourhood-level discussions on goals on operating model. Looking at use of N-R to facilitate to back fill and initial OD
- Continue to develop the same-day access offer – particularly focussing next year on ability to reduce avoidable UTC and ED usage
- Review use of estates to support integrated teams and services

Deeper dives/ development areas

1) Work via ARF and with HealthIntent team to really work through:

- Combined use of health and care data
- Design of data output and feed through delivery arm
- Incorporation of DHCS data output
- Link to intervention and evaluation

Is this something to really test in one network and then scale…

2) Deep dive look at integration of district nursing, homecare teams, reablement and other interfacing specialties – including look at other interfacing professionals, including practice nurses

3) Review outcomes of current children's pilot and determine next steps

Transformation support function:
- Programme support, service design, data expertise, coaching and OD support,

AGENDA ITEM: 9

Healthier Greenwich Partnership

Date: 23 April 2025

Title	*Healthier Greenwich Charitable Funds update – Funding Awards and Funding Themes*	
This paper is for **noting**		
Executive Summary	• *The Greenwich Healthier Communities Fund will relaunch at the end of April 2025. The Fund is being used to distribute approx. £6.6m from the NHS Greenwich Charitable Funds over 5 years to Volunteer Community Sector organisations that prevent/respond to health inequalities in Greenwich.* • *The Fund awards grants in 'Strands', which have different purposes. The Fund will relaunch with three strands: Enabling Strand, Micro Grants and Delivery Strand.* • *The Delivery Strand will also be split into Small, Medium and Large awards. The Medium and Large Awards will have set themes; Improving Health Outcomes for People with Learning Disabilities and/or Autism, Tackling Isolation, Long-Term Conditions and Active Healthy Living for Children and Young People*	
Recommended action for the Committee	• *Note for reference and to share this funding opportunity with relevant networks*	
Potential Conflicts of Interest	• *N/A*	
Impacts of this proposal	Key risks & mitigations	• *N/A*
	Equality impact	• *Fund works to tackle health inequalities*
	Financial impact	• *N/A*
Wider support for this proposal	Public Engagement	• *Members of the public and grantees were consulted to help formulate the selection of*

		these themes – through community consultation events and feedback surveys.
	Other Committee Discussion/ Internal Engagement	• *Theme proposals were opened up via a pro forma that was shared after the last HGP meeting in February 2025.* • *Partners have been consulted on this including RBG Public Health, RBG Children & Young People & Oxleas*
Author:	*Daniella Finch*	
Clinical lead:	*N/A*	
Executive sponsor:	*N/A*	

AGENDA ITEM:12

Healthier Greenwich Partnership

Date: 23 April 2025

Title	**LCP Performance Report and summary of mitigations to address underperforming priority indicators in Greenwich**	
This paper is for **noting.**		
Executive Summary	The Greenwich Local Care Partnership Performance Data Report has been published for data up to and including March 2025. This summarises Greenwich's achievement against a suite of Key Performance Indicators that reflect our directly delegated responsibilities in Greenwich and our contribution to wider SEL objectives. The Report is produced by NHS South East London ICS assurance colleagues. The Performance Data Report covers 27 individual indicators, most of which Greenwich is rated as 'Red' against target / benchmarks. The areas where we are above target relate to: • CHC assessments and referrals • LD Health Checks • Bowel Cancer screening • Flu vaccination uptake for at-risk under 65s There are a small number of GP appointment access measures that are not RAG rated as there are not targets set against these. For the performance indicators where Greenwich is rated 'Red' from the March data (or not rated), please find enclosed a brief summary of the various mitigations being led by ICB and Integrated teams to improve our performance in coming months.	
Recommended action for the Committee	To note and discuss the report.	
Potential Conflicts of Interest	None – this performance report is for noting and discussing.	
Impacts of this proposal	Key risks & mitigations	The risks around poor and potentially worsening performance are outlined in the enclosed summary of mitigations.

		Significant cuts to ICB and potneitally Integrated team staffing levels may have an impact on Greenwich's (and SEL's) ability to mitigate risks and improve performance in key areas. Therefore the collaborative efforts of all Greenwich LCP partners will be crucial in the medium and longer terms for ensuring the best possible outcomes for the health and care of Greenwich patients and residents.
	Equality impact	Not applicable.
	Financial impact	None.
Wider support for this proposal	Public Engagement	No public engagement on this report itself; however, a number of the individual work areas that delivery against performance metrics do include public engagement where appropriate.
	Other Committee Discussion/ Internal Engagement	None.
Author:	Jessica Arnold, Director of Primary Care and Neighbourhoods, Greenwich ICB	
Clinical lead:	Various, relating to the different metrics, work plans and deliverables.	
Executive sponsor:	Gabi Darby, Chief Operating Officer, Greenwich ICB	

South East London Integrated Care System

NHS South East London

Greenwich Local Care Partnership
LCP performance data report

March 2025

Introduction and summary

Reported metrics

Overview of report

- Areas of performance delegated by the ICB board to LCPs.
- Metrics aligned to the six ICB corporate objectives that fall within delegated responsibilities LCPs.
- Metrics requested for inclusion by LCP teams.

here.

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Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↓	Jan-25	National standard	67%	64%
IAPT discharge	↑	Dec-24	Operating plan	321	320
IAPT reliable improvement	↓	Dec-24	Operating plan	67%	66%
IAPT reliable recovery	↓	Dec-24	National standard	48%	46%
SMI Healthchecks	↑	Q3	Local trajectory	68%	49%
PHBs	↑	Q3 - 24/25	Local trajectory	662	498
NHS CHC assessments in acute	↔	Q3 - 24/25	National standard	0%	0
CHC - Percentage assessments completed in 28 days	↓	Q3	Local trajectory	75%	81%
CHC - Incomplete referrals over 12 weeks	↔	Q3 - 24/25	Local trajectory	0	0
Children receiving MMR1 at 24 months	↓	Q2 - 24/25	PH efficiency standard	90%	85%
Children receiving MMR1 at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	83%
Children receiving MMR2 at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	72%
Children receiving DTaP/IPV/Hib % at 12 months	↓	Q2 - 24/25	PH efficiency standard	90%	87%
Children receiving DTaP/IPV/Hib % at 24 months	↓	Q2 - 24/25	PH efficiency standard	90%	87%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	69%
Children receiving DTaP/IPV/Hib % at 5 years	↓	Q2 - 24/25	PH efficiency standard	90%	87%
LD and Autism - Annual health checks	↑	Jan-25	Local trajectory	906	1128
Bowel Cancer Coverage (60-74)	↑	Jul-24	Corporate Objective	65%	66%
Cervical Cancer Coverage (25-64 combined)	↓	Jun-24	Corporate Objective	66%	66%
Breast Cancer Coverage (50-70)	↑	Jul-24	Corporate Objective	59%	58%
Percentage of patients with hypertension treated to NICE guidance	↑	Feb-25	Corporate Objective	71%	68%
Flu vaccination rate over 65s	↑	Jan-25	Corporate Objective	66.0%	61.5%
Flu vaccination rate under 65s at risk	↑	Jan-25	Corporate Objective	34.0%	35.1%
Flu vaccination rate – children aged 2 and 3	↑	Jan-25	-	-	38.1%
Appointments seen within two weeks	↓	Jan-25	Operating plan	91%	93%
Appointments in general practice and primary care networks	↑	31 Jan-25	Operating plan	-	128846
Appointments per 1,000 population	↑	Jan-25	-	-	393

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Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Dementia diagnosis rate	↑	**Oct-24**	**National standard**	**67%**	**65%**
Plans are in progress for 2025 to support general practice to improve rates of early dementia diagnosis and coding, and to ensure newly diagnosed patients are appropriately signposted and their carers supported in primary care. However, the main risks associated with this are now lack of capacity within the ICB Primary Care team to support this, and we are looking at potential solutions to provide both the expertise/skills and capacity to focus on dementia diagnosis rates and quality of support.					
SMI Healthchecks	↓	**Q2**	**Local trajectory**	**66%**	**48%**
Focussed work between primary Care and Oxleas continued to ensure progress is sustained. Performance has slightly dropped however the learning from the previous actions supported by HIN activity will continue. Performance is shared with the MH Oversight and Coordination Board and collective actions agreed where required.					
PHBs	↑	**Q2 - 24/25**	**Local trajectory**	**488**	**362**
There has been a range of co production work with residents and staff over the last year to understand what's working well/ what could be improved around self- directed support offers including increasing access to PHBs. This has led to the development of action plans to improve the offer including self-directed to those who have Direct Payments and encouraging more uptake. Work will continue to embed these changes and consider where the newly developed Individual Service Fund offer may support those with both health and joint health and care needs. This includes work to increase uptake for those with MH and S117 needs.					
Children receiving DTaP/IPV/Hib % at 5 years	↑	**Q1 - 24/25**	**PH efficiency standard**	**90%**	**89%**
An immunisations and vaccination coordinator joined the primary care team in September 2024 and has begun to audit the recall processes of lower performing practices. The sharing of best practices from higher uptake practice will be disseminated as a recall guide and template Call and Recall SOP. The Connecting Greenwich practice development team have facilitated two Childhood immunisation thinking councils with relevant stakeholders to agree initiatives to take forward locally to improve uptake.					
Percentage of patients with hypertension treated to NICE guidance	↑	**Oct-24**	**Corporate Objective**	**69%**	**65%**
Regular data is being sent out to Practices regarding their performance against the hypertension target, together with information and resources regarding how to make improvements (learning from high performing practices).This is a regular agenda item on the LTC programme group meeting. Greenwich is currently the best performing borough in SEL for hypertension, however further work is required to meet the corporate and national target. Working together with Public Health, CESEL and Meds Optimisation to increase awareness and prioritisation with Practices. QoF has increased its funding and points allocation to meet the hypertension target which should support increased performance. Working with SEL CVD group to deliver hypertension education webinars to all primary care clinicians across SEL. Have reached out to Bannockburn Practice (Plumstead) to showcase how they have achieved the best results in the borough.					
Flu vaccination rate – children aged 2 and 3	↑	**Oct-24**	**-**	**-**	**30%**
By the flu season end, uptake among 2 and 3 years olds in Greenwich reached 36%. The Greenwich Community of Clinical Influence was held to reflect on the delivery of the winter vaccination programme and develop plans to improve uptake in the following season. Proposed strategies included targeted flu promotion and encouraging or incentivising practices to hold clinics in non-clinical, child-friendly settings e.g. libraries, play and stays and community centres.					
Appointments per 1,000 population	↑	**Oct-24**	**-**	**-**	**449**
We have worked closely with Greenwich's 29 practices and seven PCNs to ensure delivery of the national Primary Care Access Recovery Plans. All PCNs have achieved the standards for utilising digital telephony and implementing care navigation. The standard for online consultations through all core hours has been met by 4 out of 7 PCNs, and the remaining 3 PCNs will deliver this by 1st October 2025. 27 out of 29 practices have worked on a transition plan to implement new ways of working including implementing triage tools to allow them to identify which patients need to be seen and by whom, which can be managed remotely by telephone or online, and which can be redirected to other services such as community pharmacies. This is helping to provide additional appointments and sooner to the patients who need them. The remaining two practices continue to receive support.					

Standard	Trend since last period	Period covered in report	Comparator	Benchmark	Current performance
Children receiving MMR1 at 24 months	↑	Q1 - 24/25	PH efficiency standard	90%	86%
Children receiving MMR1 at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	85%
Children receiving MMR2 at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	76%
Children receiving pre-school booster (DTaPIPV%) % at 5 years	↓	Q1 - 24/25	PH efficiency standard	90%	72%
Children receiving DTaP/IPV/Hib % at 5 years	↑	Q1 - 24/25	PH efficiency standard	90%	89%

Measles outbreaks in London and Birmingham in the first half of 2024 prompted a concerted MMR campaign to improve coverage. Uptake of MMR1 has improved to 87% of children aged 5yrs, and MMR2 Uptake in children aged 5yrs is currently 77%. Three community pharmacies have been accredited to deliver MMR vaccines to children aged 5 and over and the program will continue for another year. A programmatic advertising campaign planned for the summer of 2025 to promote the MMR vaccinations available in community pharmacies and community clinics run by the HRCH Children and Young People's Immunisation Service.

SEL context and description of performance

- The 2024/25 priorities and operational planning guidance identifies improving quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025 as a National NHS objective. Dementia diagnosis rate is defined as the diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.
- South east London is achieving this target. January 2025 performance was 69.8%.
- There is, though, variation between boroughs. Greenwich has not achieved the target in 2024/25 (or during 2023/24).

		Jan-25						
Metric	**Target**	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
Dementia diagnosis rate*	**66.7%**	**71.9%**	**70.9%**	**64.3%**	**76.6%**	**62.3%**	**71.6%**	**69.8%**
Trend since last report	-	↑	↓	↓	↓	↓	↔	↓

*Nationally reported borough-level dementia diagnosis rates are aggregated based on the postcode of individual GP practices mapped to UTLAs. This does not map exactly to NHS geographies. This means that a single Lambeth practice is included as part of the figures for Southwark, and practices that serve the wider ICB (e.g. SEL Special Allocation Practice) are allocated to an individual borough.

**Reported Lewisham performance has fallen from 69% in September. The new Lewisham Care Home Practice has not been included in the nationally reported data from October 2024, which likely accounts for the reduction in dementia register size.

Talking Therapies

South East London Integrated Care System

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SEL context and description of performance

- New metrics to measure performance of NHS Talking Therapies have been introduced for 2024/25. These new targets have been welcomed by services, but they will need to adjust their delivery in line with these. New targets are as follows:
  - Number of patients discharged having received at least 2 treatment appointments in the reporting period, that meet caseness at the start of treatment.
  - Reliable improvement rate for those completing a course of treatment.
  - Reliable recovery rate for those completing a course of treatment and meeting caseness.
- The target for the number of patients discharged following at least two treatments has not been met since April 2024 and is now at its lowest level this financial year. Reliable improvement and reliable recovery targets have been achieved but is variable across individual services.

	Dec-24						
Metric	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
Talking Therapies discharge metric	120	155	320	485	425	295	1765
Trajectory	176	261	321	585	355	406	2119
Trend since last reporting period	↓	↓	↑	↓	↑	↓	↓

		Dec-24						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable recovery	48%	48.0%	45.0%	46.0%	53.0%	47.0%	45.0%	48.0%
Trend since last report	-	↔	↓	↓	↔	↑	↑	↔

		Dec-24						
Metric	Target	Bexley - MIND	BHC	Greenwich (Oxleas)	Lambeth (SLaM)	Lewisham (SLaM)	Southwark (SLaM)	SEL
TT reliable improvement	67%	64.0%	65.0%	66.0%	70.0%	70.0%	60.0%	67.0%
Trend since last report	-	↓	↓	36 ↓	↑	↑	↔	↔

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SEL context and description of performance

- The south east London ICB board has set Improving the uptake of physical health checks for people with SMI as a corporate objective.
- There was a significant increase in the number of AHCs undertaken for people with an SMI during 2023/24 and the SEL operating planning trajectory was achieved at the end of 2023/24. All LCPs significantly improved their position and delivered health checks to over 60% of their registers. Indicative trajectories, aligning with the SEL operational plan, were met by 3 out of 6 LCPs.
- As part of the operational planning process, a trajectory to achieve 70% uptake by the end of 2024/25 has been agreed for south east London.
- SMI physical health checks is also part of the 2024/25 Quality and Outcomes Framework (QOF) with an aim to reduce health inequalities. QOF rewards practices for delivering all six elements of the check.
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Q3 - 24/25						
Metric	**Bexley**	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**	**SEL**
SMI Healthchecks	54.4%	47.5%	49.0%	54.6%	45.2%	53.4%	50.6%
Trajectory	67.9%	67.9%	67.9%	67.9%	67.9%	67.9%	67.9%
Trend since last report	↑	↑	↑	↑	↑	↑	↑

***NOTE:** The above figures have been calculated based on published LCP performance for Q3: Physical Health Checks for People with Severe Mental Illness - NHS England Digital.

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SEL context and description of performance

- As part of the Long Term Plan, annual borough level targets were submitted for the total number of PHBs to be delivered annually up to the end of 2023/24. The regional team have extended the targets into 2024/25. For SEL the target is to achieve 4,926 by the end of Q4.
- The personal wheelchair budgets offer is in place across SEL and PHBs for mental health service users. This has been introduced through the South London Partnership.
- S117 PHBs have been a 'right to have' since December 2019, but this still needs implementing through SLAM and Oxleas.
- Preventative small PHBs have been introduced, linked to social prescribing in Lewisham for people with low level mental health needs, where an immediate solution or intervention isn't available. The intention is to expand the offer to all PCNs. This is primarily offered through Age UK currently.
- There is ongoing support to LCPs to implement the personalisation agenda and expand their PHB provision. A 'Community of Practice' has been developed to support the workforce to implement personalised care across the ICS. Issues relating to DPIA and data sharing agreements have been resolved.

	Q3 - 2024/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
PHBs	918	1071	498	382	219	335	3438
Trajectory	535	764	662	739	611	586	3898
Trend since last report	↑	↑	↑	↑	↑	↑	↑

SEL context and description of performance

- There are a number of national standards which systems are required to achieve consistently. Where deviating from the standard, there is an expectation that performance will be addressed as a priority. Performance standards are as follows:
    - A national target was previously set to reduce the number of CHC assessments in an acute hospital setting to less than 15%. The aim, however, is that zero assessments should be completed in an acute setting and this is the benchmark that LCP and ICB teams are measured against.
    - Complete assessments of eligibility within 28 days from the date of referral in >80% cases.
    - Reduce the number of outstanding referrals exceeding 12 weeks to Zero
- Recovery trajectories for the 28 day and 12 week metrics have been agreed with NHSE.

		Q3 - 24/25						
Metric	Target	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
NHS CHC assessments in acute	0	0	0	0	0	2	0	2
Trend since last reporting period	-	↔	↔	↔	↔	↑	↔	↑

	Q3 - 24/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Percentage assessments completed in 28 days	74%	93%	81%	41%	80%	62%	78%
Trajectory	75%	75%	75%	75%	75%	75%	75%
Trend since last reporting period	↑	↑	↓	↓	↑	↓	↑

	Q3 - 24/25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
CHC - Incomplete referrals over 12 weeks	0	0	0	0	2	0	2
Trajectory	0	0	0	0	0	0	1
Trend since last reporting period	↔	↔	↔	↓	↑	↔	↑

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NHS South East London

Description of metric and SEL context

- Vaccination saves lives and protects people's health. It ranks second only to clean water as the most effective public health intervention to prevent disease. Through vaccination, diseases that were previously common are now rare, and millions of people each year are protected from severe illness and death. South East London and our 6 local care partnerships recognise this in the ICS Strategic Priorities and our Joint Forward Plan.
- South East London ICB has recently refreshed its Vaccination and Immunisation Strategy and has embedded within the six boroughs an approach to increase uptake by developing trust and confidence in the childhood immunisation programme with local communities.
- Since December 2023 there have been a number of reported cases of measles across the country resulting in a national and regional response. SEL boroughs and programme team are co-ordinating and aligning plans across the system in response to the concerns. A full report detailing the position and proposed actions was agreed at the ICB Executive Committee in February 2024. Actions include: SRO/director level attendance at London IMT meetings; production of regular sitrep feeding up to London IMT; A sub-group of the SEL board meets on a regular basis with borough leads, public health, communications and primary care leads to co-ordinate the local response and to support local plans. Each borough has produced a local action plan and are using their local place level vaccination groups to support delivery.
- Borough plans are also in place in response to the rise in numbers of whooping cough numbers and the imperative to focus on the full range of childhood immunisations including pertussis and flu.
- The 24/25 operational planning guidance identifies the following as a key action for systems: maximise uptake of childhood vaccinations and flu vaccinations for CYP, achieving the national KPIs in the Section 7a public health functions agreement, including reducing inequalities. The 25/26 operational guidance states that it remains critical that ICSs explicitly agree local ambitions and delivery plans for vaccination and services aimed at addressing the leading causes of morbidity in all age groups, including CYP.
- The performance indicators have an efficiency standard of 90% and an optimal performance standard of 95% for childhood immunisations. Based on current performance for south east London (and London more widely), the 90% efficiency standard is used as the comparator for RAG ratings in the 2024/25 LCP performance below. This is a change in approach compared to previous year (which used the national average as comparator)

		Q2* - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 24 months	90%	84.8%	86.9%	84.9%	79.5%	84.8%	78.3%	83.2%	80.0%	88.8%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

		Q2* - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR1 at 5 years	90%	86.1%	87.1%	82.7%	79.8%	83.3%	82.6%	83.6%	81.8%	91.2%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

		Q2* - 24/25								
Metric	Efficiency standard	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving MMR2 at 5 years	90%	74.5%	81.1%	72.4%	70.0%	76.8%	72.5%	74.7%	69.5%	83.4%
Trend since last reporting period	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

***Important note: Data now includes unregistered children; previous submissions only included children registered with a GP.**

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Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 12 months	90%	88.8%	89.7%	87.4%	84.7%	86.7%	87.2%	87.3%	84.5%	90.7%
Trend since last report	-	↓	↓	↓	↓	↓	↑	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 24 months	90%	89.4%	91.5%	87.4%	85.8%	88.0%	84.8%	87.7%	85.9%	92.1%
Trend since last report	-	↓	↓	↓	↓	↑	↓	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving pre-school booster (DTaPIPV%) % at 5 years	90%	73.0%	75.1%	68.6%	63.4%	69.2%	60.9%	68.5%	62.9%	80.8%
Trend since last report	-	↓	↓	↓	↓	↓	↓	↓	↓	↓

Metric	Efficiency standard	Q2* - 24/25 Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL	London	England
Children receiving DTaP/IPV/Hib % at 5 years	90%	85.7%	90.0%	86.7%	83.6%	86.2%	85.6%	86.4%	84.8%	92.6%
Trend since last report	-	↓	↓	↓	↓	↑	↑	↓	↓	↓

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*Important Note: Data now includes unregistered children; previous submissions only included children registered with a GP.

SEL context and description of performance

- The south east London ICB board has set improving the uptake of physical healthchecks for people with LDA as a corporate objective.
- SEL achieved the 2023/24 plan with 7,104 health checks delivered against a plan of 6,018. The SEL plan for 2024/25 is to deliver a minimum of 6,600 health checks.
- All LCPs are currently delivering against the 2024/25 trajectory
- Where annual health checks are being completed, quality can vary as can onward referral to other physical health services.

	Jan-25						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
LD and Autism - Annual health checks	736	885	1128	1130	1202	893	5974
Trajectory	675	695	906	935	1094	710	4825

South East London Integrated Care System

NHS South East London

SEL context and description of performance

- The south east London ICB board has set improving breast, bowel and cervical screening a corporate objective. At an SEL level, bowel cancer screening coverage is currently above the nationally defined optimal level of screening of 60% for south east London. Cervical cancer screening is currently below the nationally defined optimal level of screening of 80%. Breast cancer screening is currently below the nationally defined optimal level of screening of 70-80%.
- For 2023/24, SEL set overall ambitions for improving breast, bowel and cervical screening a corporate objective. Indicative LCP level targets were also developed for 2024/25 and shared via the six Place Executive Leads (PELs). These are based on a standard proportional reduction in the unscreened population at an LCP level for each cancer cohort. 2024/25 performance will be reported against these trajectories.
- This means that there is an expectation that all LCPs will improve uptake in 2024/25 but those with a lower current uptake will have a slightly larger stretch for the year. Thus, supporting a reduction in inequality between boroughs. LCP and ICB performance is now being reported against the 2024/25 trajectories.
- Screening is directly commissioned by NHS England, and delivery is through regional teams. Changes to programme, workforce, capacity etc. require NHS England to action. Given this, we rely on a joint approach with other London ICBs on common issues within these areas and advocate for regional solutions such as addressing workforce and capacity challenges within programmes, improving processes and operational pressures, and coordinating potential mutual between screening providers. Local actions for SEL require focus on improvements within the current programme structure/resource.

	Jul-24						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Bowel Cancer Coverage (60-74)	73.8%	75.8%	65.5%	61.8%	63.9%	62.5%	67.6%
Trajectory	72.8%	75.3%	65.2%	62.3%	63.1%	62.2%	67.3%
Trend since last reporting period	↑	↑	↑	↑	↑	↑	↑

	Jun-24						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Cervical Cancer Coverage (25-64 combined)	71.5%	73.7%	66.0%	62.7%	67.4%	63.6%	66.9%
Trajectory	72.1%	74.4%	66.2%	63.3%	68.0%	64.4%	67.4%
Trend since last reporting period	↓	↓	↓	↓	↓	↓	↓

	Jul-24						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Breast Cancer Coverage (50-70)	70.1%	71.3%	57.7%	56.0%	57.7%	59.1%	62.1%
Trajectory	70.4%	73.5%	59.4%	57.5%	59.0%	57.4%	63.0%
Trend since last reporting period	↑	↓	↑	↑	↑	↑	↑

NOTE: Due to lag in national reporting, local data is shown. This uses the same Open Exeter data source

SEL context and description of performance

- The south east London ICB board has set improving the percentage of patients with hypertension treated to NICE guidance as a corporate objective. The board agreed a 'floor' level ambition of 69.7% as a minimum by March 2024 with the intention to achieve 77% (2023/24 operational plan target) as soon as possible.
- The SEL 'floor' level ambition for 2023/24 was achieved overall and by five of six LCPs individually. Significant improvement was achieved across all LCPs.
- The 2024/25 priorities and operational planning guidance identifies increasing the percentage of patients with hypertension treated to NICE guidance to 80% by March 2025 as a national objective. For 2024/25, this will remain the primary aspirational goal for SEL. SEL will also pursue a 'minimum achievement' target (which will serve as the revised SEL ICB corporate objective) to achieve 80% over a 2 year time period (i.e. by end March 2026). This approach has been agreed by the PELs.
- 2024/25 performance will be reported against straight line trajectories for each LCP to achieve the 80% target by March 2026.
- There is a significant time lag (of approximately 4 months) in the publishing of national reporting (CVD PREVENT) of this metric. To support local monitoring of performance, the SEL LTC team have used the local data as the basis for trajectories up to March 2026.
- Hypertension is predominantly managed in general practice and there is wide variation in achievement across practices, not always explained by demography. People at risk may not have sufficient support to understand the importance of detecting and managing raised blood pressure.

	Feb-25 (Local data reporting)						
Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Percentage of patients with hypertension treated to NICE guidance	63.0%	65.0%	68.0%	66.0%	60.0%	68.0%	65.0%
Trajectory	69.9%	71.7%	71.4%	71.2%	68.2%	71.0%	70.6%
Trend since last report	↑	↑	↑	↑	↑	↑	↑

Note: Recent data migration has resulted in correction to historic data.

SEL context and description of performance

- The south east London ICB board set improving adult flu vaccination rates as a corporate objective. The ambitions for 2023/24 was as follows: improve the vaccination rate of people aged over 65 to 73.7%, improve the vaccination rate for people under 65 at risk to 46.0%.
- Performance in 2023/24 (year 1) was significantly below ambition for both metrics and represented a decrease in performance from the previous year.
- In order to ensure that 24/25 ambitions were informed by place, their knowledge of and insights into their local population, their role in commissioning services and their strategic plans for delivery, each borough team have set their own ambitions to improve uptake for the two main adult flu cohorts for the upcoming flu season.
- The below table provides targets set at borough level
- The following slide provides the published November borough level performance and the preliminary 12 January borough level performance vs trajectory

Year end targets for 2024/25 proposed by borough teams:

	65+ cohort vaccination target for 2024/25 season	<65 at risk cohort vaccination target for 2024/25 season
Bexley	75.0%	42.0%
Bromley	76.2%	46.5%
Greenwich	66.4%	36.9%
Lambeth	60.0%	32.9%
Lewisham	61.0%	34.3%
Southwark	61.5%	34.2%
SEL	68.1%	37.3%

South East London Integrated Care System

NHS South East London

Published January Performance

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	69.7	72.9	61.5	54.2	53.7	55.4	62.7
Local December trajectory	70.0%	74.7%	66.0%	59.0%	60.8%	60.9	66.5%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	35.5	39.1	35.1	29.6	28.9	31.7	32.9
Local December trajectory	40.0%	45.6%	34.0%	32.7%	32.6%	33.2%	36.0%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	35.7%	48.7%	38.1%	36.8%	38.4%	37.1%	39.4%

Provisional data to 26 January 2025*

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Over 65s vaccinated	69.6%	72.7%	61.3%	53.8%	53.5%	55.2%	62.5%
Local January trajectory	70.0%	74.7%	66.0%	59.0%	60.8%	60.9%	66.5%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Under 65s at risk vaccinated	35.3%	39.0%	34.8%	29.3%	28.8%	31.3%	32.7%
Local January trajectory	40.0%	45.6%	34.0%	32.7%	32.6%	33.2%	36.0%

Metric	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Children aged 2 and 3 vaccinated	35.9%	48.6%	38.0%	36.5%	37.6%	36.7%	39.2%

*Borough level performance has been calculated from non-mandatory automated practice level data uploads. Coverage for all borough is >95% of practices

SEL context and description of performance

- The 2024/25 Priorities and Operational Planning guidance identifies the following as a national objective for 2024/25:
    - Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
- The following trajectories have been agreed at an SEL level as part of the annual planning process:
    - Planned number of general practice appointments.
    - Percentage of patients whose time from booking to appointment was two weeks or less for appointment types not usually booked in advance.
- Appointments totalled 790,111 in November against the operating plan of 804,747. SEL did not achieve the planning trajectory for appointments seen within 2 weeks (89.0% vs 91.0% trajectory).

		Jan-25						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments seen within 2 weeks	91.0%	89.8%	85.3%	93.3%	91.4%	86.5%	88.8%	89.2%

		Jan-25						
Metric	Planning trajectory	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	SEL
Appointments in general practice and primary care networks	727247	119408	144433	128846	186600	125724	127313	832324
Appointments per 1,000 population	-	456	401	393	412	351	351	392

AGENDA ITEM: 13

Healthier Greenwich Partnership

Date: 23 January 2025

Title	HGP Risks update	
This paper is for **noting**		
Executive Summary	The paper provides update about the latest review of some of the risks on Greenwich risk register. A range of actions are being undertaken to manage and mitigate the various risks.	
Recommended action for the Committee	HGP to note the update.	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	Not Applicable
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	Not Applicable
Author:	Business Support Lead Greenwich	
Clinical lead:		
Executive sponsor:	Gabi Darby, Chief Executive Officer, Greenwich	

Greenwich Risk Report with Review Comments

Enterprise Risk Manager View (with Risk Owner),

Risk ID	Created Date	Risk Owner	Risk Sponsor	Risk Title	Risk Description	Initial Likelihood	Initial Consequence	Initial Rating	Controls	Gaps in Control	Current Likelihood	Current Consequence	Current Rating	Assurances	Gaps in Assurance	Target Likelihood	Target Consequence	Target Rating	Review Date and Comment	Next Review Dy
464	13/7/23	Aideen Silke	Jessica Arnold	Risk to engagement with Greenwich communities.	There is a risk that residents will not engage with the programme and that communities will not see that they have a valuable role in this. There is a risk that there is insufficient capacity in the system to allow effective integrated teams to be developed at individual neighbourhood level. There is a risk of disconnect between patient report outcomes and community based outcomes. The impact on the HGP is potentially significant if it is not possible to achieve this priority which is also part of the Our Greenwich focus.	3	3	9	Developing appropriate communication plan that would address need of residents, ensure they feel listened to, and target the different parts of the community. This is partly included in the 100-day challenge, but would need a refined approach as part of our Neighbourhood engagement., Ensure there will be appropriate oversight for this work to ensure involvement of residents voice. This work needs to be appropriately resourced. The oversight would be provided through the Health Inclusion Steering Group and Integrated Neighbourhood Working Group., Understand and define patient outcomes that would be focused on, and making sure they are appropriately captured and reviewed. Develop a way of capturing and using appropriate data., Work to be undertaken to understand what services are operating within neighbourhoods and how they are currently working together; determine what needs to change, and what resources are required to enable an integrated neighbourhood based approach.	There are no gaps in controls	2	3	6	HGP Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	2	2	4	19/09/2023 - 1. A Social researcher has been nominated for 6 months to work with three neighbourhood areas and to develop a a community engagement approach for Greenwich, including working with community researchers. There will be evaluation of the impact of this approach of community engagement on reducing winter pressures. Some winter funding has been set aside to facilitate this.\nNo change made to current risk rating. 17/01/2024 - The Social researcher has provided an interim report which would form the basis for next stages of the programme.The Healthier Greenwich Partnership (HGP) public forum was held on 15 January 2024 with focus on neighbourhood engagement. Community corners in GP Practices in Blackheath and Charlton PCNs being launched early 2024.Recruitment of Community Connectors planned for early 2024. Leave the risk score as 9. 20/08/2024 - Social research findings are now being applied in practice. One community connector role in place and recruitment for a second connector planned for September 24. The community engagement approach is embedded within the connecting Greenwich programme and included in the evaluation. The risk has been downgraded to a moderate score of 6.	18/3/25
465	13/7/23	Roneeta Campbell-Butler	Dave Borland	Risk to development of an iThrive and preventative system approach to children's mental health and wellbeing including a new Single Point of Access and Schools offer	There is a risk that we don't deliver on all areas of the high impact activity covered within this strand. This is as a result of current commissioning capacity. This has presented significant challenges to drive forward more complex large scale pieces of work. To mitigate against this risk re-prioritisation of other work is being undertaken to support delivery. The impact on HGP would be a higher risk that we don't deliver on all areas within this high impact activity. PLEASE NOTE: This is related to very major strategic projects and risk reviews should happen on six monthly basis.	4	3	12	Temporary utilisation of RBG funded commissioning capacity; alongside use of external capacity to support delivery of Single Point of Access., The establishment of multi-agency task and finish group to take forward the mental health in schools work., Establishment and maintenance of the Children's Mental Health and Wellbeing Partnership Board, Recruitment of partner to develop and implement the Single Point of Access for children's mental health and emotional wellbeing., CAMHS and Commissioner representation on the Entry to Care Panel to inform future support for children in our care at an individual level. ICB representation on the Corporate Parent Partnership Board and leading the Sub-Group on Health and Wellbeing in place.	Resource to support high level mental health and wellbeing needs for children in our care, primarily within residential children's homes.	4	3	12	The Healthier Greenwich Partnership Board has oversight of the delivery plan.	No gaps in assurance have been identified at this time.	3	2	6	29/01/2025 - The development of an iThrive System continues to be a high priority for the ICS in Greenwich across partners. The CYP Mental Health and Emotional Wellbeing Partnership continues to oversee the delivery of the Mental Health and Emotional Wellbeing Delivery Plan with updates being provided at meetings on progress. The tender for identifying a partner to support the delivery of the Single Point of Access is being finalised with a provider expected to be appointed by 17 March 2025. The new Integrated Clinical Team is now in place within the Local Authority's Children's Services and providing support to families and advice and guidance to practitioners on mental health and wellbeing. In addition, new Wellbeing in Schools Hubs are beginning work with families within 8 Greenwich Schools. \n\nThis still represents a key priority for the partnership and continues to be a High Impact Areas for the Local Care Plan Refresh under Feel Well. The risk score remains at 9 due to balancing the further work progressed with the significant mental health and wellbeing need for children and young people. In addition, there are significant resource pressures particularly in respect of the mental health and wellbeing need of chidren in our care., 31/03/2025 - As a result of a job advert withdrawal of a Strategic Commissioning and System Development Lead for Mental Health and Emotional Wellbeing this risk has increased slightly from the last review. The role was withdrawn due to the recent recruitment freeze. \n\nThe appointment of a design partner in PPL for the development of the Single Point of Access has helped to mitigate against a higher increase in likelihood. Work is now underway with stakeholders to establish the governance required to take the work forward.	30/6/25
474	16/8/23	Rachel Matheson	Lisa Wilson	Risk to optimising and developing our Home First approaches by expanding virtual wards (including a virtual ward hub) to provide assessment, treatment and care to all patients in the place that they call home.	There is a risk that the Home First (HF), and associated social care allocations, will be insufficient to meet the needs of the programme moving forward. There is also a risk to the awareness of partners and colleagues across the system of the virtual ward provision. These risks are caused by; * The anticipated financial allocations being lower than anticipated for Virtual Wards (VW). * The shift of acute care into the community increasing costs in social care and other areas of primary and community care that do not have additional funding * The lack of a fully established dashboard tracking delivery of HF and VW and understanding impacts, the cause relates to a lack of join up and capacity related to data and performance. * The availability of skilled workforce to deliver the specialist and generalist roles needed in the community. * The lack of a communications strategy to widen awareness of the VW programme across partners and the wider workforce. The impact on the Healthier Greenwich Partnership would be challenges in understanding and demonstrating the impact and benefits of the Home First approach. This could lead to a loss of confidence amongst partners and a negative financial impact in other areas of the system.	3	3	9	Operational board overseeing delivery and meets regularly., The Strategic Board receives escalations from the Operations Board and have decision making functions about workforce and financial resources. Oversee the Home first dashboard.	There are no gaps in controls	3	3	9	The Operations Board oversees delivery of Home First, receives progress reports and escalates any concerns to the Strategic Board.	No gaps in assurance identified.	2	3	6	16/01/2024 - The Home first operational and strategic Boards are embedded. \nThere is a Home First dashboard developed and circulated over the last 8 months for sharing data at both boards.\nThere is also a Greenwich and Bexley (QEH System) Urgent and Emergency Care Board dashboard. This includes data relating Virtual Wards and the Urgent Community Response (UCR).\n\nFor 2023-24 there was a reduction in Virtual Wards funding against the plan from the original bid. The recurrent funding for 24/25 remains at reduced level, requiring review of virtual wards pathways against funding allocation. The risk of this is that the full number of beds that were originally planned would not be available.\n\nThere has been challenges for the workforce, especially in recruiting specialist roles. For example, recruiting advanced clinical practitioners to deliver the virtual wards within JET and recruitment of a palliative care consultant within the hospice. \n\nThe Communications Lead does attend the Home First Strategic Group and a number of resources are in development.\n\nThe Risk score should remain at 9 due to ongoing challenges regarding funding level below original modelling for virtual wards., 02/05/2024 - The Home First communications strategy is in development. The risk remains the same and all the risk issues are still relevant. The risk rating remains the same too., 07/11/2024 - The Home First Operational board and Strategic board continue to deliver the programmes and the Home First dashboard is circulated on a monthly basis. Virtual ward and UCR data is produced for the UEC board. From December 16th 2024 community providers will also be producing opel scores. A Home First communication strategy has been devised and is now being implemented by a multi provider communications group. Savings schemes have been implemented by all system stakeholders and whilst a small amount of investment was contributed to Virtual wards (£85k), this is ringfenced for standardisation and focused on data collection. Recruitment of staff has improved although specialist roles such as advanced clinical practitioners within JET remain difficult to recruit to. The model in the description of the risk has changed because there will now be a transfer of care hub rather than a virtual ward hub at QEH. All risk ratings remain the same given the lack of additional investment and impact of budget reductions across the system., 22/01/2025 - The Home First dashboard continues to be reviewed in the operational and strategic boards. An OPEL report has been in place since Dec 24 to report on the Oxleas Virtual ward capacity to SEL and NHSE. There is a workstream in place to develop a Transfer of care hub within QEH which will include the in reach clinicians for Oxleas and the Hospice to connect the virtual wards (rather than a VW hub). Funding levels for VWs have remained the same and the pathways are embedded. Plan to review the place based provision against the VW framework document and present to the HF Strategic group to guide development of the VWs. DOCCLA pilot is ongoing and will flow into ATEC.	28/7/25
494	29/12/23	Deane Kennett	Gabi Darby	Risk to delivery of Greenwich delegated performance targets	There is a risk that Greenwich would not be able to deliver all the performance targets delegated to place during 2024/25. This is caused by a number of the targets not being met, those relating to IAPT access, SMI health checks, children immunisation and cancer screening. The impact on the Healthier Greenwich Partnership (HGP) would be inability to deliver all performance targets in 2024/25.	4	3	12	Oversight is maintained by Joint Commissioning Board (JCB), with monthly reviews of the performance report during JCB monthly meetings.	No gaps	4	3	12	Oversight is maintained by Joint Commissioning Board (JCB), with monthly reviews of the performance report during JCB monthly meetings.	No gaps	3	3	9	23/02/2024 - There is ongoing review of key performance indicators related to place delegated areas, working in partnership with SEL colleagues on provider wide metrics, such as SMI Health checks, ADHD and ASD waits.\nThis risk would need to be reviewed in light of 24/25 plans and trajectories., 11/07/2024 - Risk level remains the same. \n\nWork continues to improve areas of under performance. \n\nReview risk again in 3 months., 16/10/2024 - Review undertaken no changes made, 24/10/2024 - No Changes Made - Risk remains the same. Review in 3 months, 14/01/2025 - Risk reviewed - no change from last period, 14/03/2025 - Risk reviewed - no change	14/6/25

495	29/12/23	Nick Davies	Lisa Wilson	Risk relating to co-ordination of timely discharge support for residents.	There is a risk that patients who are medically fit for discharge are unable to leave hospital. This can be caused by a combination of: internal hospital processes holding discharge up as well as pressure on community and social care services and a changing demographics of the borough. This could impact negatively on Trust A&E and elective performance as well as the best outcomes for residents.	4	4	16	•\tUEC Board has oversight of winter planning, BCF Planning Group has oversight of BCF which has main targets for discharge and admissions avoidance, including 22/23 Discharge Fund and 23/24 planning. Home First Board has oversight of TOCC review and initiatives that support discharge processes and outcomes., •\tSEL Discharge Solutions and Improvement Group looking for sub regional solutions to common challenges such as data analysis and insight.	•\tImpact of Discharge Activity on social care staffing and budget resources being financially unsustainable and needing a system solution. •\tShort term and short notice nature of winter and discharge funding flows. •\tSpecific pressures on system such as industrial action, Covid-19 outbreaks, staff shortages etc.	4	3	12	•\tJoint commissioning Board, UEC Board, SEL Discharge Solutions and Improvement Group rolling out improvement plans for acute and mental health settings. •\tDischarge framework issued across SEL for implementation in borough	Lack of accurate and reliable data insight on delayed transfers of care and demand and capacity planning - this is however under development	3	3	9	23/01/2025 - Since the last update, we have seen improved discharge performance over a difficult winter in terms of hospital discharge demands. Home First Strategic Board has supported with resources and clear steer. The Better Care Fund support team are working on site for a 3 month project to identify and implement improvements based on a better understanding of data and a focus on outcomes that residents are achieving post discharge. There are other actions being undertaken as part of the UEC recovery plan that are being actively worked on., 23/02/2024 - Reviewed the risk with Chief Operating Officer, noting the risk score should be reduced to 12 as winter is nearly over., 01/03/2024 - There is continued pressure in hospital discharge pathways. There are programmes like QE Cares, the Home First operational group and the TOCC that have focus on ensuring flow. \nThere is a focused set of actions to ensure discharge is optimised called Super March running through March 2024 with all partners contributing., 11/07/2024 - Risk scoring remains the same. \n\nTimely discharge remains a key focus, the TOCC work to ensure scrutiny of any delays and mitigations ongoing. We have the oversight of the FLOW coordinator in place. Work ongoing at Home First oBard to make sure we have the appropriate capacity in services to manage timely discharge. In addition the 7 day social care working model in JET has funding confirmed until March 25., 30/10/2024 - All actions from previous update in July are ongoing. \n\nIn addition there is local work to streamline discharge pathway between the discharge coordination team and HIDT. The Live Well support is proving successful at supporting discharges. There has been a piece of work commissioned from Better Care Fund support team to review discharge data and pathways in preparation for winter.	22/4/25
538	5/6/24	Alex Pini - (email - Alexander.Pini@selondonics.nhs.uk)	Jin On	Risk of an overspend of the Greenwich Prescribing Budget for 2024/25	There is a risk that there may be an overspend of the Greenwich Prescribing Budget for 2024/25, this is caused by a number of contributing factors: •MCR process has resulted in a smaller team in Greenwich and new way of working for both MOT and primary care. Uncertainty of how implementation and delivery will pan out especially during transition period. •Drug shortages – hard to mitigate against these, becoming more frequent and widespread, impacting many clinical areas. •Drug price rises: NCSO/price concessions and Category M •Increased patient demand for self care items to be prescribed rather than purchased as cost of living increases •New SEL bariatric surgery guidelines -> primary care prescribing of vitamins for patients who have had bariatric surgery and are now deficient/will become deficient as a result of their surgery. We used to encourage self funding of this in GW but as result of SEL guidelines these will now be on FP10. •Hayfever -> Promethazine cost pressure ongoing. Difficulty in reviewing patients and deprescribing once initiated (more for mental health indications but also licensed for hayfever). •OptimiseRx: Depends on practice engagement and individual clinician action at point of prescribing. The impact on the ICB would be that Greenwich practices are overspent compared to prescribing budget.	4	3	12	Engagement with prescribers to ensure only the quantities needed are prescribed, Bromley Education and Training for Health (BETH) is now embedded as the training and development hub., Monthly monitoring of spend and also Cat M and NCSO spend. This includes monitoring of price concessions spend jointly with Meds Op and finance colleagues. Rebate scheme income maximised by MM team. Additionally, identified efficiency schemes are being monitored to mitigate the current cost pressure. This will not remove overspend entirely.	No gaps in control for now	4	3	12	The Medicines Pathway Implementation Group (MPIG) meets monthly.	No gaps in assurance for now.	2	3	6	03/07/2024 - Review of risk has taken place.\nNo changes to score., 26/07/2024 - Price concession for ezetimibe \nIncreased detection for prostate Ca leading to increased prescribing\nSpecials and ONS - part of QIPP plan, 03/09/2024 - Same risk as previous. \n\nMitigation in place, \nPLT this month for training purposes.\nGIPN - guest speakers re: specials. \nEngagement with hospital trust re: nutrition, 24/10/2024 - Completed training at the PLT and the GP VTS around poly pharmacy dry eyes and nutrition, and continuing with monthly GIPNs since September to give better clinician knowledge and confidence and influencing prescribing habits. \nShort term - Targeted deep dives for Greenwich areas of Growth and QIPP areas to target the practices and PCN's they are not achieving workplan indicators. Working with primary care around PCN/practice engagement issues. Continue to work with specialist pharmacist around unlicensed medication. \nMedium term - Continue to work with Oxleas to reduce spend on ONS. \n\nThis is will be reviewed in December., 19/02/2025 - Continued engagement with primary care at Practice Nurse and Manager Forums - promoting Pharmacy First PLUS. \nDeep dive into LTC management - esp around respiratory and diabetes. \nMitigation and QIPP plans shared and discussed at GIPN (Integrated Pharmacy Network)\nNoted that a number of practices require support following CQC inspections - working with primary care to support borough. \nShortages and price concessions continue to be an issue., 10/03/2025 - M11 experienced jump in spending. Key drivers to the movement from M10 to M11\n- Infections, CVD, CNS, Respiratory and Endocrine largest drivers\n- Similar seasonal increase in prescribing spend by day in December 2023. Therefore a seasonal spike.\n- High number of repeats prescriptions\n- Impact of NICE approved tech such as Mounjaro\n- Price concenssions impact higher in December compared to November.	14/4/25
565	1/4/24	Chris Dance	Gabi Darby	Achievement of Financial Balance 2024/25	During 2023/24 Greenwich delivered in line with the delegated borough budget. However given material and escalating prescribing and continuing care cost pressures, material non recurrent measures were also required to achieve financial balance. These cost pressures are on an upward trend and expected to continue into 2024/25, hence a material risk the borough will not be able to achieve recurrent financial balance in 2024/25.	5	3	15	Monthly budget meetings with budget holders to review expenditure and put in place mitigation plans, Budget holders have been engaged in the budget roll over process and have been aware of the limitations within which we need to work, Sound budgetary control to ensure expenditure trends are monitored, and delivery of QIPP is measured.		3	3	9			3	3	9	12/11/2024 - Risk has been reviewed subject to review of the efficiency saving plans as monthly monitored via SMT *& other forums. This had reflected in a reduced likelihood scoring to reflect the progress to date, 24/03/2025 - Continuing to monitor via SMT, no change to note at this stage from previous assessment.	14/4/25
574	11/2/25	Jessica Arnold	Gabi Darby	Primary care premises lost / insecure lease agreements / other estates issues	Across the borough, there are a number of general practice estates that have leases coming for renewal or that may not be renewed, practices at risk of closure due to persistently poor CQC ratings, and practices that are in an excessively poor state of repair and no longer fit for purpose. Resolving these challenges is a costly and long term endeavour, such that unexpected problems at short notice are difficult to manage.	4	3	12			4	3	12								11/8/25

Conditional Format List

Cell	Initial Rating Between 1 And 3
Cell	Initial Rating Between 4 And 6
Cell	Initial Rating Between 8 And 12
Cell	Initial Rating Between 15 And 25
Cell	Current Rating Between 1 And 3
Cell	Current Rating Between 4 And 6
Cell	Current Rating Between 8 And 12
Cell	Current Rating Between 15 And 25
Cell	Target Rating Between 1 And 3
Cell	Target Rating Between 4 And 6
Cell	Target Rating Between 8 And 12
Cell	Target Rating Between 15 And 25

Forward Planner Greenwich Meetings	Apr-25		May-25			Jun-25		Jul-25	
HGP - Healther Greenwich Partnership	23-Apr	Public (easter hols w/b)	16-May	Workshop		25-Jun	in Private	23-Jul	Public scl hols
	Papers due 15/04					Papers due 18/06		Papers due 11/07	
Chair - Iain Dimond **Business Support -** Julie Mann **Standard Agenda Items** -Welcome -Introductions and apologies -Declarations of interest -Minutes of previous meetings -Action Log -Public engagement: delivering our Healthier Greenwich Plan (focus on 'well' areas) - Quarterly at **Public Meeting** -HGP Partner's Report.- Quarterly at public meeting -HGP sub-committee report - **Public Meeting** - HGP Development - **Private Meeting**	**Board meeting in public** Introduction and apologies Declarations of interest Minutes of previous meeting in public Action Log Positive partnership story Items for noting/limited discussion Healthier Greenwich Charitable Funds update HGP partners report Performance report Sub-committee report Risk register Forward planner					**Board meeting in private** Introduction and apologies Declarations of interest Minutes of previous meeting in private Action Log Items for noting/limited discussion Forward planner		**Board meeting in public** Introduction and apologies Declarations of interest Minutes of previous meeting in public Action Log Positive partnership story Items for noting/limited discussion Healthier Greenwich Charitable Funds update HGP partners report Performance report Sub-committee report Risk register Forward planner	

AGENDA ITEM: 11

Healthier Greenwich Partnership

Date: 23 April 2025

Title	Chief Operating Officer, Greenwich – Report; AND Board papers from our partners	
This paper is for **noting**		
Executive Summary	This report provides a summary of current activities being managed by the Integrated Commissioning teams, Primary Care team and Greenwich Healthier Communities Fund. The report also includes Board Papers from our partners at Healthwatch Greenwich, Greenwich & Bexley Community Hospice, Lewisham & Greenwich Trust and Oxleas	
Recommended action for the Committee	The committee is asked to note the paper/s	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	None arise directly from the report
	Equality impact	Not required for the direct purposes of the report
	Financial impact	Not applicable for the purposes of the report
Wider support for this proposal	Public Engagement	Not required for the direct purposes of the report
	Other Committee Discussion/ Internal Engagement	The COO Greenwich report has been shared with the South East London ICB Board for noting at the SEL ICB Board meeting held on 16 April 2025. Papers from our partners have been shared with their respective boards.
Author:	Gabi Darby, Chief Operating Officer, Greenwich	
Clinical lead:	Not applicable	
Executive sponsor:	Gabi Darby, Chief Operating Officer, Greenwich	

Chief Operating Officer, Greenwich - Report

1. Neighbourhood Working

In February 2025 the Healthier Greenwich Partnership (HGP) took a decision to focus on four neighbourhoods in Greenwich: Central-East Greenwich, East Greenwich, West Greenwich, and South Greenwich. This followed an options appraisal and engagement across all parties. The decision was determined according the best fit against the South East London neighbourhood health framework criteria:

- Centre around populations and natural communities
- Build on existing networks and local assets
- Include population sized between 50-100k (one neighbourhood is slightly smaller but with a fast-growing population)
- Enable, not hinder, joint working
- Adapt to specific challenges

A joint programme Board has been established across the ICB and Royal Borough of Greenwich, with key workstreams on population health, the care model, the workforce and community engagement. These tailor with South East London-wide enabler workstreams, including on estates and digital.

2. Children and Young People

Child Health Teams Pilot

As part of the piloting the Local Child Health Teams in Greenwich, work has commenced to evaluate the impact it has been having over the past 5 months. The local team in Greenwich West Primary Care Network consists of 2 Lead GPs, Patch Paediatrician from Lewisham and Greenwich Trust and a Patch Community Nurse from Oxleas NHS Foundation Trust. Further work is being undertaken to review the referral data, common presenting needs and impact. The quote below is some of the early feedback from a parent supported through the team:

"Whatever helps to improve NHS, and this initiative is amazing. One thing I liked about it I within a week we were able to see the consultant and GP together. We were able to get a diagnosis and now we know what to do next, consultant was able to do the checks and immediately refer us on to the Physio. It saved us so much time, we had anxiety about going to the hospital in a month's time, but were given treatment options very quickly."

Continuing Care and Social Care
The introduction of the new patient level data set reporting requirements for Continuing Care has necessitated some changes to recording locally with a move onto Care Track. This aligns with the recording system utilised for Continuing Healthcare. The new recording and national requirements should help to support a better local and national understanding of trends within Continuing Care. Further discussions have also been taking place Pan-London to improving joint work between Continuing Care and Social Care, with a proposed approach outlined to support the gathering of data, identification of good practice and common challenges. This also includes planning around the development of joint training.

Single Point of Access – Mental Health and Wellbeing
Greenwich has appointed PPL in partnership with Baxendale to be the design partner for the development of a Single Point of Access (SPA) for Children's Mental Health and Wellbeing. Work has already begun to develop the governance to take the work forward over the next 2 years. This will lead to the design and implementation of the new SPA helping to improve access for children to the right mental health and wellbeing support at the right time.

3. Integrated Commissioning – Adults

Staffing and team development
Collaboration across teams and with partners continues and we have seen some good progress with teams setting up new ways of working across adults, public health, children and young people and primary care teams. Plans are in place to ensure this continues this year including leadership development across teams and with partners.

Digital Health & Care Service
Following contract award this service went live on 1 April 2025.
The Digital Health and Care service will now be offered proactively to eligible residents with health and care needs, supporting residents to stay independent for longer. This will complement the work on developing integrated neighbourhood team approaches and ensure we are able to better deliver preventative and proactive care. The approach taken will allow widening of the service beyond Greenwich place in future if there are other interested Boroughs and SEL discussions around this and the use of data and insight to inform preventative and proactive care linked to neighbourhood developments continues.

Better Care Fund (BCF) discharge programme
Greenwich and Bexley have been supported by the Better Care Fund programme to review patient flow and discharge through the Queen Elizabeth Hospital in Woolwich. The Better Care Fund (BCF) supports local health and social care systems to successfully deliver integration of services in a way that supports person-centred care, sustainability and better outcomes for people and carers. Leaders across health and social care in Greenwich and Bexley are now reviewing recommendations and will implement changes across 3 key areas: discharge and flow, demand and capacity and leadership.

Continuing Health Care (CHC)
We continue to work on the areas of improvement which remain and have seen significant progress over the last period. We continue to focus on ensuring better value care and support is commissioned, outstanding reviews are completed and that we work with others across SEL to ensure consistent ways of working.

A new integrated brokerage team in Greenwich was launched in 2024 and is now supporting CHC placements. The impact of the approach will ensure we are more aware of gaps in provision which can be supported by commissioning teams, oversight of quality can be more aligned to LA approaches and we can hopefully secure better value through enhanced negotiation and data driven approaches.

Musculoskeletal (MSK) Service
Recent work was undertaken to review the timeline for recommissioning the service. The outcome of this has meant a direct award to the current provider has been put in place to ensure service continuity over the coming year. The new service will be commissioned to be in place for April 2026. This procurement process is now live.

25/26 planning – local work has continued to review outcomes, actions and progress against our Health and Wellbeing Strategy and the five-year forward view and to refresh the Local Care Plan for next year, and to set associated budgets.

4. Greenwich Healthier Communities Fund

The Greenwich Healthier Communities Fund over the next 4 years aims to prevent and respond to key health issues across Greenwich to ensure everyone has equal access to the health services and support they need. Two strands of funding for VSCE organisations were launched in April 2024. The different funding strands support different kinds of work within Greenwich, all aligned to the agreed Health & Wellbeing Strategy. The Enabling strand aims to increase organisation's capacity building to better tackle health inequalities, whilst the Delivery strand aims to fund projects that prevent and respond to key health inequalities. The programme will develop further in 2025, with plans to relaunch these strands in April 2025 with more targeted focus (set by local priorities), and further improvements based on stakeholder and grantee feedback.

The Enabling Strand has supported 31 organisations across three rounds, with a total of £245,726 awarded. 25 organisations have been supported through Round 1 the Delivery Strand totalling £542,189. In round 3 the committee funded 23 applications totalling £581,070.

For the next round of submissions, organisations will be asked to submit against a set of priority themes and for medium and large bids organisation will be asked to demonstrate collaborative working within the neighbourhoods in Greenwich.

- Improving Health Outcomes for People with Learning Disabilities and/or Autism
- Tackling Isolation
- Long-Term Health Conditions
- Active Healthy Living for Children and Young People

5. Connecting Greenwich

The Connecting Greenwich programme has been running since April 2024 and is actively working with two-thirds of Greenwich's general practices, including three PCNs.
The programme works holistically with practice teams to identify areas for improving how practices provide proactive, accessible care to their local communities and/or target population cohorts. Through specific projects with the practices or PCNs, long term culture change is embedded through coaching, thinking councils, data analysis and trialling innovations.

Many projects within the programme include a focus on reducing health inequalities, including engaging with Vietnamese, Nepalese and Somali older generations; improving hypertension control in black men; childhood immunisations outreach; integrated same day access; piloting Local Child Health Teams; and a community wellbeing café.
The programme is being evaluated by DG Cities alongside delivery.

6. General Practice Estates Strategy

Development of a Greenwich general practice estates strategy began in December 2024. The strategy will be crucial for both proactively and reactively addressing estates related challenges and opportunities in the borough. It will aid Greenwich and SEL ICB teams to ensure our decision-making and allocation of finite resources is robust and delivers maximal benefit for patient care. The Strategy will be developed ahead of the new financial year and launched in March/April, following extensive engagement with general practices and system-wide partners, including the Greenwich Local Estates Forum. It is focusing on three areas:

Achieving a comprehensive understanding of existing general practice estates and the challenges or opportunities for improvement in the short, medium and long terms at each site and across neighbourhoods.
Proactively planning ahead of the many large housing developments in the pipeline across Greenwich borough, to assess the likely impacts on healthcare provision and what our preferences would be for requesting and utilising section 106 resources in particular.
Developing and agreeing a set of core principles that can be applied to all estates related projects to ensure fair, transparent and prudent decisions are made about where we place our efforts and resources.

This will feed into a wider piece of work on how estate is used to support neighbourhood health.

COMMUNITY HOSPICE
For the people of Greenwich & Bexley

Agenda

Meeting: Board of Trustees

Date: Wednesday 12th March 2025

Time: 4.00pm

Venue: Community Hub, Community Hospice, 185 Bostall Hill, London, SE2 0GB

No	Item		Att;	Time
1	**Welcome, Introductions and Apologies (**Sarah Higgins, Sylvia Osaji, Tolu Timeyin, Kate McGranaghan Chow, Francis Drobniewski) **Guests**: Ellen Tumelty, Maria Ford	SD-M	V	4.00pm
2	Declarations of Interest	ALL	V	4.02pm
3	Minutes of the previous Board of Trustee meeting held on Wednesday 8th January 2025	SD-M	✓	4.03pm
4	Matters arising not on the Agenda	SD-M	V	4.10pm
5	**Presentations**			
5.1	Hospital Case Presentation	LB/Maria Ford	V	4.15pm
5.2	Update from Finance, Information Governance and Information Technology Committee	VDS/ DAT	✓	4.25pm
6	**For approval**			
6.1	2025/26 Consolidated Budget and Operational Plan	KH/DAT	✓	4.45pm
7	**For information**			
7.1	Finance Update (previously circulated management accounts)	DAT VDS		5.15pm
7.2	CEO Report	KH	✓	5.30pm

7.3	Risk Register	KH	✓	5.40pm
7.4	Serious Incidents	KH	V	5.45pm
8	**Policies - none**			
9	AOB		V	5.50pm

Date of next meeting: 14th May at 4pm

Minutes

Meeting: Board of Trustees

Date: Wednesday 8th January 2025

Time: 4.00pm

Venue: Community Hub, Community Hospice, 185 Bostall Hill, London, SE2 0GB

No	Item		
1	**Present:** Alison Roberts (AR) David Atterbury-Thomas (DAT) Treasurer Estelle Kerridge (EK) Komal Whittaker Axon (KWA) **Deputising Chair** Manal Sadik (MS) Mike Williams (MW) Rebecca Middleton (RM) Tim Green (TG)	**In attendance:** Aneta Saunders (AS) Graham Turner (GT) Jon Devlin (JD) Kate Heaps (KH) Kim Murphy (minutes) Lesley Bull (LB) Victor D'Arcy-Smith (VDS) **Guest**: Joss Duncan (JD) Natalie Moseley (NM) Natalie Sweeden (NS)	**Apologies**: Francis Drobniewski (FD) Kate McGranaghan-Chow (KMc) Manal Sadik (MS) Sarah Higgins (SH) **Chair** Simon Di Marino (SDM) Sylvia Osaji (SO) Tolu Timeyin (TT)
2	**Declarations of Interest** None.		
3	**Minutes of the previous Board of Trustee meeting held on Wednesday 13th November 2024** Approved.		
4	**Matters arising not on the Agenda** None		
	Presentations		
5	**Corporate Partnerships** NS gave a brief update on corporate partnerships (CP). Within the FR strategy, the CP programme has been signed off and work has begun; the hospice recruited a consultant to fast track the work. We made an offer to a CP manager (Darren Bennett), who has now been in post for 3 weeks. The first priority is for prospects and		

target organisations – we will look within our community and see what synergy we have. Another way is through our internal networks – and in particular, asking our Trustees who they know. It is more around finding out if they have contacts in a medium or large business, and understand whether there are crossovers personally within trustee groups or within the hospice. This will allow us to build a picture of our community and any potential future planning of contacts. NS will send a simple spreadsheet to the Board, and ask for ideally 5 contacts. If we feel there would be a way to move the relationship with a contact of them forward, NS will always speak with provider of the information initially.

NS noted that within CP, they are hoping to find partners that we could have a long term strategic partnership with to move forward in our strategy and goals.

AS added that this would be around relationship building, as we are not currently doing this in a structured way.

KWA questioned if there is any literature for CP to be shared and NS confirmed there is not beyond the QA however any communication would be done in a structured way. KWA questioned if we have approached organisations to become their linked charity and NS confirmed that we have not, however this programme will aim to address and become proactive on this.

KH added that within Hospice's collaboration plans, within London all hospices are unique and serve multiple areas and we have potential for national organisations to support a group of hospices to a bigger partnership with blue-chip organisations. KWA noted that public schools in her area are also supporting charities and should be considered.

DAT requested some examples of potential relationships and a summary of today's discussion and forward to the Board. AS asked the board to just consider who they may know and who we could potentially build a relationship with, not just for money. NS gave confidence in that we will not contact those given without prior permission.

NS left the meeting.

6 **Presentation from EPIC**

People Team

KH spoke briefly through the 'People Team' part of the presentation and highlighted the key themes including a look back at the past 6 months, recruitment challenges, training, inductions and appraisals. The below questions were asked:

EK questioned if the clinical supervision attendance is monitored and KH confirmed that supervisors keep a record of who has attended. It can be difficult to get

attendance from various teams for differing reasons but we are tackling this with the team leaders.

EK questioned the progress of the action plan from the previous staff survey – KH confirmed this has been threaded through the people plan and much has been achieved through this. KH agreed it would be helpful to have some comms around what we have achieved as a result of the survey to help uptake.

DAT questioned the structure of the retail pay framework and its impact on the recruitment within retail and FR and KH confirmed that it does have an effect, which is why the T&C project is so important to recruit and retain skilled staff. AS furthered that we all retail and FR are aligned with Agenda for Change, so the pay does not reflect the currently salary market. This, along with the decline in FR candidates post-covid19 has jointly had a negative impact. This project will allow us to set up a system that is appropriate for those departments.

DAT also questioned if the mandatory training is online. KH confirmed it is, however a change of platforms skewed our results and there is still work to do to improve on this.

RM questioned the timeframe for the T&C project – AS confirmed this would take around 4 months after kick-off for the consultant part and then consultations within the organisation thereafter (2-3 months). AS feels this would be 6-7 months but this will be confirmed when the kick off project begins.

Community Development & Volunteering Update
JD spoke briefly through the presentation and highlighted the key themes including highlights and learning from 2024, and looking ahead to 2025.

MW question if we have data that tracks those we engage in the community to beneficiaries of our service. JD noted that this would be an issue from a GDPR perspective however we are picking up more people who are asking questions and thinking more about the hospice and its services as we engage more communities through the borough. Working with 15 other Hospices within Compassionate Neighbours allows us to capture those we may not have who have family outside of the borough.

MW questioned if people can self-refer to the Hospice and GT confirmed that a quite recent discussion means that they now can. NM added that these groups and communities are now actively liaising and considering the Hospice and we are building more relationships and raising awareness.

KH noted that the ideally we are caring for more patients; however the added benefit is that as we are responsible for economic activity and a large employer in the organisation; driving the engagement pieces will also help our volunteers and staff diversify.

The board discussed some updates and ethnic priorities around data and enabling us to track progress and changes to our volunteer base, staff base and patients cared for and how the work we do impacts those. JD noted that Simran Kaur is going some intergenerational views on services and KWA noted the personal pathway of her family and how they had been cared for.

DAT questioned how we quantify what we are achieving in relation to the money we spent and JD gave an approx. no. of £750K in hours saved by utilising volunteers, alongside the positive outreach and community progression in relation to palliative care. KH reflected JD, we know if a patient has a CN, their community nurse is checking in with them every week which provides some form of relief to our staff if in-between checks. This enables our community to care for people approaching end of life, so we don't always have to. It's a prevention mechanism with our community.

KH noted that if we get a lottery bid, we will need to give a qualities report – although DAT is correct in that we should be doing this anyway. AS noted that each week, the hours given by volunteers or lack thereof, impacts their profits each day/week. JD added that we have issues with volunteer supervision, however we have not given any training, so this is to be as expected.

7 **Community services transformation/ new referral guidelines**

NM spoke briefly through the presentation and highlighted the key themes including referral data, time between referrals and first contact/visit and the change in referral and discharge criteria/process.

RM questioned if S1 is helping with the new process and NS confirmed that meetings with our S1 manager is helping the ease of use of this platform and we are working towards making the system easier to use.

For approval

8 **Trading Board Terms of Reference**

AS noted the below changes:

- A chairperson can be a Non-Executive Direct
- Trading is not just income generation but how we represent the Charity as a whole

The Board of Trustees approved the Trading Board Terms of Reference.

9 **Trading Board Chair and Deputy Chair**

AS noted the proposal of the chair of the Trading Board be Barry Dow, Non-Executive director and deputy chair Rebecca Middleton. The NRGC are happy for this to be approved, however we need to specify that we ensure there is continuity when Barry Dow cannot attend or report back on meetings.

The Board of Trustees approved appointing Barry Dow as Chair of the Trading Board and Rebecca Middleton as Deputy Chair.

For information

10 **Finance Update**

VDS gave a brief overview of the circulated update, highlighting the £6m legacy received and that the TB and FR are performing well. We are now forecasting a small surplus at year end, not including the potential funding recently announced through the government.

DAT added that we are currently running at a deficit however the legacy has put us in a different position and we need to keep this in mind as the continued predicted deficit is a problem due to being underfunded.

RM questioned what the improved efficacy rate is and VDS noted that these are ratios in terms of operational efficacy to do with the balance sheet – ratios commonly used within finance.

11 **HUK National legacy campaign**

AS gave a brief overview of the circulated information of the campaign and feels genuine excitement on how this will support us in our funding goals. The campaigns begins on 17th February for two weeks and will be broadcasted on a national and local stage – we are working together with other hospices to align our PR (the next initiative will be held in November). This campaign will be progressed in a data driven approach. DAT questioned if there is any information on inheritance tax review and rate and AS noted that Megan Short will be creating documentation and working on this to ensure we provide all information on a landing page within our website and digital comms.

The Board discussed the marketing surrounding this from both Hospice UK and Community Hospice.

MW questioned how much value this may generate and AS noted she does not have an estimate and would struggle to get this. Legacies are still given to healthcare charities, however noted Hospice charities are falling in below hospitals and cancer charities.

KWA asked for clarification on inheritance tax and DAT noted that if you donate 10% of your estate, you don't have to pay as much inheritance tax. KWA questioned if

we could use this as a strapline and AS noted that we need to focus on building more relationships. KH noted that we have not discussed this wider than the Board, and feels this should be communicated with all staff and volunteers.

12 **CEO Report**

KH spoke briefly through the circulated report and highlighted some key positive notes.

AS added that the Sidcup shop has now opened.

13 **Risk Register**

KH noted the HR issues have now been removed.

14 **Serious Incidents**

None to report.

15 **Sidcup Shop Lease**

Lease had been signed.

16 **Welling leaseholder extension**

VDS noted no proposal at this stage, we extended the lease 4 years ago on one of the flats owned and now the other wishes to extend their lease. This will go to FIGIT for approval and then will come to the Board thereafter.

Policies

17 - **Risk Management Policy**

The Board of Trustees approved the Risk Management policy version 3.1.

18 - **Major Incident Policy**

KWA will pick up some questions around roles with KH.

The Board of Trustees approved the Major Incident Policy version 3.1 once the requested discussion has taken place.

19 **Any other business**

JD gave the trustees new branded volunteer lanyards

KH reminded the Board that she will be trekking the Sahara in March 2025 and would welcome any donations!

The situation im presenting took place only a few weeks ago and involved a 87YOM (admitted in February this year.)

Sx

Pre-admission: lived alone in a house. He had a BD POC to assist with personal care and meals/ drinks. He was independently mobile with a W.S and was driving a car up until a few weeks before. Daughter visited every night and had recently installed a key safe- difficult to do at short notice

PMH
HTN
Hyperlipidaemia- **high cholesterol-** excess of lipids and fats in blood
COPD- chronic

ISHD - recent NSTEMI in another Hospital 10/02 MI. He self-discharged from Hospital on 11/2/25 so he would not have received full and appropriate supportive care or on going monitoring.

This admission was 7 days later

BIBA

worsening of normal SOB for the previous 2 days

He had increased pedal oedema
He had extensive bruising to the right lower leg
And a Purpuric rash bilaterally R>L

found to have Severely low platelets -? acute lymphoproliferative disorder- clotting issues
- Right CAP - tx with IVAbx
- HF.? cor pulmonale- right sided heart failure when the right ventricle of the heart enlarges

The Emergency Department Plan was for full active treatment. Patient was aware of the severity of his situation and that he could deteriorate and die despite this active treatment
He stated he was dying and would like to be home to die, and asked several times for transport to be arranged immediately.
The Dr's repeatedly explained that his platelets levels are dangerously low and he could bleed to death at any time. Patient declined a platelet transfusion
The result-
The pt began arranging transport home himself by calling various Taxi Firms
and he was becoming increasingly distressed and stating that "they were not granting a dying man his wish"- his words! He wanted to self-discharge which means he would just leave the Hospital without medications, transport or anything
His Capacity was assessed as being able to make this decision

Family were updated with his consent-
The Dr's explained the patients' medical situation and expected outcome.
They explained that the patient was aware that he may bleed to death with his current platelet level

and that he had declined a platelet transfusion and wanted to self-discharge and what that would mean- so again that's discharge without support as pt was discharging against medical advice.
It was also explained how he had capacity and that the Treating Team had to respect his decision

So where do the HPCT come into all of this.
We visit ED daily and have a very good working relationship – The Department are fully aware of our services as we keep reminding them when the opportunity arises and also when it doesn't
- The Nurse Manager bleeped the HPCT and I had the bleep that day. They requested assistance immediately- Sue McIntosh – our Hospital Palliative CARE Discharge Facilitator, left the Office immediately. It was 3.30 pm and agencies, pharmacy
, OT/PT etc close at 5 pm

Patient consented to be seen by SM and immediately began to explain to her that he was at risk of a bleed but wanted to die at home. Sue did need to explain that the bleed could be catastrophic, and emergency services, DN team would likely not get to him in time to give anticipatory meds and he may die alone. Pt reported that he understood but repeated that wanted to die at home. He was asked if he would consider the Hospice, but he strongly declined. He did consent for Fast Track documentation for DH QDS POC and to share his information with external agencies to facilitate his discharge.

Pt declined to engage with OT/PT for a functional assessment and declined equipment. Pt declined Hospice virtual ward referral, but consented to CPCT referral.
He declined to engage in any further conversations re UCP purely because he just wanted to get home stating "once home, no one could move him".
At this point he was becoming increasing distressed again so was immediately reassured and this line of conversation was stopped.

Call made to Bexley ICB to explain the situation- they agreed knowing the challenges- lack of equipment etc and stated they would work round it

FT papers were completed and sent to Bexley ICB and a copy sent to the DN Team along with the referral -We do this routinely as it holds so much vital information that they find very helpful .
CPCT referral completed
I called Duty Community CNS to update and request information to be given to CNS on call overnight and requested an early review the next day

I gave detailed advice to the ED Dr for MAAR Charts and Anticipatory medications including emergency meds in the event of a catastrophic bleed

Family updated and aware of the potential events/ risks- they did not agree with discharge but would do as their father requested

SM put all information in a folder and gave to paramedics transporting pt home to ensure nothing was forgotten or lost

The gentleman was seen at 15.35 and discharged 18.50hrs- transport
We did not know if he'd make the journey home or die alone at night- the first visit the next day may have found he'd died in the night- Family made it clear that they did not want this to be them

Because the DN Team were made aware of this pts situation by us , they did a support visit that night

Bexley ICB requested GCP to assist with providing a POC as they could not source an agency quickly enough
GCP continued for 2 days until Bexley could take over the POC

CPCT visit the day after discharge for Ongoing support

Night sits were arranged by Bexley ICB when available

This encounter was complex, challenging and emotional,

And on reflection we embraced the Hospice Values/ Behaviours

Direct-

We kept everything simple, direct and focused on what mattered most- PPC / PPD Home

Were able to stay focused using our experience and expertise to make sure we prioritised and problem solved with pt consent and understanding at all times.

We worked **with** the pt so he continued to agree to accept our involvement- with the aim to grant his wish as safely as possible and prevent further readmission. The worst outcome would have been for the pt to refuse our support and involvement and to just self-discharge

We limited the stress and the drama associated with ED and focused on the need for clear, concise and active communication.

So involving straight talking – we were and needed to be open, honest and even though the information potentially was very distressing, it was delivered with kindness and empathy and with the pt/ NOK knowledge that we understood all of their prospectives and were doing all that was possible to ensure he was discharged as safely as possible- The process was not smooth. The pt and family were never aware of that and this is what was wanted so as not to cause further distress-

ED felt very supported and very, very grateful and its strengthened out working relationship and understanding of both roles.

We are Uplifting-The pt and NOK were very pleased with the focus and progress **and that the pts wishes were at the heart of all the plans being made**

Valuing others- we needed more than just out team, we needed to work together with other services in the wider MDT and we needed it all to work well- Although the plan was formulated and coordinated by the HPCT - we needed ED- that's the Dr's , Nurses, Managers, admin and transport. We needed Bexley ICB, DN's, GCP, Duty CPCT CNS and On call CPCT CNS- all involved and worked together with a shared goal.

We flourish in this environment- we actively share our thoughts, ideas and rational, skills and time which enhances a therapeutic relationship between professionals

We are most definitely Proactive- we absolutely did everything we could to ensure pts wish was fulfilled despite its complexity- We would never say no but we may have to compromise with agreement being at the centre of everything.

We did all we could and made things happen quickly and efficiently with minimal fuss and always with in the agreed wishes of the pt- Not always what we wished for but we accept it's not about us

Moving forward we are reviewing, reflecting and learning from this interaction-

We are and do Embrace fresh thinking- looking at ideas, ways of addressing issues we faced and face and the services the Hospice provide and other available services besides and how they could be of help- How can we improve the fluidity of care between all services required and available-

We Embrace challenges, and there are many - HPC is acute and complex and we absolutely love and welcome this as we are constantly learning and able to make such a difference. Its not always the big things !!

And its not just all about the pt/ family experience and care but also the education, inspiration and support we can provide to our fellow HCP.

We aim to be a bright beacon, advocating empowerment for positive influence. This case was a positive influence

COMMUNITY HOSPICE

For the people of Greenwich & Bexley

Budget Review

Financial Year 25/26

Introduction

The draft consolidated budget for FY25/26 indicates that the Hospice is expected to operate in a deficit budget which currently stands at £594,430 before depreciation.

Although budget income is £687,694 higher than forecasted income for FY 24/25, the total expenditure is also higher than FY24/25 forecasted expenditure by £2,102,176.

Subsidiary budget:

Company	Income	Expenditure	Net surplus
Trading Company	£3,152,910	£2,479,447	£673,463
Lottery Company	£475,062	£298,080	£176,982

Expenditure

- When compared to FY24/25 forecast, total expenditure of Clinical and Medical Services increased by 15% (£1,085,634), Fundraising and Retail expenditure both increased by 35% and 39% respectively (£258,357 and £695,975 respectively), Lottery company's total expenditure also increased by 39% (£84,323) while Management and Support cost decreased by 1% (£22,114).

	FY 2025/ 26 £	%	Forecast 2024/25 £	%	Var £	%
Expenditure					-	
Clinical & Medical Services	8,463,707	58%	7,378,072	59%	1,085,634	15%
Fundraising	992,814	7%	734,456	6%	258,357	35%
Retail	2,479,447	17%	1,783,472	14%	695,975	39%
Lottery	298,080	2%	213,757	2%	84,323	39%
Management & Support	2,445,554	17%	2,467,667	20%	- 22,114	-1%
Total Expenditure	**14,679,601**		**12,577,425**		**2,102,176**	

- We have factored 0% inflationary increase on staff cost however the band increase has been reflected in the consolidated change in staff cost. The charity expects a cost of £97k for every 1% increase in staff cost
- The draft budget includes a full staffing structure for all departments in the Hospice and subsidiaries.

Summary of Consolidated Budget

Summary Consolidated Budget 2025/2026

	FY 2025/ 26 £	%	Forecast 2024/25 £	%	Var £	%	Budget 2024/25 £	%	Var £	%
Income										
Core Grant	5,109,587	36%	4,946,148	37%	163,439	3%	5,799,880	46%	- 690,294	-12%
One Bexley	1,040,000	7%	1,030,000	8%	10,000	1%	540,000	4%	500,000	93%
Ageing Well	395,861	3%	282,828	2%	113,033	40%	-	0%	395,861	0%
Donations & Fundraising	1,896,032	13%	1,475,001	11%	421,031	29%	1,591,660	13%	304,372	19%
Legacies	1,500,000	11%	2,405,116	18%	- 905,116	-38%	1,000,000	8%	500,000	50%
Retail	3,152,910	22%	2,475,595	18%	677,315	27%	2,721,574	22%	431,335	16%
Lottery	475,062	3%	428,508	3%	46,554	11%	462,824	4%	12,238	3%
Education	-	0%	-	0%	-		133,000	1%	- 133,000	-100%
Government Financial Support - Capital grant	308,191	2%	42,054	0%	266,137		-	0%	308,191	0%
Other	207,528	1%	313,227	2%	- 105,699	-34%	241,504	2%	- 33,976	-14%
Total Income	**14,085,170**		**13,398,476**		**686,694**		**12,490,443**		**1,594,728**	
Expenditure					-				-	
Clinical & Medical Services	8,463,707	58%	7,378,072	59%	1,085,634	15%	8,206,532	60%	257,175	3%
Fundraising	992,814	7%	734,456	6%	258,357	35%	986,344	7%	6,470	1%
Retail	2,479,447	17%	1,783,472	14%	695,975	39%	2,007,273	15%	472,174	24%
Lottery	298,080	2%	213,757	2%	84,323	39%	287,641	2%	10,439	4%
Management & Support	2,445,554	17%	2,467,667	20%	- 22,114	-1%	2,296,901	17%	148,653	6%
Total Expenditure	**14,679,601**		**12,577,425**		**2,102,176**		**13,784,691**		**894,910**	
Surplus/(Deficit) Before Depreciation	**(594,430)**		**821,052**		**(1,415,482)**		**(1,294,248)**		**699,818**	
Non-operational costs	**578,820**		**322,277**		256,543		**270,629**		578,820	0%
Surplus/(Deficit) After Depreciation	**(1,173,250)**		**498,775**		**(1,672,025)**		**(1,564,877)**		**120,998**	-9%

Ratios

	FY 2025/ 26	Forecast 2024/25	Budget 2024/25
Retail Margin	21%	28%	26%
Lottery Margin	37%	50%	38%
Fundraising Ratio (excluding Legacies)	1.91	2.01	1.61
Fundraising Ratio (including legacies)	3.42	5.28	2.63
Management & Support	17%	20%	17%

Ratios

	FY 2025/ 26	Budget 2024/25
Staff Costs		
Clinical & Medical Services	75%	75%
Fundraising	63%	69%
Management & Support	47%	54%
Retail	60%	60%
Lottery	21%	21%
Hospice	66%	68%

Any questions, thoughts or comments?

COMMUNITY HOSPICE

For the people of Greenwich & Bexley

COMMUNITY HOSPICE

For the people of Greenwich & Bexley

Finance, Information Governance and Information Technology

11th September 2024

Overview of the Sub-Committee

- Since October 2022 the FIGIT Sub Committee have continued to hold monthly meetings except in January (the Christmas and New Year holidays shortened the working month), July & August
- Meetings have been by Teams and this will continue to be the practice
- Minutes and reports are circulated to all Board members

Information Governance and Information Technology update

Information Governance and Information Technology update

- Data Security Protection Toolkit (DSPT) is due to be submitted to NHS Digital by end of March 2025 and we are on course to achieve this.
- The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information being handled correctly.

Information Governance and Information Technology update

- The firewall replacement project has been successfully completed. The new firewall system is now operational and has been integrated into the network infrastructure.
- The new firewall was installed and configured according to the specified requirements.
- Continuous monitoring is being done to ensure the firewall operates optimally with ongoing support to address any issues or adjustments needed.

Investment Subcommittee

Investment Subcommittee

This sub committee of the Board is chaired by Simon Di Marino and meets twice a year.

The representatives from Rathbones who manage our investment portfolio attend.

The committee took decisions on additional funds to be added to the investment portfolio and the allocation of surplus funds to interest bearing short term deposits.

We currently have two £1million short term deposits (12 months) – **first at 4.01% maturing in October 2025 & the second at 4.15% maturing in January 2026**. Plan to re-invest for further 12 months

Gains/losses from long term investment with Rathbones are reported as part of our monthly trading results.

Financials
YTD January 2025

2024/2025 Financials

YTD January 2025 Actuals	**2024/25**
Retail, Fundraising, Lottery and Legacy Income	£6,061,984
Hospice Income	£5,466,238
Total Income	£11,528,222
Expenditure	£10,892,348
Surplus/(Deficit) before depreciation	£635,874
Surplus/(Deficit) after depreciation	£402,355

This includes £241K of designated spend from the RTP Fund

Financials
Recovery and Transformation Programme fund

Recovery and Transformation programme fund

- RTP Fund was established in 2021. It is a Designated Fund.
- Established at £500K and increased in 2023/24 to £1 million. It stands at £136K as at 31st January 2025.
- Expenditure currently charged to RTP in 2024/25 is £241K .
- Investments made from this fund are principally to improve income generation and management and operational effectiveness.

Financials
Hospice funds - reserves

Hospice Funds - Reserves

- General Funds – January 2025 **£5,280K**

Designated Funds

- Building Development Fund £500K
- Recovery and Transformation Fund £136K
- Adult Social Care Fund £155K

- **Total Free Reserves** **£5,280K**
- **Reserves Target** **£6,247K**

The review of our Reserves Policy led to the introduction of a risk based approach. This takes account of the reliability of future income streams, the commitment to future expenditure and risks faced by the charity.

Financials
Auditors & year-end audit

Auditors & Year-end audit

- Moore Kingston Smith have started as new auditors for the Hospice and we have already finalised planning meeting for the 2024/2025 year-end audit.
- Audit field work is scheduled to commence in June 2025, though some shop visits took place in February 2025.
- The September 2025 FIGIT meeting will review the audit findings report and the draft consolidated statutory accounts for approval by the Board of Trustees in September 2025.
- The trading and lottery subsidiary accounts will be approved by the relevant boards

Any questions, thoughts or comments?

COMMUNITY HOSPICE

For the people of Greenwich & Bexley

Greenwich & Bexley Community Hospice Operational Plan 2025/26

Board March 2025

Purpose

This document sets out the operational plan that has informed the budget for FY25/26. It highlights the assumptions and any risks associated with the budget that we have presented.

The Finance, Information Governance and Information Technology (FIGIT) Committee have reviewed the accompanying budget and are content to recommend the budget to the Board.

Trading and Lottery budgets have already been reviewed by their relevant Boards, and they have approved the contribution to the consolidated budget.

The Board are asked to approve the budget as recommended by FIGIT. They are also asked to note the recommendations regarding annual salary increases on page 5.

Introduction

This paper gives an outline of the plan behind the budget for FY2025/26. It includes a reflection back on FY2024/25 and tries to identify and address any risks associated with the plan.

Our Purpose

To support local dying people to live as well as they can for as long as they can

Looking back

At the beginning of FY22/23 we approved our new hospice strategy. This set out our 3 main strategic priorities of 'listening', 'empowering colleagues' and 'digital. Since then we have also finalised our People Plan, Service Transformation Strategy, Digital Strategy, Trading and Fundraising Strategies and our Community Development and Volunteering Strategy. We have already begun to see significant transformation because of the implementation of these plans, and since then the work on our rebrand, values and behaviours and website upgrade has enabled us to better communicate our purpose and priorities and have laid the foundations to support ongoing transformation to ensure longer term sustainability.

Our service transformation strategy set out 4 key priorities: 'listening', 'personalised care delivered at scale', 'system working' and 'quality and impact'. Through this plan we are transforming our care, to a more episodic patient-led model, providing more tailored levels of support dependent on need and complexity but enabling us to be more inclusive, especially for people experiencing frailty.

The recruitment of Lesley as Medical Director and development of others in the medical team will provide additional leadership to help drive the clinical operation, however we are still short on senior medical staff and will need to work creatively to recruit so that we can move away from so much locum cover.

In establishing the budget being presented to Board, the team have all developed detailed departmental operational plans which are summarised in the narrative on the next pages. We have also followed the following principles to prioritise expenditure:

- Protect investment into income generation departments (Retail, Fundraising, Communications and Volunteering) - we need to continue to see sustained growth in this area to ensure long term sustainability.
- Ensure safe staffing in clinical services – but continue service transformation to free up clinical capacity rather than just exponentially growing headcount
- Continue to invest in addressing inequalities – the trust built through these relationships will reap rewards organisationally over the years and helps us to get care to where it is needed most.

The budget includes some new investment to help deliver our strategic objectives and we will continue to cover much of this investment from the Recovery and Transformation Fund to support our transformation, at present this fund sits at £136k, we will need to 'top this up' when we are clear

what our likely end of year outturn is. We also expect almost £700k from Department of Health in 2025/26 towards capital costs, the cost of the assets is not included in the budget as these are balance sheet transactions. However, the depreciation and income accruing from the capital grant are included in the budget. We need to spend this money in 2025/26, otherwise we will lose it.

2024/25 has been a much more settled year than the previous one, and in part due to a significant legacy, we anticipate ending the year in a surplus position. We have also received around £220k from Department of Health for capital in this year which will impact our bottom-line cash position.

2024/25 Performance – Headlines (Forecast vs Budget)

Income Stream	Forecast	Budget	Expenditure	Forecast	Budget
Statutory Income	46%	49%	**Clinical**	61%	58%
Fundraising	31%	26%	**Fundraising**	6%	7%
Retail	20%	22%	**Retail**	14%	17%
Lottery	3%	3%	**Lottery**	2%	2%

These changes have resulted in our forecasted outturn amounting to a surplus of £498k against a budgeted deficit of £720k after depreciation charges. This is inclusive of designated expenditure of £241k, which is funded from the designated Recovery & Transformation Fund (RTF).

Planning for 2025/26

This document sets out our priorities for the following year in line with our strategy. Each of our objectives are set out in a more detailed document and so this plan only includes the 'big ticket' items, particularly where there is investment planned in the operational budget, we have also included projects that have started or where funding is approved from RTF. For new transformational and fixed term projects, we will continue to use the RT fund or alternative income streams as a source of investment, relevant governance and approval processes will be followed where this is the case.

In determining changes to our budget for the year, we have made the following assumptions:

- Continued rise in service demand across all areas (hospice, hospital and community)
- Ongoing development of ambulatory care including clinics and outpatient services
- Continued role of digital/ virtual consultations in the community; other initiatives to support more community-based care
- Continued focus on the hospital end of our work, to support system-wide improvements in responsiveness of services
- Terms and conditions review for retail and fundraising and SLT benchmarking, aim to move to NHS AfC T&Cs for other staff
- Ongoing focus on inequalities and community development – reaching the whole community, complexity of need
- Growing volunteering to support all areas of the hospice

- Increases in employer NI have been included in this budget

The budget has been prepared collaboratively between the Finance department and SLT with additional input from other budget holders. SLT were asked to develop their operational plans and review previous budgets in their areas of responsibility, and make the changes as needed. The SLT have discussed the budget and support the plan.

Other Assumptions

We have budgeted for pay increments where they apply and at this stage no annual inflationary increase is included, except for those at the London living wage end. For each 1% salary increase, the cost to the organisation would be approximately £100k. We would like to delay the decision around annual increases for two reasons; firstly, affordability and secondly, because of the planned review of T&Cs. We anticipate this work will be completed in June with a costed proposal to be brought to board at that point, any proposal will also include any recommendations around a cost-of-living increase which could be backdated to May if we are able.

Clinical Services

As we look to the next year, we expect a continued rise in the demand for our services and the complexity of the needs that patients who present for care have. We will also maintain our focus on community delivered care.

We have made further good progress with clinical recruitment and the staffing budget will enable us to continue to deliver a safe and responsive service. We will continue to look to find additional income to support our clinical services through packaged up trust funding and statutory funds where these are available.

CARE EXPENDITURE (includes IPU, Medical, Rehab and Wellbeing, Psychological and Supportive Care, Virtual Wards, ACT, Catering, Estates, SPC Community, H@H, OneBexley, Hospital team, SELICS)

Budget 24-25	£8,023,988	Forecast 24-25	£7,077,012	Budget 25-26	**£7,603,593**

- Improve the resilience of the senior medical team, through supported development of existing staff and recruitment to substantive consultant post
- Improve integration and collaboration with external agencies with particular focus on GP surgeries and QEH
- Improve digital offer in virtual ward service
- Investment in wellbeing/ rehab team, to include speech and language therapy and dietetics
- Improve throughput and occupancy in IPU

- Review ACT/ Data and Governance Team to ensure that every role has a defined purpose and contributes to overall objectives
- Optimising Clinical Admin support across all clinical teams
- Set structure to deliver the next 4.5 years of the OneBexley Contract including implementing the findings of the external evaluation
- Develop H@H staff to move from band 2 to band 3 to enable better business continuity and to support patients with medications
- Support more patients at home and in outpatient clinics through expansion of frailty offer and involvement in system-wide integrated neighbourhood working
- Review opportunities for improvement in hospital SPC Team especially at the hospital 'front door'
- Continuation of Leadership for SEL ICS PEoLC programme of work
- Improve the energy efficiency of our estate
- Reduce reactive maintenance costs/ improve PPM
- Develop a long-term plan for the Bostall Hill site
- Reduce contractor spend by investing in internal estates staff

The Head of Community Services is driving much needed change in SPC community services to improve responsiveness. We have appointed (though not yet started) to the Team Leader for hospital SPC.

The good progress in developing our rehabilitation, wellbeing and outpatient offer continues and we anticipate this increasing in 24/25, further reducing reliance on more intensive services such as SPC in the community.

We intend to continue to work in partnership wherever we can with the hospital, community services, care homes, local authorities and other charities. Where possible we will continue to look for additional funding to support any service innovation and to enable us to challenge inequalities.

We have had confirmation of our uplift to our contract from colleagues in Greenwich and Bexley, so this figure is confirmed, however their final allocations from NHSE have not yet been confirmed, and so they have been cautious in any uplift provided.

Our statutory income was uplifted by 3.9% in 24/25 compared with 23/24 - this uplift increased partway through the year, as NHS final allocations were not settled until January 2025. We are assuming a similar uplift in 25/26 which is not confirmed at the time of writing but feels realistic, whether this is part of a recurrent increase to our statutory funding or is realised as part of one-off awards of non-recurrent funding.

The main risks we see in this area centre around recruitment and retention of the right staff to deliver against our operational plan, where necessary we will use bank in preference of agency and manage any agency spend through robust approvals and monitoring.

Support Services

SUPPORT SERVICES (includes HR, Finance, IT, CEO, Admin Services)

Budget 24-25	£1,297,418	Forecast 24-25	£1,305,749	Budget 25-26	**£1,417,773**

- Full complement of staff in People Team
- Launch wellbeing champions and identify wellbeing challenges identified through staff survey
- Continue to develop leadership capability
- Modernise terms and conditions – implement a new pay structure for retail and fundraising, benchmark SLT salaries, align all other staff to AfC
- Further enhance recruitment and onboarding and develop strategies to retain talent
- Support income generation initiatives through resource tracking
- Implement cost-control measures across departments without compromising service quality
- Continue to update IT infrastructure and staffing to improve IT and business operations
- Replace telephony system

COMMUNITY DEVELOPMENT, VOLUNTEERING and DATA/INTELLIGENCE

Budget 24-25	£272,469	Forecast 24-25	£151,072	Budget 25-26	**£252,165**

- Full year effect of full Community Development and Volunteering Team
- Implement the infrastructure the team needs to deliver their services (CRM)
- Recruiting. Onboarding and developing new volunteers to support teams to deliver their operational plans
- Systematise the Community Hospice 'Community Development Way'

Communications and Marketing

Budget 24-25	£271,321	Forecast 24-25	£365,566	**Budget 25-26**	**£424,190**

Last year saw us successfully deliver two substantial and transformational projects: the brand refresh and the new website. We are now moving our focus to delivering BAU in a more structured way based on data and outcomes. Elements of the brand deployment continue as expected, especially around communications with patients. A new comms strategy will be presented to the Board in Q4.

Key points on the budget:

- 24/25 was the first year with the full team in place and we are not planning any changes to the structure at this point
- Costs relating to BAU are in line with last year (taking account of inflationary increases)
- Comms and Marketing budget covers the main corporate activities, but each department may have direct marketing expenditure relating to their operations (e.g. marketing for events, regular patient information) this has been accounted for in individual departmental operational budgets
- Intranet/SharePoint project has been put on hold until the funding is available. Project will be assessed for FY26/27
- We plan to deliver two RT fund related projects that have been captured in the designated budget: brand deployment in retail across 11 shops and brand deployment in the hospice building.

Fundraising

FUNDRAISING							
Budget 24-25	£1,591,660	Forecast 24-25	£1,475,001	YTD actual 24-25: Jan	£1,328,778	**Budget 25-26**	**£1,896,032**
*Excludes budgeted legacy income of £1,500,000						**Net surplus 25-26**	**£1,229,762**

Fundraising strategy approved by the Board in 2024 remains relevant and the operational plan for FY 25/26 is focusing on its implementation. The team is starting the new FY in full, except for the Database Manager which is vacant. Last year's achievements set a strong basis: the new CRM is now in place and the new brand, website and strong positive culture within the team are set to support fundraising efforts. Diversifying of the income streams and our investment in high value is reducing the risks to overall contribution, but we recognise that we still have a way to go to achieve the desired fundraising income ratio. With our focus on data and analytics to drive our decisions and activities and development of income streams in line with the strategy, we hope to move to an even stronger position for the following year.

Key points on the budget:

- We have stretched our targets on all income streams but we are confident the team can reach those
- There is no contingency in the expenditure budget
- There is investment from the RT Fund to develop corporate relationships (already approved) as well as modest investment in development of community and individual giving.

Key risks

- The fundraising climate remains challenging with fast paced changes in giving trends, more competition and the impact of the global economic situation on giving power both for individuals and organisations
- Internal clarity on need and service costs are key to achieving our fundraising objectives especially within high value giving; we need a fully scoped and priced case for support and projects within Q1
- Our events partners have changed the way they work which puts some of our key events at risk (for example, Colour Run); the team is working towards minimising these risks by finding alternative income generation ideas.

LOTTERY

Budget 24-25	£462,824	YTD actual – Jan 25	£349,817	**Budget 25-26**	**£462,824**
				Net surplus 25-26	**£176,982**

The Lottery Board has reviewed the Lottery budget, approved the level of contribution and recommended approval of the budget to the FIGIT.

The Lottery contribution is in line with last year's budget. The lack of predicted growth relates mainly to continued challenges in securing canvassers. While we are starting the year with a newly recruited canvasser and the team are working towards diversifying acquisition and retention, with accounting for costs spread over two years and high drop rates, we are unlikely to see quick changes to levels of income.

It was agreed at the Lottery Board that we will deliver an in-depth review of the Lottery. This will be presented to the Board once fully worked out in Q3/Q4 with implementation taking place in FY26/27; hence for FY25/26 budget we assume the Lottery will function as is. Any outcomes of the strategy work, if delivered sooner, will be accommodated in the reforecast if necessary.

Key risk for meeting contribution level relate directly to the number of canvassers supporting our activity.

LEGACIES

Budget 24-25	£1,000,000	YTD actual – Jan 25	£2,305,116	**Budget 25-26**	**£1,500,000**

HUK Legacy Campaign has been a great opportunity for us to invest appropriately in this income stream for the first time – with the locally focused campaign taking place over February and March 2025 (costs of the campaign have been all met in the Current Financial Year). We want to use this momentum to further develop legacy marketing and administration and establish a strategic direction that will dictate our operational plans for the next three years.

Key points on the budget

- We have increased legacy income to £1,500,000 based on past performance, recent investment and a 6 year average of £1.3million per annum
- The operational budget (captured in Fundraising operational budget) accommodates HUK fee for the second year of the national Legacy Campaign and Hospice Legacy Circle consortium
- No additional funding has been designated for the September campaign. Our plan is to review the outcome and impact of the current campaign to assess viability / need / potential benefits from any activities undertaken in Q2.

Key risk for Legacy income relate directly to its unpredictability and long timescale for return on any investment.

Retail

Below are some headline comments on our approach to and rationale behind the budgeted figures.

RETAIL							
Budget 24-25	£2,721,574	Forecast 24-25	£2,475,595	YTD actual Jan 25	£2,078,273	Budget 25-26	**£3,152,910**
Net surplus 24-25 (budget)	£714,301					Net surplus 24-25	**£673,463**

While the contribution for the FY 24/25 remained strong, overall sales have declined, and we have not met our sales budget. The relatively high level of forecasted contribution is due to the vacancy levels that brought expenditure costs down, but the impact of the challenges faced across retail has made a lasting impact which we must address. Our focus for this year remains on the shop network and on strengthening the team through additional posts, as well as addressing capabilities and opening new units. There is a small growth in ecommerce, and we are postponing work on upcycling and innovation until the sales numbers are more stable. A big focus will remain on improving gift aid and addressing challenges related to the increased complexity and cost of waste management and the collapsing rags market.

Key points on the budget

- In sales the like for like (LFL) increase is circa 11.59% with 7 shops greater than this, other charities we are aware of are circa 6-8% with increased levels of paid staff.

- We are investing in new posts to address our drop in sales; this will be a phased approach and is reflected in a corresponding increase in income
- Broadway shop lease is coming to an end
- Two new shops have been budgeted for with a view to opening these in the second part of the year
- Retail Development post remains frozen and no changes to the leadership structure have been taken into account – this will be addressed through the terms and conditions project
- While the level of contribution is lower than we hoped for, we strongly believe it is important we invest appropriately in the team to allow much stronger performance in the FY2026/27 and beyond
- We have included investment into a new EPOS system captured in CAPEX budget

Risks:

- There is no contingency built into our budgets and while we have tried to account for the increase of prices and other external factors, the true impact of economic pressures or anxiety around political developments on customers might have a significant impact
- The highest risks that might impact meeting the predicted contribution is around the need to secure new units, for which there is high competition in London as well as challenging negotiations on some of our current shops
- The other key risks for meeting the trading budget centre about retaining strong staff, upskilling the team and low levels of volunteering – we have invested in this area and are starting to see improvements.

The Trading Board has reviewed the trading budget, approved the level of contribution and recommended approval of the budget to the FIGIT.

Summary

Overall Budget					
Budgeted Income 24-25	£12,490,443	Forecast Income 24-25	£13,440,530	**Budget Income 25-26**	**£14,085,170**
Budgeted Expenditure 24-25	£13,211,180	Forecast Expenditure 24-25	£12,577,425	**Budget Expenditure 25-26**	**£14,679,601**

Net surplus (deficit) before depreciation 24-25	(£720,737)	Net surplus (deficit) before depreciation	£821,052	**Net surplus (deficit) 25-26**	**£ (594,430)**

We are presenting this budget and operational plan to the Board for approval and adoption, following discussion at the recent Finance, Information Governance and Information Technology Committee. The service elements of the operational plan will be considered at the next Quality and Safety Committee.

Whilst we recognise that we are presenting a budget with a deficit to be funded out of general reserves, the ongoing economically and politically uncertain external climate including the increase in employer NI contribution has increased costs and caused us to be more cautious in some areas of income. We feel this is a realistic budget, but we sincerely hope that we will be able to end the year with a marked improvement on this initial budgeted position.

We are ending FY2024/25 in a better position than we anticipated when the Board approved the budget last April. Our currently healthy level of reserves has allowed us to invest in our future sustainability and this work is ongoing, we would hope that we will be able to 'top-up' our RT Fund when we have our end of year results. Much of the work we are doing now continues to bring opportunities, efficiencies and improvements for our future. As we implement the next year of our strategy, we should continue to invest whilst we can to enable continued growth in income and to allow us to reach a break-even position and necessary ongoing investment in clinical services.

We know that we will continue to see increased need and complexity and believe it would be a negative step to reduce or stand still where investment has already been made. As with last year, there remain several vacancies in this budget, and inevitably we will see turnover throughout the year; we have trimmed some of the vacant roles back based on likely recruitment timelines. We will continue to monitor our risk and frequent review through SLT/HLT and FIGIT will enable us to redirect our course should we find that we need to take a different tack due to unforeseen challenges.

We hope that the Board will approve our plan, so that we can continue on our improvement journey this year and continue to implement our strategy.

Summary Consolidated Budget 2025/2026

	FY 2025/ 26	%	Forecast 2024/25	%	Var	%	Budget 2024/25	%	Var	%
	£		£		£		£		£	
Income										
Core Grant	5,109,587	36%	4,946,148	37%	163,439	3%	5,799,880	46%	- 690,294	-12%
One Bexley	1,040,000	7%	1,030,000	8%	10,000	1%	540,000	4%	500,000	93%
Ageing Well	395,861	3%	282,828	2%	113,033	40%	-	0%	395,861	0%
Donations & Fundraising	1,896,032	13%	1,475,001	11%	421,031	29%	1,591,660	13%	304,372	19%
Legacies	1,500,000	11%	2,405,116	18%	- 905,116	-38%	1,000,000	8%	500,000	50%
Retail	3,152,910	22%	2,475,595	18%	677,315	27%	2,721,574	22%	431,335	16%
Lottery	475,062	3%	428,508	3%	46,554	11%	462,824	4%	12,238	3%
Education	-	0%	-	0%	-		133,000	1%	- 133,000	
Government Financial Support - Capital grant	308,191	2%	42,054	0%	266,137		-	0%	308,191	
Other	207,528	1%	313,227	2%	- 105,699	-34%	241,504	2%	- 33,976	-14%
Total Income	**14,085,170**	100%	**13,398,476**	100%	**686,694**		**12,490,443**	100%	**1,594,728**	
Expenditure					-				-	
Clinical & Medical Services	8,463,707	58%	7,378,072	59%	1,085,634	15%	8,206,532	60%	257,175	3%
Fundraising	992,814	7%	734,456	6%	258,357	35%	986,344	7%	6,470	1%
Retail	2,479,447	17%	1,783,472	14%	695,975	39%	2,007,273	15%	472,174	24%
Lottery	298,080	2%	213,757	2%	84,323	39%	287,641	2%	10,439	4%
Management & Support	2,445,554	17%	2,467,667	20%	- 22,114	-1%	2,296,901	17%	148,653	6%
Total Expenditure	**14,679,601**	100%	**12,577,425**	100%	**2,102,176**	17%	**13,784,691**	100%	**894,910**	6%
Surplus/(Deficit) Before Depreciation	**(594,430)**		**821,052**		**(1,415,482)**		**(1,294,248)**		**699,818**	
Non-operational costs	**578,820**		**322,277**		256,543	80%	**270,629**		578,820	0%
Surplus/(Deficit) After Depreciation	**(1,173,250)**		**498,775**		**(1,672,025)**	-335%	**(1,564,877)**		**120,998**	-9%

Financial Performance Summary: Year-to-Date and January 2025 Highlights

Overall Performance:

The Charity closed the month of January 2025 with an overall surplus of £213,431 and a Year-to-date (YTD) surplus of £402,355. This surplus is largely due to £257,000 income received from the One Bexley Adult Social Care contract which was renewed during the period as well as £253,000 of legacy recognised in the period to date.

The charity recorded non-operational cost on depreciation and amortization of £28,065 in the month and £233,519 YTD; therefore the operational surplus for the month was £241,496 and YTD surplus was £635,874.

Overall surplus for the period is classified as follows: Unrestricted surplus of £679,965, spend of £241,249 designated funds and £36,361 deficit from restricted funds.

Income Commentary:

Consolidated income for the month of January exceeded budget by £327,459 and the YTD income exceeded budget by £1,002,483. Income is analysed as follows:

Income for SEL ICB: Income from Southeast London ICB recorded a positive variance of £30,206 in the month of January and an adverse variance £497,756 YTD.

One Bexley ASC Contract: The previous One Bexley ASC contract yielded an income of £515,000 between April and September 2024.

A new contract was awarded to the Charity for the next 5 years and it is expected to yield £1,040,000 per annum, starting from October 2024 to September 2029. We therefore expect £520,000 from this contract between October 2024 and March 2025

Donations and Fund raising: Donations and fundraising for the YTD were £19,002 below the budget of £1,347,780 while the month of January, was £16,289 lower than the budgeted amount of £130,470.

Legacy Income: YTD Legacy income was £2,305,116, which is £1,471,783 above budget. This is because the Charity received £1,600,000 legacy income in the period under review. There are no legacies in the pipeline as of end of January 2025.

Income from subsidiaries: Trading and lottery YTD income was below budget by £199,512 and £35,870 respectively. See further commentary in section Subsidiaries' Performance:

Forecast:

We are forecasting an overall surplus of £498,775 for the Charity which contains a forecast of £280,223 for depreciation and amortization, hence the surplus from operations is expected to be £778,998.

Subsidiaries' Performance:

The Trading Company generated YTD surplus of £597,787, which was 2% below budget. YTD income fell short of the budget by £199,392 and was £25,286 below the monthly target.

Sales of donated goods had a significant adverse variance of £280,589 due to shop closures caused by staff shortages. However, Broadway Mall and Erith shops outperformed their budgets by 41% and 12%, respectively, while Eltham met its budget.

The shortfall was partly offset by YTD sales of rags (£64,355) and bank interest (£27,645). However, there has been a 50% drop in rag prices which is expected to impact future revenue.

The Lottery Company achieved a £19,536 surplus in the month against a budgeted surplus of £14,599 resulting in a favourable variance of £4,937. YTD, the company achieved a surplus of £171,792 which was 18% above the budgeted surplus of £145,986.

Balance Sheet and Liquidity:

Funds: Total YTD funds stand at £12,268,839, with unrestricted funds at £5.3m, 17% below the target of £6.2m. The charity's designated funds are £1.1m while restricted funds stand at £5.8m

Working Capital: The Charity's current working capital position increased by £204,745 between the Year ended March 2024 and period ended January 2025.
YTD working capital stands at £4.7m, which exceeds the charity's working capital requirement of £2m by £2.7m. Management has invested excess working capital funds in various fixed term deposits which will yield an average interest of 3.45%.

Efficiency: Charity's liquidity remains strong despite a slight drop of 0.16 in the quick ratio YTD, while the current ratio has improved by 0.41, reflecting better immediate cash availability. The return on assets and net asset ratio have increased, indicating more efficient use of assets to generate income.

Appendices:

Appendix I: Consolidated Income Statement

GREENWICH & BEXLEY COMMUNITY HOSPICE
Income Statement for Period 2025 January

	2025 January			2025 January YTD					
	Actuals	Budgets	Variance	Actuals	Budgets	Variance	Forecast	Budget	Variance
Income	**1,320,209**	**992,750**	***327,459***	**11,528,222**	**10,525,739**	***1,002,483***	**13,356,422**	**12,490,443**	***865,979***
South East London ICB	506,787	476,580	*30,206*	4,159,484	4,657,239	*-497,756*	4,946,148	5,057,141	*-110,993*
Ageing Well PEOLC	8,826	8,826	*0*	196,828	196,828	*0*	282,828	767,739	*-484,911*
ASC Contract	86,667	0	*86,667*	859,167	515,000	*344,167*	1,030,000	515,000	*515,000*
Donations & Fundraising	114,181	130,470	*-16,289*	1,328,778	1,347,780	*-19,002*	1,475,001	1,591,660	*-116,659*
Legacies	256,145	83,333	*172,811*	2,305,116	833,333	*1,471,783*	2,405,116	1,000,000	*1,405,116*
Education Income	0	10,667	*-10,667*	0	106,667	*-106,667*	0	128,000	*-128,000*
Trading	198,477	223,763	*-25,286*	2,078,273	2,277,785	*-199,512*	2,475,595	2,721,575	*-245,980*
Lottery	39,338	38,569	*769*	349,817	385,687	*-35,870*	428,508	462,824	*-34,316*
Catering Income	1,569	4,167	*-2,598*	16,940	41,667	*-24,727*	20,328	50,000	*-29,672*
Other Income	108,220	16,375	*91,845*	233,820	163,753	*70,066*	292,899	196,504	*96,395*
Costs of Goods Sold	**90,660**	**87,739**	***-2,921***	**1,066,507**	**1,179,333**	***112,827***	**1,215,814**	**1,325,581**	***109,767***
Inpatients	6,685	14,594	*7,909*	109,970	145,940	*35,970*	132,508	175,128	*42,620*
Fundraising	8,119	30,590	*22,471*	155,270	257,930	*102,660*	178,890	289,880	*110,990*
Trading	1,086	4,167	*3,081*	21,181	41,667	*20,485*	25,505	50,000	*24,495*
Lottery	7,000	7,579	*579*	54,250	75,792	*21,542*	65,078	90,950	*25,872*
Expenditure	**988,053**	**984,687**	***-3,366***	**9,825,842**	**10,488,562**	***662,721***	**11,361,611**	**12,456,201**	***1,094,590***
Medical	82,213	65,821	*-16,392*	594,494	*561,022*	*-33,473*	664,720	692,663	*27,943*
Inpatients	141,798	139,594	*-2,204*	1,434,710	*1,396,291*	*-38,419*	1,557,713	1,675,480	*117,767*
Psychological & Social Care	21,650	21,648	*-2*	217,411	*216,477*	*-934*	260,989	259,773	*-1,216*
Clinical Governance	11,694	9,919	*-1,776*	114,572	*99,186*	*-15,386*	137,486	119,023	*-18,463*
Community Development	6,825	6,967	*142*	62,839	*69,666*	*6,827*	75,407	83,599	*8,192*
Volunteering	9,774	11,628	*1,854*	63,054	*106,493*	*43,439*	75,665	129,750	*54,085*
Rehab	17,685	27,321	*9,637*	205,790	*262,642*	*56,852*	196,948	317,285	*120,337*
Ageing Well PEOLC	8,826	8,826	*0*	196,828	*196,828*	*0*	236,193	383,739	*147,546*
GCP	55,110	45,569	*-9,542*	521,483	*455,687*	*-65,796*	626,020	546,824	*-79,195*
ACT	29,192	25,378	*-3,814*	293,140	*253,780*	*-39,361*	351,769	304,536	*-47,233*
ASC Contract	9,209	10,892	*1,683*	114,983	*147,511*	*32,528*	137,980	169,296	*31,316*
SEL ICB	7,899	6,219	*-1,680*	86,169	*540,821*	*454,652*	103,402	384,000	*280,598*
Community	112,179	119,813	*7,634*	1,055,286	*1,169,679*	*114,393*	1,166,404	1,410,555	*244,152*
Education	7,490	4,583	*-2,907*	74,434	*45,833*	*-28,601*	89,393	55,000	*-34,393*
Hospital	41,425	47,875	*6,450*	421,711	*447,227*	*25,516*	486,054	542,977	*56,924*
Virtual Ward	26,622	20,894	*-5,728*	221,324	*193,254*	*-28,070*	265,589	235,042	*-30,548*
Fundraising	47,724	55,493	*4,743*	479,388	*605,870*	*111,352*	555,566	696,464	*140,898*
Comms & Marketing	18,875	20,063	*1,188*	304,417	*372,891*	*68,474*	365,566	412,185	*46,619*
Catering	23,260	19,000	*-4,260*	214,745	*190,000*	*-24,745*	257,694	228,000	*-29,694*
CEO	16,089	15,511	*-578*	157,851	*156,232*	*-1,619*	189,601	187,628	*-1,973*
Premises	48,562	26,915	*-21,647*	451,717	*269,153*	*-182,563*	538,658	322,984	*-215,674*
Finance	24,976	25,691	*715*	270,761	*256,909*	*-13,852*	305,413	308,291	*2,877*
Admin Services	5,186	8,008	*2,822*	126,007	*80,083*	*-45,923*	154,929	96,100	*-58,829*
IT	28,244	31,688	*3,444*	293,896	*316,877*	*22,982*	331,249	380,253	*49,004*
HR	24,094	31,881	*7,787*	264,216	*303,494*	*39,277*	324,557	361,460	*36,903*
Trading	148,648	164,124	*15,476*	1,460,839	*1,625,877*	*165,038*	1,757,967	1,956,603	*198,636*
Lottery	12,802	13,365	*563*	123,776	148,779	*25,004*	148,679	196,691	*48,012*
Surplus/ (Deficit) from Ops	**241,496**	**-79,675**	***321,172***	**635,874**	**-1,142,157**	***1,778,031***	**778,998**	**-1,291,339**	***2,070,336***
Non-Operational Costs	**28,065**	**0**	***-28,065***	**233,519**	**0**	***-233,519***	**280,223**	**0**	***-280,223***
Depreciation	24,721	0	*-24,721*	205,137	0	*-205,137*	246,164	0	*-246,164*
Amortization	3,344	0	*-3,344*	28,382	0	*-28,382*	34,058	0	*-34,058*
Surplus/ (Deficit)	**213,431**	**-79,675**	**293,107**	**402,355**	**-1,142,157**	**1,544,512**	**498,775**	**-1,291,339**	**1,790,113**

Appendix II: Consolidated Income statement by fund

GREENWICH & BEXLEY COMMUNITY HOSPICE
Income Statement by Fund for Period 2025 January

Period	Total YTD	Total	Unrestricted	Unrestricted	Designated	Designated	Restricted	Restricted	Variance
2025 January		Budget YTD	YTD	Budget YTD	YTD	Budget YTD	YTD	Budget YTD	YTD
Income	**11,528,222**	**10,525,739**	**11,279,418**	**10,442,405**	**0**	**0**	**248,804**	**83,333**	**1,002,483**
South East London ICB	4,159,484	4,657,239	4,131,128	4,582,239	0	0	28,356	75,000	(497,756)
Ageing Well PEOLC	196,828	196,828	0	196,828	0	0	196,828	0	0
ASC Contract	859,167	515,000	859,167	515,000	0	0	0	0	344,167
Donations & Fundraisin	1,328,778	1,347,780	1,305,157	1,347,780	0	0	23,621	0	(19,002)
Legacies	2,305,116	833,333	2,305,116	833,333	0	0	0	0	1,471,783
Education Income	0	106,667	0	98,333	0	0	0	8,333	(106,667)
Trading	2,078,273	2,277,785	2,078,273	2,277,785	0	0	0	0	(199,512)
Lottery	349,817	385,687	349,817	385,687	0	0	0	0	(35,870)
Catering Income	16,940	41,667	16,940	41,667	0	0	0	0	(24,727)
Other Income	233,820	163,753	233,820	163,753	0	0	0	0	70,066
Cost of Goods Sold	**1,066,507**	**1,179,333**	**1,059,307**	**1,091,833**	**7,200**	**87,500**	**0**	**0**	**112,827**
InPatients	109,970	145,940	109,970	145,940	0	0	0	0	35,970
GCP	197,878	308,089	197,878	308,089	0	0	0	0	110,211
ASC Contract	527,958	349,916	527,958	349,916	0	0	0	0	(178,042)
Fundraising	155,270	257,930	148,070	170,430	7,200	87,500	0	0	102,660
Trading	21,181	41,667	21,181	41,667	0	0	0	0	20,485
Lottery	54,250	75,792	54,250	75,792	0	0	0	0	21,542
Expense	**9,825,842**	**10,488,562**	**9,306,627**	**9,269,445**	**234,049**	**414,051**	**285,165**	**805,066**	**662,721**
Medical	594,494	561,022	594,494	561,022	0	0	0	0	(33,473)
Inpatients	1,434,710	1,396,291	1,434,710	1,396,291	0	0	0	0	(38,419)
Psychological & Social C	217,411	216,477	217,411	216,477	0	0	0	0	(934)
Clinical Governance	114,572	99,186	106,549	99,186	0	0	8,023	0	(15,386)
Community Developme	62,839	69,666	60,877	69,666	0	0	1,962	0	6,827
Volunteering	63,054	106,493	63,054	67,334	0	39,159	0	0	43,439
Rehab	205,790	262,642	205,790	177,264	0	25,836	0	59,543	56,852
Ageing Well PEOLC	196,828	196,828	0	0	0	0	196,828	0	(196,828)
GCP	521,483	455,687	521,483	455,687	0	0	0	0	(65,796)
ACT	293,140	253,780	293,140	245,905	0	0	0	7,875	(39,361)
ASC Contract	114,983	147,511	114,983	147,511	0	0	0	0	32,528
SEL ICB	86,169	540,821	8,376	0	0	0	77,792	737,648	651,480
Community	1,055,286	1,169,679	1,054,926	1,087,898	0	81,781	360	0	114,393
Education	74,434	45,833	74,234	45,833	0	0	200	0	(28,601)
Hospital	421,711	447,227	421,711	447,227	0	0	0	0	25,516
Virtual Ward	221,324	193,254	221,324	193,254	0	0	0	0	(28,070)
Fundraising	479,388	605,870	407,330	512,180	72,058	78,559	0	0	111,352
Comms & Marketing	304,417	372,891	201,813	232,027	102,604	140,864	0	0	68,474
Catering	214,745	190,000	214,745	190,000	0	0	0	0	(24,745)
CEO	157,851	156,232	157,851	156,232	0	0	0	0	(1,619)
Premises	451,717	269,153	435,163	251,563	16,554	17,591	0	0	(182,563)
Finance	270,761	256,909	263,171	256,909	7,590	0	0	0	(13,852)
Admin Services	126,007	80,083	125,867	80,083	140	0	0	0	(45,923)
IT	293,896	316,877	264,532	286,616	29,363	30,261	0	0	22,982
HR	264,216	303,494	258,476	303,494	5,740	0	0	0	39,277
Trading	1,460,839	1,625,877	1,460,839	1,625,877	0	0	0	0	165,038
Lottery	123,776	148,779	123,776	163,909	0	0	0	0	40,134
Surplus/ (Deficit)	**635,874**	**(1,142,157)**	**913,484**	**81,127**	**(241,249)**	**(501,551)**	**(36,361)**	**(721,733)**	**832,357**
Non-Operational Cost	**233,519**	**0**	**233,519**	**0**	**0**	**0**	**0**	**0**	**(233,519)**
Depreciation	205,137	0	205,137	0	0	0	0	0	(205,137)
Amortization	28,382	0	28,382	0	0	0	0	0	(28,382)
Surplus/ (Deficit)	**402,355**	**(1,142,157)**	**679,965**	**81,127**	**(241,249)**	**(501,551)**	**(36,361)**	**(721,733)**	**460,455**

Appendix III: Consolidated Income Statement Summary

GREENWICH & BEXLEY COMMUNITY HOSPICE
Income Statement for Period 2025 January

	2025 January			2025 January YTD		
	Actuals	Budgets	*Variance*	Actuals	Budgets	*Variance*
Income	**1,320,209**	**992,750**	***327,459***	**11,528,222**	**10,525,739**	***1,002,483***
South East London ICB	506,787	476,580	*30,206*	4,159,484	4,657,239	*(497,756)*
Ageing Well	8,826	8,826	*0*	196,828	196,828	*0*
Local Authority	86,667	0	*86,667*	859,167	515,000	*344,167*
Donations & Fundraising	114,181	130,470	*(16,289)*	1,328,778	1,347,780	*(19,002)*
Legacies	256,145	83,333	*172,811*	2,305,116	833,333	*1,471,783*
Education	0	10,667	*(10,667)*	0	106,667	*(106,667)*
Retail	198,477	223,763	*(25,286)*	2,078,273	2,277,785	*(199,512)*
Lottery	39,338	38,569	*769*	349,817	385,687	*(35,870)*
Other	109,789	20,542	*89,247*	250,760	205,420	*45,340*
Costs of Goods Sold	**90,660**	**87,739**	***(2,921)***	**1,066,507**	**1,179,333**	***112,827***
Clinical & Medical Services	74,456	45,403	*(29,053)*	835,806	803,945	*(31,862)*
Fundraising	8,119	30,590	*22,471*	155,270	257,930	*102,660*
Retail	1,086	4,167	*3,081*	21,181	41,667	*20,485*
Lottery	7,000	7,579	*579*	54,250	75,792	*21,542*
Expenditure	**988,053**	**984,687**	***(3,366)***	**9,825,842**	**10,488,562**	***662,721***
Clinical & Medical Services	589,591	572,947	*(16,644)*	5,678,230	6,162,398	*484,167*
Fundraising	47,724	55,493	*4,743*	479,388	605,870	*111,352*
Management & Support	189,287	178,757	*(10,530)*	2,083,609	1,945,639	*(137,970)*
Retail	148,648	164,124	*15,476*	1,460,839	1,625,877	*165,038*
Lottery	12,802	13,365	*563*	123,776	148,779	*25,004*
Surplus/ (Deficit)	**241,496**	**(79,675)**	***321,172***	**635,874**	**(1,142,157)**	***1,778,031***
Non-Operational Costs	**28,065**	**0**	**(28,065)**	**233,519**	**0**	**(233,519)**
Depreciation	24,721	0	*(24,721)*	205,137	0	*(205,137)*
Amortization	3,344	0	*(3,344)*	28,382	0	*(28,382)*
Surplus/ (Deficit)	**213,431**	**(79,675)**	**349,237**	**402,355**	**(1,142,157)**	**2,011,550**

Appendix II: Consolidated Balance Sheet

GREENWICH & BEXLEY COMMUNITY HOSPICE

Consolidated Balance Sheet as at 2025	2025 January	2025 January	Year End Mar 2024	ar End Mar 2025
ASSETS				
FIXED ASSETS				
Freehold Property	5,701,522		5,728,274	
Furniture and Fixtures	405,523		186,245	
Motor Vehicles	10,248		20,647	
Computer Equipment	86,673		106,358	
Medical Equipment	54,583		51,369	
Listed Investments	1,139,190		1,092,308	
		7,397,740		**7,185,202**
OTHER LONG TERM ASSETS				
Intangible Assets	89,609		97,279	
CURRENT ASSETS				
Legacies	2,390,110		1,018,185	
Trade Debtors	417,670		36,765	
Other Debtors	273,134		281,005	
Prepayments	359,088		382,744	
Cash at Bank & in hand	2,544,417		3,459,517	
Bank Fixed Term Deposit	2,000,000		2,000,000	
	7,984,418		**7,178,216**	
		8,074,027		**7,275,495**
LIABILITIES				
CURRENT LIABILITIES				
Trade Creditors	(178,352)		-324,802	
Accruals	(321,067)		-1,153,464	
Deferred Income	(1,648,322)		(65,675)	
VAT & Other payroll taxes	(213,845)		(167,883)	
Other Creditors	(841,342)		(838,097)	
	(3,202,928)		**(2,549,921)**	
NET CURRENT ASSETS		**4,781,490**		**4,725,574**
NET ASSETS		**12,268,839**		**11,910,776**
FUNDS				
Unrestricted Funds:				
General Fund	5,279,773		4,323,264	
Designated Funds				
Fixed Assets Fund	364,304		364,304	
Building Development Fund	500,000		500,000	
Recovery & Transformation Fund	136,053		538,137	
ASC Bexley One Fund	155,000		155,000	
Restricted Funds:				
Property Fund	5,701,522		5,797,436	
Others	132,188		232,635	
		12,268,839		**11,910,776**

Appendix III: Movement in Funds

Reserves Movements	*B/f*	*Movement YTD (IS)*	*Movement YTD (BS)*	*C/f*
General Fund	4,323,265	936,714	19,794	5,279,773
Designated Funds				
Fixed Assets Fund	364,304			364,304
Building Development Fund	500,000			500,000
Recovery & Transformation Fund	538,137	(241,249)	(160,835)	136,053
ASC Bexley One Fund	155,000			155,000
Restricted Funds:				
Property Fund	5,797,436	-256,749	160,835	5,701,522
Others	232,635	(36,361)	(64,086)	132,188
	11,910,777	**402,355**	**(44,292)**	**12,268,839**

Meeting: Board of Trustees

Date: Wednesday 12th March 2025

Item Number:

Author: **Kate Heaps**

Private and Confidential

Title	Chief Executive's Report	
This paper is for **noting**		
Contents	1. NHSE additional funding for hospices 2. RHS Chelsea Flower Show 3. Balcombe Charitable Trust 4. People 5. National Legacy Campaign 6. Assisted Dying 7. Compassionate Neighbours 8. System Working 9. Awards 10. And finally….!	
Impacts of this proposal	Key risks & mitigations	• none
	Equality impact	• none
	Financial impact	• none

Overall a busy time of year with appraisals and budgets…. Here's some key headlines.

1. NHSE additional funding for hospices

We have received confirmation of our capital funding for this year from NHSE £230k and we expect £690 in 2025/26. We have received the MOU and should get the income in this Financial Year.

2. RHS Chelsea Flower Show

On Monday (10th) a team from Community Hospice are pitching to a charity called project Giving Back. If successful, they will fund the creation and relocation of a

small garden at Chelsea. Jason, our gardener has led this work to date, but it is very much a team effort and the goal is to use it to bring in more supporters and to raise awareness of our hospice. We are one of 8, pitching for 4 gardens, so fingers crossed!

3. **Balcombe Charitable Trust**

Thanks to the concert hosted by Tim Barnes KC MBE last autumn, we have received a pledge of £250k from the Balcombe Charitable Trust. They've visited the hospice and then followed up with a glass of wine with me and Graham at Tim's house. Thank you to Tim.

4. **People**

We have appointed to the Hospital Team Leader role, this is an important appointment as there is much to do at QEH. We expect the candidate to start in a couple of months' time. The Rehab and Wellbeing Lead is still vacant as is the Palliative Medicine Consultant. Unfortunately the previous conversation with a potential candidate did not bear fruit. We have several new starters in the fundraising and retail teams and we are beginning to see new volunteers joining as the new volunteering staff settle in.

5. **National Legacy Campaign**

(From HUK) While it's still early days in measuring the full impact, here are some exciting highlights from the National Campaign so far:

- **TV Commercial Reach:** In just the first six days of the campaign, **8.6 million adults** saw the ad.
- **Media Coverage:** National and regional coverage has resulted in over **460 pieces** across numerous media outlets. This included hundreds of excellent pieces placed by hospices with their local outlets.
- **Social Media Engagement:** Hospice UK's posts have seen some of our best-ever engagement, with over **130,000 impressions** across LinkedIn, Facebook, X and Instagram, and nearly **90,000 video views**.
- **Campaign Microsite:** Nearly **3,000 page views**, with 239 people clicking through to their chosen hospice.
- **YouTube Views:** The film has been watched over **5.5k times** on Hospice UK's YouTube channel.

Following a regional hospice meeting, Megan reports that we seem to have done better than other hospices, with many packs requested and good local engagement. Our out of home advertising is now up and hopefully building brand awareness across our patch.

6. **Assisted Dying**

I have provided a response to the AD bill committee which is reporting at the end of April. We will wait to hear more over the next few weeks.

We are still engaging with other stakeholders, presenting at end of life groups and exec committees on the bill and using it as an opportunity to talk palliative and hospice care also.

As the bill proceeds it is vital that we continue to review the risks and opportunities and communicate with all stakeholders about the issue.

7. **Compassionate Neighbours**

We had a productive CN Board Away day at the end of January where we discussed strategy and importantly for me, handover of the Board Chair role (hopefully to Jon). We have two new hospices joined and some more in the pipeline. We are also planning to re-engage with HUK to get their support/ buy in.

8. **System Working**

There is a lot of work happening at the moment to look at re-organising care for people experiencing frailty and people with three or more long term conditions (absolutely our cohort). It's great to see our team well represented and influencing how services can be better delivered in neighbourhoods and community based settings. Over time this should lead to investment in our services as well as those of partners, such as District Nursing.

We hosted a stakeholder workshop to think about the Bostall Hill site at the beginning of Feb. We will bring an options appraisal for discussion to the May board.

9. **Awards**

A team from the hospice attended the RBG Business Awards (Natalie and I were U+I's guests). We were shortlisted in two categories and won highly commended in one. We are hoping next year we might sponsor an award, which will help raise our profile to gain corporate support.

10. **And finally….**

I'm doing Trek Sahara in March. The trek is drawing very close. Thank you to those of you who have already sponsored me. I am hoping to reach £5,000. If you would like to sponsor me, any donation will be gratefully received. Kate treks the sahara

				Pre mitigation		
	Principal Risks		Key Risks	Impact	Probability	IxP
1	Governance Risks	a	Inadequate reporting to Trustees - leading to poor quality decision making	3	1	3
		b	Compliance Risk leading to damage to reputation; loss of volunteer support; loss of community confidence; loss of referrals; loss of funding/ fines; loss of influence; reduced effectiveness;	3	1	3

		c	Data Protection Risks leading to potential prosecution; harm to reputation and/or compromised relationships	3	2	6
		d	Geopolitical crises - potential impact on hospice business continuty, reputation, finances, IG, workforce	2	3	6

2	External Risks	a	Legislative changes to palliative care – funding, health and social care funding generally including personal health budgets or new service frameworks; assisted suicide	2	3	6
		b	Risks of competition (for Contracts and future care work)	3	1	3
		c	Risk of failure of partners who are subcontracted to deliver community Hospice services (MC, OFT and ASC partners)	2	2	4

		d	Breakdown in relationship with LGT	2	1	2
		e	Changes to employment law; changes to tax law; changes to charity/ fundraising law/ pensions	2	2	4
3	Financial Risks	a	Failure to secure budgeted charitable income (fundraising)	4	2	8

		b	Failure to secure budgeted charitable income (retail)	4	3	12
		c	Failure to secure budgeted level of legacies	4	2	8
		d	Failure to secure realistic levels of statutory income, loss of existing statutory income	4	2	8

		e	Leases	2	2	4
		f	People's time for volunteering is reduced due to societal change	2	2	4
		g	Loss of Assets	3	2	6
		h	Inadequate cost control	3	1	3

		i	Inflation/ rising cost of living: risk to staffing	3	3	9
		j	Risk of increased Marie Curie costs impacting Community Hospice.	3	3	9
4	Technological Risks	a	Possible system failure impacting on business operations or on patient safety	3	2	6
5	Operational Risks	a	Loss of Key personnel could lead to depletion of knowledge base; loss of contacts with key individuals, damage to reputation, pressure on remaining team, gap in staffing	3	2	6

b	Poor Management Processes result in Employee Relations Issues e.g. staff incompetence, discrimination; staff injury	3	2	6
c	Recruitment Challenges (clinical posts) and Workforce Planning	3	3	9
d	Risk of Serious Untowards Incident - resulting in death or serious harm of a patient due to accident, failure of systems or negligence of a staff member	4	1	4

	e	Gaps in Senior medical cover	3	2	6

		Post mitigation		
Control Environment	Remediation	Impact	Probability	IxP
Regular Board Meetings. Strategic plan and budget set in advance. Attendance of SLT at Board. Regular contact between Chair and CEO and Trustees with specific responsibilities/ SLT. Scheme of delegation in place	Adequate briefing papers in advance of meetings. Timely and accurate reporting of activities. Timely and accurate financial reporting. Incident Management	3	1	3
Evidence of meeting relevant standards e.g. Charity Commission, Companies House, Gambling Commission, Inland Revenue, CQC, grant funders, NHS funders, NHSE/I, Fundraising Regulator, ICO, Trading Standards, HSE	Proactive Relationship with regulators (e.g. CQC) External Audit Annually; Regualr reporting to NHSE/I; Relevant compliance part of cycle of activity for each sub-committee, Strategy outlines vision and values; patient, carer and customer feedback mechanisms; effective complaints policy with regular review through Q&SC. Serious Incidents reporting standing board item. CQC Inspection 2022 rated overall 'good'	3	1	3

All data assets held securely; IG policies in place. Data sharing agreements in place with third parties. Data encryption policy in place for data assets held off site. Privacy policies reviewed and updated. NHS.net and email in use for patient data sharing outside of GBCH. Network penetration testing programme in place and IT hardware/ software upgrade completed in 2022. Two factor authentication in place.	FIGIT committee receives regular reports on data protection incidents and QSC on caldicott guardian requests. Staff and volunteers trained annually on data protection, information governance and confidentiality. GDPR implementation group regularly reviews all areas of DP and action plan. Data Protection Audit to be repeated 24-25. Recent review of GDPR compliance in Fundraising, Retail and Marketing & Comms now complete. Board have appointed DP Champion. Servers moved to cloud 2022	3	1	3
Situation extremely uncertain however BCP reviewed and all relevent guidance followed (NHSIT communication, Charity commission guidance etc). Budget reflects increased fuel costs, however we are aware there is some risk in areas, especially in income. This will be frequently reviewed at SLT and FIGIT. No obvious concerns around donors/ sanctions. Staff wellbeing a focus in strategy	Continue to review situation and reflect this in board and SLT discussions. Staff wellbeing to continue to be explored as part of strategy, but with opportunity to raise and discuss concerns 1-1 as well as in larger groups.	2	3	6

Membership of Hospice UK, collaboration with SCH and good engagement with SELICS. SLT part of G&B system development work for ICS, KH ICS lead for PEoLC.	Stay abreast of government changes – keeping in touch through umbrella bodies e.g. Hospice UK; collaboration with partners around new service models and research; evaluate existing services and publish successes. Maintain role in SEL ICS. Had in depth conversation regarding assited suicide and potential impact on hospice at Board Away day, conversation with staff November 24, encouraging system partners to do likewise and ongoing.	2	3	4
Partnership agreements in place with local providers and charities; strong presence with commissioners and decision makers. ASC contract in place	Robust Activity reporting. Regular contract management meetings. Communications strategy. ASC subcontracts and project manager to manage relationships with Bexley VCS partners.	3	1	3
Well established (large) partners. Regular monitoring/ communication, discussion with SELICS about future MC commissioning arrangements. Contracts in place. Strong relationships in SEL ICS. Contract review meetings with smaller partners in ASC	Business continuity plan, contract review meetings	2	1	2

One GBCH staff member is employed by Trust (honorary contract with GBCH). Responsible Officer for Designated Body (Drs) employed by LGT. SLA for provision of SPC to hospital in place. Pharmacy and infection control services provided by LGT	Regular meetings with main contact. Support provided to trust to ensure we are seen as partner. LGT RO to attend board/ QSC annually. KH presence in LCP and SLT membership in Resplendent group.	2	1	2
Membership of NCVO, GAVS and BVSC, proactive relationship with auditors, HR advisors	Stay abreast of government changes	2	2	4
Accurate and detailed budgeting. Regular reporting to Fundraising team, FIGIT and Board. Development of new income streams including major donor strategy and development of trusts and foundations. Contingency in budgets and reserves in place. Investment in new roles to support new activites in team	Fundraising strategy approved. Ongoing reforecasting. Ongoing review of activities and supporting alternative approaches. Accurate and detailed budgeting. Regular reporting to Fundraising team, FIGIT and Board. Development of new income streams including major donors and trusts and foundations. Contingency in budgets and reserves in place.	2	2	4

Accurate and detailed budgeting. Regular reporting to Shop Managers, FIGIT and Trading Board; Attention to detail in retail performance/ mystery shopping. Development of new income streams and new shops, contingency in budgets. Reserves in place. Trading Board in place. Retail strategy now being implemented. Need to ensure staffing is appropriate for service needs	Supporting the implementation of minimum standards and retail strategy. New shops being explored and investments being made through RTP Fund. Actively recruiting to vacancies. Review of T&C for retail underway. 2 new shops opened in 2024.	2	2	4
Detailed legacy analysis based on last 12 years. Legacy strategy with initiatives such as free will week and engagement of clinical team/ local solicitors; regular legacy communications with supporters and known legators. Contract with legacy link/ smee & ford to ensure legacies properly managed and we are notified	Further development of strategy focusing on increasing pecunary gifts and numbers of legacies. Legacy campaign planned with HUK. Large legacy secured for 24/25	2	2	4
3 year plan and clinical costs monitored by SLT and this feeds into commissioning discussions. Service contracts with SELICS; Ongoing regular dialogue with commissioners including activity reporting. CEO, DFR and DoP involved in discussions to ensure continuity and share risk. Costs of new employer NI contributions flagged with ICB	Opportunities for new developments under review. Ongoing engagement in LCP/ ICS structures. New Government capital funding 2024/25	2	1	2

Review of all leases with detailed schedule for rent reviews and lease expiry. Expert advice to support renegotiations and legal elements	Negotiations taking place in line with schedule and bear in mind impact of socio-economic climate on market	2	1	2
Robust volunteers management and strategy; Clear communication and thank you to volunteers; Links to external volunteering organisations. Recruitment campaign to be developed as part of strategy	Development of existing volunteers. Recruitment campaign for key positions and new inititiatives. EVP work ongoing. Development of partnerships with other charities. New volunteers manager recruited 2024	2	1	2
Robust financial control procedures and policies; external and internal audit processes; security policy and training of staff; security controls in place; IG Policy; Asset log; maintenance plans; monitoring of supplies; fraud training and prevention strategy in place, linked into NHS fraud prevention advice	Insurance Policy; incident reporting and policy	2	2	4
Robust financial control procedures and policies; internal audit processes; procurement policy and training of staff; robust sickness and performance management policies; budgetary authorisation limits monitored by finance team; oversight of purchase ledger by authorised signatories; fraud training and prevention strategy; management accounts reviewed monthly at SLT, regular budget holder meetings	FIGIT committee, external audit, business central being implemented to support cost control and asset managment	2	1	2

pay generally in line with NHS - planned review of T&Cs for 24/25. Awaiting outcome of NHS pay review body negotations. Good staff retention and development.	4% pay award approved for 24/5, FIGIT and the Board approved additional 1.5% increase in line with NHS offer Sept 24	2	2	4
KH & JD have initiated conversations with commissioners at a local and SEL level to highlight gap in knowledge around MC commissioning landscape, highlighting risks to local provision; internal work to be undertaken to clearly understand statutory contributions towards the funding of clinical services; exploration of credible alternatives to be carried out to be able to respond quickly to commissioning decisions; unlikely there will be a move to a SEL wide contract - however there are issues about MC price increase for 23/24	Ongoing conversations with commissioners, CCGs, ICS, place-based boards; regular briefings between SLT & 5:1 group; aim to ensure that any changes to contracts do not adversely impact on GBCH's envelope. Meeting with MC 20.12.22 and have approached Oxleas for conversation following this. Changes in costs to be included in 23/24 budget. Meeting with MC and Greenwich commissioners in Jan 23 - OOH review across SEL in 2024	3	3	9
Data stored on cloud with regular backups. Remote access also available. System upgraded 2023. Wifi upgrade complete	Basic paper record held for all inpatients	2	1	2
Regular 1-1 and appraisal; Proportionate notice periods for key staff; Timely recruitment processes; Shared contact lists; shared calendars and diaries; succession planning (retirement etc)	Training and development opportunities; clear policies and operational policies/ procedures for all departments; recruitment ongoing for medical consultant, medical director recruited - start date August 2024. Risk shared with ICS	2	2	4

Clear HR policies and processes. Training of managers. Effective internal communication. HR Support, Occupational Health Contract and Legal advice available.	Incident Management/ Grievance Procedure/ Freedom to Speak up Guardian/ Bullying and Harrasment Policy/ Work in Confidence Portal/ Managers Development Forum	3	2	6
Competitive Salaries and Terms and conditions of employment. Advertising in NHS jobs and other key platforms.	Internal staff development and pipeline for more senior positions/career progression. Strong communications strategy and awards programme. Bank staff with ongoing recruitment and favourable terms for overtime. T&C review underway alongside workforce planning review, initially focussing on community team. End to end review of recruitment processes complete and action plan developed.	3	2	6
Robust recruitment, induction, training and supervision where staff are encouraged to speak up and challenge/ ask for support. Clinical staff manage activity and flow to ensure that staffing remains safe. Policies and procedures in place and regularly reviewed to keep up to date with evidence and national guidelines. QSC monitors feedback re services and incidents/ accidents to look for trends	SUI policy - escalation to CEO and Board to manage incident and communication. Duty of Candour in place - reporting to commissioners, CQC and patients/ NOK. Insurers provide prompt advice. Out of hours support from senior Drs/ Nurses/ Managers	4	1	4

We have an SLA in place with external consultant providing support to IPU and help with on call rota. We also have contract with supportive care UK to fill on call gaps. Regular review meetings to monitor operational issues and develop vision for service. Recruitment ongoing	Ongoing consultant vacancy - recruitment pack update and re-advertising a high priority Sept 24. Locum Senior consultant well known to hospice team and CEO, regular reviews very productive. Current junior doctor cover more than adequate given 5 x training rotations - risk of this cover being reduced in subsequent rotations - LB to liaise with training programme directors regarding this. Development of existing staff into more senior roles is progressing well. Medical director in post Aug 24, experienced GP 0.2WTE settled into post since March 24.	3	2	6

Risk Owner	Second Line of Defence	Assurance/ Oversight	Date Added/ last reviewed
CEO/ Chair	Board	CQC, NHS Improvement, Charity Commission, Auditors	19.08.19 06.09.24
Departmental Managers	SLT Member	CEO	19.08.19, 06.09.24

Data Asset Owners	Caldicott Guardian/ Data Protection Lead	SIRO	19.08.19, 06.09.24
CEO	Relevant subcommittees	Board	04.03.22, 06.09.24

Director of Partnerships	CEO	FIGIT Committee	19.08.19,31.12.24
Director of Partnerships	CEO	Board	19.08.19, 08.11.24
DOCST and Contractor for ASC	Director of Partnerships	CEO	19.08.19, 06.09.24

Team Leader/ Lead Consultant/ DC&ST	CEO	Quality and Safety Committee	19.08.19, 06.09.24
DFR	CEO	FIGIT Committee, EPIC	19.08.19, 06.09.24
Head of Fundraising	DIG and DFR	FIGIT Committee and linked Trustee for fundraising	19.08.19, 06.09.24

HoR	DIG and DFR	Trading Board	3.03.20, 31.12.24
Head of Fundraising	CEO	FIGIT Committee	03.03.20, 31.12.24
Director of Partnerships	DFR/ CEO	FIGIT Committee	03.03.20, 07.03.25

Director of Income Generation	CEO	Trading Board	12.10.20, 06.09.24
Heads of Department	Volunteers Manager	Director of Partnerships	19.08.19, 31.12.24
Team Leader/ Dept Manager	SLT Member	DFR	19.08.19, 06.09.24
Budget holder/ departmental manager/ Head of Finance	DFR	FIGIT Committee	03.03.20, 06.09.24

Chief Executive	EPIC	Board	28.06.22, 08.11.24
Director of Partnerships	SLT & 5:1	CEO	05.01.22, 06.09.24
Head of IT	DFR	CEO	6.7.23, 06.09.24
Team Leader/ Dept Manager	SLT Member	CEO	19.08.19, 06.09.24

Line Manager	SLT Member	CEO	19.08.19, 31.12.24
Heads of Service / Director of Care and Service Transformation	CEO	EPIC	19.08.19, 08.11.24
Clinical Leads	CEO/ QSC	Board	19.08.19, 06.09.24

MD	CEO	QSC	2.2021, 5.9.24

Minutes

Meeting: Board of Trustees

Date: Wednesday 12th March 2025

Time: 4.00pm

Venue: Community Hub, Community Hospice, 185 Bostall Hill, London, SE2 0GB

No	Item		
1	**Present:** Simon Di Marino (SDM) **Chair** Alison Roberts (AR) David Atterbury-Thomas (DAT) Treasurer Estelle Kerridge (EK) Komal Whittaker Axon (KWA) Manal Sadik (MS) Mike Williams (MW) Rebecca Middleton (RM) Tim Green (TG)	**In attendance:** Aneta Saunders (AS) Graham Turner (GT) Jon Devlin (JD) Kate Heaps (KH) Kathy Bell (minutes) Victor D'Arcy-Smith (VDS) **Guest**: Ellen Tumelty (ET) Maria Ford (MF)	**Apologies**: Francis Drobniewski (FD) Sarah Higgins (SH) Kate McGranaghan-Chow (KMc) Sylvia Osaji (SO) Tolu Timeyin (TT)
2	**Declarations of Interest** None.		
3	**Minutes of the previous Board of Trustee meeting held on Wednesday 8th January 2025** Approved.		
4	**Matters arising not on the Agenda** None		
5	**Presentations**		
5.1	**Hospital Case Presentation**		

MF presented a patient story to illustrate the work that is done in the hospital team. A copy of this is circulated with the minutes. The case demonstrates how we had embraced all hospice values, keeping everything direct and focused, being clear concise and active with communication, always delivered with kindness and empathy. We made sure the priorities and problems were solved with the patient and his family, with the aim to grant his wish to be at home. Everything possible was done to ensure the patient was discharged safely, colleagues felt supported and we strengthened working relationships with all other services involved. We flourish in an environment where we share thoughts, rationale and skills. Moving forward we will review, reflect and learn for situations we may face, looking at how to improve fluidity of care. We aim to be a bright beacon, this was seen as a positive experience.

Board members commented on the appreciation on how the individual was looked after in a way that suited him, it is what palliative care is all about. Working as a team gave the individual what was needed.

5.2 Update from Finance, Information Governance and Information Technology Committee

VDS spoke briefly through the pre-circulated presentation and noted key highlights and developments.

- We are on track to submit the NHS Data Security Protection Toolkit by the end of March. The toolkit provides the necessary assurance that we are practising good data security to enable access to NHS systems.
- The firewall replacement has been delivered, it is now operational and continuously monitored.
- The Investment sub committee took decisions on additional funds to be added to the investment portfolio and the allocation of surplus funds to interest-bearing short-term deposits. We currently have two £1M short term deposits and we plan to re-invest for further 12 months. Gains and losses are reported as part of monthly trading results.
- Financially YTD January 2025 – Total income is £11.5M. £6M of that is from retail, fundraising and legacies and Hospice income is £5.5M. We can report a surplus of £600K.
- We are looking to increase the hospice recovery and transformation fund when we are clear on plans going forward
- Our new auditors have been onboarded and audit field work is due to start in June 2025.

DAT commended the accounts. It has been a complicated year with lots achieved and with a lot of changes accommodated.

TG asked if there were plans in place if the firewall was breached. VDS explained that it is continuously monitored so will work and the team know what to do if there are issues.

6 **For approval**

6.1 **2025/26 Consolidated Budget and Operational Plan**

VDS spoke briefly through the pre-circulated presentation.

This year we are forecasting a deficit of £594k. We have budgeted a deficit every year and been able to turn this around, except last year. Although budgeted income is £700k higher than forecasted for 24/25 the total expenditure is also higher. In summary we have a total income of £14.5M and expect a deficit of £594k before depreciation. We have included a capital grant of £230K this year and £700k next FY, only a third is included in the figures as depreciation is spread over 3 years.

DAT said that the work to prepare this information is significant and involved the whole organisation. We start with a deficit but there are challenges being accepted over and above what could be achieved.

KH wanted to recognise the hard work of team. The change in attitude from the organisation and Board in terms of how we plan to spend and invest our money has been important and helps us with driving the organisation forward.

She highlighted the principals used to prioritise elements of the budget and operational plan.

- We have continued to protect income generation, investing in all areas that help with this. In some cases, this leads to a short-term deficit but in the longer term we get a firmer foundation and will see growth.
- We ensure clinical services are safe – we are not growing teams massively, an important reason for this is because we are looking to build a more sustainable hospice. We have to change the way we work and use different techniques for a service transformation.
- We recognise that we are serious in our organisation to address inequalities. We are not going to stop this, it is important as people are struggling and we need to continue to build on relationships, not stop the progress that we are making.

An inflationary increase has not been included on the salary budget, as we do not yet know what end of year looks like. We are also doing a T&C project across parts of the organisation so do not want to give pay rises today that may to change at a later date, so it's better to pause until the full extent of the review is known. This will be communicated to staff. When the T&C project has been done we will take it to

FIGIT committee and then to the Board to have discussions and make decisions. We are expecting a report Mid May.

RM said that she is pleased to see that we continue with investing in income generation.

SDM added that is was important that we do not stop, we have got reserves and money invested so it is good to see another year of carrying on in this direction.

The Board of Trustees approved the 2025/26 Consolidated Budget and Operational Plan

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7 **For information**

7.1 **Finance Update (previously circulated management accounts)**

The presentations already given referred to this, no further questions were raised.

DAT ensured that everyone understood the reports. If there are any questions, please reach out.

7.2 **CEO Report**

A copy of the report had been circulated. Questions were welcomed.

AS gave a brief update on the Legacy campaign. It is too early for results right now but it was noted that other hospices did not generate the same number of leads. There are several reasons for this but mainly because our team were very proactive in monitoring responses and adapting the campaign as things were progressing. Social media will be live for a further two weeks more and we will then do a wash up, through the work that has been put in we have had a positive response so something we can replicate in other projects.

DAT asked about the Chelsea Flower Show. KH reported that the pitch took place on 10th March and the panel seemed very interested in our how we will use the garden to grow connections and build on work with major donors. Hospice UK are at the show this year and panel thought it would be nice to have a local hospice next year. So we are hopeful to be selected. The team gave a fantastic presentation and we will share the slides. The design has been made so that we can extend going forward once it relocates to hospice. We will know by end of April.

7.3 **Risk Register**

Nothing to highlight

7.4 **Serious Incidents**

None to report.

8	**Policies - none**
9	**Any other business** Nothing to raised

Date of next meeting: 14th May at 4pm.

Healthwatch Greenwich Ltd Board Meeting Minutes – PART 1 – FOR PUBLICATION		
18/1/25	**10am – 1pm**	**Woolwich Centre**
Chair	Anu Massey (AM) Co-Chair	
Present	**Directors:** David Thompson (DT) Co-Chair Paul Newton (PN) Tomi Oni (TO) Mostafa Mohamed (MM) Clair Livingstone – observer (CL) Lola Kehinde (LK)	
Attending	Joy Beishon (JB) – Chief Executive Kiki Bourcha (KB) – Engagement and Volunteer Manager Melody Shum (MS) – Research Officer Deepa Srivastava (DS) Research Manager	
Apologies	Josh Varghese (JV) Treasurer Tobi Aigbogun (TA)	

Update

Minutes of previous meeting:

- Oct 2024 minutes agreed as correct.

Matters arising

- None.

CEO report

- CEO report noted.
- Discussion on challenges with diabetes project

Policies

The following policies agreed by the board:

- Confidentiality and Data Protection Policy
- Social Media Policy
- Volunteer Policy
- Volunteering Policy

Staff Presentations

- KB and DS presented on their work and responsibilities. The board commended KB and DS on their work.
- Discussion on befriending project and associated risks.

Finance Report

- Finance report received and salary proposals agreed.

Board Governance Lead

- TO nominated as Board Governance Lead.
- Appointment of TO as Board Governance Lead approved by the Board.
- Wider discussion held on support for HR responsibilities and CRM challenges.

Actions:	Person responsible:
AM to contact relevant parties with a view to identifying additional support for HR and CRM	AM
Advertise for Board Member with IT expertise	JB

SEL Reference Group

- This item deferred due to the absence of TA

Safeguarding Issues

- Verbal report on safeguarding issue escalated 24hrs prior to Board meeting.

Risk Register

- Reviewed and agreed.
- Discussion held on risks with befriending.

Actions:	Person responsible:
Identify what staff wellbeing support is offered to RBG staff.	KB
If project continues, consider strengthening protocols for befriending.	KB

AOB

1. **Future Board Meeting Dates**

- Dates for future Board meetings, and format, agreed:
  - April 26th (f2f)
  - July 19th (virtual)
  - Oct 18th (f2f)
  - Jan 24 2026 (f2f)
- Discussion held on date for AGM.

2. **SELHW/ICS partnership proposals**

Discussion held on potential future models. Board preference is for a rotational leadership model. Alternatively, funding to facilitate increased collaboration including SEL-wide/cross-system engagement work

Preferred by Healthwatch Greenwich as it directly addresses the need for capacity building and inclusivity in cross-system work.

- Provides flexibility for Healthwatch leaders to participate in meetings, backfill roles, and take part in collaborative projects.
- Focuses on shared learning and collective impact, strengthening the entire partnership.

The Board noted their concern with the Independent Chair Model (Option 3). While providing structure and independence, this model might dilute the direct involvement of local Healthwatch leaders in decision-making processes.

Actions:	**Person responsible:**
Share Board feedback to the ICS on preferred model	JB

Next Board meeting

Date: Sat, 26th April 2025
Time: 10am – 1pm
Venue: Woolwich Centre

Agreed as correct by Board: Signed: Anu Massey

Lewisham and Greenwich NHS Trust

TRUST BOARD MEETING

TUESDAY 25TH MARCH 2025, 10AM

(PART 1)

KALEIDOSCOPE CHILDREN'S CENTRE

GLOSSARY OF ACRONYMS

AAC	Advisory Appointments Committee
ACU	Ambulatory Care Unit
ARCC	Audit, Risk and Compliance Committee
CFO	Chief Financial Officer
CHS	Community Health Services
CQC	Care Quality Commission
CRL	Capital Resource Limit
DDNG	Divisional Director of Nursing and Governance
DDO	Divisional Director of Operations
DHSC	Department of Health and Social Care
DIPC	Director of Infection Prevention and Control
DMDs	Divisional Medical Directors
DNA	Did Not Attend
EBME	Electro Biomedical Equipment
EDI	Equality, diversity and inclusion
EPR	Electronic Patient Record
ESR	Electronic Staff Record – often used to describe the payroll system
FBC	Full Business Case
FITC	Finance, Infrastructure and Transformation Committee
FOI	Freedom of Information
I&E	Income and Expenditure
ICB	Integrated Care Board
ICS	Integrated Care System
IFRS	International Finance Reporting Standards
IG	Information Governance
IUoR	Improving Use of Resources
KPI	Key Performance Indicator
LCFS	Local Counter Fraud service
LLOS	Long Length of Stay
LOS	Length of stay
NED	Non-Executive Director
NHSE/I	NHS England and NHS Improvement
OBC	Outline Business Case
PALS	Patient Advice and Liaison Service
PDR	Personal Development Review
PPC	People and Place Committee
PPE	Personal Protective Equipment
PTL	Patient tracking list
QEH	Queen Elizabeth Hospital
QPC	Quality and Performance Committee
RTT	Referral to treatment
SFI	Standing Financial Instructions
SI	Serious Incident
SLA	Service Level Agreement
SO	Standing Orders
SOC	Strategic Outline Case
STP	Sustainability and Transformation Plan
TJPB	Trust Joint Partnership Board
TME	Trust Management Executive
UCC	Urgent Care Centre
UHL	University Hospital Lewisham
VfM	Value for Money
WTE	Whole Time Equivalent
WW	Week Waits
YTD	Year to Date

TRUST BOARD MEETING

25TH MARCH 2025

AGENDA

PART 1 (PUBLIC SESSION)

A meeting of the Board of Lewisham and Greenwich NHS Trust will take place on **Tuesday 25th March 2025, 10am, in K2&K3, Kaleidoscope Children's Centre, 32 Rushey Green, London, SE6 4JF**

There will be an opportunity for members of the public present to raise questions related to the Trust Board agenda for a maximum period of 10 minutes after the meeting. Questions should be submitted a minimum of 24 hours before the meeting to LG.BoardSecretary@nhs.net **Tel: 020 8333 3000 ext. 48131**.

1.	**Welcome/Apologies/Quorum**	Oral	2 mins	Chair
2.	**Declarations of Interests**	Oral		All
3.	**Minutes of the Previous Meeting (28/01/25)** To ratify	Enclosure A		Chair
4.	**Matters Arising and Actions List** To review	Enclosure B	3 mins	Chair
5.	**Chair's Report** To receive • **Star of the Month – February**	Oral	10 mins	Chair
6.	**Patient Story – George's Story - Cancer Research Trial** https://www.youtube.com/watch?v=taI3ZWRhsMA&feature=youtu.be	Video	20 mins	George Debnam Research Team
7.	**Staff Story – Workforce strategy - developing our Allied Health Professionals** Staff story: developing our Allied Health Professionals	Video	10 mins	Daniel Western Victoria Jackson
8.	**Committee Reports**			
	8.1 People and Place Committee (Mar) To receive • **Workforce KPI Report** To receive	Enclosures C1 C2	10 mins	AK EP
	8.2 Finance, Infrastructure and Transformation Committee (Feb and Mar) To receive • **Finance Report** To receive	Enclosures D1, D2 D3	10 mins	HB SP
	8.3 Quality and Performance Committee (Feb and Mar) To receive • **Quality and Safety Report** To receive • **Performance Report** To receive	Enclosures E1, E2 E3 E4	20 mins	PL LC MJ
	8.4 Audit, Risk and Compliance Committee (Mar) To receive • **Corporate Risk Register (CRR) and Board Assurance Framework (BAF)** To receive	Enclosures F1 F2	10 mins	AK KA
	8.5 Charity Committee (Mar) To receive	Enclosure G		HB
9.	**NED Feedback** To receive	Oral	5 mins	NEDs
10.	**Chief Executive's Report** To receive	Oral	10 mins	BT
11.	**Questions from the Public**	Oral	10 mins	
12.	**Any other business**	Oral	5 mins	All
13.	**Date of Next Meeting -** Tuesday 27th May 2025 10am, Lecture Theatre, Owen Centre, UHL			

END OF PUBLIC MEETING

The Board is asked to resolve: -That In accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

PART 1 – PUBLIC SESSION

Lewisham and Greenwich NHS Trust

TRUST BOARD MEETING
Minutes of the Part 1 Board meeting held on 28th January 2025
at University Hospital Lewisham

Present:	M Bell (Trust Chair) G Allen (Non-Executive Director) H Bright (Non-Executive Director) N Chana (Non-Executive Director) A King (Non-Executive Director) P Li (Non-Executive Director) W Tuckley (Non-Executive Director) B Travis (Chief Executive) K Anderson (Chief of Staff) * L Crosby (Chief Nurse) N Goulbourne (Chief Strategy, Partnership and Transformation Officer and Deputy CEO) * M Jenkins (Chief Operating Officer)* M Nair (Chief People Officer) S Prosser (Chief Financial Officer) V Purday (Chief Medical Officer) **Non-Voting Member*
In Attendance:	Three Members of the Public F Cambell (Lead Nurse for Adult Safeguarding) (TB1-25/1-25/5) N Tanner (Adult Safeguarding) (TB1-25/1-25/5) L Driscoll (Adult Safeguarding) (TB1-25/5-25/5) A Coiley (Divisional Director of Nursing and Governance) (TB1-25/1-25/6) E Obarakpo (Staff Story) (TB1-25/7) I Egbuniwe (Head of Resources) (TB1-25/7) A Fillary (Patient Story) J Monte (Ward 14 Manager) (TB125/1-25/6) S Peterson (Divisional Director of Nursing and Midwifery) E Pirozzoli (Deputy Chief People Officer) C Wilkes (Director of Media, Communications and Engagement) L Bunting (Board Governance Officer), minutes
Apologies:	C Evans (Non-Executive Director) S Higgins (Associate Non-Executive Director) Dr K Car (Consultant Physician)

TB1-25/1 Welcome and apologies for absence

The Chair welcomed everyone to the first Board meeting of 2025. Apologies received are noted above.

TB1-25/2 Declarations of Interest

There were no declarations of interest.

TB1-25/3 Minutes of the Previous Meeting

The minutes of the previous meeting, held on 26th November 2024, were approved.

Resolved: The Board approved the minutes.

TB1-25/4 Matters Arising and actions list.

The Board reviewed the action log.

TB1-24/40 Health and Inequalities Quarterly Update
The Chief of Staff (CoS) confirmed Health and Inequalities, including Population Health Management, would be a topic for the Trust Board Seminar programme for 2025.

TB1-24/71 Place and Partnership Update - Board-to-Board sessions with Mental Health Partners
The Executive-to-Executive meeting with SLAM had taken place in mid-January and the meeting with Oxleas was scheduled to take place at the end of February 2025.

Resolved: To review the action log.

TB1-25/5 Chair's Report

The Chair noted the following Chair's Actions taken in December 2024 as follows:

1. Approval of the *'Delivery of an interim Urgent Treatment Centre (UTC) at University Hospital Lewisham (UHL) - Full Business Case.'*
   Approval was sought for an investment of £3.2m (inc VAT) capital funding and £302k revenue funding was required to build and operationalised an interim UTC on the UHL site, planned to open in March 2025. To ensure LGT were able to deliver the performance improvements, it was imperative that a

contract was signed before the end of December 2024. This would ensure construction work could begin in January 2025, ready for a UTC to be build, and open for patients by March 2025.

2. Urgent Approval for Electrical Transformers and Backup Generator Purchase
   This approval was crucial to proceed with the time-sensitive order of electrical transformers and backup generator, which are essential to provide the principal power supply and backup power for the UHL site. The timely procurement of these components was critical to avoid delays in the current surgical centre project. Approval was sought for: £2.8m capital for equipment and installation works.

The Chair presented the January 'All Stars Team Award' to the Adult Safeguarding Teams for LGT. The Board noted the safeguarding teams valuable role, ensuring that the most vulnerable patients had a voice, and providing support and guidance to their colleagues. The judging panel for the January award was HATS.

Resolved: The Board received the update and approved Chairs Actions.

TB1-25/6 Adam's story - ED and inpatient care QEH

The Trust Chair introduced the patient story. The Board had watched a video in advance of the Board meeting. The video featured Adam Fillery, the son of the patient, Douglas Fillary who described the patient and family experience within ED and Inpatient care wards (Wards 4,14,18 and 23) at QEH. The Divisional Director of Nursing and Governance Medicine QEH (DDNG) and Ward 14 Manager were also in attendance.

Mr Fillary reflected on the family's experience and described the care received over a three-year period. He began by discussing an initial difficult period, noting multiple miscommunications regarding discharge and appointments. He emphasised the importance of communication, highlighting how poor communication often led to frustrations and misunderstandings during his father's care. He identified a need for better documentation and understanding of patient and family needs. Despite these challenges, Adam acknowledged the excellent care his father received from clinical staff members over the three-year period, and particularly at the end of his life, and stressed he appreciated the opportunity to share his experience.

The DDNG highlighted the communication issues and discussed the new strategies being implemented across the Trust. She noted the new Compassion in Care programme was designed to enhance communication and care, and had been launched across several wards, including Ward 14. The DDNG explained that this programme trains nurses and staff to engage better with patients and families, through interventions, measures, and audits and was showing substantial progress. Mr. Fillary expressed interest in receiving regular updates, tracking improvements, and participating in the programme to share his insights. The CN offered to meet with Mr. Fillary to discuss further. **ACTION: LC**

The Board acknowledged the advantages of the Compassion in Care programme and reaffirmed their commitment to enhancing care through improved communication, training, and the active involvement of patients and their families in the care process. The Chief Executive Officer (CEO) expressed gratitude to Mr. Fillary for sharing his experience, and for his willingness to engage with management in the future to help assist the Trust in making improvements and ensure consistent care delivery.

Resolved: To Board received the Patient Story.

TB1-25/7 Staff Story – International Recruits

The Trust Chair introduced the staff story and welcomed Dr Ejiro Obarakpo. Dr Obarakpo was a junior clinical fellow, whose journey with Lewisham and Greenwich NHS Trust began at an Open Day in June 2024. In the short video, Dr Obarakpo shared her experience of attending the event, completing a clinical attachment in the Emergency Department at Queen Elizabeth Hospital, and taking the step of joining the team. The Head of Resources was also in attendance.

Dr Obarakpo came from Nigeria and was working in ED at QEH, following completion of a clinical attachment for 6 weeks. She mentioned the importance of having a welcoming environment and the significant insights gained from her interactions during the clinical attachment. She appreciated the support from consultants and colleagues, which made her experience more enjoyable and less nerve racking.

The Head of Resource (HoR) explained the re-evaluation of the approach for inviting doctors for trial periods, resulting in an open day with clinical evaluations. The support from senior medical colleagues, in this process was crucial in attracting over 90 local applicants.

The Board emphasised the importance of promoting and advertising the clinical opportunities to maintain a sustainable workforce. The HoR would discuss the programme in more detail with Dr Chana. **ACTION: IE/NC**

Resolved: The Board received the report.

TB1-25/8 People and Place Committee (PPC)

Dr. Chana presented the PPC report from the 14 January 2025 meeting. The Committee had received an update on Health and Inequalities, noting progress with stakeholder initiatives using Population Health data. A 12-month evaluation showed reduced patient stay durations, though more data is needed for further analysis. Feedback from the Guardian of Safe Working Practices highlighted the need for adequate supervision during ward rounds.

Medical engagement had improved, and the Committee had supported a centralised funding mechanism for Medical and Non-medical Education. The workforce strategy focused on recruitment and addressing significant shortages.

Workforce KPI Report

The Chief People Officer (CPO) presented the workforce KPIs and highlighted the following:

- Vacancy rate was reported at 9.5%. The net joiner current position was 56.
- M&D vacancy rate was reported at 5.61%, AHP vacancy rate at 3.94% and N&M vacancy rate at 9.35%. Consultant vacancy rate was reported at 12.58% in part due to increases in the establishment.
- The Trust is actively recruiting to posts through various campaigns, social media, and Trust wide recruitment fairs. Vacancies were expected to remain below target as there were 262 candidates in the pipeline with start dates booked and 275 awaiting checks on 8th December. Amongst those booked to start there were 73 N&M, 74 AHPs & 15 M&D (including 6 consultants). Amongst those undergoing checks there were 114 N&M, 47 AHP & 41 M&D (including 18 consultants).
- The Trust was in the top three providers for recruitment in London.
- Sickness rate was reported at 5.12%. There has been improved rigor with sickness absence case management across divisions with monthly absence review meetings supported by additional temporary employee relations support who monitor sickness absence metrics, liaise with line managers and coordinate case management documentation.
- Voluntary leavers in the first year continued the downward trend and was reported at 17.04%.
- The Trust had successful integrated and utilised the apprenticeship program, projected to involve 230 individuals.
- Temporary staffing spend was reported at 16.39% in November 2024. A central vacancy control panel is in place to review all corporate agency spend and agency requests.
- The workforce priorities board track weekly and monthly progress against medical workforce controls, bank & agency controls, roster controls and sickness.

Resolved: The Board received the reports.

TB1-25/9 Finance Infrastructure and Transformation Committee (FITC)

Mr. Bright presented the FITC reports for the meetings held on 10th December 2024 and 21st January 2025. The FITC received updates on 2024/25 Financial Forecast and Recovery, 2025/26 Planning and the financial position of the wider SEL system. The FITC had also reviewed updates on procurement and digital contracts. In December, the FITC had used Chair's Action to approve proposals for the 'Delivery of an interim Urgent Treatment Centre (UTC) at University Hospital Lewisham (UHL) and Electrical Transformers and Backup Generator Purchase (UHL).

Finance Report

The Chief Financial Officer (CFO) presented the financial position for the period ending 31st December 2024, reporting an in-month adverse variance to plan of £1.4m, resulting in a year-to-date adverse position to plan of £11.8m. The planning guidance from NHSE was expected by the end of January 2025. The key financial challenges for the Trust were:

- £3.6m of funding pressure from the cost of within-tariff and pass-through drugs above the block funding and planned funding to cover depreciation of nationally funded capital programs not realised.
- £1.2m reduction in the expected payment for 2023/24 Elective Recovery Fund work.
- £0.6m cost pressure relating to the impact of industrial action, net of £0.9m funding received
- Whilst £61.5m of efficiency improvements had been identified to date, £23.6m of these remained as productivity improvements and were not 'cashable' in year.
- A further £7.7m of non-pay pressures had accumulated, including excess inflation, additional costs of theatre consumables and increased costs of insulin pumps.

The CPO reported the year to date (YTD) position benefited from £7m one-off benefits, including VAT rebates. The closing cash balance was £101m and the Trust was forecast to achieve its revised capital plan of £52.9m. YTD spend and commitments on capital projects was £36.9m.

Resolved: The Board received reports.

TB1-25/10 Quality and Performance Committee (QPC)

Dr Li presented the QPC reports for the meeting held on 21st January 2025. The QPC had received updates on performance challenges (ED), planning 2025/26, Quality and Safety report, including Quarterly Safety Insight report and PSIRF, an update on Birthrate+, and the End-of-Life Care Strategy. The QPC supported the transfer of the management of elective vascular services to GSTT and had noted the Perinatal Mortality Report, noting the Trust had reached the requirements for compliance for CNST. The QPC also received a deep dive on Cancer Access and Quality and an update on challenges and future proposals for the Urology Service.

The Committee Chair congratulated the Cancer Services for the improvements made within breast and skin cancer services and noted the focus on reducing reliance on insourcing.

Quality and Safety Report

The Chief Nurse (CN) presented the Quality and Safety Report and highlighted the following points:

- The Trust reported 2,113 incidents, which continued to indicate a positive reporting culture.
- The number of open overdue incidents was reduced to 5,236 after implementing several actions before the end of the year.
- The Trust Patient Safety Incident Meeting (PSIM) recommended 1 Patient Safety Incident Investigation (PSII's) and 7 Patient Safety Responses (PSRs). Most themes fell within the Trust's identified priorities from its Patient Safety Incident Response Plan (PSIRP).
- Analysis of patient safety data revealed 492 incidents were reported within Emergency Departments
- (EDs). The top three categories were security (18%), access/admission/transfer and discharge (8%), and infrastructure (7%), and with the narrative including ongoing operational pressure and the impact this is having to both staff and patient safety.
- There were 984 incidents in inpatient areas, mainly falls, medication issues, and pressure ulcers. Community and outpatient areas reported 158 incidents, primarily pressure ulcers and clinical assessment issues. Reporting improved due to new leadership and upcoming community audits.
- The Trust had received 116 formal complaints in December 2024, closed 103 and re-opened 3 cases indicating our responses remain of good quality.
- The current percentage of complaints overdue was 35% and an audit had been completed of a sample of closed cases in September, to understand where the delays may be occurring.
- The Trust top three complaints themes continued to be Clinical Treatment, Values & Behaviours (Staff) and communication (replacing patient cares from last month).
- There were 74 National Clinical Audit (NCA) projects, on the Quality Account list for 2024/25, which were actively collecting data during 2024/25. There were 14 audits registered and 11 reported in December 2024. The National Institute for Health and Care Excellence (NICE) published 11 new pieces of guidance in November 2024. The redesigned Clinical Audit and Effectiveness Committee (CAEC) took place on 16th December, chaired by the CMO.

The CEO observed the effectiveness of emergency pathways in recent months. The Trust focused on timely ambulance handovers and maintaining hospital flow to promptly free up the emergency department. Colleagues were acknowledged for their efforts in managing these processes.

Performance Report

The COO presented the performance report.

- The YTD ED performance was 64.6%. Performance in December remained stable. Type 1 performance declined at both sites, while Type 3 improved. The Trust forecasted 36–78-week breaches by the end of December (75% ENT) and about 300 65-week breaches (60% ENT). There was a significant capacity deficit in ENT with further actions planned to review this position.
- The DM01 position fell to 89.2%, down 7% from October. This drop was due to increased demand for radiology and endoscopy caused by cancer, UEC, and RTT pathway pressures.
- FDS performance in October was 70.8%, a 1.2% decline since September. The 62-day performance improved to 63.9%, and 31-day performance rose to 94.8% from 90.6% in September. November's FDS performance is expected at 73%, with 62-day performance at 69%.
- Despite efforts to improve waiting times and reduce DNA rates, the winter period was challenging. January's focus would be on Length of Stay (LoS), maximising SDEC/UTC, and developing an AMU on ward 22/23 to support the medical pathway.

Perinatal Mortality Review Tool Q3 Report

The Head of Midwifery, QEH presented the Perinatal Mortality Review Q3 Report which included learning from cases of stillbirth and neonatal deaths. It also provided assurances and evidence that the Trust was compliant with CNST requirements. Key points included:

- In Q3 there were 9 new cases which met reporting requirements. Of the 9 new cases in Q3, 1 case has been reviewed as part of PMRT, and from previous quarters 9 were reviewed.
- Of these 10 reviews within Q3, there were 9 still births and 1 case of neonatal death. One of the still births was an external case where only the antenatal care was reviewed as the patient transferred care after 25 weeks gestation. Of the 10 PMRT reviews, three cases have separate MDT reviews as part of PSIRF. Also one of the 10 cases was referred to MNSI.
- As part of the MDT review issues are identified and grouped into contributory factors. The themes of contributory factors found were:
    - Education and Training
    - Risk Assessments
    - BSOTS in Triage/ staffing
    - Update/ create guidelines
- CNST requirements stipulate that data should be provided on these 3 KPIs (Intrauterine growth restriction at birth, Reduced foetal movement as a contributory factor & neonatal death with severe brain injury). There were no cases in Q3.

Birthrate+ Report 2024

The Divisional Director of Midwifery Nursing & Governance for Women's Children and Sexual Health presented the reported the summary of finding and next steps of the Birthrate+ report 2024.

Key Findings:

- Clinical Establishment Deficit: 24.31 WTE (UHL: 22.5 WTE, QEH: 1.81 WTE)
- Specialist and Management Roles Deficit: 14.54 WTE (UHL: 7.91 WTE, QEH: 6.63 WTE)
- Skill Mix Possibility: Explore an 85/15 skill mix from the current 90/10
- Increased Community-Based Activity: Significant midwifery time needed due to high attrition rate
- Safeguarding: Increased activity and acuity
- ANNB Screening: Significant hidden workload due to the attrition cohort
- High Acuity Patients: 73% in categories 4&5 at QEH, 76.9% at UHL, requiring more than 1 midwife

The service acknowledged these findings reflect true activity, despite a declining annual birth rate and financial challenges. A gap analysis and risk assessment were planned by January 2025, with results to be presented in March/April 2025. **ACTION: SPe**

The Board noted the safety improvements within the Maternity services and the findings of the Birthrate+ report and agreed to the risk analysis report. The Board requested a further analysis on the birthrate recovery be included in the next Birthrate+ update. **ACTION: SPe**

The DDMNG confirmed the Trust was fully compliant with CNST.

Resolved: The Board received the report.

TB1-25/11 Audit, Risk and Compliance Committee (ARCC)

Ms King presented the ARCC report on the meeting held on 14th January 2025. The ARCC had received:

- External Audit Progress Report and Sector Update – There was no major change to the accounting framework for the period ending March 2025. The Value for Money (VFM) assessment highlighted potential weaknesses in financial sustainability, due to the wider issue of the overall NHS financial landscape.
- Year-end update – A key challenge included IFRS16 lease documentation and ongoing commercial negotiations regarding the Trust's PFI agreement.
- Internal Audit and Local Counter Fraud Services (LCFS) Annual Reports **–** Reviews of Divisional Governance, Pathology and Data Quality were underway and the ARCC received an update on each of the 11 overdue internal audit recommendations.
- Information Commissioner's Office (ICO) audit report: FOI and Cyber Security **–** LGT had implemented the outstanding recommendations from the ICO's audit that had concluded in summer 2024. This report confirmed that all FOI recommendations had been completed and in the Cyber Security scope 10 of the 16 recommendations had been completed.
- Fire Safety Update – Following the update in October, the Trust was responding to the actions at QEH site. This focused on actions at the QEH site in response to an interim report from fire safety specialists, ARUP in relation to the QEH site. An update on progress and discussions held with NHSE and the London Fire would be presented to the private Board meeting.
- Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Report**:** - the Trust achieved full compliance with all 62 core standards for the recent NHSE EPRR annual assessment.
- Losses and Special payments - This totalled £134k due to an increase in payments due to stock losses in the pharmacy, linked to short-notice expiry dates.
- Waiving of Standing Financial Instructions Report 2024/25 - This totalled of £21,000 relating to the use of additional off-site mortuary capacity.

Corporate Risk Register (CRR)

The updated CRR was acknowledged as read. Changes to the Corporate Risk Register since the previous Board update in September 2024 included:

Risks removed:

- (CRR052) - Potential loss of KCH as OH provider
- CRR053 (Risk of cost pressure and industrial action resulting from HCSW staff re-banding)

Risk score decreased:

- CRR046 (Maternity risk) scoring reduced from 20 to 15.

Risk amended:

- (CRR002) (Delivery to Cancer Constitutional Standards), update the risk description to reflect the change in the underlying cause of the risk, additional mitigations, and further planned actions.

Resolved: The Board received the report.

TB1-25/12 NED Feedback

Mr Bright outlined several visits he had undertaken in recent months.

The Board agreed to have a discussion, to review a process to implement a formal regulatory review of recurring issues observed during the visits at a future Board Seminar. This would address the issues in a timely manner. This would be in addition to the Visit Reports already being presented to the Board.

ACTION: KA

TB1-25/13 CEO Report

The Board received the LGT performance dashboard up to 22nd January 2025.

Resolved: The Board received the CEO report.

TB1-25/14 Any Other Business

Compassionate Care Programme Executive Sponsorship

The CN requested nominations for Board sponsorship for the next round of the Compassionate Care Programme. **ACTION: LC**

Meera Nair (CPO) - Farewell

The Board bid farewell to Meera Nair, Chief People Officer, after her five years of leading workforce team at LGT. Ms Nair would join Manchester University Hospitals NHS Foundation Trust in February 2025, overseeing a team that supports ten hospitals and almost 40,000 colleagues.

The Chair and CEO thanked Meera for her significant contributions, highlighting the cultural and operational changes she had implemented at LGT.

TB1-25/15 Date of Next Meeting

Tuesday 25th March 2025, 10am, Kaleidoscope Children's Centre

ACTIONS LIST – TRUST BOARD PART 1 MEETING (PUBLIC SESSION) HELD ON 28TH JANUARY 2025

Meeting date	Minute	Action	Lead	Timescale	Outcome
28/05/24	TB1-24/40	**Health and Inequalities Quarterly Update** The Trust Chair suggested the Health and Inequalities (including Population Heath Management) be a topic for a Trust Board Seminar.	NG/KA	Q3	**In progress.** This will be scheduled in early 2025 (May)
24/09/24	TB1-24/71	**Place and Partnership Update** The Board discussed the future potential to implement regular Board-to-Board sessions with both Mental Health Trusts and asked that appetite for such meetings be considered by the executive teams.	KA	Mar 2025	**Complete –** met with both SLAM and Oxleas and are reviewing future liaison arrangements. **Updated 28th January 2025** The Executive-to-Executive meeting with SLAM had taken place in mid-January and the meeting with Oxleas was scheduled to take place at the end of February 2025.
28/01/25	TB1-25/6	**Adams Story – ED and Inpatient Care QEH** Mr. Fillary expressed interest in receiving regular updates, tracking improvements, and participating in the Compassion in Care programme to share his insights. The CN offered to meet with Mr. Fillary to discuss further.	LC/AF	March 2025	The meeting is being arranged with the Chief Nurse.
28/01/25	TB1-25/7	**Staff Story – International Recruits** Th Board emphasised the importance of promoting and advertising the clinical opportunities to maintain a sustainable workforce. The HoR would discuss the programme in more detail with Dr Chana.	IE/NC	March 2025	This meeting is being arranged with Dr Chana.
28/01/25	TB1-25/10	**Birthrate+ Report 2024** A gap analysis and risk assessment was planned by January 2025, with results to be presented in April 2025. The Board noted the safety improvements within the Maternity services and the findings of the Birthrate+ report and agreed to the risk analysis report. The Board requested a further analysis on the birthrate recovery be included in the next Birthrate+ update.	Spe Spe	April 2025 April 2025	Not yet due Not yet due

Meeting date	Minute	Action	Lead	Timescale	Outcome
28/01/25	TB1-25/12	**NED Feedback** The Board agreed to have a discussion, to review a process to implement a formal regulatory review of recurring issues observed during the visits at a future Board Seminar. This would address the issues in a timely manner. This would be in addition to the Visit Reports already being presented to the Board.	All	*Deferred to* July 2025	Not yet due To be discussed as part of the Board Development Programme.
28/01/25	TB1-25/14	**AOB** Compassionate Care Programme Executive Sponsorship The CN requested nominations for Board sponsorship for the next round of the Compassionate Care Programme**.**	LC	March 2025	Complete – A request has been circulated to the Board Members

Lewisham and Greenwich NHS Trust

TRUST BOARD REPORT

25 March 2025

Report from:	**People and Place Committee**
Date of Committee Meeting:	**11th March 2025**

Purpose of the Committee:

The key purpose of the Committee is to provide assurance to the Board that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture, so as to enable the Trust to deliver its key priorities and strategic objectives and be an employer and education provider of choice. The Committee also provides a forum to discuss and advise on the Trust's strategic approach to partnership work across our places and boroughs.

The committee will receive assurance on the Trust's development as anchor institution, and its delivery of the Trust's equality, diversity and inclusion strategy and action plan both within the Trust and in terms of the reducing health inequalities in the boroughs we serve.

The committee will receive assurance on the delivery of the Trust's workforce strategy to make this a great place to work based on the following themes:

- Recruiting staff who share our values
- Caring for the health and wellbeing of all our staff
- Developing and retaining a workforce that is fit for the future
- Creating inclusive workplaces

Purpose:	**For approval or ratification**	☒
	Item to receive/for information	☒
	For discussion	☒
	For decision	☐
Committee Chair:	**Nav Chana, Committee Chair**	
Lead Director:	**Eric Pirozzoli, Interim Chief People Officer** **Neil Goulbourne, Chief Strategy, Partnerships and Transformation Officer**	

1. ITEMS FOR ESCALATION / REFERRAL TO THE BOARD

None

2 ITEMS APPROVED / RATIFIED

- N/A

3 ITEMS RECEIVED

3.1 National Staff Survey Update

The Associate Director of Organisational Development and Inclusion (ADoODI) provided the Committee with an overview of the Trusts 2024 Staff Survey results highlighting key findings and areas for improvement.

The Committee were pleased to hear that the Trust achieved its highest ever response rate of 53%, exceeding the national median of 49%, showing an increase in staff engagement particularly with medical and estates staff.

The Trust's results are benchmarked against 122 Acute and Community Trusts. The full results were still embargoed until 13th March 2025 so comparison with London peers could not be conducted. However overall the Trust had strengthened its position in comparison to the previous year and the national average with improvements in five domains, 1 area sustained and a decline in three domains.

The Committee requested that further analysis of the results was conducted, with a focus on areas requiring improvement to ensure the appropriate targeted interventions are implemented, in particular violence and aggression.

The Committee emphasised the importance of understanding the trends and addressing the areas of concern to improve staff satisfaction and engagement.

3.2 Medical Staffing Review

The committee received a verbal update with regard to the progress of the medical staffing review, from the Chief Medical Officer (CMO).

The review (conducted with support from workforce, finance and senior medical colleagues) highlighted the need for additional doctors to ensure the delivery of high-quality services and to improve the health and wellbeing of staff. However it also noted the financial implications of the proposed workforce increase against the Trusts current financial position.

The CMO proposed a phased recruitment approach to address the medical workforce shortages, starting with the most critical areas and moving spend already in the run rate into substantive funding. The Committee discussed the need for a comprehensive recruitment strategy, including job planning and rostering.

The Committee were assured that the proposed recruitment and implementation plans would balance cost with the benefits and impact of the proposed improved service delivery.

The CMO assured the Committee that the next update would articulate the efficiency improvements expected such as reductions in length of stay, safety and staff experience.

3.3 Revalidation – Medical and Nursing

The Chief Medical Office (CMO) and Interim Chief People Officer (ICPO) provided an update on the Medical and Nursing & Midwifery revalidation processes at the Trust for the financial year 2024-25 year to date.

The Committee was assured that the Trust has a robust revalidation and appraisal system in place for Doctors, Nurses and Midwives.

3.3.1 Medical Revalidation

The report detailed improvements in compliance rates and the transition to a new appraisal system. The CMO emphasised the importance of maintaining high standards in the revalidation process and ensuring that all medical staff were compliant with the new appraisal system.

The CMO reported that as of the 25 February 2025, LGT was the Designated Body for 793 doctors and for the appraisal year 2024/25 the Trust reported 727 completed medical appraisals, giving the Trust an overall compliance rate of 91.6% which is expected to increase prior to the appraisal year end.

Recommendations were made to the GMC requesting the deferral of 12 doctor's revalidation dates.

3.3.2 Nursing and Midwifery Revalidation

The ICPO reported high compliance rates for nursing revalidation system. The process has been automated using new technology which had been well-received by staff and contributed to increased compliance. Of the 818 Trust employees due to revalidate with the NMC:

- 97.4% (718 headcount) submitted their application and revalidated before their due date
- 1.8% (13 headcount) requested additional time and obtained deferrals from the NMC. All managed to revalidate within the extended timeframe as agreed with the NMC.

3.4 Caring for the health and wellbeing of all our staff (deep dive on sickness absence) and Occupational Health update

The Associate Director of Workforce (ADoW) presented an update on the workforce strategy of caring for the health and wellbeing (HWB) of staff.

The report summarised the key Trust initiatives to support the wellbeing of staff, and reduce sickness absence, with a preventative and responsive focus. This included the recently transferred in-house Occupational Health service, which has significantly reduced waiting times for appointments and improved the overall response to sickness absence. Other key updates included local and national mental health support available for staff, exercise classes to support staff with musculoskeletal (MSK) issues and the continued efforts to improve staff access to out of hours services such as hot food and HWB support.

Challenges were noted with regard to the Employee Assistance Programme (EAP) staff uptake, improving return to work conversation compliance and capacity versus demand for the psychology service.

The committee requested the team explore the potential of digital therapeutics and other innovative solutions to support staff well-being and proposed that the Respect and Compassion Programme Board oversee and drives HWB initiatives.

4.0 Information items

The committee received the following items within their papers for information.

- Workforce Key Performance Indicators
- PPC Risk Register
- Nursing and Midwifery Safe Staffing Monthly Report
- Apprenticeship Policy
- Flexible Working Policy
- EDI Policy
- National Survey 2024 breakdown and benchmarking

Lewisham and Greenwich NHS Trust

TRUST BOARD

Title: Workforce KPI Update

Date of meeting: 25th March 2025

Summary of paper: This paper provides an update on key workforce performance indicators and the actions being undertaken to make the Trust a great place to work with high levels of employee satisfaction and an efficient and effective workforce. The information covers the period ending 31st January 2025.

Key Performance Indicators Highlights:

Recruiting staff who share Trust values

- Vacancy rate was reported at 9.84% and remains below the Trust target of 10%. The net joiner position was 49.
- M&D vacancy rate was reported at 5.37%, AHP vacancy rate at 6.47% and N&M vacancy rate at 9.37% all below the Trust target. Consultant vacancy rate was reported at 14.56% in part due to increases in the establishment (+30.3 YTD, of which +8.1 FTE in month 10).
- The Trust is actively recruiting to posts through various campaigns, social media and Trust wide recruitment fairs. Vacancies are expected to remain below target as there were 195
- candidates in the pipeline with start dates booked and 194 awaiting checks at 13th February. Amongst those booked to start there were 77 N&M, 62 AHPs & 4 M&D (of which 1 is a consultant). Amongst those undergoing checks there were 82 N&M, 39 AHP & 6 M&D (of which 3 are consultants).
- Time to hire was reported at 7.3 weeks, above the Trust target.
- Local induction compliance for November was reported at 63.3% (reported 2 months in arrears).

Caring for the health and wellbeing of all staff

- Sickness rate was reported at 5.46%, above the Trust target. The 12-month rolling sickness rate was reported at 4.92%.
- The proportion of employees who hit a sickness trigger and who are being formally managed with support from the ER team was reported at 73.81% - this includes 88% of long-term sickness cases. Significant improvement has been made since the start of monitoring, but the KPI remains below the aspirational Trust target.
- The proportion of absences with a return-to-work meeting recorded was reported at 60.75%.
- There has been improved rigor with sickness absence case management across divisions with monthly absence review meetings supported by additional temporary employee relations support who monitor sickness absence metrics, liaise with line managers and coordinate case management documentation.
- Violence & Aggression: 97 incidents reported in November, lowest month year to date.

Developing and retaining a workforce fit for the future

- Mandatory training was reported at 93.29% and remains above the Trust target.
- PDR compliance was reported at 89.34%, just below the target of 90%. Regular reports are issued to Divisions including persistent non-compliant staff to focus efforts of management to improve performance.
- Gross turnover was reported at 10.39%, below the Trust target. Voluntary turnover was reported at 9.59%.
- Voluntary leavers in the first year was reported at 16.04%, a significant improvement compared to 26.98% reported in April 2023 The roll out of 1:1 conversations continue for all new starters and HCAs.
- Stability rate was reported at 87.91%.

Creating inclusive workplaces

- The representation of Black, Asian and minority ethnic staff at bands 8a+ was reported at 37.3% with a headcount of 220. 8a+ representation for female staff was reported at 70.68%, 5.4% for LGBT+ and 8.1% for staff with disabilities. The CPO offers exit interviews to any senior leavers from minority ethnic groups.
- Average time to resolve disciplinary cases has increased and was reported at 102.7 days (20.5 weeks) year to date in 2024-25 (compared to 95.6 in 2023-24 and 86.7 in 2022-23). Additional resources have been agreed for the ER team to support with workload and investigations.

Improving workforce processes

- Temporary staffing spend was reported at 16.91% in January 2025. Bank spend increased to 15.51% whilst agency spend decreased to 1.4%. Usage increased by 8% (15,474 hours more than December 2024).
- A central vacancy control panel is in place to review all corporate agency spend and agency requests for Band 7+ in clinical divisions and bank bookings in Corporate Directorates and other workforce spend. From May 2024 the panel also has oversight of additional controls linked to new agency rules.
- The workforce priorities board track weekly and monthly progress against medical workforce controls, bank & agency controls, roster controls and sickness.
- From 1st January 2025 additional controls have been implemented which include temporary shifts requiring sign-off by 8c or above or individual appointed by Executive Director.

Purpose

Approval	Assurance	Discussion	Note
			✓

Recommendations/ decisions required:

The Trust Board is asked to:

- note performance against the Workforce KPIs and the key actions being taken to improve performance

Overall Level of Assurance

Assurance Level	
Significant	
Sufficient	✓ Actions in place to improve performance
Limited	
None	
N/a	

Link to the Trust's Key Priorities:

✓	Continually improve safety and quality.
	Put patients at the heart of everything we do.
✓	Support and develop our workforce to live our values every day
	Work effectively with partner organisations.
✓	Ensure we spend every penny wisely.

Resource Implications: No additional resources required

Regulations and legal considerations: Legally compliant with relevant employment legislation/CQC considerations/NHS Constitution rights and pledges

Quality consideration and impact on patient and carers: Supports the Trusts ability to deliver high quality care through ensuring high quality workforce in place to support delivery of care to patients and service users

Health Inequalities The workforce key performance indicators aim to improve the trust performance with regards to recruitment, retention, wellbeing, diversity and development of our workforce. As a significant proportion of our workforce are from our local communities, this work has indirect impact on our communities through improving employability and life changes.

Link to the Trust's Green Plan The activities linked to these programmes are not directly linked to the green plan. All activity related to the production of this paper has been paper-free

Consultation/ Communication: TME, TJPB

Risk issues: Risk associated with high agency spend and meeting our savings targets and NHSI ceiling level; the ability to meet requirements set out in the CQC action plan regarding PDR compliance and high sickness absence affecting staff wellbeing and additional pressure for staff at work.

Confidentiality: This report does not contain any confidential information

Equality, Diversity & Inclusion (EDI) (relating to staff, patients and the public)	The primary workforce indicators, particularly turnover, sickness, recruitment, mandatory training and PDR have been considered in light of the protected characteristics (where these are sufficient to support reporting) to ensure that there are no groups within our workforce that are being disadvantaged; and to be assured that where there is a deficit there are plans to address these with the support of the staff networks.
Name of Author:	Eric Pirozzoli, Deputy Chief People Officer
Approved by/ Lead Executive Director:	Meera Nair, Chief People Officer

NHS
Lewisham and Greenwich
NHS Trust

Workforce KPI Update

Period ending 31 January 2025

To be exceptional

Executive summary

Lewisham and Greenwich NHS Trust

This paper provides an update on key workforce performance indicators and the actions being undertaken to make the Trust a great place to work. The information covers the period ending 31st January 2025. Key Performance Indicators highlights include:

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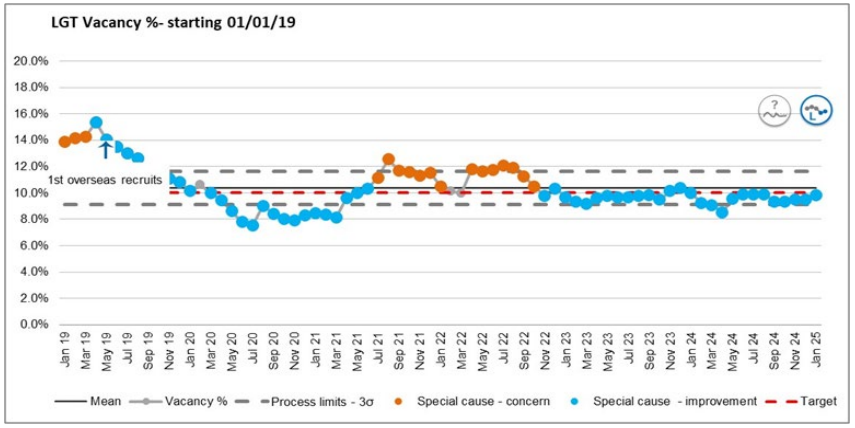
- From 1st January 2025 additional controls have been implemented which include temporary shifts requiring sign-off by 8c or above or individual appointed by Executive Director.

Recruiting staff who share our values

Lewisham and Greenwich NHS Trust

Vacancies – Trust wide



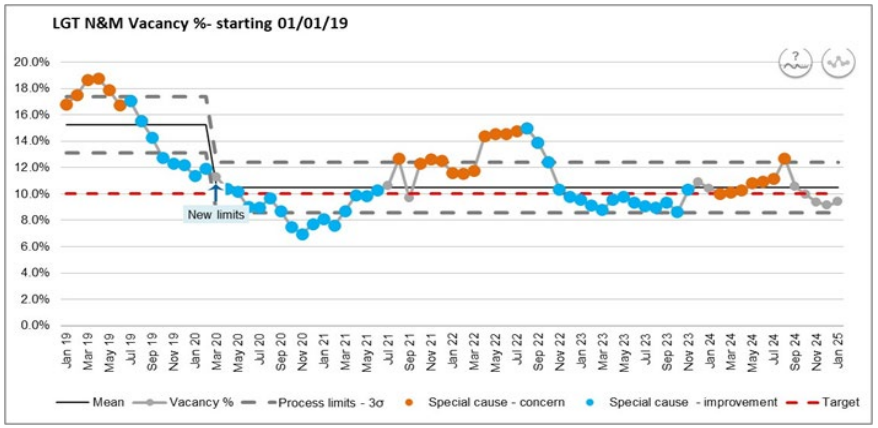
The Trust vacancy rate was reported at **9.84%,** below the Trust target of 10% (783 FTE vacancies). The Trust is actively recruiting to posts through active campaigns, social media, Trust wide recruitment and open days. International recruitment has ceased.

Vacancy rate is expected to remain below the 10% target as overall recruitment pipeline holds 195 candidates with booked start dates in coming months and a further 194 undergoing checks/awaiting start dates. Recruitment fairs in November attracted over 750 applicants. A freeze in external Corporate recruitment started in January 2025.

WCaSH reported the lowest rate at 7% followed by Surgery at 8.1% whilst QEM reported the highest rate at 15.7%.

Model Hospital position: No benchmarking data for vacancies

Vacancies – N&M



The N&M vacancy rate was reported at **9.37%,** below the Trust target (270.7 FTE vacancies). Establishment has increased by 2% over the last 12 months with theatre capacity expansion and safer staffing.

On February 13th 77 candidates were ready to start and a further 82 undergoing employment checks/awaiting start dates.
Trust wide recruitment fairs took place in November attracting 271 nurses. 21 nurses and 8 midwives were recruited internationally for 24-25 –international recruitment campaigns have ceased for now.

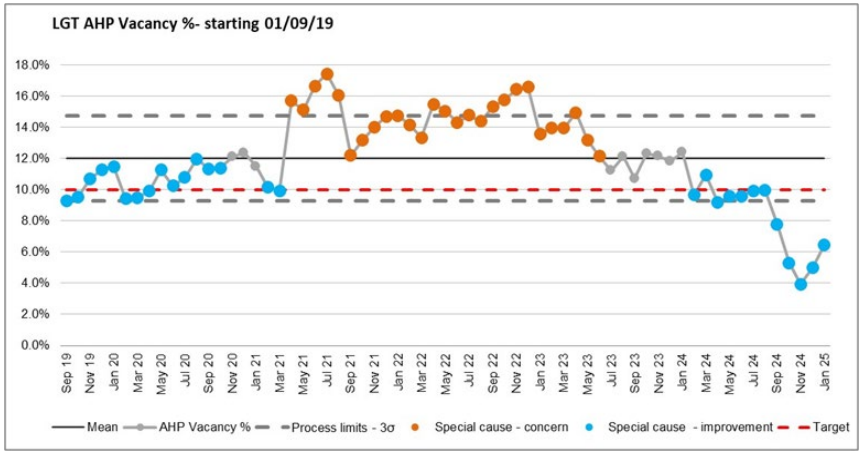
QEM reported the highest rate at 12.5%. All other clinical divisions reported rates below 9.5%.

Model Hospital position: Latest data November 2024
National median = 6.6%, Region (peer) median = 7.7%,
LGT = 10% (quartile 4) ICS peers GSTT 5.8% and KCH 7.1%

Recruiting staff who share our values

Lewisham and Greenwich NHS Trust

Vacancies – AHP



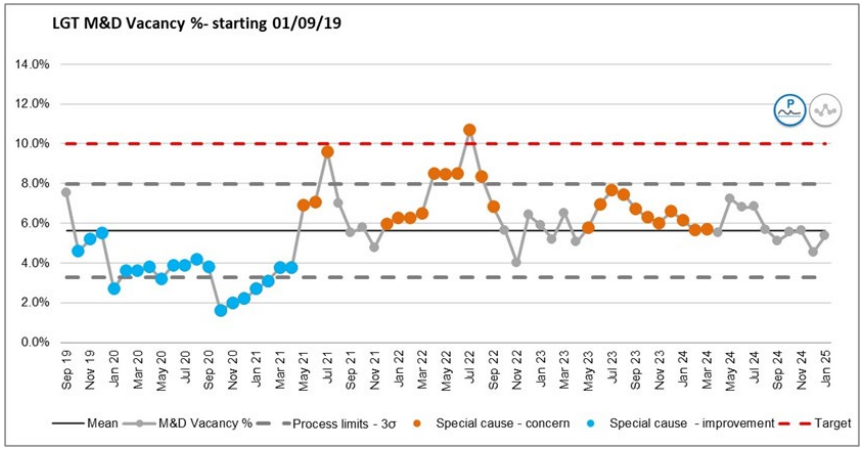
The Trust AHP vacancy rate was reported at **6.47%,** below the Trust target (36.9 FTE vacancies).

The Trust was engaged in international recruitment for AHPs via Capital AHP which resulted in 41 International AHPs joining LGT over 2 years, 12 of whom started in 24-25 including 8 radiographers, 2 OTs, 1 Physio and 1 Podiatrist . Recruitment fairs in June and November attracted additional Sonographers and Radiographers.

On February 13th there were 62 AHPs ready to start and a further 39 in the pipeline undergoing checks/awaiting start dates.

Model Hospital position: Latest data November 2024
National median = 7.2%, Region (peer) median = 10.%,
LGT = 74.1% (quartile 1) ICS peers GSTT 4.9%, KCH 6.4%

Vacancies – M&D



The Trust overall Medical vacancy rate was reported at **5.37%**, below the Trust target (58.3 FTE vacancies). The recruitment pipeline on February 13th held 10 doctors.

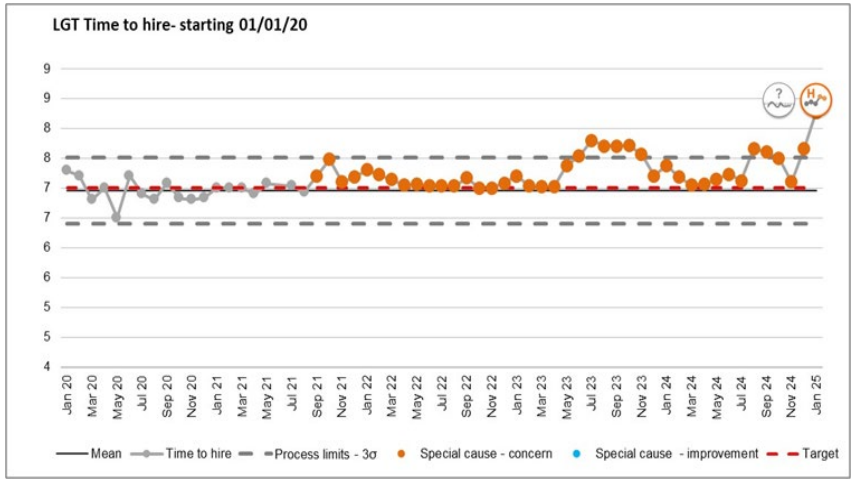
The vacancy rate for Consultants was reported at 14.56% (63 FTE), above the trust target despite increases in the establishment which increased by 30.3 FTE YTD in 24-25 in addition to 12.7 FTE in 23-24 (acute pathway safer staffing review). A recruitment strategy and action plan is in place and significant progress has been made with 32 joiners (29.7 FTE) year to date and there are 4 consultants awaiting checks/start dates.

Model Hospital position: Latest data November 2024
National median = 7.1%, Region (peer) median =6.3%,
LGT = 5.6% (quartile 2) ICS peers GSTT 0.7%, KCH 3.7%

Recruiting staff who share our values

Lewisham and Greenwich NHS Trust

Time to hire

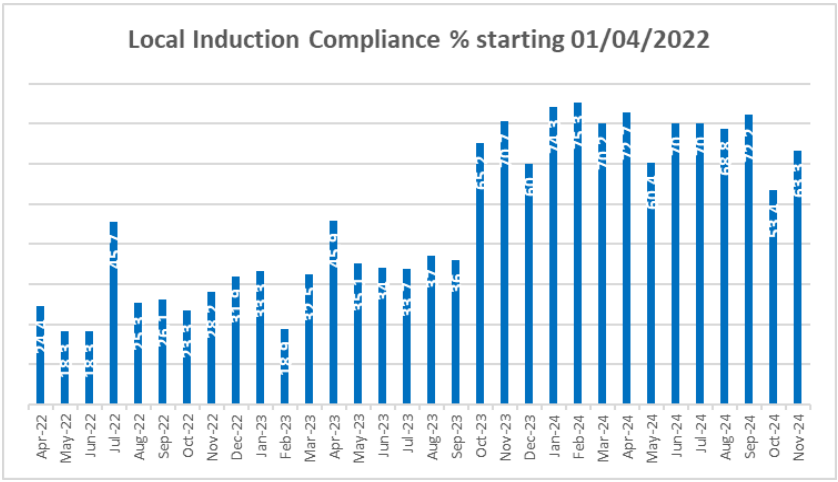


Time to hire was reported at **7.3 weeks**, above the Trust target of 7 weeks. The OH service was brought in house from 1st November 2024.

Corporate services met the Trust target whilst WCaSH reported the highest rate at 7.7 weeks.

Model Hospital position: Latest data 2023/24 from Annual Corporate Services Return, LGT reported as 47.7 days (quartile 1); Regional Median 61 days, Provider Median 61.5 days ICS Peers: GSTT 58.8 KCH 62.6

Local induction compliance



November local induction compliance was reported at **63.3**%.

To improve performance, regular chasers go out to divisional managers where records show non-completion of local induction.

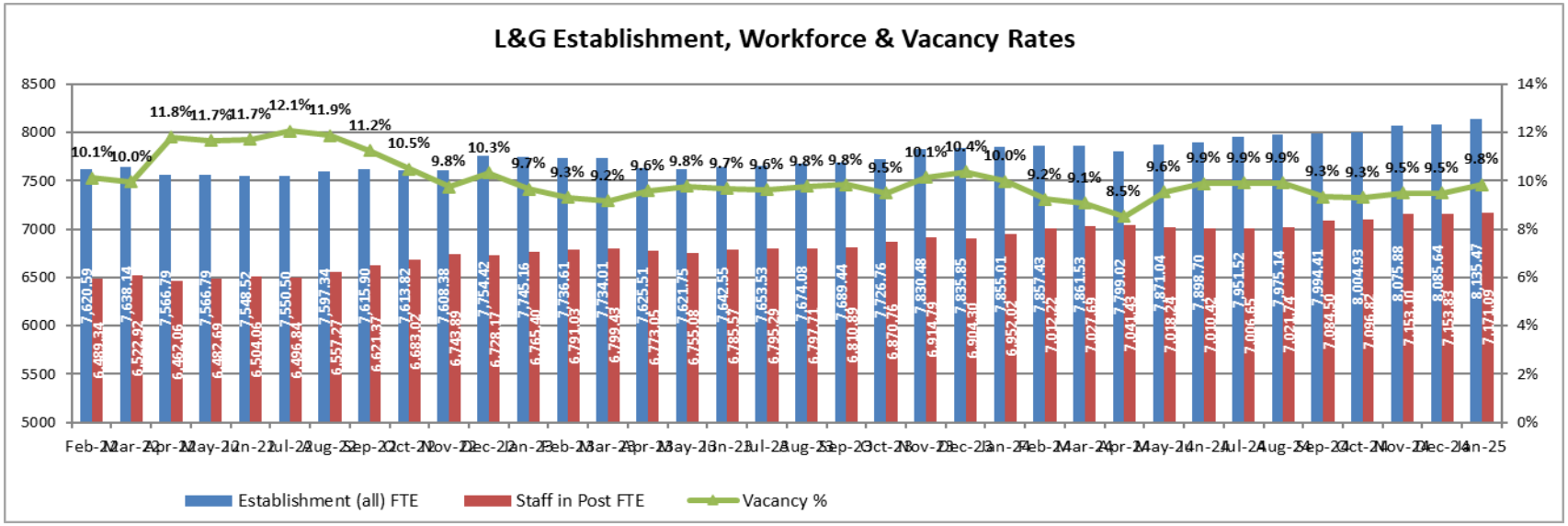
Local induction compliance has been added to the KPI report (reported 2 months in arrears) as part of the retention action plan to improve the onboarding experience for staff.

Model Hospital position: not available

Recruiting staff who share our values

Lewisham and Greenwich NHS Trust

Establishment and Staff in post changes



Establishment: 8135.47 - increased by net 273.9 FTE year to date. This is in addition to a 236 FTE in 23-24, of which 39.5 were M&D and 94.5 are N&M, 7.9 are ST&T qualified staff and 39.9 clinical support.
The reduction in Apr-23 was linked to the removal of non-recurrent funding from previous financial year, however, investment has increased the establishment throughout the year partly linked to M&D / ED Nursing safer staffing reviews and Theatre capacity expansion. From Apr-21 to Mar-23 there was significant investment in the establishment including 167 posts between Apr-22 and Mar-23 related to safer staffing and the Ockendon review. The reduction in Apr-22 was linked to the removal of temporary posts associated with Covid-19.

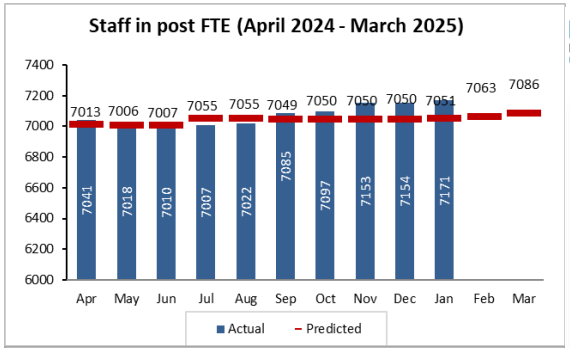
Workforce FTE: 7171.1 - increased by **143.4 FTE** year to date. 2023-24 delivered an increase of 254.6 in total**,** of which 34.2 are M&D, 85.5 are N&M,31.5 ST&T qualified staff and 43.7 clinical support.
During 22-23 staffing levels increased by 337. Staffing numbers are expected to remain stable in coming months supported through divisional active recruitment and recruitment fairs. International recruitment has ceased.

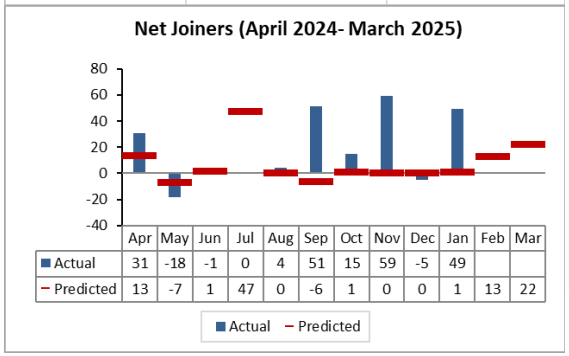
Model Hospital position: No benchmarking data

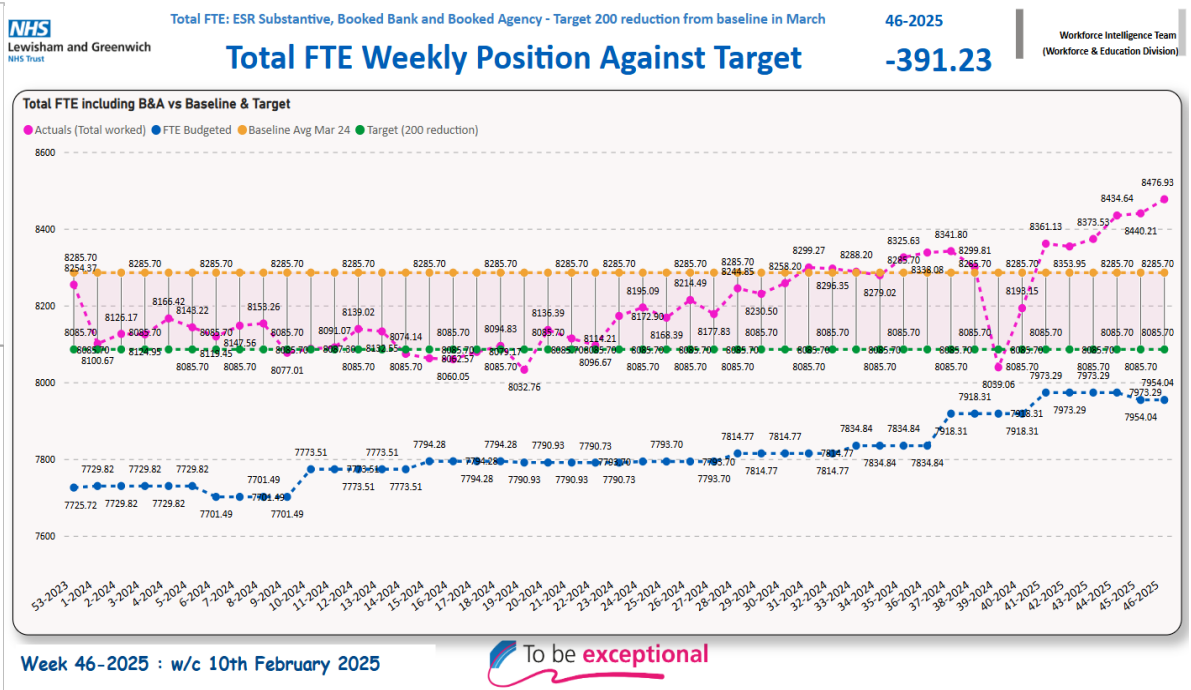
Recruiting staff who share our values

Lewisham and Greenwich NHS Trust

23-24 Workforce Plan







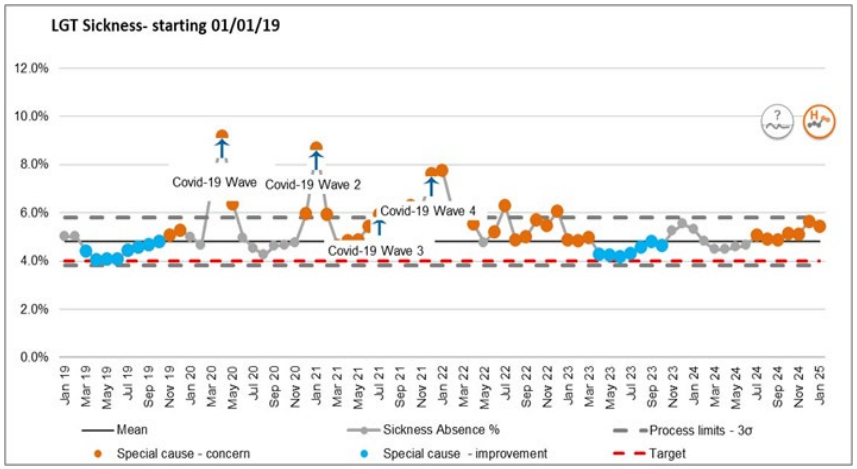
To be exceptional

Workforce Plan 24-25. The Trust is reporting **7171** staff in post against a predicted **7051 substantive staff** FTE as per the SEL planning submission and is over performing against the plan by 120 FTE.
The Trust reported a positive cumulative net joiner position year to date of **+185** FTE between April 2024 and January 2025 against a prediction of +51.
The Trust has also committed to a reduction of 200 overall worked FTE from a baseline of 8286 FTE as part of the annual workforce plan. Whilst there was initial improvement up to 23, there has been a continued increase mainly due to winter pressures and boarding.
On Week 46, worked FTE was reported at 8476.9 FTE against a target of 8085.7, 391.2 above target.

Model Hospital position: No benchmarking data

Caring for the health and wellbeing of our staff

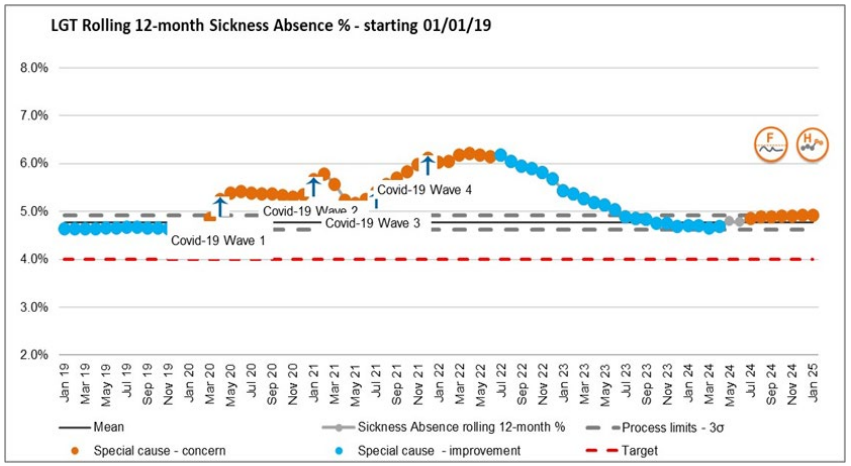
Sickness % Monthly



Sickness rate was reported at **5.46%** and remains above the Trust target. Divisions are being supported in actively reviewing and managing cases which have triggered to improve wellbeing and attendance. 12,144 days were lost to sickness with an estimated cost of £1.351 million. The most common reason during this winter has been colds/coughs/flu with 26% of sickness absences. Surgery reported the lowest rate at 5.25% whilst WCaSH reported the highest rate at 5.87%

Model Hospital position: Latest data 2022/23 from Annual Corporate Services Return, National = 6.2%, Region = 5.3%, LGT = 6.1% (quartile 2) ICS Peers: GSTT 5.1%, KCH 5.7%

Sickness % 12-month rolling



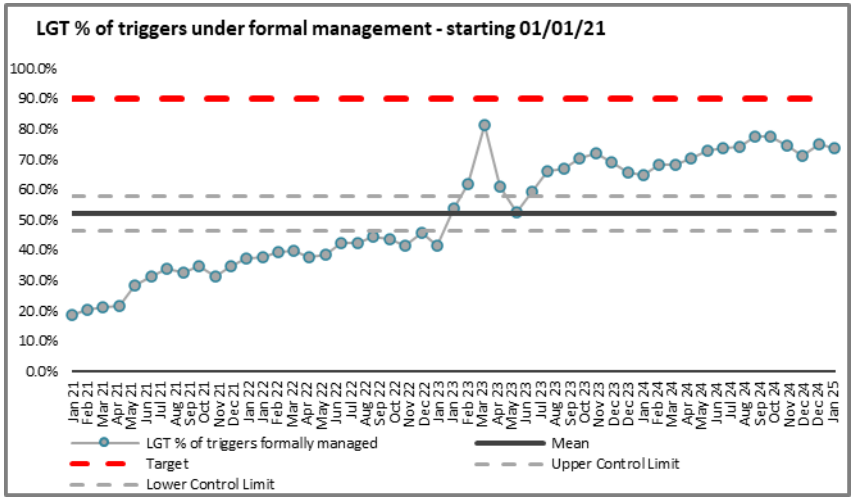
The rolling 12-month sickness rate was reported at **4.9%**, 0.15 higher than January 2024 and 0.3 points higher than prior to the Covid-19 pandemic.

An employee assistance programme (EAP) was launched 1 July 2024, to expand the Trusts holistic wellbeing support offer which in turn will support sickness absence management. The OH service was brought in house from November 2024.

Model Hospital position: currently not available

Caring for the health and wellbeing of our staff

% Triggers formally managed

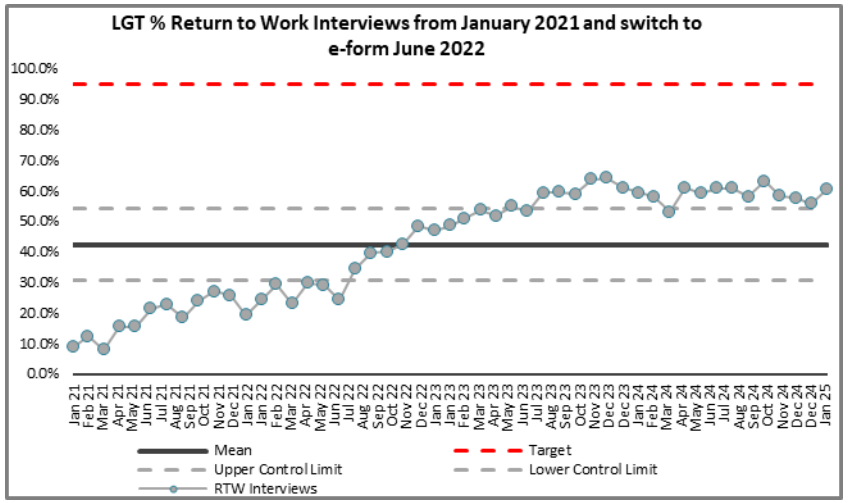


The proportion of staff under formal sickness management (compared to those who have triggered) was reported at **73.8%**. This includes 88% of long-term sickness cases. Surgery reported the highest rate at 82.44%.

Monthly absence review meetings supported by additional temporary employee relations support who monitor sickness absence metrics, liaise with line managers and coordinate case management documentation.

Model Hospital position: No benchmarking data available

Return to Work Interviews



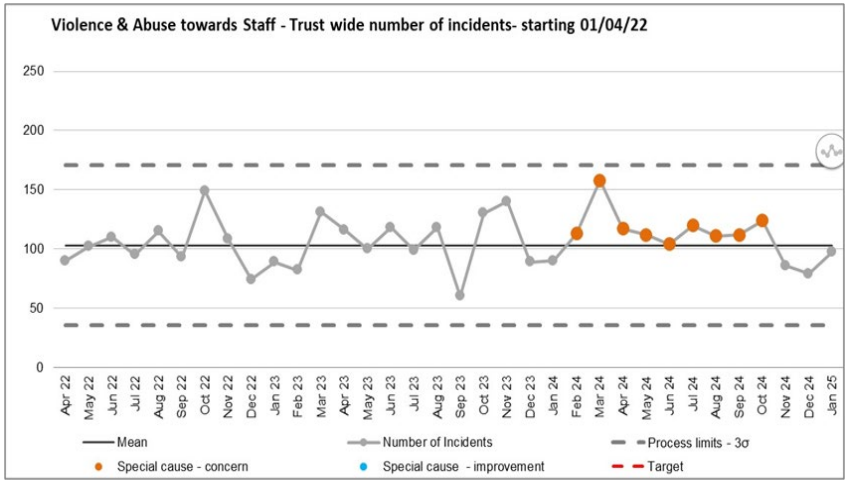
The proportion of absences with a recorded return to work interview was reported at **60.75%,** below the aspirational target of 95%.

Amongst clinical divisions ACS reported the highest compliance at 78.3% whilst QEM reported the lowest at 53.3%.
Work is underway to improve how return to work interviews are conducted to encourage engagement in all staff groups/divisions.

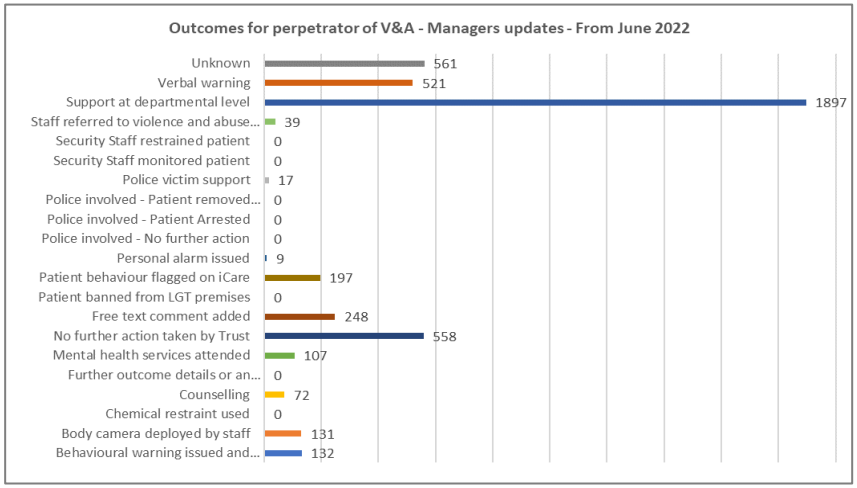
Model Hospital position: No benchmarking data available

Caring for the health and wellbeing of our staff

Violence & Abuse incidents reported



Violence & Abuse Outcomes



During January there 97 violence and abuse incidents towards staff were reported (96 per month on average YTD). V&A towards staff was the 7th largest cause of reported incidents.
UHL ED continue to report the highest number of V&A incidents, 15 in January (13 per month on average YTD) followed by Ash Ward , 7 in January. QEH ED is second highest YTD, 7 on average YTD.
The main types of V&A reported have been:

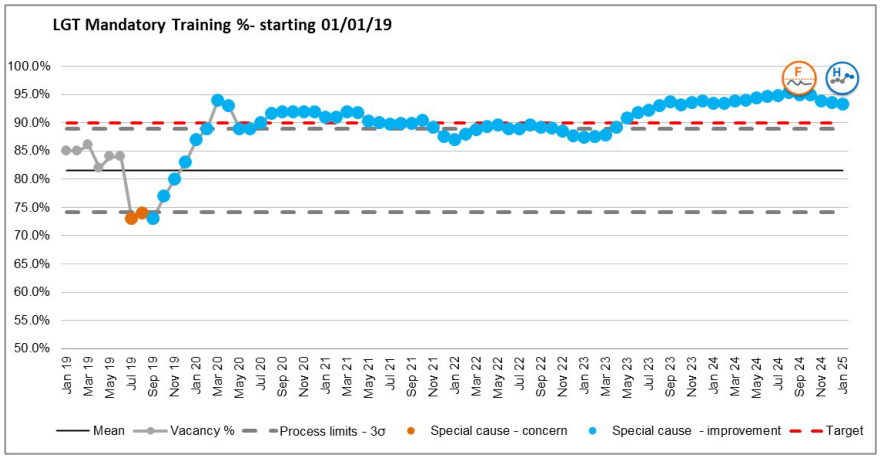
- 46% Verbal Abuse in January – 40% YTD
- 34% Physical Assault in January – 32% YTD
- 14% Behavioral difficulties in January – 20% YTD
- 3% Racial harassment in January – 5% YTD
- 2% involved the use of a weapon in January – 0.5% YTD
- 0% Sexual abuse / harassment in January – 2% YTD

There appears to be no significant disadvantage based on gender, disability or sexual orientation, however, the proportion of incidents towards Black-African staff exceeds their share of the workforce. 21% of victims have not disclosed their ethnic origin and 40% their sexual orientation making it difficult to draw conclusions.
Action taken as a result of reported V&A incidents include:

- 521 service users issued verbal warning
- 329 service users flagged on iCare, of which 132 issued behavioral warning
- 107 incidents required Mental Health Services attendance
- 72 staff provided counselling
- 131 body cameras deployed
- 17 staff received police victim support

Developing and retaining a workforce fit for the future

Mandatory Training



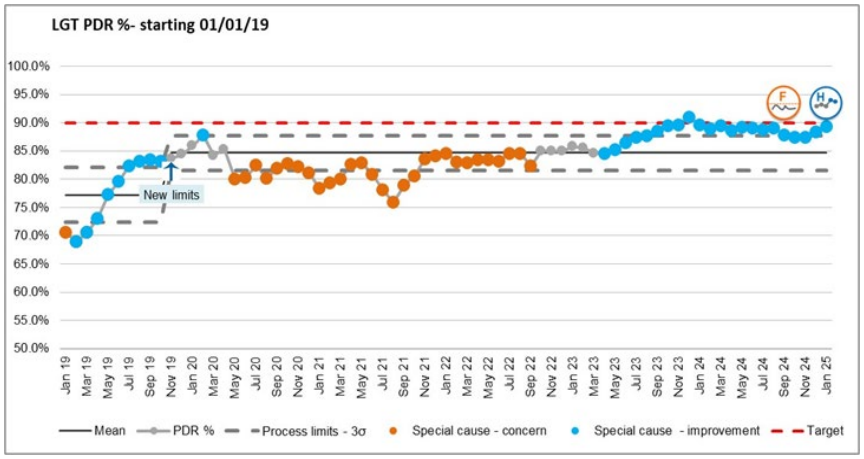
Mandatory training compliance was reported at **93.29%,** above the Trust target of 90%.

All Clinical divisions and Corporate services reported compliance rates above target with ACS and Corporate services above 95%.

Monthly reports, reminder emails, news articles and league tables are circulated to help divisions maintain compliance. The compliance rates are also a core feature of divisional performance meetings.

Model Hospital position Latest data 2023/24 from Annual Corporate Services Return, National Median = 90.9%, ICS peer median = 89.9%, LGT reported as 93.8% (quartile 4) ICS Peers: GSTT 89%, KCH 89.5%

PDRs



PDR compliance was reported at **89.34%,** below the Trust target. ACS, LMC and WCaSH reported rates above the Trust target whilst QEM reported the lowest compliance rate at 83.33%.

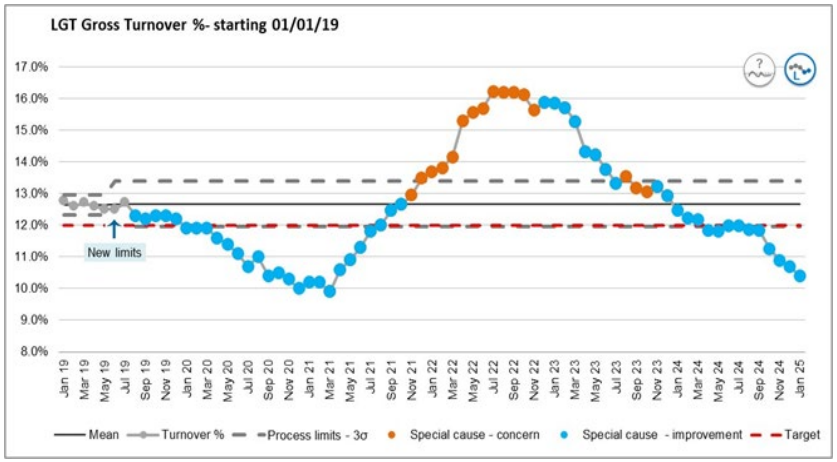
Monthly reports, reminder emails, news articles and league tables are circulated to help divisions meet the target with compliance monitored through divisional performance meetings. Training also provided to support quality conversations and staff development.

Additional work will be undertaken with each division below target to agree a plan which will achieve and maintain compliance.

Model Hospital position Latest data 2023/24 from Annual Corporate Services Return, National Median = 82%, ICS peer median = 81.6%, LGT reported as 88.7% (quartile 4) ICS Peers: GSTT 65%, KCH 91.4%

Developing and retaining a workforce fit for the future

Gross turnover

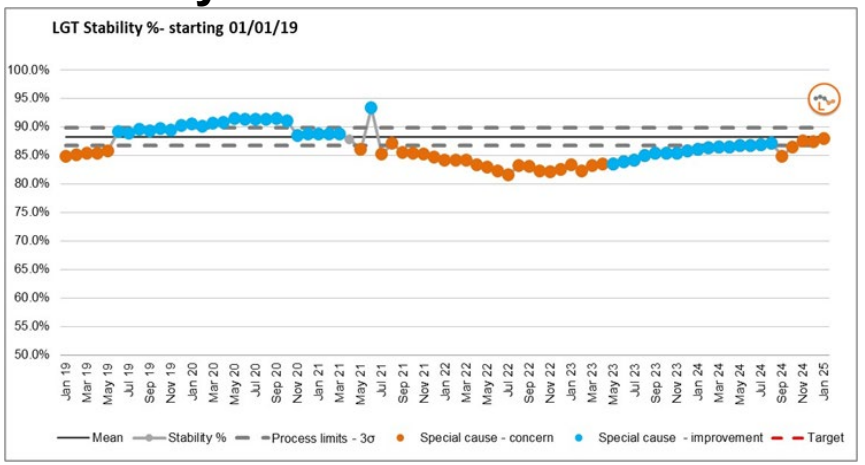


Gross annual turnover reduced to **10.39%**, below the Trust target and lowest rate since June 2021. Voluntary turnover was reported at **9.59%**. ACS reported the highest at 14.53% , however, this notes significant improvement and is below their individual 15% target. By staff group, turnover is highest amongst Support to ST&T staff, particularly support to Healthcare Scientists.

Top reasons for leaving were relocation (18.3%), promotion (18.2%), retirement (2.8%) and work-life balance (11.3%).

Model Hospital position: Latest data November 2024 NHS Turnover rate (includes junior doctors whilst local KPI does not) National 15.5%, peer 17.6%, LGT 16.6% (quartile 3) Peers: GSTT 17.6, KCH 18.2%

Stability / Retention



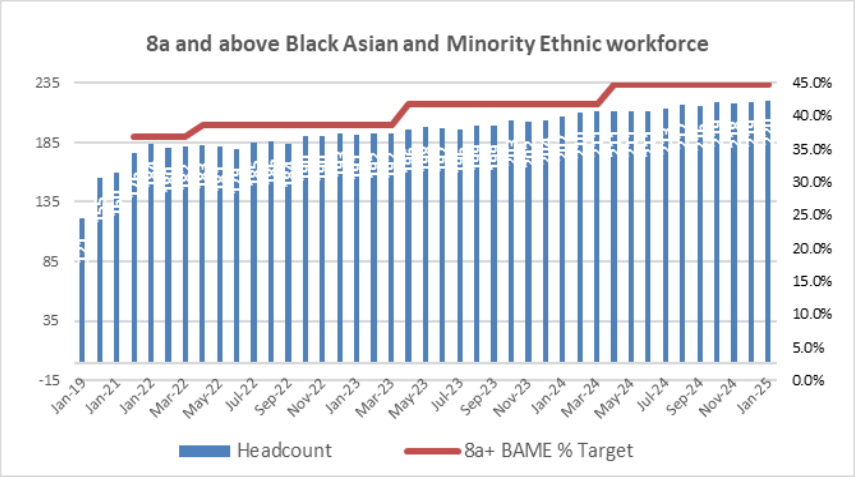
Stability was reported at **87.91%**. Surgery reported the highest rate of stability at 90.95% whilst ACS reported the lowest at 83.9%.

Voluntary leavers in the first year of their employment was reported at **16.06**%, a significant improvement compared to April 2023 (26.98%) . Plans remain in place to improve retention of new staff with the roll out of 1:1 conversations and improved monitoring of local induction. The roll out of 1:1 conversations continues for all new starters and HCAs.

Model Hospital position: No benchmarking data available

EDI: Improving representation in senior managers 8a+

Black Asian and minority ethnic staff

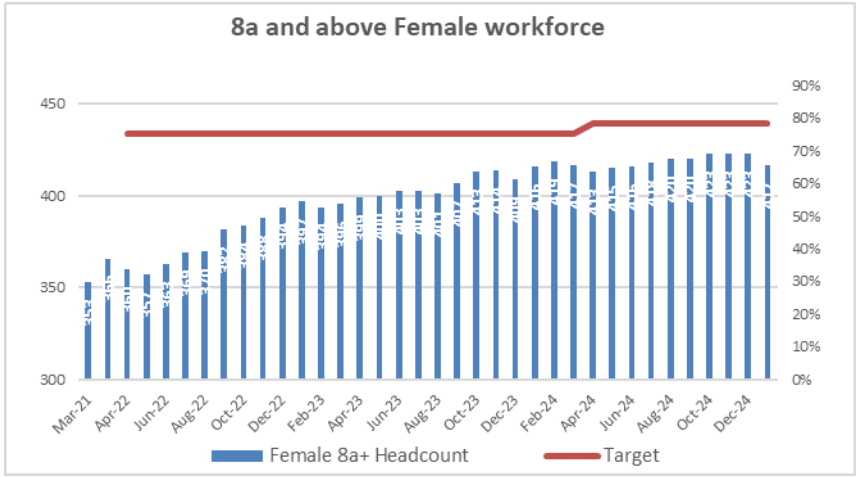


At the end of January, LGT employed **220** Black, Asian and minority ethnic staff at band 8a and above. This represents **37.3%** of the overall substantive workforce on those bands and exceeds Model Employer goals of 19% but is below the Trust's own aspirational phased target (44.8%) to be achieved by the March 2025.

- **Black :** 19.5% at 8a+ versus 32.5% of substantive workforce
- **Asian:** 11.7% at 8a+ versus 20% of substantive workforce
- **Mixed:** 2.5% at 8a+ versus 3.4% of substantive workforce
- **Other:** 3.6% at 8a+ versus 6.6% of substantive workforce

Model Hospital position: not available

Female staff



At the end of January, LGT employed **417** female staff at band 8a+. This represents **70.68%** of the workforce on those band 8a+, 7.2% lower than the overall female workforce profile (78.5%).

The EDI action plan sets out a phased target over 2 years for 8a+ representation to match overall workforce profile representation at **78.5%.**

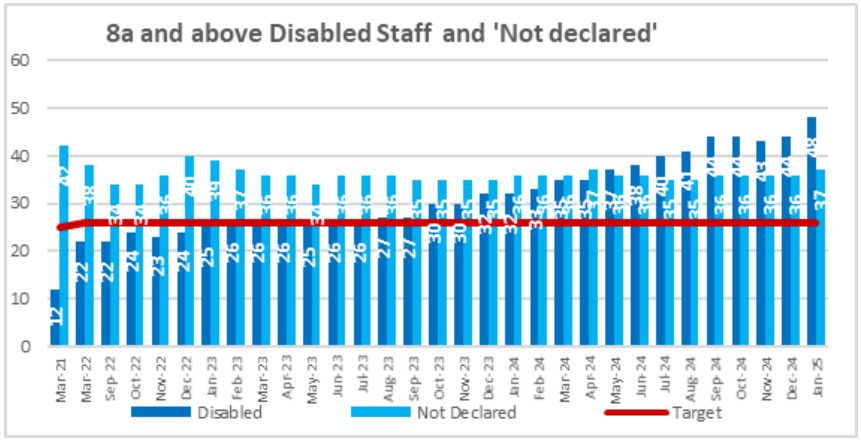
NB: Data on trans and non-binary staff is not available and therefore excluded from the report.

Model Hospital position: not available

Lewisham and Greenwich NHS Trust

EDI: Improving representation in senior managers 8a+

Disabled Staff



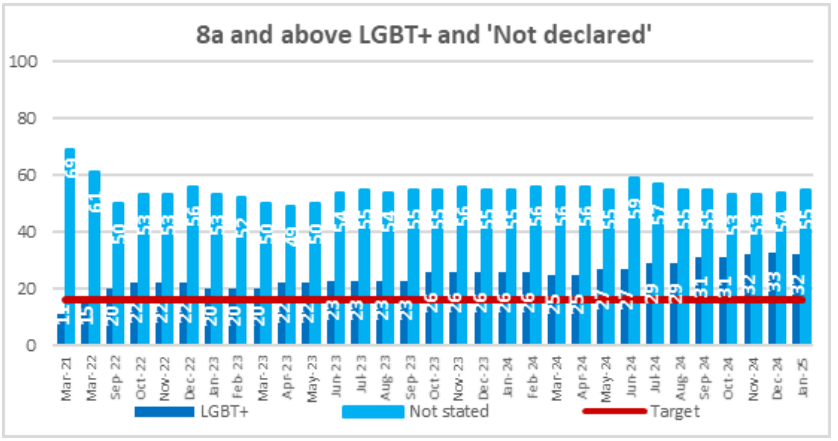
At the end of January, **8.1%** of LGT staff at band 8a+ (48 headcount) had declared a disability, compared to 6% of the overall workforce.

As the level of staff not declaring their disability status remains high, the EDI action plan proposes to reduce the % of staff who have not declared whether they have a disability or not to 7.8% for the overall workforce and 0% for 8a+ over 2 years.

In January 2025, the % of staff 'not declaring' whether they have a disability or not was reported at **6.3%** for 8a+ (37 headcount).

Model Hospital position: not available

LGBT+ staff



At the end of January, **5.4%** of staff at band 8a+ (32 headcount) declared themselves as LGBT (3.9% gay/lesbian and 1.4% bisexual. 0.2% undecided), compared to 4.2**%** of the total workforce.

As the level of staff not declaring their sexual orientation status remains high, the EDI action plan proposes to reduce the % of staff who have not declared their sexual orientation to 12.6% for the overall workforce and 0% for 8a+ over 2 years .

In January 2025, **9.3%** of staff at band 8a+ chose NOT to declare their sexual orientation (55 headcount).

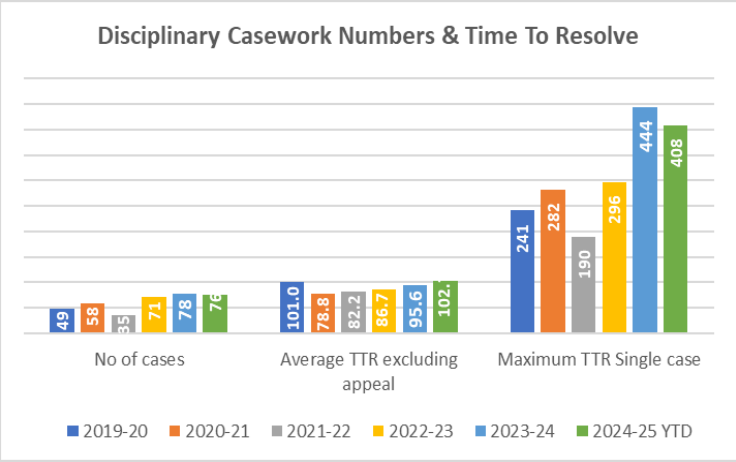
Model Hospital position: not available

Lewisham and Greenwich NHS Trust

Improving workforce processes and outcomes

Time to Resolve (TTR) Disciplinary Cases (excluding appeal stage)

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25 YTD	Trend	Target Days
No of cases	49	58	35	71	78	76		
Average TTR excluding appeal	**101.0**	**78.8**	**82.2**	**86.7**	**95.6**	**102.7**		**60**
Maximum TTR Single case	241	282	190	296	444	408		60



Average time (days) to resolve Disciplinary cases has increased and is reported at **102.7 days (20.5 weeks)** in 24-25 YTD. This represents deterioration in comparison to previous 4 years. The total number of cases closed year to date in 24-25 is **76**. The longest case closed year to date lasted **408** days excluding the appeal. The ER team is focusing on supporting managers to resolve cases via informal stages before cases enter the formal stages. This means that where cases do go forward, they are generally the more complex ones and therefore likely to take longer on average.

Operational pressures and focus on sickness management support have impacted the ability of managers to progress disciplinary matters within timeframes. This has particularly been the case through the winter. To address this problem the ER team now has two new Case Investigator positions focused on directly carrying out investigations, with one starting in post in November 2024 and one starting in March 2025. Early results have been very promising and this should make a significant impact on the KPI for 2025/26.

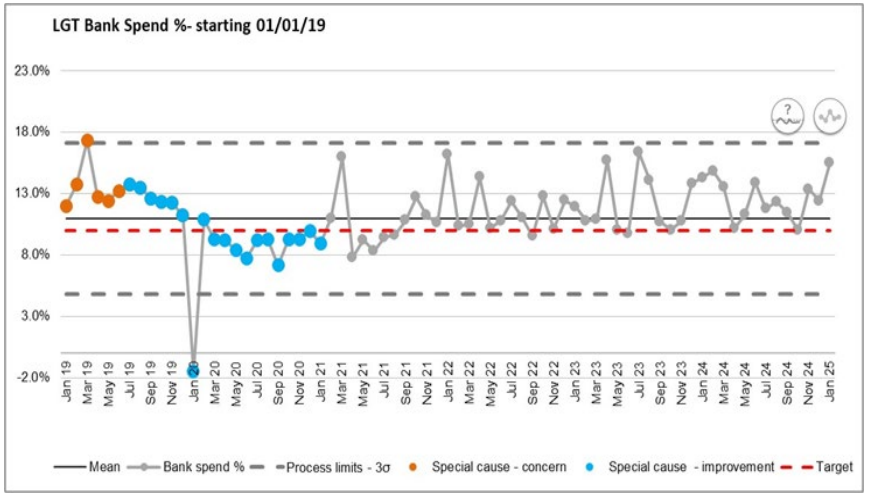
According to Model Hospital data up to March 2024 others have also been experiencing a deterioration. e.g. KCH position more than doubled from 5.7 weeks in 20/21 to 12 weeks for 23/24 and Oxleas more than doubled from 14.1 to 33 weeks within the same period.

Model Hospital position: Latest data 2023/24 from Annual Corporate Services Return for average time (weeks) to close ER cases. National Median 16 weeks, ICS peer median 16 weeks. LGT reported 19 weeks (quartile 3). GSTT 14 weeks, KCH 12 weeks, Oxleas 33 weeks. SLaM did not provide figures.

Temporary Staffing Spend

Lewisham and Greenwich NHS Trust

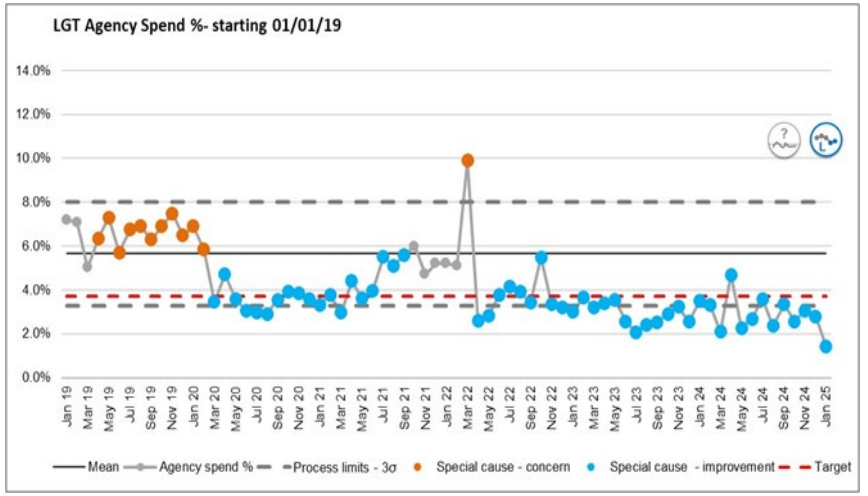
Bank



Bank spend was reported at **15.51%**.
79.7% of shifts were covered by bank workers.
Weekly meetings continue to take place to review rostering practices including management of leave, approval times, releasing shifts to bank.
From 1st January all shifts will require approval by 8c+ or individual appointed by an executive director.

Model Hospital position: Latest data November 2024
Overall Bank spend as a % of total spend
National median 8%, Peer median 9%; LGT reported as 12% (quartile 4) ICS peers: GSTT 5%, KCH 5%

Agency



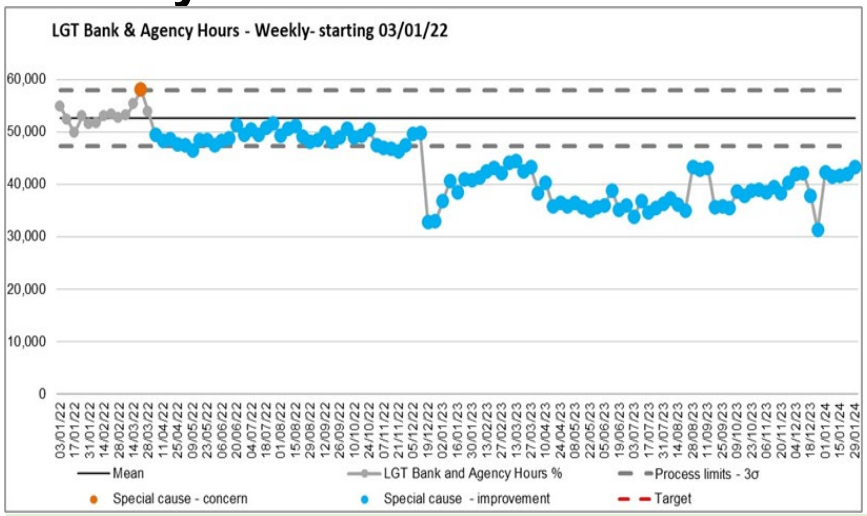
Agency spend was reported at **1.4%** below the NHSE target. THis was partly due to a correction of spend coding in month 10.
20.3% of shifts were covered by agency workers.
Agency bookings needed within 48 hours require HoN approval.
A central vacancy control panel is in place to review all corporate agency spend and agency requests for Band 7+ in clinical divisions.
From 1st January 2025 2 executive directors will be part of the vacancy control panel and all shifts will required sign off by 8c or above or individual appointed by an executive director.

Model Hospital position: Latest data November 2024
Overall agency spend as a % of total spend
National median = 2%, Peer median 3%; LGT reported as 3% (quartile 3) ICS peers: GSTT 1%, KCH 1%

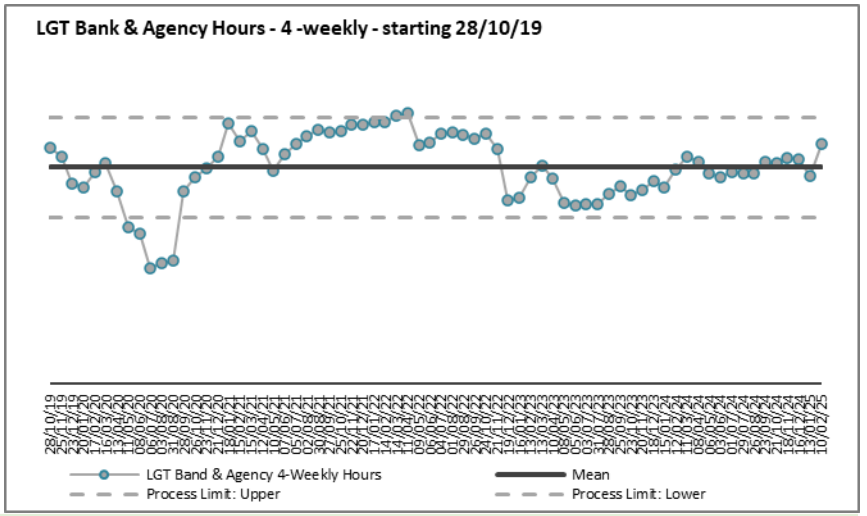
Temporary staffing usage

Lewisham and Greenwich NHS Trust

Weekly



Four-Weekly



During January 2025 temporary staffing usage increased by 8% (15474 hours more than December 2024). 79.7% of shifts were covered by bank and 20.3% by agency.

The Workforce Priorities Programme meets weekly to review medical, rostering, sickness and temporary staffing controls as well as meeting with the clinical divisions to review controls in place to reduce reliance on temporary staffing. The aim is to reduce worked FTE by 200 across all areas. Programmes of work include reviewing use of medical fixed term contracts, job planning compliance, sickness management and bank and agency breaches. Work is also underway to review RMN usage and long-term vacancies.
The central vacancy control panel continues to meet weekly to review all agency requests, advert requests and pay impacting change forms for all Corporate areas and for Medical and Band 7+ in clinical divisions.
For Nursing, Divisional meetings review compliance with rostering practices and temporary staffing KPIs including management of leave, approval times, timing of release of shifts to bank/agency and sickness. Requests for additional duties require sign-off from 8c or above.

From 1st January 2025 additional measures are being introduced to tighten financial control: all temporary staffing shifts will require sign-off from 8c or above or individual appointed by an executive director and at least 2 executive directors will attend the vacancy control panel.

Lewisham and Greenwich NHS Trust

TRUST BOARD REPORT
25 March 2025

Report from:	**Finance, Infrastructure and Transformation Committee (FITC)**
Date of Committee Meetings:	**18 February 2025**
Purpose of the Committee: The purpose of the Finance, Infrastructure and Transformation Committee is to act as a key scrutiny committee in support of Board decision making in the areas of financial planning and performance, business cases, procurement, investments and capital planning.	
Purpose:	**For approval or ratification** ☒ **Item to receive/for information** ☒ **For discussion** ☐ **For decision** ☐
Committee Chair:	**Harry Bright, Non- Executive Director**
Lead Director:	**Spencer Prosser, Chief Finance Officer**

1. ITEMS FOR ESCALATION / REFERRAL TO THE BOARD

The Committee agreed that the following items should be referred to the Trust Board:

1.1 UHL UTC Redevelopment

The Committee received an update on the progress being made in the establishment of the new UTC at UHL. The facility remained on course for a March opening which would improve type 3 attendance performance significantly. The Committee supported further design works for subsequent phases of the plans to redevelop the emergency care pathway, noting the uncer

1.3 Contracts for Approval

The Committee recommended for approval to Board the 1 contract for approval.

2. ITEMS RECEIVED

2.1 Finance Report M10 24/25

The Director of Finance explained that the Trust was reporting a cumulative deficit of £11.8m as at the end January 31st which represents a small in-month surplus of £58k. The improvement to the Trust position relates to Health Education England (HEE) and Discharge funding recognised in month. The position also includes the unexpected costs of a power outage on the UHL site. The Trust is in discussion with the ICS in respect of additional financial support to

2.2 Planning 25/26

The CSPTO provided the Committee with an overview of the planning round including timetable and performance targets. The committee heard that delivering against all of the requirements whilst maintaining financial balance was going to be extremely challenging with high levels of implementation risk.

2.3 Community Diagnostic Centre Update

The CSPTO informed the Committee that both CDCs were on track in terms of construction and commissioning. Recent changes to payment tariff has necessitated a review of the approved operating model to ensure that the facilities are self-funding. Further work is underway to attempt to resolve this issue, together with recruitment challenges in some areas.

Lewisham and Greenwich NHS Trust

TRUST BOARD REPORT
25 March 2025

Report from:	**Finance, Infrastructure and Transformation Committee (FITC)**
Date of Committee Meetings:	**18 March 2025**
Purpose of the Committee: The purpose of the Finance, Infrastructure and Transformation Committee is to act as a key scrutiny committee in support of Board decision making in the areas of financial planning and performance, business cases, procurement, investments and capital planning.	
Purpose:	**For approval or ratification** ☒ **Item to receive/for information** ☒ **For discussion** ☐ **For decision** ☐
Committee Chair:	**Harry Bright, Non- Executive Director**
Lead Director:	**Spencer Prosser, Chief Finance Officer**

1. ITEMS FOR ESCALATION / REFERRAL TO THE BOARD

The Committee agreed that the following items should be referred to the Trust Board:

1.1 2025/26 Operating Plan

The Chief Executive outlined the extent of the current challenges facing the NHS and the Trust, in respect of meeting financial, performance and quality aspirations for the coming financial year. The Chief Financial Officer, Deputy Chief Executive and Chief Operating Officer explained their respective elements of the plan to the Committee, whilst noting the trade-off between planning and delivery risks. The Committee noted the report and asked that a further update be presented to the Board to allow for a formal submission to NHS England before the prescribed deadline.

1.2 Dermatology Refurbishment

The Chief Operating Officer presented a proposal to repair structural defects in the Dermatology block at UHL. The service has temporarily relocated to alternative accommodation which is not available in the longer term. The Committee noted the additional strain the proposal put on the 25/26 capital plan and recommended the scheme to the Board for approval.

1.3 Contracts for Approval

The Committee recommended for approval to Board the 2 contracts for approval.

2. ITEMS RECEIVED

2.1 Finance Report M11 24/25

The Chief Financial Officer explained that the Trust was reporting a cumulative deficit of £10.6m as at the end of February 2025. This was in line with expectations and an improving position. The Trust has agreed with the ICB that additional income will be received by the Trust to cover some one-off issues that have arisen during the financial year. This additional receipt will be accounted for in March. The Deputy Director of Finance (Director of Recover) outlined some of the financial improvements delivered since the financial recovery programme was initiated in December.

2.2 Electronic Patient Record (EPR) Update

The CSPTO provided the Committee with an update on the progress being made with the EPR business case which is being considered by government bodies. The Committee also discussed the linkages of a new EPR with pathology services provision which is a key success criteria for any new system

2.3 Patient Portal Update

The COO updated the Committee on the progress of the patient portal project with particular reference to efficiency benefits and patient experience improvements.

2.4 FITC Risk Register

The Chief of Staff presented the current risks monitored by the Committee and reported that whilst mitigations were impacting on the risks, it was not considered appropriate to change the risk scores at this time. It was noted however that the financial risks were changing regularly and that the Board would receive a revised Board Assurance Framework for the coming financial year.

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TRUST BOARD REPORT 2024/25

Title: Financial position for period ended 28th February 2025

Date of meeting: 25th March 20025

Summary of paper: **For the period ending 28th February 2025, the Trust has reported an in-month favourable variance to plan of £1.1m, resulting in a year-to-date adverse position to plan of £10.6m.** The improvement to the Trust position relates primarily to the in-month over-achievement of ERF income (£1m) in addition to the transfer of revenue expenditure in the YTD position to capital (£0.9m).

The key financial challenges for the Trust are:

- £5.3m of funding pressure originating from cost of within-tariff and pass-through drugs above the block funding and planned funding to cover depreciation of nationally funded capital programmes not realised.
- £1.5m reduction in the expected payment for 23/24 ERF work.
- £0.6m cost pressure relating to the impact of industrial action, net of £0.9m funding received earlier in year.
- £0.5m impact (expenditure and loss of income) of power outage at the UHL site in the prior month
- Excess inflationary costs above funded levels is under review with £0.4m identified to date.
- Whilst £63.6m of efficiency improvements have been identified to date, £25.2m of these remain as productivity improvements and are not 'cashable' in year. To date a total of £35.3m has been achieved against a target of £40.8m, leaving a £5.4m shortfall against plan,
- ERF reported performance has improved in month by £0.8 with a YTD adverse position to the income plan of £2.2m of which £1.5m relates to a 23/24 ERF payment reduction, £0.50m due to the impact of industrial action earlier in year and £0.2m due to the M10 impact of power outage at the UHL site .
- A further £7.6m of non-pay pressures have accumulated including excess inflation, additional costs of theatre consumables and increasing costs of insulin pumps. Work is on-going to analyse this in further detail and tackle through the recovery programme.
- £35m FYE of additional pay has been distributed through various pay awards for 24-25 through both M07 & M08, this is funded with additional income although leaves a residual cost pressure of £2.9m if all vacancies are recruited to / backfilled with temporary staff at equivalent rates.
- £1.5m of pay HCA pay upgrade funding has been distributed in month, £0.5m above planning expectations, assuming all funded posts are upgraded. This shortfall shall be addressed in 25/26 through an expected reduction to the number of upgraded posts.
- Whilst pay budgets are materially on track, issues exist within including operational pressures on the UEC pathway, enhanced care, high levels of sickness and medical bank rates significantly higher than funded levels.
- The YTD position benefits from £9.8m one-off benefits above plan in the YTD position including unplanned for VAT rebates and release of prior year provisions.

Purpose

Approval	Assurance	Discussion	Note
	[✓]	[✓]	[✓]

Recommendations/ decisions required:

The Trust Board is asked to discuss the 2024/25 financial position for the period ended 28th February 2025

Overall Level of Assurance

Assurance Level	
Significant	
Sufficient	The risks highlighted in the report could put the deliverability of the 24-25 plan at risk.
Limited	
None	
N/a	

Link to the Trust's Key Priorities:

✓	Continually improve safety and quality.
✓	Put patients at the heart of everything we do.
✓	Support and develop our workforce to live our values every day
✓	Work effectively with partner organisations.
✓	Ensure we spend every penny wisely.

Resource Implications: As detailed in the attached report

Regulatory considerations: The Trust is required to comply with statutory financial targets, and is in regular communication regarding performance with the NHSE regional team.

Quality considerations: Ensuring value for money in delivering high quality clinical services

Health Inequalities	Whilst allocation of resources to minimise avoidance inequalities to access to, or outcomes from, Trust services is a priority for the Trust, no direct links to health inequalities are made in this finance report
Link to the Trust's Green Plan	No direct links to the Trust's Green Plan are made in this finance report.
Consultation/ Communication:	Finance, Infrastructure and Transformation Committee on 18th March 2025
Risk issues:	Deliverability of the 24/25 and 25/26 financial plan
Confidentiality:	This report does not contain confidential information
Equality, Diversity & Inclusion (EDI)	No direct links to EDI considerations are made in this finance report.
Name of Author:	Eska Desmond, Head of Financial Reporting and Analysis
Approved by/ Lead Executive Director:	David Cooper, Director of Finance

Lewisham and Greenwich NHS Trust

Financial Position for the month to 28th February 2025

TRUST BOARD

25th March 2025

Dave Cooper, Director of Finance

To be exceptional

Contents

Appendices:

1. Executive Summary

Key Messages

For the period ending 28th February 2025, the Trust has reported an in-month favourable variance to plan of £1.1m, resulting in a year-to-date adverse position to plan of £10.6m. The improvement to the Trust position relates primarily to the in-month over-achievement of ERF income (£1m) in addition to the transfer of revenue expenditure in the YTD position to capital (£0.9m).

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NHS Lewisham and Greenwich Trust

Cash

- The closing cash balance at the end of February is £106m, reflecting a £16.0m increase from January.
- This rise is primarily attributed to NHS England's Health Education training income for Q4 (£6.3m), a Capital PDC drawdown (£5.7m), and SEL ICB funding for elective recovery and financial support (£4m).Debtor days have remained the same as last month (5 days) and Creditor days have deteriorated by 3 days this month due to a net increase in creditors (£2.5m), primarily driven by outstanding invoice from Barts Health in relation to the Pathology Partnership for September (£2.05m) and R&B Decorators for UHL Passive Fire Protection Improvement Works (£0.4m).

Capital

- The Trust is forecasting to achieve it capital plan of £53.6m. YTD spend and commitments on capital projects is £42.m.

Financial Accounting summaries provided in Appendix 1 and 2 of this pack.

2. Income and Expenditure

Statement of Comprehensive Income

£000s	Annual Budget	YTD Budget	YTD Actual	YTD Variance	M11 Budget	M11 Actual	M11 Variance
INCOME							
Patient Care	792,468	726,297	727,064	767	67,216	67,717	501
L.D.A. Income	25,261	23,193	24,193	1,000	2,410	2,424	14
Other Income *(Inc. element of Patient Care)*	26,827	24,443	28,104	3,661	2,243	2,517	274
TOTAL INCOME	**844,556**	**773,933**	**779,362**	**5,429**	**71,869**	**72,659**	**789**
PAY EXPENDITURE							
Substantive	(529,306)	(485,481)	(422,470)	63,011	(47,346)	(39,263)	8,083
Bank / Locum	(4,435)	(4,009)	(59,018)	(55,009)	(95)	(4,135)	(4,040)
Agency	(2,830)	(2,565)	(16,233)	(13,668)	(227)	(3,306)	(3,079)
Pay Reserves	(5,408)	(4,648)	0	4,648	1,235	0	(1,235)
TOTAL PAY *(Inc. Reserves)*	**(541,980)**	**(496,703)**	**(497,722)**	**(1,019)**	**(46,433)**	**(46,704)**	**(271)**
NON PAY EXPENDITURE							
Clinical Service and Supplies	(45,036)	(41,189)	(53,602)	**(12,414)**	(3,839)	(4,275)	**(436)**
PBR Excluded Drugs	(33,465)	(30,676)	(36,839)	**(6,162)**	(2,789)	(3,713)	**(924)**
CNST Contributions	(35,647)	(32,473)	(32,345)	**128**	(3,175)	(3,140)	**35**
General Supplies and Services	(26,944)	(24,692)	(26,048)	**(1,356)**	(2,243)	(2,402)	**(159)**
Establishment Expenses	(14,778)	(13,599)	(14,338)	**(739)**	(1,180)	(1,326)	**(146)**
Premises and Fixed Plant	(53,087)	(48,718)	(43,104)	**5,614**	(4,528)	(3,372)	**1,156**
Other Services	(40,359)	(37,220)	(33,469)	**3,752**	(5,472)	(2,494)	**2,979**
Non Pay Reserves	2,087	2,054	0	(2,054)	2,436	0	(2,436)
TOTAL NON PAY *(Inc. Reserves)*	**(247,230)**	**(226,513)**	**(239,745)**	**(13,232)**	**(20,790)**	**(20,723)**	**67**
Total Expenditure	**(789,210)**	**(723,216)**	**(737,467)**	**(14,251)**	**(67,223)**	**(67,426)**	**(203)**
EBITDA (Excluding PSF)	**55,346**	**50,718**	**41,895**	**(8,822)**	**4,646**	**5,232**	**586**
Finance & Depreciation/PDC	(69,409)	(63,619)	(63,061)	**558**	(5,790)	(5,482)	308
Donated Asset Adj.	(386)	(354)	(206)	147	(32)	(19)	13
SURPLUS / DEFICIT	**(14,449)**	**(13,255)**	**(21,373)**	**(8,118)**	**(1,176)**	**(268)**	**908**
Donated Asset Adj.	244	231	206	(25)	21	19	(2)
IFRS16 ADJ.	14,205	13,023	10,537	(2,486)	1,184	1,403	219
REPORTED SURPLUS / DEFICIT POST D.A.	**(0)**	**(1)**	**(10,630)**	**(10,629)**	**29**	**1,154**	**1,125**

Commentary

Areas of concern from a financial point of view within the overall trust position include the following:

Income

Patient care income is £0.8m favourable to plan at month 11. Key drivers to this position are £4.4m overperformance in drugs flexing (which will be offset by additional expenditure) and underperformance of £2.5m on CDC, which will again be offset by underspends within expenditure reserves. In addition, there has been a £1.5m adverse movement recognised YTD with regards to a prior year ERF clawback for 2023/24 underperformance to the agreed year end position (due to a data capture issue) Against the Trust internal plan ERF income at month 11 is under expected levels with a 24/25 underperformance reported of £1m and a 23/24 £1.5m income reduction due to a known data submission issue, and further discussions are taking place with NHSE in this regard.

Other income variances include £1m of HEE funding above plan received in month in addition to divisional income variances for recharges received.

Pay

Pay costs at £498m YTD are £0.1m adverse to plan. Permanent staffing costs are £67.6m favourable to plan YTD predominantly due to vacancies across divisions, particularly in community services offset by YTD adverse bank variances of £55m and agency variances of £13.4m. Within month substantive pay costs reported a larger than average underspend due to the in-month allocation of HCA upgrade funding. Other key drivers of the YTD position include:

- Pay IURP variance c£7.3m
- Medical pay overspends £5.1m
- Sickness cover £5.5m
- Industrial action cover £0.6m, net of system funding.
- Enhanced care £1m
- Escalation costs of £1m, net of reserves and UEC funding.
- Offset by uncovered vacancies and underspent trust-wide pay reserves

Non-Pay

Non-Pay costs, including finance charges and technical adjustments, at £292m YTD are £15m adverse to plan year to date of which the key variances include:

- Drugs overspends (PBRE and tariff drugs) of £8m, partially offset by £4.4m income for the non-blocked element of PbRE drugs
- Estates and facilities overspends of £2.8m relating to rates, utilities. hybrid mail double running costs,, maintenance and hard/soft FM.
- Theatre consumables, £2.5m heavily contributed to by ERF activities.
- Finance charges overspends of £1.6m relating primarily to the shortfall on depreciation on nationally funded capital programmes

3. Improving Use of Resources/Executive Summary Reporting Month 11: February 2024-25

Lewisham and Greenwich NHS Trust

Key Headlines

- Trust's efficiency target for 24/25 is £44.5m.
- As of month 11, £38.6m of budget releasing savings have been identified and transacted against the £44.5m efficiency target for the year, with a forecasted delivery of £38.3m .
- With £38.3m of the required £44.5m forecast for delivery, this leaves roughly £6.2m in additional budget releasing savings to deliver for the year
- In addition to the identified budget releasing savings, £25.2m of non-budget releasing savings have also been identified, bringing total efficiencies identified for 24/25 at month 9 to £63.6m.

Month 11 Position

- With respect to delivery of savings against the budget releasing target, £35.3m has been achieved against a target of £40.8m, leaving a shortfall of £5.4m.
- The main factors driving the variance are:
    - The year-to-date impact of £4.9m unidentified savings gap. This drives around £4.2m of the variance
    - Conversion of agency to bank - £0.17m
    - Slippage of savings for the theatre improvement programme - £0.67m
    - Under delivery of savings by Surgery insourcing schemes £1.4m
- Offsetting the above is the over achievement of Outpatient Procedure coding improvement savings offsetting approx. £1.8m

Key risks for 24/25 (update)

•Unidentified savings gap – around £4.9m of additional savings opportunities to be developed to help bridge this gap
•Delays to key enabling initiatives such as patient portal, patient-initiated follow-up,
•Slippage in key efficiency schemes such as the pathology partnership, Surgery insourcing and conversion of agency to bank

Additional ideas being developed for 24/25 to help bridge the gap

•Transaction of procurement savings £0.4m
•Transaction of medicine savings £0.6m
•S106- £2m

Further mitigations undertaken to identify additional efficiency opportunities

•Review of CIP schemes across APC to identify opportunities that can be replicated
•Application of bank rate cap per recent NHSE guidance on temp spend
•Recovery Programme to mitigate underspend and identify additional savings

	M11 year-to-date				Full-year 2024/25			
	Plan	Actual	Variance		Plan	Forecast	Variance	
	£m	£m	£m	%	£m	£m	£m	%
Pay	8.9	0.3	-8.7	-97%	9.8	0.3	-9.4	-97%
Non Pay	12.4	8.4	-4.0	-32%	13.5	9.5	-4.0	-29%
Income	9.9	10.4	0.6	6%	10.8	11.2	0.4	4%
Recurrent	**31.2**	**19.1**	**-12.1**	**-39%**	**34.0**	**21.0**	**-13.0**	**-38%**
Pay	1.8	0.5	-1.2	-70%	1.9	0.7	-1.2	-65%
Non Pay	7.8	12.4	4.6	59%	8.5	13.2	4.7	55%
Income	0.1	3.2	3.2	100%	0.1	3.5	3.4	100%
Non-Recurrent	**9.6**	**16.2**	**6.56**	**68%**	**10.5**	**17.3**	**6.8**	**65%**
Total budget releasing efficiencies	**40.8**	**35.3**	**-5.4**	**-13%**	**44.5**	**38.3**	**-6.1**	**-14%**
Non-budget releasing savings	**0.0**	**23.0**	**23.0**	**100%**	**0.0**	**25.2**	**25.2**	**100%**
Overall Savings Position incl. non-budget releasing savings	**40.8**	**58.3**	**17.5**	**43%**	**44.5**	**63.6**	**19.1**	**43%**

4.1 Divisional Performance February (M11) 2024-25

Lewisham and Greenwich NHS Trust

£'000	Annual	Year to Date			M11		
	Annual Budget	Budget	Actual	Variance	Budget	Actual	Variance
Clinical Directorates:							
Lewisham Medicine & Community	(99,069)	(91,028)	(94,503)	(3,475)	(8,808)	(8,490)	318
Queen Elizabeth Medicine	(90,865)	(83,338)	(89,246)	(5,908)	(8,109)	(8,232)	(123)
Surgery	(138,384)	(126,923)	(135,532)	(8,609)	(11,908)	(12,291)	(383)
Women, Children & Sexual Health	(113,811)	(104,716)	(103,296)	1,420	(10,154)	(9,439)	715
Allied Clinical Services	(127,578)	(116,547)	(117,051)	(504)	(11,319)	(10,633)	686
Total for clinical directorates:	**(569,707)**	**(522,552)**	**(539,628)**	**(17,076)**	**(50,297)**	**(49,085)**	**1,213**
Total for corporate directorates:	**(217,622)**	**(199,160)**	**(199,727)**	**(567)**	**(20,937)**	**(17,017)**	**3,920**
Income (Excluding Divisional Income)							
Patient Care Income	792,468	726,297	727,064	767	67,216	67,717	501
Other Income / Non PCI (Actuals)	27,337	25,096	26,043	947	2,583	2,856	273
Total for Income:	**819,805**	**751,393**	**753,107**	**1,714**	**69,800**	**70,573**	**774**
Total Income less Operational Costs:	32,476	29,681	13,751	(15,929)	(1,435)	4,471	5,906
Reserves and other commitments	989	995	12,458	11,463	4,252	396	(3,857)
Pharmacy (PBRe excluded Drugs)	(33,465)	(30,676)	(36,839)	(6,162)	(2,789)	(3,713)	(924)
Surplus/(Deficit)	**(0)**	**(1)**	**(10,630)**	**(10,629)**	**29**	**1,154**	**1,126**

The table opposite shows the divisional performance for the M11 position for the clinical directorates and a sub-total for all the Corporate directorates.

The main variances within the divisional positions are reported on the following slides and include: under-delivery of IURPs, medical staffing overspends, enhanced care and escalation costs, theatre consumables and insulin pumps in addition to cover for sick above funded levels and drugs overspends. Within month the improvement to the positions was largely driven by HCA upgrade and medical cost pressure funding.
Corporate variances are driven predominately by shortfalls in IURPs delivery ,depreciation and finance charges, Trust Central provisions QMS activity in addition to Estates and Facilities overspends of £2.8m relating to rates, utilities, hybrid mail, maintenance and hard/soft FM costs partially due to excess inflation of £0.3m for PFI costs (pending full review of inflation across the directorate).

PBRE drugs overspends of £6.1m are partially offset by £4.4m income for the non-blocked element of this but the gap between income and cost is causing a financial pressure.

As of M11, the underspend on reserves comprises funding streams including funding tor CDC, Health Inequalities, escalation costs, agency premia and cost pressures yet to be allocated. These are offset by overspends on reserves allocations for assumed divisional underspends, RMNs (Registered Mental Health Nurse) expenditure and maternity cover.

The table on the below slide shows the divisional expenditure against these funding assumptions. In the YTD position, the reserves balances are £2.7m overspent against these funding streams as per the table below with escalation, maternity and RMN expenditure above planned levels offset agency premium underspends representing the main drivers. Within the YTD position, an additional £1.2m of escalation income has been recognised to partially offset the cost pressure below.

Funding Stream	Annual Reserve	YTD Reserve	YTD Expenditure LMC	QEM	SURGERY	WC&SH	ACS	CORPORATE	TOTAL	YTD Reserves Balance
RMN	(2,380)	(2,182)	(1,562)	(1,316)	(399)	(444)	0	0	(3,721)	(1,539)
Maternity Cover	(2,917)	(2,674)	(525)	(543)	(531)	(666)	(635)	0	(2,900)	(226)
Escalation	(2,000)	(1,833)	(1,183)	(1,157)	(438)	(43)	(253)	(76)	(3,150)	(1,317)
Agency Premium	(3,530)	(3,236)	(385)	(1,154)	(440)	(251)	(523)	(74)	(2,827)	409
Total	(10,827)	(9,925)	(3,655)	(4,170)	(1,808)	(1,404)	(1,411)	(150)	(12,598)	(2,673)

4.2 Divisional Performance February (M11) 2024-25

Lewisham and Greenwich NHS Trust

The Trust is holding £7.3m YTD in central reserves for agency premium, escalation costs, BBV testing and cost pressure funding in addition to a £4.8m assumption of underspends in the clinical divisions. A total of £8.6m FYE in cost pressure funding was calculated in 23/24 H2. To date, £7.4m of cost pressure funding has been allocated across the trust with the remainder to be allocated on receipt of agreed follow-up actions/business cases from the divisions The table below summarises, by clinical division, the key drivers of the M11 position net of industrial action costs and the funding held in reserves for each.

	LMC	QEM	Surgery	WC&SH	ACS	Total
M11 YTD Variance £'00	**(3,475)**	**(5,908)**	**(8,609)**	**1,420**	**(504)**	**(17,076)**
Reserves Funding:						
Agreed Cost Pressures		176	649		92	**917**
Escalation Costs	1,183	1,157	438	43	253	**3,074**
Agency Premiums	385	1,154	440	251	523	**2,753**
BBV testing					515	**515**
Underspend Targets	(914)	(798)	(867)	(1,112)	(1,162)	**(4,852)**
Total Reserves Funding:	**654**	**1,690**	**660**	**(818)**	**221**	**2,407**
Industrial Action	**130**	**150**	**317**	**246**	**91**	**934**
Underlying Position	**(2,691)**	**(4,069)**	**(7,632)**	**848**	**(192)**	**(13,735)**
Drivers:						
Sick cover	(916)	(704)	(1,255)	(1,309)	(1,067)	**(5,251)**
Medical staffing variances	597	(851)	(2,729)	(1,639)	(714)	**(5,336)**
IURPs	(1,461)	(1,220)	(1,051)	1,086	(626)	**(3,272)**
Theatres Consumables			(2,480)			**(2,480)**
Drugs	(521)	(676)	(372)	(124)	(201)	**(1,894)**
Enhanced Care	(524)	(525)				**(1,049)**
Insulin pumps	(202)	(681)				**(883)**
Telemedicine					(230)	**(230)**
ERF	124	164	1,362	203	216	**2,069**
Other	212	425	(1,107)	2,631	2,430	**4,591**
Total	**-2,691**	**-4,069**	**-7,632**	**848**	**-192**	**-13,735**

The main variances in the **LMC** division include IURP under-delivery, enhanced care, ED adult nursing, UCC, Cherry Ward, Cardiology and sick cover. These are offset by management underspends, underspends in Acute and Elderly Medicine and in Ambulatory Care in addition to uncovered posts across dermatology, diabetes, bowel, and community services.

Medical staffing , particularly in Elderly and Acute Medicine in addition to shortfalls on IURPs YTD and winter costs (including boarding, A&E co-horting and Ward 24, offset by funding for Ward 26) above planned levels in the **QEM** division are the main driver of the YTD position. These are partially offset by underspends on admin staffing, pacemakers and uncovered vacancies across the division in, particularly in dermatology and ambulatory care.

In the **Surgery** division, sick cover, unachieved IURPs, theatre consumables and medical staffing overspends continue to represent the key drivers of the financial position. Overspends on medical pay are across all services in the directorate, the largest of which are in Orthopaedics, Anaesthetics and Gastroenterology. Theatre consumables are c. £2.5m overspent YTD with activity at 15% below plan YTD. Other overspends are reported across nursing services, mainly Theatres Scrub Nurses and in the QEH wards., These are partially offset by underspends on ERF in addition to divisional management posts, breast services bowel cancer screening

The **WC&SH** division is reporting a YTD underspend of which £2.5m relates to the CNST rebate recognised in the divisional IURPs position. The balance comprises sickness cover and medical staffing overspends (Obs and Gynae and in Acute Paeds) offset by uncovered vacancies in community, sexual health, maternity and neonatal services.

Shortfall in the delivery of IURPs, drugs overspends, sick cover and Haematology and Radiology locum consultant spend above the agreed cost pressure amount constitute the main driver of the **ACS** overspend. These are offset by uncovered vacancies, particularly in Pharmacy, Stop Smoking, therapies and in divisional management.

Bank and Agency Usage: Clinical Divisions, YTD @ M11:

	YTD Variance					
£'000	LMC	QEM	SURGERY	WC&SH	ACS	TOTAL
Substantive	11,346	16,416	8,522	10,733	7,044	54,061
Agency	(1,667)	(5,052)	(1,909)	(1,089)	(2,243)	(11,960)
Bank	(11,249)	(15,331)	(12,235)	(10,486)	(4,020)	(53,322)
Total Pay Postion	**(1,570)**	**(3,966)**	**(5,622)**	**(843)**	**781**	**(11,221)**

5. Trust Forecast Outturn (M11) 2024-25

Lewisham and Greenwich NHS Trust

At month 11, the 24/25 post-recovery mitigations forecast outturn position is a £9.56m surplus against the breakeven plan. This is a £20.6m improvement to the M10 forecast due to the receipt of year-end system funding in the M12 position in addition to one-off benefits in February. The main components of the forecast are as follows:

Driver	£'000	Detail
M11 YTD variance	(10,628)	
M12 baseline overspend	(966)	Based on the M01-11 average
Removal of non-recurrent items	(551)	Includes impact of industrial action, Synnovis impact, 23/24 ERF
Capacity and acuity through winter	(696)	Additional expenditure recognised above the YTD trend
London Living Wage (LLW) inflation risk	(799)	Awaiting update
System funding	5,500	System deficit funding
	1,900	Depreciation funding
	1,200	ERF funding
	2,100	Balance of system funding
	400	Synnovis funing
	9,560	Additional system funding
Pre-recovery FOT	**7,020**	
Recovery items:		
Additional control measures via KPMG work	500	M112 mitigations
IURP catch-up / additional recovery items	2,040	
Post-recovery FOT	**9,560**	

6. Recovery (1 of 2)
Impact of Financial Recovery

Lewisham and Greenwich NHS Trust

The below table shows the financial savings achieved from controls being implemented to date in addition to a break-down of the £2m recovery items required in the M12 position to deliver the £9.56m forecast surplus.

Opportunities for consideration	Impact	M09 YTD Actual £000's	M10 Actual £000's	M11 Actual £000's	YTD Actual £000's	M12 Forecast £000's	24-25 Forecast £000's	Progress	Exec Lead
Estates and Facilities	Minor works	118	8	9	135	98	233	Already in progress and delivering	SP
	ISS Consumables	21	22	69	112	25	137		
Surgery Division	Fracture clinic	11	0	11	22	22	44	Actioned with slippage on some schemes although over-achieved in total against original plan YTD	MJ
	T&O	0	47	25	72	3	75		
	Gastro	22	40	29	91	5	96		
	Theatres Consumables	69	0	0	69	70	139		
Non-Clinical Non-Pay Panel	Reduction in areas not in recovery	0	122	306	428	118	546	Delivered M10-11	MJ
Enhanced pay controls	All pay spend	198	183	382	763	385	1,148	Already in progress and delivering. Additional savings expected M12 due to notice periods	MN/VP/LC
Contract leakage	Contract management and VFM	0	0	0	0	250	250	Working with KPMG with benefits expected M12	DC
VAT Review	Re-review of VAT paid to HMRC	0	0	0	0	100	100	Expected M12	DC
Printing controls	Restrict use of printers	0	0	0	0	10	10	Controls implemented with benefits arising M12	DC
Discretionary spend incl moratorium on purchase of fixtures, fittings and furniture	Stop new or uncommitted spend in non-essential areas	54	98	15	167	15	182	Already in progress and over-delivering against original plan	SP
Soft FM Contract Management	Reduction in charges for items such as additional deep cleans	135	84	63	282	70	352	Reductions in postage, security and sterile services M09-11	

6. Recovery (2 of 2)
Impact of Financial Recovery

Lewisham and Greenwich NHS Trust

Opportunities for consideration	Impact	M09 YTD Actual £000's	M10 Actual £000's	M11 Actual £000's	YTD Actual £000's	M12 Forecast £000's	24-25 Forecast £000's	Progress	Exec Lead
KPMG I&I work		0	0	0	0	500	500	Expected M12	
Modern Equivalent Asset Review	Reduction in Depreciation and PDC charges	0	0	0	0	TBC	0		
Prosepctive Shifts		0	0	0	0	TBC	0	Work in progress with benefits expected M12	MN
Retrospetive Shifts		0	0	0	0	TBC	0	Work in progress with benefits expected M12	MN
Midwifery Enhanced Rate	Removed Enhaced rates paid to Midwives	112	108	60	280	56	336	Actioned with benefis arising from Nov-24	LC
Medical Staffing Review	Demand and Capacity f for Job Planning and Resident Grades	0	0	0	0	TBC	0	Being worked up with benefits expected M12	VP
Pay Element Review	Review all non-essential/core pay elements	0	0	0	0	TBC	0	Starting in M12	MN
Deep Dive of areas of spend outside of core services	Re-validate agaisnt Trust Priorities	0	0	0	0	TBC	0	Starting in M12	SP
Agency to Perm workers	Convert long term agency workers to perm	1,600	266	266	2,132	268	2,400	Actioned with benefits delivered from Apr-24	MN
Duplicate Supplier Payment Review	Review all open statements from suppliers to identify duplicate payments	0	0	0	0	TBC	0		
Remove all agency workers from Corporate Areas		97	97	97	291	97	388	Actioned with benefits delivered from Oct-24	MN
Technical adjustments / IURPs		0	2,768	1,051	3,819	448	4,267	Additional procurement and medicine savings in development in addition to Section 106 (S106) savings	
Total		**2,437**	**3,843**	**2,383**	**8,663**	**2,540**	**11,203**		

Appendices

Appendix 1 – Financial Accounts KPIs

Appendix 2 – Financial Accounting Statements

Appendix 3 – NHS Patient Care Income Summary

Appendix 4 - Financial Management KPIs

NHS
Lewisham and Greenwich
NHS Trust

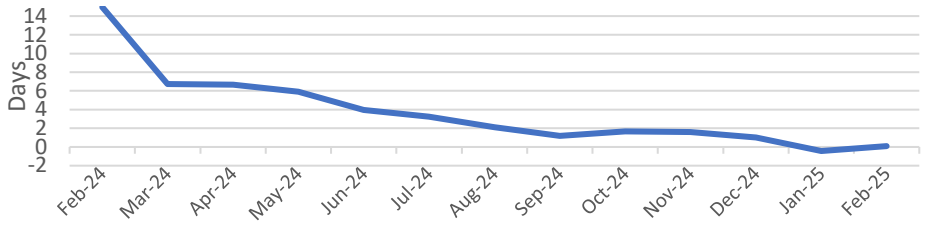
Appendix 1

To be exceptional

Appendix 1.1 Financial Accounts Key Performance Indicators

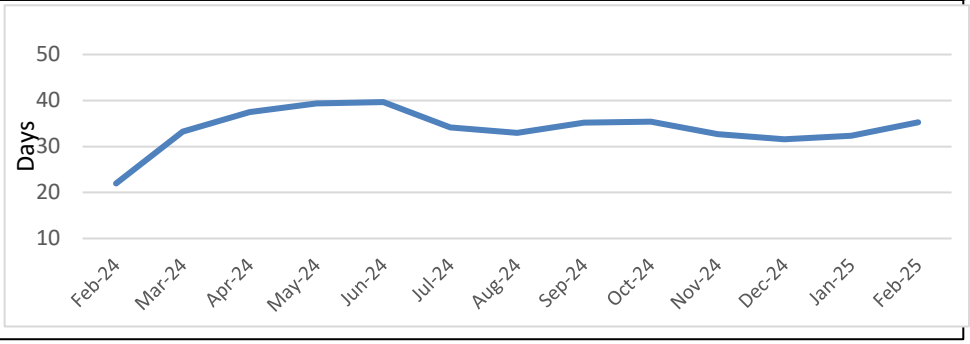
Liquidity Days

The decrease in liquidity days observed since March is primarily due to an increase in deferred income and a drop in cash reserves. However, compared to the prior month, liquidity days have increased by one day, mainly as a result of a net rise in working capital balances, which is significantly associated with the growth in cash reserves explained below.



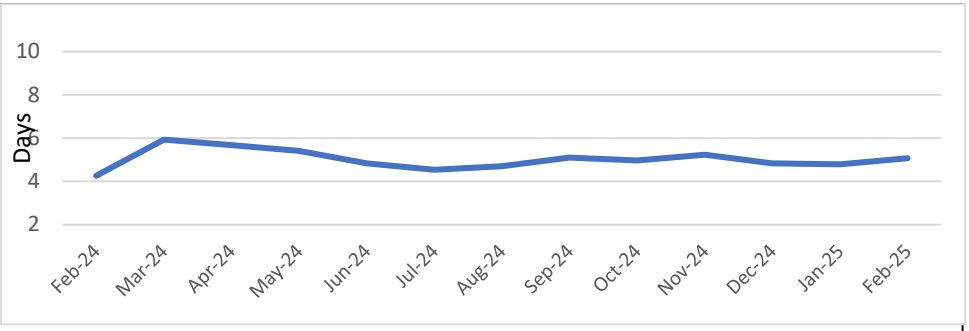
Creditor Days (AP)

This month, creditor days have worsened by 3 days, resulting from a net rise in creditors amounting to £2.5 million. This increase is mainly attributed to an outstanding invoice from Barts Health concerning the Pathology Partnership for September (£2 million) and R&B Decorators for the UHL Passive Fire Protection Improvement Works (£0.4 million).



Debtor (AR) Days

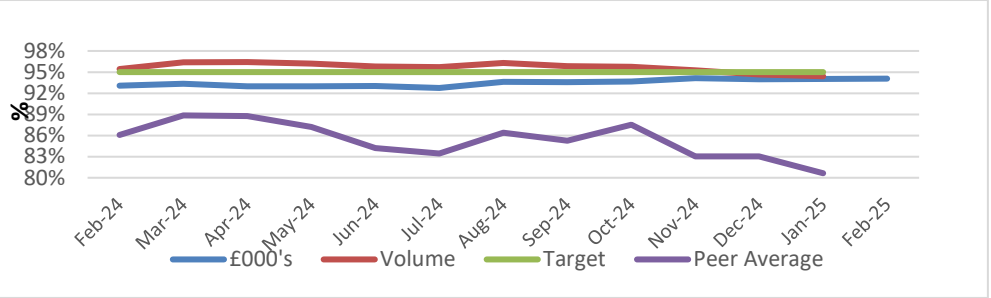
Debtor days have remained consistent with last month, standing at 5 days.



1.2 Financial Accounts Key Performance Indicators

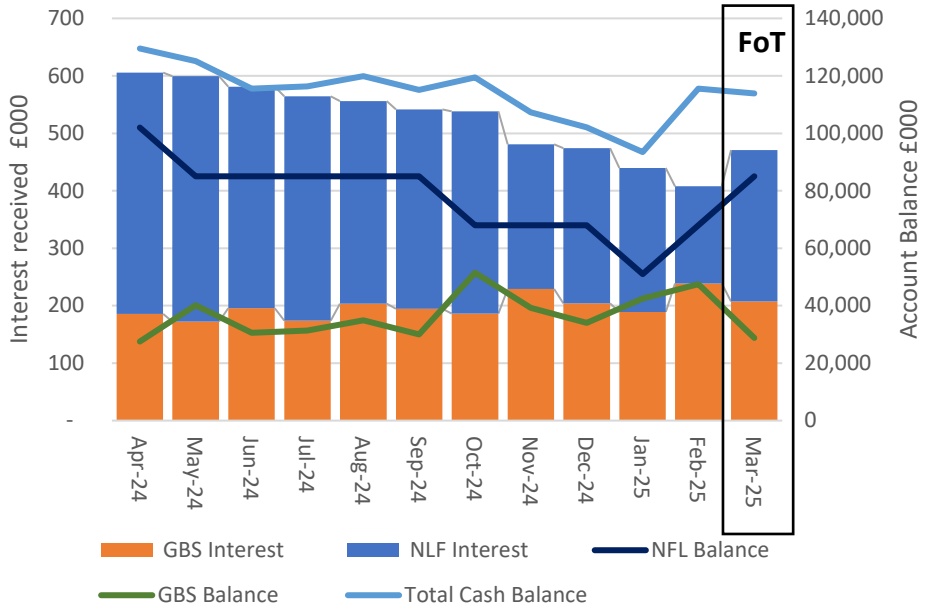
Better Payment Practice Code (BPPC)

Our performance regarding the 30-day payment target has remained consistent with last month in terms of value (£), while there has been a 1% decline in the volume of invoices settled within 30 days. We are outperforming our peers in BPPC, with our payment volume exceeding the peer average (80.64%) by 6% and surpassing the national average (88.5%) by 14%.



Cash and Investments

At the conclusion of February, the cash balance stands at £106 million, marking a £16 million increase from January. This growth is mainly due to NHS England's Health Education training income for the fourth quarter (£6.3 million), a Capital PDC drawdown (£5.7 million), and SEL ICB funding aimed at elective recovery and financial assistance (£4 million).



Lewisham and Greenwich NHS Trust

Appendix 2

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2.1 Financial Accounting Statement
Balance Sheet

Lewisham and Greenwich NHS Trust

Statement of Financial Position £000's (Balance Sheet)	Mar-24	Jan-25	Feb-25	In Month Movement	Movement YTD
Non Current Assets					
Property Plant & Equipment	408,178	403,413	407,854	4,441	(324)
Intangible Assets	16,853	13,053	12,673	(380)	(4,180)
Debtors	625	625	625	-	-
Total Non Current Assets	**425,656**	**417,091**	**421,152**	**4,061**	**(4,504)**
Current Assets					
Inventories	6,494	6,456	6,128	(328)	(366)
Debtors - Trade & Other	33,727	45,781	39,472	(6,309)	5,745
Investments (NLF)	102,000	51,000	68,000	17,000	(34,000)
Cash	26,465	38,607	37,699	(908)	11,234
Total Current Assets	**168,686**	**141,844**	**151,299**	**9,455**	**(17,387)**
Assets Held for Sale				-	-
Total Assets	**594,342**	**558,935**	**572,451**	**13,516**	**(21,891)**

Statement of Financial Position (Balance Sheet)	Mar-24	Jan-25	Feb-25	In Month Movement	Movement YTD
Current Liabilities					
Creditors - Trade & Other	(125,755)	(118,396)	(127,129)	(8,733)	(1,374)
Provisions	(4,832)	(529)	(425)	104	4,407
Borrowings - Finance Leases	(16,431)	(16,431)	(16,431)	-	-
Borrowings - DH - Capital Loan	(481)	(482)	(482)	-	(1)
Borrowings - Other - Capital Loan	(500)	(500)	(500)	-	-
Total Current Liabilities	**(147,999)**	**(136,338)**	**(144,967)**	**(8,629)**	**3,032**
Net Current Assets / (Liabilities)	**20,687**	**5,506**	**6,332**	**826**	**(14,355)**
Total Assets Less Current Liabilities	**446,343**	**422,597**	**427,484**	**4,887**	**(18,859)**
Non Current Liabilities					
Creditors - Trade & Other	(302)	(254)	(297)	(43)	5
Provisions	(5,969)	(5,969)	(5,969)	-	-
Borrowings - Finance Leases	(157,284)	(151,995)	(151,331)	664	5,953
Borrowings - DH - Capital Loan	(5,107)	(4,993)	(5,016)	(23)	91
Borrowings - Other - Capital Loan	(250)	250	250	-	500
Total Non Current Liabilities	**(168,912)**	**(162,961)**	**(162,363)**	**598**	**6,549**
Net Assets Employed	**277,431**	**259,636**	**265,121**	**5,485**	**(12,310)**
Funded By					
PDC , Revaluation & Reserves	649,383	651,799	657,557	5,758	8,174
I&E Reserve	(371,952)	(392,163)	(392,436)	(273)	(20,484)
Total	**277,431**	**259,636**	**265,121**	**5,485**	**(12,310)**

Observations

Debtor - Trade & Other:

Debtors (£39,472k) have increased by £5,745k since the year's start and by £6,309k compared to last month.

Cash and Investments

Cash (£37,699k) has risen by £11,234k since the beginning of the year but decreased by £908k since last month. Investments have dropped by £34,000k from the start of the year, though they increased by £17,000k from the previous month.

Creditors – Trade & Other:

Creditors (£127,129k) have decreased by £1,374k since the year began and by £8,733k since last month.

I & E Reserve:

The accumulated deficit (£392,436k) has grown by £20,484k since the beginning of the year and by £273k from last month.

2.2 Financial Accounting Statements
Statement of Cash Flow

Lewisham and Greenwich NHS Trust

Statement of Cash Flow	YTD Actual £000s
Cash Flows from Operating Activities	
Net Operating Surplus / Deficit	(1,500)
Depreciation and Amortisation	34,532
Increase / (Decrease) in Working Capital	(11,971)
Net Cash Inflow/(Outflow) from Operating Activities	**21,061**
Cash Flows from Investing Activities	
Interest Received	6,532
Movement in investments	34,000
(Payments) for Property, Plant and Equipment	(29,124)
Net Cash Inflow (Outflow) from Investment Activities	**11,408**
Net Cash Inflow (Outflow) Before Financing	**32,469**
Cash Flows from Financing Activities	
PDC Capital - Received	9,058
Loans from DH - Repaid	(236)
Other Loans Repaid	(500)
Capital Payments - Finance Leases	(2,777)
Capital Payment - PFI	(12,938)
Interest Paid	(12,716)
Dividend Paid	(1,126)
Net Cash Flows from Financing Activities	**(21,235)**
Net Increase / (Decrease) in Cash and Cash Equivalents	**11,234**
Opening Cash and Cash Equivalents	26,465
Cash and Cash Equivalents	**37,699**

Year to Date
At the end of the month, the closing cash balance stands at £37.7m. Year-to-date, cash has risen by £11.2m, primarily due to the return of £34m from NLF investments, which were necessary to address the Trust's underlying cash deficit, projected to be £6m.

Capital	Approved Funding Feb-25 £000 £000	Actual £000	Committed £000	Total £000	FoT (CMG) £000	FoT Variance £000	Still to be spent £000
Internal Funding							
IT	8,319	4,211	649	4,860	3,870	(4,449)	(990)
Estates	27,376	18,046	9,054	27,100	28,376	1,000	1,276
Medical Devices	1,767	968	1,415	2,383	2,744	977	361
Other	7,419	1,559	365	1,924	7,733	314	5,809
Contingency	(15)	-	-	-	1,681	1,696	1,681
Total Internal Funding	44,866	24,784	11,483	36,267	44,404	(462)	8,137
External Funding							
Estates-Ext	-	1,633	540	2,173	4,236	4,236	2,063
IT-Ext	408	61	24	85	872	464	787
Other-Ext	3,300	2,770	709	3,479	4,053	753	574
Medical Devices-Ext	-	-	-	-	-	-	-
Total External Funding	3,708	4,464	1,273	5,737	9,161	5,453	3,424
Grand Total	**48,574**	**29,248**	**12,756**	**42,004**	**53,565**	**4,991**	**11,561**

Plan and Forecast
Total internal capital funding approved by the board for 2024-25 was £46,900k.

The forecasted expenditure is £53,565k, which comprises £44,404k of internal funding which includes £130k of increase to the limit in relates of the sales of Marvels Lane and £9,161k of external funding. Additional £68k of the external funding received for Cyber Improvement Programme and £103k for Specialised Commissioning.

Actual and Committed
Total Capital expenditure for the year to date is £42,004k which is made up of £29,248k of actuals and £12,756k of committed.

Lewisham and Greenwich
NHS Trust

Appendix 3

To be exceptional

Appendix 3.1 Patient Care Income Summary

Lewisham and Greenwich NHS Trust

M11 YTD	Annual Budget	Plan	Actual	Variance
	£m	£m	£m	£m
SEL Income	657.6	602.8	602.8	0.0
SEL Income Non Contracted	28.7	26.0	22.5	(3.5)
SEL 23/24 ERF clawback	0.0	0.0	(1.2)	(1.2)
NCAs and Other ICBs	16.7	15.3	15.9	0.6
NHSE Income	72.3	66.3	70.8	4.5
Local Authority Income (Non-NHS)	13.6	12.5	12.7	0.2
Provider to Provider/ Private Income	3.7	3.4	3.6	0.2
Total	**792.5**	**726.3**	**727.1**	**0.8**

Patient care income is £0.8m favourable to plan at month 11. Key drivers to this position are £4.4m overperformance in drugs flexing (which will be offset by additional expenditure) and underperformance of £2.5m on CDC, which will again be offset by underspends within expenditure reserves. In addition, there has been a £1.5m adverse movement recognised YTD with regards to a prior year ERF clawback for 2023/24 underperformance to the agreed year end position (due to a data capture issue)

Against the Trust internal plan ERF income at month 11 is under expected levels with a 24/25 underperformance reported of £1m and a 23/24 £1.5m income reduction due to a known data submission issue, and further discussions are taking place with NHSE in this regard.

This position includes an estimate of £14.1m of additional income for forecasted 24/25 ERF over performance compared to an internal plan of £15.1m (both inclusive of A&G) . The internal plan accounts for additional activity/income from specific ERF generating schemes (£6.7m), impact of the outpatient procedure IURP (£3.7m), diagnostic imaging IURP (£1.1m), advice and guidance (A&G) income IURP (£2.8m) and theatres productivity IURP (£0.8m).

NHSE drugs and devices operate on a cost and volume basis again in 24/25, flexed throughout the year based on actual validated spend and are currently £4.4m favourable to plan at M11 YTD net of estimated challenges – this is offset by additional expenditure and overall, there is a cost pressure of £1.8m at M11 YTD predominantly due to high-cost drugs being blocked with ICBs. There are various smaller cost and volume contracts that fall within the local authority (sexual health) and provider to provider/private income categories.

Appendix 3.2 Elective Recovery Fund

Lewisham and Greenwich NHS Trust

Table 1:Adj for Working days in month	% achieved											
2024/2025 comparison to 2019/20	Activity											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Electives	97%	104%	101%	95%	93%	124%	102%	114%	104%	114%	128%	107%
Day Case	107%	102%	111%	108%	102%	96%	93%	99%	100%	97%	108%	102%
First Attendance	109%	110%	106%	104%	108%	106%	106%	109%	113%	108%	107%	108%
Outpatient Procedures	220%	227%	227%	244%	270%	267%	241%	247%	242%	242%	229%	241%
	£											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Electives	125%	106%	97%	93%	84%	114%	86%	95%	87%	121%	127%	105%
Day Case	104%	104%	111%	112%	103%	100%	90%	110%	109%	105%	112%	108%
First Attendance	108%	109%	104%	103%	107%	104%	105%	107%	111%	110%	108%	110%
Outpatient Procedures	231%	234%	225%	247%	277%	278%	254%	258%	249%	257%	245%	257%
	121.3%	119.4%	117.6%	119.2%	117.2%	119.5%	110.7%	120.6%	121.0%	120.5%	121.8%	119.1%
Internal target	118.4%	118.2%	118.6%	121.8%	120.3%	120.0%	115.2%	119.0%	121.1%	122.2%	123.7%	119.8%

The ERF income position at month 11 is £2.5m under expected levels due to a 24/25 underperformance reported of £1m against the Trust internal plan and a £1.5m reduction of income for 23/24 underperformance to the agreed year end position (due to a data submission issue).

At M11 the Trust is reporting an estimated £1m (0.7%) under delivery to the internal plan, this includes £0.5m underperformance due to industrial action at M11 YTD and a £0.2m underperformance due to the power outage in January.

Adjusting for working days, the Trust is reporting an estimated 11.6% YTD over delivery on ERF at 119.1% compared to the national target of 107.5% and a 0.7% underperformance compared to the internal target of 119.8%. There has been a £11.7m financial adjustment made for the ERF over performance in the YTD income position. In addition to the above analysis, £2.8m YTD has been recognised for the estimated 24/25 advice and guidance (A&G) income.

The table above details the draft month 10 Trust assessment at a POD level (data source: TM1 contract reporting system). Based on provisional figures the Trust is above the Feb YTD 19/20 phased baseline by 11.6% (119.1% vs 107.5% target).

Appendix 3.3 Patient Care Activity Summary

Lewisham and Greenwich NHS Trust

	Activity								
	All SItes								
	Year	Feb				Year to Feb			
	Plan	Plan	Actual	Variance		Plan	Actual	Variance	
Electives	**3,749**	**315**	**361**	**46**	**15%**	**3,369**	**3,607**	**238**	**7%**
Elective - Theatre	3,096	262	264	2	1%	2,772	2,696	(76)	(3%)
Elective - Non-Theatre	653	53	97	44	83%	597	911	314	53%
Elective Excess Bed Days	0	0	0	0	0%	0	0	0	0%
Day Cases	**32,792**	**2,761**	**2,497**	**(264)**	**(10%)**	**29,756**	**30,045**	**289**	**1%**
Day Cases - Theatre	11,301	996	739	(257)	(26%)	10,116	8,790	(1,326)	(13%)
Day Cases - Non-Theatre	21,492	1,765	1,758	(7)	(0%)	19,640	21,255	1,615	8%
Endoscopy Suite	**19,270**	**1,568**	**1,714**	**146**	**9%**	**17,626**	**16,482**	**(1,144)**	**(6%)**
Outpatients	**707,856**	**58,231**	**58,541**	**310**	**1%**	**646,958**	**675,249**	**28,291**	**4%**
First Attendance - F2F	190,619	15,856	14,699	(1,157)	(7%)	174,042	166,903	(7,139)	(4%)
First Attendance - NF2F	37,297	3,030	2,667	(363)	(12%)	34,112	31,710	(2,402)	(7%)
Follow Up Attendance - F2F	275,087	22,393	24,877	2,484	11%	251,546	283,782	32,236	13%
Follow Up Attendance - NF2F	92,291	7,491	6,086	(1,405)	(19%)	84,414	74,032	(10,382)	(12%)
Outpatient Procedures	73,056	6,175	7,850	1,675	27%	66,636	90,572	23,936	36%
Outpatient - Other	39,506	3,286	2,362	(924)	(28%)	36,208	28,250	(7,958)	(22%)
Emergencies	**55,432**	**4,252**	**5,541**	**1,289**	**30%**	**50,724**	**61,249**	**10,525**	**21%**
Emergency Non Short Stay	26,326	2,020	2,242	222	11%	24,090	26,353	2,263	9%
Emergency One Day LOS	7,140	548	649	101	18%	6,534	7,435	901	14%
Emergency Zero LOS	21,966	1,685	2,650	965	57%	20,100	27,461	7,361	37%
Emergency Other	0	0	0	0	0%	0	0	0	0%
Non Electives	**13,178**	**1,011**	**975**	**(36)**	**(4%)**	**12,059**	**12,991**	**932**	**8%**
Deliveries	**6,472**	**496**	**564**	**68**	**14%**	**5,922**	**6,053**	**131**	**2%**
A&E	**223,178**	**17,121**	**18,261**	**1,140**	**7%**	**204,223**	**214,020**	**9,797**	**5%**
Critical Care	**20,164**	**1,547**	**2,043**	**496**	**32%**	**18,452**	**18,393**	**(59)**	**(0%)**
Other	**77,558**	**6,437**	**1,920**	**(4,517)**	**(70%)**	**71,067**	**68,636**	**(2,431)**	**(3%)**
Direct Access	**128,355**	**10,467**	**12,596**	**2,129**	**20%**	**117,386**	**139,876**	**22,490**	**19%**
Community Services	**479,080**	**38,950**	**39,571**	**621**	**2%**	**438,183**	**446,276**	**8,093**	**2%**
Patient Pathways	**22,476**	**1,838**	**1,634**	**(204)**	**(11%)**	**20,568**	**21,977**	**1,409**	**7%**
Diagnostic Imaging	**72,565**	**5,909**	**6,987**	**1,078**	**18%**	**66,367**	**78,115**	**11,748**	**18%**

Appendix 3.4 Patient Care Income Summary

Lewisham and Greenwich NHS Trust

	Income £K								
	All Sites								
	Year	Feb				Year to Feb			
	Plan	Plan	Actual	Variance		Plan	Actual	Variance	
Electives	16,625	1,375	1,578	203	15%	14,939	15,076	137	1%
Elective - Theatre	15,060	1,248	1,312	65	5%	13,507	13,198	(309)	(2%)
Elective - Non-Theatre	941	77	243	166	217%	861	1,376	515	60%
Elective Excess Bed Days	624	51	22	(28)	(56%)	571	502	(69)	(12%)
Day Cases	34,652	3,040	2,333	(707)	(23%)	31,231	27,690	(3,541)	(11%)
Day Cases - Theatre	22,393	2,012	1,221	(791)	(39%)	20,048	15,444	(4,604)	(23%)
Day Cases - Non-Theatre	12,260	1,028	1,112	84	8%	11,183	12,246	1,062	9%
Endoscopy Suite	12,688	1,032	1,128	96	9%	11,606	10,797	(809)	(7%)
Outpatients	93,278	7,760	7,472	(288)	(4%)	85,187	86,352	1,166	1%
First Attendance - F2F	35,507	2,946	2,902	(44)	(1%)	32,420	33,466	1,047	3%
First Attendance - NF2F	2,779	226	213	(13)	(6%)	2,542	2,489	(53)	(2%)
Follow Up Attendance - F2F	20,338	1,657	1,817	161	10%	18,592	20,613	2,021	11%
Follow Up Attendance - NF2F	7,822	635	502	(133)	(21%)	7,155	6,227	(927)	(13%)
Outpatient Procedures	23,125	1,988	1,734	(253)	(13%)	21,080	20,211	(869)	(4%)
Outpatient - Other	3,707	309	304	(5)	(2%)	3,398	3,345	(54)	(2%)
Emergencies	164,593	12,625	15,631	3,007	24%	150,613	182,516	31,903	21%
Emergency Non Short Stay	135,070	10,361	12,448	2,087	20%	123,598	147,172	23,574	19%
Emergency One Day LOS	9,359	718	862	144	20%	8,564	10,119	1,554	18%
Emergency Zero LOS	20,409	1,566	2,342	776	50%	18,675	25,450	6,774	36%
Emergency Other	(245)	(20)	(20)	(0)	0%	(224)	(224)	(0)	0%
Non Electives	11,321	868	1,054	186	21%	10,359	12,483	2,124	21%
Deliveries	33,606	2,578	2,609	31	1%	30,752	32,952	2,200	7%
A&E	50,500	3,874	4,073	200	5%	46,211	48,291	2,081	5%
Critical Care	27,505	2,110	2,812	702	33%	25,169	24,718	(451)	(2%)
Other	256,403	24,377	21,417	(2,960)	(12%)	236,606	201,294	(35,312)	(15%)
Direct Access	8,554	697	834	137	20%	7,823	9,218	1,395	18%
Community Services	51,002	4,243	4,239	(4)	(0%)	46,766	46,772	6	0%
Patient Pathways	22,733	1,854	1,698	(156)	(8%)	20,798	19,496	(1,302)	(6%)
Diagnostic Imaging	9,008	733	836	104	14%	8,238	9,410	1,171	14%
All PODs	792,468	67,165	67,717	552	1%	726,297	727,064	767	0%

NHS
Lewisham and Greenwich
NHS Trust

Appendix 4

To be exceptional

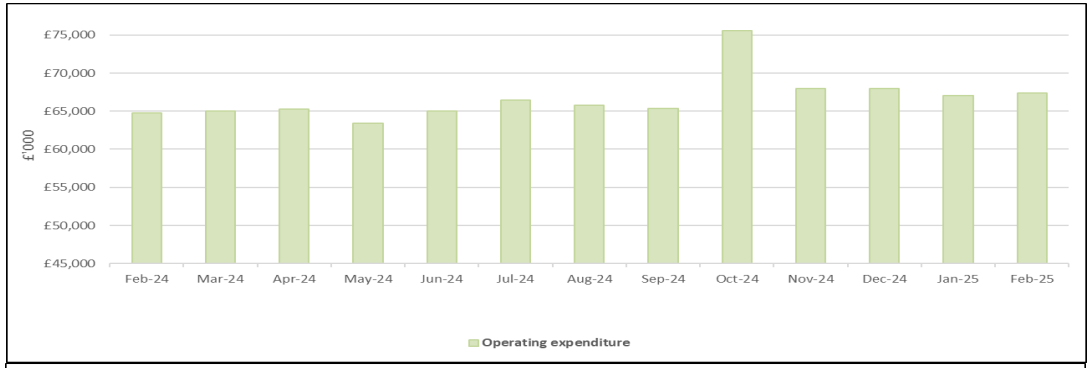
Appendix 4
Financial Management Key Performance Indicators

Lewisham and Greenwich NHS Trust

Monthly Expenditure

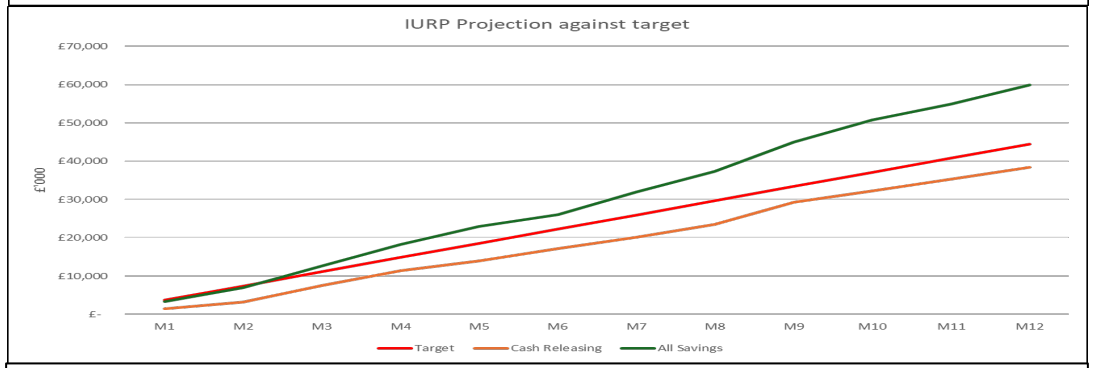
March 2023 has been 'normalised' for comparison purposes to exclude the one- off exceptional year -end pension adjustment and other non-recurrent adjustments in the M12 position.

Total trust expenditure increased by £0.4m in month due to an increase of £0.7m of drugs expenditure, net of block funding in addition to the release on non-recurrent benefits in the M10 position. This was offset by the ttransfer of revenue expenditure in the YTD position to capital (£0.9m).



IURP Performance

The Trust's efficiency target for 24/25 is £44.5m. As of month 11, £38.6m of budget releasing savings have been identified and transacted against the £44.5m efficiency target for the year, with a forecasted delivery of £38.3m. With £38.3m of the required £44.5m forecast for delivery, this leaves c..£6.2m in additional budget releasing savings to deliver for the year. In addition to the identified budget releasing savings, £25.2m of non-budget releasing savings have also been identified, bringing total efficiencies identified for 24/25 at month 10 to £63.6m.

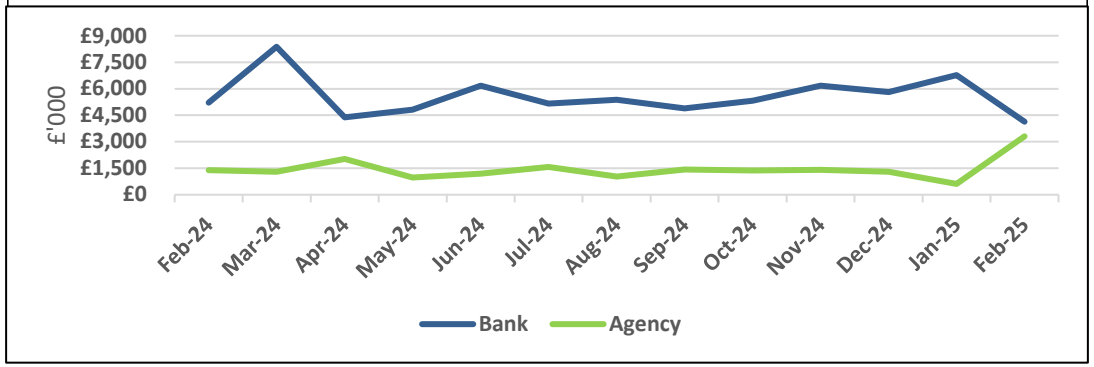


Temporary Staffing Spend

At trust level temporary staffing spend is c£75.5m YTD

Costs overall in M11 are on par with those in M10 though with a swing between bank and agency due to a recoding classification from the M10 numbers.

Agency costs at £16.3m in the YTD are at 2.7% of the total pay bill for the month, below the agency cap for the year (3.2%).



Lewisham and Greenwich NHS Trust

TRUST BOARD

Title: Report from the Quality and Performance Committee held 18th February 2025.

Date of meeting: 25th March 2025

Summary of paper: This paper provides a summary of the discussions held at the Quality and Performance Committee meeting.

Purpose

Approval	Assurance	Discussion	Note
			[✓]

Recommendations/ decisions required: The Board is asked to note the contents of this report.

Overall Level of Assurance

Assurance Level	
Significant	
Sufficient	[✓] The Trust's Performance and Quality of care is monitored at various levels within the organisation. There is oversight at various Divisional meetings as well as the Quality Safety & Patient Experience Committee & at the Quality Performance Committee. Risks related to quality and performance are managed at appropriate levels within the organisation.
Limited	
None	
N/a	

Link to the Trust's Key Priorities:

✓	Continually improve safety and quality.
✓	Put patients at the heart of everything we do.
✓	Support and develop our workforce to live our values every day
✓	Work effectively with partner organisations.
✓	Ensure we spend every penny wisely.

Resource Implications: No resource implications have been identified.

Regulations and legal considerations: This report is relevant in supporting the Trust's ability to meet its regulatory and legislation standards. This report supports the Trust's ability to meet the standards set out in the NHS Constitution for elective, cancer, and emergency care performance.

Quality consideration and impact on patient and carers: The Quality and Performance Committee supports the Trust's ability to deliver access to treatment and high quality and safe care to improve patient outcomes and experience by providing assurance against agreed quality and performance targets/plans.

Health Inequalities The Quality and Performance Committee supports holistic care in the right place at the right time; and investing in the health and wellbeing of our people.

Link to the Trust's Green Plan	The Trust has committed to reaching net zero for our direct emissions by 2040. This paper links to create a strong, unified, sustainable and well governed organisation.
Consultation/ Communication:	This paper summarises discussions at the Quality and Performance Committee.
Risk issues:	No significant risks are contained in this report.
Confidentiality:	This report does not contain any confidential information.
Equality, Diversity & Inclusion (EDI) (relating to staff, patients and the public)	The contents of this report support delivery of quality and safe care for all.
Committee Chair:	Pui-Ling Li, Non-Executive Director, Committee Chair.
Lead Directors	Louise Crosby, Chief Nurse Miranda Jenkin, Chief Operating Officer

TRUST BOARD REPORT

25th March 2025

Report from:	**Quality and Performance Committee**
Date of Committee Meeting:	**18th February 2025**
Purpose of the Committee: The Quality and Performance Committee acts as a key committee responsible for providing the Trust Board with assurance on all aspects of performance, quality and safety, including operational delivery, clinical risk management and the regulatory standards of compliance and regulation. This paper provides a summary of discussions at the Committee meeting.	
Purpose:	**For approval or ratification** ☐ **Item to receive/for information** ☒ **For discussion** ☐ **For decision** ☐
Committee Chair:	**Dr Pui-Ling Li, Non-Executive Director**
Lead Director:	**Louise Crosby, Chief Nurse** **Miranda Jenkin, Chief Operating Officer**

1.0 Items for escalation to the Board

None

2.0 Trust Performance and Quality Discussion

Theatre Utilisation and Waiting Times Inequalities - Hot Topic

The Director of Operations and Head of Nursing Critical Care Theatres Anaesthetics and Pain led a facilitated discussion on this topic. Key points included:

2.1.1 LGT theatres are supporting over 1000 elective patients per month, with a 2.3% increase in overall activity and an 8.9% rise in emergency/trauma cases.

2.1.2 Model Hospital data revealed capped theatre utilisation at 71.9%. Whilst this is below the NHSE target of 85% and LGT target of 76% data trends indicate overall improvement. Strong theatre utilisation is driven not only through theatres but how various support teams and functions come together.

2.1.3 Key Challenges included, workforce gaps with high vacancy rates and sickness, particularly at UHL, with ongoing efforts to improve recruitment and retention.

2.1.4 Skill Mix and inadequate training roles and time for skill development, with plans to address this.

2.1.5 Equipment/Stock Management requiring ongoing work with procurement partners to ensure timely availability of stock and equipment.

2.1.6 Estates and Infrastructure issues at UHL impacting efficiency, with actions required to improve resilience.

2.1.7 Pre-assessment Service Fragility due to both workforce and performance challenges, and a review was underway to benchmark against best practices.

2.1.8 Significant progress has been made on data quality and accuracy in 2024/25 with the support of the theatres operational team and business intelligence functions. Programme Pause: TPIP has been paused to refocus on core operational and clinical delivery, with a renewed focus on safety for 2025/26.

2.1.9 In the last 6 months, theatres reported no PSII or PSR incidents but 329 'low harm' incidents. Themes include HSDU incidents, medical devices, medication incidents, and treatment/procedure issues.

2.1.10 The new Lewisham Surgical Centre will increase capacity and reduce waiting times. Workforce recruitment is crucial, with over 50 WTE nurses needed. The centre aims to address health inequalities and improve patient outcomes

2.1.11 There had been a waiting list health inequalities work undertaken with efforts to address longer waits for patients from deprived areas, with significant health needs identified and improvements in fitness for surgery.

2.1.12 The Committee welcomed the report and raised a concern around the workforce challenges and the new Lewisham Surgical Centre. The Committee stressed the importance of filling vacancies across all disciplines. The Committee requested that the Executives consider adding this to the corporate risk register with regular monitoring through the Committee for ongoing assurance.

The Committee received the report.

3.0 Performance and Quality Reports

3.1 Performance Monthly Report

The Deputy Chief Operating Officer presented the report. Key points included:

3.1.1 Referral to Treatment Times (RTT) for December Actuals included the total Waiting List fell by 709 to 65,706, the lowest in the past 12 months. The >18 Week Pathways reduced from 28,952 to 28,044. The >52 Week Pathways reduced from 2,757 to 2,482. 78-Week Waits reduced from 46 to 37 and 65-Week Waits increased from 283 to 301.

3.1.2 The January Forecast indicated that the average Wait to First Appointment had reduced to 14 weeks, the lowest since 2021. The average Wait to Routine First Appointment was 22 weeks, slightly up from November but lower than last year. The number of 78-Week Breaches was 33 reported, majority in ENT (24) and 65-Week Breaches was 299 reported, with 141 in ENT.

3.1.3 Key Challenges included emergency Care and Cancer Pathway Pressures impacting progress in reducing long waits. Workforce Shortages affecting Gynaecology and Trauma services, leading to cancellations of elective activities. A generator failure at UHL causing cancellations.

3.1.4 Key action in progress included additional ENT, T&O, General Surgery and Gynea insourcing/outsourcing, recruitment of consultants, and increased community service utilisation. Weekend insourcing and optimising capacity at QMS Surgical Hub. Additional long-waiter clinics within Gastroenterology. Insourcing anaesthetic cover and recruiting senior pathway coordinators.

3.1.5 DM01 Performance fell to 84.1% in December, with endoscopy and radiology performance declining. An MRI scanner failure reduced capacity by 30% for two weeks and there were workforce gaps impacting Bowel Cancer Screening and overall diagnostic capacity.

3.1.6 The Faster Diagnosis Standard (FDS) was forecasted at 73.4% for December. The 62-Day Performance improved to 70.7% in November but was expected to drop slightly in December. The 31-Day Performance was at 96.2% in November, expected to be slightly lower in December. The backlog increased to 175 in December due to higher demand.

3.1.7 The ED Performance deteriorated to 64.1% in December, below the national average. There had been a decrease in 12 Hour Stays in January, with a reduction of 114 stays. Patients Without Criteria to Reside reduced from 147 to 136 per day on average. The Long Length of Stay (21+ days) increased to 26% in December, with a slight reduction expected in January.

3.1.8 Key Actions for UEC included creating ED SDEC space, triple boarding, and increasing discharge support. There is also a continued focus on reducing delayed discharges and improving flow through the system.

3.1.9 Elective Theatre Activity reduced to 88.1% in December but above plan year-to-date. There was a decline in the day cases to 94.4% of plan in December. First Outpatient was at 98.3% of plan in December, with overall activity above plan year-to-date.

The Committee received the report.

3.2 Performance Planning 2025/26

The Chief Strategy and Transformation Officer & Deputy CEO presented the report. Key points included:

3.2.1 National Planning Guidance was issued on Thursday 30 January.

3.2.2 The priority focus is on living within agreed budgets. The Trust is unlikely to have confirmation of indicative envelopes until mid-February (14 February). Beyond that, Planning Guidance sets a reduced number of national priorities:

- Reducing elective waits – national expectations 65% RTT (LGT intending to submit on basis of 61%), <1% 52w, 80% FDS, 75% 62DS
- Improving A&E waits and reducing ambulance handovers – 78% 4hr performance (LGT intending to submit on basis of 74%), higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25, Cat 2 ambulance response no more than 30 mins
- Improving patient access to primary care
- Improve patient flow through MH crisis and acute pathways – including reducing average LoS in acute inpatient beds.

3.2.3 This is underpinned by further detail on reform (neighbourhoods/digital), productivity, quality and safety (success measure specifically relating to maternity and neonates) and inequalities.

3.2.4 The first submission is due by the 20th February which was a tight timescale given the ongoing uncertainty about provider level budgets.

The Committee received the report.

3.3 Super March Planning

The Deputy Chief Operating Officer presented the report detailing the activities and goals for the intensive focus period. Key points included:

3.3.1 The first week of Super March will involve daily meetings to ensure all departments were aligned and any issues are promptly addressed. This intensive focus is aimed to kickstart the month with high energy and clear objectives.

3.3.2 The involvement of external partners is crucial for the success of Super March. The team is working closely with partners to ensure they are engaged and supportive of the initiatives. This included regular communication and collaboration to address any challenges that arise.

3.3.3 Support teams will play a vital role in the success of Super March. The team will ensure that support teams are well-prepared and had the necessary resources to assist with the initiatives.

3.3.4 The team plan to trial different models and approaches during Super March. This includes testing new processes, workflows, and technologies to identify what worked best. The goal was to find innovative solutions that could be sustained beyond Super March.

3.3.5 The team will focus on sustaining successful initiatives beyond Super March. This included documenting best practices, creating standard operating procedures, and ensuring that successful initiatives were integrated into business-as-usual (BAU) operations.

The Committee received the report.

3.4 Quality and Safety Report

The Chief Nurse presented the report to the committee. Key points included:

3.4.1 The Trust reported 1,888 incidents, of which 61 (3.2%) were of moderate or above harm, and 32 excellence reports in January 2025 which continues to indicate a positive reporting culture.

3.4.2 The top 3 reported incidents across the Trust were infrastructure (staffing, facilities & IT systems), pressure ulcers and falls. There has been a further small reduction of open overdue incidents to 5,110 (at time of reporting) and activities continue across the Trust to seek closure with actions/improvements taken forwards.

3.4.3 Outstanding Duty of Candour (DoC) compliance and overdue SI investigations (7 investigations at time of reporting) are improving but remain closely monitored via regular Trust meetings.

3.4.4 In January, the Trust Patient Safety Incident Meeting (PSIM) recommended 2 Patient Safety Incident Investigation (PSII's) and 7 Patient Safety Responses (PSRs). The majority of themes fall within the Trust's identified priorities including maternity, delayed diagnosis and recognition of deteriorating patients.

3.4.5 Analysis of our patient safety data reveals 437 incidents were reported within our Emergency Departments (EDs). This is 23% of the overall reporting across the Trust. The top three categories were security (11%), access/admission/transfer and discharge (10%), and infrastructure (7%), with the narrative including ongoing operational pressure and the impact this is having on both staff and patient.

3.4.6 There were 862 incidents reported across our inpatient areas (46% of overall reporting) with the top 3 categories being falls, infrastructure and pressure ulcers. There were 134 incidents from community and outpatient areas (7% of overall reporting) with top categories including pressure ulcers and maternity incidents. Actions are being taken to address these themes.

3.4.7 The Trust received 129 formal complaints in January 2025, closed 95 and re-opened 3 cases indicating our responses remain of good quality. The Trust continues to acknowledge 100% of complaints within 3 working days of being received. Our response rate within time has remained at 80% for the past two consecutive months.

3.4.8 The current percentage of complaints overdue was 35% (n=111) and the longest open complaints continue to be progressed, the oldest complaint (at time of reporting) was 277 days.

3.4.9 The top 3 reported complaint themes across the Trust were Clinical Treatment, Values & Behaviours (Staff) and communication (these are the same as last month).

3.4.10 There were 23 audits registered and 9 reported in January 2025.

3.4.11 The National Institute for Health and Care Excellence (NICE) published 10 new pieces of guidance in December 2024. The number of Self-Assessment Checklists (SAC) outstanding remained static with 21% outstanding in January 2025. 71% (n=220) Trust policies were in date at the end of January 2025.

The Committee received the report.

3.5 Mortality Learning from Deaths Report Quarter 2 2024/25

The Stroke Consultant and Mortality Lead presented the report to the committee. Key points included:

3.5.1 The review of deaths focused on identifying learning outcomes and areas for improvement. The team was working on strategies to ensure that learning outcomes are effectively communicated and implemented.

3.5.2 There were 349 (Q2 2024/25) deaths in hospital. 37 deaths were reviewed through Structured Judgement Review (SJR).

3.5.3 The percentage of deaths in hospital reviewed through SJR decreased from last quarter. 9.7% (Q2 2024/25) were reviewed against a benchmark of 20%.

3.5.4 One death in hospital reviewed through SJR were thought to be avoidable.

3.5.5 The new statutory Medical Examiner system to provide independent scrutiny of deaths was rolled out from 9 September 2024.

3.5.6 Next of Kin had concerns in 9.16% (Q2 2024/25) of deaths. The top three themes were communication, clinical treatment and patient care.

3.5.7 Three patient safety incidents in Q2 2024/25 were reported with the level of harm as death. One case is a Patient Safety Incident Investigation, one is a patient safety review and the other was a serious incident.

3.5.8 The top three themes of SJRs were treatment/procedure issues, complications of care and sepsis/deteriorating patient.

3.5.9 The Trust level and site-specific Summary Hospital-level Mortality Indicator (SHMI) was "as expected" (band 2) meaning LGT is not an outlier.

3.5.10 Additionally, all diagnosis groups with SHMI value were "as expected" (band 2).

The Committee received the report

3.6 LGT NHS Cervical screening Programme Annual performance report 2023/24
The Cervical Screening Provider Lead presented the report to the committee. Key points included:

3.6.1 The report covers both Cytopathology and Histopathology of cervical smears taken across the Trust.
3.6.2 The National targets for histopathology turnaround times were not met by the Trust during the year with the percentage of test reported within 7 days at 70% for UHL and 55% for QEH (target is 80%). The percentage reported within 10 days was 88% for UHL and 81% for QEH (target is 90%).
3.6.3 The Trust histopathology departments completed a number of mandatory audits that are reported annually including the use of minimum dataset for the reporting of cervical cancer excisions specimens, incidence of endometrial carcinomas and reporting parameters on cervical biopsy specimens as well as cervical histology turnaround time. Due to workforce shortage, no audits were carried out at QEH site last year.
3.6.4 The Colposcopy department has focused on addressing the imbalance between patient demand and capacity.
3.6.5 National targets require that 99% of all women referred with an inadequate smear test, persistent hrHPV or low-grade cytological abnormality (borderline or mild dyskaryosis) are seen within 6 weeks. 93% of women referred with a high-grade cytological abnormality (moderate or severe dyskaryosis) need to be seen within 2 weeks.
3.6.6 In this period the national target for low grade referrals was not met (86%) but does show a big improvement in the last quarter. The trust is not an outlier in its challenge to meet the 6-week target for low grade referrals. Colposcopy demand exceeds capacity in all trusts across South East London.
3.6.7 LGT has worked to increase capacity in the short term by in sourcing and running weekend nurse led clinics. In the long term, clinic capacity has been maximized by ensuring all patients are discharged to primary care for their test of cure smears and colposcopy referrals are carefully triaged therefore only screening patients and individuals with post coital bleeding are seen in colposcopy.
3.6.8 There was a risk that there had been a delay in the review of some patients diagnosed with cervical cancer within the 2022/23 reporting period. The impact is that there was a backlog of patients whose cases need to be reviewed in accordance with national guidance. This has since been reviewed and an action plan is in place to bring these records up to date. This process is ongoing, and patients have now been offered disclosure of results of this review.

The Committee received the report

3.7 Human Tissue Authority (HTA) – October 2024 Site Inspection – Final Report
The Chief Nurse presented the report to the committee. Key points included:

3.7.1 The inspections of the Mortuaries at both hospital sites and the Post Mortem (PM) tissue storage in the Histopathology laboratory at University Hospital Lewisham (UHL) were undertaken on 16th and 17th October 2024.
3.7.2 The follow up inspection focused on compliance with the following HTA standards:
• Consent (C) – Standards C2c, C2d
• Governance and Quality (GQ) – Standard 6b
• Premises, Facilities and environment (PFE) – Standards 1a, 2d, 2g, 3b
• Traceability (T) – Standards 1a, 1g, 1h and 2g.
3.7.3 The inspection identified 1 Major Shortfall: T2 - Disposal of tissue is carried out in an appropriate manner and in line with the HTA's codes of practice.
3.7.4 The inspection team tissue audit at the hub site identified one case where the tissue had not been disposed of as soon as reasonably possible. Major shortfalls require the Trust to complete any required action and provide a response to the HTA within 1-2 months of issue. The Trust provided confirmation to the HTA that this tissue was sensitively disposed of prior to the publication of this report. This update has been reflected in the final report which is also available on the HTA website.
3.7.5 The HTA provided advice to the Designated Individual (DI) to consider further improvements in practice including consideration that the risk of accidental damage to

bodies being moved more frequently is added to the corporate risk register with mitigating actions progressed.

3.7.6 All actions are being tracked via the Trusts HTA License Governance Group (HTALGG) meeting.

The Committee received the report.

3.8 Urology risk escalation to Corporate Risk Register

The Deputy Chief Operating Officer presented the Urology Risk escalation. Key points included:

3.8.1 There is a risk of not being able to continue to provide a safe Urology service to meet the current demand for both LGT and to SEL system partners.

3.8.2 The cause is due to the Urology consultant medical workforce being severely challenged with only one of the five consultant budgeted posts substantively filled and consecutive unsuccessful recruitment campaigns.

3.8.3 This risk has been escalated in its own right separate to the overall consultant vacancy risk.

The committee agreed to the inclusion of this risk on the corporate risk register.

3.9 Draft Quality and Performance Committee Terms of Reference (ToRs) and Workplan for 2025/26.

The Chair presented the Draft ToRs and Workplan. Key points included:

3.9.1 The Committee's draft Terms of Reference and Workplan for 2025/26 are being shared for review and feedback.

3.9.2 There are some minor changes throughout the Terms of Reference in order to provide further clarity and reflect the updated membership of the committee.

3.9.3 The Committee Chair suggested the Chair of the Quality, Safety and Patient Experience Committee (QSPEC) become a member QPC and attend the meeting to support the QSPEC Report and provide clarity and assurance on its content.

3.9.4 The Chief Nurse and Associate Director of Quality and Governance would look to align the QSPEC dates with QPC to ensure more up-to-date reporting from the sub-committee.

The Committee received the report.

4.0 Items for information

The summary report from the Quality, Safety and Patient Experience Committee (QSPEC) meeting held on the 9th January 2025 was noted.

5.0 Any Other Business

None

Lewisham and Greenwich NHS Trust

TRUST BOARD

Title: Report from the Quality and Performance Committee held 18th March 2025.

Date of meeting: 25th March 2025

Summary of paper: This paper provides a summary of the discussions held at the Quality and Performance Committee meeting.

Purpose

Approval	Assurance	Discussion	Note
			[✓]

Recommendations/ decisions required: The Board is asked to note the contents of this report.

Overall Level of Assurance

Assurance Level	
Significant	
Sufficient	[✓] The Trust's Performance and Quality of care is monitored at various levels within the organisation. There is oversight at various Divisional meetings as well as the Quality Safety & Patient Experience Committee & at the Quality Performance Committee. Risks related to quality and performance are managed at appropriate levels within the organisation.
Limited	
None	
N/a	

Link to the Trust's Key Priorities:

✓	Continually improve safety and quality.
✓	Put patients at the heart of everything we do.
✓	Support and develop our workforce to live our values every day
✓	Work effectively with partner organisations.
✓	Ensure we spend every penny wisely.

Resource Implications: No resource implications have been identified.

Regulations and legal considerations: This report is relevant in supporting the Trust's ability to meet its regulatory and legislation standards. This report supports the Trust's ability to meet the standards set out in the NHS Constitution for elective, cancer, and emergency care performance.

Quality consideration and impact on patient and carers: The Quality and Performance Committee supports the Trust's ability to deliver access to treatment and high quality and safe care to improve patient outcomes and experience by providing assurance against agreed quality and performance targets/plans.

Health Inequalities The Quality and Performance Committee supports holistic care in the right place at the right time; and investing in the health and wellbeing of our people.

Link to the Trust's Green Plan	The Trust has committed to reaching net zero for our direct emissions by 2040. This paper links to create a strong, unified, sustainable and well governed organisation.
Consultation/ Communication:	This paper summarises discussions at the Quality and Performance Committee.
Risk issues:	No significant risks are contained in this report.
Confidentiality:	This report does not contain any confidential information.
Equality, Diversity & Inclusion (EDI) (relating to staff, patients and the public)	The contents of this report support delivery of quality and safe care for all.
Committee Chair:	Pui-Ling Li, Non-Executive Director, Committee Chair.
Lead Directors	Louise Crosby, Chief Nurse Miranda Jenkin, Chief Operating Officer

TRUST BOARD REPORT

25th March 2025

Report from:	**Quality and Performance Committee**
Date of Committee Meeting:	**18th March 2025**
Purpose of the Committee: The Quality and Performance Committee acts as a key committee responsible for providing the Trust Board with assurance on all aspects of performance, quality and safety, including operational delivery, clinical risk management and the regulatory standards of compliance and regulation. This paper provides a summary of discussions at the Committee meeting.	
Purpose:	**For approval or ratification** ☐ **Item to receive/for information** ☒ **For discussion** ☐ **For decision** ☐
Committee Chair:	**Dr Pui-Ling Li, Non-Executive Director**
Lead Director:	**Louise Crosby, Chief Nurse** **Miranda Jenkin, Chief Operating Officer**

1.0 Items for escalation to the Board

None

2.0 Trust Performance and Quality Discussion

2.1 Mental Health (MH) - Hot Topic (revisited)

The Chief Medical Officer, Site Director of Nursing and Governance, UHL, Head of Nursing for Mental Health and the Deputy Chief Operating Officer, QEH led a facilitated discussion on this topic including successes achieved and ongoing challenges. Key points included:

2.1.1 The Trust continues to experience pressure in MH crisis care through the urgent and emergency care (UEC) pathways for both adults and children. This remains a key area of focus both locally and for SEL system.

2.1.2 The Queen Elizabeth Hospital (QEH) has seen an increase in 12 hour stays over the last 5 months with average length of stay rising to 18 hours in January 2025. Whereas University Hospital Lewisham (UHL) has seen a reduction in 12 hour stays with the overall length of stay trending down over the last 4 months to around 11.5 hours despite an increase in activity in January 2025.

2.1.3 The South East London (SEL) MH and UEC Improvement Plan forms part of the MH acute flow improvement programme. The plan ensures the system has the appropriate and dedicated focus on improving flow from EDs. The plan focuses on 3 key workstreams; MH inpatient bed access and utilisation, effective support and flow within ED and Children and Young People (CYP). CYP is a new workstream which aims to bring together the learning and actions from the recent After-Action Reviews on long waits in EDs. Actions are reviewed monthly and continuously updated.

2.1.4 A case was presented on a Child and Adolescent Mental Health Service (CAMHS) patient which outlined the growing numbers of children with MH issues, this included neurodiversity as well as the increasing risk of violence and aggression towards staff.

2.1.5 Work continues to improve the environment; the main outstanding area remains the space within children's ED at QEH.

2.1.6 The Trust continues to work in partnership with both South London and Maudsley (SLaM) and Oxleas Trusts, as well across SEL and South London partnership. SLAM colleagues had been invited to attend the Trust Board Seminar scheduled for 29th October; (first Board to Board meeting held). There had been a positive development in the relationship with partners since the last presentation.

2.1.7 The financial impact of delivering safe care to MH patients within the Trust continues to be an area of focus. The number of patients presenting to our Emergency

Departments (ED) with a MH diagnosis continues to show monthly variation and there has been minimal change in the length of stay for these patients. However, work has been undertaken across the Integrated Care System (ICS) on the staffing models employed at each acute Trust and through the sustainability team there is a proposal to fund some posts to support improvement work and reduce overall spend on MH nurses (RMNs).

2.1.8 Within the Trust, the focus of activities included ensuring staff have the right education and training to develop their competency and confidence in care for patients with a MH diagnosis. There have been a number of policies and procedures that have been ratified and implemented.

2.1.9 The implementation of code 10 has happened at both UHL and QEH. There has been a review of the Rapid Tranquilisation Policy for 16 years and above in ED. An audit is currently underway of the code 10 procedure to assess effectiveness.

2.1.10 The actions being taken at both Trust and system level are having some impact, long waits in ED at UHL had improved since additional capacity was opened. However, a large number of MH patients still wait for unacceptably long periods in our EDs and wards.

2.1.11 The Trust dashboard continues to help analyse activity to support collaboration with partners and identification of themes. There had been analysis on both primary and secondary diagnosis to provide further understanding on the number of patients being seen per month. It was noted that around 1000 inpatient spells per month have an element of mental health coding as one of their secondary diagnoses.

2.1.12 The next improvement steps include:

- a refresh of Trust action/delivery plans for MH with specific timelines;
- recruit new workforce roles when funding becomes available from SEL ICB;
- undertake specific QI work to improve quality of care and reduced spend.

2.1.13 There continues to be active discussions regarding specific estate issues including the long- term future of the Ladywell building at UHL.

2.1.14 The Committee welcomed the report and summarised that the presentation had provided an overview on the increasing demand of MH (including neurodiversity in CYP as well as the violence and aggression risk to staff). There is the need to upskill staff to support patients with MH needs, a review of approaches elsewhere could also help to develop future plans. There was a commitment to work together from partners and there continues to be the need to review estates to provide better flow.

2.1.15 The presenters and their teams were invited to come back to the committee to provide a strategic overview and system changes in regards to effort, further developments and ongoing partnership. This will be given the hot topic slot at the September 2025 committee meeting.

The Committee received the report.

3.0 Performance and Quality Reports

3.1 Performance Monthly Report

The Chief Operating Officer presented the report. Key points included:

3.1.1 The Trust's total waiting list decreased by 2,282 to 63,424 in January, continuing the improvement trend since October. The unvalidated position for February is 63,742.

3.1.2 Patients waiting over 18 weeks reduced by 854 to 27,190, with an unvalidated February position of 28,150. The number of >52-week pathways increased from 2,482 to 2,641 in January, but remains lower than October's 3,171. A modest reduction is expected in February. Average wait to first appointment dropped to 13 weeks in February from 15 in January, with significant variation between specialties.

3.1.3 Overall RTT performance against 18 weeks slightly declined to 57.1% from 57.3%, aligning with national performance but below the London average.

3.1.4 The Trust forecasts approximately 25 78-week breaches and 150 65-week breaches by the end of March, with ENT being a significant contributor. The Trust aims to achieve a minimum of 61.4% RTT performance by March 2026.

3.1.5 The national target for 52-week performance is fewer than 1% of patients waiting over 52 weeks by March 2026. The unvalidated February 2025 performance is 4.7%.

3.1.6 The Trust is taking several key actions to address capacity deficits and improve patient wait times, including increasing surgical capacity through insourcing and outsourcing options, appointing new consultants, enhancing diagnostic capacity, utilising community services, validating long waiters, and revising governance for RTT management.

3.1.7 The DM01 position for January was 83.8%, marking the third consecutive month of decline and a 12.5% fall from October. This is a slight reduction from December (-0.3%), driven by deteriorating performance in MRI (74.7%), NOUS (86.3%), Colonoscopy (76.2%), and Gastroscopy (63.7%).

3.1.8 It was noted that an increase in demand for radiology and endoscopy due to pressures on cancer, UEC, and RTT pathways contributed to this decline. Endoscopy ran additional sessions throughout February and continues to do so in March, where an improvement is expected. Trust performance remains better than the London average of 77% and national average.

3.1.9 In December, the Faster Diagnosis Standard (FDS) was 73.4%, a slight improvement from November. However, the early forecast for January indicates a decline to 67% due to treating backlog patients. Key areas needing improvement are Lower GI (51.8%), Head and Neck (57.7%), and Other (56.9%).

3.1.10 The 62-day performance in December was 70.2%, slightly down from 70.7%. January's early indication is 69-70%, slightly below London and national averages but above South East London. Key areas for improvement are Gynae (0%), Head and Neck (13.3%), and Lower GI (45.8%).

3.1.11 The 31-day performance declined to 93% in December, below the national standard of 96%. The early forecast for January is 94%, slightly better than the national average but below the London average. The Trust aims to achieve 80% for FDS and 75% for the 62-day standard by March 2026.

3.1.12 Trust ED performance improved to 64.9% in January from 64.1% in December, the highest since August, and better than January 2024's 62.2%. QEH improved from 59.7% to 61%, and UHL from 69.3% to 69.6%. February's indicative performance is 65.5%, driven by QEH's improvement.

3.1.13 Type 1 performance improved significantly at both sites compared to January 2024. LAS activity increased by 13% year-on-year, straining ED departments. Type 3 performance improved to 88.2%, the best since August. QEH improved to 93%, while UHL dropped to 83.7% but remained higher than January 2024. UHL's new Urgent Treatment Centre (UTC) opened in March and is expected to support further improvement.

3.1.14 12-hour stays in ED reduced from 2,401 to 2,282. Patients without criteria to reside averaged 128 per day in January, increasing to 137 in February but lower than February 2024's 193. Efforts continue to accurately report and address internal delays.

3.1.15 Elective theatre activity was 116.6% of plan for January, up from 94.4% in December. Day cases were 93.6% of plan, similar to December's 94.4%, both impacted by theatre disruptions due to generator issues and reduced endoscopy activity. First outpatient activity was 91.4% of plan in January, but combined outpatient procedures are delivering 106.4% of plan year to date.

The Committee received the report.

3.2 Performance Planning 2025/26

The Director of Performance presented the updated report. Key points included:

3.2.1 National Planning Guidance was issued on Thursday 30th January 2025.

3.2.2 The Trust has submitted a first draft plan on the basis of a c£50m deficit, which is underpinned by a significant (5%) savings target. Pressure is expected to move beyond this ahead of final submissions.

3.2.3 These constraints our ability for new investments beyond what has already been committed to including the Lewisham Surgical Centre, Ward 26 and EPR.

3.2.4 The Trust has submitted on the basis of 61.4% RTT performance and 2% of the list waiting 52 weeks or more by March 2026.

3.2.5 The Trust are finalising discussions with SEL on our financial envelope and performance expectations ahead of the next submission window.

3.2.6 The Trust is also finalising the theatres Plan and associated link to income as well as the efficiency plan including a series of 'top-down' Exec-led IURP proposals.

The Committee received the report.

3.3 Monthly Quality Report and Scorecard and PSIRF Reports

The Chief Nurse presented the report to the committee. Key points included:

3.3.1 The Trust reported 1,720 incidents, of which 52 (3.0%) were of moderate or above harm, and 19 excellence reports in February 2025 which continues to indicate a positive reporting culture. The top 3 reported incidents across the Trust were falls, infrastructure (staffing, facilities & IT systems) and pressure ulcers.

3.3.2 There has been a further reduction of open overdue incidents to 4,643 (at time of reporting) and actions continue across the Trust to seek closure with any required actions/improvements taken forwards. Outstanding Duty of Candour (DoC) compliance and overdue SI investigations (6 investigations at time of reporting) are improving but remain closely monitored via regular Trust meetings.

3.3.3 In February, the Trust Patient Safety Incident Meeting (PSIM) recommended 3 Patient Safety Incident Investigation (PSII's). Of these, two were Dermatology Never Events regarding wrong site surgery. There were 6 Patient Safety Responses (PSRs) and the majority of themes fall within the Trust's identified priorities including maternity, delayed diagnosis and recognition of deteriorating patients.

3.3.4 Analysis of patient safety incident data revealed 417 incidents were reported within our Emergency Departments (EDs). This is 24% of the overall reporting across the Trust. The top three categories were infrastructure (12%), security (11%), and access/admission/transfer and discharge (11%), with the narrative outlining the ongoing operational pressure and the impact this is having on both staff and patient.

3.3.5 There were 785 incidents reported across our inpatient areas (46% of overall reporting) with the top 3 categories being falls, medication and pressure ulcers. There were 122 incidents from community and outpatient areas (7% of overall reporting) with top categories including pressure ulcers and documentation incidents. Actions are being taken to address these themes.

3.3.6 The Trust received a total of 118 new formal complaints in February 2025 which is a decrease from January's figure of 129. The average number of complaints received per month has now risen to 105 (at the end of Q3) from 78 per month in Q1 and 100 in Q2.

3.3.7 The Trust closed a total of 114 cases in February 2025, an increase from previous figure of 95 cases in January 2025. The Trust also re-opened 4 cases indicating our responses remain of good quality.

3.3.8 The Trust continues to acknowledged 99% of complaints within 3 working days of being received. Our response rate within time has fallen slightly to 77% (below the target of 80%) in the last month. The current percentage of complaints overdue was 36% (n=116) and the longest open complaints continue to be progressed, the oldest complaint (at time of reporting) was 298 days.

3.3.9 The top three complaints themes are Clinical Treatment, Values & Behaviours (Staff) and Patient Care. This is similar to last month's themes and breakdowns. The top three themes from ED complaints were Clinical Treatment, Values & Behaviours & Patient Care. The top three themes for Inpatients were Patient Care, Clinical treatment & Values & Behaviours. These are the same themes as last month.

3.3.10 There were 23 audits registered and 11 reported in February 2025. The National Institute for Health and Care Excellence (NICE) published 6 new pieces of guidance in January 2025. These will be reviewed alongside the February and March guidance at the Clinical Effectiveness and Audit Committee (CAEC) meeting on the 21st March 2025 and circulated for assessment to the identified leads.

The Committee received the report.

3.4 Q3 Safety Insight Report

The Associate Director of Quality & Governance presented the report to the committee. Key points included:

3.4.1 The purpose of this report is to provide insight into safety and experience themes across the Trust through the triangulation of intelligence. This triangulation includes Patient Safety Incidents, Patient Safety Incident Investigations/Reviews, Complaints and Patient Advice and Liaison Service (PALS) as well as Patient Experience Surveys, Quality Alerts, Mortality Reviews, Claims, and Inquests.

3.4.2 The top 3 triangulated themes continue to be:

1. Delays in accessing care and treatment.
2. Communication/Info to Patients/families and Carers including discharge arrangements.
3. Delayed Diagnosis of medical conditions.

3.4.3 The report outlines some of the key actions being taken across the Trust to address these themes which are identified from key programmes of work.

3.4.4 The number of patient safety incidents reported in Q3 was 5,907 with 97.3% of these graded as a near miss, no harm or low harm. A high proportion of near miss, no harm and low harm is an indicator of a good reporting culture. While the top five reporting incidents cause groups (categories) have remained the same, Q3 saw an increase in the number of reported infrastructure (including staffing) incidents to 436 from 283 in Q2.

3.4.5 The key themes, from patient and staff reported incidents, reflects the ongoing impact of operational pressures and delays being experienced including high department acuity, adequate staffing levels, and lack of/delayed availability of beds.

3.4.6 There were 4 Patient Safety Incident Investigations (PSIIs) recommended and 19 Patient Safety Reviews (PSRs) within Q3. The majority of the themes from these investigations/reviews reflect the priorities within the Trust's Patient Safety Incident Response Plan (PSIRP).

3.4.7 In Q3, the total number of logged formal complaints was 315 which is a 6% increase from Q2 (297). The number of new complaints received remains above the mean which has been the case the for past 13 months. Our Emergency Departments (ED) are consistently the highest reporting area for complaints accounting for 21% of the total logged in Q3. The key themes from these complaints relate to access and waiting times including availability of beds.

3.4.8 The top three overarching themes remain the same as Q2 but in a different order. Clinical Treatment has replaced Values and Behaviours as the top theme while Patient Care remains the third reported theme across the Trust. A small deep dive into clinical treatment has revealed access and waiting times are a key sub-theme. This theme can also be seen through the Q3 Health Watch report for South East London which reports long waits for hospital treatment including ED a common theme across the region.

3.4.9 There was an increase in the number of PALS received (4%) compared with Q2 with key themes being communication, appointments (delays) and clinical treatment. There continues to be emphasis on early informal resolution, especially at ward stage, if the patient is an inpatient.

3.4.10 A review of Friends and Family data against national comparative scores available up to and including November 2024 indicates the Trust's overall positive experience scores for inpatient (95%), maternity (95%) and community (96%) services continues to meet or exceed the national positive experience score for these services. Feedback from patient, families and carers revealed speaking to someone about worries/fears and discharge arrangements need further improvement.

3.4.11 With ED services, the Trust FFT positive score (68%) was 9% lower than the national positive score with key themes including waiting times (delays), care and the environment.

3.4.12 The Committee requested use of the July 2025 hot topic slot in to understand the non-ED access for patients into the Trust. This would cover referral pathways (2ww, elective), the pilot on non RTT patient tracking list, outpatient transformation covering a range of areas such as appointments scheduling and cancellation, PIFU, DNAs, EPR and effectiveness of communication with our patients.

The Committee received the report

3.5 Mortality Learning from Deaths Report Quarter 3 2024/25

The Stroke Consultant and Mortality Lead presented the report to the committee. Key points included:

3.5.1 There were 467 (Q3 2024/25) deaths in hospital and 124 (27%) deaths were identified for a Structured Judgement Review (SJR). Of these, 54 (11.6%) deaths were reviewed through the SJR process. The review of deaths focused on identifying learning outcomes and areas for improvement. The team was working on strategies to ensure that learning outcomes are effectively communicated and implemented.

3.5.2 The percentage of deaths in hospital reviewed through SJR increased from quarter 2 with 11.6% (Q3 2024/25) reviewed against a benchmark of 20%.

3.5.3 One death in hospital reviewed was thought to be avoidable. Three patient safety incidents in Q3 2024/25 were reported with the level of harm as death. One case is a Patient Safety Incident Investigation, one is a patient safety review and the other is under review.

3.5.4 The new statutory Medical Examiner system to provide independent scrutiny of deaths was rolled out from 9 September 2024.

3.5.5 Next of Kin had concerns in 12.0% (Q3 2024/25) of deaths. The top three themes were communication, clinical treatment and patient care. The top three themes of SJRs were documentation, treatment/procedure issues and complications of care.

3.5.6 Trust level and site-specific Summary Hospital-level Mortality Indicator (SHMI) was 'as expected' (band 2), meaning LGT is not an outlier.

3.5.7 All diagnosis groups with SHMI value were 'as expected' (band 2).

3.5.8 The Committee noted the rising crude mortality rate at QEH and the need to further examine age, sex, ethnicity differences, and case mix. The Committee Chair suggested the Consultant Lead explore the option of seeking research funding to examine the rising mortality rate at QEH.

The Committee received the report.

3.6 Inpatient feedback survey results update

The Associate Director of Quality and Governance presented the report to the committee. Key points included:

3.6.1 The report details the 2023 Adult Inpatient Survey (IP23) findings, and outlines related action plans and reporting. This was requested by the Quality and Performance Committee in October 2024, following the patient experience hot topic presentation.

3.6.2 The 2023 survey included patients over 16 who spent at least one night in hospitals in November 2023, excluding maternity or psychiatric units. Respondents answered 61 questions about their stay, covering care quality, hospital admission, staff interactions, and overall experience.

3.6.3 Out of 162,492 invited patients, the survey achieved a response rate of 41.7%, with 63,573 participants. The report underscores both the positive outcomes and areas for improvement. Though the national results show that person centred care is being provided, patients voiced their dissatisfaction with the logistics of hospital admission and discharge.

3.6.4 Out of 1,250 of our patients invited to participate, 369 (33%) responded. This was a 1% increase on the 2022 survey response rate. There were 38 questions which have comparators with the 2022 survey results and analysis has revealed that while there have been no statistical changes between the scores, 23 questions did improve including help to eat meals, enough nurses on duty, who to contact with any concerns after leaving hospital, and discussing whether any further health or social care services was needed after leaving hospital.

3.6.5 Key areas for improvement include food and drink, pain management, being able to take own medication, and discussing any equipment/changes to support discharge.

3.6.6 The majority of themes will be address through the Trust's Compassion in Care programme, with updates on progress presented to the appropriate committees.

The Committee received the report

3.7 Corporate Risk Register and Board Assurance Framework update – Risks related to the Quality and Performance Committee

The Chief Nurse presented the Corporate Risk Register. Key points included:

3.7.1 All risks on the Corporate Risk register have been reviewed in March 2025.

3.7.2 One risk was added to the corporate risk register, CRR054 (Urology service), following discussions at TME and QPC in Feb 2025.

3.7.3 Consultant vacancies has been retained as a risk on the Corporate Risk Register and will be discussed at People and Place Committee (PPC).

3.7.4 The strategic demand/quality risks as set out in the Board Assurance Framework have been updated in March 25.

3.7.5 A review of strategic risks across system partners has been undertaken in February 25 and demand/quality identified as common themes. It is proposed that a BAF risk on demand/quality are retained on the 25/26 BAF, with work planned in March 25 with colleagues to review and update the specific issues within the demand/quality theme and reframe the 25/26 BAF accordingly, effective 1st April 25.

4.0 Items for information

The summary report from the Quality, Safety and Patient Experience Committee (QSPEC) meeting held on the 13th February was presented by the Deputy Medical Director for Quality and Safety and there were no items for escalation.

5.0 Any Other Business

None

TRUST BOARD

Title: Quality and Safety Report (February data)

Date of meeting: 25th March 2025

Summary of the paper: The purpose of this report is to provide the Committee with updates on the following:

- Highlight areas of good performance and areas for improvement based on the trust-wide quality scorecard aligned to the CQC core domains.

Patient Safety:

Key Quality Performance Metrics: The Trust reported 1,720 incidents, of which 52 (3.0%) were of moderate or above harm, and 19 excellence reports in February 2025 which continues to indicate a positive reporting culture. The top 3 reported incidents across the Trust were falls, infrastructure (staffing, facilities & IT systems) and pressure ulcers. There has been a further reduction of open overdue incidents to 4,643 (at time of reporting) and actions continue across the Trust to seek closure with any required actions/improvements taken forwards. Outstanding Duty of Candour (DoC) compliance and overdue SI investigations (6 investigations at time of reporting) are improving but remain closely monitored via regular Trust meetings.

PSIRF: In February, the Trust Patient Safety Incident Meeting (PSIM) recommended 3 Patient Safety Incident Investigation (PSII's) and 6 Patient Safety Responses (PSRs). The majority of themes fall within the Trust's identified priorities including maternity, delayed diagnosis and recognition of deteriorating patients.

Themes and trends from the data: Analysis of our patient safety data reveals 417 incidents were reported within our Emergency Departments (EDs). This is 24% of the overall reporting across the Trust. The top three categories were infrastructure (12%), security (11%), and access/admission/transfer and discharge (11%), with the narrative outlining the ongoing operational pressure and the impact this is having on both staff and patient. There were 785 incidents reported across our inpatient areas (46% of overall reporting) with the top 3 categories being falls, medication and pressure ulcers. There were 122 incidents from community and outpatient areas (7% of overall reporting) with top categories including pressure ulcers and documentation incidents. Actions are being taken to address these themes.

Patient Experience:

Key Quality Performance Metrics: The Trust received a total of 118 new formal complaints in February 2025 which is a decrease from January's figure of 129. The average number of complaints received per month has now risen to 105 (at the end of Q3) from 78 per month in Q1 and 100 in Q2. The Trust closed a total of 114 cases in February 2025, an increase from previous figure of 95 cases in January 2025. The Trust also re-opened 4 cases indicating our responses remain of good quality. The Trust continues to acknowledged 99% of complaints within 3 working days of being received. Our response rate within time has fallen slightly to 77% (below the target of 80%) in the last month. The current percentage of complaints overdue was 36% (n=116) and the longest open complaints continue to be progressed, the oldest complaint (at time of reporting) was 298 days.

Themes and trends from the data: The top three complaints themes are Clinical Treatment, Values & Behaviours (Staff) and Patient Care. This is similar to last month's themes and breakdowns. The top three themes from ED complaints were Clinical Treatment, Values & Behaviours & Patient Care. A small deep dive (5 complaints) of top theme clinical treatment revealed sub-themes including concerns around clinical treatment provided, pain not assessed/managed, and care plan/protocols not followed.
The top three themes for Inpatients were Patient Care, Clinical treatment & Values & Behaviours. These are the same themes as last month. A small deep dive of the top theme Patient Care (5 complaints) show that the themes relate to delays and management of conditions as well as the management of pain.

Clinical Effectiveness:

Key Quality Performance Metrics: There were 23 audits registered and 11 reported in February 2025. The National Institute for Health and Care Excellence (NICE) published 6 new pieces of guidance in January 2025. These will be reviewed alongside the February and March guidance at the Clinical Effectiveness and Audit Committee (CAEC) meeting on the 21st March 2025 and circulated for assessment to the identified leads. The number of Self-Assessment Checklists (SAC) outstanding remained static at 21% outstanding in February 2025.
The overall Trust position is 71.5% (n=224) for policies being in date with 89 expired.

	[✓]	[✓]	

Recommendations/ decisions required:

The Committee is asked to note and discuss the contents of the report.

Overall Level of Assurance

Assurance Level	
Significant	
Sufficient	[✓] The Quality and Safety of care is monitored at various levels within the organization. There is oversight at the Divisional level, the Patient Experience Committee meeting, Quality, Safety & Patient Experience Committee, and at the Quality and Performance Committee. Any risks identified are managed at appropriate levels within the organization.
Limited	
None	
N/a	

Link to the Trust's Key Priorities:

✓	Continually improve safety and quality.
✓	Put patients at the heart of everything we do.
✓	Support and develop our workforce to live our values every day
✓	Work effectively with partner organizations.
✓	Ensure we spend every penny wisely.

Resource Implications: No resource Implications

Regulations and legal considerations: This is relevant in supporting the Trust's ability to meet its regulatory and legislation standards including the Care Quality Commission (CQC) regulatory standards

Quality consideration and impact on patients and carers: The paper supports the Trust's ability to deliver access to treatment and high-quality and safe care to improve outcomes and patient experience by providing assurance against agreed quality and performance targets/plans.

Health Inequalities: The paper ensures the voices of our patients, families, and/or carers are heard to ensure this is embedded in all quality and performance discussions.

Link to the Trust's Green Plan: High-quality care delivered first time has a beneficial effect on green plan objectives.

Consultation/ Communication: This paper will be discussed at the Quality, Safety, and Patient Experience Committee, and the Trust Management Executive meeting, and some of the content is discussed at divisional meetings and other quality and safety groups.

Risk issues: Potential risk to patient safety, experience, and clinical effectiveness and not meeting all the Care Quality Commission standards of care.

Confidentiality: This report does not contain any confidential information.

Equality, Diversity & Inclusion (EDI): The contents of this report support the delivery of quality and safe care for all

Name of Main Author: Helen Woolford, Associate Director of Quality & Governance

Executive Director: Louise Crosby, Chief Nurse

Lewisham and Greenwich NHS Trust

Quality & Safety Report

Report for discussion at Trust Board
Analysis based on February 2025 data, unless otherwise stated

To be exceptional

Introduction

This Quality & Safety Report provides the Trust Board, Executives, Senior Leaders, Clinical Groups, and other stakeholders an overview of our position against the core domains1 of Safe, Effective, Caring, Responsive, People and Well-led.

The report includes:

- Executive Summary – a selection of indicators highlighted for Board discussion based on Statistical Process Control (SPC) variation and/or those indicators that are most significant for reporting.
- Supporting Information – This section provides information on reporting content and logic.

This report includes the Trust-wide Quality Scorecard. Due to the timing for data submissions, the scorecard data is up to February 2025 , unless otherwise stated.

1 The source of our core domains:

Safe, Effective, Caring, Responsive and well-led - CQC

Executive Summary

NHS
Lewisham and Greenwich
NHS Trust

Patient Safety

Key Quality Performance Metrics: The Trust reported 1,720 incidents, of which 52 (3.0%) were of moderate or above harm, and 19 excellence reports in February 2025 which continues to indicate a positive reporting culture. The top 3 reported incidents across the Trust were falls, infrastructure (staffing, facilities & IT systems) and pressure ulcers. There has been a further reduction of open overdue incidents to 4,643 (at time of reporting) and actions continue across the Trust to seek closure with any required actions/improvements taken forwards. Outstanding Duty of Candour (DoC) compliance and overdue SI investigations (6 investigations at time of reporting) are improving but remain closely monitored via regular Trust meetings.

PSIRF: In February, the Trust Patient Safety Incident Meeting (PSIM) recommended 3 Patient Safety Incident Investigation (PSII's), of which 2 were Dermatology Never Events regarding wrong site surgery, and 6 Patient Safety Responses (PSRs). The majority of themes fall within the Trust's identified priorities including maternity, delayed diagnosis and recognition of deteriorating patients.

Themes and trends from the data: Analysis of our patient safety data reveals 417 incidents were reported within our Emergency Departments (EDs). This is 24% of the overall reporting across the Trust. The top three categories were infrastructure (12%), security (11%), and access/admission/transfer and discharge (11%), with the narrative outlining the ongoing operational pressure and the impact this is having on both staff and patient. There were 785 incidents reported across our inpatient areas (46% of overall reporting) with the top 3 categories being falls, medication and pressure ulcers. There were 122 incidents from community and outpatient areas (7% of overall reporting) with top categories including pressure ulcers and documentation incidents. Actions are being taken to address these themes.

Patient Experience

Key Quality Performance Metrics: The Trust received a total of 118 new formal complaints in February 2025 which is a decrease from January's figure of 129. The average number of complaints received per month has now risen to 105 (at the end of Q3) from 78 per month in Q1 and 100 in Q2. The Trust closed a total of 114 cases in February 2025, an increase from previous figure of 95 cases in January 2025. The Trust also re-opened 4 cases indicating our responses remain of good quality. The Trust continues to acknowledged 99% of complaints within 3 working days of being received. Our response rate within time has fallen slightly to 77% (below the target of 80%) in the last month. The current percentage of complaints overdue was 36% (n=116) and the longest open complaints continue to be progressed, the oldest complaint (at time of reporting) was 298 days.

Themes and trends from the data: The top three complaints themes are Clinical Treatment, Values & Behaviours (Staff) and Patient Care. This is similar to last month's themes and breakdowns. The top three themes from ED complaints were Clinical Treatment, Values & Behaviours & Patient Care. A small deep dive (5 complaints) of top theme clinical treatment revealed sub-themes including concerns around clinical treatment provided, pain not assessed/managed, and care plan/protocols not followed.
The top three themes for Inpatients were Patient Care, Clinical treatment & Values & Behaviours. These are the same themes as last month. A small deep dive of the top theme Patient Care (5 complaints) show that the themes relate to delays and management of conditions as well as the management of pain.

Clinical Effectiveness

Key Quality Performance Metrics: There were 23 audits registered and 11 reported in February 2025. The National Institute for Health and Care Excellence (NICE) published 6 new pieces of guidance in January 2025. These will be reviewed alongside the February and March guidance at the Clinical Effectiveness and Audit Committee (CAEC) meeting on the 21st March 2025 and circulated for assessment to the identified leads.
The number of Self-Assessment Checklists (SAC) outstanding remained static at 21% outstanding in February 2025. The overall Trust position is 71.5% (n=224) for policies being in date with 89 expired.

1. Safe

Safety is a priority for everyone, and leaders embed a culture of openness and collaboration. We must ensure we protect our patients and staff from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Our overall performance in this area over the past month is summarised by our Trust wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Patient Safety Incidents (events)
- Patient Safety Investigations (PSIIs) and Patient Safety Reviews (PSRs)
- Learning from Excellence –Good Care Events

The Trust's separate monthly PSIRF report should be read alongside for further information on learning from Patient Safety Events.

***Outstanding Characteristic**: People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong*

Safe Key Quality Performance Indicators

Lewisham and Greenwich NHS Trust

Duty of Candour Compliance	SHMI Indicator- Trust wide	Open and overdue incidents	Overdue SI Investigations
62%	<1.00	4634	6
Of patients and families have not been informed of investigations.	The SHMI remains within range.	Incidents are open and overdue for closure.	SI investigations are over their 60-day timescale.

Safe

		Reporting Period			Monthly Performance												
	Metric Title	Key Target	Level	Target	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	Sparkline (YTD)
Incident Reporting	Never Event Incidents	✓	IS	0	0	0	0	0	2	0	0	0	0	0	0	2	
	Total Incidents Reported (Clinical & Non-Clinical)				1951	1822	1904	1758	1911	1786	1778	2113	1909	2113	1888	1621	
	Patient Safety Incidents Where the Likely Impact Could Be Moderate, Severe Harm or Unexpected Death				66	56	65	46	53	55	51	64	71	90	61	52	
	Number of open and overdue incidents for reporting period				13912	13134	12469	10921	7719	7345	7419	7619	7523	5236	5110	4634	
	Number of Patient Safety Incident Investigation recommended					4	1	2	4	1	3	3	1	1	2	3	
	Number of Patient Safety Reviews recommended					7	1	9	9	10	5	7	5	7	7	6	
	Number of Serious Incidents Declared				8	1											
	Serious incidents - Number of investigations overdue				43	46	52	44	41	28	22	20	15	10	7	6	
	Red Incidents Declared				5	2											
	Red incidents - Number overdue				44	43	43	37	36	32	31	29	27	26	24	23	
	Duty of Candour Compliance %				50%	60%	61%	80%	85%	81%	89%	60%	50%	62%	0%	0%	
	Number of CAS Alerts past deadline				0	0	0	0	0	0	0	0	0	0	0	0	
Harm Free Care	Number of Falls incidents				145	149	163	151	176	163	155	203	167	176	132	167	
	Number of Falls resulting in harm				3	8	7	4	7	2	5	10	9	5	4	6	
	Number of Medication incidents				158	117	131	125	165	145	124	166	139	157	131	121	
	Number of Medication incidents resulting in harm				3	3	5	0	4	5	7	0	5	3	8	5	
	Number of Pressure Ulcers incidents (developed and/or deteriorated)				122	96	108	89	92	98	105	139	112	115	140	121	
	Pressure Ulcers Category 3,4 & Unstageable Reported in Month	✓	IS	0	3	2	5	4	0	1	0	3	1	1	1	0	
Infection Prevention Control	Clostridium Difficile (HCIA & CAI)	✓		<37	3	6	8	6	7	8	5	4	5	2	6		
	E.coli Bacteraemia (HCAI & CAI)	✓		<81	33	36	32	33	33	27	38	24	29	32	24		
	Klebsiella Bacteraemia data (HCAI & CAI)	✓		<63	7	7	12	9	3	15	11	12	10	5	9		
	Pseudomonas aeruginosa data	✓		<22	4	6	2	4	4	1	0	2	2	2	4		
	MSSA Bacteraemia data (HCAI & CAI)	✓			9	5	8	7	7	16	9	14	16	14	5		
	MRSA Bacteraemia (HCAI)	✓	ES	0	0	1	2	2	0	1	1	0	1	1	1		
Screening on Admission	VTE Risk Assessment		EA	95%	93.99%	94.82%	97.18%	96.98%	97.04%	97.23%	96.13%	96.75%	95.49%	94.33%	97.58%	97.00%	
Medicines Management	Check 3 POD lockers. Are those containing medicines locked?	✓	ES	100%	87.50%	76.47%	100.00%	81.82%	97.14%	89.66%	95.45%	86.67%	88.00%	78.57%	89.29%	87.50%	
	Check 5 pages of the register. Has each entry been signed by 2 practitioners, no crossing out and compliant with Medicines Policy	✓	ES	100%	75.00%	89.29%	100.00%	88.89%	89.80%	93.62%	81.08%	81.48%	97.56%	81.82%	87.18%	88.24%	
	Medicines Management Adult Wards - Are all Insulins in use labelled with opened on or do not use after?	✓	OR	100%	87.50%	95.00%	100.00%	96.88%	97.73%	97.22%	100.00%	95.45%	97.44%	95.24%	89.19%	90.63%	
	Medicines Management Adult Wards - Are medicines in date? Check 5 items from cupboards or drug trolleys	✓	OR	96%	87.50%	85.71%	100.00%	88.89%	91.84%	97.87%	86.49%	92.59%	92.68%	90.91%	89.74%	93.94%	
	Medicines Management Adult Wards - Is the clinical room locked and secured by either keypad or swipe	✓	EA	96%	100.00%	88.89%	100.00%	94.29%	91.84%	97.83%	86.49%	92.59%	95.00%	68.18%	94.74%	100.00%	
Safe Discharge	EDS Completion within 24 hours of Discharge				76.32%	77.99%	77.97%	79.84%	78.61%	76.97%	76.52%	76.02%	73.69%	72.12%	71.70%	72.75%	
Mortality Indicators	Standard Hospital Mortality Indicator (SHMI) - LGT				1.00	1.00	1.00	1.00	0.99	1.01	1.00	0.99	0.98	0.97	0.96	0.73	
	Standard Hospital Mortality Indicator (SHMI) - UHL				0.92	0.92	0.91	0.91	0.89	0.90	0.89	0.89	0.90	0.88	0.88	0.85	
	Standard Hospital Mortality Indicator (SHMI) - QEH				1.07	1.07	1.08	1.08	1.07	1.09	1.07	1.07	1.05	1.03	1.01	1.01	
Safe Staffing	Safe Staffing - Average Fill Rate				105.2%	105.6%	105.7%	104.9%	101.7%	101.5%	103.3%	106.6%	108.6%				

Patient Safety Analysis – Trustwide

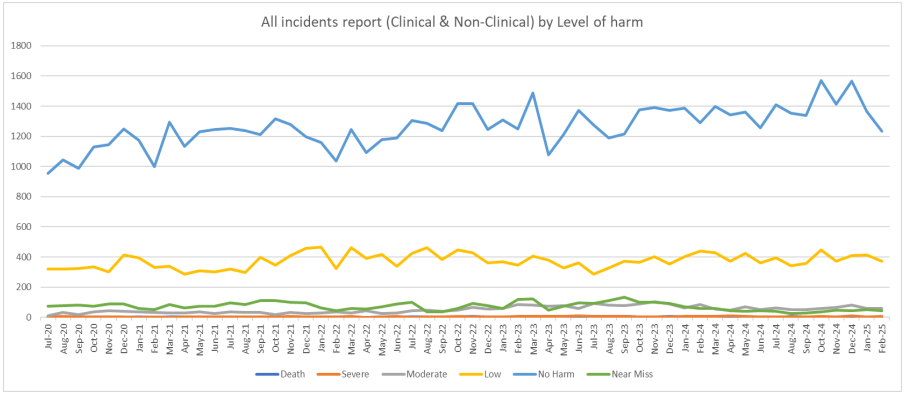
Lewisham and Greenwich NHS Trust

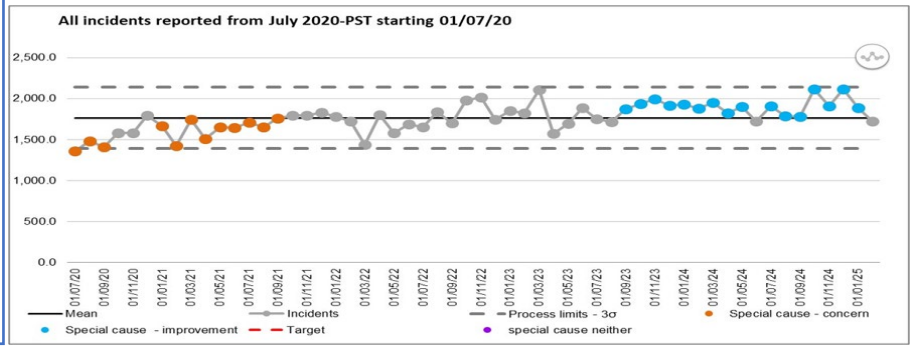
The Trust reported 1,720 incidents (Patient Safety Incidents - PSI and Non-Patient Safety Incidents - Non-PSI) in February 2025. Incident reporting has moved into Common Cause Variation (as indicated by grey dots on the chart). A break down by levels of harm is included on page 7. These incidents are reviewed and where appropriate discussed at the Trust Patient Safety Incident Meeting (PSIM).

Analysis shows that of the PSIs only, 14% of these are pressure ulcer incidents that developed prior to admission, these are left off the top 5 table. While we report these incidents, we are unable to avoid them occurring.

9% relate to Falls, 8% are related to Infrastructure and Staffing issues, 7% relate to new Pressure Ulcers. The top five Cause Groups of reported PSI's represent 50% of the total PSI incidents reported:

Top 5 Cause Groups reported - PSI's only	Feb-25	
Slips, Trips, Falls	163	9%
Infrastructure (Staffing, Facilities, IT Systems)	129	8%
Pressure Ulcer - New (Developed / Deteriorated In	121	7%
Medication Incidents	109	6%
Access/admiss/trans/discharge	95	6%



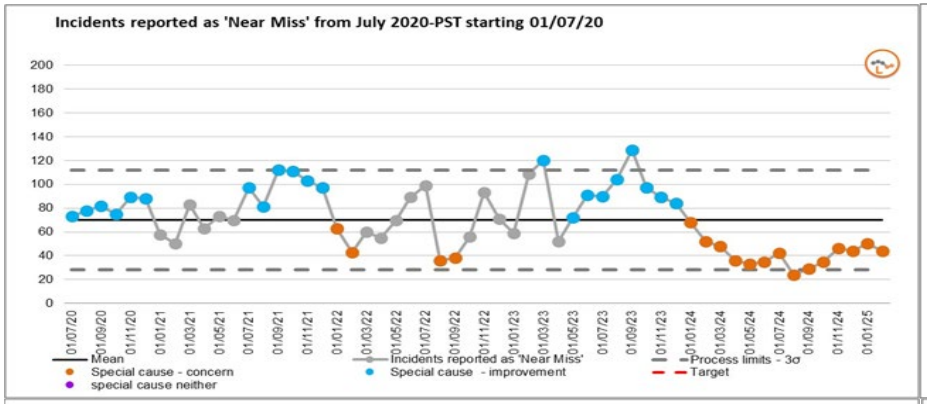


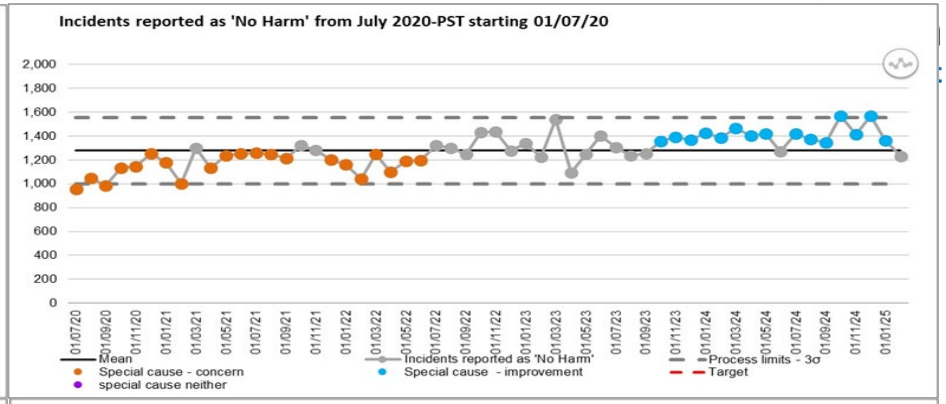
There are 4,643 incidents open on Ulysses, the Trust's Local Risk Management System. There continues to be thematically review on relevant incidents across the Trust:

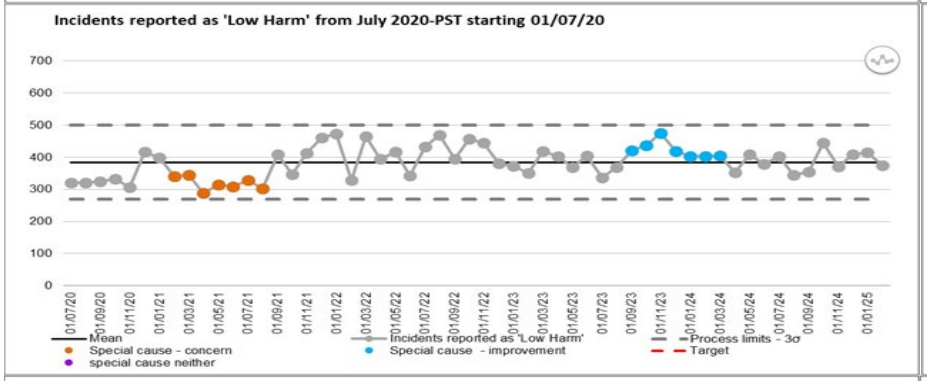
1. A thematic review of non-clinical incidents thematic to identify key learning to be taken through relevant Trust Groups/ Committees for action and improvement.
2. Divisional led thematic reviews to ensure they are reviewed, actioned and closed.
3. A quarterly review and closure of Category 2 Pressure Ulcers on Admission reported in our Emergency Departments.

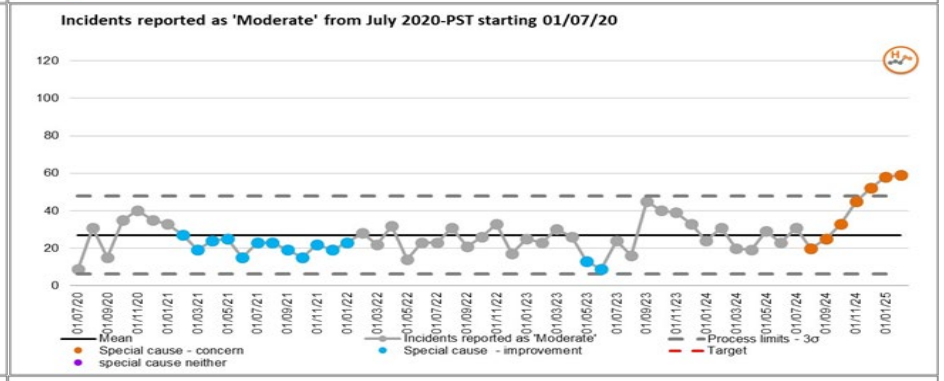
	Allied Clinical Services	QE Medicine	Surgery	UHL Medicine &	Women, Children And Sexual Hea	Grand Total
2019	0	6	0	0	0	6
2020	0	18	0	0	0	18
2021	0	35	0	4	0	39
2022	0	214	2	7	0	223
2023	0	814	62	20	9	905
2024	146	1189	519	126	268	2248
2025	155	490	231	152	176	1204
Grand Total	**301**	**2766**	**814**	**309**	**453**	**4643**

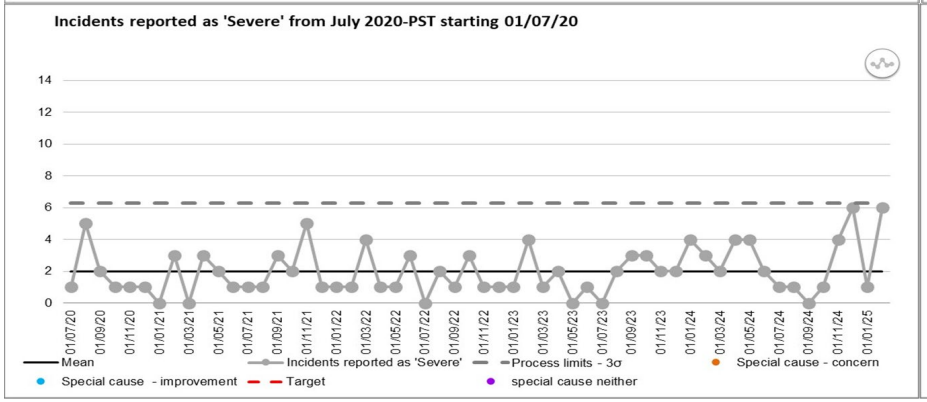
Patient Safety Incidents

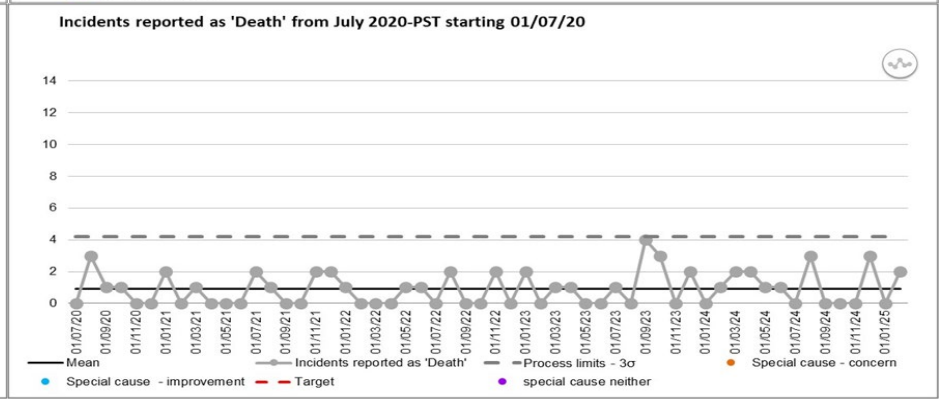










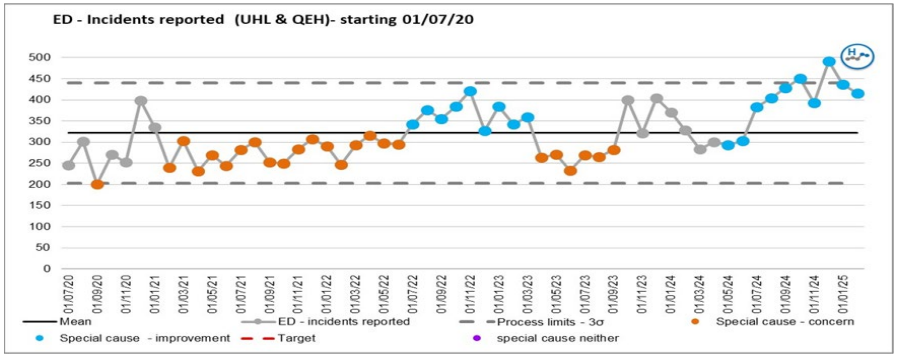


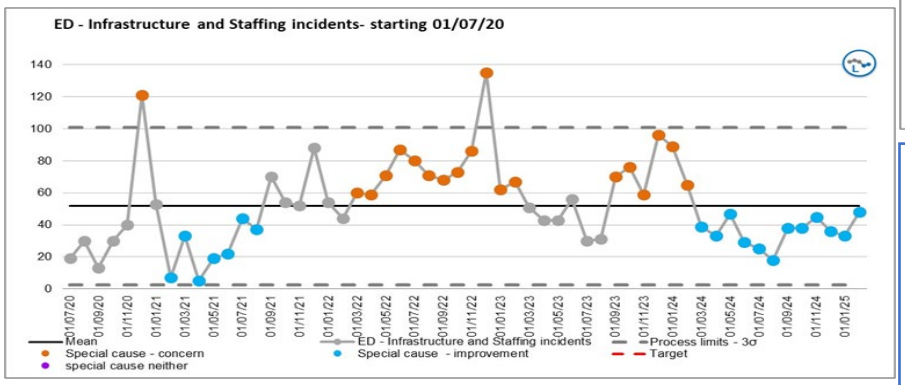
To be exceptional

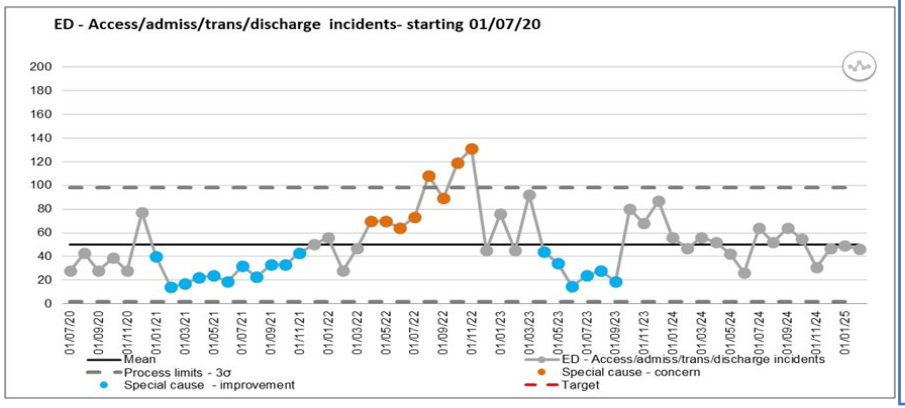
Variation colours: Orange indicates concerning special cause variation requiring action; blue indicates where improvement appears to be; and grey indicates no significant change (common cause variation).

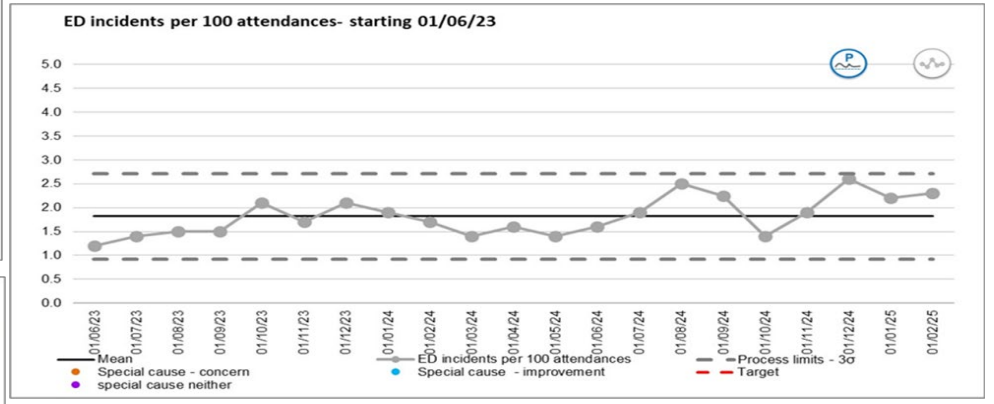
Patient Safety Analysis – Urgent and Emergency Care

Lewisham and Greenwich NHS Trust









There were 416 (UHL=211, QEH=205) incidents reported (PSI and Non-PSI). From June 2023, there have been on average 1.82 incidents reported for every 100 attendances per month. The February figure (2.3) has increased by 0.1. There are no significant statistical variances in the monthly figures.

The top Cause Group category was “Infrastructure (staffing, facilities, IT systems)” , 48/416 (12%) of incidents reported. Within this category, 20/48 of these related to an “unsafe department” with 17/20 of these incidents noting there was no capacity to place or see patients within the ED.

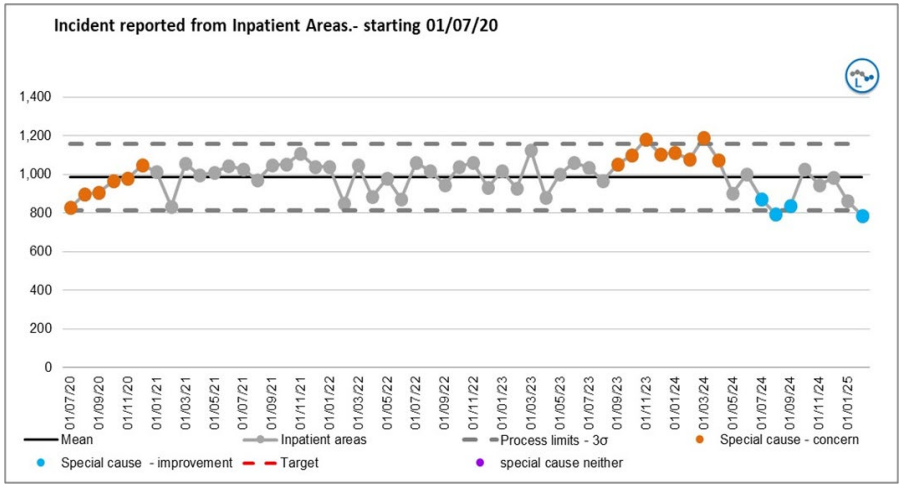
The second Cause Group category reported was Security 46/413 (11%). 34/46 (77%) were related to security staff ‘patient minding’ within the ED.

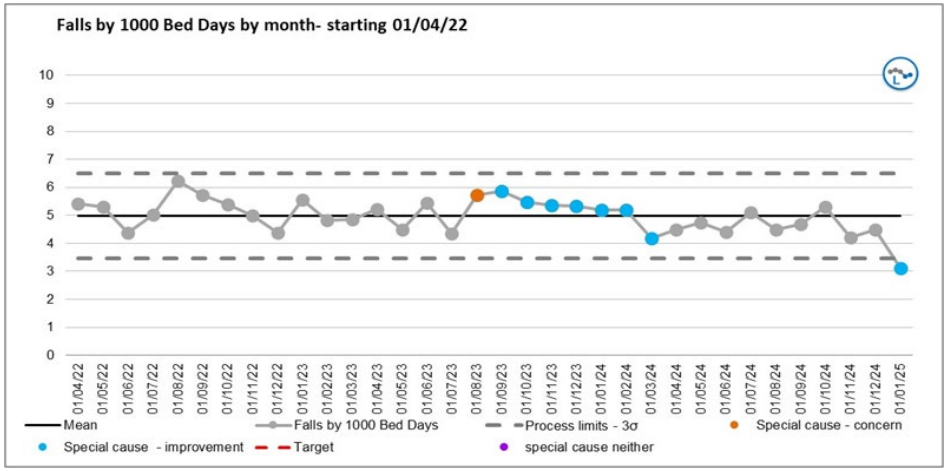
The third cause group category reported was “Access/Admission/Transfer and Discharge” 46/416 (11%). Within this category, 19/46 (41%) were related to an inability to offload patients from ambulances.

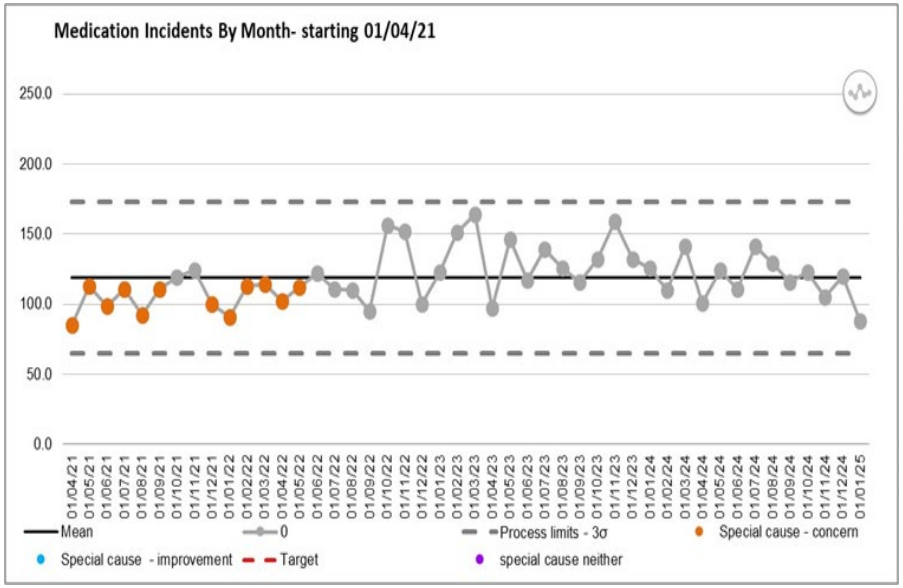
(Please note - Pressure Ulcers noted on admission were excluded from the analysis).

Patient Safety Analysis – Inpatient Care

Lewisham and Greenwich NHS Trust







There were 785 incidents reported deemed as patient safety inpatient incidents:

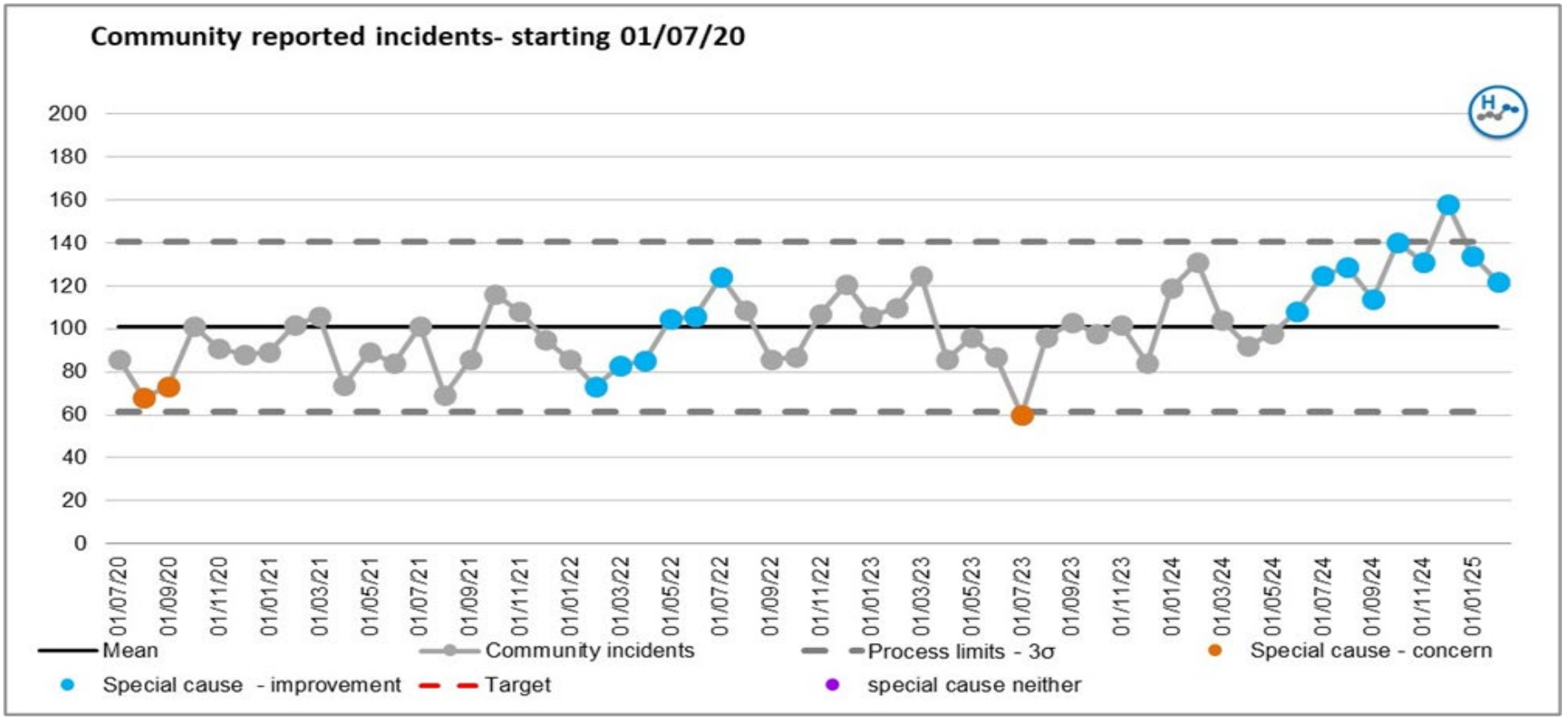
Slips, Trips and Falls (STF): There were 136 STF's deemed as patient safety, inpatient incidents in February 2025. Of these, 57/136 (57%) were reported as 'Found on Floor' (last month was 57%). 12/136 (12%) were falls from a chair. Falls per 1000 bed days in February is 4.1 and an increase from 3.1 last month. Thematic Analysis is underway to look into the "found on floor" incidents for further themes and trends.

Medication Incidents: There were 86 Medication incidents deemed as patient safety, inpatients incidents in February 2025. 13/86 (15%) were related to prescribing issues. 11/86(13%) were related to omitted or delayed medications being given to a patient.

Pressure Ulcers (New) : There were 77 incidents reported in this category. 38/77 (49%) were related to new Cat 2 PU's being identified. 15/77 (19%) related to new Deep Tissue Injuries (DTI's) being identified.

(Please note - Pressure Ulcers noted on admission were excluded from the top 3)

Patient Safety Analysis – Outpatient Care



There were 122 incidents from community and outpatient areas reported in February 2025. New pressure ulcers make up 40/122 (33%) of these reports. The largest number are reported by the District Nursing teams.

Documentation incident were 12/122 (10%) of incidents reported within the Community. 6/12 (50%) related to missing documentation issues. 2/12 (17%) clerical errors being identified

The SPC shows there has been an improvement in the number of incidents being reported over the past six months. This indicates a good reporting and safety culture within the outpatient care services we provide.

Patient Safety Incident Investigations

Lewisham and Greenwich NHS Trust

The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) on 1st April 2024. Within February, the Trust Patient Safety Incident Meeting (PSIM) recommended three Patient Safety Incident Investigations (PSII's) and six Patient Safety Responses (PSR's) for the purpose of learning and improvement

There was 3 PSII's recommended in February 2025:

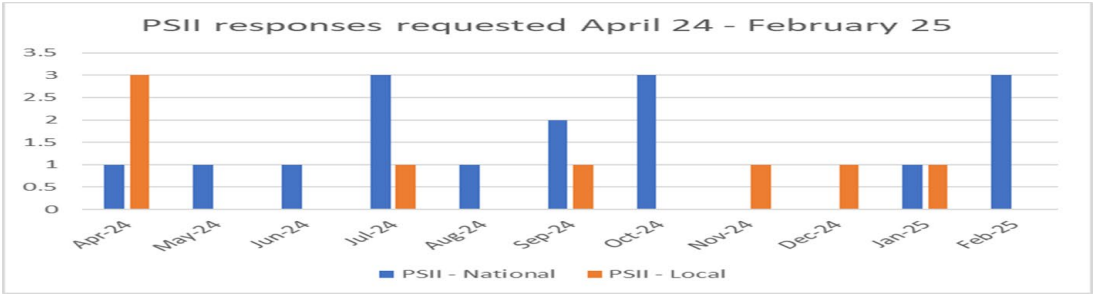
National PSII:
2x Never Event incidents: Incorrect lesion excised
1x Intrauterine death

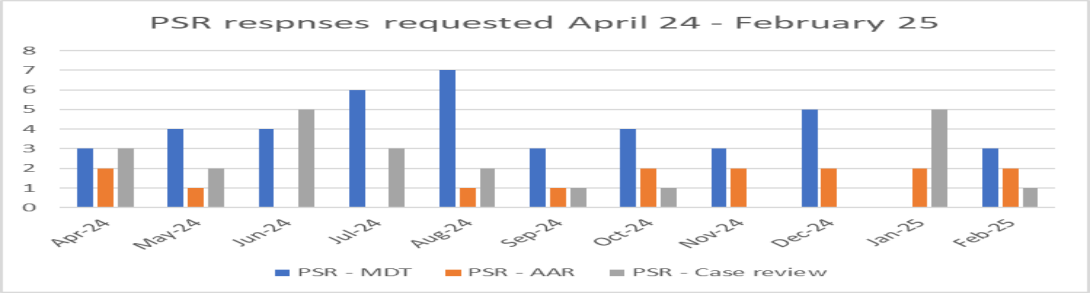
The 6 PSR's requested in February 2025 include:

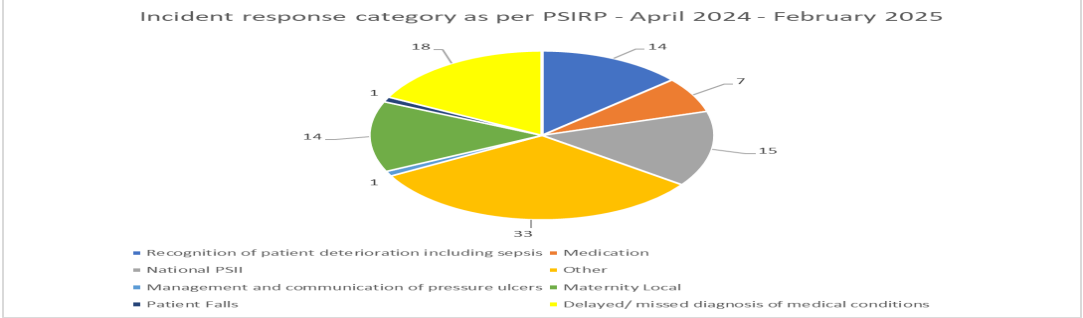
After Action Reviews:
1x Unexpected term admission to the Neonatal Intensive Care Unit.
1x Identification issues. A patient received the correct blood transfusion but under another patient's name.

Case review:
1x Delayed cancer diagnosis

Multi Disciplinary Team review:
1x Incorrect blood product transfused
1x Methadone prescribed and given to the wrong patient
1x Missed cancer diagnosis

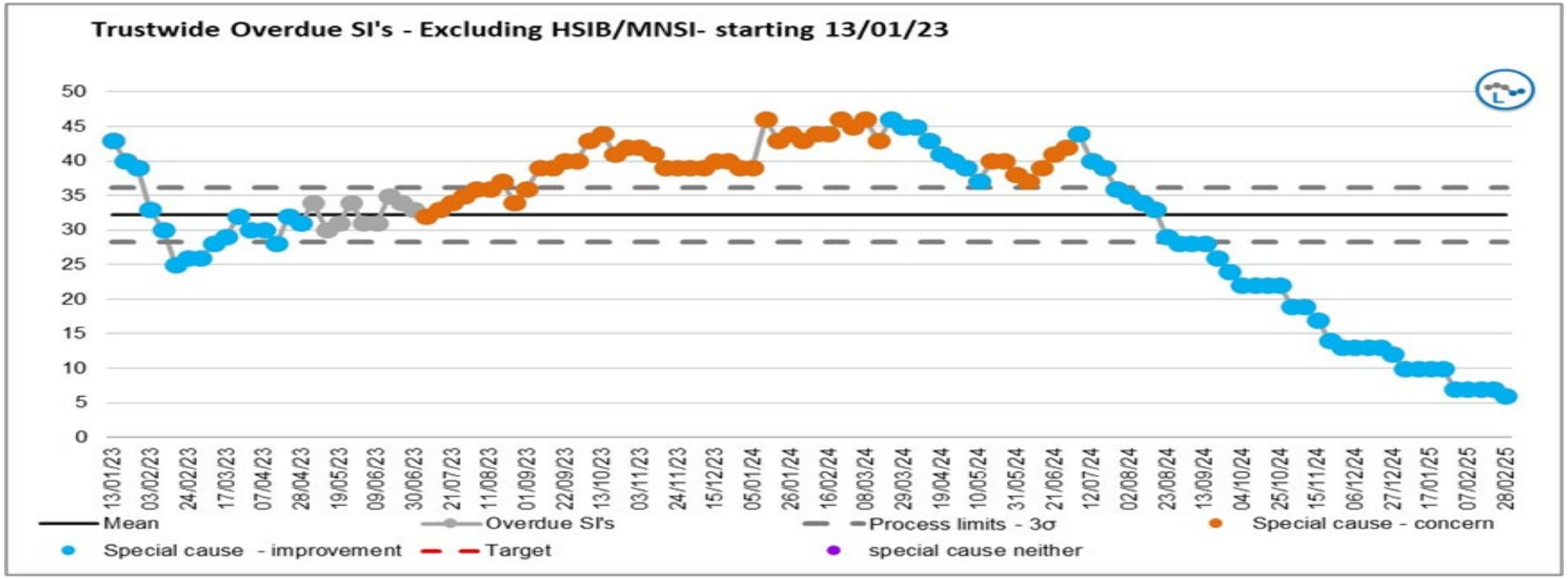






Open & Overdue Serious Incidents

NHS
Lewisham and Greenwich



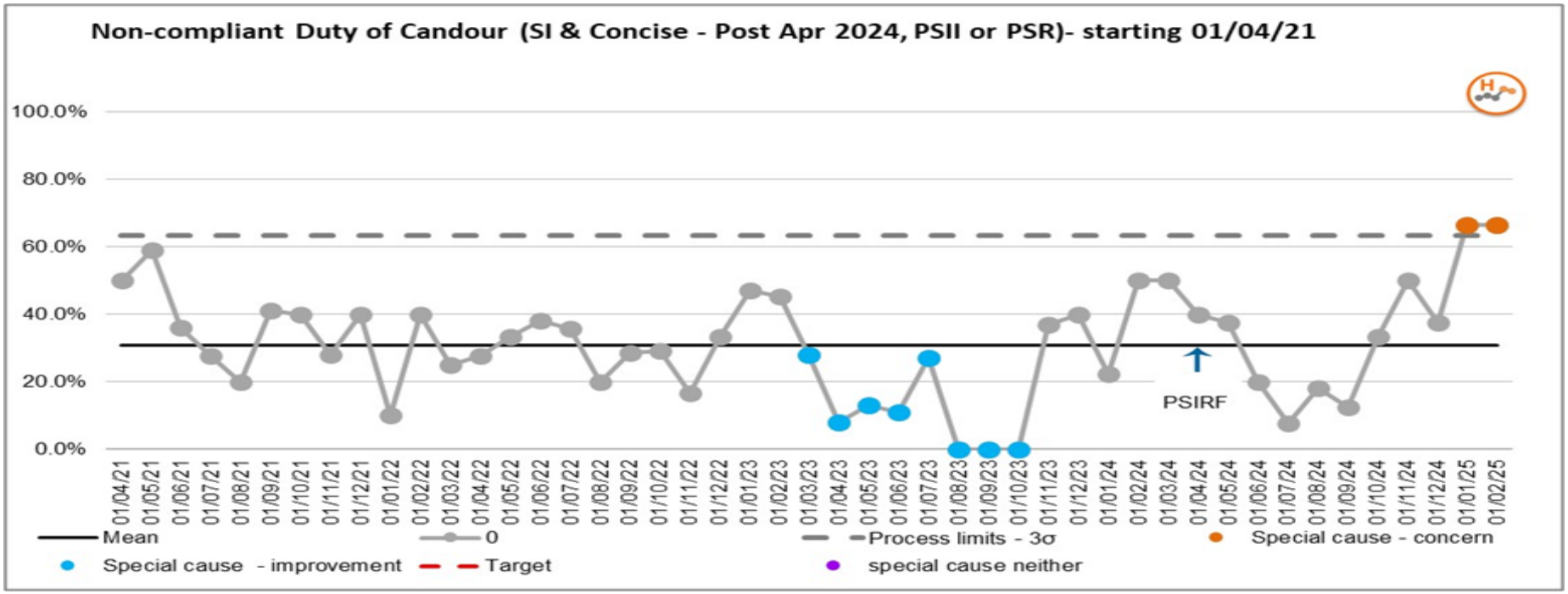
As of 28/02/2025, 6 SI investigations were over their mandatory 60 working day timeframe, there of no further MNSI SI investigations ongoing

The following actions are being taken to complete overdue SI investigations:

1. Regular oversight via sitrep reports to senior leaders with progress being tracked through monthly performance review and weekly sitrep meetings with the Chief Nurse.
2. A fortnightly support forum has been set up and led by the Deputy Medical Director, Quality and Safety to identify any challenges and unblock barriers. The aim is to discuss issues the lead investigators are having and provide support and advice to aid more timely completion of the reports.
3. Resource being made available to help with the completion of investigation reports across the divisions.
4. The Trust's Patient Safety Committee will also monitor this and oversee the implementation of actions from these investigations for ongoing assurance purposes.

Duty of Candour compliance

NHS
Lewisham and Greenwich



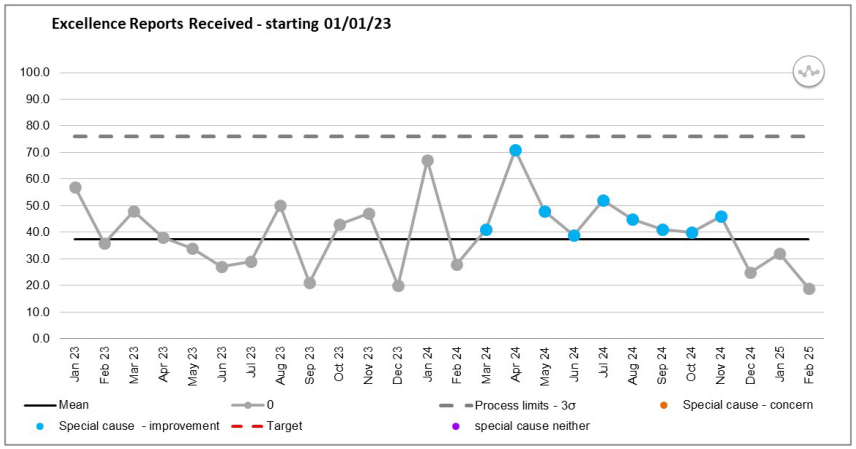
The above SPC chart shows the percentage of recommended learning responses where Duty of Candour (DoC) is currently non-compliant. The SPC shows we are in high, Special Cause Concerning Variation (orange dots) the past two months. The Trust moved to PSIRF April 2024, ensuring we are open and honest remains important and can help provide a positive patient / family experience following an event.

The following actions are being taken to improve the timeliness of conversations with patients and families:

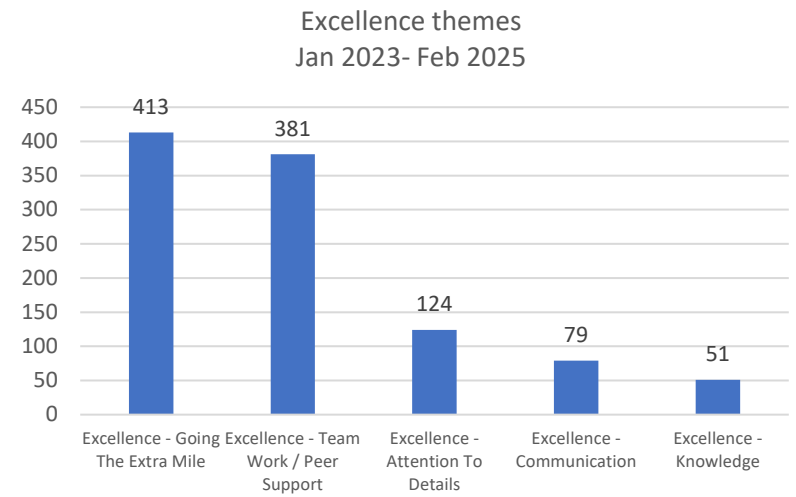
1. Development of central oversight with regular compliance reports being shared with the Chief Nurse and division for action.
2. Changes made to the Local Risk Management System, Ulysses to support the capture of DoC on the system.
3. Development of training on Duty of Candour and undertaking these conversations “breaking bad news” in development. First DoC training provided in January with good attendance and positive feedback.
4. The Trust’s Quality, Safety and Patient Experience Committee is overseeing this, and clinical divisions provide updates on local actions being taken to evidence DoC compliance and ensure conversations are taking place in a timely manner.

Learning from Excellence – Good Care

The Trust launched its Staff Excellence Reporting (ER) system through our Local Trust Risk Management System, Ulysses in January 2023. Safety in healthcare has traditionally focused on avoiding harm by learning from error but it is important that opportunities for learning is also taken from excellent practice. Excellence in healthcare is highly prevalent and by capturing these it creates the opportunities for learning and improving.
resilience and staff morale.



- This SPC chart shows the number of Excellence reports received monthly. The number of excellence reports received for February was 19 which is a decrease on the figure in January 2025 (25). As of 28.02.2025 1048 excellence reports have been received since the January 2023 launch.
- Excellence Reporting now features at weekly Trust Inductions since August 2023 Monthly reports are also shared with Divisions and are also uploaded onto the Trust Excellence reporting intranet page so all Trust staff can access.
- Excellence- Going the Extra Mile continues to be the top reported theme followed closely by Teamwork/Peer Support.



Excellence examples in February 2025 :

"Oluwabukola was visiting a patient at home and discovered the patient had fallen and was stuck on the floor. She called for help from the fire brigade who helped her to gain access to the property so she could help the patient to re-assure and she stayed with the patient until the paramedics arrived."

"Child came to triage as a 111 referral with an abscess. Child had no features suggesting diabetes, but Amanda was very thorough and asked for a blood glucose to be checked as part of her triage assessment. Child found to have a new diagnosis of type 1 diabetes, which could easily have been missed if Amanda had not thought about it and taken prompt action".

"Anne-Marie showed great professionalism during an unprecedented day in the COPD She escalated appropriately and showed great communication skills. It was a pleasure to work alongside her".

2. Effective

To be effective we must ensure that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we provide additional data and analysis on:

- NICE Guidance
- Clinical Audit Performance
- Nursing and Midwifery Quality Rounds
- The Improving Together Accreditation Programme (ITAP)

Outstanding Characteristic: *Outcomes for people who use services are consistently better than expected when compared with other similar services.*

Effective Key Performance Indicators

Lewisham and Greenwich NHS Trust

NICE Compliance – status unknown	Number of registered audits	Number of completed audits
5%	23	11
The Trust has 39 pieces of guidance awaiting assessment from a total of 766 applicable	In February 2025, 23 local audits were registered	In February 2025, 11 local audits were completed with reports submitted

Effective

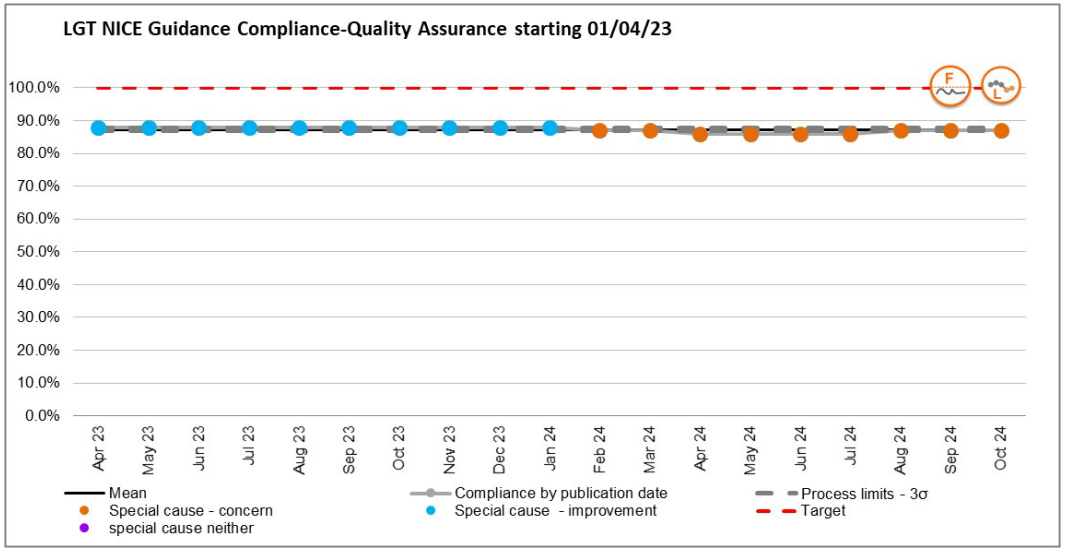
		Reporting Period			Monthly Performance												
	Metric Title	Key Target	Level	Target	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	Sparkline (YTD)
Clinical Best Practice	National Audit Participation				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Number of National Audit Recommendations Self Assessments (SAC) which are Outstanding - > than 3 months post publication				76	79	79	79	40	40	47	41	34	39	39	40	
	Percentage of National Audit Recommendations Self Assessments (SAC) which are Outstanding - > than 3 months post publication				53%	46%	44%	33%	25%	25%	27%	24%	18%	21%	21%	21%	
	NICE guidance - Compliant					86.0%	86.0%	86.0%	86.0%	86.0%	87.0%	87.0%	87.0%	87.0%	86.0%	85.0%	
	NICE guidance - Partially Compliant					8.0%	8.0%	8.0%	8.0%	8.0%	7.0%	7.0%	7.0%	8.0%	8.0%	8.0%	
	NICE guidance - Awaiting Status					6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	5.0%	6.0%	7.0%	
	NICE guidance - Of awaiting status guidance the percentage > than 6 months post publication					62.0%	57.0%	70.0%	73.0%	73.0%	72.0%	72.0%	72.0%	77.0%	67.0%	59.0%	
	30 Day Emergency Readmissions				18.53%	18.26%	17.19%	18.61%	17.93%	19.87%	18.35%	17.67%	16.39%	14.60%	15.77%	15.55%	

NICE Guidance

Lewisham and Greenwich NHS Trust

Trust compliance reported in February 2025 against guidance published up to 28th February 2025.

NICE Guidance compliance - February 2024	LGT	
	#	%
Total Applicable guidance	777	100%
Trust Opting out of guidance	2	0%
Awaiting Status (red)	54	7%
Partially Compliant - implementation actions outstanding (amber)	61	8%
Compliant (green)	660	85%



NICE Compliance – Trust Level - Awaiting Status

There are currently 54 pieces of NICE guidance (7%) that are Awaiting Status. Of these, 32 (59%) were published greater than 6 months ago.

NICE Guidance – Published January 2025

6 pieces of NICE guidance were published in January 2025. These will be reviewed alongside the February and March guidance at the Clinical Effectiveness and Audit Committee (CAEC) meeting on the 21st March 2025 and circulated for assessment to the identified leads.

NICE Monitoring – Transfer to Alerts Module on Ulysses

The Quality Assurance team is in the process of transitioning the monitoring of NICE guidance compliance to the Ulysses Safeguard system, Alerts module.

NICE guidance compliance assessments and action plans will be centrally accessible to all Divisions via the Alerts module once the migration is complete.

NICE Guidance

Divisional compliance reported in December 2024 against guidance published up to 30th November 2024.

Lewisham and Greenwich NHS Trust

Allied Clinical Services						
NICE Guidance compliance	LGT		UHL		QEH	
	#	%	#	%	#	%
Total Applicable guidance	**289**	**100%**	**259**	**100%**	**276**	**100%**
Trust Opting out of guidance	0	0%	0	0%	0	0%
Awaiting Status (red)	14	5%	14	5%	12	4%
Partially-compliant - implementation actions outstanding (amber)	14	5%	14	5%	12	4%
Compliant (green)	261	90%	231	90%	276	92%

Lewisham Medicine and Community		
NICE Guidance compliance	UHL	
	#	%
Total Applicable guidance	**238**	**100%**
Trust Opting out of guidance	1	0%
Awaiting Status (red)	21	9%
Partially-compliant - implementation actions outstanding (amber)	21	9%
Compliant (green)	195	82%

QEH Medicine		
NICE Guidance compliance	QEH	
	#	%
Total Applicable guidance	**236**	**100%**
Trust Opting out of guidance	1	0%
Awaiting Status (red)	21	9%
Partially-compliant - implementation actions outstanding (amber)	15	6%
Compliant (green)	236	84%

Surgery						
NICE Guidance compliance	LGT		UHL		QEH	
	#	%	#	%	#	%
Total Applicable guidance	**157**	**100%**	**140**	**100%**	**136**	**100%**
Trust Opting out of guidance	1	1%	1	1%	1	1%
Awaiting Status (red)	6	4%	6	4%	6	4%
Partially-compliant - implementation actions outstanding (amber)	12	8%	11	8%	10	7%
Compliant (green)	138	88%	124	87%	119	88%

Women's, Children and Sexual Health						
NICE Guidance compliance	LGT		UHL		QEH	
	#	%	#	%	#	%
Total Applicable guidance	**184**	**100%**	**179**	**100%**	**160**	**100%**
Trust Opting out of guidance	0	0%	0	0%	0	0%
Awaiting Status (red)	19	10%	19	10%	19	10%
Partially-compliant - implementation actions outstanding (amber)	42	23%	37	21%	34	20%
Compliant (green)	123	67%	123	69%	160	70%

Corporate		
NICE Guidance compliance	LGT	
	#	%
Total Applicable guidance	**34**	**100%**
Trust Opting out of guidance	0	0%
Awaiting Status (red)	7	20%
Partially-compliant - implementation actions outstanding (amber)	14	40%
Compliant (green)	13	40%

National Audits

National Clinical Audit (NCA) projects, on the Quality Account list for 2024/25 which were actively collecting data during February 2025 (**n= 75 NCA but multiple sites participate in single audits*)

Lewisham and Greenwich NHS Trust

Table - National Audit Participation – February 2025

Divisions	Feb-25
Allied Clinical Services	7
Corporate Nursing	2
Lewisham Medicine and Community	21
QEH Medicine	18
Surgery	16
Women, Children and Sexual Health	11
Trust Wide Totals	75

National Audit Recommendations – Self-Assessment Checklists (SAC) from - January 2021 to November 2024 - Upon publication of a national clinical audit report, the recommendations in the report are included in a SAC and sent to the audit leads to complete a gap analysis within 3 months of the report publication. 21% (n=40/189) SACs were awaiting completion greater than 3 months after report publication. **Action being taken:** Timely completion of SAC is a Quality Account priority for 2024/25 and is being monitored at Divisional Governance Board meetings monthly.

SAC Status – Feb 2025	ACS	C.NUR	LMC	QEH	Med LGT	SUR	WCASH	Totals
Awaiting Status	3	5	8	3	3	8	10	**40**
Partially/Non-Compliant	2	0	22	26	4	7	25	**86**
Compliant	1	0	13	16	2	11	20	**63**
Totals	6	5	43	45	9	26	55	**189**

National Audit Findings – National Early Inflammatory Arthritis Audit, (NEIAA) State of the Nation Summary Report 2024 – Published October 2024

Background
The NEIAA aims to improve the quality of care for people living with rheumatic diseases by collecting demographic and care quality data on all eligible newly diagnosed patients with inflammatory arthritides, systemic vasculitides and connective tissue diseases over the age of 16.

Aims and Objectives
Data are collected over the first 12 months of care for all those recruited. (1st April 2022 to 31st March 2023). These data assess waiting times, time to treatment, clinical response to treatment, and patient-reported outcomes.

Method
Healthcare providers performance is measured against the National Institute for Health and Care Excellence (NICE) quality standard [QS33] 'Rheumatoid arthritis in over 16s', including Quality statement two (QS2) which is used for outlier analysis: Outlier status is attributed to any unit whose performance against QS2 is three standard deviations or greater below the national mean. Units are also treated as an outlier if they recruit fewer than 11 patients.

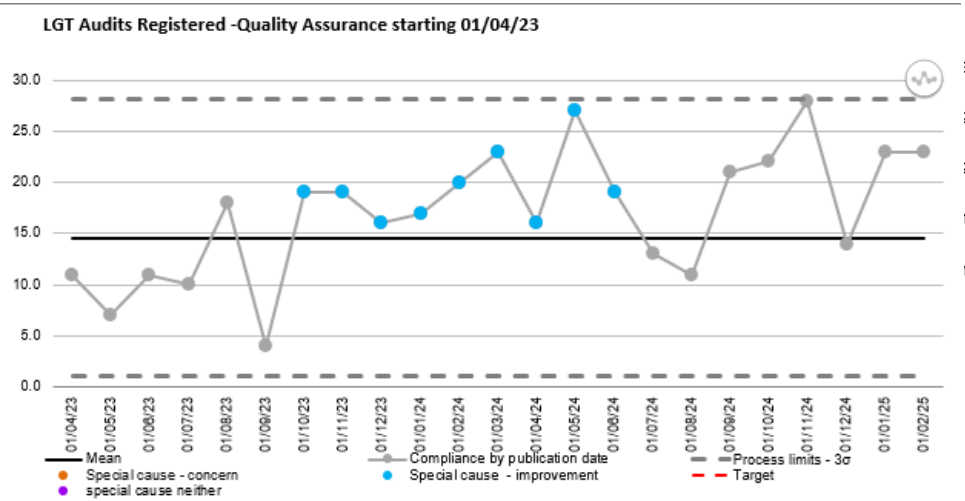
Findings

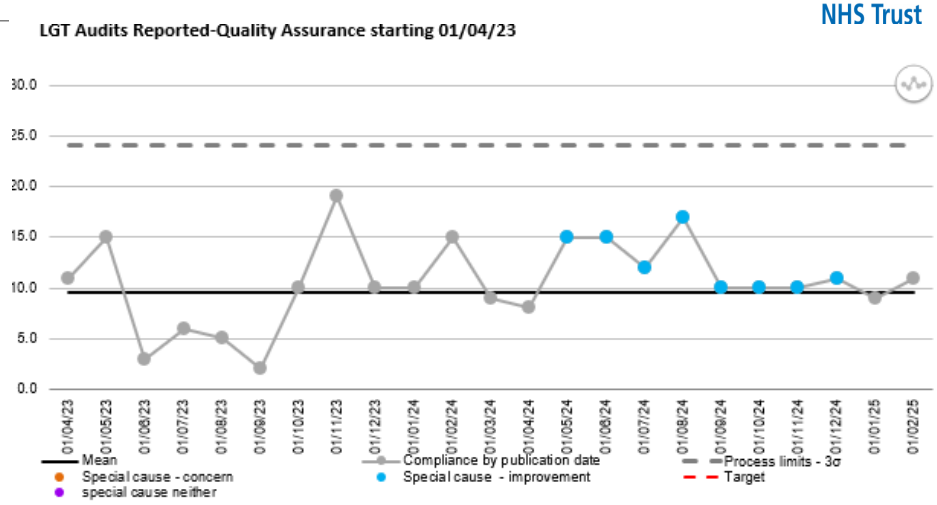
% meeting QS1 target (GP referral in 3 days)			% meeting QS2 target (assessment in 3 weeks)			% meeting QS3 target (treatment within 6 weeks)			No. of pts eligible for follow up	
1st April 2022 – 31st March 2023										
LGT	QEH	LMC	LGT	QEH	LMC	LGT	QEH	LMC	QEH	UHL
44% (64 pts recruited)	46% (47 pts)	41% (17 pts)	44% (64 pts recruited)	28% (47 pts)	88% 17 (pts)	58% (64 pts recruited)	20% (47 pts)	86% (17 pts)	17/ 47	15/ 17
1st April 2023 – 31st March 2024										
25% (19 pts recruited)	**0% (3 pts)**	**33% (16 pts)**	**74% (19 pts recruited)**	**33% (3 pts)**	**81% 16 (pts)**	**57% (19 pts recruited)**	**0% (3 pts)**	**57% (16 pts)**	**<11 patients**	**<11 patients**

Clinical Audit

Local clinical audit and service evaluation projects by Division registered and reported to the Quality Assurance Department between April 23 and February 2025 and activity over the past 23 months.

Lewisham and Greenwich NHS Trust





**Figures in the SPC charts are not cumulative.*

Divisions	Apr-24		May-24		Jun-24		Jul-24		Aug-24		Sep-24		Oct-24		Nov-24		Dec-24		Jan-25		Feb-25	
	Registered	Reported	Registered	Reported	Registered	Reported	Registered	Reported	Registered	Reported	Registered	Reported	Registered	Reported	Registered	Reported	Registered	Reported	Registered	Reported	Registered	Reported
Allied Clinical Services	3	2	9	5	15	12	18	15	21	15	25	16	33	18	36	21	37	24	39	25	44	28
Corporate Nursing	0	0	1	1	1	1	1	1	1	1	1	1	2	1	2	1	3	1	3	1	3	1
QEH Medicine	2	0	4	1	5	1	7	2	7	4	7	5	8	6	10	6	10	7	12	7	14	7
Lewisham Medicine and Community	2	0	4	1	6	2	6	3	9	5	9	5	10	5	12	6	12	7	12	7	14	7
Surgery	6	4	16	9	22	14	26	19	28	22	32	24	36	30	44	31	52	34	60	36	67	39
Women's, Children and Sexual Health	3	2	9	6	13	8	17	10	20	20	33	26	40	27	53	32	57	35	68	35	75	46
Totals	**16**	**8**	**43**	**23**	**62**	**38**	**75**	**50**	**86**	**67**	**107**	**77**	**129**	**87**	**157**	**97**	**171**	**108**	**194**	**117**	**217**	**128**

***Figures in the table are cumulative*

Clinical Audit Report – February 2025

Lewisham and Greenwich NHS Trust

A sample of the findings from a clinical audit report submitted in February 2025 has been included below.

Project Reference: 7634
Project Title: Early Pregnancy Unit Self-Referral Form

Division: Women, Children and Sexual Health	Speciality: Maternity	Data Collection Period: July-August 2024	Report Publication Date: 7th Feb 2025

Background

Between August 2020 and December 2021, 32% of formal complaints to the Early Pregnancy Assessment Unit (EPAU) were related to difficulties accessing the service. In response, an electronic self-referral form was introduced. A local survey conducted one month after its implementation found that 97% of patients found the form easy to use. To evaluate the long-term effectiveness of this intervention and identify potential improvements, a follow-up survey was conducted two years after the self-referral form was introduced. The self-referral pathway, accessible via the hospital website, was launched in March 2022. Since its introduction, there have been no formal complaints regarding access to the EPAU. However, further feedback is sought to enhance the pathway and ensure it remains as accessible as possible for patients.

Aims and Objectives

The aim is to evaluate the accessibility and usability of the self-referral form, assess the efficiency of the referral process—including nurse contact times—and identify areas for further improvement. Additionally, it seeks to determine whether the introduction of the web-based self-referral pathway has been beneficial for patients.

Method

A paper survey was distributed to all patients who self-referred to the Early Pregnancy Unit (EPU) at Queen Elizabeth Hospital (QEH) and University Hospital Lewisham (UHL). The survey included 100 patients across both sites who used the self-referral pathway between 29/07/2024 and 31/08/2024.

Findings

A total of 62 responses were collected.

- 100% of patients found the questionnaire easy to find on the hospital website (62% 'very easy').
- 100% found the questionnaire easy to complete (63% 'very easy').
- 100% were contacted by an EPU triage nurse within 48 hours (73% within 24 hours).
- If the self-referral form was unavailable, 67% would have attended A&E, and 27% would have visited their GP.

Areas for Improvement

Enhancing Form Usability:
- Add a free-text box for additional comments or concerns (2 patients).
- Shorten the form (1 patient).
- Provide an option for a paper-based form (1 patient).

Improving Accessibility:
- Increase awareness of the form (2 patients).
- Make the form more visible on the hospital website (2 patients).
- Clarify access via the NHS website/app (2 patients).
- Offer a paper form option (1 patient).

Conclusions and Recommendations

The findings were reviewed with the EPU team, including the lead consultant.

Key actions include:
- Website Enhancements: Liaising with the IT team to add a more prominent button on the hospital website for easier access to the self-referral form.
- Form Improvements: A free-text box is now available for patients to include additional symptoms or concerns.
- Increased Awareness: Collaborating with the LGT communications team to feature the self-referral process in the next staff newsletter and disseminate information to local GP practices via a dedicated bulletin.

These changes aim to further streamline the self-referral process, improve patient experience, and reduce unnecessary A&E and GP visits.

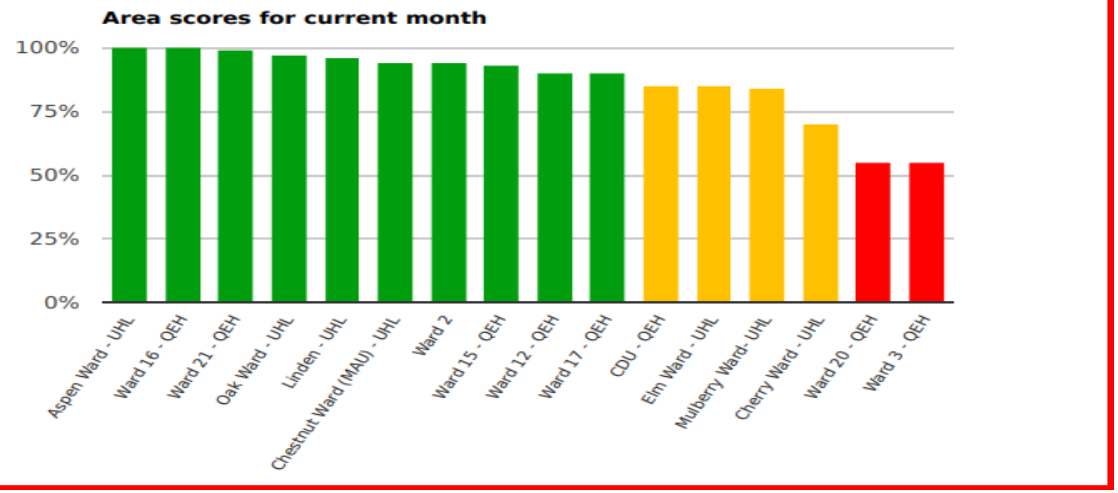
Quality Rounds Theme: Falls prevention and management

Lewisham and Greenwich

- Falls and fractures are a common health problem for everyone, especially those over 65. Every year more than 700,000 older people in the UK attend Emergency Departments following a fall, and for those over 75, falls are the leading cause of mortality
- Fear of falling can have a big impact on psychological well-being – but also, being inactive increases the risk of falling by reducing muscle strength and balance. It's a widespread health issue – but the good news is that many falls can be prevented with specialist interventions and awareness

At the Trust, we are tackling the issue of falls in many ways, both in our hospitals and in community settings—particularly in Lewisham, where we have responsibilities for community healthcare.

- Our Falls team work closely with ward-based staff at both of our hospitals to monitor inpatient falls, in line with the Trust falls policy (available on the intranet). They also provide advice and training to ward staff.
- Falls prevention and management is part of the six standards of Compassion in Care **(Independence).**

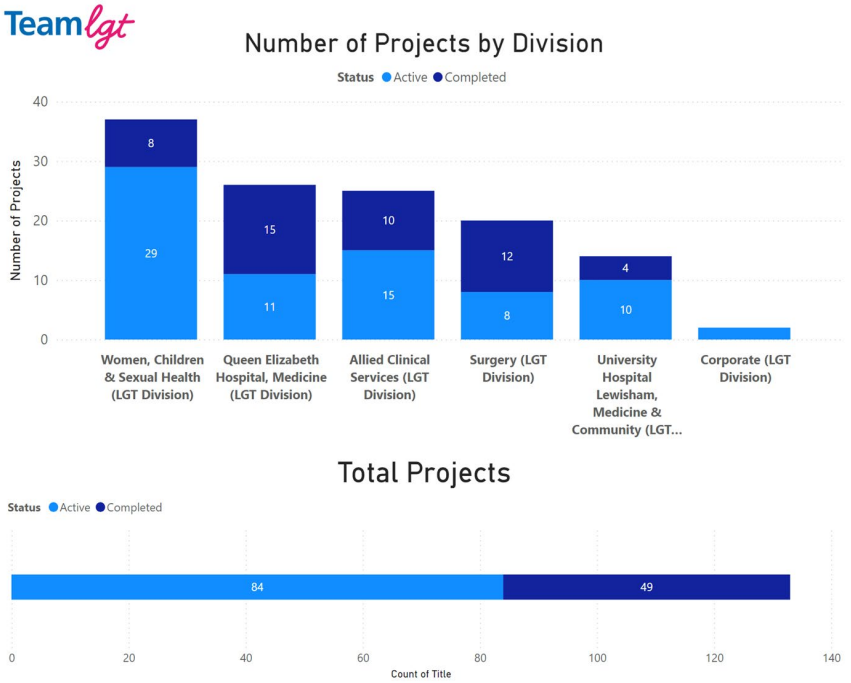


7 Wards audited at UHL
9 wards audited at QEH
An action plan was initiated for the wards to meet 95% compliance with the fall risk assessment.

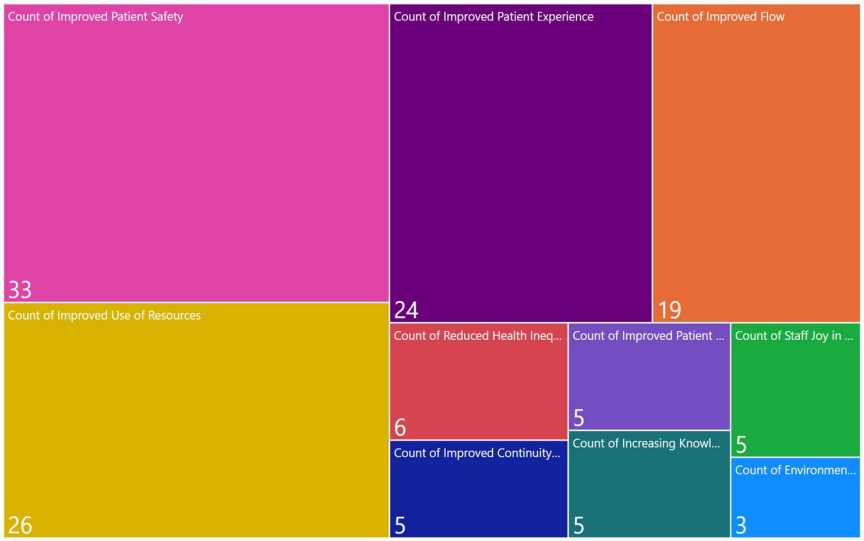
QI Programme project overview

At the end of January 2025, there were **84 active QI projects** across the Trust.
55 projects have shown special cause improvement, 49 of these have been completed and the remainder are still active, working towards improvement goals

Lewisham and Greenwich NHS Trust



Number of Active projects by theme



Definitions
Active= Live project (ongoing)
Completed= Projects that have completed with data to demonstrate improvement (minimum progress score of 3.5)

To note: the QI monthly report is in the process of being re-developed in PowerBI for a more automated, interactive report and therefore looks visually different from previous reports.
Changes to highlight: 1)Removal of cancelled projects- this will be reported and monitored through divisional DGBs
2)Threshold for a completed project increased from 3.0 (anecdotal evidence for improvement) to a score of 3.5 (special cause improvement evidenced by data)

3. Caring

We must ensure that people are treated with compassion, kindness, dignity and respect. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Friends and Family Test
- Patient Experience workstreams

Outstanding Characteristic: *People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.*

Caring Key Performance Indicators

Lewisham and Greenwich NHS Trust

Inpatient Positive Score	Community Positive Score	A&E Positive Score	Maternity Positive Score	Outpatient Positive Score
95%	96%	69%	93%	94%
This has remained above 90% target	This has remained above 90% target	This remains below 90% target	This has remained above 90% target	This has remained above 90% target

Caring

		Reporting Period														
	Metric Title	Key Target	Level	Target	(Last Year) 2022-05	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	Sparkline (YTD)
A&E Care	FFT ED Response Numbers					1452	824	1295	11331	1223	1061	1061	1127	1152	1048	972		
	FFT ED Response Rate %				4.58%	7.00%	4.42%	6.32%	6.00%	5.90%	5.86%	5.47%	5.58%	5.67%	5.09%	5.01%		
	FFT ED Recommend %				66.91%	63.00%	64.34%	68.88%	73.00%	73.83%	76.53%	70.69%	72%	68%	68%	69%		
Community Care	FFT Adult Community Response Numbers					319	468	478	413	419	373	263	646	743	592	747		
	FFT Adult Community % Recommended				96.59%	91%	100%	99.32%	98%	97.76%	96.67%	98.50%	98%	96%	97%	96%		
	FFT Childrens Community Response Numbers					38	79	79	38	78	49	44	39	38	47	54%		
	FFT Childrens Community % Recommended				98.18%	96%	98.73%	98.73%	97.37%	94.87%	95.92%	95.18%	100%	95.00%	100%	94.44%		
Admitted Care	FFT Inpatient Response Numbers					1953	1503	1867	1783	1964	1971	1910	1893	1831	1596	1838		
	FFT Inpatient Response Rate				38.0%	29%	23.20%	27.90%	27.84%	29.10%	31.40%	25.00%	28.48%	28.55%	25.80%	30.80%		
	FFT Inpatient Recommend % - LGT				95.23%	95%	93.59%	95.02%	96.00%	96.54%	95.38%	95%	95%	95%	97%	95%		
Outpatient Care	FFT Outpatient Response Numbers					5964	3963	5546	5403	5304	4836	4960	5552	5034	4511	5194		
	FFT Outpatient % Recommended - LGT				92.18%	93.00%	92.50%	92.50%	93.00%	93.02%	93.11%	92.46%	93%	93%	94%	94%		
Maternity Care	FFT Maternity Response Numbers					263	185	272	253	213	217	166	337	298	228	225		
	FFT Maternity Composite % Recommended				90.53%	92.00%	95.22%	95.22%	92.00%	92.49%	95.39%	95.78%	93.00%	95.00%	92%	93%		
	Percentage of Maternal Readmissions after Vaginal/Instumental Birth	✓	EA	3.00%	1.20%		1.11%	0.96%	1.15%	2.27%	1.88%	1.44%	2.17%	1.49%	1.11%	1.08%		
	Percentage of Maternal Readmissions after Caesarean Section Birth						3.07%	3.77%	3.17%	2.27%	2.26%	2.87%	3.56%	3.05%	2.84%	1.91%		
	Ante-Natal Bookings by 10 Weeks - % of Total Bookings						68.73%	71.04%	70.59%	68.97%	70.11%	64.76%	71.80%	70.74%	74.48%	66.22%		
	FFT Maternity Response Rate Composite				3.87%	11.00%	10.93%	10.93%	11.00%	8.62%	9.51%	7.30%	13.19%	12.74%	9.91%	9.42%		

Patient Experience Summary report

The Patient Experience team are developing an FFT dashboard to triangulate key themes for action alongside response rates for monitoring.

Lewisham and Greenwich NHS Trust

	Number of responses*				Percent very good/ good				Percent poor/very poor					
Division	2024 Nov	2024 Dec	2025 Jan	Trend	2024 Nov	2024 Dec	2025 Jan	Trend	2024 Nov	2024 Dec	2025 Jan	Trend	Positive themes	Negative themes
Allied Clinical Services	2,514	2,500	2,484	↓	94.47%	94.81%	94.97%	↑	2.39%	2.82%	2.50%	↑	Professional & Competent, Friendliness, Waiting, Emotional & Physical support	Waiting, Emotional & Physical support, Politeness, Feeling safe
QEH Medicine	1,502	1,254	1,240	↓	86.75%	84.86%	85.08%	↓	8.66%	10.10%	8.15%	↑	Professional & Competent, Compassion, Emotional & Physical support, Helpfulness	Waiting, Emotional & Physical support, Quality of treatment and care, Comfort
Surgery	2,236	1,889	2,318	↑	92.58%	92.68%	92.84%	↑	4.11%	4.28%	3.75%	↑	Friendliness, Professional & Competent, Compassion, Emotional & Physical support	Waiting, Emotional & Physical support, Pain, Comfort
UHL Medicine and Community	1,625	1,357	1,620	↑	86.15%	88.81%	87.90%	↓	7.26%	6.37%	6.05%	↑	Compassion, Professional & Competent, Emotional & Physical support, Friendliness	Waiting, Emotional & Physical support, Pain, Comfort
Women's, Children and Sexual Health	1,027	902	1,111	↑	88.70%	87.63%	81.81%	↓	7.40%	7.63%	4.23%	↑	Compassion, Emotional & Physical support, Friendliness, Professional & Competent	Waiting, Comfort, Pain, Emotional & Physical support

Actions to increase returns and satisfaction scores

Returns

Monthly meetings are ongoing with Matrons and Ward Managers to review feedback and explore approaches to increase returns and or sustain their increased returns.
The manager of Oak Ward has set up a dedicated WhatsApp group for staff to communicate with each other. The platform is used to remind all staff to offer the FFT survey to patients as well as reminders in the daily huddles. Historically, this has always fallen to the ward clerk to have sole responsibility for FFT completion.

Satisfaction scores

- Monthly meetings are established with matrons, ward managers and other staff to review feedback and identify opportunities to make improvements.
- Patient Experience Officers met with the new Ward Manager of Maple and the New Matron for CYP at UHL to discuss patient experience, FFT and You Said We Did (YSWD).
- Real time feedback survey commenced on wards 14,17, 19, Alder and Juniper (similar questions to those in the FFT survey which is reported monthly)

Ongoing work - (Patient Experience team input)

- Supporting volunteers to gain confidence to undertake the real time survey independently on the adult inpatient wards that joined the first phase of Compassion in Care
- Co-ordinating engagement and enter and view visits for the Healthwatch groups cross sites.
- Recruiting patient/carer reps to support the Palliative Care team with their service review of support offered to bereaved families, carers and significant others.
- An advert was set up on Eventbrite promoting a webinar for teenagers with asthma who are transitioning to adult services.
- Attended handover on Cherry ward to discuss patient experience, including importance of capturing FFT feedback and issues around food and drink
- Finalising the draft criteria and certificate to recognise services with sustained improved FFT satisfaction scores, return rates or new initiatives to improve the experience for patients.
- Working with the QEH Theatre team to capture more feedback through the use of QR codes, lanyard cards and posters
- The Patient Experience team met with the Roald Dahl CNS for teenagers and young adults from Barts Health NHS Trust to learn more about how they engage in projects to improve patient experience and what we can learn from them and possibly implement with the LGT Youth Board.
- FFT surveys with bar codes were implemented to make logging against the correct service more efficient. Demographics updated to reflect the most recent census.
- Working on a new maternity FFT solution to incorporate the Cultural Humility questions into the FFT survey and remove the need for a separate survey.
- Four (4) new bespoke surveys were created, two (2) for ACS (MAGS and sickle cell) and two (2) for CYP one of which will be hosted on the Patient Portal.
- Four (4) You Said We Did poster were created in response to patient feedback, one (1) for UHL Medicine division and three (3) for the maternity directorate .

4. Responsive

As an organisation we must ensure we are responsive and that services meet people's needs. Our overall performance in this area over the past month is summarised by our Trust-wide Scorecard.

For further assurance we then provide additional data and analysis on:

- Complaints and PALS
- PHSO Cases
- Actions and Learning from complaints
- Compliments

Outstanding Characteristic: *Services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.*

Responsive Key Performance Indicators

Lewisham and Greenwich NHS Trust

Complaints acknowledged within 3 working days	Complaints Response Rate	Number of reopened complaints	Overdue complaints
99%	77%	4	36%
This metric has remained above the 90% target.	This decreased from the 80% target	Over the past 6 months this has remained low.	This remains above the 15% target

Responsive

		Reporting Period			Monthly Performance												
	Metric Title	Key Target	Level	Target	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	Sparkline (YTD)
Complaint and PALS Management	Complaints - % resolved within agreed timescales (letter sent to complainant)				63%	67%	59%	49%	55%	83%	78%	70%	68%	80%	69%	77%	
	Complaints Opened in Month				105	116	89	104	117	90	91	95	103	116	129	118	
	Complaints Closed in Month				107	119	118	118	89	98	110	90	92	103	95	114	
	Complaints Reopened in Month				6	3	4	3	3	2	5	1	1	3	3	4	
	PALS Concerns Opened in Month				430	519	444	400	445	412	361	469	459	358	471	387	
	PALS Concerns Closed in Month					217	223	432	490	347	390	419	473	354	423	370	
	Number of Formal Compliments received				23	33	24	21	56	25	18	7	82	50	33	38	

Complaints Performance

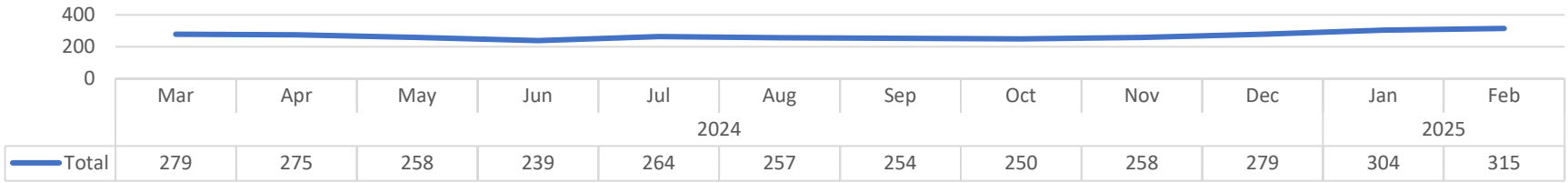
- The Trust received a total of **118** new formal complaints in **February 2025** which is a **decrease from January's figure of 129**. The average number of complaints received per month has now risen to 105 (at the end of Q3) from 78 per month in Q1 and 100 in Q2.
- The Trust closed a total of **114 cases in February 2025**. This is an increase from previous figure of 95 cases in January 2025. An audit is has been completed of a sample of closed cases in September 2024, to understand where the delays may be occurring. This will be presented to PEC in April 2025.
- The number of re-opened complaints remains low with **4 in February 2025** (3 in January 2025) indicating responses continue to be of high quality.
- The Trust open caseload for **February 2025 was 315**. Q3 has seen a gradual increase in the number of open complaints; October's figure of 250, November's figure of 258, December's figure of 279 and January's figure of 304. In line with winter pressures this is to be expected.
- Continued focus on reducing complaints backlog to reduce to less than 15% overdue. The current percentage of complaints overdue was 36% (n=116) on 03.03.25.
- The top three complaints themes are **Clinical Treatment, Values & Behaviours (Staff) and Patient Care**. This is similar to last month's themes and breakdowns.

Learning/Actions

NHS
Lewisham and Greenwich
NHS Trust

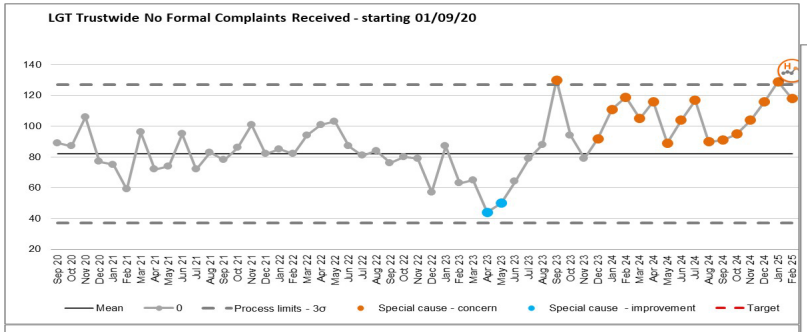
- PALS and Complaints automated reminders for all overdue PALS and Complaints cases are helping Divisional oversight of PALS and complaints with the escalation and closure of most overdue cases.
- The PALS web platform greatly improved data quality and ongoing monitoring of this continues. This will help triangulate of themes for Trust overview and improvement.
- Mapping of complaints data against Trust activity (per attendance) has been completed for ED on both sites. Trust overall data and activity has been received via the BI Hub. This has been included in the Trust Complaints Annual report.
- Focused work has commenced in September 2024 in regards PHSO processes. PHSO process mapping has been completed as well as PHSO training for the complaints team. Draft guidance and processes around financial remedy are being further developed and scoped.
- Complaints policy remains under review and is in the process of being updated, including best practice around consent. The first draft has been compiled and is currently being reviewed by the governance teams.
- PALS and Complaints Training dates for 2025 have been finalised with Learning and Development team. These will be advertised shortly. Training delivered to date has been attended by approximately 60 staff (since October), with the majority of feedback being positive.

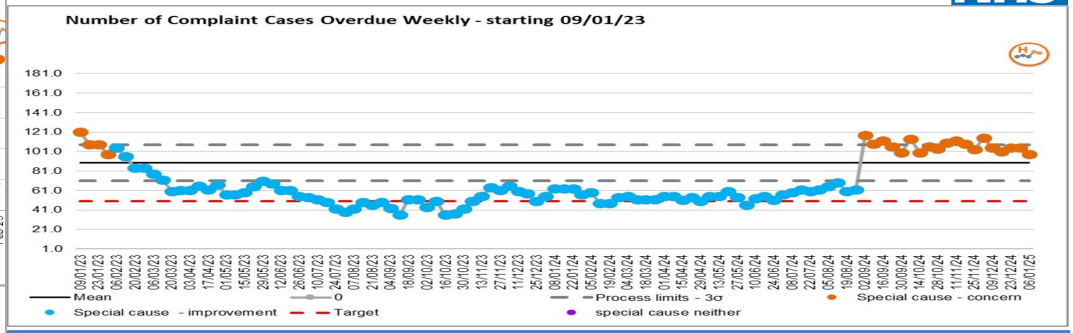
Trustwide Open Caseload Per Month

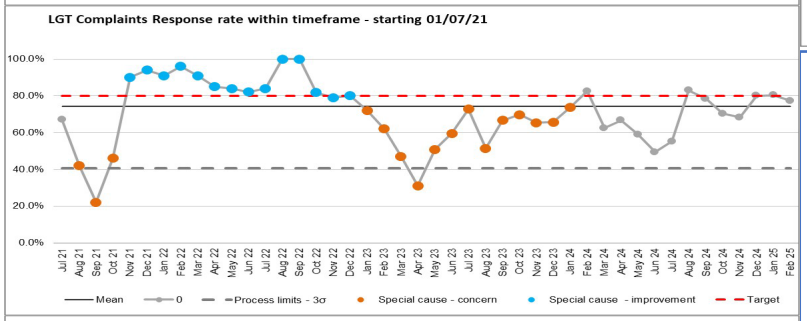


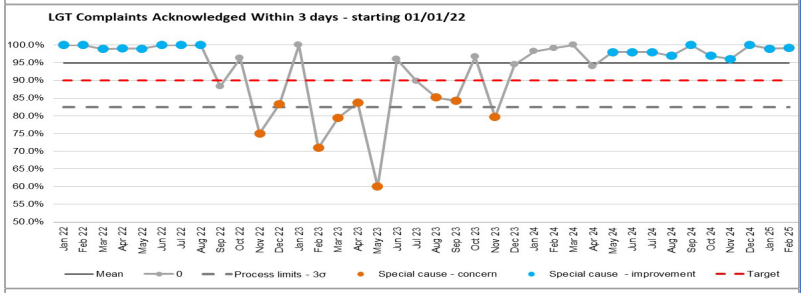
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
	2024										2025	
Total	279	275	258	239	264	257	254	250	258	279	304	315

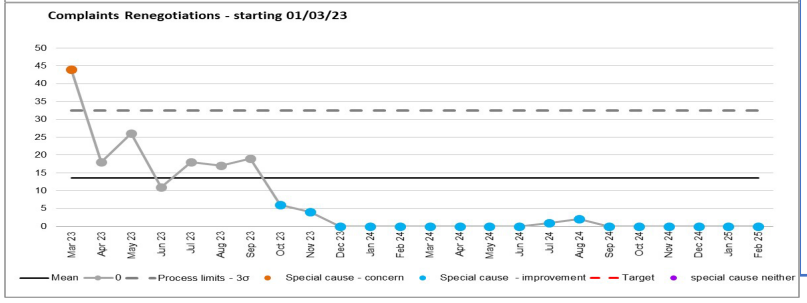
Complaints Performance











New Complaints

The number of new complaints for February 2025 (n= 118) has decreased from previous month's figure of 129 in January 2025. Overall, the number of Trust new complaints has risen significantly, this is indicated by the orange dots representing special cause concern. The numbers of re-opened complaints remains low with just 4 in February 2025, there were 3 re-opened complaints in January 2025. The overall figure is low indicating that the standard of response is high quality, and more complaints are being dealt with effectively. Complaints acknowledged within timeframe for January was 99% which is above the target. The previous month of December was 100% of complaints were acknowledged within the 3 working day timeframe.

Response Rate

The response rate for February 2025 is 77% which is an decrease from 80% in January 2025. The longest open complaints continue to be progressed, the oldest complaint as @ 3.3.2025 was 298 days. There have been no renegotiations since September 2024. This represents a truer picture of the Trust response rate. There were only 3 exceptional cases considered for Executive approval in July/August 2024, all of which were approved. Renegotiations should be only be permitted in the most complex of cases and the process around granting of these is being tightened. Renegotiations data will continue to be closely monitored to provide oversight and assurance. *To note this data is for any complaints showing as closed. This does not include complaints that were due within the above timeframes but have not yet been resolved. This data also includes cases which have been previously renegotiated before the internal change in process.

Overdue Complaints

There has been statistically significant improvement seen in the numbers of overdue complaints. The current percentage of complaints overdue was 36% (n=116) on 3.3.25. *Please note, the recent noted increase is due to a change in operational measures with the inclusion of Level 2 complaints, that have become overdue that are now included in the redesigned Sitrep.

Renegotiations

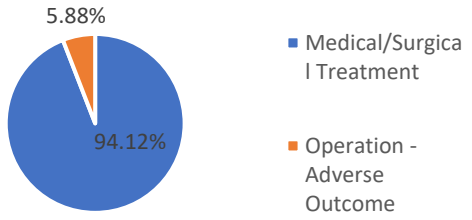
There was zero renegotiations from December 2023- July 2024. There was 1 request in July 2024 (QE Medicine) and 2 requests in August 2024 (ACS and LMC Medicine & Community). All 3 renegotiation requests were appropriate and related to exceptional circumstances. These were discussed with Complaints manager/ Head of Patient Safety & Experience in advance prior to DDNG sign off. All three were approved by Chief Nurse. This means continued focus on ensuring original deadlines are met and responses shared with complainants and families.

Renegotiations are only be permitted in the most complex of cases. As of April 2024, any renegotiations will require Executive approval and this process is being followed.

Top 3 Overarching Themes for All Complaints (March 2024 - February 2025)

Lewisham and Greenwich NHS Trust

Clinical Treatment - Highest Overarching Theme

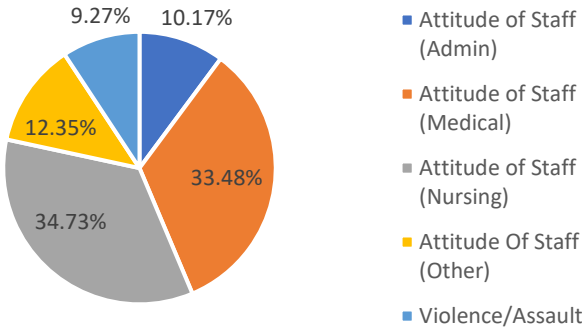


Clinical treatment – now *top Trust theme this month

1. Clinical Treatment

- Medical/Surgical treatment (94.12%)
- Operation- adverse outcome (5.88%)

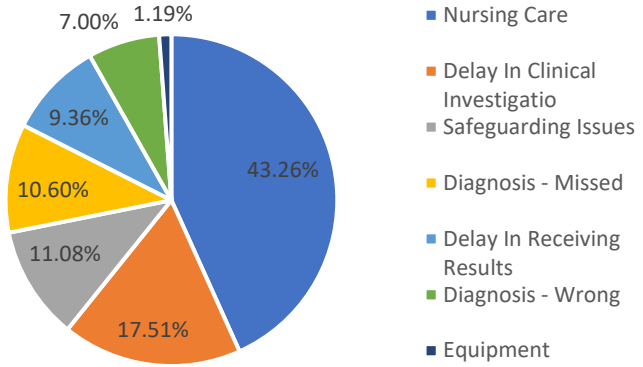
Values and Behaviours (Staff) – 2nd Highest Overarching theme



2. Values & Behaviours (Staff)

- Attitude of nursing staff (34.73%)
- Attitude of medical staff (33.48%)
- Attitude of other staff (12.35%)
- Attitude of admin staff (10.17%)
- Violence and assault (9.27%)

Patient Care – 3rd Highest Overarching Theme



3. Patient Care

- Nursing Care (43.26%)
- Delay in clinical investigation (17.51%)
- Safeguarding Issues (11.08%)
- Diagnosis - Missed (10.60%)
- Delay in receiving results (9.36%)
- Diagnosis – Wrong (7.%)
- Equipment (1.19 %)

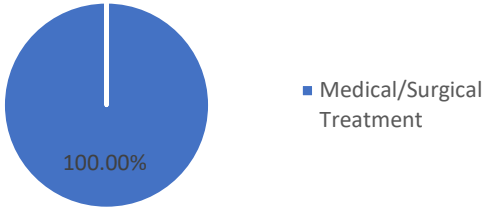
*These top three themes and percentage breakdowns are very similar to last month's figures, apart from a change in third position from communication last month to patient care.

****Improvement work underway includes: Quality Rounds, Compassion in Care Programme, Values & Behaviours Trust work, Flow and Outpatient Improvement work.***

Top 3 Overarching Themes for Complaints- ED Only (March 2024 - February 2025)

Lewisham and Greenwich NHS Trust

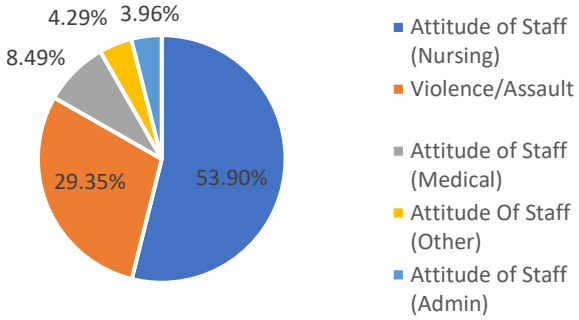
1.Clinical Treatment



1. Clinical Treatment

- Medical/surgical treatment (100%)

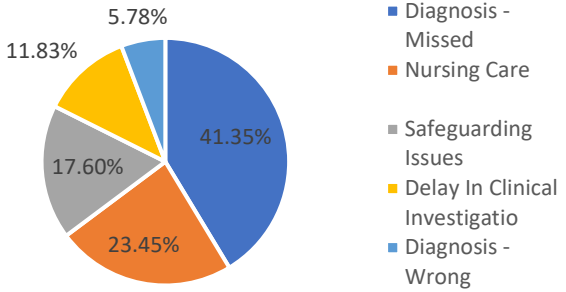
2.Values and Behaviours (Staff)



2. Values & Behaviours

- Attitude of nursing staff (53.90%)
- Violence and assault (29.35%)
- Attitude of medical staff (8.49%)
- Attitude of other staff (4.29%)
- Attitude of admin staff (3.96%)

3. Patient Care



3. Patient Care:

- Diagnosis – Missed (41.35%)
- Nursing Care (23.45%)
- Safeguarding Issues (17.60%)
- Delay in clinical investigation (11.83%)
- Diagnosis – Wrong (5.78%)

***** These themes and breakdowns are very similar to previous month***

**Improvement work underway includes: Improving flow (QE Cares, Programme, SDEC), Values & Behaviours Trust work.*

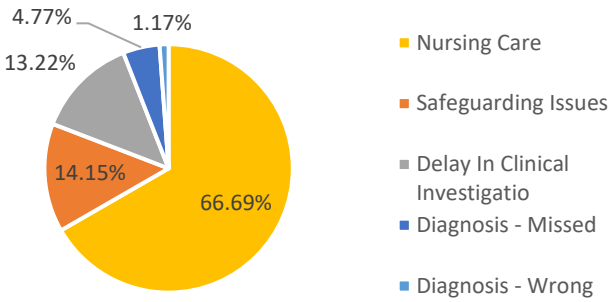
The top three themes for ED: are Clinical Treatment, Values & Behaviours & Patient Care.
While the themes of clinical treatment & values behaviours hold the same position as the previous month. In January patient care has now moved to third. A small deep dive of complaints (5) relating to clinical treatment reveal:

- **Clinical Treatment**: Concerns raised that care plan/protocol was not followed in the first 48 hours the patient was in ED.
- **Values & Behaviours:** Attitude of administrative and medical staff.
- **Patient Care:** Delay in the administration of medication, appropriate diabetic care and support not provided.

Top 3 Overarching Themes for Complaints- Inpatient Only (March 2024 - February 2025)

Lewisham and Greenwich NHS Trust

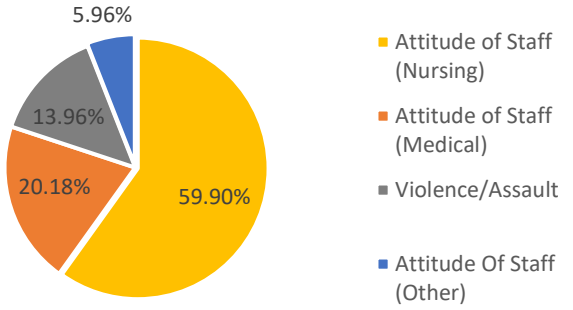
1.Patient Care



1. Patient Care:

- Nursing Care (66.69%)
- Safeguarding Issues (14.15%)
- Delay in Clinical Investigation (13.22%)
- Diagnosis missed (4.77%)
- Diagnosis wrong (1.17%)

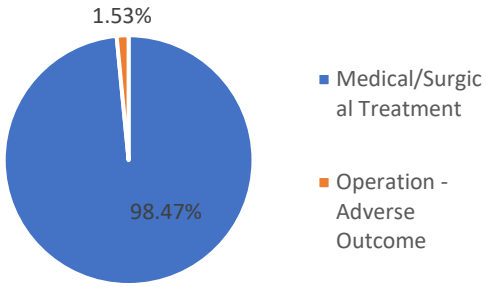
3.Values and Behaviours (Staff)



3. Values & Behaviours:

- Attitude of nursing staff (59.90%)
- Attitude of medical staff (20.18%)
- Violence & assault (13.96%)
- Attitude of other Staff (5.96%)

2. Clinical Treatment



2. Clinical Treatment

- Medical/Surgical Treatment (98.47%)
- Operation- adverse outcome (1.53%)

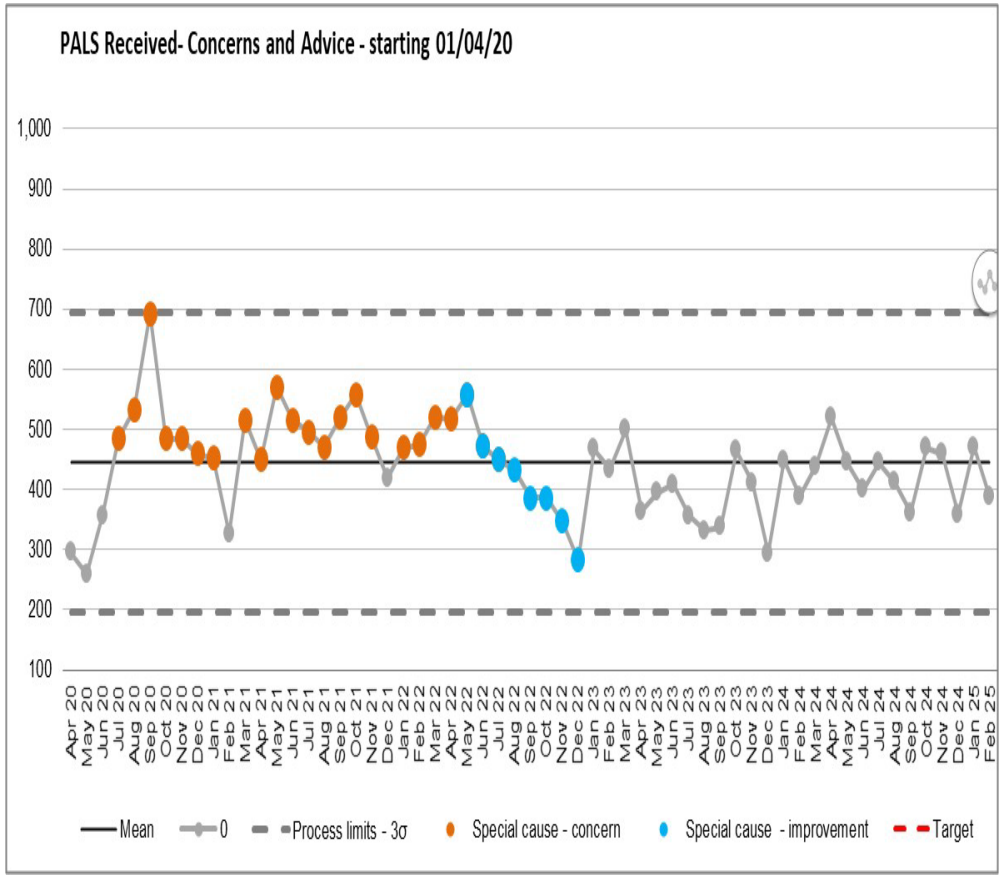
The top three themes for Inpatients are Patient Care, Clinical treatment & Values & Behaviours. These are the same themes as last month.
A small deep dive of the top theme Patient Care (5 complaints) show that the themes relate to:

- **Patient care:** Care provided failed to diagnose condition, delay in diagnosis of cancer.
- **Values & Behaviours:** staff member refused to identify self, inconsistencies in information provided.
- **Clinical treatment:** concerns about management of blocked stent and pain not managed adequately.

**** Improvement work underway includes: Compassion in Care programme, Quality Rounds, improving Together Accreditation, early resolution of PALS & Complaints, Values & Behaviours workshops.***

PALS Performance

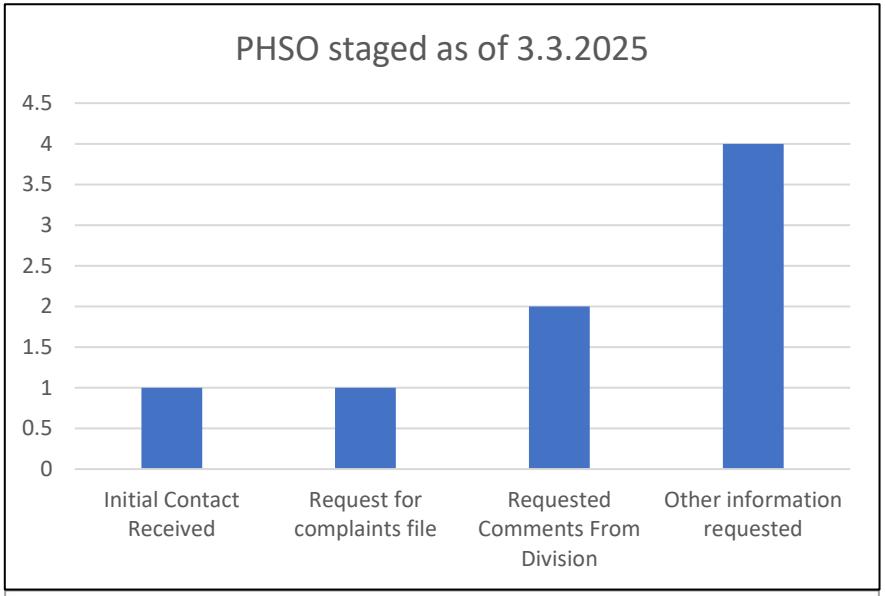
Lewisham and Greenwich NHS Trust

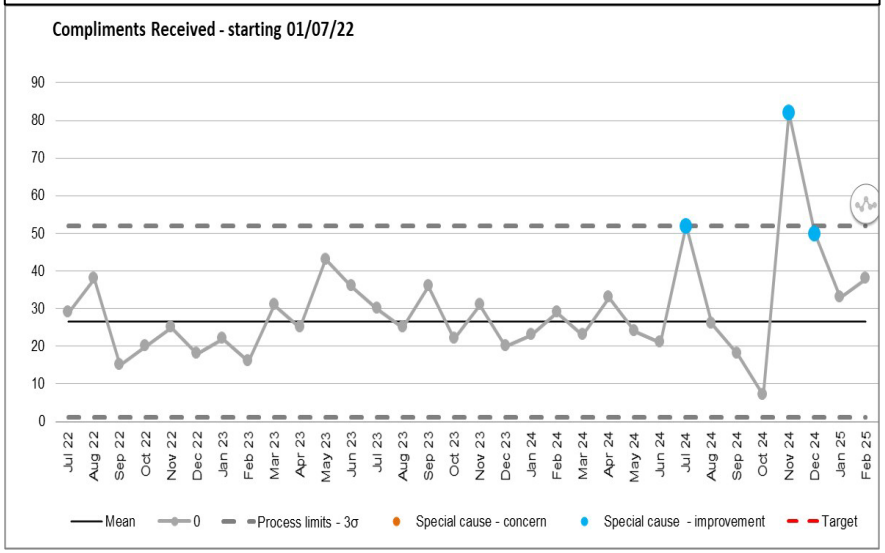


- The number of PALS (both concerns and advice) received by the Trust for February was 387 which is a decrease from January's figure of 471.
- There was a total of 370 PALS closed in February 2025, which is an decrease from previous figure of 423 in January 2025.
- PALS auto chasers have also helped in regards progressing of cases. Bi- weekly reports are shared with PALS case officers and reports also shared with the areas with highest number of PALS open cases such as ENT and Outpatients.
- The response target is for PALS concerns is to be acknowledged and resolved within 5 working days.
- There are actions underway to start measuring this data and setting targets around improved timeliness of responses. This is to commence from July 2025.

Lewisham and Greenwich NHS Trust

PHSO Stages Data





PHSO Cases

This data is from the PHSO based on current PHSO stages as of 3.3.2025

- Initial contact received- 1
- Request for complaints file - 1
- Other information requested- 4
- Requested comments from Division- 2

PHSO Outcome decisions received in February 2025

- One complaint investigated and final report received for joint complaint for LGT and GSTT
- PHSO decision to partially uphold complaint
- LGT to provided apology for management of joint complaint
- LGT to develop action plan regarding management of complaints that involve other organisations.

Interventions underway:

- New weekly PHSO Actions report shared with complaints team- to help Divisions meet deadlines.
- PHSO Outcomes report in progress and monthly checking of all cases with Complaints team and/or PHSO.
- PHSO review of processes initial work commenced. This review has included review of data, Ulysses review, process mapping and review of policy and guidance for decision making around financial remedy.

Compliments Received

This is the number of compliments that are received centrally to Complaints team. The figure for February is 38 which is an increase from January's figure of 33. The average is around 30 compliments a month but the true figure is probably much higher as some areas collect own local data.

The process of logging compliments across the Trust is being reviewed to improve capture and system functionality on Ulysses.

5. Well-Led

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

In this section we examine whether the actions we are taking to support the Quality of the organisation are having the necessary impact.

For further assurance we then provide additional data and analysis on:

- Trust wide policies

Outstanding Characteristic: *The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.*

Well-led Key Performance Indicators

Lewisham and Greenwich NHS Trust

Mandatory Training	Safeguarding Training (L3)	Policies in Date – Trust wide
94%	90%	71%
This has been above the 90% target for the past 6 months.	This has achieved the 90% target.	The overall Trust position has improved by 0.5% in February 2025. 71.5% (n=224) policies, are in date. 89 have expired.

Well Led

		Reporting Period			Monthly Performance												
	Metric Title	Key Target	Level	Target	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025 -02	Sparkline (YTD)
	Temporary Staffing Spend - Bank					10.13%	11.28%	13.86%	11.76%	10.03%	11.41%	10.00%	13.34%	12.39%			
	Temporary Staffing Spend - Agency					4.68%	2.27%	2.67%	3.59%	3.53%	3.35%	2.57%	3.05%	2.78%			
	Mandatory Training Safeguarding			90%	95.89%	95.89%	95.89%	95.89%	95.89%	95.89%	95.89%	94.13%	94.22%	94.04%			
	Mandatory Training Compliance - Trustwide			90%	95.33%	95.33%	95.33%	95.33%	95.33%	95.33%	95.33%	95.00%	94.00%	93.54%	94.00%	94.00%	
	Mandatory Training Compliance - Maternity					89.55%	89.67%	89.13%	89.60%	89.65%	89.78	89.07%	89.34%	88.33%			
	Children Safeguarding Training Compliance (level 3)					89.88%	90.86%	92.37%	92.51%	91.20%	89.79%	90.19%	89.82%	90.43%		90.00%	
	Percentage of Trust wide Policies in date			90%	68%	67%	67%	67%	66%	65%	65%	67%	68%	67%	71%	71%	

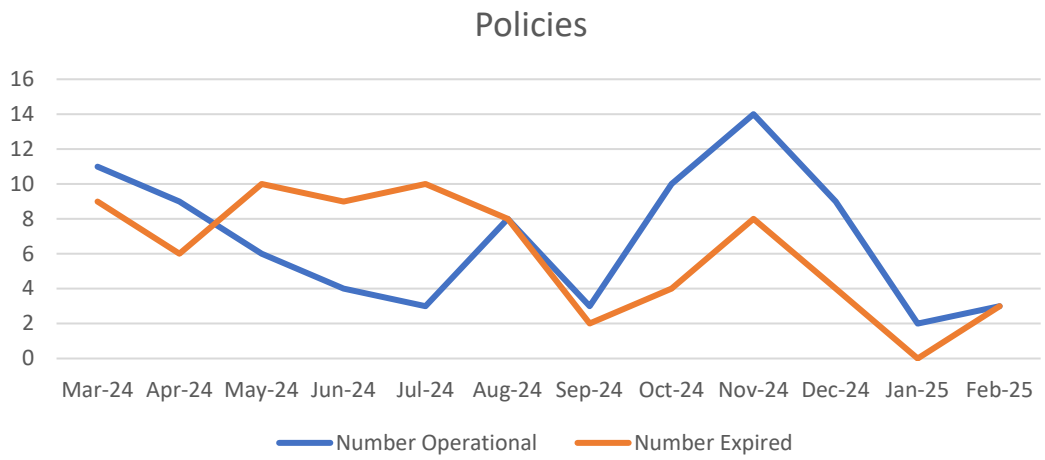
Policies in Date – Trust wide

Lewisham and Greenwich NHS Trust

Policies Expired – Divisional Breakdown

Division	Dec-24	Jan-25	Feb-25	Movement
Allied Clinical Services	12	12	12	⟷
Chief Nurse and Clinical Quality	33	33	34	↑
Chief Medical Officer	1	1	1	⟷
Corporate Affairs	2	2	1	↓
Estates and Facilities	7	7	7	⟷
Finance	0	0	0	⟷
Information Technology	0	0	0	⟷
Media, Communications and Engagement	2	2	2	⟷
Performance and Business Intelligence	1	1	1	⟷
QEH and LMC Medicine	4	4	2	↓
Site Operations	4	4	3	↓
Surgery	1	1	1	⟷
Women's, Children and Sexual Health	2	2	2	⟷
Workforce	22	21	21	⟷
Totals	91	90	89	↓

Policies	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Number Operational	11	9	6	4	3	8	3	10	14	9	2	3
Number Expired	9	6	10	9	10	8	2	4	8	4	0	3



The Quality Assurance Team is continuing to work with divisional leads to provide support in the review and update of Trust policies where these have expired.

The Procedural Documents Review Group meetings are scheduled monthly to provide an additional forum for existing Trust policies to be approved and ratified to expedite the review process between monthly Trust committee meetings where documents are ready for review.

Supporting Information

SPC definitions

Statistical Process Control (SPC) charts allow you to identified statistically significant changes in data. The SPC confidence (or process) limits represent the expected range for data points if variation is within the expected limits. A number of rules have been applied in line with the NHSE SPC approach to identify when indicators are showing special variation. Each rule is calculated using the latest month values.

Common cause variation
Indicator has not triggered any SPC rules for current month

Special cause variation – single point
A single point outside the SPC confidence limits (mean +/- 3 sigma)

Special cause variation – trend/shift
A run of 7 points above or below the mean (a shift), or a run of 7 points consecutively ascending/descending (a trend)

Special cause variation – moving range
There is a large change in the moving range (greater than 3.27 & average moving range)

Special cause variation – 2 of 3
2 out of 3 points are within 1 sigma of the upper or lower confidence limit

Lewisham and Greenwich NHS Trust

Trust Board

Title: M11 – Performance Report

Date of meeting: 25 March 2025

Summary of paper:

Referral to treatment times (RTT) – January actual, February forecast

The total trust waiting list fell by 2,282 to 63,424 in January part of a trend of continuous improvement since October and this is expected to fall further in February, with the unvalidated position currently at 63,742. The number of patients over 18 weeks also reduced from 28,044 to 27,190 (-854) this follows the same improvement trend since October and is expected to continue into February, with the unvalidated position at 28,150 at the time of writing.

The number >52-week pathways rose from 2,482 to 2,641 in January, stopping a trend of reduction since October, but still significantly lower than the 3,171 in October. A modest reduction is expected in February. Both 78 and 65 weeks require further validation, but we are expected to report approximately 270 65-week breaches and 25 78-week breaches for the end of February, which is a small reduction from the January position (296 65-week and 33 78-week breaches), but keeps us amongst the lowest performing trusts in London for long waiters.

Average wait to first appointment across the Trust dropped to 13 weeks at the end February from 15 in January. This is a continued improvement from 21 weeks in March 24. There remains significant variation between specialties with some services having waits above 30 weeks. Average wait to routine first appointment is 21 weeks down from 22 weeks in January and showing a continued improvement since March which was 28 weeks. The Trust total referral volumes remain consistent with 23/24 out-turn.

The Trust is currently forecasting approximately 25 78-week breaches at the end of March. The number of 65-week breaches is expected to be approximately 150 (66% ENT). There remains a sizeable capacity deficit within ENT and further actions/support are planned to redress this capacity deficit (see below). The speed at which LGT will deliver zero 65 weeks is contingent on a number of actions being delivered as part of the H2 plan and further Elective Recovery plans developed in Q3/Q4.

Closures of theatres due to generator issues in early 2025 significantly hampered progress against the long waiter position. Increased pressures through the emergency care and cancer pathways accompanied by increased demand on diagnostics have impeded progress in some areas.

Overall RTT performance against 18 weeks declined slightly to 57.1% from 57.3% in line with national performance but lower than London average. The unvalidated position for February, suggests that we will maintain this level of performance. This in part is driven by the reduction in overall PTL size rather than a deterioration although, as above, long waits remain a significant challenge. The Trust target for 25/26 is to achieve a minimum of 61.4% by March 26.

Our 52-week performance will be monitored from 2025/26 and, whilst our local target is still under consideration, the national target is that fewer than 1% of patients should be waiting for more than 52 weeks for treatment by March 2026. Our unvalidated performance for February 2025 is 4.7%.

Key actions in progress:

ENT:

- Additional insourcing of surgical capacity ongoing, with lists planned throughout March
- Options to outsource to an external provider are currently being considered.

- One locum consultant has been appointed and is starting in April 2025. A further 3 ENT consultant posts are in the process of being recruited to, with an interview panel scheduled for 26th March 2025.
- Partial booking technical issues have now been resolved, with the first part of the robotic process automation having been completed successfully in early March. Impact of this will be realised from June onwards.
- MRI and CT capacity at Eltham Community Diagnostic Centre will ease the diagnostic demand pressures.
- Increased utilisation of community ENT service; joint working ongoing with the community service provider to maximise use of the service and opportunities for transfer.
- Reevaluating the community contract along with SEL ICB, to identify diagnostic requirements.

Vascular:
- Additional insourcing operationalised for both surgical cases and outpatient capacity has been running since December 2024.
- Transfer to GSTT now partially complete. Admit patients, completed in February 2025 and non-admit patients to be completed by the end of March.
- Insourced non –RTT PTL validation work to support transfer of service to GSTT completed in February 2025.

T&O:
- Continued insourcing of surgical capacity throughout Q4 2024/25
- Intensive review of the pre-assessment pathway for T&O patients to ensure fitness for surgery, particularly for joint replacements.

General Surgery:
- Weekend insourcing recommenced in has continued throughout Q4 in line with Board approved elective recovery paper.
- Optimising capacity available at QMS.

Gastro:
- Running additional long-waiter clinics throughout Q4 in line with Board approved elective recovery paper.

Gynae:
- Additional internally provided capacity coupled with insourcing for Uro/gynae outpatient capacity commenced December 2024.
- Continuation of the ‘Physio First pilot.
- Establishment of a temporary space to enable additional hysteroscopies is being scoped in QE Day Theatre.
- Optimising capacity available at QMS.
- Additional emergency insourcing linked to vacancies and sickness.

Theatres and anaesthetics:
- Continuation of insourcing arrangement for anaesthetic cover to reduce cancellations of lists due to anaesthetic shortages; additional operational management resources to strengthen capacity
- New senior pathway coordinator roles have been established and are progressing through recruitment processes. These are now in post.

Cross-cutting:
- Insourced validation of long waiters underway, with 9000 patients to have had pathways additionally validated by the end of March 2025
- Revised governance and assurance structure to manage RTT launching incrementally throughout Q4 and into Q1. Phase 1 launched in February 2025.
- This includes an Elective Improvement strand focussing on areas identified in the National Elective Reform plan, plus additional focus on ENT, Gynae and Gastro.

Diagnostics – January actual, February forecast

The DM01 position for January was 83.8%, which marks the third consecutive month of our position declining, and a 12.5% fall from our position in October. This, however, is only a 0.3% reduction from the December position

- Urodynamics from 68.2% down to 62.2%
- Echocardiography from 96.6% down to 94.8%
- Barium Enema from 100% down to 97.4%
- Non obstetric Ultrasound from 81.7% up to 74.7%
- MRI from 83.5% down to 74.7%
- Endoscopy modalities from 80.8% down to 75.7%

The DM01 position for January was 83.8% a slight reduction from December (-0.3%). This continues to be driven by deteriorating performance in MRI 74.7%, NOUS 86.3%, Colonoscopy 76.2, Gastroscopy 63.7%.

Note since October this has included the planned patients for endoscopy not seen on their due date (additional 75 over 6 weeks). The remaining modalities will be added from March which is currently forecast to further impact the position by around -2%.

The deterioration has been caused by increased demand for radiology and endoscopy due to pressures on cancer, UEC and RTT pathways. Endoscopy have run additional sessions throughout February and continue to do this in March where we expect to see an improvement in our position.

Trust performance remains better for DM01 than the London average of 77% and national average of 77.2% but is a significant reduction from the Trusts average before March of 95%.

Cancer – December actual, January forecast

Our current position for Faster Diagnosis Standard (FDS) December is 73.4% a slight improvement from November of 0.4% continuing a trend of performance above 70% since September. Early forecast is that January will decline to 67% with some backlog patients being treated as treatments are higher than trend. Key services for improvement are Lower GI 51.8%, Head and Neck 57.7% and Other 56.9%.

62-day performance in December was 70.2% a slight reduction from 70.7%. Early indication for January is 69-70% holding the current performance trend. Performance is slightly lower than the London and national averages of 73.6% and 71.3% respectively but above Southeast London of 66.8%. Key services for improvement are Gynae 0%, Head and neck 13.3%, and Lower GI 45.8%.

31-day performance declined to 93% from 96.2% not meeting the national standard of 96%. Early forecast for January are that performance will be 94%. Performance remains slightly better than the national average of 91.5% but below London average although had been higher the previous five months.

The performance targets for March 26 are to achieve 80% for FDS and 75% for the 62-day standard.

Head and Neck - Continued increase in referrals since April (+19% compared to 2023–24), competing with RTT demand. Only three consultants currently able to manage 2WW cases; however, an additional consultant has been recruited. A new consultant sonographer, specialising in the H&N pathway, is now in post, enhancing diagnostic capacity (including increased one-stop scanning) and supporting advanced training for sonographers. Protected slots will be in place from 10 March 2025, with 20 slots per week allocated to the service

Lower GI - Colorectal FDS performance has shown a slow decline in 2024–25. A deep dive with SELCA has been completed, focusing on pathway improvements such as incorporating pre-assessment into clinical triage (TAC) and implementing same day staging CT (introduced on 27 December). Efforts are underway to improve consistency in clinical capacity (particularly TAC and endoscopy) and to address diagnostic shortfalls, including gaps in the bowel cancer screening service. Slower recovery expected for Lower GI performance.

Urology - Significant drop in Urology FDS performance since October 2024 due to workforce challenges. No immediate solution: options are being explored internally and with SELCA. An insourcing company is being engaged to establish a TP biopsy service with a focus on nurse-led training.

Intensive COO-led/Deputy COO-led monitoring is in place to ensure delivery of recovery actions and escalation of key risks. Tumour group services are working to updated performance standards (tumour group) specific to support delivery of FDS standard overall.

As well as ongoing focus on FDS improvement to drive quicker diagnosis to support earlier treatment, additional recovery actions are in place at a tumour group level across Lower GI, Prostate and Lung. This includes:

- Introduction of earlier diagnostics to expedite treatment plans (e.g. commencement of same day staging in Lower GI)
- Additional clinical capacity for constrained parts of a tumour group treatment pathway (e.g. TP biopsy in urology)
- Utilisation of other sector capacity for more complex imaging (e.g. PET-CT capacity from QMS – Sidcup)

UEC – January actual, February forecast

Trust ED performance improved to 64.9% in January from 64.1% in December and was the highest performance since August despite it being January and compared with January 2024 which was 62.2%. Performance rose at QEH from 59.7% to 61% and UHL from 69.3% to 69.6%. Indicative performance for February is 65.5% with the improvement being seen from the QEH site.

Both sites saw an improvement to their type 1 performance and were both significantly higher than previous January 24 levels (+7.8% QEH and +0.9% UHL). T1 has improved by a further 0.8% for February.

LAS activity has been increasing month on month and in January was 13% higher than the previous January. This has placed strain on the ED department where doubling up in ED cubicles and resus has become very common. Work is underway to improve communications and data recording with LAS.

Type 3 performance also improved in January to 88.2%, this was again the best performance since August and around 2.6% better than January 2024. QEH saw an improvement to type 3 performance improving from 89.3% to 93%. UHL saw a drop in performance from 86.3% to 83.7% but higher than January 24 which was 79.2%. UHL is expected to open the new UTC in March which will support further type 3 improvement.

12 hour stays in ED (from arrival to departure) reduced from 2,401 to 2,282 although remains high compared to previous months. The average number of patients without a criteria to reside reduced further from 136 to 128.

The number of patients without a criteria to reside reduced to an average of 128 patients per day in January, this has increased again in February to 137 but is significantly lower that 193 of February 2024. Work continues to ensure that we accurately report the proportion of these delays which are internally driven and within the gift of the trust to influence. A current estimate is that around 13% of UHL delayed patients have an internal delay and around 38% of QEH patients.

UHL context and headline actions

- LAS activity has been increasing month on month and in January was 13% higher than the previous January. This has placed strain on the ED department where doubling up in ED cubicles and resus has become very common.
- For T3 activity the trust has committed to an improvement to 95% alongside the timelines for the interim UTC unit to be created from March 2025.
- T1 non-admitted, the creation of an ED SDEC space and increased utilisation of the main SDEC space is the focus. Surgical pathways are being agreed. Rating at the front door commenced in early December.
- T1 admitted, the trust has agreed a full capacity protocol moving to triple boarding where possible and brokered agreement on the use of 6 beds on Sapphire ward for surge management. The next stage of the FCP has been signed off before Christmas and was implemented toward the end of January
- Flow matron and flow co-ordinators continue to support movement out of ED
- LAS direct to SDEC pathways continue to grow to support ED
- Discharge – a drop in P3 delays across January has supported the bed state each day
- Winter monies focusing on supporting discharge delays have been implemented.
- A focus on incentivising teams to reduced delayed discharges has generated a plan for increased Social Services and community therapy provision which commenced in January 2025.
- Internally a focus on red to green and ensuring patients are discharge ready is helping to ensure that the pressures are shared across the site.

QEH context and Headline actions

- T3 performance has improved but is not consistently hitting 95% 2 spaces have been provided to the UTC team for streaming, and there is a requirement to increase physical space need for streaming but also reduce the time to streaming through a review and adjustment of the model – monthly partnership board with GH led by DAS and LGT Health to work on QEH UTC performance and flow is showing positive signs. There are also signs of progress in terms of data sharing and interoperability. A local workstream co-led by LGT and GH will focus on best use of our collective resources.
- T1 non admitted – SDEC service change and increased pathways commenced on 4th November with an increase in consultant covered hours from January. The commitment in the case was to a trajectory to 9% performance improvement over coming months. The current calculations show that the unit is impacting performance positively by around 5% each day through 45 patients per day moving more quickly out of ED.
- T1 Admitted – Triple boarding occurring on a regular basis. Ward 26 now unlikely to come online until January 2026, hence rapid plans to more safely create 21 extra bedded capacity on Ward 22/23 were completed in January 24.
- High levels of norovirus in the community have impacted QEH site with around 20 bed spaces closed from late January to mid-February
- With support from our improvement programme team, a stocktake of current workstreams, alongside recommendations from NHSE, NHSE elect and other external visitor has helped up create a road map for UEC focus and set up a programme governance. The first QE UEC board took place at the end of January.
- AMU – model for maximised usage of the Ward 22/23 beds driving flow and efficiency is being worked up across MDT teams and with support from improvement programme managers. Workshop took place in January, business case to be submitted in March 2025.

- Support from imaging, pathology, surgery and portering to ensure more rapid pathways into and out of SDEC and AMU are all being garnered via weekly executive sponsored project boards.
- Discharge –TOCC winter posts appointed with start dates set for early February. Work on analysis of pressure points for discharge helping to highlight areas of opportunity.
- Work commissioned by monies from the Better Care Fund is underway between January and March with an aim to create a shared narrative on the issues to be resolved, a shared way to look at data and increasingly mature leadership leaderships.
- A focus on incentivising teams to reduced delayed discharges has generated a proposal for increased social services and increased access to step down and intermediate care bed commenced in January 2025 and is showing signs of success
- Focus on internally delayed patients and on weekend and criteria led discharge on the work plan for future focus.
- NHSE visit in December highlighted key areas for action to be completed within 1 week and one month, these cover actions which have been fed into our QE UEC Site plan, the key challenge being to create enough space in ED for patients to be seen rapidly by reducing the number of patients awaiting admission on any day by around 20. This challenged was raised again later in January with a request from ED consultants to free up 20 beds of patients from ED. Ongoing conversations to discuss and agree a way forward are underway.

LGT wide headlines:

- A renewed focus on the internal professional standards and the need for the Trust to own the 4 hour standard as a whole Trust responsibility
- Increased all site and all consultant engagement and communications to drive the focus
- More regular comms both on the intranet and internet are starting to share the pressures to raise broader awareness.
- Full capacity plan agreed in November and trialled with adjustments in December.
- Bringing together of MH partners to focus on operational performance and future models has commenced with regular meetings occurring with SLAM and Oxleas
- Bringing together of paediatric teams and surgical teams has commenced led by the DCOO to support UEC flow pathways and create improvement trajectories.
- First meeting with portering, cleaning and transport services also took place to ensure that services are best serving UEC pathways and that operational teams are providing timely information to allow estates colleagues to best manage the contracts.
- A new UEC dashboard has been published allowing teams to look at performance over time by specialty, site, time and borough.
- Standardisation of recording patients awaiting a bed in ED has been agreed on both sites to align with other SEL sites from 10th March 2025.
- Incentives to discharge have been agreed to run between January and March 2025. Evaluation of the impact and benefits will run monthly, and positive evidence of impact is being seen from January
- Continue to refocus the UEC Assurance meeting over the coming months to better record actions and progress against trajectories.
- Work is also underway with partners across SEL to ensure that we are all recording pressures in a way which allows better comparison.

Activity

Elective theatre activity was 116.6% of plan for January having been 94.4% in December. Day cases were 93.6% of plan similar to 94.4% in December both months were impacted by theatres disruption due to generator, day case has also been impacted by endoscopy activity reduction.

First Outpatient activity was 91.4% of plan in January but doesn't reflect the overperformance of outpatient procedures combined is delivering 106.4% of plan year to date.

Purpose

Approval	Assurance	Discussion	Note
	ü		

Recommendation/ decisions required:

The Board is asked to note:

- RTT waiting list size and 52-week waits have continued to improve but there remains a challenge around long waits with a forecast of 150 65-week breaches forecast at the end of March.
- Diagnostics performance remains challenged at 83.8% but has stabilised.
- Cancer FDS performance was 73.4% continuing a trend of improvement, however, early indications are that January performance will dip back below 70% as backlog is caught up. 62-day performance was 70.2% continuing improved performance.
- ED performance improved to 64.9% due to improvements in type 1 performance on both sites and is significantly higher than the previous year's performance for the same period although it remains below the national average.

Overall Level of Assurance

Assurance Level	
Significant	
Sufficient	
Limited	ü There is scope for improvement in all performance areas see narrative.
None	
N/a	

Link to the Trust's Key Priorities:

ü	Continually improve safety and quality.
ü	Put patients at the heart of everything we do.
	Support and develop our workforce to live our values every day
	Work effectively with partner organisations.
	Ensure we spend every penny wisely.

Resource Implications: N/A

Regulations and legal considerations: The NHS Constitution sets out standards for access and waiting times. These was updated by 2024/5 NHSE national planning targets: ED performance >78% (trust target 74%); Cancer FDS >78% (trust target 77%); 62-day cancer >70% (trust target 73%); 65-weeks at zero by October 2024

Quality consideration and impact on patient and carers: There is an impact on patient experience and quality of service delivered to patients through extended waiting times.

Health Inequalities Relationship between all services and equality of access and outcome is highly significant.

Link to the Trust's Green Plan Outside scope of report

Consultation/ Communication: Quality Performance Committee

Risk issues: Key risks

- Long waits for RTT (CRR001)

- Anaesthetic capacity and wider theatres staffing position (vacancy and sickness at UHL)
- Workforce fragility impacting key service areas and delivery of elective constitutional standards
- Balance of priorities between emergency, cancer and routine care

Confidentiality:	This report does not contain any confidential information.
Equality, Diversity & Inclusion (EDI)	The Trust is working to ensure that no patient groups are adversely affected due by long waits and other access delays.
Name of Author:	Alex Drake, Director of Performance and Information Jo Sutcliffe, Deputy COO Tom Hastings, Deputy COO
Approved by/ Lead Exec Director:	Miranda Jenkins, Chief Operating Officer

Trust Operational Performance Report

Background and purpose of report:
This report provides key measures such as inpatient volumes by activity type, average length of stay (LOS), number of occupied bed days, patient waiting list sizes, cancer and emergency department waits. The figures are at trust level. This report has been developed with the intention of being the single source for TME reporting at LGT.

Criteria:
This report covers both the QEH and UHL sites and the data is sourced from nationally submitted data where available via the metric library. The calculation used for all metrics, and any specific inclusion criteria can be found on the glossary page.

Reporting Timetable:
Viewing this report prior to the dates listed below may result in missing or incomplete data, charts and figures.

Reporting Month	Report Ready
April	22/05/2024
May	22/06/2024
June	22/07/2024
July	22/08/2024
August	23/09/2024
September	22/10/2024
October	22/11/2024
November	23/12/2024
December	22/01/2025
January	24/02/2025
February	24/03/2025
March	22/04/2025

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NHS Trust

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Operational Performance Report

	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	National Target	Plan Target	Trust Target
Activity Metrics															
Activity - Day Case Activity against Day Case Plan	105.6%	100.5%	101.2%	103.2%	98.2%	103.6%	107.2%	87.8%	93.7%	101.1%	94.4%	93.6%			**100.0%**
Activity - Elective Activity against Elective Plan	102.5%	115.6%	107.0%	125.1%	98.8%	100.9%	106.2%	95.7%	109.5%	119.3%	87.5%	116.6%			**100.0%**
Activity - First Outpatient Appointment Activity against First Outpatient Appoint	97.8%	92.3%	100.4%	98.8%	93.6%	95.1%	101.3%	92.9%	92.4%	95.7%	98.5%	91.4%			**100.0%**
Outpatient Procedures & First Appointments as % of Total Outpatient Activity	43.8%	44.1%	46.3%	45.7%	45.4%	44.6%	45.3%	44.7%	44.3%	44.8%	44.8%	44.5%			**48.0%**
RTT and Diagnostics Metrics															
RTT Incomplete Pathways	67,142	67,155	69,594	68,361	69,635	69,926	70,371	68,863	69,338	66,429	65,706	63,424			
RTT Incomplete Pathways Over 18 Weeks	30,567	30,527	30,509	29,852	30,694	30,766	31,507	30,311	30,555	28,952	28,044	27,190			
RTT Incomplete Pathways Over 52 Weeks	3,362	3,602	3,549	3,443	3,566	3,263	3,323	3,150	3,171	2,757	2,482	2,641			
RTT Incomplete Pathways Over 65 Weeks	1,059	782	722	752	876	728	627	368	352	283	301	296	**0**	**150**	**150**
RTT Incomplete Pathways Over 78 Weeks	231	155	113	90	38	54	47	57	44	46	37	33		**0**	**0**
DM01 - All Diagnostics within 6 Weeks %	97.4%	96.9%	95.6%	97.3%	97.4%	95.5%	97.1%	96.8%	96.3%	89.2%	84.1%	83.8%	**99.0%**	**99.0%**	**97.0%**
Theatres Metrics															
Theatre Session Utilisation (Capped) - Model Hospital	71.5%	70.8%	73.3%	71.6%	73.2%	74.6%	0.0%	0.0%						**85.0%**	**75.0%**
Cancer Metrics															
Urgent Cancer Referrals	2,765	2,853	2,856	2,941	2,854	3,149	2,908	2,970	3,054	3,014	2,652				
Cancer 28 Day FDS	81.2%	77.7%	71.0%	72.9%	71.1%	68.0%	69.8%	72.0%	70.8%	73.0%	73.4%		**77.0%**	**77.0%**	**77.0%**
Cancer 31 Day Performance	92.1%	87.7%	95.5%	94.4%	92.4%	92.4%	93.6%	90.6%	94.8%	96.2%	92.9%		**96.0%**		
Cancer 62 Day Performance - Internal	57.7%	69.1%	71.3%	58.7%	60.9%	52.8%	51.9%	50.4%	62.9%	69.3%	66.8%		**85.0%**	**70.0%**	**73.0%**
Cancer 62 Day Performance - NHS Statistics Version	59.6%	73.8%	74.8%	65.6%	62.8%	57.6%	55.7%	54.7%	63.9%	70.7%	70.2%		**85.0%**	**70.0%**	**73.0%**
Cancer 62 Day Backlog - Urgent Suspected Cancer - All Tumour Sites	129	126	138	137	149	196	220	177	170	143	175	199		**< 155**	**< 155**
Non-Elective Flow Metrics (Site based ED metrics available within TME pack)															
ED Attendances (All Types)	24,788	26,948	24,498	26,624	25,035	25,268	22,755	24,173	25,411	25,398	26,110	25,080			
ED Performance (All Types) - Trust	61.0%	62.5%	64.7%	64.4%	67.2%	68.4%	69.0%	64.4%	64.1%	64.6%	64.1%	64.9%	**95.0%**	**78.0%**	**74.0%**
ED Performance (Type 1) - Trust	42.3%	43.3%	45.0%	47.9%	50.9%	53.5%	53.5%	47.5%	47.2%	48.1%	46.1%	46.9%	**95.0%**		**56.9%**
ED Performance (Type 3) - Trust	82.8%	85.5%	87.3%	82.9%	87.7%	88.1%	90.0%	87.6%	86.3%	87.1%	87.8%	88.2%	**95.0%**		**95.4%**
% Ambulance Handovers < 30 Minutes	74.3%	77.2%	72.5%	75.9%	78.5%	80.2%	84.3%	75.6%	74.2%	73.1%	71.3%	72.0%	**95.0%**		
ED 12hr Breaches - From Decision to Admit to Departure	853	782	735	592	465	521	317	640	803	800	702	835			
ED 12Hr Breaches - From Arrival to Departure	2,513	2,475	2,102	1,989	1,775	1,701	1,409	1,987	2,366	2,304	2,401	2,282			
ED Length of Stay (in Hours) - Mean	6.3	6.0	6.0	5.8	5.6	5.4	4.9	5.5	6.0	6.2	6.2	6.2			
ED Conversion Rate (All Types)	18.8%	18.9%	20.3%	20.5%	20.8%	21.8%	24.1%	22.2%	21.6%	23.8%	24.1%	25.5%			
Average Bed Occupancy (Excl. Critical Care)	98.2%	97.6%	98.0%	96.9%	97.1%	97.2%	95.2%	98.1%	98.7%	98.5%	97.6%	98.2%			
Patients Stranded 7+ Days as % of Occupied Beds	57.3%	57.4%	58.6%	57.3%	53.1%	54.3%	52.9%	53.1%	55.1%	55.3%	55.5%	55.9%			
Patients Stranded 21+ Days as % of Occupied Beds	27.2%	27.5%	28.1%	26.7%	24.1%	23.5%	23.2%	21.5%	24.5%	24.8%	25.8%	24.4%			
Patients Not Meeting the Criteria to Reside (Avg Per Day)	193	203	177	156	165	170	165	171	139	147	136	128			
Discharges (Mean Average per Day)	115.3	115.7	116.8	130.6	90.8	91.5	92.2	93.3	96.5	90.3	94.0	91.3			
Weekend to Weekday Discharges Ratio	0.48	0.55	0.51	0.51	0.52	0.50	0.46	0.47	0.48	0.47	0.40	0.50			
Pre 5PM Discharges as % of Total Discharges	57.9%	58.7%	57.4%	57.4%	59.6%	62.1%	60.2%	59.1%	59.4%	65.3%	64.8%	62.9%			

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Benchmarking

Cancer 28 Day FD Standard						
Target: 75% Plan: 78%	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12
LGT - Internal	68.0%	69.8%	72.0%	70.8%	73.0%	73.4%
LGT - National	67.9%	69.6%	71.5%	70.5%	72.9%	73.3%
South East London	75.2%	75.3%	75.5%	76.3%	76.7%	76.8%
London	75.6%	75.4%	75.7%	77.5%	78.2%	78.2%
National	76.2%	75.5%	74.8%	77.1%	77.4%	78.1%

Month	National Ranking (inc ties)	London Ranking (inc ties)
2024-12	120 out of 142	17 out of 20

Cancer 31 Day Standard						
Target: 95%	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12
LGT - Internal	92.4%	93.6%	90.6%	94.8%	96.2%	92.9%
LGT - National	92.4%	93.8%	90.6%	94.8%	96.2%	93.0%
South East London	85.9%	83.9%	82.8%	86.2%	91.5%	92.2%
London	93.3%	92.1%	91.4%	92.7%	93.6%	94.5%
National	91.9%	91.7%	90.6%	91.5%	91.0%	91.5%

Month	National Ranking (inc ties)	London Ranking (inc ties)
2024-12	94 out of 140	16 out of 20

Cancer 62 Day Standard						
Target: 85% Plan: 73%	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12
LGT - Internal	52.8%	51.9%	50.4%	62.9%	69.3%	66.8%
LGT - National	57.6%	55.7%	54.7%	63.9%	70.7%	70.2%
South East London	58.3%	57.1%	54.2%	57.0%	66.5%	66.8%
London	69.2%	71.0%	67.7%	69.3%	71.8%	73.6%
National	67.7%	69.2%	67.3%	68.2%	69.4%	71.3%

Month	National Ranking (inc ties)	London Ranking (inc ties)
2024-12	100 out of 148	16 out of 21

DM01 % - All Modalities						
Target: 99% Plan: 97%	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01
LGT - Internal	97.1%	96.8%	96.3%	89.2%	84.1%	83.8%
LGT - National	97.1%	96.8%	96.3%	89.2%	84.1%	
South East London	59.4%	60.1%	63.6%	63.2%	60.5%	
London	77.9%	78.8%	80.8%	80.5%	77.0%	
National	76.1%	77.3%	79.3%	80.1%	77.2%	

Month	National Ranking (inc ties)	London Ranking (inc ties)
2024-12	212 out of 430	30 out of 46

RTT 18 Weeks %						
Target: TBC	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01
LGT - Internal	55.2%	56.0%	55.9%	56.4%	57.3%	57.1%
LGT - National	55.2%	56.0%	55.9%	56.4%	57.3%	
South East London	56.0%	56.4%	57.2%	58.2%	58.7%	
London	58.9%	59.1%	59.7%	59.9%	59.8%	
National	57.3%	57.6%	58.0%	58.2%	58.0%	

Month	National Ranking (inc ties)	London Ranking (inc ties)
2024-12	94 out of 155	15 out of 20

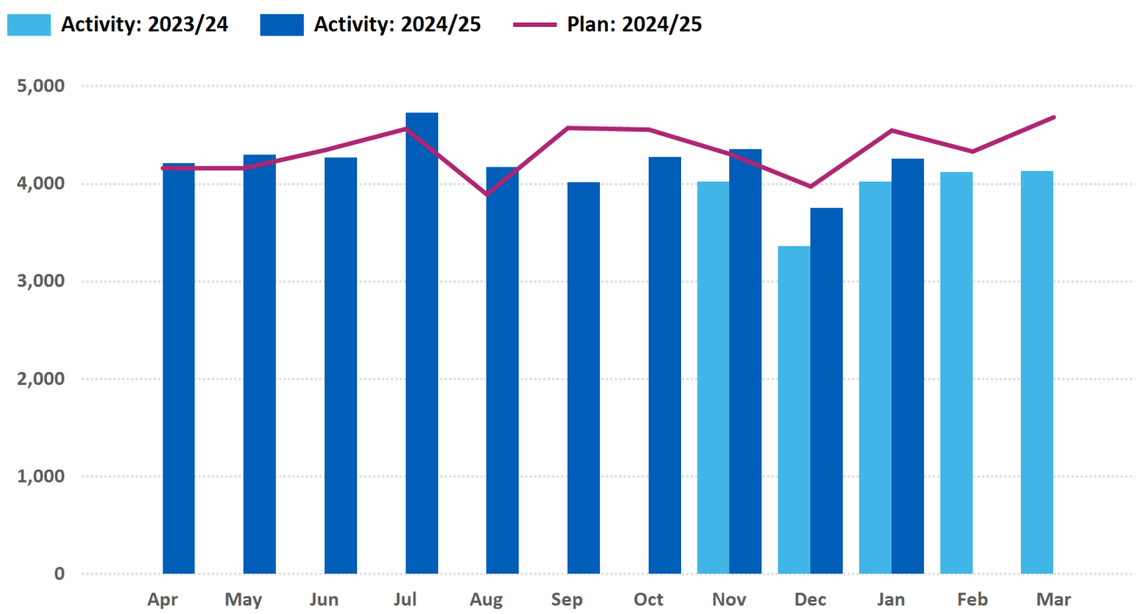
ED Performance % - All Types						
Target: 95% Plan: 76%	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01
LGT - Internal	69.0%	64.4%	64.1%	64.6%	64.1%	64.9%
LGT - National	69.0%	64.4%	64.1%	64.6%	64.1%	64.9%
South East London	76.7%	73.3%	71.1%	72.6%	73.5%	74.0%
London	78.1%	75.9%	75.0%	74.4%	74.4%	75.4%
National	76.3%	74.2%	73.0%	72.1%	71.1%	73.0%

Month	National Ranking (inc ties)	London Ranking (inc ties)
2024-12	144 out of 198	24 out of 26

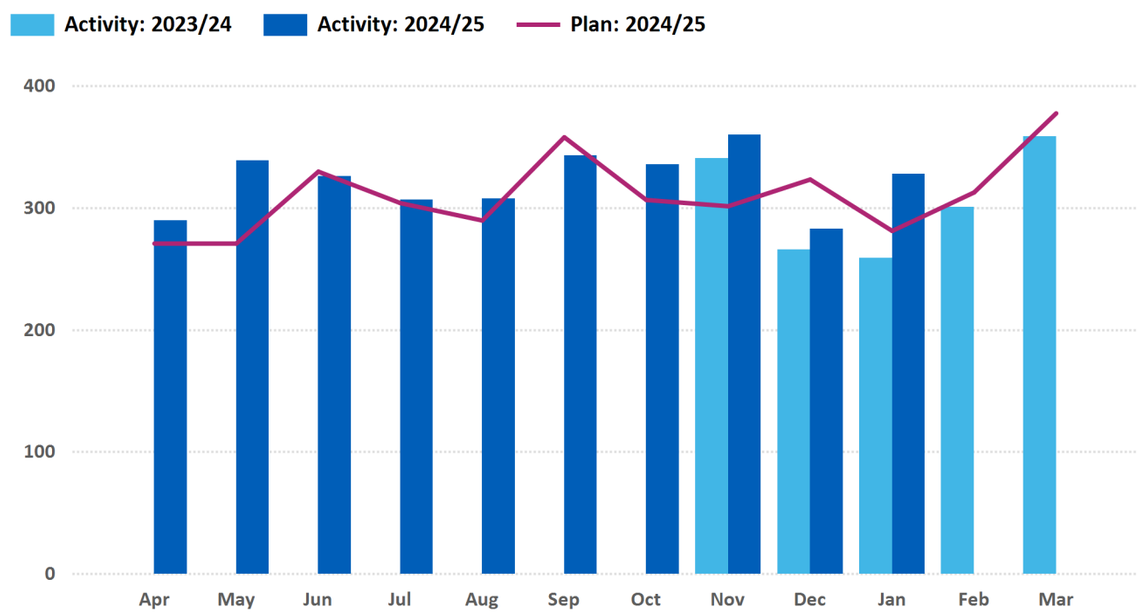
Benchmarking figures are sourced from the NHS England statistics website, and are subject to revision at any time.

Activity against Trust Plan

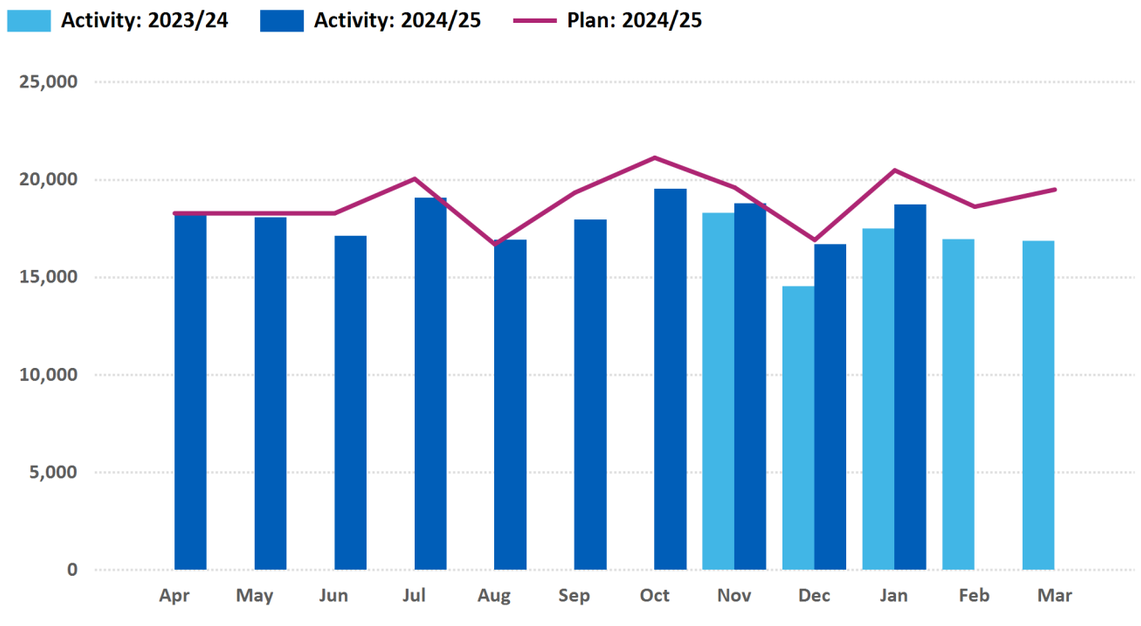
Day Case Activity against Trust Plan



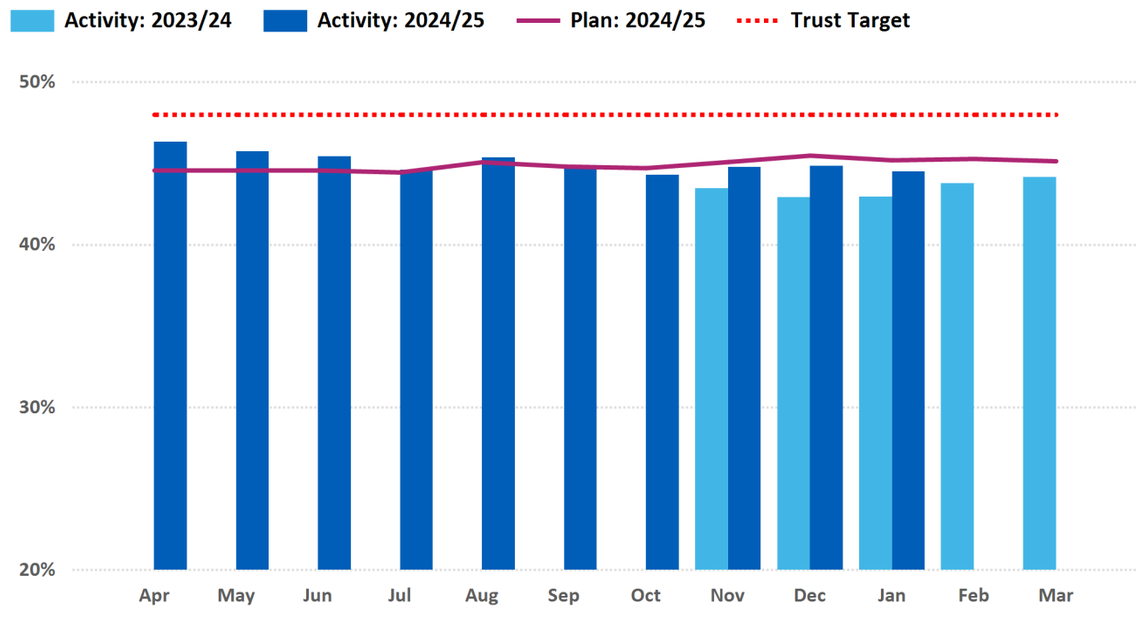
Elective Activity against Trust Plan



First Outpatient Activity against Trust Plan



First OP Attendances and OP Procedures as % of Total OP Activity against Trust Plan



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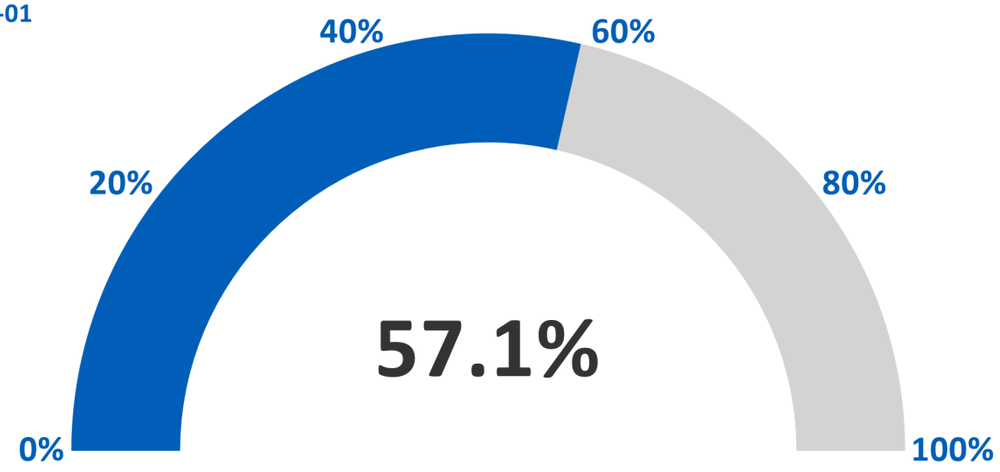
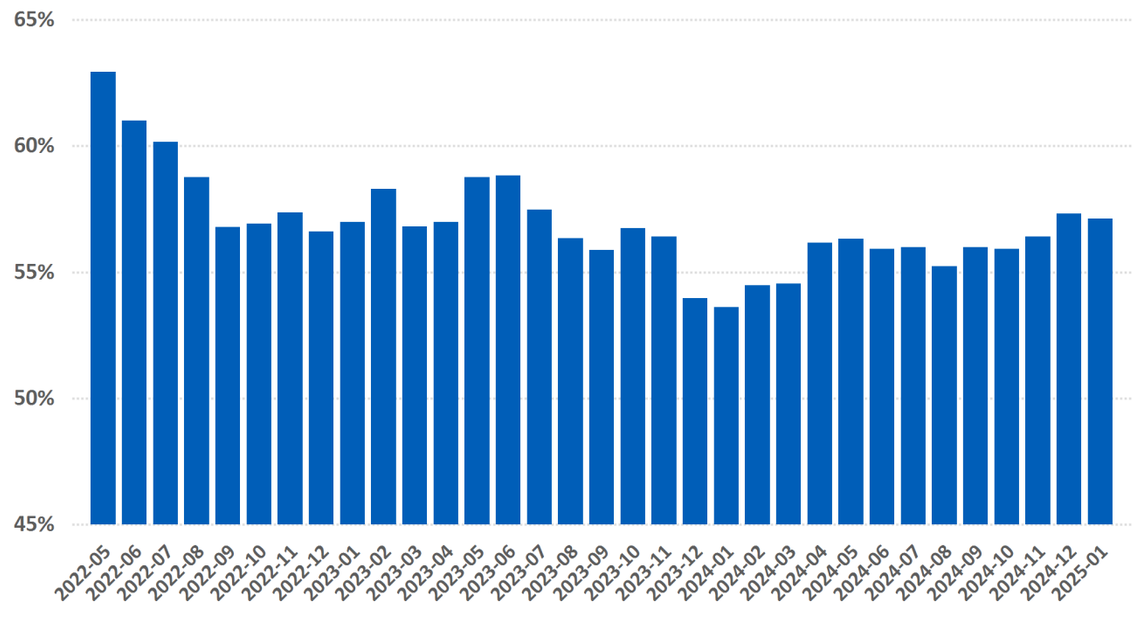
Referral to Treatement (RTT)

RTT Performance % (18wks)

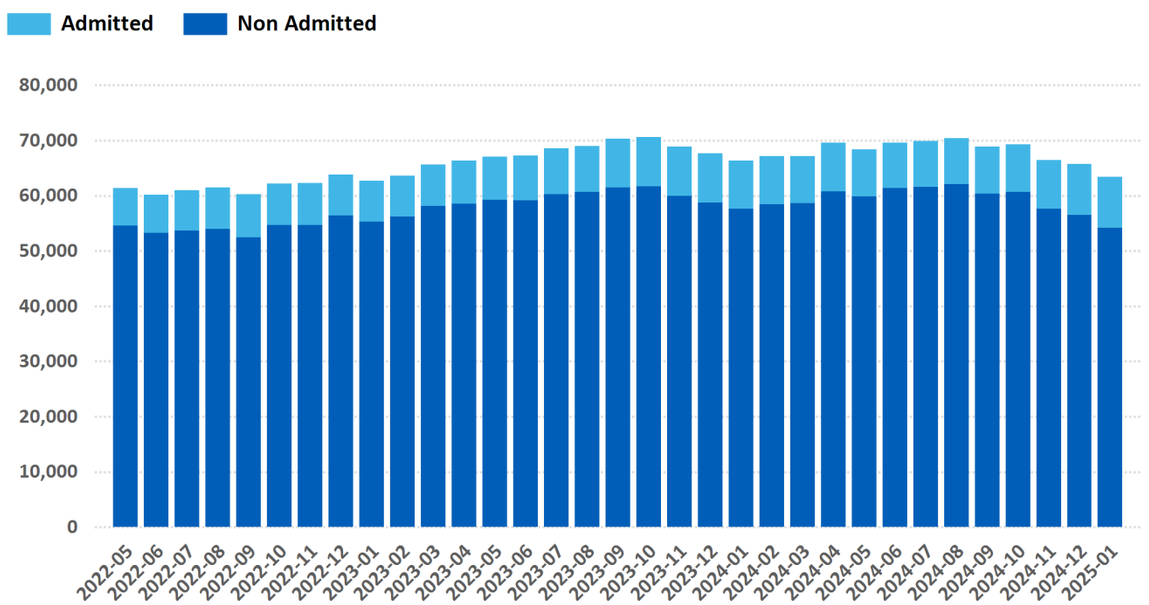
Metric: RTT
CQC Domain: Responsive
Month: 2025-01



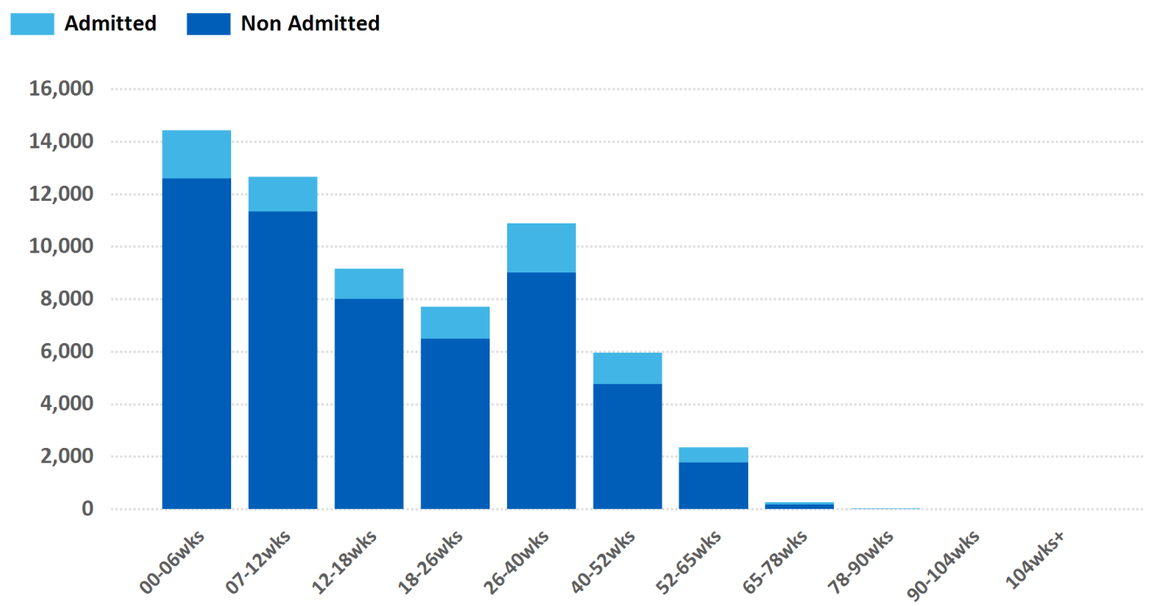
RTT Performance % (18wks)



Open Pathways by Admitted and Non-Admitted



RTT PTL by Week Group - 2025-01



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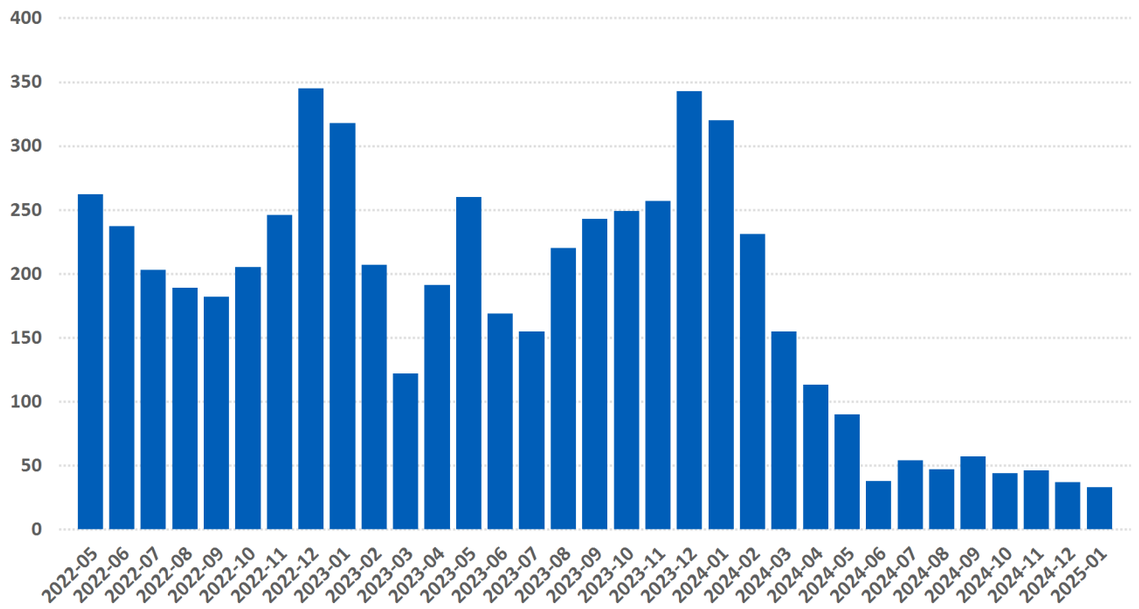
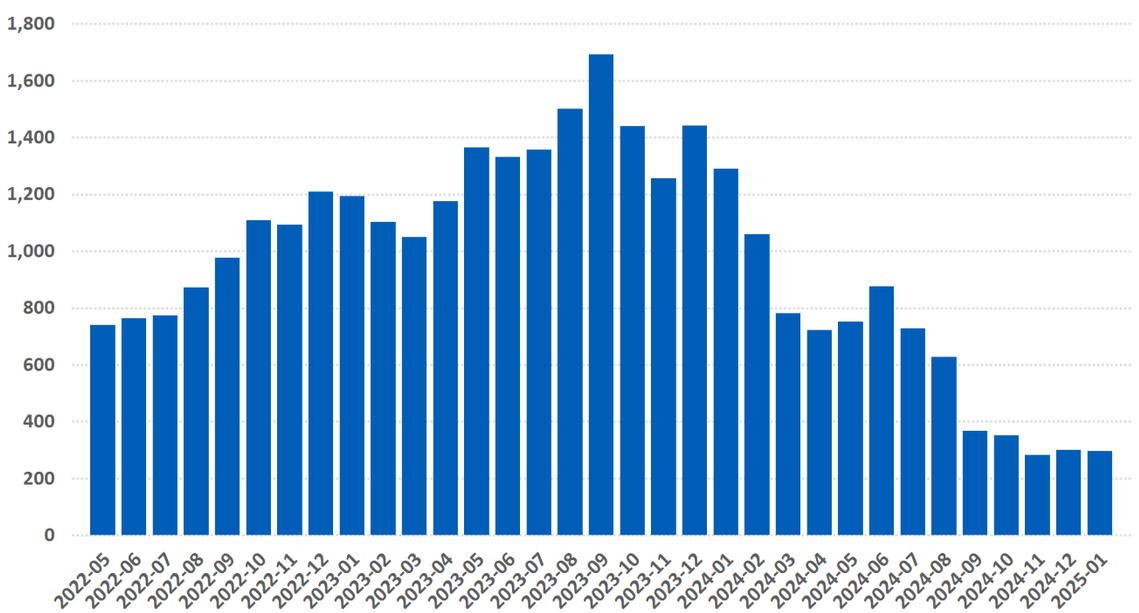
Referral to Treatement (RTT) - Backlog

78 Week Waiters



65 Week Waiters

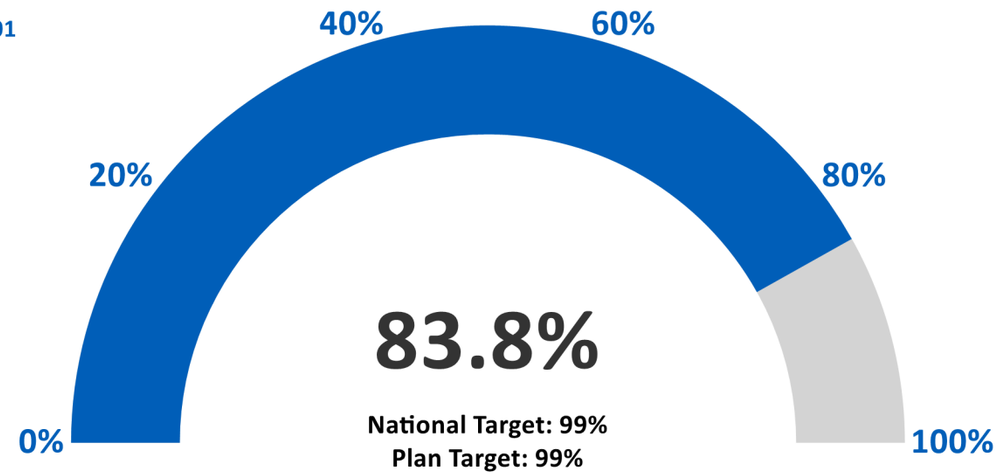


Specialty - 2025-01	78 Week Waiters	65 Week Waiters	52 Week Waiters
100 - General Surgery	2	27	220
101 - Urology	0	8	65
107 - Vascular Surgery	4	29	153
110 - Trauma and Orthopaedic	2	22	327
120 - ENT	22	139	518
160 - Plastic Surgery	0	0	1
191 - Pain Management	0	4	65
300 - General Medicine	0	0	1
301 - Gastroenterology	1	15	389
302 - Endocrinology	0	0	1
303 - Clinical Haematology	0	3	19
309 - Haemophilia	0	0	1
320 - Cardiology	0	0	75
330 - Dermatology	0	3	68
340 - Thoracic Medicine	0	0	52
400 - Neurology	0	5	230
410 - Rheumatology	0	0	1
420 - Paediatrics	0	3	8
502 - Gynaecology	2	38	445
663 - Podiatric Surgery Service	0	0	1
Total	33	296	2,640

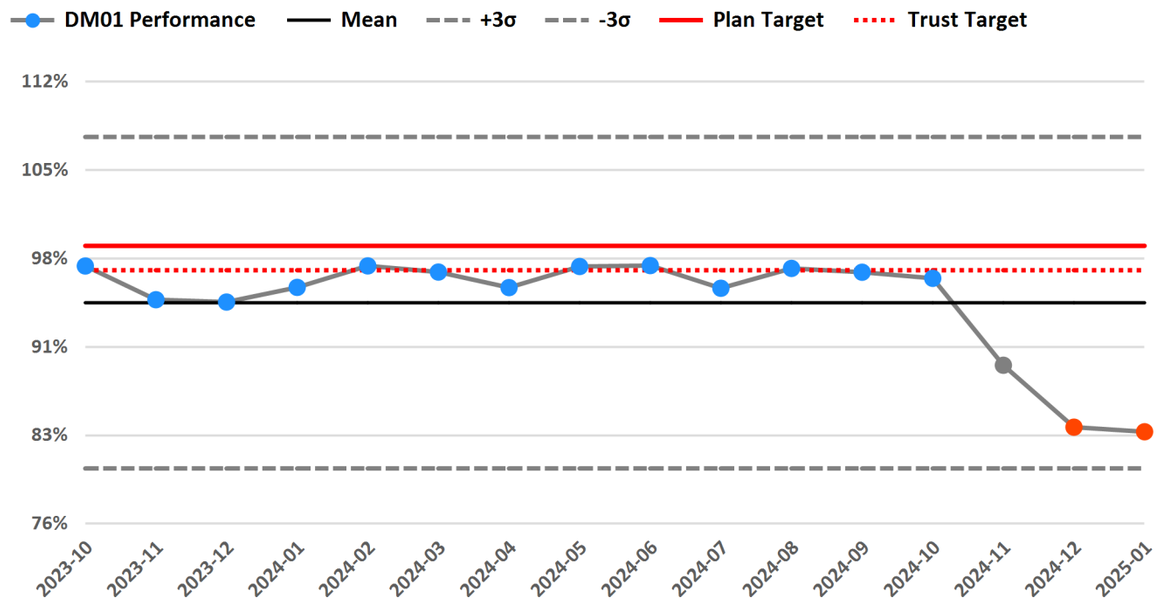
Diagnostics (DM01)

DM01 Diagnostic Performance

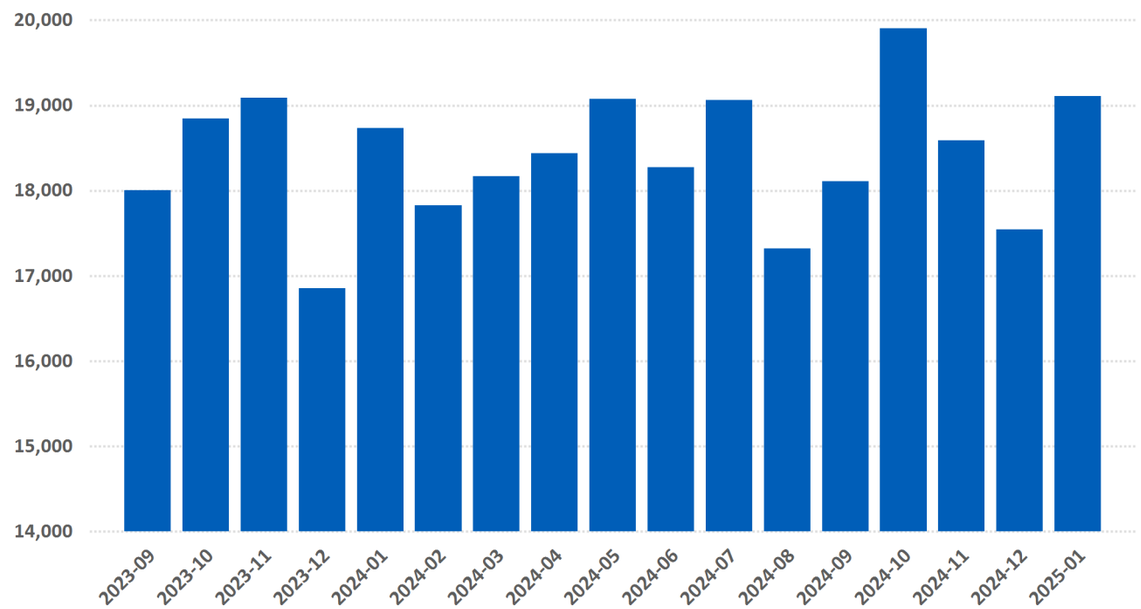
Metric: Diagnostic Waiting <6 wks
CQC Domain: Responsive
Target: >99%
Month: 2025-01



DM01 - All Diagnostics within 6 Weeks % - SPC



Diagnostics Activity



Diagnostic Test - 2025-01	Total Waits	<= 6 Wks Waits	% Within 6 Wks
Audiology - Audiology Assessments	14	14	100.0%
Barium Enema	57	54	94.7%
Cardiology - Echocardiography	710	673	94.8%
Colonoscopy	599	471	78.6%
Computed Tomography	1,320	1,299	98.4%
Cystoscopy	208	202	97.1%
DEXA Scan	672	610	90.8%
Flexible sigmoidoscopy	136	101	74.3%
Gastroscopy	516	330	64.0%
Magnetic Resonance Imaging	3,881	2,901	74.7%
Non-obstetric Ultrasound	7,437	6,418	86.3%
Respiratory physiology - Sleep Studies	64	28	43.8%
Urodynamics - Pressures & Flows	111	69	62.2%
Total	15,725	13,170	83.8%

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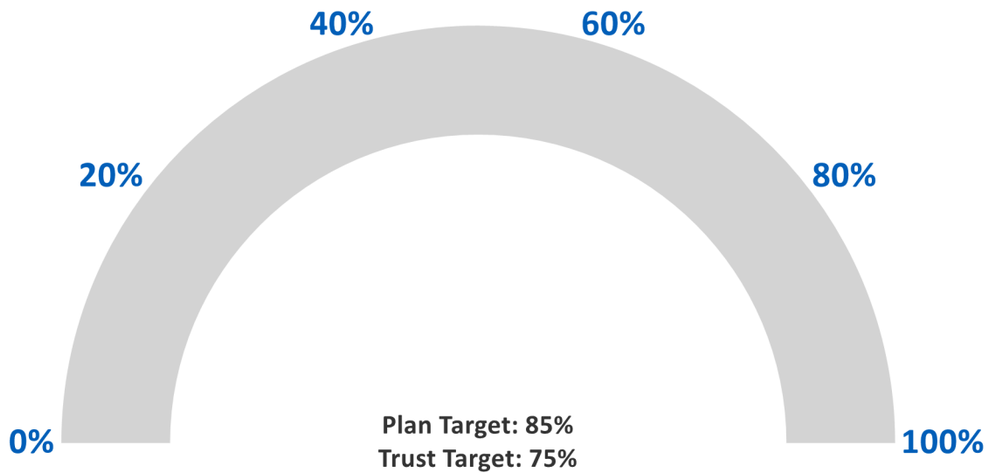
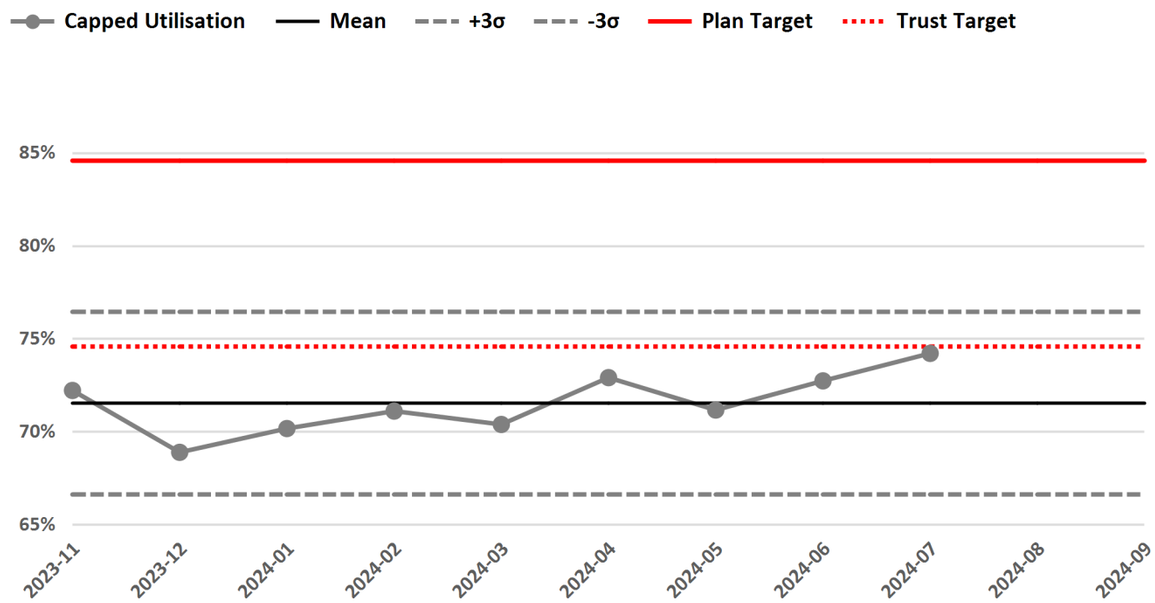
Theatre Utilisation - Capped

Theatre Utilisation Capped - Model Hospital

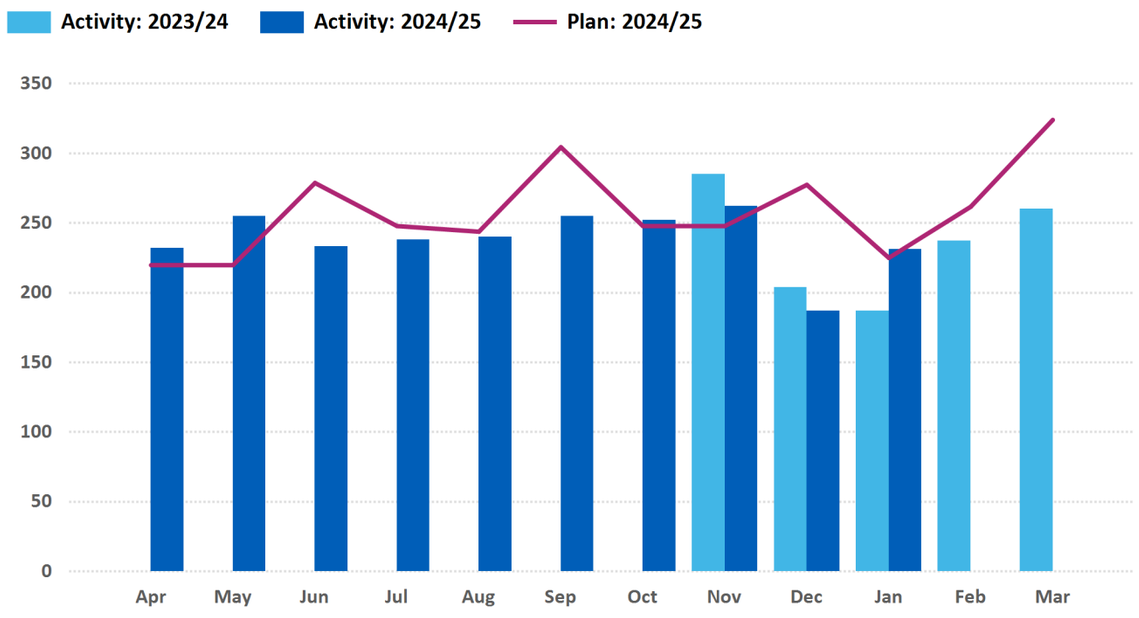
Metric: Theatre Utilisation
CQC Domain: Effective
Target: >85%
Month:



Theatre Utilisation Capped - Model Hospital - SPC



Elective Theatre Activity against Trust Plan

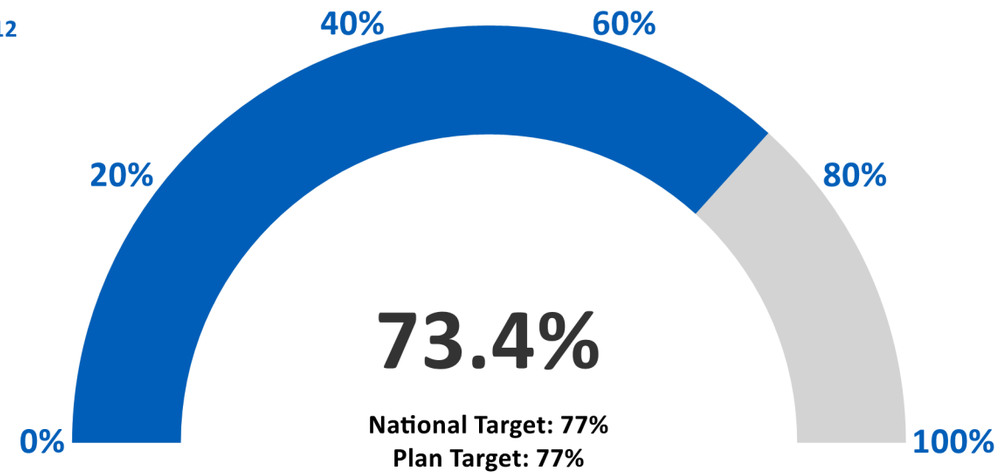


Session Specialty	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09
General Surgery	73.5%	75.8%	72.2%	77.3%	80.6%	0.0%	0.0%
Trauma and Orthopaedics	75.2%	79.8%	75.9%	77.4%	75.7%	0.0%	0.0%
Urology	64.6%	66.2%	62.2%	61.9%	64.2%	0.0%	0.0%
Ear, Nose and Throat	67.0%	70.6%	68.3%	68.4%	74.6%	0.0%	0.0%
Gynaecology	73.1%	72.4%	76.8%	75.7%	74.8%	0.0%	0.0%
Plastic Surgery			38.3%		45.8%	0.0%	0.0%
Other	63.5%	65.5%	64.4%	66.0%	64.1%	0.0%	0.0%
Total	**70.8%**	**73.3%**	**71.6%**	**73.2%**	**74.6%**	**0.0%**	**0.0%**

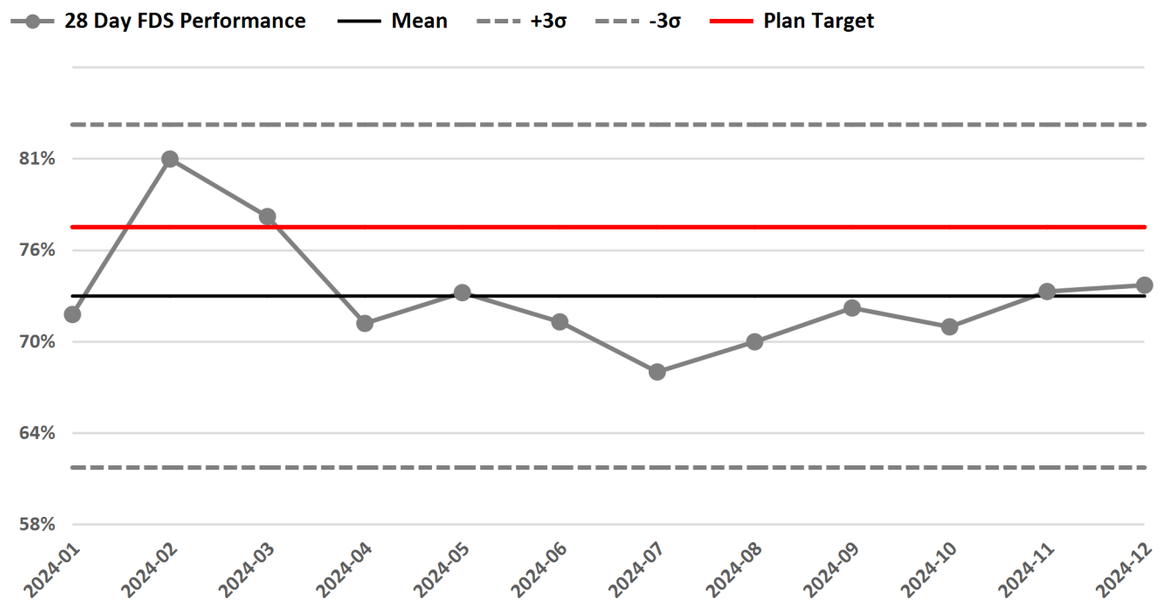
Cancer 28 Day Faster Diagnosis Standard (FDS)

Cancer 28 Day FDS Performance

Metric: Faster Diagnosis
CQC Domain: Responsive
Target: >75%
Month: 2024-12

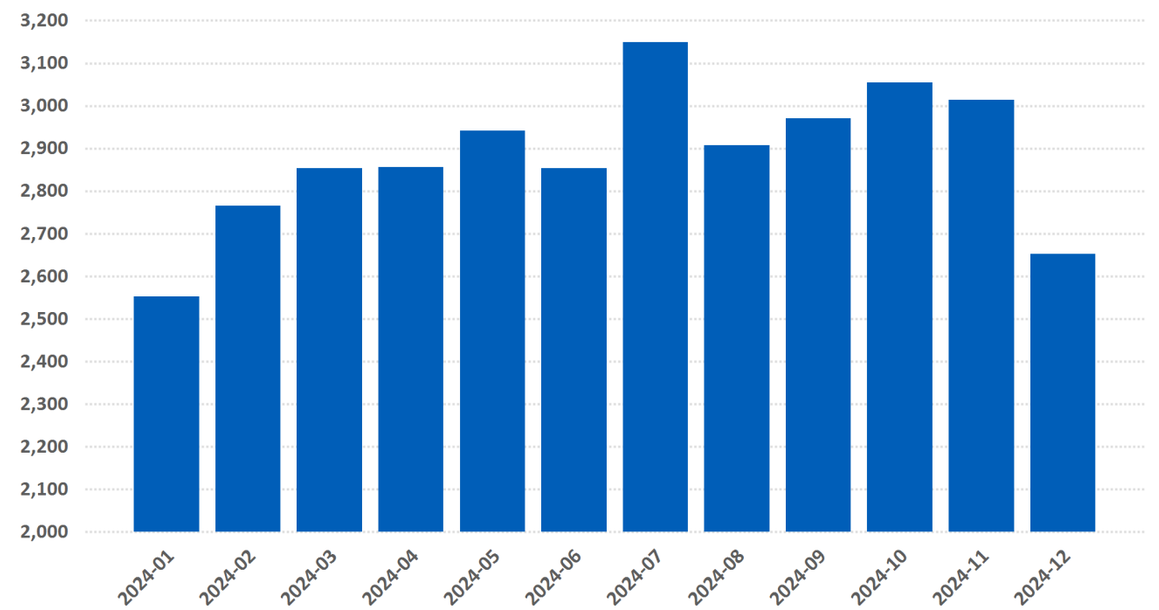


Cancer 28 Day FDS Performance - SPC



Cancer Tumour Site 2024-12	28 Day FDS Performance	Urgent Suspected Cancer Referrals
Brain/CNS	88.9%	12
Breast	83.8%	520
Gynaecological	71.0%	303
Haematological	73.8%	57
Head & Neck	57.7%	225
Lower gastrointestinal	51.8%	381
Lung	80.0%	67
Other (inc. Sarcoma)	56.9%	80
Skin	88.0%	650
Upper gastrointestinal	77.5%	161
Urological	68.5%	196
Total	**73.4%**	**2,652**

Urgent Suspected Cancer (USC) Referrals



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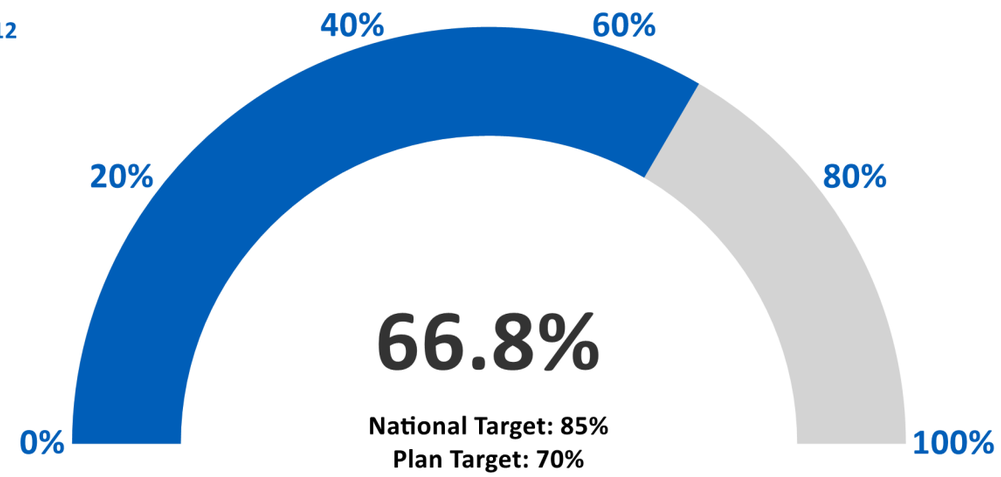
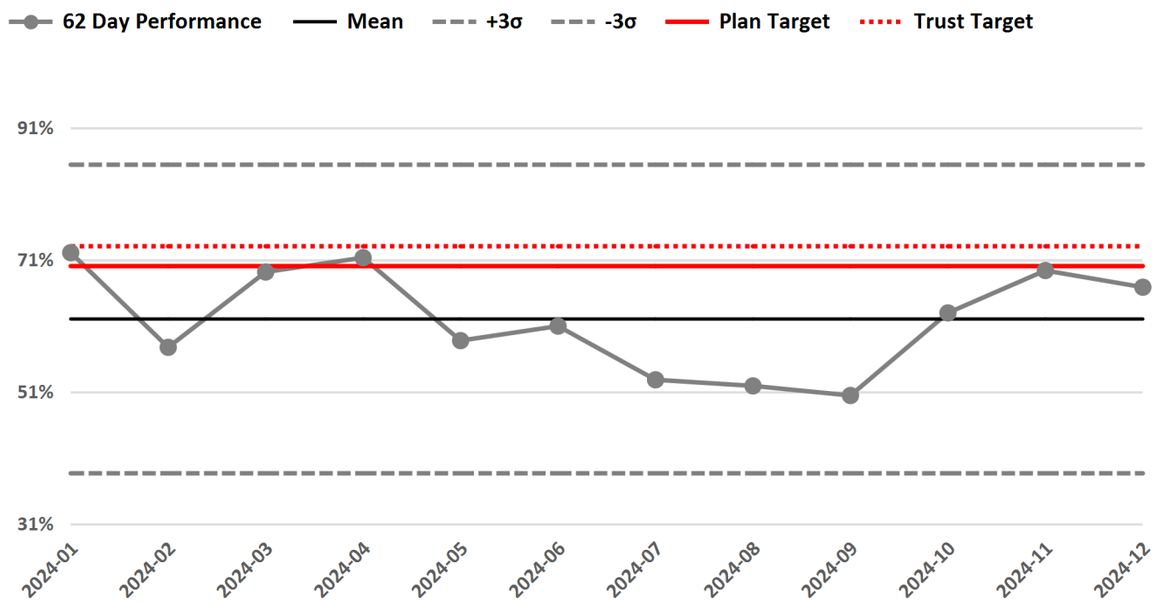
Cancer 62 Day Performance - Internal

Cancer 62 Day Performance - Internal

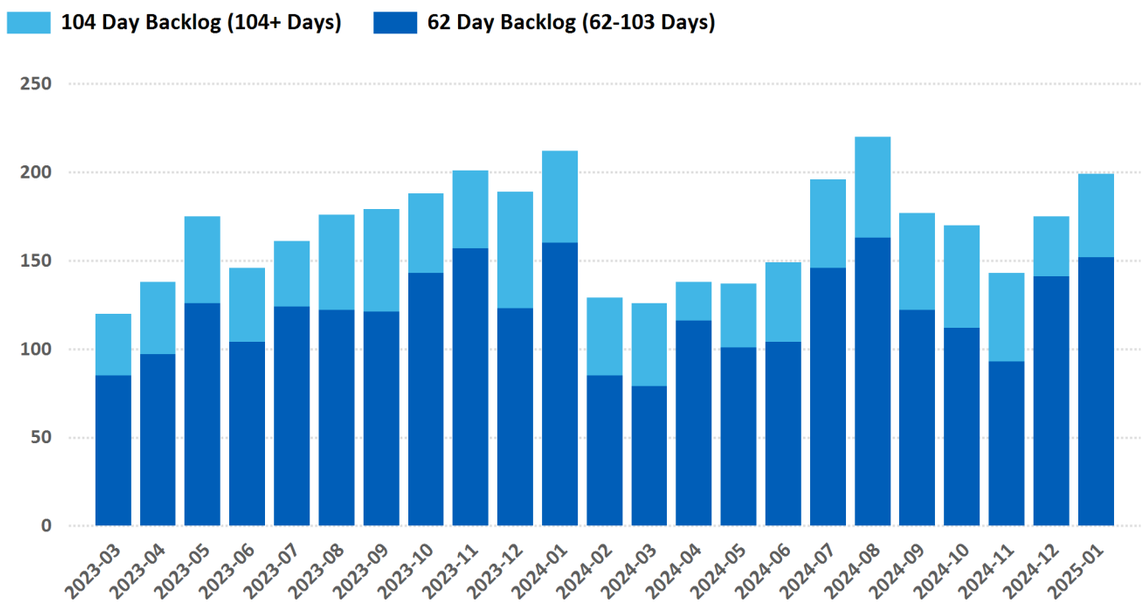
Metric: 62 Day Performance
CQC Domain: Responsive
Target: >85%
Month: 2024-12



Cancer 62 Day Performance - Internal - SPC



Cancer Backlog



Cancer Tumour Site 2025-01	62-103 Day Waits	104+ Day Waits	62 Day Performance - Internal Cases, Sucesses & Performance		
Brain/CNS	1	0			
Breast	15	2	16.0	11.5	71.9%
Childrens	0	0			
Gynaecological	20	5	5.0	0.0	0.0%
Haematological	5	3	14.0	11.0	78.6%
Head & Neck	15	10	7.5	1.0	13.3%
Lower gastrointestinal	51	17	12.0	5.5	45.8%
Lung	2	3	13.5	8.5	63.0%
Other (inc. Sarcoma)	1	0			
Skin	10	2	8.0	6.0	75.0%
Unknown	0	0			
Upper gastrointestinal	6	1	10.0	9.0	90.0%
Urological	26	4	37.5	30.0	80.0%
Total	**152**	**47**	**123.5**	**82.5**	**66.8%**

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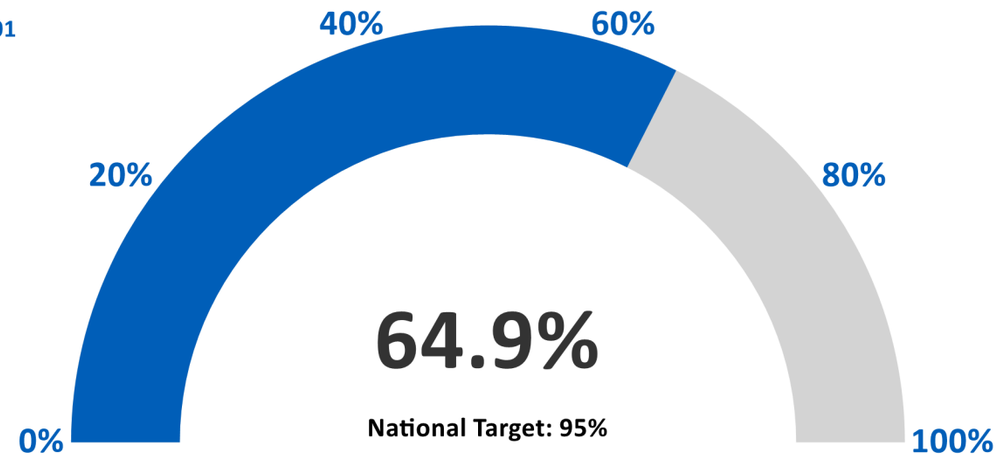
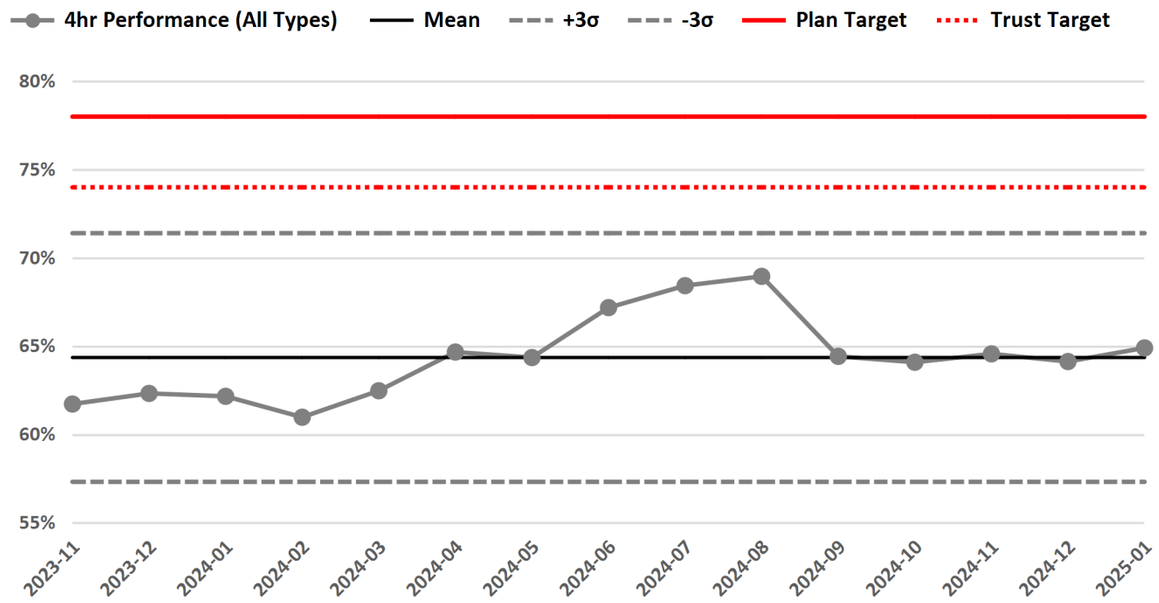
Emergency Department - LGT

ED 4hr Performance (All Types)

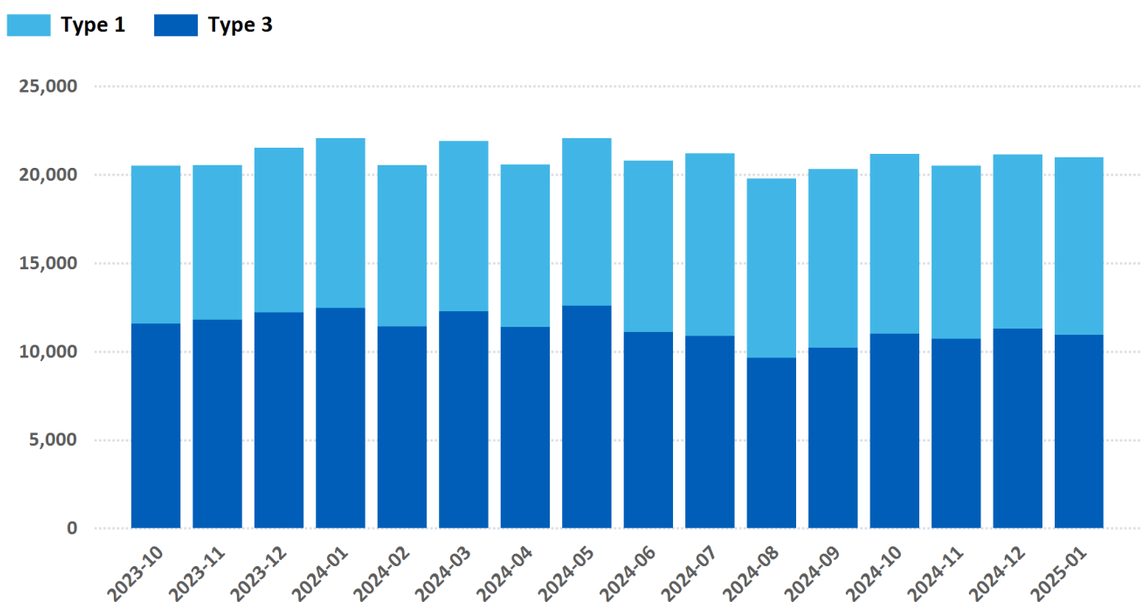
Metric: 4 Hour Emergency Access
CQC Domain: Responsive
Target: >76%
Month: 2025-01



ED 4hr Performance (All Types) - SPC



ED Attendances by Stream Type

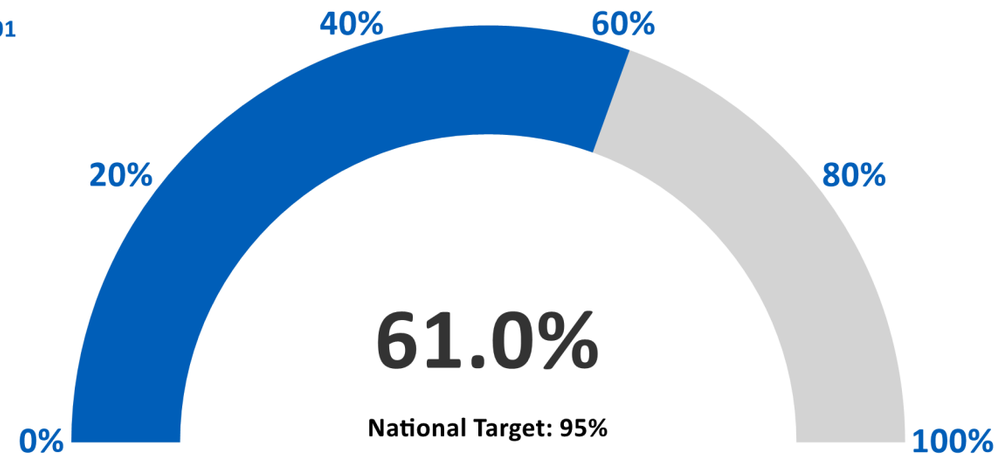


	ED 4hr Performance All Types	ED 4hr Performance Type 1	ED 4hr Performance Type 3	ED 12 Hr LoS Arrival to Departure
2023-11	61.7%	41.9%	84.7%	2,162
2023-12	62.3%	42.9%	84.6%	2,357
2024-01	62.2%	41.1%	85.6%	2,586
2024-02	61.0%	42.3%	82.8%	2,513
2024-03	62.5%	43.3%	85.5%	2,475
2024-04	64.7%	45.0%	87.3%	2,102
2024-05	64.4%	47.9%	82.9%	1,989
2024-06	67.2%	50.9%	87.7%	1,775
2024-07	68.4%	53.5%	88.1%	1,701
2024-08	69.0%	53.5%	90.0%	1,409
2024-09	64.4%	47.5%	87.6%	1,987
2024-10	64.1%	47.2%	86.3%	2,366
2024-11	64.6%	48.1%	87.1%	2,304
2024-12	64.1%	46.1%	87.8%	2,401
2025-01	64.9%	46.9%	88.2%	2,282

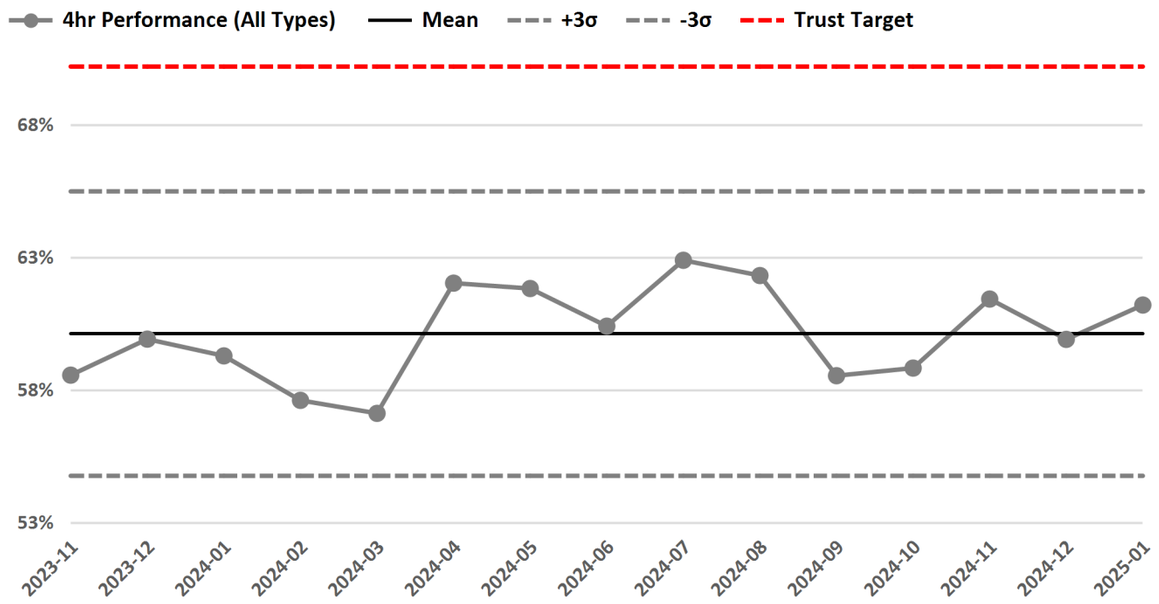
Emergency Department - QEH

ED 4hr Performance (All Types)

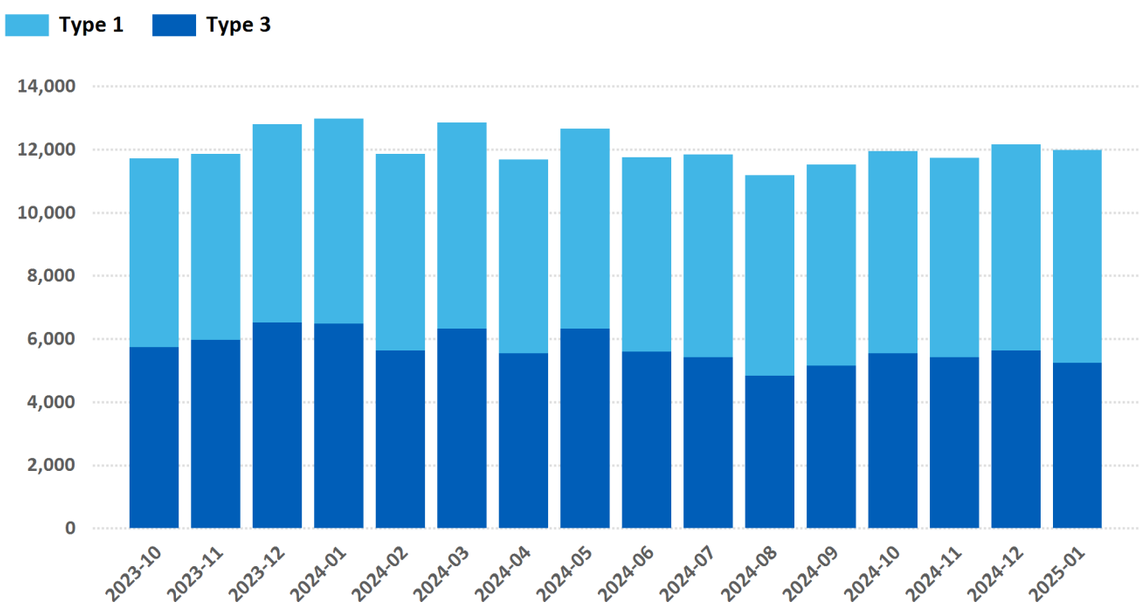
Metric: 4 Hour Emergency Access
CQC Domain: Responsive
Target: >76%
Month: 2025-01



ED 4hr Performance (All Types) - SPC



ED Attendances by Stream Type



	ED 4hr Performance All Types	ED 4hr Performance Type 1	ED 4hr Performance Type 3	ED 12 Hr LoS Arrival to Departure
2023-11	58.4%	35.2%	88.8%	1,633
2023-12	59.7%	36.5%	88.7%	1,626
2024-01	59.1%	33.3%	91.4%	1,744
2024-02	57.4%	35.4%	88.0%	1,646
2024-03	56.9%	33.7%	87.6%	1,778
2024-04	61.8%	39.3%	93.0%	1,349
2024-05	61.6%	42.1%	86.3%	1,393
2024-06	60.2%	39.4%	88.9%	1,409
2024-07	62.7%	44.5%	89.1%	1,294
2024-08	62.1%	44.0%	90.2%	1,154
2024-09	58.3%	38.4%	88.3%	1,413
2024-10	58.6%	38.8%	87.5%	1,661
2024-11	61.2%	42.2%	90.2%	1,693
2024-12	59.7%	40.0%	89.3%	1,686
2025-01	61.0%	41.1%	93.0%	1,602

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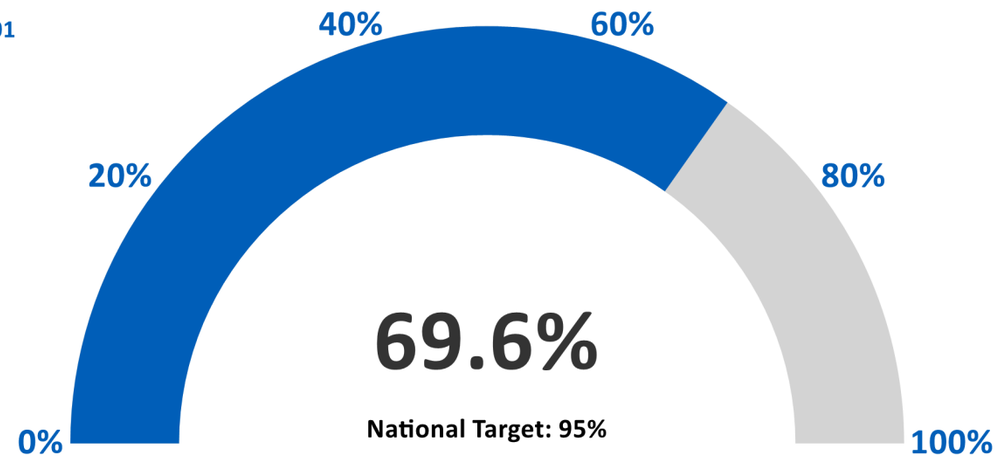
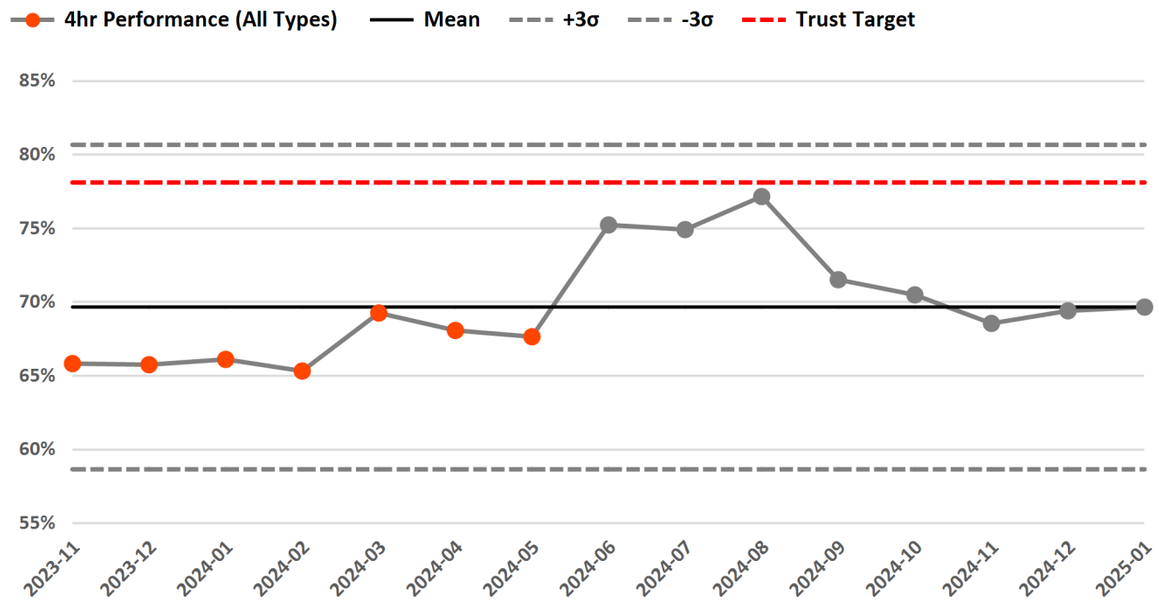
Emergency Department - UHL

ED 4hr Performance (All Types)

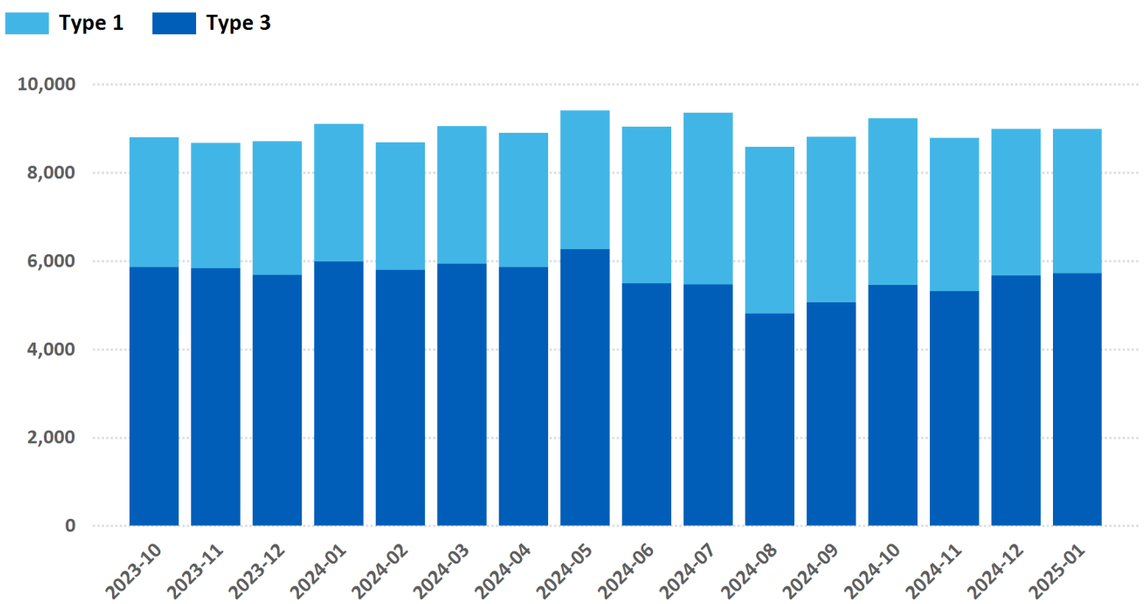
Metric: 4 Hour Emergency Access
CQC Domain: Responsive
Target: >76%
Month: 2025-01



ED 4hr Performance (All Types) - SPC



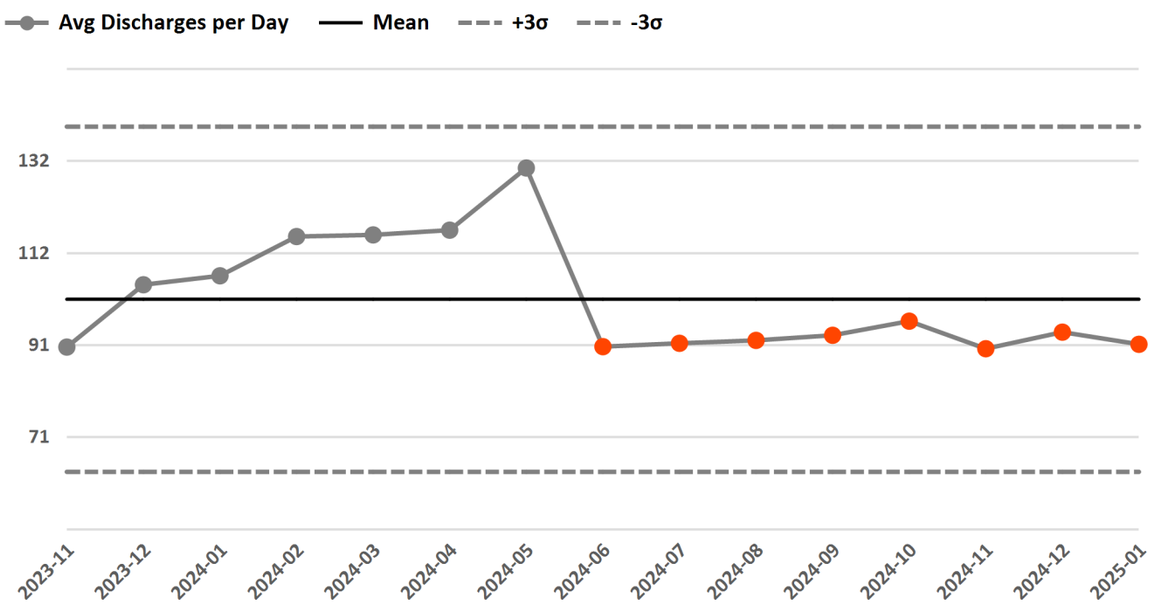
ED Attendances by Stream Type



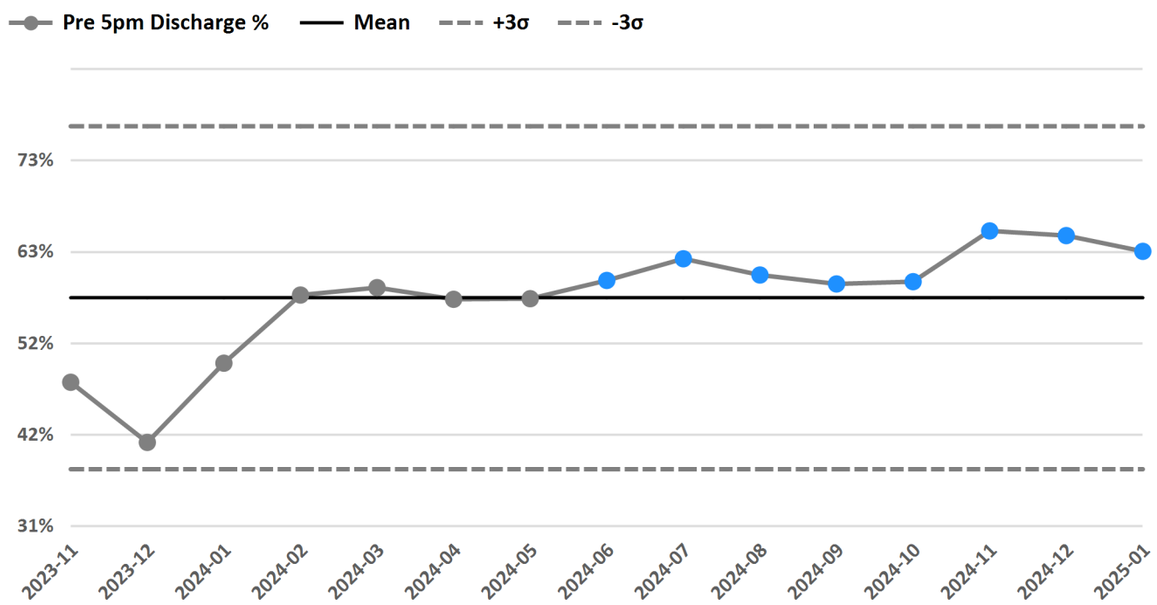
	ED 4hr Performance All Types	ED 4hr Performance Type 1	ED 4hr Performance Type 3	ED 12 Hr LoS Arrival to Departure
2023-11	65.7%	50.9%	80.5%	529
2023-12	65.6%	51.9%	79.8%	731
2024-01	66.0%	52.2%	79.2%	842
2024-02	65.2%	52.0%	77.9%	867
2024-03	69.2%	55.9%	83.3%	697
2024-04	68.0%	53.0%	82.0%	753
2024-05	67.5%	55.4%	79.4%	596
2024-06	75.1%	65.0%	86.5%	366
2024-07	74.8%	64.4%	87.1%	407
2024-08	77.0%	66.1%	89.8%	255
2024-09	71.4%	58.9%	86.8%	574
2024-10	70.4%	57.8%	85.1%	705
2024-11	68.4%	55.7%	83.9%	611
2024-12	69.3%	54.2%	86.3%	715
2025-01	69.6%	55.4%	83.7%	680

Discharges - LGT

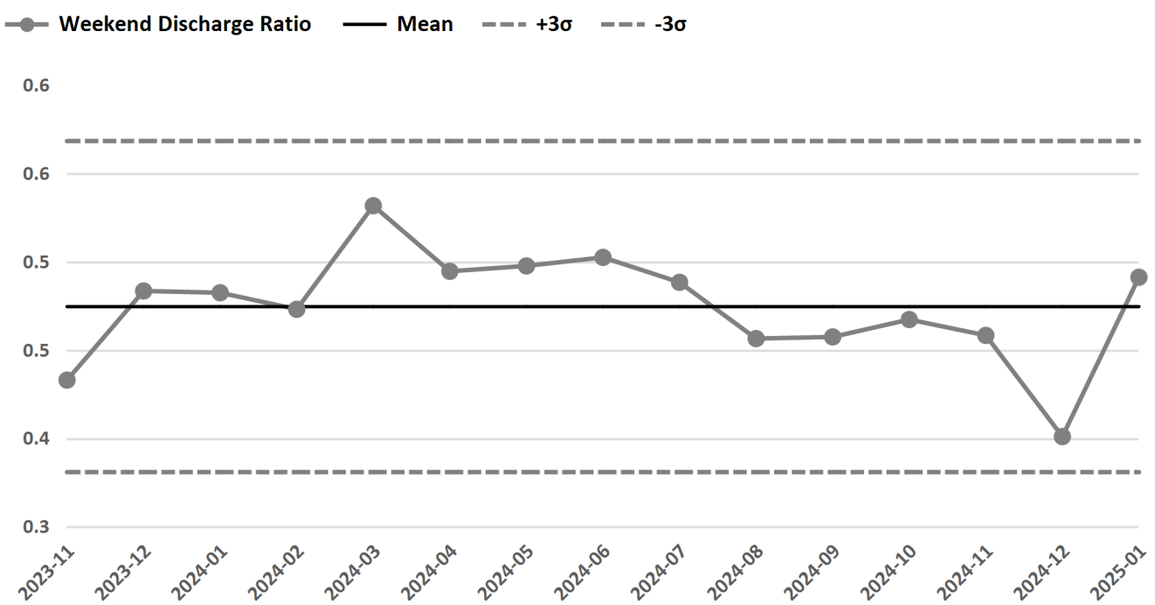
Mean Average Discharges per Day - SPC



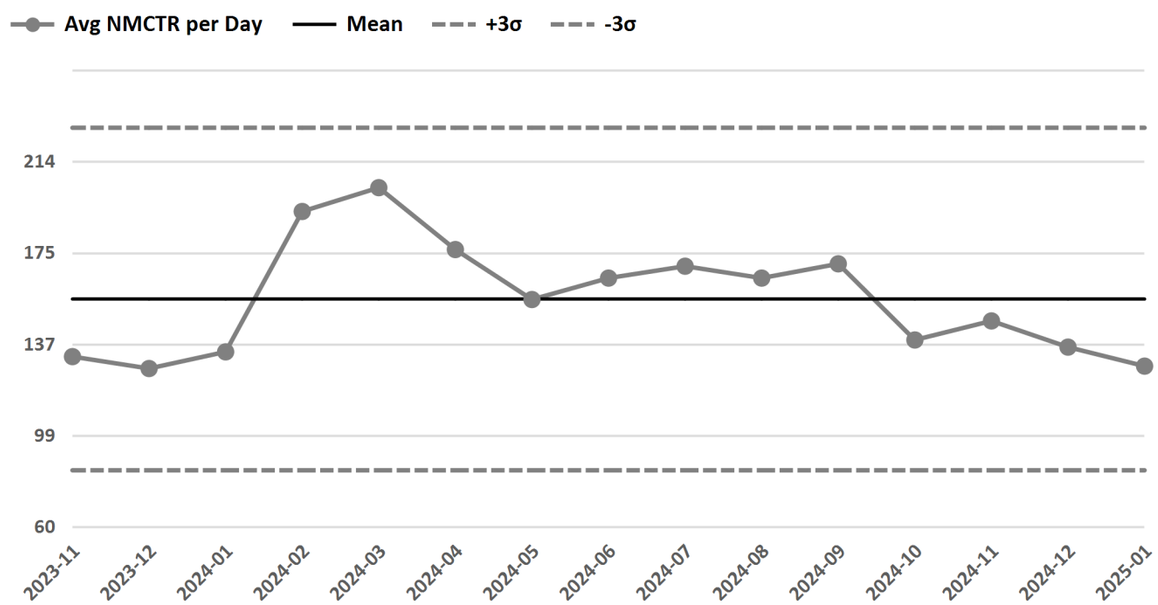
Pre 5pm Discharges as Percentage of Total Discharges - SPC



Weekend to Weekday Discharge Ratio - SPC



Patients Not Meeting Criteria To Reside (Average Per Day) - SPC



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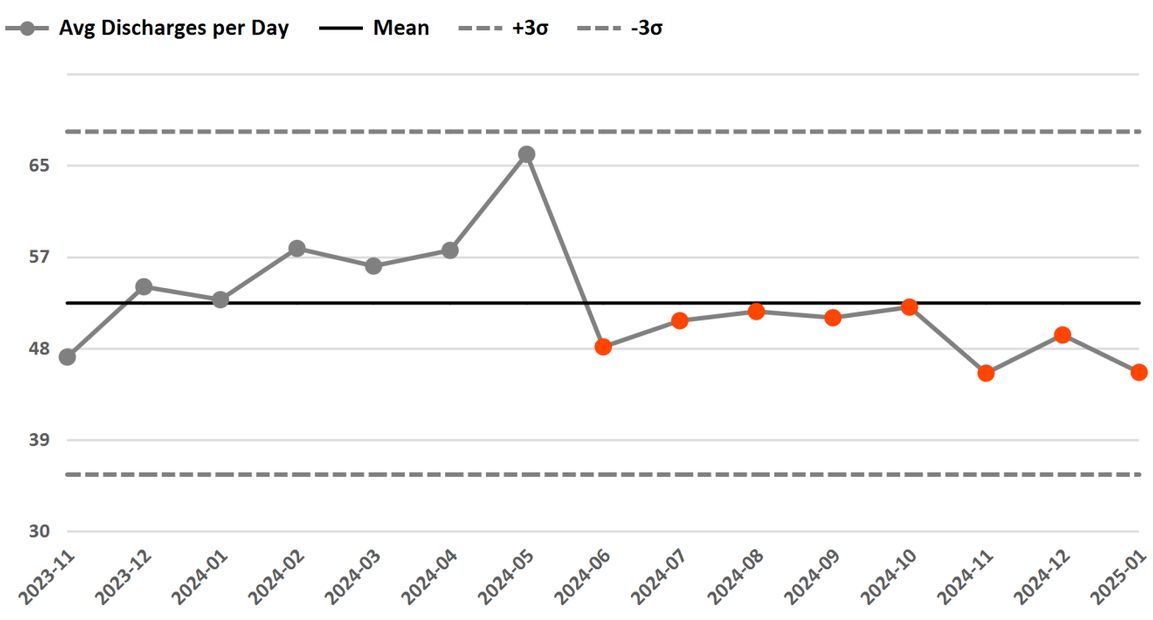
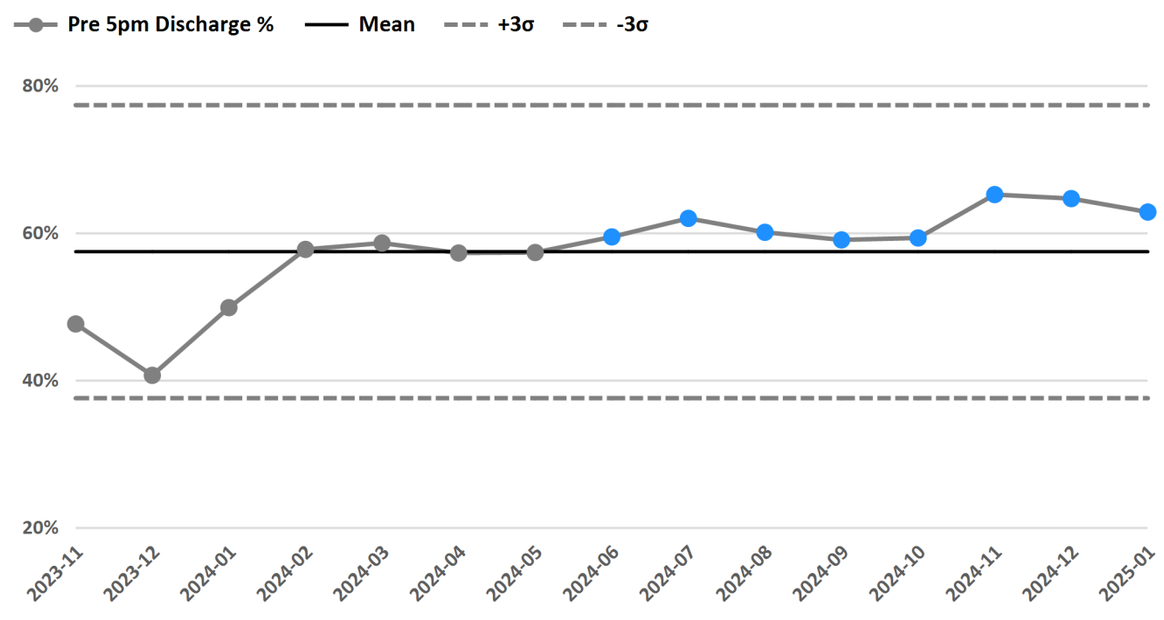
Discharges - QEH

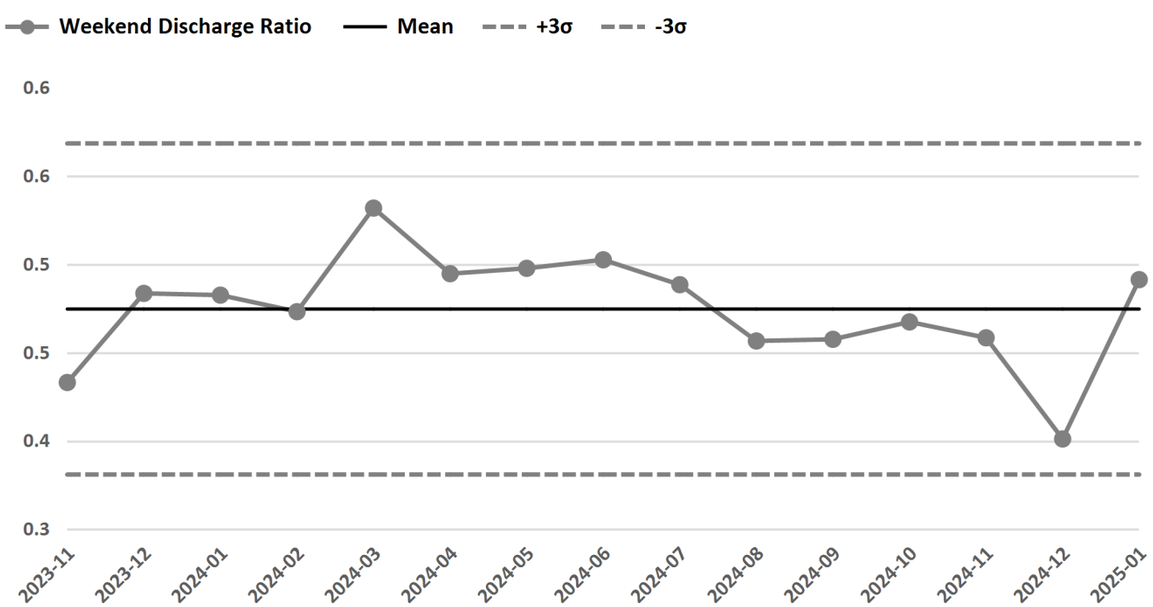
Mean Average Discharges per Day - SPC



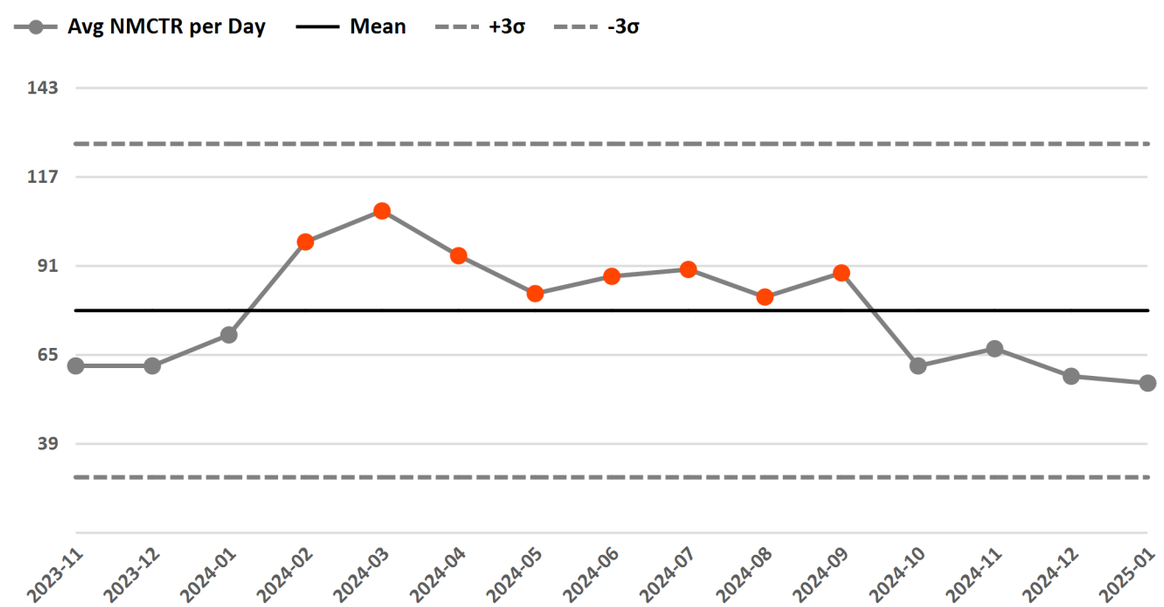
Pre 5pm Discharges as Percentage of Total Discharges - SPC



Weekend to Weekday Discharge Ratio - SPC



Patients Not Meeting Criteria To Reside (Average Per Day) - SPC



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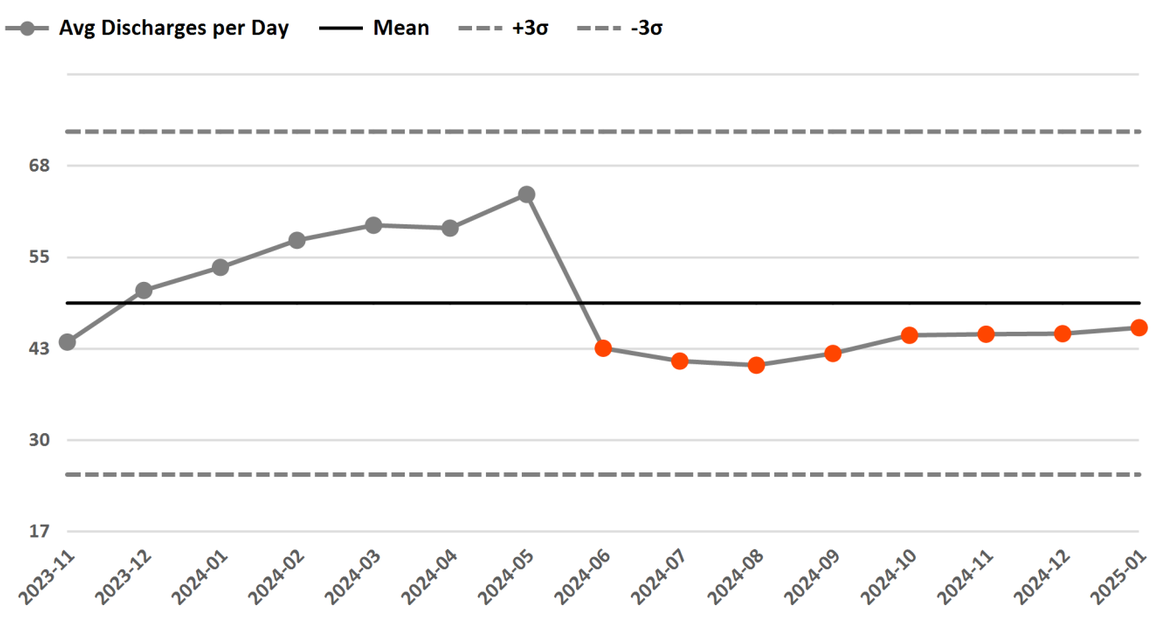
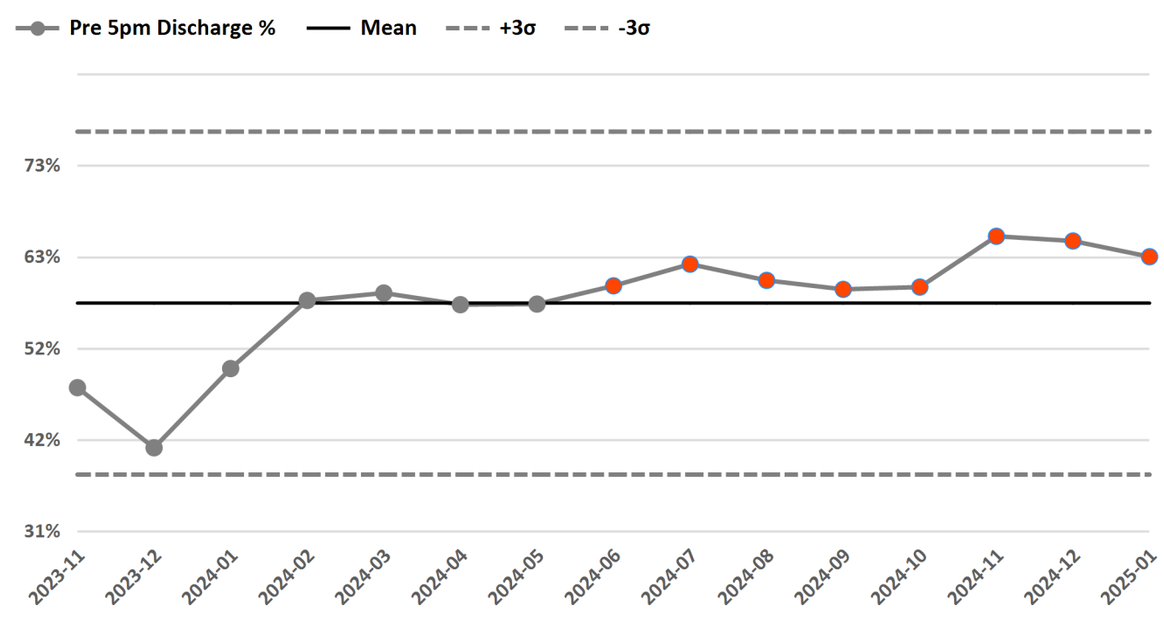
Discharges - UHL

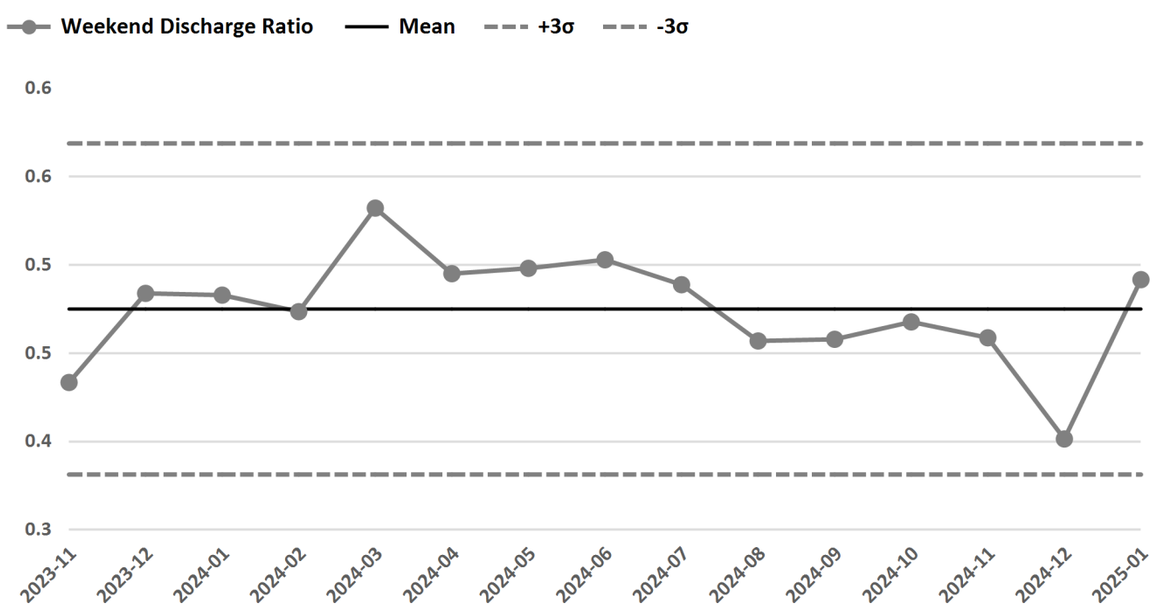
Mean Average Discharges per Day - SPC



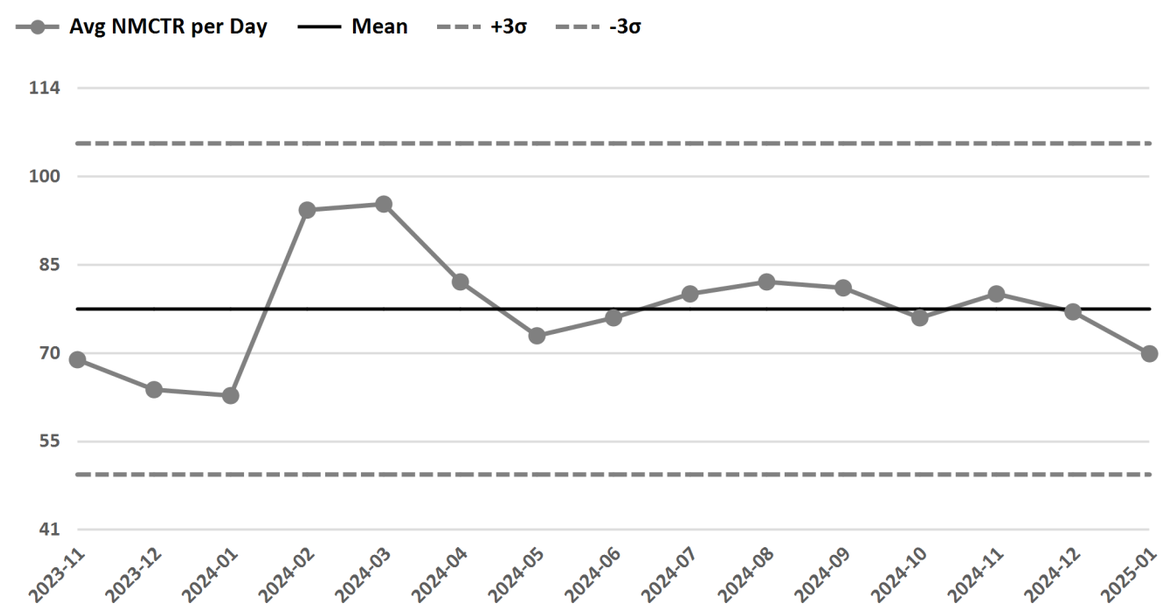
Pre 5pm Discharges as Percentage of Total Discharges - SPC



Weekend to Weekday Discharge Ratio - SPC



Patients Not Meeting Criteria To Reside (Average Per Day) - SPC



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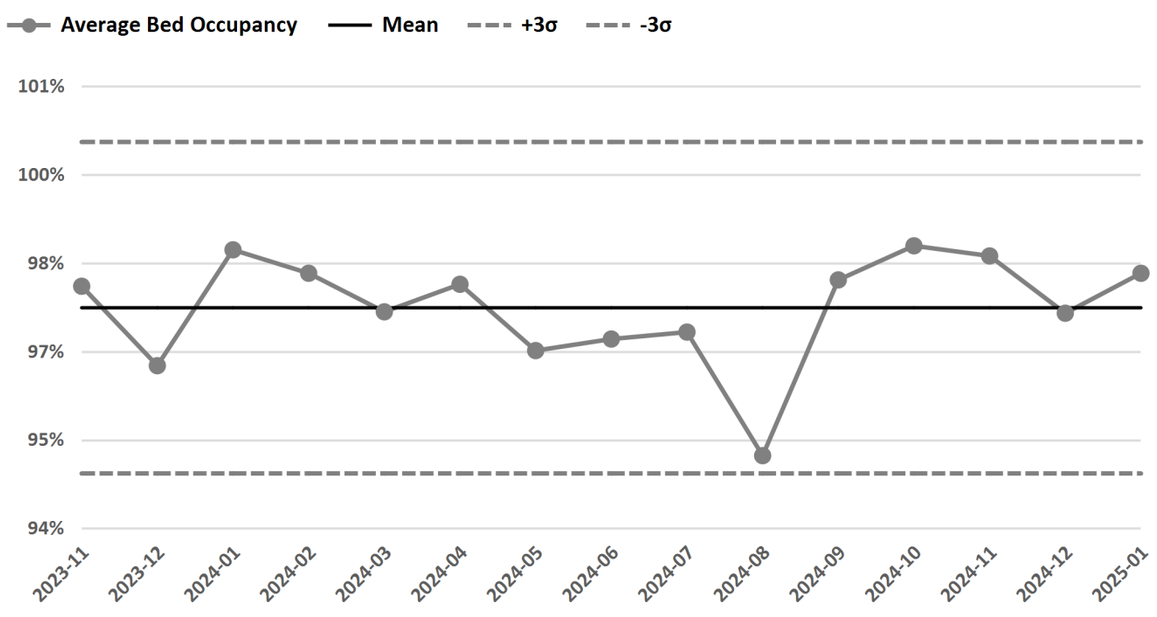
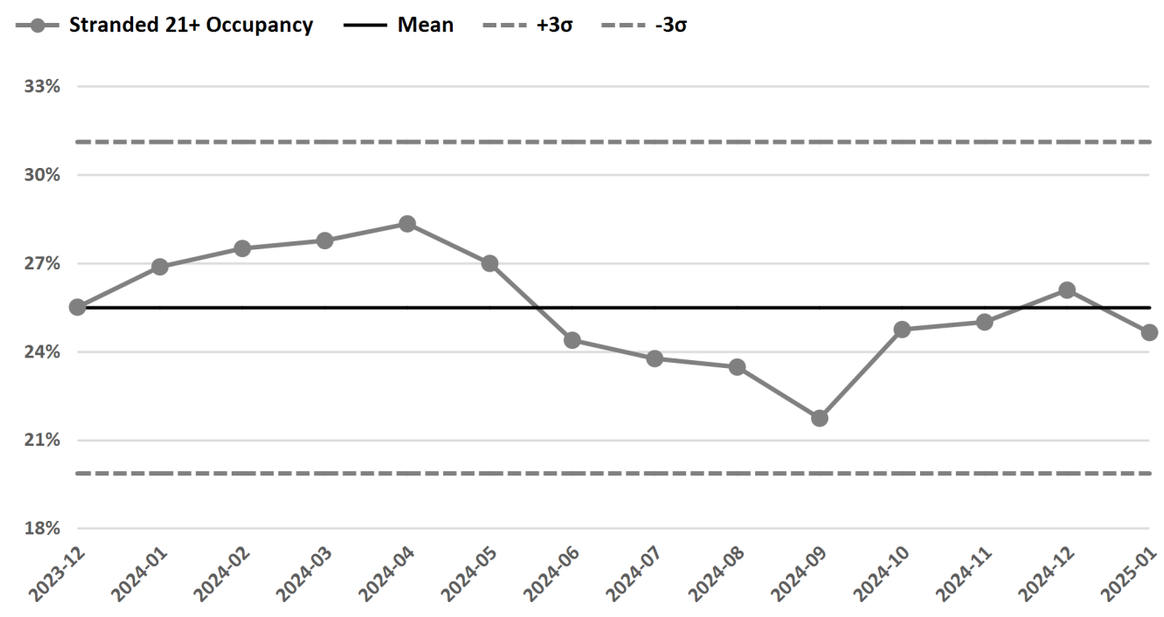
Bed Occupancy and Length of Stay - LGT

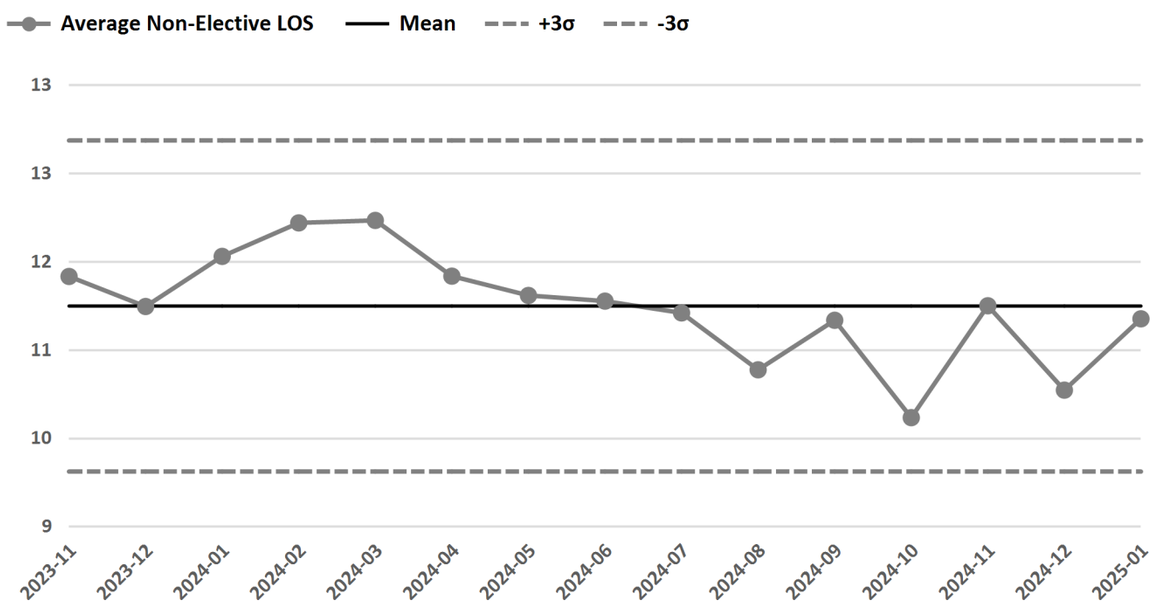
Average Bed Occupany (Excl Critical Care) - SPC



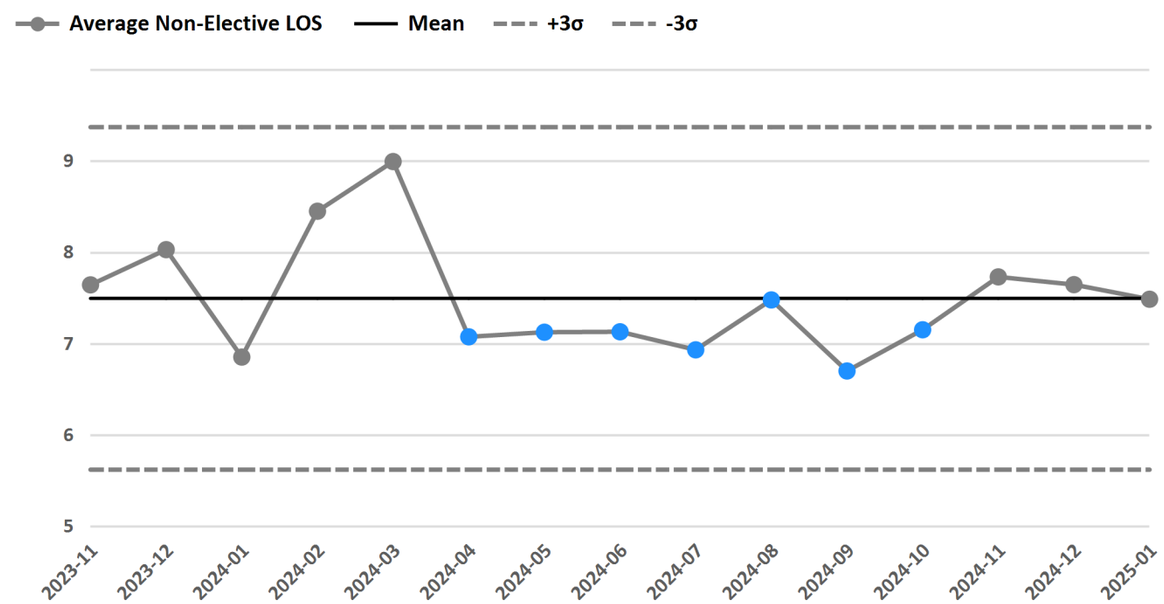
Patients Stranded 21+ Days as Percentage of Occupied Beds - SPC



Average LOS Non-Elective Medicine (Excl Zero Day Stays) - SPC



Average LOS Non-Elective Surgery (Excl Zero Day Stays) - SPC



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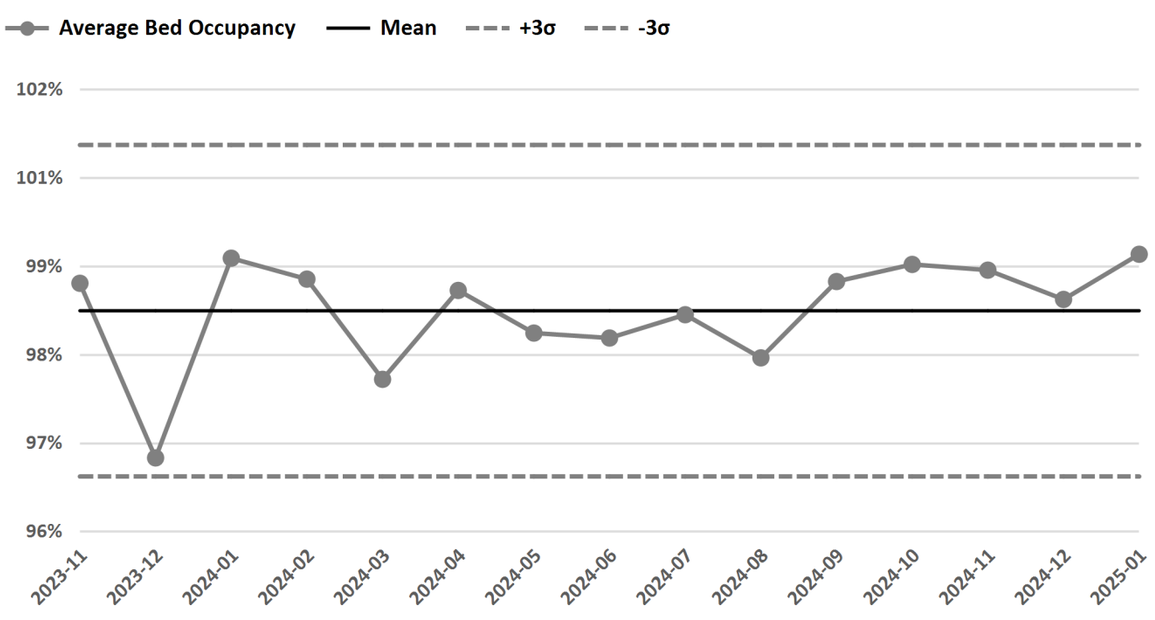
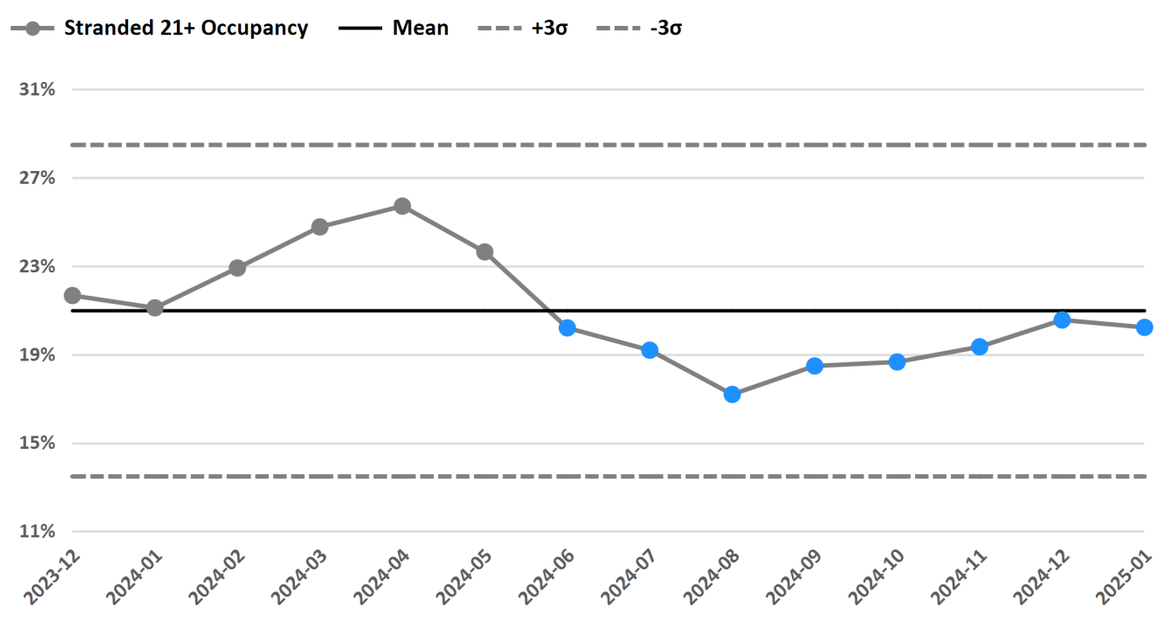
Bed Occupancy and Length of Stay - QEH

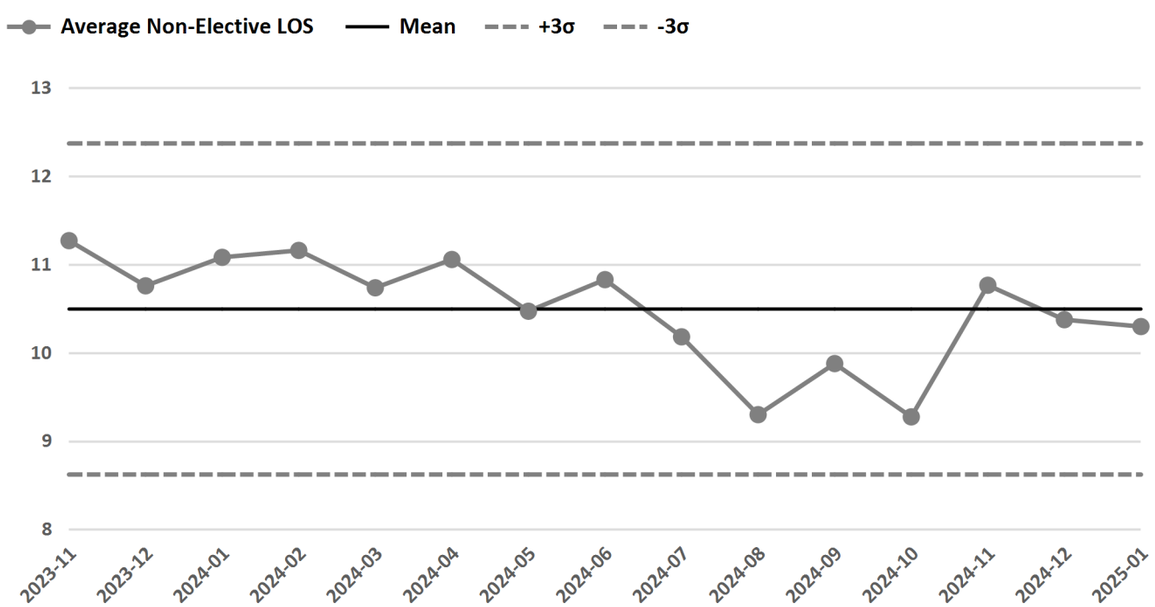
Average Bed Occupany (Excl Critical Care) - SPC



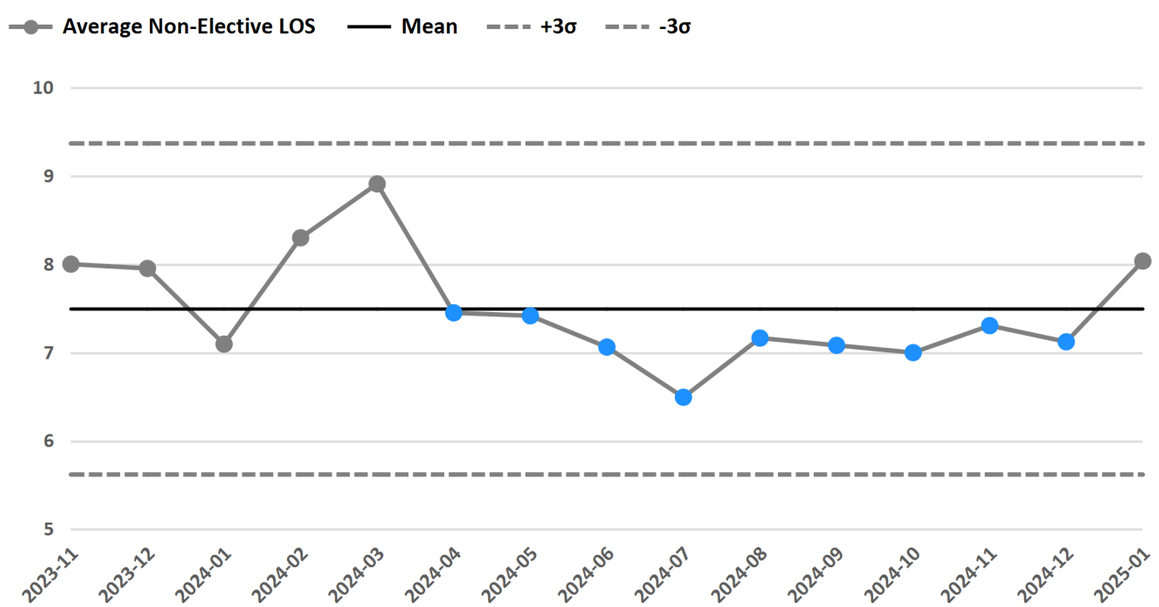
Patients Stranded 21+ Days as Percentage of Occupied Beds - SPC



Average LOS Non-Elective Medicine (Excl Zero Day Stays) - SPC



Average LOS Non-Elective Surgery (Excl Zero Day Stays) - SPC



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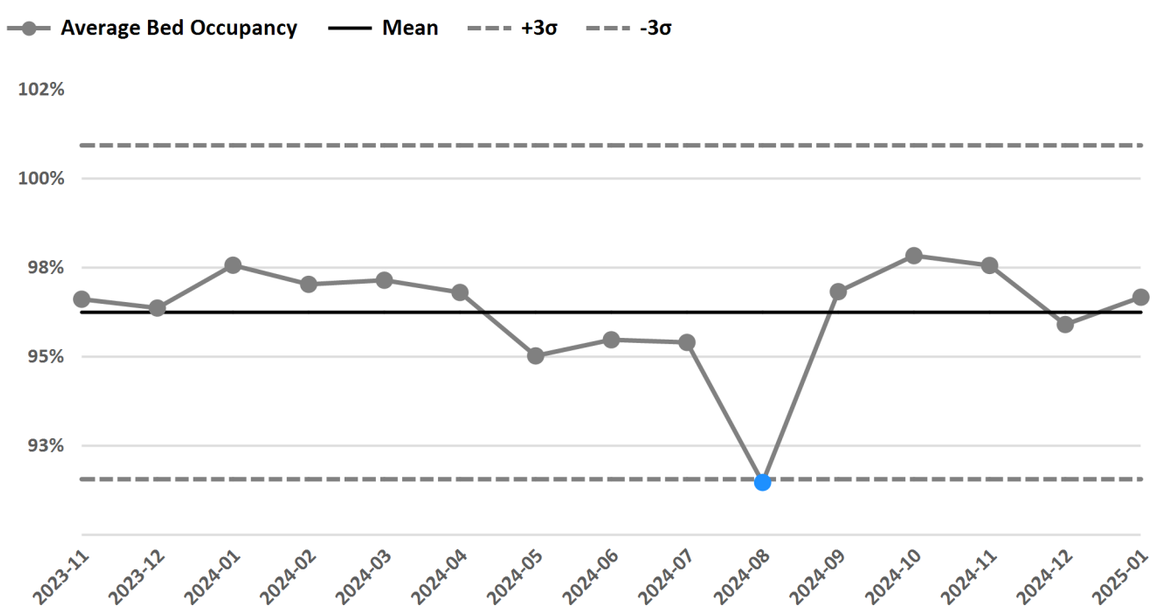
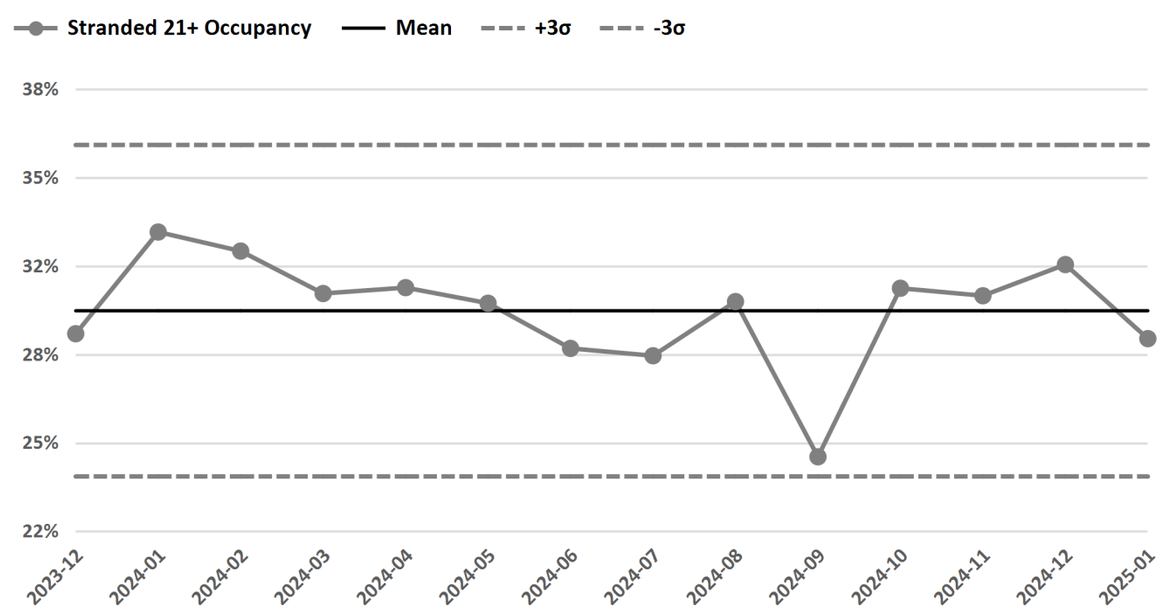
Bed Occupancy and Length of Stay - UHL

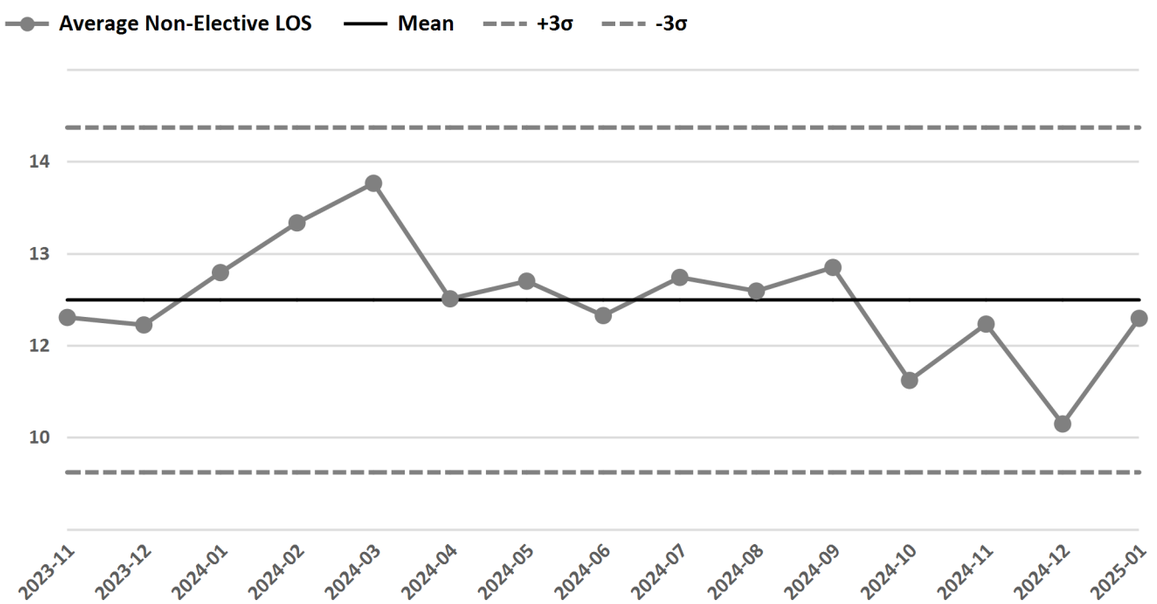
Average Bed Occupany (Excl Critical Care) - SPC



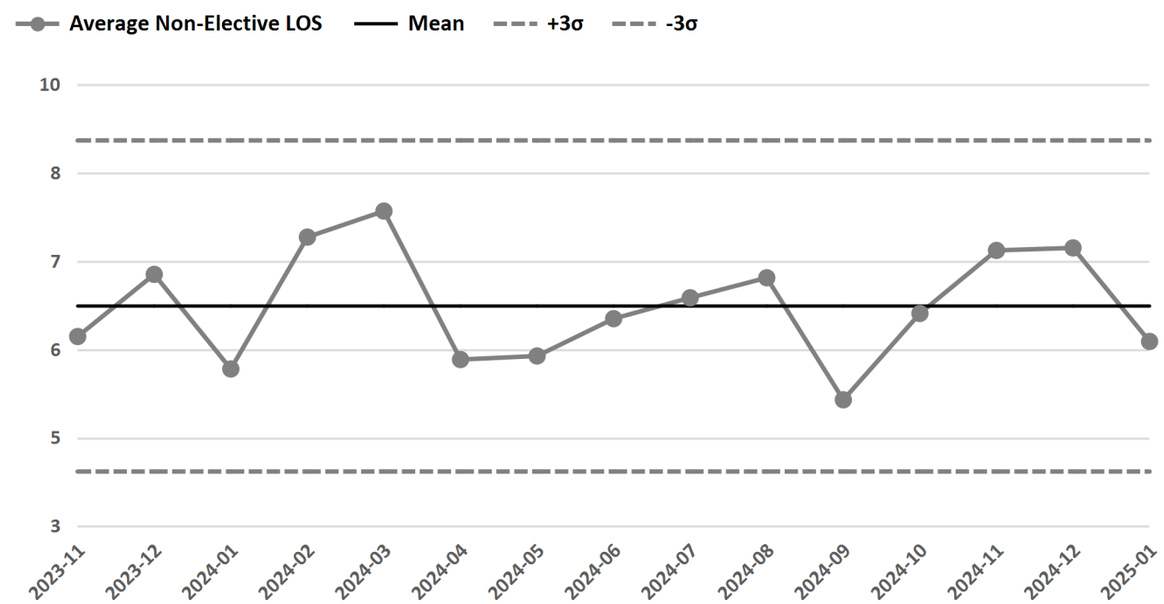
Patients Stranded 21+ Days as Percentage of Occupied Beds - SPC



Average LOS Non-Elective Medicine (Excl Zero Day Stays) - SPC



Average LOS Non-Elective Surgery (Excl Zero Day Stays) - SPC



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Metric Glossary

METRIC ID	METRIC DESCRIPTION	SPECIFICATION	NUMERATOR SPECIFICATION	DENOMINATOR SPECIFICATION	METRIC DATA SOURCE	METRIC UPDATED
M1001	ED Performance (All Types) - Trust	ED Performance against the national 4 hour target (all patients)	Count of patients treated and discharged from ED within 4 hours of their arrival.	Count of all patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35
M1002	ED Performance (Type 1) - Trust	ED Performance against the national 4 hour target (Type 1 Patients)	Count of TYPE 1 patients treated and discharged from ED within 4 hours of their arrival.	Count of all TYPE 1 patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35
M1003	ED Performance (Type 3) - Trust	ED Performance against the national 4 hour target (Type 3 Patients)	Count of TYPE 3 patients treated and discharged from ED within 4 hours of their arrival.	Count of all TYPE 3 patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35
M1005	ED Attendances (All Types)	Count of attendanced to ED by date of arrival	Count of attendanced to ED by date of arrival		MSitAE Monthly ED Sitrep	01/03/2025 12:35
M1007	ED 12hr Breaches - From Decision to Admit to Departure	Count of ED attendances still in ED 12hrs after a decision to admit as been made	Count of patients waiting in ED for 12 hours or great after a decision to admit has been made.		LGTSQL3.BIDATAFEED.dbo.SITREPSUBMISSIONLASTVIEW	01/03/2025 12:35
M1010	DM01 - All Diagnostics within 6 Weeks %	Percentage of patients waiting less that 6 weeks for their diagnostic test	Count of patients waiting less that 6 weeks for diagnostic tests	Count of all patient waiting for diagnostic tests	LGTSQL3.BIReportingDB.dbo.DM01_ReturnSite	22/02/2025 12:39
M1076	ED Performance (All Types) - QEH	ED Performance against the national 4 hour target (all patients)	Count of patients treated and discharged from ED within 4 hours of their arrival.	Count of all patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35
M1077	ED Performance (All Types) - UHL	ED Performance against the national 4 hour target (all patients)	Count of patients treated and discharged from ED within 4 hours of their arrival.	Count of all patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35
M1133	Adult Attendances - Type 1 - Activity	Count of Adult Type 1 patients attending ED			LGTDWH02.INFORMATION.DBO.EDVALIDATIEDPERFORMANCE	01/03/2025 12:35
M1134	Adult Attendances - Type 3 - Activity	Count of Adult Type 3 patients attending ED or UCC. UHL figure includes Paeds Type 1 which cannot be split out.			LGTDWH02.INFORMATION.DBO.EDVALIDATIEDPERFORMANCE	01/03/2025 12:35
M1138	ED 12Hr Breaches - From Arrival to Departure	Count of ED attendances still in ED 12hrs after a their arrival	Count of patients waiting in ED for 12+ hours after arrival.		LGTDWH02.APOLLO.DBO.ECDS	01/03/2025 12:35
M1154	% Ambulance Handovers < 30 Minutes	Percentage of ambulance arrivals waiting less than 30 minutes from arrival at site to handover.	Count of LAS arrivals waiting 30 minutes or less before handover to ED.	Count of all LAS arrivals.	LGTSQL3.BIReportingDB.dbo.LAS_Rolling_12_Month_Data	01/03/2025 12:35
M1210	RTT PTL - Admitted	Count of all incomplete RTT pathways with a decision to admit	Count of all incomplete RTT pathways with a decision to admit		LGT835-7.BI_RTT_Reporting.dbo.RTTMonthly_Submission_PatLevel	22/02/2025 12:39
M1211	RTT PTL - Non Admitted	Count of all incomplete RTT pathways without a decision to admit	Count of all incomplete RTT pathways without a decision to admit		LGT835-7.BI_RTT_Reporting.dbo.RTTMonthly_Submission_PatLevel	22/02/2025 12:39
M1218	ED Performance (Type 1) - QEH	ED Performance against the national 4 hour target (Type 1 Patients)	Count of TYPE 1 patients treated and discharged from ED within 4 hours of their arrival.	Count of all TYPE 1 patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35
M1219	ED Performance (Type 3) - QEH	ED Performance against the national 4 hour target (Type 3 Patients)	Count of TYPE 3 patients treated and discharged from ED within 4 hours of their arrival.	Count of all TYPE 3 patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35
M1220	ED Performance (Type 1) - UHL	ED Performance against the national 4 hour target (Type 1 Patients)	Count of TYPE 1 patients treated and discharged from ED within 4 hours of their arrival.	Count of all TYPE 1 patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35
M1221	ED Performance (Type 3) - UHL	ED Performance against the national 4 hour target (Type 3 Patients)	Count of TYPE 3 patients treated and discharged from ED within 4 hours of their arrival.	Count of all TYPE 3 patient attending ED.	LGTDWH02.INFORMATION.DBO.EDValidated Performance	01/03/2025 12:35

METRIC ID	METRIC DESCRIPTION	SPECIFICATION	NUMERATOR SPECIFICATION	DENOMINATOR SPECIFICATION	METRIC DATA SOURCE	METRIC UPDATED
M1245	Urgent Cancer Referrals	Total number of urgent cancer referrals recevied in the period.	Count of urgent cancer referrals recevied		LGTSQL3.BIReportingDB.dbo.CANCER_RPT_TARGET_RESULTS_PBI	01/03/2025 12:34
M1246	Cancer 2 Week Wait	Percentage of 'Two Week Wait' patients seen withing two weeks of referral	Count of 'Two Week Wait' cases, seen within two weeks of referral.	Count of 'Two Week Wait' cases.	LGTSQL3.BIReportingDB.dbo.CANCER_RPT_TARGET_RESULTS_PBI	01/03/2025 12:34
M1247	Cancer 28 Day FDS	Percentage of Cancer FDS patients sucessfully seen withing 28 days of referral.	Count of patient sucesses where the cancer group meets the dollwing criteria: '28 Day FDS Breast Symptomatic','28 Day FDS Screening','28 Day FDS TWW'	Count of patient cases where the cancer group meets the dollwing criteria: '28 Day FDS Breast Symptomatic','28 Day FDS Screening','28 Day FDS TWW'	LGTSQL3.BIReportingDB.dbo.CANCER_RPT_TARGET_RESULTS_PBI	01/03/2025 12:35
M1276	Patients Not Meeting the Criteria to Reside (Avg Per Day)	Average number of patients not meeting the criteria to reside in the hospital (Mean average per day)	Cumulative count of the daily number of patients not meeting the criterial to reside in the hospital.	Number of days in the month.	LGTSQL3.BIReportingDB.dbo.DPTL_DischargeDailyReturn	01/03/2025 12:39
M1279	Pre 5PM Discharges as % of Total Discharges	Percentage of monhtly discharges that take place before 5pm	Count of inpatient discharges before 5pm.	Count of all inpatient discharges.	LGTSQL3.BIReportingDB.dbo.DPTL_DischargeDailyReturn	01/03/2025 12:39
M1280	Weekend to Weekday Discharges Ratio	The ratio of average daily discharge on a weekend vs average daily discharge on a weekday (includes bank holidays as weekends)	Cumulative count of weekend discharges in the month, divided by the number of weekend days in the month.	Cumulative count of weekday discharges in the month, divided by the number of weekdays in the month.	LGTSQL3.BIReportingDB.dbo.DPTL_DischargeDailyReturn	01/03/2025 12:39
M1285	Average Bed Occupancy (Excl. Critical Care)	Mean average bed occupancy for the month for all General & Acute beds (excluding Critical Care areas). Sourced from Daily CSM Bed State files and aggregated monthly.	Total of occupied beds.	Total of open beds	LGTSQL3.BIDATAFEED.dbo.BEDSTATEUPLOAD	01/03/2025 12:13
M1303	Activity - Elective - Plan Monthly	Plan for the amount of Elective activity undertaken each month.			LGTDWH02.OCD.dbo.SLATarget2022	01/03/2025 12:27
M1304	Activity - Day Case - Plan Monthly	Plan for the amount of Day Case activity undertaken each month.			LGTDWH02.OCD.dbo.SLATarget2022	01/03/2025 12:27
M1309	Activity - New Outpatients Appointments - Plan Monthly	Plan for the number of New OP Appointments each month.			LGTDWH02.OCD.dbo.SLATarget2022	01/03/2025 12:27
M1311	Activity - Elective - Actual Monthly	Count of activity where the POD is recorded as 'EL'. Indicating Elective activity.			LGTDWH02.APOLLO.DBO.APC	01/03/2025 12:27
M1312	Activity - Day Case - Actual Monthly	Count of activity where the POD is recorded as 'DC', 'DC-SCOPES','DC-SCOPES-DM01','DC-SCOPES-OTH' or 'DC-SCOPES-NON'. Indicating Day Case activity.			LGTDWH02.APOLLO.DBO.APC	01/03/2025 12:28
M1317	Activity - New Outpatients Appointments - Actual Monthly	Count of outpatient appointments where the FIRST APPOINT<ENT flag = 1 and the appointment POD is in a specific list of PODs	Count of attended outpatient appointments where the appointment POD meets the following criteria: 'MSK-BACK','MSK-BACK-FIRST','MSK-UPPER','MSK-UPPER-FIRST','MSK-LOWER','MSK-LOWER-FIRST' and the FIRST_ATTENDANCE flag = 1 OR the attendance POD = 'FIRST-NF2F','VC-NEW','NF2F','FIRST-CON-MP','FIRST-CON-SP','FIRST-NONCON-SP','PREADM-FIRST','AMBCARE-FIRST','MSK-BACK-FIRST','MSK-LOWER-FIRST','MSK-UPPER-FIRST','PHYSIOADULTNEW','PHYSIOCHILDNEW','PHYSIOOP-NEW','AUDIOOP-NEW','DIETOPNEW','ICD1'		LGTDWH02.APOLLO.DBO.OPA	01/03/2025 12:29
M1350	RTT Incomplete Pathways Over 52 Weeks	Count of RTT Incomplete Pathways waiting over 52 weeks at the month end. From the trusts submitted monthly RTT position			LGT835-7.BI_RTT_Reporting.dbo.RTTMonthly_Submission_PatLevel	22/02/2025 12:39
M1351	RTT Incomplete Pathways Over 65 Weeks	Count of RTT Incomplete Pathways waiting over 65 weeks at the month end. From the trusts submitted monthly RTT position			LGT835-7.BI_RTT_Reporting.dbo.RTTMonthly_Submission_PatLevel	22/02/2025 12:39

METRIC ID	METRIC DESCRIPTION	SPECIFICATION	NUMERATOR SPECIFICATION	DENOMINATOR SPECIFICATION	METRIC DATA SOURCE	METRIC UPDATED
M1352	RTT Incomplete Pathways	Count of RTT Incomplete Pathways at the month end. From the trusts submitted monthly RTT position			LGT835-7.BI_RTT_Reporting.dbo.RTTMonthly_Submission_PatLevel	22/02/2025 12:39
M1355	RTT Incomplete Pathways Over 78 Weeks	Count of RTT Incomplete Pathways waiting over 78 weeks at the month end. From the trusts submitted monthly RTT position			LGT835-7.BI_RTT_Reporting.dbo.RTTMonthly_Submission_PatLevel	22/02/2025 12:39
M1356	RTT Incomplete Pathways Over 18 Weeks	Count of RTT Incomplete Pathways waiting over 18 weeks at the month end. From the trusts submitted monthly RTT position			LGT835-7.BI_RTT_Reporting.dbo.RTTMonthly_Submission_PatLevel	22/02/2025 12:39
M1437	Cancer 62 Day Backlog - Urgent Suspected Cancer - All Tumour Sites	Count of Cancer patients waiting 62+ days for treatment. The last Weekly UNIFY submission position of the calendar month.	Count of Cancer patients waiting 62+ days for treatment. All Tumour Groups		LGTSQL3.BIReportingDB.dbo.CANCER_UNIFY_SUBMISSION	01/03/2025 12:35
M1442	Cancer 31 Day Performance	Percentage of Cancer pathways starting treatement within 31 days of diagnosis	Count of 31 Day Cancer Pathways starting treatment within 31 Days	Count of 31 Day Cancer Pathways	LGTSQL3.BIReportingDB.dbo.CANCER_RPT_TARGET_RESULTS_PBI	01/03/2025 12:35
M1443	Outpatient Procedures & First Appointments as % of Total Outpatient Activity	OP Procedures and First Appoinments as a percentages of total OP appoinments	Sum of OP Procedures and OP First Appoinments	Sum of all OP Appointments	LGTDWH02.APOLLO.DBO.OPA	01/03/2025 12:32
M1444	Patients Stranded 7+ Days as % of Occupied Beds		Monthly total of patients stranded 7+ Days	Monthly total of occupied bed days	LGTSQL3.BIDataFeed.dbo.SubmissionHistory	01/03/2025 12:39
M1446	Patients Stranded 21+ Days as % of Occupied Beds		Monthly total of patients stranded 21+ Days	Monthly total of occupied bed days	LGTSQL3.BIDataFeed.dbo.SubmissionHistory	01/03/2025 12:39
M1447	Cancer 62 Day Performance - Internal	Percentage of Cancer pathways starting treatement within 62 days of diagnosis. Uses internal patient level data.			LGTSQL3.BIReportingDB.dbo.CANCER_RPT_TARGET_RESULTS_PBI	01/03/2025 12:35
M1448	ED Length of Stay (in Hours) - Mean	Mean LOS (in hours) for ED patients	Cumulative time (in minutes) between patient arrival timestamp and departure timestamp. Divided by 60 to convert to hours.	Count of patients attending ED for treatment.	LGTDWH02.APOLLO.DBO.ECDS	01/03/2025 12:38
M1449	Discharges (Mean Average per Day)	Mean number of discharges on per day during the month	Cumulative inpatient discharges during the month.	Count of days in the month.	LGTSQL3.BIReportingDB.dbo.DPTL_DischargeDailyReturn	01/03/2025 12:39
M1450	ED Conversion Rate (All Types)	The percentage of ED attendances that are subsequently admitted as an inpatient	Number of emegency admissions via ED	Number of ED attdannces	MSitAE Monthly ED Sitrep	01/03/2025 12:38
M1451	DM01 - All Activity				LGTSQL3.BIReportingDB.dbo.DM01_ReturnSite	22/02/2025 12:39
M1453	Average Length of Stay in Days - (Non-Elective - Medicine - Excl Zero Day Spells)	Mean average spell length in days for non elective patients in the month. Excludes zero day spells	Sum of spell days for non elective patients in the Medicine divisions	Count of spells for non elective patients in the Medicine divisions	LGTDWH02.APOLLO.DBO.APC	01/03/2025 12:23
M1454	Average Length of Stay in Days (Non-Elective - Surgery - Excl Zero Day Spells)	Mean average spell length in days for non elective patients in the month. Excludes zero day spells	Sum of spell days for non elective patients in the Surgery division	Count of spells for non elective patients in the Surgery division	LGTDWH02.APOLLO.DBO.APC	01/03/2025 12:23
M1459	Cancer 62 Day Performance - NHS Statistics Version	Percentage of Cancer pathways starting treatement within 62 days of diagnosis. Figure sourced from NHS Statistics website			NHS Statistics Website	01/03/2025 12:35
M1462	Activity - Day Case Activity against Day Case Plan				LGTDWH02.APOLLO.DBO.APC	01/03/2025 12:33
M1463	Activity - Elective Activity against Elective Plan				LGTDWH02.APOLLO.DBO.APC	01/03/2025 12:33
M1464	Activity - First Outpatient Appointment Activity against First Outpatient Appointment Plan				LGTDWH02.APOLLO.DBO.OPA	01/03/2025 12:33
M1465	Theatre Session Utilisation (Capped) - Model Hospital				Model Hospital	01/03/2025 12:38

Lewisham and Greenwich NHS Trust

TRUST BOARD REPORT
25th March 2025

Report from:	**Audit, Risk and Compliance Committee (ARCC)**
Date of Committee Meeting:	**11 March 2025**

Purpose of the Committee:

The purpose of the Audit, Risk and Compliance Committee is to assist the Board to deliver its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Board that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards;
- Public money is safeguarded and properly accounted for;
- Financial Statements are prepared in a timely manner and give a true and fair view of the financial position of the Trust for the period in question;
- Affairs are managed to secure economic, efficient and effective use of resources;
- The Trust is compliant with all applicable legislation;
- Reasonable steps are taken to prevent and detect fraud and other irregularities; and.
- The processes underpinning the corporate risk register are robust in relation to the review, mitigation and escalation of risks at a division, executive strategy group and Trust Board level.

Purpose:	**For approval or ratification** ☐ **Item to receive/for information** ☒ **For discussion** ☐ **For decision** ☐
Committee Chair:	**Anna King, Non-Executive Director**
Lead Director:	**Kate Anderson, Chief of Staff** **Spencer Prosser, Chief Financial Officer**

1. ITEMS APPROVED

Proposed Bad debt write off
The ARCC approved £1.5m of bad debts to be written off detailed in the 'Losses and Special payments' report. This amount was proposed for write off in accordance with the Corporate Governance Manual and included £1,154k for Accounts Receivable (All debt with an existing provision over three years old) and £384k for Income Collection Receivables (This was comprised of cases older than three years and withdrawals determined and processed by the Compensation Recovery Unit at source)
.
No further items were presented to the ARCC for approval in March.

2. ITEMS DISCUSSED / RECEIVED

2.1. External Audit 2024/25 Audit plan
The ARCC received the proposed plan, noting no major changes to the accounting framework for the period ending March 2025. The Committee noted:

- Materiality for the 2024/25 audit will be £15.3m (PY £10.25m), which equates to 1.8% of the Trusts prior year gross operating costs for the year.
- Those risks identified as requiring special audit consideration and procedures to address the likelihood of a material financial statement were confirmed as:
    - Management override of controls
    - Fraud in revenue recognition-Patient Care activities
    - Fraud in Revenue Recognition – Other operating Income (rebutted)
    - Valuation of land and buildings
- The Value for Money (VFM) assessment highlighted potential weaknesses in financial sustainability due to the wider issue of the overall NHS financial landscape.

2.2. Internal Audit and Local Counter Fraud Services (LCFS) Annual Reports
The ARCC received an update detailing Internal Audit activity since the last meeting. This included:

- The Data Quality: Patient Complaints audit report which provided an assurance rating of *partial assurance with improvements required*, focusing on the accuracy and completeness of the data. Assurance was provided to the Committee by management that the high priority recommendation identified in the audit had been completed.
- The ARCC was informed that reviews relating to Divisional Governance, Pathology and the Data Security and Protection Toolkit were underway and would be presented to the ARCC meeting in May.
- The Committee reviewed the status of audit recommendations and was provided with an update on each of the six overdue recommendations. Of these, two recommendations in relation to estate contract monitoring arrangements had been closed in discussions between KPMG and the finance team ahead of the meeting.

The ARCC received an update detailing LCFS activity since the last meeting. This included:

- Completion of fieldwork for an agreed review focused on Secondary Working; and
- Progression of investigations for ten open referrals

2.3. Review of Clinical and Non-Clinical Claims
The ARCC received a report on claims and premium costs, noting that this report was commissioned to analyse the Trust's litigation of clinical and non-clinical claims between 2019 – 2024/25, with the aim of identifying themes and learning, as well as potential opportunities to reduce the Trust's NHSR insurance premium cost (2025/26: £39.2m). The review also identified a number of actions that clinical and non-clinical teams could take forward to help limit future increases in the premium cost.

2.4. Human Tissue Authority Report on previous actions:
The ARCC received a report detailing the findings of the follow up site inspections undertaken by the HTA in October 2024 of the mortuaries at both hospital sites, and post mortem tissue storage in the Histopathology laboratory at UHL. The inspection had identified one major shortfall in relation to the disposal of tissue in line with the HTA's codes of practice which was resolved immediately. Management confirmed to the ARCC that actions had been put in place to address this issue and prevent recurrence of delays in tissue disposal.

2.5. Corporate Risk Register and BAF
The ARCC received the latest version of the corporate risk register (CRR) and Board Assurance Framework (BAF). All risks in the CRR had been reviewed in March and would be subject to the usual Committee scrutiny.

The ARCC received the latest version of the BAF, and noted Executive leads and Committee Chairs would be consulted in March/April as part of the development of an updated BAF being presented to the Board in April 2025. This would detail proposed strategic risks for the 2025/26 period.

2.6. Fire Safety Update

Further to an update to the January Committee, the ARCC received an update on fire safety risks at the Trust. This focused on actions at the QEH site in response to the Milestone Two interim and final reports received from fire safety specialists ARUP in relation to the QEH site. This Milestone two report related to a detailed survey jointly commissioned by the Trust and Meridian Hospital Company PLC to undertake a full audit of the condition of the QEH site ahead of the break clause within the PFI contract.

The ARCC was informed of progress to implement a series of immediate and important mitigations to reduce the potential fire risks identified within the report. These included:

- Enhanced Trust-wide communications, fire training and increased recruitment of fire marshals;
- Focused fire safety audits;
- Daily site walks, external inspections of the facades and unit specific evacuation exercises;
- Fire Safety Committees on each site chaired by the Deputy Chief Operating Officers; and
- Investment in additional essential fire safety equipment including evacuation chairs, fire blankets and ResQsheets.

The ARCC was informed of recent discussions with NHS England, and an action plan agreed with NHS England to help mitigate fire safety risks on the QEH site. The ARCC was also advised a meeting was planned with London Fire Brigade on the 13 March 2025, at which LFB would conduct an onsite review and consider its standard incident response.

As reflected on the risk register, the Committee was informed that a recent independent external fire safety audit, conducted by Leviathan, had highlighted several fire safety compliance issues at St Nicholas Tower in addition to historical design and construction shortcomings. Whilst Meridian Hospital Company and Vinci were preparing a building application to undertake remedial works, ongoing options for the future use of this building were under consideration by management.

The ARCC noted the increased risk attached to the fire risk reflected on the Corporate Risk Register and discussed the importance of compliance with fire safety measures and ongoing monitoring and training.

The ARCC requested the interim ARUP report was presented to the January Part Two Trust Board meeting with an update on the progress to implement the actions put in place by management.

2.7. Losses and Special payments

The Committee received a report outlining a breakdown of Losses and Special payments made in the period to 28 February 2024. This totalled £1.7m and included £1.5m of proposed bad debt write-offs as noted in section 1 to this report.

3. MATTERS OF ESCALATION

The ARCC requested a further Fire Safety update and Milestone Two ARUP report summary (in relation to the fire risks at the QEH site) was shared in full at the March meeting of the Trust Board.

4. INFORMATION ITEMS

The ARCC received the following items for information:

- Information Governance and Security Steering Group Summary
- Health and Safety Committee Summary

Lewisham and Greenwich NHS Trust

TRUST BOARD

Title: **Corporate Risk Register and Board Assurance Framework update**

Date: 25 March 2025

Summary of paper: The **Corporate Risk Register** is included in *Appendix 1* which has been presented to TME and Board sub-committees in March 25. There are currently 17 risks on the register. Changes to the risk register since last updated to Trust Board (Jan 2025) are as follows:

One risk added

- One risk has been added to the corporate risk register: **CRR054 (Urology service),** following discussions at TME and QPC in Feb 2025.

One risk proposed for score reduction and removal

- It was agreed at PPC in March 25 to reduce the risk score for **CRR050 (Nursing Vacancy risk).** Whilst recruitment to the HVLC theatres at UHL remains a risk ahead of opening later in 2025 and QE26, the improved retention and low vacancy rate is noted; it was therefore agreed to reduce the risk score from 15 to 12 and remove from the Corporate Risk Register.

One risk retained

- Trust Board is asked to note the agreement to retain the risk **CRR035 (Consultant vacancies)** at the agreed risk score of 15. Discussion at committees in February 25 proposed that the risk be retained on the Corporate Risk Register and in parallel, specialty specific risks developed as appropriate. With this in mind, a Urology risk has been added to the corporate risk register in Feb 25 (CRR054), as outlined above.

The strategic risks as set out in the **Board Assurance Framework 2024/25** have been updated in March 25 and are included at *Appendix 2*. The BAF risks have been discussed at the relevant Board sub-committees in March 25.

Committees were also asked to consider whether the strategic risks as defined on the current BAF remain relevant for the 25/26 period. Follow up meetings with Executive leads and committee Chairs have been scheduled to finalise these.

Purpose:

Approval	*Assurance*	*Consideration*	*Note*
	✓	✓	

Recommendations / decisions required:

Board members are asked to:

- **Note** the changes presented in this latest version of the Corporate Risk Register and Board Assurance Framework

Overall Level of Assurance:

Assurance Level	
Significant	✓ The Board Assurance Framework and Corporate Risk Register are intended to provide assurance to the Trust Board that significant risks to delivery of the Trust's agreed priorities are identified and appropriately mitigated to a tolerable level (as set out in the agreed risk appetite statement).
Sufficient	
Limited	
None	
N/a	

Link to the Trust's Key Priorities:

✓	Continually improve safety and quality.
✓	Put patients at the heart of everything we do.
✓	Support and develop our workforce to live our values every day
✓	Work effectively with partner organisations.
✓	Ensure we spend every penny wisely.

Resource Implications: No identified resource requirement.

Regulations and legal considerations: The potential for regulatory intervention and relevant legal considerations are identified against each risk considered in the Corporate Risk register and Board Assurance Framework.

Quality consideration and impact on patient and carers: High standards of risk identification and appropriate risk mitigation and management by Trust officers will contribute towards the Trust's public ambition to provide high quality care to every patient, every day.

Health Inequalities Risks that could result in inequalities for populations of staff, patients and stakeholders with protected characteristics are considered for each key risk area identified.

Link to the Trust's Green Plan	The Trust's Green Plan objectives are integral to the risk profile of the organisation and specific risks and mitigations are included in the appropriate key risk areas identified.
Consultation/ Communication:	Ongoing review through Divisional Boards, Trust Execs, TME, Board sub-committees
Risk issues:	As detailed in the attached documents.
Confidentiality:	This report does not contain any confidential information
Equality, Diversity & Inclusion (EDI) (relating to staff, patients and the public)	No specific considerations in relation to EDI matters have been identified in the preparation of these documents. Risks that could result in inequalities for populations of staff, patients and stakeholders with protected characteristics are considered for each key risk area identified.
Approved by/ Lead Executive Director	Kate Anderson, Chief of Staff

	BAF STRATEGY OBJECTIVE	TRUST PRIORITY	RISK APPETITE	Date Added	Summary Description (Cause-Effect-Impact)	Responsible Director	Summary of Mitigation	Progress	Expected date for completion	ORIGINAL Risk Score (SxL)	CURRENT Risk Score (SxL)	TARGET Risk Score (SxL)	Movement	Date of Last Review	Review Committee/Source of internal Assurance	Regulatory Body/Agency
CRR001	**1,3**	**1**	***LOW***	**New Risk Added 23/10/19 Amended Dec. 2020**	**DELAYS TO TREATMENT RESULT IN PATIENT HARM / RTT PATHWAYS:** Following the suspension of most elective surgery (excluding urgent and emergency) during wave 1 and 2 of the covid-19 pandemic, the backlog of patients waiting over 18 weeks has increased substantially and there are very significant numbers of patients waiting over 52 and even 104 weeks. As of September 2021 there are 2,043 patients waiting more than 52 weeks for treatment (996 admitted and 1047 non-admitted) and 109 waiting >104 weeks (91 admitted and 18 non-admitted). Whilst all patients on the admitted PTL have been clinically prioritised (>95%), there is an increased risk of harm to patients because they may not be treated in the timescales indicated by their clinical prioritisation. Services with the longest waits are: general surgery, trauma and orthopaedics, gynaecology, ENT.	Chief Operating Officer	Key areas of focus: 1. Clinical review and clinical management of patients on the waiting list including clinical prioritisation of all admitted patients. 2. Appropriate administrative and RTT management of all patients as per national RTT policy and the local RTT/PTL improvement plan (approved by the Board in June 2021). 3. Increasing activity including improved internal productivity (outpatient and theatres transformation programmes), use of the independent sector and mutual aid from GSTT and KCH (developments in the APC). Addressing the anaesthetic vacancy gap in the short term. 4. Communication with waiting patients. Current actions: • Administrative and clinical review of all long wait patients to agree clear next steps in line with RTT policy. • Weekly PTL meetings with all services to ensure appropriate management of all long waiting patients and clinical priorities. • Clinical prioritisation group (chaired by CMO, attended by CDs and GMs) returned to a weekly meeting from July to ensure appropriate allocation of prioritisation categories and treatment of prioritised patients. Clinical harm reviews undertaken for all P2 patients waiting >4 weeks (consistent with NHSE London practice). • Implementation of the PTL improvement plan (roles, responsibilities, training, reports and SOPs) underway and with in-depth pilot areas of ENT, general surgery and gynae. • Improvement in theatre utilisation led by theatre productivity programme. • Outpatient improvement led by the outpatient transformation programme. • Mutual aid from GSTT and KCH in key services. Ongoing use of independent sector for low complexity, long wait patients. • Plans in place to use new QMS capacity for gynae and general surgery from September.	**Mar 25:** In January, the target of 243 patients waiting 65 weeks was not met, with 296 patients recorded, including 33 waiting over 78 week. The external forecast for February is 209 65 week waits and 20 78 week waits. The current cohort for February is 416 patients, of whom 345 require action to avoid breaching. ENT remains the specialty with the biggest challenge, making up 32% of the February cohort and 45% of the forecast position. The challenge in ENT is driven by an increase in Urgent Suspected Cancer referrals, diagnostic demand increases due to increased community activity and a high number of P2 patients listed for surgery. Plans to address each of these challenges are in train. The transfer of the vascular service to GSTT is also in progress and will have a positive impact on our long wait position. For March we have forecast 150 and 25 patients and, at the time of writing, the current cohort is 815 patients. **Jan 25:** Progress on the long waiter position remains positive, although slightly slower than forecast. At the end of November, we reported 283 patients over 65 weeks and 46 over 78 weeks. The December position requires further validation in early January following the Christmas break, but we anticipate that we will report 36 patients for 78 weeks and a maximum of 320 65-weeks. For January 65-week waits we have a forecast of 243 patients. The current cohort of 902 includes 730 patients in high-risk specialties (ENT, Gynaecology, Vascular, General Surgery, and T&O), of which 439 remain un-booked. More than half of these are in ENT. The H2 Elective Recovery plan is in progress, with January seeing the delivery of key projects, including vascular service transfer to GSTT, insourcing for urogynaecology and urodynamics and increased outpatient and diagnostic capacity. All services except ENT and Vascular are forecasting 0 patients at 78 weeks by the end of January.	Ongoing - plan to reduce patients waiting 52w or longer in line with agreed trajectory set out in operational plans.	**5x4 =20**	**5x4 =20**	**5x2 =10**	↔	Mar 25	Trust Board QPC TME Div PR	NHSEI / CQC
CRR035	**1,3**	**3**	***LOW***	**10.09.21 (Risk updated 26/1/23)**	**CONSULTANT VACANCIES** As at November 2022 the Trust has vacancies of 48.7 WTE (12.4%) across its consultant workforce. There are currently a number of specialties with particularly high vacancy levels including anaesthetics (6.6 WTE,15%); radiology (3.9 WTE, 17%), acute medicine (20 WTE, 25%), QEH ED (4.7, 29%), endocrinology (3.5 WTE, 39%), urology (3.19 WTE, 55%) and elderly care (5.1 WTE, 21%). The medical workforce is reliant on a high number of fixed term locum consultant appointment which will impact on turnover and retention rates and place greater reliance on sub-consultant grades and other clinical staff. There is a risk that high vacancy levels, and consequent high reliance on temporary staff, prevent the Trust from delivering agreed activity plans, in particular the demands (theatre lists) of our clinically urgent and long wait patients; and result in delays to the discharge of patients.	Chief Medical Officer/ Chief People Officer/ Chief Operating Officer	The Trust has put a number of mitigations in place to address this risk: ***Short term – covering gaps in the rota:*** *1. Bank and agency coverage including internal cover.* *2. Continued and innovative use of fixed term locum appointments* *3. Meet with divisional leads to plan recruitment activity /AACs* *4. Mutual aid from SEL for urgent gaps.* *5. Regular clinical review/prioritisation of all patients awaiting treatment* ***Medium-term – recruitment:*** *1. Clear recruitment plan and enhanced strategy* *2. Updated recruitment materials* *3. Exploration of joint appointments with GSTT* *4. Exploration of new training pathways with SEL.* *5. Development of a recruitment and retention strategy for consultants*	**Mar 25:** The medical workforce continues to be invested in and has grown by 8.1WTE consultants (including Radiology and Cardiology). This has resulted in an increase in the vacancy position to 14.56%. With 4 staff in the pipeline this will reduce down to 13.8% and above Trust target. Specialty level risks continue to be developed and escalated with Urology being escalated. Ongoing active recruitment continues with planned improvement of marketing materials and further review of workforce plans to improve staffing levels. **Jan 25:** Consultant vacancies remain above 10%. Vacancy levels for the consultant workforce have been maintained at 12.5% despite a 17% growth in posts. With the exception of a small	30/03/25	**5x4 =20**	**5x3 =15**	**2x4 =8**	↑	Mar 25	Trust Board TME PPC /QPC	NHSI / CQC

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								number of hard to recruit areas, the Trust has been able to successfully recruit to vacancies. See deep dive report.								
CRR038	**5**	**1**	***LOW***	**Amended risk July 23 10.09.21 (New risk added Sept 21)**	**Lack of management capacity within estates to deliver the estates strategy:** • Premises Assurance Model (PAM), the NHS's mandated method to provide assurance across estates and facilities for the Executive Team, actions have not been completed • Reporting to routinely assure executives and duty holders of compliance with statutory, HTM/HBN and ACoP is not in place. • The IT platform (CAFM and PDA's) and supporting SOP's which should drive workflow and reporting on compliance, as well as a repository and record of all actions and progress from statutory inspections, is not in place • Resource structure is unable to support the AP structure with an appropriate level of resilience and consistency, nor does it provide 24/7 cover for retained or the PFI Riverside estate (which given Lewisham's importance in the SEL system is a weakness). Minimal formal or coordinated management of the Trusts property, rent and lease obligations or oversight and control of space and relocations. Community properties are in poor condition and reflect minimal maintenance.	Chief Financial Officer	• Ensure capacity is in place to complete the PAM • Establishment of Compliance manager role with responsibility for tracking and monitoring key indicators and providing assurance • Implementation of CAFM system to drive the workflow and reporting on compliance and smooth process for clinical colleagues to raise issues. • Review of establishment to ensure appropriate roles and resource is in place to deliver statutory obligations. Managing immediate need with use of contractors in the interim period. • Appointment of Community property Manager to ensure robust management of SLAs and ongoing process to provide assurance •	**Mar 25:** • PAM – The CFO/COS/DoE&F met with the Estates Leads for PAM in February 2025. They discussed the governance for PAM and the new process for collating and presenting information. • There is a recruitment freeze in place until the end of March 2025. Business Case will be completed and presented as part of Business Planning for 25/26. • Community Premises: Interviews taken place and post offered, waiting for various checks to be completed. **Jan 25:** • PAM – regular meetings taking place. • Additional posts approved and currently recruiting. Further business case to be submitted in February 2025 • Community Premises: Readvertised the post and interviewing in the New Year.	Risk is being managed to prioritise projects on an ongoing basis.	**4x5 =20**	**3x5 =15**	**2x3 =6**	↔	Mar 25	Trust Board TME FITC	CQC/HSE
CRR002	**1,3**	**2**	***NONE***	**Amended risk Jan 2025** **NEW RISK ADDED FOLLOWING TME REVIEW 22/06/18 (amalgamation of some of previous single risks) Revised Dec. 2020**	**DELIVERY TO CANCER CONSTITUTIONAL STANDARDS:** Whilst the initial cancer backlog was caused by the COVID-19 pandemic resulting in suspension of elective and diagnostic activity to ensure stringent infection prevention control measures, the risk is now driven by several other factors, leading to a significant number of patients waiting for cancer diagnosis and treatment. There are challenges in particular with delivery to Faster Diagnosis Standard (FDS) and 62/day performance. Cause: • Ongoing service sustainability • Workforce gaps, particularly in the medical (Consultant) workforce across services such as dermatology, urology, gynaecology, haematology, and head and neck. • Head and Neck: The cessation of head and neck services by GSTT and KCH has led to a 19% increase in referrals to LGT over the last 12 months. This increase in referral rates has further challenged the clinical team, which are concurrently meeting with UEC demand, RTT/tiering, and 65/78-week targets. • Seasonal increase in dermatology referrals • Complex pathways for Lower GI Effect: • Capacity challenges for first appointments across various tumour groups.	Chief Operating Officer/Chief Medical Officer	Actions: 1. Clinical review of patients on our PTL being undertaken to assess clinical priority. 2. Trust-wide recovery planning underway to improve utilisation on elective and diagnostic activities. 3. Close working with ACN and provider partners to ensure on-going access to independent sector capacity. 4. Weekly Cancer PTL meetings to focus on long waiting patients and clinical reviews. 5. Development of cancer action plans by cancer services to ensure focus on key recovery actions. 6. Plan to review trust-wide issues including training, MDT co-ordination capacity and processes, and roles and responsibilities. Assurance: 7. Intensive COO-led/Deputy COO-led monitoring is in place to ensure delivery of recovery actions and escalation of key risks. 8. Establishment of weekly cancer operational group chaired by the Chief Medical Officer and Director of Performance. 9. New cancer board to be established to ensure trust-wide focus on cancer across services and divisions.	**Mar 25:** The Trust cancer backlog continues to increase, now reporting +200 at end of Feb, against an overall SELCA backlog target of 115 patient by March 2025. At Feb 25 (pre-validation), the FDS stands at 72.2% (regional/sector target of 77%), 31-day is at 95.2% (national target: 96%) and 62-day is at 60.7% (national target: 85%). This position is driven by consultant workforce gaps and diagnostic capacity, causing front end capacity constraints which has largely contributed to the backlog position. Services are continuing medical recruitment drives while also mitigating with additional clinics activities such with agency/bank recruitment for Locums. **Jan 25:** Since the last update the Trust's cancer backlog has remained consistent at an average of 145 per week for USC referrals. This is against the backlog reduction targets of 115 patients. This is driven by medical workforce gaps, complex medical pathways and challenges within diagnostic capacity. Where impacted, services are creating additional clinics facilitated by SELCA support. Pathway improvement plans are also underway, to streamline patient experience and to maximise resources. FDS is on an improving trajectory to c. 72/73% with linked improvements to 62/day performance.	Ongoing	**5x4 =20**	**4x4 =16**	**2x5 =10**	↔	Mar 25	Trust Board QPC TME Div PR	NHSEI CQC

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					• Delays to treatment across Cancer stage pathways including: Faster Diagnosis Standard (FDS), 62-day, 31-day treatment, and 38 Inter-Provider Transfer (IPT). Impact: • Delays to cancer diagnosis and treatment resulting in risk of poor patient outcomes and experience • Increased scrutiny by NHSE and potential tiering process for cancer.											
CRR006	**5**	**1**	***LOW***	**Amended risk July 23** **First added 18/01/2016**	**Lack of estates infrastructure resilience (underlying infrastructure issues) on both acute sites** **UHL:** Infrastructure with lack of resilience and ability to maintain aging estate. Management structure needs to better reflect the seniority and experience needed to manage an aged and underfunded retained estate, as well as oversight of 2 significant PFI's. **Riverside**: LV Distribution Board which is a Single Point of Failure (SPOF) from design **QEH:** Failing infrastructure with lack of resilience and poor condition or obsolete components. • Electrics: incoming utility supply, HV distribution and transformers, LV sub-main electrical switchgear and final circuit distribution boards (QEH five major power outages 2012-2017). • Other significant infrastructure issues include hot and cold water, gas, ventilation, medical gas and drainage.	Chief Financial Officer	UHL • Implement new management structure and complete Six Facet Survey • Back-up generator in place. PPM's in place to monitor on-going condition. QEH • Improved management of PFI Project Agreement to ensure service failure and where possible unavailability penalties are applied. The strategy is to over manage the contract. • Infrastructure Business Case approved by NHSI/DH, £48m of funding available to invest in infrastructure improvements. Project team established to progress the design and prepare for a negotiation with MHC. Governance and reporting structure in place. Discussions to progress via NHSI seeking CCG revenue support resulting from the works.	**Mar 25:** UHL • Recruiting to additional posts already approved for 24/25. Business Case will be completed and presented as part of Business Planning for 25/26 for the remaining posts. Riverside • RHS/Trust agreed to split the cost 50/50 QEH • SIP project complete. Ongoing discussions with MHC regarding the Asset Register and O&M manuals issued by McLaren. **Jan 25:** UHL • A number of posts have been approved and are now being recruited to. Further business case to be submitted in February 2025 Riverside • Further meetings taken place. Letter sent to RHS on 12th December 20224 requesting information on Electrical Installation Condition Report's and Thermal Imaging Report.	Ongoing in line with capital improvement programme	**4x4 =16**	**4x4 =16**	**4x2 =8**	↔	Mar 25	Trust Board TME Liaison Ctte FITC	NH SIE/ DH
CRR003	**1,3**	**1**	***LOW***	**NEW RISK ADDED FOLLOWING TME DISCUSSION 12/10/18**	**MENTAL HEALTH PATHWAYS AND PATIENT MANAGEMENT:** Mental health patients managed in an inappropriate and unsupportive (for their needs) ED environment. Increasing numbers of mental health patients attending ED and due to lack of timely availability of community beds are managed in the department for unsafe periods of time in unsafe (for their needs) environment (lack of sufficient purpose designed mental health facilities within ED). In addition all other speciality patients that stay in ED due to bed pressure have a drug chart written by speciality team so receive medication daily they need, however mental health team not licensed to prescribe on a LGT drug chart therefore patients can go days without their regular medication. ED's do not stock psychiatric medicines; some psychiatric medications ED are not licensed to prescribe. Therefore patients will go without medication until admission to ward. The environment in ED is completely unsuitable - noisy busy and bright - have been occasions when	Chief Operating Officer/ Chief Nurse	Unless indicated mitigations apply to both sites: QEH has got a Mental Health Assessment Area that can accommodate 5 patients staffed by RMNs and Support workers. The workforce is funded by OXLEAS. This area is not purposefully built and therefore the environment does not meet all the needs of the patients. UHL, due to acuity of mental health patients RMNs are booked proactively to work and support patient. Currently waiting for the Board to make a decision regarding the Mental Health Assessment Area Daily escalation protocols in place to address the delay in accessing beds beds. LGT has signed up to the "Mental Health/UEC Task and Finish Group" membership. The Group is accountable to both the ICS UEC Board and the ICS Mental Health Board and the focus is to discuss and agree on short term action plans to meet the demands and to consider long term strategy for mental health patients in Emergency Dept Mental Health Workforce currently been implemented on Ward1/2 and Chestnut Ward. The Mental Health Wellbeing Practitioners will also be expected to work in ED dept wherever possible	**Mar 25:** The Trust has seen an increase in the number of MH presentations in recent weeks. These have been escalated and prioritised through the twice daily SEL MH meetings between acute and MH providers, but have had an impact on ED capacity. However there has been progress on the issues that LGT control including the completion of the minor works on the MH assessment unit at QEH to address some of the risks that had been identified. Bespoke training for the Paediatric ED staff has been commissioned and will be delivered from Q1 25/26. The pilot MH matron post for the UHL site has been recruited to and commences on 24th March. However due to the number of presentations to ED the risk remains unchanged **Jan 25:** The number of patients waiting in ED more than 72hrs for a MH bed has decreased, however the Trust has seen an increase in the number of patients waiting more than 24hrs and 48hrs for a bed. Consequently, this continues to put pressure on cubicle capacity within ED. There has been no significant	The risks identified are expected to reduce during the 2022/23 period as a result of the initiatives taken by LGT to improve the care pathway and environment for MH patients attending ED dept and partnership working with SLAM and Oxleas	**5x4 =20**	**4x4 =16**	**2x2 = 4**	↔	Mar 25	Trust Board TME QPC A&E Delivery Board LMC/ QEM DMB	CQC

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					several volatile mental health patients have clashed with each other resulting in extremely dangerous situations. Real and actual risk of a significant adverse clinical outcome or staff or patient-related health and safety incident.		UHL, Consultant Psychiatrist are now able to prescribe medication electronically as they have honorary contract with the trust, however this remains a problem for weekends and out of hours. QEH, conversation ongoing Clear pathway agreed and implemented for Children under 16 and under 18 Refurbishment of High-Risk assessment room at QEH Refurbishment of High-Risk assessment room Business case submitted fort UHL Protocol of managing MH patients presenting with aggression and violence been developed collaboratively with Psychiatric Liaison Team Mental health training for Security personnel Scoping High- Risk Assessment Room in Children's ED Health and Safety and Security risk assessments in place.	change in the number of patients waiting in an inpatient bed for transfer to a mental health bed. The Executive team have agreed to fund a 3mth MH matron post on each site as a pilot to determine if this role can improve the care and management of MH patients. Recruitment is currently underway. The risk score remains unchanged this month.								
CRR041	**5**	**1**	***LOW***	**Dec 21**	**National Cyber Security Centre - NATIONAL Alerts (NCSC - GCHQ)** Worldwide alert issued regarding code used across software applications and online services.	Chief Strategy and Transformation Officer	The National Cyber Security Centre have issued advice on actions to take to mitigate risk and these are central to the Trust's plan to mitigate risks to the organisation or individuals.	**Mar 25:** Ongoing work on establishing a risk dashboard to track exposure. IT Consultation has been completed creating a small dedicated Cyber Security team, update to strategy road map in flight. Work is now progressing on the DSPT/CAF submission. **Jan 25:** Strategy now being implemented and factored into 25/26 business plan. An approach to risk management is being worked on for the FIT/TME to track risk exposure to Cyber-attack.	30/03/2025	**5x4 =20**	**5x3 =15**	**5x1 =5**	↔	Mar 25	Trust Board TME FITC	NHSI DH / CQC
CRR042	**5**	**1**	***LOW***	**Amended July 24**	**Fire safety risks as a result of QEH infrastructure and compliance with corporate fire safety processes across both sites** **QEH infrastructure** The Trust has commissioned three surveys of the external cladding / external walls at QEH. Whilst each survey appears to have been commissioned for different purposes the three surveys have consistent themes : 1) The cladding contains combustible material, 2) cavity barriers which prevent the spread of fire through cavities are in some cases missing or incorrectly fixed 3) where in places wings of the building run parallel to each other there is a risk of flame spread between the two parallel wings of the building. • **St Nicholas House (QEH)** A specific risk has been identified relating to St Nicholas House as a result of the most recent Fire risk assessment. Means of escape, fire doors and behavioural issues are all concerns that need to be addressed. **Corporate fire safety processes** There is a risk regards the Trust compliance with the standards required to maintain fire safety and care of staff and patients. There are concerns about quality of FRA's, evacuation plans, as well as the investment in fire systems infrastructure (also reflected in CRR038).	Chief Financial Officer	The Trust is in the process of commissioning a further, more comprehensive survey to fully understand the risk and seek from the Fire Engineer carrying out the survey proposals as to remediation required. Once those recommendations are received the Trust will implement them. Fire safety team in place to manage risk of fire. Phased works have been completed to replace/repair fire doors, fire alarm systems and compartmentation. Mandatory training to all staff on fire safety response. Task and finish group established to address immediate issues identified in St Nicholas House.	**Mar 25:** The Trust has received the Milestone two report from ARUP, which recommends two options. Ongoing discussions with MHC regarding remedials aligned with option two. The Trust is currently working through a list of actions compiled following the meeting with NHSE in January 2025. A meeting is scheduled with the LFB and NHSE in March 2025. The Fire Safety Team is conducting audits and updating FRAs. St Nicks (QEH) - MHC and Vinci are currently preparing a building application to remediate or replace the fire doors as St Nicolas Tower falls under the higher risk building category. Ongoing options for use of the building are under review as part of this process. **Jan 25:** The Milestone 2 report, which will cover all aspects of fire safety compliance - including the external wall - is scheduled for issue in February/March 2025. Given the potential significance of risks noted in the interim ARUP report the Trust has approached both LFB and NHS England in order to discuss the Trust's proposed approach to risk mitigations and seek expert advice in terms of the future management of these potential risks.	To be confirmed following review of the milestone report	**5x3 =15**	**5x4 =20**	**5x1 =5**	↔	Mar 25	Trust Board TME FITC	CQC/Fire Brigade/ NHSE

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								The Trust is currently working through a set of priority actions agreed by the TME. The latest update on these is provided to the January TME, ARCC and Board.								
CRR0 43	**2**	**6**	***LOW***	**Amended July 24** **Added Sept 22**	**Financial Resilience of the Trust** The 2024-25 financial breakeven plan contains several challenging assumptions that require mitigation to avoid an unplanned financial deficit **IURP** £44.5m total delivery ask with £15m currently unidentified or identified as high risk **Elective Recovery** The trust has an elective recovery target of 108% of the 2019-20 activity delivery. Failure to deliver this target will result in a loss of income, which for every percentage point equates to £1m pa It has been assumed in the plan that the ERF will operate without a cap for the Trust. Internal activity plans assume over-performance in excess of £10m **Strike Action** Impact of strike action will result in increase in costs and loss of activity and therefore income. **High Cost Drugs** No new funding has been allocated for drugs not yet commissioned yet, however these are likely to be commissioned during the year **Underlying Deficit** The 2024-25 breakeven plan includes a material amount of non-recurrent income and efficiency measures (£24m, net of NR costs) which if not addressed in year or through 25-26 planning will lead to a deficit in future years.	Chief Financial Officer	**Non-Delivery of IuRPs** Productivity and Efficiency Team (PReT) continue to work with all areas of the Trust to support delivery of planned projects and identify new projects to mitigate any shortfall. Desktop gap analysis undertaken to identify new areas for opportunity / stretch. Estate reduction (sq m), utilities reduction, clinical coding, enhanced procurement, and improved use of technology have been identified as new programmes with ability to close the gap. Leads and delivery forums being agreed. Project management tools utilised to keep current programme on track and actively mitigate delays and risks. Non-recurrent opportunities being explored to counteract any in-year delays. Elective Recovery The trust has assumed an additional cost of £8.995m in the 2023-24 plan that will help deliver this increase in activity as well as planned improvements in productivity. The trust has also entered into a number of contracts with Independent Sector Providers to support the delivery of this activity plan Strike Action Non-recurrent savings or income Financial Control Environment and Recovery Programme Ensuring the controls environment is robust and adherence from all trust employees. Should the trust not deliver on its financial plan we will look to move towards a financial recovery regime which is akin to SOF4 external regulation	**Mar 25:** The Trust is off-plan by £11.8m YTD but is forecast to break-even at year-end with £6.5m of recovery items to deliver in M11-12 in addition to the receipt of system funding throughout the same period. Baseline budgets for 25/26 have been calculated at a £76m planned deficit with £26m of interventions required to reduce this to a £50m deficit plan. These include freezing of bank and agency rates, reducing divisional budgetary pressures, product swaps to offset inflationary pressures and securing additional ERF income from the ICB. **Jan 25:** Financial Recovery plan developed with potential upsides of £4m in year. Continued winter pressures leading to increased cost of escalation capacity and difficulty in securing efficiency savings, risk worsening the position by a further £2m ERF payments for 23/24 not to be reviewed risk £1m loss in year, uncertainty remains for 24/25 payments. Total risk to position of between £10-15m at March 25.	31/03/2025	**4x5 =20**	**4x5 =20**	**3x2 =6**	↔	Mar 25	Trust Board TME FITC	NSHI DH
CRR0 44	**1,3**	**1**	***LOW***	**Nov 22**	**Risk to quality and safety in the service provided to patients due to delays experienced in delivery of ED pathways due to:** • Consistently high ED demand from both blue lights and walk in patients, limiting flow across sites and causing long delays. • Increased ambulance handover delays. Staffing shortages and morale due to continuing demand further compound this risk	Chief Operating Officer/Chief Nurse	Implementation of the 'Woolwich Way' at the QEH site, with roll out planned to UHL Whole systems working to improve pathways both into and out of acute care Bed Management meetings x 3 a day with additional meetings when required. Daily operational meetings to address site pressures Staff wellbeing programme with specific focus on ED nursing led by Chief Nurse	**Mar 25:** Performance remained challenged with slight improvement to 64.9% in Jan 25. The Trust saw an increase of T1 patients through ED compared to Dec 23 and Jan 24. There were signs of improvement, particularly in T1 admitted at QEH and non-admitted performance at UHL. LAS activity increased in Jan 25 (+13% compared to previous year), adding strain to the ED department. The number of 12-hour stays in ED decreased overall, with reductions at both QEH and UHL. The number of patients without a criteria to reside also decreased, with improvements at both sites. Occupancy of patients with a long length of stay of 21+ days saw a slight reduction in Jan 25. NHSE's visit in Nov 24 highlighted the need to create more space in ED for patients to be seen rapidly. Ongoing conversations are underway to address this challenge. Super March plan presented at QPC (Feb 25), outlining the activities and goals for the intensive focus period to improve patient pathways and flow. **Jan 25:**	Risk is expected to reduce in line with implementation of new patient flow.	**5x4 =20**	**5x4 =20**	**5x2 =10**	↔	Mar 25	TME QPC Trust Board	NHSE/I CQC

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								Performance remains challenged at both sites with continued improvement works across multiple workstreams. The number of long stays in ED has increased, but there has been a reduction in patients without a criteria to reside. The implementation of SDEC initiatives, including the opening of the ED-led generic SDEC at QEH and new pathways, has positively impacted performance and patient flow. There has been renewed focus on internal professional standards to improve the 4-hour standard, and efforts are being made to bring together mental health partners, paediatric and surgical teams, and ISS to enhance operational performance and support UEC flow pathways.							
CRR0 46	**1,3**	**1**	***LOW***	**Feb 23**	Risk that **maternity services are not staffed** appropriately or safely due to an ongoing shortage of midwifery staff within the Trust, particularly experienced staff. This is due to national shortages which have various causes including retirement and challenges with recruitment and retention. There is also a recognised increase in activity and complexity of women and babies. This shortfall to the establishment is chronic and is anticipated to continue in the long term, when local and national forecasts are considered. There is impact locally across site, in both community and acute settings, however vacancies are consistently higher on the QEH site. The consequences of this are severe and ongoing staffing challenge are mainly as follows: 1) Running a safe maternity service can no longer be guaranteed 2) Patient experience is suffering. There are many delays, particularly in the elective pathways (induction of labour) and caesarean section. These are due to not having the staffing capacity to provide both emergency and elective work alongside each other. 3) Ongoing impact on the attrition rate 4) Risk of reputational harm 5) Risk of financial harm due to litigation if harm is to occur due to short staffing	Chief Nurse	A number of mitigations are in place which include realignment of staff, reducing service capacity and continued recruitment drives as detailed below. Realignment of staff to support clinical service delivery as needed: • Centralisation of staff to high risk areas • Redeployment from non-clinical activities • Careful roster planning • Utilisation of staff such a RNs • Suspend/cancel or redeploy required staff from study days • Office based staff support clinical areas Reducing service capacity: • Close beds on Antenatal ward, move antenatal patients to postnatal ward • Close Birth Centres to centralise the work force • Suspend Homebirth Service to either bring staff in or because of team sickness • Activate Pan London Divert Policy Attracting staff/recruitment drives: • Continued recruitment drive in place with a range of actions to ensure recruitment pipeline • Ongoing agreement for increased hourly bank rates • 'Golden handshake' for new QEH midwives to compensate for lower London weighting. • Offer development opportunities to experienced staff (Any speciality) • Offer substantive 'Any hours' contracts	**Mar 25:** UHL - vacancy rate currently sits at 9wte. 16 students qualifying this summer have all expressed an interest in substantive appointment, with recruitment process due to start in the next few weeks. QEH - the vacancy rate currently sits at 19wte which is a steady improvement month on month. The first 6 IEM's have received their PIN numbers and started their preceptorship. A further 6 have passed their OSCE exam and awaiting full NMC registration. A further 4 are due to sit their OSCE exams in the next 3-4 weeks. The current cohort of 3rd year midwifery students due to qualify in the summer have also expressed an interest in substantive employment. There are 4 planned retirements at QEH and 2 at UHL. Additionally, there are 3 upcoming maternity leaves at each site, totalling 6. The full Birthrate Plus staffing review paper will be presented in April 2025. **Jan 25:** UHL's vacancy rate is stable at 5.6 WTE, with all new starters in place. At QEW, midwifery staffing is improving: 17/23 internationally educated midwives (IEMs) have arrived, with 6 more due in Jan 2025. 7 IEMs have passed their OSCE assessments and are awaiting NMC PIN numbers, expected within 4-6 weeks. Consequently, this is expected to reduce QEW vacancies from 26 WTE to 19 WTE once the first IEMs achieve full NMC registration. However, several new maternity leaves and retirements are upcoming in the next few months at both UHL and QEW sites which will impact. The first cohort of UK-trained nurses on an 18-month midwifery apprenticeship will start in Jan 2025, supporting the pipeline in the longer term. In light of the progress made, it is proposed to reduce the risk score to 5x3=15, with a view of a further reduction as the IEM cohort obtains full NMC registration and settles into their midwifery preceptorship.	Ongoing. Plans to recruit additional midwives in place.	**5x4 = 20**	**5x3 = 15**	**5x2 =10**	↓	Mar 25	TME QPC Board	NHSE/I CQC

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CRR0 47	**5**	**1**	***LOW***	**Amended July 23** **Added March 23**	**Water (hygiene) systems** **Water flow restrictions and blockages (various blocks e.g. BOB, DOD, FOO, COO, BOC etc)** The risk of proliferation of bacteria (Legionella) due to the issue that the age and condition of the pipework has on the Trust's ability to manage the water (hygiene) systems in line with Department of Health guidance. The ability to maintain temperature, flow and cleanliness of water is prevented by; old steel barrel domestic hot and cold water pipes, corroded and with lime scaled causing water flow restrictions and blockages leading to lack of primary control; temperature, flow and cleanliness (HTM04-01, HSG274 & HSE ACoP: L8). This is further compounded by asbestos contaminated under-croft spaces making any remedial works very restrictive in this confined space area in a working operational hospital. The restricted and blocked flow will cause stagnating flow, provide nutrients (rust and scale) and non-compliant temperatures (compliant is cold <20C and hot >55C). The build-up of corrosion and scale will prevent the secondary control (biocide: copper/silver) being effective, leading to the potential for legionella/pseudomonas aeruginosa infection from the water supply. **QEH -Management of water safety system to prevent colonisation by Legionella / pseudomonas aeruginosa of water supply.** Cause: The inability to keep water hot, cold, flowing and clean. Effect: Potential for legionella/pseudomonas aerufinosa proliferation in water system. Impact: Potential for serious patient harm/death, HSE and CQC prosecution, financial and reputational impact.	Chief Financial Officer	The installation of point of use microbiological filters to specific high-risk areas (Oncology Day Care, Clinical Decision Unit and all showers) to protect the users of water outlets. The addition of biocide (secondary control) and monitoring levels. Mechanical works (e.g. remove blind ends, dead legs and TMVs) where possible are ongoing. Monitoring temperatures, sampling for Legionella and Pseudomonas Complete survey of hot and cold water pipes in the asbestos contaminated under croft to determine the extent of the steel barrel issue. Survey of the effected blocks for the installation of an additional biocide (silver stabilised hydrogen peroxide) to supplement the current copper/silver dosing. QEH Water safety Water risk assessment completed and reviewed as per HTM04-01; logging and monitoring by Water Safety Group. Local, site-based technical water meets: Water Asset Management Meeting (WAMM) at QEH, Water Action Group (WAG) at Riverside and Retained Estates Water Action Group (REWAG) at UHL. The local meetings generate water assurance reports to the Trust WSG every 2 months. The Trust Water Safety Group takes expertise from contracted external Authorising Engineer (water). An AE(w) annual report is presented to Water Safety Group and the Infection Prevention & Control Committee to provide assurance that the Trust water safety arrangements are reducing risk and the Water Safety Group is working effectively. External audit of systems, processes and governance is commissioned periodically	**Mar 25:** UHL - Duct surveys have been completed and are with DSSR for POO pipework. DSSR will visit the site to examine the ducts. FOO block AEC asbestos clearance tender spec with Curry & Brown. Works to commence 2025/26 under Capital Scheme. QEH - Legionella results remain low cross-site. The Q-WSG has reduced frequency of meeting to monthly. Further surveys and work continues to address the underlying infrastructure issues. **Jan 25:** UHL - Duct survey drawings updated and to be reviewed by DSSR. FOO block asbestos survey tender spec is with AEC. FOO works to commence next financial year. QEH - QEWSG meets fortnightly now. Legionella results are well below the WSG 10% threshold. The Ag H2O2 biocide systems are working well and achieving good levels at outlets. Pipework sampling is underway to determine the condition of the pipework across the hospital. Vinci have engaged a domestic hot water commissioning engineer to undertake a review of the hot water system to determine its abilities to achieve HTM04 parameters.	31/07/25	**4 x5 = 20**	**4x5 = 20**	**2x5 =10**	↔	Mar 25	ARCC TME H, S & R ctte Water Safety Group	DoH CQC UKHSA
CRR0 48	**1,3**	**1**	***LOW***	**Oct 23**	**ENT RISK OF HARM:** As a result of delay to treatment arising from insufficient capacity to treat patients in a timely way. The ENT admitted PTL comprises 20% of the total admitted waiting list. Total ENT PTL 14,710 open pathways, 1420 waiting over 52 weeks, 157 over 78 weeks, 21 over 90 weeks. Non-admitted: - ENT receive c20,870 referrals per year of which c8% are ROTTd or rejected. - The national average new to follow up ratio is 1.2 which means we need to complete c42,240 appointments per year to not grow the backlog (19,200 new and 23,040 follow up) which is 812 per week. - There are currently 2,021 patients in the 65-week backlog, assuming they all require 1 appointment then this capacity is needed in addition. This equates to 67 per week. - Overall, this requires 26,381 appointments by end of March 24, with 24,360 required to stop the backlog growing.	Chief Operating Officer	**Trust Initiatives** 1. Insourcing: Continuation of Medinet capacity to March 24 to support non-admitted (5,801 total for the year) 2. Service management investment - additional ASM B7 and 1st year graduate 3. Prioritisation of theatre capacity when reletting theatre sessions 4. Continuation of the Right Procedure Right Place pilot 5. Targeted interventions re theatre improvements/on time start work 6. Introduction of Care Coordination System to optimise scheduling 7. Review of PIFU volumes (GIRFT) 8. Internal CPG process / RCoS risk prioritisation stratification 9. 'Dr Dr' patient portal admin validation of longer waiting patients **System initiatives** Collectively working on a system wide recovery plan to support the reduction of 65 week wait patients by March	**Mar 25:** ENT remains challenged, making up 32% of the February cohort and 45% of the forecast position. As of March 2025, there are 104 breaches of the 65-week target, down from 165 in January, and 20 patients have been waiting for 78 weeks. This is due to increased Urgent Suspected Cancer referrals, higher diagnostic demand, and a high number of P2 patients listed for surgery. ENT outpatient service- Medinet clinics ceased in February, with Communitas clinics taking over. Most patients from Communitas are now referred back to LGT for diagnostics, causing capacity challenges and impacting long waiters across all specialties, including ENT. Plans to address these challenges are underway, including recruitment for three consultants by the end of March 2025, and a business case for more clinic rooms in Area G at QE is in progress.	Ongoing	**4x5 = 20**	**4x5 = 20**	**4x3 = 12**	↔	Mar 25	Trust Board QPC TME Div PR	NHSE

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					Admitted: - Internal capacity is above 1,590 level required to reduce the backlog which means that we will start to reduce the backlog. - We are 1,022 short of the required capacity to clear 65 weeks by March. - This forecasts the backlog to reduce by 199 (7 per week) which would make the backlog 1,224 in March 24 but would take a further 146 weeks to clear. - To clear the backlog by September 24 we need to increase backlog clearance to 24 per week. In addition to the delays presented by Covid, the service has been significantly impacted by the following: • Anaesthetic capacity • Increase in referrals • Overall reduction in SEL capacity • Impact of strike action		'24. SEL has already invested in ENT services to try to mitigate the long wait patient numbers, this includes: 1. ISP insourced outpatient capacity at GSTT and LGT 2. Additional operational management and A&C resources 3. Additional resource to manage mutual aid transfers 4. SEL standardised referral form Development of community ENT service (April 24) to manage non-admitted demand	**Jan 25:** ENT continues to make measurable progress in improving access and reducing the waiting list overall, reporting 165 patients at 65-weeks (against a trajectory of 178) and 36 patients at 78-weeks as at Dec 2024. A room has been allocated for real-time audiology hearing tests, which is expected to expand capacity and positively impact on performance from Jan 2025 onwards. The community service continues to triage referrals from GPs to LGT, with approximately 2,000 patients redirected so far. ENT initiatives mentioned in Nov 2024 are ongoing, and recruitment is underway for both locum and substantive ENT consultant roles.								
CRR0 49	5	1, 2	***LOW***	**March 24**	**IT Infrastructure** There is a risk associated with the Trust's ageing digital infrastructure, including LAN, WAN, Wi-Fi, switches, etc., being susceptible to security breaches, system failures, and data breaches due to inadequate management and maintenance. The risk extends to Community sites, amplifying the potential consequences on patient care and operational continuity across all Trust facilities. There is an additional risk related to the status of the Digital Maturity of the applications and data flow in terms of technical debt at the Trust. LGT has had a phased roll out over several years of its existing EPR system which has left the Trust with a partially deployed EPR for acute services and a separate community EPR with only 80% of our clinical systems integrated and linked to the LGT Patient Master Index. The Trust has recognised the need for further investment in IT to enable delivery of a comprehensive digital strategy which fully meets the needs of Trust. For example provision which includes the use of digital dictation / voice recognition, document management, systems integration and EPR functional areas OP's, patient flow and surgical (which currently remain paper based). The impact of this risk includes potential disruptions to patient care due to compromised digital systems. Consequently, diminished operational efficiency may occur, hindering the timely access to patient information and coordination of care among clinical and administrative staff. The consequence of these disruptions could result in delayed treatments, miscommunications, or errors in patient records, ultimately leading to increased clinical risks, and an adverse impact on the quality and experience of patient care.	Chief Strategy and Transformation Officer	• Ensure that the Trust's technical Infrastructure is robust and will support the requirement of any new comprehensive EPR that the Trust deploys in the medium term. • Develop the Clinical System Support function to cover the BAU maintenance and development of all clinical systems (including EPRs) to provide greater assurance to the Trust around the management, development and support of all systems. • Technical Readiness Assessment to review and feedback on the Trusts current position regarding technology infrastructure is underway, with the output / report expected around end of March 2024 which will then help planning of Capital budget going forward. • Procure and implement a fully functional EPR integrating Acute and Community, linking with SEL, EPR OBC currently under the NHS E review process. • A EPR Technical readiness assessment has been commissioned from which the recommendation will be actioned to ensure LGT have a digital department with the capabilities and resources to support its patients and staff. • Establishment of Systems Managers / Owners forum to start to bring together all staff working across the Trust together to ensure that issues such as System security, system upgrades and issue management are understood, and the staff feel supported	**Mar 25:** Continued use of iCare outsourced resources required to cover highly technical tasks/changes. Technical team consultation complete and now in the 2nd round of recruitment. **Jan 25:** Data Warehouse roles recruited to and handover of community servers planned. ICare plan is to use outsourcing. Technical team consultation has been approved and closes 3rd January 2025 to allow EPR readiness preparation and Cyber focus.	31/03/2025	**4x4 =16**	**4x4 =16**	**4x2 =8**	↔	Mar 25	Trust Board FITC TME Trust Digital	NHSE/I
CRR0 50	4	3, 6	***LOW***	**May 24**	**Nursing Vacancy risk due to reduced international recruitment** There is a risk of compromised patient care and safety due to a potential increase in the nursing	Chief Nurse	• International Business case submitted for significant reduced numbers of overseas nurses and midwives submitted (awaiting approval)	**Mar 25:** Active recruitment continued in January with 271.39 nursing and Midwifery posts out to advert. The pipeline includes 77 new joiners with start dates, 82 undergoing pre-	Ongoing	**5x3 =15**	**4x3 =12**	**4x2 =8**	↓	Mar 25	Trust Board TME QPC PPC	NHSE/I CQC

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					vacancy rate due to the 50% reduction in International Nursing recruitment, due to affordability. A risk to removing the international pipeline is that the Registered Nursing & Midwifery vacancy rates (10.38%, Jan 2024) could rise due to reduction in net joiner rate and increase in net leavers (including retirements). Trust data analysis shows that it could rise as high as 27.03%, should the recruitment pipeline not keep pace with leavers and retirements.(Workforce data, March 2023). Should vacancies increase to this rate, the Trust will increase its reliance on agency staff at an estimated agency premium cost of £1.5m. The impact and effect of increase in vacancy rates will result in increased workload for existing nursing staff, leading to fatigue, burnout, and decreased morale. This may result in decreased quality of care, heightened risk of errors, compromised patient outcomes and further increased leavers. There are also adverse impacts which include patient satisfaction and potential compromise to quality and safety of patient care due to gaps in the nursing workforce. There are also addition financial implications stemming from increased costs associated with temporary staffing (bank/agency), overtime payments, and potential legal ramifications in cases of serious incidents attributable to staffing shortages.		• Aim to increase number of direct applicants from overseas, with targeted campaign • Increase in the number of student placements hosted at the Trust • Continuous UK wide recruitment campaign, including open day events. Rolling adverts for all areas, including specialist areas • NHSE Capital Nurse, on behalf of London Trusts, has procured 6 recruitment agencies to support the nursing and midwifery workforce supply for London. • Continue to work on local retention programme • Promotion of professional development opportunities as part of recruitment offer and incentives • Further scoping of all nursing students and plan to secure guaranteed employment • Review of areas and Recruitment Retention Premia	employment checks, and a reduction to 10 awaiting post allocation. The Trust vacancy rate for Nursing and Midwifery is 9.37% (Jan 2025), a further reduction on November. Turnover is 9.36%, below the Trust KPI of 12%, with voluntary leaver rates in the first year at 7.96% (Jan 2025), Recruitment to the HVLC theatres at UHL remains a risk ahead of it opening later in 2025 and QE26 at a similar time, it is vital that the Trust has a strong pipeline. However, given the improved retention KPI it is proposed to reduce the risk from 15 to 12 and therefore removal from the register. **Jan 25:** Active recruitment continues with 2 recruitment fairs held in November. The pipeline includes 73 new joiners with start dates, 114 undergoing pre-employment checks, and 49 awaiting post allocation. The Trust vacancy rate for Nursing and Midwifery is 9.35% (Nov 2024), down from 11.08% in Aug 2024. Turnover is 10.33%, below the Trust KPI of 12%, with an average of 25 nurses and midwives leaving the Trust. However, with the HVLC theatres at UHL opening later in 2025 and QE26 at a similar time, it is vital that the Trust has a strong pipeline and therefore the risk remains unchanged.							
CRR0 51	1	1,2	***LOW***	**May 24**	**Triple boarding patients to ease ED flow** During 2023/24, the Trust experienced continual pressure on the urgent and emergency care pathway which resulted in very high numbers of patients in the Emergency Departments. This had a direct impact on safety in the department due to the volume of patients and a lack of capacity to see and treat patients in a timely manner. To mitigate this the Trust implemented 'boarding', where additional patients are admitted to the adult inpatient wards over and above the ward's agreed funded bed capacity to maintain flow out of the Emergency department. Over the winter of 2023/24 the Trust has limited this to a maximum of 2 additional patients per ward in non-designated bed spaces, however in recent weeks the continual pressure on the system has meant that triple boarding has been considered and is likely to be necessary to maintain safety in the Emergency Department. This is in the absence of the Trust's ability to open additional bed capacity to manage surges in attendance, due to a lack of appropriate space. The effect of admitting additional patients as 'boarded' patients does provide flow to the Emergency department thus reducing the risk to patient safety. However, patients admitted to a boarded bed space and the patients already in the bay experience a significant impact to their privacy and dignity, a potential negative impact on their length of stay as it can be difficult to support patients	Chief Nurse	• Standard Operating policy for boarding drafted and going through Trust Governance ratification process. This details the threshold for implementing boarding and also the triggers for stepping down from boarding and returning to BAU • As part of the SOP a letter has been included to be given to all patients affected by boarding, explaining the rationale for it. • Trust is developing plans for additional inpatient capacity for both acute sites. • Both medicine divisions have workstreams focused on reducing length of stay. • The Trust is continuing to work with system partners to reduce the number of patients who have delayed transfers of care. • Ward 26 on the QEH site planned to open in Q3 of 24/25 • Prepare business case to develop additional inpatient ward capacity on the UHL site	**Mar 25:** Both sites have been challenged for capacity and flow. The QEH site has had an outbreak of norovirus which has resulted in the closure of some wards to new admissions. This has resulted in those areas not affected by infection having to maximise their boarding capacity. Work is underway to provide a robust infrastructure for 21 additional beds on QE22/23 from their baseline capacity. At the UHL site in both January and February quadruple boarding was instigated on 2 occasions (6 days in total) in response to capacity challenges. Work continues across both sites to reduce length of stay and the number of patients not meeting criteria to reside. The risk remains unchanged. **Jan 25:** Both sites continue to have significant pressure both in their EDs and on their inpatient bed capacity. As a result both sites have had to maximise boarding and regularly triple board. An additional 10 bed spaces have been agreed on QE22/23 as well as making the 11 current boarded spaces permanent., increasing the bed numbers by 21. The Trust Management team have discussed and agreed the Full capacity protocol which includes an escalation ladder for both sites to manage safety. This will be regularly reviewed throughout the winter. The risk score remains unchanged.	Ongoing	**4x4 =16**	**4x4 =16**	**4x2 =8**	↔	Mar 25	Trust TME QPC	NHSE/I CQC

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					to mobilise in the reduced bed spaces and affect staff morale. When wards are double boarding and considering triple boarding additional staff, over and above the funded establishment are required which requires temporary staff and is a cost pressure for the Trust.											
CRR0 54	1,4	1,4	***LOW***	**Feb 25**	**Urology service** There is a risk of not being able to continue to provide a safe Urology service to meet the current demand of services to both LGT and to SEL system. This is due to significant recruitment challenges regards the Urology Consultant workforce, impacting both delivery of elective activity, RTT and Cancer targets as well as impacting the ability to sufficiently support the junior medical workforce. There is further impact on the Emergency on call service rota for the QEH site (GSTT continue to provide cover to UHL site) with reliance on existing two consultants working additional on calls, supported by a small number of bank staff to fill gaps. There is an associated risk of patient harm due to the inability to meet cancer targets and growing PTL and the risks associated with the emergency pathway due to variations in provision between sites and concerns in relation to the torsion pathway (patients presenting with possible testicular torsion require surgical exploration within 6 hours from onset of pain), intra-operative inpatient emergencies including obstetric, gynaecological and colorectal surgery where they might not have a urologist available to support.	Chief Medical Officer	• Joint working group established with GSTT, inc. Exec support • Cancer pathways – Prioritisation of capacity, GSTT Consultant continues to work at QEH re outpatient prostate cancer pathway. • Outpatient supervision – Review of consultant job plans to ensure cover. Retired consultant working 27 hrs/week on bank. • Elective lists – prioritisation of capacity for cancer cases and longest waits. Weekly review of PTL by service. • On-call cover – 1:5 rota devised including substantive & fixed term post holders, remainder gaps covered by 6 bank • Torsion pathway - Updated torsion pathway being finalised. • Outline business case for £2.29M capital and change in income for the service with full implementation of the proposed business case - from 5.26m 24/25 estimate to 11.86m FYE of full scheme in 26/27, to enable development of a Urology Investigation Unit (UIU) outpatient model at Lewisham and Consolidation and growth in theatre capacity to provide an elective Surgical Centre for Urology with improved productivity and system partnerships	**Mar 25:** Development of UIU – At design RIBA stage 4, progressing with MEP aspects, with a measured survey to be undertaken and the design pack issued to John Sisk & Sons under P23 and awaiting response to confirm capital costs. Once completed BSR application to be submitted. Dermatology outpatient services have temporarily moved into Bell ward due to urgent structural repairs in existing clinic space, meaning earliest date for the strip out works on Bell ward are now August 25, with the impact to UIU timelines being reviewed. Consultant recruitment – Following interviews, service is to appoint an additional fixed term consultant 3 days a week, start date to be confirmed. Division continues to closely monitor incidents and complaints. **NEW RISK ADDED FEB 2025**	31/03/2026	**4x5 =20**	**4x5 =20**	**4x2 =8**	↔	Mar 25	Trust TME QPC PPC (for info)	NHSE/I CQC

Board Assurance Framework 2024/25

The Board Assurance Framework (BAF) is the tool used for capturing and managing the key strategic risks to the delivery of the Trust's agreed strategic objectives. The BAF is an important element of the overall risk management framework and regular review supports the creation of a culture that allows the Trust to anticipate and respond to adverse events, unwelcome trends and significant opportunities. The BAF is used to assist the Board in identifying where to effectively deploy its resources to improve the quality and safety of care.

At the start of the financial year, the Board takes the opportunity to review and confirm the strategic risks around which the BAF is based. Following agreement in March 2024 by the Trust Board, BAF risks (key Strategic Risks) for 2024/25 are shown in the table below.

These risks have been mapped against proposed strategic outcomes (as defined by the Trust's strategy) and are identified as those risks that have the potential to significantly impact on the delivery of patient care, patient and staff experience, financial sustainability and/or public confidence in the services provided by the Trust. These BAF risks are also those areas that require the most focus from the Board.

Section one: Strategic risk summary

Key strategic risk	Strategic Aim	Board Assurance Framework risks (BAF risks) Proposed for routine review	Lead and Committee	Current score (Likelihood x Impact)	Risk appetite
BAF1: As a result of demand on services* the Trust is unable to maintain safe, high-quality services for patients and local communities.	**1. To meet demand within local communities served for the provision of safe, high quality clinical services.**	1a) If there is insufficient capacity to **meet demand for emergency services** patients may not receive the care they need on a timely basis leading to significant patient harm, poor patient experience, a lack of patient confidence in services and an increased prospect of regulatory intervention.	**Chief Operating Officer, supported by the Chief Medical Officer and Chief Nurse Quality and Performance Committee**	**5x4=20**	**Very Low** – management will take steps to avoid the risk and reduce its impact
		1b) If there is insufficient capacity to **address elective waiting times**, then patients will wait longer for elective treatments leading to patient harm, poor clinical outcomes a deterioration in patient experience, and an increased prospect of regulatory intervention. There may also be a loss of income.		**5x4=20**	
		1c) If there is insufficient capacity to **address cancer pathway waiting times**, then patients will wait longer for cancer diagnosis and treatment leading to patient harm, poor clinical outcomes a deterioration in patient experience, and an increased prospect of regulatory intervention.		**5x4=20**	
BAF2: Failure to deliver a financially sustainable organisation (including delivery of both capital and revenue plans), in the light of wider financial uncertainty within the NHS landscape and the wider economy.	**2. Improve financial sustainability of the Trust and the wider health economy across South East London**	2a) If the Trust receives **insufficient revenue funding** through changes to national and local commissioning arrangements and is unable to identify planned levels of efficiency (with appropriate governance in place), then there will be a failure to remain financially sustainable. This will lead to a deterioration in the provision of high-quality patient care, patient and staff experience, staff health and wellbeing, public confidence in services and increased likelihood of regulatory intervention.	**Chief Finance Officer Finance, Infrastructure and Transformation Committee**	**5x4 = 20**	**Moderate** – The Trust will continue to make balanced decisions to ensure that available resources are effectively directed to balance delivery against performance targets and service needs and demands with quality and safety imperatives
		2b) If the Trust is unable to **access sufficient capital funding** to enable investment in critical areas, this may lead to a deterioration in the quality of estate, the inability to purchase items that could mitigate clinical risk, an inability to innovate or deliver strategic changes and a subsequent impact on the delivery of patient care and provision of an appropriate clinical/working environment.		**4x4=16**	

Key strategic risk	Strategic Aim	Board Assurance Framework risks (BAF risks) Proposed for routine review	Lead and Committee	Current score (Likelihood x Impact)	Risk appetite
BAF 3: Failure to take appropriate action to ensure equality of healthcare access and outcomes for the Trust's local populations.	**3. The Trust should work effectively with system partners to ensure that all patients and communities served by the Trust have equal access to services and inequalities of health outcomes are minimised**	3a) If the Trust fails to put in place processes to manage access to services and does not monitor outcome of services provided to particular population groups, avoidable **inequalities in the delivery of services** may impact the communities served by the Trust. This may lead to increased clinical risks, and an adverse impact on the quality and experience of patient care.	**Chief Strategy, Transformation and Partnerships Officer** **People and Place Committee**	**3x4=12**	**Low** – The Trust has a low acceptance of risk which may result in inequalities in access to health services of service outcomes.
		3b) If the Trust does not effectively **engage with ICS partners** as a 'true system player' there is a risk that the access and quality accessed by the communities served by the Trust will be compromised, leading to adverse impacts on public confidence in services and patient experience.		**2x4=8**	**Moderate** – To deliver upon both the expectations of the future form whilst delivering business as usual, the Trust is prepared to work differently across traditional areas and boundaries to provide the best outcomes for patients. As such, the Trust has a significant appetite for partnership arrangements that support and benefit its communities, partners and stakeholders.
BAF 4: Failure to attract and retain staff and meet the wellbeing, resilience and inclusivity needs of the Trust's workforce resulting in an adverse impact on patient care.	**4. Develop attract, motivate and retain a high quality and diverse workforce.**	4a) If the Trust fails to put in place sufficient support for staff and does not develop a robust processes to ensure **staff health and wellbeing**, this will lead to increased stress and sickness absence, poor staff engagement, increased recruitment/retention challenges and the detriment of staff morale.	**Chief People Officer** **People and Place Committee**	**3x4=12**	**Low** – To address workforce and skill-mix shortfalls the Trust is prepared to work in new ways to recruit the right staff and to introduce new roles to meet recognised needs. The Trust is: - Committed to recruit and retain staff that meet the high-quality standards of the organisation - Committed to prioritising the wellbeing of the workforce and supporting all staff to perform in their roles to the best of their ability. We will not accept risks associated with unprofessional conduct, bullying or an individual's competence to perform roles or tasks safely.
		4b) If the Trust does not have a robust **workforce plan** and plans to secure a pipeline of clinical and non-clinical staff (particularly in hard to recruit areas) through both external recruitment and the development of future leaders within its workforce, there will be staff shortages and skill gaps resulting in insufficient numbers of staff available in key areas and adverse impacts on the quality and safety of patient care and the development of a positive culture across the Trust. Increased agency staffing will also increase the financial pressure on the Trust and would likely have an adverse impact on morale (which in turn will affect both the staff and patient experience).		**3x4=12**	
		4c) If the Trust does not secure **clinical and medical engagement** from its workforce and effective **clinical and medical leadership** within the organisation, actions to address urgent issues are unlikely to be effective and the quality of care offered to patients may be placed at risk.		**3x5=15**	
		4d) If the Trust does not put in place measures to ensure **respect and compassion** between staff and to protect staff (and patients) from **violence and aggression** there will be an impact on staff wellbeing and retention leading to low staff morale and staff retention, adverse impacts on wellbeing and increased risks to patient care.		**2x5=10**	
BAF 5: Lack of investment or strategic focus on infrastructure (including technology) impedes the Trust's provision of safe,	5. **Ensuring appropriate infrastructure to enable the delivery of safe,**	5a) If the Trust fails to put in place appropriate security measures then it may be open to a **cyber-attack** leading to prolonged unavailability of critical systems which results in an inability to operate essential services, potential harm to patients, major data breaches and reduced public confidence in services provided by the Trust	**Chief Strategy, Transformation and Partnerships Officer**	**3x5=15**	**Low –** The Trust has a low risk appetite for issues related to cybersecurity, and the internal team has worked hard with partners (including NHS Digital) to reduce this risk.

Key strategic risk	Strategic Aim	Board Assurance Framework risks (BAF risks) Proposed for routine review	Lead and Committee	Current score (Likelihood x Impact)	Risk appetite
efficient and high-quality services	**high quality services**	5b) If the Trust fails to anticipate the estates infrastructure demands (in terms of **identifying estate maintenance and development risks)** then the intended improvements in quality, safety, patient experience and efficiency will not be realised leading to poor clinical outcomes, potential harm to patients and regulatory concern.	**Finance, Infrastructure and Transformation Committee**	**3x5=15**	Moderate - The Trust is limited by financial constraints and the extent of the capital budget to only address the highest and most pressing risks in this category rather than all estates related risks. An agreed programme is being methodically followed to prioritise projects for delivery in accordance with the severity of risk that is presented. ***Management will seek to fully mitigate any health and safety risks that could result in direct harm to members of the staff or the public***.
		5c) If the Trust fails to anticipate the **IT infrastructure demands** (in terms of the update and adoption of appropriate digital technologies) then the intended improvements in quality, safety, patient experience and efficiency will not be realised leading to poor clinical outcomes, potential harm to patients and regulatory concern.	**Finance, Infrastructure and Transformation Committee**	**3x5=15**	Moderate - The Trust is limited by financial constraints and the extent of the capital budget to only address the highest and most pressing risks in this category rather than all estates related risks. An agreed programme is being methodically followed to prioritise projects for delivery in accordance with the severity of risk that is presented. ***Management will seek to fully mitigate any health and safety risks that could result in direct harm to members of the staff or the public***.

Section Two: Evaluation of proposed BAF risks by strategic aim

Strategic aim: Meeting demand within local communities served for the provision of safe, high quality clinical services

Risk ID	1a
Strategic theme	**To meet demand within local communities served for the provision of safe, high quality clinical services**
Risk Description	If there is insufficient capacity to meet demand for **emergency services** patients may not receive the care they need on a timely basis leading to significant patient harm, poor patient experience, a lack of patient confidence in services and an increased prospect of regulatory intervention.
Exec lead	Miranda Jenkins, Chief Operating Officer
Assurance Committee	Quality and Performance Committee
Change since last review	None

Controls / Mitigations	Assurance
• Effective system-wide working • Full Capacity Protocol • Patient pathway management arrangements • Monthly UEC and elective care pathway system meetings • Safer staffing establishment levels reviewed for all nursing and medical teams in the past 12 months. • UEC focus on both sites / 'QEH Cares' work programme • Capital investment in the 'Front door' at UHL • Boarding SOP developed and implemented	• Monthly monitoring of performance against waiting times standards and other access and flow metrics including mixed sex breaches; cancelled operations • Regular regional performance reports • Monitoring of performance against constitutional standards • Monthly divisional performance meetings • Monitoring of recovery plans for elective and emergency services. • Acute provider/ MH collaborative arrangements in place • KPIs monitored at local and system level • Current CQC ratings, CQC Inspection reports

Gaps in Controls or Assurance

- Current performance against the ED four-hour target remains significantly challenged. The Trust reported estimated 65% 4/hr access in January 2025. Trust performance is consistently in the bottom quartile of London Trusts.
- Failure to secure a good or outstanding rating for CQC domains: Safe, Responsive and Use of Resources
- Current SOF score of 3 (since November 2021). Delivery of agreed Trust Strategy will result in improved future CQC ratings.
- New risk of triple boarding to ease ED flow has been added to the Corporate Risk register in May 2024

	Initial score	Current score	Target score
Likelihood	5	5	3
Impact	4	4	3
Risk Score	**20**	**20**	**9**

Executive Commentary/ update

- Twelve-hour breaches and ambulance handover delays remain at high levels, although marginally reduced compared to winter period last year. LAS step arrangements and cohorting policies in place, in line with new LAS Winter Plan. LAS activity has been increasing month on month and in January was 13% higher than the previous January.
- Patient flow and high patient acuity continue to impede ED performance across both sites which is consistently reported in the bottom quartile of London trusts.
- Both acute sites have UEC focused initiatives in place, with activity managed through the non-elective assurance work programme which is overseen by the Chief Operating Officer.
- An updated Full Capacity Protocol has been developed for both sites to support flow over winter
- In addition:
  - A new Urgent Treatment Centre (UTC) is being developed for the University Hospital Lewisham site [March 2025]
  - At QEH, with support from LGT's improvement programme team, a stocktake of current workstreams (alongside recommendations from NHSE, NHSE elect and other external visitors) has helped up create a road map for UEC focus and set up a programme governance. The first QE UEC board took place at the end of January.
  - A discharge incentive scheme has been trialled over winter 2024 to help support patients not meeting criteria to reside and reduce length of stay attributed to external delays – the impact of this is being assessed

Risk ID	1b
Strategic theme	**To meet demand within local communities served for the provision of safe, high quality clinical services**
Risk Description	If there is insufficient capacity to address waiting times, then patients will wait longer for elective treatments leading to patient harm, poor clinical outcomes a deterioration in patient experience, and an increased prospect of regulatory intervention. There may also be a loss of income.
Exec lead	Miranda Jenkins, Chief Operating Officer
Assurance Committee	Quality and Performance Committee
Change since last review	None

Controls / Mitigations	Assurance
• RTT lists to track 6 week and 18-week access standards • Clinical prioritisation of patients, and increased focus on specialties with high volumes of long waits. • Patient pathway management arrangements • Continued delivery and increase of virtual outpatient appointments to reduce waiting times. • Relationships with SEL APC, including provision of pooled lists, mutual aid, receipt and transfer of patients to different location in the sector to speed up access to treatment. • Sector investment in diagnostic activity levels • Outpatient transformation initiatives: advice & guidance, PIFU • Focus on pathways and plans to reduce length of stay • Weekend elective lists /insourcing support to address long waits in challenged specialties	• Monitoring of the PTL and implementation of recovery plans • Monitoring of performance against key national standards (62 ww, 78ww) and other access and flow metrics including mixed sex breaches; cancelled operations • Clinical prioritisation of waiting lists • Monthly divisional performance meetings • Monitoring of recovery plans for elective and emergency services. • Trust accountability framework • Acute provider/ MH collaborative arrangements in place to manage activity • Monitoring of patient outcomes across populations with protected characteristics • Current CQC ratings • Routine reviews of staffing levels against safer staffing guidance. • Elective recovery programme

Gaps in Controls or Assurance

- Focus on clinically urgent patients first may delay routine treatment for other patients, which may increase our overall waiting list size and volume of patients waiting beyond 52 weeks for treatment.
- Need for clear rebooking process prioritisation where planned treatments are postponed.
- Development of outpatient transformation metrics on advice and guidance and patient-initiated follow-up into our longer-term response to waiting times challenges.
- Specific ENT risk added to the Corporate Risk Register in October 2023
- The Trust is in Tier 2 for elective waits regionally and is engaging in regular discussion with SEL and regional colleagues to ensure delivery of agreed targets.

	• Initial score	Current score	Target score
Likelihood	5	5	3
Impact	4	4	4
Risk Score	**20**	**20**	**12**

Executive Commentary/ update

- The Trust is working collaboratively with partners across SEL to manage and spread demand on services, including development of plans to address long waits
- Overall waiting list size reduced to 64k (as of Feb 25) – however tail of long waits remain in ENT, Gynae, General Surgery, T&O and Gastro; vascular PTL in process of being transferred to GSTT
- Plans to deliver Investment in two additional theatres at UHL – expected delivery in December 2025
- Work is ongoing to review patients on the admitted PTL to maintain safety and identify any clinical risk. ENT waits present a specific challenge with continued focused work both with APC partners and internally to target improvements in this pathway
- Community ENT service is now up and running (June 24) with impact of this service beginning to be seen in Q2
- Focused pathway redesign work planned in ENT, Gynae and Gastro into 2025/26 – areas which make up approximately 30% of the overall Trust waiting list
- Internal assessment underway against new measures within the national elective reform guidance – expected requirement of >61% RTT 18/week performance.

Risk ID	1c
Strategic theme	**To meet demand within local communities served for the provision of safe, high quality clinical services**
Risk Description	If there is insufficient capacity to address cancer pathway waiting times, then patients will wait longer for cancer diagnosis and treatments leading to patient harm, poor clinical outcomes a deterioration in patient experience, and an increased prospect of regulatory intervention. There may also be a loss of income.
Exec lead	Miranda Jenkins, Chief Operating Officer
Assurance Committee	Quality and Performance Committee
Change since last review	No change

Controls / Mitigations	Assurance
• Trust-wide recovery planning underway with a focus on re-instating elective and diagnostic activities. • Close working with SEL Cancer Alliance, SEL ICB and provider partners to develop pathway improvements and explore options for mutual aid and joint posts. • Short-term SELCA funding for insourcing and additional activity in key areas with capacity constraints. • Clinical Reviews of the Backlog, to fast-track clinical decisions. • Development of cancer action plans by cancer services to ensure focus on key recovery actions. • Strategic reviews of key services (such and Breast and Oncology) to facilitate improved access.	• Daily monitoring of Cancer PTLs and patient level escalations to clinical and diagnostic services. • Weekly Cancer Clinical PTL meetings to focus on patients requiring clinical input and review. • Weekly Cancer Assurance Meetings to focus on long-waiting patients and patients breaching constitutional standards and Weekly Divisional Meetings to escalate any unresolved issues. • Bi-weekly weekly Cancer Delivery Group chaired by the Chief Operating Officer/Deputy Chief Operating Officer • Cancer Action Plan development and implementation process, with oversight from the Cancer Delivery Group (above). • Service specific trajectories for performance improvement to be monitored via the above assurance framework. • External assurance provided to SEL ICB and SELCA via 62 Day Group and Faster Diagnosis Board. • Trust accountability framework • Acute provider collaborative structure • Monitoring of patient outcomes across populations with protected characteristics • Current CQC ratings

Gaps in Controls or Assurance

Historically, we have not held service specific trajectories for performance improvement. Implementing these over Q2/3 of 24/25 will improve quality of the assurance we receive from services. Metrics have been developed for the backlog and FDS, and further work is required to implement for the other constitutional standards.
There has also been a slight gap in how cancer quality metrics are monitored and this will be addressed by the establishment of the Cancer Quality Group (mentioned below).

	Initial score	Current score	Target score
Likelihood	5	5	3
Impact	4	4	3
Risk Score	**20**	**20**	**9**

Executive Commentary/ update

LGT has failed to meet the 28 day Faster Diagnosis Standard throughout this financial year to date. This is in contrast to 23/24, where we met the standard in 9 out of 12 months. Our 62 day performance remains relatively stable, but significantly short of our planned trajectory performance of 77%. Trajectory agreed for April 2025 to return to 75% for FDS. Full briefing on cancer provided to QPC in January 2025.

This position is driven by an increase in referral volumes and consultant workforce challenges in some of our key challenged areas, such as Skin, Head & Neck, Colorectal and Urology. This created front end capacity constraints which have largely contributed to the FDS performance, which has in turn, affected the size of our PTL and ultimately the backlog. Access and timeliness from Nov 24 to Jan 25 has also been impacted by diagnostic access challenges, particularly in endoscopy and radiology.

Services that are impacted by workforce challenges are on active recruitment drives and where applicable, approved pathway improvement projects identified with SELCA are underway. Our re-defined assurance processes, detailed above, will enable us to develop and monitor improvement plans and trajectories more effectively. Cancer Quality Metrics will also be monitored via new Cancer Quality Group, chaired by the Chief Nurse which is due to start in March 2025.

Strategic aim: Improving financial sustainability of the Trust and the wider health economy across South East London

Risk ID	2a
Strategic theme	**Improve financial sustainability of the Trust and the wider health economy across South East London**
Risk Description	If the Trust receives **insufficient revenue funding** through changes to national and local commissioning arrangements and is unable to identify planned levels of efficiency (with appropriate governance in place), then there will be a failure to remain financially sustainable. This will lead to a deterioration in the provision of high-quality patient care, patient and staff experience, staff health and wellbeing, public confidence in services and increased likelihood of regulatory intervention.
Exec lead	Chief Finance Officer
Assurance Committee	Finance, Infrastructure and Transformation Committee
Change since last review	None

Controls / Mitigations	Assurance
• Ongoing engagement with SEL Integrated Care System and national colleagues, including in the design of new payment mechanisms and financial architecture. • Effective system-wide working • SFIs and Scheme of Delegation • Focus on embedding a strong financial control environment. • Focus on underlying cost base and on rigorous cost improvement planning, delivery and oversight. • Increasing focus on costing analysis and information. • Quality impact assessment of savings schemes prior to acceptance into the programme. • Use of safer nursing care tool to determine ward staffing levels • Robust governance arrangements to support delivery of the efficiency Programme - emphasis on targeting waste and improving patient experience through greater efficiency • Corporate Governance Manual	• Trust/ NHSE review of financial planning and in-year position • NHSE instigated Investigation and Intervention (I&I) process underway • Internal audit programme, including review of financial controls • In-year monthly financial reporting and forecasting • Vacancy control procedures • Progress against identifying cost improvement plans monitored through Finance Oversight Group KPMG commissioned by SEL ICB to support the I&I process, reviewing robustness of current plans and opportunities for additional in-year savings delivery (due Sept 24)

Gaps in Controls or Assurance

- Overspends in two business areas in particular – instigation of recovery plan underway
- Recovery plan enacted in Q3/Q4 focusing on two divisions with ongoing support with one.
- 2024/25 position managed with non-recurrent income leaving significant underlying deficit, work is underway to finalise 2025/26 plan

	Initial score	Current score	Target score
Likelihood	5	5	3
Impact	4	4	3
Risk Score	**20**	**20**	**9**

Executive Commentary update

- The 2024/25 breakeven position will be delivered with additional non-recurrent funding from SEL
- Overall NHSE funding is reducing in real terms in 2025/26
- The Trust has starting deficit plan for 25/26 with ongoing discussion with system partners, to be finalised by 27 March 2025.
- A recovery programme successfully delivered 24/25 position and residual actions are being transposed into existing governance support
- There also remains significant (unquantified) risk within the SEL financial system which could have a significant impact for the Trust in the coming period.

Risk ID	2b
Strategic theme	**Improve financial sustainability of the Trust and the wider health economy across South East London**
Risk Description	If the Trust is unable to access a sufficient capital envelope to invest in critical areas, this may lead to a deterioration in the quality of estate, the inability to purchase items that could mitigate clinical risk, an inability to innovate or deliver strategic changes and a subsequent impact on the delivery of patient care and provision of an appropriate clinical/working environment.
Exec lead	Chief Finance Officer
Assurance Committee	Finance, Infrastructure and Transformation Committee
Change since last review	No change

Controls / Mitigations	Assurance
• Capital Planning and completion of spend prioritisation exercise • Access to alternative funding sources and mechanisms • Effective system-wide working • Robust business and investment cases	• Capex included in monthly finance report and FITC reports • Routine capital and exception reporting to FITC • Discussions at system level • Monitored through Capital Planning Board and FITC. • Annual Board approval of capital plan

Gaps in Controls or Assurance

Finalising 25/26 capital allocations

	Initial score	Current score	Target score
Likelihood	3	4	3
Impact	4	4	3
Risk Score	**12**	**16**	**9**

Executive Commentary/ update

- Given the current financial landscape the outlook in terms of available CDEL (capital departmental expenditure limit) for the Trust in future years is likely to be challenging.
- Capital expenditure is likely to be constrained across the NHS, with the capital budget not being increased in line with inflation or in line with the NHSE revenue settlement, leading to a significant reduction in purchasing power.
- The need to balance the needs of the Trust with competing demands for significant strategic schemes across South East London may result in a reduced capital limit for The Trust, increasing this risk further.

Strategic aim: The Trust should work effectively with system partners to ensure that all patients and communities served by the Trust have equal access to services and inequalities of health outcomes are minimised

Risk ID	3a
Strategic theme	**The Trust should work effectively with system partners to ensure that all patients and communities served by the Trust have equal access to services and inequalities of health outcomes are minimised**
Risk Description	If the Trust fails to put in place processes to manage access to services and does not monitor outcome of services provided to particular population groups, there is a risk that avoidable inequalities in the delivery of services may impact the communities served by the Trust. This may lead to increased clinical risks, and an adverse impact on the quality and experience of patient care.
Exec lead	Chief Strategy, Partnerships and Transformation Officer
Assurance Committee	People and Place Committee
Change since last review	None

Controls / Mitigations	Assurance
• Inequalities steering group in place • Have established inequalities-focused objectives for each clinical division and included inequalities as a specific strand of our business planning • Priority workstreams agreed (data, prevention, pop health, anchor, system working) and all have activity underway • Links made with ICS and place-based inequalities programmes • Project around Reasonable Adjustments Digital Flag established.	• Reported progress against workstreams and priorities • Equality Delivery System report published per NHSE requirements – being updated for 24/25 • 12-month evaluation of our waiting lists inequalities work produced and shared with PPC • Patient / community feedback • Outcome measures available in some areas • KPIs for individual workstreams now agreed and in place Health inequalities steering group is now in place Annual Report now includes new NHSE requirements regarding inequalities reporting.

Gaps in Controls or Assurance

- Borough based inequalities actions plan under development
- Development of NHSE requirement regarding annual reporting on inequalities

	Initial score	Current score	Target score
Likelihood	4	3	3
Impact	4	4	3
Risk Score	**16**	**12**	**9**

Executive Commentary/ update

- SELICS plan to address health inequalities in development https://selondonccg.nhs.uk/wp-content/uploads/2022/03/Primary-Care.-Health-Inequalities.pdf
- LGT has an agreed health inequalities programme in place with underpinning metrics identified on key programmes monitored by the Health Inequalities Steering Group
- As part of the planning process for 2024/25 the Trust developed Trust-wide divisional objectives for population health, health inequalities and prevention – these will be refreshed for 25/26

Risk ID	3b
Strategic theme	**The Trust should work effectively with system partners to ensure that all patients and communities served by the Trust have equal access to services and inequalities of health outcomes are minimised**
Risk Description	If the Trust does not effectively engage with ICS partners as a 'true system player' there is a risk that the access and quality accessed by the communities served by the Trust will be compromised, leading to adverse impacts on public confidence in services and patient experience.
Exec lead	Chief Strategy, Partnerships and Transformation Officer
Assurance Committee	People and Place Committee
Change since last review	None

Controls / Mitigations	Assurance
• Attendance at System wide meetings • Relationship with local provider Trusts • Attendance at LA Scrutiny Boards • Established Executive-chaired quarterly borough partnership meetings to monitor progress	• ICS Board meetings • Acute Provider Collaborative meetings • ICS support for Trust investment – UHL theatres, Community Diagnostic Centre in Eltham, development of programme for additional QEH beds • Development of relationships working with local partners • Joint working on system leadership projects as both system leader, partner or contributor • Bi-monthly partnership reports to PPC/Board • Quarterly partnership meetings

Gaps in Controls or Assurance

As above

	Initial score	Current score	Target score
Likelihood	2	2	1
Impact	4	4	4
Risk Score	**8**	**8**	**4**

Quarterly Executive Commentary

- The Trust has nominated exec directors to lead on borough engagement – these Execs convene quarterly meetings to review progress in key areas. These were stood down over winter but re-established for April onwards.
- Through planning, we have set ourselves clear objectives relating to improving the primary-secondary care interface and developing integrated models of care with system partners
- Work continues to develop plans for extended provision at Community diagnostic centres at Eltham (opened 2023) and QMS.
- Work is underway to develop proposals to accelerate progress with the acute collaboration. This work is being led by SEL Executive colleagues, notwithstanding challenges with the current financial position in SEL. Collaborating with the APC on clinical strategies in gynaecology, orthopaedics, imaging, and breast care.

Strategic aim: Develop, attract, motivate and retain a high quality and diverse workforce

Risk ID	4a
Strategic theme	**Develop, attract, motivate and retain a high quality and diverse workforce.**
Risk Description	If the Trust fails to put in place sufficient support for staff and does not develop robust processes to ensure **staff health and wellbeing**, this will lead to increased stress and sickness absence, poor staff engagement, increased recruitment/retention challenges and the detriment of staff morale.
Exec lead	Chief People Officer
Assurance Committee	People and Place Committee
Change since last review	None

Controls / Mitigations	Assurance
• Wellbeing programme in place • Monitoring of absence in accordance with established absence management policy • Workforce strategy to create inclusive workplaces with a programme of work to address concerns. • Implementation of staff survey action plans • Mechanisms to ensure effective engagement with staff/groups (e.g. all staff webinars, AskBen, staff networks, TJPB) • Ongoing engagement with SEL ICS and London-wide programmes to support wellbeing and inclusion	• Monthly divisional performance meetings • Workforce Priorities Programme • Monthly workforce reports to PPC • KPI reports for a suite of workforce indicators • Monitoring of key datasets (WRES, staff survey, Workforce KPIs by protected characteristic) • Absence / Recruitment data • Annual equality indicators (e.g., WRES, WDES and Staff survey data) • Reported progress against delivery of the Trust's Workforce strategy • Feedback provided by the staff networks • Good rating for the CQC well-led domain • 2023 staff survey results

Gaps in Controls or Assurance

As at March 2025 the Trust reported:

- Sickness rates remain above the Trust target (5.46% in Jan '25, target 4%)

	Initial score	Current score	Target score
Likelihood	3	3	1
Impact	5	4	5
Risk Score	**15**	**12**	**5**

Executive Commentary/ update

- Wellbeing initiatives continue.
- Vacancy rate in line with the Trust target (9.84% in Jan '25, target 10%)
- People Promise Exemplar Programme – cohort 4. Establishing initiatives to support retention efforts and improve job satisfaction.
- Gross annual turnover reduced to 10.39% (Jan 25), voluntary turnover (9.59%) and voluntary leavers in their first year (16.06%)
- OH services brought in house to improve control and demand – overall positive feedback to date
- Work on the Trust's Violence and Aggression programme continues.
- The 2024 staff survey response rate increased to 53% in 2024, compared to (51% in 2023 and 47% in 2022) – the national median was 49%. Overall, the Trust has strengthened its position and improved in 5 domains above national average, remained at national average in 1 domain and below national average for 3 domains which is an improvement from the previous year

Risk ID	4b
Strategic theme	**Develop attract, motivate and retain a high quality and diverse workforce.**
Risk Description	If the Trust does not have a robust **workforce plan** and plans to secure a pipeline of clinical and non-clinical staff (particularly in hard to recruit areas) through both external recruitment and the development of future leaders within its workforce, there will be staff shortages and skill gaps resulting in insufficient numbers of staff available in key areas and adverse impacts on the quality and safety of patient care and the development of a positive culture across the Trust. Increased agency staffing will also increase the financial pressure on the Trust and would likely have an adverse impact on morale (which in turn will affect both the staff and patient experience).
Exec lead	Chief People Officer
Assurance Committee	People and Place Committee
Change since last review	None

Controls / Mitigations	Assurance
• Monthly monitoring of fill rates and movement of staff internally through the transfer process • Monthly monitoring of recruitment rates into posts and • national/international markets • Monitoring of time to hire rates • Daily levelling of staff across areas, including redeployment. • Exit interview and local workforce intelligence within clinical boards • Review of temporary staff usage via bank partners • Targeted recruitment campaigns for the areas affected • Review of local induction compliance and 1:1s • Regular recruitment fairs and active recruitment to mitigate the risk of reduction in international recruitment	• Workforce Priorities Programme • Medical Staffing review 2023 • ED nursing staff review 2023 • Vacancy rate reports (division and staff group) • Agency and bank staff usage data, return to practice numbers • and other routes into nursing. • Regional and other system groups • Transfer request trends, student learners in placement, • apprenticeship numbers • Agency and bank staff usage data • Return to practice numbers and other routes into nursing, e.g. • Nursing Associates, RNAs • Freedom to speak up Guardian Service reports

Gaps in Controls or Assurance

As at March 2025 the Trust reported:

- Increased spend on bank and agency above workforce plan. Fill rate fluctuates and do not always meet demand
- Consultant vacancies above Trust target at 14.56% - this is in part due to increasing establishment as the Trust continues to invest in the medical workforce establishment
- On-going E-Rostering implementation and monitoring of efficiencies by area

	Initial score	Current score	Target score
Likelihood	3	3	2
Impact	5	4	4
Risk Score	**15**	**12**	**8**

Executive Commentary/ update
• Work continues to implement the agreed Workforce plan • Vacancy rate in line with the Trust target (9.84%, target 10%) • Regular recruitment fairs for N&M, AHP and medical staff • Gross annual turnover reduced to 10.39% (Jan 25), voluntary turnover (9.59%) and voluntary leavers in their first year (16.06% • Targeted focus on sickness monitoring • Launch of Clinical Excellence in Partnership programme for the medical workforce focussing on workforce planning, recruitment, onboarding and retention; talent management and leadership development; and employee voice and wellbeing • Workforce and recruitment plans in place for transformation project (CDC and the Lewisham Surgical Centre/HVSH)

Risk ID	4c
Strategic theme	**Develop attract, motivate and retain a high quality and diverse workforce.**
Risk Description	If the Trust does not secure **clinical and medical engagement** from its workforce and effective **clinical and medical leadership** for all clinical services within the organisation, actions to address urgent issues are unlikely to be effective and the quality of care offered to patients may be placed at risk.
Exec lead	Chief Medical Officer (Medical engagement) working with the Chief People Officer
Assurance Committee	People and Place Committee
Change since last review	None

Controls / Mitigations	Assurance
• Comprehensive approach to Leadership & Management Development for all levels of staff • Learning, education and OD strategy for the trust • Coaching and mentoring opportunities, including coaching and a reverse mentoring programme for senior leaders • Leadership & management apprenticeships • Medical workforce engagement events – Clinical Director development programme, Junior Doctors fora • TME ensures appropriate clinical input to all papers presented for approval to the Board and its Committees	• Regular workforce reports to the Board on progress include education, training and development metrics • Clinical Excellence in Partnership programme and roll out. Regular review of objectives and actions • Updates to PPC on Education and Leadership Development • Regular updates to SDT on key areas of work • HEE visits • 2023/4 Staff survey results

Gaps in Controls or Assurance
• Increased spend on bank and agency above workforce plan. Fill rate fluctuates and do not always meet demand • Plans are in place to review the Trust's leadership succession programme. • Implementation and review of Talent Management pilot for senior managers and OD development programme for ward managers. • Feedback from the staff survey indicates the need for further work to improve the experience of the clinical and medical workforce. • Engagement with the Medical workforce remains a priority area of focus for the Trust Board.

	Initial score	Current score	Target score
Likelihood	3	3	1
Impact	5	5	5
Risk Score	**15**	**15**	**5**

Executive Commentary/ update
• Launch of the Clinical Excellence in Partnership programme for the medical workforce focussing on workforce planning, recruitment, onboarding and retention; talent management and leadership development; and employee voice and wellbeing. Objectives and timescales within the 3-year strategy • The Trust has continued the roll out of a Talent Management programme to improve the succession of future Trust leaders. • New leadership team in place within the CMO Office • 39% improvement in job planning compliance in 2024 – 82% compliance overall (compared to 43% in 2023) • CD away days held for both sites • Improvement in responses to the People promise domains and overall response rate for medical staff in the 2024 staff survey

Risk ID	4d
Strategic theme	**Develop attract, motivate and retain a high quality and diverse workforce.**
Risk Description	If the Trust does not put in place measures to ensure **respect and compassion** between staff and to protect staff (and patients) from **violence and aggression** there will be an impact on staff wellbeing and retention leading to low staff morale and staff retention, adverse impacts on wellbeing and increased risks to patient care
Exec lead	Chief People Officer
Assurance Committee	People and Place Committee
Change since last review	None

Controls / Mitigations	Assurance
• Trust-wide respect and Compassion Programme Board and Violence and Aggression Programme Board – both of which have full work programmes. • Review of good practice both within LGT and across the NHS • Trust wide 'V&A' campaign to improve staff experience • Freedom to Speak up Guardian provides external, independent contact point for staff to raise concerns • Local action plans to address specific staff survey concerns in place • Staff networks • Sexual safety	• Staff Survey Results - annually and quarterly • Formal ER case numbers • Workforce Race Equality Standards (WRES) metrics • Turnover rates • Freedom to speak up Guardian Service reports • Recent independent review of arrangements for speaking up demonstrated progress made by the Trust in recent years

Gaps in Controls or Assurance
• There are agreed work programmes in place, but this is a longer-term piece of work, which will take a sustained and multi-faceted approach. More regular feedback and review of different sources of data to understand the different sources of the issue.

	Initial score	Current score	Target score
Likelihood	2	2	1
Impact	5	5	5
Risk Score	10	10	5

Executive Commentary/ update

- Work to continue to promote the Guardian Speak up service continues through comms, as well as to promote the support available. This is a high focus area for the Trust and remains a priority. A comprehensive action plan has been put in place and a number of supporting documents have been implemented for managers and staff. Improvement in the speak up culture at the Trust
- Successful EDI conference during October 2023 and 2024
- September 2023 and 2024 HPMA Excel Award for leading in equality, diversity, and inclusion

Strategic aim: Ensuring appropriate infrastructure to enable the delivery of safe, high quality services Strategic aim: Ensuring appropriate infrastructure to enable the delivery of safe, high quality services

Risk ID	5a
Strategic theme	**Ensuring appropriate infrastructure to enable the delivery of safe, high quality services**
Risk Description	If the Trust fails to put in place appropriate security measures then it may be open to a **cyber-attack** leading to prolonged unavailability of critical systems which results in an inability to operate essential services, potential harm to patients, major data breaches and reduced public confidence in services provided by the Trust
Exec lead	Chief Strategy, Transformation and Partnerships Officer
Assurance Committee	Finance, Infrastructure and Transformation Committee
Change since last review	None

Controls / Mitigations	Assurance
• The Trust has an Information Security Policy which includes Cyber Security. • The Trust is subscribed to receive NHS Digital's CareCERTalerts and cyber security threat notifications. • The Trust maintains a Hardware Asset Register which sits with IT and a list of critical systems which sits with IG. • MFA compliance for NHS mail. • ITSM tool procurement in process to improve asset management. • Cyber Security function now part of the IT Services Team following a consultation. • All policies are in date and approved.	• Minutes from the Digital Steering Group • ICO review of Cybersecurity arrangements (October 2023) and closure of audit in October 2024. • Annual IG Toolkit review (submission 2024) and DSPT / CAF audit baseline submission Feb 2025. • The Trust has adopted the National Cyber Security Centre's 10 Steps to Cyber Security as a baseline for its cyber security arrangements. • The Trust network is protected at the perimeter by resilient Palo Alto firewalls, which have Intrusion Prevention System (IPS) capabilities, vulnerability scanners, anti-malware scanners and a demilitarised zone • Sophos Anti-virus (AV) protection is used to protect machines from malware. • Microsoft Defence Endpoint tracking monthly low for infrastructure and moderate for end user devices. • Tabletop simulations held every 6 months. • Cyber security strategy approved by FIT/TME and now being deployed.

Gaps in Controls or Assurance

- Use of AI policy completed and to be issued Trust wide in March 2025.
- Cyber strategy is complete and is currently being implemented to reduce risk over the next 2 years.
- KPMG audit due in 2025 for DSPT / CAF optional items.

	Initial score	Current score	Target score
Likelihood	3	3	1
Impact	5	5	5
Risk Score	**15**	**15**	**5**

Executive Commentary/ update

- Ongoing communications plan to increase staff awareness of Cyber throughout 24/25
- ICO audit of cyber security arrangements in October 2023 reached a conclusion of 'reasonable assurance'
- Cyber strategy approved and is being implemented
- MFA compliance completed for NHS email access
- ICO audit actions near completion focusing on remaining item – 3rd party supplier auditing and monitoring
- Cyber Tabletop Exercises planned for every 6 months and in flight.
- 2024 penetration test recommendations being worked on and mitigated due for completion by August 2025.

Risk ID	5b
Strategic theme	**Ensuring appropriate infrastructure to enable the delivery of safe, high quality services**
Risk Description	If the Trust fails to anticipate the infrastructure demands (in terms of **identifying estate maintenance and development risks**, and the adoption of appropriate digital technologies**)** then the intended improvements in quality, safety, patient experience and efficiency will not be realised leading to poor clinical outcomes, potential harm to patients and regulatory concern.
Exec lead	Chief Financial Officer Chief Strategy, Transformation and Partnerships Officer
Assurance Committee	Finance, Infrastructure and Transformation Committee
Change since last review	None

Controls / Mitigations	Assurance
• Routine testing of infrastructure – fire, water, electricity • Trust Estate strategy – including infrastructure investment at both hospital sites • Monthly contract meetings with hard FM provider • Monthly Risk register reviews • Quarterly Liaison meetings with PFI Partners • Monthly Water Safety meetings • Monthly Ventilation meetings • Monthly Electrical Safety meetings • Monthly and Quarterly Fire Safety Committee Meetings	• Updates on the Estate strategy • Minutes of Finance, Infrastructure and Transformation Committee and the Audit, Risk and Compliance Committee • Updates on Fire and Water compliance testing provided to Health, Safety and Resilience Committee • Risks in relation to Water, RAAC and Asbestos presented to ARCC in March 2024. • Risks in relation to Fire Safety at QEH (and UHL) presented to TME and ARCC in January 2025.

Gaps in Controls or Assurance

- Specific risks raised regarding water safety across sites – added to the CRR March 2023
- Specific risks raised regarding fire safety across sites- added to the CRR May 2022 and updated in July 2024 following recent fire risk assessments

	Initial score	Current score	Target score
Likelihood	3	3	1
Impact	5	5	5
Risk Score	15	15	5

Executive Commentary/ update
Key projects include • Plans in place to support the infrastructure development of the CDC at Eltham (networking, devices, comms links) • Consideration of RAAC and asbestos risks (presented to March 2024 ARCC) has not identified significant risks for the Trust • Backlog programme at UHL (Retained Estates) following six-facet survey conducted in 2022 • QEH - SIP Project now completed apart from completion of paperwork e.g. Operational & Maintenance manuals • Reduction in Legionella results at QEH • Commissioning Fire surveys and awaiting recommendations. The interim report has been received from ARUP, and this has been presented to TME and ARCC. Milestone 2 report is due in February 2025. • Works commenced July 2024 on Lewisham Surgical Centre at UHL

Risk ID	5c
Strategic theme	**Ensuring appropriate infrastructure to enable the delivery of safe, high quality services**
Risk Description	If the Trust fails to anticipate the IT infrastructure demands (in terms of the update and adoption of appropriate digital technologies) then the intended improvements in quality, safety, patient experience and efficiency will not be realised leading to poor clinical outcomes, potential harm to patients and regulatory concern.
Exec lead	Chief Strategy, Transformation and Partnerships Officer
Assurance Committee	Finance, Infrastructure and Transformation Committee
Change since last review	New BAF risk 24/25

Controls / Mitigations	Assurance
• Representation at SEL Estates and Digital Steering Group to ensure alignment with decisions made by SEL ICB • Ongoing programme of iCare development/training • Trust Digital strategy including patient portal which is now live • Movement to a single tenancy / platform with Community Services to align to the acute.	• Updates on the Digital and Estate strategy • Minutes of Finance, Infrastructure and Transformation Committee and the Digital Steering Group • Inclusion of digital tools (including the new patient portal) as a core part of Outpatient Strategy. • Plans in place to deploy an electronic bed management system by June 2025

Gaps in Controls or Assurance
• Trust is currently reviewing options for its future EPR system and is considering a potential move to a converged solution within SEL. • Absence of national/ICS digital strategy/ funding clarity to provide guardrail for decision-making. • EPR Readiness implementation – data and infrastructure.

	Initial score	Current score	Target score
Likelihood	3	3	1
Impact	5	5	5
Risk Score	15	15	5

Executive Commentary/ update
Key projects include • Delivery of the Trust future EPR Strategy (OBC and next steps) • Utilisation of a Patient Portal across Acute and Community services to support improved ways of communicating with patients, service users, carers, and local populations.

TRUST BOARD REPORT
25th March 2025

Report from:	**Charity Committee**
Date of Committee Meeting:	**18th March 2025**

Purpose of the Committee:

The role of the Committee is to oversee the management, investment and disbursement of the Lewisham and Greenwich NHS Trust Charitable Fund (Registered Charity No: 105052), and to ensure compliance with statutory or other legal requirements or best practice required by the Charity Commission.

This is a delegated duty carried out on behalf of the Board of Lewisham and Greenwich NHS Trust (the Trust), which is the sole corporate trustee of the charity. As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role, it is accountable to the Charity Commission for those funds deemed to be charitable, as well as the Secretary of State for Health.

As set out in the Trust's Standing Orders, the objectives of the Committee are to:

a. Oversee the conduct and propriety of the Trust's stewardship of Funds held in the Trust
b. Ensure that policies are in place in respect of Charitable Funds, their use, investment, and disbursement.
c. Raise charitable funds for the benefit of the Trust, to invest them in accordance with the requirements of the Trustee Act 2000, or other appropriate guidelines.
d. Consider applications for support within the Trust and to disburse funds in accordance with the wishes of the donor or the relevant legislation; and
e. Review the Charitable Fund Accounts and Annual Report on behalf of the Charity Trustees.

Purpose:	**For approval or ratification** ☐ **Item to receive/for information** ☒ **For discussion** ☐ **For decision** ☐
Committee Chair:	**Harry Bright, Non-Executive Director and Committee Chair**
Lead Director:	**Kate Anderson, Chief of Staff**

ITEMS FOR APPROVAL

1. 2024 Annual Report and Financial Accounts for the year ended December 2024

The Committee received the 2024 annual report setting out a review of the Charity's activity for the 2024 calendar year The accounts had been subject to independent examination and had been prepared in line with the Charity Commission standards. Income for the period was £281k, expenditure was £240k. The balance of the Charity's funds for the period ended 31 December 2024 was £802k (made up of unrestricted funds of £234k and the restricted funds £568k).

The Committee approved the 2024 Annual Report and Financial Accounts for the year ended December 2024.

2. Purchase of a Hilotheraphy device for cancer patients receiving chemotherapy at QEH

The Committee was presented with a proposal from the Cancer Services team at QEH to purchase a Hilotheraphy device for cancer patients receiving chemotherapy at QEH. This device would enhance the care of cancer patients at QEH by treating/preventing Chemotherapy-induced peripheral neuropathy, a side effect from chemotherapy treatment. The cost of the equipment (including a two-year maintenance package) was £15,000. In the longer term, and following impact assessment of this device, the team noted it would like the Charity to consider purchase of a similar device for patients at the UHL site.

The Committee approved the proposed purchase and requested that the Cancer team undertake the proposed review of benefits.

ITEMS DISCUSSED

3. Voluntary Services update

The Committee received an update following the restructure of the Charity and Volunteering team which concluded in Autumn 2024. A new Head of Volunteering had joined the Trust in December 2025, and whilst there remained some absence within the combined team due to sickness and maternity leave, roles and responsibilities for members of the team were now much more clearly defined.

The Committee received the report and requested an update on the Voluntary services team (including details of the voluntary services strategy and current volunteering activity) be presented to the next meeting of the Committee.

4. Charity Update and Focus

The Committee received an update on the charity's activities over the past quarter and plans for the remainder of the 2025 year. The Committee discussed the success of the recent Trust awards – for which the Charity had raised £64k of sponsorship from stakeholders and new income streams such the 'tap-to-donate' machines installed across the site and the website income. The Committee also noted that the Charity had recently received several larger donations from patients, local schools and had recently been informed of a significant legacy.

It was noted the Charity team was continuing work to raise the profile and income streams of the charity, and a full calendar of events was planned for 2025.

5. Legacy notified to the Charity

The Charity received an update to the Committee in relation to a legacy notified to the Charity for which the Trust was the residual beneficiary. This legacy included the estate of a former patient of the Trust who received care at the UHL site which includes a one-bedroom property in New Cross. As outlined by the Head of Charity, there were other beneficiaries listed in the will who would receive £25k of the proceeds from sale of the property. A further claim on proceeds from the estate had also been made by a third party – this Charity was currently seeking legal advice in relation to the treatment of this claim.

Trustees noted the need to maximising the income available from the property but agreed that the Charity is not in the business of property development. As such the Trustees agreed the Charity would not be looking to refurbish the property prior to its sale. Noting receipt of a recent cash offer below the current asking price for the property (£225k), the Committee agreed the Head of Charity would instruct the executors of the will to list the property for auction with a reserve price equivalent to the recent cash offer. The 3rd party claim the proceeds of the sale of the property would be reconsidered by Trustees following its sale and receipt of further legal advice.

Oxleas NHS
NHS Foundation Trust

170th Meeting of the Board of Directors

Thursday 6 March 2025
10am
James Conference Room, Queen Mary's Hospital, Sidcup
(Will also be available and broadcast publicly on Teams)

AGENDA – Part I

ITEM		ACTION	PRESENTED BY	ENC
1 15 mins	**Apologies for absence, declarations of interest and reflections**	To note	Andrew George Chair	-
2 p3 5 mins	**Minutes of last meeting**	To approve	Andrew George Chair	**1**
3 p10 5 mins	**Matters arising**	To monitor	Andrew George Chair	**2**
Governance and Strategy items				
4 p12 15 mins	**Service user and carer involvement focus**	To note	Neil Springham Chief Therapies Officer	**3**
5 p15 5 mins	**Board assurance framework update**	To agree	Ify Okocha Chief Executive	**4**
6 5 mins	**Chair's report**	To note	Andrew George Chair	**verbal**
7 p42 15 mins	**Chief Executive's report**	To note	Ify Okocha Chief Executive	**5**
8 p53 15 mins	**Operational report**	To note	Iain Dimond Chief Operating Officer	**6**
9 p62 5mins	**Non Executive Directors' reports**	To note	Andrew George Chair	**7**
Committees reports				
10 p76 10 mins	**Quality Committee**	To note	Suzanne Shale, Non Executive Director	**8**
11 p85 10 mins	**Business and Infrastructure Committee**	To note	Jo Stimpson, Non Executive Director	**9**
12 p91 10 mins	**People Committee**	To note	Nina Hingorani-Crain, Non Executive Director	**10**
13 p138 10 mins	**Audit and Risk Assurance Committee**	To note	Damien Régent Non Executive Director	**11**
14 p144 10 mins	**Partnership Committee**	To note	Jo Stimpson, Non Executive Director	**12**

Committees reports				
15 p148 5 mins	**Council of Governors' report**	To note	Andrew George Chair	**13**

COMMITTEE EFFECTIVENESS AND ANY OTHER BUSINESS				
16 p150 5 mins	**Review** *Did today's meeting achieve our aims? How is it improving patient and/or staff experience? How could the meeting be improved?*	To note	All	-
17 2 mins	**Forward agenda** *Consider items for future meetings that would benefit from greater service user/carer feedback*	To agree	All	**14**
18 2 mins	**Any other business**	To note	All	-

DATE OF NEXT MEETING
Thursday 1 May 10am

Reading room: background papers
Items included as optional background reading for committee members

Improving lives

NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 2

Enclosure 1

Subject	Minutes of the Board of Directors' Meeting held on 7 January 2025
Author	Susan Owen, Head of Risk and Governance
Accountable Director	Andrew George, Chair
Confidentiality/ FOI status	Public

What is the purpose of bringing this report to the Board meeting?	For approval by the Board. The Board is asked to agree the minutes as a true record of the meeting.

Oxleas NHS Foundation Trust

169th Meeting of the Board of Directors
Minutes of the meeting held on Thursday 9 January 2025
James Room, Queen Mary's Hospital Sidcup

Board of Directors

Prof Andrew George	Trust Chair
Muneeza Aumir	Non-executive Director
Nina Hingorani-Crain	Non-executive Director
Sophy Proctor	Non-executive Director
Damien Régent	Non-executive Director
Prof Suzanne Shale	Non-executive Director
Dr Jim Shaikh (JSh)	Non-executive Director
Jo Stimpson (JSt)	Non-executive Director
Dr Ify Okocha	Chief Executive
Iain Dimond	Chief Operating Officer
Azara Mukhtar	Chief Finance Officer
Dr Abi Fadipe (AFa)	Chief Medical Officer
Jane Wells	Chief Nursing Officer
Dr Neil Springham	Chief Therapies Officer

In attendance

Sally Bryden	Director of Corporate Affairs and Strategic Development (Trust Secretary)
Rachel Evans (RTE)	Chief Estates Officer
Alison Furzer (AFu)	Chief Digital Information Officer
Julie Onyegbula	Deputy Chief Nursing Officer
Susan Owen	Head of Risk and Governance (minutes)
Dr Farid Jabbar	Deputy Chief Medical Officer and Director of Flow
Olivia Ellis	Quality Improvement Advisor for Forensic and Offender Healthcare (for item 4)

Observing governors

Les Clark	Public: Greenwich
Lin Gillians	Public: Bromley
Tina Strack	Service User/Carer: Carers and Lead Governor

Item	Subject	Action
1	**Apologies for absence from board members** • Rachel C Evans, Chief People and Strategy Officer. **Apologies for absence from those in attendance** • None received. **Declarations of interest** • None declared.	**Noted**
2	**Minutes of last meeting** Pending amendments submitted in advance, the minutes of the meeting on 7 November 2024 were agreed as an accurate record.	**Approved**
3	**Matters arising** None raised. The items on the tracker were noted.	**Noted**
4	**Service user and carer involvement focus** The board received a presentation and film on service user and carer involvement in quality improvement projects, highlighting the positive impact this can have. It was noted that the film was produced using AI to overcome difficulties of filming within a prison setting.	**Noted**

Item	Subject	Action
	JSt asked about the challenges of engaging with the prisons service staff. OE said that the projects primarily involve healthcare staff, but specialist services are getting involved. The main challenge is patients being enabled to attend. The 'Did not attend' (DNA) project at HMP Rochester will rely on involvement from the prison service in terms of movement of prisoners. AFa asked how staff felt about removing the power dynamic. OE said that this is included in the roles of patient engagement leads in the south west, and they work with staff, officers and patients to understand what the areas of interest are. OE said that some staff have been apprehensive, but generally now see the benefits. SS asked for more detail on sustainable improvement projects. OE said that one such project was improving the patient welcome packs, with patient involvement from the outset to gain views and contribute to the design. The 'Can you understand it?' group were also involved. AG asked how we learn about how we involve staff. NS said that we have public participation leads, but it takes work on both sides to build bridges. Staff are willing, but need time and support. OE said that from a QI perspective, the right end users need to be involved as experts and we need to understand concerns to be able to remove barriers. The use of AI in trust films was discussed and information will be added to products when AI is used to ensure transparency.	
5	**Board Assurance Framework** IO presented the Board Assurance Framework. The in-year revenue and capital plan risk has been reduced as the trust will continue to use non-recurrent flexibility to meet the CIPs gap for the rest of this financial year. The People Committee risks have been updated to reflect feedback from the Service User and Carer Shadow Committee. JSh asked how we will address long term risks. AM said that this is reflected in the financial sustainability risk. SB said that for long term risks it was important that mitigations are refreshed. DR said that he was confident that processes and procedures are good and he was keen to understand more about the bottom up and top-down approach.	**Noted**
6	**Chair's Report** AG reported that his visit to HMYOI Isis had increased his understanding of trauma informed care, particularly in minority communities. AG said that he had attended the Medical Advisory Committee and medical excellence awards and was impressed with the realism and determination of medical staff. AG said that he had met with Gareth Bacon MP, during a visit to the EIP Team and he had indicated a strong interest in this work. AG said that we need to develop a stronger understanding of how we can benefit from academic networks.	**Noted**
7	**Chief Executive Report** IO reported that the trust has submitted a comprehensive response to the 10-year plan consultation. The government has announced new reforms to transform adult social care. This should be a cross-party activity, with clear guidance on the responsibilities of the state and individuals. The plans for elective care reform will have implications for the community diagnostic centre (CDC). For Oxleas services, 59% of patients are seen within 18 weeks, but we will need to consider how we can make improvements without additional funding or staff. The trust was pleased to learn that we achieved a 60% completion rate on the national staff survey, which is our highest completion rate yet.	**Noted**
8	**Strategy update** SB presented the strategy update on behalf of RCE. The strategy was launched in September 2024, and since then, directorates have focused on how this will be operationalised within their teams. Further workshops will be held to form their ideas into detailed plans and a dashboard for reporting progress is being developed.	**Noted**

Item	Subject	Action
	JSh suggested that we need to consider how we define innovation and that the template should reference implementation plans. SB said that a session on innovation is being planned and board committees would have oversight of implementation plans. SP asked how the board will receive information on partnerships. SB said that a discussion on partnerships would take place at a board strategic awayday. SS asked for more detail on the approach to collating data and how the board will understand where aspirations are not being met. AM said that it would be helpful to have more detail on improving data quality and how this links to productivity. IO said what we need to be mindful that we cannot capture everything, that we should agree the metrics we are going to use and seek assurance that we have addressed issues raised in complaints. ID said that in terms of inequalities, directorates have been asked to name three priorities to be framed as enablers and the support need from the wider organisation. SS said that we need to have balance between kindness and compassion and meeting targets. SB said that the next stage will be discussion with committee chairs.	**SB**
0	**Operational Report** ID presented the Operational Report. The report provides an update on neighbourhood-based care and delivering an aligned framework across all six places. These are at different stages in their journey. Services are feeling the impact of seasonal winter pressures. Our physical health teams are supporting acute trusts, by looking at opportunities to provide care in the community as an alternative to hospital. We are also working to reducing mental health demand in ED. The performance update enhances visibility on waits. Lisa Thompson is to retire as Director of Children and Young People at the end of March 2025, and Jenny Ioseliani has been appointed as her successor. JSt asked if we are seeing changes in terms of which services will be funded. ID said that these conversations have started but are in the early stages. Neighbourhood-based care is an opportunity to flow the money appropriately, but this is a complex process, and pressure on acute trusts can drive short term thinking. IO said that the ICB has an initial proposal on funding for community mental health. JSh asked for more detail on older persons demographics in community health. ID said that there is a societal shift on how we define an older person, and these are challenging conventions around risk management and views on older people. AFa said that we are starting to see early onset dementia sooner. SS asked about flow in the Home First team. ID said that this is part of an agreed system response. We are adept at identifying treatment needs with primary care services, but there are times when people need to be in hospital. SS said that this was an interesting reflection on the limitations of delivering care in the community. ID said that in addition to front end intervention, clinicians see patients on the acute wards to assess who can be discharged home. ID said that there can sometimes be a risk adverse approach from clinicians in an acute setting, who may not fully understand what can be delivered in the community. MA asked if there is any resistance from commissioners. ID said that friends and family can become anxious, and this can be a challenge for clinicians. SP asked how this relates to how care in community is received by carers, and if it is perceived negatively. NS said that this will be taken forward through the Carers and Support Network Strategy, which will be reported to the board via the Quality Committee.	**Noted**
10	**Non-executive Directors reports** JSt reported on her visits noting that Joydens Unit has a strong focus on physical health and well-being. The unit is in a remote location on the Bracton site, and staff have raised that they would appreciate better security lighting. The visit to the Bexleyheath Police Custody suite was positive. The Tilt (male hostel) is a good example of partnership working between Oxleas and Bridge, but it can be challenging to find appropriate places for the men to move on to. JSh asked	**Noted**

Item	Subject	Action
	how on-going contact with the community team is managed after discharge. ID said that they will continue to have contact, and the extent depends on the index offence and risk profile of the individual. The visit to the FIND team was also positive and but staff expressed concerns about the on-going consultation on reconfiguration. ID said that there are some specific issues with this service but reflected that we do need to look at our processes when working in partnership. **SP** reported that it was interesting to see the dementia friendly environment at Holbrook Ward, and hear staff reflections on the emotional impact of providing compassionate care. **ID** reported on the visit to the HBPOS and Oxleas House. We need to continue conversations about managing damage to the suite and providing better staff rest facilities at Oxleas House. The visit to the older persons liaison team was positive and staff praised the leadership of Kevin Clinch, but staff raised issues about space to see patients in ED. The working age adult mental liaison team are seeing more people presenting with social and substance misuse issues. The conversion rate of assessment to admission is getting lower which suggests we are finding alternative pathways. Staff do struggle with emotional impact of dealing with people in distress. **MA** reported that it was useful to see the benefits of the Bromley Hub. **SS** said that we need to consider the estate implications from her visits, for example ensuring that staff have healthy options for lunch and staff restrooms. Staff were enthusiastic about BAFO but were not aware of BAFOS. ID said that we need to do more work to bring our approach to inequalities to light, and a workshop is to take place next week to consider this through the lens of the directorates. SS said that staff can see the potential of digital tools but commented that it can take time to get approval within the trust. AFu said that it would be useful to explore this further.	
11	**Mortality Committee report** JW presented the report from the Mortality Committee. The committee received assurance that all deaths have been fully reviewed. The Head of Nursing for south-west prisons has reviewed a cluster of eight self-inflicted deaths at HMP Bristol to identify any thematic learning. This found 40 factors including lack of sleep, bereavement, and violent offences, and the team will continue to look at those factors. AG asked if the number of self-inflicted deaths is higher than general population and by how much. AFa said that we can explore if the figures are available from the prison service or confidential enquiries. JSt commended the excellent work undertaken with care and compassion.	**Noted**
12	**Quality Committee report** SSh presented the report from the Quality Committee. The board has been alerted to the concerns about the windows in the Bracton Centre, and the need to focus on systemic solutions ie adjusting the windows, rather than expecting staff to manage the risk. RTE said that the windows are anti-ligature but are an older version of the current product. RTE said that we need to be mindful of the cost-benefit of continually investing in updating products. A cultural shift in using the patient safety incident reporting framework (PSIRF) is taking place, and in future reports there will be a stronger focus on learning. The “Triangle of Care” risk is to be reviewed by the Quality Committee. JSt commented that even without early release schemes, safe release from prison is an area of concern and we need to consider opportunities to influence policy. ID said that the directorates are keen to do more, and we have been invited to a round table conversation with Prof Chris Whitty. AG said that the NHS Confederation are interested to have a focus on prison healthcare.	**Noted**

Item	Subject	Action
	JSt asked for more detail on the reasons for the increase in patient safety incidents. JW said that she would review the data and provide an update.	
13	**Business and Infrastructure Committee report** JSt presented the report from the Business and Infrastructure Committee. Work on the procurement of the soft FM contract has commenced, and this will need Cabinet Office approval due to value of contract. PFI surveys are due to start next month. The committee received a detailed report on the oversight of the use of the firm, Rydon, and was satisfied that the right processes are in place. The Council of Governors also received an update on the same.	**Noted**
14	**People Committee report** NHC presented the report from the People Committee. The committee were assured on the processes for safe staffing and the improvements on rostering practice. NHC commended the work on providing the level of granularity needed to understand rostering practice, and future reports will show how this is tracked over time. AG said that there is a tension between safe staffing, activity and funding. JW said that we need to have a focus on having right staff with right skills in the right place, with optimised rosters, and that we need to upskill staff and create new roles for advanced practice, with goals to aspire to. JO said that we need to change the culture to focus on skill mix and training, rather than the assumption that we need more staff to be safer. MA said that we need to make time for kindness and compassion. NHC asked if we are using the right tools to review safe staffing data. JO said that the Mental Health Optimal Staffing Tool (MHOST) is to be updated. Holbrook Ward uses the same tool as Meadowview – the Safer Nursing Care Tool (SNCT) - to reflect frailty. The Freedom to Speak Up report showed that there is a 76% increase in raising concerns and this should be taken as a positive of greater visibility. The most common reason for using The Guardian Service is because staff want impartial advice, but some use the service because they do not feel listened to. JSh asked for more detail on the theme of training on neuro-diversity. NHC said that this is a new issue that we may wish to explore further. The People Committee has reviewed the risk register in light of feedback from Service User and Carer Shadow Committee. The committee noted new legislation on the duty of employers to prevent sexual harassment in the workplace, and further work on this will be brought back to the committee. The committee continues to discuss fire safety compliance, and search and contraband are areas of focus.	**Noted**
15	**Audit and Risk Assurance Committee report** DR presented the report from the Audit and Risk Assurance Committee. DR said that he was confident that the trust's governance processes work well. The committee received a positive report on emergency preparedness, resilience and response (EPRR), and we perform well compared to our peers. The internal audit plan is on track and a brainstorming session is to be held with the internal auditors and NEDs for plan for next year. DR said that the next committee will receive a report of the top operational risks. **Charitable Funds Accounts 2023/24** There were 26 Trust Funds as of March 2024. The opening fund balance was £451k. The income for the year was £59k, and expenditure £119k. The closing fund balance was £391k, of which £213k are unrestricted and £178k are restricted. The cash balance as of 31 March 2024 was £409k. The Charitable Funds are not consolidated with the trust accounts due to materiality. **The Board of Directors approved the Charitable Funds Accounts 2023/24 for submission to the Charities Commission by the end of January 2025.**	**Noted**
16	**Council of Governors update** AG presented the update from the Council of Governors. The Council of Governors approved recommendations from the NED Nominations Committee for the appointment of Martin	**Noted**

Item	Subject	Action
	Machray to the Board of Directors, and the re-appointment of Sophy Proctor and Jim Shaikh. The Council of Governors supported the Board's proposal to appoint Suzanne Shale as Vice Chair.	
17	**Review of effectiveness of meeting** The board agreed that this was an effective meeting.	**Noted**
18	**Forward agenda** The Board of Directors noted the forward agenda.	**Noted**
19	**Question from the member of the public** None raised.	**Noted**
20	**Any other business** None raised.	**Noted**
Next meeting of the Board of Directors Thursday 6 March 2025 at 10:00 James Conference Room, Queen Mary's Hospital, Sidcup		

Improving lives

NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 3
Enclosure 2

Subject	Matters arising
Author	Sally Bryden, Trust Secretary
Accountable Director	Andrew George, Chair
Confidentiality/ FOI status	Public

What is the purpose of bringing this report to the Board meeting?	For the Board to note

Board Actions Tracker 2025 - progress on matters arising from last meeting and on-going matters from previous meetings

No	Minutes reference	Action raised (Board date)	Raised under item	Action details	Action for	Bring forward to	Report under	Action closed	Comments
1	2024-09/#1	05/09/2024	item 5: Board Assurance Framework	For the Business and Infrastructure Committee to discuss the priorities relating to business continuity planning and whether this needed to be considered at board level. For the Executive Team to decide when it would be appropriate to bring an update.	Alison Furzer Abi Fadipe Rachel T Evans	06/03/2025	Business and Infrastructure Committee update	Complete	**November 2024:** AFa, ID, AFu, RTE are to meet to discuss the way forward, with a view to reporting to the Business and Infrastructure Committee in January 2025, and then to the Board in March 2025. **January 2025:** Not due until March 2025. **March 2025:** A meeting was held in January 2025 and actions were agreed. Subsequently, the Emergency Preparedness, Resilience and Response (EPRR) Manager has asked the EPRR service leads to make sure that all system suppliers, even those without contracts, are listed in the Trust Information Asset Register. The Information Governance Group is responsible for this register and is reviewed annually. The EPRR service leads were also asked to ensure that BCP plans include these systems and their backup plans in case of a long outage.
2	2024-09/#2	05/09/2024	Item 7: Chief Executive's report	For the board to be updated on progress on the trust response to the recommendations from the CQC special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust, in particular the role of the ICMP and CMHRES teams.	Abi Fadipe	06/03/2025	Operational report	On-going	**January 2025:** It is expected that the NHSE next steps and core standards will be published in draft imminently, so the bring forward date has been extended to March 2025 to allow time for these to be reviewed and any implication for the trust to be understood before reporting to the board. **March 2025:** A brief update is included in the Chief Executive's Report. Following the publication of the independent report, all trusts have been asked to undertake a further review, which is in progress. A more detailed update will be presented to the Board in May 2025.

Board of Directors
6 March 2025

Item 4
Enclosure 3

Subject	Involve and Building Fairer Oxleas Services
Author	Japleen Kaur
Accountable Director	Neil Springham
Confidentiality/ FOI status	Not confidential

What is the purpose of bringing this report to the Board meeting?	For the Board's information
What risks/issues in the report need to be noted or acted upon?	Underutilisation of the Service user and Carer Reference Group – Equity by directorate leads in order to achieve their action plans for the workstreams
Where has this report been previously discussed?	Involved Advisory Group
Are there any issues in the report that might cause upset?	No
Glossary of terms/acronyms used in the report	SUCRG- Equity: Service user and Carer Reference Group for Equity BAFOS- Building a Fairer Oxleas Services

Link to trust strategy	Strong patient and carer voice and involvement Cultivating continuous improvement Equity for All	
Link to Board Assurance Framework	Greater service user and carer involvement	

Please summarise implications for:	
Quality	By integrating these videos into ongoing initiatives, the project aims to create a more inclusive and understanding healthcare environment, ultimately contributing to the overall quality of care at Oxleas
Finances	

	No immediate financial implications
Equality analysis	Equality monitoring data is collected as part of the onboarding process for all Involvement members via the register.
Service users/ carers/staff	Adds the service users' and carers' perspective, explores the links between the global majority's experiences of accessing health care services and enhancing cultural understanding for staff.

Executive Summary	**EXECUTIVE SUMMARY** *(High-level / strategic summary)* The presentation for the March 2025 board welcomes Involve member, Merlina Sanusi, who presents a co-development project resulting in five short videos to enhance cultural competence and inclusivity within our services. This initiative is a response to feedback from our Black Asian and Minority Ethnic community members represented via the service user and carer reference group, focusing on patient and carer experience. The first webinar was successfully conducted on the 14th of Feb, with 27 members in attendance, with some great discussions on what good care looks like from a cultural lens. This project is being conducted as part of the BAFOS workstreams under Equity for all. **Purpose and Objectives of the videos:** • Promote Cultural Understanding by encouraging staff to explore cultural differences and understand their impact on healthcare access, experience, and outcomes in a safe and supportive environment. • Empower the Community: Enable patients and carers to educate staff about their cultural identities and needs. Each 8-10 minute video features: • Introduction by the speaker, sharing their background and cultural identity. • Discussion of personal experiences with our services. • Highlighting community challenges and suggestions for improvement. The aims of the videos is: • Enhancing Cultural Competence by equipping staff with the knowledge and sensitivity needed to provide more inclusive care.	

	• Fostering Trust and Confidence by building relationships and genuinely listen to everyone's needs, creating a trusting and confident community. • Sustaining Good Practices by building on existing positive work and ensure it is shared and maintained.	

Improving lives

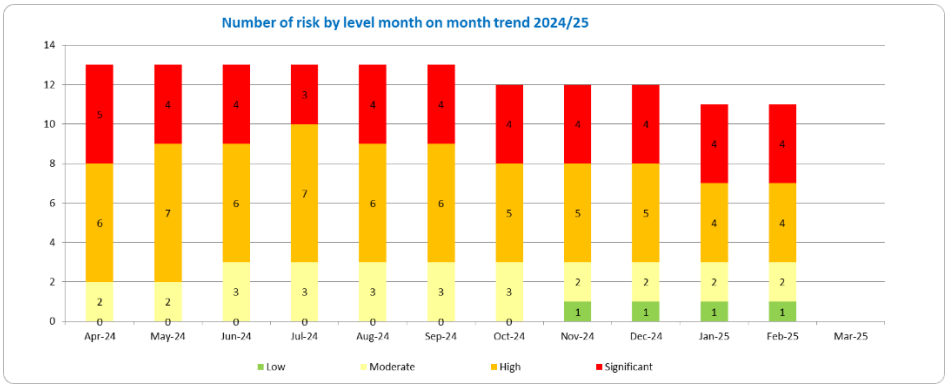
NHS Oxleas NHS Foundation Trust

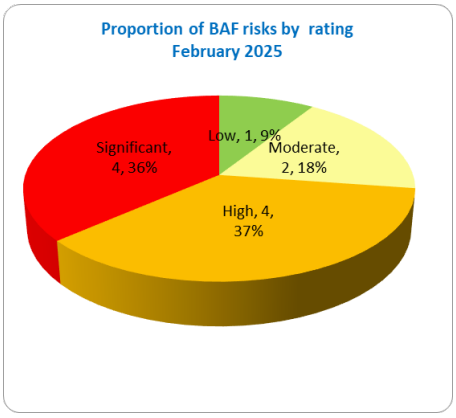
Board of Directors
6 March 2025

Item 5
Enclosure 4

Subject	Board Assurance Framework
Author	Susan Owen, Head of Risk and Governance
Accountable Director	Ify Okocha, Chief Executive
Confidentiality/ FOI status	Risks on the Board Assurance Framework are disclosable under FOI

What is the purpose of bringing this report to the board?	For the Board of Directors to note the current position with the Board Assurance Framework.
Are there any issues in the report that might cause upset?	No such issues.
Link to trust strategy and integrated care system priorities	The Board Assurance Framework includes risks relating to three priorties and all nine core commitments. Maintaining oversight of these risks will help to ensure that the trust is able to deliver the strategy. The risks relating to finance and recruitment pressures also relate to system priorities.
Glossary of terms/acronyms used in the report	BAF – Board Assurance Framework CIP – Cost Improvement Programme ICB – Integrated Care Board ICS - Integrated Care System MTFS - medium term financial strategy PFI – Private Finance Initiative SEL – South East London SIEM - security information and event management

Executive Summary	The Board of Directors receives a full report on Board Assurance Framework (BAF) risks twice a year. As of February 2025, there are 11 risks on the Board Assurance Framework (BAF). 



Business and Infrastructure Committee

1177: Financial sustainability of the Trust in the medium/long term (significant - 16)
The NHS is entering a three year period of extremely challenging revenue and capital finances. This is going to make the medium term financial planning, more difficult than was previously calculated. We would expect, more challenging CIPs targets due to constrained funding envelopes and due to the SEL ICS position (financially and operationally). We expect to have reduced capital funding.
Our latest assessment of the recurrent gap between income and expenditure is circa £36.4m (7% efficiency). The SEL capital allocation has been reduced from £241m to £191m (£50m reduction).

2024/25 revenue and capital plan delivery (low – 4)
We remain on track to deliver the plan. We have agreed with the Board and ICB to stretch our surplus to £2.5m, £1.5m improvement, in order to contribute to the the delviery of the SEL ICS control total. This was required in order to offset adverse movements in other trusts and has been achieved through non-recurrent measures

2006: ICS capital regime (moderate – 8)
We have, to date, successfully negotiated a capital envelope with the ICB that was sufficient to meet our capital needs. This had been a concern when we moved to the new methodology for capital funding 3 years ago. However the overall operating capital envelope for SEL ICS has reduced by £50m for 2025/26 and therefore negotiating sufficient funds for the trust will become more difficult and as a result the Business and Infrastructure Commitee agreed to keep this risk as moderate as the environment will be more challanging in future years.

2413: Bexley Private Finance Initiative (PFI) Expiry (significant – 16)
The Trust will be entering into a 'Standstill Deed' with Project Co/Semperian. This will enable 'Centre of Best Practice' fire safety and asset condition surveys to take place (via a joint appointment), linked to a relief period of 14 months to

enable remediation works. The surveys will provide assurance on the condition of the buildings.
The Trust continues to engage with Project Co/Semperian regarding the Standstill Deed with a small number of clauses within the drafting left to finalise. The delay in signing the standstill deed is causing increased time constraints on the remaining expiry process which is being monitored closely.

1994: Cyber security - strategic risk (significant – 16)
We are looking to invest in a security information and event management (SIEM) solution for the next 12 to 18 months as a trial, to give us full visiablity of our infrastructure. Longer term, we may be able to invest as an ICS. We are also looking to implement segragation between the server environment and staff device networks and limit who can gain access to them, with an aim to implement by December 2025.

1995: Achieving Carbon Zero (high – 12)
The Business and Infrastructure Committee continues to receive updates outlining progress in key areas. A net zero operational group has been established to facilitate whole trust engagement and oversight and a number of projects are being progressed. Projects requiring substantial capital are being worked up to enable bids for grant funding to be submitted .

Quality Committee

2378: Bed management – quality and financial impact (significant – 16)
In line with the trajectory agreed with ICB, the block beds of 30 between Oxleas and SLAM reduced by to 24 (Oxleas 18 and SLAM 6) end of October. Currently, the trust is using slightly more than 27 block beds and has had high usage of male and female PICU beds with occasional spot purchase of working age adult beds.

The Business and Infrastructure Risk asked for an update on this risk to be brought to the March 2025 meeting. This will be reported to the Board of Directors in May 2025.

2177: South West Prisons service quality (high – 12)
The Quality Committee agreed that this risk should be re-framed to reflect how the trust responds to external factors such as the prison environment, the prison regime and other initiatives such as the early release of prisoners under standard determinate sentence schemes, operation safeguard, an increase in urgent notifications from HMIP and the impact of these factors on the ability of healthcare to deliver a quality service.

It is proposed that the risk in its current format should be closed, and the potential new risk discussed at the Quality Committee.

People Commmitee

1213: Vacancies and staffing pressures (high – 12)
An extensive programme of activity is in place to boost Oxleas' reputation as an employer of choice, and to mitigate the risks related to recruitment and retention. This activity has delivered results in terms of reduced turnover (now at 16%) and reduced vacancy levels (now at 11%), that compare favourably with peer trusts. Nevertheless, pockets of significant staffing challenges remain. These are raised as risks in a number of directorate operational review discussions and impact on the great and timely care that we want to provide.

The text has been adjusted to bring out more clearly the risk of vacancies to continuity of care, in response to the points raised by the Shadow Service User and Carer Committee.

The People Committee agreed that the target date for reducing this risk to a moderate (9) risk should be towards the end of the current Oxleas strategy, ie April 2027.

2307: Staff experiencing violence, aggression or abuse at work (high – 12)
This risk has been substantially updated in light of discussions with the Shadow Service User and Carer Committee. The People Committee agreed that the target date for reducing this risk to a moderate (9) risk should be towards the end of the current Oxleas strategy, ie April 2027.

1471: Discrimination at work, based on protected characteristics (moderate – 9)
This remains a moderate risk. The established Building a Fairer Oxleas (BAFO) programme aims to create an inclusive culture focused on dismantling inequity. The programme has delivered improvements in representation at senior levels and improvements in perceptions of fairness and equality in our Staff Survey, but there is still significant scope for improvement. The Committee agreed that the target date for reducing this risk to a moderate (6) risk should be towards the end of the current Oxleas strategy, ie April 2027.

Risks removed since last board meeting

2472: Harm to triangle of care due to poor communication (high – 12)
The Quality Committee agreed that this does not need to be a BAF risk. Updates will be reported to the Quality Committee through the Great Care work, and the risk will be removed from the BAF listing.

Action required
The Board of Directors is asked to note progress.

Analysis	
What risks/issues in the report need to be noted or acted upon?	The report summarises the risks currently held on the Board Assurance Framework.
Quality implications	The Board Assurance Framework includes risks relating to quality.
Financial impact	The Board Assurance Framework includes risks relating to financial sustainability.
Equality analysis	The Board Assurance Framework includes risks relating to workforce issues some of which are mitigated through Building a Fairer Oxleas (BAFO).
Net zero impact	The Board Assurance Framework includes a risk relating to achieving net zero.
Impact on service users, carers and families	The Board Assurance Framework includes risks relating to patient safety, patient experience and outcomes.
Partner organisation	Partnership working is a theme across all risks on the Board Assurance Framework.
Staf	The Board Assurance Framework includes risks relating recruitment and retention, and staff well-being and morale.
Additional information	A full version of the Board Assurance Framework is available on request.

Board Assurance Framework 2024/25: contents 26 February 2025

Title	Overview	Frequency
List of risks	This report lists all the risks on the Board Assurance Framework as at the date of the report, including the board-subcommittee that owns the risk, and the risk rating	Monthly
Link to strategy	Sets out how the risks relate to the trust strategy	By exception if there are significant changes
Service risks	Sets out how the BAF risks link to service directorate risks	Monthly
Rating overview	This report provides a high level overview of the number and level of all the risks on the Board Assurance Framework on a month by month basis	Monthly
Rating by risk	This report provides a trend analysis of the month on month change in rating for each risk on the Board Assurance Framework.	Monthly
Actions	This repots show the status of the actions against each risk	Monthly
Longevity of risk	This report shows the length of time each risk has remained on the risk register	Monthly
Risks de-escalated in year	This report lists risks de-escalated from the Board Assurance Framework in year	Monthly
Risks by committee	This report provides an overview of the number and level of risks by board sub-committee	By exception if there are significant changes
Current rating versus target rating	This report provides an analysis of the current rating of each risk, set against the initial rating and the target rating, so as to give an indication of how close the trust is to reaching the target level. This data is presented based in on the position as at the end of each quarter	Quarterly

Board Assurance Framework 2024/25 - list of risks as of: 26 February 2025

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ID	Summary risk description	Executive Lead	Board sub-committee	Opened	Date added to BAF	Initial risk level when risk opened	Current risk score (as at date of report)				Target risk rating	Date target rating to be achieved	Linked service risks?
							Consequence	Likelihood	Rating	Level			
1213	Vacancies and staffing pressures	Rachel C Evans	People Committee	02/01/2021	01/06/2021	High	4	3	12	High	Moderate (9)	31/03/2027	Yes
1471	Discrimination at work, based on protected characteristics	Rachel C Evans	People Committee	17/05/2023	17/05/2023	High	3	3	9	Moderate	Moderate (6)	31/03/2027	No
2301	Staff experiencing violence, aggression or abuse at work	Rachel C Evans	People Committee	17/05/2023	17/05/2023	High	3	4	12	High	Moderate (9)	31/03/2027	Yes
2488	2024/25 revenue and capital plan delivery	Azara Mukhtar	Business and Infrastructure Committee	21/05/2024	21/05/2024	Moderate	2	2	4	Low	Low (4)	31/05/2025	No
1177	Financial sustainability of the Trust in the medium/long term	Azara Mukhtar	Business and Infrastructure Committee	01/04/2021	01/04/2021	Significant	4	4	16	Significant	Moderate (8)	31/03/2028	Yes
2006	ICS capital regime	Azara Mukhtar	Business and Infrastructure Committee	14/10/2021	14/10/2021	Significant	4	2	8	Moderate	Low (4)	31/03/2025	No
2378	Bed management – quality and financial impact	Iain Dimond	Quality Committee (BIC)	19/09/2023	19/09/2023	Significant	4	4	16	Significant	Moderate (9)	31/03/2025	Yes
1994	Cyber security strategic risk	Alison Furzer	Business and Infrastructure Committee	13/08/2021	17/08/2021	High	5	3	15	Significant	Moderate (8)	30/03/2025	No
1995	Achieving Carbon Zero	Rachel T Evans	Business and Infrastructure Committee	17/08/2021	17/08/2021	High	4	3	12	High	Low (4)	31/03/2030	No
2413	Bexley Private Finance Initiative (PFI) Expiry	Azara Mukhtar Rachel T Evans	Business and Infrastructure Committee	21/11/2023	05/12/2023	Significant	4	4	16	Significant	High (12)	31/12/2026	No
2177	Southwest prisons service quality	Iain Dimond	Quality Committee	19/01/2023	15/11/2023	Significant	3	4	12	High	Moderate (8)	31/03/2025	Yes

The five risks that have links to service directorates are mapped on page 4 and 5 of this report

Commentary

2177: Southwest prisons service quality

The Quality Committee agreed that this risk should be re-framed to reflect how the trust responds to external HMPPS factors such as the prison environment, the prison regime and other initiatives such as early release of prisoners under standard determinate sentence schemes, operation safeguard , increase in urgent notifications from HMIP and the impact of this factors on the ability of healthcare to deliver a quality service. The risk in its current format will be closed and a new risk agreed through the Quality Committee.

Board Assurance Framework 2024/25 - link to trust strategy

26 February 2025

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Risk title	Strategic priorities			Core commitments								
	1: Great care	2: Timely care	3: Best place to work	1: Equity for all	2: Strong patient and carer voice and involvement	3: Force for good in local communities	4: Cultivating Continuous Improvement	5: A thriving safety, listening and learning culture	6: Partnerships	7: Innovation	8: Embedding sustainability into the culture of Oxleas	9: Living within our means and maximising productivity
1177: Financial sustainability of the Trust in the medium/long term	X	X			X			X	X			X
1213: Vacancies and recruitment pressures			X			X			X			X
1471: Discrimination at work, based on protected characteristics			X			X			X			
2301: Staff experiencing violence, aggression or abuse at work			X	X				X	X			
2488: 2024/25 revenue and capital plan delivery									X			
2378: Bed management – quality and financial impact	X	X			X		X		X	X		X
1994: Cyber security strategic risk									X	X		
1995: Achieving carbon zero									X		X	
2006: ICS capital regime									X			
2177: Southwest prisons service quality Southwest prisons service quality	X	X	X	X			X	X	X	X		
2413: Bexley Private Finance Initiative (PFI) Expiry									X			
2472: Harm to triangle of care due to poor communication	X	X		X	X	X	X	X	X	X		

Board Assurance Framework 2024/25 - link to service directorate risks

26 February 2025

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BAF level risk	1177: Financial sustainability of the Trust in the medium/long term	2378: Bed management – quality and financial impact	1213: Vacancies and recruitment pressures	2301: Staff experiencing violence, aggression or abuse at work	2177: Southwest prisons service quality
Acute and Crisis Services	2475: Financial stability of the directorate 2425: Risk to financial stability, and risks to the safety of service users and staff due to the funding and environment at QEH MHAA	2475: Financial stability of the directorate		2425: Risk to financial stability, and risks to the safety of service users and staff due to the funding and environment at QEH MHAA 2152: Assaults on staff contributing to work placed stress	
Adult Community Mental Health Services	2285: Financial stability		1980: Clinical vacancies 1992: Greenwich AMHP vacancies 2468: CMHT staff retention 2399: CMHT staff retention	1544: Lone working safe systems of work	
Adult Community Physical Health Services	1569: Delivering CIPs		1576: Recruitment of permanent staff 1951: Difficulty recruiting suitably qualified temporary staffing to cover vacancies		
Adult Learning Disability (ALD) Services	None of the ALD risks link to the BAF				

Board Assurance Framework 2024/25 - link to service directorate risks

26 February 2025

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BAF level risk	1177: Financial sustainability of the Trust in the medium/long term	2378: Bed management – quality and financial impact	1213: Vacancies and recruitment pressures	2301: Staff experiencing violence, aggression or abuse at work	2177: Southwest prisons service quality
Children and Young People			**2496:** Audiology short staffing **2452:** CAMHS DBT Service - reduction in capacity due to vacancies and long term sickness **2556:** Reduction in staffing in Greenwich SLT Dysphagia Service		
Forensic and Offender Healthcare Services	**2345:** Cost pressures - south west prisons		**2239:** Recruitment and retention of staff in south west prisons **1183:** Vacancies across the directorate, particularly nursing		**A separate SW region risk register is maintained and sites also maintain team specific risk registers**

Board Assurance Framework 2024/25: month on month risk rating

26 February 2025

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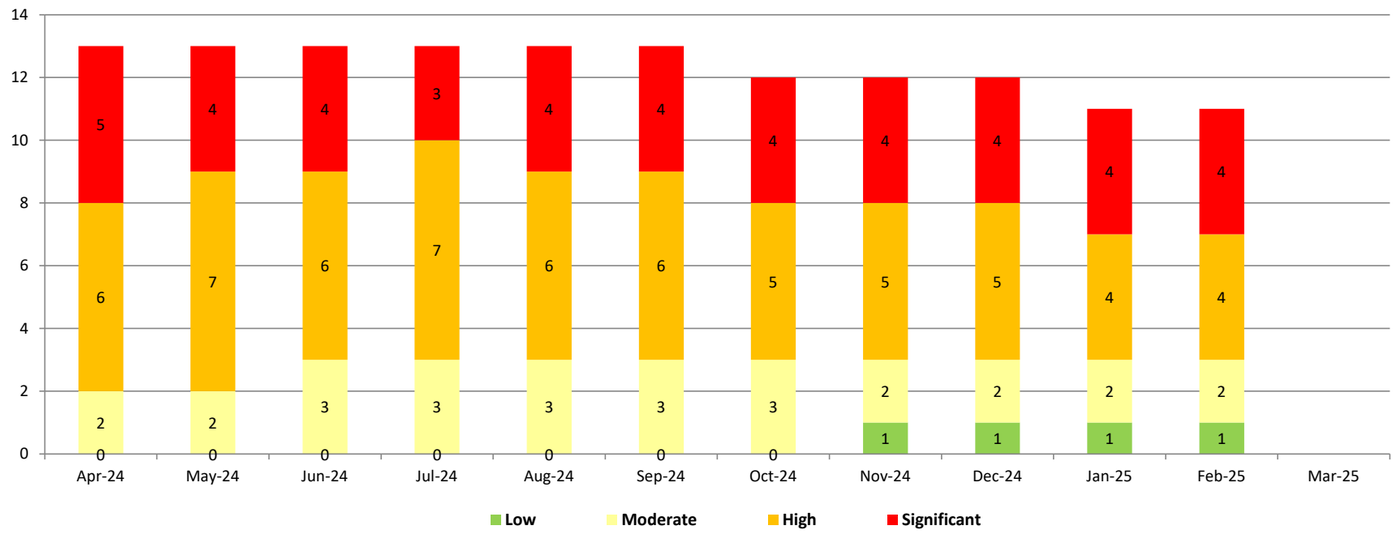
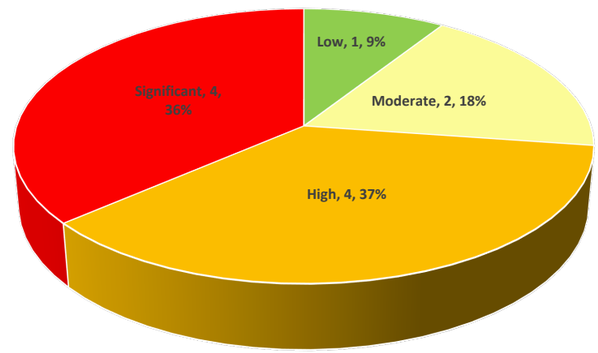
Risk level	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Low	0	0	0	0	0	0	0	1	1	1	1	
Moderate	2	2	3	3	3	3	3	2	2	2	2	
High	6	7	6	7	6	6	5	5	5	4	4	
Significant	5	4	4	3	4	4	4	4	4	4	4	
Total	**13**	**13**	**13**	**13**	**13**	**13**	**12**	**12**	**12**	**11**	**11**	**0**

Number of risk by level month on month trend 2024/25



Board Assurance Committee Risk profile February 2025



New risks added 2024/25

May 2024

2488 - 2024/25 revenue and capital plan delivery: New in-year risk opened to replace risk ID 2303. Agreed in June 2024 that the rating is moderate (9).

July 2024

2472 - Harm to triangle of care due to poor communication: Risk co-designed by the Service User and Carer Shadow Committee. Quality Committee agreed to escalate risk to the BAF.

Changes to risk ratings 2024/25

April 2024

2177 - South West prisons service quality: Sufficient progress has been made to reduce the risk to high (12). Some further actions are due by end May 2024.

August 2024

1994 - Cyber security strategic risk: Likelihood increased from 2 to 3, and given the current environment, the likelihood of the trust being affected by a cyber attack has increased.

November 2024

2488 - 2024/25 revenue and capital plan delivery: Reduced from a moderate to a low risk as it is unlikely that the ICS would ask us for further stretch. This is particularly so, as we have already given up of the £1.2m other non-NHS pay-award income uplift and the associated industrial action funding of £28k.

Risks removed 2024/25

May 2024

2303- 2023/24 revenue and capital plan delivery: Closed and replaced with 2024/25 in year risk ID 2488

June 2024

2159 - Impact of service expansion: Agreed by People Committee in May 2024 to treat as a managed risk.

July 2024

1912: Pressure on district nursing teams: Agreed at Quality Committee that this risk can be de-escalated from the BAF.

October 2024

2424 - Doctors industrial action: Agreed at People Committee September 2024 that the risk could be closed as junior doctors have accepted the pay offer.

January 2025

2472 - Harm to triangle of care due to poor communication: Revised wording for this risk was agreed at the Quality Committee, and also that this does not need to be a BAF risk. Updates will be reported to the Quality Committee through the Great Care work.

Board Assurance Framework: month on month ratings by risk 2023/24

26 February 2025

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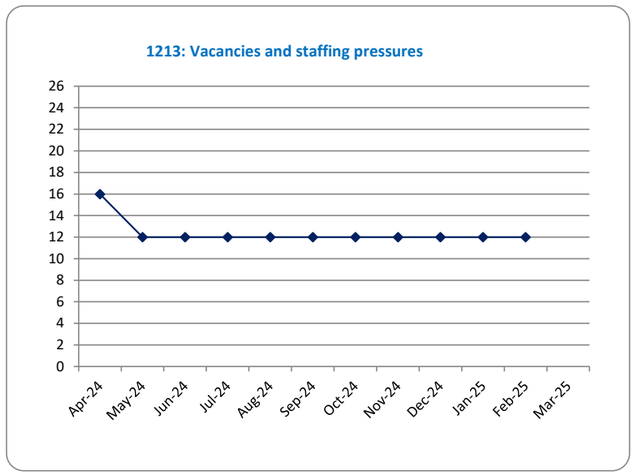
Summary risk description	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
1213: Vacancies and staffing pressures	16	12	12	12	12	12	12	12	12	12	12	
1471: Discrimination at work, based on protected characteristics	9	9	9	9	9	9	9	9	9	9	9	
2301: Staff experiencing violence, aggression or abuse at work	12	12	12	12	12	12	12	12	12	12	12	
2488: 2024/25 revenue and capital plan delivery			9	9	9	9	9	4	4	4	4	
1177: Financial sustainability of the Trust in the medium/long term	16	16	16	16	16	16	16	16	16	16	16	
2006: ICS capital regime	8	8	8	8	8	8	8	8	8	8	8	
2378: Bed management – quality and financial impact	16	16	16	16	16	16	16	16	16	16	16	
1994: Cyber security strategic risk	10	10	10	10	15	15	15	15	15	15	15	
1995: Achieving carbon zero	12	12	12	12	12	12	12	12	12	12	12	
2413: Bexley Private Finance Initiative (PFI) Expiry	16	16	16	16	16	16	16	16	16	16	16	
2177: Southwest prisons service quality	12	12	12	12	12	12	12	12	12	12	12	

Target risk rating	Date target rating to be achieved
Moderate (9)	31/03/2027
Moderate (6)	31/03/2027
Moderate (9)	31/03/2027
Low (4)	31/05/2025
Moderate (8)	31/03/2028
Low (4)	31/03/2025
Moderate (9)	31/03/2025
Moderate (8)	30/03/2025
Low (4)	31/03/2030
High (12)	31/12/2026
Moderate (8)	31/03/2025



Full risk description

There is a risk that the trust cannot recruit and retain optimum levels of substantive staff. Sub-optimal staffing levels negatively impact the quality of care, the continuity of care, the patient and carer experience, and the patient outcomes.

C=4	L=3	12	High

Commentary

November 2024: Risk update to include feedback from the Service User and Carer Shadow Committee
May 2024: The People Committee agreed to reduce this risk from significant (16) to high (12).

Controls

Long term initiatives
1. Raising Oxleas' profile as a great place to work through high staff survey results, national awards and more. New joiners often report that this is a key factor in them choosing to join us.

2. Taking a proactive and innovative approach to recruitment, including rolling recruitment, job fairs, Geofencing (an innovative targeted online advertising approach) and more. These approaches are having a positive effect.

3. Exploring creative solutions to address recruitment challenges, including use of Lived Experience Practitioners (LXPs), alternative roles etc. Agency panels consider alternatives where recruitment to particular roles is proving challenging.

4. Identifying and implementing new pipelines - e.g., graduate scheme, apprenticeships. Intensified focus on workforce planning.

5. Intensifying focus on retaining existing staff. People Promise manager role focusing on induction, flexible working and career development. Informed by Leavers Surveys and other data. Staff Assemblies. Building a Fairer Oxleas.

Recent innovations include:
- Smashing It! series for career development
- Geofencing for recruitment
- Recruitment films for District Nursing and CYP
- Regular focus on Workforce Planning at Executive meetings
- Improved approach to induction and flexible working
- Innovative work on raising issues around racism

Assurances

Vacancy rate monitoring - rates compare favourably with neighbouring mental health and community trusts.

We monitor the time we take to recruit. We generally do this more quickly than our peer NHS organisations , other than for prison recruitment. This is because of the additional time take to recruit to Offender Healthcare roles.

We have undertaken a detailed workforce planning review to understand our trends and likely gaps. These inform our Directorate plans.

Mitigation action	By when
We seek to provide continuity of care through up-to-date care records and by managing known transitions to new clinicians with additional support and handovers. This is more difficult when staff move on suddenly, temporary cover ends or through sickness. This reinforces the need for teamwork, planning and knowing patients on the caseload. We recognise the perceived loss when a therapeutic relationship comes to an end and how notice periods can be used to help the service user come to term with the change and provide time to reflect on the positive elements that can inform the new therapeutic relationship. Explore opportunities for pathway redesign and digital opportunities through the period of the Oxleas strategy 2024 - 2027, to ensure that our resources are used to best effect.	On-going

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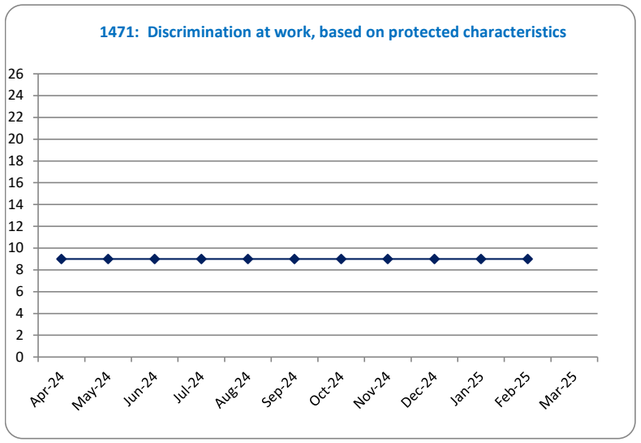

Full risk description
Staff may experience discrimination at work, based on their protected characteristics. This may impact on sickness absence, morale and retention.

C=3	**C=3**	**9**	**Moderate**

Commentary

April 2024: The 2023 Staff Survey shows a significant improvement to the question 'Have you personally experienced discrimination from a manager or colleague?' but this remains significantly below the sector.

Of the 9% who stated that they had experienced discrimination, this was predominantly on grounds of ethnicity (56%), with gender (20%) and age (16%).

A significant programme of work (Building a Fairer Oxleas) is already in place to address this and this grows year by year. A significant number of teams are now engaged in the 'BAFO 5 Step Challenge'.

Controls

An extensive and ambitious programme of work to 'Build a Fairer Oxleas', which grows each year. The focus was initially on (a) improving the fairness of our promotion and recruitment processes, (b) improving cultural understanding and competence. At the start, the focus was on race and it has now expanded to cover all protected characteristics. The work is supported by a detailed action plan overseen by the Building a Fairer Oxleas Assurance Group attended by NEDs, EDs and others, and by People Committee.

There have been improvements in representation at senior levels (increase of more than 30%) and we achieved parity in shortlisting.

Continued focus on reducing incidents of abuse, including racist and homophobic and other types of abuse, from service users, patients and members of the public. Specific leads for each Directorate and a dedicated sub-Committee.

Values and behaviours framework provide clarity on the behaviours that are expected from our staff in all Oxleas settings.

We are asking all teams to undertake the BAFO 5 Step Challenge so that everyone is involved in discussions around diversity and inclusion. Progress across Directorates is monitored at Executive level and is currently at over 60%.

Innovation
- Co-designed prototype for raising issues about racism
- Smashing It! programme launching in December
- Specific work programmes for Forensics around cultural understanding

Assurances

WRES and WDES data
BAFO Challenge completion rates
Qualitative feedback from staff through hosted BAME wellbeing sessions, network engagement, Building a Fairer Oxleas volunteers etc.
Datix reports
Reports to the Violence and Abuse Sub-Group
National Staff Survey results
Reports to the Equality and Human Rights Group
Staff Friends and Family Test

Mitigation action	By when
A package of measures has been designed to 'Build a Fairer Oxleas' and the current focus is on the BAFO 5 Step Challenge to ensure maximum coverage across teams and directorates. Continued focus on reducing incidents of abuse from service users, patients and members of the public. We are part of the Mayor of London Design Lab approach which brings together organisations who are leaders on creating inclusive cultures to share best practice and implement best-practice design approaches. We are taking forward two significant programmes of work - (1) around storytelling, and (2) a new comprehensive 'Smashing It!' Career Development programme.	On-going

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Full risk description
2301: Staff may experience violence, aggression or abuse from service users, carers or the public, leading to poor mental and physical health, trauma, low resilience, low productivity and potentially increased turnover.

C=3	C=4	12	High

Commentary

November 2024: Risk update to include feedback from the Service User and Carer Shadow Committee
April 2024: The 2023 Staff Survey has shown a significant improvement in staff experiencing physical violence from patients and this is significantly better than the sector.

The survey also shows that staff experiencing discrimination from patients has significantly improved, but this remains worse than comparator trusts. This will continue to be monitored at the Violence and Abuse sub-Committee.

Despite the staff survey improvements, we know from qualitative discussions with staff, particularly in in-patient settings, that this continues to have a substantial impact on their experience at work.

The People Committee will review this at the next meeting, but it is proposed that the current rating remains.

Controls

Oxleas takes seriously the impact of violence, aggression and verbal abuse on our staff. We have a dedicated sub-committee of the People Committee, chaired by the Chief Nursing Officer, to monitor improvements and share best practice. This includes attendance the V&A leads from all directorates.

Our strategic approach reducing violence, aggression and abuse is to focus on 4 key elements - Prevention, Prediction, People and Prosecution and Restorative Justice. We call this approach the '4Ps'.

We have put in place 'Violence and Abuse leads' for each Directorate. They are responsible for implementing the 4Ps on a local basis, drive improvement and ensure that the right support is made available to affected staff. They review all incidents of V&A, actions taken, and staff support with their directorate management teams.

A key part of our approach is to reduce the risk of aggression by taking a 'Relational Security' and 'Trauma-informed' approach to our care. This helps to ensure that our patients feel heard, understood and valued.

We work with the shared learning collaborative CSG 'London Safety and Equality in Mental Health Settings' to strengthen safety culture and strengthen staff skills, confidence, and resilience. The programme has successfully engaged with a wide range of mental health staff and lived experience colleagues. The embedding of Relational Security: See Think Act is central to this and has been embedded across the wards. It supports reduction in V&A and reduces restrictive practice.

We encourage and support staff to take action with the police where this is appropriate. We have been working closely with the police across our boroughs to implement Operation Cavell - a programme to ensure that violence against NHS staff is taken seriously.

We have PeopleSafe devices to support people who are lone-working.

We have an established flowchart of staff support following incidents of V&A. Staff support also include access to restorative clinical supervision by professional nurse advocates and Schwartz rounds focused on experiences of V&A enable a space to discuss emotional issues they face caring for patients.

We have embedded Safe Wards which includes establishing clear mutual expectations upon admission.

Essential to role training is provided to all staff:
- Prevention and Management of Violence and Aggression (PMVA): Clinical staff in mental health / learning disability services who would be expected to engage in physical intervention (restraint) as part of the normal routine - 2 yearly
- Breakaway: Clinical staff in Mental Health and Learning Disability services who would not be expected to engage in physical intervention (restraint) and all (other) staff who have face-to-face contact with service users in Prison, Mental Health and Learning Disability services - 2 yearly
- Conflict Resolution: All other staff in lower risk roles (i.e. those not required to complete Breakaway or PMVA training) – 3 yearly

Assurances

Review of V&A data as part of Health and Safety surveys.
Staff Survey data.
Qualitative feedback from Directorate leads.
V&A audits.

Mitigation action	By when
Building on the excellent work in some areas of the Trust, we will be increasing our organisational focus on becoming a 'Trauma-informed' care provider. Controls set out the extensive mitigation work already embedded in the trust. In 2024 we joined the Royal College of Psychiatrist Culture of Care Programme to improve the culture of inpatient mental health wards for patients and staff so that they are safe, therapeutic, and equitable places to be cared for, and fulfilling places to work. The approach is trauma informed, autism -informed and based on anti-racism and has a personalised approach to risk. It is co-led by people with lived experience, underpinned by our commitment to lived experience leadership, coproduction, and collaboration	On-goimg

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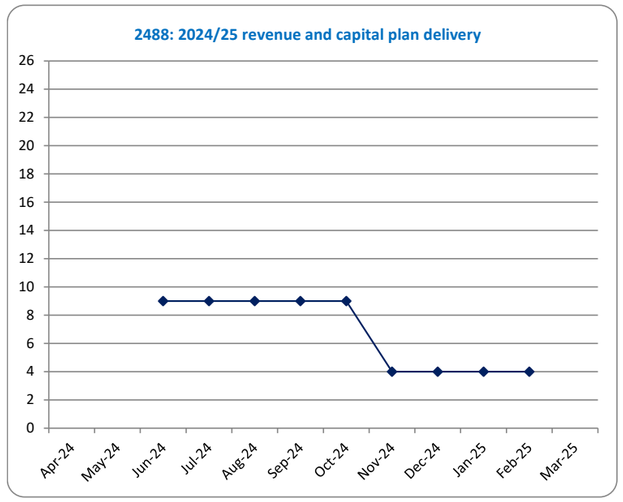

Full risk description
2488: The Trust has planned for a breakeven revenue plan for 2024/25 and a capital plan of £9.04m, with £3m for QMH and £6m for QMH CDC. There are delivery risks:- -CIPs, through recurrent and non-recurrent measures; -agency and bank spend remaining within plan; -our ability to meet our trajectory on beds – adult MH beds; -and the Trust having slippage of MHIS and SDF in excess of the £9m built into the CIP plan delivery; over-commitment on capital. The risk pertains to the potential challenges and uncertainties associated with the delivery of the revenue and capital plans for the fiscal year 2024/25. Despite careful planning and forecasting, various internal and external factors could impact the trust's ability to achieve revenue targets and execute capital projects as scheduled. Factors such as excess inflation, shifts in patient volumes, recruitment, demand for beds, supply chain disruptions, regulatory changes, and unexpected economic conditions could influence capital and revenue expenditure outcomes.

C=2	L=2	4	Low

Commentary
February 2025: We are still on track to deliver the plan. There are additional conversation between the ICB and the providers on the potential additional support that each provider can make to the SEL overall position. The Committee and Board has agreed to improve the overall FOT to £3.03m (increase of £2m). At a SEL CFO meeting held recently the required improvement was set at £1.5m. November 2024: The underlying deficit is £23.9m. Recurrent savings are needed to address this challenge. The trust will continue to use non-recurrent flexibility to meet the CIPs gap for the rest of the financial year. This gap will be rolled over into next year and will add to any gap in next year. There are four key revenue risks: consistent and high levels of private beds (we are not using significant private beds outside of block contracts); agency spend that exceeds our plan (we are exceeding our 10% reduction in agency) ; cost pressures arising from SW England prisons (we currently living within budgets), identification and delivery of recurrent CIP plans (we have identified £1.7m of the £23.9m and are yet to fully identify recurrent CIPs). The trust is on track for delivering its capital plan.

Controls
The SEL ICS CFO formal monthly financial review meetings to review both capital and revenue with all NHS organisations. The Trust will keep tight control on both the in-month and forecast revenue and capital positions. Monthly meetings in place between Finance, IT and Estates to review capital spend and forecast to ensure full utilisation of envelope. Regular meetings with ICS finance where national updates are reviewed. Financial sustainability group attended by Trust CEO and CFO. CIPs will be a rolling item for all the directorates monthly finance meetings, in addition there is a quarterly strategic directorate review meeting with the CFO.

Assurances
The Formal Executive, Business & Infrastructure Committee (BIC) and Board will be updated on progress Reports to BIC Monthly/quarterly finance meeting with service and corporate directorates Monthly ICS Finance update report provided to the Formal Executive and BIC, one month in arrears`

Mitigation action	Date
Finance has tight controls over agreed budgets and non-recurrent funds to mitigate any unforeseen costs and costs pressures in future months The trust and ICB would have to abide by the requirement within the national planning guidance and the long term plan.	31/03/2025

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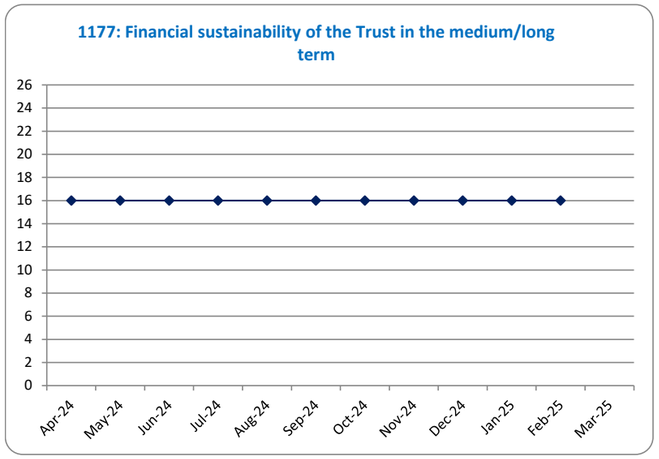

Full risk description
1177: There is a risk to the financial sustainability of the Trust if required recurrent costs are not met with recurrent income. This requires increased contribution or CIPs (Cost Improvement Programmes) to be delivered on a recurrent basis as non-recurrent mitigations cannot be relied upon year on year. Any CIPs would require an assessment of their impact on service users, carers, staff and quality of service prior to implementation.

C= 4	L=4	16	Significant

Commentary

February 2025: The NHS is entering a 3 year period of extremely challenging revenue and capital finances. This is going to make the medium term financial planning, more difficult than was previously calculated. We would expect, more challenging CIPs targets due to constrained funding envelopes and due to the SEL ICS position (financially and operationally). We expect to have reduced capitla funding.
Our latest assessment of the recurrent gap between income and expenditure would is circa £41m (8% efficiency). The SEL capital allocation has been reduced from £241m to £191m (£50m reduction).
November 2024: The CIP target is £23.9m; of which we have identified £1.7m worth of recurrent CIPs with the remaining balance being delivered non-recurrently. We are continuing to pursue further recurrent CIP delivery as the current position would result in roll-over CIP of £22.2m.

There is a significant risk to the financial sustainability of the ICS if required recurrent costs are not met with recurrent income. To address this challenge, the ICS must deliver Cost Improvement Programmes (CIPs) on a recurrent basis, as non-recurrent mitigations cannot be relied upon year after year. The control total of £100m deficit may not be achievable in the current year. Failure of other ICS members to meet their target will require further stretch targets to mitigate adverse variances. The Trust may have to further stretch both its in-year and medium term financial plan to help mitigate more challenging ICS financial deficit (revenue and capital).
At he end of M7, the trust is on track with meeting its planned surplus
May 2024: The rollover CIP gap into 2024/25 is £13.6m. Persistent budget deficits have resulted in the trust running a recurrent £24m planning deficit. If this is not addressed sufficiently, it could lead eventually to financial strain and potential liquidity problems
February 2024: Reflected feedback from service users/carers. Started planning for 2024/25.

Controls
The 2024/25 plan is a breakeven with £24m mitigated savings target. As at month 1 we have identified £12.6?m (recurrent and non-recurrent) worth of schemes and the remaining gap is covered using non-recurrent mitigations. CIPs are rolling item for all the directorates monthly finance meetings. Directorates will be invited to the monthly Financial and Planning meeting to be monitored and held to account for CIP development and delivery We will aim to include 13% contribution to existing overheads. There have been no new bids in 2024/25 and we were not able to topslice new monies in 2024/25 as the non recurrent and recurrent uplifts were utilised to mitigate recurring overspends

Assurances
Reports to Board, Business and Infrastructure Committee (BIC), Formal Executive and Finance and Planning meeting Monthly/quarterly finance meeting with service and corporate NHSE Risk Rating an indicator of financial risk

Mitigation action	Date
The work on developing the MTFS is on-going. This is expected to identify mitigations and opportunities that will be crucial in bridging the financial gap.	31/03/2028
Financial Planning and Forecasting: Develop comprehensive rolling financial plans and forecasts to anticipate potential revenue shortfalls, cost increases, and funding uncertainties, enabling proactive management of financial risks.	On-going
Cost savings: Implement cost-saving measures, efficiency improvements, and resource optimisation initiatives to streamline operations and minimise unnecessary expenditures while maintaining service quality and patient care standards. Roll out a compulsory 10% reduction on Corporate operating cost.	
SEL ICS Sustainability - The system has set up a sustainability meeting including ICB and NHS provider CEOs and CFOs together with representation of COO and Medical Directors (as well as Primary care reps) across the system. This group is focused on collective actions that SEL NHS organisations can takeover the medium term to address financial challenges. The group has already identified, a range of programmes, which are in the early stages of being fully worked up and starting to mobilise in the tatter half of 2025/26.	31/03/2025
There are on-going internal discussions regarding the approach we intend to adopt to address the significant gaps.	

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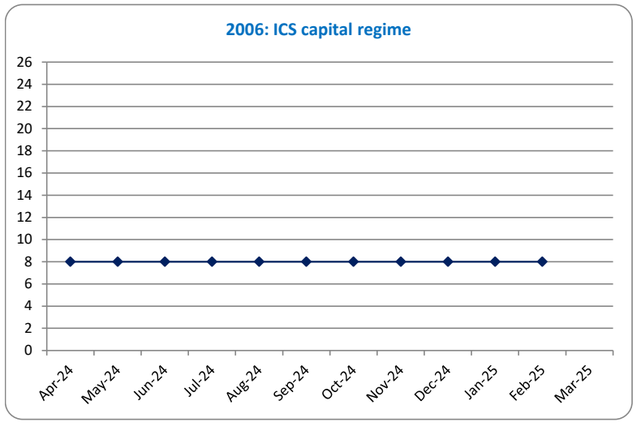

Full risk description
2006: The Integrated Care Systems (ICS) capital regime may limit the Trusts ability to invest in maintaining and improving its Estates and Digital infrastructure. This could prevent the level of investment required to ensure safe environments (for example: anti-ligature work, slips/falls prevention, and cyber security), maintain the quality of environment in an ageing estate, and maintain and improve the IT infrastructure, as required for modern service delivery. This could create unacceptable risks to patient safety, service efficiency and the creation of a safe, therapeutic environment that are welcoming and gives confidence to service users and carers. The restrictions on capital spend also has the potential to inhibit the planning of longer term capital investment needed to remodel and enable continuous improvement in service delivery. The NHSE finance regime now has a provision for reducing capital allocations if the ICS does not meet its finance and operational plan. This meant the 2024/25 trust allocation was reduced by £0.7m due to revenue and operational under-performance of other organisations. Potential consequence: 1) Scope reduction or compromise

C=4	L=2	8	Moderate

Commentary

February 2025: We have, to date, successfully negotiated a capital envelope with the ICB that was sufficient to meet our capital needs. This had been a concern when we moved to the new methodology for capital funding 3 years ago. However the overall operating capital envelope for SEL ICS has reduced by £50m for 2025/26 and therefore negotiating sufficient funds for the trust will become more difficult and as a result the Business and Infrastructure Commitee agreed to keep this risk as moderate as the environment will become more challanging.

November 2024: This risk will be re-visited once the planning guidance for 2025/26 is available.
To navigate the limitations of the current ICS capital regime and ensure the continuous improvement and maintenance of our infrastructure, the Trust must prioritize the establishment of robust long-term capital plans. These plans should ensure Strategic Vision and Future-proofing.
June 2024: To navigate the limitations of the current ICS capital regime and ensure the continuous improvement and maintenance of our infrastructure, the Trust must prioritize the establishment of robust long-term capital plans. These plans should ensure Strategic Vision and Future-proofing. 2024/25 planning has highlighted a further in-year risk factor being, the dependency of delivery of revenue and operational targets across the ICS on the operational capital allocation to the Trust. E.g. £0.7m reduction in Trust operational capital due to other organisations in the ICS not meeting their financial targets in 2023/24 and failure to meet the fair share national control total.

Controls

• A rolling 5-year capital programme has been developed to ensure the ICS are aware of our capital needs over this period.
• Asset surveys are underway or planned for all major building components across our estate.
• 6 monthly monitoring is undertaken of all sites to ensure quality standards are maintained to ensure positive patient and carer experience, and any safety issues addressed.
• Plan Preventative Maintenance (PPM) programme in place across the Trust.
• Plans to rationalise the estate portfolio to enable more targeted expenditure.
• Ligature audits are undertaken annually and both capital and operational management plans developed.
• A move to a rolling laptop estate and the introduction of IT personas for all staff to ensure a targeted provision of spend on the right equipment for all staff
• The Estates, IT and Finance teams are represented at all SEL ICS meetings relating to capital expenditure.
• Good relationships are in place with SEL ICS.
• Cash reserves are available within the Trust to fund projects and there is no requirement at present for central funding.
• Condition Surveys. Some specific surveys (roofs and windows) have been completed and other are on-going.
•2024/25 capital plans have been reassessed to meet the current capital allocations between estates an digital services. There has been some slippage to future years

SEL ICS CEOs and CFOs are meeting monthly to monitor the overall finance position and a sustainability group has been established to look at mitigations to ensure financial plans are met.

Assurances

• Estates and Facilities and IT Projects point management works are being identified, that can be taken forward should there be underspends
• Capital spend is reviewed on a regular basis at Formal Executive and Business & Infrastructure Committee (BIC).
• A focus on ligature management is maintained through the Ligature Management group, Acute Care Forum and Ward Managers meeting
• Regular reports are received from maintenance providers
• Monthly meetings are held with Service Directorates
• Discussions with staff assemblies and Staff partnership group to hear staff experience
• Patient and carer experience feedback is fed back to Estates and Facilities team via service teams and regular directorate Estates meetings.

Mitigation action	By when
Condition Surveys. Some specific surveys (roofs and windows) have been completed and others are on-going.	On-going
Rolling five-year capital plan for both Estate and ICT.	On-going
Audit the Mechanical and Electrical asset register to develop a programme of replacement	Complete
Trust wide Wi-fi survey to inform 5 year capital programme	Complete
Established robust monitoring and reporting mechanisms to track budget utilisation, identify variances, and promptly address any deviations from the planned expenditure.	On-going

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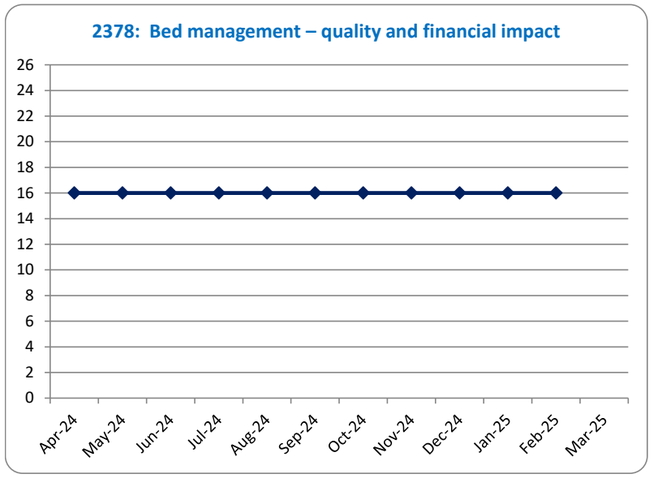

Full risk description
There is a risk to the quality of care that we provide to patients and to the financial stability of the trust should we continue to have more than five* people in the private beds. The impact of this includes: •Delays in accessing inpatient beds (HBPOS, AMHP, community, ED, from other trusts) •High number of private placements (cost, quality ,user experience issues, reputation and relationships) •Delay in returning people from PICU to acute beds •Impact on staff morale and staff wellbeing The objective is for Oxleas to sustain a bed capacity which eliminates use of private beds. •Adverse impact on service users being away from their support networks and localities. This is likely to impact on their access to wider Oxleas input and the ability for their support network to visit regularly. Inadequate bed management practices can lead to a range of issues, including patient safety concerns, operational inefficiencies, revenue loss, and reputational damage. Factors contributing to this risk include fluctuating patient demand, insufficient staffing levels, inefficient discharge processes, and sub-optimal utilisation of resources.

C= 4	L=4	16	Significant

Commentary

February 2025: In line with the trajectory agreed with ICB, the block beds of 30 between Oxleas and SLAM reduced by to 24 (Oxleas 18 and SLAM 6) end of October. Currently, the trust is using slightly more than 27 block beds available and has had high usage of male and female PICU beds with additional spot purchase of working age adult beds.

November 2024: In line with the trajectory agreed with ICB, the block beds of 30 between Oxleas and SLAM reduced by to 24 (Oxleas 18 and SLAM 6) end of October. Currently, the trust is using slightly more than 18 beds and has had high usage of male and female PICU beds with occasional spot purchase of working age adult beds.

May 2024: Investment to cover 30 non-recurrent beds and robust recovery plans. At M2 we maintained our private bed usage within our block beds purchased and the one spot purchase WAA bed in M1 ceased part way through the month. We saw reduced male PICU usage but increased female PICU usage.

Controls
A detailed recovery plan with trajectories has been developed with sets out the actions to mitigate this risk. Bed recovery plans - actual spend against planned funding. Acute MH Working Age Adult bed usage has been steadily growing above the available Oxleas bed base for some time, with a greater dependence on Private Bed capacity This has resulted in limited availability of beds each day, which in turn is having a significant impact on patients waiting for extended times for admission from ED, HBPoS, the community and acute Hospital wards. The trust is undertaking a programme with three key workstreams to try and address this demand: 1) Preadmission and Community based initiatives to prevent ED 2) Optimising use of beds - Flow within Mental Health Trusts 3) ED Front door - Improved partnership working , management and processes in ED The ICB invested a non-recurrent funding to cover for 30 beds in 2024/25. This, reduced to 24 at the end of October.

Assurances

Progress against the Recovery Plan is monitored at the Formal Executive meeting, Quality Committee and Business and Infrastructure Committee

Mitigation action	Date
The trust has set a target to achieve 95% bed occupancy by March 2025. A long-term recovery plan is in place, and we are using a QI approach to address cultural issues and ensure that all teams act in a coherent way	31/03/2025
Conduct regular assessments of bed capacity and patient demand to anticipate fluctuations and optimise resource allocation. Implement strategies to flexibly adjust bed availability based on patient needs and acuity levels.	31/05/2025

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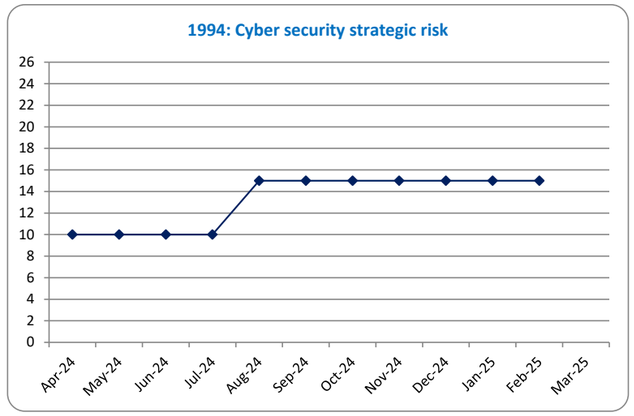

Full risk description

1994: Oxleas could be subjected to a cyber-attack resulting in Trust information (staff, patient, corporate etc.) falling into the hands of cyber criminals. The risk to the organisation falls into five broad categories which are covered by individual risks in our Trust risk register

1) Zero-day attack- a completely new cyber risk where no work around or patch exists to prevent the attack, and therefore we cannot mitigate against it;
2) insider threat from our own staff
3) specific identified vulnerabilities, where we know we have an issue, or a potential issue and we need to implement technology to close the vulnerability.
4) Human element - ie staff member unintentionally introducing a cyber threat due to not adhering to information governance (including errors) and ICT protocols
5) Supplier risk. Suppliers who hold Oxleas information on systems hosted externally to the Trust could be subject to a cyber security attack

C=5	L=3	15	Significant

February 2025: We are looking to invest in a SEIM solution for the next 12 - 18 months as a trial, to give us full visibility of what is happening on our infrastructure. Longer term this may be something that we invest in as an ICS
We are looking to implement segregation between the server environment and staff device networks and limit who can gain access to them. Aim to implement by December 2025.

April 2024: We will be writing to all information asset owners over the next month to ask them to complete their training and ensure that their system security policy is up to date.
We will be writing to all asset owners with systems hosted out on the Internet to ask them to get MFA enabled. The Head of ICT has contracted a third party to enable MFA on our Internet facing systems and we hope to have this in place later on this year.
We have also been asking if all new systems have or are looking to have MFA capability as part of the DPIA process.

Controls

•Zero day attack - Make sure our Antivirus and all available patches are up to date
•Insider threat - Restrictions on admin accounts related to job roles across the trust
•Specific vulnerabilities - Identified solutions for vulnerabilities implemented asap as requested by NHSD
•Human element - Continuous programme of advice and guidance communicated to staff
•Supplier risk - we ask for assurance as part of Data Privacy Impact Assessment (DPIA) for new systems and suppliers

Assurances

•We have systems that monitor our network that identify any potential known threats **which we will continue to invest in**
•Admin rights are regularly reviewed and scrutinized
•NHSD best practice guidance is followed in relation to specific vulnerabilities
• KPMG Cyber Security Audit (2022) and subsequent actions
•ICS commissioned EY CAF Report
•Annual KPMG DSPT audits and associated actions
•NHSE Bitsite monthly reports published to ICS and Trust
•NHSE MDE reports published each month. NHSE Care Cert notifications for server and desktop environment

Mitigation action	By when
All non-windows servers will be migrated on to the regular patching programme	Complete
Establish a routine of regular phishing tests (NHSD recommend every 6 months). One is planned for later this year.	Complete
To take forward the recommendations from the KPMG audit of cyber security February 2022: -Documented cyber security plan (by 30/04/2022) -Raising cyber awareness (by 31/07/2022) -Cyber security strategy (by 31/03/2022) -Policy review (by 31/03/2022) -Security principles documentation (by 31/05/2022) -Training needs analysis (30/04/2022) -Digital risk management (by 31/07/2022)	Complete
On-going: We will increase our investment and thinking into how we prevent, monitor and respond to cyber security threats, for example by purchasing technology, improving documentation and communication and learning from recent 'phishing' incidents. This will provide evidence for the data security and protection (DSP) toolkit. In addition, following the recent cyber attack on Advanced healths systems we are reviewing the learning from this incident, as it becomes available to strengthen out own cyber security plans as well as following up with our suppliers. One of the actions from the above mentioned KPMG audit was to purchase a SIEM. This has been taken forward at an ICS level but no agreement has been reached in 2024/5. It is likely that Trusts without a full SIEM need to purchase a local solution for the next year/2 years with procurement at an ICS level being a possibility in the longer term. This position will be confirmed early in 2025, **The Trust are looking to purchase a Full SIEM solution for the next 18 months while the ICB and NHS England look to provide a long term solution, building on the solutions they already have in place(MDE).**	On-going
We continue to refine our future cyber requirements based on the findings of an external company that we commissioned alongside SLP partners to help us find solutions to resolve our current cyber security gaps. Due to the costs that this proposal would have incurred we are now exploring other options including a different solution that SWLSG are now pursuing as well as further options that NHSE may make available too. In addition, the ICS has recently commissioned EY to benchmark all organisations within the ICS and we will be combining all this information to develop a business case to support our future needs	Complete
A programme of work is being developed for Information asset owners in 2025. Regular monitoring of IAO training and required policies is in place along with compliance on MFA adoption. A teams channel has been set up to aid communication and knowledge sharing and there will be a twice annual report to IGG. The cyber team are also working closely with the Trust EPRR team to help further refine teams BCP plans	On-going
Plan for multi-factor authentication (MFA) **for all remote user access systems** to be in place by June 2024, for compliance with Data Security and Protection Toolkit. This is in place for all available systems and is tracked via the Information asset register and will be reported at IGG.	Complete
We are looking to implement segregation between the server environment and staff device networks and limit who can gain access to them. Aim to implement by December. We are implementing a new gateway system to restrict suppliers access just to there own systems for support that are hosted within the Oxleas network. This will give us the functionality to monitor and record what it is the providers are doing and where they can gain access to. Aim to implement by December.	31/12/2025

Board Assurance Framework: month on month ratings by risk 2023/24

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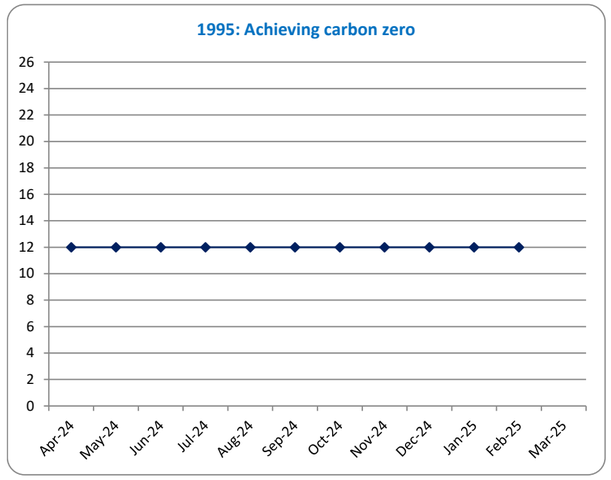

Full risk description
1995: The Trust may be unable to meet the NHS target of net zero carbon emissions by 2040 and 80% reduction by 2032 due to: •Lack of capital. The level of capital investment required to make the progress needed to achieve net zero is significant, at a time when the capital regime is particularly restrictive. •Lack of resources to progress at the pace needed. •Lack of commitment from all Trust directorates to reduce carbon emissions within their sphere of influence.

C=4	L=3	12	High

Commentary
February 2025: The BIC agreed to keep this as a strategic risk and to maintain it as high 4 x 3. **April 2023:** The BIC agreed to keep this as a strategic risk and to maintain it as high 4 x 3.

Controls
•A Sustainability Action Group is in place to develop and implement carbon reduction projects •A Net Zero Delivery Group is in place to drive and implement carbon reductions across all Trust directorates •External platform and consultants (Smart Carbon Calculator) appointed to provide carbon calculations on scope 1, 2 and 3, and provide technical support. •Strategy (Green Plan) being developed for 2025-2028 to reach the targets set by the government (80% reduction of carbon from operations by 2032 and Net Zero by 2040 for scope 1 and 2; 80% reduction of carbon emissions from procurement and supply chain by 2038, and Net Zero by 2045). •Sustainability Manager in post to deliver against Trust Green Plan and action plan. •Engagement in SEL ICS Sustainability Group to ensure we have access to a wider range of expertise and linked into system-wide developments. •Estates plan to remove reliance on fossil fuel, including outline costs and a program for completion of physical works for QMH, Bracton, Memorial and Goldie Leigh. Plan to expand the plan to the wider estate. Investment will be phased due to availability of capital and resources, and to allow the market to mature so that best technological solutions are adopted.

Assurances
•Energy usage is monitored •Recycling levels are monitored •A sustainability report will be provided bi-annually to the Business and Infrastructure Committee

Mitigation action	By when
Complete the Trust Green Plan for 2025 - 2028 Leads required for all areas covered by the Green Plan	In Progress
Complete an Estates action plan for each building to remove reliance on fossil fuel. Including outline costs and a program for completion of physical works. These have been completed for QMH, Bracton, Memorial and Goldie Leigh. Plan to extend to the wider estate.	Complete In progress
We will implement the actions in the Green Plan as per the agreed milestones Progress will be reported the Business and Infrastructure Committee every six months	On-going with 6 monthly updates
Various schemes are being taken forward including: - Heat Decarbonisation schemes: A number of projects are being worked up to create a pipeline of projects for submission for grants. - Renewable energy project being developed for Queen Mary's Hospital with a large scale solar array. - Heat District network at Memorial Hospital and Highpoints House, and improvements to building management systems. - New waste management system being implemented to improve quality of waste segregation. - Biodiversity: improvements including tree planting, changes to the management of grounds and improved access to nature for health and wellbeing are underway. - Campaign to reduce use of single use products, including Gloves Off campaigns, and other quality improvements. - Electric bike pilot undertaken	On-going

Board Assurance Framework: month on month ratings by risk 2023/24

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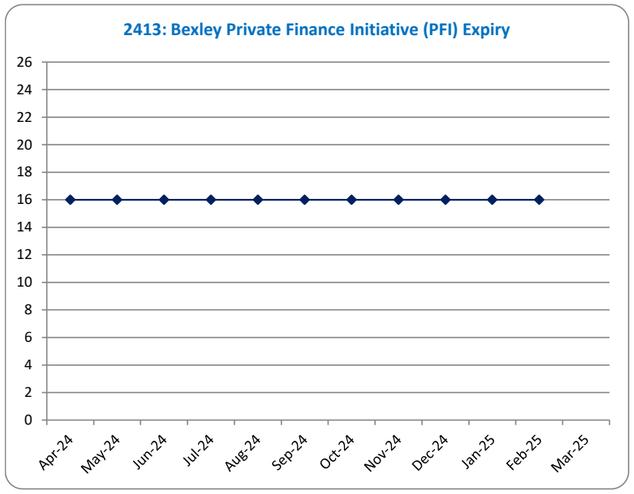

Full risk description
2413: The Trust is working towards a December 2028 contractual break date in relation to the Bexley and QMH Private Finance Initiative (PFI); contracts that would otherwise expire in 2048. The work required to manage this is resource intensive and technically, commercially, and legally challenging, given the poor drafting of the Project Agreements. For termination on 13 December 2028, notice must be given by 13 December 2026 for Bexley PFI and 13 December 2027 for QMH PFI. Despite the various workstreams in progress there are operational, financial, and legal risks associated with this process, relating to ensuring VFM revenue costs, capital and CDEL implications for the Trust and SELICB, operational service delivery, time sensitive decisions and management expertise and capacity to mitigate these risks.

C=4	L-4	16	Significant

Commentary
February 2025: The Trust continues to engage with Project Co/Semperian regarding the Standstill Deed with a few clauses within the drafting left to finalise. The delay in signing the standstill deed is causing time constraints on the remaining expiry process which is being monitored closely. **November 2024:** The Trust will be entering a into a 'Standstill Deed' with Project Co/Semperian. This will enable 'Centre of Best Practice' fire safety and asset condition surveys to take place (via a joint appointment), linked to a relief period of 14 months to enable remediation works. The surveys will provide assurance on the condition of the buildings. **February 2024:** Update on the contractual break date. December 2028. Updated readiness report received from the IPA. **November 2023:** Opened as a significant risk.

Controls
•Bi-weekly PFI Working Group meetings occurring with internal stakeholders, regular meetings with the Infrastructure and Projects Authority (IPA) along with actions tracker maintained on a bi-weekly basis. •Bi-weekly meetings with Semperian with actions tracker maintained on a bi-weekly basis. •External experts have been appointed and additional resource will be accessed as and when needed. •Reporting into the Executive and Business and Infrastructure Committee as and when required. •Project manager appointed. •Full project risk register has been developed and maintained by the PFI Working Group. • Regular communications with NHSE and DHSC

Assurances
•Full financial implications to be understood before decision to break and when, is made, with review and approval by the Executive, Business and Infrastructure Committee and NHS England (subject to valuation of the head lease buyout) prior to break option being utilised. •IPA support into the PFI working group to support and track progress •Reporting into the Executive and Business and Infrastructure Committee as and when required. •Ensure SEL ICS are aware of the potential CDEL cover needed in 2028/29 if the Trust decides to 'buy out' the head leases. •14 month period agreed with Semperian to rectify any defects or areas of non-compliance identified in the conditions surveys •Full reconciliation of historic payments almost complete. •IPA review has been carried out and all of time sensitive actions in relation to the first break clause have been carried out. •IPA has issued an updated readiness report which is rated as Amber from the first version which was rated Red.The next review is set for March 2026

Mitigation action	By when
PFI Working Group to keep under review and take updates to the Formal Executive and Business and Infrastructure Committee as required. Next report to be taken to March BIC. The Trust will be entering a into a 'Standstill Deed' with Project Co/Semperian. This will enable 'Centre of Best Practice' fire safety and asset condition surveys to take place (via a joint appointment), linked to a relief period of 14 months to enable remediation works. The surveys will provide assurance on the condition of the buildings.	On-going

Board Assurance Framework: month on month ratings by risk 2023/24

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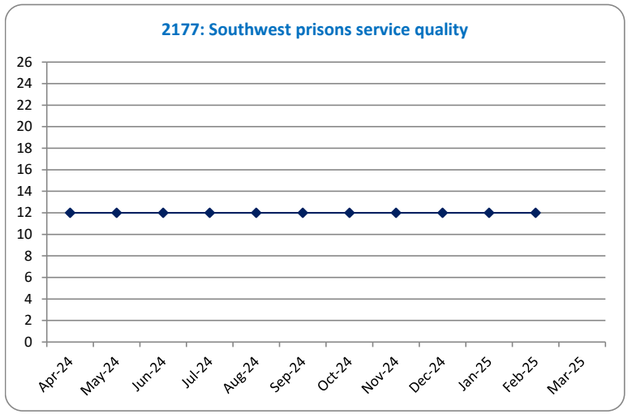

Full risk description

2177: Oxleas have been providing healthcare services for 10 prisons in southwest England since October 2022. Identified through our quality governance processes, there is a significant risk that some services have quality challenges, due to poor staffing levels, leadership and operational model of care, causing an unsafe service and risk of increased scrutiny from the CQC.

C=3	L=4	12	High

Commentary

January 2025: The Quality Committee agreed that this risk should be re-framed to reflect how the trust responds to external factors such as the prison environment, the prison regime and other initiatives such as the early release of prisoners under standard determinate sentence schemes, operation safeguard, an increase in urgent notifications from HMIP and the impact of these factors on the ability of healthcare to deliver a quality service. The risk in its current format will be closed and a new risk agreed through the Quality Committee.
September 2024: Discussed at Quality Committee. Consideration was given to whether this needs to be a directorate wide risk, given findings from recent CQC inspection in Kent. Agreed to defer discussion until the new director is in post.
June 2024: HMP Erlestoke have an HMIP and CQC inspection week commencing 17 June and HMP Bristol has an Independent Review of Progress (IRP) week commencing 24 June. Action and target date extended to end September 2024 to allow time for reports to be issued and any further actions identified.
April 2024: The CQC visited Exeter in November 2023 and saw noticeable improvements in practice. All urgent notifications for HMP Bristol are complete. The new self-assessment process is reported to the Quality Assurance Oversight Group, then to the Quality Committee and the Board of Directors. However, we still need robust governance at directorate level and quality governance for Offender Healthcare needs to be embedded. HMP Bristol and HMP Erlestoke are rated as More Focus Needed with actions due by 31 May 2024. However, we still need robust governance at directorate level and quality governance for Offender Healthcare needs to be embedded. HMP Bristol and HMP Erlestoke are rated as More Focus Needed with actions due by 31 May 2024. Sufficient progress has been made to reduce the risk to high (12). Some further actions are due by end May 2024.

Controls

- Quality governance structure in place with quality leads in post
- Good relationships with NHSE and CQC
- Regional managers in each area

Assurances

- Progress monitored through meeting with commissioners and CQC
- Improving lives reviews - on-going programme of reviews
- Consolidated action tracker
- The self-assessment process is reported to the Executive Team, Quality Assurance Oversight Group, then to the Quality Committee and the Board of Directors.

Mitigation action	By when
Furter Intelligence gathering and development of an improvement plan to be actioned as soon as take over for all SW prisons. To include partnership working with current providers and NHS England	Complete
Support the significantly high-risk prisons with existing Oxleas leadership team until roles recruited to and in place. Substantive Heads of Healthcare now in post at HMP Portland and HMP Exeter	Complete
Governance review undertaken and implemented in collaboration with HMPPS and NHS England	Complete
Consolidated action trackers, performance and quality metrics agreed and monitored via the revised governance framework	Complete
Recruitment to key posts, Head of Nursing and Practice Development Nurse have been recruited, but successful candidates are working out their notice. Associate Clinical Director role to be recruited to.	Complete and on-going
Action plans are in place in HMPs Bristol and Exeter to monitor progress with the urgent notification requirements. As of April 2024 all urgent notifications for HMP Bristol are complete, and the few remaining for HMP Exeter relate to long-term challenges	Complete and on-going
More Focus Needed' actions for HMP Bristol and HMP Erlestoke are in progress	Complete and on-going
Embed a robust quality governance structure at directorate level. The Director of Quality has been working with the directorate team to develop a good sub contractor quality and performance review process. This is being trialled with the GPs first and then will be amended for all other sub contractors.	31/03/2025

Board Assurance Framework 2024/25 - action status

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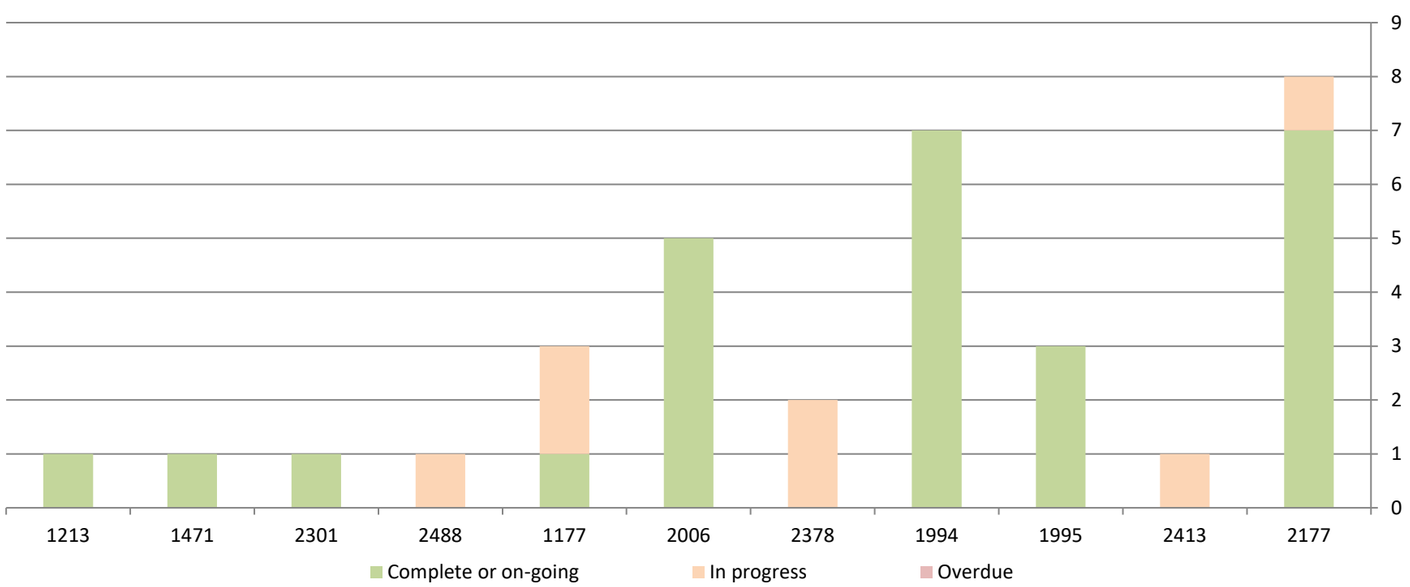
ID	Summary risk description	Complete or on-going	In progress	Overdue
1213	Vacancies and staffing pressures	1	0	0
1471	Discrimination at work, based on protected characteristics	1	0	0
2301	Staff experiencing violence, aggression or abuse at work	1	0	0
2488	2024/25 revenue and capital plan delivery	0	1	0
1177	Financial sustainability of the Trust in the medium/long term	1	2	0
2006	ICS capital regime	5	0	0
2378	Bed management – quality and financial impact	0	2	0
1994	Cyber security strategic risk	7	0	0
1995	Achieving Carbon Zero	3	0	0
2413	Bexley Private Finance Initiative (PFI) Expiry	0	1	0
2177	Southwest prisons service quality	7	1	0
		26	**7**	**0**

Action status of BAF risk



Commentary
February 2025: There are seven actions in progress and no overdue actions.

Board Assurance Framework 2024/25 - longevity of risk as of 26 February 2025

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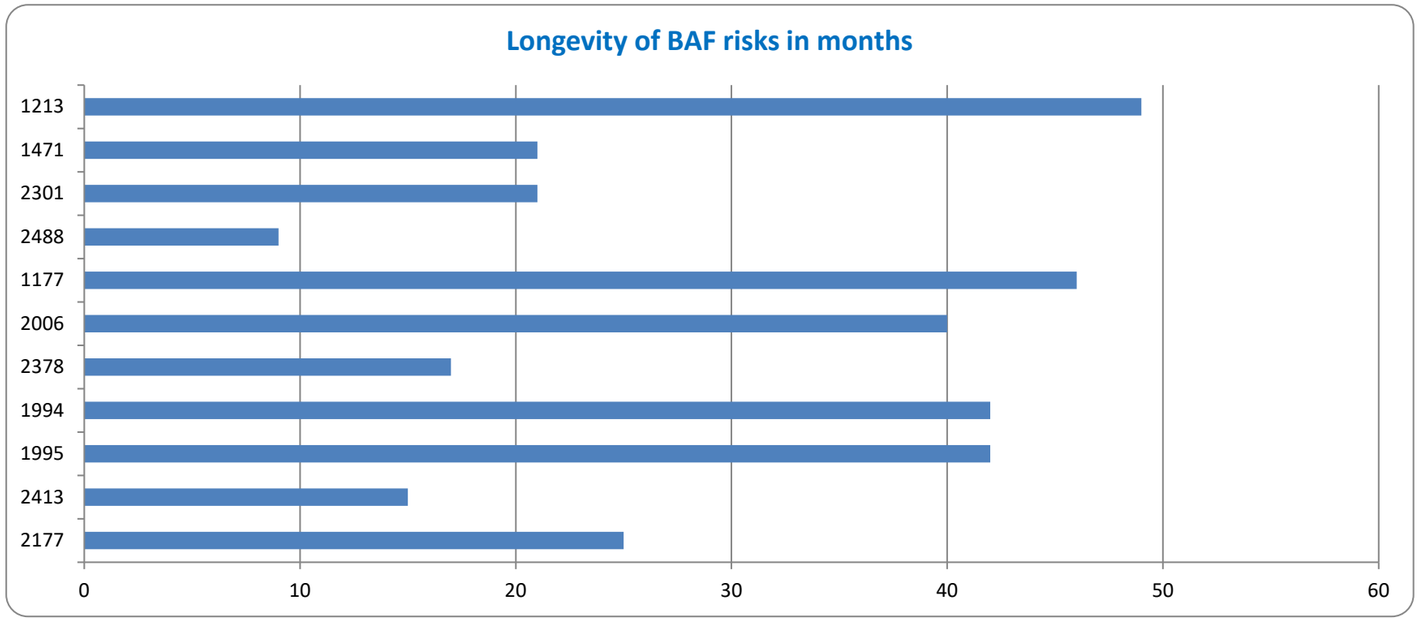
ID	Summary risk description	Risk opened	Longevity in months
1213	Vacancies and staffing pressures	02/01/2021	49
1471	Discrimination at work, based on protected characteristics	17/05/2023	21
2301	Staff experiencing violence, aggression or abuse at work	17/05/2023	21
2488	2024/25 revenue and capital plan delivery	21/05/2024	9
1177	Financial sustainability of the Trust in the medium/long term	01/04/2021	46
2006	ICS capital regime	14/10/2021	40
2378	Bed management – quality and financial impact	19/09/2023	17
1994	Cyber security strategic risk	13/08/2021	42
1995	Achieving Carbon Zero	17/08/2021	42
2413	Bexley Private Finance Initiative (PFI) Expiry	21/11/2023	15
2177	Southwest prisons service quality	19/01/2023	25



Commentary
February 2025: There are five risks which have remained on the risk register for three to four years: 1177: Financial stability in the medium and long term 1213: Vacancies and recruitment pressures 1994: Cyber security strategic risk 1995: Achieving carbon zero 2006: ICS capital regime

Board Assurance Framework - risks de-escalated 2024/25

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ID	Description	Risk status	Date added to BAF	Date removed from BAF	Reason for de-escalating from BAF	Controls	Assurances	Consequence (Current)	Likelihood (Current)	Rating (Current)	Level (Current)
2472	**Harm to triangle of care due to poor communication** If communication is poor between the three parts of the triangle of care (patient, support network and clinicians), and we are unclear about terminology (carer v support network) then this can harm the triangle of care. If carers are not involved or listened to, the cared for (ie patient or service user) can deteriorate, or the health and well-being of the carer will be affected. This may lead to the delivery of ineffective care to the patient and the resultant poor outcomes and experience. This may also lead to harm and serious incidents.	**Live**	17/07/2024	21/01/2025	Revised wording agreed at Quality Committee, and also that this does not need to be a BAF risk. Updates will be reported through the Great Care work.	•The Support Network and Engagement Tool (SNET) is a means on enabling the triangle of care, and a way to think about the cared for in three dimensions with all the people in their lives, including those who may not be a carer. •There are some positive experiences of regular consultations where everyone in the triangle of care meets – service user, carer, staff. •Training on understanding data protection, confidentiality and information sharing is being organised by the Information Governance Team. A significant programme of work relating to care documentation has been underway in the trust for some time, and there is already good engagement from directorate clinical effectiveness leads, so this will be the main mechanism to drive this forward. There is already a place to capture the views of carers and the support network in care documentation, and the care documentation audit tool is used to capture qualitative data and evidence that this is taking place. The Clinical Effectiveness Group dashboard is used to monitor compliance. Where compliance is low, improvement work is taken forward on a team-by-team basis. However, in response to this risk, there will be a renewed focus on: •Reviewing service standards for care documentation, including the involvement of carers and the support network. •Ensuring that audit tool to ensure that it aligns with the service standards. •Triangulating data from the audit tool, the dashboard and patient experience reports to identify gaps. •Targeted training to teams, led by the Involved Team.	The Service User and Carer Shadow Committee have suggested that the measures of successed would be: •Care plan entries should be looked at on a regular basis to check that views of carers are reflected. •Feedback from carers through surveys and questionnaires. Feedback should be requested at the point of care planning, with regular checkpoints. Method of obtaining feedback should be quick and easy, including on-line collection. •Reduced admissions and repeat admissions. •Feedback from the cared for (the service user). •Decrease in negative feedback, including PALS and complaints, and increase in positive feedback, including compliments. •Reduction in incidents of harms due to poor communication and care planning, including near misses – but we need to consider if and how this is captured, how we can encourage staff to report. •Outcomes – improvements in quality of life, goals achieved.	Moderate (3)	Likely (4)	12	High
2424	**Doctors industrial action** Junior doctors still have a mandate for Industrial action, and if further dates are announced, their action will be a full walk out. There is a risk that this will impact on patient experience, outcomes, equality of access and safety. There will also be an impact on staff morale and may lead to burn out for staff covering strike action since March 2023. As the strikes have continued there has been harm to patients which has been difficult to quantify, which is being collated by NHSE.	**Closed**	27/12/2023	15/10/2024	Agreed at People Committee September 2024 that the risk could be closed as junior doctors have accepted the pay offer.	During previous periods of industrial action, this has been managed by •Cancelling clinics as needed while ensuring that the same patients are not cancelled twice. •Cancelling elective and non-emergency work where necessary. •Delivering consultant led services in most directorates. •Daily ICC meetings are held on strike days to ensure that services can escalate any concerns and agree action plans	Oxleas is required to submit daily data on •numbers who have gone strike •any escalations and mitigation plans •number of cancelled appointments	Major (4)	Possible (3)	12	High
1912	**Pressure on district nursing teams** If the trust does not reduce pressure on district nursing services in Bexley and Greenwich, there is a risk that this will impact upon quality of care and staff morale.	**Live**	24/09/2020	16/07/2024	Our negotiations with place-based colleagues in Bexley and Greenwich have resulted in non-recurrent funding for our district nursing services which overspent by £2.1m in 2023/24. A new system review group is being set up to look at our current model of provision and whether there are new ways to deliver care that could have a positive impact on reducing demand on the service. The Audit and Risk Assurance Committee agreed that this risk can be de-escalated from the Board Assurance Framework. The risk will continue to be managed through the Adult Community Physical Health directorate risk register.	The pressures on the district nursing teams are recognised as a risk at system level through relationship building within the ICS, the borough level local care partnerships, and the Resplendent Group. At local level, service directorate is authorising the use of additional bank or agency staff to reduce the pressure on teams. Despite additional funding of £400k in 22/23 the demand continues to outstrip capacity. Place based workstreams in both Bexley and Greenwich aim to optimise service delivery which will in turn identifying the shortfall in funding so that this is clear for the 24/25 commissioning round. Adjustments have been made to requirements within the person specification for band 6 roles to recognise experience rather than the district nurse qualification to aid recruitment. This is in line with other SEL community providers. Since January 2023 a service manager is working across both boroughs, enabling consistency, analysis of demand and capacity and vital re-modelling to explore all aspects required to relieve the pressure on district	Monitoring activity levels, referrals and allocated daily visits. Demand and capacity modelling reviewed regularly through the district nurse quality workstream.	Major (4)	Likely (4)	16	Significant
2159	**Impact of service expansion** As the trust expands both in scope and geography, there is a risk that this could have a detrimental impact on our ability to ensure the maintenance of a positive Oxleas culture and values.	**Managed**	15/11/2022	15/06/2024	Agreed by People Committee that this could be treated as a managed risk.	The maintenance and expansion of existing quality governance arrangements to include the new services. Dedicated Executive meetings to monitor the mobilisation and expansion. Oversight of workforce and culture elements by the People Committee. Mobilisation and induction plan for services joining the trust including communications, staff engagement and quality Corporate resources were reviewed and added to in preparation.	Reported through Executive Team, People Committee and Board of Directors A six-month review of Quality Impact Assessments (QIAs) is part of the assurance process	Major (4)	Possible (3)	12	High
2303	**2023/24 revenue and capital plan delivery** The Trust has planned for a breakeven revenue plan for 2023/24 and a capital plan of £16m. There are delivery risks:- -CIPs, through recurrent and non-recurrent measures; -agency and bank spend remaining within plan; -our ability to meet our trajectory on beds – adult MH beds; -and the Trust having slippage of MHIS and SDF in excess of the £5m built into the CIP plan delivery; over-commitment on capital.	**Closed**	20/06/2023	21/05/2024	In-year risk closed and new in-year risk 2488 opened.	Trust DoF is fully engaged in drafting SEL ICB financial recovery board. The SEL ICS formal monthly financial review meetings to review both capital and revenue with all NHS organisations. The Trust will keep tight control on both the in-month and forecast revenue and capital positions. Monthly meetings in place between Finance, IT and Estates to review capital spend and forecast to ensure full utilisation of envelope. Regular meetings with ICS finance where national updates are reviewed. CIPs will be a rolling item for all the directorates monthly finance meetings, in addition there is a quarterly strategic directorate review meeting with the DoF.	The Formal Executive, Business & Infrastructure Committee (BIC) and Board will be updated on progress Reports to BIC Monthly/quarterly finance meeting with service and corporate directorates Monthly ICS Finance update report provided to the Formal Executive and BIC, one month in arrears`	Minor (2)	Unlikely (2)	4	Low

Board Assurance Framework 2024/25: proportion of risks by committee as of: 26 February 2025

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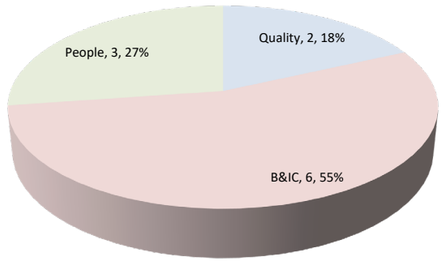
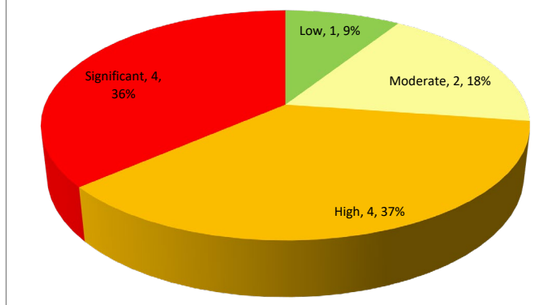
Risk level	Quality	B&IC	People	Total
Low	0	1	0	**1**
Moderate	0	1	1	**2**
High	1	1	2	**4**
Significant	1	3	0	**4**
Total	**2**	**6**	**3**	**11**

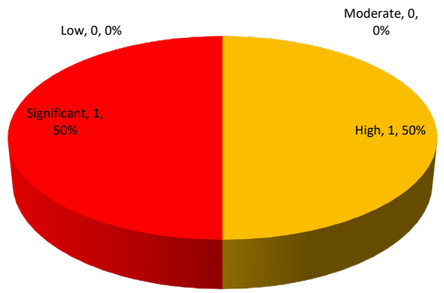
Proportion of BAF risks by committee



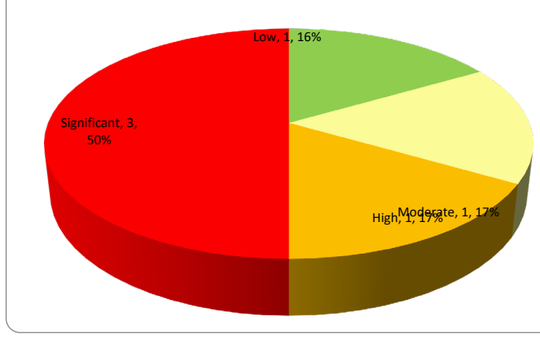
Proportion of BAF risks by rating



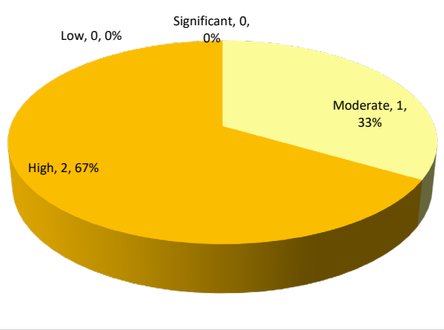
Quality Committee
Proportion of BAF risks by rating



Business and Infrastructure Committee
Proportion of BAF risks by rating



People Committee
Proportion of BAF risks by rating



Board Assurance Framework: comparison of initial, target and current risk ratings 2024/25

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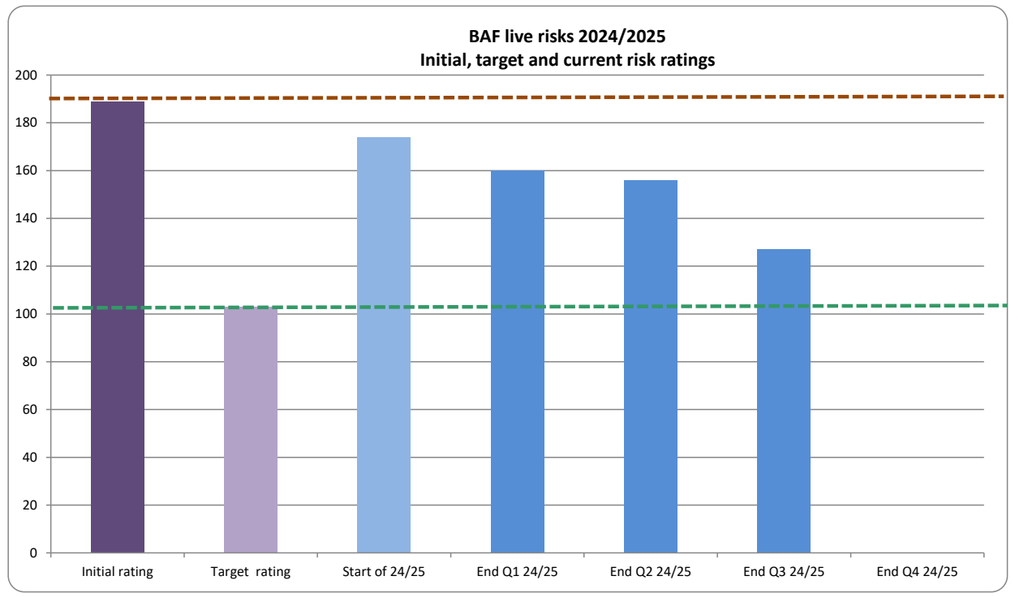
Initial rating when risk first opened
Target risk rating
Risk rating as at start of 2024/25
Risk rating at end of each quarter of 2024/25

Initial rating compared to actual rating

Target rating compared to actual rating

ID	Summary risk description	Risk rating as at						
		Initial rating	Target rating	Start of 24/25	End Q1 24/25	End Q2 24/25	End Q3 24/25	End Q4 24/25
1213	Vacancies and recruitment pressures	12	9	16	12	12	12	
1471	Discrimination at work, based on protected characteristics	9	6	9	9	9	9	
2301	Staff experiencing violence, aggression or abuse at work	12	9	12	12	12	12	
2488	2024/25 revenue and capital plan delivery	9	4	4	9	9	4	
1177	Financial sustainability of the Trust in the medium/long term	16	8	16	16	16	16	
2006	ICS capital regime	16	4	8	8	8	8	
2378	Bed management - quality and financial impact	16	9	16	16	16	16	
1994	Cyber security strategic risk	10	8	10	10	10	10	
1995	Achieving Carbon Zero	12	4	12	12	12	12	
2413	Bexley Private Finance Initiative (PFI) Expiry	16	12	16	16	16	16	
2177	Southwest Prisons service quality	16	8	15	12	12	12	
2159	Impact of service expansion	12	8	12	De-escalated	De-escalated	De-escalated	De-escalated
1912	Pressure on district nursing teams	9	8	16	16	De-escalated	De-escalated	De-escalated
2424	Doctors industrial action	12	tba	12	12	12	De-escalated	De-escalated
2472	Harm to triangle of care due to poor communications	12	6	0	0	12	12	De-escalated
Total risk score		**189**	**103**	**174**	**160**	**156**	**127**	**0**



Improving lives

NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 7
Enclosure 5

Subject	Chief Executive Report
Author	Sally Bryden, Director of Corporate Affairs and Strategic Development
Accountable Director	Ify Okocha, Chief Executive
Confidentiality/ FOI status	Public

What is the purpose of bringing this report to the Board meeting?	For the Board's information
Are there any issues in the report that might cause upset?	No
Link to trust strategy and integrated care system priorities	It links to several of the priorities and core commitments of Oxleas strategy. It also links to the South East London Integrated Care System priorities in particular reducing health inequalities.
Glossary of terms/acronyms used in the report	ICS – Integrated Care System CEO – Chief Executive Officer LGBTQ+ - Lesbian, Gay, Bisexual, Transgender, Queer/Questioning plus

Executive Summary	The report includes: - Changes at NHS England - Public perceptions of the NHS - 10-year Health Plan consultation - 2025/26 planning guidance - Post graduate Medical Education review - The Independent Mental Health Homicide Report into the treatment of Valdo Calocane - Plans to improve services for children with neurodiversity and services for weight management in south east London - Developments in Oxleas to increase access to services and to support local career opportunities. **The report is brought to the Board for information and to note the contents.**

Analysis	
What risks/issues in the report need to be noted or acted upon?	The report links to risks on our Board Assurance Framework risks on financial sustainability, service quality, workforce capacity and staff morale.

Quality implications	The 10 year plan consultation aims to improve quality. The 2025/26 guidance aims to improve financial control without negatively impacted the quality of health services.
Financial impact	The report includes information on financial planning and performance
Equality analysis	Items cover how services are aiming to reduce health inequalities by increasing access to services by people from minoritised groups.
Net zero impact	Plans for the NHS to achieve net zero are highlighted in the Green Plan
Impact on service users, carers and families	The 10 year plan consultation seeks feedback from service users, carers and families.
Partner organisations	Developments in the Integrated Care System are reported
Staff	The report includes information on the programmes to support Building a Fairer Oxleas and career development.
Additional information	**Further information** Links to further information are included in the report and other reports in the board pack give more information on operational, people financial and quality issues.

National update

1. Changes in leadership at NHS England

Amanda Pritchard has formally notified the NHS England Board of her decision to stand down as chief executive at the end of this financial year. She has been Chief Executive since August 2021 and chief operating officer since 2019, leading the NHS through the most challenging period in its 76-year history.

Sir James Mackey will be taking over as Transition CEO of NHS England, working closely with Amanda for the next month before taking up post formally on the first of April.

More information is available at NHS England » NHS Chief to stand down at end of March

2. Public perceptions of health and care

The Health Foundation has published a new poll on health care with Ipsos on the public's views towards the NHS and social care.

This survey (conducted between 21 and 27 November) is the first under the new Labour government. Findings highlight that:

- For the first time in their polling series, the public's top priority for the NHS is making it easier to get appointments at GP practices (38%).
- Across the NHS and social care, the public is less negative and more optimistic about the performance of services than under the previous government, though perceptions are still largely negative overall.
- The majority of the English public is unaware of the government's proposals for a National Care Service (76% unaware) and a 10-Year Health Plan (73%).
- The NHS/health care is the public's top priority for extra public spending by a substantial margin.

More information is available at: Things can only get better? - The Health Foundation

3. 10 year Health Plan for England

Following submissions from NHS organisations, voluntary sector and the wider public and consultation sessions in January, February and March, plans are underway for a National Summit in Spring 2025 to finalise the 10 year health plan. Feedback themes received so far include:

From the public
People are positive about:

- NHS being a universal service, available to everyone, free at point of use
- dedicated and hardworking staff, doing incredible work in difficult circumstances
- NHS being there when people really need it, with emergency services saving lives every day.

People have experienced:

- difficulty getting appointments
- long wait times in A&E
- a lack of joined up care

And the public would like to see:

- easier and quicker access to appointments, especially with GPs
- better co-ordination between different health and care services
- greater investment in staff recruitment and retention
- reducing waste and inefficiency across the NHS

From NHS Staff
Staff have expressed that they:

- are proud of the NHS, and in their colleagues,
- feel they make a real difference for patients and their families.

But the challenges staff face include:

- staff shortages

- inefficient systems
- poor working conditions
- lack of resources
- the disconnect between management and frontline staff.

More information on the consultation and next steps are available at Change NHS.

4. Post graduate Medical Training Review

A nationwide postgraduate medical training review has been launched overseen by NHS England's National Medical Director, Professor Sir Stephen Powis and the Chief Medical Officer, Professor Sir Chris Whitty.

The review will be based on feedback from current resident doctors and students, locally employed doctors and medical educators, with a series of engagement events around the country starting from this month. The review will cover placement options, the flexibility of training, difficulties with rotas, control and autonomy in training, and the balance between developing specialist knowledge and gaining a broad range of skills.

The national listening events in February and March will be followed by a call for evidence in the spring. A report on the review's findings is due to be published in the summer.

More information is available at NHS England » Postgraduate medical training review

5. Winter pressures on the NHS

The pressures on health services nationally and locally have continued over the past few months with record cases of norovirus infections being recorded.

NHS England reported that, during February, an average 1,160 patients a day were in hospital with norovirus which is more than double the same period last year. We have experienced some cases on our wards which can affect our ability to admit patients.

6. 2025/26 priorities and operational planning guidance

This guidance, published on 30 January 2025, sets out a smaller number of national priorities for 2025/26 with an emphasis on improving access to timely care for patients, increasing productivity and living within allocated budgets, and driving reform. To support this, systems will have greater control and flexibility over how local funding is used to best meet the needs of the local population.

National priorities and success measures for 2025/26

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
Improve A&E waiting times and ambulance response times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
	Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)
Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

*Against the November 2024 baseline, with all providers required to increase their RTT performance to a minimum of 60% and performance on wait for first appointment to a minimum of 67%

The guidance is supported by a range of contracting, revenue and allocation of resources documents. These are available at [NHS England » 2025/26 priorities and operational planning guidance]

We are working with South East London Integrated Care Board partners to develop plans by the end of March to meet the national objectives and local priorities alongside financial targets.

7. Green Plan guidance

Updated guidance to help NHS organisations plan to achieve net zero was published on 4 February 2025. We are using this to refresh our plans and plan our annual report information.

We will be reviewing our Green Plan in light of this guidance and will bring an update a future Board meeting and publish updated plans on our website and share with NHS England by 31 July 2025.

8. The Independent Mental Health Homicide Report into the treatment of Valdo Calocane

This report was published on 5 February 2025 following the independent investigation into the NHS care and treatment provided to Valdo Calocane by Nottinghamshire Healthcare NHS Foundation Trust prior to the tragic events of 13 June 2023, and the interactions the NHS had with other agencies involved in his c are. Valdo Calocane was convicted of the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber in January 2024. The review identified clear failings in the care and treatment provided to Valdo Calocane and produced a series of recommendations for Nottinghamshire Healthcare NHS Foundation Trust and NHS England.

Building on the work that is already taking place to improve intensive and assertive community treatment for people with severe mental illnesses, all trusts providing mental health services and integrated care boards have been asked to review local action plans. This is to ensure they address the issues identified in the independent review with particular attention to:

- personalised assessment of risk across community and inpatient teams
- joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)
- multi-agency working and information sharing
- working closely with families
- eliminating Out of Area Placements

We have been asked to discuss the action plans in our public board meeting by 30 June 2025. We are therefore planning to bring this to our May Formal Board meeting.

Regional and system update

1. New regional director for NHS England - London

Dr Usman Khan has been appointed as the new regional Director of Improvement, Transformation and Partnerships for the NHS in London. The role, which is a joint appointment between the NHS, the Greater London Authority and London Councils, is

central to how the health and care system in the capital works in a joined-up way to deliver high quality care and outcomes.

Dr Khan is a health policy and management professional who has held senior board roles in the public, private and not-for-profit sectors over the last 25 years. Most recently, this has included holding the role of Chair of South East Coast Ambulance Service NHS Foundation Trust and Non-Executive Director at North Central London Integrated Care Board. Dr Khan is expected to take up the role in early March and will succeed Martin Machray, who retired in December 2024 after 35 years of dedicated service to the NHS.

2. London-wide breast screening awareness campaign

The NHS in London is launching an awareness campaign to encourage more women to attend potentially life-saving breast screening appointments, as national figures show more than four in ten women (46.3%) invited for the first time don't act on their invitation. The latest figures show London has the lowest breast screening uptake rates in the country (64.5% vs 70.4%). There are significant inequalities in screening uptake, with women from minoritised groups, those who live in deprived areas and those who do not speak English as a first language less likely to attend. Information about breast screening and how to make an appointment is available at https://www.london-breastscreening.org.uk/

3. Programme to improve NHS support offer for neurodivergent children and young people in south east London

NHS South East London Integrated Care Board is looking to make improvements in access to and offers of support for children and young people who are neurodivergent and their parents/carers across Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

Colleagues are seeking feedback from local parents/carers who have experience of their child waiting for an ADHD or ASD assessment in NHS services in south east London to help decide what the offer of support should look like (while waiting and post assessment).

A workshop is planned to involve parents/carers and health professionals to collectively design the offer. More information is available at Help us shape the NHS support offer for neurodivergent children and young people in south east London | Let's Talk Health and Care South East London

4. Improving weight management in south east London

South East London Integrated Care System and King's Health Partners are bringing together patients, health professionals, and representatives from local authorities to improve weight management services.

Obesity in south east London is a significant concern, with 56% of adult residents carrying excess weight and some boroughs above the London average. This is putting pressure on our weight management system, which provides different tiers of care depending on a patient's needs – ranging from lifestyle management all the way to surgery. System colleagues are looking to improve access to services and reduce delays.

Anyone interested in becoming a member of the overweight and obesity expert lived experience reference group can email: admin@allaboutobesity.org.

Organisational update

1. Local MP hears how we have increased the diversity of people using our talking therapies service

We were pleased to welcome local MP Clive Efford to our Time to Talk service in Greenwich in January to share with him how we have increased the diversity of people using our talking therapies service. Colleagues described how they have worked with local community leaders to deliver workshops on common mental health difficulties adapted to the culture and needs of the local population.

These workshops offered people tools to support their mental health and raised awareness of our service. More than 1,500 people attended the workshops and gave very positive feedback.

2. National apprentice week celebrations

We supported February's national apprentice week by sharing how our colleagues and our services have benefitted from the career opportunities offered through the scheme. A member of our district nursing team Teressa Riley was featured in The Guardian newspaper showcasing her apprenticeship journey with the University of Greenwich. We also took part in apprenticeship events in local schools to highlight the opportunities on offer.

3. LGBTQ+ history month

February is LGBTQ+ history month and we are marking it at Oxleas with a trustwide online event. The national theme for the month is activism and change and the event involves network members, senior leaders and guest speakers sharing their experiences and personal commitment to LGBTQ+ activism and social change. More information is available at - LGBT+ History Month

4. Older People's Services Conference

Our first trustwide Older People's conference was held in February to share the exciting work being done across our services to improve the health and wellbeing of people in later life.

Chaired by Chief Medical Officer, **Dr Abi Fadipe**, keynote speakers included **Dr Amanda Thompsell**, National Advisor of Older People's Mental Health at NHS England, and **Dr Jan Oyebode**, Professor of Dementia Care at the University of Bradford.

The conference included presentations, posters and interactive stalls from colleagues working with in community mental health, acute and crisis, adult learning disability, adult community health and forensic and offender services.

Integrated Performance Overview

The table below lays out a review of performance metrics. There are detailed discussions on these at Board committees with further detail in committee papers, minutes and the reading room.

Dashboard	Summary	Monitoring committee
Operational and quality performance	The following metrics in the performance and quality measures have not been reaching the required targets in at least four out of the last six months: • Referral to Treatment – Incomplete Pathways • Referral to treatment – Allied Health Professionals • Referral to Treatment – Psychological Therapies • Greenwich NHS Talking Therapies: Completing Treatment • Number of Out of Area bed days occupied in month for working age adult mental health • Length of Stay in Episode for working age adult mental health • Number of Patients staying over 90 days for working age adult mental health • Patients waiting longer than 72 hrs in emergency departments **Three mental health legislation metrics** have failed to meet their target for 4 out of the last 6 months. • Mental Health Act – s132 compliance • Mental Health Act – s58 Consent to Treatment	Quality Committee

Dashboard	Summary	Monitoring committee
	• Health based Place of Safety 24 hour breaches More information is included in the Operational and Quality Committee reports.	
Workforce	• Vacancies remain stable at 11% • Turnover remains stable at 16% - a sustained 3% reduction on the previous financial year • We continue the significant focus on agency reduction. Medical agency is a particular challenge • We achieved a 60% completion rate for the Staff Survey – 6% higher than the average in comparable trusts. The embargo on our Staff Survey results will be lifted on March 13th.	People
Finance	We continue to make strong progress toward delivering our revised 2024/25 financial plan, targeting a surplus of £1.03M, inclusive of a £0.61M technical adjustment. This aligns with the South East London Integrated Care System's revenue control total of a breakeven position. As of Month 10, Oxleas is on track to achieve our planned surplus. In response to a request from the SEL Integrated Care Board for organisations to reassess their financial forecasts - following a deterioration in two SEL NHS providers' positions - our finance team conducted a detailed review with directorates. This identified balance sheet flexibility, enabling an improved financial outlook. Following Board discussions, there was in-principle agreement to revise the Forecast Outturn to a £3.1M surplus - an improvement of £2M compared to plan. However, at the SEL Chief Finance Officers (CFO) meeting on 21st February 2025, it was confirmed that the system requires Oxleas to improve our surplus by £1.5M instead, bringing our revised Forecast Outturn to £2.5M. This adjustment will be reflected in the Month 12 position. **South East London Integrated Care System Financial Context** • The SEL system submitted a breakeven revenue plan for 2024/25, supported by £100 million in non-recurrent deficit funding. • The impact of the Synnovis cyber attack on SEL trusts is currently reported at £33.7M, with an	Business and Infrastructure

Dashboard	Summary	Monitoring committee
	additional £4.7M forecast to year-end, bringing the total to £38.4M. • The system is assuming that the Synnovis impact will be an allowable deficit as this event occurred after the plan was agreed. NHS England is expected to confirm the treatment of Synnovis prior to year end. • The formally reported system forecast remains at breakeven excluding the impact of Synnovis. • However, the underlying financial run rate projects a deficit of £59.0M (unmitigated) and £20.6M (mitigated). • Chief Financial Officer discussions indicate that breakeven remains achievable, contingent on the treatment of the Synnovis incident and securing £20.6M in post-Month 10 system-wide improvements.	

Improving lives

NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 8
Enclosure 6

Subject	Board Operational Report
Author	Iain Dimond, Chief Operating Officer
Accountable Director	Iain Dimond, Chief Operating Officer
Confidentiality/ FOI status	Public

What is the purpose of bringing this report to the Board meeting?	For the Board's information
Are there any issues in the report that might cause upset?	References to waiting times in some directorates
Link to trust strategy and integrated care system priorities	The content of the report links with all three key strategic priorities and many of the building blocks of the strategy. Additionally, it outlines a number of pieces of work which relate to system priorities at both an ICS and Place level.
Glossary of terms/acronyms used in the report	ADAPT – Anxiety, Depression, Affective, Personality Disorder and Trauma ADHD – Attention deficit and hyperactivity disorder ASD – Autistic Spectrum Disorder BCU – Basic Command Unit CAMHS – Child and Adolescent Mental Health Service CMHRES – Community Mental Health Rehabilitation Service CMHT – Community Mental Health Team COMHAD - Co-Occurring Mental Health, Alcohol and Drugs COPD – Chronic Obstructive Pulmonary Disease CQC – Care Quality Commission CRHTT – Crisis Resolution and Home Treatment Team CTR – Care & Treatment Reviews CYP – Children and Young People DMT – Directorate Management Team DN – District Nurse DToC- Delayed Transfer of Care ED – Emergency Department EIP – Early Intervention in Psychosis HBPOS – Health Based Place of Safety HEPA – high efficiency particulate air ICMP – Intensive Case Management for Psychosis INT – Integrated Neighbourhood Team IPS – Individual Placement and Support JET – Joint Emergency Team

	LA – Local Authority LAS – London Ambulance Service LDA – Learning Disability and Autism LPP – London Pathway Partnerships LSEC – London South East Colleges LSA – Learning Support Assistant LTC – Long-Term Condition MDT – Multi-Disciplinary team MH – Mental Health MHJRC – Mental Health Joint Response Car MSK – Musculo-Skeletal OBD – Occupied Bed Days PCP – Primary Care Plus PICU – Psychiatric Intensive Care Unit PIPE – Psychologically Informed Planned Environment PRUH – Princess Royal University Hospital PTL – Patient Task List SNET – Support Network Engagement Tool SQuIRe - Stroke Quality Improvement for Rehabilitation TUPE – Transfer of Undertakings (Protection of Employment) UCR – Urgent Community Response UEC – Urgent and Emergency Care

Executive Summary	**Highlights from the Board Operational Report** The report includes updates on: • Bed Recovery Programme • Neighbourhood Developments • Standardising NHS ICB Funded Community Health Services • • Directorate updates • Performance exceptions **Action required** The Board is asked to note the report	

Analysis	
What risks/issues in the report need to be noted or acted upon?	The report highlights a number of risks which feature on the BAF and which are owned by the Quality Committee
Quality implications	The report outlines steps being taken to improve quality of services

Financial impact	The report outlines the impact of investment in several developments. The report also outlines areas of financial overperformance most significantly around occupied acute mental health bed days purchased from the private sector; and actions continue to be taken to address bank & agency spend in the Forensic directorate and to flex and adapt the operational model in SW prisons.
Equality analysis	The report references pieces of work related to addressing inequalities for both colleagues and service users with protected characteristics:
Net zero impact	Although the report does not address this specifically, a number of the directorates are exploring what they can do to reduce carbon emissions. Any plans that arise from these discussions will feature in future reports to the Board.
Impact on service users, carers and families	The report focuses on operational service delivery across all service lines
Partner organisations	The report refers to several areas of operation which are integrated within the wider system and makes mention of work we are undertaking with other organisations
Staff	The report outlines increased demand on services and therefore staff. All directorates keep this under review in terms of workforce planning. A number of initiatives are described that aim to develop and support staff further.
Additional information	Additional information regarding the performance data is available

1. Bed Recovery Programme

As part of the latest phase of this programme, we have commenced an MDT programme to support the workstream focused on optimising the use of our beds. The programme aims to address variation in length of stay between wards by focusing on MDT (Multidisciplinary Team) working across three pilot wards. The goal is to create a shared sense of purpose, understanding, and responsibility among team members. There are three phases to the work:

1. **Diagnostic Phase:** Collecting data on ward structure, staffing, and MDT meetings to understand the current state.
2. **Workshops:** Facilitated sessions to create shared agreements on MDT roles and responsibilities.
3. **Improvement Cycles:** Teams will agree on key areas to focus on and test improvements to address ward variations.

The key points are:

- An emphasis on collective ownership of challenges.
- Inclusion of all relevant MDT members, including care coordinators and senior managers.

- A focus on creating time for staff to engage in MDT work by reducing other meeting commitments.
- The Importance of supervision and reflective practice as part of the MDT process.

In addition, work is planned to understand the rise in formal admissions of people unknown to mental health services through ED. The approach will involve undertaking a quick analysis using available data to identify common themes and touchpoints. This includes triangulating data from various sources like GP surgeries and mental health practitioners. In the long-term we will consider a more detailed research project to understand the population and reasons for their admissions. We will explore a cross-directorate Qi (Quality Improvement) project to understand and address the reasons behind these admissions. The next step is to develop a process map to identify key areas for measurement and focus on collecting relevant data.

2. Neighbourhood Developments

It is understood that a case for change and a target operating model for a Neighbourhood Health Service in London are in the process of being drafted. The former will set out the economic and health disparities which are putting the NHS and Local Authorities under strain and restate how a shift to community-based community care based upon system collaboration, ensuring quality and sustainable social care will be crucial to the success of the plan which is intended to improve population health outcomes, support economic activity, and provide consistent, high-quality care for all Londoners, tailored to meet individual needs by leveraging existing resources and infrastructure to better serve the population and reduce health inequalities.

It is anticipated that the target operating model will further codify the “team of teams” approach to deliver this by enabling meaningful, co-ordinated working on a human scale, while affording the flexibility and authority to adapt and bring in specialist input where required. In the meantime

3. Standardising NHS ICB-funded Community Health Services

NHS England has published an overview of the core community health services that integrated care boards (ICBs), service providers and their partners should consider when planning services for their local population.

Standardising community health services describes the core components of NHS ICB-funded community health services for children, young people and adults across England. These services support people throughout their lives, from birth to the end of their life.

The hope is that, by defining and categorising community health services, ICBs and their partners will be able to measure demand, capacity, service activity and workforce more clearly and consistently. This will support improvements in designing, commissioning and delivering community health services for patients and carers. It is also intended to help systems make investment choices as they design neighbourhood health provision that shifts care to community-based settings.

4. Forensic Mental Health AWOLs

Since the beginning of the year, Forensic Mental Health Services have reported 4 patients unlawfully at large: one of these patients was residing at the TILT hostel, one is an inpatient in our low secure provision at the Memorial Hospital and the remaining two inpatients at the Bracton Centre. At the

time of writing, all but one of these patients are now accounted for. There is no discernible pattern to the incidents. In the case of the patients absent from the Bracton Centre, one was on unescorted leave to the local shop and the other absconded from Queen Elizabeth Hospital after being escorted to ED out of hours as he was experiencing chest pains. In neither case was use of the BUDDI system considered necessary, either because of the patient's risk profile (in the first case) or because of the urgent nature of the patient's physical health condition (coupled with the fact that the system is administered through a security contract which does not operate out of hours. Given this incident we will be reviewing that arrangement).

5. Directorate updates

Acute & Crisis Mental Health

The directorate is working on various initiatives aimed at placing patients and carers at the core of their operations. The goal is to ensure staff are skilled, competent, and spend ample time with patients and carers, thereby fully understanding their symptoms, personalities, and strengths. Leaders are expected to support and coach staff consistently, rather than defaulting to meetings.

January and February 2025 saw a rise in demand for mental health care, putting stress on resources. Norovirus outbreaks further strained the system by closing multiple wards to admission. Despite these challenges, inpatient staff, the Crisis Resolution and Home Treatment Team (CRHTT), and Liaison teams continued to provide impressive care. However staff sickness and absence have increased, depleting resources, and requiring attention to staff well-being.

Efforts are being made to support the medical staff workforce better, focusing on structured recruitment and retention to reduce dependence on locum medical staff. The target is set to cut agency spending across all professional groups by 30% and bank staff spending by 10%, emphasizing the need to address reliance on locum staff in 2025.

Community Mental Health

In July 2022, the Complex Care PPG approved funding of around £300,000 for each of the three Mental Health Trusts within the SLP to set up Complex Emotional Needs (CEN) services, aiming to limit the need for private specialist inpatient provisions and support individuals with Personality Disorder (PD). Oxleas Mental Health NHS Foundation Trust's team became operational in November 2023.

The CEN service focuses on personalized community services to facilitate transitions from acute services and support recovery. Key objectives include providing bespoke care packages and normalizing the service users' high-risk profiles.

Eligibility is for individuals with a personality disorder diagnosis who have had three or more admissions in the past 12 months and require specialist input after 30 days in a specialist inpatient unit. The service utilizes a trauma-informed care (TIC) approach and various therapeutic interventions.

Since starting, the CEN team has received 99 referrals, with over half deemed inappropriate, highlighting the need for clearer referral pathways. Nonetheless, the team has maintained a stable

caseload of around 30 active cases, with interventions predominantly led by the Occupational Therapist.

Initial analysis shows a positive trend in reducing occupied bed days and crisis contacts among CEN patients, indicating the service's impact on reducing acute admissions. However, prolonged engagement and the need for structured discharge planning are emphasized.

The future focus includes streamlining referral pathways, enhancing care planning and patient engagement, and expanding crisis prevention support. Further data collection and analysis will ensure equitable service provision and address barriers faced by diverse populations.

The service has made notable progress but requires more time to fully evaluate its impact. A review has been recommended to commence in November 2025 to provide a robust data set and assess the service's effectiveness.

Adult Learning Disability

In the Directorate's ongoing efforts to enhance physical health initiatives, two notable women's health projects have emerged: the Menopause Project and the Maternity Pathway. The Menopause Project, spearheaded by Jill Davies, Dr. Sarah Pape, and Stella Haddow-Mendez, aims to support women with intellectual disabilities through menopause by providing accessible and tailored information. The project has yielded positive results, with participants demonstrating improved understanding and self-advocacy. Future plans include expanding the sessions and raising awareness among GPs.

The Maternity Pathway project, a collaboration between Oxleas CLDT and Lewisham and Greenwich NHS Trust, focuses on creating a reasonably adjusted maternity pathway for people with learning disabilities. The project seeks to improve prenatal, pregnancy, and postnatal care by ensuring early identification, appropriate referrals, and seamless service provision between Maternity and LD services. Ongoing workstreams also address key physical health areas such as respiratory pathway, cardiac health, end-of-life care, nutrition, and constipation.

These initiatives highlight the Directorate's commitment to improving health outcomes for individuals with intellectual disabilities through specialized support and tailored interventions.

Adult Community Physical Health

In February 2025, the Home First services continued to address the pressures in local acute hospitals. Senior management engaged in the Better Care Fund development programme, focusing on discharge pathways at Queen Elizabeth Hospital. This initiative has led to the development of a transfer of care hub.

Notable achievements include the presentations by Bexley Rapid Response and Greenwich Frailty teams at the Trustwide Older People's conference resulting in an invitation by the keynote speaker to contribute to national discussions around integration; and the successful recruitment of a joint health and social care manager for the Joint Emergency Team in Greenwich. Environmental renovations are also underway at The Source in Horn Park to enable the expansion of services for the local population, which have been very well received.

Challenges persist, with a significant increase in demand, particularly in the district nursing service. Contract discussions for 2025/26 highlight the financial pressures and the need to manage services within budgeted capacity.

Developments include preparing our bid for the Greenwich MSK service tender (which was issued on 18 February and closes on 17 March) and continuing neighbourhood development programmes in Bexley, focusing on integrated support for residents with multiple long-term conditions.

Children & Young People

CYP has integrated the Patient Tracking List (PTL) into its governance, leading to improved wait times in both the Specialist and CAMHS Directorates, particularly with regard to RTT compliance. Ongoing collaboration with data services aims to enhance dashboards and automate metrics, with a Power BI pilot underway. All CIP targets for 24/25 have been met.

CYP has a low vacancy rate of 2.3%, with supervision, PDR, and training rates above target. A successful recruitment for the CYP Service Director role has taken place, with the new Director starting in April. An awards event in February celebrated long service and new joiners, receiving positive feedback. A joint away day with Oxleas and RBG Children's Services is planned to strengthen partnerships.

The CAMHS Sub-Directorate has made progress in reducing the longest assessment wait times, despite a slight increase in shorter wait times. The DBT service mitigation plan remains under review. The CAMHS Brief Intervention Home Treatment Team will launch in March 2025. The Greenwich redesign continues, with efforts to optimize services. New MHST leadership is in place, and a steering group oversees extended services. A pilot of myHappymind in Bexley primary schools received positive feedback. The Bexley CAMHS redesign was praised at the Oxleas Inspire event, and the Bromley JTAI inspection concluded with positive feedback. Discussions are ongoing to resolve estate challenges at Highpoint House and Park Crescent.

The Specialist Sub-Directorate has improved waiting times, with AHP RTT metrics above the 92% target for the first time in over two years. PTL waits have significantly decreased in Greenwich and Bexley Specialist Services since November 2024. ADHD and ASD wait times remain high, but improvement efforts are ongoing. The Greenwich Operational Manager has started in post, and recruitment for a new Service Manager is underway. The Audiology Service faces recruitment challenges and has an upcoming NHSE visit. Support is being provided to prepare for this visit. The Asthma Business Case is awaiting feedback, and the respiratory hub has seen 20 patients. The Greenwich Jaundice Business Case has been approved, and the Doccla technology pilot is collecting data. A Young Greenwich away day in February generated ideas for enhancing services, with positive feedback from partners.

Forensic Mental Health & Offender Healthcare

In Forensic Services, the co-produced Culture Review programme is underway with activities in all four programmes being taken forward with volunteers from the service.

The Forensics Directorate has undertaken an analysis of abuse and aggression incidents (Sept 2023-Sept 2024) to identify patterns, trends, and key insights into incidents occurring across various wards, locations, and patient categories. Relational security training is being rolled out across the Directorate and it is anticipated this will reduce incidents.

There has been a recent increase in patients within Forensic services being absent without leave and the Directorate is identifying learning related to these cases.

The bid for Liaison & Diversion and Male Mental Health Treatment Requirement services in south London as part of a London tender, is being led by Oxleas on behalf of SLP. The L&D bid has been submitted and we await the outcome and next steps. The tender for the re-procurement of supported step-down accommodation for adult forensic female service users at Mariposa House has closed with a contract award expected by April 2025. The bid for the LPP OPD Pathway Services Most Suitable Provider Process was submitted by Oxleas on behalf of LPP in January 2025. The FIND team consultation has concluded and the three South London partners are collaborating on the implementation plan for this service.

In Offender Healthcare there are several key developments for noting: At HMP Wandsworth the new purpose-built healthcare centre has opened with pharmacy and administrative functions on-site. Oxleas remains closely involved in the Urgent Notification (UN) Strategic Action Group to support HMPPS actions. There will be an Independent Review of Progress (IRP) against the UN actions on 31st March and 1st April, and plans are in place to collate information with a focus on healthcare enablement.

The mobilisation of integrated working across HMP Cookham Wood and HMP Rochester is progressing. We are discussing the planned cohort change at Cookham Wood to host a Category C, adult male (PCoSO) population with decants from other prisons in Kent, Surrey, Sussex and London commencing in April. The HMP Rochester action plan following the joint HMIP/CQC visit is being implemented with significant progress against all action areas.

In South West prisons, a consultation is underway with staff previously working at HMP Dartmoor. We are working closely with NHSE regarding the financial approach to the site closure. The IMB Annual Report for HMP The Verne was recently published and highlighted the excellent high quality care provided by Oxleas. There was some media interest in the report's recommendation for the development of an end of life unit to meet the needs of the ageing prison population.

Quality improvement action plans are being implemented at HMP Exeter, Bristol, and Erlestoke to address issues arising from inspections. The South West Prisons service delivery model continues to adapt to meet the population's needs - a Neurodiversity Lead post is currently out to advert in South West prisons to oversee neurodevelopmental service provision.

6. Performance Exceptions

There are a small number of exceptions highlighted in the performance and quality dashboards. These are:

- **8 performance metrics** have failed to meet their target for 4 out of the last 6 months.
    - **19248** Referral to Treatment – Incomplete Pathways
    - **11268** Referral to treatment – Allied Health Professionals

- **10024** Referral to Treatment – Psychological Therapies (PT)
- GTTT – NHS Talking Therapies: Completing Treatment
- **11849** Number of Out of Area bed days occupied in month WAA
- **11866** Length of Stay in Episode – WAA
- **11965** Number of Patients staying over 90 days – WAA
- Patients waiting longer than 72 hrs in ED

- **3 MHLOG Metrics** have failed to meet their target for 4 out of the last 6 months.
  - **10323** Mental Health Act – s132 compliance
  - **10004** Mental Health Act – s58 Consent to Treatment
  - HBPoS 24 hour breaches

Detailed reports setting out the reasons for the exceptions and the plans to address these have been discussed and reviewed by the Executive and further assurance provided to the Quality Committee. The Quality Committee has continued to receive positive exception reports.

Improving lives

NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 9
Enclosure 7

Subject	Non Executive Directors' reports
Author	Various
Accountable Director	Andrew George, Chair
Confidentiality/ FOI status	Public

What is the purpose of bringing this report to the board?	For the Board to note the non-executive directors' feedback from visits and trust activities
Are there any issues in the report that might cause upset?	There are references to racism and serious incidents
Link to trust strategy and integrated care system priorities	The non-executive director visits to services and participation in other trust activities provide the opportunity to engage with staff and service users on trust and system strategic priorities.
Glossary of terms/acronyms used in the report	A&E – Accident and Emergency AI – Artificial intelligence AMHP – Allied Mental Health Professionals BAFO – Building a fairer Oxleas CLDT – Community Learning Disability Team CMHRES – Community Mental Health Rehabilitation and Recovery Service CTO – Community Treatment Order DNACPR – Do not attempt cardiopulmonary resuscitation ED – Emergency Department FEES – Fibreoptic endoscopic evaluation FIND – Forensic Intellectual Neurodevelopmental Disabilities Community Service FTSU – Freedom to Speak UP ICS – Integrated care system HBPOS – Health based place of safety HTT – Home Treatment Team L&DCJT – Liaison and Diversion Criminal Justice Team LGT – Lewisham & Greenwich NHS Trust OT – Occupational therapy MDT – Multi disciplinary team MHAA – Mental Health Act Assessment MHLT – Mental health Liaison Team NFA – No fixed abode QE/QEH – Queen Elizabeth Hospital SaLT – Speech and Language Therapist SEL – South East London

	SLAM – South London and Maudsley NHS Foundation Trust SLP – South London Partnership SMT – Senior Management Team SPA – Single point of access VCSE – Voluntary, Community and Social Enterprise WTE – Whole time equivalent

Executive Summary	Several visits and participation in trust activities have been undertaken by Board members since the last Board meeting. At the March meeting, non-executive directors will share feedback from their visits and other trust activities. An action log is maintained of the issues raised which is monitored by our Head of Risk and Governance with the Executive team.

Analysis	
What risks/issues in the report need to be noted or acted upon?	The reports highlight some of the impacts for staff of difficulties in recruiting and the impact of violence on staff.
Quality implications	The reports include information on how teams are working to maintain and improve quality of services and reduce waiting times
Financial impact	The financial implications of some issues are raised
Equality analysis	Equality issues such as the trust's Building a Fairer Oxleas programme were discussed as well as dealing with incidents of racist abuse.
Net zero impact	The reports highlight some environmental issues that may have net zero impacts.
Impact on service users, carers and families	The reports consider impact on service users and carers.
Partner organisations	The reports consider impacts on partnership working and delivering services through partnership arrangements.
Staff	The reports consider impact on staff and highlight issues such as reducing violence and aggression or managing change effectively.
Additional information	Further details of the reports are available on request.

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Oxleas NHS

Template for Non-Executive Directors' board visits

Date of visit	Service	Attendees
18 November 2024	Bexley Community Mental Health Rehabilitation and Recovery Service (CMHRES)	Lorraine Regan (LR) Azara Mukhtar (AM)

Brief description of service

Service outline:
Bexley CMHRES offers a specialist multi-disciplinary service for individuals suffering with and recovering from severe and enduring mental health problems. We work closely with In-patient, Community teams and Primary Care Services.

The aim of the service is to promote independence in order for service users to move to independent or less supported accommodation, working with third sector providers in monitoring, by working collaboratively with service users, carers and family networks, in actively pursuing their goals and aspirations, whilst minimising the impact of their long-term mental health difficulties and fostering a culture of hope and empowerment.

Who we are:
We are a team of nursing staff, doctors, support workers, occupational therapist and psychologist. We offer intensive rehabilitation and enablement support to clients with mental health difficulties who have their own tenancy; are working towards moving to their own tenancy or stepping down from supported accommodation.

Overview of visit

We met with a good cross section of the team with representatives from all professions, the team manager was on leave and so the service manager attended.

Capacity and caseload of 45 clients.

We discussed the psychology vacancy at length. Prior to the current vacancy the post was 8A a 50:50 1 wte post shared with Barefoot Lodge. When the post holder left Barefoot Lodge went with another way of filling their vacancy leaving a difficult to recruit to 0.5wte post. The Bexley CMHRES vacancy is now covered by a senior psychologist 8B 1 day a week ie 0.2wte and a 0.6wte B7 psychologist. The team is looking to develop the B7 via preceptorship into an 8A. The issue came about due to the move from borough to service line reporting and the split of the directorates in which the previous incumbent was working. Psychology is a hard to recruit

specialty due to the lack of a national pool of candidates and as such a piecemeal approach to recruitment over what can be posts services a number of different specialties can be problematic and result in stranded wtes that are difficult to recruit to. We discussed the piecemeal workforce planning for this group of staff and explored the idea of a Trustwide workforce strategy.

See lots of clients with personality disorders and lots of blocking from clients who need ongoing clozapine/depos who primary care will not accept clients even once stabilised. CTO recall is another problem area with one client taking 6 months to locate. As AM and LR had recently visited Bromley CMHRES who had some similar issues but also some solutions we discussed how regularly all 3 teams met to discuss and possibly resolve issues or provide mutual aid. To date this was not regularly featuring.

We explored some contentious family dynamics which can make providing services to service users challenging. The team have had some service users on the caseload for 9 years when the model of rehabilitation is 2 years. The key was to build family trust but this is time-consuming and challenging in certain cases.

AM explored some of the issue re such as racism from carers of service users with the team as this was something the Trust took very seriously and should not be something our staff are exposed to. This could be challenging and upsetting for staff but as it was not from service users the team did not feel that they could refuse service as the service users did not exhibit this behaviour. The impact on staff was covered in reflective practice. We had a discussion about a number of initiatives that may help ,from clear paperwork or a policy on this issue from the Trust, to making behaviour expectations clear for both service users and carers at the point of the initial assessment. It could be a possible QI project and LR thought that there was already a policy on this but would check.

A further issue was about neighbours of service users complaining to staff about service users and not wanting them in their neighbourhood. The team advocated for their service users in these circumstances. There are still stigmas for people with MH conditions and the team highlighted a chaplain in the community who has been trying to break down this stigma in the community.

Lastly the team talked through the issue of Older Adult patients who could not be discharged from the caseload as the Older Adults team would not take patients who did not have dementia.

The team overall were dedicated to their service users but did have a range of challenges that were explored during the visit.

Actions will be reviewed regularly by service directors and a board visits action tracker will be used to monitor progress

Issues raised	Action	Assigned To	Deadline
Difficulty of recruiting to part time psychologist role	Consider Psychologist Trustwide workforce plan given the models and job plans of psychologists who may work across different teams	Neil Springham	December 25
Issues of fragile services or workload which are difficult to manage with in borough teams	Hold regular team meetings with other CMHRES across the Trust to learn from others and perhaps get support	Three borough CMHRES managers	March 2025

The team highlighted racist behaviour from carers of their service users and felt unable to challenge or change this	Team were unsure of anti racism policy or if this existed re racist behaviour and whether this covered carers • Check current policy • Consider covering behaviour requirements of carers as well as service users at initial assessment making clear consequence of breaches. This may be a QI project	Service Manger	February 2025

Improving lives

Oxleas NHS

Non-Executive Directors' board visits

Date of visit	Service	Attendees
29 November 2024	Acute & Crisis Directorates Oaktree Lodge Memorial Hospital Shooters Hill London SE18 3RZ	Sophy Proctor (SP) Iain Dimond (ID) Rachel Evans (RE) Peter DeBacker (PD) Claire Tobias (CT) – Operational Manager Janet Folasire (JF) – Oaktree Ward Manager <u>Apologies:</u> Aisling Clifford (AC) – Service Director Maggie Miller (MM) – Service Manager Naidoo Armoordon (NA) – Head of Nursing

Brief description of service
Oaktree Lodge Originally commissioned as a 17-bed inpatient unit for continuing care for older people with complex functional mental health needs and long-term conditions. The clinical model was updated in 2023/24 and focusses on a needs led service for people with enduring functional mental health conditions and who have either complex physical health or long term conditions, and who are frail. Five beds are currently allocated for purposes of income generation; however, this offer is currently paused and is affected by Low Volume Activity rules. We are promoting Oaktree with other Trusts who may be interested in block purchasing our beds.

Overview of visit
The Management team shared the progress made with implementing the new model. Significantly the admission criteria is no longer age based leading to a greater mix of age ranges as well as in clinical conditions. This has required adaptability amongst the staff group, and significant preparation, and training before new admissions but the team had proved very willing and had seen tangible improvements in some patients following their admission. Admission is expected to be for no longer than 2 years and robust plans are developed at an early stage in preparation for discharge. Although finding suitable placements is a challenge 2 patients have now been discharged and 2 are on leave. A recent incident involving a patient who had been on the unit for many years has impacted heavily on the staff who knew her well. They had remained in touch with the family following the incident.

The unit was in good condition, and provided a light airy environment with an accessible and recently upgraded garden area which is maintained by volunteers and well used in the summer. There is supportive interaction between Oaktree Lodge, and Hazelwood and Greenwood units which are adjacent.

The staff group were highly committed, very happy working on the unit and enjoyed caring for their patients. The impact of the Low Activity Rules on income generation related to 5 beds, had been shared with staff who were anxious that this would lead to the unit closing and were seeking clarity and certainty.

A commitment was made to maintaining an honest and open dialogue, and ensuring staff are communicated with as soon as a decision is made. Any decision would be based on whether there are patients who need the service. The clear model and excellent work undertaken by the team was commended.

The staff expressed their pride in the personalised care they delivered and their embedded approach to engaging families, who were regularly updated on their relatives' care, invited to ward rounds and with whom sensitive discussions regarding death were initiated when necessary.

Staff described the small but significant improvements they had seen in patients, with a diverse range of conditions, who had not made progress elsewhere. A range of professionals attend the unit to deliver care including GP's, optician, and chiropodist, and staff had trained to enable them to take blood samples etc rather than patients having to attend hospital and potentially wait for long periods. Trips out took place including to the pub, for meals and shopping.

There was some anxiety expressed about moving to long shifts, but views differed amongst the staff group and a 6-month review had been promised post implementation.

The commitment and passion amongst this staff group for the work of the unit was clear and Janet who was considered to provide exemplary leadership, was greatly valued.

Actions will be entered on to Board visits action tracker which will be reviewed at Board every six months.

Issues raised	Action	Assigned To	Deadline
None noted			

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Oxleas NHS

Template for Non-Executive Directors' board visits

Date of visit	Service	Attendees
13 January 2025	Bexley ICMP	Lorraine Regan (LR) Azara Mukhtar (AM)

Brief description of service

Service Outline: Bexley ICMP

Overview: Bexley ICMP is a multi-disciplinary service dedicated to supporting individuals recovering from severe and enduring mental health issues, specifically psychosis and bipolar affective disorder. The service works collaboratively with in-patient, crisis, community teams, and primary care services to provide comprehensive care.

Service Aim: The primary aim of the service is to support clients in promoting their independence and helping them progress with their lives. This is achieved through a recovery-based approach that emphasises collaboration with service users, their support networks, and the third sector.

Overview of visit

LR and AM met a cross section of staff from the team including representatives from each discipline of the team.

The team stated that they look after the most mentally ill patients in the borough. We discussed the clozapine and depot caseload of patients that were retained within the service as they could not be discharged back to primary care. The personality disorder and psychosis patients were retained from the trust previous assertive outreach service which was transitioned away from in 2015. The team has an MDT approach and about half of the team is dealing with the patients on the old assertive outreach programme.

The main caseload is from the most deprived areas of the borough, Erith and Belvedere as opposed to the more affluent south of the A2. The more deprived areas match areas in Greenwich and Thamesmead and Sidcup have higher population who are Black, Asian and

Minority Ethnic with higher needs. There has been increase in population in the borough which has resulted in greater need. The current caseload has more males than females with c 20-30% Black, Asian and Minority Ethnic . The team is trying to capture ethnicity of clients and are asking GPs to include this information on the referral. Trauma is a significant issue for clients and has strong links to psychosis. We discussed intergenerational trauma and inherited inequalities in the client group. There was also an issue with drug and alcohol use linked to the psychosis. There were 700 people of the caseload at the peak. The team is now working with GPs on medicine optimisation and the current caseload is 480, c180 on clozapine or depot, 50 on Community Treatment Orders (CTOs).

The team shared a number of challenges. Recruitment continues to be an issue. Medical staffing is better as they now have 2 consultants. B6 CPNs have the most vacancies and there is some cover with B7 and B5 nurses. Social worker gaps/agency are an ogoing challenge for the service. OTs are moving around to address needs and there has been lots of good work in the last 6 months here.

The team has a number of ASD clients, they are keen to get some specific autism training for the team, they had approached our Oxleas ASD team who have limited capacity and provide specific sessions at QMH, as the team want a whole team approach Lorraine agreed to look at securing external training.

Overall the client base has more physical health needs, due to the nature of long term SMI that the tram need to address, the team highlighted weight issues and diabetes as two common issues. The team use Agile Physical Health Intervention Team (APHIP) who are currently working across all community MH teams but recognise more support would be useful.

The team highlighted they felt the SLAM substance misuse team should be more assertive in their outreach. LR will discuss issues with Carl Knopp who leads Co occurring Misuse of Alcohol and Drugs (COMAD) services for the whole of Bexley. The team highlighted that drugs and alcohol abuse was often the root cause of incidents which resulted in calls to police. There were incidents of verbal abuse from clients which had resulted in clients being discharged from GPs and that a more system approach was required.

Older adult clients can't be discharged so the team is now also dealing with clients with dementia. The social worker in the team felt that they were doing more non social worker work as they were picking up issues which were not related to their core role. For these older clients it felt like the ICMP team was the "dumping ground" for clients that nobody else wanted to deal with. LR said the team should be escalating any clients over the age of 75. A suggestion that clustering client needs to understand the resource input required from other services and the system.

The admin team raised that over the Xmas period they did not feel they had a consultant to escalate any issues to. LR stated that there was a roster of on call consultants as well as on call managers and directors over that period that the team could access if they had any issues. Also that the admin team should have the link with the MLO who would identify the consultants covering.

Lastly the CTA team said they had been requested to make 50 visits each week across the team and needed an easier way to submit expenses. AM said she would raise the expenses issue with their team.

LR and AM thanked the team for their time and for all the work that they were doing.

Actions will be reviewed regularly by service directors and a board visits action tracker will be used to monitor progress

Issues raised	Action	Assigned To	Deadline
Team felt they needed Autism training	Review with Oxleas ASD team and then consider bringing in external training	Lorraine Regan	March 2025
SLAM drug and Alcohol service lacks responsiveness and does limited outreach	Discussion with Carl Knopp in the first instance before raising at contract board	Lorraine Regan	March 2025
Team find it very time consuming and difficult submitting travel expenses	Discuss with finance team	Azara Mukhtar	March 2025

Improving lives

Oxleas NHS

Template for Non-Executive Directors' board visits

Date of visit	Service	Attendees
30 January 2025	Greenwich Learning Disability Team	Lorraine Regan Muneeza Aumir

Brief description of service

Service outline:

Greenwich Community Learning Disability Team (CLDT) is an integrated health and social care team supporting individuals with learning disabilities in the borough of Greenwich. The social care component of the team is provided by Royal Borough of Greenwich. The service has three pathways within the structure of the team, Preparing for Adulthood, Complex Physical Health and Challenging behaviour and Mental Health. Each of the pathways is integrated in their approach to and contains both health and social care staff.

The preparing for adulthood pathway supports individuals from aged 16 through to adulthood transitioning them through from children's services into adult services. The complex physical health pathway supports individuals from aged 18 upwards with associated co-morbid health conditions and the Challenging behaviour and mental health pathway supports individuals from aged 18 upwards with either mental health concerns or behaviour that can challenge services or a combination of both.

The purpose of the CLDT is to provide specialist health and social care services to people with learning disabilities and their carers whose lives and needs are so complex that universal services are unable to meet their needs.

The CLDT operates a Single Point of Access (SPA). This is a one-stop integrated administration, referral and duty point into adult CLDT. This is a multi-disciplinary service that will ensure that service users and carers receive an efficient and timely response when accessing CLDT or needing advice, support, and signposting. The SPA provides a streamlined and centralised entry point to the CLDT. It ensures that all emergency, urgent and routine referrals are processed and responded to in a timely way.

The service has been involved with some highly innovative projects since the end of the covid-19 pandemic, these have included the Heart and Soul project, Fun and Fitness project, Let's Talk about sexuality group, No Barriers Here Project, and the anti-discriminatory forum for staff.

Overview of visit

We started the visit meeting with the team manager who provided an overview of the teams work and current issues. This was a very positive report, with some recruitment issues raises as the only area of concern.
We then met with a group of staff from the Complex Physical Health team, they showcased some projects they have been involved in including work around DNACPR and End of life. When discussing challenges they raised the challenges staff have completing travel expenses, two members said they never claim because the system is so difficult.
Finally, we spoke with staff from the Mental Health and challenging behaviour team. This included the new Team Psychiatrist who spoke about how welcoming and supportive the team had been as had the wider OXleas organisation, other staff echoed the culture at Oxleas being the main reason they stay and talked about colleagues that have left and then returned.
They talked about relationships with other OXleas teams being broadly positive with some challenges experienced in relation to individual cases.
We heard some good work showcased including family work, groups and some positive outcomes.

There were no actions raised at the visit.

Actions will be reviewed regularly by service directors and a board visits action tracker will be used to monitor progress

Improving lives

Oxleas NHS

Non-Executive Directors' board visits

Date of visit	Service	Attendees
24 February 2025	Greenwood and Hazelwood Memorial Hospital	Jo Stimpson, Non-Executive Director Jane Wells, Chief Nursing Officer Aisling Thompson, Service Director Dr Harneet Hundal, Clinical Director

Brief description of service

Greenwood and Hazelwood provide care for men with complex mental health needs and challenging behaviour in a low secure, controlled environment. Greenwich provides 16 rehabilitation beds. Hazlewood provides 15 acute beds. Both units are located on the Memorial Hospital site, several miles from the medium secure wards at the Bracton Centre. The focus is on stabilising mental health, reducing risks and preparing patients for transitions to less secure settings through a combination on medication, therapy and support.

Overview of visit

Greenwood

The team were proud of their rehabilitation ethos supporting service users with meaningful personalised goals based on their individual needs and management of their risks. They are working hard to create the least restrictive practice and have been reviewing practices that no longer support this. Service users are encouraged to support this and participate and bring issues to the daily huddles. The huddles are valued and held in the morning everyday and through out the day as needed. The team continue to balance the gender mix of staff. There is a weekly one-day wellbeing clinics, well utilised activities kitchen and access to a gym.

A key challenge recently has been the physical security of the building. A design fault has been identified on the front door in respect of the sensors and an issue relating to the override system for the internal door. Unlike the Bracton, the wards open externally rather than to an internal environment. A new design to the doors is being carried out this week and, in the meantime, mitigations are in place always including a member of staff in reception by the front door. The same is being applied to the Hazlewood entrance.

A further issue which the team would like support with work planned to address the ventilation and temperature control in staff areas including the nurses' station and ward managers office. The manager's office is also awaiting a vent. There was a request to follow this up.

Hazelwood

The team were proud of their multidisciplinary ethos, which was reflected by new team members as being much more established than in some areas where they had previously worked, and gave good job satisfaction. It includes doctors, nurses, psychologist and assistant, occupational therapist and helpful a proactive pharmacist. As an acute ward in the South London Partnership pathway, but one that is not located with other acute wards, they take great care to assess the suitability of admissions and the mix with existing service users. They acknowledge that despite proactive risk mitigations the ward can be unpredictable and quickly shift from being calm to very acute.

They have recently overcome some challenges getting consistent transport for their service users for psychology held in the William Morris Centre through introducing volunteer drivers. The team

are managing several long-term sicknesses but have seen positive improvements in gender mix of staff. A key challenge is contraband items, and they have established systems to identify and reduce risks. Due to the location in Woolwich, the team must liaise with the Met Police, in addition to Kent Police who cover the Bracton Centre.

The issues of service users not being registered with a general practitioner is ongoing and causing delays in access to secondary physical health services for routine tests. The SLP continue to raise this with NHSE and there are plans to locally make direct contact with local general practitioners.

The team raised worries about staffing numbers and lack of support available from other wards which is established in the set up at the Bracton. As a result, if staff must leave the ward, such as to escort a service user to a hospital, when remaining staff take a break, the number of staff feels low. This is being reviewed through safer staffing establishment meetings.

The team also raised the issue of not having the dates that work planned to address the ventilation and temperature control in staff areas including the nurses' station and the meeting room will be carried out. The zip tap is broken in the patient area. There was a request to follow this up.

Actions will be reviewed regularly by service directors and a board visits action tracker will be used to monitor progress.

Issues raised	Action	Assigned To	Deadline
Follow up estates work on temperature and air conditioning issues reported	Monitor estates work progress through the Forensic Environment and Estates Group (FEEG). Update from last FEEG meeting provided on 26/02/25: **Hazelwood** MDT room is being reviewed during February. Work on heating was completed 10/2/25, temperatures are being monitored and manager has been advised to contact Rydons if the temperature drops to below an agreed level. The temperature in the conference room has been monitored closely and data shows it reaches the threshold for air conditioning. Plans to address need to be made. **Greenwood** Air Vent in Nursing Station/managers office not working- repaired 7/10/24 Restrictor bar in window reducing air circulation -gap increased 11/6/24 FEEG to be asked to review.	Aisling Thompson	30/03/2025

NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 10
Enclosure 8

Subject	Quality Committee Report
Author	Vicky Woods, Director of Quality Simon Henley-Castleden, Director of Performance
Accountable Director	Iain Dimond, Chief Operating Officer Suzanne Shale, Non-Executive Director
Confidentiality/ FOI status	Public

What is the purpose of bringing this report to the Board meeting?	To alert, assure and advise the Board.
Are there any issues in the report that might cause upset?	The report may contain references to long waiting times, harms (including self-harm and death), patient safety incidents such as violence and abuse and mortality reviews which may cause upset.
Link to trust strategy and integrated care system priorities	Quality committee links with all three key priorities and all eight building blocks of the strategy. In addition, the Trust annual quality priorities.
Glossary of terms/acronyms used in the report	• **ADHD**: Attention Deficit Hyperactivity Disorder • **CEG**: Clinical Effectiveness Group • **CQC**: Care Quality Commission • **CTO**: Community Treatment Orders • **DNA**: Did Not Attend • **Exec**: Executive • **FFT**: Friends and Family Test • **GSTT**: Guy's and St Thomas' NHS Foundation Trust • **HMIP**: Her Majesty's Inspectorate of Prisons • **ICMP**: Integrated Care Management Program • **ILR**: Improving Lives Review • **MHLOG**: Mental Health Law Operations Group • **NED**: Non-Executive Director • **NIHR**: National Institute for Health Research • **PERT**: Pancreatic Enzyme Replacement Therapy • **PNA**: Professional Nurse Advocate • **PSG**: Patient Safety Group • **PSIRF**: Patient Safety Incident Response Framework • **QAOG**: Quality Assurance Oversight Group

Improving lives

NHS Oxleas NHS Foundation Trust

Quality Committee meeting Key issues report			
Report date: 24/02/2025		**Report of**: Quality Committee	
Date of meeting		15 January 2025	19 February 2025
Membership numbers:		6/ 8 (3 NED, 3 Exec)	6 / 8 (2 NED, 4 Exec)
Quoracy met		Yes 75%	Yes 75%
1	**Agenda**	The Quality Committee continues to meet monthly. The Quality Committee considered the two agendas, which are attached.	
2a	**Alert**	The Quality Committee wish to alert members of the Board that: **A) Acute and Crisis Directorate:** In November 2024, the Care Quality Commission (CQC) received concerns from carers, patients, and staff regarding the Woodlands Unit, specifically Lesney and Millbrook working age adult mental health wards. An Improving Lives Review (ILR) conducted on Norman Ward identified similar quality concerns. **Action:** A robust internal review was undertaken for these wards. A must do action plan was developed and implemented by the directorate to resolve the immediate safety concerns. Progress is being monitored weekly by the directorate and monthly at the QAOG. All actions except the 2 estates issues have been completed. An overarching support package is being developed by the quality, OD, Nursing teams and directorate SMT to address the individual needs of each ward. The committee will be updated on the progress of the improvement plans on a quarterly basis. **B) Adult Community Mental Health Services:** The committee would like to alert the Board regarding the positive achievements and innovation within the directorate, especially the ADHD service improvements (they won the Royal College Award for team of the year), the Dragons' Den initiative and the Rough Sleeping Team which is demonstrating significant positive impact on health outcomes for rough sleepers. **C) Mental Health Hubs:** They are facing significant demand and capacity challenges, which is impacting their ability to be responsive. This was reflected in their self-assessment scores, presented to the committee. • **High Demand**: The mental health hubs are experiencing significant demand, which is impacting their ability to be responsive. This demand includes both mental illness and cases where individuals are experiencing mental distress. Demand has been increasing over the last 4 years • **Resource Challenges**: There is a need to balance resources to ensure that the most unwell patients are not left lacking while also contributing to neighbourhood team development. • **Unmet Need**: The hubs have identified a vast amount of unmet need in the community, which has contributed to the high demand. • **Capacity Issues**: The current capacity of the hubs is being stretched, and there is a need to find additional resources to address the demand.	

		Action: There is an ongoing review to determine the resources needed to address the demand experienced by the hubs. Efforts are being made to manage the demand more effectively, including understanding the prevalence of mental distress and its impact on services.

2b	**Assurance**	The Quality Committee wish to assure members of the Board that:
		
		A) Directorate Updates
		
		Offender Healthcare Directorate: In January, the committee sought assurance from the Offender Healthcare directorate and reviewed their self-assessment scores as agreed by the Quality Assurance Oversight Group including key issues, and improvements.
		
		Key Highlights:
		• Mental Health Transfers: There are ongoing efforts to meet the 28-day expectation for transferring prisoners to secure mental health settings within our southeast prisons. Currently, 39% of transfers meet this target, with a focus on improving this through a mental health action group and regular monitoring.
		• Regional Updates:
		  ○ London and South-East: A comprehensive action plan for Wandsworth is in place, with a new healthcare facility opened in January. An Associate Director post covering London and Kent has been recruited to.
		  ○ South-West: Challenges remain with remand prisons, particularly in HMP Bristol, but there is a continued focus on safety and learning culture.
		• Initiatives: The directorate is implementing several initiatives, including immediate life support training, trauma and risk management training, and a self-harm reduction trial at HMP Wandsworth.
		• Research Projects: Collaboration with Oxford University on a risk assessment tool to reduce suicide and self-harm among prisoners, and a new trial of enhanced skills training for complex PTSD with the University of Glasgow.
		• Staffing and Recruitment: Staffing remains a challenge, but improvements are being seen, particularly in the South-West, with efforts such as geofencing to attract applicants.
		• Governance: The directorate has undergone a review of its current governance processes and is implementing significant changes to ensure robust processes are in place, that are harmonised across the whole directorate.
		
		In summary, the committee acknowledged the challenges, but noted the increasingly positive picture across offender healthcare, particularly in the South-West, and the improvement and research work being undertaken.
		
		Adult Community Mental Health Directorate: In February, the committee sought assurance from the Adult Community Mental Health Directorate and reviewed their self-assessment scores as agreed by Quality Assurance Oversight Group, key issues, and improvements.
		
		Key Highlights:
		• Nottingham Review Response: this highlights issues in psychosis provision, prompting a gap analysis and action plan. The Nottinghamshire review identified high caseloads in psychosis teams, particularly in ICMPs and specific gaps in care and risk management. Actions are being taken to address these issues, including creating one-

page guides for non-engagement and family involvement; plans to operationalise a depot step down service to manage stable patients on depots separately from ICMP (to aim to reduce caseloads); evaluation of the care teams approach showed positive results, including increased patient contacts and reduced hospital admissions so it is proposed to roll out care teams to the full caseload, with adjustments to prevent staff burnout.

- The committee heard about a number of positive and creative staff initiatives and achievements in face of the very high demand in the directorate
- Challenges: Developing the actions and plans following the Psychosis audit whilst there is uncertainty around funding and national core standards; delivering change programmes whilst keeping the day-to-day work going; neighbourhood developments in the context of ensuring appropriate Mental Health input and realistic expectations.
- Summary: The presentation highlighted significant efforts to address high caseloads, improve patient engagement, and manage funding uncertainties, with notable successes in ADHD services and support for rough sleepers. Additional discussions emphasised the importance of family involvement, addressing broader homelessness issues, the need to address Community treatment orders (CTO) effectiveness and potential increase in use due to defensive practices; and improving how staff locate and understand operational policies.

B) Patient Safety Group Chair's Report

Key Highlights:

- Ligature Incidents: Slight increase in ligature incidents over the reporting year 2023-2024, with around 75% of these incidents occurring in prisons.
- Ligature Management: All audits are up to date, and necessary mitigations and estate works are being implemented to manage ligature risks.
- Duty of Candour: Ongoing review of the duty of candour practices to ensure compliance with cultural and training requirements.
- Metrics Scrutiny: Continued assurance around the scrutiny of patient safety metrics, with improvement plans in place for areas not meeting targets. Variability between teams in achieving patient safety metrics, with some teams showing significant improvements
- Sleep Study: Consideration of engaging in a randomized controlled trial on sleep within the acute mental health wards.
- The Strategy Update on the patient safety core commitment: This highlighted the need to shift focus from inputs to measurable outcomes. Assurance was provided through progress in the PNA program and the domestic abuse strategy. Alignment with the Great Care strategy and further consideration of PSIRF metrics was advised. This was the first time the report was received in this form so the committee considered how it could be most informative in future.

C) Medicines Management Update:

Key Highlights:

- Medication Shortages: Ongoing shortages of medications such as pancreatic enzyme replacement therapy (PERT) and various strengths of quetiapine, which may impact patient care. Continue to log and monitor any harm caused by medication shortages and work with regional medical directors to address these issues.
- Controlled Drugs Audit: Actions are being taken to address concerns raised in the controlled drugs audit within the district nursing service, with a re-audit scheduled for April 2025.

- Rapid Tranquillization: Significant improvement in post-tranquillization physical health observations, particularly respiratory rate monitoring, primarily due to changes in the way data are collected.

D) Clinical Effectiveness Group Update:

Key Highlights:

- Research Developments: Successful recruitment for NIHR studies and the establishment of a hub and spoke model for commercial research with GSTT, with Oxleas as a spoke.
- The dashboard and metrics are still being reviewed, and data validation is ongoing. Improvement plans are being developed for areas with difficulties, mainly around care planning and outcomes.
- Knowledge and Library Services: Improvements in library services, including the identification of new spaces and the purchase of required books, to support staff needs.
- Power BI Implementation: Introduction of Power BI to allow teams to analyse their data, including outcomes and care planning, with a focus on protected characteristics.

E) Patient Experience Group Update: There are currently 20 Patient Experience Metrics on iFOx. Of these, two metrics were highlighted to the committee as exceptions.

a. Mental Health positive responses ("good/very good") to the Friends and Family Test (FFT) question "Overall, how was your experience of this service?" Trust average 83% against 90% target
b. Physical Health positive responses ("good/very good") to the FFT question "Overall, how was your experience of this service?" – Trust average 90% against 95% target

Although the proportion of FFT positive responses is not meeting the target for physical health/mental health, the proportion of negative response ("poor/very poor") is consistently exceeding the target of <5%/<10% respectively. The committee was advised of the actions the directorates were taking to increase responses with regard to both patient and carer surveys and improvement plans such as roll out of family inclusive training, Dialog+ and Life beyond the cubicle.

F) Quality Assurance Regulatory Update: Assurance was provided regarding the positive progress within the Devon prisons, HMP Bristol (91% recruitment fill, with no vacancies in primary care) and the positive feedback for healthcare from the recent HMIP/CQC inspection at HMP Guys Marsh, despite the challenges around safety and illicit substance misuse within the prison.

G) Performance Update: 8 performance metrics have failed to meet their target for 4 out of the last 6 months.

- **19248** Referral to Treatment – Incomplete Pathways
- **11268** Referral to treatment – Allied Health Professionals
- **10024** Referral to Treatment – Psychological Therapies (PT)
- GTTT – NHS Talking Therapies: Completing Treatment
- **11849** Number of Out of Area bed days occupied in month WAA
- **11866** Length of Stay in Episode – WAA
- **11965** Number of Patients staying over 90 days – WAA
- Patients waiting longer than 72 hrs in ED

		• **3 MHLOG Metrics** have failed to meet their target for 4 out of the last 6 months.
		  ○ **10323** Mental Health Act – s132 compliance
		  ○ **10004** Mental Health Act – s58 Consent to Treatment
		  ○ HBPoS 24 hour breaches
		
		H) MHLOG Quarterly Update: The MHLOG update highlighted a notable increase in the number of people being detained under the Mental Health Act. The digitalisation of the Mental Health Act is set to go live on 25 March 2025, with training available and minimal go-live issues anticipated. Assurance is provided through the progress in digitalization and the focused oversight of the Assisted Dying Bill (summary in the 'advise' section of the report). The committee emphasised the need to ensure staff engagement in training for the E-Mental Health Act to ensure a smooth transition onto the new digital platform.

2c	**Advise**	The Quality Committee wish to advise members of the Board that: **A) Improvement Focus: Sexual safety -** The presentation covered data from 2021 to 2024, showing an increase in sexual safety incidents, particularly in the Acute and Crisis, Forensic and Offender Healthcare Directorates. Most incidents occurred in communal areas of inpatient wards, where staff reported feeling uncomfortable and unsafe due to inappropriate comments from patients. An anonymous staff survey revealed that 23% of respondents did not feel comfortable discussing sexual safety with patients, citing reasons such as lack of training and cultural differences. However, 88% of respondents did not experience any form of sexual harm at work, although there is a need for extra training and information. Completed sexual safety work includes signing up to the NHS England Sexual Safety Charter, circulating posters, implementing ward charters, and conducting webinars and learning events. The impact of sexual safety work so far includes increased awareness among staff and patients and understanding of the importance of reporting incidents, identification of training gaps, and positive feedback from staff on the open discussion of the topic. Ongoing work involves developing a Sexual Misconduct Policy, e-learning modules, and a communications campaign. B) **Assisted Dying Bill -** The Assisted Dying Bill is currently under review, with significant changes being proposed, including the removal of the requirement for a judge's involvement. The bill's implications for clinical staff, particularly around the discomfort and ethical considerations of being involved in assisted dying, were discussed by the committee. The committee expressed the need for clear policies and standard operating procedures for deaths occurring in inpatient units to ensure staff are well-prepared and informed and the importance of ongoing discussions and awareness-raising within the trust and the broader healthcare system about the potential implications of the bill. The bill will continue to be monitored, and updates will be provided to the Clinical Effectiveness Group as more information becomes available**.** **C) Equalities Delivery System Report 2024:** The committee provided their approval of the quality elements of the Equality Delivery System report 2024, which is a joint submission by Oxleas, the Royal Borough of Greenwich (RBG), and the Southeast London Integrated Care Board (SEL ICB). The report addresses health inequalities

		across services. The report will be published in early March 2025 to comply with the Public Sector Equality Duty and will also be approved by People Committee.
2d	**Review of risks**	The committee reviewed the following risks: • **2472:** Harm to triangle of care due to poor communication: the Committee agreed that it would be more effective to monitor this risk in the Quality Committee rather than the BAF, with progress on the risk to be reported as part of 'great care'. • **2177:** Offender healthcare service quality (Southwest): the Committee agreed this risk should be reduced and removed from the BAF and potentially re-framed as a global risk in light of the increasing external issues challenging the delivery of high-quality healthcare across all prisons. This was due to the significant assurance provided to the committee via the offender healthcare feedback and quality assurance update on the improvements within the south west prisons.
2e	**Sharing of learning**	**Improvement Focus:** Welcome to Healthcare - Patient Information Packs were presented to the committee in February. This improvement project was a scale up and spread initiative following its successful implementation in the Forensic directorate to address patient and staff feedback and support reducing the did not attend (DNA) rates. The initiative aims to enhance patient understanding and engagement with healthcare services in prisons, promoting better health outcomes and operational efficiency, by codesigning clear and accessible information to patients about the healthcare services available in prisons.
3	**Actions/implications to be considered by the Board**	There is a potential impact on patient safety, poorer outcomes, and experience of care due to long waiting times and reduced staffing levels in some services.
4	**Report compiled by:** Suzanne Shale – NED (Chair) Vicky Woods – Director of Quality (co-compiled the report) Simon Henley-Castleden – Director of performance (co-compiled the report) **Minutes available from:** Vicky Woods - Director of Quality (included within Board pack) **Reports provided in the reading room:** • Operational Performance Pack • Directorate presentations for Offender Health and Adult Community Mental Health directorates	

Quality Committee

Wednesday 15th January 2025

9.30am-12.30pm, MS teams

AGENDA

ITEM		ACTION	PRESENTED BY	ENC
1	**Apologies for absence and declarations of interest**	To note	Suzanne Shale Chair	-
2 5 mins	**Minutes of last meeting**	To approve	Suzanne Shale Chair	**1**

3 5 mins	**Matters arising** • Action tracker	To note	Suzanne Shale Chair	**2**
STRATEGIC FOCUS - GREAT CARE, TIMELY CARE, EQUITY				
4 30 mins	**Directorate quality update** • Offender Healthcare	Alert, Advise and Assure	Aisling Thompson Service Director Peter Stevens Clinical Director	**3**
STRATEGIC FOCUS – GREAT CARE, TIMELY CARE				
5 20 mins	**Improvement focus** • Sexual safety survey	To note	Juliette Feddon Patient Safety Incident Investigator and Inquest Assistant	**4**
6 30 mins	**Operational Performance & MHLOG Dashboards** • Exception reports • Bed recovery plan	Alert, Advise and Assure	Iain Dimond Chief Operating Officer	**5**
Break – 10 mins				
STRATEGIC FOCUS – STRONG PATIENT & CARER VOICE				
7 10 mins	**Patient Experience** • PEG Chair's report	Alert, Advise and Assure	Neil Springham Chief Therapies Officer	**6**
STRATEGIC FOCUS - GREAT CARE, AND A SAFETY & LEARNING CULTURE				
8 15 mins	**Quality assurance regulatory update** • QA regulatory update	Agree	Vicky Woods Director of Quality	**7**
9 30 mins	**Patient Safety Group** • PSG chairs report • Food & drink strategy (verbal update)	Alert, Advise and Assure	Jane Wells Chief Nursing Officer	**8**
10 15 mins	**Risk Register**	Alert, Advise and Assure	Abi Fadipe Chief Medical Officer	**9**
COMMITTEE EFFECTIVENESS AND OTHER BUSINESS				
11 5 mins	**Strategic reflection** • What barriers have we seen to achieving our strategic aims?	To consider	Suzanne Shale Chair	-
12 5 mins	**Items to report to the Board of Directors** • Alert, Assure, Advise	To agree	Suzanne Shale Chair	-
DATE OF NEXT MEETING				
Wednesday 19th February 2025 9.30am-12.30pm, MS teams Directorate feedback: **CMHT**				

Quality Committee

Wednesday 19th February 2025

9.00am-12.00pm, MS teams

AGENDA

ITEM		ACTION	PRESENTED BY	ENC
1	**Apologies for absence and declarations of interest**	To note	Suzanne Shale Chair	-
2 5 mins	**Minutes of last meeting**	To approve	Suzanne Shale Chair	**1**
3 5 mins	**Matters arising** • Action tracker	To note	Suzanne Shale Chair	**2**

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STRATEGIC FOCUS - GREAT CARE, TIMELY CARE, EQUITY				
4 20 mins	**Improvement focus** • Improving patient experience in prison – patient information packs	To note	Olivia Ellis Quality Improvement Advisor	**3**
5 30 mins	**Directorate quality update** • CMHT	Alert, Advise and Assure	Lorraine Regan Service Director Kemi Mateola Clinical Director	**4**
STRATEGIC FOCUS – GREAT CARE, TIMELY CARE				
6 30 mins	**Operational Performance & MHLOG Dashboards** • Exception reports • Waiting time targets **Health Inequalities** • Oxleas Equality Delivery System 24 Submission	Alert, Advise and Assure	Iain Dimond Chief Operating Officer	**5a-d** **6**
Break – 10 mins				
STRATEGIC FOCUS - GREAT CARE, AND A SAFETY & LEARNING CULTURE				
7 15 mins	**Clinical Effectiveness** • CEG Chair's report • Medicines Management	Alert, Advise and Assure	Dr Abi Fadipe Chief Medical Officer	**7-7a**
8 15 mins	**Patient Safety Group** • PSG chairs report • MHLOG	Alert, Advise and Assure	Jane Wells Chief Nursing Officer	**8-8a**
9 10 mins	**Quality assurance regulatory update** • QA regulatory update	Agree	Vicky Woods Director of Quality	**9**
COMMITTEE EFFECTIVENESS AND OTHER BUSINESS				
10 10 mins	**Annual committee effectiveness review**	To consider	Suzanne Shale Chair	-
11 5 mins	**Strategic reflection** • *What are we learning from our committee discussions about the challenges to our strategic aims?*	To consider	Suzanne Shale Chair	-
12 5 mins	**Items to report to the Board of Directors** • Alert, Assure, Advise	To agree	Suzanne Shale Chair	-
DATE OF NEXT MEETING				
Wednesday 19th March 2025 9.30am-12.30pm, MS teams Directorate feedback: **Acute & Crisis**				

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NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 11
Enclosure 9

Subject	Business & Infrastructure Committee
Author	Alex Owoo – Associate Director of Financial Management & Planning Sat Dhinsa – Associate Director of Finance – Financial Services & Assurance
Accountable Director	Jo Stimpson, Non-executive Director and Chair of Business & Infrastructure Committee Azara Mukhtar, Chief Financial Officer
Confidentiality/ FOI status	Not confidential

What is the purpose of bringing this report to the Board meeting?	To update the Board of Directors on the work of the Business & Infrastructure Committee.
What risks/issues in the report need to be noted or acted upon?	Please see key issues report attached.
Where has this report been previously discussed?	Business and Infrastructure Committee – 21 January 2025 Special Business and Infrastructure Committee – 03 February 2025 Business and Infrastructure Committee – 18 February 2025
Are there any issues in the report that might cause upset?	No such issues to note.
Glossary of terms/acronyms used in the report	AFC – Agenda for Change APC – Acute Provider Collaborative BAF – Board Assurance Framework BIC – Business and Infrastructure CDC – Community Diagnostic Centre CDEL – Capital Departmental Expenditure Limit CEOs – Chief Executive Officers CIPs – Cost Improvement Programmes COO – Chief Operating Officer DoF – Director of Finance F&P – Finance & Planning ICB – Integrated Care Board ICS – Integrated Care Systems IFRS – International Financial Reporting Standards GP – General Practitioners GSTT – Guy's & St' Thomas NHS Foundation Trust LDA – Learning Disability and Autism LGT – Lewisham and Greenwich NHS Trust LPP – London Pathway Partnership

	MHIS – Mental Health Investment Standard MTFS – Medium Term Financial Strategy NED – Non-Executive Director OPD – Outpatient Department OPD – Offender personality disorder PLICS – Patient Level Information & Costing System QMH – Queen Mary Hospital SDF – Service Development Fund SEL – South East London SLP – South London Partnership STW – Single Tender Waiver YTD – Year to date I&I – Investigation & Intervention

Link to trust strategy and integrated care system priorities	The financial position underpins all the Trust priorities and building blocks but more importantly building block 8 (Making best use of resources) in the Trust strategy.
Link to Board Assurance Framework	• 2006: ICS capital regime • 1177: Financial sustainability of the Trust in the medium/long term • 2378: Bed management – Quality and Financial impact • 2488: 2024/25 revenue and capital plan delivery • 1995: Achieving Carbon Zero • 1994: Cyber security strategic risk • 2413: Bexley Private Finance Initiative (PFI) Expiry

Please summarise implications for:	
Quality	The report highlights the potential indirect impact on the delivery of quality resulting from unsustainable financial performance. We have an established QIA process that will ensure all the quality related implications are considered and our risk register review also takes this into account.
Financial impact	The report highlights our year-on-year reliance on non-recurrent measures to meet our planned financial target. This is not sustainable; we need to focus on delivering sustainable recurrent cost improvement plans and increasing contributions from our service portfolio in order to ensure that both our revenue and planned capital investment programmes can be afforded.
Equality analysis	The report includes descriptions of risks relating to the financials of workforce department as well as the cost of embedding Building a Fairer Oxleas. Any decrease in capital budget for 2024/25 may impact on some social groups by inhibiting estate and IT development.
Environmental impact	There are no specific environmental impacts arising from this report.

Service users, carers and families	The feedback from the Service Users and Carer Shadow Committee have strengthened the impact of financial and infrastructure decisions on these stakeholders
Partner organisations	The reports include direct/indirect impact from our work with the following partner organisations – SEL ICB, SLP, BexleyCare and Local Authorities and Bromley and Greenwich Local Care Partnerships
Staff	Recruitment and retention remain a significant risk for the trust, this is reflected in the level of temporary staffing the Trust have to employ to cover vacant shifts.

Business & Infrastructure Committee
Key issues report

Report date:		**Report of**: Business & Infrastructure Committee (BIC) meeting 21 January 2025; 03 February 2025 and 18 February 2025.
21 January 2025 **03 February 2025** **18 February 2025**		Membership numbers: January (9); February Special BIC (9) February (8). **Quoracy met** = Minimum of four members of which two must be NEDs
1	**Agenda**	The agendas for November and December are included below.
2a	**Alert**	The Business & Infrastructure Committee wish to alert members of the Board of Directors that: 1) Financial pressures, we are likely to face in the next two to three years, particularly in light of the potential planning gap next year. The estimated CIP gap is £36.4m (7% efficiency). 2) Deadline for submitting planning papers to ICS. 3) Mariposa – The Committee is seeking delegation from Board for the approval of the contract award in March.
2b	**Assurance**	The Business & Infrastructure Committee wish to assure members of the Board of Directors that: 1. <u>Oxleas Financial position M10</u> - The Trust continues to make strong progress toward delivering its revised 2024/25 financial plan, targeting a surplus of £1.03 million, inclusive of a £0.61 million technical adjustment. This aligns with the South East London (SEL) system's revenue control total of a breakeven position. As of Month 10, the Trust remains on track to achieve its planned surplus. In response to a request from the SEL Integrated Care Board (ICB) for organisations to reassess their financial forecasts—following a deterioration in two SEL NHS providers' positions—our Finance team conducted a detailed review with directorates. This identified balance sheet flexibility, enabling an improved financial outlook.

		Following Board discussions, there was in-principle agreement to revise the Forecast Outturn (FOT) to a £3.1 million surplus—an improvement of £2 million compared to plan. However, at the SEL Chief Finance Officers (CFO) meeting on 21st February 2025, it was confirmed that the system requires Oxleas to improve its surplus by £1.5 million instead, bringing the Trust's revised FOT to £2.5 million. This adjustment will be reflected in the Month 12 position. 2. CIP deep dive – The Committee carried out a deep dive on the trust cost improvement programmes. The Committee noted an improvement of £600k largely within the CYP directorates. This brings the overall recurrent identified CIPs o £2.3m. 3. SEL Financial position FOT: The SEL system submitted a breakeven revenue plan for 2024/25, supported by £100 million in non-recurrent deficit funding. The impact of the Synnovis cyber attack on SEL trusts is currently reported at £33.7 million, with an additional £4.7 million forecast to year-end, bringing the total to £38.4 million. The system is assuming that the Synnovis impact will be an allowable deficit as this event occurred after the plan was agreed. NHS England (NHSE) is expected to confirm the treatment of Synnovis prior to year end. The formally reported system forecast remains at breakeven excluding the impact of Synnovis. However, the underlying financial run rate projects a deficit of £59.0 million (unmitigated) and £20.6 million (mitigated). CFO discussions indicate that breakeven remains achievable, contingent on the treatment of the Synnovis incident and securing £20.6 million in post-Month 10 system-wide improvements. 4. The Committee noted a detailed analysis of the payroll Corporate benchmark output. 5. The Committee reviewed, discussed and amend it's risk register.
2c	**Advise**	The Business & Infrastructure Committee wish to advise members of the Board of Directors that: 1. The Committee noted the following updates on Bids: **MSK** • The MSK tender has not yet been released. **Sexual Health Tender** • Similarly, the sexual health tender is delayed. The only update from the procurement portal was that further information would be posted at the end of January. 2. The Committee reviewed and endorsed the bid submission of the Liaison and Diversion bid for South London.

		3. The Committee approved the three Adult Forensics business cases as Lead Provider.
2d	**Review of risks**	There are no new risks (live, tolerated or closed) that require escalation. The Committee completed the review of the Business and Infrastructure Committee risks in February 2025.
2e	**Sharing of learning**	n/a
3	***Actions to be considered by Business & Infrastructure Committee***	The committee remains focused on delivering the financials in line with the regulatory constraints set out by NHSE. These include the agency spend threshold. The Committee will continue to explore options available to them in ensuring that our wards and services are staffed properly using substantive staff and the identification of the Trust CIPs.
4	***Report compiled by:*** Jo Stimpson, Chair - Business & Infrastructure Committee Azara Mukhtar, Chief Financial Officer Alexander Owoo, AD Financial Planning and Management Sat Dhinsa – Associate Director of Finance – Financial Services & Assurance ***Minutes available from:*** Minutes are available in the Board reading room.	

AGENDA – 21 January 2025

Item	Subject	Lead(s)	Action Required	Enclosure
1.	Apologies for Absence • Declaration of any conflicts of interest	Jo Stimpson	To Note	**Verbal**
2.	Committee Minutes • December 2024 draft minutes	Jo Stimpson	To Approve	**1**
3.	Matters Arising • Action Tracker	Jo Stimpson	To Monitor	**2**
4.	Bids and Tenders • Special BIC date (tbc)	Iain Dimond	To Note	**Verbal**
5.	Financial Performance • Finance report update – Oxleas M9	Alex Owoo	To Note	**4**
6.	CIPs Deep dive	Azara Mukhtar	To Discuss	**5**
7.	2025/26 Planning update	Azara Mukhtar	To Note	**Verbal**
8.	Bed options paper	Aisling Clifford	To Discuss	**7**
9.	Any Other Business • Rolling agenda	Jo Stimpson	To Note	**8**

Date of Next Meeting
Tuesday 18th February 2025
9.00am – 12noon
MS Teams

Agenda – 18 February 2025

Item	Subject	Lead(s)	Action Required	Enclosure
1.	Apologies for Absence • Declaration of any conflicts of interest	Jo Stimpson	To Note	Verbal
2.	Committee Minutes • January 2025 draft minutes	Jo Stimpson	To Approve	1
3.	Matters Arising • Action Tracker	Jo Stimpson	To Monitor	2
4.	Bids and Tenders	Iain Dimond	To Note	Verbal
5.	Financial Performance • Finance report update – Oxleas M10 • SEL ICS Finance report M9	Alex Owoo	To Note	4
6.	Corporate benchmark: Payroll further analysis	Azara Mukhtar	To Discuss	5
7.	2025/26 Planning update Capital update	Azara Mukhtar	To Note	6
8.	SLP Inpatient Ward Business Cases	Azara Mukhtar	To Approve	7
9.	Risk Register Update	All	To Discuss/Approve	8
10.	Any Other Business • Rolling agenda	Jo Stimpson	To Note	9

Date of Next Meeting
Tuesday 18th March 2025
9.00am – 12noon
MS Teams

Improving lives

NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 12
Enclosure 10

Subject	People Committee update – January meeting (including the Medical Guardian of Safe Working report and the Equality Delivery System report)
Author	Rachel Clare Evans, Director of Strategy and People
Accountable Director	As above
Confidentiality/ FOI status	No

What is the purpose of bringing this report to the Board meeting?	For the Board's information and assurance.
What risks/issues in the report need to be noted or acted upon?	The Board is invited to note the risks and issues highlighted in the report.
Are there any issues in the report that might cause upset?	No.
Glossary of terms/acronyms used in the report	

Link to trust strategy and integrated care system priorities	Big Priority 3: Making Oxleas the Best Place to Work Core Commitment 1: Equity for All
Link to Board Assurance Framework	**1213:** Vacancies and recruitment pressures **1471:** Staff experiencing discrimination at work **2301:** Staff experiencing violence or abuse from service users, patients or carers

Quality	The experience of our staff directly impacts the quality of our care.
Financial impact	Failure to manage our key people risks leads to increased turnover, increased vacancies and increased spend on agency staff.
Equality analysis	Our BAF People risks directly relate to the experiences of protected staff groups in Oxleas and how we improve their experiences.
Service users, carers and staff	Managing our People risks benefits our staff, carers and our patients, by improving staffing and performance.
Partner organisations	Our Oxleas People priorities align with the SE London workforce priorities relating to wellbeing, equality and inclusion, and workforce planning. They also align with the NHS People Plan.

People Committee – January meeting Key issues report		
Report		Report of the January People Committee
Date of last meeting		The meeting was held on 15 January 2025 on Microsoft Teams from 12.45 to 3.15pm.
1	**Agenda**	The Committee considered the agenda which is attached.
2a	**Alert**	The Committee wish to alert the Board that – 1. There has been an increase in numbers of fire incidents on the acute wards. Responses to fire are good, but further work is needed to reduce the availability of the sources of ignition. Work is underway to increase the effectiveness of searches within Acute & Crisis Services. A robust action plan has been implemented for the Health Based Place of Safety where the presence of police enables a full search to ensure further mitigation. The Committee agreed to set aside dedicated time at each meeting to consider fire issues further and requested visibility of Fire Risk Assessments.
2b	**Assurance**	The People Committee wish to assure members of the Board that: 1. The Committee received the Medical Feedback report. This highlighted that vacancies are at 15.1%, which is a 1.9% decrease since April 2024. There is a 17% vacancy rate within the consultant grade with particular challenges in Offender Health and Greenwich Community Health. There has been positive recruitment within Community Paediatrics. SAS grade has the highest vacancy rate at 32% which is in line nationally. 2. Positive results were received in the GMC National Survey. 3. The Committee received the Medical Guardian of Safe Working Report. In the period from July 2023 – October 2024, there were 42 exception reports, and no fines were received. This is in line with previous years.
	Advise	The People Committee wish to advise members of the Board that: 1. Oxleas achieved its highest completion rate of the staff survey at 60% for substantive staff. The results are currently subject to embargo and

		will be released on March 13th. A detailed report will be brought to the May Board. 2. The Committee received a draft People Strategy to support the new Oxleas strategy. The strategy was commended for its ambition, but the Committee wanted to be assured that the level of activity was achievable, given the demands on patient-facing teams. A revised draft will be brought to the March Committee for sign-off. 3. Plans to reduce resident doctor numbers in London as part of the national levelling up agenda have been abandoned. NHS England will now review alternative methods of redistributing resident doctor posts. 4. The Equality Delivery System report has been considered by both the People Committee and the Quality Committee and is attached for information. The EDS system requires topics to explored on an ICS footprint and these are agreed at a SE London level. 5. The Committee received an update on the plans around Sexual Safety. A survey has been undertaken to better understand staff experience and how they feel about speaking about this subject with patients and others. The extent to which sexual safety incidents are experienced across the organisation varies, with Forensic & Offender Healthcare and Acute & Crisis settings experiencing this more regularly. 6. The Health & Safety Audit Programme commenced slightly later than usual but remains on target to be complete by the end of April. 7. The Committee considered the age demographic of Oxleas nurses. It was noted that although the Trust is aware of the number of staff that are eligible to retire, it is not possible to know when they plan to retire or whether they plan to work in another capacity. The Committee noted that the majority of the nursing workforce are over 46 years old and the number of people training to become nurses has reduced, particularly in Learning Disability areas, so there is an ongoing focus in terms of retaining and attracting individuals into the profession. 8. The Committee received an update from the Adult Community Physical Health team. It was noted that during 2023/24 the focus centred on recruitment, onboarding, retention, branding and workforce sustainability. The Directorate continues to provide the highest number of patient contacts per year (570,000 p.a.) with an increase in budget from December 2023 to September 2024 due to new posts from additional

		funding streams being incorporated into the establishment. Bank spend has increased by 8% and it was noted that the Directorate is actively recruiting to the bank where possible. Agency spend has decreased by 30% and as part of this 15 long-term agency nurses in District Nursing are transferring onto the bank with ten already transferred.
4	***Report compiled by:*** Rachel Clare Evans, Director of Strategy and People, on behalf of Nina Hingorani-Crain. ***Minutes available from:*** Deborah Jones, Corporate Admin Team.	

Improving lives

Oxleas NHS

PEOPLE COMMITTEE

Wednesday 15 January 2025 @ 12.45-3.15pm, MS Teams

AGENDA

Item	Subject	Action	Presented by	Duration	Enc
1.	Apologies for Absence & declarations of interest	To note	Nina Hingorani-Crain	5 min	-
2.	Minutes of the last meeting	To agree	Nina Hingorani-Crain		1
3.	Action tracker & forward plan	To agree	Nina Hingorani-Crain		2
4.	Matters Arising	To note	Nina Hingorani-Crain		-
5.	People Summary paper a) Sexual Safety update b) OxLead Update c) KPI	To note	Rachel C Evans	10 min	3
6.	People Strategy		Kim Gilbey	10 min	4
7.	Staff Survey		Rachel Townsend	10 min	5
8.	Equality Delivery System		Juliana Frederick-James	5 min	6
9.	People Committee Risk Register	To note	Rachel C Evans	5 min	7
10.	Medical Workforce strategy 2025 - 2028	To note	Abi Fadipe / Lilian Prokopic	20 min	8
11.	Medical Feedback Report	To note	Abi Fadipe / Lilian Prokopic	5 min	9
12.	Medical Guardian of Safe Working report	To note	Abi Fadipe / Lilian Prokopic	10 min	10
13.	Health & Safety Report	To note	Rachel T Evans	10 min	11
14.	Service Director presentation / update	To note	Sarah Burchell	15 min	12
15.	Review of age profile demographic of nurses to establish impact of retirement	To note	Julie Onyegbula	5 min	13
16.	AOB	To note	Nina Hingorani-Crain	5 min	-
Date of Next Meeting **Monday 24 March @ 12.45 – 3.15pm, MS Teams**					

Classification: Official

Publication approval reference: PAR1262

NHS England

NHS Equality Delivery System 2022
EDS Reporting Template

Version 1, 15 August 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation		**Oxleas NHS Foundation Trust**	**Organisation Board Sponsor/Lead**
			Domain 1: Iain Dimond, Chief Operating Officer Domain 2: Rachel Evans, Chief People and Strategy Officer Domain 3: Dr Ify Okocha, Chief Executive Officer
Name of Integrated Care System		South East London Integrated Care System	

EDS Lead	Juliana Frederick-James, Head of Equality & Human Rights		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	05 December 2024		**Individual organisation**	Oxleas NHS Foundation Trust
			Partnership* (two or more organisations)	South East London Integrated Care Board and the Royal Borough of Greenwich
			Integrated Care System-wide*	Guys & St Thomas NHS Foundation Trust Lewisham & Greenwich NHS Trust Kings College Hospital NHS Foundation Trust South London and Maudsley NHS Foundation Trust

				South East London Integrated Care Board

Date completed		**Month and year published**	
Date authorised		**Revision date**	

Completed actions from previous year	
Action/activity	**Related equality objectives**
Domain 1: Provided Service actions **Oxleas Perinatal Services** • Service continues to provide perinatal mental health services across Bexley, Bromley and Greenwich • The Helix project continues to support bereaved mothers • Wellbeing support for service users was delivered during maternal mental health week • Public exhibition of work delivered by Perinatal Services at Queen Mary's Hospital, Sidcup to highlight the work and encourage mothers to access the service when needed • The South London Mental Health and Community Partnership (SLP) created a perinatal collaborative across south London. This was to improve care for women experiencing mental health problems during pregnancy and the first year after birth. The Oxleas Perinatal Service provided a template of good practice shared across the patch • A successful symposium into infant mental health was held in November 2024 with the Perinatal Team taking a lead role in this	All this activity demonstrates the Trust commitment to addressing health inequality experienced by service users and carers

Oxleas Patient and Carer Race Equality Framework Provides a collaborative approach to achieving ant-racism and equity for minority communities. The following work positively impacts on PCREF goals • Community Mental Health Hubs have been established in Bexley, Bromley and Greenwich to provide comprehensive and holistic care to those experiencing mental health difficulties in their local communities. These are innovative collaboratives with staff from the Trust and South London MIND and the local authority working together • AGILE Physical Health Team: this team works to ensure those with severe mental illness receive their annual physical health checks to address locally identified inequality of access • Three Trusts came together and delivered a series of events to focus on restrictive practice in in-patient settings. Oxleas, East London and North East London NHS Foundation Trusts prove that working together will always provide opportunity for learning and growth	
Domain 2: Workforce Health and Wellbeing • Fostering an inclusive work environment that values and celebrates cultural diversity through implementation of the Building a Fairer Oxleas 5 Step Challenge.	All the ongoing activity reflect and demonstrates the Trusts commitment to promoting workforce health and well-being and tackling inequality experienced by staff

• Using Schwarz rounds to create safe spaces for staff to explore experience of being different and working with difference • Continued focus on staff wellbeing through our dedicated resources such as our health and well-being champions; Occupational Health and Guardian service for staff support and reporting mechanisms. • Promote diversity and inclusion with equity of opportunity through targeted initiatives to address all domains within the WRES and WDES • Continued fair recruitment and career progression activity which has resulted in average improved representation rates of 28% in all NHS pay bands 7 and above.	
Domain 3: Inclusive Leadership • Continued implementation and monitoring of the Trust Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) Action plans. • Representation of diversity at Board level remains good with 40% of Board members coming from Black, Asian and Minority Ethnic backgrounds; 60% being women and 13% have a disability. • Board committee papers including minutes continue to identify equality and health inequalities related impacts and risks with how these will be mitigated and managed.	All this activity reflects and demonstrates the Trust commitment to inclusive leadership addressing inequality experienced by both staff and our service users and carers.

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

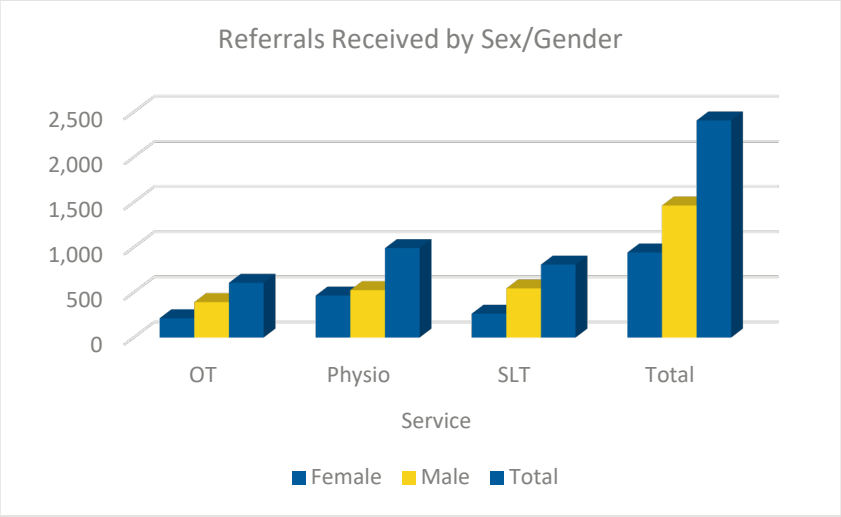
Domain 1: Commissioned or provided services – **Engagement**

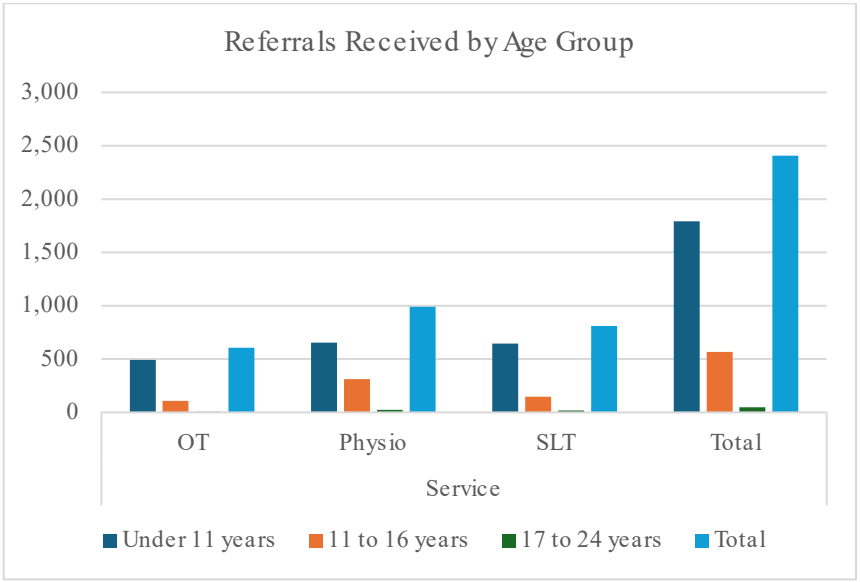
Please explain how you engaged with your patients and services users, their carers and representatives? Was this different to previous engagement?	The Greenwich Integrated Therapies School Years Service was identified as an example of jointly commissioned services to be assessed under EDS24 as a collaborative project between Oxleas NHS Foundation Trust; Royal Borough of Greenwich (RBG) and the South East London Integrated Care Board (SEL ICB). This required an engagement process and collaboration across 3 agencies. Previous engagement sessions have focussed on the service users and carers of Trust services so did not require input from outside agencies.
When did you start engagement with your patients and services users, their carers and representatives? Was this different to previous engagement?	Engagement began in early October 2024 via schools. Schools are sites where the clinics and support are delivered and it was possible to access subjects with the support of RBG. Simple questionnaires and a briefing document was drafted collaboratively and then distributed to identified schools to ensure participation. By using RBG, there was a level of objectivity brought into the process which may not have been in play if the service was facilitating the consultation process. Also children using these services would require support and confidence to participate, so the questionnaires were devised with support of clinicians and SENCO staff.
Who was part of your engagement? How did you decide who to engage with?	Engagement with the children and young people using the service was facilitated through the RBG SENCO Forum. This group of staff support the children and were informed of the aims of the consultation. An online carers and parents scoring event was also organised in the early evening to try and reach as many parents and carers as possible.

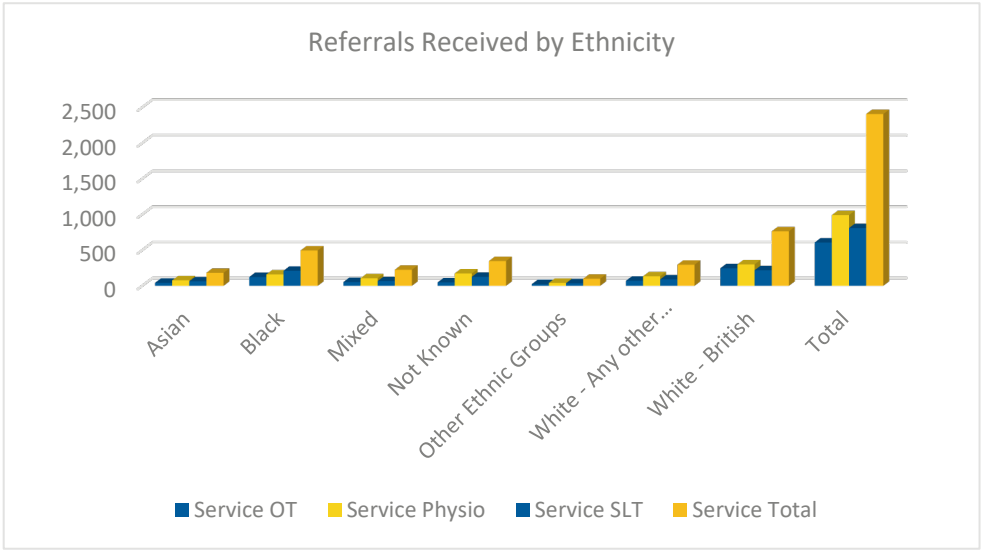
Please describe any issues or barriers you experienced during the delivery of your engagement	The engagement process was very much a collective one and was reliant on various people delivering their part. To ensure this process was as inclusive as possible there were different sessions to engage with various groups. We had to gather feedback from the children currently using the services in school; plus consulting with the SENCO staff involved in facilitating access to the services in schools; and we wanted to hear from parents and carers. I have not had to arrange for engagement through several parties before and this has meant the process was rather prolonged. We had hoped to engage with the Greenwich Carer and Parent Forum to complete the necessary scoring for this report but it would not have been possible within our given timeframe. So a bespoke scoring event was organised using RBG to promote this to carers and this was arranged for 5 December 2024. This has impacted on the timeframe for the final report production as the submission has to be agreed at the Trust Board.
If you have delivered your engagement differently to your last EDS submission, what impact has it had on your process and outcomes?	 20241214 Domain 1 CYPIT Engagement Se A powerpoint is attached containing the Engagement Session Feedback which has been compiled by colleagues in the SEL ICB. Again, this was a collaborative effort as the scoring session was co-hosted by Oxleas and SEL ICB. This involved some further delay to the outcome as a local voluntary sector partner helped to moderate the scores based on the data shared and the feedback from participants. Despite 25 spaces being booked for the session, on the day 4 participants joined the session and so the scores are from a very small sample. The session feedback has collated responses from all the different groups in this presentation.
Please provide any other comments	All the feedback included in the engagement session has been shared with the service provider and will help to shape activity going forward.

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	Brief Description of Service	The Greenwich Children's Integrated Therapies Service provides Occupational Therapy, Physiotherapy and Speech and Language Therapy to children and young people within Greenwich. In 2022, we engaged with families known to the Integrated Therapies Service (ITS) across special schools, school years and early years, via an electronic survey and face to face communication. 95% of families reported they were either satisfied or very satisfied with the service they had received from ITS. They outlined the following as being important to them: • Quicker access to expertise • Videos of workshops to re-watch • Online training relevant to a child's needs • Activities for home • Reduced wait and more sessions, more frequently • Parents included in their child's care and offered a choice of appointment times This feedback has been used to develop and deliver the current Greenwich Integrated Therapies Service **Service areas** The service operates within the following three service areas:		

		• ***Early Years Team*** - Offers assessment and intervention for children under the age of five years or who are yet to start school. Support is needs-led and provided in one-to-one or group formats. The team also works with parents and nursery staff. • ***School Years Team*** - Provides assessment and intervention for children and young people aged five to 19 who attend mainstream schools. This is extended up to the age of 25 for young people with an EHCP. Speech and Language Therapy is usually provided at school, while Physiotherapy and Occupational Therapy sessions generally take place in a clinic. • ***Special Schools Team*** - Provides assessment and intervention for people who have profound and complex needs and attend a Greenwich Special School. Most support takes place in schools. However, home visits are provided when required. • **Our stand-alone services** • Three stand-alone support services also sit across the service areas: • ***The MOVE team*** - A physiotherapy team that works with schools to facilitate the integration of movement opportunities into a child's daily routine. • ***Rapid response team*** - A physiotherapy team that delivers urgent support to babies born with congenital conditions. It also supports complex hospital discharges. • ***Dysphagia and Complex Needs (DCN) team*** - A speech and language therapy team that primarily supports the eating and drinking skills of babies and young children with complex needs.		

	1A: Patients (service users) have required levels of access to the service	Data has been collated over the period from September 2023 to August 2024, using the available protected characteristics of age, sex and ethnicity. Some information has been collected around religion and belief but because this is not mandatory, the results are not reliable. The charts below show referrals received to the service. Here we can see a good mix of ethnicity groups represented and the majority of children and young people are under age 11 when they access the services. There is a more equal representation between the genders for OT and Physio services but more boys access speech and language services 	**Achieving**	


Referrals Received by Age Group
3,000
2,500
2,000
1,500
1,000
500
0
OT
Physio
SLT
Total
Service
Under 11 years
11 to 16 years
17 to 24 years
Total


Referrals Received by Ethnicity
2,500
2,000
1,500
1,000
500
0
Asian
Black
Mixed
Not Known
Other Ethnic Groups
White - Any other...
White - British
Total
Service OT
Service Physio
Service SLT
Service Total

		Due to level of need and early identification of need there are a higher number of patient referrals across all three therapies for the under 11 years age bracket. There are a higher number of referrals for Physio than OT or SLT due to difference between demand and supply. Contextual background: information from the Royal Borough of Greenwich (RBG) Joint Strategic Needs Assessment (JSNA) highlighting how many children in Greenwich have SEND compared to London and England and the Age & Sex profile of SEND pupils in Greenwich was used as a comparator for service access. **Numbers:** As of **January 2024**, there were **45,218** children and young people **attending a Greenwich school**. Of these **9,527** were identified as **having Special Educational Needs and Disabilities (SEND)**, representing **21%** of the school population. Of these: • **Educational Health Care Plans (EHCPs)** reflect **4.4%** of pupils • **Special Educational Needs (SEN) Support** reflects **16.6%** of pupils It is becoming clear that with other overall growth of school populations, the prevalence of Special Educational Needs and Disability (SEND) is also increasing. The age and sex profile of the RBG schools send cohort is not that dissimilar to London and England. Most pupils with SEND are aged 5 to		

15 and male pupils are consistently overrepresented within the SEND cohort at both SEN Support and EHCP level.

EHCPs

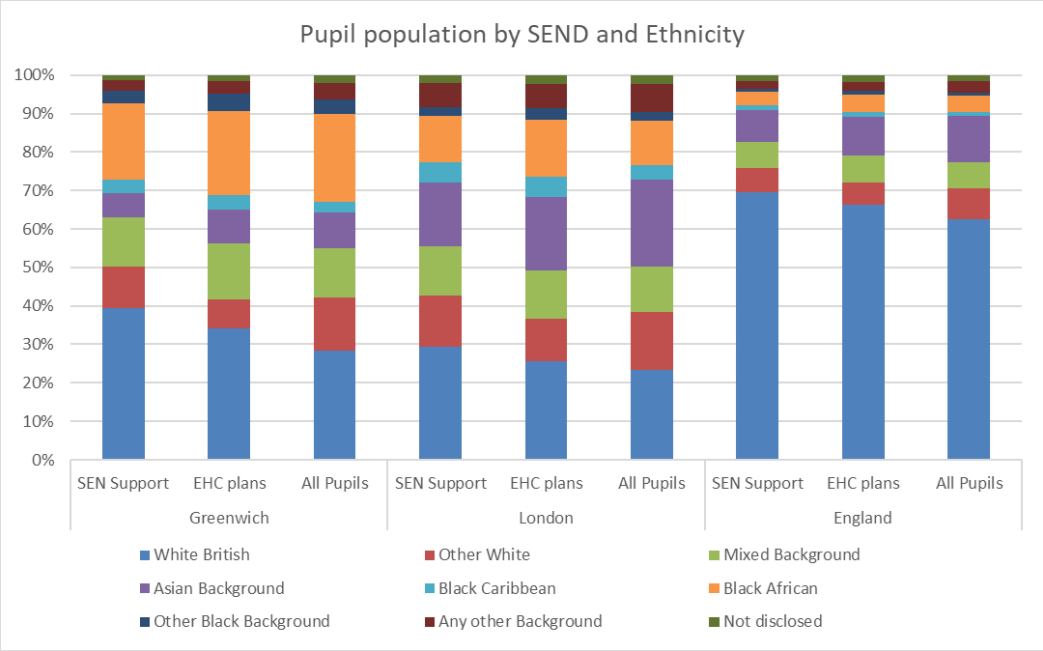
Pupil age	F	M	Total	RBG Age %	London Age %	England Age %
Under 5	18	35	53	3%	6%	5%
5 to 10	272	646	918	46%	47%	44%
11 to 15	217	625	842	42%	40%	44%
16+	56	134	190	9%	7%	6%
Total	**563**	**1,440**	**2,003**			
F/M %	**28%**	**72%**				
London F/M	**28%**	**72%**				
England F/M	**28%**	**72%**				

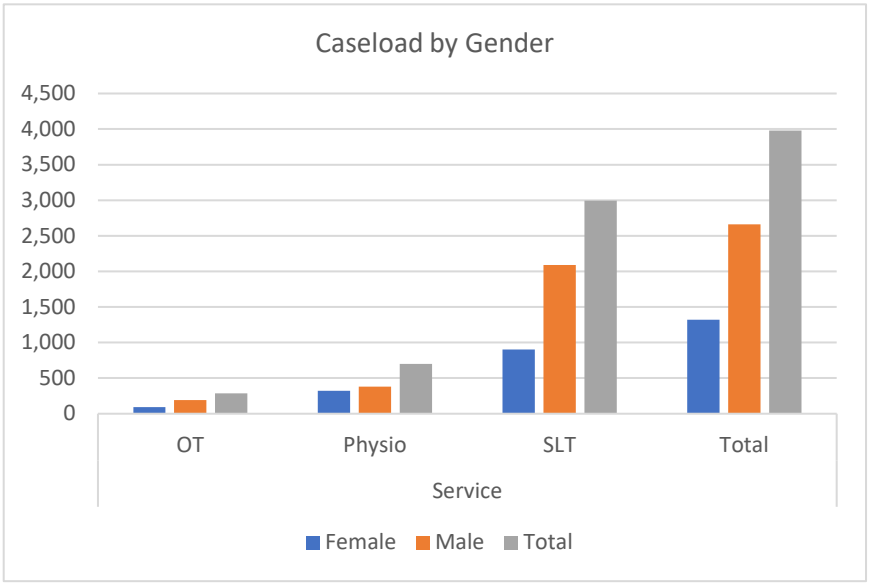
SEN Support

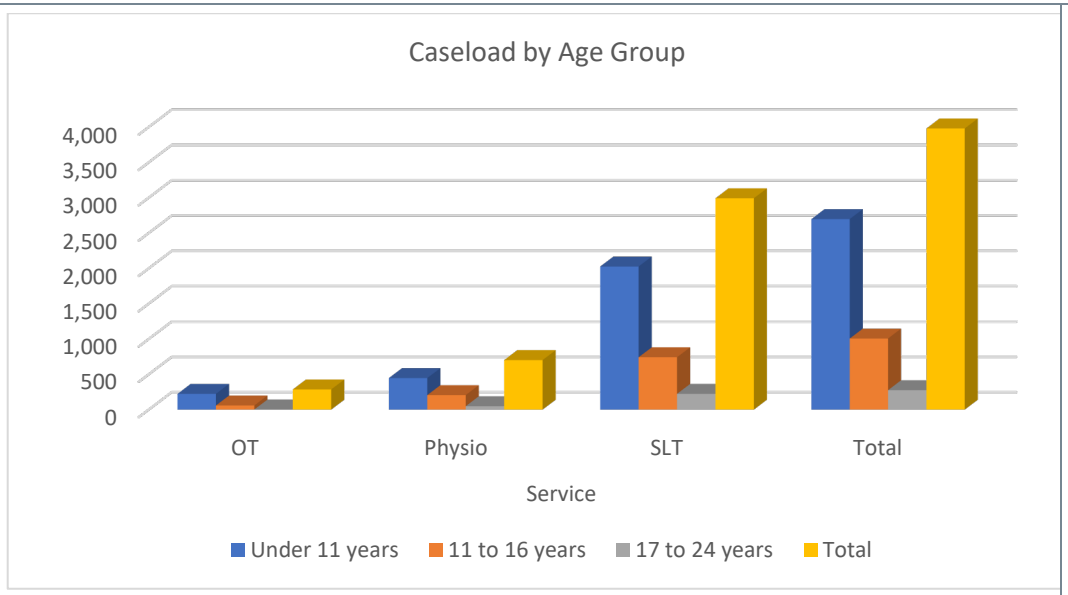
Pupil age	F	M	Total	RBG Age %	London Age %	England Age %
Under 5	260	425	685	9%	10%	8%
5 to 10	1299	2365	3664	49%	50%	51%
11 to 15	1093	1645	2738	36%	36%	39%
16+	215	222	437	6%	5%	3%
Total	**2867**	**4,657**	**7,524**			
F/M %	**38%**	**62%**				
London F/M	**38%**	**62%**				
England F/M	**38%**	**62%**				

The ethnicity profile of SEND pupils shows White British pupils are overrepresented in the SEND cohorts (SEN support and EHCP) in RBG. They make up 28% of the overall RBG pupil population but 39% of SEN Support and 34% of EHCP pupils.

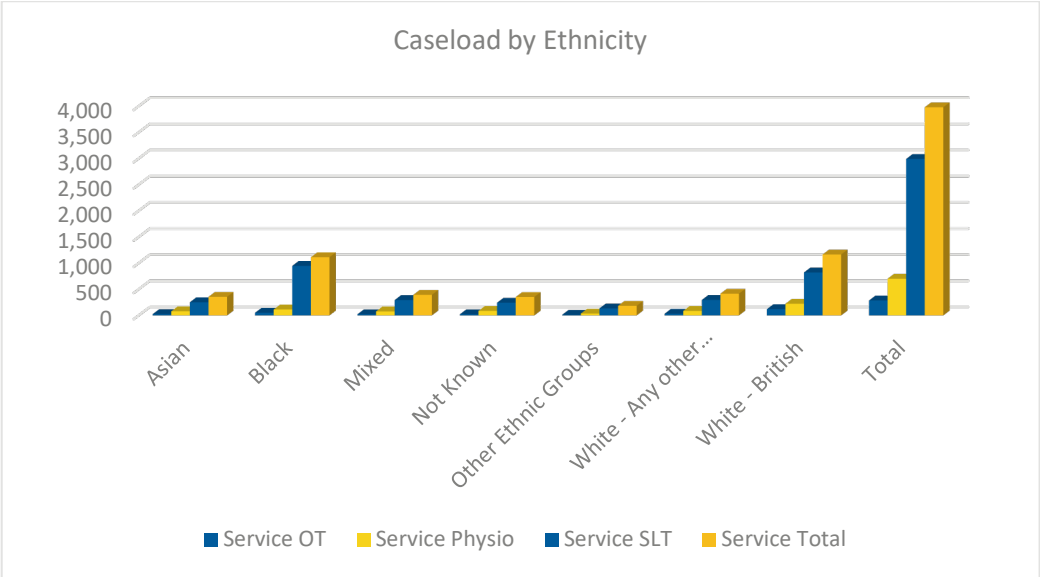
Black African pupils show a more proportional representation across SEND (20% and 22%) and the overall pupil population (23%).

		 All the information provided shows the service is accessible in relation to local demographic data		
	1B: Individual patients (service users) health needs are met	Data has been collated related to service caseloads over the period from September 2023 to August 2024, using the available protected characteristics of age, sex and ethnicity. Some information has been collected around religion and belief but because this is not mandatory, and so the results are not reliable. Historically, boys are more likely to be diagnosed as having special educational needs requiring integrated therapy support. This is reflected in the caseload for the Greenwich Integrated Therapies service.	**Achieving**	

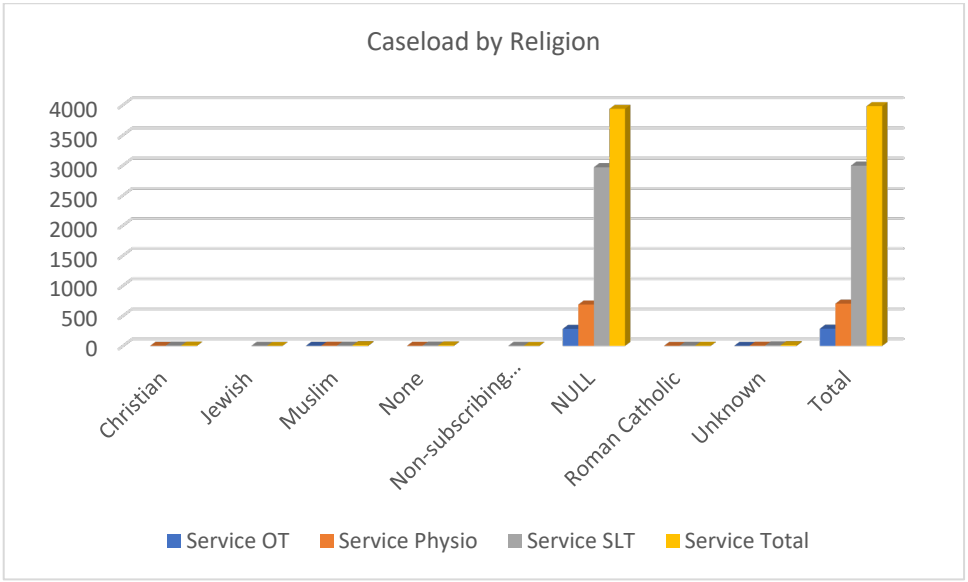
		However, although this is evident for speech and language therapy, there is a more even gender/sex split for occupational and physiotherapy services. These charts show that more boys access speech and language therapy services more so than girls but ther is a more even gender/sex split for occupational(OT) and physiotherapy services. Also, most of the children and young people access services under the age of 11. 		



The chart below show there is a mix of ethnicities within the service caseload with speech and language therapy having a large representation from Black, Asian and Mixed community groups.

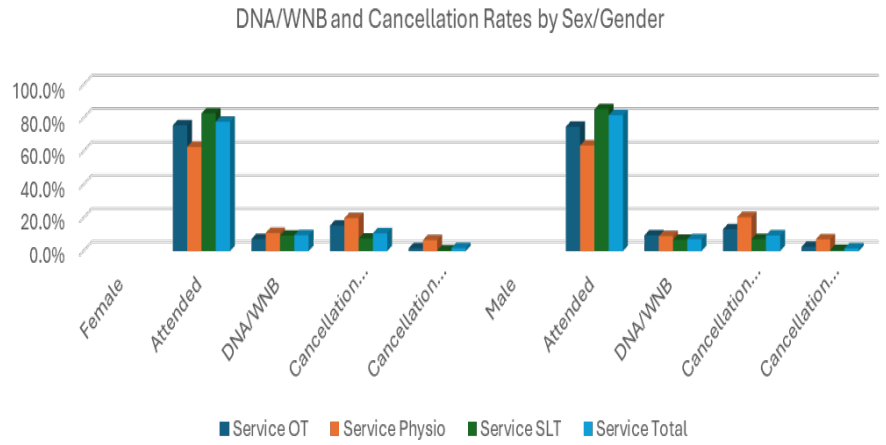


Our data on religion shows the majority of people as NULL which probably reflects that we have not asked the question/people are choosing not to respond



It is difficult to analyse this data with great accuracy as the collection of data regarding religion is not mandated and most cases has no religion identified.

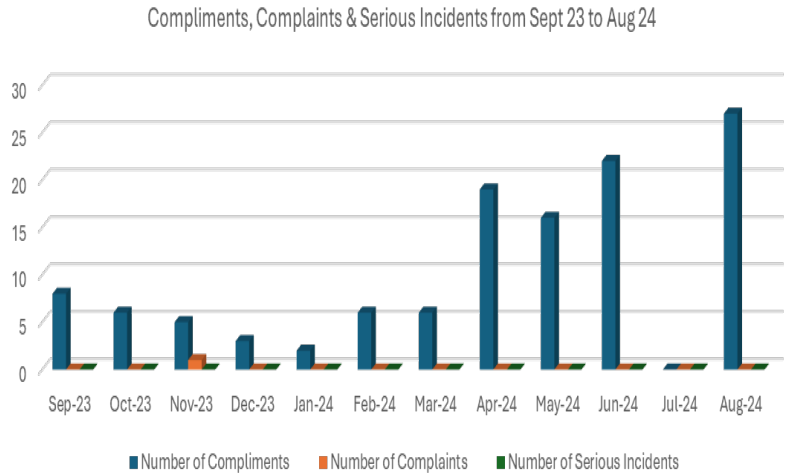
Did Not Attend/Was Not Brought and Cancellation rates were also examined as part of this submission. Although this was explored for all 4 of the identified protected characteristics, the chart below relates to gender/sex as an example of what we collect.

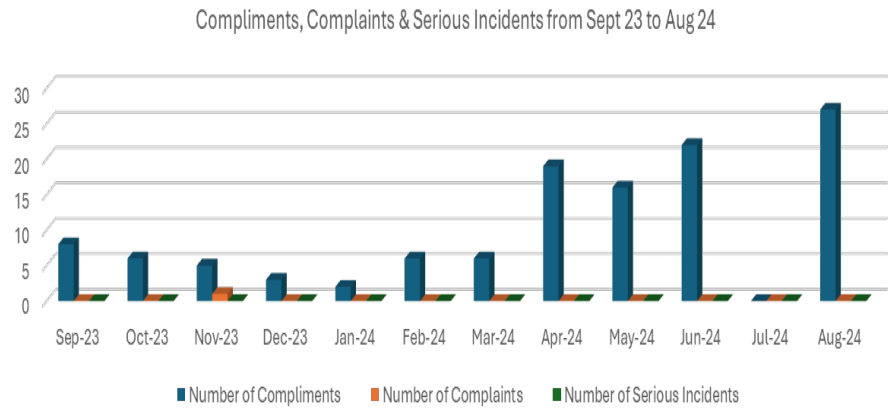


The overall attendance rates for girls is 78% and for boys is 82% and the DNA/WNB rate is 10% for girls and 7% for boys.

Cancellation by provider is 11% for girls and 9% for boys. There are National and Local staffing shortages within Occupational Therapy and Speech and Language Therapy. This has led to high staff vacancies and longer waiting times in some areas. Additional assistants/techs have been employed to provide support where possible. Staff vacancies are being regularly monitored and discussed within commissioner meetings

Finally, referral sources were examined and despite an open referral policy, the top three referral sources were education, GP and other Oxleas services. There is a very low uptake of referrals from parents and carers. It may be that the referrals from schools and GPs are instigated by a parent or carer but more can be done to promote self-referrals.

	1C: When patients (service users) use the service, they are free from harm	The chart below shows that for the period from September 23 to August 24 this service had no serious incidents to investigate. The service has maintained an excellent record in keeping service users free from harm.  Oxleas staff remain strongly committed to meeting core standards as evidenced in the 93% - 94% completion rates of mandatory training. This applies to all our core training including safeguarding children and young people; equality, diversity and inclusion; basic life support; fire	**Achieving**	

		safety; Oliver McGowan mandatory training in learning disability and autism; data security and many others. In addition, staff have access to risk assessment and management training; cultural competency and staff well-being activity.		
	1D: Patients (service users) report positive experiences of the service	The table below highlights the service only received one complaint for the year. And better still has consistently improved in the number of compliments throughout the year.  This appears to show the experience of the services is really positive because of the lack of complaints. It will be worth exploring the outcome measures currently being used by the service to create a narrative about the effectiveness of the interventions.	**Achieving**	

		Further customer satisfaction can be sought through the local authority patient/carer forum once re-instated		
Domain 1: Commissioned or provided services overall rating			**8**	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
in 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• We launched the new Trust Strategy for 2024-2027, at the Trust Annual Members Meeting in October 24. This will underpin all the Trust activity in delivering great and timely care to the people who use our services (and their carers) as well as seeking to make Oxleas the best place to work. • Our Well-Being Passports continue to encourage staff to share their long-term conditions requiring support and build on the individual staff risk assessments identified during the Covid-19 Pandemic. • Our disability leave policy, reasonable adjustment central budget and flexible working toolkit all contribute to our capacity to provide support to staff addressing long term conditions and disabilities • Our Health and Wellbeing Champions and wellbeing offer focuses on physical, mental and financial wellbeing. Additionally, we have: a	Achieving	Staff Experience and Engagement Adviser and the Equality & Human Rights Team, People Directorate

		series of wellbeing activities internally including walks, yoga and exercise sessions; regular wellbeing weeks to remind staff about looking after themselves; Schwartz rounds, a staff gym at the Queen Mary's site as well as promoting NHS discounts at local gyms and fitness suites. • We collaborate closely with Occupational Health to provide health checks and additional support for our staff, making reasonable adjustments where required for long term conditions.		
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Every Directorate continues to have an active Violence and Abuse lead who drives local improvements, supports staff, engages with the police and tests new approaches. • There is a Violence and Abuse sub-Committee, chaired by the Director of Nursing, that reports directly to People Committee. • We continue to implement new relational security approaches – 'See, Think, Act', supported by new roles, in our Acute and Crisis directorate to reduce incidence of abuse.	**Achieving**	Head of Employee Relations, HR Business Partners and Advisers, People Directorate.

		• Our 'It's Not OK' approach sets out a clear framework for addressing issues and a flowchart to ensure that the right support is in place for staff when they experience abuse, harassment, bullying and physical violence from any source. • We hold regular meetings with the Metropolitan Police to review incidents and address ways to prevent this, including action against perpetrators. • Our values are: 'we're kind, we're fair, we listen, we care'. These are supported by a comprehensive behavioural framework which sets out the behaviours which are expected, those we aspire to and those we will not tolerate. These behaviours have been designed following extensive staff engagement and the behaviours supporting the 'We're fair' value draw directly on the feedback from our BAME staff through Building a Fairer Oxleas (BAFO) and our workstream focusing on Bullying and Harassment. • We maintain a Respectful Resolution approach to address concerns informally. • Our Guardian Service provides staff with access to independent and confidential support in order to support staff to get concerns addressed.		

		• We are tackling issues related to poor team culture and behaviours through our BAFO 5 Step Team Challenges. • We are in the processing of drafting and implementing a new sexual safety policy in line with NHS England guidelines to improve sexual safety for staff.		
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• We provide independent support for staff via our Occupational Health and Employee Assistance Programmes • Oxleas Health and Wellbeing Champions operate throughout our services, providing support and guidance to colleagues for their health and wellbeing. The goal is to foster cultures of wellbeing across Oxleas, ensuring that colleagues feel nurtured and supported. • The Guardian Service provides confidential support for staff to raise workplace concerns, available 24/7. It covers patient care, safety, whistleblowing, and grievances. The service offers independent, non-judgmental assistance.	**Achieving**	People Directorate

	2D: Staff recommend the organisation as a place to work and receive treatment	• The NHS Staff Survey results in 2024 showed further improvement in terms of staff recommending the organisation as a place to work. • Support for Staff Network Executives, including development and communications. • Celebrations of diversity – Black History Month (October); LGBT History Month (February) and PRIDE (June); Gypsy, Romany and Traveller History Month (June), International Women's Day (March); and South-East Asian History Month (July); Disability History Month (November); International Men's Day (November) and the acknowledgement of various cultural and religious festivals and holy days.	**Excelling**	Strategy, Improvement and Organisational Development department; Head of Equality and Human Rights and Trust Executive Board Champions
Domain 2: Workforce health and well-being overall rating			**9**	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Notably, our board members and system leaders are actively and visibly engaged in the Building A Fairer Oxleas (BAFO) initiative, Building Fairer Oxleas Services (BFOS), staff networks, and the Equality & Human Rights Governance Group. This group serves as a platform where issues are discussed and taken to the board, underscoring their commitment as an integral and visible part of Oxleas' overall strategy.	**Achieving**	Head of Equality and Human Rights, Service Directors and Chief People and Strategy Officer
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	In Board/Committee papers, impacts and risks related to equality and health inequalities are consistently addressed. Mitigation strategies, guided by the Workforce Race Equality Standard (WRES) and Disability Equality Standard (WDES) for staff, and the Building Fairer Oxleas Services (BFOS) and Patient and Carer Race Equality Framework (PCREF) for service users, are outlined. These efforts align with the Oxleas Priorities for Improvement, reflecting a streamlined approach to promoting equity across the organisation.	**Achieving**	Chief People and Strategy Officer, Chair and Chief Executive

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Ethnicity Pay Gap report: identity themes and actions based on data • Continue progress against Model Employer Aspirational Goals (increase in representation of Black, Asian and minority ethnic staff at Bands 6 and above) • Identify services / Directorates where there is significant under-representation of Black, Asian and minority ethnic staff to raise awareness and provide targeted support	**Excelling**	Head of Equality and Human Rights Chief People and Strategy Officer Head of Equality and Human Rights / Inclusion Manager / HR Business Partners
Domain 3: Inclusive leadership overall rating			**7**	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s):	**Independent Evaluator(s)/Peer Reviewer(s):**

EDS Organisation Rating (overall rating): **28 Achieving**
Organisation name(s): **Oxleas NHS Foundation Trust**
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action/ Improvement Plan	
EDS Lead	**Year(s) active**
Juliana Frederick-James (Head of Equality & Human Rights)	2024-2025
EDS Sponsor	**Authorisation date**
Iain Dimond (Chief Operating Officer) & Rachel C Evans (Chief People and Strategy Officer)	

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	The scope of this data collection focused on primary and secondary school age children and young people.	**Referrals**: despite an open referral policy, the top referral sources are from schools and GPs with Oxleas services coming in 3rd place. Perhaps there is scope for more promotion of this locally to encourage parents and carers to refer directly themselves. Implement an education campaign	June 2025

	1B: Individual patients (service users) health needs are met	**Data** is important to allow the service to respond appropriately to local needs:	• No specific national data is available for a comparison regarding OT/Physio and Speech and Language Therapies. However local responses can aim to address known patterns • Religion data: is not mandatory and so the current data is not reliable for detailed analysis, so more needs to be done to collect as much demographic data as possible. • Ethnicity data: current ethnicity categories are too broad to capture specific local needs. We may need to look at using languages spoken as another means of identifying different ethnicities • Gender data: females are under-represented in access speech and language therapies. We need to show what steps we are taking locally to address this.	June 2025 Nov 2025 Nov 2025 Nov 2025 June 2025

	1C: When patients (service users) use the service, they are free from harm	Ensure the safety of children and young people using Greenwich Integrated Therapy Service.	• Continue to implement Trust policies and procedures to ensure patient safety • Continue to offer help to all children who need it and make them feel safe	Ongoing Ongoing
	1D: Patients (service users) report positive experiences of the service	Improve the overall patient experience.	• Develop robust mechanisms to engage with CYP parents and carers. This will improve communication channels and allow for parents/carers to learn about new projects and services • Focus some attention to transitions – especially from primary to secondary school as this can be difficult if communication between schools, services and parents/carers is poor • Encourage more parents/carers to use the Trust complaints process to help identify areas for improvement	June 2025 Ongoing Sept 2025

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Improving Staff self-reporting rates for having long term conditions requiring support	Embark on an equality data campaign explaining why it is important for staff to share information on all protected characteristics including health conditions for improved support from the organisation	June 2025
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Implement a 'Trauma-Informed Care' approach and Relational Security Methodology in delivering our services to reduce incidents of abuse, harassment, bullying and physical violence.	Continued actions implemented in our Forensic & Offender Health Care Directorate and our Acute and Crisis Directorates to be shared in an embedded learning event across the Trust	April 2025
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Improve Staff Survey results related to this experience year on year.	Continue to create spaces where staff can explore their experiences and how to cope with these in association with our staff networks. Continue to embed the 'Respectful Resolution' approach to improve the way in which bullying is addressed.	Ongoing

	2D: Staff recommend the organisation as a place to work and receive treatment	Foster Positive Workplace and Treatment Environment	• Continue to create a supportive work environment valuing staff well-being. • Continue to monitor employee satisfaction feedback mechanisms (staff surveys; complaints and grievances; Guardian Service Reports etc) • Promote a culture of collaboration and open communication. • Involve staff in developing services to better address the needs of service users and carers using Quality Improvement methodology. • Establish more peer support roles so people who use services can contribute to delivering good quality care	Ongoing Ongoing Ongoing Ongoing Ongoing

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Continue to create an environment where commitment to equality and health inequalities is publicly acknowledged.	• Board to receive regular updates regarding work addressing equality and health inequality happening across the Trust. • BAFO Accredited teams to support regular team discussions on race, equalities, and inclusion. • Reflective Practice sessions/Schwarz Rounds/ Group and Individual Supervision sessions to regularly address equality and health inequality for staff and service users/carers	Ongoing Ongoing Ongoing
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Maintain the current positive position of all papers submitted to the Board and its subcommittees containing a front sheet/executive summary identifying equality and health inequalities related impacts and risks	• Board to receive regular updates from subgroups designed to address equality and health inequality issues • These reports to include targets and achievements as a means of mitigating and managing impacts and risks.	Ongoing
	3C: Board members and system leaders (Band 9 and	Improving diversity within the workforce at each of the AfC	• Ethnicity and Gender Pay Gap reports: identity themes and actions based on data.	Ongoing

	VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	bands and VSM (including Executive Board members).	• Continue progress against Model Employer Aspirational Goals (increase in representation of Black, Asian and minority ethnic staff at Bands 6 and above). • Identify services / Directorates where there is significant under-representation of Black, Asian and minority ethnic staff to raise awareness and provide targeted support.	Ongoing Ongoing

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NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 13
Enclosure 11

Subject	Report from the Audit and Risk Assurance Committee
Author	Susan Owen, Head of Risk and Governance
Accountable Director	Damien Régent, Non-executive Director and Chair of the Audit and Risk Assurance Committee Azara Mukhtar, Chief Financial Officer
Confidentiality/ FOI status	Subject to Freedom of Information (FOI)

What is the purpose of bringing this report to the Board meeting?	To update the Board of Directors on the work of the Audit and Risk Assurance Committee.
Are there any issues in the report that might cause upset?	No such issues.
Link to trust strategy and integrated care system priorities	The Audit and Risk Assurance Committee has delegated responsibility for clinical and non-clinical risk, so has oversight of any risks which may impact on the delivery of the trust strategy and the system priorities. The committee also has oversight of financial reporting, which contributes towards the building block of making the best use of resources.
Glossary of terms/acronyms used in the report	BAF – Board Assurance Framework DSPT - Data Security and Protection Toolkit EPRR - Emergency Preparedness, Resilience and Response HMRC – His Majesty's Revenue and Customs LCFS – Local Counter Fraud Specialist

Audit and Risk Assurance Committee
Key issues report

Report date: 6 March 2025		**Report of**: Audit and Risk Assurance Committee
Date of last meeting: 21 January 2025		**Membership:** The membership of the committee comprises of three non-executives, Damien Régent (committee chair), Jo Stimpson and Nina Hingorani-Crain. The meeting on 21 January 2025 was fully quorate.
1	**Agenda**	The Audit and Risk Assurance Committee continues to meet every two months. The agenda for the meeting on 21 January 2025 is attached.
2a	**Alert**	The Audit and Risk Assurance Committee wish to **alert** members of the board that: • The committee heard that there has been a recent increase in fire incidents in adult acute mental health units. Whilst it was noted that no one has been harmed from these incidents, and investigations are being undertaken to learn lessons, the committee asked that the executive team agree a **process to**

Audit and Risk Assurance Committee Key issues report		
		provide assurance on fire safety across the trust, including search processes and managing contraband items.
2b	**Assurance**	The Audit and Risk Assurance Committee wish to **assure** members of the board that: • The committee received the internal audit on **Core Financial Controls: General Ledger and Journals**. This audit received a rating of significant assurance (green), with three low priority recommendations. The review found that this was a well-designed process, which was operating effectively, with no heightened risk factors. • The committee received the internal audit on **Directorate Emergency Preparedness, Resilience and Response (EPRR) processes**. This audit received a rating of significant assurance with minor improvement opportunities, with three medium priority recommendations and three low priority recommendations. The review identified minor improvements to policies and procedures and highlighted the need for better central oversight of directorate work. • The committee received an overview of **significant service directorates risks.** The committee was assured that each service directorate has its own arrangements for the review and monitoring of risks through their directorate quality governance structure and senior management team, and that no gaps were identified from the review of significant risks. • The committee received an update on the trust's **approach to the non-consolidation of subsidiaries**. The decision not to consolidate took effect from 1 April 2020 on the grounds that the results and net assets of these subsidiaries were immaterial, once transactions between these entities and the trust were excluded. The external auditors commented that the decision should be guided by how the organisation wishes to report and the expectations of stakeholders and were comfortable with the approach taken. The committee was satisfied that our current approach of non consolidation is consistent with releasing transparent accounts to external stakeholders.
2c	**Advise**	The Audit and Risk Assurance Committee wish to **advise** members of the board that: • The committee received the **risk register report from the People Committee**. This includes long-running risks related to staffing, violence and abuse, and discrimination. The committee recognised the importance of on-going attention to these risks and the need to retain these on the Board Assurance Framework for continued oversight. The mitigations plans are long-term, with a target to reduce the risks by April 2027. The committee also noted the

Audit and Risk Assurance Committee Key issues report		
		importance of continuously assessing the board's adherence to our values to maintain a positive culture. • The committee received the **internal audit progress report and recommendations tracker** and noted that the trust is on track to complete the 2024/25 plan. There are two overdue actions relating to the data security and protection toolkit (DSPT). Both actions were due in December 2024 and neither have been extended previously. Both are due to complete by 30 April 2024. Planning for the 2025/26 programme has commenced and a brainstorming session, to inform the 2025/26 plan, was held with KPMG, committee members and members of the senior team which was a productive discussion. • The committee received the **Local Counter-Fraud Specialist (LCFS) progress report.** The plan for 2024/25 is nearing completion and there are good levels of engagement. The committee noted the HMRC technical update on a tax fraud and avoidance, and that the trust has a focus on ensuring that agencies are contracted on direct engagement terms. • The committee heard that planning for the **2024/25 external audit** is almost complete and interim testing continues. The audit plan will be reported to the March 2025 meeting. It was noted that the deadline for the submission of the final audited accounts and annual report for 2024/25 is 30 June 2025. • The independent review of the **Charitable Accounts 2023/24** is complete, with no issues raised, and the accounts were submitted to the Charity Commission by the statutory deadline of 31 January 2025.
2d	**Review of risks**	**Board Assurance Framework** The Audit and Risk Assurance Committee receives the Board Assurance Framework as a standing item at every meeting. Any changes, or issues to be escalated to the Board of Directors, are reported under a separate item.
2e	**Sharing of learning**	No exceptions to note.
3	**Actions/implications to be considered by the Board of Directors**	Approach to a review of fire safety.
4	**Report compiled by:** Damien Régent, Chair of the Audit and Risk Assurance Committee. Susan Owen, Head of Risk and Governance **Minutes available from:** Susan Owen, Head of Risk and Governance	

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Oxleas NHS NHS Foundation Trust

Audit and Risk Assurance Committee

Tuesday 21 January 2025

12:45 to 13:00 - pre-meet for NEDs and Grant Thornton only

Main meeting 13:00 to 15:30

MS Teams

There is no pre-meet in this occasion

AGENDA

ITEM		ACTION	PRESENTED BY	ENC
1 1 min	**Apologies for absence and declarations of interest**	To note	Damien Régent Chair	-
2 2 mins	**Minutes of last meeting**	To approve	Damien Régent Chair	**Enc 1**
3 2 mins	**Matters arising** • Action tracker	To monitor	Damien Régent Chair	**Enc 2**
EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ASSURANCE				
4 10 mins	**Risk register report from the People Committee**	To note	Nina Hingorani-Crain Non-executive Director and Chair of the People Committee Rachel C Evans Chief People and Strategy Officer	**Enc 3**
INTERNAL AUDIT AND COUNTER-FRAUD				
5 5 mins	**KPMG progress report and recommendation tracker**	To note	Hannah Andrews KPMG	**Enc 4**
6 10 mins	**KPMG internal audit reports** a) Core Financial Controls: General Ledger and Journals b) Directorate Emergency Preparedness, Resilience and Response (EPRR) annual assurance return	To note	Hannah Andrews KPMG	**Enc 5a&b**
7 5 mins	**Local Counter-Fraud Specialist (LCFS) progress report**	To note	Amy Warby KPMG	**Enc 6**
8 5 mins	**Local Counter-Fraud Specialist (LCFS) risk based report - secondary working**	To note	Amy Warby KPMG	**Enc 7**

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EXTERNAL AUDIT				
9 10 mins	**External audit update – audit progress report**	To note	Ade Oyerinde Engagement Lead Grant Thornton and Raymund Daganio Engagement Manager Grant Thornton	**Enc 8**

5 MINUTE BREAK

RISK MANAGEMENT, GOVERNANCE AND ASSURANCE				
10 10 mins	**Board Assurance Framework**	To note	Susan Owen Head of Risk and Governance	**Enc 9**
11 10 mins	**Thematic risk analysis – service directorate significant risks**	To note	Susan Owen Head of Risk and Governance	**Enc 10**

FINANCE				
12 5 mins	**Non-consolidation of subsidiaries**	To note	Azara Mukhtar Chief Finance Officer	**Enc 11**
13 5 mins	**Policy update**	To note	Azara Mukhtar Chief Finance Officer	**Enc 12**

COMMITTEE EFFECTIVENESS AND ANY OTHER BUSINESS				
14 5 mins	**Did today's meeting achieve our aims? How is it improving patient and/or staff experience? How could the meeting be improved?** *Identify a person in advance who is going to lead on this item*	To note	Damien Régent Chair	-
15 5 mins	**Items to report to the Board of Directors – Alert, Assure, Advice**	To agree	Damien Régent Chair	-
16 5 mins	**Rolling agenda** *Consider items for future meetings that would benefit from service user/carer feedback*	To agree	Damien Régent Chair	**Enc 13**
17 5 mins	**Any other business**	To note	Damien Régent Chair	-

DATE OF NEXT MEETING
Tuesday 18 March 2025 **13:00 to 15:30** **MS Teams**

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READING ROOM
Items included as optional background reading for committee members

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Board of Directors
6 March 2025

Item 14
Enclosure 12

Subject	SLP Partnership Committees in Common (PCiC) report – February 2025
Author	Jeremy Walsh – Managing Director, SLP
Accountable Director	Jeremy Walsh, Managing Director, SLP
Confidentiality/ FOI status	

What is the purpose of bringing this report to the Board meeting?	For information - the report provides update from the PCiC meeting in January 2025
Are there any issues in the report that might cause upset?	No
Link to trust strategy and integrated care system priorities	Links to SLP Partnership Strategy
Glossary of terms/acronyms used in the report	FFtF - Fitness For the Future

Oxleas Board meeting Key issues report		
Report date: 24/02/2025		**Report of**: South London Partnership Committees in Common
Date of last meeting: 17 January 2025		**Membership:** Were all the committee members present? Yes Was the meeting quorate? Yes
1	**Agenda**	The Partnership Committees continue to meet in common every two months. The agenda is attached.
2a	**Alert**	Nothing to alert.
2b	**Assurance**	The Partnership Committees wish to assure members of the board that the meeting discussed the items noted on the agenda. Perinatal Provider Collaborative Strategic Review: A strategic review was presented to the committees, noting the key achievements and highlights, and areas for further development. The strategic objectives for the financial years 2024/25 and 2025/26 were highlighted, along with key risks and management plan.

		The committees were advised of the following: • The delegation of specialist perinatal services took place on 1st October 2023 and the business case was an all pathway one. SLP have one Mother and Baby Unit and there are two others across London. • An all pathway improvement structure was set up for the programme focused on community services, workforce, maternal mental health services, training and education. The maternal mental health service deals with issues such as pregnancy loss, stillbirths, and babies removed to social care. There are clinical leads for all the workstreams and they drive improvement. • There are areas for further development. The first is to continue the partnership with south London integrated care boards to consolidate the community aspect of the commissioning. The other areas will focus on the themes contained in the workstream priorities. These are inpatients, community, workforce, training and education, maternal mental health. • The programme is also looking at themes such as health inequalities and clinical outcomes for mothers and babies. Part of the workstreams includes a focus on families and resources to support partners, staff retention and identifying gaps in training. • The programme uses a robust set of measures to determine clinical outcomes for the mother, the mother infant relationship and the quality of experience of service user. The programme uses a number of tools, like the HONOS, which is a health information outcome scale. Another tool used is a brief psychiatric rating scale, called the Postpartum Bonding Questionnaire, which talks about the bonding relationships. • Perinatal is a programme that is hugely preventative because preventing mental illness is at the core of it.
2c	**Advise**	The Partnership Committees wish to advise members of the board that the committee received the SLP annual review 2023-2024 and noted the following: • It is patient focused and a celebration of areas the SLP made a difference to the people; • All three SLP partners worked together in producing the review and their inputs were appreciated; • The next annual review would have greater focus on health inequalities and population health to highlight the differences SLP made in those areas. There was also an update on the SLP Quality and Commissioning report.

2d	**Review of risks**	There are no risks for escalation.
2e	**Sharing of learning**	There was sharing of learning from the PCiC meeting and the following was noted: - It is important to have service outcomes being routinely reported, along with aspects such as patient experience and access.
3	**Actions/implications to be considered by the Board.**	Not applicable
4	**Report compiled by:** Jeremy Walsh, SLP Managing Director **Minutes available from:** Jeremy Walsh, SLP Managing Director	

Partnership Committees in Common Meeting – Part A
17 January 2025
9:00am -9:50am
MS Teams

	Description	Purpose	Paper	Presented By	Time	Page
1.	Welcome and introductions.		Verbal	Chair	9:00	-
	1a) Declarations of interest	For noting	Verbal	Chair	9:00	-
2.	Minutes and actions – Partnership Committees in Common 25 September 2024	For approval	Attached	Chair	9:00	5 mins
	A: COMMISSIONING					
	Strategy Items					
3.	Strategic Review – Perinatal Provider Collaborative	For discussion	Attached	Dr. Ify Okocha/ Dr.Trudi Seneviratne	9:05	20 mins
4.	SLP Annual Review 23-24	For discussion and feedback	Attached	Vanessa Ford	9:25	5 mins
5.	Summary – PCiC Development Session (November)	For noting	Attached	Chair	9:30	5 mins
	Quality and Commissioning Items – Commissioning					
6.	SLP Quality and Commissioning Report	For discussion	Attached	Jeremy Walsh	9:35	10 mins
	Governance Items					
	B: PROVIDER					
	C: CLOSING					
7.	Meeting Review and Learning	For discussion	Verbal	Chair	9:45	3 mins
8.	AOB – If notified to the Chair in advance				9:48	2 mins

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NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 15
Enclosure 13

Subject	Council of Governors update
Author	Sally Bryden, Director of Corporate Affairs and Strategic Development (Trust Secretary)
Accountable Director	Andrew George, Chair
Confidentiality/ FOI status	Public

What is the purpose of bringing this report to the Board meeting?	• For the Board to note
Are there any issues in the report that might cause upset?	No
Link to trust strategy and integrated care system priorities	Updates on the strategy are shared with the Council of Governors.
Glossary of terms/acronyms used in the report	NED – non executive director

Executive Summary	**EXECUTIVE SUMMARY** The Council of Governors will be meeting on 13 March 2025. **Membership Committee** The Membership Committee met on 24 February. Liz Moss chaired the meeting which mainly focussed on considering the draft Membership Strategy 2025-2027 produced following a governor workshop to develop the strategy on 16 January 2025. An update was provided on the developmental work being undertaken with young people to create a membership offer for young people. Governors are keen to develop a hybrid member health event with a focus on Dementia. **Governor training** A number of governors attended the 'Keep yourself safe online' session in January, provided by Lee Christie, Head of ICT. **Governor opportunities and activities**

	Governors currently have the opportunity to participate in the chair's appraisal survey. The January Board update meeting took place on 16 January. This was an opportunity for the Chair to update governors on the items discussed at the recent Board meeting and answer any queries. The next Board update will take place during the informal Council of Governors on 13 March. Oxleas new partnership briefing has been shared with governors. Governors were invited to the Older People's Conference held in February. **Upcoming governor activities - 2025** 5 March - Governors NHS Finance information session 6 March (rescheduled from 17 February) – Healthwatch meeting with Adult Acute and Crisis Mental Health Directorate 13 March – Council of Governors meeting 17 March – Healthwatch meeting with Adult Learning Disability and Community Mental Health Services Directorate

Analysis	
What risks/issues in the report need to be noted or acted upon?	There are no specific risks to act upon
Quality implications	Governors have been invited to events that aim to promote quality of services
Financial impact	Some of the governor activities and training have resource implications
Equality analysis	The NED recruitment process has been developed to be inclusive and fair
Net zero impact	The Membership Committee aims to reduce printed materials.
Impact on service users, carers and families	Some governors represent service users and carers
Partner organisations	Some governors represent partner organisations
Staff	Some governors represent staff
Additional information	Minutes of the Council of Governors meetings are available

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NHS Oxleas NHS Foundation Trust

Board of Directors
6 March 2025

Item 17
Enclosure 14

Subject	Forward agenda
Author	Sally Bryden, Trust Secretary
Accountable Director	Andrew George, Chair
Confidentiality/ FOI status	Public

What is the purpose of bringing this report to the Board meeting?	For the Board to note items for future meetings.

Board of Directors - 12 Month Rolling Agenda 2025

Standing Items	Jan-25	Mar-25	May-25	Jul-25	Sep-25	Nov-25
Apologies and conflict of interest	✔	✔	✔	✔	✔	✔
Minutes of the last meeting	✔	✔	✔	✔	✔	✔
Action tracker	✔	✔	✔	✔	✔	✔
Board Assurance Framework	✔	✔	✔ full	✔	✔	✔ full
Sub- committee reports	✔	✔	✔	✔	✔	✔
Chief Executive Update	✔	✔	✔	✔	✔	✔
Operational Service Report	✔	✔	✔	✔	✔	✔
Chair and non executive director reports	✔	✔	✔	✔	✔	✔
Council of Governors update	✔	✔	✔	✔	✔	✔
Any other business	✔	✔	✔	✔	✔	✔
Annual reports/plans/statements						
Annual operational plan sign off and associated workforce plan (and delegation as necessary)		✔				
Draft Annual Report and Accounts (delegation to May Audit Committee)			✔			
Annual Governance Statement (delegation to May Audit Committee)			✔			
Charity accounts	✔					
Annual NHS staff survey results			✔			
NHS Provider licence self-certification			✔			
Health and safety annual report					✔	
Medical revalidation report					✔	
Safeguarding annual reports - adult and children and young people						✔
Annual risk management report (via A&RA Committee)					✔	
Annual legal services report (via A&RA Committee)					✔	
Safe Working Guardian report				✔		
Equality Delivery System		✔				
Workforce Disability and Race Equality Standard reports				✔		
Equality standards delivery action plans						✔
Gender pay gap report						✔
Equality annual report/EDS2		✔				
Mental Health Legislation annual report					✔	
Information governance/cyber security/digital strategy annual report					✔	
Infection control annual report					✔	
Patient safety annual report					✔	
Medicines Management annual report (via Quality)	✔					
Research annual report (via Quality)						✔
Patient experience annual report						✔
Flu assurance report						✔
Complaints annual report (via Quality)						✔
Board evaluation		✔				
Bi-annual reports						
Trust strategy updates (following agreed schedule)	✔	✔	✔	✔	✔	✔
Freedom to Speak Up Guardian reports	✔			✔		
Board visit actions update		✔		✔		
Safe staffing report	✔			✔		
Updates on Green Plan (via B&I Cttee)	✔		✔			
Quarterly reports						
Mortality surveillance committee report	✔		✔	✔		✔