Bundle Board of Directors - Part 1 5 June 2025

1 09:00 - Welcome and introductions
Tim Briggs
For noting
250605 TB Part I Item 00 Agenda

2 09:05 - Staff story
Sue Steen
For noting

3 09:25 - Apologies for absence
Tim Briggs
For noting

4 Declarations of interest
Tim Briggs
For noting

5 Minutes of the previous meeting
Tim Briggs
For approval
250605 TB Part I Item 05 Minutes of Meeting in Public 250327 DRAFT SA

6 Matters arising and actions log
Time Briggs
For noting
250605 TB Part I Item 06 Action log

7 09:30 - Chief Executive's Report
Peter Ridley
For noting
250605 TB Part I Item 07 CEO report

8 09:40 - Integrated Performance Report
Jon Spencer
For assurance
250605 TB Part I Item 08 Integrated Performance Report - April 2025 (OPEN Version)

9 09:50 - Finance Report
Justin Betts
For assurance
250605 TB Part I Item 09 Public Board Finance Performance Report - Cover Sheet
250605 TB Part I Item 09 Public Board Finance Performance Report - FINAL

10 10:00 - Summary of our 2025/26 Operating Plan
Justin Betts
For noting
250605 TB Part I Item 10 2025-26 Financial Plan Update v3 FINAL c2
250605 TB Part I Item 10 2025-26 Operational Plan cover sheet

11 10:10 - Staff survey
Sue Steen
For assurance
250605 TB Part I Item 11 2024 Staff Survey Action Plan - May 2025 Rev5

12 10:20 - Learning from Deaths
Louisa Wickham
For assurance
250605 TB Part I Item 12 Learning from deaths Q4 2024-25

13 10:25 - Standing orders and SFIs
Justin Betts
For approval
250605 TB Part I Item 13 Update to SFIs cover sheet WS

14 10:30 - Board Assurance Framework

Sam Armstrong
For approval

250605 TB Part I Item 14 Board Assurance Framework coversheet
250605 TB Part I Item 14 Board Assurance Framework (2)

15 10:35 - Committee reports
a) People & Culture Committee |Michael Marsh | for assurance
b) Quality & Safety Committee | Michael Marsh | for assurance
c) Quality & Safety Committee annual report| Michael Marsh | for assurance

250605 TB Part I Item 15a Report of the People and Culture Committee
250605 TB Part I Item 15b QSC summary report for 13-05-2025
250605 TB Part I Item 15c QSC annual report 2024-25

16 10:40 - Committee Terms of Reference
Sam Armstrong
For approval
a) Finance & Performance Committee
b) Quality & Safety Committee

250605 TB Part I Item 16a FPC Terms of Reference 2025
250605 TB Part I Item 16b QSC Terms of Reference 2025_26 v1.1

17 10:45 - Identify risks arising from the agenda
Tim Briggs
For noting

18 AOB
Tim Briggs
For noting
Committee memberships - Sam Armstrong

19 10:50 - Date of the next meeting - 24 July 2025
July meeting will be held at St George's Hospital

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on
Thursday 5 June 2025 at 09.00
at the Lecture Theatre, 2nd Floor, Ebenezer Street and via MS Teams

No.	Item	Action	Paper	Lead	Mins
1.	Welcome	Note	Oral	TB	5
2.	Staff story	Note	Oral	SS	20
3.	Apologies for absence	Note	Oral	TB	5
4.	Declarations of interest	Note	Oral	TB	
5.	Minutes of the previous meeting	Approve	Enclosed	TB	
6.	Matters arising and action log	Note	Enclosed	TB	
7.	Chief executive's report	Note	Enclosed	PR	10
8.	Integrated performance report	Assurance	Enclosed	JS	10
9.	Finance report	Assurance	Enclosed	JB	10
10.	Summary of our 25/26 Operating Plan	Note	Enclosed	JB	10
11.	Staff survey	Assurance	Enclosed	SS	10
12.	Learning from deaths	Assurance	Enclosed	LW	5
13.	Standing orders and SFI	Approve	Enclosed	JB	5
14.	Board assurance framework	Assurance	Enclosed	SAr	5
15.	Committee reports a) People and Culture b) Quality and Safety c) Quality and Safety annual committee report	 Assurance Assurance Assurance	 Enclosed Enclosed Enclosed	 MM MM MM	10
16.	Terms of reference a) Finance & Performance b) Quality and Safety	 Approve Approve	 Enclosed Enclosed	SAr	
17.	Identifying any risks from the agenda	Note	Oral	TB	5
18.	Any other business • Committee memberships - SAr	Note	Oral	TB	

19.	Date of next meeting – 24 July 2025				

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
DRAFT Minutes of the meeting of the Board of Directors held in public on 27 March 2025
Lecture Theatre, 2nd Floor, Ebenezer Street and via MS Teams

Board members:	Laura Wade-Gery (LWG)	Chair
	Peter Ridley (PR)	interim Chief executive
	Asif Bhatti (AB)	Non-executive director (via Teams)
	David Hills (DH)	Non-executive director
	Michael Marsh (MM)	Non-executive director
	Aaron Rajan (AR)	Non-executive director
	Elenor Lokteva (EL)	Non-executive director
	Sheila Adam (SA)	Chief nurse and director of AHP
	Justin Betts (JB)	acting Chief financial officer
	Hilary Fanning (HF)	Director of discovery (via Teams)
	Jon Spencer (JS)	Chief operation officer
	Sue Steen (SS)	Chief people officer
	Louisa Wickham (LW)	Medical director
In attendance:	Sam Armstrong (SAr)	Company secretary (minutes)
	Victoria Moore (VM)	Director of excellence delivery and chief of staff
	Elena Bechberger (EB)	Director of strategy & partnerships
	Amy Butler (ABu)	Patient story (item 2)
	Ian Tombleson (IT)	Director of quality and safety (item 2)
	Paul Foster (PF)	Head of facility management (item 2)
	Jess Humphries (JH)	Patient experience manager (item 2)
	Robin Tall (RT)	Head of patient experience (item 2)

A number of staff and governors observed the meeting in the room and online, including: Allan MacCarthy, Kimberley Jackson, Emmanuel Zuridis, John Sloper, Dinesh Solanki, Robert Goldstein, Emily Brothers, Ian Humphreys, Paul Murphy, Professor Naga Subramanian, Joy Adesanya, John Russell, Tricia Smikle, Jennie Phillips (deputy company secretary) and Nic De Beer (committee secretary).

1. Welcome

The chair opened the meeting at 9.00am and welcomed all those present and in attendance.

Introductions were completed.

The Board noted that LWG had resigned as chair. Her leaving date would be coordinated with the commencement of the interim chair, once confirmed.

2. Staff story

The chair welcomed and introduced Amy Butler, who was speaking on behalf of her husband.

It was noted that Amy's husband was currently aged 82, disabled with multiple hidden challenges, and an otherwise capable mind. Amy was a former nurse and had become an NHSE peer leader three years ago, and a member of the Strategic Co-production Group. Amy had joined the Trust's Patient Participation and Engagement group and was hoping to work with the VRE Working Group too. She commented that it was important to get to know the whole patient regardless of what the focus of treatment was.

She expressed her gratitude to the Trust for saving her husband's vision in his left eye. She detailed his history including attending two emergency surgeries for a detached retina last year. They were reassured that additional help would be arranged in the theatre to cater for his other physical limitations. When

people were aware of his disabilities, she found them to usually be helpful, whether they were staff or members of the public attending the hospital.

She reported that the only issue was their confusion on the post-operative posture instruction, which eventuated an avoidable ache all over Tony's body. She added that they could not reach the staff at Mackellar Ward or PALs to rectify their individualised misunderstanding. They did get through to the Trust Patient Experience and Customer Care team and received a prompt and helpful response.

There was a need for a second emergency operation to repair scar tissue. This was organised in quick time. The consultant nurse, in particular, went above and beyond to assist and care for her husband.

The negative experience they had related to transport. She reported that it was stressful when the hospital transport failed to arrive on time and the Trust called to find out where they were. The ambulance arrived circa three hours later than planned, and they missed the initial surgery booking. Amy felt that the experiences with transport were exhausting and time-consuming, particularly the booking system, and more was needed to improve this.

The clinics were very good, however the support for Tony's disabilities could have been better. The main challenge was finding a wheelchair, and it was difficult finding an appropriate toilet for him when needed. There were also some challenges to obtaining an escort, which may be the guidance or the process that was failing this.

Amy thanked all staff involved in her husband's care and reported that it was mostly very good. She particularly noted the compassion and kindness of Trust staff. Mostly, staff listened intently and looked to respond in a helpful manner. They were approachable and appeared patient focused.

The Board acknowledged that transport services were a challenge across the NHS. They reflected that while the Trust was well setup for sight disabilities, it may not be as good as it needs to be for other disabilities. LW pointed out the challenges for the service as it pertains to urgent procedures.

The Board noted the staff story and thanked Amy.

3. Apologies for absence

Apologies were received from Richard Holmes, non-executive director, Andrew Dick, non-executive director, Adrian Morris, non-executive director, and Martin Kuper, chief executive.

4. Declaration of interest in relation to the agenda

There were no declarations made.

5. Minutes of the previous meeting

The minutes of the meeting held on 23 January 2025 were approved as a correct record.

6. Matters arising and action log

The action log and updates were noted.

7. Chief executive's report

PR presented the report.

He highlighted key areas of the report, which included:

- The Trust's performance against 18-week standard had improved in-month to 82.5%. There was an increase in the number of patients waiting over 52 weeks. Elective activity remained below plan.
- Oriel construction remained on time, and work on target operating model specifications was nearing completion.

- Trust financial performance was favourable to plan and while a surplus was expected this year, next year would be very challenging at the Trust and across the NHS. NHSE and ICB staffing was to reduce by 50% and trusts would be expected to deliver cost reduction plans.
- Adam Dunlop had commenced at interim CIO and Author Vaughn was expected to commence as CFO at the Trust in the summer.
- The Trust was working with governors to recruit an interim chair and to commence work on procuring two independent reviews on behalf of the Membership Council.

The Board noted the report.

8. Integrated performance report

JS presented the report and highlighted the following:

- The total waiting list size had increased and was now at 33,406. Longer waiting times in paediatric and adnexal services continue to impact the Trust's overall 18-week position.
- The number of patients waiting over 52 weeks for their treatment had increased to 12. Most of these patients experienced longer outpatient waits due to capacity pressures in paediatrics and adnexal. All patients waiting over 52 weeks had clear next steps in place to ensure they were seen and treated as quickly as possible.
- The Trust's elective activity level was below plan due to the known issue of lower than anticipated cataract referrals, leading to underutilised theatre capacity. The changes in the case mix of patients treated at City Road had continued and additional sessions had been reduced accordingly. South division delivered well above their elective activity plan in February.
- The 31-days standard had not been met due to delays in listing four patients for surgery.
- Appraisal compliance had reduced to 69.7%, reflecting, among other things, the transition to the new appraisal process.
- Staff sickness rates remained above Trust target, increasing to 5.4% in February, which was thought partly due to seasonal issues.

In response to a question from LWG, SS clarified that the Trust was moving from a process of annual appraisals occurring on staff commencement date anniversaries to a period where all appraisals in the Trust would take place: this would focus the Trust on completing appraisals within a window from 1st April for four months. The Trust was also implementing an online appraisal system to be used Trust-wide, where possible.

In response to a question from EL, it was clarified by SAd that the Friends and Family Test had a variable response rate across the Trust with a high rate of circa 45% and a low rate of circa 12%. While this was considered average across NHS trusts, the Trust was working to improve on its response rates. EL made the point that the Board would need assurances throughout the year that the need to reduce costs for 2025/26 would not negatively impact quality and safety.

In response to a question from MM, JS confirmed that the cancer patient numbers at the Trust were small and could be skewed by a handful of cases. These situations could be due to patient choice or complications in treatment.

In response to AR, SS advised that there was a seasonal spike in flu that had contributed to an increase in the sickness absence rate being reported. She also confirmed that the psychological support services the Trust offered staff were being well utilised. She informed the Board that there was an issue with the occupation health service contract to the Trust and this was being escalated to achieve resolution.

The Board noted the report.

9. Finance report

JB presented the report.

It was noted that the Trust was reporting an in-month surplus of £1.98m, which was £1.91m favourable to plan, and yielded a £6.23m surplus year-to-date, which was £1.26m favourable to plan. This favourable position included £1.53m slippage in IT EPR and IT project workstreams, and £0.27m adverse core operational performance.

Operating income was favourable to plan by £1.62m, which included £0.98m following confirmation that NHSE/ICB would not proceed with depreciation underspends clawback. The efficiencies programme was expected to deliver £7.1m against a plan of £11m, and cash reserves were £61m.

Capital expenditure was £84.7m, with business-as-usual capital totalling £3.4m, and other capital totals £81.3m (£76.3m of Oriel expenditure, £3.3m EPR expenditure and £1.0m of NIHR research expenditure). IFRS16 lease capital was £0.8m.

In response to a question from MM, it was confirmed that the key messages in the report should read £1.98m 'surplus' in-month and not a 'deficit'.

The Board noted the report.

10. Staff survey

SS presented the report.

It was noted that the Trust had achieved a response rate of 69%, which was an increase of 3% from the previous year, and was circa 12% higher than the average response rates for the staff survey. Overall, the Trust's results were steady with no statistically significant changes.

SS highlighted some of the results including that 85% of staff would recommend their family and friends for treatment at the Trust, and 83% believed that patient care was the Trust's top priority. There was also a 3% increase in staff who would recommend the Trust as a place to work.

There were also improvements in metric stating appraisals being helping to improve staff work, however as noted, the Trust needed to increase its level of completed appraisals, which was expected from the recent improvement made to the appraisal system. A reduction in bullying, harassment and physical violence, and fewer staff reporting working unpaid additional hours was also observed in the survey. There was concern over a lack of diversity at senior levels.

Next steps were noted, and the Board acknowledged that the People and Culture Committee would oversee the actions and related plans from this data. PR added that staff were experiencing uncertainty at present with the need for cost reductions in the NHS and recent Trust specific developments at Board level. Feedback sessions were to be conducted and recently the executive had worked closely with the consultant body to build relationships, however there was a need to do so with other staff groups in due

course. AR added that in working to achieve inclusion the Trust needed to also consider assisting staff with disabilities. It was agreed that appraisals would be an important area to help make overall improvements.

The Board noted the report.

11. Equality Delivery System (EDS) annual report

SS presented the report.

The Board noted the scoring system, and that after reviewing evidence, the Trust had yielded a score of 16. This indicted that the Trust was rated as 'developing' under the EDS framework. The emerging themes from the assessment process would form an action plan for making improvements.

The Board noted the domains. SS reported that the Trust was liaising with trusts with a better score to assist in its development. The Board would need to reflect on how it could improve on its work, ensuring discussions and actions better reflected EDI and health inequalities. The EDI team would work jointly with the Trust secretariat to improve board reporting for this matter.

The Board approved the EDS annual report for publication.

12. Freedom to speak up

SAd presented the quarter three report.

It was noted that there had been a slight reduction of cases raised in the quarter. SAd reminded the Board that the new model had been in place for a year. The interim guardian was to finish her contract in April and the fulltime guardian was expected to return from maternity then.

The report demonstrated that the group most likely to speak up was the admin & clerical staff, which was possibly a reflection of the numbers in that cohort. The largest concerns were around leadership and management. The Trust was working to improve the ability of managers to reduce these instances.

In response to a question from EL, SAd advised the Board that the Trust did not monitor the age of those speaking up, although it does record ethnicity.

The Board noted the report.

13. Annual safe staffing report

SAd presented the report, explaining its background and methodology.

It was noted that the Trust did not have many inpatient beds and therefore it was reporting on three areas: Observation Ward (6 beds), Cumberledge Ward (8 beds) and Duke Ward (4 beds). The report demonstrated planned staffing with actual staffing for the reporting period. The Trust mostly reported between 98 – 100%.

The Trust had met the expectations to report upon the compliance with nursing and care hours for inpatient areas. There was one reported incident of safe staffing in these reporting areas for Cumberlege ward following an unplanned admission and staffing was arranged for the overnight stay.

The Board noted the report and next steps.

14. Guardian of safe working

LW presented the report.

It was noted that there was only one exception report on an additional hour worked in clinic. It was pointed out that the low frequency of exception reporting reflected the trainees' positive well-being and satisfaction with their working conditions.

The Board noted the report.

15. Learning from deaths

LW presented the report.

It was noted that there had been no death in the period or for the year-to-date.

16. Committee reports

a. Quality and Safety Committee

MM highlighted the following from the last two meetings of the committee:

- He raised awareness of the issue of ventilation at St Ann's after the Trust received a letter from the Health and Safety Executive. While the problem was caused by the landlord, the Trust bore responsibility for it. JS added that this experience should be considered for future contractual arrangements at network sites.
- There was concern over outstanding completion of duty of candour processes, which would be progressed by respective management forums.

b. People and Culture Committee

AR highlighted the following from the last meeting of the committee:

- He noted a number of topics from the meeting had been covered in substantive items at the Board.
- The presentation of topics and work to improve programmes had been developing well.
- The effectiveness review for the committee was mostly positive.

c. Remuneration and Nominations Committee terms of reference

The Board approved the terms of reference for the Remuneration and Nominations Committee

17. Identifying any risks on the agenda

There were no specific risks identified not already on the Trust risk register.

18. Any other business

In closing the meeting, LWG made a personal statement.

On behalf of the Board, PR thanked LWG for her works and achievements

19. Date of next meeting

It was noted that the next meeting of the Board would take place on 5 June 2025 at the Trust Education Centre.

The meeting was closed 10:50am

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

5 June 2025

No.	Date	Minute item	Item title	Action	By	Update	Open/ closed/due
01/02	23/01/24	8.0	Integrated performance report	Report on research studies in the Trust to be presented to the board, to include breakdown of recruitment to different studies.	HF	To be incorporated in research annual report. Report deferred to May.	July 2025 (revised)

Report title	Chief executive's report
Report from	Peter Ridley, Interim chief executive
Prepared by	Interim chief executive and executive team
Link to strategic objectives	The chief executive's report links to all five strategic objectives

Brief summary of report

The report covers the following areas:

- Performance, Quality and Activity Review
- Sector Update
- National Update
- Oriel update
- MoorConnect (EPR)
- Financial Performance
- Governance
- Moorfields in the News

Action required/recommendation.

The board is asked to note the chief executive's report.

For assurance		**For decision**		**For discussion**		**To note**	✓

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

PUBLIC BOARD MEETING – 5 JUNE 2025

Chief Executive's report

Performance, Quality and Activity Review
In April, the Trust's performance against the 18-week standard worsened marginally in month to 82.7%. Our performance against this standard is being maintained at a broadly consistent level, and we continue to work on plans to improve this by 5 percentage points in 2025/26 as per NHS planning guidance. The total number of patients waiting over 52 weeks for their treatment rose in month to 24 as a result of specific capacity challenges within our paediatrics and adnexal services. These services have both received additional capacity over the last few weeks and we are therefore expecting to see an improvement in performance against this target.

Both elective and outpatient activity levels were higher than the plan for the month of April.

Sector Update
As the lead provider for ophthalmology services in North Central London we have now established a number of regular forums that bring together all providers and other system partners on a regular basis. Our digital referral management platform, the 'Single Point of Access', focussed on expanding the proportion of North Central London referrals it processes, and is ensuring that patients are directly referred to the most suitable place for their care. Patients referred for cataract surgery are also provided with transparent information to inform their choice of a provider. A major public deliberation on patient choice of provider has concluded with its report due to be published in June. This will be a major contribution to national conversations about patient choice.

We also provide a Single Point of Access for patient referrals across Inner North East London and have agreed with local commissioners to continue this service during the current financial year.

Our Elective Surgical Hub in Stratford, North East London, is continuing to provide support to neighbouring NHS trusts who have limited outpatient and surgical capacity in ophthalmology. Suitable patients, including those who might have already waited a longer time for a consultation or treatment, are being transferred to our hub for diagnostic services and elective procedures.

The refurbishment work at our Potters Bar site has now concluded. The changes are making a positive difference and have improved privacy and dignity for patients as well as welfare spaces for staff.

National Updates
Contracting Guidance
The 2025/26 NHS Payment Scheme (NHSPS) for NHS Clinical income contracts proposed an introduction of a payment limit to be applied to all contracts with variably funded activity. Following consultation, this proposal was withdrawn, with revised proposals allowing commissioners to raise an Activity Management Plan (AMP) notice to limit activity to the plan. This would therefore still enable an activity, and associated financial, limit.

As per previous years, 2025/26 contracts will continue to be predominantly via Aligned Payment and Incentive (API) contracts. These cover almost all NHS provider activity and comprise 'fixed' and 'variable' elements, with almost all elective activity included in the variable element and paid for using 100% of NHSPS unit prices.

For each commissioner relationship, an Indicative Activity Plan (IAP) needs to be agreed with signatures, required by 29 May 2025 to confirm 2025/26 income and activity.

However, during quarter one of 2025/26, all ICB's are also required to review contract values for NHS providers with which they have an API contract to understand how their current contract values compare to the value of the fixed and variable activity being undertaken. The expectation is that any differences identified would lead to adjustments to be made in 2026/27.

All providers are likely to have historical differences between funding and fixed/variable activity levels, with the added risk that some commissioners may propose those adjustments in 2025/26 due to the financial environment.

This review is being led by the ICB for North Central London to understand the local provider impact as part of feeding into to national review process.

NHSE Performance Assessment Framework

NHS England have recently published a proposed approach and methodology for the updated NHS Performance Assessment Framework. The approach is designed to evaluate and improve the performance of ICBs and NHS trusts and foundation trusts to help ensure that health services are effective, efficient, and patient-centred while supporting continuous improvement. All trusts would be assessed through a series of metrics across four domains – Operating Priorities, Finance & Productivity, Public Health & Patient Outcomes and Quality & Inequality. Based on this assessment allocated from 1 (high performing, and as a result greater autonomy) to 4 (poorly performing) with an additional segment 5 indicating those needing more intensive support. NHS England are seeking views on the proposed framework which we will consider by 30 May.

MEH Performance

A review of the MEH integrated performance report is in progress, supported by the Performance and Information team. Indicators are being reviewed with relevant directors and the executive team including the flow of indicators through to board subcommittees. The exercise is considering all national reporting requirements, and taking note of the proposed Performance Assessment described above, as well as local focus areas including an increased emphasis on productivity.

The Operational efficiency and productivity dashboard is informing a suite of productivity metrics. These will be integrated into both the integrated performance report and the relevant performance reviews. This is part of the overall approach to productivity, alongside the Productivity Review group.

Release of National Very Senior Manager (VSM) Pay Framework

On 15 May 2025, NHS England (NHSE) published the very senior managers (VSM) pay framework and supporting documents, which has been jointly produced by NHSE and the

Department of Health and Social Care (DHSC) and which replaces all previous guidance provided by those organisations and predecessors such as the TDA.

The framework states that it seeks to strengthen the link between reward and performance outcomes, increase transparency and offer flexibility to attract talented candidates to the most challenging roles.

Key points to note:

- Compliance with the framework is expected but is not mandatory. Where an organisation does not comply, they must explain their reasons in their annual report and accounts on a "comply or explain" basis.
- The new framework puts all VSMs (Chief Executives, Directors that report to Chief Executives, and all other designated VSMs) across all NHS organisations (ICBs, NHS trusts and NHS foundation trusts) onto the same salary ranges.
- The framework applies to new VSM appointments, salary reviews and pay awards from 1 April 2025. It does not apply retrospectively and does not override existing contractual arrangements
- Local remuneration committees remain responsible for setting VSM employment terms and salaries within the applicable pay ranges (which depend on weighted population for ICBs and turnover for provider trusts). VSM remuneration should be based on specific organisational circumstances and the complexity of the role.
- NHSE approval will be required for any ICB VSM salaries above the applicable operational maximum, and for all NHS trust and NHS foundation trust salaries above £170,000.
- New appointments of medically qualified Chief Executives should be on VSM terms. When appointing Medical Directors, it is expected that local remuneration committees will work with them to offer appropriate remuneration packages acknowledging medical remuneration packages vary significantly to those of VSMs
- The 'earn back' provision (the withholding of 10% of basic salary pending an annual performance review) no longer applies.
- A pay premium of up to 10% of base salary may be awarded if a VSM takes on additional responsibilities, works across multiple organisations, or performs exceptionally well.
- An individual's annual VSM pay award may be withheld if they are subject to internal performance management processes (conduct or capability) and/or fail to meet appraisal objectives.
- Annual pay awards will be withheld for all VSMs of organisations in the recovery support programme. However, so that VSMs are not discouraged from moving to challenged organisations, this will not apply if they have been in role for less than two years and there will be a 15% salary incentive that will apply for a period of up to 24 months.

What we will need to consider:

- The new VSM framework is part of a broader package of NHS reforms proposed by the government. In relation to NHS managers, this includes the introduction of professional standards and regulation, as well as investing in training and development by establishing a College of Executive and Clinical Leadership.
- As all NHS organisations are encouraged to review their local remuneration policies, reporting processes and VSM contracts and arrangements to ensure that they comply with the new framework a further paper and discussion will be convened at the Remuneration Committee.

Oriel
The façade of the building is now being fireproofed and the internal fit out is progressing across all floors. The clinical approval of the 1:50 design plans has been delayed for a few weeks, though we are still on track to approve the final version of these plans, including the technical aspects, by October 2025.

A revised timeline for the IT/ SMART activities has been agreed with BYUK so that these are now aligned with the construction programme. Work to agree the areas that need transforming prior to the centre opening are close to finalisation and these are being fed into the trust's transformation programme for this year.

We are reviewing the remaining risks in the programme; it is currently forecast to be completed on time and within the available budget.

MoorConnect (Electronic Patient Record)
A critical path has been developed for this programme to ensure that it is delivered on time by May 2026.

A significant amount of work has been undertaken to confirm the interdependencies between the different projects within the programme and to facilitate effective team working between the different professional groups who are contributing to it.

Team members are being trained on how to build the modules within the system so that they are tailored to the clinical pathways within this trust and there is significant focus on completing the design of these pathways so that the build can then begin.

Finance Performance for M1
For April the Trust is reporting a £1.8m deficit, £0.1m favourable to the £1.9m deficit plan. Broadly the Trust's income and expenditure were in line with plan, with NHS clinical income assumed, whilst the Trust finalises its commissioner contracts.

Patient activity during April was 101% for Elective, 104% on Outpatient First, and 102% against Outpatient Follow Up activity, against the Trust activity plan. The Trust is reporting an over-performance in high-cost drug/injection income which remains a variable and payable element under the new contracting arrangements.

The Trust has a £15.1m internal efficiencies plan for the financial year, reporting £0.3m delivery in April, in line with a lower planned delivery in quarter one whilst efficiency and productivity governance is enhanced.

The Trust cash position was £88.2m, equivalent to 99 days of operating cash.
Capital expenditure was £9.86m in April with £9.53m relating to the Oriel development.

Governance
We continue to work with Governors regarding the concerns raised by consultants over the leadership of the trust. The Governors have agreed to the appointment of an independent legal firm to conduct the first review into issues raised in the letter from the chair of the consultant committee. This review has now commenced and is expected to report in July. We are supporting the Governors in procuring an independent firm to conduct the second review on board governance and its work with the Membership Council. The reviews are being overseen by a steering group made up of Governors, with reports to the Membership Council as appropriate.

Moorfields in the news
The hard work of our colleagues and teams at Moorfields have been recognised in the press.

- Moorfields patient Ellie Irwin's stubborn and debilitating eye inflammation was successfully treated as a result of a new metagenomic service identifying the cause of this as a rare infection. https://www.moorfields.nhs.uk/about-us/news-and-blogs/news/new-genomic-test-saves-moorfields-patient-s-sight

- Moorfields Eye Hospital consultant ophthalmologists Mahi Muqit and Niaz Islam were invited to Dhaka by Bangladesh's interim government to help 120 patients with bullet wounds to their eyes. Their injuries were a result of their involvement in protests against the previous government last summer, and 24 of these patients received complex sight saving surgery across two days of intensive support. https://www.moorfields.nhs.uk/about-us/news-and-blogs/news/moorfields-surgeons-saves-sight-of-wounded-students

- Genetic therapy gives infants life-changing improvements in sight. Four young children have gained life-changing improvements in sight following treatment with a pioneering new genetic medicine through Moorfields Eye Hospital and UCL Institute of Ophthalmology, with the support of MeiraGTx. https://www.moorfields.nhs.uk/about-us/news-and-blogs/news/genetic-therapy-gives-infants-life-changing-improvements-in-sight

Integrated Performance Report
Reporting Period - April 2025

Brief Summary of Report

The Integrated Performance Report highlights a series of metrics regarded as Key Indicators of Trust Performance, and covers a variety of organisational activities within several directorates including Operations, Quality and Safety, Workforce, Finance and Research.

The report uses a number of mechanisms to put performance into context, showing achievement against target, in comparison to previous periods, and as a trend. The report also identifies additional information and narrative for KPIs, including those showing concern, falling short of target, or highlighting success where targets and improvement have been achieved.

The data within this report represents the submitted performance position, or a provisional position as of the time of report production, which would be subject to change pending validation and submission

Performance & Information
Delivering quality data to empower the trust

Skills Development Network
Excellence in Informatics
Level 1

Introduction to 'SPC' and Making Data Count

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

This report uses a modified version of SPC to identify common cause and special cause variations, and assurance against agreed thresholds and targets. The model has been developed by NHS improvement through the 'Making Data Count' team, which uses the icons as described to the right to provide an aggregated view of how each KPI is performing with statistical rigor

Variation					Assurance		
							
Common cause - no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Special cause showing an increasing trend	Special cause showing an decreasing trend	Inconsistent passing and failing of the target	Variation indicates consistenly (P)asssing the target	Variation indicates consistenly (F)alling short of the the target

Special Cause Concern - This indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold. High (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold.

Special Cause Improvement - This indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold. High (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold.

Common Cause Variation - No significant change or evidence of a change in direction, recent performance is within an expected variation

Purple arrows - These are metrics with a change in variation which neither represents an improvement or concern

Failing Process (F) - Indicates the metric consistently falls short of the target, and unlikely to ever regularly meet the target without redesign. To be classified as a failing process, either the target would have not been met for a significant period, or the target falls outside the calculated process limits so would only be achieved in exceptional circumstances or due to a change in process.

Capable process (P) - Indicates the metric consistently passes the target, indicating a capable process. To be classified as a capable process, either the target has not been failed for a significant period, or the target falls outside the calculated process limits so would only fail in exceptional circumstances or due to a change in process.

Unreliable Process - This is where a metric will 'flip flop' (pass or fail) the target during a given period due to variation in performance, so is neither deemed to be a 'Failing' or 'Capable' process.

Moorfields Eye Hospital NHS Foundation Trust

Name of the lead responsible for the metric

Why this metric is being reported

The national or local target performance is being measured against

Performance for the most recent period

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 2 week waits - first appointment urgent GP referral	Jon Spencer	Statutory Reporting	Monthly	≥93%	100.0%	100.0%		

Name of metric/KPI

How often and timing of the reporting of this metric

Performance for the financial year (Apr-Mar)

These are the Variance and Assurance Icons

KPI/Metric Name

Upper/lower Limit

Summary Icons
This graph has a variation icon, showing common cause variation but no assurance icon as there is no target

Improving Special Cause *

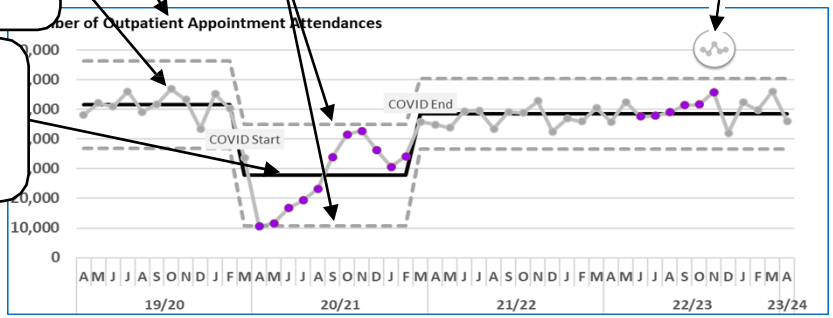
Summary Icons *

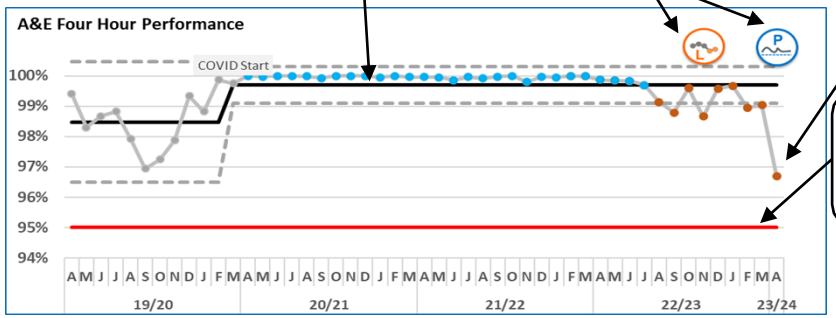
Concerning Special Cause *

Common Cause Variation *

Mean
Average performance for the period

Local or national target





Upper/Lower Control Limits: These are control limits of where we would expect the performance to fall between. Where they fall outside these limits, special cause will be highlighted.
Recalculation Periods: Where there has been a known change in process or performance has been affected by external events (e.g. COVID), the control limits and average have been recalculated to provide a better comparison of data against that period.
Further Reading / other resources
The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology.
This includes are number of videos explaining the approach and a series of case studies - these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

Highlights

Metrics With "Failing Process"

- 52 Week RTT Incomplete Breaches
- Appraisal Compliance
- Basic Mandatory IG Training
- Staff Sickness (Month Figure and Rolling Annual Figure)

Celebrations

- 19 Metrics are showing as a capable process, with 18 showing either an improving or stable performance, this includes:
  - All Research Metrics
  - Posterior Capsular Rupture rates
  - All FFT Performance Targets
  - Infection Control Metrics
- Four metrics are also showing an improving position including Referral to Treatment (RTT) performance and Waiting Lists, Recruitment Time to Hire, Proportion of Temporary Staffing.

Other Metrics showing "Special Cause Concern"

- Proportion of patients participating in research studies due to the recent conclusion of two major studies

Other Areas To Note

- We are currently reviewing the content of the IPR to ensure all national and local defined metrics are monitored, this will be an ongoing process.
- All Elective and Outpatient Activity plans were met in April 2025

Executive Summary

In April, the Trust's 18 Week referral to treatment time performance reduced slightly to 82.7% of patients receiving their treatment within the required period. The total waiting list size is stable at 33,228. There are continued waiting list challenges in a small number of high-volume specialist services which are seeing a deteriorating 18-week referral to treatment position. Additional outpatient clinics and theatre sessions are now in place in the adnexal service and work continues to increase the number of clinical staff in the paediatric service to reduce waiting times.

The number of patients waiting over 52 weeks for their treatment has increased to 22. Most of these patients are under the care of the paediatric and adnexal services. These patients have clear next steps in place to ensure they are seen and treated as quickly as possible.

Elective activity levels were above plan in April. There was some variation across our sites with St Ann's and Stratford sites under plan due the delay in establishing new theatre sessions in medical retina and adnexal services at these sites. The shortfall in activity in the North division was offset by over performance in South division.

Outpatient and injection activity was above plan.

We maintained a compliant position for the faster diagnosis standard in month and A&E four-hour performance remained above target at 97.2%.

Three patients were waiting longer than 6 weeks for their diagnostic test, at the end of April. This was due to patient unavailability and one unavoidable cancellation.

The Trust's Booking Centre was unable to achieve the agreed standard for call waiting time and call abandonment rate, due to number of staff available to answer calls. Plans are in place to improve this performance, and this will be closely monitored.

Appraisal compliance remains below target at 62.8%. The new appraisal window is now open and this will see compliance improve. Basic Mandatory IG training is just below the required standard at 89.8% and staff sickness rates remain above Trust target, at 4.8% in April. Staff and managers continue to be supported to reduce sickness rates.

Performance Overview

April 2025		Assurance			
		Capable Process	Hit and Miss	Failing Process	No Target
Variation	Special Cause - Improvement	- FFT Outpatient Scores (% Positive) - Occurrence of any Never events - NatPSAs breached - Recruitment to NIHR portfolio studies - Active Commercial Studies	- Serious Incidents open after 60 days - Recruitment Time To Hire (Days)	-	- RTT Waiting List - Recruitment to All Research Studies - Proportion of Temporary Staff - Proportion of Agency Staff - Proportion of Permanent Staff
	Common Cause	- Total Outpatient FlwUp Activity (% Plan) - A&E Four Hour Performance - Mixed Sex Accommodation Breaches - VTE Risk Assessment - Posterior Capsular Rupture rates - MRSA Bacteraemias Cases - Clostridium Difficile Cases - E. Coli Cases - MSSA Rate - cases - FFT Inpatient Scores (% Positive) - FFT A&E Scores (% Positive) - FFT Paediatric Scores (% Positive) - Summary Hospital Mortality Indicator	* See Next Page	- 52 Week RTT Incomplete Breaches	* See Next Page
	Special Cause- Concern	- % of patients in research studies	- Average Call Waiting Time	- Appraisal Compliance - Basic Mandatory IG Training - Staff Sickness (Month Figure) - Staff Sickness (Rolling Annual Figure)	-
	Special Cause - Increasing Trending	- No. of Theatre Emergency Admissions			
	Special Cause - Decreasing Trending	-			

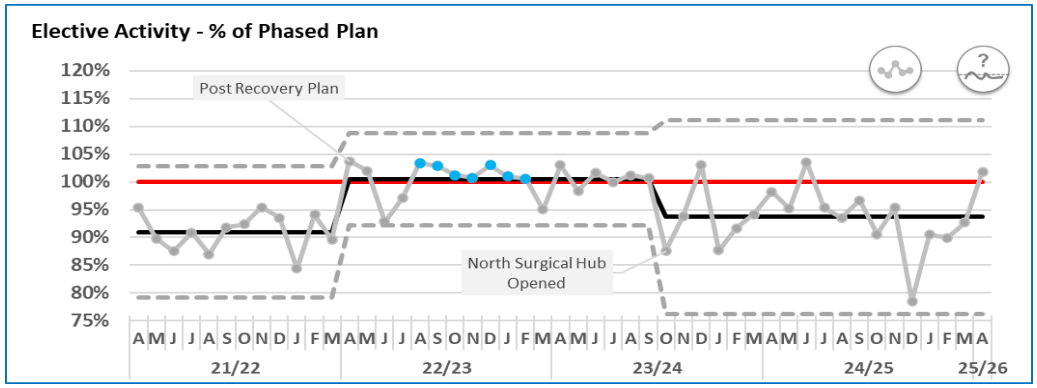
Performance Overview

Common Cause & Hit and Miss	Common Cause (No Target)
- Elective Activity - % of Phased Plan	- 18 Week RTT Incomplete Performance
- Total Outpatient Activity (% Plan)	- RTT Incomplete Pathways Over 18 Weeks
- Outpatient First Activity (% Plan)	- Number of Incidents open after 28 days
- Cancer 28 Day Faster Diagnosis Standard	- OP Journey Times - Non-Diagnostic FtF
- Elective waits over 65 weeks	- OP Journey Times - Diagnostic FtF
- % Diagnostic waiting times less than 6w	- No. of A&E Arrivals
- Average Call Abandonment Rate	- No. of A&E Four Hour Breaches
- Emergency readmissions in 28d (ex. VR)	- No. of Outpatient Attendances
- % FoI Requests within 20 Days	- No. of Outpatient First Attendances
- Theatre Cancellation Rate (Non-Medical)	- No. of Outpatient Flw Up Attendances
- Non-medical cancelled 28 day breaches	- No. of Referrals Received
	- No. of Theatre Admissions
	- No. of Theatre Elective Day Admissions
	- No. of Theatre Elective Inpatient Adm.
	- Proportion of Bank Staff

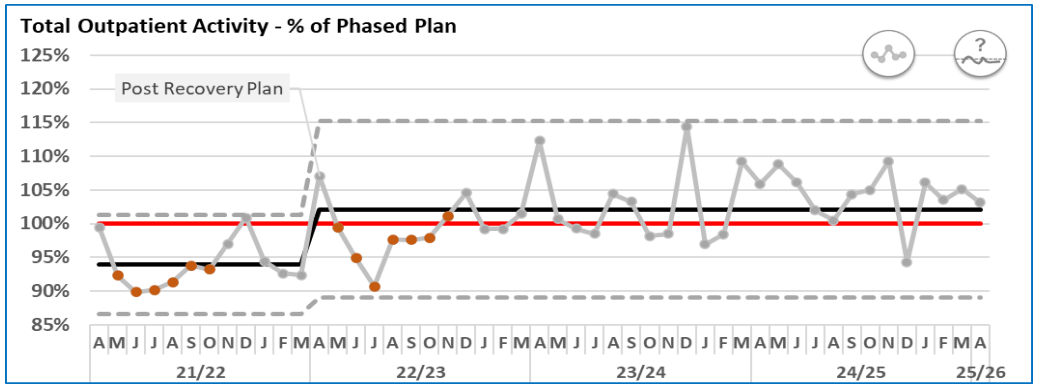
Deliver (Activity vs Plan) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Elective Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	101.9%	101.9%		
Total Outpatient Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	103.1%	103.1%		
Outpatient First Appointment Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	104.8%	104.8%		
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥85%	102.7%	102.7%		

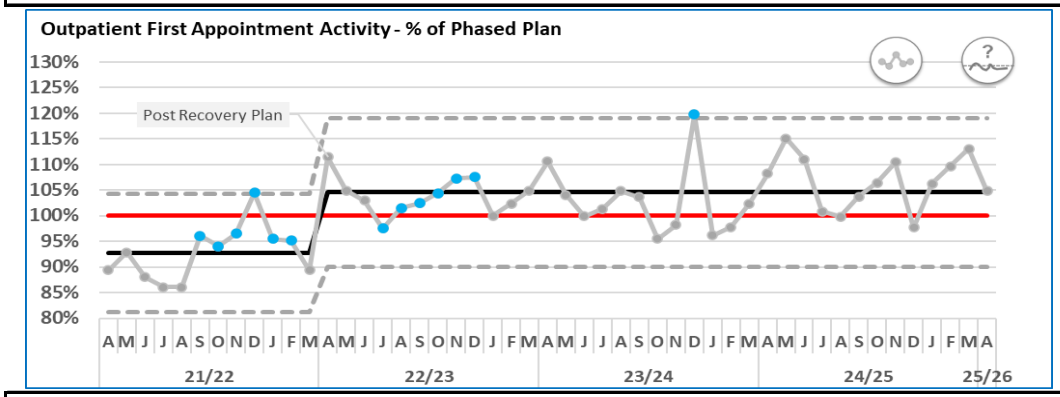
Deliver (Activity vs Plan) - Graphs (1)



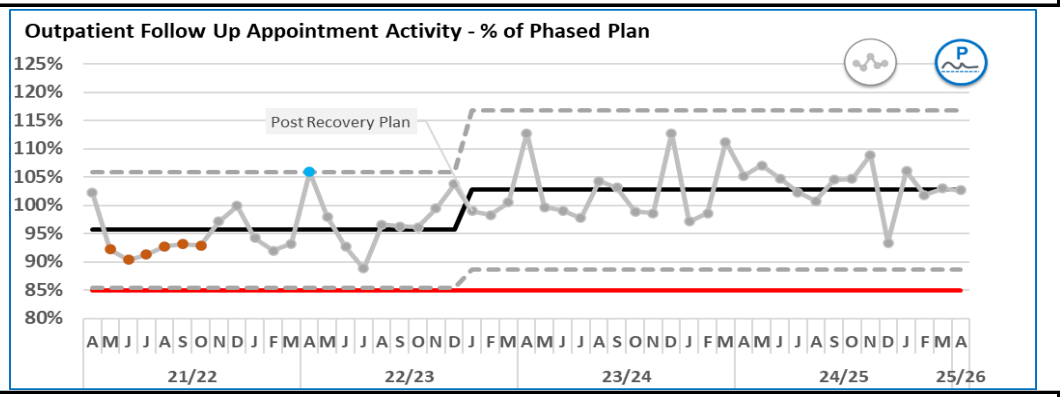
'Elective Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 101.9%.



'Total Outpatient Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 103.1%.



'Outpatient First Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 104.8%.



'Outpatient Follow Up Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 102.7%.

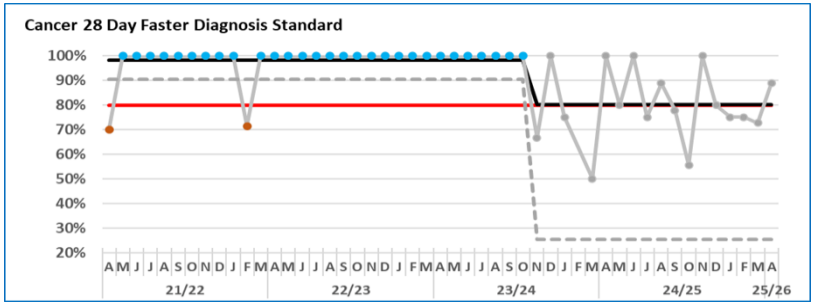
Elective activity was above plan in April. This was driven by over-performance in the South Division. Stratford and St Ann's did not meet plan, due to delays starting new services in MR and Adnexal (lists transferred from cataract). It is a priority to get these sessions in place. As agreed, weakened additional sessions continued in April at Croydon, but these will stop at the end of May. Additional weekend sessions continued at City Road based on clinical needs in VR, adnexal and glaucoma. Outpatient and injection activity was above plan.

Review Date: Jun 2025 ***Action Lead:*** Kathryn Lennon

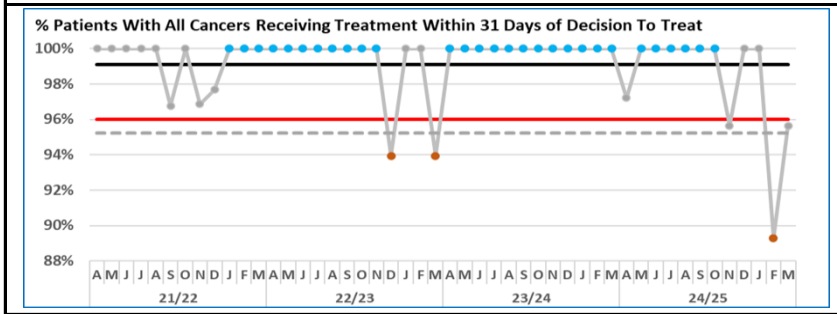
Deliver (Cancer Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	Performance Assessment Framework	Monthly	≥80%	88.9%	88.9%		
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat	Jon Spencer	Statutory Reporting	Monthly	≥96%	n/a	n/a		
% Patients With All Cancers Treated Within 62 Days	Jon Spencer	Performance Assessment Framework	Monthly	≥85%	n/a	n/a		

Deliver (Cancer Performance) - Graphs (1)

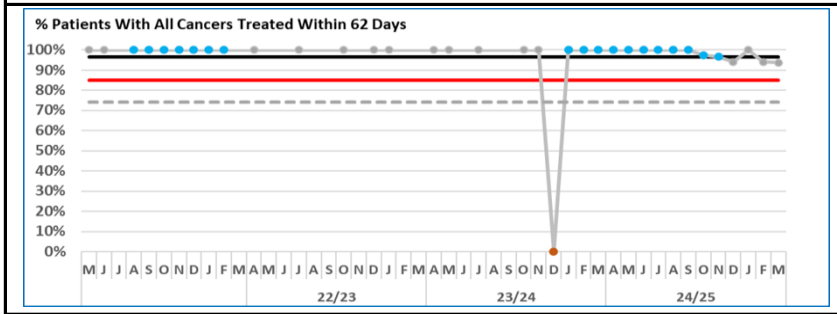


'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 88.9%.



'% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat' for this reporting period not available.

Cancer Performance for April 2025 is not available as the time of reporting as this is still being validated by the Cancer Multidisciplinary Team (MDT).



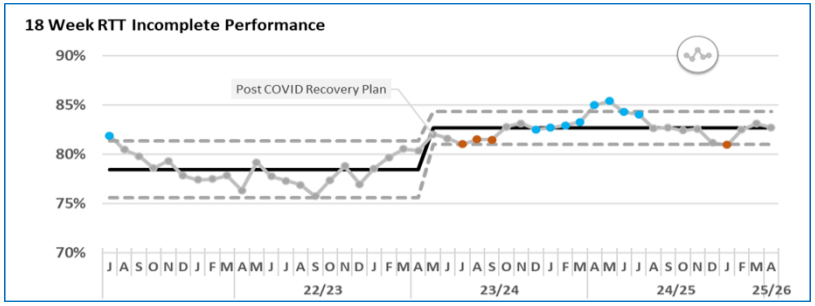
'% Patients With All Cancers Treated Within 62 Days' for this reporting period not available.

Cancer Performance for April 2025 is not available as the time of reporting as this is still being validated by the Cancer Multidisciplinary Team (MDT).

Deliver (Access Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
18 Week RTT Incomplete Performance	Jon Spencer	Performance Assessment Framework	Monthly	No Target Set	82.7%	82.7%		
RTT Incomplete Pathways (RTT Waiting List)	Jon Spencer	Operational Planning Submission	Monthly	≤ Previous Mth.	n/a	33228		
RTT Incomplete Pathways Over 18 Weeks	Jon Spencer	Operational Planning Submission	Monthly	≤ Previous Mth.	n/a	5737		
52 Week RTT Incomplete Breaches	Jon Spencer	Performance Assessment Framework	Monthly	≤5 Breaches	22	22		
Eliminate waits over 65 weeks for elective care	Jon Spencer	24/25 Planning Guidance	Monthly	Zero Breaches	3	3		
A&E Four Hour Performance	Jon Spencer	Performance Assessment Framework	Monthly	≥95%	97.2%	97.2%		
Percentage of Diagnostic waiting times less than 6 weeks	Jon Spencer	Performance Assessment Framework	Monthly	≥99%	98.4%	98.4%		

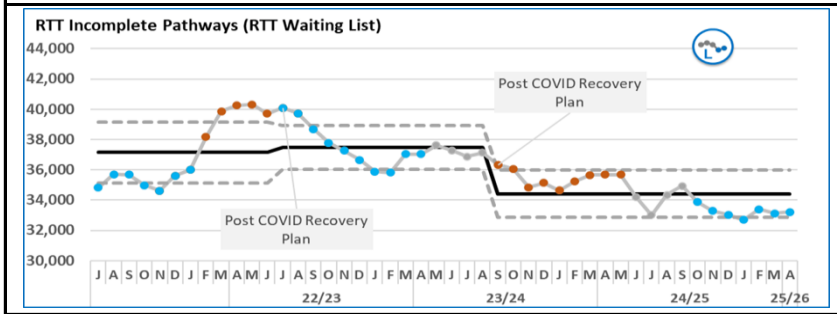
Deliver (Access Performance) - Graphs (1)



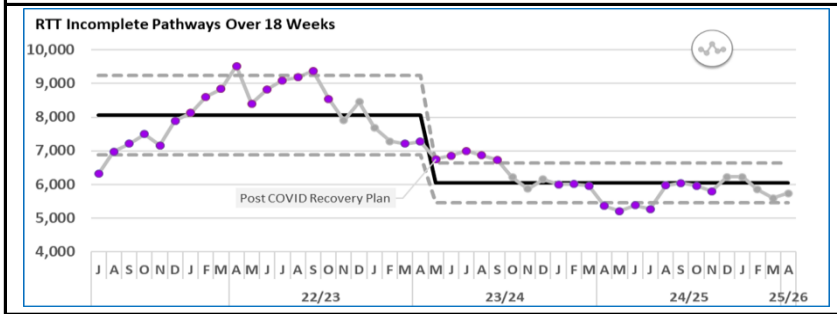
'18 Week RTT Incomplete Performance ' is showing 'common cause variation'. The figure is currently at 82.7%.

RTT incomplete performance remains in common cause. Adnexal, paediatrics and external are the challenges services. Short term actions: ensure adnexal capacity is fully utilised, plan for additional paediatric and external outpatient activity in Q1 and Q2 in advance of service development approval (subject to resource availability)). Longer term actions: increase proportion of patients following an asynchronous pathway in paediatrics and external. Improve clinic utilisation in adnexal. Develop demand management initiatives of advice and guidance and PIFU.

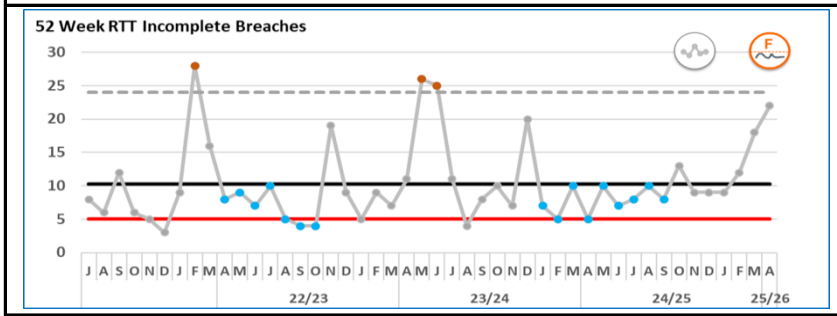
Review Date: Jun 2025 ***Action Lead:*** Kathryn Lennon



'RTT Incomplete Pathways (RTT Waiting List)' is showing 'special cause improvement' (decreasing rate). The figure is currently at 33,228.



'RTT Incomplete Pathways Over 18 Weeks' is showing 'common cause variation'. The figure is currently at 5,737.

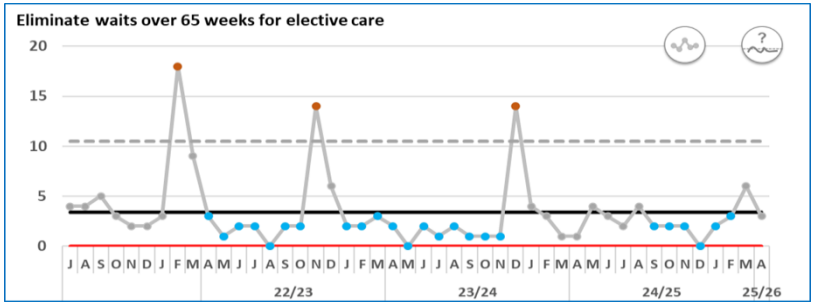


'52 Week RTT Incomplete Breaches ' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 22.

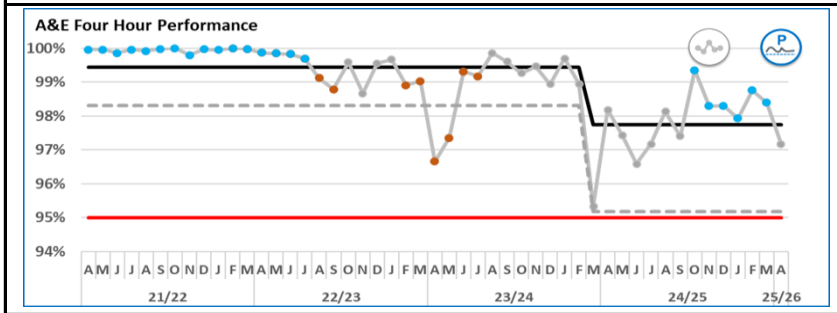
Increased to 22 but remains in common cause. Paediatrics and adnexal are driving the 52 week position. All patients have clear next steps to treat/discharge. Actions in place to mitigate the risk the number over 52 weeks increases further: outpatient drive in March in paediatrics to see longest waiting patients. Transfer of adnexal patients from City Road to South to see longest waiting patients.

Review Date: Jun 2025 ***Action Lead:*** Kathryn Lennon

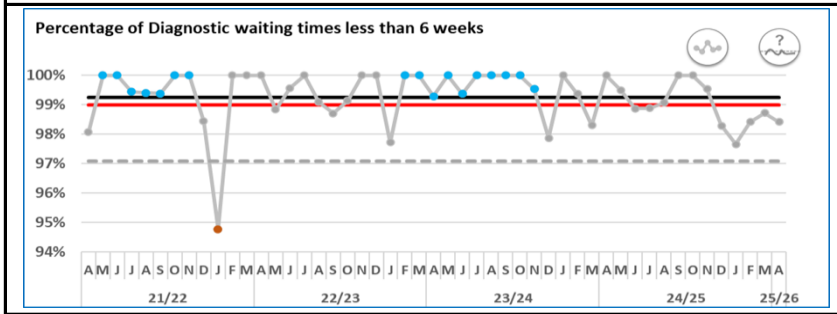
Deliver (Access Performance) - Graphs (2)



'Eliminate waits over 65 weeks for elective care' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 3.



'A&E Four Hour Performance' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 97.2%.

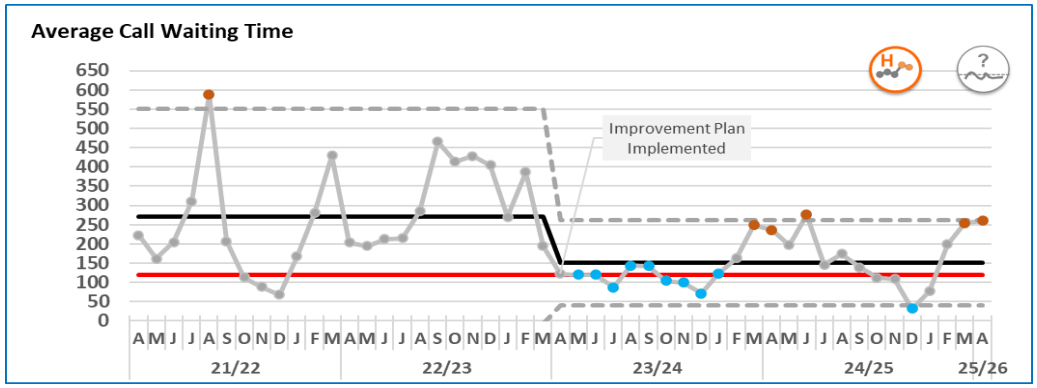


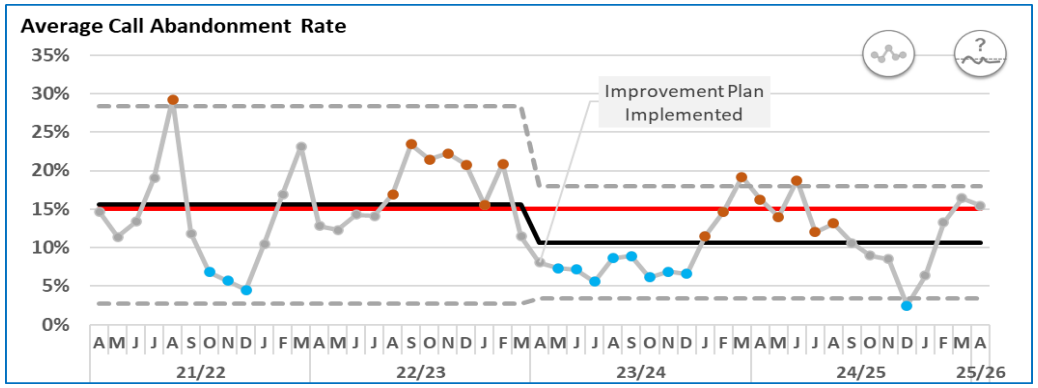
'Percentage of Diagnostic waiting times less than 6 weeks' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 98.4%.

Deliver (Call Centre and Clinical) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Average Call Waiting Time	Jon Spencer	Internal Measure	Monthly	≤ 2 Mins (120 Sec)	n/a	260	H	?
Average Call Abandonment Rate	Jon Spencer	Internal Measure	Monthly	≤15%	15.5%	15.5%		?
Mixed Sex Accommodation Breaches	Sheila Adam	Statutory Reporting	Monthly	Zero Breaches	0	0		P
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Jon Spencer	Internal Measure	Monthly	≤ 2.67%	n/a	2.86%		?
VTE Risk Assessment	Jon Spencer	Statutory Reporting	Monthly	≥95%	99.2%	99.2%		P
Posterior Capsular Rupture rates (Cataract Operations Only)	Jon Spencer	Clinical Statutory Reporting	Monthly	≤1.95%	0.62%	0.62%		P
MRSA Bacteraemias Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Clostridium Difficile Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
MSSA Rate - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P

Deliver (Call Centre and Clinical) - Graphs (1)



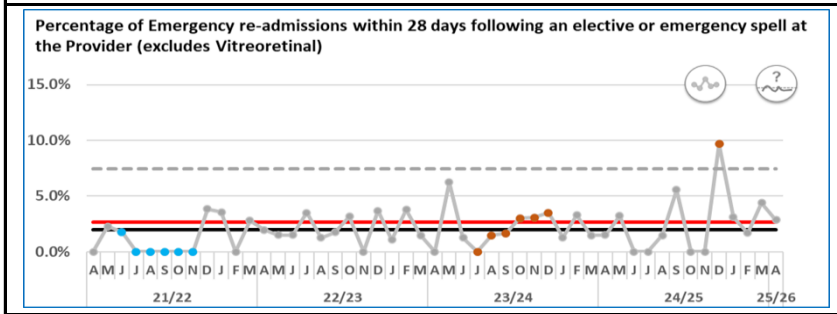
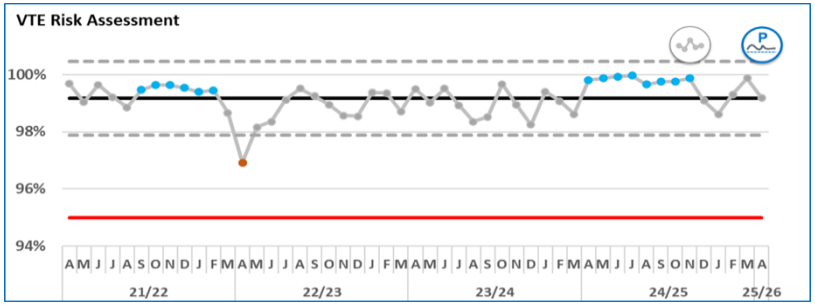
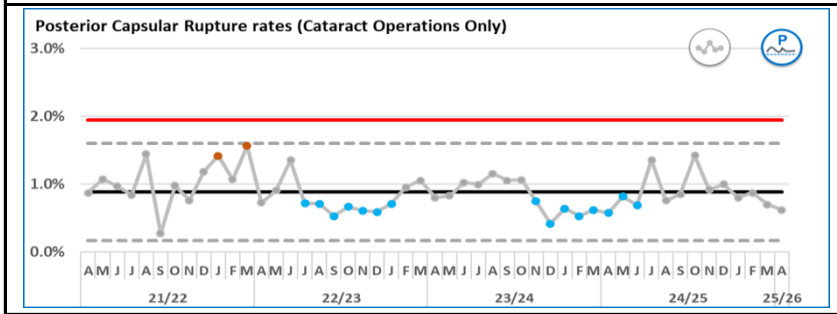


'Average Call Waiting Time' is showing 'special cause concern' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 260.	**'Average Call Abandonment Rate' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 15.5%.**

Performance remain above the agreed KPI, due to the number of agents available and an increase in the average duration of calls. Mitigating actions include: recruitment to vacancies, appropriate management of absence, on-going training of new staff and support to the team managing new queries associated with the OWL. Performance monitored on weekly basis.

Review Date: Jun 2025 ***Action Lead:*** Kathryn Lennon

Deliver (Call Centre and Clinical) - Graphs (2)

No Graph Generated, No breaches since June 2017	'Mixed Sex Accommodation Breaches ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.
	'% Emergency re-admissions within 28 days (excludes Vitreoretinal)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 2.86%.
	'VTE Risk Assessment' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 99.2%.
	'Posterior Capsular Rupture rates (Cataract Operations Only)' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.62%.

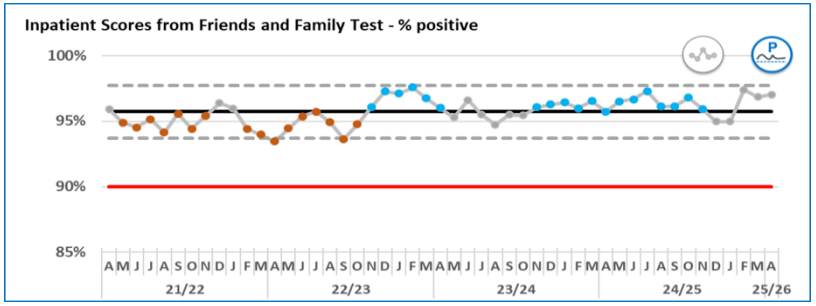
Deliver (Call Centre and Clinical) - Graphs (3)

No Graph Generated, No cases reported since at least April 17	**'MRSA Bacteraemias Cases' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**
No Graph Generated, No cases reported since at least April 17	**'Clostridium Difficile Cases' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**
No Graph Generated, No cases reported since at least April 17	**'Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**
No Graph Generated, No cases reported since at least April 17	**'MSSA Rate - cases' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**

Deliver (Quality and Safety) - Summary

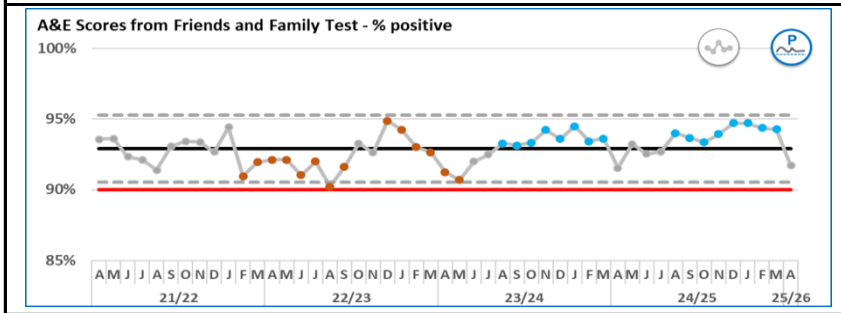
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Inpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	97.0%	97.0%		
A&E Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	91.7%	91.7%		
Outpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	95.8%	95.8%		
Paediatric Scores from Friends and Family Test - % positive	Ian Tombleson	Internal Measure	Monthly	≥90%	97.0%	97.0%		
Percentage of responses to written complaints sent within 25 days	Ian Tombleson	Internal Measure	Monthly (Month in Arrears)	≥80%	n/a	n/a		
Percentage of responses to written complaints acknowledged within 3 days	Ian Tombleson	Quality Statutory Reporting	Monthly	≥80%	n/a	n/a		
Freedom of Information Requests Responded to Within 20 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	n/a	92.3%		
Subject Access Requests (SARs) Responded To Within 28 Days	Kathryn Lennon	Statutory Reporting	Monthly (Month in Arrears)	≥90%	n/a	n/a		

Deliver (Quality and Safety) - Graphs (1)



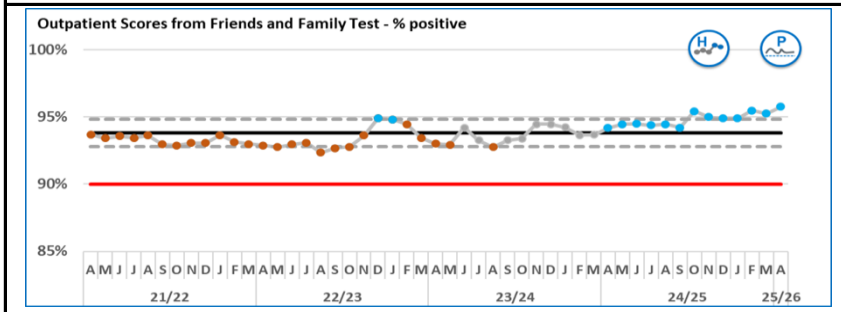
'Inpatient Scores from Friends and Family Test - % positive ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 97.0%.

Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.



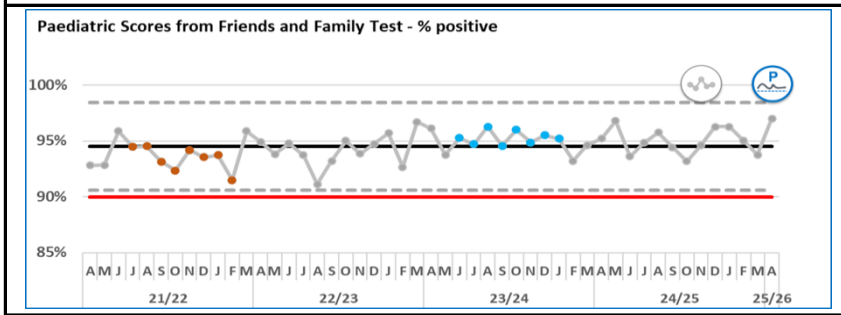
'A&E Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 91.7%.

Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.



'Outpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 95.8%.

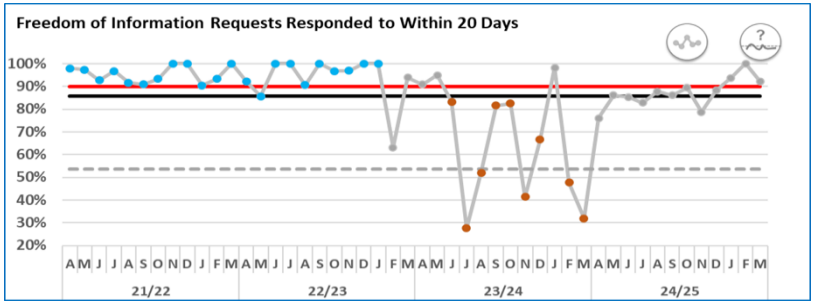
Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.



'Paediatric Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 97.0%.

Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.

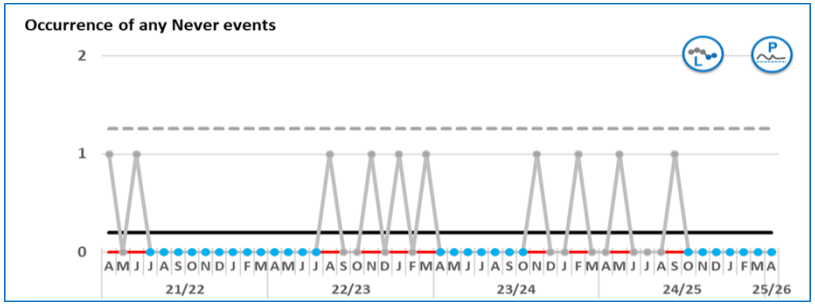
Deliver (Quality and Safety) - Graphs (2)

Metric Under Review	**'Percentage of responses to written complaints sent within 25 days' for this reporting period not available.**
	'Percentage of responses to written complaints acknowledged within 3 days' for this reporting period not available.
	Staff sickness and turnover has meant that a number of complaints have not been accounted for exactly in line with our processes and a number of complaints have exceeded their deadlines. As a double check an audit is being undertaken to confirm all complaints correspondence has been accounted for. This will complete very shortly but not in time for this IPR. New staff have been appointed and strict adherence to process has now been restored. ***Review Date:*** Jun 2025 ***Action Lead:*** Robin Tall
	**'Freedom of Information Requests Responded to Within 20 Days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 92.3%.**
	Process improvements have been made and FOI response performance has increased. The following further measures are in place to ensure that performance is consistent: 1) Continue working to update our Freedom of Information dashboard to capture when the Standard Operating Procedure is not being followed and address these areas. This will support managers in meeting deadlines. 2) Continue to work with communication teams to get the disclosure log active to improve efficiency in responding to requests.
Metric Under Review	**'Subject Access Requests (SARs) Responded To Within 28 Days' for this reporting period not available.**
	SAR data has been temporarily suspended whilst the operations team re-draft the processes across the Trust to ensure that all sites and teams are reporting accurately; IG support is being provided. When complete, the Trust will be able report on the outturn against the revised process. The Deputy COO has taken on responsibility for Trust-level reporting. This is expected to be completed for the next version of this report. ***Review Date:*** Jun 2025 ***Action Lead:*** Jonathan McKee/Kathryn Lennon

Deliver (Incident Reporting) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Occurrence of any Never events	Sheila Adam	Quality Statutory Reporting	Monthly	Zero Events	0	0		
Summary Hospital Mortality Indicator	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		
National Patient Safety Alerts (NatPSAs) breached	Sheila Adam	CAS (Central Alerting) Requirement	Monthly	Zero Alerts	n/a	0		
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Sheila Adam	Internal Measure	Monthly	No Target Set	n/a	283		

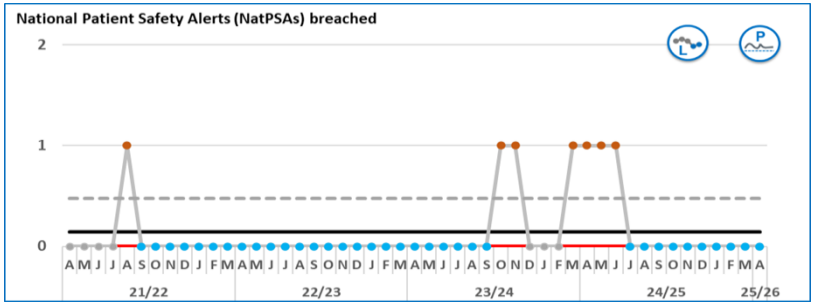
Deliver (Incident Reporting) - Graphs (1)



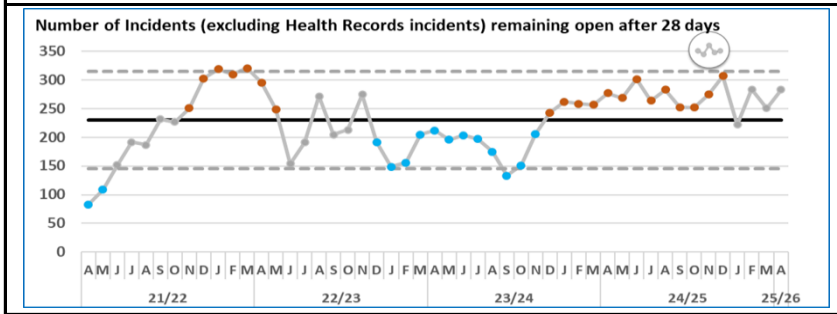
'Occurrence of any Never events ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 0.

No Graph Generated, No cases reported since February 2017

'Summary Hospital Mortality Indicator' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.



'National Patient Safety Alerts (NatPSAs) breached' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 0.

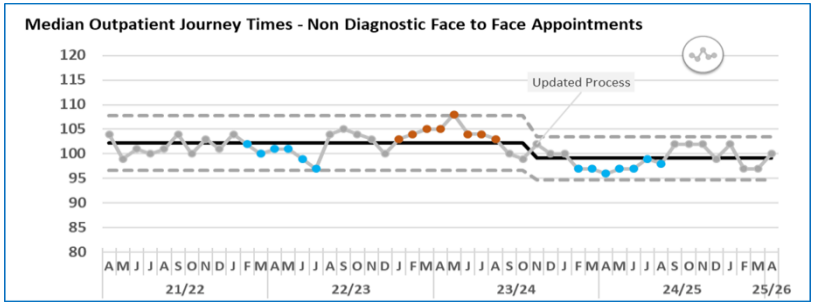


'Number of Incidents (excluding Health Records incidents) remaining open after 28 days' is showing 'common cause variation'. The figure is currently at 283.

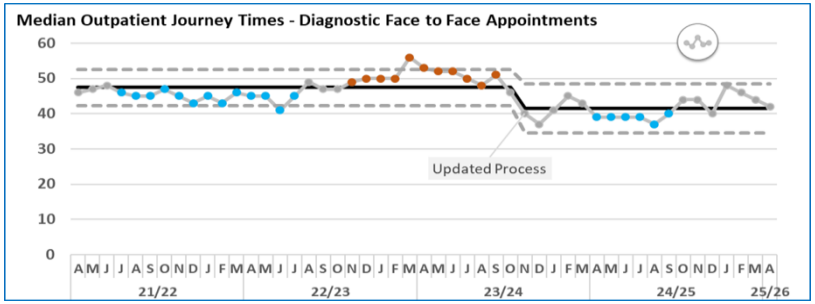
Sustainability and at Scale - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	100		
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	42		
Median Outpatient Journey Times - Virtual TeleMedicine Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	n/a		
Theatre Cancellation Rate (Non-Medical Cancellations)	Jon Spencer	Statutory Reporting	Monthly	≤0.8%	1.05%	1.05%		
Number of non-medical cancelled operations not treated within 28 days	Jon Spencer	Statutory Reporting	Monthly	Zero Breaches	0	0		
Overall financial performance (In Month Var. £m)	Justin Betts	NHS Oversight Framework	Monthly	≥0	0.08	0.08		
Commercial Trading Unit Position (In Month Var. £m)	Justin Betts	Internal Measure	Monthly	≥0	-0.17	-0.17		

Sustainability and at Scale - Graphs (1)

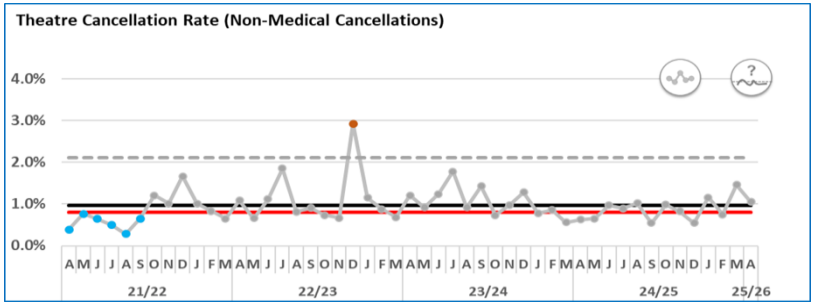


'Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments' is showing 'common cause variation'. The figure is currently at 100.

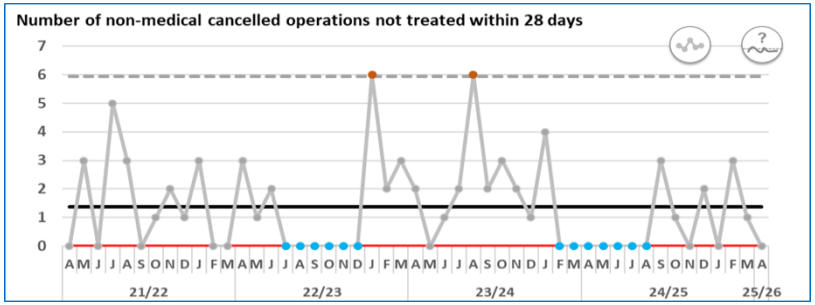


'Median Outpatient Journey Times - Diagnostic Face to Face Appointments' is showing 'common cause variation'. The figure is currently at 42.

Sustainability and at Scale - Graphs (2)

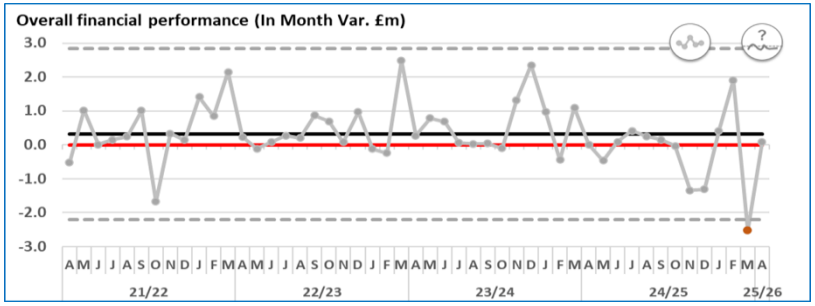


'Theatre Cancellation Rate (Non-Medical Cancellations)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 1.05%.

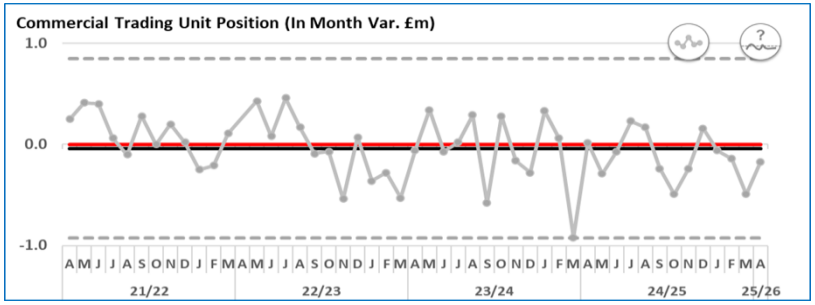


'Number of non-medical cancelled operations not treated within 28 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.

Sustainability and at Scale - Graphs (3)



'Overall financial performance (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 0.08.

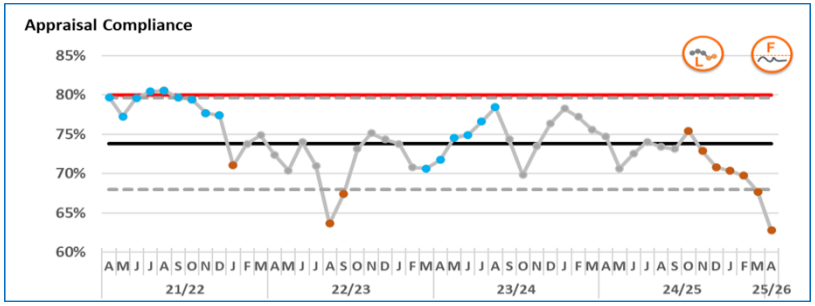


'Commercial Trading Unit Position (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at -0.17.

Working Together - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Appraisal Compliance	Sue Steen	Internal Measure	Monthly	≥80%	n/a	62.8%		
Basic Mandatory IG Training	Samuel Armstrong	DSPT Toolkit (Locally Monitored)	Monthly	≥90%	n/a	89.8%		
Staff Sickness (Month Figure)	Sue Steen	Performance Assessment Framework	Monthly (Month in Arrears)	≤4%	n/a	4.8%		
Staff Sickness (Rolling Annual Figure)	Sue Steen	Performance Assessment Framework	Monthly (Month in Arrears)	≤4%	n/a	4.8%		
Recruitment Time To Hire (Days)	Sue Steen	Internal Definition	Monthly	≤ 40 Days	n/a	41		
Proportion of Temporary Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	8.8%	8.8%		
Proportion of Bank Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	7.0%	7.0%		
Proportion of Agency Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	1.9%	1.9%		
Proportion of Permanent Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	91.2%	91.2%		

Working Together - Graphs (1)



'Appraisal Compliance' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 62.8%.

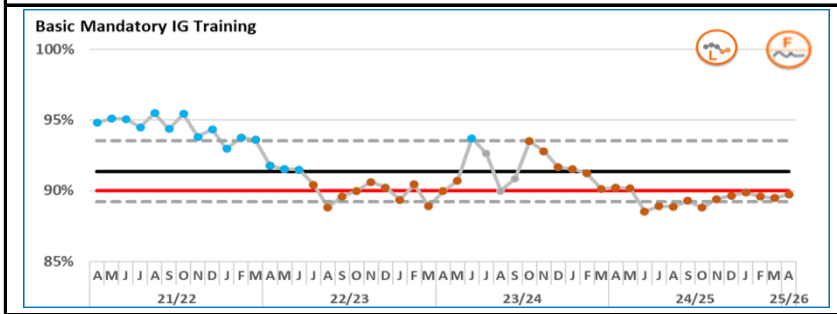
The transition to the new appraisal process via PERFORM is reflected in the current reduced compliance rate, as employees adapt to the fully digital, paper-free system. The appraisal window, which began on 1 April 2025, will remain open until 31 July 2025, supported by ongoing manager workshops that commenced in February.

To facilitate the change, digital resources have been created and are available to all staff, offering a suite of topics that can be accessed as a full course or as individual guidance. These resources are accessible via Insight under "All Staff e-Learning + Resources – PERFORM – My Appraisal."

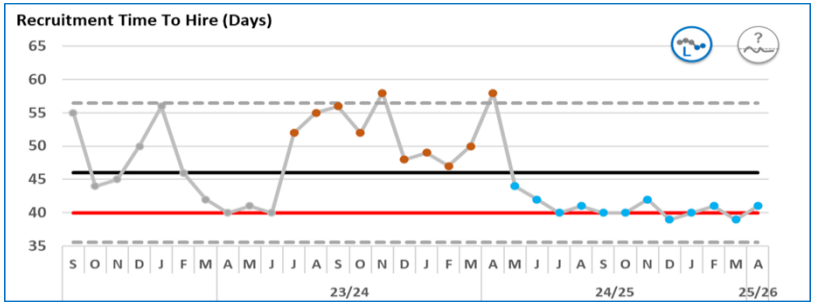
Additionally, FAQs and regular updates are provided through eyeQ, with weekly engagement reports shared with senior managers for oversight. The team are attending department / directorate meetings and visiting network sites to engage with teams to stress the value and importance of appraisal conversations.

To date only 566 appraisals have been completed with 1,800 still required to meet 80% by the end of July

Review Date: Jun 2025 ***Action Lead:*** Jan Lonsdale



'Basic Mandatory IG Training' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 89.8%.



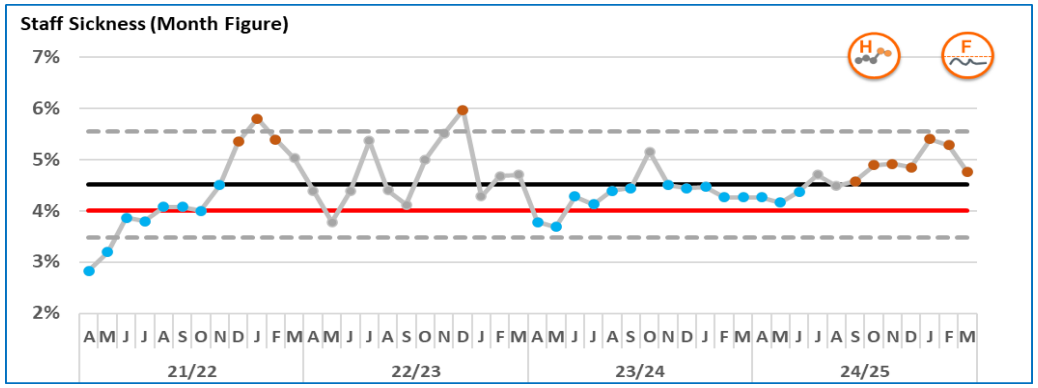
'Recruitment Time to Hire (Days)' is showing 'special cause improvement' and that the current process is not consistently achieving the target. The figure is currently at 41.

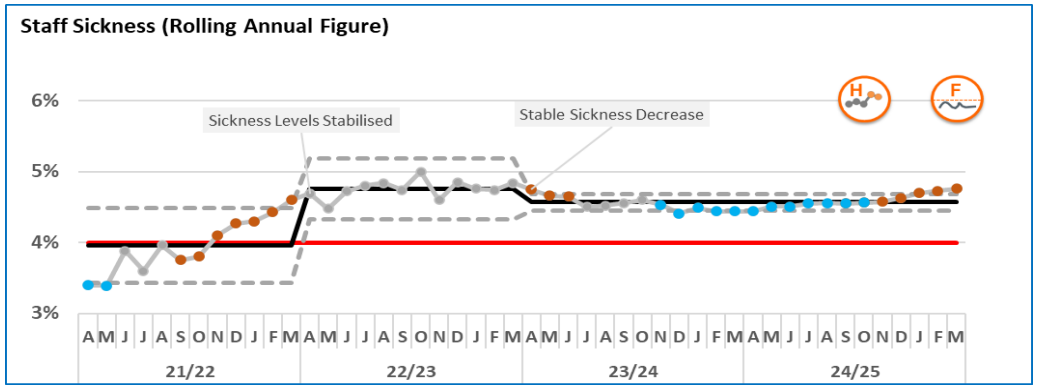
The time to hire (TTH) performance for April is 41 days, which is one day under the Trust target.

Sustaining and improving the time to hire target continues with the Recruitment team supporting and advising managers.

Review Date: Jun 2025 ***Action Lead:*** Jenny Donald

Working Together - Graphs (2)





'Staff Sickness (Month Figure)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 4.8%.	**'Staff Sickness (Rolling Annual Figure)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 4.8%.**

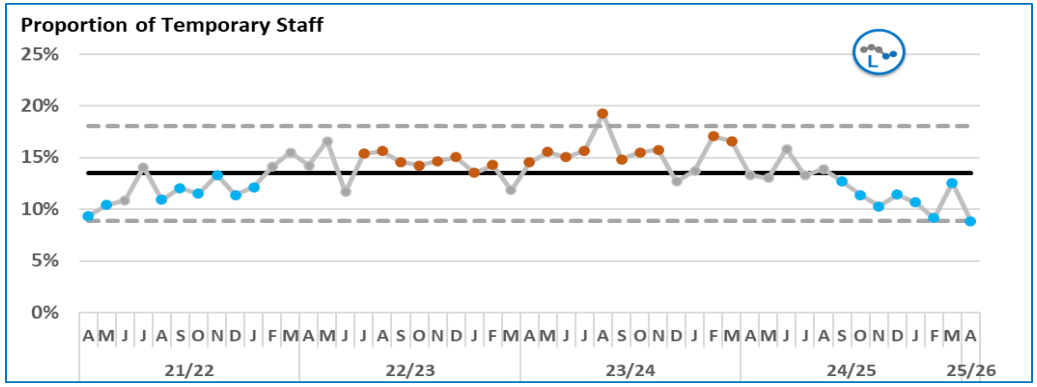
In Month Sickness Rate is 4.61%, which has decreased since last month (4.76%) which is above the 4% target.

The top 3 reasons for sickness absences continues to be the same (in month) reporting.
1. Anxiety/stress/depression/other psychiatric illness,
2. Cold, Cough, Flu – Influenza
3. Musculoskeletal problems.

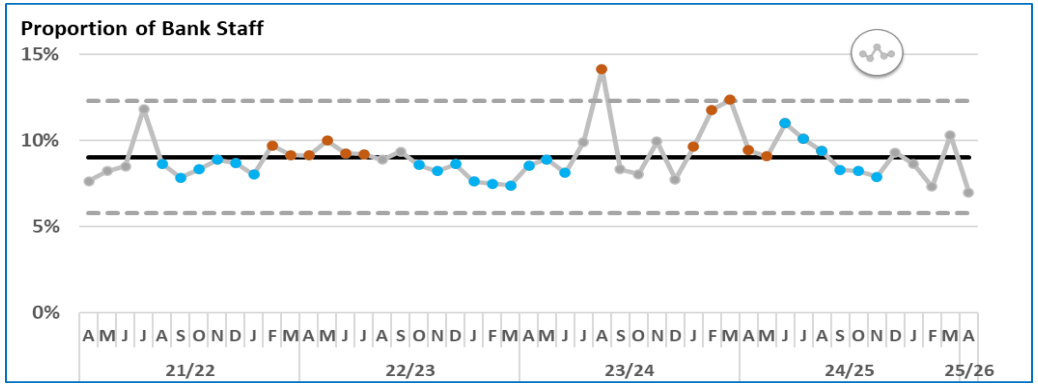
Work continues in providing:
• targeted sickness absence training to hotspot areas with high level absence rates for both short- and long-term cases.
• targeted coaching to managers in relation to the management of complex sickness absence cases, with key focus on long terms absence cases that are 100 days.
• On-going promotion of Thrive, Moorfields (Wellbeing Programme) which outlines offers available to all staff via webinars such as: (Henpicked) a platform helping women thrive in work and Health Hero Assist both held in April.

Review Date: Jun 2025 ***Action Lead:*** Jackie Wyse

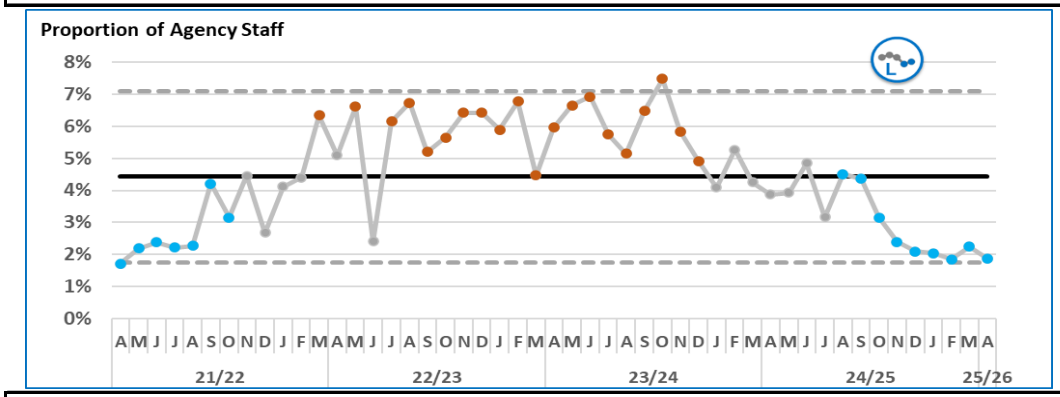
Working Together - Graphs (3)



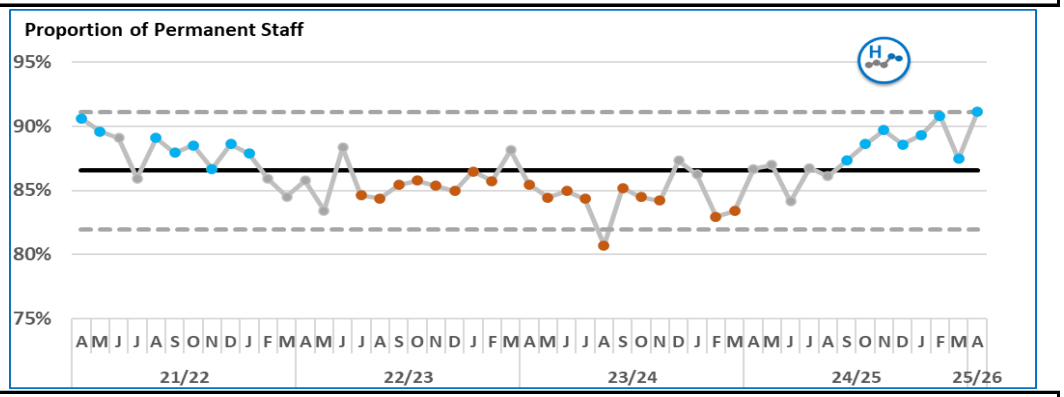
'Proportion of Temporary Staff ' is showing 'special cause improvement' (decreasing rate). The figure is currently at 8.8%.



'Proportion of Bank Staff' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 7.0%.



'Proportion of Agency Staff' is showing 'special cause improvement' (decreasing rate) - This is a change from the previous month. The figure is currently at 1.9%.



'Proportion of Permanent Staff' is showing 'special cause improvement' (increasing rate) - This is a change from the previous month. The figure is currently at 91.2%.

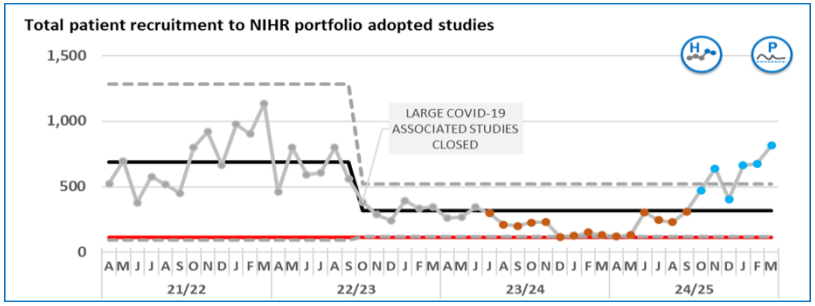
- The Temporary staffing reduction group has refreshed its governance, reporting and monitoring approach to ensure better; (i) Exec oversight, grip and control pertaining to the utilisation and spend of temporary staff which will also enable delivery of reduction targets for 2025/26
- The utilisation of bank has grown over the last 12 months to support the Trust's approach of reducing agency reduction. This has been due to converting of agency to bank utilisation which resulted in a £300,000 saving which has contributed to the overall 39% reduction in 2024/25.
- The top three reasons for temporary staffing utilisation and spend continues to be undertaking of additional shifts, covering of vacancy, and long-term sickness absences. The temporary staffing team and our supplier, Bank Partners, continue to work with hiring managers in the utilisation and spend with focus on governance, monitoring, and delivery of required reduction.

Review Date: Jun 2025 ***Action Lead:*** Geoff Barsby / Rakni Anand

Discover - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Total patient recruitment to NIHR portfolio adopted studies	Hilary Fanning	Internal Measure	Monthly (Month in Arrears)	≥115 (per month)	n/a	815	H	P
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Hilary Fanning	Internal Measure	Monthly (Month in Arrears)	No Target Set	n/a	883	H	
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Hilary Fanning	Internal Measure	Monthly (Month in Arrears)	≥44	n/a	61	H	P
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Hilary Fanning	Internal Measure	Monthly (Month in Arrears)	≥2%	n/a	3.6%	L	P

Discover - Graphs (1)



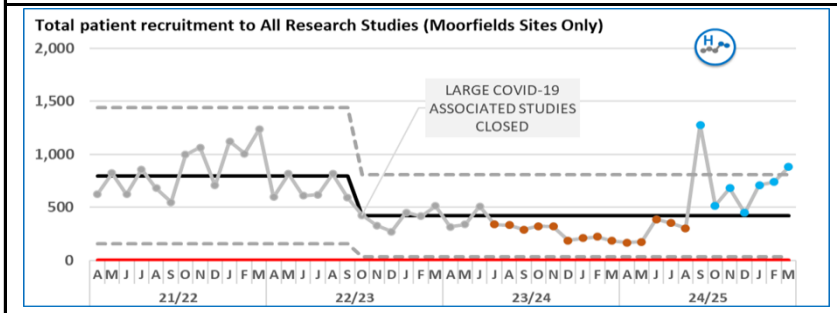
'Total patient recruitment to NIHR portfolio adopted studies' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 815.

The majority of Moorfield's studies are NIHR Portfolio adopted. The percentage split for currently active studies is 83% NIHR portfolio and 17% non- NIHR portfolio. Total recruitment to NIHR portfolio adopted studies in the recently completed financial year 24/25 is 5845, an increase of over 2000 compared to the last year, so we continue to maintain an upward trajectory of recruitment, and is closer to our 22/23 figure of 5,856 which still included some of our higher recruiting COVID studies.

To maintain these recruitment levels, it is important that we continue to attract more grants and awards.
We were awarded 5 NIHR project grants over the last financial year. One is being led by Moorfields and will recruit 250 patients with proliferative diabetic retinopathy over 25 sites from across the UK onto a study that will compare efficacy and safety of rapid surgical intervention for patients with retinal bleeds to the current standard of care where surgical intervention is offered as a last resort. The award of £1,029,194 will financially support the study for 42 months.

For the other two projects, Moorfields are collaborators on the award. In one project, Moorfields is collaborating with Ufonia Limited, a company developing next-generation technology to automate routine clinical conversations. Moorfields is the sole patient recruitment site on the project and intends to recruit 800 patients to the study over 10 months.

Review Date: Jun 2025 ***Action Lead:*** Hilary Fanning



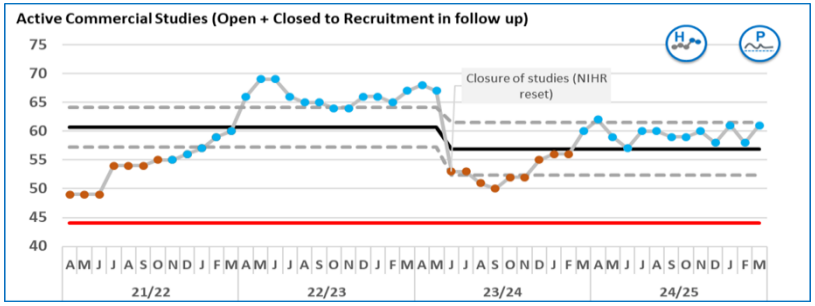
'Total patient recruitment to All Research studies (Moorfields Sites Only)' is showing 'special cause improvement' (increasing rate). The figure is currently at 883.

The total patient recruitment in March 2025 across both NIHR portfolio and non NIHR portfolio studies was 883 recruits. This metric includes commercial and non-commercial studies. Our commercial study recruitment varies from month to month, with March having 14 recruits, which is 1.6% of the monthly total and higher than in the past few months. Recruitment to non-NIHR portfolio studies was to 56 in March (6%).

In February 2025, Professors Lyndon da Cruz & Pete Coffey were awarded funding from Moorfields Eye Charity for a project led by UCL IoO and supported by MEH. Their project builds on the work of The London Project to advance stem cell derived tissue transplantation as a treatment for age-related macular degeneration (AMD) . Their work with the funding will refine patch and delivery tools of these cells and expand the use of cell lines according to good manufacturing practice guidelines. Whilst this project dose not involve patients, the work has the potential to support future clinical trials involving stem cell derived therapies in patients with the wet or dry form of AMD and diabetic retinal disease, all currently incurable, providing a strong foundation for potentially curative therapies for chronic disorders which will be of enormous benefit for patients.

Review Date: Jun 2025 ***Action Lead:*** Hilary Fanning

Discover - Graphs (2)



'Active Commercial Studies (Open + Closed to Recruitment in follow up)' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 61.

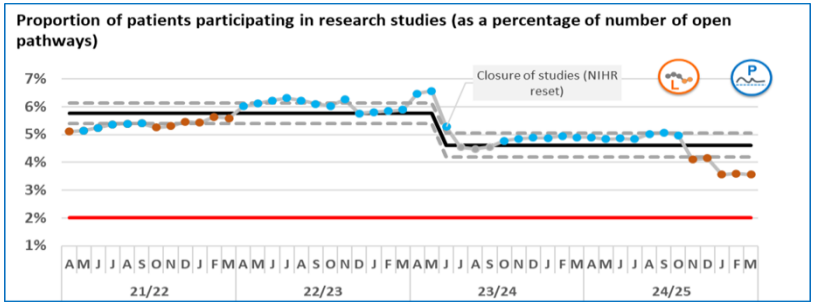
There are currently 60 commercial studies recruiting and in follow up . This metric displays a good level of consistency. This is keeping in line with our average across 2023/24 which was 58. Our medium-term goal is to increase the percentage of patients recruited to commercial studies, to the NIHR recommended level of 25% of all patient's recruited going into commercial studies. For this financial year our % of recruitment into commercial studies stands at 2%.

Commercial studies are frequently interventional, requiring intensive investigations by skilled multidisciplinary staff and close monitoring. They give our patients access to new Investigational Medicinal Products (IMP) and devices. The current pipeline of 26 hosted studies in "set up" should ensure that we continue to increase recruitment to commercial studies. 13 out of 17 (76%) of commercial studies recruited fully within the target time.

Set-up times for commercial and non-commercial studies continue to improve, some anomalies are still present, mainly due to the complexity of contracting for certain types of studies, which can delay things. The median set-up time for clinical trials has decreased to 94 days in March, compared to 99 days at the end of December 2024. We are actively looking for new innovative methods of shortening the set up time to ensure that studies start recruiting as soon they open.

In February we opened a commercial Open-label Extension Study for Participants who Completed Study IMVT-1401-3201 or Study IMVT-1401-3202 to Assess the Efficacy and Safety of Batoclimab for the Treatment of Thyroid Eye Disease (UDDJ1004). Our first patient has already transferred over meaning the target has been met for this study.

Review Date: Jun 2025 ***Action Lead:*** Hilary Fanning



'Proportion of patients participating in research studies (as a percentage of number of open pathways)' is showing 'special cause concern' however the current process will consistently pass the target. The figure is currently at 3.6%.

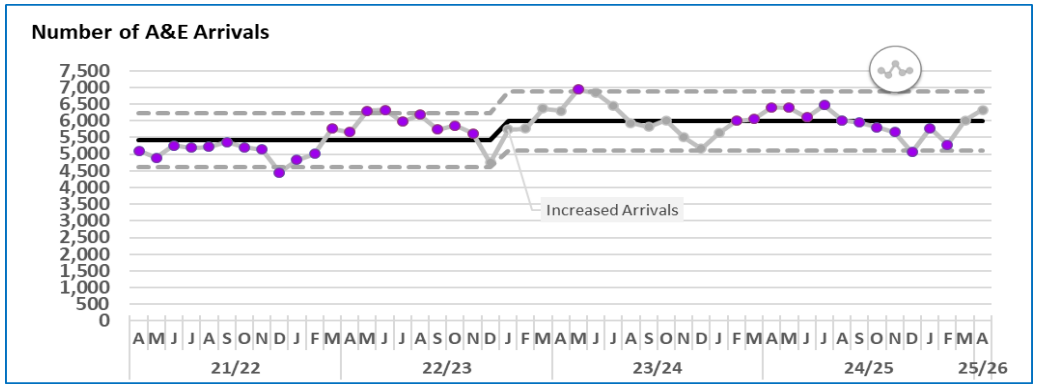
We have recently acheived a sustained increase in the number of patients recruited each month, however, the conclusion of two recent studies, one large non-commercial study, Hercules and one large genetics study, the NIHR Bioresource Tissue Bank, prevents an increase in the overall number of patients currently participating in research. We continue to exceed the 2.0% target . We continue to place emphasis on and investment in patient and public involvement and engagement (PPIE), delivered through the work of our NIHR Biomedical Research Centre (BRC) and Clinical Research Facility (CRF). Our Equity, Diversity, and Inclusion strategy for both the BRC and CRF seeks to increase the diversity of our patients recruited to clinical trials, as well as provide increased opportunities for patients to contribute to research.

Review Date: Jun 2025 ***Action Lead:*** Hilary Fanning

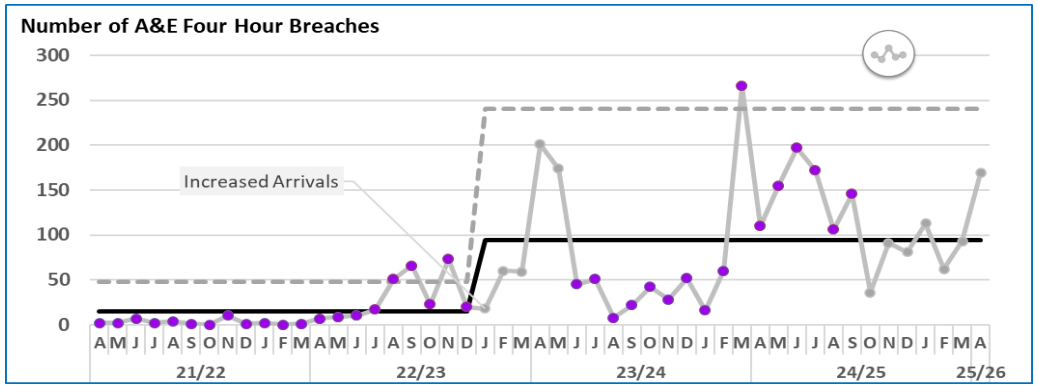
Context (Activity) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Number of A&E Arrivals	Jon Spencer	Internal Requirement	Monthly	No Target Set	6323	6323		
Number of A&E Four Hour Breaches	Jon Spencer	Internal Requirement	Monthly	No Target Set	169	169		
Number of Outpatient Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	53454	53454		
Number of Outpatient First Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	12935	12935		
Number of Outpatient Follow Up Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	40519	40519		
Number of Referrals Received	Jon Spencer	Internal Requirement	Monthly	No Target Set	15197	15197		
Number of Theatre Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	3087	3087		
Number of Theatre Elective Daycase Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	2778	2778		
Number of Theatre Elective Inpatient Admission	Jon Spencer	Internal Requirement	Monthly	No Target Set	67	67		
Number of Theatre Emergency Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	242	242		

Context (Activity) - Graphs (1)

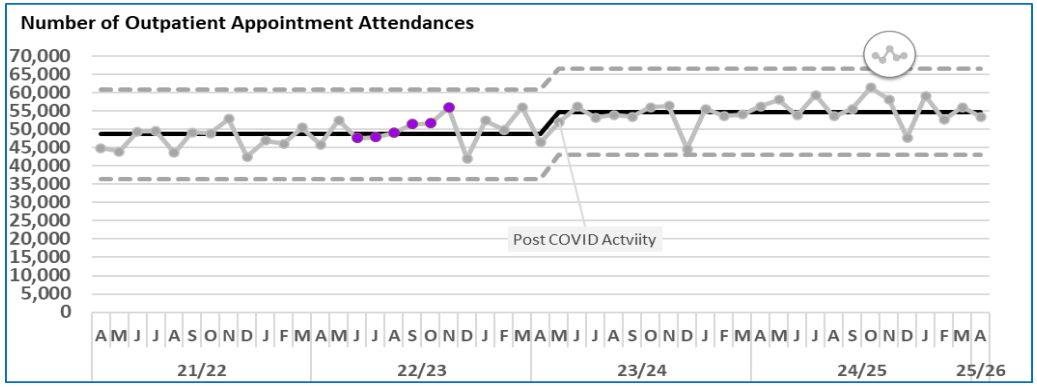


'Number of A&E Arrivals' is showing 'common cause variation'. The figure is currently at 6,323.

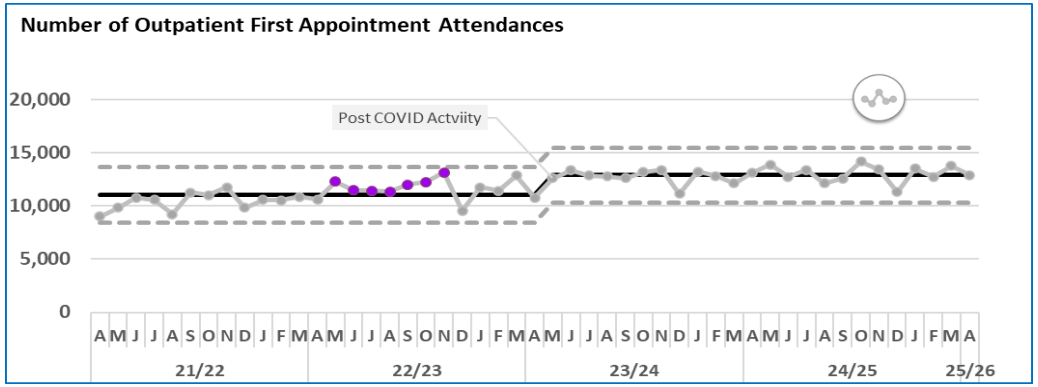


'Number of A&E Four Hour Breaches' is showing 'common cause variation'. The figure is currently at 169.

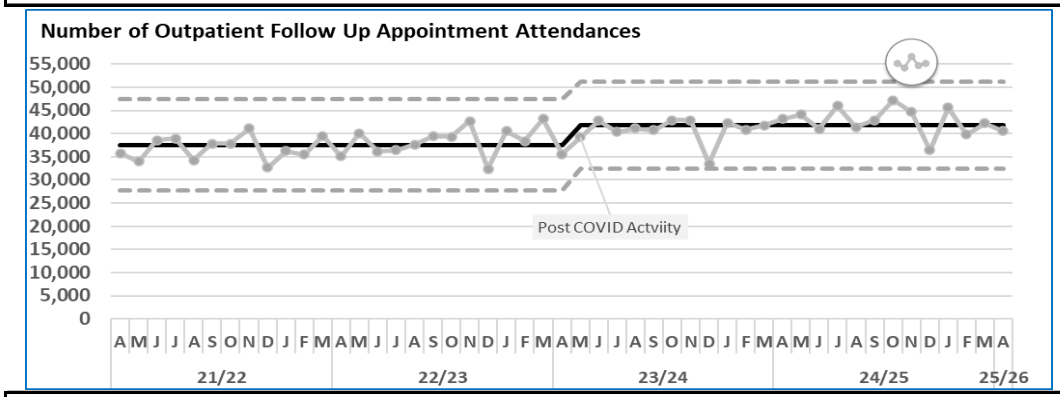
Context (Activity) - Graphs (2)



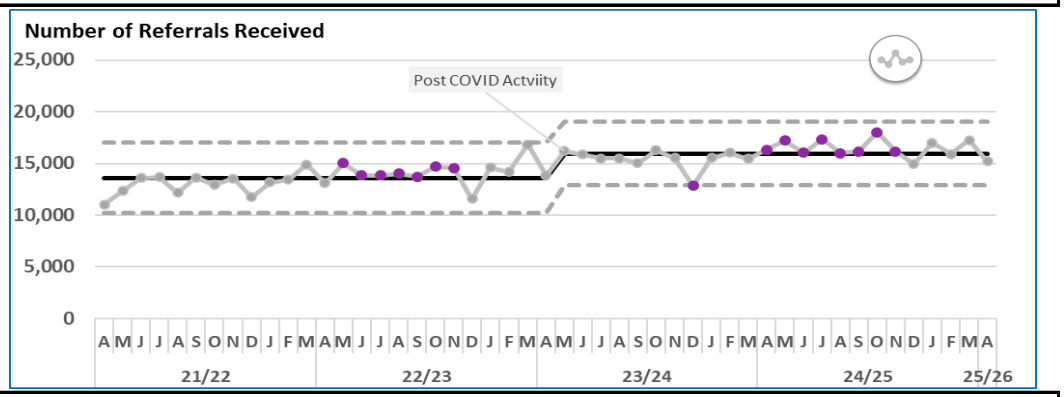
'Number of Outpatient Appointment Attendances' is showing 'common cause variation'. The figure is currently at 53,454.



'Number of Outpatient First Appointment Attendances' is showing 'common cause variation'. The figure is currently at 12,935.

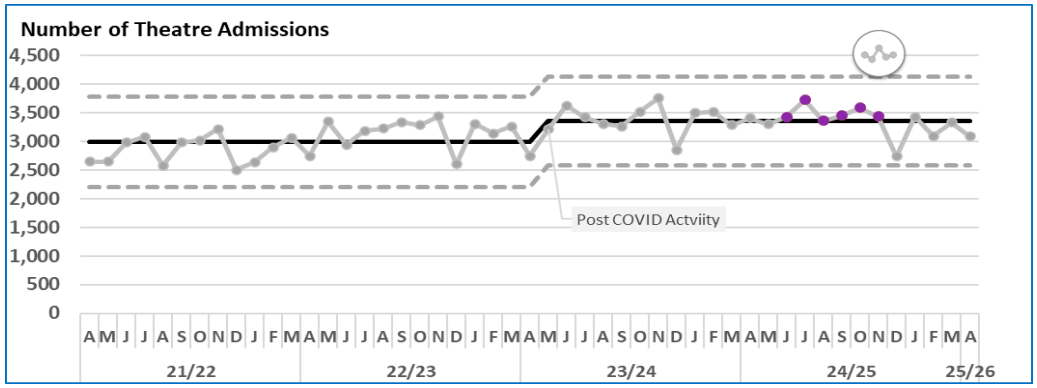


'Number of Outpatient Follow Up Appointment Attendances' is showing 'common cause variation'. The figure is currently at 40,519.

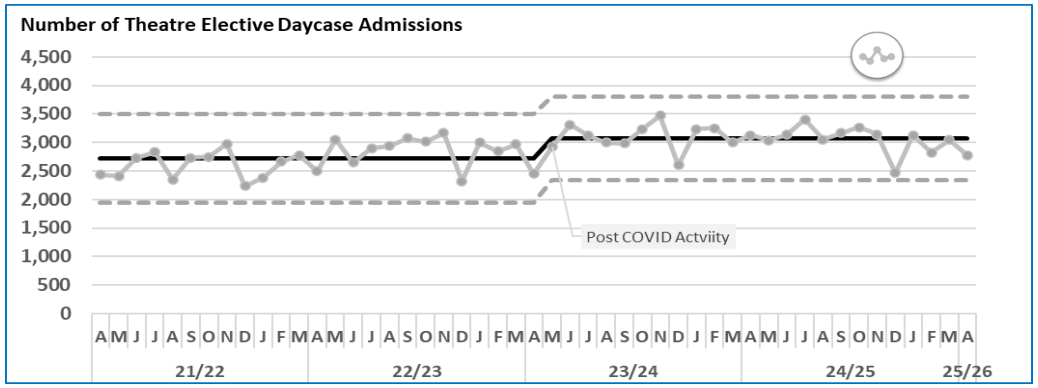


'Number of Referrals Received' is showing 'common cause variation'. The figure is currently at 15,197.

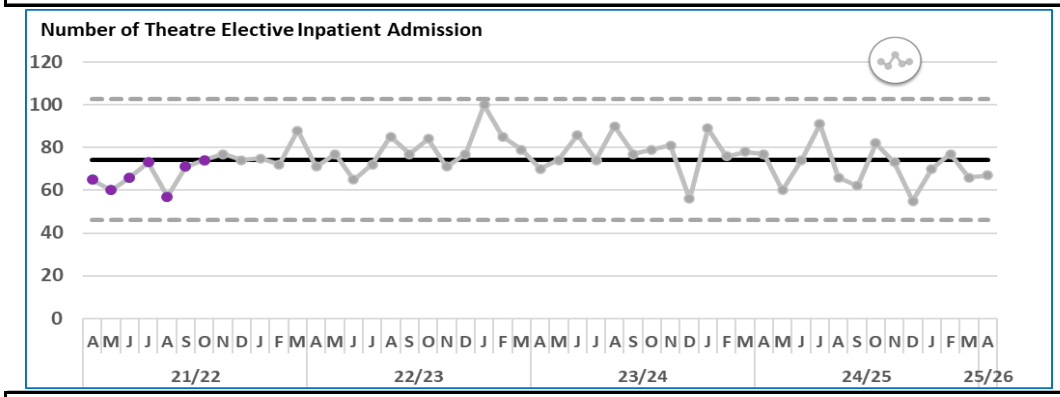
Context (Activity) - Graphs (3)



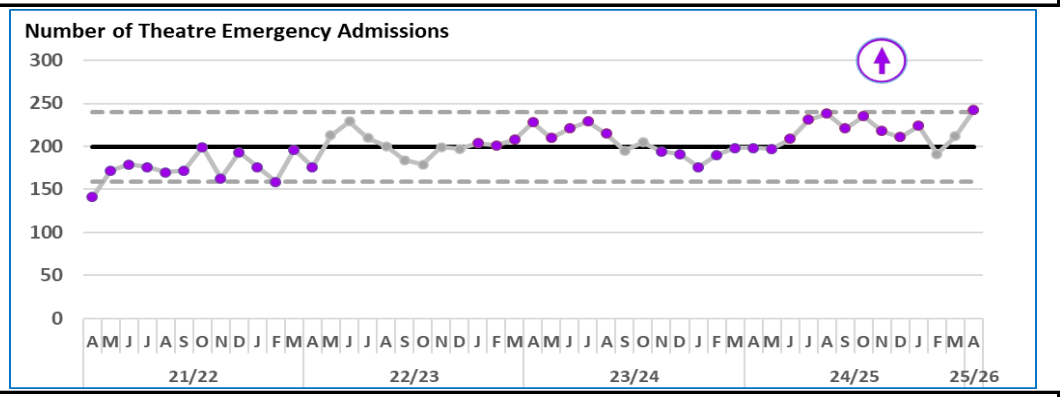
'Number of Theatre Admissions' is showing 'common cause variation'. The figure is currently at 3,087.



'Number of Theatre Elective Daycase Admissions' is showing 'common cause variation'. The figure is currently at 2,778.



'Number of Theatre Elective Inpatient Admission' is showing 'common cause variation'. The figure is currently at 67.



'Number of Theatre Emergency Admissions' is showing an 'special cause variation' (increasing rate) - This is a change from the previous month. The figure is currently at 242.

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Deliver (Activity vs Plan)																						
Elective Activity - % of Phased Plan	Apr-25	101.9%	≥100%	Monthly	Common Cause	Hit or Miss	93.7%	76.2%	111.1%	98.2%	95.2%	103.6%	95.3%	93.6%	96.7%	90.6%	95.3%	78.5%	90.5%	89.9%	92.7%	101.9%
Total Outpatient Activity - % of Phased Plan	Apr-25	103.1%	≥100%	Monthly	Common Cause	Hit or Miss	102.1%	89.1%	115.2%	105.9%	108.8%	106.1%	102.0%	100.5%	104.3%	105.0%	109.3%	94.3%	106.1%	103.5%	105.2%	103.1%
Outpatient First Appointment Activity - % of Phased Plan	Apr-25	104.8%	≥100%	Monthly	Common Cause	Hit or Miss	104.6%	90.1%	119.0%	108.2%	115.1%	111.0%	100.8%	99.8%	103.7%	106.4%	110.5%	97.7%	106.3%	109.6%	113.0%	104.8%
Outpatient Follow Up Appointment Activity - % of Phased Plan	Apr-25	102.7%	≥85%	Monthly	Common Cause	Capable	102.7%	88.7%	116.8%	105.3%	107.1%	104.8%	102.3%	100.7%	104.5%	104.7%	108.9%	93.4%	106.1%	101.8%	102.9%	102.7%
Deliver (Cancer Performance)																						
Cancer 28 Day Faster Diagnosis Standard	Apr-25	88.9%	≥75%	Monthly	Common Cause	Hit or Miss	80.0%	25.3%	134.7%	100.0%	80.0%	100.0%	75.0%	88.9%	77.8%	55.6%	100.0%	80.0%	75.0%	75.0%	72.7%	88.9%
% Patients with all cancers receiving treatment within 31 days of decision to treat	Apr-25	n/a	≥96%	Monthly	Not Available	Not Applicable	99.1%	95.2%	103.0%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	89.3%	95.7%	n/a
% Patients with all cancers treated within 62 days	Apr-25	n/a	≥85%	Monthly	Not Available	Not Applicable	96.5%	74.2%	118.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.5%	96.7%	94.1%	100.0%	94.1%	93.8%	n/a

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Deliver (Access Performance)																						
18 Week RTT Incomplete Performance	Apr-25	82.7%	No Target Set	Monthly	Common Cause	Not Applicable	82.7%	81.0%	84.3%	85.0%	85.4%	84.3%	84.0%	82.6%	82.7%	82.4%	82.6%	81.2%	80.9%	82.5%	83.1%	82.7%
RTT Incomplete Pathways (RTT Waiting List)	Apr-25	33,228	≤ Previous Mth.	Monthly	Improvement (Run Below Average)	Not Applicable	34,421	32,848	35,994	35,674	35,682	34,201	33,017	34,357	34,932	33,872	33,281	33,039	32,691	33,406	33,136	33,228
RTT Incomplete Pathways Over 18 Weeks	Apr-25	5,737	≤ Previous Mth.	Monthly	Common Cause	Not Applicable	6,043	5,452	6,633	5,361	5,205	5,377	5,271	5,966	6,038	5,963	5,801	6,222	6,229	5,849	5,594	5,737
52 Week RTT Incomplete Breaches	Apr-25	22	≤5 Breaches	Monthly	Common Cause	Failing	10	-3	24	5	10	7	8	10	8	13	9	9	9	12	18	22
Eliminate waits over 65 weeks for elective care	Apr-25	3	Zero Breaches	Monthly	Common Cause	Hit or Miss	3	-4	11	1	4	3	2	4	2	2	2	0	2	3	6	3
A&E Four Hour Performance	Apr-25	97.2%	≥95%	Monthly	Common Cause	Capable	97.7%	95.2%	100.3%	98.2%	97.4%	96.6%	97.2%	98.1%	97.4%	99.4%	98.3%	98.3%	97.9%	98.8%	98.4%	97.2%
Percentage of Diagnostic waiting times less than 6 weeks	Apr-25	98.4%	≥99%	Monthly	Common Cause	Hit or Miss	99.3%	97.1%	101.4%	100.0%	99.5%	98.9%	98.9%	99.1%	100.0%	100.0%	99.5%	98.3%	97.7%	98.4%	98.7%	98.4%
Deliver (Call Centre and Clinical)																						
Average Call Waiting Time	Apr-25	260	≤ 2 Mins (120 Sec)	Monthly	Concern (Higher Than Expected)	Hit or Miss	150	40	261	236	197	276	146	174	139	112	109	32	77	199	255	260
Average Call Abandonment Rate	Apr-25	15.5%	≤15%	Monthly	Common Cause	Hit or Miss	10.7%	3.4%	17.9%	16.3%	14.0%	18.8%	12.0%	13.2%	10.6%	9.0%	8.5%	2.5%	6.4%	13.3%	16.4%	15.5%
Mixed Sex Accommodation Breaches	Apr-25	0	Zero Breaches	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Apr-25	2.86%	≤ 2.67%	Monthly	Common Cause	Hit or Miss	2.02%	-3.44%	7.48%	1.52%	3.23%	0.00%	0.00%	1.47%	5.56%	0.00%	0.00%	9.68%	3.13%	1.69%	4.41%	2.86%
VTE Risk Assessment	Apr-25	99.2%	≥95%	Monthly	Common Cause	Capable	99.2%	97.9%	100.5%	99.8%	99.9%	99.9%	100.0%	99.7%	99.8%	99.8%	99.9%	99.1%	98.6%	99.3%	99.9%	99.2%
Posterior Capsular Rupture rates (Cataract Operations Only)	Apr-25	0.62%	≤1.95%	Monthly	Common Cause	Capable	0.88%	0.17%	1.60%	0.57%	0.82%	0.69%	1.36%	0.76%	0.85%	1.42%	0.92%	1.00%	0.80%	0.87%	0.70%	0.62%
MRSA Bacteraemias Cases	Apr-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile Cases	Apr-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Apr-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Rate - cases	Apr-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Deliver (Quality and Safety)																						
Inpatient Scores from Friends and Family Test - % positive	Apr-25	97.0%	≥90%	Monthly	Common Cause	Capable	95.7%	93.7%	97.7%	95.7%	96.5%	96.7%	97.3%	96.1%	96.2%	96.8%	95.9%	95.0%	95.0%	97.4%	96.8%	97.0%
A&E Scores from Friends and Family Test - % positive	Apr-25	91.7%	≥90%	Monthly	Common Cause	Capable	92.9%	90.5%	95.3%	91.5%	93.2%	92.5%	92.7%	94.0%	93.7%	93.4%	93.9%	94.7%	94.7%	94.4%	94.3%	91.7%
Outpatient Scores from Friends and Family Test - % positive	Apr-25	95.8%	≥90%	Monthly	Improvement (Run Above Average)	Capable	93.8%	92.8%	94.8%	94.2%	94.5%	94.5%	94.4%	94.4%	94.2%	95.4%	95.0%	94.9%	94.9%	95.5%	95.3%	95.8%
Paediatric Scores from Friends and Family Test - % positive	Apr-25	97.0%	≥90%	Monthly	Common Cause	Capable	94.5%	90.6%	98.5%	95.2%	96.8%	93.6%	94.8%	95.8%	94.4%	93.2%	94.6%	96.3%	96.3%	95.0%	93.8%	97.0%
Percentage of responses to written complaints sent within 25 days	Mar-25	n/a	≥80%	Monthly (Month in Arrears)	Not Available	Not Applicable	76.6%	35.7%	117.5%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Percentage of responses to written complaints acknowledged within 3 days	Apr-25	n/a	≥80%	Monthly	Not Available	Not Applicable	89.6%	62.3%	116.8%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Freedom of Information Requests Responded to Within 20 Days	Mar-25	92.3%	≥90%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	85.6%	53.6%	117.6%	76.1%	86.0%	85.4%	82.8%	87.8%	86.1%	89.4%	78.7%	88.2%	93.8%	100.0%	92.3%	n/a
Subject Access Requests (SARs) Responded To Within 28 Days	Mar-25	n/a	≥90%	Monthly (Month in Arrears)	Not Available	Not Applicable	96.0%	86.1%	105.9%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Deliver (Incident Reporting)																						
Occurrence of any Never events	Apr-25	0	Zero Events	Monthly	Improvement (Run Below Average)	Capable	0	-1	1	0	1	0	0	0	1	0	0	0	0	0	0	0
Summary Hospital Mortality Indicator	Apr-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Patient Safety Alerts (NatPSAs) breached	Apr-25	0	Zero Alerts	Monthly	Improvement (Run Below Average)	Capable	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Apr-25	283	No Target Set	Monthly	Common Cause	Not Applicable	230	145	315	277	269	302	264	283	253	252	275	307	222	284	251	283

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Sustainability and at Scale																						
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Apr-25	100	No Target Set	Monthly	Common Cause	Not Applicable	99	95	103	96	97	97	99	98	102	102	102	99	102	97	97	100
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Apr-25	42	No Target Set	Monthly	Common Cause	Not Applicable	42	35	48	39	39	39	39	37	40	44	44	40	48	46	44	42
Theatre Cancellation Rate (Non-Medical Cancellations)	Apr-25	1.05%	≤0.8%	Monthly	Common Cause	Hit or Miss	0.97%	-0.19%	2.12%	0.62%	0.65%	0.97%	0.90%	1.02%	0.55%	0.99%	0.82%	0.55%	1.16%	0.75%	1.46%	1.05%
Number of non-medical cancelled operations not treated within 28 days	Apr-25	0	Zero Breaches	Monthly	Common Cause	Hit or Miss	1	-3	6	0	0	0	0	0	3	1	0	2	0	3	1	0
Overall financial performance (In Month Var. £m)	Apr-25	0.08	≥0	Monthly	Common Cause	Hit or Miss	0.31	-2.21	2.83	0.01	-0.47	0.09	0.41	0.25	0.15	-0.03	-1.34	-1.31	0.41	1.91	-2.53	0.08
Commercial Trading Unit Position (In Month Var. £m)	Apr-25	-0.17	≥0	Monthly	Common Cause	Hit or Miss	-0.04	-0.93	0.85	0.02	-0.29	-0.07	0.23	0.17	-0.24	-0.49	-0.24	0.16	-0.06	-0.14	-0.49	-0.17
Working Together																						
Appraisal Compliance	Apr-25	62.8%	≥80%	Monthly	Concern (Lower Than Expected)	Failing	73.8%	68.0%	79.7%	74.7%	70.6%	72.5%	74.1%	73.4%	73.1%	75.5%	72.9%	70.8%	70.3%	69.7%	67.7%	62.8%
Basic Mandatory IG Training	Apr-25	89.8%	≥90%	Monthly	Concern (Run Below Average)	Failing	91.4%	89.2%	93.6%	90.2%	90.1%	88.5%	88.9%	88.9%	89.3%	88.8%	89.4%	89.6%	89.9%	89.6%	89.5%	89.8%
Staff Sickness (Month Figure)	Mar-25	4.8%	≤4%	Monthly (Month in Arrears)	Concern (Run Above Average)	Failing	4.5%	3.5%	5.6%	4.3%	4.2%	4.4%	4.7%	4.5%	4.6%	4.9%	4.9%	4.8%	5.4%	5.3%	4.8%	n/a
Staff Sickness (Rolling Annual Figure)	Mar-25	4.8%	≤4%	Monthly (Month in Arrears)	Concern (Higher Than Expected)	Failing	4.6%	4.5%	4.7%	4.4%	4.5%	4.5%	4.5%	4.6%	4.5%	4.6%	4.6%	4.6%	4.7%	4.7%	4.8%	n/a
Recruitment Time To Hire (Days)	Apr-25	41	≤ 40 Days	Monthly	Improvement (Run Below Average)	Hit or Miss	46	36	56	58	44	42	40	41	40	40	42	39	40	41	39	41
Proportion of Temporary Staff	Apr-25	8.8%	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	13.5%	8.9%	18.0%	13.3%	13.0%	15.9%	13.3%	13.9%	12.7%	11.4%	10.3%	11.4%	10.7%	9.2%	12.6%	8.8%
Proportion of Bank Staff	Apr-25	7.0%	No Target Set	Monthly	Common Cause	Not Applicable	9.0%	5.8%	12.3%	9.4%	9.1%	11.0%	10.1%	9.4%	8.3%	8.2%	7.9%	9.3%	8.6%	7.3%	10.3%	7.0%
Proportion of Agency Staff	Apr-25	1.9%	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	4.4%	1.8%	7.1%	3.9%	3.9%	4.9%	3.2%	4.5%	4.4%	3.2%	2.4%	2.1%	2.0%	1.9%	2.2%	1.9%
Proportion of Permanent Staff	Apr-25	91.2%	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	86.5%	82.0%	91.1%	86.7%	87.0%	84.1%	86.7%	86.1%	87.3%	88.6%	89.7%	88.6%	89.3%	90.8%	87.5%	91.2%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Discover																						
Total patient recruitment to NIHR portfolio adopted studies	Mar-25	815	≥115 (per month)	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	320	118	522	124	132	306	247	231	310	472	641	406	663	676	815	n/a
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Mar-25	883	No Target Set	Monthly (Month in Arrears)	Improvement (Run Above Average)	Not Applicable	421	36	806	169	174	387	353	304	1,278	516	681	450	712	741	883	n/a
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Mar-25	61	≥44	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	57	52	61	62	59	57	60	60	59	59	60	58	61	58	61	n/a
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Mar-25	3.6%	≥2%	Monthly (Month in Arrears)	Concern (Lower Than Expected)	Capable	4.6%	4.2%	5.0%	4.9%	4.8%	4.9%	4.8%	5.0%	5.1%	5.0%	4.1%	4.2%	3.6%	3.6%	3.6%	n/a
Context (Activity)																						
Number of A&E Arrivals	Apr-25	6,323	No Target Set	Monthly	Common Cause	Not Applicable	5,992	5,100	6,884	6,401	6,394	6,105	6,469	6,011	5,943	5,807	5,667	5,062	5,783	5,285	6,016	6,323
Number of A&E Four Hour Breaches	Apr-25	169	No Target Set	Monthly	Common Cause	Not Applicable	94	-52	241	110	155	197	172	106	146	36	91	81	113	62	93	169
Number of Outpatient Appointment Attendances	Apr-25	53,454	No Target Set	Monthly	Common Cause	Not Applicable	54,745	43,016	66,473	56,324	57,993	53,777	59,371	53,584	55,497	61,401	58,134	47,773	59,158	52,541	56,025	53,454
Number of Outpatient First Appointment Attendances	Apr-25	12,935	No Target Set	Monthly	Common Cause	Not Applicable	12,922	10,355	15,489	13,103	13,883	12,766	13,401	12,159	12,609	14,195	13,430	11,321	13,534	12,739	13,796	12,935
Number of Outpatient Follow Up Appointment Attendances	Apr-25	40,519	No Target Set	Monthly	Common Cause	Not Applicable	41,823	32,489	51,157	43,221	44,110	41,011	45,970	41,425	42,888	47,206	44,704	36,452	45,624	39,802	42,229	40,519
Number of Referrals Received	Apr-25	15,197	No Target Set	Monthly	Common Cause	Not Applicable	15,965	12,857	19,072	16,328	17,190	16,033	17,315	15,979	16,151	18,006	16,171	14,958	17,018	15,899	17,246	15,197
Number of Theatre Admissions	Apr-25	3,087	No Target Set	Monthly	Common Cause	Not Applicable	3,357	2,584	4,129	3,401	3,294	3,423	3,725	3,357	3,447	3,585	3,433	2,734	3,425	3,094	3,327	3,087
Number of Theatre Elective Daycase Admissions	Apr-25	2,778	No Target Set	Monthly	Common Cause	Not Applicable	3,072	2,334	3,810	3,126	3,037	3,140	3,403	3,053	3,164	3,268	3,142	2,468	3,131	2,826	3,049	2,778
Number of Theatre Elective Inpatient Admission	Apr-25	67	No Target Set	Monthly	Common Cause	Not Applicable	74	46	103	77	60	74	91	66	62	82	73	55	70	77	66	67
Number of Theatre Emergency Admissions	Apr-25	242	No Target Set	Monthly	Increasing (Higher Than Expected)	Not Applicable	199	160	239	198	197	209	231	238	221	235	218	211	224	191	212	242

Moorfields Eye Hospital NHS Foundation Trust

NHS

Report title	Monthly Finance Performance Report Month 01– April 2025
Report from	Justin Betts, Acting Chief Financial Officer
Prepared by	Justin Betts, Acting Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

For April, the trust is reporting:-

Financial Performance £m		In Month			Year to Date		
	Annual Plan	Plan	Actual	Variance	Plan	Actual	Variance
Income	£368.7m	£26.4m	£26.8m	£0.4m	£26.4m	£26.8m	£0.4m
Pay	(£193.2m)	(£16.6m)	(£16.6m)	(£0.0m)	(£16.6m)	(£16.6m)	(£0.0m)
Non Pay	(£131.3m)	(£10.5m)	(£10.9m)	(£0.4m)	(£10.5m)	(£10.9m)	(£0.4m)
Financing & Adjustments	(£44.2m)	(£1.3m)	(£1.2m)	£0.1m	(£1.3m)	(£1.2m)	£0.1m
CONTROL TOTAL	**-**	**(£2.0m)**	**(£1.9m)**	**£0.1m**	**(£2.0m)**	**(£1.9m)**	**£0.1m**

Income and Expenditure

- A £1.9m deficit year to date compared to a planned deficit of £2.0m; £0.1m favourable to plan.

Efficiency and Productivity

- The Trust has identified £4.0m of the £15.1m target required to achieve a break-even financial plan.
- Delivery in April reported £0.23m, broadly in line with the Trusts financial plan.
- However, if reporting the £15.1m efficiency plan in twelfths demonstrating the scale of run-rate reductions required, the trust would be £1.0m adverse to plan compared to a £1.3m pm month target.

Capital Expenditure

- Capital expenditure as of 30th April totalled £9.9m, predominantly linked to Oriel and EPR schemes.
- Internal business as usual schemes are being prioritised subject to finalisation of EPR and ICT transition capital requirements.

Cash

- The cash balance as at the 30th April was £88.2m, an increase of £2.1m since the end of March 2025.

Quality implications
Patient safety has been considered in the allocation of budgets.

Financial implications
Delivery of the financial control total will result in the Trust being eligible for additional benefits that will support its future development.

Risk implications
Potential risks have been considered within the reported financial position and the financial risk register is discussed at the Audit Committee.

Action Required/Recommendation
The board is asked to consider and discus the attached report.

For Assurance		**For decision**		**For discussion**	✓	**To note**	✓

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report

Trust Board Report

For the period ended 30th April 2025 (Month 01)

Report Period	M01 | April 2025
Presented by	Justin Betts| Acting Chief Financial Officer
Written by	Amit Patel | Head of Financial Management Lubna Dharssi | Head of Financial Control Richard Allen | Head of Income and Contracts

Monthly Finance Performance Report

For the period ended 30th April 2025 (Month 01)

Key Messages

Statement of Comprehensive Income

Financial Position

£1.89m deficit in month

For April, the trust is reporting:-

- A £1.89m deficit in-month against a planned deficit of £1.97m, a £0.08m favourable variance to plan
- A £1.89m deficit cumulatively against a planned deficit of £1.97m, £0.08m favourable to plan.

Key Drivers of the Financial Variance

Key Drivers of the core operational performance include:-

- Trusts income and expenditure is broadly in-line with plans for April.
- NHS Clinical income is assumed in line with planning assumptions, until commissioner contracts have been received.
- Activity is also broadly in-line with plans:-
  - Elective activity is 101% in April, 101% cumulatively of the activity plans; reporting £77k over plans in terms of volume
  - Stratford elective activity is 93% of revised demand plans cumulatively.
  - St Ann's elective activity is 86% of revised demand plans cumulatively.
  - Cataract activity is 103% of revised demand plans cumulatively.
  - Outpatients Firsts and Procedures are 104% and 89% respectively cumulatively.
- Efficiency delivery is £0.2m in month, in line with the external efficiency and productivity delivery plan.
  - However when reporting the £15.1m efficiency plan in twelfths reflecting the level of monthly run-rate savings required across the year, the trust would be £1.0m adverse to plan compared to the £1.3m pm month requirement.

Statement of Financial Position

Cash and Working Capital Position

The cash balance as at the 30th April was £88.2m, an increase of £2.1m since the end of March 2025. This equates to approximately 99 days operating cash.

The Better Payment Practice Code (BPPC) performance in April was 95% (volume) and 96% (value) against a target of 95% across both metrics.

Capital

(both gross capital expenditure and CDEL)

Capital expenditure as of 30th April totalled £9.9m.

- Business as usual capital totalled £0.1m.
- Other capital totalled £9.8m including £9.5m of Oriel expenditure and £0.3m for EPR

Business as usual capital remaining excluding internally funded EPR totals £3.8m and are being prioritised subject to previously committed capital expenditure and finalisation of Oriel ICT transition costs and EPR programmed funds.

Other Key Information

Efficiencies

£15.1m Trust Target

£0.2m YTD actual

£11.1m un-identified and non recurrently identified schemes

The trust has a planned efficiency programme of £15.1m for 2025/26 to deliver the control total.

The trust has identified £4.0m, £11.1m adverse to plan. Of the total identified:-

- £2.3m is identified central schemes
- £0.4m is identified as income generation schemes;
- £0.9m is forecast recurrently;

The efficiency and productivity programme governance is being reviewed to enhance identification and implementation of schemes including revised terms of reference and accountability frameworks.

Agency Spend

£0.30m spend YTD

1.8% total pay

Trust wide agency spend totals £0.30m cumulatively, approximately 1.8% of total employee expenses spend, below the system allocated target of 2.5%.

Workforce have instigated temporary staffing committees for oversight in relation to managing and reporting temporary staffing agency usage and reasons.

Trust Financial Performance - Financial Dashboard Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income	£368.7m	£26.4m	£26.8m	£0.4m	£26.4m	£26.8m	£0.4m	2%	
Pay	(£193.2m)	(£16.6m)	(£16.6m)	(£0.0m)	(£16.6m)	(£16.6m)	(£0.0m)	(0)%	
Non Pay	(£131.3m)	(£10.5m)	(£10.9m)	(£0.4m)	(£10.5m)	(£10.9m)	(£0.4m)	(4)%	
Financing & Adjustments	(£44.2m)	(£1.3m)	(£1.2m)	£0.1m	(£1.3m)	(£1.2m)	£0.1m	7%	
CONTROL TOTAL	**-**	**(£2.0m)**	**(£1.9m)**	**£0.1m**	**(£2.0m)**	**(£1.9m)**	**£0.1m**		
Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income									
Memorandum Items									
Research & Development	£0.40m	£0.02m	(£0.13m)	(£0.16m)	£0.02m	(£0.13m)	(£0.16m)	(638)%	
Commercial Trading Units	£5.45m	£0.46m	£0.29m	(£0.16m)	£0.46m	£0.29m	(£0.16m)	(36)%	
ORIEL Revenue	(£1.31m)	(£0.11m)	(£0.18m)	(£0.08m)	(£0.11m)	(£0.18m)	(£0.08m)	(69)%	
Efficiency Schemes	£15.10m	£1.28m	£0.23m	(£1.05m)	£1.28m	£0.23m	(£1.05m)	(82)%	

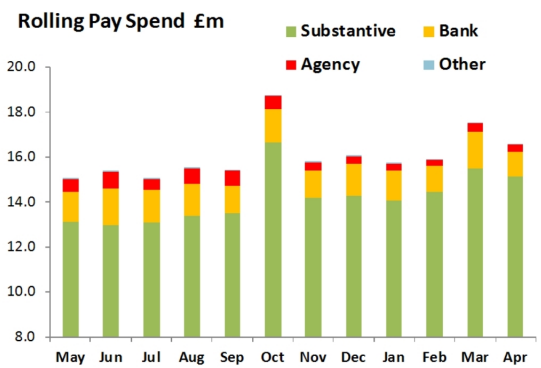
INCOME BREAKDOWN RELATED TO ACTIVITY

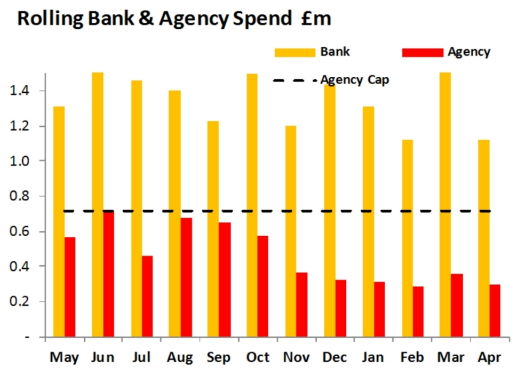
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£210.4m	£16.1m	£16.1m	(£0.1m)				
Pass Through	£40.2m	£3.0m	£3.4m	£0.4m				
Other NHS Clinical Income	£11.9m	£0.9m	£1.0m	£0.1m				
Commercial Trading Units	£48.4m	£3.9m	£3.8m	(£0.2m)				
Research & Development	£15.6m	£1.2m	£1.2m	£0.1m				
Other	£42.3m	£1.3m	£1.4m	£0.1m				
INCOME INCL ERF	**£368.7m**	**£26.4m**	**£26.8m**	**£0.4m**				

RAG Ratings Red > 3% Adverse Variance, Amber < 3% Adverse Variance, Green Favourable Variance, Grey Not applicable

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	% Total
Employed	(£190.9m)	(£16.4m)	(£15.1m)	£1.3m	(£16.4m)	(£15.1m)	£1.3m	91%
Bank	(£1.0m)	(£0.1m)	(£1.1m)	(£1.0m)	(£0.1m)	(£1.1m)	(£1.0m)	7%
Agency	(£0.6m)	(£0.0m)	(£0.3m)	(£0.3m)	(£0.0m)	(£0.3m)	(£0.3m)	2%
Other	(£0.6m)	(£0.1m)	(£0.1m)	(£0.0m)	(£0.1m)	(£0.1m)	(£0.0m)	0%
TOTAL PAY	**(£193.2m)**	**(£16.6m)**	**(£16.6m)**	**(£0.0m)**	**(£16.6m)**	**(£16.6m)**	**(£0.0m)**	





Pay spend chart adjusted for £5.8m pension cost contributions received in March 2024.

*Agency cap levels set by NHSIE

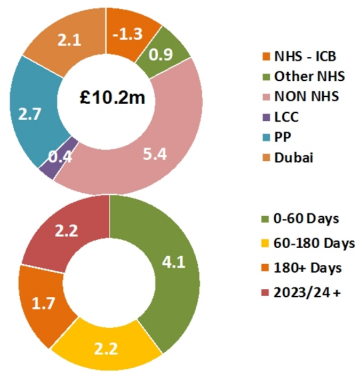
CASH, CAPITAL AND OTHER KPI'S

Capital Programme £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£3.8m)	(£0.1m)	(£0.1m)	£0.0m				
Donated/Externally funded	(£145.2m)	(£9.5m)	(£9.5m)	-				
TOTAL	**£149.0m**	**£9.6m**	**£9.6m**	**£0.0m**				

Key Metrics	Plan	Actual	RAG
Cash	71.4	88.2	
Debtor Days	45	12	
Creditor Days	45	55	
PP Debtor Days	65	49	

Better Payment Practice	Plan	Actual
BPPC - NHS (YTD) by number	95%	93%
BPPC - NHS (YTD) by value	95%	96%
BPPC - Non-NHS (YTD) by number	95%	97%
BPPC - Non-NHS (YTD) by value	95%	96%

Net Receivables/Ageing £m



Trust Income and Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income									
NHS Commissioned Clinical Income	250.57	19.14	19.43	0.29	19.14	19.43	0.29	2%	
Other NHS Clinical Income	11.87	0.89	0.99	0.10	0.89	0.99	0.10	11%	
Commercial Trading Units	48.42	3.91	3.75	(0.16)	3.91	3.75	(0.16)	-4%	
Research & Development	15.56	1.17	1.24	0.07	1.17	1.24	0.07	6%	
Other Income	42.26	1.30	1.43	0.13	1.30	1.43	0.13	10%	
Total Income	**368.68**	**26.41**	**26.84**	**0.44**	**26.41**	**26.84**	**0.44**	**2%**	
Operating Expenses									
Pay	(193.15)	(16.58)	(16.58)	(0.00)	(16.58)	(16.58)	(0.00)	0%	
Of which: undernoted CIP	5.30	0.77	-	(0.77)	0.77	-	(0.77)		
Drugs	(43.02)	(3.27)	(3.69)	(0.42)	(3.27)	(3.69)	(0.42)	13%	
Clinical Supplies	(27.24)	(2.20)	(2.09)	0.11	(2.20)	(2.08)	0.11	-5%	
Other Non Pay	(61.06)	(5.02)	(5.15)	(0.13)	(5.02)	(5.15)	(0.13)	3%	
Of which: undernoted CIP	2.87	0.34	-	(0.34)	0.34	-	(0.34)		
Total Operating Expenditure	**(324.47)**	**(27.07)**	**(27.51)**	**(0.45)**	**(27.07)**	**(27.51)**	**(0.45)**	**2%**	
EBITDA	44.22	(0.66)	(0.67)	(0.01)	(0.66)	(0.67)	(0.01)	1%	
Financing & Depreciation	(18.96)	(1.36)	(1.26)	0.09	(1.36)	(1.26)	0.09	-7%	
Donated assets/Impairment adjustment	(25.29)	0.05	0.04	(0.00)	0.05	0.04	(0.00)	9%	
Control Total Surplus/(Deficit) 7	**(0.00)**	**(1.97)**	**(1.89)**	**0.08**	**(1.97)**	**(1.89)**	**0.08**	**4%**	

PERFORMANCE AGAINST PLAN

Commentary

Operating Income

£0.44m favourable to plan in month

Total operating income is reporting £26.84m in-month, £0.44m favourable to plan, and £0.44m favourable cumulatively. Key points of note are:-

- Clinical income was £19.43m, £0.29m favourable to plan in-month.
- Underlying elective activity was at 101% (101% cumulatively). Elective activity was below plan in the north-east locality with Stratford activity at 93% and St Anns activity at 86% during April. QMR was also below plan at 64%.
- Commercial trading income was £3.75m, £0.16m adverse to plan.
- Research and Development income at £1.24m, £0.07m favourable to plan
- Other income was £0.13m favourable driven by HEE and commercial course income

Employee Expenses

Break-even to plan in month

April pay is reporting £16.58m (2,865wte); break-even to plan in month. Key points of note are:-

- Substantive pay costs (2,656wte) were £15.48m, higher than the prior average of £14.03m. Pay award accrual estimated at 2.8% has been accrued whilst the Trust is now incurring additional employer NI charges of circa 1.9%
- Temporary staffing costs were £1.422m in April.
  - Agency costs (34wte) are £0.30m in month, lower than the 12-month trend of £0.49m. Use continues mainly on administration in both clinical and corporate areas.
  - Bank costs (174wte) are £1.12m in month, lower than the rolling trend of £1.39m. Bank use continues to be mainly in clinical areas and within the medical staffing group.
  - £0.77m unachieved pay CIP (£0.77m cumulatively)

Non-Pay Expenses

£0.35m adverse to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in April were £10.93m, £0.44m adverse to plan. Key points of note are:-

- Drugs was £0.42m adverse to plan in month with £3.69m expenditure against a 12-month trend of £3.61m. Injections were at 112% of planned activity in month.
- Clinical supplies was £0.11m favourable to plan in month. Costs were £2.09m in month against a 12-month trend of £2.11m.
- Other non-pay was £0.13m adverse in month with £5.15m expenditure against a 12-month trend of £4.87m.
- £0.34m unachieved non-pay CIP (£0.34m cumulatively)

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

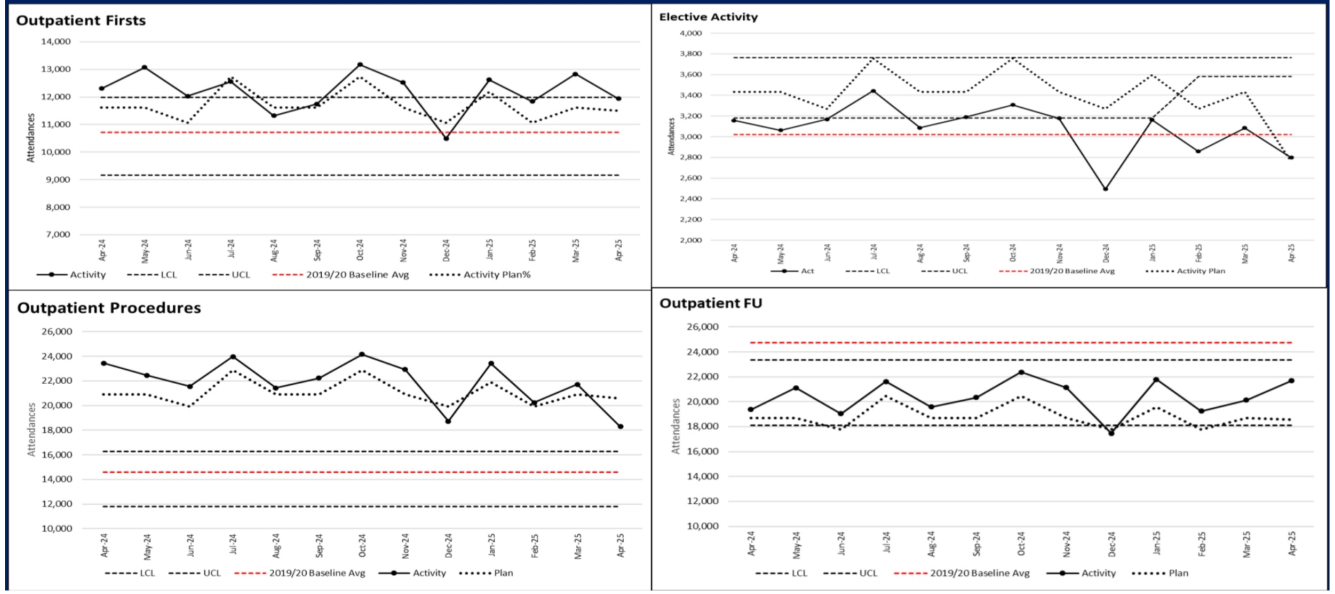
ER	Point of Delivery	Activity In Month				Activity YTD			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	2,761	2,799	38	101%	2,761	2,799	38	101%
	OP Firsts	11,499	11,938	439	104%	11,499	11,938	439	104%
	OP Procedures	20,585	18,295	(2,290)	89%	20,585	18,295	(2,290)	89%
	ERF Activity Total								
Non ERF Acti	OP Follow Ups	18,568	21,684	3,116	117%	18,568	21,684	3,116	117%
	High Cost Drugs Injections	4,282	4,793	511	112%	4,282	4,793	511	112%
	Non Elective	219	246	27	112%	219	246	27	112%
	AandE	6,016	6,101	85	101%	6,016	6,101	85	101%
	Total	63,930	65,856	1,926	103%	63,930	65,856	1,926	103%

Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

Performance % figures above, represent the Trust performance against the external activity target. Financial values shown are for ERF activity only.

ACTIVITY TREND - ERF COMPONENTS



Commentary

NHS Income

Contractual Status

The Trust is awaiting finalised contracts from ICB's expected to be received by the 29th May. Until contracts are finalised, income has been assumed based on the 2025/26 planning assumptions and activity delivery to date.

2025/26 Activity performance achievement

- **Inpatient activity** achieved 101% in month and 101% year to date of the revised demand plan.
- The table also splits out Stratford and St Annes activity reported at 90% overall in month, being 93% and 86% respectively, and 90% year to date overall being 93% and 86% respectively.
- **Outpatient Firsts Activity** achieved 104% of the revised demand plan in month; 104% year to date
- **Outpatient Procedures Activity** achieved 89% of revised demand plans in month; 89% cumulatively

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 112% of activity plans in month; 112% year to date.
- **A&E** achieved 101% of activity plans in month; 101% year to date

ERF Achievement

2024/25 ERF performance to January 2025 has been published and full year performance is expected to be finalised in June 2025. Current indications are that ERF performance is in line with planning expectations.

Activity plans and ERF

Activity plans are based on operational services demand based view of patients waiting for treatment.

- 2024/25 performance for ERF is now confirmed to month 10 but with the year end performance finalised in June
- 2025/26 ERF reporting from NHSE will replicate 2024/25, although finalised transactional process are yet to be clarified.

Activity Plans

The charts to the left demonstrate the in-year activity levels compared to the previous year. The red line represents average 2019/20 activity levels.

Trust Statement of Financial Position – Cash, Capital, Receivables and Other Metrics

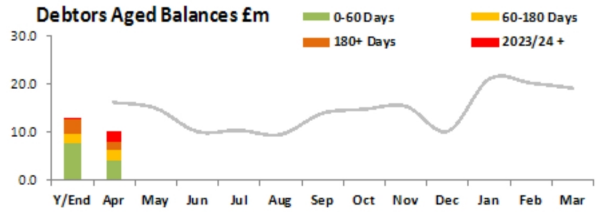
CAPITAL EXPENDITURE

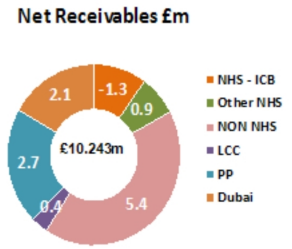
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Medical Equipment	-	-	0.0	0.0
Estates	0.3	-	0.0	0.0
IMT	-	-	-	-
Commercial	0.5	0.0	0.0	-
Network Strategy	-	-	-	-
Other - Trust funded	3.0	0.1	-	(0.1)
TOTAL - TRUST BAU CAPITAL	**3.8**	**0.1**	**0.1**	**0.0**
Oriel Programme	145.2	9.5	9.5	-
EPR Project	9.6	0.3	0.3	-
NiHR Capital Grant	-	-	-	-
Other & Charity	0.5	-	-	-
IFRS16	5.1	-	-	-
TOTAL INCLUDING DONATED	**164.2**	**9.9**	**9.9**	**0.0**

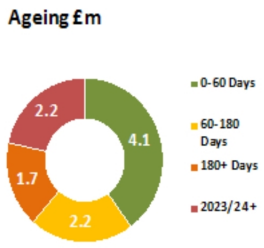
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Depreciation	11.9	11.9	-	100%
Cash Reserves - Oriel	-	-	-	-
Cash Reserves - B/Fwd	0.1	0.1	-	100%
Capital Loan Repayments	(1.8)	(1.8)	-	100%
TOTAL - ICS Allocation	**10.2**	**10.2**	**-**	**100%**
IFRS 16 Leases	5.1	5.1	-	100%
Externally funded	122.9	122.9	-	100%
Donated/Charity	26.1	26.1	-	100%
TOTAL INCLUDING DONATED	**164.2**	**164.2**	**-**	**100%**

RECEIVABLES

Net Receivables £m	0-60 Days	60-180 Days	180+ Days	2022/23 +	Total
CCG Debt	(1.3)	0.0	0.0	-	(1.3)
Other NHS Debt	0.5	0.2	0.1	0.2	0.9
Non NHS Debt	2.6	0.5	0.9	1.3	5.4
Commercial Unit Debt	2.4	1.4	0.7	0.7	5.2
TOTAL RECEIVABLES	**4.1**	**2.2**	**1.7**	**2.2**	**10.2**







STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Non-current assets	597.3	408.7	411.5	2.8
Current assets (excl Cash)	29.8	29.8	24.1	(5.7)
Cash and cash equivalents	62.7	62.9	88.2	25.3
Current liabilities	(45.9)	(46.0)	(57.0)	(10.9)
Non-current liabilities	(288.0)	(146.8)	(170.5)	(23.7)

OTHER METRICS

Use of Resources	Plan	Current Month	Prior Month
BPPC - NHS (YTD) by number	95%	93%	91%
BPPC - NHS (YTD) by value	95%	96%	89%
BPPC - Non-NHS (YTD) by number	95%	97%	95%
BPPC - Non-NHS (YTD) by value	95%	96%	95%

Commentary

Cash and Working Capital

The cash balance as at the 30th April was £88.2m, an increase of £2.1m since the end of March 2025.

Capital Expenditure/ Non-current assets

Capital expenditure as of 30th April totalled £9.9m.

- Business as usual capital totals £0.1m for schemes started but not completed in 2024/25.
- Other capital totals £9.8m with £9.5m of Oriel expenditure and £0.3m EPR expenditure.

Business as usual capital remaining excluding internally funded EPR totals £3.8m and are being prioritised subject to previously committed capital expenditure and finalisation of Oriel ICT transition costs and EPR programmed funds.

Capital Planning and Oversight Committee (CPOC) is prioritising the highest risk submitted plans across fire remediation, estates critical infrastructure backlog maintenance, and highest priority medical equipment replacement plans.

Receivables

Receivables have reduced by £2.7m to £10.2m since the end of the 2024/25 financial year. Debt in excess of 60 days increased by £0.9m in April and current reduced by £3.6m.

Payables

Payables totalled £19.7m at the end of April, a reduction of £1.0m since the end of March 2025.

The trust's performance against the 95% Better Payment Practice Code (BPPC) is shown to the left. In aggregate it was:-

- 95% volume of invoices (prior month 95%) and
- 95% value of invoices (prior month 95%).

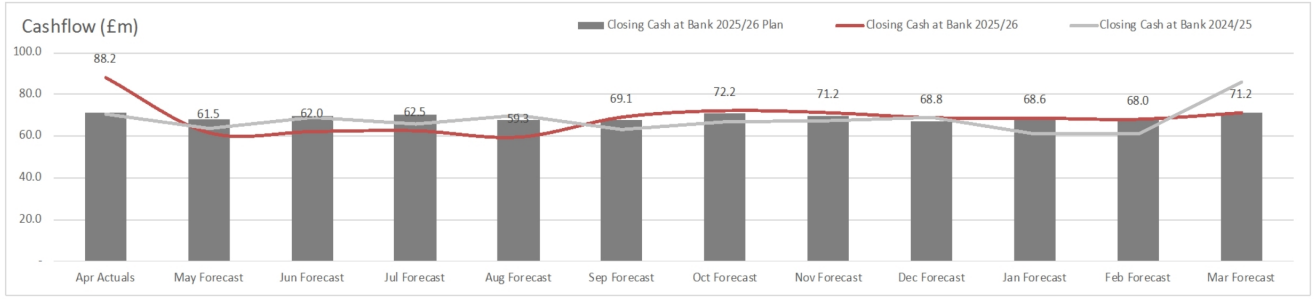
Use of Resources

Use of resources monitoring and reporting has been suspended.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Apr Forecast	Apr Var
Opening Cash at Bank	**86.1**	**88.2**	**61.5**	**62.0**	**62.5**	**59.3**	**69.1**	**72.2**	**71.2**	**68.8**	**68.6**	**68.0**	**86.1**		
Cash Inflows															
Healthcare Contracts	22.0	20.1	22.8	23.7	20.1	23.7	24.6	21.8	20.1	21.0	21.7	22.8	264.4	20.0	1.9
Other NHS	4.3	1.3	1.4	1.3	1.2	1.3	1.4	1.4	1.2	1.4	1.3	1.3	18.8	1.3	3.0
Moorfields Private/Dubai/NCS	4.4	3.3	4.1	4.1	3.7	4.0	4.2	4.4	3.4	4.6	4.1	4.1	48.4	3.9	0.5
Research	0.9	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	15.2	1.3	(0.3)
VAT	2.2	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	14.3	1.1	1.1
PDC / Loan	-	-	9.0	14.0	14.5	14.3	12.9	12.8	7.9	10.7	8.7	4.5	109.4	-	-
Charity Donation	-	-	5.0	-	-	10.0	-	-	5.0	-	-	5.9	25.9	-	-
Other Inflows	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.8	**0.2**	(0.2)
Total Cash Inflows	**34.1**	**27.3**	**44.8**	**45.8**	**42.2**	**56.0**	**45.8**	**42.9**	**40.2**	**40.3**	**38.5**	**41.2**	**499.1**	**27.8**	**6.0**
Cash Outflows															
Salaries, Wages, Tax & NI	(14.1)	(14.5)	(14.5)	(14.5)	(14.5)	(16.0)	(15.5)	(15.5)	(15.5)	(15.5)	(15.5)	(15.5)	(181.1)	(14.5)	0.4
Non Pay Expenditure	(15.4)	(13.2)	(14.0)	(13.5)	(13.5)	(13.5)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(154.6)	(13.7)	(1.7)
Capital Expenditure	(0.8)	(0.5)	(0.5)	(2.2)	(1.0)	(1.0)	(1.0)	(2.4)	(1.0)	(1.0)	(1.0)	(2.4)	(14.8)	(0.5)	(0.3)
Oriel	(0.2)	(24.5)	(14.0)	(14.0)	(14.5)	(13.7)	(12.9)	(12.8)	(12.9)	(10.7)	(8.7)	(6.1)	(145.2)	(12.5)	12.3
Moorfields Private/Dubai/NCS	(1.4)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(15.7)	(1.3)	(0.1)
Financing - Loan repayments	-	-	-	-	(0.6)	(0.7)	-	-	-	-	(0.6)	(0.7)	(2.6)	-	-
Dividend Payable	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Cash Outflows	(31.9)	(54.0)	(44.3)	(45.4)	(45.4)	(46.2)	(42.7)	(44.0)	(42.7)	(40.4)	(39.1)	(38.0)	**(514.0)**	**(42.5)**	**10.6**
Net Cash inflows /(Outflows)	2.2	(26.7)	0.5	0.4	(3.1)	9.7	3.1	(1.0)	(2.4)	(0.1)	(0.6)	3.2	(14.9)	(14.7)	16.6
Closing Cash at Bank 2025/26	**88.2**	**61.5**	**62.0**	**62.5**	**59.3**	**69.1**	**72.2**	**71.2**	**68.8**	**68.6**	**68.0**	**71.2**	**71.2**		
Closing Cash at Bank 2025/26 Plan	71.4	68.0	69.6	70.5	67.9	67.5	70.7	69.7	67.2	67.6	67.5	71.2	71.2		
Closing Cash at Bank 2024/25	70.4	63.9	69.2	65.9	70.1	63.4	67.1	67.5	68.8	61.4	61.0	**86.1**	86.1		



Commentary

Cash flow

The cash balance as at the 30th April was £88.2m, an increase of £2.1m since the end of March 2025. The current financial regime has resulted in block contract payments which gives some stability and certainty to the majority of cash receipts. The trust currently has 99 days of operating cash (prior month: 104 days).

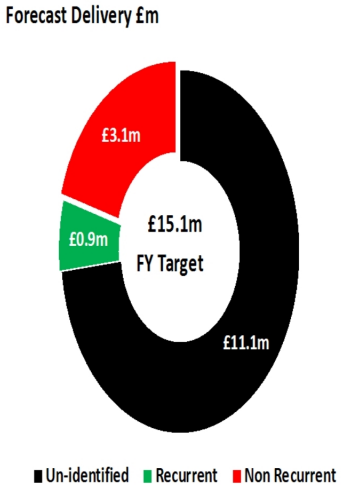
April cashflow saw a £2.2 inflow against a forecast outflow of £14.7m. This was due to timings of capital payments in relation to Oriel which were made in early May.

Trust Efficiency Scheme Performance

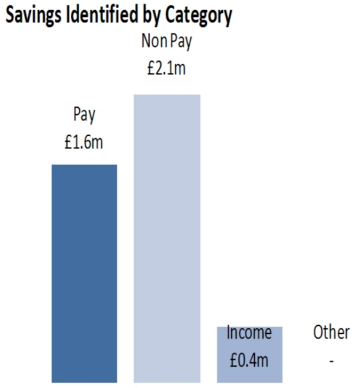
EFFICIENCY SCHEMES PERFORMANCE

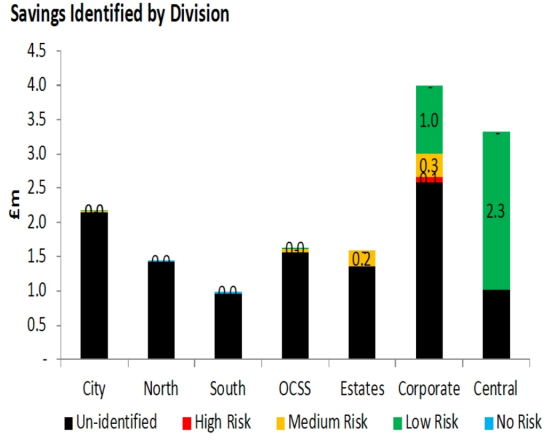
Efficiency Schemes £m	Annual Plan	In Month			Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
City Road	£2.17m	£0.18m	£0.00m	(£0.18m)	£0.18m	£0.00m	(£0.18m)	£2.17m	£0.02m	(£2.15m)
North	£1.43m	£0.12m	-	(£0.12m)	£0.12m	-	(£0.12m)	£1.43m	£0.00m	(£1.42m)
South	£0.98m	£0.08m	£0.01m	(£0.08m)	£0.08m	£0.01m	(£0.08m)	£0.98m	£0.03m	(£0.95m)
Ophth. & Clinical Serv.	£1.62m	£0.13m	£0.01m	(£0.13m)	£0.13m	£0.01m	(£0.13m)	£1.62m	£0.06m	(£1.56m)
Research & Development	£0.49m	£0.04m	-	(£0.04m)	£0.04m	-	(£0.04m)	£0.49m	-	(£0.49m)
Trading	£0.83m	£0.07m	-	(£0.07m)	£0.07m	-	(£0.07m)	£0.83m	-	(£0.83m)
Corporate	£5.59m	£0.47m	£0.13m	(£0.34m)	£0.47m	£0.13m	(£0.34m)	£5.59m	£1.64m	(£3.94m)
DIVISIONAL EFFICIENCIES	**£13.10m**	**£1.09m**	**£0.14m**	**(£0.95m)**	**£1.09m**	**£0.14m**	**(£0.95m)**	**£13.10m**	**£1.75m**	**(£11.35m)**
Central	**£2.00m**	**£0.19m**	**£0.09m**	**(£0.10m)**	**£0.19m**	**£0.09m**	**(£0.10m)**	**£2.00m**	**£2.30m**	**£0.30m**
TRUST EFFICIENCIES	**£15.10m**	**£1.28m**	**£0.23m**	**(£1.05m)**	**£1.28m**	**£0.23m**	**(£1.05m)**	**£15.10m**	**£4.05m**	**(£11.05m)**

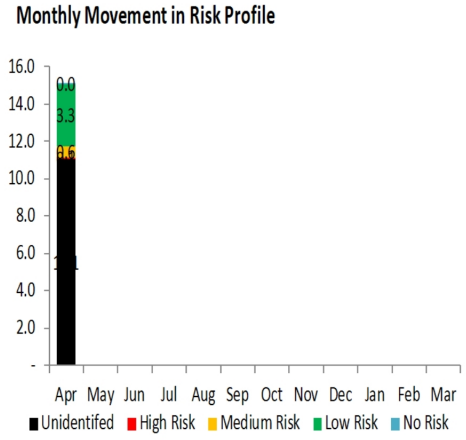
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







* charts may include rounding differences

Commentary

Internal £15.1m efficiency programme.

The Trust is reporting its efficiency programme against an internal plan of £15.1m and straight-line delivery to emphasis the monthly run-rate savings required to delivery £15.1m from April 2025.

- The Trusts external plan has efficiency programme profiled towards half two to allow quarter one/two for identification implementation and execution of schemes.

Governance & Reporting

The trust had a planned efficiency programme of £15.1m for 2025/26 to deliver the Trust control total.

- The governance of trust efficiencies and productivity programmes are being reviewed to enhance current governance, programme management, implication and execution of schemes.

In Year Delivery

The trust is reporting efficiency savings achieved of:-

- £0.23m in month, compared to an internal plan of £1.26m, £1.05m adverse to plan;

Identified Savings

The trust has identified £4.0m, £11.1m adverse to plan.

Of the total identified:-

- £2.3m is identified central schemes
- £0.4m is identified as income generation schemes;
- £0.9m is forecast recurrently;

The CIP programme board are working through further efficiency scheme delivery for full financial validation towards increasing the level of identified and forecast delivery in 2024/25.

£11.1m represents the value of un-identified and non-recurrently identified savings.

Risk Profiles

The charts to the left demonstrates the

- identified saving by category,
- divisional identification status including risk profiles, and
- the trust wide monthly risk profile changes for identified schemes as the year progresses.

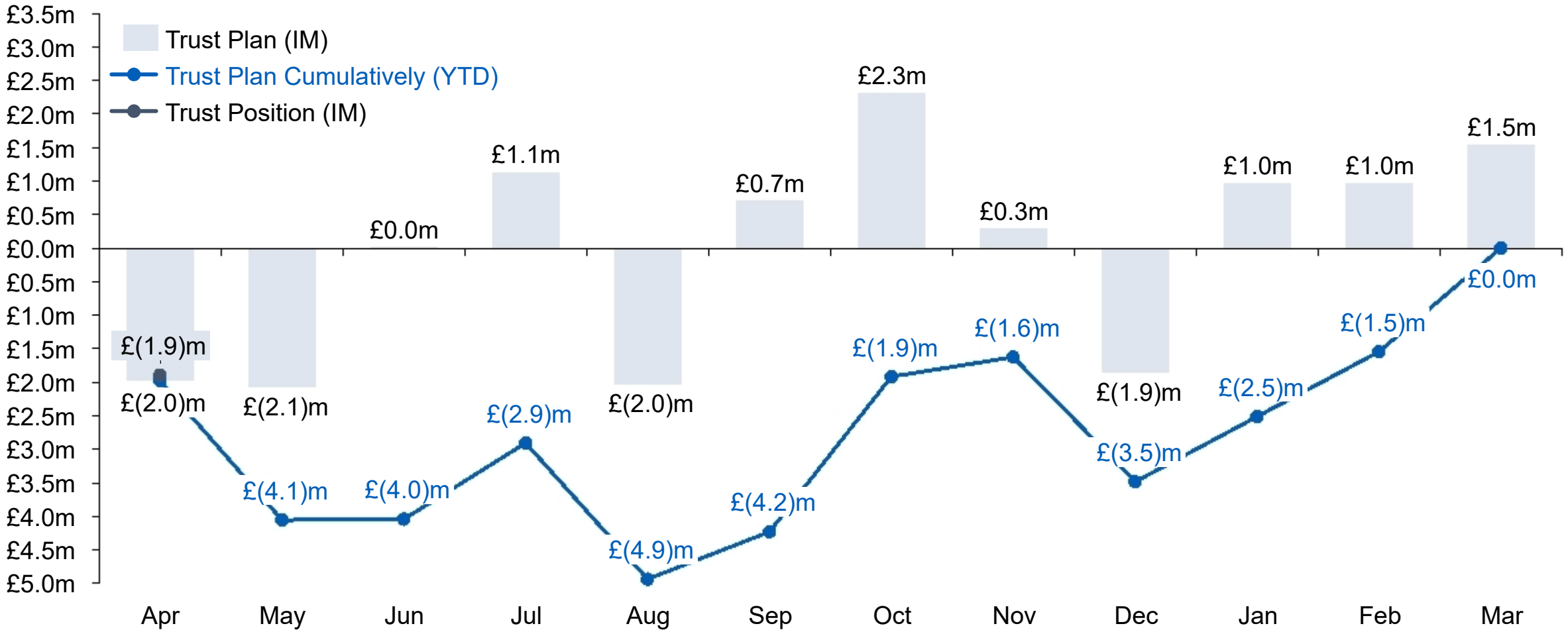
Supplementary Information

Moorfields Eye Hospital NHS Foundation Trust

NHS

The Trust financial performance is £1.9m deficit in month

The Trust is reporting a £1.9m deficit In Month, £0.1m favourable to plan.
The Trusts financial plan is predicated on the delivery of efficiency savings of £15.1m which has a material impact on in month and cumulative financial plans.
A drivers of the variance will be shown overleaf after April reporting.



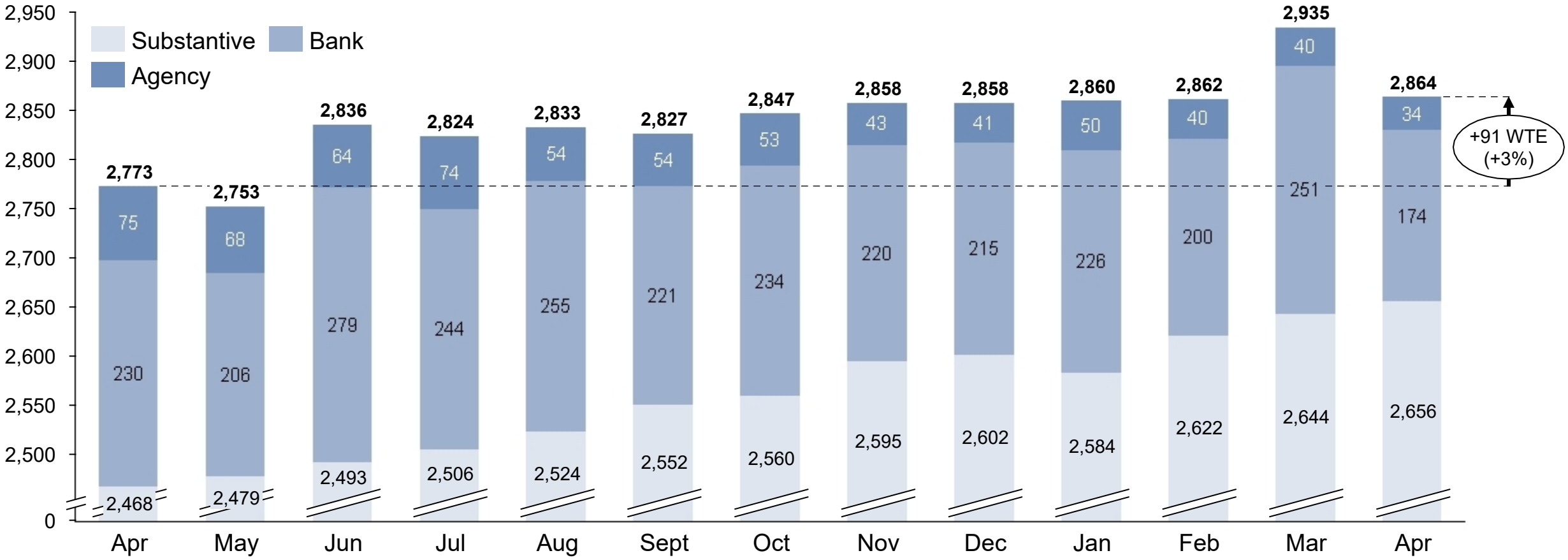
The Trusts financial plan is predicated on typical assumptions for income and expenditure categories as laid out below, including efficiencies which due to its size (£15.1m) has a material impact on in month and cumulative financial plans. Planning assumptions have included:-

- NHS Income based activity plans point of delivery and working days/calendar days adjusted for bank holidays, and leave periods. Pay based on generalised twelfths unless where specifically planned. Non pay clinical supplies matched to NHS clinical activity. Efficiencies profiled on a quarterly phased basis using indicative statuses of scheme identification at the beginning of the year.

Workforce WTE Trend reporting

National planning guidance includes the requirement to reduce spend on temporary staffing[&] and support functions. The below chart reports the worked Whole Time Equivalent (WTE)*[#] for a rolling 13 months.

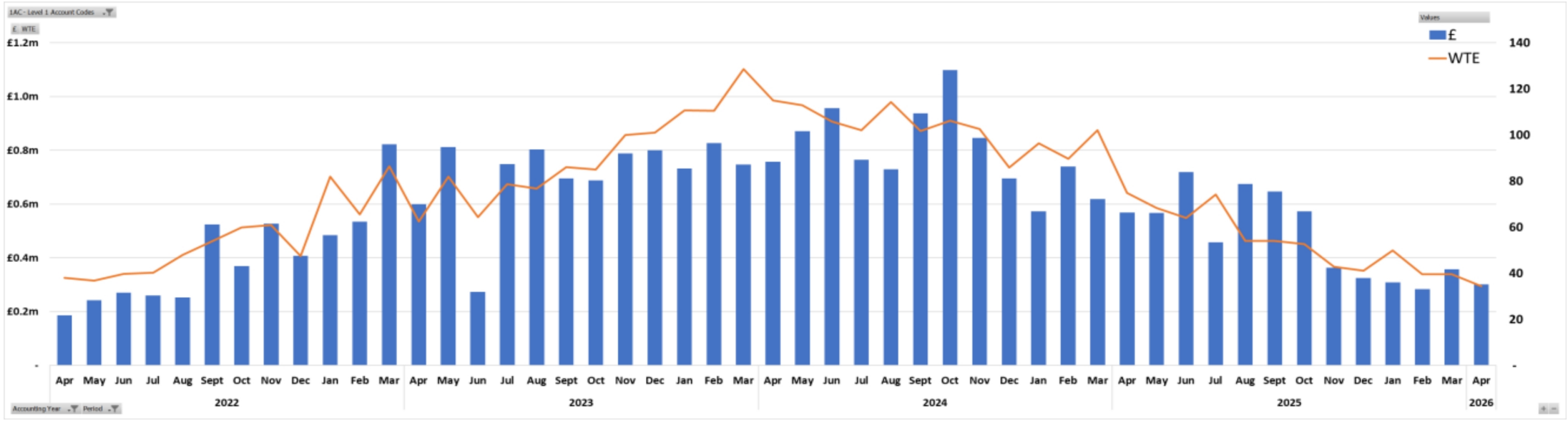
- WTE Trends are reported by pay type, staff type, staff group, division and department further in this pack.
- Across the year the Trusts WTE has increased by +91 WTE +3%, inclusive of Oriel and EPR WTE reported below.



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Oriel	7	7	8	7	8	8	7	7	8	7	9	10	8
EPR	12	13	16	17	20	22	23	26	29	32	36	37	34
Total	**19**	**20**	**24**	**24**	**28**	**30**	**30**	**33**	**37**	**39**	**45**	**47**	**42**

[&]National planning expectations are agency reductions of 30%, bank reductions of 10%, and corporate support functions to reduce growth since 2018/19 by 50% by quarter 3 of 2025/26
*WTE during March is often impacted by annual leave and backfill and can't be used as a baseline WTE for reductions in year.
[#]Financial ledger WTE reporting has known and legitimate differences to Workforce WTE reporting. Workforce reporting should be used for formal analysis and narrative.

Workforce – Agency Reporting in Board Report



Moorfields Eye Hospital NHS Foundation Trust

NHS

2025/26 Financial Plan

Trust Board – Abridged Financial Plan Summary

5 June 2025

Report Period	2025/26

2025/26 Executive Summary - £ Breakeven plan approved

Breakeven financial plan approved including £15.1m of efficiencies to achieve a balanced financial position

Purpose

The purpose of this document is to provide an abridged summary of the 2025/26 financial plan approved by the Trust board and submitted as part of the national submission process on 27th March 2025. The slides overleaf outline:-

- The abridged income and expenditure and capital planning submissions.
- The monthly and cumulative financial plan for the year
- The phased efficiency and productivity delivery planned
- The historical adjusted control total, and underlying financial position of the Trust to 2025/26

Breakeven financial operating plan approved

The trust board approved a break-even financial plan submission for 2025/26 following Finance and Performance Committee meetings during March 2025.

The finance and performance committee discussed a number key risks within the current operational plans as part of the summarised board assurance assessments including:-

- NHS clinical income levels and uncertainty surrounding ERF and payment mechanisms;
- The level of required efficiency and productivity savings required and status of identified schemes;
- Achievement of strategic priority projects including the Oriel new hospital programme, ICT Transition to Oriel and EPR implementation;
- Activity changes, utilisation, site reconfiguration, productivity and impact on workforce;
- Workforce implications of the above and approach to national expectations in relation to workforce reductions, implementation and execution

2025/26 Financial Plan - Breakeven Plan

Initial Outlook

The table to the right outlines the financial plan submitted on 27th March 2025 for a break-even balanced financial plan.

Planning assumptions include:-

- The financial plan has been compiled in accordance with national planning guidance including NCL ICB mandated guidance and assumptions.

Key areas to note include:-

- NHS Clinical income assumptions based on national planning assumptions and 2024/25 income received;
- Oriel and ICT Transition costs of £6.5m
- Efficiency and productivity plans of £15.1m
- Activity plans in aggregate consistent with 2024/25 levels
- Trust wide approach to reducing agency costs and responding to national productivity requirements and Corporate services reductions

Summary of Draft Initial Outlook

£m	2024/25 Budget	2024/25 Forecast	2024/25 Underlying Position	2025/26 Submitted Plan
Summary Income and Expenditure Account				
Operating income				
NHS Clinical income	249.2	262.5	249.6	250.6
Non-NHS Clinical Income	9.7	11.8	11.7	11.9
Commercial Trading	46.7	45.0	45.4	48.4
Research	16.4	15.8	12.5	15.5
Other	27.1	30.6	26.4	41.7
Total Income	**349.1**	**365.7**	**345.6**	**368.0**
Operating expenses				
Employee expense	(189.1)	(201.6)	(188.7)	(194.3)
Non-Pay expense	(120.9)	(127.0)	(125.3)	(129.5)
Total	**(310.0)**	**(328.6)**	**(314.0)**	**(323.8)**
EBITDA	39.1	37.0	31.6	44.2
EBITDA Margin %	0.1	0.1	0.1	0.1
Other & Non Operating expenses				
Depreciation & Amortisation	(17.9)	(17.3)	(17.6)	(17.6)
Net Interest (Payable less receivable)	1.0	2.1	1.8	(1.4)
PDC expense	(1.8)	(1.7)	(2.0)	-
Share of Joint Venture P/L	0.7	(0.3)	0.1	0.3
Donated Assets Adjustments	(15.8)	(15.7)	(15.9)	(25.3)
Gain / (Losses) on asset disposals		0.1	0.1	-
Taxation		(0.2)	(0.2)	(0.3)
Total	**(33.8)**	**(32.9)**	**(33.6)**	**(44.2)**
Surplus / (Deficit)	**5.3**	**4.1**	**(2.0)**	**0.0**
Memorandum				
National Tariff Efficiency @2%				4.2
Additional Efficiency's to achieve Trust Plan				10.9
				15.1

2025/26 Capital Planning

£164.2m Capital Expenditure Plans

The below outlines the current planning assumptions of £164.2m Capital Expenditure for 2025/26.

Planning assumptions include:-

- Indicative ICB planning allocation of £10.3m has been agreed for planning
- If the ICB does not deliver a breakeven revenue plan then capital allocations will be reduced by 10%

Key areas to note include:-

- **Internally funded capital of £10.228m** including:-
    - £7.1m of EPR expenditure
    - £2.1m of internal BAU
    - £1.045m contribution to Oriel
- **Externally funded capital of £148.9m** Including:-
    - £144.2m Oriel Capital (from total £145.7m)
    - £4.3m EPR funded capital (from total £11.4m)

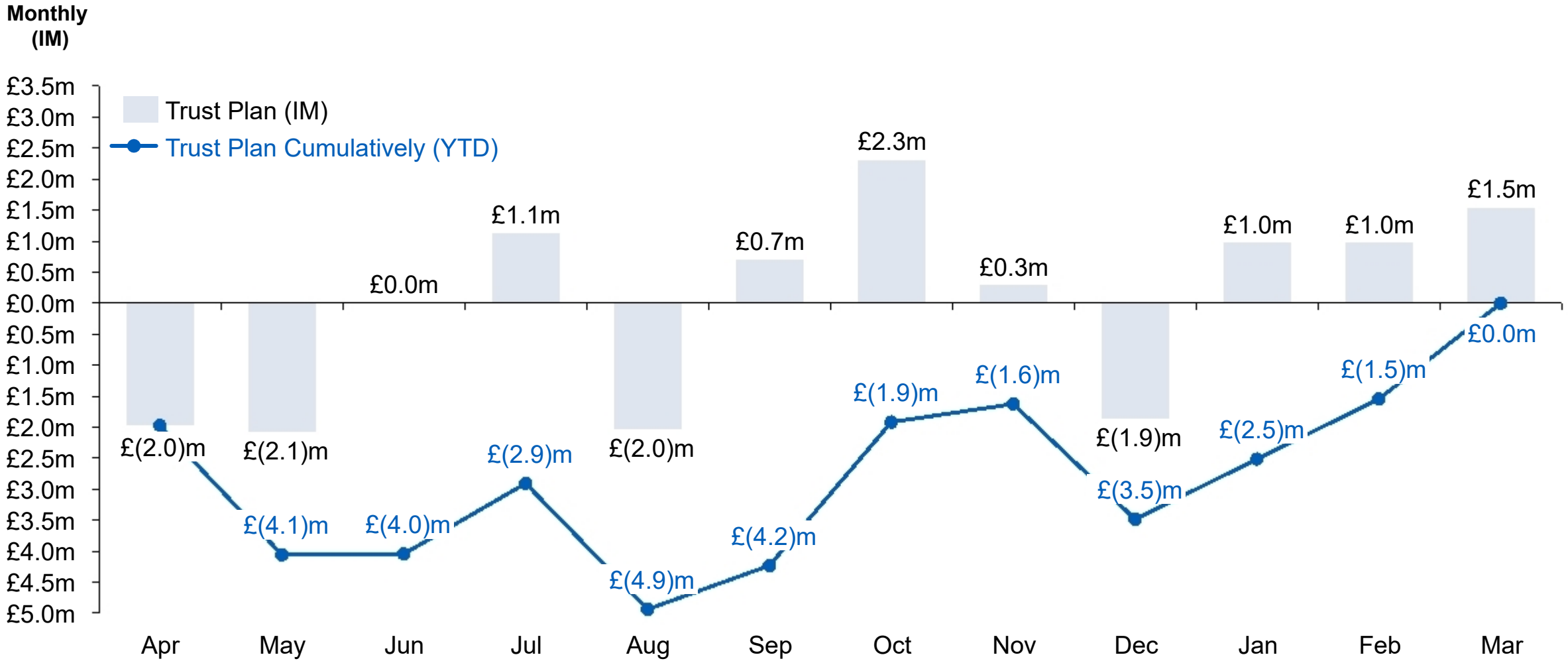
Summary of 2025/26 Capital Plan

Capital Planning £m	2025/26 Planning Assumptions	Status	Sources & Applications
Summary Capital Allocations and funding sources			
ICS BAU Allocation	2.084	Awaiting Confirmation	Internally generated Cash
ICS Oriel contribution	1.045	Awaiting Confirmation	Internally generated Cash
ICS EPR Contribution	7.099	Awaiting Confirmation	Internally generated Cash
Subtotal - Internal Plans	**10.228**		
Oriel - Loan Funded	118.332	Confirmed	Loan
Oriel - Charity Funded	25.800	Confirmed	Charity Donation
EPR Nationally Funded	4.278	Confirmed	PDC
Other/Charity	0.464	Awaiting Confirmation	Various
Subtotal - External Plans	**148.874**		
IFRS16 - Leases	**5.082**		
Total Capital Expenditure	**164.184**		
Of which:-			
Oriel Total	145.177		
EPR Total	11.377		

The Trust financial plan profile across the year

The Trusts financial plan is predicated on typical assumptions for income and expenditure categories as laid out below, including efficiencies which due to its size (£15.1m) has a material impact on in month and cumulative financial plans. Current planning assumptions have included:-

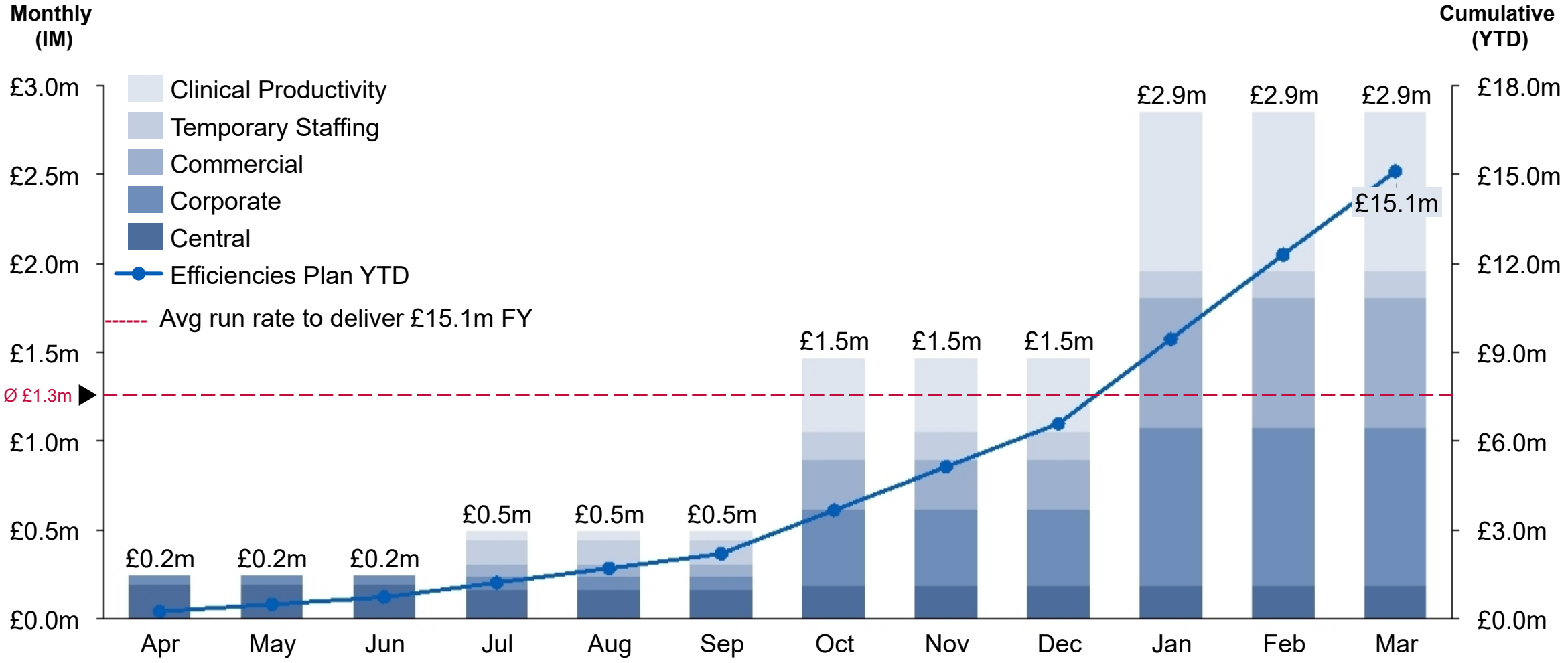
- NHS Income based activity plans point of delivery and working days/calendar days adjusted for bank holidays, and leave periods.
- Pay based on generalised twelfths unless where specifically planned.
- Non pay clinical supplies matched to NHS clinical activity.
- Efficiencies profiled on a quarterly phased basis using indicative statuses of scheme identification at the beginning of the year.



The Trust efficiency programme is planning a revised £15.1m target

The efficiency and productivity workstreams are shown below, highlighting the increase required in the later half of the financial year.
At the point of submission the profiling and quality risk assessment maturity for submitted plans is low leading to risk surrounding the veracity of 2025/26 delivery values i.e. part year or full year effects. The submitted plan assumptions included the pro-rata of identified schemes across their identified status including:-

- Schemes with a status of 'Fully developed' have been phased from Month 1;
- Schemes with a status of 'Plans in progress' have been phased from Q2;
- Schemes with a status of 'Opportunity' have been phased from Q3;



The historical financial performance has reported favorable ‘top-line’ surpluses, however the ‘underlying’ financial position is less favorable after removing one-off benefits and reliance on non-recurrent efficiencies over previous years.

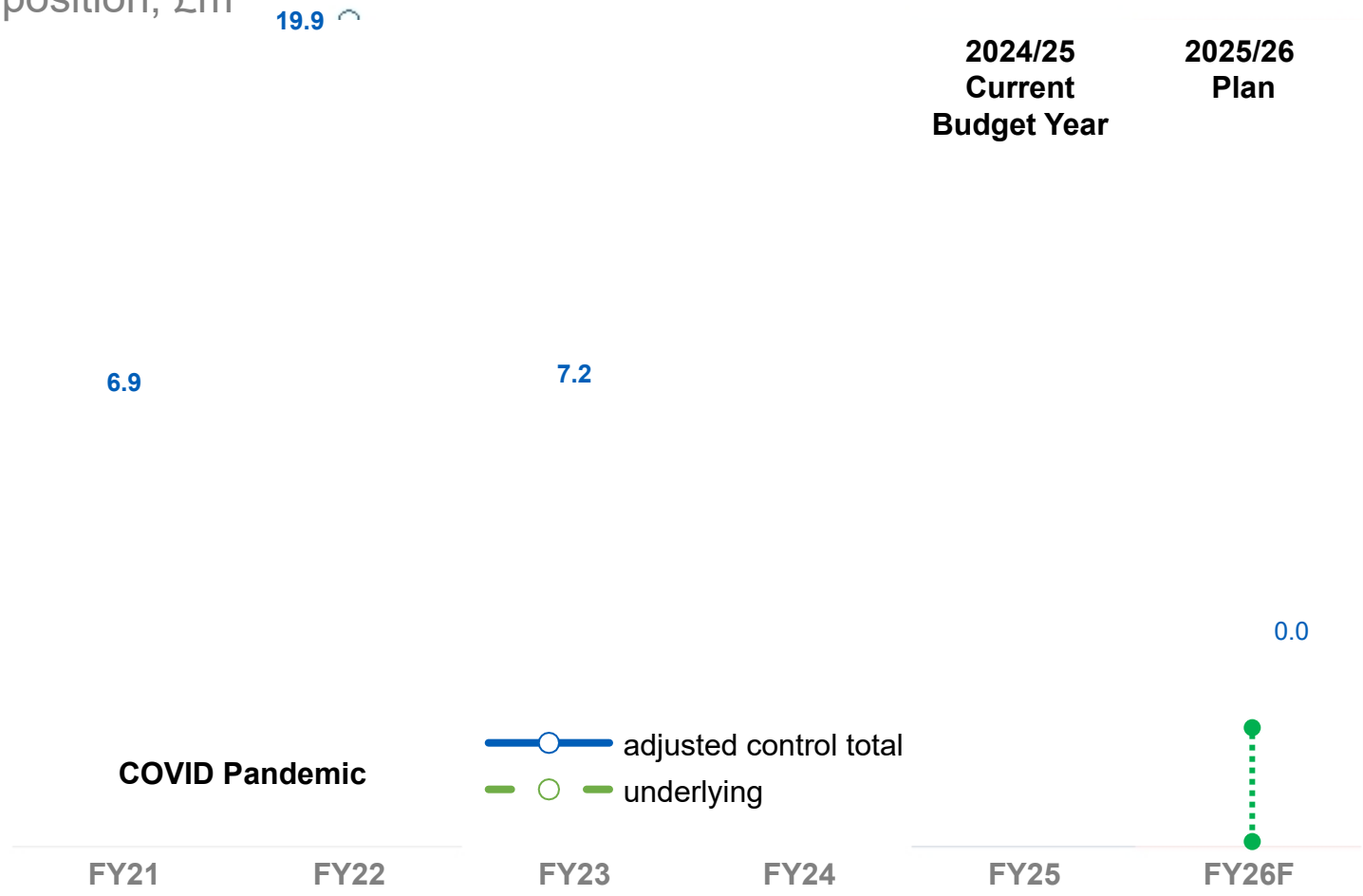
Underlying Financial Position

- The chart to the right highlights the current and prior years **reported** financial surpluses, and the **underlying financial** standing of the Trust when non-recurrent and one-off benefits and efficiencies are removed.
- Significant benefits in the past related to post-pandemic payment mechanisms and high levels of one-off Insight and other R&D income which were reported at the time as to the core drivers of the difference between the control total and underlying financial position.
- The £6.1m difference between headline and underlying FY25 (£4.1m to £(2.0)m) includes assumptions of:-
  - £6.9m unidentified and non-recurrent efficiencies delivery in FY25 from the £11.2m planned.
- Prior year surpluses have also increased the Trusts cash balances in advance of Oriel completion and improved working capital.

FY26 is critical sensitivity as the LTFM Starpoint

- The current FY26 budget year represents a breakeven plan with £15.1m efficiencies which must be achieved to maintain a sustainable underlying financial position.

Historic and budget **adjusted control total** and **underlying** net position, £m



* Adjusted control total relates to regulatory performance reporting excluding statutory donations and charity income. This is reported to the finance committee as part of LTFM modelling.

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 10

2025-26 Operational Plan

Board of directors
5 June 2025

Report title	**2025-26 Operational Plan**		
Report from	Justin Betts Interim Chief Finance Officer		
Prepared by	Justin Betts Interim Chief Finance Officer		
Previously considered at		**Date**	
Link to strategic objectives	Deliver financial sustainability as a Trust		

Quality implications Patient safety has been considered in the allocation of resources
Financial implications Delivery of the financial control total will result in the Trust being eligible for additional benefits that will support its future development
Risk implications Potential risks have been considered within the reported financial plan and the financial risk register is discussed at the Audit and Financial and Performance Committees.
Action required/recommendation. The board is asked to consider and discuss the attached report.

For assurance		**For decision**		**For discussion**		**To note**	**x**

Moorfields Eye Hospital NHS Foundation Trust

Item 11
2024/25 Staff Survey Action Plan
Board of Directors
5 May 2025

Report title	**2024/25 Staff Survey Action Plan**		
Report from	Sue Steen, Chief People Officer		
Prepared by	Ade Adetukasi. Associate Director of Employee Experience		
Previously considered at		**Date**	
Link to strategic objectives	Working Together - We will work together to ensure our workforce supports future care models and a consistently excellent patient and staff experience, in accordance with our values.		

Quality implications

There is an evidenced correlation between staff experience and patient experience. Poor staff experience among NHS staff are linked to poorer patient outcomes, including increased errors and reduced care quality. A focus on improving staff experience will therefore have a positive impact on patient experience and the quality of the services we provide. It will also support the recruitment and retention of quality staff.

Financial implications

Poor staff experience, culture of bullying, and a work environment that is not inclusive are proven to significantly increase sickness absence, presenteeism, and staff turnover.

Risk implications

For us to continue to improve our staff morale and experience, we must be able to progress our people and culture ambitions against a tough financial backdrop, which may serve to distract or reduce our ability to implement key cultural and leadership initiatives. Delivering sustained and continuous organisational and cultural improvement remains a critical challenge in the current climate.

Action required/recommendation.

The Board is asked to note the staff survey action plan, take assurance from it, and to confirm if any further actions should be considered.

For assurance	✓	**For decision**		**For discussion**	✓	**To note**	✓

1. Executive Summary

The NHS staff survey is a key measure of staff engagement and morale, offering valuable insights to guide the trust's strategy and workforce development. Our 2024 NHS Staff Survey results indicated an overall average performance, and with a response rate that is higher than the national average. While the results do not indicate immediate cause for concern, they highlight areas requiring targeted improvement to enhance staff experience.

Notably, 85% of respondents would be happy for their friends and family to receive care from the trust, and 83% believe patient care remains the organisations top priority. In addition, staff recommending the trust as a place to work has risen from 63% to 66%, reflecting a modest but encouraging upward trend.

There were improvements in three important areas: the quality of appraisals, a reduction in bullying and harassment, and fewer staff reporting unpaid additional hours. However, persistent challenges remain. The trust continues to score poorly on fair access to career progression, and free-text feedback highlights a lack of diversity in senior leadership which does not reflect our diverse workforce.

This action plan outlines steps to consolidate recent gains and urgently address the identified issues. It also reflects the output of the staff survey result engagement sessions held with staff across the trust, ensuring that the actions and their prioritisation are co-produced with staff.

2. Background

The NHS Staff Survey is a critical tool for understanding staff experiences and shaping our workforce strategy. In 2024, the trust achieved 69% response rate which is 12% higher than the average for other similar acute specialist trusts (57%), and 3% higher than our 2023 response rate (66%). The survey results highlighted key improvement, including:

- Improved scores in appraisals helping to improve job performance
- Reduction in bullying, harassment and physical violence
- Fewer staff reported working unpaid additional hours

However, several areas were identified for improvement:

- Continued concern expressed in free-text comments about a lack of diversity in senior leadership.
- The trust scored poorly in acting fairly regarding career progression.
- No significant improvement across all the NHS People Promise themes.
- Ongoing concerns about discrimination based on ethnicity.

3. Engagement and Communication

To ensure staff feel heard, acknowledged, and involved in exploring solutions to the themes and issues raised in the survey result, we carried out an extensive staff survey result engagement process. Working in conjunction with the Communication and the HRBP teams, and using both face-to-face and MS Teams meetings, we hosted series of open sessions to share the staff survey result and co-produce required interventions to address themes requiring actions from the trust. The engagement events included:

- Dedicated staff survey result review session with BeMoor, MoorAbility, and MoorPride staff networks.
- Series of staff survey result review sessions opened to all staff on MS Teams and led by executive directors.
- Since the survey result were published in March, there has also been ongoing local review of staff survey result at divisional, service, and team levels.
- The staff survey results have also been presented and reviewed at SMT, TMC, and ManEx allowing for senior leaders input in responding to themes from the survey result.

The action plan below reflects the output of the staff survey result engagement sessions ensuring that the actions and their prioritisation are co-produced with staff and leaders in the trust.

4. Objectives of the Action Plan

This action plan aims to:

- Build on areas of recent improvement and strong performance.
- Address persistent issues, particularly regarding fairness in career progression and leadership diversity.
- Further embed the NHS People Promise into everyday working life in the trust.
- Create a more inclusive environment for our workforce.

5. Action Plan

The results of the staff survey, along with insights from staff engagement sessions, will inform the ongoing development of our 2025–2027 People and Culture Strategy. This will ensure a sustained and strategic approach in our response to the staff survey result and also ensure alignment with our wider strategic priorities.

In the short term, and in response to the key themes from the staff survey, the following action plan outlines key areas for immediate focus and targeted interventions aimed at delivering meaningful improvements to staff experience.

The action plan also complements local action plans currently being implemented across services and teams within the trust. While each local plan addresses specific issues highlighted by local survey results, a common priority across all the local action plans is for managers to undertake training on the new appraisal system. This is to ensure an enhanced approach to supporting staff personal development and wellbeing.

ACTION PLAN

Issue	Action	Time Scale	Lead	Success Measures
Lack of fairness in career progression	The EDI Programme Fair Opportunities workstream will carry out diagnostic work, based on EDI and workforce metrics, to identify gaps and process failures or poor practices that could be contributing to inequality, or perception of it, in career progression.	June 25 – December 25	Head of EDI	Pulse survey and staff survey data showing actions taken leading to improvement in both staff experience and perception of career development and progression in the trust.
	The EDI team will be work in collaboration with the Workforce Education team to raise awareness of foundational educational programmes available in the trust to support career progression. Ongoing programmes include: Functional skills training, digital skills courses, and access to higher development awards.	May 25 – September 25	Associate Director for Workforce Education & Associate Director of Employee Experience	Data showing successful uptake and completion of education programmes
	Development of MEH's Ophthalmology Clinical Competency Framework. This will define clinical competencies required at all levels of practice and mapped against educational activities.	March 23 – August 26	Associate Director of Workforce Education	Implementation of the new competency framework across all sub-specialities
	A new single system online appraisal system went live in April 2025 and initial feedback indicates that it is already enhancing career conversation in the trust. Under the new system, all staff appraisals will take place during a fixed four-month period window, April to July – every year. Personal development and wellbeing are at the heart of the new appraisal process. It is designed to help staff grow in their role and career in the trust.	Completed	Associate Director of Employee Experience	Pulse survey, annual staff survey, and post-appraisal feedback showing that the new appraisal system is leading to improvement in both staff experience and perception of career development and progression in the trust.

Lack of diversity in senior leadership	The trust has enrolled in the NHSE NExT Director scheme. The scheme was developed to support the creation of a pipeline of strong and diverse candidates for future non-executive director roles in the NHS. New medium and longer term targets, based on NHSE WRES Model Leadership Ambition Framework for band 8C and above, will be included in the trust's EDI programme objectives and targets. The WRES leadership ambition targets are aimed at increasing BME representation at senior levels in the NHS.	June 25 – March 26 July 25 – December 26	Chief People Officer Associate Director of Employee Experience	Appointment of non-executive directors from minority ethnic groups. Workforce and EDI metrics showing improved diversity in senior leadership and creation of a pipeline of strong and diverse candidates for future senior roles in the trust.
No significant improvement across all NHS People Promise themes	The Shared Values campaign and toolkits will include content and tools aligning the trust's values to the NHS People Promise. This will include prompts to help managers understand their role in improving staff experience.	June 25 – December 25	Associate Director of Employee Experience	Staff survey and pulse survey data showing improvement in People Promise scores.
Ongoing call for increased support for line managers	New band 4 – 7 leadership development pilot programme launched, to be evaluated, and then rolled out for all frontline managers. New managers induction programme to be introduced. This will help new managers become more effective quickly and establish a uniform approach to people management in the trust.	May 25 – March 26 September 25 – March 26	Associate Director of Employee Experience Head of Learning & Development	Pilot programme completed with successful evaluation. Successful rollout of the leadership development programme for all band 4 – 7 managers. New managers induction programme launched with positive feedback from participants
Ongoing concern about bullying	Funding secured from Moorfield Eye Charity to relaunch the Active Bystander training programme	July 25 – March 26	Associate Director of Employee Experience	Reduction in bullying & harassment cases reported to FTSU, ER, and HR.

culture in parts of the trust	including introduction of e-learning option offering more flexibility to operational and clinical staff.			Improvement in WRES and WDES data on bullying and harassment.
	An external independent review of the Employee Relations (ER) function, commissioned by the Chief People Officer, has just been concluded. Proposed changes from the review are aimed at improving ER support for both staff and managers in relation to bullying concerns. The recommendation also includes the introduction of restorative practices and other preventative measures aimed at driving fairness, equity, and improving staff experience	April 25 – April 26	Associate Director of Workforce Transformation	Same as above

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 22

Learning from deaths (Q4 2024/25)

Board of directors
5 June 2025

Report title	Learning from deaths
Report from	Louisa Wickham, medical director
Prepared by	Julie Nott, head of risk & safety and patient safety specialist
Link to strategic objectives	We will consistently provide an excellent, globally recognised service

Executive summary

This report provides an update regarding how we learn from deaths that occur within Moorfields defined by criteria (see Annex below) as set out in trust policy. It is a requirement for all trusts to have a similar policy.

The trust has identified **zero** patient deaths in Q4 2024/25 that fell within the scope of the learning from deaths policy.

Quality implications

The Board needs to be assured that the trust is able to learn lessons from patient safety incidents, in order to prevent repeat mistakes and minimise patient harm.

Financial implications

Provision of the medical examiner (ME) role for Moorfields may have small cost implications if costs are ever required.

Risk implications

If the trust fails to learn from deaths, then there is clinical risk in relation to our ability to provide safe care to patients leading to possible reputational risk, financial risk of potential litigation and legal risk to directors.

Action required/recommendation

The Board is asked to receive the report for assurance and information.

For assurance	✓	**For decision**		**For discussion**		**To note**	✓

This report satisfies the requirement to provide the trust board with an update regarding compliance with, and learning from, the NHSE learning from deaths agenda. The 2024/25 data is shown in the table below.

Indicator	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	0	0	0
% of cases reviewed under the structured judgement review (SJR) methodology	N/A	N/A	N/A	N/A
Deaths considered likely to have been avoidable	N/A	N/A	N/A	N/A

Learning and improvement opportunities identified during Q4 (outside the criteria set out in Annex 1)

1. Death of a patient within one month of being reviewed in the accident and emergency (A&E) department

In Q4, notification was received that a patient had died within one month of being reviewed in A&E and having been diagnosed with viral conjunctivitis. The incident has been reviewed at the incident review group (IRG) part 2 meeting and it has been agreed that a Structured Judgement Review (SJR) will be completed by a consultant ophthalmologist to establish if there were any concerns regarding the patient's review and diagnosis and if learning and/or improvement opportunities exist.

2. Notification of paediatric deaths

The Q1/Q2 report identified a concern regarding receipt of notification following the death of two children who were under the care of Moorfields and other providers. Two incidents were reported to highlight that Moorfields staff had contacted the parents of deceased children to enquire regarding non-attendance at appointments. Staff were unaware that the patients had passed away because notification had not been received via the national deceased registry reports. Notification of the incidents were made to the National Back Office for the Personal Demographics Service to establish the reason for this. It was confirmed by NHS England that details will only appear in national deceased registry reports when an active search of the National Care Record Summary (NCRS) has been undertaken by a member of staff listed to organisation code RP6. A multi-disciplinary after action review was held and actions were agreed.

A further incident has been identified in which notification of a death was not received via the agreed route. On this occasion, a consultant received verbal notification informally and outside of the agreed pathway. This notification meant that trust systems could be updated prior to the deceased child's parents receiving inappropriate communication from us and that

it was a near miss, however because it was informal it means that the trust would not have had visibility of, and timely involvement in, the statutory child death review process.

A further request has been submitted to North Central London ICB providers that the Moorfields contact details be added to local shared details of death lists where there is any reference to a child having an eye condition. A local process will be developed for managing child death information received outside of the national RP6 death registry report.

Annex 1

Included within the scope of this policy:

1. All in-patient deaths;
2. Patients who die within 30 days of discharge from inpatient services (where the Trust becomes aware of the death);
3. Mandated patient groups identified by the NQB Learning from Deaths guidance including individuals with a learning disability, mental health needs or an infant or child;
4. The death of any patient who is transferred from a Moorfields site and who dies following admission to another provider hospital;
5. The death of any patient, of which the trust is made aware, within 48 hours of surgery;
6. All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision by Moorfields;
7. Deaths of which the trust becomes aware following notification, and a request for information, by HM Coroner;
8. Persons who sustain injury as a result of an accident (e.g. a fall down stairs) whilst on Trust premises and who subsequently die;
9. Individual deaths identified by the Medical Examiner or through incident reporting or complaints or as a result of the Inquest process;

Excluded from the scope of this Policy:

1. People who are not patients who become unwell whilst on trust premises and subsequently die.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Report title	Standing Financial Instructions Update 2025/26
Report from	Justin Betts, Acting CFO
Prepared by	Lubna Dharssi, Head of Financial Control and Wayne Sexton, Chief Commercial Officer
Link to strategic objectives	Deliver financial sustainability as a trust

Executive summary

The Board is asked to approve the following amendments and renew the Standing Orders and Standing Financial Instructions for 2025/26. This review has now been completed with updates made outlined on the following page.

The Board is asked to note the new procurement rules that came into effect in England, Wales and Northern Ireland from 24 February 2025, which will impact the trust. The Procurement Act 2023 sees the biggest changes to public procurement in almost 30 years. As a result, the SFIs have been reviewed and the following changes made:

- Updates related to the Procurement Act 2023 and related processes
- Update to the quotation process
- Update to the single tender waiver process

There are no current proposed changes to the standing orders, although the constitution was recently updated to allow a provision for non-executive directors to serve on other NHS related boards.

Quality implications

None

Financial implications

None

Risk implications

To deliver financial governance and sustainability as a trust.

Action Required/Recommendation

The Board is asked to approve the changes below.

For Assurance		**For decision**	✓	**For discussion**		**To note**	

Moorfields Eye Hospital NHS Foundation Trust

The following updates have been made to reflect legislative changes and improve clarity, consistency, and governance:

1. Procurement Legislation

All references to the Public Contracts Regulations 2015 (PCR 2015) have been replaced with references to the Procurement Act 2023, in line with the new legal requirements.

2. Competitive Selection Requirements

The quotation thresholds and requirements under “Competitive Selection Requirements” (Table 2) have been revised. These changes simplify the process, align with the Procurement Act 2023, and bring the Trust in line with approaches taken by other NHS organisations.

3. Single Tender Waiver Process

The waiver process has been updated to introduce a more streamlined approach, including a clearer approval pathway based on contract value. This strengthens governance and oversight for non-competitive awards.

4. Contract Signing and Approval Thresholds

Approval requirements for signing contracts for goods, services, and minor works have been updated. These now reflect a tiered structure based on contract value, ensuring appropriate levels of scrutiny at each stage.

5. Naming Conventions and Committees

References to external organisations and internal committees have been updated to reflect current naming conventions and organisational structure, improving consistency throughout the document.

The document with tracked changes has been placed in the reading room.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Report title	Board assurance framework (BAF)
Report from	Company Secretary
Author	Company Secretary
Previously discussed	with individual risk owners, ManEx, Audit and Risk Committee
Link to strategic objectives	The risk appetite statement link to all strategic objectives

Brief summary of report

The board assurance framework (BAF) supports a culture which allows Moorfields to anticipate and respond to adverse events and unwelcome trends. The BAF helps to clarify what risks are likely to compromise the Trust's strategic objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

The BAF report are presented quarterly to the Board and at every ARC meeting, progressing through ManEx first.

Quality implications

The Trust has a robust approach to risk management in order to maintain the highest standards of quality care provided to patients. Identification and mitigation of risk is an important tool in being able to manage events that could have a detrimental impact.

Financial implications

There are no financial implications arising from this paper.

Risk implications

As detailed in the paper.

Action Required/Recommendation.

The Board is asked to note the report.

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

Board assurance framework executive summary

1. Background

The Board has in place a Board Assurance Framework (BAF) which is reviewed quarterly. The BAF records the principal risks that could impact on the Trust's ability in achieving its strategic objectives.

The Moorfields Risk Management Strategy and Policy details the processes for identifying, managing, monitoring and reporting risks. The BAF provides the highest-level view for management of key risks to the Trust's strategic objectives. It details controls in place to mitigate risks and sources of assurance that controls are operating effectively. Strategic risks are captured within the BAF, and key operational risks are recorded within the Corporate Risk Register (CRR).

The Audit & Risk Committee and the Board regularly review the BAF, and this work is focused on monitoring: risk mitigations (based on processes and structures in place across the Trust); outcomes and trajectories to determine risk reduction; target risk ratings; gaps in mitigations; and cumulative impact of organisational risks. The BAF currently includes nine priority strategic risks.

It is important to note that, whilst the Board should normally expect the implementation of mitigating actions to result in risks tracking against their residual target over time, the nature of strategic risks is such that external factors may change during the life of the risk, impeding progress or causing increases in risk that require further management action.

Risk assessment necessarily includes an element of subjectivity. Executive directors are required to apply careful judgment in the assessment of risk. It is therefore important to use the annual risk scores and target scores as guidance, supporting the Board's own critical judgment in determining whether mitigation is having the desired impact.

2. BAF analysis and summary of changes

All BAF risks have been identified as risks that could have a significant impact on the delivery of the strategic objectives. The identified areas are those that require the most focus from the Board in terms of scrutiny and provision of assurance from the executive team.

The BAF report is presented quarterly to the board, and to every ARC.

2.1 Amendments made to the BAF since the last meeting – presented to ARC

All risks have been reviewed. Specific updates (in bold) were completed for risks 1, 2, 3, 5, 6, 7, and 9 have all been reviewed and updated.

Risk 8 is to be reallocated following some organisational changes at exec level.

2.2 Risks added or removed to/from the BAF this quarter

There are no additional risks added to, and no risk removed from, the BAF since the last meeting.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

Board Assurance Framework (BAF)

Risk Scoring Matrix and Colour Codes					
	Likelihood				
Consequence	1. Very Unlikely	2. Unlikely	3. Likely	4. Very Likely	5. Almost Certain
5. Catastrophic	5	10	15	20	25
4. Major	4	8	12	16	20
3. Moderate	3	6	9	12	15
2. Minor	2	4	6	8	10
1. Negligible	1	2	3	4	5

Risk Number:	Strategic Outcome:	Risk description:	Lead:	Lead Committee/s:	Risk appetite
1	All strategic outcomes.	If the trust is unable to manage appropriately the impact of unpredictable events such as workforce and transport strike action or a successful cyber attack then there will be an impact in a number of areas including significant harm to staff and patients, significant financial risk both in the short and long term, reputational risk, workforce impact and system working risk.	Chief operating officer	Management executive	Moderate – not within risk appetite
2	**Working together:** Create and collaborate in Oriel, our new centre for advancing eye care, research and education.	If the key assumptions behind **Oriel** are not achieved, then there may be insufficient capital and resources available leading to a failure to be able to deliver a new facility that is fit for purpose and improves the patient and staff experience.	Chief operating officer	Major projects and digital committee	Moderate – not within risk appetite
3	**Working together:** People will reach their full potential. More will aspire to, and gain experience of, leadership. There will be evidence of ongoing and open dialogue with staff and a continuing focus on kindness and empathy.	If the trust does not have a **robust workforce plan** in place, **that proactively responds to known clinical supply pressures nationwide, the need for increased diversity in leadership, and the need for the development of an optimised skill mix in support of new pathways** then there will be staff shortages and skill gaps leading to insufficient numbers of staff available in key areas and a subsequent impact on the quality of patient care, pressure on staff and a decrease in morale which will affect both the staff and patient experience.	Chief People Officer	People committee	Moderate – within risk appetite
4	**Working together:** People will reach their full potential. More will aspire to, and gain experience of, leadership. There will be evidence of ongoing and open dialogue with staff and a continuing focus on kindness and empathy.	If the trust fails to put in place sufficient support for staff and processes/procedures to manage **staff health and wellbeing**, then this will lead to increased stress and sickness absence, poor staff engagement with the organisation, poor recruitment and retention and a significant impact on staff morale.	Chief People Officer	People committee	Moderate –not within risk appetite
5	**Discover:** We will be at the leading edge of research making new discoveries with our partners and patients.	If the trust cannot attract sufficient **research funding** to maintain its position, then its capacity to conduct appropriate research will diminish leading to an inability to compete effectively for funding and a significant risk to the trust brand and reputation in the field	Director of R&D	Discovery and commercial committee	Moderate – within risk appetite
6	**Develop:** Use digital technology and clinical data to transform care pathways and outcomes.	If the trust's **Digital infrastructure** fails to provide robust resilience and adequate performance **(viewed in terms of reliability but also our strategic ambition for digital leadership across many domains),** then treatment of patients may be compromised through either a lack of access to digital patient and administrative data, or a slowness of information delivery that reduces patient throughput enough that some patients may need to re-book and return for their treatment.	Chief information officer	Major projects and digital committee and management executive	Moderate – not within risk appetite
7	**Deliver:** Optimise our systems, infrastructure and capabilities to deliver excellent and efficient care	If the **current financial pressures** impact, and may compromise, the ophthalmic care for both new and existing patients, then this may lead to patient harm, reputational risk and potential financial risk through litigation.	Medical director	Quality & safety committee	Moderate –within risk appetite
8	**Sustainability and at scale:** Build our commercial capability to grow and support new	If the **growth in commercial activity** is not to plan, then there will not be sufficient revenue generated leading to pressure on trust finances elsewhere and a lack of ability	TBC	Discovery & commercial committee	Moderate –within risk appetite

	opportunities in support of our change this to financial sustainability, value for money and delivering excellent care to more people.	to effectively compete in the market and to continue to provide high quality NHS services to patients as well as having an impact on the assumptions for Oriel.			
9	**Sustainability and at scale:** We will be seen as a valued partner in our integrated care system footprints, our region, nationally and internationally.	**Future funding models are being reviewed nationally with a view to returning to a price x activity basis, a review of fixed versus variable funding elements, and alignment to fair shares.**	Chief financial officer	Management executive	Moderate –not within risk appetite

Risk No.	**1**
Objective	All strategic objectives
Risk Description	If the trust is unable to manage appropriately the impact of unpredictable events such as workforce and transport strike action or a successful cyber attack then there will be an impact in a number of areas including significant harm to staff and patients, significant financial risk both in the short and long term, reputational risk, workforce impact and system working risk.
Executive Lead	Chief Operating Officer
Lead Committee	Management Executive
Source	External
Change since last review	Newly established risk, replacing the Covid-19 specific risk

Controls	**Assurance**
1. Business continuity planning including remote access and other appropriate policies to mitigate the likelihood and provide appropriate response to any unpredictable events 2. The Trust is learning from recent cyber attack on Guy's and St Thomas' and potential cyber attacks from third-parties	➢ GSB command structures and updates to ManEx ➢ Reports to board and committees including EPRR annual report and external assessment
3. Recovery planning procedures to return business to usual by mitigating impact of events	➢ Reviewed on a regular basis by the IT team, IT governance and quarterly board report, reviewed at Information Governance Committee- quarterly
4. System and London-wide recovery protocols to mitigate the likelihood and provide appropriate response to any unpredictable events	➢ EPRR annual report to board and external assessment
5. IT security policy details steps taken to maintain a secure IT system as well as monitoring	➢ Reviewed annually through Policy & Planning Review Group and the Information Governance Committee ➢ Annual DSP Toolkit submission by the IG team, including annual cyber security assessment
6. Annual penetration testing conducted by external company to test Trust resilience to possible treats	➢ IT governance and quarterly board report
7. NHSE (Digital) real-time cyber control alerts to highlight any threats; active Firewalls management and use of monitoring tools; Distributed Denial of Service (DDOS) protection on external connections	➢ IT Security Group monthly IT governance and quarterly board report ➢ Annual DSP Toolkit submission by the IG team, including annual cyber security assessment
8. Robust patching policy and procedures to ensure security of IT and responses where needed.	➢ Monthly information governance committee reporting through to QSC, Information governance committee, management executive and annual board report, annual governance statement
9. Annual cyber-security assessment to ensure all actions and mitigations are up to date.	➢ Report to board ➢ Annual DSP Toolkit submission by the IG team, including annual cyber security assessment
10. Third party assurances gained as part of the tendering process for EPR	➢ Reported to Board and MP&D Committee
11. Performance reviews established that will monitor patching monthly	➢ Reports to ManEx

Gaps in Controls

- Limited proactive monitoring
- Issues with patching - DH has requested a 14-day schedule rather than a 28-day schedule
- Inability to plan for unpredictable strike action (workforce or transport)

Risk Scores

	Initial Score	**Current Score**	**Target Score**

Consequence	4	4	3
Likelihood	4	4	4
Risk Scores	**16**	**16**	**12**

Action Required

No.	Action	Responsible Person/s	Due date	Progress/ Status
1.	Implementation of the vaccination booster programme	SN	31.03.22	**Complete**
2.	Monitoring and analysis of the impact of new ways of working through diagnostic hubs ongoing and to be reported to the Board in Nov (JS, Jan 22)	JS	Jan 2022	**Complete**
3.	Weekly scrutiny through divisional and executive governance processes	JS		**In place and ongoing**
4.	Ad hoc groups are stood up to deal with local outbreaks and take necessary mitigating actions.	JS		**In place and ongoing**
5.	Completed DSPT Improvement Action Plan		Dec 22	**Complete**
6.	Cyber Maturity Assessment due to Trust Board in May 2023		May 23	**Complete**
7.	Cyber Maturity Assessment Action Plan in place		May 24	**In place and ongoing**
8.	Completion of MEH Dubai security improvements	CIO	17.12.22	**Complete**

Executive Commentary

The prevalence of Covid has declined significantly and so this risk has been developed to encompass unpredictable events. Much of what is expected in this area is cyber and IT related, however there are events such as industrial action or major accidents.

There has been significant progress in increasing our cyber protection and in managing actual threats in real-time. The risk must therefore reflect likelihood of imminent and actual threats but also limited consequences. Our data and technology estate has further improved protection since the 2021 attack and additional proactive monitoring measures continue to be enhanced. Our trajectory for consequences going forward is reducing. However, the likelihood of a cyber-attack has increased with the Ukraine/Russia situation. The mitigations in place are effective for a known attack and reduce our likelihood. The risk of a new variant back door attack remains high. Given the macro climate, a target score of 12 requires a further reduction in consequence of a successful attack which is difficult to achieve with so many potential new threats. **The Trust is learning from the most recent Guys and St Thomas' cyber incident, which includes lessons on potential attacks on the Trust from third party suppliers. Business continuity remains a focus to mitigate related risks. A paper will be coming to the Trust Board in July to assure that the Trust has learnt from the recent incidents at other Trusts.**

Due to its unpredictable nature, industrial strike action is dealt with in a reactive manner. The Trust has learned from previous instances of strike action and is therefore able to react effectively and mitigate some of the potential impact, however successful responses rely on the ongoing good will of staff.

Risk No.	**2**
Objective	**Working together:** Create and collaborate in Oriel, our new centre for advancing eye care, research and education.
Risk Description	If the key assumptions behind **Oriel** are not achieved, then there may be insufficient revenue and resources available leading to a failure to be able to deliver a new facility that is fit for purpose and improves the patient and staff experience.
Executive Lead	Chief Operating Officer
Lead Committee	Major Projects and Digital Committee
Source	External
Change since last review	No change

Controls	**Assurance**
1. Active engagement with current owner of preferred site as part of NCL STP	➢ Monthly St Pancras Development meeting chaired by NCL ICB ➢ Monthly update provided to board of directors ➢ Monthly update to Oriel risk register
2. Ongoing implementation of influencing strategy for key individuals and organisations across the system is in operation to ensure the Trust's needs are fully represented and met as appropriate	➢ Regular meetings with external stakeholders (patient groups and residents) ➢ Weekly discussion at informal Oriel executive board ➢ Monthly review at formal Oriel executive board ➢ Monthly review at chief partners groups for escalation as required
3. Regular meetings with NHP, NHSE and NCL ICB teams to update them on the progress that is being made on site and to flag any potential risks which are arising	➢ Regular meetings with NHP, NHSE and NCL ICB
4. Weekly meeting with preferred construction partner (BYUK) to manage the ground works on site and monitor the delivery of key assumptions for the Trust	➢ Monthly review at formal Oriel executive board ➢ Bi-monthly review at major projects and digital committee
5. Optimism bias built into business case to ensure accurate information and planning	➢ Board of directors have a robust process in place to assess contract progress
6. Project scrutiny monthly to monitor progress and mitigations of the risk	➢ Board and JVC reports
7. Rebasing governance of project to reflect how the Trust will use the building: appointed workstream leads, prioritising transformation for agreement.	Reported to Board
8. User engagement to ensure the building delivers a fit for purpose facility for those who will be using it	There has been a series of user engagement sessions through the programme and users will play a key role in the sign off of the stage 4 plans
9. One Granary Street Full Business Case for additional administration accommodation near Oriel	Business case presented to July 2024 Board for approval
10. Appointed 1.65WTE as joint programme director for Oriel	Updates reports to MP&D committee, JDV and Trust Board
11. Engagement strategy	

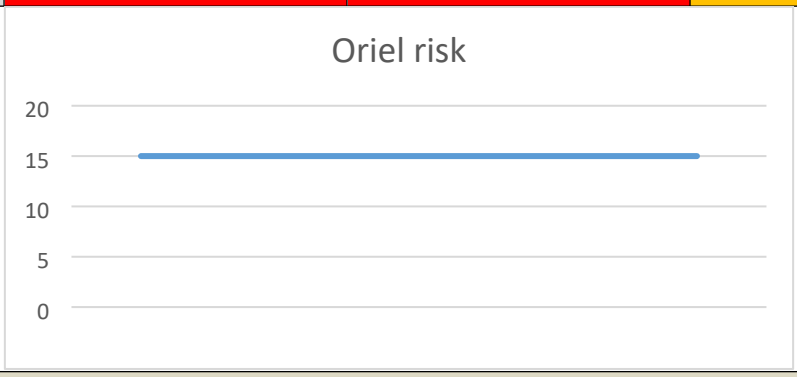
Gaps in Controls

- **Annual review of actual activity against FBC clinical case assumptions to occur once baseline is established. The Trust was near to completing transformation initiatives.**
- **Speed of decision-making by external stakeholders; this has improved, however it still requires monitoring.**
- **Inability to control inflation increases; this is mostly resolved, however a small amount is still in effect.**

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	5	5	5
Likelihood	3	3	2

Risk Scores	15	15	10



Action Required

No.	Action	Responsible Person/s	Due date	Progress/ Status
1.	Contract negotiation with preferred bidder	KMD	28.02.22	**Complete**
3.	Development and submission of FBC	JM	31.05.22	**Complete**
3.	Approval of the FBC	JM	09.11.22	**Complete**
4.	Close monitoring of the key milestones continues on a monthly basis	JS/KMD	Mar 22	**Completed**
5.	Negotiations taking place with preferred bidder, updates provided to CSC	KM	Jan 22	**Complete**
6.	Development and approval of FBC	JM	Mar 22	**Complete**
7.	Establishment of the JDV and completion of the sale of City Road	JS	Dec 22	**Complete**
8.	JDV has been established on 1/4/23 and demolition is complete	JS	Jun 23	**Complete**
9.	Work is underway to finalise stage 4 of the design of the building and to quantify the impact of rising inflation.	JS	**May 25**	**Completed**
10.	SMART – defining interdependencies with functions and EPR	JS	**June 25**	**Ongoing**

Executive Commentary

The programme is progressing well. Some previously identified risks are being overcome, however the risk score had been maintained at 15 due to the high level of inflation which presented an ongoing threat to the affordability of the programme. While inflation is generally on a downward trajectory, it is still subject to volatility as evidenced in the last month; other factors such as progressing the ICT workstream and shifting the focus from the construction to how the building will be used, also mean it is appropriate to maintain the current risk rating.

Programme directors in place. Enhanced refresh of governance has taken place. The 1:50 expected to be finalised in July 2025.

Risk No.	**3**
Objective	**Working together:** People will reach their full potential. More will aspire to, and gain experience of, leadership. There will be evidence of ongoing and open dialogue with staff and a continuing focus on kindness and empathy.
Risk Description	If the trust does not have a **robust workforce plan** in place, **that proactively responds to known clinical supply pressures nationwide, the need for increased diversity in leadership, and the need for the development of an optimised skill mix in support of new pathways** then there will be staff shortages and skill gaps leading to insufficient numbers of staff available in key areas and a subsequent impact on the quality of patient care, pressure on staff and a decrease in morale which will affect both the staff and patient experience.
Executive Lead	Chief People Officer
Lead Committee	People and culture committee
Source	Internal
Change since last review	No change

Controls	**Assurance**
1. KPIs reported monthly to TMC, directorates and departments and local action plans in place to ensure Trust stays on plan or responds if slippages	➢ Monthly TMC and divisional performance review and management executive escalation ➢ Staff Survey results
2. Staff development through job planning process and personal development plans includes making staff feel valued, which helps contribute to positive morale	➢ Quarterly audit committee and internal audit reporting
3. Understanding of drivers of high turnover to ensure vacancies can be kept to as low an instance as possible	➢ Quarterly through people and culture committee
4. 2-year priorities have been agreed for Workforce and OD team	➢ People and Culture Committee
5. External support been commissioned to develop a leadership training approach for the organisation, which will begin to be delivered in 2024/25	➢ Leadership development plan and approach
6. Action plan now in place to improve on issues raised in the latest staff survey (2023/24)	➢ Presented to Trust Board and People and Culture Committee

Gaps in control

- Systematic workforce strategy and planning (although a new post of associate director of workforce strategy and transformation is being recruited to)
- Clarity on future operating model to enable long-term workforce planning
- Implementation of Team Brief as a two-way form of communication

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	3	3
Likelihood	3	3	3
Risk Scores	**12**	**9**	**9**

Action Required				
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/ Status**
1.	Work on technical workforce and diagnostic hubs ongoing	JS	Mar 23	**In place and ongoing**
2.	Workforce planning infrastructure developing via business planning and excellence programme	SS	Jun 24	**In place and ongoing**
3.	Workforce strategy and priorities being monitored through the people committee on a quarterly basis.	SS	Feb 24	**In place and ongoing**
4.	Team brief to be developed and implemented	CF	Jun 24	**In place and ongoing**

Executive Commentary
The key risk is that of supply. The workforce modelling work done in conjunction with E&Y has put the trust in a more robust position and particularly in terms of clinical workforce modelling and technicians/technical hubs. There is a risk in theatre staffing which is being managed through operations, nursing and workforce. The new Associate Director of Workforce Strategy and Transformation will lead on this agenda.

Risk No.	**4**
Objective	**Working together:** People will reach their full potential. More will aspire to, and gain experience of, leadership. There will be evidence of ongoing and open dialogue with staff and a continuing focus on kindness and empathy.
Risk Description	If the trust fails to put in place sufficient support for staff and processes/procedures to manage staff health, wellbeing and engagement, then this will lead to increased stress and sickness absence, poor staff engagement with the organisation, poor recruitment and retention and a significant impact on staff morale.
Executive Lead	Chief People Officer
Lead Committee	People & culture committee
Source	Internal
Change since last review	No change

Controls	Assurance
1. Workforce recovery planning and guidance for staff to respond to staff experiencing stress and assist to develop wellbeing.	➢ Workforce issues and guidance monitored and approved through weekly management executive
2. Staff survey	➢ Annually to management executive with divisional plans agreed with TMC
3. Staff health and wellbeing group activities centred to assist staff when troubled and keep them from harm	➢ Reporting quarterly to people and culture committee
4. Freedom to speak up and staff network feedback ensures if things are missed and not responded to then this can be remedied.	➢ Chair and CE and board of directors, quarterly reporting to board and increased visibility of staff networks
5. ~~Develop~~ Action plan now in place following staff survey to address areas of staff wellbeing the Trust has been made aware of.	➢ Monitored through ManEx, TMC and People & Culture Committee and presented to the Board
6. Staff risk assessments focus on wellbeing.	➢ Staff survey
7. Improved line manager capacity and people capability to ensure staff are well led and their wellbeing is monitored and responded to quickly.	➢ Monitored through ManEx, TMC and People & Culture Committee
8. Plan to implement the behaviours which underpin the trust values this year	➢ ManEx and People and Culture Committee

Gaps in control

- Differences in impact on individuals make it more challenging to look at a 'one-size fits all' approach
- Increased activity impacts on ability to participate in engagement and health and wellbeing support

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	4	4	4
Likelihood	4	4	3
Risk Scores	**16**	**16**	**12**

Action Required

No.	Action	Responsible Person/s	Due date	Progress/ Status
1.	More granular reporting of staff satisfaction measures to be developed	SS	30 .04.23	**In place and ongoing**
2.	Action plan following staff survey to be developed	SS	30 .04.23	**In place and ongoing**
3.	Continued monitoring of staff satisfaction levels through staff survey, health and wellbeing group and other subgroups via the people & culture committee	SS	30 .04.23	**In place and ongoing**
4.	Health and wellbeing agenda and initiatives in place and being monitored	SS	30 .04.23	**In place and ongoing**

5.	Developing use of pulse survey in Trust for better monitoring of staff issues and attitudes	SS	Oct 24	**In place and ongoing**
Executive Commentary				
Considerable work continues to be undertaken on health and wellbeing. However, we recognise that there is more to do in this area. The role of managers and communications teams is important, and they are conducting a review of their channels. There is a fragmentation of staff experience particularly in relation to E&D. The score remains high to take into account the staff survey.				

Risk No.	**5**
Objective	**Discover:** We will be at the leading edge of research making new discoveries with our partners and patients.
Risk Description	If the trust cannot attract sufficient research funding in existing and new fields its capacity to conduct research will diminish preventing it competing effectively for funding and then delivering new treatments to patients. This poses a significant risk to the trust brand and reputation which is being reduced by actively collaborating with research partners in other medical and basic science disciplines as well as with funders worldwide.
Executive Lead	Director of R&D
Lead Committee	Discovery and commercial committee
Source	External
Change since last review	No change

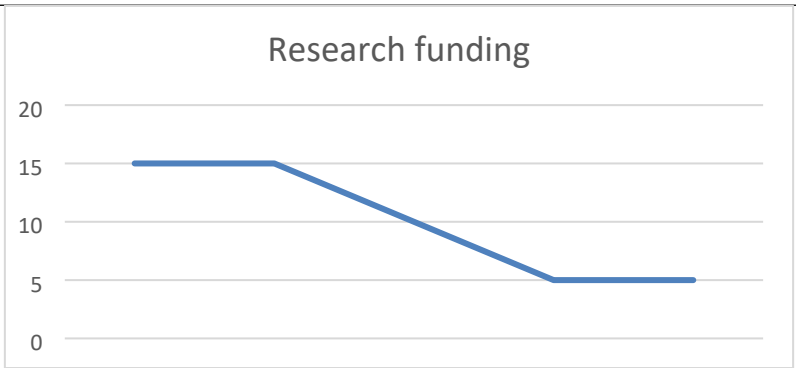
Controls	**Assurance**
1. R&D processes in place to monitor activity, safety, outputs and expenditure	➢ Reviewed by R&D committees (Research Management, Research Financial Performance, CRF performance Governance, External reviews of R&D to ensure MHRA compliance) reporting to Moorfields Discovery and Commercial Committee. In addition, BRC and CRF activity and financial reporting to NIHR.
2. New BRC4 (2022-2027) executive board with responsibility to monitor funding arrangements and respond to challenges	➢ Review of BRC progress, including finances and performance provided by Theme groups ➢ Governance processes to ensure executive and non-executive scrutiny and oversight. Regular financial and activity reporting to NIHR. ➢ Reporting to Discovery and Commercial Committee and UCL IO committees
3. NIHR BRC application - successful £21m 2022-2027 with uplift in grant, in context of most London, Cambridge, KCL and Oxford BRCs losing significant funding. Recently extended with pro rata funding to March 2028 to align with NIHR financial year.	➢ Research management, performance and governance committee(s) ➢ BRC Executive Board ➢ Joint Vision Strategy Committee (JVIS) ➢ UCL IOX Board ➢ Moorfields Discovery and Commercial committee ➢ Moorfields Board of Directors
4. NIHR Clinical Research Facility funding with uplift £5.5M 2022-2027; recently extended to 2028. Previous successful collaboration with Google DeepMind, leading to Librarian software and OCTane AI - subsequent £10M grant HDR UK created with NIHR BRC infrastructure, resulting in successful licencing data and possible joint partnership development. Continued grant, commercial trial, partnerships and spinout development.	➢ Discovery and Commercial Committee ➢ **Trust is currently halfway through its BRC funding**

Gaps in Controls

- Continue further research capacity building strategy and investment.
- Accurate, clear, timely accounting - live accounts accessible to be read by researchers and administrators to optimise research financial management. **This gap is now mitigated with reporting to DCC and FPC from a substantive staff member in post.**

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	5	5	5
Likelihood	3	1	1
Risk Scores	**15**	**5**	**5**



Action Required

No.	Action	Responsible Person/s	Due date	Progress/ Status
1.	BRC Executive and Theme Boards fully running	PTK/AD/AK	1.03.23	**Ongoing**
2.	Continued development of Discovery portfolio and capacity building, including OCTane and INSIGHT	LW/SS/PK	1.6.23	**Ongoing**
3.	BRC Executive board with financial and research progress reports from Theme Lead meetings. Regular NIHR BRC and CRF reporting as required by NIHR funding contract. Improved sign off systems for research projects. Capacity development in research, and infrastructure support to build research translation. Commercial reporting in place**. Discovery Board has oversight, data licencing and commercial activities to be reported to DCC regularly.**	LW/SS	Mar 23	**Ongoing**

Executive Commentary

Moorfields, in partnership with UCL-IO, has been successful recently with five-year funding NIHR BRC (£210M) and NIHR CRF (£5.5M) (end 2022-2027), taking us through to Oriel.

The Trust **is reviewing its work related to OCTane**. INSIGHT has been supported for another year with internal funding of circa £1m. Further current and future spin outs from advanced therapy projects are also in progress. The number of commercial trials continues to increase with an associated increase in income.

The support for clinicians in writing grant applications, the set-up process and the monitoring to ensure that trials deliver to time and target has been reviewed and strengthened. **The policy to allow subawards funded by the USA Federal Government is being further reviewed.** This will ensure that our clinical investigators continue to have access to one of the largest funders of ophthalmic trials in the world.

The Clinical Research Facility has appointed a full-time grant writer **and now has a Director of Research Statistics.** This will help to ensure that grant applications and indeed commercial studies are as scientifically robust as possible.

The Trust now has a Director of Discovery in post.

Risk No.	**6**
Objective	**Develop:** Use digital technology and clinical data to transform care pathways and outcomes.
Risk Description	If the trust's **Digital infrastructure** fails to provide robust resilience and adequate performance **(viewed in terms of reliability but also our strategic ambition for digital leadership across many domains),** then treatment of patients may be compromised through either a lack of access to digital patient and administrative data, or a slowness of information delivery that reduces patient throughput enough that some patients may need to re-book and return for their treatment.
Executive Lead	Chief information officer
Lead Committee	Major projects and digital committee and management executive
Source	Internal
Change since last review	No change

Controls	**Assurance**
1. Incident alerts to CIO Leadership Team to assess response plan	➢ Major incident reviews to CIOLT Executive Performance Review and Management Executive
2. Bi-weekly IT Leadership Team to ensure any necessary course corrections made	➢ Escalations to Management Executive
3. Improved Change Advisory Board processes to mitigate incidents	➢ CIOLT Executive Performance Review oversight and escalations to management executive and Major Projects and Digital Committee
4. Incidents report to finance committee	➢ Number of incidents reported to Finance Committee on a quarterly basis
5. Imaging Programme Board with enhanced clinical membership and new project manager to oversee imaging infrastructure improvements	➢ Weekly IT leadership team
6. Disaster Recovery and Business Continuity Plans are documented and reviewed annually	➢ Bi-Monthly Information Governance Committee
7. Selection of EPR supplier and commencement of project to implement	➢ Approved at Trust Board, reviewed at MP&D Committee

Gaps in Controls

- Real-time monitoring capability
- Non-enterprise strength imaging infrastructure from some manufacturers
- Inadequate imaging systems design

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	4	4	2
Risk Scores	**16**	**16**	**8**

Action Required				
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/ Status**
1	Investment made in additional SolarWinds tools now to be implemented and staff trained.	Nick Roberts	Sept 21	**Complete**
2	Moving of key application and data assets to Google Cloud Platform, starting with OpenEyes.	Nick Roberts	Complete prior to Oriel	**Ongoing**
3	Completion and approval of EPR full business case.	Nick Roberts	Dec 23	**Ongoing**
4	Deliver IT Remediation Programme	Nick Roberts	July 23	**Ongoing**
5.	Successful delivery of OpenEyes upgrade and hosting on Google Cloud	Nick Roberts	Sept 22	**Complete**
6.	Migration of Virtual Server Platform to Cloud-based Applications Platform	Nick Roberts	March 27	**Ongoing**
7.	Further capital investment in business planning to improve stability and capacity	Nick Roberts	-	**Ongoing**

Executive Commentary

Successful upgrade and migration of OpenEyes to Google Cloud has provided significant stability and availability improvement to our core clinical system. Remaining work from the IT Remediation Programme focused on delivery of Oculus Data Warehouse in 2024, Imaging systems upgrades completed. Issues during H2 of 2022 with on-premise applications hosting which led to systems downtime on two occasions have led to a comprehensive review of IT Transition to the Cloud. Joint work with Gartner Consulting to build a delivery plac for FY24/25. Our EPR Programme submitted the Outline Business Case to trust board in March 23 to replace the majority of our clinical systems with one new integrated solution, significantly enhancing clinical applications' functionality, stability, and availability. FBC was approved at the Trust Board in June 2024, with target delivery date of March 2026. The risk will not be reduced until significant and sustained progress stabilising the infrastructure is demonstrable.

Risk No.	**7**
Objective	**Deliver:** Optimise our systems, infrastructure and capabilities to deliver excellent and efficient care
Risk Description	If the **current financial pressures impact, and may compromise, the ophthalmic care for both new and existing patients**, then this may lead to patient harm, reputational risk and potential financial risk through litigation.
Executive Lead	Medical director
Lead Committee	Quality and Safety Committee, Finance and Performance Committee
Source	Internal
Change since last review	No change

Controls	**Assurance**
1. Oversight of adherence to guidance and impact on clinical practice on an ongoing basis to mitigate potential risks	➢ Weekly reporting to management executive on position
2. Outpatient and surgery **activity** plan which is reviewed weekly and allows for appropriate responses and adjustments, where needed, to be made	➢ Weekly reporting to management executive
3. Serious incident and never event monitoring for lessons **within the PSIRF framework** would reduce likelihood of future instances **and improve organisational learning and development**	➢ Monthly SI panel and bi-monthly quality and safety
4. Clinically led risk stratification process on an ongoing basis	➢ Service level monitoring scrutinised at monthly performance reviews
5. Regular audit cycles, which are presented within service, education-based systems meetings and action plans devised.	➢ Written in the annual quality report and presented to the board. Part of the NOD cataract database, **and ARMD database** which benchmarks the outcomes nationally
6. Administration processes and procedures are designed and implemented to ensure access is appropriately available to new and existing patients.	➢ Divisional performance reviews and silver recovery

Gaps in Controls

- Patient choice to defer or refuse treatment
- Government restrictions and guidance

Risk Scores

	Initial Score	**Current Score**	**Target Score**
Consequence	4	4	4
Likelihood	3	3	2
Risk Scores	**12**	**12**	**8**

Action Required				
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/ Status**
1.	Close monitoring of 52 week waits and clinical services as well as implementing and analysing diagnostic hub performance	JS		**In place and ongoing**
2.	The formation of the excellence board will help to provide additional oversight of how the trust continues to support and deliver clinical excellence	LW		**In place and ongoing**
3.	**Medical directorate restructure to support introduction of service-based job planning and help to deliver increased productivity of services whilst maintaining quality and safety.**	**LW**	**July 2025**	**Work underway**

Executive Commentary
The main risks highlighted have been issues such as a reduced number of fellows and digital resilience (see risk 9). The volume of patients presenting with more acute problems is an issue that is being kept under close review. It is proposed that the risk score remains, as mitigations will not yet have sufficient impact to reduce, and there is a risk that the emergence and prevalence **of financial pressures may have a negative impact on quality and safety of services.**

Risk No.	**8**
Objective	**Sustainability and at scale:** Build our commercial capability to grow and support new opportunities in support of our change this to financial sustainability, value for money and delivering excellent care to more people.
Risk Description	If the **growth in commercial activity** is not to plan then there will not be sufficient revenue generated leading to pressure on trust finances elsewhere and a lack of ability to compete effectively in the market and to continue to provide high quality NHS services to patients, as well having an impact on the assumptions for Oriel.
Executive Lead	**Reallocation to be confirmed**
Lead Committee	Discovery and commercial committee
Source	Financial report for commercial operations
Change since last review	No change

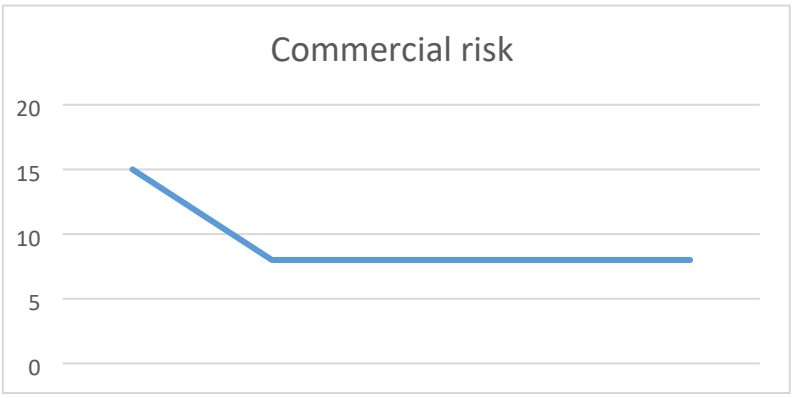
Controls	**Assurance**
1. Regular granular reports to the Board on commercial activity, which ensures monitoring and responding where needed to mitigate risks	➢ Monthly board reporting for commercial operations
2. Commercial opportunities screening tool, which ensures activity and risks are monitored and mitigated	➢ Discovery and commercial committee reports
3. Commercial governance structure approved by DCC, which ensures Trust provides appropriate resources to plan and monitor	➢ Discovery and commercial committee bi-monthly review
4. Strategic assessment of commercial opportunities, which ensures activity and risks are monitored and mitigated	➢ Finance committee quarterly review
5. Debt recovery processes to mitigate instances of the Trust losing money	➢ Moorfields private performance monthly review
6. Operational ownership of budgets including budget sign-off, which ensures activity is managed locally	➢ Approved through executives and regular ManEx updates
7. Growth strategy for MP approved and under review from Discovery and Commercial Committee	Discovery and commercial committee reports

Gaps in Controls

- Future corporate structure

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	5	4	4
Likelihood	3	2	2
Risk Scores	**15**	**8**	**8**



Action Required				
No.	**Action**	**Responsible Person/s**	**Due date**	**Progress/ Status**
1.	Completion of new theatre at the Claremont	AR	Oct 22	**Complete**
2.	Mobilisation plan post-completion	AR	Oct 22	**Complete**
3.	Assess achievement against post-completion mobilisation plan	AR	Mar 23	**Complete**
4.	Regular monitoring of commercial unit activity through financial reporting, discovery and commercial committee and performance reviews	MB/EH	Ongoing	**In place and ongoing**
5.	Monitoring of 3-5 year business plan through SCC	MB/EH	Ongoing	**In place and ongoing**
6.	Implementation of refractive laser suite BC and expansion into 60 Wimpole Street	AR	Feb 22	**Complete**
Executive Commentary				
The key risks to growth in commercial activity are the wider financial environment and the impact of falling NHS waiting lists and how this manifests. UAE is budgeting for year-on-year growth with the key action being the finalisation of a business case for expansion in Abu Dhabi.				

Risk No.	**9**
Objective	**Sustainability and at scale:** We will be seen as a valued partner in our integrated care system footprints, our region, nationally and internationally
Risk Description	**Future funding models are being reviewed nationally with a view to returning to a price x activity basis, a review of fixed versus variable funding elements, and alignment to fair shares.**
Executive Lead	Chief financial officer
Lead Committee	Management executive and finance & performance committee
Source	External (Commissioners)
Change since last review	No change

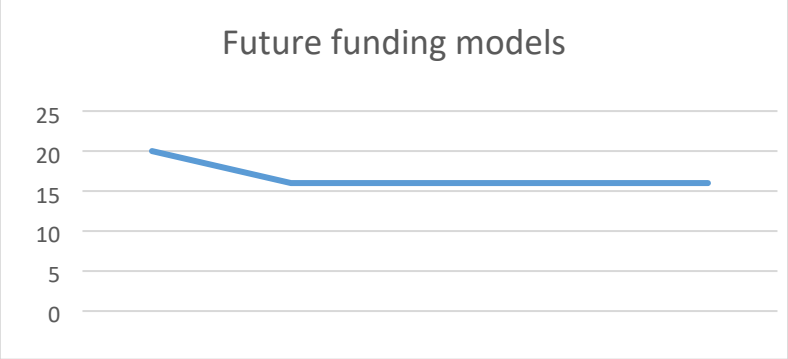
Controls	**Assurance**
1. Modified fixed funding envelopes	➢ Review of current underlying and recurrent cost bases over previous years against potential and likely future funding scenarios.
2. Management of employee cost bases across the network to match activity and high productivity levels	➢ **Workforce reporting and rostering controls**
3. Monthly reporting for expenditure run rate	➢ **Reports to ManEx, FPC, Board**

Gaps in Controls

- Clarity within future financial architecture
- Clear mechanism for ERF/Incentive schemes and operation at ICB level
- Impact on sustainability for future planning
- External ICB influence

Risk Scores

	Initial Score	Current Score	Target Score
Consequence	5	4	4
Likelihood	4	4	3
Risk Scores	**20**	**16**	**12**



Action Required

No.	Action	Responsible Person/s	Due date	Progress/ Status
1.	To interpret future guidance once received and keep the Board updated as to progress	JB	July 25	**Ongoing**
2.	Assessment of the impact of the **structural changes in ICBs/NHSE implications for and influence** of sector and individual provider finances	JB	July 25	**Ongoing**
3.	Continuing reporting of the underlying position within the organisation	JB	July 25	**Ongoing**

Executive Commentary

Following operational planning guidance being issues in January 2025, there remains a high degree of uncertainty surrounding income levels, ERF mechanisms and approach from other ICBs to contracting**. Until the organisations income is confirmed there remains significant uncertainty. As part of 2025/26 business planning the focus is now on completing NHS commissioner contracts by the end of May, understanding activity reductions specifically in**

cataract and mapping this to workforce pay and WTE reductions impacts, whilst efficiencies are fully developed and executed.
The current landscape of Elective Recovery Funding during 2025/26 will be continuously monitored.

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 15a

Summary of the People and Culture Committee

Board of directors
5 June 2025

Meeting:	Public Trust Board
Date:	5 June 2025
Report title:	Summary of the People and Culture Committee (PCC) held on 6 May 2025
Executive Sponsor	Sue Steen, Chief People Officer
Report Author	Jennie Phillips, Deputy Company Secretary
Presented by	Aaron Rajan, Non-executive Director and Committee Chair
Status	Noting for assurance
Link to strategic objectives	Working Together - We will work together to ensure our workforce supports future care models and a consistently excellent patient and staff experience, in accordance with our values.

Summary of report

The People and Culture Committee is a formal Committee of the Board and is authorised to either provide assurance to the Board or carry out delegated functions on its behalf. The Committee meets four times a year and a summary of the key updates at each meeting is provided to the Trust Board of Directors for noting.

This report provides a brief summary of the meeting held on 5 May 2025.

Action Required/Recommendation.

The Board is asked to note the report and approve the term of reference.

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

PEOPLE AND CULTURE COMMITTEE SUMMARY REPORT	
Governance	• Quorate – Yes
Current activity	**Workforce priorities and change projects (including Oriel workforce priorities and emerging themes)** • Key priorities for Q1 had included finalising the People and OD Strategy, conducting the ER service review, progressing EDI priorities, and advancing the leadership and development programme. • Divisional performance reviews had identified a requirement to incorporate people productivity metrics into reporting. While a broader overview was provided in the report, the intention would be to develop more specific KPIs going forward, which would align with the Integrated Performance Report (IPR). • The committee received updates for the Oriel workstreams; the *Communications and Engagement Strategy* would begin to focus on the move and planning and the associated comms; the *People and Culture Workstream* scoping document was nearing completion; the *Ways of Working and Patient Flow Workstream* was progressing. The committee discussed in detail the importance of implementing service and operational changes ahead of the move, where feasible, to minimise disruption to both patients and staff. Some of these changes would be necessitated by the transition to the new EPR system. • The committee also discussed the importance of strategic messaging and the detailed cascading comms that should support this. **Workforce performance** • A Long-Term Sickness review was underway with the Occupational Health team to identify potential actions to reduce absence rates. • The average time to hire had reduced to 39 days, which was below the trust's Ceiling. Managers were being encouraged to improve this further by approving vacancies on Trac quicker. • Appraisal rates had decreased slightly from 70.3% to 69%, which had been anticipated due to the implementation of a new appraisal process. This was expected to begin improving towards the end of May. The committee discussed in some detail how the organisation must promote the value of a robust appraisal process, which should be cascading messaging from the leadership team. • The Health Roster team had been working closely with managers to reduce reliance on bank staff. This included ensuring staff's contracted 37.5 working hours were fully rostered before allocating additional hours via the Bank. **People & OD Strategy** • The chief people officer informed the committee of the developments across the wider NHS People profession and how Moorfields would aim to align its own strategy with some aspects. • Extensive engagement with staff and stakeholders had taken place to ensure the trust strategy was tailored to MEH with the initial draft expected to be ready in June **Freedom To Speak Up (FTSU) Report** • The committee received a summary report which covered of Q2-Q4 (July 2024-March 2025) data. A total of 135 cases were raised during the reporting period. • The highest number of cases originated from the North Division, followed by OCCS and City Road, respectively. • The top theme was leadership and management behaviour. However, this theme decreased from Q2 through to Q4. It was noted that peaks in reporting aligned with targeted FTSU listening events and learning from these cases had been incorporated into the trust's new leadership development programme. • A draft of the trust's three-year FTSU strategy had been shared for comment.

	• The FTSU Champion network continues to expand. • Listen Up and Speak Up training had seen strong uptake, particularly in the South Division. **Review of the Employee Relations (ER) Function and Action Plan** • The committee received a report which provided an overview of an independent review of the trust's ER services. • The review, which had taken six weeks to complete, examined the quality and effectiveness of the current ER model. It involved a desktop review of related policies, data and reports, and stakeholder interviews with HR colleagues, operational managers, directors, and union representatives. • The report set out a number of recommendations to support long-term structural and culture reform, which would now be taken into consideration, alongside the trust's overarching People Strategy. **Gender Pay Gap Report** • A year-on-year comparison showed a widening of the gender pay gap in 2024 compared to 2023. Increases were noted in two key metrics: actual pay gap and median pay gap. The report identified several contributing factors and areas requiring further investigation. **Organisational Development (OD) Projects Update** • The Embedding the Values & Behaviours Framework programme remained on track with trust-wide comms now launched. The next phase would involve engagement at satellite sites using a train the trainer model which would align with exec site visits. • The Leadership Development Programme pilot was currently underway. Feedback will be reviewed by the committee in due course to inform of decisions regarding the future operating model of the programme. • The committee acknowledged the importance of these initiatives in supporting cultural change across the organisation. It also recognised that, in the context of the current financial environment and the need to deliver CIPs, investment in such programmes must be carefully considered.
Key concerns	There were no concerns to note.
Date of the next meeting	The next meeting was scheduled for 28 July 2025.

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 15b

Summary report of the Quality and Safety Committee 13 May 2025

Board of directors – 5 June 2025

Report title	**Summary report of the Quality and Safety Committee meeting of 13 May 2025**		
Report from	Michael Marsh, Chair of the Quality and Safety Committee		
Prepared by	Ian Tombleson, Director of Quality and Safety		
Previously considered at	N/A	**Date**	N/A
Link to strategic objectives	We will consistently provide an excellent, globally recognised service		

Quality implications This report provides a summary of the committee's meeting held on 13 May 2025. It outlines the items discussed at the meeting and highlights any issues for the attention of the board.
Financial implications None.
Risk implications No specific escalations to trust board. Any risks are described the main report.
Action required/recommendation. The board is asked to note the report of the Quality and Safety Committee.

For assurance	**X**	**For decision**		**For discussion**		**To note**	

Moorfields Eye Hospital NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

13 May 2025

Committee Governance	• Quorate – Yes • Attendance (membership) – 71.4% • Action completion status (due items) – 100% • Agenda completed – No (presentation from Moorfields Private deferred due to sickness absence)
Current activity and concerns	**Clinical Audit Presentation** The committee received a presentation about Clinical Audit. The following issues were highlighted: • Overall performance for audit is good, however not every clinical audit that is started is completed. • Service teams would like to see a return of service clinical audit half days. Consideration of this would be a balance between the impact on revenue and the quality benefits. • Fewer audits are taking place in Private and this requires following up. • Oriel requires a re-mapping exercise for the *Tendable* audit tool. • EPR (MoorConnect) will help the collection of outcome data. **Infection Control Update** The regular infection control (IPC) update was presented. The following were highlighted: • There have been two endophthalmitis cases (both at Croydon, but unrelated). • There was one measles case (a child in A&E). Exposed staff have received an OH (Occupational Health) follow-up. Cases of measles are being carefully monitored. • Updated PPE (personal protective equipment) guidance has been reviewed and appropriate adjustments made due to the perceived low level of risk presented by the clinical cases seen. **Patient Safety Incidents** There were two patient safety incident reports for the committee. The regular duty of candour report was presented. The following were highlighted: • The wrong muscle botulinum toxin was a never event. Challenges of using the current version of *OpenEyes* were noted as a contributory factor. • The misdiagnosis of retinoblastoma incident demonstrated the complexities of working between hospitals, and the impact of using multiple systems. **Bedford transformation** The latest update was presented – all 10,000 patients have been seen. The following were raised: • Bedford has one WTE failsafe officer – this is a fixed-term contact and is pending review. • The Phase 2 IT transition will be discussed at ManEx and then at Board (5th June 2025). • The team were commended on their extensive and thorough work to resolve these issues. **Quality Account** The draft quality account was presented. This provides a record of 2024-25 performance and sets the quality priorities for 2025-26. There was discussion around its intended audience. The quality account will be presented to Board on 5 June. QSC encouraged an accessible summary to be produced.

	Quality and Safety The committee received the Q&S update, and the quality and safety reports (Trust-wide and UAE) for Q4. The following areas were highlighted: • Engagement with the CQC - this happens regularly and is reported at the Clinical Governance Committee. • The trust-wide PSIRF policy and plan will be reviewed later this year, and national patient safety syllabus training is mandatory for all staff. **QSC Committee Governance** The committee received its annual report for 2024-25, and terms of reference (ToR) for 2025-26. The following issues were highlighted: • The ToR and annual report were signed off. • It was noted that there are currently three Non-Executive Directors attending this committee. **Fire Safety** The committee received its regular fire safety update. The following were highlighted: • The list of site-cover nurses has been completed - training is in progress. This will be tested. • The local fire safety plans will also be tested through drills. The updated fire safety policy will be going to the policy and procedure review group for approval later this month. **Reports from Other Committees** Summary reports from the following committees were circulated: • Risk and Safety Committee (12/03/2025) • Research Quality Review Group (24/03/2025) • Information Governance Committee (01/04/2025) • Clinical Governance Committee (28/04/2025). The following issues were highlighted: • Good progress with Data Security and Protection Toolkit project was highlighted in relation to the IGC summary. • Assurance was provided in relation to the information possessed/shared by contractors working on Oriel. • An RSC escalation about Clatterbridge and treatment of our oncology patients was noted. This is being progressed through RSC. • The usage of lasers in and outside of theatres was also highlighted in the RSC summary. This is also being progressed, with updates going to RSC.
Escalations	There were no escalations to the Trust Board. The Board's attention is particularly directed to the positive progress with the Bedford transformation and noting the IT transition in progress.
Date of next meeting	22 July 2025

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 15c

Quality and Safey Committee Annual Report 2024-25

Board of directors
5 June 2025

Report title	**Quality and Safety Committee - Annual Report 2024-25**		
Report from	Michael Marsh, Chair of the Quality and Safety Committee		
Prepared by	Ian Tombleson, Director of Quality and Safety		
Previously considered at	Quality & Safety Committee	**Date**	13/05/2025
Link to strategic objectives	We will consistently provide an excellent, globally recognised service		

Quality implications

This report provides a summary of the committee's activity during 2024-25. This report demonstrates how through constructive review and challenge, and through the evaluation of its performance, including this annual report, the committee is performing its functions well and is meeting its Terms of Reference (ToR). Through doing this it provides oversight and supports improvement and quality assurance across Moorfields.

Financial implications

None.

Risk implications

None.

Action required/recommendation.

The board is asked to note the annual report of the Quality and Safety Committee.

For assurance	**X**	**For decision**		**For discussion**		**To note**	

Moorfields Eye Hospital NHS Foundation Trust

NHS

Quality and Safety Committee

Annual Report for 2024-25

Michael Marsh, Chair, Quality and Safety Committee

May 2025

Version: 1.0
Status: FINAL
Approved: 13/05/2025
Authors: David Flintham, Kylie Smith, Ian Tombleson

Contents

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Executive summary

Formed in 2011, the Quality and Safety Committee is a sub-committee of the Board. It has a broad assurance function and employs a variety of proportionate mechanisms to discharge its functions. Over the years, it has evolved and develop its functions to meet the demands of a changing landscape as Moorfields Eye Hospital (MEH) Foundation Trust grows in terms of activity and size.

This annual report demonstrates how, through constructive review and challenge, and through the evaluation of its performance, including this annual report, the committee is performing its functions well, and is meeting its Terms of Reference (ToR). In so doing, it provides oversight and supports improvement and quality assurance across MEH. Amongst the key areas overseen by the committee during 2024-25 was the implementation of the Patient Safety Incident Response Framework (PSIRF).

During the period of this report, Ros Given-Wilson stood down from her long-standing role as chair of the committee and has been replaced by Michael Marsh. Thus, this report is both a tribute to Ros, and a welcome to Michael.

1. Introduction

The Quality and Safety Committee ('the committee') is a standing committee of Moorfields' board of directors. Its purpose is to provide the board with a means of independent and objective review for the governance (oversight and scrutiny) of all aspects of quality and safety relating to patient care and patient experience. It also has oversight of the trust's research governance arrangements. Thus, supporting the best clinical outcomes and experiences for patients and recipients of services at all network sites.

This annual report describes how the committee has complied with and satisfied the requirements of its ToR during the period 1 April 2024 to 31 March 2025, highlighting how it has responded to the changes brought by the continuing growth and complexity of the organisation.

In July 2024, Ros Given-Wilson stood down from her long-standing role as chair of the committee. She joined the committee in June 2015 and took over as chair in September 2016. During time, she attended 52 meetings, chairing 45 of them. She leaves an impressive legacy to Michael Marsh who succeeded her in November 2024.

2. Terms of Reference

The committee's ToR cover all areas of Moorfields' provision of care and services, NHS and commercial, at all network locations, both in the UK and United Arab Emirates (UAE) and also research governance. To ensure its functions are discharged effectively, the committee has an annual work plan, which is regularly reviewed to take account of changing priorities.

The ToR for 2024-25 (reviewed in May 2024) are included as Appendix 1. Appendix 2 illustrates the trust's committee structure, highlighting the relationship between the committee and other committees, including those reporting to the board, and the management executive.

During 2024-25, the committee met six times and reported progress on its work to the board via the committee's chair. Member attendance is summarised in Appendix 3. Through 2024-25, all the committee's meetings were held remotely, members attending from a variety of locations.

The dispatch of meeting papers remains the only area where the terms of reference are not being continually met, typically, the papers are being distributed a day after the due date. This is an area for improvement in 2025-26.

3. Topics of focus

During 2024-25, a wide range of topics were presented and discussed:

Meeting	Specific topic of focus
May 2024	SLAs and relationships with host Trusts 2023-2024 quality account Health inequalities
July 2024	Patient safety incident response framework (PSIRF) Divisional presentation – Moorfields UAE
September 2024	Divisional presentation – Moorfields South Bedford transformation Committee annual reports
November 2024	Divisional presentation – Ophthalmology and Clinical Support Services Duty of Candour Bedford transformation
January 2025	Divisional presentation – Moorfields North IPC BAF action plan Committee annual reports Bedford transformation
March 2025	Divisional presentation – City Road[1] Research Governance Draft quality priorities for 2025-26 Bedford transformation Safer staffing

Figure 1 - Summery of topics presented to Q&SC

4. Quality

4.1. Quality Account

The Quality Account is a mandated document setting out how the trust develops and implements the principles and objectives set out in its five-year strategy, ensuring that quality remains a strategic theme, providing patient-centred care with exceptional clinical outcomes and an excellent patient experience. It provides a review of the previous year and sets the quality priorities for the coming year.

As the development of the quality account cut across different financial years (development commences in November/December with final publication taking place the following June), this section outlines the development of the quality account for 2023-24 (published in June 2024 – section 4.1.1), as well as the development of the 2024-25 quality account (due to be published in June 2025) up to 31 March 2025 (section 4.1.2).

[1] Moorfields Private are scheduled to present at the May 2025 meeting

4.1.1. 2023-24 Quality Account (including quality priorities for 2024-25)

As described in the annual report for 2023-24, development of the quality account for 2023-24 commenced in December 2023, the committee receiving the draft quality priorities at its meeting on 12 March 2024.

The draft quality account was presented to the committee at its meeting on 14 May 2024, after which it was presented to Trust Board for approval (6 June 2024), as well as to the North Central London Clinical Commission Group, and Healthwatch Islington. The quality account was published on 28 June 2024. It was subsequently presented to the Membership Council on 15 July 2024 as part of the council's annual quality and safety briefing.

4.1.2. 2024-25 Quality Account (including quality priorities for 2025-26)

Development of the quality account for 2024-25 commenced in November 2024 with the patient feedback received during Safer September. From this, as part of the business planning cycle, quality themes were identified, which was followed by consultation with various committees and groups.

In January 2025, the draft quality priorities were developed and these were agreed by CGC and ManEx in February 2025, and were presented to the committee at its meeting on 11 March 2025. At the time of writing (April 2025), work with the quality account itself is progress to schedule, and a draft of the quality account is due to be presented to the committee at its May meeting.

4.2. Quarterly quality & safety report

The quality and safety report was presented to the committee quarterly. This report details learning and improvement actions to ensure sharing of learning across the organisation. Moorfields UAE, and Moorfields Private both provide a separate report. These reports provide an overview of the clinical quality and safety activities and performance of MEH and are mapped against the three Darzi headings of patient safety, patient experience and clinical effectiveness. See also section 6.1.

4.3. Policy governance

The committee has oversight of the governance of all trust policies, receiving regular highlight reports. As of 31 March 2025, 91% (199 out of a total of 218) of the Trust's policies were in date. The KPI target is 90%, and during 2024-25 the monthly average achieved was 92% (the average achieved for 2023-24 was 93%).

4.4. Care Quality Commission (CQC) inspection

The trust is required to be registered with the CQC and is currently registered without conditions. Whilst there were no inspections of any part of Moorfields conducted during 2024-25, regular 'catch-up' meetings are held with the CQC.

The CQC has not taken any enforcement action against the trust in 2024-25, nor at any time previously.

5. Safety

5.1. Monitoring of Serious Incidents (SIs) / Patient Safety Incidents - process management

In its role as an overview and scrutiny committee, the committee reviews the executive summaries (including learning) and action plans of all completed SI and never event (NE) investigation reports. The committee provides assurance to the trust board regarding the adequacy of the processes in place for identifying and managing SIs and NEs, in accordance with the required timescales and the SI national framework. As part of this process, it routinely receives a report which identifies the SI management timeline for each reported SI. The same report also reports the trust's Duty of Candour compliance for SIs and other relevant incidents. During 2023/24, the committee received and reviewed the following executive SI summaries and action plans:

Meeting	Incident investigation title
May 2024	• Implantation of incorrect graft material (Moorfields at St George's - 23 November 2023)
November 2024	• Intravitreal injection to the incorrect eye (Moorfields at Bedford - 15 February 2024)

Figure 2 - Review of executive SI summaries

A summary of all reported serious incidents, NE, and incident reporting is also included as part of the quarterly quality and safety report (see 6.1).

It should be noted that the Trust transitioned to the PSIRF in April 2024. Therefore, all future investigations will be undertaken in accordance with this framework. The Trust's PSIRF plan and policy were both approved under delegated authority from the Board.

5.2. Risk Management

The corporate risk register is presented to the Trust Board. Divisional risk management forms an integral part of the divisional annual presentations to the committee. These presentations follow a pre-defined format and, in addition to divisional risks, also covers local issues and challenges, priorities for the year, sustainability of improvement, and what the division is proud of.

5.3. Claims management

The number of clinical (CNST) and personal injury (LTPS) claims remains low both in terms of actual numbers and when compared to other speciality trusts. The analysis of claims has been enhanced by the annual production of clinical and non-clinical claims scorecards by NHS Resolution. Claims management including learning from claims forms part of the quarterly quality and safety report.

6. Learning, improvement, and process monitoring

6.1. Quarterly quality & safety report

As set out under 4.2, the committee receives a quarterly quality and safety report. The report includes learning and improvements against each quality item for all services/networks. Separate reports from Moorfields Private, and Moorfields UAE are also received. During 2024-25 these reports were received as follows:

Quarter	Date received by the committee
Q4 (2023-24)	14/05/2024
Q1 (2024-25)	16/07/2024
Q2	12/11/2024
Q3	28/01/2025
Q4	To be presented on 13/05/2025

Figure 3 - Quarterly Q&S reports received

6.2. Incident reporting

As discussed in 5.1, data and narrative describing the trust position in relation to the number of open and reported incidents is included in the quarterly quality and safety reports. Emphasis continues to be on the management of incidents that are older than 28 days to ensure timely sharing of learning across the organisation. Incidents that may be expected to exceed the 28-day target have included incidents associated with complaints or claims, those to which the duty of candour applies and incidents that have been reviewed at the Incident Review Group (IRG) which has replaced the SI panel, and for which it has been agreed that a structured and documented investigation report is required. Divisional responses to this performance data are included within the divisional presentations to the committee.

6.3. Claims management

As indicated in section 5.3 the number of CNST and LTPS claims remains low both in terms of actual numbers and when compared to other trusts. Although the analysis of claims has been enhanced by the annual production of clinical and non-clinical claims scorecards by NHS Resolution, this remains an area of learning in which we continue to develop and improve. Learning from claims is included in the quarterly quality and safety report. New claims are also reported as an incident, if

not done previously, and discussed at IRG to ensure learning is shared across the organisation and improvements are made as quickly as possible where relevant. Legal Services regularly review cases for any additional learning to be shared.

6.4. CQC inspection

As described in section 4.4, the trust's previous CQC inspections have provided a good source of learning as the trust plans for future inspections.

6.5. Quality and Safety update

At each of its meetings the committee receives a report and presentation covering quality, compliance, and safety activity during the preceding 2 months.

6.6. Committee governance

The Quality and Compliance Manager, part of the central quality and safety team, is the secretary to the committee. To further improve the effective administration of the committee, in January 2024, a dedicated standard operating procedure was introduced. This covers every aspect of the committee's governance, including roles, responsibilities, and expectations. This document, along with various templates and other resources can be found at https://eyeq.moorfields.nhs.uk/quality-and-compliance. This document was reviewed in March 2024 and will be due its next review during 2025-26.

7. Conclusions and recommendations

The committee meets every two months and continuously reviews the ways it prioritises and targets the focus of its activities. It works closely with other Board sub-committees, including the Audit and Risk Committee (A&RC - the chair of the Q&SC committee is also a member of the A&RC).

As a result of the timely availability of relevant data, the committee is appropriately informed of quality and safety performance and is able to support improvement actions and escalation processes to drive improvement. In so doing, it continues to strengthen its role in supporting the provision of board assurance about quality and safety. Thus, the committee continues to meet the requirements of its terms of reference, and these are due their annual review in May 2025.

Quality performance is owned locally by the divisions, including through the divisional quality forums. The quality and safety committee receives representations from divisional management teams, each making significant contributions to the committee's activities and ensuring the committee has a ward to board flow of information.

Looking ahead, the committee will continue to improve its own governance, including the assurance it receives from management committees, and how its forward work plan operates. This will help ensure that the committee is in a good position to focus further on quality improvement. An outline of the future work plan for the committee can be found in appendix 6.

It is recommended that this report is approved as a record of the committee's activities during 2024-25, demonstrating its adherence to its terms of reference.

2. Appendix 1 - Quality and Safety Committee - Terms of Reference (2024-25)

Authority	The Quality and safety committee is a formal committee of the board and is authorised to provide assurance to the board and carry out delegated functions on its behalf. These terms of reference have been approved by the board and are subject to annual review.
Purpose	The purpose of the committee is to review, on behalf of the board, the following key areas; • to provide oversight and board assurance about the quality and safety aspects of clinical services • to provide assurance about legal compliance with health and safety and related legislation • to steer the quality elements of the trust's strategy • to support the implementation of the quality strategy and quality improvement plan • to oversee the development and implementation of the quality account
Membership	The members of the committee will be appointed by the board as follows: • Four non-executive directors, one of whom shall be nominated as chair • Chief executive • Medical director* • Chief Nurse and allied health professions* • Chief operating officer (*Board leads for Quality and Safety)
Quorum	The quorum will be three members (one of whom must be either the medical director or the director of nursing and allied health professions, or their nominated deputies), including two non-executive directors
Attendees	The following will also regularly attend the committee; • Director of quality and safety • Head of quality and safety • Divisional (or equivalent) directors (if absent, Divisional head of nursing) • Clinical lead for patient safety • Moorfields Private (representative) • Quality and compliance manager (secretariat) Others may attend as agreed by the committee chair.
Frequency of meetings	The committee will meet six times per year and members and regular attendees are expected to attend at least 75% of meetings in any year.
Duties	The committee will only carry out functions authorised by the board, as referenced in these terms of reference. **Delegated functions** The committee will carry out the following on behalf of the board: • Analyse and challenge appropriate information on organisational and operational performance in relation to the committee's purpose **Assurance functions**

The committee will review the following to provide assurance to the board;

Clinical effectiveness

- the content and effectiveness of the structures, systems, and processes for quality assurance, clinical, research, information, and quality governance;
- the development and compliance requirements for the following:
  - NHS outcomes framework,
  - NICE pathways of care standards,
  - the Trust's quality plan and any other KPIs relating to quality measures

Patient Safety

- reports about compliance with external assessments and reporting, including those from:
  - Care Quality Commission
  - NHS Resolution
  - NHS England
  - NHS Improvement
  - Medicines and Healthcare products Regulatory Authority (MHRA)
  - Health and Safety Executive (HSE),
  - Organisations responsible for professional standards (GMC, NMC, etc.)
  - Regulatory bodies in the United Arab Emirates
  - Any other relevant regulatory bodies
- progress with implementing actions arising from CQC reports, and any other reports issued of a similar nature
- internal reports, local or national reviews and enquiries and other data and information that may be relevant for understanding quality and safety within the Trust
- the meaning, significance and learning from trends in complaints, incidents, and serious incidents
- compliance with surgical safety checklists
- how the Trust is addressing the requirements of safeguarding for children and vulnerable adults

Patient participation and experience

- patient participation activities
- environmental and other issues affecting patient experience

Overall

- the development of the quality account and priorities
- supporting the implementation of the quality strategy
- monitoring the implementation of the quality objectives and other actions arising from the quality strategy and quality account
- address specific risks on the corporate risk register allocated by the board

Other duties as agreed by the board

	• oversight of quality and safety related aspects of research activity		
Reporting and review	Following each meeting of the committee, an update will be provided to the board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination. Minutes of meetings will be available for any board member on request. The committee will carry out an annual review of its effectiveness against these terms of reference and this will be reported to the board via the committee's annual report, at the first available meeting after 1 April of each year.		
Sub-committees	There are no formal sub-committees of the committee but the outcomes of the following management groups will be reviewed on a regular basis to gain assurance • Clinical governance committee • Information governance committee • Risk and safety committee • Research and development quality review group		
Meeting administration	The executive lead for the quality and safety committee will be the director of quality and safety, and the secretary for the meeting will be the quality and compliance manager. The secretary's role will be to • Agree the agenda with the chair • Ensure compliance with the committee's *requirements for presenters* • Ensure the agenda and papers are despatched five clear working days before the meeting, in line with the board's standing orders • Maintain a forward plan of items for the committee • Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) • Ensure a summary of the meeting is issued to the chair for review within one week of the meeting • Ensure actions arising from the meeting are captured, notified to owners within two weeks of the meeting. These will be followed up where necessary Any other administrative arrangements not listed here will be as shown in the standing orders of the board of directors.		
Approved by the quality and safety committee			May 2024
Approved by the board	June 2024	**Date of next review**	May 2025

Appendix 2 - Organisational structure

The following diagram illustrates the trust's committee structure, highlighting the relationship between this and other committees, including those reporting to the board, and the management executive (as of April 2024 - this diagram will be revised in 2025).

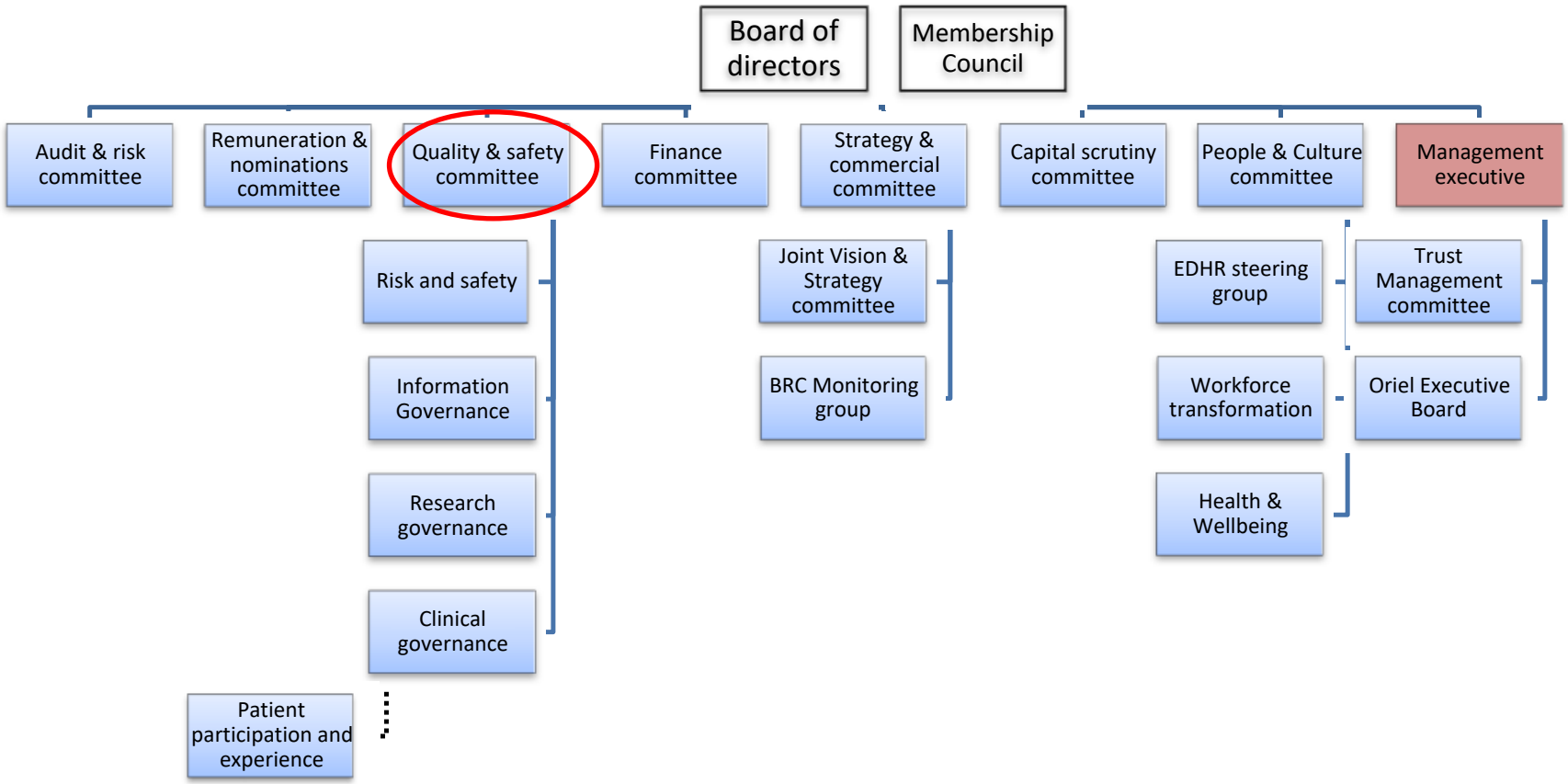

Figure 4 - Trust committee structure (April 2024)

Appendix 3 - Review of attendance in line with the terms of reference

This table demonstrates the attendance if the committee's membership (as defend under the terms of reference – see appendix 1) at each of the committee's meetings.

Dates (►) **Members (▼)**	14.05.24	16.07.24	17.09.24	12.11.24	28.01.25	11.03.25	***Totals***
Ros Given-Wilson	Y	Y	N/A	N/A	N/A	N/A	*2*
Laura Wade-Gery	Y	Y	Y	Y	N	Y	*5*
Andrew Dick	Y	Y	Y	Y	Y	Y	*6*
Asif Bhatti	Y	N	Y	Y	N	N	*3*
Martin Kuper	Y	Y	Y	N	N/A	N/A	*3*
Jon Spencer	Y	Y	Y	Y	Y	Y	*6*
Louisa Wickham	Y	N	N	N	Y	Y	*3*
Sheila Adam	Y	Y	N	Y	Y	Y	*5*
Michael Marsh	N/A	N/A	N/A[2]	Y	Y	Y	3
Peter Ridley	N/A	N/A	N/A	N/A	N	Y	1
Total attendance	*8*	*6*	*5*	*6*	*5*	*7*	

Figure 5 - Membership attendance during 2024-25

[2] Michael attended September's meeting as an observer

Appendix 4 – Summary of committee activity

QUALITY AND SAFETY COMMITTEE 14 May 2024
SUMMARY REPORT

Committee Governance	• Quorate – Yes • Attendance (membership) – 100% • Action completion status (due items) – 100% • Agenda completed – yes • Author - David Flintham
Current activity and issues raised	Actions from the previous meeting Following discussion at March's meeting, the committee received a further update about smoking cessation, and in particular its inclusion within the 'making every contact count' initiative. Committee Governance The committee received its annual report for 2023-24, and its revised terms of reference for 2024-25. Both documents were approved. SLAs and relationships with host Trusts The committee received a comprehensive presentation about SLAs and the occupational status at networked sites, including the various models of occupation and the on-going work to align these. The following issues were raised: • Differences, advantages and disadvantages between NHS and commercial sector models • Challenges with specific sites and the bespoke nature of host relationships • Priorities and the site strategy. SLAs and the site strategy are to be escalated to the Trust Board as an area of focus. Infection control update The regular infection control update was presented. This focused on measles, and the new occupational health provider. Winter vaccination programmes were raised as an issue and an area of continued focus to build numbers. Quality and Safety The quality and safety update included the 2023-2024 quality account which was presented for comment. The quality and safety reports for Q4 were also presented. Learning is a key aspect. The following issues were raised: • How to make the information contained within the quality account, particularly outcome data, accessible to staff, patients, and partners • Incident hotspots and how the data supported their identification

	• Duty of Candour, particularly completing this is as soon as possible and how this is recorded. Duty of candour is to be escalated to the Trust Board. Summary reports from committees The committee received summary reports from the following meetings: Risk and Safety Committee (13/03/2024), Research Quality Review Group (25/03/2024), Information Governance Committee (26/03/2024), and Clinical Governance Committee (29/04/2024). There were no issues raised. Fire Safety The regular update was circulated. There were no issues raised. Health Inequalities This topic was presented to Quality and Safety Committee about a year previously. Substantial progress had been made. The project looks at healthcare inequalities. Trends between 2015-23 were considered, highlighting attendances compared with appointments made, and the reasons behind this. The following issues were raised: • The availability of real time data • The impact of diagnostic hubs, and their popularity amongst patients • The relative geographical location of patients, both in terms of deprivation, and also accessing services. Putting the analysis to practical use forms part of a quality priority for 2024-25. Serious Incidents (SI) The committee received one SI report (Implantation of incorrect graft material (Moorfields at St George's - 23 November 2023)). Also circulated was the Patient Safety Incident Response Framework (PSIRF) and Serious Incident (SI) update, and the Duty of candour tracker. The following issues were raised: • Duty of candour (and also learning) • Some basic processes that were not followed which resulted in the SI. As noted previously, Duty of Candour is to be escalated to the Trust Board.
Escalations	There were two escalations to the Trust Board: • Challenges with SLAs and site strategy (agenda item 31/24) • Duty of candour (agenda items 28/24 and 33/24)
Date of next meeting	16 July 2024

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
16 July 2024

Committee Governance	• Quorate – Yes • Attendance (membership) – 75% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	Quality and Safety The Quality and Safety update confirmed that the Quality Account was published as per timetable on 28 June 2024. The update also included confirmation of an excellent clinical audit week, the positive impact that Tendable has had on other systems, and how a final SI report will be presented to the committee. The following issues were raised: • Despite incident reporting remaining within SPC chart limits, staff may be under reporting. • A number of incidents have exceeded 28 days, a large proportion of which reside within the north division. This has previously been brought to the attention of QSC and has been raised as a concern to the North divisional management team. The central team are also providing support. • Complaints have remained steady, but PALS numbers have increased 21% from Q4 to Q1. This is being examined to determine the cause of the increase. • In relation to the Private Q1 report, overall incident reporting engagement has been positive and remains a priority, however, the closing of incidents needs to be improved. One Serious Incident report was presented relating to the lost to follow up of a patient at Bedford. The recommendations from the report will be actioned by the Bedford improvement work already underway. Reports from Other Committees One matter from the Information governance committee update related to escalations surrounding final closure of actions for the DSPT. These have now been completed with all requirements of DSPT being met for the year. Infection Control Update The regular infection control update was presented. Three areas were highlighted: • The Trust has responded to the increasing number of Whooping Cough cases nationally by providing guidance for A&E and the Paediatrics department, and that some staff members may need re-vaccination. The Trust currently does not offer re-vaccination as it is not required for MEH staff under the current guidance, which currently focusses on those in maternity and midwifery roles or staff caring for neonates. • There have been two further Trust-related endophthalmitis cases in May, which are not related - a full investigation will take place. No further cases were reported in June. • There was a cluster of Serratia marcescens identified (5), which has led to initiation of identifying areas of practice that may be improved. • The IPC Board Assurance Framework (BAF) findings were presented. Although no area has been marked as non-compliant, some have been marked as partially compliant. Action plans

	have been put in place to address those areas. IPC audits remain compliant, although 'below the elbow' compliance is an area of focus. Patient Safety Incident Response Framework (PSIRF) An update was provided on PSIRF, how it differs from the previous framework, and how it is being implemented. The outcome of PSIRF has been positive, which has increased staff and patient support, as well as engagement. • The main concern raised by the committee related to how PSIRF is difficult to communicate, especially the operational processes, and how emerging risks and harm will be managed. Patient Safety Incidents – Incident review group (IRG) activity The IRG report presented a wide distribution in the allocation of confirmed local priorities, with the North division having the most. These mostly related to lost to follow up incidents. • An escalation/concern from the IRG report related to an in-depth review on ophthalmology referrals between 19/20 and 23/24 being undertaken at Bedford. Patient review is being prioritised for possible follow-up. There has been no harm found to date. Presentation by Moorfields UAE The UAE presentation focused on patient waiting times and patient journey times. • The waiting times demonstrated that the average first patient contact is ten minutes, with the aim being five minutes. This figure decreased to seven minutes in June as smart queuing has been introduced. • Patient journey times showed an average of 63 minutes, with the UAE hoping to improve this to below 60 minutes. • Initiatives are being worked on to improve incident reporting rates. • Patient satisfaction surveys are being automated, which has increased patient engagement. Fire Safety The update indicated that fire warden training has increased, with comprehensive training being provided. Farewell to Ros Given-Wilson QSC thanked Ros for her leadership of the Committee over the previous nine years and wished her well for the future.
Escalations	There was one escalation to the Trust Board: • A comprehensive review of patient referrals at Bedford.
Date of next meeting	17 September 2024

Committee Governance	• Quorate – Yes • Attendance (membership) – 71% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	Infection Control Update The regular infection control (IPC) update was presented. The following areas were highlighted: • Guidance around Mpox (Monkeypox) • Neisseria meningitidis, measles, and TB incidents • Surveillance (including endophthalmitis), including use of surgicubes • Service Level agreement to deliver IPC expertise to Tavistock and Portman NHS Foundation Trust • Flu and COVID-19 Seasonal Vaccination programme (commencing 03/10/2024). Committee Annual Reports Annual reports from the following committees were circulated: • Safeguarding (Adults, and Children and Young People) • Resuscitation • Clinical Governance • IPC Annual report. The safeguarding reports were presented individually by the teams. The following issues were raised: • Impact of staffing issues (sickness and other unplanned leave) on safeguarding services • The development of the '*was not brought*' process (Safeguarding Children and Young People) • Flagging of safeguarding concerns, and ensuring accessibility and consistency across all sites. The other annual reports were noted. Presentation by Moorfields South The committee received an annual presentation from Moorfields South. The following issues were raised: • Capacity and overcrowding, and the acquisition of a new local site • The transition to *OpenEyes* at Croydon • The trust-wide transport improvement project • The benefits of having a new patient co-ordinator role in Croydon. Bedford Transformation This item resulted from an action at July's meeting for updates at each meeting. The background to the issue was explained as was the current position. The following issues were raised: • The harm review is currently on-going. To date, there have been no patients identified who have come to harm

	• IT transformation (waiting list management, electronic paper records, and *OpenEyes*) is critical, and a key priority is to harmonise Bedford with the rest of the Trust. March 2025 is still a viable target for completion • A working group with Bedford Hospital has been set up. Fire Safety The committee received its regular fire safety update. Training remains a key topic. The following issues were highlighted: • Fire warden training is currently around 80% (compliance level) • Training has become more flexible, with training being provided at network sites • Site cover nurse training is more challenging, but this is being progressed • Ensuring that the fire safety function can be represented at various committees. Patient Safety Incidents The committee received a report about Duty of Candour (DoC). The following issues were raised: • DoC is becoming more 'business as usual' • There is still an issue of logging that DoC has taken place • Whilst the spirit of DoC exists, there is still a tendency to wait until the harm is confirmed before issuing DoC letters • PSIRF transition was also discussed and it was noted that there is one remaining SI report (a Bedford incident) remaining under the old system. Quality and Safety The Quality and Safety update included current developments with the CQC, as well as an overview of Safer September (17/09/2024 was World Patient Safety Day). The committee received the WHO audit report for Q4 (2023-24). The following issue was raised: • Where there are instances of repeated 100% compliance and what is being done to investigate/challenge this. Reports from Other Committees Summary reports from the following committees were circulated: • Research Quality Review Group (15/07/2024) • Information Governance Committee (30/07/2024) • Clinical Governance Committee (12/08/2024) The new DSPT work including cyber standards was highlighted from the IGC summary report.
Escalations	There were no escalations to the Trust Board.
Date of next meeting	12 November 2024

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
12 November 2024

Committee Governance	• Quorate – Yes • Attendance (membership) – 75% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	Infection Control Update The regular infection control (IPC) update was presented. The following areas were highlighted: • Low rate of take up with the trust's vaccination programme compared to previous years (whilst still being the highest in London). Potentially vaccine fatigue, and hearts and minds are issues. Key is to have leadership visibly continuing to drive vaccination programme • Flu and COVID rates are currently low, and the flu season has yet to get underway • IPC audits are continuing, and IPC training is above target levels • There were two reported endophthalmitis cases, and these have been reviewed by the IPC lead. Presentation by Ophthalmology and Clinical Support Services The committee received an annual presentation from Ophthalmology and Clinical Support Services. The following areas were highlighted: • There has been a journey of transformation across the service since its establishment about 2 years ago. Improvements to the Eyebank, and EDD accreditation were particularly noted • Tissue usage/preparation was discussed, and how this will change as part of Oriel • In the last 12 months, the service had only received 6 complaints • The service has ambitions for further accreditation and improvement which was strongly supported. Duty of Candour The committee received a presentation about Duty of Candour (DoC). This was an action from the May 2024 meeting and part of the forward programme. The following areas were highlighted: • DoC has evolved from Being Open (2005), through the Francis Report (2013), and is now a foundation of the Patient Safety Incident Response Framework (PSIRF) • Regular monitoring of DoC letters takes place, but the detailed audit that was presented to the committee was the first for some time • Whilst 100% compliance was sought, the outcome of the audit presented varying levels of compliance across the process • It was felt that the areas particularly lacking were in the qualitative responses and showing empathy; these required a cultural change • The committee expressed fully its commitment to DoC and the actions planned and being taken forward by the quality and safety team, and that saying sorry is the right thing to do.

	Patient Safety Incidents One serious incident report (Intravitreal injection to the incorrect eye at Bedford in February 2024) was presented. The following was highlighted: • The incident highlighted the issue of carers/relatives staying with the patient during a procedure. There are safety issues with this, as well as other considerations, but this is something to be standardised across Moorfields and supported as an option. Quality and Safety The committee received the WHO audit reports for Q1 and Q2, the regular quality and safety update, and the Q2 Q&S reports (trust-wide, UAE, and Private). The following areas were highlighted: • A presentation accompanied the WHO audit reports, which highlighted four areas that are being monitored in particular: audit submission variability, peer review, theatre lists, and staff introductions • The WHO audit will be renamed 'Safer Surgery Checklist' • The Q&S update highlighted Safer September, and the upcoming trust-wide half-day (04/12/2024) • It was noted that the Private Q&S report showed a lot of 'red' under patient feedback – this is because the bar is set very high. Presentation of this data may require reconsideration. Bedford transformation This item resulted from an action at July's meeting, and updates are being presented at every meeting. The following issues were raised: • The harm review is currently on-going. There are 372 patients to be seen, and all of these should be seen by December (except for those who have requested January appointments) • One glaucoma patient has been identified as coming to harm. The DoC is due to be completed in November • It was noted that there had been some slippage with the IT transition at Bedford. Fire Safety The committee received its regular fire safety update. The following issues were highlighted: • The revised Fire Safety policy will shortly be approved and published • Fire risk assessments are underway • Good levels of training are being achieved • Fire safety function is adequately represented at various committees. Reports from Other Committees Summary reports from the following committees were circulated: • Risk and Safety Committee (11/09/2024) • Research Quality Review Group (23/09/2024) • Information Governance Committee (24/09/2024) • Clinical Governance Committee (14/10/2024)
Escalations	There were no escalations to the Trust Board.
Date of next meeting	28 January 2025

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
28 January 2025

Committee Governance	• Quorate – Yes • Attendance (membership) – 62.5% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	Infection Control Update and Board Assurance Framework (BAF) Action Plan The regular infection control (IPC) update was presented. The following were highlighted: • There is an increase in cold and flu cases, which is to be expected during winter. • There were two reported endophthalmitis cases in December 2024. • There were two notifications from an external agency about patients with respiratory tuberculosis. • Completed audits are all green (an audit at St. Ann's is to be repeated following staff training). Board Assurance Framework (BAF) Action Plan for infection control (this resulted from an action at July's meeting) was presented and discussed. The following were highlighted: • Overall the performance was solid. • PLACE inspections took place in November 2024; the results of these are expected soon. • There are delays in receiving reports in respect of the monitoring of ventilation safety. • Actions in respect of planned maintenance, food hygiene training, Personal Protective Equipment (PPE) fit-testing, and pathology were discussed. Take up of fit-testing is a concern. • The Trust's network will be discussed at the next Board Strategy Day. Presentation by the North Division The committee received a presentation from the North Division. The following were highlighted: • There are issues faced by the North West sector including the theatre at Ealing and paediatric provision at Northwick Park. • IT transition at Bedford (phase 1 complete, phase 2 being planned). • The challenges of operating over a wide geographical area. • Improvements across the Division should be considered in the longer term. Significant progress has already been made, but it is probably only half-way to completion. Bedford transformation This item resulted from an action at July's meeting, and updates are being presented at every meeting. The following issues were raised: • 1,000 patients have been seen, with only 15 remaining. 1 patient has been identified as coming to harm. • The move to *OpenEyes* is a significant improvement. St. Ann's site – HSE Letter This was presented and discussed. It concerns a generator at St. Ann's and its impact on the sites ventilation. The following issues were raised:

	• The incident occurred in October 2023. HSE wrote formally to Moorfields on 17 December 2024 asking about improvements. • Amongst the actions taken were the implementation of a Standard Operating Procedure (SOP) to support staff, and increased ventilation provision for the generator. Fire Safety The committee received its regular fire safety update. The following issues were highlighted: • There is strong fire safety management at Moorfields and good relations with the local fire brigade. • There is continuity through to Oriel; this is a two-way process which enables learning and improvement for the current estate. • Take up of fire warden training remains a concern: this will be reported to ManEx. Site cover safety training is a priority. Patient Safety Incidents There were no patient safety incident reports for the committee. The regular duty of candour report was presented. The following was highlighted: • It is acknowledged that duty of candour remains a challenge, although it is hoped that the activity in this area (particularly in the North) will result in improved figures in the next report. Quality and Safety The committee received the regular Q&S update, quality and safety reports (Trust-wide, Private, and UAE) for Q3, and the Complaints, and the Risk and Safety annual reports. The following areas were highlighted: • The regular catch-up meeting with the CQC took place the previous week. This was positive. • The Q&S Q3 Trust-wide report stresses the importance of learning rather than process. • Incidents open over 28-days in Private remains a challenge. • Issues with the reliability of the IT infrastructure are causing concerns, especially the impact it is having in respect of clinical reporting, investigation of patient safety incidents, and patient communication. Reports from Other Committees Summary reports from the following committees were circulated: • Information Governance Committee (26/11/2024) • Research Quality Review Group (02/12/2024) • Clinical Governance Committee (09/12/2024) • Risk and Safety Committee (11/12/2024)
Escalations	There were three escalations to the Trust Board: • Ventilation assurance at all sites, including delays in receiving engineers' reports. • The HSE letter in respect of the generator and ventilation flue at St. Ann's. • IT outage/system issues and the knock-on impact this has on staff usage, incident reporting, and patient communication.
Date of next meeting	11 March 2025

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
11 March 2025

Committee Governance	• Quorate – Yes • Attendance (membership) – 87.5% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	Presentation by the City Road Division The committee received a presentation from the City Road Division. The following issues were highlighted: • Zero tolerance of abuse or violence, particularly in A&E • Transition from children to adult services, including educating young people about their own conditions. There is also an issue with DNA rates amongst 16 to 24 year olds • Staffing levels remain a challenge • Waiting times and patient communication are an on-going issue • Transition of children into adult clinics with the use of the "Ready, Steady, Go" programme • Incident reporting, particularly near misses. Research Governance QSC received its annual research governance update. The following points were highlighted: • There are 32 sponsored and 104 contracted studies. Governance is supported by an increasing number of SOPs and SLAs. Overall, the governance structure is now fully formed, and is aided by innovation, especially digital. The number of investigators remains an issue • The service is now able to undertake several types of studies including gene therapy • This year to date, there have been 10 research applications, including 6 NHIR grants. The total NIHR grant is £2.1m. This is part of the notable grant success that has been archived. SLAs and site strategy The committee received an update on SLAs and site strategy. This was in response to an action from the May 2024 meeting. The following issues were highlighted: • There was a discussion around the type of leases and how these are described and function, and the associated issues • The current status of leases and SLAs were set out, including who is responsible for maintenance, and how the various relationships are managed • There are priorities around the future size and shape of the Moorfields estate. Clarity around the associated risks is critical. Quality and Safety The committee received the regular Q&S update which included the proposed quality priorities for 2025-26. The committee also received the safer surgery checklist report for Q3. The following was highlighted: • The programme of walkabouts was highlighted. Continued NED involvement is welcomed

	• The draft quality priorities for 2025-26 were presented. These follow the standard format of grouping under the three Darzi headings (safety, experience, and effectiveness). The slides highlighted which of the priorities are new, and which are taken forward from 2024-25 • The surgical safety checklist will be re-launched on 1 April 2025. Bedford transformation This item resulted from an action at July's meeting, and updates are being presented at every meeting. The following issues were raised: • Six patients await review (out of the original 10,000 patients validated, of which 1,000 were given an appointment). One patient experienced avoidable harm – duty of candour has been completed • There has been a significant reduction in incidents around delayed patient follow-up • The aim is to move to monthly failsafe reporting. Patient Safety Incidents There were no patient safety incident reports for the committee. The regular duty of candour report was presented. The following was highlighted: • There are still instances, stretching back several months, where duty of candour has not been completed • Whilst outstanding duty of candour is being progressed via divisional quality forums, it needs to be picked up via respective management forums. This will be escalated to Board. Annual safe staffing report This is a new report and is a statutory requirement. This is a two-part report. The first part covers nursing staff and is presented for assurance. The second part covers other staff groups and is presented to make the committee aware of its scope and is work in progress. Infection Control Update The regular infection control (IPC) update was presented. The following was highlighted: • The flu season is coming to an end, and in terms of staff vaccination levels, Moorfields has performed well in comparison with other London Trusts, although less than half of Moorfields staff were vaccinated • The two respiratory tuberculosis exposure cases reported at January's meeting have been closed. Reports from Other Committees Summary reports from the following committees were circulated: • Research Quality Review Group (27/01/2025); • Information Governance Committee (28/01/2025); • Clinical Governance Committee (10/02/2025).
Escalations	There was one escalation to the Trust Board: • Outstanding duty of candour – this will be progressed via respective management forums.
Date of next meeting	13 May 2025

Appendix 5 - Quality and Safety Committee work plan 2024-25

Work-stream	May 2024	July 2024	September 2024	November 2024	January 2025	March 2025
Main Topic(s):	*SLAs / host trusts; Health Inequalities; Committee governance*	*Moorfields UAE; PSIRF*	*South Division; Annual reports; CQC assessment process*	*O&CSS Division; Duty of Candour*	*North Division; IPC BAF*	*City Road Division; SLAs; Research Governance*
Assurance and escalations from other committees	Yes	Yes	Yes	Yes	Yes	Yes
Quality and safety – matters arising	Yes	Yes	Yes	Yes	Yes	Yes
Quality, safety, compliance, and risk update	As required	As required	As required	As required	As required	As required
Quality, safety, compliance, external visits, and inspections	As required	As required	As required	As required	As required	As required
Reports (annual)	Yes	Yes	N/A	N/A	N/A	N/A
Reports (other)	Yes	Yes	Yes	Yes	Yes	Yes
Quality Priorities / Quality Account	Yes	N/A	N/A	N/A	Yes	Yes
Quality & Safety Quarterly Report	Yes	Yes	N/A	Yes	Yes	N/A
SI reports – status update and receipt of SI summaries	Yes	Yes	Yes	Yes	Yes	Yes
Key questions for next deep dive	Yes	Yes	Yes	Yes	Yes	Yes

Figure 6 - Committee work plan 2024-25

Appendix 6 - Quality and Safety Committee forward work plan 2025-26

Work-stream	May 2025	July 2025	September 2025	November 2025	January 2026	March 2026
Main Topic(s):	*Moorfields Private; Clinical Audit; Committee Governance*	*Signage and wayfinding*[3]	*Moorfields UAE*	*South Division*	*O&CSS Division*	*North Division*
Assurance and escalations from other committees	Yes	Yes	Yes	Yes	Yes	Yes
Quality and safety – matters arising	Yes	Yes	Yes	Yes	Yes	Yes
Quality, safety, compliance, and risk update	As required	As required	As required	As required	As required	As required
Quality, safety, compliance, external visits, and inspections	As required	As required	As required	As required	As required	As required
Reports (annual)	Yes	Yes	N/A	N/A	N/A	N/A
Reports (other)	Yes	Yes	Yes	Yes	Yes	Yes
Quality Priorities / Quality Account	Yes	N/A	N/A	N/A	Yes	Yes
Quality & Safety Quarterly Report	Yes	Yes	N/A	Yes	Yes	N/A
SI reports – status update and receipt of SI summaries	Yes	Yes	Yes	Yes	Yes	Yes
Key questions for next deep dive	Yes	Yes	Yes	Yes	Yes	Yes

Figure 7 - Committee forward work plan 2025-26

[3] *Other possible agenda topics for 2025-26 include Anaesthesia, Theatres, Junior Doctors/Trust Fellows, Safety of artificial intelligence, Safer September

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 16a

Finance & Performance Committee Terms of Reference

Board of directors
5 June 2025

Report title	Finance & Performance Committee Terms of Reference		
Report from	Sam Armstrong, Company Secretary		
Prepared by	Jennie Phillips, Deputy Company Secretary		
Previously considered at	Finance & Performance Committee	**Date**	19.05.2025
Link to strategic objectives	Deliver: Optimise our systems, infrastructure and capabilities to deliver excellent and efficient care		

Quality implications Not applicable
Financial implications Not applicable
Risk implications The committee oversees risk management on behalf of the Board.
Action required/recommendation. Following a review and approval at Finance & Performance Committee on 19 May 2025; the Board is asked to approve the terms of reference for annual ratification.

For assurance		**For decision**	✓	**For discussion**		**To note**	

Finance and Performance Committee – TOR

Authority	The Finance and Performance Committee is a formal committee of the board and is authorised to provide assurance to the board and carry out delegated functions on its behalf. These terms of reference have been approved by the board and are subject to annual review.
Purpose	The purpose of the committee is to gain assurance, on behalf of the board, of the following key areas: • Financial performance and delivery of the Trust's budget • Operational performance • Performance management principles and processes • Estates (business as usual, excluding Oriel, MoorConnect)
Membership	The members of the committee will be appointed by the board so that there is a majority of non-executive directors over voting executive directors, as follows: • Up to three non-executive directors, one of whom shall be nominated as Committee Chair (proposal to add MM) • Chief Financial Officer • Chief Operating Officer The Committee Chair will have a casting vote, if needed. Others expected to be in attendance in full or part of the meeting, at the discretion of the Committee Chair, include: • Chief People Officer • Deputy Chief Financial Officer The Committee Chair may also invite others to attend where needed, such as the CN and MD.
Quorum	The quorum will be three, including at least two non-executive directors and one executive director
Frequency of meetings	The committee will meet at least six times per year and members are expected to attend at least 75% of meetings in any year.
Duties	The committee can only carry out functions authorised by the board, as referenced in these terms of reference. **Assurance Functions** The committee will review the following to provide assurance to the board: **Annual priorities** • Annual set priporities for the committee and monitor progress throughout the year **Business case monitoring** • Methodologies used to assess business cases and other investments **Financial planning** • The financial aspects of the trust's annual business plans and the annual plan prior to submission to the board for approval • The assumptions underlying budgets and plans

	• Scenario planning and stress testing of plans • Financial forecasts, including outturn and cash flow **Financial performance** • Financial performance, including in depth analysis of income, expenditure, capital and cash • Overall financial performance of the trust's portfolio of investments (individual committees responsible for assuring the specific investment performance of the decisions they take and the business cases they assure) • Development, management and delivery of cost improvement programme schemes • ensure that financial performance monitoring across the organisation is effective and sufficiently granular **Operational Performance** • Seek assurance that performance management principles and processes are embedded throughout the Trust • Seek assurance operational performance is in line with agreed plans in order to drive service improvements • Review specific key performance metrics as agreed at the start of the year • Monitor productivity development and gains periodically • Ensure the Board is briefed on emerging performance management requirements, taking into account local and national policy • Seek assurance that the procurement performance is optimal and providing value for money **Estates** • Assurance on items relating to business as usual activities of Estates function as required. **Other Risk Management** • All finance category risks on the Trust risk register, any operational categrory risks and Board Assurance Framework risks identified under both • Receive a presentation annually on each divisions risk register **OTHER** • Receive reports from subcommittees as agreed by FPC and ManEx **Other duties as agreed by the Board** • Exceptional items explicitly requested by the board that fall outside the terms of reference
Reporting and review	Following each meeting of the committee, an update will be provided to the board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination. Minutes of meetings will be available for any board member on request. The committee will carry out an annual deep dive review of its effectiveness against these terms of reference, including setting the forward plan for the next year. Dedicated time will be held at the last meeting of the FY for this review. This will be reported to the board via the committee's annual report, at the first available meeting after 1 April of each year.
Meeting administration	The lead executive for the committee will be the chief financial officer and the secretary for the committee will be the company secretary. The secretary's role will be to; • Agree the agenda with the chair

	• Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board's standing orders • Maintain a forward plan of items for the committee • Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) • Ensure minutes are issued to the chair for review within one week of the meeting, and to committee members within two weeks of the meeting. • Ensure actions are captured, notified to relevant staff and followed up Any other administrative arrangements not listed here will be as shown in the standing orders of the board of directors		
Date approved by the board		**Date of next review**	June 2026

Standing financial instructions and scheme of delegation

https://eyeq.moorfields.nhs.uk/download.cfm?doc=docm93jijm4n815.pdf&ver=8492

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 16b

Quality and Safety Committee Terms of Reference (2025-26)

Board of directors
5 June 2025

Report title	**Quality and Safety Committee – Terms of Reference 2025-26**		
Report from	Michael Marsh, Chair of the Quality and Safety Committee		
Prepared by	Ian Tombleson, Director of Quality and Safety		
Previously considered at	Quality and Safety Committee	**Date**	13/05/2025
Link to strategic objectives	We will consistently provide an excellent, globally recognised service		

Quality implications

The Quality and safety committee is a formal committee of the board and is authorised to provide assurance to the board and carry out delegated functions on its behalf.

The committee's terms of reference set out the committee's purpose, membership, meeting frequency, duties, and administration. They are reviewed by the committee annually and then presented to the board for approval.

Financial implications

None.

Risk implications

None.

Action required/recommendation.

The board is asked to approve these terms of reference.

For assurance	**X**	**For decision**	**X**	**For discussion**		**To note**	

Moorfields Eye Hospital NHS Foundation Trust

NHS

Quality and safety committee - Terms of Reference

Authority	The Quality and safety committee is a formal committee of the board and is authorised to provide assurance to the board and carry out delegated functions on its behalf. These terms of reference have been approved by the board and are subject to annual review.
Purpose	The purpose of the committee is to review, on behalf of the board, the following key areas; • to provide oversight and board assurance about the quality and safety of clinical services • to provide assurance about legal compliance with health and safety and related legislation • to steer the quality elements of the trust's strategy • to support the implementation of the quality strategy and quality improvement plan • to oversee the development and implementation of the quality account
Membership	The members of the committee will be appointed by the board as follows: • Four non-executive directors, one shall be nominated as chair • Chief executive • Medical director* • Chief nurse and director of allied health professionals* • Chief operating officer (*Board leads for Quality and Safety)
Quorum	The quorum will be three members (one of whom must be either the medical director or the chief nurse and allied health professions, or their nominated deputies), including two non-executive directors
Attendees	The following will also regularly attend the committee; • Director of quality and safety • Head of quality and safety • Divisional directors (if absent, Divisional head of nursing) • Clinical lead for patient safety • Moorfields Private (representative) • Quality and compliance manager (secretariat) Others may attend as agreed by the committee chair.
Frequency of meetings	The committee will meet six times per year and members and regular attendees are expected to attend at least 75% of meetings in any year.
Duties	The committee will only carry out functions authorised by the board, as referenced in these terms of reference.

Delegated functions

The committee will carry out the following on behalf of the board:

- Analyse and challenge appropriate information on organisational and operational performance in relation to the committee's purpose

Assurance functions

The committee will review the following to provide assurance to the board:

Clinical effectiveness

- the content and effectiveness of the structures, systems, and processes for quality assurance, clinical, research, information, and quality governance
- the development and compliance requirements for the following:
  - NHS outcomes framework
  - NICE pathways of care standards
  - the Trust's quality plan and any other KPIs relating to quality measures

Patient Safety

- reports about compliance with external assessments and reporting, including those from:
  - Care Quality Commission
  - NHS England
  - Medicines and Healthcare products Regulatory Authority (MHRA)
  - Health and Safety Executive (HSE)
  - Organisations responsible for professional standards
  - Regulatory bodies in the United Arab Emirates
  - Any other relevant regulatory bodies.
- progress with implementing actions arising from CQC reports, and any other reports issued of a similar nature
- internal reports, local or national reviews and enquiries and other data and information that may be relevant for understanding quality and safety within the Trust
- the meaning, significance and learning from trends in complaints, incidents, and serious incidents
- compliance with surgical safety checklists
- how the Trust is addressing the requirements of safeguarding for children and vulnerable adults

Patient participation and experience

- patient participation activities
- environmental and other issues affecting patient experience

Overall

- the development of the quality account and priorities
- supporting the implementation of the quality strategy
- monitoring the implementation of the quality objectives and other actions arising from the quality strategy and quality account

	• address specific risks on the corporate risk register allocated by the board **Other duties as agreed by the board** • oversight of quality and safety related aspects of research activity
Reporting and review	Following each meeting of the committee, an update will be provided to the board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination. Minutes of meetings will be available for any board member on request. The committee will carry out an annual review of its effectiveness against these terms of reference and this will be reported to the board via the committee's annual report, at the first available meeting after 1 April of each year.
Sub-committees	There are no formal sub-committees of the committee but the outcomes of the following management groups will be reviewed on a regular basis to gain assurance • Clinical governance committee • Information governance committee • Risk and safety committee • Research and development quality review group.
Meeting administration	The executive lead for the quality and safety committee will be the director of quality and safety, and the secretary for the meeting will be the quality and compliance manager. The secretary's role will be to: • Agree the agenda with the chair • Ensure compliance with the committee's *requirements for presenters* • Ensure the agenda and papers are despatched five clear working days before the meeting, in line with the board's standing orders • Maintain a forward plan of items for the committee • Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) • Ensure a summary of the meeting is issued to the chair for review within one week of the meeting • Ensure actions arising from the meeting are captured, notified to owners within two weeks of the meeting. These will be followed up where necessary. Any other administrative arrangements not listed here will be as shown in the standing orders of the board of directors.

Approved by the quality and safety committee			13 May 2025
Approved by the board		**Date of next review**	May 2026