Bundle Board of directors - Part 1 23 January 2025

1 09:00 - Welcome and introductions
Laura Wade-Gery - for noting
250123 TB Part I Item 00 Agenda

2 09:05 - Staff / Patient story
Paul Sullivan - for noting

3 09:25 - GMC national training survey report summary 2024
Paul Sullivan - for noting
250123 TB Part I Item 03a GMC National Training Survey Results for Moorfields NHSFT 2024
250123 TB Part I Item 03b GMC National training survey summary report 2024

4 09:35 - Apologies for absence
Laura Wade-Gery - for noting

5 Declarations of interest
Laura Wade-Gery - for noting

6 Minutes of the previous meeting
Laura Wade-Gery - for approval
250123 TB Part I Item 05 Minutes of Meeting in Public 241128 DRAFT (LWG)

7 09:40 - Matters arising and actions log
Laura Wade-Gery - for noting
250123 TB Part I Item 06 - Action log

8 09:45 - Chief Executive's Report
Jon Spencer - for noting
250123 TB Part I Item 08 CEO report

9 09:55 - Integrated Performance Report
Jon Spencer - for assurance
250123 TB Part I Item 09 Integrated Performance Report - December 2024 (OPEN Report)

10 10:10 - Finance Report
Justin Betts - for assurance
250123 TB Part I Item 10a Cover sheet Public Finance Performance Board Report
250123 TB Part I Item 10b Public Finance Performance Board Report - FINAL

11 10:25 - Constitution amendment
Sam Armstrong - for approval
250123 TB Part I Item 11 MC NED constitution change LWG

12 10:30 - Identify risks arising from the agenda
Laura Wade-Gery - for noting

13 AOB
Laura Wade-Gery - for noting

14 10:35 - Date of the next meeting - 27 March 2025

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on
Thursday 23 January 2025 at 09.00
Albert House, Old Street EC1V 9DD and via MS Teams

No.	Item	Action	Paper	Lead	Mins
1.	Welcome and introductions	Note	Oral	LWG	5
2.	Staff Story – to complement the GMC national Training Survey report 2024.	Note	Oral	LW/PS	20
3.	GMC national Training Survey report summary 2024	Note	Enclosed	LW/PS	10
4.	Apologies for absence	Note	Oral	LWG	5
5.	Declarations of interest	Note	Oral	LWG	
6.	Minutes of the previous meeting 28.11.24	Approve	Enclosed	LWG	
7.	Matters arising and action log	Note	Enclosed	LWG	
8.	Chief executive's report	Note	Enclosed	JS	10
9.	Integrated performance report	Assurance	Enclosed	JS	15
10.	Finance report	Assurance	Enclosed	JB	15
11.	Constitution amendment	Approval	Enclosed	SA	5
12.	Identifying any risks from the agenda	Note	Oral	LWG	5
13.	Any other business	Note	Oral	LWG	
14.	Date of next meeting – 27 March 2025				

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 03
GMC National Training Survey Results for Moorfields 2024
Board of directors
23 January 2025

Report title	**GMC National Training Survey Results for Moorfields NHSFT 2024**
Report from	Paul Sullivan
Prepared by	Paul Sullivan
Link to strategic objectives	Enhancing the Quality of Education at Moorfields and thereby delivering safe and effective patient care.

Quality implications The GMC training survey is one of the few useful metrics available for the quality of training. The very positive results show that the trust is continuing to deliver high quality education and training to ophthalmology trainees. Past experiences in other trusts (eg in mid Staffordshire) have shown that this survey is also a strong surrogate indicator of safe patient care.
Financial implications Reduced rota gaps has a positive impact in many areas including financial.
Risk implications None raised by this report
Action required/recommendation. Continued support for education and training in the trust. These positive results should not be taken as indicating that there may not be better ways of working that could allow further improvement. The introduction of a new curriculum for training in ophthalmology will drive some changes in the way supervision responsibilities are reflected in consultant job planning.

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

NATIONAL TRAINING SURVEY

2024 results

General Medical Council

General Medical Council

National training survey 2024

Foreword

The results of this year's national training survey evidence concerning issues within the postgraduate training system and underline why it is a priority to increase the capacity of the trainer workforce.

When we recently published our priorities for the future of medical education and training we identified this as a key shared responsibility. A stronger, better supported, and appropriately valued trainer workforce is a critical enabler of ambitious workforce expansion plans. We depend on it for the development of the future senior medical workforce, and the clinical leadership capability rightly expected of UK public healthcare provision.

Half of trainers are at moderate or high risk of burnout, and twenty-nine percent told us they struggle to use time allocated for training for that purpose. It is the responsibility of employers to make sure that trainers are appropriately supported as they fulfil their responsibilities, and that training time is not eroded. Although challenges inevitably arise when the system is under extreme pressure, training must be seen as a priority - ringfencing time is essential if standards are to be maintained.

The new UK government is committed to supporting the Long Term Workforce Plan in England. The planned increase in numbers of UK medical students means there will soon be many more postgraduate trainees coming into a system that is already operating at maximum capacity.

For these plans - alongside those in Northern Ireland, Scotland, and Wales – to succeed, additional capacity needs to be created with the expansion of the educator workforce. This must be accompanied by better support for trainers to avoid compounding the issue with a retention challenge.

As in previous years, the majority of doctors in training rate the quality of their training highly, which stands testament to the skills and talents of their trainers. However, more than a fifth are at high risk of burnout, which raises serious questions about sustainability and retention.

It is troubling that doctors in training with particular protected characteristics experience more discriminatory behaviours than their peers and are less confident in reporting discrimination when it occurs. Every doctor in the UK has the right to work and train in an environment free from discrimination and all parties must understand that there is work we must do together to achieve that.

Additionally, the proportion of trainees who believe they have opportunities to develop leadership skills in their posts has fallen. Good leadership is inextricably linked to the delivery of good patient care and this aspect of training should not be jettisoned or neglected, even in the face of extreme service pressures. Indeed, there is a compelling case to be made that it is even more important in the context of current challenges and those that undoubtedly lie ahead.

Efforts to solve the problems of the health services through training more doctors in the UK will fail if training capacity and prioritisation are not addressed and if employers do not address their responsibilities to support wellbeing. The intensity of current pressures must not divert them from the need to provide fair and compassionate training environments, where experienced doctors are supported in their efforts to help doctors in training learn and flourish.

While workloads are one of the major contributors to wellbeing, we know that other factors may play a part, such as effective induction, rota design and, in the case of early career doctors, geographic relocation. Later this summer we'll publish our report *The state of medical education and practice in the UK: workplace experiences 2024* which will provide detailed insights into how doctors' experiences impact on their practice and the care they provide to patients.

The national training survey is the largest annual survey of doctors in the UK, and 74,000 doctors participated this year. Employers and policymakers must use these data to further their understanding of the intensity of workloads and wellbeing issues within training environments, and develop action plans to ensure system sustainability.

Listening to what doctors in training and trainers have to say about their experiences is not only important now, it is also critical to the development and retention of the future medical workforce. The nuances and complexity of the postgraduate training system may be largely invisible to the general public, but the way it functions or fails impacts the care of patients today and will do so for generations to come.

Charlie Massey

Chief Executive and Registrar

Key findings

Doctors in training

- **Quality of training –** Despite the many pressures on the health services, the quality of training across the UK remains high. As in 2023, 86% of trainees were positive about their clinical supervision and 83% said the quality of experience in their post was good or very good.
- **Wellbeing –** Although there was a slight improvement in the responses to our questions about wellbeing, the survey results remain very concerning. Over a fifth (21% ↓2pp compared to 2023) of trainees measured to be at high risk of burnout and over half (52% ↓3pp) described their work as emotionally exhausting to a very high or high degree.
- **Rota design –** Over a quarter (26% ↓3pp) of trainees in secondary care posts said their training is adversely affected because rota gaps aren't dealt with appropriately.
- **Developing leadership skills –** Since 2022, there's been a decline of six percentage points (69% to 63%) in the proportion of trainees agreeing that their posts gave them opportunities to develop their leadership skills. Given the many systemic pressures affecting the health services, it's likely this vital aspect of training isn't being given the necessary focus and attention.
- **Discriminatory behaviours –** The majority of trainees continue to say that they work in supportive workplaces. However, findings from the demographic breakdowns of our questions about discriminatory behaviours provide insight into the extent to which unprofessional behaviours are taking place in some healthcare environments. The analysis shows that factors, including gender, ethnicity, religion, sexual orientation, and disability status affect a trainee's experience.

Trainers

- **Time for training –** Although the majority (90% ↑1pp) of trainers enjoy their role, they continue to voice concerns about the level of time and support they receive for training. Over a quarter (27% ↓1pp) don't think their job plan contains enough designated time for their role as a trainer. And less than half (48% ↑2pp) said they were always able to use the time allocated for training, specifically for that purpose.
- **Wellbeing –** Half (50% ↓2pp) of all trainers are measured to be at high or moderate risk of burnout. As in 2022 and 2023, a third (32%) said their work frustrates them to a high or very high degree.
- **Rota design –** Nearly a third (31% ↓2pp) of secondary care trainers told us that their trainees' education and training are adversely affected because rota gaps aren't always dealt with appropriately.

Acting on the results

It's a testament to the hard work and commitment demonstrated by trainees, trainers, their postgraduate deans, and training providers, that the quality of postgraduate medical training across the UK remains high.

However, the data also highlight how sustained pressures on our health services are continuing to impact doctors' wellbeing and experiences at work and how service pressures can often conflict with education and training. The intensity of workloads and risk of burnout levels reported by both trainees and trainers remain very high. And while most trainees said they work in supportive environments, the demographic breakdowns to our questions about discriminatory behaviours show that this isn't the case for everyone.

This picture is compounded by the structural issues reported by doctors in training and their trainers, including concerns about rota design, time for training, and access to opportunities to develop key skills for career development, such as leadership.

The issues raised in the survey by both trainees and trainers will continue to deteriorate unless plans to expand medical student numbers are delivered alongside corresponding increases in trainer capacity. And while such plans are welcome and necessary, in the short term it's essential that we better support the trainers and trainees we already have.

Trusts and boards across the UK must play their part in this, providing vital support and development opportunities and make a clear commitment to protect and prioritise educators' time. They must also make sure all doctors are able to work in environments free from discrimination and have all the information they need to raise concerns.

It's crucial that doctors' wellbeing is prioritised as part of any plans to reform the NHS and reduce waiting times. Retaining the vital skills and experiences of both trainers and doctors in training is central to achieving the longer-term change that is needed to safeguard patient care. By working with those responsible for the planning and delivery of medical education we must tackle the challenges highlighted in this year's report and help create the supportive environments that all doctors deserve.

Introduction

The national training survey is the largest annual survey of doctors across the UK. It's designed to gather the views of trainees about the quality of their training and the environments where they work. And it asks trainers about their experience as a clinical and/or educational supervisor. The questions test compliance with our standards for medical education and training, and are organised around the following themes:

- learning environment and culture
- educational governance and leadership
- supporting learners
- supporting educators
- developing and implementing curricula and assessments.

This summary report presents high-level findings from the survey to support organisations in improving the quality of training and their training environments. It focuses on UK-wide trends in postgraduate medical education, although we have included country-specific data where there are notable differences. The report concentrates on:

- the supportive nature of working environments, including discrimination in the workplace
- the quality of training and support for trainers
- doctors' wellbeing at work and workload.

This year, for the first time we've included analysis of some of the national training survey data by personal characteristics. This will support our ongoing work, and that of education providers, to tackle inequalities that exist in medical education and help create supportive, inclusive, and fair environments for all doctors.

A note about the 2024 trainee survey

In 2023, we piloted fourteen optional questions that asked about discriminatory behaviours in the workplace. We also asked trainees how confident they felt about reporting and challenging discrimination from colleagues. After a comprehensive review involving doctors, senior leaders, and education providers, we retained nine of the optional questions in the 2024 survey. Three were removed, as the unprofessional behaviours are now covered through other questions. Two questions about feedback were incorporated into the main body of the survey, along with the question about access to a mentor.

A note about the 2024 trainer survey

The trainer survey was shortened in 2022 following feedback from trainers, and a greater emphasis was placed on questions about support and development. The survey hasn't been changed since then, to enable direct comparisons of the results over the last three years.

How we use the findings

The survey data support our quality assurance of postgraduate medical education. *Promoting excellence* sets out the standards that we expect organisations responsible for educating and training medical students and doctors in the UK to meet. We use the responses to check how these standards are being delivered, and to make sure that training across the UK is being provided in safe, effective, and appropriately supportive environments.

If we identify risks, we work with those responsible for delivering and providing training, to tackle them. In some cases we may activate our enhanced monitoring procedures, to protect training and ensure patient safety.

Doctors in training can also use the survey to report concerns relating to patient safety, bullying, or undermining that haven't been resolved locally. This information is shared with the relevant postgraduate dean, who must tell us what action has been taken to address the issue.

Analysis of the findings enables us to identify trends across postgraduate education environments and specialties and allows us to highlight examples of excellence, innovation, and notable practice.

By sharing these data, we call attention to the issues that currently affect doctors delivering and receiving training. And by working with others across the healthcare system on policies or initiatives, we'll help to drive the necessary improvements to retain the vital skills and experience of the workforce needed for the future.

The education data tool

Our education data tool (formerly called the reporting tool) has been updated to enable access to our survey data more quickly and efficiently. As well as looking at the responses to individual survey questions, you can scrutinise national, regional, local, and specialty breakdowns for all indicators. For the first time, you can also view response data for the questions in the 2024 survey by demographic characteristics.

We provide other reports based on national training survey data. These include trainee and trainer risk of burnout, and an aggregation report, which allows you to combine national training survey data across years or reporting groups. Our help video explains how to use the tool.

What we expect from others

With the UK health services under constant pressure, maintaining the necessary focus on the provision and development of high-quality medical training is essential.

Our approval of postgraduate training relies on organisations being able to deliver the opportunities for trainees to achieve their curricular requirements and fulfil our standards in *Promoting excellence*. Listening to what doctors in training and their trainers have told us through the survey plays an important part.

We ask postgraduate deans, training providers, medical royal colleges, and employers to make full use of the comprehensive data available in our education data tool. By scrutinising what trainees and trainers are telling them about training in their country, region, specialty, and site,

they can target areas of concern, promote and share examples of good practice and support career progression for trainees.

Identifying and sharing examples of good practice can help contribute to the development of environments that support doctors from all backgrounds, grades, and specialties, to deliver safe patient care. Our case studies from across the UK, demonstrate how previous national training survey results have been used to effect positive change.

We also ask that policy makers use the findings to inform their planning to develop the supportive, inclusive, and fair working environments that will not only help retain and sustain trainees and trainers but also support the medical workforce pipeline for the future.

Responses to the survey

This year over 74,000 doctors in training and trainers completed the survey. 76% of all trainees responded, slightly higher than in 2023 (74%). And 38% (as in 2023) of all trainers took part (see Table 1). Having such a large number of responses enables us to effectively monitor the quality of training environments in all four countries of the UK.

Table 1: 2024 completion rates by country (change vs 2023)

	England	NI	Scotland	Wales	UK
Trainees	75% (↑2pp)	76% (↓1pp)	78% (↓2pp)	86% (↓2pp)	**76% (↑2pp)**
(No. of doctors)	43,362	1,422	4,811	2,612	52,207
Trainers	37% (as 2023)	40% (↓9pp)	31% (↓2pp)	57% (↓5pp)	**38% (as 2023)**
(No. of doctors)	18,097	701	1,839	1,608	22,245

High level findings

Supportive environments

Inclusive and supportive working environments are promoted through the shared values and behaviours of those working together in the interests of patients. In January 2024 we updated our core guidance on the professional standards for doctors, *Good medical practice*, setting out the principles, values, and standards of care and professional behaviour expected of all those registered with us. It reiterates that everyone has the right to work and train in environments that are fair, free from discrimination, and where they're respected and valued as an individual. While responses from trainees and trainers to our questions about the supportive nature of the working environment have remained broadly similar (see Tables 2 and 3), we know unprofessional and discriminatory behaviours do exist in some healthcare settings.

Table 2: Trainees – Supportive environment questions

Question		2021	2022	2023	2024
The working environment is a fully supportive one.	Positive	81%	79%	80%	80%
	Negative	6%	7%	7%	7%
Staff, including doctors in training, are always treated fairly.	Positive	70%	67%	68%	68%
	Negative	12%	15%	15%	14%
Staff, including doctors in training, always treat each other with respect.	Positive	79%	76%	77%	77%
	Negative	8%	10%	10%	10%
My department/unit/practice provides a supportive environment for everyone regardless of background, beliefs, or identity.	Positive	89%	88%	88%	88%
	Negative	3%	3%	4%	3%

Table 3: Trainers – Supportive environment questions

SC = secondary care trainers, GP = general practice trainers

Question		2021	2022	2023	2024
Staff are always treated fairly by my employer/in my practice.	Positive	72% SC 68% GP 97%	67% SC 62% GP 97%	67% SC 61% GP 97%	67% SC 61% GP 97%
	Negative	10% SC 12% GP 1%	11% SC 13% GP 1%	11% SC 12% GP 1%	10% SC 12% GP 1%
My employer/practice provides a supportive environment for everyone regardless of background, beliefs, or identity.	Positive	80% SC 77% GP 99%	82% SC 79% GP 98%	81% SC 78% GP 98%	82% SC 79% GP 98%
	Negative	6% SC 7% GP 1%	5% SC 6% GP 0%	5% SC 6% GP 0%	5% SC 6% GP 0%

To help us understand the scale and extent of these discriminatory behaviours, we piloted a set of optional questions for trainees in our 2023 national training survey. We have since evaluated and revised them for 2024. Over 30,000 trainees, 58% of those who completed the survey, answered the questions - providing a valuable insight into whether training is being provided in the type of working environments exemplified in *Good medical practice*.

As Table 4 illustrates, the proportion of negative responses in 2024 were broadly similar to those in 2023.

Table 4: Trainees – Discriminatory behaviours questions

In your current post how often, if at all:	Daily / Weekly	Monthly	Less than once a month	Never
do you hear insults, stereotyping or jokes in your presence on the grounds of a person's protected characteristics?*	4% (as 2023)	6% (as 2023)	16% (↓1pp)	74% (↑2pp)
do you experience micro-aggressions, negative comments, or oppressive body language from colleagues?	7% (↑1pp)	7% (↑1pp)	16% (↑1pp)	71% (↓2pp)
are you not given the same training opportunities as your peers at the same stage of training? (such as the opportunity to observe an unusual case)	7% (↑2pp)	4% (as 2023)	8% (as 2023)	81% (↓3pp)
are you ignored or excluded from conversations, groups, or meetings?	3% (as 2023)	3% (↑1pp)	10% (↑2pp)	84% (↓3pp)
are you intentionally humiliated in front of others?	1% (as 2023)	2% (as 2023)	9% (↑1pp)	88% (as 2023)
do you experience unwelcome sexual comments or advances causing you embarrassment, distress, or offence?	1% (↑1pp)	1% (as 2023)	5% (as 2023)	93% (↓1pp)

* The question in full: In your current post how often, if at all do you hear insults, stereotyping or jokes in your presence on the grounds of age, race (colour, nationality, ethnic or national origin), sex, gender reassignment, disability, sexual orientation, religion or belief, marital status, or pregnancy/maternity?
There are nine 'protected characteristics' under the Equality Act 2010. They are sex, age, disability, race, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment, and marriage and civil partnership. Section 75 of the Northern Ireland Act 1998 does not refer to 'protected characteristics' but instead includes a statutory obligation on public authorities to promote equality of opportunity between: people of different religious belief, political opinion, racial group, age, marital status, or sexual orientation.

The following analysis of each question summarises the key findings when the data are explored by the specialty, gender, ethnicity, sexual orientation, disability status, religion, primary medical qualification (PMQ), and training level of the trainees who responded.

The analysis has been grouped under headings used in *Good medical practice* to call attention to six relevant new duties* in the updated standards.

All of the questions concern discriminatory behaviours from colleagues and/or healthcare professionals, not from patients or relatives. Percentages reflect the total proportion of all negative responses, when the negative behaviour had been experienced daily, weekly, monthly, or less than once a month, unless otherwise stated.

* *Good Medical Practice* includes the following new duties:

- **Paragraph 52:** You must help to create a culture that is respectful, fair, supportive, and compassionate by role modelling behaviours consistent with these values.
- **Paragraph 54:** You should be aware of the risk of bias, and consider how your own life experience, culture and beliefs influence your interactions with others, and may impact on your decisions and actions.
- **Paragraph 55:** You must show respect for, and sensitivity towards, others' life experience, cultures and beliefs.
- **Paragraph 57:** You must not act in a sexual way towards colleagues with the effect or purpose of causing offence, embarrassment, humiliation or distress. What we mean by acting 'in a sexual way' can include – but isn't limited to – verbal or written comments, displaying or sharing images, as well as unwelcome physical contact. You must follow our more detailed guidance on *Maintaining personal and professional boundaries*.
- **Paragraph 59:** If you have a formal leadership or management role and you witness – or are made aware of – any of the behaviours described in paragraphs 56 or 57, you must act. You must:
  - make sure such behaviours are adequately addressed
  - make sure people are supported where necessary, and
  - make sure concerns are dealt with promptly, being escalated where necessary.
- **Paragraph 64:** If part of your role is helping staff access training, development and employment opportunities, you should do this fairly.

The working and training environment

In your current post how often, if at all do you hear insults, stereotyping or jokes in your presence on the grounds of age, race (colour, nationality, ethnic or national origin), sex, gender reassignment, disability, sexual orientation, religion or belief, marital status, or pregnancy/maternity?

- A larger proportion of female trainees (29%) reported hearing such comments than male trainees (22%). There was also a variation between specialties. For example, 41% of female surgery trainees and 39% of female anaesthetics trainees said that they'd heard insults, stereotyping, or jokes in their presence on the grounds of someone's protected characteristics, compared to 25% and 31% of their male colleagues respectively. The proportion of negative responses was noticeably lower in some specialties. For example, 13% of female and 10% of male GP trainees told us that they'd experienced these unprofessional behaviours.
- More than a quarter (29%) of trainees with a UK PMQ reported hearing such comments compared to a fifth (20%) of those with a primary medical qualification from overseas. Table 5 shows how a larger proportion of negative responses were received from doctors from an ethnic minority background holding a UK PMQ, compared to their white peers.

Table 5: UK PMQ trainees – In your current post how often, if at all do you hear insults, stereotyping or jokes in your presence on the grounds of someone's protected characteristics?

By ethnicity and gender, % negative responses

PMQ	Asian		Black		Mixed		Other		White	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
UK	32%	26%	34%	26%	35%	24%	33%	26%	30%	23%

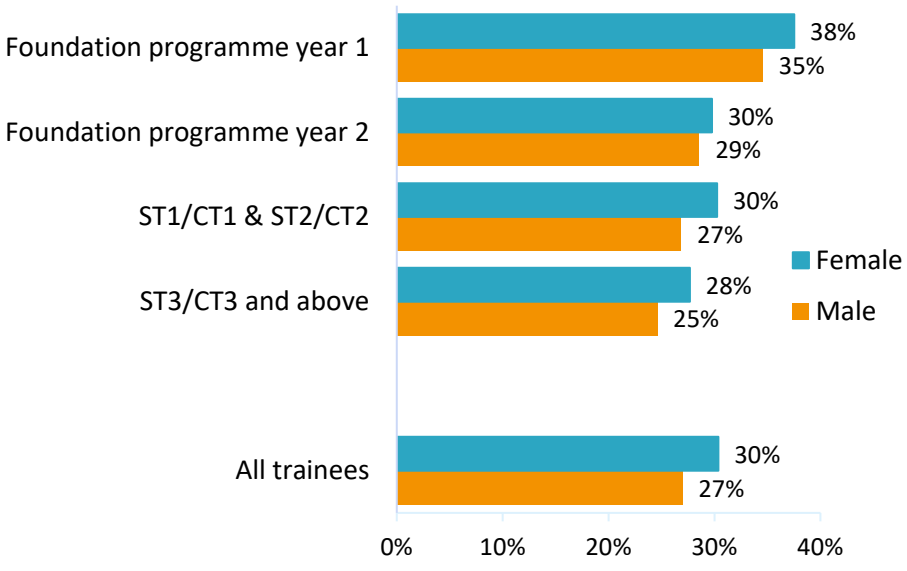
- A considerably larger proportion of gay (38%) and bisexual (47%) doctors in training reported hearing such discriminatory comments, than those who are heterosexual (24%). 44% of gay and 51% of bisexual female trainees said this had occurred, compared to 27% of heterosexual female trainees. Likewise, a larger proportion of gay (36%) and bisexual (35%) male doctors in training said that they'd heard such insults, stereotyping or jokes than those who are heterosexual (21%).
- There was a larger proportion of negative responses from doctors who have declared a disability. 29% of male trainees with a disability said they experienced this unprofessional behaviour, compared to 22% who are not disabled - as did 37% of female trainees who declared a disability, compared to 27% who didn't.

In your current post how often, if at all do you experience micro-aggressions, negative comments, or oppressive body language from colleagues?

- A larger proportion of trainees from an ethnic minority background (32%) said they'd experienced micro-aggressions, negative comments, or oppressive body language from colleagues than white trainees (26%).
- 37% of black and 36% of Asian female doctors in training with a UK PMQ said they'd experienced these negative behaviours compared to 33% and 27% of their mixed heritage and white peers respectively. 9% of black or Asian female trainees with a UK PMQ said this happened daily or weekly, compared to 5% of white female doctors in training. Similarly, a third of black (35%) and Asian male (33%) trainees with a UK PMQ told us they'd experienced these behaviours from colleagues, compared to 25% of mixed heritage and 23% of white males.
- 37% of female and 34% of male trainees who have declared a disability, said they'd experienced micro-aggressions, negative comments, or oppressive body language from colleagues, compared to 29% of female trainees and 26% of male trainees who stated they didn't have a disability. 11% of trainees with a disability said this happened daily or weekly compared to 6% of those who aren't disabled.
- There was also some variation according to religion. For example, 33% of Sikh and 32% of Muslim and Hindu trainees told us they'd experienced these negative behaviours, compared to 27% of Christian trainees and those who do not follow a faith.
- As with the other questions about discrimination, a larger proportion of trainees in the earlier stages of their training said they'd experienced these behaviours (Figure 1).

Figure 1: Trainees – In your current post how often, if at all do you experience micro-aggressions, negative comments, or oppressive body language from colleagues?

By training level and gender, % negative responses



Being fair and objective

In your current post how often, if at all are you not given the same training opportunities as your peers at the same stage of training? (eg opportunity to observe an unusual case)

- There was some variation between specialties in response to this question. For example, 31% of female and 27% of male obstetrics and gynaecology trainees told us that they are not given the same training opportunities as their peers at the same stage of training, compared to 22% of female and 17% of male anaesthetics trainees.
- A larger proportion of ethnic minority trainees said they were not given the same training opportunities as their peers. 21% of ethnic minority trainees with a UK PMQ said this was the case, compared to 16% of white trainees with a UK PMQ. Further analysis of this group of trainees shows that 21% of black and 22% of Asian female trainees said they'd experienced this, compared to 18% of white and 17% of mixed heritage females. And 18% of black, 19% of mixed heritage, and 21% of Asian male trainees felt they'd not been given the same training opportunities as their peers, compared to 14% of white male trainees.
- There was also a variation according to religion. For example, over a fifth of Muslim (22%), Hindu (23%), and Sikh trainees (25%) responded to say they'd experienced this, compared to 18% of Christian trainees, and 16% of those who do not follow a religion.

Treating colleagues with kindness, courtesy, and respect

In your current post how often, if at all are you ignored or excluded from conversations, groups, or meetings?

- There was variation according to specialty and gender, with a larger proportion of negative responses from female doctors in training. 26% of female surgery trainees said they had been ignored or excluded from conversations, groups, or meetings compared to 16% of male surgery trainees. Similarly, 12% of female ophthalmology trainees said they'd experienced such behaviour compared to 6% of male trainees in that specialty, as did 19% of female anaesthetics trainees and 16% of their male peers.
- A larger proportion of trainees from an ethnic minority background said they were ignored or excluded from conversations, groups, or meetings. 17% of trainees from an ethnic minority background with a UK PMQ said this was the case, compared to 14% of their white colleagues. Further analysis shows 21% of black, 17% of mixed heritage, and 18% of Asian female trainees said they'd experienced this, as did 14% of black, 13% of mixed heritage and 15% of Asian male trainees. This compared to 16% and 11% of their white female and male colleagues.
- Once again, a variation was observed between different religions. For example, 18% of Muslim and Sikh trainees said that they were ignored or excluded from conversations, groups, or meetings compared to 14% of Christian trainees and 15% of those who don't follow a religion.

- 22% of female and 18% of male trainees who declared a disability said that they had experienced these marginalizing behaviours, compared to 16% of female and 13% of male trainees who stated they had no disability.

In your current post how often, if at all are you intentionally humiliated in front of others?

- There was a marked variation according to specialty in response to this question. For example, 22% of female and 16% of male surgery trainees said they had been intentionally humiliated in front of others. And 20% of female and 18% of male obstetrics and gynaecology trainees said they'd experienced this unprofessional behaviour. This compared to 4% of female and 3% of male GP doctors in training.
- A larger proportion of trainees from an ethnic minority background said they'd been intentionally humiliated in front of others. 16% of trainees from an ethnic minority background with a UK PMQ said this had occurred, compared to 11% of their white peers. Analysis of these trainees shows that 19% of black and 16% of Asian female trainees said this had happened to them, compared to 12% of white female and mixed heritage trainees. 15% of Asian and 13% of black, and 14% of mixed heritage male trainees said that this had occurred, compared to 9% of white male doctors in training.
- There was also some variation according to religion. For example, 15% of Sikh and 14% of Hindu and Muslim trainees said they'd been intentionally humiliated, in comparison to 11% of Christian trainees and those that don't follow a faith.
- 19% of female and 16% of male trainees who have declared a disability said they had experienced this discriminatory behaviour, compared to 12% of female and 11% of male trainees who said they do not have a disability.

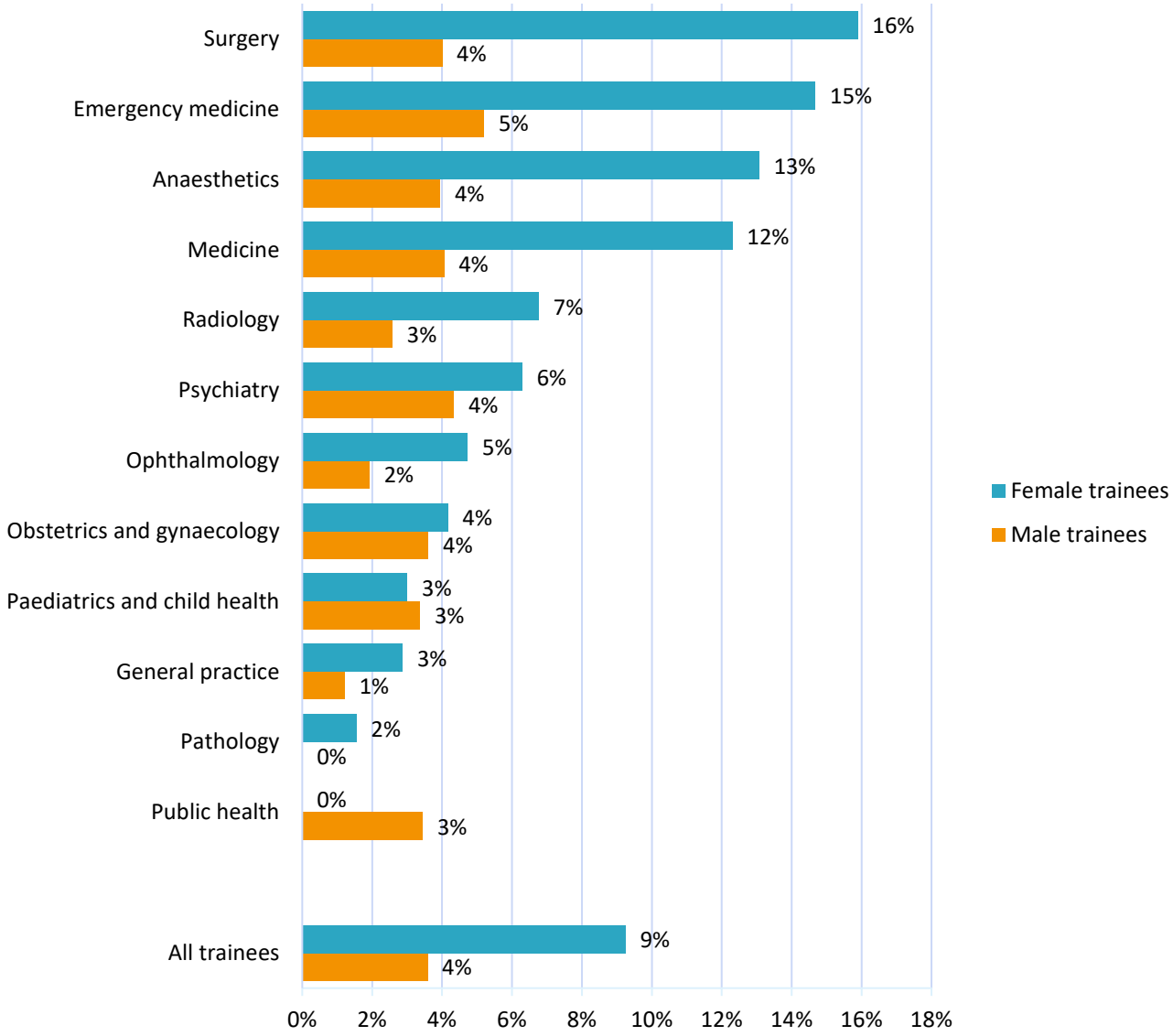
Maintaining personal and professional boundaries

In your current post how often, if at all do you experience unwelcome sexual comments or advances causing you embarrassment, distress, or offence?

- Nearly one out of ten (9%) of female doctors in training reported experiencing unwelcome sexual comments, or advances causing embarrassment, distress, or offence compared to 4% of males. There was also a notable variation according to specialty (see Figure 2). For example, 16% of female surgery trainees said they'd experienced this, compared to 3% of female GP trainees.
- A larger proportion of female doctors in their early stages of postgraduate training said they'd experienced unwelcome sexual comments, or advances causing embarrassment, distress, or offence. 18% of F1 doctors and 13% of F2 doctors said they had experienced these behaviours, compared to 6% of those at higher training levels.
- There was some variation according to religion. For example, a larger proportion of female trainees who do not follow a religion (12%) said that they had experienced these unwelcome sexual behaviours compared to 6% of Muslim female doctors in training.

Figure 2: Trainees – In your current post how often, if at all do you experience unwelcome sexual comments or advances causing you embarrassment, distress, or offence?

By post specialty and gender, % negative responses



Reporting discrimination and the responsibility to speak up

I am confident that I know how, or could find out how, to report discrimination where I work.

- A slightly smaller proportion of female trainees (71%) said they are confident that they know how, or could find out how, to report discrimination where they work than male doctors in training (75%). This variation could be seen within different specialties. For example, 68% of female surgery trainees agreed with the statement compared to 75% of their male peers. And 68% of female ophthalmology trainees agreed, compared to 74% of male ophthalmology trainees.

- A smaller proportion of trainees who graduated overseas (68%) agreed that they are confident that they know how, or could find out how, to report discrimination where they work, than those with a UK PMQ (74%).
- Trainees from an ethnic minority background were also less confident about reporting discrimination. 67% agreed with the statement compared to 79% of white trainees. Further analysis of doctors in training with a UK PMQ, shows that 58% of black, 72% of mixed heritage and 64% of Asian female trainees are confident they know how, or could find out how, to report discrimination where they work, compared to over three quarters (77%) of white female trainees. Notably, over a fifth (22%) of black female trainees disagreed. Similarly, 68% of black, 76% of mixed heritage and 70% of Asian male trainees said that they were confident about reporting discrimination where they work, compared to 82% of their white peers.
- 67% of Muslim trainees said they were confident that they know how, or could find out how, to report discrimination where they work, compared to 74% of Christian trainees and 77% of those who do not follow a faith.

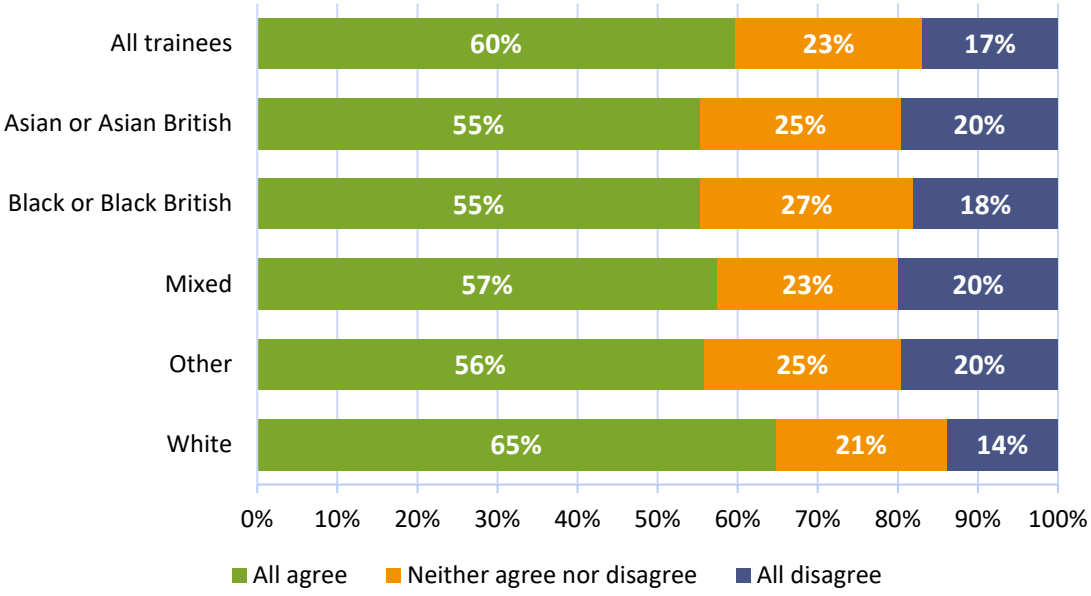
I feel confident about reporting discrimination where I work without fear of adverse consequences (reporting can be during your post or afterwards).

- While two thirds (65%) of male doctors in training said that they feel confident about reporting discrimination where they work without fear of adverse consequences, only 56% of their female peers agreed. Nearly one fifth (19%) of female trainees disagreed with the statement compared with 14% of males.
- There was some variation between specialties. For example, less than half (49%) of female surgery trainees said that they feel confident about reporting discrimination where they work without fear of adverse consequences, while 26% disagreed. This compares with 63% of male trainees in the same specialty who agreed, and 15% who disagreed. And while over three quarters (76%) of male GP trainees agreed with the statement, a smaller proportion (67%) of female GP trainees did.
- There was a variation according to ethnicity in response to this question (see Figure 3). Analysis of doctors in training with a UK PMQ, shows that 41% of black, 53% of mixed heritage, and 49% of Asian female trainees agreed with the statement, compared to 61% of white female trainees. One third (32%) of black females disagreed with the statement. 54% of black, 60% of Asian, and 66% of mixed heritage male trainees agreed with the statement compared to 72% of white males.
- There was some variation according to religion. For example, 57% of Muslim and Sikh trainees agreed with the statement and a fifth (19% and 18%) disagreed. In comparison 61% of Christian trainees and 63% of those who don't follow a religion agreed with the statement and 15% disagreed.
- 51% of female and 63% of male trainees who declared a disability agreed with the statement, while a quarter of females (25%) and 19% of males disagreed. In comparison,

57% of females and 66% of males who stated they did not have a disability agreed with the statement.

Figure 3: Trainees – I feel confident about reporting discrimination where I work without fear of adverse consequences.

By ethnicity



In this post, I feel confident to challenge discrimination and unprofessional behaviours amongst my colleagues and healthcare professionals.

- Just over half (53%) of female trainees said that they feel confident to challenge discrimination and unprofessional behaviours among colleagues and healthcare professionals, compared to two thirds (67%) of male trainees. One fifth (20%) of female trainees disagreed with the statement.
- Once again, there's a variation according to specialty. Less than half of female trainees in obstetrics and gynaecology (48%) and surgery (47%) said that they feel confident about challenging discrimination. In comparison 57% and 66% of male trainees in these posts agreed with the statement.
- A smaller proportion of trainees from an ethnic minority background (55%) said that they feel confident to challenge discrimination and unprofessional behaviours than those who are white (64%). Analysis of doctors in training with a UK PMQ shows that 44% of black, 54% of mixed heritage, and 47% of Asian female trainees agreed compared to 58% of their white peers. Notably, over a quarter of black (27%) and Asian (26%) female trainees disagreed. While three quarters (74%) of white male trainees with a UK PMQ said that they feel confident to challenge discrimination, a smaller proportion of black (63%), mixed heritage (69%) and Asian (62%) males agreed.

- Half (50%) of female and two thirds (66%) of male trainees who have stated they have a disability agreed that they feel confident to challenge discrimination and unprofessional behaviours amongst their colleagues, compared to 54% of female and 68% of male trainees who said they did not have a disability.
- There was also some variation between different religions. 54% of Buddhist and 55% of Muslim trainees agreed with the statement, compared to 59% of Christian trainees and 63% of those who do not follow a faith. Nearly a fifth (18%) of Muslim trainees and a quarter (23%) of Jewish trainees said they weren't confident to challenge discrimination and unprofessional behaviours.

Tackling discrimination and building inclusive environments

These data reveal the extent of unprofessional and discriminatory behaviours that some trainees experience during training, whether it be negative interactions with colleagues, hearing inappropriate language, or being treated unfairly by others.

Having previously shared analysis showing the differential attainment that can be found when comparing different groups, these data present new evidence of the inequalities that exist in medical education. The variation in the proportion of negative responses according to gender, ethnicity, religion, disability status, and sexual orientation, suggests these are all factors that can affect a trainee's personal experience of training.

However, discrimination doesn't just affect the individual, it impacts teamwork, communication, and collaboration. These are all fundamental to patient safety and to creating workplaces that both attract and retain staff.

Good medical practice makes clear the standards expected of all doctors to ensure that working environments in medicine are fair and compassionate for all. We're engaging with employers, educators, and doctors to support them in using the new standards in their practice.

From January to May 2024, we delivered 240 *Good medical practice* implementation sessions, reaching over 10,500 doctors across all countries of the UK.

We've also run professional behaviours and patient safety workshops with doctors across the country, which aim to equip them with the skills needed to challenge unprofessional behaviours and maintain effective working relationships. Of the doctors who attended our workshops, four fifths (79%) reported they intend to change their practice as a result.

Discrimination of any kind is unacceptable. We'll continue to use our insights to challenge discrimination, and we ask that all doctors and organisations do the same. It's only by working together and challenging discrimination in all its forms that we'll create long-lasting and meaningful change.

The quality of training

Table 6: Trainees – Proportion rating the quality of teaching/clinical supervision/induction as very good or good 2019–2024*

Question	2019	2021	2022	2023	2024
Please rate the quality of teaching in this post.	74%	76%	74%	74%	74%
Please rate the quality of clinical supervision in this post.	88%	88%	87%	86%	86%
Please rate the quality of the induction you received for this post.	73%	71%	72%	74%	75%

As in 2022 and 2023, three quarters (74%) of all trainees rated the quality of teaching as either good or very good (see Table 6), with one out of ten (10% as 2023) describing it as poor or very poor. 86% of trainees rated their clinical supervision positively. There was some variation in responses between specialties to both questions, consistent with previous years. For example, 94% (as 2023) of anaesthetics trainees said the quality of their clinical supervision was good or very good, compared to 79% (↑1pp) of trainees in surgery posts.

When asked to rate the quality of the induction they received for their post, three quarters (75%) of trainees said it was very good or good, maintaining the steady improvement in the proportion of positive responses since the Covid-19 pandemic.

After piloting an optional question in 2023 about access to a mentor, the question was refined for 2024 and put into the main body of the survey (Table 7). 56% of trainees said they had no support from a mentor. Of those who did, the largest proportion of trainees said it was an informal arrangement from another clinician (20%). There was some variation in response to this question between different specialties. A fifth (20%) of GP trainees said they received mentoring through a formal scheme run by their employer, while a similar proportion (21%) of trainees in secondary care posts said they had informal mentoring through another clinician.

Our research highlighted mentorship as a key intervention to help address differential attainment. As studies have shown that formal mentorship schemes may be more equitable than informal arrangements, we've worked with stakeholders to produce a toolkit for organisations to help them set up schemes that will benefit trainees.

* The 2020 national training survey was revised to focus on the impact of the Covid-19 pandemic on training.

Table 7: Trainees – Do you have support from a mentor (excluding the meetings you have with your education or clinical supervisor) who supports and guides you with your career and/or personal development? (tick all that apply).

Yes – formal mentoring scheme through my employer (eg your trust or site of work)	13%
Yes – formal mentoring scheme through my deanery/NHSE* regional team	10%
Yes – formal scheme through my royal college or faculty	2%
Yes – formal scheme through another organisation	1%
Yes – informal mentoring from another clinician	20%
Yes – informal other	8%
No support from a mentor	56%

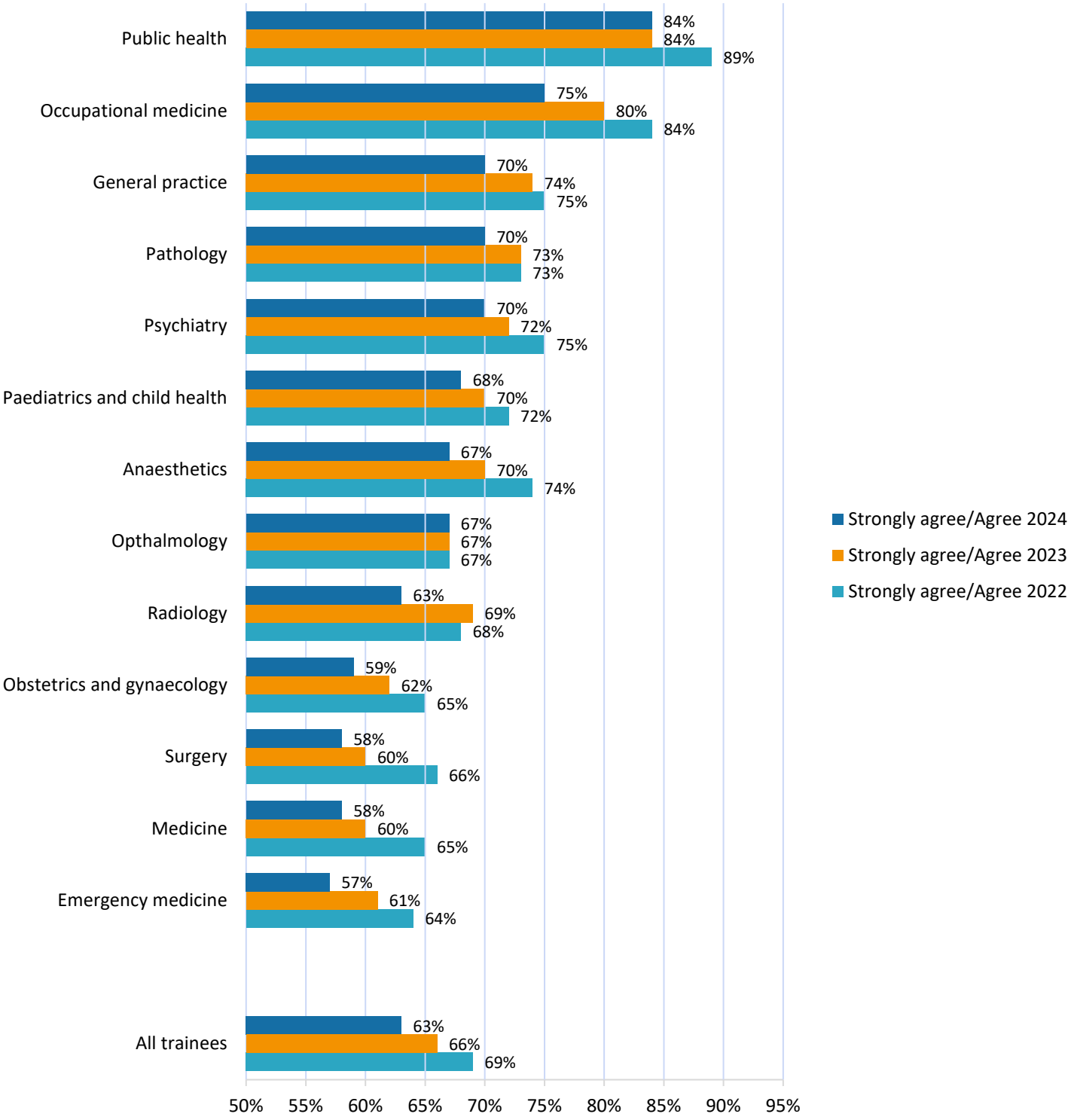
Supporting the development of leadership skills, be it through promoting shadowing opportunities or enabling doctors to step into leadership positions, is vital to the future sustainability of the health services and patient care. *Good medical practice* places greater emphasis on leadership, with the expectation that all doctors will demonstrate leadership skills relevant to their role.

It's therefore concerning that the decline in the proportion of trainees agreeing that their post gave them opportunities to develop such skills, relevant to their stage of training (63% ↓3pp), has continued. This was seen across all specialties except ophthalmology and public health (see Figure 4).

* National Health Service England

Figure 4: Trainees – In this post I am given opportunities to develop my leadership skills relevant for my stage of training.

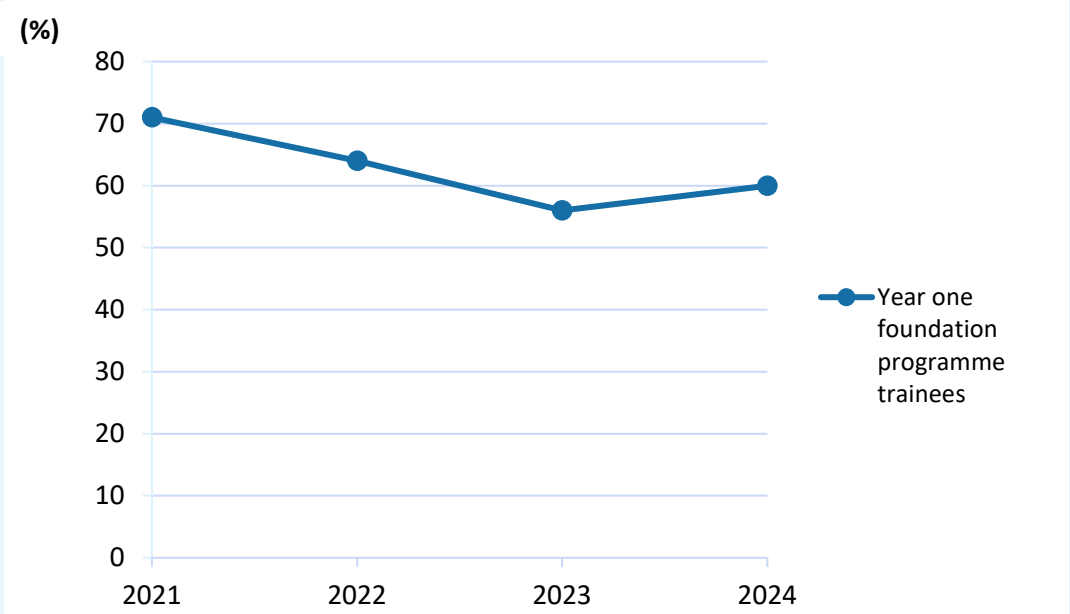
By post specialty 2022–2024



Foundation programme doctors in training

Each year we ask trainees completing year one of their foundation programme (F1) if they felt that they were adequately prepared for their first foundation post. In 2024 six out of ten (60% ↑4pp) F1 trainees said that they were, stemming the gradual decline in the proportion of positive responses to this question seen since 2021 (Figure 5).

Figure 5: Year one foundation programme trainees – I was adequately prepared for my first foundation post, % agreeing/strongly agreeing 2021–2024



When asked what contributed to them feeling less prepared, the majority of F1 trainees said it was due to a limited knowledge of the day-to-day reality of working as a foundation doctor (56%). After this, working in a different type of hospital or health system compared to previous experience (40%), geographic relocation (35%), lack of knowledge and guidance on the paperwork required (35%), and inadequate training in how to use the IT in the hospital (34%) were the most commonly selected factors contributing to feeling unprepared.

64% of F1 doctors rated the quality of their induction for their post positively, while 16% said it was poor or very poor.

When asked if their core teaching sessions covered all fifteen specific areas of core teaching listed in the curriculum just half (50%) of all doctors on the foundation programme agreed. And a quarter (25%) of trainees in the second year of their foundation programme (F2) agreed that doctors from certain backgrounds, such as those with protected characteristics, international medical graduates and those working less than full time, are disadvantaged in achieving the Foundation Programme curriculum requirements. 31% of F2 doctors from an ethnic minority background agreed with this statement compared to 19% of white F2 trainees.

Trainers – development and support

The proportions of positive and negative responses from trainers to the questions about support and development opportunities have remained broadly similar since their introduction in 2022 (see Table 8).

But while the majority of trainers do enjoy their role (90% ↑1pp), they continue to express their concerns about training time. Nearly a third (31% ↓2pp) of secondary care trainers and over a fifth (22% ↓2pp) of GP trainers said that they weren't always able to use the time allocated for training, specifically for that purpose.

Table 8: Trainers – Support and development questions

Question	Secondary care trainers		GP trainers	
	Positive	Negative	Positive	Negative
Please rate the support available to you from your employer/local education team when you have a trainee requiring extra support.	72% (as 2023)	6% (as 2023)	83% (↓2pp)	4% (as 2023)
Do you know what support is available to you from your SEB office (statutory education body) if you have a trainee requiring extra support?	66% (↑2pp)	34% (↓2pp)	72% (↓2pp)	28% (↑2pp)
The resources I need to perform my role as a trainer are available to me in my workplace.	72% (as 2023)	12% (as 2023)	85% (↑1pp)	8% (↑1pp)
I have access to the training and support I need to provide effective feedback on my trainees' performance.	84% (as 2023)	3% (as 2023)	91% (↓2pp)	2% (↑1pp)
I have access to the resources I need to confidently support trainees of all backgrounds, beliefs, and identities.	73% (↑1pp)	5% (as 2023)	83% (as 2023)	4% (↑1pp)

Seven out of ten trainers (68% as 2023) rated the support they receive from their employer or local education team as good or very good. GP (84%) and public health (82%) trainers were the most positive specialties, compared to 56% of surgery trainers. The variation between the four countries of the UK can be seen in Table 9.

Table 9: Trainers – Please rate the support you receive from your employer/local education team in your role as a trainer

Country	Very good/Good	Poor/Very poor
England	69% (↑1pp)	8% (as 2023)
NI	67% % (as 2023)	8% (↑3pp)
Scotland	64 %(↑1pp)	9% (↓3pp)
Wales	67% (↑2pp)	7% (↓2pp)
UK	68% (as 2023)	8% (as 2023)

Rota design

Responses to questions about rota design varied between the different specialties, consistent with previous years. 42% (↓1pp) of obstetrics and gynaecology trainees said their training is adversely affected because rota gaps aren't dealt with appropriately compared to 11% (as 2023) of anaesthetics and 13% (↓2pp) of psychiatry trainees. 26% (↓3pp) of all trainees in secondary care posts felt this way.

Secondary care trainers voiced similar concerns, with nearly a third (31% ↓2pp) saying that their trainees' education and training is adversely affected because rota gaps aren't always dealt with appropriately. As in 2023, trainers in obstetrics and gynaecology (46% ↓1pp) and surgery (41% as 2023) gave the highest proportion of negative responses.

Enabling high-quality training

Thanks to the hard work and dedication of trainers, trainees' satisfaction with their teaching remains high.

However, firm commitments are needed to enable the necessary growth of training opportunities and capacity across the system, including increasing the educator workforce.

Given their vital role in supporting the workforce pipeline, it's essential that trainers have the necessary support, time, resources, and development opportunities. It's a concern then, that less than half of those surveyed (48% ↑2pp) said that they were always able to use the time allocated to them in their role as a trainer, specifically for that purpose.

Demands on trainers across the UK will only grow as plans for the future expansion of medical school places are realised. We believe that now is the time to make a very specific commitment to protect time for training. Employers and education providers must use the education data tool to help make improvements for both doctors in training and their trainers.

Tackling burnout

To help us assess the extent of burnout and better understand trainee and trainer wellbeing in the workplace, we include seven voluntary work-related questions taken from the Copenhagen Burnout Inventory in the survey. This year over 47,500 doctors (61% of trainees and 71% of trainers) completed the questions.

Trainees – responses to questions about burnout

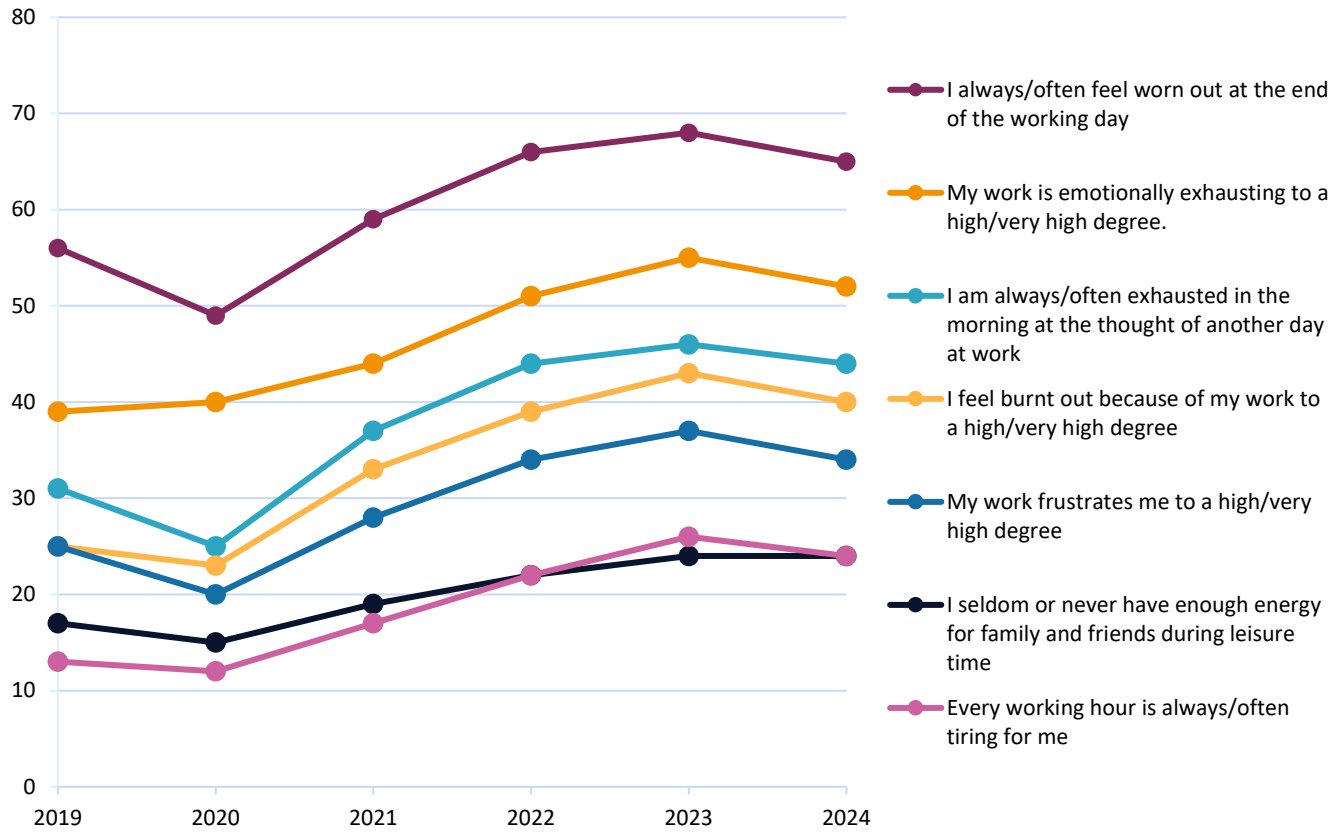
The proportion of negative responses from trainees to most of the burnout questions remains high, despite a slight decrease since 2023, with two fifths of trainees (40% ↓3pp) feeling burnt out because of their work.

Nearly a quarter of those who responded (24% ↓2pp) said they felt that every working hour is tiring for them and 65% (↓3pp) said they always or often feel worn out at the end of the working day.

34% (↓3pp) of trainees told us that their work frustrates them, and over a half (52% ↓3pp) felt that their work was emotionally exhausting to a high or very high degree (see Figure 6).

As in previous years there was a variation between the different specialties. Trainees in emergency medicine posts once again gave the highest proportion of negative responses to most of the seven questions. Over two thirds (69% ↓3pp) said their work is emotionally exhausting and 45% (↓4pp) told us their work frustrates them to a high or very high degree. While most specialties witnessed similar small decreases in the proportions of negative responses, there were some exceptions. For example, half of obstetrics and gynaecology trainees (49% ↑2pp) said they were exhausted in the morning at the thought of another day at work. And two thirds of GP trainees (66% ↑1pp) said they were always or often worn out at the end of the working day.

Figure 6: Trainees – Negative responses to individual burnout questions, 2019–2024



Trainers – responses to questions about burnout

The proportion of negative responses to the burnout questions from trainers has remained broadly similar since 2022 (see Figure 7). Responses from secondary care and GP trainers can be compared in Figure 8 and 9. 68% (↓5pp) of GP trainers said they always or often feel worn out at the end of the working day, while a half of those working in secondary care (49% ↓1pp) said this was the case.

As in 2023, trainers in emergency medicine gave the most negative set of responses. 28% (↑2pp) said that every working hour is tiring for them, and three fifths (59% ↑3pp) said their work frustrates them to a high or very high degree.

Figure 7: All trainers – Negative responses to individual burnout questions, 2019–2024

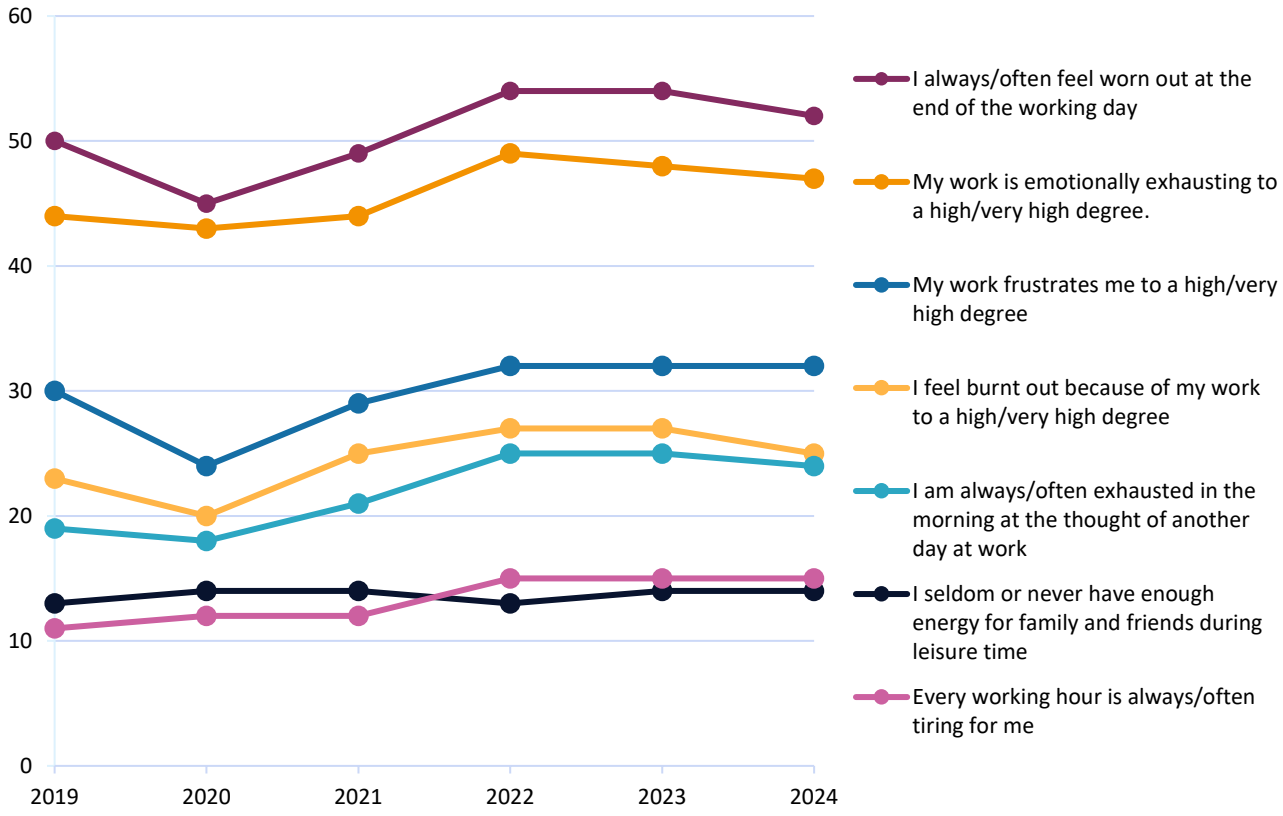
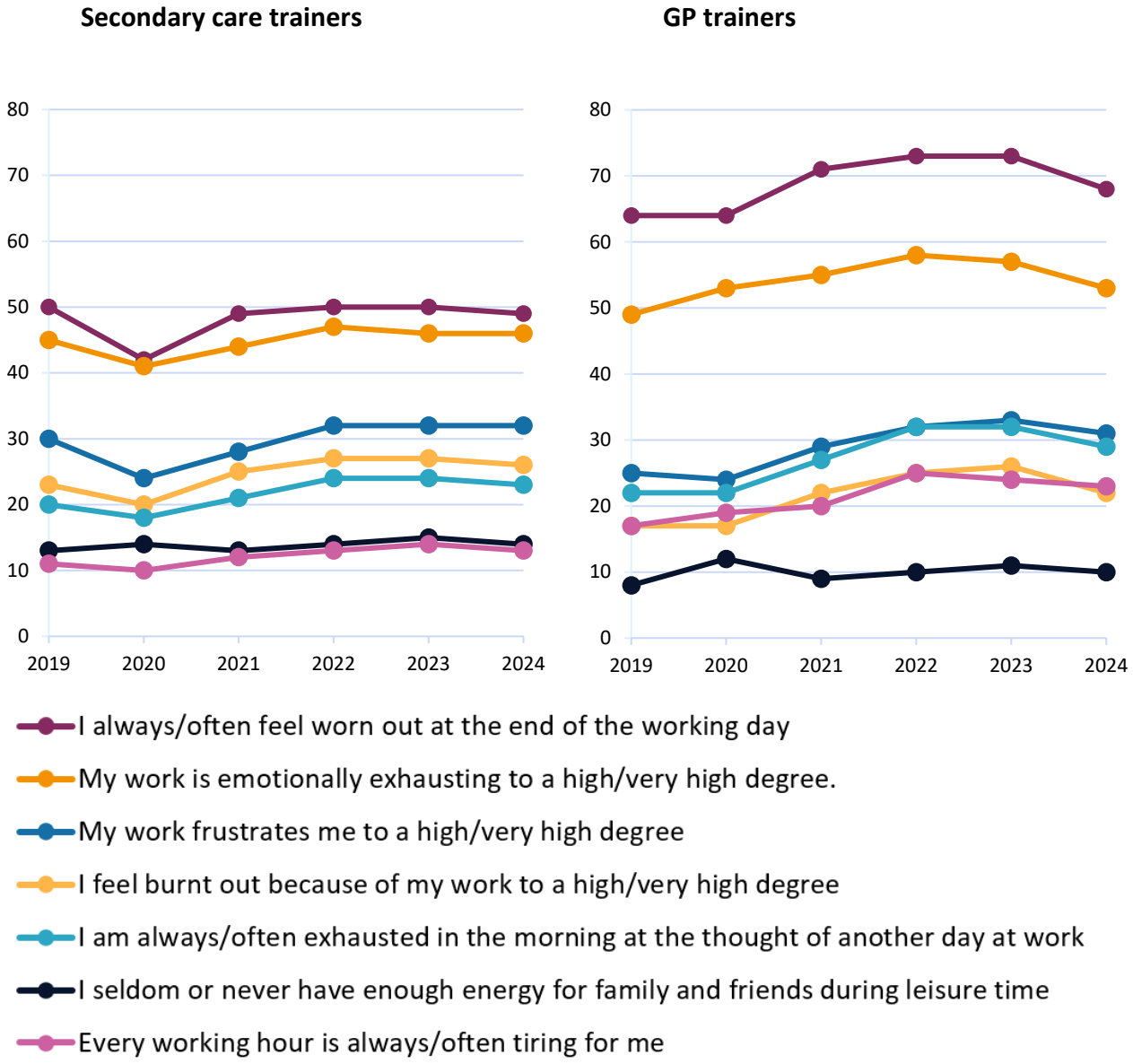


Figure 8 and 9: Negative responses to individual burnout questions, 2019–2024

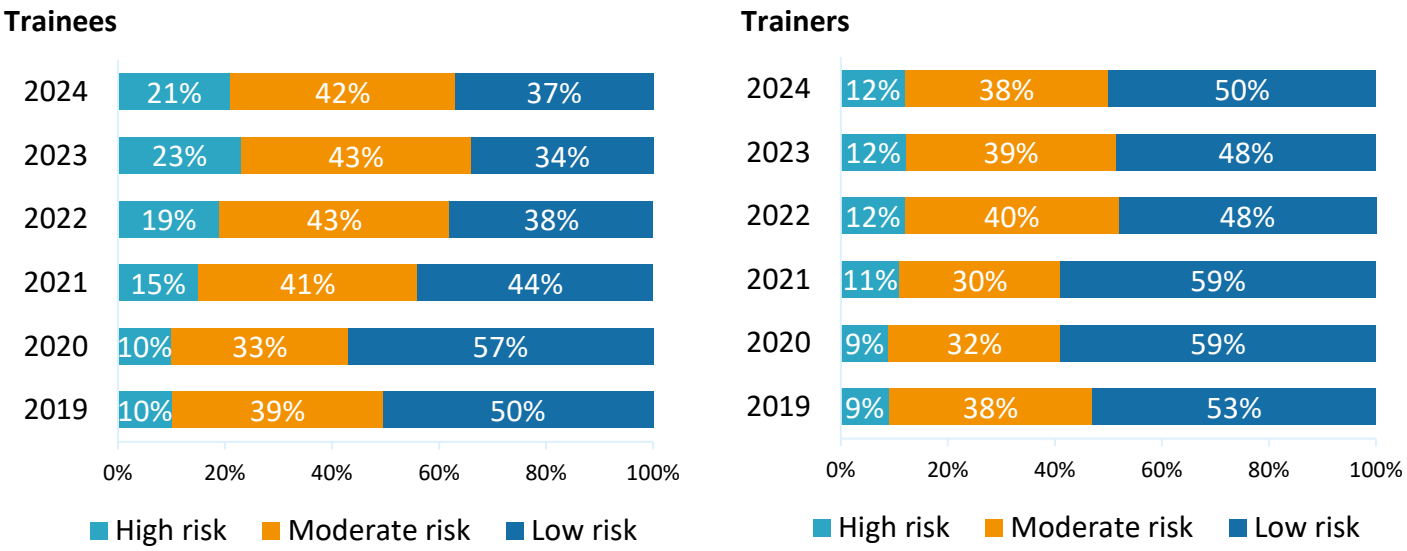


Risk of burnout

Responses to the seven questions, are used to measure overall risk of burnout.

The proportion of trainees measured to be at a high or moderate risk of burnout (63%) is a slight decline from 2023, similar to the levels seen in 2022. Half of all trainers (50% ↓2pp) are measured to be at high or moderate risk of burnout.

Figure 10: Trainees and trainers – Calculated risk of burnout 2019–2024



Trainees at high risk of burnout

While the proportion of trainees measured to be at a high risk of burnout has decreased slightly from the high levels reported in 2023, one fifth (21% ↓2pp) are in this category. The largest decreases were seen in ophthalmology (13% ↓9pp) and public health (5% ↓4pp), while emergency medicine (32% ↓2pp) continues to have the largest proportion of trainees at a high risk of burnout (see Figure 11).

Each year we ask trainees whether they know who to contact in their trust/board (or equivalent) to discuss matters relating to occupational health and wellbeing. Two thirds (66% as 2023) said they did. However, when looking at trainees at high risk of burnout only half (52% ↑1pp) agreed, compared to three quarters (74% as 2023) of those measured to be at low risk of burnout.

Figure 11: Trainees – Post specialty variation at high risk of burnout, 2024 vs 2023

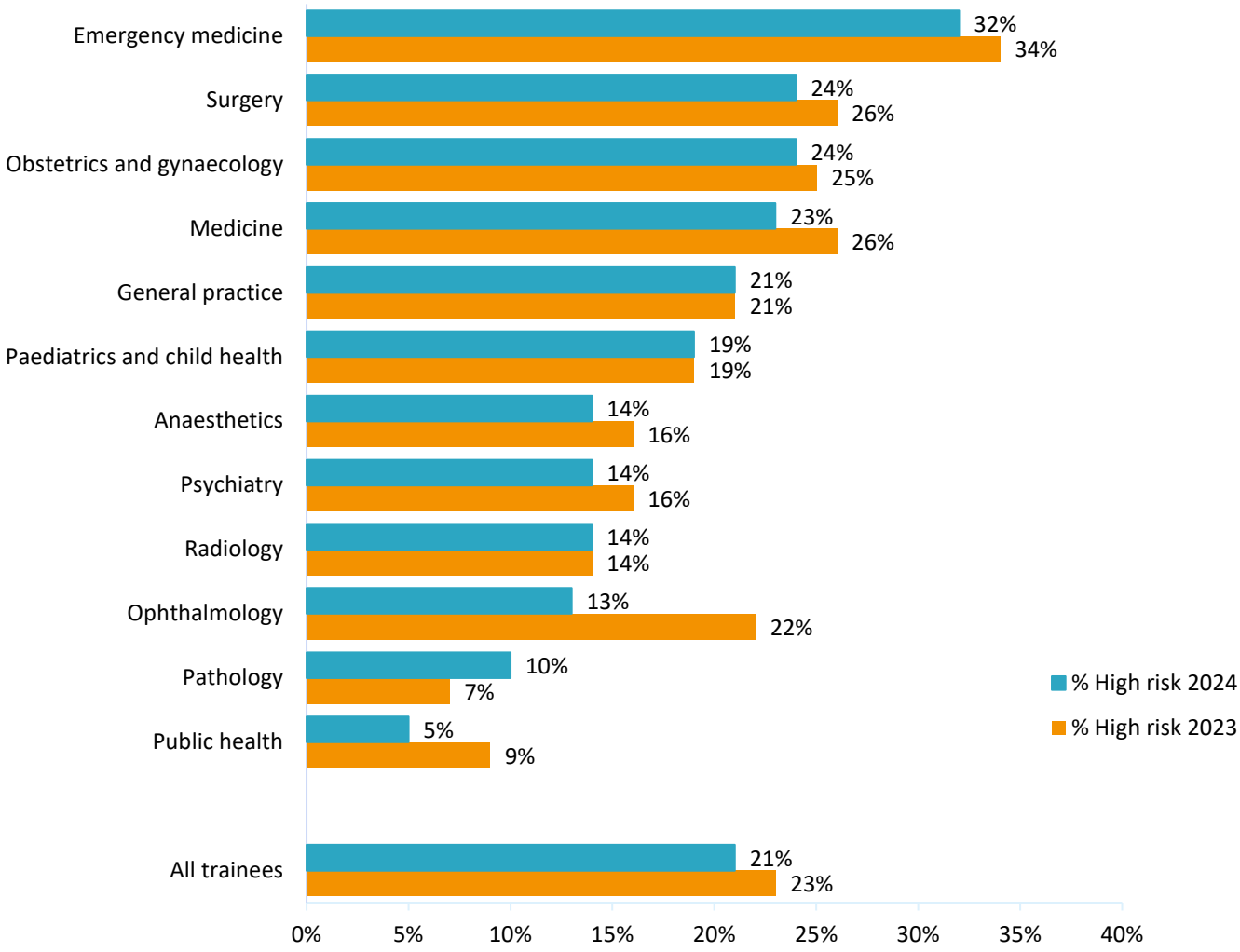


Table 10: Trainees – Calculated risk of burnout by country

Trainee country	High risk	Moderate risk	Low risk
England	21% (↓2pp)	42% (↓1pp)	37% (↑3pp)
NI	26% (↓1pp)	42% (↓2pp)	31% (↑2pp)
Scotland	18% (↓1pp)	43% (↓2pp)	40% (↑3pp)
Wales	20% (↓3pp)	42% (as 2022)	38% (↑4pp)
UK	21% (↓2pp)	42% (↓1pp)	37% (↑3pp)

Trainers at high risk of burnout

As in 2023 and 2022, 12% of all trainers were calculated to be at high risk of burnout, although some specialties did see a small increase (see Figure 12). These were emergency medicine (26% ↑2pp), ophthalmology (16% ↑5pp) and radiology (11% ↑1pp).

Figure 12: Trainers – Specialty variation at high risk of burnout, 2024 vs 2023

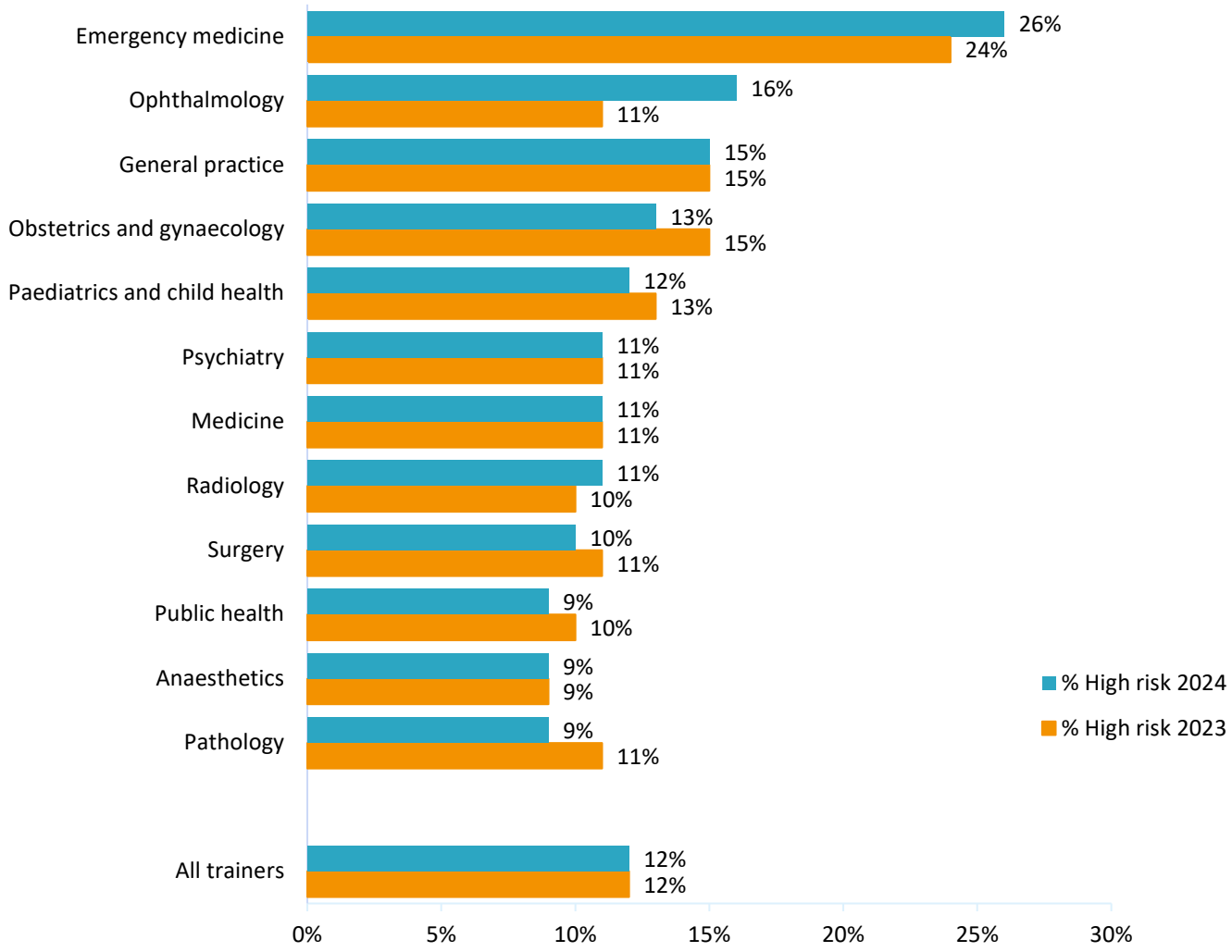


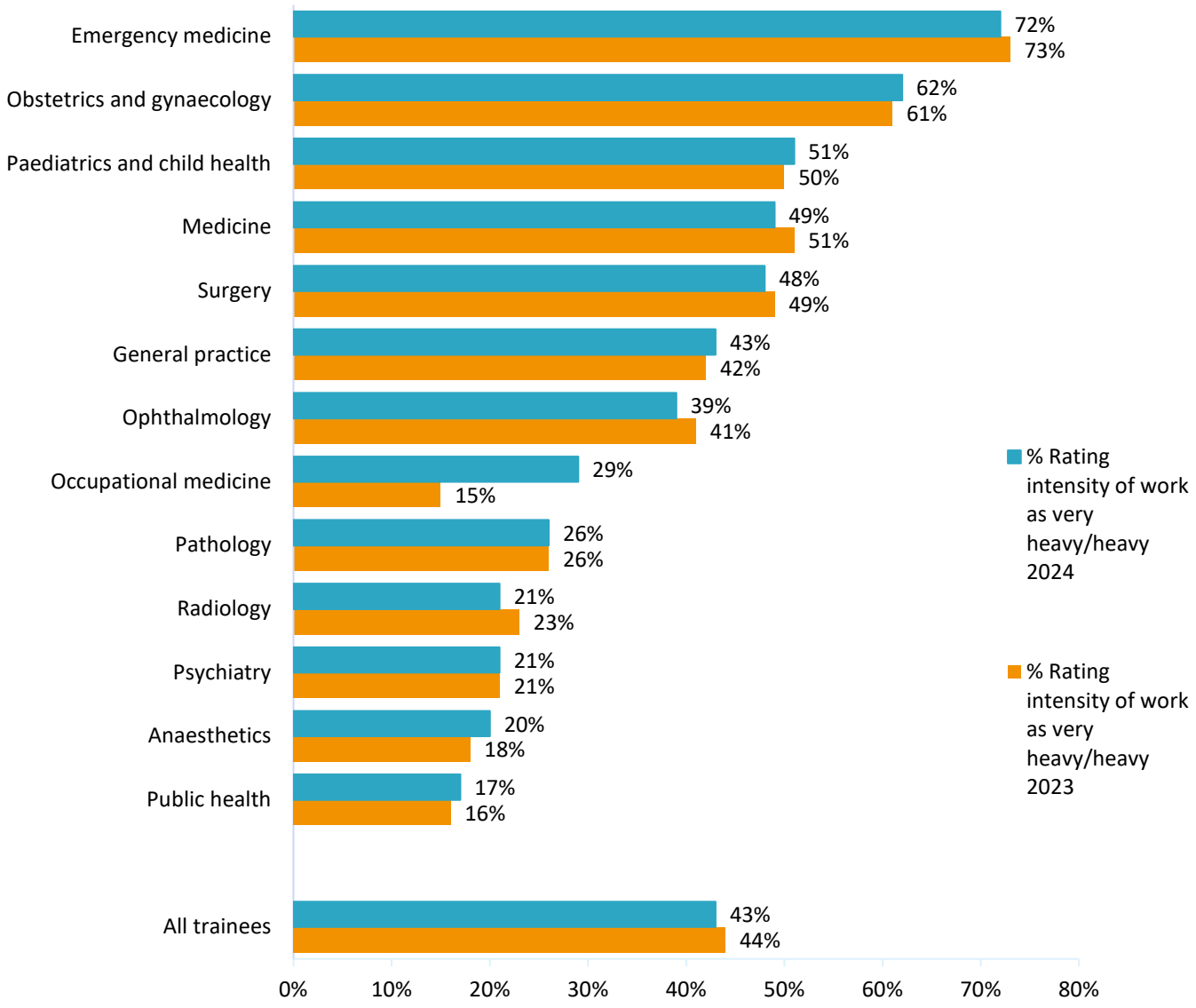
Table 11: Trainers – Calculated risk of burnout by country

Trainer country	High risk	Moderate risk	Low risk
England	12% (as 2023)	37% (↓2pp)	51% (↑3pp)
NI	18% (as 2023)	41% (↑1pp)	41% (↓1pp)
Scotland	12% (as 2023)	40% (↑1pp)	48% (as 2023)
Wales	13% (↑2pp)	37% (↓4pp)	50% (↑2pp)
UK	12% (as 2023)	38% (↓1pp)	50% (↑2pp)

Workload

Figure 13: Trainees – % rating intensity of workload as very heavy/heavy 2024 vs 2023

By post specialty



Over two fifths (43% ↓1pp) of doctors in training rated the intensity of their work by day as heavy or very heavy. However, as Figure 13 illustrates, as in previous years there was a wide variation between specialties. Seven out of ten (72% ↓1pp) of trainees in emergency medicine rated the intensity of work as heavy or very heavy, compared to a much smaller proportion of those in anaesthetics (20% ↑2pp) and public health (17% ↑1pp).

Addressing burnout and the impact on doctors' health

Despite there being a slight improvement in the responses to our questions about wellbeing, the survey results remain very concerning. For the third year running, a quarter of trainers and a third of trainees in emergency medicine posts measured to be at high risk of burnout, suggesting unsustainable workplace pressures have become the norm in this specialty.

Workplace stress in healthcare organisations affects quality of care for patients as well as doctors' own health, with studies demonstrating clear links between patient safety and doctors' wellbeing.

Good medical practice states that doctors should take care of their own health and wellbeing needs, recognising and taking appropriate action if they may not be fit to work. While it's possible that any small positive changes seen in the data may have been driven by doctors taking such steps to protect their own wellbeing, it's vital that employers prioritise the issue of easing workload stress.

Improving working conditions for all healthcare staff and supporting the development of fair and inclusive workplaces will help improve retention, reduce workplace pressure, and help to protect patients as well as staff.

Taking action

Listening to what trainees and trainers have to say about their experiences of training is important both now, and as part of building for the future. As the largest annual survey of doctors in training and their trainers, the national training survey provides a wealth of valuable data to support governments in both reviewing and informing plans for the UK health services.

Our evidence and data point to long-standing issues affecting training. The risk of burnout, poor rota design, and a lack of training time have been highlighted in previous summary reports. The 2024 survey results reaffirm why action must be taken to address these issues.

The new UK government is committed to supporting the Long Term Workforce Plan in England and similar expansions in the workforce in Scotland, Wales and Northern Ireland. We welcome ambitions to increase medical school student numbers, but it's essential this is mirrored by a significant expansion of multidisciplinary educators to account for this workforce expansion. Plans will need to set out how this will be achieved, and employers will need to rebalance the important need to support training, by protecting training time and providing resources and adequate support, alongside the continuing service pressures.

Developing leaders for the future is also crucial for the sustainability of the health services and patient care. Our findings show that the proportion of trainees saying they'd been given opportunities to develop leadership skills declined further in 2024. It's imperative this vital aspect of training is not overlooked, given its importance in succession planning.

With many challenges facing the health services, now is the perfect opportunity to reflect on what trainees and trainers are telling us through the survey. As part of our regulatory responsibility for overseeing all stages of education and training for doctors, we are undertaking a review of the standards, outcomes, and processes that underpin medical education. Critical to our review will be exploring ways to explicitly make sure that educators have the time and space

to undertake this vital function – and how we can better support career development and lifelong learning for all doctors.

We'll continue to work in collaboration with partners across the four UK nations and ask that governments and employers play their part in addressing the challenges described in this summary report.

Survey development

Each year we review the survey to make sure that the questions remain relevant and deliver the data we need to quality assure postgraduate medical training. Any changes are the result of our ongoing engagement with doctors, medical educators, representative organisations, and employers.

After completing the survey, we invite doctors to help us develop and test proposed changes for future years. If you'd like to get involved, we'd value your input. Please email nts@gmc-uk.org.

Our data

Percentages in all tables and charts are rounded and may not add up to 100.

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I ofyn am y cyhoeddiad hwn mewn fformat neu iaith arall, ffoniwch ni ar **0161 923 6602** neu e-bostiwch ni ar **gmc@gmc-uk.org**.

You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

Published July 2024

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MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
DRAFT Minutes of the meeting of the Board of Directors held in public on 28 November 2024 in the Lecture Theatre at Moorfields Education Hub (and via MS Teams)

Board members:	Laura Wade-Gery (LWG)	Chair
	Jon Spencer (JS)	Acting chief executive and COO
	Asif Bhatti (AB)	Non-executive director
	Andrew Dick (AD)	Non-executive director
	Nick Hardie (NH)	Non-executive director
	David Hills (DH)	Non-executive director
	Michael Marsh (MM)	Non-executive director
	Adrian Morris (AM)	Non-executive director
	Aaron Rajan (AR)	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
	Sue Steen (SS)	Chief people officer
	Louisa Wickham (LW)	Medical director
In attendance:		
	Elena Bechberger (EB)	Director of strategy & partnerships
	Annemarie Richardson (ARi)	Senior theatre nurse
	Truda Scriven (TSc)	Acting company secretary (minutes)

A number of staff and governors observed the meeting in the room and online, including: Onyinye Nwulu (general counsel), Amnah Shah (acting FTSU guardian), Sally Longhurst (information governance), Rob Jones, Allan MacCarthy, Kimberley Jackson, Emmanuel Zuridis, Professor Naga Subramanian, John Sloper, Vijay Arora, Dinesh Solanki, Robert Goldstein, Emily Brothers, Yasir Khan, Ian Humphreys, Jennie Phillips (deputy company secretary) and Nic De Beer (committee secretary).

1. Welcome

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

Introductions by all were completed.

2. Staff story

The chair welcomed and introduced Annemarie Richardson, senior theatre nurse, to present her staff story to the Board.

As a new appointment, Annemarie reflected on inheriting a department where staff morale was low, engagement was strained, and confidence to speak up was lacking, resulting in a significant number of grievances. Recognising that this environment was unsustainable for both staff well-being and patient care, she prioritised fostering a supportive and inclusive culture, addressing issues promptly and with clarity.

Annemarie's leadership was rooted in compassion. From the outset, she made it a priority to actively listen to staff at all levels—nurses, surgeons, and everyone at all levels. Her empathetic approach helped create a safe space where staff felt heard and respected. By acknowledging concerns and tackling challenges head-on, she rebuilt trust and encouraged a spirit of kindness and mutual respect across the team. While she

was clear in setting expectations, she did so in a way that balanced accountability with support, ensuring that staff knew they were valued and integral to the department's success.

Annemarie tackled deep-seated issues by introducing several key initiatives, including regular team meetings, peer support networks, and recognition programmes to celebrate contributions and achievements. Her approach was collaborative—rather than imposing solutions, she engaged the team in developing strategies that addressed their shared goals. This inclusive style empowered staff, fostering a sense of ownership and pride in the department's progress.

Annemarie emphasised the importance of partnership with HR, investing in regular meetings to ensure outstanding grievances were addressed and that she had robust support to manage emerging issues swiftly. This close collaboration helped to create a foundation of trust and fairness, which further enhanced staff confidence.

During discussions, board members noted that what distinguished Annemarie's leadership was her unwavering commitment to empathy, resilience, and engagement. By focusing on the value of each individual, she created a more compassionate, people-centred approach to leadership. This human connection reinvigorated the team, enabling staff to approach their work with renewed energy, knowing they were appreciated and supported.

The transformation in the theatres was remarkable. Annemarie not only improved engagement but also fostered an environment where staff felt they could grow and thrive. Through her focus on people, she turned a struggling culture into one characterised by collaboration, respect, and high performance. Her dedication to staff development and well-being created a sense of shared purpose, motivating individuals to contribute their best.

Finally, Annemarie highlighted the critical need for enhanced support from Occupational Health, particularly to better address the physical and emotional challenges faced by staff. She urged the Board to prioritise a more responsive and effective Occupational Health service, noting that improved access would directly enhance staff well-being and the overall working environment. The Board acknowledged this request and committed to overseeing executive action to ensure these improvements were delivered.

The Board noted the staff story and thanked Annemarie for her thoughtful and inspiring account.

3. Apologies for absence

Apologies had been received from Richard Holmes, non-executive director and Martin Kuper, CEO. The chair thanked those who had conveyed their good wishes for his health to MK at this time.

4. Declaration of interest

MM declared that he continued to work at NHSE and that this had been declared in the register.

HF declared that she was the Senior Responsible Owner of the Data for Research and Development Programme for NHSE.

There were no other declarations made not already recorded in the register.

5. Minutes of the previous meeting

The minutes of the meeting held on 26 September 2024 were approved as a correct record.

6. Matters arising and action log

The action log and updates were noted.

7. Chief executive's report

As acting CEO, JS highlighted key areas of the report, which included:

- The number of patients waiting for their treatment continued to reduce.
- Although most services were improving their compliance with the 18-week standard, a small number of specialist services had a deteriorating position due to capacity challenges.
- The Trust's outpatient activity was above target for the year. However, elective activity levels had reduced further in-month. The drivers for this included a reduction in the number of patients who were transferring to us for treatment from the Royal London.
- 'Single Point of Access' was now fully implemented in NCL. Several groups were being convened to identify opportunities to further integrate services and to identify and address any variation in healthcare equalities. The chair was delighted to inform the Board that the SPoA had won the Acute Sector Innovation of the Year award at the HSJ Awards 2024. The team was presented with the award on 21 November 2024 by Sam Roberts, chief executive at the National Institute of Health and Care Excellence (NICE).
- Bedford was progressing with switching over of the clinical noting system to Open Eyes which was due to take place in January 2025.
- The construction of Oriel was progressing well. The frame of the building stood at level 9. The 1:50 designs would be completed by January 2025. Work was ongoing to interpret the user requirements to inform the SMART IT specifications
- The Electronic Patient Record (EPR) system contract with MEDITECH was approved by the Board on 24 October 2024. The team now moved into the implementation phase for EPR to go live in 2026.
- The Professional Nurse Advocate (PNA) initiative, launched by the Chief Nursing Officer for England, saw eight nurses completing as PNAs with four more in various stages of training.
- The Patient Safety Incident Framework (PSIRF) was advancing in Phase 2, developing tools and training for effective governance and continuous learning from incidents.
- The actions set out following the 2023 staff survey were on track to be delivered. The Board was assured sickness levels were stable and that a robust sickness management policy was in place.

AB questioned whether the full range of levers able to be used to improved operational performance was being used of which CIP was only one. JS and EB replied that there were several initiatives currently ongoing to drive performance and that these were also across the commercial landscapes.

JB as acting CFO, presented the financial summary to Board:

- For October the Trust reported a £2.58m surplus, £0.03m favourable to plan, with a cumulative surplus of £4.83m, £0.4m favourable to plan.
- Patient activity for October was 89% for Elective, 98% on Outpatient First, and 101% against Outpatient Procedures activity respectively against the Trust's revised activity demand plan.
- Efficiencies were reporting £3.9m cumulatively, £2.6m adverse to plan. For the full year, £6.7m had been identified against the increased £11.2m plan with further schemes being validated.
- Capital expenditure was £43.9m cumulatively with the majority relating to the Oriel development. This represented a £13.4m variance to plan, primarily relating to the Oriel build, which was reviewing its in-year construction cashflows for reforecasting.
- The Trust's cash position was £67m, a decrease of £3.7m from the previous month, and equivalent to 81 days of operating cash.

The Board noted the report.

8. EDI annual report and WRES/WDES report

SS presented the 2024 EDI Annual Report along with a report providing an overview of the Trust's EDI activities and performance for the current period. These matters had been considered by the People & Culture Committee.

It was noted that the publication of an annual report was a requirement of the 2010 Equality Act's Public Sector Equality Duty (PSED). It was demonstrated how the Trust was meeting the PSED requirements. In particular, the Board supported the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relationship between people who had protected characteristics

Progress was reviewed by Board members, including Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), Gender Pay Gap (GPG), and Ethnicity Pay Gap (EPG). The Board assessed the Trust's work on the internal equality, diversity and inclusion agenda and our work to address health inequalities.

In discussion, Board members fully recognised that there was no silver bullet solution to these complex matters and that there was still a significant amount of work required to improve staff experience, our performance on national EDI standards, and to achieve our EDI vision. Areas for development were accepted as:

- Recruitment: WRES indicator 2, regarding the likelihood of BME staff been appointed, showed a decline in our position compared to the previous year and currently formed part of a recruitment outcome review under the EDI programme. Addressing this was a key deliverable under the Fair Opportunities for All workstream of the EDI Programme.
- Staff Experience at work: staff survey feedback indicated that only 63% of our workforce would recommend the organisation as a place to work compared to the national average of 71%. A series of listening and engagement sessions were being conducted with network groups and the wider workforce to identify required actions and to refine interventions.
- Board and Senior Leadership Representation: representation of both BME and disabled staff at the board and wider senior leadership levels had decreased, highlighting a need to diversify senior leadership. Initial scoping for a new talent management and succession planning programme had been carried out under the Fair Opportunities for All workstream.
- EDI Ambition: the new EDI baseline data in setting medium (2025/26) and long term (2028) EDI targets and goals was being used. The ambition was to achieve a top quartile score and performance across all the core EDI metrics recommended by the Data Driven Change workstreams by 2028. A proposal on the EDI ambition would be presented to ManEx for consideration and approval in December 2024.

The progress achieved in 2024 was acknowledged by the Board:

- Feedback from staff network showed significant improvement in the operation and support for staff network groups. In particular, the introduction of a monthly "Staff network report" as a standing agenda item for the monthly EDI steering group meeting had enabled structured escalation of staff network issues and empowered staff network leaders.
- A significant step forward was taken to become an anti-racist organisation by signing the Unison Anti- Racism Charter with the supporting delivery programme mapped to our EDI programme to deliver the charter pledges.
- Staff and key internal stakeholders had co-produced and launched a new EDI vision to reinforce and drive the Trust's commitment to EDI.
- A new EDI baseline data set had been delivered and this would evolve into a new EDI dashboard.

- Our latest WRES data showed an improvement in the fairness of disciplinary processes for BME staff.

Having considered the EDI Annual Report for 2024, the Board noted it for assurance and approved the report for publication to be made available on the Trust's public-facing website. The Board reaffirmed that EDI remained a top priority area both for the Board itself and the wider organisation.

9. Freedom to Speak Up

SA introduced Amnah Shah (acting FTSU guardian) and the Freedom to Speak Up Q2 2024/25 report.

The Board reviewed the summary of Q2 2024/25 Freedom to Speak Up (FTSU) proactive and reactive work. SA described the work being undertaken by the FTSU team which demonstrated that speaking up was valued and championed by Trust Board, Management Executive team, managers and a wide range of other stakeholders across Moorfields.

Board members supported the Trust's approach to developing and supporting the work of the FTSU Guardians as an important element of providing an open culture, and supporting the improvements indicated by the staff survey. It was agreed that if staff felt able to raise concerns in a safe environment and that their concerns were acted on, this would have a positive impact on patient safety and staff well-being and improve the Trust's ability to learn lessons from incidents and support good practice. Comments from Board members confirmed their approach to leadership and support for an effective FTSU service delivery, in order to foster an open and transparent speaking up culture.

After considering the report, the Board noted that overall, good progress continued to be made by the FTSU service ensuring that the key deliverables detailed in the work plan were met. The number of concerns raised over Q2 and the themes and trends emerging from them, were also noted. Oversight of the on-going FTSU work activities would be maintained by the Board.

10. Integrated performance report

JS presented the report.

It was noted that considerable work continued to move activity across different Trust sites to utilise areas with current capacity. Nevertheless, it remained a challenging process.

The Board was pleased to note that there were 20 metrics showing either an improving or stable performance, these included:

- All Cancer Performance Metrics
- Posterior Capsular Rupture rates
- All FFT Performance Targets
- Infection Control Metrics
- Improving positions in Recruitment Time to Hire, Referral to Treatment performance and Waiting Lists

However, there remained some areas of concern which were discussed by the Board. These were highlighted as: 52 Week RTT Incomplete Breaches, Elective waits over 65 weeks, % FoI Requests completed within 20 Days and Appraisal Compliance.

Also noted at the meeting were that against the updated plan, all Outpatient Plans were above target for October and year-to-date with overall and Follow Up Appointments against Plan showing as an improving and capable process. Elective Activity remained below 100% for October and year-to-date.

The Board noted the report.

11. Finance report

JB had earlier presented the key financial metrics as part of the CEO's report above.

The Board noted the report.

12. Learning from Deaths

LW presented the report which satisfied the requirement to provide the Board with an update regarding compliance with, and learning from, the NHSE learning from deaths agenda.

There were no patient deaths in Q1 and Q2 2024/25 that fell within the scope of the learning from deaths policy.

In terms of Learning and Improvement opportunities identified during Q1 and Q2, the Board was notified that two incidents were reported that Moorfields staff had contacted the parents of children regarding non-attendance at appointments. Unfortunately, they were informed that sadly the children had passed away. Staff were unaware that the patients had passed away as notification had not been received via the national deceased registry reports. Notification of the incident was made to the National Back Office for the Personal Demographics Service to establish the cause of this communication failure.

LW stated that it was now known that this was not an event specific to Moorfields, and that the data quality team had been working with NHSE, alongside over 65 other trusts to support improved service user death reports across all organisations.

Board members expressed their sadness to learn of these upsetting incidents. This would be addressed through a daily process which ensured that all planned and RTT activity for these patients were closed. It is the clear intention that no oral or written communication would leave the organisation which could cause distress to relatives.

An update on the role of the medical examiner was given by LW. Since 9 September 2024, all deaths in any health setting that were not investigated by a coroner were reviewed by NHS medical examiners. The changes to the death certification process aimed to provide independent scrutiny of deaths in all cases and give bereaved people a voice. Moorfields had introduced a new policy to describe the local arrangements that were in place to satisfy the new legislative requirements. This included a clear role for the senior manager on call to oversee the process, which may need to be implemented out of hours.

The report was noted.

13. Guardian of Safe Working

LW introduced the item which summarised progress in providing assurance that doctors were safely rostered, and that their working hours were compliant with the 2016 terms and conditions of service (TCS) for doctors in training. The report covered 16 July 2024 to 19 November 2024.

LW stated that only one Exception Report had been filed by an ST3 due to an extra hour of work in clinic. There had been no instances reported of breaching the mandatory 8-hour rest period between shifts, exceeding the 48-hour average working week, or surpassing the 72-hour maximum limit within any seven-day period. Consequently, no financial penalties were incurred. Currently, there were no gaps in the rota.

There was some discussion of work schedules and hours; specified working hours were 08:30 to 17:00. It was noted that junior doctors had multiple commitments, including on-call duties, and the current schedule was designed to ensure compliance with these obligations. LW had sent a reminder to all Moorfields consultants emphasising the importance of respecting these working hours.

The Board noted the report.

14. Committee updates

MM as chair of the Quality & Safety Committee, and AR as chair of the People & Culture Committee, each presented their reports which were noted.

The terms of reference for the Discovery & Commercial Committee and Major Projects and Digital Committee had been reviewed in committee. No changes had been proposed. Therefore, the Board approved the annual review and the existing terms of reference.

15. (for information) GMC national Training Survey report summary 2024

The Board received the report for information. Paul Sullivan would present Moorfields own report at the 23 January 2024 board meeting for discussion.

16. Identifying any risks from the meeting

There were no specific risks identified.

17. Any other business

Nick Hardie was retiring from his role as Non-Executive Director after eight years of service.

On behalf of the Board, the chair expressed members' sincere gratitude for his exceptional contribution to the Trust. His experience in development and finance had been invaluable as we continued to progress with Oriel. However, beyond his expertise, it was the quality of Nick's committee chairmanship and his genuine interest in all aspects of Moorfields that truly stood out. His insights had always been thoughtful, respectfully delivered, and highly relevant, reflecting his understanding and commitment to the Moorfield's mission for its patients.

Other members echoed the considerable contribution made by Nick, and for his extraordinary time and commitment dedicated to the role. His personal and professional support had been greatly appreciated by all.

In response, Nick said that he was sad to be leaving and that it had been his privilege to serve the Trust. He had been pleased to see the significant progress being made across many important areas. He would miss his colleagues and conveyed his very best wishes for the continued success of Moorfields.

The register of sealings was made available to the Board.

There was no further business.

18. Date of next meeting

It was noted that the next meeting of the Board would take place on 23 January 2025 at Albert House.

The meeting was closed 11:00.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

23 January 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 March.	March 2025 (revised)

Report title	Chief executive's report
Report from	Jon Spencer, acting chief executive
Prepared by	The 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 and activity review
- Sector update
- Oriel update
- EPR
- Excellence portfolio update
- Financial performance
- Staff survey action plan

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 – 23 JANUARY 2025

Chief Executive's report

Performance and activity review

The Trust's performance against the 18-week standard worsened slightly in month, however the total number of patients waiting to be treated continued to improve. A small number of specialist services are continuing to seek to address individual capacity challenges, however this is being frustrated by their ability to recruit to specialist clinical roles.

The number of patients waiting over 52 weeks for their treatment remained stable at nine patients. Outpatient and elective activity levels were both below the in-month plan, however the outpatient activity level remained above the year-to-date plan.

Sector update

As the new lead provider for ophthalmology services in North Central London, we are continuing to implement our approach to engage with all providers and other system partners on a regular basis, and also on establishing new ways to share information and progress joint improvement priorities. Our digital referral management platform, the 'Single Point of Access', is now processing the majority of all ophthalmology referrals into secondary care in North Central London 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.

Our Elective Surgical Hub in Stratford, North East London, is providing support to neighbouring NHS trusts who have limited outpatient and surgical capacity in ophthalmology, particularly over the current winter period. 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.

In Bedford we are progressing with a switch of the clinical noting system to Open Eyes which is taking place in January 2025. Subject to a successful contract negotiation with the local commissioners, this will then be followed by the Trust taking over the clinical and operational management of ophthalmology patients in the Bedford region. The timeframe for this will be driven by the ability to safely transition the remaining IT systems.

Oriel

In light of the construction of the Oriel centre reaching its highest point, the Trust and the Institute of Ophthalmology hosted a successful topping out ceremony in December. This was attended by colleagues, major donors, patients and other key stakeholders.

Work continues on the target operating model SMART specifications that we are aiming for in the centre, both of which should be completed by March 2025. The 1:50 designs are slightly behind plan and are now due to be signed off by our user group chairs in February 2025. The Oriel Joint Advisory Group has explored innovative approaches to operations, alongside updates on the progress of the Legible London initiative and external wayfinding solutions strategy.

A new Director of Operational Change is now in post and she will be focussed on developing the plans to move services from City Road to Oriel.

Electronic Patient Record

Following the approval of our contract with Meditech on 30 October 2024, the Trust has had an executive launch of the EPR programme with colleagues from Meditech. The Electronic Patient Record (EPR) programme is now called MoorConnect, through which we will deploy Meditech's 'Expanse' product.

A new Programme Director has been onboarded to lead the programme and he is leading the development of an implementation plan for the programme, which will be completed by the end of January. This will ensure that our people, processes, tech and data will be ready for go live in May 2026 and will help to define the interdependencies between the EPR and Oriel programmes.

Excellence Portfolio

In Bedford, we have undertaken staff engagement for our transition to Open Eyes, including jointly developing messaging and producing posters, to help people access support from superusers and floorwalkers.

We have begun a project to develop how we manage patient referrals. This will deliver improvements for our patients and staff, including better triage processes, reduced safety risks and greater booking efficiency. We will also use NHS England's Federated Data Platform to improve our approach to patients' referral

to treatment pathways, while also enhancing surgical theatre scheduling through the deployment of our patients.

The Single Point of Access initiative was recognised with the Acute Sector Innovation of the Year award at the HSJ Awards 2024, and has become a cornerstone of our operations, now seamlessly integrated into business as usual. Its steady growth and ongoing success are being managed by the Digital Clinical Services division, driving enhanced efficiency and accessibility across our services.

The trust-wide leadership development program, aligned with our values and best practices, has launched to provide accessible training, support diverse learning styles, and enhance frontline leadership. The team is actively collaborating with managers to assemble a diverse and inclusive cohort for the pilot, guided by a Project Steering.

Finance Performance

For December the Trust is reporting a £2.48m deficit, £0.07m adverse to plan, with a cumulative surplus of £2.17m, £1.05 adverse to plan. The Trust has engaged with the ICB in regard to a revised full year financial forecast below the original planned £5.4m surplus.

Patient activity during December was 77% for Elective, 88% on Outpatient First, and 82% against Outpatient Procedures activity respectively against the Trust revised activity demand plan.

Efficiencies are reporting £5.3m cumulatively, £3.1m adverse to plan. For the full year £7.1m have been identified against the increased £11.2m plan with further schemes being validated.

Capital expenditure was £59.8m cumulatively with the majority relating to the Oriel development. This represents a £23.9m variance to plan, primarily relating to the Oriel build, which is reviewing its in year construction cashflows for reforecasting.

The Trust cash position was £68m, equivalent to 83 days of operating cash.

Staff survey

The 2024 annual staff survey campaign, conducted from 7 October to 29 November 2024, demonstrated high levels of staff engagement. The results, including response rates, remain embargoed until 31 March 2025.

In the meantime, we continue to implement actions from the 2023 staff survey response plan, aligned with our organisational development priorities. Two key initiatives are outlined below:

- **Embedding Trust Values**: We have launched a programme to bring our core values—Excellence, Equity, and Kindness—into daily practice, supported by a new behaviours framework. This initiative, delivered in partnership with Moorhouse Consulting, is progressing well and is on track for completion in May 2025.

- **Leadership Development**: We have initiated a leadership development programme aimed at first line and middle managers, focusing on strengthening fundamental people management skills and enhancing staff experience of line management. This programme is also scheduled for completion in May 2025.

The national pulse survey is running from 6 January to 31 January 2025. We continue to leverage quarterly pulse surveys as key listening tools to track and improve staff experience. Feedback from the July 2024 pulse survey is being used to refine and measure ongoing EDI (Equality, Diversity, and Inclusion) and OD (Organisational Development) initiatives.

Jon Spencer
Acting Chief executive

Integrated Performance Report
Reporting Period - December 2024

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 postion, 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.

Guide to this Report

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

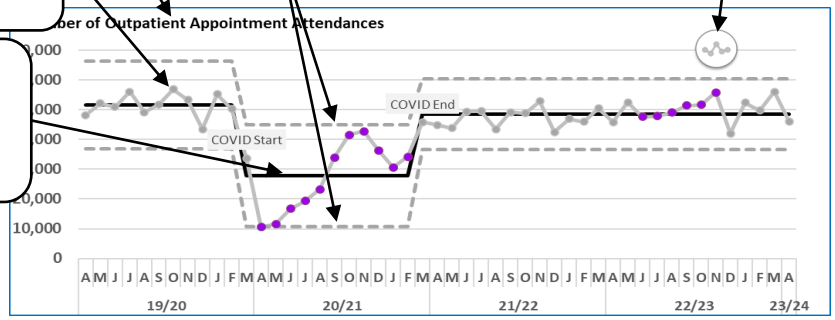
Improving Special Cause *

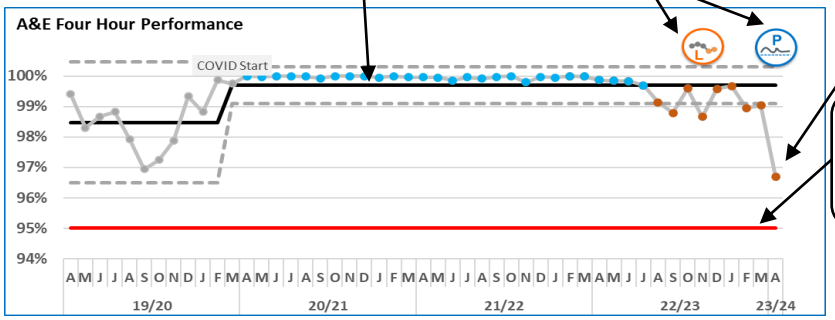
Summary Icons *

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"

- Elective Activity - % of Phased Plan
- 52 Week RTT Incomplete Breaches
- Freedom of Information Requests Responded to Within 20 Days
- Appraisal Compliance
- Basic Mandatory IG Training
- Staff Sickness (Month Figure and Rolling Monthly)

Celebrations

- 20 Metrics are showing as a capable process, all showing either an improving or stable performance, this includes:
  - All Research Metrics
  - Posterior Capsular Rupture rates
  - All FFT Performance Targets
  - Infection Control Metrics
- Six metrics are showing an improving position including Referral to Treatment (RTT) performance and Waiting Lists, Call Centre Performance, and Recruitment Time to Hire

Other Metrics showing "Special Cause Concern"

- Percentage of responses to written complaints sent within 25 days
- Number of Incidents (excluding Health Records incidents) remaining open after 28 days
- Proportion of patients participating in research studies (due to closure of major study)

Other Areas To Note

- All Activity plans were remains below 100% for December, however all Outpatient Plans remain above plan for YTD
- A Never Event was reported retrospectively, and has been added to September 2024.

Executive Summary

In December, the Trust's 18 Week referral to treatment time performance reduced slightly to 81.2% of patients receiving their treatment within the required period. The total waiting list size has continued to reduce and is now at 33,039. There are continued capacity challenges in a small number of high-volume specialist services which are seeing a deteriorating position. It is more challenging to increase capacity in these services due to specialist roles being hard to fill. A workforce plan is being developed to support recruitment and proposals for additional clinical space are being considered.

The number of patients waiting over 52 weeks for their treatment is stable at 9. These patients were a combination of those who have been transferred to us from other Trusts through a mutual aid process or our own patients who have experienced longer waits due to capacity pressures in specialist services. These patients have clear next steps in place to ensure they are seen and treated as quickly as possible.

Elective activity levels were below plan due to the known issue of lower than anticipated cataract referrals. Additionally, the number of staff taking annual leave over the Christmas and New Year period reduced activity in the second half of the month. There is a continued focus on referral engagement and communicating current waiting times with our patients.

Outpatient activity was also below plan in December, due to annual leave but remains above plan year to date.

We maintained a compliant position for the faster diagnosis standard in month and A&E four-hour performance remained above target at 98.3%.

Four patients were waiting longer than 6 weeks for their diagnostic test at the end of December due to patient unavailability. All patients have a confirmed date for their test in January.

The Trust's Booking Centre delivered strong performance against the operational metrics in December, with the average abandonment rate now showing special cause improvement following a sustained period of achieving the metric.

Two patients waited longer than 28 days to be rebooked following a non-medical cancelled operation.

Appraisal compliance remains below target at 70.8%. A new weekly report is supporting managers to accurately identify staff who need an appraisal. Basic Mandatory IG training is just below the required standard at 89.6% and the staff sickness rates remain above Trust target, at 4.9% in December due to an increase in seasonal illness.

Performance Overview

December 2024		Assurance			
		Capable Process	Hit and Miss	Failing Process	No Target
Variation	Special Cause - Improvement	- Average Call Abandonment Rate - FFT Outpatient Scores (% Positive) - NatPSAs breached - Serious Incidents open after 60 days - Recruitment to NIHR portfolio studies - Active Commercial Studies	- Average Call Waiting Time - Recruitment Time To Hire (Days)	-	- 18 Week RTT Incomplete Performance - RTT Waiting List - OP Journey Times - Diagnostic FtF - Recruitment to All Research Studies
	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 - % FoI Requests within 20 Days - Appraisal Compliance - Staff Sickness (Month Figure) - Staff Sickness (Rolling Annual Figure)	* See Next Page
	Special Cause- Concern	- % of patients in research studies	- % Complaints Responses Within 25 days	- Elective Activity - % of Phased Plan - Basic Mandatory IG Training	- Number of Incidents open after 28 days
	Special Cause - Increasing Trending	- No. of Theatre Emergency Admissions			
	Special Cause - Decreasing Trending	- RTT Incomplete Pathways Over 18 Weeks - No. of A&E Arrivals			

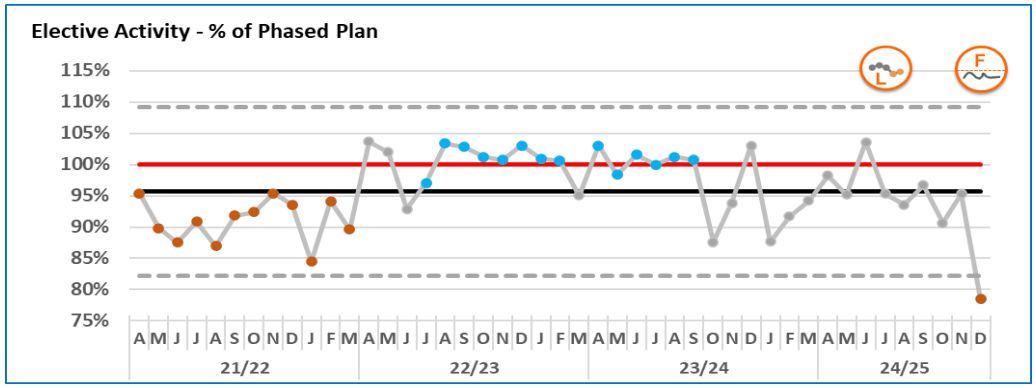
Performance Overview

Common Cause & Hit and Miss	Common Cause (No Target)
- Total Outpatient Activity (% Plan)	- OP Journey Times - Non-Diagnostic FtF
- Outpatient First Activity (% Plan)	- Proportion of Temporary Staff
- Cancer 28 Day Faster Diagnosis Standard	- No. of A&E Four Hour Breaches
- Elective waits over 65 weeks	- No. of Outpatient Attendances
- % Diagnostic waiting times less than 6w	- No. of Outpatient First Attendances
- Emergency readmissions in 28d (ex. VR)	- No. of Outpatient Flw Up Attendances
- % Complaints Acknowledged Within 3 days	- No. of Referrals Received
- Occurrence of any Never events	- No. of Theatre Admissions
- Theatre Cancellation Rate (Non-Medical)	- No. of Theatre Elective Day Admissions
- Non-medical cancelled 28 day breaches	- No. of Theatre Elective Inpatient Adm.

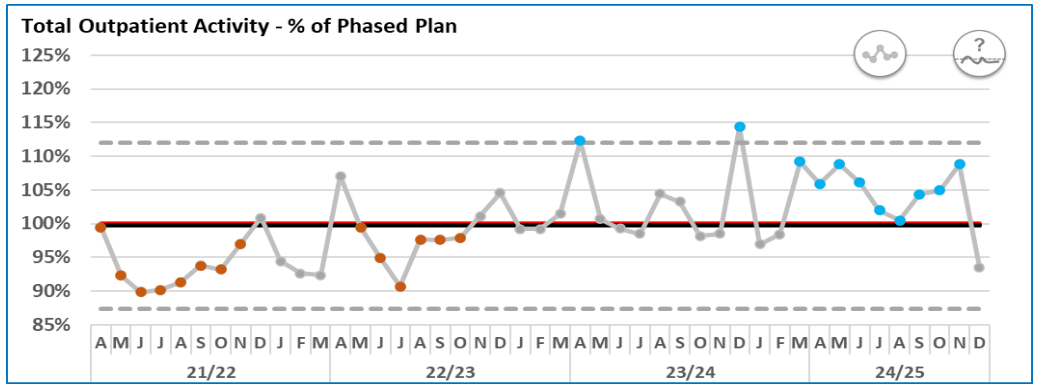
Deliver (Activity vs Plan) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Elective Activity - % of Phased Plan	Jon Spencer	24/25 Planning Guidance	Monthly	≥100%	94.1%	78.5%		
Total Outpatient Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	103.9%	93.5%		
Outpatient First Appointment Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	105.6%	95.8%		
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jon Spencer	24/25 Planning Guidance	Monthly	≥85%	103.4%	92.9%		

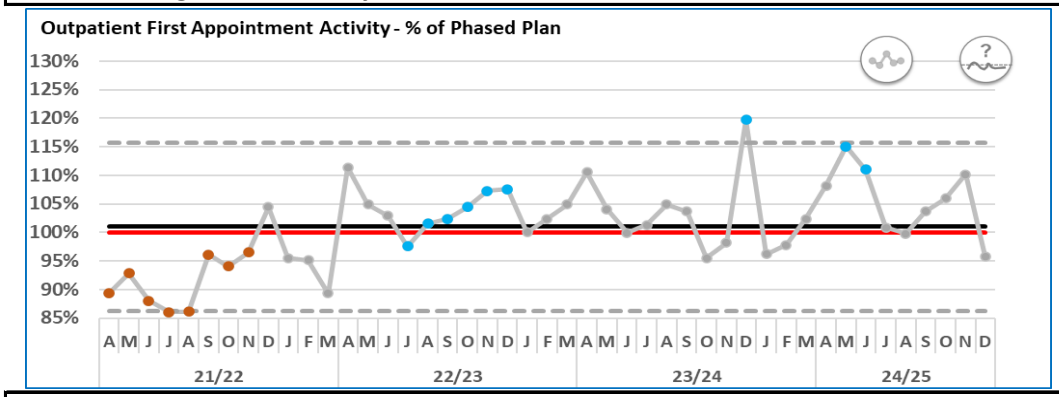
Deliver (Activity vs Plan) - Graphs (1)



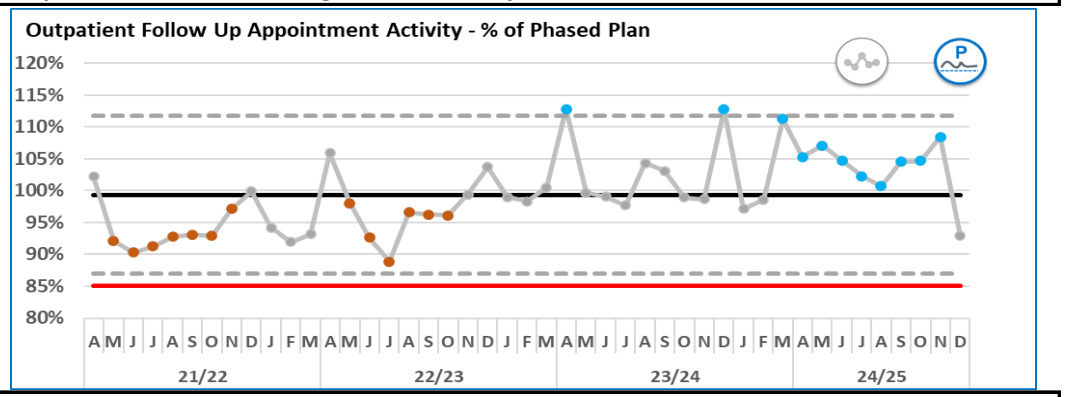
'Elective Activity - % of Phased Plan' is showing 'special cause concern' and that the current process is unlikely to achieve the target - This is a change from the previous month. The figure is currently at 78.5%.



'Total Outpatient 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 93.5%.



'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 95.8%.



'Outpatient Follow Up Appointment Activity - % of Phased Plan' 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 92.9%.

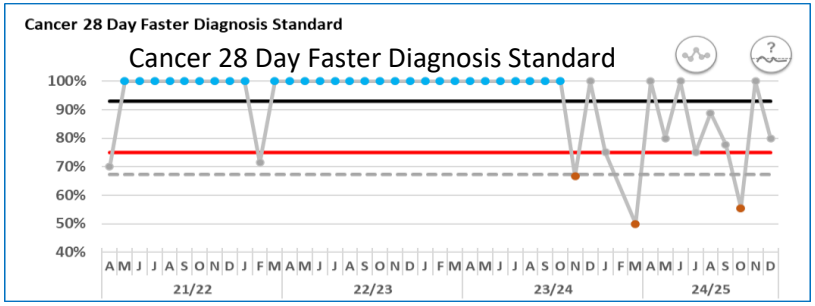
Elective activity is below target this month with delivery significantly below the revised demand plan. Elective activity reduced significantly in the second half of December as theatre lists were closed to allow staff to take annual leave. Additionally, it was more challenging to find patients for the lists which were running due to the time of year. The known issue of lower than anticipated referrals to the cataract service remain, with most challenge in the North division. Outpatient activity also reduced over the Christmas and new year period, due to annual leave. There is a continued focus on referrer and patient engagement to ensure there is an awareness of the services provided. There is also a review of the configuration of our services across sites, to see how our capacity can be used optimally to increase activity and reduce waiting times.

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

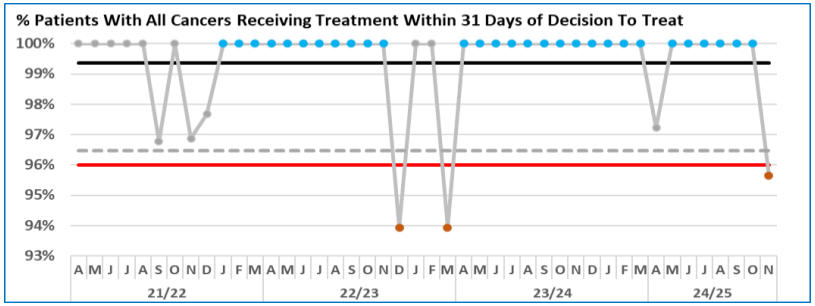
Deliver (Cancer Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	Statutory Reporting With Local Target	Monthly	≥75%	83.1%	80.0%		
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat	Jon Spencer	Statutory Reporting	Monthly	≥96%	99.1%	n/a		
% Patients With All Cancers Treated Within 62 Days	Jon Spencer	Statutory Reporting	Monthly	≥85%	100.0%	n/a		

Deliver (Cancer Performance) - Graphs (1)

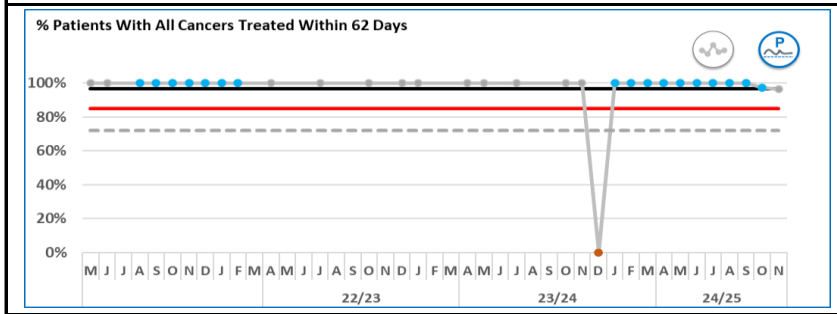


'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 80.0%.



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

December Data to be confirmed, awaiting additional validation of results



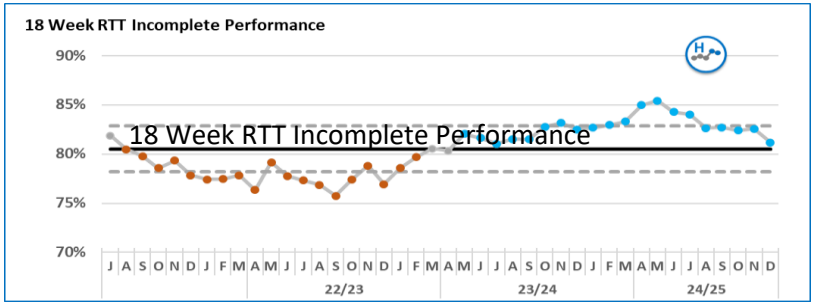
'% Patients With All Cancers Treated Within 62 Days' for this reporting period not available.

December Data to be confirmed, awaiting additional validation of results

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	Statutory Reporting	Monthly	No Target Set	83.4%	81.2%		
RTT Incomplete Pathways (RTT Waiting List)	Jon Spencer	Internal Requirement	Monthly	≤ Previous Mth.	n/a	33039		
RTT Incomplete Pathways Over 18 Weeks	Jon Spencer	Internal Requirement	Monthly	≤ Previous Mth.	n/a	6222		
52 Week RTT Incomplete Breaches	Jon Spencer	24/25 Planning Guidance	Monthly	≤5 Breaches	79	9		
Eliminate waits over 65 weeks for elective care	Jon Spencer	24/25 Planning Guidance	Monthly	Zero Breaches	20	0		
A&E Four Hour Performance	Jon Spencer	24/25 Planning Guidance	Monthly	≥95%	97.8%	98.3%		
Percentage of Diagnostic waiting times less than 6 weeks	Jon Spencer	24/25 Planning Guidance	Monthly	≥99%	99.2%	97.8%		

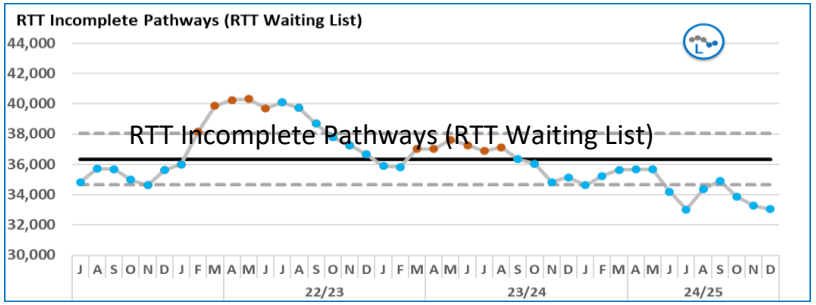
Deliver (Access Performance) - Graphs (1)



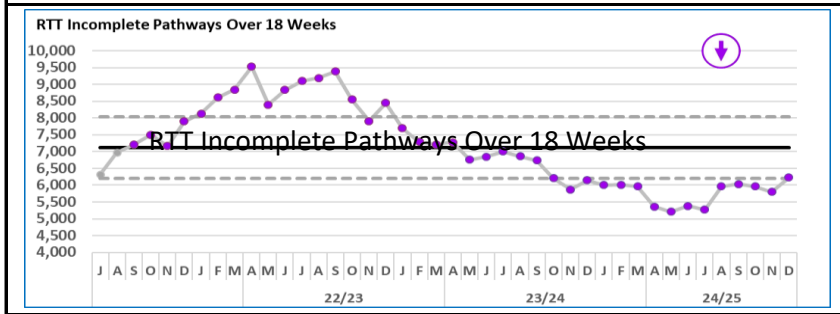
'18 Week RTT Incomplete Performance ' is showing 'special cause improvement' (increasing rate). The figure is currently at 81.2%.

RTT performance remains in decline from a high point earlier in the year. This is driven by challenges in three high volume, specialised services: paediatrics, adnexal and external. Plans are in development to increase capacity where appropriate and to maximise productivity to reduce waiting times. A workforce plan for hard to fill, specialist roles is in development.

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



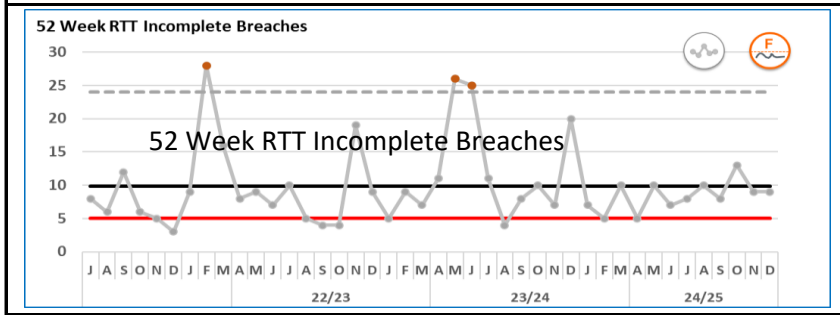
'RTT Incomplete Pathways (RTT Waiting List)' is showing 'special cause improvement' (decreasing rate). The figure is currently at 33,039.



'RTT Incomplete Pathways Over 18 Weeks' is showing an 'special cause variation' (decreasing rate). The figure is currently at 6,222.

Pathways over 18 weeks are increasing, with particular challenges in paediatrics, adnexal and external. Action described above.

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

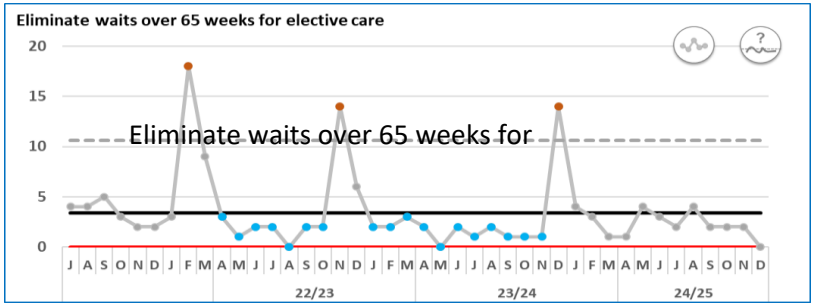


'52 Week RTT Incomplete Breaches ' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 9.

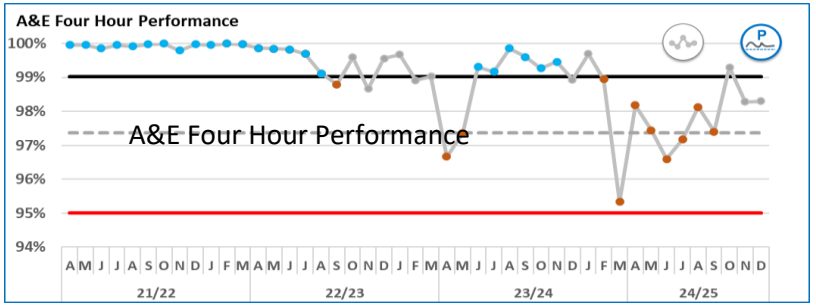
The number of patients over 52 weeks remains consistent at 9. The capacity challenges in paediatrics, adnexal and external are causing long waiting times. These patients often require transfer between sites. Weekly patient tracking meetings will continue to monitor patient pathways and expedite next events.

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

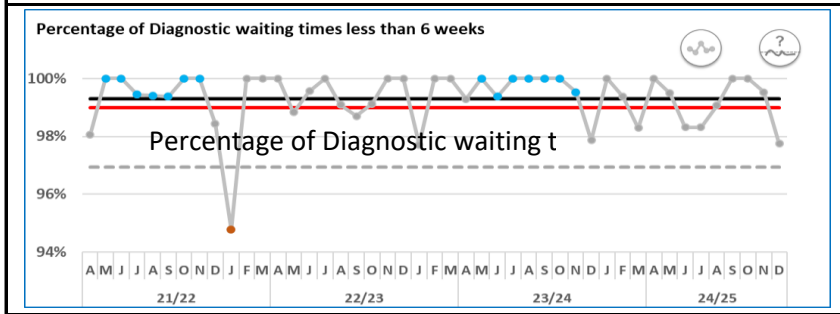
Deliver (Access Performance) - Graphs (2)



'Eliminate waits over 65 weeks for elective care' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 0.



'A&E Four Hour Performance' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 98.3%.



'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 97.8%.

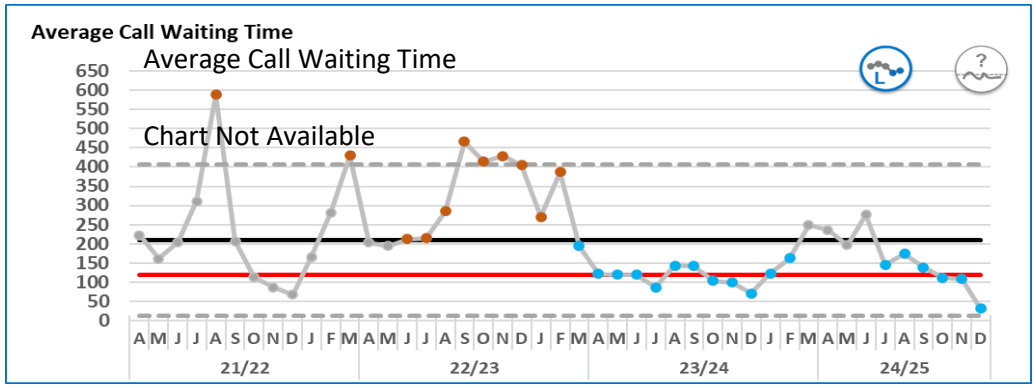
There were four patients waiting over six weeks at the end of December. Three of these patients were unavailable due to illness.

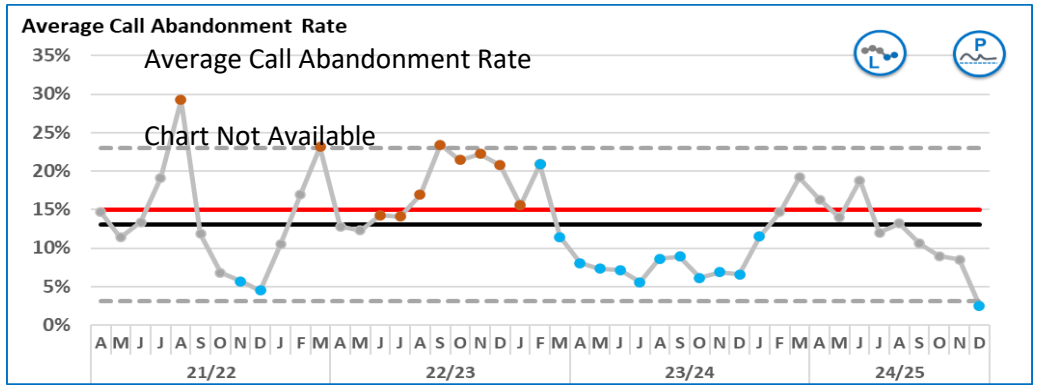
Review Date: Feb 2025 ***Action Lead:*** Kathryn Lennon

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 Requirement	Monthly	≤ 2 Mins (120 Sec)	n/a	32	L	?
Average Call Abandonment Rate	Jon Spencer	Internal Requirement	Monthly	≤15%	12.1%	2.5%	L	P
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 Requirement	Monthly (Rolling 3 Months)	≤ 2.67%	n/a	4.44%		?
VTE Risk Assessment	Jon Spencer	Statutory Reporting	Monthly	≥95%	99.8%	99.0%		P
Posterior Capsular Rupture rates (Cataract Operations Only)	Jon Spencer	Statutory Reporting	Monthly	≤1.95%	0.94%	1.00%		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)



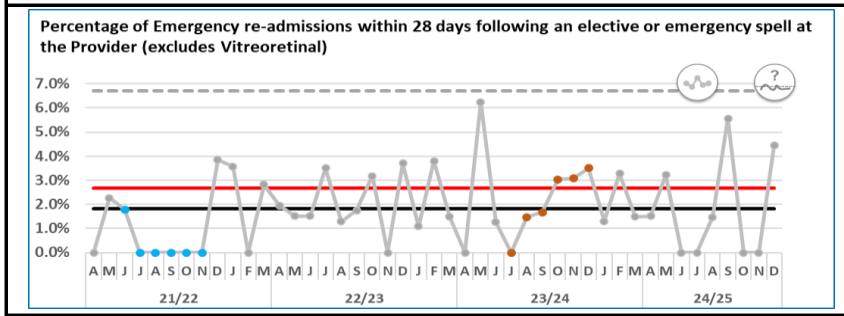
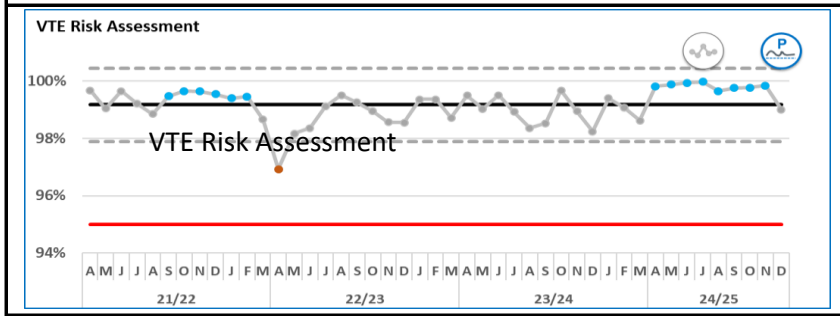
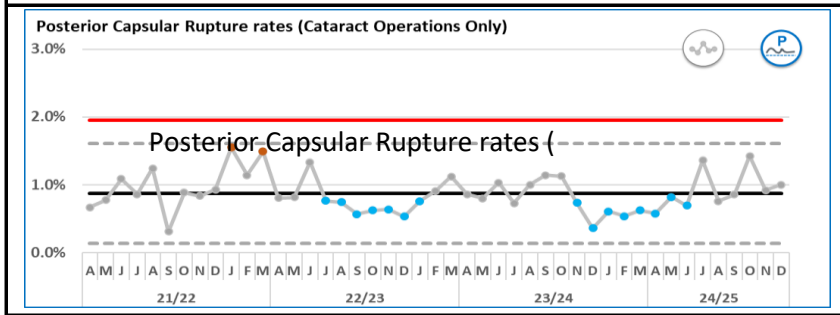


'Average Call Waiting Time' is showing 'special cause improvement' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 32.	**'Average Call Abandonment Rate' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 2.5%.**

Both metrics were achieved in month and the average call abandonment rate is now showing special cause improvement. The contact centre team is now fully established and supervisory roles are being introduced. The benefit of an earlier start time for some staff, by agreement, is improving answer times in the morning. The management team will continue to support new and existing staff to cope with peaks in demand.

Review Date: Feb 2025 ***Action Lead:*** Anoju Devi

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.
	'Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 4.44%.
	'VTE Risk Assessment' 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 99.0%.
	'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 1.00%.

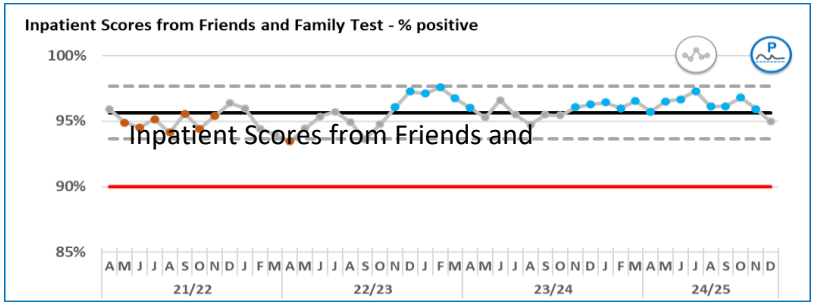
Deliver (Call Centre and Clinical) - Graphs (3)

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

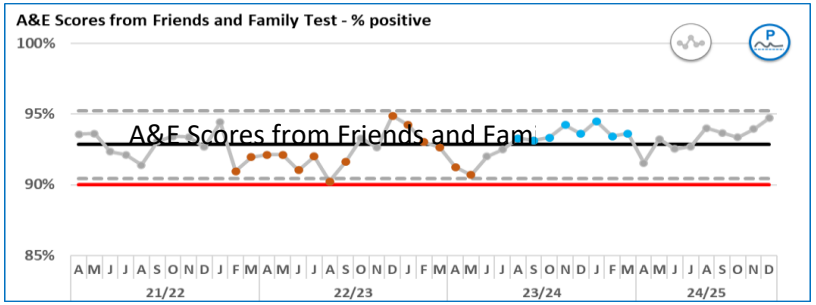
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Inpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	96.3%	95.0%		P
A&E Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	93.3%	94.7%		P
Outpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	94.6%	94.9%	H	P
Paediatric Scores from Friends and Family Test - % positive	Ian Tombleson	Internal Requirement	Monthly	≥90%	95.0%	96.3%		P
Percentage of responses to written complaints sent within 25 days	Ian Tombleson	Internal Requirement	Monthly (Month in Arrears)	≥80%	78.0%	83.3%	L	?
Percentage of responses to written complaints acknowledged within 3 days	Ian Tombleson	Internal Requirement	Monthly	≥80%	91.3%	90.0%		?
Freedom of Information Requests Responded to Within 20 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	84.0%	78.7%		F
Subject Access Requests (SARs) Responded To Within 28 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	n/a	n/a		

Deliver (Quality and Safety) - Graphs (1)



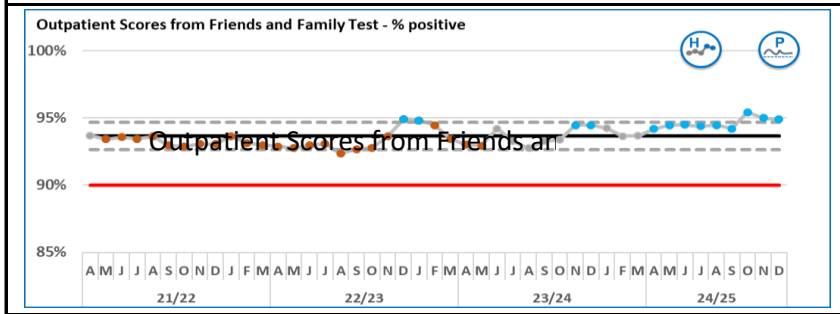
'Inpatient Scores from Friends and Family Test - % positive ' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 95.0%.

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.



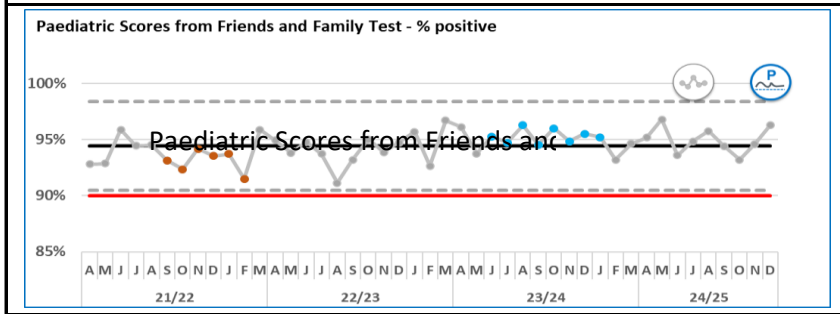
'A&E Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 94.7%.

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 94.9%.

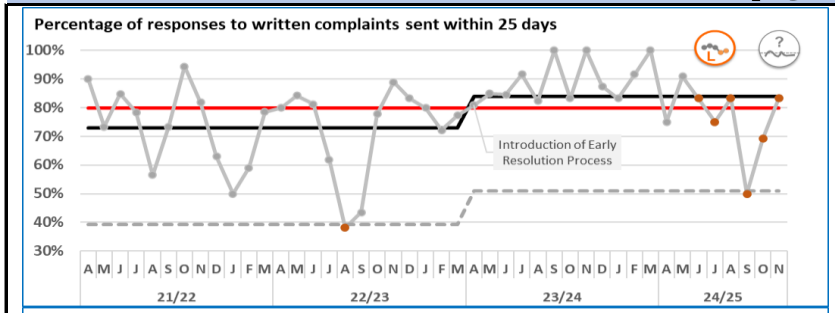
Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.

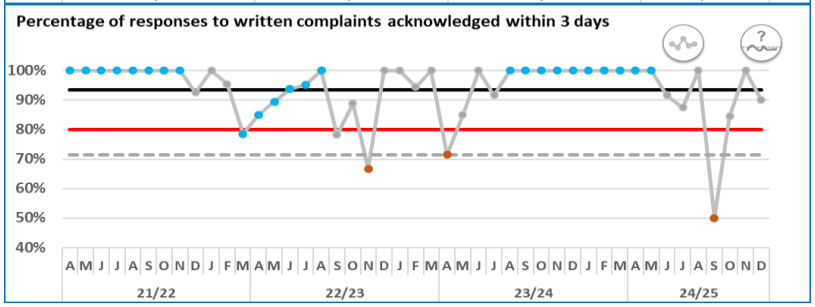


'Paediatric Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 96.3%.

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)



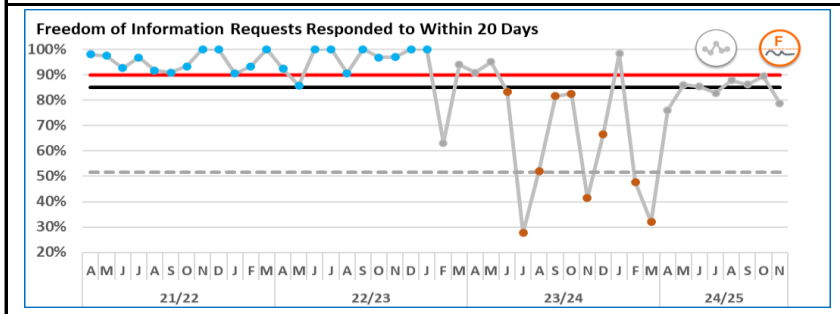


'Percentage of responses to written complaints sent within 25 days' is showing 'special cause concern' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 83.3%.

'Percentage of responses to written complaints acknowledged within 3 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 90.0%.

The team has worked hard to improve processes and focus, including better vigilance of when deadlines may be missed and improved collaborative working with divisions. Performance (back dated 2 months) has been restored for October 2024. The team need to maintain this through consistent application of process, including improved escalations to ensure targets are met on an on-going basis.

Review Date: Feb 2025 ***Action Lead:*** Robin Tall



'Freedom of Information Requests Responded to Within 20 Days' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 78.7%.

Process improvements have been made and FOI response performance is consistently better. The following further measures are in place to ensure that full performance is restored and the target is met:
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.

Review Date: Feb 2025 ***Action Lead:*** Jonathan McKee

Metric Under Review

'Subject Access Requests (SARs) Responded To Within 28 Days' for this reporting period not available.

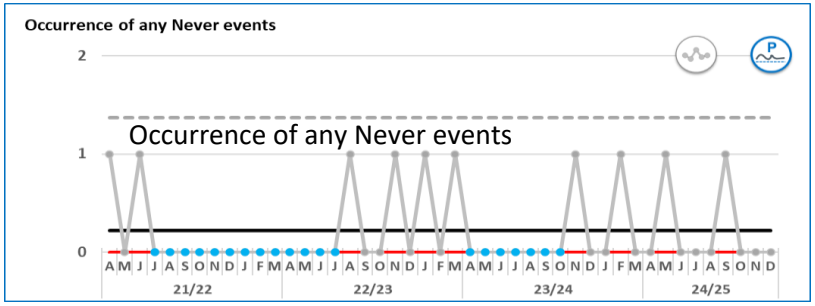
SAR data recording is temporarily suspended as the IG team are reviewing the processes across the trust to ensure that all sites and teams are reporting accurately. A new reporting process may be required.

Review Date: Feb 2025 ***Action Lead:*** Jonathan McKee

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	Statutory Reporting	Monthly	Zero Events	2	0		P
Summary Hospital Mortality Indicator	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
National Patient Safety Alerts (NatPSAs) breached	Sheila Adam	NHS Oversight Framework	Monthly	Zero Alerts	n/a	0	L	P
Number of Serious Incidents remaining open after 60 days	Sheila Adam	Statutory Reporting	Monthly	Zero Cases	1	0	L	P
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Sheila Adam	Internal Requirement	Monthly	No Target Set	n/a	307	H	

Deliver (Incident Reporting) - Graphs (1)



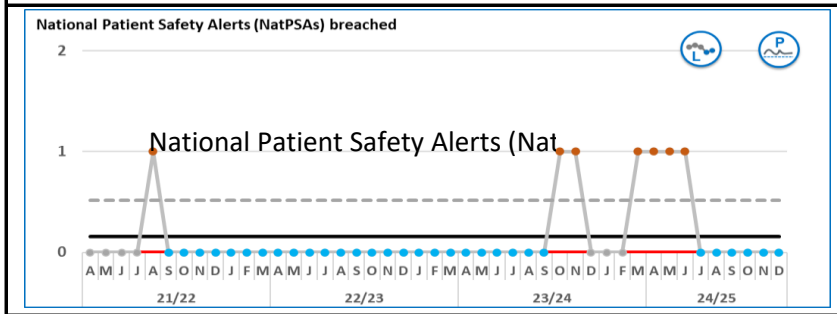
'Occurrence of any Never events ' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.

One new never event declared - a trocar (VR port) used in vitreo-retinal surgery on 8 March 2021 was retained. The incident was identified in September 2024 when the patient reported the device had fallen out of their eye. This incident will be investigated as a PSII (Patient Safety Incident Investigation).

Review Date: Feb 2025 ***Action Lead:*** Kylie Smith

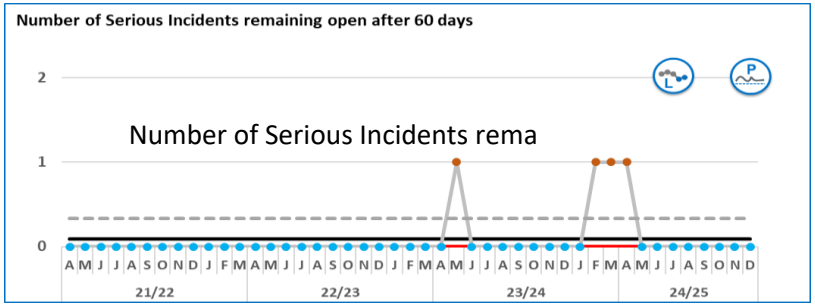
No Graph Generated, No cases reported since February 2017

'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.



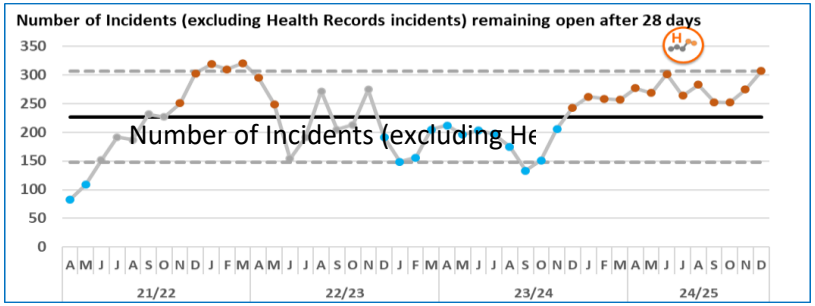
'National Patient Safety Alerts (NatPSAs) breached' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 0.

Deliver (Incident Reporting) - Graphs (2)



'Number of Serious Incidents remaining Open after 60 days' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 0.

All serious incident investigations have now been completed. Future reports will monitor patient safety incident investigation (PSII) progress.



'Number of Incidents (excluding Health Records incidents) remaining open after 28 days' is showing 'special cause concern' (increasing rate). The figure is currently at 307.

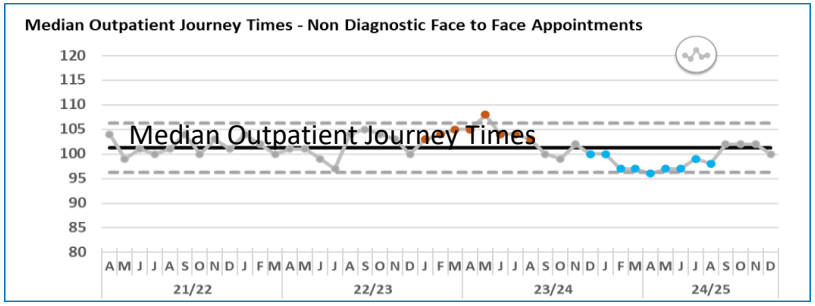
There has been an increase in the >28-days open metric, primarily driven by capacity challenges within the divisions and corporate teams. This has been further compounded by migration to OE in the North and the priority placed on EPR-related activities. The Central Quality Team is working with teams to support the closure of these incidents.

Review Date: Feb 2025 ***Action Lead:*** Julie Nott

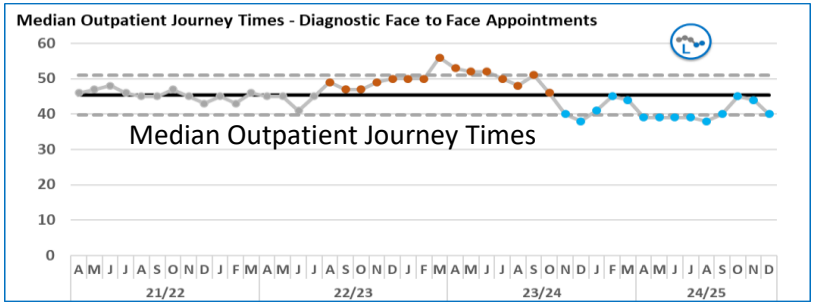
Sustainability and at Scale - Summary

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 Requirement	Monthly	No Target Set	n/a	100		
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	40		
Median Outpatient Journey Times - Virtual TeleMedicine Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	n/a		
Theatre Cancellation Rate (Non-Medical Cancellations)	Jon Spencer	Statutory Reporting	Monthly	≤0.8%	0.78%	0.37%		
Number of non-medical cancelled operations not treated within 28 days	Jon Spencer	Statutory Reporting	Monthly	Zero Breaches	6	2		
Overall financial performance (In Month Var. £m)	Justin Betts	Internal Requirement	Monthly	≥0	-11.37	-1.31		
Commercial Trading Unit Position (In Month Var. £m)	Justin Betts	Internal Requirement	Monthly	≥0	-0.97	0.16		

Sustainability and at Scale - Graphs (1)

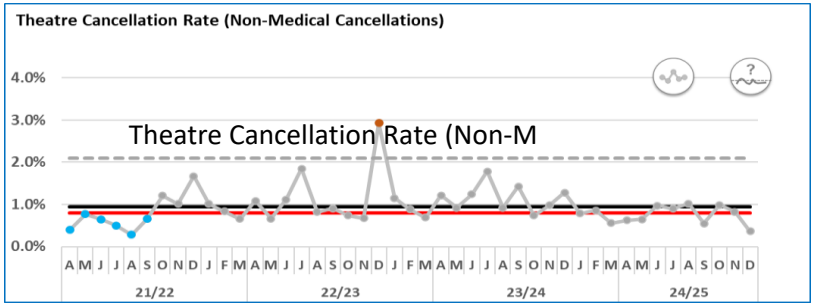


'Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments' is showing 'common cause variation'. The figure is currently at 100.

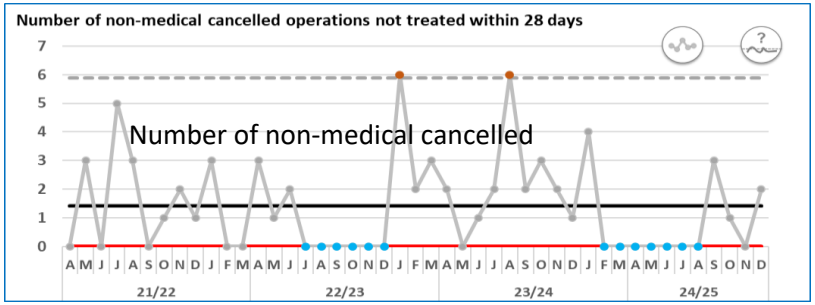


'Median Outpatient Journey Times - Diagnostic Face to Face Appointments' is showing 'special cause improvement' (decreasing rate). The figure is currently at 40.

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 0.37%.

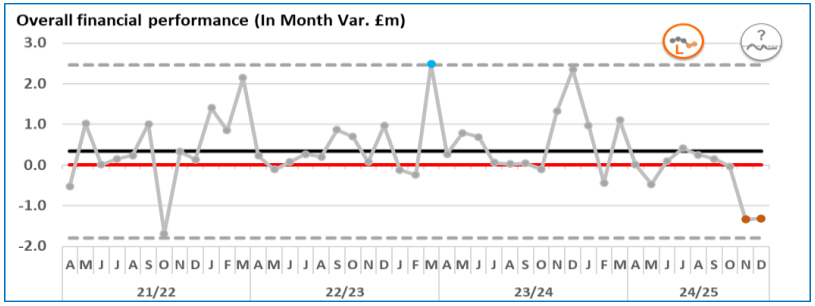


'Number of non-medical cancelled operations not treated within 28 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 2.

These patients was not prioritised for rebooking. A reminder of the requirement to rebook patients within 28 days has been given to staff.

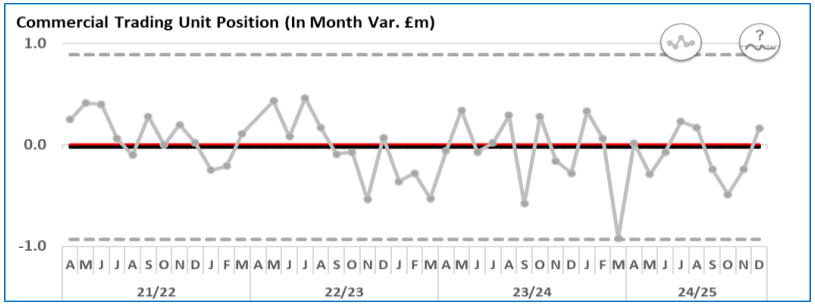
Review Date: Feb 2025 ***Action Lead:*** Kathryn Lennon

Sustainability and at Scale - Graphs (3)



'Overall financial performance (In Month Var. £m)' 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 -1.31.

For commentary, see Finance Report.



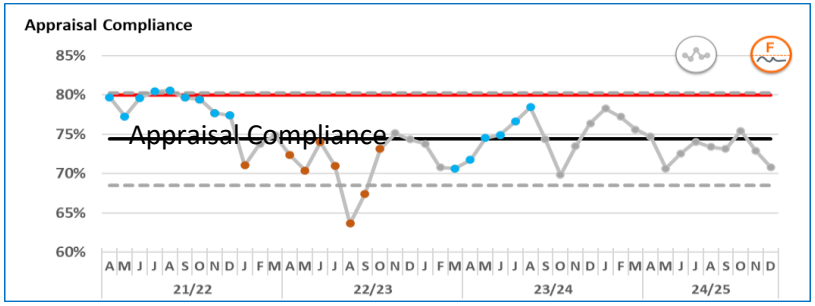
'Commercial Trading Unit Position (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.16.

For commentary, see Finance Report.

Working Together - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Appraisal Compliance	Sue Steen	Statutory Reporting	Monthly	≥80%	n/a	70.8%		F
Basic Mandatory IG Training	Samuel Armstrong	Internal Requirement	Monthly	≥90%	n/a	89.6%	L	F
Staff Sickness (Month Figure)	Sue Steen	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.9%		F
Staff Sickness (Rolling Annual Figure)	Sue Steen	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.6%		F
Recruitment Time To Hire (Days)	Sue Steen	Internal Requirement	Monthly	≤ 40 Days	n/a	39	L	?
Proportion of Temporary Staff	Sue Steen	23/24 Planning Guidance	Monthly	No Target Set	12.7%	11.4%		

Working Together - Graphs (1)

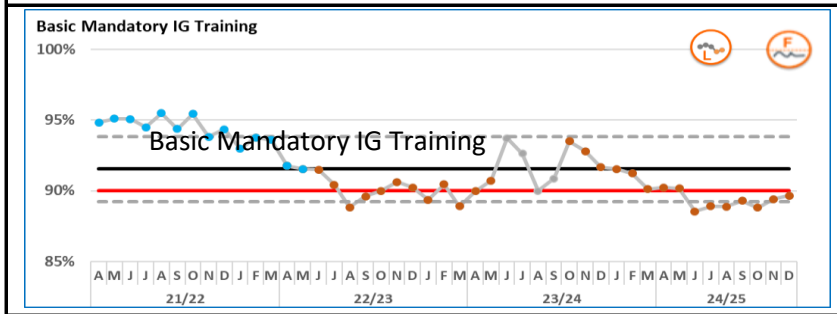


'Appraisal Compliance' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 70.8%.

Appraisal compliance is recorded as 70.8%. There has been a fluctuation between 70% and 75% over the past 3 months

As part of the ongoing implementation of the single digital appraisal process, and the introduction of an appraisal completion window effective from April 2025 work continues on:
o Liaising with managers to utilise the new scheduled weekly MaST reports This is to serve as an ongoing reminder of appraisals due to expire and also to flag gaps or errors in data enabling an active and quick turnaround in data cleansing.
o Making provision for appraisal training, with effect from February 2025, for both appraisers and appraisees to support the use of the refreshed process and ensure the meaningfulness of appraisal conversations going forward.
o Regular communications to support managers in the use of the Perform online appraisal system to achieve prompt and meaningful appraisal completion.

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

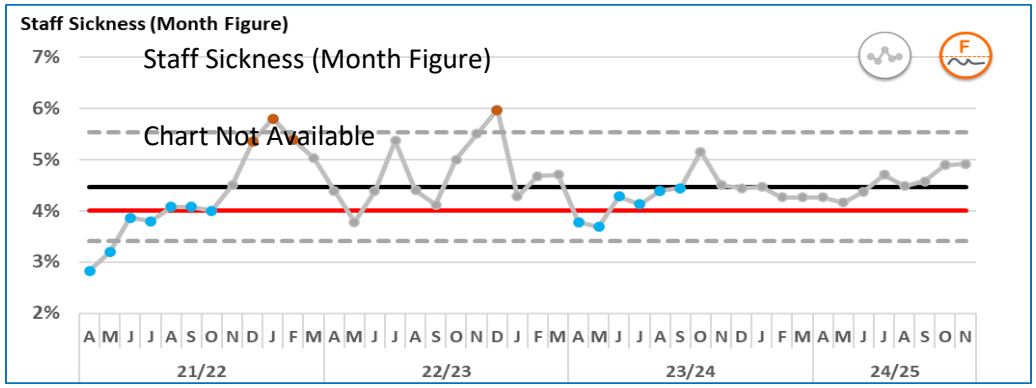


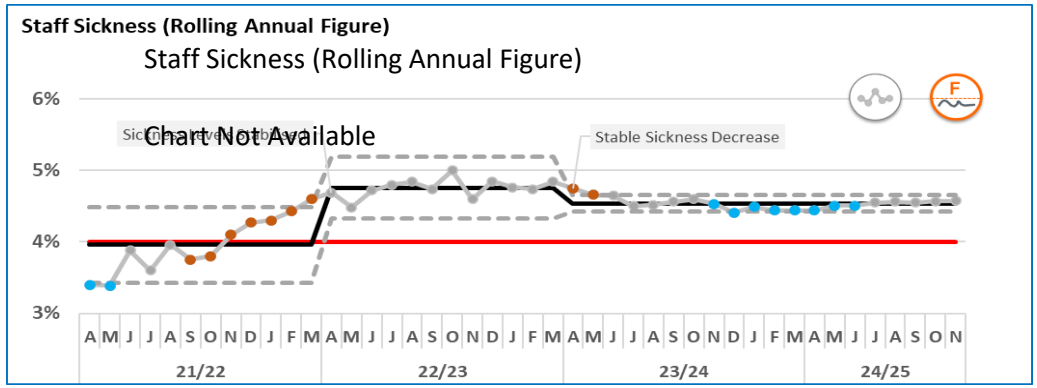
'Basic Mandatory IG Training' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 89.6%.

Monthly performance has fallen below the 90% target but is consistently very close and the monthly trend is better performance. This metric has been escalated to Management Executive and is being taken to SMT on a monthly basis to support managers identifying specific hot spots and put in place their remediation plans. Data quality issues have been re-raised with L&D and this is work in progress.

Review Date: Feb 2025 ***Action Lead:*** Jonathan McKee

Working Together - Graphs (2)





'Staff Sickness (Month Figure)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 4.9%.	**'Staff Sickness (Rolling Annual Figure)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 4.6%.**

The top 3 reasons for sickness absences continues to be:

1. Anxiety/stress/depression/other psychiatric illness,
2. Cold, Cough, Flu – Influenza
3. Other musculoskeletal problems.

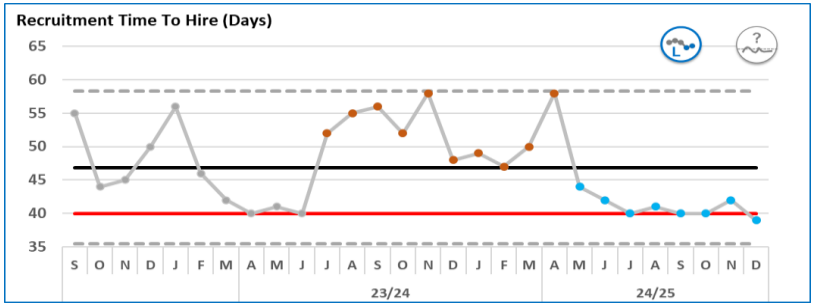
In November, there has been a rise in seasonal illnesses of flu/cold which is also one of the top 3 reasons for sickness absence.

The Employee Relations (ER) team, in collaboration with the HRBPs, continue to work closely with managers through undertaking the actions below:

- All Long-Term Sickness (LTS) that are over 100 days have case plans in place. For this month 12 LTS cases have been closed.
- Targeted sickness absence training continues to be delivered by the ER team. Sessions have been delivered to hotspot areas with high short -term sickness absence and long-term sickness rates. Targeted interventions are planned for Private, Estate and Facilities and North Divisions.
- The ER team continues to provide targeted coaching to managers in relation to the management of complex sickness absence cases. This is to provide managers with confidence and techniques in handling such cases.
- On-going promotion of Thrive, Moorfields (Wellbeing Programme) which outlines offers available to all staff such as Move at Your Desk – a Pilates and a Managing Stress Workshops both taking place in January.

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

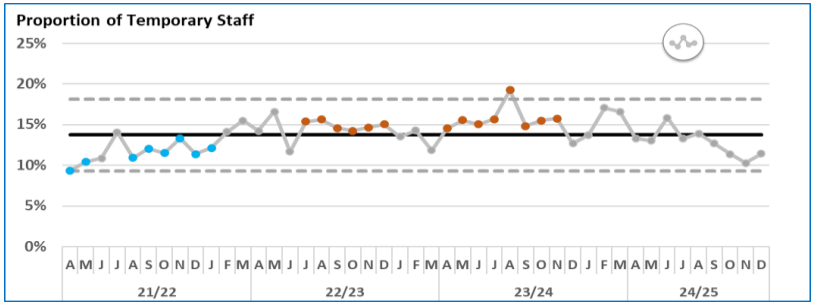
Working Together - Graphs (3)



'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 39.

The time to hire (TTH) performance for December 2024 is 39 days, which is one day under the Trust target and an improvement against 40 days in November 2024. Work is ongoing to sustain and improve the time to hire target with the Recruitment team continuing to support and advise managers, especially in hotspot areas to improve time taken to shortlist.

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



'Proportion of Temporary Staff ' is showing 'common cause variation'. The figure is currently at 11.4%.

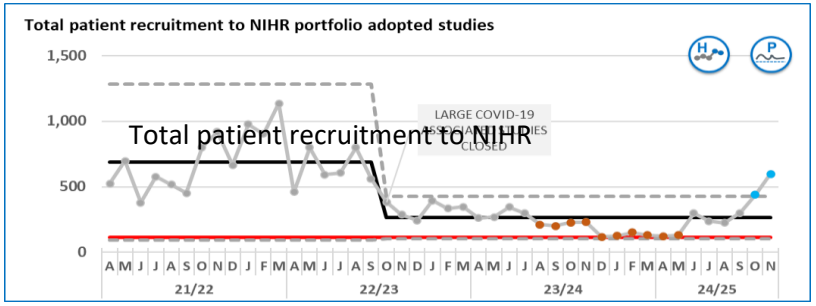
- Agency spends continues in a downward trajectory, with December spend at £325,000, with a reduction of £30,000 from November and £370,000 less than the same period in December 2023.
- Against the agency reduction target (15%) set by the NCL, the Trust had the largest percentage reduction.
- The top three reasons for temporary staffing utilisation were additional shifts, vacancy and long term sickness. The temporary staffing team and our supplier, Bank Partners, continue to work with hiring managers on utilisation and reducing spend.

Review Date: Feb 2025 ***Action Lead:*** Geoff Barsby

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 Requirement	Monthly (Month in Arrears)	≥115 (per month)	2357	599	H	P
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Hilary Fanning	Internal Requirement	Monthly (Month in Arrears)	No Target Set	2936	680	H	
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Hilary Fanning	Internal Requirement	Monthly (Month in Arrears)	≥44	n/a	60	H	P
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Hilary Fanning	Internal Requirement	Monthly (Month in Arrears)	≥2%	n/a	4.1%	L	P

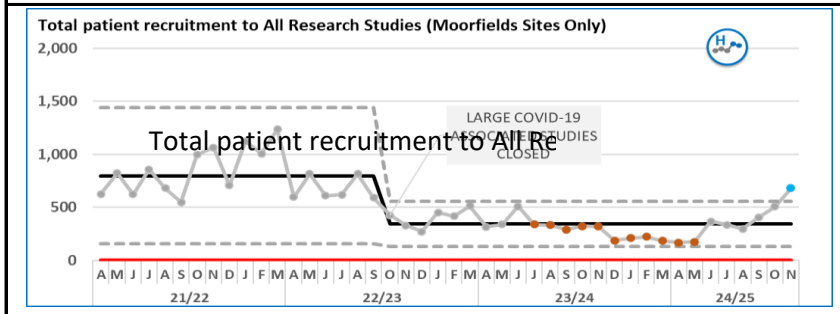
Discover - Graphs (1)



'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 599.

The number of patients recruited to NIHR Portfolio studies has increased to 599 recruits which is the highest since September 2022. To maintain these level it is important that we continue to attract more NIHR grants. We were awarded a new, substantial Efficacy and Mechanism Evaluation (EME) NIHR grant in December 2024, to investigate the role of early vitrectomy in the management of severe Diabetic Eye Disease, worth approximately 1 million pounds. We are leading this national multi-centre study, which will recruit patients from 20 NHS sites and address this major public health research question. A key contributor to this successful grant application was the new Director of Statistics in the Clinical Research Facility.

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



'Total patient recruitment to All Research Studies (Moorfields Sites Only)' is showing 'special cause improvement' (increasing rate) - This is a change from the previous month. The figure is currently at 680.

This has increased to 680 recruits which is the highest since September 2022. This reflects increased recruitment in a wide range of studies, in particular childhood Uveitis. This metric includes commercial and non- commercial studies as well as NIHR portfolio adopted and non-portfolio adopted studies. Recruitment to non-portfolio studies increased to 80 in November but is still below the average of 92 a month between June and September.

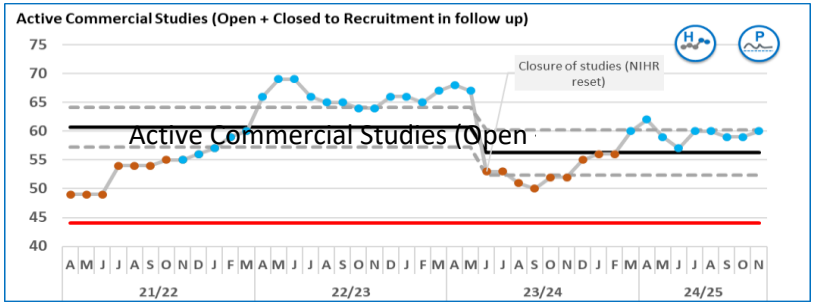
We are seeking to diversify our sources of non-commercial research funding and have been successful in obtaining funding for 3 studies, funded by sub awards from the National Eye Institute in the USA (NEI). The first of these studies, exploring the use of a new agent in the treatment of Retinitis Pigmentosa, run jointly with the John Hopkins University, Baltimore, is recruiting rapidly and Moorfields is one of the largest recruitment sites worldwide.

The new Improving Black Health Outcomes (IBHO) national multicentre Bioresource study, with a Moorfields target of over 500 and a national target of 5000, opened in October and is recruiting slowly. We are actively looking at ways to attract more patients to this important study in an ethnically diverse population. We continue to collaborate with the St George's clinical resource facility (CRF) in delivering trials there. An innovative study to explore methods of improving the consenting process for cataract surgery in non-English speaking patients in the Moorfield's satellite in Stratford is recruiting rapidly.

An interventional Thyroid Eye disease study run in UCLH by Moorfields and UCLH clinicians has met its recruitment target. We continue to have a strong, sustainable pipeline of interventional Thyroid Eye disease studies, all but one of which have met their recruitment targets.

Review Date: Feb 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 60.

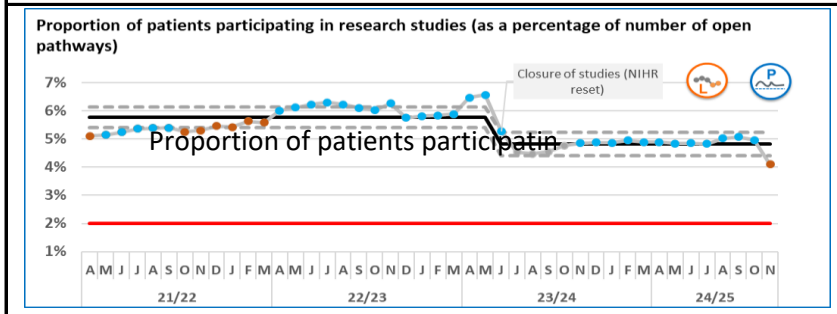
There are currently 60 commercial studies recruiting and in follow up . This is significantly higher than in 2019/20 when we was averaging 44. Our medium term goal is to increase the % of patients recruited to commercial studies from 6% to the NIHR recommended level of 25%.

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 24 hosted studies in "set up" should ensure that we continue to increase recruitment to commercial studies. 14 out of 16 (88%) of commercial studies recruited fully within the target time which meets the NIHR target of 80%. This has increased from 65% of studies in June 2023.

Some studies, commercial and non-commercial, are still taking too long to be set up. Despite data cleansing, as well as increased efforts on setting up complex studies, the median set up time increased to 126 days in November compared to 113 days at the end of October 2024. We are therefore actively looking for new innovative methods of shortening the set up time as well as ensure that studies start recruiting as soon they open. Two new commercial ocular oncology studies have opened recently, one joint with University College London Hospital, which will explore the efficacy of drug treatments for Choroidal Melanoma. The treatment of Choroidal Melanoma has not changed fundamentally for many years and the development of drug treatments for this condition is long overdue. Moorfields, as the largest centre for Choroidal Melanoma treatment in the UK is well placed to offer these treatments to patients should the drugs be shown to deliver better outcomes than current treatment.

Interventional Uveitis studies in rare diseases are notoriously difficult to recruit to, and frequently have an intensive treatment and assessment regime. We are pleased to report that the SANDCAT study, which is a global multi centre study investigating the use of a new monoclonal antibody in the treatment of intra-ocular inflammation, has over recruited against its target.

Review Date: Feb 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 - This is a change from the previous month. The figure is currently at 4.1%.

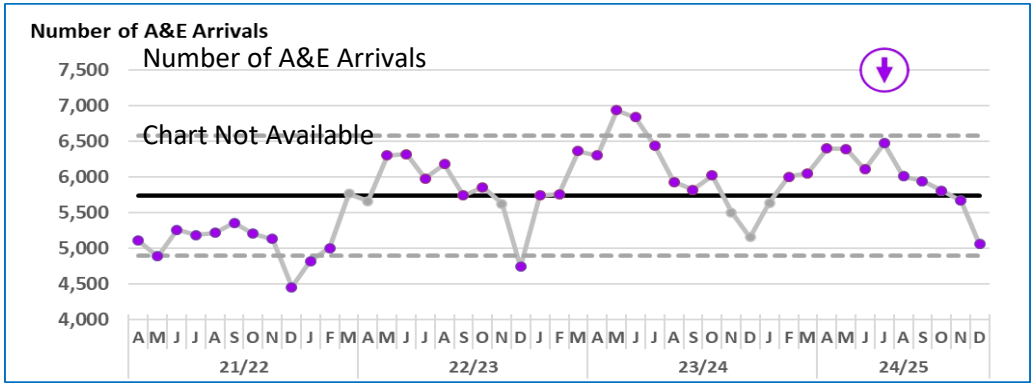
The number of patients participating in research has dropped from 13,976 to 11,544. This is due to the conclusion of the large non-commercial Hercules study. However, at 4.1% we still exceed the 2.0% target. This reflects our emphasis on and investment in patient and public engagement as part of our NIHR Biomedical Research Centre (BRC) and Clinical Research Facility (CRF) strategy. 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. We have redesigned the Research Opportunities at Moorfields (ROAM) website and will launch it in January 2025. This will continue to help raise awareness of the research opportunities available to Moorfields and non-Moorfields patients, and thus attract more patients to research studies.

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

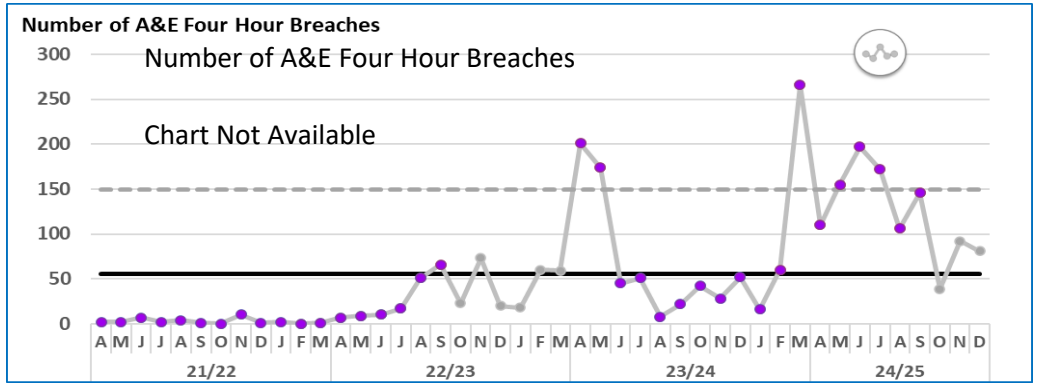
Context (Activity) - Summary

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	53859	5062		
Number of A&E Four Hour Breaches	Jon Spencer	Internal Requirement	Monthly	No Target Set	1098	81		
Number of Outpatient Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	503157	47368		
Number of Outpatient First Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	116564	11109		
Number of Outpatient Follow Up Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	386593	36259		
Number of Referrals Received	Jon Spencer	Internal Requirement	Monthly	No Target Set	144928	12693		
Number of Theatre Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	30398	2732		
Number of Theatre Elective Daycase Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	27799	2467		
Number of Theatre Elective Inpatient Admission	Jon Spencer	Internal Requirement	Monthly	No Target Set	641	55		
Number of Theatre Emergency Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	1958	210		

Context (Activity) - Graphs (1)

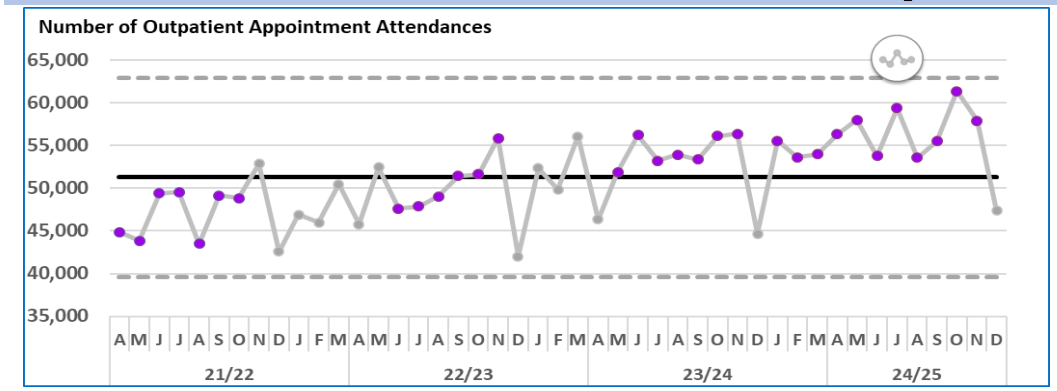


'Number of A&E Arrivals' is showing an 'special cause variation' (decreasing rate) - This is a change from the previous month. The figure is currently at 5,062.

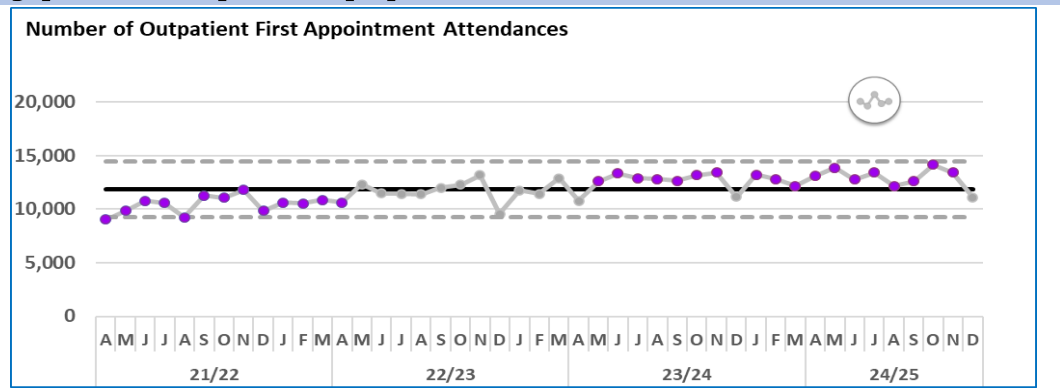


'Number of A&E Four Hour Breaches' is showing 'common cause variation'. The figure is currently at 81.

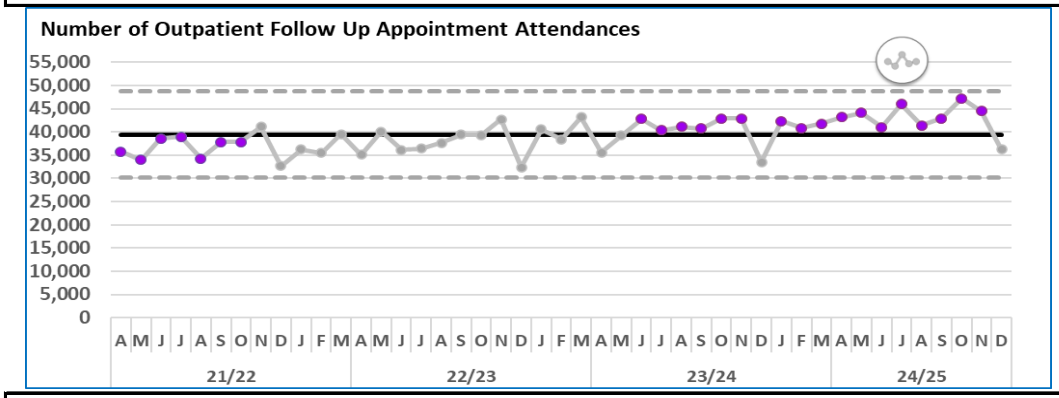
Context (Activity) - Graphs (2)



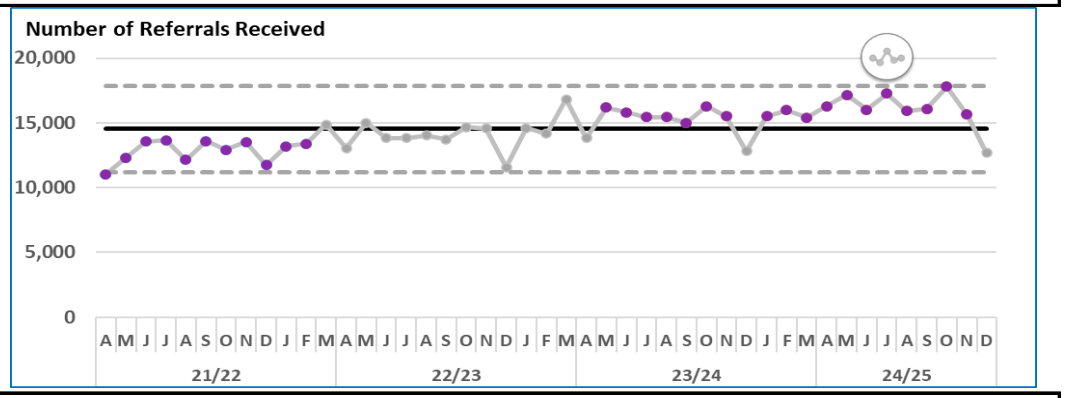
'Number of Outpatient Appointment Attendances' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 47,368.



'Number of Outpatient First Appointment Attendances' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 11,109.

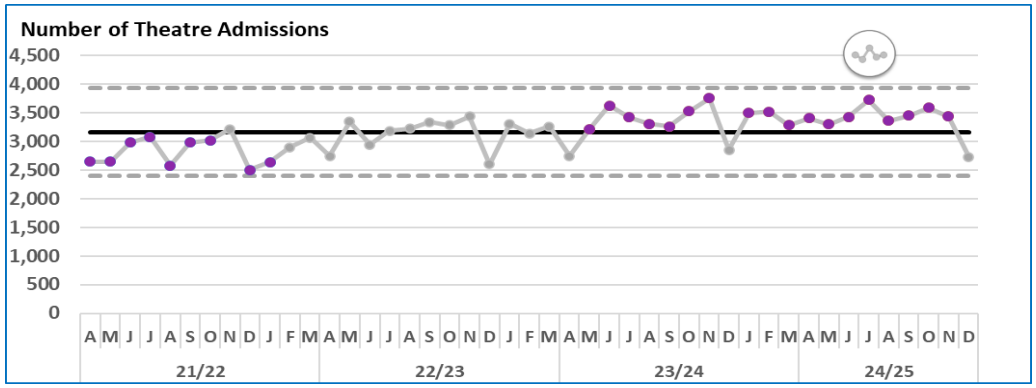


'Number of Outpatient Follow Up Appointment Attendances' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 36,259.

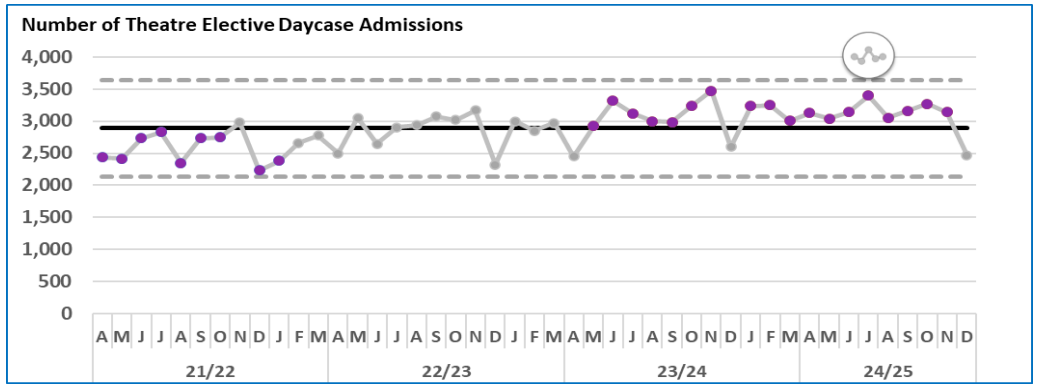


'Number of Referrals Received' is showing 'common cause variation'. The figure is currently at 12,693.

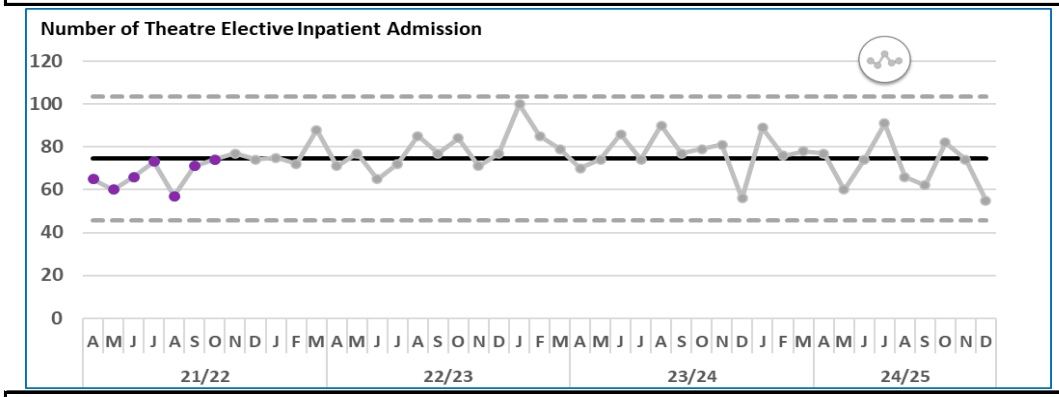
Context (Activity) - Graphs (3)



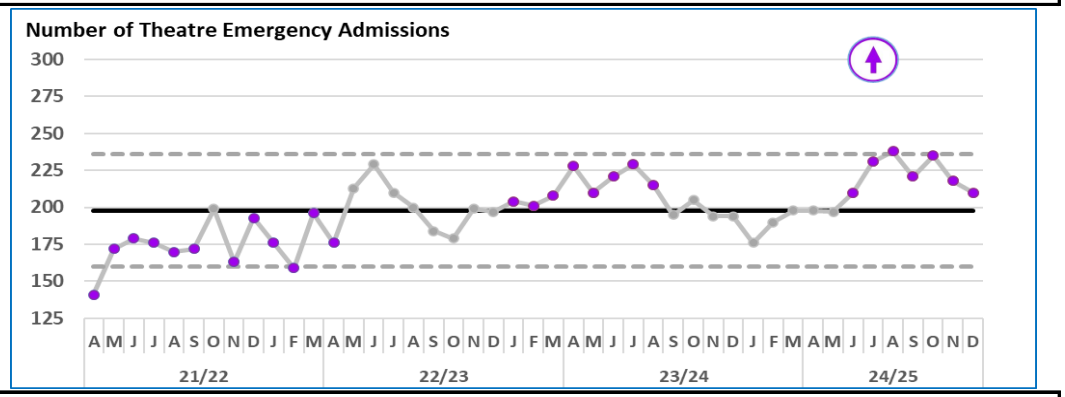
'Number of Theatre Admissions' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 2,732.



'Number of Theatre Elective Daycase Admissions' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 2,467.



'Number of Theatre Elective Inpatient Admission' is showing 'common cause variation'. The figure is currently at 55.



'Number of Theatre Emergency Admissions' is showing an 'special cause variation' (increasing rate). The figure is currently at 210.

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Deliver (Activity vs Plan)																						
Elective Activity - % of Phased Plan	Dec-24	78.5%	≥100%	Monthly	Concern (Run Below Average)	Failing	95.7%	82.2%	109.1%	103.0%	87.7%	91.7%	94.2%	98.2%	95.2%	103.6%	95.3%	93.6%	96.7%	90.6%	95.3%	78.5%
Total Outpatient Activity - % of Phased Plan	Dec-24	93.5%	≥100%	Monthly	Common Cause	Hit or Miss	99.7%	87.4%	112.0%	114.3%	96.9%	98.4%	109.2%	105.9%	108.8%	106.1%	102.0%	100.5%	104.3%	105.0%	108.8%	93.5%
Outpatient First Appointment Activity - % of Phased Plan	Dec-24	95.8%	≥100%	Monthly	Common Cause	Hit or Miss	101.0%	86.3%	115.7%	119.7%	96.2%	97.8%	102.4%	108.2%	115.1%	111.0%	100.8%	99.8%	103.7%	106.0%	110.2%	95.8%
Outpatient Follow Up Appointment Activity - % of Phased Plan	Dec-24	92.9%	≥85%	Monthly	Common Cause	Capable	99.4%	87.0%	111.8%	112.7%	97.1%	98.6%	111.2%	105.3%	107.1%	104.8%	102.3%	100.7%	104.5%	104.7%	108.4%	92.9%
Deliver (Cancer Performance)																						
Cancer 28 Day Faster Diagnosis Standard	Dec-24	80.0%	≥75%	Monthly	Common Cause	Hit or Miss	93.0%	67.3%	118.6%	100.0%	75.0%	n/a	50.0%	100.0%	80.0%	100.0%	75.0%	88.9%	77.8%	55.6%	100.0%	80.0%
% Patients with all cancers receiving treatment within 31 days of decision to treat	Dec-24	n/a	≥96%	Monthly	Not Available	Not Applicable	99.4%	96.5%	102.3%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	n/a
% Patients with all cancers treated within 62 days	Dec-24	n/a	≥85%	Monthly	Not Available	Not Applicable	96.6%	70.0%	123.2%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	n/a	n/a

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Deliver (Access Performance)																						
18 Week RTT Incomplete Performance	Dec-24	81.2%	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	80.5%	78.2%	82.8%	82.5%	82.7%	82.9%	83.3%	85.0%	85.4%	84.3%	84.0%	82.6%	82.7%	82.4%	82.6%	81.2%
RTT Incomplete Pathways (RTT Waiting List)	Dec-24	33,039	≤ Previous Mth.	Monthly	Improvement (Run Below Average)	Not Applicable	36,351	34,641	38,061	35,138	34,639	35,233	35,656	35,674	35,682	34,201	33,017	34,357	34,932	33,872	33,281	33,039
RTT Incomplete Pathways Over 18 Weeks	Dec-24	6,222	≤ Previous Mth.	Monthly	Decreasing (Run Below Average)	Not Applicable	7,120	6,201	8,039	6,148	6,000	6,012	5,962	5,361	5,205	5,377	5,271	5,966	6,038	5,963	5,801	6,222
52 Week RTT Incomplete Breaches	Dec-24	9	≤5 Breaches	Monthly	Common Cause	Failing	10	-4	24	20	7	5	10	5	10	7	8	10	8	13	9	9
Eliminate waits over 65 weeks for elective care	Dec-24	0	Zero Breaches	Monthly	Common Cause	Hit or Miss	3	-4	11	14	4	3	1	1	4	3	2	4	2	2	2	0
A&E Four Hour Performance	Dec-24	98.3%	≥95%	Monthly	Common Cause	Capable	99.0%	97.4%	100.7%	98.9%	99.7%	98.9%	95.3%	98.2%	97.4%	96.6%	97.2%	98.1%	97.4%	99.3%	98.3%	98.3%
Percentage of Diagnostic waiting times less than 6 weeks	Dec-24	97.8%	≥99%	Monthly	Common Cause	Hit or Miss	99.3%	96.9%	101.7%	97.9%	100.0%	99.4%	98.3%	100.0%	99.5%	98.3%	98.3%	99.1%	100.0%	100.0%	99.5%	97.8%
Deliver (Call Centre and Clinical)																						
Average Call Waiting Time	Dec-24	32	≤ 2 Mins (120 Sec)	Monthly	Improvement (Lower Than Expected)	Hit or Miss	211	14	408	72	124	163	249	236	197	276	146	174	139	112	109	32
Average Call Abandonment Rate	Dec-24	2.5%	≤15%	Monthly	Improvement (Lower Than Expected)	Capable	13.1%	3.1%	23.1%	6.6%	11.5%	14.7%	19.2%	16.3%	14.0%	18.8%	12.0%	13.2%	10.6%	9.0%	8.5%	2.5%
Mixed Sex Accommodation Breaches	Dec-24	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)	Dec-24	4.44%	≤ 2.67%	Monthly (Rolling 3 Months)	Common Cause	Hit or Miss	1.81%	-3.08%	6.71%	3.51%	1.30%	3.28%	1.49%	1.52%	3.23%	0.00%	0.00%	1.47%	5.56%	0.00%	0.00%	4.44%
VTE Risk Assessment	Dec-24	99.0%	≥95%	Monthly	Common Cause	Capable	99.2%	97.9%	100.4%	98.2%	99.4%	99.1%	98.6%	99.8%	99.9%	99.9%	100.0%	99.7%	99.8%	99.8%	99.8%	99.0%
Posterior Capsular Rupture rates (Cataract Operations Only)	Dec-24	1.00%	≤1.95%	Monthly	Common Cause	Capable	0.87%	0.13%	1.61%	0.36%	0.61%	0.54%	0.62%	0.58%	0.82%	0.69%	1.36%	0.76%	0.85%	1.42%	0.92%	1.00%
MRSA Bacteraemias Cases	Dec-24	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	Dec-24	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	Dec-24	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	Dec-24	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	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Deliver (Quality and Safety)																						
Inpatient Scores from Friends and Family Test - % positive	Dec-24	95.0%	≥90%	Monthly	Common Cause	Capable	95.7%	93.6%	97.7%	96.3%	96.4%	96.0%	96.5%	95.7%	96.5%	96.7%	97.3%	96.1%	96.2%	96.8%	95.9%	95.0%
A&E Scores from Friends and Family Test - % positive	Dec-24	94.7%	≥90%	Monthly	Common Cause	Capable	92.8%	90.4%	95.3%	93.6%	94.5%	93.4%	93.6%	91.5%	93.2%	92.5%	92.7%	94.0%	93.7%	93.4%	93.9%	94.7%
Outpatient Scores from Friends and Family Test - % positive	Dec-24	94.9%	≥90%	Monthly	Improvement (Run Above Average)	Capable	93.7%	92.6%	94.7%	94.5%	94.2%	93.6%	93.7%	94.2%	94.5%	94.5%	94.4%	94.4%	94.2%	95.4%	95.0%	94.9%
Paediatric Scores from Friends and Family Test - % positive	Dec-24	96.3%	≥90%	Monthly	Common Cause	Capable	94.4%	90.5%	98.4%	95.5%	95.2%	93.2%	94.6%	95.2%	96.8%	93.6%	94.8%	95.8%	94.4%	93.2%	94.6%	96.3%
Percentage of responses to written complaints sent within 25 days	Nov-24	83.3%	≥80%	Monthly (Month in Arrears)	Concern (Run Below Average)	Hit or Miss	84.0%	50.9%	117.2%	87.5%	83.3%	91.7%	100.0%	75.0%	90.9%	83.3%	75.0%	83.3%	50.0%	69.2%	83.3%	n/a
Percentage of responses to written complaints acknowledged within 3 days	Dec-24	90.0%	≥80%	Monthly	Common Cause	Hit or Miss	93.6%	71.5%	115.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	87.5%	100.0%	50.0%	84.6%	100.0%	90.0%
Freedom of Information Requests Responded to Within 20 Days	Nov-24	78.7%	≥90%	Monthly (Month in Arrears)	Common Cause	Failing	84.9%	51.7%	118.1%	66.7%	98.3%	47.7%	32.0%	76.1%	86.0%	85.4%	82.8%	87.8%	86.1%	89.4%	78.7%	n/a
Subject Access Requests (SARs) Responded To Within 28 Days	Nov-24	n/a	≥90%	Monthly (Month in Arrears)	Not Available	Not Applicable				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	Dec-24	0	Zero Events	Monthly	Common Cause	Hit or Miss	0	-1	1	0	0	1	0	0	1	0	0	0	1	0	0	0
Summary Hospital Mortality Indicator	Dec-24	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	Dec-24	0	Zero Alerts	Monthly	Improvement (Run Below Average)	Capable	0	0	1	0	0	0	1	1	1	1	0	0	0	0	0	0
Number of Serious Incidents remaining open after 60 days	Dec-24	0	Zero Cases	Monthly	Improvement (Run Below Average)	Capable	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Dec-24	307	No Target Set	Monthly	Concern (Run Above Average)	Not Applicable	227	147	307	243	262	259	257	277	269	302	264	283	253	252	275	307

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Sustainability and at Scale																						
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Dec-24	100	No Target Set	Monthly	Common Cause	Not Applicable	101	96	106	100	100	97	97	96	97	97	99	98	102	102	102	100
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Dec-24	40	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	45	40	51	38	41	45	44	39	39	39	39	38	40	45	44	40
Theatre Cancellation Rate (Non-Medical Cancellations)	Dec-24	0.37%	≤0.8%	Monthly	Common Cause	Hit or Miss	0.95%	-0.19%	2.09%	1.28%	0.79%	0.86%	0.56%	0.62%	0.65%	0.97%	0.90%	1.02%	0.55%	0.99%	0.82%	0.37%
Number of non-medical cancelled operations not treated within 28 days	Dec-24	2	Zero Breaches	Monthly	Common Cause	Hit or Miss	1	-3	6	1	4	0	0	0	0	0	0	0	3	1	0	2
Overall financial performance (In Month Var. £m)	Dec-24	-1.31	≥0	Monthly	Concern (Lower Than Expected)	Hit or Miss	0.34	-1.79	2.47	2.35	0.98	-0.44	1.10	0.01	-0.47	0.09	0.41	0.25	0.15	-0.03	-1.34	-1.31
Commercial Trading Unit Position (In Month Var. £m)	Dec-24	0.16	≥0	Monthly	Common Cause	Hit or Miss	-0.02	-0.93	0.89	-0.28	0.33	0.06	-0.92	0.02	-0.29	-0.07	0.23	0.17	-0.24	-0.49	-0.24	0.16
Working Together																						
Appraisal Compliance	Dec-24	70.8%	≥80%	Monthly	Common Cause	Failing	74.4%	68.5%	80.3%	76.4%	78.3%	77.2%	75.6%	74.7%	70.6%	72.5%	74.1%	73.4%	73.1%	75.5%	72.9%	70.8%
Basic Mandatory IG Training	Dec-24	89.6%	≥90%	Monthly	Concern (Run Below Average)	Failing	91.5%	89.2%	93.8%	91.6%	91.5%	91.2%	90.1%	90.2%	90.1%	88.5%	88.9%	88.9%	89.3%	88.8%	89.4%	89.6%
Staff Sickness (Month Figure)	Nov-24	4.9%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.5%	3.4%	5.5%	4.4%	4.5%	4.3%	4.3%	4.3%	4.2%	4.4%	4.7%	4.5%	4.6%	4.9%	4.9%	n/a
Staff Sickness (Rolling Annual Figure)	Nov-24	4.6%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.5%	4.4%	4.7%	4.4%	4.5%	4.4%	4.4%	4.4%	4.5%	4.5%	4.5%	4.6%	4.5%	4.6%	4.6%	n/a
Recruitment Time To Hire (Days)	Dec-24	39	≤ 40 Days	Monthly	Improvement (Run Below Average)	Hit or Miss	47	35	58	48	49	47	50	58	44	42	40	41	40	40	42	39
Proportion of Temporary Staff	Dec-24	11.4%	No Target Set	Monthly	Common Cause	Not Applicable	13.7%	9.3%	18.2%	12.7%	13.7%	17.1%	16.6%	13.3%	13.0%	15.9%	13.3%	13.9%	12.7%	11.4%	10.3%	11.4%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Discover																						
Total patient recruitment to NIHR portfolio adopted studies	Nov-24	599	≥115 (per month)	Monthly (Month in Arrears)	Improvement (Higher Than Expected)	Capable	266	105	427	118	127	153	132	124	132	299	239	226	300	438	599	n/a
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Nov-24	680	No Target Set	Monthly (Month in Arrears)	Improvement (Higher Than Expected)	Not Applicable	343	132	554	187	209	224	185	169	174	367	335	298	407	506	680	n/a
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Nov-24	60	≥44	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	56	52	60	55	56	56	60	62	59	57	60	60	59	59	60	n/a
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Nov-24	4.1%	≥2%	Monthly (Month in Arrears)	Concern (Lower Than Expected)	Capable	4.8%	4.4%	5.2%	4.9%	4.9%	5.0%	4.9%	4.9%	4.8%	4.9%	4.8%	5.0%	5.1%	5.0%	4.1%	n/a
Context (Activity)																						
Number of A&E Arrivals	Dec-24	5,062	No Target Set	Monthly	Decreasing (Decreasing Trend)	Not Applicable	5,738	4,902	6,574	5,161	5,636	6,001	6,053	6,401	6,394	6,105	6,469	6,011	5,943	5,807	5,667	5,062
Number of A&E Four Hour Breaches	Dec-24	81	No Target Set	Monthly	Common Cause	Not Applicable	56	-38	149	52	16	60	266	110	155	197	172	106	146	39	92	81
Number of Outpatient Appointment Attendances	Dec-24	47,368	No Target Set	Monthly	Common Cause	Not Applicable	51,291	39,630	62,951	44,678	55,529	53,622	53,958	56,323	57,991	53,776	59,367	53,585	55,497	61,352	57,898	47,368
Number of Outpatient First Appointment Attendances	Dec-24	11,109	No Target Set	Monthly	Common Cause	Not Applicable	11,852	9,261	14,443	11,156	13,224	12,823	12,155	13,101	13,882	12,766	13,400	12,158	12,606	14,144	13,398	11,109
Number of Outpatient Follow Up Appointment Attendances	Dec-24	36,259	No Target Set	Monthly	Common Cause	Not Applicable	39,439	30,135	48,742	33,522	42,305	40,799	41,803	43,222	44,109	41,010	45,967	41,427	42,891	47,208	44,500	36,259
Number of Referrals Received	Dec-24	12,693	No Target Set	Monthly	Common Cause	Not Applicable	14,539	11,205	17,873	12,818	15,519	16,000	15,419	16,303	17,170	16,006	17,261	15,923	16,089	17,821	15,662	12,693
Number of Theatre Admissions	Dec-24	2,732	No Target Set	Monthly	Common Cause	Not Applicable	3,164	2,392	3,936	2,850	3,498	3,518	3,279	3,401	3,294	3,424	3,723	3,357	3,447	3,586	3,434	2,732
Number of Theatre Elective Daycase Admissions	Dec-24	2,467	No Target Set	Monthly	Common Cause	Not Applicable	2,892	2,141	3,642	2,600	3,233	3,252	3,003	3,126	3,037	3,140	3,401	3,053	3,164	3,269	3,142	2,467
Number of Theatre Elective Inpatient Admission	Dec-24	55	No Target Set	Monthly	Common Cause	Not Applicable	75	46	104	56	89	76	78	77	60	74	91	66	62	82	74	55
Number of Theatre Emergency Admissions	Dec-24	210	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	198	160	236	194	176	190	198	198	197	210	231	238	221	235	218	210

Moorfields Eye Hospital NHS Foundation Trust

NHS

Report title	Monthly Finance Performance Report Month 09 – December 2024
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 December, the trust is reporting:-

Financial Performance £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Plan	Actual	Variance
Income	£349.8m	£29.3m	£30.4m	£1.2m	£260.3m	£263.0m	£2.6m
Pay	(£189.3m)	(£15.9m)	(£16.1m)	(£0.2m)	(£141.4m)	(£142.2m)	(£0.9m)
Non Pay	(£121.4m)	(£9.0m)	(£10.2m)	(£1.2m)	(£90.6m)	(£93.6m)	(£3.0m)
Financing & Adjustments	(£33.8m)	(£6.7m)	(£6.6m)	£0.1m	(£25.1m)	(£25.0m)	£0.1m
CONTROL TOTAL	**£5.4m**	**(£2.4m)**	**(£2.5m)**	**(£0.1m)**	**£3.2m**	**£2.2m**	**(£1.1m)**

Income and Expenditure

- A £2.17m surplus year to date compared to a planned surplus of £3.23m; £1.05m adverse to plan.
- The £1.05m adverse variance YTD is comprised of:-
  - £1.49m favourable slippage in IT EPR and IT project workstreams.
  - £(2.54)m adverse core operational performance.
- The Trust has engaged with the ICB in regard to a revised full year financial forecast below the original planned £5.4m surplus.

Capital Expenditure

- Capital expenditure as of 31st December totalled £59.8m.
  - Business as usual capital totals £2.1m.
  - Other capital totals £57.7m with £53.6m of Oriel expenditure, £2.0m EPR expenditure and £0.6m of NIHR research expenditure.
  - IFRS16 lease capital totals £1.6m
- Business as usual capital allocations have been fully committed, and forecast.

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 31st December 2024 (Month 09)

Report Period	M09 | December 2024
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 31st December 2024 (Month 09)

Key Messages

Statement of Comprehensive Income

Financial Position £2.46m deficit in month	For December, the trust is reporting:- • A £2.46m deficit in-month against a planned deficit of £2.46m, a £0.07m adverse variance to plan • A £2.17m surplus cumulatively against a planned surplus of £3.23m, £1.06m adverse to plan.

Key Drivers of the Financial Variance	The £1.06m adverse variance cumulatively is comprised of:-
	• £1.49m favourable slippage in IT EPR and IT project workstreams.
	• (£2.55)m adverse core operational performance
	
	Key Drivers of the adverse core operational performance include:-
	• Clinical divisions and core activity performance including efficiencies under-delivery are reporting £(5.55)m adverse cumulatively.
	  • Elective activity is 77% In December, 94% cumulatively of revised activity plans; reporting £3m behind demand plans in terms of volume, offset by £1.3m price mix gains.
	  • Stratford elective activity is 57% of revised demand plans cumulatively.
	  • St Ann's elective activity is 51% of revised demand plans cumulatively.
	  • Cataract activity is 73% of revised demand plans cumulatively.
	  • Outpatients Firsts and Procedures are 99% and 102% respectively cumulatively, partially offsetting underperformance on elective activity.
	• Research is reporting a £(1.21)m adverse cumulatively comprised of research costs in excess of study activity, lower than planned commercial IP income, and higher than planned management and strategic project costs.
	• Corporate areas (excluding IT EPR and IT project workstreams) are reporting £(1.38)m adverse cumulatively, predominantly linked to higher than planned legal fees (£0.30)m and undelivered CIP (£0.83)m.
	• Trading areas are £(0.98)m adverse to plan cumulatively across all commercial units.
	• Depreciation & financing, and central budgets are supporting the above position primarily consisting of £1.7m depreciation and financing linked to capital programme slippage and interest on cash balances, and £1.9m non recurrent and prior year benefits.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 31st December was £68.7m, a reduction of £2.0m since the end of March 2024.This equates to approximately 83 days operating cash. The Better Payment Practice Code (BPPC) performance in December was 95% (volume) and 95% (value) against a target of 95% across both metrics.
Capital (both gross capital expenditure and CDEL)	Capital expenditure as of 31st December totalled £59.8m. • Business as usual capital totals £2.1m. • Other capital totals £57.7m with £53.6m of Oriel expenditure, £2.0m EPR expenditure and £0.6m of NIHR research expenditure. • IFRS16 lease capital of £1.6m Business as usual capital allocations have been fully committed, and forecast.

Other Key Information

Efficiencies £11.2m Trust Target £7.0m Forecast	The trust has a planned efficiency programme of £11.2m for 2024/25 to deliver the control total. The trust has identified and is forecasting £7.0m, leaving a remaining £4.2m to be identified. Of the total identified:- • £5.9m is identified central schemes • £4.7m is identified as income generation schemes; • £4.3m is forecast recurrently; The CIP programme are working through efficiency scheme delivery for further opportunities to be fully financial validated towards increasing the level of identified and forecast delivery in 2024/25.
Agency Spend £4.90m spend YTD 3.4% total pay	Trust wide agency spend totals £4.90m cumulatively, approximately 3.4% of total employee expenses spend, below the system allocated target of 4.8%. 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	£349.8m	£29.3m	£30.4m	£1.2m	£260.3m	£263.0m	£2.6m	1%	
Pay	(£189.3m)	(£15.9m)	(£16.1m)	(£0.2m)	(£141.4m)	(£142.2m)	(£0.9m)	(1)%	
Non Pay	(£121.4m)	(£9.0m)	(£10.2m)	(£1.2m)	(£90.6m)	(£93.6m)	(£3.0m)	(3)%	
Financing & Adjustments	(£33.8m)	(£6.7m)	(£6.6m)	£0.1m	(£25.1m)	(£25.0m)	£0.1m	1%	
CONTROL TOTAL	**£5.4m**	**(£2.4m)**	**(£2.5m)**	**(£0.1m)**	**£3.2m**	**£2.2m**	**(£1.1m)**		
Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income									
Memorandum Items									
Research & Development	(£0.08m)	£0.05m	(£0.02m)	(£0.08m)	(£0.26m)	(£1.46m)	(£1.21m)	(472)%	
Commercial Trading Units	£6.05m	(£0.22m)	(£0.06m)	£0.16m	£3.97m	£3.00m	(£0.97m)	(25)%	
ORIEL Revenue	(£1.39m)	(£0.18m)	(£0.50m)	(£0.33m)	(£0.86m)	(£1.17m)	(£0.31m)	(36)%	
Efficiency Schemes	£11.20m	£0.93m	£0.49m	(£0.44m)	£8.40m	£5.32m	(£3.08m)	(37)%	

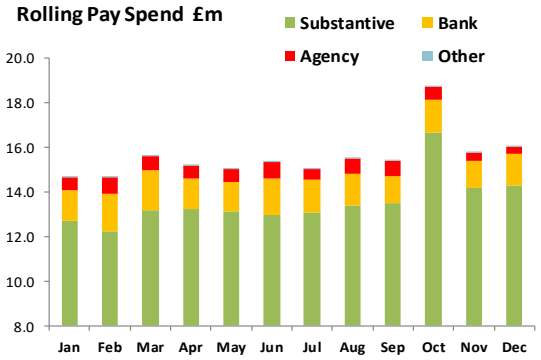
INCOME BREAKDOWN RELATED TO ACTIVITY

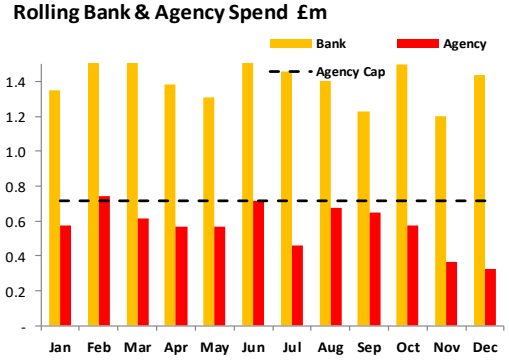
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£209.6m	£156.8m	£158.7m	£1.9m				
Pass Through	£39.7m	£29.9m	£29.7m	(£0.1m)				
Other NHS Clinical Income	£10.2m	£7.5m	£8.7m	£1.2m				
Commercial Trading Units	£46.7m	£34.2m	£33.4m	(£0.9m)				
Research & Development	£16.4m	£11.9m	£10.9m	(£1.0m)				
Other	£27.2m	£20.1m	£21.6m	£1.5m				
INCOME INCL ERF	**£349.8m**	**£260.3m**	**£263.0m**	**£2.6m**				

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	(£186.7m)	(£15.7m)	(£14.3m)	£1.4m	(£139.5m)	(£124.3m)	£15.2m	87%
Bank	(£1.6m)	(£0.1m)	(£1.4m)	(£1.3m)	(£1.2m)	(£12.6m)	(£11.4m)	9%
Agency	(£0.4m)	(£0.0m)	(£0.3m)	(£0.3m)	(£0.2m)	(£4.9m)	(£4.7m)	3%
Other	(£0.6m)	(£0.1m)	(£0.1m)	(£0.0m)	(£0.5m)	(£0.5m)	(£0.0m)	0%
TOTAL PAY	**(£189.3m)**	**(£15.9m)**	**(£16.1m)**	**(£0.2m)**	**(£141.4m)**	**(£142.2m)**	**(£0.9m)**	





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

*Agency cap levels set by NHSIE

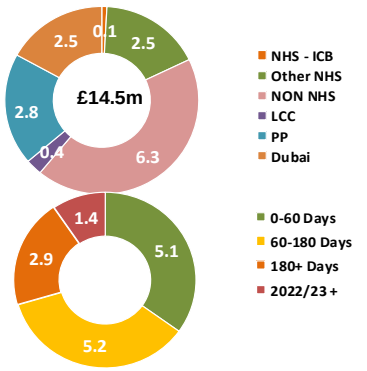
CASH, CAPITAL AND OTHER KPI'S

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	(£7.4m)	(£2.8m)	(£2.1m)	(£0.7m)				
Donated/Externally funded	(£119.0m)	(£75.5m)	(£53.6m)	(£21.9m)				
TOTAL	**£126.4m**	**£78.3m**	**£55.7m**	**(£22.7m)**				

Key Metrics	Plan	Actual	RAG
Cash	73.4	68.7	
Debtor Days	45	15	
Creditor Days	45	51	
PP Debtor Days	65	45	

Better Payment Practice	Plan	Actual
BPPC - NHS (YTD) by number	95%	92%
BPPC - NHS (YTD) by value	95%	90%
BPPC - Non-NHS (YTD) by number	95%	95%
BPPC - Non-NHS (YTD) by value	95%	95%

Net Receivables/Ageing £m



Trust Income and Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month			Year to Date				
		Plan	Actual	Variance	Plan	Actual	Variance	%	RAG
Income									
NHS Commissioned Clinical Income	249.34	18.05	18.76	0.71	186.66	188.39	1.74	1%	
Other NHS Clinical Income	10.22	0.77	1.11	0.34	7.47	8.68	1.22	16%	
Commercial Trading Units	46.68	2.85	3.16	0.31	34.25	33.35	(0.89)	(3)%	
Research & Development	16.42	1.39	1.38	(0.01)	11.88	10.93	(0.95)	(8)%	
Other Income	27.17	6.20	6.03	(0.17)	20.09	21.63	1.54	8%	
Total Income	**349.82**	**29.26**	**30.44**	**1.17**	**260.34**	**262.98**	**2.64**	**1%**	
Operating Expenses									
Pay	(189.25)	(15.91)	(16.07)	(0.16)	(141.39)	(142.24)	(0.86)	(1)%	
Of which: Unidentifed CIP	*3.19*	*0.28*	*-*	*(0.28)*	*2.37*	*-*	*(2.37)*		
Drugs	(42.53)	(3.23)	(3.35)	(0.11)	(31.87)	(32.37)	(0.50)	(2)%	
Clinical Supplies	(25.22)	(1.66)	(1.82)	(0.16)	(19.02)	(19.58)	(0.56)	(3)%	
Other Non Pay	(53.66)	(4.15)	(5.06)	(0.91)	(39.74)	(41.66)	(1.92)	(5)%	
Of which: Unidentifed CIP	*0.92*	*0.09*	*-*	*(0.09)*	*0.66*	*-*	*(0.66)*		
Total Operating Expenditure	**(310.67)**	**(24.95)**	**(26.29)**	**(1.34)**	**(232.01)**	**(235.85)**	**(3.84)**	**(2)%**	
EBITDA	*39.15*	*4.31*	*4.14*	*(0.17)*	*28.33*	*27.14*	*(1.19)*	(4)%	
Financing & Depreciation	(17.92)	(1.57)	(1.46)	0.11	(13.00)	(12.82)	0.18	1%	
Donated assets/impairment adjustments	(15.83)	(5.14)	(5.15)	(0.01)	(12.11)	(12.15)	(0.04)	(0)%	
Control Total Surplus/(Deficit) Pre ERF	**5.40**	**(2.39)**	**(2.46)**	**(0.07)**	**3.23**	**2.17**	**(1.05)**	**(33)%**	

Commentary

Operating Income

£1.17m favourable to plan in month

Total operating income is reporting £30.44m in-month, £1.17m favourable to plan, and £2.64m favourable cumulatively. Key points of note are:-

- Clinical income was £18.76m, £0.71m favourable to plan in-month. Key points of note are:-
- Underlying elective activity was at 77% (94% cumulatively) driving an adverse variance offset by prior year ERF over-performance. Elective activity was below plan in the north-east locality with Stratford activity at 57% and St Anns activity at 51% during December.
- Commercial trading income was £3.16m, £0.31m favourable to plan.
- Research and Development income at £1.38m was break-even to plan.
- Other income was £0.17m adverse to plan.

Employee Expenses

£0.16m adverse to plan in month

December pay is reporting £16.07m; £0.16m adverse to plan in month. Key points of note are:-

- Substantive pay costs were £14.3m in month, higher than the year-to-date average of £13.8m. There are 145 more WTE employed in Q3 than in Q1 of the year.
- Temporary staffing costs were £1.76m in December.
  - Agency costs are £0.33m in month, lower than the 12-month trend of £0.60m. Use continues mainly on administration in both clinical and corporate areas, with IMT and Workforce being the highest corporate areas of use.
  - Bank costs are £1.44m in month, higher than the rolling trend of £1.41m. There were a significant number of retrospective medical bank claims paid in December. Medical, nursing and clinical admin continue to be the drivers for bank spend.
- £0.28m unachieved pay CIP (£2.37m cumulatively)

Non-Pay Expenses

£1.18m adverse to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in December were £10.22m, £1.18m adverse to plan. Key points of note are:-

- Drugs was £0.11m adverse in month with £3.35m expenditure in December against a 12-month trend of £3.55m. Injections were at 95% of planned activity in month.
- Clinical supplies was £0.16m adverse to plan in month. Costs were £1.82m in month against a 12-month trend of £2.18m.
- Other non-pay was £0.91m adverse reflecting Oriel consultancy costs £0.3m and significant IT projects expenditure catch-up from earlier in the year of (£0.4m) in month.
- £0.09m unachieved non-pay CIP (£0.66m cumulatively)

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

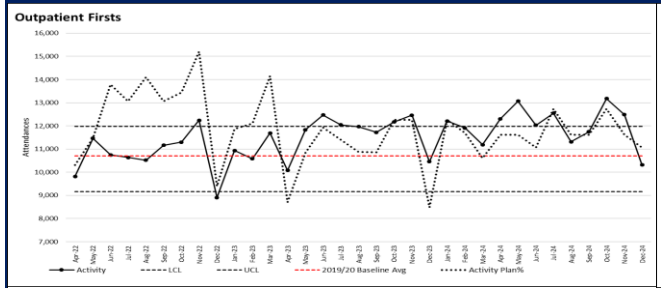
ER	Point of Delivery	Activity In Month				Activity YTD			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	3,190	2,469	(721)	77%	29,978	28,065	(1,913)	94%
	Of which - SA & ST	606	329	(277)	54%	5,340	3,875	(1,465)	73%
	OP Firsts	11,699	10,316	(1,383)	88%	110,369	108,998	(1,371)	99%
	OP Procedures	20,358	16,691	(3,667)	82%	194,423	198,697	4,274	102%
	ERF Activity Total								
Non ERF Acti	OP Follow Ups	18,527	19,195	668	104%	175,960	183,874	7,914	104%
	High Cost Drugs Injections	4,435	4,193	(242)	95%	42,357	42,247	(110)	100%
	Non Elective	217	204	(13)	94%	1,926	1,952	26	101%
	AandE	6,222	5,063	(1,159)	81%	55,194	53,860	(1,334)	98%
	Total	64,648	58,131	(6,517)	90%	610,207	617,693	7,486	101%

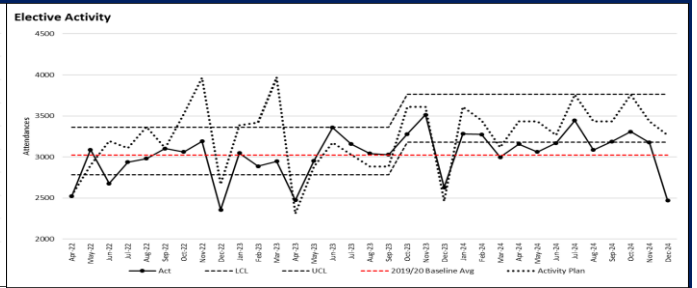
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

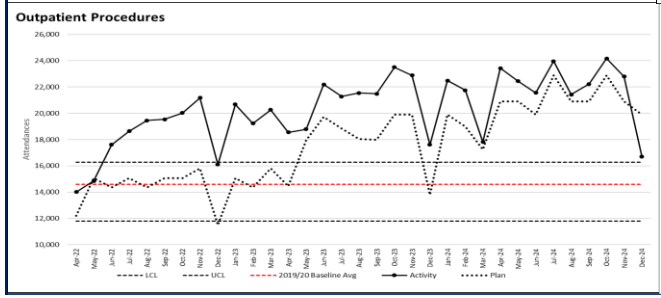
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

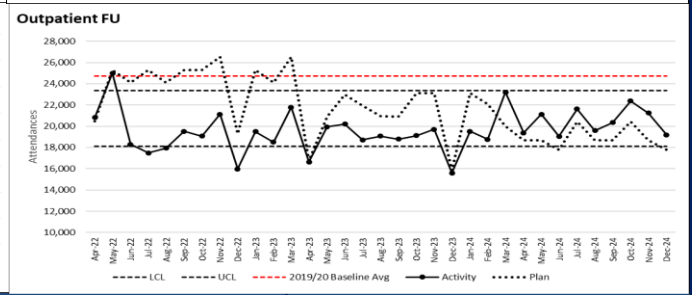
Performance % figures above, represent the Trust performance against the external activity target. Financial values shown are for ERF activity only.

ACTIVITY TREND - ERF COMPONENTS









Commentary

NHS Income

ERF Achievement

ERF performance for 2023/24 has been issued, however further clarification and details from NHSE are awaited for final payments.

ERF performance to September 2024 has been published and is in line with planning expectations and payments are expected in December.

ERF Activity performance achievement

- **Inpatient activity** achieved 77% in month and 94% year to date of the revised demand plan.
- The table also splits out Stratford and St Annes activity reported at 54% overall in month, being 57% and 51% respectively, and 73% year to date overall being 70% and 76% respectively.
- **Outpatient Firsts Activity** achieved 88% of the revised demand plan in month; 99% year to date
- **Outpatient Procedures Activity** achieved 82% of revised demand plans in month; 102% cumulatively

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 95% of activity plans in month; 100% year to date
- **A&E** achieved 81% of activity plans in month; 98% year to date

Activity plans and ERF

Current activity and income plans have been amended to the Trust 'Demand' plan levels further to the ratification of the Stratford activity capacity/demand rectification plan.

Pay, non-pay and CIP allocation aspects of the rectification plans have also been received and amended in the finance ledger for reporting purposes based on Information from operational teams.

- 2024/25 performance for ERF is now confirmed to month 6 but with further clarification to come for year end processes.

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

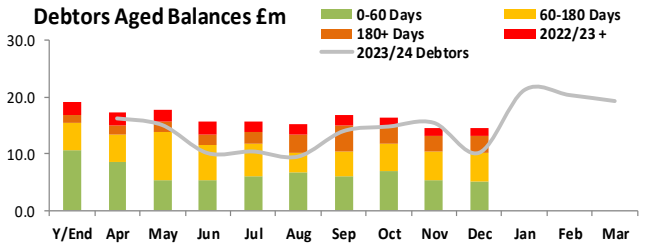
CAPITAL EXPENDITURE

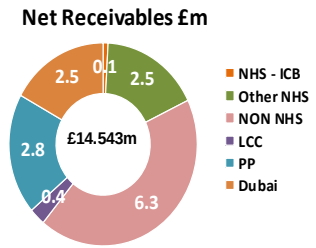
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Medical Equipment	2.9	0.9	1.2	0.3
Estates	2.0	0.7	0.2	(0.6)
IMT	0.4	0.1	0.1	-
Commercial	1.3	0.8	0.6	(0.3)
Network Strategy	-	-	-	-
Other - Trust funded	0.7	0.2	0.0	(0.2)
TOTAL - TRUST BAU CAPITAL	**7.4**	**2.8**	**2.1**	**(0.7)**
Oriel Programme	119.0	75.5	53.6	(21.9)
EPR Project	5.7	2.4	2.0	(0.4)
NiHR Capital Grant	1.7	0.9	0.6	(0.4)
Other & Charity	0.3	0.0	-	(0.0)
IFRS16	2.8	2.0	1.6	(0.4)
TOTAL INCLUDING DONATED	**136.8**	**83.7**	**59.8**	**(23.9)**

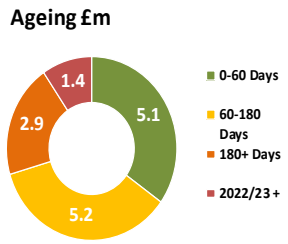
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
ICS Capital Allocation	16.5	16.5	-	100%
Cash Reserves - Oriel	1.0	1.0	-	100%
Cash Reserves - B/Fwd	0.8	0.8	-	100%
Capital Loan Repayments	(1.8)	(1.8)	-	100%
TOTAL - TRUST FUNDED	**16.5**	**16.5**	**-**	**100%**
Externally funded	109.0	109.0	-	100%
Donated/Charity	16.6	16.5	0.2	99%
TOTAL INCLUDING DONATED	**142.2**	**142.0**	**0.2**	**100%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2022/23 +*	*Total*
CCG Debt	0.0	0.0	0.0	0.0	0.1
Other NHS Debt	1.7	0.2	0.3	0.3	2.5
Non NHS Debt	0.6	3.5	1.4	0.9	6.3
Commercial Unit Debt	2.8	1.5	1.2	0.2	5.7
TOTAL RECEIVABLES	**5.1**	**5.2**	**2.9**	**1.4**	**14.5**







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	453.8	399.5	341.9	(57.6)
Current assets (excl Cash)	31.4	31.1	27.9	(3.1)
Cash and cash equivalents	72.2	73.4	68.7	(4.7)
Current liabilities	(55.7)	(55.9)	(48.6)	7.3
Non-current liabilities	(199.7)	(154.1)	(103.5)	50.5
TOTAL ASSETS EMPLOYED	**301.9**	**294.1**	**286.5**	**(7.6)**

OTHER METRICS

Use of Resources	Plan	Current Month	Prior Month
BPPC - NHS (YTD) by number	95%	92%	92%
BPPC - NHS (YTD) by value	95%	90%	90%
BPPC - Non-NHS (YTD) by number	95%	95%	95%
BPPC - Non-NHS (YTD) by value	95%	95%	95%

Commentary

Cash and Working Capital

The cash balance as at the 31st December was £68.7m, a reduction of £2.0m since the end of March 2024.

Capital Expenditure/ Non-current assets

Capital expenditure as of 31st December totalled £59.8m, including £1.6m of lease variations.

- Business as usual capital totals £2.1m.
- Other capital totals £57.7m with £53.6 of Oriel expenditure, £2.0m EPR expenditure and £0.6 of NIHR research expenditure.
- IFRS16 leases capital of £1.6m

Business as usual capital allocation have been fully allocated, and forecast.

The variance on non-current assets of £38.9m is due to a shortfall in capital expenditure, primarily relating to the Oriel build, which is reviewing it's in year construction cashflows for reforecasting.

Receivables

Receivables have reduced by £4.7m to £14.5m since the end of the 2023/24 financial year. Debt in excess of 60 days increased by £0.1m in December and current debt also reduced by £0.2m.

Payables

Payables totalled £17.4m at the end of December, a reduction of £8.8m since the end of March 2024.

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%).

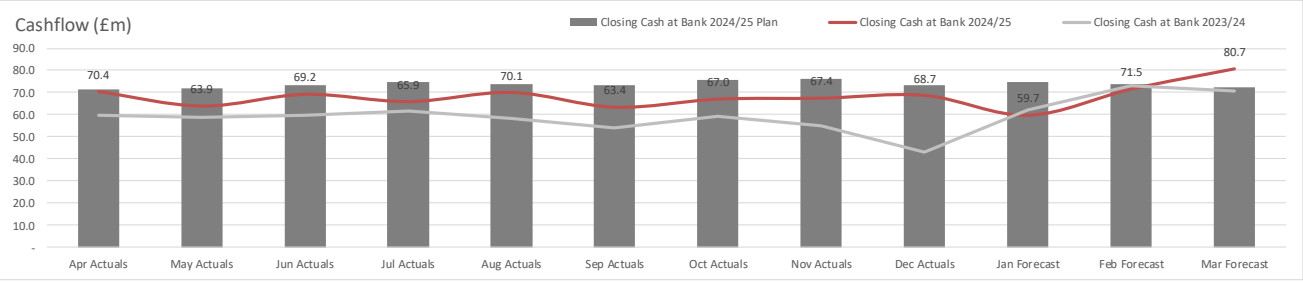
Use of Resources

Use of resources monitoring and reporting has been suspended.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Actuals	Aug Actuals	Sep Actuals	Oct Actuals	Nov Actuals	Dec Actuals	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Dec Forecast	Dec Var
Opening Cash at Bank	**70.7**	**70.4**	**63.9**	**69.2**	**65.9**	**70.1**	**63.4**	**67.0**	**67.4**	**68.7**	**59.7**	**71.5**	**70.7**		
Cash Inflows															
Healthcare Contracts	20.4	20.3	21.4	21.7	21.1	19.1	25.2	20.9	25.3	22.3	20.3	20.7	258.7	17.7	7.7
Other NHS	2.6	1.3	2.0	0.5	3.4	0.8	2.1	3.2	3.9	1.0	0.9	1.0	22.5	0.9	3.0
Moorfields Private/Dubai/NCS	4.7	3.8	4.0	4.5	3.6	4.0	4.8	4.7	3.4	4.3	4.1	4.3	50.2	3.4	(0.0)
Research	3.1	1.0	1.3	1.5	0.8	0.7	2.1	1.0	1.4	1.3	1.3	1.3	17.0	1.4	0.1
VAT	1.5	1.1	1.0	-	1.8	2.1	1.0	1.0	1.0	0.5	0.5	0.5	11.9	0.5	0.5
PDC	7.8	-	-	2.7	9.1	-	3.5	17.6	-	5.7	30.0	30.1	106.5	-	-
Other Inflows	0.3	0.4	7.3	0.3	0.3	0.3	0.3	0.3	7.4	0.8	0.8	0.8	19.2	8.0	(0.6)
Total Cash Inflows	**40.2**	**27.9**	**36.9**	**31.2**	**40.1**	**27.0**	**39.0**	**48.5**	**42.5**	**35.8**	**58.0**	**58.8**	**486.0**	**31.8**	**10.7**
Cash Outflows															
Salaries, Wages, Tax & NI	(13.0)	(13.3)	(12.9)	(12.8)	(13.0)	(13.1)	(15.1)	(16.0)	(14.5)	(14.5)	(14.5)	(14.5)	(167.4)	(13.8)	(0.7)
Non Pay Expenditure	(21.4)	(12.7)	(12.6)	(15.9)	(11.9)	(12.7)	(11.6)	(12.5)	(12.4)	(13.5)	(13.2)	(12.6)	(163.1)	(12.4)	0.0
Capital Expenditure	(0.9)	(0.2)	(0.5)	(0.3)	(0.1)	(0.3)	(0.3)	(0.5)	(1.0)	(3.3)	(5.3)	(5.0)	(17.6)	(2.7)	1.8
Oriel	(4.0)	(6.6)	(4.1)	(4.1)	(9.1)	(4.1)	(7.0)	(18.0)	(11.9)	(12.1)	(11.4)	(14.4)	(106.8)	(11.0)	(1.0)
Moorfields Private/Dubai/NCS	(1.2)	(1.5)	(1.6)	(1.3)	(1.2)	(1.3)	(1.4)	(1.1)	(1.4)	(1.4)	(1.4)	(1.4)	(16.1)	(1.4)	(0.0)
Financing - Loan repayments	-	-			(0.6)	(0.7)				-	(0.4)	(0.5)	(2.2)	-	-
Dividend and Interest Payable	-	-				(1.5)				-	-	(1.3)	(2.7)	-	-
Total Cash Outflows	(40.5)	(34.4)	(31.6)	(34.5)	(35.9)	(33.7)	(35.4)	(48.1)	(41.2)	(44.8)	(46.2)	(49.6)	**(476.0)**	(41.3)	0.1
Net Cash inflows /(Outflows)	(0.3)	(6.5)	5.3	(3.3)	4.2	(6.7)	3.7	0.4	1.3	(9.0)	11.8	9.2	10.0	(9.4)	10.7
Closing Cash at Bank 2024/25	**70.4**	**63.9**	**69.2**	**65.9**	**70.1**	**63.4**	**67.0**	**67.4**	**68.7**	**59.7**	**71.5**	**80.7**	**80.7**		
Closing Cash at Bank 2024/25 Plan	71.5	72.0	73.1	74.8	73.7	73.5	75.7	76.3	73.4	74.7	73.8	72.2	72.2		
Closing Cash at Bank 2023/24	59.8	58.8	59.8	61.8	58.1	54.0	59.4	55.2	43.2	62.1	72.9	70.7	70.7		



Commentary

Cash flow

The cash balance as at the 31st December was £68.7m, a reduction of £2.0m since the end of March 2024. 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 83 days of operating cash (prior month: 82 days).

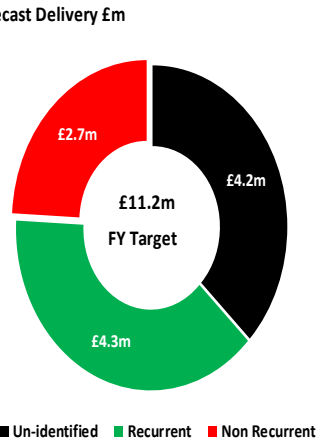
December saw a cash inflow of £1.3m against a forecast of £9.4m outflow due to receipt of ERF cash and NHS provider SLAs.

Trust Efficiency Scheme Performance

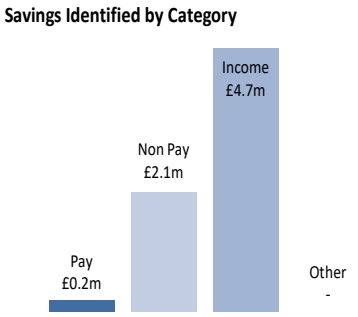
EFFICIENCY SCHEMES PERFORMANCE

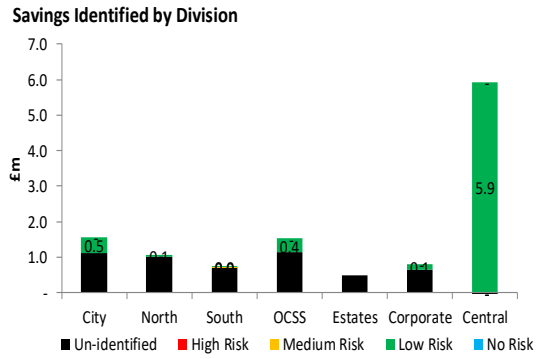
Efficiency Schemes £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Plan	Forecast Actual	Forecast Variance
City Road	£1.57m	£0.13m	(£0.03m)	(£0.16m)	£1.18m	£0.33m	(£0.85m)	£1.57m	£0.46m	(£1.11m)
North	£1.08m	£0.09m	£0.01m	(£0.08m)	£0.81m	£0.05m	(£0.76m)	£1.08m	£0.07m	(£1.01m)
South	£0.73m	£0.06m	£0.00m	(£0.06m)	£0.55m	£0.01m	(£0.54m)	£0.73m	£0.02m	(£0.70m)
Ophth. & Clinical Serv.	£1.53m	£0.13m	£0.02m	(£0.11m)	£1.15m	£0.35m	(£0.80m)	£1.53m	£0.40m	(£1.13m)
Estates & Facilities	£0.49m	£0.04m	-	(£0.04m)	£0.37m	-	(£0.37m)	£0.49m	-	(£0.49m)
Corporate	£0.80m	£0.07m	£0.01m	(£0.06m)	£0.60m	£0.13m	(£0.47m)	£0.80m	£0.15m	(£0.65m)
DIVISIONAL EFFICIENCIES	**£6.20m**	**£0.52m**	**-**	**(£0.52m)**	**£4.65m**	**£0.87m**	**(£3.79m)**	**£6.20m**	**£1.10m**	**(£5.10m)**
Central										
R&D Income	£2.20m	£0.18m	£0.18m	(£0.00m)	£1.65m	£1.65m	-	£2.20m	£2.20m	-
Utilities Reduction	£1.60m	£0.13m	£0.14m	£0.00m	£1.20m	£1.23m	£0.03m	£1.60m	£1.64m	£0.04m
Activity Complexity	£1.20m	£0.10m	£0.18m	£0.08m	£0.90m	£1.58m	£0.68m	£1.20m	£2.10m	£0.90m
TRUST EFFICIENCIES	**£11.20m**	**£0.93m**	**£0.49m**	**(£0.44m)**	**£8.40m**	**£5.32m**	**(£3.08m)**	**£11.20m**	**£7.04m**	**(£4.16m)**

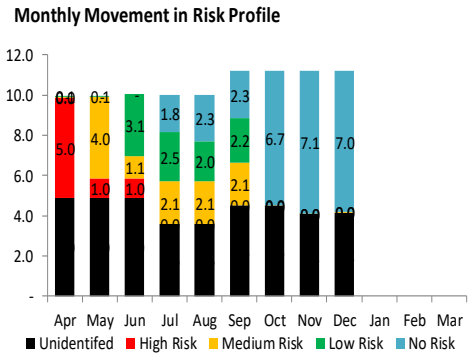
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







* charts may include rounding differences

Commentary

In Year Delivery

The trust is reporting efficiency savings achieved of:-

- £0.49m in month, compared to a plan of £0.93m, £0.44m adverse to plan;
- £5.32m year to date, compared to a plan of £8.4m, £3.08m adverse to plan.

Governance & Reporting

The trust had a planned efficiency programme of £10m for 2024/25 to deliver the Trust control total.

This has increased by £1.2m to £11.2m in relation to the Stratford activity capacity and demand rectification plan.

- Trust efficiencies are managed and reported via the Cost Improvement Programme (CIP) Board.

Identified Savings

The trust has identified £7.0m, leaving a remaining £4.2m to be identified.

Of the total identified:-

- £5.9m is identified central schemes
- £4.7m is identified as income generation schemes;
- £1.6m is related to utilities price reductions; and
- £4.3m 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.

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.

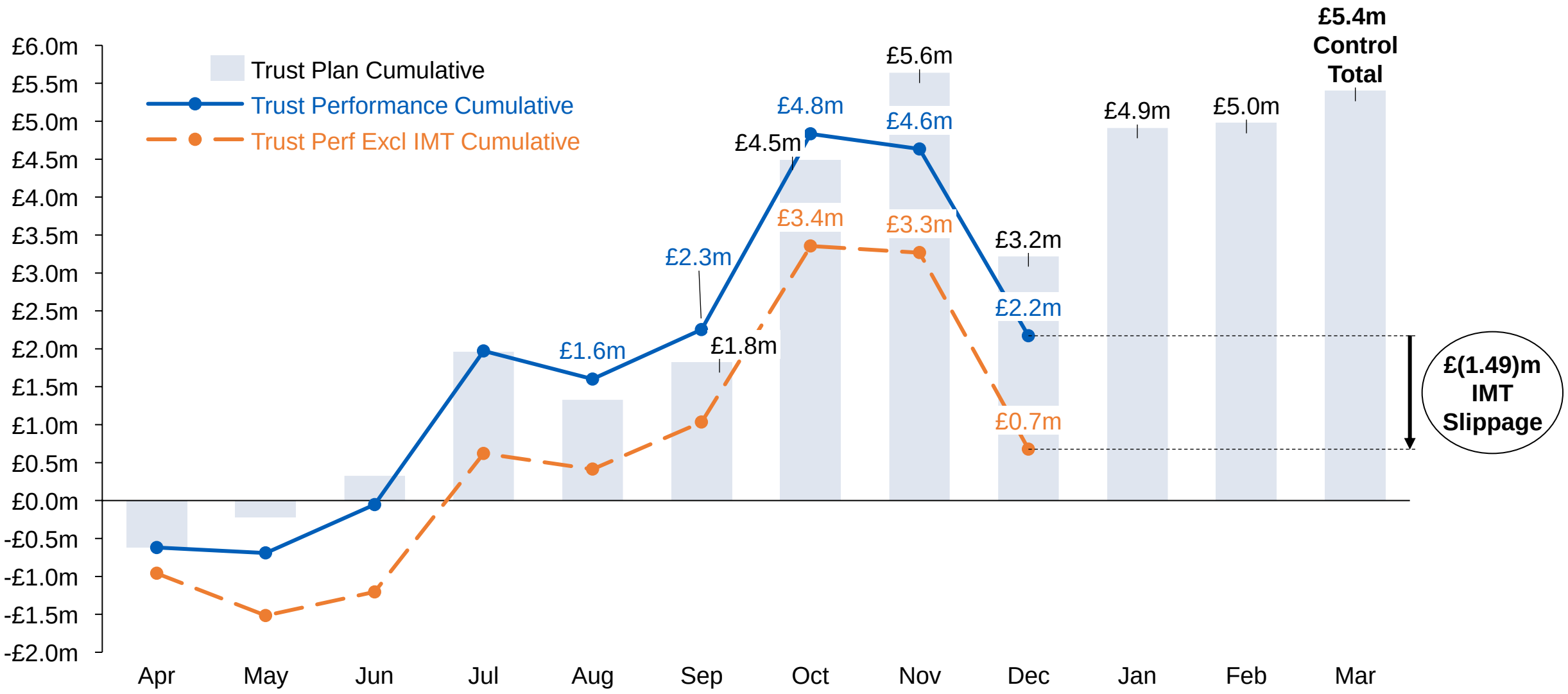
Supplementary Information

Moorfields Eye Hospital NHS Foundation Trust

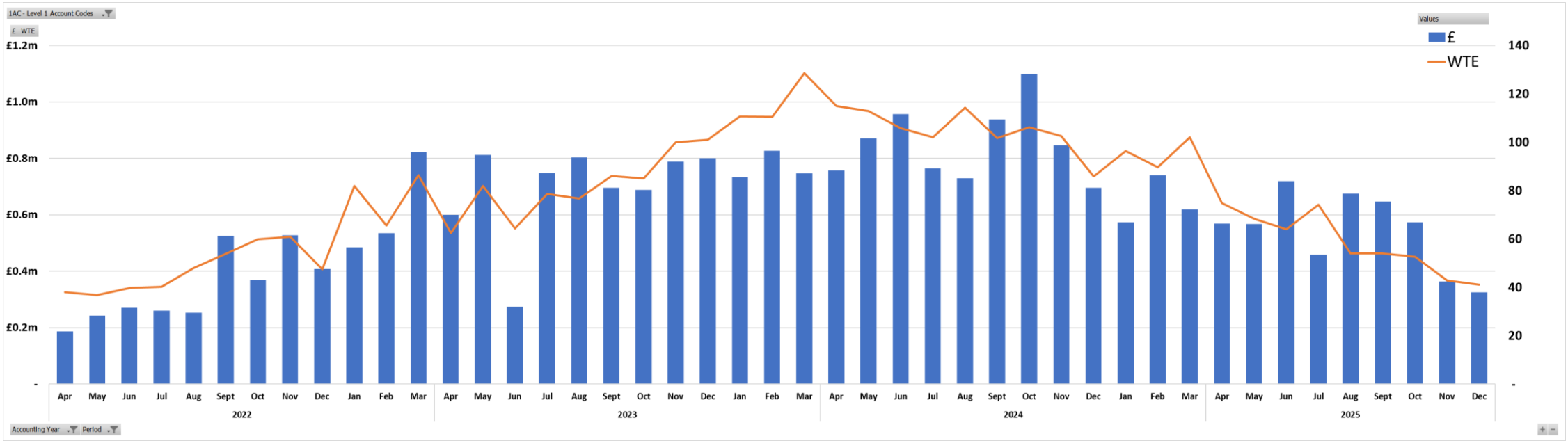
NHS

Trust financial performance is being supported by £1.49m IMT slippage

The trust is reporting a £2.2m surplus YTD, £1.0m adverse to a plan of £3.2m. However, excluding IMT favourable surpluses due to slippage, the Trusts financial position is £0.7m, £2.5m less than plan.
Adverse core operational performance is being supported by the IT EPR (£0.872)m and IT Projects slippage (£0.622)m.



Workforce – Agency Reporting in Board Report



Report title	Proposed amendment to the Trust constitution
Report from	Sam Armstrong, company secretary
Prepared by	Sam Armstrong, company secretary

Brief summary of report

Elena Lokteva was appointed by the Membership Council to replace Nick Hardie as a non-executive director.

It has been realised that the Trust constitution does not allow for someone to be a NED at more than one NHS trust, albeit this is an old NHS rule that no longer applies.

In order to ensure Elena's appointment it is proposed to change the current clause:

8.7.1 A person may not become or continue as Director of the Trust if:…

8.7.10 he is an executive or non-executive director of another Foundation Trust, or a governor, non-executive director, chairman, chief executive officer of another Health Service Body, or a body corporate whose business includes the provision of health care services, including for the avoidance of doubt those who have a commercial interest in the affairs of the Trust;

By adding the following:

unless the Board of Directors judge that it is in the best interest of the Trust.

Action required/recommendation.

The Membership Council is asked to approve the proposed wording for Article 8 of the Trust constitution.

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

Governors will be aware that Elena Loktova was appointed as a new non-executive director by the Membership Council on 28th November 2024, to replace Nick Hardie whose tenure as a non-executive director was expiring at the end of December.

The Nominations and Remuneration Committee and the Membership Council were keen to benefit from Elena's considerable NHS NED experience, as prior knowledge of NHS finances and ways of working are very helpful in being the chair of the Finance and Performance Committee, as well as a wider complement to the Board as a whole. Elena is currently, and will continue as, a non-executive director at Essex Partnership University NHS Foundation Trust, which is a mental health trust, where she is chair of their Audit Committee.

Since this appointment, it has been discovered that, currently, the Trust constitution does not allow for any of its directors to simultaneously be a director of another NHS trust (including foundation trusts). Specifically, the relevant article states:

8.7.1 A person may not become or continue as Director of the Trust if:…

8.7.10 he is an executive or non-executive director of another Foundation Trust, or a governor, non-executive director, chairman, chief executive officer of another Health Service Body, or a body corporate whose business includes the provision of health care services, including for the avoidance of doubt those who have a commercial interest in the affairs of the Trust;

It is worth pointing out that most clauses pertaining to article 8.7.1 relate to character and being a fit and proper person.

This provision though (8.7.10) would not allow for Elena to continue in the role as a non-executive director of our Trust.

These rules were in place in the NHS some time ago, and likely when the constitution was first drafted. Legal advice has confirmed there is no longer a legal requirement to include this provision in the constitution. Some years ago, the NHS removed this as a requirement as they moved from a competitive context to a collaborative one. It appears that some other trusts now do not have that clause at all, and some that have retained it have added a provision and mechanism that enables them to make exceptions, if and when they are needed.

It would be preferable to keep the existing clause and have a mechanism for making an exception. The alternative of removing the clause altogether as some trusts have done, removes an important next step of formally considering potential conflicts of interest, hence why we are not recommending it.

Therefore, it is proposed that the provision is amended to include the following, '…unless the Board of Directors judge that it is in the best interest of the Trust'. This would enable the appointment of directors who hold relevant positions in other health service bodies where the Board of Directors considers that this is in the best interests of the Trust. Please note that this does not change the governors' authority to make the appointment of non-executive directors and, as part of the process in the future, the Board would report their view on such a proposed appointment to the

Nominations and Remuneration Committee and the Membership Council to assist in their deliberations for the appointment made by the Membership Council, should such a situation occur.

The new clause, if approved, would read (italicising the change):

8.7.10 he is an executive or non-executive director of another Foundation Trust, or a governor, non-executive director, chairman, chief executive officer of another Health Service Body, or a body corporate whose business includes the provision of health care services, including for the avoidance of doubt those who have a commercial interest in the affairs of the Trust *unless the Board of Directors judge that it is in the best interest of the Trust.*

There does not appear to be any conflict-of-interest issues, or any other concerns about Elena retaining her post at Essex Partnership University NHS Foundation Trust.

Legal advice has further stated that the Trust can deem Elena to be appointed at the point that her appointment was approved by the Membership Council in November. Article 8.5 of the Constitution provides that the validity of any act of the Trust is not affected by any vacancy among the directors or by any defect in the appointment of any director. The proposed amendment to the Constitution will rectify the “defect” in Elena’s appointment. She could not, however, continue into the future if the Board and/or Membership Council decided to retain the existing clause as it currently stands.

Governors may be aware already that we do have a review of the constitution planned, which will commence soon and would likely conclude with any recommendation for consideration and approval within the next six months.

For completeness in preparing this item, the chair and company secretary engaged the lead governor, deputy chair of the membership council, chair of the governors development group and the chair of the Membership Council Nominations and Remuneration Committee in creating this plan. The Trust also sought legal advice.

In order to amend the Constitution, the proposed amendment must be approved by more than half of the members of the Board of Directors present and voting at a quorate meeting of the Board, and by more than half of the members of the Membership Council present and voting at a quorate meeting of the Membership Council.

Procedure for amending the Constitution:

Article 18 of the Trust’s Constitution provides for amendment of the Constitution in the following terms:

The Trust may make amendment to this Constitution only if:

18.1 more than half of the members of the Membership Council present and voting at a

meeting of the Membership Council approve the amendments; and
18.2 more than half of the members of the Board of Directors present and voting at a meeting of the Board of Directors approve the amendments.

The amendment does not alter the powers or duties of the Membership Council and therefore will not need to be presented to the next AGM for ratification.

The proposed amendment to the Constitution will have effect as soon as it has been approved by the required majorities of the Membership Council and Board of Directors. However, there is a requirement for the Trust to notify NHS England of the amendment once approved, which will be done if the amendment is approved.

In order to mitigate any risk of challenge to the Trust's decision-making, it has been decided that pending the approval of the proposed amendment, the Trust will ensure that there is a quorum for any Board meetings without counting the attendance of Elena.

Governors will be aware of a related article, that being Article 7, in relation to governor eligibility. Specifically,

7.15 Disqualification
A person may not become or continue as a Governor of the Trust if:…

7.15.10 they are an Executive Director or Non-Executive Director of the Trust, or a governor, non-executive director, chairman, chief executive officer of another Health Service Body (unless they are appointed by a sponsoring organisation which is a Health Service Body), or services, including for the avoidance of doubt those who have a commercial interest in the affairs of the Trust;

During the planned constitutional review, governors will be able to reflect and discus if this clause need remain or not, and if any related provisions be introduced.