Moorfields Eye Hospital NHS Foundation Trust

A MEETING OF THE BOARD OF DIRECTORS

To be held in public on

Thursday 4 July 2019 at 09:30am

In the Boardroom, 4th Floor, Kemp House, 152 – 160 City Road, EC1V

AGENDA

No.	Item	Action	Paper	Lead	Mins	S.O
	Divisional presentation – Moorfields North	**Assurance**	**Present**	**JQ**	**00:30**	**All**
1.	Apologies for absence	Note	Verbal	TG		
2.	Declarations of interest	Note	Verbal	TG		
3.	Minutes of the meeting held on 28 May 2019	Approve	Enclosed	TG		
4.	Matters arising and action points	Note	Enclosed	TG	00:05	
5.	Chief Executive's Report	Note	Enclosed	DP	00:10	All
6.	Integrated Performance Report	Assurance	Enclosed	JQ	00:10	1
7.	Finance Report	Assurance	Enclosed	JW	00:10	7
8.	Safeguarding adults and children annual reports	Assurance	Enclosed	TL	00:15	1
9.	Infection control annual report	Assurance	Enclosed	TL	00:05	1
10.	Guardian of safe working	Assurance	Enclosed	NS	00:05	1
11.	Medical revalidation annual report	Assurance	Enclosed	NS	00:15	1
12.	Membership Council report	Assurance	Enclosed	TL	00:05	3
13.	Report from the quality and safety committee	Assurance	Enclosed	RGW	00:10	1
14.	Report from the people and culture committee	Assurance	Enclosed	SS	00:10	5
15.	Identify any risk items arising from the agenda	Note	Verbal	TG	00:05	
16.	AOB	Note	Verbal	TG	00:05	

17. Date of the next meeting – Thursday 5 September 2019 09:30am

* Strategic Objectives

1 Care 2 Research 3 Knowledge sharing 4 Policy 5 People 6 Infrastructure 7 Finance 8 Enterprise

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON
THURSDAY 28 MAY 2019

Attendees:	Tessa Green (TG)	Chairman
	David Probert (DP)	Chief executive
	Andrew Dick (AD)	Non-executive director
	Nick Hardie (NH)	Non-executive director
	David Hills (DH)	Non-executive director
	Ros Given-Wilson (RGW)	Non-executive director
	Sumita Singha (SS)	Non-executive director
	Tracy Luckett (TL)	Director of nursing and AHPs
	Jonathan Wilson (JW)	Chief financial officer
	John Quinn (JQ)	Chief operating officer
	Peng Khaw (PK)	Director of R&D
	Nick Strouthidis (NS)	Medical director
In attendance:	Nora Colton (NC)	Director of education
	Helen Essex (HE)	Company secretary (minutes)
	Kieran McDaid (KM)	Director of estates, capital and major projects
	Ian Tombleson (IT)	Director of quality and safety
	Elisa Steele (ES)	Chief information officer
Governors present:	Brenda Faulkner (BF)	Patient governor
	Rob Jones (RJ)	Patient governor
	Jane Bush (JB)	Public governor

19/2310 Apologies for absence

Apologies were received from Steve Williams, Sandi Drewett and Jo Moss.

19/2311 Declarations of interest

There were no declarations of interest.

19/2312 Minutes of the last meeting

The minutes of the meeting held on 2 May 2019 were agreed as an accurate record.

19/2313 Matters arising and action points

19/2314 Chief Executive's Report

DP reported that the public consultation led by Camden CCG for Oriel on 24 May had been formally launched. The board registered their satisfaction with the quality of the documentation

M1 financial performance reporting has concluded and the trust is slightly behind plan. A more formal review of M1 and M2 will take place at the board meeting in July.

JQ referenced the operational issues the trust has experienced with healthcare records and moving them off site, as well as how they are managed internally. The primary reason for the move was to reduce the fire risk in the records store. The company had a challenge in relation to the volumes being handled in the initial period but this is now being controlled. The trust is currently experiencing between 4% and 5% temporary notes although this is higher in some individual clinics than others. There is no apparent pattern but an opportunity to look into the subspecialties to see which are less affected and why. Although problems have improved there is still room for further improvement. There does not appear to have been any severe impact on patient care, but there is a clear need to make sure there is a robust process in place during the acute period of the move. It was also noted that there will always be a certain level of temporary notes but the reconciliation of different sets of notes is the most important issue.

19/2315 Report from the audit and risk committee

NH advised that the purpose of the committee is to gain assurance in specific areas of work. Evidence for this is given by the internal audit review of the year and head of internal audit opinion. For this year the head of internal audit opinion was as follows:

The overall opinion from the Head of Internal Audit for the period 1 April 2018 – 31 March 2019 is that significant assurance with minor improvements required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Assurance is also provided by external audit and the conclusion of their report for the year is as follows:

In our opinion the financial statements of Moorfields Eye Hospital NHS Foundation Trust (the 'foundation trust'):

- *Give a true and fair view of the state of the foundation trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended;*
- *Have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of Foundation Trusts; and*
- *Have been prepared in accordance with the requirements of the National Health Service Act 2006*

External audit look at a number of different testing and judgement areas such as valuations of land and buildings, new IFRS standards and issues of contract dispute with commissioners. The work of the auditors is now concluded and they did not identify any significant risks relating to vfm. The annual report and annual governance statements have been reviewed and have been prepared in accordance with the annual reporting manual.

Auditors will be issuing a modified opinion on the quality report and this specifically relates to the A&E indicator. The main issue is of clocking people in and out of A&E but this will continue as long as we have in place a paper-based system.

There is no modified opinion on the 62-day cancer wait. The governor indicator will be reported to them separately but there were no concerns raised.

The committee also reviewed the statement of going concern and management representation letter. With the exception of comments on the new reporting standards it is a standard letter and there are no issues with the representations being given.

One of the key areas of focus must be preparation for new accounting standards being implemented in the coming year, as the groundwork needs to be done in advance.

The overall conclusion of the committee is that the board should feel comfortable in approving the annual report, accounts, quality report and management representation letter and that the accounts show a true and fair view of the business.

The audit committee recommended the approval of the documents.

19/2316 Annual report, annual accounts and quality report

The board was advised of some minor amendments made to the annual report since circulation which included narrative in the performance analysis section and changes to the staff report and financial report. All changes were made in consultation with the auditors.

JW advised that this was a clean audit and provides a basis to move into 19/20. The implementation of IFRS 16 (meaning that property leases will in future come onto the balance sheet) will need preparation from the outset.

The board approved the annual report, annual accounts, quality report and management representation letter.

19/2317 Compliance statements

The board approved the compliance statements for G6 (licence conditions) and FT4 (corporate governance).

19/2318 Issues arising from the agenda for the risk register

There are emerging risks relating to the stagnation in funding for research & development which has the potential to slow down the funding for Oriel. It was agreed that the executive should think about how to reflect macro and micro economics in terms of capital ambitions and R&D.

For discussion at the next corporate risk register quarterly review

19/2319 AOB

None.

18/2320 Date of next meeting – Thursday 4 July 2019

BOARD ACTION LOG

Meeting Date	Item No.	Item	Action	Responsible	Due Date	Update/Comments	Status
7 Feb 2019	19/2254	Workforce strategy	Final workforce strategy to be approved in April	Sandi Drewett	4 Jul 2019	Deferred to July to allow sufficient time for analysis of consultation outcomes	Closing
28 May 2019	19/2318	Issues arising from the agenda for the risk register	Reflect on how to articulate the macro and micro economics surrounding R&D funding and our capital ambitions	HE/Exec	4 Jul 2019		Open

NB Items greyed out have been completed and will be removed from the next log

Bold shows updates

Moorfields Eye Hospital NHS Foundation Trust

NHS

Glossary of terms – July 2019	
Oriel	A project that involves Moorfields Eye Hospital NHS Foundation Trust and its research partner, the UCL Institute of Ophthalmology, along with Moorfields Eye Charity working together to improve patient experience by exploring a move from our current buildings on City Road to a preferred site in the Kings Cross area by 2023.
AAR	After action review
AHP	Allied health professional
AIS	Accessible information standard
ALB	Arms length body
AMRC	Association of medical research charities
ASI	Acute slot issue
BAF	Board assurance framework
BAME	Black, Asian and minority ethnic
BRC	Biomedical research centre
CCG	Clinical commissioning group
CIP	Cost improvement programme
CPIS	Child protection information sharing
CQC	Care quality commission
CQUIN	Commissioning for quality innovation
CSSD	Central sterile services department
CTP	Costing and transformation programme
DSP	Data security protection [toolkit]
ECLO	Eye clinic liaison officer
EDI	Equality diversity and inclusivity
EDHR	Equality diversity and human rights
EMR	Electronic medical record
EU	European union
FBC	Full business case
FFT	Friends and family test
FTSUG	Freedom to speak up guardian
GDPR	General data protection regulations
GIRFT	Getting it right first time
GoSW	Guardian of safe working
HCA	Healthcare assistant
I&E	Income and expenditure
IFRS	International financial reporting standards
IPR	Integrated performance report
iSLR	Integrated service line reporting
KPI	Key performance indicators
LCFS	Local counter fraud service
LD	Learning disability
MFF	Market forces factor
NCL	North central london
NHSE	NHS England

NIHR	National institute for health research
NIS	Network and information systems
NMC	Nursing & midwifery council
OBC	Outline business case
OD	Organisation development
PAS	Patient administration system
PDC	Public dividend capital
PID	Patient identifiable data
PP	Private patients
PROMS	Patient related outcome measures
PSF	Provider sustainability fund
QIA	Quality impact assessment
QIPP	Quality, innovation, productivity and prevention
QSC	Quality & safety committee
QSIS	Quality service improvement and sustainability
RAG	Red amber green [ratings]
R&D	Research & development
RTT	Referral to treatment
SCC	Strategy & commercial committee
SGH	St Georges University Hospital
SI	Serious Incident
SLA	Service level agreement
STP	Sustainability and transformation partnership
UAE	United Arab Emirates
UCL	University College London
VFM	Value for money
WAEH	World association of eye hospitals
WDES	Workforce disability equality standards
WRES	Workforce race equality standards
YTD	Year to date

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 05
Chief executive's report
Board of directors 4 July 2019

Report title	Chief executive's report
Report from	David Probert, chief executive
Prepared by	David Probert and the executive team
Previously discussed at	Management Executive
Link to strategic objectives	The chief executive's report links to all eight strategic objectives

Brief summary of report

The report covers the following areas:

- WAEH conference
- Financial position M2
- Interim NHS workforce plan
- New clinical leadership appointments
- NHS England chief operating officer
- Queen's birthday honours awards
- CHKS award
- Innovate UK Digital Health Technology Grant application

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 – 4 JULY 2019

Chief Executive's report

1. Quality

At the start of June Moorfields welcomed colleagues from the world's leading eye hospitals to the international **World Association of Eye Hospitals annual conference**. Over 160 delegates joined the event which was regarded incredibly positively by all those involved. We were delighted to welcome keynote speakers from across the world of science and ophthalmology such as Professor Sir Jeremy Farrar, Director of the Wellcome Trust, Dr Alan Karthikesalingam of Google Deepmind and Professor Carrie MacEwen, past president of the Royal College of Ophthalmologists and current President of the Academy of Medical Sciences. It was also incredibly uplifting to welcome partially sighted paralympians Georgie Bullen and Marc Powell to help ensure the voice of the patient was heard throughout the meeting. Moorfields was well represented at the WAEH with a number of presentations, roundtables and posters led by Moorfields staff including keynote addresses from Professor Nora Colton and Professor Sir Peng Khaw.

On Wednesday 12 June Moorfields, in collaboration with University College London Hospitals NHS Foundation Trust, was presented the **award for data quality in clinical coding at the CKHS Top Hospitals Awards** for the second year running. The CHKS Top Hospitals Awards celebrate healthcare organisations across the UK and internationally that have excelled in the areas of patient safety, data quality, patient experience, quality of care and healthcare efficiency. This particular award recognises the importance of clinical coding and data quality, and the essential role they play in delivering high quality patient care. Congratulations to Ranjita Sen and the performance & information team for their continued excellence in this area.

2. Financial

The Trust reported a surplus of £0.34m in May against a planned surplus of £0.34m, a nil variance to plan. The cumulative Year to Date position is a deficit of £0.78m, a £0.20m adverse performance against plan. Whilst performance in May achieved the in-month plan in both activity and financial terms, the under-achievement of performance in April continues to impact on the financial position. Efficiency scheme performance currently stands at £0.38m – adverse to plan by £0.44m, and is a major area of focus within the trust. The trust working capital position remains strong, with debt having reduced by £3.0m since March, and cash balances at £42.1m.

3. People

At the start of June the **interim NHS people plan** was launched by NHSI in advance of the full NHS people plan which is expected to be released in the autumn this year by Prerana Issar, the CPO for NHSI.

Key things for the board to include:

- The focus on subsidiarity and developing ICSs as a key platform for delivery, looking at five-year workforce plans for each ICS within a year and expecting more emphasis and justification for delivery at a regional or national level.
- The ICS developing role to take ownership of workforce planning and transformation, dependent on the maturity of the system to take this on.
- The plan requirement for investment; we need to await the comprehensive spending review to see what is identified and ear marked, otherwise the plan will need to be resourced locally

- There is an increased focus on workforce issues from a regulatory perspective linked to the ambition for the NHS to be the best employer, with a balanced workforce scorecard being a central part of the NHS oversight framework and CQC well-led domain.

The two priorities that will be delivered at scale are international recruitment and apprenticeships. Equality & diversity is a strong theme and will be enhanced for the final plan including targets on BME representation at senior levels, including at board level.

The workforce plan is based on five key areas:

- Best place to work – staff engagement and health and wellbeing.
- Improving leadership culture, especially working across boundaries and systems leadership, talent management and inclusive leadership.
- Tackling the nursing challenge – 7.5k nursing associates, pre-registration supply, workforce supply, retention, increasing the number of placements.
- Delivering 21st century care – reforming care and transformation, digitisation, care closer to home, multidisciplinary team working, new roles, increasing digital skills and ability.
- Developing a new operating model for workforce.

Moorfields is well placed to respond and lead in these areas. Sandi has started talks with other acute specialist trusts in the STP to identify what the contribution of this sector could make to the wider STP.

I am pleased to announce the following strategic **clinical leadership appointments** within the medical directorate:

- Clinical director for service design – Mariepi Cylwik
- Joint clinical director for external engagement and clinical lead for job planning – Alison Davis
- Joint clinical director for external engagement – Melanie Hingorani
- Fellowship director – Carlos Pavesio
- Chief surgeon and clinical lead for Moorfields Private – Louisa Wickham

In addition, Louisa Wickham, Dilani Siriwardena and Alison Davis have been appointed deputy medical directors. I am sure the board will join me in welcoming everyone to these important roles.

In June it was confirmed that Amanda Pritchard, currently CEO of Guy's and St Thomas' NSH Foundation Trust, will be taking up the newly created role of **NHS Chief Operating Officer** later this summer. Amanda is well known to many of us at Moorfields and we look forward to welcoming her to a visit later in the year to discuss our strategic plans and ambitions moving forward; we also wish her the very best of luck in her new and critically important role.

I am delighted to announce that **Andrew Nebel** was awarded an MBE as part of the Queen's birthday honors for his services to charitable fundraising. Andrew was previously a Non-executive Director at Moorfields (until March 2017) and remains a member of the Moorfields Eye Charity Fundraising committee.

4. Research

I am pleased to report that the trust has been successful in its recent **'Innovate UK Digital Health Technology Grant' application**. This is to develop an Artificial Intelligence platform for cataract surgery aiming to improve theatre flow, risk estimation and reduction, nursing support (especially when rotating to different theatres) and provide intraoperative simulation training. In summary, this involves:

- Collaboration with TouchSurgery (also based on City Road)

- £615k from Innovate UK (Moorfields to directly receive just over £200k). TouchSurgery injecting a further £275k (total project just under £900k)
- This phase runs for 18 months starting September 2019
- City Road to be primary recruiting location (network sites also involved)
- A special note of reference for James Wawrzynski, one of our ST4s, who co-authored the application

5. Strategy

The commissioner-led **public consultation** on the proposal to move our City Road services to a new centre at the St Pancras hospital site was successfully launched on 24 May. The website and consultation documents were released on the day, including accessible online versions in text and audio. Braille versions were delivered the same day and printed copies followed on 28 May.

Communications support included:

- Embargoed media release
- Posts to Twitter, Facebook and LinkedIn
- Promotion via patient information screens throughout Moorfields City Road and network of services across London and south east
- Leaflets and consultation summaries made available at Moorfields' patient information points and via Friends of Moorfields
- Articles released in trust and commissioner newsletters
- Promotional messages on trust and commissioner websites
- Eye charities, local authorities and other stakeholders were asked to cascade the information to their staff and contacts and include notices on intranets and websites.

As at 26 June, a total of 147 responses have been received mainly from patients, carers and the public. Responses from staff at Moorfields and UCL account for 26% of responses received to date. Eighteen public meetings have been held to date, with a total of 200 attendees. Most people at discussion groups are supportive of the proposal, with concerns about improving patient experience and access to the proposed centre from transport hubs.

An in depth interview was held with RNIB connect radio about the proposed move, which was later adapted into a podcast for download. Social media activity around this broadcast helped us reach around 7,000 people.

Five drop-in events have been held at Moorfields, resulting in around 60 conversations with a range of staff.

We are planning two weeks of intensive activity – the week commencing 8 July and the week commencing 9 September. All staff will be encouraged to engage in at least one conversation about Oriel during the week, with a call to action to complete the survey.

David Probert
Chief Executive
July 2019

Report to Trust Board	
Report Title	**Integrated Performance Report - May 2019**
Report from	John Quinn, Chief Operating Officer
Prepared by	Performance And Information Department
Previously discussed at	Trust Management Committee
Attachments	

Brief Summary of Report

The Integrated Performance Report highlights a series of metrics regarded as Key Indicators of Trust Performance and cover a variety of organisational activities within Operations, Quality and Safety, Workforce, Finance, Research, Commercial and Private Patients . 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 Remedial Action Plans for KPIs falling short of target and requiring improvement.

Executive Summary

Executive summary

The Board is asked to note the new IPR which is grouped into four scorecards in order that the Board can identify the areas that contribute to our ambition of service excellence. Through good financial health with good infrastructure and culture as enablers and good people as enablers this should ensure the Trust delivers service excellence.

Context

A&E activity is higher than this time last year and higher for the second month. This is against the general trend of activity reduction last year. We will monitor this closely to assess if this is an ongoing trend.
Other activity has seen positive growth in month which is in line with our plan. There is though further need to catch up from lost activity in April.

Service Excellence

Overall performance remains strong and the Trust is meeting the national access targets year to date. Areas of note:

- The NHSE locally agreed 14 day cancer target is slightly lower than target however is showing a more stable position to that of last year. Two patients were not seen with the 31 day diagnosis to first appointments due to issues beyond the Trusts control.

- Journey times have improved although remain slightly above target.

- There are a number of key indicators missing there target in the admitted section. The deputy COO is revising theatre oversight across the Trust and is presenting a paper to Trust Management Committee in July on those plans. The Board will be updated as this progresses.

People

This indicator will be further commented on in the quarter one version of the IPR.

Infrastructure and culture

The research domain remains strong further indicating the Trusts commitment to its research mission.

Financial Health and Enterprise

Distance from financial plan has improved in May based in improved activity in month. Cost improvement plans remain a challenge and potential special measures will be implemented.

Action Required/Recommendation

The report is primarily for information purposes but will inform discussion regarding how the Trust is performing against its key organisational measures. This may in turn generate subsequent action.

As this is one of the first Integrated Performance Report produced in this format, the audience of this report is also asked to provide feedback on the style and content of the report, so that these can be considered for future iterations.

For Assurance	X	For decision		For discussion		To Note	

Trust Executive Summary By Scorecard Domain - May 2019

Service Excellence (Ambitions)

Patient Centred Care

	G	A	R
Total	**29**	**1**	**10**
Cancer	3	0	2
Access & Outpatients	5	0	2
Admitted	4	0	3
Quality & Safety	17	1	3
Private Patients	0	0	0

Collaborative Research

G	A	R
2	**0**	**0**

Innovation & Education

G	A	R
In Developemnt		

Influence National Policy

G	A	R
In Developemnt		

People (Enablers)

Workforce Metrics

G	A	R
2	**0**	**0**

Staff Satisfaction & Advocacy

G	A	R
0	**0**	**0**

Infrastructure & Culture (Enablers)

Digital Delivery

G	A	R
1	**0**	**1**

Research

G	A	R
2	**1**	**0**

Education

G	A	R
2	**1**	**0**

Financial Health & Enterprise (Enablers)

Overall Plan

G	A	R
1	**1**	**0**

Commercial Operations

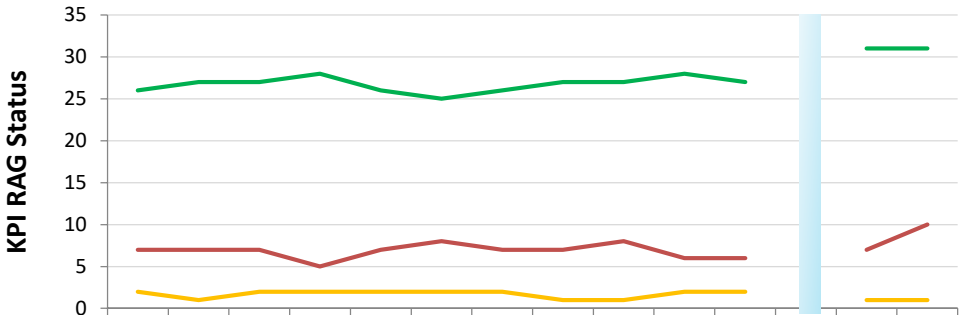
G	A	R
0	**0**	**1**

Cost Improvement Plans

G	A	R
0	**0**	**0**

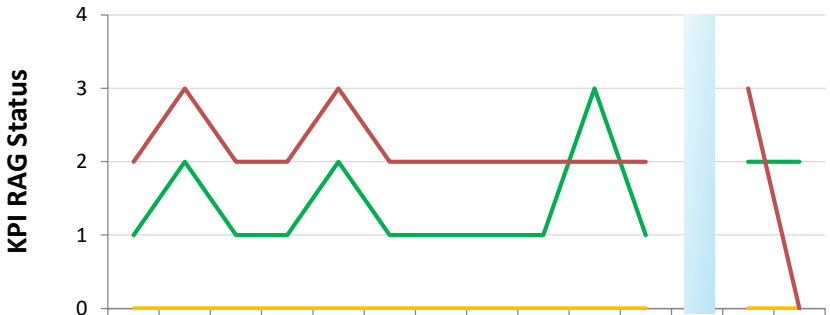
Executive Summary - Scorecard Domain Trends

Service Excellence (Ambitions)



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	-	Apr	May
Green	26	27	27	28	26	25	26	27	27	28	27		31	31
Amber	2	1	2	2	2	2	2	1	1	2	2		1	1
Red	7	7	7	5	7	8	7	7	8	6	6		7	10

People (Enablers)

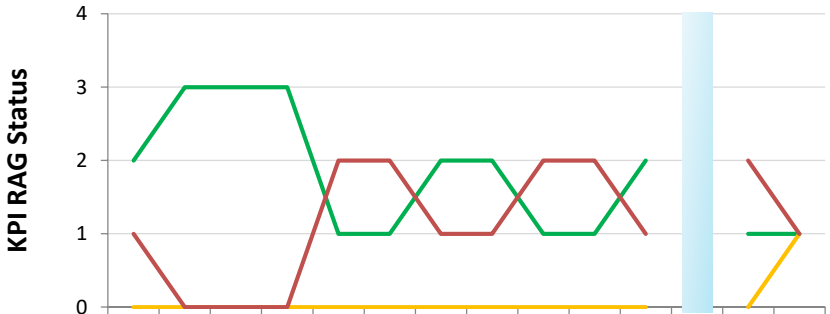


	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	-	Apr	May
Green	1	2	1	1	2	1	1	1	1	3	1		2	2
Amber	0	0	0	0	0	0	0	0	0	0	0		0	0
Red	2	3	2	2	3	2	2	2	2	2	2		3	0

Infrastructure & Culture (Enablers)

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	-	Apr	May
Green	3	3	3	3	3	3	3	3	3	3	2		3	5
Amber	0	0	0	0	0	0	0	0	0	0	1		1	2
Red	1	1	1	1	1	1	1	1	1	1	1		1	1

Financial Health & Enterprise



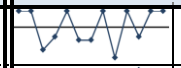
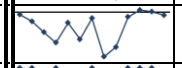
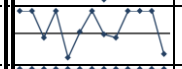
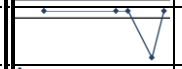
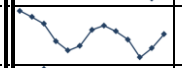
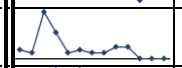
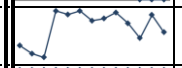
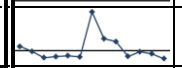
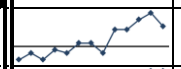
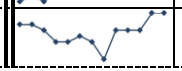
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	-	Apr	May
Green	2	3	3	3	1	1	2	2	1	1	2		1	1
Amber	0	0	0	0	0	0	0	0	0	0	0		0	1
Red	1	0	0	0	2	2	1	1	2	2	1		2	1

Lines split by financial year due to different number of metrics

Context - Overall Activity - May 2019

		May 2019		Monthly Variance	Year To Date		YTD Variance
		2018/19	2019/20		2018/19	2019/20	
Accident & Emergency	A&E Arrivals (All Type 2)	8,204	8,805	+ 7.3%	16,289	17,223	+ 5.7%
	Number of 4 hour breaches	204	146	- 28.4%	470	195	- 58.5%
Outpatient Activity	Number of Referrals Received	12,401	12,898	+ 4.0%	23,328	25,028	+ 7.3%
	Total Attendances	50,545	51,877	+ 2.6%	98,835	99,897	+ 1.1%
	First Appointment Attendances	11,647	11,364	- 2.4%	22,456	21,957	- 2.2%
	Follow Up (Subsequent) Attendances	38,898	40,513	+ 4.2%	76,379	77,940	+ 2.0%
Admission Activity	Total Admissions	3,211	3,403	+ 6.0%	6,303	6,454	+ 2.4%
	Day Case Elective Admissions	2,926	3,038	+ 3.8%	5,723	5,754	+ 0.5%
	Inpatient Elective Admissions	82	89	+ 8.5%	167	200	+ 19.8%
	Non-Elective (Emergency) Admissions	203	276	+ 36.0%	413	500	+ 21.1%

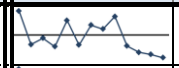
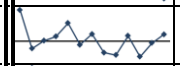
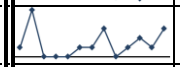
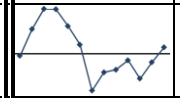
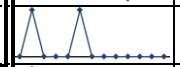
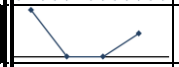
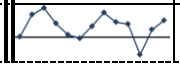
These figures are not subject to any finance or commissioning business logic. They present all activity, whether chargeable or not

Patient Centred Care (Cancer)	Cancer 2 week waits - first appointment urgent GP referral	≥93%										→
	Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	≥93%										↓
	Cancer 31 day waits - diagnosis to first appointment	≥96%										↓
	Cancer 31 day waits - subsequent treatment	≥94%										→
	Cancer 62 days from urgent GP referral to first definitive treatment	≥85%										↑
Patient Centred Care (Access & Outpatients)	18 Week RTT Incomplete Performance *	≥92%										↑
	52 Week RTT Incomplete Breaches *	Zero Breaches										→
	A&E Four Hour Performance	≥95%										↓
	Percentage of Diagnostic waiting times less than 6 weeks	≥99%										→
	Average Call Waiting Time	≤ 3 Mins (180 Sec)										↓
	% AIS Actions That Meet Patient Needs/Requirements	≥ 90%										
	% Patients Asked About Accessbility Needs	≥ 90%										
	Median Clinic Journey Times - New Patient appointments	≤ 95 Mins										↓
	Median Clinic Journey Times -Follow Up Patient appointments	≤ 85 Mins										→

* Provisional Figure for May 2019

** Provisional Figure for Apr-May 19

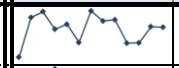
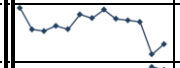
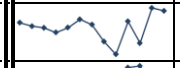
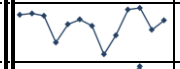
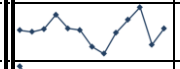
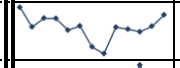
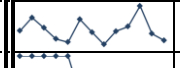
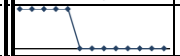
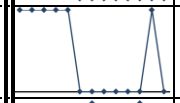
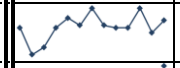
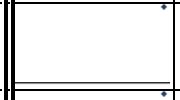
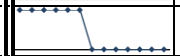
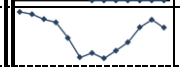
Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Patient Centred Care (Admitted)	Theatre Cancellation Rate (Overall)	≤7.0%										↓
	Theatre Cancellation Rate (Non-Medical Cancellations)	≤0.8%										↑
	Number of non-medical cancelled operations not treated within 28 days **	Zero Breaches										↑
	Mixed Sex Accommodation Breaches	Zero Breaches										→
	Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	≤ 2.67%										↑
	VTE Risk Assessment	≥95%										↑
	Posterior Capsular Rupture rates	≤1.95%										↓
Patient Centred Care (Quality & Safety)	Occurrence of any Never events	Zero Events										→
	Endopthalmitis Rates - Aggregate Score	Zero Non-Compliant										
	MRSA Bacteraemias Cases	Zero Cases										→
	Clostridium Difficile Cases	Zero Cases										→
	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Zero Cases										→
	MSSA Rate - cases	Zero Cases										→
	Inpatient (Overnight) Ward Staffing Fill Rate	≥90%										↑

* Provisional Figure for May 2019

** Provisional Figure for Apr-May 19

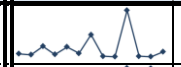
Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Patient Centred Care (Quality & Safety)	Inpatient Scores from Friends and Family Test - % positive	≥90%										→
	A&E Scores from Friends and Family Test - % positive	≥90%										↓
	Outpatient Scores from Friends and Family Test - % positive	≥90%										↑
	Paediatric Scores from Friends and Family Test - % positive	≥90%										↓
	Inpatient Scores from Friends and Family Test - % response rate	≥30%										↑
	A&E Scores from Friends and Family Test - % response rate	≥20%										↑
	Outpatient Scores from Friends and Family Test - % response rate	≥15%										↑
	Paediatric Scores from Friends and Family Test - % response rate	≥15%										↓
	Summary Hospital Mortality Indicator	Zero Cases										→
	NHS England/NHS Improvement Patient Safety Alerts breached	Zero Alerts										↓
	Number of Written Complaints	YTD ≤ 40										↑
	Freedom of Information Requests Responded to Within 20 Days	≥90%										♦
	Subject Access Requests (SARs) Responded To Within 28 Days	≥90%										♦
	Number of Serious Incidents remaining open after 60 days	Zero Cases										→
	Percentage of Incidents (excluding Health Records incidents) remaining open after 28 days	≤5%										↓

* Provisional Figure for May 2019

** Provisional Figure for Apr-May 19

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Collaborative Research	Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	≥300										↑
	Percentage of Trust Patients Recruited Into Research Projects	≥2%										↓
Innovation & Education	Metrics In Development	tbc				tbc	*In Development*					
Influence National Policy	Metrics In Development	tbc				tbc	*In Development*					

* Provisional Figure for May 2019

** Provisional Figure for Apr-May 19

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

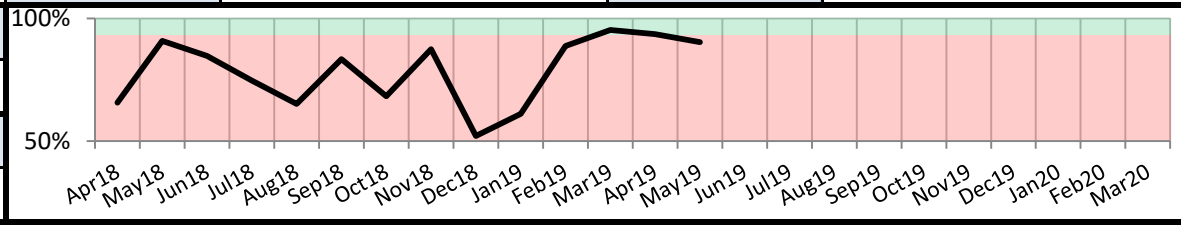
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Cancer)
Lead Manager	Tim Reynolds	Responsible Director	John Quinn

Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≥93%	Red	91.9%	88.7%	95.2%	93.6%	90.4%

Divisional Benchmarking (May 19)	City Road	North	South
	90.4%	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
All breaches to the NHSE 14-day standard in May were as a result of patient choice.	Patient choice remains a significant a factor as this is a national service with patients attending from a long distance away in some cases, meaning time is required to make travel plans. Clinical intevention continues to be sought where patients do not demonstrate understanding of the reason that their referral is urgent.	No Further Action Required

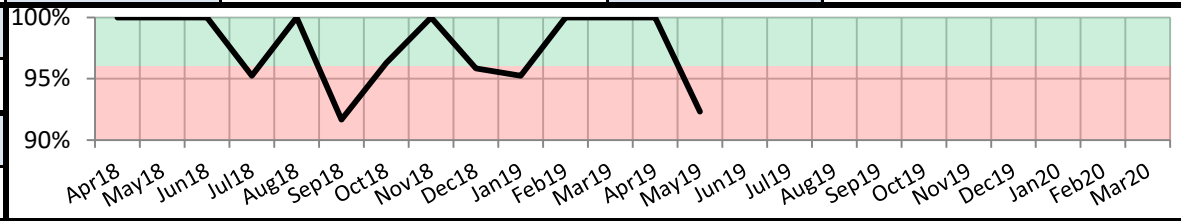
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Cancer)
Lead Manager	Tim Reynolds	Responsible Director	John Quinn

Cancer 31 day waits - diagnosis to first appointment

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≥96%	Red	96.4%	100.0%	100.0%	100.0%	92.3%

Divisional Benchmarking (May 19)	City Road	North	South
	92.0%	n/a	100.0%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There were two 31 day breaches in May. Both were as a result of cases being cancelled at Bart's in April due to a lack of beds. Once cancelled, the patients could not be treated before breach as there were no suitable plaques available.	These breaches were unavoidable.	No Further Action Required

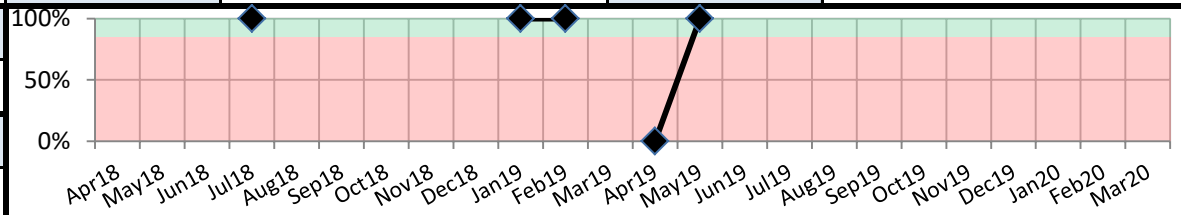
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Cancer)
Lead Manager	Tim Reynolds	Responsible Director	John Quinn

Cancer 62 days from urgent GP referral to first definitive treatment

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≥85%	Green	50.0%	100.0%	n/a	0%	100.0%

Divisional Benchmarking (May 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There was one 62 day breach in April. Adnexal referred the patient to Medical Oncology at St George's for systemic treatment of MALT Lymphoma, which was diagnosed here via orbital biopsy. The patient subsequently chose to have her treatment at the Royal Marsden as this is closer to her home – this was only identified when the Marsden submitted the treatment on the Cancer Waiting Times system. We have not been able to apply an adjustment, so the breach sits with MEH according to the new CWT rules, despite Moorfields referring on in good time on day 34 and the breach occurring as a result of the patient's wish for more local treatment	This breach was unavoidable - however we have flagged to NHS England that there needs to be clarity about how we should flag patient choices earlier to capture the information.	July 2019

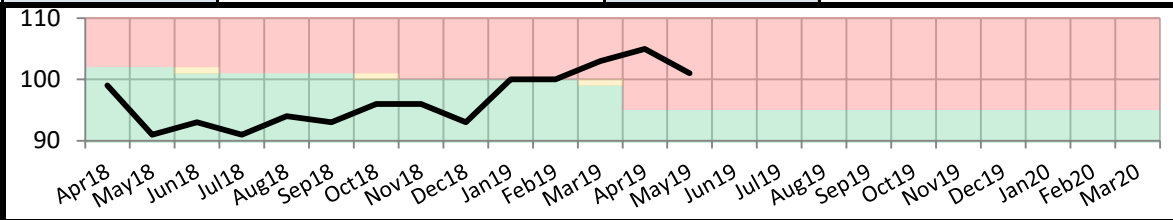
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Access & Outpatients)
Lead Manager	Naomi Sheeter	Responsible Director	John Quinn

Median Clinic Journey Times - New Patient appointments

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≤ 95 Mins	Red	102	100	103	105	101

Divisional Benchmarking (May 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
- There has been a greater increase in journey times in the City Road Division, relative to the other divisions. - The glaucoma service at City Road has seen a particular spike, it is notable that patient numbers seen in that service in April were signficantly reduced, the lowest per month since December 2018. - The new patient journey times for the glaucoma service at City Road has reduced by 6 minutes in comparison to March, but remains significantly higher than preceding months.	We are supporting the ongoing roll-out of the agreed sub-specialty clinical stratification, which is expected to reduced outpatient journey times. The initial focus is on medical retina and glaucoma.	Jun 2019	

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
New patient journey times increased across the trust from December 2018 to April 2019. They then decreased in May 2019, however this remains above the 2019-20 target of ≤95mins. Although data completeness across the trust has increased, the glaucoma service - which sees on average 19% of the trust's outpatient activity - showed a significant decrease in data completeness for new patients in each month from December to May; this then significantly increased in May. The decrease in data completeness, as well as the fact that new patient attendances are significantly lower than follow-ups in terms of numbers, means that the journey time measurements over this time period are much more variable, and give a much less accurate representation of actual time spent in clinic by patients.	Data completeness is now being reviewed by operational management teams both by site and by service. We are supporting the ongoing roll-out of agreed sub-specialty clinical stratification, which will reduce outpatient journey times - focussing on reducing demand on consultant-led clinics across the trust to reduce journey times in these clinics.	December 2019
	Site and service level journey time data is reviewed weekly by operational management teams and fortnightly in the clinical administration project board.	No Further Action Required

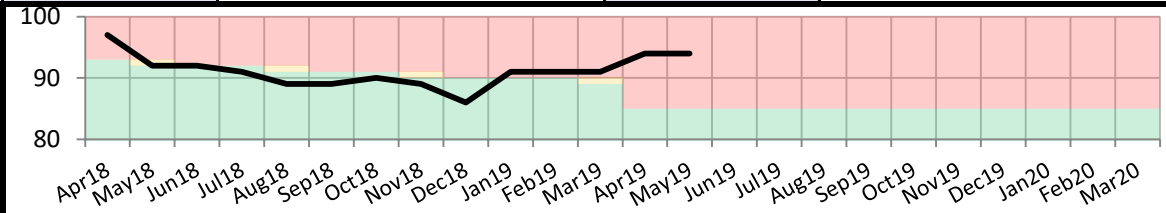
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Access & Outpatients)
Lead Manager	Naomi Sheeter	Responsible Director	John Quinn

Median Clinic Journey Times -Follow Up Patient appointments

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≤ 85 Mins	Red	94	91	91	94	94

Divisional Benchmarking (May 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
- There has been a greater increase in journey times in the City Road Division, relative to the other divisions. - The glaucoma service at City Road has seen a particular spike, it is notable that patient numbers seen in that service in April were signficantly reduced, the lowest per month since December 2018.	- We are supporting the ongoing roll-out of the agreed sub-specialty clinical stratification, which is expected to reduced outpatient journey times, focussing on medical retina and glaucoma. - Site & service level journey time data is reviewed weekly in team meetings and fortnightly in the clinical administration project board.	Jun 2019	

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
There has been a gradual increase in follow-up journey times from December 2018 and it is now 9 minutes longer than target; this has not been attributed to a particular site or service. However data completeness has increased by 8.8% in the period, meaning that a more representative picture of journey times is now being measured. Follow-up journey times at City Road remain higher than those in the North and South divisions; again data completeness is highest at City Road. There were also approximately 2,500 more follow-up attendances across the trust in May compared to April.	Data completeness is now being reviewed by operational management teams both by site and by service. We are supporting the ongoing roll-out of agreed sub-specialty clinical stratification, which will reduce outpatient journey times - focussing on reducing demand on consultant-led clinics across the trust to reduce journey times in these clinics.	December 2019
	Site and service level journey time data is reviewed weekly by operational management teams and fortnightly in the clinical administration project board.	No Further Action Required

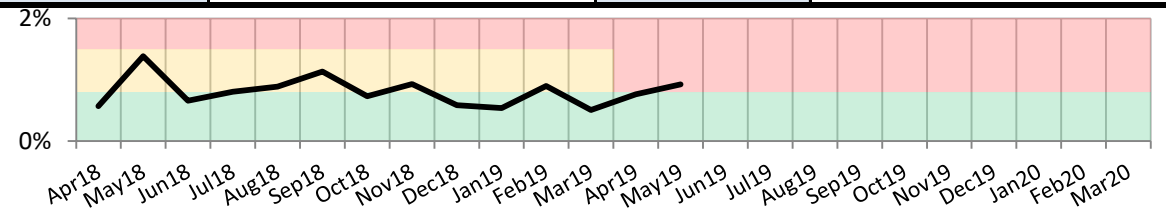
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Admitted)
Lead Manager	Alex Stamp	Responsible Director	John Quinn

Theatre Cancellation Rate (Non-Medical Cancellations)

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≤0.8%	Red	0.85%	0.90%	0.51%	0.76%	0.92%

Divisional Benchmarking (May 19)	City Road	North	South
	0.94%	0.58%	1.60%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
South - 9 NMC in May. 3 of these occurred on the same day due to theatre equipment failure which could not be rectified in time to avoid cancellations. A further 2 were due to an emergency theatre case taking priority, resulting in cancellations on the day.	Both of these cases were unavoidable but have resulted in the South Division breaching the target of <0.80%. If these unavoidable cancellations had not occurred then the South division's performance would have been 0.7%. South are reviewing process for monitoring theatre performance and are instigating weekly review.	August 2019
Specific lens required which are being sourced from a new supplier.	Review of current suppliers in regards to lens supply to avoid delays in patient pathways.	July 2019

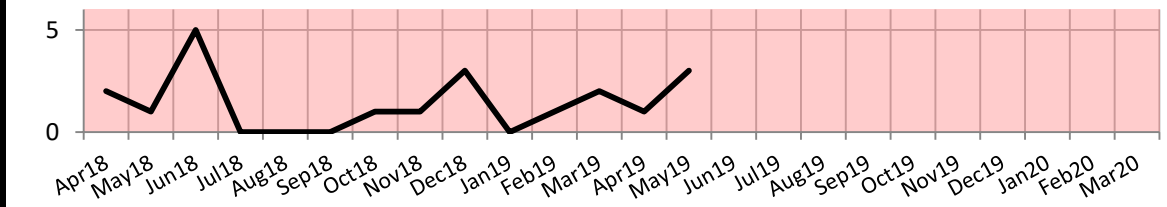
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Admitted)
Lead Manager	Alex Stamp	Responsible Director	John Quinn

Number of non-medical cancelled operations not treated within 28 days

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
Zero Breaches	Red	4	1	2	1	3

Divisional Benchmarking (May 19)	City Road	North	South
	3	0	0



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Locum consultant anaesthetist unable to attend list due to mix up with their schedule. Patient cancelled on the day. Booked outside 28 days due to failure to find appropriate anaesthetic covered list.	Divisional Director discussing with new anaesthetic lead, review of locum requests being undertaken by North management team.	Jun 2019	

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Information is incorrect for City Road as there were two patients who have been counted but who should not have been (one DNA on the day, another who requested a referral to St George's).	Deputy Divisional Manager liaising with P&I to clarify how these can be correctly recorded moving forward.	July 2019

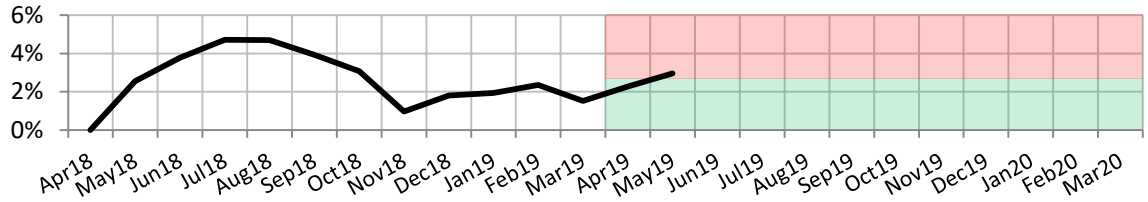
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Admitted)
Lead Manager	Alex Stamp	Responsible Director	John Quinn

Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal) - Rolling 3 Months

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≤ 2.67%	Red	n/a	2.36%	1.53%	2.27%	2.95%

Divisional Benchmarking (May 19)	City Road	North	South
	3.72%	0.00%	0.00%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Ongoing review of readmission rates undertaken by City Road. No specific issues identified.	Review ongoing	September 2019

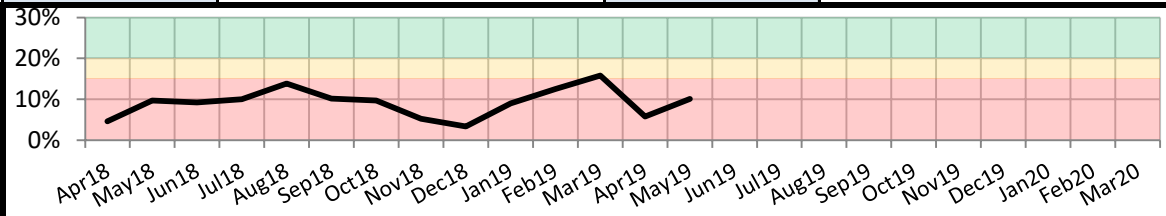
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Quality & Safety)
Lead Manager		Responsible Director	Ian Tombleson

A&E Scores from Friends and Family Test - % response rate

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≥20%	Red	8.0%	12.5%	15.8%	5.8%	10.1%

Divisional Benchmarking (May 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Better staff engagement, new processes and commitment are required from teams to improve performance to the required level and beyond	An action plan has been developed. Actions include: Changing the point patients are asked to complete the cards. New printed cards. Posters and signs for collection boxes have been re-done. Encouraging staff to ask patients to complete the cards at discharge. Having concentrated periods with a 'push' to encourage patients to complete cards. Technological solutions are being procured to supesede manual processes in the medium term	Mar 2019	
Performance is considerably improved from the previous three months. Volunteers have been engaged to support departmental staff. Improvement is occurring month on month as actions from December embed.	A new system to collect FFT scores and comments by text is actively being implemented over the next 1 to 2 months and should replace the need for hand written cards. Bench-marking indicates this has the potential to substantially improve performance	Jun 2019	In Progress (No Update)
Systematic distribution of cards is still not fully embedded across all team members and is very reliant on the volunteer to support it. This drop in performance was due to the annual leave of the volunteer.	Nurses (ENPs) and doctors will be given daily targets for distribution of cards and will be expected to be less reliant on the volunteer to complete this process. In parallel the new FFT text messaging system will be introduced in the next 2 months.	Jun 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions		

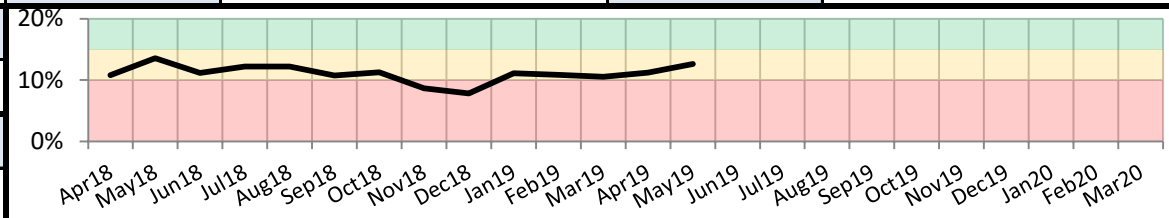
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Quality & Safety)
Lead Manager		Responsible Director	Ian Tombleson

Outpatient Scores from Friends and Family Test - % response rate

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≥15%	Amber	11.9%	10.9%	10.6%	11.2%	12.6%

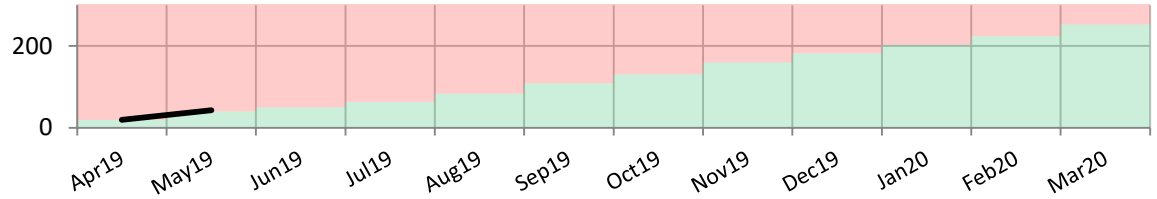
Divisional Benchmarking (May 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Overall performance has improved. Recent customer care training for clerical staff is having some impact including setting new expectations about improving patient experience through data collection	Plans continue for implementation of the FFT system in the next two months	Jun 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions		

Remedial Action Plan - May 2019							Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Quality & Safety)
Number of Written Complaints							Lead Manager		Responsible Director	Ian Tombleson
Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19				
YTD ≤ 40	Red	43	21	29	19	24				
Divisional Benchmarking (May 19)				City Road	North	South				
				14	4	5				



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The 'Red' rating is derived from a comparison with the same period last year. Across the whole trust we have received just 3 more complaints than at the same time last year and monthly numbers remain within expected tolerences.	The trust systematically monitors all complaints in order to identify themes or trends - none have been identified from those received this year to date. The annual Quality & Safety report outlines further detail for 2018/19.	No Further Action Required

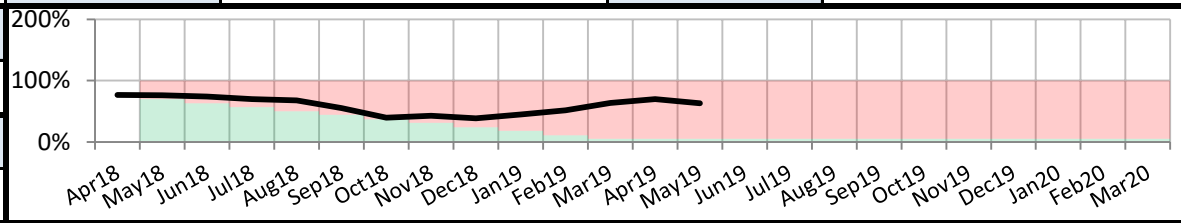
Remedial Action Plan - May 2019

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Quality & Safety)
Lead Manager		Responsible Director	Ian Tombleson

Percentage of Incidents (excluding Health Records incidents) remaining open after 28 days

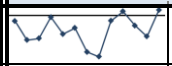
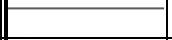
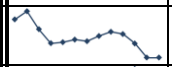
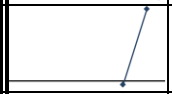
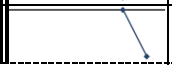
Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≤5%	Red	n/a	51.6%	63.6%	69.6%	63.2%

Divisional Benchmarking (May 19)	City Road	North	South
	38.5%	72.8%	14.7%

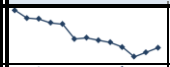
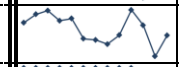
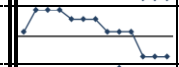
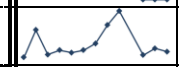


Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Trust wide position continues to be adversely affected by the quantity of open incidents associated with the review of glaucoma patients at Bedford. Other divisions have also experienced challenges as a consequence of the health record project, with attentions diverted to ensure records are available for patient appointments.	The most recent data (17 May) indicates there has been an improvement in the overall position with all 3 divisions (<38% for City Road, <30% for South and around 65% for North). A number of Bedford glaucoma incidents have been closed which has contributed positively to the overall performance within the North. The central quality & safety team is closely monitoring performance within each division with a deadline of 30 June for the divisions to reach the agreed targets of <10 incidents older than 28 days for City Road and <5 for the other 3 divisions.	Aug 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions		

Workforce Metrics	Appraisal Compliance	≥80%											↑
	Information Governance Training Compliance	≥95%											
	Staff Turnover (Rolling Annual Figure)	≤15%											→
	Proportion of Temporary Staff	RAG as per Spend											↓
Staff Satisfaction & Advocacy	Percentage of Staff agreeing with the staff survey statement "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	≥90%											
	Percentage of Staff agreeing with the staff survey statement "I would recommend my organisation as a place to work"	≥70%											

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Digital Delivery	Data Quality - Ethnicity recording (Outpatient and Inpatient)	≥94%										↑
	Data Quality - Ethnicity recording (A&E)	≥94%										↑
Research	70 Day To Recruit First Research Patient	≥80%										→
	Percentage of Research Projects Achieving Time and Target	≥65%										→
	Percentage of Patients Recruited Against Target (Studies Closed In Month)	100%										↓
	Number of Publications	None Set										

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

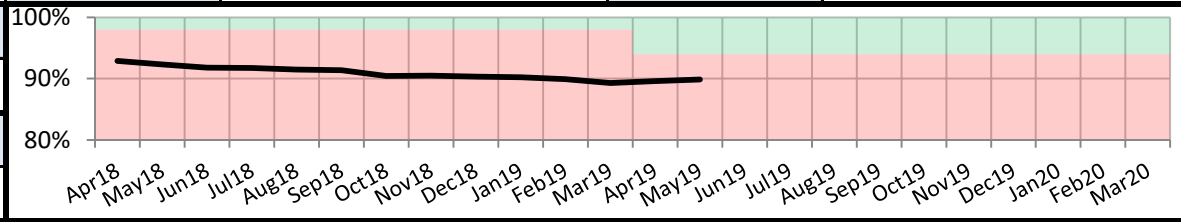
Remedial Action Plan - May 2019

Domain	Infrastructure & Culture (Enablers)	Theme	Digital Delivery
Lead Manager		Responsible Director	John Quinn

Data Quality - Ethnicity recording (Outpatient and Inpatient)

Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≥94%	Red	89.7%	89.9%	89.3%	89.6%	89.9%

Divisional Benchmarking (May 19)	City Road	North	South
	90.9%	84.8%	93.1%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
This is a long standing issue for the organisation and whilst benchmark performance is better than many other trusts the national target has never been achieved and is extremely stretching. Underlying reasons include the lack of comprehensive operating procedures, customer service training and the inherent sensitivities surronding the collection if these data.	The pilot exercise carried out in the North East directorate whereby clinic clerks were supplied with prompt cards to simplify the requesting of patients ethnicity status will be extended across the Trust and linked to the Standard Operating Procedures documents currently being compiled.	Mar 2019	Complete
	The Data Quality team have been tasked with an Ethnicity data improvement project.	Aug 2019	In Progress (No Update)
	At the June Data Quality and Information Management Group it was agreed that alongside the prompt card process being used across the trust it would be useful to have a floor walking exercise to collect ethnicity from patients and explain the reason for collecting the data. The DQ team could support this process once the prompt card pilot has been completed. Further improvements should be seen as the check-in kiosks are embedded across the trust.	Jun 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions		

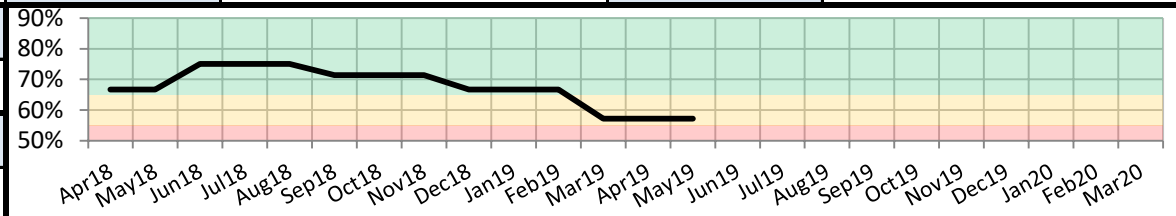
Remedial Action Plan - May 2019

Domain	Infrastructure & Culture (Enablers)	Theme	Research
Lead Manager	**Julian Hughes**	**Responsible Director**	**Maria Hassard**

Percentage of Research Projects Achieving Time and Target

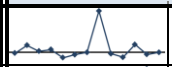
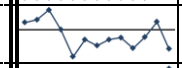
Target	Rating	YTD	Feb-19	Mar-19	Apr-19	May-19
≥65%	Amber	57.1%	66.7%	57.1%	57.1%	57.1%

Divisional Benchmarking (May 19)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
4 studies successful and 3 studies unsuccessful in reaching recruitment target during the reporting period. 1. CLAJ1012 (The Efficacy and Safety of Bimatoprost SR in Patients With Open-angle Glaucoma or Ocular Hypertension; Clarke): 0/1 recruited (i) Patients did not want to receive an injection for the study; (ii) Patients from mile end did not want to travel to city road for assessments; (iii) Patients reported the study visits were too long and onerous and interfered with work commitments due to the length of visits. 2. SIVS1039 (A dose-ranging study of intravitreal OPT-302 in combination with ranibizumab, compared with ranibizumab alone, in participants with neovascular age-related macular degeneration wet AMD; Sivaprasad): 1/4 patients recruited. Contract negotiations for costings delayed initial opening of the study and study closed 3 weeks early as global recruitment target was met. Study had high screening failure rate i.e. most patients ineligible as vision was too good or had previous injections. 3. Mauv 1011 (Post-Market Clinical Investigation of the Clareon« IOL; Maurino): 3/10 recruited. (i) study ended up opening during the summer months when theatre space was at a low as well as maintenance works in theatre limiting availabilityl (ii) Difficulty finding eligible patients with bilateral cataracts with no other condition.	Internal feasibility analysis will enable the setting of better targets in potentially difficult to recruit to studies. Negotiations with partners will in future develop target ranges which will allows us to report against both the lower and upper ends of that range. This will cater for those occasions where we are opening as a site later than most other international sites and avoid the risk of having studies close early before we have been able to meet our agreed target locally. We are also looking at predicted closure dates 6 months in advance and engaging with sponsors early to try to avoid missing future recruitment targets.	Jul 2019	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
No Further Issues or Actions		

Overall Plan	Overall financial performance (In Month Var. £m)	≥0										↑
	Distance from Financial Plan (Current in Trust Metric : Trust Underlying Overall Position - Surplus / Deficit)	1										↓
Commercial Operations	Commercial Trading Unit Position (In Month Var. £m)	≥0										↓
Cost Impovement Plans	Cost Improvement Plan Variance	≥0										↑

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 07
Finance report
Board of directors 4 July 2019

Report title	Monthly Finance Performance Report Month 02 - May 2019
Report from	Jonathan Wilson, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

The Trust has reported a control total surplus of £0.3m in May, compared to a planned surplus of £0.3m, a break-even position. Year to date the Trust has reported a £0.8m deficit, an adverse variance against plan of £0.2m.

Financial Performance £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Budget	Actual	Variance
Income	£236.4m	£19.9m	£19.9m	(£0.0m)	£39.6m	£39.0m	(£0.6m)
Pay	(£133.7m)	(£11.1m)	(£10.7m)	£0.4m	(£22.5m)	(£22.0m)	£0.5m
Non Pay	(£94.5m)	(£7.7m)	(£8.1m)	(£0.4m)	(£16.3m)	(£16.5m)	(£0.2m)
Financing & Adjustments	(£8.2m)	(£0.7m)	(£0.7m)	£0.0m	(£1.4m)	(£1.3m)	£0.1m
CONTROL TOTAL	**£0.0m**	**£0.3m**	**£0.3m**	**£0.0m**	**(£0.6m)**	**(£0.8m)**	**(£0.2m)**

Efficiency scheme performance is reporting delivery of £0.21m in May, compared to a planned £0.51m, an adverse variance against plan of £0.30m. Year to date delivered savings are £0.38m against a planned £0.81m, an adverse variance against plan of £0.44m.

The Trust has identified £4.97m of savings schemes inclusive of £1.45m red risk rated schemes from the planned £7.0m target. There remains un-identified savings of £2.00m.

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

For the period ended 31st May 2019 (Month 02)

Presented by	Jonathan Wilson; Chief financial Officer
Prepared by	Justin Betts; Deputy Chief Finance Officer Amit Patel; Head of Financial Management Assad Choudry; Head of financial Control

Monthly Finance Performance Report

For the period ended 31st May 2019 (Month 02)

Key Messages

Statement of Comprehensive Income

Control Total Financial Position	The Trust is reporting a control total surplus of £0.34m in May, against a planned surplus of £0.34m – a breakeven position to plan. Year to date performance stands at a deficit of £0.78m compared to a planned deficit of £0.58m, an adverse variance of £0.20m.
Income	NHS clinical income is £0.59m adverse to plan YTD - predominantly linked to lower activity than planned in April. Other income is broadly in line with plan.
Expenditure (pay, non pay and financing)	Pay costs are £0.47m below plan YTD primarily due to vacancies within non-medical/nursing staff groups. Agency costs are below planned levels and reflect the positive move to increase substantive recruitment and availability of bank staff.
Research	R&D is reporting a favourable position of £0.10m in month and £0.10m YTD. Over-achievement of Income is offset with overspends within Pay and Non-Pay.
Commercial Trading Units	Commercial Trading Units are reporting a surplus YTD of £0.43m, which is £0.16m adverse to plan. Moorfields Private reported adverse variances in month of £0.021m, whilst Dubai and Abu Dhabi reported a net adverse variance of £0.09m.
Efficiency Programme	The Trust is reporting YTD efficiency savings achieved of £0.38m compared to a plan of £0.81m, an adverse variance of £0.43m. There are currently £2.0m of unidentified savings schemes, and a further £1.5m schemes assessed as high risk.

Statement of Financial Position

Cash and Working Capital Position	The cash balance at the 31st May is £42.6m, £1.1m below plan primarily due to higher than planned levels of payments to creditors which have reduced by £5.1m since March 2019.
Capital (both gross capital expenditure and CDEL)	Total capital expenditure YTD is £0.8m compared to an internal plan of £1.2m, and adverse variance of £0.4m. The key areas of variance relate to the ORIEL project (£0.3m); with strategic planning and AECOM cost slipping to later in the financial year, and IT projects (£0.1m).
Use of Resources	The Use of Resources rating is 3; in line with the planned rating of 3. The year end rating is forecast to be 1.
Receivables	Trust receivable debt has reduced by £3.0m to £17.8m since the start of the financial year.
Payables	Trust creditors has reduced by £5.1m to £11.5m since the start of the year. Payment of invoices YTD is at 89% by volume, against a threshold of 95%.
Forecast	The Trust is currently forecasting to meet its planned full year control total of breakeven, and is reviewing and preparing potential mitigations in respect of known challenges such as efficiency programme identification levels, and known operational risks.

Trust Financial Performance
Executive Financial Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Budget	Forecast Actual	Forecast Variance
Income	£236.4m	£19.9m	£19.9m	(£0.0m)	£39.6m	£39.0m	(£0.6m)		£236.4m	£236.4m	-
Pay	(£133.7m)	(£11.1m)	(£10.7m)	£0.4m	(£22.5m)	(£22.0m)	£0.5m		(£133.7m)	(£133.7m)	-
Non Pay	(£94.5m)	(£7.7m)	(£8.1m)	(£0.4m)	(£16.3m)	(£16.5m)	(£0.2m)		(£94.5m)	(£94.5m)	-
Financing & Adjustments	(£8.2m)	(£0.7m)	(£0.7m)	£0.0m	(£1.4m)	(£1.3m)	£0.1m		(£8.2m)	(£8.2m)	-
CONTROL TOTAL	**£0.0m**	**£0.3m**	**£0.3m**	**£0.0m**	**(£0.6m)**	**(£0.8m)**	**(£0.2m)**		**£0.0m**	**£0.0m**	-
Memorandum Items											
Research & Development	£0.88m	£0.07m	£0.08m	£0.01m	£0.15m	£0.16m	£0.01m				
Commercial Trading Units	£4.77m	£0.39m	£0.10m	(£0.29m)	£0.58m	£0.43m	(£0.16m)				
ORIEL Revenue	(£2.30m)	(£0.25m)	(£0.18m)	£0.07m	(£0.50m)	(£0.45m)	£0.05m				
Efficiency Schemes	£7.00m	£0.51m	£0.21m	(£0.30m)	£0.81m	£0.38m	(£0.44m)				

INCOME BREAKDOWN RELATED TO ACTIVITY

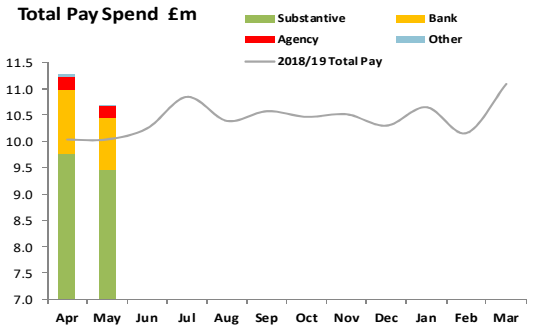
Income Breakdown £m	Annual Plan	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Budget	Forecast Actual	Forecast Variance
NHS Clinical Income	£146.5m	£24.3m	£23.8m	(£0.5m)		£146.5m	£146.5m	-
Pass Through	£38.0m	£6.3m	£6.1m	(£0.1m)		£38.0m	£38.0m	-
Commercial Trading Units	£31.6m	£4.9m	£4.8m	(£0.1m)		£31.6m	£31.6m	-
Research & Development	£10.1m	£2.6m	£2.7m	£0.2m		£10.1m	£10.1m	-
Other	£10.1m	£1.6m	£1.6m	(£0.0m)		£10.1m	£10.1m	-
TOTOAL OPERATING REVENUE	**£236.4m**	**£39.6m**	**£39.0m**	**(£0.6m)**		**£236.4m**	**£236.4m**	-

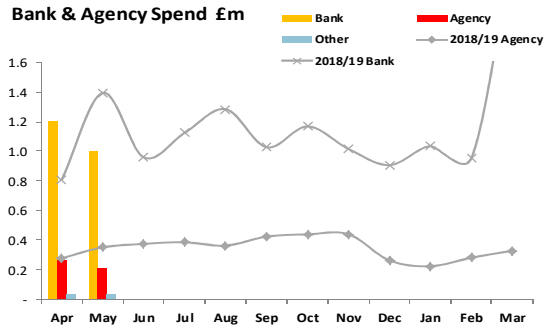
RAG Ratings

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

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	% Total
Employed	(£129.8m)	(£10.8m)	(£9.5m)	£1.32m	(£21.8m)	(£19.2m)	£2.56m	87%
Bank	(£3.0m)	(£0.3m)	(£1.0m)	(£0.73m)	(£0.5m)	(£2.2m)	(£1.68m)	10%
Agency	(£0.4m)	(£0.0m)	(£0.2m)	(£0.18m)	(£0.1m)	(£0.5m)	(£0.41m)	2%
Other	(£0.4m)	(£0.0m)	(£0.0m)	(£0.00m)	(£0.1m)	(£0.1m)	(£0.00m)	0%
TOTAL PAY	**(£133.7m)**	**(£11.1m)**	**(£10.7m)**	**£0.40m**	**(£22.5m)**	**(£22.0m)**	**£0.47m**	





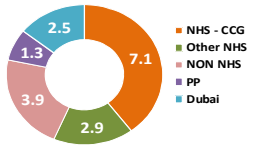
CASH, CAPITAL AND OTHER KPI S

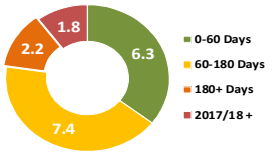
Capital Programme £m	Annual Plan	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Budget	Forecast Actual	Forecast Variance
Trust Funded	(£17.7m)	(£1.2m)	(£0.8m)	£0.4m		(£17.7m)	(£17.7m)	-
Donated	(£0.4m)	-	-	-		(£0.4m)	(£0.4m)	-
TOTAL	**£18.1m**	**£1.2m**	**£0.8m**	**(£0.4m)**		**£18.1m**	**£18.1m**	-

Key Metrics	Plan	Actual	RAG
Cash	43.7	42.6	
Debtor Days	45	46	
Creditor Days	45	65	
PP Debtor Days	65	54	

Use of Resources	Plan	Actual
Capital service cover rating	1	3
Liquidity rating	1	1
I&E margin rating	4	4
I&E margin: distance from financial	1	2
Agency rating	1	1
OVERALL RATING	**3**	**3**

Net Receivables £m





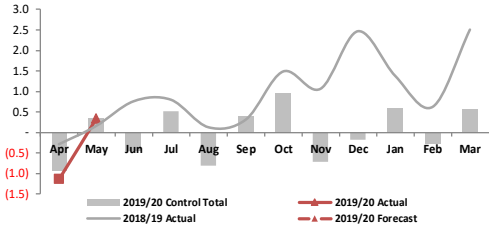
Trust Income & Expenditure Performance

FINANCIAL PERFORMANCE

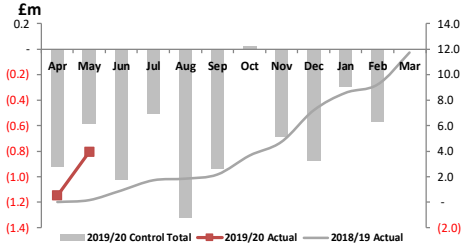
Statement of Comprehensive Income £m	Annual Plan	In Month			Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance	Budget	Actual	Variance
Operating Income										
NHS Clinical Income	184.50	15.77	15.76	(0.00)	30.54	29.94	(0.59)	184.50	184.50	-
Commercial Trading Units	31.64	2.59	2.32	(0.26)	4.94	4.80	(0.15)	31.64	31.64	-
Research & Development	10.11	0.76	0.97	0.22	2.55	2.72	0.17	10.11	10.11	-
Other Income	10.14	0.80	0.81	0.01	1.60	1.58	(0.02)	10.14	10.14	-
Total Income	**236.40**	**19.91**	**19.87**	**(0.04)**	**39.63**	**39.04**	**(0.60)**	**236.40**	**236.40**	**-**
Employee Expenses										
Medical Staff	(36.19)	(3.02)	(2.94)	0.07	(5.96)	(5.94)	0.03	(36.19)	(36.19)	-
Nursing Staff	(22.41)	(1.86)	(1.87)	(0.00)	(3.78)	(3.85)	(0.07)	(22.41)	(22.41)	-
Scientific & Technical	(12.76)	(1.08)	(0.97)	0.12	(2.14)	(1.98)	0.15	(12.76)	(12.76)	-
Clinical Support	(11.50)	(0.94)	(0.82)	0.12	(1.93)	(1.67)	0.26	(11.50)	(11.50)	-
Admin & Other	(32.25)	(2.69)	(2.57)	0.13	(5.38)	(5.22)	0.15	(32.25)	(32.25)	-
Research & Development	(6.41)	(0.52)	(0.59)	(0.07)	(1.26)	(1.42)	(0.16)	(6.41)	(6.41)	-
Commercial Trading Units	(12.16)	(0.99)	(0.95)	0.04	(2.01)	(1.89)	0.12	(12.16)	(12.16)	
Total Employee Expenses	**(133.68)**	**(11.11)**	**(10.70)**	**0.40**	**(22.46)**	**(21.99)**	**0.47**	**(133.68)**	**(133.68)**	**-**
Non Pay Expenditure										
Drugs And Medical Gases	(33.28)	(2.66)	(2.78)	(0.12)	(5.32)	(5.27)	0.05	(33.28)	(33.28)	-
Clinical Supplies & Services	(18.12)	(1.45)	(1.46)	(0.00)	(2.88)	(2.89)	(0.01)	(18.12)	(18.12)	-
General Supplies & Services	(8.23)	(0.71)	(0.77)	(0.06)	(1.37)	(1.41)	(0.04)	(8.23)	(8.23)	-
Premises	(10.07)	(0.93)	(0.94)	(0.00)	(1.78)	(1.76)	0.02	(10.07)	(10.07)	-
Other Expenditure	(7.49)	(0.62)	(0.64)	(0.02)	(1.49)	(1.59)	(0.10)	(7.49)	(7.49)	-
Research & Development	(2.81)	(0.17)	(0.30)	(0.13)	(1.15)	(1.14)	0.00	(2.81)	(2.81)	-
Commercial Trading Units	(14.51)	(1.19)	(1.24)	(0.05)	(2.32)	(2.46)	(0.14)	(14.51)	(14.51)	
Total Non-Pay Expenditure	**(94.51)**	**(7.73)**	**(8.12)**	**(0.39)**	**(16.31)**	**(16.52)**	**(0.21)**	**(94.51)**	**(94.51)**	**-**
Financing & Depreciation	(8.75)	(0.77)	(0.75)	0.02	(1.54)	(1.40)	0.14	(8.75)	(8.75)	-
SURPLUS/(DEFICIT)	**(0.54)**	**0.29**	**0.29**	**0.00**	**(0.68)**	**(0.87)**	**(0.20)**	**(0.54)**	**(0.54)**	**-**
Adjustments for donated assets	0.54	0.05	0.05	(0.00)	0.09	0.09	(0.00)	0.54	0.54	-
CONTROL TOTAL	**0.00**	**0.34**	**0.34**	**0.00**	**(0.58)**	**(0.78)**	**(0.20)**	**0.00**	**0.00**	**-**

PERFORMANCE AGAINST PLAN

Trust Monthly Plan v Actual



Trust Cumulative Plan v Actual



Commentary

Income

The Trust is reporting Income of £19.87m in May, compared to a plan of £19.91m, an adverse variance of £0.04m.

Patient care income is on-plan in May. A&E attendances (£0.08m), inpatients (£0.07m) and injection activity were above plan in-month (£0.13m), but were off-set by outpatient activity being significantly behind plan (£0.15m).

Commercial income was £0.26m behind plan in month. Other income was broadly on-plan in May.

Pay

Total pay was £0.40m favourable to plan in May predominantly within clinical divisions which were £0.36m favourable, largely within non medical/nursing staff groups.

Medical additional/locum session payments during May totalled £0.29m of which £0.08m relates to A&E, and the Trust incurred back-dated costs of £0.120m for funded Medical CEA's awards. Trading units and corporate functions were £0.04m and £0.05m favourable to plan respectively due to vacancies.

Bank hours used were reduced in May compared to the March/April trend and booking reasons were unavailable at the time of reporting.

Non Pay

(non pay and financing)

Non pay reported an adverse variance of £0.39m in May, this was partly driven by non delivery of efficiency schemes of £0.17m. Additionally drugs issues were adverse to plan by £0.12m primarily due to the increased activity on injections. Health Records reported an adverse variance of £0.13m in-month, which was partially off-set by an favourable variance in pay.

Financing and adjustments were broadly on plan with a favourable variance on depreciation costs following the Trusts estate revaluation exercise performed in 2018/19.

Trust Patient Clinical Income Performance

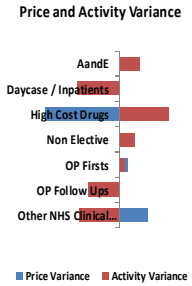
PATIENT CLINICAL INCOME

Point of Delivery	Activity YTD Plan	Activity YTD Actual	Activity YTD Variance	YTD Income £'000 Plan	YTD Income £'000 Actual	YTD Income £'000 Variance	RAG
AandE	16,514	17,223	709	£2,571	£2,711	£140	
Daycase / Inpatients	6,079	5,873	(206)	£6,695	£6,421	(£274)	
High Cost Drugs	8,325	8,679	354	£6,259	£6,124	(£135)	
Non Elective	449	491	43	£866	£959	£93	
OP Firsts	20,556	20,731	175	£3,473	£3,551	£77	
OP Follow Ups	77,553	75,925	(1,628)	£7,883	£7,621	(£262)	
Other NHS Clinical Income	4,110	3,198	(912)	£973	£909	(£64)	
Total	133,585	132,120	(1,465)	£28,720	£28,295	(£425)	

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

PRICE & ACTIVITY VARIANCE

Average price Per Plan	Average price Received	Average price Variance %	£000's Price Variance	£000's Activity Variance
£156	£157	1%	£30	£110
£1,101	£1,093	-1%	(£48)	(£227)
£752	£706	-6%	(£401)	£266
£1,930	£1,953	1%	£11	£82
£169	£171	1%	£48	£30
£102	£100	-1%	(£97)	(£165)
£237	£284	20%	£152	(£216)
			(£305)	(£120)

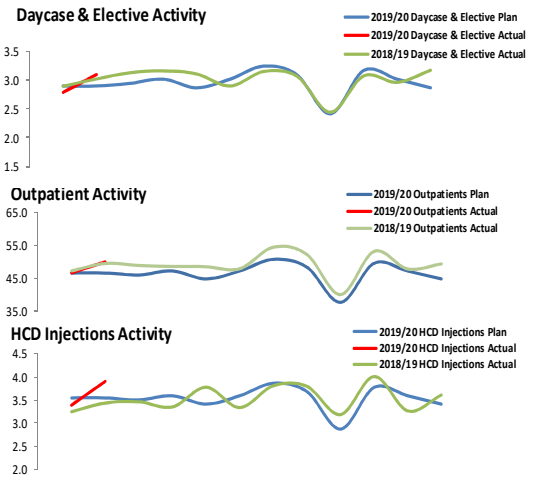


CONTRACT SLA PERFORMANCE

Divisional Income Performance £m	Activity Plan	Activity Actual	Activity Variance	YTD Income £'000 Plan	YTD Income £'000 Actual	YTD Income £'000 Variance
City Road	83,601	83,849	248	£17,788	£17,418	(£371)
North	26,645	26,871	226	£6,137	£6,340	£203
South	23,340	21,400	(1,940)	£4,795	£4,538	(£257)

Top CCG's	Activity Plan	Activity Actual	Activity Variance	YTD Income £'000 Plan	YTD Income £'000 Actual	YTD Income £'000 Variance
NHS Croydon CCG	9,753	8,709	(1,043)	£2,106	£1,851	(£255)
NHS Ealing CCG	6,730	7,170	440	£1,559	£1,782	£223
NHS City and Hackney CCG	6,145	6,019	(126)	£1,269	£1,252	(£17)
NHS Harrow CCG	5,426	5,228	(198)	£1,258	£1,211	(£47)
NHS Wandsworth CCG	5,481	5,451	(30)	£1,195	£1,094	(£102)
NHS Islington CCG	4,142	4,210	68	£856	£874	£19

ACTIVITY TREND



Commentary

NHS Income Overall NHS Patient Clinical Income is reporting an adverse variance to plan YTD of £0.590m of which Contract CCG income represents an adverse £0.425m. This is predominantly due to low activity levels within Daycase/Inpatient and Outpatient activity during April impacting on the YTD performance.

Outpatients Activity exceeded plan during May, however due to the low level of activity seen during April, total activity for the period was adverse to plan contributing to the adverse financial variance YTD of £0.185m. Overall activity YTD is lower than the same period last year.

Day case and Inpatient Activity exceeded plan during May, however due to low levels of activity seen during April, total activity for the period was adverse to plan contributing to the adverse financial variance YTD of £0.274m.

High Cost Drugs/ Injections Activity exceeded plan during May, and YTD, resulting in a net favourable activity price financial performance of £0.165m, however the national change in price for the drug Adalimumab from £344 to £140 has created an adverse price variance of £0.401m.

High Cost Drugs/injections represent a pass through cost for the organisation and any under/over performance within income is compensated within non pay, therefore not affecting the Trusts overall financial performance.

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

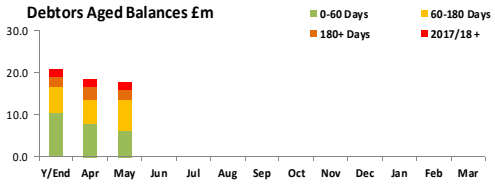
CAPITAL EXPENDITURE

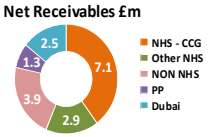
Capital Expenditure £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Plan	Actual	Variance
Estates - Trust Funded	4.1	-	(0.0)	(0.0)	0.0	(0.0)	(0.0)
Medical Equipment - Trust Funded	3.3	-	-	-	0.2	0.2	0.0
IT - Trust Funded	4.0	0.2	0.1	(0.1)	0.3	0.2	(0.1)
ORIEL - Trust Funded	6.0	0.4	0.3	(0.1)	0.7	0.4	(0.3)
Dubai - Trust funded	0.3	-	0.0	0.0	-	0.0	0.0
Other - Trust funded	-	-	-	-	-	-	-
TOTAL - TRUST FUNDED	**17.7**	**0.5**	**0.4**	**(0.2)**	**1.2**	**0.8**	**(0.4)**
IT - Externally Funded	0.4	-	-	-	-		-
TOTAL INCLUDING DONATED	**18.1**	**0.5**	**0.4**	**(0.2)**	**1.2**	**0.8**	**(0.4)**

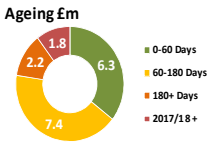
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Planned Total Depreciation	7.1	7.1		100%
Cash Reserves - B/Fwd cash	8.7	8.7		100%
Capital investment loan funding	-			
Cash Reserves - Other (PSF)	3.6	3.6		100%
Capital Loan Repayments	(1.8)	(1.8)		100%
TOTAL - TRUST FUNDED	**17.7**	**17.7**	**-**	**100%**
Externally funded	0.4		0.4	0%
TOTAL INCLUDING DONATE	**18.1**	**17.7**	**0.4**	**98%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2017/18 +*	*Total*
CCG Debt	1.1	5.0	0.8	0.2	7.1
Other NHS Debt	1.3	0.6	0.3	0.7	2.9
Non NHS Debt	2.3	0.5	0.4	0.6	3.9
Commercial Unit Debt	1.6	1.3	0.7	0.2	3.8
TOTAL RECEIVABLES	**6.3**	**7.4**	**2.2**	**1.8**	**17.8**

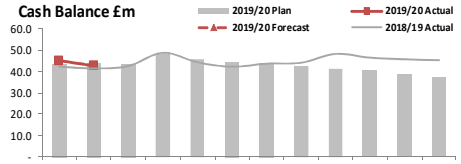






STATEMENT OF FINNCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date		
		Plan	Actual	Variance
Non-current assets	102.9	90.6	89.6	(1.0)
Current assets (excl Cash)	19.6	26.8	30.9	4.1
Cash and cash equivalents	37.3	43.7	42.6	(1.1)
Current liabilities	(39.9)	(39.9)	(36.9)	3.1
Non-current liabilities	(36.1)	(37.9)	(38.1)	(0.2)
TOTAL ASSETS EMPLOYED	**83.8**	**83.2**	**88.0**	**4.8**



OTHER METRICS

Use of Resources	Weighting	Plan YTD	Score
Capital service cover rating	20%	1	3
Liquidity rating	20%	1	1
I&E margin rating	20%	4	4
I&E margin: distance from financial	20%	1	2
Agency rating	20%	1	1
OVERALL RATING		**3**	**3**

Working Capital Metrics	KPI	Apr 19	May 19
BPPC - NHS (YTD) by number	95%	64%	56%
BPPC - NHS (YTD) by value	95%	51%	33%
BPPC - Non-NHS (YTD) by number	95%	89%	90%
BPPC - Non-NHS (YTD) by value	95%	87%	86%
Debtor Days (YTD)	45	51	46
Creditor Days (YTD)	45	147	65
PP Debtor Days (YTD)	65	65	54

Commentary

Cash and Working Capital

The cash balance at the 31st May is £42.6m, £1.1m below plan primarily due to higher than planned levels of payments to creditors which have reduced by £5.1m since March 2019.

Capital Expenditure

Total capital expenditure in May was £0.4m, and YTD was £0.8m, compared to the Capital Planning Oversight Committees internal expenditure plan. This is reporting a £0.4m adverse variance YTD, with the key area of variance being in regards to Oriel expenditure due to slippage in strategic planning and AECOM areas.

Use of Resources

The overall Use of Resources rating in May is 3, in line with a planned 3 for May. Key points to note are:-

- I&E margin metric is reporting a 4 for May, in line with a plan of 4, due to the reported adverse financial variance anticipated in quarter 1.
- Capital Service Cover rating is reporting a 3 compared to a planned 1, due to the trust operating surplus being behind plan.

Overall this has not changed the Trusts' overall score against plan of 3.

Receivables

Receivables totalled £17.8m in May, a reduction of £3.0m since March 2019.

Payables

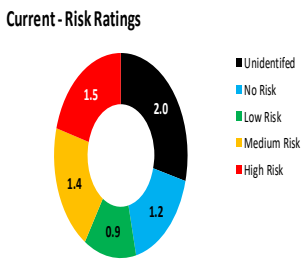
Payables totalled £11.5m in May, a reduction of £5.1m since March 2019.

Efficiency Schemes Performance

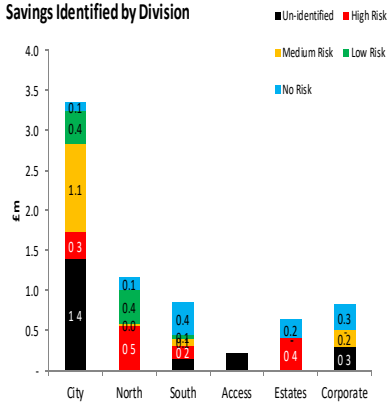
EFFICIENCY SCHEME PERFORMANCE

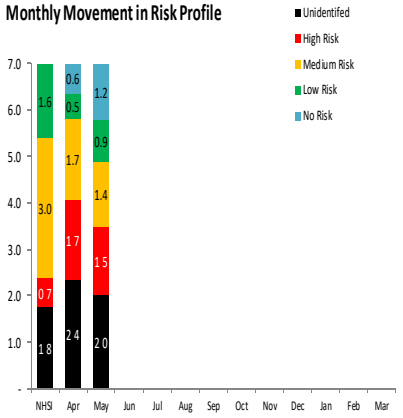
Efficiency Schemes £m	Annual Plan	In Month			Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
City Road	3.354	0.250	0.051	(0.199)	0.372	0.091	(0.281)	3.354	1.706	(1.648)
North	1.153	0.082	0.041	(0.041)	0.162	0.087	(0.075)	1.153	0.910	(0.243)
South	0.848	0.063	0.038	(0.025)	0.108	0.072	(0.036)	0.848	0.620	(0.228)
Access	0.198	0.018	-	(0.018)	0.018	-	(0.018)	0.198	-	(0.198)
Estates & Facilities	0.623	0.018	0.025	0.007	0.038	0.038	-	0.623	0.630	0.007
Corporate	0.824	0.079	0.051	(0.028)	0.116	0.088	(0.028)	0.824	0.532	(0.292)
TOTAL EFFICIENCIES	**7.000**	**0.510**	**0.206**	**(0.304)**	**0.814**	**0.376**	**(0.438)**	**7.000**	**4.398**	**(2.602)**

TRUST WIDE IDENTIFICATION



DIVISIONAL REPORTING & OTHER METRICS





Commentary

In Year Delivery The Trust is reporting efficiency savings achieved of £0.20m in May, compared to a plan of £0.51m. YTD efficiency savings achieved are £0.376m compared to a plan of £0.814m, an adverse variance of £0.438m.

Identified Savings There are currently £2.0m of unidentified savings schemes, and a further £1.5m of schemes assessed as high risk.

The divisional reporting segment highlights the level of identified schemes by division and the corresponding risk profile for these schemes.

Risk Profiles The chart to the left demonstrates the changing risk profiles of identified schemes, since the beginning of the year.

Forecast Of the planned target for £7.0m efficiency savings, the currently assessed forecast achievement based on the level of identified schemes, and risk profile is £4.398m, an adverse forecast of £2.6m compared to plan.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 08

Safeguarding annual reports

Board of directors 4 July 2019

Report title	Safeguarding and Promoting the Welfare of Children and Young People (0-18y) Annual Report 2018 – 2019
Report from	Tracy Luckett, Director of Nursing and Allied Health Professions / Executive Lead for Safeguarding
Prepared by	Tracey Foster, Safeguarding Children and Young People (0-18y) Lead Nurse / Named Nurse Child Protection
Previously discussed at	Safeguarding Children and Young People Group Meeting 25 April 2019
Attachments	Summary paper pages 1 - 2
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive Summary

This report demonstrates compliance with the statutory and mandatory requirements relating to safeguarding and promoting the welfare of children and young people. All staff within the Moorfields Eye Hospital NHS Foundation Trust have a responsibility for ensuring that children and young people under our care or associated with the Trust are protected and safe, and to ensure that the safeguarding is an integral part of our governance systems. This report also demonstrates to the Care Quality Commission that the trust is meeting its responsibilities under statutory Section 11 duties of the Children Act.

It also details how the trust is assessed on its performance both internally and externally regarding safeguarding children and young people.

Quality implications

This report provides assurance of the trusts response to children and young people for whom there are safeguarding and/or child protection concerns and improving patient safety, outcomes and experience.

Financial implications

There are no financial implications arising from this report.

Risk implications

Maintaining effective safeguarding arrangements increases the safety of children and young people and the quality of the services we provide and reduces the reputational risk to the Trust or potential regulatory action.

Action Required/Recommendation

The Board is asked to note the report and take assurance from it.

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

Title of Summary Paper	Safeguarding and Promoting the Welfare of Children and Young People (0-18y) Annual Report 2018 – 2019
Executive Safeguarding Lead	Tracy Luckett
Author	Tracey Foster

Safeguarding children and young people (SGC&YP) remains a high priority within Moorfields Eye Hospital NHS Foundation Trust through a continued commitment to promoting safeguarding as an integral component of practice, keeping the child or young person at the centre of safeguarding decision making and ensuring the trust fulfils its statutory duties and responsibilities.

This summary paper provides an overview of safeguarding children and young people activity over the period 01 April 2018 to 31 March 2019. Within this summary paper the safeguarding children and young people team is referred to as the team.

Quality Assurance

During the reporting period the following learning and improvement outcomes have been achieved:

- Queries to the safeguarding children and young people team rose by 117% compared to 2017 – 2018 demonstrating staff are having greater awareness and understanding of safeguarding and child protection and safeguarding is becoming a more integral part of practice.

- Mandatory safeguarding children training compliance at levels 1, 2 and 3 remained above 80% with the exception of two months for level 3 in May and June of quarter one when additional staff working with a mixed caseload were added to the denominator.

- The SGC&YP moved to quarterly meetings to align with quarterly data and external reporting.

- Incident reporting by staff from a wide range of roles and responsibilities rose by 23% and identified no acts or omissions.

- Referrals to children's social care rose by 140% a third of which were related to children and young people of adult patients which demonstrates engagement with the "child behind the adult" agenda in safeguarding the children of adult patients.

- A third cohort of staff completed their initial Safeguarding Champions training.

- Moorfields provided assurances to Islington Clinical Commissioning Group (CCG) regarding the Child K Serious Case Review. Although Child K was not a known patient of the trust, a flowchart was developed detailing how accident & emergency respond when children and young people attend following an alleged physical assault. This facilitates a robust response to physical assaults including liaison with external agencies to ensure any safeguarding concerns are addressed.

- 11 trust policies with a safeguarding focus or section were reviewed and updated, including where relevant, in line with the publication of the updated Working Together (2018) Statutory Guidance ensuring staff have access to and are working with current best practice policy's and processes.

- Systemic learning is supported through a variety of activities including face to face training, via team meetings and briefings, disseminated via SGC&YP group members, distribution of the internal Safeguarding Snippets newsletter, attendance at meetings, presentations at clinical governance sessions, via question and answer sessions and comprehensive feedback through incident reporting.

- The serious incident (SI) Process was strengthened to ensure any SI involving a child and/or young person includes a review by the safeguarding children lead irrespective of why the SI has been declared. This has brought the SI process in line with the safeguarding overview of all complaints involving children or young people received by the trust. There have been no SIs relating to child protection or safeguarding during this reporting period.

- A data cleanse and review of child protection risk (CPR) flags on the electronic patient administration system (PAS) & Open Eyes commenced. A flagging system to identify children and young people for whom there are safeguarding concerns is a requirement from the CQC (2009) following the inquiry into the death of Baby P. The review is ensuring that relevant information is included on both PAS and Open Eyes and that information pertaining to the flag contributes to protecting children, is up to date and meaningful to staff who are professionally involved with the child. The data cleanse and review will form part of an audit which will be completed in reporting year 2019 - 2020.

- The team have supported managers to respond to complaints with a SGC&YP feature to ensure a high quality response and understanding of the trusts legal obligations to safeguard. A total of 14 complaints were reviewed by the team with 2 involving safeguarding issues.

Key Achievements

During this reporting period we have:

- Continued to increase both the cohort of staff and the departments/services across the trust who have completed level 3 training.
- Held a safeguarding awareness stand at the clinical governance half day in November 2018.
- Further developed the safeguarding champions including training another two cohorts.
- Took part in the Domestic Violence and Abuse Bill consultation.
- Worked collaboratively with Solace Woman's Aid and Mankind to promote awareness of domestic violence and abuse including supporting the international "16 Days of Action".
- Extended the distribution of the internal Safeguarding Snippets newsletter.
- Contributed to the review of and had our feedback included in the Safeguarding Children and Young People Roles and Competencies for Healthcare Staff Intercollegiate Document (2019).
- Hosted the inaugural pan London Band 7 safeguarding children & young people acute trusts professionals network meeting.
- Been compliant with National Institute for Clinical Excellence (NICE) quality standards relating to safeguarding children and young people.
- Commenced question and answer sessions at Moorfields south network sites.

Priorities for 2019 - 2020

- To re-introduce face to face training at level 1 to ensure all levels of safeguarding children training (1-3 inclusive), are available across in both face to face and e-learning options.
- To audit staff's feelings, perceptions and fears in relation to their safeguarding responsibilities to inform the further development of level 3 face to face training.
- To audit how clinical staff, who attend the structured safeguarding children supervision sessions have changed their safeguarding practice and the impact this has on contributing to keeping children and young people safe.
- To complete and submit Section 11 Audit for period 2019 – 2021.
- To complete the child protection risk flagging audit.
- To further embed knowledge and understanding of safeguarding of 16 and 17 year olds.
- To develop a SGC&YP special edition of the Safeguarding Snippets newsletter.

Safeguarding and Promoting the Welfare of Children and Young People

Annual Report 2018 – 2019

Presented by:
Tracy Luckett
Director of Nursing and Allied Health Professions / Executive Lead for Safeguarding

Author:
Tracey Foster
Safeguarding Children and Young People Lead Nurse / Named Nurse Child Protection

Purpose:
To report on progress against the delivery of the safeguarding children and young people's agenda in the Trust in line with statutory responsibilities, the legal framework for child protection and national and local guidance

Previously considered:
Safeguarding Children and Young People Group Meeting 26th April 2019

Report to Trust Board
04th July 2019

"Safeguarding and promoting the welfare of children and young people is defined as protection from maltreatment and abuse, preventing impairment of health or development and ensuring that children and young people are growing up in circumstances consistent with the provision of safe and effective care".
(Working Together 2018)

"Child protection is a subset of safeguarding and promoting the welfare of children and young people. It refers to the activity that is undertaken to protect children and young people who are suffering, or likely to suffer, significant harm under the categories of emotional abuse, neglect, physical abuse and sexual abuse".
(Children Act 1989 and 2004).

1. Introduction

The safeguarding of children and young people (SGC&YP), including unborn babies, remains a high priority within Moorfields Eye Hospital NHS Foundation Trust through a continued commitment to promoting safeguarding as an integral component of practice and keeping the child or young person at the centre of safeguarding decision making.

Safeguarding is governed by a range of legal and regulatory requirements including: 'Working Together to Safeguard Children (2018)' which sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and 2004 including the duties set out under Section 11 of the Act; the Care Quality Commission Domain 1: is the organisation safe and Regulation 13 on safeguarding service users from abuse and improper treatment; and 'Getting the Right Start', the National Service Framework for Children Standard for Hospital Services (Standard 7).

This safeguarding children and young people annual report sets out the work carried out by Moorfields Eye Hospital NHS Foundation Trust (including the network sites where the trust provides services), in relation to:

- Providing assurance that the trust continues to fulfil its statutory responsibilities to safeguard and promote the welfare of children and young people, as stated in Section 11 of the Children's Act 1989/2004.

- Providing assurance that the trust is maintaining effective safeguarding children and young people systems and processes.

- Providing assurance that the trust is compliant with CQC key lines of enquiry (safe, effective and responsive).

- Providing an update to internal and external stakeholders on the developments in relation to safeguarding children and young people including progress following the 2017 – 2018 report.

- Identifying any areas of risk in relation to its statutory responsibilities during the reporting period.

Understanding the impact of this work in terms of effectiveness in helping to keep children and young people safe, the quality of work required to safeguard, improving outcomes and to do things differently where needed to improve safeguarding practice is integral to the commitment to our Section 11 duties.

The trust recognises that safeguarding children extends much further than paediatric services and also includes 16 – 18 year olds being seen in adult services, siblings of paediatric patients, unborn babies and dependent children of adult patients known as the "child behind the adult" agenda. The philosophy that 'child protection and safeguarding children and young people is everyone's business' (Laming 2003) underpins our strategy to involve staff at every level in this important endeavour.

This report is brought to Trust Board for assurance prior to dissemination to Islington Clinical Commissioning Group and Islington Safeguarding Children Board (ISCB).

Throughout this report the SGC&YP team are referred to as the team.

2. Key messages and quality assurance

During the reporting period 2018 – 2019 the following improvement and learning outcomes have been achieved:

- Queries to the team rose by 117% compared to 2017 – 2018 demonstrating Trust staff having greater awareness and understanding of safeguarding and child protection and safeguarding is becoming a more integral part of practice.

- Mandatory safeguarding children training compliance at levels 1, 2 and 3 remained above 80% with the exception of two months for level 3 in May and June of quarter one, when additional staff working with a mixed caseload were added to the denominator.

- The SGC&YP moved to quarterly meetings to align with quarterly data submission and external reporting.

- Incident reporting by staff from a wide range of roles and responsibilities rose by 23% and identified no acts or omissions. See additional information on page 13.

- Referrals to children's social care rose by 140% a third of which were related to children and young people of adult patients which demonstrates engagement with the "child behind the adult" agenda in safeguarding the children of adult patients.

- A third cohort of staff completed their initial Safeguarding Champions training.

- Moorfields provided assurances to Islington Clinical Commissioning Group (CCG) regarding the Child K Serious Case Review. Although Child K was not a known patient of the Trust, a flowchart was developed detailing how accident & emergency respond when children and young people attend following an alleged physical assault. This facilitates a robust response to physical assaults including liaison with external agencies to ensure any safeguarding concerns are addressed.

- 11 trust policies with a safeguarding focus or section were reviewed and updated, including where relevant, in line with the publication of the updated Working Together (2018) Statutory Guidance ensuring staff have access to and are working with current best practice policy's and processes.

- The serious incident (SI) Process was strengthened to ensure any SI involving a child and/or young person includes a review by the safeguarding children lead irrespective of why the SI has been declared. This has brought the SI process in line with the safeguarding overview of all complaints involving children or young people received by the trust. There has been no SI's relating to child protection or safeguarding during this reporting period.

- A data cleanse and review of child protection risk (CPR) flags on the patient administration system (PAS) & Open Eyes commenced. A flagging system to identify children and young people for whom

there are safeguarding concerns is a requirement from the CQC (2009) following the inquiry into the death of Baby P. The review is ensuring that relevant information is included on both PAS and Open Eyes and that information pertaining to the alert flag contributes to protecting children, is up to date and meaningful to Moorfields staff who are professionally involved with the child. The data cleanse and review will form part of an audit which will be completed in reporting year 2019 - 2020.

- The team have supported managers to respond to complaints with a SGC&YP feature to ensure a high quality response and understanding of the trusts legal obligations to safeguard. A total of 14 complaints were reviewed with 2 involving safeguarding issues.

- Systemic learning is supported through a variety of activities including face to face training, via team meetings and briefings, disseminated via SGC&YP group members, distribution of the internal Safeguarding Snippets newsletter, attendance at meetings, presentations at clinical governance sessions, via question and answer sessions and comprehensive feedback through incident reporting.

3. Key achievements

During this reporting period we:

- Continued to increase both the cohort of staff and the departments/services across the trust who have completed level 3 training.
- Held a safeguarding awareness stand at the clinical governance half day in November 2018.
- Further developed the safeguarding champions including training another two cohorts.
- Took part in the Domestic Violence and Abuse Bill consultation.
- Worked collaboratively with Solace Woman's Aid and Mankind to promote awareness of domestic violence and abuse including supporting the international 16 Days of Action.
- Extended the distribution of the internal Safeguarding Snippets Newsletter.
- Contributed to the review of and had our feedback included in the Safeguarding Children and Young People Roles and Competencies for Healthcare Staff Intercollegiate Document (2019).
- Hosted the inaugural pan London Band 7 safeguarding children & young people acute trusts professionals network meeting.
- Compliant with National Institute for Clinical Excellence (NICE) quality standards (QS) relating to safeguarding children and young people. QS 179 Child Abuse and Neglect, QS 89 Child Maltreatment and QS31 Health and Wellbeing of Looked After Children.
- Commenced question and answer sessions at Moorfields south network sites.

4. Key priorities Islington Safeguarding Children Board (ISCB)

The trust remains committed to achieving ISCB key priorities and throughout the reporting period have engaged in a variety of activities to engage staff in their safeguarding responsibilities, meet the priorities and promote the welfare of children.

Child protection

- The cohort of staff completing level 3 training has continued to rise. There are currently 14 sites and 13 departments across the trust where staff are level 3 trained. This is an increase from 6 sites and 2 departments since November 2014. Additional staff will be identified to complete level 3 training in line with the publication of the updated Intercollegiate Document in February 2019.
- A procedure flowchart was developed for children and young people attending accident and emergency (A&E) following an assault.
- Awareness of County Lines has been included in the content of all face to face training and the quarterly internal Safeguarding Snippets Newsletter.
- Ongoing development of the well maintained SGC&YP intranet pages provides staff with a one stop shop to access up to date procedures, processes, statutory guidance and information. Subjects

included child sexual exploitation, female genital mutilation, a news page, Prevent and a topic of the month page.

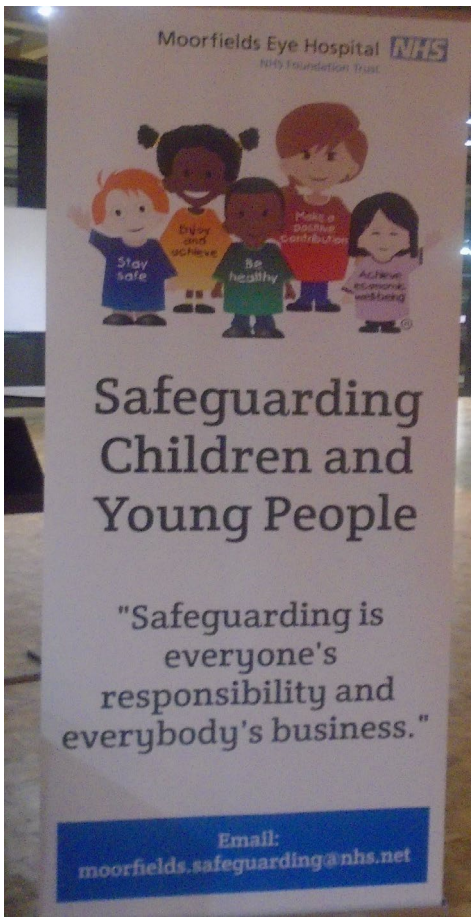
Child sexual exploitation and abuse (CSEA)

- Scenario's relating to CSEA form part of level 2 and level 3 face to face SGC&YP training and includes recognising children and young people as perpetrators.
- The trust raised awareness of CSEA through content included within Safeguarding Snippets newsletter and via the intranet. National CSEA Awareness Day in March 2019 was promoted via the trust Twitter page and the intranet.
- The sexually transmitted infection (STI) process flowchart was updated to strengthen the safeguarding component of managing these ophthalmic infections.
- The trust were involved in the Islington Joint Targeted Area Inspection (JTAI) which focussed on child sexual abuse.

Domestic violence and abuse (DVA)

- As a core safeguarding topic for the trust and engagement with the child behind the adult agenda, awareness raising of and responding to domestic violence and abuse (DVA) continues.
- The trust supported the "16 Days of Action" in November 2018 by holding a white ribbon awareness raising stall at City Road. This international annual event raises awareness of gender based violence. Offering information, advice & support, 116 people visited the stall including patients, visitors and staff.
- The DVA policy was reviewed and the procedure flowchart strengthened to include asking for perpetrator details and recognising children and young people as perpetrators of DVA.
- The trust took part in the domestic violence and abuse bill consultation including in support of strengthening the law around non-physical abuse. The changes are awaiting Royal Assent.
- The DVA patient information leaflet was reviewed and updated and an easy read version was developed by the safeguarding adult advisor whose background is in learning disability nursing.
- The DVA intranet page was maintained ad mirrored on both the SGC&YP site and the safeguarding adults (SGA) site. This ensures staff are only required to visit one page when responding to DVA concerns that involve both adults and children.
- In collaboration with Solace Women's Aid and the Islington named general practitioner for safeguarding, the trust SGC&YP advisor delivered DVA training sessions attended by clinical staff.

Promoting the welfare of children and young people



- The team had an awareness raising stand at the clinical governance (CG) half day held at the Barbican Centre in November 2018. Staff from a wide range of services and disciplines and Chris Turner from the Civility Saves Lives who was one of the main speakers at the event, visited the stand for discussion, information and advice.

- Safeguarding question and answer sessions commenced at Moorfields south network sites. Facilitated by the SGC&YP lead and advisor, these sessions provided a safe informal space for staff to ask safeguarding and child protection questions.

- In February 2019, Moorfields hosted the inaugural Band 7 SGC&YP acute trusts professionals network meeting. This new pan London forum brings together professionals working in Band 7 safeguarding roles in acute Trusts to share ideas, practice, discuss common themes and concerns and showcase innovation. The trust SGC&YP advisor gave a presentation on the development of the safeguarding champions, the safeguarding administrator provided his experiences of being a champion as part of the presentation and a nurse from adult A&E came and shared with the group their positive journey and professional development of becoming and being a champion.

- The named doctor for child protection provided a SGC&YP update for staff attending the paediatric clinical governance half day session in June 2018.
- The SGC&YP lead nurse delivered a safeguarding update for staff attending the Moorfields at Northwick Park Hospital network site clinical governance half day in May 2018.
- An animal bites procedure flowchart was developed in response to a cluster of children seen following dog bite injuries to strengthen the safeguarding response to these types of injuries.
- Easy to follow flowcharts for a variety of topics including assaults and animal bite injuries have been collated, laminated and are available in hard copy format within the accident and emergency departments, in addition to being available electronically via the intranet.

5. Safeguarding children and young people / child protection personnel

Safeguarding Children Personnel		
Position	**Name**	**WTE**
Director of nursing / executive safeguarding lead	Tracy Luckett	1.0 WTE as director with safeguarding as required
SGC&YP lead / named nurse child protection	Tracey Foster	1.0 WTE
Named doctor for child protection	Dion Alexandrou	0.4 WTE as paediatrician with 0.5 PA (2 hours) / per week for SGC&YP
SGC&YP advisor	Stacey Newman	1.0 WTE
Administrator SGC&YP/Adults	Urim Jaha	1.0 WTE
Specialist Trainer	Bon Ndili	Sessional

6. Governance

The Director of Nursing and Allied Health Professions is the executive lead for safeguarding, representing the trust at Islington Safeguarding Children Board (ISCB). The safeguarding professionals represent the trust at Islington Safeguarding Children Board sub-groups.

The SGC&YP Group, chaired by the Director of Nursing, moved to quarterly meetings to align with quarterly data and external key performance indicator (KPI) metrics reporting. The group continues to monitor progress the annual work plan, KPI's, training compliance, risks, incident reporting and ISCB priorities. Safeguarding children and young people representation on the trust Board is via the executive lead.

The SGC&YP group reports into the Clinical Governance Committee (CGC) including submission of agreed quarterly meeting minutes and completion of sub-committee summary report.

This annual safeguarding report is presented internally to the SGC&YP Group, the CGC, the Quality and Safety Committee, the Trust Board and the Clinical Quality Review Group (CQRG) and externally to Islington CCG and Islington Safeguarding Children Board.

The quality assurance SGC&YP declaration to the public is available on the trust internet site and will be updated after the Board have received this report.

https://www.moorfields.nhs.uk/content/safeguarding-children-declaration

7. Safeguarding children and young people activity data

Activity overview and monitoring

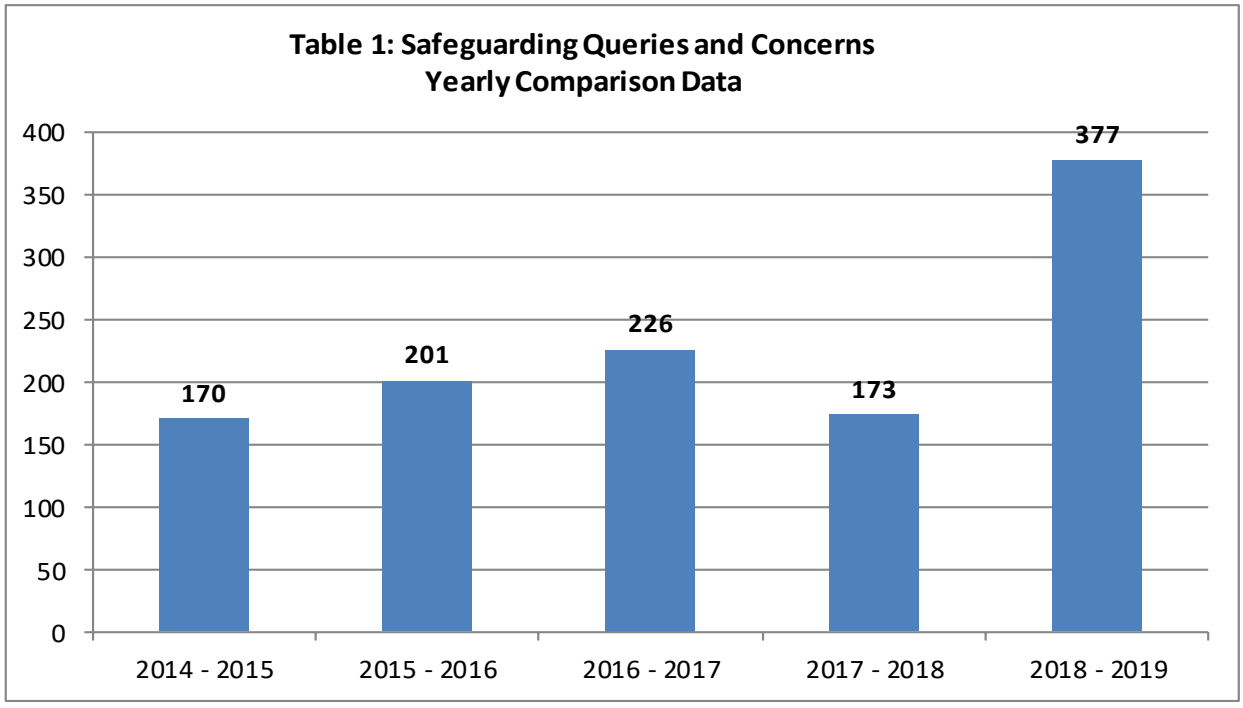
During this reporting period, queries and concerns raised with and to the team continued to rise with a 117% increase overall compared to 2017 – 2018, (See Table 1 page 8), and all quarters seeing an increase: quarter one by 204%, quarter two by 285%, quarter three by 39% and quarter 4 by 103%. The queries continue to be raised internally to the trust from a wide range of services and staff and also from external agencies where children, young people and/or adults with children are known patients of the trust.

Quarterly activity data is presented and discussed at the SGC&YP Group and includes the category of concern or query raised, the network site and staff group raising the query and any theme/s noted in quarter three. The number of queries raised by safeguarding champions was introduced as a staff group as an additional way of monitoring the effectiveness and impact of having safeguarding champions across the trust.

The continual increase in queries, concerns and issues being raised with the team demonstrates there is a greater awareness and development of a deeper understanding of the need to safeguard and promote the welfare of children and young people. Staff feel more confident about their roles and responsibilities within safeguarding and are more empowered to recognise and respond to concerns. The Intercollegiate Document (2014) states that "training should be tailored to the participants" and the bespoke approach to all face to face safeguarding training within the trust supports staff engagement with this mandatory training.

The rise in queries and concerns may be also be attributed to an increased awareness of safeguarding since the implementation of the safeguarding champions in December 2017 where staff feel supported by their departmental champions.

The internal quarterly Safeguarding Snippets newsletter has been disseminated electronically and face to face with a wider staff distribution thus promoting safeguarding to a wider cohort of staff.



The ongoing development of the well maintained and updated intranet portal provides resources which promotes staff's understanding of and engagement with the safeguarding agenda. Part of the three year audit (2016 – 2019) exploring professional's views and perceptions of safeguarding to inform level 3 training is also exploring staff use of the intranet.

Analysis

There have been common themes (See Table 2 page 9) in the top five reasons for discussion with the team over the past three consecutive reporting years: information sharing, concern regarding parental behaviour/coping, was not brought to appointments, information requests and eye injuries.

Table 2: Top five reasons for discussion with Safeguarding Team			
2018 - 2019		**2017 - 2018**	
Information Sharing	36%	Information Sharing	37%
Concerns regarding parental abilities/coping and/or behaviour	24%	Concerns regarding parental abilities/coping and/or behaviour	25%
Was Not Brought to Appointment	18%	Information Requests	22%
Information Requests	13%	Was Not Brought to Appointment	9%

Eye Injuries with concerns	9%	Eye Injuries with concerns	7%

Information sharing
Information sharing remains the top reason for discussion with the team for the second consecutive year and is defined as any information shared into the trust or within the trust in relation to safeguarding and/or child protection. The booking centre is one example of proactive safeguarding and information sharing internally. Staff are screening referral letters for any safeguarding e.g. child is looked after, on a child protection plan, have been identified as vulnerable and/or who have involvement with children's social care. They then inform the team who liaise with children's social care ahead of the child's first appointment and child protection risk flags are activated on PAS and OpenEyes. Information from general practitioners, health visitors, school nurses and children's social workers informing the trust that known child/young person patients are under the care of children's social care continued to rise – see Table 5 on page 11.

Concerns regarding parental abilities/coping and/or behaviour
For the fifth consecutive year concerns regarding parenting ability, coping and behaviours was the second highest reason for discussion with the Team. Parental behaviours which may impact on the welfare of a child encompass child neglect due to the parent's actions or inactions; this reflects national trends in relation to referrals made to children's social care.

Was not brought (WNB) to appointment
Children who have not been brought to an outpatient appointment and young people not attending was the third most reason for discussion with the team and the third consecutive year for inclusion in the top five reasons. This may in part be due to the further embedding of the WNB flowchart and policy into practice and more staff recognising WNB within the category of neglect. The WNB policy & procedures were reviewed during this reporting period.

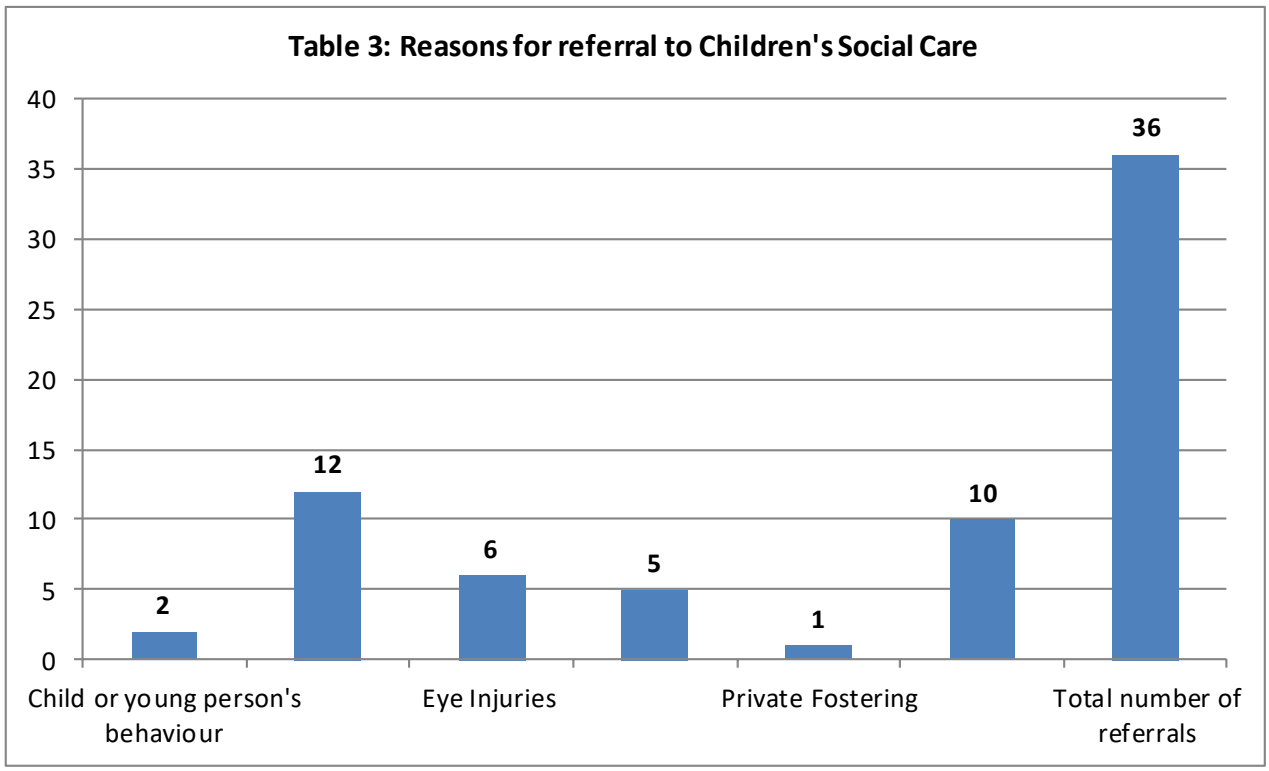
The use of the term 'did not attend' (DNA) is recognised and acknowledged as not appropriate where infants, children and young people are concerned. An infant, child or young person reliant on a parent /carer to bring them to an appointment '*Was Not Brought' (WNB) to their appointment, rather than the fact that they DNA. This is important, because not only is access to health care their fundamental right (United Nations Convention on the Rights of the Child, 1989: Article 24), but failure to attend for health care is recognised as a child protection issue within statutory definitions of neglect.

Information Requests
Information requests have also remained in the top five reasons for discussion with the team for the fifth consecutive year. An information request is defined as any external request into the trust for information relating to safeguarding and/or child protection. Requests for medical information to support the legal aspects of safeguarding e.g. court proceedings and/or witness statements for the police or court have risen in the year 2018 - 2019. Requests for medical information to inform child protection conferences or Section 17 assessments continue. The convening of Serious Case Reviews prompts requests to see if children and/or young people are/were known patients along with Channel Panel Information requests as part of the Prevent strategy forming part of the information request category.

Eye Injuries with concerns
For the fourth consecutive year eye injuries with concerns has been in the top five reasons for discussion with the team. As a single speciality ophthalmic hospital this is not unusual. The concerns raised include injuries as a result of assaults, gang and/or criminal activity, bullying and children's behaviours such as substance misuse leading to an eye injury. Other common eye injuries discussed with the team include those sustained from liquitabs (washing clothes capsules) or strong adhesive glue where there are concerns regarding parental behaviour, stressors and coping or parental supervision where there may be issues of parental mental ill-health and/or substance misuse.

Referrals to children's social care (CSC)

During this reporting period there have been a total of 36 referrals made to children's social care (CSC), See Table 3, which is a 140% increase since 2017 – 2018. An additional 8 referrals would have been made had the referring hospital not already made the referral or the child or young person had presented directly at the trust. In these circumstances the team will confirm with the referring hospital and CSC that the referral has been made and facilitate information sharing directly to CSC including the outcome of the ophthalmic examination and/or treatment and any other concerns identified.



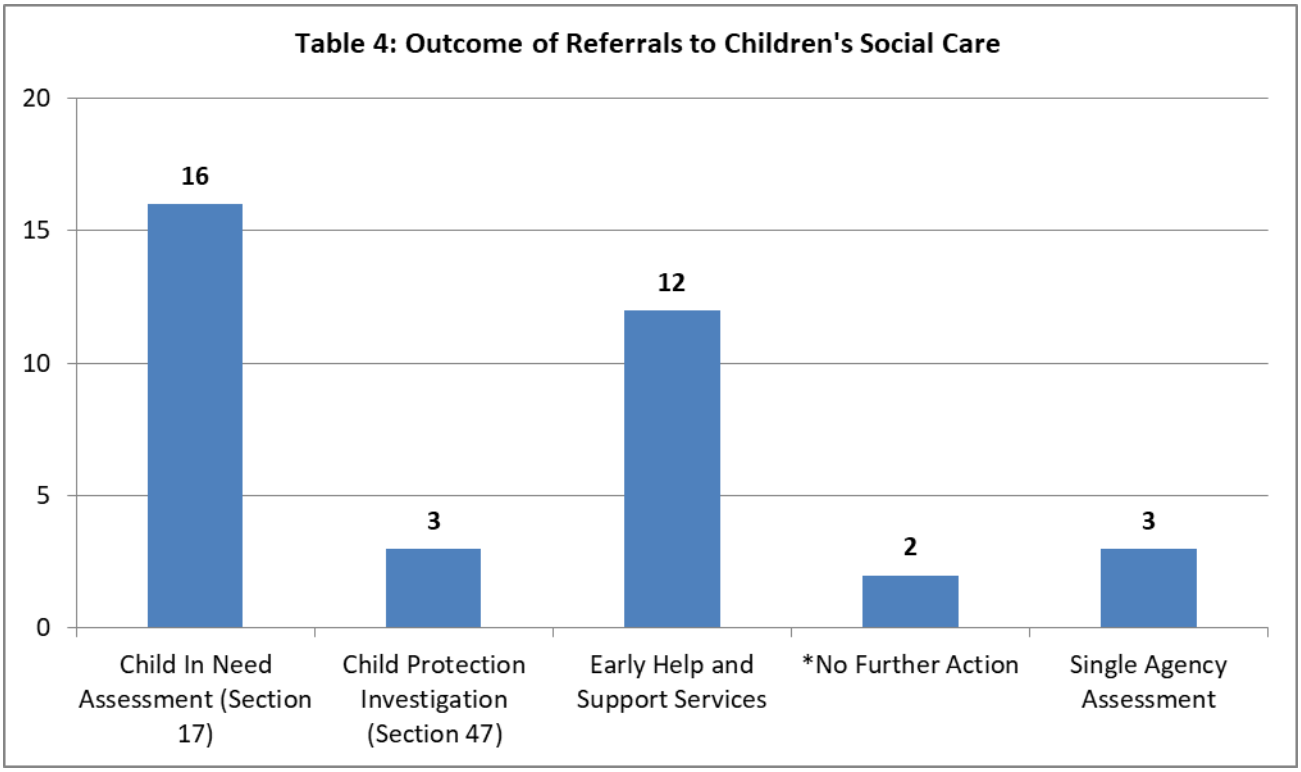
The Intercollegiate Document stipulates that any member of staff who has undertaken level 2or 3 safeguarding training must be able to complete a referral to CSC. The team and the safeguarding champions support staff with completing this and as part of the governance structure staff must complete an incident report. This ensures that the team are notified a referral has been made and follow up the outcome. Feedback to the member of staff via the incident reporting system is made under the headings of areas of good practice, case update and areas for learning or improvement. The team are responsible for closing of any incident relating to a referral made to CSC.

Referrals for concerns relating to domestic violence and abuse account for the top reason for referral and this is consistent with the preceding reporting year 2017 – 2018.

66% of the referrals were for children and young people as patients and 33% were referrals for children, young people and grandchildren of adult patients.

The outcome of all referrals made to children's social care (CSC) must be received by the trust See Table 4 (page 11), documented and professionally challenged where needed. In the reporting year 94% of referrals made were actioned by CSC and 6% deemed no further action (NFA). On review the referrals deemed NFA did not meet the threshold of need and also included referrals for young people who attended appointments on their own. Whilst unaccompanied young people may present with safeguarding concerns 16 and 17 year olds are entitled to attend appointments and accident & emergency unaccompanied. Ongoing training regarding understanding the safeguarding of young people and the "Threshold of Need" is included in level 3 face to face training.

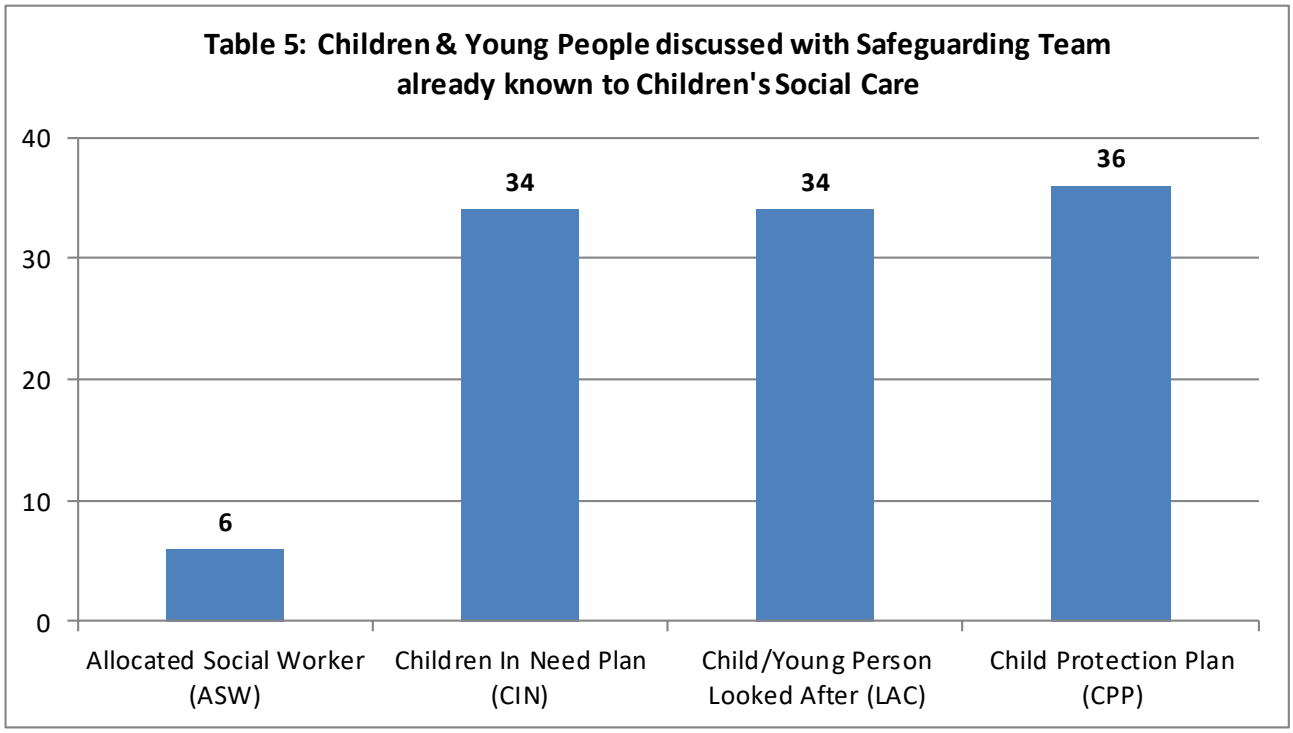
As part of the governance structure staff must complete an incident report when making referrals to CSC. This process automatically notifies the team of the referral who then take responsibility for following up the outcome, challenging the outcome if required and providing feedback to staff to support learning. No outcome in this reporting period required the instigation of the escalation/conflict resolution (disagreements relating to a child's welfare) procedure.



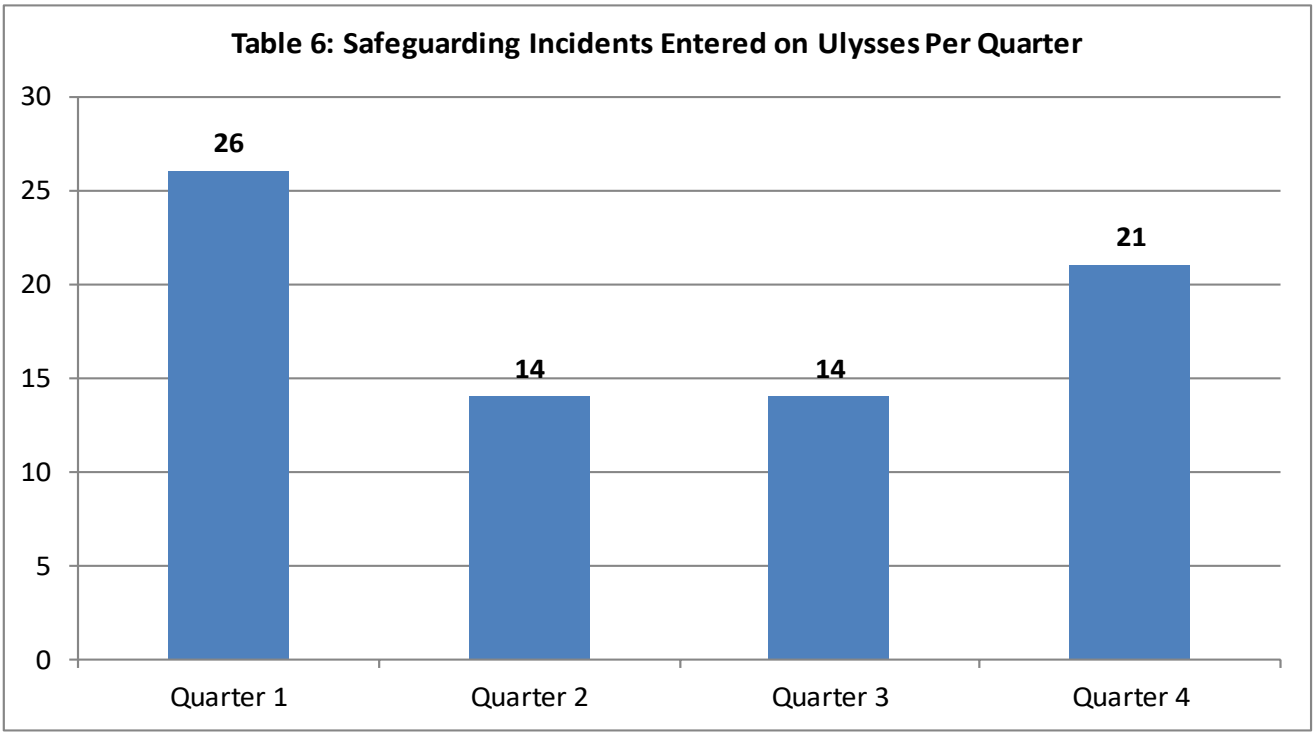
Vulnerable groups of children and young people

The trust is committed to safeguarding and promoting the welfare of vulnerable groups of children and young people as defined by ISCB. To increase staff awareness and recognition of vulnerable groups in contact with the trust the team:

- Took queries and concerns in relation to children and young people who were already subject to a child protection plan (CPP), children and young people looked after (in foster care) and children and young people on a child in need (CIN) plan or who had an allocated social worker (ASW) – See Table 5. These types of queries have all seen an increase since the preceding reporting period 2017 – 2018: CPP↑63%, LAC ↑25%, CIN↑ 112% and ASW↑ 12%.



- Used anonymised real case scenarios in face to face SGC&YP training.
- Provided departmental training for adult accident and emergency staff around a case study presentation to promote awareness of vulnerable 16 and 17 year olds.
- Promoted the use of the Was Not Brought Flowchart.
- Commenced question and answer sessions at Moorfields south network sites.
- Continued to raise awareness of child sexual exploitation, county lines, female genital mutilation, Prevent, through the internal quarterly Safeguarding Snippets newsletter, safeguarding champions training, the SGC&YP intranet portal, presenting at divisional clinical governance half days and attending staff meetings.
- Reviewed all entries made on the trusts electronic incident reporting system Ulysses, including SGC&YP concerns, child protection concerns and any referral made to CSC. Anonymised reports of the incidents are discussed at the SGC&YP group meeting including identified themes and trends. This supports learning, facilitates group participants to feedback trends and themes within their departments and provides assurance to Islington CCG. For staff entering the incident report, the feedback loop is completed which encourages learning and enables staff to use these professional experiences within appraisals and professional revalidation. This facilitates a more integrated approach and response, supporting safeguarding as an integral part of practice rather than an add-on. 75 incidents were entered in the reporting period – See Table 6 page 13.
- Continued providing mandatory Workshop to Raise Awareness of Prevent (WRAP) training focusing on the grooming and exploitation of vulnerable individuals to support and/or commit acts of terrorism (known as radicalisation).
- Ensured the trust was compliant with the NICE quality standard 31 meeting the health needs of looked after children and young people.



Themes reflected in incident reporting throughout 2018 – 2019, have seen parental/carer behaviours and Was Not Brought reflected in two of the quarters See Table 7 below. The remainder have been varied. Themes identified inform training requirements, any additional training needs, recommendations and the development of additional resources to support good safeguarding practice.

Table 7: Trends and Themes identified Each Quarter	
Quarter 1	• Dog Bite Injuries • Eye Injuries requiring referral to children's social care • Parental/carer behaviour/s impacting or may impact on a child's welfare
Quarter 2	• Disclosures of sexual assaults • Was Not Brought
Quarter 3	• Parental/carer behaviour/s impacting or may impact on a child's welfare • Was Not Brought
Quarter 4	• Child & Young People Substance Misuse • Domestic Violence and Abuse • Information Sharing

The child behind the adult / "Think Family" agenda

The trust recognises that safeguarding children extends much further than paediatric services and remains committed to promoting the welfare of children and young people of adult patients. The trust provides adult outpatient and day case surgery services across multiple networks and a level two adult A&E department at Moorfields Eye Hospital. SGC&YP continues to be addressed in relation to:

- children living in homes experiencing/witnessing domestic violence.
- understanding stressors in adult patients which may impact on their ability to parent.
- identifying children living in homes where parents are living with visual impairment which may impact on their ability to parent effectively.
- raising awareness of child carers including the development of a carers policy and leaflet which includes young/child carers.
- recognising situations such as parental intoxication and how this might impact on children's welfare.

8. Training

Safeguarding Children and Young People Training

The trust is committed to ensuring that all staff complete mandatory training to safeguard children (0-18 years) from harm and abuse. All health care staff must have the competences to recognise children and young people at risk of harm and abuse, and to take action to safeguard and their promote welfare.

Training continued to be delivered on a rolling three year cycle through a blended approach of face to face training and e-learning, with staff identified as requiring each level of training, content and frequency stipulated by the Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2014). The reviewed Intercollegiate Document was published in February 2019.

The trust is committed to achieving its target of 80% compliance as set by NHS England (2013) and Islington Clinical Commissioning Group in training levels 1 – 3 and 100% in level 4.

Overall training compliance continues to be monitored by the SGC&YP group whilst each division is responsible for monitoring and maintaining training compliance for their staff groups. Compliance reminders are generated and sent electronically via INSIGHT and continue to do until compliance is achieved. Training compliance is readily accessible for individual staff and managers to view via INSIGHT.

All new starters complete level 1 e-learning prior to undertaking an induction programme which includes face to face safeguarding awareness and local processes within the context of the trust. Staff required to complete level 2 or 3 have the compliance added to their mandatory and statutory training (MAST) requirement.

The e-learning safeguarding modules are hosted by E-Learning for Health for all levels and quality assured by the Royal College of Paediatrics and Child Health (RCPCH) with a direct link to update staff's INSIGHT learning record automatically once complete.

Training compliance for Safeguarding levels 1, 2 and 3 remained above 80% with the exception of two months for level 3 in May and June of quarter one. The later was the result of the identification of additional staff with mixed caseloads (of both children and adults) being added to the denominator. Staff identified who require level 3 training rose by 15% in this reporting period. The bespoke approach to the delivery of face to face training, including the nuances of how child protection and safeguarding presents in an ophthalmic setting has contributed to the increase in queries raised with the safeguarding team. A three year audit will finish in December 2019 exploring professional's perceptions and views on safeguarding which will further inform the content of level 3 training.
Figures are provided by the Learning and Development Department via INSIGHT.

Safeguarding Children	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target
Level 1	**89%**	**92%**	**95%**	**95%**	**80%**
Level 2	**89%**	**94%**	**96%**	**95%**	**80%**
Level 3	**78%**	**90%**	**95%**	**97%**	**80%**
***Level 4**	**100%**	**100%**	**100%**	**100%**	**100%**

*Level 4 is set against 3 members of staff who are required to undertake this level, the SGC&YP lead nurse, the named doctor for child protection and the SGC&YP advisor.

Mental Capacity Act (MCA) Training

MCA applies to individuals aged 16 years and over. Basic awareness of the MCA and its application to practice is mandatory for all staff. To support clinical staff in meeting their statutory duty to work within the Act and the MCA Code of Practice, staff are required to complete a basic awareness e-learning module before completing face to face MCA training which is provided and delivered by the safeguarding adults lead and an external trainer.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target
Basic Awareness	**84%**	**81%**	**90%**	**92%**	**80%**
MCA	**68%**	**77%**	**83%**	**86%**	**80%**

Prevent Training

Prevent is part of the Government's Counter Terrorism Strategy led by the Home Office to safeguard vulnerable individuals who may be exploited and groomed to support and/or commit acts of terrorism (known as radicalisation). PREVENT sits across children, young people and adult safeguarding. Basic awareness of Prevent is delivered via e-learning as part of safeguarding adult training and awareness is also included as part of level 1, 2 and 3 SGC&YP face to face training. WRAP (Workshop to Raise Awareness of Prevent) Training is mandatory for all clinical staff and since October 2017, the SGC&YP advisor and the safeguarding adults advisor have worked consistently to deliver WRAP sessions across the Trust including providing bespoke departmental sessions and taking training to the staff. Compliance for basic awareness and WRAP is included in quarterly PREVENT returns submitted to NHS England and Islington Clinical Commissioning Group.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target
Basic Awareness	**66%**	**82%**	**90%**	**92%**	**80%**
WRAP	**73%**	**81%**	**85%**	**87%**	**80%**

9. Safeguarding supervision

Safeguarding children and young people supervision involves a retrospective review of a safeguarding case identified by staff with a trained safeguarding supervisor. The process provides a structured format in a one to one or group setting that involves both reflection and direction regarding case management. Group supervision facilitated by the Safeguarding Children Advisor using the Signs of Safety Model is available monthly and staff from a variety of disciplines have attended including paediatric nurses, orthoptists, safeguarding champions and student nurses.

The breadth of cases discussed with supervision has been extremely rich and covers the spectrum of safeguarding. An audit will be completed in October 2019 to capture the outcomes of formal group supervision since the commencement in October 2017.

The number of staff attending supervision is reported quarterly as part of Islington Clinical Commissioning Group Key Performance Indicator Metrics and in this reporting period the Trust's Safeguarding Supervision Policy was reviewed and strengthened.

10. Safeguarding champions

In December 2017 the trust launched the safeguarding champions model with the first cohort of 23 staff, from a variety of disciplines and departments, both clinical and non-clinical completing their initial training. Over the reporting period another two cohorts of staff have been trained. Currently there are 47 champions across the Trust with a total of 51 having completed their initial training (this includes staff who have since left the trust).

The champions are an additional resource to raise awareness of safeguarding and support staff within their local department/area and have access to resources including support from the team, a shared drive, an intranet page and group email.

Champions are provided with a written contract outlining their responsibilities and can be identified by wearing their champion's badge. After completing an initial days training the champions commit to attending 2 out of the 3 half day training sessions, which are run each year to further develop their role, facilitated by the trusts SGC&YP and SGA professionals, Champions completed an anonymised questionnaire to identify their training needs for the half day. One of the half days is ear marked as a focussed or themed session.

"the training we had was informative, at the right pace, fun and I got a lot out of it including the graduation ceremony at the end! I have already put the training into use for the benefit of our patients. I am far more confident now knowing how to support/inform my colleague with best practice in safeguarding."

"the training day was very informative and I will spend time encouraging staff to be more aware and act on any concerns they may have. Looking forward to further training and updates from the safeguarding team. I would recommend being a champion to colleagues.

"this was such a great day you put together for us. For me it has been a bit daunting, taking on the role and not knowing what will be expected of me, but the day eliminated my fears! I found it so interesting, the whole area of safeguarding, and this day increased my interest and confidence further. It was good meeting all the other champions too. A bonus was all the food and drinks you provided – we felt very looked after!"

Safeguarding champions initial training feedback.

The champions have been involved in a variety of SGC&YP activity including:

- Contributing to supporting Young Carers Awareness day in January 2019.
- Attending the SGC&YP Group meeting.
- Attending SGC&YP supervision.
- Presenting a paediatric case study at the champions half day training.
- Receiving a presentation from the Metropolitan Police on Modern Day Slavery.

pics and resources including the reviewed and updated SGC&YP policy infographic.

- Participating in a confident conversations workshop on how to have conversations with children, young people and parents when there are safeguarding concerns. This session was attended by both champions and other trust staff.
- Ensuring safeguarding is a standing item agenda on team / departmental meetings.
- Participating in a quiz "Serious Case Reviews – what do you need to know?"
- Developing safeguarding information boards in their clinical areas.

11. Serious Case Reviews (SCR), Individual Management Reviews (IMR), Domestic Homicide Reviews (DHR)

Learning from local and national enquiries, SCR's, IMR's and DHR's and case learning reviews are discussed at the SGC&YP Group meetings and cascaded via training, the internal Safeguarding Snippets newsletter and the trusts electronic news bulletin, the SGC&YP Intranet pages and are used in scenario based learning. Action plans for any reviews are monitored by the SGC&YP Group.

During this reporting period the Trust has been involved with the following:

Child or Young Person	Type of Review	Safeguarding Children Board	Status
Child A	SCR	Barking & Dagenham	Awaiting publication
Child H	SCR	Barking & Dagenham	Awaiting publication
Child O	Learning Review	Islington	Ongoing

Dissemination of learning from Child O has been incorporated into all levels of face to face SGC&YP training including as an anonymised scenario exploring the subtler signs of neglect and strengthening the importance of liaison with external universal health services for children.

12. Inspection monitoring, performance and audit Care Quality Commission (CQC)

The trust was inspected by the CQC on the 14 and 15 November 2018 with the well-led inspection taking place on the 4 and 5 December 2018. During the well-led inspection a member of the team was interviewed. It was a pleasure to read in the report: "staff understood how to protect children and young people from abuse and worked well with other agencies to do so, had received training to level 3 and were clear about their safeguarding responsibilities, had a good understanding of current safeguarding issues and the process for reporting these and related policies and there were sufficient safeguards in place to protect children and young people from harm or abuse." The CQC also recognised the safeguarding champions model within the trust.

Islington Joint Targeted Area Inspection (JTAI)

In December 2018, the trust participated in the focussed Islington JTAI on child sexual abuse (CSA). A member of the team was interviewed and as part of the Islington CCG action plan ongoing work to

ensure the understanding of and response to CSA is included in face to face training, included on the intranet portal, disseminated via briefings, team meetings, the members of the SGC&YP group and the Safeguarding Snippets newsletter.

Section 11 audit

The Section 11 audit tool assess each agency/organisation against eight standards based on the requirements of Section 11 of the Children Act 2004, as set down in the "Statutory Guidance on making Arrangements to Safeguard and Promote the Welfare of Children under Section 11 Children Act 2004."

The trust completed the audit for Islington Safeguarding Children Board in May 2017 which was also shared with City and Hackney CCG who commission ophthalmic services from the trust for children and young people in Hackney. All actions have been delivered within the agreed time frames. The Section 11 audit will be due for resubmission in 2019.

13. Safer recruitment, employment practice and managing allegations

The trust is committed to minimising risk to patients by ensuring staff who are employed by the trust are safe. The Safer Recruitment and Selection Policy was reviewed in 2018. All job descriptions include a statement regarding employee's responsibilities to safeguard children, young people and adults at risk.

Compliance with Disclosure and Barring Scheme (DBS) checks continued, led and undertaken by the Human Resources department for staff in posts that require DBS checks and renewals every 3 years for existing eligible staff. DBS compliance was a standing item agenda reported into the quarterly SGC&YP Group. The DBS policy is due for review in the later part of 2019.

There is a process in place, led by Human Resources, to ensure up and coming professional renewal registrations are captured and followed through.

Human Resources staff support managers in using these documents to manage any of the issues outlined for example: Bullying and Harassment Policy, Capability Policy, Disciplinary Policy and freedom To Speak Up (including Whistleblowing) Policy.

The Director of Nursing and Executive Lead for Safeguarding is the named senior officer with overall responsibility for ensuring the organisation has appropriate arrangements in place for the management of allegations of abuse against staff and volunteers. The team support Human Resources and managers in managing allegations. The team have provided input into the Managing Allegations Policy.

Curing this reporting period, no allegations of abuse have been made against staff working in the trust, in relation to children or young people. There were four queries raised with the team regarding DBS checks.

14. Child Protection Information Sharing (CP-IS) System

This national information sharing system connects the Local Authority (Children's Social Care), IT systems with IT systems in NHS unscheduled care settings e.g. accident and emergency to identify children who are on a child protection plan (CPP), who are looked after (in foster care) or pregnant women whose unborn baby is on a CPP. Following IT upgrades and at the time of submitting this report the system is live within the trust and training for staff accessing the programme is currently ongoing.

15. Clinical policies, procedures, guidance and statutory legislation

Eleven policies across the Trust with either a safeguarding focus or containing a safeguarding section have been reviewed and updated including, where relevant, in line with the publication of the Working Together (2018) statutory guidance ensuring staff have access to and are working with current best practice policy's and processes. A further 3 flowcharts were developed including one in response to a Serious Case Review.

There has been a noted increase in this reporting period of policy owners approaching the team for inclusion of SGC&YP content within other trust policies.

Title of Document	Type of Document	Status
Access	Policy	Section Reviewed and ratified
Access to Healthcare Records	Policy	Section Reviewed and ratified
Duty of Candour and Being Open	Policy	Section Reviewed and ratified
Incident and SI/Never Event	Policy	Section Reviewed and ratified
Managing Allegations	Policy and Procedures	Awaiting ratification
Animal Bite Injuries	Procedure Flowchart	Developed and ratified
Assault	Procedure Flowchart	Developed and ratified
Pre-Operative Pregnancy Testing	Policy and Procedures	Awaiting ratification
Serious Case Review	Process Flowchart	Developed and ratified
Sexually Transmitted Infections	Procedure Flowchart	Developed and ratified
Carers including young carers	Policy	Developed and ratified
Clinical Holding	Policy and Procedures	Reviewed and ratified
Death of a patient	Policy	Reviewed and ratified
Domestic Violence and Abuse	Policy and Procedures	Reviewed and ratified
Prevent	Policy and Procedures	Reviewed and ratified
Safeguarding Supervision	Policy	Reviewed and ratified
Safeguarding Children & Young People	Infographic	Reviewed and ratified
Safeguarding Children & Young People	Policy Summary	Reviewed and ratified
Was Not Brought (WNB)	Policy and Procedures	Reviewed and ratified

The team and the SGC&YP group has a role to scrutinise any newly published national guidance and consider any implications to the staff and services within the Trust.

16. Priorities for 2019 – 2020

- To re-introduce face to face training at level 1 to ensure all levels of safeguarding children training (1-3 inclusive), are available across the Trust in both face to face and e-learning options.
- To audit staff's feelings, perceptions and fears in relation to their safeguarding responsibilities to inform the further development of level 3 face to face training.
- To audit how clinical staff, who attend the structured safeguarding children supervision sessions have changed their safeguarding practice and the impact this has on contributing to keeping children and young people safe.
- To provide assurance through the completion and submission of Section 11 Audit for period 2019 – 2021.
- To complete the child protection risk flagging audit.
- To further embed knowledge and understanding of the safeguarding of 16 and 17 year olds in adult services.
- To develop in conjunction with the focussed SGC&YP half day champions training, a special edition of the Safeguarding Snippets newsletter in recognition of the 30th anniversary of the signing of the United Nations Convention on The Rights of the Child.

17. Conclusion

The team is committed to ensuring that the trust effectively executes its duties and responsibilities in child protection and safeguarding and promoting the welfare of children and young people. It is recognised that this is not achievable without the support and collaborative working of our partner agencies.

This report demonstrates the significant progress made against the safeguarding children and young people agenda since the appointment at the trust of full time safeguarding children professionals, the named nurse in November 2014 and the advisor in July 2017.

The team will continue to strive to ensure all the trusts safeguarding processes are robust and effective, build on existing systems to further improve and develop the trusts response to safeguarding and continue to achieve and improve good compliance against internal and external safeguarding standards.

Ensuring safeguarding is maintained as a high priority for the trust, all the team are committed to further improving and developing the trusts understanding and knowledge of and response to safeguarding and that “safeguarding is everyone’s responsibility” is embedded within the culture of the trust and is an integral part of practice.

Report title	Safeguarding Adults Annual Report 2018 – 2019
Report from	Tracy Luckett Director of Nursing and Allied Health Professions / Executive Lead for Safeguarding
Prepared by	Sarah Phillip Safeguarding Adults Lead
Previously discussed at	Safeguarding Adults Committee 30th May 2019
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive summary

This Safeguarding Adults Annual Report sets out the work carried out by Moorfields Eye Hospital NHS Foundation Trust in relation to:

- Providing assurance that the trust continues to fulfil its statutory duties and responsibilities to safeguard adults, as stated in the Care Act 2014 and the Care & Support Statutory Guidance (updated 2018)
- Providing assurance that the Trust continues to be compliant with the Mental Capacity Act (MCA) 2005 and MCA Code of Practice 2007
- Providing an update to internal and external stakeholders on the developments in relation to safeguarding adults, MCA, Prevent, dementia and learning disability.
- Identifying areas of risk in relation to its statutory responsibilities during the reporting period

Quality implications

This report provides assurance of the trusts response to adults at risk and on improving patient safety, outcomes and experience.

Financial implications

There are no financial implications

Risk implications

Maintaining effective safeguarding arrangements ensures the wellbeing of patients is upheld and adults at risk are protected, and reduces the reputational risk to the Trust or potential regulatory action.

Action Required/Recommendation

The Board is asked to note the report.

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

Title of Summary Paper	Safeguarding Adults Annual Report 2018 – 2019
Executive Safeguarding Lead	Tracy Luckett
Author	Sarah Phillip

Safeguarding adults remains a high priority within Moorfields Eye Hospital NHS Foundation Trust through a continued commitment to promoting safeguarding as an integral component of practice, and ensuring the trust fulfils its statutory duties and responsibilities.

This summary paper provides an overview of safeguarding adults, Prevent, mental capacity act (MCA), dementia and learning disability activity over the reporting period.

Quality Assurance

During the reporting period the following activity was evidenced:

- Queries to the Safeguarding Adults Team rose by 20% compared to 2017 – 2018 demonstrating a greater staff awareness and understanding of adults at risk and the mental capacity act.

- 89 safeguarding adult incident reports were completed during 2018 – 2019 highlighting a variety of issues. This is a significant 33% increase with the reporting period 2017 – 2018 (67), which is likely due to a greater understanding of safeguarding adults and the mental capacity act.

- 23 incidents resulted in a safeguarding referral to ASC, and 3 resulted in a referral for care and support. In accordance with Making Safeguarding Personnel, patients' wishes were established and a significant number of patients declined a referral. Referrals are not made without consent unless an exemption is identified.

- All complaints are reviewed by the Safeguarding Adults Team. Four complaints had a safeguarding/vulnerable adult feature during the reporting period and of these, three had a mental health component and one a dementia component.

- The Safeguarding Adults Team attends the weekly Serious Incident panel where appropriate. One complaint was discussed and did not meet the threshold for a serious incident investigation. There was one root cause analysis investigation with a safeguarding element during the reporting period

- There were two section 42 enquiries involving the trust, led by Adult Social Care (ASC), during the reporting period. Comprehensive investigations were undertaken and reports, including action plans, were submitted to ASC who were satisfied with the trust response.

- The Domestic Homicide Review final report, commissioned by Luton Safeguarding Adults Board, involving one adult male known patient was published in August 2018. The key themes for learning, including agencies being 'carer aware' of the pathways to follow, were disseminated across the trust.

- A Safeguarding Adults at Risk Audit 2018 – 2019 was completed and submitted to Islington Safeguarding Adults Board. All actions were completed against the agreed timeframe and new priorities were identified for 2019 – 2020.

- 12 trust policies with safeguarding adults, MCA, dementia and learning disability focus were created or reviewed, and 4 policy summaries and infographics were created or reviewed.

- The Safeguarding Adults Committee and the Dementia & Learning Disability Working Group moved to quarterly meetings to align with quarterly data and external reporting.

- Training compliance increased for safeguarding, MCA, Prevent, dementia and learning disability and national targets were achieved

.

- Learning from national and local Safeguarding Adults Reviews and Domestic Homicide Reviews was cascaded via training, safeguarding champions, the Safeguarding Adults Committee, the Safeguarding Snippets Newsletter, safeguarding supervision and the staff e-bulletin.

Key achievements

- Safeguarding champions model was embedded and a broad range of comprehensive training was delivered to support good safeguarding, MCA, Prevent, learning disability and dementia practice.
- Improved MCA practice was evidenced due to increased level 3 training compliance, delivery of bespoke MCA training, development of MCA flowchart, and review of templates and consent forms to ensure legal compliance and user friendliness.
- Carers policy and processes, and information were developed, and training was delivered to increase awareness of the needs of carers and strengthen support to carers.
- Learning from a Section 42 Enquiry and a Domestic Homicide Review was disseminated in a range of formats across the trust.
- Dementia and learning disability strategies were developed and launched.
- A range of easy read documentation was developed.
- Awareness raising events were held, and consultation with service users and carers, and partnership working with national specialist organisations was strengthened.
- The innovative Adult Vision Clinic for adult patients with severe learning disabilities increased to monthly.
- Safeguarding adults, MCA, Prevent, dementia and learning disability training compliance increased and national targets were achieved.

Priorities for 2019/20

- Commence Service Level Agreement with ELFT to ensure the trust responds effectively to patients with comorbid acute or chronic mental health problems.
- Continue to strengthen the implementation of the Mental Capacity Act and Code of Practice across the trust, and commence planning to meet statutory requirements regarding Liberty Protection Safeguards contained in the Mental Capacity (Amendment) Act 2019 and Code of Practice (upon publication).
- Complete staff mapping, develop a training strategy, and deliver a training programme that meets level 2 & level 3 safeguarding adults training competencies and minimum requirements laid out in the new Safeguarding Adults Intercollegiate document.
- Strengthen support to homeless people across the trust and implement learning identified in the Safeguarding Adults Review, due to be published in June 2019.
- Further strengthen support provided to unpaid carers.
- Develop trust website to include information on safeguarding adults, care & support needs, carers, learning disability & dementia.
- Hold awareness raising events during Dementia Week, Learning Disability Week and Carers Week 2019 and continue to work in partnership with Mencap, Alzheimer's Society, HIVE, service users and carers.
- Progress actions in Dementia and Learning Disability Strategies.
- A working group will develop and launch a cognitive impairment pain/distress assessment tool to be used trust wide, in response to the CQC recommendation regarding Moorfields at Bedford.
- Continue implementation of 'Clare's Story' action plan and share learning at further clinical governance half days across the trust.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Safeguarding Adults Annual Report 2018 – 2019

Presented by:
Tracy Luckett
Director of Nursing & Allied Health Professionals

Author:
Sarah Phillip
Safeguarding Adults Lead / MCA & DoLS Lead

Report to Trust Board:
4th July 2019

1. Introduction

This Safeguarding Adults Annual Report sets out the work carried out by Moorfields Eye Hospital NHS Foundation Trust in relation to:

- Providing assurance that the trust continues to fulfil its statutory duties and responsibilities to safeguard adults, as stated in the Care Act 2014 and the Care & Support Statutory Guidance (updated 2018)
- Providing assurance that the trust continues to be compliant with the Mental Capacity Act (MCA) 2005 and MCA Code of Practice 2007
- Providing an update to internal and external stakeholders on the developments in relation to safeguarding adults, Prevent, MCA, learning disability and dementia.
- Identifying areas of risk in relation to its statutory responsibilities during the reporting period

The trust recognises at an operational and strategic level that 'safeguarding adults is everyone's business' and this underpins the strategy to involve trust staff at every level in this important endeavour. The trust remains focused on outcomes. It ensures that patients are treated with dignity and respect, and demonstrates a commitment to promoting well-being and preventing abuse and neglect, and ensuring the safety and wellbeing of patients who have been subject to abuse or neglect. The trust is committed to 'making safeguarding personal', and adopts a person centred approach to support the empowerment of adults and promote choice and control for all adults.

2. Organisation and Structure

Safeguarding adults is an integral part of any healthcare organisation. The Director of Nursing and Allied Health Professionals holds the role of Executive Safeguarding Lead. The Safeguarding Adults Team consists of a Safeguarding Adult and Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) Lead, a Safeguarding Adults Advisor and a Safeguarding Administrator. The Executive Safeguarding Lead acts as the Prevent Lead for the trust, and the Safeguarding Adults Lead and the Safeguarding Children & Young People Lead act as the trust Prevent managers. The Safeguarding Adults Lead also leads on learning disability and dementia across the trust.

The Designated Safeguarding Adults Professional at Islington Clinical Commissioning Group (CCG) provides support and guidance to the Safeguarding Adults Lead.

3. Safeguarding Adults Committee

The Safeguarding Adults Committee meets quarterly and is chaired by the Executive Safeguarding Lead, or the Safeguarding Adults Lead in her absence. In each meeting the committee monitors progress against the safeguarding adults annual work plan, key performance indicators, risk register, audits, complaints, incident reporting, serious incidents, trends and Islington Safeguarding Adults Board priorities.

Safeguarding adult assurances and areas for escalation are reported bi-monthly to the Clinical Governance Committee (CGC), and Safeguarding Adults Committee meeting minutes and escalation summary reports are submitted to each CGC meeting. This includes operational issues, trends, training issues, Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs) or Serious Incident (SI) investigations.

The Policy & Procedure Review Group (PPRG) is the forum for the approval of trust clinical policies following consultation and agreement with the Safeguarding Adults Committee.

Membership of the Safeguarding Adults Committee includes medical representation and representation from across Moorfields network, and attendance has been positive. Members are expected to supply a deputy to attend on their behalf if they are unavailable. The Head of Adults Safeguarding at Islington Council and the Designated Professional for Safeguarding Adults at Islington CCG are members, providing constructive challenge and expertise.

The Terms of Reference for the Safeguarding Adults Committee highlights the function, membership and reporting mechanism of the committee.

4. Dementia and Learning Disability Working Group

The Dementia and Learning Disability Working Group meets quarterly and is chaired by the Executive Safeguarding Lead or the Safeguarding Adults Lead in her absence. The group monitors and supports progress across the trust against the trust's Dementia and Learning Disability Strategies, and national and local dementia and learning disability agendas.

The group feeds into the Safeguarding Adults Committee, and links into the Patient Participation and Engagement Committee, the Patient Information Committee and the Privacy and Dignity Group

The group has met four times during the reporting period and attendance has been positive. Representatives and service users from Mencap, Alzheimer's Society, and Hackney Informed Voices Enterprise (HIVE) attend the meetings.

The Terms of Reference for the Dementia and Learning Disability Working Group highlight the function, membership and reporting mechanism of the group.

5. Safeguarding Adults Activity

5.1 Meetings & Networks

The trust is represented on the appropriate safeguarding committees and networks, demonstrating engagement with and commitment to multi-agency working.

Effective partnership working with key agencies including Islington Safeguarding Adults Board and its subgroups was maintained. The Executive Safeguarding Lead is the deputy chair of Islington Safeguarding Adult Board (ISAB) and represents the trust at ISAB meetings. The Safeguarding Adults Lead is a member of the Quality Assurance subgroup, and Islington Pressure Ulcer Task & Finish Group, and attends ISAB meetings. Information from the various meetings is cascaded to the trust Safeguarding Adults Committee and the Dementia & Learning Disability Working Group.

The Safeguarding Adults Team attends meetings held by the trust Clinical Governance Committee, the Privacy and Dignity Group, and the Safeguarding Children & Young People Group.

Safeguarding adults representation on the Trust Board is via the Executive Safeguarding Lead who chairs the Safeguarding Adults Committee.

The Safeguarding Adults Lead regularly attends: NHS England London Safeguarding Adult and Prevent Provider Forum; North Central London Safeguarding Adults Forum; MCA/DoLS London Network; and North Central London STP Prevent briefing days. This supports sharing good practice, gaining updates and contributing to national developments and local policy and procedural decisions.

The Safeguarding Adults Advisor regularly attends NHS England Learning Disability Leadership Forum, and the Access to Acute A2A Network for learning disability nurses which was nominated for a Nursing Times Award 2018 for the innovative learning disability work undertaken. This involves the trust in sharing good practice and contributing to national and local developments within the learning disability arena.

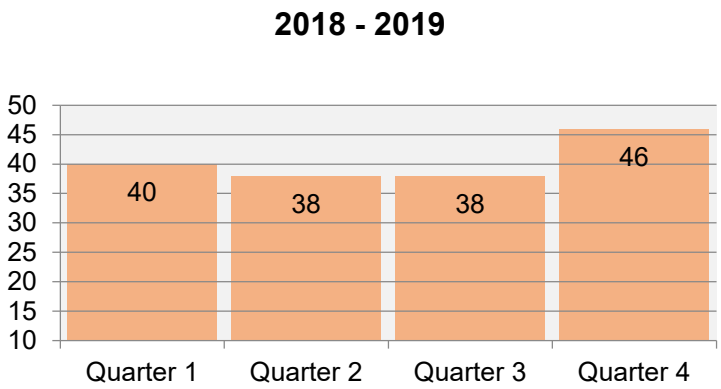
The Safeguarding Adults Lead is a member of Islington Learning Disability Mortality Review (LeDeR) Steering Group and has attended bi-monthly meetings during the reporting period.

The Safeguarding Adults Team maintained close links with Mencap, Alzheimer's Society and Hackney Informed Voices Enterprise (HIVE) during the reporting period. HIVE is a social enterprise run by people with learning disabilities and they supported the development of easy read literature for the trust and representation at meetings.

5.2 Queries & Safeguarding Concerns

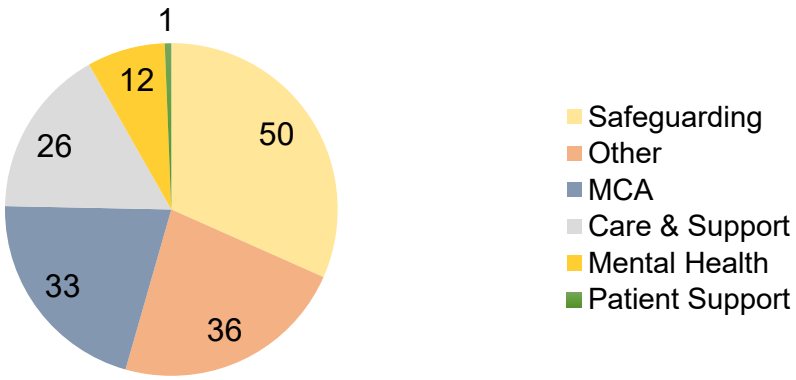
During 2018 – 2019 a total of 162 queries were made to the Safeguarding Adults Team for advice and support from staff across the Trust. The charts below show the number of queries per quarter, the type of advice sought, and the number of concerns raised with Adult Social Care.

Table 5.2.1 Queries to Safeguarding Adults Team



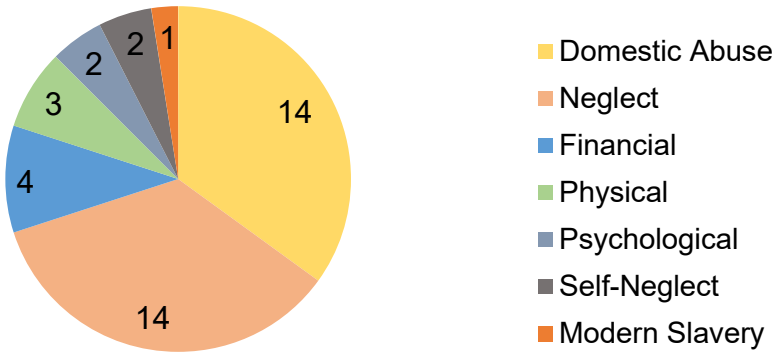
The activity throughout 2018 - 2019 is a significant 20% increase from activity reported in 2017 – 2018 (131), and could reflect a growing awareness among staff of safeguarding and safeguarding related issues, and the need to respond to concerns and support vulnerable adults.

Table 5.2.2 Reason for the Query



The most common reason for staff seeking advice and support from the Safeguarding Adults Team is safeguarding concerns. 50 queries is an almost 50% increase on the previous reporting period and is likely to reflect improved awareness among staff of potential safeguarding issues and the requirement to take action. The second most common reason for seeking advice is 'other' which includes a variety of issues such as missing patients, security concerns, homelessness, and is very similar to the previous reporting period. The number of MCA queries has decreased slightly from 2017 – 2018 and could reflect that staff are increasingly confident and competent in their duty to work within the Act and Code of Practice. Advice sought regarding care & support needs is very similar in number to the previous reporting period. A new category, mental health, was created in quarter 3 to reflect the increase in queries regarding patients who present in mental health crisis. In quarter 4 a further new category, patient support, was created to capture the practical support the team provides to assist in supporting vulnerable adult patients, particularly those with a significant learning disability or dementia, while attending appointments at Moorfields.

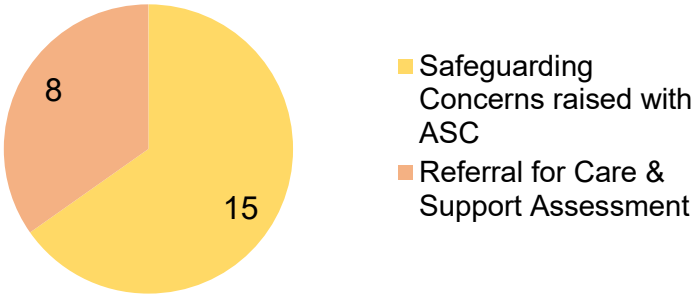
Table 5.2.3 Type of Abuse



When seeking advice & support from the safeguarding adults team, the four most common types of abuse reported were domestic abuse, neglect, financial abuse and physical abuse. There were a small number of concerns regarding psychological abuse, self-neglect and modern slavery, and no concerns regarding sexual abuse, organisational abuse and discriminatory abuse. With the exception of domestic abuse, this reflects local and national trends as reported by Islington Safeguarding Adults Board, NHS Digital Safeguarding Adults 2017 - 2018 Experimental Statistics, and NHS England Safeguarding Adult & Prevent Providers Forum. As a single speciality ophthalmic hospital it is expected that

there would be a higher incidence of domestic abuse and associated eye injuries, than the reported national average. It is also consistent with the pattern reported in 2017 – 2018, as highlighted in the safeguarding adults annual report 2016 – 2017.

Table 5.2.4 Referrals to Adult Social Care



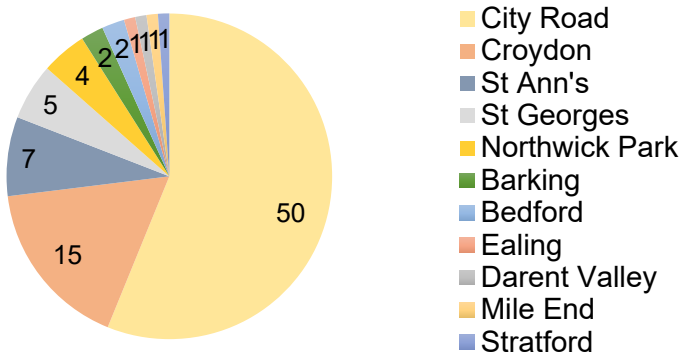
During 2018 – 2019 the Safeguarding Adults Team was informed of 23 referrals to Adult Social Care. It is important to note that this is not the total number of referrals made by the trust to Adult Social Care, and is only the referrals that the Safeguarding Adults Team were made aware of when staff sought advice and support. The team were informed that 15 adults were referred for an assessment of care & support needs and 8 were referred due to a safeguarding concern. Referrals were made after establishing the wishes and preferences of the adult and seeking agreement, unless an exception was identified such as the adult appeared to be at significant risk of harm, a person in a position of trust was involved or other vulnerable adults were at risk. This number is a slight decrease on the previous year 2017 – 2018 (28).

5.3 Incident Reporting

Safeguarding adult concerns are entered on the trust Incident Reporting System. All entries are reviewed by the Safeguarding Adults Team to assure that appropriate action is taken, or the staff member is contacted to advise on appropriate action before the report can be closed. To capture robust data to report on externally and internally and identify trends, a safeguarding adult questionnaire was introduced in April 2018. The questionnaire captures data on location of abuse, person causing harm, and referral to ASC.

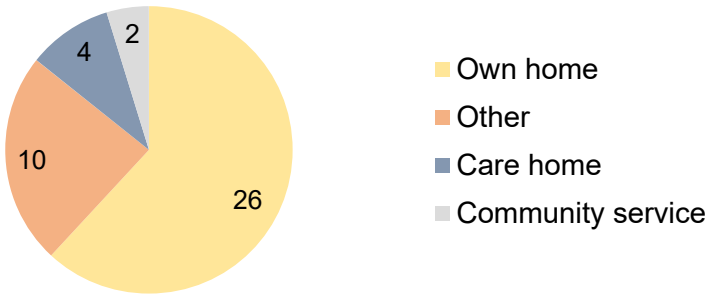
89 safeguarding adult incident reports were completed during 2018 – 2019 highlighting a variety of issues regarding adults at risk. This is a significant 33% increase with the previous reporting period 2017 – 2018 (67), which is likely due to a greater understanding of safeguarding concerns.

Table 5.3.1 Moorfields Network Site



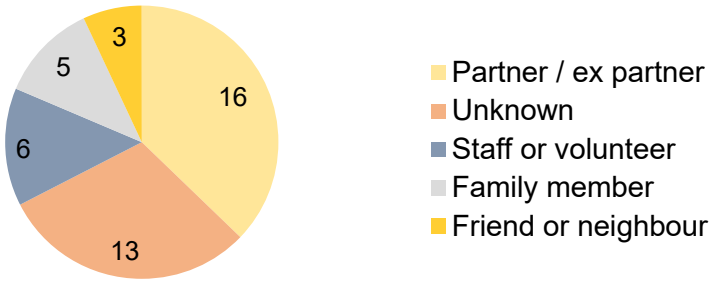
11 sites across Moorfields completed safeguarding adult incident reports, with the majority of concerns concentrated in the large network sites.

Table 5.3.2 Location of Abuse



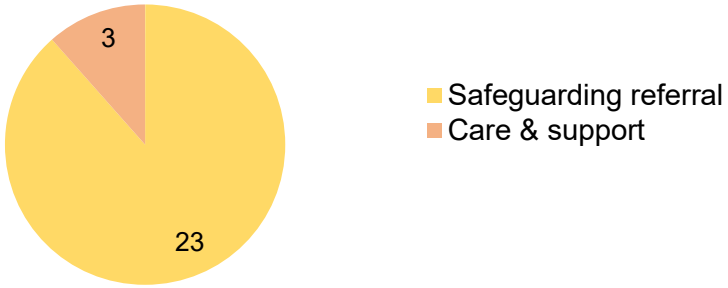
42 incident reports identified the 'location of abuse', and the majority occurred in the patient's own home. This is consistent with national and local data, and with domestic abuse being the most common type of abuse reported at the trust.

Table 5.3.3 Person Causing Harm



45 incident reports identified the 'person causing harm', and partner/ex-partner was most commonly reported which is consistent with domestic abuse being the most common type of abuse. The staff or volunteer category includes staff or volunteers at other organisations.

Table 5.3.5 Referrals to Adult Social Care



Of the 89 incident reports completed, 23 resulted in a safeguarding referral to ASC, and 3 resulted in a referral for care and support needs. A significant number of patients declined a referral to ASC, and as the trust has an embedded Making Safeguarding Personal approach, patients' wishes are established and acted upon, and referrals are not made without consent, unless an exemption is identified.

5.4 Care Quality Commission inspection

The trust's Care Quality Commission (CQC) unannounced inspection took place in November 2018 followed by a well-led inspection in December 2018. The Safeguarding Adults Lead and Safeguarding Adults Advisor were interviewed as part of the inspection. The inspection report was published in March 2019 and the trust achieved a 'Good' rating overall and Moorfields City Road achieved an 'Outstanding' rating overall. The report identified that: staff understood how to protect patients from abuse and they had training on how to recognise and report abuse; staff understood how and when to assess if patients had the capacity to make decisions about their treatment; services took account of patients' individual and diverse needs such as disability, gender, and religion; accessible information for patients living with learning disabilities and dementia was available. In terms of areas for improvement, the report identified that surgical services at Moorfields at Bedford should ensure that all patients' individual pain needs are met.

5.5 Audits

Audits and reports of safeguarding adult arrangements, activity and compliance remained comprehensive.

The trust submitted the Safeguarding Adults at Risk Audit 2018 – 2019 to Islington Safeguarding Adults Board in November 2018, and all actions were completed against the agreed timeframe and new priorities were identified for 2019 - 2020.The Safeguarding Adults at Risk Audit Tool, developed by the London Chairs of Safeguarding Adults Boards network and NHS England London, reflects statutory guidance and best practice. The audit tool is a two-part Safeguarding Adults Assessment Framework (SAAF) process involving the completion of a self-assessment audit and a safeguarding adult board challenge and support event. The Executive Lead for Safeguarding and Safeguarding Adults Lead attended the North Central London Challenge & Progress Event in December 2018 and the Islington SAB Challenge Event in February 2019.

Information regarding trust activity was submitted to Islington Safeguarding Adults Board and the Quality Assurance sub-group on request.

In June 2018 NHS Improvement published Learning Disability Improvement Standards for NHS Trusts.The standards, the first of their kind aimed solely at NHS Trusts, are intended to help the NHS measure the quality of service provided to people with learning disabilities, autism or both. Four standards, each aimed at improving the care people receive, include: Respecting and Protecting Rights, Inclusion and Engagement, Workforce and a specialist Learning Disability Services Standard (aimed solely at specialist mental health trusts). In December 2018 the trust completed and submitted a benchmarking audit tool, and on publication of the national benchmarking report, later in 2019, the trust will review the areas for improvement identified.

5.6 Policies and Procedures

The Trust continues to review systems, policies and procedures to safeguard adults at risk and to ensure compliance with legislation, statutory guidance, national and local guidance, and practice developments.

The Safeguarding Adults Team and the trust Safeguarding Adults Committee has a role to scrutinise any newly published national guidance and legislation, consider any implications for the trust, and ensure policies and procedures are legally compliant and follow national guidance. The Safeguarding Adults Committee is consulted and agrees all reviewed and new policies regarding safeguarding adults, Prevent, MCA, learning disability, dementia and mental health, and the Policy and Procedure Review Group approves all policies.

The following trust policies and procedures were reviewed during the reporting period:

- Safeguarding Adults at Risk Policy
- Safeguarding Supervision Policy
- Mental Capacity Act Policy
- Consent Policy
- Prevent Policy
- Suicide Guideline
- Mental Health Crisis Protocol
- Dementia Policy
- Learning Disability Policy
- Pressure Ulcer Prevention Policy
- Adult Admission, Transfer and Discharge Policy

A new Carers Policy was developed during the reporting period to strengthen the support to unpaid carers across the trust.

The following trust infographics and policy summaries were reviewed (R) or developed (D) during the reporting period:

- Learning disability policy summary (R)

- Learning disability infographic (R)
- Dementia policy summary (R)
- Dementia infographic (D)

5.7 Communication

To support staff, all safeguarding polices, practice guidance, care pathways and templates are available on the comprehensive safeguarding adults intranet, which includes pages for safeguarding champions, MCA, Prevent, learning disability, dementia, and domestic abuse. The intranet is regularly updated by the safeguarding team to ensure it reflects new guidance and information.

To promote understanding of and engagement with the safeguarding agenda, new and revised guidance, good practice, information, and national and local priorities regarding safeguarding, Prevent, MCA, learning disability and dementia are included in the quarterly Safeguarding Snippets Newsletter. The newsletter is published by the safeguarding team and is circulated to all teams and services throughout the trust. Newsletters in 2018 – 2019 included information and updates on a broad range of topics including: modern slavery, neglect, homelessness, domestic abuse, safeguarding champions, trust learning disability events, and county lines.

Key information and updates are communicated to staff via the weekly e-bulletin, and information was included on the safeguarding adults leaflet for patients and the easy read version, the updated consent form & MCA templates, and events held during Learning Disability Week.

In November 2018 the Safeguarding Adults Team held a safeguarding awareness stand at the trust Clinical Governance Half Day, at the Barbican, which was attended by approximately 1,300 staff.

5.8 Safeguarding Supervision

Safeguarding supervision offers staff an opportunity to discuss safeguarding concerns and cases either individually or in a group environment to support learning and development and promote good practice. A Safeguarding Supervision Policy incorporates adult and children supervision and was reviewed during the reporting period. Safeguarding supervision is offered to staff across the trust.

In June 2018 safeguarding group supervision was provided at a clinical governance half day to approximately 50 staff at a network site. Throughout the reporting period regular safeguarding group supervision was provided to the safeguarding champions in the champions meetings.

5.9 Safeguarding Champions

A safeguarding champions model was launched in December 2017 as an additional resource to support good safeguarding practice. There are currently 47 champions across the trust. In addition to safeguarding, champions develop knowledge and skills in relation to the MCA, dementia, learning disability and Prevent agendas. They are a point of contact in their team/department to support staff and act as an advisor and disseminate information. They maintain strong links and communication with the trust Safeguarding Team and alert them of any issues or trends regarding practice.

Champions complete an initial one days training and are required to attend 2 out of 3 half day champions meetings annually. They are provided with a written contract outlining their role and can be identified by wearing their champion's badge. They have access to resources including a shared drive, an intranet page and group email.

The champions meetings are facilitated by the safeguarding team and focus on further training, consultation and case studies. External trainers provide specialist training, and during the reporting period a 'Confident Conversations Workshop' was held to improve staff confidence and skills when having difficult conversations with patients, family and carers regarding safeguarding concerns. A session on 'dementia and carers' was delivered by the Alzheimer's Society, a man with dementia and three carers. A case study was also presented on a patient who had been street homeless for over 20 years and required significant multi agency working to meet his complex health, social and housing needs.

During Learning Disability Awareness week in June 2018 the champions supported and participated in the events held by the trust.

5.10 Modern Slavery

The trust continued to raise awareness of modern slavery, which is included in the safeguarding adults policy and safeguarding adults training. Safeguarding champions received additional comprehensive training and updates, and in early 2018 the Metropolitan Police delivered training to the champions on modern slavery and human trafficking.

A Modern Slavery section has been included on the safeguarding intranet page with links to the Royal College of Nursing (RCN) modern slavery pocket guide, the Metropolitan Police presentations, and the national modern slavery helpline.

5.11 Domestic Abuse

The trust continued to strengthen its response to those that are experiencing domestic abuse. The Domestic Violence and Abuse (DVA) Policy was reviewed in May 2018, the procedure flowchart was updated, and the DVA information leaflet was reviewed and an easy read version was developed. To support the 16 days of activism against gender based violence, the Safeguarding Children's & Young People Team held an awareness raising and information stall at City Road in November 2018, which was supported by Solace Women's Aid.

5.12 Prevent and radicalisation

The trust is committed to supporting the Government's Prevent strategy which is part of the Counter Terrorism Strategy led by the Home Office. The trust submitted quarterly Prevent data to NHS England and Islington CCG, which monitors the key elements of the prevent duties and responsibilities including:

- Identification of Prevent leads – strategic and operational

- Delivery of training
- The levels of referrals made via the Channel process
- Representation and engagement with local and regional Prevent leads

There have been no adult referrals from the trust to the Channel panel in 2018 - 19.

The trusts safeguarding leads and safeguarding advisors are Home Office accredited to deliver Prevent training, and the advisors delivered a comprehensive WRAP training programme throughout the reporting period to achieve the national 85% compliance target set. Prevent training was reviewed during the reporting period to ensure it is kept relevant and up to date. The Safeguarding Adults Lead attended the London Regional Prevent Conference in November 2018 and the North Central London Counter Terrorism Local Profiling Briefing where updates and information is shared on local threats and activity.

To support staff, the safeguarding intranet includes a Prevent page that contains information, flowcharts and guidance.

5.13 Mental Capacity Act and Deprivation of Liberty Safeguards

To support robust implementation of the Act and Code across the trust, the Safeguarding Adults Team:

- delivered comprehensive level 1, 2 and 3 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training
- developed a MCA flowchart
- reviewed consent forms, MCA templates, and MCA pocket prompt
- maintained a comprehensive MCA intranet page including templates, policy summaries and videos
- provided support and advice to staff across the trust
- attended Best Interest meetings
- sought legal advice and offered guidance on complex cases

During 2018 – 2019 the trust made no referrals to supervisory authorities (Local Authority) seeking authorisation of a deprivation of liberty. This is to be expected within the context of the trust as few patients are admitted overnight and those that are would not usually stay more than one night, and so the threshold for a deprivation of liberty is rarely met.

The Mental Capacity (Amendment) Bill returned to the House of Lords in April 2019 where members discussed the insertion of two new clauses on defining the deprivation of liberty and provision of a code of practice. On the 16th May 2019 the Bill achieved Royal Assent and is now an Act of Parliament. This vital reform will replace the Deprivation of Liberty Safeguards with a new system, Liberty Protection Safeguards (LPS). The date of commencement is still to be decided but is estimated to be autumn 2020. Work on the implementation, including the LPS Code of Practice and regulations has commenced. During the coming year the trust will start planning for the new statutory requirements, which will require:

- workforce planning, both the number of staff and the knowledge, skills and qualifications needed
- training requirements
- information and supporting materials including templates, leaflets, intranet content, videos

- review of MCA and DoLS policy and procedures

5.14 Learning Disability and Dementia

To further strengthen the trusts support to patients with learning disabilities and dementia, the Safeguarding Adults Team developed and launched a Learning Disability Strategy 2018 - 22 and a Dementia Strategy 2018 – 2021, and Mencap, Hive (a social enterprise for people with learning disabilities) and Alzheimer's Society were involved and consulted.

The trust continues to have robust policies and processes for supporting patients with learning disabilities and dementia, including risk alerts on PAS and OpenEyes, offering hospital passports and This is Me leaflets, placing helping hands stickers on the patients record, availability of easy read documentation, and making reasonable adjustments.

During Learning Disability Week in June 2018, three half day events were held at City Road to raise awareness and demonstrate support and commitment to enhancing the patient experience of people with learning disabilities. HIVE, people with learning disabilities, and Mencap were involved in the events, and Mencap commended the Trust on the work undertaken. A lunch celebrating Learning Disability Week was also hosted by the Trust CEO, David Probert.

The Safeguarding Adults Advisor, who has a background in learning disability nursing, reviewed the hospital passport and developed a range of easy read leaflets following consultation with HIVE. As a member of the A2A London Network for learning disability nurses who work in acute settings, she facilitated the filming of a video made by A2A and people with learning disabilities, at City Road.

The innovative Adult Vision Clinic for patients with severe learning disabilities increased from quarterly to monthly clinics in response to feedback from patients and families that it is an excellent and essential service.

To further promote inclusivity and engagement, service users with learning disabilities and a carer became members of the trust Learning Disability and Dementia Working Group. Alzheimer's Society, carers and a person with dementia also led a dementia awareness session with the safeguarding champions.

Mencap's Treat Me Well (2018) campaign describes simple reasonable adjustments that all healthcare professionals can make, including tips on clearer communication and allowing more time for consultations, and has been included in the trusts learning disability training which is delivered to staff. In response to learning from incidents and to promote excellent practice, the Safeguarding Adults Advisor delivered bespoke training to teams and services and safeguarding champions, and 'Clare's Story' was presented at a Schwarz round, to the trust Board and at clinical governance half days.

The Learning Disabilities Mortality Review (LeDeR) programme was established in 2015 and LeDeR released its second annual report in May 2018 summarising findings from death notifications between July 2016 and November 2017. 1311 deaths of people with a learning disability were reported and only 103 initial reviews and 13 multi-agency reviews were completed. NHS England has allocated £1.4 million to support local CCGs to finalise the reviews in a timely manner. The Safeguarding Adults Lead is the trusts LeDeR organisational lead and is a member of

Islington LeDeR Steering Group, and the Safeguarding Adults Advisor attended LeDeR reviewer trainer in July 2018 and is a reviewer.

5.15 Carer Support

In response to the recognition nationally and locally that the needs of carers is commonly a feature in Safeguarding Adults Reviews and Domestic Homicide Reviews, the trust has strengthened the support to unpaid carers.

In the reporting period the trust developed a Carers Policy, a Carers leaflet, and an easy read leaflet, for patients and carers. The Safeguarding Adults Lead delivered a presentation on carers at the trust Nursing Development Forum, and unpaid carers participated in a session delivered to the safeguarding champions. Information on carers was included in the safeguarding snippets newsletter, and a section on carers was added to the safeguarding adult intranet page. Patient information screens across the trust include information on carers, as does the patient information board at Moorfields City Road entrance.

5.16 Homelessness

The trust has seen an increase of patients who are homeless and have complex health, social care and housing needs, and the Safeguarding Adults Team has increasingly been contacted to provide advice & support.

Simultaneously the Homelessness Reduction Act 2017, implemented on 3 April 2018, significantly reformed England's homelessness legislation and introduced a duty on specified public authorities, including NHS trusts, to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness teams. This Duty to Refer became effective from 1 October 2018.

To strengthen the support provided to patients who are homeless and meet the Duty to Refer, the trust: reviewed the Adult Admission, Transfer and Discharge Policy; delivered training to safeguarding champions; and included information in the Safeguarding Snippets Newsletter. Going forward, the
Safeguarding Adults Team and external housing professionals will deliver updates and training to a range of staff.

5.17 Patient Information

Patient information was improved to support adults and family/carers. A safeguarding adults leaflet and a carers leaflet, and easy read versions, were developed. Patient information screens on safeguarding adults, dementia, learning disability, and carers, detailing how to access support within the trust and through national specialist organisations were introduced across the trust. An information panel at the City Road entrance displays the same information. The health information hub at City Road displays safeguarding adults leaflets, easy read documentation, hospital passports and This is Me leaflets, so ensuring that they are easily accessible. Information for staff to access & provide to patients, family and carers is on the comprehensive safeguarding adults intranet pages.

5.18 Complaints & Serious Incidents

The Safeguarding Adults Lead reviews all complaints to the trust and scrutinises for a safeguarding adult element. The Safeguarding Adults Team attends the weekly Serious Incident panel where appropriate.

There have been four complaints with a safeguarding/vulnerable adult feature during the reporting period and of these, three had a mental health component and one a dementia component. One complaint was discussed at the Serious Incident panel and did not meet the threshold for a Serious Incident investigation. There were two section 42 enquiries led by Adult Social Care (ASC) during the reporting period. At the request of ASC, comprehensive investigations were undertaken and reports, including action plans, were submitted to ASC who were satisfied with the trust response. The Safeguarding Adults Team was involved in the section 42 enquiries, providing expert safeguarding advice and guidance. There was one root cause analysis investigation with a safeguarding element during the reporting period and a safeguarding concern was raised with the relevant Local Authority. The trust adopted a transparent approach with information sharing, multi-agency working and key learning actioned in all cases.

Actions and learning from a section 42 enquiry undertaken in 2017 – 2018 were completed during this reporting period. To facilitate learning across the trust a video titled 'Clare's Story' was made with the parents of the patient, who had a significant learning disability. A 'Clare's Story' Schwarz Round was held in November 2018 at the network site involved, and presentations were delivered at clinical governance half days at various network sites and to the trust Board in early 2019. During the coming year, learning will also be shared at Clinical Governance half days and Quality Forums, and included in customer care training.

5.19 Safeguarding Adult Reviews and Domestic Homicide Reviews

The final report from the DHR commissioned by Luton Safeguarding Adults Board in 2017 – 2018 involving one adult male known patient was published in August 2018. The key themes for learning included: agencies being 'carer aware' of the pathways to follow (i.e. to Adult Social Care) when someone is identified as having care and support needs that may require an assessment; and the need for professionals to demonstrate professional curiosity and proactively enquire with patients about their personal circumstances, and to identify and record who accompanies them.

The learning was taken forward during the reporting period by raising awareness of the needs of unpaid carers and strengthening the support to carers across the trust. Improving professional curiosity has been a focus in safeguarding champions training and is included in safeguarding adults training.

There has been no other Domestic Homicide Reviews (DHRs) or Safeguarding Adult Reviews (SARs) involving the trust during the reporting period.

Learning from national and local SARs and DHRs are discussed at the Islington Safeguarding Adults Board and its sub-groups, and cascaded via training, safeguarding champions, the Safeguarding Adults Committee, the Safeguarding Snippets Newsletter, safeguarding supervision and the staff e-bulletin.

5.20 Performance Metrics and Reporting

Safeguarding reporting provides assurance to the trust, NHS England, Islington Clinical Commissioning Group (CCG) and Islington Safeguarding Adults Board (ISAB) with the following completed and submitted:

- Islington CCG Quarterly Safeguarding Adults Performance Metrics
- NHS England Quarterly National Prevent Duty Data Set
- Moorfields Eye Hospital Quality and Safety Report, Safeguarding Adults Section
- Moorfields Eye Hospital contribution to ISAB Annual Plan 2017 – 2018
- Moorfields Eye Hospital contribution to ISAB Annual Report 2017 – 2018

5.21 Safer recruitment and employment practice

The Safer Recruitment and Selection Policy was reviewed in 2018, and all job descriptions include a statement regarding employee's responsibilities to safeguard adults. Safer recruitment processes are followed and Human Resources and the Safeguarding Team work closely with if there are potential concerns.

Disclosure and Barring Service (DBS) regulations are in place for the trust, led by the Human Resources department for new staff that require DBS checks and renewals every 3 years for existing employees. DBS compliance was a standing item agenda reported into the Safeguarding Adults Committee meetings.

5.22 Key achievements

During the reporting period key achievements are:

- Safeguarding champions model was embedded and a broad range of comprehensive training was delivered to support good safeguarding, MCA, Prevent, learning disability and dementia practice.
- Improved MCA practice was evidenced due to increased level 3 training compliance, delivery of bespoke MCA training, development of MCA flowchart, and review of templates and consent forms to ensure legal compliance and user friendliness.
- Carers policy and processes, and information were developed, and training was delivered to increase awareness of the needs of carers and strengthen support to carers.
- Learning from a Section 42 Enquiry and a Domestic Homicide Review was disseminated in a range of formats across the trust.
- Dementia and learning disability strategies were developed and launched.
- A range of easy read documentation was developed.
- Awareness raising events were held, and consultation with service users and carers, and partnership working with national specialist organisations was strengthened.
- The innovative Adult Vision Clinic for adult patients with severe learning disabilities increased to monthly.
- Safeguarding adults, MCA, Prevent, dementia and learning disability training compliance increased and national targets were achieved.

5.23 Challenges and Risk

In recognition of the increase in patients presenting with acute/chronic mental health issues, the trust agreed a service level agreement (SLA) with East London Mental Health Foundation Trust (ELFT), who will provide the following services from 1st July 2019:

- Nurse consultant advice, guidance and review of current clinical guidelines ensuring that they are compliant with national guidance.
- Provision of a 24/7 help line supporting clinicians across the trust in their decision making and helping to identify onward referral services near to where the patient lives.
- Bespoke mental health teaching sessions for clinical and non-clinical staff in order to meet the needs of the trust.

Increasingly patients are presenting with complex health, social care and housing needs which are consistent with activity reported by other London NHS trusts. At other trusts this typically falls within the remit of professionals such as social workers, homelessness teams and mental health experts, who deliver a multi-disciplinary/agency approach on site. The Safeguarding Adults Team is increasingly being asked to advise and support on a broad range of complex issues that fall outside the remit of safeguarding.

Across the trust, pockets of poor practice are still occurring and it is evident that learning has not always been embedded in practice, despite training, presentations at clinician governance half days, clear processes and pathways, awareness raising events, comprehensive intranet, support from the Safeguarding Team and Safeguarding Champions, and regular communication via the safeguarding newsletter. Complaints have involved: the lack of MCA implementation, particularly regarding documented capacity assessments and involvement of family in best interest decisions; and poor staff attitude and lack of implementation of the trust's dementia pathway with a patient with dementia.

6. Training

6.1 Safeguarding Adults

The Adult Safeguarding: Roles and Competencies for Health Care Staff was launched by the Royal College of Nursing in August 2018, outlining the safeguarding adults and MCA minimum training requirements that all staff at healthcare organisations will need to meet. The guidance was commissioned by NHS England and involved 30 other Royal Colleges and professional healthcare organisations. It is a new and ambitious document and the colleges recognise it will not be possible for all staff to access the training within the first year of publication. It is anticipated that organisations will reach the required levels of workforce training over time and is expected by the next iteration in 2021 all staff will have received training to attain the appropriate competencies. In the coming year the trust will undertake a staff mapping exercise, develop a training strategy and further develop level 3 training to ensure the competencies are achieved.

Safeguarding adults training continues to be delivered on a rolling 3-year cycle to all staff. Level 1 is mandatory for all staff and level 2 is mandatory for clinical staff, and is delivered through a blended approach of eLearning and face to face training.

Overall training compliance continues to be monitored by the Safeguarding Adults Committee whilst each division is responsible for monitoring and maintaining training compliance for their staff groups. Compliance reminders are generated and sent electronically via INSIGHT and continue until compliance is achieved. Training compliance is

readily accessible for individual staff and managers to view via INSIGHT. Figures are provided by the Learning and Development Team via INSIGHT and take into account staff turnover.

All new starters to the trust undertake an induction programme which includes face-to-face safeguarding awareness and local processes. The E-Learning safeguarding modules are hosted by E-Learning for Health with a direct link to update staff's INSIGHT learning record automatically once complete.

Quarterly performance metric returns on safeguarding adults training, including Prevent and MCA, are submitted to Islington Clinical Commissioning Group.

Safeguarding Adults	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target
Level 1	84%	85%	92%	94%	80%
Level 2	84%	75%	88%	92%	80%

6.2 Prevent

In line with the Prevent Training and Competencies Framework (2017), Basic Prevent Awareness (BPA) is mandatory for all staff and Level 3 Workshop Raising Awareness of Prevent (WRAP) is mandatory for all clinical staff. BPA was included in Safeguarding Adults training until June 2018 and then switched to eLearning. Competency in WRAP is acquired by attending a face to face session, delivered by the Safeguarding Team.

Quarterly Prevent returns are submitted to NHS England and Islington Clinical Commissioning Group.

Prevent	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target
Basic Prevent Awareness (BPA)	78%	75%	88%	91%	80%
WRAP	72%	76%	83%	86%	80%

Number of staff completed Basic Prevent Awareness (BPA) 2018 2019	Number of clinical staff completed WRAP 2018 2019
1,929	1,171

6.3 Mental Capacity Act (MCA)

To support clinical staff in meeting their statutory duty to work within the Act and Code of Practice, they are required to complete face to face MCA level 3 training, delivered by the Safeguarding Adults Lead, and all staff must complete a basic awareness eLearning module. Due to a comprehensive training programme delivered over the last 3 years, this trust is already compliant with the Safeguarding Adults intercollegiate document with regards to MCA.

MCA	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target
Basic awareness	75%	73%	88%	91%	80%
MCA level 3	72%	71%	81%	85%	80%

Number of clinical staff requiring MCA training 2018 2019	Number of clinical staff compliant with MCA Training 2018 2019
1,345	1,151

6.4 Learning Disability and Dementia

In July 2018 the Learning and Development Team began reporting compliance for learning disability and dementia modules independently of safeguarding adults. All staff are required to compete the learning disability and dementia eLearning packages to achieve compliance.

In addition, bespoke learning disability training was delivered to specific teams/services across the trust, and to the safeguarding champions, by the safeguarding adults advisor.

E Learning	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Target
Learning Disability		31%	65%	78%	80%
Dementia		32%	67%	79%	80%

7. Key Priorities for 2019 - 2020

- Commence Service Level Agreement with ELFT to ensure the trust responds effectively to patients with comorbid acute or chronic mental health problems.
- Continue to strengthen the implementation of the Mental Capacity Act and Code of Practice across the trust, and commence planning to meet statutory requirements regarding Liberty Protection Safeguards contained in the Mental Capacity (Amendment) Act 2019 and Code of Practice (upon publication).
- Complete staff mapping exercise, develop a training strategy, and deliver a training programme that meets level 2 & level 3 safeguarding adults training competencies and minimum requirements laid out in the new Safeguarding Adults Intercollegiate document.
- Strengthen support to homeless people across the trust and implement learning identified in the Safeguarding Adults Review, due to be published in June 2019.
- Further strengthen support provided to unpaid carers.
- Develop trust website to include information on safeguarding adults, care & support needs, carers, learning disability & dementia.

- Hold awareness raising events during Dementia Week, Learning Disability Week and Carers Week 2019 and continue to work in partnership with Mencap, Alzheimer's Society, HIVE, service users and carers.
- Progress actions in Dementia and Learning Disability Strategies.
- A working group will develop and launch a cognitive impairment pain/distress assessment tool to be used trust wide, in response to the CQC recommendation regarding Moorfields at Bedford.
- Continue implementation of 'Clare's Story' action plan and share learning at further clinical governance half days across the trust.

8. Conclusion

The trust takes its safeguarding adults responsibilities extremely seriously, and has demonstrated that it is fulfilling its statutory duties by protecting people's health, wellbeing and human rights, and enabling individuals to live free from abuse and neglect. 2018/19 was another busy and dynamic year for Safeguarding Adults Team who successfully delivered and implemented key objectives which resulted in positive patient outcomes and provided safety for vulnerable adults. The report details a year of significant activity and improvement, and demonstrates that there are robust mechanisms in place to safeguard adults and to continually develop and strive for excellence.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 09

Infection control annual report

Board of directors 4 July 2019

Report title	Infection Control Annual Report 2018 – 2019
Report from	Tracy Luckett Director of Nursing and Allied Health Professions / Director of Infection Prevention and Control
Prepared by	Amita Sharma Lead Infection Control Nurse & Catherine Wagland Infection Control Matron
Previously discussed at	Infection Control Committee
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience We will innovate by sharing our knowledge and developing tomorrow's experts

Executive Summary

The report provides an overview of infection prevention and control activity at Moorfields' trust for the reporting period of 1st of April 2018 to the 31st of March 2019. The report demonstrates compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare related guidance (Department of Health 2015).

The report seeks to provide assurance to the trust board of the progress made in the prevention and control of healthcare associated infections (HCAI) through delivery of an effective programme of work. It also provides assurance that appropriate measures are being followed to maintain the safety of patients, visitors and staff.

In addition to progress made with programme of work the report also includes information on external inspections, CQC, PLACE and projects/campaigns undertaken by the infection control team.

This report includes contributions from the antimicrobial pharmacist for assurance with antimicrobial stewardship compliance and the sterile services department for statutory regulation compliance.

Quality Implications

The report provides assurance on the measures that are in place to safeguard patients, visitors and staff from acquiring a healthcare associated infection. The report also provides information on the trust rates of infection.

Financial Implications

There are no financial implications arising from this report.

Risk implications

A detailed programme of work provides assurance that measures are in place to maintain safety of patients, visitors and staff. Through delivery of the programme any risks identified would be acted upon promptly.

Action Required/Recommendation

The report is for the board members to gain assurance on the infection control measures in place at the trust.

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

Title of Summary Paper	Infection Control Annual Report 2018 – 2019
Executive Safeguarding Lead	Tracy Luckett
Author	Amita Sharma Lead Infection Control Nurse & Catherine Wagland Infection Control Matron

Moorfields Eye Hospital NHS Foundation Trust (MEH) is committed to ensuring that effective prevention and control of healthcare associated infections (HCAIs) is embedded into everyday practice. Keeping patients safe from avoidable healthcare associated infections remains a high priority for the trust.

This summary paper provides an overview of the infection prevention and control activity at Moorfields' trust for the reporting period of 1st of April 2018 to the 31st of March 2019. In addition it demonstrates compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare related guidance (Department of Health 2015).

Quality Assurance

Key Achievements

The key achievements for 2018/19

During the past year the Trust has maintained and achieved in the following areas:

- The rates of infection for the trust overall have remained low with no cases of bacteraemia nor *Clostridium difficile* to report.
- Endophthalmitis rates of infection for cataracts, intravitreal injections, vitrectomy, acute glaucoma and corneal grafts have been reported below the trust benchmarks
- Reporting on infection rates against trust benchmarks has increased from two to six procedures.
- High standards of hand hygiene compliance have been maintained throughout the trust with an average compliance score of 97%.
- Infection control training of all trust staff has remained above the 80% target figure throughout the year.
- The infection control audit programme for this year has been completed
- The trust was successful in achieving the national flu target for staff influenza immunisations with a compliance score of 78%.
- An alcohol-based hand rub solution was introduced in operating theatres and intravitreal injection rooms for undertaking a surgical scrub

Priorities for 2019 - 2020

- The prevention of healthcare associated infections will remain a priority for the infection control team
- The ICNs will continue to work to a robust annual programme of work to help ensure that a high standard of infection control service continues at the trust.
- The ICT will be developing an IC strategy which will focus on key objectives for the department

Infection Control Annual Report

April 2018 – March 2019

Contents

Executive Summary

Moorfields Eye Hospital NHS Foundation Trust (MEH) is committed to ensuring that effective prevention and control of healthcare associated infections (HCAIs) is embedded into everyday practice. Keeping patients safe from avoidable healthcare associated infections remains a high priority for the trust.

The Trust has a statutory responsibility to be compliant with The Health and Social Care Act 2008 (DH, 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control (DIPC).

The purpose of this report is to provide assurance to the trust board of the progress made in the prevention and control of healthcare associated infections (HCAI) for the reporting period from 1st April 2018 to 31st March 2019 through delivery of an effective programme of work. In addition the report provides assurance that appropriate measures are being followed to maintain the safety of patients, visitors and staff.

The key achievements for 2018/19

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Introduction

Healthcare associated infections (HCAI) can cause harm to patients compromising their safety and leading to a suboptimal patient experience, therefore prevention of a healthcare associated infections remains a key priority for the trust. The Infection Control Team at MEH strives to promote and embed evidence based best practice with regards to the prevention and control of infection and maintain patient safety. The Infection Control Nurses (ICN's) do recognise that infection control is everyone's responsibility and must remain a high priority for all staff to ensure that patients are safe from acquiring a preventable HCAI.

During the year, the ICN's have worked with staff across all sites to enable effective infection prevention and control and safe reliable services. The delivery of this assurance may not always be within the remit of the infection control team, but clear responsibilities, competence and timely reporting of information is fundamental to achieving this.

Delivery of Service

The infection control team has continued to lead on the implementation of the infection control work plan and audit programme and provide advice about the prevention and control of infection.

Duties

- The infection control service is delivered and facilitated by an infection control team which consists of:
- One 0.8 Infection Control Matron, Two 1.0 WTE Infection Control Nurses, Infection Control doctor as part of a service level agreement with Guys and St Thomas' NHS Foundation Trust, a designated Director of Infection Prevention and Control, Consultant Ophthalmologist who is the chair of the Infection Control Committee and One 1.0 WTE Administrator. The administrator post is shared with the Resuscitation Team.
- The trust also has a 1.0 WTE antimicrobial pharmacist.
- The main microbiology and virology laboratory services are provided by an off-site independent company called The Doctors Laboratory who the trust has arranged a Service Level Agreement with although there are other providers. Infection control support and advice is provided by Guys and St Thomas' NHS Trust infection control team. Additional support is provided by Moorfields Estates and Facilities Teams, matrons, infection control link practitioners and sterile services department. The Occupational Health service is provided by Team Prevent on a contracted basis.
- The Director of Infection Prevention and Control (DIPC)
- The Infection Control Team reports directly to the DIPC, who is the trust Director of Nursing and Allied Health Professions and the Decontamination Lead. The DIPC is directly accountable to the Chief Executive and has an overarching responsibility for the strategy, policies, implementation and performance relating to infection prevention and control. The DIPC attends the trust board and other meetings as planned or required, including the monthly infection control team meetings and quarterly infection control committees.

Delivery of Service

- The trust Infection Control Committee (ICC) is a multidisciplinary trust committee which meets quarterly. The committee ensures that there are effective systems in place to reduce the risk of infection and where infection does occur to minimise its impact on patients, visitors and staff.

- The committee is chaired by the Chairman of the Committee and Ophthalmology Consultant in the Medical Retina (MR) Service.
- Membership of the ICC includes representation from key service areas:
- Facilities, Estates, Pharmacy, Theatre, Surgical Services Department, Eye Bank, Infection Control Nurses, DIPC, Infection Control Doctor & Deputy DIPC from GSTT, Occupational Health, Risk and Safety, Representation from Public Health England and the Commissioning Support Unit.
- Other trust staff may be invited to attend as required.

Director of Infection Prevent and Control (DIPC) Role

- Governance Structure

The DIPC co-chairs the Clinical Governance Committee (CGC) with the Medical Director which meets every two months. Minutes from the ICC are sent to CGC and there is also infection control representation at CGC.

Infection Control Committee

- Infection Control Representation at Committees

Infection Control has representation on the Risk and Safety Committee and Medical Devices Committee.

Programme of Work

- The Infection Control Team is responsible for ensuring that a coordinated programme of work is agreed at committee and implemented annually.

IC Links

- Infection control link-staff meet every 6 months for training updates and infection control news and in addition attend annual study days and an annual conference which is provided by Guy's and St Thomas' infection control team.

Education and Training

- The ICNs provide education and training throughout the organisation, undertake a programme of audits, policy formulation, alert organism surveillance with associated epidemiology of cases and provide infection control support as required to staff both internal and external to the trust. The matron and lead ICN attend the quarterly London region DIPC forum to share trust experience and current infection issues.

Infection Control Programme of Work

IC Programme

- The ICNs work to an annual programme of work (POW) that is produced to assist in providing assurance and monitoring the trusts compliance with the Code of Practice. The POW is set out against the criteria of the Code of Practice.
- Progress against the programme of work is discussed at the quarterly ICC and the monthly infection control team meetings.
- This year the ICN's have completed the audit programme of work for 2018/19.

Trust Surveillance of Possible Healthcare Associated Infections

The Infection Control Committee has agreed the following alert incidents for continuous surveillance within the trust to ensure that healthcare associated infections relevant to ophthalmology patients is promptly recognised, investigated and managed.

Performance Data

	2017/18	Target	2018/19 Q1	Q2	Q3	Q4	YTD
C diff infection	0	**0**	0	0	0	0	**0**
*Bacteraemia	0	**0**	0	0	0	0	**0**
MRSA Screening	100%	**100%**	100%	100%	100%	100%	**100%**
Endophthalmitis post cataract	0.22	**0.40**	0.64	0.00	0.33	0.43	**0.35**
Endophthalmitis post intravitreal injection[1]	0.15	**0.50**	0.09	0.34	0.08	0.17	**0.17**
Endophthalmitis post vitrectomy	-	**0.60**	0.90	0.00	0.00	0.00	**0.22**
Endophthalmitis post-acute glaucoma	-	**1.0**	1.44	0.00	0.00	1.35	**0.73**
Endophthalmitis post Graft-EK	-	**3.60**	8.40	0.00	0.00	0.00	**2.58**
Endophthalmitis post Graft-PK	-	**1.60**	0.00	0.00	0.00	0.00	**0.00**
Adenovirus possible hospital acquisition	1.5%	**N/A**	0.8%	1.1%	3.4%	0.0%	**1.2%**

***Bacteraemia includes MRSA, MSSA, E coli, Pseudomonas aeruginosa & Klebsiella Spp.**

The trust submits data to the national HCAI Data Capture System monthly as required.

Endophthalmitis

- Endophthalmitis at Moorfields Eye Hospital (MEH) is defined as an inflammation or infection of intraocular space diagnosed within 6 weeks of surgery or of any invasive procedure (e.g. suture removal or intraocular injection) or within 16 weeks of surgery where the pathogen is fungal in nature and vitreous and aqueous fluid specimen and treatment with intravitreal antimicrobial therapy has been required. All infections identified beyond the 16 weeks' timescale will be investigated for up to one year to check whether the infection is linked to the original ophthalmic procedure.
- MEH incidence data is based on clinical criteria and not only on those cases which yield a positive microbiology culture.
- The trust reports on infections following all procedures MEH and has in preceding years established two specific benchmarks for cataracts and intravitreal injections.
- All cases of endophthalmitis are reported either as benchmarked or exception reported cases.

Benchmarked Endophthalmitis

In addition to cataract surgery and intravitreal injections benchmarks have been agreed for a further four further ophthalmic procedures. These include External Disease (PK and EK procedures), Glaucoma (acute cases) and Vitreoretinal (Vitrectomy). Reporting on the rates of infection against the benchmarks for these procedures commenced from 1st April 2018.

Cataract Endophthalmitis

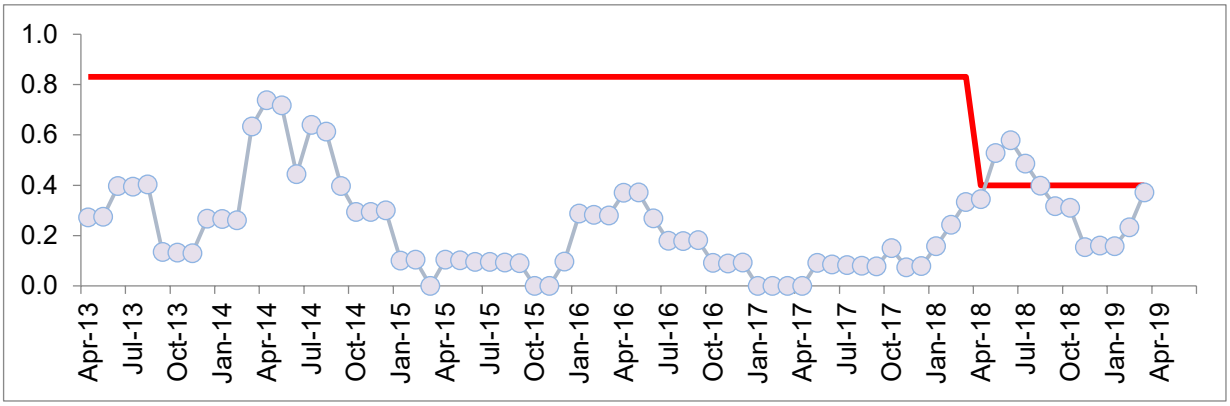
- The benchmark for cataract related endophthalmitis was lowered from 0.83 per 1000 procedures to 0.4 per 1000 procedures from 1st April 2018.
- For 2018/19 the total number of cataract related cases of endophthalmitis was 9. This is an increase in number from 2017/18 where there were 5 cases.
- The rate of endophthalmitis following cataract procedures for this year is **0.35 per 1000 procedures** which remains below the benchmark of **0.40**.

Table 1A: Quarterly surveillance of cataract Endophthalmitis

Endophthalmitis - quarterly	2018/19					2017/18	2016/17
	Q1	Q2	Q3	Q4	YTD	YTD	YTD
Post Cataract	4	0	2	3	9	5	1
Cataract procedure (HRG)	6207	6435	6115	7025	25782	22946	19782
Rate post cataract per 1000	0.64	0.00	0.33	0.43	0.35	0.22	0.05

- A root cause analysis was undertaken for each case and no common themes were identified. The cataract service lead was made aware of the increase the number of endophthalmitis cases.

Fig 1B: Rate of Endophthalmitis post Cataract Surgery – 6month rolling average



Intravitreal Injection Endophthalmitis

- The intravitreal injection endophthalmitis data is based on injections administered for the treatment of conditions such as age-related macular degeneration (AMD) or diabetic macular oedema (DMO). The injections consist of medicines such as Lucentis, Avastin or Eylea. This data does not include injections of

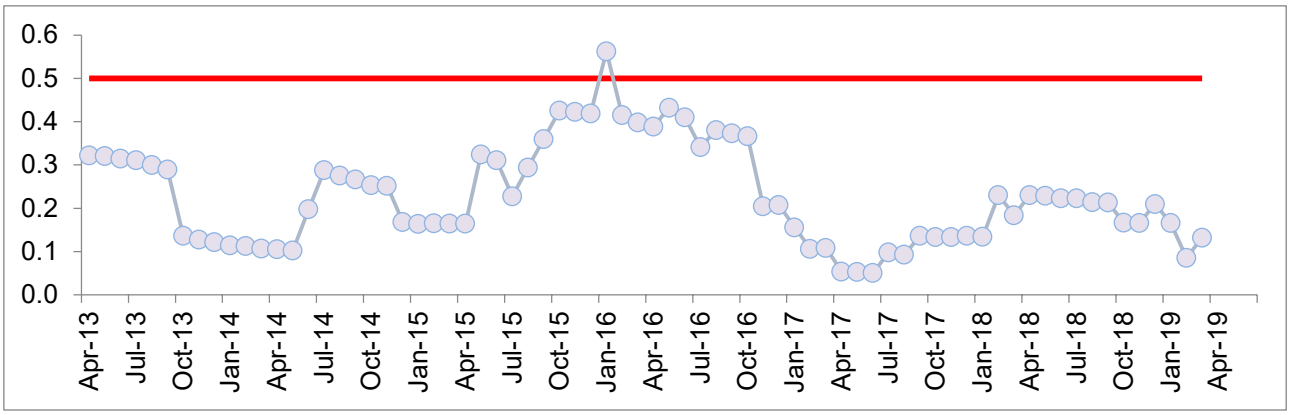
Ozurdex or Triamcinolone. These injections are reported separately due to the increased complexity of Ozurdex injections and, for Triamcinolone injections, to prevent cases of sterile endophthalmitis, resulting from drug irritation, being inappropriately included in reports.

- The total number of endophthalmitis cases following intravitreal injections reported for 2018/19 was 8. This is an increase in number by 2 from last year. This equates to a rate of infection of **0.17 per 1000 procedures** which remains below the trust benchmark of 0.50 per 1000.

Table 2A: Quarterly surveillance of intravitreal Injection

Endophthalmitis - quarterly	2018/19					2017/18	2016/17
	Q1	Q2	Q3	Q4	YTD	YTD	YTD
Post Intravitreal Injections	1	4	1	2	8	6	8
Intravitreal Procedure	11496	11863	11934	11713	47006	38856	33505
Rate post injection per 1000	0.09	0.34	0.08	0.17	0.17	0.15	0.24

Fig.2B: Rate of Endophthalmitis post Intravitreal Procedure- 6 month rolling average



The expected rate of infection is 1:2,000 intravitreal injections or 0.5:1,000 injections.

- The performance graphs for glaucoma, vitrectomy and corneal grafts have not been included as this information is available in the performance data table.

Procedures resulting in Endophthalmitis 2018/19

Table 3A: All Endophthalmitis by Procedure

Procedure	2018/19
Cataract	**9**
Intravitreal Injection	**8**
Vitrectomy	**1**
Endothelial Keratoplasty	**1**
Revision of Trabeculectomy	**2**
Removal of suture	**1**

- The table above outlines the total number of endophthalmitis cases reported for the trust. For 2018/19 the total number was 22, this is 2 less than the preceding year, 2017/18 where there were a total of 24 cases of endophthalmitis.

Adenovirus – possible hospital acquisition

- Adenovirus is an infection that can cause severe viral conjunctivitis commonly involving the cornea. It is caused by different adenovirus serotypes which may be transmitted from person to person in a number of different ways, for example, contact with contaminated surfaces/equipment or contact with an infected persons tear fluid.
- The trust definition of a possible nosocomial case is a patient who has presented with an adenoviral positive swab result from day 5 to 21 days post visiting MEH for a non-infective eye condition.
- Over the past year, the trust has identified 4 cases of possible hospital acquisition. This is an decrease from the preceding year, where there were 7 cases making the rate of infection 1.2% as opposed to 1.5% as in 2017/18.
- As it is difficult to determine whether adenovirus was acquired during a visit to MEH, from 1st April 2018 the ICNs have continued to monitor the number of cases each month however this data is not presented to trust board.

Table 4A: Quarterly surveillance of Adenovirus

Adenovirus - quarterly	2017/18				2018/19				
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Year
Positive cases	156	91	103	115	127	89	59	71	346
Possible MEH acquired	3	0	4	0	1	1	2	0	4
%possible MEH acquired	1.9%	0.0%	3.9%	0.0%	0.8%	1.1%	3.4%	0.0%	1.2%

Routine Screening

Methicillin Resistant Staphylococcus Aureus (MRSA)

- At the trust, all patients previously identified as colonised or infected with MRSA are screened for MRSA carriage.

- The DOH requires the trust to report 100% compliance with screening all patients who meet the national criteria for screening.

MRSA screening trust data

No. Patients Screened	No. Patients MRSA positive	% Patients Positive	% Compliance for Screening Cohort
194	5	2.58%	100%

Carbapenemase-producing Enterobacteriaceae (CPE)

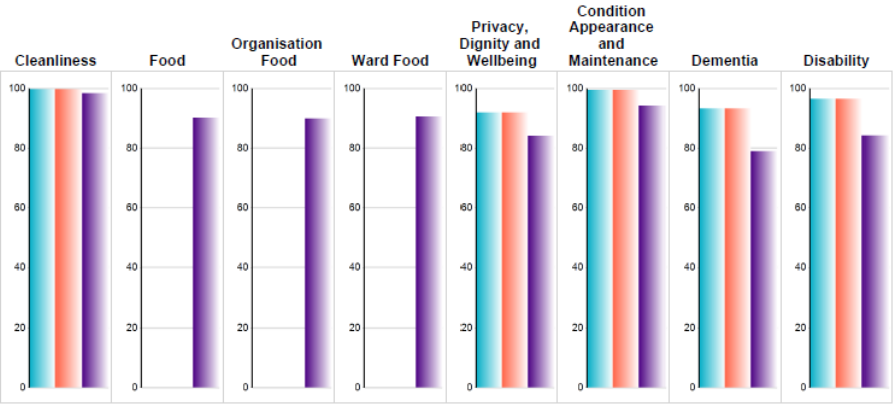
- All patients at the trust are risk assessed for the likelihood of CPE carriage and any patients identified at risk of carriage are managed in accordance with the trust CPE policy.
- The numbers of all suspected or confirmed cases of CPE are monitored by the ICN's. The numbers of cases for each quarter are included in the ICN's report that is presented at ICC.
- The following is the trust data for CPE YTD 2018/19.

Number of Patients Suspected of Carriage having met risk group criteria	Number of Patients with Confirmed Carriage of CPE
19	3

External Inspections

Patient Led Assessments of the Care Environment (PLACE)

- The ICN's were key contributors to the annual PLACE assessment undertaken at the trust in May 2018. The domains that were assessed achieved pleasing scores and showed improvements in scores from 2017 for cleanliness and dementia. This inspection does not include the satellite sites therefore it was agreed at the ICC that PLACE light is undertaken at the satellite sites by the facilities department and clinical teams.



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1555.0000	0.0000	0.0000	0.0000	158.3333	727.0000	418.0000	280.0000
Available Score (Actual)	1558.0000	0.0000	0.0000	0.0000	172.0000	730.0000	448.0000	290.0000
Site Score	99.81%				92.05%	99.59%	93.30%	96.55%
Organisation Average	99.81%	0.00%	0.00%	0.00%	92.05%	99.59%	93.30%	96.55%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	78.89%	84.19%

Antimicrobial Stewardship

Antimicrobial prescribing and guidelines

- Moorfields antimicrobial app is the most up-to-date, shared resource for treatment of ophthalmic infections. A further four versions of the app have been published since the last financial year demonstrating our commitment to ensure the most up-to-date information is made available to healthcare professionals on the go. We are proud to report that 77% of users are clinicians, with a total of 827 active users recorded in March 2019. Quarter two and four are the busiest for downloads (>1,000 hits) possibly due to promotion of the app at various events like Trust Induction and through the NCL antimicrobial stewardship network.
- Furthermore work on guidelines for management of paediatric ophthalmic infections is underway jointly with Great Ormond Street Hospital for children. A protocol for management of paediatric bacterial endophthalmitis has been published in 2018. The protocols for managing ophthalmic infections in children will enable prompt recognition, treatment and management of conditions across Moorfields and Great Ormond Street Hospital. They will be made available on a separate platform of Microguide app, effectively segregating adult from paediatric infection management.
- The antimicrobial pharmacist has been assisting the review of sub-specialty A&E handbooks. A successful bid has been obtained by the antimicrobial pharmacist and consultant ophthalmologist, for a Moorfields Emergency Guideline App (MEGA). This demonstrates how antimicrobial stewardship at Moorfields extends beyond guidelines generated by pharmacy.
- The CQC inspection report positively remarked on apparent evidence of antimicrobial stewardship within Moorfields Eye Hospital.

Audit Work

- The audit programme for the financial year 2018/19 has been successfully completed, with four audits looking into service specific antimicrobial prescribing and treatment compliance issues
    - Adherence to Trust Prescribing Guidelines for Azithromycin 1.5% eye drops
    - Review of appropriateness of topical quinolone prescribing in A&E
    - Review of topical quinolone prescribing in cornea service
    - Adherence to Toxoplasmosis treatment protocols

Involvement and contribution

- The antimicrobial pharmacist lead on a project for improving patient accessibility to emergency ophthalmic treatment: Emergency Endophthalmitis Boxes (EEBs) for rapid treatment of endophthalmitis. Diagnosis of endophthalmitis includes sampling intraocular fluid for microbiological analysis and administering antibiotics by intravitreal injection. Bacterial load in the eye can double within 30 minutes. For this reason, European guidelines recommend delivery of endophthalmitis treatment within 1 hour of presentation. Past audit and simulation at Moorfields identified that time used in gathering equipment and preparing antibiotics for emergency treatment needed to be significantly reduced. It was also apparent that standardising an endophthalmitis care package was vital in ensuring all patients treated across a large network of MEH sites have access to immediate treatment. EEBs have achieved the set goal and new response times from diagnosis to treatment achieved within the running audit are down to <20 minutes from 61 minutes.
- The project was commended as a quality and safety improvement initiative at Bayer's annual Ophthalmology Honours Awards and selected for a poster presentation at WAEH 13th annual meeting in London 2019.
- The antimicrobial pharmacist contributed to the 2018/19 flu campaign as a peer vaccinator, running pharmacy based clinics. In 2019/20 the antimicrobial pharmacist will take the ownership for reviewing and adapting the influenza PGD for use within Moorfields Eye Hospital ensuring frontline staff have easy access to the vaccine.

Decontamination

Monitoring and Test Results

- The Sterile Services department is accredited to government regulatory standards and holds an ISO 13485 (2016) & a Medical Device Directive (MDD 93/42 EU ECC) accreditation.
- As part of this accreditation status, the department has to undergo several monitoring and test which include: periodic protein testing of instruments compliant with the HTM01:01, Bioburden monitoring, Environmental monitoring to ISO Class 8 standards, compliant with ISO 14644-1 & ISO 14698, annual revalidation of the Clean room compliant with HTM 03 -01 & ISO 14644-1.
- All machinery (Washer disinfectors, sterilisers etc.) have regulatory daily, weekly, quarterly and annual testing, and the steam used for the machines also undergoes periodic steam quality and condensate tests.

SSD Productivity & Theatre Non-Conformance summary

- The average monthly productivity is about 4,400 Single Instruments (± 5%) & 9,500 Instrument Trays containing varying amounts of Instruments.

- Monthly theatre non-conformance is 0.05%. This represents a considerable level of quality control and theatre acceptance of the quality of the products from the department. The department however will work continuously towards further reduction in the levels of the non-conformances.

Surveillance & Accreditation

- The Department has yearly surveillance audits from government regulatory External audit firm SGS, for the following scope of Certification Standards "ISO 13485:2016 – Medical Device Certification & the Directive 93/42/EEC – Medical Device Directive".
- The department performs very well in these audits and any compliance issues are reviewed, and closed-off appropriately.

Quality Management Systems

The department operates a robust Quality Management System (QMS) which comprises:

- SSD Quality Manual incorporating the Quality Policy
- SSD Technical Assessment compliant with the requirements of the MDD 93/42 EEC
- Risk Assessment compliant with ISO 14971 - Risk Management / Analysis
- Various SSD Procedures and SOP's compliant with:
  - *BSEN980 - Graphical Symbols for use in labelling Medical Devices*
  - *ISO 11607 - Packaging for terminally sterilised Medical Devices*
  - *EN 868-1: Packaging Validation; HTM 01-01: Hospital Technical Memorandum: Decontamination of surgical instruments*
  - *GMP: Good Manufacturing Practices*
  - *BS EN 1041: Information that is supplied by the manufacturer of medical devices*
  - *BS EN ISO 17664: Sterilisation of Medical Devices*
  - *BS 6254: Specification for Crepe Sterilisation Paper for Medical Devices;*
  - *BS 6255: Specification for Plain Sterilisation Paper for Medical Devices*
  - *BS 6256 & BS 6257: Specification for Paper, pouches, bags for steam sterilisation*
  - *BS 6871: Specification for Heat Sealable Pouches*
  - *BS 867: Non-Biological systems in sterilising medical devices (use of autoclave tapes, Class B indicator, Bowie Dick)*
  - *ISO 14644-1: Cleanroom Classification*
  - *ISO 14937: Sterilisation of Healthcare Products*

The departmental QMS is written to comply with MEH standards as well as regulatory standards and it is regularly reviewed for compliance and to ensure it is up to date with current regulatory requirements.

Training

- Training and re-training programmes are being implemented and documented in staff files and the department's Training Matrix.

Infection Control Policy

Policy

During this year the ICNs have continued to review and update policies, guidelines and standard operating procedures to ensure staff are provided with the most up to date information to enable best evidence based practice to be delivered to patients.

Infection Control Audit

Audit

Compliance with key infection control policies is monitored through policy and practice audits which provide evidence of staff performance and knowledge.

Policy Audit

The trust performance of policy audit compliance is as follows:

Green Compliance	Amber Compliance	Red Compliance
13	1	0

- In addition to this, the trust overall compliance scores for departmental monthly audits of hand hygiene and cleanliness were green.
- Below is the scoring system used to score the level of compliance as red, amber or green. This scoring system is used for all infection control audits.

Overall Score	Compliance Level	Rag Rating
85% or above	Compliant	Green
76% - 84%	Partial compliance	Amber
75% or below	Minimal compliance	Red

Environment Audits

Department audits are undertaken by the ICN's annually unless otherwise indicated.

Green Compliance	Amber Compliance	Red Compliance
22	4	0

- This year 26 clinical areas including 11 theatre sites containing 21 operating facilities, 9 injection sites comprising of 17 individual injection rooms, 1 minor ops suite, 4 wards and the Accident and Emergency Department were audited.
- Theatres at St Georges Hospital and Duke Elder Ward moved to St Anthony's Hospital, Cheam in January 2018 for major refurbishment works to take place of the theatres and the ward at St Georges Hospital. The intravitreal injection facility moved to City Road.

Infection Control Risk Register

The IC risk register was reviewed at the ICC twice during the year and was reviewed by the ICT quarterly. The risks identified included a change in the use of a clinical premises from overnight stay to longer length of stay for patients

and recognised that there is no capital planning procedural document which outlines the process for full stakeholder sign off

Hand Hygiene Campaign

The ICNs delivered a trust wide hand hygiene campaign from September to December.

The aim of the campaign was to:
Review staff compliance with hand hygiene practices which included compliance with 'Bare below the elbow', review the availability of hand hygiene facilities, assess staff knowledge and awareness on the trust hand hygiene policy, refresh hand hygiene posters for both patients and staff, review hand hygiene products in theatres used for surgical scrubbing

As part of the campaign the ICNs reviewed the hand hygiene products used for undertaking a surgical scrub and a waterless solution for undertaking a surgical scrub was introduced in all the theatres and intravitreal injection rooms at the trust.

NHS Improvement National Policy and Guidance (NPG) Consensus Group
An ICN was a member of the national policy and guidance consensus group and was actively involved in the development of a national hand hygiene and personal protective equipment policy which was published by NHS England and NHS Improvement in March 2019.

International Visits

Visit to UAE
In April 2018 two ICNs visited Moorfields Dubai and Abu Dhabi. The aim of the visit was to review the facilities and resources and gain an insight in the infection control practices and procedures in place. Audits were undertaken in the operating theatre and outpatient departments. Feedback was provided verbally which was followed up with comprehensive reports. The visit proved to very beneficial for the teams and assisted in building a good networking system.

Chile
A small group of experts travelled to Santiago, Chile, in April to provide a knowledge transfer with the Pasteur network of ophthalmology. The infection control matron participated in the organisational review and developed an infection control programme as part of a larger quality governance framework. This assisted the Pasteur clinic to strengthen their quality objectives and obtain national accreditation.

Presenting at WAEH in Michigan, US
In June the infection control matron took part in the international World Association of Eye Hospitals conference at the Kellogg Eye Centre in Michigan. Presenting on the surveillance work that had been developed and lessons learnt following a rare cluster of cases experienced at the trust a year previous, the talk was received well and a commitment to work collaboratively on endophthalmitis benchmarks in the future was agreed.

Matters of the Estate

Water Safety and Ventilation Management Group

- A water safety and ventilation management group meet quarterly to discuss issues relating to the operational management of water and ventilation systems.
- This group reports quarterly via the estates department to the Infection Control Committee any exceptions to water and ventilation management.

Water Safety

Statutory water testing at the trust is undertaken by an independent company and the Estates Team is notified of the findings including details of control measures required. The estates team inform the infection control team of routine samples that detected legionella. The ICNs liaise with the clinical staff in the area(s) as required and provide advice on any additional measures that need to be implemented.

Theatre Ventilation

All theatres have an annual ventilation inspection undertaken by independent companies to ensure that the theatre facilities meet the required minimum standards per HTM guidance and are safe for use. The estates team receive all such inspection reports including host sites. Reports are reviewed by estates, infection control nurses and the infection control doctor and any remedial work required is followed up by the estates team.

Refurbishment/Capital Planning

This year the ICN's have had input into plans before, during and after completion of works on various sites where refurbishments have been undertaken to ensure that infection control standards were met.

These have included:

- refurbishment and new builds of theatres and Duke Elder Ward at St Georges Hospital
- refurbishment and development of facilities for private patients, 4th floor City Road
- refurbishment of the pharmacy department at St Ann's Hospital
- renovation works in the clinical research unit laboratory and dirty utility at City Road
- refurbishment and development of storage facilities – main theatre corridor
- development of facilities of a staff room and patient shower/toilet facilities on the Observation Ward

Facilities - Cleaning

- A clean environment is crucial for maintaining patient safety. A cleanliness monitoring meeting is held quarterly to discuss issues relating to cleanliness, waste and linen at the trust.
- The meeting is attended by infection control, estates, ISS facilities, SSD and matrons. A summary report is provided by each department of their activity for the quarter and any concern/questions are discussed at the meeting.
- Cleanliness at MEH is monitored through monthly cleaning audits undertaken by link practitioners, environmental audits undertaken by the ICNs and monthly walkabouts by facilities, estates, ICNs and matrons.

- A summary from this meeting highlighting any areas that require escalation is presented at the quarterly Infection Control Committee.

CQC Unannounced Inspection

An unannounced CQC inspection was undertaken at the trust in November 2018. The inspection reflected on high standards of infection control across all sites visited by the inspectors. There were no infection control concerns highlighted in the final report which required addressing.

Education and Training

Mandatory Training

- The ICN's have delivered face to face training sessions to all staff groups at corporate induction and as part of the mandatory training programme. In addition to face to face training both clinical and non-clinical staff have the facility to do the training online using e-learning packages.
- The trust overall compliance for clinical staff was **91%** and **96%** for non-clinical staff achieving above the trust target of 80%.

Infection Control Link Practitioners

- The trust has link practitioners in clinical areas across all sites. Link practitioners are a key resource for disseminating infection control information. Two workshops were held during year and were well attended by staff from different departments across the trust. Specific sessions and training was provided which included:
  - Administration of intravitreal Injections
  - The environment as a vector for infection
  - Hand Hygiene- Feedback from hand hygiene campaign
  - Influenza
- The ICN's also used this opportunity to provide an update on new published national guidelines and changes to current practices and procedures in the trust.

Measles Awareness Sessions

- As a result of an increase in the number of measles cases seen in the London area during the year, NHS improvement sent a letter to all trusts in July with recommendations. As a result the ICNs delivered sessions on measles to staff in the Accident and Emergency Departments and provided posters for staff and patients.

The Monthly Bug Brief

This infection control newsletter has covered a variety of information this year including compliance scores and key findings from audits, new and revised policies, upcoming infection control study days, conferences and any new national guidelines.

Infection Control Liaison Officer Clinical from Singapore

An ophthalmic nurse who provides an infection control service in an ophthalmic hospital spread across multiple sites in Singapore spent two weeks with the ICNs in November 2018. During this time the nurse observed practices in the

operating theatres and nurse led clinics and had the opportunity to visit some satellite sites. This was an opportunity for the ICNs to share knowledge and experiences.

Project Search Intern

A project search intern spent 3 months with the ICNs. Objectives were set by the ICNs with the intern to help develop skills for future employment. During this period the intern accompanied the ICNs during audits and undertook a range of administrative roles under the supervision of the ICNs.

Infection Control Web Page

The trust IC web page has been kept up to date by the IC administrator. IC information available on this page includes:

All IC leaflets, IC newsletter, information on management of sharps/splash injury, any new IC information and link to all IC policies

Conclusion

2018/19 has overall been a pleasing year for the ICT. This report demonstrates the achievements and continuous improvements in infection control that have been made which have contributed to maintaining patient safety. An expansion of benchmarks for further ophthalmic procedures has meant that there is increased surveillance and reporting which has assisted the trust in monitoring performance in individual services.

The report provides assurance of processes in place to ensure that the trust meets the requirements of the Health and Social Care Act 2008 (amended 2015): Code of Practice for the NHS on the prevention and control of healthcare related guidance.

The completion of the ICT audit programme and alert organism surveillance is a proven method of achieving high standards across the trust and it is the ICN's implementation of this that ensures assurance processes are focused on patient, visitor and staff safety as a priority.

Looking forward to 2019/20, prevention of healthcare associated infections will remain a priority for the infection control team at the trust. The ICNs will continue to work collaboratively with other stakeholders at the trust and work to a robust annual programme of work to help ensure that a high standard of infection control service continues at the trust. The IC service will be developing an IC strategy which will focus on the key objectives for the department.

Appendix 1: Explanation of Commonly Used Terms

- Healthcare-associated infection - Infections resulting from medical care or treatment in hospital (in or out-patient), nursing homes, or even the patient's own home. Previously known as 'hospital acquired infection' or 'nosocomial infection' the current term reflects the fact that a great deal of healthcare is now performed outside the hospital setting. Healthcare associated infection (HCAI) can affect any part of the body, including the urinary system (urinary tract infection), the lungs (pneumonia or respiratory tract infection), the skin, surgical wounds (surgical site infection), the digestive (gastrointestinal) system and even the bloodstream (bacteraemia).
- MRSA- MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections. The full name of MRSA is meticillin-resistant staphylococcus aureus.
- CPE - carbapenemase-producing enterobacteriaceae (CPE) are gram-negative bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections.
- DMO - diabetic macular oedema is where blood vessels leak fluid into the retina.
- AMD - Age related Macular degeneration is the leading cause of severe vision loss in people over age 60. It occurs when the small central portion of the retina, known as the macula, deteriorates. The retina is the light-sensing nerve tissue at the back of the eye.
- Surveillance - Refers to the collection of data on healthcare associated infections occurring in a defined subgroup, such as those on a particular ward, those undergoing a particular procedure or those acquiring a particular infection.
- Clostridium difficile Infection (CDI): diarrhoea or colitis cause by infection with the Bacterium Clostridium difficile and detected by a positive test for Clostridium difficile Toxin.
- Bacteraemia- The presence of bacteria in the blood. The term 'fungaemia' is used if the micro-organisms in the blood are fungi (e.g. yeasts) rather than bacteria
- Bloodstream infection - The presence of micro-organisms in the blood with signs of infection. This can be 'primary' i.e. inoculated directly into the bloodstream e.g. via an IV line or 'secondary' spread to the bloodstream from an original focus somewhere in the body e.g. urinary tract, etc.
- MRSA Bacteraemia The presence of Meticillin resistance Staphylococcus aureus bacteria in the blood stream.
- MSSA Bacteraemia The presence of Meticillin sensitive Staphylococcus aureus bacteria in the blood stream.
- E.coli Bacteraemia The presence of E.coli bacteria in the blood stream.
- Intravitreal is a route of administration of a drug or other substance, in which the substance is delivered into the eye. "Intravitreal" literally means "inside the eye".
- Screening - Process through which carriers of a trait may be identified within a population.
- Rate - amount in relation to standard figure: the amount, frequency of something expressed as a proportion of a larger figure or in relation to a whole.
- Coliforms - describes rod-shaped bacteria that are normally found in the colons of humans and animals and become a serious contaminant when found in the food or water supply.

- *Pseudomonas aeruginosa* - is a common bacterium that can cause disease in animals, including humans. It is citrate, catalase, and oxidase positive. It is found in soil, water, skin flora, and most man-made environments throughout the world.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 10

Guardian of safe working

Board of directors 4 July 2019

Report title	Guardian of Safe Working Report
Report from	Nicholas Strouthidis, medical director
Prepared by	Andrew Scott, guardian of safe working
Attachments	N/A
Link to strategic objectives	We will attract, retain and develop great people

Brief summary of report

The guardian of safe working report summarises progress in providing assurance that doctors are safely rostered and their working hours are compliant with the 2016 terms and conditions of service (TCS) for doctors in training. This report covers the period from 28/02/18 – 22/06/19

Historically the trust would satisfy itself of safe working practice by monitoring trainees' hours. Monitoring hours has ceased under the 2016 junior doctors contract and the trust and trainees are now required to raise concerns of unsafe working through exception reports. My role as guardian of safe working is to have oversight to the exception reporting process and ensure that junior doctors are listened to and that practices are put into place to mitigate any unsafe working.

Trainees are notified of the detail of their rota in a work schedule document that they receive prior to starting. All trainees received induction training on exception reporting and allocate software. A recent online survey (78% response rate) showed that 76% of respondents know how to exception report.

During the last quarter, there have been 4 exception reports by two trainees working outside of their allocated rota. Both trainees are from the St George's rota. One upper house second on-call reported 3 exceptions during a weekend and a bank holiday on-call. One first on call ST3 reported an exception on a bank holiday on call. Review with the respective Educational supervisors has been done in a timely fashion and exception reports closed.

One of these exception reports has been flagged up as an immediate safety concern by a St Georges Upper House (UH) trainee working excessive hours (16.5 hours) and unable to take natural breaks on Good Friday bank holiday. The first on-call ST3 working on this day also reported this shift. Over 30 patients were seen on this Good Friday Bank Holiday. Although this is an average number for a regular Saturday on-call at St Georges, some patients were complex needing extended amount of time. Moreover, there was no Emergency Nurse Practitioners (ENP) present on Good Friday (usually present on Saturday and Sunday for 9-15hrs and weekdays till 9pm). ENPs have been shown to be highly effective in triaging patients and managing low risk primary care emergencies.

The other 2 exceptions were reported by the same Georges UH trainee for a weekend on-call at St Georges in May. Excessive hours were worked during these 2 day shifts and trainee rest between shifts was interrupted by an orbital emergency (retrobulbar haemorrhage) requiring the trainee to drive in to the hospital in the middle of the night to perform emergency surgery. This constitutes a breach of the minimum rest period between shifts and the hospital will be fined accordingly and trainee to be compensated by x1.5 the enhanced hourly rate for extra hours worked.

There have been no instances of a breach of the 48-hour average working week (across the reference period agreed); no instances of a breach of the maximum 72-hour limit in any seven days; and there have been no reports of any trainee missing greater than 25% of their natural breaks.

There have been no exception reports from outpatient clinics in the past quarter.

Currently there are the following trainee vacancies within the trust: One gap on the St Georges 2nd on-call rota due to maternity leave which is being managed by locums. Two gaps on the Adnexal TSC rota due to fellows leaving (resulting in 6 from 8 fellows). Only one of these fellows is a TSC. The rota has been amended and this trainee compensated with extra zero days.

It has been decided at the last Junior Doctor Forum that money from fines will help purchase plastic eye models for surgical training.

We are delighted that Moorfields Eye Hospital NHS Foundation Trust will receive the sum of £30,000 from Health Education England to make improvements that will impact positively on the working conditions of junior doctors. Currently there is an ongoing survey amongst Junior doctor trainees to identify needs

according to the BMA Fatigue and Facilities Charter and this will be used as a guide to spend the funds locally. This will be discussed at the next Junior Doctor Forum in July.

High level data

Number of doctors in training (total):	47
Amount of time available in job plan for guardian to do the role:	1 PA/week
Admin support provided to the guardian (if any):	Ad Hoc provided by HR
Amount of job-planned time for educational supervisors:	1 PA per week

Actions/Discussions taking place:

1. Whist there have been significant improvements to the rota at St Georges, there are still some exceptions reported by UH trainees one of which has resulted in a fine due to breach of safe working hours. The absence of a LH on-site during the night increases the risk of an UH first on call being called in and breaching. We will therefore continue to make improvements on this rota to ensure that there sufficient cover, including investing in emergency nurse practitioners (EMP)to deal with the less complex workload. We need to ensure that EMPs are rostered on all days including Bank holidays.
2. Committing to the delivery of the proposals by junior doctors to ensure that the £30,000 funding from Health Education England is used to make improvements that will impact positively on the working conditions of junior doctors. The Director of Medical Education and Junior Doctors' Forum should determine, sign off, and monitor, the funding allocation locally.

Summary

All Moorfields trainees are safely rostered in compliant rota patterns with only 1 breach of the terms and conditions of service occurring during this reporting period. Most trainees are familiar with the process of exception reporting and there are systems in place to ensure prompt compensation payment for excessive hours worked. In general trainee morale is high and working conditions good. There are relatively few exception reports from on-call rotas and none from clinics. EMPs on the St George's rota have been highly effective in triaging patients and reducing workload and need to be rostered on all days including bank holidays. Moorfields Eye Hospital NHS Foundation Trust will receive the sum of £30,000 from Health Education England to make improvements that will impact positively on the working conditions of junior doctors who are actively involved in the allocation and spending of this funding.

Quality implications

There are clear implications for patient care if the trust does not make sure it is adhering to the new contract and stricter safer working limits, reduction in the maximum number of sequential shifts and maximum hours that a junior doctor is able to work.

Financial implications

The guardian of safe working may impose fines if specific breaches of the terms of conditions of service occur where doctor safe working has been compromised.

Risk implications

The risk implications are detailed in the report in terms of reasons for exception reporting and potential impacts on the quality of care provided to patients if there are breaches in the contract.

Action required

The board is asked to consider the report for assurance.

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 11
Medical revalidation and appraisal annual report
Board of directors 4 July 2019

Report title	Annual report on medical appraisal and revalidation 2018 - 2019
Report from	Mr Nicholas Strouthidis, medical director and responsible officer /Mr Declan Flanagan medical director and responsible officer (until 15 August 2018)
Prepared by	Mr Nicholas Strouthidis, medical director and responsible officer /Mr Declan Flanagan medical director and responsible officer (until 15 August 2018) Dr Poornima Rai – trust appraisal & revalidation lead Sean Martin, hr manager – medical staffing Sandi Drewett, director of workforce and organisation development
Link to strategic objectives	We will attract, retain and develop great people We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive summary

Overall arrangements for ensuring doctors are appraised to a standard that meets the requirements of the Responsible Officer Regulations and are revalidated in a timely manner are working effectively. The board is asked to gain assurance from the report as to compliance with Responsible Officer Regulations.

Quality implications

The trust ensures that all Medical staff with a prescribed connection to the trust are appraised and revalidated in line with national regulations which ensures all medical staff are safe to practice, regularly receive feedback on their performance and are of the highest standard. This has a positive impact on patient care and safety. The report forms part of the medical director's duties as responsible officer.

Financial implications

There are no direct financial implications arising from this paper.

Risk implications

There are a number of risks to having medical staff who are not safe or competent to practice. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as reputational risk.

The trust may also be subject to regulatory sanctions or as a result of failing to comply with Medical Profession (Responsible Officers) Regulations 2010 as amended in 2013.

Action Required/Recommendation

The board is asked to:

- Discuss and gain assurance from the content of the paper
- Approve the statement confirming that Moorfields Eye Hospital is compliant with the Responsible Officer Regulations.

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

1. Executive summary

Moorfields Eye Hospital NHS Foundation Trust has a prescribed connection with 325 doctors as a designated body for the purposes of medical revalidation. This number includes Consultants, Associate Specialists, Trust Fellows, Research Fellows with continuing clinical commitments, some honorary contract holders and NHS locum doctors.

In the appraisal year from 1st April 2018 – 31st March 2019 (18/19 appraisal year) the following medical appraisals were completed:

• 237 doctors completed an enhanced appraisal

• 88 doctors had not yet completed their 18/19 appraisal at the time of completion of the Annual Organisational Audit (AOA) on 01 June 2019.

To date a further 34 have completed their appraisals within the previously accepted 15 month window. Of the 88 clinicians, 54 had started within this year, and were not technically due an appraisal. However the AOA asked us to include this in our figures.

This represents a 72.9% completion rate for appraisals in 18/19, compared to the 17/18 appraisal completion of 98.5%

There were four decisions taken to defer revalidation. Three have since been revalidated and the other is scheduled for 2018/19 reporting period.

2. Purpose of the Paper

The purpose of this paper is to assure the Trust Board that we are discharging our statutory responsibilities in respect of Medical Appraisal and Revalidation for doctors who have a prescribed relationship with Moorfields Eye Hospital as designated body.

3. Governance Arrangements

Organisational structure and responsibilities:

Responsible Officer (RO) – Mr Nicholas Strouthidis, Medical Director (from August 2018)

The Responsible Officer has executive responsibility for overseeing the appraisal process for all Doctors with a prescribed connection and making revalidation recommendations to the General Medical Council (GMC).

Trust Clinical Lead for Appraisal – Miss Poornima Rai, Consultant Ophthalmologist

The Trust Clinical Lead for Appraisal is responsible for the quality improvement of appraisals in respect to inputs and outputs.

Medical Appraisers – Identified Consultants and Associate Specialists

Medical appraisers are responsible for reviewing and advising individual doctors on their appraisal portfolios and assessing whether they have met the GMC Domains of Good Medical Practice [Reference

3], giving their final recommendation to the Responsible Officer and agreeing a personal development plan with the individual.

Risk & Safety Department

The Risk & Safety Department supplies information to individual doctors on their named involvement in complaints and Serious Incidents Requiring Investigation (SIRIs). This then provides them with a specific source of evidence to reflect upon in their appraisal portfolio.

The Risk & Safety Department then provide the Medical Director with reports on named involvement in complaints and serious incidents, for triangulation checks at the point of revalidation portfolio review.
Revalidation Team - Human Resources Department

The Revalidation team working closely with the Medical Director, is responsible for maintaining the following:-

Maintenance of the appraisal system, coordinating revalidation and the deferrals and communication with all medical staff regarding the expectations of the appraisal process.

Progress Monitoring

Monitoring of appraisal and revalidations is carried out through the following:

1. *Quarterly Appraisal Rates*

Appraisal rates are reported to the Responsible Officer and then through him to the Regional Responsible Officer and is in the format of a Quarterly Appraisal Return as required by the Framework of Quality Assurance for Responsible Officers and Revalidation.

2. *Annual Organisational Audit (AOA)*

The AOA is a tool to help ROs and Boards assure themselves that the system underpinning the recommendations they make to the GMC on doctors fitness to practice, the arrangements for medical appraisal and responding to concerns are in place.

3. *Annual Board Report*

An annual report (this document) is reviewed by the Trust Board to assure members of the progress made and asks them to confirm to the Regional RO that we are fulfilling our statutory requirements.

4. Medical Appraisal

<u>Appraisers</u>
Currently there are 63 consultant and associate specialists who have undergone appraiser training by an external provider in line with GMC standards. The expectation is that each appraiser will complete up to 6 appraisals per annum.

During each appraisal year, consultants have the chance to take up the role as a trained appraiser, continue with the role or drop-out. Additional courses for appraisal training are organised based upon demand.

Feedback

Feedback on the doctor's experience of both the appraisal and the systems around it is sought from all individuals after successful completion of appraisal.

Ongoing review of policy and guidance documentation is carried out by the Revalidation Team within the Human Resources Department.

5. Revalidation Recommendations

Between 1st April 2018 and 31st March 2019, there were 72 doctors who required revalidation. All recommendations were completed by the Responsible Officer in time, 68 revalidated and 4 deferrals. The appraisal evidence of doctors due for revalidation are reviewed in the months prior to revalidation by the Revalidation team and the Medical Director. All doctors are reminded by both the GMC and the Revalidation team, at least 4 months in advance of the submission date, to ensure that they have submitted sufficient evidence in all categories.

Of those 4 deferrals 3 have since been revalidated and the other is due to be revalidated in October 2019.

6. Recommendations

That the Board to receives the report (noting that it will be shared, along with the annual audit, with the Higher Level Responsible Officer) and to note the contents.

The Board is asked to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations.

7. Further Information

The Medical Profession (Responsible Officers) Regulations 2010, Found at URL:

http://www.legislation.gov.uk/uksi/2010/2841/pdfs/uksi_20102841_en.pdf

The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012, Found at URL:

http://www.gmc-uk.org/LtP_and_Reval_Regs_2012.pdf_50435434.pdf

Good medical Practice, General Medical Council (2013), Found at URL:

http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0914.pdf

The GMC protocol for making revalidation recommendations, Third Edition, General Medical Council (2014), Found at URL:

http://www.gmc-uk.org/Responsible_Officer_Protocol.pdf_56096180.pdf

Annual Organisational Audit (AOA)
End of year questionnaire 2018-19

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	000182
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2019
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2017/18 AOA cleared with Publications Gateway Reference 07760
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

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Annual Organisational Audit (AOA)

End of year questionnaire 2018-19

Version number: 1.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016, 24 March 2017, 23 March 2018,

January 2019

Prepared by: Lynda Norton Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Please do not use this version of the form to submit your response.

Contents

1 Introduction

The Annual Organisational Audit (AOA) is an element of the Framework of Quality Assurance (FQA) and is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of the responsible officer function across England. Where small designated bodies are concerned, or where types of organisation are small, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

As the first cycle of medical revalidation is now complete, it is the right time to update the FQA and its underpinning annexes. The update started by reviewing the AOA and taking account of the feedback received at the beginning of this work, we have produced a slimmed down questionnaire for responsible officers to compete for the 2018/19 exercise.

In response to feedback from designated bodies, we have simplified the categories of appraisals in the 2018/19 AOA to:

- Category 1 - a single figure of completed medical appraisals
- Category 1a – fully compliant appraisal figure (optional)
- Category 2 – no change (‘approved missed’ e.g. maternity, sickness)
- Category 3 – no change (‘unapproved missed)

This slimmed down AOA concentrates primarily on the quantitative measures of previous AOAs, the numbers of doctors with a prescribed connection and their appraisal rates. As the systems and processes that support medical revalidation are established, the emphasis has moved to reporting on how these should be developed year on year through the newly revised Board report instead. The Board report is also a component of the FQA. In time, we expect to introduce suitable quantitative measures about the remaining components of the responsible officer function, for example responding to concerns, monitoring of performance and identity checks.

The AOA 2018/19 questionnaire is divided into four sections:

Section 1: The designated body and the responsible officer
Section 2: Appraisal
Section 3: Annual Board report and Statement of Compliance
Section 4: Additional Comments

The questionnaire is to be completed by the responsible officer on behalf of the designated body for the year ending 31 March 2019. Inputting the information can be appropriately delegated. The completed questionnaire should be submitted before or by the deadline

The final date for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2019.
Whilst NHS England is a single designated body, for this audit, the national, regional and local offices of NHS England should answer as a ‘designated body’ in their own right..

Following completion of this AOA exercise, designated bodies should:

- Consider using the information gathered to produce a status report and to conduct a review of their organisations’ appraisal developmental needs.
- Complete their Board report and submit it to NHS England by 27 September 2019. The Board report template has also been revised as described above and now includes the annual statement of compliance. The new version will enable designated bodies to review and develop their systems and processes. It will also enable them to provide assurance that they are supporting patient care by fulfilling their statutory obligations in respect of the responsible officer function.

For further information, references and resources can be found at page 16 www.england.nhs.uk/revalidation

2 Guidance for submission

Guidance for submission:

- A small number of questions require a ‘Yes’ or ‘No’ answer. To answer ‘Yes’, you must be able to answer ‘Yes’ to all the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter is responsible for checking the information is correct and should update the information if and where required before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Moorfields Eye Hospital NHS Foundation Trust	
	Head Office or Registered Office Address if applicable line 1 162 City Road	
	Address line 2	
	Address line 3	
	Address line 4	
	City London	
	County	Postcode EC1V 2PD
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☑
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities – NHS Litigation Authority, now NHS Resolution, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (Local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

Please do not use this version of the form to submit your response.

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☐
		NHS England London	☑
		NHS England South East	☐
		NHS England South West	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • The responsible officer has been formally nominated/appointed by the board or executive of the organisation.		☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2019 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 12-14 for assistance completing this table**		1	1a	2	3	
		Number of Prescribed Connections	Completed Appraisal (1)	(Optional) Completed Appraisal (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	138	116	0	12	10	138
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	26	22	0	3	1	26
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	160	98	0	48	14	160
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	1	1	0	0	0	1
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	325	237	0	63	25	325

Please do not use this version of the form to submit your response.

2.1	**<u>Column - Number of Prescribed Connections:</u>** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2019** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **<u>Column - Measure 1 Completed medical appraisal:</u>** A *completed annual medical appraisal* is one where either: a) All of the following three standards are met: i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, iii. the entire process occurred between 1 April and 31 March. Or b) the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **<u>Column - Measure 1a (Optional) Completed medical appraisal:</u>** For designated bodies who wish to and can report this figure, this is the number of completed medical appraisals that meet all **three** standards defined in Measure 1 a) above. This figure is not reported nationally and is intended to inform the internal quality processes of the designated body.	

Column - Measure 2: Approved incomplete or missed appraisal:

An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal for it to be counted as an *Approved incomplete or missed annual medical appraisal*.

Column - Measure 3: Unapproved incomplete or missed appraisal:

An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal.

Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.

Column Total:

Total of columns 1+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2019.

* Appraisal due date:

A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month.

For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook: (NHS England 2015).

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and unapproved) for the appraisal year 2018/19 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. **Additional guidance:** A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. **Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of a *Category 1 completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☑ Yes ☐ No ☐ N/A

5 Section 3 – Annual Board Report and Statement of Compliance

Section 3		
3.	The last Annual Board Report was signed off on: 20/09/2019 The last Statement of Compliance was signed off on: 20/09/2019	

6 Section 4 – Comments

Section 4	Comments	
4	54 of the 63 approved incomplete/missed appraisals are staff who are new to the Trust and have been working at Moorfields for less than a year. Within the 63 approved incomplete/missed appraisals we are accounting for staff who work in Dubai, as well as staff who work at UCL and are appraised twice. The process takes a bit longer as they are working on 2 appraisals simultaneously, but we have sight of the UCL appraisal. The annual board report and statement of compliance were submitted in September 2018 - the date in section 3 may not be exact.	

7 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)

2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)

3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)

4. The National Health Service (Performers Lists) (England) Regulations 2013

5. Revalidation: A Statement of Intent (GMC and others, 2010)

6. Guidance on Colleague and Patient Questionnaires (GMC, 2012)

7. Effective clinical governance for the medical profession: A handbook for organisations employing, contracting or overseeing the practice of doctors (GMC 2018)

8. The GMC protocol for making revalidation recommendations: Guidance for responsible officers and suitable persons (GMC, 2012, updated in 2014)

9. Providing a Professional Appraisal (NHS Revalidation Support Team, 2012)

10. Appraisal in the Independent Health Sector (British Medical Association and Independent Healthcare Advisory Services, 2012)

11. Joint University and NHS Appraisal Scheme for Clinical Academic Staff (Universities and Colleges Employers Association, 2002, updated in 2012)

12. Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

13. Medical Appraisal Logistics Handbook (NHS England, 2015)

Annex E – Statement of Compliance

Designated Body Statement of Compliance

The board of Moorfields Eye Hospital NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Yes

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Yes

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 12
Membership Council report
Board of directors 4 July 2019

Report title	Membership council report
Report from	Tessa Green, chair
Prepared by	Helen Essex, company secretary
Previously discussed at	N/A
Attachments	N/A
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience We will be at the leading edge of research making new discoveries with our partners and patients We will innovate by sharing our knowledge and developing tomorrow's experts We will have an infrastructure and culture that supports innovation

Brief summary of report

Attached is a brief summary of Membership Council meeting that took place on 18 April 2019.

Action Required/Recommendation.

Board is asked to note the membership council report

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

REPORT FROM THE MEMBERSHIP COUNCIL MEETING – 18 APRIL 2019

Matters arising from the minutes

Governors received an update on the automated booking system and the rationale for the removal of cash machines at the City Road site.

The results of the recent election were confirmed. The chair welcomed new and re-elected governors to the membership council and thanked all outgoing governors for their commitment and contribution.

Interpreting and translation services presentation

This issue had been raised by governors as a theme arising from their visits to sites. Governors received a presentation on the current service provision and review of the policy. Governors were also advised of the next steps with regard to how the service is promoted and best utilised as well as improvement in data collection, reporting and presentation.

Feedback from governors

The **governance development group** are in the process of discussing a number of different issues:

- Voting system – the group will be recommending a change from FPTP to STV voting at a future meeting.
- Membership council self-assessment – the process is planned for later in the year when new governors have had a chance to settle in to their roles. The membership council is required to conduct a review of its effectiveness every three years.
- Induction pack – further refining and updates following feedback from new governors.
- Election preparation – it has been agreed that information needs to be given to prospective governors prior to elections in order to make sure they understand the role and commitments.

The **membership development group** provided feedback on a meeting held with South London governors and Moorfields South divisional management. This provided a good opportunity for governors to get to know staff and the issues they are facing.

Members' week is planned for 28 – 31 May and another event will be held in the autumn. This is to make sure as many governors as possible are able to take part. Another 'Meet your governor' event is scheduled prior to this year's AGM.

The **patient and carer forum** is looking at issues to do with administering drops and the importance of making sure carers are involved in the process. The purpose of this forum is to check that other groups are appropriately engaging with patients.

Governors attended the **children and young person's group** where the group were asked to comment on Project Oriel and given a first aid session.

Feedback was given from various **governor visits** and an emerging theme is the restrictions MEH experiences when co-located with other trusts (host sites). Governors are keen to understand how this impacts the patient experience, particularly in areas such as transport.

Oriel

Governors were given an update on the public consultation timeline and feedback was provided from Emily Brothers, who is the new chair of the Oriel Advisory group. Governors were advised that at this stage (pre-consultation) approximately 80% of respondents are content with the plans so far. Although clinical excellence is always well regarded by patients, there is always more to do on patient experience. Moving to a new hospital will be a good opportunity to change culture.

Key points made so far are that the last 'half mile' needs to be right and a comprehensive access audit should be done. Moorfields can be at the forefront of wayfinding and patient-led design.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 13
Report of the quality & safety committee
Board of directors 4 July 2019

Report title	Report of the quality and safety committee
Report from	Ros Given-Wilson, chairman, quality and safety committee
Prepared by	Helen Essex, company secretary
Previously discussed at	N/A
Attachments	N/A
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience We will be at the leading edge of research making new discoveries with our partners and patients We will innovate by sharing our knowledge and developing tomorrow's experts We will have an infrastructure and culture that supports innovation

Brief summary of report

Attached is a brief summary of the quality and safety committee meeting that took place on 14 May 2019.

Action Required/Recommendation.

Board is asked to note the report of the quality and safety committee and gain assurance from it.

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

Committee Governance	• Quorate – Yes • Attendance (membership) - 87% • Action completion status - 93% • Agenda completed – Yes
Current activity	• The committee received a presentation on **Complex Surgery**, in particular orbital surgery in response to decompression. • There was a review of the **committee's actions** which were all completed or in progress. • **WHO audit report** for March 2019 was circulated. From now on the committee will receive exceptions on a quarterly basis. • Four **committee summary reports** were received. • An update about **fire safety** was presented to the committee. This included the fire safety audit and resulting action plan. • A presentation about **Patient admin processes** was delivered to the committee. • The committee received its regular **Quality and Safety update**. This included an update on the CQC action planning process. • The **quality account** was presented as part of the quality and safety update. • The latest **SI tracker** was presented and it was noted all SIs were on track. • There were no **SI reports** presented to the committee on this occasion. • The committee received its **annual report** for 2018/19. • The committee approved its reviewed **terms of reference**.
Key concerns	• It was noted that some members/attendees of the committee have difficulties making an early morning Tuesday morning. A short survey will be undertaken to gauge preferences. • Concerns have been expressed about fire safety at the hostel. It was noted that this matter is being prioritised via ManEx. • It was noted that e-Rostering is being underutilised in some areas, but work is being undertaken to address this. • Given the issues with health records, this only appears on local risk registers, not the corporate risk register. This will be addressed.
Key learning	• The orbital surgery undertaken at Moorfields is safe – there is now the data available to prove this. The audit however covered a single surgeon's work and a wider audit of complex surgery has been requested. The Trust does not currently possess spatial imaging technology for use during complex surgery. • WHO audit reporting to this committee would now be by exception. • Effectiveness of immunosuppression blood monitoring and patients with co-morbidities will be a future agenda item. • It was noted that the Trust had received a very good fire safety audit. The action plan and exceptions will be brought to future meetings of the committee as part of the regular fire safety update. • In response to a question asked during the patient admin. process presentation, the major barriers are the bedding in of the new management structure and resolution that issues around health records are taking to resolve. With regard to the latter point, three issues were identified: staffing (competences and performances), off-site storage of records, and the prepping of records. An update on the patient admin. process will be brought to the next meeting. • Following the publication of the Trust's CQC report, an action plan is in development.
Escalations	• Medical records: medical records-related incidents and off-site storage

Items for discussion outside of committee	• This summary to be distributed to the Board and Membership Council.
Date of next meeting	• 9th July 2019

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 14
Report of the people committee
Board of directors 4 July 2019

Report title	Report of the people and culture committee
Report from	Sumita Singha, chairman, people and culture committee
Prepared by	Helen Essex, company secretary
Previously discussed at	N/A
Attachments	N/A
Link to strategic objectives	We will have an infrastructure and culture that supports innovation We will attract, retain and develop great people

Brief summary of report

Attached is a brief summary of the people and culture committee meeting that took place on 14 May 2019.

Action Required/Recommendation.

Board is asked to note the report of the people and culture committee and gain assurance from it.

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

People & culture committee summary report – 14 May 2019

Governance	• Quorate – Yes • Attendance (membership) - 100%
Discussion points	***Matters arising*** • The committee was updated on a number of posts in the new medical directorate structure, including a new fellowship director and a lead for consultant job planning. There will also be additional support for both of these roles in the medical staffing team. • A discussion took place about fellows and how to view the roles in a wider context, taking into account other roles such as physician's assistants. There is a need to understand the potential of this workforce and what support and funding might be required to increase. ***Apprenticeships*** • The trust needs to think about its strategic vision for apprentices and where the £400k per annum apprentice levy can best be utilised. • The trust currently has 53 apprentices, of which 13 are local and the rest existing staff on the apprenticeship route. • Support structures also need review to make sure there is suitable pastoral care, peer support and management oversight in place. • Workforce modelling needs to be in place for the FBC, in around a year's time. ***Gender pay gap*** • The committee discussed the data available and whether it gives enough information to establish whether there is a problem. • The stratification of consultant salaries along with issues such as fellows undertaking ad-hoc work are not easily captured in the figures. • The importance of making positive changes in areas of influence, such as making sure we build inclusive panels for consultant jobs and composition of short listing panels, was discussed as a priority. • Once 2019 data is available it will be reviewed at a more granular level. ***EDHR governance*** • Workshop held in April to look at the current position and to undertake the EDS2 grading previously done in 2016. • The grading suggests that the position has made a positive shift in all three areas of patient experience, workforce and leadership. • This will be used as a baseline to develop a divisional tool to be used at local level. • Three listening exercises on equality in the workplace are scheduled. ***Workforce metrics*** • Resource should be put in to reducing the overall annual sickness rate. • Need better management of expectation of what clinical support roles entail and what might happen in reality. • Retaining experienced nurses but also need to think about how to make ophthalmology a specialty of choice amongst nursing graduates.

Key concerns	• HR and finance working together on accuracy of vacancy rates, particular in nursing
Discussions outside the cttee	• Divisional staff survey action plans will be discussed at the TMC in May.
Escalations	• None.
Date of next meeting	• 9 July 2019