Bundle Board of directors - Part 1 6 June 2024

Agenda

1 Welcome
LWG - note
240606 TB Part I Item 00 Agenda

2 Patient Story
SAd - note

3 Apologies for absence
LWG - note

4 Declarations of interest
LWG - note

5 Minutes of the previous meeting
LWG - approve
240606 TB Part I Item 5 LWG Draft Minutes Public

6 Matters arising and action log
LWG - note
240606 TB Part I Item 6 - Actions log

7 Chief Executive's report
MK - note
240606 TB Part I Item 7 CEO report

8 Integrated performance report
JS - assurance
240606 TB Part I Item 8 Integrated Performance Report - April 2024 (OPEN version)

9 Finance Report
JW - assurance
240606 TB Part I Item 9 Public Finance Performance Board Report

10 Staff survey
MG - approve
240606 TB Part I Item 10 Staff Survey 2023 Report and Action Plan- May 2024 Board

11 Well led and functional model and governance review update
MK - note
240606 TB Part I Item 11 LWG Well led and functional governance review update_v1.1

12 Learning from deaths
LW - assurance
240606 TB Part I Item 12 Learning from deaths

13 Standing orders and SFI
SAr - approve
240606 TB Part I Item 13 Update to SFIs

14 Committee Reports
People and Culture - assurance - LWG
Quality and Safety - assurance and approve - RGW
240606 TB Part I Item 14a LWG Report of the People and Culture Committee
240606 TB Part I Item 14b QSC summary report for Board (v0.2)
240606 TB Part I Item 14c QSC annual report (2023-24) v1.0 Q&SC APPROVED
240606 TB Part I Item 14d Quality and Safety Committee ToR 2024-25 APPROVED BY Q&SC

15 Register of interests
SAr - note
240606 TB Part I Item 15 Board Register of interests BoD

16 Identifying any risks from the agenda
LWG - note

17 Any other business
LWG

18 Date of next meeting - 25 July 2024

Moorfields Eye Hospital NHS Foundation Trust

NHS

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on
Thursday 6th June 2024 at 09.00 at Albert House, EC1V 9DD

No.	Item	Action	Paper	Lead	Mins
1.	Welcome	Note	Oral	LWG	5
2.	Patient story	Note	Oral	SAd	20
3.	Apologies for absence	Note	Oral	LWG	5
4.	Declarations of interest	Note	Oral	LWG	
5.	Minutes of the previous meeting	Approve	Enclosed	LWG	
6.	Matters arising and action log	Note	Enclosed	LWG	
7.	Chief executive's report	Note	Enclosed	MK	10
8.	Integrated performance report	Assurance	Enclosed	JS	10
9.	Finance report	Assurance	Enclosed	JW	10
10.	Staff survey	Approve	Enclosed	MG	15
11.	Well led and functional model and governance review update	Note	Enclosed	MK	10
12.	Learning from deaths	Assurance	Enclosed	LW	5
13.	Standing orders and SFI	Approve	Enclosed	SAr	5
14.	Committee reports • People and Culture • Quality and Safety	 Assurance Assurance / Approve	 Enclosed Enclosed	 LWG RGW	5
15.	Register of interests	Note	Enclosed	SAr	5
16.	Identifying any risks from the agenda	Note	Oral	LWG	
17.	Any other business		Oral	LWG	
18.	Date of next meeting – 25 July 2024				

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
DRAFT Minutes of the meeting of the Board of Director held in public on 28 March 2024 in Boardroom, Bedford Hospital, Kempston Road, Bedford, MK42 9DJ (and via MS Teams)

Board members:	Laura Wade-Gery (LWG)	Chair
	Martin Kuper (MK)	Chief executive
	Andrew Dick (AD)	Non-executive director
	David Hills (DH)	Non-executive director (via MS Teams)
	Adrian Morris (AM)	Non-executive director
	Asif Bhatti (AB)	Non-executive director
	Rosalind Given-Wilson (RGW)	Non-executive director
	Aaron Rajan (AR)	Non-executive director
	Sheila Adam (SAd)	Chief nurse and director of AHPs
	Jonathan Wilson (JW)	Chief financial officer
	Jon Spencer (JS)	Chief operating officer
In attendance:		
	Mark Gammage (MG)	Interim director of workforce
	Sam Armstrong (SAr)	Company secretary (minutes)

A number of staff and governors observed the meeting in the room and online, including: Rob Jones, Emmanuel Zuridis, Paul Murphy, Kimberley Jackson, Professor Naga Subramanian, Emily Brothers, Robert Goldstein, John Sloper and Andrew Clarke.

1. Welcome

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

She particularly welcomed Aaron Rajan to his first meeting since becoming a non-executive director of the Trust. The chair also advised the Board that she would be requesting the Membership Council to extend the term of Ros Given-Wilson as there had been some delays in the recruitment of her successor.

The chair noted that this meeting was being held at one of the Trust's network sites, and she thanked Bedford Hospital for hosting the Trust Board. There was no patient story this month, however instead the Board members would visit Moorfields services after the meeting, with opportunities to talk to both staff and patients. She mentioned that she would like the Board to hold its meetings in other network sites in the future.

2. Apologies for absence

Apologies were received from Richard Holmes and Nick Hardie, non-executive directors, and Louisa Wickham, Medical director.

3. Declaration of interest

There were no declarations made.

4. Minutes of the previous meeting

The minutes of the meeting held 23rd January 2024 were approved as a correct record.

5. Matters arising and action log

The action log and updates were noted.

It was agreed to close action 1.

6. Chief executive's report

MK highlighted key areas of his report, which were:

- The strong performance of the Trust on activity and finance.
- That the Trust had submitted its bid for the NCL ICB tender, however there were some concern regarding the effects of purdah, related to the mayoral elections, which may affect announcements.
- The Brend Cross facility was now open.

The Board noted the report.

7. Integrated performance report

JS presented the report.

The Trust's 18-week position was improving. In response to a question from LWG, JS informed the Board that performance monitoring meetings at specialist level were taking place. MK added that the Trust was keen for patient and performance data for its Bedford service to be incorporated into the Trust's system as presently it was held with Bedford Hospital.

In response to a question from RGW, JS informed the Board that contacting the Moorfields Bedford service also went through the Bedford Hospital system. Work was underway to have the Trust systems used for the Moorfields Bedford service. In response to a question from AD, JS assured the Board that a training programme was planned for Bedford staff when crossover to the Trusts systems was achieved.

Challenges remained in relation to appraisal rates and sickness absence.

In response to a question, SAd noted that measles cases remained high in London. The Trust was providing training to staff as well as testing. This was also an escalation from the Quality and Safety Committee.

The Board noted the report.

8. Finance report

JW presented the report.

It was noted that in February the Trust was reporting a £0.87m surplus against a planned surplus of £1.31m, which was £0.43m adverse to plan; and a £10.18m cumulative surplus against a planned surplus of £2.86m, which was £7.32m favourable to plan.

It was highlighted that waiting lists were coming under control, which would ultimately diminish demand and potential for unlimited work. The Trust would need to be aware of how it wanted to manage its activity and income within this context.

The Trust had been working to spend its capital allowance effectively before year-end.

In response to a question from AS, JW informed the Board that the Trust would achieve the CIP total of £7.8m, and that this was largely achieved through strike action mitigation and over-performance rather than all the planned cost reduction.

The Board noted the report.

9. Staff survey

MG presented the report.

He highlighted that while the Trust received regular feedback from staff, the annual staff survey was really important and provided the Trust with vital intelligence. It was pleasing to see an increase in participation, which was now among the best in the sector.

The Board had not planned to discuss the results in detail in this meeting, however it would be reviewed at the next People and Culture Committee meeting and then return to the Board with an action plan in due course. MK added that the executive thought it better to review the results in detail and then develop an appropriate plan in due course.

SAd added that the Trust was already undertaking actions to improve staff experiences at the Trust, which should be recognised when developing a new plan. MG added that teams could access their data, which was more relevant to them. LWG suggested that improvements in management capability through management development and training was crucial to making wider improvements across the Trust for staff.

JS reported that the divisions now had committees to oversee and discuss these issues. MK pointed out the differential on the friends and family test where staff would recommend relatives and friends for treatment to the Trust but not readily endorse it as a place to work. Possible reasons for this were discussed. AM suggested learning from other trusts. There was also a need to mine the data better. The Board discussed ways they could use data better and gather intelligence on the issues that really mattered to staff.

The Board noted the report.

10. Freedom to Speak Up report

The paper was taken as read and noted. It complements the more detailed confidential report covered in Part 2.

SAd highlighted that since January 2024, the Trust had an anonymous reporting system, which was being used by staff, and it had also recruited its first fulltime lead guardian, Princess Cole, who joined the Trust in February 2024. All part of the recent reforms undertaken by the Trust for FTSU.

The Board noted the report.

11. Guardian of safe working

The paper was taken as read and noted.

12. Committee reports

a. People and Culture Committee

The report was presented by LWG.

It was noted that the team that MG had reenergised had started to show improvements in developing the function, and delivering on key projects for the wider organisation.

It was evident that there were issues in the department, including too low a level of permanent staff (as opposed to temporary contractors). This had created the need to replace these temporary staff with substantive staff, leading to 15 new staff members needing to be recruited . This was a significant task and would need time and focus to deliver.

There were two key issues for the Trust that required the HR function's leadership: management development and translating the Trust values into a behavioural framework to help ensure everyone could live the Trust values. Work would be undertaken to deliver this work to drive improvements to management capability and culture that would ultimately improve staff experience and morale.

In response to a question, MG assured the Board there was an action plan in place to improve rates of appraisals. This included deep root cause analysis to understand why this KPI has been failing for so long.

The Board noted the report.

b. Quality and Safety Committee

RGW presented the report.

She reported that at the May meeting, the committee, with delegated authority from the Board, approved the PSIRF policy and process. It was acknowledged that this would be a major cultural change for the Trust.

At the March meeting, the committee reviewed the quality priorities. It was thought that patient experience should be a golden thread though the priorities.

The committee noted the 'good' CQC result for Moorfields Private.

They also discussed research governance.

The Board noted the report.

c. Membership Council

LWG presented the report.

She highlighted that the meeting coincided with the Oriel showcase, which was a great success.

The governors raised concerns about the last mile for Oriel, which the team were working on.

The next Board meeting would be on the same day as the Membership Council. This would be the first time the Trust had tried this and it was hoped it would increase the interaction between members of both groups, with a shared lunch.

The Board noted the report.

13. Identifying any risks from the agenda

There were no specific risks identified.

14. Any other business

There was no other business.

15. Date of next meeting

It was noted that the next meeting of the Board would take place on 6th June in the Boardroom, Moorfields Eye Hospital, 162 City Road, EC1V 2PD.

The meeting was closed 9.55am.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

6th June 2024

No.	Date	Minute item	Item title	Action	By	Update	Open/ closed
01/02	23/01/24	8.0	Integrated performance report	Report on research studies in the Trust to be presented to the board, to include breakdown of recruitment to different studies.	LW	To be incorporated in research annual report.	July 2024
01/03	23/01/24	9.0	Finance report	Provide details on breakdown of agency costs for discussion at Finance and Performance Committee	JW	To be discussed at July F&P committee meeting	July 2024
01/04	23/01/24	10.0	PSIRF	Provide review of implementation and impact of PSIRF to the Trust once fully established	SAd	Report to be presented in due course	Sept 2024

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

Brief summary of report

The report covers the following areas:

- Performance and activity review
- Sector update
- Oriel
- Staff survey
- Excellence portfolio update
- Financial performance

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

BOARD MEETING – 6th June 2024

Chief Executive's report

Performance and activity review

In April, the number of patients waiting over 52 weeks for their treatment reduced to 5 and the proportion of patients who are now waiting over 18 weeks for their treatment has reduced by 10% in month.

The Trust has improved performance against the outpatient 1st metric such that we are now meeting that target, however we remain under plan against the elective activity target. This underperformance continues to be driven by an ongoing reduction in cataract referrals into the St Ann's and Stratford sites and work is therefore underway to mitigate this by focussing resources at these sites on patients who require treatment from other specialities.

Sector update

The Trust is still waiting to hear the outcome of the tender which was run by the NCL ICB to run a single point of access and to coordinate community optometry provision across the region. We are continuing to run our single point of access in the NCL in the interim and have agreed to continue doing the same for a number of boroughs in the NEL ICB for a further 12 months.

Along with colleagues at Imperial NHS Trust, we have taken a joint decision not to bid for the community ophthalmology services tender which was put out by the NWL ICB. This tender did not seek the same use of a single point of access as the one which was put out by the NCL ICB.

The Trust is providing ongoing mutual aid for a number of NHS providers including Barts Health, Imperial and the North Middlesex NHS Trusts. We are also in the process of assessing which of our community units we should develop next as part of our ongoing Site Strategy.

Oriel

The construction of Oriel is progressing well. Work has just begun on the third floor of the building, and we remain on track to complete the highest point by November of this year.

The RIBA stage 4 detailed design has been approved at a 1:200 level by the respective Boards of our two organisations and work is now well underway to finalise the design

at a 1:50 level. This process will continue through 2024, with final sign off likely to be achieved in Q1 of 2025.

The governance of Oriel is being refreshed to ensure that it will support the next phase of the programme effectively. This refresh is predominately focussed on the workstreams which will oversee how we will use the centre to deliver optimal clinical care for our patients.

Staff Survey Report and action plan

When comparing our latest NHS staff survey results with the previous year, we improved against five of the NHS People Promise themes (we are recognised and rewarded, we are safe and healthy, we are always learning, we work flexibly, and we are a team). We maintained against 'we are compassionate and inclusive' and deteriorated against 'we each have a voice that counts.' This shows we are heading in the right direction in most areas.

However, when benchmarking overall, our scores are below the national average – so we recognise that we have a lot of work to do to improve staff experience.

We had a significant increase in the staff survey response rate from 50% the year before to 66%. This is significantly higher than the national average (54%). This shows improvement in staff engagement, and we want to thank all staff, especially those who completed the staff survey for their feedback.

The survey result and action plan have been shared with ManEx and the People and Culture Committee. We are working through the action plan to ensure that feedback from staff is listened to and promptly acted on.

Excellence Portfolio

A major focus for this period has been assurance of the Electonric Patient Record (EPR). The XDU team are embedded into the ERP team to provide live assurance and receive a weekly summary update as well as routine assurance at IT Programme Board and Major Projects and Digital board subcommittee.

During this period, some key projects completed and transitioned to business as usual. The launch of the new Freedom to Speak Up model has seen the introduction of an anonymous reporting route for staff to raise any concerns with a comprehensive launch plan for teams. The platform was launched as planned on 24 January 2024. In the first three weeks of launch 25 user accounts were registered,

ten conversations were started with the guardians and 26 cases were logged into the case management system (14 of these were historical cases that were still open).

The Pathway to Excellence team achieved accreditation for the trust in autumn 2023, enabling excellence in nursing and supporting recruitment and retention. Making every contact count focused on supporting patients with smoking cessation, due to the related impact on eyes. They recruited champions, and their campaign included updated patient information and celebrating national no smoking day.

Other projects to complete include workforce medical optimisation, E-roster optimisation, learning and development infrastructure review, leadership academy and private patients New Cavendish Street. Post project reviews will be undertaken 6-9 months after the projects close and any ongoing monitoring of sustainability will be carried out in the relevant performance reviews where appropriate.

The XDU team are supporting the Excellence in Oriel group and to ensure that change work related to Oriel is reflected in the multiyear plans of the Excellence Boards. The Excellence Delivery team have supported 24/25 projects to be brought online, confirming leadership teams, resource requirements and confirming scope and key performance indicators where required. The team have been working with new members of project teams to support them with good practice project management tools and the trust digital assurance system.

April Performance

Financial planning for 2024/25 continues across North Central London ICB with the trust having submitted a £3.4m surplus plan at the end of April, although further changes are anticipated until an overall breakeven position across the ICB is achieved. Against this £3.4m plan, the trust is reporting a £0.61m deficit in April, £0.01m favourable. Patient activity during April was 91% for Elective, 104% on Outpatient First, and 101% against Outpatient Procedures activity respectively against the trust activity plan. The trust cash position was £70.4m, equivalent to 85 days of operating cash. Capital expenditure was £2.9m in month with the majority relating to the Oriel development as internal capital plans are finalised. Efficiencies of £6.6m have been identified so far against a £10m plan.

Integrated Performance Report
Reporting Period - April 2024

Brief Summary of Report

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

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

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

Performance & Information
Delivering quality data to empower the trust

Skills Development Network
Excellence in Informatics
Level 1

Introduction to 'SPC' and Making Data Count

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

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

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

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

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

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

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

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

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

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

Guide to this Report

Name of the lead responsible for the metric

Why this metric is being reported

The national or local target performance is being measured against

Performance for the most recent period

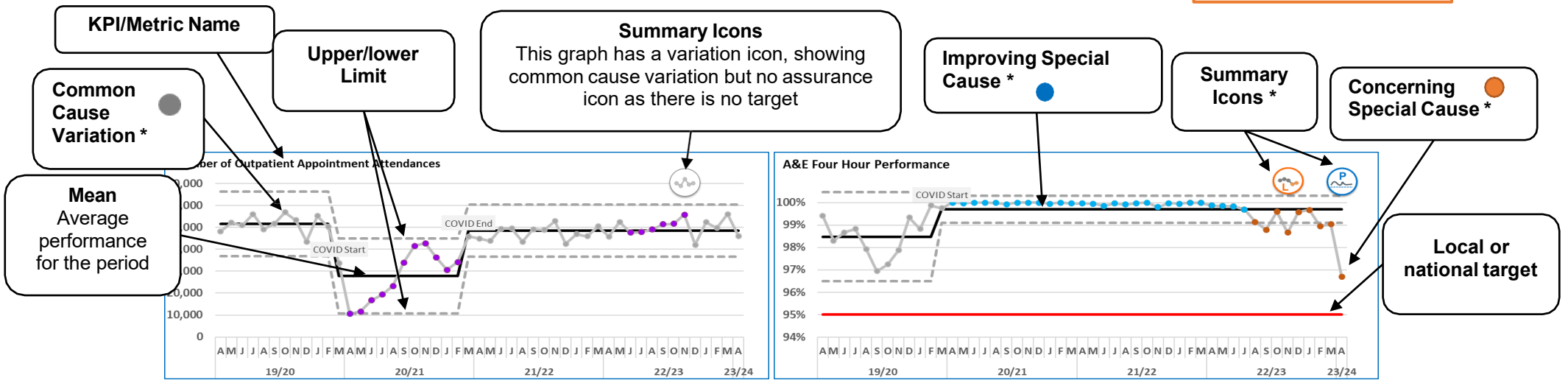
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 2 week waits - first appointment urgent GP referral	Jon Spencer	Statutory Reporting	Monthly	≥93%	100.0%	100.0%		

Name of metric/KPI

How often and timing of the reporting of this metric

Performance for the financial year (Apr-Mar)

These are the Variance and Assurance Icons



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

Highlights

Metrics With "Failing Process"

- Appraisal Compliance
- Staff Sickness (Monthly & Rolling Annual Figure)
- Recruitment Time To Hire (Days)

Celebrations

- 23 Metrics are showing as a capable process, with 21 showing either an improving or stable performance, this includes:
  - Posterior Capsular Rupture rates
  - All FFT Performance Targets
  - Complaints Performance
  - Infection Control Metrics
- A further three metrics are showing an improving position; 18 Week RTT Performance and Clinic Journey Times

Other Metrics showing "Special Cause Concern"

- Basic Mandatory Training
- Recruitment to NIHR portfolio studies
- % FoI Requests within 20 Days
- NatPSAs breached
- Serious Incidents open after 60 days

Other Areas To Note

- The Activity vs. Plan positions in this report represent a provisional position, however this shows the elective position continuing to under perform while the outpatient position is above plan.
- For 2024/25, the 52 week pathway target has been set from zero to five breaches as we are regularly providing mutual aid to other Trusts for long waiting patients. We are also monitoring patient waiting over 65 weeks as required withn the latest Priorities and Operational Planning Guidance.

Executive Summary

In April the Trust saw a further improvement in performance against the 18 week waiting time standard and is now delivering 85% of treatments within 18 weeks, against a 92% standard. The number of patients waiting over 52 weeks for their treatment has stabilised at 5 patients.

The outpatient 1st activity level has improved over the past 2 months, such that we are now achieving 105.5% of the target set last financial year. Elective activity remains below the plan for last year and is again being influenced by the reduced number of cataract referrals being received in our North Division. Work is underway to reallocate resources to treat patients from other specialities and we are reviewing options to identify how the reduction in referrals can be addressed. We anticipate that these initiatives will lead to an improvement in the elective activity performance through this year.

It is pleasing to see that both of the outpatient journey time metrics (face to face diagnostic and non-diagnostic appointments) are continuing to see an improvement in journey time. Work is ongoing to show further improvement in this area.

The metrics which measure the performance of the booking centre showed some improvement in month but did not meet the required standard. The primary driver behind this has been an increase in call volumes coming into the service since the start of 2024. A number of interventions are being taken to identify both the reasons for the calls and then to improve performance of the service and these are beginning to have an impact through April and May. It is anticipated that the planned introduction of an outpatient waiting list later this year will have a significant impact on the number of calls coming into the service.

Performance against the appraisal standard fell in month to 74.7%. It is recognised that the current actions being taken are unlikely to achieve the required standard on a regular basis and a working group has therefore been tasked with developing some transformative actions which will provide a significant improvement in performance. The actions coming out of this group should be available to be socialised with the wider senior leadership team by the next board report.

Although compliance with IG training remains just above the required standard, the reduction in performance seen over the past few months is noted and the IG team are proactively encouraging staff to complete their training.

Sickness absence levels have reduced from 4.5% to 4.4% over the past 2 months. The Employee Relations Team are continuing to work with managers on a number of actions to improve this position, however it is proving difficult to reduce levels down to the required 4% standard.

Performance Overview

April 2024		Assurance			
		Capable Process	Hit and Miss	Failing Process	No Target
Variation	Special Cause - Improvement	- Posterior Capsular Rupture rates - FFT Inpatient Scores (% Positive) - FFT Outpatient Scores (% Positive) - % Complaints Responses Within 25 days - % Complaints Acknowledged Within 3 days - Active Commercial Studies	-	-	- 18 Week RTT Incomplete Performance - OP Journey Times - Non-Diagnostic FtF - OP Journey Times - Diagnostic FtF
	Common Cause	- Total Outpatient FlwUp Activity (% Plan) - Cancer 28 Day Faster Diagnosis Standard - % Cancer 31 Day Waits (All) - A&E Four Hour Performance - Mixed Sex Accommodation Breaches - VTE Risk Assessment - MRSA Bacteraemias Cases - Clostridium Difficile Cases - E. Coli Cases - MSSA Rate - cases - FFT A&E Scores (% Positive) - FFT Paediatric Scores (% Positive) - % SARs Requests within 28 Days - Summary Hospital Mortality Indicator - % of patients in research studies	* See Next Page	- Appraisal Compliance - Staff Sickness (Month Figure) - Staff Sickness (Rolling Annual Figure) - Recruitment Time To Hire (Days)	* See Next Page
	Special Cause- Concern	- Basic Mandatory IG Training - Recruitment to NIHR portfolio studies	- % FoI Requests within 20 Days - NatPSAs breached - Serious Incidents open after 60 days	-	- Recruitment to All Research Studies
	Special Cause - Increasing Trending	-			
	Special Cause - Decreasing Trending	- RTT Waiting List - RTT Incomplete Pathways Over 18 Weeks			

Performance Overview

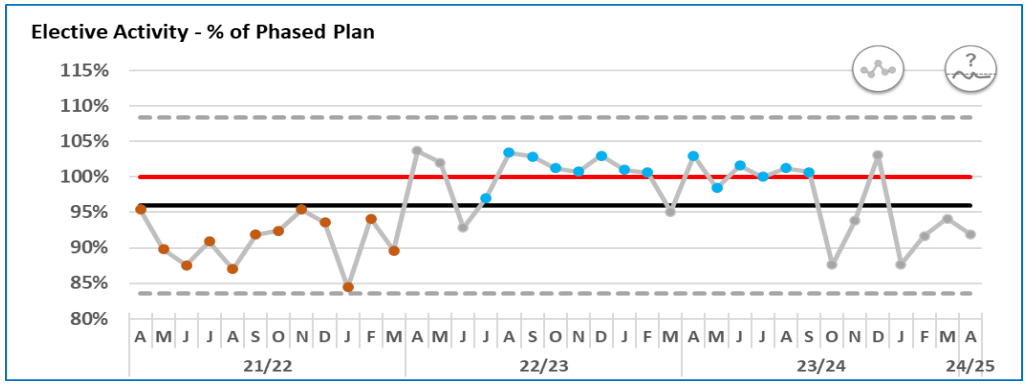
Common Cause & Hit and Miss	Common Cause (No Target)
- Elective Activity - % of Phased Plan	- Elective waits over 65 weeks
- Total Outpatient Activity (% Plan)	- Number of Incidents open after 28 days
- Outpatient First Activity (% Plan)	- Proportion of Temporary Staff
- % Cancer 62 Day Waits (All)	- No. of A&E Arrivals
- 52 Week RTT Incomplete Breaches	- No. of A&E Four Hour Breaches
- % Diagnostic waiting times less than 6w	- No. of Outpatient Attendances
- Average Call Waiting Time	- No. of Outpatient First Attendances
- Average Call Abandonment Rate	- No. of Outpatient Flw Up Attendances
- Emergency readmissions in 28d (ex. VR)	- No. of Referrals Received
- Occurrence of any Never events	- No. of Theatre Admissions
- Theatre Cancellation Rate (Non-Medical)	- No. of Theatre Elective Day Admissions
- Non-medical cancelled 28 day breaches	- No. of Theatre Elective Inpatient Adm.
- Overall financial performance	- No. of Theatre Emergency Admissions
- Commercial Trading Unit Position	

Deliver (Activity vs Plan) - Summary

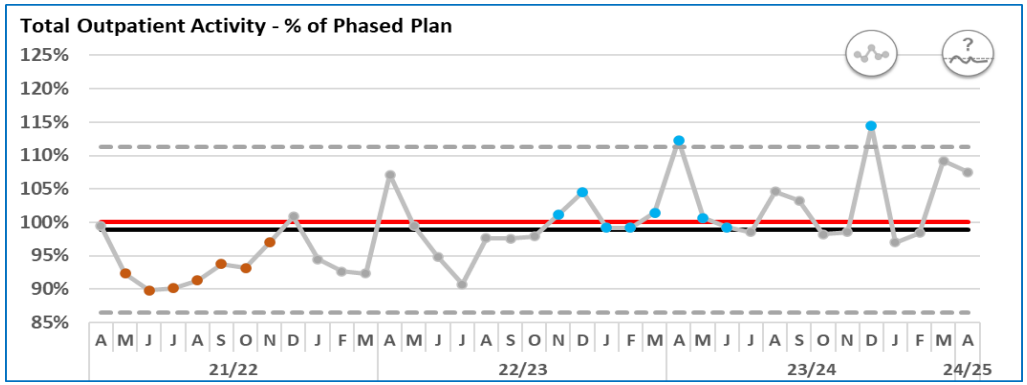
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Elective Activity - % of Phased Plan	Jon Spencer	24/25 Planning Guidance	Monthly	≥100%	91.9%	91.9%		
Total Outpatient Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	107.5%	107.5%		
Outpatient First Appointment Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	105.5%	105.5%		
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jon Spencer	24/25 Planning Guidance	Monthly	≥85%	108.2%	108.2%		

Please note at the time of reporting the 2024/25 activity plan is under review, all figures above represent a provisional position.

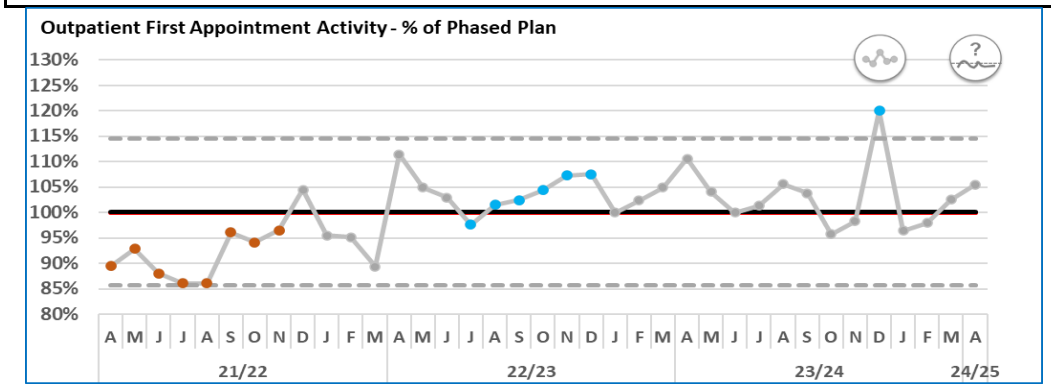
Deliver (Activity vs Plan) - Graphs (1)



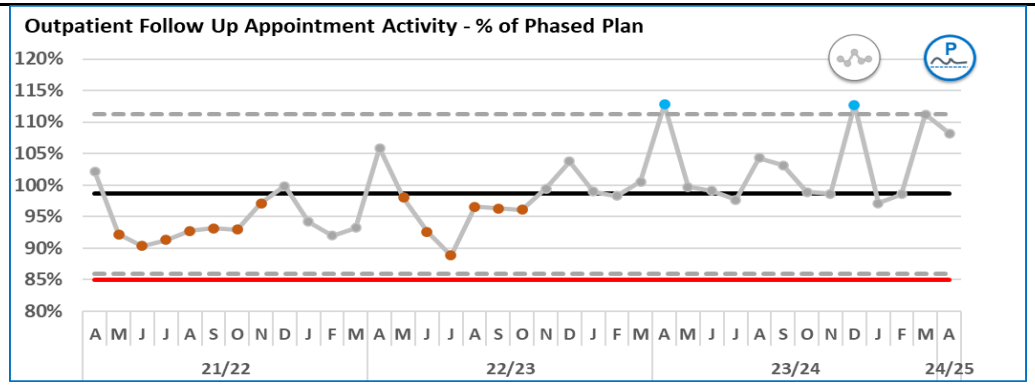
'Elective Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 91.9%.



'Total Outpatient Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 107.5%.



'Outpatient First Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 105.5%.



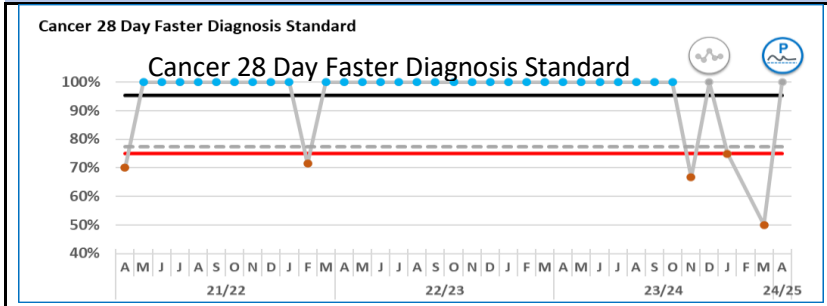
'Outpatient Follow Up Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 108.2%.

Deliver (Cancer Performance) - Summary

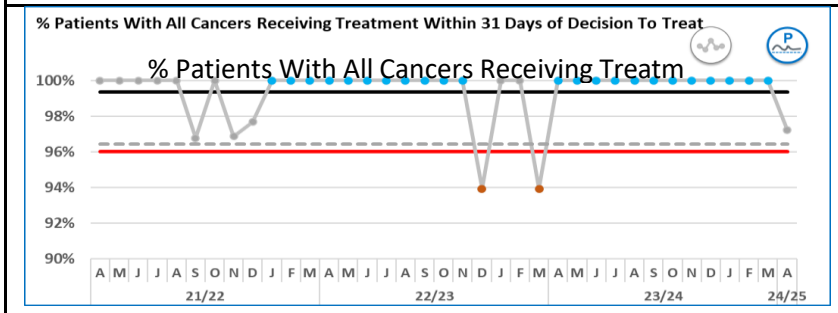
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	Statutory Reporting With Local Target	Monthly	≥75%	100.0%	100.0%		
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat	Jon Spencer	Statutory Reporting	Monthly	≥96%	97.2%	97.2%		
% Patients With All Cancers Treated Within 62 Days	Jon Spencer	Statutory Reporting	Monthly	≥85%	100.0%	100.0%		

Please note that Moorfields Eye Hospital is exempt from reporting Cancers Diagnosed at Stages 1 and 2 via the Cancer Outcomes and Services Data set (COSD). This is because Moorfields does not investigate or is informed of nodal involvement, with patients referred to other trusts for further investigations.

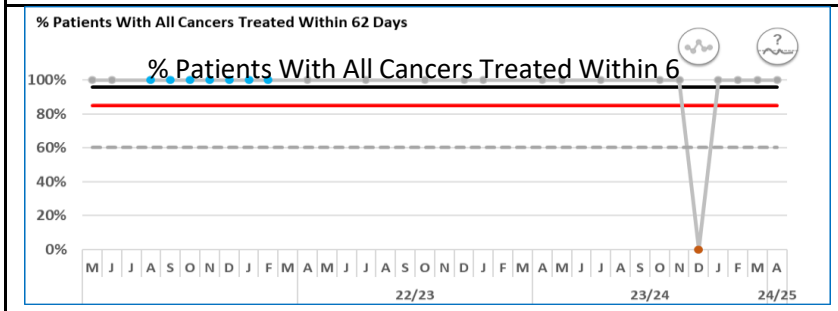
Deliver (Cancer Performance) - Graphs (1)



'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 100.0%.



'% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 97.2%.

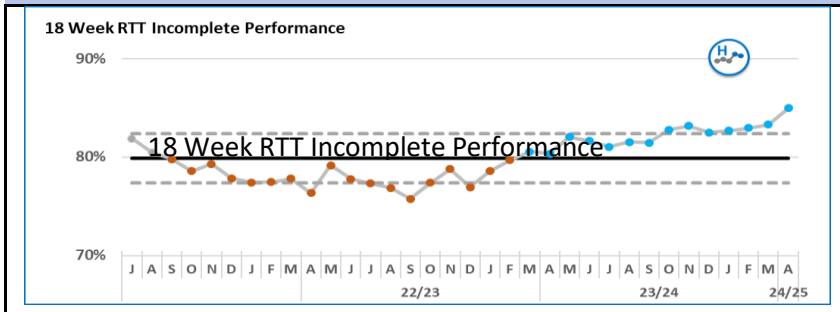


'% Patients With All Cancers Treated Within 62 Days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 100.0%.

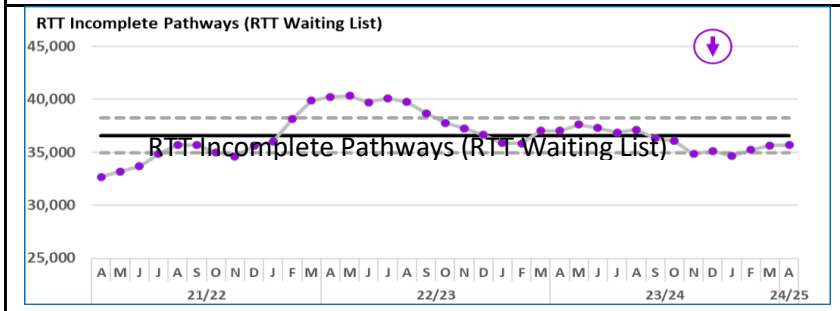
Deliver (Access Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
18 Week RTT Incomplete Performance	Jon Spencer	Statutory Reporting	Monthly	No Target Set	85.0%	85.0%		
RTT Incomplete Pathways (RTT Waiting List)	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	35674		
RTT Incomplete Pathways Over 18 Weeks	Jon Spencer	Internal Requirement	Monthly	≤ Previous Mth.	n/a	5361		
52 Week RTT Incomplete Breaches	Jon Spencer	24/25 Planning Guidance	Monthly	≤ 5 Breaches	5	5		
Eliminate waits over 65 weeks for elective care	Jon Spencer	24/25 Planning Guidance	Monthly	No Target Set	1	1		
A&E Four Hour Performance	Jon Spencer	24/25 Planning Guidance	Monthly	≥95%	98.2%	98.2%		
Percentage of Diagnostic waiting times less than 6 weeks	Jon Spencer	24/25 Planning Guidance	Monthly	≥99%	100.0%	100.0%		

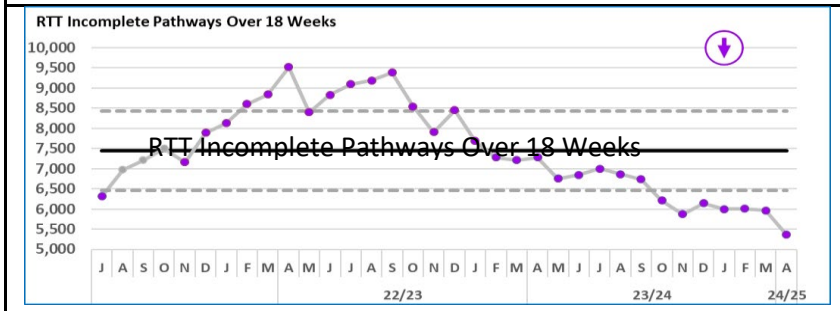
Deliver (Access Performance) - Graphs (1)



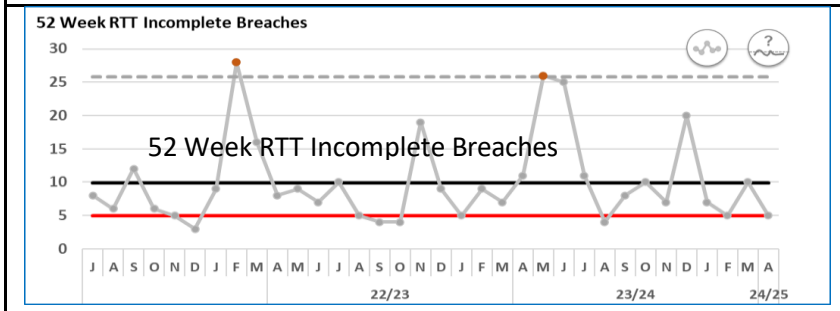
'18 Week RTT Incomplete Performance ' is showing 'special cause improvement' (increasing rate). The figure is currently at 85.0%.



'RTT Incomplete Pathways (RTT Waiting List)' is showing an 'special cause variation' (decreasing rate). The figure is currently at 35,674.

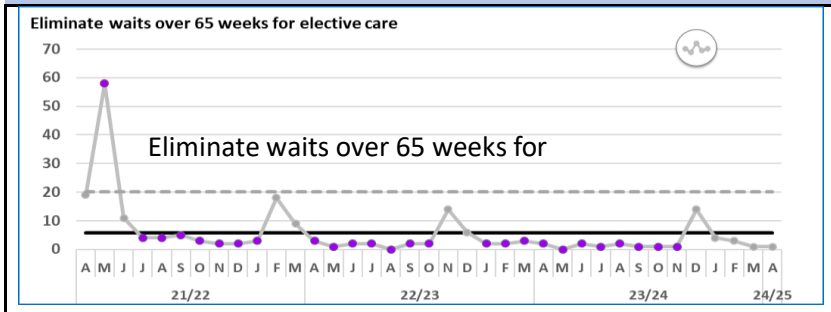


'RTT Incomplete Pathways Over 18 Weeks' is showing an 'special cause variation' (decreasing rate). The figure is currently at 5,361.

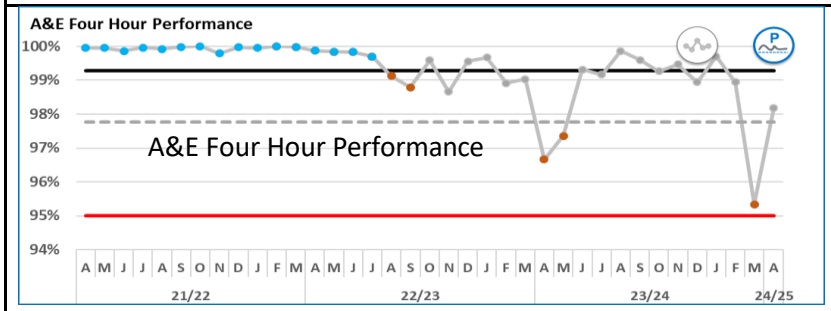


'52 Week RTT Incomplete Breaches ' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 5.

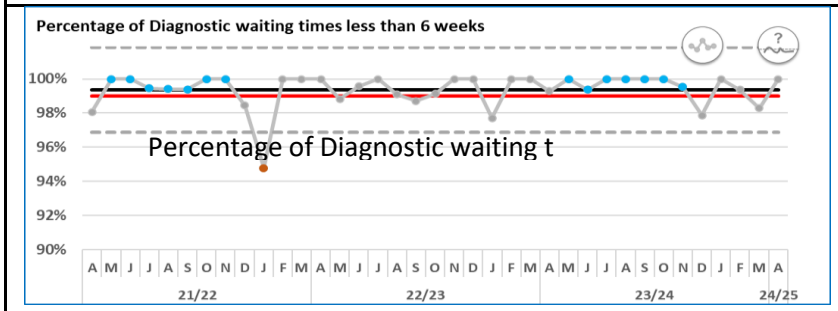
Deliver (Access Performance) - Graphs (2)



'Eliminate waits over 65 weeks for elective care' is showing 'common cause variation'. The figure is currently at 1.



'A&E Four Hour Performance' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 98.2%.

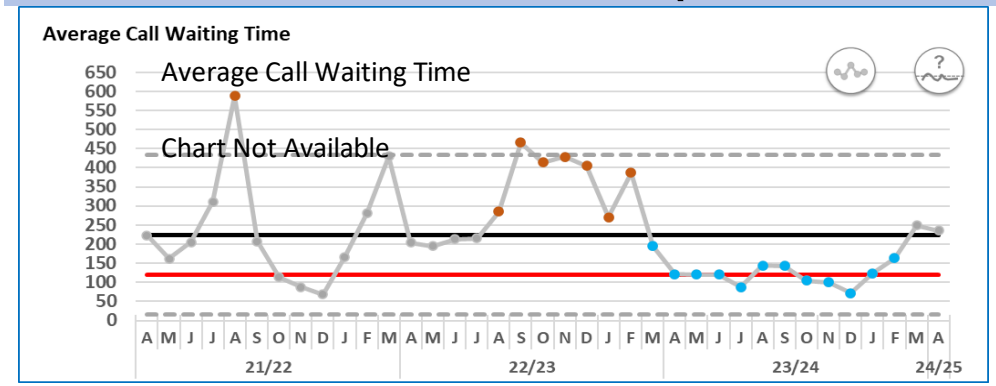


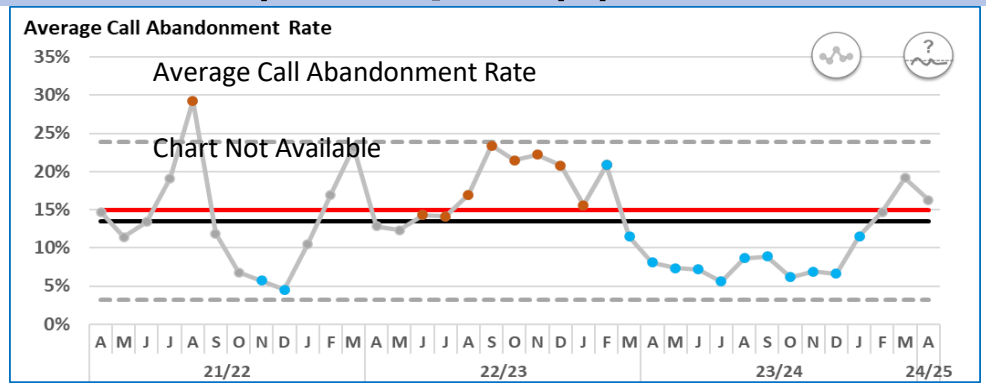
'Percentage of Diagnostic waiting times less than 6 weeks' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 100.0%.

Deliver (Call Centre and Clinical) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Average Call Waiting Time	Jon Spencer	Internal Requirement	Monthly	≤ 2 Mins (120 Sec)	n/a	236		?
Average Call Abandonment Rate	Jon Spencer	Internal Requirement	Monthly	≤15%	16.3%	16.3%		?
Mixed Sex Accommodation Breaches	Sheila Adam	Statutory Reporting	Monthly	Zero Breaches	0	0		P
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Jon Spencer	Internal Requirement	Monthly (Rolling 3 Months)	≤ 2.67%	n/a	1.61%		?
VTE Risk Assessment	Jon Spencer	Statutory Reporting	Monthly	≥95%	97.9%	97.9%		P
Posterior Capsular Rupture rates (Cataract Operations Only)	Jon Spencer	Statutory Reporting	Monthly	≤1.95%	0.57%	0.57%	L	P
MRSA Bacteraemias Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Clostridium Difficile Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
MSSA Rate - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P

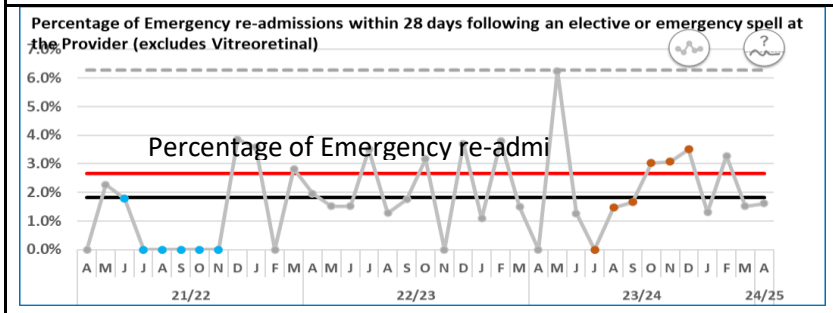
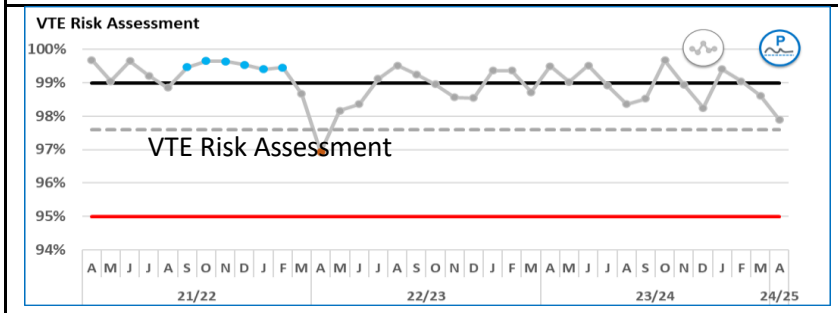
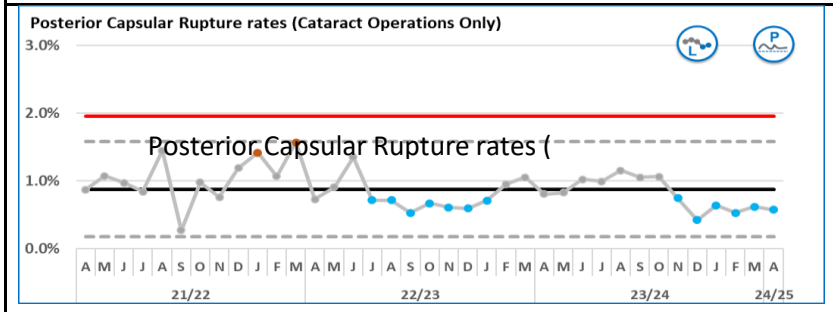
Deliver (Call Centre and Clinical) - Graphs (1)





'Average Call Waiting Time' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 236.	**'Average Call Abandonment Rate' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 16.3%.**

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

No Graph Generated, No breaches since June 2017	**'Mixed Sex Accommodation Breaches ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**
	**'Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 1.61%.**
	**'VTE Risk Assessment' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 97.9%.**
	**'Posterior Capsular Rupture rates (Cataract Operations Only)' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 0.57%.**

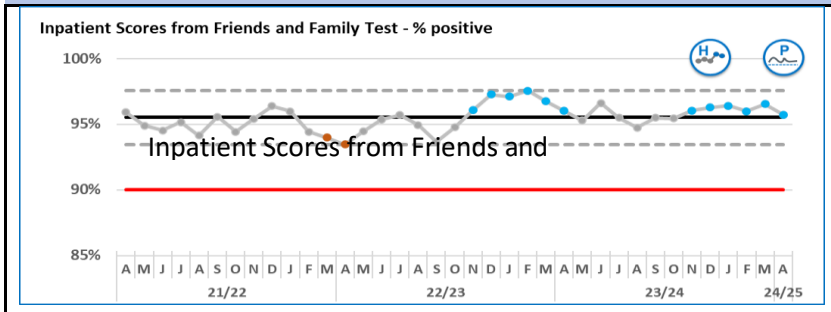
Deliver (Call Centre and Clinical) - Graphs (3)

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

Deliver (Quality and Safety) - Summary

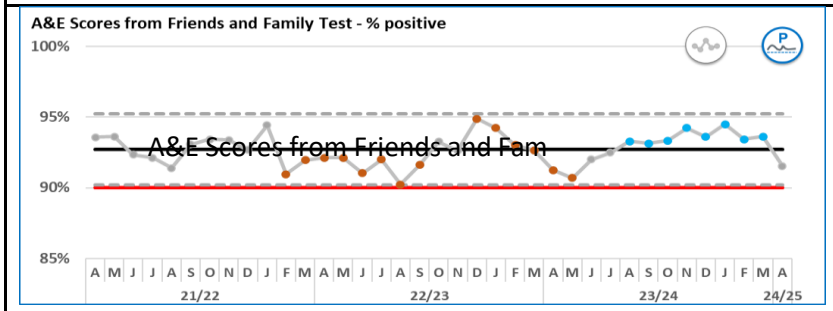
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Inpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	95.7%	95.7%	H	P
A&E Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	91.5%	91.5%		P
Outpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	94.2%	94.2%	H	P
Paediatric Scores from Friends and Family Test - % positive	Ian Tombleson	Internal Requirement	Monthly	≥90%	95.2%	95.2%		P
Percentage of responses to written complaints sent within 25 days	Ian Tombleson	Internal Requirement	Monthly (Month in Arrears)	≥80%	88.6%	100.0%	H	P
Percentage of responses to written complaints acknowledged within 3 days	Ian Tombleson	Internal Requirement	Monthly	≥80%	100.0%	100.0%	H	P
Freedom of Information Requests Responded to Within 20 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	65.6%	32.0%	L	?
Subject Access Requests (SARs) Responded To Within 28 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	94.4%	97.3%		P

Deliver (Quality and Safety) - Graphs (1)



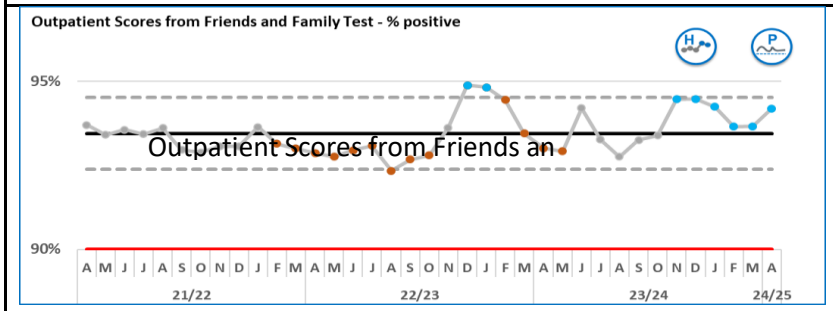
'Inpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 95.7%.

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



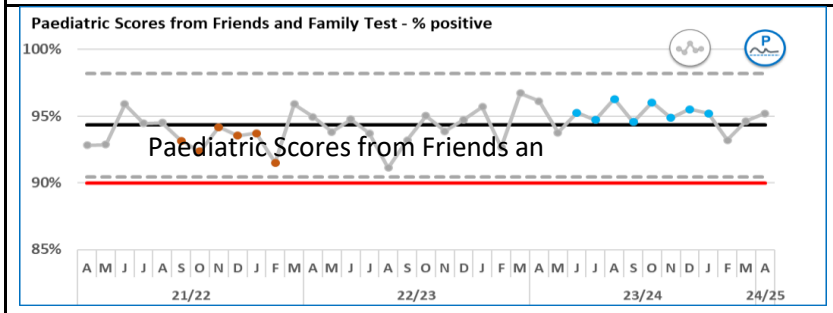
'A&E Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 91.5%.

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



'Outpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 94.2%.

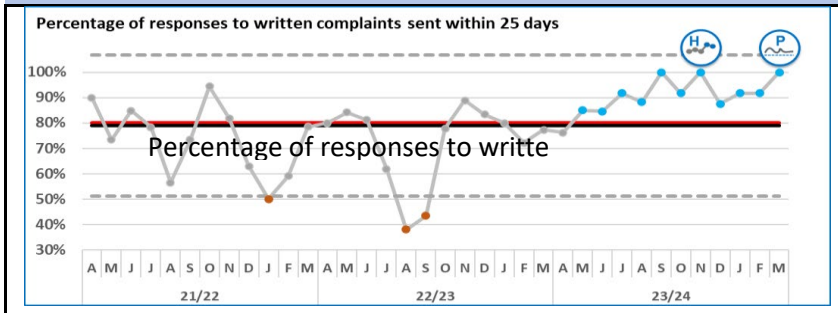
Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.



'Paediatric Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 95.2%.

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

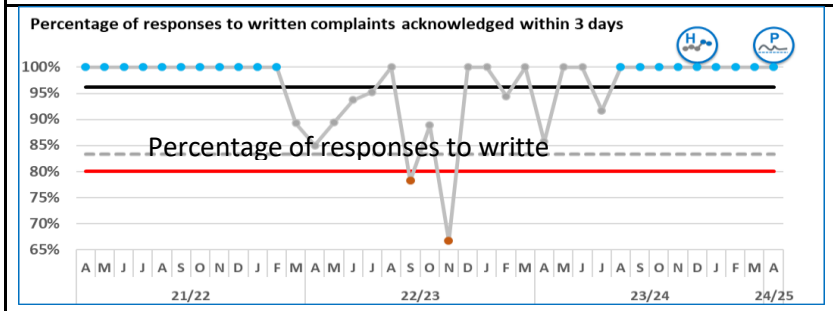
Deliver (Quality and Safety) - Graphs (2)



'Percentage of responses to written complaints sent within 25 days' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 100.0%.

Over the previous eleven months we have exceeded the 80% target, so this metric showing as a capable process showing special cause improvement. Reasons for the recent improvements include the introduction of an "early resolution process" that improves interaction with complainants through face to face meetings and telephone calls.

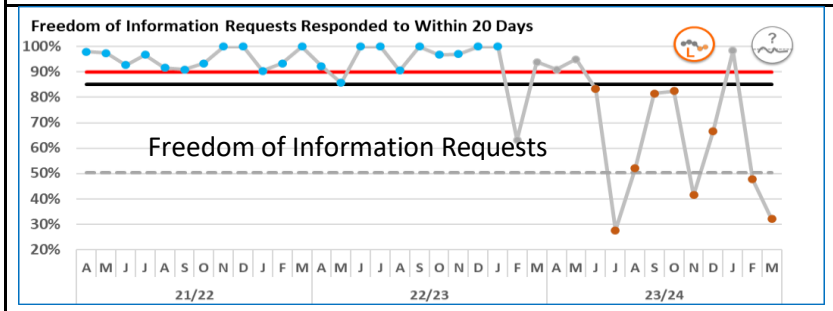
Review Date: ***Action Lead:***



'Percentage of responses to written complaints acknowledged within 3 days' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 100.0%.

Following tightening of the process to acknowledge receipt of a complaint at the end of 2022, this continues to exceed the 80% performance target with 14 of the last 17 months at 100%, and is now showing special cause improvement with the last nine months at 100%.

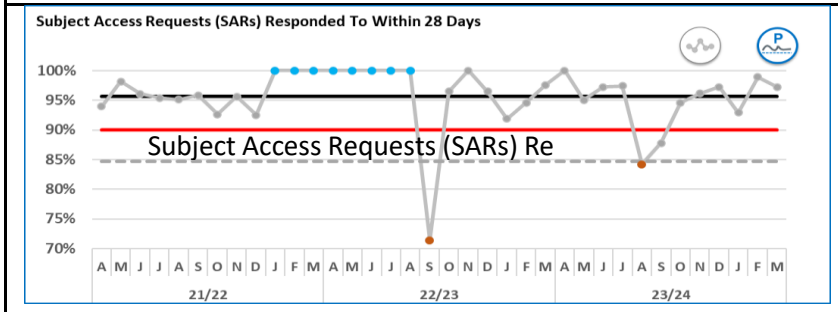
Review Date: ***Action Lead:***



'Freedom of Information Requests Responded to Within 20 Days' is showing 'special cause concern' and that the current process is not consistently achieving the target. The figure is currently at 32.0%.

A discontinuity in staffing for this function led to further decline in outcomes. This is being addressed through the use of temporary staff with IG mangement support, and additional resource from within the IG team. Further support has been provided in the form of better reporting, training for directorate FOI leads, and improved metrics. Due to the lag in reporting (figures are presented only for requests made 28 or more days previously) it will be some time before data shows an improvement trend, but it is not expected to decline further.

Review Date: ***Action Lead:***



'Subject Access Requests (SARs) Responded To Within 28 Days' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 97.3%.

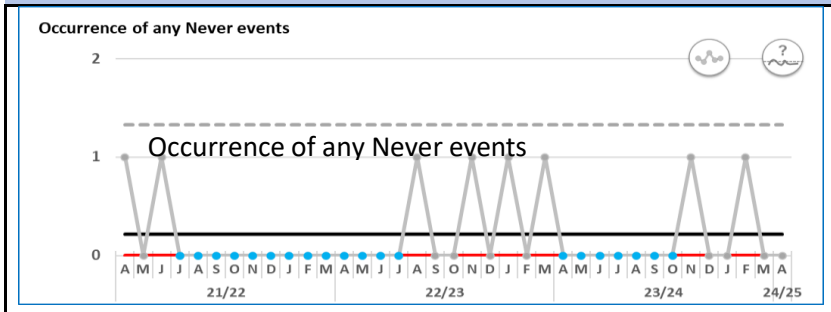
Following a run of Performance above the 90% target for the previous six months, this has now returned to being a passing metric, showing as common cause variation. This will continued to be monitored.

Review Date: ***Action Lead:***

Deliver (Incident Reporting) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Occurrence of any Never events	Sheila Adam	Statutory Reporting	Monthly	Zero Events	0	0		
Summary Hospital Mortality Indicator	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		
National Patient Safety Alerts (NatPSAs) breached	Sheila Adam	NHS Oversight Framework	Monthly	Zero Alerts	n/a	1		
Number of Serious Incidents remaining open after 60 days	Sheila Adam	Statutory Reporting	Monthly	Zero Cases	1	1		
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Sheila Adam	Internal Requirement	Monthly	No Target Set	n/a	257		

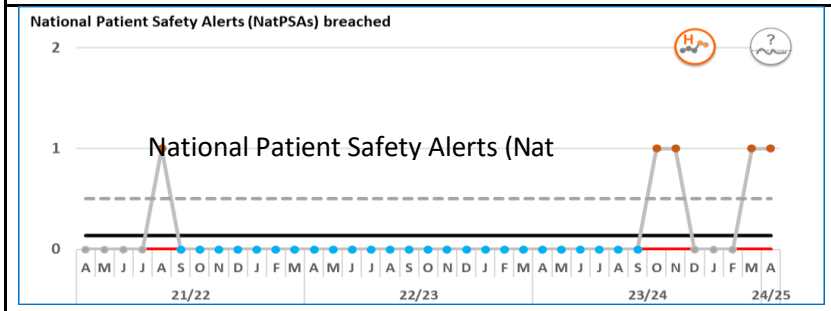
Deliver (Incident Reporting) - Graphs (1)



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

No Graph Generated, No cases reported since February 2017

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

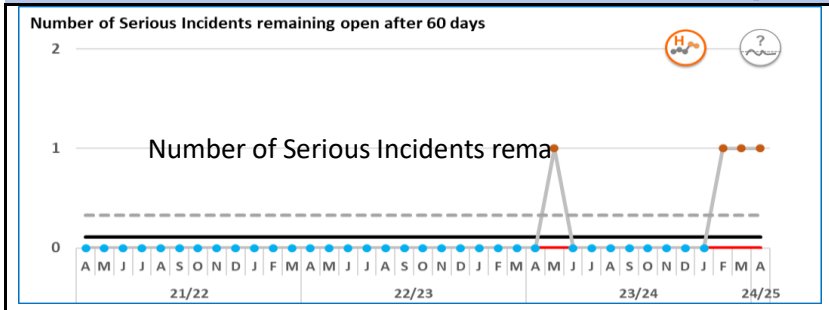


'National Patient Safety Alerts (NatPSAs) breached' is showing 'special cause concern' and that the current process is not consistently achieving the target. The figure is currently at 1.

This alert relates to medical beds and the associated components, as a serious risk had been identified relating to entrapment and falls. Several actions have been included in the alert including the purchase of new beds which are compliant with national standards. A new policy is in development to ensure the standards are met and maintained going forward.

Review Date: Jun 2024 ***Action Lead:*** Julie Nott

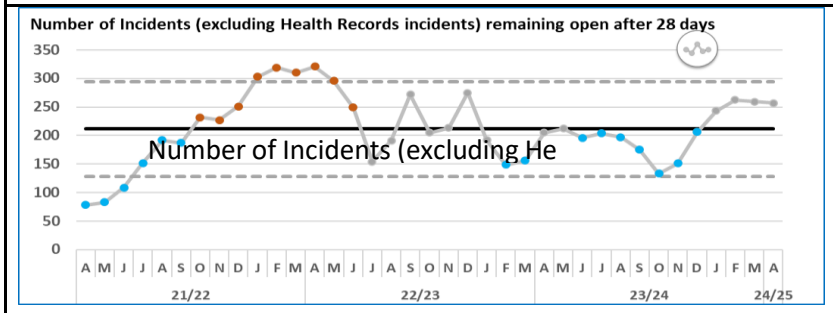
Deliver (Incident Reporting) - Graphs (2)



'Number of Serious Incidents remaining Open after 60 days' is showing 'special cause concern' and that the current process is not consistently achieving the target. The figure is currently at 1.

We have a draft report which will be shared with staff involved for a factual accuracy check shortly ahead of the recommendations and safety actions being finalised. The delay here has been associated with resource, competing priorities, and annual leave.

Review Date: Jun 2024 ***Action Lead:*** Julie Nott

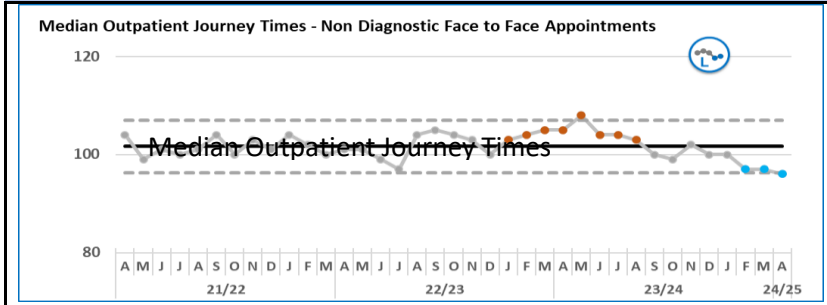


'Number of Incidents (excluding Health Records incidents) remaining open after 28 days' is showing 'common cause variation'. The figure is currently at 257.

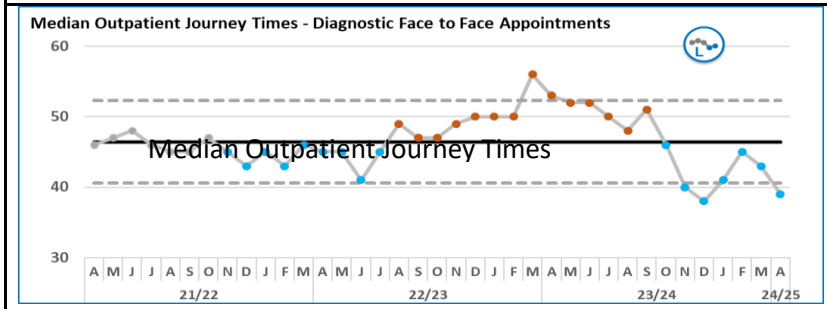
Sustainability and at Scale - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	96		
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	39		
Median Outpatient Journey Times - Virtual TeleMedicine Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	n/a		
Theatre Cancellation Rate (Non-Medical Cancellations)	Jon Spencer	Statutory Reporting	Monthly	≤0.8%	0.49%	0.49%		
Number of non-medical cancelled operations not treated within 28 days	Jon Spencer	Statutory Reporting	Monthly	Zero Breaches	0	0		
Overall financial performance (In Month Var. £m)	Jonathan Wilson	Internal Requirement	Monthly	≥0	0.01	0.01		
Commercial Trading Unit Position (In Month Var. £m)	Jonathan Wilson	Internal Requirement	Monthly	≥0	0.02	0.02		

Sustainability and at Scale - Graphs (1)

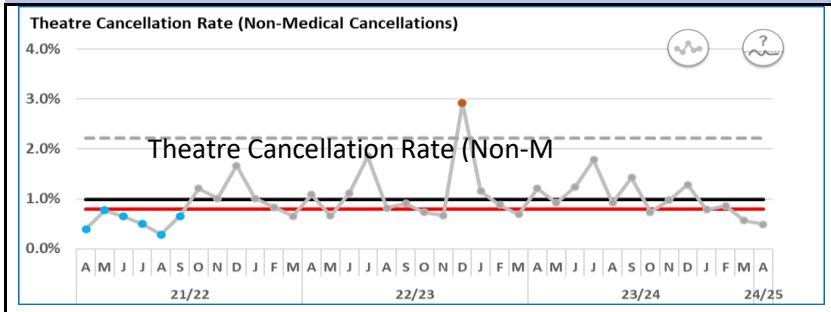


'Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments' is showing 'special cause improvement' (decreasing rate). The figure is currently at 96.

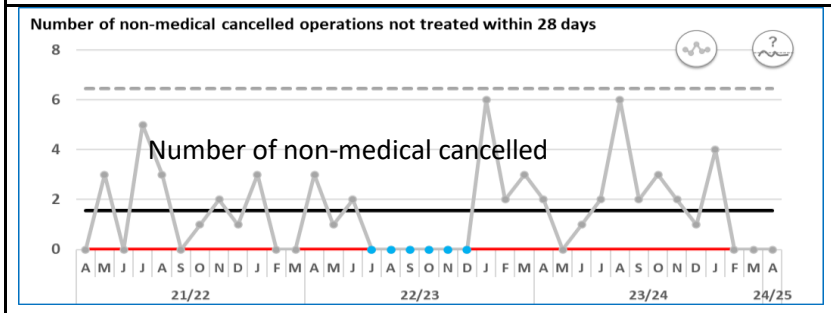


'Median Outpatient Journey Times - Diagnostic Face to Face Appointments' is showing 'special cause improvement' (decreasing rate). The figure is currently at 39.

Sustainability and at Scale - Graphs (2)

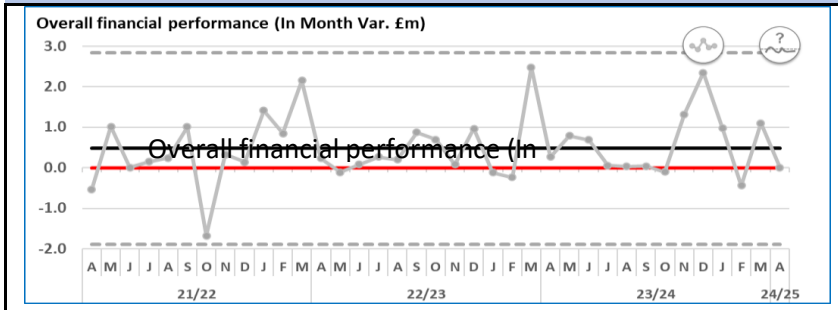


'Theatre Cancellation Rate (Non-Medical Cancellations)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.49%.

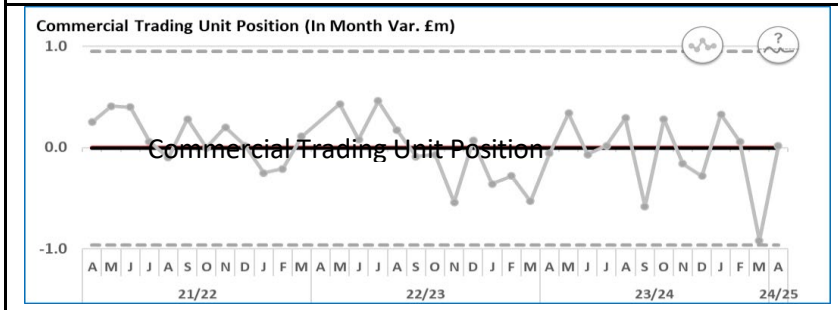


'Number of non-medical cancelled operations not treated within 28 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.

Sustainability and at Scale - Graphs (3)



'Overall financial performance (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.01.

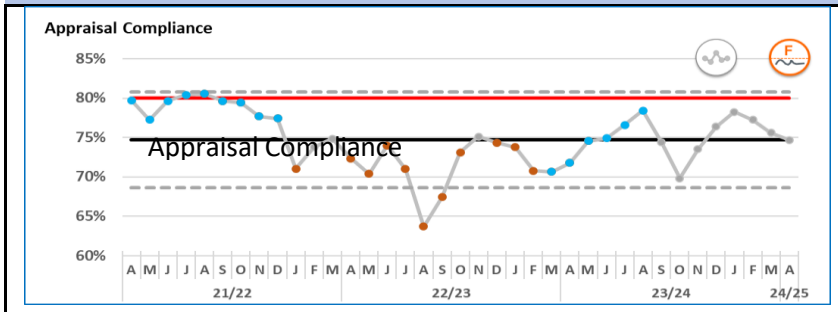


'Commercial Trading Unit Position (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 0.02.

Working Together - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Appraisal Compliance	Mark Gammage	Statutory Reporting	Monthly	≥80%	n/a	74.7%		F
Basic Mandatory IG Training	Samuel Armstrong	Internal Requirement	Monthly	≥90%	n/a	90.2%	L	P
Staff Sickness (Month Figure)	Mark Gammage	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.3%		F
Staff Sickness (Rolling Annual Figure)	Mark Gammage	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.4%		F
Recruitment Time To Hire (Days)	Mark Gammage	Internal Requirement	Monthly (Month in Arrears)	≤ 40 Days	n/a	50		F
Proportion of Temporary Staff	Mark Gammage	23/24 Planning Guidance	Monthly	No Target Set	13.3%	13.3%		

Working Together - Graphs (1)

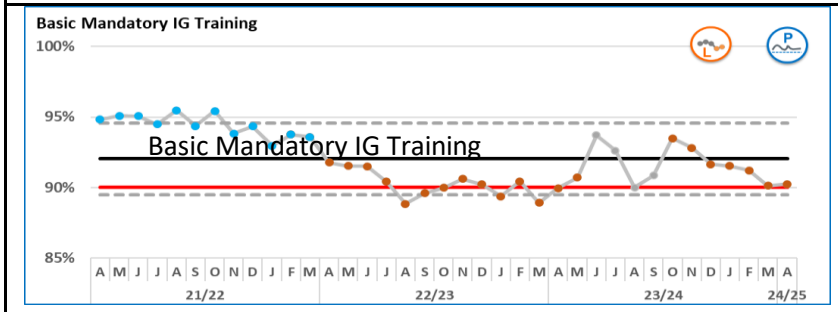


'Appraisal Compliance' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 74.7%.

Appraisal compliance rate between April 2023 (72%) and April 2024 (76%) shows a positive upward trajectory, though still below the required Trust target of 80%. It should be noted that Appraisal Compliance Rate has stabilised over the past 3 months. The Learning and Development (L&D) Team will continue to provide support by the actions below:

- Supporting managers within the identified hotspot areas;
  - o Administration & Clerical 57%
  - o Estates & Ancillary 63%
  - o Allied Health Professionals 69%
  - o Additional Clinical Services 69%
- Provision of ongoing Appraisal Training across the Trust including Bite Size Sessions delivered by the L&D team.
- Sending weekly reports to Senior Managers to update them on Team progress outlining required actions from them along with available support from the L&D team.
- Arranging drop-in sessions and meetings with Managers to go through their Reports and any areas of concern.
- Ongoing working arrangements with the Comms Team to promote and raise awareness on the importance of conducting an Appraisal with regular feature on Eye Q and Moorfields News.
- Identifying periods of high activity in previous year and providing Managers with advance notice of expiration so that the Appraisal is conducted before the expiry date.
- Supporting the outcomes from the Appraisal Compliance Task and Finish Group, to increase, sustain and embed appraisal completion rates throughout the year.

Review Date: May 2024 ***Action Lead:*** Stephen Imuere

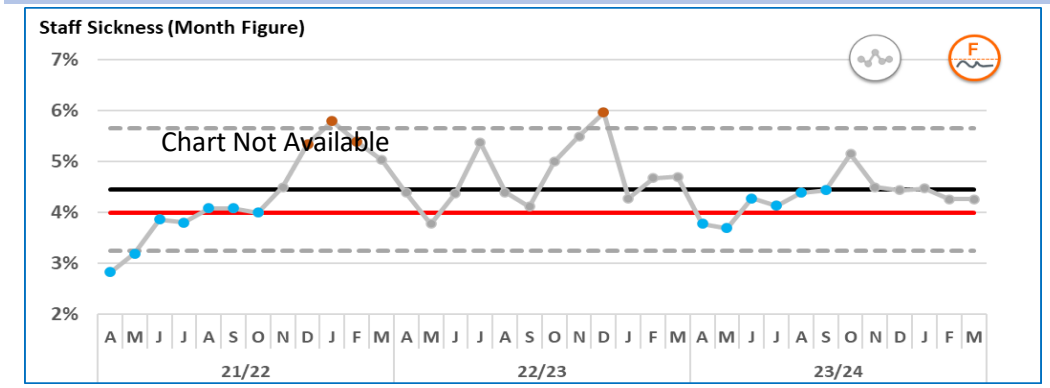


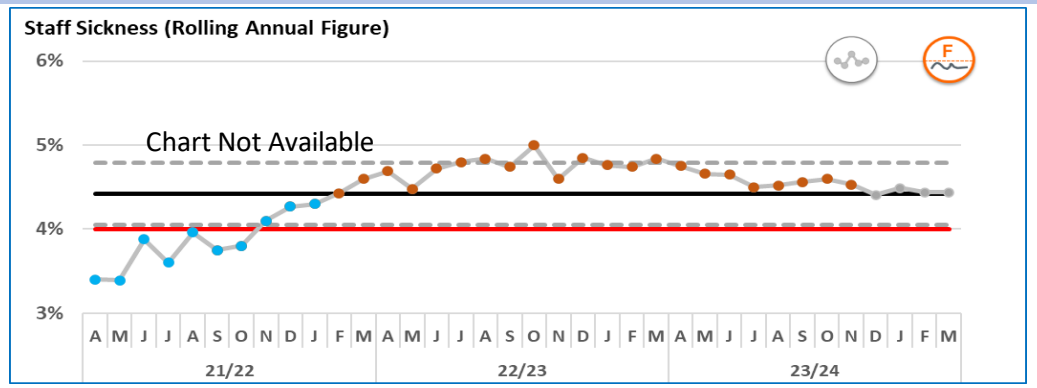
'Basic Mandatory IG Training' is showing 'special cause concern' however the current process will consistently pass the target. The figure is currently at 90.2%.

Recent monthly performance has been above 90% so this metric is classed as a 'capable' (passing) process, however the steady decline over the last 6 months has been noted and the IG team will proactively encourage staff to complete this training. There also remain data quality issues that impact an estimated 1 to 2% of performance that are being worked through.

Review Date: Jun 2024 ***Action Lead:*** Jonathan McKee

Working Together - Graphs (2)





'Staff Sickness (Month Figure)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 4.3%.	**'Staff Sickness (Rolling Annual Figure)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 4.4%.**

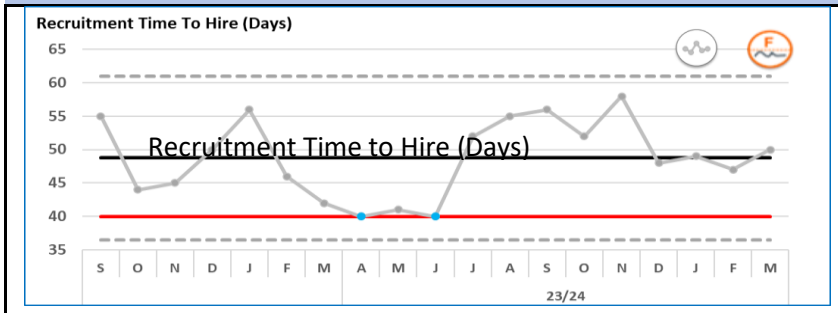
Sickness Absences over the past 12 months between April 2023 (3.78%) and April 2024 (4.4%) shows a 0.62% increase which is still above the Trust target of 4%.

The current top 3 reasons for absence are:
- Anxiety/stress/depression/other psychiatric illness
- Cold, Cough, Flu – Influenza
- Other musculoskeletal problems

Whilst the overall level of sickness absence remains stable, it should be noted that the ER team continue to work closely with line managers as outlined below:
- Reviewing LTS cases, with key focus on absences over a year. The aim of this is to support the staff members concerned in returning to work as soon as possible, with appropriate reasonable adjustments, if required, put in place to enable this.
- Targeted sickness absence training has been in place since July 2023 and continues to be delivered by the ER team – with sessions delivered to hotspot areas within the Trust with high short -term sickness absence and long-term sickness rates.
- Targeted coaching for managers is being offered by the ER team with focus on the complex sickness absence cases. Aim is to support and provide managers with confidence and techniques in handling such cases.

Review Date: Jun 2024 ***Action Lead:*** Jackie Wyse

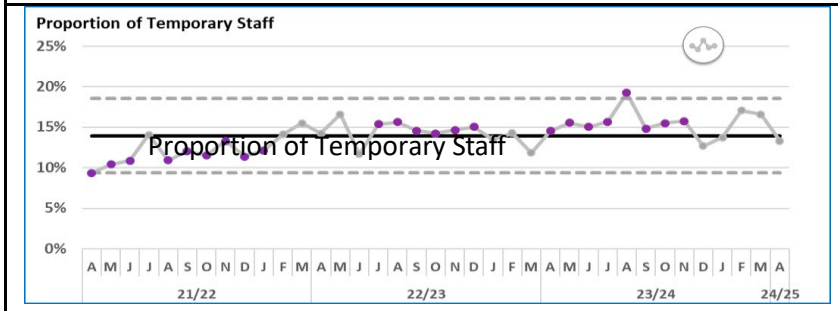
Working Together - Graphs (3)



'Recruitment Time to Hire (Days)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 50.

The Trust monitors Time to Hire(TTH), which is an indicator of employee experience during the recruitment onboarding process. The TTH metrics measure and Trust target is 40 days. The current performance against this Trust target, while stable, is at around 50 days. In light of this, the metric has been labelled as a 'Failing process'. Over the next 12 months, actions will be undertaken to improve the TTH and achieve the 40 days target, which was last achieved in June 2023. From June 2024 monthly progress updates will be provided on actions being taken to improve and achieve the Trust target over the next 12 months.

Review Date: Jun 2024 ***Action Lead:*** Jenny Donald



'Proportion of Temporary Staff ' is showing 'common cause variation'. The figure is currently at 13.3%.

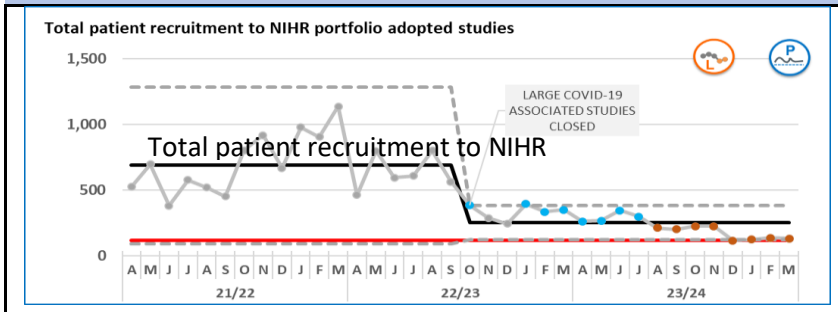
- Demand on temporary staffing utilisation continues to increase. The temporary staffing team are working closely with areas of high utilisation to understand their requirement and ensure cost effective options are being considered. In April 2024, the total number of temporary staffing shifts requested was 6,804, this is a 15% increase on demand when compared to the same period last year.
- Agency reduction remains a key priority with an agency reduction plan being implemented. The Trust has successfully reduced the number of off-framework placements and is working towards finding alternative workers to replace the remaining off framework placements. In April 2024, the Trust used 1,378 Agency shifts which was a 10% reduction on the previous month, we expect to see an increase in the number of Bank filled shifts as agency migration activity continues.
- The temporary staffing group, who meet monthly, continues to ensure continued monitoring and sustained improvement in temporary staffing utilisation. This group comprises of Operational stakeholders from across the business. The group's key aim is to monitor progress on reducing agency spend and off framework usage.
- A vacancy control panel will be established in Q2, this will monitor our temporary staffing usage against our funded posts and provide relevant advice support as required.

Review Date: Jun 2024 ***Action Lead:*** Geoff Barsby

Discover - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Total patient recruitment to NIHR portfolio adopted studies	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	≥115 (per month)	n/a	130	L	P
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	No Target Set	n/a	445	L	
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	≥44	n/a	60	H	P
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	≥2%	5.1%	4.9%		P

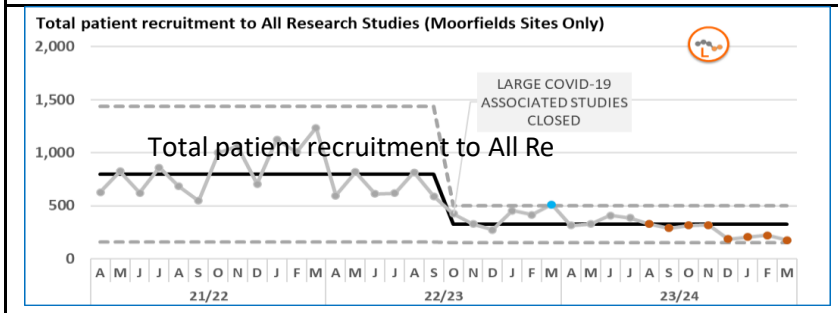
Discover - Graphs (1)



'Total patient recruitment to NIHR portfolio adopted studies' is showing 'special cause concern' however the current process will consistently pass the target. The figure is currently at 130.

This reporting period now starts in April 2021 similar to reports from all other trust divisions. Recruitment to these studies is similar to what is was in April 2021.

Review Date: Jun 2024 ***Action Lead:*** Louisa Wickham

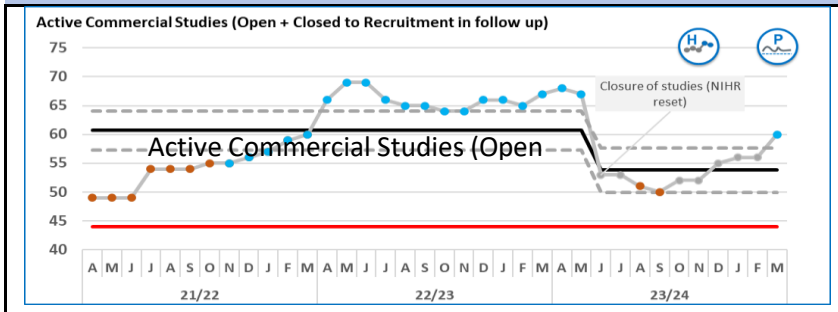


'Total patient recruitment to All Research studies (Moorfields Sites Only)' is showing 'special cause concern' (decreasing rate). The figure is currently at 178.

This new metric is designed to reflect our total recruitment to all studies. This includes commercial and non-commercial studies as well as NIHR portfolio adopted and non-portfolio adopted studies. Recruitment to non-portfolio studies has dropped from 70 recruits in February 2024 to 48 in March 2024. The additional staff to support recruitment to rare and genetic eye disease studies are now fully established. This enlarged genetic recruitment team are recruiting to 1 large local and 2 national NIHR genomic studies. We anticipate that this will lead to a substantial increase in recruitment in the coming months. These large long running genomic cohort studies have been and remain crucial to the research output and publications from Moorfields and the UCL Institute of Ophthalmology.

Review Date: Jun 2024 ***Action Lead:*** Louisa Wickham

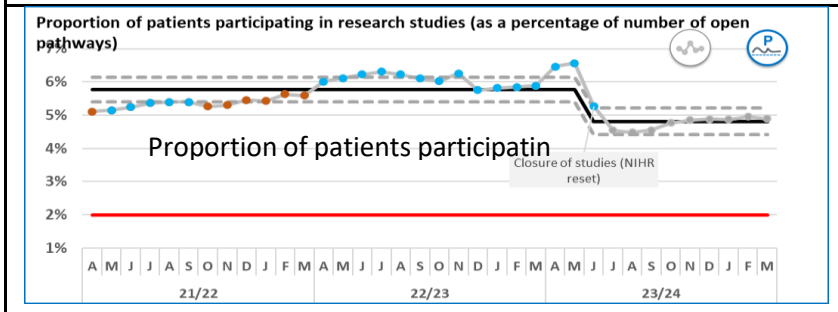
Discover - Graphs (2)



'Active Commercial Studies (Open + Closed to Recruitment in follow up)' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 60.

There are currently 60 commercial studies recruiting and in follow up . This is significantly higher than 2019/20 when we was averaging 44. However, recruitment to commercial studies is still only 5% of our total recruitment. These studies are frequently interventional, requiring intensive investigations and close monitoring. They do give our patients access to new Investigational Medicinal Products (IMP) and devices. The current pipeline of 21 hosted studies in "set up" should ensure that we continue to increase recruitment to commercial studies. 17 of 20 (85%) studies in the past year of our commercial studies now recruit fully within the target time. This has increased from 57% one year ago. Despite this some studies, commercial and non-commercial are still taking too long to be set up. We are actively addressing this by ensuring that investigators, research administrators and sponsors work closely together and adhere to agreed target timelines. We have also taken steps to ensure that studies start recruiting as soon they open.

Review Date: Jun 2024 ***Action Lead:*** Louisa Wickham



'Proportion of patients participating in research studies (as a percentage of number of open pathways)' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 4.9%.

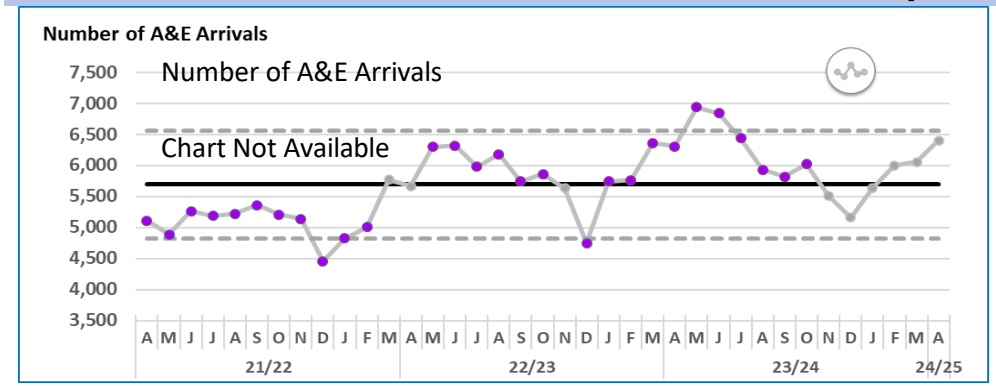
Our aim to have > 2% of our patient population involved in a research study has been achieved and at 5.0% currently exceed this. This reflects our emphasis on and investment in patient and public engagement as part of our NIHR Biomedical Research Centre (BRC) and Clinical Research Facility (CRF) strategy. Our Equity Diversity, and Inclusion strategy for both the BRC and CRF seeks to increase the diversity of our patients recruited to clinical trials as well as provide increased opportunities for patients to contribute to research.

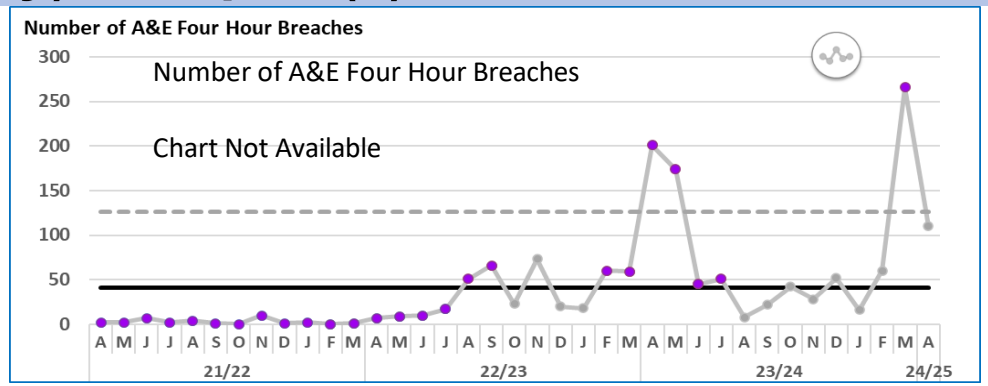
Review Date: Jun 2024 ***Action Lead:*** Louisa Wickham

Context (Activity) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Number of A&E Arrivals	Jon Spencer	Internal Requirement	Monthly	No Target Set	6401	6401		
Number of A&E Four Hour Breaches	Jon Spencer	Internal Requirement	Monthly	No Target Set	110	110		
Number of Outpatient Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	56113	56113		
Number of Outpatient First Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	12976	12976		
Number of Outpatient Follow Up Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	43137	43137		
Number of Referrals Received	Jon Spencer	Internal Requirement	Monthly	No Target Set	15290	15290		
Number of Theatre Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	3392	3392		
Number of Theatre Elective Daycase Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	3113	3113		
Number of Theatre Elective Inpatient Admission	Jon Spencer	Internal Requirement	Monthly	No Target Set	81	81		
Number of Theatre Emergency Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	198	198		

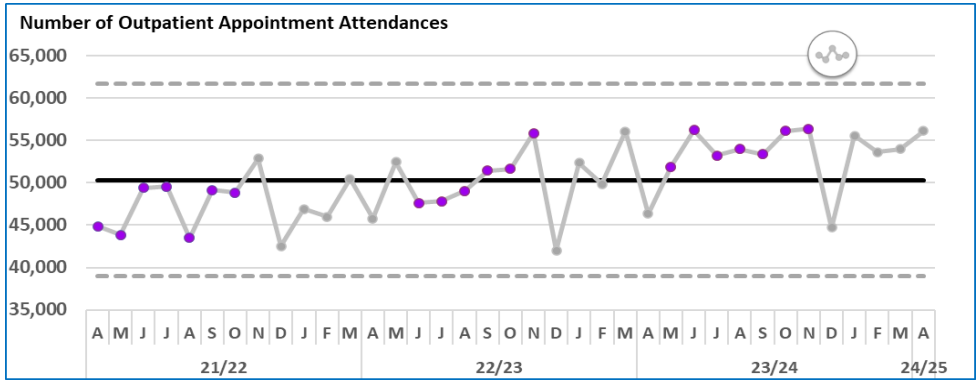
Context (Activity) - Graphs (1)



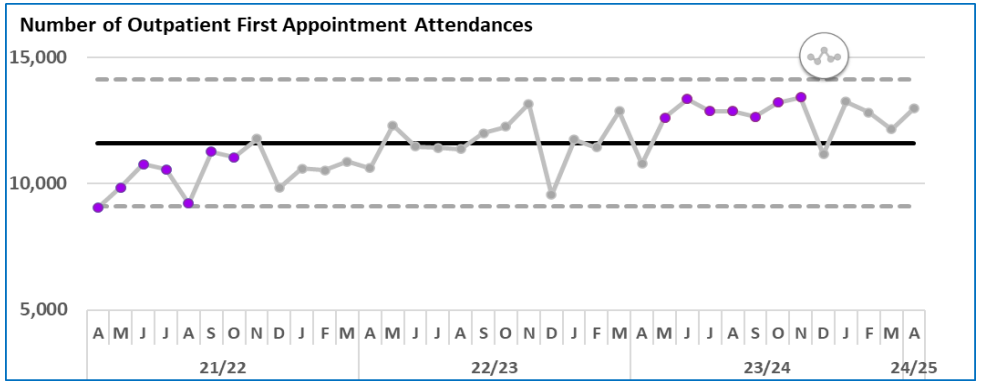


'Number of A&E Arrivals' is showing 'common cause variation'. The figure is currently at 6,401.	**'Number of A&E Four Hour Breaches' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 110.**

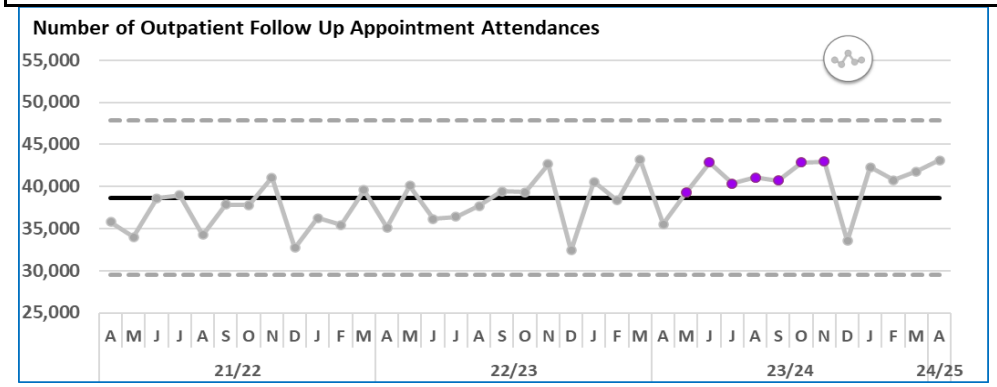
Context (Activity) - Graphs (2)



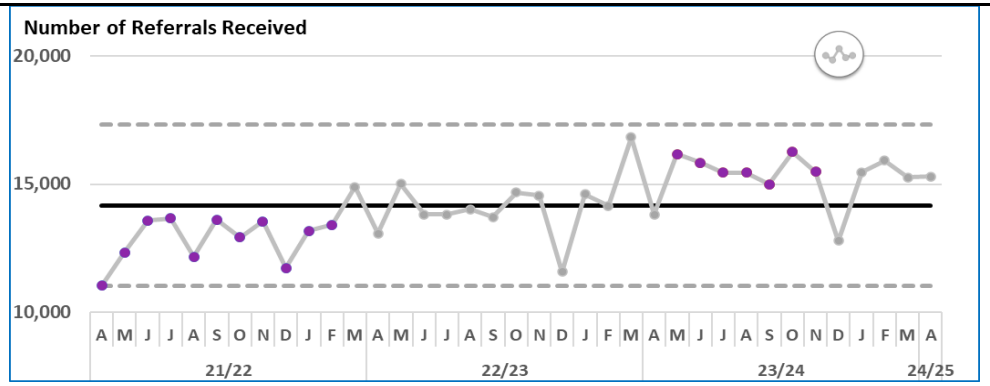
'Number of Outpatient Appointment Attendances' is showing 'common cause variation'. The figure is currently at 56,113.



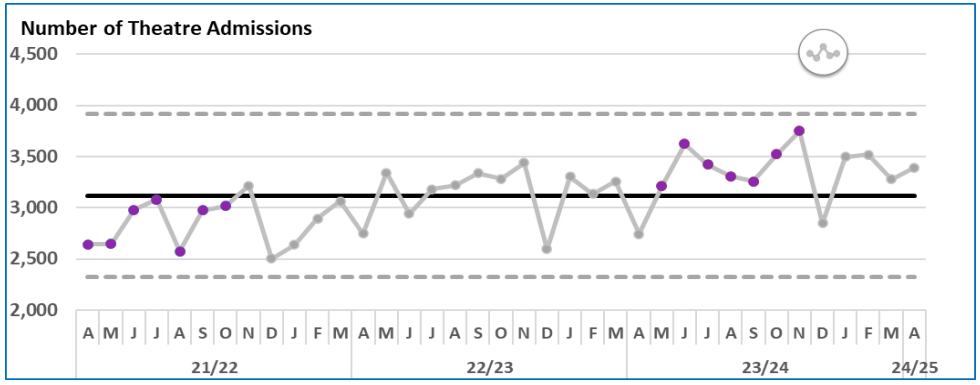
'Number of Outpatient First Appointment Attendances' is showing 'common cause variation'. The figure is currently at 12,976.



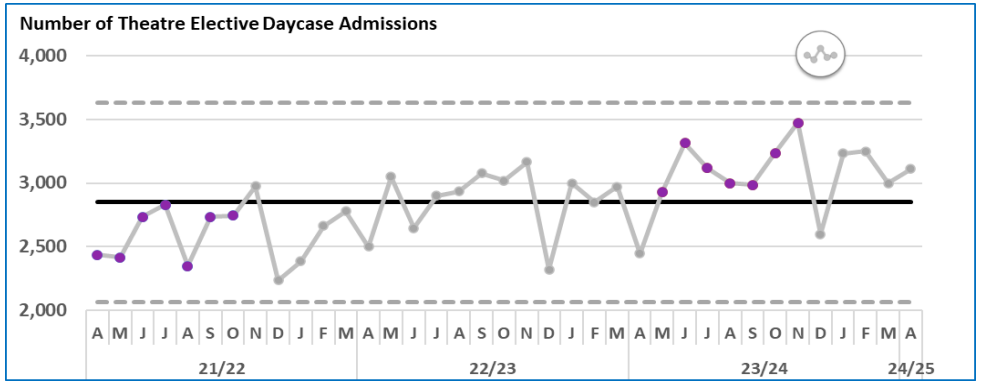
'Number of Outpatient Follow Up Appointment Attendances' is showing 'common cause variation'. The figure is currently at 43,137.



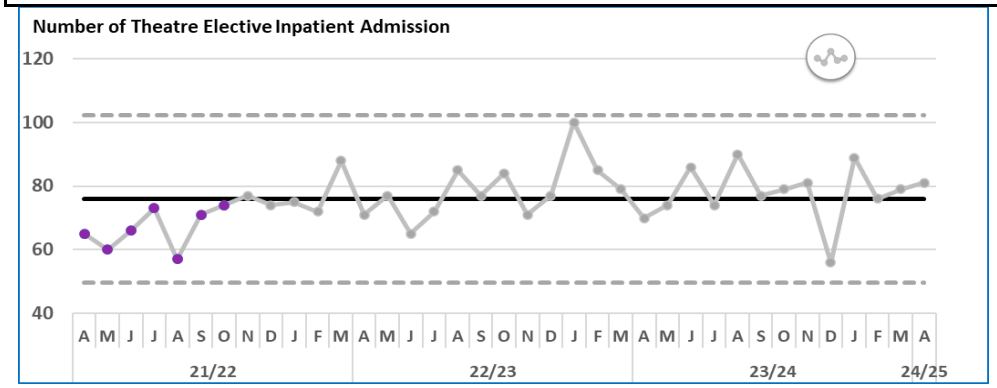
'Number of Referrals Received' is showing 'common cause variation'. The figure is currently at 15,290.



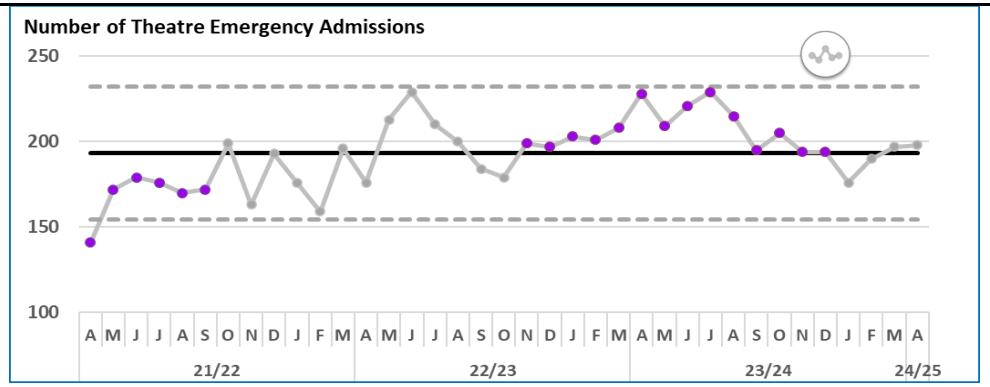
'Number of Theatre Admissions' is showing 'common cause variation'. The figure is currently at 3,392.



'Number of Theatre Elective Daycase Admissions' is showing 'common cause variation'. The figure is currently at 3,113.



'Number of Theatre Elective Inpatient Admission' is showing 'common cause variation'. The figure is currently at 81.



'Number of Theatre Emergency Admissions' is showing 'common cause variation'. The figure is currently at 198.

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Deliver (Activity vs Plan)																						
Elective Activity - % of Phased Plan	Apr-24	91.9%	≥100%	Monthly	Common Cause	Hit or Miss	96.0%	83.5%	108.4%	103.0%	98.4%	101.6%	100.0%	101.2%	100.7%	87.6%	93.9%	103.0%	87.7%	91.7%	94.1%	91.9%
Total Outpatient Activity - % of Phased Plan	Apr-24	107.5%	≥100%	Monthly	Common Cause	Hit or Miss	98.9%	86.5%	111.3%	112.3%	100.7%	99.3%	98.5%	104.6%	103.3%	98.2%	98.5%	114.4%	97.0%	98.4%	109.2%	107.5%
Outpatient First Appointment Activity - % of Phased Plan	Apr-24	105.5%	≥100%	Monthly	Common Cause	Hit or Miss	100.1%	85.7%	114.5%	110.6%	104.0%	99.9%	101.3%	105.6%	103.8%	95.8%	98.3%	120.0%	96.4%	98.0%	102.5%	105.5%
Outpatient Follow Up Appointment Activity - % of Phased Plan	Apr-24	108.2%	≥85%	Monthly	Common Cause	Capable	98.6%	86.0%	111.2%	112.8%	99.7%	99.1%	97.7%	104.3%	103.1%	98.9%	98.6%	112.7%	97.1%	98.6%	111.2%	108.2%
Deliver (Cancer Performance)																						
Cancer 28 Day Faster Diagnosis Standard	Apr-24	100.0%	≥75%	Monthly	Common Cause	Capable	95.4%	77.5%	113.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	75.0%	n/a	50.0%	100.0%
% Patients with all cancers receiving treatment within 31 days of decision to treat	Apr-24	97.2%	≥96%	Monthly	Common Cause	Capable	99.4%	96.4%	102.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.2%
% Patients with all cancers treated within 62 days	Apr-24	100.0%	≥85%	Monthly	Common Cause	Hit or Miss	95.8%	60.4%	131.3%	100.0%	100.0%	n/a	100.0%	n/a	n/a	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Deliver (Access Performance)																						
18 Week RTT Incomplete Performance	Apr-24	85.0%	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	79.9%	77.4%	82.4%	80.4%	82.0%	81.6%	81.0%	81.5%	81.5%	82.8%	83.1%	82.5%	82.7%	82.9%	83.3%	85.0%
RTT Incomplete Pathways (RTT Waiting List)	Apr-24	35,674	No Target Set	Monthly	Decreasing (Run Below Average)	Not Applicable	36,593	34,966	38,219	37,034	37,634	37,282	36,887	37,130	36,341	36,062	34,842	35,138	34,639	35,233	35,656	35,674
RTT Incomplete Pathways Over 18 Weeks	Apr-24	5,361	≤ Previous Mth.	Monthly	Decreasing (Run Below Average)	Not Applicable	7,447	6,455	8,438	7,277	6,757	6,852	7,000	6,863	6,735	6,210	5,871	6,148	6,000	6,012	5,962	5,361
52 Week RTT Incomplete Breaches	Apr-24	5	≤ 5 Breaches	Monthly	Common Cause	Hit or Miss	10	-6	26	11	26	25	11	4	8	10	7	20	7	5	10	5
Eliminate waits over 65 weeks for elective care	Apr-24	1	No Target Set	Monthly	Common Cause	Not Applicable	6	-9	20	2	0	2	1	2	1	1	1	14	4	3	1	1
A&E Four Hour Performance	Apr-24	98.2%	≥95%	Monthly	Common Cause	Capable	99.3%	97.8%	100.8%	96.7%	97.4%	99.3%	99.2%	99.9%	99.6%	99.3%	99.5%	98.9%	99.7%	98.9%	95.3%	98.2%
Percentage of Diagnostic waiting times less than 6 weeks	Apr-24	100.0%	≥99%	Monthly	Common Cause	Hit or Miss	99.4%	96.9%	101.8%	99.3%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	99.5%	97.9%	100.0%	99.4%	98.3%	100.0%
Deliver (Call Centre and Clinical)																						
Average Call Waiting Time	Apr-24	236	≤ 2 Mins (120 Sec)	Monthly	Common Cause	Hit or Miss	224	15	434	122	120	120	87	144	143	104	100	72	124	163	249	236
Average Call Abandonment Rate	Apr-24	16.3%	≤15%	Monthly	Common Cause	Hit or Miss	13.5%	3.2%	23.8%	8.1%	7.4%	7.2%	5.6%	8.7%	8.9%	6.2%	6.9%	6.6%	11.5%	14.7%	19.2%	16.3%
Mixed Sex Accommodation Breaches	Apr-24	0	Zero Breaches	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Apr-24	1.61%	≤ 2.67%	Monthly (Rolling 3 Months)	Common Cause	Hit or Miss	1.81%	-2.66%	6.29%	0.00%	6.25%	1.27%	0.00%	1.47%	1.67%	3.03%	3.08%	3.51%	1.30%	3.28%	1.52%	1.61%
VTE Risk Assessment	Apr-24	97.9%	≥95%	Monthly	Common Cause	Capable	99.0%	97.6%	100.4%	99.5%	99.0%	99.5%	98.9%	98.4%	98.5%	99.7%	98.9%	98.2%	99.4%	99.0%	98.6%	97.9%
Posterior Capsular Rupture rates (Cataract Operations Only)	Apr-24	0.57%	≤1.95%	Monthly	Improvement (Run Below Average)	Capable	0.88%	0.18%	1.58%	0.80%	0.82%	1.03%	0.99%	1.15%	1.05%	1.06%	0.75%	0.42%	0.64%	0.53%	0.62%	0.57%
MRSA Bacteraemias Cases	Apr-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile Cases	Apr-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Apr-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Rate - cases	Apr-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Deliver (Quality and Safety)																						
Inpatient Scores from Friends and Family Test - % positive	Apr-24	95.7%	≥90%	Monthly	Improvement (Run Above Average)	Capable	95.5%	93.4%	97.6%	96.0%	95.3%	96.6%	95.5%	94.7%	95.5%	95.4%	96.1%	96.3%	96.4%	96.0%	96.5%	95.7%
A&E Scores from Friends and Family Test - % positive	Apr-24	91.5%	≥90%	Monthly	Common Cause	Capable	92.7%	90.2%	95.2%	91.3%	90.7%	92.0%	92.5%	93.3%	93.1%	93.3%	94.2%	93.6%	94.5%	93.4%	93.6%	91.5%
Outpatient Scores from Friends and Family Test - % positive	Apr-24	94.2%	≥90%	Monthly	Improvement (Run Above Average)	Capable	93.5%	92.4%	94.5%	93.0%	92.9%	94.2%	93.3%	92.8%	93.3%	93.4%	94.5%	94.5%	94.2%	93.6%	93.7%	94.2%
Paediatric Scores from Friends and Family Test - % positive	Apr-24	95.2%	≥90%	Monthly	Common Cause	Capable	94.3%	90.5%	98.2%	96.1%	93.8%	95.3%	94.7%	96.3%	94.6%	96.0%	94.9%	95.5%	95.2%	93.2%	94.6%	95.2%
Percentage of responses to written complaints sent within 25 days	Mar-24	100.0%	≥80%	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	78.9%	51.1%	106.7%	76.2%	85.0%	84.6%	91.7%	88.2%	100.0%	91.7%	100.0%	87.5%	91.7%	91.7%	100.0%	n/a
Percentage of responses to written complaints acknowledged within 3 days	Apr-24	100.0%	≥80%	Monthly	Improvement (Run Above Average)	Capable	96.2%	83.3%	109.0%	85.7%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Freedom of Information Requests Responded to Within 20 Days	Mar-24	32.0%	≥90%	Monthly (Month in Arrears)	Concern (Lower Than Expected)	Hit or Miss	85.1%	50.3%	119.9%	90.9%	95.0%	83.3%	27.7%	52.0%	81.6%	82.5%	41.5%	66.7%	98.3%	47.7%	32.0%	n/a
Subject Access Requests (SARs) Responded To Within 28 Days	Mar-24	97.3%	≥90%	Monthly (Month in Arrears)	Common Cause	Capable	95.6%	84.7%	106.6%	100.0%	95.1%	97.2%	97.4%	84.2%	87.8%	94.6%	96.2%	97.3%	92.9%	98.9%	97.3%	n/a
Deliver (Incident Reporting)																						
Occurrence of any Never events	Apr-24	0	Zero Events	Monthly	Common Cause	Hit or Miss	0	-1	1	0	0	0	0	0	0	0	1	0	0	1	0	0
Summary Hospital Mortality Indicator	Apr-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Patient Safety Alerts (NatPSAs) breached	Apr-24	1	Zero Alerts	Monthly	Concern (Higher Than Expected)	Hit or Miss	0	0	1	0	0	0	0	0	0	1	1	0	0	0	1	1
Number of Serious Incidents remaining open after 60 days	Apr-24	1	Zero Cases	Monthly	Concern (Higher Than Expected)	Hit or Miss	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1	1
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Apr-24	257	No Target Set	Monthly	Common Cause	Not Applicable	211	128	294	205	212	196	204	197	175	133	151	206	243	262	259	257

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Sustainability and at Scale																						
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Apr-24	96	No Target Set	Monthly	Improvement	Not Applicable	102	96	107	105	108	104	104	103	100	99	102	100	100	97	97	96
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Apr-24	39	No Target Set	Monthly	Improvement	Not Applicable	46	41	52	53	52	52	50	48	51	46	40	38	41	45	43	39
Median Outpatient Journey Times - Virtual TeleMedicine Appointments	Apr-24	n/a	No Target Set	Monthly	#N/A	Not Applicable				n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Theatre Cancellation Rate (Non-Medical Cancellations)	Apr-24	0.49%	≤0.8%	Monthly	Common Cause	Hit or Miss	0.98%	-0.26%	2.22%	1.21%	0.92%	1.24%	1.78%	0.92%	1.43%	0.74%	0.98%	1.28%	0.79%	0.86%	0.57%	0.49%
Number of non-medical cancelled operations not treated within 28 days	Apr-24	0	Zero Breaches	Monthly	Common Cause	Hit or Miss	2	-3	6	2	0	1	2	6	2	3	2	1	4	0	0	0
Overall financial performance (In Month Var. £m)	Apr-24	0.01	≥0	Monthly	Common Cause	Hit or Miss	0.48	-1.89	2.85	0.27	0.79	0.69	0.06	0.03	0.04	-0.10	1.32	2.35	0.98	-0.44	1.10	0.01
Commercial Trading Unit Position (In Month Var. £m)	Apr-24	0.02	≥0	Monthly	Common Cause	Hit or Miss	-0.01	-0.96	0.95	-0.06	0.34	-0.07	0.02	0.29	-0.58	0.28	-0.16	-0.28	0.33	0.06	-0.92	0.02
Working Together																						
Appraisal Compliance	Apr-24	74.7%	≥80%	Monthly	Common Cause	Failing	74.7%	68.7%	80.8%	71.8%	74.5%	74.9%	76.6%	78.4%	74.4%	69.8%	73.5%	76.4%	78.3%	77.2%	75.6%	74.7%
Basic Mandatory IG Training	Apr-24	90.2%	≥90%	Monthly	Concern (Lower Than Expected)	Capable	92.0%	89.5%	94.6%	90.0%	90.7%	93.7%	92.6%	90.0%	90.9%	93.5%	92.8%	91.6%	91.5%	91.2%	90.1%	90.2%
Staff Sickness (Month Figure)	Mar-24	4.3%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.5%	3.3%	5.7%	3.8%	3.7%	4.3%	4.1%	4.4%	4.4%	5.2%	4.5%	4.4%	4.5%	4.3%	4.3%	n/a
Staff Sickness (Rolling Annual Figure)	Mar-24	4.4%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.4%	4.1%	4.8%	4.8%	4.7%	4.7%	4.5%	4.5%	4.6%	4.6%	4.5%	4.4%	4.5%	4.4%	4.4%	n/a
Recruitment Time To Hire (Days)	Mar-24	50	≤ 40 Days	Monthly (Month in Arrears)	Common Cause	Failing	49	36	61	40	41	40	52	55	56	52	58	48	49	47	50	n/a
Proportion of Temporary Staff	Apr-24	13.3%	No Target Set	Monthly	Common Cause	Not Applicable	14.0%	9.4%	18.5%	14.5%	15.5%	15.1%	15.7%	19.3%	14.8%	15.5%	15.8%	12.7%	13.7%	17.1%	16.6%	13.3%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Discover																						
Total patient recruitment to NIHR portfolio adopted studies	Mar-24	130	≥115 (per month)	Monthly (Month in Arrears)	Concern (Lower Than Expected)	Capable	251	119	383	261	266	343	298	211	201	225	224	114	123	136	130	n/a
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Mar-24	178	No Target Set	Monthly (Month in Arrears)	Concern (Lower Than Expected)	Not Applicable	327	152	503	315	329	409	387	327	289	315	320	186	206	221	178	n/a
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Mar-24	60	≥44	Monthly (Month in Arrears)	Improvement (Higher Than Expected)	Capable	54	50	58	68	67	53	53	51	50	52	52	55	56	56	60	n/a
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Mar-24	4.9%	≥2%	Monthly (Month in Arrears)	Common Cause	Capable	4.8%	4.4%	5.2%	6.5%	6.6%	5.3%	4.5%	4.5%	4.6%	4.8%	4.9%	4.9%	4.9%	5.0%	4.9%	n/a
Context (Activity)																						
Number of A&E Arrivals	Apr-24	6,401	No Target Set	Monthly	Common Cause	Not Applicable	5,696	4,827	6,565	6,303	6,937	6,838	6,440	5,931	5,819	6,020	5,506	5,161	5,636	6,001	6,053	6,401
Number of A&E Four Hour Breaches	Apr-24	110	No Target Set	Monthly	Common Cause	Not Applicable	41	-44	126	201	174	45	51	8	22	42	28	52	16	60	266	110
Number of Outpatient Appointment Attendances	Apr-24	56,113	No Target Set	Monthly	Common Cause	Not Applicable	50,304	38,938	61,669	46,355	51,892	56,204	53,234	53,984	53,373	56,118	56,378	44,701	55,565	53,631	53,962	56,113
Number of Outpatient First Appointment Attendances	Apr-24	12,976	No Target Set	Monthly	Common Cause	Not Applicable	11,620	9,112	14,129	10,797	12,616	13,355	12,882	12,886	12,651	13,222	13,424	11,176	13,254	12,835	12,161	12,976
Number of Outpatient Follow Up Appointment Attendances	Apr-24	43,137	No Target Set	Monthly	Common Cause	Not Applicable	38,683	29,550	47,816	35,558	39,276	42,849	40,352	41,098	40,722	42,896	42,954	33,525	42,311	40,796	41,801	43,137
Number of Referrals Received	Apr-24	15,290	No Target Set	Monthly	Common Cause	Not Applicable	14,164	11,015	17,313	13,822	16,178	15,827	15,450	15,447	14,990	16,262	15,486	12,790	15,462	15,921	15,257	15,290
Number of Theatre Admissions	Apr-24	3,392	No Target Set	Monthly	Common Cause	Not Applicable	3,119	2,322	3,915	2,745	3,210	3,622	3,422	3,306	3,259	3,522	3,749	2,850	3,498	3,517	3,277	3,392
Number of Theatre Elective Daycase Admissions	Apr-24	3,113	No Target Set	Monthly	Common Cause	Not Applicable	2,850	2,067	3,632	2,447	2,927	3,315	3,119	3,001	2,987	3,238	3,474	2,600	3,233	3,251	3,001	3,113
Number of Theatre Elective Inpatient Admission	Apr-24	81	No Target Set	Monthly	Common Cause	Not Applicable	76	50	102	70	74	86	74	90	77	79	81	56	89	76	79	81
Number of Theatre Emergency Admissions	Apr-24	198	No Target Set	Monthly	Common Cause	Not Applicable	193	154	232	228	209	221	229	215	195	205	194	194	176	190	197	198

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report

Trust Board Report

For the period ended 30th April 2024 (Month 01)

Report Period	M01 | April 2024
Presented by	Jonathan Wilson | Chief Financial Officer
Written by	Justin Betts | Deputy Chief Financial Officer Amit Patel | Head of Financial Management Lubna Dharssi | Head of Financial Control Richard Allen | Head of Income and Contracts

Monthly Finance Performance Report

For the period ended 30th April 2024 (Month 01)

Key Messages

Statement of Comprehensive Income

Financial Position £0.61m deficit in month	For April, the trust is reporting:- • a £0.61m deficit against a planned deficit of £0.62m, £0.01 favourable to plan • a £0.61m cumulative deficit against a planned deficit of £0.61m.
Income £26.20m in month (including £1.7m ERF funding)	Total trust income was £26.20m in April, a favourable variance of £0.06m. Material variances include:- • Total income has been matched to income plans whilst activity information is received. There is no national reporting in April 2024 for month 1 reporting. • Commercial patient income was £0.22m adverse to plan • R&D income was on £0.11m favourable in month • Other income was break-even in month
Expenditure £25.42m in month (pay, non-pay, excl financing)	Pay is reporting expenditure of £15.20m in April, £0.38m adverse to plan (£0.38m cumulatively). • Medical staffing was £0.13m adverse in month in primary driven by arrears payments • Unachieved pay CIP has driven an adverse variance of £0.41m Non-pay is reporting expenditure of £10.22m in April, £0.13m favourable to plan (£0.13m cumulatively). • Drugs is £0.10m adverse in month (£0.10m adverse cumulatively). This has partially been driven by wholesale drugs of £0.05m. Reviews are taking place in External Disease and Theatres as areas of high spend • Unidentified CIP contributed a £0.26m adverse variance.
Financing and Depreciation £1.39m in month	Financing is reporting a favourable variance of £0.20m in month (£0.20m favourable cumulatively) consisting of:- • Interest receivable benefits linked to the trust cash balance and increases in BoE interest rates. • Depreciation £0.19m favourable to plan due to lower than planned spend.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 30th April was £70.4m, a reduction of £0.3m from the position at the end of March 2024. The Better Payment Practice Code (BPPC) performance in April was 95% (volume) and 94% (value) against a target of 95% across both metrics.
Capital (both gross capital expenditure and CDEL)	Capital expenditure as of 30th April totalled £2.9m. • Trust funded capital totals £0.2m. • Externally funded capital totals £2.7 due to Oriel expenditure. The capital plan is currently being developed

Other Key Information

Efficiencies £10m Trust Target £6.6m Identified	The trust has planned a £10m CIP for 2024/25. The trust has identified central schemes of £5m, leaving a remaining ask of £5m for the clinical and corporate divisions. • Currently £1.6m has been identified by clinical and corporate areas, totalling £6.6m identified. • £3.4m remains currently unidentified. Clinical Divisions and corporate areas are working to validate opportunities and additional schemes to increase the level of efficiencies during quarter one.
Agency Spend £0.57m spend YTD 3.7% total pay	Trust wide agency spend totals £0.57m cumulatively, approximately 3.7% of total employee expenses spend, lower than national expectations of 4.8%. Workforce have instigated temporary staffing committees for oversight in relation to managing and reporting temporary staffing agency usage and reasons.

Trust Financial Performance - Financial Dashboard Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income	£338.5m	£26.1m	£26.2m	£0.06m	£26.1m	£26.2m	£0.1m	0%	
Pay	(£177.8m)	(£14.8m)	(£15.2m)	(£0.38m)	(£14.8m)	(£15.2m)	(£0.4m)	(3)%	
Non Pay	(£122.0m)	(£10.3m)	(£10.2m)	£0.13m	(£10.3m)	(£10.2m)	£0.1m	1%	
Financing & Adjustments	(£35.4m)	(£1.6m)	(£1.4m)	£0.20m	(£1.6m)	(£1.4m)	£0.2m	12%	
CONTROL TOTAL	**£3.4m**	**(£0.6m)**	**(£0.6m)**	**£0.01m**	**(£0.6m)**	**(£0.6m)**	**£0.0m**		
Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income									
Memorandum Items									
Research & Development	(£0.71m)	(£0.23m)	(£0.26m)	(£0.04m)	(£0.23m)	(£0.26m)	(£0.04m)	(16)%	
Commercial Trading Units	£3.28m	£0.18m	£0.11m	(£0.07m)	£0.18m	£0.11m	(£0.07m)	(36)%	
ORIEL Revenue	(£0.80m)	(£0.07m)	(£0.07m)	(£0.00m)	(£0.07m)	(£0.07m)	(£0.00m)	(1)%	

INCOME BREAKDOWN RELATED TO ACTIVITY

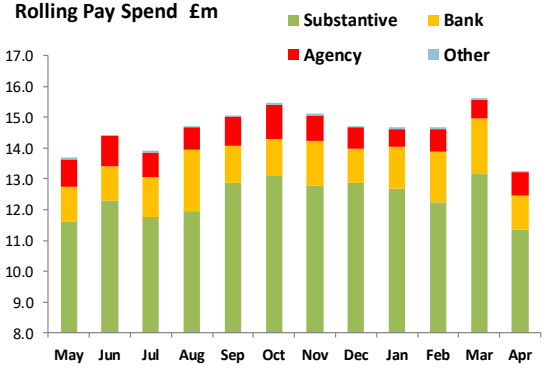
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£198.0m	£16.3m	£16.3m	(£0.0m)				
Pass Through	£41.8m	£3.4m	£3.4m	£0.0m				
Other NHS Clinical Income	£9.7m	£0.8m	£1.0m	£0.2m				
Commercial Trading Units	£46.3m	£3.6m	£3.4m	(£0.2m)				
Research & Development	£15.9m	£1.2m	£1.3m	£0.1m				
Other	£26.8m	£0.9m	£0.9m	£0.0m				
INCOME INCL ERF	**£338.5m**	**£26.1m**	**£26.2m**	**£0.1m**				

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

PAY AND WORKFORCE

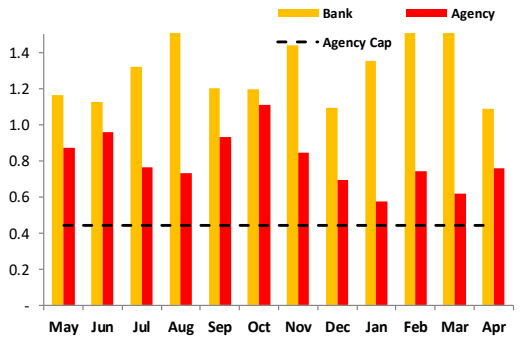
Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	% Total
Employed	(£176.6m)	(£14.7m)	(£13.2m)	£1.5m	(£14.7m)	(£13.2m)	£1.5m	87%
Bank	(£0.7m)	(£0.1m)	(£1.4m)	(£1.3m)	(£0.1m)	(£1.4m)	(£1.3m)	9%
Agency	-	-	(£0.6m)	(£0.6m)	-	(£0.6m)	(£0.6m)	4%
Other	(£0.6m)	(£0.0m)	(£0.1m)	(£0.0m)	(£0.0m)	(£0.1m)	(£0.0m)	0%
TOTAL PAY	**(£177.8m)**	**(£14.8m)**	**(£15.2m)**	**(£0.4m)**	**(£14.8m)**	**(£15.2m)**	**(£0.4m)**	

Rolling Pay Spend £m



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

Rolling Bank & Agency Spend £m



*Agency cap levels set by NHSIE

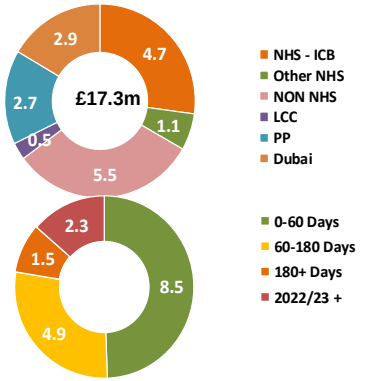
CASH, CAPITAL AND OTHER KPI'S

Capital Programme £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£12.6m)	-	(£0.2m)	£0.2m				
Donated/Externally funded	(£125.6m)	-	(£2.7m)	£2.7m				
TOTAL	**£138.2m**	**-**	**£2.9m**	**£2.9m**				

Key Metrics	Plan	Actual	RAG
Cash	53.9	70.4	
Debtor Days	45	13	
Creditor Days	45	55	
PP Debtor Days	65	44	

Better Payment Practice	Plan	Actual
BPPC - NHS (YTD) by number	95%	95%
BPPC - NHS (YTD) by value	95%	92%
BPPC - Non-NHS (YTD) by number	95%	95%
BPPC - Non-NHS (YTD) by value	95%	94%

Net Receivables/Ageing £m



Trust Income and Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income									
NHS Commissioned Clinical Income	239.75	19.70	19.70	0.00	19.70	19.70	0.00	0%	
Other NHS Clinical Income	9.74	0.79	0.96	0.17	0.79	0.96	0.17	21%	
Commercial Trading Units	46.33	3.61	3.39	(0.22)	3.61	3.39	(0.22)	(6)%	
Research & Development	15.90	1.16	1.26	0.11	1.16	1.26	0.11	9%	
Other Income	26.83	0.87	0.88	0.01	0.87	0.88	0.01	1%	
Total Income	**338.54**	**26.14**	**26.20**	**0.06**	**26.14**	**26.20**	**0.06**	**0%**	
Operating Expenses									
Pay	(177.80)	(14.82)	(15.20)	(0.38)	(14.82)	(15.20)	(0.38)	(3)%	
Of which: Unidentifed CIP	*4.90*	*0.41*	*-*	*(0.41)*	*0.41*	*-*	*(0.41)*		
Drugs	(43.91)	(3.57)	(3.67)	(0.10)	(3.57)	(3.67)	(0.10)	(3)%	
Clinical Supplies	(27.39)	(2.15)	(2.03)	0.12	(2.15)	(2.03)	0.12	6%	
Other Non Pay	(50.68)	(4.63)	(4.53)	0.11	(4.63)	(4.53)	0.11	2%	
Of which: Unidentifed CIP	*3.10*	*0.26*	*-*	*(0.26)*	*0.26*	*-*	*(0.26)*		
Total Operating Expenditure	**(299.77)**	**(25.17)**	**(25.42)**	**(0.25)**	**(25.17)**	**(25.42)**	**(0.25)**	**(1)%**	
EBITDA	*38.78*	*0.97*	*0.78*	*(0.19)*	*0.97*	*0.78*	*(0.19)*	(19)%	
Financing & Depreciation	(19.55)	(1.64)	(1.44)	0.20	(1.64)	(1.44)	0.20	12%	
Donated assets/impairment adjustments	(15.83)	0.05	0.04	(0.01)	0.05	0.04	(0.01)	(17)%	
Control Total Surplus/(Deficit) Post ERF Income	**3.40**	**(0.62)**	**(0.61)**	**0.01**	**(0.62)**	**(0.61)**	**0.01**		

Commentary

Operating Income

£1.37m adverse to plan in month

Clinical activity levels recorded were 91% for Daycases, 104% for Outpatients First Attendances and 101% for Outpatient Procedures during April, with activity-based income totalling £16.49m. Notable variances include:-

- Clinical income was £19.70m, break-even to plan. Elective activity is reporting 91% compared wo plan with Stratford (42%) and St Anns (72%) during April.
- Commercial trading income was £3.39m, £0.22m adverse to plan.
- Research and Development income at £1.26m was £0.11m favourable
- Other Income was break-even; additional commercial education income was offset by lower than planned estates rental income.

Employee Expenses

£0.38m adverse to plan in month

April pay is reported as £15.20m; £0.38m adverse to plan in month. Drivers of the in-month variance include:-

- £0.10m of medical arrears payments.
- Temporary staffing costs were £1.95m in April
  - Agency costs are £0.56m in month, lower than the 12-month trend of £0.80m. High agency use continues mainly in theatres and corporate areas, with IT and Workforce being the highest corporate areas of use.
  - Bank costs are £1.38m in month on trend with the last 12 month but significantly lower than March
- £0.26m relates to unachieved pay CIP (£0.26m cumulatively) whilst efficiencies are identified in quarter one.

Non-Pay Expenses

£0.13m favourable to plan in month

(non-pay and financing)

Non-Pay costs in April were £10.22m £0.13m favourable to plan. Drivers of the in-month variance include:-

- Drugs was £0.10m adverse in month with £3.67m expenditure in April against a 12-month of £3.55m. Wholesale drugs at Moorfields Private West End (offset by income) is the main driver however there are several services where expenditure will be reviewed.
- Clinical supplies £0.12m favourable in month with £2.03m expenditure in April against a 12-month trend of £2.04m
- Other non-pay £0.11m favourable with £4.53m expenditure in April against a 12-month trend of £4.88m. There was approximately £0.50m of flow through Invest To Save scheme expensed in April.
- £0.20m Financing favourable variance linked to interest receivable of £0.09m and lower the expected depreciation of £0.19m

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

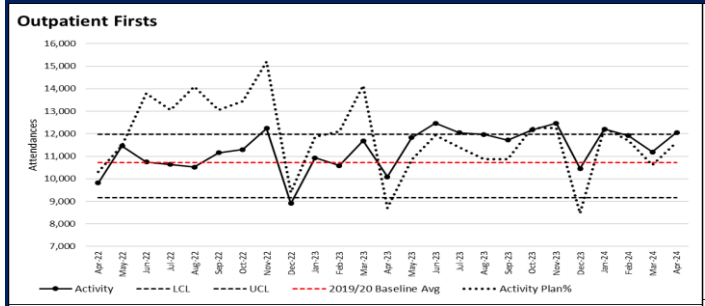
ER	Point of Delivery	Activity In Month				Activity YTD				Weighted YTD Income £m			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	3,432	3,111	89	91%	3,432	3,111	89	91%				
	Of which - SA & ST	854	445	(409)	52%	854	445	(409)	52%				
	OP Firsts	11,624	12,056	432	104%	11,624	12,056	432	104%				
	OP Procedures	20,873	21,080	207	101%	20,873	21,080	207	101%				
	ERF Activity Total												
Non ERF Acti	OP Follow Ups	18,509	21,488	2,979	116%	18,509	21,488	2,979	116%				
	High Cost Drugs Injections	4,716	4,688	(28)	99%	4,716	4,688	(28)	99%				
	Non Elective	206	197	(9)	96%	206	197	(9)	96%				
	AandE	6,021	6,401	380	106%	6,021	6,401	380	106%				
	Total	65,381	69,021	4,050	106%	65,381	69,021	4,050	106%				

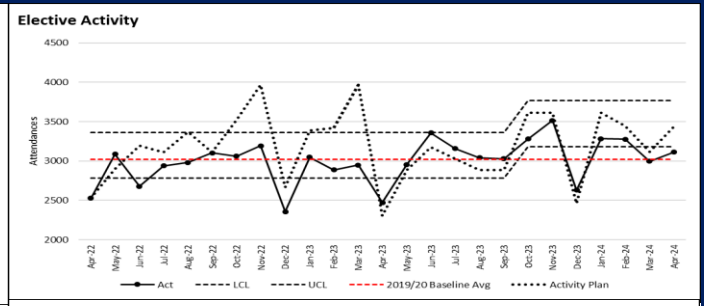
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

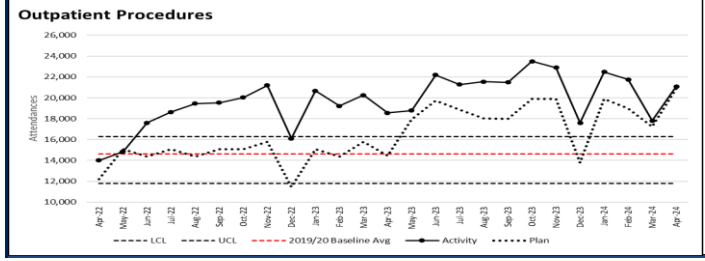
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

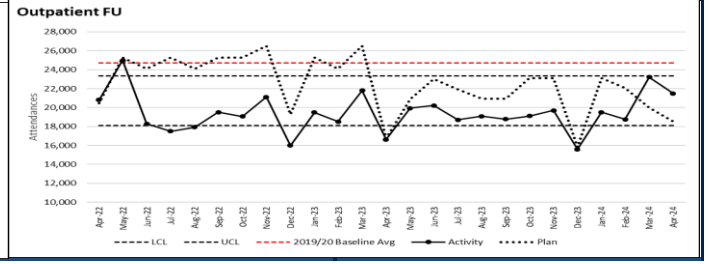
Performance % figures above, represent the Trust performance against the external activity target. Financial values shown are for ERF activity only.

ACTIVITY TREND - ERF COMPONENTS









Commentary

NHS Income

ERF Achievement

ERF performance is yet to be calculated as the targets have not yet been confirmed for 2024/25 :-

ERF Activity performance achievement

- **Inpatient activity** achieved 91% of the capacity plan. The table also splits out Stratford (ST) and St Annes (SA) which is reporting 52% of activity plans, with Stratford at 42% and St Annes 70% respectively.
- **Outpatient Firsts Activity** achieved 104% of the capacity plan in April;
- **Outpatient Procedures Activity** achieved 101% of activity plans in April;

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 99% of activity plans in April;
- **A&E** achieved 106% of activity plans in April;

Activity plans and ERF

Current activity plans are based on approved capacity plans.

- 2024/25 targets for ERF are yet to be confirmed.

Activity Plans

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

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

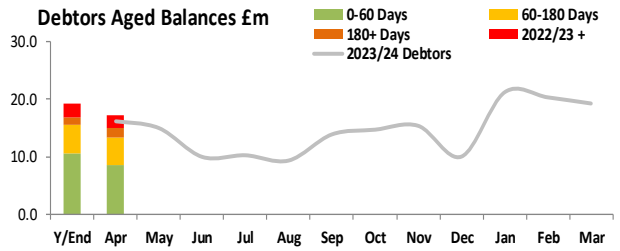
CAPITAL EXPENDITURE

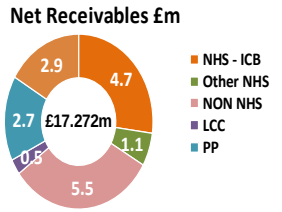
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Estates - Trust Funded	12.6	-	0.0	0.0
Medical Equipment - Trust Funded	-	-	0.1	0.1
IT - Trust Funded	-	-	0.1	0.1
ORIEL - Trust Funded	-	-	-	-
Commercial - Trust funded	-	-	0.0	0.0
Other - Trust funded	-	-	-	-
TOTAL - TRUST FUNDED	**12.6**	**-**	**0.2**	**0.2**
Externally funded	125.6	-	2.7	2.7
TOTAL INCLUDING DONATED	**138.2**	**-**	**2.9**	**2.9**

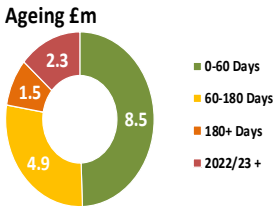
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
ICS Fair Share Allocation	12.6	12.6	-	100%
Cash Reserves - Oriel	1.0	1.0		100%
Cash Reserves - B/Fwd	0.8	0.8		100%
Capital Loan Repayments	(1.8)	(1.8)		100%
TOTAL - TRUST FUNDED	**12.6**	**12.6**	**-**	**100%**
Externally funded	109.0	109.0	-	100%
Donated/Charity	16.6	16.6		100%
TOTAL INCLUDING DONATED	**138.2**	**138.2**	**0%**	**100%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2022/23 +*	*Total*
CCG Debt	3.9	0.8	0.0	(0.0)	4.7
Other NHS Debt	0.3	0.3	0.2	0.3	1.1
Non NHS Debt	1.8	2.1	0.2	1.3	5.5
Commercial Unit Debt	2.5	1.7	1.1	0.8	6.1
TOTAL RECEIVABLES	**8.5**	**4.9**	**1.5**	**2.3**	**17.3**







STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Non-current assets	262.8	216.5	264.2	47.8
Current assets (excl Cash)	33.9	33.9	30.4	(3.5)
Cash and cash equivalents	57.1	53.9	70.4	16.5
Current liabilities	(68.2)	(68.3)	(46.6)	21.7
Non-current liabilities	(66.9)	(63.9)	(80.3)	(16.4)
TOTAL ASSETS EMPLOYED	**218.6**	**172.1**	**238.1**	**66.1**

OTHER METRICS

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

Commentary

Cash and Working Capital

The cash balance as at the 30th April was £70.4m, a reduction of £0.3m from the position at the end of March 2024.

Capital Expenditure

Capital expenditure as of 30th April totalled £2.9m.

- Trust funded capital totals £0.2m from schemes carried forward from 2023/24.
- Externally funded capital totals £2.7m of Oriel expenditure.

Trust capital plans are currently being developed.

Receivables

Receivables have reduced by £1.9m to £17.3m since the end of the 2023/24 financial year. Debt in excess of 60 days increased by £0.2m in April, which was offset by a reduction in current debt by £2.1m.

Payables

Payables totalled £18.3m at the end of April, a reduction of £7.8m since the end of March 2024.

The trust's performance against the 95% Better Payment Practice Code (BPPC) was

- 95% volume of invoices (prior month 95%) and
- 94% value of invoices (prior month 95%).

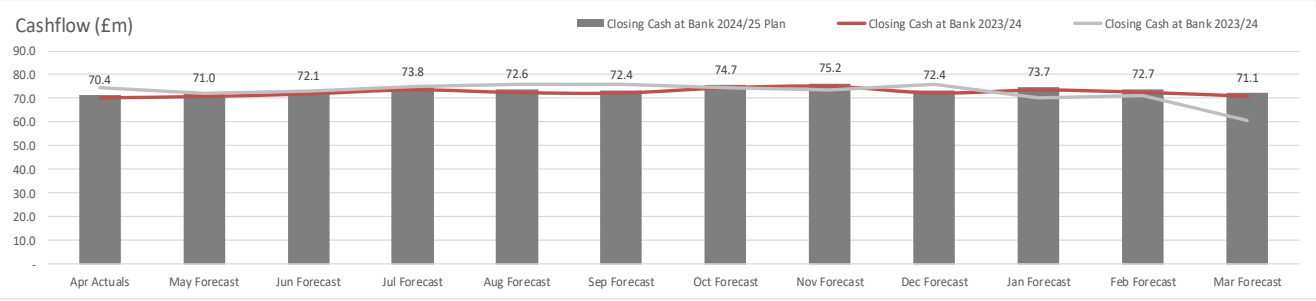
Use of Resources

Use of resources monitoring and reporting has been suspended.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Apr Forecast	Apr Var
Opening Cash at Bank	**70.7**	**70.4**	**71.0**	**72.1**	**73.8**	**72.6**	**72.4**	**74.7**	**75.2**	**72.4**	**73.7**	**72.7**	**70.7**		
Cash Inflows															
Healthcare Contracts	20.4	21.3	20.4	22.3	19.5	20.4	23.2	21.3	17.7	22.3	20.3	20.4	249.4	20.4	(0.0)
Other NHS	2.6	0.9	7.9	1.0	0.9	0.9	1.0	1.0	8.7	1.5	1.5	1.5	29.4	0.9	1.6
Moorfields Private/Dubai/NCS	4.7	3.6	3.9	3.7	3.5	4.1	4.4	4.4	3.4	4.3	4.1	4.3	48.6	3.4	1.3
Research	3.1	1.1	1.1	1.4	1.4	1.4	1.4	1.4	1.4	1.3	1.3	1.3	17.5	1.1	1.9
VAT	1.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	7.0	0.5	1.0
PDC	7.8	-	-	6.1	11.0	10.5	11.9	14.0	5.6	12.9	12.8	16.5	109.0	7.8	-
Other Inflows	0.3	0.2	7.2	0.2	0.2	0.3	0.3	0.3	8.0	0.8	0.8	0.8	19.4	0.2	0.1
Total Cash Inflows	**40.2**	**27.8**	**41.1**	**35.1**	**37.0**	**38.0**	**42.6**	**42.7**	**45.2**	**43.6**	**41.3**	**45.5**	**480.1**	**34.3**	**5.9**
Cash Outflows															
Salaries, Wages, Tax & NI	(13.0)	(12.6)	(12.6)	(12.6)	(12.6)	(12.6)	(12.6)	(12.6)	(12.6)	(12.6)	(12.6)	(12.6)	(151.7)	(12.6)	(0.4)
Non Pay Expenditure	(21.4)	(12.2)	(19.0)	(12.5)	(11.9)	(11.1)	(13.1)	(12.8)	(19.3)	(13.5)	(13.2)	(11.8)	(171.8)	(11.8)	(9.6)
Capital Expenditure	(0.9)	-	-	(0.8)	(0.8)	(0.8)	(2.7)	(2.7)	(2.7)	(3.3)	(3.3)	(4.5)	(22.7)	-	(0.9)
Oriel	(4.0)	(1.0)	(7.0)	(6.1)	(11.0)	(10.5)	(10.6)	(12.6)	(12.0)	(11.5)	(11.4)	(15.1)	(112.7)	(7.8)	3.8
Moorfields Private/Dubai/NCS	(1.2)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(16.6)	(1.4)	0.2
Financing - Loan repayments	-	-	-	-	(0.4)	(0.5)	-	-	-	-	(0.4)	(0.5)	(1.8)	-	-
Dividend and Interest Payable	-	-	-	-	-	(1.3)	-	-	-	-	-	(1.3)	(2.5)	-	-
Total Cash Outflows	(40.5)	(27.2)	(40.0)	(33.5)	(38.2)	(38.2)	(40.4)	(42.1)	(48.0)	(42.3)	(42.3)	(47.1)	**(479.7)**	(33.6)	(6.9)
Net Cash inflows /(Outflows)	(0.3)	0.6	1.1	1.7	(1.1)	(0.2)	2.2	0.6	(2.8)	1.3	(1.0)	(1.6)	-	0.7	(1.0)
Closing Cash at Bank 2023/24	**70.4**	**71.0**	**72.1**	**73.8**	**72.6**	**72.4**	**74.7**	**75.2**	**72.4**	**73.7**	**72.7**	**71.1**	**71.1**		
Closing Cash at Bank 2024/25 Plan	71.5	72.0	73.1	74.8	73.7	73.5	75.7	76.3	73.4	74.7	73.8	72.2	72.2		
Closing Cash at Bank 2023/24	74.7	71.9	73.0	74.8	75.7	75.8	74.7	73.5	76.1	70.3	71.2	60.6	60.6		



Commentary

Cash flow

The cash balance as at the 30th April was £70.4m, a reduction of £0.3m from the position at the end of March 2024.

The current financial regime has resulted in block contract payments which gives some stability and certainty to the majority of cash receipts. The trust currently has 85 days of operating cash (prior month: 86 days).

April saw a cash outflow of £0.3m against a plan of £0.7m inflow. April also saw a receipt of Oriel PDC of £7.8m.

The cashflow will be refined as the income and expenditure and capital plans are finalised.

Trust Efficiency Scheme Performance

Summary of Savings Identified

Summary Efficiencies - Internally Identified

£m	High Risk	Medium Risk	Low Risk	Total Identified	Un-identified
Centrally Identified sub-total	**-**	**2.000**	**3.000**	**5.000**	
City Rd Division	0.785	-	-	0.785	
Ophth. & Clin. Serv. Division	-	-	-	-	
Moorfields North Division	0.377	-	0.005	0.382	
Moorfields South Division	0.260	0.050	-	0.310	
Corporate Departments	0.050	-	0.100	0.150	
Total	**1.472**	**2.050**	**3.105**	**6.627**	**3.374**
Of which:-					
Income				4.815	48%
Pay				0.382	4%
Non Pay				1.430	14%
Unidentified				**3.374**	34%
Of which:-					
Recurrent				2.947	29%
Non Recurrent				3.680	37%
Unidentified				**3.374**	34%

Commentary

Reporting Trust efficiencies are managed and reported via the CIP Board.

Target

£10m The trust has an efficiency programme target of £10m in 2023/24 as part of the £3.4m surplus financial plan.

Identified Savings

£6.6m The CIP Board is working to identify its full requirement of £10m efficiency savings within the overall Trust financial plan.

Central schemes have been identified of £5m, leaving a remaining ask of £5m for the clinical and corporate divisions.

Currently £1.6m has been identified by clinical and corporate areas, totalling £6.6m identified, with £3.374m remaining as unidentified.

Clinical Divisions and corporate areas are working to validate opportunities and additional schemes to increase the level of efficiencies during quarter one.

Supplementary Information

Moorfields Eye Hospital NHS Foundation Trust

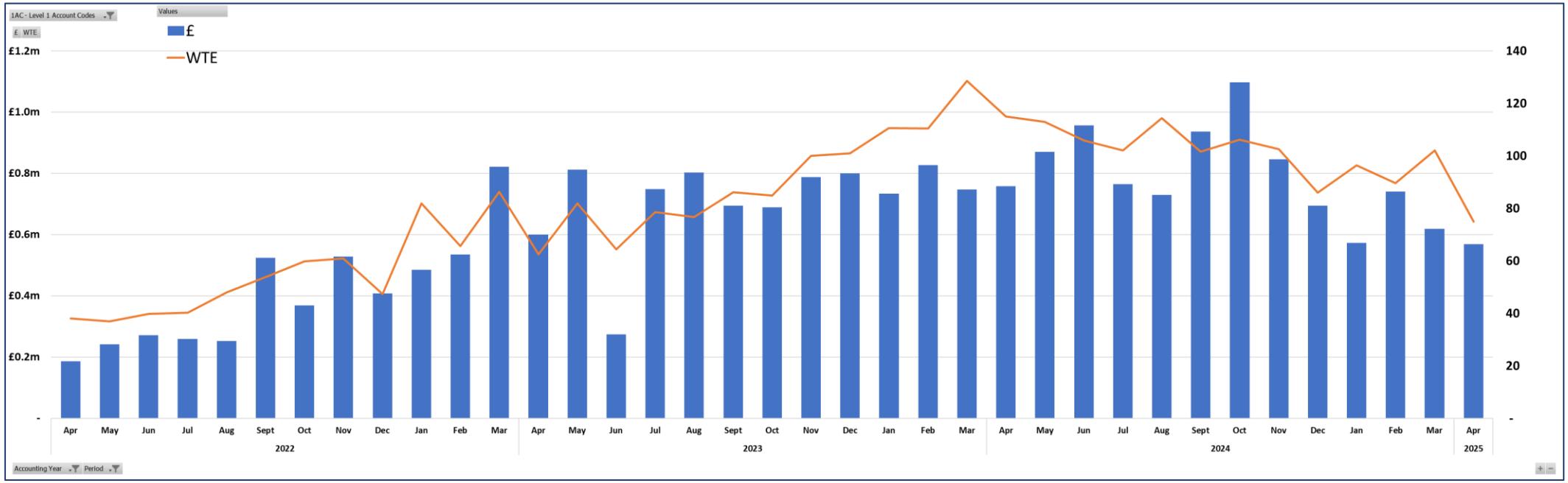
NHS

Workforce – Agency Reporting in Board Report

AGENCY SPEND REPORTING

Pay Expense Reporting £m	2023/24 Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	2024/25 Apr 24	YTD £m	YTD %
Agency															
Clinical Divisions	0.372	0.504	0.508	0.491	0.428	0.592	0.647	0.507	0.351	0.214	0.337	0.162	0.269	0.269	46%
Coporate Departments	0.261	0.279	0.320	0.281	0.190	0.261	0.310	0.258	0.259	0.295	0.287	0.313	0.247	0.247	42%
Commercial/Trading	0.025	0.027	0.045	0.020	0.077	0.035	0.097	0.028	0.022	0.031	0.057	0.064	0.063	0.063	11%
Research	0.100	0.059	0.085	(0.027)	0.035	0.049	0.044	0.053	0.063	0.034	0.059	0.052	0.015	0.015	3%
Total Agency	**0.758**	**0.871**	**0.957**	**0.765**	**0.730**	**0.937**	**1.097**	**0.846**	**0.695**	**0.573**	**0.740**	**0.591**	**0.595**	**0.595**	
Agency														-	
Medical Staff	0.077	0.080	0.098	0.100	0.104	0.103	0.095	0.104	0.078	0.047	0.095	0.083	0.094	0.094	16%
Nursing Staff	0.186	0.249	0.191	0.140	0.105	0.139	0.273	0.133	0.125	0.140	0.121	0.213	0.107	0.107	18%
Scientific & Technical	0.039	0.056	0.062	(0.031)	0.051	0.252	0.158	0.125	0.093	0.076	0.069	(0.137)	0.034	0.034	6%
Allied Health Professionals	0.009	0.004	0.001	-	-	0.003	0.016	0.001	0.005	-	0.002	0.005	0.017	0.017	3%
Clinical Support	0.033	0.110	0.132	0.291	0.143	0.091	0.101	0.073	0.039	0.060	0.055	0.022	0.022	0.022	4%
Admin And Clerical	0.405	0.360	0.435	0.257	0.282	0.337	0.442	0.400	0.338	0.234	0.376	0.411	0.309	0.309	53%
Ancillary Services	0.010	0.011	0.038	0.008	0.044	0.012	0.013	0.011	0.017	0.016	0.022	(0.005)	0.002	0.002	0%
Total Agency	**0.758**	**0.871**	**0.957**	**0.765**	**0.730**	**0.937**	**1.097**	**0.846**	**0.695**	**0.573**	**0.740**	**0.591**	**0.586**	**0.586**	

*Excludes central budgets



Report title	Staff Survey Report and Action Plan
Report from	Mark Gammage, Interim Chief People Officer
Prepared by	Carolyn Parker, Former Associate Director Employee Experience and Ade Adetukasi, Associate Director of Employee Experience
Link to strategic objectives	Working Together - We will work together to ensure our workforce supports future care models and a consistently excellent patient and staff experience, in accordance with our values.

Executive summary:

This paper sets out the trust's performance for Staff Survey 2023 as compared with other 12 acute specialist trusts who make up our benchmarking group.

The paper acknowledges the trust's progress, whilst recognising that against the themes measured in the Staff Survey, we consistently score below the average for our benchmarking group of 12 acute specialist trusts, and in many cases are the worst performing trust within the group.

In recognition of the fact that a number of the acute specialist trusts are based outside of London and comparability is therefore more questionable, the paper also includes a comparison with North Central London (NCL) Integrated Care System (ICS). Our performance against this comparator group is more positive, with staff engagement and morale in particular noted as being above average. Nonetheless the trust recognises the considerable work that is required to realise our ambition of being an organisation which has exemplary people management practices.

Considering the results, the paper proposes a focus on three of the NHS People Promise themes with supporting rationale, including:

- We are compassionate and inclusive.
- We each have a voice that counts.
- We are always learning.

Actions to address the results in these areas are outlined in the paper. These reflect previous discussions regarding aligning our action plan with trust wide strategic priorities, to ensure appropriate allocation of resources and effort.

The paper was discussed at the People Committee on 7 May 2024. It was agreed that one or two metrics should be elevated and reported on as measures to judge progress and 'recommending the trust as a place to work' will form one of these metrics. Quarterly pulse surveys of staff will allow more regular reporting then relying exclusively on the annual staff survey.

High level results and comparator data:

This year, we achieved a final, confirmed response rate of 66%. This is a 16% year-on-year increase on our 2022 response rate of 50%, and significantly higher than the national average (54%) for our comparative group.

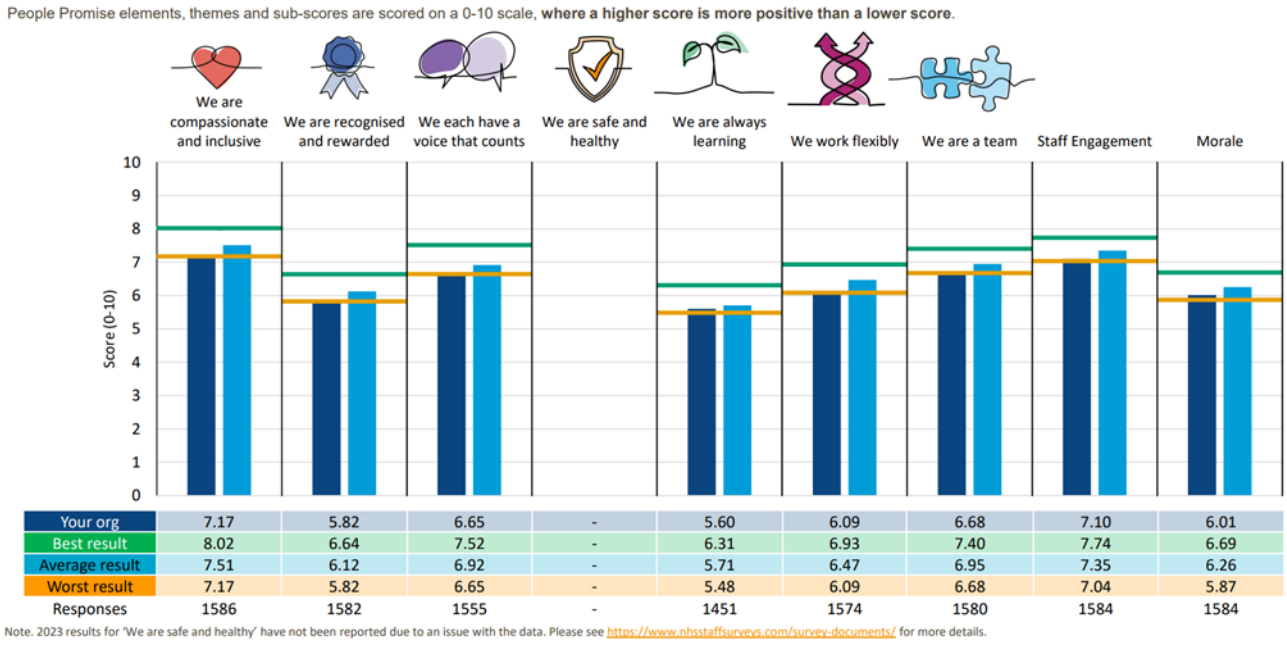
Against the seven NHS People Promise themes, plus the themes of Engagement and Morale, we have seen scores improve against six themes, maintain against two themes, and worsen against one theme. The theme 'We each have a voice that counts' was the only theme to worsen year-on-year. This is primarily driven by a reduction in the sub-theme score related to raising concerns.

All of the themes that were prioritised for action in our trust-wide action plan have seen an improvement year-on-year. These are: We are recognised and rewarded; We are safe and healthy; and We are always learning.

The NHS Staff Survey Coordination Centre undertake statistical significance testing, to identify whether changes in scores represent a statistically significant change. The improvements in the theme scores for 'We are safe and healthy' and 'Morale' were the only statistically significant shifts. We are safe and healthy increased from 6.1 to 6.3* year on year, whilst Morale increased from 5.8 to 6.0 year on year.

*<u>*Please note that this score was reported prior to the national data quality issue being identified, this score is therefore subject to validation and is not reported in the following images.*</u>

Additionally, the report provides an overview of our performance against our benchmark group, which comprises 12 other specialist trusts who work with our Staff Survey provider, Picker (see Appendix c).



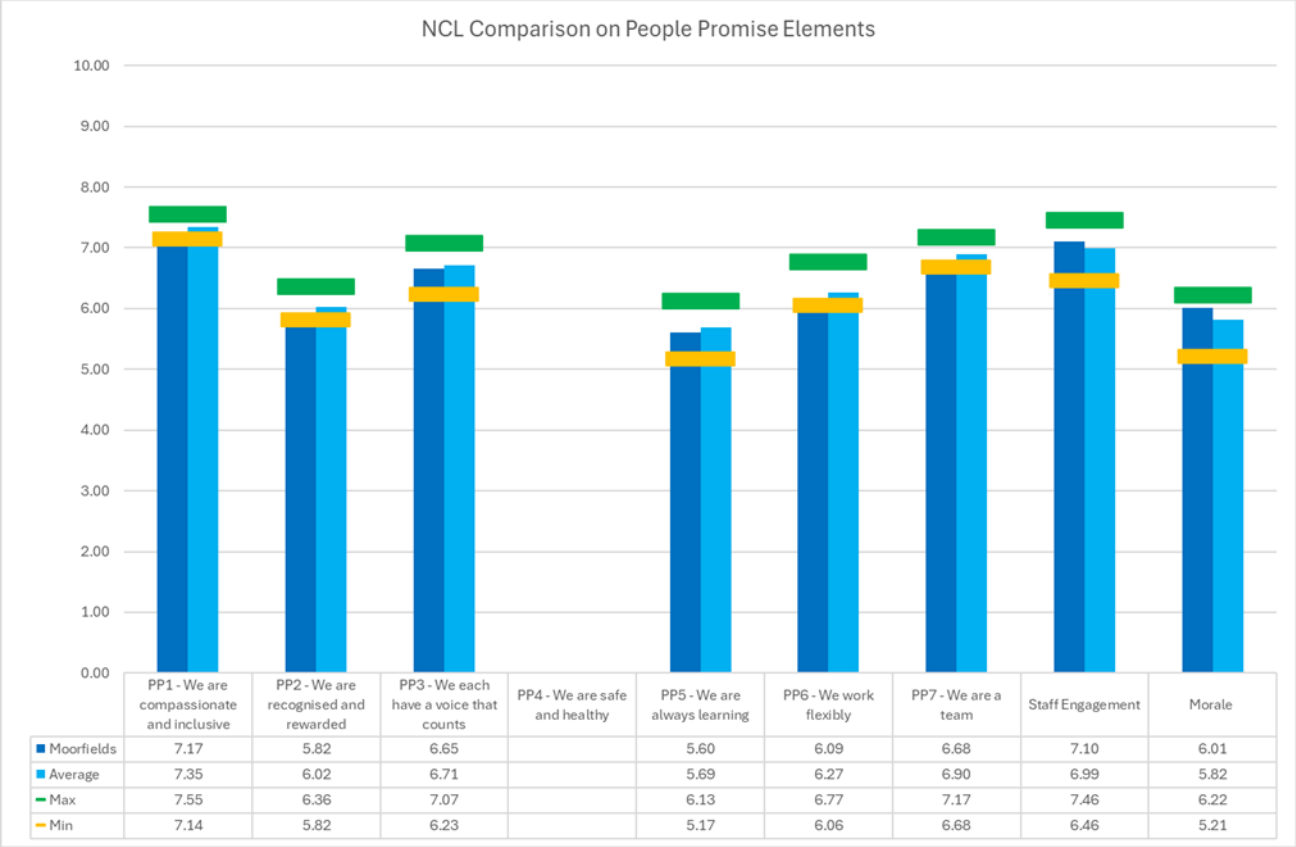
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.17	5.82	6.65	-	5.60	6.09	6.68	7.10	6.01
Best result	8.02	6.64	7.52	-	6.31	6.93	7.40	7.74	6.69
Average result	7.51	6.12	6.92	-	5.71	6.47	6.95	7.35	6.26
Worst result	7.17	5.82	6.65	-	5.48	6.09	6.68	7.04	5.87
Responses	1586	1582	1555	-	1451	1574	1580	1584	1584

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Image 1: Trust results as compared with the average, best and worst scores for our benchmark group.

It is clear from this that whilst we have made improvements, our theme scores are consistently lower than the average for our benchmarking group, and for five themes we are the lowest performing trust. These are: We are compassionate and inclusive; We are recognised and rewarded; We each have a voice that counts; We work flexibly; and We are a team.

Meanwhile, against the trusts comprising NCL, our performance is as follows:



	PP1 - We are compassionate and inclusive	PP2 - We are recognised and rewarded	PP3 - We each have a voice that counts	PP4 - We are safe and healthy	PP5 - We are always learning	PP6 - We work flexibly	PP7 - We are a team	Staff Engagement	Morale
Moorfields	7.17	5.82	6.65		5.60	6.09	6.68	7.10	6.01
Average	7.35	6.02	6.71		5.69	6.27	6.90	6.99	5.82
Max	7.55	6.36	7.07		6.13	6.77	7.17	7.46	6.22
Min	7.14	5.82	6.23		5.17	6.06	6.68	6.46	5.21

Image 2: Trust results as compared with the average, best and worst scores for North Central London

When we compare ourselves to other trusts within NCL, it is an improved picture. Staff engagement and morale in particular are scored above average although people scored 'we are recognised and rewarded' and 'we are a team' lower than other trusts.

Proposed areas for focus:

Historically, we have selected the lowest scoring NHS People Promise themes and focussed our action plan against these areas. For this year, it is proposed that we prioritise those themes that align with our strategic focus. This approach would reflect discussions held last year, but not enacted due to timing. It also has the benefit of demonstrating shared leadership for this work, amplifying our strategic focus areas through multiple channels and mitigates risks associated with resource capacity.

As such, it is recommended that our action plan focusses on themes listed for the following reasons:

- **We are compassionate and inclusive.** Whilst this is our highest scoring theme, it is also the theme where we have the biggest gap between our score and the average score for our benchmarking group, and the second biggest gap between our score and the best score for our benchmarking group. Additionally, it includes questions pertaining to experiences of discrimination, perceptions regarding career progression, and respecting individual differences. All of which we are an outlier for when compared with our benchmarking group.

- **We each have a voice that counts.** This was our only theme score to deteriorate, albeit it wasn't a statistically significant change. It is also the theme with the biggest gap between our score and the best score for our benchmarking group.
- **We are always learning.** This remains our lowest scoring theme score.

Responding to the Staff Survey Result

It is important for staff to know that their staff survey feedback have been heard, especially considering the significant increase in the response rate and engagement from staff. In addition, the staff survey is a rich and credible source of data in understanding the experience of our staff. Therefore, as well as developing an action plan, as set out in Appendix A and in alignment with organisational development priorities, the following are our immediate next steps.

Next steps

1. Rollout the 2023 staff survey result communication and engagement plan as set out in the timeline below.

Timeline	Activity
April 24	ManEX approval of Trust-wide staff survey action plan
May 24	Engagement with TMC on the Trust-wide staff survey action plan
	Discussion with staff-side colleagues at JSCC and LNC and gaining their support for the action plan
	People and Culture Committee discussion on staff survey result and action plan
	Divisional and corporate department staff survey results shared, reviewed and action plans agreed
	Ongoing – You said, We have communication
June 2024	Colleagues' engagement sessions on the staff survey result and the Trust response. Each session will be led by a member of the executive and co-facilitated by Associate Director of Employee Experience.
	Board update on staff survey result and action plan following the People Committee

2. To ensure a triangulated approach in our response to staff feedback from the staff survey, we will be carrying out further analysis of the staff survey data including considering staff feedback from other sources. This will be used in refining, designing and measuring ongoing and planned interventions, especially in relation to our EDI, values and leadership programmes.

3. The Employee Experience and the HRBP teams will be working with divisional and corporate leaders across the trust to review local staff survey result. This will then inform local interventions and priorities in response to feedback from staff. In line with the areas of focus identified above, and to improve staff experience, there will be emphasis on driving inclusion, enabling a speak up culture, and supporting local managers capabilities.

4. Data will be analysed by staff group (nursing, medical etc) and protected characteristic. An analysis of verbatim comments is also being completed and will be discussed with the executive team.

5. To build on the increase in the survey response rate and the corresponding improvement in staff engagement, the Employee Experience team have commenced planning for improving the usage of the national quarterly pulse survey in the trust. The national quarterly pulse survey is of one of the key employees listening tools in the NHS, but yet to be fully maximised in the trust. The quarterly pulse

survey will help track and enable improvement in staff experience. The next national quarterly pulse survey is scheduled for July 2024. The question on 'recommending the trust as a place to work' will form one of the key metrics to be reported through the workforce and integrated performance reports.

See Appendix A for the action plan, aligned to the themes above.

Where there are outstanding actions from the previous staff survey action plan, these will be incorporated into the relevant team's business-as-usual delivery plans. These include:

- Finalising the pilot of Designing Work to Mitigate Stress. The evaluation and wider scale roll-out of this approach is outstanding. This will be completed by the Health and Wellbeing team by September 2024.
- Developing and delivering a pilot to deliver a proactive approach to addressing musculoskeletal (MSK) issues via a defined MSK Pathway. This will be completed by the Health and Wellbeing team by December 2024.
- Continued roll out of Active Bystander and Active Bystander extra. This will be delivered by the OD and engagement team.

See Appendix B for a progress report against the Staff Survey Action Plan 2022.

Quality implications

Staff experience is closely linked to patient care and outcomes, and improvements in our colleagues' experience and engagement will positively contribute to patient experience.

Our ability to recruit and retain staff is driven by people's experience of working here and improving staff satisfaction will have a positive impact on this need.

Financial implications

Support for actions identified have been built into our budgeting. There are no further financial requirements at this time.

Risk implications

The greatest risk is not acting on the results of the survey and/ or not communicating progress. Regular updates on the actions we agree to address issues will be reported to the Executive, People Committee and Board.

Colleague engagement can be detrimentally impacted by lag between survey completion and results being shared more widely. This should be mitigated by continuing to share "You said, We have" communications to demonstrate our ongoing commitment, plus clear signalling of when our results will be shared.

Action Required/Recommendation

The Board is asked to endorse the action plan outlined.

For Assurance		**For decision**	**x**	**For discussion**		**To note**	

Moorfields Eye Hospital NHS Foundation Trust

NHS

Appendix A: Staff Survey Action Plan 2023

This action plan is for:	Moorfields Eye Hospital – Trust wide action plan 2023			
Theme	**Action**	**Lead**	**Deadline**	**Intended outcome(s)**
We are compassionate and inclusive	Launch our Equity, Diversity and Inclusion vision and supporting programme plan, providing regular updates on our progress.	Associate Director Employee Experience	Vision launch – June 2024 Programme delivery - ongoing	Colleagues know and understand the trust's commitment to EDI. The EDI programme delivers against its agreed timeline, with colleagues engaged and communicated with throughout. Our values are embedded in the trust, as evidenced through policies, practices and processes, with the behavioural framework clearly communicated, so people know what is expected of them.
	Deliver a programme of work to embed our trust values of Excellence, Equity and Kindness, with an underpinning set of behaviours.	Associate Director Employee Experience	April 2025	
We each have a voice that counts	Embed our revised Freedom to Speak up approach.	FTSU Lead Guardian	December 2024	Colleagues understand how to raise concerns and have confidence that these will be addressed. Lead Guardian is visible and known to colleagues. Work in confidence scheme is well utilised, with a shift away from anonymous reporting as trust builds.
	Implement a regular line manager briefing to support managers to brief their teams on key issues of interest and provide opportunities for two-way feedback.	Internal Communication Lead	December 2024	Colleagues have increased awareness of important trust matters. Feedback and questions are highlighted and responded to.

This action plan is for:	Moorfields Eye Hospital – Trust wide action plan 2023			
Theme	**Action**	**Lead**	**Deadline**	**Intended outcome(s)**
We are always learning	Deliver a management and leadership development programme.	Associate Director Employee Experience	From April 2025	The trust has a clear management and leadership development offer in place. 50% of line managers have completed the programme within agreed timeline. Line managers have the skills and confidence to lead and manage their teams.

Please provide your feedback, thoughts, and ideas by sending an email to moorfields.od@nhs.net

Appendix B: Staff Survey Action Plan 2022 – progress update

This action plan is for:	Moorfields Eye Hospital – Trust wide action plan 2022		
Theme	**Action**	**Lead**	**Progress update**
We are recognised and rewarded	Launch "good deed feed" on eyeQ to enable colleagues to provide shout outs to one another online	Internal Comms team	Recognition forum launched in May 2023, with 110 threads created as of 11 March 2024. Employee of the Month relaunched in January 2024. Decision taken not to implement Great-ix, based on it being similar in purpose to the recognition forum. Stars 2023 celebrated 27 September.
	Reinstate Employee of the Month	OD team	
	Explore Great-ix technology as a way of providing instant recognition certificates	OD team and Dr John Shubaker	
	Celebrate Stars recognition awards for 2023	Internal Comms and OD team	
We are always learning	Deliver Meaningful Appraisals project	L&D team	Meaningful Appraisals project completed, with updated forms issued for paper-based reviews and new line manager training offered. L&D brochure updated, with expanded offer, and issued most recently in November 2023. CPD and apprentice review completed, with Education Committee established to provide greater transparency regarding allocation of funding and development opportunities.
	Refresh L&D brochure on quarterly basis	L&D team	
	Continuous Professional Development (CPD) and Apprenticeship review	Rachele Johnson	
We are Safe & Healthy	Continue to roll out Active Bystander	OD Team	Active Bystander workshops continue to be offered, with over 625 participants to date.
	Develop and deliver Active Bystander Extra	OD team	
	Pilot the organisational stress risk assessment framework with a team or	OD team in collaboration	

	department where burnout scores indicate they are a hotspot	with identified leads	Active Bystander extra is outstanding, the workshops have been purchased and work is underway to define target audiences. Stress risk assessment approach piloted via 'Designing Work to Mitigate Stress' project, involving four teams. Evaluation and decision regarding wider rollout due in June 2024. MSK Pathway is being developed, with plan to pilot approach in May/June 2024.
	Develop and implement Musculoskeletal (MSK) Pathway to prevent and mitigate impact of MSK absences	OD team	

Appendix C: Comparator Trusts

Twelve acute specialist trusts comprise our benchmarking group. These are:
Royal National Orthopaedic Hospital NHS Trust;
Liverpool Heart and Chest Hospital NHS Foundation Trust;
The Christie NHS Foundation Trust;
The Clatterbridge Cancer Centre NHS Foundation Trust;
Liverpool Women's NHS Foundation Trust;
The Walton Centre NHS Foundation Trust;
Royal Papworth Hospital NHS Foundation Trust;
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust;
Great Ormond Street Hospital for Children NHS Foundation Trust;
Queen Victoria Hospital NHS Foundation Trust;
The Royal Marsden NHS Foundation Trust; and
The Royal Orthopaedic Hospital NHS Foundation Trust.

Report title	Well led development review and functional model and governance review update
Report from	Martin Kuper, Chief executive officer
Prepared by	Victoria Moore, Associate Director of Excellence Delivery
Link to strategic objectives	Working Together, Discover, Develop and Delivery, Sustainable and at Scale

Quality implications The improvements to governance mean that the board will have line of sight of all functional areas within the trust and can therefore receive assurance on all aspects of quality.
Financial implications There are no financial implications relating to this paper.
Risk implications Improvements have been made to risk policy and guidance and has been cascaded and a consistent approach on risk categorisation and management shared at every level of the trust. The process for risks flowing from Divisional level to corporate risk register, and into each of the board subcommittees has been clarified and will be further refined in line with the new board subcommittee structure.
Action required/recommendation. This paper is presented for noting and does not include recommendations.

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

1. Background

1.1 In response to Well-led development review (March 2022) findings, which highlighted a number of areas of challenge and opportunity with existing Trust governance, Moorfields commissioned a review of the top tiers of Trust governance in order to recommend how to evolve its structure and model.

1.2 The review aimed to identify challenges with the existing model/framework and to co-design the future state. The future state model aimed to improve clarity of structure, responsibilities and information/ reporting flow at an executive and Board level.

1.3 In the summer of 2022, Moorfields also finalised and launched their strategy "Excellence, equity and kindness at the forefront of eye care 2022-2027". The strategy brings together all aspects of Moorfields work across clinical care, research and education and applies to our NHS and commercial services, both in the UK and internationally.

1.4 The strategy sets out our purpose as 'working together to discover, develop and deliver excellent eye care, sustainably and at scale'. It places an emphasis on the opportunities to embrace the wider NHS commitment to integration by promoting joined up care for the communities we serve and make the most of opportunities created by digital technology.

1.5 To enable the governance review to reflect the ambitions set out in the strategy, Moorfields further commissioned a review into their functional model as there was consensus that it no longer aligned to the Trust's new strategic priorities, and there was a lack of clarity over functional areas, which had grown organically.

1.6 The review and redesign were undertaken in two phases of work. Phase one (Oct - Dec '22) consisted of as-is analysis and considerations of future state, whereas phase two (Jan - Apr '23) focused on developing detailed future state design and an implementation roadmap. Both phases were undertaken through a combination of document review, stakeholder interviews and workshops and was overseen by a weekly steering group, chaired by Martin Kuper, Chief executive officer.

1.7 The approach to taking this forward has seen the well led governance review recommendations progressed, launch of the new strategy, launch of the Excellence portfolio, providing a framework for strategy delivery, review of the functional model and governance arrangements of the organisation, review of the executive board structure, functional model changes enacted, board sub committees reviewed and a review of management governance arrangements. This paper provides a summary of the changes made and those still in progress.

2. Launch of the strategy '2022-2027 Excellence, equity and kindness at the forefront of eye care' and Excellence Portfolio

2.1 The strategy '2022-2027 Excellence, equity and kindness at the forefront of eye care' brings together all aspects of our work across clinical care, research and education and applies to our NHS and commercial services, both in the UK and internationally. This new strategy builds on our previous five year 'Vision of Excellence' sets out our motivation 'People's Sight Matters' and our values equity, excellence and kindness.

2.2 Our purpose '**Working together to discover, develop and deliver excellent eye care, sustainably and at scale'** summarises the role we want to play in the world, in response to our motivation and our contact and forms our five strategic objectives that describe what we need to do to realise our ambitions.

2.3 To make the implementation of our strategy focused and measurable, we use these objectives to shape our

transformation programme, the Excellence Portfolio. Through the executive led portfolio, we plan our work to align with our strategic objectives and track our progress towards them. The Excellence Portfolio launched in September 2022 and continues to provide the framework for our change activities.

3. functional model and governance arrangements of the organisation

3.1 The changes to the functional model and governance review are summarised here. Broadly speaking the changes fall into the following categories board, Membership Council, committees, portfolios, risk and tools.

3.2 Board of Directors

- Board meetings now alternate between a Board meeting and Board Development Session on a monthly basis. Over the year there will be 6 Board meetings and 5 Board Development Sessions. Three Board Development sessions have now been held in February, April and June.
- Public Board meetings now begin with a patient or staff story in order to bring the patient and staff voice into the meeting, this has been in place since March '23. Patient stories have been heard in March, July, Nov (2023) and June (2024); staff stories May, Sept (2023) and January (2024). We also had a review of previous stories for lessons learnt at November 2023 board and have second paper on the agenda for the July board meeting.

3.3 Membership Council

- A new governor onboarding process is being developed, and new governors in 2024 are receiving an initial induction meeting with the company secretary. A wider training day is planned with NHS Providers for all governors later in the summer.
- We now have a full schedule of the NED / governor meetings, a site visits programme is being developed and we have moved to have two times a year where the Membership Council and Board meet on the same day, sharing lunch, and NEDs attending the Membership Council meeting.

3.4 Committees

- An Education committee has been created to oversee all business as usual elements of education delivery. The committee meets monthly and has recently overseen the development of the Moorfields Education strategy.
- Board sub-committee reporting of Education and Performance are currently being finalised, as part of the revised board sub committee structure.

3.5 Portfolios

- The Integrated Performance Report (IPR) has been reviewed to align with the current organisational strategy and to use the best practice Making Data Count methodology in its presentation. The Board received a presentation from the national Making Data Count team to support its implementation.
- The is a regular flow of information from the Divisional performance updates into Management Executive.
- The future state functional model clarified the different facets of Education, including what sits within the joint Education Directors portfolio.
- The Education vision and key strategic priorities have been set out in the Education strategy.

3.6 Risk

- The risk policy and guidance and has been cascaded and a consistent approach on risk categorisation shared at every level of the trust.
- The process for risks flowing from Divisional level to CRR, and into each of the Board sub-committees has been clarified and will be further refined in line with the new board sub-committee structure.

3.7 Tools

- A set structure and guidance for Board and Sub-Committee reports. e.g. one common template, one common approach has been recommended as part of the functional model and governance review.
- The approach to Trust Board and Sub-Committees minutes have been adjusted to ensure that test and challenge at is accurately captured and reflected in meeting minutes to show richness of discussion.

4. Review of the Executive Board structure

4.1 Following the functional model and governance review, adjustments to the executive structure function were proposed to and approved by the trusts Renumeration and Nominations committee to provide a coherent, consistent leadership model aligned to the future in July 2023. The new structure took effect from 1st October 2023.

4.2. The proposed adjustments aligned the executive structure to the organisational reality today, with new areas growing in importance and complexity

4.3 The Chief People Officer role became a voting executive director role, recognising the strategic importance of workforce and organisational development to the trust. This post has been filled with interim cover arrangements however we are delighted that a new substantive Chief People Officer, Sue Steen, is due to join the board in October 2024.

4.4 A new non-voting executive board role was created to lead our Digital Development activities. We are pleased that Dr Pete Thomas, leads digital strategy, planning and development, piloting and early implementation of virtual division and the development of the virtual hospital including creation of digital hospital, management of Single Point of Access, and the department of digital medicine as the Director of Digital Development.

4.5 Each functional area of the trust became the responsibility of one of the seven voting executives. So for example, Sheila Adam, our Chief Nursing Officer, became responsible for Education and Quality and Safety, in addition to her nursing portfolio, while Jon Spencer, our Chief Operating Officer, became responsible for Technology, Oriel, and Digital Development, in addition to his operating officer responsibilities.

4.6 Given the strategic importance and increasing complexity of the Discovery domain (with developments in data, AI, as well as innovation more broadly), and the importance of getting the right structure to optimise the relationship with UCL as we move together towards Oriel, the leadership structure in this functional area has been harmonised with the rest of the Trust, with a dedicated, solely Moorfields employed, full time Director of Discovery (consolidating the current non-timetabled role of Director of R&D and the half time role of Clinical Director of R&D). Sir Peng Khaw retains his key role as co-Director of the BRC as well as his clinical activities.

4.7 The Director of Discovery role is in active recruitment with both stakeholder and interview panels planned in June. Both include engagement with key research and innovation stakeholders including in particular Andrew Dick, UCL representative NED and BRC co-Director and other members of the UCL Institute of Ophthalmology.

4.8 The Director of Strategy and Partnerships is also under active recruitment with selection stages planned to take place in June.

4.9 All changes have been enacted through the appropriate governance with oversight and engagement from the trust board and approval from the Renumeration and Nominations committee including all our independent Non-executive directors and following the appropriate human resource policies and good practice. Individual consultation has been undertaken where roles were impacted.

4.10 The board includes eight independent Non-Executive Directors (including the chair) and one non independent Non-Executive Director representing University College London. After Membership Council approval, we welcomed Aaron Rajan to join the board earlier this year and are working with governors in active recruitment for a successor to our Non-Executive Director responsible for Quality and Safety Committee.

5. Board sub committees

The board has seven committees, each chaired by a non-executive director. These committees were reviewed and relaunched under new terms of reference on 1st October, aligning with the principle of ensuring that all functional

areas within the Trust are assured by an appropriate board sub-committee. The committees that underwent significant changes had the new terms of reference approved at the September board meeting in part 1. Changes have been implemented and each committee reports to the board after it has a meeting. They are currently completing their committee effectiveness reviews.

6. Management Governance

6.1 The functional model and governance review made recommendations regarding the executive governance of the organisation and Management Executive approved a way forward to response to these in March 24.

6.2 The proposals for the management governance structure broadly fall into three categories;

1. Revised terms of reference for key management governance forums (listed below)
2. Move to a proactively planned and structured work programme for Management Executive to support oversight of performance and risk
3. Introduction of a leadership forum and corporate performance review for each functional area (a key enabler to the above).

The following management governance forums have been considered:

- Management Executive
- Trust Management Committee
- Excellence Portfolio Board
- Operational Executive
- Corporate performance reviews

6.3 Proposed terms of reference for the forums are currently undergoing engagement and review. The aim is to engage and commence transition to the governance framework in Q1 of 24/25 with revised terms of reference for key forums and corporate performance reviews for each of the 12 functional areas to be in place by the end of Q2.

Annex A – Recommendations from Phase 1 Functional Model and Governance review (with mapping to Well Led development review) – December '22

Theme		Challenge	Recommendation	Well-led recommendation	Short *Within 6-12 weeks*	Medium -long *Beyond 12 weeks*	Phase 2
Board		Presently, no Board development in place.	Consider a review of Board frequency, and incorporation of an alternating Board and Board Development Session on a monthly basis. E.g. Month 1 Trust Board, Month 2 Board Development Session, Month 3 Trust Board etc.	3, (10)	✓*		
		Inconsistent inclusion of patient voice at Board meetings.	Review frequency and format of patient voice at Board meetings.	26	✓		
Membership Council		Limited visibility of membership council of NED activity.	Increase engagement of NEDs with membership council to improve ability of governors to discharge statutory duties.	14		✓*	
		Inconsistent onboarding process and understanding of role.	Review governor on-boarding process to ensure consistent approach and clarity of role and statutory duties.	14		✓	
Sub-Committees		Limited Sub-Committee oversight of Performance.	Extend the remit of the Finance Sub-Committee to become the 'Finance and Performance' Board sub-committee to provide formal Sub-Committee oversight of performance reporting.	18	✓		
		Limited Sub-Committee oversight of Education.	Agree Sub-Committee oversight for Education, e.g. where do key Education updates flow to.		✓		
Committees		Siloed components of Education portfolio.	Establish an Education committee, which will act as the key forum for Education related updates and discussion.		✓		
Portfolios	**Operations**	Imbalance in reporting across performance domains.	Consider how IPR can be developed further to provide greater metrics and further balance across each performance domain (finance, workforce, quality and operations), and act as a key tool across these, including reflecting national best practice, e.g. Making data count.	19		✓	
		Lack of formal information flow, regarding performance, from Divisional reviews to broader Trust.	Ensure there is a clear and regular flow of information from Divisional Performance Reviews into the broader Trust to give visibility of activity. E.g. performance update into Manex and Finance and Performance Sub-Committee.				✓
		Presently, majority operational resource at performance review meetings.	Ensure a balance of attendees across performance domains at all performance review meetings.	20	✓		
	Education	Lack of clarity regarding scope of Education portfolio.	Clarify the different facets of Education, including what sits within the joint Education Directors portfolio.		✓		
		Lack of clarity regarding Education strategic priorities.	Clarify the Education vision and key strategic priorities.			✓	
	BRC	Proposed governance for BRC is new, and as yet, untested.	Implement the proposed BRC governance structure and agree review point to assess effectiveness.		✓		
Risk		Inconsistent categorisation of risk across organisation.	Leverage the existing Risk policy and guidance and cascade expectations and approach on risk categorisation to each level of the Trust.	(17)	✓		
		Inconsistent management of risk across the organisation.	Leverage the existing Risk policy and guidance and cascade expectations and approach on risk management to each level of the Trust.	(17)	✓		
		Lack of robust approach to ensuring the flow of risk from Divisional level to the Corporate Risk Register (CRR).	Review/ clarify how risk flows from Divisional level to CRR, and into each of the Board Sub-Committees.				✓
Tools and Materials		Inconsistent quality of Board and Sub-Committee reports.	Implement a set structure and guidance for Board and Sub-Committee reports. E.g. one common template, one common approach, length of report limited.		✓		
		Inconsistent quality of meeting minutes.	Ensure test and challenge at Trust Board and Sub-Committees is accurately captured and reflected in meeting minutes to show richness of discussion.	1	✓		

Annex B – Recommendations from Phase 2 Functional Model and Governance review – July '23

No.	Area	Recommendation	Short	Medium	Long
1	**Board Governance**	Engage Chair and Non-Executive Directors to review and approve proposed changes to Board Committee terms of reference and work-plans.	✓		
2	**Board Governance**	Review Board Committee dates with view to align to Management Governance meeting schedule and IPR timelines (performance data) from 2024/25.		✓	
3	**Board Governance**	Review skills mix and expertise of Non-Executive Board members to feed into succession planning to ensure appropriate balance.		✓	
4	**Board Governance**	Implement Board development programme to ensure Board is operating as effective unitary Board, to enable new proposed structure to operate effectively.		✓	
5	**Board Governance**	Board to develop Board Strategy Session TOR and forward plan for the year.	✓		
6	**Board Governance**	Review SFI's and agree which Board Committees are the most appropriate to review/ approve.	✓		
7	**Management & Board Governance**	Decision to be made over threshold for items to go to Board Committees for assurance rather than Management Governance (i.e., Quality & Safety Committee assurance over incidents from Divisions).	✓		
8	**Management Governance**	Management Executive to review and approve proposed changes to ManEx, TMC, Excellence Portfolio Board and senior functional area meetings.	✓		
9	**Management Governance**	Establish Management Executive as the forum with oversight of all Trust Board and Board Committee agendas and papers.	✓		
10	**Management Governance**	Align new Integrated Performance Report (IPR) to strategic priorities.		✓	
11	**Management Governance**	Review as-is risk and performance oversight processes to ensure alignment with documented policies and good practice outlined in supporting material.		✓	
12	**Management Governance**	Review appropriate delegated authority (Scheme of Delegation/ Standing Financial Instructions) for functional areas once assured of maturity.			✓
13	**Functional Model & Board Governance**	Review Board composition and attendance, and align Executive Board members to proposed functional model, ensuring this meets the constitution and aligns to key strategic areas for the Trust.	✓		
14	**Operating Model**	Opportunity to define in detail the other key elements of the operating model, such as processes, people, technology and partnerships.		✓	

Moorfields Eye Hospital NHS Foundation Trust

NHS

ITEM XX

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

Executive summary

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

The trust has identified **zero** patient deaths in Q4 2023/24 that fell within the scope of the learning from deaths policy.

Quality implications

The Board needs to be assured that the trust is able to learn lessons from serious incidents (SIs)[1] in order to prevent repeat mistakes and minimise patient harm.

Financial implications

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

Risk implications

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

Action Required/Recommendation

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

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

[1] The trust is now operating under the patient safety incident response framework (PSIRF). This means that the term SI will no longer feature in this report and will be replaced by a specified learning response (e.g., patient safety incident investigation (PSII) or after action review (AAR)).

This report satisfies the requirement to provide the trust board with an update regarding compliance with, and learning from, the NHSE learning from deaths agenda. The Q4 2023/24 data is shown in the table below.

Indicator	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	0	0	0
% of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident (SI) panel	N/A	N/A	N/A	N/A
Deaths considered likely to have been avoidable	N/A	N/A	N/A	N/A

Learning and improvement opportunities identified during Q4

1. Inquest into the death of a patient, City Road (Complete)

During Q4 all actions associated with this serious incident investigation were confirmed to be complete. Confirmation of this was provided to the patient's family and the coroner, as requested at the inquest in September 2023.

2. Inquest into the death of a patient, Croydon (New)

At the end of December 2023, notification was received that statements had been requested to inform an inquest that was scheduled to take place on 21 February 2024. The coroner requested information in relation to the patient's eyesight, the level of vision, and details of treatment and care given. An update will be provided in the Q1 2024/25 report regarding the inquest outcome, if available.

3. Child death review

Moorfields continues to contribute to the child death review process, which is being led by the host trust, St George's Hospital. To date, learning has been identified as follows:

- Moorfields was not represented at the Joint Agency Review meeting, which was an oversight. The trust safeguarding team must be informed by the host trust.
- Different IT systems are used by the host trust and Moorfields, which can make communication challenging. Verbal communication may be helpful in some cases.
- Out of office messages must be displayed if an e-mail is sent to an account that is not monitored.
- Moorfields must be given adequate opportunity to provide timely contribution to the investigation process and the review of final draft reports to check for factual accuracy.

ME role update

In April 2024 it was confirmed that The Medical Certificate of Cause of Death Regulations and The Medical Examiners (England) Regulations will come into effect in September 2024. From 9 September all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. Ahead of this change, the trust has already launched a new process for notifying and engaging with the medical examiner if a death occurs at any Moorfields site. A policy is also being developed.

Medical Examiner update - March 2024

Annex 1

Included within the scope of this policy:

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

Excluded from the scope of this Policy:

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

Report title	Standing Orders and Standing Financial Instructions Update 2024/25
Report from	Sam Armstrong, Company Secretary
Prepared by	Lubna Dharssi, Head of Financial Control and Sam Armstrong, Company Secretary
Link to strategic objectives	Deliver financial sustainability as a trust

Executive summary

The Board is asked to approve the following amendments and renew the Standing Orders and Standing Financial Instructions for 2024/25. This review has now been completed with updates made outlined on the following page.

The Board is asked to note that new procurement rules will come into effect in the UK from October 2024 which will impact the trust. The Procurement Act 2023 was made law on 27th October 2023, and are the biggest changes to UK public procurement since 2015. The act is due to go live in October 2024 following the completion of the secondary legislation and a 6-month notice period. As a result, the SFIs will need to be reviewed once the impact of the new rules have been assessed.

These amendments were considered at the April Audit and Rick Committee meeting and endorsed there and commended to the Board for ratification.

The updated SFIs and Scheme of Delegation (SoD) are not attached here, however we will make them available to anyone who wishes to review the document.

Quality implications

None

Financial implications

None

Risk implications

To deliver financial governance and sustainability as a trust.

Action Required/Recommendation

The Board is asked to review and approve the amendments to the standing orders and SFIs.

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

REVIEW OF STANDING FINANCIAL INSTRUCTIONS, SCHEME OF DELEGATION AND STANDING ORDERS, 2024/25

Introduction

The Trust's Standing Financial Instructions, Scheme of Delegation and Standing Orders have been reviewed to ensure they remain up to date and fit for purpose. This document sets out the proposed changes and the rationale for each.

Section	New/Amendment	Rationale
To add section 4.3 to the standing order, and renumber thereafter where appropriate	"The Trust Board may take decisions in respect of the business of the Trust outside of a formal meeting of the Board by written resolution by email or correspondence, sent by the Company Secretary or nominee. This is subject to the quorum of the Board endorsing the required decision."	The Board meets six time per year and on occasion a decision is needed outsides these times that do not necessitate an emergency.
SFI/scheme of delegation Discovery and Commercial Committee	• Approval of business cases with a maximum of £2m (capital) as specified in standing financial instructions • Ratification of contracts between £1.5m and £2m (revenue) • Approval of variations to contracts with a maximum of £2m (revenue) • Business cases over £2m prior to consideration by the board, in line with standing financial instructions • Complex or critical business cases below £1m (capital) or below £1.5m (revenue), as referred by the chief executive • Contracts awarded outside standing financial instructions in excess of £1m	Updates to the delegation to committees.
SFI/scheme of delegation Major Projects and Digital Committee	• Approval of business cases with a maximum of £2m (capital) as specified in standing financial instructions • Ratification of contracts between £1.5m and £2m (revenue) • Approval of variations to contracts with a maximum of £2m (revenue)	Updates to the delegation to committees.

2.3 Role of the Chief Financial Officer	Amendment to add Chief Financial Officer must inform the LCFS if a referral is made directly to them.	Recommendation by LCFS
3.5 Fraud and Bribery	LCFS will also attend and present papers at the Audit Committee	Recommendation by LCFS

Meeting:	Public Trust Board
Date:	6 June 2024
Report title:	Summary of the People and Culture Committee (PCC) held on 7 March 2024
Executive Sponsor	Mark Gammage, interim CPO
Report Author	Nic De beer, committee secretary
Presented by	Laura Wade-Gery –Committee Chair
Status	Noting for assurance
Link to strategic objectives	Working Together - We will work together to ensure our workforce supports future care models and a consistently excellent patient and staff experience, in accordance with our values.

Summary of report

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

This report provides a brief summary of the meeting held on 7 March 2024.

Action Required/Recommendation.

The board is asked to note the report.

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

PEOPLE AND CULTURE COMMITTEE SUMMARY REPORT	
Governance	• Quorate – Yes
Current activity	**Workforce priorities and change projects (including programme updates)** • The committee received a progress report on workforce priorities and change projects. Updates to the Trust people strategy, priorities and deliverables were noted. • Since the external review of the function, the team had moved from a position where over 60% of the HR function was filled by temporary staff to a position where the substantive posts are now over 70% of positions, with a further 13 still vacant. This was excellent progress and will go a long way to stabilising the function and enabling it to make the agreed improvements to the function and its ability to support the organisation. • HR projects and priorities had been better aligned with the people deliverables, and were recently discussed at Manex to ensure they aligned fully to the business planning outputs moving forward. • 10 key projects had been identified going forward and would be monitored through XDU or locally led initiatives. • Significant progress had been made on the projects originally identified for 2023/24 and several XDU projects had been completed. • It was clarified at the meeting that the agile working project was within pillar 4 of the People Strategy 2023 – 2025 and that work was being done with XDU as it formed part of a wider project. The committee decided that as there were two parts to the project, one of which was workforce supported, there should be dual reporting to both the People and Culture Committee as well as Major Projects and Digital Committee. • The committee noted that on almost every metric over the last year there had been a significant improvement. • The committee noted that although our sickness and absence rate had remained above the Trust's target, a lot of work had gone into supporting managers with long term sickness cases. • Over the last 12 months, 20 long term sickness cases had been closed. • Employee relations cases year-to-date had reduced from 25 to 9. **Temporary staffing** • The committee took a deep dive into the position on temporary staffing. It acknowledged the NCL objective to reduce temporary staffing spend across the sector. • The Trust had established an agency spend steering group to help control and reduce agency spend and off framework usage. It was continuing to develop an appropriate wider plan to meet the new requirements of NHSE including updating current policy, creating a dashboard with the right data and a monthly report to Manex on non compliance. Strong management of the outsourced bank arrangements and review of opportunities to improve the bank service offering **Appraisal** • The committee noted the appraisal rate of 77%, which was not considered satisfactory. • A task and finish group had been set up and its recommendations were accepted by the committee. These included moving to a single electronic appraisal system later in the year, extending the training for those being appraised , and improving the ease of finding the right toolkits to support manager and appraisees, • The Committe asked for further work to enable the trust to move to have appraisals for everyone at the same time of the year rather than on employment anniversaies in order to align to organisational annual priorities and plans.

	Staff survey • The committee noted that the NHS national staff survey was based on seven 'people element themes' namely: that we are recognised, we are safe, we are healthy, we are learning, we are working flexibly, and we are a team, while also measuring engagement and overall morale. • While our response rate had risen 16 points to 66% (significantly higher than our comparators), we have a mixed picture for the actual results. For six areas, we've improved year on year; for two we've remained unchanged, and for 'we have a voice that counts', the Trust's score had deteriorated slightly. • It was noted that the Trust scored below average across all areas when measured against other specialist trusts but was about the same as the average of our NCL ICB peer group. • The plan is to focus on "We are compassionate and inclusive", "We each have a voice that counts" and "We are always learning". • An action plan was being implemented to improve on these metrics, and would be discussed further at Board. **FTSU Guardian** • The committee received a progress update on the implementation of the new FTSU model, which they noted. • A robust work plan had been created for the year which set out strategic objectives and key deliverables. **Risk register** The committee received and noted the latest risk register.
Key concerns	The Committee agreed to add risks related to Oriel and temporary staffing.
Date of the next meeting	The next meeting was schedule for August 2024.

Moorfields Eye Hospital NHS Foundation Trust

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QUALITY AND SAFETY COMMITTEE 14 May 2024
SUMMARY REPORT

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

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

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Quality and Safety Committee

Annual Report – 2023/24

Ros. Given-Wilson, Chair, Quality and Safety Committee

May 2024

Version: 1.0
Status: FINAL
Approved: 14/05/2024
Authors: David Flintham, Kylie Smith, and Ian Tombleson

Contents

Executive summary

Formed in 2011, the Quality and Safety Committee is a sub-committee of the Board. It has a broad assurance function and continues to use a variety of proportionate mechanisms to discharge its functions. The committee evolves and develops its functions to meet the demands of a changing landscape where Moorfields Eye Hospital (MEH) Foundation Trust grows in terms of activity and overall size. Amongst the key areas overseen by the committee during 2023/24 was the implementation of the Patient Safety Incident Response Framework (PSIRF).

This annual report demonstrates how, through constructive review and challenge, and evaluation of its performance, including this annual report, the committee is performing its functions well, and is meeting its Terms of Reference (ToR) to provide oversight, and support quality improvement and quality assurance across MEH.

This year also marked a milestone in the history of the committee with Ros Given-Wilson standing down after nearly eight years as the committee's chair. This annual report recognises the enormous effort, enthusiasm, and expertise that Ros has brought to the committee, and huge contribution that Ros has made to the development of quality and safety across the whole of the Trust.

1. Introduction

The Quality and Safety Committee ('the committee') is a standing committee of Moorfields' board of directors. Its purpose is to provide the board with a means of independent and objective review for the governance (oversight and scrutiny) of all aspects of quality and safety relating to patient care and patient experience. It also has oversight of the trust's research governance arrangements. This supports obtaining the best clinical outcomes and experiences for Moorfields' patients and recipients of services at all network sites. This annual report describes how the committee has complied with and satisfied the requirements of its ToR during the period 1 April 2023 to 31 March 2024, highlighting how it has responded to the changes brought by the continuing growth and complexity of the organisation.

2. Terms of Reference

The committee's ToR cover all areas of Moorfields' provision of care and services, NHS and commercial, at all network locations, both in the UK and United Arab Emirates (UAE) and also research governance. To ensure its functions are discharged effectively, the committee has an annual work plan, which is regularly reviewed to take account of changing priorities. Please refer to the ToR in Appendix 1, which were reviewed in May 2023. Appendix 2 illustrates the trust's committee structure, highlighting the relationship between the committee and other committees, including those reporting to the board, and the management executive.

During 2023/24, the committee met six times and reported progress on its work to the board via the committee's chair. Member attendance is summarised in Appendix 3. Through 2023-24, all the committee's meetings were held remotely, members attending from a variety of locations.

To further strengthen the committee's governance processes, a standard operating procedure for the administration of the committee was introduced in January 2024. This document can be viewed at https://eyeq.moorfields.nhs.uk/quality-and-compliance.

3. Topics of focus

During 2023/24, a wide range of topics were presented and discussed:

Meeting	Specific topic of focus
May 2023	Infection control Divisional Presentation – Moorfields UAE Patient Letters Theatres Health Inequalities
July 2023	Infection control Divisional Presentation – South Division

Meeting	Specific topic of focus
	Patient experience and engagement
September 2023	Infection control Patient Safety Incident Response Framework Divisional Presentation – Ophthalmology and Clinical Support Services Learning from Lucy Letby verdict
November 2023	Infection control Divisional Presentation – North Division Research & Development
January 2024	Infection control Divisional Presentation – City Road Division Patient Safety Incident Response Framework Learning Disability & Autism Training CITO
March 2024	Infection control Quality Account/Priorities Smoking Cessation Divisional Presentation – Moorfields Private Research Governance

4. Quality

4.1. Quality Account

The Quality Account is a mandated document which sets out how the trust continues to develop and implement the principles and objectives set out in its five-year strategy, emphasising that quality remains a strategic theme – providing patient-centred care with exceptional clinical outcomes and an excellent patient experience. The account provides both a review of the previous year and sets the quality priorities for the coming year.

As the development of the quality account cut across different financial years (development commences in November/December with final publication taking place the following June), this section outlines the development of the quality account for 2022-23 (published in June 2023 – section 4.1.1), as well as the development of the 2023-24 quality account (due to be published in June 2024) up to 31 March 2024 (section 4.1.2).

4.1.1. 2022-23 Quality Account (including quality priorities for 2023-24)

Development of the quality account for 2022-23 commenced at the end of December 2022 with the identification of quality themes (from which the quality priorities would be developed). This was followed by a process of consultation with various committees and groups (including Central Quality Forum, Sight Loss Awareness Group, AIS, Risk and Safety, and Clinical Governance Committees, SMT, and the Quality and Safety Committee). This

led to the development of the draft quality priorities which were presented to the committee at its meeting on 14 March 2023.

The committee received the draft quality account for 2022-23 including the quality priorities for 2023-24 at its meeting on 16 May 2023. The quality account was then presented to Trust Board (25 May 2023), as well as to - North Central London Clinical Commission Group, and Healthwatch Islington. The quality account was then approved by Trust Board on 22 June, and was published on 28 June.

4.1.2. 2023-24 Quality Account (including quality priorities for 2024-25)

Development of the quality account for 2023-24 commenced in September with the patient feedback received during Safer September. From this, during November 2023 a number of quality themes were identified, which was followed by consultation with various committees and groups (including Central Quality Forum, the Vision Loss Awareness Group, and CGC). As a development from previous years, the quality priorities have been integrated with central business planning process.

The quality priorities were agreed by CGC and ManEx in February 2024, and were presented to the committee at its meeting on 12 March 2024. At the time of writing (April 2024), work with the quality account itself is progress to schedule, and a draft of the quality account is due to be presented to the committee at its May meeting.

4.2. Quarterly quality & safety report

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

4.3. Quality Strategy and Quality Governance Framework

The Quality Governance Framework (QGF) is an important component of the Trust's quality improvement journey, setting out how quality governance (the framework for ensuring the delivery of safe, effective, and high-quality healthcare) is applied across services and divisions. It also details how quality is managed across the Moorfields network with its widespread geographical footprint. The QGF details guidance on how to deliver consistently high-quality care every day at every site.

4.4. Policy governance

The committee has oversight (the in the form of regular highlight reports) of the management and governance of all trust policies. As of 28 March 2024, 95% (203 out of a total of 214) of the Trust's policies were in date. The KPI target is 90%, and

during 2023/24 the monthly average achieved was 93% (this is the same average as it was for 2022/23).

4.5. Care Quality Commission (CQC) inspection

The trust is required to be registered with the CQC and is currently registered without conditions. The CQC has not taken any enforcement action against the trust in 2023/24, nor at any time previously.

The trust's most recent CQC inspection took place on 12 September 2023 when the CQC visited Moorfields Private Eye Centre (MPEC). The subsequent report (published: 17 November 2023) gave an overall rating of 'Good' was achieved with 'Good' across each of the five key questions.

5. Safety

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

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

Meeting	Incident investigation title
May 2023	• Treatment of a paediatric patient (August 2022) • Implantation of incorrect intraocular lenses (IOL) (two in November 2022, one in January 2023)
July 2023	• Patient death following cataract surgery
September 2023	• Never event – Wrong Intraocular lens • Allegation of abuse, City Road

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

Early in 2024, as part of the implementation the Patient Safety Incident Response Framework the weekly SI panels were changed to become the Incident Review Group (IRG).

5.2. Risk Management

The corporate risk register is presented to the Trust Board. Divisional risk management forms an integral part of the divisional annual presentations to the

committee. These presentations follow a pre-defined format and, in addition to divisional risks, also covers local issues and challenges, priorities for the year, sustainability of improvement, and what the division is proud of.

5.3. Claims management

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

6. Learning, improvement, and process monitoring

6.1. Quarterly quality & safety report

As set out under 4.2, the committee receives the quality and safety report quarterly. Learning and improvements against each quality item for all services/networks is included within the report.

6.2. Incident reporting

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

6.3. Claims management

As indicated in section 5.3 the number of CNST and LTPS claims remains low both in terms of actual numbers and when compared to other trusts. Although the analysis of claims has been enhanced by the annual production of clinical and non-clinical claims scorecards by NHS Resolution, this remains an area of learning in which we continue to develop and improve. Learning from claims is included in the quarterly quality and safety report. New claims are also reported as an incident, if not done previously, and discussed at the SI panel (now IRG) to ensure learning is shared across the organisation and improvements are made as quickly as possible where relevant. Legal Services regularly review cases for any additional learning to be shared.

6.4. CQC inspection

As described in section 4.5, the trust's CQC inspections have provided a good source of learning as the trust plans for future inspections.

6.5. Quality and Safety update

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

6.6. Committee governance

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

7. Conclusions and recommendations

The committee meets every two months and continuously considers the ways it prioritises and targets the focus of its activities. The terms of reference are due for their next review in May 2024. The committee works closely with other Board sub-committees, including the Audit and Risk Committee (A&RC) (the chair of the Q&SC committee is a member of the A&RC).

Due to timely availability of relevant data, the committee is appropriately informed of quality and safety performance and is able to support improvement actions and escalation processes to drive improvement. In so doing, it continues to strengthen its role in supporting the provision of board assurance about quality and safety. Thus, the committee continues to meet the requirements of its terms of reference.

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

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

It is recommended that this report is approved as a record of the committee's activities during 2023/24, demonstrating its adherence to its terms of reference.

Appendix 1 - Quality and Safety Committee - Terms of Reference (2023/24)

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

Assurance functions

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

Clinical effectiveness

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

Patient Safety

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

Patient participation and experience

- how the Trust is addressing the requirements of safeguarding for children and vulnerable adults
- patient participation activities
- environmental and other issues affecting patient experience

Overall

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

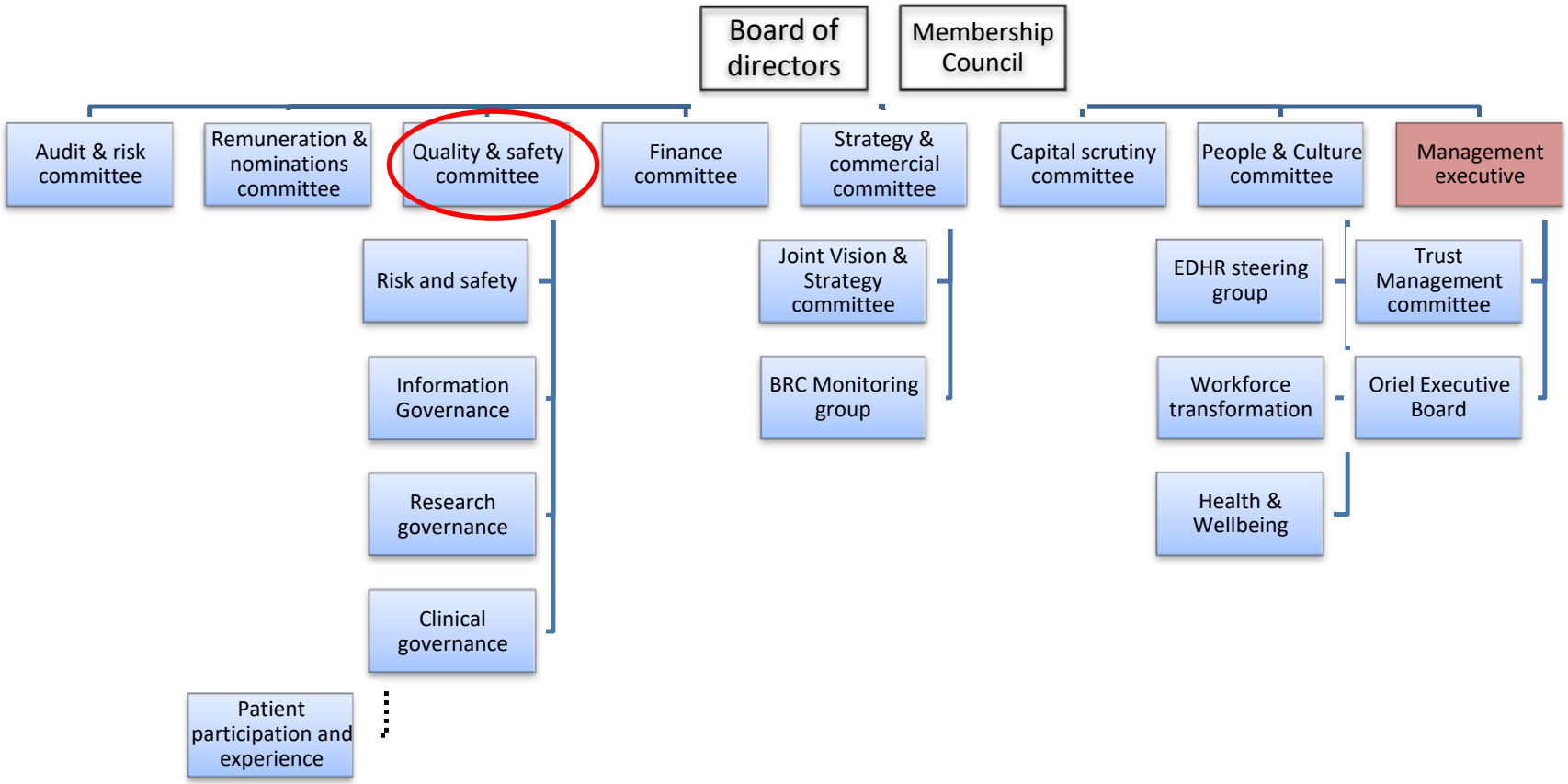
Other duties as agreed by the board

- oversight of quality and safety related aspects of research activity

Reporting and review	Following each meeting of the committee, an update will be provided to the board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination. Minutes of meetings will be available for any board member on request. The committee will carry out an annual review of its effectiveness against these terms of reference and this will be reported to the board via the committee's annual report, at the first available meeting after 1 April of each year.		
Sub-committees	There are no formal sub-committees of the committee but the outcomes of the following management groups will be reviewed on a regular basis to gain assurance • Clinical governance committee • Information governance committee • Risk and safety committee • Research and development quality review group		
Meeting administration	The executive lead for the quality and safety committee will be the director of quality and safety, and the secretary for the meeting will be the quality and compliance manager. The secretary's role will be to • Agree the agenda with the chair • Ensure compliance with the committee's *requirements for presenters* • Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board's standing orders • Maintain a forward plan of items for the committee • Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) • Ensure minutes are issued to the chair for review within one week of the meeting, and to committee members within two weeks of the meeting • Ensure actions are captured, notified to relevant staff and followed up Any other administrative arrangements not listed here will be as shown in the standing orders of the board of directors.		
Approved by the quality and safety committee			July 2023
Approved by the board	July 2023	**Date of next review**	2024

Appendix 2 - Organisational structure

The following diagram illustrates the trust's committee structure, highlighting the relationship between this and other committees, including those reporting to the board, and the management executive (June 2023 – updated April 2024: this diagram will be revised in May 2024).



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

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

Dates (►) **Members (▼)**	16.05.23	11.07.23	19.09.23	14.11.23	30.01.24	12.03.24	***Totals***
Ros Given-Wilson	Y	Y	Y	Y	Y	Y	*6*
Laura Wade-Gery	Y	N	Y	Y	Y	Y	*5*
Andrew Dick	Y	Y	Y	Y	Y	Y	*6*
Asif Bhatti	Y	Y	N	Y	Y	N	*4*
Martin Kuper	Y	N	Y	Y	Y	Y	*5*
Jon Spencer	Y	Y	N	N	Y	Y	*4*
Louisa Wickham	Y	Y	N	N	Y	Y	*4*
Sheila Adam	Y	Y	N	Y	Y	Y	*5*
Total attendance	*8*	*6*	*4*	*6*	*8*	*7*	

Appendix 4 – Summary of committee activity

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
16 May 2023

Committee Governance	• Quorate – Yes • Attendance (membership) – 100% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and issues raised	Presentation by Moorfields UAE: The committee received the annual presentation from Moorfields UAE which set out significant developments and changes, an incident reporting summary, surgical outcomes, and key achievements. Infection control update: Asymptomatic testing has been reduced with symptomatic testing remaining in place. The committee raised the following: • Long-term sickness rate is higher than before COVID. This is being monitored. • COVID vaccine project and the possibility of a risk-based approach before roll out. • Serious incidents: Four serious incident (SI) reports were presented. One concerned the delayed treatment of a paediatric patient (August 2022). The other three related to implantation of incorrect intraocular lenses (IOL) (two in November 2022, one in January 2023). The committee raised the following points: • The need for standardisation of biometry and related processes across the organisation. • The use of biometry safety summits, which also involved the equipment manufacture. • Learning as a result of this group of SIs (and others) that needs to be combined, embedded and monitored. • Delays to neurology cases and how this was reflected in the reported incident. Patient Letters: The committee received an update covering the relaunch of the patient participation committee (PPEC), the systemic review of patient letters, and other ways to improve the patient experience. The following issues were raised: • There is an XDU project underway which requires further resource. • Booking centre performance was outside the target for April but is on target for May. Theatres update: The committee received an update covering the surgical excellence transformation work, the establishment of the shared decision-making council, Freedom to Speak Up (including FTSU champions) and positive impacts to improve culture, and the new management team in theatres. The following issue was raised: • Requirement for a staff temperature check to ensure the necessary processes to engage with staff and to act on feedback and concerns is effective and monitored in the future.

	Health Inequalities: The committee received a presentation entitled *Making Better Use of Routine Health Data*. The presentation covered the background, drivers, aims and project framework with the 2020 cataract drive provided as a case study. The following considerations were raised: • It is important not to worsen inequalities (digital exclusion for example) whilst the use of digital technology is transformed. • Where and how data is used is very important and will become clearer as the project develops. • The project's roll in identifying and understanding DNAs (did not attends) and cancellation rates. Committee Governance: The committee received its annual report for 2022/23 and updated terms of reference for 2023/24. Attention was drawn to the forward plan in the annual report. The terms of reference will be signed off at the July meeting. Fire safety report: The numbers attending fire warden training is improving, and in parallel, work is on-going to ensure that fire wardens are available and deployed in the right place at the right time. Quality and Safety: The committee received the Q4 Q&S update, which included CQC registration (Stratford), policies and procedures, and the walkabout programme, which now includes NED participation. The Q4 quality and safety reports: trust wide Q4 quality and safety report, the Q4 report from Moorfields UAE, and the Moorfields private quality and safety report for Q3 and Q4. The draft quality account was also presented. The draft will go to May's trust board, and following any revisions, will be presented for final sign-off at June's board. • It was noted that PPEC had re-launched. Feedback from this committee forms part of the CGC summary report. Summary reports from committees: The committee received the summary reports from the meetings of the Risk and Safety Committee (15/03/2023), Research & Development Quality Review Group (20/03/2023), Information Governance Committee (28/03/2023), and the Clinical Governance Committee (24/04/2023).
Escalations	• IOL serious incidents: a focus on ensuring that learning is combined across all related SIs, is fully embedded, and there are ways to monitor to help prevent recurrence.
Date of next meeting	11 July 2023

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
11 July 2023

Committee Governance	• Quorate – Yes • Attendance (membership) – 75% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and issues raised	Committee Terms of Reference The committee's terms of reference for 2023/24 were approved. Infection control update The update focused on the continued roll-back of COVID-19 requirements (the rates are now in the green zone). The board assurance framework is being revised and will come to QSC in due course. Overall, it is business as usual for IPC. The following issue was raised: • There has been one reported case of endophthalmitis (the previous one was in October/November 2022). There was no evidence this was part of a wider pattern or trend. South Division Presentation The committee received an annual update from South Division. This focused on the services delivered from its sites, the top three achievements, its challenges, resolved and unresolved issues, and looking ahead, including the introduction of the Osteo-odonto-keratoprosthesis (OOKP) service. The following issues were raised: • Wayfinding at Croydon is a significant issue (highlighted by FFT comments) and the team was putting in plans to improve this. • Referral pathway communications was a significant factor in a recent incident (concerning a 48-hour wait by a patient). An after-action review of this incident was underway following consideration at the serious incident panel. • A review of the *Failsafe* processes, division-by-division. This will come back to the committee as a future full agenda item. Patient experience and engagement This presentation was in two sections: the first covered the Patient Experience and Customer Care team (including PALS, other comments, and complaints); the second part was about the development of the patient experience framework, including the patient experience principles, and how this is being implemented. There was a discussion about the level of formal complaints and whether they are higher or lower than might be expected. Numbers are likely to be influenced by overall access to the complaints process, which the team continue to work on. Formal complaints are likely to be reduced by an effective PALS service and the general (positive) trust policy to resolve complaints locally. Formal complaint numbers had been fairly consistent for a few years, although increased for a period following COVID-19. Annual Reports The committee received four annual reports: • Clinical Governance & Clinical Audit

	• Complaints • Resuscitation • Safeguarding Adults. It was noted that the complaints report had been included in the previous item, and there has been an annual update (March 2023 was the last) about clinical audit. The resuscitation, and safeguarding adults reports were presented. The following issues were raised from the annual reports: • Concerns were raised about the resourcing for the continuation of the Schwartz rounds which are known to be beneficial. This is being discussed by the Quality and Workforce teams. • The space available for the resuscitation team, particularly in relation to Oriel was raised. This is being discussed as part of preparing for Oriel. • It was noted that the safeguarding team had not been at its full complement since 2019; this has been resolved, although additional specialist training provision still needs addressing. Fire Safety This item focused on the review of the fire safety policy (and the transition to more localised processes), the recent fire safety audit (and the positive feedback from two satellite sites), and the project to improve the deployment of fire wardens. Serious Incidents (SIs) Current progress with two current SIs (incorrect IOL, Never Event, Ealing), and allegation of assault (City Road) were summarised, together with a Duty of Candour update. One SI report was presented (Patient death following cataract surgery); although the date for the inquest is still awaited, actions are being implemented where possible. Quality and Safety Included within the report was PSIRF (which will be an agenda item at the next meeting), and a patient experience update (already covered on the agenda). Other highlights for the period include clinical audit week, walkabouts (including a CQC-style mock inspection of MPEC), and the robust policy and procedural document process. The quality and safety report for Q1 was presented; along with the Q1 Q&S report from Moorfields UAE. Summary reports from committees The committee received summary reports from the following meetings: Risk and Safety Committee (meeting on 14/06/2023), Research & Development Quality Review Group (22/05/2023), Information Governance Committee (23/05/2023), and Clinical Governance Committee (12/06/2023). The following concern was raised: • The report from the Risk and Safety Committee highlighted racial abuse of staff by patients. This will be covered as part of a future QSC item.
Escalations	There were no escalations for Trust Board.
Date of next meeting	19 September 2023

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
19 September 2023

Committee Governance	• Quorate – Yes • Attendance (membership) – 50% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and issues raised	Infection control update The infection control annual report for 2022/23 was presented as was the regular infection control update. This focused on COVID symptom management, and also the commencement of COVID and flu vaccinations (commencing on 25 September and running until mid-December). The following issues were raised: • Staffing within the infection control team: nursing staffing has now returned to its full complement, but administration support is reliant on agency staff. • The committee recognised the challenges of the COVID and Flu vaccine roll-out, and that the figures for last year's uptake were higher for COVID than for flu. Serious Incidents (SIs) Current progress with serious incident (SI) investigations was summarised, together with a Duty of Candour update. Two SI reports were presented: an allegation of abuse and a Never Event (wrong Intraocular lens). Both were discussed in detail. An update on the recent IOL incidents (6 since August 2021), focused on the improvements being made. The following issues were raised: • The process for discussing the allegation of abuse incident with the staff took too long; improvement was required in the language used in the report to ensure that findings are expressed in plain language. • It was recognised that the dating of biometry results was an issue and is being addressed through improvements to IT systems and processes. Patient Safety Incident Response Framework This item provided an update regarding the implementation of PSIRF, with particular focus on the patient safety incident response plan, and policy. The development of the Incident Review Group (which replaces the existing SI panel) was also presented. The following issue was raised: • Engagement is key for the success of PSIRF, including the use of plain English (and not acronyms) in order for the PSIRF to be understood by all key stakeholders, including patients and staff. Learning from Lucy Letby verdict This paper outlined learning from the recent verdict from the Lucy Letby case. The paper covered PSIRF, Freedom to Speak Up (FTSU), medical examiner, paediatric early warning scores, and the fit and proper persons test. The following issue was raised: • There are concerns about generic employment references from other Trusts that provide limited background on staff; it was noted that the recruitment process is under review. Ophthalmology and Clinical Support Services Division Presentation

	The committee received an annual update from the Ophthalmology and Clinical Support Services Division. This included an introduction to the division, the City Road theatres leadership development programme, life sciences, improvements and opportunities, patient safety, and experience, the Ophthalmic Vision Science conference (March 2023). There were no issues raised, and the improvements in theatres was highlighted. The committee congratulated the division for their hard work and focus on improvement. Patient Transport update This highlighted that waiting times were coming down. The DHL contact is likely to be extended, whilst the patient eligibility criteria are being reviewed. Further discussion would be had outside the meeting about the contract going forward. Fire Safety The regular update was presented, and the following issue raised: • Attendance at fire warden training: although the training level had improved slightly, there are significant number of cancellations and non-attendance. The divisions are urged to encourage attendance and this would be raised at SMT. Quality and Safety The quality and safety update included the CQC registration of Stratford, and the good work in relation to the Trust's procedural documents. A CQC inspection of MPEC on 11 (on-line interviews) and 12 (on-site inspection) September was noted: formal feedback is awaited. The WHO audit report, and Q1 quality and safety report (Moorfields Private) were also presented. The following issue was raised: • The number of complaints and incidents reported at Moorfields Private (MP) appears relatively high. This will be reviewed by MP. Summary reports from committees The committee received summary reports from the following meetings: Research and Development Quality Review Group (10 July 2023), Clinical Governance Committee (14 August 2023), Information Governance Committee (25 July 2023). The following escalation was raised: • The CGC summary raised a concern related to outstanding DBS checks. Plans were being put in place to resolve this. An update on this will be provided at the next meeting.
Escalations	There were no escalations for the Trust Board.
Date of next meeting	14 November 2023

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
14 November 2023

Committee Governance	• Quorate – Yes • Attendance (membership) – 75% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and issues raised	Infection control update The regular infection control update was presented. This covered COVID-19, vaccination rates (COVID and Flu), Endophthalmitis, and the recent PLACE (Patient-led assessment of the care environment) inspections. The following issue was raised: • Nationwide, COVID and flu vaccine uptake is poor, with London having the lowest uptake. Whilst Moorfields is in the top five for uptake, only around 30% of staff have been vaccinated. Staff will continue to be encouraged to increase uptake. This is being escalated to Board. Safeguarding This covered DBS checks and the Childrens and Young Persons Safeguarding annual report. The DBS element focused mainly on enhanced DBS checks; the current backlog should be fully reduced by February 2024. There is an increase in both enquiries to the safeguarding team, and referrals to the local authority. The following issues were raised: • It was emphasized that all staff go through a DBS check, and the issues concern enhanced DBS checks. • The take up of safeguarding training (particularly amongst honorary and locum staff) is a concern and this is being investigated, and the necessary actions taken. Research Governance The committee received the annual report from the Clinical Research Facility (CRF). This included current activity, the NIHR/Department of Health reset programme, workflow management, and the governance of research. The following issues were raised: • What is the risk assessment process for drug trials; how does this differ from other (non-commercial) types of trials? • The recruitment of patients to trials. • Assurance of the governance processes particularly with the possibility of an MHRA inspection, including that staffing levels are adequate. This is being escalated to Board. North Division Presentation The presentation focused on recent successes, particularly Stratford and Bedford. The current objective of improving access to services was highlighted, as were recent innovations (such as the *Surgicube* at Stratford). Recent collaboration with neighbouring Trusts is also noteworthy. The following issues were raised: • Health and well-being. It was noted that the priorities for the coming year are particularly workforce focused. • The Potters Bar hospital environment was highlighted as needing improvement (architects are currently looking at the site).

	Failsafe The Failsafe project was introduced, including key definitions, its current approach, and the risks related to RTT patients, as well as follow-up patients, and high-risk patients. There is an outpatient waiting list project, and a failsafe policy is under development. The following issues were raised: • *OpenEyes* transition at Croydon (first) and Bedford. • The care coordination system with other Trusts (associated local data sharing issues were highlighted). • The development of a standard operating procedure (SOP) and the review of the current administration SOP handbook. Fire Safety The regular update was circulated and noted. Mention was made of the fire-risk associated with e-bike and e-scooter batteries. Two issues were raised: • Fire warden training: this should be brought to SMT again to be proactively managed. • The e-bike and e-scooter issue would be discussed in another meeting. Patient Transport update This highlighted the eligibility criteria, renewal of the current contract (likely to be extended), reduction in waiting times, and KPIs. A single issue was raised: • Whilst there has been a slight dip recently, performance trends are better and are a big improvement compared with this time last year. Serious Incidents There were no SI reports, and from the tracker, there were no concerns. There is one SI currently under investigation. Quality and Safety The Quality and Safety summary included Safer September, an update on PSIRF, and the 31 January 2024 deadline. The Q&S report for Q2 was summarised. There were two issues raised: • The current vacancy to the information security position which is being recruited to. • A legal claim in relation to a cataract procedure. Moorfields Private was congratulated on their recent CQC inspection at MPEC (Moorfields Private Eye Centre) and the result was anticipated to be a 'Good' rating when published by the CQC. Summary reports from committees The committee received summary reports from the following meetings: Research and Development Quality Review Group (18 September 2023), Clinical Governance Committee (09 October 2023) No issues were raised.
Escalations	There were two escalations for the Trust Board: • Increasing vaccination rates for COVID and Flu (both around 30%). • Research Governance processes: assurance of the processes, preparation for external inspection and that the staffing levels for this are adequate.
Date of next meeting	30 January 2024 (to be confirmed)

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
30 January 2024

Committee Governance	• Quorate – Yes • Attendance (membership) – 100% • Action completion status (due items) – 100% • Agenda completed – Yes • Author - David Flintham
Current activity and issues raised	Quality and Safety The Q&S update included the process for the quality priorities for 2024-25, policies and guidance, and a brief update on the new evolving CQC assessment process. It was noted that there is now a Standard Operating Procedure in place to support the administration and governance of the committee. Also included were the Q3 Q&S reports (Trust-wide, Private, UAE), and the Q3 WHO report. The following issues were raised: • The quality priorities will be presented at February's Clinical Governance Committee meeting and then recommendations made to Management Executive. • It was noted that the number of 28+ days incidents has increased. • The WHO audit results suggest that data analysis has been maximised; the next step is to generate further improvements based on the results. • The consistent improvement in the complaints and PALS service was noted. Summary reports from committees The committee received summary reports from the following meetings: Information Governance Committee (28 November 2023), Clinical Governance Committee (11 December 2023), Research and Development Quality Review Group (13 December 2023), Risk and Safety Committee (13 December 2023). Infection control update The regular infection control update was presented. This highlighted the increased number of measles cases. The Trust's response is currently being developed. The following issue was raised: • As a result of the increased number of measles cases and the possible impact on the Trust, it was agreed that this should be escalated to the Board. Serious Incidents (SI) The SI Tracker was presented (there were no SI reports). The following issue was raised: • It was noted that there was slippage in the timeliness of Duty of Candor. Patient Safety Incident Response Framework (PSIRF) Following its presentation to Board, QSC had been delegated authority to sign off the PSIRF (patient safety strategy) on its behalf. The PSIRF principles had been applied to several previous SIs to review its impact which had been a positive exercise. QSC approved the policy and plan. The following issues were raised: • It was recognised that PSIRF represents a significant cultural shift for both patients and staff.

	• Peer-review with other Trusts is important. Fire Safety The regular update was circulated and noted. The discussion focused on fire wardens and improving uptake in fire warden training. The fire safety policy, and the fire assembly point at City Road was also discussed. The following issue was raised: • Whilst fire warden training numbers have improved, non-attendance is still an issue. This will continue to be managed through the Fire Safety Committee. City Road Presentation The presentation included a review of the last 12 months, FFT and complaints, incidents, and future priorities. The following issues were raised: • The provision of accurate waiting time information to patients in clinics (up to date information on dry-wipe boards, is an on-going issue). • Patient transport. The perception is that this is improving due to the combined efforts of Moorfields and DHL but there is further work to be done. Learning Disability & Autism Training The committee received a paper discussing staff training to support patients with learning disabilities and autism. Currently, the Trust is in a good position with more than 90% trained; the new requirements include more engagement, and 1-day training for tier-2 staff (all patient-facing staff). The following issues were raised: • There is a new code of practice (yet to be finalised); Moorfields is ahead in implementing this. • Moorfields patients have particular needs, making implementation of the requirements more challenging. • Trust Board heard a recent patient story which highlighted the lack of a specialist role. CITO update This provided a summary of the on-going harm review, and how patients had been prioritised. The item also set out the process of moving away from CITO (internal referrals by February, and external referrals by May). Points to note were: • No patient harm had been found to date. • A methodology was not in place in 2022 to enable a move away from CITO to a new system. • CITO also provides a document management tool which, although more reliable, will be moved to OpenEyes. Any other business A recent internal audit report gave partial assurance against our safeguarding processes. From the audit, there were five medium level actions and three low level actions. QSC noted the action plan in place.
Escalations	There was one escalation to the Trust Board: • Noting there is an increase in measles cases and the Trust is responding (agenda item 03/24)
Date of next meeting	12 March 2024

QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
12 March 2024

Committee Governance	• Quorate – Yes • Attendance (membership) – 87.5% • Action completion status (due items) – 100% • Agenda completed – One item postponed to next meeting • Author - David Flintham
Current activity and issues raised	**Smoking Cessation** The committee received and discussed a paper about activity in relation to smoking cessation. This included staff training, national no smoking day, and the revised smoking policy. **Infection control update** The regular infection control update was presented. This focused on measles (particularly staff immunity status, and training), COVID and flu vaccination, hand and cleaning audits, and the recent PLACE reviews at City Road and St Ann's. **Serious Incidents (SI)** The regular SI Tracker (including Duty of Candour) was presented - there were no SI reports. There are three SI investigations in progress, and these are all on track. No issues were raised. **Quality and Safety** The quality and safety update included a discussion about the recent walkabout at Stratford which included Non-Executive Directors. The update also included the presentation of the Trust's quality priorities for 2024-25. There are eleven priorities which tie into the XDU programme. These have been devised with both patient and staff involvement. The following issues were raised: • Those suggestions which did not make it to the final list would be picked up by other workstreams. • Patient experience principles should not only be a priority in its own right, but a theme running through all the quality priorities. • The team would ensure good communication back to staff about how their involvement had helped shape the priorities. **Summary reports from committees** The committee received summary reports from the following meetings: Research and Development Quality Review Group (22 January 2024), Information Governance Committee (23 January 2024), and Clinical Governance Committee (12 February 2024). In respect of the IGC summary report, it was noted that the record retention period is now 30 years. **Fire Safety**

	The regular update was circulated, and the improved training position noted. There were no issues raised. **Moorfields Private Presentation** The presentation reviewed the last 12 months. This included incidents (and incident themes), issues and challenges, achievements, patient feedback, and future priorities. The success of the recent Moorfields Private Eye Centre (MPEC) CQC inspection to achieve a 'Good' rating was noted. The following issues were raised: • Consultant 'buy-in' with all the improvements being made. • The honorary contract process for MPEC staff which also enables NHS.net email addresses and accessing patient records. **Research Governance** The committee received a presentation about the mitigation of risk in clinical research trials. This covered both Moorfields-sponsored, and externally sponsored trials, risk assessments, and how trials were signed-off. The following issues were raised: • How the process links into the new technologies and procedures committee, and ethics approval. • How both the process and capability of any new procedure is signed off and ratified. • The composition of the research management committee. **Service level agreements (SLAs) / relations with host trusts** This item was postponed until the May meeting. **Any other business** Tributes were paid to Ros Given-Wilson who will be standing down as chair of the committee after nine years of service. Her leadership and enormous contribution to the committee, and quality and safety across the Trust were acknowledged.
Escalations	There were no escalations to the Trust Board.
Date of next meeting	14 May 2024

Appendix 5 - Quality and Safety Committee work plan 2023/24

Work-stream	May 2023	July 2023	September 2023	November 2023	January 2024	March 2024
Main Topic(s):	*UAE Division; Patient Letters; Theatres; Health Inequalities*	*South Division; Patient Experience*	*PSIRF; O&CSS Division; Learning from Lucy Letby verdict*	*North Division; Safeguarding; Research Governance; Failsafe; Patient Transport*	*City Road Division; PSIRF; Learning Disability & Autism Training; CITO*	*Moorfields Private; Research Governance*
Assurance and escalations from other committees	Yes	Yes	Yes	Yes	Yes	Yes
Quality and safety – matters arising	Yes	Yes	Yes	Yes	Yes	Yes
Quality, safety, compliance, and risk update	As required	As required	As required	As required	As required	As required
Quality, safety, compliance, external visits, and inspections	As required	As required	As required	As required	As required	As required
Reports (annual)	Yes	Yes	Yes	N/A	N/A	N/A
Reports (other)	Yes	Yes	Yes	Yes	Yes	Yes
Quality Priorities / Quality Account	Yes	N/A	N/A	N/A	Yes	Yes
Quality & Safety Quarterly Report	Yes	Yes	N/A	Yes	Yes	N/A
SI reports – status update and receipt of SI summaries	Yes	Yes	Yes	Yes	Yes	Yes
Key questions for next deep dive	Yes	Yes	Yes	Yes	Yes	Yes

Appendix 6 - Quality and Safety Committee forward work plan 2024/25

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

*Other possible topics include Anaesthesia, Theatres, Junior Doctors/Trust Fellows, Safety of artificial intelligence, and Clinical Audit

Moorfields Eye Hospital NHS Foundation Trust

Quality and safety committee - Terms of Reference

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

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

Assurance functions

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

Clinical effectiveness

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

Patient Safety

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

Patient participation and experience

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

Overall

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

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

Approved by the quality and safety committee			May 2024
Approved by the board		**Date of next review**	May 2025

Moorfields Eye Hospital NHS Foundation Trust

NHS

REGISTER OF INTERESTS APRIL 2024

(Board of Directors)

Name	Job Title	Interest declared
Laura Wade-Gery	Chair	Non-executive director, NHSE Chair, Snape Maltings Trading Limited, subsidiary of Britten Pears Arts Trustee, Britten Pears Arts Non-executive director, British Land plc Non-executive director, Legal & General Group plc Small direct shareholdings: • British Land, Marks & Spencer, Tesco
Martin Kuper	Chief executive	Director, Moorfields Private West End Ltd. Director, MEH Ventures LLP Trustee, Moorfields Eye Charity Director, UCL Health Alliance Ltd
Aaron Rajan	Non-executive director	Nothing to declare
Andrew Dick	Non-executive director	Director, Institute of Ophthalmology, UCL President, European Association of Vision and Eye Research Foundation Chair and Professor, Ophthalmology, University of Bristol Consultancy, 4DT Consultancy, Abbvie Consultancy, Novartis Consultancy, Roche Consultancy, Hubble Tx Consultancy, Affybody Co-founder, stock option, Cirrus Therapeutics
David Hills	Non-executive director	Director of programme delivery, University of Cambridge
Nick Hardie	Non-executive director	Director, Hammerson Pension Fund Trustees Limited Chair of trustees, Hammerson Group management Pension and Life Assurance Scheme Director, Frome Renewable Energy Community Ltd (FRECO)

Asif Bhatti	Non-executive director	Group Director of Risk and Audit, Compass Group PLC
Richard Holmes	Non-executive director	Non-executive director, Lok'n Store Group Plc Director, Moorfields Private West End Ltd Director, Schiehallion Shareholding in Lok n Store Deputy Director of Citizens Advice
Ros Given-Wilson	SID and Vice-Chair	Chair, UK Adult Reference Group of UK National screening Committee Member UKNSC Consultant Radiologist, St Georges University Hospitals NHS FT Trustee, United Learning Private Practice, Parkside Hospital, Wimbledon Chair, United Church Schools Trust Trustee Symposium Mammographicum
Adrian Morris	Non-executive director	Director, Tesco Stores Limited Director, Tesco Holdings Limited Director, Tesco Overseas Investments Limited Director, Tesco Services Limited Director, dunnhumby Limited Director, Tesco Personal Finance Group PLC Director, Tesco Personal Finance PLC Group General Counsel and member of executive committee, Tesco PLC
Jonathan Wilson	Chief financial officer	Director, Moorfields Private West End Ltd Member, Finance Committee of North Central London ICB Director, MEH Ventures Nominee LLP (Dormant) Director, MEH Ventures LLP
Louisa Wickham	Medical director	Private practice, Moorfields Private Trustee, Moorfields Eye Charity National Clinical Director for Eye Care, NHS England Talks remunerated at <£1.5k
Sheila Adam	Chief nurse and director of AHPs	Nothing to declare
Jon Spencer	Chief operating officer	Trustee, Friends of Moorfields
Non-voting directors		
Ian Tombleson	Director of quality & safety	Governor, Royal Alexandra and Albert School

Nick Roberts	Chief information officer	Nothing to declare
Mark Gammage	Interim Director of Workforce & OD	Managing Director, Dearden HR Managing Director, Dearden Interim Managing Director, Mark Gammage Ltd Non-executive Director, Kingsgate Consulting
Kieran McDaid	Director of estates, capital and MP	Nothing to declare
Mark Bounds	Interim private patient MD	Nothing to declare
Michèle Russell	Joint director of education	Joint Director of Education UCL/Moorfields Eye Hospital Honorary Professor of Clinical Education New York University and Newcastle University Chief Advisor - Ministry of Defence and Her Majesty's Government
Pete Thomas	Consultant Ophthalmologist Chief Clinical Information Officer	Consultant, Alcon Speaker, Pfizer, Novartis, Roche, Bayer, CooperVision, AOS, Thea. Clinical lead, National Eyecare Programme Member, OpenEyes Clinical Design Authority Shareholder, Microsoft Director, Thomas Medtech Advisory Ltd