Bundle Board of directors - Part 1 23 January 2024

1 Welcome
LWG - open meeting
240123 TB Part I Item 00 Agenda

2 09:00 - Staff story
MG - note

3 Apologies for absence
LWG - note

3 Declarations of interest
LWG - note

5 Minutes of the previous meeting
LWG - approve
240123 TB Part I Item 5 Draft Minutes Public

6 09:20 - Matters Arising
LWG - note
240123 TB Part I Item 06 - Actions log

7 09:25 - Chief Executive's Report
MK - note
240123 TB Part I Item 7 CEO report

8 09:35 - Integrated Performance Report
JS - note
240123 TB Part I Item 8 Integrated Performance Report (OPEN version)

9 09:45 - Finance Report
JW - note
240123 TB Part I Item 9a Public Finance Performance Board Report - Cover Sheet
240123 TB Part I Item 9b Public Finance Performance Board Report

10 09:55 - PSIRF policy and plan
SAd - approve
240123 TB Part I Item 10a Draft PSIRF policy and plan Trust Board cover sheet
240123 TB Part I Item 10b Draft Patient Safety Incident Response Policy
240123 TB Part I Item 10c Draft Patient Safety Incident Response Plan

11 10:05 - EPRR annual report
JS - note
240123 TB Part I Item 11 EPRR Assurance Results 2023
240123 TB Part I Item 11b Action Plan following 2023 EPRR Assurance Review

12 10:15 - Learning from deaths
LW - note
240123 TB Part I Item 12 Learning from deaths

13 10:20 - Committee reports
ARC (AB) - note
PCC (LWG) - note
240123 TB Part I Item 13 Report of the People and Culture Committee

14 10:25 - Identifying any risks from the agenda

15 Any other business

16 10:30 - Date of next meeting

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on
Tuesday 23rd January 2024 at 09.00
Education hub

No.	Item	Action	Paper	Lead	Mins
1.	Welcome	Note	Oral	LWG	20
2.	Staff story	Note	Oral	MG	
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.	PSIRF policy and plan	Approve	Enclosed	SAd	10
11.	EPRR annual report	Note	Enclosed	JS	10
12.	Learning form deaths	Assurance	Enclosed	LW	5
13.	Committee reports • Audit and Risk • People and Culture	 Assurance Assurance	 Verbal Enclosed	 AB LWG	5
14.	Identifying any risks from the agenda	Note	Oral	LWG	5
15.	Any other business		Oral	LWG	5
16.	Date of next meeting – 28 March 2024				

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
DRAFT Minutes of the meeting of the Board of Director held in public on 23 November 2023 in Education Hub (and via MS Teams)

Board members:	Laura Wade-Gery (LWG)	Chair
	Martin Kuper (MK)	Chief executive
	Andrew Dick (AD)	Non-executive director (via MS Teams)
	Nick Hardie (NH)	Non-executive director
	Richard Holmes (RH)	Non-executive director
	Adrian Morris (AM)	Non-executive director
	David Hills (DH)	Non-executive director
	Rosalind Given-Wilson (RGW)	Non-executive director
	Sheila Adam (SAd)	Chief nurse and director of AHPs
	Louisa Wickham (LW)	Medical director
	Jonathan Wilson (JW)	Chief financial officer
	Jon Spencer (JS)	Chief operating officer (via MS Teams)
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.

1. Welcome

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

2. Patient story

The chair welcomed Bola, who provided the patient story on behalf of her son, as a patient of the Trust, and herself as a parent and his carer.

It was noted that Bola's son (S) had severe learning difficulties with autism. Having vision problems only exacerbated the challenges of autism, so support from the Trust team was invaluable. Overall, the care from the Trust had been excellent and had enabled S to continue to live as independently as possible, recently starting work.

Regrettably, at a recent attendance for a procedure there was a miscommunication of the plan during the anaesthetic procedure and Bola was asked to leave the theatre before the anaesthetic had taken effect. This was not what was planned and caused both of them some distress.

The initial assessment and formulating of the plan had been positive, although some information for what to expect had not been communicated, which added some distress. It was thought that time and clinic list pressures had meant that the clinical team lost track of the reasonable adjustments that had previously been agreed. The operation could not take place as a result and time was needed to prepare for a future attempt.

The next attempt was more positive as they knew what to expect and could prepare better. The surgery was positive and when S awoke after the procedure, he was anxious and his mother was able to attend to help him calm himself. Post recovery was good and unfolded as expected.

The Board discussed the experience and in response to questions, it was noted that there had been a communication breakdown at points in the treatment, and relevant information had not followed the patient across Trust campuses. Bola added that the materials, particularly use of picture books, were good, however they needed to be available. SAd noted a challenge that the Trust did not have specialised environment for vulnerable patients, however the staff were usually able to make reasonable adjustments that helped the patient.

In concluding the item, the chair thanked Bola on behalf of the Board for her telling her story.

3. Apologies for absence

An apology was received from Asif Bhatti.

4. Declaration of interest

There were no declarations made.

5. Minutes of the previous meeting

The minutes of the meeting held 28th September 2023 were approved as a correct record.

6. Matters arising and action log

The action log and updates were noted.

7. Chief executive's report

MK highlighted key areas of his report, which were:

The Trust performance and finances overall were reasonably good in a context of many trusts being under great challenges at present. The industrial action taken my medical staff and the delayed opening of the surgical floor of the Trust's ophthalmology centre in Stratford, had impacted the Trust's ability to deliver its outpatient 1st and elective activity targets.

The Trust had reached a provisional agreement to receive ophthalmology calls from the 111 service for ICBs other than NCL, and was focussing on rolling this offer out to NEL and NWL.

The Trust was progressing well in the number of responses to the NHS national staff survey, and currently had recorded under 60% of staff that had completed the survey; this compared positively with a 31% response rate at a similar point in the survey window in 2022. The survey was open until Friday 24 November, and the Trust was undertaking actions to increase participation for colleagues.

MK noted that EDI issues were separate items on the agenda and would be covered in detail then.

The excellence program was progressing and achieving well. Victoria Moore had recently been appointed as MK's chief of staff and would continue to oversee the excellence programme.

In response to a question, MK reported that the Trust was testing open plan working at the Trust Education Hub in preparation for how Trust staff would work in Oriel. There was more to be done in regard to planning and preparing for open working, and the Trust would need to support staff into a new way of working.

The Board noted the report.

8. WRES / WDES report

MK introduced the report, and assured the Board that the Trust had been undertaking much activity in relation to equality, diversity and inclusion well before the recent tribunal hearing outcome.

MG continued the report introduction. It was noted that ongoing work was underway to achieve improvements, and that there had been some progress to date. Some challenges included that current diverse representation across the Trust was not optimal, instances of bullying and harassment were too high, and that staff with a protected characteristic had fewer positive experiences working in the Trust.

The Trust networks were well engaged and progressing work in their areas. Funding for the networks was now in the budgets of the respective lead executives. This allows them to use funds allocated for the networks without having to complete a separate financial process. This had made the management of the networks and achieving their goals much more efficient.

MG added that the NHSE national plan actions would be worked through by the Trust, however much of what was required had already be completed by the Trust in its own action plan.

It was noted that Board members would need to have an EDI objective. In response to a question from AM, MG stated that work was underway to achieve better appraisal rates. Leadership and management skills were being developed throughout the Trust with EDI aspects included. It was added that a consistent approach was needed across the Trust and that any progress needed to be measurable.

In response to points regarding the gender pay gap, it was noted that much of the pay awards were set nationally, which helped set expectation, however there was an imbalance with clinical excellence awards (CEA), which needed addressing by the Trust. Some initial ideas were shared, however more work was needed to achieve improvements in this area.

The Board noted the reports.

9. EDI annual report

The item had been taken in conjunction with item 8.

The Board noted the report.

10. Patient and staff story six-month review

SAd presented the report.

The Board noted the four stories that had been presented in the period. There was a rolling programme of work from issues raised in the stories and where appropriate immediate responses were made to the patient or staff member.

Actions from the stories were overseen by the divisional performance reviews. These would be included into the patient experience programme and aligned with the patient priorities in the Quality Account.

The Board discussed how best the Trust could use this feedback and considered examples from other industries. Metrics, particularly related to ‘kindness’, needed further development, and breaking

down to departments and teams within the Trust. It was suggested that improvement work in the Trust have more alignment with patient experience. It was agreed that the staff and patient stories would be reviewed at periods throughout the year **(action SAd&MG)** and that follow up with patients who present to the Board be conducted **(action SAd&MG)**.

The Board noted the report.

11. Freedom to speak up report

SAd presented the report.

The Board noted the report and that more detailed discussions would occur in private. It was hoped that the anonymous speak up platform would go live in January 2024. Unfortunately, the Trust had been unable to appoint a lead guardian in its recent attempt, however interviews of a new cohort of shortlisted candidates would take place in December 2023.

October was FTSU month nationally and this went well across Moorfields raising the profile of FTSU, with good promotion across the organisation. There were 13 site visits across the network and the Guardians spoke to approximately 500 members of staff.

MK added that training on how to use the new anonymous reporting system being adopted by the Trust was underway and would continue.

The Board noted the report.

12. Integrated performance report

JS presented the report.

It was noted that the Trust had made some changes to the report format from feedback from the governors. In particular page 4 provided a more approachable snapshot with a smaller range used, and text highlighting issues rather than graphs and tables.

The continued industrial action in the NHS had some effect on Stratford at the start of the month, however this was now green rated. The Trust's performance against the 52 Week RTT target continued to cause common cause variation, which was unlikely to achieve the target. The service had put a recovery plan in place.

Although performance against the 2-week wait cancer standard was now classified as showing special cause concern, the Trust had met the standard for several months in a row and the reduction this month was due to a single patient waiting longer than the required standard.

The number of non-medical cancelled operations not treated within 28 days continued to show common cause variation which may not meet the anticipated standard. This month the Trust had three breaches which were due to the ability to contact one of the patients and capacity constraints for the other two.

It was thought that the actions in place to reduce staff sickness was the right approach, however to achieve improvements of appraisals, it would likely benefit from a task and finish group. The call centre had maintained its good performance. In response to a question from RGW, JS reported that the call centre performance improved from a combination of call monitoring and good local leadership.

In response to a question, JS advised the Board that the NPSA incident was most likely a one-off and there were no particular lessons from it.

The Board noted the report.

13. Finance report

JW presented the report.

It was noted that the ERF income for months 1-6 had been confirmed. The Trust continued to achieve its stretch target for activity of 121%. Debts over 128 days had reduced. JW stated he was confident the Trust would achieve the financial plan at year-end.

The Trust has a £2.5m surplus year-to-date compared to a planned deficit of £0.64m. The trust was reporting a full year forecast of a £3.40m surplus in line with the plan. Capital expenditure as at 31st October was £23.9m predominantly due to Oriel, IT prior year committed expenditure, Stratford and Brent Cross against Trust funded allocations.

NH raised agency spend as a disappointing result. JW explained that the rate had increased from 2019/20, however work was needed to understand the current drivers which were different to those before the Covid-19 pandemic. It was expected that the Trust would break its agency cap this year. MK added that there was likely an influence of increased activity as well as increased work in the corporate areas of the Trust, done at pace.

The Board noted the report.

14. Learning from deaths report

LW presented the report.

It was noted that there had been minor criticism by the coroner regarding the tardy response in submitting statements relating to a death of a child at St George's Hospital. This involved a person who was not a member of Trust staff, which proved difficult to manage. The Board noted the details of the sad case of a child death. It was pointed out that subsequent to the incident, the communications between St George's and the Trust had been challenging and the Trust did not have the opportunity to contribute to the lessons learned process.

In response to a question by RGW, LW confirmed that the St George's SI report would be presented at the Trust's Quality and Safety Committee. SAd advised the Board that she would be meeting with the chief nurse from St George's soon. MK added that recognising deterioration was an important goal across the NHS.

15. Guardian of safe working

The paper was taken as read and noted.

LW highlighted the successful onboarding of trainees. The Board recognised the very good results demonstrated by the report.

16. Committee reports

a. Quality and Safey Committee

The paper was taken as read and noted.

RGW escalated the issues of vaccination update at the Trust, which was currently only 30%; and research governance processes related to assurance of the processes, preparation for external inspection and that the staffing levels for this are adequate. The Board noted the escalations.

b. Audit and Risk Committee

The paper was taken as read and noted.

The Board agreed to renew the existing terms of reference for the Quality and Safey Committee and Audit and Risk Committee and noted that they would be reviewed in full and presented again for approval in May 2024.

17. Identifying any risks from the agenda

The Board noted potential risks raised from the learning from deaths item, including communications between trusts and recognising deteriorating patients.

18. Any other business

19. Date of next meeting

It was noted that the next meeting of the Board would take place on 23rd January 2023.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

28th September 2023

No.	Date	Minute	Item	Action	By	Update	Open/ closed
1.	23/11/23	10.0	Patient and staff story six-month review	Ensure that patient and staff stories are reviewed periodically throughout the year	SAr/SAd/MG	Item added as biannual report.	Suggest to close
2.	23/11/23	10.0	Patient and staff story six-month review	Ensure follow up with patients who present to Board is conducted	SAd	Follow up has been conduced in the past and is now part of the process	Suggest to close

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
- Urgent care update
- Sector update
- Oriel update
- 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 – 23rd January 2024

Chief Executive's report

Performance and activity review

In December, the Trust met both the elective and outpatient 1st activity targets for the month. This improvement in performance was due to a combination of us starting to make better use of the new capacity which is available at our new Stratford site and being able to mitigate the impact of ongoing strike action.

The number of patients waiting over 52 weeks for their treatment has risen to 21, primarily due to a number of patients being identified within a recent validation exercise of our CITO system. The majority of these patients have been offered appointments in December / January and will be prioritised to receive their treatment over the coming weeks.

Urgent care update

The Trust has begun triaging and managing 111 calls received from patients in North West and North East London and this process is working well. We are exploring a further roll out of this service in the South West London ICB in the near future, however this requires some workforce modifications to be implemented before it can proceed.

Sector update

The Trust's Telemedicine Support Unit continues to progress well in both North Central London, where as at 2nd 2023 December we had processed 5,522 referrals, and in North East London, where we had supported 834 referrals.

We have an active innovation programme that is enhancing the service that we are providing as well as delivering quality and efficiency improvements to the referrals which we receive.

Discussions are ongoing with SWL and NWL commissioners to confirm when they would like us to roll the service out in to their respective ICBs.

As anticipated, NCL have issued a tender to appoint a provider to run a single point of access and to coordinate community optometry provision across the region. The Trust intends to bid for this contract and has therefore put together a team to coordinate this bid.

The building programme for the new diagnostic facility at Brent Cross is currently one week behind schedule, due an unavoidable delay, which was caused by additional asbestos being located. As planned, we vacated our previous facility in the shopping centre in November. In advance of the new unit opening in February, we are now working hard to offer patients options to receive their diagnosis at alternative sites around the MEH network.

Oriel

The Oriel construction programme completed the deep basement excavation on 14th November 2023 and is now focussed on the sub structure works.

The RIBA stage 4 detailed design continues to be developed in line with the BYUK programme schedule. The majority of the design has been frozen so that it can be approved through a process which will begin shortly but take several weeks to complete.

A final design workshop took place at the end of November and the focus has now switched to the three-day showcase exhibition which is being planned to run from 5th to 7th March 2024.

Excellence Portfolio

Support has been secured for the portfolio under the invest to save scheme launched in December 2023. The focus is on the following type 1 projects with 'Agile Working', 'Equality, Diversity & Inclusion', 'Commercialisation Framework' and 'CITO to ERS' all onboarding consultancy support from week commencing 8th January 2024. Support for 'Accessible Information Standard' is also in procurement. Additionally, 'Sustainability' is also receiving support with a particular emphasis on developing a paperless roadmap.

The first proactive type 1 project healthcheck has reported through Develop and Deliver Excellence Programme Board in December 2023. Five further healthchecks have been undertaken and will be reported through the January 2024 Excellence Programme Boards. All type 1 projects will have had a healthcheck during 2023/24. Early lessons learnt include the need to include all stakeholders at the scoping phase of a project, sustainability planning and use of the reporting tools to highlight risks and issues to boards for support.

Planning for the 2024/25 Excellence Portfolio has been developing as a gateway in the wider business planning process. The future eye care pathway has been shared with clinical and corporate business planning leads to inform strategic priorities and projects

for the coming year. In addition, work has started to identify projects aligned to Oriel objectives to inform 2024/25 plans.

The Excellence Delivery Unit have recruited an Excellence Delivery Manager and Head of Excellence Delivery, both due to start in Q4. One post is due to turnover in the team and the other reflects the addition of the Chief of Staff function to the Excellence Delivery team.

Resource to refine the approach to project assurance with support from our audit partners RSM has also been approved through the invest to save scheme. The aim is to support the XDU and Programme Board SROs to develop tools to assure projects against the agreed lifecycle in a standardised way.

December Finance Performance

The Trust is reporting a £0.30m deficit in December, £2.35m favourable to plan, with a cumulative surplus of £6.08m, £6.77m favourable to plan. Patient activity during December was 106% for Elective, 125% on Outpatient First, and 124% against Outpatient Procedures activity respectively against the equivalent month in 2019/20, with the trust exceeding the 121% weighted financial value plan.

The Trust cash position was £43.3m, equivalent to 60 days of operating cash as substantial capital payments into Oriel were made. Capital expenditure is £35.4m cumulatively, £12.4m behind plan, with the variance largely in relation to Oriel. Efficiencies were £0.65m in December, breakeven to plan in-month, with an adverse cumulative variance of £1.42m. The forecast outturn for the year is achieved efficiencies of £7.81m, equating to plan.

Martin Kuper
Chief Exec

Integrated Performance Report
Reporting Period - December 2023

Brief Summary of Report

The Integrated Performance Report highlights a series of metrics regarded as Key Indicators of Trust Performance and cover a variety of organisational activities within Operations, Quality and Safety, Workforce, Finance, Research, Commercial and Private Patients. The report uses a number of mechanisms to put performance into context, showing achievement against target, in comparison to previous periods and as a trend. The report also identifies additional information and Remedial Action Plans for KPIs falling short of target and requiring improvement.

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

Performance & Information
Delivering quality data to empower the trust

Skills Development Network
Excellence in Informatics
Level 1

Introduction to 'SPC' and Making Data Count

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

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

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

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

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

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

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

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

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

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

Guide to this Report

Name of the lead responsible for the metric

Why this metric is being reported

The national or local target performance is being measured against

Performance for the most recent period

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

Name of metric/KPI

How often and timing of the reporting of this metric

Performance for the financial year (Apr-Mar)

These are the Variance and Assurance Icons

KPI/Metric Name

Upper/lower Limit

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

Improving Special Cause *

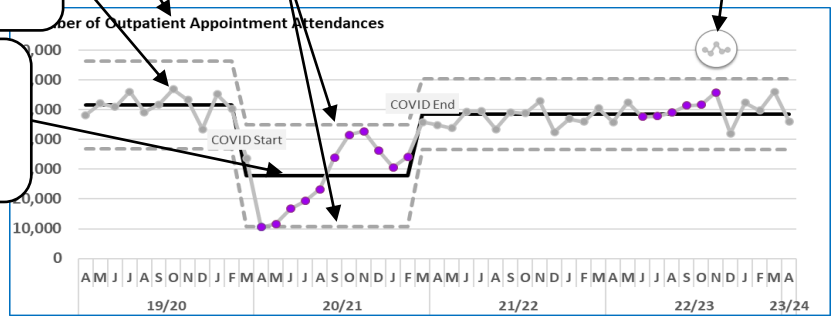
Summary Icons *

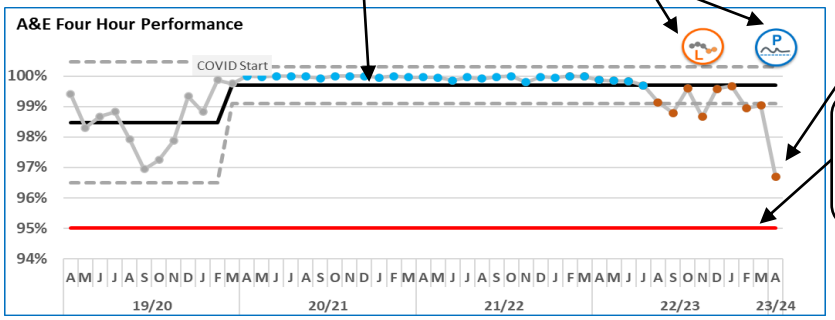
Concerning Special Cause *

Common Cause Variation *

Mean
Average performance for the period

Local or national target





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

Highlights

Metrics With "Failing Process"

- 52 Week RTT Incomplete Breaches
- Number of non-medical cancelled operations not treated within 28 days
- Freedom of Information Requests Responded to Within 20 Days
- Appraisal Compliance
- Information Governance Training Compliance
- Staff Sickness (Monthly & Rolling Annual Figure)

Celebrations

- 22 Metrics are showing as a capable process, all which are showing either an improving or stable performance, this includes:
  - A&E Four Hour Performance
  - Posterior Capsular Rupture rates
  - All FFT Performance Targets
  - Complaints Performance
  - Infection Control Metrics
  - All Research Metrics
- A further six metrics are showing an improving position

Other Metrics showing "Special Cause Concern"

- No other metrics in December 2023 showing concern

Other Areas To Note

- All Activity vs Phased Plan metrics met their respective targets this month
- Percentage of Diagnostic waiting times less than 6 weeks did not achieve target due to a number of patient choice breaches, and not considered as a concern
- The number of RTT Incomplete Pathways Over 18 Weeks continues to show a decreasing trend

Executive Summary

In December, despite ongoing industrial action being taken by our junior medical staff, the Trust managed to exceed both the elective and outpatient 1st activity targets for the month (102.5% and 119% respectively). The 119% outpatient 1st activity achievement in month appears to be artificially high due the method used to phase activity over the financial year and we may therefore see a level of underperformance in a future month. At present we are comfortably meeting the outpatient first target for the year to date (103.5%) and have improved the elective year to date position to 98.2%.

As indicated in the previous IPR, the Trust's performance against the 52 Week RTT target has worsened significantly from 7 patients to 20 as a result of a validation process which has been undertaken recently. Additional capacity has being created in January, to be able to treat these patients as quickly as possible and we anticipate seeing a significant improvement against this standard by next month.

The number of non-medical cancelled operations not treated within 28 days continues to be a failing process as the trust has yet to avoid a monthly breach for a prolonged period, with December seeing one breach of the standard. Work is ongoing between our operational and performance teams to improve the visibility of patients who are at risk of breaching this standard so that they can be prioritised to be rebooked for their treatment.

Performance against the diagnostic waiting times standard has dropped below the 99% target for the first time since January 2023, predominately due to 3 patients choosing to wait longer than the 6 week standard for their diagnosis.

The Trust's process to respond to freedom of information requests within 20 days is showing special cause concern. This is due to a combination of a rise in the number of requests being made and local sickness absence with the team who coordinate the responses.

Performance against the appraisal standard has improved for a second month in a row to move the Trust's performance to 76.4%. The previously reported Task and Finish Group has now begun meeting to target actions which will improve this performance further.

Staff sickness levels improved in month to 4.5% against a 4% standard. Although this metric is now showing common cause variation, which is unlikely to achieve the target, a number of actions continue to be taken to improve this position including targeted training for line managers and regular review meetings to discuss how best to support members of staff back to work.

Performance Overview

December 2023		Assurance			
		Capable Process	Hit and Miss	Failing Process	No Target
Variation	Special Cause - Improvement	- Total Outpatient FlwUp Activity (% Plan) - Average Call Abandonment Rate - FFT Paediatric Scores (% Positive) - % Complaints Responses Within 25 days - Serious Incidents open after 60 days	- Total Outpatient Activity (% Plan) - Outpatient First Activity (% Plan) - Average Call Waiting Time - Overall financial performance	-	- 18 Week RTT Incomplete Performance - OP Journey Times - Diagnostic FtF
	Common Cause	- Cancer 28 Day Faster Diagnosis Standard - A&E Four Hour Performance - Mixed Sex Accommodation Breaches - VTE Risk Assessment - Posterior Capsular Rupture rates - MRSA Bacteraemias Cases - Clostridium Difficile Cases - E. Coli Cases - MSSA Rate - cases - FFT Inpatient Scores (% Positive) - FFT A&E Scores (% Positive) - FFT Outpatient Scores (% Positive) - % Complaints Acknowledged Within 3 days - Summary Hospital Mortality Indicator - Recruitment to NIHR portfolio studies - Active Commercial Studies - % of patients in research studies	* See Next Page	- 52 Week RTT Incomplete Breaches - Non-medical cancelled 28 day breaches - Appraisal Compliance - IG Training Compliance - Staff Sickness (Month Figure)	* See Next Page
	Special Cause- Concern	-	-	- % FoI Requests within 20 Days - Staff Sickness (Rolling Annual Figure)	-
	Special Cause - Increasing Trending	-			
	Special Cause - Decreasing Trending	- RTT Incomplete Pathways Over 18 Weeks			

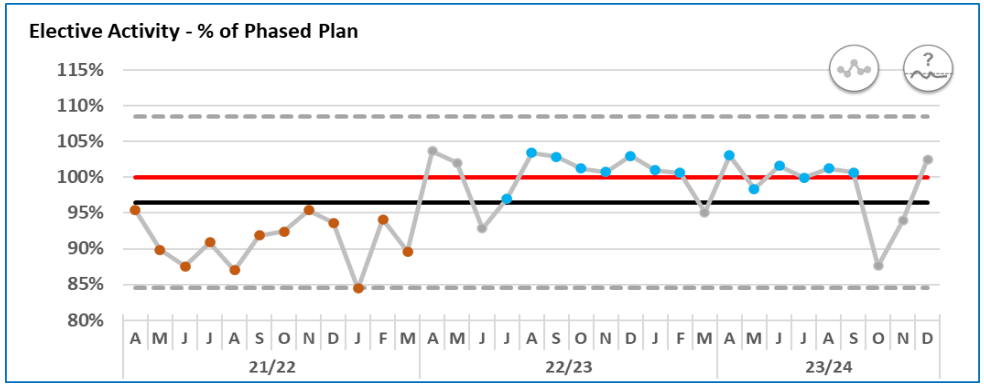
Performance Overview

Common Cause & Hit and Miss	Common Cause (No Target)
- Elective Activity - % of Phased Plan	- Number of Incidents open after 28 days
- % Cancer 2 Week Waits	- OP Journey Times - Non-Diagnostic FtF
- % Cancer 14 Day Target	- Proportion of Temporary Staff
- % Diagnostic waiting times less than 6w	- No. of A&E Arrivals
- Emergency readmissions in 28d (ex. VR)	- No. of A&E Four Hour Breaches
- % SARs Requests within 28 Days	- No. of Outpatient Attendances
- Occurrence of any Never events	- No. of Outpatient First Attendances
- NatPSAs breached	- No. of Outpatient Flw Up Attendances
- Theatre Cancellation Rate (Non-Medical)	- No. of Referrals Received
- Commercial Trading Unit Position	- No. of Theatre Admissions
	- No. of Theatre Elective Day Admissions
	- No. of Theatre Elective Inpatient Adm.
	- No. of Theatre Emergency Admissions

Deliver (Activity vs Plan) - Summary

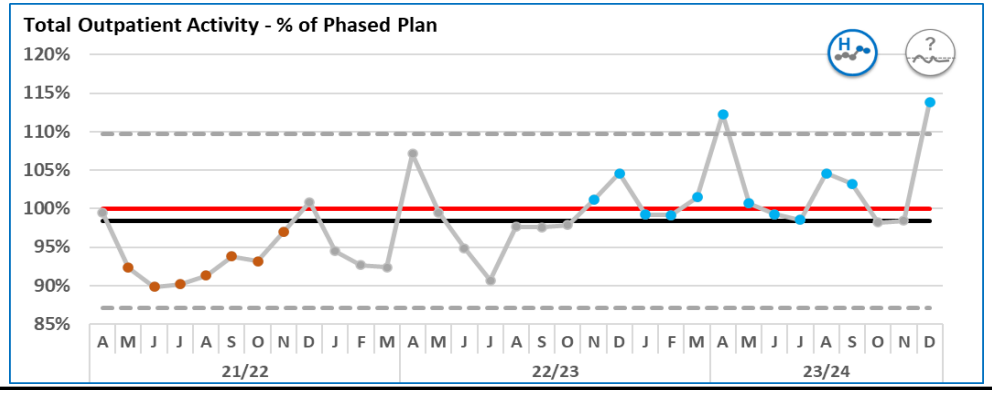
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Elective Activity - % of Phased Plan	Jon Spencer	23/24 Planning Guidance	Monthly	≥100%	98.2%	102.5%		
Total Outpatient Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	102.5%	113.8%		
Outpatient First Appointment Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	103.5%	119.0%		
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jon Spencer	23/24 Planning Guidance	Monthly	≥85%	102.3%	112.3%		

Deliver (Activity vs Plan) - Graphs (1)



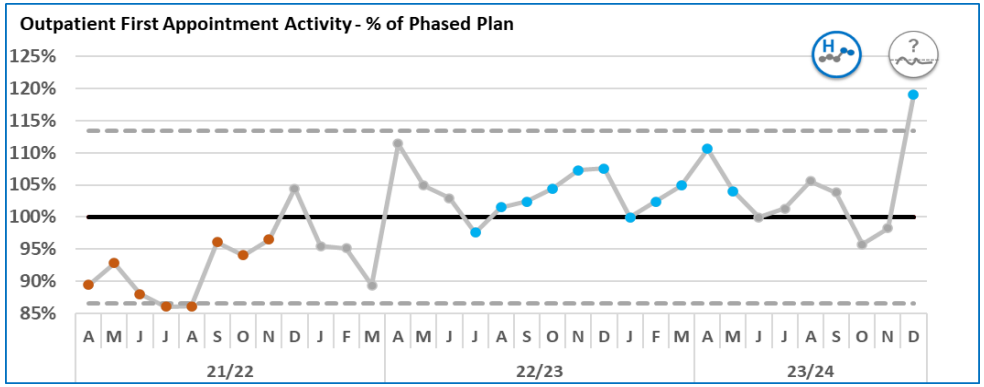
Elective Activity - % of Phased Plan

This metric is showing common cause variation and that the current process may not meet the target consistently



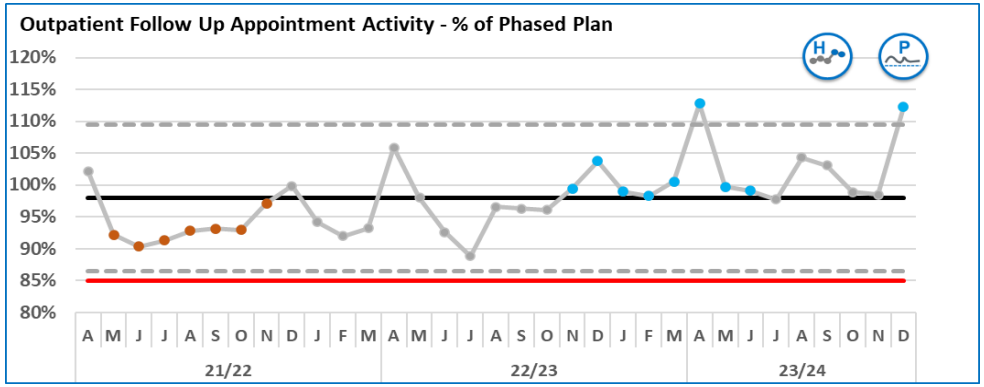
Total Outpatient Activity - % of Phased Plan

This metric is showing special cause improvement and that the current process may not meet the target consistently



Outpatient First Appointment Activity - % of Phased Plan

This metric is showing special cause improvement and that the current process may not meet the target consistently - This is a change from the previous month



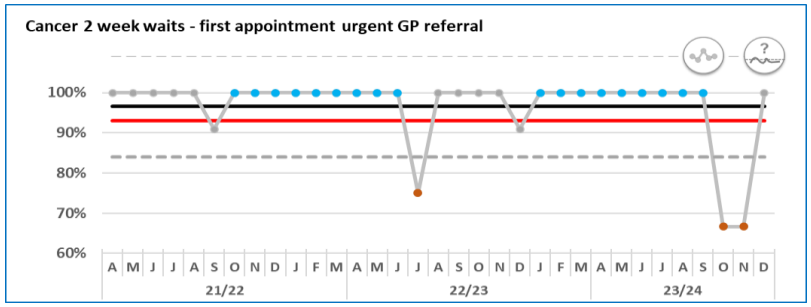
Outpatient Follow Up Appointment Activity - % of Phased Plan

This metric is showing special cause improvement and that the current process will consistently pass the target

Deliver (Access Performance) - Summary

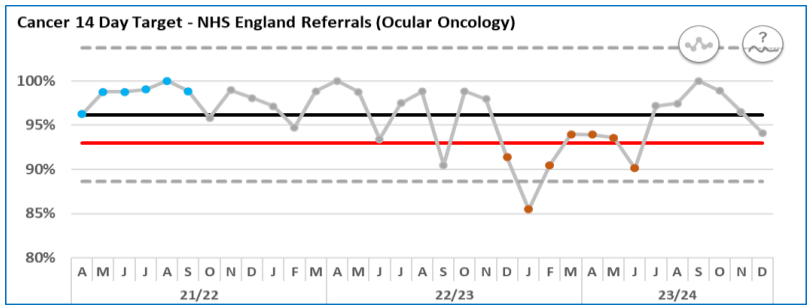
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 2 week waits - first appointment urgent GP referral	Jon Spencer	Statutory Reporting	Monthly	≥93%	94.3%	100.0%		
Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	Jon Spencer	Statutory Reporting	Monthly	≥93%	95.8%	94.1%		
Cancer 31 day waits - Decision to Treat to First Definitive Treatment	Jon Spencer	Statutory Reporting	Monthly	≥96%	100.0%	n/a		
Cancer 31 day waits - Decision to Treat to Subsequent Treatment	Jon Spencer	Statutory Reporting	Monthly	≥94%	100.0%	n/a		
Cancer 62 days from Urgent GP Referral to First Definitive Treatment	Jon Spencer	23/24 Planning Guidance	Monthly	≥85%	100.0%	n/a		
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	23/24 Planning Guidance	Monthly	≥75%	97.0%	100.0%		
18 Week RTT Incomplete Performance	Jon Spencer	Statutory Reporting	Monthly	No Target Set	81.8%	82.5%		
RTT Incomplete Pathways Over 18 Weeks	Jon Spencer	Internal Requirement	Monthly	≤ Previous Mth.	n/a	6148		
52 Week RTT Incomplete Breaches	Jon Spencer	23/24 Planning Guidance	Monthly	Zero Breaches	122	20		
A&E Four Hour Performance	Jon Spencer	23/24 Planning Guidance	Monthly	≥95%	98.8%	98.9%		
Percentage of Diagnostic waiting times less than 6 weeks	Jon Spencer	23/24 Planning Guidance	Monthly	≥99%	99.5%	97.9%		

Deliver (Access Performance) - Graphs (1)



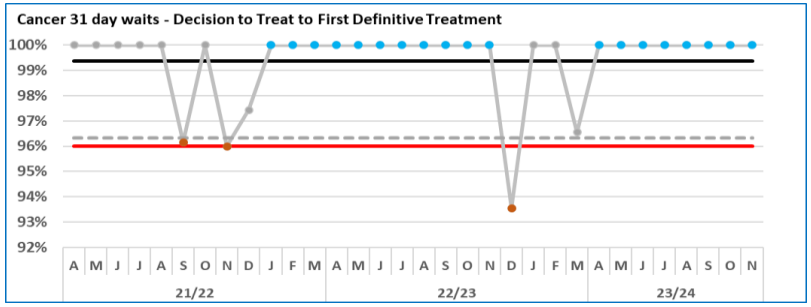
Cancer 2 week waits - first appointment urgent GP referral

This metric is showing common cause variation and that the current process may not meet the target consistently - This is a change from the previous month



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

This metric is showing common cause variation and that the current process may not meet the target consistently



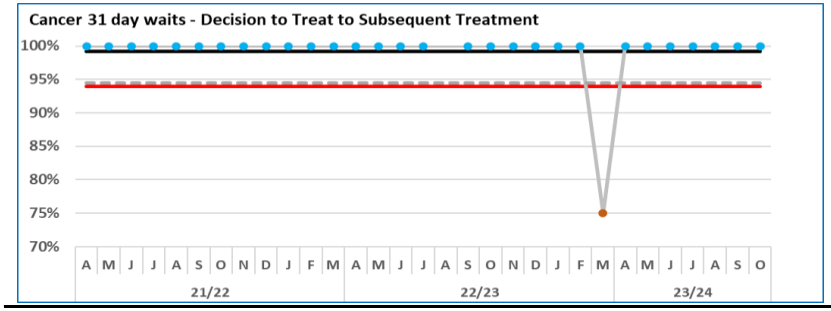
Cancer 31 day waits - Decision to Treat to First Definitive Treatment

Data for reporting period not available

Data not available until Tuesday 16th January

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

Deliver (Access Performance) - Graphs (2)

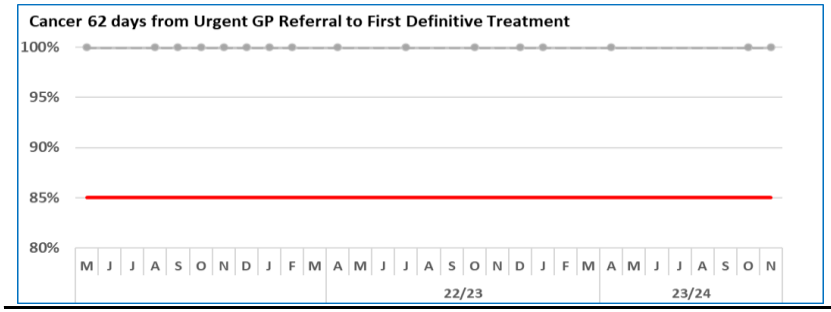


Cancer 31 day waits - Decision to Treat to Subsequent Treatment

Data for reporting period not available

Data not available until Tuesday 16th January

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

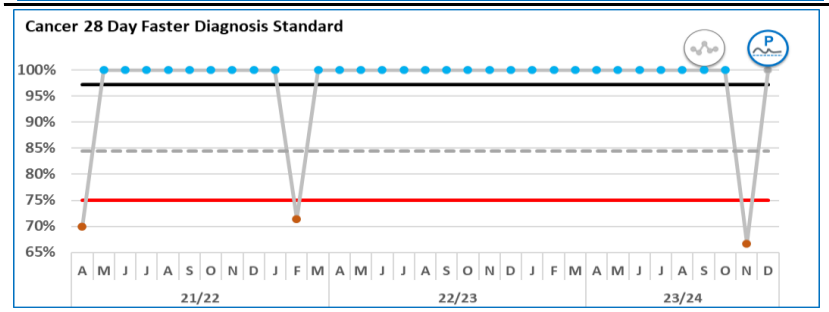


Cancer 62 days from Urgent GP Referral to First Definitive Treatment

Data for reporting period not available

Data not available until Tuesday 16th January

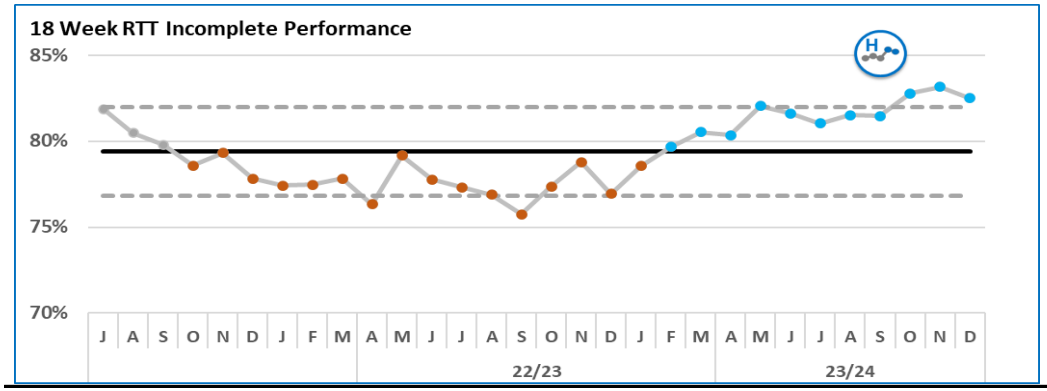
Review Date: ***Action Lead:***



Cancer 28 Day Faster Diagnosis Standard

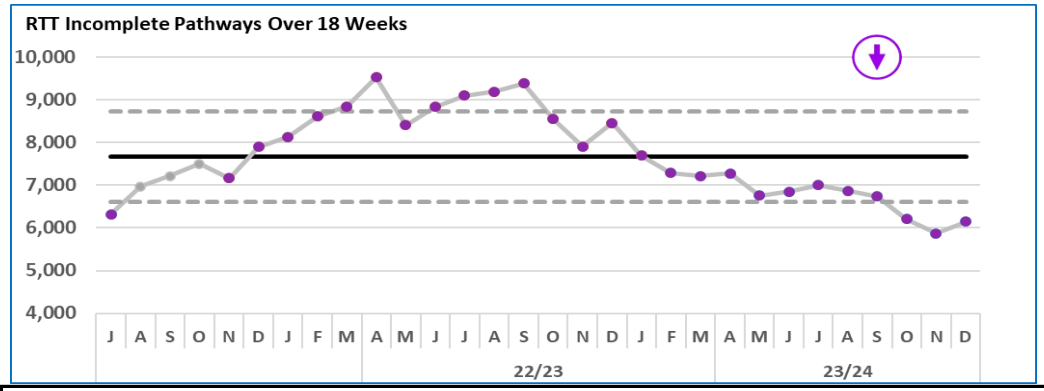
This metric is showing common cause variation and that the current process will consistently pass the target

Deliver (Access Performance) - Graphs (3)



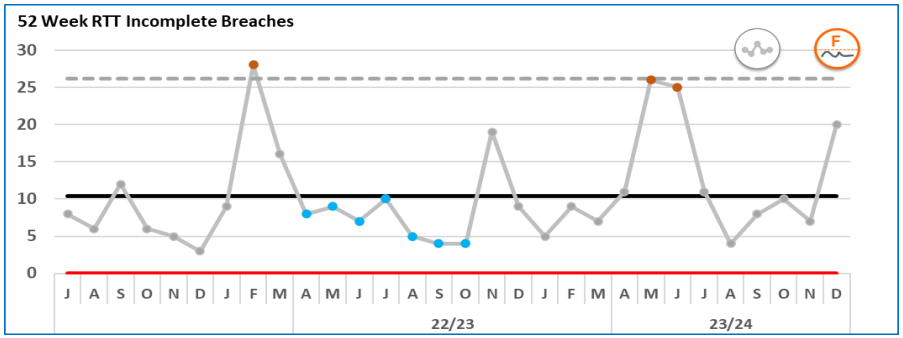
18 Week RTT Incomplete Performance

This metric is showing special cause improvement (increasing rate)



RTT Incomplete Pathways Over 18 Weeks

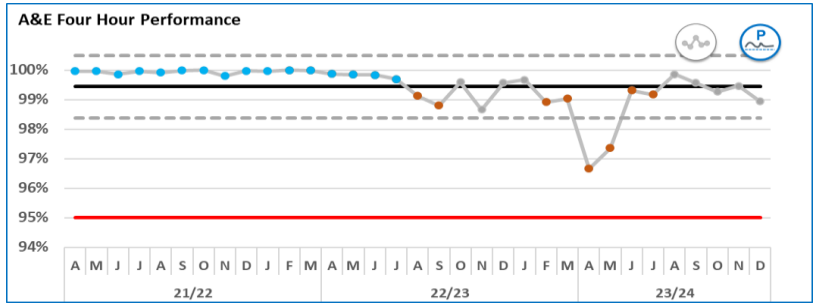
This metric is showing an special cause variation (decreasing rate)



52 Week RTT Incomplete Breaches

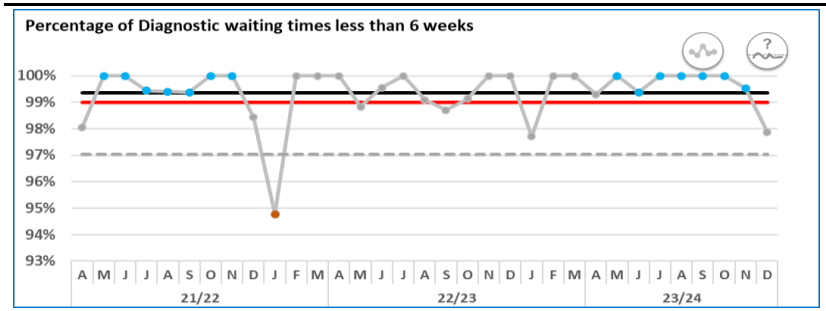
This metric is showing common cause variation with the current process unlikely to achieve the target

Deliver (Access Performance) - Graphs (4)



A&E Four Hour Performance

This metric is showing common cause variation and that the current process will consistently pass the target



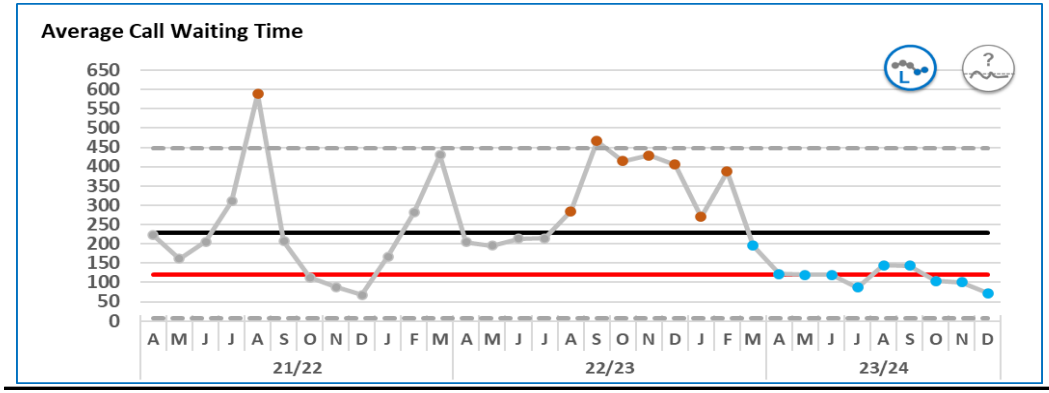
Percentage of Diagnostic waiting times less than 6 weeks

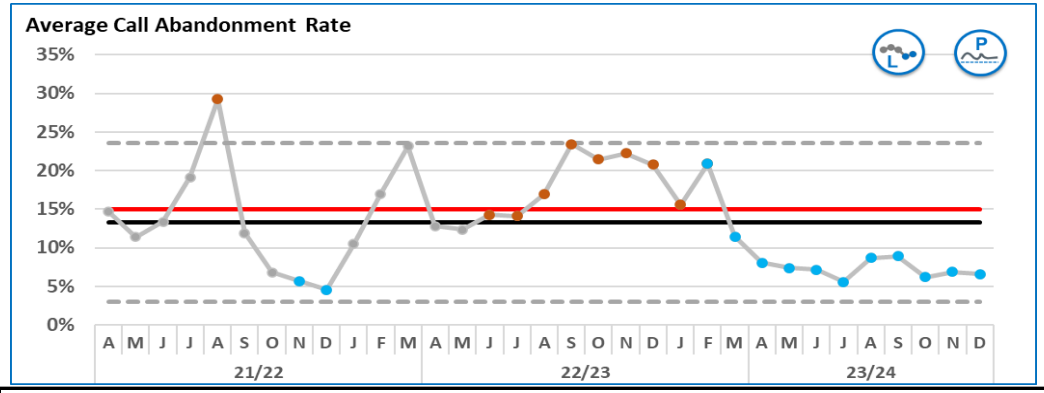
This metric is showing common cause variation and that the current process may not meet the target consistently - This is a change from the previous month

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	72	L	?
Average Call Abandonment Rate	Jon Spencer	Internal Requirement	Monthly	≤15%	7.2%	6.6%	L	?
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	2.94%		?
VTE Risk Assessment	Jon Spencer	Statutory Reporting	Monthly	≥95%	99.0%	98.2%		P
Posterior Capsular Rupture rates (Cataract Operations Only)	Jon Spencer	Statutory Reporting	Monthly	≤1.95%	0.91%	0.42%		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

This metric is showing special cause improvement and that the current process may not meet the target consistently

Average Call Abandonment Rate

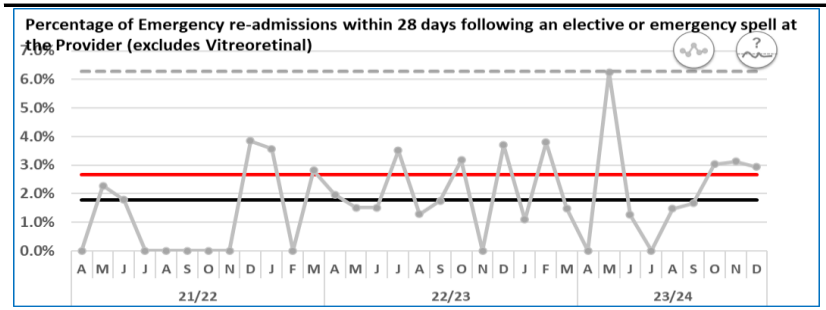
This metric is showing special cause improvement and that the current process will consistently pass the target

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

No Graph Generated, No breaches since June 2017

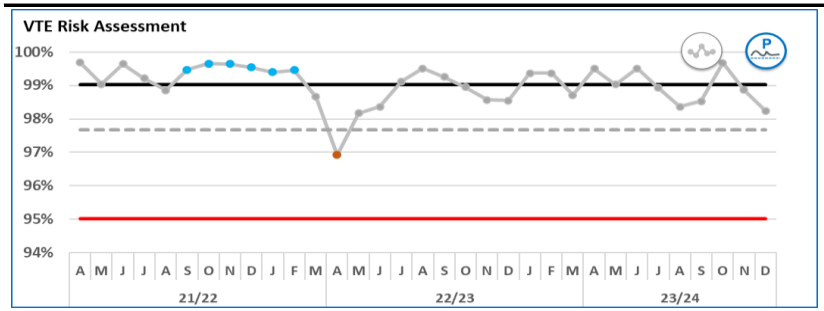
Mixed Sex Accommodation Breaches

This metric is showing common cause variation and that the current process will consistently pass the target



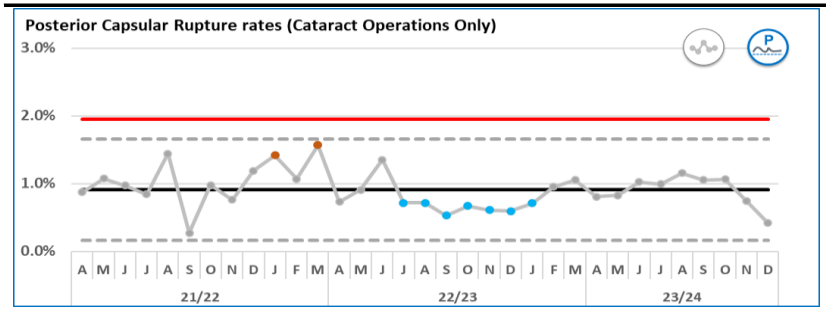
% Emergency re-admissions within 28 days (excludes Vitreoretinal)

This metric is showing common cause variation and that the current process may not meet the target consistently



VTE Risk Assessment

This metric is showing common cause variation and that the current process will consistently pass the target



Posterior Capsular Rupture rates (Cataract Operations Only)

This metric is showing common cause variation and that the current process will consistently pass the target

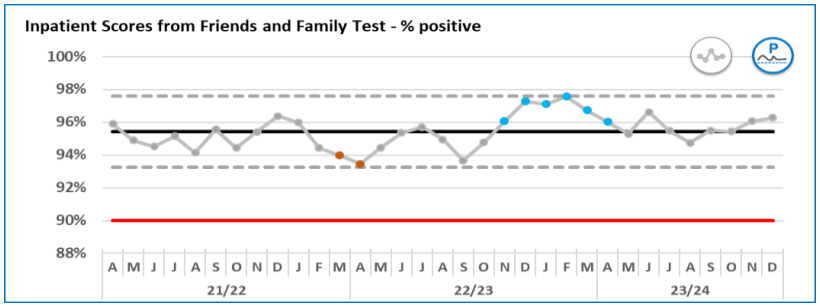
Deliver (Call Centre and Clinical) - Graphs (3)

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

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%	96.3%		P
A&E Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	92.6%	93.6%		P
Outpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	93.5%	94.5%		P
Paediatric Scores from Friends and Family Test - % positive	Ian Tombleson	Internal Requirement	Monthly	≥90%	95.2%	95.5%	H	P
Percentage of responses to written complaints sent within 25 days	Ian Tombleson	Internal Requirement	Monthly (Month in Arrears)	≥80%	85.4%	81.8%	H	P
Percentage of responses to written complaints acknowledged within 3 days	Ian Tombleson	Internal Requirement	Monthly	≥80%	96.6%	100.0%		P
Freedom of Information Requests Responded to Within 20 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	67.1%	41.5%	L	F
Subject Access Requests (SARs) Responded To Within 28 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	93.2%	96.2%		?

Deliver (Quality and Safety) - Graphs (1)

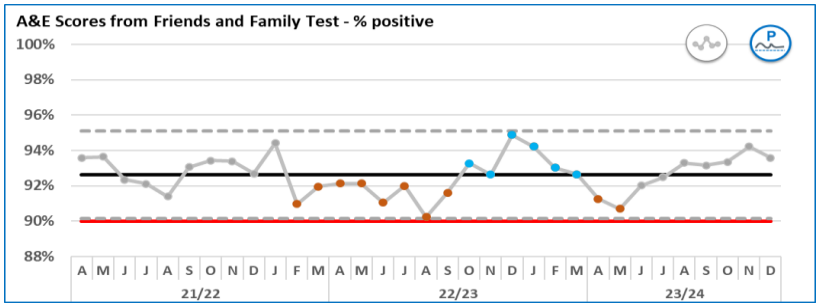


Inpatient Scores from Friends and Family Test - % positive

This metric is showing common cause variation and that the current process will consistently pass the target

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.

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

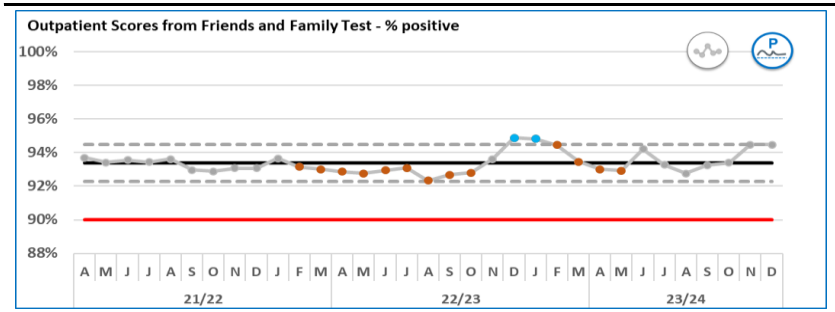


A&E Scores from Friends and Family Test - % positive

This metric is showing common cause variation and that the current process will consistently pass the target

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.

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

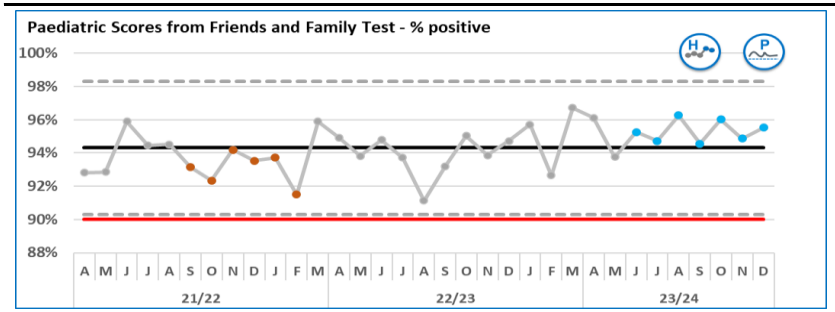


Outpatient Scores from Friends and Family Test - % positive

This metric is showing common cause variation and that the current process will consistently pass the target

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.

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



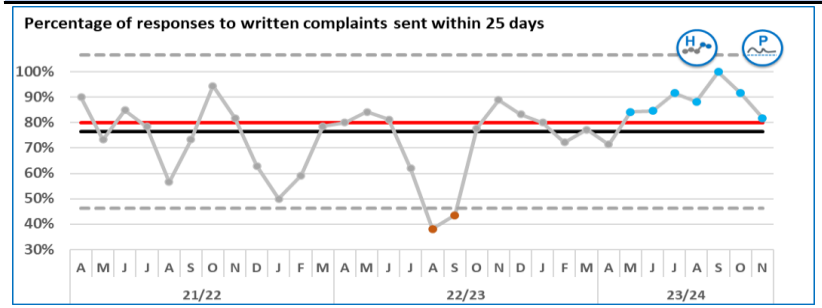
Paediatric Scores from Friends and Family Test - % positive

This metric is showing special cause improvement and that the current process will consistently pass the target

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.

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

Deliver (Quality and Safety) - Graphs (2)

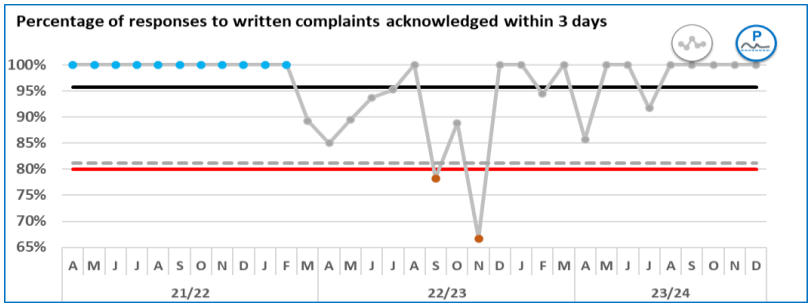


Percentage of responses to written complaints sent within 25 days

This metric is showing special cause improvement and that the current process will consistently pass the target

Over the previous seven months the 80% target has been met, so this metric now 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:***

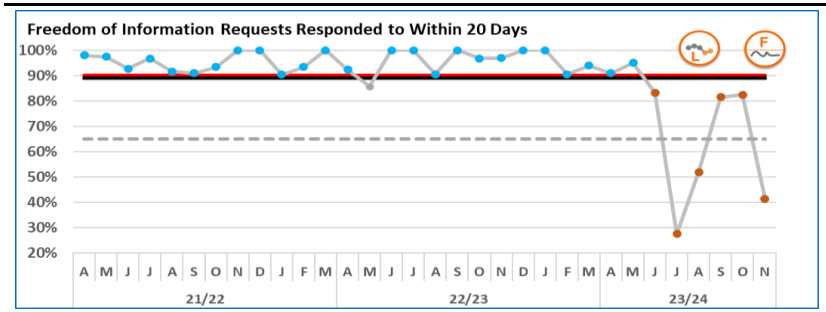


Percentage of responses to written complaints acknowledged within 3 days

This metric is showing common cause variation and that the current process will consistently pass the target

Following tightening of the process to acknowledge receipt of a complaint at the end of 2022, this continues to achieve the 80% performance target with 10 of the last 13 months at 100%.

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

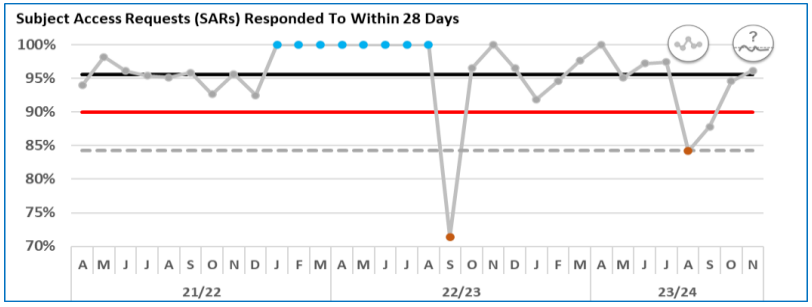


Freedom of Information Requests Responded to Within 20 Days

This metric is showing special cause concern and that the current process is unlikely to achieve the target - This is a change from the previous month

Staff sickness/absence has had an adverse effect on performance; staff are now back in place and work is underway to address the backlog; additional temporary resource is being sought via Bank Partners but it has not been possible to appoint via this route to date due to apparent lack of prospective staff. We have also seen an increase in the number of FoI requests over the last six months from an average of 32 a month in 2022/23 to 40.

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



Subject Access Requests (SARs) Responded To Within 28 Days

This metric is showing common cause variation and that the current process may not meet the target consistently

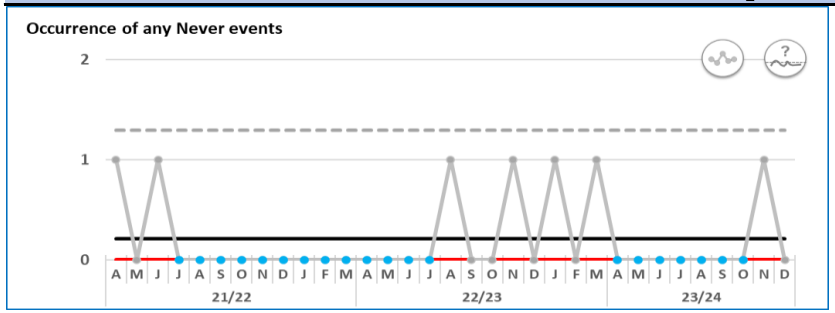
Performance is now back above the 90% target and showing as common cause variation, this will continued to be monitored. There continues to be staff absence within the department, however a temporary member of staff has been brought in to cover this The number of SARs continues to be higher than average.

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	1	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	0		
Number of Serious Incidents remaining open after 60 days	Sheila Adam	Statutory Reporting	Monthly	Zero Cases	1	0		
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Sheila Adam	Internal Requirement	Monthly	No Target Set	n/a	206		

Deliver (Incident Reporting) - Graphs (1)



Occurrence of any Never events

This metric is showing common cause variation and that the current process may not meet the target consistently - This is a change from the previous month

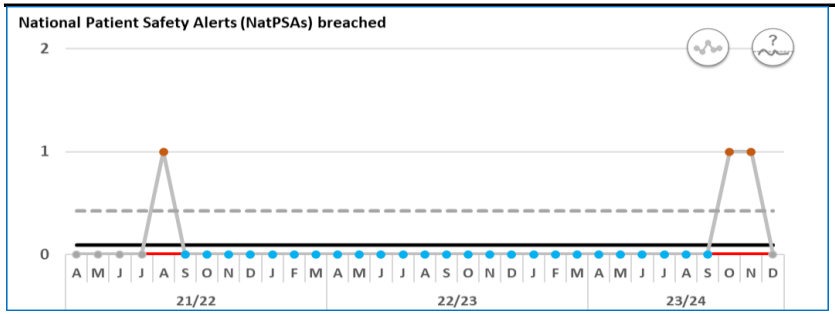
A never event was declared in November concerning the wrong implantation of graft material. This has been reviewed by the Serious Incident Panel and is under investigation.

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

No Graph Generated, No cases reported since February 2017

Summary Hospital Mortality Indicator

This metric is showing common cause variation and that the current process will consistently pass the target



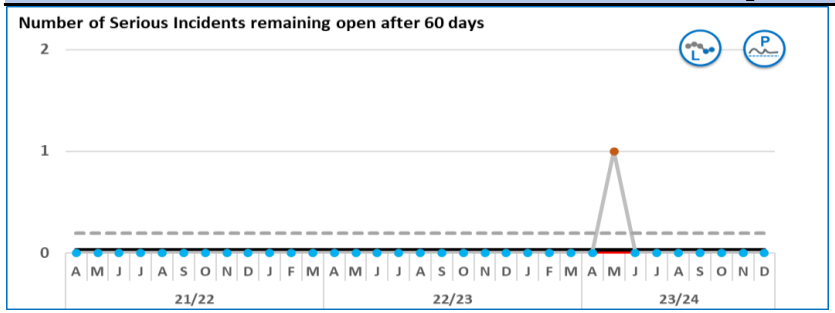
National Patient Safety Alerts (NatPSAs) breached

This metric is showing common cause variation and that the current process may not meet the target consistently - This is a change from the previous month

The actions relating to the previous alert have now been completed and the alert has been closed.

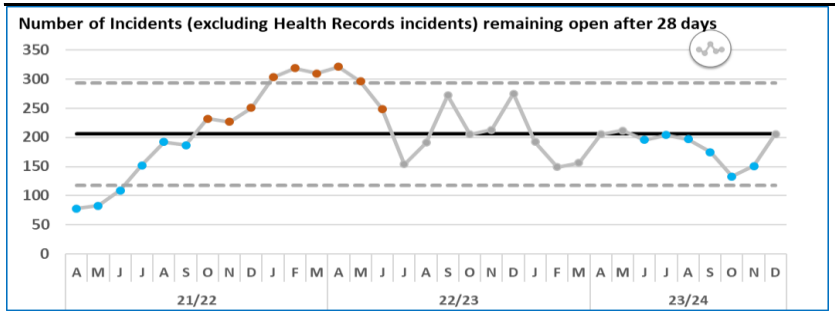
Review Date: ***Action Lead:***

Deliver (Incident Reporting) - Graphs (2)



Number of Serious Incidents remaining Open after 60 days

This metric is showing special cause improvement and that the current process will consistently pass the target



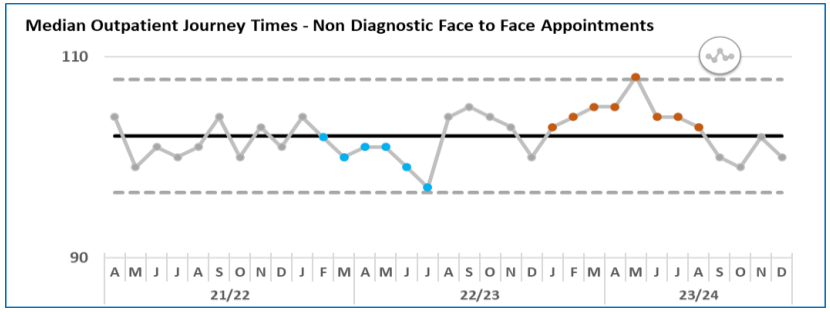
Number of Incidents (excluding Health Records incidents) remaining open after 28 days

This metric is showing common cause variation - This is a change from the previous month

Sustainability and at Scale - Summary

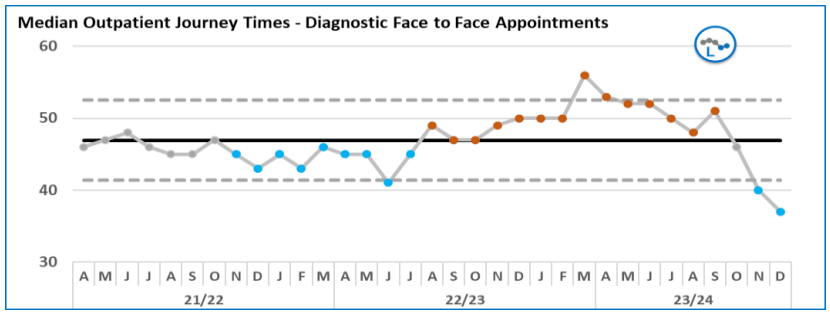
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	100		
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	37		
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%	1.17%	1.30%		
Number of non-medical cancelled operations not treated within 28 days	Jon Spencer	Statutory Reporting	Monthly	Zero Breaches	20	1		
Overall financial performance (In Month Var. £m)	Jonathan Wilson	Internal Requirement	Monthly	≥0	6.77	2.35		
Commercial Trading Unit Position (In Month Var. £m)	Jonathan Wilson	Internal Requirement	Monthly	≥0	0.03	-0.28		

Sustainability and at Scale - Graphs (1)



Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments

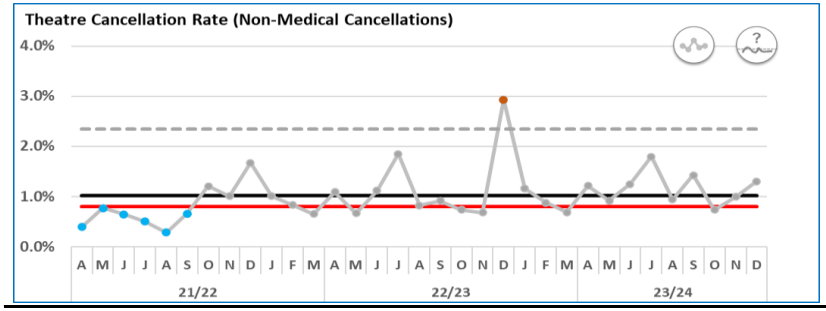
This metric is showing common cause variation



Median Outpatient Journey Times - Diagnostic Face to Face Appointments

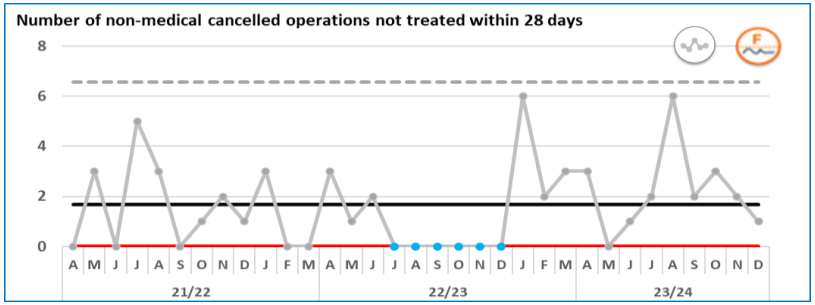
This metric is showing special cause improvement (decreasing rate)

Sustainability and at Scale - Graphs (2)



Theatre Cancellation Rate (Non-Medical Cancellations)

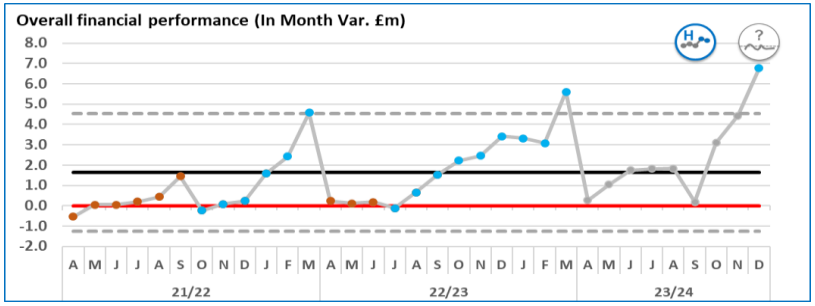
This metric is showing common cause variation and that the current process may not meet the target consistently



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

This metric is showing common cause variation with the current process unlikely to achieve the target

Sustainability and at Scale - Graphs (3)

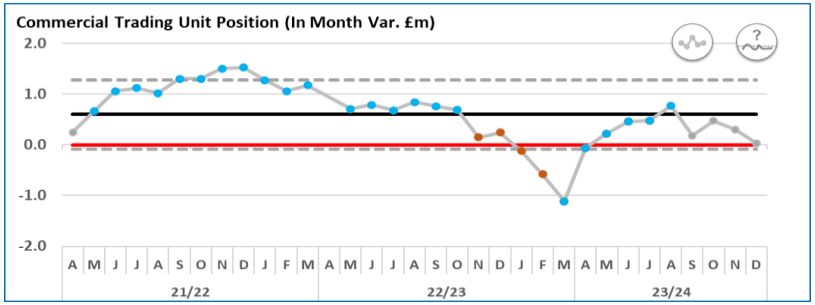


Overall financial performance (In Month Var. £m)

This metric is showing special cause improvement and that the current process may not meet the target consistently

For Narrative, See Finance Report

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



Commercial Trading Unit Position (In Month Var. £m)

This metric is showing common cause variation and that the current process may not meet the target consistently

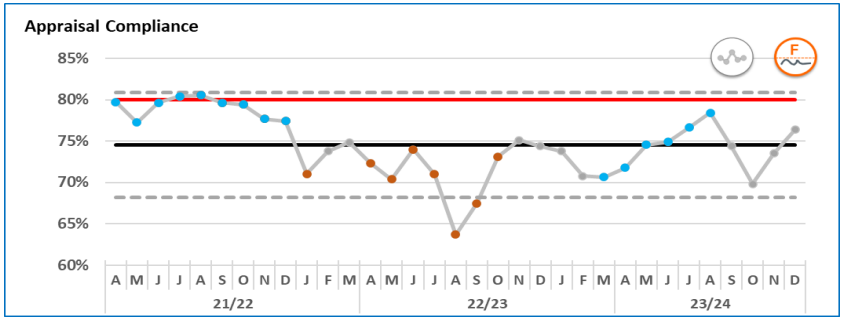
For Narrative, See Finance Report

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

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	76.4%		F
Information Governance Training Compliance	Ian Tombleson	Statutory Reporting	Monthly	≥95%	n/a	91.6%		F
Staff Sickness (Month Figure)	Mark Gammage	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.5%		F
Staff Sickness (Rolling Annual Figure)	Mark Gammage	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.5%	H	F
Proportion of Temporary Staff	Mark Gammage	23/24 Planning Guidance	Monthly	No Target Set	15.4%	12.7%		

Working Together - Graphs (1)

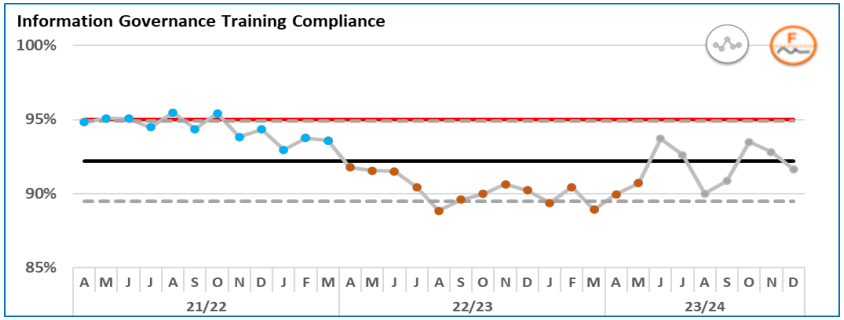


Appraisal Compliance

This metric is showing common cause variation with the current process unlikely to achieve the target

• 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 and targeting Managers in Hot Spot areas. At present these are:
-- Corporate Governance 6%
-- EPR Projects 26%
-- Director of Education 28%
• 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 newly formed Appraisal Compliance Task and Finish Group to increase, sustain and embed appraisal completion rates throughout the year.
• 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.
• Provision of ongoing Appraisal Training across the Trust including Bite Size Sessions delivered by the L&D team.

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



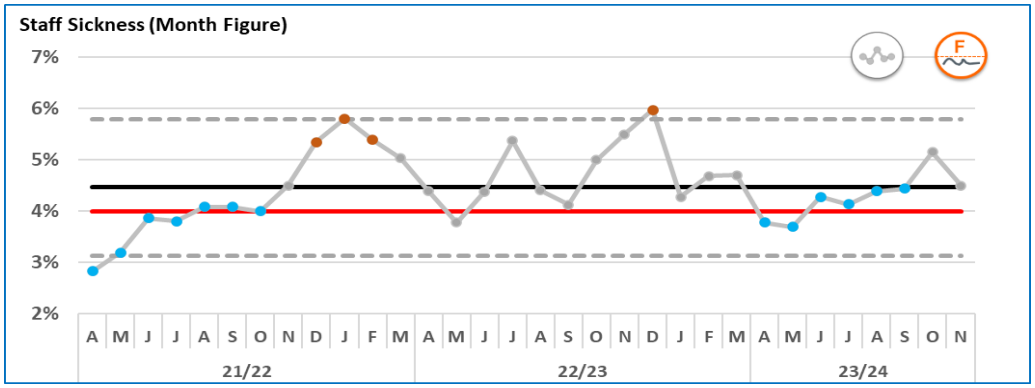
Information Governance Training Compliance

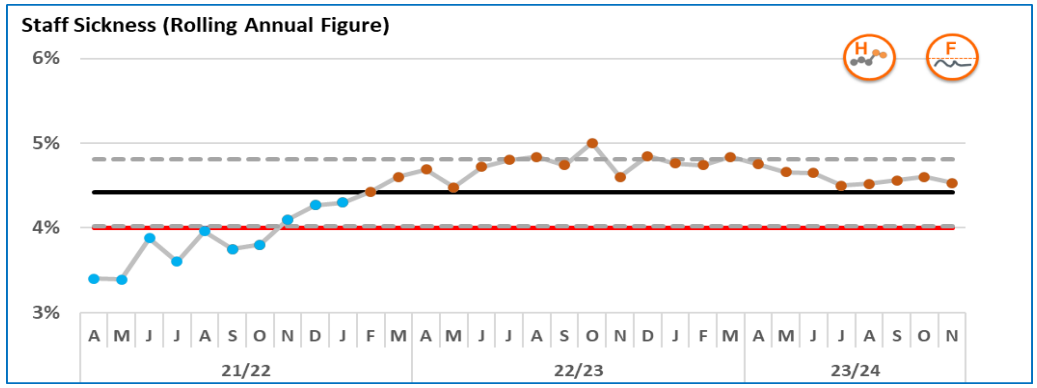
This metric is showing common cause variation with the current process unlikely to achieve the target

Solid DSPT performance and compliance enables Moorfields to establish its own IG mandatory training standard. A recommendation has been made to the Mandatory and Statutory Training Committee (MAST) to set new and realistic target for IG training compliance levels that does not increase any risk and still meets compliance. There remain data quality issues that impact an estimated 1 to 2% of performance that are being worked through

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

Working Together - Graphs (2)





Staff Sickness (Month Figure)

This metric is showing common cause variation with the current process unlikely to achieve the target - This is a change from the previous month

Staff Sickness (Rolling Annual Figure)

This metric is showing special cause concern and that the current process is unlikely to achieve the target

The overall sickness absence for the rolling year for this month's reporting remains unchanged - slightly above the 4% Trust target at 4.53%.

The top 3 sickness absence reasons for this month's reporting remain unchanged namely:

- Anxiety/stress/depression/other psychiatric illness
- Cold, Cough, Flu – Influenza
- Other musculoskeletal problems

This has been the case for the last 6 months reporting.

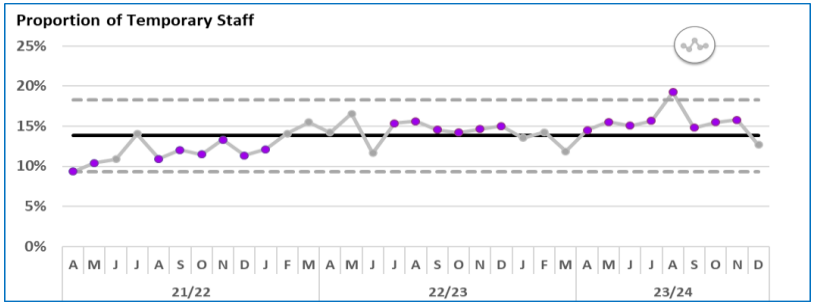
Whilst the overall level of sickness absence remains unchanged, it should be noted that the ER team continue to work closely with Line Managers with the following support to be delivered and or are in place:

- Targeted sickness absence training continues to be delivered by the ER team - training sessions have been delivered to those hotspot areas within the Trust with high short - term sickness absence and long-term sickness rates since July through to December. Dates are planned for January.
- Regular review meetings are being held with staff who are on LTS alongside regular OH referrals as well as staff and managers being signposted to the Trust's Health and wellbeing initiatives offering a holistic support to aid staff recovery and prevention of sickness.

Targeted training sessions on - How to make an Effective OH referral for Line Managers is to be delivered and is in place already for some service lines starting from January 2024 onwards. This would enable line managers to support staff members at work who have underlying health conditions.

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

Working Together - Graphs (3)



Proportion of Temporary Staff

This metric is showing common cause variation - This is a change from the previous month

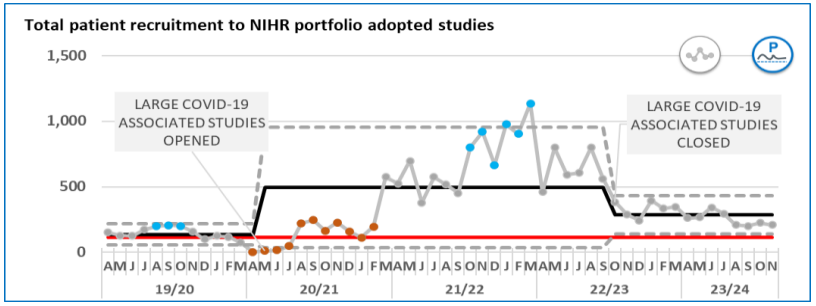
• The number of unpaid invoices continues to reduce as the query log currently stands at £65,443, a reduction from £86,269 last month, we aim to have the remaining invoices cleared by the end of March 2024.
• Engagement work continues with our hiring managers who have high agency spend, we are proactively working with them to better understand their temporary staffing needs. Temporary staffing utilisation and spend is a workforce priority and will remain so for 2024/25 – with HR working with respective Divisions on putting appropriate plans in place.
• A plan is in place to work with the NCL Reservists team to replace costly agency workers with reservist candidates, to date 10 reservist candidates have been placed within the Trust.
• An agency reduction steering group has been set up with the first meeting due to take place on 31st January, the purpose of the Temporary Staffing Agency Reduction Group is to meet on a regular basis to monitor progress on reducing Agency spend, reducing / eliminating Off-Framework Agencies and reducing Overtime.

Review Date:	Feb 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)	2014	209		
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	≥44	n/a	52		
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	≥2%	n/a	4.9%		

Discover - Graphs (1)

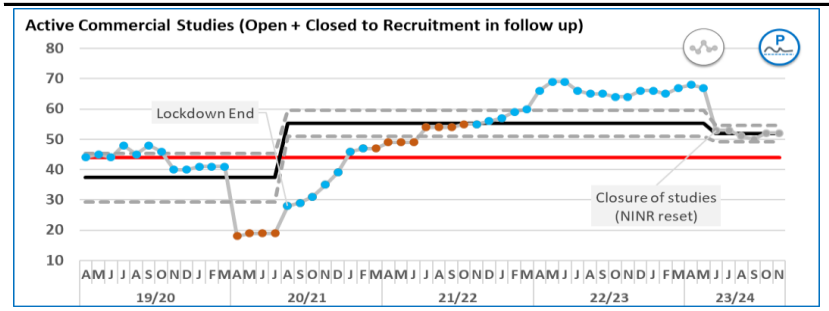


Total patient recruitment to NIHR portfolio adopted studies

This metric is showing common cause variation and that the current process will consistently pass the target

We continue to exceed our target for monthly portfolio recruitment and are recruiting more patients than in the comparable periods for 2020/21 and 2021/22. Portfolio recruitment in 2022/23 was higher than usual because it incorporated all the highly successful very high volume COVID-19 studies, which have now finished recruiting. These were non-interventional and non-intensive. These have now been replaced by more interventional, early phase high-cost studies which require intensive investigations including imaging and follow up.

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

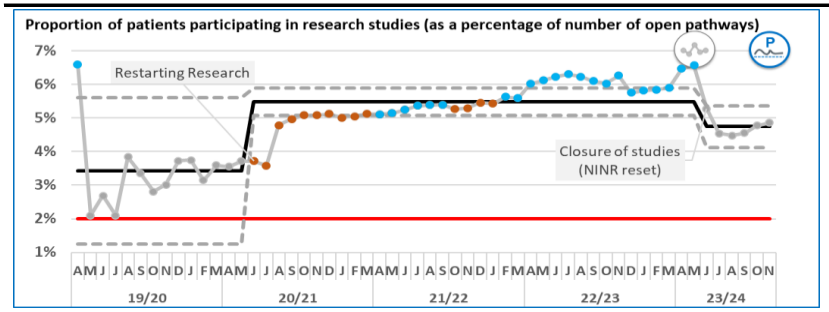


Active Commercial Studies (Open + Closed to Recruitment in follow up)

This metric is showing common cause variation and that the current process will consistently pass the target

We continue to run above our target number of commercial studies, with the average number of studies being over 50 compared to 44 in 2019/20. These studies generate income and provide our patients with access to the latest innovative treatments and therapies. The current pipeline of 32 hosted studies in "set up" should ensure that we continue to meet our commercial study target. Our current real time, robust monitoring process minimises delays. This will attract more commercial studies which is a key National Institute of Health Research [NIHR] & Department of Health priority.

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



Proportion of patients participating in research studies (as a percentage of number of open pathways)

This metric is showing common cause variation and that the current process will consistently pass the target - This is a change from the previous month

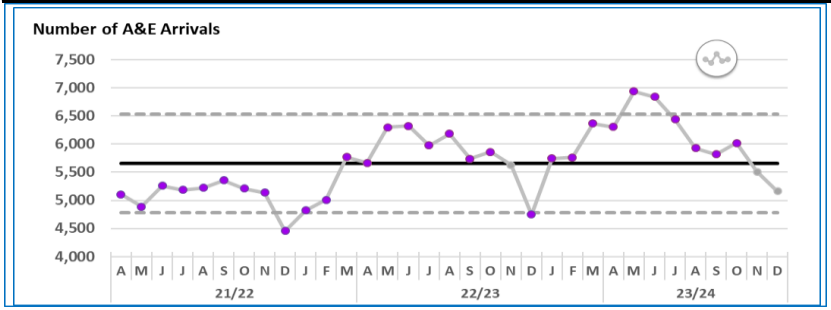
Our aim to have > 2% of our patient population involved in a research study has been achieved and at 4.9% currently exceed this. This reflects our emphasis on and investment in patient and public engagement as part of our NIHR Biomedical Research Centre (BRC) and Clinical Research Facility (CRF) strategy. 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. Finally, it is a priority to increase the number of patients recruited to genetic and rare disease studies. The BRC has therefore increased investment in staff, improving recruitment to genetic and rare disease research.

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

Context (Activity) - Summary

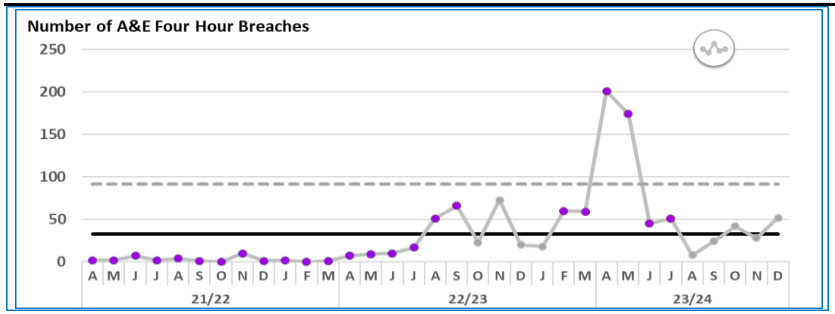
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Number of A&E Arrivals	Jon Spencer	Internal Requirement	Monthly	No Target Set	54955	5161		
Number of A&E Four Hour Breaches	Jon Spencer	Internal Requirement	Monthly	No Target Set	625	52		
Number of Outpatient Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	471895	44474		
Number of Outpatient First Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	112913	11091		
Number of Outpatient Follow Up Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	358982	33383		
Number of Referrals Received	Jon Spencer	Internal Requirement	Monthly	No Target Set	125415	11182		
Number of Theatre Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	29676	2843		
Number of Theatre Elective Daycase Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	27093	2587		
Number of Theatre Elective Inpatient Admission	Jon Spencer	Internal Requirement	Monthly	No Target Set	687	55		
Number of Theatre Emergency Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	1896	201		

Context (Activity) - Graphs (1)



Number of A&E Arrivals

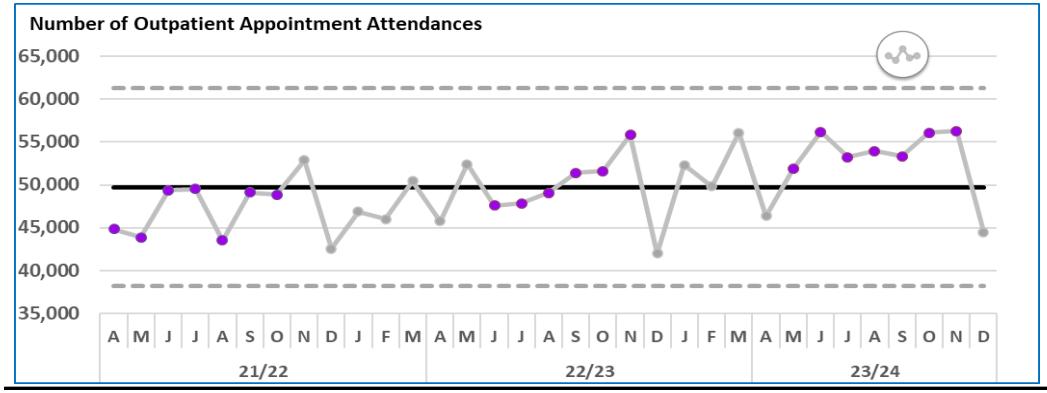
This metric is showing common cause variation



Number of A&E Four Hour Breaches

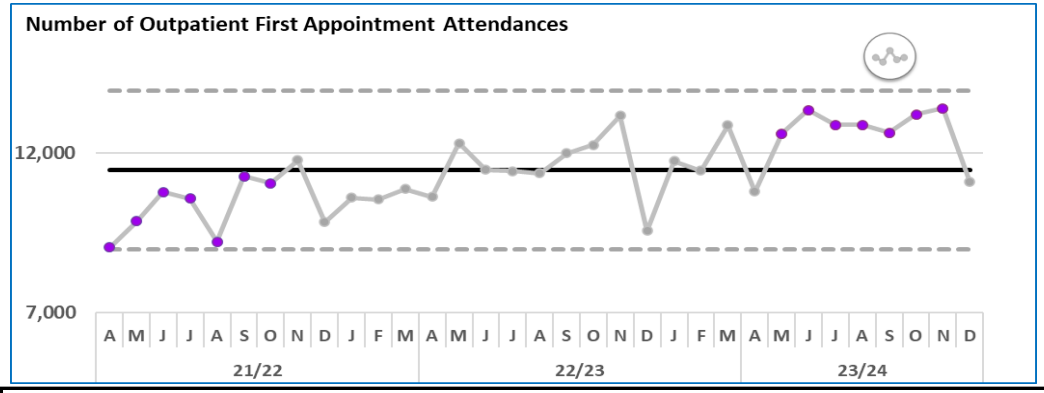
This metric is showing common cause variation

Context (Activity) - Graphs (2)



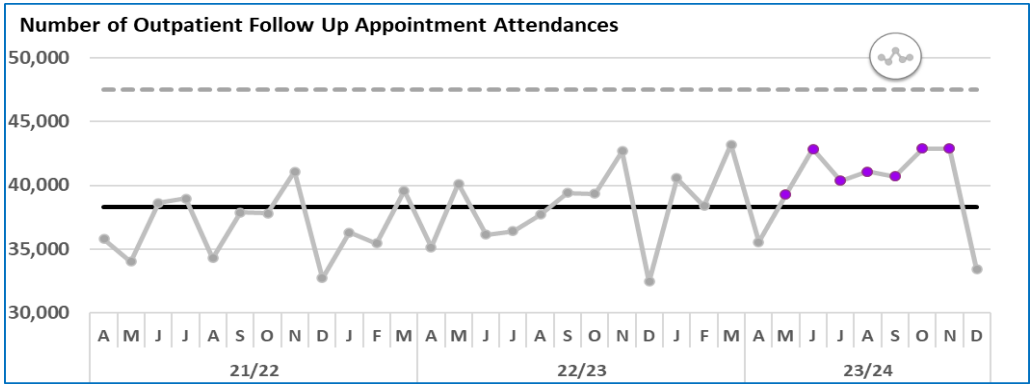
Number of Outpatient Appointment Attendances

This metric is showing common cause variation - This is a change from the previous month



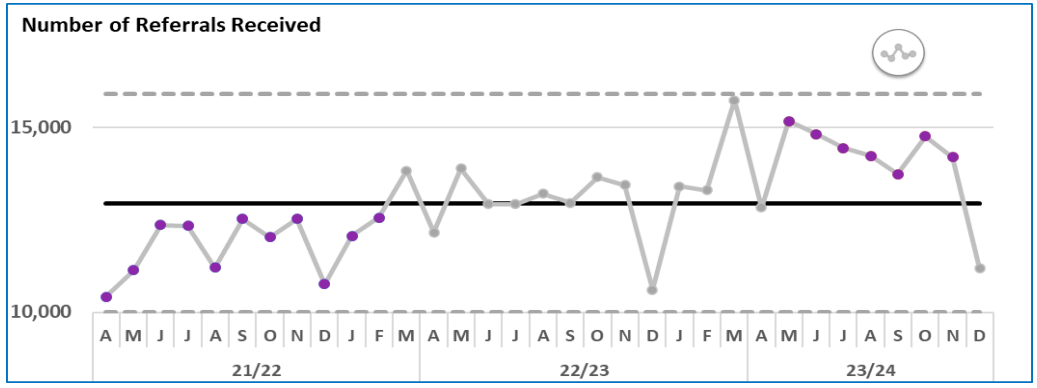
Number of Outpatient First Appointment Attendances

This metric is showing common cause variation - This is a change from the previous month



Number of Outpatient Follow Up Appointment Attendances

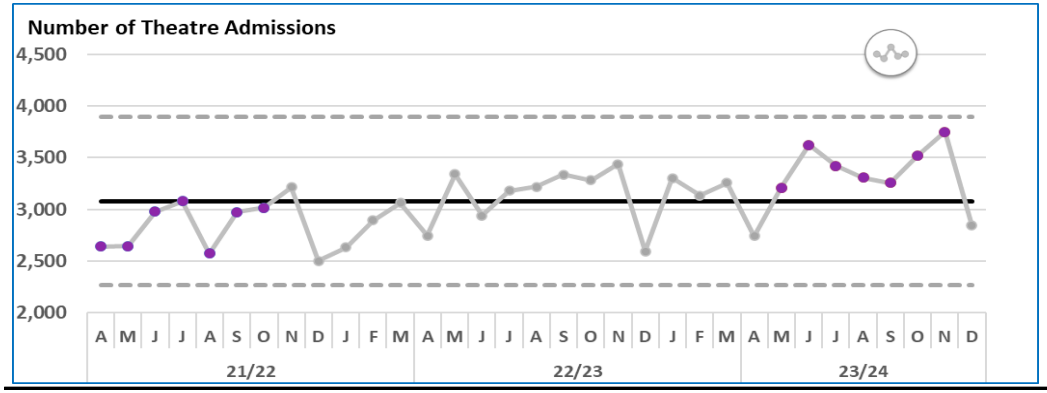
This metric is showing common cause variation - This is a change from the previous month



Number of Referrals Received

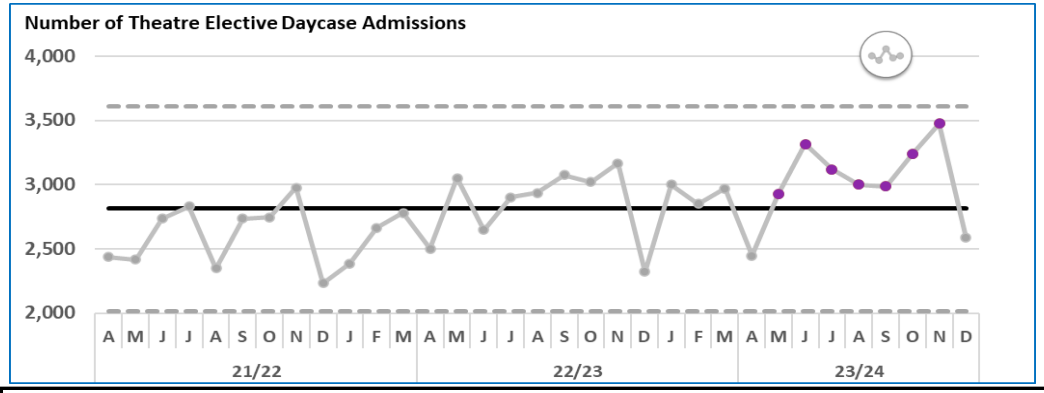
This metric is showing common cause variation - This is a change from the previous month

Context (Activity) - Graphs (3)



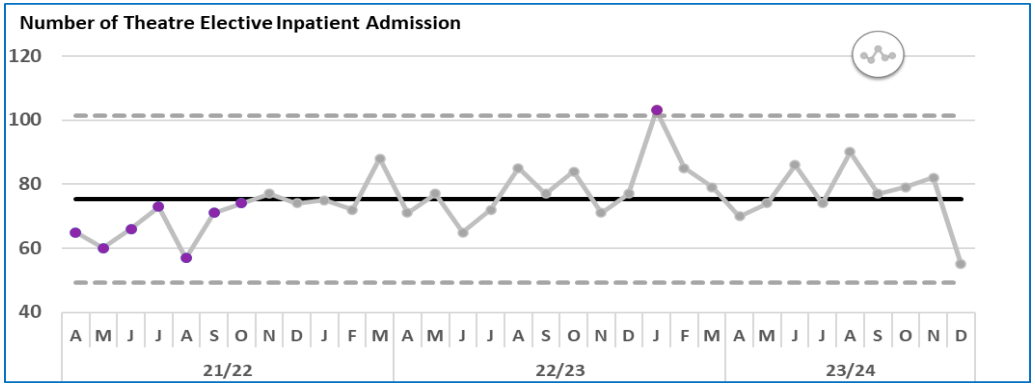
Number of Theatre Admissions

This metric is showing common cause variation - This is a change from the previous month



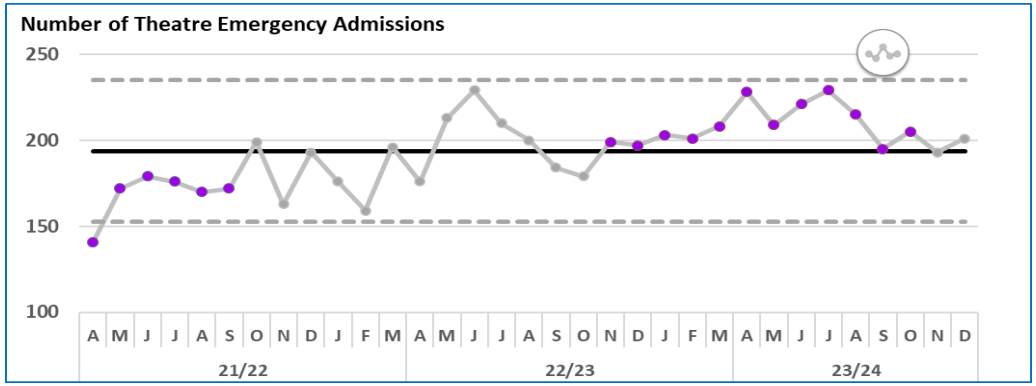
Number of Theatre Elective Daycase Admissions

This metric is showing common cause variation - This is a change from the previous month



Number of Theatre Elective Inpatient Admission

This metric is showing common cause variation



Number of Theatre Emergency Admissions

This metric is showing common cause variation

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Deliver (Activity vs Plan)																						
Elective Activity - % of Phased Plan	Dec-23	102.5%	≥100%	Monthly	Common Cause	Hit or Miss	96.5%	84.5%	108.5%	103.0%	101.0%	100.6%	95.1%	103.0%	98.4%	101.6%	100.0%	101.2%	100.7%	87.6%	93.9%	102.5%
Total Outpatient Activity - % of Phased Plan	Dec-23	113.8%	≥100%	Monthly	Improvement (Higher Than Expected)	Hit or Miss	98.4%	87.1%	109.7%	104.6%	99.2%	99.2%	101.5%	112.3%	100.7%	99.3%	98.5%	104.6%	103.2%	98.2%	98.4%	113.8%
Outpatient First Appointment Activity - % of Phased Plan	Dec-23	119.0%	≥100%	Monthly	Improvement (Higher Than Expected)	Hit or Miss	100.0%	86.6%	113.4%	107.6%	100.0%	102.4%	104.9%	110.6%	104.0%	99.9%	101.3%	105.6%	103.8%	95.8%	98.2%	119.0%
Outpatient Follow Up Appointment Activity - % of Phased Plan	Dec-23	112.3%	≥85%	Monthly	Improvement (Higher Than Expected)	Capable	98.0%	86.5%	109.4%	103.7%	99.0%	98.3%	100.5%	112.8%	99.7%	99.1%	97.7%	104.3%	103.1%	98.9%	98.5%	112.3%
Deliver (Access Performance)																						
Cancer 2 week waits - first appointment urgent GP referral	Dec-23	100.0%	≥93%	Monthly	Common Cause	Hit or Miss	96.7%	84.0%	109.4%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	66.7%	100.0%
Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	Dec-23	94.1%	≥93%	Monthly	Common Cause	Hit or Miss	96.2%	88.7%	103.7%	91.4%	85.5%	90.5%	94.0%	93.9%	93.6%	90.1%	97.2%	97.5%	100.0%	98.9%	96.5%	94.1%
Cancer 31 day waits - Decision to Treat to First Definitive Treatment	Dec-23	n/a	≥96%	Monthly	Not Available	Not Applicable	99.4%	96.3%	102.4%	93.5%	100.0%	100.0%	96.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a
Cancer 31 day waits - Decision to Treat to Subsequent Treatment	Dec-23	n/a	≥94%	Monthly	Not Available	Not Applicable	99.2%	94.4%	103.9%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	n/a
Cancer 62 days from Urgent GP Referral to First Definitive Treatment	Dec-23	n/a	≥85%	Monthly	Not Available	Not Applicable	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	100.0%	100.0%	n/a
Cancer 28 Day Faster Diagnosis Standard	Dec-23	100.0%	≥75%	Monthly	Common Cause	Capable	97.2%	84.4%	110.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%
18 Week RTT Incomplete Performance	Dec-23	82.5%	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	79.4%	76.8%	82.0%	76.9%	78.6%	79.7%	80.5%	80.4%	82.0%	81.6%	81.0%	81.5%	81.5%	82.8%	83.1%	82.5%
RTT Incomplete Pathways Over 18 Weeks	Dec-23	6148	≤ Previous Mth.	Monthly	Decreasing (Decreasing Trend)	Not Applicable	7662	6608	8716	8451	7692	7282	7210	7277	6757	6852	7000	6863	6735	6210	5871	6148
52 Week RTT Incomplete Breaches	Dec-23	20	Zero Breaches	Monthly	Common Cause	Failing	10	-5	26	9	5	9	7	11	26	25	11	4	8	10	7	20
A&E Four Hour Performance	Dec-23	98.9%	≥95%	Monthly	Common Cause	Capable	99.4%	98.4%	100.5%	99.6%	99.7%	98.9%	99.0%	96.7%	97.4%	99.3%	99.2%	99.9%	99.6%	99.3%	99.5%	98.9%
Percentage of Diagnostic waiting times less than 6 weeks	Dec-23	97.9%	≥99%	Monthly	Common Cause	Hit or Miss	99.4%	97.0%	101.7%	100.0%	97.7%	100.0%	100.0%	99.3%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	99.5%	97.9%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Deliver (Call Centre and Clinical)																						
Average Call Waiting Time	Dec-23	72	≤ 2 Mins (120 Sec)	Monthly	Improvement (Run Below Average)	Hit or Miss	228	8	448	405	270	387	195	122	120	120	87	144	143	104	100	72
Average Call Abandonment Rate	Dec-23	6.6%	≤15%	Monthly	Improvement (Run Below Average)	Capable	13.3%	3.0%	23.6%	20.8%	15.6%	20.9%	11.5%	8.1%	7.4%	7.2%	5.6%	8.7%	8.9%	6.2%	6.9%	6.6%
Mixed Sex Accommodation Breaches	Dec-23	0	Zero Breaches	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Dec-23	2.94%	≤ 2.67%	Monthly (Rolling 3 Months)	Common Cause	Hit or Miss	1.78%	-2.73%	6.29%	3.70%	1.09%	3.80%	1.49%	0.00%	6.25%	1.27%	0.00%	1.47%	1.67%	3.03%	3.13%	2.94%
VTE Risk Assessment	Dec-23	98.2%	≥95%	Monthly	Common Cause	Capable	99.0%	97.7%	100.4%	98.5%	99.4%	99.4%	98.7%	99.5%	99.0%	99.5%	98.9%	98.4%	98.5%	99.7%	98.9%	98.2%
Posterior Capsular Rupture rates (Cataract Operations Only)	Dec-23	0.42%	≤1.95%	Monthly	Common Cause	Capable	0.91%	0.16%	1.66%	0.59%	0.71%	0.95%	1.05%	0.80%	0.82%	1.03%	0.99%	1.15%	1.05%	1.06%	0.75%	0.42%
MRSA Bacteraemias Cases	Dec-23	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile Cases	Dec-23	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Dec-23	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Rate - cases	Dec-23	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Deliver (Quality and Safety)																						
Inpatient Scores from Friends and Family Test - % positive	Dec-23	96.3%	≥90%	Monthly	Common Cause	Capable	95.4%	93.3%	97.6%	97.3%	97.1%	97.6%	96.7%	96.0%	95.3%	96.6%	95.5%	94.7%	95.5%	95.4%	96.1%	96.3%
A&E Scores from Friends and Family Test - % positive	Dec-23	93.6%	≥90%	Monthly	Common Cause	Capable	92.6%	90.2%	95.1%	94.9%	94.2%	93.0%	92.6%	91.3%	90.7%	92.0%	92.5%	93.3%	93.1%	93.3%	94.2%	93.6%
Outpatient Scores from Friends and Family Test - % positive	Dec-23	94.5%	≥90%	Monthly	Common Cause	Capable	93.4%	92.3%	94.5%	94.9%	94.8%	94.5%	93.5%	93.0%	92.9%	94.2%	93.3%	92.8%	93.3%	93.4%	94.5%	94.5%
Paediatric Scores from Friends and Family Test - % positive	Dec-23	95.5%	≥90%	Monthly	Improvement (Run Above Average)	Capable	94.3%	90.3%	98.3%	94.7%	95.7%	92.7%	96.7%	96.1%	93.8%	95.3%	94.7%	96.3%	94.6%	96.0%	94.9%	95.5%
Percentage of responses to written complaints sent within 25 days	Nov-23	81.8%	≥80%	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	76.4%	46.3%	106.6%	83.3%	80.0%	72.2%	77.3%	71.4%	84.2%	84.6%	91.7%	88.2%	100.0%	91.7%	81.8%	n/a
Percentage of responses to written complaints acknowledged within 3 days	Dec-23	100.0%	≥80%	Monthly	Common Cause	Capable	95.7%	81.2%	110.2%	100.0%	100.0%	94.4%	100.0%	85.7%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%
Freedom of Information Requests Responded to Within 20 Days	Nov-23	41.5%	≥90%	Monthly (Month in Arrears)	Concern (Run Below Average)	Failing	88.9%	64.9%	113.0%	100.0%	100.0%	90.6%	93.9%	90.9%	95.0%	83.3%	27.7%	52.0%	81.6%	82.5%	41.5%	n/a
Subject Access Requests (SARs) Responded To Within 28 Days	Nov-23	96.2%	≥90%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	95.5%	84.3%	106.7%	96.5%	91.9%	94.6%	97.6%	100.0%	95.1%	97.2%	97.4%	84.2%	87.8%	94.6%	96.2%	n/a
Deliver (Incident Reporting)																						
Occurrence of any Never events	Dec-23	0	Zero Events	Monthly	Common Cause	Hit or Miss	0	-1	1	0	1	0	1	0	0	0	0	0	0	0	1	0
Summary Hospital Mortality Indicator	Dec-23	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Patient Safety Alerts (NatPSAs) breached	Dec-23	0	Zero Alerts	Monthly	Common Cause	Hit or Miss	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0
Number of Serious Incidents remaining open after 60 days	Dec-23	0	Zero Cases	Monthly	Improvement (Run Below Average)	Capable	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Dec-23	206	No Target Set	Monthly	Common Cause	Not Applicable	206	118	294	275	192	149	156	205	212	196	204	197	175	133	151	206

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Sustainability and at Scale																						
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Dec-23	100	No Target Set	Monthly	Common Cause	Not Applicable	102	96	108	100	103	104	105	105	108	104	104	103	100	99	102	100
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Dec-23	37	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	47	41	53	50	50	50	56	53	52	52	50	48	51	46	40	37
Theatre Cancellation Rate (Non-Medical Cancellations)	Dec-23	1.30%	≤0.8%	Monthly	Common Cause	Hit or Miss	1.02%	-0.30%	2.34%	2.93%	1.16%	0.88%	0.69%	1.21%	0.92%	1.25%	1.80%	0.94%	1.43%	0.74%	0.99%	1.30%
Number of non-medical cancelled operations not treated within 28 days	Dec-23	1	Zero Breaches	Monthly	Common Cause	Failing	2	-3	7	0	6	2	3	3	0	1	2	6	2	3	2	1
Overall financial performance (In Month Var. £m)	Dec-23	6.77	≥0	Monthly	Improvement (Higher Than Expected)	Hit or Miss	1.64	-1.25	4.54	3.42	3.32	3.08	5.61	0.27	1.05	1.75	1.81	1.83	0.18	3.09	4.42	6.77
Commercial Trading Unit Position (In Month Var. £m)	Dec-23	0.03	≥0	Monthly	Common Cause	Hit or Miss	0.60	-0.09	1.28	0.24	-0.12	-0.58	-1.11	-0.06	0.22	0.46	0.48	0.77	0.18	0.47	0.30	0.03
Working Together																						
Appraisal Compliance	Dec-23	76.4%	≥80%	Monthly	Common Cause	Failing	74.5%	68.1%	80.9%	74.4%	73.8%	70.8%	70.6%	71.8%	74.5%	74.9%	76.6%	78.4%	74.4%	69.8%	73.5%	76.4%
Information Governance Training Compliance	Dec-23	91.6%	≥95%	Monthly	Common Cause	Failing	92.2%	89.5%	94.9%	90.2%	89.4%	90.4%	88.9%	90.0%	90.7%	93.7%	92.6%	90.0%	90.9%	93.5%	92.8%	91.6%
Staff Sickness (Month Figure)	Nov-23	4.5%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.5%	3.1%	5.8%	6.0%	4.3%	4.7%	4.7%	3.8%	3.7%	4.3%	4.1%	4.4%	4.4%	5.2%	4.5%	n/a
Staff Sickness (Rolling Annual Figure)	Nov-23	4.5%	≤4%	Monthly (Month in Arrears)	Concern (Run Above Average)	Failing	4.4%	4.0%	4.8%	4.8%	4.8%	4.7%	4.8%	4.8%	4.7%	4.7%	4.5%	4.5%	4.6%	4.6%	4.5%	n/a
Proportion of Temporary Staff	Dec-23	12.7%	No Target Set	Monthly	Common Cause	Not Applicable	13.8%	9.4%	18.3%	15.0%	13.5%	14.3%	11.8%	14.5%	15.5%	15.1%	15.7%	19.3%	14.8%	15.5%	15.8%	12.7%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Discover																						
Total patient recruitment to NIHR portfolio adopted studies	Nov-23	209	≥115 (per month)	Monthly (Month in Arrears)	Common Cause	Capable	286	139	434	243	394	334	349	261	266	343	297	211	201	226	209	n/a
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Nov-23	52	≥44	Monthly (Month in Arrears)	Common Cause	Capable	52	49	54	66	66	65	67	68	67	53	53	51	50	52	52	n/a
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Nov-23	4.9%	≥2%	Monthly (Month in Arrears)	Common Cause	Capable	4.7%	4.1%	5.4%	5.8%	5.8%	5.8%	5.9%	6.5%	6.6%	5.3%	4.5%	4.5%	4.6%	4.8%	4.9%	n/a
Context (Activity)																						
Number of A&E Arrivals	Dec-23	5161	No Target Set	Monthly	Common Cause	Not Applicable	5657	4782	6531	4745	5743	5761	6364	6303	6937	6838	6440	5931	5819	6020	5506	5161
Number of A&E Four Hour Breaches	Dec-23	52	No Target Set	Monthly	Common Cause	Not Applicable	32	-27	92	20	18	60	59	201	174	45	51	8	24	42	28	52
Number of Outpatient Appointment Attendances	Dec-23	44474	No Target Set	Monthly	Common Cause	Not Applicable	49746	38220	61272	41995	52323	49830	56076	46355	51892	56205	53235	53981	53349	56105	56299	44474
Number of Outpatient First Appointment Attendances	Dec-23	11091	No Target Set	Monthly	Common Cause	Not Applicable	11474	8977	13970	9564	11750	11445	12872	10798	12616	13356	12882	12886	12648	13222	13414	11091
Number of Outpatient Follow Up Appointment Attendances	Dec-23	33383	No Target Set	Monthly	Common Cause	Not Applicable	38272	29044	47500	32431	40573	38385	43204	35557	39276	42849	40353	41095	40701	42883	42885	33383
Number of Referrals Received	Dec-23	11182	No Target Set	Monthly	Common Cause	Not Applicable	12955	10000	15910	10614	13419	13308	15744	12839	15175	14825	14445	14232	13747	14773	14197	11182
Number of Theatre Admissions	Dec-23	2843	No Target Set	Monthly	Common Cause	Not Applicable	3082	2270	3893	2597	3305	3137	3258	2745	3209	3622	3421	3306	3258	3522	3750	2843
Number of Theatre Elective Daycase Admissions	Dec-23	2587	No Target Set	Monthly	Common Cause	Not Applicable	2813	2016	3610	2323	2999	2851	2971	2447	2926	3315	3118	3001	2986	3238	3475	2587
Number of Theatre Elective Inpatient Admission	Dec-23	55	No Target Set	Monthly	Common Cause	Not Applicable	75	49	101	77	103	85	79	70	74	86	74	90	77	79	82	55
Number of Theatre Emergency Admissions	Dec-23	201	No Target Set	Monthly	Common Cause	Not Applicable	194	152	235	197	203	201	208	228	209	221	229	215	195	205	193	201

Moorfields Eye Hospital NHS Foundation Trust

NHS

Report title	Monthly Finance Performance Report Month 09 – December 2023
Report from	Jonathan Wilson, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

For December, the trust is reporting:-

Financial Performance £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Plan	Actual	Variance
Income	£310.5m	£21.6m	£25.0m	£3.4m	£229.1m	£239.4m	£10.4m
Pay	(£168.6m)	(£14.2m)	(£14.7m)	(£0.5m)	(£126.6m)	(£130.6m)	(£4.0m)
Non Pay	(£121.4m)	(£8.6m)	(£9.1m)	(£0.5m)	(£90.2m)	(£90.9m)	(£0.7m)
Financing & Adjustments	(£17.1m)	(£1.4m)	(£1.5m)	(£0.1m)	(£13.0m)	(£11.9m)	£1.1m
CONTROL TOTAL	**£3.4m**	**(£2.7m)**	**(£0.3m)**	**£2.4m**	**(£0.7m)**	**£6.1m**	**£6.8m**

Income and Expenditure

- A £6.08m surplus year to date compared to a planned deficit of £0.69m; £6.67m ahead of plan.
- The trust is reporting a full year forecast of a £11.20m surplus against a planned surplus of £3.40m, in accordance with current forecast change protocols, and with agreement within NCL ICB.

Capital Expenditure

- Capital expenditure as at 31st December totalled £35.4m predominantly due to Oriel, IT, Stratford and Brent Cross against trust funded allocations.
- Trust funded capital expenditure of £9.5m has been committed against a revised £9.5m allocation.

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

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

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

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

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report

For the period ended 31st December 2023 (Month 09)

Presented by	Jonathan Wilson; Chief Financial Officer
Prepared by	Justin Betts; Deputy Chief Finance 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 31st December (Month 09)

Key Messages

Statement of Comprehensive Income

Financial Position £0.30m deficit in month	For December, the Trust is reporting:- • a £0.30m deficit against a planned deficit of £2.65m, £2.35m favourable • a £6.08m YTD surplus against a planned deficit of £0.69m, £6.77m favourable.
Income £24.99m in month (including £1.6m ERF funding and £6.9m performance ERF YTD)	Total trust income was £24.99m in December, a favourable variance of £3.38m. Material variances include:- • NHS Clinical activity income in December has been estimated based on current Elective Recovery Funding (ERF) guidance. • Activity levels achieved have exceeded the Trusts external activity plan required to reach the full year 118% ERF target. • Commercial patient income was £0.42m adverse to plan • R&D income was £0.32m ahead of plan
Expenditure £23.79m in month (pay, non-pay, excl financing)	Pay is reporting expenditure of £14.72m in December, £0.47m adverse to plan (£3.99m cumulatively). • Medical staff is £0.26m adverse in month (£1.98m cumulatively), with a significant driver being additional session payments. • Nursing staffing was £0.10m adverse in month driven by additional staffing requirements at Stratford Hub as the site fully opens and the continuation of high usage of off-framework agency staff in theatre areas. • Unachieved pay CIP has driven an adverse variance of £0.18m Non-pay is reporting expenditure of £9.07m in December, £0.49 adverse to plan (£0.70m adverse cumulatively). • Drugs is £0.41m adverse in month (£1.50m adverse cumulatively). The cumulative variance is driven by injection activity (£0.59m) and off-contract drugs premium (£0.40m). • Unidentified CIP contributed a further £0.20m to the adverse variance.
Financing and Depreciation £1.50m in month	Financing is reporting an adverse variance of £0.07m in month and £1.26m favourable cumulatively consisting of:- • Interest receivable benefits linked to the trust cash balance and increases in BoE interest rates.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 31st December was £43.3m, a reduction of £17.3m since the end of March 2023. The Better Payment Practice Code (BPPC) performance in December was 96% (volume) and 95% (value) against a target of 93% across both metrics.
Capital **(both gross capital expenditure and CDEL)**	Capital expenditure as at 31st December totalled £35.4m predominantly due to Oriel, and IT, Stratford and Brent Cross against trust funded allocations. Trust funded capital plans are being progressed with a total of £9.5m committed expenditure against the revised £9.5m notified allocation.

Other Key Information

Efficiencies £7.81m identified v £7.81m plan £4.44m delivered YTD £1.42m adverse	The trust is reporting £4.44m efficiencies cumulatively, £1.42m adverse to plan. The trust has identified full year savings of £7.81m compared to a plan of £7.81m shown below. • £0.86m Divisional efficiencies identified/forecast • £2.85m Productivity efficiencies identified/forecast • £2.98m Industrial Action settlement • £0.53m Central efficiencies including non-recurrent identified/forecast
Agency Spend £7.66m spend YTD 5.9% total pay	Trust wide agency spend totals £7.66m cumulatively, approximately 5.9% of total employee expenses spend,, in excess of national expectations of 3.7%. The forecast outturn spend is estimated at £10.10m. • Enhanced temporary staffing oversight is being implemented trust-wide via Workforce in relation to managing and reporting 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	£310.5m	£21.6m	£25.0m	£3.4m	£229.1m	£239.4m	£10.4m	5%	
Pay	(£168.6m)	(£14.2m)	(£14.7m)	(£0.5m)	(£126.6m)	(£130.6m)	(£4.0m)	(3)%	
Non Pay	(£121.4m)	(£8.6m)	(£9.1m)	(£0.5m)	(£90.2m)	(£90.9m)	(£0.7m)	(1)%	
Financing & Adjustments	(£17.1m)	(£1.4m)	(£1.5m)	(£0.1m)	(£13.0m)	(£11.9m)	£1.1m	8%	
CONTROL TOTAL	**£3.4m**	**(£2.7m)**	**(£0.3m)**	**£2.4m**	**(£0.7m)**	**£6.1m**	**£6.8m**		
Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income									
Memorandum Items									
Research & Development	(£0.37m)	£0.29m	£0.37m	£0.08m	(£1.23m)	£0.21m	£1.43m	117%	
Commercial Trading Units	£5.55m	£0.15m	(£0.13m)	(£0.28m)	£3.88m	£3.91m	£0.03m	1%	
ORIEL Revenue	(£1.92m)	(£0.16m)	(£0.07m)	£0.09m	(£1.44m)	(£1.52m)	(£0.08m)	(6)%	
Efficiency Schemes	£7.81m	£0.65m	£0.65m	£0.00m	£5.85m	£4.44m	(£1.42m)	(24)%	

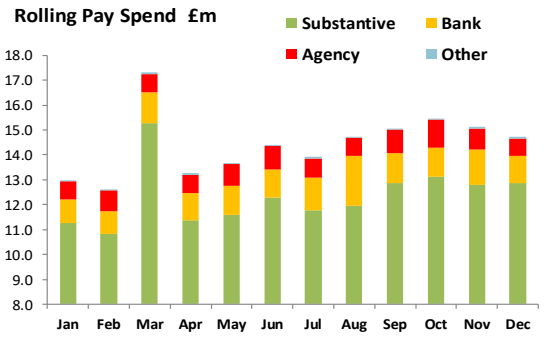
INCOME BREAKDOWN RELATED TO ACTIVITY

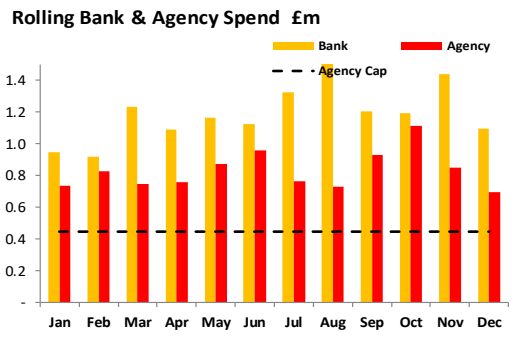
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£188.5m	£139.1m	£146.0m	£6.9m				
Pass Through	£39.2m	£29.1m	£29.6m	£0.4m				
Other NHS Clinical Income	£9.7m	£7.2m	£8.0m	£0.8m				
Commercial Trading Units	£45.2m	£33.6m	£32.8m	(£0.8m)				
Research & Development	£15.5m	£10.8m	£12.9m	£2.1m				
Other	£12.3m	£9.2m	£10.2m	£1.0m				
INCOME INCL ERF	**£310.5m**	**£229.1m**	**£239.4m**	**£10.4m**				

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

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	% Total
Employed	(£167.0m)	(£14.1m)	(£12.9m)	£1.2m	(£125.4m)	(£110.9m)	£14.5m	85%
Bank	(£1.0m)	(£0.1m)	(£1.1m)	(£1.0m)	(£0.8m)	(£11.6m)	(£10.9m)	9%
Agency	(£0.0m)	(£0.0m)	(£0.7m)	(£0.7m)	(£0.0m)	(£7.7m)	(£7.6m)	6%
Other	(£0.5m)	(£0.0m)	(£0.0m)	(£0.0m)	(£0.4m)	(£0.4m)	(£0.0m)	0%
TOTAL PAY	**(£168.6m)**	**(£14.2m)**	**(£14.7m)**	**(£0.5m)**	**(£126.6m)**	**(£130.6m)**	**(£4.0m)**	





*Agency cap levels set by NHSIE

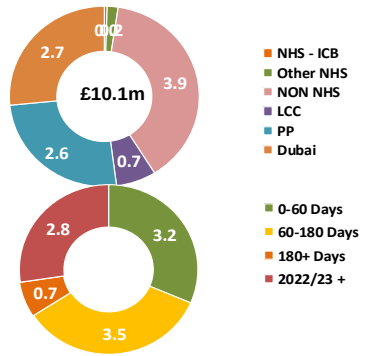
CASH, CAPITAL AND OTHER KPI'S

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	(£9.5m)	(£6.9m)	(£6.3m)	(£0.7m)				
Donated/Externally funded	(£55.3m)	(£41.5m)	(£29.1m)	(£12.4m)				
TOTAL	**£64.8m**	**£48.4m**	**£35.4m**	**(£13.1m)**				

Key Metrics	Plan	Actual	RAG
Cash	46.8	43.3	
Debtor Days	45	12	
Creditor Days	45	59	
PP Debtor Days	65	48	

Use of Resources	Plan	Actual
Capital service cover rating	-	-
Liquidity rating	-	-
I&E margin rating	-	-
I&E margin: distance from fin. plan	-	-
Agency rating	-	-
OVERALL RATING	**-**	**-**

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	202.26	13.38	14.13	0.75	149.31	149.72	0.41	0%	
Other NHS Clinical Income	9.74	0.62	0.83	0.21	7.23	8.00	0.77	11%	
Commercial Trading Units	45.21	3.36	2.94	(0.42)	33.57	32.79	(0.78)	(2)%	
Research & Development	15.51	1.63	1.95	0.32	10.84	12.90	2.06	19%	
Other Income	12.30	1.02	1.20	0.18	9.21	10.22	1.01	11%	
Total Income	**285.02**	**20.01**	**21.05**	**1.03**	**210.15**	**213.62**	**3.47**	**2%**	
Operating Expenses									
Pay	(168.59)	(14.25)	(14.72)	(0.47)	(126.64)	(130.62)	(3.99)	(3)%	
Of which: Unidentifed CIP	*1.17*	*0.18*	*-*	*(0.18)*	*0.62*	*-*	*(0.62)*		
Drugs	(41.11)	(2.64)	(3.04)	(0.41)	(30.53)	(32.03)	(1.50)	(5)%	
Clinical Supplies	(26.29)	(1.80)	(1.80)	0.00	(19.56)	(18.00)	1.57	8%	
Other Non Pay	(53.97)	(4.15)	(4.23)	(0.09)	(40.07)	(40.84)	(0.77)	(2)%	
Of which: Unidentifed CIP	*1.93*	*0.20*	*-*	*(0.20)*	*1.31*	*-*	*(1.31)*		
Total Operating Expenditure	**(289.97)**	**(22.83)**	**(23.79)**	**(0.95)**	**(216.80)**	**(221.49)**	**(4.69)**	**(2)%**	
EBITDA	*(4.96)*	*(2.82)*	*(2.74)*	*0.08*	*(6.65)*	*(7.87)*	*(1.22)*	(18)%	
Financing & Depreciation	(17.67)	(1.47)	(1.40)	0.07	(13.35)	(12.09)	1.26	9%	
Donated assets/impairment adjustm	0.52	0.04	(0.10)	(0.14)	0.39	0.23	(0.17)	(42)%	
Control Total Surplus/(Deficit) Pre ERF	**(22.10)**	**(4.25)**	**(4.24)**	**0.01**	**(19.60)**	**(19.73)**	**(0.13)**	**(1)%**	
Elective Recovery Funding	25.51	1.59	3.94	2.34	18.92	25.82	6.90	36%	
Control Total Surplus/(Deficit) Post ERF Income	**3.40**	**(2.65)**	**(0.30)**	**2.35**	**(0.69)**	**6.08**	**6.77**		

Commentary

Operating Income

£3.34m favourable to plan excl ERF

Clinical activity levels recorded were 106% for Daycases, 125% for Outpatients First Attendances and 124% for Outpatients Procedures during December, with activity-based income totalling £14.13m. Notable variances include:-

- Clinical income was £14.13m, £0.75m favourable to plan;
- Commercial trading income was £2.94m, £0.42m adverse to plan.
- Research and Development income was £1.95m; £0.32m favourable to plan
- Other Income was £1.20m; £0.18m favourable to plan.

Employee Expenses

£0.47m adverse to plan in month

December pay is reported as £14.72m against a cumulative trend of £14.30m in the prior 12 months. Pay is £0.47m overspent in month and £3.99m YTD.

- The significant drivers for the year to date overspend are:-
  - Medical staffing Working Time Directive arrears of £0.61m
  - Medical staffing additional sessions £1.5m higher than prior year
  - Nursing off-framework agency premium in Theatres £1.0m
  - Agency cover in corporate areas for projects and vacancies £1.3m
- Bank and agency costs totalled £1.79m in month against a rolling 12-month average of £2.06m. Agency costs are £0.69m in month and £7.66m YTD. Areas where agency continues to be at increased levels are theatre nursing staffing, anaesthetists, and administration in corporate areas.
- Unachieved CIP accounts for £0.18m of the in-month adverse variance and £0.62m cumulatively.

Non-Pay Expenses

£0.57m adverse to plan in month

(non-pay and financing)

Non-Pay costs in December were £10.47m against a cumulative trend of £11.48m in the prior 12 months.

- Drugs expenditure was £0.41m adverse to plan reflecting injection activity in excess of plan in month. Actual expenditure was £3.04m in month against prior month expenditure of £3.98m.
- Clinical supplies expenditure was £1.80m break-even to plan in month with actual expenditure of £1.80m in December against £1.87m in the prior month.
- Other non-pay was on plan in month.

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

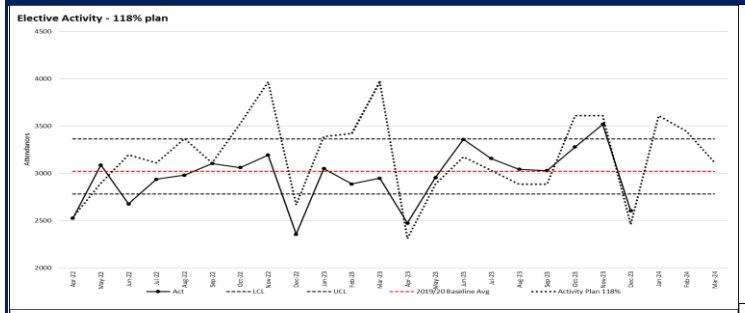
ERF Point of Delivery		Activity In Month				Activity YTD				Weighted YTD Income £m			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	2,461	2,603	142	106%	26,848	27,413	565	102%	£40.38	£40.80	£0.43	
	OP Firsts	8,263	10,306	2,043	125%	98,051	105,058	7,007	107%	£18.30	£19.33	£1.03	
	OP Procedures	13,691	16,989	3,298	124%	162,462	187,003	24,541	115%	£22.35	£27.79	£5.44	
	ERF Activity Total									£81.03	£87.93	£6.90	127%
Non ERF Activity	OP Follow Ups	15,583	15,712	129	101%	184,921	167,991	(16,930)	91%				
	High Cost Drugs Injections	3,029	3,963	934	131%	35,947	39,975	4,028	111%				
	Non Elective	234	197	(37)	84%	2,076	1,885	(191)	91%				
	AandE	6,696	5,160	(1,536)	77%	59,396	54,942	(4,454)	93%				
	Other NHS clinical income												
	Total	49,957	54,930	4,973	110%	569,701	584,267	14,566	103%				

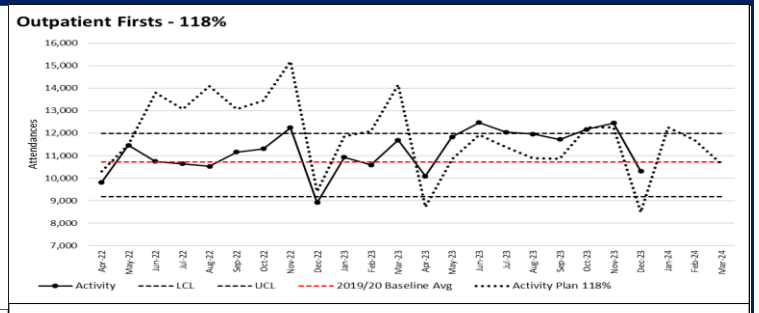
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

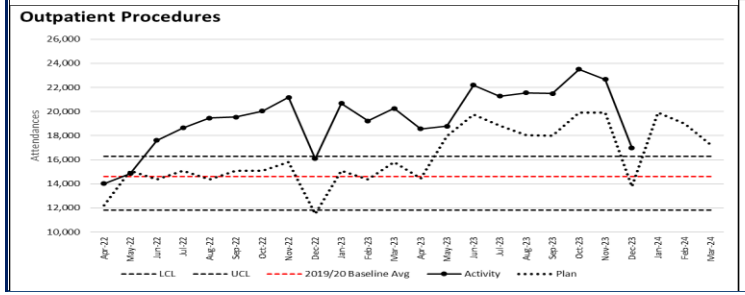
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

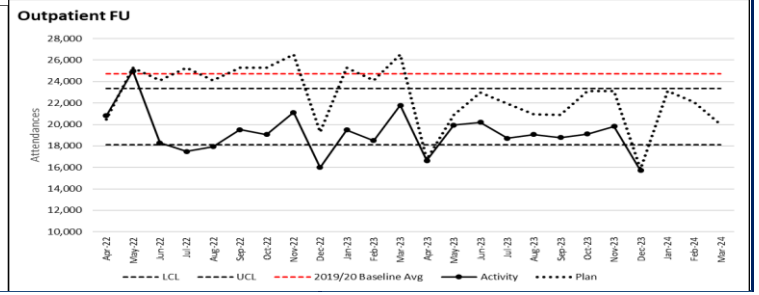
Performance % figures above, represent the Trust performance against the external activity target. Financial values shown are for ERF activity only.

ACTIVITY TREND - ERF COMPONENTS









Commentary

Activity plans and ERF

The Trust has an external Elective Recovery Fund (ERF) target of 118% for financially Weighted Activity Units (WAU) and has a stretch target of 121% in order to contribute towards the trusts efficiencies and productivity plans as shown on slide eight.

The monetary values to the left are representative of activity relating to ERF activity only, and will include WAU income based on the casemix and complexity recorded.

NHS Income

NHS Patient Clinical activity income in December has been estimated based on draft Elective Recovery Funding (ERF) calculations received in December and is subject to confirmation with the ICB.

ERF Achievement

The calculated ERF performance (against the 118% target) is estimated at £6.9m favourable variance equating to 127% activity delivery (including the national IA adjustment of 4%) consisting of:-

ERF Activity performance achievement

- **Inpatient activity** achieved 106% of activity plans in December (102% YTD);
- **Outpatient Firsts Activity** achieved 125% of activity plans in December (107% YTD);
- **Outpatient Procedures Activity** achieved 124% of activity plans in December; (115% YTD)

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 131% of activity plans in December (111% in YTD);
- **A&E** achieved 77% of activity plans in December (93% YTD);

Activity Plans

The charts to the left demonstrate the in-year activity levels compared to the previous year, including the 118% activity plans, and 2019/20 average activity levels for comparison.

The red line represents average 2019/20 activity levels.

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

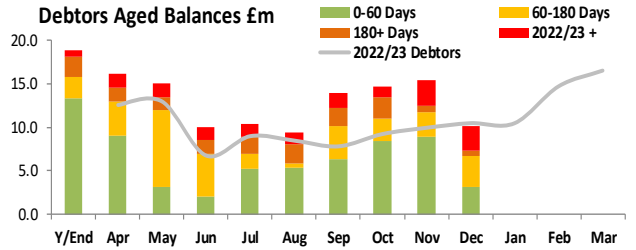
CAPITAL EXPENDITURE

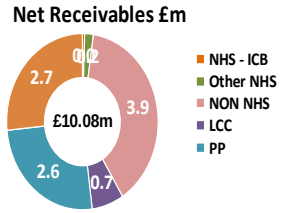
Capital Expenditure £m	Annual Plan	Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance
Estates - Trust Funded	4.1	3.5	3.4	(0.2)	4.1		
Medical Equipment - Trust Funded	2.1	1.1	1.0	(0.1)	2.1		
IT - Trust Funded	1.2	1.0	1.1	0.1	1.2		
ORIEL - Trust Funded	-	-	-	-	-		
Commercial - Trust funded	1.3	1.0	0.8	(0.2)	1.3		
Other - Trust funded	0.8	0.3	(0.0)	(0.3)	0.8		
TOTAL - TRUST FUNDED	**9.5**	**6.9**	**6.3**	**(0.7)**	**9.5**		
Externally funded	55.3	41.5	29.1	(12.4)	55.3		
TOTAL INCLUDING DONATED	**64.8**	**48.4**	**35.4**	**(13.1)**	**64.8**		

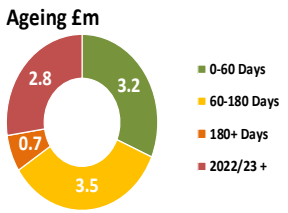
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
ICS Fair Share Allocation	9.5	10.5	(1.0)	110%
Cash Reserves - Oriel	-	-		-
Cash Reserves - B/Fwd	-	-		-
Capital Loan Repayments	-	-		-
TOTAL - TRUST FUNDED	**9.5**	**10.5**	**(1.0)**	**110%**
Externally funded	55.1	53.9	1.2	98%
Donated/Charity	0.2	0.2		100%
TOTAL INCLUDING DONATED	**64.8**	**64.6**	**0%**	**100%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2020/21 +*	*Total*
CCG Debt	(0.0)	-	-	(0.0)	(0.0)
Other NHS Debt	(0.7)	0.3	0.2	0.5	0.2
Non NHS Debt	1.2	1.2	0.1	1.5	3.9
Commercial Unit Debt	2.8	2.0	0.4	0.9	6.0
TOTAL RECEIVABLES	**3.2**	**3.5**	**0.7**	**2.8**	**10.1**







STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date		
		Plan	Actual	Variance
Non-current assets	262.8	251.0	236.6	(14.4)
Current assets (excl Cash)	33.9	33.9	42.6	8.7
Cash and cash equivalents	57.1	46.8	43.3	(3.5)
Current liabilities	(68.2)	(68.5)	(69.6)	(1.1)
Non-current liabilities	(66.9)	(69.2)	(59.2)	10.1
TOTAL ASSETS EMPLOYED	**218.6**	**194.0**	**193.8**	**(0.2)**

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 31st December was £43.3m, a reduction of £17.3m since the end of March 2023.

Capital Expenditure

Capital expenditure as at 31st December totalled £35.4m predominantly due to Oriel, and IT prior year committed expenditure, Stratford and Brent Cross against trust funded allocations.

Trust funded capital expenditure of £9.5m has been committed against a revised £9.5m allocation.

Receivables

Receivables have reduced by £8.7m to £10.1m since the end of the 2022/23 financial year. Debt in excess of 60 days increased by £0.4m in December. There was also a reduction of £5.7m in current debt.

Payables

Payables totalled £11.2m at the end of December, a reduction of £13.2m since the end of March 2023.

The trust's performance against the Better Payment Practice Code (BPPC) was 95% (volume) and 93% (value) against a target of 95%. Prior month achievement was 96% (volume) and 96% (value).

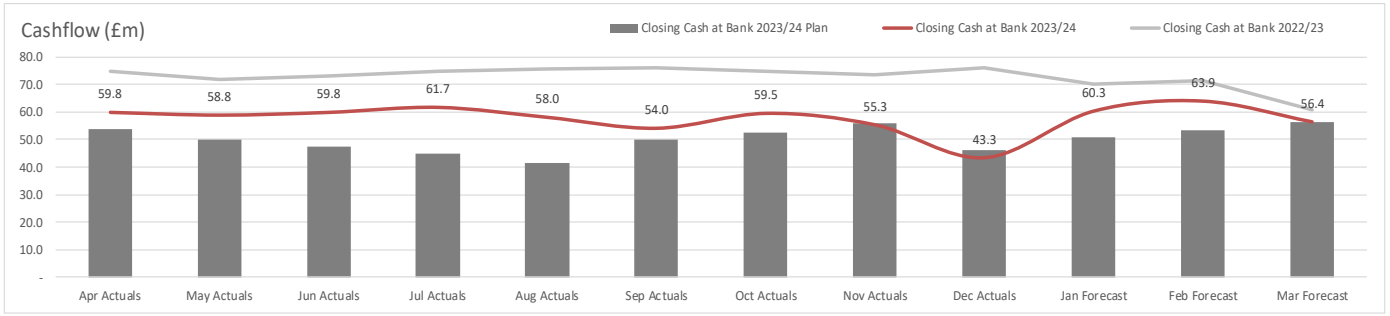
Use of Resources

Use of resources monitoring and reporting has been suspended.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Actuals	Aug Actuals	Sep Actuals	Oct Actuals	Nov Actuals	Dec Actuals	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Dec Forecast	Dec Var
Opening Cash at Bank	**60.6**	**59.8**	**58.8**	**59.8**	**61.7**	**58.0**	**54.0**	**59.5**	**55.3**	**43.3**	**60.3**	**63.9**	**60.6**		
Cash Inflows															
Healthcare Contracts	19.6	18.5	24.0	20.4	18.9	19.0	20.9	18.5	18.9	21.2	20.2	19.2	239.3	16.1	2.9
Other NHS	5.3	0.8	5.1	3.3	1.3	0.4	3.2	1.7	2.6	0.8	0.8	0.8	26.1	1.8	0.8
Moorfields Private/Dubai/NCS	3.0	4.3	3.5	3.3	3.3	3.7	4.2	3.9	3.7	3.7	3.6	3.8	44.2	3.0	0.7
Research	1.2	1.0	0.7	0.9	0.8	1.1	0.7	0.5	1.6	1.6	1.6	1.6	13.3	1.6	0.1
VAT	0.6	0.4	0.4	-	1.3	0.4	0.3	0.5	0.5	0.5	0.5	0.5	6.0	0.5	0.0
PDC	-	-	-	-			13.0	-	-	17.1	10.0	-	40.1	-	-
Other Inflows	0.8	0.4	0.2	0.8	0.2	0.3	0.2	0.2	0.2	0.3	0.3	0.3	4.1	0.3	(0.0)
Total Cash Inflows	**30.5**	**25.4**	**33.9**	**28.7**	**25.9**	**25.0**	**42.6**	**25.4**	**27.6**	**45.1**	**36.9**	**26.1**	**373.2**	**23.1**	**4.5**
Cash Outflows															
Salaries, Wages, Tax & NI	(10.9)	(11.6)	(14.4)	(13.5)	(11.7)	(12.2)	(12.5)	(12.3)	(12.6)	(12.6)	(12.6)	(12.6)	(149.8)	(12.0)	(0.6)
Non Pay Expenditure	(15.7)	(12.3)	(15.4)	(11.6)	(14.7)	(13.4)	(12.0)	(14.4)	(10.0)	(11.7)	(11.7)	(10.5)	(153.4)	(9.6)	(0.4)
Capital Expenditure	(2.7)	(1.1)	(1.3)	(0.6)	(0.8)	(0.2)	(2.1)	(0.9)	(0.1)	(0.5)	(3.5)	(4.5)	(18.2)	(0.5)	0.4
Oriel	(0.2)	(0.2)	(0.4)	(0.1)	(0.3)	(0.6)	(9.3)	(0.7)	(15.5)	(1.5)	(2.9)	(2.6)	(34.3)	(11.8)	(3.7)
Moorfields Private/Dubai/NCS	(1.8)	(1.2)	(1.5)	(1.0)	(1.5)	(1.2)	(1.2)	(1.3)	(1.3)	(1.8)	(1.8)	(1.8)	(17.5)	(1.8)	0.5
Financing - Loan repayments	-	-	-	-	(0.6)	(0.7)	-	-	-	-	(0.6)	(0.7)	(2.7)	-	-
Dividend and Interest Payable	-	-	-	-	-	(0.6)	-	-	-	-	-	(0.9)	(1.5)	-	-
Total Cash Outflows	(31.3)	(26.4)	(32.9)	(26.8)	(29.5)	(29.0)	(37.1)	(29.5)	(39.6)	(28.2)	(33.3)	(33.6)	**(377.4)**	(35.7)	(3.9)
Net Cash inflows /(Outflows)	(0.7)	(1.0)	1.0	1.8	(3.6)	(4.0)	5.4	(4.2)	(12.0)	17.0	3.6	(7.5)	-	(12.6)	0.6
Closing Cash at Bank 2023/24	**59.8**	**58.8**	**59.8**	**61.7**	**58.0**	**54.0**	**59.5**	**55.3**	**43.3**	**60.3**	**63.9**	**56.4**	**56.4**		
Closing Cash at Bank 2023/24 Plan	53.9	50.0	47.2	44.9	41.4	49.8	52.4	55.9	46.3	50.6	53.1	56.4	56.4		
Closing Cash at Bank 2022/23	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 31st December was £43.3m, a reduction of £17.3m since the end of March 2023.

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 60 days of operating cash (prior month: 76 days).

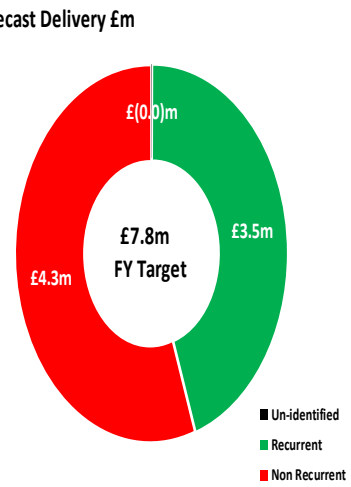
December saw a cash outflow of £12.0m against a forecast of £12.6m as higher than anticipated cash receipts offset Oriel capital and JDV payments. Matching PDC funding in relation to Oriel will be received in January. The cash flow forecast for the end of the financial year is showing achievement of plan.

Trust Efficiency Scheme Performance

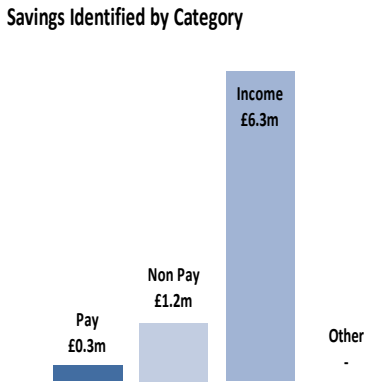
EFFICIENCY SCHEMES PERFORMANCE

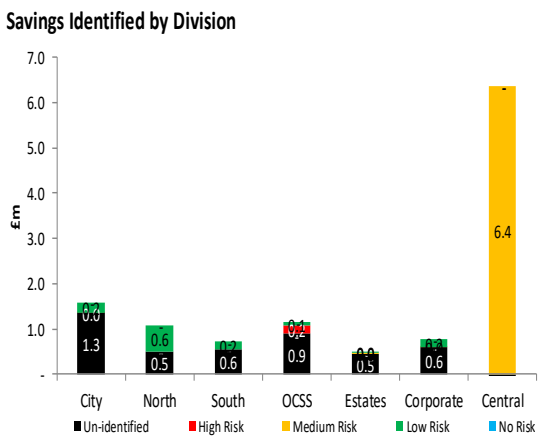
Efficiency Schemes £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Plan	Forecast Actual	Forecast Variance
City Road	£1.59m	£0.13m	£0.02m	(£0.11m)	£1.19m	£0.22m	(£0.98m)	£1.59m	£0.25m	(£1.34m)
North	£1.09m	£0.09m	£0.01m	(£0.08m)	£0.82m	£0.14m	(£0.68m)	£1.09m	£0.58m	(£0.51m)
South	£0.72m	£0.06m	£0.01m	(£0.05m)	£0.54m	£0.15m	(£0.39m)	£0.72m	£0.16m	(£0.55m)
Ophth. & Clinical Serv.	£1.14m	£0.10m	£0.02m	(£0.08m)	£0.86m	£0.19m	(£0.67m)	£1.14m	£0.25m	(£0.90m)
Estates & Facilities	£0.49m	£0.04m	£0.00m	(£0.04m)	£0.37m	£0.03m	(£0.34m)	£0.49m	£0.04m	(£0.45m)
Corporate	£0.77m	£0.06m	£0.01m	(£0.06m)	£0.58m	£0.14m	(£0.44m)	£0.77m	£0.17m	(£0.60m)
DIVISIONAL EFFICIENCIES	**£5.81m**	**£0.48m**	**£0.07m**	**(£0.42m)**	**£4.35m**	**£0.86m**	**(£3.49m)**	**£5.81m**	**£1.45m**	**(£4.36m)**
Central										
Productivity/Activity @ 121%	£2.00m	£0.17m	£0.28m	£0.11m	£1.50m	£0.98m	(£0.52m)	£2.00m	£2.85m	£0.85m
Industrial Action Settlement	-	-	£0.25m	£0.25m	-	£2.24m	£2.24m	-	£2.98m	£2.98m
Other/Non Recurrent schemes	-	-	£0.06m	£0.06m	-	£0.34m	£0.34m	-	£0.53m	£0.53m
TRUST EFFICIENCIES	**£7.81m**	**£0.65m**	**£0.65m**	**£0.00m**	**£5.85m**	**£4.44m**	**(£1.42m)**	**£7.81m**	**£7.81m**	**£0.00m**

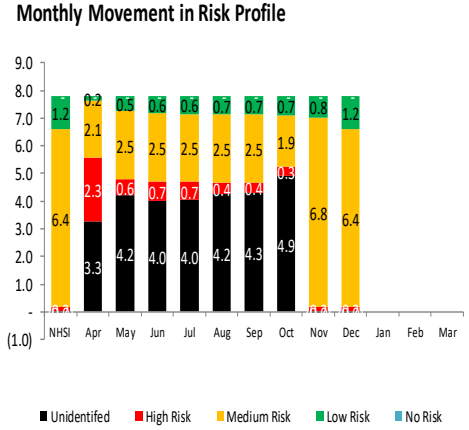
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







* charts may include rounding differences

Commentary

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

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

In Year Delivery The trust is reporting efficiency savings achieved of:-

- £0.65m in month, compared to a plan of £0.65m, break-even to plan;
- £4.44m year to date, compared to a plan of £5.85m, £1.42m adverse to plan.

Productivity Productivity efficiency schemes represent the level of ERF activity performance in excess of the external 118% activity target, by financial weighted average income, less the estimated level of costs of delivery within clinical divisions.

- The trust has set baseline internal activity targets of 121%+, which subject to case mix and national guidance would represent £3.0m additional income prior to identified marginal costs of delivery.
- The trust has also benefited from the national Industrial Action settlement reported as a non-recurrent benefit.

Risk Profiles The charts to the left demonstrates the identified saving by category, divisional identification status including risk profiles, and the trust wide monthly risk profile changes for identified schemes as the year progresses.

Forecast The trust is currently forecasting to achieve £7.81m of savings against a £7.81m plan.

Supplementary Information

Moorfields Eye Hospital NHS Foundation Trust

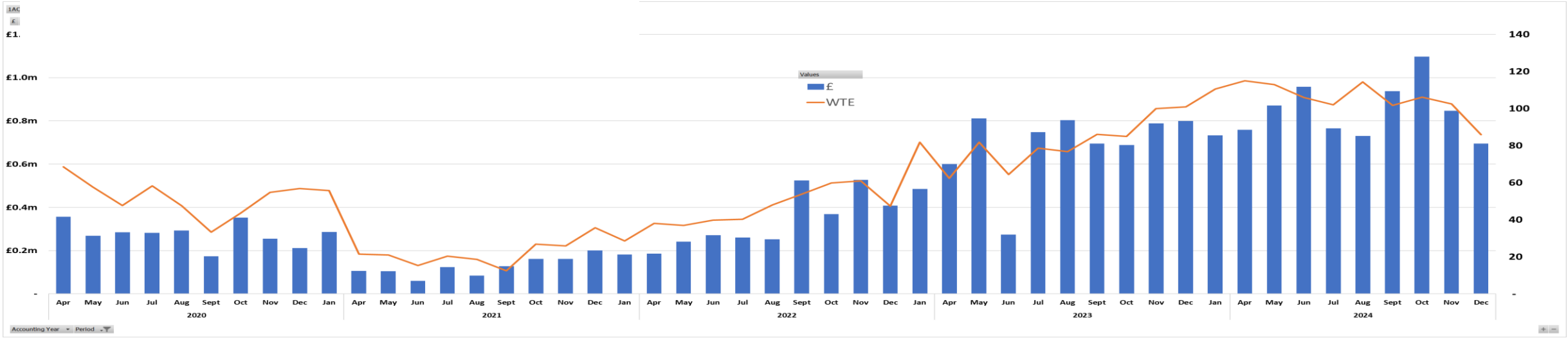
NHS

Workforce - Agency Spend Reporting

AGENCY SPEND REPORTING

Pay Expense Reporting £m	2022/23 Jan 23	Feb 23	Mar 23	2023/24 Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	YTD £m	YTD %
Agency														
Clinical Divisions	0.660	0.543	0.520	0.372	0.504	0.508	0.491	0.428	0.592	0.647	0.507	0.351	4.400	**57%**
Coporate Departments	0.047	0.246	0.328	0.261	0.279	0.320	0.281	0.190	0.261	0.310	0.258	0.259	2.419	**32%**
Commercial/Trading	(0.063)	(0.016)	(0.066)	0.025	0.027	0.045	0.020	0.077	0.035	0.097	0.028	0.022	0.376	**5%**
Research	0.089	0.054	0.065	0.100	0.059	0.085	(0.027)	0.035	0.049	0.044	0.053	0.063	0.461	**6%**
Total Agency	**0.733**	**0.827**	**0.847**	**0.758**	**0.871**	**0.957**	**0.765**	**0.730**	**0.937**	**1.097**	**0.846**	**0.695**	**7.656**	
Agency														
Medical Staff	0.136	0.097	0.068	0.077	0.080	0.098	0.100	0.104	0.103	0.095	0.104	0.078	0.839	**11%**
Nursing Staff	0.201	0.224	0.186	0.186	0.249	0.191	0.140	0.105	0.139	0.273	0.133	0.125	1.541	**20%**
Scientific & Technical	0.116	0.065	0.065	0.039	0.056	0.062	(0.031)	0.051	0.252	0.158	0.125	0.093	0.804	**11%**
Allied Health Professionals	-	-	0.001	0.009	0.004	0.001	-	-	0.003	0.016	0.001	0.005	0.038	**1%**
Clinical Support	0.121	0.104	0.036	0.033	0.110	0.132	0.291	0.143	0.091	0.101	0.073	0.039	1.013	**13%**
Admin And Clerical	0.144	0.324	0.391	0.405	0.360	0.435	0.257	0.282	0.337	0.442	0.400	0.338	3.255	**43%**
Ancillary Services	0.014	0.015	(0.003)	0.010	0.011	0.038	0.008	0.044	0.012	0.013	0.011	0.017	0.165	**2%**
Total Agency	**0.733**	**0.827**	**0.744**	**0.758**	**0.871**	**0.957**	**0.765**	**0.730**	**0.937**	**1.097**	**0.846**	**0.695**	**7.656**	

*Excludes central budgets



Report title	Draft Patient safety incident response framework (PSIRF)policy and plan
Report from	Sheila Adam, chief nurse and executive director of allied health professionals
Prepared by	Ian Tombleson, director of quality and safety, Kylie Smith, head of quality and safety
Link to strategic objectives	Working together

Executive summary

The Patient Safety Incident Response Framework (PSIRF) is an integral component of the NHS national patient safety strategy, presenting a novel and innovative approach to how the NHS addresses patient safety incidents. The PSIR policy, along with the accompanying PSIR plan (referred to as the Plan), outlines the trust's methodology for responding to incidents under PSRIF with the aim of optimising learning and facilitating improvement.

The local incident priorities outlined in the Plan (pages 12-18) have been formulated through the analysis of various data sources, including incidents, complaints, freedom to speak up, and focus groups, as detailed in the document. These documents have been developed collaboratively and in consultation with key stakeholders, including patient safety partners. The Plan has undergone consultation with clinical governance committee members and was discussed at the meeting on 9 December 2023. Additionally, the draft policy and plan were shared with ICB, and their feedback has been incorporated.

The draft policy and plan are scheduled for presentation to Quality and Safety Committee (Q&SC) on January 30, 2024, for approval, following delegation at the trust board. Upon approval, they will be published on the trust website, pending approval by the ICB. Furthermore, the documents will be disseminated at TMC on January 24, 2024.

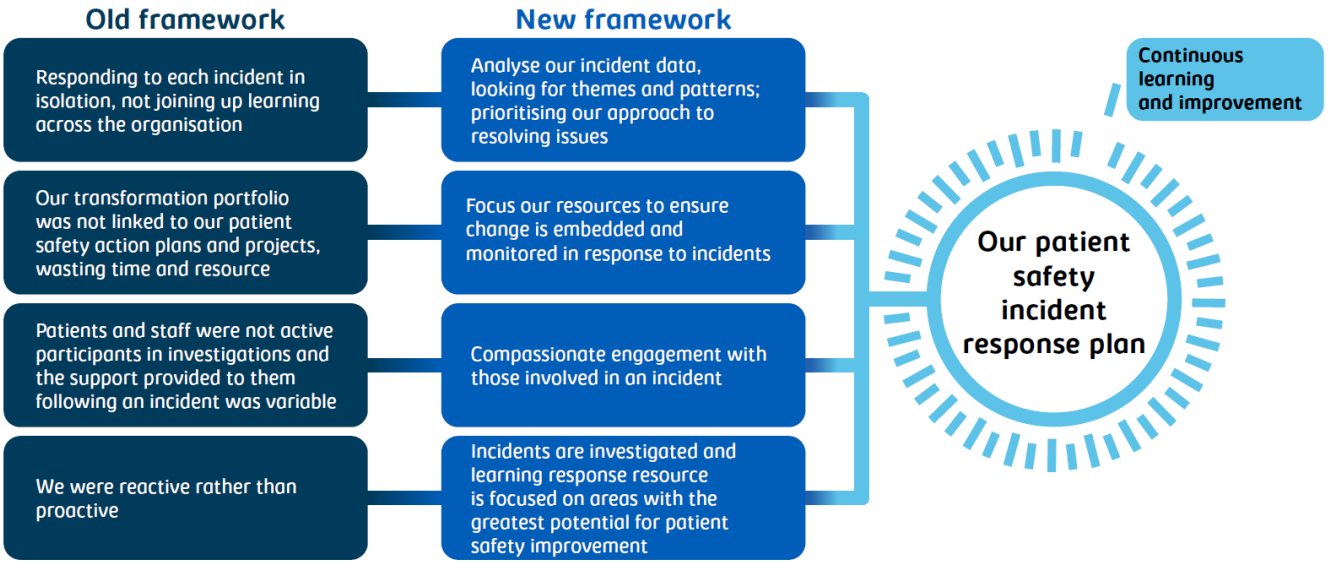
Prior to approval at QS&C the new EHIA assessment will be added to the policy.

Significant work remains to embed the PSIRF. Post-approval, a transition phase from the old systems to the new will commence and PSIRF will be implemented in 2024/25. The progress of this transition will be documented in a PSIRF implementation plan and monitored by the working together board.

What is PSIRF?

Moorfields Eye Hospital NHS Foundation Trust

The **Patient Safety Incident Response Framework** (PSIRF) is a new approach to responding to patient safety incidents. It focuses on effective learning, continuous improvement, and compassionate engagement with patients and staff following an incident.



Quality implications

The policy and plan will significantly change the way we learn from and improve as a result of patient safety incidents and ways to evaluate this will be put in place

Financial implications

There are potential financial implications, but these have not yet been quantified. This includes support for data analysis and quality improvement.

Risk implications

If we do not publish our policy and plan by 1 April 2024, we will not meet the national deadline for transition from SIF to PSIRF. We may miss learning and improvement opportunities due to any delay.

Action required/recommendation.

The Board is requested to delegate the detailed consideration and approval of PSIRF to Q&SC at its meeting of 30 January 2024. Once agreed, the documents will be shared with ICB for approval before publication.

For assurance		For decision	✓	For discussion		To note	

Moorfields Eye Hospital NHS Foundation Trust

Patient safety incident response policy

Summary

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how the Trust will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

Version: **0.9**

Status: **Draft:** **x**

Approved: **(date)**

Ratified: **(date)**

Version history

Version	Date issued	Brief summary of change	Author
		New document	Julie Nott

For more information on the status of this document, please contact:	Quality & safety team Moorfields.QANDS@nhs.net	
Policy author	Head of risk & safety and patient safety specialist Head of quality & safety	
Policy owner	Director of quality & safety	
Accountable director	Chief nurse & director of allied health professions	
Department	Quality & safety	
Applies to (audience):	Trust wide	
Groups / individuals who have overseen the development of this policy	• PSIRF implementation group • Risk & safety committee • Clinical governance committee • Divisional management teams • Service directors	
Committees which were consulted and have given approval (name | date)	Clinical governance committee Trust management committee Quality & safety committee	09/12/2023 24/01/2024 (TBC) 30/01/2024 (TBC)
Responsible committee/group for approval	Policy and Procedural Review Group (PPRG)	
Ratified by (name | date)	Quality & Safety Committee (on behalf of the Trust Board)	30/01/2024 (TBC)
Date of issue	TBC	
Date of next formal review		

Contents

Executive summary

The Patient Safety Incident Response Framework (PSIRF) is a different and exciting approach to how we respond to patient safety incidents. Unlike the Serious Incident Framework (SIF), which we have operated under since 2013, PSIRF is **not** an investigation framework. It does not mandate investigation as the only method for learning from patient safety incidents (PSIs) and it does not prescribe which incidents we must investigate. It is a framework that supports development and maintenance of an effective patient safety incident response system with four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.

2. Application of a range of system-based approaches to learning from patient safety incidents.

3. Considered and proportionate responses to PSIs.

4. Supportive oversight focused on strengthening response system functioning and improvement.

This PSIR policy, and the associated PSIR plan (the Plan), describe how the trust responds to incidents under PSRIF to maximise learning and improvement. (see Appendix 1). With the exception of incidents that require a nationally mandated response to certain categories of events, such as Never Events, this policy supports how we will:

- Balance effort between learning from responding to incidents and/or exploring issues and our improvement work.

- Broaden the methodologies that we use to learn from PSIs, e.g., clinical audit, thematic analysis.

- Focus our attention on understanding events that we may not have previously had the resource to examine. Our chosen response will not be solely based on harm that has already occurred; we will be able to consider the risk of future harm occurring and then identify how that risk can be reduced across the organisation.

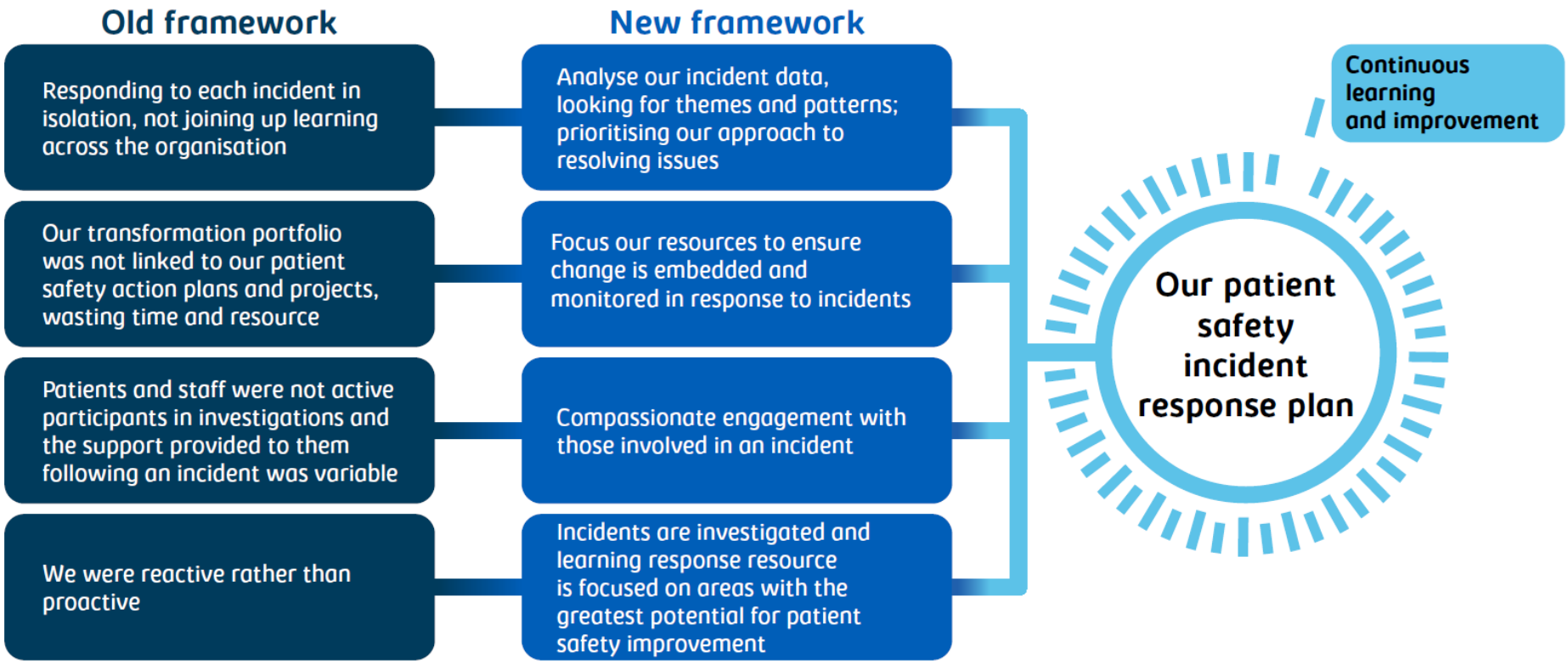
- Further develop our existing learning system and ensure that the output of the proportionate learning responses that we undertake are shared across the organisation and that local improvement opportunities, in areas other than that in which an event occurred, can be considered by teams.

  A glossary of terms used can be found at Appendix 2.

What is PSIRF?

Moorfields Eye Hospital NHS Foundation Trust

The **Patient Safety Incident Response Framework** (PSIRF) is a new approach to responding to patient safety incidents. It focuses on effective learning, continuous improvement, and compassionate engagement with patients and staff following an incident.



1. Introduction

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents (PSIs)[1] for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'PSIs' and 'Serious Incidents'. As such, it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to PSIs by ensuring resources allocated to learning are balanced with those needed to deliver improvement. Unlike SIF, it is **not** an investigation framework.

PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. Therefore, organisations can explore PSIs relevant to their context and the populations they serve rather than exploring only those that meet a certain nationally defined threshold.

The PSIRF also advocates a co-ordinated and data-driven response to PSIs. It embeds PSIs within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management and provides the tools to support this shift Purpose

2. Purpose

This policy supports the requirements of the NHS England PSIRF and sets out how Moorfields Eye Hospital NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to PSIs and issues for the purpose of learning and improving patient safety.

This policy also supports the development and maintenance of an effective PSI response system that integrates the four key aims of the PSIRF.

- Compassionate engagement and involvement of those affected by PSIs.
- Application of a range of system-based approaches to learning from PSIs.
- Considered and proportionate responses to PSIs and safety issues.

[1] Patient safety incidents (PSIs) are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

- Supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with the documents listed in section 18, including the trust's patient safety incident response plan ('the Plan'), which is a separate document setting out how this policy will be implemented.

It should be noted that this policy will evolve as the organisation transitions to PSRIF, and the PSIRF is embedded in the trust.

3. Scope

This policy is specific to PSI responses that are conducted solely for the purpose of learning and improvement, across all Trust NHS and Private services.

Those leading patient safety incident responses (learning response leads) and those involved in the oversight of learning and improvement emerging from patient safety incident response require specific knowledge and experience.

Responses under this policy will follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components (e.g., people, tasks, equipment, environment (internal and external) and organisation), and not from a single component.

Responses to PSIs **will not** take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in responses to PSIs that are conducted for the purpose of learning and improvement. The processes listed below exist for that purpose and are outside the scope of this policy:

- Claims handling.
- Human resources investigations into employment concerns.
- Professional standards investigations.
- Coronial inquests.
- Criminal investigations.
- Information governance concerns.
- Financial investigations and audits.

- Fraudulent activity.
- Complaints (except where a patient safety concern is highlighted).

Information from a PSI learning or improvement response process can be shared with those leading other types of responses, but these processes should not influence the remit of the PSI responses described in this policy.

Some departments and services within the trust (eg eye bank, pathology, electro-physiology department, contact lens and prosthetics manufacturing) are subject to accreditation, certification, license or permit inspection by an Approved Body or a Regulatory Body. As such, there is a requirement to record non-conformities identified with work processes and systems against certain standards, so that improvement opportunities can be identified and considered as stipulated by these bodies. These non-conformities do not fall within the remit of this policy unless a patient is involved or affected, in which case a PSI will be reported on Safeguard (the trust electronic incident reporting system) via the trust incident reporting process and will then be within scope.

The process for the management of non-PSIs is described in the incident reporting policy and procedure[2].

Learning and improvement

The learning responses available under PSIRF provide a range of tools and approaches to elicit learning from PSIs. These tools and approaches enable us to understand any vulnerabilities in our systems which need to be addressed, to avoid repeat. The Plan that supports this policy outlines the trust learning responses against our identified incident priorities.

The incident review group (IRG) will determine, using the Plan as guidance, where a learning response to explore the contributory factors to a patient safety incident or cluster of incidents, is required to inform improvement.

Where the IRG determines that the contributory factors are known, and determines there is already a robust workstream in place to support improvement (that is a learning response has already occurred), the PSI will be fed into the most appropriate improvement workstream as described in the Plan and Appendix 1 in this policy.

[2] This policy will be updated to take account of the change from the SIF to the PSIRF and introduction of the NHS England Learning from Patient Safety Events (LFPSE) service.

4. Our patient safety culture

This policy supports the trust's commitment to improving the existing patient safety culture and recognises the direct correlation between the experiences of staff in relation to engagement and the impact on safety and clinical outcomes for patients. We are striving to be an employer that staff feel they can trust, and to create an environment in which staff feel valued, respected, and supported. This is being done in accordance with the Trust values of *Excellence*, *Equity*, and *Kindness* and the NHS People Promise themes.

The annual staff survey is recognised as a primary source of data to inform our priorities and processes, and the trust is committed to reviewing the results of the survey yearly and identifying mechanisms to improve the response rate. There is also an expectation that improvement plans are developed in response to the survey findings. There will be executive oversight of the organisational improvement plans, as a minimum.

Our work to enhance our patient safety culture is evolutionary and the specific priorities within each workstream, not all of which are explicitly referenced below, will be refreshed based on the work that is completed and feedback we receive during the PSIRF implementation phase.

In respect of PSIs, and as a priority to support the development of a positive patient safety culture, we will strive to ensure we:

- Have effective processes that support open and transparent reporting, and that staff are aware of the importance and significance of engaging with these processes. To achieve this, alongside this policy, we will seek feedback from staff regarding the effectiveness of these processes (e.g., electronic incident reporting of PSIs via Safeguard (Ulysses)), and any barriers to engaging with them in order to drive improvements, where possible. We will continue our efforts to ensure that staff are aware of the importance of reporting near misses, and that they understand the ways in which this can proactively prevent future harm.
- Effectively engage and involve those affected by PSIs as described in our involving and supporting patients and staff following a patient safety incident policy[3].
- Prioritise our learning and improvement responses to PSIs, and provide staff with the information, instruction, and training that they need to be able to respond appropriately and in a timely manner.

[3] This policy is currently under development and will replace the existing 'being open and duty of candour policy'.

- Continue to seek to evaluate and improve the effectiveness of our freedom to speak up service (FTSU), to ensure that it is accessible by all staff, staff recognise it as a safe way in which to raise concerns so that timely and appropriate action can be taken.

- Continue to encourage completion of the level 1 National Patient Safety Syllabus (NPSS) training, so that staff recognise that safety is a key priority and to meet the national PSRIF standards requirement.

- Ensure that the barriers and facilitators to the conduct of an effective safety huddle are being identified, as safety huddles are recognised within the trust to:

    - Enhance teamwork through communication and co-operative problem-solving

    - Encourage shared understanding of the focus and priorities for the day

    - Improve situational awareness of safety concerns.

    - Further develop our learning system and create an environment in which there is both system level and organisational level shared learning, and that the ability to learn will be reinforced through the culture and behaviour of staff.

Supporting the development of a just culture

The trust recognises that effective learning can only take place in a non-threatening environment and that fear of disciplinary action may deter staff from reporting an incident. This message should be reiterated to staff and managers wherever possible. To this end, managers who are reviewing an incident will be supported to apply Just Culture principles where a potential concern regarding an individual action is identified. Application of Just Culture principles will support consistent, constructive, and fair evaluation of the actions of staff involved in PSIs.

5. Patient safety partners (PSPs)

PSP are a new and evolving role that has been developed by NHS England to help improve patient safety across the NHS. The role recognises the important effect that patients, carers, and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. Our PSPs are either a previous or existing Trust patient and/or an individual who has experienced Moorfields as a close family member/carer. We are in the process of developing the role and recognise that it will take time and commitment from both the organisation and PSPs to shape the role to ensure that PSPs can fulfil our shared vision

that improving patient safety, experience and outcomes should be at the forefront of everything that we do.

The Trust recognises that the involvement of patients in their care and in the development of services is an essential element of safety. The PSP role at Moorfields is central to ensuring that decisions made by the trust are considered from a patient/service user perspective. There are many ways in which this is achieved including, but not limited to, the involvement of our PSPs in:

- Key governance committees and groups focussing on safety, risk, quality, and experience.
- Range of inspection programmes, including those that are executive-led and national inspections such as the Patient-Led Assessments of the Care Environment (PLACE).
- The development of projects delivered by divisional teams, service improvement & sustainability, central quality & safety and patient experience teams ensuring that patient co-design is promoted
- The development of plans to deliver services from new locations, such as a new site
- Development of our quality priorities.

Specifically in relation to the PSIRF, our PSPs have been consulted regarding our initial and on-going delivery and implementation plans (see Appendix 3). We will continue to engage our PSPs in the development of PSIRF-related documents and materials, ensuring that we have an effective PSI response system that prioritises compassionate engagement with those affected by PSIs.

6. Addressing health inequalities

The trust recognises the importance of reducing the health inequalities of the populations we serve and under the Equality Act (2010), as a public authority, we have statutory obligations that we are committed to delivering on.

The trust also supports the NHS National Patient Safety Strategy objective to understand populations with respect to demography, ethnicity, and social deprivation factors to improve safety and outcomes. We will aim to gain further evidence about disparities in the safety of the services that we provide, as experienced by different groups. As such, we will determine a methodology to analyse incident reporting by protected characteristics to give insight into any apparent inequalities in reporting. Once established, this will be included in our incident reporting and management policy and procedure.

The trust is also committed to reducing health inequalities as described in our excellence portfolio, monitored by the Excellence Delivery Unit (XDU) working together board, including:

- Accessible Information Standard (AIS)

This work aims to support effective communication by improving our compliance with the AIS standard. The AIS principles will be applied to the use of supportive tools, such as easy read, translation, and interpretation services to ensure that we maximise the ability and potential for patients and staff to be involved in patient safety incident responses. This will be considered under the engaging staff and patients policy which is being developed as part of the PSIRF implementation phase.

- 'Make Every Contact Count' (MECC)[4]

In 2022/23 the trust identified a quality priority relating to the need to develop systems and processes to reduce health inequalities by working in partnership with staff. By utilising the principles of MECC, and our day to day interactions with patients to encourage changes in behaviour, there is an opportunity to have a positive effect on the health and well-being of our patients, the community, and the wider population. A quality priority for 2023/24, relating again to MECC, was developed, and the trust plans to develop a MECC evaluation framework to assist with implementation of the quality priority and measurement of the impact of MECC interventions.

- Making better use of routine health data

Making better use of routine health data' was included as a trust quality priority for 2023/24. The aim of the priority is to identify and quantify any health inequalities or disparities across our Network or within Clinical Services, as a means for addressing underlying predisposing factors and for taking necessary actions. This project has provided the trust with better understanding of our patient population and their experience with our services. It will also provide assurance and demonstrable accountability on our compliance with current requirements for actively monitoring and addressing unwarranted disparities. In addition, systems will be developed to triangulate the information with patient safety data.

[4] Many long-term diseases are closely linked to known behavioural risk factors such as tobacco, hypertension, alcohol, being overweight or being physically inactive. Making every contact count (MECC) is an approach to behaviour change that utilises day-to-day interactions with patients to encourage changes in behaviour that have a positive effect on the health and well-being of the individual, but also the wider population.

The arrangements for the following are specifically described in section 9 of this policy:

- How the tools the trust will use to respond to PSIs will prompt consideration of inequalities, including when developing safety actions.
- How the trust will engage and involve patients, families and staff following a PSI with consideration of their different needs.
- How the trust will uphold a system-based approach (not a 'person focused' approach) and ensure staff have the relevant training and skill development to support this approach.

7. Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a PSI can only be achieved if supportive systems and processes are in place. It supports the development of an effective PSI response system that prioritises compassionate engagement and involvement of those affected by PSIs (including patients, families, and staff). This involves working with those affected[5] by PSIs to understand and answer any questions they have in relation to the incident and signpost them to support as required[6].

The post-PSI engagement arrangements the trust has in place are as described in the 'policy for engaging and involving patients, families, and staff following a PSI'[7]. The same policy describes how we will meet our professional and regulatory requirements in relation to the statutory duty of candour, which requires that we are open and transparent with people who receive care from us.

Our PSPs will be integral to the continued development and implementation of this policy.

8. Patient safety incident response planning

The PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and

[5] The term 'those affected' include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

[6] Until the engaging patient and staff following a patient safety incident policy has been developed staff and patients seeking support or information following an incident should contact the central quality team at moorfields.qands@nhs.net

[7] This policy is currently under development and will replace the existing 'being open and duty of candour policy'.

subjective definitions of harm. Beyond nationally set requirements, organisations can explore PSIs relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

8.1 Resources and training to support patient safety incident response

○ Resources

Delivery of the PSIRF is accommodated within our existing trust staffing resource, however it is acknowledged that as we develop and improve our learning responses and our learning system, there may be a need to increase this. As such, the effectiveness of our implementation of the PSIRF will be subject to continuous review, using quality improvement methodology. The adequacy of the number of staff trained, along with their placement across the organisation, will be considered as part of this.

The PSIRF standards define the competencies required for individuals leading on the implementation of PSIRF. The following sections describe how the trust will resource PSI responses, including the training and competencies that staff undertaking the responses require.

To meet the PSIRF standards we must:

- Have in place sufficient governance arrangements to ensure that learning responses are not led by staff who were either involved in or affected by the PSI itself, or by those who directly manage those staff. The central quality and safety team will provide advice and support regarding cross-system and cross-divisional working, where required, and will support and record the allocation of learning response leads.

- Ensure that learning responses are only be led by staff who have completed the relevant training[8] and who have an appropriate level of seniority and influence within the organisation. The expectation is that a PSI investigation (PSII) will normally be led by a member of staff who is a band 8a or above[9].

- Ensure that learning responses are not undertaken by staff working in isolation.

[8] The NPSS is a system-wide, multi-professional syllabus that has been developed for all staff in the NHS. Completion of both level one (essentials of patient safety) and level two (access to practice) of the syllabus is an essential requirement for any staff member in an oversight role or those appointed as a learning response lead and/or an engagement lead. This is in addition to the PSIRF-specific role training.

[9] Exceptions to this may exist providing it has been agreed by the Incident Review Group (IRG).

- Maintain a list of involvement in a learning response, in order to ensure that:
    - There is equitable allocation across the organisation, and
    - Learning response leads can satisfy the national requirement to contribute to a minimum of two learning responses per year.
- Continuously review the sufficiency of the capacity that we have for co-ordinating and monitoring the effectiveness of our learning and improvement responses and for sharing learning. Identification of additional need will be included in the annual business planning process, where necessary.
- Strive to ensure that staff involved in understanding learning responses, or staff affected by a PSI who are contributing to a learning response, are provided with allocated time (as part of their normal working day) in which to participate. Arrangements to backfill staff who are participating in learning responses will be considered, where possible, and in agreement with the relevant management team.
- Seek to engage subject matter expert involvement, (e.g., peer support from another organisation), if appropriate. Such involvement must be notified to the central quality and safety team so that the correct application of information governance requirements can be ensured. This may also include the support of a healthcare provider learning response lead from within North Central London Integrated Care System NCL ICS.

Training for specific PSIRF roles

Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience. Training for the PSIRF-specific roles must be delivered by a training provider that satisfies the requirements identified in the NHS England PSIRF standards[10].

Learning response lead training and competencies

In addition to the training previously described, learning response leads must:

- Undertake appropriate continuous professional development in incident response skills and knowledge.

[10] Training will only be conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in learning response best practice and have both conducted and reviewed learning responses.

- Network with other leads at least annually to build and maintain expertise. An annual networking event will be arranged by the central quality & safety team in the event that an alternative activity has not occurred during the year.
- Be able to apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate highly complex matters and in difficult situations.

Engagement and involvement lead behaviour and competencies

Engagement and involvement with those affected by a PSI (e.g., staff, patients, families, carers) must be led by staff members who have had at least six hours of training in involving those affected by PSIs in the learning process.

- Engagement leads must:
  - Have completed levels one and two of the NPSS.
  - Undertake appropriate continuous professional development in engagement and communication skills and knowledge.
  - Network with other leads at least annually to build and maintain expertise.
  - Contribute to a minimum of two learning responses per year.
- As a trust we expect that all engagement leads will always:
  - Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
  - Listen and hear the distress of others in a measured and supportive way.
  - Maintain clear records of information gathered and contact with those affected.
  - Identify key risks and issues that may affect the involvement of patients, families, and staff.
  - Recognise when those affected by PSIs require onward signposting or referral to support services.

- Seek support from the central quality and safety team in relation to the above, where queries exist or if support is required.

Oversight roles training and competencies

- All PSI response oversight must be led/conducted by staff:
  - With at least two days formal training and development in learning from PSIs **and** one day training in oversight of learning from PSIs.
  - Who have completed either level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the NPSS.
  - Who undertake continuous professional development in incident response skills and knowledge.
  - Who network with peers at least annually to build and maintain expertise.
- All staff with PSIRF oversight roles should:
  - Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
  - Apply human factors and systems thinking principles.
  - Obtain (e.g., through conversations) and assess both qualitative and quantitative information from a wide range of sources.
  - Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
  - Recognise when safety actions following a PSI response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
  - Summarise and present complex information in a clear and logical manner and in report form.

8.2 Our patient safety incident response plan

Our Plan sets out how Moorfields Eye Hospital NHS Foundation Trust intends to respond to PSIs over a period of 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each PSI occurred and the needs of those affected, as well as the plan. The plan includes our

PSI response arrangements for PSIs occurring during the provision of both NHS and privately funded healthcare services.

The plan has been developed following completion of an extensive stakeholder engagement exercise and review of available information (e.g., PSIs, risks, complaints, claims, NHS staff survey, junior doctor survey, Freedom to Speak Up data). A detailed account of the work that has been completed is described in sections 3 and 4 of our Plan.

A copy of our current plan can be found at LINK TO BE ADDED TO INTERNET ONCE PUBLISHED

8.3 Reviewing our patient safety incident response policy and plan

Our Plan is a 'living document' that will be amended and updated as we use it and learn how to respond to PSIs most effectively under the PSIRF. We will formally review the plan and policy after 18 months, following initial implementation, to ensure our focus remains up to date. We recognise that on-going improvement work means that our PSI profile is likely to change. Early review will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes that have occurred in the previous 18 months.

Given the changes to mindset and trust processes that PSIRF introduces and encourages we acknowledge that there may be changes to our policy and plan that were unforeseen and which cannot be accommodated for 18 months. We will establish methods for monitoring and measurement, using quality improvement (QI) methodology and key performance indicators, in order to detect any unwarranted variation in our data or feedback from staff, PSPs, integrated care board (ICB) or our service users. Interim changes to our policy or plan will require approval from the clinical governance committee (CGC), and these will be reported to the quality & safety committee as a sub-committee of the trust board.

A rigorous planning exercise will be undertaken every three years and more frequently if appropriate (as agreed with our ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (e.g., PSI investigation reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Updated plans will be published on our website, replacing the previous version.

9. Responding to patient safety incidents

9.1 Patient safety incident reporting arrangements

All staff, of all grades and disciplines, are responsible for reporting PSIs and near misses that they become aware of in accordance with the trust incident reporting policy[11]. All incidents, relating to patients receiving both NHS-funded and privately funded care and treatment must be reported via the trust e-reporting system (Ulysses Safeguard) as soon as possible following discovery of the incident.

Reporting incidents and near misses via this mechanism will ensure that relevant managers and specialist advisers are notified either automatically or following review of the incident by the central quality & safety team. Clinical divisions/corporate teams have an equivalent checking process, to ensure that all incidents are reviewed and that additional relevant staff not already aware of the incident receive notification.

The harm impact of all incidents and near misses will be graded by the reporter in the first instance, at the point at which the incident is reported. It is not necessary for the reporter to be in possession of all facts at the time of initial grading. At the point of incident notification, clinical divisions and services are responsible for reviewing the harm grading ensuring that duty of candour processes[12] have been initiated or for taking action to ensure that this happens as a priority.

Incidents requiring notification to another provider organisation will ordinarily be identified following review by the clinical division/service and/or be identified by the central quality & safety team (see section 9.3).

9.2 Patient safety incident response decision-making

The trust has governance arrangements in place to allow it to meet the requirements associated with the review of incidents under the PSIRF. Our local governance arrangements (see Appendix 1) include a process by which we will use the Incident Review Group (IRG) to confirm:

- If a particular incident meets the requirements for completion of a learning response, in accordance with our Plan.

[11] Note, modification to this policy is required to remove reference to serious incidents (SIs) and the National Reporting and Learning Service (NRLS). Amendments will include reference to the new Learn from Patient Safety Events (LFPSE) and PSIRF.

[12] As described in the ‘being open and duty of candour policy’ that will be replaced by the policy for engaging and involving patients, families, and staff following a PSI’.

- The proportionate learning response(s) required.

Identification of our local incident priorities, as described in our Plan, has been informed through the analysis and identification of our patient safety profile. The proportionate learning response that is planned to be undertaken is also defined. The following rules apply to our selection of the appropriate learning response, where for our national and local priorities we will be seeking to learn from 'everyday work'[13] to inform improvement:

- **National PSI priority** - Patient safety incident investigation (PSII) is mandated. The PSII may be informed by another learning response (e.g., after action review (AAR)).

- **Local PSI priority** – PSII or application of another learning response tool, as described in the plan. Multiple learning responses may be conducted. Escalation to PSII as the preferred learning response may occur, even when not described in the plan as such.

- **Priority unconfirmed** – where it is unclear if a PSI fulfils the criteria for either a national or local priority, an assessment will be undertaken to determine whether there were any problems in care that require further exploration and potentially action.

- **PSIs that are not a national or local priority** – PSIs that do not fulfil the criteria as either a national or local priority will normally be managed locally, by the reporting team or divisional management team. The local reporting team/divisional management team will be responsible for selecting the proportionate learning response and/or improvement response.

  Exceptions to this are where a concern is identified, by any person (including patient/family), or if a PSI which signifies an unexpected level of risk and/or potential for learning and improvement is recorded. If a concern is raised, careful consideration will be given regarding whether a learning response is the best way to address concerns and questions. Any request for a learning response will be carefully considered and a decision regarding the appropriateness of conducting a learning response will be made by the Incident Review Group (IRG).

[13] 'Everyday work' describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work.

The IRG governance reporting arrangements are as shown in Figure 1, below. The role of IRG, and the reporting arrangements, are described in more detail in the incident reporting and management policy.

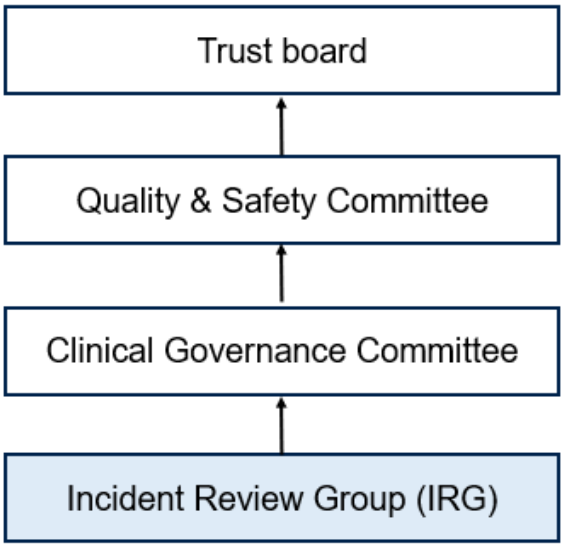


Figure 1 Governance structure

9.3 Responding to cross-system incidents/issues

The trust central quality & safety (risk & safety) team will securely (e.g., via an NHS.net to NHS.net e-mail account) forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting will be used to share insight with another provider about their patient safety profile. Incidents of this type will normally be identified in the PSI reports submitted by staff, or during review by the IRG.

We will work with partner providers (peer trusts) and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The quality & safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

We will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. It is anticipated that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

Providers wanting to engage with the trust regarding a cross-system incident/issue should e-mail moorfields.QANDS@nhs.net in the first instance.

9.4 Timeframes for learning responses

Patient safety incident investigations (PSIIs)

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the PSI is identified and should ordinarily be completed within three months of the start date. No local PSII should take longer than six months.

The timeframe for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This action would require authorisation from either the medical director or the chief nurse and director of allied health professions, on behalf of the CGC.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the trust and those affected, including the patient.

The IRG will monitor timescales and progress of PSIIs.

Other forms of learning response

A learning response must be started as soon as possible after the PSI is identified and ordinarily should be completed as soon as possible, but within no more than two months of the start date. No learning response should take longer than six months to complete.

9.5 Safety action development

A thorough understanding of the work system will only be gained where a learning response is conducted; led by an individual who has completed the relevant training and secured the associated competencies (see section 8.1). We will have an integrated process for developing, implementing, and monitoring safety actions to not limit our attempts to reduce risks and potential for harm.

Our process for development of safety actions will align with the NHS England Safety Action Development Guide 2022. This has been summarised for local use and can be found in Appendix 4. Use of the guide, which will include working through the following steps, will prompt consideration of health inequalities during the development of safety actions. A collaborative approach to the development of safety actions, involving those beyond our 'immediate and obvious' professional groups (e.g., doctors, nurses, optometrists) such as patients, PSPs, estates and facilities teams and administrative staff will be taken.

1. **Agree areas for improvement** (where improvement is needed, without defining how that improvement is to be achieved).
2. **Define context** (agree approach to developing safety actions by defining context).
3. **Define safety actions to address areas for improvement** (focus on the system, using a collaborative approach).
4. **Prioritise safety actions** (using the iFACES criteria – Appendix 4, table 2).
5. **Define safety measures** (identify how we will know if the safety action is influencing what it intended, who, what, when and how).
6. **Write safety actions** (document in a learning response report or safety improvement plan, including details of measurement and monitoring).
7. **Monitor and review** (confirm that safety actions are impactful and sustainable).

9.6 Safety action monitoring

All safety actions will be added to the relevant PSI record on the trust local incident reporting system, Safeguard, so that implementation can be monitored. Monitoring reports will be generated from Safeguard and presented to the Incident Review Group (IRG) and the Clinical Governance Committee (CGC), in accordance with the relevant terms of reference. Local monitoring of the implementation and effectiveness of safety actions, to ensure that they continue to have an impact and are sustainable, will be overseen by the divisional head of nursing and quality partner for the location in which the PSI occurred. Updates will be provided at monthly quality forums and/or monthly executive performance meetings, as a minimum. Where safety actions have broader organisational or trust wide relevance, the specific ad-hoc monitoring plans will be as described in the safety action report (see template in Appendix 5).

9.7 Safety improvement plans

Safety improvement plans bring together findings from various responses to PSIs and issues. There are no thresholds for when a safety improvement plan should be developed

after completion of learning responses. The decision to do so will be based on knowledge gained through the learning response process and other relevant data.

Within the trust committee structure, the CGC is accountable for ensuring that there is continuous improvement of the quality of clinical services and for safeguarding high standards of care. There are numerous governance committees with reporting responsibility into CGC, including resuscitation, drugs and therapeutics, and infection prevention and control. Our local priorities and the national priorities, described in our Plan, were selected either because of the opportunity they offer for learning and improvement across areas where there is no existing plan, or where improvement efforts have not been accompanied by reduction in apparent risk or harm. Each priority has been allocated a committee, who will be responsible for overseeing implementation of the safety improvement plan(s).

We will use a variety of approaches to the development of safety improvement plans, as outlined below:

- We will develop safety improvement plans that focus on specific services, pathways, or issues. Examples of such safety improvement plans are those arising from trust wide safety summits. Safety summits are to be used where an organisation-wide, multi-disciplinary response is required to a particular patient safety issue or set of similar issues. Safety summit progress updates will be reported to the CGC.

- Where multiple learning responses (a minimum of two) associated with individual incidents generate sufficient understanding of any underlying, interlinked system issues, an overarching safety improvement plan may be developed.

- A review of the outcomes from our existing PSI reviews, such as investigations undertaken under the SIF, will be undertaken to identify whether it is possible to create safety improvement plans to help focus our improvement work, where this has not already happened.

- Where overarching issues are identified by learning responses, and there is already an existing improvement plan or review that is considering the specific issue (e.g., a quality priority) the findings from the learning response will be fed into the relevant workstream.

- Where overarching system issues are identified by a learning response, a safety improvement plan will be developed.

Monitoring of progress with safety improvement plan implementation will be overseen by the committee that has been identified alongside each of the national and local priorities.

Updates will be provided to IRG and the CGC, with escalation of concerns being made to the quality and safety committee.

10. Oversight roles and responsibilities

We will work with the NHS North Central London ICB and the Care Quality Commission (CQC), the independent regulator of health and social care in England, to ensure that the PSIRF mindset principles (see Appendix 6) underpin the oversight of our PSI response. Following these key principles will allow us to demonstrate improvement rather than compliance with prescriptive and centrally mandated measures.

Organisational responsibilities in relation to PSIRF oversight

The trust has designated the chief nurse and director of allied health professions and the medical director as joint executive leads for PSIRF, as members of the trust board. The PSIRF executive leads, via the quality & safety committee (the sub-committee of the trust board to whom responsibility for PSIRF has been delegated) are responsible and accountable for effective PSI management in the trust.

The executive leads will maintain oversight by fulfilling the following responsibilities:

- **Ensure the organisation meets national patient safety incident response standards**

The joint executive leads will oversee the development, review and approval of the trust PSI response policy and plan. They will ensure that both documents meet the expectations set out in the PSIRF standards.

The trust executive leads will be supported by the director of quality & safety and the central quality & safety team in the preparation of the policy and the plan, the on-going review and development of which will be informed by our PSI profile and continued engagement with internal and external stakeholders. The trust approach to the initial development of both are as described in section 3 of our Plan.

- **Ensure PSIRF is central to overarching safety governance arrangements**

The trust board will receive assurance regarding the implementation of PSIRF via existing reporting mechanisms, including the quality & safety committee escalation summary and chief executive briefing to the board.

The quality & safety committee, which meets six times per year, will receive updates regarding PSIRF implementation, the development and monitoring of safety improvement plans and the learning system via the following mechanisms:

- Quarterly quality & safety report[14].
- Escalation and activity report from the CGC.

The quarterly report will provide assurance regarding implementation of the PSIRF and detail the positive impacts that the PSIRF is having on the organisation. Both documents will seek to highlight any specific risks that are known or emerging, either in relation to implementation of the PSIRF and the associated processes or arising directly from learning responses.

The CGC, which is jointly chaired by the executive PSIRF leads, will be responsible for the operational oversight of PSIRF. It will receive summary reports at each meeting in relation to learning responses initiated and completed, in line with our Plan, and the development and delivery of safety actions and improvement plans. The report will also detail the identification of incident(s) which signify an unexpected level of risk and/or potential for learning and improvement.

Divisional quality forums will receive quarterly reports, as a minimum, regarding the initiation and completion of learning and improvement responses in the division. This activity will be reviewed at executive performance meetings. Clinical divisions will be responsible for identifying any financial resources required to deliver safety actions and improvement plans, and for including resources required in the business planning process.

The effectiveness of the governance structure will be monitored, and changes will be made to the policy and plan where the need to do so is identified and approved by the CGC.

- **Quality assure learning response outputs**

A final report will be produced for all individual PSIIs, and this will be reviewed and signed off as complete by the PSIRF executive leads. This process will be supported by the central quality and safety team.

There is not a requirement for formal executive lead sign-off of other learning responses (e.g., AAR, thematic reviews). All learning responses will be reviewed by IRG.

[14] It is anticipated that the format in which learning and improvement activity associated with the PSIRF is reported will evolve over time (e.g., it may be more appropriate for the information to be presented in a standalone report). Over time the report will be developed to include an assessment of the balance of resources going into patient safety incident response versus improvement.

11. Complaints and appeals

The trust recognises that there will be occasions when patients, service users, and carers are dissatisfied with aspects of care and/or the services provided by the organisation. We have established processes for identifying PSIs arising from complaints and PALS enquiries/concerns and ensure either that an incident form has been completed or provide instruction where needs to be completed retrospectively.

Our PSPs are involved in scrutiny of the complaints system and processes to ensure that the complainant and their concerns remain at the forefront of our processes and individual responses.

Complaints and concerns will be handled respectfully, ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner. Any complaints or appeals received specifically in relation to our response to PSIs will be managed in line with our normal complaint management process.

Patients, service users, and carers wishing to contact the trust in relation to a response to a PSI can do so via the PALS department in the first instance. The PALS team provides confidential advice and support to help service users with any concerns that they have about the service or care that the trust provides, including how a formal complaint can be made.

Any concerns or complaints made to the PALS/complaints team of the host trust from which the trust runs a service will be shared and the process described in our policy will then apply.

Complaints regarding NHS services

The team can be contacted via:

- Post: The complaints manager, Moorfields Eye Hospital NHS Foundation Trust, 162 City Road, London, EC1V 2PD
- Telephone: 020 7566 2324/2325
- E-mail: moorfields.pals@nhs.net (for queries or concerns) or moorfields.complaints@nhs.net (for formal complaints)

In person at: the PALS office (address as above, 9:30-16:00 on normal working days)Patients who are dissatisfied with the outcome of the local resolution process are entitled to go to the second stage of the NHS complaints procedure and request their

complaint is considered by the Parliamentary and Health Service Ombudsman for England (PHSO).

The PHSO can be contacted as follows:

- In writing: Millbank Tower, Millbank, London, SW1P 4QP
- Email: phso.enquiries@ombudsman.org.uk
- Telephone: 0345 015 4033
- Website (for further information): www.ombudsman.org.uk

Complaints regarding Private services

The team can be contacted via:

- Post: Moorfields Private Complaints Team, Moorfields Private, 9-11 Bath Street, London. EC1V 9LF
- Email: moorfields.privatecomplaints@nhs.net

Moorfields Private is a member of The Independent Sector Complaints Adjudication Service (ISCAS), the recognised independent adjudicator of complaints for the private healthcare sector. ISCAS can be contacted via:

- Post: ISCAS, CEDR, 3rd Floor, 100 St. Paul's Churchyard, London, EC4M 8BU
- Email: info@iscas.org.uk
- Telephone: 020 7536 6091

12. Stakeholder engagement and communication

The central quality and safety team has engaged with key stakeholders, over a 12-month period, to inform the policy. The engagement activities undertaken have been summarised below and described in more detail in Appendix 3 and have included:

- Communication with the organisation regarding the introduction and purpose of the PSIRF.
- Involvement of our Patient Safety Partners (PSPs).
- Presentation of the Plan and PSIRP at governance meetings, including the trust's quality and safety committee and clinical governance committee.
- Safety culture focus groups.

- Attendance at networking events, in particular those attended by partnership organisations.
- Both the policy and the plan have been developed collaboratively and in consultation with key stakeholders, including patient safety partners. The policy has undergone consultation with clinical governance committee members.
- The draft policy and plan were shared with the ICB, and their feedback has been incorporated into the final version.

13. Approval and ratification

For completion following approval and ratification.

14. Dissemination and implementation

A PSIRF implementation group is in place to support the implementation of this policy.

A transition phase from the old systems to the new will commence. The progress of this transition will be documented in a PSIRF implementation plan and monitored by the working together board.

15. Review and revision arrangements

The policy will be reviewed every 12-18 months in the first instance, however, it is anticipated that earlier review may be required as the PRISF processes are tested and embedded in the trust.

16. Document control and archiving

The current and approved version of this document can be found on the trust's intranet site. Should this not be the case, please contact the quality and compliance team.

Previously approved versions of this document will be removed from the intranet by the quality and compliance team and archived in the policy repository. Any requests for retrieval of archived documents must be directed to the quality and compliance team.

This document will be available on the trust internet page (www.moorfields.nhs.uk). The document will be made available to the communications team, who will be responsible for updating the webpage, by the quality and compliance team.

17. Monitoring compliance with this policy

The trust will use a variety of methods to monitor compliance with the processes in this policy, including the following methods:

Measurable policy objective	Monitoring/ audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, including responsibility for reviewing action plans
Compliance with Incident Review Group terms of reference	Audit	Annual	Quality & safety team	Clinical governance committee
Reports submitted to clinical governance committee	Audit	Continuous during implementation	Quality & safety team	Clinical governance committee

18. Supporting references/evidence base

For completion following approval and ratification

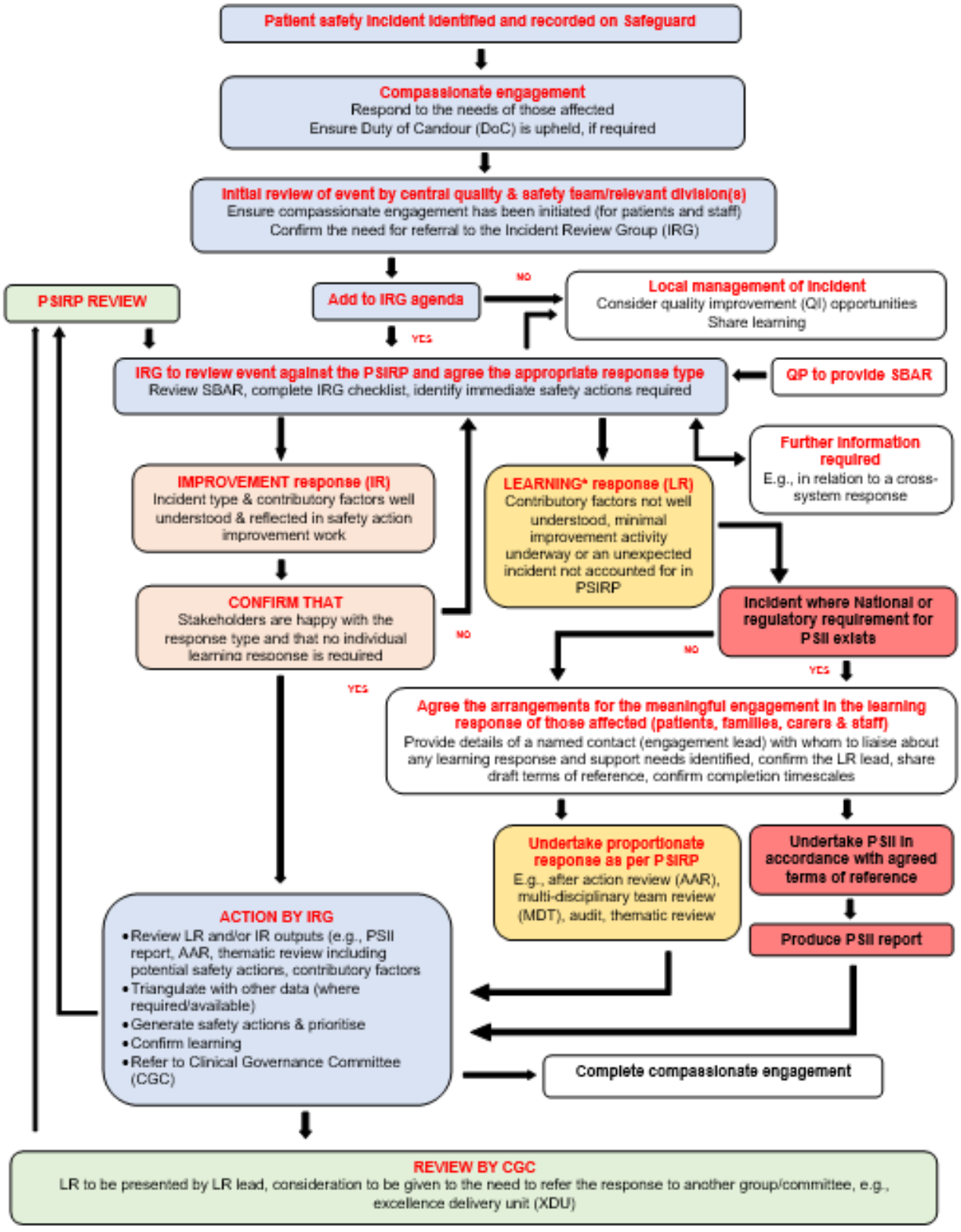
19. Supporting documents

Supporting documents/references	Owner
Patient safety incident response plan	Director of quality & safety
Incident reporting and management policy and procedure	Head of risk & safety
Policy for engaging and involving patients, families & staff following a patient safety incident[15] (formerly the being open and duty of candour policy)	Head of risk & safety
Risk management strategy and policy	Head of risk & safety

[15] Currently under development

Complaints policy	Head of patient experience and customer care
Policy & procedure for the management of clinical negligence, third party liability and property expenses claims (claims policy)	Director of quality & safety
Information governance policy	Director of quality & safety/senior information risk owner (SIRO)
Disciplinary policy & procedure	Deputy director of workforce and organisational development
Freedom to speak up policy	Director of quality & safety

Appendix 1: Patient safety incident management process



*** ALL RESPONSES MUST**
Understand everyday work, gather information, engage with staff affected, engage with patients and families (where agreed)

Appendix 2: Glossary of terms

Term	Definition/Explanation
After Action Review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning? It aims to capture learning from these to identify the opportunities to improve and increase occasions where success occurs.
Compassionate engagement	An approach that prioritises and respects the needs of people who have been affected by a patient safety incident.
Duty of candour (DoC)	The duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur.
Engagement	Everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

Term	Definition/Explanation
Everyday work	Everyday work describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work. Exploring everyday work shifts the focus from developing quick fixes to understanding wider system influences and is central to any learning response conducted to inform improvement. The following tools can be used to explore everyday work: • Observation guide Brief guide to conducting observations • Walkthrough guide Brief guide to walkthrough analysis • Link analysis guide Brief guide to link analysis • Interview guide Guidance on planning and conducting interviews as part of a patient safety incident learning response
Horizon scanning	The horizon scanning tool uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to structure conversations about work as done and emerging patient and staff safety risks Horizon scanning tool
Involvement	Part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.
Multi-disciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Never Event (NE)	Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. A list of NEs can be found here: Never Event list February 2021

Term	Definition/Explanation
Patient Safety Audit (PSA)	A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline)
Patient Safety Incidents (PSIs)	Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.
Patient Safety Incident Investigation (PSII)	PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.
Patient Safety Incident Response Framework (PSIRF)	This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.
Patient Safety Incident Response Plan	Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.
Patient safety partners (PSPs)	PSPs are patients, carers, family members or other lay people (including NHS staff from another organisation working in a lay capacity) who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation.

Term	Definition/Explanation
Systems Engineering Initiative for Patient Safety (SEIPS)	SEIPS is a framework for understanding outcomes within complex socio-technical systems. Patient safety incidents result from multiple interactions between work system factors (i.e., external environment, organisation, internal environment, tools and technology, tasks and person(s). SEIPS prompts us to look for interactions rather than simple linear cause and effect relationships. SEIPS quick reference guide and work system explorer
Structured Judgement Review (SJR)	Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.
Thematic review	A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. Top tips for completing a thematic review

Appendix 3: Background to the PSP role and a sample of activity relevant to PSIRF

Our PSIRF preparatory work has included the engagement of one of our PSPs in our PSIRF implementation and planning meetings, to help inform the development of our PSIRP and organisational readiness arrangements. Our PSP has had the opportunity to review and comment on our local priorities for inclusion in our PSIRP and support and challenge our assessment of our local improvement profile. A comprehensive review of our previous investigation reports, completed under the SIF, has been undertaken by the same PSP, to ensure that we improve the quality of our learning responses conducted under PSIRF. The review considered the following elements:

- Are contextual factors prioritised for investigation over behaviour and decision-making?
- Is blame avoided?
- Is 'local rationality' considered (that is, how and why did decisions make sense at the time)?
- Are safety actions system based?
- Appropriateness of terminology used in investigation reports.
- Compassionate engagement and involvement of those affected by patient safety incidents.
- Responding to patient safety incidents for the purpose of learning and improving patient safety.
- Identification of wording in investigation reports that does not align with wording in corresponding policies.
- Equity in engaging and involving patients, families and staff involved in a patient safety incident.
- Duty of Candour requirements.

We have reviewed, in detail, the findings of the PSP review of previous SI investigations and the improvement opportunities identified. We will continue to involve our PSPs in the development and review of our learning responses, in particular during the drafting of patient safety incident investigation reports, and the development of information resources to be shared with those affected by PSIs. We will specifically focus on improving the following, as priorities:

- The introduction of the Systems Engineering Initiative for Patient Safety (SEIPS) as a framework to guide the review of specified PSIs, as the mechanism to migrate from the linear root cause analysis investigation to the exploration of the interactions between the individual factors of a work system (i.e., external environment, organisation, internal environment, tools and technology, tasks, and person(s)).

- The application of Appendix 4 to support the development of safety actions, ensuring that there is a process for their development and subsequent monitoring.

- Ensuring that the language and terminology used within learning responses and patient information resources are both appropriate and easy to understand.

- The provision of support for staff and patients involved in a PSI.

Our PSPs have been attending some of our existing governance committees and will continue to attend when the new PSI response oversight arrangements are introduced. During transition from the SIF to the PSIRF, and following establishment of our new arrangements, there is an expectation that our PSPs will help us to scrutinise and improve our processes, particularly in relation to the:

- Ways in which we engage with and support patients and their families/carers following a PSI.

- Effectiveness of the mechanisms that we have in place for undertaking a learning response.

- Robustness of our on-going measuring and monitoring arrangements for our improvement responses.

- Arrangements that we have in place for supporting staff involved in or affected by a PSI, recognising that the services that our patients receive are directly impacted by the health and well-being of our staff.

Mechanisms that we have in place to identify and reduce health inequalities that exist within, or are exacerbated by, our services.

Appendix 4: Development of safety actions

Defining safety actions (SAs)

1.

- **Agree areas for improvement (AFI) - the problem(s) to be solved/risk(s) to be reduced**
- Specify where improvement is needed, without defining how the improvement is to be achieved.
- Involve the multi-disciplinary team, and patients, so that an informed decision can be made.
- AFI must be linked to the outcome of a learning response or other review type.

2.

- **Define context (specific local OR wider organisation)**
- Agree the approach to developing SAs by defining the context.
- Where SAs will take time to develop and implement, record the area for improvement in a learning response report but note that the SAs will be developed as part of a wider improvement plan.

3.

- **Define safety actions to address AFIs**
- Continue to involve the team - defining SAs should be a collaborative process.
- The Human Factors Intervention Matrix (table 1) uses questions to prompt thinking about how each AFI identified might be translated in to possible safety actions to reduce risk.

4.

- **Prioritise safety actions**
- Decide which SA, or set of SAs, to test for implementation. The iFACES tool (table 2) can help quantify, and prioritise, the potential value of each identified SA using six criteria.
- Test the SAs (in 'real life' or under simulated conditions) that are being considered. During testing observe and discuss the SA, to identify any issues that people had (make the necessary safety improvements) and confirm that users behaved as expected (if not, update the SA).

5.

- **Define safety measures**
- Before finalising a SA, plan how you will evaluate its effectiveness and progress towards specific goals. Identify meaningful measures, that can be monitored through normal work processes, to ensure that the benefits of change are sustained. Plan when to abandon a SA, if it isn't working. Seek the opportunity to invest in better alternatives.

6.

- **Write safety actions**
- Safety actions must be SMART (specific, measurable, achievable, relevant, time-bound). They must **1)** be documented in a learning response report/safety improvement plan; **2)** start with the owner (e.g., head of risk & safety to.....); **3)** be directed at the people who have the levers to activate change; **4)** be succinct; **5)** standalone (readers should know what it means without reading the report); **6)** make it obvious why it is required. SAs, including measurement and monitoring arrangements, must be summarsied in a table at the end of the learning response.

7.

- **Monitor and review**
- Monitor that SAs put in place remain impactful and are sustainable.
- A review should be carried out periodically (typically annually) or if substantial changes are made.

Table 1: Human factors intervention matrix (HFIX) (with added questions)

Area for improvement		Set out where improvement is needed
Work system	**Person(s):** *Includes both characteristics of an individual and of a team*	How **can individual or team characteristics** be modified or changed to reduce risk or improve performance? – How could changes be made to the way individuals are recruited or selected for employment to ensure that they have the appropriate knowledge and skills necessary to perform their required tasks safely and efficiently? – How could the content of training programmes be developed or modified to improve individual's knowledge of procedures or tasks? – How could the method of training delivery be improved or modified to enhance its impact on individual's knowledge and skills (eg use of simulation)? – How could an individual's stress and fatigue be reduced or monitored to improve safety and performance? – How could verbal communication procedures be improved to reduce the likelihood of miscommunication among team members (eg standardisation, readback)? – How could the use of non-verbal communication (eg gestures or hand signals) be developed and standardised to improve communication? – How could team briefings/planning sessions be developed or improved to improve communication and co-ordination – Could procedures be developed to improve interactions between team members? – When individuals are working as a team, how could the responsibilities of each team member be more clearly defined? – How could changes be made to ensure that team leaders are identifiable and responsible? – How could handoffs/handovers be developed or improved to facilitate the communication between team members?
	Tasks: *Specific actions within larger work processes*	How can the **task or activity** be modified or redesigned to reduce risk or improve performance? – How can the task be restructured so that it requires less reliance on human memory (ie use checklists or technology that signals next step in task)? – If the task is done simultaneously with other tasks (divided attention), can it be done on its own? How can the mental workload/timesharing be reduced? – How could checklists be developed to guide the task or verify that the task has been performed properly? – How could immediate feedback be integrated into the task to allow operators to know when they have done things correctly or incorrectly? – How can procedures or checklist be redesigned to be clearer or more user-friendly? – If a task is repetitive, monotonous or boring, how could it be made more interesting? How could 'time on task' be changed to reduce vigilance decrements or mental lapses in attention? – How could procedures be rewritten so that they are less ambiguous or inapplicable to the safety critical tasks operators perform? – When operators switch tasks, what procedures could be developed to reduce negative transfer (habit interference)? – How could a task be modified to reduce the demands on the operator's physical or perceptual limitations?

Area for improvement		Set out where improvement is needed
Work system	**Tools and technology:** *Equipment, tools, software, and documents used to perform work*	How can **tools, equipment or technology** be modified or redesigned to reduce risk or improve performance? – How can warnings or alarms be improved to increase awareness of hazards or the presence of abnormal conditions? – How could tools, checklists, manuals or displays be redesigned to reduce confusion and errors? (eg highlight with bold text the items in a checklist that are the most important and/or should be memorised)? – Are better tools currently available but not purchased? What are these tools and how would they reduce errors on the job? – How could technologies be developed to reduce the task demands on the human decision-making processes, perceptual processes or physical limitations? – How could controls be more easily identified and/or better designed in terms of shape, size and other relevant considerations? – How could information sources be integrated or located in a more effective manner? – How could equipment be redesigned for more convenient maintenance? – How could inspection or troubleshooting aids be developed to ensure equipment is in proper working order? – How could maintenance procedures or schedules be improved to prevent equipment from failing during use?
	Internal environment: *Physical working environment in which individuals and teams perform their tasks*	How can the **physical environment** be modified or redesigned to reduce risk or improve performance? – How could the number of distractions in the environment be reduced to allow the operator to focus attention more fully on the task? – How could workspace arrangements or dimensions be modified to improve task performance? – How could the workspace be made better suited to the range of individuals who will use the facility? – How could lighting be changed to reduce shadows, glare or stark lighting changes (eg going from light to dark settings)? – How could the noise level be modified or reduced to reduce fatigue, improve concentration or enhance communication? – How could the temperature conditions be modified or improved to improve concentration, mood or performance? – How could physical/technological barriers to performance or communication be modified or rearranged? – How could the physical arrangement of workspaces/rooms be standardised to reduce confusion, delays or errors? – How could floor surfaces be modified or improved to allow for better movement or rearrangement of equipment when needed? – How could clutter be reduced or housekeeping improved to make the working environment more conducive to safe and productive work?
	Organisation: *Structures external to a person (but often put in place by people) that organise time, space, resources, and activity*	How can **organisational factors** be modified or redesigned to reduce risk or improve performance? – How could standard operating procedures (SOPs) be modified to reduce risks and improve safety? – How could the organisation ensure that SOPs are in place and that they are relevant and not out-of-date? – How could operational risk management procedures be implemented to reduce safety hazards? – How could tools that help supervisors plan activities and set goals be improved? – What tools or job aids could be developed to help supervisors create schedules, improve team composition or reduce operator fatigue? – How could the organisation improve its process for recruiting and hiring people who are better qualified or more experienced? – How could the organisation improve its process for evaluating and purchasing equipment that is user friendly and designed for safety?

Area for improvement		Set out where improvement is needed
		– How could leadership better communicate the importance and value of safety? – How could the organisation better disseminate and share safety information or lessons learned from safety events across units (ie become more transparent)? – How could the organisation better promote, reinforce or encourage safe practices? – How could the organisation's structure be redesigned to improve the co-ordination and integration of activities across divisions/departments?
	External environment: *Societal, economic, regulatory and policy factors outside an organisation*	How can **regulatory or societal factors** be modified or redesigned to reduce risk or improve performance? – How can manufacturers be influenced to improve the design of their products? – How can regulation be changed to improve safety? – How can external oversight/monitoring be improved to impact safety? – How can national safety programmes be redesigned to improve safety?

Table 2: iFACES tool (use to quantify and help prioritise safety actions)

Criterion	Low 1	Medium 2 3 4	High 5
Inequality Does the intervention ensure fair treatment and opportunity for all?	The intervention is not accessible to the diverse population that will use it.	The intervention accommodates some inequalities but further investigation is needed.	Inequalities are reduced by this intervention.
Feasibility Can the change be implemented easily or quickly?	The intervention does not exist today nor is it likely to become available in the near future; it is highly impractical and not suitable for your organisation.	The intervention exists but is not readily available or will require modifications to better fit the context in which it is intended to be use.	The intervention is readily available and could be implemented in a relatively short period of time without much effort.
Acceptability Will those being impacted by the intervention readily accept the change?	The intervention will not be tolerated by those it impacts. People are likely to consistently resist the change and attempt to work around the change.	The intervention will be tolerated by those it impacts. There may be moderate resistance but attempts to undermine the change will not be widespread.	The intervention will be readily accepted by those is impacts. People are likely to welcome the change and make every attempt to ensure it works.
Cost/Benefit Does the benefit of the intervention outweigh the costs?	The cost of the intervention is exorbitant relative to its minimal expected impact on safety and performance.	The intervention is moderately expensive but cost could be justified by its expected benefit. Return on investment (benefits) is relatively equal to cost.	The cost of the intervention is nominal relative to the impact on safety and performance.
Effectiveness How effective will the intervention be at eliminating the problem or reducing its consequences?	The intervention will not directly eliminate the problem or hazard and it relied heavily on wilful compliance with the change and/or requires humans to remember to perform the task correctly.	The intervention reduces the likelihood of the problem or hazard occurring but relies in part on human memory and/or wilful compliance with the change.	The intervention will very likely eliminate the problem or hazard and it does not rely on wilful compliance with the change or require humans to remember to perform the task correctly.
Sustainability How well will the intervention last over time?	The impact of the intervention will diminish rapidly after it's deployed and/or will require extraordinary effort to keep it working.	The benefits of the intervention may have a tendency to slowly dissipate over time and will require moderate efforts to maintain its benefits.	The impact of the intervention will persist overtime with minimal efforts being required to maintain its benefits.

Appendix 5: Safety action reporting template

Area for improvement: ***(e.g., review of test results)***								
Ref.	**Safety action description** ***(SMART)***	**Safety action owner**	**Target date for implementation**	**Date implemented**	**Tool/measure (e.g., audit)**	**Measurement frequency**	**Responsibility for monitoring oversight (i.e., specific group, individual)**	**Planned review date (e.g., annually)**
1.								
2.								
3.								
4.								
5.								

Appendix 6: PSIRF mindset principles

1. Improvement is the focus

PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.

2. Blame restricts insight

Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.

3. Learning from patient safety incidents is a proactive step towards improvement

Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.

4. Collaboration is key

A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.

5. Psychological safety allows learning to occur

Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.

6. Curiosity is powerful

Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

Appendix 7: Policy applicability to trust sites

This document applies to all premises occupied by trust staff/activities, unless explicitly stated otherwise.

For any sites that are excluded from the policy, the policy must list those sites together with a brief explanation as to why the site is excluded and name the local/host policy and any other documents that are used in its place.

Excluded sites	Reason for exclusion	Host policy and any other documents used in its place
UAE	Framework applies to UK services only.	N/A

Where the list indicates that the policy does not apply, this implies that the trust will adhere to the policy of the host. Where a query exists then this must be referred, in the first instance, to either the:

- Divisional manager/head of nursing
- Policy owner
- Accountable director
- Service director

Moorfields Dubai will adhere to their own local policies and procedures and trust-wide documents will not apply, unless explicitly stated otherwise.

Patient safety incident response plan

Summary

This plan describes how the trust will respond to patient safety incidents, in accordance with the Patient Safety Incident Response Framework (PSIRF) and national reporting requirements.

Version: **0.9**

Status: **Draft:** **x**

Approved: **(date)**

Ratified: **(date)**

Version history

Version	Date issued	Brief summary of change	Author
		New document	Julie Nott

For more information on the status of this document, please contact:	Quality & safety team Moorfields.QANDS@nhs.net	
Plan author	Julie Nott, head of risk & safety and patient safety specialist Kylie Smith, head of quality & safety	
Plan owner	Ian Tombleson, director of quality & safety	
Accountable director	Sheila Adam, chief nurse and director of allied health professions	
Department	Quality & safety	
Applies to (audience):	Trust wide	
Groups / individuals who have overseen the development of this plan	Quality & safety team PSIRF implementation group Clinical governance committee members Risk & safety committee members Divisions and services	
Committees which were consulted and have given approval (name | date)	Clinical governance committee Trust management committee Quality & safety committee	09/12/2023 24/01/2024 (TBC) 30/01/2024 (TBC)
Responsible committee/group for approval	Quality & safety committee (on behalf of the Trust Board)	
Ratified by (name | date)	Policy and procedural review group (PPRG)	
Date of issue	TBC	
Date of next formal review		

Contents

Foreword

The Patient Safety Incident Response Framework (PSIRF) is a different and exciting approach to how we respond to patient safety incidents. PSIRF is **not** an investigation framework; it does not mandate investigation as the only method for learning from patient safety incidents (PSIs) and it does not prescribe which incidents we must investigate. It is a framework that supports development and maintenance of an effective patient safety incident response system with four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to PSIs.
- Supportive oversight focused on strengthening response system functioning and improvement.

The PSIRF, and specifically this plan, will support the trust to respond to incidents in a way that maximises learning and improvement. Except for incidents that require a nationally mandated response to certain categories of events, such as Never Events, we will be able to:

- Balance effort between learning from responding to incidents and/or exploring issues and our improvement work.
- Broaden the methodologies that we use to learn from PSIs, e.g., clinical audit, thematic analysis.
- Focus our attention on understanding events that we may not have previously had the resource to examine. Our chosen response will not be solely based on harm that has already occurred; we will be able to consider the risk of future harm occurring and then identify how that risk can be reduced across the organisation.
- Further develop our existing learning system and ensure that the output of the proportionate learning responses that we undertake are shared across the organisation and that local improvement opportunities, in areas other than that in which an event occurred, can be considered by teams.

At the heart of the PSIRF is compassionate engagement with patients and staff who have been affected by a PSI. The PSIRF aims to align with the trust 2022-2027 strategic objectives and our quality priorities for 2023/24, and therefore these have been at the forefront of the development of this Patient Safety Incident Response Plan (PSIRP) and the associated Patient Safety Incident Response Policy.

A glossary of terms used can be found at Appendix 1.

1. Introduction

This patient safety incident response plan (the Plan) sets out how Moorfields Eye Hospital NHS Foundation Trust (the trust) intends to respond to patient safety incidents over a period of 12 to 18 months. The Plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected. It is to be acknowledged that the introduction of the Plan represents a significant change in the way we expect our staff to respond to patient safety incidents. As such, it is acknowledged that it will take time for the new approach to be embedded and to become an integral part of service delivery.

The Plan is underpinned by our trust incident reporting and management policy, the learning framework, and the new trust patient safety incident response policy[1].

2. Our services

Moorfields Eye Hospital NHS Foundation Trust is a single-specialty trust, which is the leading provider of adult and paediatric eye health services in the UK and is a world-class centre of excellence for ophthalmic research and education. The trust supports the treatment and care of patients with a wide range of eye problems, from common complaints to rare conditions that require treatment not available elsewhere in the UK.

The trust delivers NHS emergency, urgent care, and routine ophthalmic services from multiple number of locations, which are geographically spread across the UK. The lead commissioner of trust services is North Central London Integrated Care Board (ICB). A comprehensive list of sites and services, which is correct at the time of plan approval, is shown in Appendix 2. Many of the NHS services provided by the trust are interlinked with services used in Moorfields Private. For this reason, the Plan does not distinguish between NHS and Private services.

In addition to the main Moorfields Eye Hospital, on City Road in London, the trust provides a networked site model of care, based on three geographical networks: Moorfields North, Moorfields South, and Moorfields East. Within these geographical networks, care is generally sub-divided into five different types of service, ensuring a comprehensive range of eye care provision closer to patients' homes:

[1] The trust incident reporting policy will be updated to take account of all new arrangements introduced to support implementation of the NHS England National Patient Safety Strategy. A new policy (policy for engaging and involving patients, families & staff following a patient safety incident) is under development and this will supersede the existing 'being open and duty of candour policy'.

Service type	Explanation
Moorfields eye centres (district hubs)	Co-located with general hospital services, eye centres provide comprehensive outpatient and diagnostic care as well as more complex eye surgery and will increasingly serve as local centres for eye research and multidisciplinary ophthalmic education.
Moorfields eye units (local surgical centres)	Eye units provide more complex outpatient and diagnostic services alongside day-case surgery for the local area.
Moorfields community eye clinics (community-based outpatient clinics):	These clinics focus predominantly on outpatient and diagnostic services in community-based locations.
Moorfields partnerships (partnerships and networks)	In this model, the trust offers medical and professional support and joint working to eye services managed by other organisations. The trust also provides clinical leadership to various diabetic retinopathy screening services and to networks across London that deal with retinopathy of prematurity diagnostics.
Moorfields diagnostic hubs	Diagnostic hubs take patients through a series of rapid tests within a 45-minute visit. Patients will only be asked to attend a subsequent hospital visit if the consultant sees something requiring urgent or personal attention following review of the test findings.

3. Defining our patient safety incident profile

The trust has existing processes in place to identify, examine and learn from PSIs. We are committed to improving our processes and strengthening the way in which we learn from all events, including PSIs, and continue to monitor and review the effectiveness of our learning system.

To fully implement the PSIRF, the Trust has completed a review of what types of PSI occur, or may occur, to understand where we need to prioritise our learning resources to

improve. Data from various sources has also been reviewed to inform the selection of PSIs that require a specific learning response (see table 2, section 6).

3.1 Stakeholder engagement

The central quality and safety team has engaged with key stakeholders, over a 12-month period, to inform the Plan. The engagement activities undertaken have been summarised below and described in more detail in Appendix 3 and have included:

- Activities undertaken to support delivery of the PSIRF as a quality priority.
- Communication with the organisation regarding the introduction and purpose of the PSIRF.
- Involvement of our Patient Safety Partners (PSPs).
- Presentation of the Plan and PSIRP at governance meetings, including the trust's Quality and Safety committee and Clinical governance committee.
- Sharing and development of resources made available by NHS England and other NHS organisations.
- Development of a PSIRF implementation group.
- Safety culture focus groups.
- Attendance at networking events, in particular those attended by partnership organisations.

3.2 Data sources

We have reviewed numerous data, from both internal and external sources, to inform the Plan and identify our local incident priorities, as listed below. Where possible we have also considered what the data tells us about inequalities in patient safety.

Internal sources

- Reported incidents (3 years), including incidents reviewed by the Serious Incident (SI) panel – NHS & Private.
- SI and Never Event (NE) investigation reports – NHS & Private.
- Complaints data (as presented in the relevant quarterly reports – Q1 2020/21 to Q4 2022/23) – NHS only.

- PALS data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.
- Friends and Family Test (FFT) data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.
- Claims data (as presented in the quarterly quality & safety reports – Q1 2020/21 to Q4 2022/23) – NHS only.
- Divisional risk profiles, based on a review of open risks – NHS & Private.
- Staff survey results (2 years) – NHS & Private.
- Junior doctor survey – NHS only.
- Freedom to speak up (FTSU) thematic data – NHS & Private.
- Output of safety culture focus groups – NHS & Private.
- Safety summit output (held for biometry and intraocular lenses (IOLs) and referral management) – NHS & Private.
- Data from quality surveillance processes (e.g., surgical safety checklist audits, pharmacy audits, infection control quarterly reports) – NHS & Private.
- Review of reports to/from specialist risk management committees (e.g., patient falls, resuscitation, medicines management) – NHS & Private.

External sources

- Inquest outcomes, including prevention of future death (PFD) reports.
- Clinical Negligence Scheme for Trusts (CNST) claims scorecards (3 years).
- Healthwatch reports (none of relevance).

3.3 Services covered by the plan

This PSIRP covers trust UK activity (NHS and Private).

Some departments and services within the trust (eg eye bank, pathology, electro-physiology department, contact lens and prosthetics manufacturing) are subject to accreditation, certification, license or permit inspection by an Approved Body or a Regulatory Body. As such, there is a requirement to record non-conformities identified with work processes and systems against certain standards, so that improvement opportunities can be identified and considered as stipulated by these bodies. These non-conformities do

not fall within the remit of this Plan unless a patient is involved. or affected, in which case a PSI will be reported on Safeguard (the trust electronic incident reporting system) via the trust incident reporting process and will then be within the scope of this Plan.

4. Defining our patient safety improvement profile

The data outlined in section 3.2, was used to identify our patient safety improvement profile, and used to thematically identify incidents or safety issues appearing in the highest number of sources of safety data. This information was then utilised to inform where there was the greatest opportunity for improvement and learning.

In accordance with NHS England guidance on developing the Plan, we also identified the trust's quality improvement work and quality priorities (set out in the trust's Quality Account 2023).

Our quality priorities form part of our strategic vison and over the next five years the trust will deliver its strategic vision through the excellence portfolio, supported by the trust excellence delivery unit (XDU). The excellence portfolio supports project activity across the trust by:

- Providing a consistent project delivery and reporting framework for projects.
- Driving the use of data for project decision making.
- Supporting the management of interdependencies and assumptions across excellence programmes.

The quality priorities for 2023/24, and the drivers for each, are shown in Appendix 4. A list of the projects included in the Excellence portfolio for 2023/24 can be found in Appendix 5.

In addition to this, the quality, service improvement and sustainability (QSIS) team provide project support and change management expertise to deliver service improvement projects across a variety of services in both clinical and non-clinical areas. The team works collaboratively with colleagues from the department of digital medicine (DoDM) to ensure integration with digital innovation.

To further determine our improvement profile, outputs from safety summits were also reviewed. Safety summits are an emerging improvement response pathway that the trust has used to address systemic safety risks. They bring together a diverse group of stakeholders, to discuss safety issues and develop solutions.

As our learning culture and improvement cycle evolve, we will look to continually embed robust processes which will also link to our excellence portfolio and other improvement work (monitored by committees). Oversight of the improvement work will be through the trust's clinical governance committee and quality and safety committee. This will allow us

to connect, across the organisation, improvement work which delivers against our known risks.

By comparing this improvement work with our patient safety incident profile, and sharing them with key stakeholders for feedback, the trusts local patient safety priorities have emerged, as described in section 6.

5. Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Events meeting these requirements are described in the table below:

Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Incidents meeting the Never Events criteria	Trust-led patient safety incident investigation (PSII) (see glossary for description)	Develop local organisational safety actions and feed these into the most appropriate improvement workstream/consider development of a new workstream	Clinical governance committee
Patient death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	Trust-led PSII	Develop local organisational safety actions and feed these into the most appropriate improvement workstream/consider development of a new workstream	Clinical governance committee

Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Death of a person who has a learning disability	Refer for Learning Disability Mortality Review (LeDeR) Liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	Respond to recommendations from external referred agency/organisation as required and feed actions into the most appropriate improvement workstream/consider development of a new workstream.	Safeguarding adults committee or safeguarding children and young persons committee, as appropriate (escalations to clinical governance committee)
Child death	Refer for Child Death Overview Panel (CDOP) review Liaise with CDOP as locally led PSII may be required	Respond to recommendations from external referred agency/organisation as required and feed actions the most appropriate improvement workstream/consider development of a new workstream.	Safeguarding children and young persons committee (escalations to clinical governance committee)

Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
A safeguarding incident in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Respond to recommendations from external referred agency/organisation as required and feed actions into the most appropriate improvement workstream/consider development of a new workstream.	Safeguarding children and young persons committee or safeguarding adults committee, dependent on PSI (escalations to clinical governance committee)

Patient safety incident type	Required learning response	Anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Incident in a diabetic eye screening (DES) programme	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes	Respond to recommendations from external referred agency/organisation as required and feed action into the most appropriate improvement workstream/consider development of a new workstream.	Clinical governance committee

6. Our patient safety incident response plan: local focus

The table below outlines our local incident priorities developed from the exploration of our data sources and improvement work.

It takes account of the resources available to complete proportionate learning responses following a PSI and recognises that further learning is required to inform improvement. The quantity of learning responses required for each PSI incident type or issue will be agreed by our incident review group (IRG). The safety actions will monitored by the relevant committee, and progress against the actions reviewed and monitored by IRG to ensure the PSIRF standards are met, with oversight provided by our clinical governance committee.

We will not continue to conduct individual learning responses when sufficient learning exists to inform improvement.

It should be noted that the Plan is a starting point, and our learning responses and identification of incident priorities will evolve as PSRIF becomes embedded in the trust. As such, IRG (as will be reflected in the IRG TORs) has the discretion to agree another learning response to that listed in the table, if more appropriate.

As described in section 3.3, the trust provides services that are subject to accreditation, certification, license or permit inspection by an Approved Body or a Regulatory Body. Learning responses will be considered for these services only where a PSI, and not a non-conformity, is recorded.

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Delayed or missed diagnosis of a tumour in a glaucoma patient referred to the neuro-ophthalmology service	Patient Safety Incident Investigation (PSII)	• A review of our PSIs, previous serious incidents (SIs) and complaints has shown that referral from the glaucoma to the neuro-ophthalmology service is complex, and there are multiple factors that can contribute to a delay. • Due to the complexity, organisational impact and the number of services involved, a PSII will ensure that a rigorous and in-depth review addressing system factors is undertaken.	Clinical governance committee
Unplanned omission/ deviation to intended care or treatment plan because of the use of hybrid health records/systems	After Action Review (AAR) or another agreed learning response, if more appropriate	• Some contributory factors related to the use of hybrid records are known. However, PSIs have indicated that more learning will help inform the development of local safety actions. • AAR will support the identification of areas for improvement by understanding the expectations and perspectives of all those involved. Learning from the AARs, will feed into the safety improvement plan, or equivalent, related to the development of a comprehensive electronic patient health record.	Digital clinical safety committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Clinically unacceptable delay in the review/ treatment of a 'follow-up' patient, where the provision of a timely appointment has not been impacted by clinician instruction or known capacity issues	AAR or another agreed learning response, if more appropriate	• Improvement of our failsafe processes is a trust priority and is on the trust's risk register. The review of our data has highlighted this as an area for improvement. • AAR will support the identification of areas for improvement by understanding the expectations and perspectives of all those involved. New safety actions identified from the AAR will be incorporated in the failsafe and Outpatient Waiting List (OWL) improvement workstream.	Develop and deliver excellence board Oversight and escalations via clinical governance committee
Mismanagement of internal referrals between sites and services and referrals from external providers into the organisation	Thematic review of PSIs related to referral management	• Reported PSIs, feedback from focus groups and learning from a referral safety summit have evidenced this as an opportunity for improvement. • New safety actions identified from the thematic review of PSIs will be incorporated in the safety improvement plan being developed as part of the ERS (electronic referral service), OpenEyes (OE, electronic patient record) and booking centre improvement workstreams.	Develop and deliver excellence board IT programme board Oversight and escalations via clinical governance committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Communication of patient information between the trust and external organisations (e.g., letters and referrals relating to continuity of care not sent)	Thematic review of new PSIs relating to the external communication of information	• Reported PSI, feedback from focus groups, patients, and learning from a referral safety summit have evidenced this as an opportunity for improvement. • A thematic review will allow for a structured approach to identify themes and inform the trust wide safety improvement plan. Clinical governance committee will review the recommendations from the thematic review to determine a mechanism for implementation of the improvement plan.	To be determined by the clinical governance committee following the thematic review
Deviation to intended care or treatment plan resulting in intravitreal injection of the wrong drug and/or to the incorrect eye	AAR or another agreed learning response, if more appropriate	• Review of PSI near misses and incident data, feedback from key stakeholders and focus groups has identified this as an opportunity for improvement. • Output from the AAR will identify activities, resources and behaviours that will support the development of safety actions and create a trust wide safety improvement plan, if required.	Drugs, therapeutics, and medicines management committee Oversight and escalations via clinical governance committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Any incident or near miss relating to the application of a laser to a patient	AAR or another agreed learning response, if more appropriate	• PSI and near misses have been reported relating to the use of lasers. PSIs can have an impact on patient outcomes and vision. • The output from AARs will identify activities, resources and behaviours that will be incorporated in the development of a laser safety improvement plan and/or safety summit.	Laser safety committee Oversight and escalations via risk and safety committee
Delayed recognition of a deteriorating patient	AAR or another agreed learning response, if more appropriate	• Reported PSIs have identified an opportunity for improvement in the way the trust responds to patient deterioration. • Output from the ARR will quickly identify activities, resources, and behaviours, that will be fed into the 'deteriorating patients' improvement work.	Resuscitation committee Oversight and escalations via clinical governance committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Delayed processing or review of a diagnostic test or sample leading to a clinically unacceptable delay in treatment	AAR or thematic review, or another agreed learning response, if more appropriate	• Reported PSI have evidenced this as an opportunity for improvement. • Output from the AAR will identify activities, resources, and behaviours, that will feed into local safety actions. In turn these will feed into the most appropriate improvement workstream/consider development of a new workstream.	Pathology improvement group Radiation protection advisory committee Oversight and escalations: via risk and safety committee
Clinically unacceptable delay, not impacted by known capacity issues, in actioning an outcome of a review of a patient managed through a virtual pathway.	AAR or thematic review, or another agreed learning response, if more appropriate	• Reported PSI have evidenced this as an opportunity for improvement. • Output from the ARR will identify activities, resources, and behaviours, that will feed into local safety actions. In turn these will feed into the most appropriate improvement workstream/consider development of a new workstream.	Develop and deliver excellence board. Oversight and escalations via clinical governance committee

Patient safety incident type or issue	Planned learning response	Rationale and anticipated improvement route	Committee/Group with responsibility for monitoring improvement
Incident(s) which signify an unexpected level of risk and/or potential for learning and improvement	Assessment by the Incident Review Group to determine if a learning response is required	• To ensure there is a mechanism to add to the Plan as our PSRIF approach develops and new themes emerge.	To be agreed by IRG, depending on the PSI type or issue

Appendix 1: Glossary of terms

Term	Definition/Explanation
After Action Review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning? It aims to capture learning from these to identify the opportunities to improve and increase occasions where success occurs.
Compassionate engagement	An approach that prioritises and respects the needs of people who have been affected by a patient safety incident.
Duty of candour (DoC)	The duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur.
Engagement	Everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

Term	Definition/Explanation
Everyday work	Everyday work describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work. Exploring everyday work shifts the focus from developing quick fixes to understanding wider system influences and is central to any learning response conducted to inform improvement. The following tools can be used to explore everyday work: • Observation guide Brief guide to conducting observations • Walkthrough guide Brief guide to walkthrough analysis • Link analysis guide Brief guide to link analysis • Interview guide Guidance on planning and conducting interviews as part of a patient safety incident learning response
Horizon scanning	The horizon scanning tool uses the Systems Engineering Initiative for Patient Safety (SEIPS) framework to structure conversations about work as done and emerging patient and staff safety risks Horizon scanning tool
Involvement	Part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.
Multi-disciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Never Event (NE)	Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. A list of NEs can be found here: Never Event list February 2021

Term	Definition/Explanation
Patient Safety Audit (PSA)	A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline)
Patient Safety Incidents (PSIs)	Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.
Patient Safety Incident Investigation (PSII)	PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.
Patient Safety Incident Response Framework (PSIRF)	This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.
Patient Safety Incident Response Plan	Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.
Patient safety partners (PSPs)	PSPs are patients, carers, family members or other lay people (including NHS staff from another organisation working in a lay capacity) who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation.

Term	Definition/Explanation
Systems Engineering Initiative for Patient Safety (SEIPS)	SEIPS is a framework for understanding outcomes within complex socio-technical systems. Patient safety incidents result from multiple interactions between work system factors (i.e., external environment, organisation, internal environment, tools, and technology, tasks, and person(s). SEIPS prompts us to look for interactions rather than simple linear cause and effect relationships. SEIPS quick reference guide and work system explorer
Structured Judgement Review (SJR)	Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.
Thematic review	A thematic review may be useful for understanding common links, themes, or issues within a cluster of investigations, incidents, or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. Top tips for completing a thematic review

Appendix 2: List of sites and medical services (as at January 2024)

	Accident & Emergency	Adnexal	Anaesthetics	Cataract	External disease	General ophthalmology	Genetics	Glaucoma	Intravitreal injections	Medical retina	Neuro-ophthalmology	Ocular oncology	Paediatrics	Private Patients	Refractive laser	Strabismus	Surgery	Urgent Care	Uveitis	Vitreoretinal
Barking Hospital								■												
Bedford Hospital (South Wing)		■		■				■	■	■			■				■	■		
Brent Cross				■				■		■										
Cayton Street				■														■		
City Road	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Croydon University Hospital		■		■	■	■		■	■	■	■		■			■	■	■	■	■
Ealing Hospital				■	■	■		■	■	■			■			■	■		■	
Homerton Hospital (Partnership)						■							■							
Hoxton								■		■										■
MeiraGTX Hoxton Maze																				
Moorfields Private Eye Centre														■	■		■			
Moorfields Private Outpatient Centre														■						
Nelson Health Centre						■		■		■										
Northwick Park Hospital		■		■	■	■		■	■	■			■			■	■			
Parkway Health Centre*																				
Potters Bar Community Hospital				■		■		■	■	■			■			■	■			
Purley War Memorial Hospital								■		■										
Queen Mary Hospital				■				■									■			
Richard Desmond Childrens' Eye Centre	■												■	■						
Sanderstead Health Centre*																				
St Ann's Hospital			■	■				■	■	■							■			
St Bartholomew's Hospital												■								
St George's Hospital		■		■	■	■		■	■	■	■		■			■	■	■	■	■
Stratford			■	■		■		■	■	■							■			

- Orthoptist services only.
- This table does not include the support services provided (e.g., orthoptics, optometry, contact lens, imaging, pathology, EDD, prosthetics). For more information regarding these services please contact the ophthalmology and clinical support services (OCSS) division.

Appendix 3: Detailed stakeholder engagement activities completed to inform our Plan

- For 2022/23 implementation of the National Patient Safety Strategy, including the PSIRF, was introduced as a quality priority for the trust. Delivery against the priority was included for monitoring by the Excellence Delivery Unit (XDU) as a type 1 project (now re-categorised as a type 2) and monthly progress updates were provided to the working together board (jointly chaired by the chief nurse and director of allied health professions and the director of workforce and organisational development (the function of the XDU is described in more detail in section 4).

- The purpose and expectations of PSIRF were communicated to the organisation in advance of the NHSE launch of the final PSIRF documents in mid-August 2022. The early adopter information was discussed with the caveat that the published versions would contain differences. Routine updates were provided to the risk and safety committee and the clinical governance committee, and National Patient Safety Strategy updates have also been presented to the quality and safety committee as a sub-committee of the trust board.

- Patient safety partners were involved via their membership of our clinical governance committee. One patient safety partner reviewed of our SI responses under SIF to inform the Plan. They were also specifically asked to comment on the safety incident profile and the draft PSIR policy.

- The proposed incident priorities were presented at governance meetings, including the trust's Clinical governance committee for oversight, feedback, and discussion prior to approval.

- The trust welcomed access to the resources made available for use via the NHS Futures platform, and the central quality and safety team has widely advocated such access. For example, the NHS England short animation 'Introducing the Patient Safety Incident Response Framework (PSIRF): A framework for learning' has been shown to staff attending the chief executive briefing, at various department/team meetings and at quality forums. Staff have been afforded the opportunity to share insight or concerns and ask questions regarding PSIRF, either in the forum or on a 1:1 basis.

- Our PSIRF implementation group was first convened towards the end of 2022. Engagement with members of the implementation team continued on an ad-hoc basis, until the implementation group was formally reconvened in Q1 2023/24 to review the output of the diagnostic and discovery phase and to help draft our PSIRP local priorities prior to consultation.

- A significant achievement that PSIRF has enabled for the central quality & safety team was the development of safety culture focus groups to support the diagnostic and

discovery phase of the PSIRP development. A series of focus groups were held across the organisation, and these afforded the team the opportunity to understand any specific concerns that participants may have in relation to patient safety and psychological safety.

- The UCL Partners health innovation partnership has hosted PSIRF events and provided a safe environment in which trust representatives from partnership organisations, including the ICB, networked and sought advice and support from each other. This will also assist with the co-ordination of any cross-system learning responses that are required in the future.

Appendix 4: 2023/24 quality priority drivers

	Quality Account Priority 2023/24	Quality Domain	Underpinning drivers				
			Excellence programme (XDU)	National initiative	Learning from SIs/ Complaints/ feedback	Themes from patient/staff engagement	Carried over from 2022/23
1	Implementation of the National Patient Safety Incident Response Framework (PSIRF)	Safe	✓	✓	✓	✓	✓
2	An integral part of PSIRF, is the development of a learning system to support knowledge transfer following events as described in the trust's patient safety incident response plan (PSIRP)		✓	✓	✓	✓	✓
3	Improved care of deteriorating patients		✓	✓	✓	✓	
4	Implementation of patient experience principles	Patient experience	✓		✓	✓	
5	Virtual reality to improve communication project		✓			✓	
6	Patient Portal – Digital Patient Communications		✓	✓		✓	
7	Continue to embed the Accessible Information Standard (AIS) across Moorfields' network		✓	✓	✓	✓	✓
8	Making Better Use of Routine Health Data		✓		✓	✓	
9	Build further on the work undertaken in 2022/23 to reduce health inequalities via 'Make Every Contact Count'	Effective	✓	✓	✓	✓	✓
10	Patient Initiated Follow Up (PIFU)		✓	✓	✓	✓	

Appendix 5: 2023/24 Excellence portfolio categorisation

The objectives of the excellence programme boards and projects can be found in the tables below. The projects from the IT and Discover Excellence programmes are not included below. This list is subject to change throughout the year.

Programme board	Objective	Excellence area
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.	• Workforce • Quality
Discover	We will discover new treatments and clinical pathways for excellent eye care.	• Innovation • Education
Develop and deliver	We will develop our clinical pathways, our physical and digital network, and our operational systems, to deliver reliably excellent eye care.	• Clinical • Network • Operational
Sustain and scale	We will ensure that more people can access excellent eye care sustainably and at scale, reducing waste and inefficiency.	• Enterprise • Sustainability

2023/24 Excellence portfolio categorisation

Type 1	Type 2	Type 3
1. Major project (external PMO): Oriel	1. D&D: Surgical Excellence – operational	1. D&D: Digital Remote Consenting
2. Major project: EPR	2. D&D: Inventory Management System (IMS)	2. D&D: Patient Portal
3. D&D: Central Sterile Supply Dept. (CSSD) – phase 1&2	3. D&D: Asynchronous and Virtual appointments	3. D&D: PIFU
4. D&D: Single Point of Access (SpOA) - rollout	4. D&D: Bedford contract renewal and capital works	4. D&D: Attend Anywhere – St George's
5. D&D: Outpatient Waiting List	5. D&D: Development of Clinical Strategy	5. D&D: Follow Up Reduction
6. D&D: Brent Cross II	6. D&D: Failsafe - Implementation phase *	6. D&D: Site reviews – Sanderstead / Parkway / Croydon *
7. D&D: Stratford Hub - phase 1&2	7. D&D: Digital Pre-operative assessment	7. D&D: New Amin model *
8. WT-Q: Accessible Information Standard	8. WT-Q: National Patient Safety Strategy (PSIRF)	8. D&D: Barking CDC
9. WT-Q: EDI strategic priorities (x4)	9. WT-Q: Certificate of Visual Impairment	9. D&D: Robotic Process Automation (ON HOLD)
10. WT-W: Temporary Staffing Provision – bank partners	10. WT-Q: Patient Experience Framework	10. WT-Q: Comprehensive audit tool (Tendable)
11. WT-W: E-Roster optimisation	11. WT-Q: Patient Experience Principles – phase 2	11. WT-W: Infrastructure Review – CPD, Apprenticeships and LMS
12. WT-W: FTSU	12. WT-W: ESR Optimisation *	12. WT-Q: Professional Nurse Advocate
13. WT-W: Agile – phase 1 & 2	13. WT-Q: Health Inequalities Data Analytics	13. WT-Q: Virtual Reality
14. S&S: Commercialisation Framework	14. WT-Q: Website redevelopment	14. WT-Q: MEC philantrophy culture framework
15. S&S: Primary and Community Eye Care Services	15. WT-W: Medical Workforce Optimisation	15. WT-Q: Information Asset Management
	16. WT-W: OD programme	16. WT-Q: MEC My Thank You
	17. S&S: Paperless Campaign	17. WT-Q: Veterans Aware Accreditation
	18. D: Education hub @ Ebenezer Street *	18. WT-Q: Making Every Contact Count – Smoking Cessation *
	19. D&D: Pathology Unit Transfer **	19. D: BYOD clinical photography *
	20. WT: Future Shape of Workforce (ON HOLD)	20. S&S: Carbon Footprint
	21. D&D: Surgical Excellence – workforce **	21. WT: International Nurse Recruitment **
		22. WT: Resuscitation Improvement Project **
		23. S&S: Energy Management Phase 1 **
		24. S&S: Moorfields Private West End – Outpatients **
		25. S&S: Moorfields Private West End – Theatres **
		26. S&S: Sustainability Awareness Campaign **
		27. S&S: Trust Green Travel Plan **
		28. WT: Digital Accessibility / Inclusion **
		29. WT: Pathway to Excellence (ANCC) **
		30. WT: Eye Envoys **

Key:

* Projects have not begun reporting via XDU
** Projects have submitted closure reports and transitioned to benefits realisation

Moorfields Eye Hospital NHS Foundation Trust

Report to Board, January 2024	
Report title	Emergency Preparedness Resilience and Response Assurance Process Review Report 2023
Report from	Jon Spencer, Chief Operating Officer
Prepared by	Juliana Richardson, Emergency Planning Lead
Previously discussed at	EPRR Steering Group
Attachments	Action Plan for 2023 EPRR Assurance

Brief summary of report:

The 2023 annual EPRR assurance process review for the trust took place on 19th October 2023. The aim of this process is to assure NHS England (London) of EPRR processes and policies within individual Trusts.

Prior to the meeting the trust carried out and submitted a RAG rated self-assessment against the NHS Core Standards for EPRR. In addition to this a set of 'deep dive' questions in relation to Training and Exercising formed part of this year's process.

This year the trust was awarded a green RAG rating with fully compliant.

Action Required/Recommendation

The board is asked to note the annual assurance survey outcome as substantial compliance, along with recommended next steps section.

For Assurance	√	**For decision**		**For discussion**		**To note**	

Executive Summary
This paper provides a summary of the outcomes of Moorfields' emergency preparedness, resilience and response (EPRR) annual assurance survey submission to NHS England during 2023. It assures as far as reasonably practicable, cohesive coordination in all aspects of emergency preparedness, resilience and response, across all sites and services provided by the trust.

1. Introduction

The trust is required to prepare for and respond to a wide range of incidents or emergencies that could impact on health or patient care. These could be anything from extreme weather events, infectious disease outbreaks, terrorist attacks to major transport accidents. The trust must be internally resilient and be able to respond safely to such incidents, or other internal disruptions, whilst maintaining its services to patients.

The Trust is termed as 'a Category One Responder' under the Civil Contingencies Act (2004) due to its 24 hour A&E ophthalmic service; however Moorfields is not a designated receiving hospital. This being the case, the trust is still required to meet all EPRR core standards. The trust also has a duty to cooperate with the wider integrated healthcare and civil resilience systems to ensure there is a seamless and coordinated response for protecting both the health of local communities and the nation against the challenges of natural hazards, accidents, infectious disease outbreaks and the enduring threat of terrorism.

The NHS service-wide objective for emergency preparedness, resilience and response (EPRR) set by NHS England is to:

'ensure that the NHS is capable of responding to significant incidents or emergencies of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that brings about a speedy return to normal levels of functioning; it will do this by enacting its capability to work across organisational boundaries'

2.0 EPRR assurance process

The EPRR Assurance process is an annual survey which is submitted to NHS England on behalf of the trust. The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards. The compliance levels are Full (green), Substantial (green), Partial (amber) and Non-compliant (red). The core standards are listed as follows:

- Governance
- Duty to assess risk
- Duty to maintain plans
- Command and control
- Training and exercising
- Response
- Warning and informing (duty to communicate with the public, partners etc)
- Co-operation
- Business continuity framework
- Hazmat (hazardous material) & CBRN (chemical, biological, radiological and nuclear)

The organisation undertook a self-assessment, which entailed RAG rating the trust's compliance on each of the core standards i.e. green, amber, and red. This self- assessment was submitted during early September 2023 to NHS England, followed up with a review meeting in October 2023.The Emergency Planning Lead in consultation with the COO, RAG rated all core standards as green. Based on discussions in the Assurance meeting, all core standards were awarded green.

An additional set of 'deep dive' questions was included this year, which entailed a further 13 questions and encompassed Training and Exercising. The trust RAG rated itself fully compliant in these planning

questions bar one which was rated amber. The one amber was awarded green after discussion with NHS England. The outcome of the deep dive section does not affect the overall rating awarded to the trust.

NHS England awarded the trust a full level of compliance (green) RAG rating.

2.1 EPRR assurance process Moorfields 2022 Results

EPRR Core Standards	Moorfields RAG Rating 2023
Governance	
Duty to assess risk	
Duty to maintain plans	
Command and Control	
Training and exercising	
Response	
Warning and informing	
Co-operation	
Business continuity framework	
Hazmat & CBRN	

3. EPRR sustained improvement

Year on year improvements have been achieved in regards to the EPRR work streams, ultimately improving the trust's overall resilience when responding to incidents. NHSE stated that the trust had clearly demonstrated its commitment to EPRR. It was noted that the trust continues to maintain a high standard for EPRR arrangements and reference was made to continuous improvement.

4. Next steps

The EPRR function will continue to strive to maintain the high standards achieved this year, with the main objective of continuous improvement. The EPRR focus at present centres around resilience in relation to the contamination of buildings and other significant business continuity types of incidents, and how to mitigate against these.

Moorfields Eye Hospital NHS Foundation Trust
Action Plan following 2023 EPRR Assurance Review

Core Standard Ref	Core Standard	Action to be taken	Self-Assessment RAG rating	Completion date
2	EPRR Policy Statement	Trust to review in line with recommendations from the assurance process	N/A	28th June 2024
10	Procedure for Declaring a Major Incident	Trust to review in line with recommendations from the assurance process	N/A	28th June 2024
44	Business Continuity Policy Statement	Trust to review in line with recommendations from the assurance process	N/A	28th June 2024
47	Business Continuity Plan	Trust to review in line with recommendations from the assurance process	N/A	28th June 2024
N/A	Board level sign off of 2023 assurance results	Emergency Planning Lead to send assurance results 2023 report to the Board for sign off.	N/A	January 2024

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 Q3 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 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**	✓

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 Q3 2023/24 data is shown in the table below.

Indicator	Q4 2022/23	Q1 2023/24	Q2 2022/23	Q3 2022/23
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 Q3

1. Inquest into the death of a patient, City Road (On-going)

In the Q2 report, notification was provided that trust clinicians had been asked to provide written statements to inform an inquest into the death of a patient who had recorded A&E and City Road outpatient activity immediately prior to death. This case remains on-going and an update will be provided in the Q4 report, if available.

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 is currently scheduled to take place on 21 February 2024. The coroner would like information in relation to the patient's eyesight, the level of vision, and details of treatment and care given. In particular the coroner is keen to understand if there were any delays to the patient's treatment and the effect that this could have had on their eyesight. This request is being processed and an update will be provided in the Q4 report, if available.

ME role update

The new death certification reforms will be effective from April 2024 and draft regulations for England and Wales have been published. Primary legislation was commenced on 1 October 2023, and changes from April 2024 will affect all healthcare providers. Once the new death certification process comes into force, all deaths in England and Wales will be independently reviewed, without exception, either by a medical examiner or a coroner.

Medical examiner update (December 2023)

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	Report of the People and Culture Committee
Report from	Laura Wade-Gery interim committee chair
Prepared by	Sam Armstrong, company secretary
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.

Brief summary of report

Attached is a brief summary of the meeting that took place on 12 December 2023.

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 • Attendance – 83%
Current activity (as at date of meeting)	**Workforce priorities and change projects (including programme updates)** • The committee received a report on workforce priorities and change projects. The Trust people strategy, priorities and deliverables were noted. • There were currently 20 workforce and OD programmes/projects underway: 11 locally led projects and nine XDU programmes/projects. • The overall RAG status for Workforce & OD Programme/projects was 'amber' with 13 projects on track and green rated, four projects not on track but with a plan in place and rated amber, two on hold and one project rated red, which was due to lack of EDI lead being in place; a recruitment for this was currently underway. • A communications plan was being developed. • The committee recognised it was an ambitious list of projects that would need to followed the XDU reporting methodology. • The Committee agreed that the Trust needed to be in a better place on this in 12 months' time. **Review of workforce and OD** • The committee received the review and noted the background and scope. • There had been a good commitment from the workforce team to the review recommendation and they participated well and openly in the review process. • Some existing good practices were observed in the review, however strategies and priorities had issues that needed development. There were also key issues around systems, with a lack of resources. The high number of temporary staff and vacancies was easily observable. • The Trust executive had agreed to make an investment to implement the recommendations and achieve the planned improvements. Areas of focus included such as medical HR, workforce systems, leadership development and EHIR. • To ensure managers received the appropriate training to lead people as well as manage, induction for new managers would be developed along with training for existing managers. • Business partners and training would be key in achieving improvements. • Some concern was expressed that leads would be distracted away from leadership and leadership development by business-as-usual pressures. The committee was reassured that support staff would be recruited to ensure other leaders could focus on the important development actions. • It was agreed that monitoring of the implementation of the recommendations would be through XDU and local project management. • The committee agreed with the proposals. **CPO Job Description** • The committee approved the job description subject to any further comments after the meeting. **Workforce metrics –** • The committee was provided with an update on workforce metrics for October 2023, and noted the contents. • The reduced number of appraisals from 75% to 71% (below a target of 80%) was noted. The corporate areas required further support to improve their results. A task and finish group was being commissioned by the Interim Director of Workforce & OD to explore how appraisal completion rates could be improved.

	• There had also been an increase of six employment relation cases in the last month. The cases included long-term sickness stage three, formal sickness stage two, grievances, and bullying and harassment. • Sickness rates and causes were noted. The workforce team was working to support staff as appropriate. The committee noted the current ethnicity and gender profile of Trust staff. **Appraisal Task and Finish Group terms of reference** • The committee approved the terms of reference. **FTSU Guardian** • The committee received a progress update on the implementation of the new FTSU model, which they noted. **Staff survey** • The committee was updated on progress on the staff survey including the response rate and timeline for further actions. As all information pertaining to the staff survey is still embargoed, it cannot be detailed here. **Workforce risks** • The committee noted the workforce risk register. **Workforce Sub-committee reports:** • The committee received and noted reports from the Health and Wellbeing Committee and the Equality and Diversity Steering Group
Key concerns	• While the committee welcomed the proposed changes to workforce, they recognised the related risks.
DONM	• 13th February 2024