Bundle Board of Directors - Part 1 2 October 2025

1 09:00 - Welcome and introductions
Tim Briggs, interim Chair
for noting
251002 TB Part I Item 00 Agenda

2 09:05 - Patient story
Sheila Adam, Chief Nurse
for noting

3 09:25 - Apologies for absence
Tim Briggs, interim Chair
for noting

4 Declarations of interest
Tim Briggs, interim Chair
for noting

5 Minutes of the previous meeting held 24 July 2025
Tim Briggs, interim Chair
For approval
251002 TB Part I Item 05 DRAFT Minutes of Meeting in Public 250724

6 09:30 - Matters arising and actions log
Tim Briggs, interim Chair
For noting
251002 TB Part I Item 06 Action log

7 09:30 - Chief Executive's Report
Peter Ridley, interim Chief Executive Officer
For noting
251002 TB Part I Item 07 CEO report

8 09:40 - Integrated Performance Report
Executive Team
For noting
251002 TB Part I Item 08 IPR coversheet - August 25 (OPEN Version)
251002 TB Part I Item 08 Integrated Performance Report - August 25 (OPEN Section)

9 09:50 - Finance Report
Arthur Vaughan, Chief Finance Officer
For noting
251002 TB Part I Item 09 Public Finance Performance Board Report - Cover Sheet
251002 TB Part I Item 09 Public Finance Performance Board Report

10 10:00 - Guardian of safe working
Louisa Wickham, medical director
for assurance
251002 TB Part I Item 10 Guardian of Safe Working report

11 10:05 - Appraisal and Revalidation Board Report 2024-2025
Louisa Wickham, medical director
for approval
251002 TB Part I Item 11 MEH Appraisal and Revalidation cover sheet
251002 TB Part I Item 11 MEH Appraisal and Revalidation Board Report 2024-2025

12 10:10 - Infection prevention control annual report (to receive)
Sheila Adam, chief nurse and Director of allied professionals
for assurance
251002 TB Part I Item 12(i) IPC annual report 2025 cover
251002 TB Part I Item 12(ii) IPCT Annual Report slides Oct 25
251002 TB Part I Item 12(iii) Infection Control Annual Report 2024-25 final - CGC

13 10:15 - Adult & Young Person Safeguarding annual report (to receive)
Sheila Adam, chief nurse and Director of allied professionals
for assurance

251002 TB Part I Item 13 Safeguarding Annual Report 2024 - 2025 final

14 10:20 - Committee reports
a) Audit & Risk Committee | Asif Bhatti | for assurance
b) Quality & Safety Committee | Michael Marsh| for assurance

251002 TB Part I Item 14a Report of ARC
251002 TB Part I Item 14b QSC summary report cover sheet
251002 TB Part I Item 14b(i) QSC summary report 220725
251002 TB Part I Item 14b(ii) QSC summary report 160925

15 10:25 - Audit and Risk Committee Terms of Reference
Sam Armstrong, company secretary
for approval

251002 TB Part I Item 15 ARC ToR Cover sheet
251002 TB Part I Item 15 2025 Audit & Risk Committee ToR

16 Register of interests
Sam Armstrong, company secretary
for assurance

251002 TB Part I Item 16 Register of interests BoD v2

17 10:30 - Identify risks arising from the agenda
Tim Briggs, interim Chair
For noting

18 10:35 - Any other business
Tim Briggs, interim Chair
For noting

19 10:40 - Date of the next meeting - 27 November 2025

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on Thursday 2 October 2025 at 09.00
at The Education Centre and via MS Teams

No.	Item	Action	Paper	Lead	Mins
1.	Welcome	Note	Oral	TB	5
2.	Patient story	Note	Oral	SAd	20
3.	Apologies for absence	Note	Oral	TB	5
4.	Declarations of interest	Note	Oral	TB	
5.	Minutes of the previous meeting 24 July 2025	Approve	Enclosed	TB	
6.	Matters arising and action log	Note	Enclosed	TB	
7.	Chief executive's report	Note	Enclosed	PR	10
8.	Integrated performance report	Assurance	Enclosed	Exec	10
9.	Finance report	Assurance	Enclosed	AV	10
10.	Guardian of safe working	Note	Enclosed	LW	5
11.	Appraisal & revalidation annual report	Approve	Enclosed	LW	5
12.	Infection prevention control annual report (to receive)	Assurance	Enclosed	SAd	5
13.	Adult & Young Person Safeguarding annual report (to receive)	Assurance	Enclosed	SAd	5
14.	Committee reports a) Audit and Risk Committee (20.06.25) b) Quality and Safety (22.07.25, 16.09.25)	 Assurance Assurance	 Enclosed Enclosed	 AB MM	5
15.	Audit and Risk Committee Terms of Reference	Approve	Enclosed	SAr	5
16.	Register of interests	Assurance	Enclosed	SAr	
17.	Identifying any risks from the agenda	Note	Oral	TB	5
18.	Any other business	Note	Oral	TB	
19.	Date of next meeting – 27 November 2025				

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
DRAFT Minutes of the meeting of the Board of Directors held in public on 25 July 2025
The Rose Centre, St Georges Hospital and via MS Teams

Board members:	Professor Tim Briggs (TB)	interim Chair
	Peter Ridley (PR)	interim Chief executive
	Andrew Dick (AD)	Non-executive director
	David Hills (DH)	Non-executive director
	Michael Marsh (MM)	Non-executive director
	Elenor Lokteva (EL)	Non-executive director (via Teams)
	Adrian Morris (AM)	Non-executive director (via Teams)
	Sheila Adam (SAd)	Chief nurse and director of AHPs
	Arthur Vaughan (AV)	Chief financial officer
	Hilary Fanning (HF)	Director of discovery (via Teams)
	Sue Steen (SS)	Chief people officer
	Louisa Wickham (LW)	Medical director
In attendance:	Elena Bechberger (EB)	Director of strategy & partnerships
	Kathryn Lennon (KL)	interim Chief operation officer (representing JS)
	Victoria Moore (VM)	Director of excellence delivery and chief of staff
	Princess Cole (PC)	FtSu Guardian (via Teams) (item 11)

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

1. Welcome

The chair opened the meeting at 10.00am and welcomed all those present and in attendance. He welcomed AV to his first Board meeting as CFO.

The chair explained that the Board was meeting at St George's so Board member could spend the afternoon visiting the Moorfields teams there.

It was noted that there was no staff story due to the site visit.

Introductions were completed.

2. Apologies for absence

Apologies were received from Aaron Rajan, non-executive director, Asif Bhatti, non-executive director, Jon Spencer, chief operating officer and Sam Armstrong, company secretary.

3. Declaration of interest in relation to the agenda

There were no declarations made.

4. Minutes of the previous meeting

The minutes of the meeting held on 5 June 2025 were approved as a correct record.

5. Matters arising and action log

The action log and updates were noted.

6. Chief executive's report

PR presented the report.

He highlighted key areas of the report, which included:

- The Trust was working through the 10-Year plan which seemed to align well with our strategy
- Performance statistics showed the Trust was benchmarking well
- Planned industrial action was due to take place. The Trust had plans in place to cover its emergency services, and normal levels of planned activity was expected to be delivered
- The annual Moorfields Star's event, which recognised staff, had received more nomination than ever before with over 800 nominations

The Board noted the report.

7. Integrated performance report

KL introduced the report, which was presented by various executive directors. The following highlights were noted:

- The Trust's 18-Week referral to treatment time performance had increased to 83.1% of patients receiving their treatment within the required period. The total waiting list size had increased to 34,491
- Outpatient and injection activity was below plan and there was an area of focus around Paediatrics and External Disease
- 52-week wait had reduced to 19 at the end of June.
- Elective activity was below plan at 94.4% in June, this had been impacted by estates issues at two sites. Year to date was above plan at 100.4%.
- The Finance & Performance Committee and Quality & Safety Committee would be monitoring the effects of the CIPs to ensure there was no negative impact to the quality of care provided, or any health inequalities
- The Booking Centre was unable to achieve the agreed standard for call waiting time and call abandonment rate, due to the number of staff available to answer calls. Plans were in place to improve this performance, and this would be closely monitored
- Complaints response times had been heavily impacted by staff sickness and staff turnover, however, there was a new complaints manager in place who would lead an improvement plan to restore performance and provide an overall improvement to the service over the next three months
- Appraisal compliance remained below target at 54.4%. The Trust had recently changed platform for appraisals which had created some challenges in recoding accurate data. This was being reviewed with a decision to be made rearing possible extensions to the deadline
- Staff sickness rates remained above Trust target at 4.6% in June. The Trust was working with managers to ensure policy was followed and also meetings were being held with the external occupational health provider to improve the service.

MM assured the Board that to date, Quality & Safety Committee had not reported any issues regarding the Trust's cost improvement plan, however it would continue to monitor closely.

In response to a question from TB regarding Paediatrics, KL informed that Board that discussions were taking place with external providers to ensure the appropriate patients were being referred to Moorfields. In addition, discussions were being held with community providers to understand change requirements that would impact our activity. LW added that the Trust was working collaboratively with Great Ormond Street by combining general paediatric care with Ophthalmology. It was noted that different IT platforms were an issue in delivering this model of care.

AD advised the board that, in his experience, when switching from paper to electronic it could takes circa two years for an organization to get back into a normal rhythm.

The Board noted the report.

8. Finance report

AV presented the report. The following highlights were noted:

- There was a £3.06m deficit, cumulatively, against a planned deficit of £4.04m, which was £0.99m favourable variance to plan
- The CIP had identified £7.5m against the £15m target; £3m of that was recurrent
- Income had been a risk last month which had been addressed, with contracts now in place. The Trust was performing at 100% YTD. However, this would remain a risk due to block contract arrangements
- Capital expenditure YTD variance was due to the Oriel programme and was expected to balance out throughout the year.

In response to a question from DH, AV noted the Trust CIP had implemented the immediate savings but was reviewing the transactional spend and transformation for longer-term savings. The CIP Board was focusing on workforce deep dives, transformation initiatives and productivity for the longer-term savings. AV was encouraged by his findings since joining the Trust and felt he was seeing a cultural shift and understanding for the need to change. PR assured the Board there was £10-11m more in the process recognising there was still work to be done, though in the meantime, there was tactical holding back such as vacancy controls and agency staff. AM observed that the Trust needed to increase pace of achievement in order to hit in-year targets.

In response to AD, VM explained that the favourable plan was partly due to timing with the EPR and Oriel projects, and partly due to a reduction in the underlying run rate due to the impact of bank and agency reductions and the impact of the vacancy panel which had led to reduced WTE.

In response to a question from TB, LW was confident the work that had taken place over the previous six-months around job planning would put the Trust in a good position by the end of the year. SAd added that the CIP was providing a good opportunity to development new ways of working and although this would take time, the outcome would add real value to the organisation.

The Board noted the report.

9. Risk Management Strategy

SAd presented the report. The following changes were noted:

- The renaming of the Corporate Risk Register to the Trust Risk Register to facilitate understanding
- The revision of the escalation threshold for risks requiring Executive Oversight (ManEx), from 12 to 15
- Alignment with the requirements identified through RSM's internal audits of our risk management processes
- The Risk Appetite section has been updated by the company secretary to reflect the current strategic objectives.

It was noted that the Risk Management Strategy had been reviewed at the Audit and Risk Committee and commenced to the Board for approval.

The Board approved the Risk Management Strategy.

10. Learning from deaths

LW presented this report. The following highlights were noted:

- No deaths were reported in Q1 2025/26.
- There were two opportunities for learning and improvement identified during Q1:
    - The Trust was notified of a patient death from a family member. The Medical Examiner who had reviewed the case at the hospital in which the patient died confirmed that no concerns had been identified. The case was being reviewed out of scope as no 'significant concerns' had been raised by family members.
    - Notification has been received regarding the death of a child, whose care was under review as a patient safety incident investigation. Learning from this review would be shared with the Board at a later date.

The Board approved the report.

11. Freedom to Speak up update

SAd presented the report. The report covered Q4 2024/25 and Q1 2025/26. The following highlights were noted:

- The number of concerns had dropped slightly in comparison to the same time last year. It was thought the reason was due to the strong relaunch of the FTSU platform last year
- Reporting now included the number of concerns raised by staff group, against the proportion of staff within the organisation, which would enable better tracking to identify any areas of concern
- The Trust was working on an initiative with the GMC to increase confidence for medical staff to use FTSU platform as a reporting tool
- No patient safety or sexual safety concerns were raised during the reporting period.
- A newly formed MDT group, who would be reviewing patient safety incidents, had their inaugural meeting
- The National Guardians Office (NGO) will be closing and moving to NHSE.

In response to a question from AD, PC explained that a site visit by a FTSU guardian to the North division had resulted in an increased number of reports. It had recently undergone a number of changes and PC was pleased to report all concerns raised had since been closed.

In response to MM, SAd confirmed there had been concerns regarding the NGO retaining its independence after it moves to NHSE. However, PC confirmed there were no plans for the role to change and the Board would be kept informed of further updates.

In response to EL, PC informed the Board the MDT group would be focusing on culture and restorative work and would use a number of data sources including staff survey results and EDI data to triangulate data.

In response to DH, PC confirmed a guardian would always ask if the staff member has spoken to their manager in the first instance. It is made clear that there should be no involvement by HR and that investigations were carried out by the managers within the division. To support this, the FTSU policy gave clear guidance that concerns raised via this platform were not the same as whistle blowing.

The Board noted the report.

12. Green Plan Refresh

EB presented the report. The following highlights were noted:

- There was a national requirement for the Trust to publish a refreshed Green Plan by 31 July 2025
- Integrated Care Boards would also be publishing separate plans at the same time
- The Trust did not have a dedicated sustainability team and had approached external advisors to assist.
- A Sustainability Working Group had been established along with new staff initiative groups, MoorGreen and Green Theatre Working Group.
- The report outlined a number of actions which sat under nine themes.

DH commented that the Trust must be conscious of making cost effective decisions given the CIP.

The Board approved the report.

13. Committee reports

a. Quality and Safety Committee

MM noted there were no concerns to raise from the QSC meeting held on 22 July 2025 and a written report for the meeting would be provided at the next Board meeting.

14. Identifying any risks on the agenda

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

15. Any other business

There was no other business.

16. Date of next meeting

It was noted that the next meeting of the Board would take place on 2 October 2025 at the Trust Education Centre.

The meeting was closed 11:15am

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

2 October 2025

No.	Date	Minute item	Item title	Action	By	Update	Open/ closed/due
01/02	23/01/24	8.0	Integrated performance report	Report on research studies in the Trust to be presented to the board, to include breakdown of recruitment to different studies.	HF	Closed at meeting held 24 July 2025.	Closed
06/01	05/06/25	14.	Board Assurance Framework	Board strategy session on the risk management process and BAF to discuss risk appetite and structure.	SAr	Session planned for June strategy day, which was cancelled. Will be picked up at next strategy session due to take place on 5 November 2025.	November 2025

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

Brief summary of report

The report covers the following areas:

- Performance, Quality and Activity Review
- Oriel update
- MoorConnect (EPR)
- Financial Performance
- Sector update
- NICE updates
- People
- Stars Awards
- Moorfields in the News

Action required/recommendation.

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

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

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

PUBLIC BOARD MEETING – 2 October 2025

Chief Executive's report

Performance, Quality and Activity Review
In August, the trust's performance against the 18-week worsened in month to 80.5% of patients being treated within the required standard, and the total number of patients waiting over 52 weeks for their treatment also increased to 31. The 18-week wait position was driven by a continuation of challenging performance in three specialist services at City Road, and the 52-week wait position was driven by an incident in which referrals were processed incorrectly due to an administration error.

Both of the elective and outpatient activity levels showed improvement in month but remained under plan year to date.

Oriel
The construction of the centre remains on plan. On level one, carpets are now being fitted and the power has been switched on. The design of the centre has now been signed off by our User Group Chairs, which now leaves us with a known list of issues to resolve and technical validations to be finalised.

Our IT Workstream is starting a process to confirm the design of the SMART capability in the centre and an external wayfinding company has been engaged to advise on both our internal strategy and the demonstration of our historic artifacts.

A business case to fit out our new administration centre on the nearby Granary Street is due to be considered imminently and we hope to be able to finalise the name of the centre in the next reporting cycle.

MoorConnect (Electronic Patient Record)
In the last months, we have progressed the final design of the new system and there are now just a few areas that are still awaiting resolution. In areas where technical solutions to integration design are not possible, workarounds are being designed to support how our clinicians will provide care to patients.

We continue to build the system and have completed the first two stages of this. These two stages were delivered by their deadlines, however a planned third stage has been delayed and a new resourcing plan has therefore been developed to support completion of the build.

A group of MoorConnect staff from clinical, technical and operational backgrounds are visiting our network sites to share updates on the programme and get information on IT equipment, changes to processes and staff training. We have also had a good response to an initiative in which we are asking people to volunteer to be MoorConnectors. When trained, these individuals will be our frontline champions and support staff through the roll out of the new system.

Financial Performance – Month 5
For August the trust reported a £1.1m deficit IM, £0.9m favourable to the plan of £2.0m in month. Cumulatively the trust is reporting a £2.9m deficit YTD, £2.0m favourable to the £4.9m planned deficit YTD.

Patient activity during August was 95% for Elective, 97% on Outpatient First, and 97% against Outpatient Follow Up activity respectively against the trust activity plan. The trust is reporting an over-performance in high-cost drug/injection income which remains a variable payable element under the new contracting arrangements.

The trust has a £15.1m internal efficiencies plan for the financial year. Delivery to date is reporting £2.02m, in line with a lower planned delivery in first 5 months. This phasing highlights to external stakeholders the need for internal governance, identification and validation in the earlier part of the year with implementation and execution increasing as the year progresses.

The cash balance as at the 31 August was £85.3m, a reduction of £0.8m since the end of March 2025. This equates to approximately 90 days operating cash

Capital expenditure was £55.6m YTD predominantly related to Oriel and for EPR.

Sector Update
The Boards of North West and North Central London Integrated Care Boards (ICBs) have individually approved moving to a full integrated merger. The ICBs, responsible for planning and paying for local NHS and care services, are set to legally merge – becoming a new organisation serving 13 boroughs and circa 4.5m residents and service users.

In recent months, the teams at North Central London ICB (NCL) and North West London ICB (NWL) have been working together to explore how greater levels of collaboration could produce cost savings for both organisations, facilitate a move to being highly effective strategic commissioners, while still delivering for local populations.

Both boards considered options appraisals which set out a range of potential approaches as well as a full merger, including remaining standalone, keeping an informal collaborative approach; and clustering – where both would remain legally separate organisations but with some elements of joint leadership.

These options were evaluated against key criteria to explore the extent to which each would enable both organisations to continue to provide high quality and robust services. This week, the two Boards have both supported a recommendation that a fully-integrated merger was the best option.

NICE approval for treatment of rare disease
The National Institute for Health and Care Excellence (NICE) has approved a treatment for Leber Hereditary Optic Neuropathy (LHON) in those aged 12 and above.

LHON is a rare mitochondrial genetic disease that leads to rapidly worsening vision in both eyes, and there is currently no cure. It affects the cells that make up the optic nerve, which carry visual information from the eye to the brain, and early symptoms include blurred central and loss of colour vision. While typically painless, it progresses to severe sight loss and then legal blindness within a few weeks.

Idebenone, an oral medicine taken three times a day, reduces damage and can improve vision by boosting energy production in these cells, giving people the chance to regain greater independence, confidence and a better quality of life.

People report an improvement in their central vision, making it easier to recognise faces and non-verbal cues, which are critical for communicating.

NICE approval of eye tests at diagnosis of dementia
NICE has also updated its national guidance to recommend that all patients newly diagnosed with dementia are offered an eye health assessment with an optometrist.

Previously, patients diagnosed with dementia were not routinely referred for ophthalmic review. As many of them might not notice a decline in their eyesight, people could experience significant, avoidable and sometimes irreversible deterioration in their eye health before being prompted to take a test.

Worsening vision can affect confidence; the ability to read and write; the frequency of leaving the home (meaning fewer interactions with other people and less exercise); and falls and injuries. All of these can also accelerate the progression of their dementia. This change in guidance could have a profound impact on the safety, independence and quality of life of many thousands of patients each year. It could also delay institutional care and ease the burden on families and carers.

The updated guidance has taken over a year of research and advocacy.

People
On 22 September we welcomed John Middleton as our new Director of Private Practice. John will be leading the strategy for our private services as well as the operational delivery. John joins us from Barts Health where he was Deputy Chief Executive ay Newham University Hospital.

Moorfields' Stars 2025
On 17 September, we held Moorfields' Stars 2025, our annual staff recognition event, in London. Staff, volunteers and guests from across the trust, Moorfields eye charity, Friends of Moorfields, Moorfields Private, and the Institute of Ophthalmology came together to find out this years' winners and celebrate the fantastic work going on across our Moorfields.

Stars is an important event in our Moorfields calendar – it is an opportunity to recognise people who bring our values of excellence, equity, and kindness to life.

The theme, 'Together we are Moorfields', highlights the dedication and hard work of all our staff. Every colleague contributes to our shared purpose. Whether it's performing life-changing surgery, welcoming patients at the front door, or supporting project delivery behind the scenes. We all play a vital role in ensuring our patients receive the highest standard of treatment and care.

The winners were a combination of individuals and teams from across the Moorfields network including City Road, St George's, Bedford, Brent Cross, Croydon and Ealing.

The event was kindly sponsored by Moorfields Eye Charity and supported by several of our partners.

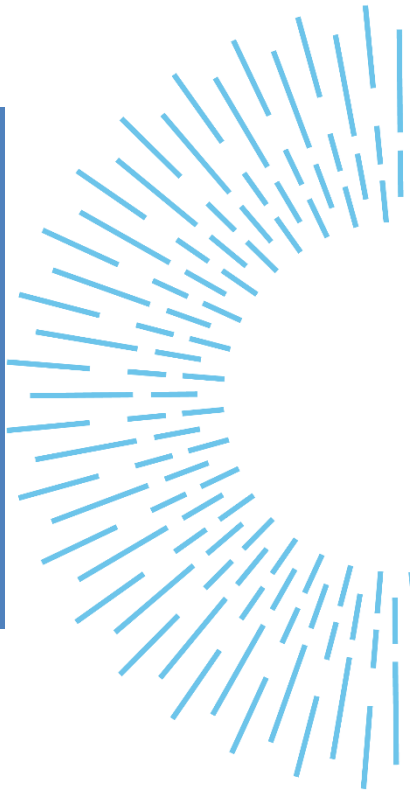
Moorfields in the News
Moorfields featured in first NHS national outcomes framework ‘league table’. NHS England has, for the first time, published tables that compare trusts against a wide range of criteria for the NHS Oversight framework. Against this raft of measures, Moorfields was rated highest among acute and specialist trusts for Quarter 1, 2025/26.

The evaluation covered a number of performance and finance themes, as well as safety and engagement metrics from the annual staff survey.

This performance reflects the dedication and commitment of all of our staff at Moorfields.

Moorfields Eye Hospital NHS Foundation Trust

Integrated Performance Report
Board of directors – Part I
2 October 2025



Report title	**Integrated Performance Report**		
Report from	Executive team		
Prepared by	Stephen Chinn, Performance Reporting Manager		
Previously considered at	NA	**Date**	NA
Link to strategic objectives	Working Together, Discover, Develop, Deliver, Sustainability and Scale		

Executive Summary

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

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

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

Quality implications

If the Trust does not achieve the required performance standards, then this is likely to have a significant impact on the quality of care that we are able to provide for our patients.

Financial implications

If the Trust does not achieve the required performance, activity and efficiency standards then this is likely to have a significant impact on the income that we receive and the level of expenditure that we incur to deliver care to our patients.

Risk implications

If the Trust does not achieve the required performance standards, then this is likely to have a significant impact on the risk that we pose to our patients by not offering timely care

Action required/recommendation.

The Board provided with this report for assurance.

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

Integrated Performance Report
Reporting Period - August 2025

Brief Summary of Report

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

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

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Performance & Information
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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 *

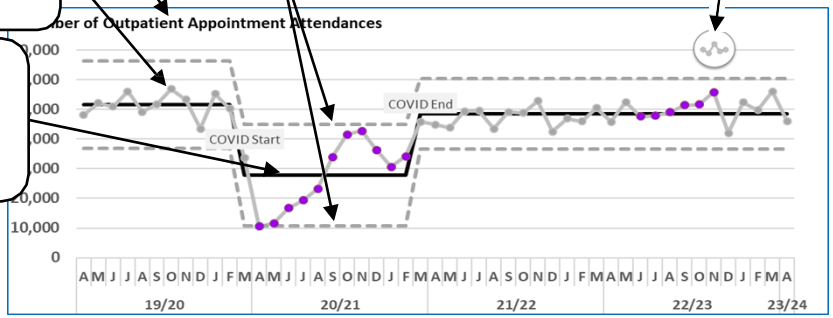
Summary Icons *

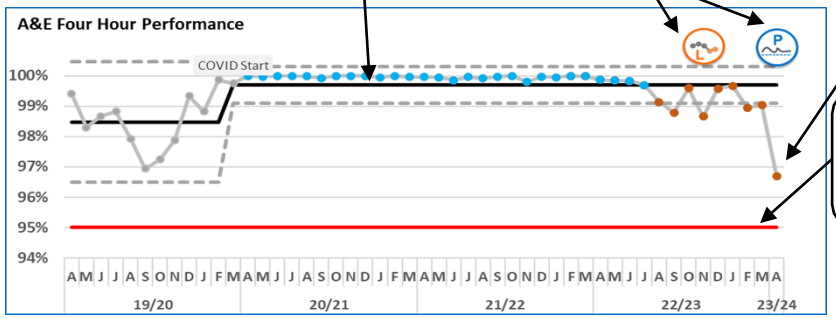
Concerning Special Cause *

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"

- Staff Sickness (Month & Rolling Annual Figure)
- 52 Week RTT Incomplete Breaches
- Eliminate waits over 65 weeks for elective care
- Average Call Waiting Time
- Percentage of responses to written complaints sent within 25 days
- Percentage of responses to written complaints acknowledged within 3 days
- Theatre Cancellation Rate (Non-Medical Cancellations)

Celebrations

- In total,19 Metrics are showing as a capable process, with 18 showing either an improving or stable performance, this includes:
  - Infection Control Metrics
  - All Research Metrics
  - Posterior Capsular Rupture rates
  - All FFT Performance Targets
- Seven metrics are also showing an improving position including proportion of Temporary Staffing

Other Metrics showing "Special Cause Concern"

- 18 Week RTT Incomplete Performance
- Number of Incidents (excluding Health Records incidents) remaining open after 28 days
- Basic Mandatory IG Training
- Proportion of patients participating in research studies (as a percentage of number of open pathways)

Other Areas To Note

- A new version of Integrated Performance Report is in development. This will include an updated suite of metrics and domains that align to national reporting guidance including the NHS Oversight Framework.

- Activity vs. Plan for all areas is below plan both for August and year to date

Executive Summary

In August, the Trust's 18 Week referral to treatment time performance reduced to 80.5% of patients receiving their treatment within the required period. The total waiting list size has decreased to 34,788. There are continued waiting list challenges in our adnexal, external and paediatric services which are seeing a deteriorating 18-week referral to treatment position. We are refocusing performance improvement plans to prioritise actions in each stage of the patient pathway, with initiatives which will seek to improve productivity and increase capacity.

The number of patients waiting over 52 weeks for their treatment has increased to 31 at the end of August. This is due to error in the management of referrals sent to us via the electronic Referral Service (eRS). This has led to a group of patients not receiving an appointment and therefore waiting over 52 weeks for their first appointment. All patients have now been offered an appointment and no harm has been identified so far.

Elective activity was below plan at 96.1% in August, with the year-to-date position at 98.6%. This is an improvement on the previous month, but restrictions on weekend activity at City Road and small waiting lists at St Ann's is impacting on overall activity performance. Vacancies also made it more difficult to cover available operating sessions over the summer period.

Outpatient activity was below plan in August at 97.1%. The main reason for this was the timing of service development approval for activity included in the plan. Outpatient activity was also impacted by annual leave, which this could not always be covered due to vacancies.

The non-medical theatre cancellation rate was above target at 1.08%. Three patients were unfortunately not treated within 28 days of cancellation, due to a combination of patient and surgeon availability.

We maintained a compliant position for the diagnostic waiting times and A&E standards in August. We were not able to meet the cancer 28 day faster diagnosis standard due to three patients not being informed of their diagnosis within the required timeframe. One of these patients was a late referral from another trust.

The Trust's Booking Centre was unable to achieve the agreed standard for call waiting time, due to number of staff available to answer calls because of vacancies and staff absence. Demand and capacity analysis is being repeated to provide additional evidence of the need to recruit to vacancies.

Complaints response times have been impacted by staff sickness and staff turnover. An improvement plan is in place to recover performance over the next six months and provide an overall improvement to the service.

Following the closure of the new appraisal window, we have achieved our target with 82.7% of staff having a completed appraisal. Basic Mandatory IG training is below the required standard at 88.7% and staff sickness rates remain above Trust target and increased in August to at 5.6%. Staff and managers continue to be supported to reduce sickness rates.

Performance Overview

August 2025		Assurance			
		Capable Process	Hit and Miss	Failing Process	No Target
Variation	Special Cause - Improvement	- FFT Inpatient Scores (% Positive) - FFT Outpatient Scores (% Positive) - NatPSAs breached - Active Commercial Studies	- Appraisal Compliance	-	- % A&E Waits Over Twelve Hours - % Discharged on DRD - Average Days (DRD) - Proportion of Temporary Staff - Proportion of Bank Staff - Proportion of Agency Staff - Proportion of Permanent Staff
	Common Cause	- % 52 Week RTT Incomplete Breaches - % Cancer 62 Day Waits (All) - A&E Four Hour Performance - MRSA Bacteraemias Cases - Clostridium Difficile Cases - E. Coli Cases - Mixed Sex Accommodation Breaches - VTE Risk Assessment - Posterior Capsular Rupture rates - MSSA Rate - cases - FFT A&E Scores (% Positive) - FFT Paediatric Scores (% Positive) - Summary Hospital Mortality Indicator - Recruitment to NIHR portfolio studies	* See Next Page	- Elective waits over 65 weeks - Average Call Waiting Time	* See Next Page
	Special Cause- Concern	- % of patients in research studies	- 18 Week RTT Incomplete Performance - Basic Mandatory IG Training	- Staff Sickness (Month Figure) - Staff Sickness (Rolling Annual Figure) - 52 Week RTT Incomplete Breaches - % Complaints Responses Within 25 days - % Complaints Acknowledged Within 3 days - Theatre Cancellation Rate (Non-Medical)	- Number of Incidents open after 28 days
	Special Cause - Increasing Trending	- RTT Incomplete Pathways Over 18 Weeks - No. of Theatre Emergency Admissions			
	Special Cause - Decreasing Trending	-			

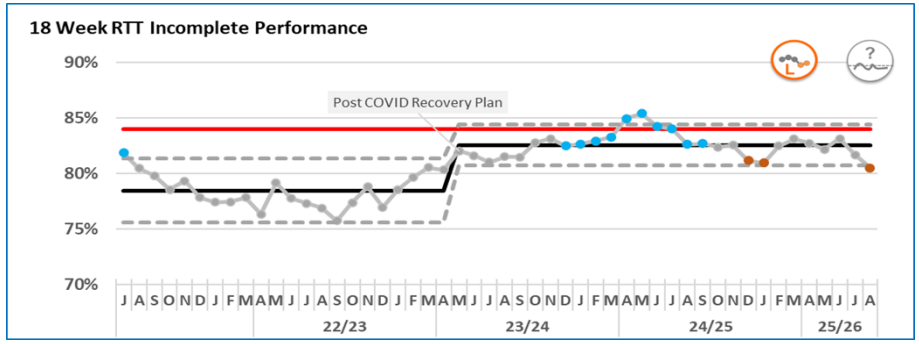
Performance Overview

Common Cause & Hit and Miss	Common Cause (No Target)
- Cancer 28 Day Faster Diagnosis Standard	- RTT Waiting List
- Elective Activity - % of Phased Plan	- OP Journey Times - Non-Diagnostic FtF
- Total Outpatient Activity (% Plan)	- OP Journey Times - Diagnostic FtF
- Outpatient First Activity (% Plan)	- Recruitment to All Research Studies
- Total Outpatient FlwUp Activity (% Plan)	- No. of A&E Arrivals
- % Cancer 31 Day Waits (All)	- No. of A&E Four Hour Breaches
- % Diagnostic waiting times less than 6w	- No. of Outpatient Attendances
- Average Call Abandonment Rate	- No. of Outpatient First Attendances
- Emergency readmissions in 28d (ex. VR)	- No. of Outpatient Flw Up Attendances
- % FoI Requests within 20 Days	- No. of Referrals Received
- Occurrence of any Never events	- No. of Theatre Admissions
- Non-medical cancelled 28 day breaches	- No. of Theatre Elective Day Admissions
- Recruitment Time To Hire (Days)	- No. of Theatre Elective Inpatient Adm.

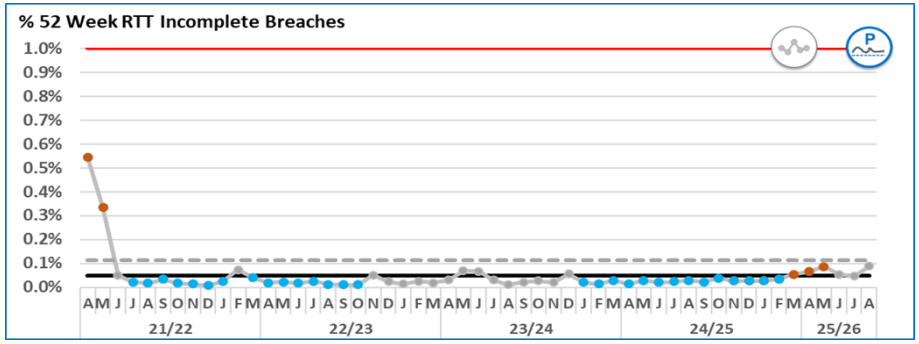
NHS Oversight Framework - Core Metrics (Access Domain)

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
18 Week RTT Incomplete Performance	Jon Spencer	NHS Oversight Framework	Monthly	≥84.0%	82.0%	80.5%	L	?
% 52 Week RTT Incomplete Breaches	Jon Spencer	NHS Oversight Framework	Monthly	≤1%	0.07%	0.09%		P
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	NHS Oversight Framework	Monthly (Month in Arrears)	≥80%	83.9%	77.8%		?
% Patients With All Cancers Treated Within 62 Days	Jon Spencer	NHS Oversight Framework	Monthly (Month in Arrears)	≥85%	98.6%	100.0%		P
A&E Four Hour Performance	Jon Spencer	NHS Oversight Framework	Monthly	≥95%	97.3%	98.2%		P
A&E Twelve Hour Performance	Jon Spencer	NHS Oversight Framework	Monthly	No Target Set	0.0%	0.0%	L	

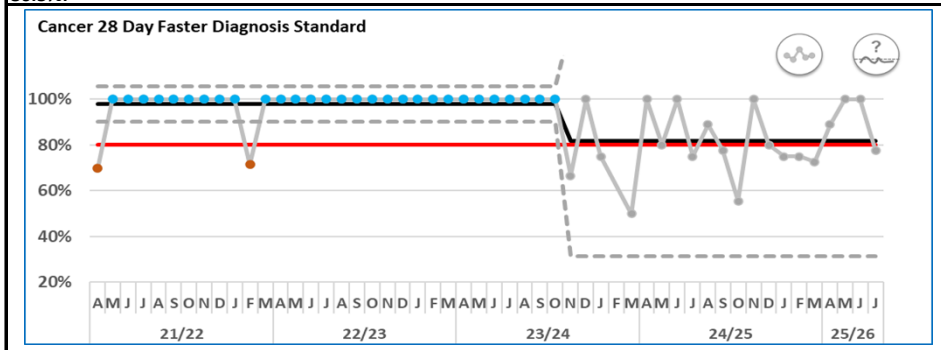
NHS Oversight Framework (Access Domain) - Graphs (1)



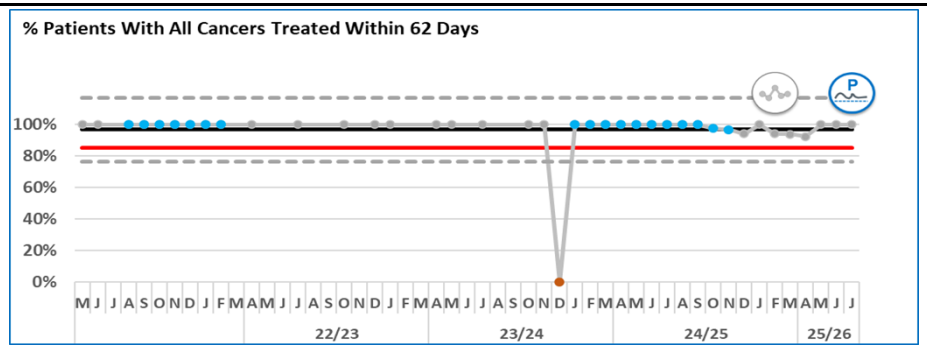
'18 Week RTT Incomplete Performance ' is showing 'special cause concern' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 80.5%.



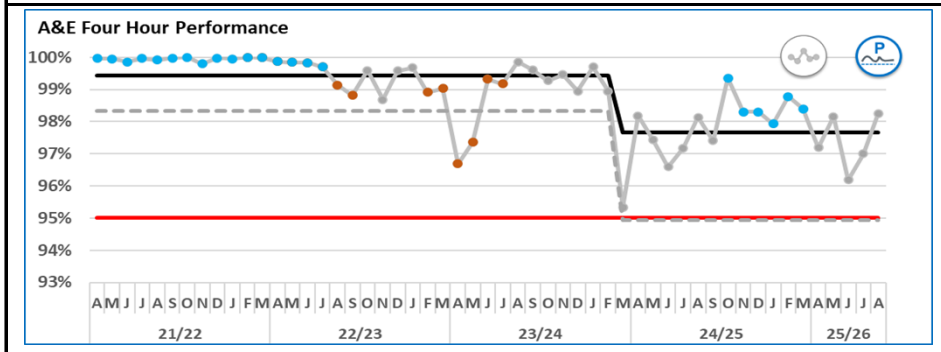
'% 52 Week RTT Incomplete Breaches' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.09%.



'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 77.8%.



'% Patients With All Cancers Treated Within 62 Days' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 100.0%.



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

No Graph Generated, No cases reported since April 2021

'A&E Twelve Hour Performance' is showing 'special cause improvement' (decreasing rate). The figure is currently at 0.00%.

NHS Oversight Framework - Core Metrics (Multiple Domains)

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
% Discharged on Discharge Ready Date (DRD)	Jon Spencer	NHS Oversight Framework	Monthly	No Target Set	100.0%	100.0%	H	
Average Days Between DRD and Discharge Date	Jon Spencer	NHS Oversight Framework	Monthly	No Target Set	n/a	0.0	L	
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
Staff Sickness (Month Figure)	Sue Steen	Performance Assessment Framework	Monthly (Month in Arrears)	≤4%	n/a	5.6%	H	F
Staff Sickness (Rolling Annual Figure)	Sue Steen	Performance Assessment Framework	Monthly (Month in Arrears)	≤4%	n/a	4.9%	H	F
Planned surplus/deficit	Arthur Vaughan	NHS Oversight Framework	Monthly	No Target Set	In Dev.	In Dev.		
Variance year-to-date to financial plan	Arthur Vaughan	NHS Oversight Framework	Monthly	No Target Set	In Dev.	In Dev.		

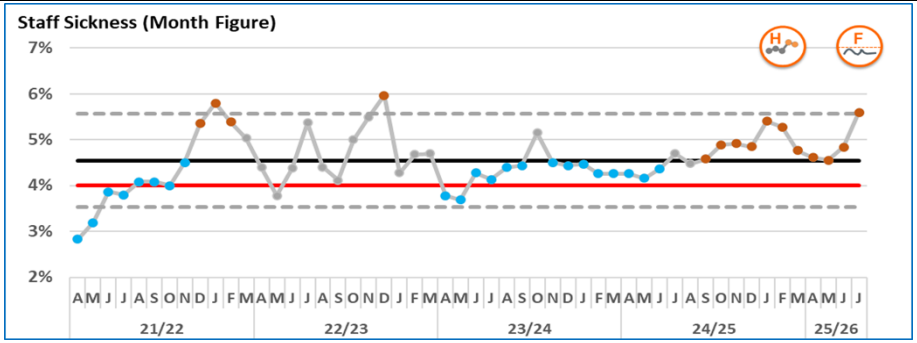
NHS Oversight Framework (Multiple Domains) - Graphs (1)

All Months since August 2024 at 100% DRD

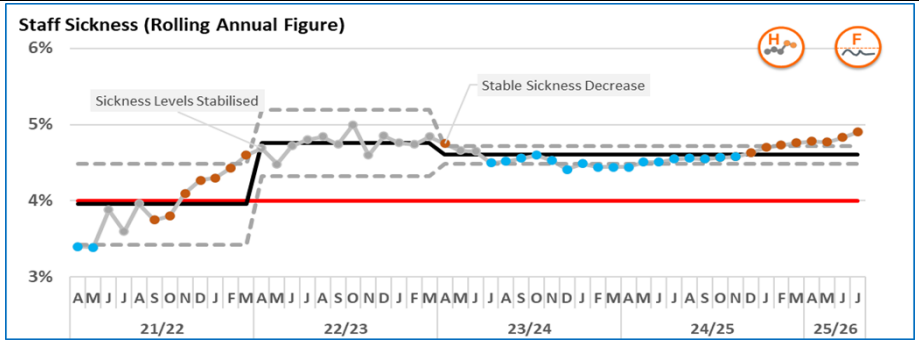
'% Discharged on Discharge Ready Date (DRD)' is showing 'special cause improvement' (increasing rate). The figure is currently at 100.0%.

All Months since August 2024 at 0 Days

'Average Days Between DRD and Discharge Date' is showing 'special cause improvement' (decreasing rate). The figure is currently at 0.



'Staff Sickness (Month Figure)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 5.6%.



'Staff Sickness (Rolling Annual Figure)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 4.9%.

Metric In Development

'Planned surplus/deficit' for this reporting period not available.

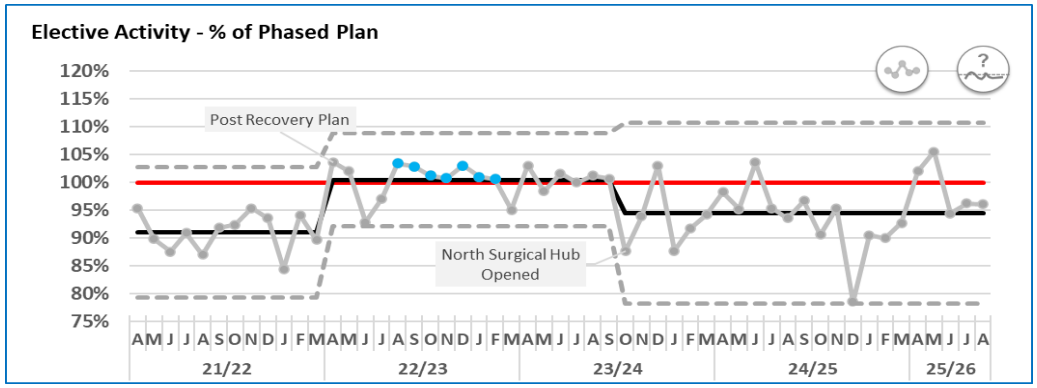
Metric In Development

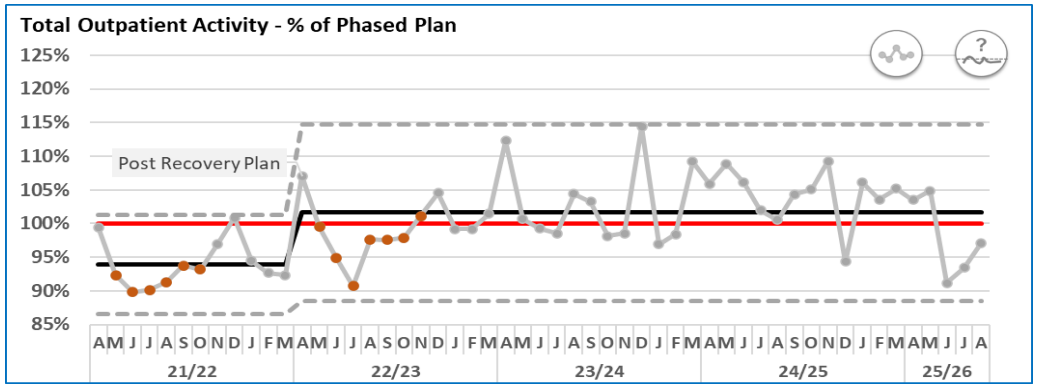
'Variance year-to-date to financial plan' for this reporting period not available.

Deliver (Activity vs Plan) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Elective Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	98.6%	96.1%		
Total Outpatient Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	97.6%	97.1%		
Outpatient First Appointment Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	98.6%	98.3%		
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	97.3%	96.8%		

Deliver (Activity vs Plan) - Graphs (1)





'Elective Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 96.1%.	**'Total Outpatient Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 97.1%.**

Elective activity was below plan in August, with City Road and North division unable to meet their activity targets.

At City Road, the cataract elective activity plan was achieved in August; however, activity was below plan in Adnexal, Glaucoma, External and Strabismus. Weekend sessions have been reduced so only those required for clinical urgency are taking place. Fellow vacancies in external and glaucoma has made it more challenging to cover sessions during periods of annual leave.

There are theatre improvement initiatives in place at City Road in medical retina, strabismus and cataract with the aim of adding an additional case per list to improve utilisation and activity levels.

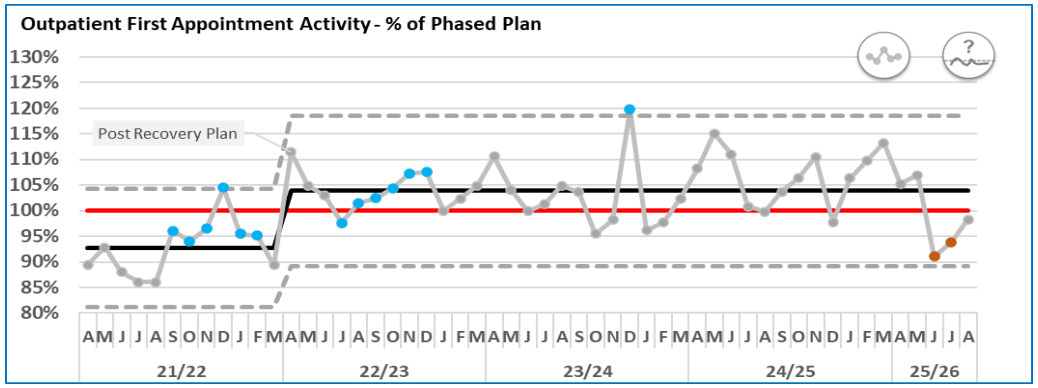
In the North, a small waiting list at St Ann's continues to create difficulty in booking lists optimally. Staff consultation to reduce the number of lists running and improve utilisation has now been completed. Elective activity at Potters Bar was also below plan in August due to the bank holiday and patient choice limiting theatre bookings during the summer period.

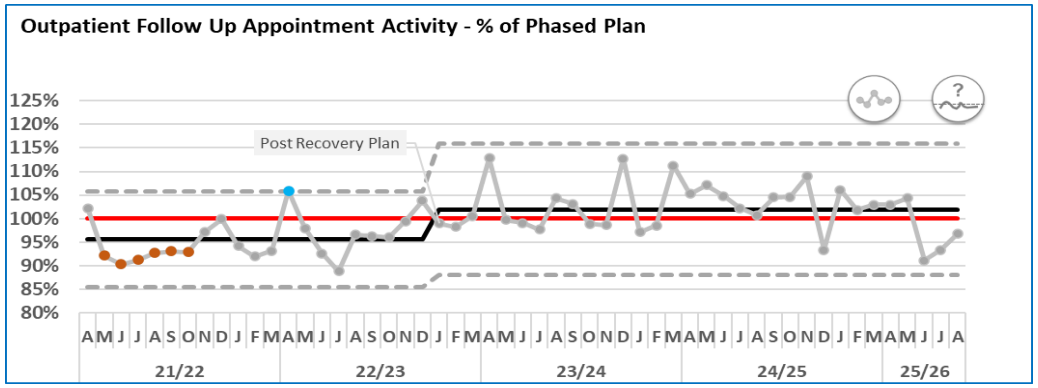
St Ann's activity remains most challenged. There is a small waiting list, with short waits for outpatients and surgery and therefore the decision the configuration of theatres on this site will be an important aspect of this years' business planning round.

South divisions were able to deliver their activity plan in August, despite the closure of the Queen Mary's Roehampton by the host Trust. Achieving at least 8 cases on all cataract lists is required to ensure the activity plan continues to be met.

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

Deliver (Activity vs Plan) - Graphs (2)





'Outpatient First Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 98.3%.	**'Outpatient Follow Up Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 96.8%.**

First outpatient activity

First outpatient activity improved in August but remains below plan with North, City Road and OCSS divisions unable to meet their activity plan.

At City Road, the timing of the approval of service developments has impacted activity delivery. These service developments could not be approved until resources were returned from North division, reflecting the reduced activity plan. Service developments in genetics and neuro are now able to proceed and the impact of this has been set out in the activity forecast. The City Road paediatric service development remains unapproved, which will continue to impact on the activity plan.

In North division, first outpatient activity was impacted by consultant annual leave in August, with some clinics converted to follow-up to ensure clinics were able to run with available staff. Teams are focused on booking to plan in September, however there is some risk in the cataract clinics where waiting times are short.

Follow-up outpatient activity

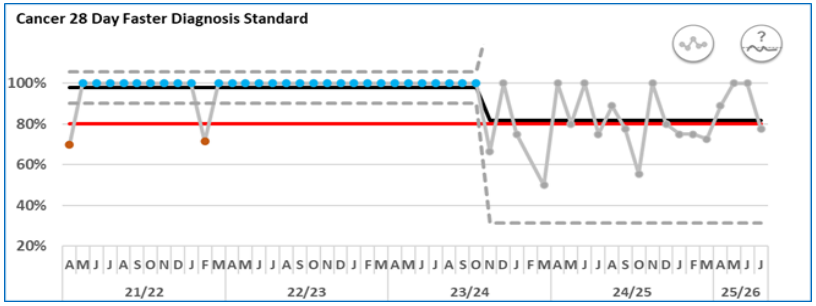
Follow-up activity was below plan in August, driven by the timing of the approval of service developments at City Road.

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

Deliver (Cancer Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	NHS Oversight Framework	Monthly (Month in Arrears)	≥80%	83.9%	77.8%		
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat	Jon Spencer	Statutory Reporting	Monthly (Month in Arrears)	≥96%	99.0%	100.0%		
% Patients With All Cancers Treated Within 62 Days	Jon Spencer	NHS Oversight Framework	Monthly (Month in Arrears)	≥85%	98.6%	100.0%		

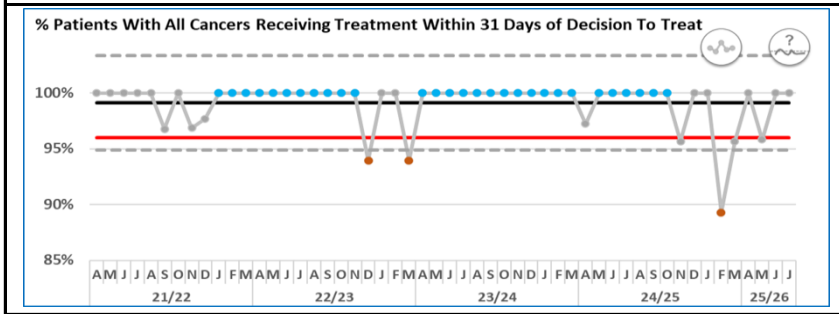
Deliver (Cancer Performance) - Graphs (1)



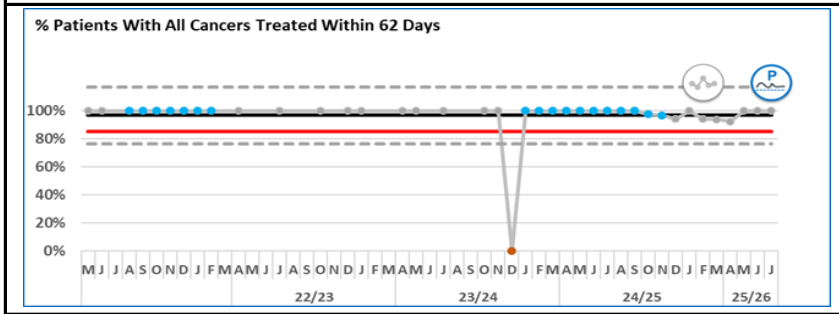
'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 77.8%.

We were not able to meet the cancer 28-day faster diagnosis standard due to three patients not being informed of their diagnosis within the required timeframe. One of these patients was referred late referred from another trust.

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



'% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 100.0%.

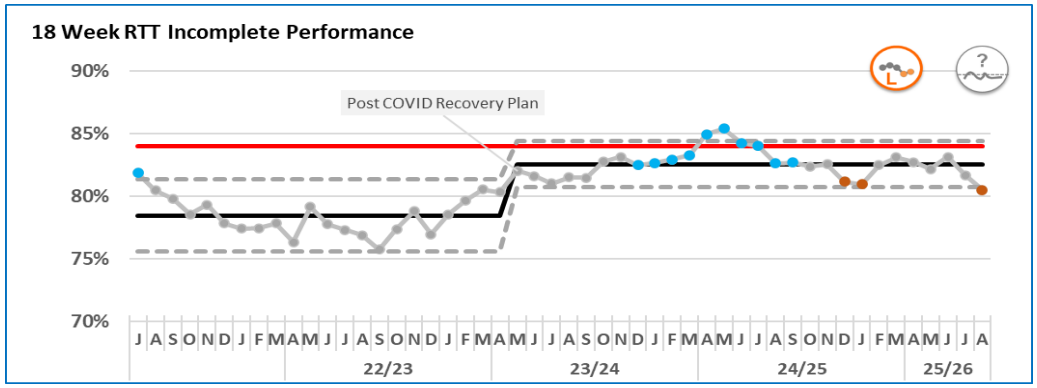


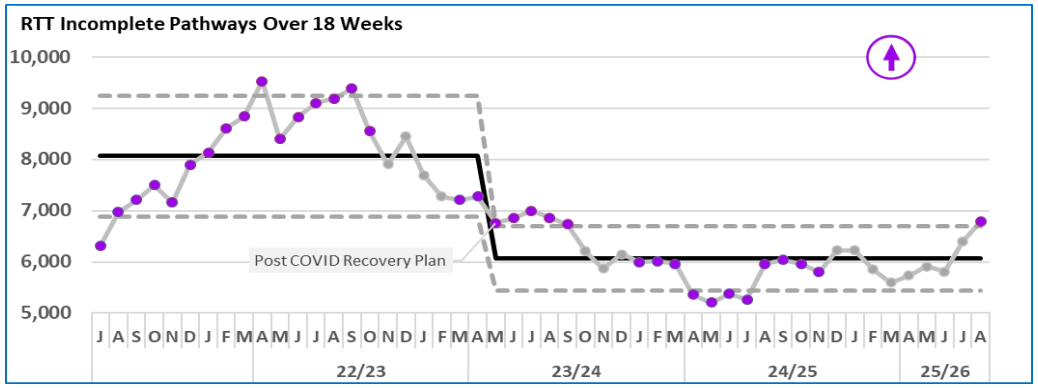
'% Patients With All Cancers Treated Within 62 Days' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 100.0%.

Deliver (Access Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
18 Week RTT Incomplete Performance	Jon Spencer	NHS Oversight Framework	Monthly	≥84.0%	82.0%	80.5%		
RTT Incomplete Pathways (RTT Waiting List)	Jon Spencer	Operational Planning Submission	Monthly	≤ Previous Mth.	n/a	34788		
RTT Incomplete Pathways Over 18 Weeks	Jon Spencer	Operational Planning Submission	Monthly	≤ Previous Mth.	n/a	6782		
52 Week RTT Incomplete Breaches	Jon Spencer	Performance Assessment Framework	Monthly	Zero Breaches	117	31		
% 52 Week RTT Incomplete Breaches	Jon Spencer	NHS Oversight Framework	Monthly	≤1%	0.07%	0.09%		
Eliminate waits over 65 weeks for elective care	Jon Spencer	24/25 Planning Guidance	Monthly	Zero Breaches	10	3		
A&E Four Hour Performance	Jon Spencer	NHS Oversight Framework	Monthly	≥95%	97.3%	98.2%		
A&E Twelve Hour Performance	Jon Spencer	NHS Oversight Framework	Monthly	No Target Set	0.0%	0.0%		
Percentage of Diagnostic waiting times less than 6 weeks	Jon Spencer	Performance Assessment Framework	Monthly	≥99%	99.8%	100.0%		

Deliver (Access Performance) - Graphs (1)





'18 Week RTT Incomplete Performance ' is showing 'special cause concern' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 80.5%.	**'RTT Incomplete Pathways Over 18 Weeks' is showing an 'special cause variation' (increasing rate) - This is a change from the previous month. The figure is currently at 6,782.**

18-week RTT incomplete performance is at 80.5% for August and is showing as a concern. Performance is improving in North and South division; however, it is deteriorating in City Road and this is impacting overall trust performance. The high volume and deteriorating services are Adnexal, Paediatrics and External.

We are strengthening performance recovery plans for these services and approaching this by focusing on a timed pathway, assessing capacity shortfalls and action plans for each stage in the pathway.

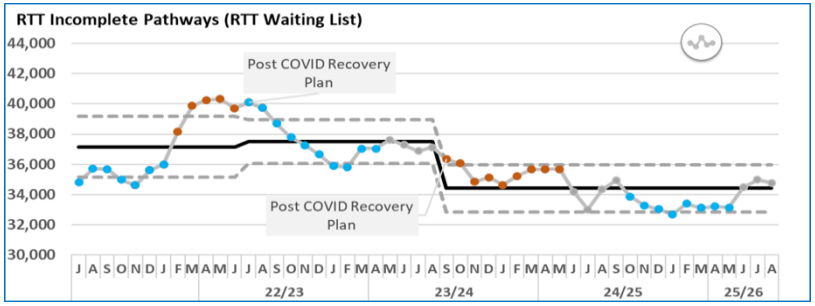
Immediate action has been taken to increase activity in Adnexal, adding additional patients to existing clinics to get our longest waiting patients booked. Recruitment plans are being finalised to cover vacant consultant sessions and provide further additional sessions to increase activity further. Key outstanding actions include agreeing a sustainable approach to triage and confirming to what extent diverting patients to alternative sites will improve overall trust performance and / or equalise waiting times.

It is a priority to resolve resourcing for the paediatric service development included in the 25/26 activity plan, as this will increase activity in the most pressured paediatric pathways.

The External service is reviewing how they can further expand asynchronous pathways and where productivity improvements could be made. It is anticipated that additional activity will be required to stabilise the position, and the City Road divisional management team is finalising a recovery plan, for inclusion in the activity forecast.
RTT improvement plans are monitored at monthly executive performance review.

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

Deliver (Access Performance) - Graphs (2)

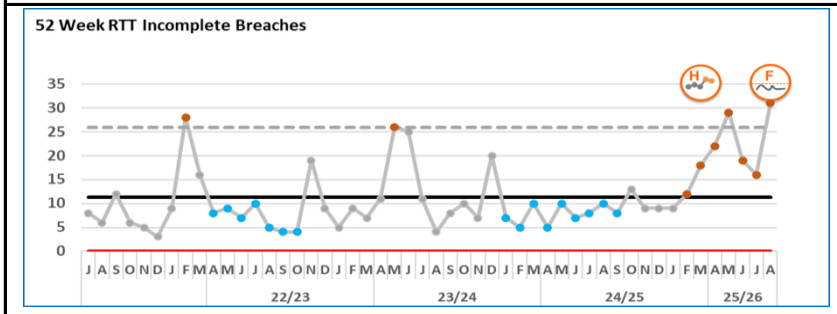


'RTT Incomplete Pathways (RTT Waiting List)' is showing 'common cause variation'. The figure is currently at 34,788.

The number of RTT incomplete pathways fell slightly to 34,788, with the number in common cause variation.

We are supporting divisions to improve activity levels to meet our activity plan and are focusing on demand management initiatives such as advice and guidance and patient-initiated follow-up in our most challenged services with support from the transformation programme.

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

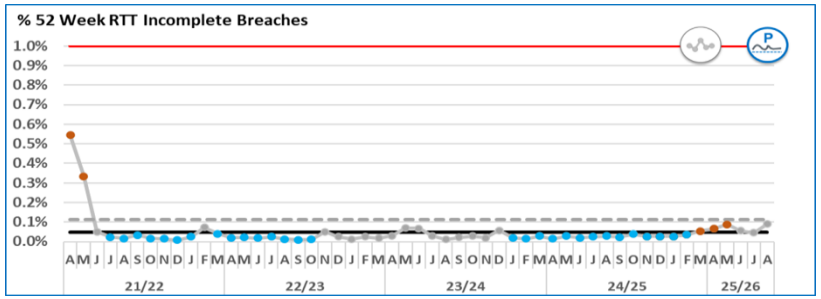


'52 Week RTT Incomplete Breaches ' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 31.

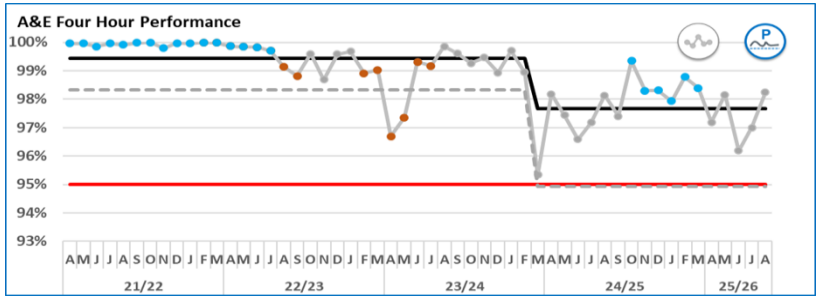
The number of patients over 52 weeks was 31 at the end of August. The increase is due to an incident which was reported by the outpatient booking centre regarding an error in the management of referrals coming via the electronic Referral Service (eRS). This error has led to a group of patients not receiving an appointment and being discharged in error. All patients have now been offered an appointment in the appropriate service and clinicians are carrying out harm reviews, as required. No harm has been identified to date. This will be closely monitored, and Board members will receive a weekly update on progress.

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

Deliver (Access Performance) - Graphs (3)



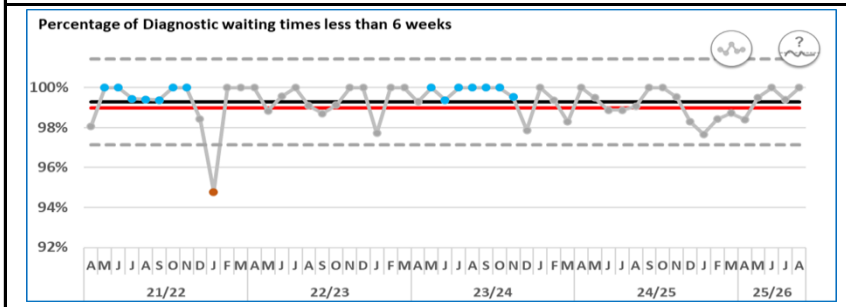
'% 52 Week RTT Incomplete Breaches' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.09%.



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

No Graph Generated, No cases reported since April 2021

'A&E Twelve Hour Performance' is showing 'special cause improvement' (decreasing rate). The figure is currently at 0.00%.

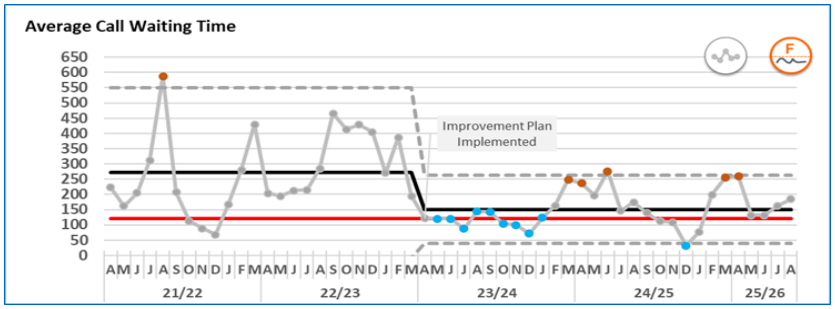


'Percentage of Diagnostic waiting times less than 6 weeks' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 100.0%.

Deliver (Call Centre and Clinical) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Average Call Waiting Time	Jon Spencer	Internal Measure	Monthly	≤ 2 Mins (120 Sec)	n/a	184		F
Average Call Abandonment Rate	Jon Spencer	Internal Measure	Monthly	≤15%	10.9%	11.5%		?
Mixed Sex Accommodation Breaches	Sheila Adam	Statutory Reporting	Monthly	Zero Breaches	0	0		P
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Jon Spencer	Internal Measure	Monthly (Rolling 3 Months)	≤ 2.67%	n/a	5.88%		?
VTE Risk Assessment	Jon Spencer	Statutory Reporting	Monthly	≥95%	99.1%	98.9%		P
Posterior Capsular Rupture rates (Cataract Operations Only)	Jon Spencer	Clinical Statutory Reporting	Monthly	≤1.95%	0.80%	0.38%		P
MRSA Bacteraemias Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Clostridium Difficile Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
MSSA Rate - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P

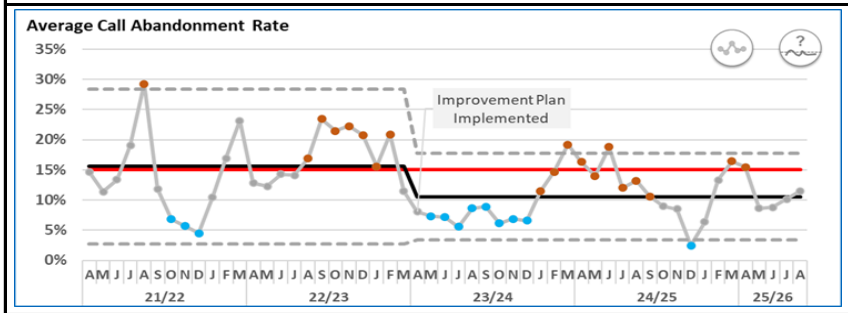
Deliver (Call Centre and Clinical) - Graphs (1)



'Average Call Waiting Time' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 184.

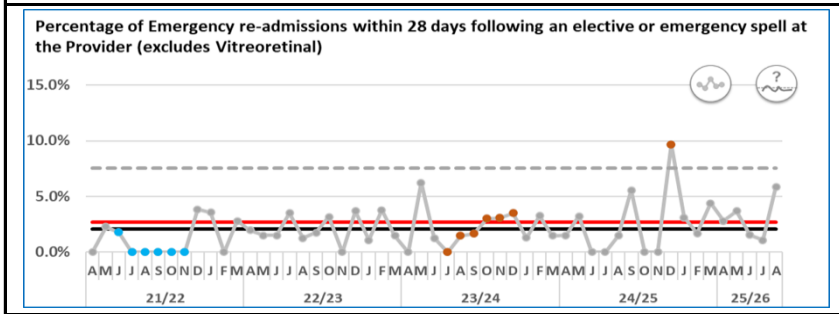
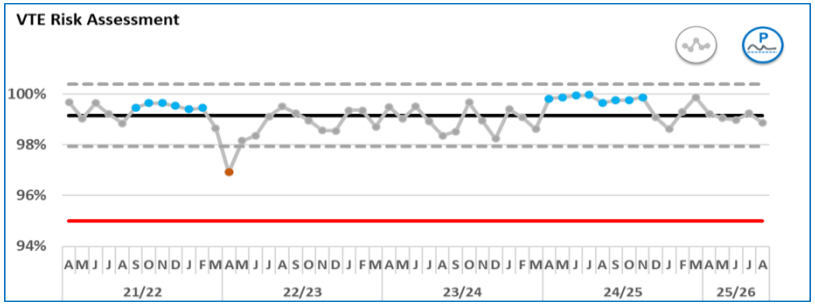
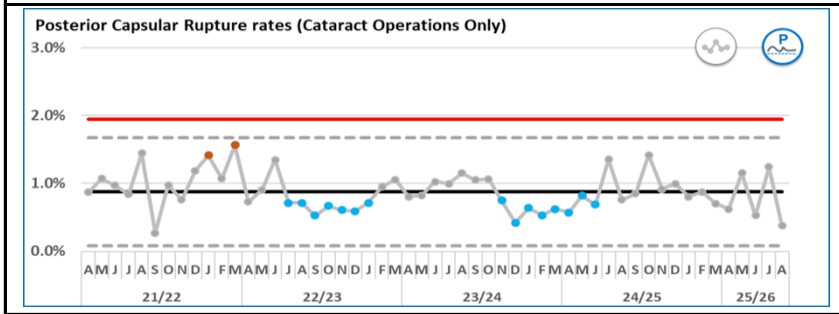
The average call wait time target was not met in August and staff absence continues to challenge the delivery of this key performance indicator. OCSS divisional management team are supporting the department in refreshing the capacity and demand exercise to evidence the requirement for recruitment to vacancies. The call abandonment rate target was achieved in August.

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



'Average Call Abandonment Rate' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 11.5%.

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

No Graph Generated, No breaches since June 2017	'Mixed Sex Accommodation Breaches ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.
	'% Emergency re-admissions within 28 days (excludes Vitreoretinal)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 5.88%.
	'VTE Risk Assessment' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 98.9%.
	'Posterior Capsular Rupture rates (Cataract Operations Only)' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.38%.

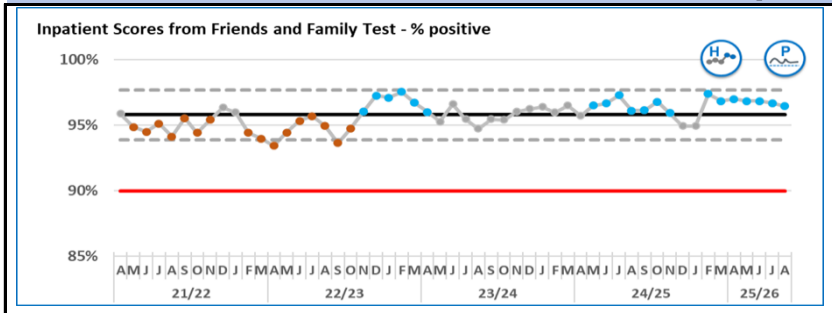
Deliver (Call Centre and Clinical) - Graphs (3)

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

Deliver (Quality and Safety) - Summary

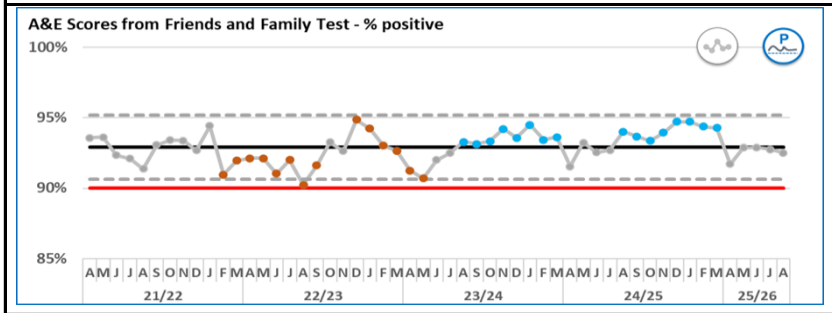
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Inpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	96.8%	96.5%		
A&E Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	92.6%	92.5%		
Outpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	95.5%	95.6%		
Paediatric Scores from Friends and Family Test - % positive	Ian Tombleson	Internal Measure	Monthly	≥90%	94.6%	94.2%		
Percentage of responses to written complaints sent within 25 days	Ian Tombleson	Internal Measure	Monthly (Month in Arrears)	≥80%	18.0%	14.0%		
Percentage of responses to written complaints acknowledged within 3 days	Ian Tombleson	Quality Statutory Reporting	Monthly	≥80%	59.8%	54.5%		
Freedom of Information Requests Responded to Within 20 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	92.8%	93.0%		
Subject Access Requests (SARs) Responded To Within 28 Days	Kathryn Lennon	Statutory Reporting	Monthly (Month in Arrears)	≥90%	n/a	n/a		

Deliver (Quality and Safety) - Graphs (1)



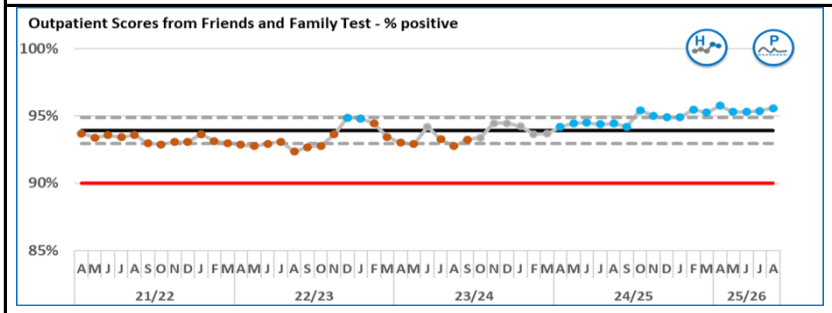
'Inpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 96.5%.

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



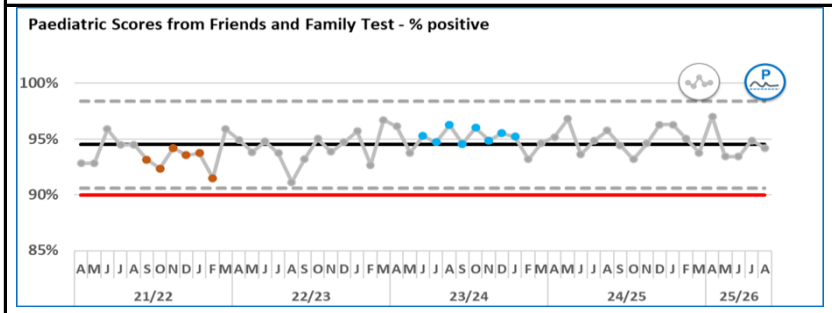
'A&E Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 92.5%.

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



'Outpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 95.6%.

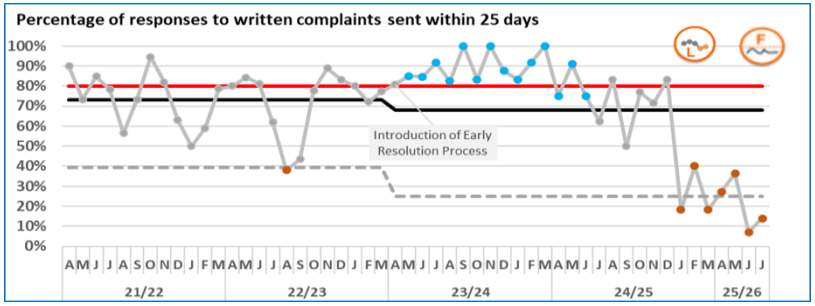
Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.



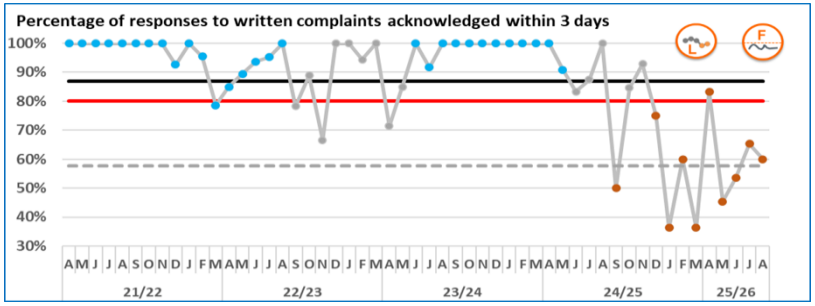
'Paediatric Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 94.2%.

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

Deliver (Quality and Safety) - Graphs (2)



'Percentage of responses to written complaints sent within 25 days' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 14.0%.

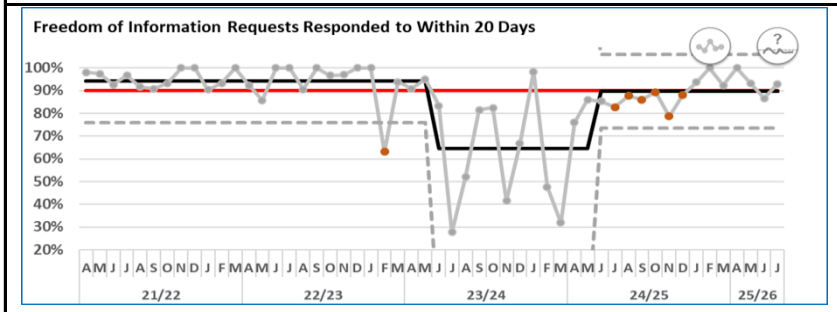


'Percentage of responses to written complaints acknowledged within 3 days' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 54.5%.

Responded With 25 days:
This has been challenged by a number of factors, including staff sickness in the patient experience team and divisional priorities. A six month recovery plan has been agreed with SMT starting 1 October, with accurate baseline data, recovery trajectories, local monitoring, and oversight through appropriate groups/committees. Recovery performance will be closely tracked.

Acknowledgment within 3 days:
Staff sickness and turnover of staff has impacted performance. From 8 September the team is confident that the acknowledgement process is working effectively and the target is being achieved from this date onwards.

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



'Freedom of Information Requests Responded to Within 20 Days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 93.0%.

Metric under review

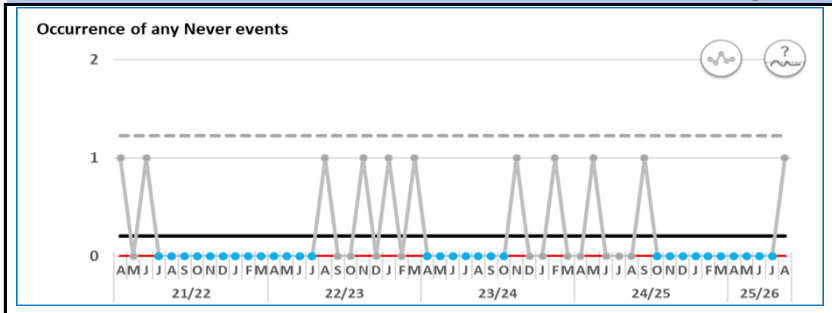
'Subject Access Requests (SARs) Responded To Within 28 Days' for this reporting period not available.

Data Under Review

Deliver (Incident Reporting) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Occurrence of any Never events	Sheila Adam	Quality Statutory Reporting	Monthly	Zero Events	1	1		
Summary Hospital Mortality Indicator	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		
National Patient Safety Alerts (NatPSAs) breached	Sheila Adam	CAS (Central Alerting) Requirement	Monthly	Zero Alerts	n/a	0		
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Sheila Adam	Internal Measure	Monthly	No Target Set	n/a	325		

Deliver (Incident Reporting) - Graphs (1)



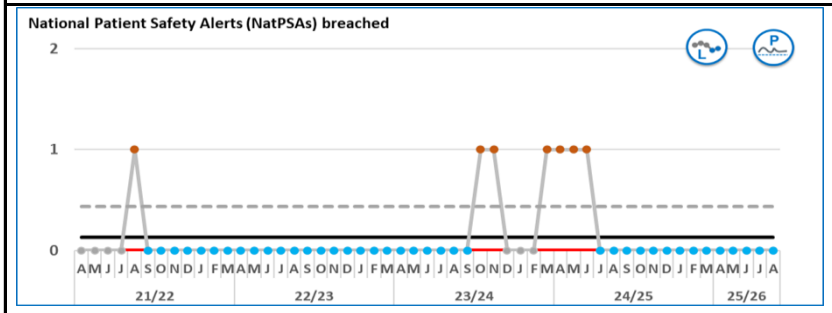
'Occurrence of any Never events ' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 1.

This Never Event relates to a wrong implant (lens) and is being investigated as a PSII with oversight with the central quality team.

Review Date: Oct 2025 ***Action Lead:*** Kylie Smith / Julie Nott

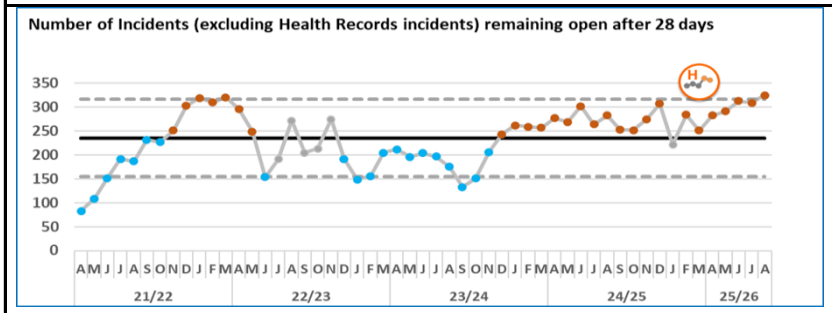
No Graph Generated, No cases reported since February 2017

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



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

No breaches since July 2024



'Number of Incidents (excluding Health Records incidents) remaining open after 28 days' is showing 'special cause concern' (increasing rate). The figure is currently at 325.

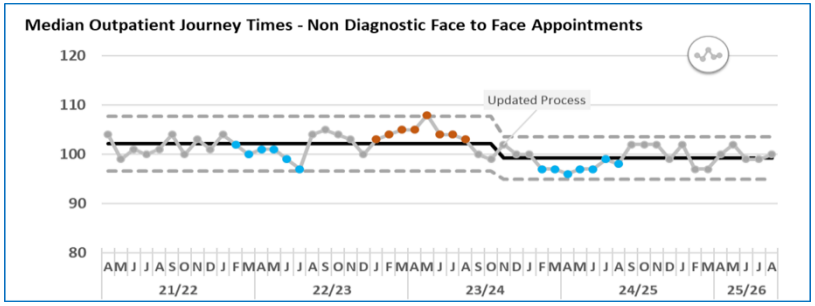
At the start of September, approximately 50 more incidents had outcomes added and are awaiting review prior to final closure by the Q&S team. Approximately 95% of these are older than 28 days. On 4 September, North division incidents older than 28 days accounted for 31% of the total figure, and City Road accounted for 26%. There will be renewed, targeted improvement work with clinical divisions and corporate directorates to close incidents over the next month.

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

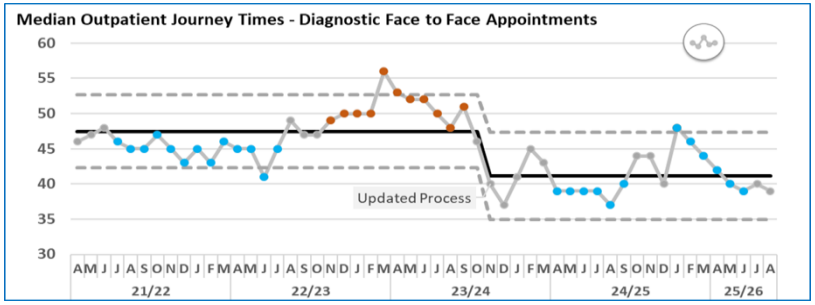
Sustainability and at Scale - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	100		
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	39		
Median Outpatient Journey Times - Virtual TeleMedicine Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	n/a		
Theatre Cancellation Rate (Non-Medical Cancellations)	Jon Spencer	Statutory Reporting	Monthly	≤0.8%	1.36%	1.08%		
Number of non-medical cancelled operations not treated within 28 days	Jon Spencer	Statutory Reporting	Monthly	Zero Breaches	7	3		
Overall financial performance (In Month Var. £m)	Arthur Vaughan	NHS Oversight Framework	Monthly	≥0	1.99	0.89		
Commercial Trading Unit Position (In Month Var. £m)	Arthur Vaughan	Internal Measure	Monthly	≥0	0.07	0.03		

Sustainability and at Scale - Graphs (1)

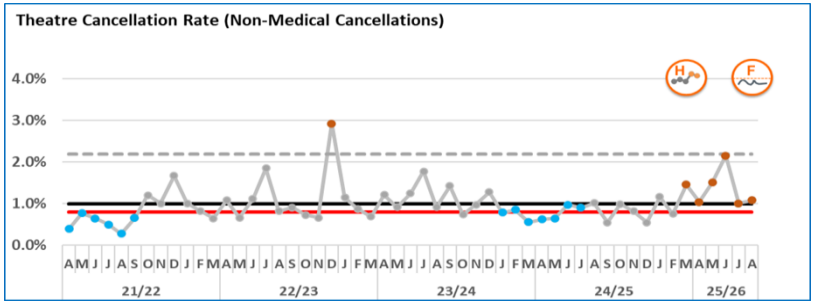


'Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments' is showing 'common cause variation'. The figure is currently at 100.



'Median Outpatient Journey Times - Diagnostic Face to Face Appointments' is showing 'common cause variation'. The figure is currently at 39.

Sustainability and at Scale - Graphs (2)

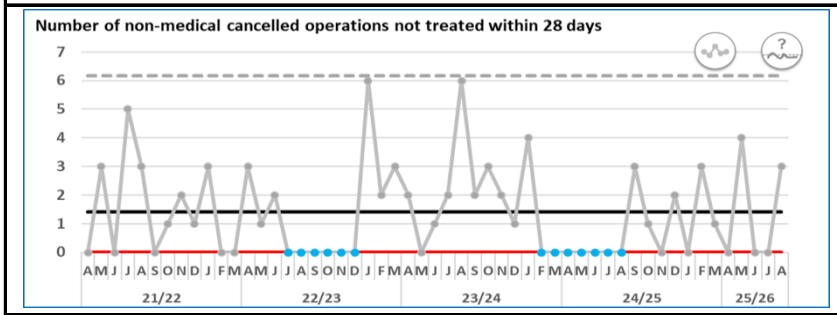


'Theatre Cancellation Rate (Non-Medical Cancellations)' is showing 'special cause concern' and that the current process is unlikely to achieve the target - This is a change from the previous month. The figure is currently at 1.08%.

The non-medical cancellation rate was above the expected target. The main reason was a list which over ran at City Road due to emergency cases, which led to the cancellation of elective patients. Three patients were not rebooked within 28 days of their cancellation.

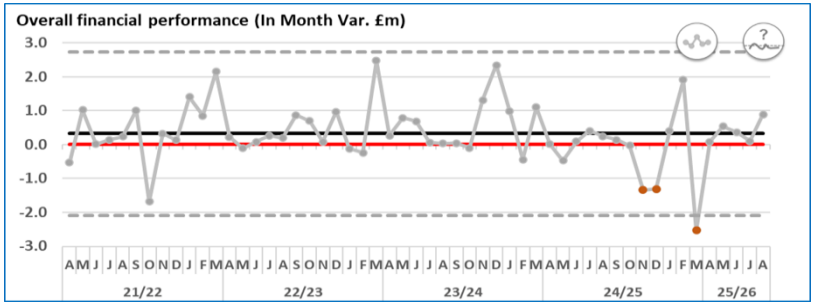
Reducing the cancellation rate will be a focus of the theatre oversight groups and themes will be picked up by the surgical transformation board, if any support is required.

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



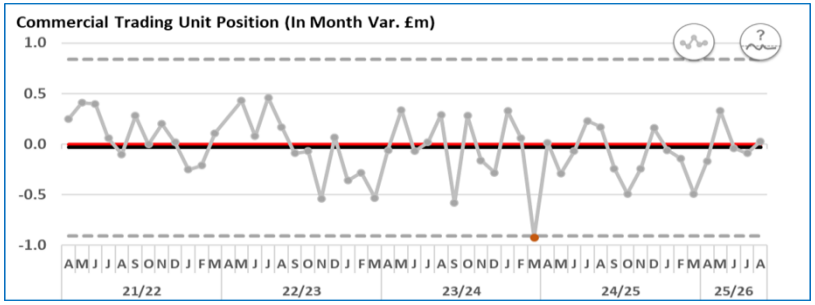
'Number of non-medical cancelled operations not treated within 28 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 3.

Sustainability and at Scale - Graphs (3)



'Overall financial performance (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.89.

For further narrative, see finance report



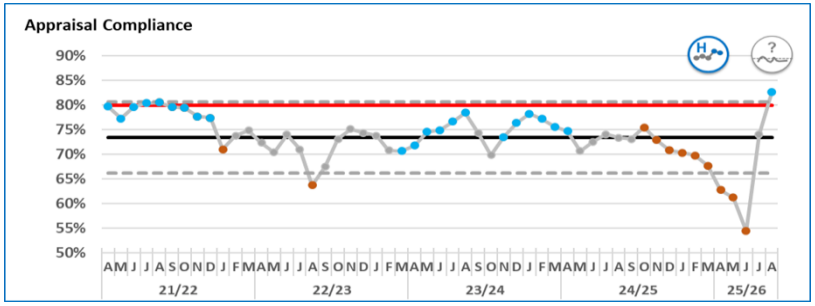
'Commercial Trading Unit Position (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.03.

For further narrative, see finance report

Working Together - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Appraisal Compliance	Sue Steen	Internal Measure	Monthly	≥80%	n/a	82.7%		
Basic Mandatory IG Training	Samuel Armstrong	DSPT Toolkit (Locally Monitored)	Monthly	≥90%	n/a	88.7%		
Staff Sickness (Month Figure)	Sue Steen	Performance Assessment Framework	Monthly (Month in Arrears)	≤4%	n/a	5.6%		
Staff Sickness (Rolling Annual Figure)	Sue Steen	Performance Assessment Framework	Monthly (Month in Arrears)	≤4%	n/a	4.9%		
Recruitment Time To Hire (Days)	Sue Steen	Internal Definition	Monthly	≤ 40 Days	n/a	36		
Proportion of Temporary Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	15.8%	6.4%		
Proportion of Bank Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	6.6%	5.3%		
Proportion of Agency Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	1.4%	1.1%		
Proportion of Permanent Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	92.0%	93.6%		

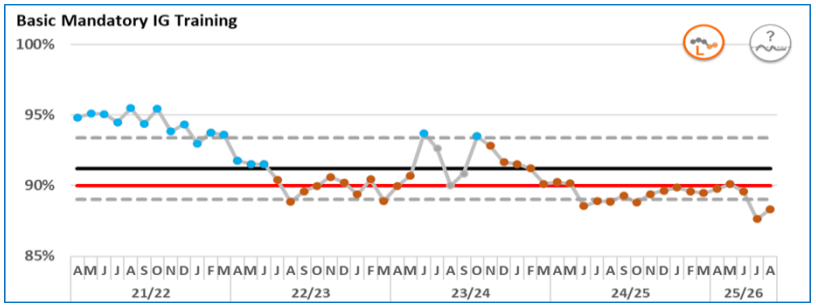
Working Together - Graphs (1)



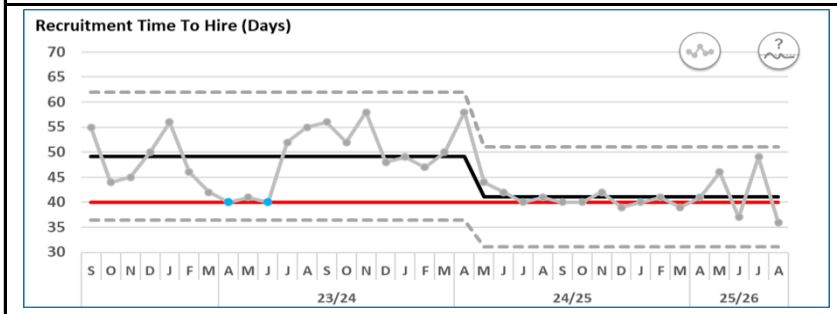
'Appraisal Compliance' is showing 'special cause improvement' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 82.7%.

- The 2025 appraisal window closed on 29th August with the trust achieving 82% compliance rate. The trust's appraisal compliance target is 80%
- As this was a transitional year with staff and managers adjusting to the new appraisal system and window, the focus on appraisal completion this year will be re-balanced with quality of appraisal for the 2026 appraisal window to ensure improvement in quality of appraisals.
- Managers who attended the appraisal workshops felt confident and prepared to carryout appraisals and we are getting positive feedback from staff. We will be carrying out a formal evaluation and feedback exercise.
- One of the key learning from the just concluded appraisal window is the need for ongoing ESR and LMS data cleansing. Data errors and related queries made the appraisal process a difficult experience for a lot of managers and staff.
- There has been a successful shift from paper-based appraisal to digital online appraisal across all professional groups in the trust.

Review Date: Oct 2025 ***Action Lead:*** Ade Adetukasi



'Basic Mandatory IG Training' is showing 'special cause concern' and that the current process is not consistently achieving the target. The figure is currently at 88.3%.

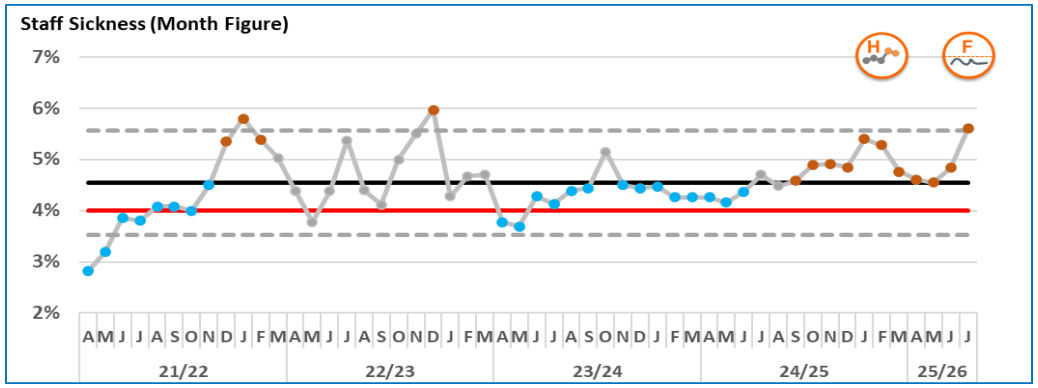


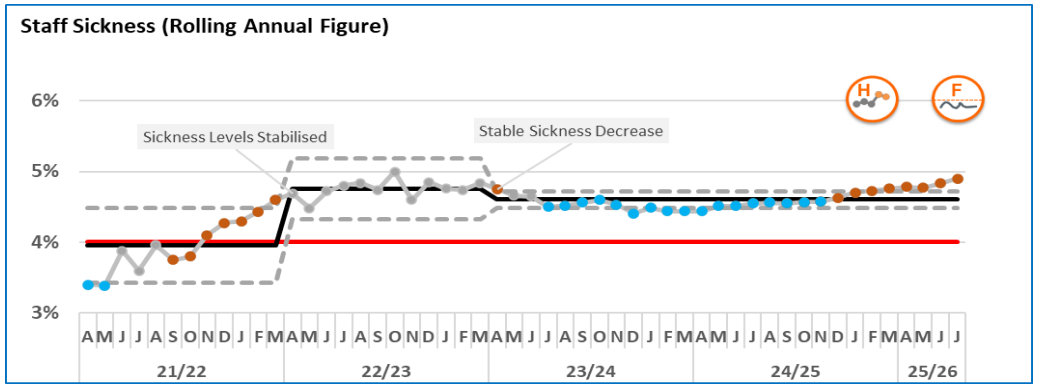
'Recruitment Time to Hire (Days)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 36.

The time to hire (TTH) performance for August is 36 days, which is below the Trust target.
Sustaining and improving the time to hire target continues with the Recruitment team supporting and advising managers.
Time to shortlist still remains the KPI which is significantly over target.
Time to approve a vacancy and time to advertise has increased slightly with the introduction of the vacancy escalated approval panel
There has been a decrease in the number of roles the Trust is currently advertising; there are 12 roles currently live with 2 ringfenced for internal only applications

Review Date: Oct 2025 ***Action Lead:*** Helen Dove

Working Together - Graphs (2)





'Staff Sickness (Month Figure)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 5.6%.	**'Staff Sickness (Rolling Annual Figure)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 4.9%.**

The top 3 reasons for sickness absences are;

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

The team continues to provide ongoing managerial support to managers to help them effectively manage sickness absence.

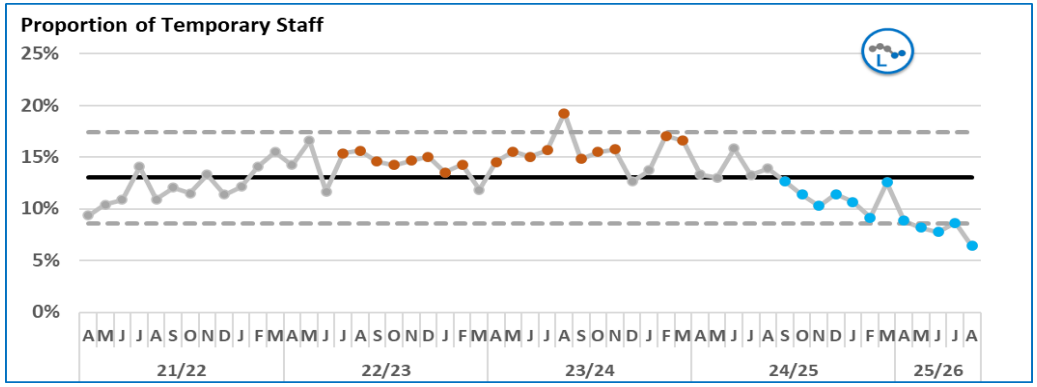
- ER Advisors are actively guiding managers on how to complete sickness reports and understand the appropriate next steps. They also schedule regular check-ins with managers to ensure supportive contact is maintained with employees on long-term sickness.
- A monthly meeting is held with Occupational Health to discuss referrals for employees on long-term sickness, with the aim of supporting their return to work with necessary adjustments.

Several training initiatives are underway to equip managers with the necessary skills:

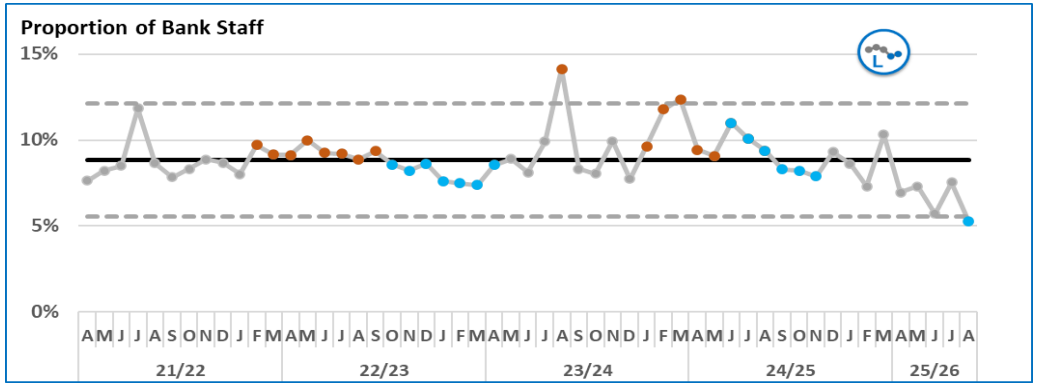
- Bite-sized Training (in development): Short training modules are being developed and will be uploaded to the managers' section of EyeQ once finalised to provide support for managing sickness absence.
- In-person ER training sessions: Face-to-face training sessions will be delivered to managers by ER Managers and Advisors, with a planned rollout from October/November 2025 as this was paused last year.
- Divisional Training: A training session has planned for managers in the North division for September, to review cases and identify specific training or support needs. Same approach will be replicated for remaining hotspots.
- Lunch and Learn Sessions: These sessions, run by OH, will be restarted to allow managers to ask questions about ill-health retirement and reasonable adjustments.
- Collaboration with the Health and Well-being team to expand initiatives that promote employee physical and mental wellbeing. This could include access to mental health support, stress management workshops, or wellness programmes

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

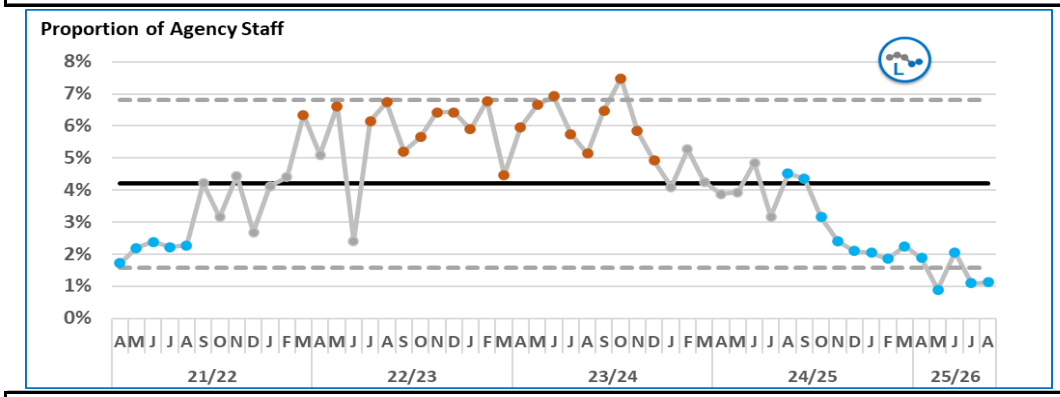
Working Together - Graphs (3)



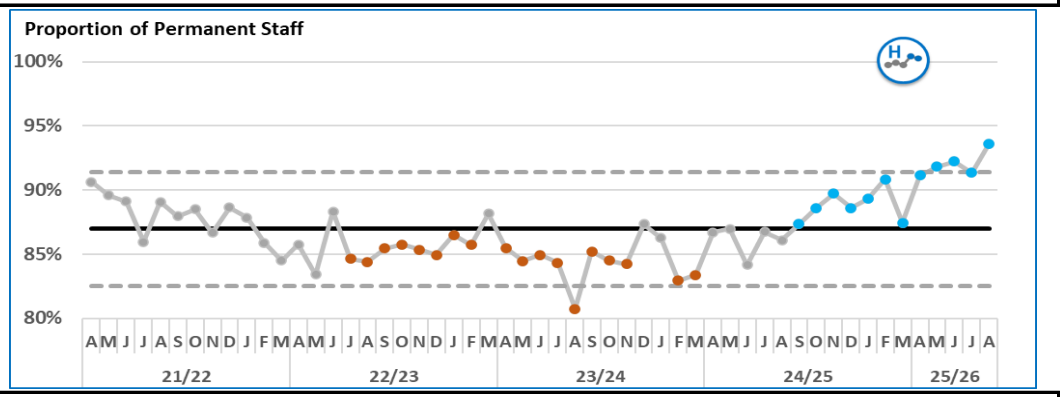
'Proportion of Temporary Staff ' is showing 'special cause improvement' (decreasing rate). The figure is currently at 6.4%.



'Proportion of Bank Staff' is showing 'special cause improvement' (decreasing rate) - This is a change from the previous month. The figure is currently at 5.3%.



'Proportion of Agency Staff' is showing 'special cause improvement' (decreasing rate). The figure is currently at 1.1%.



'Proportion of Permanent Staff' is showing 'special cause improvement' (increasing rate). The figure is currently at 93.6%.

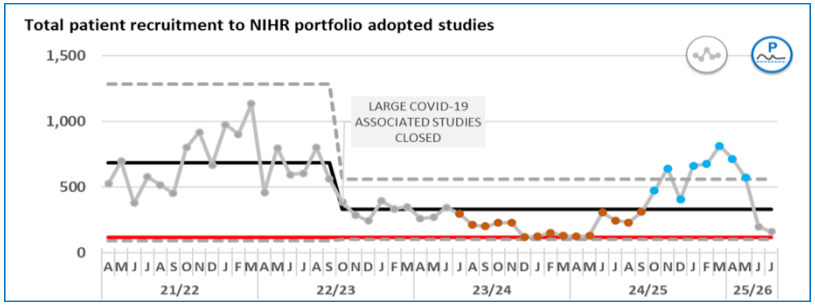
- Temporary staffing usage continues to reduce because of increased governance, reporting, and monitoring.
- Year to date, Agency Spend is 38% ahead of target.
- MEH has the second highest variance to target for Bank spend in terms of both cash value and percentage.
- The top reasons for temporary staffing utilisation remain the same: Vacancy and long term sickness absence.

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

Discover - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Total patient recruitment to NIHR portfolio adopted studies	Research Lead	Internal Measure	Monthly (Month in Arrears)	≥115 (per month)	1645	160		P
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Research Lead	Internal Measure	Monthly (Month in Arrears)	No Target Set	1813	167		
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Research Lead	Internal Measure	Monthly (Month in Arrears)	≥44	n/a	62	H	P
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Research Lead	Internal Measure	Monthly (Month in Arrears)	≥2%	n/a	3.3%	L	P

Discover - Graphs (1)



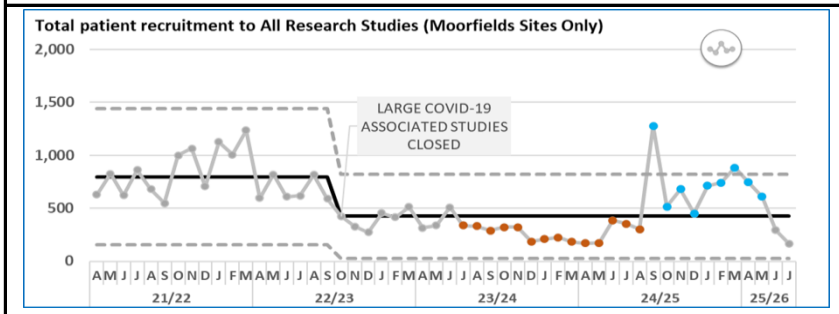
'Total patient recruitment to NIHR portfolio adopted studies' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 160.

The monthly recruitment total for July is in the same range as last month. This was due to two main reasons. Firstly, one of our high recruiting studies (SIBA) has now finished recruitment, exceeding its target and recruiting over 1750 participants. Secondly, one of our high recruiting studies in genetics experienced a staff shortage which impacted recruitment. The majority of Moorfield's studies are NIHR Portfolio adopted.
As we can see, in order to maintain our recruitment levels, it is important that we continue to attract more grants and awards.

Recently, a project grant funded by Alcon, led by Moorfields and that will be portfolio adopted plans to recruit 310 patients over the age of 45 that require cataract surgery. These patients will be provided with one of two next-generation intra-ocular lenses that will be compared over a period of 3 months in terms of vision quality and patient satisfaction. This project is designed to help ensure that emerging cataract technologies meet the needs of a growing patient population. The award of £677,655 will financially support the study for 36 months.
We have also been successful in other industry funded grants including that from Alcon, Bayer and Boehringer-Ingelheim. These grants will be led and will be delivered by Moorfields in the coming months. The projects proposed will investigate (i - Alcon) treatment options for patients with ocular hypertension and glaucoma, (ii - Bayer) treatment options for patients with polypoidal choroidal vasculopathy in neovascular age-related macular degeneration, and (iii - Boehringer-Ingelheim) retinal structure of age related macular degeneration to predict new onset.

The percentage split for currently active studies is 82% NIHR portfolio and 18% non- NIHR portfolio. Currently our NIHR Portfolio recruitment for this financial year is 1892, and if we maintain the same rates of recruitment we should approach a total of around 5250 by the end of the financial year.

Review Date: Oct 2025 ***Action Lead:*** Research Lead

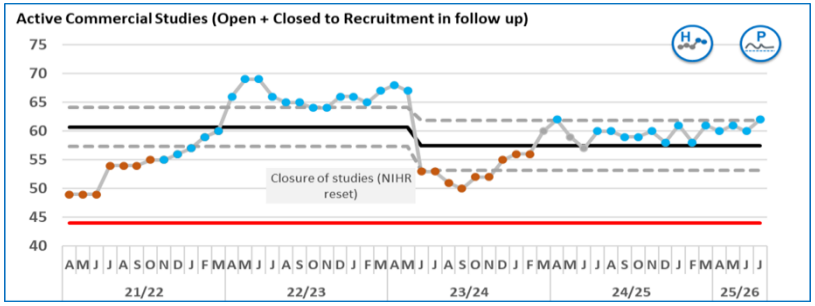


'Total patient recruitment to All Research studies (Moorfields Sites Only)' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 167.

The total patient recruitment in July 2025 across both NIHR portfolio and non NIHR portfolio studies was 167 recruits. This metric includes commercial and non-commercial studies. Our commercial study recruitment varies from month to month, with July having 18 recruits, which is almost 11% of the monthly total and the highest percentage for some time.

Review Date: Oct 2025 ***Action Lead:*** Research Lead

Discover - Graphs (2)



'Active Commercial Studies (Open + Closed to Recruitment in follow up)' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 62.

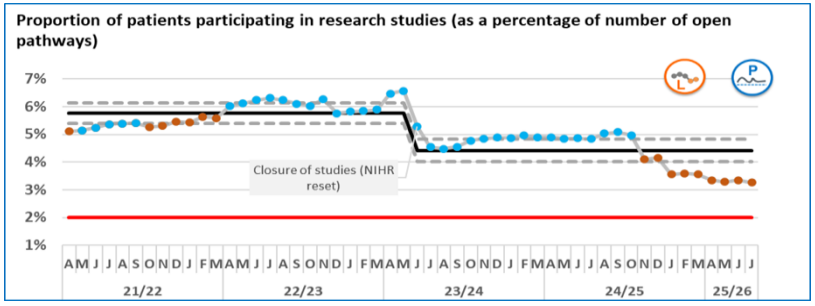
There are currently 62 commercial studies recruiting and in follow up . This metric displays a good level of consistency. This is keeping in line with our average across 2024/25 which was 58. Our medium-term goal is to increase the percentage of patients recruited to commercial studies, to the NIHR recommended level of 25% of all patient's recruited going into commercial studies. For this financial year our % of recruitment into commercial studies stands at 4%.

Commercial studies are frequently interventional, requiring intensive investigations by skilled multidisciplinary staff and close monitoring. They give our patients access to new Investigational Medicinal Products (IMP) and devices. The current pipeline of 22 hosted studies in "set up" should ensure that we continue to increase recruitment to commercial studies. 14 out of 18 (77%) of commercial studies recruited fully within the target time.

Set-up times for commercial and non-commercial studies continue to improve, some anomalies are still present, mainly due to the complexity of contracting for certain types of studies, which can delay things. There was a slight increase to 16 days median set up time in July but this is still well below the figure of 99 days at the end of December 2024. We continue to look for new innovative methods of shortening the set up time to ensure that studies start recruiting as soon they open.

Archer II - a study Investigating the Efficacy and Safety of Intravitreal Injections of ANX007 in Patients with Geographic Atrophy achieved its recruitment target. Study is sponsored by Annexon, Inc. We also successfully completed recruitment for a Randomized, Double-masked, Placebo-controlled, trial to Evaluate the Efficacy, Safety and Tolerability of Subcutaneous Teprotumumab in Participants with Moderate-to-Severe Active Thyroid Eye Disease. This study was sponsored by Horizon Therapeutics.

Review Date: Oct 2025 ***Action Lead:*** Research Lead



'Proportion of patients participating in research studies (as a percentage of number of open pathways)' is showing 'special cause concern' however the current process will consistently pass the target. The figure is currently at 3.3%.

We have recently seen increase in the number of patients recruited each month, however, the conclusion of four recent studies, SIBA, one large non-commercial study, Hercules and one large genetics study, the NIHR Bioresource Tissue Bank and the KAP study, prevents an increase in the overall number of patients currently participating in research. We continue to exceed the 2.0% target .

We continue to place emphasis on and investment in patient and public involvement and engagement (PPIE), delivered through the work of our NIHR Biomedical Research Centre (BRC) and Clinical Research Facility (CRF). Our Equity, Diversity, and Inclusion strategy for both the BRC and CRF seeks to increase the diversity of our patients recruited to clinical trials, as well as provide increased opportunities for patients to contribute to research.

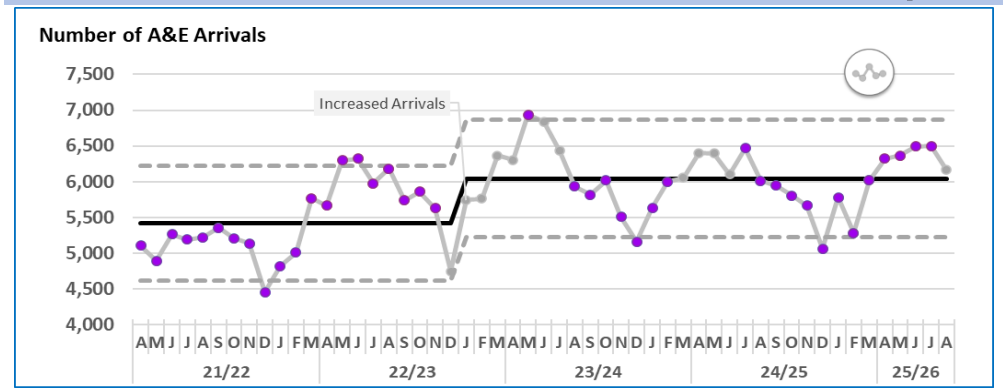
We have been considering the addition of new metrics to give assurance that align to the newly published NIHR guidance for study set up, for implementation in Q3. This process is now on hold as a result of a change in directorship.

Review Date: Oct 2025 ***Action Lead:*** Research Lead

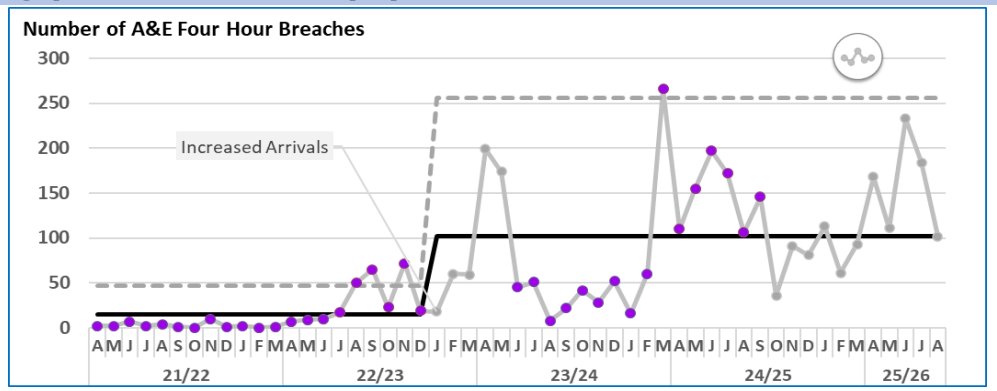
Context (Activity) - Summary

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	31841	6165		
Number of A&E Four Hour Breaches	Jon Spencer	Internal Requirement	Monthly	No Target Set	798	102		
Number of Outpatient Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	273232	50488		
Number of Outpatient First Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	65521	12103		
Number of Outpatient Follow Up Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	207711	38385		
Number of Referrals Received	Jon Spencer	Internal Requirement	Monthly	No Target Set	79502	13382		
Number of Theatre Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	16157	2947		
Number of Theatre Elective Daycase Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	14491	2622		
Number of Theatre Elective Inpatient Admission	Jon Spencer	Internal Requirement	Monthly	No Target Set	372	72		
Number of Theatre Emergency Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	1294	253		

Context (Activity) - Graphs (1)

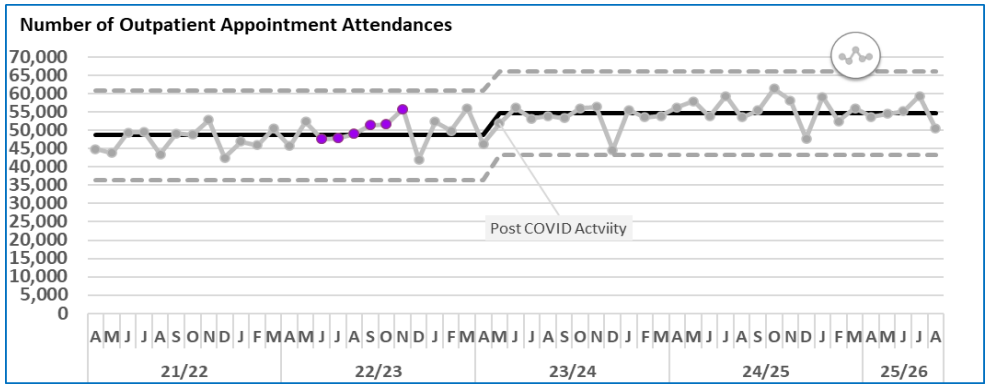


'Number of A&E Arrivals' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 6,165.

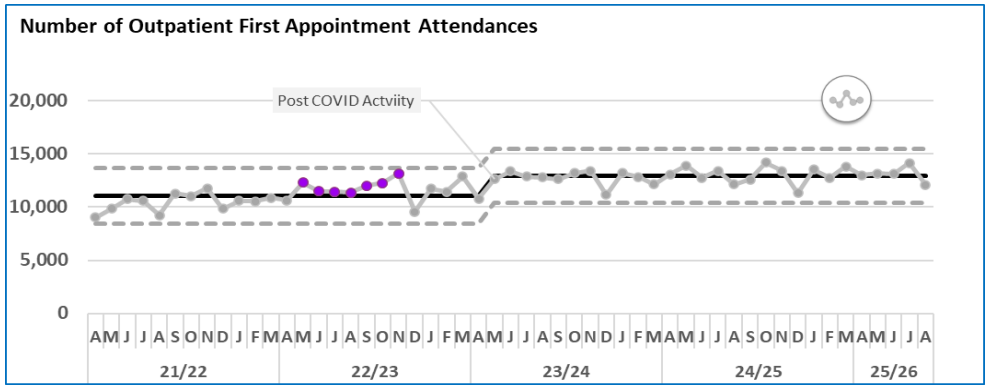


'Number of A&E Four Hour Breaches' is showing 'common cause variation'. The figure is currently at 102.

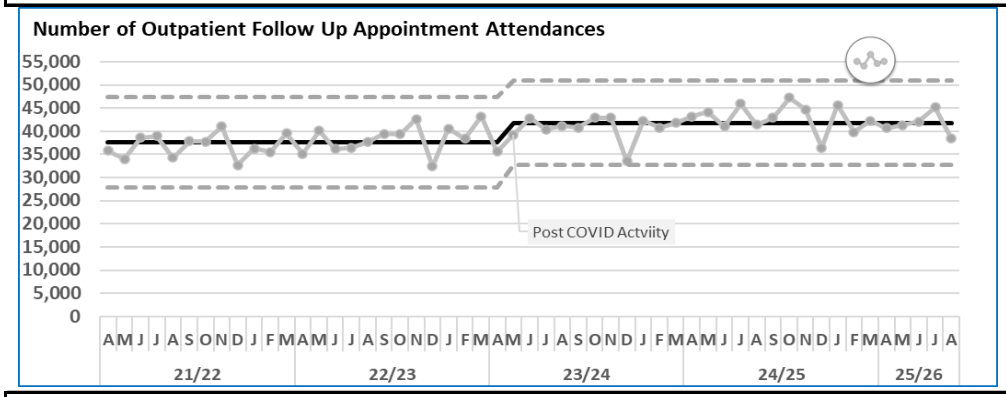
Context (Activity) - Graphs (2)



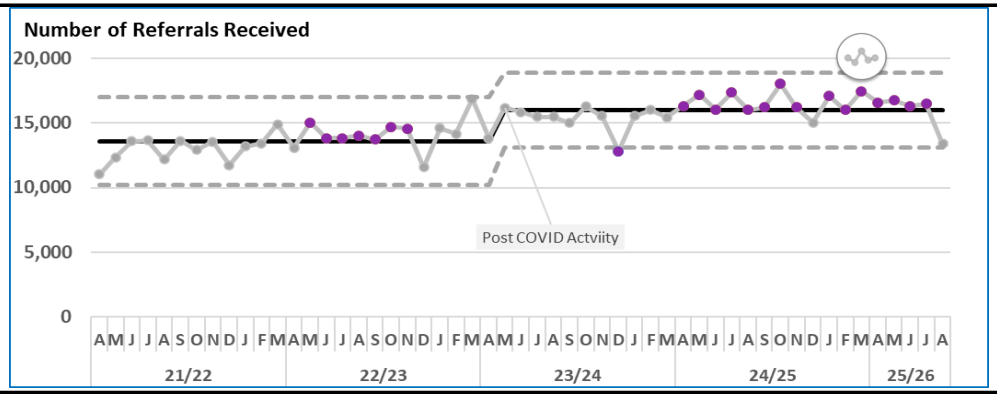
'Number of Outpatient Appointment Attendances' is showing 'common cause variation'. The figure is currently at 50,488.



'Number of Outpatient First Appointment Attendances' is showing 'common cause variation'. The figure is currently at 12,103.

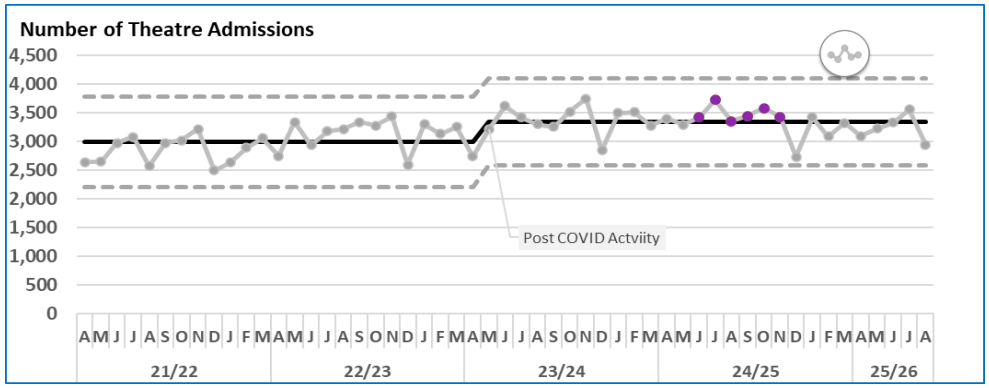


'Number of Outpatient Follow Up Appointment Attendances' is showing 'common cause variation'. The figure is currently at 38,385.

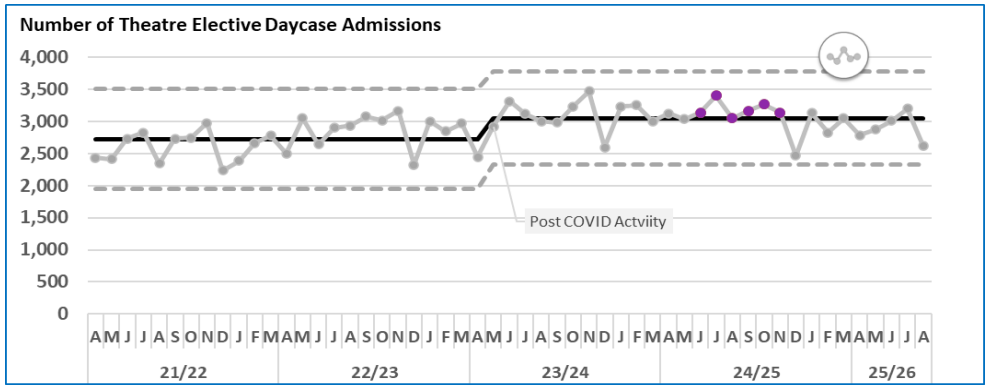


'Number of Referrals Received' is showing 'common cause variation'. The figure is currently at 13,382.

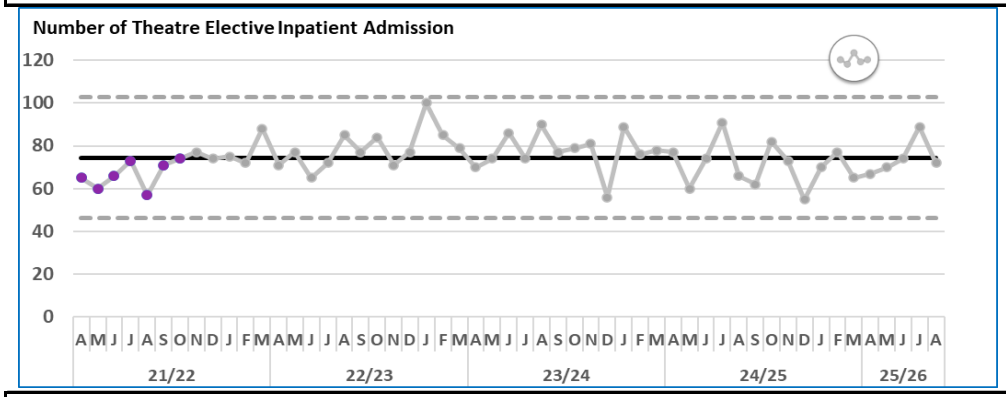
Context (Activity) - Graphs (3)



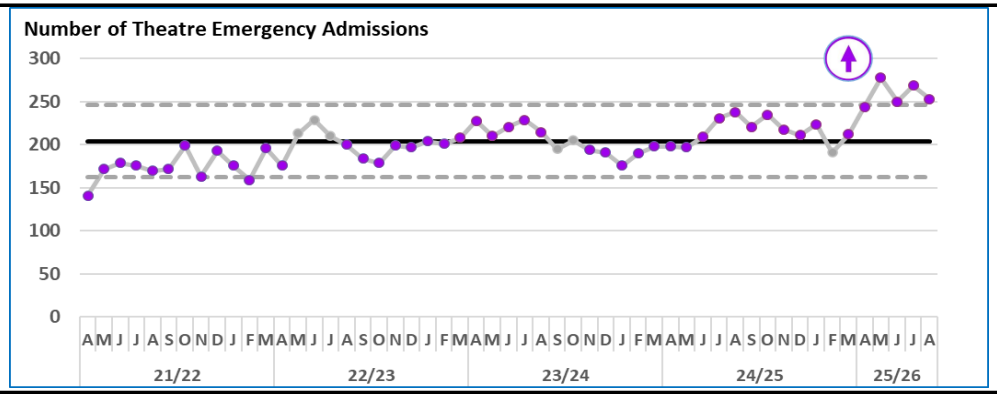
'Number of Theatre Admissions' is showing 'common cause variation'. The figure is currently at 2,947.



'Number of Theatre Elective Daycase Admissions' is showing 'common cause variation'. The figure is currently at 2,622.



'Number of Theatre Elective Inpatient Admission' is showing 'common cause variation'. The figure is currently at 72.



'Number of Theatre Emergency Admissions' is showing an 'special cause variation' (increasing rate). The figure is currently at 253.

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
NHS Oversight Framework - Core Metrics (Access)																						
18 Week RTT Incomplete Performance	Aug-25	80.5%	≥84.0%	Monthly	Concern (Lower Than Expected)	Hit or Miss	82.6%	80.7%	84.4%	82.6%	82.7%	82.4%	82.6%	81.2%	80.9%	82.5%	83.1%	82.7%	82.2%	83.1%	81.7%	80.5%
% 52 Week RTT Incomplete Breaches	Aug-25	0.09%	≤1%	Monthly	Common Cause	Capable	0.05%	-0.02%	0.11%	0.03%	0.02%	0.04%	0.03%	0.03%	0.03%	0.04%	0.05%	0.07%	0.09%	0.06%	0.05%	0.09%
Cancer 28 Day Faster Diagnosis Standard	Jul-25	77.8%	≥80%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	81.9%	31.4%	132.4%	88.9%	77.8%	55.6%	100.0%	80.0%	75.0%	75.0%	72.7%	88.9%	100.0%	100.0%	77.8%	n/a
% Patients With All Cancers Treated Within 62 Days	Jul-25	100.0%	≥85%	Monthly (Month in Arrears)	Common Cause	Capable	96.5%	75.7%	117.4%	100.0%	100.0%	97.5%	96.7%	94.1%	100.0%	94.1%	93.8%	92.3%	100.0%	100.0%	100.0%	n/a
A&E Four Hour Performance	Aug-25	98.2%	≥95%	Monthly	Common Cause	Capable	97.7%	94.9%	100.4%	98.1%	97.4%	99.4%	98.3%	98.3%	97.9%	98.8%	98.4%	97.2%	98.2%	96.2%	97.0%	98.2%
A&E Twelve Hour Performance	Aug-25	0.00%	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
NHS Oversight Framework - Core Metrics (Multiple Areas)																						
% Discharged on Discharge Ready Date (DRD)	Aug-25	100.0%	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	100.0%	99.8%	100.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Average Days Between DRD and Discharge Date	Aug-25	0	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA Bacteraemias Cases	Aug-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile Cases	Aug-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Aug-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staff Sickness (Month Figure)	Jul-25	5.6%	≤4%	Monthly (Month in Arrears)	Concern (Higher Than Expected)	Failing	4.5%	3.5%	5.6%	4.5%	4.6%	4.9%	4.9%	4.8%	5.4%	5.3%	4.8%	4.6%	4.5%	4.8%	5.6%	n/a
Staff Sickness (Rolling Annual Figure)	Jul-25	4.9%	≤4%	Monthly (Month in Arrears)	Concern (Run Above Average)	Failing	4.6%	4.5%	4.7%	4.6%	4.5%	4.6%	4.6%	4.6%	4.7%	4.7%	4.8%	4.8%	4.8%	4.8%	4.9%	n/a
Planned surplus/deficit	Aug-25	n/a	No Target Set	Monthly	Not Available	Not Applicable				n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Variance year-to-date to financial plan	Aug-25	n/a	No Target Set	Monthly	Not Available	Not Applicable				n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Deliver (Activity vs Plan)																						
Elective Activity - % of Phased Plan	Aug-25	96.1%	≥100%	Monthly	Common Cause	Hit or Miss	94.5%	78.2%	110.8%	93.6%	96.7%	90.6%	95.3%	78.5%	90.5%	89.9%	92.7%	102.0%	105.6%	94.5%	96.2%	96.1%
Total Outpatient Activity - % of Phased Plan	Aug-25	97.1%	≥100%	Monthly	Common Cause	Hit or Miss	101.6%	88.5%	114.8%	100.5%	104.3%	105.0%	109.3%	94.3%	106.1%	103.6%	105.2%	103.5%	104.9%	91.2%	93.5%	97.1%
Outpatient First Appointment Activity - % of Phased Plan	Aug-25	98.3%	≥100%	Monthly	Common Cause	Hit or Miss	103.9%	89.2%	118.6%	99.8%	103.7%	106.4%	110.5%	97.7%	106.3%	109.7%	113.2%	105.2%	106.9%	91.1%	93.9%	98.3%
Outpatient Follow Up Appointment Activity - % of Phased Plan	Aug-25	96.8%	≥100%	Monthly	Common Cause	Hit or Miss	102.0%	88.0%	115.9%	100.7%	104.5%	104.7%	108.9%	93.4%	106.1%	101.8%	103.0%	103.0%	104.3%	91.2%	93.3%	96.8%
Deliver (Cancer Performance)																						
Cancer 28 Day Faster Diagnosis Standard	Jul-25	77.8%	≥80%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	81.9%	31.4%	132.4%	88.9%	77.8%	55.6%	100.0%	80.0%	75.0%	75.0%	72.7%	88.9%	100.0%	100.0%	77.8%	n/a
% Patients with all cancers receiving treatment within 31 days of decision to treat	Jul-25	100.0%	≥96%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	99.1%	94.9%	103.3%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	89.3%	95.7%	100.0%	95.8%	100.0%	100.0%	n/a
% Patients with all cancers treated within 62 days	Jul-25	100.0%	≥85%	Monthly (Month in Arrears)	Common Cause	Capable	96.5%	75.7%	117.4%	100.0%	100.0%	97.5%	96.7%	94.1%	100.0%	94.1%	93.8%	92.3%	100.0%	100.0%	100.0%	n/a
Deliver (Access Performance)																						
18 Week RTT Incomplete Performance	Aug-25	80.5%	≥84.0%	Monthly	Concern (Lower Than Expected)	Hit or Miss	82.6%	80.7%	84.4%	82.6%	82.7%	82.4%	82.6%	81.2%	80.9%	82.5%	83.1%	82.7%	82.2%	83.1%	81.7%	80.5%
RTT Incomplete Pathways (RTT Waiting List)	Aug-25	34,788	≤ Previous Mth.	Monthly	Common Cause	Not Applicable	34,410	32,865	35,954	34,357	34,932	33,872	33,281	33,039	32,691	33,406	33,136	33,228	33,142	34,491	34,982	34,788
RTT Incomplete Pathways Over 18 Weeks	Aug-25	6,782	≤ Previous Mth.	Monthly	Increasing (Higher Than Expected)	Not Applicable	6,069	5,444	6,694	5,966	6,038	5,963	5,801	6,222	6,229	5,849	5,594	5,737	5,910	5,814	6,403	6,782
52 Week RTT Incomplete Breaches	Aug-25	31	Zero Breaches	Monthly	Concern (Higher Than Expected)	Failing	11	-3	26	10	8	13	9	9	9	12	18	22	29	19	16	31
Eliminate waits over 65 weeks for elective care	Aug-25	3	Zero Breaches	Monthly	Common Cause	Failing	3	-4	10	4	2	2	2	0	2	3	6	3	2	1	1	3
A&E Four Hour Performance	Aug-25	98.2%	≥95%	Monthly	Common Cause	Capable	97.7%	94.9%	100.4%	98.1%	97.4%	99.4%	98.3%	98.3%	97.9%	98.8%	98.4%	97.2%	98.2%	96.2%	97.0%	98.2%
Percentage of Diagnostic waiting times less than 6 weeks	Aug-25	100.0%	≥99%	Monthly	Common Cause	Hit or Miss	99.3%	97.1%	101.5%	99.1%	100.0%	100.0%	99.5%	98.3%	97.7%	98.4%	98.7%	98.4%	99.5%	100.0%	99.4%	100.0%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Deliver (Call Centre and Clinical)																						
Average Call Waiting Time	Aug-25	184	≤ 2 Mins (120 Sec)	Monthly	Common Cause	Failing	151	38	263	174	139	112	109	32	77	199	255	260	131	131	163	184
Average Call Abandonment Rate	Aug-25	11.5%	≤15%	Monthly	Common Cause	Hit or Miss	10.6%	3.4%	17.7%	13.2%	10.6%	9.0%	8.5%	2.5%	6.4%	13.3%	16.4%	15.5%	8.7%	8.8%	10.2%	11.5%
Mixed Sex Accommodation Breaches	Aug-25	0	Zero Breaches	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Aug-25	5.88%	≤ 2.67%	Monthly (Rolling 3 Months)	Common Cause	Hit or Miss	2.10%	-3.37%	7.56%	1.47%	5.56%	0.00%	0.00%	9.68%	3.13%	1.69%	4.41%	2.82%	3.70%	1.54%	1.09%	5.88%
VTE Risk Assessment	Aug-25	98.9%	≥95%	Monthly	Common Cause	Capable	99.2%	97.9%	100.4%	99.7%	99.8%	99.8%	99.9%	99.1%	98.6%	99.3%	99.9%	99.2%	99.1%	99.0%	99.2%	98.9%
Posterior Capsular Rupture rates (Cataract Operations Only)	Aug-25	0.38%	≤1.95%	Monthly	Common Cause	Capable	0.88%	0.08%	1.68%	0.76%	0.85%	1.42%	0.92%	1.00%	0.80%	0.87%	0.70%	0.62%	1.16%	0.53%	1.25%	0.38%
MRSA Bacteraemias Cases	Aug-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile Cases	Aug-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Aug-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Rate - cases	Aug-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Deliver (Quality and Safety)																						
Inpatient Scores from Friends and Family Test - % positive	Aug-25	96.5%	≥90%	Monthly	Improvement (Run Above Average)	Capable	95.8%	93.9%	97.7%	96.1%	96.2%	96.8%	95.9%	95.0%	95.0%	97.4%	96.8%	97.0%	96.9%	96.9%	96.7%	96.5%
A&E Scores from Friends and Family Test - % positive	Aug-25	92.5%	≥90%	Monthly	Common Cause	Capable	92.9%	90.6%	95.2%	94.0%	93.7%	93.4%	93.9%	94.7%	94.7%	94.4%	94.3%	91.7%	92.9%	92.9%	92.7%	92.5%
Outpatient Scores from Friends and Family Test - % positive	Aug-25	95.6%	≥90%	Monthly	Improvement (Run Above Average)	Capable	93.9%	93.0%	94.9%	94.4%	94.2%	95.4%	95.0%	94.9%	94.9%	95.5%	95.3%	95.8%	95.3%	95.3%	95.4%	95.6%
Paediatric Scores from Friends and Family Test - % positive	Aug-25	94.2%	≥90%	Monthly	Common Cause	Capable	94.5%	90.6%	98.4%	95.8%	94.4%	93.2%	94.6%	96.3%	96.3%	95.0%	93.8%	97.0%	93.4%	93.4%	94.9%	94.2%
Percentage of responses to written complaints sent within 25 days	Jul-25	14.0%	≥80%	Monthly (Month in Arrears)	Concern (Lower Than Expected)	Failing	67.9%	24.9%	110.8%	83.3%	50.0%	76.9%	71.4%	83.3%	18.2%	40.0%	18.2%	27.3%	36.4%	7.1%	14.0%	n/a
Percentage of responses to written complaints acknowledged within 3 days	Aug-25	54.5%	≥80%	Monthly	Concern (Lower Than Expected)	Failing	86.9%	57.5%	116.3%	100.0%	50.0%	84.6%	92.9%	75.0%	36.4%	60.0%	36.4%	81.8%	45.5%	53.6%	66.0%	54.5%
Freedom of Information Requests Responded to Within 20 Days	Jul-25	93.0%	≥90%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	89.8%	73.5%	106.1%	87.8%	86.1%	89.4%	78.7%	88.2%	93.8%	100.0%	92.3%	100.0%	93.3%	86.7%	93.0%	n/a
Subject Access Requests (SARs) Responded To Within 28 Days	Jul-25	n/a	≥90%	Monthly (Month in Arrears)	Not Available	Not Applicable				n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Deliver (Incident Reporting)																						
Occurrence of any Never events	Aug-25	1	Zero Events	Monthly	Common Cause	Hit or Miss	0	-1	1	0	1	0	0	0	0	0	0	0	0	0	0	1
Summary Hospital Mortality Indicator	Aug-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Patient Safety Alerts (NatPSAs) breached	Aug-25	0	Zero Alerts	Monthly	Improvement (Run Below Average)	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Aug-25	325	No Target Set	Monthly	Concern (Higher Than Expected)	Not Applicable	236	155	317	283	253	252	275	307	222	284	251	283	291	313	309	325

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Sustainability and at Scale																						
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Aug-25	100	No Target Set	Monthly	Common Cause	Not Applicable	99	95	104	98	102	102	102	99	102	97	97	100	102	99	99	100
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Aug-25	39	No Target Set	Monthly	Common Cause	Not Applicable	41	35	47	37	40	44	44	40	48	46	44	42	40	39	40	39
Theatre Cancellation Rate (Non-Medical Cancellations)	Aug-25	1.08%	≤0.8%	Monthly	Concern (Run Above Average)	Failing	1.00%	-0.18%	2.19%	1.02%	0.55%	0.99%	0.82%	0.55%	1.16%	0.75%	1.46%	1.04%	1.51%	2.15%	1.01%	1.08%
Number of non-medical cancelled operations not treated within 28 days	Aug-25	3	Zero Breaches	Monthly	Common Cause	Hit or Miss	1	-3	6	0	3	1	0	2	0	3	1	0	4	0	0	3
Overall financial performance (In Month Var. £m)	Aug-25	0.89	≥0	Monthly	Common Cause	Hit or Miss	0.32	-2.09	2.74	0.25	0.15	-0.03	-1.34	-1.31	0.41	1.91	-2.53	0.08	0.54	0.37	0.11	0.89
Commercial Trading Unit Position (In Month Var. £m)	Aug-25	0.03	≥0	Monthly	Common Cause	Hit or Miss	-0.03	-0.90	0.84	0.17	-0.24	-0.49	-0.24	0.16	-0.06	-0.14	-0.49	-0.17	0.33	-0.04	-0.09	0.03
Working Together																						
Appraisal Compliance	Aug-25	82.7%	≥80%	Monthly	Improvement (Higher Than Expected)	Hit or Miss	73.4%	66.1%	80.7%	73.4%	73.1%	75.5%	72.9%	70.8%	70.3%	69.7%	67.7%	62.8%	61.2%	54.4%	74.0%	82.7%
Basic Mandatory IG Training	Aug-25	88.3%	≥90%	Monthly	Concern (Lower Than Expected)	Hit or Miss	91.2%	89.0%	93.4%	88.9%	89.3%	88.8%	89.4%	89.6%	89.9%	89.6%	89.5%	89.8%	90.1%	89.6%	87.6%	88.3%
Staff Sickness (Month Figure)	Jul-25	5.6%	≤4%	Monthly (Month in Arrears)	Concern (Higher Than Expected)	Failing	4.5%	3.5%	5.6%	4.5%	4.6%	4.9%	4.9%	4.8%	5.4%	5.3%	4.8%	4.6%	4.5%	4.8%	5.6%	n/a
Staff Sickness (Rolling Annual Figure)	Jul-25	4.9%	≤4%	Monthly (Month in Arrears)	Concern (Higher Than Expected)	Failing	4.6%	4.5%	4.7%	4.6%	4.5%	4.6%	4.6%	4.6%	4.7%	4.7%	4.8%	4.8%	4.8%	4.8%	4.9%	n/a
Recruitment Time To Hire (Days)	Aug-25	36	≤ 40 Days	Monthly	Common Cause	Hit or Miss	41	31	51	41	40	40	42	39	40	41	39	41	46	37	49	36
Proportion of Temporary Staff	Aug-25	6.4%	No Target Set	Monthly	Improvement (Lower Than Expected)	Not Applicable	13.0%	8.6%	17.5%	13.9%	12.7%	11.4%	10.3%	11.4%	10.7%	9.2%	12.6%	8.8%	8.2%	7.8%	8.6%	6.4%
Proportion of Bank Staff	Aug-25	5.3%	No Target Set	Monthly	Improvement (Lower Than Expected)	Not Applicable	8.8%	5.5%	12.1%	9.4%	8.3%	8.2%	7.9%	9.3%	8.6%	7.3%	10.3%	7.0%	7.3%	5.7%	7.5%	5.3%
Proportion of Agency Staff	Aug-25	1.1%	No Target Set	Monthly	Improvement (Lower Than Expected)	Not Applicable	4.2%	1.6%	6.8%	4.5%	4.4%	3.2%	2.4%	2.1%	2.0%	1.9%	2.2%	1.9%	0.9%	2.1%	1.1%	1.1%
Proportion of Permanent Staff	Aug-25	93.6%	No Target Set	Monthly	Improvement (Higher Than Expected)	Not Applicable	87.0%	82.5%	91.4%	86.1%	87.3%	88.6%	89.7%	88.6%	89.3%	90.8%	87.5%	91.2%	91.8%	92.2%	91.4%	93.6%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Discover																						
Total patient recruitment to NIHR portfolio adopted studies	Jul-25	160	≥115 (per month)	Monthly (Month in Arrears)	Common Cause	Capable	330	100	561	231	310	472	641	406	663	676	815	715	571	199	160	n/a
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Jul-25	167	No Target Set	Monthly (Month in Arrears)	Common Cause	Not Applicable	425	29	821	304	1,278	516	681	450	712	741	883	744	610	292	167	n/a
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Jul-25	62	≥44	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	58	53	62	60	59	59	60	58	61	58	61	60	61	60	62	n/a
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Jul-25	3.3%	≥2%	Monthly (Month in Arrears)	Concern (Run Below Average)	Capable	4.4%	4.0%	4.8%	5.0%	5.1%	5.0%	4.1%	4.2%	3.6%	3.6%	3.6%	3.4%	3.3%	3.3%	3.3%	n/a
Context (Activity)																						
Number of A&E Arrivals	Aug-25	6,165	No Target Set	Monthly	Common Cause	Not Applicable	6,041	5,220	6,861	6,011	5,943	5,807	5,667	5,062	5,783	5,285	6,016	6,323	6,367	6,490	6,496	6,165
Number of A&E Four Hour Breaches	Aug-25	102	No Target Set	Monthly	Common Cause	Not Applicable	102	-52	256	106	146	36	91	81	113	61	93	168	111	233	184	102
Number of Outpatient Appointment Attendances	Aug-25	50,488	No Target Set	Monthly	Common Cause	Not Applicable	54,776	43,365	66,186	53,585	55,498	61,400	58,138	47,775	59,170	52,551	56,058	53,657	54,526	55,215	59,346	50,488
Number of Outpatient First Appointment Attendances	Aug-25	12,103	No Target Set	Monthly	Common Cause	Not Applicable	12,956	10,444	15,468	12,160	12,612	14,197	13,431	11,323	13,538	12,747	13,813	12,988	13,157	13,111	14,162	12,103
Number of Outpatient Follow Up Appointment Attendances	Aug-25	38,385	No Target Set	Monthly	Common Cause	Not Applicable	41,820	32,765	50,874	41,425	42,886	47,203	44,707	36,452	45,632	39,804	42,245	40,669	41,369	42,104	45,184	38,385
Number of Referrals Received	Aug-25	13,382	No Target Set	Monthly	Common Cause	Not Applicable	16,008	13,097	18,919	16,027	16,207	18,042	16,230	15,024	17,083	16,009	17,475	16,583	16,741	16,325	16,471	13,382
Number of Theatre Admissions	Aug-25	2,947	No Target Set	Monthly	Common Cause	Not Applicable	3,344	2,581	4,107	3,357	3,447	3,585	3,433	2,734	3,425	3,094	3,327	3,095	3,225	3,333	3,557	2,947
Number of Theatre Elective Daycase Admissions	Aug-25	2,622	No Target Set	Monthly	Common Cause	Not Applicable	3,052	2,325	3,778	3,053	3,164	3,268	3,142	2,468	3,131	2,826	3,050	2,784	2,877	3,009	3,199	2,622
Number of Theatre Elective Inpatient Admission	Aug-25	72	No Target Set	Monthly	Common Cause	Not Applicable	75	46	103	66	62	82	73	55	70	77	65	67	70	74	89	72
Number of Theatre Emergency Admissions	Aug-25	253	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	204	162	246	238	221	235	218	211	224	191	212	244	278	250	269	253

Moorfields Eye Hospital NHS Foundation Trust

NHS

Report title	Monthly Finance Performance Report Month 05 – August 2025
Meeting	Board of Directors – Part I
Date	2 October 2025
Report from	Arthur Vaughan, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

For August, the trust is reporting:-

Financial Performance		In Month			Year to Date		
£m	Annual Plan	Plan	Actual	Variance	Plan	Actual	Variance
Income	£370.5m	£26.5m	£26.4m	(£0.1m)	£145.2m	£144.7m	(£0.5m)
Pay	(£195.1m)	(£16.7m)	(£16.4m)	£0.3m	(£83.5m)	(£82.9m)	£0.6m
Non Pay	(£131.3m)	(£10.4m)	(£9.8m)	£0.7m	(£54.8m)	(£53.1m)	£1.7m
Financing & Adjustments	(£44.2m)	(£1.5m)	(£1.4m)	£0.1m	(£11.9m)	(£11.7m)	£0.2m
CONTROL TOTAL	**-**	**(£2.0m)**	**(£1.1m)**	**£0.9m**	**(£4.9m)**	**(£2.9m)**	**£2.0m**

Income and Expenditure

- A £2.9m deficit year to date compared to a planned deficit of £4.9m; £2.0m favourable to plan.

Efficiency and Productivity

- The Trust has identified £8.4m of the £15.1m target required to achieve a break-even financial plan.
- Delivery in August reported £0.87m, £0.34m favourable to the Trusts external delivery plan which is predominantly towards the second half of the year.

Capital Expenditure

- Capital expenditure as of 31st August totalled £55.6m, predominantly linked to Oriel and EPR schemes.
- Business as usual capital £10.2m plan; £6.7m (66%) committed awaiting finalisation of key projects prior to further progression.

Cash

- The cash balance as at the 31 August was £85.3m, a reduction of £0.8m since the end of March 2025. This equates to approximately 96 days operating cash.

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 discuss the attached report.

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report

Trust Board Report

For the period ended 31st August 2025 (Month 05)

Report Period	M05 | August 2025
Presented by	Arthur Vaughan| Chief Financial Officer
Written by	Justin Betts | Deputy Chief Financial Officer Amit Patel | Head of Financial Management Lubna Dharssi | Head of Financial Control Richard Allen | Head of Income and Contracts

Monthly Finance Performance Report

For the period ended 31st August 2025 (Month 05)

Key Messages

Statement of Comprehensive Income

Financial Position £1.14m deficit in month	For August, the trust is reporting:- • A £1.14m deficit in-month against a planned £2.03m deficit, a £0.89m favourable variance to plan • A £2.95m deficit cumulatively against a planned deficit of £4.94m, £1.99m favourable to plan.

Key Drivers of the Financial Variance	Key Drivers of the core operational performance include:-
	• NHS Clinical income is assumed in line with planning assumptions, until commissioner contracts have been received.
	• Clinical divisions and core activity performance are reporting £0.43m adverse to plan cumulatively. Clinical income is £0.10m adverse to plan in addition to efficiency under delivery of £1.46m.
	  • Elective activity is 95% in August, 99% cumulatively of the activity plans;
	  • Stratford elective activity is 95% of plans cumulatively.
	  • St Ann's elective activity is 83% of plans cumulatively.
	  • Cataract activity is 101% of plans cumulatively.
	  • Outpatients Firsts and Procedures are 97% and 93% respectively cumulatively.
	• Research is reporting a £(0.42)m adverse position cumulatively comprised of research costs in excess of study activity and income adverse to plan within the Insight project.
	• Corporate departments are reporting £1.51m favourable cumulatively including £0.92m of underspend linked to slippage on major IT projects, Moorconnect and Oriel (£0.74m) and further underspends (£0.9m) offset by CIP underachievement (£1.39m)
	• Trading areas are £0.07m favourable to plan cumulatively across all commercial units.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 31st August was £85.3m, a reduction of £0.8m since the end of March 2025. This equates to approximately 96 days operating cash. The Better Payment Practice Code (BPPC) performance in August was 97% (volume) and 96% (value) against a target of 95% across both metrics.
Capital (both gross capital expenditure and CDEL)	Capital expenditure as of 31st August totalled £55.6m. • Business as usual capital £10.2m plan; £6.7m (66%) committed awaiting finalisation of key projects prior to further progression. • Externally funded schemes £149m plan; £55.4m cumulative expenditure including £53.5m of Oriel expenditure and £1.8m for EPR. • IFRS16 £5.1m capital plan; nil expenditure cumulatively.

Other Key Information

Efficiencies £15.1m Trust Target £2.02m YTD actual £11.5m un-identified and non recurrently identified schemes	The trust has a planned efficiency programme of £15.1m for 2025/26 to deliver the control total. The trust has identified £8.4m, £6.6m adverse to plan. Of the total identified:- • £1.8m is identified central schemes; • £0.7m is identified as income generation schemes; • £3.5m is forecast recurrently; The CIP programme delivery group are progressing further proposed efficiency scheme documentation for additional opportunities to be fully financial validated towards increasing the level of identified and forecast delivery in 2025/26.
Agency Spend £1.11m spend YTD 1.3% total pay	Trust wide agency spend totals £1.11m cumulatively, approximately 1.3% of total employee expenses spend, below the system allocated target of 2.5%. Workforce have instigated temporary staffing committees for oversight in relation to managing and reporting temporary staffing agency usage and reasons.

Trust Financial Performance - Financial Dashboard Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income	£370.5m	£26.5m	£26.4m	(£0.1m)	£145.2m	£144.7m	(£0.5m)	(0)%	
Pay	(£195.1m)	(£16.7m)	(£16.4m)	£0.3m	(£83.5m)	(£82.9m)	£0.6m	1%	
Non Pay	(£131.3m)	(£10.4m)	(£9.8m)	£0.7m	(£54.8m)	(£53.1m)	£1.7m	3%	
Financing & Adjustments	(£44.2m)	(£1.5m)	(£1.4m)	£0.1m	(£11.9m)	(£11.7m)	£0.2m	2%	
CONTROL TOTAL	**-**	**(£2.0m)**	**(£1.1m)**	**£0.9m**	**(£4.9m)**	**(£2.9m)**	**£2.0m**		
Memorandum Items									
Research & Development	£0.40m	£0.04m	(£0.15m)	(£0.20m)	(£0.08m)	(£0.49m)	(£0.42m)	(532)%	
Commercial Trading Units	£5.35m	£0.22m	£0.25m	£0.03m	£2.06m	£2.13m	£0.07m	3%	
ORIEL Revenue	(£3.96m)	(£0.37m)	(£0.19m)	£0.17m	(£1.60m)	(£0.86m)	£0.74m	46%	
Efficiency Schemes	£18.00m	£0.53m	£0.50m	(£0.03m)	£0.37m	£1.16m	£0.79m	215%	

Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income

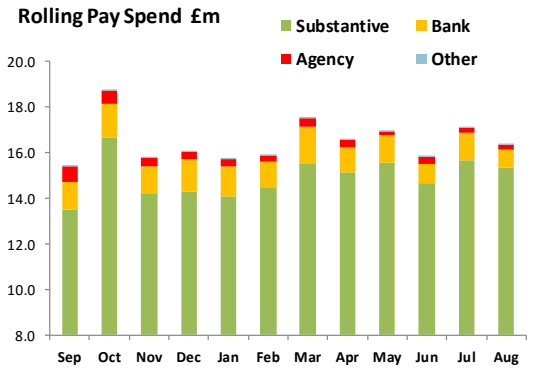
INCOME BREAKDOWN RELATED TO ACTIVITY

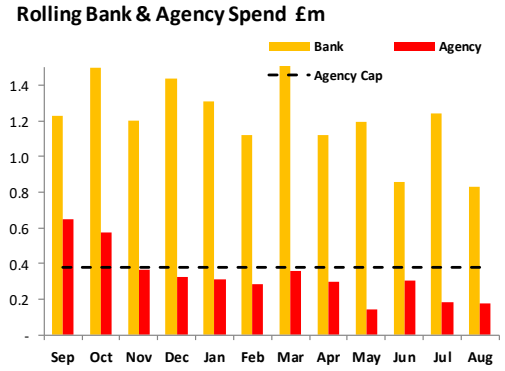
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£212.2m	£86.6m	£85.4m	(£1.2m)				
Pass Through	£40.2m	£16.2m	£16.9m	£0.7m				
Other NHS Clinical Income	£11.9m	£4.8m	£5.1m	£0.3m				
Commercial Trading Units	£48.4m	£19.6m	£19.6m	(£0.1m)				
Research & Development	£15.6m	£6.1m	£6.1m	(£0.0m)				
Other	£42.3m	£11.9m	£11.6m	(£0.3m)				
INCOME INCL ERF	**£370.5m**	**£145.2m**	**£144.7m**	**(£0.5m)**				

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	(£193.5m)	(£16.5m)	(£15.3m)	£1.2m	(£82.8m)	(£76.2m)	£6.6m	92%
Bank	(£0.5m)	(£0.0m)	(£0.8m)	(£0.8m)	(£0.2m)	(£5.2m)	(£5.0m)	6%
Agency	(£0.5m)	(£0.0m)	(£0.2m)	(£0.1m)	(£0.2m)	(£1.1m)	(£0.9m)	1%
Other	(£0.6m)	(£0.1m)	(£0.1m)	£0.0m	(£0.3m)	(£0.3m)	(£0.0m)	0%
TOTAL PAY	**(£195.1m)**	**(£16.7m)**	**(£16.4m)**	**£0.3m**	**(£83.5m)**	**(£82.9m)**	**£0.6m**	





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

*Agency cap levels set by NHSIE

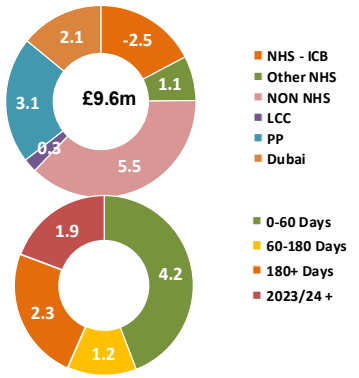
CASH, CAPITAL AND OTHER KPI'S

Capital Programme £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£5.6m)	(£0.3m)	(£0.1m)	(£0.2m)				
Donated/Externally funded	(£145.2m)	(£67.3m)	(£42.1m)	(£25.2m)				
TOTAL	**£150.8m**	**£67.6m**	**£42.2m**	**(£25.4m)**				

Key Metrics	Plan	Actual	RAG
Cash	59.4	85.3	
Debtor Days	45	10	
Creditor Days	45	38	
PP Debtor Days	65	49	

Better Payment Practice	Plan	Actual
BPPC - NHS (YTD) by number	95%	92%
BPPC - NHS (YTD) by value	95%	94%
BPPC - Non-NHS (YTD) by number	95%	97%
BPPC - Non-NHS (YTD) by value	95%	96%

Net Receivables/Ageing £m



Trust Income and Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income									
NHS Commissioned Clinical Income	252.32	19.31	19.20	(0.12)	102.79	102.27	(0.51)	(1)%	
Other NHS Clinical Income	11.87	0.89	1.03	0.14	4.80	5.13	0.34	7%	
Commercial Trading Units	48.42	3.71	3.63	(0.09)	19.62	19.57	(0.06)	(0)%	
Research & Development	15.60	1.29	1.40	0.11	6.14	6.11	(0.03)	(0)%	
Other Income	42.33	1.32	1.14	(0.18)	11.89	11.62	(0.28)	(2)%	
Total Income	**370.54**	**26.53**	**26.40**	**(0.13)**	**145.25**	**144.71**	**(0.54)**	**(0)%**	
Operating Expenses									
Pay	(195.07)	(16.66)	(16.37)	0.28	(83.48)	(82.87)	0.61	1%	
Of which: Unidentifed CIP	*7.32*	*0.34*	-	*(0.34)*	*3.15*	-	*(3.15)*		
Drugs	(43.23)	(3.25)	(3.79)	(0.54)	(17.82)	(19.14)	(1.33)	(7)%	
Clinical Supplies	(26.75)	(2.13)	(1.72)	0.41	(11.42)	(10.21)	1.21	11%	
Other Non Pay	(61.28)	(5.06)	(4.27)	0.79	(25.55)	(23.75)	1.80	7%	
Of which: Unidentifed CIP	*0.10*	*(0.10)*	-	*0.10*	*0.05*	-	*(0.05)*		
Total Operating Expenditure	**(326.33)**	**(27.10)**	**(26.16)**	**0.94**	**(138.27)**	**(135.98)**	**2.29**	**2%**	
EBITDA	*44.22*	*(0.57)*	*0.24*	*0.81*	*6.98*	*8.73*	*1.75*	25%	
Financing & Depreciation	(18.93)	(1.51)	(1.43)	0.08	(7.15)	(6.79)	0.37	5%	
Donated assets/impairment adjustments	(25.29)	0.05	0.04	(0.00)	(4.76)	(4.89)	(0.12)	(3)%	
Control Total Surplus/(Deficit)	**-**	**(2.03)**	**(1.14)**	**0.89**	**(4.94)**	**(2.95)**	**1.99**	**40%**	

Commentary

Operating Income

£0.13m adverse to plan in month

Total operating income is reporting £26.40m in-month, £0.13m adverse to plan, and £0.54m adverse cumulatively. Key points of note are:-

- Directly commissioned clinical income was £19.20m, £0.12m adverse to plan in-month.
- Underlying elective activity was at 95% (99% cumulatively). Elective activity was below plan in the north-east locality with Stratford activity at 100% and St Anns activity at 63% during August. St Georges were above plan at 121%.
- Commercial trading income was £3.63m, £0.09m adverse to plan.
- Research and Development income at £1.40m, £0.11m favourable to plan
- Other income was on £0.18m adverse to plan.

Employee Expenses

£0.28m favourable to plan in month

August pay is reporting £16.37m (2,757wte); £0.28m favourable to plan. Key points of note are:-

- Substantive pay costs (2,621wte) were £15.30m, higher than the prior 12 month average of £14.67m, and includes the national pay award and employers NI increases
- Temporary staffing costs were £1.01m in August.
  - Agency costs (12wte) are £0.18m in month, lower than the 12-month trend of £0.37m. Use continues mainly on administration in both clinical and corporate areas.
  - Bank costs (124wte) are £0.83m in month, lower than the rolling trend of £1.27m. Bank use continues to be mainly in clinical areas and within the medical staffing group.
  - £0.34m unachieved pay CIP (£3.15m cumulatively)

Non-Pay Expenses

£0.73m favourable to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in August were £9.78m, £0.66m favourable to plan. Key points of note are:-

- Drugs were £0.54m adverse to plan in month with £3.79m expenditure against a 12-month trend of £3.67m. Injections were at 106% of planned activity in month.
- Clinical supplies were £0.41m favourable to plan in month predominantly linked to lower activity v prior months. Costs were £1.72m in month against a 12-month trend of £2.07m.
- Other non-pay was £0.79m favourable in month with £4.27m expenditure against a 12-month trend of £5.01m.
- £0.10m over achieved non-pay CIP (£0.05m cumulatively underachieved)

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

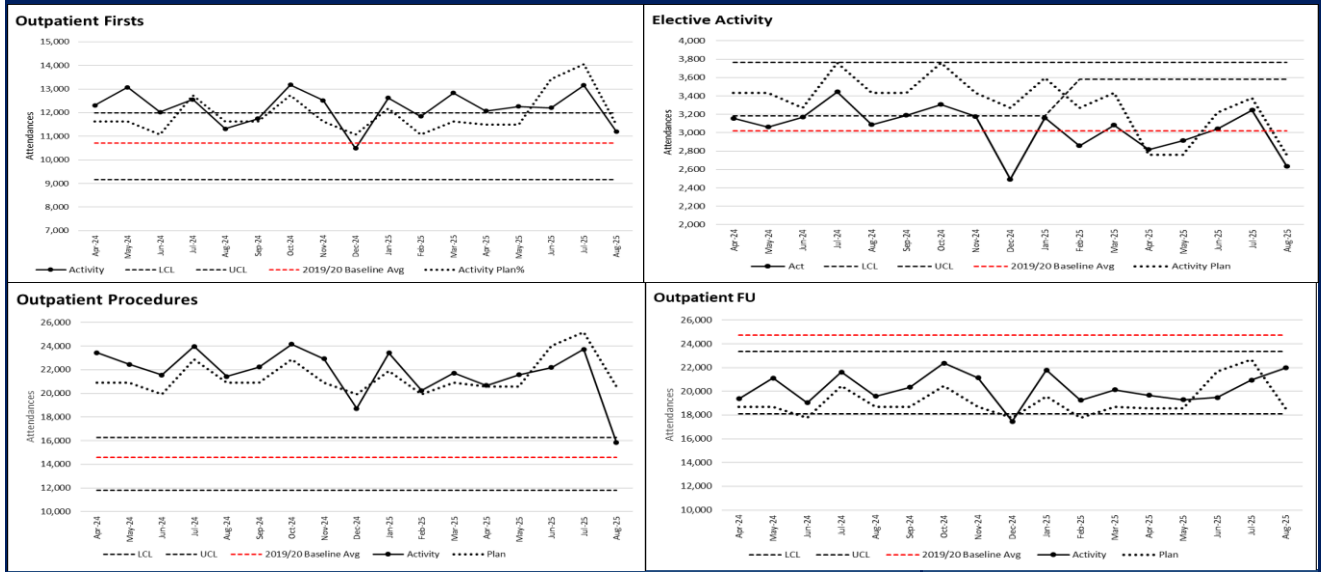
ER	Point of Delivery	Activity In Month				Activity YTD			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	2,761	2,637	(124)	96%	14,881	14,660	(221)	99%
	OP Firsts	11,499	11,201	(298)	97%	61,968	60,895	(1,073)	98%
	OP Procedures	20,585	15,851	(4,734)	77%	110,928	104,011	(6,917)	94%
	ERF Activity Total								
Non ERF Acti	OP Follow Ups	18,568	21,979	3,411	118%	100,059	101,351	1,292	101%
	High Cost Drugs Injections	4,282	4,556	274	106%	23,075	24,119	1,044	105%
	Non Elective	226	243	17	108%	1,117	1,278	161	114%
	AandE	6,217	6,164	(53)	99%	30,682	31,839	1,157	104%
	Total	64,138	62,631	(1,507)	98%	342,710	338,153	(4,557)	99%

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

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

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

ACTIVITY TREND - ERF COMPONENTS



Commentary

NHS Income

Contractual Status

The Trust has finalised contracts from ICB's and signed the documentation on the17th August. As contracts are finalised, income has been assumed based on the 2025/26 activity delivery to date.

2025/26 Activity performance achievement

- **Inpatient activity** achieved 95% in month and 99% year to date of the revised demand plan.
- **Outpatient Firsts Activity** achieved 97% of the revised demand plan in month; 98% year to date
- **Outpatient Procedures Activity** achieved 77% of revised demand plans in month; 94% cumulatively. Once fully coded this will return to planned levels

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 106% of activity plans in month; 105% year to date.
- **A&E** achieved 99% of activity plans in month; 104% year to date

ERF Achievement

Final 2024/25 ERF performance to March 2025 has now been published and full year performance is expected to be finalised in September 2025. Final ERF performance is in line with planning expectations.

Activity plans and ERF

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

- 2024/25 performance for ERF is now confirmed to month 12 but with the year end performance finalised in September 2025.
- 2025/26 ERF reporting from NHSE will be the same as 2024/25. IAPs are being agreed with commissioners regarding the funded levels of activity for this year.

Activity Plans

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

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

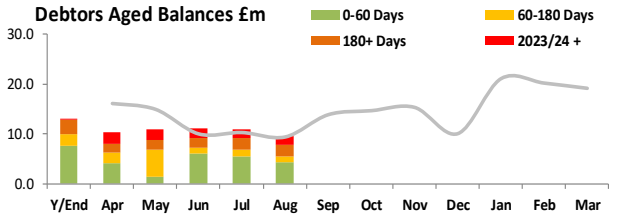
CAPITAL EXPENDITURE

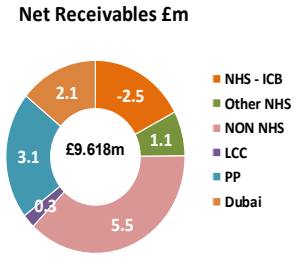
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Medical Equipment	0.2	0.0	0.1	0.1
Estates	1.3	0.0	0.1	0.0
IMT	0.1	0.0	-	(0.0)
Commercial	0.5	0.2	0.0	(0.1)
Network Strategy	-	-	-	-
Other - Trust funded	4.5	0.1	-	(0.1)
Oriel Programme	145.2	67.3	53.5	(13.8)
EPR Project	7.9	2.6	1.8	(0.8)
NiHR Capital Grant	-	-	-	-
Other & Charity	0.5	0.2	0.1	(0.1)
IFRS16	5.1	-	-	-
TOTAL INCLUDING DONATED	**165.2**	**70.4**	**55.6**	**(14.8)**

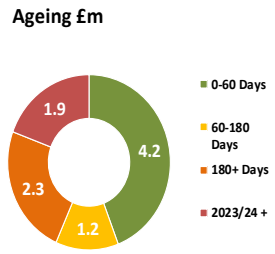
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Depreciation	11.9	11.9	-	100%
Cash Reserves - Oriel	-	-	-	-
Cash Reserves - B/Fwd	0.1	0.1	-	100%
Capital Loan Repayments	(1.8)	(1.8)	-	100%
TOTAL - ICS Allocation	**10.2**	**10.2**	**-**	**100%**
IFRS 16 Leases	5.1	5.1	-	100%
Externally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

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2022/23 +*	*Total*
CCG Debt	0.0	(2.6)	-	0.0	(2.5)
Other NHS Debt	0.3	0.4	0.2	0.2	1.1
Non NHS Debt	1.2	2.2	1.0	1.1	5.5
Commercial Unit Debt	2.7	1.2	1.1	0.5	5.6
TOTAL RECEIVABLES	**4.2**	**1.2**	**2.3**	**1.9**	**9.6**







STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Non-current assets	597.3	480.0	490.3	10.2
Current assets (excl Cash)	29.8	29.8	27.9	(1.9)
Cash and cash equivalents	62.7	59.4	85.3	25.9
Current liabilities	(45.9)	(46.1)	(63.1)	(17.0)
Non-current liabilities	(288.0)	(211.2)	(240.2)	(28.9)

OTHER METRICS

Use of Resources	Plan	Current Month	Prior Month
BPPC - NHS (YTD) by number	95%	92%	92%
BPPC - NHS (YTD) by value	95%	94%	94%
BPPC - Non-NHS (YTD) by number	95%	97%	97%
BPPC - Non-NHS (YTD) by value	95%	96%	96%

Commentary

Cash and Working Capital

The cash balance as at the 31st August was £85.3m, a reduction of £0.8m since the end of March 2025.

Capital Expenditure/ Non-current assets

Capital expenditure as of 31st August totalled £55.6m, predominantly Oriel related/EPR related.

Business as usual capital £10.2m

- £6.7m (66%) has been committed.
- Critical infrastructure, fire remediation, and high priority EBME equipment have been prioritised along with previously committed expenditure. Initial costs for the Ealing site have been committed in advance of the final approval of the FBC.
- Remaining capital commitments are held in abeyance awaiting finalisation of key projects including, EPR budget programme finalisation, Ealing site options, Oriel adjacent costs and ICT BAU and ICT transition to Oriel cost implications; including potential external funding options thereof for the above.
- IFRS16 expenditure is planned from September 2025 subject to pending leases, rent reviews and negotiations.

Receivables

Receivables have reduced by £3.3m to £9.6m since the end of the 2024/25 financial year. Debt in excess of 60 days reduced by £0.2m in August and current reduced by £1.2m.

Payables

Payables totalled £13.4m at the end of August, a reduction of £7.3m since the end of March 2025.

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

- 97% volume of invoices (prior month 97%) and
- 96% value of invoices (prior month 96%).

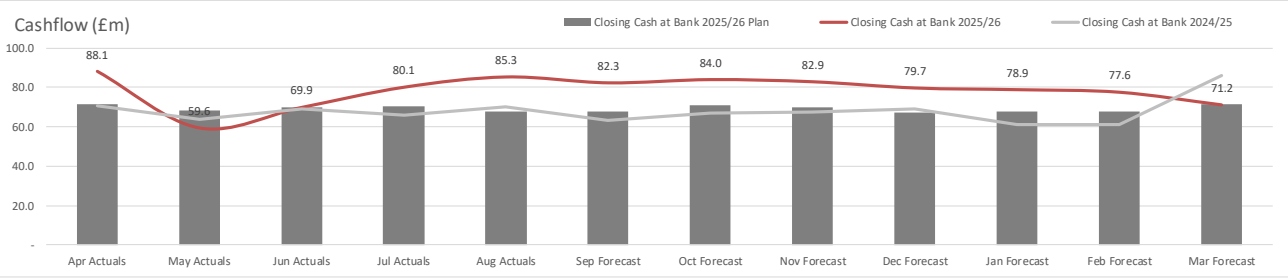
Use of Resources

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 Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Aug Forecast	Aug Var
Opening Cash at Bank	**86.1**	**88.1**	**59.6**	**69.9**	**80.1**	**85.3**	**82.3**	**84.0**	**82.9**	**79.7**	**78.9**	**77.6**	**86.1**		
Cash Inflows															
Healthcare Contracts	22.0	20.9	22.5	23.0	25.1	21.7	24.6	21.8	20.1	21.0	21.7	22.8	267.3	20.1	5.1
Other NHS	4.3	1.6	0.6	3.2	3.6	1.3	1.4	1.4	1.2	1.4	1.3	1.3	22.7	1.2	2.3
Moorfields Private/Dubai/NCS	4.4	3.8	4.0	4.5	4.1	4.0	4.2	4.4	3.4	4.6	4.1	4.1	49.6	3.7	0.4
Research	0.9	0.9	1.9	0.8	1.0	1.3	1.3	1.3	1.3	1.3	1.3	1.3	14.5	1.3	(0.4)
VAT	2.2	0.0	2.3	-	1.6	1.1	1.1	1.1	1.1	1.1	1.1	1.1	13.8	1.1	0.5
PDC / Loan	-	-	19.6	14.0	14.5	3.7	12.9	14.2	7.9	10.7	8.7	3.1	109.4	14.5	-
Charity Donation	-	-	5.0	-		10.0	-	-	5.0	-	-	5.9	25.9	-	-
Other Inflows	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.8	**0.2**	0.0
Total Cash Inflows	**34.1**	**27.5**	**56.1**	**45.7**	**50.1**	**43.4**	**45.8**	**44.4**	**40.2**	**40.3**	**38.5**	**39.7**	**505.9**	**42.2**	**7.9**
Cash Outflows															
Salaries, Wages, Tax & NI	(14.1)	(14.6)	(14.8)	(14.8)	(15.7)	(15.3)	(15.2)	(15.2)	(15.2)	(15.2)	(15.2)	(15.2)	(180.5)	(15.8)	0.1
Non Pay Expenditure	(15.5)	(12.0)	(11.6)	(12.8)	(10.2)	(13.5)	(13.8)	(13.8)	(13.0)	(13.0)	(13.0)	(13.2)	(155.0)	(13.5)	3.3
Capital Expenditure	(0.8)	(0.7)	(0.6)	(0.7)	(0.1)	(1.0)	(1.0)	(2.4)	(1.0)	(1.0)	(1.0)	(5.8)	(16.1)	(1.0)	0.9
Oriel	(0.2)	(27.6)	(17.3)	(5.9)	(16.8)	(13.7)	(12.9)	(12.8)	(12.9)	(10.7)	(8.7)	(9.1)	(148.8)	(16.8)	0.0
Moorfields Private/Dubai/NCS	(1.4)	(1.1)	(1.4)	(1.3)	(1.5)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(15.9)	(1.3)	(0.2)
Financing - Loan repayments	-	-	-		(0.6)	(1.6)	-	-	-	-	(0.6)	(1.6)	(4.3)	(0.6)	0.0
Dividend Payable	-	-	-		-	-	-	-	-	-	-	-	-	-	-
Total Cash Outflows	(32.0)	(56.1)	(45.8)	(35.6)	(44.9)	(46.3)	(44.2)	(45.5)	(43.4)	(41.1)	(39.8)	(46.1)	**(520.7)**	**(49.0)**	**4.0**
Net Cash inflows /(Outflows)	2.1	(28.6)	10.4	10.2	5.2	(3.0)	1.6	(1.1)	(3.1)	(0.8)	(1.3)	(6.4)	(14.9)	(6.7)	11.9
Closing Cash at Bank 2025/26	**88.1**	**59.6**	**69.9**	**80.1**	**85.3**	**82.3**	**84.0**	**82.9**	**79.7**	**78.9**	**77.6**	**71.2**	**71.2**		
Closing Cash at Bank 2025/26 Plan	71.4	68.0	69.6	70.5	67.9	67.5	70.7	69.7	67.2	67.6	67.5	71.2	71.2		
Closing Cash at Bank 2024/25	70.4	63.9	69.2	65.9	70.1	63.4	67.1	67.5	68.8	61.4	61.0	**86.1**	86.1		



Commentary

Cash flow

The cash balance as at the 31st August was £85.3m, a reduction of £0.8m since the end of March 2025.

The trust currently has 96 days of operating cash (prior month: 90 days).

August cashflow saw a £5.2m inflow against a forecast outflow of £6.7m due to additional receipts of NHS income and timing of supplier payments.

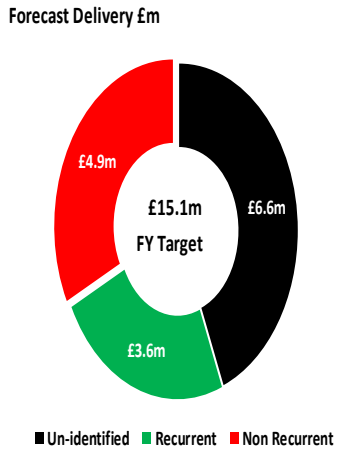
The current forecast cash balance to the end of the financial year is £71.2m in line with plan.

2025/26 Trust Board Efficiency Scheme Performance Reporting

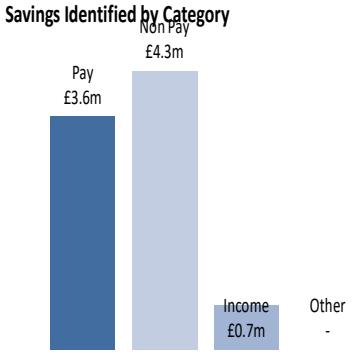
EFFICIENCY SCHEMES PERFORMANCE

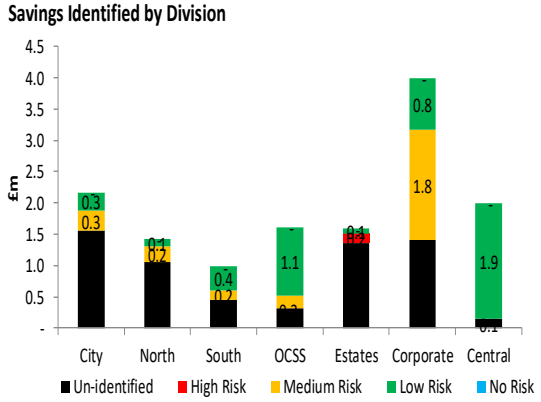
Efficiency Schemes £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Plan	Forecast Actual	Forecast Variance
City Road	£2.17m	£0.18m	£0.20m	£0.02m	£0.90m	£0.29m	(£0.61m)	£2.17m	£0.62m	(£1.55m)
North	£1.43m	£0.12m	£0.12m	£0.00m	£0.59m	£0.12m	(£0.47m)	£1.43m	£0.36m	(£1.06m)
South	£0.98m	£0.08m	£0.05m	(£0.03m)	£0.41m	£0.14m	(£0.27m)	£0.98m	£0.54m	(£0.44m)
Ophth. & Clinical Serv.	£1.62m	£0.13m	£0.23m	£0.10m	£0.67m	£0.57m	(£0.10m)	£1.62m	£1.29m	(£0.32m)
Research & Development	£0.49m	£0.04m	-	(£0.04m)	£0.20m	-	(£0.20m)	£0.49m	£0.50m	£0.01m
Trading	£0.83m	£0.07m	-	(£0.07m)	£0.35m	-	(£0.35m)	£0.83m	£0.48m	(£0.35m)
Corporate	£5.59m	£0.47m	£0.27m	(£0.20m)	£2.33m	£0.89m	(£1.44m)	£5.59m	£2.82m	(£2.76m)
DIVISIONAL EFFICIENCIES	**£13.10m**	**£1.09m**	**£0.87m**	**(£0.22m)**	**£5.46m**	**£2.02m**	**(£3.44m)**	**£13.10m**	**£6.62m**	**(£6.48m)**
Central	**£2.00m**	**£0.19m**	**-**	**(£0.19m)**	**£0.96m**	**-**	**(£0.96m)**	**£2.00m**	**£1.85m**	**(£0.15m)**
INTERNAL EFFICIENCIES	**£15.10m**	**£1.28m**	**£0.87m**	**(£0.41m)**	**£6.42m**	**£2.02m**	**(£4.40m)**	**£15.10m**	**£8.47m**	**(£6.63m)**
Adjustment to external plan	£2.90m	(£0.76m)	-	£0.76m	(£4.77m)	-	£4.77m	£2.90m	-	(£2.90m)
TRUST EFFICIENCIES	**£18.00m**	**£0.53m**	**£0.87m**	**£0.34m**	**£1.65m**	**£2.02m**	**£0.37m**	**£18.00m**	**£8.47m**	**(£9.53m)**

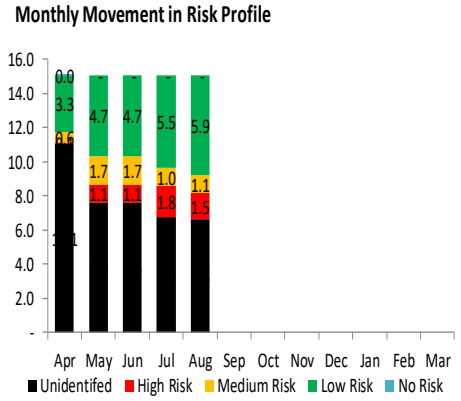
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







* charts may include rounding differences

Commentary

Governance & Reporting

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

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

In Year Delivery

The trust is reporting efficiency savings achieved of:-

- £0.87m in month, compared to a plan of £0.53m, £0.34m favourable to plan; and
- £2.02m year to date, compared to a plan of £1.65m, £0.37m favourable to plan.

The Trust has an efficiency plan with delivery more towards half two of the financial year.

- Compared to a straight-line savings plan which would assume delivery evenly across the year the Trust would be reporting £0.3m adverse in month and £4.27m adverse YTD.

Identified Savings

The trust has identified £8.47m, £6.63m adverse to plan.

Of the total identified:-

- £1.9m is identified central schemes
- £0.70m is identified as income generation schemes;
- £3.5m is forecast recurrently;

The CIP programme board are working through further efficiency scheme delivery for full financial validation towards increasing the level of identified and forecast delivery in 2025/26.

£11.5m represents the value of un-identified and non-recurrently identified savings.

Risk Profiles

The charts to the left demonstrates the

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

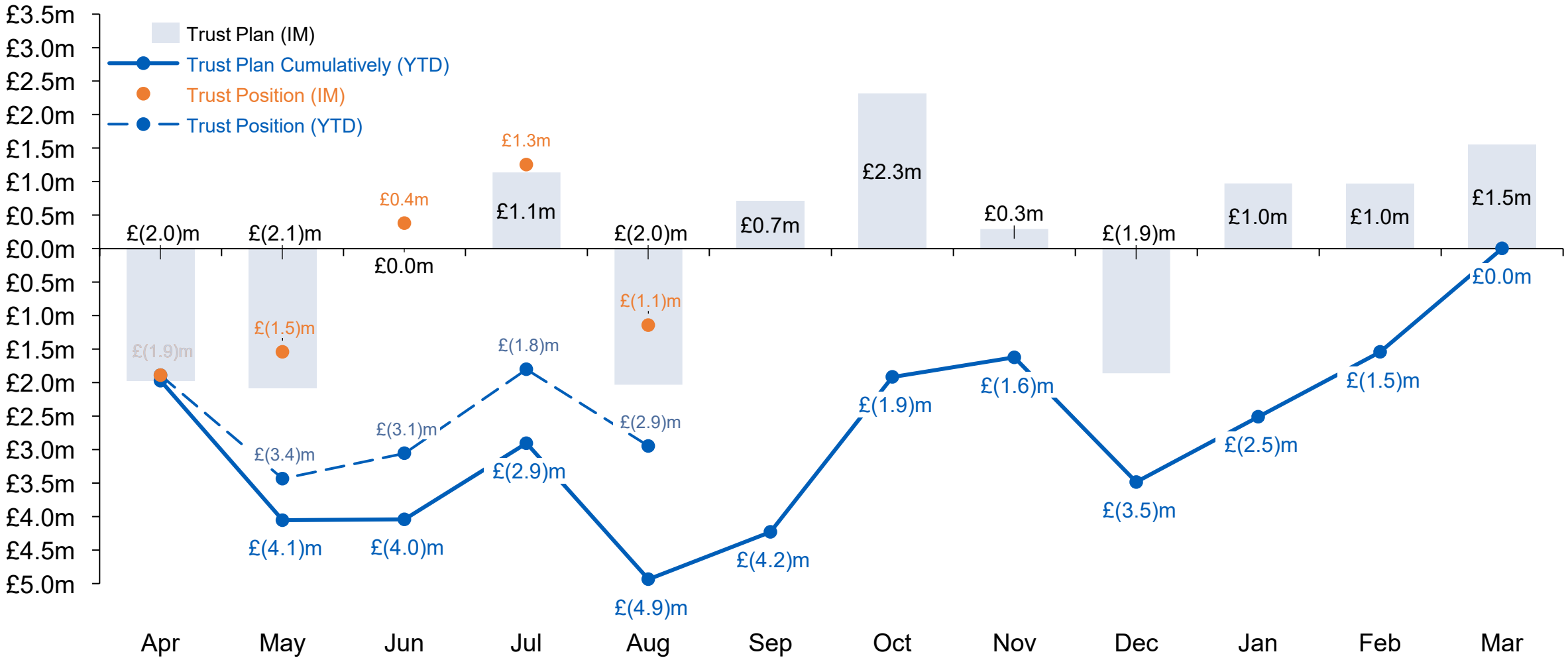
Supplementary Information

Moorfields Eye Hospital NHS Foundation Trust

NHS

The Trust financial performance is £1.1m deficit in month, £2.9m deficit YTD

For August the trust reported a **£1.1m deficit IM**, £0.9m favourable to the plan of £2.0m in month.
Cumulatively the trust is reporting **a £2.9m deficit YTD**, £2.0m favourable to the £4.9m planned deficit YTD.
The Trusts financial plan is predicated on the delivery of efficiency savings of £15.1m which has a material impact on in month and cumulative financial plans.



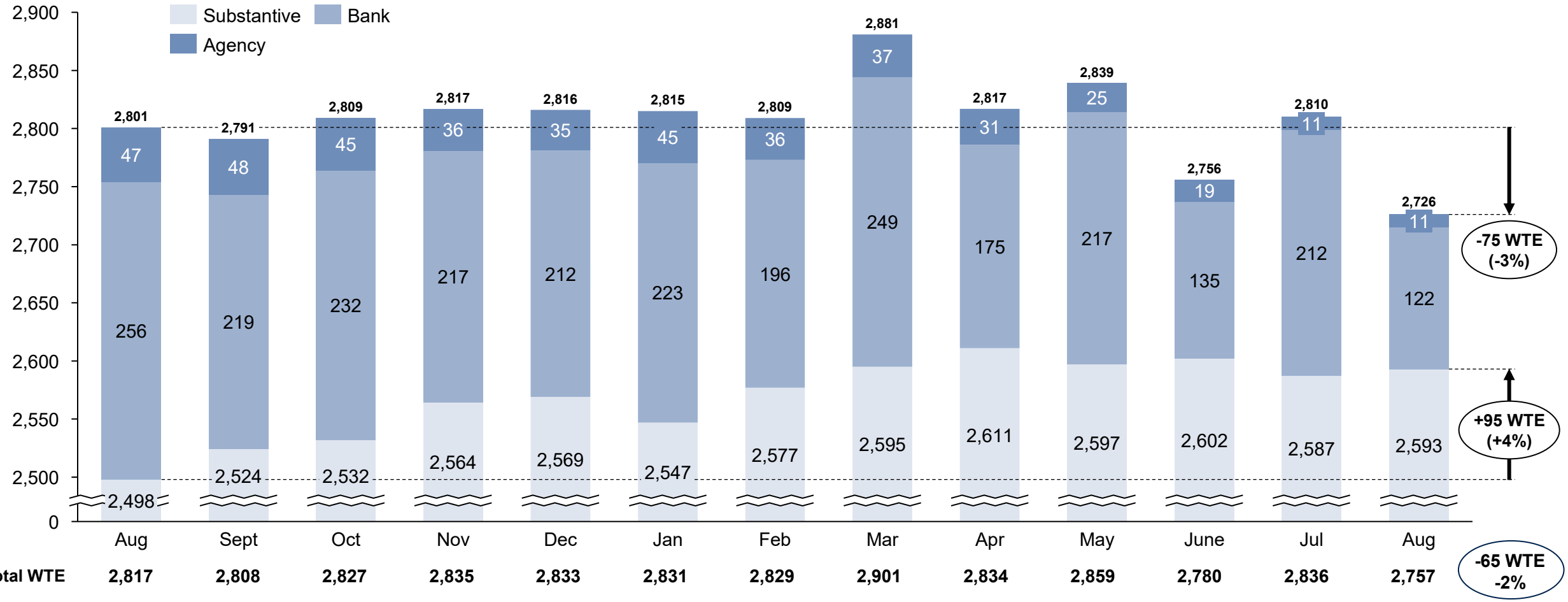
The Trusts financial plan is predicated on typical assumptions for income and expenditure categories as laid out below, including efficiencies which due to its size (£15.1m) has a material impact on in month and cumulative financial plans. Planning assumptions have included:-

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

Workforce WTE Trend reporting

The below chart reports the worked Whole Time Equivalent (WTE)*# for a rolling 12 months, excluding EPR, Oriel, and IT Projects. Total trust WTE is shown below the chart. National planning guidance includes the requirement to reduce spend on temporary staffing& and support functions.

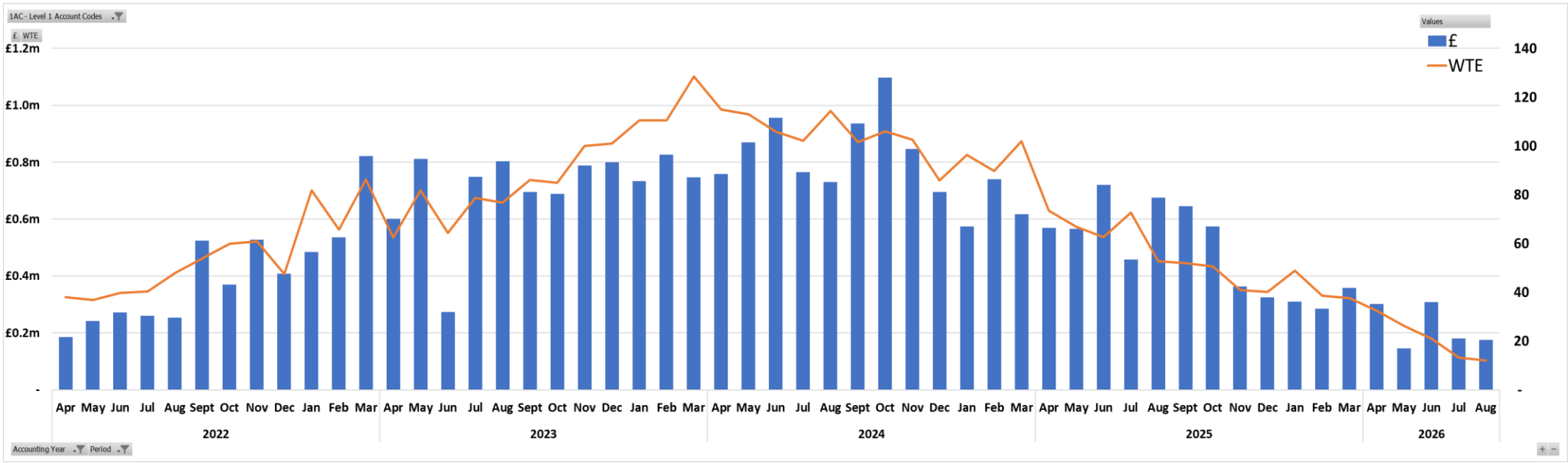
- WTE Trends are reported by pay type, staff type, staff group, division and department further in this pack.
- Total WTE **excluding EPR/Oriel and IT** projects have changed by -75 WTE from the same period last year. Substantive staff have changed by +95 WTE.



	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug
Total WTE	**2,817**	**2,808**	**2,827**	**2,835**	**2,833**	**2,831**	**2,829**	**2,901**	**2,834**	**2,859**	**2,780**	**2,836**	**2,757**

&National planning expectations are agency reductions of 30%, bank reductions of 10%, and corporate support functions to reduce growth since 2018/19 by 50% by quarter 3 of 2025/26
*WTE during March is often impacted by annual leave and backfill and can't be used as a baseline WTE for reductions in year.
#Financial ledger WTE reporting has known and legitimate differences to Workforce WTE reporting. Workforce reporting should be used for formal analysis and narrative.
Bank and agency WTE are derived from Healthroster and are subject to staff adding, correcting and finalising rotas in a timely manner, and can including retrospective corrections.

Workforce – Agency Reporting in Board Report



Moorfields Eye Hospital NHS Foundation Trust

Guardian of Safe Working
Board of directors
2 October 2025

Report title	Guardian of Safe Working Report
Report from	Louisa Wickham, Medical Director
Prepared by	Andrew Scott, Guardian of Safe Working
Link to strategic objectives	We will attract, retain and develop great people

Brief summary of report

The guardian of safe working report summarises progress in providing assurance that doctors are safely rostered, and their working hours are compliant with the 2016 terms and conditions of service (TCS) for doctors in training. This report encompasses the period from 20th March 2025 to 16th September 2025.

Exception Reports:

During this timeframe, no Exception Reports have been submitted. There have been no instances reported of breaching the mandatory 8-hour rest period between shifts, exceeding the 48-hour average working week, or surpassing the 72-hour maximum limit within any seven-day period. Consequently, no financial penalties were incurred.

At the resident induction in August, I have reminded and encouraged all new residents to Exception Report to better support doctors working beyond their contracted hours. I also gave them an update about exception report reforms secured by the BMA resident doctors committee (UKRDC). They have been reassured that Moorfields will respect the deadline for implementing these reforms. Though the initial September 12, 2025 date is no longer viable due to the BMA dispute, a new timeline has been agreed for updating the relevant Terms and Conditions of Service (TCS), which will be published by September 19, 2025.

Rota issues:

At Moorfields, rotas are divided internally into the Lower House (ST1–ST4), who are first on call for night shifts, and the Upper House (ST5 and above). This division is not stipulated by the College as a training requirement.

Two less-than-full-time (LTFT) trainees were initially allocated to an Upper House work schedule, which they received eight weeks before starting their rotations in August. However, following late communication from the London Deanery, this allocation was deemed incorrect, as the trainees had not yet completed 48 months of Lower House training. As a result of this unfortunate delay, they were required to move to the Lower House rota from November onwards.

Moves of this sort can have implications for affected trainees in terms of reduced speciality exposure, achieving required training competencies and work-life balance. In response, College Tutors, the Medical Director, the Director of Education, and I will be meeting with the residents in a dedicated forum next month to seek a resolution and ensure this situation does not recur. Suggestions raised include:

- College Tutors verifying the accuracy of information received from the Deanery before issuing work schedules.
- Reserving Vitreoretinal service rotations (which do not include night-shift commitments) exclusively for Upper House trainees, to avoid creating Lower House rota gaps.

- Exploring the option of funding locum cover for Lower House rota gaps using LTFT funding provided by the Deanery, as LTFT trainees are funded at 100%, unlike full-time trainees who only receive partial funding.

High level data:

Number of doctors in training (total):	58
Amount of time available in job plan for guardian to do the role:	1 PA/week
Admin support provided to the guardian (if any):	Ad Hoc provided by HR
Amount of job-planned time for educational supervisors:	1 PA per week

Summary

All Moorfields trainees are safely rostered in compliant rota patterns with no breaches of the terms and conditions of service occurring during this reporting period. All trainees are familiar with the process of exception reporting and there are systems in place to ensure prompt compensation payment for excessive hours worked and mechanisms in place to rectify unfavourable working conditions. The low frequency of exception reporting reflects the trainees' well-being and satisfaction with their working conditions.

Trainee morale remains high, supported by a strong culture of dispute resolution and a clear commitment to enhancing the working lives of all our residents.

Quality implications

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

Financial implications

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

Risk implications

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

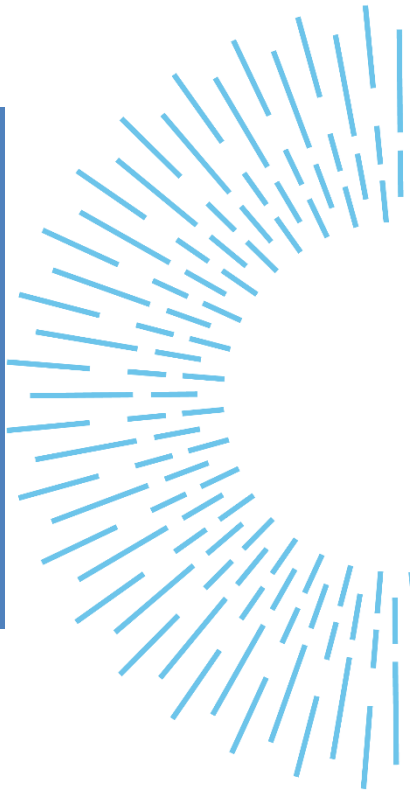
Action required/recommendation.

The board is asked to consider the report for assurance.

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

Moorfields Eye Hospital NHS Foundation Trust

Appraisal & Revalidation Annual Report
Board of directors
2 October 2025



Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	
Comments:	Dilani Siriwardena remains as Responsible Officer and Miriam Minihan remains as appraisal lead.
Action for next year:	Maintain support for RO and ensure ongoing CPD to remain compliant.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes (developing but still an area of risk)
Action from last year:	Establish dedicated role for Appraisal and Revalidation
Comments:	In last year's report, the need for a new dedicated Revalidation Manager role was highlighted as critical. However, HR (Medical HR included) has undergone a broader restructure with cost reduction requirements and the previously proposed structure did not progress. Instead, within the new model, appraisal and revalidation remain under Head of Medical HR, supported by: • A general Medical HR Advisor Band 4 role to reenforce notion for providing dedicated administrative support, • Oversight from the Medical HR Manager (in post since July 2025, having replaced previous postholder that started in Sept 2024 and left in Feb 2025), and • Strategic leadership from the Head of Medical HR (in post since September 2024). This team will be responsible for building and implementing standard operating procedures (SOPs) to support appraisal and revalidation, ensuring improved governance and sustainability.

	The current Responsible Officer role is not specifically funded, but is undertaken by one of the Deputy Medical Director roles. The Medical Directorate is also undergoing a parallel restructure aimed at strengthening governance, and an allocation of 1PA will be specifically assigned to the Responsible Officer role.
Action for next year:	Fully embed the Band 4 role, implement SOPs, and align Medical HR and Medical Directorate governance structures.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	
Comments:	Processes for recording and maintaining accurate data on prescribed connections have improved significantly, with occasional data cleanses. Integration with HR (e.g. fixed-term end dates) will further strengthen governance. A particular area requiring focus is the high number of “bank-only” doctors**.** This presents challenges for oversight, as these doctors may not have substantive roles and their clinical practice may be undertaken across multiple organisations. The Trust recognises the need to review these arrangements more widely, both to: • Establish more substantive roles where appropriate, • Reduce reliance on bank and agency staff, and • Strengthen governance of prescribed connections to ensure adequate oversight of clinical practice.
Action for next year:	Undertake a review of all bank-only prescribed connections, align with workforce planning to reduce reliance on bank/agency spend, and ensure oversight of where and how clinicians practise.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	
Comments:	The Trust’s Appraisal and Revalidation Policy was reviewed and approved in June 2024 and is monitored with an enabler plan. However, an important area for improvement is the SPA tariff for appraisers, which is not formally in place. NHS England guidance emphasises that appraisers should have time allocated in their job plans to undertake appraisals. Currently, there is significant imbalance, with some appraisers

	completing as many as 28 appraisals while others have undertaken only one or two in recent years.
Action for next year	Review and formalise SPA tariff; audit appraiser workload distribution; introduce appraisal audits; hold appraisers to account for quality.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	
Comments:	No external review this year, and an apparent Higher-Level Responsible Officer Review in August 2023. However, the appointment of the Head of Medical HR in September 2024 effectively acted as an internal review, highlighting areas of weakness and driving improvements. In addition, the new Medical HR Manager (in post since July 2025), also brings another perspective with a wealth of experience in the field.
Action for next year:	Time is required to refresh and continue to review processes, if not over the next year, during the following year, the Trust should seek external peer review for benchmarking. (2026/2027)

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	
Comments:	Fellows previously underwent paper-based reviews that did not meet GMC/NHSE requirements. Now, fellows receive Premier IT logins for appraisals, ensuring compliance. This formalisation increases workload for appraisers and HR. With no SPA tariff for appraisers, capacity pressures persist. The Trust must ensure sufficient trained appraisers and avoid appraisal delays.
Action for next year	Review and strengthen appraisal arrangements for fellows, ensuring compliance with national requirements, adequate appraiser capacity, and timely completion of all appraisals.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	
Comments:	Medical appraisal rate has improved from a previous low of 68% and currently maintaining above the 80% rate for the last 6 months. The Trust uses the Premier IT system to record appraisals. While the system has been essential for compliance, it has proved ineffective on the administrative side and challenging to use for both appraisees and appraisers. To mitigate this, automated notifications have been set up to remind users of upcoming appraisal due dates, with the Responsible Officer "supercharging" the reminder format. In addition, the Head of Medical HR follows up directly with clinicians whose appraisal is due but incomplete, providing resources and requesting resolution by month end. Despite these improvements, further work is needed to: • Improve the user experience and administrative efficiency of the system, • Ensure clinicians are confident in where to access the information needed to prepare for appraisal, and • Embed a culture where appraisal is understood as a professional obligation that must be completed on time.
Action for next year:	Review system effectiveness and user experience; strengthen cultural ownership of timely appraisals through training, resources, and consistent follow-up.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	
Comments:	Missed appraisals typically arise from: • Incorrect due dates in the system, • Confusion about designated body connections, • New joiners with overdue appraisals. Appraisals are managed via Premier IT, which is difficult to administer and use. Automated reminders have been introduced and “supercharged” by the RO. The Head of Medical HR follows up with overdue clinicians, providing resources and requesting completion. Despite progress, the system requires strengthening to reliably track due dates, improve advance communication, and establish consistent escalation up to GMC referral if necessary. This is a cultural as well as technical issue, requiring change management.
Action for next year:	Eliminate administrative causes of missed or delayed appraisals by improving system access, accuracy, prescribed connection management, and escalation pathways; embed culture change so appraisals are completed on time as standard.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board’s approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	
Comments:	Reviewed and approved June 2024; monitored against national standards.
Action for next year:	Continue review cycle; update with any NHSE/GMC changes.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	
Comments:	The Trust has 64 appraisers, a ratio of 5 appraisees per appraiser. However, workload distribution is highly uneven, with some appraisers undertaking 20+ appraisals and others very few. Absence of a formal SPA tariff compounds this.
Action for next year:	Formalise tariff/job plan time, rebalance workload, and audit activity/quality.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	
Comments:	The Clinical Appraisal Lead (appointed November 2023) plays a key role in supporting appraisers. From 2025, the Appraisal Lead will host an annual appraiser workshop designed to empower appraisers to deliver effective, consistent, and constructive appraisals. In addition, refresher licences for appraisers have been obtained, ensuring compliance with system requirements. The Trust recognises the need to maintain a clear record of appraiser training and development**.** This will ensure that appraisers are equipped with the tools and confidence to hold meaningful conversations, deliver high-quality appraisals, and support robust revalidation outcomes.
Action for next year:	Establish annual appraiser workshops; build and maintain a training and development record for all appraisers; ensure calibration, accountability, and continuous quality improvement.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	
Comments:	Appraisal paperwork is robustly scrutinised at point of revalidation preparation, and any concerns or gaps in paperwork are discussed. These are reported to Board via this paper. However, there is more quality assurance that can be put in place to help embed appraisal and revalidation At present the sense checking and quality assurance falls within Responsible Officer, Appraisal Lead, and Head of Medical HR. there is an opportunity to follow NHS England recommendations and introduce ASPAT tool, and also to create awareness of this among Appraisers and Appraisees to improve quality of input and outputs.
Action for next year:	Consider introduction of ASPAT tool

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	
Comments:	Clinicians are better prepared for Revalidation They are encouraged to ensure that required information is part of portfolio. We can now recommend a revalidation up to 12 months in advance and are beginning to write to individuals to inform them and ensure that they are prepped for this to avoid disappointment or delay. In addition to this we are also reviewing and ensuring that compulsory aspects, such as 360 appraisals are completed 2 years in advance of revalidation, and advance notice is given, to avoid deferral due to running out of time. This is a work in progress.
Action for next year:	Ensure recommendations are made within expected timelines and where this doesn't happen, the reasons are recorded and understood.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	**Yes**
Action from last year:	
Comments:	Doctors are part of the decision-making process. We request all information to be on file at least two weeks in advance of Revalidation due date and this has been put into the new policy and is now being encouraged.
Action for next year:	No action required.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	
Comments:	Clinical governance systems were strengthened through regular reporting to the Board, ongoing clinical audit activity, and the ratification of an updated MHPS policy (February 2025) to support consistent handling of conduct and performance concerns. Freedom to Speak Up processes and quarterly reporting also contributed towards encouraging an open and transparent culture. Moorfields fosters an environment where doctors are supported to deliver safe, high-quality care through clear governance structures, improved robustness of appraisal and revalidation processes, and an emphasis on fairness, equity, and transparency.
Action for next year:	Embed the new MHPS policy by delivering training for case managers and investigators, strengthen Board oversight of governance data through enhanced reporting.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	A new Maintaining High Professional Standards *(MHPS)* policy was ratified by the Board and published in February 2025. Due to other organisational priorities, minimal activity in this area, and a key vacancy, implementation of the

	project plan to embed the policy (including training and allocation of case managers) was deferred.
Comments:	The MHPS policy provides a clear framework for monitoring doctors' conduct and performance, aligned with national standards. While the policy is in place, full operationalisation—including awareness raising, structured training, and establishment of case managers—remains outstanding.
Action for next year:	The project plan will be initiated to operationalise the policy. Case managers and investigators will be appointed and trained in line with the MHPS policy and national frameworks to ensure consistency, fairness, and compliance.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	**Yes**
Action from last year:	
Comments:	There has been a historical checklist for the purposes of Revalidation that includes MAST compliance, CPD, Colleague and Patient Feedback, Complaints and Incidents reports, Audit reports, including various declarations. These are accessible via pathways and should be visible for clinicians to be able to obtain this information. In the last year, an information page was created for the intranet to help any clinician that may have questions, and a starter pack was created to include NHS England factsheets, and systems quick user guide.
Action for next year:	Continue to raise awareness of these components of appraisal, and signposting

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	
Comments:	Moorfields Eye Hospital have processes to ensure that information about doctors is shared securely between responsible officers and relevant governance leads across organisations. For doctors primarily connected to Moorfields but who also practise elsewhere, the Responsible Officer (RO) ensures that any concerns or relevant information are communicated to the other organisation's RO through established NHS England protocols and secure communication channels (using MPIT and similar

	variations). Similarly, for doctors whose prescribed connection is with another organisation but who also work at Moorfields, the RO seeks and shares relevant information, ensuring that governance oversight is comprehensive and consistent across all practice settings.
Action for next year:	We need to refine the process of obtaining information or confirming lack of concerns in a more efficient way to reduce the length of time that it takes to produce a return

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	
Comments:	Concerns about doctors are overseen by the Responsible Officer (RO) and Medical Director. Each case is reviewed to ensure fairness, proportionality, and adherence to national guidance. A quality assurance process is in place whereby data on the number, type and outcomes of concerns is collated, analysed, and reported through governance committees up to the Trust Board. This analysis includes demographic information such as doctors' protected characteristics and country of primary medical qualification, enabling the Trust to monitor for any evidence of bias or disproportionate impact. The RO / Medical Director feeds back to the Board, providing assurance that all concerns are handled appropriately, outcomes are consistent, and patterns are identified and addressed. This oversight allows Moorfields to strengthen its systems continually and ensure alignment with GMC expectations and the Trust's values of equity, excellence and kindness.
Action for next year:	The mechanism and process of this could do with a review as part of the implementation of updated MHPS policy

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	

Comments:	Established processes were maintained to ensure communication between the Responsible Officer (RO) at Moorfields and ROs in other organisations. Information sharing took place via secure channels in line with NHS England guidance, particularly during appraisals, revalidation, and when managing concerns. The system functions, with the RO engaging proactively with counterparts at other trusts and designated bodies. Information flows are documented to provide assurance and to demonstrate compliance with national governance expectations.
Action for next year:	Continue to embed this process by ensuring all information transfers are formally logged and reviewed through governance reporting. Strengthen links with external ROs by agreeing consistent escalation and feedback mechanisms, and provide refresher training for those involved in information governance to support safe and timely communication.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	
Comments:	We are fortunate that we do not have many instances to deal with here at Moorfields. Concerns about a doctor's practice are managed in line with the GMC's governance handbook and Trust policy, with clear escalation pathways, oversight from the Responsible Officer and Medical Director, and reporting through our clinical governance structures. Independent case investigators are used where appropriate, and equality, diversity and inclusion (EDI) considerations are embedded throughout the process. Safeguards also include access to Freedom to Speak Up Guardians, HR support, and confidential staff support services to ensure doctors are treated equitably and with respect. Outcomes and actions are reviewed at executive and Board level to provide assurance that governance processes are applied consistently and without prejudice. In the last few years, Moorfields has strengthened its appraisal and revalidation processes, ensuring that feedback and concerns are handled objectively, supported by external advice (GMC) where needed, and monitored through regular clinical governance audits. This provides assurance that doctors' practice is scrutinised fairly, in line with both national standards and our organisational values of equity, excellence and kindness.

Action for next year:	

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	
Action from last year:	At Moorfields Eye Hospital we have networks and committees to ensure that learning from national reviews, reports and enquiries is incorporated into our governance arrangements. National findings are routinely considered at Board and committee level, and recommendations are reviewed for local applicability. Where relevant, these are translated into updated policies, refreshed governance processes, and staff development programmes. As an example, in response to the Messenger Review, Moorfields has strengthened leadership and professional development, including introducing programmes such as EyeThrive to support consistent leadership behaviours across staff groups. Learning from the Francis and Ockenden reviews has also informed the way we strengthen our Freedom to Speak Up processes, enhance transparency, and promote a culture where staff feel safe to raise concerns. These actions are supported by regular clinical governance audits, quarterly Freedom to Speak Up reports to the Board, and integration of findings into our Quality Plan, ensuring that external learning is embedded in both policy and day-to-day culture.
Comments:	
Action for next year:	

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	
Comments:	Moorfields Eye Hospital has put several measures in place that link to the Messenger Review's call for consistent professional standards. The Trust runs leadership development programmes (such as EyeThrive) and promotes values like equity, kindness, and excellence to guide staff behaviour. It has a clear clinical governance framework with regular audits, a Freedom to Speak Up policy with guardians who report to the Board, and quarterly assurance reports to strengthen accountability. Staff are supported through well-being initiatives, and the Trust's

	strategy and quality plan emphasise safety, effectiveness, and patient experience. However, challenges remain around ensuring these initiatives align fully with national leadership standards, and concerns have been raised externally about culture and openness, suggesting further work is needed to embed consistency across all professional groups.
Action for next year:	

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	**Yes**
Action from last year:	
Comments:	All doctors complete pre-employment checks prior to joining the Trust
Action for next year:	

1F – **Organisational Culture**

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	**Yes**
Action from last year:	
Comments:	The Trust's approach to professional standards is designed to go beyond compliance and actively support a culture of clinical excellence. Appraisal and revalidation processes are aligned with national guidance and locally embedded through policies, training, and oversight from the Responsible Officer and Medical HR. By strengthening governance, improving data quality, and embedding structured support for appraisers and appraisees, the organisation is building an environment where professional standards underpin safe, high-quality care. A shift towards earlier communication, consistent escalation for non-compliance, and quality assurance of appraisals is helping to drive cultural change so that appraisal and revalidation are understood as integral to good medical practice. This work complements wider organisational priorities, including the Medical Directorate restructure for improved

	governance, and the integration of HR and appraisal processes to ensure clarity, accountability, and sustainability.
Action for next year:	Continue embedding appraisal and revalidation processes as a driver for cultural improvement; strengthen links between professional standards activities, governance, and organisational development to ensure continual enhancement of clinical excellence.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	
Comments:	The Trust is committed to embedding compassion, fairness, respect, diversity and inclusivity (EDI) across all professional standards processes. This includes recruitment, appraisal, revalidation, and responses to concerns. Doctors are supported in line with Just Culture principles, ensuring decisions are fair, transparent, and proportionate. Appraisal and revalidation processes explicitly consider equality, diversity and inclusion, and the Medical HR team is working to ensure that outcomes are monitored for parity across groups. This is particularly important given the diverse workforce and the number of clinicians with complex working arrangements (e.g. fellows, honorary and bank-only doctors). The organisation recognises that promoting inclusivity is not only about compliance, but also about creating an environment where clinicians feel valued and supported to deliver excellent patient care.
Action for next year:	

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	
Comments:	The Trust actively promotes a culture of openness and transparency, underpinned by established Freedom to Speak Up Guardians and whistleblowing procedures. Clinicians are encouraged to raise concerns early, with assurance that these will be treated fairly, confidentially, and constructively.

	Alongside formal processes, the Responsible Officer, Medical Director and Workforce & OD emphasise a “Just Culture” approach, ensuring that issues raised through appraisal, revalidation, or case management are used as opportunities for learning and improvement rather than solely performance management. This aligns with the Trust’s broader aim of embedding a learning culture that supports staff wellbeing and professional development. Ensuring this culture remains visible and consistent requires continued leadership engagement, active promotion of safe reporting routes, and integration of lessons learned into training and governance systems.
Action for next year:	Continue to strengthen the Freedom to Speak Up and Just Culture framework, ensuring clinicians have confidence in raising concerns; embed lessons learned from appraisals and concerns into organisational governance and workforce training.

1F(iv) Mechanisms exist that support feedback about the organisation’ professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	
Comments:	We use the standard MPIT form to transfer information between organisations We do occasionally get requests in different format. Work needs to be done to streamline process of obtaining information – governance has improved from previous side where only appraisal portfolio’s were checked, to include writing out to service directors and managers to confirm no local concerns. But do need to improve on responsiveness to fellow Trusts.
Action for next year:	Prioritise completion of MPIT forms, both incoming and outgoing. Have this embedded as part of process

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	
Comments:	We only have a few cases where doctors are involved in concerns or disciplinary process – but we do record characteristics so that this can be monitored
Action for next year:	Review process and make sure it is fit for purpose and in line with requirements

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	
Comments:	The RO participates in RO/Appraisal network; the Head of Medical HR participates in London Medical Staffing and Appraisal/Revalidation networks.
Action for next year:	Increase engagement in peer review and benchmarking networks.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .
All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	380
Total number of appraisals completed	261
Total number of appraisals approved missed	119* (includes unapproved)
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	94
Total number of late recommendations	10
Total number of positive recommendations	74
Total number of deferrals made	20
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	1
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer[2]	2
Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March (working days)	-
Median duration of concerns processes closed (working days)[3]	-
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	130
Total number of new employment checks completed before commencement of employment	130
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld[4]	Pending

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Appointment of new Medical HR leadership (Sept 2024) has strengthened governance, improved compliance, and formalised communication processes. MFA introduced in 2024/25 in the Appraisal and Revalidation system.
Actions still outstanding
SPA tariff for appraisers; appraisal system change; governance of bank-only connections; external peer review.
Current issues
High missed appraisal numbers (119); system inefficiencies; workload disparity among appraisers.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Fully implement HR restructure (Band 4 role, SOPs). • Embed appraisal tariff and rebalance workloads. • Procure and implement new appraisal supplier. • Review bank-only connections. • Seek external peer review.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
The Trust has made encouraging progress in strengthening compliance, communication, and governance arrangements over the past year. Notable achievements include the introduction of a new MHPS policy, development of an intranet resource hub for appraisal and revalidation, and the creation of supporting materials such as an appraisal and revalidation pack, improved reminder systems, and an appraiser checklist to promote more robust, consistent documentation and conversations. These initiatives have already led to improvements in appraisal quality and accuracy of data within the system. The Medical HR team has undergone significant change, with new management introduced, and although there were challenges following staff turnover, key posts have now been filled and additional Band 4 support has been secured to provide resilience in appraisal and revalidation processes. Improvements have also been made to communication with clinicians, including revamped reminders, more accurate due-date tracking, and escalation of overdue appraisals. Importantly, appraisal timeliness has been linked to pay progression, supporting cultural change and reinforcing accountability. Challenges remain in embedding the new MHPS policy, addressing ongoing system limitations with Premier IT and query management tools, and ensuring workload equity across the governance process. Overdue appraisals continue to require active monitoring and escalation, and further work is needed to shift mindsets around the importance of appraisal and revalidation.

Looking ahead, the coming year will be critical in embedding sustainable processes, completing the roll-out of training for case managers and investigators, and refining governance systems to support both organisational culture and clinical excellence. The Trust remains committed to fostering transparency, accountability, and continuous improvement in appraisal and revalidation, with a clear aspiration to build on recent progress and deliver a fair, consistent, and high-quality governance framework for all doctors. Appraisal due reminders were also revamped to help remind Appraisees of upcoming due dates, and impending due dates are followed up manually with NHS England literature to help encourage concise documentation.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Moorfields Eye Hospital NHS Foundation Trust

Name:	Peter Ridley
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Lloyd Carrasco
Email address:	moorfields.revalidation@nhs.net

Moorfields Eye Hospital NHS Foundation Trust

Infection Prevention and Control Annual Report 2024/25

Board of directors

2 October 2025

Report title	**Infection Prevention and Control Annual Report**		
Report from	Sheila Adam, Director of Infection Prevention and Control		
Prepared by	Catherine Wagland – Deputy Director of Infection Prevention and Control		
Previously considered at	QSC CGC ICC	**Date**	16.09.2025 11.08.2025 25.04.2025
Link to strategic objectives	**Working together** with key partners to support our purpose **Develop** clinical pathways, our physical and digital network and operational systems to provide reliably excellent eye care **Deliver** a workforce able to support future care models and excellent patient and staff experience, in accordance with our values Working **Sustainably and at Scale** to reduce waste and inefficiency		

Quality implications

The report provides assurance to the Trust Board on the measures that are in place and the work that has been undertaken to safeguard patients, visitors and staff from acquiring a healthcare associated infection through monitoring, inspection, education and surveillance.

Financial implications

There are no financial cost implications arising from this report

Risk implications

A detailed programme of work provides assurance that measures are in place to maintain safety of patients, visitors and staff. Risks identified during the delivery of work are managed in accordance with the trusts risk management and PSIRF policy.

Action required/recommendation.

The report is to provide assurance on the infection prevention and control measures in place at the trust to maintain the safety of patients, visitors and staff.

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Infection prevention and control Annual Report April 2024 – March 2025

Sheila Adam
Chief Nurse & Director of Allied Health Professionals, DIPC
Prepared by Catherine Wagland

Trust Board Meeting October 2025

IPC Annual Report 2024/25

This year the IPCT have achieved a range of successes which are covered in more detail in the report.

Today we are sharing five of these:

1. Surveillance

- All endophthalmitis healthcare associated infections have been below the trust best practice benchmarks with no cases of mandatory reported infections

- A new trust wide benchmark for simple cataracts of 0.02% has been agreed with the Cataract Service

	2023/2024	Target	2024/2025
Clostridioides difficile infection	0	0	0
*Bacteraemia	0	0	0
MRSA Screening	100%	100%	100%
Endophthalmitis post cataract	0.08	0.40	0.16↑
Endophthalmitis post intravitreal injection	0.09	0.30	0.04↓
Endophthalmitis post Ozurdex implants	N/A	1.0	0.00
Endophthalmitis post vitrectomy - simple	0.68	0.80	0.00↓
Endophthalmitis post vitrectomy - combined	0.85	2.5	0.00↓
Endophthalmitis post-acute glaucoma	0.36	1.0	0.80↑
Endophthalmitis post Graft-EK	2.67	3.60	0.00↓
Endophthalmitis post Graft-PK	0.00	1.60	0.00
Adenovirus possible hospital acquisition	0.60%	N/A	0.8%↑

Moorfields Eye Hospital NHS Foundation Trust

NHS

IPC Annual Report 2024/25

2. Vaccination Protection

- The trust flu vaccine compliance in March was the highest performing trust in the London region at 48.2%

3. Safer Design in the Built Environment

- The IPCT have recommended a safer tap design for key areas within the Oriel build to prevent water contamination with microbes and by doing this also delivered cost benefits from reduced ongoing maintenance costs by an estimated £200 000 per annum

4. Sustainability Improvements

- In line with the trusts green plan the IPCT are engaged with several projects to deliver sustainable practices and efficiencies. Working with the estates department, the IPCT, were able to approve the shut down of overnight theatre ventilation at City Road, reducing carbon emissions by 10%.

Moorfields Eye Hospital NHS Foundation Trust

NHS

IPC Annual Report 2024/25

- A Lead IPCN worked with the Medical Retina service to implement a pilot for replacing single use Tropicamide 1% eye drops for reusable bottles. The safe administration to patients was ensured with training in non-touch techniques, inclusion criteria and monitored closely for adverse outcomes. The findings were positive and demonstrated effective practice, carbon emissions reduction by 37%, plastic waste reduction by 37% and a cost reduction of 76%.

5. Excellence

- The IPCT secured an external contract with the Tavistock and Portman NHS Mental Health Trust to set up their infection prevention service on a 12-month contract. This has generated income for the trust and provided a development opportunity for an internal staff member to join the IPCT for one day a week for 12 months.

- A Lead ICN has been asked to speak at the international infection prevention society conference in September, this is the first time that IPC in ophthalmology is on the agenda.

Moorfields Eye Hospital NHS Foundation Trust

NHS

IPC Annual Report 2024/25

The future

- The IPCT will continue to embed the trusts strategy and purpose in our Programme of Work
- The IPCT will finalise the trusts response to the National Action Plan: Confronting Antimicrobial Resistance, with key stakeholders
- The IPCT Strategy will be developed

Moorfields Eye Hospital NHS Foundation Trust

NHS

Moorfields Eye Hospital NHS Foundation Trust

Infection Control Annual Report

April 2024 – March 2025

Version	**1.0**
Status:	**FINAL**
Authors:	**Catherine Wagland and Amita Sharma**
Approved:	**July 2025**

ITEM 53.25

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Executive Summary

All registered care providers must demonstrate compliance with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance[1] which outlines ten criteria which care organisations must demonstrate compliance against (Table 1). The National IPC Board Assurance Framework [2](BAF) is available to support organisations to effectively self-assess compliance with the code of practice and to provide assurance in NHS settings or settings where NHS services are delivered.

The purpose of this report is to inform patients, public, staff and the Board of Directors of the infection prevention and control work undertaken for the period from 1st April 2024 to the 31st March 2025 to keep patients safe from avoidable healthcare associated infections and provide assurance on trust compliance with the ten criteria in the Health and Social Care Act (2008). This report will be published on the trust website to demonstrate good governance.

Table 1 outlines the ten-criterion covered in the code.

Compliance Criteria	What the registered provider will need to demonstrate
1	**Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.**
2	**The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.**
3	**Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.**
4	**The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.**
5	**That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.**
6	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.**
7	**The provision or ability to secure adequate isolation facilities.**
8	**The ability to secure adequate access to laboratory support as appropriate.**
9	**That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.**
10	**That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.**

The key achievements for 2024/25

This year the IPCT have achieved a range of successes which will be covered in more detail in the report. Below are the headline achievements:

- There have been no cases of bacteraemia or *Clostridioides difficile* for the trust to report
- All endophthalmitis HCAI's have been below the trust best practice benchmarks, this includes cataracts, vitrectomy, acute glaucoma, intravitreal injections, Ozurdex implants and corneal grafts.
- A new trust wide benchmark for simple cataracts of 0.02% has been agreed with the Cataract Service.
- The trust flu vaccine compliance was the highest performing Trust in the London region at 48.2%
- The Annual Infection Control Programme of Work for 2024-25 was fully completed
- The IPCT extended their remit in providing a funded service to the Tavistock and Portman trust for a year
- The ICN's have agreed in collaboration with the Estates department to reduce external contractor inspections throughout the trust, achieving significant financial savings
- The ICN's have delivered further cost benefits by recommending non-TMV tap design for areas within the Oriel build that reduces ongoing maintenance costs by an estimated £200 000 per annum.
- A Lead ICN has been asked to speak at the international infection prevention society conference in September, this is the first time ophthalmology is on the agenda.
- The Band 6 IPCN completed their PG Dip in Infection Control in March and was awarded a Distinction.

Introduction

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

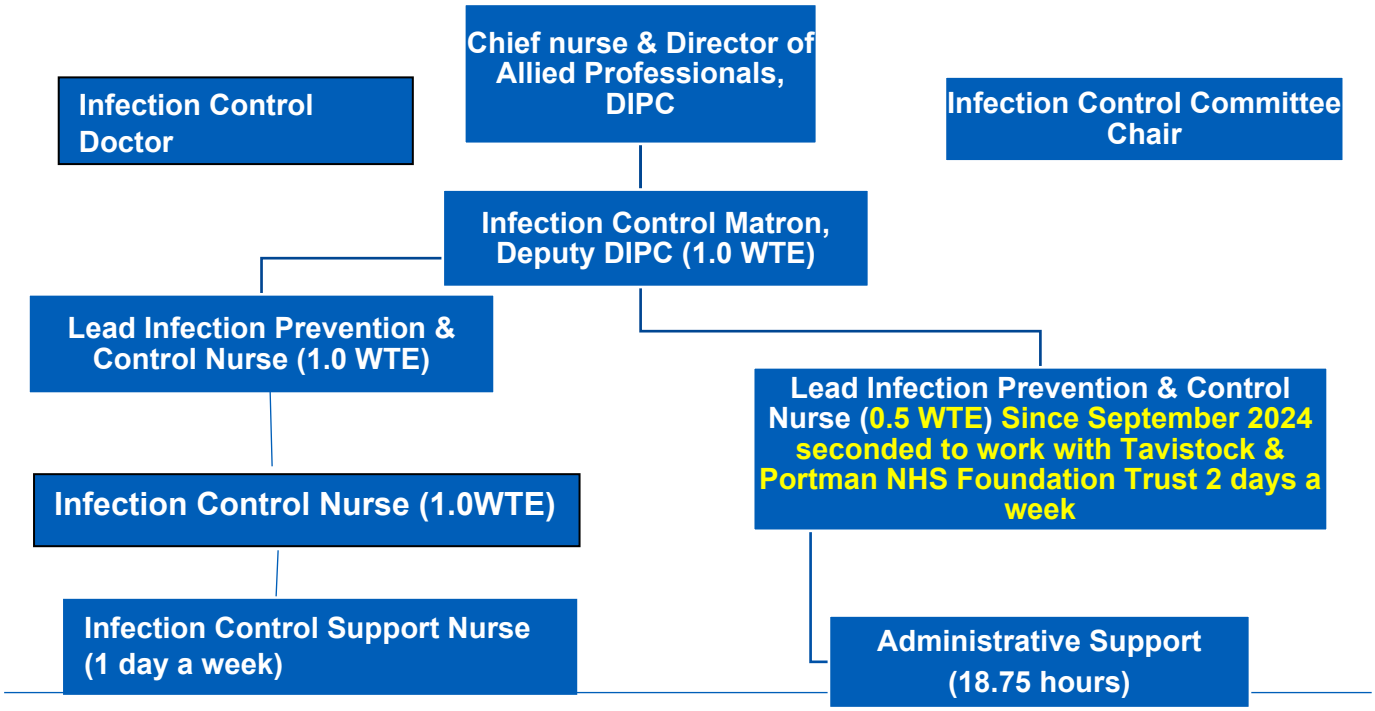
During the year, the IPCNs have worked with staff across all sites to enable effective infection prevention and control and safe reliable services. The delivery of this assurance may not always be within the remit of the infection prevention and control team, but clear responsibilities, competence, guidance,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

This report acknowledges the valuable contribution of all staff who have played a role in helping to reduce the risk of patients acquiring a healthcare associated infection and colleagues who contributed to this report.

Delivery of Service

There is an established infection prevention and control team that has continued to lead on the implementation of the infection control work plan and audit programme and provide advice about the prevention and control of infection.

The IPCT structure is outlined below as at the 31st March 2025.



Secondment positions within the IPC Team

In September 2024 the IPCN's organised a Service Level agreement with Tavistock and Portman Mental Health NHS Trust to provide an infection control service for 1 year. This SLA has generated income for the trust which provided a development opportunity for an internal staff member to join the IPCT as an Infection Prevention and Control Support Nurse for one day a week on a 12-month fixed term contract.

The IPCT Administrative Support Officer role was successfully recruited into as a part-time role, requiring 18.75 hours per week. In February 2025, the post holder started maternity leave for one year, and the team have since recruited a replacement on a fixed-term contract.

The Trust also has a:

- Consultant Ophthalmologist who is the chairperson of the Infection Control Committee
- Infection Control Doctor as part of a service level agreement with Guys and St Thomas's NHS Foundation Trust
- A Lead Antimicrobial Pharmacist (WTE)
- A Microbiologist as part of a Service Level Agreement with the main microbiology and virology laboratory services that are provided by an off-site independent company
- Additional support is provided by Moorfields Estates and Facilities Teams, Heads of Nursing and Matrons, Infection Prevention and Control Link Practitioners and Sterile Services Department.
- The Occupational Health service is provided by North London Partners Shared Services (NLPSS).

Infection Prevention & Control Governance Reporting & Accountability Structure

The IPC Team have governance arrangements in place to provide assurance to other committees and Trust Board of compliance with IPC practices, **(see Appendix 1)**.

Infection Control Committee

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

The committee is chaired by Professor Carlos Pavesio, Ophthalmology Consultant and Director of the Uveitis Service.

Membership of the ICC includes representation from key service areas:

Facilities, Estates, Pharmacy, Theatre, OCSS, Heads of Nursing, Eye Bank, Infection Control Nurses, DIPC, Infection Control Doctor & Deputy DIPC from GSTT, Occupational Health, Risk and Safety, NE and NCL HPT, Consultant Ophthalmologist.

Chief Executive

The chief executive has overall corporate responsibility for IPC within the Trust

Director of Infection Prevent and Control (DIPC)

The DIPC is an executive member of the Board and provides oversight and assurance on IPC matters. They attend the Clinical Governance Committee (CGC) and Quality and Safety Committee (QSC) which meet every two months. Minutes from the ICC are sent to CGC and any items for escalation and the IPC provide an update report to the QSC.

Infection Control Team

The Infection Prevention and Control Team are responsible for delivering a programme of work annually to assist in providing assurance and monitoring the trusts compliance with requirements of the Health & Social Care Act (2008) Code of Practice for the prevention and control of infections.
The programme includes surveillance, audit, policy development, education and training, and the response to outbreaks and infection incidents to contain and prevent onward transmission. The IPCT Programme of Work for 2024/25 can be found in **Appendix 2**.
Working collaboratively within the trust across all departments, the team employ specialist knowledge to improve standards of care for patients and uphold staff and visitor safety. With a focus on cleanliness, decontamination and safety within the estate, the team undertakes risk assessments and sets priorities for action and assurance.

IC Links

The IPCNs have continued to deliver infection control link practitioner workshops virtually every 3 months and in addition the link practitioners had the opportunity to attend the annual conference provided by Guy's and St Thomas' infection control team virtually.

Trust Surveillance of Possible Healthcare Associated Infections

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

Performance Data

	2023/2024	Target	2024/2025 Q1	Q2	Q3	Q4	YTD
C.diff infection	0	0	0	0	0	0	0
*Bacteraemia	0	0	0	0	0	0	0
MRSA Screening	100%	100%	100%	100%	100%	100%	100%
Endophthalmitis post cataract	0.08	0.40	0.15	0.15	0.16	0.20	0.16 ↑
Endophthalmitis post intravitreal injection	0.09	0.30	0.07	0.00	0.07	0.8	0.04 ↓
Endophthalmitis post Ozurdex implants	N/A	1.0	0.00	0.00	0.00	0.00	0.00
Endophthalmitis post vitrectomy - simple	0.68	0.80	0.00	0.00	0.00	0.00	0.00 ↓
Endophthalmitis post vitrectomy - combined	0.85	2.5	0.00	0.00	0.00	0.00	0.00 ↓
Endophthalmitis post acute glaucoma	0.36	1.0	0.00	0.00	2.60	0.00	0.80 ↑
Endophthalmitis post Graft-EK	2.67	3.60	0.00	0.00	0.00	0.00	0.00 ↓
Endophthalmitis post Graft-PK	0.00	1.60	0.00	0.00	0.00	0.00	0.00
Adenovirus possible hospital acquisition	0.60%	N/A	0	0	2	1	0.8% ↑

***Bacteraemia includes MRSA, MSSA, E coli, Pseudomonas aeruginosa & Klebsiella Spp.**
Endophthalmitis rates are based on cases per 1000 procedures.

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

Endophthalmitis

Endophthalmitis at Moorfields Eye Hospital (MEH) is defined as an inflammation or infection of the intraocular space diagnosed within 6 weeks of surgery or of any invasive procedure (e.g. suture removal or intraocular injection) or within 16 weeks of surgery where the pathogen is fungal in nature and vitreous and aqueous fluid specimen and treatment with intravitreal antimicrobial therapy has been required. All infections identified beyond the 16 weeks' timescale

will be investigated for up to one year to check whether the infection is linked to the original ophthalmic procedure.

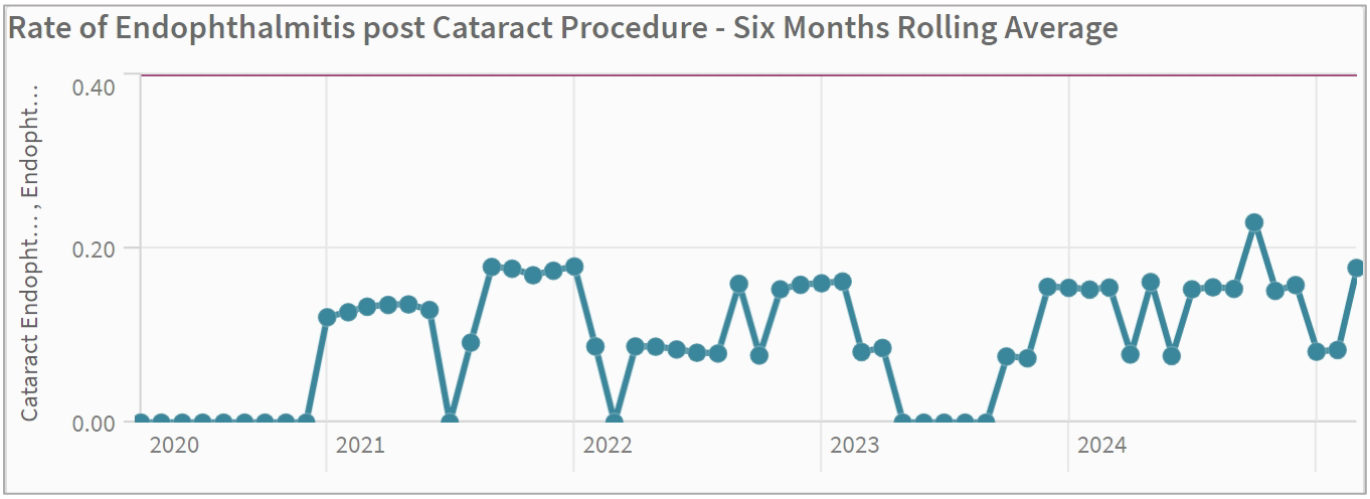
- MEH incidence data is based on clinical criteria and not only on those cases which yield a positive microbiology culture.
- All cases of endophthalmitis are reported either as benchmarked or exception reported cases.

Benchmarked Endophthalmitis
The trust reports on infections following all procedures and has specific benchmarks for: Cataracts, Intravitreal Injections, External Diseases (PK and EK procedures), Glaucoma (acute cases), Ozurdex implants and Vitreoretinal procedures (both combined Vitrectomy and simple).

A new trust benchmark for simple Phacoemulsification and IOL procedures was agreed with the Cataract Service Leads of **0.02%**, whilst combined Phacoemulsification with other procedures will remain at **0.04%.**

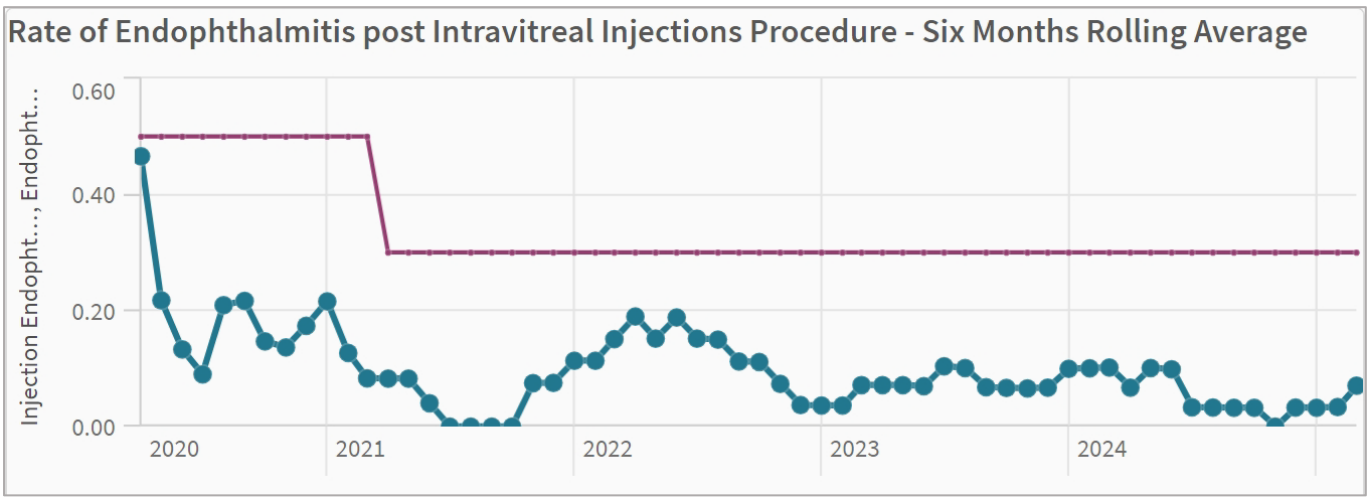
The graphs below show the rates of post-operative endophthalmitis for the benchmarked procedures for the preceding 5 years. The red line depicts the benchmark.

Cataract Endophthalmitis 6 month rolling average



The agreed benchmark for cataract infections was previously 0.4 or 1 in 2400 procedures. The national average reported by the Royal College of Ophthalmologists[3] is 0.2 therefore the trust will be adopting this rate for simple cataract procedures and retaining 0.4 per 1000 procedures for combined cataract procedures. This separate data will be provided in the coming years data.

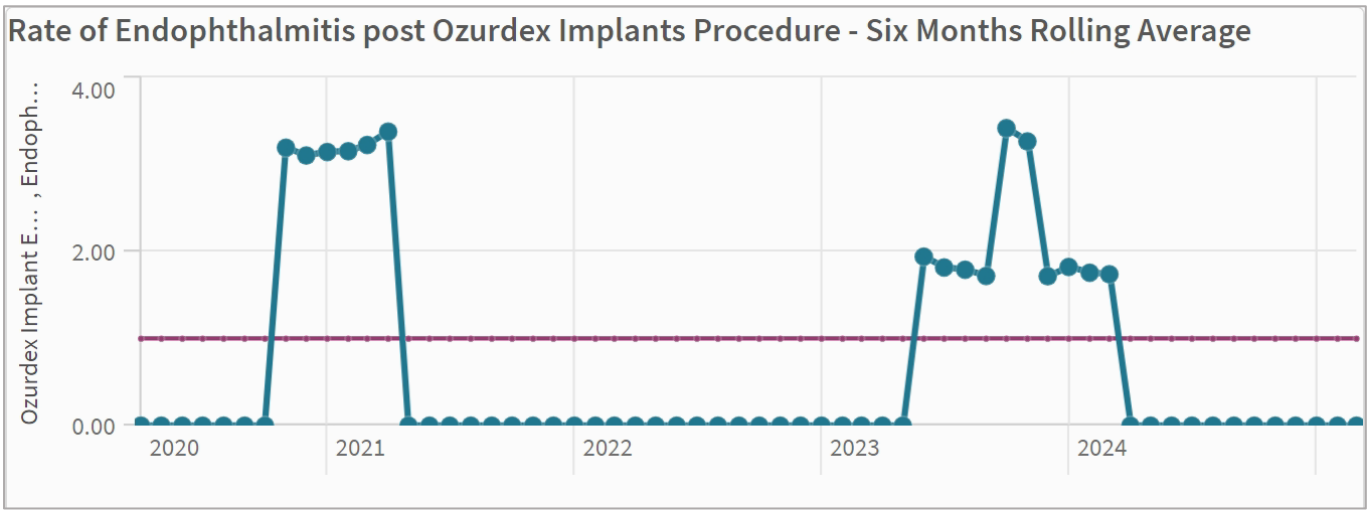
Intravitreal Injection Endophthalmitis 6 months rolling average



The expected rate of infection is 0.3 or 1 in 3333 intravitreal injections.

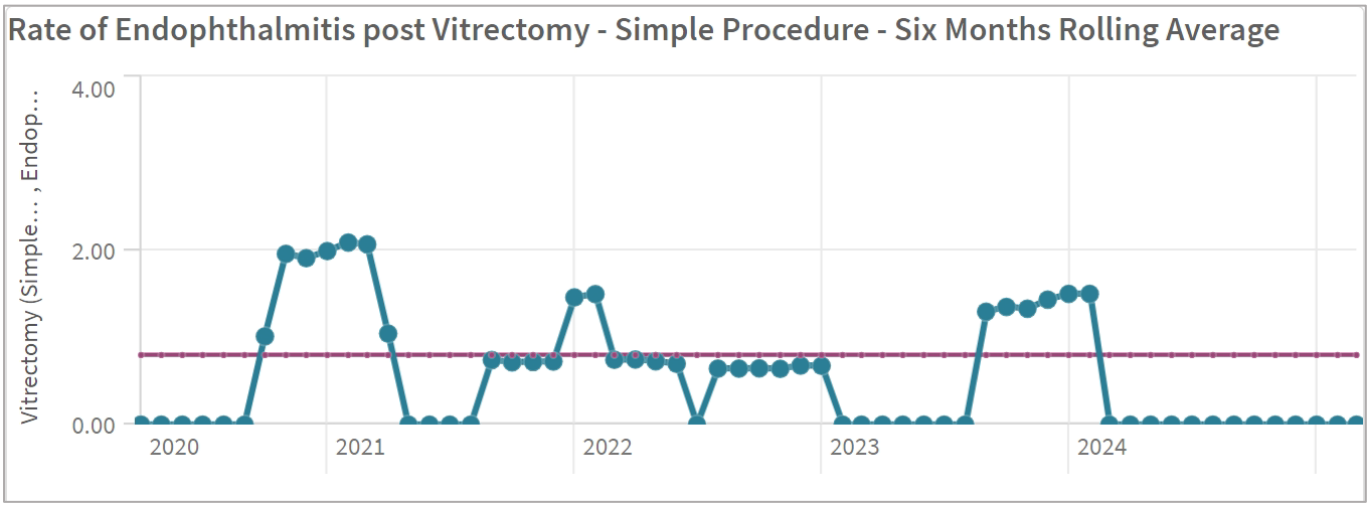
Intravitreal injections consist of medicines such as Lucentis, Avastin, Eylea and Vabysmo. Triamcinolone injections are reported separately.

Ozurdex Implant Endophthalmitis 6 months rolling average



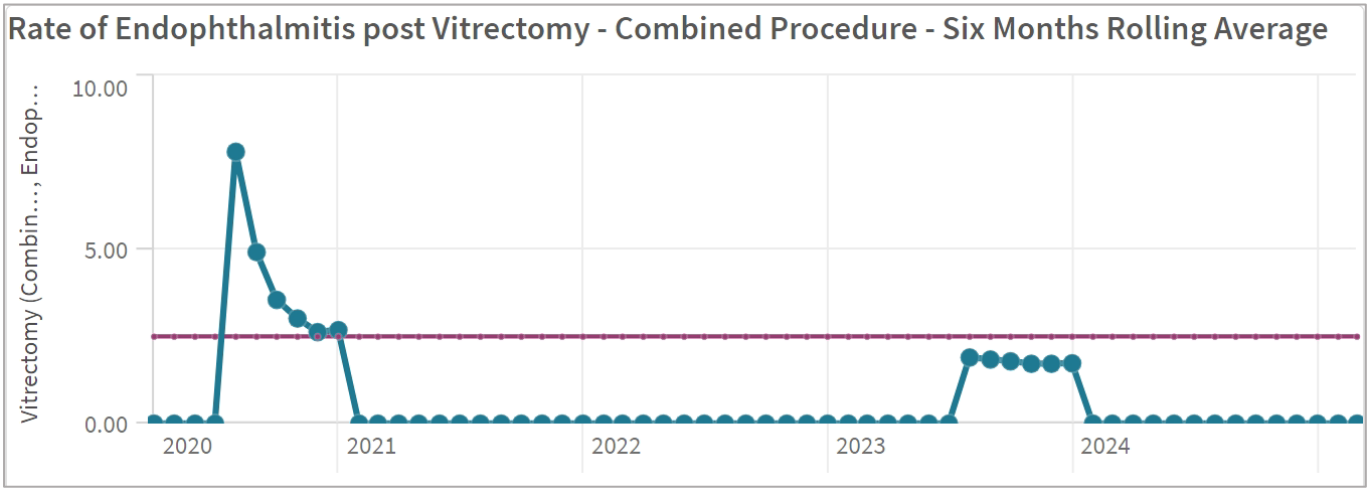
The expected rate of infection is 1.0 or 1 in 1000 Ozurdex implant procedures.

Vitrectomy Endophthalmitis– Simple 6 month rolling average



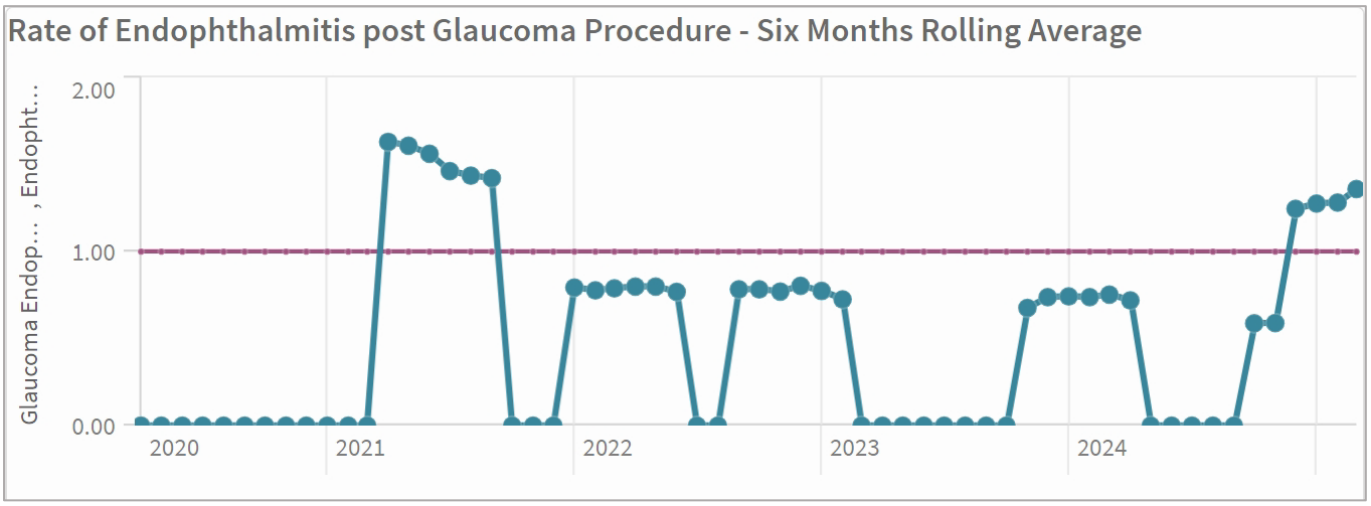
The expected rate of infection is 0.8 or 1 in 1250 procedures.
* Rates should be viewed over a longer time frame due to the low number of procedures, e.g. 12 month rolling rate is 0.66.

Vitrectomy Endophthalmitis – Combined 6 month rolling average



The expected rate of infection is 2.5 or 1 in 400 procedures.
*Rates should be viewed over a longer time frame due to the low number of procedures, e.g. 12 month rolling rate is 0.78.

Endophthalmitis Post-acute Glaucoma 6 month rolling average



The expected rate of infection is 1:1,000 acute glaucoma procedures.

*Rates should be viewed over a longer time frame due to the low number of procedures, e.g.12 month rolling rate is 0.35.

Endothelial Keratoplasty and Penetrating Keratoplasty

There were no cases of endophthalmitis reported for the above procedures for the last year.

Adenovirus – possible hospital acquisition

Adenovirus is an infection that can cause severe viral conjunctivitis commonly involving the cornea. It is caused by different adenovirus serotypes which may be transmitted from person to person in a number of different ways, such as contact with contaminated surfaces/equipment or infected persons tear fluid.

There were three cases of possible hospital acquisition identified in the reporting period, two in November 2024 and one in March 2025.

The two cases in November were investigated by the IPCNs as they occurred on the same day and location. The IPCNs informed the doctor who saw both patients and reinforced the importance of good hand hygiene practices and decontamination of equipment with staff to reduce the risk of further cases. No further cases were identified from this site.

Routine Screening

Methicillin Resistant Staphylococcus Aureus (MRSA)

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

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

MRSA screening

No. Patients Screened	No. Patients MRSA positive	% Patients Positive	% Compliance for Screening Cohort
261	38	14.6%	100%

Carbapenemase-producing Enterobacteriaceae (CPE)

All patients at the trust are risk assessed for the likelihood of CPE carriage and any patients identified at risk of carriage are managed in accordance with the trust CPE policy.

The numbers of all suspected or confirmed cases of CPE are monitored by the IPCN's. The numbers of cases for each quarter are included in the surveillance report that is presented at ICC.

CPE screening

Number of Patients Suspected of Carriage having met risk group criteria	Number of Patients with Confirmed Carriage of CPE
22	5

Antimicrobial Stewardship by Hira Parvez Lead Antimicrobial Pharmacist

Antimicrobial Stewardship is an organisational or healthcare system wide approach to promote and monitor the judicious use of antimicrobials in order to preserve their future effectiveness (NICE guideline, NG15). It is an ongoing responsibility of every staff member and pharmacy in particular plays an active role in ensuring they are good antimicrobial guardians.

At MEH our three pillar-approach to AMS (antimicrobial stewardship) includes:

- Optimising the use of antimicrobials through ensuring our guidelines are up-to-date, antimicrobial consumption is closely monitored, and wise usage is promoted through effective face-to-face communication with prescribers, education and training for patients as well as clinical and non-clinical staff.
- Encouraging all staff including pharmacy staff to follow good infection control practices that will help prevent the transmission of drug-resistant organisms. These include following good hand hygiene practices and cleaning equipment between each patient use in line with the Trust's Infection Control Policies available on the intranet.
- Continuous surveillance of environmental decontamination including using disinfectants – think slit lamps, telephones, desk space!

Antimicrobial prescribing and guidelines

The Trust has an adult antimicrobial guideline which is available online on the intranet and via the Eolas medical app. This is an evidence-based document which all healthcare professionals are required to use when using antimicrobials at the Trust. This guideline has migrated as of Sep 2024 from the MicroGuide platform to Eolas Medical app in line with other Trusts nationally. This was a great collaboration with

A&E service to ensure all guidelines in the form of an app are under one platform. To ensure greater compliance to guidelines. The Trust also has an Antimicrobial Prescribing and Management Policy to promote good principles of antimicrobial stewardship across the Trust.

The Trust is also in the process of finalising the Trust's first paediatric antimicrobial guideline. This will be presented at the paediatric service meeting as well as the Drugs & Therapeutics & Medicines Management Committee (DTMMC). Once approved it will then be added onto the Eolas app and made live.

Pharmacy has contributed on numerous guidelines and documents at the Trust:

- Reviewed Adult Sepsis policy
- Reviewed Paediatric Sepsis policy
- Produced and reviewed dilution instructions of common intravitreal to ensure standardised practice; intravitreal vancomycin, amphotericin and clindamycin.
- Updated Emergency Endophthalmitis & Viral Retinitis Guidelines
- Collaboration with NCL antimicrobial pharmacists – Joint Statement of Fluoroquinolones.
- Fluoroquinolone Patient letter created in response to MHRA drug safety update regarding Fluoroquinolone use within the Trust

National Action Plan (NAP)

UK 5-year action plan for antimicrobial resistance (AMR) 2024 to 2029[4] was launched in 2024 which has been acknowledged as a Trust. The action plan has 4 themes and 9 outcomes.

Many practices at MEH align with the vision of the NAP. Below is a summary of how some of this is being achieved within the Trust. However, a specific action plan will be developed and shared with infection control committee to ensure the Trust plays its role to reduce AMR further.

Theme 1 – Reducing the need for, and unintentional exposure to, antimicrobials

At MEH this is achieved by reviewing clinical and non-clinical practices in the context of infection prevention and management. The Trust has an established infection control committee (ICC) with representation of various stakeholders to ensure good practices are followed to reduce transmission of infections.

The Trust has also engaged with various public health campaigns such as the winter flu vaccination and World Antimicrobial Awareness Week (WAAW) from 18 - 24 November 2024. Campaigns as such are vital to raise awareness amongst patients and staff to ensure antimicrobials are used appropriately to reduce the risk of antimicrobial resistance.

The ICC quarterly meetings discuss surveillance of infections and usage of antimicrobials to ensure evidence-based practice is followed to reduce unnecessary use of antimicrobials.

Theme 2 – Optimising the use of antimicrobials

At MEH use of antimicrobials is informed by the antimicrobial guidelines which ensure evidenced based use of antimicrobials. The document not only facilitates usage of antimicrobials for the correct indication but at the optimal dose and duration to ensure infections are resolved effectively. This reduces risk of antimicrobial resistance.

Education and training regarding antimicrobial stewardship is also incorporated upon various platforms including teaching, inductions and meetings. This is to empower staff to reflect and share practices to optimise use of antimicrobials.

Theme 3- Investing in innovation, supply and access

MEH is actively involved in clinical trials and innovative programmes to aid drug discovery. Though the NAP plan relies on government's collaboration with pharmaceutical companies to incentivise the development of new vaccines, diagnostics and therapeutics (including alternatives to antimicrobials), MEH is driving forward new methods of ophthalmology treatment.

Audit work

Pharmacy is currently undertaking an audit to see whether as a Trust oral voriconazole tablets are being used in line with Trust guidelines, particularly the monitoring. This is a re-audit of a previous audit carried out in 2020. Voriconazole prescriptions from Jan 2024 to Jan 2025 will be included. Summary and recommendations will be provided in a shared report.

Involvement and contribution

As a member of the ICC, pharmacy monitors the usage of oral antimicrobials across the Trust on a quarterly basis. These are analysed closely to identify trends in antimicrobial usage including those antimicrobials categorised as 'restricted'. Pharmacy also contributed to the development of specific Trust related infection control policies as part of ICC.

Additionally, regular reviewal of incidents concerning antimicrobials has continued to take place and specific action plans are created to reduce recurrence.

Pharmacy is also involved in the management of stock shortages of antimicrobials to ensure stock is reserved for true infectious cases which require this. As well as supporting clinicians by recommending alternatives to support continuity of patient care.

Pharmacy regularly presents at medical inductions of new starters and uses the platform for education and training. The purpose of the interactive sessions includes promoting principles of responsible antimicrobial prescribing. As well as signposting medical prescribers to a range of resources to ensure evidence-based use of antimicrobials.

Over the course of 1 week pharmacy department across the Trust including network sites celebrated World Antimicrobial Awareness Week (WAAW) from 18 - 24 November 2024. The pharmacy team worked tirelessly to organise this week to raise awareness amongst patients and staff.

Infection Control Policies

In accordance with the Health and Social Care Act 2008 which requires trusts to have a range of IPC policies available for staff, the IPCNs review and update policies, guidelines and standard operating procedures (SOP) to ensure staff are provided with the latest guidance. All 18 updated documents were published for staff on the Trust intranet site (EyeQ) and this was disseminated via staff communication messages and in the monthly Bug Brief (Infection Control Newsletter).

In addition, since the publication of the National Infection Prevention and Control Manual for England (NIPCM)[5] the trust has adopted its use, with the link to the manual being provided in trust policies when

updated. The Trust Hand Hygiene and Standard Infection Prevention and Control policies were replaced with the NIPCM for England. The manual is available on the Trust intranet, Infection Control page for staff to access.

Infection Control Audit

Compliance with key infection control policies is monitored through policy and practice audits which provide evidence of staff performance and knowledge. These audits are mainly undertaken by link practitioners who have received training on the audit process and the standards required.

The scoring system used to score the level of compliance is red, amber or green. This scoring system is used for all infection control audits.

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

Policy and Practice Audits

A total of eleven policy and practice audits were completed during 2024/25.

All audits achieved an overall compliance score of **Green = >85%**. Reports from each audit are available on Tendable (electronic audit system) and can be accessed by heads of departments, heads of nursing, matrons and link practitioners for compliance scores. In addition, key findings from audits are discussed at the Infection Prevention and Control Operational Group (IPCOG), the ICC and results are shared with the QSC.

Hand Hygiene and Cleaning Audits

Adherence to the hand hygiene practices is monitored through monthly audits against the World Health Organisation's 5 moments for hand hygiene undertaken by IPC link practitioners. Staff compliance with "Bare below the elbows" is included in the hand hygiene audit.

The standard of environmental cleaning is monitored through monthly cleaning audits that are carried out by IPC link practitioners in their areas.

The trust target for both audits is 90%

Average scores for 2024/25 were:

Hand Hygiene	Cleanliness
97.5%	96.5%

Audit scores are discussed at the IPCOG Meetings and Cleanliness Operational Group (COG) Meetings (previously known as the Cleanliness Monitoring Meeting) and scores are shared with the ICC and the QSC.

Environment Audits
These are comprehensive annual audits that are undertaken by the IPCNs. Audits include auditing environmental and cleaning standards and staff adherence to IPC practices and policies. The audit tool that is used is based on the Quality Improvement Tool (QIT) that was developed by the Infection Prevention Society.

Environmental audits undertaken in 2024/25 included:

- Eleven operating theatre departments containing twenty-three operating facilities. This includes two sites where there are SurgiCube units (a modular system alternative to an operating room) that can be used for defined ophthalmic surgery.
- Eleven intravitreal injection sites comprising of twenty individual intravitreal injection rooms.
- Four Minor Procedure Rooms
- Six Wards
- Adult & Paediatric Accident & Emergency Departments

All audits achieved an overall compliance score of **Green (compliant)** except for one intravitreal injection room that achieved an overall compliance score of **Amber (Partial Compliance).** This department will be revisited within six months for a repeat audit.

In the IPC POW for 2025/26 Urgent Care Centres have been added to the list of annual audits that will be carried out.

Patient Information Leaflets

Six patient information leaflets were updated and are available on the Trust intranet Infection Control page for staff and on the Trust website for patients to access.

Outbreaks and Incidents

Outbreaks and incidents investigated in the reporting period are detailed below:

Serratia Positive Isolates
The IPCT were alerted by the microbiology lab of an increased number of Serratia species samples received in April 2024.

Four samples were collected in the A&E department and one sample was collected in the External Diseases Clinic at City Road. A collaboration investigation took place with pathology, the External Disease team, TDL laboratory, IPCT and the trust Infection Control Doctor. The investigation looked at possible contributory factors which included contamination of sampling equipment, staff practices, patient contact lenses and environmental cleaning. Samples were sent for typing and HSL laboratory reviewed their bench practices for any contamination risks.

No common link was identified. All sampling equipment swabbed tested negative to Serratia, typing results for the two samples had different sequence typing, all samples were collected by different staff and no issues were identified from patients who wear contact lenses. Specimens for Serratia declined.

The IPCT recommended snap-point PCR swabs be implemented to prevent staff from having to

manipulate the swab with scissors.

Toxic Anterior Segment Syndrome (TASS)

Two cases of Toxic Anterior Segment Syndrome (TASS) following cataract procedures on the 17th April 2024 were investigated by the IPCT. Both patients were private patients and had the procedures performed by the same consultant in the same operating theatre. Symptoms developed for both patients the day after the procedure. The IPCNs looked at possible contributory factors which included ascertaining whether the procedures were complicated, obtaining assurance from the Surgical Services Department (SSD) that there were no issues with the washer/disinfector cycle and the correct temperatures was achieved, checking with estates whether there were any issues with the ventilation supply during the time of the procedures, checking the batch numbers of all the medication used for all four patients and looking at whether the assisting staff were the same staff for all four patients.

The investigation confirmed:

- There were no issues with the water/disinfector cycle and all cycles met the minimum standards.
- There were no complications with both procedures
- Majority of the medication used for all four patients was the same.
- The anaesthetist was the same for all four patients and the scrub nurse was the same for three out of the four patients which included the two TASS cases.
- There were no issues with the ventilation supply to the theatre at the time the two procedures were operated on.

No single source was identified, and no further cases were reported.

Pulmonary Tuberculosis

Two cases of open pulmonary TB were investigated by the IPCT.

Case 1

In August 2024 UK Health Security Agency (UKHSA) notified the IPCT of a patient who had tested positive for respiratory Tuberculosis. Contact tracing identified that the patient had attended three out-patient visits and two planned surgical procedures during the timeframe of infectivity. TB incident meetings were held with key stakeholders including representation from UKHSA and the North Central London TB Team. In total 38 patients and their GPs were sent ‘warn and inform’ letters, of these 6 had high-risk conditions and were screened by TB clinics. No patients were identified as having onward transmission. A total number of 33 staff were followed up by the Occupational Health Team and one staff member was identified with a high-risk condition. All staff were sent ‘warn and inform’ letters and the screening of one staff member did not prove evidence of onward transmission. The Index patient is no longer considered infectious, and this incident was closed with UKHSA.

Case 2

In November 2024 UKHSA notified the IPCT of a patient with respiratory TB considered infectious from January 2024, diagnosed in July 2024. There was a 4-month delay in the NCL Health Protection Team being notified and this led to a delay in contact tracing procedures.

During these investigations, the patient had attended eight out-patient visits and three planned surgical procedures, including an overnight admission for four days at City Road. Incident meetings were conducted with key stakeholders. The IPCT worked collaboratively with the matron and department managers to gather patient and staff information.

Contact tracing identified 30 patients who were sent 'warn and inform' letters including their GPs by the IPCT. There were 35 staff identified as exposed of which 5 staff requested follow up screening. These staff were followed up by the Occupational Health Team, who reported one staff member receiving treatment for latent TB with no affected staff identified to date. The patient tested negative following treatment and final screening and the case was closed with the UKHSA in March.

Neisseria meningitidis

Two patients who attended the A&E department at City Road on the same day at different times in July 2024 tested positive to Neisseria meningitidis from corneal swabs. There were no common links identified between the two patients, and following treatment with a short course of antibiotics the Health Protection Team confirmed that no further actions were required.

Measles

Three cases of measles were investigated by the IPCN's.

The first case was an adult patient with infectious measles referred by their GP, who attended the A&E department in July 2024. The A&E staff identified this infection risk at triage and isolated the patient in the designated room and attended to the patient wearing the appropriate personal protective equipment. Due to the prompt identification and isolation of the patient, no contact tracing for staff or patients in the department was required. The GP was contacted by the IPCN as the A&E department had not been informed in advance of the patient's measles status.

The second case was a patient who had attended the A&E department at City Road in September 2024 with a painful eye and following the visit the IPCNs were informed by a neighbouring Trust that the patient was diagnosed with measles. The patient was not isolated and appropriate personal protective equipment was not worn by staff as the patient did not have typical symptoms of measles.

Contract tracing involved 52 patients and 9 staff, no persons were identified as high risk, and all were sent information on signs and symptoms. No secondary cases were identified and shared with the IPCNs.

The third case was a child who attended the A&E department in March 2025 whilst infectious. The case was investigated, and it was confirmed by the A&E team that the child was isolated in the designated isolation room therefore no other patients were exposed. A contact list of all staff exposed identified four immune to measles and one staff member needed a second dose of the MMR vaccine.

Seasonal Vaccination Programme

The IPCNs supported the annual vaccination programme, advising on the planning and delivery, key messages for staff and sharing national and regional data for Covid-19 and flu. In addition to this one ICN dedicated time to train as a peer vaccinator, delivering roving vaccine clinics, supporting the trust Clinical Governance Day vaccination hub and the campaign as led by the vaccine lead.

The trust achieved **48.2%** compliance with the flu vaccination of staff. As a consequence, Moorfields was the highest performing trust in the London region.

Oriel IPC Support

The IPC Matron has been an integral part of the major Oriel project since 2022, providing specialist advice and guidance on safe standards and regulatory requirements. Over the past year this work has included advising on design layout, fixtures and fittings appropriate to ophthalmology healthcare, site visits to review mock-up design, meetings with construction partners and attendance and response to Water and Ventilation Safety Group meetings and agenda items. Further to this, the IPC Matron has undertaken reviews and contribution to change request forms, presented to the Oriel Clinical and Operational Oversight Group on IPC aspects of water, reviewed DDA compliance requirements and ventilation requirements for specialist laser facilities, worked with clinical leads and design engineers at ARUP to prioritise ventilation and temperature control requirements, appraised the Moh's Lab design, scrutinized the location of clinical hand wash basins, provided pass through hatch dimensions in theatre for BYUK, evaluated window dressings in critical areas, appraised the requirement for flexible shower hoses in light of HSE regulations and secured a contract to enable the Oriel project to have infection control doctor support.

IPCT support to the project will continue to be provided in 2025/26.

International IPC Support

In June 2024 the IPCN's were contacted by Oslo University Hospital, Norway, and asked to assist in sharing specific management of instruments during Vitreoretinal surgery to negate the risk of Creutzfeldt-Jakob disease (CJD).
A detailed account of theatre practice was supplied to the Oslo team which was gratefully received. Sharing best practice with international ophthalmology organisations enhances the quality of patient care and safety and support future collaborative working opportunities in the global healthcare community.

National IPC Guidance Updates

- In May 2024 the UK Government published the 5 year National Action Plan (NAP): Confronting Antimicrobial Reistance 2024 to 2029[4]. The IPCT will collaborate with key stakeholders to implement actions in accordance with the relevant themes and outcomes for the trust as part of the annual programme of work.

- In February 2025 the High consequence infectious disease (HCID) personal protective equipment (PPE) guidance[6] was issued advocating total body coverage in assessment areas for patients suspected of HCID e.g. Ebola virus, Avian Flu H5N1 or SARS. The IPCT risk assessed the trusts position and it was agreed at committee that no changes to current PPE would be made on proportionality of risk.

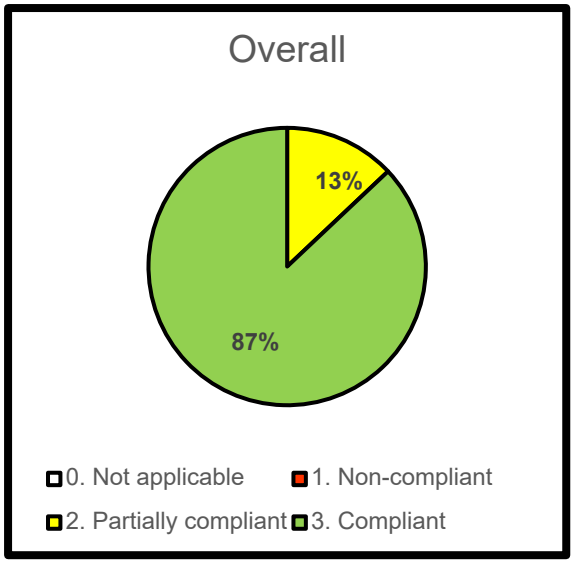
- In March 2025 national guidelines on Candida auris management7 were published. The IPCT reviewed these in relation to preadmission screening of patients at risk and it was agreed at committee that a question on the admission forms would be a reasonable approach.

IPC Board Assurance Framework

The Infection Prevention and Control Board Assurance Framework (BAF)[2] is a live document. The aim of the BAF is to provide an assurance structure for the Trust Board through self-assessing compliance with measures set out in the National Infection Prevention and Control Manual for England, the Health and Social Care act 2008: code of practice on the prevention and control of infections and other related disease specific infection prevention and control guidance issued by UKHSA. The aim of the framework is to identify any gaps/risks in standards and for the Trust to manage the gaps/risks.

The BAF comprises of a RAG rating for each criterion as not applicable, non-compliant, partially compliant, compliant with an option for a commentary for each criterion to outline any gaps in assurance and mitigating actions.

The IPCT undertook a comprehensive review of the the BAF (version 0.1) and this was presented at the ICC and QSC in July 2024. Following review of the BAF at the ICC it was suggested that some areas met full compliance with the evidence provided. A further review of the BAF was undertaken and the compliance status increased to 83%. This was presented to the QSC in January 2025. The latest review shows **87%** compliance overall



IPC BAF version 1.2 May 2025

The IPCT in collaboration with other key stakeholders will continue to review and update the BAF regularly with a view to improving compliance.

IPC Meetings

Infection Prevention and Control Operational Group (IPCOG)

The IPCOG has been established as a sub-group of the infection control committee that meets twice quarterly to review performance reports and actions to ensure safe running of services and optimum

patient outcomes within the trust. The group is chaired by the Chief Nurse/DIPC or a deputy. The membership for this group was reviewed and revised in March 2024. The membership includes IPCT, Matrons/Sisters from each division, leads of departments, communications manager and a consultant Ophthalmologist. Items for escalation and assurances from this group are shared at ICC. The work identified in these twice quarterly meetings inform and prepare for the assurances or escalations at committee.

Eye Bank by David Essex, Head of Life Sciences

HTA inspected the Moorfields Lions Eye Bank in November 2024. A total of 4 findings raised, all minor and related to updates to procedures, which have been made and submitted. We await the formal notification of the closure of these NCs, which is scheduled by HTA for May 2025. Supplementary internal and external audits (21 in total) have identified no major shortfalls against the HTA standards and continual improvement is made to the overall Quality Management System.

There were 1368 ocular products procured in FY 24/25, overwhelmingly from the United States as a Third Country Supplier. 4 SAERS were raised against these tissues, representing a rate of 0.29%, in comparison the SAER rate for NHSBT was 1.12%. Of these SAERS 2 related to Primary Graft Failure and 2 to post-graft infections, neither of which were present in the sister corneas, nor were there indications through the preparation of infections being present.

Venice Eye Bank are now supplying material to MEH also, albeit at around 2 tissues/week maximum. The same rigorous review of VEB practices has been conducted as with other TCS to meet the requirements of the HTA standards. Supplier performance remains stable, however the overall global picture is still dim, with insufficient donation numbers to meet demand. We are still awaiting a return to NHSBT tissues, an arrangement which should have recommenced in January 2025.

Decontamination by Steris Contract Provider

The Trust has outsourced its Sterile Services provision to external company Steris since November 2023. The facility is being run from City Road.

Management

The trust has employed two managers during this time to assist with the continued running of services whilst transition to an external provider was concluded.

Accreditation Status

The department has always maintained its compliance and certification to an international standard ISO 13485:2016 and Medical Device Regulations (2017/745) — Quality management systems — Requirements for regulatory purposes.
The current certification is valid until September 2025 and will remain valid subject to annual satisfactory surveillance audits. The certification to this standard indicates the testament and commitment in place which demonstrates the ability to process reusable medical devices and related services that consistently meet customer and applicable regulatory requirements. All resources used in the

department are assessed to meet all applicable regulatory requirements and standards. All equipment utilised in the department are subject to a strict periodic preventive maintenance schedule to maintain their good condition, reliable performance and prevent future unexpected failures.

Monitoring and Test Results

The trust has received assurance that monitoring of the SSD environment on a quarterly basis to ascertain the cleanliness of the IOS Class 8 SSD Clean Room where each instrument is checked for cleanliness, functionality and is fit for purpose before instruments are packed and labelled. This was carried out by an external provider in January 2025 and all testing passed.

Further to this environmental monitoring was undertaken and all air particulate pressure differentials passed. In addition to this the microbiological sample results passed the acceptance criteria.

Bioburden Testing

Instruments where sets were sent to an independent laboratory for testing in January 2025 were all within the required limits.

Machinery Testing

All machinery and equipment are managed directly by the Moorfields Estates Department.
AVM carry out the quarterly testing for all autoclaves and washer disinfectors that are in use.

PPM Reports

The ICC received assurance that all machinery and equipment were routinely tested daily, weekly, quarterly and 6 monthly as applicable to standards. Several PPM tests were performed repeatedly over the course of the year of all equipment utilised in the SSD to meet applicable regulatory/standard requirements.
All tests met specifications required and any non-conformities with the results and recommendations are assessed and a corrective action and a preventive action plan is put in place to prevent re-occurrence and for improvement.

Staff Training

All staff working in the Sterile Services Department will be fully trained to perform their roles and responsibilities safely and to meet customer requirements and are subject to an annual competency assessment.

The SSD is committed to meet all customer and regulatory requirements and continually aims to improve services to achieve best practice.

Matters of the Estates **by Peter Foster Head of Facilities Management**

Water Safety and Ventilation Group

The Trust has a local Water Safety and Ventilation Group which meets quarterly to discuss issues relating to the operational management of water and ventilation systems and assure compliance with the

Trust Water Safety Plan and Ventilation Policy. The group identifies risks and mitigating those risks through testing, action and adherence to Statutory Regulations, HTM's and other respective guidance.

This group reports quarterly via the estates department to the Infection Control Committee any exceptions to water and ventilation management.

The membership for the group has been developed to include independent authorising engineers (AE) for ventilation and for water.

Water Safety

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

Theatre Ventilation

All theatres are required to have an annual ventilation inspection undertaken by independent companies to ensure that the theatre facilities meet the required minimum standards as per the Health Technical Memorandum (HTM) 03-01: Specialised ventilation for healthcare premises Part B: and are safe for use. The estates team receive all such inspection reports including host sites. Reports are reviewed by estates, infection prevention and control nurses and the infection control doctor and any remedial work required is followed up by the estates team. If the ventilation report indicates that the theatre is not preforming to the acceptable standard, then the appropriate action is taken and if deemed necessary the theatre is taken out of use until the required work has been undertaken and there is evidence that the theatre is safe to be used.

Theatre Ventilation System Shut Down

As part of the drive towards the NHS Net Zero programme, a pilot that was undertaken in theatres 1 to 4 at City Road where the ventilation system was completely shut down overnight when the theatres were not in use. This practice is in accordance with the Health Technical Memorandum (HTM) 03-01. The outcomes from the pilot were shared at Water Safety and Ventilation Group and at ICC and based on the evidence provided which provided assurance that the shutdown of the ventilation system overnight did not pose a risk, it was agreed at ICC that this practice could be implemented in all theatres at City Road following the development of a Standard Operating Procedure. The estates team aim to look at implementing this practice in the theatres at the network sites that are managed by the MEH team.

Capital Planning Projects

The IPC Team remain committed to assisting the Estates department and the Divisions in the development of safe and regulatory standards approved projects which includes the building works, water safety and ventilation in accordance with national guidance, Health Building Note 00-09 (HBN 00-09) 'Infection Control in the Built Environment' and other HTM's and HBN's are used for as required.

Projects that the IPC Team have been involved with and have provided IPC advice for patient safety:

- Ealing

- Potters Bar

IPCT Projects

Sustainability

As part of the sustainability in IPC agenda, the IPCN is a member of the trust sustainability steering group and has been working in collaboration with the trust sustainability lead to look at initiatives where IPC changes could be made.

Multi-use dilating eye drops

As part of the Medical Retina Green initiative to reduce carbon emissions and as a cost improvement venture, the use of single use dilating eye drops was reviewed, and a trial of multi-use dilating eye drops was undertaken in diagnostic hub at City Road for 3 weeks from the beginning of February 2025. The IPCNs participated in this trial and provided guidance on the procedure and practices that were required to prevent cross infection. The trial evaluated well and has been extended for a further 6 months in the diagnostic hub before it is rolled out trust wide.

Facilities – Cleaning **by Nigel Lambert Soft Services Manager**

A clean and safe healthcare environment is crucial for maintaining patient safety and promotes patient confidence in the organisation.

Medirest is the provider for cleaning, security and catering services at City Road, Brent Cross, Hoxton and Stratford. The National Standards of Healthcare Cleanliness 2021 has been implemented, and all functional areas have been categorised according to the functional risk categories and standards of cleaning are monitored through the audit process.

The frequency of audits is determined through the functional risk category assigned in accordance with the national standards. Any issues with cleaning identified during the audits are fed back to the Medirest front line managers to address and audit reports are shared with the clinical leads. In addition, cleanliness is monitored through monthly cleaning audits undertaken by link practitioners, annual environmental audits undertaken by the IPCNs and bi-monthly walkabouts undertaken by facilities, estates, IPCNs, Medirest and matrons at City Road. These walkabouts are undertaken at some network sites with the matron and domestic service provider supervisor. Key concerns related to cleaning, waste, pest control and linen are included in the recently rebooted Soft Services Manager led, Cleanliness Monitoring Meeting (CMM), which is now held monthly and now renamed the Cleanliness Operational Group (COG), the reasoning for these charges is to be more responsive to any issues that may arise. The group includes representatives from infection control, estates, Medirest,, eye bank and matrons. A summary report from the meetings highlighting any areas that require escalation is submitted to the quarterly ICC.

A trial of reusable sharps bins led by Soft Services was undertaken in 6 clinical areas at City Road in February 2025. The IPCNs attended meetings and provided IPC advice and support to the staff in areas where the sharps bins were being trialled.

Patient-Led Assessment of the Care Environment (PLACE)

The aim of PLACE[8] assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care, which include cleanliness, the condition, appearance and maintenance of healthcare premises, the extent to which the environment supports the delivery of care with privacy and dignity, how well the needs of patients with dementia are met, how well the needs of patients with a disability are met and the quality and availability of food and beverages. These assessments are undertaken by teams made up of staff and members of the public.

The IPCN's were key contributors to the annual PLACE assessment undertaken at the trust in November 2024. Three sites were inspected including City Road, Croydon and Bedford Network sites.

The National results have been shared and are located on the Soft Services Teams audit group.

Overall scores for each category for each site were:

Site	Cleanliness	Food-Ward	Privacy, Dignity & Well being	Condition and Appearance	Dementia	Disability
MEH at Croydon University Hospital	**93.57%**	**NA**	**82.05%**	**92.41%**	**80.56%**	**83.61%**
MEH at Bedford Hospital	**87.07%**	**NA**	**90.24%**	**80.26%**	**80.95%**	**80.70%**
MEH at City Road	**97.70%**	**97.78%**	**89.67%**	**97.18%**	**84.97%**	**85.71%**

An action plan has been developed to address the issues identified from the assessment. A proposal will be presented at the next Clinical Governance Committee to agree possible standardisation and priorities across all areas of the Trust to address the areas highlighted for improvement by Soft Services.

Education and Training

Infection Control Mandatory Training

All IPC mandatory training is available via e-learning. There are 2 levels, level 1 & level 2 training packages one for clinical staff and one for non-clinical staff. Both packages are designed to meet the relevant learning outcomes in the UK Core Skills Training Framework.

Clinical staff are required to complete the training annually and non-clinical every 3 yearly. Assurance mechanisms within the Trust include monitoring of IC mandatory training compliance and this is presented at ICC.

During the year, the IPCNs have delivered focused face to face training in departments including at network sites. The training has included reinforcing the importance of hand hygiene and Bare below the Elbow compliance, the appropriate wearing of gloves and decontamination of patient equipment.

The trust overall average compliance for clinical staff was **89%** and **95%** for non-clinical staff achieving above the trust target of **80%**.

Infection Control Link Practitioners

The trust has link practitioners in clinical areas across all sites. Link practitioners are a key resource for disseminating infection control information. Four virtual half day link practitioner workshops were held in the year.

Topics covered included:

- Measles Awareness
- The correct use of Personal Protective Equipment
- Management of a patient with suspected or confirmed Whooping Cough
- Decontamination of Equipment
- Mpox Awareness
- Management of a suspected or confirmed case of Open Pulmonary Tuberculosis
- Update on new IPC national IPC guidelines
- Bare Below the Elbows requirements

Measles awareness sessions

In response to the high number of measles cases reported in London, the IPCNs delivered measles awareness sessions both virtually and face to face for staff in the Accident & Emergency Departments, Urgent Care Centres and Paediatrics at City Road and at some network sites. Measles posters were disseminated to all sites for patients, staff and visitors for information and awareness.

World Hand Hygiene Day May 2024

The theme for the world hand hygiene day[9] was ‘sharing knowledge about hand hygiene through, impactful training and education on infection prevention and control for health and care workers. To celebrate the day, the IPCNs visited departments in City Road to offer hand hygiene training using the glo box that staff could use to check their hand hygiene technique. Staff were reminded about the need to be ‘Bare below the Elbows when delivering patient care and reminded on the correct use of disposable gloves. Posters and other promotional materials were shared with all departments and network sites.



The Monthly Bug Brief

This infection control newsletter has covered a variety of information this year, examples include:

- updates on Covid-19 guidance, nationally and locally- for example measles
- compliance scores for audits and key findings with recommendations for improvement in practice
- new Trust policies and standard operating procedures published on the intranet
- changes in practices at the Trust
- promoting the seasonal vaccinations

IPCT Professional Development

The band 6 IPCN completed the PG Dip in Infection Control in March 2024 and was awarded a distinction by the University of Essex.

Annual Infection Prevention Society (IPS) Conference and Hospital Infection Society Conference

Two IPCNs attended the Infection Prevention Society conference and the Hospital Infection Society conference in September and November 2024. Both conferences provided a platform for collaboration, sharing knowledge and provided an opportunity to learn from and interact with experts gaining insights into the latest developments and best practice in IPC globally.
Amongst many topics covered a clear national focus was on sustainability in IPC.
The IPCNs were able to gain knowledge and information about products that met the sustainability requirement in healthcare such as recyclable curtains, reusable torniquets, sustainable sharps bins and a natural disinfectant cleaning solution.

The IPCNs aim to look at these products in collaboration with key stakeholders with a view to moving away from single use disposable items as part of the trust's strategic sustainability objective.

Conclusion

Overall, the IPC Annual Report for 2024/25 has demonstrated achievements and areas of improvement through compliance criteria with the Health and Social Care Act and the IPC BAF which covers all aspects of IPC to protect patients and staff.

The surveillance has met all performance standards, and the audits have also been meeting high standards. Many programmes raising awareness of key issues have been undertaken by the wider IPC members, including antimicrobial awareness, sharps safety, hand hygiene, measles alerts and seasonal vaccinations. Effective responses from the IPCN's in controlling infectious disease exposures and preventing onward transmission has provided assurance for clinical care and patient safety.

Looking forward to 2024/25 the IPCT aim to continue to work to an annual IPC programme of work which will include supporting antimicrobial stewardship through the development an action plan based on the UK 5-year action plan for antimicrobial resistance 2024 to 2029 in collaboration with the trust antimicrobial pharmacist and other key stakeholders.

The IPC Team will continue to strive to maintain high standards within IPC and will continue to work with staff, patients and other service users to help ensure care is delivered in a clean and safe environment.

References

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5 NHS England (2022) National Infection, Prevention and Control Manual for England NHS England » National infection prevention and control manual (NIPCM) for England

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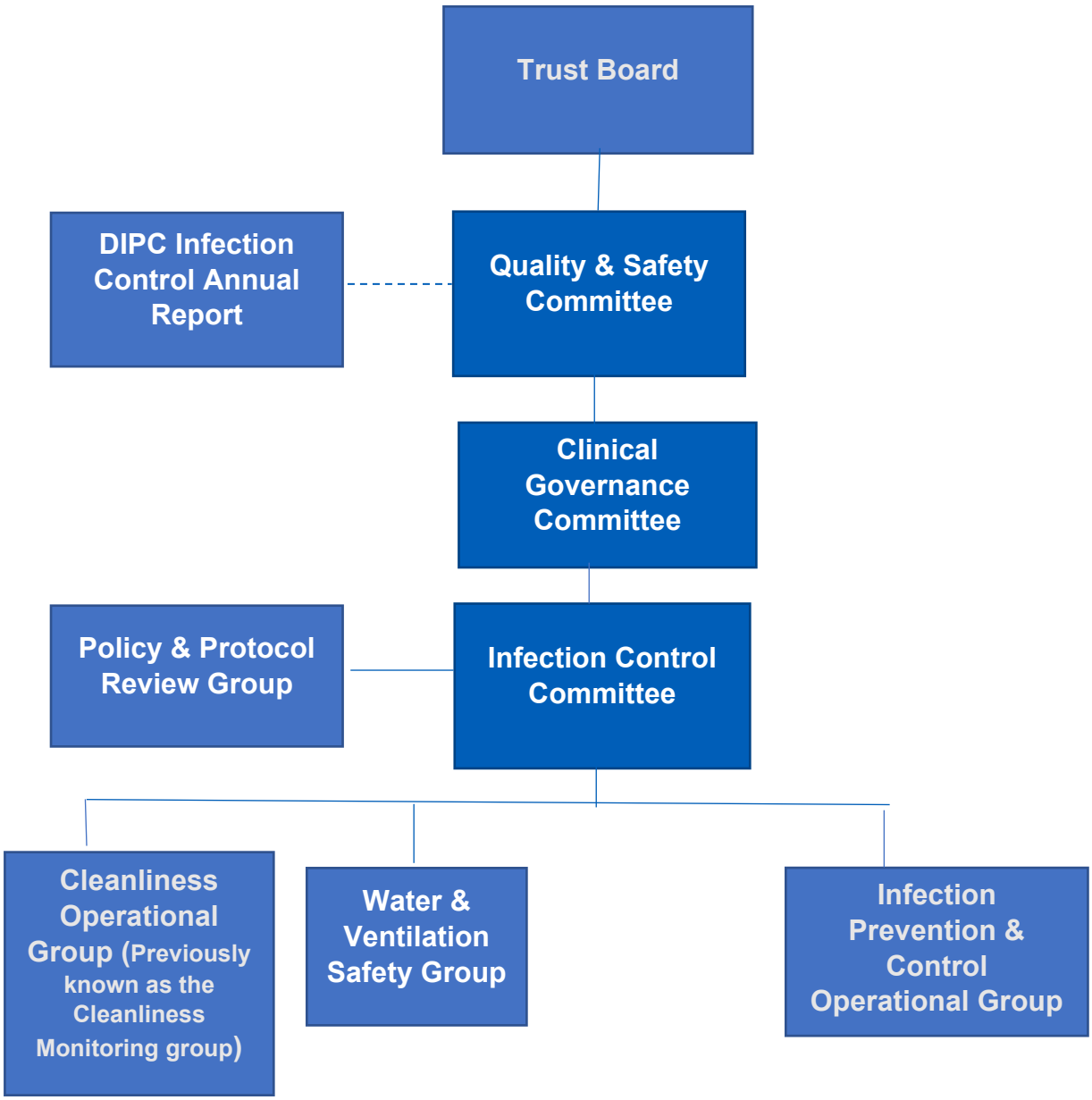
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8. Patient-Led Assessments of the Care Environment (PLACE) - NHS England Digital

9. World Hand Hygiene Day 2024

Appendix 1

Infection Prevention & Control Governance Reporting & Accountability Structure



Appendix 2

Moorfields Eye Hospital NHS Foundation Trust

NHS

Infection Control Programme of Work 2024/25

Introduction

The Infection Prevention and Control Programme of Work (POW) is developed by the Infection Prevention and Control Team (IPCT). The POW focuses on continuous implementation of IPC measures and systems to embed best practice into everyday service provision.

The IPCT have taken the lead in the development of the Programme trust wide but requires department leads and IC link practitioners to execute parts of the programme, such as audits and reporting on surveillance screens. It is recognised that the IPCT can advise, monitor and educate, but it is the responsibility of every member of Trust staff, clinical and non-clinical to put infection prevention and control into practice to ensure the best outcome for patients.

The IC Programme describes the infection prevention and control activities that the Trust will focus on for the specified time frame.

The focus of the IC programme this year will be on:

- Surveillance of key alert organisms reported monthly and quarterly.
- A planned programme of training and education
- Audits of policies and practices
- IPCN audits of high-risk areas throughout the trust
- Update or review of policies/protocols & develop new polices/guidelines as required.
- Identify campaigns and projects for IPCT Action

The trust seeks to be compliant with the current version of Health and Social Care Act 2008 (amended 2022) and registration with the Care Quality Commission (CQC) which requires compliance with their registration standards including those that relate to infection prevention and control. Any issues or actions required to achieve the mentioned objectives will inform the IC Programme.

This POW will endeavour to ensure trust compliance with the National Infection Prevention and Control manual for England (2022) NHS England » National infection prevention and control manual (NIPCM) for England, NICE Guidelines on healthcare-associated infection (QS113 and QS61) as appropriate to the workings of Moorfields and the Infection Prevention and Control Commissioning Toolkit, 2016.

Surveillance

The close monitoring of alert organisms and ophthalmic infections is undertaken in accordance with Trust Policy.

Mandatory Alert Organism Reporting				
Receiving Body	**Alert Organism**	**Frequency**	**Responsible Person/s**	**Timescale**
UK Health Security Agency, Trust Board, Integrated Care Board, Infection Control Committee, Clinical Governance Committee	Bacteraemia MRSA MSSA Gram negative - E. coli, Pseudomonas aeruginosa, Klebsiella Spp.	Monthly Quarterly	Infection Prevention and Control Nurses	Ongoing
	Clostridium difficile > 2yr	Monthly Quarterly		
	MRSA and CPE Screening Surveillance	Monthly Quarterly		

Voluntary reporting of MRSA & Carbapenemase Producing Enterobacteriaceae (CPE) identified patients with suspected or confirmed carriage quarterly.

Ophthalmic Infection Reporting				
Receiving Body	**Infection**	**Frequency**	**Responsible Person/s**	**Timescale**
Trust Board, Quality and Safety Committee, Infection Prevention and Control Operational Group, Infection Control Committee, Clinical Governance Committee, Leads of Departments	Post-procedure Endophthalmitis	Monthly Quarterly	Infection Prevention and Control Nurses	Ongoing

- Monitoring of possible adenovirus will be undertaken by the Infection Prevention and Control Team and shared with the departments and Infection Control Committee as relevant.

- SSI – The development of other ophthalmic surveillance will be included as systems are developed.

Training and Education

Infection Control level 1 and level 2 online e-learning mandatory training packages are available.

Programme	Frequency	Mode of delivery	Responsible Person/s
Awareness Training Level 1 – Non-clinical staff	3 yearly	E-Learning	Online
Awareness Training Level 2 – Clinical staff	Annually	E-Learning	Online
Volunteer Training	As requested	Face to face	Infection Prevention and Control Nurses
Link Practitioners' Workshop	Quarterly for 2 hours	Virtual	Infection Prevention and Control Nurses

Audit

The traffic light rating of audits is based on IPS standards.

Policy	Frequency	Responsible Person/s	Timescale	2022/23	2023/24	2024/25
Standard Precautions	Annually	Link Practitioners	**February**	**98.7%**	**97.6%**	**96.4%**
Sharps Management	Annually	Link Practitioners	**March**	**92.3%**	**98.6%**	**95.8%**
Isolation Precautions	Annually	Link Practitioners	**June**	**97.5 %**	**96.7 %**	**97.1%**
Surgical Site Infection	Annually	Link Practitioners	**August**	**98.6%**	**100%**	**100%**
Antimicrobial prescribing policy + Antibiotic sensitivity data	Annually	Antimicrobial pharmacist	variable	Adherence to Abx px audit Perioperative Abx px in Adnexal audit	Fluoroquinolone px audit Antibiotic px compliance in MPEC audit	Voriconazole monitoring audit

Practices	Frequency	Responsible Person/s	Timescale	2022/23	2023/24	2024/25
Hand Hygiene	Monthly	Link practitioners	Ongoing	98.5%	98.2%	**97.7%**
Cleanliness	Monthly	Link practitioners	Ongoing	97.5%	97.3%	**96.5%**
Slit Lamps	6 monthly	Link practitioners	**July**	97.9 % July 2022	98.4% July 2023	**98%**
			January	97.7% January	97.0% January	**97%**
Hand Hygiene Facilities	Annually	Link Practitioners	**October**	98.7%	97.8%	**98%**
Decontamination	Annually	Link Practitioners	**September**	100%	99.5%	**99.5%**
Venflon Insertion Technique	Annually	Link Practitioners	**August**	99.4%	100%	**98%**
Linen, Curtains and Blinds Audit	Annually	Link Practitioners	**February**	88.8% February however 81.4% is recorded on Tendable	94.7% February	**95.1%**
Sharps Bins	Annually	Daniels	**November**	94.9% January 2023	Completed	**96.8%**
Toilets and Bathrooms	Annually	Link Practitioners	**April**	95.4%	96.5%	**96.6%**

ICN audits are an indication of standards observed at a single point in time and do not reflect continual performance. The recommendations from audit findings are provided to achieve improvements in quality of service and to guide staff towards best practice. It is expected that departmental staff will lead on infection prevention in their day-to-day work, highlighting areas of concern to members of the ICT and working to sustain high standards of patient care at all times. (Board to Ward, 2008)

Environmental Audits

Annual environmental audits are undertaken by the ICNs.

Location	2022-23	2023-24	2024-25
Operating Theatres			
City Road Theatres Private Patients Theatres	83.5% September 2022	91.6% June 2023	**91.1% July**
Ealing Theatres	93.6% April 2022	94.4% July 2023	**95.7% September**
Bedford Theatres	94.7% April 2022	94.3% July 2023	**96.3% September**
St Ann's Theatre*	83.4% June 2022 92% December 2022	91.4% December 2023	**88.3% December**
St George's Theatres	88.1% February 2023	**Completed**	**93.7% June**
Potters Bar Theatres	95.8% June 2022	92.9% June 2023	**87.5% July**
Northwick Park Theatres	94.0% March 2023	**95.5% March**	**92.4% December**
QMR Theatres	97.6% February 2023	**Completed**	**97.1% June**
CUH Theatres	94.4% June 2022	**93.4% July 2023**	**94.4% September**
MPEC Theatre	New Unit – 95.5% March 2023	92.5% March	**96.6% February 2025**
Stratford			**New Site** **96.4% June 2024**
Intravitreal Injection rooms & Minor Ops Rooms	**February**		
RTU – LGF injection Suite/ 3rd Floor x 4	87.5% July 2022	**83.3% November 2023 – Due May 2024**	**91.7% June 2024**
Clinical Research Unit x 1	95.8% March 2022	95.8% May 2023	**91.7% July 2024**
MPOC 2nd Floor Injection Roomx1	87.5% August 2022	95.8% December 2023	**95.8% December 2024**
MPOC Minor Ops/Treatment Room x1	87.5% August 2022	95.7% December 2023	**89.7% December 2024**
Bedford North Wing IV Suite x2	91.3% April 2022	95.7% July 2023	**Now situated in South Wing** **95.8% September**
Sir Ludwigg Guttmann Injection Room	95.7% May 2022	90.9% July 2023	**Site closed**
Croydon Injection Room x2	82.6% June 2022 100% March 2023	**81.8% - March Will be repeated in 6 months – Sept 2024**	**87.0% September 2024**
St George's Injection Room x 2	100% January 2023	**Completed**	**100% June 2024**
Ealing Injection Rooms x2	93.6 April 2022	**91.3% July**	**100% September**
Northwick Park Injection Rooms x 2	87.0% March 2023	**91.7% March**	**95.8% December**
St Ann's Injection room x1	82.6% June 2022 100% December 2022	**90.4% December**	**81% December will be repeated in June 2025**
MPEC IV rooms x1	95.8% March 2023	**95.8% March**	**95.7% February 2025**
MPEC Minor Ops/Treatment Room x1			**100% February 2025**
Stratford x2 Injection Rooms			**New site** **91.7% June 2024**
Wards & A&E			
Mackellar Ward	96.6% February 2023		**93.3% December 2024**
Sedgwick Ward	92.7% February 2023		**92.3% January 2025**
Observation Bay	97.1% February 2023		**95.1% December 2024**

Cumberlege Ward		95.6% January 2024	**98% February 2025**
Duke Elder Ward	94.5% January 2023		**94.9% June 2024**
RDCEC Ward		94.8% October 2024	**93.3% October 2024**
A+E City Road- Adults	**92% July 2023**		**92.4% February 2025**
A+E RDCEC- Paediatric		**93.3% August**	**94.8% October 2024**
Minor Ops Room (Theatre 9 City Road)	88.9% December 2022	**94.6% December 2023**	**89.7% December 2024**

Policy Review

Policy	Review Date
Closure of wards – Infection Outbreaks	**Published**
CPE Management	**Published**
Creutzfeldt-Jakob Disease (CJD)	**Published**
Management of an infection outbreak or incident	**Published**
Respiratory Viral Infection	**Published**
Measles vaccination	**Published**
Varicella zoster	**Published**
Viral Haemorrhagic Fever	**Published**
Tuberculosis (TB)	**Published**
Notifiable infectious diseases and Notification	**Published**
Sharps Injuries and Blood Borne Virus Exposures (Prevention)	**Published**
Sharps injuries and blood borne virus exposure (Management)	**Published**
Standard Precautions	**Archived replaced with National IPC Manual**
Communicable Diseases Management	**Published**
MRSA	**Published**
Surveillance	**Published**
Surgical Site Infection (Prevention)	**Published**
Decontamination - Medical Devices and Equipment & Disinfection	**Published**
Intravenous access and devices	**28.02.2025**
SOP/Protocol/Guidelines	**Review Date**
Enhanced Cleaning of IV rooms	**Published**
Adenovirus	**Published**
Maintenance, decontamination & disinfection of mattresses, couches, trolley covers and pillows	**Published**
Povidone Iodine	**Published**
Patient & Visitor Information Leaflets	**Review Date**
MRSA screening	**Published**
Clostridium difficile	**Published**
MRSA Decolonization	**Published**
Sharps Injury Management	**Published**
Infection Prevention and Control for Contractors and Volunteers	**Published**
Infection Prevention and Control & MEH	**Published**

Moorfields Eye Hospital NHS Foundation Trust

NHS

Safeguarding Annual Report 2024 - 2025



Version: 1.0
Status: Final
Approved: 23 July 2025
Ratified: xxxx 2025

Report Title:	**Safeguarding Children, Young People and Adults** **Annual Report 2024 - 2025**
Report From:	**Sheila Adam** Chief Nurse and Director of Allied Professionals / Executive Lead for Safeguarding
Prepared By:	**Tracey Foster** Lead Nurse SafeguardingTeam **Alison McIndoe** Named Nurse Safeguarding Children & Young People (SGC&YP) **Lucy Howe** Lead Nurse Vulnerable Adults **Claire Lloyd** Safeguarding Nurse Advisor Chidren & Young People (SGC&YP) **Helen Carpenter** Safeguarding Adults (SGA) Advisor & Mental Capacity Act (MCA) Practice Development Nurse **Karen Wong** Named Doctor for Safeguarding Children, Young People and Adults **Urim Jaha** Safeguarding Co-ordinator & Liaison Manager / Safeguarding Champion
Previously Discussed At:	**Safeguarding Assurance Committee** **Clinical Governance Committee**
Link to Trust Strategic Objectives:	**We will work together to discover, develop and deliver.**

Executive Summary

All staff within Moorfields Eye Hospital NHS Foundation Trust have a responsibility for ensuring that children and young people under our care or associated with the Trust and vulnerable adults are protected and safe, and that safeguarding is an integral part of our governance systems.

This Safeguarding Annual Report sets out the work carried out in relation to providing assurance that the Trust:

- Continues to fulfil its statutory and mandatory duties, responsbilities and requirements relating to safeguarding and promoting the welfare of children and young people under Section 11 duties of the Children Act 1989 and 2004 and to safeguard vulnerable adults, as stated in the Care Act 2014 and the Care and Support Statutory Guidance (updated 2018).
- Actively collaborates with a wide range of partner organisations and contributes to local multi-agency Safeguarding Partnerships and subgroups across the North Central London (NCL) footprint and is compliant with contractual standards set by Integrated Care Boards (ICBs).
- Continues to be compliant with the Mental Capacity Act (MCA) 2005 and MCA Code of Practice 2007.
- Is compliant with the key mandatory elements of the PREVENT duties and responsibilities.
- Maintains effective safeguarding systems and processes.
- Is compliant with CQC key lines of enquiry (safe, effective and responsive).
- Is responsive to emerging trends and themes in relation to safeguarding concerns.
- Is assessed on its performance both internally and externally regarding safeguarding.
- Has identified and responded to any areas of risk in relation to its statutory safeguarding responsibilities during the reporting period.
- Is providing an update to internal and external stakeholders on the developments in relation to safeguarding children, young people and adults, MCA, Prevent, dementia and learning disability and autism since the previous report 2023 - 2024.

Quality Implications This report provides assurance of the Trust's response to children, young people and vulnerable adults for whom there are safeguarding and/or child or adult protection concerns and improving patient safety, outcomes and experience.
Financial Implications There are no financial implications arising from this report.
Risk Maintaining effective safeguarding arrangements increases the safety of children and young people and adults at risk are protected, ensures the wellbeing of patients is upheld and reduces the reputational risk to the Trust or potential regulatory action.
Action required / Recommendation The Board is asked to note the report and take assurance from it.

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

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Introduction

The safeguarding of children, young people (SGC&YP), vulnerable adults and adults at risk (SGA) remains a high priority within Moorfields Eye Hospital NHS Foundation Trust and is a collective responsibility. Safeguarding is governed by a range of legal and regulatory requirements including the Children's Act 1989 and 2004, the Care Act 2014, the Mental Capacity Act (MCA) 2005 and the PREVENT duties.

The Trust recognises that safeguarding children extends much further than paediatric services and includes 16 – 17-year-olds (young people) seen in adult services, siblings of paediatric patients, unborn babies and dependent children of adult patients known as the "Think Family / Child behind the Adult" agenda.

This safeguarding annual report sets out the work carried out by Moorfields Eye Hospital NHS Foundation Trust (including the network sites where the Trust provides services), in relation to providing assurance that the Trust is compliant with statutory safeguarding duties and responsibilities as outlined in the executive summary. The report also provides an update to internal and external stakeholders on developments in relation to SGC&YP, vulnerable adults, PREVENT, MCA, dementia and learning disability and autism including progress following the 2023 – 2024 annual reports.

This report is brought to the Trust Board for assurance prior to dissemination to Islington Directorate of North Central London Integrated Care Board (NCL ICB) and Islington Safeguarding Children Partnership (ISCP) and Islington Safeguarding Adults Board (ISAB).

Throughout this report the safeguarding professionals, who are collocated and work collaboratively are referred to as the safeguarding team or team. All resources and documents referenced and additional data are available on request from: **moorfields.safeguarding@nhs.net**

Governance and Safeguarding Committee

Accountability and Governance

The Chief Nurse / Director of Allied Professionals is the Executive Lead for Safeguarding. The safeguarding team represent Moorfields at the Islington Safeguarding Children Partnership (ISCP) Board and the Islington Safeguarding Adults Board (ISAB). There is a clear line of safeguarding accountability and governance structure included in the safeguarding policies.

Safeguarding Committee

In October 2024 the two safeguarding committees combined to become one oversight and assurance safeguarding committee. The meetings are well attended with representation from a wide variety of staff from services and departments across the Trust and is chaired by the Chief Nurse / Director of Allied Professionals or their deputy.

The Committee met quarterly via MS Teams and continued to monitor the progress of the annual work plans, Key Performance Indicators, training compliance, risks and incident reporting. A new approach to the committee meeting to further disseminate and embed learning is an agenda item entitled Safeguarding in Action. Examples of these are included in this report.

The Designated Safeguarding Professionals from Islington Directorate of NCL ICB attend the committee providing support, guidance and constructive professional challenge.

The Safeguarding Committee reports into the Clinical Governance Committee (CGC) including submission of agreed quarterly meeting minutes and the sub-committee escalation summary report.

This annual safeguarding report is presented to and approved by the safeguarding Committee prior to dissemination to the Clinical Governance Committee, the Quality and Safety Committee, the Trust Board and externally to Islington Directorate of NCL ICB, the ISCP and ISAB. The quality assurance safeguarding declaration to the public will be available on the Trust internet site once development of the new safeguarding pages are completed and after the Board have received this report.

Key Achievements

Safeguarding Children and Adults – Working Together:

- Establishment of integrated Children, Young People and Adult Safeguarding Committee including Safeguarding in Action agenda item.
- Co-development and delivery of an integrated safeguarding session to support the face-to-face classroom training Care Certificate programme.
- Active Participation in Safer September 2024 with a safeguarding awareness stand focusing on Child Exploitation and County Lines, Information Sharing, Was Not Brought, Cuckooing, Homelessness and contributing to an interactive staff intranet quiz.
- Participation in Mandatory All Staff 2024 event with a safeguarding awareness stand focusing on Mental Capacity Act, Professional Curiosity, Information Sharing, the 4 Steps to Safeguarding and a staff participatory quiz.
- Co-development and delivery of two new cohorts of safeguarding champions initial training.

Safeguarding Children and Young People:

- Enhanced team visibility and support.
- Responsive approach to emerging safeguarding themes.
- Successful recruitment to vacant Safeguarding Children & Young People Nurse Advisor post.
- Development of Child Protection Information Sharing (CPIS) Policy and training materials.
- Strengthened CP-IS training and local capacity building.
- Enhanced early intervention through paediatric Was Not Brought (WNB) pathway development.
- ISCP Case review subgroup representation and national research contribution.
- Continued development of the quarterly internal Safeguarding Nuggets Newsletter to support learning.

- Safeguarding training workshops delivered Trust-wide on key safeguarding topics including professional curiosity, WNB, consent, and parental responsibility. A bespoke session for administration and clerical teams focused on the safeguarding importance of accurate demographic data.
- Strategic contribution to the Islington Safeguarding Children Partnership Annual Report (2022–2024).

Safeguarding Vulnerable and at Risk Adults:

- Continued delivery of creative, high-quality classroom-based multiagency Level 3 safeguarding adults training.
- Development of Easy Read materials to support the Accessible Information Standard.
- Supporting the development of the Vulnerable Patient Cataract Pathway Pilot.
- Implementation of face-to-face, bespoke, classroom-based Mental Capacity Act training programme offered to all staff, including as part of clinical induction.
- Development of the Moorfields external internet pages for Easy Read.
- Supporting the Trust's commitment to the Sexual Safety Charter.
- Supporting development of Vulnerable Patient Cataract Pathway.
- Continued development of the quarterly internal Safeguarding Snippets and Caring Voices Newsletter to support learning.
- Continued attendance at thematic reviews to ensure that learning is disseminated across the Trust using a wide variety of media and platforms.
- Strategic contribution to Islington Safeguarding Adults Board Annual **Report** 2023 – 2024.

Audit

Compliance with Safeguarding Incident Reporting Protocols Internal Audit

As committed in the 2023/2024 annual report, an internal audit was undertaken during 2024/2025 to evaluate the impact of the updated *Safeguarding Children and Child Protection Procedure Policy* and to assess compliance with safeguarding incident reporting protocols across Moorfields

Eye Hospital sites. Findings of the audit reinforced the importance of continuous improvement, operational alignment, and safeguarding leadership to maintain high standards of care and statutory compliance.

Section 11 Safeguarding Assurance Submission

The biannual Section 11 assurance audit was submitted to the Islington Safeguarding Children Partnership Board, confirming full compliance with all eight safeguarding standards.

Safeguarding Adults Partnership Audit Tool (SAPAT) Submission

The annual SAPAT assurance audit was submitted to Islington Safeguarding Adults Board reflecting the Trust's contribution to the fourteen safeguarding elements of the audit tool.

Key Risks and Risk Mitigation Factors

Safeguarding has a shared risk register which is reviewed monthly and discussed and monitored as a standing agenda item at the quarterly Safeguarding Committee. Over the past reporting year there have been 4 risks which have all had risk ratings reduced. Further discussion regarding the risk ratings and closure, where, appropriate, will take place at the Safeguarding Committee Meeting in July 2025.

One relates to Disclosure and Barring Scheme (DBS) Renewals Compliance. Following the identification of low compliance in 2023, extensive work was undertaken and compliance rates are reported into the Safeguarding Committee Meetings, the risk has remained on the risk register to support assurance that DBS renewals compliance is maintained.

One recurring risk regarding the team capacity when there are unplanned absences has been mitigated by reviewing deliverables and reprioritising work and exploring different ways of working.

One current risk relates to fulfilling increased statutory training requirements as the safeguarding agenda continues to expand. Mitigations have included reviewing how to develop current knowledge, skills, and behaviours required to appropriately respond to safeguarding concerns, exploring creative learning opportunities for all staff and access to external safeguarding training opportunities.

Finally, there is also one current risk relating to the inconsistent use of the Was Not Brought Pathway (WNB) for children who are not brought to their appointments. Mitigations have included the development of an enhanced WNB pathway launched in July 2024.

Incidents and complaints

During 2024/2025, the Safeguarding Children & Young People Team managed 84 incidents reported through the incident reporting process. Of these, 53 incidents (63%) were formally closed by the service following thorough review and intervention. The remaining 31 incidents (37%) received input for ongoing management or monitoring. Of note there were no acts of omission identified.

However, several safeguarding themes and key learnings emerged from national practice reviews, supervision, and multi-disciplinary discussion, contributing to Trust-wide shared learning and service improvement and have been added to safeguarding training.

Incidents are entered on the Trust Incident Reporting System. All entries are reviewed by the Team to assure that appropriate action is taken, or the staff member is contacted to advise on appropriate action before the report can be closed.

During the same time period, 232 incidents were reported under the category of safeguarding adult, an increase of 45%, highlighting a variety of issues regarding adults at risk. Every incident is reviewed and action taken to provide assurance that any safeguarding concerns have been identified and appropriate action taken. Following this initial review, 74 were reported as no further action required by safeguarding, and 158 involved safeguarding either through providing additional information or actions to support closure, providing information post closure or in some circumstances closing the incident.

Themes identified during this reporting period have again included Mental Health, MCA and patient falls. It is recognised that incidents which are mental health related were attributed to safeguarding as there was no mental health option. Steps are being taken to address this within the reporting system. The team has also developed face to face MCA training to support learning and are active members of the Falls Committee to ensure a safeguarding overview of patient falls.

During 2024/2025 the Safeguarding Children and Young People (SGC&YP) Team contributed to the management of two formal complaints where safeguarding considerations were identified. None involved vulnerable children with safeguarding concerns, however the safeguarding team recommended improvements to enhance safeguarding-informed clinical practice.

The Safeguarding Adults team reviews all complaints to the Trust and scrutinises for any safeguarding adult element. A safeguarding review ensures a high-quality response to the complaint and understanding of the Trusts legal obligation to safeguard. There have been 102 complaints reviewed by the safeguarding team, 11 with a safeguarding/vulnerable adult feature including a learning disability, dementia or mental health component. Themes requiring safeguarding input included reasonable adjustments, vulnerable patients being discharged after they did not attend (DNA) and repeated outpatient appointment cancellations by Trust in vulnerable patients.

Safeguarding Champions

The Safeguarding Champions Model was introduced in December 2017 with Trust Board endorsement and the model aligns with Trust safeguarding policies and governance, contributing to high standards of patient safety and care and improving patient outcomes in relation to children, young people and vulnerable adults. Champions act as local safeguarding resources and points of contact, supporting and signposting colleagues with safeguarding queries.

Two new cohorts of staff from a diverse range of roles, departments and sites completed their initial training bringing to date 122 champions who have been trained, with 76 currently active across clinical and non-clinical areas, including volunteers.

The role of the Safeguarding Liaison Manager was established to act as a key link between the corporate Safeguarding Team and the network of Safeguarding Champions. This role supports communication, coordination, and the dissemination of safeguarding messages, learning and training opportunities including from the local safeguarding partnership across Moorfields. The Safeguarding Champions EyeQ intranet page continued to be maintained to support ongoing champions and provide information for staff interested in becoming a champion. While competing priorities have presented some challenges with the role, further development is planned to enhance the consistency and visibility of this role.

Further development of the Safeguarding Champions Model will be presented to the Safeguarding Committee in the upcoming reporting year reflecting Moorfields' continued commitment to safeguarding excellence, ensuring champions remain confident, informed, and empowered to promote safeguarding across all services. These efforts reflect Moorfields' commitment to excellence in safeguarding and continuous improvement in safeguarding children and young people and child protection processes.



Cohort 8 Initial Champions Training Graduation with Kathy Adams, Deputy Chief Nurse, and Safeguarding Team Members – December 2024

Safeguarding Children and Young People



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

(Working Together 2023)

Safeguarding Children In Action

As part of Quarter 4 2024–2025 Safeguarding Committee Meeting, a case study was presented that exemplified the core principles of effective safeguarding practice. The vignettes describe how professional curiosity and collaboration from the wide multi-professional team ensured indicators for wellbeing support and neglect were acted upon to keep patients safe.

By asking the right questions and being alert to subtle signs, they ensured that appropriate safeguarding measures were swiftly implemented. See Infographic Page 19.

Safeguarding Children and Young People (SGC&YP): Activity Overview 2024 - 2025

1 - Queries and Concerns



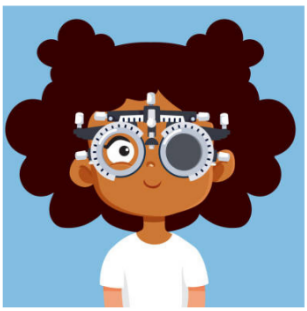
A total of **1,012** safeguarding queries were raised by internal staff and external professionals supporting children and young people.
This represents a **31% increase** compared to 2023/2024, reflecting **ongoing growing awareness** and **further embedding** of safeguarding children and young people practices across the organisation.



2 - Reasons for Discussion

Consistent with previous reporting years the top five reasons for discussion were **Was Not Brought (**396), **Information Sharing** (125)**, Eye Injuries** (78)**, Activating Safeguarding Flags** (44) and **Information Requests** (63)**.** The significant increase in queries relating to Was Not Brought (WNB) reflects the implementation and embedding of the enhanced WNB pathway launched in July 2024 encompassing medical neglect. Analysis of factors in section 5 have all contributed to the top five query and concern categories raised with the Team.

3 - Referrals to Children's Social Care (CSC)



32 referrals were made representing a 22% decrease compared to 2023/2024. While the reduction in referrals may initially appear to reflect decreased safeguarding concerns, **internal analysis** suggests it is more **indicative** of **improved staff awareness**, **earlier identification of need**, and **increased use** of **internal safeguarding advice pathways**. The simultaneous **31% increase** in internal safeguarding queries demonstrates that **staff** are **continuing** to **seek support** and **escalate concerns appropriately,** often before a statutory threshold is reached and **31%** of queries involved **children** who were **already known to CSC**. This figure highlights the **importance** of **effective multi-agency working** and **information sharing** in **safeguarding practice**.

4 - Think Family / The Child Behind The Adult.



The **Think Family** approach across all clinical settings, continues to be embedded ensuring that **safeguarding risks to children** are considered even when they **are not** the **primary patient**. This principle supports the **identification of children** who may be **at risk** due to the **circumstances of adult patients**, particularly in cases involving **domestic violence and abuse (DVA)**, **parental mental health**, or **substance misuse**. 16% of the referrals were most commonly due to **DVA**.

5 - Activity Overview Analysis



The increasing volume and complexity of queries reflects a **clear indicator** of Moorfields' **ongoing commitment** to SGC&YP, **growing visibility** and **accessibility** of the **Trust's safeguarding function**, **strengthened multi-agency working relationships**, and **staff confidence** in identifying and escalating concerns appropriately. Staff are not only more adept at **identifying risk** but are also taking **appropriate, timely action** to protect children including those potentially affected by an adult's health or behaviour.
Preventative, **informed safeguarding practice** is a positive indicator of **system maturity** and will continue to be **supported** through **training, supervision**, and **multi-agency collaboration** in future reporting periods.

Was Not Brought (WNB)

In alignment with Islington Safeguarding Children Partnership's key priorities, the Safeguarding Children Team contributed to the review and development of the Trust's paediatric Was Not Brought (WNB) pathway. This work focused on embedding best practice to support early identification and intervention in situations where missed healthcare appointments may indicate emerging safeguarding concerns. The revised pathway promotes a proactive and consistent approach to ensure children's access to healthcare is safeguarded appropriately.

As such, there was a significant increase in the WNB (Was Not Brought) Incidents (53% increase from 2022/23 to 2024/25 (n= 208 to n=319)), being reported and acted upon. This reflects a growing recognition of non-attendance as a potential safeguarding concern.

Child Protection Information Sharing (CPIS) System

Development of Child Protection Information Sharing (CPIS) Policy and Training Materials

The SGC&YP team developed a comprehensive Child Protection Information Sharing Policy, accompanied by guidance and a training resource, to support colleagues in identifying and responding to safeguarding concerns. This included specific focus on children presenting in unscheduled care settings and those not brought to scheduled appointments, helping to strengthen professional curiosity and early intervention. All accessible to staff via the SGC&YP EyeQ intranet page.

Strengthened CP-IS Training and Local Capacity Building

CP-IS training was delivered across paediatric departments to enhance colleagues' knowledge and confidence in safeguarding and information sharing. A Train-the-Trainer model was introduced to enable local ownership and sustainability of training delivery, with the Safeguarding Children Team providing continued oversight, mentorship, and support as needed.

Islington Safeguarding Children Partnership Board Priorities

Throughout 2024/2025, Moorfields Eye Hospital has actively aligned its safeguarding practice with the strategic priorities of the Islington Safeguarding Children Partnership (ISCP).

These were:

1. Structural Inequalities
2. Early Intervention and Prevention (Family Support)
3. Neglect and Parental Factors

4. Social Emotional Mental Health (SEMH), Special Educational Needs and Disability (SEND), and Inclusion

Key achievements to meet these priorities include the Trust-wide rollout of the updated Was Not Brought (WNB) pathway, integration of the Think Family approach into safeguarding training, enhancements to domestic violence risk assessment tools, and development of a paediatric SEND hospital passport. These initiatives have strengthened early intervention, improved identification of vulnerability and exploitation, and embedded child-focused practice across services. Ongoing learning has been shared through supervision, multidisciplinary training, incident closure reports, and policy development, reinforcing a consistent safeguarding culture across the organisation.

Supporting Improved Outcomes for Children with Additional Needs

In alignment with the Islington Safeguarding Children Partnership's key priorities, the team contributed to improving outcomes for children and young people with additional needs by initiating the development of a Paediatric Special Educational Needs and Disability (SEND) Hospital Passport. Building on the existing adult-focused Learning Disability Hospital Passport, this work involved collaboration with paediatric stakeholders, including the Orthoptics SEND Lead, to co-design a child-centred tool that will support safer, more individualised care for children with complex needs accessing hospital services.

These activities reflect the Trust's alignment with ISCP priorities and its ongoing commitment to strengthening safeguarding culture, enhancing workforce capability, and ensuring the needs of children and young people remain central to all care delivered. Learning has been shared across the organisation through supervision, targeted training, policy development, and multidisciplinary collaboration, supporting consistency and high-quality safeguarding practice Trust-wide.

Safeguarding Children in Action: Shared Learning Vignettes

Identifying Mental Health Concerns in a Child with Complex Health Needs



Ben*, a 12-year-old with **complex medical needs**, presented at Moorfields A&E with subconjunctival haemorrhages secondary to excessive coughing. During his visit, the **play leader** engaged Ben in conversation and identified **significant concerns** around his **emotional well-being** and **social isolation**. Ben disclosed suicidal thoughts and described feeling like a burden to his mother and younger sibling.

The concerns were immediately escalated. A **safeguarding plan** was agreed involving **liaison** with CAMHS, **information sharing** with the GP and school nursing team and a **referral to Children's Social Care** for **Early Help**, which led to the case being allocated to the **Children with Disabilities Team**.

A **home visit** confirmed Ben was safe and no longer expressing suicidal thoughts. **School related issues** were identified and explored further through a **Child and Family Assessment**.

This case illustrates the value of **holistic care** in **acute specialist settings**, where informal conversations can uncover serious safeguarding concerns and trigger **multi-agency intervention** to support the child and family.

Preventing Medical Neglect Through the WNB Pathway



Zoe*, aged 9, was under the care of the **orthoptics department** for reduced vision and a squint. Although vision problems are most treatable in early childhood, Zoe **was not brought** to four consecutive follow-up appointments — placing her eyesight at risk.

The orthoptics team recognized the risk of **medical neglect** early. After the first missed appointment, they contacted Zoe's parents to re-engage them with care. Concerns were also **shared** with the GP and school nurse. When the **pattern of non-attendance continued**, a safeguarding **referral** was made to **Children's Social Care**.

Zoe was made subject to a **Child Protection Plan** under the category of **neglect**, confirming wider safeguarding concerns. As a result of timely intervention by the orthoptics team, Zoe was brought to her appointments and wore her new glasses consistently.

This case demonstrates the **importance** of using the **WNB pathway** to **identify** potential neglect and **protect** a **child's health** and **development** through coordinated **multi-agency** action.

Professional Curiosity and Information Sharing to Safeguard a Vulnerable Young Person



Aidan*, a 17-year-old with Usher's Syndrome, was referred to Moorfields due to deteriorating vision, hearing loss, and balance issues. He **disclosed** feelings of **isolation** and **depression**, reporting that he was **homeless** and living with a friend, despite recently being **adopted**.

The **Eye Clinic Liaison Officer (ECLO)**, concerned about Aidan's wellbeing, demonstrated **professional curiosity** by seeking further clarity about his circumstances. When follow-up contact with Aidan failed, the ECLO **liaised** with his GP, who facilitated contact with Aidan's mother. This clarified that Aidan was living at home and helped re-establish communication with the family.

The ECLO **escalated** concerns appropriately, **contacting** Children's Social Care and ensuring **information** was **shared**, including the C**ertificate of Visual Impairment (CVI)** to support ongoing assessment and registration. Aidan was also referred for **counselling**.

This case illustrates the importance of **professional curiosity** and **proactive information sharing** in **safeguarding** practice. Without this, Aidan may have remained disconnected from **essential support services**.

*All Names changed to protect identity

Safeguarding Vulnerable and At Risk Adults

"Safeguarding means protecting a person's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding vulnerable adults and adults at risk is a collective responsibility and includes people with sensory or physical disabilities or impairments of mind and brain, and those with learning disabilities.

(Safeguarding Accountability and Assurance Framework 2024)



Safeguarding In Action

As part of Quarter 4 2024–2025 Safeguarding Committee Meeting, a case study was presented that exemplified the core principles of effective safeguarding practice. The staff member who initially identified and escalated the concern was invited to the meeting and formally commended for their proactive approach. Their actions demonstrated a commitment to safeguarding, embodying the values of vigilance, holistic care, and professional curiosity.

By asking the right questions and being alert to subtle signs, they ensured that appropriate safeguarding measures were swiftly implemented. See Infographic Page 25.

Safeguarding Adults (SGA): Activity Overview 2024 - 2025

1 - Queries and Concerns

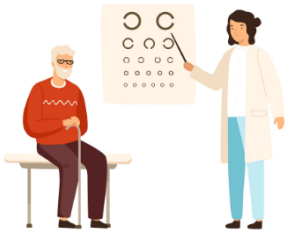


407 queries were made for advice and support from staff across the Trust and external agencies. This is a slight increase in comparison to 2023-2024 but the **complexity** and **diversity** of the queries has escalated significantly. This demonstrates that staff are continuing to have a **greater awareness** of safeguarding adults and the importance of **early identification** of concerns, and **understand** that safeguarding is an **integral part of their role**.



2 - Reasons for Discussion

The top five reasons for discussion were **mental health** (64), **safeguarding** (41), **care and support needs** (41), **Patient Did Not Attend/Was Not Brought** (28) **MCA and best interest decisions** (26).



Patient **Did Not Attend/Was Not Brought**. Queries in this category have increased significantly and can be attributed to staff recognising that n**on-attendance** can highlight a **concern** for **vulnerable adults at risk** and that **early intervention** may be required. The concept of "Was Not Brought" is explored within safeguarding adults training and encourages staff to be **professionally curious** and **seek advice.**



Staff Concerns. This category has increased significantly over the past reporting year. The team **work collaboratively** with **Human Resources**, **managers** and **Freedom To Speak Up Guardians** to ensure that advice and guidance is given to support staff members who are experiencing safeguarding and/or mental health concerns and that they are signposted to appropriate services.

3 - Category of Abuse



Domestic Abuse and Violence (DVA) and **self-neglect** queries and concerns remained the most prevalent categories identified.
Responding to DVA demonstrates the Trusts commitment to responding to safeguarding the children of adult patients demonstrating the "Think Family" approach; a way of working where the needs of the entire family are considered.



4 - Referrals

The Team was informed of **20 new referrals** to **Adult Social Care** (ASC) predominantly for **care and support needs**. Information was shared regarding concerns in 2 patients in whom ASC were undertaking **section 42 investigations**.

5 - Identifying themes and sharing learning



Based on **activity, identified themes** e.g **falls**, **DNA**, **self-neglect** are further explored within **newsletters**, **safety briefings, committees** and **meetings**. Incorporated into **safeguarding related training** by creating **anonymised case studies showcases good practice** and shares **areas for learning**.

Complex Patients Discharge

Complex patient discharges can arise when staff have been unaware of a person's holistic needs or those who require specialist support or interventions, particularly after an urgent admission. Often complex discharges are multifaceted in nature, for example, homelessness, mental health and substance misuse often go hand in hand and it can prove challenging to access the appropriate support for safe discharge.

The safeguarding team have worked closely with the surgical matron, pre-assessment and ward teams to ensure early identification of potential issues and multidisciplinary management of complex discharge, including via the weekly complex care meeting. A marked improvement has been noted in the length of stay for complex patients and an audit is planned for 2025, together with the delivery of complex patient workshops for nurses in conjunction with the safeguarding team.

Homelessness

The number of queries received regarding patients who presented as homeless and with complex health, social care and housing needs decreased slightly during this reporting period. This may be in relation to the further promotion of the homelessness flowchart and information available for staff to support patients, in addition to closer liaison with the Surgical Matron, Pre-Assessment and ward teams.

The continuing cost of living crisis along with increased pressures on local authorities to meet demand mean that homelessness is still an important focus and the Team continue to promote information and provide advice, signposting and facilitate liaison with external agencies.

A Homelessness section is included on the safeguarding adults intranet page including the duty to refer, homelessness charity and further support information and a procedure flowchart. Homelessness was again a recurring theme in the Safeguarding Snippets and Caring Voices internal newsletters.

Mental Health

The team are actively involved in the monitoring of the Mental Health Service Level Agreement (MH SLA) through the monthly monitoring meeting between East London Foundation Trust and Moorfields. The SLA provides a telephone helpline advice service and training for staff in

supporting patients attending Moorfield's for care and treatment. The MH SLA monitoring meeting provides assurance to the Safeguarding Committee on a quarterly basis.

We have worked collaboratively with colleagues to strengthen staff awareness of the mental health helpline, informed development of training content, policies, and staff resources, including a comprehensive mental health advice leaflet. Work to update the patient mental health resource page on EyeQ is planned for the upcoming reporting year.

Queries to the safeguarding team regarding mental health concerns for both patients and staff have increased by 25%. The team are not trained mental health professionals and therefore continue to promote the mental health advice line and staff wellbeing pages on EyeQ as appropriate.

Modern Day Slavery

The Trust has continued to raise awareness of modern slavery, embedding it within the Safeguarding Adults Policy and staff training. A dedicated section on modern slavery is available on the safeguarding intranet page, providing staff with direct access to key resources, including the Royal College of Nursing (RCN) Modern Slavery Pocket Guide, Metropolitan Police presentations, and the National Modern Slavery Helpline.

The Modern Day Slavery and Human Trafficking **Statement** on the Trust's internet site demonstrates Moorfields commitment to the Modern Slavery Act 2015 and their safeguarding duty.

Following feedback from staff, additional training is planned for summer 2025 to raise further awareness of modern slavery. This will be delivered by an external trainer, a former detective police officer, with specialist expertise in modern slavery and human trafficking.

The training will focus on helping staff understand the various forms of modern slavery and human trafficking, recognise the signs and indicators of exploitation, and know what actions to take if a patient or another individual is suspected to be at risk or experiencing harm.

Accessible Information Standard (AIS)

The Team supported the Trust wide accessible information standard (AIS) project which enabled a range of services to support patients with accessible needs, as part of its commitment to excellent

and equitable patient care, and its legal obligation to meet the AIS. This included development of Easy Read information lunch and learn sessions, updating Moorfields website and promotion of AIS to staff and patients at information stalls.

Patient Information and Working in Partnership

Information to support adults and family/carers continues to be available. The health information hub at City Road displays safeguarding adults leaflets, domestic abuse and violence support information leaflets, easy read information, hospital passports and This is Me leaflets, along with easily accessible information from Mencap, Alzheimer's society and Carers UK.

As part of the AIS project, the safeguarding team produced several of the most used patient information leaflets in Easy Read format. This was achieved in collaboration with the staff and service users of the Create Community Hub; an Adult Health and Communities service based in Tower Hamlets in the development and review of our Easy Read leaflets. Easy Read is a way of presenting information that uses simple language and images to make it easier to understand. It's often used for people with learning disabilities, but it can also be helpful for others, such as people with low literacy levels, English as a second language, dementia, or those who have had a stroke.

The safeguarding team worked in collaboration with the communications team to design an **Easy Read** page for the Moorfields website. This includes all the patient information available in Easy read, presented in a simplified, pictorial layout to ensure accessibility for everyone.

Other information available to the public via the Moorfields internet includes **safeguarding** support, **carer information**, **learning disability** and **dementia**.
Staff can access & provide information to patients, family and carers via the comprehensive safeguarding adults, learning disability and autism and dementia EyeQ intranet pages which are well maintained and reviewed regularly.

Carer Support

Carers play an important role in the lives of our patients, and the needs of carers is commonly a feature in Safeguarding Reviews. The Trust remains committed to supporting unpaid carers and the recognition of staff who are carers. Strong links have been maintained with Carers UK and the Trust endorses **Johns Campaign** which pledges support to carers of patients with dementia. Information is available for carers on the Moorfields website and staff intranet.

Safeguarding Adults in Action: Shared Learning Case Study
The Importance of Professional Curiosity and Holistic Care in Safeguarding



This annonymised case study highlights the golden threads of **professional curiosity** and **information sharing** and taking an **holistic approach** to identify and address **safeguarding concerns** to ensure the **safety** and **well being** of vulnerable individuals.

*Pauline an 88 year old lady had attended the pre-assessment clinic and was in the phlebotomy department to have routine bloods prior to her upcoming surgery. She lives in **extra care housing** with **additional support,** has a formal diagnosis of **dementia** and was accompanied by her **carer** during her visit.

The **phlebotomist** noticed **significant bruising** on Pauline's right arm and inquired about its cause. Pauline appeared **confused** and unable to provide a clear explanation, whilst the carer **responded abruptly** attributing the bruise to a **fall** but seemed reluctant to provide further explanation.

The **phlebotomist** was **concerned** about the bruising and the carers limited and slightly off hand response and **shared their concerns** with their line manager. An **incident report** was **submitted** as they felt further checks might be needed.

The safeguarding team **reviewed** health care information held on **HIE **(the Health Information Exchange**) where it was evidenced that Pauline had a **history of falls** and carers had previously **expressed concerns** to her GP regarding **safety** in her **accommodation**. After reviewing the incident the **Safeguarding Team** contacted the relevant Local Authority (**Adult Social Care**) to seek their opinion and if further action, including a **safeguarding referral** was advised.





A **social worker** had recently been assigned to **assess Pauline's safety** in her current living environment, due to concerns regarding safety and falls and was **working closely** with her family to support a possible move to a nursing home. A report summarising **concerns identified** during her hospital visit was welcomed. The **phlebotomist,** with **support** from the **safeguarding team** provided a **clear and factual statement** which would assist the social worker to **support Pauline** and **her family** in making **informed decisions** regarding her **future care arrangements**.

Key Learning Take Aways

Vigilance:

All staff must remain **vigilant** and **attentive** to signs of **possible abuse** and/or **neglect**.

Professional Curiosity:

Asking questions and **seeking clarification** when something seems amiss is vital.

Holistic Care:

Considering the patient's **overall situation** including their medical history and living conditions is **essential** for **effective safeguarding**.

Reporting Concerns:

Promptly reporting any concerns to the appropriate agencies supports **timely intervention** and **support**.

*Name changed to protect identity

**HIE is an electronic system that enables clinicians to view a partial electronic patient record held by a GP or other Health Services

Dementia, Learning Disability and Autism

As a specialist ophthalmic Trust, Moorfields is committed to ensuring that people living with dementia and those with a learning disability and/or autism are provided with care and treatment in a manner that is right for them. We proactively look at ways to improve the person's experience of our services by ensuring all reasonable adjustments are met to provide holistic person-centred care (Equality Act 2010). The Trust continues to have robust policies and a variety of processes for supporting patients with dementia and learning disabilities as listed in Appendix 1.

Learning Disability and Autism Training

In 2023 a consultation took place on the introduction of the requirement for mandatory learning disability and autism training by the Health and Care Act 2022 and publication of the draft Code of Practice which informed the current recommendations for training and the promotion of the Oliver McGowan training programme. Moorfields has had mandatory learning disability and autism training since October 2017 with excellent training compliance.

In 2024 it was agreed that Moorfields would adapt their current learning disability and autism training to meet the needs of our patients and ensure staff training meets the key aspects of the draft Code of Practice. NCL ICB recognised Moorfields specialism and supported the approach to provide an alternative training that meets the requirement of the draft Code of Practice.

After extensive development and testing, the new eLearning and interactive myth busting session will be launched in June 2025 and was strongly promoted during Mencap Learning Disability week.

Vulnerable Patient Cataract Pathway Pilot

Recognising that many patients with dementia or learning disabilities require a different approach to cataract assessment and treatment, and that some are unfortunately cancelled on the day of surgery due to unsuitability, the team worked in conjunction with the cataract service, Pre Assessment and Anaesthetic Team to support the development of a cataract pathway pilot at City Road tailored to this patient group.

The Vulnerable Patient Cataract Pathway supports the early identification of individual patient needs, enabling timely and more effective assessment of suitability for treatment. Where appropriate a best interest discussion takes place before offering a face-to-face appointment or a

decision is made to refer to a hospital better equipped to meet any specialist patient need. The new pathway is designed to improve patient experience and reduce cancellations on the day of surgery.

Eye Health Session for People with Learning Disabilities

The team worked collaboratively with 2 specialist optometrists (Darzi Fellow) to provide an eye health education session for people with learning disabilities based at Create Day service in Tower Hamlets. This interactive session provided service users with an opportunity to meet staff from Moorfields, to ask questions and challenge some of the myths and beliefs associated with vision loss and eye health. This session was organised to recognise the support that Create have provided Moorfields in the production of Easy Read information.

Learning Disability Improvement Standards

The Learning Disability Improvement Standards for NHS Trusts are intended to help the NHS measure the quality of service provided to people with learning disabilities, autism or both.

Moorfields have submitted data for this audit for the previous 5 years. The focus for 2024/25 audit was primarily inpatient care and mortality review, which due to the ambulatory model of the Trust, meant that Moorfields would become a significant outlier. It was agreed, after stakeholder engagement and discussion at the safeguarding committee in October 2024, that there would not be a submission for the current year. This will be reviewed for 2025/26 data submission.

Named Doctor for Safeguarding

During 2024-2025, an information gathering exercise was conducted among medical staff using a questionnaire-based approach. This initiative aimed to assess current levels of safeguarding awareness and to evaluate the visibility and engagement of the safeguarding team within clinical practice.

The findings highlighted several areas for development, particularly around understanding clinicians individual safeguarding responsibilities and awareness of available support mechanisms. In response, a series of targeted actions were implemented, including improved communication methods and a range of learning opportunities—such as drop-in sessions, one-to-one discussions, and formal safeguarding teaching sessions tailored to individual needs.

Follow-up questionnaires demonstrated a measurable increase in clinicians' confidence when managing safeguarding concerns.

Plans were put in place to expand learning opportunities and foster an environment that supports clinicians to act confidently and appropriately in safeguarding situations.

To ensure sustained progress, the information gathering exercise will be repeated with each new intake of medical staff. This provides an understanding of baseline knowledge and confidence levels, allowing for the delivery of targeted, personalised support from the outset of their clinical roles.

The Named Doctor played an integral role in supporting the Safeguarding Committee, providing assurance that medical staff are represented and challenges and successes are recognised. The Named Doctor has participated in weekly meetings, jointly led by both Named professionals, to provide a structured forum for reviewing complex cases, supporting multidisciplinary decision-making, and coordinating safeguarding activity including training, audit, and inter-agency communication. This approach has improved oversight, supported timely interventions, and embedded safeguarding into everyday practice.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs)

The MCA 2005 provides a legal framework for supporting individuals aged 16 and over who may lack capacity to make their own decisions. The DoLS are an amendment to the MCA 2005 and apply when a person resident in a care home or an inpatient in hospital, lacks capacity to consent to their care and treatment, and where measures involving restriction and restraint are deemed necessary to keep the patient safe, it may amount to a deprivation of liberty.

To ensure robust and consistent implementation of the Mental Capacity Act (MCA) 2005 and its Code of Practice (COP) a range of key activities were undertaken:

- Provided expert advice and support to staff across all departments, helping to embed MCA principles into everyday practice.

- Attended and advised on Best Interests meetings, ensuring that decisions made on behalf of individuals lacking capacity were lawful, ethical, and person-centred.
- Maintained a comprehensive MCA intranet page, including up-to-date templates, policy summaries, and training videos to support staff understanding and application of the Act.
- Sought legal advice and offered guidance on complex or high-risk cases.
- Provided expertise from the Trust having two trained Best Interest Assessors (BIAs) in post.
- Revised the Mental Capacity Act Pocket Prompt which was professionally printed and reflects amendments to the Act bringing it in line with current case law.
- Membership of two NHS England London Region MCA working groups, one focused on Children and Young People (MCA/DoLS) and another practitioner network that promotes shared learning and resource development.

All staff complete a mandatory basic awareness e-learning module, with clinical staff undertaking Level 3 training to meet statutory requirements. In response to staff feedback around length of time necessary to complete the 12 modules of the Health Education England (HEE) E-learning for Health course. An alternative, bespoke and classroom-based training programme was developed by the team. This interactive training covers all required learning outcomes and is specifically tailored to ophthalmology, incorporating Moorfields specific scenarios to boost engagement and practical understanding. The revised Pocket Prompts are distributed to all participants attending the face-to-face training sessions and are also available for wider dissemination across the Trust as needed. The Pocket Prompt ensures staff are equipped with clear, accessible guidance to support lawful and person-centred decision-making in practice.

The new training is now a core part of induction for all new starters and can be delivered at any Moorfields site upon request, ensuring accessibility and consistency across the Trust.

Deprivation of Liberty Safeguards (DoLs)

During 2024–2025 the Trust made no referrals to supervisory bodies (Local Authority) seeking authorisation of a deprivation of liberty. This is to be expected within the context of Moorfields, as an ambulatory model Trust, with few patients admitted overnight and those that are would not usually stay more than one night, and so the threshold for a deprivation of liberty is rarely met.

Liberty Protection Safeguards (LPS)

The implementation of the Liberty Protection Safeguards (LPS), introduced as the planned replacement for the Deprivation of Liberty Safeguards (DoLS), remains on hold following the Government's decision in April 2023 to delay its rollout. This decision was part of a broader reprioritisation of social care reforms. Should implementation be required in the future, planning will re-commence to support the implementation at Moorfields.

PREVENT

The aim of the PREVENT Duty (which is part of the Counter-Terrorism and Security Act 2015) is to protect those who are vulnerable to exploitation from those who seek to exploit and groom them to support or commit acts of violence, by preventing the radicalisation of vulnerable children and adults. It is inclusive of all terrorism - international extremism and those in the UK who are inspired by it, and domestic activity such as those from the far right and far left and extreme animal rights campaigners.

In line with the PREVENT Training and Competencies Framework (2017), Basic Prevent Awareness (BPA) is mandatory for all staff and a Level 3 Workshop Raising Awareness of Prevent (WRAP) is mandatory for all clinical staff. Competency in WRAP is currently attained by completing a nationally accredited eLearning course. A Trust applicable local information infographic supports the e-learning and the safeguarding EyeQ intranet includes a PREVENT page that contains information, flowcharts and guidance.

Submission of quarterly PREVENT data continued. There have been no referrals from the Trust in relation to concerns regarding radicalisation and no information sharing requests for Channel Panel assessment received during 2024 - 2025.

Training

Training continued to be delivered on a rolling three-year cycle with the requirement that all staff are provided with the appropriate level of training commensurate to their role as defined in the Intercollegiate Document Roles and Competencies for Health Care Staff which outlines the minimum training requirements that all staff in healthcare organisations are required to meet.

The e-learning safeguarding modules are hosted by E-Learning for Health. Face-to-face Level 3 safeguarding training is co-facilitated by a social worker (children Level 3) and a former detective police officer (adults Level 3). Staff also have access to external mandatory training provision from the safeguarding partnerships.

Overall training compliance continues to be monitored by the Mandatory and Statutory Training (MAST) Committee and the Safeguarding Committee. Quarterly training data returns are submitted.

Other Safeguarding Training

Attendance at other training to support learning and staff awareness is promoted through the dissemination of various topics and opportunities. Training figures below are provided by the Learning and Development Department via INSIGHT.

Table 1: Permanent Staff and Volunteers

MAST Topic	Target %	March 2024	March 2025
Safeguarding Children and Young People:			
Level 1	80%	91%	92%
Level 2	80%	84%	93%
Level 3	80%	87%	81%
*Level 4	80%	100%	100%
Safeguarding Adults:			
Level 1	80%	93%	94%
Level 2	80%	95%	93%
Level 3	80%	81%	75%
*Level 4	80%	75%	50%
Mental Capacity Act (MCA):			
Mental Capacity Act Awareness - Level 1	80%	90%	92%
Mental Capacity Act (Clinical Staff) - Level 2	80%	85%	83%
Preventing Radicalisation:			
Basic PREVENT Awareness	80%	92%	91%

Workshop To Raise Awareness of PREVENT (WRAP)	80%	88%	93%
Vulnerable and At Risk People:			
Dementia	80%	92%	92%
Learning Disability and Autism	80%	91%	91%

*Level 4 Training is assigned to staff working in a specialist safeguarding role. Two staff requiring Level 4 Safeguarding Adults training will become compliant in June 2025.

Table 2: Honorary and Locum Staff

MAST Topic	Target %	March 2024	March 2025
Safeguarding Children and Young People:			
Level 1	80%	57%	54%
Level 2	80%	47%	44%
Level 3	80%	55%	73%
Safeguarding Adults:			
Level 1	80%	57%	56%
Level 2	80%	41%	43%
Mental Capacity Act (MCA):			
Mental Capacity Act Awareness - Level 1	80%	49%	48%
Mental Capacity Act (Clinical Staff) - Level 2	80%	31%	33%
Preventing Radicalisation:			
Basic PREVENT Awareness	80%	50%	43%
Workshop To Raise Awareness of PREVENT (WRAP)	80%	39%	49%
Vulnerable and At Risk People:			
Dementia	80%	52%	49%
Learning Disability and Autism	80%	49%	49%

Honorary and locum staff MAST Compliance remains below target. Targeted work continues in collaboration with the Human Resources department and the Medical Resource Lead to improve access, monitoring, and accountability for safeguarding training within this cohort including

capturing accreditation of MAST Topics achieved in other NHS Trusts. Progress on compliance is reported into the MAST Committee and the Safeguarding Committee and is on the Central (Corporate) Risk Register.

Safeguarding Reflection and Supervision

Safeguarding supervision for children and young people (SGC&YP) is a critical component of safeguarding practice, providing structured, reflective support for staff managing safeguarding concerns. It enables practitioners to engage in retrospective case reviews in collaboration with a trained safeguarding supervisor, helping to ensure high-quality care, robust risk analysis, and consistent practice in line with Local Safeguarding Children Partnerships, Safeguarding Adult Boards, and organisational procedures.

Supervision is delivered using a flexible, blended approach designed to meet the varying needs of practitioners across services. Throughout the 2024/2025 reporting period, supervision was provided through:

- Structured supervision - Individual and group sessions.
- Ad hoc face-to-face, remote delivery via Microsoft Teams, telephone, and email liaison.
- Safeguarding children workshops and Q&A sessions.
- Case debriefs and after-action reviews.

In addition, a sustained programme of safeguarding supervision workshops was established at City Road across various paediatric-facing departments. These workshops used real-life case examples to promote tailored learning, peer discussion, and reflective practice within teams.

To further strengthen access and support, the safeguarding children team increased their on-site visibility through a rolling programme of quarterly network site visits. These in-person sessions provided colleagues with additional opportunities for safeguarding supervision in their local environments. Attendance was recorded to ensure equitable access across departments and locations.

Safeguarding supervision for medical staff was facilitated by the Named Doctor for Safeguarding Children and Adults, and delivered through a blended model incorporating:

- Ad hoc drop-in sessions

- Peer review activities
- Inclusion in clinical governance meetings

To support the continued development of safeguarding leadership, the Named Doctor and Named Nurse for Safeguarding Children and Young People both received external peer review supervision through the Islington Named and Designated Doctors' Network.

Supervision activity is monitored and reported quarterly as part of the Safeguarding Key Performance Metrics. This approach has ensured that safeguarding supervision remains accessible, responsive, and aligned with statutory expectations and best practice standards, ultimately supporting safe and consistent care for children and young people.

Whilst there is currently no statutory guidance around Safeguarding Adult supervision, the Adult Safeguarding Team are committed to embedding supervision and feedback throughout our everyday practice. This is achieved through attendance at team meetings, case reviews, and training sessions.

We utilise a variety of informal and structured feedback mechanisms to support professional development and maintain high standards of safeguarding practice. This includes the use of anonymised case studies that highlight examples of good practice or identify areas for learning. These case studies are regularly featured in trust-wide newsletters, providing opportunities for reflection and shared learning across teams. By showcasing Moorfields specific scenarios and outcomes, staff are encouraged to critically evaluate their own practice and apply insights to future safeguarding practice.

Learning from Safeguarding Practice Reviews

Learning from national and local enquiries and reviews including child safeguarding practice reviews (CSPR's), Safeguarding Adult Reviews (SAR's), Domestic Homicide Review's (DHR's), or Offensive Weapons Homicide Reviews (OWHR's) are cascaded through a variety of methods, media and forum acknowledging that staff learn in different ways.

Action plans for any reviews are monitored by the Safeguarding Committee. The Trust may be contacted by any Local Safeguarding Board (Children and/or Adults) when the subject of the review has been a known patient of the Trust.

The Trust has not been involved in any new commissioned safeguarding child or adult reviews during 2024 – 2025.

Multiagency Learning Review "Mary"

Moorfields has been involved in a multi-agency learning review for 'Mary' who was a known patient of the Trust historically to the dates of the review and for whom the report was published in 2024.

- Strengthened collaborative working with the eye clinic liaison officers (ECLO) service to discuss complex cases when patients eligible for a certificate of visual impairment (CVI) are declining certificate registration and information sharing with local authorities and GPs.
- Developed the weekly complex care meeting and internal reporting regarding social admissions and information sharing.
- Significant and sustained reduction in delayed discharges.

Inspections and Monitoring

During this reporting period there have been no inspections by the Care Quality Commission, no inspections relating to safeguarding adults or any Joint Targeted Area Inspections (JTAI) relating to safeguarding children.

Safeguarding Partnership Boards, Meetings and Engagement

External Engagement

Moorfields is represented on the Islington Safeguarding Children and Safeguarding Adult Boards and attend a wide variety of safeguarding committees and networks, across North Central London, pan London and nationally demonstrating engagement with and commitment to effective partnership and multi-agency working, supporting and sharing good practice, gaining updates and contributing to national developments and local policy and procedural decisions. Information from the various meetings is cascaded into the Trust through a variety of different forums and media including the Safeguarding Committee.

Internal Engagement

All members of the safeguarding team are engaged in a wide variety of internal meetings and forums disseminating key information, areas for safeguarding learning, highlighting examples of good practice and safeguarding in action and promoting safeguarding as an integral part of practice.

Key Performance Indicators and Metrics Reporting

Safeguarding reporting set against a variety of reporting measures and metrics provides assurance to the Trust and to NCL ICB and NHSE. All submissions are overseen through the Safeguarding Committee or the Executive Lead for Safeguarding or delegated deputy. Despite activity pressures all metrics reporting have been submitted on time throughout the past reporting year including via the newly established electronic Data Collection Framework.

Policies, Procedures and Guidelines Updates

The Trust continues to review systems, policies and procedures to safeguard and to ensure compliance with legislation, statutory guidance, national and local guidance, and practice developments. The Safeguarding Committee has a role to: scrutinise any newly published national guidance and legislation, consider any implications for the Trust, ensure policies and procedures are legally compliant and follow national guidance, agree on reviewed and new policies regarding safeguarding and its associated polices.

Policies, guidelines and SOPs across the Trust with either a safeguarding focus or containing a safeguarding section are developed or reviewed ensuring staff have access to and are working with current best practice policies and processes. There continues to be a recognition by policy owners for the team to review and/or consider the need for inclusion of safeguarding content within other Trust policies.

The Policy and Procedure Review Group approves all policies relating to safeguarding.

Safer Recruitment

Disclosure and Barring Scheme (DBS) Compliance

All job descriptions include a statement regarding employee's responsibilities to safeguard children and vulnerable adults. Compliance with Disclosure and Barring Scheme (DBS) checks on appointment to the Trust continue, led and undertaken by the Human Resources department. DBS compliance remains a standing agenda item reported into the quarterly Safeguarding Committee. There is also a process in place, led by Human Resources, to ensure up and coming professional renewal registrations are captured and followed through. There have been two queries raised regarding new starter DBS checks neither of which required withdrawal of employment offer.

Managing Safeguarding Allegations

The Chief Nurse is the named senior officer with overall responsibility for ensuring Moorfields has appropriate arrangements in place including a Managing Safeguarding Allegations Policy and Procedures for the management of allegations of abuse against staff and volunteers. The Team support Human Resources and managers in managing safeguarding allegations against staff. There has been consultation with the Local Authority Designated Officer (LADO) on 5 occasions during this reporting period in relation to safeguarding children concerns in staff's personal lives that may have impacted on their professional role. One required referral to a professional body and termination of a locum contract employment with the Trust.

Priorities 2025 – 2026

Safeguarding Children and Adults – Working Together:

- Further development of the Safeguarding Champions Model Training Programme.
- Collaboration on development of the system wide Non-Fatal Strangulation (NFS) Referral Pathway leading to the creation and implementation of a Trust-wide NFS policy supported through education and awareness-raising to support staff to be equipped to recognise NFS as a safeguarding concern and respond appropriately.
- Consider how processes and procedures for Safeguarding reflect the principles of the Patient Safety Incident Response Framework (PSIRF) and Learning.

Safeguarding Children and Young People:

- Evaluation of Level 3 face to face classroom safeguarding training.
- Reflective practice-based supervision sessions.
- Enhancing access to Mental Health Resources.
- Development of Clinical Induction Materials.
- Policy Impact Re-Audit.
- Facilitate teaching workshops and distribute guidance on trauma-informed practice, professional curiosity, and the use of reasonable adjustments in care, in line with holistic and person-centred principles.
- Further embed the Paediatric SEND Hospital Passport into clinical pathways, supporting consistent, personalised care for children with special educational needs and disabilities.
- Support inclusion and accessibility by raising awareness of the importance of tailored care and reasonable adjustments.
- Actively participate in the Ready Steady Go working group, contributing to the implementation of safe, supported, and person-centred transitions from paediatric to adult services.
- Re-audit of 'Was Not Brought' (WNB) Cases.
- Review and Update of the WNB Policy.

Safeguarding Adults including Dementia, Learning Disability and Autism:

- Launch of the new Learning Disability and Autism eLearning and myth busting sessions.
- Develop additional safeguarding related training for staff based on themes identified by queries.
- Work collaboratively with Matrons, senior nurses and ward staff to develop guidance and workshops to support with the admission and management of complex patients.
- Support Surgical Matron to audit the length of stay for complex patient's audit.
- Continue to deliver high quality and accessible Mental Capacity Act training.
- Review and update adapted pathways for complex patients, with learning disabilities, autism, dementia or cognitive impairment.

Conclusion

The Trust takes its safeguarding responsibilities seriously and has demonstrated that it is fulfilling its statutory duties in child protection and safeguarding, promoting the welfare of children and young people as well as protecting people's health, wellbeing and human rights, enabling individuals to live free from abuse and neglect.

The past year has been another busy year for both Teams who successfully delivered and implemented key objectives which resulted in positive patient outcomes. The report details a year of significant activity and improvement and demonstrates that there are robust mechanisms in place to safeguard adults, children and young people and to continually develop and strive for excellence.

Ensuring safeguarding is maintained as a high priority, the teams are committed to further improving and developing Moorfields understanding and knowledge so that "safeguarding is everybody's business" and is embedded within the Trust response to safeguarding.

Appendix 1

Table 1:

Metrics or Reporting	Frequency	Reporting Into
Learning Disability & Autism MAST Compliance	Monthly	NCL ICB
Prevent Duty Data Set Metrics	Quarterly	NHSE
Moorfields Content into Partnership Board Report	Annual	Islington SAB
Moorfields Content into Partnership Board Report	Annual	Islington SCP
Safeguarding Adults Partnership Audit Tool (SAPAT)	Annual	Islington SAB
Section 11 Audit	Biannual	Islington SCP
*Safeguarding Adults Performance Metrics	Quarterly	NCL ICB → NHSE
*Safeguarding Children Performance Metrics	Quarterly	NCL ICB → NHSE
*Includes DBS Compliance, MAST Training Compliance, Safeguarding Activity and Supervision		

Table 2:

Safeguarding Partnership Boards and Meeting Engagement
Access to Acute (A2A) Learning Disability National Network
Islington Child Criminal and Sexual Exploitation Briefings
Islington Dementia Friendly Steering Group
Islington SAB Case Review Subgroup
Islington SAB Prevention and Learning Subgroup
Islington SAB Quality Assurance Subgroup
Islington Safeguarding Children Health Leads Forum
Islington SCP Case Review Subgroup
Islington SCP Quality Assurance Subgroup
Islington SCP Training and Professional Development Subgroup
Islington Violence Against Women and Girls (VAWG) Board
NHSE Learning Disability Leadership Forum
NHSE Safeguarding Adults National Network (SANN)
NCL Oliver McGowan Learning and Development Leads Group
NCL ICS Oliver McGowan Strategic Group
NCL ICS Safeguarding System Learning Conversation
Pan London Counter Terrorism Briefings

Title of Document	Type	Status
Cayton Street Operational Handbook	Operational Handbook – review of safeguarding content	Approved
Child Protection Information Sharing (CP-IS) System	New SOP, Training Guide and Flowchart	Approved
Managing Individuals who Pose A Risk of Harm	Policy – 3-year review	Approved
Management of Safeguarding Shared Mailbox	New SOP	Approved
Paediatric Discharge	Policy – 3-year review of SGC&YP content	Approved
Paediatric Transfer	Policy – 3-year review of SGC&YP content	Approved
Safeguarding Adults Update	Policy	Approved
Was Not Brought	Policy – 3-year review	Approved

Meeting:	Trust Board
Date:	2 October 2025
Report title:	Summary of the Audit and Risk Committee meeting held on 20 June 2025
Report Author	Sam Armstrong, Company Secretary
Presented by	Asif Bhatti, Non-executive Director

Brief summary of report

Attached is a summary of the Audit and Risk Committee, meeting which took place on 20 June 2025.

Action Required/Recommendation.

The board is asked to:

- Note the report.

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

AUDIT & RISK COMMITTEE SUMMARY REPORT	
Governance	• Quorate – Yes
Meeting items	**Internal Audit progress report and Head of Internal Audit Opinion** • The committee received and discussed a review on appraisals non-medical, which was rated as providing partial assurance. • Issues highlighted from the review included that appraisals were at 70% completion for staff, below the target of 80%, in some instances objectives were either not SMART or not aligned to trust strategic objectives, and there were some inconsistent uses of systems that may have led to underreporting. • The committee noted the related management actions and that there had already been some progress in implementing these. • The committee discussed the need to improve quality of appraisals as well as the number completed in-year, and they noted improvements in place to achieve these, including training of line managers and moving to a new system. • The committee noted outstanding management actions from previous reviews and noted good recent progress at completing these. There were no high priority actions outstanding. • The committee received the Head of Internal Audit Opinion, which was that 'there are weaknesses in the framework of governance, risk management and internal control such that it could become inadequate and ineffective.'
	External • The committee received the draft annual auditors report, which included the value for money assessment, the auditor's report to the Membership Council, which was to be included in the Trust annual report and accounts, letter of representation, and the audit finds report for 2024/25. • The committee noted and discussed the assessment on current arrangements, most of which were green rated. The auditors had noted the challenges to the trust around financial sustainability in relation to the scale of the CIP for the current year, which they risk rated as amber. • The auditors identified two concerns over governance, which were rated red. These included recent board turnover and how the trust could evidence it was well-led. They also identified issues of transparency as referenced from the consultant letter, and while they noted that the reviews in response had not been completed, they raised some management actions for the trust to complete in due course. The committee discussed these points and felt improvements were in place.
	Annual Report and Accounts • The committee received the draft annual report and accounts for 2024/25. • The committee noted that the draft had been reviewed by the board, Finance and Performance Committee and a subgroup of governors. • After discussion and due consideration, the committee approved the annual report and accounts for commending to the board to ratify.
	Local Counter Fraud update • The committee received an update report. • It was noted that two local proactive exercises had been completed: one on expenses and the other on declarations of interest. While some issues had been recognised, it was noted that there were no significant concerns or impact on the fraud risk score.
	Risk Management Strategy • The committee received the strategy and after discussion agreed to commend it to the board for ratification.
	Board Assurance Framework and Corporate Risk Register • The committee received and noted the latest version of the BAF and CRR.

	Other reports: • The committee received the latest tender waivers report • The committee received the latest losses and special payments report • The committee received the annual board declarations of interest and FPPT compliance audit • The committee reviewed its terms of reference for commending to the board for ratification. • The committee noted its workplan and upcoming items for the next meeting.
Date of next meeting	13 October 2025

Moorfields Eye Hospital NHS Foundation Trust

Quality and Safety Committee summary reports
22 July and 16 September 2025

Board of directors
02 October 2025

Report title	**Summary reports of the Quality and Safety Committee meetings of 22 July and 16 September 2025**		
Report from	Michael Marsh, Chair of the Quality and Safety Committee		
Prepared by	David Flintham, Quality and Compliance Manager Ian Tombleson, Director of Quality and Safety		
Previously considered at	Produced after QSC meetings	**Date**	17/09/2025
Link to strategic objectives	We will consistently provide an excellent, globally recognised service		

Quality implications
These reports provides a summary of the committee's meetings held on 22 July and 16 September 2025. They outline the main items discussed at the meetings and highlight issues for the attention of the board.

Financial implications
None.

Risk implications
No specific risk escalations. The Board is asked to note the issues raised for Board attention.

Action required/recommendation
The board is asked to note the report of the Quality and Safety Committee.

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

Moorfields Eye Hospital NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

22 July 2025

Committee Governance	• Quorate – Yes • Attendance (membership) – 57% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	**Financial decisions and mitigation assurance** The committee received a presentation about the risks to quality associated with Trust financial decisions and mitigation assurance. This was discussed and the following issues were highlighted: • The committee noted the challenges of the current position, but highlighted that this also brought opportunities which must not be ignored. • There is scrutiny and challenge at every level. • There will be regular reports coming to Q&SC meetings. **Presentation by Moorfields Private** The committee received a presentation by Moorfields Private. The following issues were highlighted: • Moorfields Private is facing particular challenges as a result of the absence of its quality partner. • There is a spike in incident reporting, and this and other risks and issues are being addressed. • Moorfields Private is working closely with Estates and Facilities to address the issues around laser room humidity. The findings of this work have also informed Oriel. • The issue of 24-hour follow-up for Private patients is being addressed with Moorfields A&E. **Infection Control Update** The regular infection control (IPC) update was presented. The following issues were highlighted: • Low levels of infection were reported, and Q1 surveillance and environmental audits are green. • The infection control team are supporting sustainability, and there is an on-going cost improvement project. Trust's cleaning policy has been revised, and current SLAs with other Trusts have been reviewed (resulting in some cost reductions). **Patient-Led Assessments of the Care Environment (PLACE)** The committee received a presentation about the recent PLACE assessment. The following were highlighted: • The PLACE assessment was completed in November 2024 and overall scored very well. • Signage and wayfinding, taps, and food safety standards were the areas for attention. • Compared with other Trusts, Moorfields is in the top 50%. **Signage and wayfinding** The committee received a presentation about Signage and wayfinding (both current and future). The following issues were highlighted: • There will be an increased demand for physical wayfinding support since every patient will be new to Oriel. The new hospital will not be totally reliant on digital wayfinding.

	• Wayfinding specialists are being engaged (from August). The wayfinding workstream is well established and is working closely with the 'last half mile' workstream. • There is a design advisory group to advise on the final decisions. The decision process will be discussed at July's Board. **Patient Safety Incidents** There were no patient safety incident reports presented. The regular duty of candour report was presented. The following were highlighted: • Current Duty of Candour performance is below the standards required and is being challenged (including during site visits). **Quality and Safety** The committee received the Q&S update, and the Q1 quality and safety reports (Trust-wide, Moorfields Private, and UAE). The following areas were highlighted: • As highlighted in their presentation, there remain challenges with Private's incidents and complaints. • There are no exceptions in the UAE Q1 report. There is a pre-meet where UAE present their report prior to it going to Q&SC. UAE will present their divisional update at September's meeting. • The Trust-wide Q1 report explained the current challenges currently faced by the patient experience team – there are a number of improvement actions underway to address these. • An engagement meeting with the CQC took place in July. The CQC were impressed with the Trust's innovation and improvement. The next meeting is in November. **Reports from Other Committees** Summary reports from the following committees were circulated: • Risk and Safety Committee (11/06/2025) • Research Quality Review Group (02/06/2025) • Information Governance Committee (03 & 24/06/2025) • Clinical Governance Committee (23/06/2025) The following issues were highlighted: • The new DSPT standards have been met. • The referral to the Clatterbridge Cancer Centre for proton beam therapy was discussed and will come back to a later meeting. **Annual Reports** The committee received the following annual reports: • Clinical Governance Committee • Risk and Safety Committee • Research Quality Review Group (this included the revised terms of reference for the group) The following issue was highlighted: • The reporting and assurance paths for the Research Quality Review Group will be reviewed.
Escalations	There were no escalations to the Trust Board, although it was noted that the decision making process for Oriel (Signage and wayfinding item) will be discussed at Board.
Date of next meeting	16 September 2025

Moorfields Eye Hospital NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

16 September 2025

Committee Governance	• Quorate – Yes • Attendance – 86% (6 out of 7 members attended) • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	**Actions from the previous meeting** There were no Quality issues highlighted in relation to the Cost Improvement Programme (CIP). This will be on the agenda for November's meeting. **Presentation by MEH UAE** The committee received a presentation by Moorfields UAE. The following issues were highlighted: • During the year, Moorfields UAE had achieved accreditation with the Australian Council on Healthcare Standards, and the Joint Commission International (reaccreditation) • The greatest impact on patient experience were booking/communication errors, and waiting times. Ways to improve the collection of patient feedback are being investigated • There is an issue of failing to follow required identification procedures around prescription collection, largely when the patient is a frequent user. This is being investigated and corrective action is being taken • The Trust will look at ways to improve the sharing of learning from Moorfields UAE with the rest of the Trust and also from the rest of Moorfields with UAE. **Infection Control Update** The regular infection control (IPC) update, and the infection control annual report were presented. The following issues were highlighted: • All surveillance and audits for the period were green • There was a single endophthalmitis case during the period, at New Cavendish Street • The annual flu vaccine programme starts at the beginning of October • The infection control team have completed their annual programme of works (including audits, inspections, training, and policy review) • The team have undertaken several cost-saving/fund generation pieces of work including the provision of a service to the Tavistock and Portman Trust, and non-thermostatic mixer valve taps (this relates to the fitting out of Oriel as well as current use). **Safeguarding Annual Report** The committee received the safeguarding annual report. The following issues were highlighted: • Adults and Children and Young People safeguarding is being brought together under a single committee • Work (including training) around learning disabilities is a particular strength • The ICB (integrated care board) is assured of the Trust's compliance.

	Fire Safety The committee received its regular fire safety update. The following was highlighted: • Whilst overall, the report was positive, the issue of fire warden training take up is still an issue. However, it was noted that there is work around this taking place, and future reports should reflect an improvement. **Patient Safety Incidents** There was one patient safety incident investigation (PSII) report presented about a Never Event - retained foreign object. The following issues were highlighted: • The length of time between the incident taking place (2021), and it being discovered and reported (September 2024) was noted • Missed failsafes, and the use of hybrid notes were identified as contributory factors. The regular duty of candour report was presented. The following were highlighted: • Training compliance now stands at 92% • Moorfields continues to work towards improving compliance with the duty of candour. **Quality and Safety** The committee received the Q&S update (which included the complaints performance recovery plan), and the Safer Surgery Audit Report for Q1. The following areas were highlighted: • The patient safety incident reporting framework (PSIRF) is undergoing a review • Safer September is continuing throughout September. There are a number of associated activities, including a programme of walkabouts • It is estimated that the complaints recovery plan will take 6-months to restore performance with a concerted effort across the organisation • Peer reviews as part of the Safer Surgery audit process are being introduced. A particular focus of this will be the team debrief stage. **Reports from Other Committees** Summary reports from the following committees were circulated: • Research Quality Review Group (14/07/2025) • Information Governance Committee (05/08/2025) • Clinical Governance Committee (11/08/2025) There were no issues highlighted.
Escalations	There were three items highlighted for the Trust Board's attention: • Improved mechanisms for sharing learning from UAE with the rest of the Trust (and vice-versa) • It is estimated that the complaints recovery plan will take 6-months (1 October 2025 to 31 March 2026) to restore performance with a concerted effort across the organisation • Peer reviews as part of the Safer Surgery audit process have been introduced. A particular focus of this is the team debrief stage.
Date of next meeting	18 November 2025

Report title	Audit & Risk Committee Terms of Reference
Meeting	Board of Directors – Part I
Date	2 October 2025
Report from	Sam Armstrong, company secretary
Prepared by	Sam Armstrong, company secretary
Link to strategic objectives	Deliver: Optimise our systems, infrastructure and capabilities to deliver excellent and efficient care

Executive summary

This Committee terms of reference were presented for review at Audit & Risk Committee on 20 June 2025 and approved for onwards annual ratification by the Trust Board.

No changes were recommended by the committee.

Quality implications

Not applicable.

Financial implications

Not applicable.

Risk implications

The committee oversees risk management on behalf of the Board.

Action Required/Recommendation

The Board is asked to approve the terms of reference for annual ratification.

For Assurance		For decision	✓	For discussion		To note	

Moorfields Eye Hospital NHS Foundation Trust

NHS

Audit and Risk Committee – terms of reference

Authority	The Audit and Risk Committee is a formal committee of the Board and is authorised to provide assurance to the Board and carry out delegated functions on its behalf. The committee is empowered to initiate investigations and other reviews as it considers necessary to provide necessary assurance. These terms of reference have been approved by the board and are subject to annual review.
Purpose	The purpose of the Committee is to review the effectiveness of the Trust's corporate governance and internal control systems, and report to the Board on its findings. Details of its responsibilities are set out below. • external and internal audit arrangements, • the annual report and accounts, • financial and IT systems and processes, • robustness and reliability of financial and other information, • risk management and other controls, including the board assurance framework, • counter-fraud prevention and detection.
Membership	The members of the Committee will be appointed by the Board, as follows: • Three non-executive directors (including the chair of the quality and safety committee), one of whom shall be nominated as chair The Committee Chair will have a casting vote, if needed. The following will also regularly attend the committee: • Chief Financial Officer • Financial Controller • Company Secretary • External auditor • Internal auditor • Local counter-fraud specialist Others may attend as agreed by the Committee Chair as necessary. The Chief Executive will be invited to attend the committee on an annual basis in order to provide assurance in relation to his responsibilities as the

	Accounting Officer. This should be the same meeting during which the review of the annual accounts and report takes place. The Committee shall meet at least once a year separately with internal audit and external audit with no trust officers present.
Quorum	The quorum will be two members
Frequency of meetings	The Committee will meet at least four times per year and members are expected to attend at least 75% of meetings in any year.

Duties	The Committee can only carry out functions authorised by the Board, as referenced in these terms of reference.
	
	Delegated Functions
	
	The Committee will carry out the following on behalf of the Board:
	
	• review waivers to the standing financial instructions (including single tenders), to ensure they are reasonable and do not represent a significant weakening of internal control
	• review write offs to ensure they represent value for money and do not represent a significant weakening of internal control
	• review and approve the internal audit plan
	• review internal audit reviews and oversee the completion of management actions
	• carry out 'deep dives' as appropriate
	• review any known breaches to the Trust constitution, standing orders and/or SFIs
	
	Assurance Functions
	
	The Committee will carry out the following functions to provide assurance to the Board:
	
	Financial reporting
	• through meetings with management and the external auditors, ensure the annual report (including the annual governance statement) and financial statements of the trust
	  o are complete
	  o consistent with the information known to the committee and the external auditors
	  o reflect current accounting policies and principles,
	  o comply with statutory and legal requirements and accounting standards
	• review the extent to which financial, performance and other information for decision making is effective, robust, comprehensive, timely and up to date

Internal control and risk management

- assess the effectiveness of the Trust's internal control systems, including financial, operational and risk management controls
- review the effectiveness of the work of the quality and safety committee in ensuring an independent review of the annual quality report (quality account)
- review on a regular basis the Trust's risk management framework and the management controls and procedures in place to manage risk
- undertake an annual assessment of risk management before submission to the trust board, in the context of the annual report and financial statements
- review on a regular basis the board assurance framework and interrogate specific risks as requested by the Board or as identified by the Committee
- oversee the operation of the Trust's declaration of interests, gifts and hospitality policy
- oversee the local security management service

Internal auditors and counter-fraud

- ensure that the Trust has appropriate and effective internal audit arrangements that meet the requirements of NHS internal audit standards and are suitably independent [i]
- monitor the implementation of the audit plan, reviewing internal audit recommendations, management responses and monitor the implementation of actions
- evaluate the performance of the internal auditors and value for money
- monitor and review the findings of the local counter-fraud specialist function including an annual report of counter-fraud work undertaken

External auditors

- ensure that the Trust has appropriate and effective external audit arrangements that meet the requirements of NHS external audit standards and are suitably independent[ii]
- make recommendations to the Membership Council in relation to the appointment, reappointment and removal of the external auditor
- oversee the tendering process for new external auditors
- approve the external audit plan
- review the performance of the external auditors and evaluate their performance and value or money
- meet formally with the external auditors, review the annual management letter and management's responses and report matters of significance to the Board

	Other duties as agreed by the Board • Exceptional items explicitly requested by the Board that fall outside the terms of reference		
Reporting and review	Following each meeting of the Committee, an update will be provided to the Board, in a standard format, highlighting any issues for escalation or dissemination. Minutes of meetings will be available for any board member on request. The Committee will carry out an annual review of its effectiveness against these terms of reference and this will be reported to the Board.		
Sub-committees	There are no sub-committees of the Audit and Risk Committee.		
Meeting administration	The executive lead for the committee will be the Chief Financial Officer. The secretary for the Committee will be the Company Secretary. The secretary's role will be to; • Agree the agenda with the chair • Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board's standing orders • Maintain a forward plan of items for the committee • Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) • Ensure actions are captured, notified to relevant staff and followed up Any other administrative arrangements not listed here will be as shown in the standing orders of the board of directors		
Date approved by the board		**Date of next review**	

Standing financial instructions and scheme of delegation

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

[i] https://www.nao.org.uk/code-audit-practice/wp-content/uploads/sites/29/2015/03/Auditor-Guidance-Note-01-General-Guidance-Supporting-Local-Audit.pdf

[ii] As above

Moorfields Eye Hospital NHS Foundation Trust

NHS

REGISTER OF INTERESTS SEPTEMBER 2025

(Board of Directors)

Name	Job Title	Interest declared
Tim Briggs	Interim Chair	Son is Director and Fonder of Naitive Technologies Limited National director for clinical improvement & elective recovery, NHSE GIRFT and GIRFT chair Chair, Getting It Right First Time (RNOH Projects) Chair and national lead, Veterans Covenant Healthcare Alliance (VCHA) Honorary Colonel, 202 (Midlands) Field Hospital RAMC
Peter Ridley	Interim chief executive	Sister works for CHKS which provides services to the NHS around data, analytics and insight. She holds client relationships with a number of NHS trusts Trustee of professional body for finance staff working in healthcare Wife works for HFMA
Aaron Rajan	Non-executive director	Chief Digital Officer & VP Consumer Experience, Unilever Operations
Andrew Dick	Non-executive director	Director, Institute of Ophthalmology, UCL President, European Association of Vision and Eye Research Foundation Chair and Professor, Ophthalmology, University of Bristol Consultancy, 4DT (not active) Consultancy, Abbvie (not active) Consultancy, Novartis (not active) Consultancy, Roche Consultancy, Hubble Tx (not active) Consultancy, Affybody (not active) Co-founder, stock option, Cirrus Therapeutics
David Hills	Non-executive director	Director of programme delivery, University of Cambridge
Asif Bhatti	Non-executive director	Group Director of Risk and Audit, Compass Group PLC Non-executive director, House of Lords
Michael Marsh	Non-executive director	Non-executive director, University Hospital Dorset which includes Bournemouth, Christchurch and Poole Hospitals
Adrian Morris	Non-executive director	General Counsel, Haleon PLC
Elena Lokteva	Non-executive director	Owner and director of Strategic Initiatives LTD Non-executive director, Essex Partnership University NHS Foundation Trust Fractional CFO, Tera Sky LTD Non-executive director at Technoenergy AG (Switzerland) Non-executive director at Ratnamani Finow Spooling Solutions Private Limited (India)

Louisa Wickham	Medical director	Private practice, Moorfields Private Trustee, Moorfields Eye Charity National Clinical Director for Eye Care, NHS England Talks remunerated at <£1.5k
Sheila Adam	Chief nurse and director of AHPs	Nothing to declare
Sue Steen	Chief people officer	Trustee, St Margarets Hospice Trustee, Victim Support UK
Jon Spencer	Chief operating officer	Trustee, Friends of Moorfields
Arthur Vaughan	Chief financial officer	Nothing to declare
Non-voting directors		
Elena Bechberger	Director of Strategy & Partnerships	Trustee, The Brain Tumour Charity
Ian Tombleson	Director of quality & safety	Nothing to declare
Adam Dunlop	interim Chief information officer	Advisor (short term arrangement) Veracity Consulting
Kieran McDaid	Director of estates, capital and MP	Nothing to declare
Michèle Russell	Joint director of education	Joint Director of Education UCL/Moorfields Eye Hospital Honorary Professor of Clinical Education New York University and Newcastle University (not active)
Victoria Moore	Director of Excellence Delivery	Nothing to declare