Bundle Board of Directors - Part 1 4 June 2026

1 09:00 - Welcome and introductions
Tim Briggs, Interim Chair
For noting
260604 TB Part I Item 00 Agenda

2 09:05 - Staff story
Sue Steen, Chief People Officer
for noting

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

4 Declarations of interest
Tim Briggs, Interim Chair
For noting
260604 TB Part I Item 03 Register of interests BoD v2.2

5 Minutes of the previous meeting
Tim Briggs, Interim Chair
For approval
260604 TB Part I Item 04 Minutes of Meeting in Public 260326 DRAFT

6 09:30 - Matters arising and actions log
Tim Briggs, Interim Chair
For noting
260604 TB Part I Item 05 Action log

7 09:35 - Chief executive's report
Peter Ridley, Chief Executive Officer
For noting
260604 TB Part I Item 07 CEO's report

8 09:45 - Quality & safety committee chair's report
Michael Marsh, Non-executive Director
for assurance
260604 TB Part I Item 08(i) QSC summary coversheet
260604 TB Part I Item 08(i) QSC summary for meeting held 260512

9 09:55 - Chief nurse's report
Simmi Naidu, Chief Nurse and Director of Allied Professionals
for assurance
260604 TB Part I Item 09 CN quality report

10 10:00 - Learning from deaths
Louisa Wickham, Chief Medical Officer
for noting
260604 TB Part I Item 10 Learning from deaths Q4 2025-26)

11 Guardian of safe working
Louisa Wickham, Chief Medical Officer
for noting
260604 TB Part I Item 11 Guardian of Safe Working report

12 10:05 - People & culture committee chair's report
Aaron Rajan, Non-executive Director
for assurance

260604 TB Part I Item 12 PCC AAA June report

13 10:15 - Annual EDI report
Sue Steen, Chief People Officer
for assurance
260604 TB Part I Item 13(i) 2025 EDI annual report cover
260604 TB Part I Item 14(ii) 2025 EDI annual report Rev 5

14 10:25 - Finance & performance committee chair's report
Elena Lokteva, Non-executive Director
for assurance
260604 TB Part I Item 14 FPC chair's report

15 10:35 - Finance report
Arthur Vaughan, Chief Finance Officer
For noting
260604 TB Part I Item 15(i) 2025-26 Public finance board report M12 cover sheet
260604 TB Part I Item 15(ii) 2025-26 Public finance board report M12
260604 TB Part I Item 15(iii) 202-27 Public finance board report M1 cover sheet
260604 TB Part I Item 15(iv) 202-27 Public finance board report M1

16 10:40 - Integrated performance report
Executive Team
For noting
260604 TB Part I Item 17(i) IPR cover sheet
260604 TB Part I Item 17(ii) IPR M1
260604 TB Part I Item 17(iii) IPR Appendix A monitoring metrics

17 10:45 - Board assurance framework
Ben Westmancott, Interim Company Secretary
for approval
260604 TB Part I Item 18(i) BAF cover
260604 TB Part I Item 18(ii) BAF

18 10:50 - Governance improvements / committee terms of reference
Ben Westmancott, Interim Company Secretary
for approval
260604 TB Part I Item 19(i) Governance improvements
260604 TB Part I Item 19(ii) DCC terms of reference
260604 TB Part I Item 19(iii) FPC terms of reference
260604 TB Part I Item 19(iv) MPDC terms of reference
260604 TB Part I Item 19(v) PCC terms of reference
260604 TB Part I Item 19(vi) QSC terms of reference

19 Starred items:
Tim Briggs, Interim Chair
For noting
Governance schedule v1.4
260604 TB Part I Item 20(i) 2026 Governance Schedule cover
260604 TB Part I Item 20(ii) 2026 Governance Schedule v1.5

20 11:00 - Any other business
Tim Briggs, Interim Chair
For noting

21 11:05 - Q&A with governors and observers
Tim Briggs, Interim Chair
For noting

22 11:20 - Date of the next meeting: 30 July 2026

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on Thursday 4 June 2026, 09:00 to 11:20
In the Lecture Theatre, Education Centre, Ebenezer Street and MS Teams

No.	Item	Action	Paper	Lead	Mins
1.	Welcome	Note	Oral	TB	5
2.	Staff story	Note	Oral	SS	20
3.	Apologies for absence	Note	Oral	TB	5
4.	Declarations of interest	Note	Enclosed	TB	
5.	Minutes of the previous meeting	Approve	Enclosed	TB	
6.	Matters arising and action log	Note	Enclosed	TB	
7.	Chief executive's report	Note	Enclosed	PR	10
	Quality				
8.	Quality & Safety Committee chair's report	Assurance	Enclosed	MM	10
9.	Chief Nurse's report	Assurance	Enclosed	SN	5
10.	Learning from deaths	Note	Enclosed	LW	5
11.	Guardian of safe working	Note	Enclosed	LW	
	People and Culture				
12.	People and Culture Committee chair's report	Assurance	Enclosed	AR	10
13.	Annual EDI report	Assurance	Enclosed	SS	10
	Finance and Performance				
14.	Finance & Performance Committee chair's report	Assurance	Enclosed	EL	10
15.	Finance report	Assurance	Enclosed	AV	5
16.	Integrated performance report	Assurance	Enclosed	Exec team	5
	Governance and compliance				
17.	Governance improvements / committee terms of reference	Approve	Enclosed	BW	10
18.	Starred items *(for discussion by exception only)* • *Governance schedule v1.4*	Note	Enclosed	BW	-
19.	Any other business	Note	Oral	TB	5
	11:05 Meeting close followed by questions from members of the public and governors				
	Date of next meeting – 30 July 2026 09:00-13:00				

Cover Sheet	
Report title	**Register of interest – May 2026**
Meeting	Board of Directors
Date	4 June 2026
Report from	Ben Westmancott, Interim Company Secretary
Prepared by	Jennie Phillips, Deputy Company Secretary
Previous forum consideration	N/A

Relevant strategic objectives	Working together	**X**	Discover	**X**	Develop	**X**	Deliver	**X**	Sustainability and Scale	**X**

Purpose of report	Assurance		Decision		Discussion		For information	**X**

Summary

The register of interests is presented to ensure transparency and good governance by confirming that all directors' interests are current and visible. This enables the Board to identify and manage any actual or potential conflicts before decisions are taken, ensuring discussions are objective and in the best interests of patients and the organisation. It also provides assurance to regulators, auditors, and stakeholders that the board is operating openly and in line with NHS governance standards.

Quality implications

An up-to-date register of interests supports good governance and transparency, as it helps potential conflicts to be identified and properly managed. If not managed well this can lead to biased or poorly justified decisions, including those affecting patient care, procurement, and partnerships. It also creates regulatory, reputational, and legal risks, and may result in negative findings under CQC "Well-led" assessments.

Financial implications

An up-to-date register reduces the risk of financial inefficiency, loss, and challenge, and strengthens assurance that public money is being used properly.

Risk implications

This register is a control to mitigate risks associated with decision making i.e. objectivity, and exposure to governance, legal, and operational harm.

REGISTER OF INTERESTS MAY 2026

(Board of Directors)

Name	Job Title	Interest declared	Last updated
Tim Briggs	**Interim chair**	**Son is Director and Founder 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**	17 March 2026
Peter Ridley	**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 the Healthcare Financial Management Association (HFMA)** **Wife works for HFMA** **Trustee for Moorfields Eye Charity** **Director of UCL Partners** **Director of Moorfields Private West End Ltd**	11 March 2026
Asif Bhatti	**Non-executive director**	**Group Director of Risk and Audit, Compass Group PLC** **Non-executive director at House of Lords**	28 May 2026
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**	17 March 2026
David Hills	**Non-executive director**	**Director of programme delivery, University of Cambridge**	11 March 2026
Elena Lokteva	**Non-executive director**	**Owner and director of Strategic Initiatives LTD** **Non-executive director, Essex Partnership University NHS Foundation Trust** **Trustee, Herts Mind Network** **Fractional CFO, Tera Sky LTD**	10 March 2026

		Non-executive director, Technoenergy AG Non-executive director Ratnamani Finow Spooling Private Limited	
Michael Marsh	Non-executive director	Non-executive director and Vice Chair at University Hospitals Dorset, effective September 2025	17 March 2026
Adrian Morris	Non-executive director	General Counsel, Haleon PLC	11 March 2026
Aaron Rajan	Non-executive director	Chief Digital Officer & VP Consumer Experience, Unilever PLC	13 March 2026
Simmi Naudi	Chief nurse and director of AHPs	Nothing to declare	11 March 2026
Jon Spencer	Chief operating officer	Trustee, Friends of Moorfields Director of Moorfields Private West End Ltd	17 March 2026
Sue Steen	Chief people officer	Trustee, St Margarets Hospice Trustee, Victim Support UK	10 March 2026
Arthur Vaughan	Chief financial officer	Nothing to declare	10 March 2026
Louisa Wickham	Chief medical officer	Private practice, Moorfields Private Trustee, Moorfields Eye Charity National Clinical Director for Eye Care, NHS England Talks remunerated at <£1.5k	10 March 2026
Non-voting directors			
Elena Bechberger	Director of strategy & partnerships	Trustee, The Brain Tumour Charity	10 March 2026
Brendan Mahony	Chief information officer	Nothing to declare	10 March 2026
Kieran McDaid	Director of estates, capital and MP	Nothing to declare	20 March 2026
Victoria Moore	Director of transformation & performance improvement	Nothing to declare	12 March 2026
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)	21 March 2026
Ian Tombleson	Director of quality & safety	Nothing to declare	19 March 2026

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
Minutes of the meeting of the Board of Directors held in public on 26 March 2026
The Committee Room, Bedford Hospital, and via MS Teams

Board members:	Professor Tim Briggs (TB)	Interim chair
	Peter Ridley (PR)	Chief executive
	Asif Bhatti (AB)	Non-executive director (via MS Teams)
	Michael Marsh (MM)	Non-executive director
	Elenor Lokteva (EL)	Non-executive director
	Adrian Morris (AM)	Non-executive director
	Simmi Naidu (SN)	Chief nurse and director of AHPs
	Arthur Vaughan (AV)	Chief financial officer
	Jon Spencer (JS)	Chief operating officer
	Sue Steen (SS)	Chief people officer
In attendance:	Elena Bechberger (EB)	Director of strategy & partnerships
	Victoria Moore (VM)	Director of transformation & performance improvement
	Brendon Mahony (BM)	Chief information officer
	John Shubhaker (JSh)	Medical director for quality and safety (via MS Teams)
	Ian Tombleson (IT)	Director of quality & safety (via MS Teams)
	Princess Cole (PC)	Freedom to speak up guardian (via MS Teams item 10)
	Ben Westmancott (BW)	Interim company secretary
	Jennie Phillips (JP)	Deputy company secretary

Several staff, governors and members of the public observed the meeting in-person and online.

1. Welcome

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

Introductions were completed.

2. Apologies for absence

Apologies were received from Louisa Wickham, chief medical officer, David Hills, non-executive director, Aaron Rajan, non-executive director and Andrew Dick, non-executive director.

3. Declaration of interest in relation to the agenda

There were no declarations made in relation to this meeting. The register of board members' interests was noted.

4. Minutes of the previous meeting

The minutes of the meeting held on 5 February 2026 were approved as an accurate record.

5. Matters arising and action log

The action log and updates were noted. The board assurance framework was an item for discussion in the part two meeting and an additional meeting of the Quality and Safety Committee had been scheduled to carry out a deep dive into paediatrics.

6. Chief executive's report

The chief executive presented the report which covered:

- Performance, quality and activity review
- Middle East
- New chief nurse

- Oriel and service transformation
- Digital transformation, MoorConnect and pathways
- Culture, leadership and staff experience
- Governance, partnerships and the national context
- External reviews
- Wider NHS context
- Ophthalmology power list
- Moorfields in the news

The Board was particularly pleased to see the high number of Moorfields' consultants appearing in the Ophthalmology power list for the year.

The Board duly noted the report.

7. Quality & Safety Committee chair's report

Michael Marsh introduced the report and drew attention to the following points:

- Improvements were being seen in North division including positive improvements from the improvements at Bedford.
- Health inequalities were highlighted in the context of access to services and treatment. It was recommended that a board strategy session be set up to look at this issue in more detail.
- Assurances had been gained at the meeting on the governance and oversight of research projects.
- Positive assurances had been gained on the process for assessing that no negative impacts on quality and safety had been caused by cost improvement programmes (CIPs). The process may need to change in 2026/27 due to the increasing quantity of CIPs to be achieved compared to 2025/26.
- Cancer wait times at Clatterbridge were variable.
- Complaints response times were improving; increased focus would now be given to quality of responses.

In discussion the following points emerged:

- A question was asked about what was being done to hit the information governance mandatory training. Pockets of low compliance were being targeted and 88.6% vs a target of 90% was expected to improve.
- A question was asked about 'revolving door' complainants i.e. those who complained about the same thing more than once. It was queried whether this was borne out by the data and confirmed that the clinical governance team identified themes and that a learning approach was in place.

The Board duly noted the report.

8. Chief nurse's report

The chief nurse and director of allied health professionals introduced her report and highlighted:

- An internal review against the CQC well-led criteria was underway with actions to make improvements being identified.
- There had been no escalations from the CQC since the previous board meeting; however, in the preceding 48 hours a site in north London had been flagged relating to estates and processes. An initial review of the concerns has been carried out by staff and no patient safety issues had been identified.
- Friends and family test (PPT) responses were improving and the director of quality was working on triangulating data from FFT, patient advice and liaison service (PALS), and

complaints data to gain a richer picture of how patients and carers experience the trust's services.
- Patient safety incidence response framework (PSIRF) was a core part of the trust's quality improvement programme, and the incoming chief nurse had identified the need to learn from findings across all 20 of the trust's sites in order to create greater consistency.

The chief nurse was asked about early reflections, and she stated that the focus was on improvement, building on a good foundation. Her initial emphasis would be on consistency across the organisation and strengthening assurances.

9. People & Culture Committee chair's report

On behalf of AR, MM introduced the report, and drew attention to the following points:

- Feedback from the trust indication programme had improved since the reintroduction of in-person sessions.
- The trust was compliant with safer staffing requirements.
- Oriel workforce transition was strategically critical and required explicit risk tracking via the board assurance framework.
- Culture and leadership inconsistency was a theme in freedom to speak up cases.
- The staff survey high-level results had been scrutinised, and it was noted that improvements were apparent in some areas; other areas are trending in the wrong direction.
- The Purley site was somewhat 'isolated', and a site visit would soon take place to understand risks and issues more clearly, taking care to triangulate with other data sources.

In discussion, the following points emerged:

- Noting that the staff survey had not shown significant increases in staff satisfaction scores, it was queried when improvements linked to the culture and behaviours work would be seen. In response, the chief people officer commented that the 66% response rate was very good compared to peers and this, alongside with 90% of staff reporting that they had had an appraisal, indicated good staff engagement. Culture improvement was a continuous programme.
- It was queried whether the right focus on estates and facilities improvement was in place given that there was a lot of focus on the new building at St Pancras.
- In terms of whether we have the right leadership skills across the organisation, it was noted that the recent strengthening of medical leadership was an important step.

The Board duly noted the report.

10. Freedom to Speak up report

The chief nurse introduced the report and highlighted the following:
- 33 cases were raised to the freedom to speak up team during Q3 25/26, three of which were reported anonymously.
- This indicated a shift in safety culture as more people speak up.
- Inappropriate attitudes and behaviours, and leadership and management remained outlying reported themes, accounting for 27% and 24% of cases respectively.
- There were no cases raised regarding detriment, health and safety, patient safety, sexual misconduct and worker safety.

- Administrative and clerical staff use the freedom to speak up process disproportionately more than other staff groups.
- The National Guardian's Office would be closing on 30 June 2026. Essential freedom to speak up functions will transfer to NHS England, the Department of Health and Social Care, the Care Quality Commission and providers.

In discussion the following emerged:

- Data from freedom to speak up was being triangulated with staff survey, grievances, and employee relations cases in order to help prioritise management actions.
- Training was progressing well and improvements in awareness of freedom to speak up was increasing as was an improvement in staff 'listening up'. The area to work on next was follow-up to ensure that freedom to speak up cases were acted upon in a timely manner.
- A question was raised about the impact of closing the National Guardian's Office and it was confirmed that this would mainly impact guardians, their routes to support, and the reporting of data.

11. Safer Staffing report

The chief nurse introduced the safer staffing report as an assurance to the Board on continued compliance with the required staffing standards particularly in inpatient areas. Between January and December 2025, the trust was compliant with the monthly safe staffing reporting; data had been triangulated with patient safety and staff experience demonstrating safe and effective staffing for inpatient areas. The trust was compliant with NHS England and Care Quality Commission requirements. During this period, 121 incidents had been reported where staffing was noted as a factor but, on investigation, no safe staffing standards had been breached.

There was a discussion on vacancy levels in healthcare assistants and ophthalmic technicians. It was noted that healthcare assistants weere a gateway step towards becoming an ophthalmic technician and vacancies were expected as people develop their careers.

There was a question about wards where safe staffing levels might be compliant at the start of the shift but by the end, might not be. The trust followed a lone working policy to ensure staff were safe and cross-cover was utilised in smaller wards with low numbers of patients. Moving staff between wards to provide cover could lead to temporary drops in staff numbers at any given time. In 2026/27 there would be a greater focus on roster planning and skills mix.

John Shubaker (representing the chief medical officer) added that recruitment and retention levels were acceptable however sickness levels were higher than ideal and this caused temporary gaps. The conversation moved to the 'civility saves lives' programme which aimed to help people understand the impact of poor behaviours on patient care and outcomes. Positive event reporting was also suggested to have a positive impact on patient care.

The chief nurse was championing the programme and the chief executive urged everyone to get behind the campaign.

The Board duly noted the report.

12. Finance & Performance Committee chair's report

EL introduced the report and drew attention to the following:

- The trust was on track to deliver its year-end financial obligations; the financial position was stable due to a good cost improvement programme processes and productivity improvements.
- The cost improvement programme for 2026/27 would be £17.6mn, significantly higher than 2026/27.
- Some cancer patients had been logged as urgent when they were not; no clinical risk was associated with this but there had been an impact on the trust's performance against the 28-day treatment target for urgent cancers.
- The chief finance officer and team were commended for good management of the capital budget.

The Board was informed that the finance and performance committee had reviewed the financial plan for 2026/27 and oversaw the submission of a balanced plan to NHS England for 2026/27 using the delegated powers given to it by the Board. The Board ratified this decision.

The Board duly noted the report.

13. Integrated performance report

The chief operating officer introduced the report which set out a range of performance indicators to measure the trust's performance against contracts, standards and other targets. He drew attention to referral to treatment times (RTT) which had dropped to 84.3% against the 18-week standard with 30 patients breaching the 52-week standard. Targeted recovery plans were in place. Moorfields was also providing temporary support to King's College Hospital to provide appointments for patients who had been waiting a long-time there. This would lead to a temporary increase in Moorfields waiting list as these patients are assessed and treated.

He stated that there were variations in theatre productivity and cataract theatres were set up to treat eight patients on a four-hour session. Compliance against this locally set target was 66.7%.

Average wait times in the call-centre had reduced and stood at 212 seconds. This was driven in part by significant staffing issues and vacancies. Digital solutions were being explored. Non-executives and governors would be briefed on progress.

There was a discussion on asking clinical fellows to carry out extra shifts to reduce waiting lists. This had been considered however agreement could not be reached on remuneration for additional shifts.

There was a discussion on making rapid progress to improving theatre productivity. Eight patients per session was the target although this was likely to average seven due to patients who do not attend (DNA's). The chief operating officer was pressed to give a date by which the target would be achieved. This would require discussions at operational level before commitment to a date could be given.

It was observed that issues relating to the booking system emerged from a variety of sources and the executive were pressed to ensure consistency of processes. The chief operating stated that the current model would never deliver an appropriate standard; call-wait times would only be shortened by improving online and self-service booking and rebooking of appointments which would reduce the number of calls. It was reported that in some cases patients did not attend, in some cases patients cancelled their appointments, and in others the hospital cancelled the

appointment. The Board strongly urged the organisation to focus on and eliminate hospital cancellation of clinics. Options to improve the position were suggested: sending text reminders to patients; offering short-term cancellations to patients to bring their appointment forward. The ease and speed of implementation text reminders and patients' limitations in responding to these were important factors.

It was observed that some letters sent to patients were unclear and it was important to use plain English.

It was reported that a pilot project looking at the pre-op assessment model was coming to a close. It had identified that working aged men and people from lower socio-economic groups were most likely to DNA. It was suggested that virtual appointments for patients who DNA might help.

The chief executive stated that DNA rates at Moorfields had been stubbornly high for first outpatient appointments and this would be a priority area to improve in 2026/27. Achieving the constitutional standard for RTT was important.

The Board discussed people and quality standards in the integrated performance report. The only area for further attention was a deep dive into sickness absence rates that would be carried out by the people and culture committee.

The Board thanked everyone for their input and duly noted the integrated performance report.

14. Finance report

The chief finance officer introduced the month 11 finance report and stated that the headline position was that a £5.1m surplus year to date had been achieved compared to a planned deficit of £1.5m. Thanks were extended to staff across the organisation for their efforts in achieving the strong financial position.

A question was asked about the drop in cash held by the organisation, and it was confirmed that £68.8m against a turnover of £350m was good.

The chief finance officer urged caution, stating that the underlying surplus of the organisation stood at £0.3m and was set to drop in future years. Action needed to be taken early in 2026/27 to prevent slipping into a recurrent deficit position. He stated that there were £20m non recurrent costs in 2026/27 due in part to Oriel.

The chief executive stated that staff were working very hard to meet the financial targets. The £5m surplus is important to ensure we have money to deliver the change programmes. He also added that following a technical change to the treatment of capital and revenue, the trust had benefitted in-year.

The Board noted the month 11 finance report and thanked staff for their efforts across the whole year.

15. Governance schedule (starred item)

The governance schedule setting out membership of committees and terms of officer was duly noted.

16. Any other business

A question was asked about the upcoming resident doctors' strike and the impact it could have on Moorfields. The chief executive stated that Moorfields had not been badly affected by previous

strikes and there was a tried and tested operating model in place to ensure patient care could continue.

17. Date of next meeting
The next meeting of the Board would take place on 4 June 2026 in the Education Centre, Ebeneezer Street.

The meeting was closed and, due to the confidential nature of topics to be discussed in part 2, the Board resolved to exclude members of the public, press, and governors.

Questions and answer session

Immediately following the closure of the part 1 board meeting there was a question-and-answer session with the board and governors/staff/members of the public. Topics discussed were:

- Clatterbridge specialist cancer services
- Resident doctors
- Variations in call abandonment rates
- Proportions of patients at City road versus satellite sites
- Addressing sickness absence rates among staff and identifying hotspots
- Addressing DNA rates
- The planning of cataract procedures at Bedford hospital (a satellite unit) was thought to be good practice.

The chair thanked everyone for their participation.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

4 June 2025

No.	Date	Minute item	Item title	Action	By	Update	Open/ closed/due
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.	BW	The executive directors have thoroughly reviewed the BAF and set out the key risks to realising our strategic objectives. These will be discussed with the board, including risk appetite, at the 23 April Board strategy session	Closed On the agenda
2026/01	05/02/2026	11.	Paediatrics	The board resolved to request the Quality and Safety Committee to consider the points raised in the discussion i.e.: impact on quality of sickness absence and methods to address it; waiting times in paediatrics; meeting diverse patient and carer's needs in paediatrics; application of ready, steady, go methodology; and impact of transferring patients from some satellite units to City Road for procedures requiring general anaesthetic.	KA/IT	An additional meeting of the Quality and Safety Committee meeting is being scheduled for 14th May to carry out an assurance deep dive into paediatrics.	Closed A thorough and positive deep dive took place on 14 May.

Cover Sheet	
Report title	Chief Executive's report to the Trust Board
Meeting	Board of Directors
Date	4 June 2026
Report from	Peter Ridley, Chief Executive
Prepared by	Ben Westmancott, Interim Company Secretary
Previous forum consideration	N/A

Relevant strategic objectives	Working together	X	Discover	X	Develop	X	Deliver	X	Sustainability and Scale	X

Purpose of report	Assurance		Decision		Discussion	X	For information	X

OVERVIEW

Since the previous report, the Trust has continued to make progress across its core priorities, with a sustained focus on operational delivery, quality of care and readiness for major strategic change. As we move further into 2026, there is an increasing emphasis on execution, ensuring that our transformation programmes translate into tangible improvements for patients and staff, while maintaining strong day-to-day performance.

Performance and operational delivery

The Trust continues to perform strongly against key operational standards, maintaining its position as a leading specialist provider. While demand remains high and elective care pressures persist, the organisation has demonstrated resilience in managing activity levels and maintaining timely access for patients.

We note some areas where performance is below trajectories, e.g. RTT 18-week targets however it is early in the year and we are confident that we have actions focused on productivity, pathway redesign and capacity optimisation to recover.

We also must report that a data breach has occurred in this reporting period. Following a configuration change to our Trust Integration Engine during its migration from on-premise servers to the cloud. The result is that a number of patient outcome letters have been sent to the wrong patient and wrong GP.

We have taken appropriate actions to contain the incident, including the use of manual process in the interim period. We have reported the incident to the Information Commissioners Office (ICO) and are contacting all patients who may have been impacted. Our investigation continues and we will update further on the outcomes.

Oriel and Service Transformation

The Oriel programme has now moved further into its delivery and implementation phase. The focus has shifted from planning and design to **practical readiness**, including:

- Detailed operational commissioning
- Workforce transition planning

- Alignment of clinical pathways with the new model of care

Workstreams are increasingly interdependent, and there is a growing emphasis on ensuring organisational readiness for day-one operations. Engagement with clinical teams remains strong, with clear recognition that Oriel represents both a significant opportunity and a major operational transition for the Trust.

There has however been an issue in relation to the construction workstream. On 30th April the Registered Building Control Approvers (RBCA) for the Oriel Project advised the Trust that their company were preparing to go into administration. As a consequence a Cancellation Notice for the Original Building Control application would need to be served to the local authority London Borough of Camden. As a result of the cancellation notice being served the Oriel Project would no longer have an accountable RBCA in place and all "notifiable works" would need to cease on site. On 6th May this cancelation notice was uploaded to the Local Authority.

The Oriel building is classified as a ***"transitional High-Risk Building"*** (HRB). Transitional status applies to all building projects that had started work on site in advance of the new Building Safety Regulations coming into effect. As such the original application cannot revert to the Local Authority or any another private inspector be appointed without seeking the prior approval of the Building Safety Regulator (BSR).

We have proposed a solution to the issue and are working closely with both UCL and the New Hospitals Programme as we seek to gain the necessary approvals from the regulator (the Building Safety Regulator, a specialist division of the Health & Safety Executive).

MoorConnect and digital enablement

The MoorConnect programme continues to progress, with increasing activity across the organisation in preparation for implementation. Recent efforts have concentrated on:

- End-user engagement and training
- Clinical safety assurance and workflow testing
- Data readiness and migration planning

Alongside the core EPR rollout, we are accelerating the development of digitally enabled pathways, supporting more integrated, patient-centred care. This includes expansion of virtual models of care and improved use of data to support clinical decision-making.

The scale of this change is significant, and we remain mindful of the operational and cultural impact on staff, with continued investment in change management and support. We are including digital quality assurance in order to ensure that services remain safe and of high quality.

Workforce, culture, and leadership

Following the publication of the NHS Staff Survey, the Trust has begun a structured programme of engagement to translate findings into meaningful improvement actions. Early themes include:

- Strengthening staff voice and visibility of leadership
- Improving consistency of experience across teams
- Supporting wellbeing during a period of sustained organisational change

Leadership development and cultural alignment remain central priorities. There is a continued focus on ensuring that behaviours across the organisation reflect our values, particularly as we approach major milestones in our transformation programmes.

The Board will continue to receive updates on progress against agreed actions through the People and Culture Committee.

Governance and organisational effectiveness

Work to strengthen governance arrangements is progressing, with several strands now moving into implementation:

- Further refinement of the Board Assurance Framework including risk appetite
- Development of a governance improvement plan informed by known matters and recent additions
- Committee effectiveness review changes

There is a clear focus on ensuring that governance structures are fit for purpose during a period of complexity, with clarity of roles, effective oversight and strong assurance mechanisms.
This work will be further updated once the reports and recommendations of the independent reviews (the reviews commissioned following the consultant letter) have been received

Engagement with the Membership Council remains an important component of this work, particularly in the context of external review findings.

Staff support and wellbeing

Recognising ongoing global and national uncertainties, the Trust has continued to prioritise staff wellbeing both in the UK and UAE. Support mechanisms remain in place for colleagues affected by international events or personal circumstances, alongside broader wellbeing initiatives.

There has been positive feedback on the accessibility of support and the visibility of leadership during this period.

Research and Innovation

The Trust's position as a global leader in ophthalmology continues to be reinforced through its research and innovation activity. Recent work has emphasised:

- Expanding data-driven and AI-enabled approaches through the Insight programme
- Strengthening collaborations particularly with UCL through the NIHR Moorfields Biomedical Research Centre.

This remains a key area of strategic differentiation for the organisation and will be central to future development at the new centre.

The new Health Bill

The Government's Health Bill, introduced to Parliament in May 2026, represents a significant reform with wide-ranging implications for health and care systems, accountability, and service delivery.
Some key points I would like to bring to your attention are:

- Centralisation of accountability and authority
  The Bill fundamentally recentralises the NHS, abolishing NHS England and transferring its functions to DHSC, with significantly expanded powers for the Secretary of State over system direction, performance and senior appointments.
- Simplification of system architecture and strengthening of strategic commissioning
  National and system structures are streamlined, with Integrated Care Boards repositioned as the primary strategic commissioners, alongside a stronger emphasis on digital integration (including a single patient record) and more joined-up care delivery.
- Reconfiguration of local governance, including foundation trusts
  The role of foundation trust governors is substantially reduced, potentially removed in its current statutory form, with traditional functions (including elements of board accountability and appointments) either shifting to trust boards or being absorbed into the more centralised governance framework, impacting on local democratic oversight.

In Q2 I will be setting up a working group to consider options on the future role of governors to bring forward to discuss with governors and board members.

Moorfields in the news

During week commencing 11 May, our Stratford, St Ann's and City Road sites took part in the GIRFT (Getting It Right First Time) Perfect Week. During this, teams will be carrying out over 200 cataract operations, using GIRFT methodology to drive this increase in capacity. GIRFT is a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. Their Perfect Week initiative focused on the details of every process for every person connected with each patient's journey through surgery, making it a whole team effort.

Awards success for Moorfields

Moorfields at Stratford has been awarded the prestigious GIRFT (Getting it right first time) surgical hub accreditation for efficiency, safety and quality. This award is made to sites which have two or more theatres and reach these exacting standards, and has now been achieved by every possible Moorfields site. We are extremely proud of the hard work that the Stratford team have put in to this achievement which means that more patients can be treated more quickly thus improving patient outcomes.

Quality implications

Quality of care and safe services remain at the heart of what we do and our transformational priorities will help us in this endeavour.

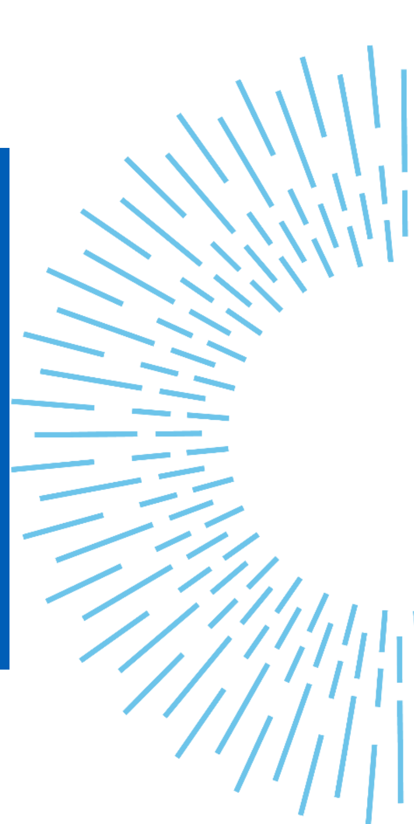
We should note the implications of the data breach reported here.

Financial implications

Financial performance remains under close review, with a continued focus on maintaining control while supporting strategic investment and transformation.

Risk implications

Key risks relate to the scale and complexity of concurrent transformation programmes, workforce capacity, and maintaining operational performance during transition. These are being actively managed through existing governance structures



Summary report of the Quality and Safety Committee Meeting - 12 May 2026

Board of directors
4 June 2026

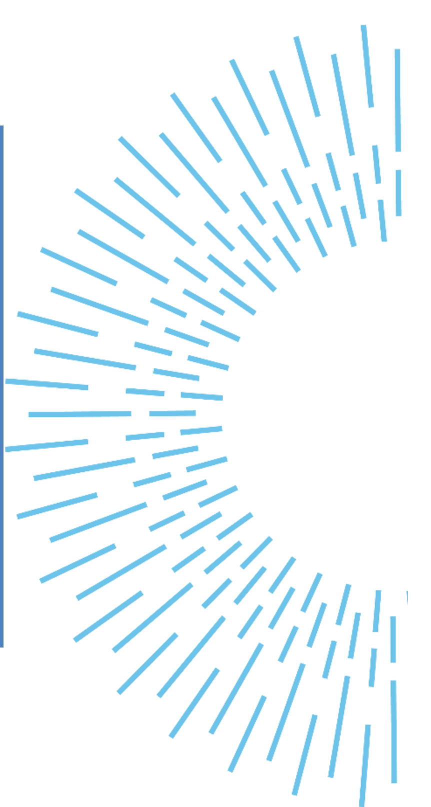
Report title	**Summary report of the Quality and Safety Committee Meeting - 12 May 2026**		
Report from	Michael Marsh, Chair of the Quality and Safety Committee		
Prepared by	David Flintham, Quality and Compliance Manager Kylie Smith, Head of Quality and Safety Ian Tombleson, Director of Quality and Safety		
Previously considered at	Quality and Safety Committee	**Date**	12 May 2026
Link to strategic objectives	We will consistently provide an excellent, globally recognised service		

Quality implications This report provides a summary of the committee's meeting held on 12 May 2026. It outlines the items discussed at the meeting and highlights any issues for the attention of the Board.							
Financial implications None.							
Risk implications No specific risk escalations from this meeting. There are points in the report which are highlighted for the Board's specific 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**	

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT - 12 May 2026

Committee Governance	• Quorate – yes • Attendance – 100% (5 of 5 members) • Action completion status (due items) – 100% • Agenda completed – yes
Assure	**Fire Safety** The committee received the regular Fire Safety update - the following was highlighted: • Following a system issue, information relating to fire warden training was lost and is being restored manually • Site cover nurse training is now on track • Fire safety work in conjunction with Oriel is on track. **Financial decisions and mitigation assurance** The committee received its regular update - the following was highlighted: • The Equality Diversity Inclusion-Quality Inclusion Assessment (EDI-QI) panel functions effectively • Planning for 2026-27 includes an ambition to have fewer and larger CIP schemes • Going forwards QSC will receive assurance reports every six months. **Digital Clinical Safety** The committee received a presentation about Digital Clinical Safety. The following points were made: • Digital clinical safety is organised with robust governance • The many ways in which digital clinical safety supports the EPR project were highlighted, including the risks during transition to the new system(s) • Wider staff training and awareness is key to effective digital clinical safety and this is being expanded and mainstreamed • Assurance about the safe introduction of information technology systems/new processes is vital. **Presentation by Moorfields City Road** QSC received a presentation by Moorfields City Road team. The following points were made: • The division highlighted patient experience, transition from children to adults, and the recent 'super Saturday' clinics • An area of improvement is around waiting times • Care and treatment is the most frequent issue for both patient complaints and patient compliments: a deeper dive is required. **Infection Control Update** The regular infection control (IPC) update was presented. The following issues were highlighted: • The trust infection data for Q4 showed all key performance targets were green, and the annual IPC Programme of Work 2025/26 has been fully completed • There have been two Trust reportable cases of endophthalmitis • The flu vaccine compliance for Moorfields was 51.1% (second highest in the region)

	• An After-Action Review was undertaken following the high particle counts in SurgiCubes at Stratford - ongoing daily monitoring is in place with no recent issues reported • A PLACE inspection report from 2025 has been published - an action plan has been developed and is being worked through. **Patient Safety Incidents and Duty of Candour** There were two patient safety incident investigation (PSII) reports – a delayed review of an MRI, and a Never Event (incorrect IOL): • The PSII highlighted issues relating to needing accurate and well-defined processes. Also, the need for better advocacy/support for more vulnerable patients. This will be facilitated through a named Learning Disability lead appointed in the Safeguarding team • The discussion around the incorrect IOL NE highlighted potential issues with consent and also how lens selection is recorded. The regular duty of candour report highlighted the ongoing need for improvement. **Committee Governance** The committee's annual report for 2025/26 and its terms of reference for 2026/27 were presented: • The annual report was approved • The membership and attendee element of the terms of reference will be further reviewed. **Quality and Safety** The committee received reports about two IT incidents, the Quality Account for 2025/26, Q4 reports (Trust-wide and UAE) and the regular Q&S update. The following were highlighted: • The Quality Account was approved by the committee prior to it receiving Board agreement and subject to any further comments by 19 May • The Q4 report from UAE was commended for its focus and clarity • The successful outcome from the recent CQC IR(ME)R was noted. **Summary Reports from Committees** • Risk and Safety Committee (11/03/2026) • Research and Development Quality Review Group (23/03/2026) • Information Governance Committee (07/04/2026) • Clinical Governance Committee (20/04/2026) One issue in respect of IGC was highlighted. Current IG training level is 1 percentage point (about 50 staff) away from compliance target of 90%. This is being very actively progressed to meet the target by the end of May.
Advise	The Trust Board is advised of: • The importance of digital clinical safety and its integration and close linkage with EPR and IT projects • A wrong IOL never event highlighted potential issues with the lens selection process and consent.
Alert	The Trust Board is alerted to: • A Bedford data migration which commenced on 31 March 2026, resulted in an issue effecting 580 patients. No patient harm or IG breach has been so far identified - investigation is on-going. The ICO has been informed. • A second IT incident has been reported separately to the Board.
Next meeting	21 July 2026 (there was an extraordinary meeting of the committee on 14 May 2026)



Chief nurse report
Board of directors
4 June 2026

Report title	Chief nurse quality report		
Report from	Suminthra Naidu, Chief Nurse and Director of Allied Health Professionals		
Prepared by	Ian Tombleson, Director of Quality and Safety		
Previously considered at	Clinical Governance Committee and Quality and Safety Committee	Date	NA
Link to strategic objectives	Underpins all strategic objectives		

Executive Summary

This report provides assurance on key nursing-led quality, safety and governance arrangements across Moorfields Eye Hospital NHS Foundation Trust. Overall, appropriate systems and processes are in place to support safe, effective care, with ongoing work to strengthen leadership, learning and assurance.

Care Quality Commission (CQC) compliance

The Trust continues to maintain an overview of CQC compliance through the clinical governance committee with oversight and engagement led by the Chief Nurse and assurance provided to the Quality and Safety Committee

A CQC inspection of the IR(M)ER (ionising radiation regulations which protect patients) pathway, took place in April A draft report has been received. Feedback from this inspection has been positive with no concerns or recommendations raised. Moorfields good practice and collaboration with Barts Health NHS Trust was recognised.

At present there have been no CQC enforcement actions or regulatory escalations to report this period.

Well-led

An update on the internal well-led review was made to the board's committees in May 2026.

Recommendations appear elsewhere on the board's agenda.

Patient experience and feedback

Patient experience continues to be monitored through multiple sources, including Friends and Family Test (FTT) results, complaints, compliments, PALS and targeted engagement activity. Overall performance against our FFT remains solid - some further focus/investigation is required following a slight dip in our response rate and numbers of negative responses in some areas, for example A&E. Complaints performance continues to improve. The 3-day complaints acknowledgement target (90% within 3-days) is consistently exceeding the target. Performance against the 80% final response target within 25 days has improved to and has been exceeded in both the previous two months. We will continue to work to maintain this across all divisions, services and departments.

Overall feedback consistently reflects positive patient experiences of staff professionalism and compassion. Key improvement themes remain focused on communication, coordination of care and

waiting times in some services. Actions arising from patient feedback are monitored through divisional and Trust-level governance processes.

Risk and incident management

The Trust maintains a structured approach to risk management, with risks identified and reviewed locally and escalated as appropriate through committees to the Trust risk register (which holds the Trust's most significant operational risks). Work is supported by the Risk and Safety Committee.

Current priorities include:

- embedding the recently reviewed risk management strategy and policy
- ensuring effective oversight and management of risks including regular updates to the risk register
- working with the new executive meeting structure to raise the profile of trust wide risks, and need for effective mitigation.

Internal Audit (RSM) have completed an audit of divisional/departmental risk management arrangements. The management actions focus on effective controls and assurances, and that risk mitigating actions are clearly defined and resolved in a timely way.

In addition, a key focus is to ensure that our incidents are closed in a timely way, particularly those over 28 days.

Safety

The Quality Account for 2025/26, Q4 reports (Trust-wide and UAE) were ratified at the last Quality and Safety Committee. The Q4 report from the UAE was commended for its focus and clarity.

Patient Safety Incident Response Framework (PSIRF)

The Trust continues to embed PSIRF as its standard approach to responding to patient safety incidents. This focuses on compassionate engagement, proportionate system-based learning, and strong oversight of themes and improvement actions.

There were two patient safety incident investigation (PSII) reports – a delayed review of an MRI, and a Never Event (incorrect intra-ocular lens):

The PSII highlighted issues relating to needing accurate and well-defined processes. Also, the need for better advocacy/support for more vulnerable patients. This will be facilitated through a named Learning Disability lead appointed in the Safeguarding team

The discussion around the incorrect intra-ocular lens Never Event highlighted potential issues with consent and also how lens selection is recorded.

Improvements have been identified and actions are being delivered locally with oversight from the central team.

Our performance against our stage one apologies for our Duty of Candour responses has improved, meeting or exceeding the 80% target for three of the past four months, We must maintain this performance every month and ensure all the stages are met on time. This is a key area of focus.

Infection Control

The trust infection data for Q4 showed all key performance targets were green, and the annual IPC Programme of Work 2025/26 has been fully completed. There have been two Trust reportable cases of endophthalmitis. The flu vaccine compliance for Moorfields was 51.1% (second highest in the region). An After-Action Review was undertaken following the high particle counts in SurgiCubes at Stratford - ongoing daily monitoring is in place with no recent issues reported. A PLACE inspection report from 2025 has been published demonstrating a good overall outcome with a few recommendations relating to environment and Estates. An action plan has been developed and is being worked through.

Information Governance

A Bedford data migration which commenced on 31 March 2026, resulted in an issue effecting 580 patients. No patient harm or IG breach has been so far identified - investigation is on-going. The ICO has been informed.

A second IT incident has been reported separately to the Board. Again no patient harm has been identified at the time of writing this report. This incident involved an IG Breach and the ICO has been informed.

Moorfields current IG training level is 0.5 percentage point (about 25 staff) away from compliance target of 90%. This is being very actively progressed to meet the target by the end of May.

Digital Clinical Safety

Digital clinical safety is organised with robust governance. A full review of how digital clinical safety supports the EPR project has been undertaken by the Quality and Safety Committee, including the need to identify potential risks during transition to the new system(s).

Wider staff training and awareness is key to effective digital clinical safety, and this is being expanded and mainstreamed. Assurance about the safe introduction of information technology systems/new processes is included within the training offer.

Conclusion

As new in post I am familiarising myself with existing systems and processes and have been impressed by what I have seen to date. I will be focusing on strengthening assurance, leadership and learning and will work closely with the nursing team across the trust and with Michael Marsh, the Non-Executive chair of the Quality and safety Committee, to this effect.

Quality implications

This report is a high-level summary alongside the quality and safety committee chair's report.

Financial implications

None specified in this report

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

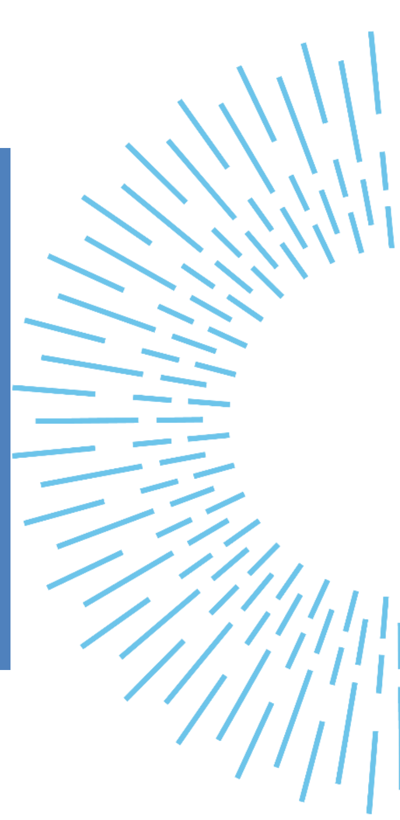
Action required/recommendation.

The Board is asked to note this report for assurance.

For assurance	X	For decision		For discussion		To note	

Learning from deaths (Q4 2025/26)

Board of directors
4 June 2026



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

Executive summary

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

The trust has identified **one** patient death in Q4 2025/26 that falls within the scope of the learning from deaths policy.

Quality implications

The Board needs to be assured that the trust is able to learn lessons from patient safety incidents, in order to prevent repeat mistakes and minimise patient harm.

Financial implications

Provision of the medical examiner (ME) role for Moorfields may have small cost implications if the service is ever required.

Risk implications

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

Action required/recommendation

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

For assurance	✓	For decision		For discussion		To note	✓

This report satisfies the requirement to provide the trust board with an update regarding compliance with, and learning from, the NHSE learning from deaths agenda. The 2024/25 data is shown in the table below.

Indicator	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	1	0	1
% of cases (in scope) reviewed under the structured judgement review (SJR) methodology	N/A	100	N/A	100
Deaths considered likely to have been avoidable	N/A	0	N/A	Pending

Learning and improvement opportunities identified during Q4 (including those outside the criteria set out in Annex 1)

1. Notification of a patient death received, City Road (in scope – see annex 1)

In the Q1 2025/26 update it was reported that a request for information had been received from the coroner regarding a patient who had passed away two days after routine cataract surgery. All requested information was supplied in line with the deadline that had been set. An SJR was completed by a consultant ophthalmologist and a consultant anaesthetist, and no concerns were identified. The document now awaits final approval by the multi-disciplinary team (MDT) that has been established for this purpose.

2. New notification of a patient death received, City Road (in scope – see annex 1)

In March 2026 the trust became aware that a patient, who had been admitted for social reasons following uncomplicated surgery, had died within 24 hours following discharge. It has been established that the death has been reviewed by the coroner, without involvement from the trust, and that it was attributable to ‘natural causes’. An SJR is being completed to establish whether or not there is any learning that can be identified. Engagement with the family remains on-going and the SJR is being supplemented with a staff engagement exercise to ensure that the family concerns, which relate primarily to admission and discharge, are addressed.

3. Notification of a patient death received, Moorfields Private (not in scope – see annex 1)

A complaint was received regarding a patient who required emergency admission to hospital the day after being reviewed as an outpatient. An SJR is currently not planned, with the complaint investigation being prioritised in the first instance. The outcome of the complaint investigation will determine if completion of an additional learning response is required.

Annex 1

Included within the scope of this policy:

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

Excluded from the scope of this Policy:

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

Guardian of Safe Working

Board of directors
4 June 2026

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 16th September 2025 to 19th March 2026.

Exception Reports:

Exception Reports (ER) over past quarter

Reference period of report	18/09/25 - 19/03/26
Total number of exception reports received	18
Number relating to immediate patient safety issues	0
Number relating to hours of working	7
Number relating to pattern of work	1
Number relating to educational opportunities	10
Number relating to service support available to the doctor	0

Reasons for ER over last quarter by specialty & grade

ER relating to:	Specialty	Grade	No. ERs raised
Immediate patient safety issues			
Total			**0**
No. relating to hours/pattern	Ophthalmology	ST5	7
	Ophthalmology	ST6	1
Total			**8**
No. relating to educational opportunities	Ophthalmology	ST5	8
	Ophthalmology	ST6	2
Total			**10**
No. relating to service support available			
Total			**0**

During this timeframe, 18 Exception Reports have been submitted. There have been **no exception reports relating to immediate safety issues.** 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.

Educational Exception Reports:

Ten of the 18 exception reports submitted were educational in nature, highlighting missed training opportunities. All were submitted by less-than-full-time trainees, who may be disproportionately affected by loss of training exposure.

Eight of these reports related to missed subspecialty training opportunities, particularly subspecialty surgical experience, as a result of trainees being allocated more than the recommended number of casualty sessions. The Royal College of Ophthalmologists (RCOphth) advises that trainees should undertake no more than two casualty sessions per week on average in order to safeguard subspecialty training.

Two reports specifically noted that scheduled cataract operating lists had been replaced with cataract clinics.

Additional Hours/ patterns of work Exception Reports:

Eight exception reports related to additional hours worked due to overrunning clinics. This resulted in disruptions to working patterns, including missed breaks and delayed starts to afternoon clinics.

All exception reports were reviewed in detail at the Resident Doctor Forums. Trainees were appropriately compensated, with additional payment for extra hours worked and time off in lieu provided where required. This included an instance in which a senior trainee was asked to cover a Lower House on-call shift due to the sickness of a junior colleague; appropriate adjustments to their clinical duties over the following days were made to ensure compliance with safe working requirements.

Most trainees recognise the need for occasional flexibility in service provision. Additionally, many acknowledge that casualty work can provide valuable educational opportunities, including exposure to a broad range of subspecialty cases.

Exception Reporting Reforms:

I am pleased to report that exception reporting reforms have been discussed with trainees and implemented successfully into our systems from February 2026. The key national changes include the following:

- Resident doctors must be provided with access to the exception reporting system within seven calendar days of commencing employment, rotating, or changing work schedules
- Exception reports are reviewed by Medical HR and the Guardian of Safe Working Hours rather than educational or clinical supervisors
- Confidentiality of personal data within exception reports is strengthened
- Failure to provide timely access to exception reporting may attract contractual fines

These changes are intended to enforce confidentiality and remove barriers to reporting and to ensure concerns are identified and addressed promptly. There have been no exception reports by residents since the implementation of these changes in February 2026.

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 absence of exception reports since the implementation of the reforms in February—which focused on improving confidentiality and removing barriers such as fear of detriment—likely reflects a genuine improvement in trainee wellbeing 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**	✓

Meeting:	Board of Directors
Date:	4 June 2026
Report title:	Assurance report from the chair of the People and Culture Committee
Lead executives	N/A
Report Author	Aaron Rajan, chair of the People and Culture Committee
Presented by	Aaron Rajan, chair of the People and Culture Committee
Status	For assurance
Link to strategic objectives	All

Brief summary of report

Attached is a summary of the findings from the People and Culture Committee held on 8 May 2026.

It is set out in three sections of assure, advise, and alert.

Action Required/Recommendation.

The board is asked to:

- Note and discuss the People and Culture Committee chair's report

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

Key messages for the Board:

Assure

- **Progress on the culture programme -** The culture programme has continued to evolve into an integrated, trust-wide approach, using data insights to target improvements in leadership, psychological safety, and staff experience, with further work planned through the Transformation Steering Group. The committee is assured that good progress is being made.

Advise

- **Long-term sickness absence trends and financial implications -** Sickness absence remains above the trust target, with data identifying persistent hotspots and increasing occupational health referrals, highlighting both workforce pressures and potential financial impacts associated with sustained absence levels.
- **EDI progress and pay gap analysis -** Progress has been made in increasing BME representation and improving staff experience; however, ongoing analysis of gender and ethnicity pay gaps is required, particularly regarding concentration of BME staff in lower pay bands, to inform targeted interventions.
- **Potential inclusion of staff experience narratives -** The committee discussed the value of incorporating staff experience narratives, including survey free-text and lived experience insights, to strengthen understanding of workforce issues and inform culture and EDI interventions.

Alert

- **Urgency of Learning Management System (Kallidus) procurement -** The LMS (Kallidus) system contract is approaching renewal, and there is an urgent need to progress procurement activity to avoid reliance on short-term extensions and ensure continuity of learning management provision.
- **Need for rostering system (Allocate) upgrades -** Limitations of the current rostering system are impacting workforce planning and staff experience, and system upgrades or replacement are required to support improved roster visibility, demand alignment, and productivity.

Cover Sheet	
Report title	Annual EDI Report 2025
Meeting	Board of directors
Date	4 June 2026
Report from	Sue Steen, Chief People Officer
Prepared by	Ade Adetukasi, Associate Director of Employee Experience Idrees Mohammed, Interim Head of EDI
Previous forum consideration & date	People and Culture Committee – 8 May 2026

Relevant strategic objectives	Working together	X	Discover		Develop		Deliver		Sustainability and Scale	

Purpose of report	Assurance	X	Decision		Discussion	X	For information	

Executive Summary

Moorfields Eye Hospital's 2025 Equality, Diversity and Inclusion (EDI) report reflects the trust's continued commitment to creating a fair, inclusive and equitable environment for patients, staff and learners. Over the past year, Moorfields made significant progress across its three EDI workstreams—leadership and culture, data-driven change, and fair opportunities for all—while also advancing its transition toward a broader Cultural Improvement Programme that integrates EDI, values, and leadership development.

Key Achievements

The trust delivered large-scale anti-racism and unconscious bias sessions and delivered 90% of the UNISON Anti-Racism Charter pledges. Data capability improved through enhanced WRES/WDES insight and the rollout of a Qlik Sense EDI dashboard. Career development initiatives continued with the second cohorts of the Career Sponsorship and Leadership Academy Programmes, alongside a recruitment audit aligned with NHS England's *No More Tick Boxes* framework.

WRES and WDES Insights

The trust saw positive movement in several indicators. BME representation rose to 58.8%, with improved perceptions of career progression and reduced bullying and harassment. However, disparities in recruitment outcomes and Board-level BME representation require targeted action.

For disabled staff, representation and recruitment fairness improved, and satisfaction with reasonable adjustments increased. However, a decline in feeling valued and overall engagement highlights the need for stronger inclusive leadership and better day-to-day experiences.

Pay Gap Findings

The trust's gender pay gap widened, driven primarily by under-representation of women in senior and consultant roles and higher rates of part-time working among women. While bonus gaps now favour women, upper-quartile female representation fell and ethnicity-related pay gaps worsened, particularly in senior and medical roles.

Planned Interventions
Key activities for 2026 include further development of EDI dashboards, Board and senior leadership pipeline initiatives (including the NHS England NExT Director scheme), a learning review of anti-racism and bias training, readiness for psychological safety and reverse mentoring, and the introduction of a Shadow Board to improve diversity and create a pipeline.

Recommendations

Sustained governance focus is required to ensure equitable recruitment, increase senior and Board diversity, and strengthen disability inclusion through lived-experience-focused leadership, consistent reasonable adjustments, and improved declaration confidence.

Action required
The Board is asked to note the 2025 Annual EDI report for assurance.

Quality implications

Delivery of the EDI programme continues to have a direct and measurable impact on the quality of care, patient experience and staff wellbeing. A diverse and inclusive workforce is strongly associated with improved clinical outcomes, higher patient satisfaction and safer services. Strengthened EDI insight, improved leadership behaviours and fairer recruitment processes contribute to a more engaged workforce, which in turn improves compassion, communication and overall care standards.

Financial implications

EDI delivery has both cost pressures and financial opportunities. Investment in leadership development, data systems (such as EDI dashboards), and training programmes is required to maintain progress. However, these investments mitigate wider organisational costs by reducing turnover, sickness absence and employee relations cases—each of which has a significant financial impact when unmanaged.

The shift toward a Cultural Improvement Programme allows the trust to consolidate resources and deliver EDI, leadership and values initiatives more efficiently.

Risk implications

Failure to meet statutory duties under the Equality Act 2010, the Public Sector Equality Duty, WRES, WDES and gender pay reporting requirements exposes the trust to regulatory, legal and reputational risk. Gaps in representation—particularly at senior levels—carry a risk of reduced Board diversity, limited decision-making insight, and potential challenge from regulators or external partners. Mitigating these risks requires sustained governance oversight, timely action plans, transparent reporting and robust leadership accountability across all departments.

Equality, Diversity and Inclusion (EDI) Annual Report 2025

Contents

Contents 2

Introduction 3
1.1 Our motivation 3
1.2 Our values 3

Executive Summary 4
2.1 Key achievements 4
2.1(a) Progress in leadership and culture workstream 4
2.1(b) Progress in data-driven change workstream 4
2.1(c) Progress in fair opportunities for all workstream 5
2.2 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) insights 5
2.3 Gender pay gap (2024) 5
2.4 Ongoing work and areas for further development 6
2.5 Other planned interventions: 6
2.6 Recommendations 6
3.1 The EDI Programme Workstreams 7
3.2 Leadership and culture workstream 7
3.2(a) Workstream highlight 8
3.3 Data-driven change 8
3.3(a) Workstream highlight 8
3.4 Fair opportunities for all 8
3.4(a) Workstream highlight 9
3.5 What is Next - Cultural Improvement Programme 9
3.7 Conclusion 9

Workforce EDI data reporting 10
4.1 Introduction 10
4.1(a) Key Themes (2025) and Five-year snapshot: WRES and WDES (2021 to 2025) 10
4.2 WRES Data Comparison: 2024 and 2025 11
4.3 WDES Data Comparison: 2024 and 2025 12
4.4 Key Highlights for WRES and WDES Action Plan (2025/2026) 14
4.6 Conclusion 15

Gender pay gap (2024) 15
5.1 Introduction 15
5.2 Gender pay gap 15
5.3 Ethnicity pay gap (EPG) 18
5.4 Ongoing Actions 19
5.5 Conclusion 20

Appendix A: 21
Table 1: WRES five-year snapshot (2021–2025) 21
Table 2: WDES five-year snapshot (2021–2025) 21

Appendix B: 23
EDI Roadmap .... **Error! Bookmark not defined.**

Introduction

Moorfields Eye Hospital is pleased to present its annual equality, diversity and inclusion (EDI) report for 2025.

Moorfields is committed to ensuring equity, diversity and inclusion. This remains a priority for the trust, and we remain steadfast on our journey. We will continue to take purposeful actions to ensure everyone at Moorfields has an equitable experience and to foster an environment where EDI is integral to how we deliver excellent care, education and research.

Our EDI vision strapline, Equity in Action, reflects our commitment to creating an inclusive culture where every individual feels respected, valued and able to thrive. In 2025, the trust continued delivery across the EDI workstreams and progressed the transitioning of this work into a Cultural Improvement Programme, bringing together EDI, Embedding Values and Leadership Development into one coherent approach to culture change. This report highlights delivery across the EDI workstreams and the insight from key workforce datasets, including WRES, WDES and pay gap analysis, and sets out the actions being taken to strengthen fairness in recruitment and progression, build confidence in disability declaration, and close the gap between policy intent and everyday lived experience of inclusion.

1.1 Our motivation

People's sight matters, and this belief shapes everything we do. Providing a working environment that attracts and retains the best people and where individuals feel supported, challenged and empowered is fundamental to achieving our organisational aims. Discrimination plays no part in a healthy, inclusive culture and will not be tolerated in the trust.

1.2 Our values

- **Excellence**: is at the heart of Moorfields' purpose and history. It is also fundamental to our future as we innovate at the forefront of eyecare, delivering the best care and experience.
- **Equity:** means everyone can expect that we will do our best for them – our patients,

staff and system partners – providing appropriate, accessible, excellent and sustainable care based on clinical need. Everyone can be confident their voice is listened to in decisions about their care.

- **Kindness:** means we are friendly and considerate – treating everyone with respect and going out of our way to reassure and give confidence.

Executive Summary

This annual report sets out activities and delivery across the Moorfields' Equality, Diversity and Inclusion (EDI) programme during 2025. This includes the progress across the EDI workstreams, including insight from WRES, WDES, and pay gap analysis.

2.1 Key achievements

2.1(a) Progress in leadership and culture workstream

- Trust-wide delivery of anti-racism and unconscious bias awareness sessions at scale, with over 1000 attendees over a four-month period.
- Executive EDI floor-walking embedded as business as usual.
- UNISON Anti-Racism Charter delivery sustained, with over 90% of pledges implemented and now being monitored through the EDI Steering Group.
- Workstream closure achieved and activities transitioned to business as usual.

2.1(b) Progress in data-driven change workstream

- Integrated EDI insight strengthened across WRES, WDES, staff survey and employee relations themes to identify issues, root causes, and to target interventions.

- Share Not Declare campaign resources for disability and sexual orientation made available to support declaration confidence and data quality.

- Qlik Sense EDI dashboard developed, alongside EDI metrics trend analysis (including employee relations and Freedom to Speak Up themes) to support tracking of outcomes and impact.

2.1(c) Progress in fair opportunities for all workstream

- Career Sponsorship Programme cohort 2 delivered (April to November 2025), building on cohort 1 learning and strengthening the pipeline for career progression for BME staff.

- Leadership Academy Programme cohort 2 completed in September 2025, with planning underway for cohort 3.

- Recruitment audit completed and translated into a high-level improvement plan aligned to NHSE No More Tick Boxes framework, with ongoing assurance to June 2026.

2.2 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) insights.

WRES

- BME representation increased to 58.8%, with a step change in perceived equal opportunities for career progression (42.2% to 52.6%).
- Bullying and harassment indicators improved notably for BME colleagues, including staff-to-staff harassment reducing to 22.2% from 30.4%.
- Recruitment outcomes from shortlisting worsened (relative likelihood from 1.47 to 1.586), and Board representation is recorded as 0.0% in 2025, requiring focused action on senior and Board visibility and improved recording.

WDES

- Disabled representation increased to 3.41%, and recruitment fairness improved materially (relative likelihood 3.3 to 1.64), moving closer to parity.
- Reasonable adjustments satisfaction improved (61.4% to 67.3%), but feeling valued (31.9% to 26.0%) and engagement (6.5 to 5.1) deteriorated, indicating a lived-experience and leadership behaviour priority.

2.3 Gender pay gap (2024)

- Gender pay gap has widened since 2023: as at 31 March 2024, MEH's mean GPG is 21.23%, and median is 17.41%, both higher than 2023.
- Bonuses now favour women: mean bonus gap -4.38%, but the main pay gap driver is still senior representation: women are 68% of the workforce but only 40% of consultants, and more women work part-time (27% vs 19%).
- Upper-quartile female representation has fallen, and ethnicity pay gaps are worsening: women in the upper pay quartile declined from 54.16% to 50.32%, while equality pay

gap continue to widen, especially in senior and medical roles.

2.4 Ongoing work and areas for further development

- Fair recruitment and progression: closing gaps from shortlist to appointment for BME and disabled applicants and strengthening career progression pipelines to improve senior representation and visibility.
- Disability inclusion and data confidence: increasing disability declaration confidence and data quality, and improving everyday team inclusion so disabled colleagues feel valued, supported, and able to access adjustments.
- Staff Health Adjustment Passport Guidance launched in February 2026 with ongoing trust-wide promotion.
- Pay gap action (gender and ethnicity): delivering sustained long-term actions by targeting representation and progression, with focused insight on senior and medical workforce distribution.

2.5 Other planned interventions:

- Continued development of EDI dashboards and reporting rhythm (Qlik Sense), strengthening tracking of EDI metrics and trend analysis.
- Board and senior leadership pipeline interventions, including enrolment on NHS England's NExT Director scheme.
- Learning review following completion of anti-racism and unconscious bias awareness sessions, and review of readiness to progress psychological safety and reverse mentoring in Q1 2026/27.
  - Introduction of Shadow Board scheme to increase diversity of voices and develop future diverse leaders.
  - The trust is evolving the EDI programme into a cultural transformation programme to ensure sustained culture change.

2.6 Recommendations

- It is important that trust continue to prioritise recruitment equity as a core organisational need requiring consistent governance oversight, decision-quality controls and transparent monitoring of outcomes.
  • More work is needed to strengthen senior leadership and Board diversity through pipeline interventions and improved declaration and recording practices, alongside a targeted development pipeline.

• More effort is needed to shift disability inclusion delivery from process to lived experience by strengthening inclusive leadership behaviours, local accountability and consistent reasonable adjustment practice.

3.1 The EDI Programme Workstreams

The trust's EDI programme was introduced in 2024, in response to issues identified through staff engagement and EDI performance, and in alignment with the trust's strategy. Governance for the programme is provided through the EDI Steering Group, chaired by the Chief People Officer and regular reporting to the People and Culture Committee.

Delivery of the programme was structured through three connected workstreams that translate the trust's EDI vision into measurable actions:

- Leadership and culture: strengthening inclusive leadership, visibility and accountability.
- Data-driven change: improving insight, transparency and measurement to target inequity and track progress.
- Fair opportunities for all: strengthening equity in recruitment, progression and access to development.

Together, these workstreams provided a clear route from cultural and leadership development, to evidence and assurance, and to practical interventions that improve staff experience and reduce variation across teams and sites.

3.2 Leadership and culture workstream

The leadership and culture workstream focused on embedding EDI values across senior leadership and strengthening the trust's approach to inclusion, visibility and accountability. The workstream was formally closed at the project level in October 2025, with seven initiatives successfully delivered and being monitored or transitioned into business as usual. Key initiatives under this workstream included:

- UNISON's Anti-Racism Charter
- EDI objectives for the Executive team
- Senior leaders' listening exercises and EDI floor walking
- Executive coaching support linked to inclusive leadership
- Staff and ally networks governance and sponsorship
- Building psychological safety toolkit (de-scoped at closure due to capacity constraints and to be covered under the new cultural transformation programme)

- Reverse mentoring programme (de-scoped at closure due to capacity constraints and to be covered under the new cultural transformation programme)

3.2(a) Workstream highlight

The trust delivered anti-racism and unconscious bias awareness sessions at scale and embedded executive EDI walkabouts as business as usual, with more than 50 senior leader visits completed. The workstream activities remained within the approved budget, especially for training support. A dedicated learning review is recommended following the final anti-racism and unconscious bias awareness sessions delivered by Diversity Marketplace, and the trust will review readiness to progress the psychological safety and reverse mentoring initiatives in Q1 2026/27.

3.3 Data-driven change

The data-driven change workstream is focused on using workforce and staff experience data to identify inequity, strengthen transparency, and support leadership accountability. Key initiatives under this workstream include:

- Development of the EDI dashboard and reporting rhythm
- Increasing declaration rates and staff confidence in data sharing
- Using data to measure success and inform interventions
- Improving data transparency across recruitment, progression and experience measures
- Implementing NHS England Equality Delivery System (EDS) 2022

3.3(a) Workstream highlight

The trust is strengthening its approach to integrated EDI insight across WRES, WDES, staff survey and employee relations themes to identify where variation in experience persists requiring targeted interventions. Learning from the workstream work reinforces the need for strong project management and appropriate technical capacity to deliver dashboards and reporting tools at pace.

3.4 Fair opportunities for all

The Fair Opportunities for all workstream focused on improving equitable access to recruitment, career development, talent management and training opportunities. This work continues through structured business-as-usual implementation, informed by early learning, including the audit of recruitment practices and the emerging impact of career progression and leadership interventions. Key initiatives include:

- Career Sponsorship Programme
- Leadership Academy Programme
- Refreshing guidance to support diverse and inclusive panels
- Learning and Development initiatives to widen access to development opportunities

- Succession planning and improving the transparency of career development opportunities

3.4(a) Workstream highlight

Staff survey results indicate early improvement in perceptions of fairness on career progression, reflecting the impact and recognition of targeted initiatives such as the Career Sponsorship Programme and Leadership Academy Programme. The trust is strengthening fair recruitment controls, informed by the recruitment audit, to reduce bias at key organisational gateways.

3.5 What is Next - Cultural Improvement Programme

From 2026, the trust is evolving the EDI programme into a Cultural Improvement Programme. By integrating ongoing EDI and other key organisational development initiatives, the programme aims to create a unified, inclusive and values-driven organisational culture. This will enable coherent and consistent cultural change across the trust so that variations in staff experience are effectively addressed.

The programme will build on and turn emerging green shoots into continuous improvement with sustainable impact, support embedding the right mindset, behaviours and ways of working, and align with the evolving national shift in HR from transactional workforce management to a renewed focus on shaping culture, leadership, organisational development and inclusion. The programme will also support an employee experience that mirrors the NHS People Promise.

The programme will align the trust's behaviour framework and core values with internal systems to transform staff experience, develop leaders at all levels with the capability and accountability to model organisational behaviour and best practice, and embed EDI principles into everyday practice. It will also connect the trust's core values with leadership expectations and EDI commitments, enabling delivery of the vision and principles of the NHS People Promise through a compassionate, inclusive and supportive culture.

Success will be tracked through measuring improvement in staff experience of belonging, fairness, equity, psychological safety, recognition and wellbeing, and disparity in outcomes and staff experience. We will also monitor movement in leadership capability and modelling of organisational values and behaviours, and employee relations casework.

3.7 Conclusion

The EDI programme has helped establish important EDI foundations and delivered practical

improvements, particularly in senior leadership visibility, sponsorship and governance. In 2025–26, the trust will build on this progress through the Cultural Improvement Programme. The programme provides a clearer route to required cultural transformation and inclusive practices across the trust. Progress will be evidenced through improved staff experience of belonging, fairness, equity, psychological safety, recognition and wellbeing, narrowed variation in outcomes and experience, and clearer organisational assurance through sustained improvement over time.

Workforce EDI data reporting

4.1 Introduction

Below are the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data and action plans for 2024 and 2025 at Moorfields Eye Hospital NHS Foundation Trust. This section highlights key issues, provides insights from both datasets and compares progress between the two years, focusing on the overarching action plans and narrative shifts.

The sub-section below highlights key themes of 2025 and also the five-year snapshot for WRES and WDES data.

4.1(a) Key Themes (2025) and Five-year snapshot: WRES and WDES (2021 to 2025)

2025 Key Themes: Equal Opportunity and Recruitment Fairness:

- WRES Indicator 7: Equal opportunities perception (BME colleagues) - 42.2% → 52.6%
    a) Improved by +10.4 percentage points (this is a notable improvement in perceived fairness of progression)
- WDES Indicator 2: Recruitment fairness (relative likelihood Non-Disabled appointed vs Disabled) - 3.30 → 1.64.
    a) Improved by -1.66 (a major move towards parity at 1.00).

The five-year snapshots are captured below in the appendix in tables 1 and 2.

Key Insights

- Workforce representation has strengthened over time, but senior leadership and Board visibility remains the weakest signal for both race and disability inclusion.

- Recruitment is the most persistent structural inequality signal: WRES recruitment data moved further from parity in 2024 to 2025, while WDES recruitment data improved materially in 2025 but remains above parity.
- Workplace experience for BME colleagues improved sharply in 2025, including reduced staff-to-staff harassment and a step-change in perceived equal opportunities.
- Disability inclusion shows an uneven experience: reasonable adjustments improved, while feeling valued and engagement deteriorated in 2025, pointing to an everyday inclusion and leadership behaviour gap.
- Under-declaration continues to limit organisational visibility of disability-related need at scale.

Please refer to the Appendix for Tables 1 and 2:

- Table 1: WRES five-year snapshot (2021–2025)
- Table 2: WDES five-year snapshot (2021–2025)

4.2 WRES Data Comparison: 2024 and 2025

2025 headline: Workforce-level representation remains strong, and lived-experience indicators improved, particularly access to CPD, bullying and harassment, and perceived equal opportunities. The two priority gaps are recruitment outcomes from shortlisting and senior/Board visibility.
Representation (WRES 1)

- 2024: BME workforce representation was 57.6%.
- 2025: BME workforce representation increased to 58.8%.
- Senior/VSM representation is recorded as 0.0% in 2025, reflecting both a senior diversity gap and sensitivity to declaration/ESR recording.

Recruitment outcomes (WRES 2)

- 2024: The relative likelihood of White applicants being appointed from shortlisting compared with BME applicants was 1.47.
- 2025: This worsened to 1.586, moving further from parity.
- Recruitment remains the most persistent structural inequality signal. The trust is responding through a recruitment system/process audit and a defined improvement plan with governance oversight.

Disciplinary processes (WRES 3)

- 2024: Relative likelihood of BME staff entering formal disciplinary processes compared with White staff was 0.76.

- 2025: This moved to 0.88, remaining below 1.00.

Access to CPD and non-mandatory training (WRES 4)

- 2024: Relative likelihood of White staff accessing non-mandatory training and CPD compared with BME staff was 1.4 (inequity in access).
- 2025: This improved to 0.83, indicating BME colleagues are now more likely than White colleagues to access CPD.

Bullying, harassment, discrimination, and opportunity (WRES 5–8)

- Harassment, bullying or abuse from staff (BME) reduced from 30.4% in 2024 to 22.2% in 2025.
- Harassment, bullying or abuse from patients/public (BME) reduced from 25.5% in 2024 to 22.5% in 2025.
- Perception that the trust provides equal opportunities for career progression (BME) improved from 42.2% in 2024 to 52.6% in 2025.
- Discrimination at work from a manager or team leader (BME) reduced from 17.0% in 2024 to 14.0% in 2025.
- These improvements indicate progress on culture and everyday experience, while retaining a clear focus on closing remaining gaps and sustaining psychological safety.

Board representation (WRES 9)

- 2024: BME Board membership was recorded as 5.6%.
- 2025: BME Board membership is recorded as 0.0%.
- BME representation at the Board level fell from 5.6% in 2024 to 0.0% in 2025, partly due to the declaration and recording of Board members' demographic details on ESR. This is now being corrected. In addition, the trust has enrolled on NHSE's NExT Director scheme to improve Board diversity and succession planning.

WRES 2025 priorities

- Close recruitment disparity from shortlisting to appointment through a defined improvement plan and stronger decision quality.
- Strengthen senior and Board diversity through pipeline interventions, targeted development, and improved declaration and recording.
- Sustain the gains in culture and experience by preventing bullying and discrimination and strengthening psychologically safe reporting and response pathways.

4.3 WDES Data Comparison: 2024 and 2025

2025 headline: Recruitment fairness and reasonable adjustments improved, and several bullying and harassment indicators moved in the right direction. However, disabled colleagues' sense of

being valued and engagement deteriorated, indicating a lived-experience and leadership behaviour priority.

Representation and declaration (WDES 1)

- 2024: Disabled workforce representation (ESR) was 3.1%.
- 2025: Disabled workforce representation (ESR) increased to 3.41%.
- Under-declaration remains material. Staff survey responses indicate a much higher prevalence of long-term conditions or disability than shown in ESR.

Recruitment outcomes (WDES 2)

- 2024: The relative likelihood of Non-Disabled applicants being appointed from shortlisting compared with Disabled applicants was 3.3.
- 2025: This improved to 1.64, a substantial move towards parity (1.00), though the disadvantage remains.
- Plans are in place for inclusive recruitment practices, including adjustments at interview, accessible assessments, and structured panel decision-making.

Capability processes (WDES 3)

- 2025: Disabled colleagues entering formal capability processes are recorded as 0.0. This may indicate improved support and early resolution and should be monitored to ensure consistent reporting and appropriate use of pathways.

Bullying, harassment, and safety (WDES 4)

- Bullying or harassment from managers (Disabled) reduced from 28.1% in 2024 to 23.8% in 2025.
- Despite improvement, Disabled colleagues continue to report higher rates of bullying or harassment than Non-Disabled colleagues.

Career progression and pressure to attend work (WDES 5–6)

- Perception of equal opportunities for career progression (Disabled) improved slightly from 36.8% in 2024 to 39.0% in 2025, but remains low.
- Pressure to attend work when unwell (Disabled) improved from 37.5% in 2024 to 32.7% in 2025, but remains higher than for Non-Disabled colleagues.

Feeling valued and engagement (WDES 7 and 9a)

- Feeling satisfied that the trust values their work (Disabled) reduced from 31.9% in 2024 to 26.0% in 2025.
- Engagement score (Disabled) reduced from 6.5 in 2024 to 5.1 in 2025.

Reasonable adjustments (WDES 8)

- Reasonable adjustments in place (Disabled) increased from 61.4% in 2024 to 67.3% in 2025.

- This indicates improving system maturity and should be sustained through consistent practice, manager capability, and clear assurance and feedback loops.

Board representation (WDES 10)

- Board representation (Disabled) remains 0.0% in 2024 and 2025.
- No change. We still lack visible Disabled representation at the Board level. The trust enrolment on the NHSE's NExT scheme offers a targeted intervention for addressing disabled representation at the Board level.

WDES 2025 priorities

- Increase disability declaration confidence and data quality to enable planning and targeted support.
- Shift focus from process to lived experience: improve feeling valued and engagement through team-level inclusion and leadership behaviours.
- Embed reasonable adjustments maturity and consolidate recruitment improvements to move closer to parity.

4.4 Key Highlights for WRES and WDES Action Plan (2025/2026)

- Recruitment fairness (WRES 2): Recruitment audit completed, with a high-level improvement plan aligned to No More Tick Boxes and ongoing assurance process.
- Culture and safety (WRES 5, 6 and 8): Unison anti-racism charter delivery is being sustained, supported by trust-wide anti-racism training and prevention of bullying, harassment and discrimination.
- Progression and development (WRES 4, 7 and 9): Career Sponsorship Programme cohort 2 (April to November 2025) builds on cohort 1 learning and positive feedback, strengthening the talent pipeline.
- Senior and Board visibility (WRES 9): Executive objectives, coaching and increased leader engagement with staff networks aim to strengthen the senior leadership pipeline and improve confidence in declaration and recording.
- Declaration confidence (WDES 1): Share Not Declare resources for disability and sexual orientation are live, with Race materials (BeMoor) in development, supported by accessible guidance and communications.
- Recruitment fairness (WDES 2): Recruitment practice improvement continues, including structured decision-making and consistent adjustments at interview and assessment to sustain the move towards parity.

- Reasonable adjustments maturity (WDES 8): Reasonable adjustments guidance and manager education are established, the health passport final draft is completed with a plan to launch in Feb 2026, and central funding discussions are ongoing.
- Voice, engagement and belonging (WDES 7 and 9): Listening events and an engagement framework are being used to strengthen Disabled colleague voice and respond to the decline in feeling valued and engagement.
- Leadership development (WDES 5): Leadership Academy Programme cohort 2 completed in September 2025, with planning underway for cohort 3.
- Cross-cutting enablers: Qlik Sense dashboard development, alongside ER and FTSU trend analysis, supports monthly monitoring and targeted interventions across WRES and WDES indicators.

4.5 Conclusion on WRES and WDES Data

Moorfields' 2025 WRES and WDES data show clear progress, including better CPD access for BME colleagues, fewer reports of bullying and harassment, improved perceptions of equal opportunity for BME colleagues, fairer recruitment for disabled applicants, and higher satisfaction with reasonable adjustments.

However, key gaps remain: BME recruitment outcomes have moved further from parity, senior and Board representation is still weak for race and disability, disability declaration remains low, and disabled colleagues' experience of feeling valued and engaged has declined. The 2025 to 2026 action plan therefore focuses on recruitment fairness, declaration confidence, senior pipeline and visibility, and everyday inclusion and psychological safety.

Gender Pay Gap (GPG) 2024

5.1 Introduction

The data reported shows the pay gap as of 31 March 2024, as required by the regulations.

5.2 Gender pay gap

In 2024, male employees earned an average of £30.67 per hour compared with £24.16 for female employees, a difference of £6.51, giving a mean gender pay gap of 21.23%. Looking at the midpoint (median) hourly rate, men earned £26.30 versus £21.72 for women, a £4.58 difference and a median pay gap of 17.41%. Both measures have increased since 2023, when the mean pay gap was 17.86%, and the median pay gap was 16.52%.

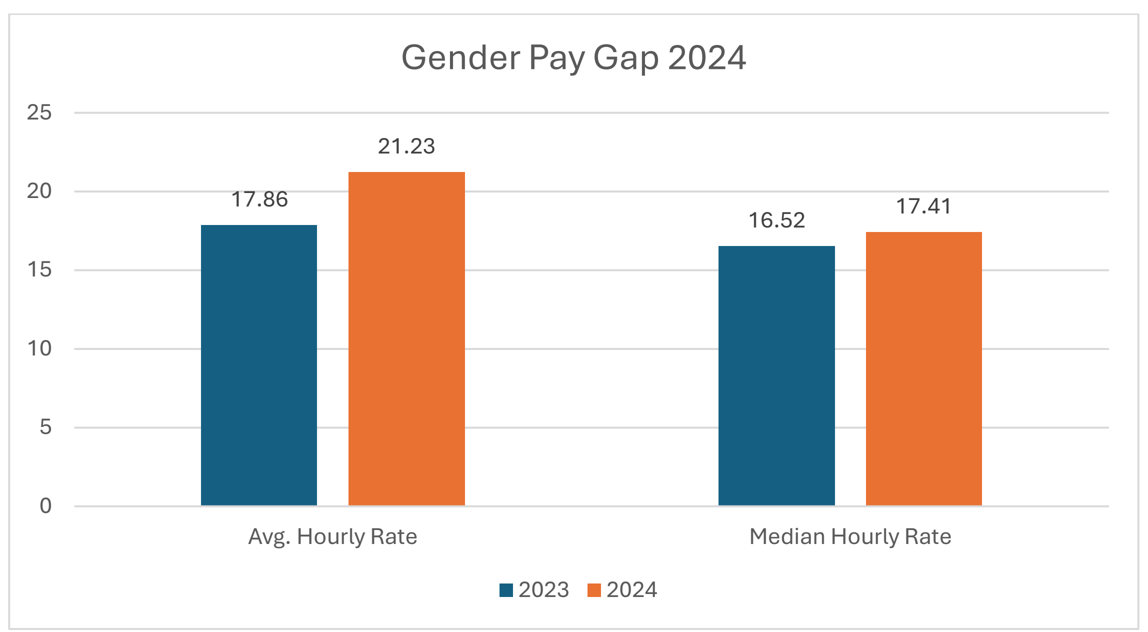


Figure 1: Average and median gender pay gap 2024 compared with 2023

The drivers of the gender pay gap are structural and reflect how men and women are distributed across roles, seniority, and working patterns. Women make up 68.4% of the Moorfield's workforce (1,757 of 2,567), which is consistent with representation across the NHS and are more concentrated in staff groups that are typically weighted towards lower pay bands, including Administrative and Clerical (594 of 856, 69.4%), Additional Clinical Services (294 of 421, 69.8%), and Nursing and Midwifery Registered (408 of 491, 83.1%). By contrast, men are more represented in groups such as Medical and Dental (200 of 384, 52.1%) and Estates and Ancillary (32 of 33, 97.0%).

Working patterns also play a role: 27% of women work part-time compared with 19% of men, which can reduce access to additional earnings and progression opportunities over time. This is reflected in the pay distribution, with women representing 71.0% of the lowest pay quartile and 50.3% of the highest pay quartile, indicating a more even gender split at the top of the pay range than at the bottom.

Compared with 2023, the trust headcount has increased by 206 in total. The largest increases were in Administrative and Clerical (+49), Medical and Dental (+42), and Nursing and Midwifery Registered (+39).

Staff Overview	**Headcount**		**% in Band**	
Staff Group	**Female**	**Male**	**Female**	**Male**
Add Prof Scientific and Technic	188	67	74%	26%
Additional Clinical Services	294	127	70%	30%

Administrative and Clerical	594	262	69%	31%
Allied Health Professionals	45	10	82%	18%
Estates and Ancillary	1	32	3%	97%
Healthcare Scientists	39	29	57%	43%
Medical and Dental	184	200	48%	52%
Nursing and Midwifery Registered	408	83	83%	17%
Students	4		100%	0%
Grand Total	**1757**	**810**	**68%**	**32%**

Table 1: Staff Group Breakdown AfC

Staff Overview	**Headcount**		**% in Band**	
Staff Group	**Female**	**Male**	**Female**	**Male**
Consultant	77	115	40%	60%
Non-consultant career grade	83	56	60%	40%
Trainee grades	24	29	45%	55%
Grand Total	**184**	**200**	**48%**	**52%**

Table 2: Staff Group Breakdown Medical

Whilst women make up 68.4% of our workforce, they are overrepresented in the lower, lower middle and upper middle pay quartiles and underrepresented in the upper pay quartile. This has improved compared to 2023.

Quartile	**Female**	**Male**	**Female %**	**Male %**
0 25%	409	167	71.01%	28.99%
25% 50%	441	177	71.36%	28.64%
50% 75%	494	166	74.85%	25.15%
75% 100%	311	307	50.32%	49.68%

Table 3: Gender by Pay Quartile

Medical vs. non-medical gender pay gap

	Female	**Male**	**GPG**

Band Groupings	Mean Hrly Rate	Median Hrly Rate	Mean Hrly Rate	Median Hrly Rate	Mean GPG	Median GPG
Band 1-4	£ 15.12	£ 15.07	£ 15.02	£ 15.07	-0.64%	0.00%
Band 5-7	£ 23.74	£ 22.92	£ 24.16	£ 25.44	1.70%	9.90%
Bands 8-9	£ 35.53	£ 33.29	£ 39.98	£ 33.56	11.13%	0.80%
Medical Staffing	£ 44.04	£ 44.00	£ 49.39	£ 51.57	10.85%	14.67%

Table 4: Medical vs. Non-Medical Gender Pay Gap

When considering the data on a more granular level, it is clear that the main driver of the gender pay gap at Moorfields is the difference our consultant workforce makes on pay across the organisation.

Whilst the overall percentage comparison of men and women at a medical grade (52% and 48% respectively) has moved slightly closer to parity compared with 2023, the split at consultant grade has remained at 60% and 40% in favour of men. In addition, the women in the medical grades form part of a much larger population of women when looking at the gap at the organisational level (as the trust is 68% female). Consequently, the pay impact of male consultants on male average pay is proportionately greater than the impact of female medical staff on female average pay at the organisational level.

5.3 Ethnicity pay gap (EPG)

Whilst not required to report on it formally, the trust continues our practice of analysing our pay data by ethnicity.

- The mean EPG has increased from 14.17% in 2023 to 18.95% in 2024. The biggest gap within the pay band groupings is in bands 8–9 where it is 14.11%.
- Table 6 shows that EPG is primarily driven by pay at the AfC bands 8-9 and within the medical staffing workforce. This reflects our under-representation rates for Black, Asian and Minority Ethnic (BME) colleagues within band 7, and similarly at bands 8c and above.

Ethnicity	Avg. Hourly Rate	Median Hourly Rate

BME	£23.95	£21.22
White	£29.55	£25.76
Difference	£5.60	£4.54
Pay Gap %	18.95%	17.62%

Table 5: EPG Mean and Median

Band Groupings	BME		WHITE		GPG	
	Mean Hrly Rate	Median Hrly Rate	Mean Hrly Rate	Median Hrly Rate	Mean GPG	Median GPG
Band 1-4	£ 15.03	£ 15.07	£ 15.18	£ 15.07	0.95%	0.00%
Band 5-7	£ 23.59	£ 22.92	£ 24.26	£ 24.46	2.72%	6.30%
Bands 8-9	£ 34.02	£ 31.90	£ 39.62	£ 34.12	14.11%	6.50%
Medical Staffing	£ 46.42	£ 49.24	£ 51.58	£ 52.99	9.99%	7.08%

Table 6: Pay by Ethnicity, analysed by pay band groupings as of 31 March 2024

5.4 GPG and EPG Ongoing Actions

These actions are intended to support the long-term reduction of both the gender and ethnicity pay gaps. Because these gaps are shaped by workforce composition, senior representation and progression pathways, progress will be evidenced through sustained, long-term improvement, and the expectation is not immediate corrective impact but rather a gradual reduction in the disparity, reflecting structural and historical patterns in representation, seniority and access to career development opportunities.

Building on the actions set out in the 2024 annual report, the trust's 2025 focus included:

- **Women's progression and succession**: establishing the Aurora Women's Network to provide a dedicated platform for themes linked to career progression, succession and equality.
- **Ethnicity pay gap and progression:** extending the Career Sponsorship Programme beyond the successful 2023 cohort to strengthen progression and promotional opportunities for BME colleagues. A new cohort ran in 2025, with the programme refreshed into a more impactful development ecosystem, supported by Band 8 and above sponsors.
- **Senior medical workforce representation**: working with medical workforce team to better understand barriers and pathways into senior medical roles, where pay is highest, and to inform targeted improvement activity over time.

- **Recruitment equity:** embedding the WRES Model Employer approach and the No More Tick Boxes principles to strengthen fair, consistent recruitment practice and reduce bias in shortlisting and appointment outcomes.
- **Data-led insight with ESR and Aurora:** undertaking a detailed ESR data review with the Aurora Women's Network to pinpoint the key drivers of the gender pay gap (including part-time patterns and senior medical grade distribution) and use these insights to target and track improvement actions over time.

5.5 Conclusion

The gender pay gap increased in 2024 (mean 21.23%, median 17.41%), driven mainly by workforce distribution, part-time patterns, and the continued imbalance at consultant grade. The ethnicity pay gap also widened (mean 18.95%), linked to underrepresentation in senior AfC bands 8–9 and medical roles. The trust will sustain long-term action on fair recruitment, progression pathways, senior representation, and data-led insight to reduce both gaps over time.

Appendix A:

Table 1: WRES five-year snapshot (2021–2025)

Metric	2021	2022	2023	2024	2025
WRES 1: BME representation (overall)	**53.0%**	**54.4%**	**55.9%**	**57.6%**	**58.80%**
WRES 1: BME representation (VSM)	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
WRES 2: Recruitment RL (White appointed vs BME)	**1.24**	**1.38**	**1.21**	**1.47**	**1.586**
WRES 3: Disciplinary RL (BME vs White)	**0.91**	**0.76**	**0.98**	**0.76**	**0.88**
WRES 4: CPD RL (White vs BME)	**0.73**	**1.11**	**0.85**	**1.4**	**0.83**
WRES 5: Harassment from patients/public (BME)	**29.2%**	**29.4%**	**31.8%**	**25.5%**	**22.50%**
WRES 6: Harassment from staff (BME)	**31.5%**	**31.8%**	**32.5%**	**30.4%**	**22.20%**
WRES 7: Equal opportunities perception (BME)	**45.3%**	**41.7%**	**41.7%**	**42.2%**	**52.60%**
WRES 8: Discrimination at work (BME)	**15.6%**	**17.3%**	**17.6%**	**17.0%**	**14.00%**
WRES 9: BME Board membership	**15.0%**	**10.0%**	**10.0%**	**5.6%**	**0.00%**

[Note: Relative Likelihood (RL) above 1 means disadvantage for the protected group, RL closer to 1 is better]

Table 2: WDES five-year snapshot (2021–2025)

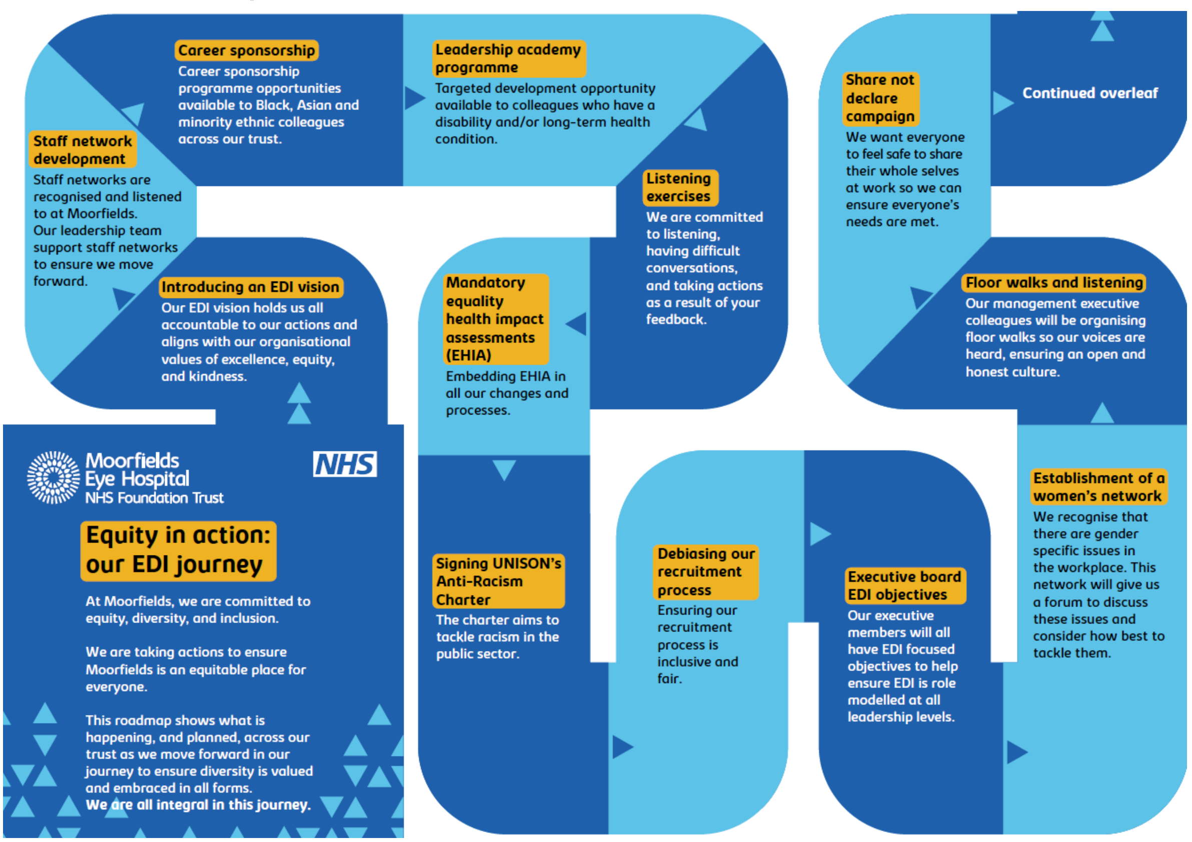
Metric	2021	2022	2023	2024	2025
WDES 1: Disabled representation (ESR)	**2.2%**	**2.2%**	**2.7%**	**3.1%**	**3.41%**
WDES 2: Recruitment RL (Non-disabled appointed vs Disabled)	**1.5**	**1.7**	**1.3**	**3.3**	**1.64**
WDES 3: Formal capability process (Disabled vs Non-Disabled)	**43.34**	**42.9**	**17.1**	**Statistically not able to determine**	**0**

WDES 4: Harassment from patients/public (Disabled)	**38.2%**	**37.8%**	**33.5%**	**32.4%**	**31.70%**
WDES 4: Harassment from managers (Disabled)	**28.0%**	**28.3%**	**21.4%**	**28.1%**	**23.80%**
WDES 4: Harassment from colleagues (Disabled)	**33.6%**	**35.8%**	**30.9%**	**32.9%**	**30.30%**
WDES 4b: Reported last incident (Disabled)	**55.3%**	**57.9%**	**53.6%**	**43.3%**	**53.10%**
WDES 5: Equal opportunities perception (Disabled)	**42.8%**	**40.1%**	**49.7%**	**36.8%**	**39.00%**
WDES 6: Pressure to attend work (Disabled)	**39.0%**	**42.7%**	**35.4%**	**37.5%**	**32.70%**
WDES 7: Feels valued by organisation (Disabled)	**51.3%**	**36.6%**	**33.5%**	**31.9%**	**26.00%**
WDES 8: Adequate adjustments (Disabled)	**66.3%**	**62.5%**	**64.8%**	**61.4%**	**67.30%**
WDES 9a: Staff engagement score (Disabled)	**7.00**	**6.5**	**6.6**	**6.5**	**5.1**
WDES 10: Board representation (Disabled voting member)	**6%**	**6.3%**	**0.0%**	**0.0%**	**0.0%**

[Note: Relative Likelihood (RL) above 1 means disadvantage for the protected group, RL closer to 1 is better]

Appendix B:

EDI Roadmap



Development of transgender policy
We recognise the importance of having a transgender equality policy to help ensure everyone has an equitable experience.
Leadership development programme
Ensuring all our managers are skilled and developed for inclusive leadership.
Behaviours (values) framework
To help people understand our expected behaviours to ensure we all act with equity, excellence, and kindness.
EDI dashboard
Introducing an EDI dashboard will enable us to monitor progress, identify challenges and assist continuous learning and progress. We are committed to transparency and sharing information with staff.
Data accuracy
We are working to improve the collection, reporting and transparency of our EDI data.
Onboarding changes
We are looking at the way we onboard to ensure equity and include staff experience at Moorfields.
Our names matter campaign
Research shows that our brains 'light up" when we hear our name, while mispronunciation can lead to feelings of isolation and alienation. At Moorfields 'our names matter'.
EDI glossary
Language is important. We have listened, and are creating an EDI glossary to help us all understand EDI terminology.
Introducing local EDI champions
EDI champions will help ensure equity across our trust.
Reverse mentoring programme campaign
We are introducing reverse mentoring to foster mutual learning and help bridge gaps in knowledge and perspectives.
Psychological safety
As part of the culture change element of our EDI programme we are working on a series of initiatives to ensure we all feel psychologically safe at work, as well as physically safe.
EDI objectives in appraisals
To ensure equity, we plan to introduce EDI focused objectives for all staff.
Annual EDI report
You will have the opportunity to feed into, review, and comment upon our annual EDI report.
Our journey towards equity continues
Please scan the QR code with your phone camera or visit eyeQ and search 'EDI' for more information on each step of our journey.

Meeting:	Board of Directors
Date:	4 June 2026
Report title:	Assurance report from the chair of the Finance & Performance Committee
Lead executives	N/A
Report Author	Elena Lokteva, chair of the Finance & Performance Committee
Presented by	Elena Lokteva, non-executive director
Status	For assurance
Link to strategic objectives	All

Brief summary of report

Attached is a summary of the findings from the Finance & Performance Committee meeting held on 4 June 2026.

It is set out in three sections of assure, advise, and alert.

Action Required/Recommendation.

The board is asked to:

- Note and discuss the Audit and Risk Committee chair's report.

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

Chair's report to the Board from the

Finance and Performance Committee meeting held on 4 June 2026

Assure

1. The month twelve finance report was received and showed a favourable position. The committee was assured of robust financial management throughout the year and looks forward to continued strong financial performance over 2026/27, noting the need to meet cost improvement programmes targets in order to maintain longer-term financial sustainability.
2. The committee was assured that medical workforce agency spend was reducing. Further reductions are envisaged over the coming year.

Advise

3. The committee noted some rostering issues across consultant workforce and has requested assurances during the year that these are being addressed.

Alert

4. Productivity has been discussed at the committee and the variation in the number of procedures per theatre list has been noted. The committee has asked the executive to address the 4/5 areas that need to improve.

Cover Sheet	
Report title	Monthly Finance Performance Report Month 12 – March 2026
Meeting	Public Board
Date	4 June 2026
Report from	Arthur Vaughan, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Previous forum consideration	Trust Executive Committee

Relevant strategic objectives	Working together	☐	Discover	☐	Develop	☐	Deliver	☐	Sustainability and Scale	☒

Purpose of report	Assurance	☐	Decision	☐	Discussion	☒	For information	☒

Executive summary

For March, the trust is reporting:-

Income and Expenditure

- A £6.6m surplus year to date compared to a planned break-even position; £6.6m favourable to plan.

Efficiency and Productivity

- The Trust has delivered £14.1m of the £15.1m target.
- Delivery in March reported £1.2m, with £14.1m delivered cumulatively.

Capital Expenditure

- Capital expenditure for the year totalled £149.3m against a final plan of £151.2m. Of this, total spend of £120.0m related to Oriel compared to a final plan of £122.1m.
- Internally funded schemes totalled £13.1m against a plan of £16.2m. This included £3.8m for Oriel, plan £5.9m and £4.9m for EPR, plan £5.2.
- IFRS 16 lease expenditure was £14.9m against a plan of £13.8m including the Granary Steet lease. The overspend related to an increase in the Bedford lease.
- Externally funded expenditure was £121.2m against a final plan of £121.2. This included £116.2m for Oriel including NHP and MEC funding and £4.3m of PDC funded EPR costs.

Cash

- The cash balance as at the 31st March was £62.8m, a reduction of £23.3m since the end of March 2025.This equates to approximately 71 days operating cash.

Action Required/Recommendation

- The board is asked to consider and discus the attached report.

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 & Risk Committee.

2025/26 Monthly Finance Performance Report

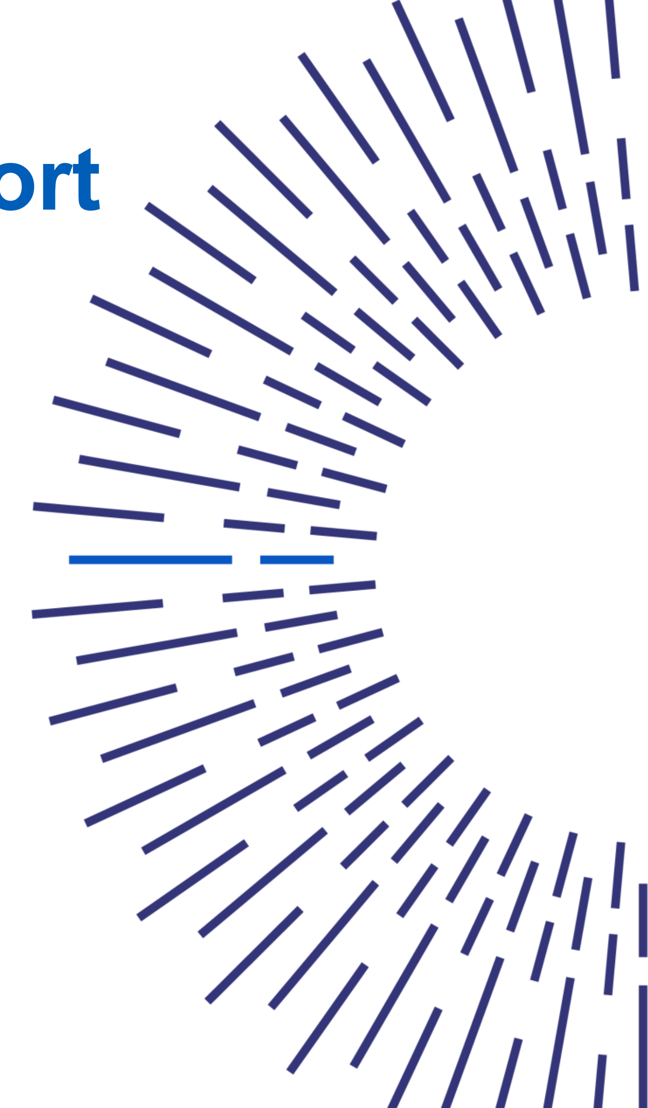
Operational Financial Performance

Trust Board

4 June 2026

Updated 20 May 2026

Report Period	M12 | March 2026
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 31 March 2026 (Month 12)

Key Messages

Statement of Comprehensive Income

Financial Position

£1.56m surplus in month

For March, the trust is reporting:-

- A £1.56m surplus in-month against a planned £1.55m surplus, break-even to plan
- A £6.64m surplus cumulatively against a planned break-even position, £6.64m favourable to plan.

Key Drivers of the Financial Variance

The trusts financial position is being supported by £3.59m of slippage in major projects expenditure, £1.41m clinical supplies non-pay benefits linked to activity below trust plan, and demonstrable reductions in bank, agency, whilst income levels are maintained due to fixed contractual income.

Key Drivers of the core operational performance include:-

- NHS Clinical income is assumed in line with fixed contracts for ERF activity.
  - Income levels would be approximately £4.3m adverse to plan cumulatively as a result of activity levels below plan if based on cost and volume contracts.
- Clinical divisions are reporting operational activity performance below planned levels.
  - Elective activity is 104% in March, 97% cumulatively;
  - Outpatients Firsts and Procedures are 93% and 94% respectively cumulatively;
  - St Ann's elective activity is 71% of plans cumulatively.
  - Cataract activity is 95% of plans cumulatively.
  - As a result, clinical divisions are reporting £6.21m adverse to plan cumulatively, with clinical income being £5.97m adverse (other income £0.31m favourable), pay £1.32m favourable and non-pay including clinical consumables £0.56m favourable. This has been off-set by efficiency under delivery of £2.44m.
- Corporate departments are reporting £3.08m favourable to plans cumulatively including £3.59m linked to slippage on major strategic projects MoorConnect (EPR) (£1.36m), Oriel (£0.92m), and IT projects (£1.31m) and further underspends (£1.20m) offset by CIP underachievement (£1.29m)
- Research is reporting a £0.82m adverse variance to plans cumulatively comprised of central research management costs and RCF costs in excess of income.
- Trading areas are £1.19m favourable to plan cumulatively across all commercial units.

Statement of Financial Position

Cash and Working Capital Position

The cash balance as at the 31st March was £62.8m, a reduction of £23.3m since the end of March 2025.This equates to approximately 71 days operating cash.

The Better Payment Practice Code (BPPC) performance in March was 95% (volume) and 94% (value) against a target of 95% across both metrics.

Capital

(both gross capital expenditure and CDEL)

Capital expenditure for the year totalled £149.3m against a plan of £151.2m.

- Excluding leases, Internal capital plans were £16.2m including £5.9m for Oriel and £5.2m for EPR. Actual spend was £13.1, with the underspend primarily due to slippage in Oriel and IT spend.
- IFRS16 £13.8m plan, £14.9m outturn. The overspend was related to a cost increase in the Bedford lease.
- Externally funded £121.2m plans; £121.2m outturn including £102.2m of Oriel expenditure and £4.3m for EPR.

Other Key Information

Efficiencies

£15.1m Trust Target

£14.2m YTD actual

£6.7m of 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 £18.1m of schemes, of which the programme has delivered £14.1m in year, £0.9m adverse to plan.

Of the total identified:-

- £5.8m is identified central schemes;
- £0.5m is identified high risks to delivery;
- £6.9m identified as non-pay schemes;
- £8.4m 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 2026/27.

Agency Spend

£2.55m spend YTD 1.2% total pay

Trust wide agency spend totals £2.55m cumulatively, approximately 1.2% 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	£384.1m	£46.9m	£45.8m	(£1.1m)	£384.1m	£383.8m	(£0.3m)	(0)%	
Pay	(£206.4m)	(£26.5m)	(£28.1m)	(£1.7m)	(£206.4m)	(£210.5m)	(£4.0m)	(2)%	
Non Pay	(£133.4m)	(£11.2m)	(£13.2m)	(£2.0m)	(£133.4m)	(£128.2m)	£5.3m	4%	
Financing & Adjustments	(£44.2m)	(£7.6m)	(£2.8m)	£4.8m	(£44.2m)	(£38.5m)	£5.7m	13%	
CONTROL TOTAL	**-**	**£1.5m**	**£1.6m**	**£0.0m**	**-**	**£6.6m**	**(£6.6m)**		

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

Memorandum Items	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Research & Development	(£0.44m)	(£0.04m)	(£0.27m)	(£0.24m)	(£0.44m)	(£1.26m)	(£0.82m)	(187)%	
Commercial Trading Units	£5.25m	£0.36m	£0.39m	£0.03m	£5.25m	£6.44m	£1.19m	23%	
ORIEL Revenue	(£3.96m)	(£0.33m)	(£0.68m)	(£0.35m)	(£3.96m)	(£3.04m)	£0.92m	23%	
Efficiency Schemes	£18.00m	£3.34m	£1.22m	(£2.12m)	£15.10m	£14.17m	(£0.93m)	(6)%	

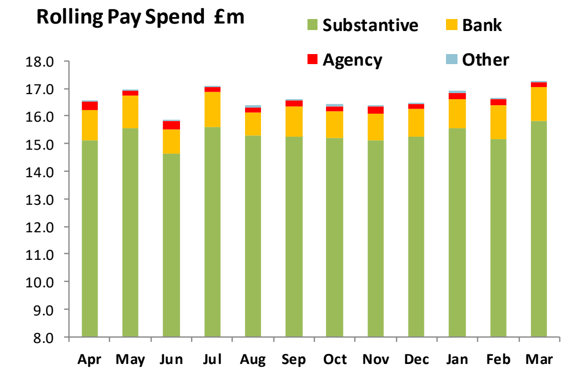
INCOME BREAKDOWN RELATED TO ACTIVITY

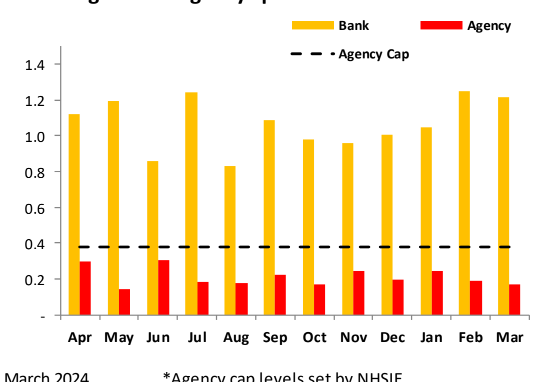
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£223.6m	£223.6m	£226.6m	£3.0m				
Pass Through	£40.2m	£40.2m	£39.0m	(£1.1m)				
Other NHS Clinical Income	£12.2m	£12.2m	£12.4m	£0.3m				
Commercial Trading Units	£48.4m	£48.4m	£48.6m	£0.2m				
Research & Development	£15.7m	£15.7m	£16.8m	£1.1m				
Other	£44.0m	£44.0m	£40.3m	(£3.6m)				
INCOME INCL ERF	**£384.1m**	**£384.1m**	**£383.8m**	**(£0.3m)**				

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	(£204.8m)	(£26.3m)	(£26.7m)	(£0.3m)	(£204.8m)	(£194.4m)	£10.4m	92%
Bank	(£0.5m)	(£0.0m)	(£1.2m)	(£1.2m)	(£0.5m)	(£12.8m)	(£12.3m)	6%
Agency	(£0.5m)	(£0.0m)	(£0.2m)	(£0.1m)	(£0.5m)	(£2.6m)	(£2.1m)	1%
Other	(£0.6m)	(£0.1m)	(£0.1m)	(£0.0m)	(£0.6m)	(£0.7m)	(£0.1m)	0%
TOTAL PAY	**(£206.4m)**	**(£26.5m)**	**(£28.1m)**	**(£1.7m)**	**(£206.4m)**	**(£210.5m)**	**(£4.0m)**	





Pay spend chart adjusted for £5.8m pension cost contributions received in March 2024. *Agency cap levels set by NHSIE

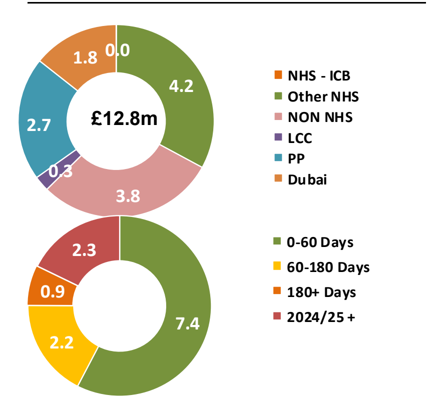
CASH, CAPITAL AND OTHER KPI'S

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	(£5.0m)	(£5.0m)	(£4.4m)	(£0.6m)				
Donated/Externally funded	(£146.2m)	(£146.2m)	(£144.9m)	(£1.4m)				
TOTAL	**£151.2m**	**£151.2m**	**£149.3m**	**(£2.0m)**				

Key Metrics	Plan	Actual	RAG
Cash	62.7	62.8	
Debtor Days	45	12	
Creditor Days	45	77	
PP Debtor Days	65	40	

Better Payment Practice	Plan	Actual
BPPC - NHS (YTD) by number	95%	92%
BPPC - NHS (YTD) by value	95%	91%
BPPC - Non-NHS (YTD) by number	95%	95%
BPPC - Non-NHS (YTD) by value	95%	94%

Net Receivables/Ageing £m



Trust Income and Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income									
NHS Commissioned Clinical Income	263.80	32.75	36.05	3.30	263.80	265.67	1.87	1%	
Other NHS Clinical Income	12.17	1.06	0.97	(0.09)	12.17	12.43	0.26	2%	
Commercial Trading Units	48.42	4.11	3.72	(0.38)	48.42	48.59	0.17	0%	
Research & Development	15.72	1.37	1.92	0.55	15.72	16.80	1.08	7%	
Other Income	43.96	7.58	3.10	(4.48)	43.96	40.31	(3.65)	(8)%	
Total Income	**384.07**	**46.87**	**45.76**	**(1.11)**	**384.07**	**383.80**	**(0.28)**	**(0)%**	
Operating Expenses									
Pay	(206.41)	(26.47)	(28.13)	(1.66)	(206.41)	(210.46)	(4.04)	(2)%	
Of which: Unidentifed CIP	*5.62*	*0.18*	*-*	*(0.18)*	*5.62*	*-*	*(5.62)*		
Drugs	(44.00)	(3.63)	(3.22)	0.42	(44.00)	(44.03)	(0.03)	(0)%	
Clinical Supplies	(26.47)	(1.85)	(2.51)	(0.66)	(26.47)	(25.06)	1.41	5%	
Other Non Pay	(62.97)	(5.76)	(7.51)	(1.75)	(62.97)	(59.09)	3.88	6%	
Of which: Unidentifed CIP	*(0.89)*	*(0.19)*	*-*	*0.19*	*(0.89)*	*-*	*0.89*		
Total Operating Expenditure	**(339.86)**	**(37.71)**	**(41.37)**	**(3.66)**	**(339.86)**	**(338.64)**	**1.22**	**0%**	
EBITDA	*44.22*	*9.16*	*4.40*	*(4.76)*	*44.22*	*45.16*	*0.94*	2%	
Financing & Depreciation	(18.93)	(1.80)	(1.91)	(0.10)	(18.93)	(17.83)	1.10	6%	
Donated assets/impairment adjustments	(25.29)	(5.81)	(0.93)	4.88	(25.29)	(20.69)	4.60	18%	
Control Total Surplus/(Deficit)	**-**	**1.54**	**1.56**	**0.02**	**-**	**6.64**	**6.64**	-	

Commentary

Operating Income

£1.11m adverse to plan in month

Total operating income is reporting £45.76m in-month, £1.11m adverse to plan, and £0.28m adverse cumulatively. Key points of note are:-

- Directly commissioned clinical income was £36.05m, £3.30m favourable to plan.
- Cumulative activity deliver is below plans shown on slide five.
- The Trusts cumulative NHS Clinical income includes agreed ICB brokerage as a result of activity delivery.
- Commercial trading income was £3.72m, £0.38m adverse to plan driven the middle east conflict and reduced patient activity in Dubai.
- Research and Development income at £1.92m, £0.55m favourable to plan
- Other income was on £3.10m, £4.48m adverse to plan, driven by the deferral of MEC Oriel income into 2026/27.

Employee Expenses

£1.66m adverse to plan in month

March pay is reporting £28.13m (2,850wte); £1.66m adverse to plan. Key points of note are:-

- Substantive pay costs (2,618wte) were £28.13m, higher than the prior 12-month average of £15.25m, driven by a £10.8m NHS employer pension adjustment.
- Temporary staffing costs were £1.39m in March. In addition, the trust provided for additional job planning costs, release of the annual leave provision MARS redundancies and PILON payments
  - Agency costs (15wte) are £0.17m in month, lower than the 12-month trend of £0.23m. Use continues mainly on medical staff & administration in both clinical and corporate areas.
  - Bank costs (217wte) are £1.22m in month, lower than the rolling trend of £1.10m. Bank use continues to be mainly in clinical areas and within the medical and clinical admin staffing group.
  - £0.18m unachieved pay CIP (£5.62m cumulatively)

Non-Pay Expenses

£2.79m favourable to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in March were £13.24m, £1.99m adverse to plan. Key points of note are:-

- Drugs were £0.42m favourable to plan in month with £3.22m expenditure against a 12-month trend of £3.70m. The reduction in expenditure has been driven by the change to a lower priced AMD injection drug (income also reduced).
- Clinical supplies were £0.66m adverse to plan in month. Costs were £2.51m in month against a 12-month trend of £2.02m. The driver for the increased cost was £0.15m for the theatre stock adjustment.
- Other non-pay was £1.75m adverse in month with £7.51m expenditure against a 12-month trend of £4.83m. This was driven by consultancy spend within Oriel, IT BAU and IT projects.
- £0.19m overachieved non-pay CIP (£0.89m cumulatively overachieved)

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

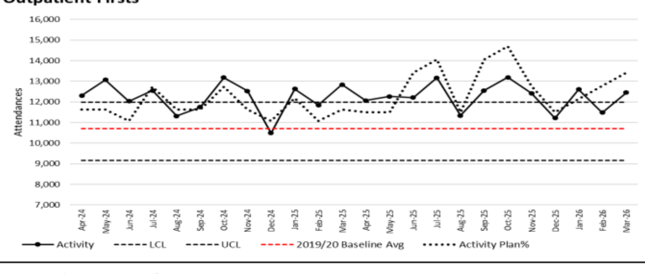
ERF	Point of Delivery	Activity In Month				Activity YTD			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	3,222	3,349	127	104%	36,819	35,654	(1,165)	97%
	OP Firsts	13,416	12,448	(968)	93%	153,324	146,944	(6,380)	96%
	OP Procedures	24,015	18,144	(5,871)	76%	274,462	257,665	(16,797)	94%
	ERF Activity Total								
Non ERF Activity	OP Follow Ups	21,662	25,060	3,398	116%	247,569	243,771	(3,798)	98%
	High Cost Drugs Injections	4,996	4,709	(287)	94%	57,093	57,663	570	101%
	Non Elective	226	270	44	119%	2,664	2,965	301	111%
	AandE	6,217	6,732	515	108%	73,196	74,260	1,064	101%
	Total	73,754	70,712	(3,042)	96%	845,127	818,922	(26,205)	97%

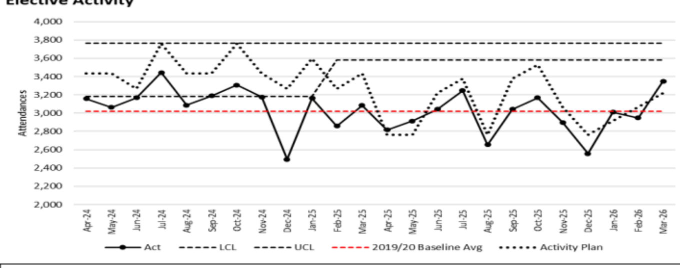
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

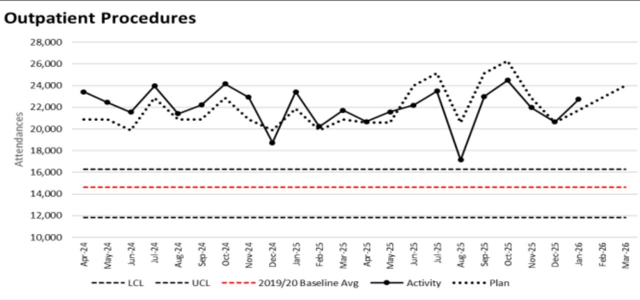
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

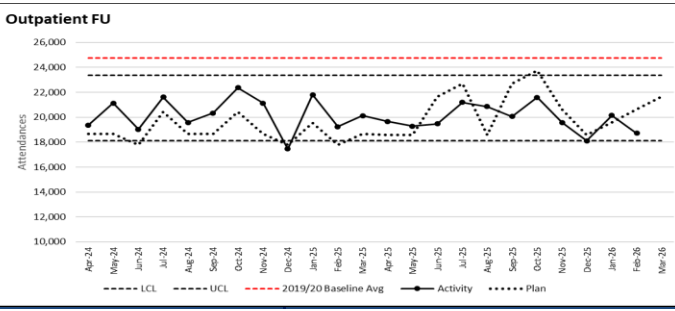
Performance % figures above, represent the Trust performance against the external activity target. Financial values shown are for ERF activity only.

ACTIVITY TREND - ERF COMPONENTS









Commentary

NHS Income

Contractual Status

The Trust has finalised contracts from ICB's and signed the documentation on the 17th December. 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 104% in month and 97% year to date of the revised demand plan.
- **Outpatient Firsts Activity** achieved 93% of the revised demand plan in month; 96% year to date
- **Outpatient Procedures Activity** achieved 76% 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 94% of activity plans in month; 101% year to date.
- **A&E** achieved 108% of activity plans in month; 101% year to date

ERF Achievement

Final 2024/25 ERF performance to March 2025 has now been published and full year performance has been finalised in December 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.
- 2025/26 ERF reporting from NHSE will be the same as 2024/25. IAPs are agreed with commissioners regarding the funded levels of activity for this year. Performance to M12 was achieved based on the latest information available.

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

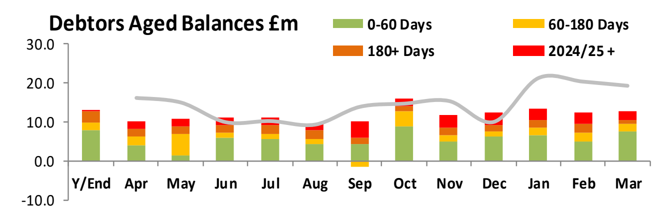
CAPITAL EXPENDITURE

Capital Expenditure £m	Annual Plan	Year to Date Plan	Actual	Variance
Medical Equipment	2.3	2.3	1.9	(0.3)
Estates	2.5	2.5	1.5	(1.0)
IMT	3.4	3.4	0.6	(2.8)
Commercial	0.5	0.5	0.3	(0.2)
Network Strategy	-	-	-	-
Other - Trust funded	(3.7)	(3.7)	-	3.7
Oriel Programme	122.1	122.1	120.0	(2.1)
EPR Project	9.5	9.5	9.2	(0.3)
NiHR Capital Grant	-	-	-	-
Other & Charity	0.8	0.8	0.8	(0.0)
IFRS16	13.8	13.8	14.9	1.1
TOTAL INCLUDING DONATED	**151.2**	**151.2**	**149.3**	**(2.0)**

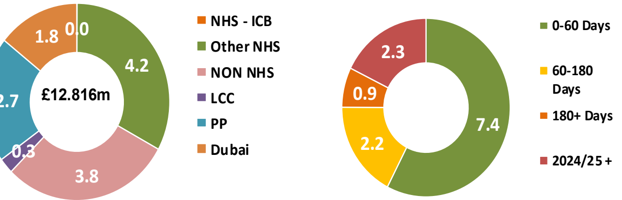
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Depreciation	11.9	11.9	-	100%
Cash Reserves - Oriel	-	-	-	-
Cash Reserves - B/Fwd	6.0	6.0	-	100%
Capital Loan Repayments	(1.8)	(1.8)	-	100%
TOTAL - ICS Allocation	**16.2**	**16.2**	**-**	**100%**
IFRS 16 Leases	13.8	13.8	-	100%
Externally funded	100.0	100.0	-	100%
Donated/Charity	21.3	21.3	-	100%
TOTAL INCLUDING DONATED	**151.2**	**151.2**	**-**	**100%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2024/25 +*	*Total*
CCG Debt	-	0.0	-	0.0	0.0
Other NHS Debt	3.5	0.4	0.2	0.2	4.2
Non NHS Debt	1.8	0.9	0.1	0.9	3.8
Commercial Unit Debt	-	1.0	0.6	1.2	2.8
TOTAL RECEIVABLES	**5.3**	**2.2**	**0.9**	**2.3**	**10.8**



Net Receivables £m



STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date Plan	Actual	Variance
Non-current assets	597.3	597.3	607.4	10.1
Current assets (excl Cash)	29.8	29.8	28.2	(1.5)
Cash and cash equivalents	62.7	62.7	62.8	0.1
Current liabilities	(45.9)	(45.9)	(55.9)	(10.0)
Non-current liabilities	(288.0)	(288.0)	(312.2)	(24.2)

OTHER METRICS

Use of Resources	Plan	Current Month	Prior Month
BPPC - NHS (YTD) by number	95%	92%	92%
BPPC - NHS (YTD) by value	95%	91%	91%
BPPC - Non-NHS (YTD) by number	95%	95%	95%
BPPC - Non-NHS (YTD) by value	95%	94%	94%

Commentary

Cash and Working Capital

The cash balance as at the 31st March was £62.8m, a reduction of £23.3m since the end of March 2025.

Capital Expenditure/ Non-current assets

Capital expenditure for 2025/26 totalled £149.3m, predominantly Oriel, leases and EPR related.

Against a total full year capital plan of £151.2m :-
Internally funded capital £16.2m plan excluding leases including £5.9m for Oriel and £9.5m for Oriel

- The internally funded plan increased during the year due slippage in other NCL organisations. In agreement with the ICB the Trust sought to maximise the use of these resources to bring forward capital plans from 2026/27 into quarter 4.
- The outturn was £13.1m, with the £3m underspend due primarily to slippage in Oriel and IMT.

Leases (IFRS16) £13.8m plan

- The lease plan also increased during the year with the Granary Street lease being brought forward to 2025/26.
- The outturn was £14.9m, with all new and extended leases finalised in March. The £1.1m overspend related to an increase in the Bedford lease.
- Against an ICB target of £30.0m including leases, the outturn was £28.0

Externally funded capital £121.3m plan including £116.2m for Oriel and £4.3m for EPR

- During the year the total 2025/26 Oriel budget was reduced following a review of construction phasing.
- The outturn was £121.3m, with underspends on Oriel and EPR shown against internal budgets for these schemes.

Receivables

Receivables have reduced by £0.1m to £12.8m since the end of the 2024/25 financial. Debt in excess of 60 days shows reduction of £2.2m in March and current debt increased by £2.6m.

Payables

Payables totalled £26.8m at the end of March, an increase of £6.1m since the end of March 2025.

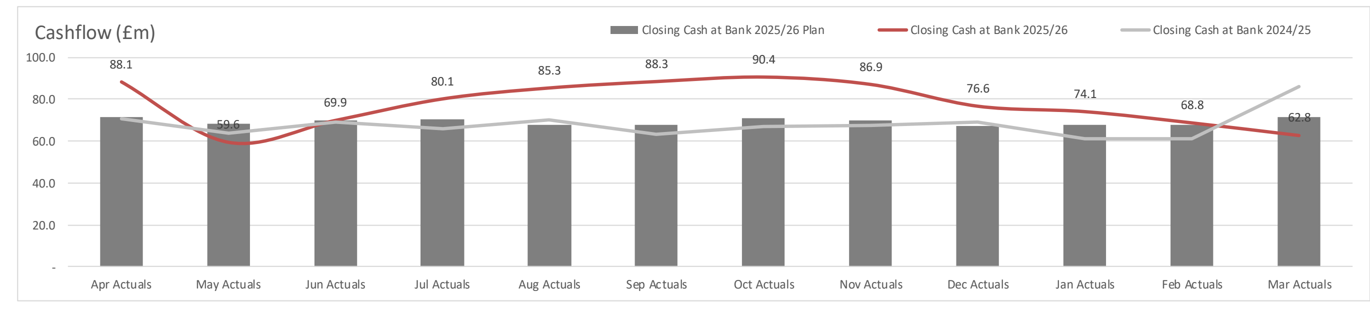
The trust's performance against the 95% Better Payment Practice Code (BPPC) is shown to the left. In aggregate it was:-

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

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Actuals	Aug Actuals	Sep Actuals	Oct Actuals	Nov Actuals	Dec Actuals	Jan Actuals	Feb Actuals	Mar Actuals	Outturn Total	Mar Forecast	Mar Var
Opening Cash at Bank	**86.1**	**88.1**	**59.6**	**69.9**	**80.1**	**85.3**	**88.3**	**90.4**	**86.9**	**76.6**	**74.1**	**68.8**	**86.1**		
Cash Inflows															
Healthcare Contracts	22.0	20.9	22.5	23.0	25.1	23.7	20.4	21.4	21.6	20.5	20.8	19.7	261.6	22.8	(3.1)
Other NHS	4.3	1.6	0.6	3.2	3.6	1.6	2.0	6.0	1.0	1.7	1.9	6.4	33.8	1.3	5.1
Moorfields Private/Dubai/NCS	4.4	3.8	4.0	4.5	4.1	3.8	4.6	3.9	3.8	3.9	4.0	3.6	48.4	4.1	(0.5)
Research	0.9	0.9	1.9	0.8	1.0	1.0	1.0	1.0	1.4	1.2	0.8	0.8	12.5	1.3	(0.5)
VAT	2.2	0.0	2.3	-	1.6	2.4	1.5	1.4	1.2	1.4	1.3	1.5	16.7	1.4	0.1
PDC / Loan	-	-	19.6	14.0	14.5	3.7	12.9	-	-	4.3	0.3	10.1	79.4	9.7	0.5
Charity Donation	-	-	5.0	-		10.0	-	-	5.0	-	-	1.0	21.0	0.9	0.1
Other Inflows	0.3	0.3	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.2	0.2	0.2	3.0	**0.2**	(0.0)
Total Cash Inflows	**34.1**	**27.5**	**56.1**	**45.7**	**50.1**	**46.4**	**42.6**	**33.9**	**34.3**	**33.1**	**29.3**	**43.2**	**476.5**	**41.6**	**1.6**
Cash Outflows															
Salaries, Wages, Tax & NI	(14.1)	(14.6)	(14.8)	(14.8)	(15.7)	(16.1)	(15.1)	(15.0)	(15.1)	(15.2)	(15.8)	(16.1)	(182.4)	(15.2)	(0.9)
Non Pay Expenditure	(15.5)	(12.0)	(11.6)	(12.8)	(10.2)	(12.9)	(12.3)	(9.8)	(12.5)	(12.4)	(10.0)	(16.5)	(148.5)	(10.2)	(6.3)
Capital Expenditure	(0.8)	(0.7)	(0.6)	(0.7)	(0.1)	(0.7)	(0.2)	(0.1)	(2.8)	(0.9)	(0.8)	(2.0)	(10.3)	(4.9)	3.0
Oriel	(0.2)	(27.6)	(17.3)	(5.9)	(16.8)	(10.9)	(11.7)	(11.3)	(12.6)	(6.1)	(5.9)	(11.2)	(137.6)	(6.1)	(5.2)
Moorfields Private/Dubai/NCS	(1.4)	(1.1)	(1.4)	(1.3)	(1.5)	(1.2)	(1.2)	(1.1)	(1.6)	(1.2)	(1.6)	(1.1)	(15.8)	(1.3)	0.2
Financing - Loan repayments	-	-	-	-	(0.6)	(1.6)	-	-			(0.6)	(2.3)	(5.0)	(1.6)	(0.8)
Dividend Payable	-	-	-	-	-	-	-	-					-	-	-
Total Cash Outflows	(32.0)	(56.1)	(45.8)	(35.6)	(44.9)	(43.4)	(40.5)	(37.4)	(44.6)	(35.7)	(34.6)	(49.2)	**(499.8)**	**(39.2)**	**(10.0)**
Net Cash inflows /(Outflows)	2.1	(28.6)	10.4	10.2	5.2	3.0	2.1	(3.5)	(10.3)	(2.6)	(5.3)	(6.0)	(23.3)	2.4	(8.4)
Closing Cash at Bank 2025/26	**88.1**	**59.6**	**69.9**	**80.1**	**85.3**	**88.3**	**90.4**	**86.9**	**76.6**	**74.1**	**68.8**	**62.8**	**62.8**		
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 March was £62.8m, a reduction of £23.3m since the end of March 2025.

The trust currently has 71 days of operating cash (prior month: 77 days).

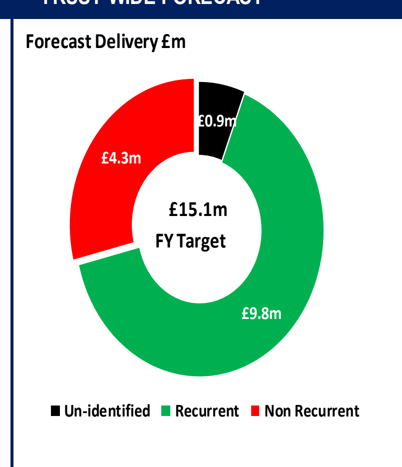
March cashflow saw a £6.0m outflow against a forecast inflow of £2.4m due to timing of ICB receipts and Oriel capital payments made in March.

Efficiency Scheme Performance Reporting

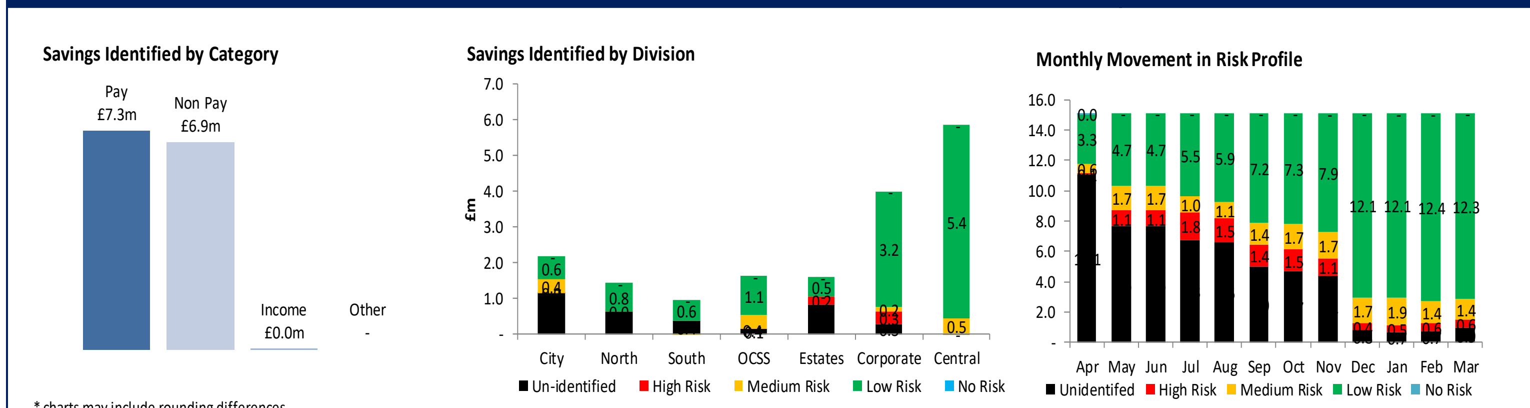
EFFICIENCY SCHEMES PERFORMANCE

Efficiency Schemes £m	Annual Plan	In Month			Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
City Road	£2.17m	£0.18m	£0.15m	(£0.03m)	£2.17m	£1.02m	(£1.15m)	£2.17m	£1.02m	(£1.15m)
North	£1.43m	£0.12m	£0.17m	£0.05m	£1.43m	£0.80m	(£0.63m)	£1.43m	£0.80m	(£0.63m)
South	£0.98m	£0.08m	£0.04m	(£0.04m)	£0.98m	£0.58m	(£0.41m)	£0.98m	£0.58m	(£0.41m)
Ophth. & Clinical Serv.	£1.62m	£0.13m	£0.11m	(£0.03m)	£1.62m	£1.48m	(£0.14m)	£1.62m	£1.48m	(£0.14m)
Research & Development	£0.49m	£0.04m	-	(£0.04m)	£0.49m	-	(£0.49m)	£0.49m	-	(£0.49m)
Trading	£0.83m	£0.07m	-	(£0.07m)	£0.83m	-	(£0.83m)	£0.83m	-	(£0.83m)
Corporate	£5.59m	£0.47m	£0.48m	£0.01m	£5.59m	£4.46m	(£1.13m)	£5.59m	£4.46m	(£1.13m)
DIVISIONAL EFFICIENCIES	**£13.10m**	**£1.09m**	**£0.94m**	**(£0.15m)**	**£13.10m**	**£8.33m**	**(£4.77m)**	**£13.10m**	**£8.33m**	**(£4.77m)**
Central	**£2.00m**	**£0.17m**	**£0.27m**	**£0.11m**	**£2.00m**	**£5.84m**	**£3.84m**	**£2.00m**	**£5.84m**	**£3.84m**
INTERNAL EFFICIENCIES	**£15.10m**	**£1.26m**	**£1.22m**	**(£0.04m)**	**£15.10m**	**£14.17m**	**(£0.93m)**	**£15.10m**	**£14.17m**	**(£0.93m)**
Adjustment to external plan	£2.90m	£2.08m	-	(£2.08m)	-	-	-	£2.90m	-	(£2.90m)
TRUST EFFICIENCIES	**£18.00m**	**£3.34m**	**£1.22m**	**(£2.12m)**	**£15.10m**	**£14.17m**	**(£0.93m)**	**£18.00m**	**£14.17m**	**(£3.83m)**

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:-

- £1.22m in month, compared to a plan of £3.34m, £2.12m adverse to plan; and
- £14.17m year to date, compared to a plan of £15.10m, £0.93m adverse to plan.

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

Identified Savings

The trust has delivered £14.1m, £0.9m adverse to plan.

Of the total identified:-

- £5.8m is identified central schemes;
- £0.5m is identified high risks to delivery;
- £6.9m identified as non-pay schemes;
- £8.4m is forecast recurrently;

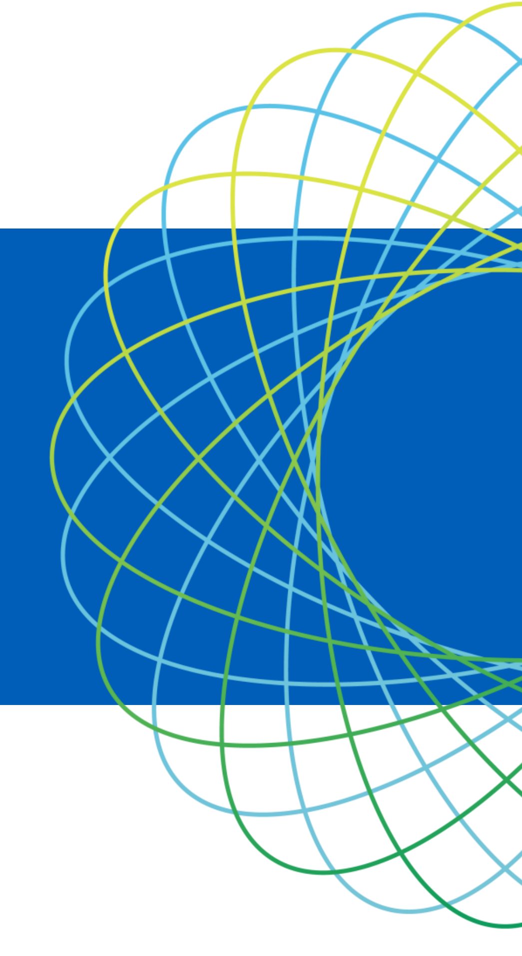
The CIP programme board are working through further efficiency scheme delivery for full financial validation towards increasing the level of identified and forecast delivery in 2025/26.

£6.7m represents the value of un-identified and non-recurrently identified savings.

Risk Profiles

The charts to the left demonstrates the

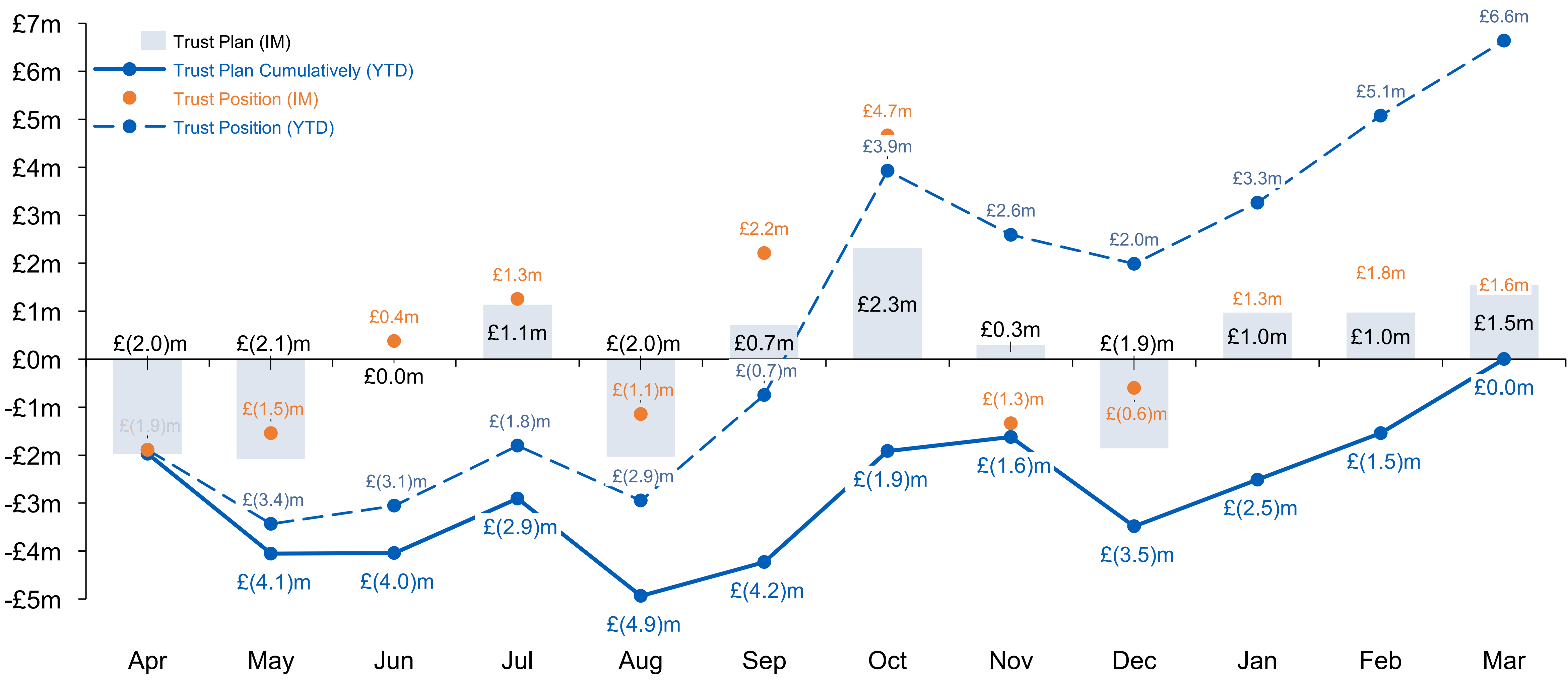
- identified saving by category,
- divisional identification status including risk profiles, and
- the trust wide monthly risk profile changes for identified schemes as the year progresses.



Supplementary Information

The Trust financial performance is £1.6m surplus in month, £6.6m surplus YTD

For MArch the trust reported a **£1.6m surplus IM, £0.1m favourable to the planned surplus of £1.5m** in month.
Cumulatively the trust is reporting a **£6.6m surplus YTD, £6.6m favourable to the planned break-even position 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.

Cover Sheet	
Report title	Monthly Finance Performance Report Month 01 – April 2026
Meeting	Board of Directors
Date	4 June 2026
Report from	Arthur Vaughan, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Previous forum consideration	Trust Executive Committee

Relevant strategic objectives	Working together	☐	Discover	☐	Develop	☐	Deliver	☐	Sustainability and Scale	☒

Purpose of report	Assurance	☐	Decision	☐	Discussion	☒	For information	☒

Executive summary

For April, the trust is reporting:-

Income and Expenditure

- A £0.3m deficit year to date compared to a planned £0.6m deficit; £0.3m favourable to plan.

Efficiency and Productivity

- The Trust has delivered £0.7m of the £17.6m full year target.
- Delivery in April reported £0.7m, with £0.7m delivered cumulatively.

Capital Expenditure

- Capital expenditure for April totalled £6m against an indicative plan of £6.3m.
- The Trust has received £25.3m of capital submissions against an allocation of £17.7m.
    - £14.3m of capital submission are pre-commitments largely linked to Trust Major Projects including EPR, IT City Road Migration, Oriel, Hoxton, and Ealing.
- Capital Planning and Oversight Committee (CPOC) is prioritising the highest risk submitted plans.

Cash

- The cash balance as at the 30th April was £63.8m, an increase of £1.0m since the end of March 2026.This equates to approximately 68 days operating cash.

Action Required/Recommendation

- The board is asked to consider and discus the attached report.

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.

2026/27 Monthly Finance Performance Report

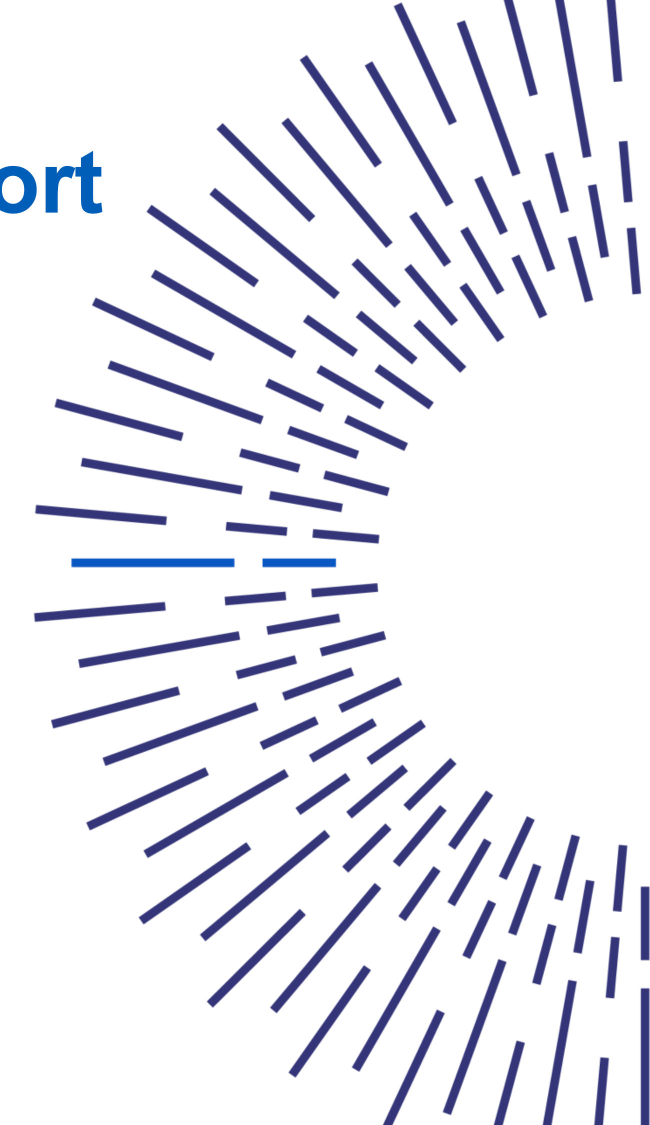
Operational Financial Performance

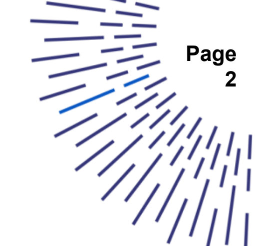
Trust Board

04 June 2026

Updated 15 May 2026

Report Period	M01 | April 2026
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 30th April 2026 (Month 01)

Key Messages

Statement of Comprehensive Income

Financial Position £0.27m deficit in month	For April, the trust is reporting:- • A £0.27m deficit in-month against a planned £0.62m deficit, £0.35m favourable to plan • A £0.27m deficit cumulatively against a planned £0.62m deficit, £0.35m favourable to plan

Key Drivers of the Financial Variance	The trusts financial position is being supported by £0.20m of slippage on Oriel projects expenditure, £0.24m pass through drug benefits linked to price reductions, and demonstrable reductions in bank, agency, whilst income levels are maintained due to fixed contractual income.
	
	Key Drivers of the core operational performance include:-
	• NHS Clinical income is assumed in line with fixed contracts for ERF activity.
	  • Income levels would be approximately £0.38m adverse to plan cumulatively as a result of activity levels below plan if based on cost and volume contracts.
	• Clinical divisions are reporting operational activity performance below planned levels.
	  • Elective activity is 100% April;
	  • Outpatients Firsts and Procedures are 105% and 88% respectively cumulatively;
	  • Bedford activity is now included in the plan
	  • Clinical divisions are reporting £0.24m favourable to plan cumulatively, with clinical income being £0.38m adverse (other income £0.04m favourable), pay £0.15m favourable and non-pay including drugs £0.53m favourable. This has been off-set by efficiency under delivery of £0.11m.
	• Corporate departments are reporting £0.28m favourable to plans cumulatively including £0.22m linked to slippage on Oriel, offset by CIP underachievement (£0.33m)
	• Research is reporting a £0.06m favourable variance to plans cumulatively comprised of study income in excess of costs.
	• Trading areas are £0.22m favourable to plan cumulatively across all commercial units.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 30th April was £63.8m, an increase of £1.0m since the end of March 2026.This equates to approximately 68 days operating cash. The Better Payment Practice Code (BPPC) performance in April was 95% (volume) and 95% (value) against a target of 95% across both metrics.
Capital (both gross capital expenditure and CDEL)	Capital expenditure for April totalled £6m against an indicative plan of £6.3m. The Trust has received £25.3m of capital submissions against an allocation of £17.7m. • £14.3m of capital submission are pre-commitments largely linked to Trust Major Projects including EPR, IT City Road Migration, Oriel, Hoxton, and Ealing Capital Planning and Oversight Committee (CPOC) is prioritising the highest risk submitted plans.

Other Key Information

Efficiencies £17.6m Trust Target £0.7m YTD actual £9.5m of un-identified and non recurrently identified schemes	The trust has a planned efficiency programme of £17.6m for 2026/27 to deliver the control total. The trust has identified £9.7m of schemes, of which the programme has delivered £0.7m in year, £0.7m adverse to plan. Of the total identified:- • £6.5m is identified central schemes; • £7.5m identified as non-pay schemes; • £8.0m is forecast recurrently; • £1.5m is forecast non-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 2026/27.
Agency Spend £0.07m spend YTD 0.4% total pay	Trust wide agency spend totals £2.55m cumulatively, approximately 0.4% of total employee expenses spend, below the system allocated target of 1.0%. 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 Executive Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	%	RAG
Income	£373.6m	£33.3m	£33.2m	(£0.1m)	£33.3m	£33.2m	(£0.1m)	(0)%	
Pay	(£206.4m)	(£17.2m)	(£16.9m)	£0.2m	(£17.2m)	(£16.9m)	£0.2m	1%	
Non Pay	(£128.5m)	(£10.2m)	(£10.1m)	£0.1m	(£10.2m)	(£10.1m)	£0.1m	1%	
Financing & Adjustments	(£38.6m)	(£6.6m)	(£6.5m)	£0.1m	(£6.6m)	(£6.5m)	£0.1m	1%	
CONTROL TOTAL	**(£0.0m)**	**(£0.6m)**	**(£0.3m)**	**£0.3m**	**(£0.6m)**	**(£0.3m)**	**(£0.3m)**		

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

Memorandum Items	Annual Plan	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	%	RAG
Research & Development	(£0.36m)	(£0.08m)	(£0.02m)	£0.06m	(£0.08m)	(£0.02m)	£0.06m	80%	
Commercial Trading Units	£6.05m	£0.42m	£0.63m	£0.22m	£0.42m	£0.63m	£0.22m	51%	
ORIEL Revenue	(£7.14m)	(£0.42m)	(£0.22m)	£0.21m	(£0.42m)	(£0.22m)	£0.21m	49%	
Efficiency Schemes	£17.63m	£1.47m	£0.71m	(£0.76m)	£1.47m	£0.71m	(£0.76m)	(52)%	

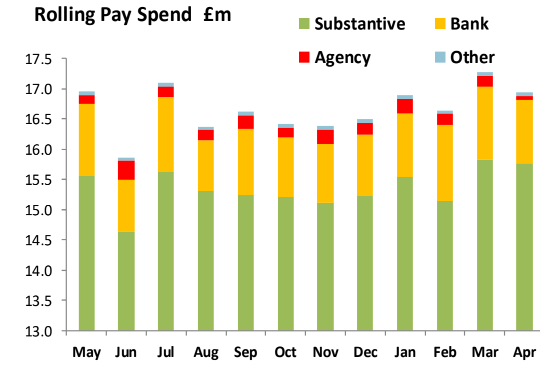
INCOME BREAKDOWN RELATED TO ACTIVITY

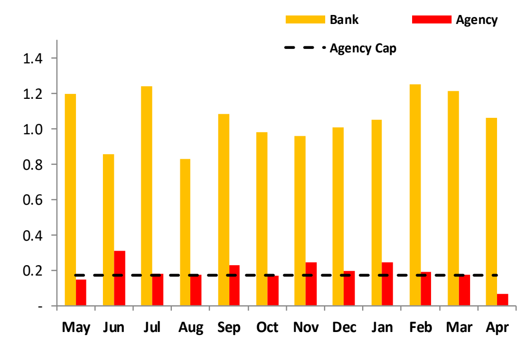
Income Breakdown £m	Annual Plan	YTD Plan	YTD Actual	YTD Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£236.1m	£18.8m	£18.7m	(£0.1m)				
Pass Through	£34.9m	£2.7m	£2.8m	£0.1m				
Other NHS Clinical Income	£0.5m	£0.0m	£0.0m	(£0.0m)				
Commercial Trading Units	£48.0m	£3.8m	£4.0m	£0.1m				
Research & Development	£17.0m	£1.4m	£1.2m	(£0.1m)				
Other	£37.0m	£6.5m	£6.4m	(£0.1m)				
INCOME INCL ERF	**£373.6m**	**£33.3m**	**£33.2m**	**(£0.1m)**				

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

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	YTD Plan	YTD Actual	YTD Variance	% Total
Employed	(£204.6m)	(£17.0m)	(£15.8m)	£1.3m	(£17.0m)	(£15.8m)	£1.3m	93%
Bank	(£0.6m)	(£0.1m)	(£1.1m)	(£1.0m)	(£0.1m)	(£1.1m)	(£1.0m)	6%
Agency	(£0.5m)	(£0.0m)	(£0.1m)	(£0.0m)	(£0.0m)	(£0.1m)	(£0.0m)	0%
Other	(£0.7m)	(£0.1m)	(£0.1m)	-	(£0.1m)	(£0.1m)	-	0%
TOTAL PAY	**(£206.4m)**	**(£17.2m)**	**(£16.9m)**	**£0.2m**	**(£17.2m)**	**(£16.9m)**	**£0.2m**	





Pay spend chart adjusted for £10.8m pension cost contributions paid in March 2026.

*Agency cap levels set by NHSIE

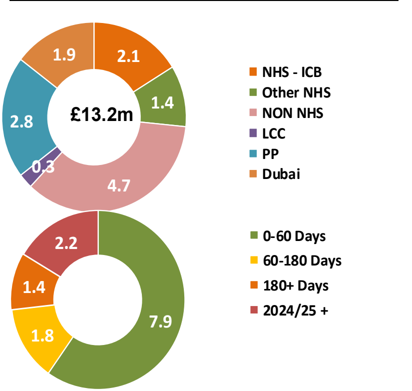
CASH, CAPITAL AND OTHER KPI'S

Capital Programme £m	Annual Plan	YTD Plan	YTD Actual	YTD Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£17.7m)	(£1.0m)	(£1.0m)	£0.0m				
Donated/Externally funded	(£103.5m)	(£5.3m)	(£5.3m)	£0.0m				
TOTAL	**£121.2m**	**£6.3m**	**£6.3m**	**£0.0m**				

Key Metrics	Plan	Actual	RAG
Cash	59.3	63.6	
Debtor Days	45	9	
Creditor Days	45	40	
PP Debtor Days	65	41	

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

Net Receivables/Ageing £m



Statement of Comprehensive Income

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	271.00	21.60	21.54	(0.05)	21.60	21.54	(0.05)	(0)%	
Other NHS Clinical Income	0.53	0.04	0.04	(0.00)	0.04	0.04	(0.00)	(2)%	
Commercial Trading Units	48.02	3.83	3.97	0.14	3.83	3.97	0.14	4%	
Research & Development	17.03	1.37	1.24	(0.13)	1.37	1.24	(0.13)	(10)%	
Other Income	36.99	6.48	6.43	(0.06)	6.48	6.43	(0.06)	(1)%	
Total Income	**373.58**	**33.33**	**33.22**	**(0.11)**	**33.33**	**33.22**	**(0.11)**	**(0)%**	
Operating Expenses									
Pay	(206.45)	(17.18)	(16.94)	0.24	(17.18)	(16.94)	0.24	1%	
Of which: Unidentifed CIP	*4.39*	*0.36*	*-*	*(0.36)*	*0.36*	*-*	*(0.36)*		
Drugs	(36.42)	(2.94)	(2.73)	0.21	(2.94)	(2.73)	0.21	7%	
Clinical Supplies	(26.38)	(2.10)	(2.06)	0.04	(2.10)	(2.06)	0.04	2%	
Other Non Pay	(65.67)	(5.18)	(5.29)	(0.11)	(5.18)	(5.29)	(0.11)	(2)%	
Of which: Unidentifed CIP	*4.13*	*0.41*	*-*	*(0.41)*	*0.41*	*-*	*(0.41)*		
Total Operating Expenditure	**(334.93)**	**(27.39)**	**(27.02)**	**0.37**	**(27.39)**	**(27.02)**	**0.37**	**1%**	
EBITDA	*38.65*	*5.94*	*6.20*	*0.27*	*5.94*	*6.20*	*0.27*	4%	
Financing & Depreciation	(22.00)	(1.71)	(1.64)	0.08	(1.71)	(1.64)	0.08	4%	
Donated assets/impairment adjustments	(16.65)	(4.84)	(4.84)	0.01	(4.84)	(4.84)	0.01	0%	
Control Total Surplus/(Deficit)	**(0.00)**	**(0.62)**	**(0.27)**	**0.35**	**(0.62)**	**(0.27)**	**0.35**	0.56	

Donated assets include contributions from the Moorfields Eye Chairty towards Oriel.

Commentary

Operating Income

£0.11m adverse to plan in month

Total operating income is reporting £33.22m in-month, £0.11m adverse to plan, and £0.11m adverse cumulatively. Key points of note are:-

- Directly commissioned clinical income was £21.54m, Break-even to plan.
- Cumulative activity delivery is below plans shown on slide five.
- Commercial trading income was £3.97m, £0.14m favourable to plan driven by improved performance in Dubai
- Research and Development income at £1.24m, £0.13m adverse to plan
- Other income was on £6.43m, £0.06m adverse to plan

Employee Expenses

£0.24m favourable to plan in month

April pay is reporting £16.94m (2,797wte); £0.24m favourable to plan. Key points of note are:-

- Substantive pay costs (2,623wte) were £15.76m, higher than the prior 12-month average of £15.25m, driven by the 2026/27 pay award.
- Temporary staffing costs were £1.13m in April.
  - Bank costs (163wte) are £1.06m in month, in line with rolling trend of £1.07m. Bank use continues to be mainly in clinical areas and within the medical and clinical admin staffing group.
  - Agency costs (11wte) are £0.06m in month, lower than the 12-month trend of £0.20m. Use continues mainly on medical staff & administration in clinical areas.
  - £0.36m unachieved pay CIP (£0.36m cumulatively)

Non-Pay Expenses

£0.22m favourable to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in April were £10.08m, £0.14m favourable to plan. Key points of note are:-

- Drugs were £0.21m favourable to plan in month with £2.73m expenditure against a 12-month trend of £3.67m. The reduction in expenditure has been driven by the change to a lower priced AMD injection drug .
- Clinical supplies were break-even to plan in month. Costs were £2.06m in month against a 12-month trend of £2.09m.
- Other non-pay was £0.11m adverse in month with £5.29m expenditure against a 12-month trend of £4.93m.
- £0.41m unachieved non-pay CIP (£0.41m cumulatively overachieved)

Clinical Activity Performance

PATIENT ACTIVITY AND CLINICAL INCOME

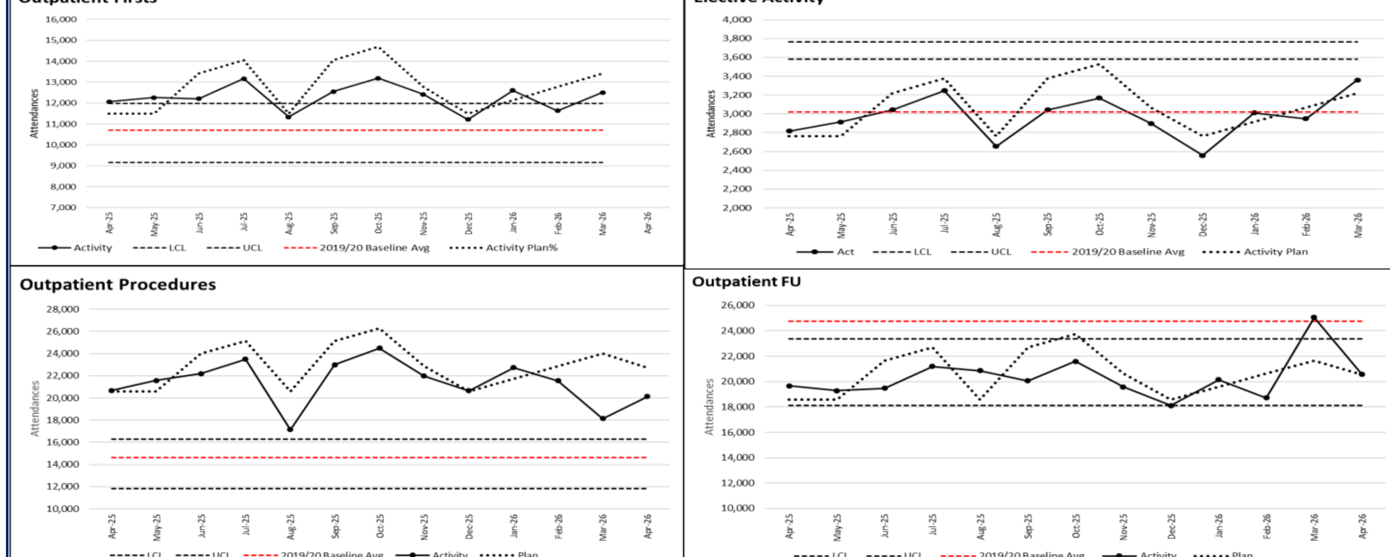
ER	Point of Delivery	Activity In Month				Activity YTD			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	3,029	3,027	(2)	100%	3,029	3,027	(2)	100%
	OP Firsts	12,921	13,595	674	105%	12,921	13,595	674	105%
	OP Procedures	22,741	20,124	(2,617)	88%	22,741	20,124	(2,617)	88%
	ERF Activity Total								
Non ERF Activity	OP Follow Ups	20,562	20,594	32	100%	20,562	20,594	32	100%
	High Cost Drugs Injections	4,923	4,924	0	100%	4,923	4,924	0	100%
	Non Elective	219	238	19	109%	219	238	19	109%
	AandE	6,016	6,754	738	112%	6,016	6,754	738	112%
	Total	70,411	69,256	(1,156)	98%	70,411	69,256	(1,156)	98%

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 the 28th April. As contracts are finalised, income has been assumed based on the 2026/27 activity delivery to date.

2025/26 Activity performance achievement

- **Inpatient activity** achieved 100% in month and year to date of the demand plan.
- **Outpatient Firsts Activity** achieved 105% in month of the demand plan in month; but 93% not including Bedford
- **Outpatient Procedures Activity** achieved 88% of demand plans in month; Once fully coded this will return to planned levels.

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 100% of activity plans in month and year to date.
- **A&E** achieved 112% of activity plans in month and year to date

Contractual Status

- We are in the process of agreeing block contract with commissioners due to EPR and Oriel.

Activity plans

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

- Activity and Income will be monitored on Cost & Volume to compare to the plan that has been set.
- Service Developments are yet to be agreed and added to the plan.

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.

financial position by division excluding central, financing and depreciation budgets.

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

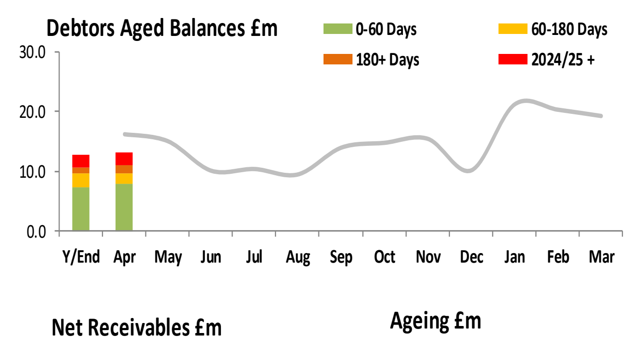
CAPITAL EXPENDITURE

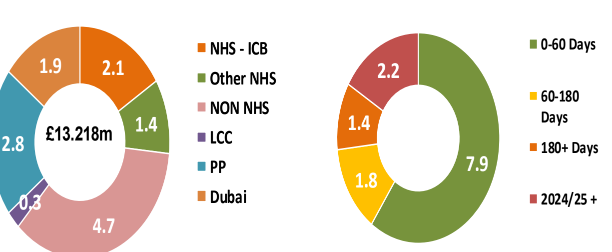
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Medical Equipment	-	-	0.0	0.0
Estates	-	-	0.0	0.0
IT	0.2	-	0.0	0.0
Commercial	0.5	-	-	-
EPR Programme	6.0	0.5	0.5	
IT Projects - Oriel Adjacent	3.1	0.3	0.3	-
Hoxton	-	-	-	-
Ealing	1.0	0.2	0.1	(0.1)
Oriel	105.4	5.3	1.0	(4.3)
Other & Charity	5.1	-	-	-
TOTAL - TRUST CAPITAL	**121.2**	**6.3**	**2.4**	**(4.0)**

Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Depreciation	11.2	11.2	-	100%
Cash Reserves - Oriel	2.1	2.1	-	100%
Cash Reserves - B/Fwd	6.2	6.2	-	100%
Capital Loan Repayments	(1.8)	(1.8)	-	100%
TOTAL - ICS Allocation	**17.7**	**17.7**	**-**	**100%**
IFRS 16 Leases	-	-	-	0%
Externally funded	85.9	85.9	-	100%
Donated/Charity	17.5	17.5	-	100%
TOTAL INCLUDING DONATED	**121.2**	**121.2**	**-**	**100%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2024/25 +*	*Total*
CCG Debt	2.1	-	-	0.0	2.1
Other NHS Debt	0.7	0.3	0.2	0.2	1.4
Non NHS Debt	2.8	0.6	0.4	0.9	4.7
Commercial Unit Debt	-	0.9	0.8	1.1	2.8
TOTAL RECEIVABLES	**5.7**	**1.8**	**1.4**	**2.2**	**11.0**





Ageing £m

2.2
1.4
1.8
7.9
0-60 Days
60-180 Days
180+ Days
2024/25 +

Commentary

Cash and Working Capital

The cash balance as at the 30th April was £63.8m, an increase of £1.0m since the end of March 2026

Capital Expenditure/ Non-current assets

Capital expenditure for April totalled £6m against an indicative plan of £6.3m.

The Trust has received £25.3m of capital submissions against an allocation of £17.7m, £7.3m higher than affordable.

£14.3m is already pre-committed.

Based on current assumptions this allows £3.7m for all other Trust wide Capital including medical devices.

Capital Planning and Oversight Committee (CPOC) is prioritising the highest risk submitted plans including

- £6.6m of Medical equipment to be prioritised.
- £4.9m of service developments to be decided.
- £0.4m of Estates backlog, buildings, other to be confirmed.
- £0.7m of all other IT schemes to be validated

Receivables

Receivables have increased by £0.4m to £13.2m since the end of the 2025/26 financial. Debt in excess of 60 days shows a reduction of £0.1m in April and current debt increased by £0.5m.

Payables

Payables totalled £14.8m at the end of April, a reduction of £12.0m since the end of March 2026.

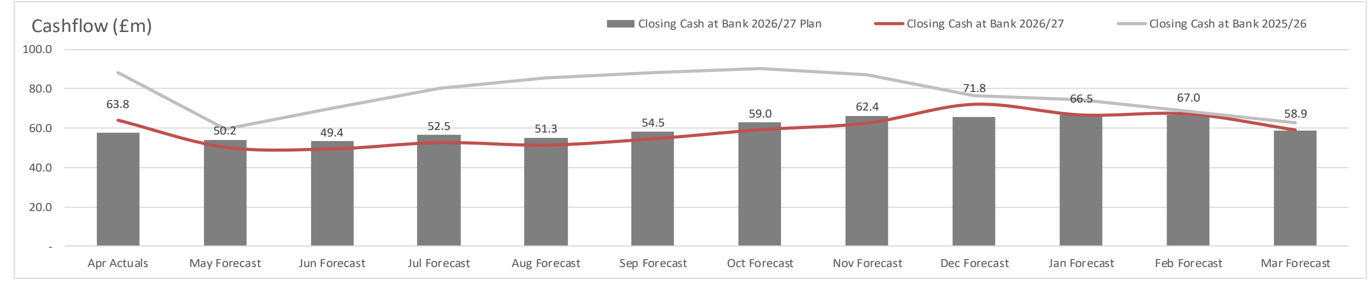
The trust's performance against the 95% Better Payment Practice Code (BPPC) is shown to the left. In aggregate it was:-

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

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Apr Forecast	Apr Var
Opening Cash at Bank	**62.8**	**63.8**	**50.2**	**49.4**	**52.5**	**51.3**	**54.5**	**59.0**	**62.4**	**71.8**	**66.5**	**67.0**	**62.8**		
Cash Inflows															
Healthcare Contracts	23.8	20.6	24.2	24.2	20.6	24.2	24.2	23.3	20.6	21.5	22.2	22.4	272.1	21.5	2.3
Other NHS	3.6	1.4	1.6	1.4	1.4	1.4	1.5	1.5	1.3	1.7	1.6	1.6	19.9	1.3	2.3
Moorfields Private/Dubai/NCS	3.5	4.0	4.1	4.1	3.9	4.4	4.3	4.4	3.5	4.4	4.0	3.8	48.3	3.6	(0.1)
Research	1.0	1.4	1.4	1.4	1.4	1.6	1.4	1.4	1.4	1.4	1.4	1.6	16.5	1.4	(0.4)
VAT	2.4	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	18.9	1.5	0.9
PDC / Loan	-	5.1	14.7	5.0	2.5	1.1	0.9	1.0	10.0	-	-	26.5	66.9	5.0	(5.0)
Charity Donation	4.9	-	2.1	-	-	7.0	-	-	3.4	-	-	-	17.3	4.9	-
Other Inflows	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.3	0.2	(0.0)
Total Cash Inflows	**39.2**	**34.2**	**49.7**	**37.8**	**31.4**	**41.3**	**34.1**	**33.2**	**41.9**	**30.8**	**30.9**	**57.7**	**462.3**	**39.3**	**(0.1)**
Cash Outflows															
Salaries, Wages, Tax & NI	(15.8)	(15.8)	(15.8)	(15.8)	(15.8)	(15.8)	(15.8)	(15.8)	(15.8)	(15.8)	(15.8)	(15.8)	(189.6)	(15.8)	0.0
Non Pay Expenditure	(20.0)	(10.5)	(12.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(11.5)	(12.4)	(147.4)	(20.0)	-
Capital Expenditure	(0.0)	(5.1)	(1.2)	(1.0)	(1.0)	(0.9)	-	(0.3)	(1.5)	(1.5)	(1.2)	(2.3)	(15.9)	(2.3)	2.2
Oriel	(1.5)	(15.1)	(19.7)	(5.0)	(2.5)	(6.1)	(0.9)	(1.0)	(2.4)	(6.1)	-	(31.4)	(91.8)	(5.0)	3.5
Moorfields Private/Dubai/NCS	(1.0)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(15.3)	(1.4)	0.4
Financing - Loan repayments	-	-	-	-	(0.6)	(2.5)	-	-	-	-	(0.6)	(2.5)	(6.2)	-	-
Dividend Payable	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Cash Outflows	(38.2)	(47.8)	(50.5)	(34.6)	(32.7)	(38.2)	(29.5)	(29.9)	(32.5)	(36.2)	(30.4)	(65.7)	**(466.1)**	**(44.4)**	**6.2**
Net Cash inflows /(Outflows)	1.0	(13.6)	(0.8)	3.2	(1.3)	3.2	4.6	3.3	9.5	(5.4)	0.5	(8.1)	(3.9)	(5.1)	6.2
Closing Cash at Bank 2026/27	**63.8**	**50.2**	**49.4**	**52.5**	**51.3**	**54.5**	**59.0**	**62.4**	**71.8**	**66.5**	**67.0**	**58.9**	**58.9**		
Closing Cash at Bank 2026/27 Plan	57.6	54.1	53.2	56.4	55.1	58.3	62.9	66.2	65.7	66.4	66.9	58.9	58.9		
Closing Cash at Bank 2025/26	88.1	59.6	69.9	80.1	85.3	88.3	90.4	86.9	76.6	74.1	68.8	62.8	62.8		



Commentary

Cash flow

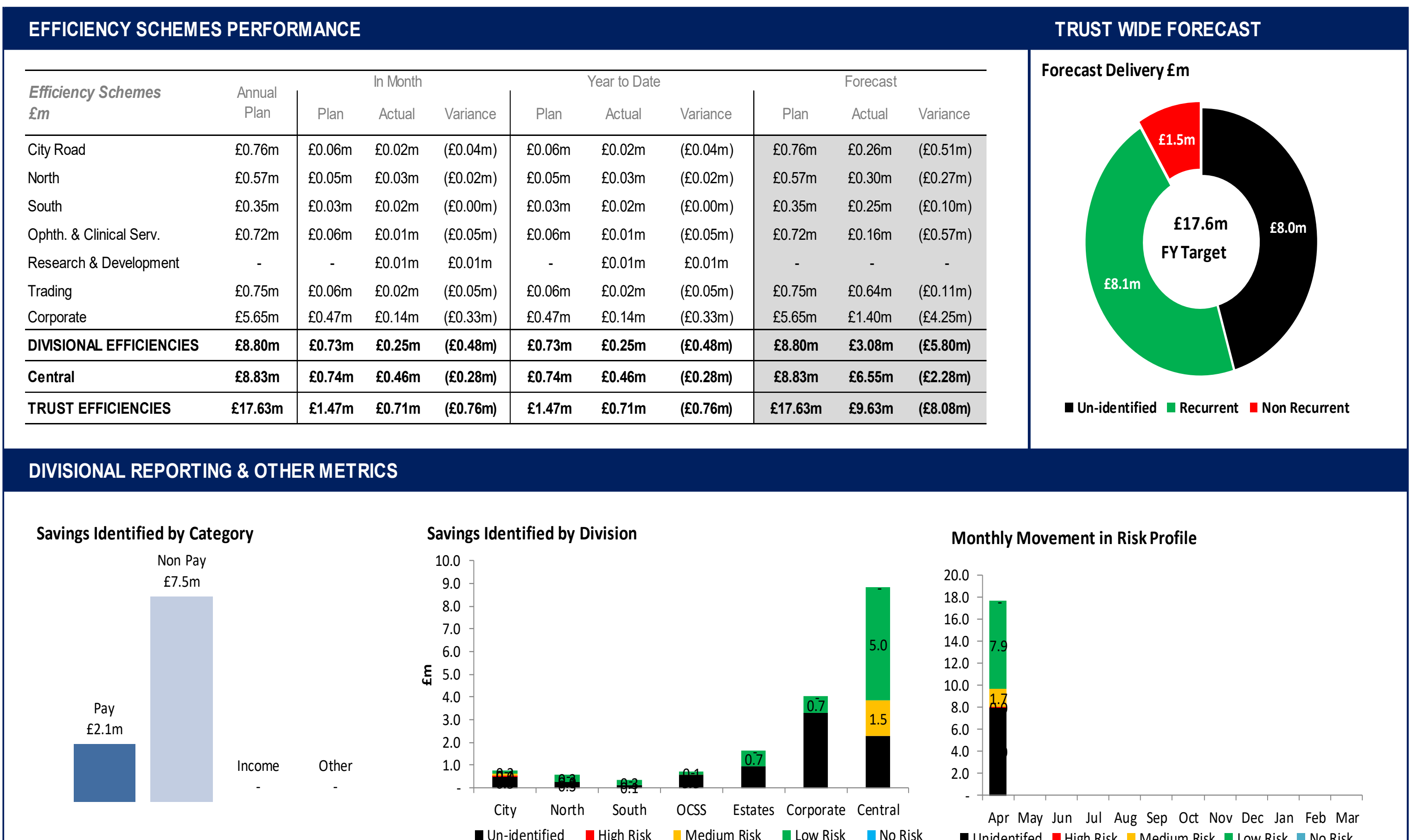
The cash balance as at the 30th April was £63.8m, an increase of £1.0m since the end of March 2026..

The trust currently has 68 days of operating cash (prior month: 71 days).

April cashflow saw a £1.0m inflow against a forecast outflow of £5.1m due to timing of Oriel capital payments. The profiling for Oriel loans, PDC and capital payments are currently being refined and will be updated in future cashflow forecasts.

financial position by division excluding central, financing and depreciation budgets.

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	£0.76m	£0.06m	£0.02m	(£0.04m)	£0.06m	£0.02m	(£0.04m)	£0.76m	£0.26m	(£0.51m)
North	£0.57m	£0.05m	£0.03m	(£0.02m)	£0.05m	£0.03m	(£0.02m)	£0.57m	£0.30m	(£0.27m)
South	£0.35m	£0.03m	£0.02m	(£0.00m)	£0.03m	£0.02m	(£0.00m)	£0.35m	£0.25m	(£0.10m)
Ophth. & Clinical Serv.	£0.72m	£0.06m	£0.01m	(£0.05m)	£0.06m	£0.01m	(£0.05m)	£0.72m	£0.16m	(£0.57m)
Research & Development	-	-	£0.01m	£0.01m	-	£0.01m	£0.01m	-	-	-
Trading	£0.75m	£0.06m	£0.02m	(£0.05m)	£0.06m	£0.02m	(£0.05m)	£0.75m	£0.64m	(£0.11m)
Corporate	£5.65m	£0.47m	£0.14m	(£0.33m)	£0.47m	£0.14m	(£0.33m)	£5.65m	£1.40m	(£4.25m)
DIVISIONAL EFFICIENCIES	**£8.80m**	**£0.73m**	**£0.25m**	**(£0.48m)**	**£0.73m**	**£0.25m**	**(£0.48m)**	**£8.80m**	**£3.08m**	**(£5.80m)**
Central	**£8.83m**	**£0.74m**	**£0.46m**	**(£0.28m)**	**£0.74m**	**£0.46m**	**(£0.28m)**	**£8.83m**	**£6.55m**	**(£2.28m)**
TRUST EFFICIENCIES	**£17.63m**	**£1.47m**	**£0.71m**	**(£0.76m)**	**£1.47m**	**£0.71m**	**(£0.76m)**	**£17.63m**	**£9.63m**	**(£8.08m)**

Commentary

Governance & Reporting

The trust has a planned efficiency programme of £17.6m for 2026/27 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:-

- £0.71m in month, compared to a plan of £1.47m, £0.76m adverse to plan; and
- £9.63m forecast, compared to a plan of £17.63m, £8.0m adverse 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 £0.76m adverse in month.

Identified Savings

The trust has delivered £0.7m, £0.7m adverse to plan.

Of the total identified:-

- £6.5m is identified central schemes;
- £7.5m identified as non-pay schemes;
- £8.0m is forecast recurrently;
- £1.5m is forecast non-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 2026/27.

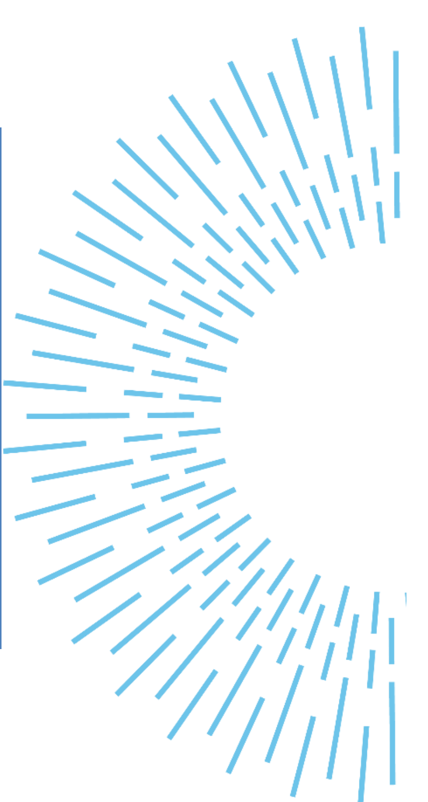
£9.5m represents the value of un-identified and non-recurrently identified savings.

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.

financial position by division excluding central, financing and depreciation budgets.



Integrated Performance Report

Board of directors
4 June 2026

Report title	Integrated Performance Report (IPR)
Report from	Executive team
Prepared by	Victoria Moore, Director of Transformation & Performance Improvement Stephen Chinn, Performance Reporting Manager
Link to strategic objectives	Working together, discover, develop and deliver, sustainably and at scale

Executive summary

The integrated performance report provides a single, integrated view of organisational performance. It brings together metrics from operations, quality & safety, workforce, finance & research and enables the Board to see the whole-system performance in one place.

The integrated performance report has been refreshed for 2026/27 reporting, in line with a set of design principles agree with the Board. The report has been updated to provide a more focused set of indicators, aligning with the domains of the NHS national oversight framework and are that reflect the indicators pertinent to Moorfields, as a specialist ophthalmology hospital and NHS trust.

The more focused set of indicators that will be routinely discussed by the Board with appendix A setting out a suite of metrics that will be monitored but not routinely reported going forward. Any metrics in this suite that require further attention, will be brought forward as required for more in-depth review.

The format of the report has maintained the good practice ‘making data count’ methodology but enhancements have been made to the accessibility of the information, recognising the public facing nature of the document.

Following the refreshed IPR confirmation, further alignment with board subcommittees and the organisations internal performance review framework is in progress. The work is being led by the director of transformation and performance improvement and has been undertaken by a working group including representatives from clinical and operations, corporate and finance, strategy and performance improvement teams have been coordinating this work.

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 are provided with this report for assurance.

For assurance	✓	For decision		For discussion		To note	

Integrated Performance Report

April 2026

Brief Summary of Report

This report highlights a series of metrics regarded as Key Indicators of Trust Performance.

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.

Executive Summary

The Integrated Performance Report for April 2026 presents a picture of steady progress across many of the Trust's services, alongside some ongoing pressures that are being actively managed.

During the month, access to services remained broadly stable, with referral-to-treatment performance slightly exceeding the planned level. This reflects continued efforts to reduce waiting times and improve patient flow across pathways. The number of patients waiting the longest for treatment continues to fall, with only five patients waiting over 52 weeks, all due to specific clinical circumstances or personal choice. Work is ongoing to further reduce long waits through more targeted management of waiting lists, increased clinical activity in high-demand areas, and the validation of patient pathways.

The Trust continues to focus on improving efficiency in planned surgical care. Theatre utilisation has improved in recent months, especially within cataract services, where most operating lists are now achieving expected productivity levels. However, there is still variation in performance across services, and further work is underway to ensure consistency. This includes strengthening booking processes, improving start times, and reducing late cancellations.

In outpatients, DNA rates remain a challenge, with missed appointments higher than expected. Encouragingly, early trials of AI-supported reminder systems have shown positive results in reducing non-attendance, and there will be a request to expand this approach. Demand on the contact centre has increased, leading to longer waiting times and higher call abandonment rates. This is largely due to staffing shortages and a rise in patient queries. Recruitment to vacant roles is ongoing, alongside short-term measures to increase staffing capacity.

Across patient safety, clinical effectiveness, and experience, performance continues to be closely monitored. There are no significant concerns highlighted in the narrative for April, and established processes remain in place to oversee key clinical quality indicators.

Workforce indicators show a generally positive position. Overall staff turnover remains below the Trust's target, suggesting improving stability, although there are some areas where turnover is higher than expected, particularly in certain corporate and clinical teams. The Trust is continuing to examine the reasons behind staff departures and is taking steps to improve retention, especially among newer employees. Sickness absence is being managed more proactively, with training provided to managers and stronger follow-up processes in place to support staff and enable timely returns to work. New approaches are also being introduced to bring together workforce data and staff feedback to identify local issues and develop targeted solutions. Temporary staffing usage remains well controlled, with high rates of shift coverage and a reduction in spending on agency staff compared to plan. This reflects closer management and increased reliance on internal staffing solutions. Nevertheless, temporary staffing is still required to cover sickness absence and maintain safe service delivery.

In research activity, patient recruitment to studies was lower than the monthly target. This is largely due to the completion of several high-recruiting studies rather than a reduction in underlying capability. Recruitment to more complex and higher-value studies has remained stable, and new studies are beginning to open, which is expected to support future growth. The Trust continues to focus on attracting new research opportunities to maintain its contribution to advancing eye care and improving patient outcomes.

Performance Overview

April 2026		Assurance		
		Capable Process	**Hit and Miss**	**Failing Process**
Variation	**Special Cause Improvement**	• % Complaints Acknowledged in 3 days • Staff Turnover Rate		• Theatre Utilisation (MEH) • DNA Rate (Follow Up Outpatients)
	Common Cause	• % 52 Week RTT Incomplete Breaches • A&E Four Hour Performance • Endophthalmitis Rates • Statutory Mandatory Training	• RTT 18w Perf vs. Planned • 52 Week RTT Incomplete Breaches • Cancer 28 Day FDS	• Cataract Eyes Per List • DNA Rate (First Outpatients) • Duty of Candour • Sickness Absence Rate (Monthly)
	Special Cause Concern		• Recruitment NIHR portfolio studies	• Average Call Waiting Time

Access to Services

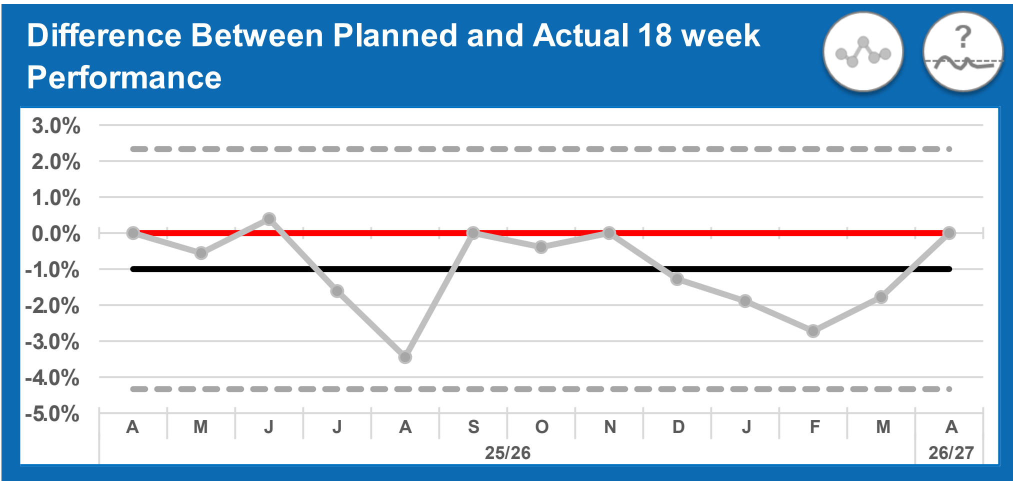
IPR Metric Overview

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Difference Between Planned and Actual 18 week Performance		?	n/a	0.02%	≥0%	Jon Spencer	NHS Oversight Framework	Monthly
52 Week RTT Incomplete Breaches		?	5	5	≤7 Breaches	Jon Spencer	NHS Operational Planning	Monthly
Cancer 28 Day Faster Diagnosis Standard		?	94.3%	90.0%	≥80%	Jon Spencer	NHS Oversight Framework	Monthly (Month in Arrears)
Theatre Utilisation (MEH Definition)	H	F	65.9%	65.9%	≥85%	Jon Spencer	Insightful Board	Monthly
Cataract Eyes Per Four Hour Theatre List		F	6.4	6.4	≥ 8 Per 4hr List	Jon Spencer	GIRFT Guidance	Monthly
DNA Rate (First Outpatients)		F	13.5%	13.5%	≤9.4%	Jon Spencer	Model Hospital	Monthly
DNA Rate (Follow Up Outpatients)	L	F	9.3%	9.3%	≤8.1%	Jon Spencer	Model Hospital	Monthly
Average Call Waiting Time	H	F	n/a	394	≤ 2 Mins (120 Sec)	Jon Spencer	Internal Measure	Monthly

Access to Services

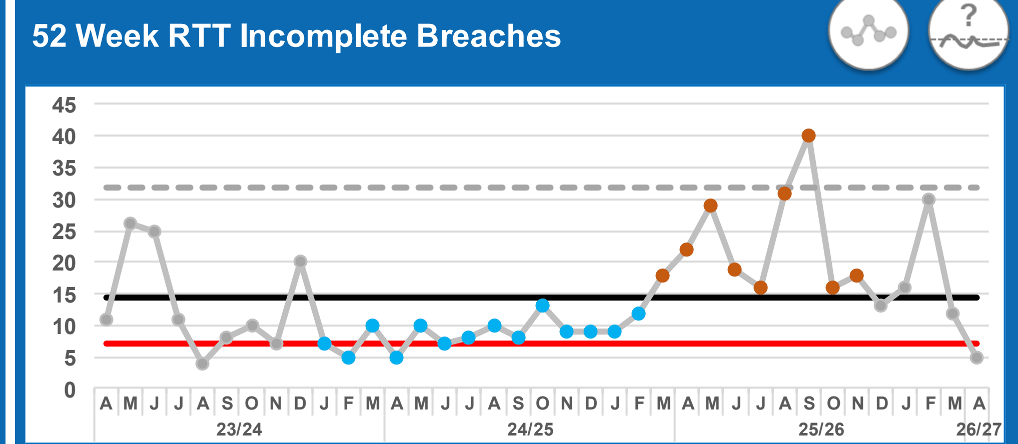
IPR Metrics – Referral To Treatment

Difference Between Planned and Actual 18 week Performance



'Difference Between Planned and Actual 18 week Performance' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.02%.

52 Week RTT Incomplete Breaches



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

- The current April position for 18-week performance is above the planned level by 0.02%.
- The plan for April takes into account a small reduction in activity and RTT clock stops due to the Easter holidays.
- The final April position will include validated RTT pathways for our Bedford site, following the transition of activity from Bedfordshire Hospitals to Moorfields.
- We will continue to reduce the number of patients over 18 weeks and improve RTT performance, by focusing on the validation of our waiting list and increasing activity in services with the longest waiting times.
- Service developments in paediatrics, adnexal and external services have been recommended for approval and we anticipate substantive capacity and activity increasing in these services in the second half of this year. Until then we will continue with additional sessions, as required.

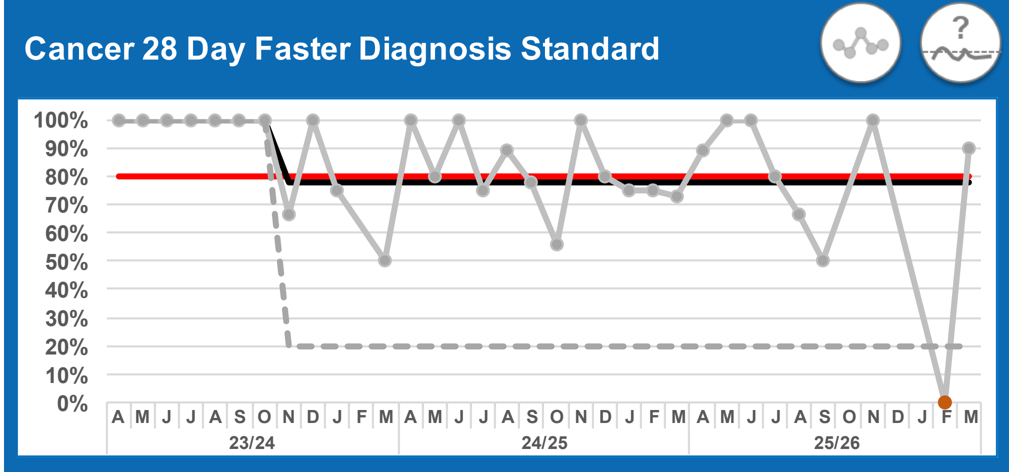
- Our project to centralise triage and roll out a new platform for triage, will support a reduction in waiting times for our patients across all services.
- The current April position is 5 patients waiting over 52 weeks for treatment.
- This includes patients transferred to Moorfields from King's to reduce their waiting times, patients who chose to wait until May for treatment and a complex patient who could not be treated earlier.
- The number of patients waiting over 40 weeks for treatment continues to reduce. We will continue to track these patients on a weekly basis, speeding up treatment where possible and reducing the number of patients waiting over 52 weeks in line with our plan.

Action Lead: Kathryn Lennon ***Review Date:*** July 2026

Access to Services

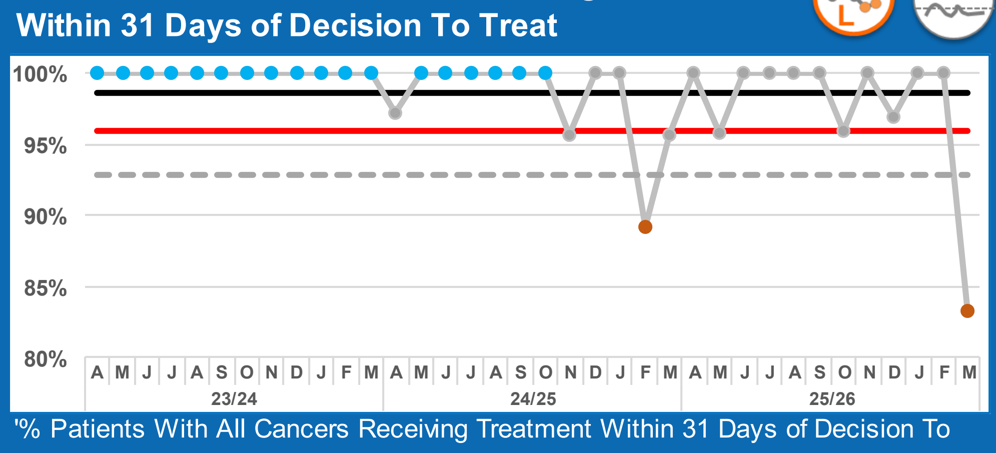
IPR Metrics – Cancer Performance

Cancer 28 Day Faster Diagnosis Standard



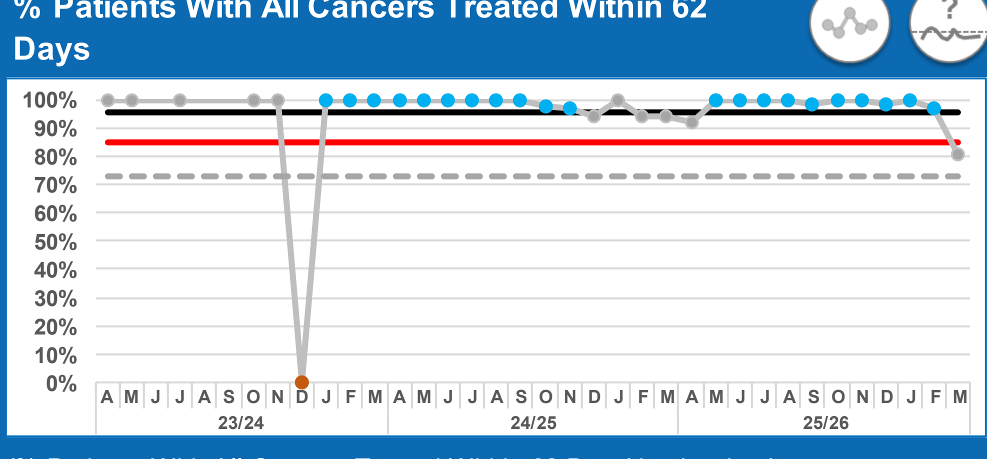
'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process is not consistently achieving the target.The figure is currently at 90.0%.

% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat



'% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat' is showing 'special cause concern' and that the current process is not consistently achieving the target. - This is a change from the previous month. The figure is currently at 83.3%.

% Patients With All Cancers Treated Within 62 Days

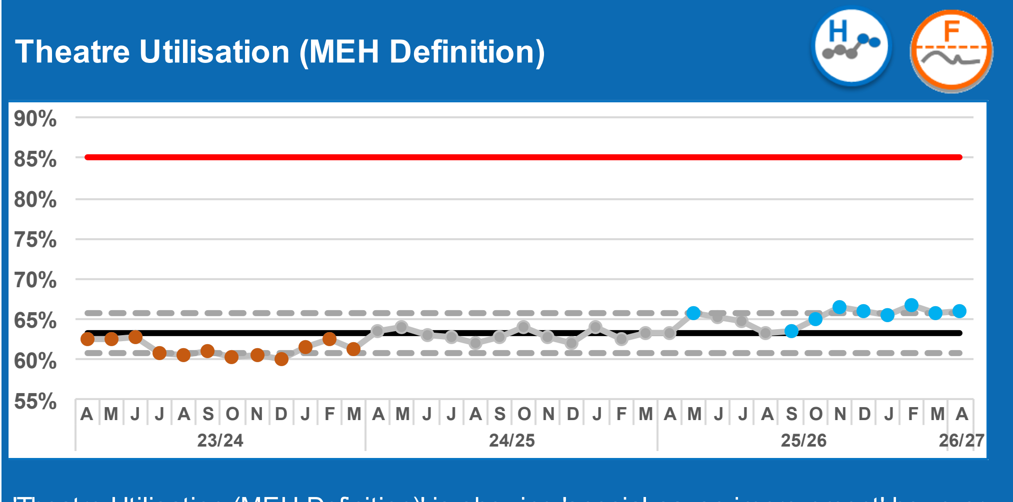


'% Patients With All Cancers Treated Within 62 Days' is showing 'common cause variation' and that the current process is not consistently achieving the target. - This is a change from the previous month. The figure is currently at 81.0%.

Access to Services

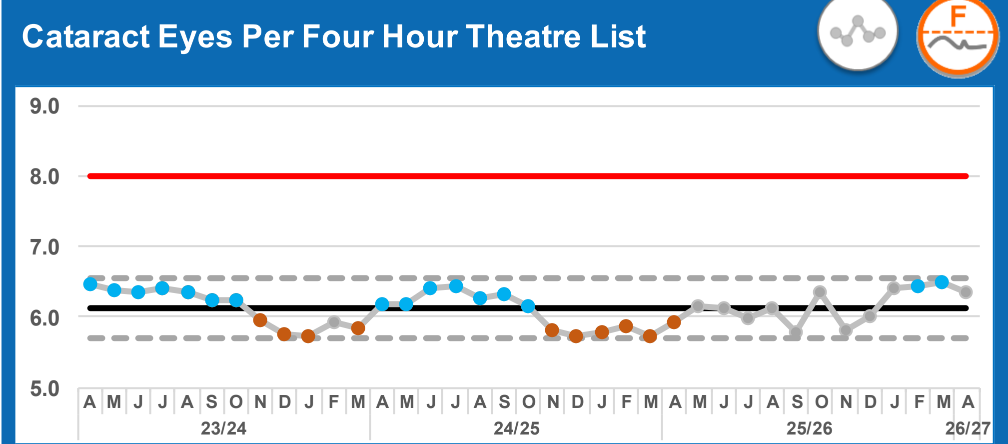
IPR Metrics – Theatre Performance

Theatre Utilisation (MEH Definition)



'Theatre Utilisation (MEH Definition)' is showing 'special cause improvement' however the current process is unlikely to achieve the target. The figure is currently at 65.9%.

Cataract Eyes Per Four Hour Theatre List



'Cataract Eyes Per Four Hour Theatre List' is showing 'common cause variation' with the current process unlikely to achieve the target.The figure is currently at 6.40.

Our internal metric is improving but below the required standard. Theatre Oversight Groups are focusing on:

- Start times: to ensure the multi-disciplinary team is aligned and expectations are clear
- Optimising booking: following 6-4-2 principles and using the new theatre scheduling module effectively
- Reducing cancellations: ensuring clinical input to 6-4-2 and creating a pool of patients available at short notice.

In May we are taking part in the GIRFT hub optimisation week, which will offer us an opportunity to test new ideas and see how we can best use our resources to improve theatre utilisation.

- We have made good progress in recent months and most of our cataract lists are booked to the required standard of 8 eyes per four hours.
- More support is needed to increase the overall trust average and to address lists consistently booked below target.
- We are reviewing the cataract booking SOP to assess any changes needed related to training, complexity and on-the-day cancellation rates to support further improvement.

Action Lead: Kathryn Lennon ***Review Date:*** July 2026

Access to Services

IPR Metrics – Did Not Attend (DNA) Performance

DNA Rate (First Outpatients)

'DNA Rate (First Outpatients)' is showing 'common cause variation' with the current process unlikely to achieve the target.The figure is currently at 13.5%.

DNA Rate (Follow Up Outpatients)

'DNA Rate (Follow Up Outpatients)' is showing 'special cause improvement' however the current process is unlikely to achieve the target. The figure is currently at 9.3%.

DNAs rates are above target for first and follow-up outpatient attendances.

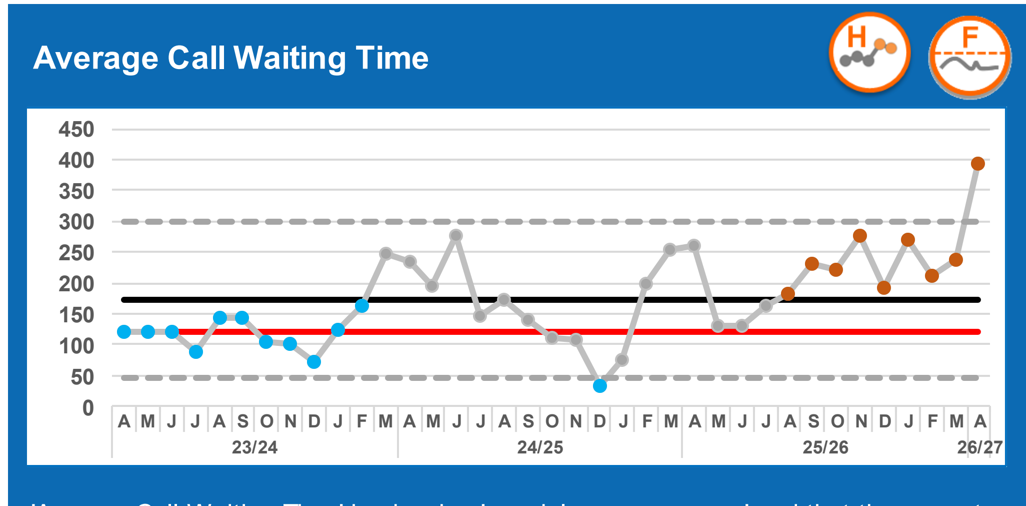
We are piloting AI call reminder technology, which shows positive results with reduced DNA rates in the five clinics in scope. We have started the evaluation of the pilot to consider further roll out.

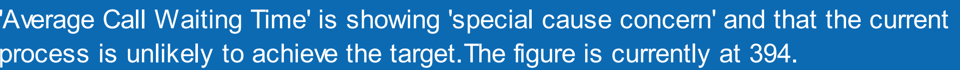
A DNA 'deep dive' analysis has been undertaken which has investigated different characteristics of those patients that do not attend for their appointments including age, gender, ethnicity, and depravation indices. This research has helped the trusts understand more about specific groups and patient clusters which are more likely to not attend. This work has been incorporated into internal discussions as part of the Clinical and Operational Productivity Group with a view to addressing those specific findings.

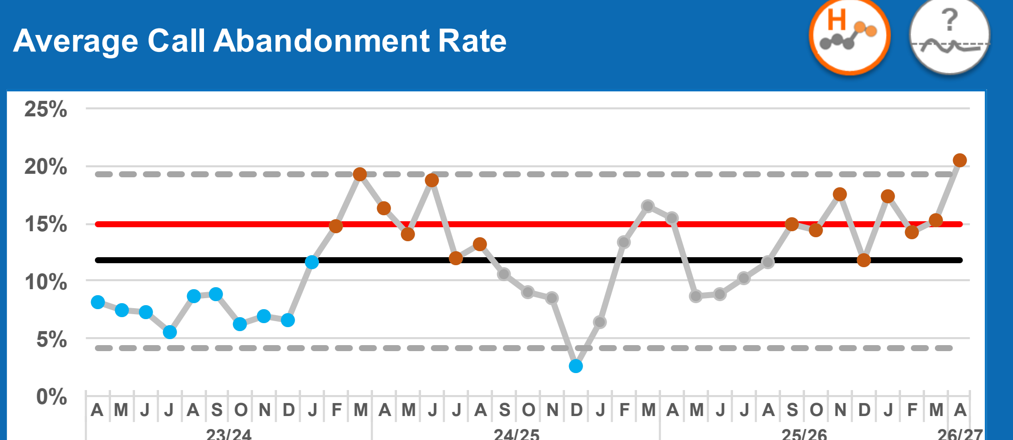
Action Lead: Kathryn Lennon ***Review Date:*** July 2026

Access to Services

IPR Metrics – Call Centre Performance




'Average Call Waiting Time' is showing 'special cause concern' and that the current process is unlikely to achieve the target.The figure is currently at 394.



'Average Call Abandonment Rate' is showing 'special cause concern' and that the current process is not consistently achieving the target. The figure is currently at 20.6%.

The average call waiting time and average call abandonment rate increased in April, due to staffing issues. All vacant roles are being recruited to permanently; however, the recent round of recruitment was unsuccessful, and posts are back out to advert. Additional hours and bank shifts are being offered however, fill rate is low. Staff from other teams are redirected to support where possible. In May, we have seen a significant increase in the volume of calls linked to patient letter queries and expect the waiting time and abandonment rate to increase further.

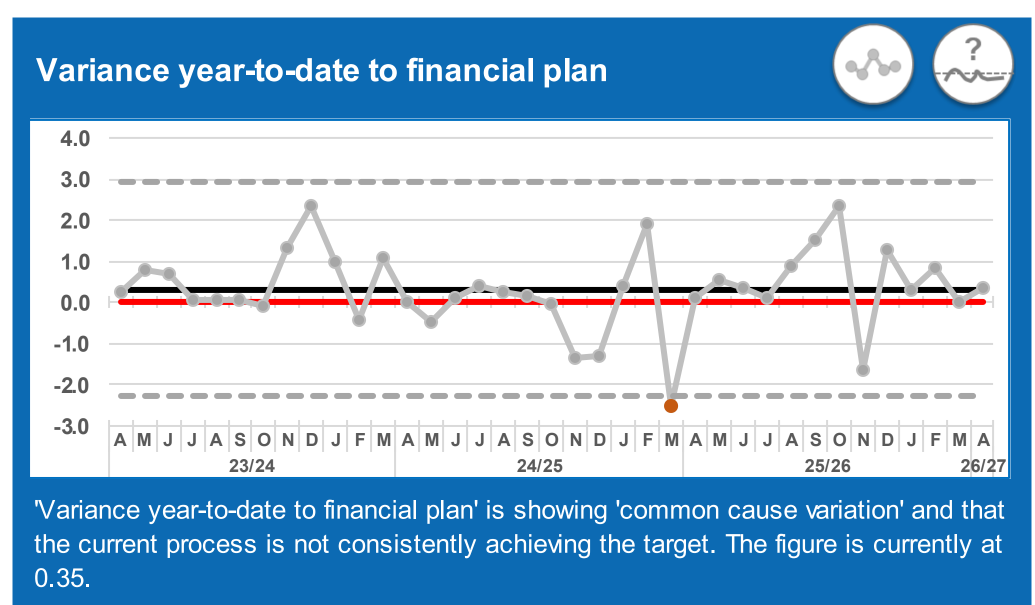
Action Lead: Kathryn Lennon ***Review Date:*** July 2026

Finance Metrics

IPR Metric Overview

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Variance year-to-date to financial plan			0.35	0.35	≥0	Arthur Vaughan	NHS Oversight Framework	Monthly

Narrative for Finance and Productivity can be found in the Finance Report



'Variance year-to-date to financial plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.35.

Patient Safety & Effectiveness and Experience

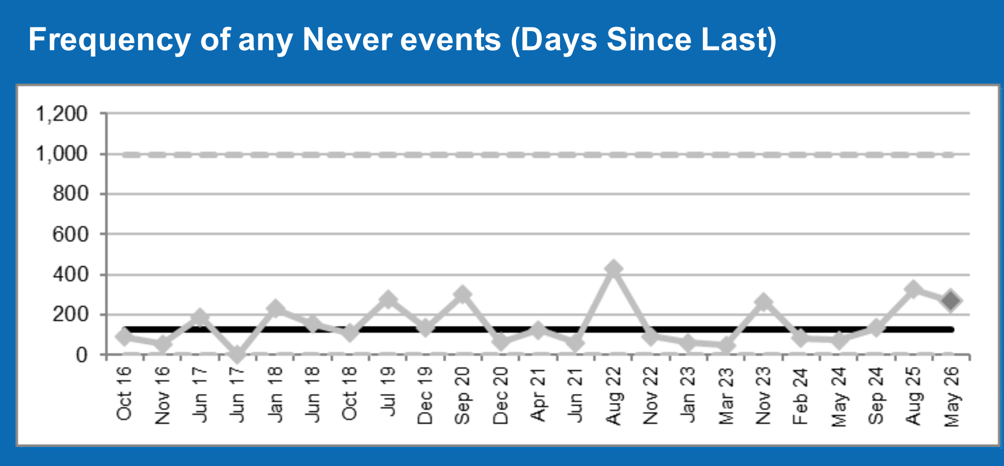
IPR Metric Overview

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Frequency of any Never events (Days Since Last)			n/a	269	No Target Set	Suminthra Naidu	Internal Measure	Days Since Last
Endophthalmitis Rates Within Threshold (Out of 8)		P	n/a	8	8	Suminthra Naidu	Internal Measure	Quarterly
Percentage of responses to written complaints acknowledged within 3 days	H	P	100.0%	100.0%	≥80%	Ian Tombleson	Statutory Submission	Monthly
Duty of Candour (% conversations informing family/carer occurred within 10 working days)		F	n/a	80.0%	No Breaches	Suminthra Naidu	Statutory Submission	Monthly (Month in Arrears)

Patient Safety & Effectiveness and Experience

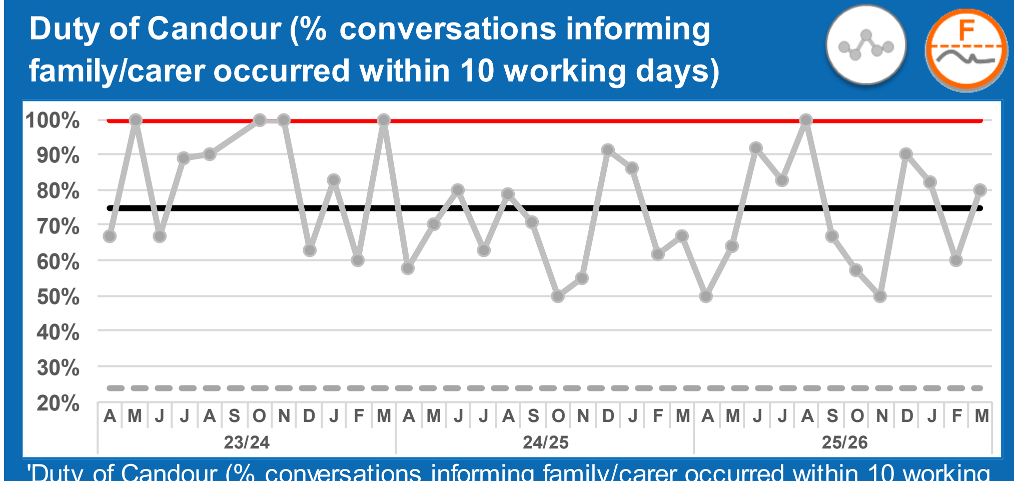
IPR Metrics – Incidents & Duty of Candour

Frequency of any Never events (Days Since Last)



'Frequency of any Never events (Days Since Last)' is showing 'common cause variation'. The figure is currently at 269.

Duty of Candour (% conversations informing family/carer occurred within 10 working days)



'Duty of Candour (% conversations informing family/carer occurred within 10 working days)' is showing 'common cause variation' with the current process unlikely to achieve the target. - This is a change from the previous month. The figure is currently at 80.0%.

We continue to work with divisions and services to improve consistency against this target. This will be further supported through the new consultant site leadership structure and resident medical education, which will provide opportunities to raise awareness of DoC principles. A multidisciplinary workshop is planned to review DoC processes with divisions. We are also reviewing how other trusts report this metric to ensure we are using the most appropriate method, given the complexity of the conversations required.

Review Date: July 2026 **Action Lead:** Kylie Smith / Julie Nott

Patient Safety & Effectiveness and Experience

Primary Metrics – Endophthalmitis

Endophthalmitis table

Procedure	Benchmark Target*	2025/26 Q1	Q2	Q3	Q4	YTD	2024/25
Cataract[1]	0.4	0.00	0.18	0.00	0.00	**0.06**	0.16
Intravitreal Injection	0.3	0.00	0.07	0.07	0.07	**0.05**	0.05
Ozurdex implants	1.0	0.00	0.00	0.00	0.00	**0.00**	0.00
Vitrectomy – simple	0.8	0.00	0.00	0.00	0.00	**0.00**	0.00
Vitrectomy – combined	2.5	0.00	0.00	0.00	2.98	**0.73**	0.00
Acute Glaucoma	1.0	0.00	0.00	0.00	0.00	**0.00**	0.80
Graft – Endothelial Keratoplasty	3.6	0.00	0.00	0.00	0.00	**0.00**	0.00
Graft – Penetrating Keratoplasty	1.6	0.00	0.00	0.00	0.00	**0.00**	0.00

*benchmark is the rate per 1000 of procedure undertaken
[1]Cataract benchmark to be split into simple and combined when denominator data available

There were seven cases of trust reportable endophthalmitis within the year. Two exception reported cases (non-benchmarked procedures) included a patient post Botox injection and a patient post Descemet's Stripping Automated Endothelial Keratoplasty (DSAEK) with 6mm EndoART.

Mandatory Healthcare Associated Infections (HCAI)

The trust reports no cases for the year of 2025/26 on the following mandated infections:

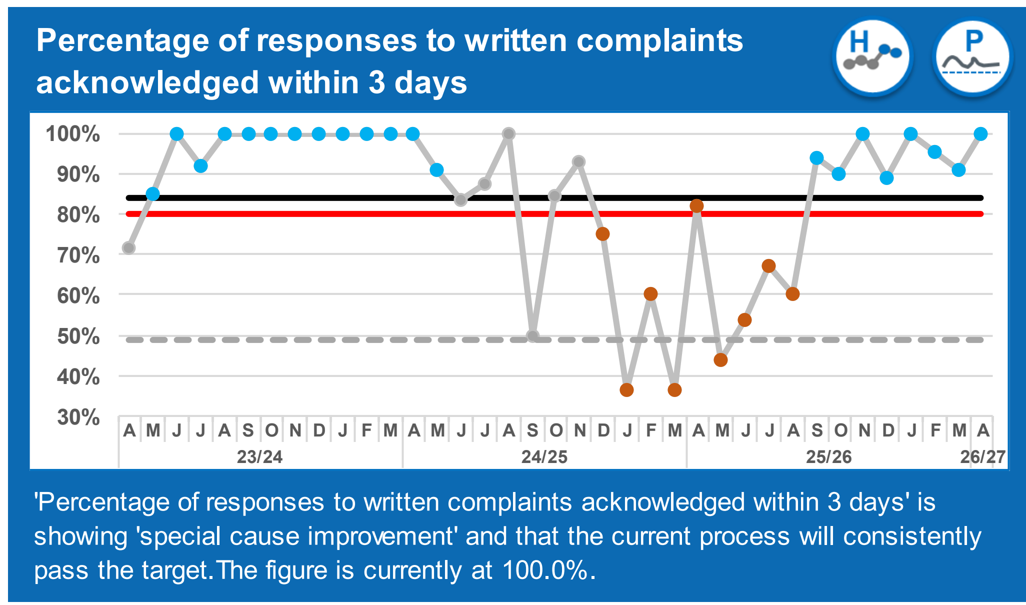
Bacteraemia including MRSA, MSSA, Pseudomonas aeruginosa, E.coli and Klebsiella Spp.
Clostridioides difficile
Carbapenemase-producing Enterobacteriaceae

Patient visual outcomes for Endophthalmitis 2025/26

Procedure	Pre-Op Visual Acuity	Visual Outcome	Change
Cataract	6/12	6/9 unaided	Improved VA
Intravitreal Injection	6/3.8	6/4.8 unaided	Equivalent VA
Intravitreal Injection	1/60	6/18 unaided	Improved VA
Intravitreal Injection	6/12	No Perception of Light	Decrease in VA
Vitrectomy - combined	3/60	No Perception of Light	Decrease in VA
Botox injection	6/4.8	Hand Movement	Decrease in VA
DSAEK with 6mm EndoART	6/24	Hand Movement	Decrease in VA

Patient Safety & Effectiveness and Experience

IPR Metrics – Complaints Performance



The organisation is consistently meeting this target and will work to maintain this performance

Complaints Acknowledgement performance was at 100% (20 complaints), this is now showing as an improving and capable (passing) process as it has achieved the 80% target for eight months in a row.

Complaints Responded Performance (April) will be confirmed shortly, but is provisionally showing at 70% (0 breaches at this stage).

Action Lead: Ian Tombleson

Review Date: July 2026

People and Workforce & Advancing Eye Care

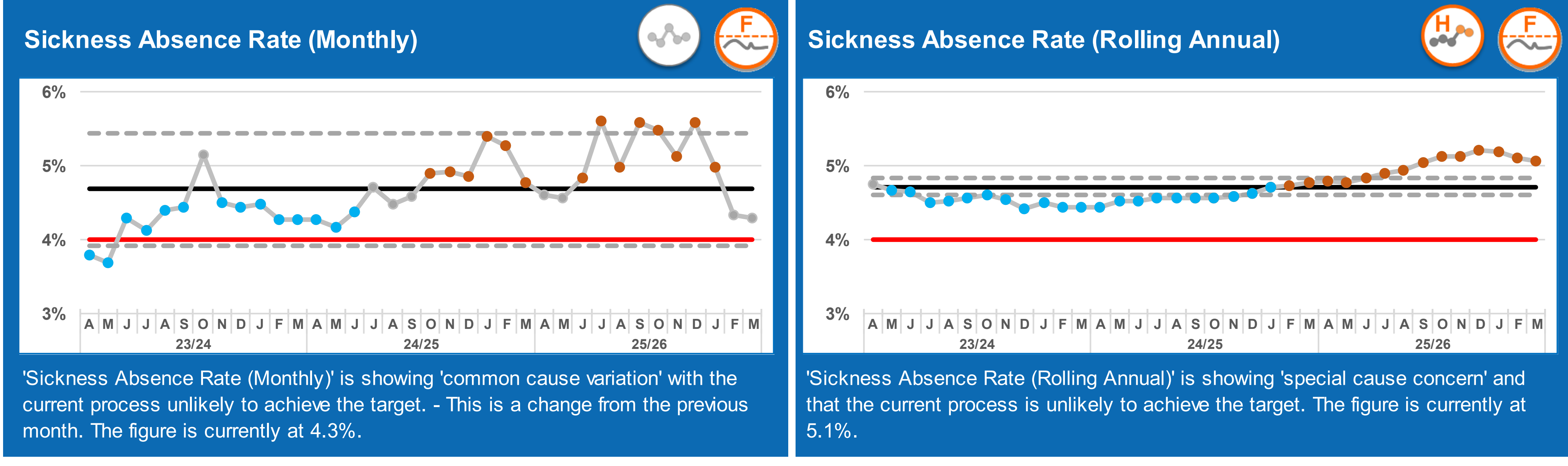
IPR Metric Overview

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Sickness Absence Rate (Monthly)		F	n/a	4.3%	≤4%	Sue Steen	NHS Oversight Framework	Monthly (Month in Arrears)
Staff Turnover (Rolling Annual Figure)	L	P	n/a	9.3%	≤10.0%	Sue Steen	Insightful Board	Monthly (Month in Arrears)
Proportion of Temporary Staff	L		6.9%	6.9%	No Target Set	Sue Steen	NHS Operational Planning	Monthly
Statutory Mandatory Training Compliance		P	n/a	87.1%	≥80%	Sue Steen	Internal Measure	Monthly

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Total Patient Recruitment to NIHR Portfolio Adopted Studies	L	?	n/a	83	≥115 (per month)	Viren Jeram	Internal Measure	Monthly (Month in Arrears)

People and Workforce

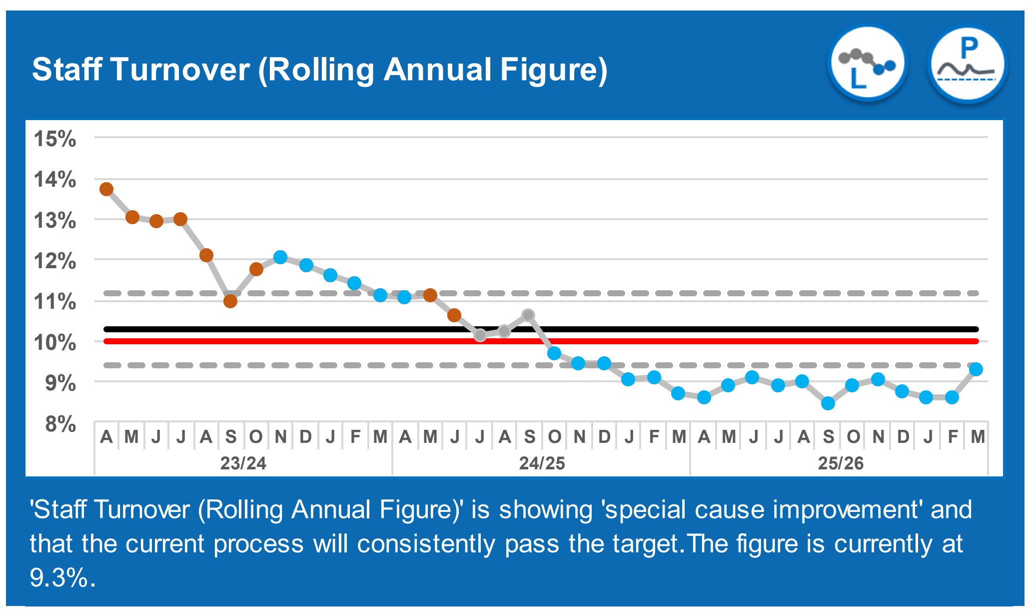
IPR Metrics – Sickness Absence Rate



- Sickness absence management training: ER team delivered 7 training sessions for managers in March, April and May. In addition to this, further bespoke sessions have been delivered to Estates and Facilities, North Division and Private; 87 managers attended these sessions. Further sessions will be delivered throughout 2026 (monthly), as bookable training sessions and bespoke sessions delivered to divisions.
- Support for managers: All new cases of absence within the Trust (500-600 cases monthly on average) are also followed up by the ER team with emails to the managers, advising them of the next steps they are required to take. The ER team will chase and record the Return to Work forms for all sickness cases.
- Number of new Long Term Sickness cases identified in April: 31 new LTS cases; 13 employee returned to work, 18 new open LTS cases
- Triangulation of data with divisions and action planning: we are introducing regular meetings with divisional representatives to discuss all the data which may relate to sickness absence, including staff experience and survey responses. The purpose of this meeting will be to triangulate all the available data and to agree actions which will be taken locally, with support from the People and OD section. The first meeting is going to take place on 19 May and we will be starting with the North Division.
- Reasonable adjustments: Feedback received during sickness management training sessions delivered to managers and submitted through Orial consultation indicates the need to review Trust's processes relating to the provision of reasonable adjustments. The way forward will be discussed at the EDI Steering Group on 20 May.
- ***Action Lead:*** Emeka Ezechukwu ***Review Date:*** July 2026

People and Workforce

IPR Metrics – Staff Turnover



'Staff Turnover (Rolling Annual Figure)' is showing 'special cause improvement' and that the current process will consistently pass the target.The figure is currently at 9.3%.

The rolling 12-month turnover rate for the period is 8.7% which is below the Trust target. It reflects special cause of an improving nature.

For Divisions with more than 30 staff, Finance Director has the highest turnover rate currently at 24% (8 FTE Leavers) followed by Human Resources at 20.3% (10.5 FTE Leavers). The clinical division with the highest turnover is North Division at 12.5% (42.5 FTE Leavers). Departments with the highest turnover in that Division are North East Theatres (41.6%), Ealing (17.3%) and St. Ann's (16.0%).

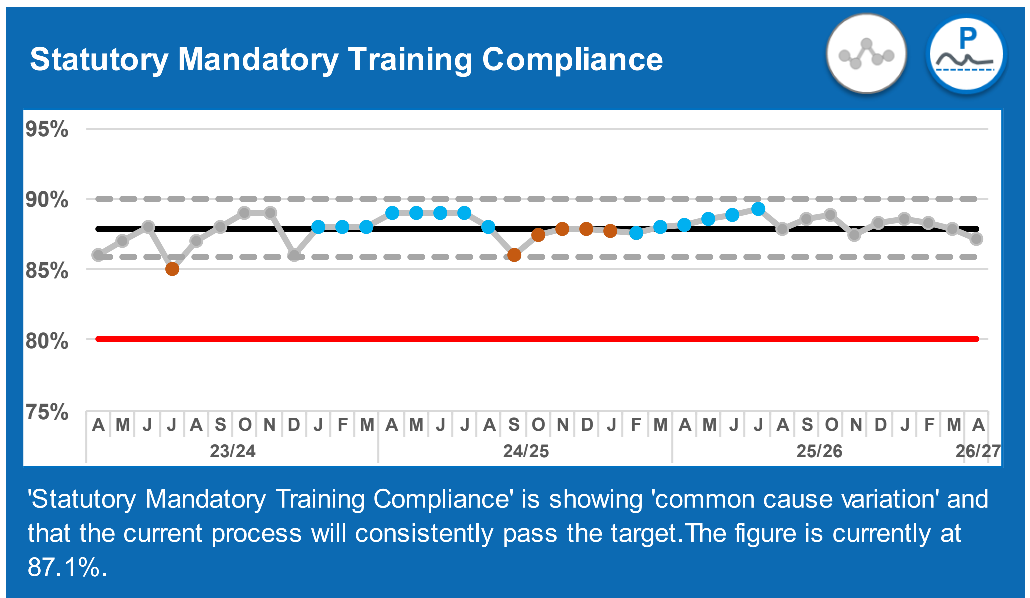
Top 3 reasons for leaving are: Voluntary Resignation – Other/Not known, Promotion & Relocation.

18.6% of leavers had less than 1 year of service. The staff group with the highest turnover rate is currently Admin & Clerical at 11.6%

Action Lead: Helen Dove ***Review Date:*** July 2026

People and Workforce

IPR Metrics – Statutory Mandatory Training Compliance



The level of Mandatory Training Compliance Rate reported for the month of April was 87%, this is above the 80% required target level.

This KPI has shown consistency in the range of 86% to 89% for more than a year with the metric surpassing the target, indicating a capable process.

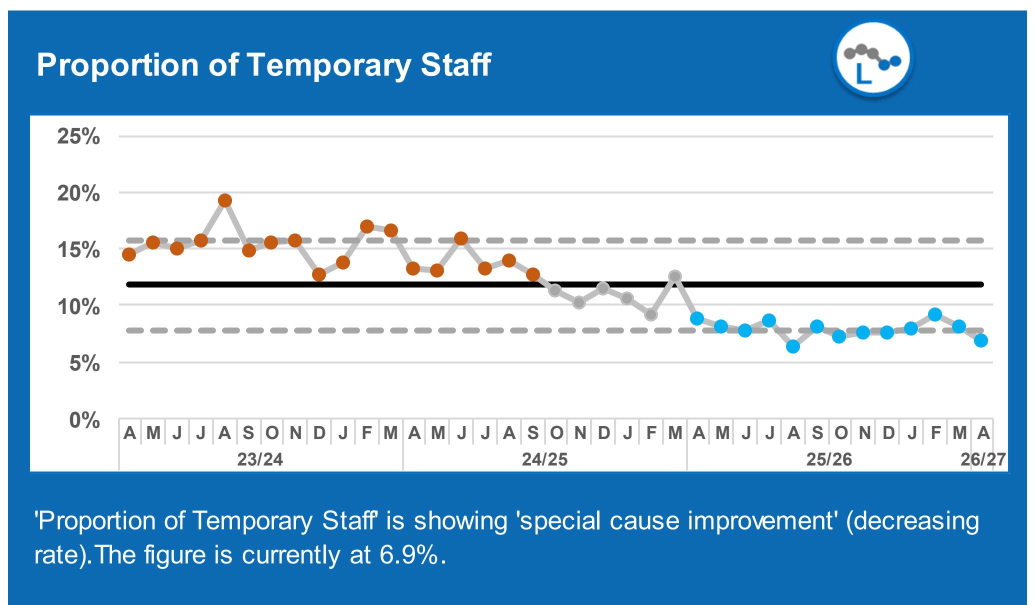
The last two months show stable, well-controlled compliance; however, performance appears to have plateaued. There is no immediate risk to overall compliance, however, subjects including moving and handling level 2, Resuscitation Level 3 (Adult Immediate Life Support and Paediatric Immediate Life Support) continue to underperform. Meaningful improvement will require targeted intervention.

Action Lead: Yvette Bryan

Review Date: July 2026

People and Workforce

IPR Metrics – Temporary Staff



'Proportion of Temporary Staff' is showing 'special cause improvement' (decreasing rate).The figure is currently at 6.9%.

The level of Nursing shift fill rate reported in month was 92% (All Bank) AHP shift fill rate reported for the month is 85% (83% Bank 2% Agency) Admin & Clerical shift fill rate reported for the month is 90% (Bank 87% Agency 3%).

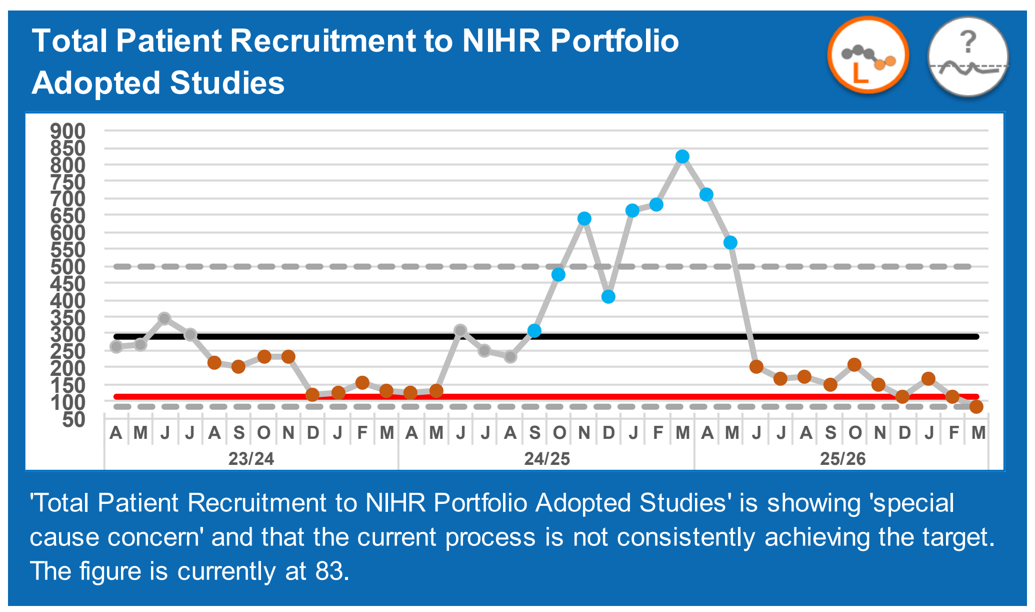
The Trust has saw a positive decline In its temporary staffing over the financial year, 26/27 has also started off strong with agency spend being lower than our planned target.

The top three reasons for temporary staffing utilisation and spend continues to be undertaking of additional shifts, short term and long-term sickness absences. The temporary staffing team and our supplier, Bank Partners, continue to work with hiring managers in the utilisation and spend with focus on governance, monitoring, and delivery of required reduction.

Action Lead: Helen Dove   ***Review Date:*** July 2026

Improving Health and Reducing Inequality

IPR Metrics – Research Charts



'Total Patient Recruitment to NIHR Portfolio Adopted Studies' is showing 'special cause concern' and that the current process is not consistently achieving the target. The figure is currently at 83.

In April 2026, at the time of submitting the metrics, 83 patients were recruited to NIHR Portfolio studies. Although this is below our monthly target of 115, recruitment to higher-value interventional and commercial studies has remained comparatively stable.

It is worth noting that overall recruitment levels are similar to those observed between December 2023 and August 2024. The higher recruitment figures seen between August 2024 and May 2025 were largely driven by several high-recruiting observational studies, which have since closed and are yet to be replaced.

To maintain and increase recruitment levels, it is important that we continue to attract new grants and awards to replace closed studies, such as the recently completed SIBA study. Encouragingly, the WABS study has opened and aims to recruit 500 patients to evaluate the burden of care for patients, carers, and service providers in the treatment of exudative age-related macular degeneration.

The majority of Moorfields' studies remain NIHR Portfolio adopted.

Action Lead: Viren Jeram ***Review Date:*** July 2026

Appendix

Guide to Chart Icons

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

Common Cause: No Significant Change or Variation

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 of showing an **increasing** trend

Special cause of showing a **decreasing** trend

Assurance

Inconsistent passing and failing of the target ("**Hit-or-Miss**")

Recent performance or variation indicates consistent **passing** of the target

Recent performance or variation indicates the target is n**ot consistently met**

Data Table

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/ Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Access to Services																						
Difference Between Planned and Actual 18 week Performance	Apr-26	0.02%	≥0%	Monthly	Common Cause	Hit or Miss	-1.02%	-4.37%	2.32%	0.00%	-0.57%	0.41%	-1.65%	-3.45%	0.00%	-0.38%	0.01%	-1.28%	-1.89%	-2.72%	-1.80%	0.02%
52 Week RTT Incomplete Breaches	Apr-26	5	≤7 Breaches	Monthly	Common Cause	Hit or Miss	14	-3	32	22	29	19	16	31	40	16	18	13	16	30	12	5
Cancer 28 Day Faster Diagnosis Standard	Mar-26	90.0%	≥80%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	77.9%	19.7%	136.1%	88.9%	100.0%	100.0%	80.0%	66.7%	50.0%	n/a	100.0%	n/a	n/a	0.0%	90.0%	n/a
Theatre Utilisation (MEH Definition)	Apr-26	65.9%	≥85%	Monthly	Improvement	Failing	63.3%	60.8%	65.7%	63.4%	65.7%	65.3%	64.8%	63.2%	63.6%	65.0%	66.4%	65.9%	65.4%	66.7%	65.8%	65.9%
Cataract Eyes Per Four Hour Theatre List	Apr-26	6.40	≥ 8 Per 4hr List	Monthly	Common Cause	Failing	6.12	5.68	6.56	5.90	6.10	6.10	6.00	6.10	5.80	6.40	5.80	6.00	6.40	6.40	6.50	6.40
DNA Rate (First Outpatients)	Apr-26	13.5%	≤9.4%	Monthly	Common Cause	Failing	13.0%	11.8%	14.2%	12.2%	12.3%	12.4%	12.4%	13.0%	13.7%	13.5%	12.8%	13.2%	13.5%	12.7%	12.7%	13.5%
DNA Rate (Follow Up Outpatients)	Apr-26	9.3%	≤8.1%	Monthly	Improvement	Failing	10.6%	9.2%	11.9%	9.4%	9.5%	9.4%	9.4%	9.9%	10.0%	9.7%	9.5%	9.9%	10.0%	10.0%	10.0%	9.3%
Average Call Waiting Time	Apr-26	394	≤ 2 Mins (120 Sec)	Monthly	Concern	Failing	167	50	284	260	131	131	163	184	232	222	277	191	269	212	238	394
Patient Safety & Effectiveness and Experience																						
Percentage of responses to written complaints acknowledged within 3 days	Apr-26	100.0%	≥80%	Monthly	Improvement	Capable	84.1%	48.8%	119.4%	81.8%	44.0%	53.6%	67.3%	60.0%	94.1%	90.0%	100.0%	88.9%	100.0%	95.5%	90.9%	100.0%
Duty of Candour (% conversations informing family/carer occurred within 10 working days)	Mar-26	80.0%	No Breaches	Monthly (Month in Arrears)	Common Cause	Failing	75.0%	23.8%	126.2%	50.0%	64.0%	92.0%	83.0%	100.0%	67.0%	57.0%	50.0%	90.0%	82.0%	60.0%	80.0%	n/a
People and Workforce																						
Sickness Absence Rate (Monthly)	Mar-26	4.3%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.7%	3.9%	5.4%	4.6%	4.5%	4.8%	5.6%	5.0%	5.6%	5.5%	5.1%	5.6%	5.0%	4.3%	4.3%	n/a
Staff Turnover (Rolling Annual Figure)	Mar-26	9.3%	≤10.0%	Monthly (Month in Arrears)	Improvement	Capable	10.3%	9.4%	11.2%	8.6%	8.9%	9.1%	8.9%	9.0%	8.5%	8.9%	9.1%	8.8%	8.6%	8.6%	9.3%	n/a
Proportion of Temporary Staff	Apr-26	6.9%	No Target Set	Monthly	Improvement	Not Applicable	11.8%	7.8%	15.8%	8.8%	8.2%	7.8%	8.6%	6.4%	8.2%	7.3%	7.6%	7.6%	8.0%	9.1%	8.1%	6.9%
Statutory Mandatory Training Compliance	Apr-26	87.1%	≥80%	Monthly	Common Cause	Capable	87.9%	85.8%	90.0%	88.1%	88.6%	88.9%	89.3%	87.8%	88.6%	88.8%	87.4%	88.3%	88.5%	88.3%	87.9%	87.1%
Advancing Eye Care																						
Total Patient Recruitment to NIHR Portfolio Adopted Studies	Mar-26	83	≥115 (per month)	Monthly (Month in Arrears)	Concern	Hit or Miss	289	82	497	714	569	200	168	170	147	207	148	112	169	115	83	n/a

Integrated Monitoring Metrics

April 2026

Brief Summary of Report

This report highlights a series of metrics regarded as Monitoring Indicators of Trust Performance.

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 indicates as a summary where these metrics show concern or are consistently 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.

Performance Overview

April 2026		Assurance		
		Capable Process	**Hit and Miss**	**Failing Process**
Variation	**Special Cause Improvement**	• % A&E Waits Over Twelve Hours • Theatre Utilisation (MH) • Occurrence of any Never events • NatPSAs breached • % Discharged on DRD • Average Days (DRD) • Ward Fill Rate	• 18 Week RTT Incomplete Performance	
	Common Cause	• % 52 Week RTT Incomplete Breaches • A&E Four Hour Performance • Summary Hospital Mortality Indicator • MRSA Bacteraemias Cases • Clostridium Difficile Cases • E. Coli Cases • Mixed Sex Accommodation Breaches • VTE Risk Assessment • FFT Inpatient Scores (% Response)	• % Cancer 62 Day Waits (All) • % Diagnostic WT less than 6w • Theatre Cancellation Rate (NHM) • Elective Activity - % of Phased Plan • Total Outpatient Activity (% Plan) • Outpatient First Activity (% Plan) • Outpatient Flw Up Activity (% Plan) • Injection Activity (% Plan)	• % FoI Requests within 20 Days
	Special Cause Concern	• FFT Outpatient Scores (% Response) • FFT A&E Scores (% Response)	• % Cancer 31 Day Waits (All) • HNM Cancelled 28 day breaches • Average Call Abandonment Rate	• Sickness Absence Rate (Annual)

Access to Services

Monitoring Metrics – Referral To Treatment

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
18 Week RTT Incomplete Performance			84.67%	84.67%	≥84.65%	Jon Spencer	NHS Oversight Framework	Monthly
RTT Incomplete Pathways (RTT Waiting List)			n/a	34916	≤ Previous Mth.	Jon Spencer	NHS Operational Planning	Monthly
RTT Incomplete Pathways Over 18 Weeks			n/a	5353	≤ Previous Mth.	Jon Spencer	NHS Operational Planning	Monthly
% 52 Week RTT Incomplete Breaches			0.01%	0.01%	≤1%	Jon Spencer	NHS Oversight Framework	Monthly
% of RTT Patients Waiting For a First Appointment			89.7%	89.7%	No Target Set	Jon Spencer	NHS Operational Planning	Monthly
Under 18s Elective Waiting List (Monitoring Growth)			3523	3523	No Target Set	Jon Spencer	NHS Oversight Framework	Monthly

Access to Services

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
A&E Four Hour Performance		P	96.9%	96.9%	≥95%	Jon Spencer	NHS Oversight Framework	Monthly
% A&E Waits Over Twelve Hours	L	P	0.0%	0.0%	No Breaches	Jon Spencer	NHS Oversight Framework	Monthly
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat	L	?	n/a	83.3%	≥96%	Jon Spencer	Statutory Submission	Monthly (Month in Arrears)
% Patients With All Cancers Treated Within 62 Days		?	n/a	81.0%	≥85%	Jon Spencer	NHS Oversight Framework	Monthly (Month in Arrears)
Percentage of Diagnostic waiting times less than 6 weeks		?	97.9%	97.9%	≥99%	Jon Spencer	NHS Oversight Framework	Monthly
Theatre Utilisation (Model Hospital)	H	P	94.6%	94.6%	≥85.0%	Jon Spencer	Insightful Board	Monthly
Theatre Cancellation Rate (Non-Medical Cancellations)		?	0.95%	0.95%	≤0.8%	Jon Spencer	Statutory Submission	Monthly
Number of non-medical cancelled operations not treated within 28 days	H	?	12	12	Zero Breaches	Jon Spencer	Statutory Submission	Monthly

Access to Services

Monitoring Metrics – Call Centre & Outpatient Efficiency

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Average Call Abandonment Rate			20.6%	20.6%	≤15%	Jon Spencer	Internal Measure	Monthly
% Outpatient Attendances That Were Performed Remotely			6.0%	6.0%	No Target Set	Jon Spencer	Model Hospital	Monthly
% PIFU of Total Outpatient Attendances			0.1%	0.1%	No Target Set	Jon Spencer	NHS Operational Planning	Monthly
Outpatient Cancellation Rate (Hospital cancellations)			3.90%	3.90%	No Target Set	Jon Spencer	Internal Measure	Monthly
Outpatient Rebooking Rate (Hospital cancellations)			6.8%	6.8%	No Target Set	Jon Spencer	Internal Measure	Monthly
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments			n/a	105	No Target Set	Jon Spencer	Internal Measure	Monthly
Median Outpatient Journey Times - Diagnostic Face to Face Appointments			n/a	37	No Target Set	Jon Spencer	Internal Measure	Monthly

Access to Services

Monitoring Metrics – Activity vs. Plan

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Elective Activity - % of Phased Plan			99.9%	99.9%	≥100%	Jon Spencer	NHS Operational Planning	Monthly
Total Outpatient Activity - % of Phased Plan			97.1%	97.1%	≥100%	Jon Spencer	NHS Operational Planning	Monthly
Outpatient First Appointment Activity - % of Phased Plan			106.8%	106.8%	≥100%	Jon Spencer	NHS Operational Planning	Monthly
Outpatient Follow Up Appointment Activity - % of Phased Plan			94.2%	94.2%	≥100%	Jon Spencer	NHS Operational Planning	Monthly
Injections Activity - % of Phased Plan			100.3%	100.3%	≥100%	Jon Spencer	NHS Operational Planning	Monthly

Patient Safety & Effectiveness and Experience

Monitoring Metrics – Incident Reporting, FoI and Infection Control

Moorfields Eye Hospital NHS Foundation Trust

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Summary Hospital Mortality Indicator		P	0	0	Zero Cases	Suminthra Naidu	NHS Oversight Framework	Monthly
Occurrence of any Never events	L	P	0	0	Zero Events	Suminthra Naidu	Statutory Submission	Monthly
National Patient Safety Alerts (NatPSAs) breached	L	P	n/a	0	Zero Alerts	Suminthra Naidu	Statutory Submission	Monthly
Freedom of Information Requests Responded to Within 20 Days		F	82.6%	78.6%	≥90%	Ian Tombleson	Statutory Submission	Monthly (Month in Arrears)
MRSA Bacteraemia Cases		P	0	0	Zero Cases	Suminthra Naidu	NHS Oversight Framework	Monthly
Clostridium Difficile Cases		P	0	0	Zero Cases	Suminthra Naidu	NHS Oversight Framework	Monthly
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - Cases		P	0	0	Zero Cases	Suminthra Naidu	NHS Oversight Framework	Monthly

Patient Safety & Effectiveness and Experience

Monitoring Metrics – Clinical

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Mixed Sex Accommodation Breaches		P	n/a	0	Zero Breaches	Suminthra Naidu	Statutory Submission	Monthly
% Discharged on Discharge Ready Date (DRD)	H	P	100.0%	100.0%	No Breaches	Suminthra Naidu	NHS Oversight Framework	Monthly
Average Days Between DRD and Discharge Date	L	P	n/a	0.0	0 Days	Suminthra Naidu	NHS Oversight Framework	Monthly
VTE Risk Assessment		P	99.2%	99.2%	≥95%	Suminthra Naidu	Statutory Submission	Monthly
% Emergency re-admissions within 30 days following an elective or emergency spell			4.6%	4.6%	No Target Set	Louisa Wickham	NHS Oversight Framework	Monthly
Safer Staffing - Inpatient (Overnight) Ward Fill Rate	H	P	102.8%	102.8%	≥90.0%	Suminthra Naidu	Statutory Submission	Monthly

Patient Safety & Effectiveness and Experience

Secondary Metrics – Patient Experience

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Inpatient Scores from Friends and Family Test - % Response Rate		P	36.4%	36.4%	≥30%	Ian Tombleson	Statutory Submission	Monthly
Outpatient Scores from Friends and Family Test - % Response Rate	L	P	30.1%	30.1%	≥15%	Ian Tombleson	Statutory Submission	Monthly
A&E Scores from Friends and Family Test - % Response Rate	L	P	23.5%	23.5%	≥20%	Ian Tombleson	Statutory Submission	Monthly

People and Workforce

Monitoring Metrics

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Sickness Absence Rate (Rolling Annual)	H	F	n/a	5.1%	≤4%	Sue Steen	NHS Oversight Framework	Monthly (Month in Arrears)

Appendix

Guide to Chart Icons

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	
	Common Cause: No Significant Change or Variation
H L	Special cause of **concerning** nature or higher pressure due to (H)igher or (L)ower values
H L	Special cause of **improving** nature or higher pressure due to (H)igher or (L)ower values
	Special cause of showing an **increasing** trend
	Special cause of showing a **decreasing** trend

Assurance	
?	Inconsistent passing and failing of the target ("**Hit-or-Miss**")
P	Recent performance or variation indicates consistent **passing** of the target
F	Recent performance or variation indicates the target is n**ot consistently met**

Cover Sheet	
Report title	Board Assurance Framework
Meeting	Board of Directors
Date	4 June 2026
Report from	Peter Ridley, Chief Executive
Prepared by	Ben Westmancott, Interim Company Secretary
Previous forum consideration	Trust Executive Committee, Board strategy session

Relevant strategic objectives	Working together	X	Discover	X	Develop	X	Deliver	X	Sustainability and Scale	X

Purpose of report	Assurance	X	Decision	X	Discussion	X	For information	

Executive Summary

The Board Assurance Framework (BAF) sets out the principal risks to the successful delivery of the Trust's strategy. These risks are aligned to the Trust's strategic objectives and reflect the Executive's assessment of the current strategic risk landscape.

The initial risk landscape was discussed with the Board at its strategy session on 23 April. Following that discussion, each principal risk has been further developed into the full BAF presented here.

Each risk entry describes the nature of the uncertainty, its potential impact over time, and the Board's agreed risk tolerance. It also sets out the key controls in place to mitigate risk, the sources of assurance available to the Board, and any identified gaps in controls or assurance, together with associated actions.

Risk tolerances have been established for each principal risk, aligned to the risk appetite statements considered by the Board on 23 April.

What the Board Is Being Asked to Do

The Board is asked to:

1. **Review and comment on the principal risks identified**, including whether they appropriately reflect the Trust's most significant strategic risks and opportunities.
2. **Provide feedback on the overall focus and usability of the BAF**, particularly the extent to which it supports effective Board-level assurance and strategic decision-making.
3. **Agree the proposed use of the BAF to inform Board and committee work programmes**, ensuring that targeted assurance on the effectiveness of key controls is systematically considered alongside routine assurance.

Next Steps

- A regular update cycle will be implemented, aligned as far as practicable to the committee timetable.
- The BAF will be used to inform committee agendas from July onwards.

Quality implications Effective identification and management of strategic risks supports the Trust in delivering safe, high-quality care and meeting its statutory duties. Quality considerations are integral to the BAF.
Financial implications Effective management of strategic risks underpins the Trust's financial sustainability and the delivery of its objectives.
Risk implications This report sets out the Trust's principal strategic risks and the associated assurance framework.

The **Board Assurance Framework** sets out the key risks to successfully realising our strategy. Our strategic objectives guide our work. The graphic below sets out the things we have said we'll do in 2022-2027 and the risks to success. Each subsequent entry in this BAF takes a key uncertainty in turn, and describes the level of uncertainty and impact over time alongside the risk tolerance. It also sets out the key controls to manage the uncertainty, the assurances that are received, along with gaps in both controls and assurances and further actions.

Risks to realising our strategy

1 Working together We will collaborate with one another as individuals, in our teams, with our patients and our partners

1A. If we do not improve the consistency and quality of leadership behaviours across the Trust, there is a risk that staff experience, team functioning and patient outcomes will not improve at the pace required to deliver our strategy

1B. If the organisation does not effectively prioritise and sequence work, and actively manage capacity during periods of change, there is a risk of staff overload leading to reduced wellbeing, increased absence and reduced organisational performance.

1C. If strategic partnerships are not actively managed to deliver measurable value, the organisation may fail to realise opportunities for innovation, research growth and improved patient care

2 Discover We will focus on setting the agenda, pioneering new pathways and treatments

2A. If research funding environment changes and access to funding becomes harder, opportunities to increase research activities leading to loss of reputation as a worldclass centre.

2B. Leadership and succession planning within research and innovation activities

3 Develop We will practically apply our discoveries and global best practice to benefit our patients, staff and the services we provide

3A If major programmes do not deliver to time or budget and benefits are not realised, opportunities to improve patient care will be reduced as reputational damage, and financial consequences.

3B. If we do not invest in new innovations, opportunities to exploit discoveries will reduce leading to loss of opportunities to improve patient outcomes and potential loss of income and market share.

4 Deliver We will consistently provide an excellent, globally recognised service

4A. Given the geopolitical position, increased likelihood of severe weather events, cyber threat, and supply chain risks, the likelihood of serious service disruption increases leading to negative impact on patient care.

4B If we do not have sufficient resources in place to effectively monitor the quality and safety of care, there is a risk that issues may not be identified promptly, which could adversely affect patient outcomes and experience. If the risk materialises there is likely to be regulatory intervention e.g. by the CQC and associated reputational damage.

5 Sustainably and at scale We will use our resources responsibly, safeguarding what we have for the next generation; and we will design our services so that more people can access excellent care

5A. If the Trust is unable to improve the financial sustainability of the services it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future.

5B: . If we do not respond to changes in the market then market share could be lost to competitors impacting out longer-term financial sustainability and our ability to deliver high quality care.

Cross-cutting risks

XA. If cyber criminals attempt to access and disrupt the trust's systems then our systems may be compromised leading to disruption in patient care, regulatory fines, and data breaches..

XB: If we do not handle receipt of the external reviews then we risk prolonging a period of disruption leading to attention being diverted from service delivery and patient care.

Risks mapped to lead executive and lead assurance committee (paraphrased)

Strat Obj	Ref	Risk	Lead exec	Lead committee
Working together	1A	Leadership and behaviours	CPO	People and Culture
	1B	Overload	CPO	People and Culture
	1C	Strategic partnerships	DofS&P	Discovery and Commercial
Discover	2A	Research funding	CMO	Discovery and Commercial
	2B	Leadership and succession planning in research	CMO	Discovery and Commercial
Develop	3A	Major programmes delivery	COO	Major Projects and Digital
	3B	Insufficient capital/investment to implement innovations	CFO	Major Projects and Digital
Deliver	4A	Business Continuity	COO	Quality and Safety
	4B	Quality governance and assurance	CNO	Quality and Safety
Sustainability and at scale	5A	Financial sustainability	CFO	Finance and Performance
	5B	Market changes	DofS&P	Discovery and Commercial
All	XA	Cyber	CIO	Major Projects and Digital
	XB	Governance and quality	CEO	Trust Board

Board Assurance Framework

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Working together: Are we collaborating with one another as individuals, in our teams, with our patients and our partners?										
1A	**Leadership and behaviours:** If we do not improve the consistency and quality of leadership behaviours across the Trust, there is a risk that staff experience, team functioning and patient outcomes will not improve at the pace required to deliver our strategy.	3 February 2026	29 May 2026	Sue Steen	People and Culture Committee	• Culture priority workstream	• People performance metrics to PCC each quarter. • Integrated performance report.	• As the programme develops, controls will become more explicit.	• As the programme develops, assuranc4es on initiatives will be presented to the people and culture committee for scrutiny.	• Culture diagnostic

Risk Score over time

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar

Legend: Risk Score; Projected risk score; Risk Tolerance. Y-axis: 0, 5, 10, 15, 20, 25.

Executive Assurance Commentary:
This entry has been amended following the board strategy session in April.

Risk score is likelihood 4 x impact of 4

The risk tolerance is suggested on the basis that the outcome affected is patient care and service quality (i.e. minimalist 6-9)

Assurance Committee's commentary:

At the board strategy session on 23 April, the board requested that this risk be clarified to add leadership and focus on staff behaviours. The board stressed that this was an important risk to mitigate as ultimately it had an impact on patient care.

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Working together: Are we collaborating with one another as individuals, in our teams, with our patients and our partners?										
1B	**Overload:** If the organisation does not effectively prioritise and sequence work, and actively manage capacity during periods of change, there is a risk of staff overload leading to reduced wellbeing, increased absence and reduced organisational performance.	3 February 2026	29 May 2026	Sue Steen	People and Culture Committee	• Board agreed four priorities for the year.		• Need to ensure that these priorities cascade down through the organisation	• How do we get assurance that we are not introducing new risks by stopping doing things?	• Continued communication to staff of the priorities and what they mean in the context of each team.
						• Staff wellbeing interventions	• People performance metrics reported each quarter	• Is there more we should be doing to support staff health and wellbeing?		

Risk Score over time

Risk Score
Projected risk score
Risk Tolerance

25
20
15
10
5
0

Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar

Executive Assurance Commentary:

Risk score is likelihood 4 x impact of 4

Risk tolerance has been selected based on a risk appetite of 'open' with regard to workforce (15-16)

Assurance Committee's commentary:
At the board strategy session on 23 April, the board agreed that this risk be described in the context of failure to prioritise effectively *and* supporting staff's health and wellbeing.

At the people and culture committee meeting on 7 May it was recommended to reflect the financial impact of long-term sickness.

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Working together: Are we collaborating with one another as individuals, in our teams, with our patients and our partners?										
1C	**Strategic partnerships:** successfully delivering our strategic objectives relies on strong partnerships with organisations we collaborate with (primarily UCL). If strategic partnerships are not actively managed to deliver measurable value, the organisation may fail to realise opportunities for innovation, research growth and improved patient care.	23 April 2026	22 May 2026	Elena Bechberger	Discovery and Commercial	• Comprehensive partnership stock-take and prioritisation exercise, jointly with UCL IoO and MEC, to agree a clear framework for partnership management and targeted improvements and benefits	• Regular reporting on progress to Discovery & Commercial Board Sub-Committee	• There is the need for all organisations to continue to openly share relevant information and to use agreed channels for partnership management going forward		• Partnership stocktake and strategy to be presented to Discovery & Commercial Committee by Sep 26
						• New Oriel Partnership Steering Group established bringing together key stakeholders from MEH, UCL and MEC, to jointly pursue the key Oriel partnership benefits across innovation, research, education	• Regular reporting to Oriel Programme Board		• We need to agree ongoing management of joint strategy ambitions and partnership arrangements post project completion, including a vehicle for UCL-MEH Board to Board engagement	• Series of Oriel Partnership workshops taking place quarterly throughout 2026

Risk Score over time

Risk Score
Projected risk score
Risk Tolerance

25
20
15
10
5
0

Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar

Executive Assurance Commentary:

Risk score is likelihood 4 x impact of 4.

Risk tolerance has been set at 8 on the basis that the negative impact will be on patient care.

Assurance Committee's commentary:

This is a new risk described following discussions at the board strategy session on 23 April. It was previously intertwined with 1A. (1A is focussed on working together internally, 1C is working together with external partners).

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Discover: Are we focusing on setting the agenda, pioneering new pathways and treatments?										
2A	**External environment – pace of adoption of new technology and patient impact.** If research funding environment changes and access to funding becomes harder, opportunities to increase research activities leading to loss of reputation as a worldclass centre.	3 February 2026	18 May 2026	Louisa Wickham	Discovery and Commercial Committee	• Research governance arrangements in place.	• Reports to the discovery and commercial committee on research income and activity.	• Function leadership is in an interim phase while recruitment takes place.	• Additional required assurances to be discussed at the discovery and commercial committee.	• Recruit to director of research and innovation role. • Identify interim director of research and innovation • BRC application

Risk Score over time

Executive Assurance Commentary:

Risk score is likelihood 4 x impact of 4

Risk tolerance has been set at 10 i.e. cautious risk appetite with respect to reputation.

Without a successful BRC funding bid we will be less able to retain our world-leading research position.

Assurance Committee's commentary:

To be completed after the DCC meeting in July.

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Discover: Are we focusing on setting the agenda, pioneering new pathways and treatments?										
2B	**Leadership and succession planning within research and innovation activities:** if we don't restructure and recruit it will potentially undermine research and innovation governance processes with potential impact on the success with external grants and awards, and lack of clarity for researchers thus undermining our reputation as a world-class centre for research.	3 February 2026	28 May 2026	Louisa Wickham	Discovery and Commercial Committee	• New structure for research leadership described and agreed	• Updates to the discovery and commercial committee	• Vacancy for Director of Discovery/Director of Research and Innovation. • Insufficient succession plan for BRC leadership • Other gaps in medical leadership posts in research and innovation	• The DCC will receive an update on progress with the recruitment process at its meeting on 14 July. This will include update on agreeing objectives for new potholders and the directorate.	• Interview for interim director of research and innovation 1 June. • Permanent recruitment live for the director of research and innovation and co-director of Biomedical Research Centre post (closing date 29 May). • Job descriptions for all vacant posts updated, internal expressions of interest to follow. • Leadership of BRC to be discussed and to be confirmed. • Roles for fellows in the research and development leadership structure designed to enable progression.

Executive Assurance Commentary:

Risk score is likelihood 4 x impact of 5

Risk score predicted to drop once an interim director in post and further drop once a permanent appointment has been made.

The risk appetite is based on a cautious/open appetite for reputational risk.

Assurance Committee's commentary:

This will be completed after the discovery and commercial committee meeting on 14 July.

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Develop: Are we practically applying our discoveries and global best practice to benefit our patients, staff and the services we provide?										
3A	**Major programmes delivery:** If major programmes do not deliver to time or budget and benefits are not realised, opportunities to improve patient care will be reduced as reputational damage, and financial consequences.	3 February 2026	18 May 2026	Jon Spencer	Major projects and Digital Committee	• Oriel programme management and governance	• Update reports to the Plan Delivery Group and Major Projects and Digital Committee • New Hospital Programme assurance process	• There is a significant risk relating to the collapse of CAI (building safety inspector for the new centre).	• Work is underway to assess how quickly the regulator will respond to a required level 2 application under the Building Safety Act.	• Submit a level 2 application to the Building Safety Act regulator and work with the regulator to support a restarting of construction activities on the Oriel site as soon as possible.
						• EPR programme management and governance	• Update reports to the Plan Delivery Group and Major Projects and Digital Committee • NHSE assurance process	• There are red rated risks for the programme which are highlighted in the update report for these groups / committees.	• After action reviews are required to learn from the recent IT system upgrades / transfers and this learning then needs to be applied to the EPR programme.	• Carry out after action reviews on the IT upgrades / transfers and confirm whether the learning points will impact on the planned EPR go live date.
						• City Road migration project management and governance	• Update reports to the Plan Delivery Group and Major Projects and Digital Committee	• There is a need to assess whether this project can be enabled fast enough to support the requirements of the Oriel and EPR go lives.	• When the contract with the new provider is in place then there is a need to finalise the interdependencies between this project and the Oriel / EPR programmes.	• Finalise the contract with the new provider and assess the interdependencies with the Oriel / EPR programmes.

Risk Score over time

Risk Score
Projected risk score
Risk Tolerance

25
20
15
10
5
0

Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar

Executive Assurance Commentary:

Risk score is likelihood 3 x impact of 5

Towards the end of the year the risk will be reduced due to progress with implementing EPR and the further progress with Oriel.

Assurance Committee's commentary:

At the board strategy session on 23 April 2026, they discussed the importance of expanding assurances to include our capacity to develop new ideas into positive change and emphasised the impact not delivering major programmes on patient services and outcomes (this has been reflected in the risk description).

The Major Projects Committee reviewed the risk at its meeting on 6 May 2026 and concurred with the risk wording, made recommendations for what to include under controls, assurances, and gaps, and noted that the executive lead would add further detail (which has since been done).

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Develop: Are we practically applying our discoveries and global best practice to benefit our patients, staff and the services we provide?										
3B	**Insufficient capital/investment to implement innovations:** If we do not invest in new innovations, opportunities to exploit discoveries will reduce leading to loss of opportunities to improve patient outcomes and potential loss of income and market share.	3 February 2026	18 May 2026	Arthur Vaughan	Major projects and digital committee	Capital Planning and Oversight Committee: • reviews and approves the Trust's annual and three-year capital expenditure plans prepared by the Chief Operating Officer and Chief Finance Officer for authorisation by the Trust Main Board (TMB) and submission to NHSE. • Establishes the overall methodology, processes and controls which govern the Trust's annual capital expenditure and projects and to evaluate, scrutinise and monitor all capital expenditure projects. • Reviews and monitors progress against the Trust Major Capital Projects including: - o Oriel construction (formally monitored via Oriel programme) o EPR Programme (Also reported via EPR Finance Sub-group) o IT City Road Migration Project (formally monitored via IT Programme Board) o Major IT projects.	• Prioritised Plan monitored by Finance and Performance Committee	• Capital and cash constrained – impact on ability to invest fully into satellite sites and technology required to fully unlock operational productivity in short term (EPR and Oriel).	• Updated Prioritised Plan	• Prioritised Plan to come to July Finance and Performance Committee

Risk Score over time

Risk Score
Projected risk score
Risk Tolerance

25
20
15
10
5
0

Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar

Executive Assurance Commentary:
The risk affects our ability to reduce risks associated with our estate, invest in our estate, and invest in technology and innovation. The risk tolerance relates to cyber, satellite estates and digital innovation. A digital strategy will help prioritise investment and this will follow the refresh of the trust's overall strategy.

Assurance Committee's commentary:
The Major Projects Committee reviewed the risk at its meeting on 6 May 2026 and concurred with the risk wording, made recommendations for what to include under controls, assurances, and gaps, and noted that the executive lead would add further detail (which has since been done).

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Deliver: Are we consistently providing an excellent, globally recognised service?										
4A	**Service disruption and business continuity.** Given the geopolitical position, increased likelihood of severe weather events, cyber threat, and supply chain risks, the likelihood of serious service disruption increases leading to negative impact on patient care.	3 February 2026	18 May 2026	Jon Spencer	Quality and safety committee	• Business Continuity Plan.	• EPRR assurance from NHSE.			• Discussion to take place at the finance and performance committee on any further actions that could/should be taken and on any further assurances that might be required.

Risk score over time

Risk Score
Projected risk score
Risk Tolerance

25
20
15
10
5
0

Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar

Executive Assurance Commentary:
The risk has been scored at likelihood 3, impact 4. That is, there is a medium likelihood of significant disruption to patient care.

The tolerance has been set at 9, the upper end of our appetite for risk relating to patient care on the basis that there are events outside our control and even with green rated business continuity plans in place, we cannot control the external environment.

Assurance Committee's commentary:

The quality and safety to review this at their meeting on 21 July.

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Deliver: Are we consistently providing an excellent, globally recognised service?										
4B	**Quality governance and assurance:** If we do not have sufficient resources in place to effectively monitor the quality and safety of care, there is a risk that issues may not be identified promptly, which could adversely affect patient outcomes and experience. If the risk materialises there is likely to be regulatory intervention e.g. by the CQC and associated reputational damage.	3 February 2026	26 May 2026	Simmi Naidu	Quality and safety committee	• PSIRF • FFT and complaints • Internal IPR reporting. • National KPIs. • Internal processes and systems within the quality assurance framework. • Audits and clinical effectiveness • Policies and guidelines and SOPs. • Escalation frameworks. • Local governance arrangements/meetings at Divisional level. • Information governance controls and training.	• Trust-wide governance reporting through committees and the board. • Clinical walkarounds by executives. • Patient participation experience committee (reports into clinical governance committee).	• Lack of consistently applying the process of learning from never events and incidents of harm. • Internal planned peer reviews and quality deep dives. • Increasing the independence of assurances that our service are delivering high quality, effective and safe care. • We need to embed quality improvement to create a culture that is continuously learning and improving.	• We do not have a consistent and thorough way of providing and testing assurance of digital clinical safety.	• Clinical visibility framework. • Quality assurance committee (every 2 months); mix of peer reviews and deep dives. • Create a digital framework that allows for planning, testing, and wider understanding of clinical risks linked to upgrades and new programmes. • Youth forum recently launched to test ideas, planning and design of services. • Setting up London-wide children's and young people's ophthalmology clinical network. (With plans to extend this nationally for adults and children).

Risk score over time

Executive Assurance Commentary:
Quality and safety governance is in a good place overall. However, recognising and in line with our strategic ambition our processes need strengthening and in some areas, resetting. In line with our evolving digital journey, we are now working to embed robust safety processes to safeguard clinical systems and patients.

This would put us in a strong position from an information governance perspective whilst also providing the opportunity to enable patients to have access to their clinical records and increasing ownership of their care. Our ambition is to collaborate at both local and national levels to bring clinical expertise together to progress care from a quality and safety perspective.

Assurance Committee's commentary:

After reviewing the entry at its meeting on 21 July, the Quality and Safety Committee to add commentary on the degree to which they concur with the exec assurance comments and any other points they think they board should be aware of.

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Sustainability and at scale: Are we using our resources responsibly, safeguarding what we have for the next generation; and are we designing our services so more people can access excellent care?										
5A	**Financial sustainability** If the Trust is unable to improve the financial sustainability of the services it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future	3 February 2026	18 May 2026	Arthur Vaughan	Finance and Performance committee	• Annual integrated activity financial plan • Capital prioritisation process • Key financial system controls framework • Business Case Review Group. Board committee review of business cases >£[x]m • Monthly Financial performance review meetings – for sites and corporate departments. • Vacancy/Pay controls process reviewed/updated incl. temporary staffing controls • Transformation programmes in place to support efficiency and productivity • Budget holder training • Engagement with ICS partners to support SEL system financial planning. • Efficiency and Transformation Board governance in place • Scheme of Delegation and Standing Financial Instructions (SFIs) • Monthly review of Oriel and EPR project progress • Planning gateway process in place for sites and corporate departments.	• **Positive** • Monthly Financial performance reporting – TEC, F&C & Board • 2025/26 CIP delivery oversight embedded and reviewed monthly by executive and bi monthly at Board. • 2024/25 External Audit Opinion unqualified • Financial performance reporting – including monthly forecasting, site analysis and risk update. • Internal Audit reports on key financial controls • Long-term financial model in place aligned to 5 year planning and Oriel FBC. • 3 operational year plan developed for 2026/27 to 2028/29. • Major projects oversight of EPR and Orial Projects • **Negative** • 2025/26 Head of Internal Audit Opinion '[x]' • 2026/27 CIP not fully identified.	• Procurement Strategy	• None Identified	• None outside normal financial governance arrangements.

Executive Assurance Commentary:

As long as the trust delivers its cost improvement programme early in the year, projections indicate we will continue to be financially stable. Reducing recurrent costs is important for the successful realisation of the medium-term financial plan.

Assurance Committee's commentary:

The finance and performance committee has agreed a balanced financial plan for the year and continues to monitor progress against it.

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Sustainability and at scale: Are we managing our finances in a sustainable way?										
5B	If we do not respond to changes in the market then market share could be lost to competitors impacting our longer-term financial sustainability and our ability to deliver high quality care.	3 February 2026	22 May 2026	Elena Bechberger	Discovery and commercial committee	• Investment in relevant market data to better understand changes in referral flows and impact on activity levels, both for NHS as well as Private • New Moorfields Private Strategy agreed in April 2026 • Delivery of Moorfields UAE expansion project in 2026, plus agreement to development of additional country expansion opportunities from Q3 26/27 • Referrer engagement strategy to be agreed in Q1 26/27, with implementation of high impact actions to improve referrer relationships and retain activity levels during 26/27 • Expansion of our Single Point of Access service (SPARC) across ICBs in London, and conversations with NHS England about possible national collaboration with NHS Online	• Set-up of new Commercial Group from June 2026 to provide improved cross-departmental focus on commercial work and opportunities – to report into DCC • Oversight of SPARC expansion and possible NHS Online collaboration via Major Projects Committee	• Unequal playing field with regards to investment ability in advertising, ability to offer complementary services such as free travel, and selection of patients compared with private sector competitors for NHS patients • Commissioner reluctance to prevent referrals circumventing the Single Point of Access via mandation due to concerns about legal challenges	• None identified	

Executive Assurance Commentary:

Elena to add commentary on the level of assurance the organisation should take.

Assurance Committee's commentary:

After reviewing the entry, the Finance and Performance Committee to add commentary on the degree to which they concur with the exec assurance comments and any other points they think they board should be aware of

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Impacts on all strategic objectives										
XA	**Cyber & IT Resilience:** If malicious actors gain access to the Trust's IT infrastructure then our data and systems may be compromised, leading to disruption to patient care, data breaches, and regulatory fines.	3 February 2026	18 May 2026	Brendan Mahony	Major projects and digital committee	• People: security awareness activities so that all staff understand how they can support cyber security. Board cyber training. • Process: information security policy framework. Compliance activity including Data Security and Protection Toolkit and other regulatory requirements. • Technology: technical security by design. Security operations including incident handling. System resilience as per disaster recovery plans	• IPR metrics. • DSPT submission (annual) • Internal information security reporting (monthly) • Penetration & Phishing Testing (annual)	REDACTED under s31 of the Freedom of Information Act		• 2026/27 DSPT Submission (due June-26) • Cyber Monitoring business case to BRCG (Due: Jul-26) • Annual infosec report to MPDC (due: TBC) • Independent Cyber Audit to MPDC (due: TBC) • Intellectual property Policy being developed.

Executive Assurance Commentary:

The risk is scored at 20. Likelihood 4 impact 5. (Maps to risk 790 in the risk register)

Plans are underway to address technical gaps in control but plans to address gaps in assurance need to be developed.

Risk appetite has been set at 9 (patient care risk).

Assurance Committee's commentary:

At the board strategy session on 23 April the board emphasised the people aspect to this risk and the importance of training and awareness. They also requested that intellectual property risk and data protection should feature in this BAF entry and that assurances were required.

The major projects and digital committee reviewed this entry at its meeting on 6 May and emphasised the importance of fully understanding the risk and clarity of the controls and assurances.

ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Impacts on all strategic objectives										
XB	**External reviews:** If we do not handle receipt of the external reviews well then we risk prolonging a period of disruption leading to attention being diverted from service delivery and patient care.	3 February 2026	18 May 2026	Peter Ridley	Trust Board	• Governor led governance structure in place via the governors review group. • Independent advice to governors in place.	• Once the governors review group have received the reports and instructed the board to take action we will be able to describe assurances	• None identified in relation to receipt of the reports.	• We do not yet know what will be in the reports.	• We are strengthening governance mechanisms and will further refine them once we know the recommendations in the reports.

Risk score over time

Executive Assurance Commentary:

There is medium likelihood (3) that there will be significant disruption (4)

The projected risk profile is based on the likelihood increasing for a period after the reports are received. It is envisaged that once any recommendations in the reports and from the governors are acted on, the risk of disruption to patient care will reduce.

The risk tolerance has been set at 6, the lower end of the risk appetite range for impact on patient care.

Assurance Committee's commentary:

At the board strategy session on 23 April the board agreed that this risk should be overseen by the chief executive. Assurances would go direct to the board with ongoing assurance on delivery against the governance improvement plan to be reported to relevant committees, coming together as one assurance to the board.

Governance improvements

Board of directors
4 June 2026

Report title	Governance improvements		
Report from	Ben Westmancott, interim company secretary		
Prepared by	Various board level inputs		
Previously considered at	Trust executive committee and board committees	Date	February-May
Link to strategic objectives	Strengthened governance supports successful delivery of all our objectives		

Executive Summary

Over the past six months a number of measures have been taken to strengthen the governance of Moorfields. They key strands have been:

1. Introduction of assure, advise, alert reporting from committees to the board to provide improved structure and consistency.
2. An internal review against the Care Quality Commission's well-led criteria identifying areas for strengthening
3. Carrying out board committee effectiveness reviews with committee members and key contributors leading to recommendations for improvement.
4. Executive then board review of the risk landscape and a reshaping of the board assurance framework to strengthen strategic risk management.
5. The introduction of a governance improvement plan structure to support continuous improvement.

This paper brings together these developments for the board's consideration and recommends next steps.

These improvements are being put forward in the context of the two external governance reviews that are expected to make a number of recommendations. It could be the case that we might need to alter the recommendations in the report; should that be the case, we will bring back an update to the next board meeting.

Quality implications
Good governance across the board is fundamental to high quality and safe services.

Financial implications
No new financial implications.

Risk implications
Risk management forms part of the overall governance agenda.

Action required/recommendation.
The Trust Board is asked to note the overall improvements to governance and consider the following recommendations:

Recommendation 1: The board is asked to agree the areas to improve the way the organisation is led (well-led recommendations).
Recommendation 2: The board is asked to agree that the key themes emanating from the committee effectiveness review are the right ones and, if so, commit to responding to them over the year.
Recommendation 3: The board is asked to approve the terms of reference of its committees as set out in annex 1 of this paper.

Recommendation 4: The board is asked to note that any changes to these recommendations, necessitated by the external governance reviews, will be brought to the next board meeting by way of an update.							
For assurance	**X**	**For decision**	**X**	**For discussion**		**To note**	**X**

1. Introduction and Purpose

Over the past six months the board has carried out work to review and strengthen the way it functions. This follows a successful restructuring of the executive committee structure to provide clearer leadership of executive matters, engagement of the wider leadership team, and delivery.

We are expecting two external governance reviews to arrive in the coming months. Should those reviews necessitate changes to the recommendations in this paper, an update will be brought to the board at its next meeting.

2. Well-led framework

The executives carried out an internal review against the regulator's well-led criteria in January and February 2026. This was a light-touch review with the intention of identifying where we can improve and strengthen the way we work. This took place alongside a review against the same criteria at divisional level. Pending a broader discussion by the board in a strategy session, the outputs of the high-level internal review were discussed further by the Trust Executive Team and shared with each board committee for their input. As a result of the committee scrutiny, there was a further step to focus on the suggested areas for improvement and prioritise them, specifically focusing on those that will enable to trust to deliver on its major change programmes in this and next year as well as its other priorities in pursuit of high quality and safe care.

The areas for prioritising were reviewed by a sub-group of executives and then by the Trust Executive Team on 19 May. These are presented here for consideration by the board; any reframing or amendment following receipt of the external governance reviews will be brought back to the board at its next meeting by way of an update.

Shared direction and culture

1. We need to improve how we close the loop i.e. check that we've done what we said we'll do and validate that it has made a positive difference (benefits realisation).

2. A management group has been set up which is looking at compliance with our policies.

3. The improvements to the integrated performance report are helping us identify and address unwarranted variation. The divisional level reviews of the IPR strengthen this.

4. By communicating the four priorities consistently we can strengthen how these translate to objectives that cascade throughout the organisation.

5. By strengthening the quality and consistency of appraisals, the focus on the four priorities will be strengthened.

Capable, compassionate and inclusive leaders

6. We have a stable leadership team. Given that we have a big agenda, it is important that we check-in regularly with our teams to ensure we are not inadvertently overloading people and that people's contributions are acknowledged and celebrated.

7. Leadership is more visible than before, and this is valued by staff. We need to ensure that this remains the case and is stepped up particularly through the transformation period. This covers executives, divisional, and clinical leaders.

8. We should capture leadership coaching and development support provided and ensure coaching is promoted especially to leaders stepping up into new roles.

Governance, management, sustainability

9. We have a clearer articulation of our risks as an organisation. Work needs to be done to further align the Board assurance framework and the trust wide risk register.

10. Leadership at executive level has been strengthened and this supports financial sustainability during increasingly pressured times on NHS resources. We could improve the way we join the dots between decisions that have financial, quality, and workforce implications i.e. the 'integratedness' of things.

Partnership and communities

11. We have strengthened the way we engage patients and receive feedback e.g. through clinical patient groups and patients as experts. We can strengthen the way we feedback (and the consistency of this across all our services) to the people we care for on changes that have been made in response to their contributions.

12. The strategy team is working on metrics to measure success and impact of our partnerships and the governance and oversight if this.

13. Regarding health inequalities, we are improving the way we capture data e.g. deprivation index captured via the single point of access (SPoA). The eye healthcare inequalities improvement group is looking at data and will be making recommendations. Leadership in this area from the incoming chief nurse and the director of strategy will help.

Freedom to speak up

14. We need to increase the consistency of how cultural intelligence is captured. We know there are inconsistencies across staff groups in speaking up and in staff experiences of working at Moorfields. Visible actions to acknowledge and address variation will help.

Workforce equality, diversity and inclusion

15. We know there are areas where staff are less confident about reporting bullying and harassment. From the WRES and DES data we know that representation at senior levels of the organisation needs to improve. We need to demonstrate the positive impact of equality and diversity initiatives.

Learning, improvement, and innovation

16. PSIRF is embedded as business as usual. We need to improve the consistency with timely reporting of incidents, documenting actions and evidencing positive changes made as a result of actions, and consistency of disseminating learning.

17. We need to improve how we learn from all forms of information including incidents, complaints, FFT, risk reporting, and quality monitoring/audit.

Environmental sustainability

18. We have strengthened resources to play our part in addressing the pressures on our planet with finite resources. Our green plan has been refreshed. We need to embed initiatives across all our sites and ensure that sustainability step changes expected from our major projects and evidenced and promoted.

Recommendation 1 **The board is asked to agree the areas to improve the way the organisation is led (well-led recommendations).**

3. Committee effectiveness

In March 2026 the board's committees carried out a review of the effectiveness alongside a paper review. The finding were presented to the May meetings of the committee. This section sets out the headline recommendations (for approval) and presents the refreshed terms of reference, annex 1 (for approval). In addition to the below, ways to strengthen executive ownership of papers brought to the board's committees emerged from committee discussions.

Key themes

- Committee structure is fit for purpose – no structural changes required
- Paper quality, timeliness, and presentation can be improved
- Some areas of overlap between committees
- Further work linking BAF, IPR, and strategy and alignment with committees
- Consideration of quality indicators to be reported for assurance
- Forward plan of business for the board and committees based on tors and assurance

Recommendation 2 **The board is asked to agree that the key themes emanating from the committee effectiveness review are the right ones and, if so, commit to responding to them over the year.**

Recommendation 3

The board is asked to approve the terms of reference of its committees as set out in annex 1 of this paper.

Recommendation 4:
The board is asked to note that any changes to these recommendations, necessitated by the external governance reviews, will be brought to the next board meeting by way of an update.

4. Next Steps

Recommendations agreed by the board will be implemented by the executives with assurances flowing into the board's committees as appropriate.

END

Annex 1: refreshed terms of reference for the board's committees

Discovery and Commercial Committee – TOR

Authority	1. The Discovery and Commercial 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. 2. These terms of reference have been approved by the Board and are subject to annual review.
Purpose	3. The purpose of the committee is to gain assurance, on behalf of the Board, of the following key areas; a. Discovery strategy and activity b. All commercial activity and areas of income generation c. Investment proposals relating to discovery and commercial, including the approval of business cases up to £2m d. Review of business cases and projects, including the return on capital and revenue invested
Membership	4. The members of the committee will be appointed by the Board and have a majority of non-executive directors over voting executive directors, as follows; a. Five non-executive directors, one of whom shall be nominated as chair b. Chief executive c. Chief finance officer d. Director of discovery e. Director of strategy and partnerships f. Chief medical officer 5. The committee chair will have a casting vote, if needed. 6. Others to be in attendance in full or part of the meeting, at the discretion of the committee chair, include: a. Director of BRC b. Director of CRF c. Head of commercial services 7. The committee chair may also invite others to attend where needed.
Quorum	8. The quorum will be four members, including two non-executive directors
Frequency of Meetings	9. The committee will meet bi-monthly and members are expected to attend at least 75% of meetings in any financial year.
Duties	10. The committee can only carry out functions authorised by the Board, as pertaining to discovery and commercial activities. **Delegated Functions** 11. The committee will carry out the following on behalf of the Board; a. Approval of business cases with a maximum of £2m (capital) as specified in standing financial instructions b. Ratification of contracts between £1.5m and £2m (revenue) c. Approval of variations to contracts with a maximum of £2m (revenue) d. Review of business cases and projects, including the return on capital and revenue invested

	Assurance Functions 12. The committee will review the following activities, pertaining to discovery and commercial, to provide assurance to the Board: a. Business cases over £2m prior to consideration by the Board, in line with standing financial instructions. b. Complex or critical business cases below £1m (capital) or below £1.5m (revenue), as referred by the chief executive. c. Contracts awarded outside standing financial instructions in excess of £1m. **Discovery** 13. Strategy 14. Intellectual property and income generation 15. Financial performance of discovery 16. Partnership with the Institute of Ophthalmology 17. Commercial partnership opportunities 18. Assurance on progress of discovery excellence projects **Partnerships** 19. NHS partnership activity **Commercial** 20. Commercial strategy (including Moorfields Private, international, and UAE) 21. Income generation and new collaborative or commercial partnerships (other than Discovery) **Other** 22. Specific risks on the board assurance framework allocated by the Board 23. Analyse and challenge appropriate information on performance related to discovery and commercial 24. Annual review and forward look for committee
Reporting and Review	25. Following each meeting of the committee, an update will be provided to the Board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination. 26. Minutes of meetings will be available for any board member on request. 27. The committee will carry out an annual deep dive review of its effectiveness against these terms of reference, including setting the forward plan for the next year. Dedicated time will be held at the last meeting of the FY for this review.
Sub-committees	28. The committee has the power to establish sub-committees or targeted working groups to address specific tasks. Sub-committees will be subject to annual review, or as required based on organisational priorities, against their terms of reference and reported to the committee in time for them to be included in the committee's own review of its effectiveness. Any sub-committee or working group will require its own terms of reference, approved by this committee. 29. Regular updates to the committee will be produced to provide assurance or request support. Efforts should be made to avoid

	duplicating items and discussions at the committee meeting that have taken place in sub-committees. 30. The committee has established an executive led Commercial Group to preview papers prior to presentation to the committee.		
Meeting administration	31. The lead executive for the committee will be the director of discovery and the secretary for the committee will be the company secretary. 32. The secretary's role will be to; a. Agree the agenda with the chair b. Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board's standing orders c. Maintain a forward plan of items for the committee d. Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) e. Ensure minutes are issued to the chair for review within one week of the meeting, and to committee members within two weeks of the meeting. f. Ensure actions are captured, notified to relevant staff and followed up 33. 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**	

Finance and Performance Committee – TOR

Authority	1. The Finance and Performance 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. 2. These terms of reference have been approved by the Board and are subject to annual review.
Purpose	3. The purpose of the committee is to gain assurance, on behalf of the Board, of the following key areas: a. Financial performance and delivery of the trust's budget b. Operational performance c. Performance management principles and processes d. Estates (business as usual, excluding Oriel, MoorConnect)
Membership	4. The members of the committee will be appointed by the Board so that there is a majority of non-executive directors over voting executive directors, as follows: a. Up to three non-executive directors, one of whom shall be nominated as committee chair b. Chief financial officer c. Chief operating officer 5. The committee chair will have a casting vote, if needed. 6. Others expected to be in attendance in full or part of the meeting, at the discretion of the committee chair, include: a. Chief people officer b. Deputy chief financial officer 7. The committee chair may also invite others to attend where needed, such as the chief nurse and chief medical officer.
Quorum	8. The quorum will be three, including at least two non-executive directors and one executive director
Frequency of meetings	9. The committee will meet at least six times per year and members are expected to attend at least 75% of meetings in any year.
Duties	10. The committee can only carry out functions authorised by the Board, as referenced in these terms of reference. **Assurance Functions** 11. The committee will review the following to provide assurance to the Board: **Annual priorities** 12. Annual set priorities for the committee and monitor progress throughout the year **Business case monitoring** 13. Methodologies used to assess business cases and other investments **Financial planning** 14. The financial aspects of the trust's annual business plans and the annual plan prior to submission to the Board for approval 15. The assumptions underlying budgets and plans 16. Scenario planning and stress testing of plans 17. Financial forecasts, including outturn and cash flow

<table>
<tr><td></td><td>Financial performance
18. Financial performance, including in depth analysis of income, expenditure, capital and cash
19. Overall financial performance of the trust’s portfolio of investments (individual committees responsible for assuring the specific investment performance of the decisions they take and the business cases they assure)
20. Development, management and delivery of cost improvement programme schemes
21. Ensure that financial performance monitoring across the organisation is effective and sufficiently granular

Operational Performance
22. Seek assurance that performance management principles and processes are embedded throughout the trust
23. Seek assurance operational performance is in line with agreed plans in order to drive service improvements
24. Review specific key performance metrics as agreed at the start of the year
25. Monitor productivity development and gains periodically
26. Ensure the Board is briefed on emerging performance management requirements, taking into account local and national policy
27. Seek assurance that the procurement performance is optimal and providing value for money

Estates
28. Assurance on items relating to business as usual activities of estates function as required.

Other Risk Management
29. All finance category risks on the trust risk register, any operational category risks and board assurance framework risks identified under both
30. Receive a presentation annually on each divisions risk register

Other
31. Receive reports from subcommittees as agreed by FPC and Trust Executive Committee

Other duties as agreed by the Board
32. Exceptional items explicitly requested by the board that fall outside the terms of reference</td></tr>
<tr><td>Reporting and review</td><td>33. Following each meeting of the committee, an update will be provided to the board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination.
34. Minutes of meetings will be available for any board member on request.
35. The committee will carry out an annual deep dive review of its effectiveness against these terms of reference, including setting the forward plan for the next year. Dedicated time will be held at the last meeting of the FY for this review. This will be reported to the board via the committee’s annual report, at the first available meeting after 1 April of each year.</td></tr>
<tr><td>Meeting administration</td><td>36. The lead executive for the committee will be the chief financial officer and the secretary for the committee will be the company secretary.
37. The secretary’s role will be to;
a. Agree the agenda with the chair
b. Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board’s standing orders
c. Maintain a forward plan of items for the committee</td></tr>
</table>

	d. Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) e. Ensure minutes are issued to the chair for review within one week of the meeting, and to committee members within two weeks of the meeting. f. Ensure actions are captured, notified to relevant staff and followed up 38. 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

Major Projects and Digital Committee – TOR

Authority	1. The Major Projects and Digital 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. 2. These terms of reference have been approved by the Board and are subject to annual review.
Purpose	3. The purpose of the committee is to gain assurance, on behalf of the Board, of the following key areas; a. Estates and facilities strategy b. Plans for future major physical estates projects c. Delivery of major physical (estates, facilities, major equipment) projects, and review, including the return on capital and revenue invested d. Digital development and IT strategy e. Plans for future major digital and IT projects f. Delivery of major digital and IT projects, and review, including the return on capital and revenue invested g. Capital strategy, business case processes and post project review
Membership	4. The members of the committee will be appointed by the Board and have a majority of non-executive directors over voting executive directors, as follows; a. Four/Five non-executive directors (including the chair of Audit and Risk Committee), two of whom shall be nominated as co-chair b. Chief finance officer c. Director of strategy and partnerships d. Chief operating officer e. Director of estates, capital and major projects f. Chief information officer g. Clinical representative 5. The appropriate committee co-chair at the time of voting will have a casting vote, if needed. 6. Others to be in attendance in full or part of the meeting, at the discretion of the committee chair, include: a. Trust chair b. The committee chair may also invite others to attend where needed.
Quorum	7. The quorum will be six members, including at least two non-executive directors
Frequency of Meetings	8. The committee will meet bi-monthly and members are expected to attend at least 75% of meetings in any financial year.
Duties	9. The committee can only carry out functions authorised by the Board, as pertaining to capital, estates, facilities, IT and digital activities. **Delegated Functions** 10. The committee will carry out the following on behalf of the Board; a. Approval of business cases with a maximum of £2m (capital) as specified in standing financial instructions b. Ratification of contracts between £1.5m and £2m (revenue) c. Approval of variations to contracts with a maximum of £2m (revenue)

	d. Review of business cases and projects, including the return on capital and revenue invested **Assurance Functions** 11. The committee will review the following activities pertaining to capital, estates, facilities, IT and digital, to provide assurance to the Board; **Estates and facilities** 12. Strategy and annual plans, including annual review of site strategy 13. Implementation of major physical projects (estates, facilities and major equipment) 14. Major contracts within estates and facilities 15. Delivery and progress of major projects incl. relevant Excellence projects 16. Assurance on items relating to Estates function (other than major project delivery) as required, which includes specialist equipment and facilities (but not BAU – covered in the Finance and Performance Committee) **Digital Development and IT** 17. Strategy and annual plans 18. Implementation of major projects 19. Delivery and progress of major projects including relevant Excellence projects digital related excellence projects 20. IT operations and delivery of BAU **Capital** 21. Annual review of capital plan 22. Annual evaluation of capital allocation and sign off process 23. Review risks and benefits of the Trust's capital programme 24. Review key assumptions and methodologies used to inform the Trust's capital programme **Other** 25. Specific risks on the Board Assurance Framework allocated by the Board 26. Analyse and challenge appropriate information on performance related to Major Projects and Digital 27. Annual review and forward look for committee
Reporting and Review	28. Following each meeting of the committee, an update will be provided to the Board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination. 29. Minutes of meetings will be available for any board member on request. 30. The committee will carry out an annual deep dive review of its effectiveness against these terms of reference, including setting the forward plan for the next year. Dedicated time will be held at the last meeting of the FY for this review.
Sub-committees	31. The committee has the power to establish sub-committees or targeted working groups to address specific tasks. Sub-committees will be subject to annual review, or as required based on organisational priorities, against their terms of reference and reported to the committee in time for them to be included in the committee's own review of its effectiveness. Any sub-committee or working group will require its own Terms of Reference, approved by this committee. 32. Regular updates to the committee will be produced to provide assurance or request support. Efforts should be made to avoid duplicating items and discussions at the committee meeting that have taken place in sub-committees.

<table>
<tr><td>Meeting administration</td><td colspan="3">33. The lead executive for the committee will be the chief operating officer and the secretary for the committee will be the company secretary.
34. The secretary’s role will be to;
a. Agree the agenda with the chair
b. Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board’s standing orders
c. Maintain a forward plan of items for the committee
d. Be responsible for the production and quality of the minutes (even if taken by a separate minute taker)
e. Ensure minutes are issued to the chair for review within one week of the meeting, and to committee members within two weeks of the meeting.
f. Ensure actions are captured, notified to relevant staff and followed up
g. Any other administrative arrangements not listed here will be as shown in the standing orders of the Board of Directors.</td></tr>
<tr><td>Date approved by the Board</td><td></td><td>Date of next review</td><td></td></tr>
</table>

Standing financial instructions and scheme of delegation

https://eyeq.moorfields.nhs.uk/download.cfm?doc=docm93jijm4n815.pdf&ver=8492

People & culture committee - terms of reference

Authority	1. The people & culture committee is a formal committee of the Board and is authorised to either provide assurance to the Board or carry out delegated functions on its behalf. 2. These terms of reference have been approved by the Board and are subject to annual review.
Purpose	3. The overarching purpose of the committee is to gain assurance, on behalf of the board, that the Trust workforce can deliver current and future quality healthcare. This is broken down into the following areas: 4. Workforce Transformation: strategic alignment with trust strategy and progress with delivery of strategy covering: a. the alignment and effectiveness of the workforce strategy with the overall strategy for the Trust and the wider NHS b. the effectiveness of the Moorfields team to deliver the workforce strategy (including any new operating model) 5. Education and training* covering: a. the strategic alignment of the development of the Trust workforce with overall strategies b. progress with delivery of strategy through assurance of education and training outputs 6. Oversight of Workforce (through quantitative KPIs and qualitative Feedback) covering: a. the wellbeing, recruitment, retention, management and development of the Trust's workforce b. the Trusts obligations across all aspects of ED&I (Equality, Diversity, and Inclusion) c. organisational capacity management (skills, locations, sourcing) for the Trust's affairs and additional responsibilities across the wider system d. issues relating to ethics and duty of care in the conduct of the Trust's affairs towards its workforce (including Freedom to speak up) e. the effectiveness of workforce operations (processes, data, and systems) in the delivery of Moorfields services f. oversight of risk management for workforce and education related risks 7. The committee will oversee a balanced scorecard of key performance metrics relating to its remit on behalf of the Board. 8. * The commercialisation of the Education and training strategy will be covered by the D&C Committee
Membership	9. The members of the committee will be appointed by the Board as follows; a. At least two non-executive directors, one of whom shall be nominated as chair

	b. Chief People Officer c. Director of Nursing and Allied Health Professions d. Medical Director e. Chief Operating Officer f. Director of Education 10. Others may attend as agreed by the committee chair as necessary.
Quorum	11. The quorum will be four members, including one non-executive director
Frequency of meetings	12. 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	13. The committee can only carry out functions authorised by the Board, as referenced in these terms of reference. **Delegated Functions** 14. The committee will carry out the following on behalf of the Board: 15. analyse and challenge appropriate information on organisational and operational performance in relation to the committee's purpose. This information should cover: a. strategic priorities (e.g. diversity, skills, talent, NHS targets etc (tbc)) b. workforce utilisation c. health (including sickness) and well being d. engagement e. financial measures **Assurance Functions** 16. The committee will review the following to provide assurance to the Board: a. the existence and effective operation of systems to ensure that the trust has in place sufficient capacity and appropriately qualified/skilled to ensure compliance with the conditions of the licence b. wellbeing, recruitment, retention, management and development policies and processes c. the workforce strategy of the trust and its implementation d. the education strategy of the trust and its effectiveness e. the approach the trust has to ensuring it fulfils its public sector equality duty for staff, patients and visitors f. specific risks on the corporate risk register allocated by the board g. the development of workforce governance, including workforce engagement processes **Other duties as agreed by the board** 17. Exceptional items explicitly requested by the Board that fall outside the terms of reference
Reporting and review	18. Following each meeting of the committee, an update will be provided to the board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination. 19. Minutes of meetings will be available for any board member on request.
Sub-committees	20. The Committee has the power to establish sub-committees or targeted working groups to address specific tasks. This will be reviewed on an annual

<table>
<tr><td></td><td colspan="3">basis, or as required based on organisational priorities. Any sub-committee will require its own terms of reference, approved by this committee.
21. The committee may also appoint a workforce advisory group with specific objectives to :
a. improve engagement between the committee and the workforce
b. to ensure the voice of the employee plays a prominent role in the operations of the committee.</td></tr>
<tr><td>Meeting administration</td><td colspan="3">22. The lead executive for the committee will be the Chief People Officer and the secretary for the committee will be the company secretary (or an appointee on behalf of the company secretary).
23. The role of the lead executive, in conjunction with the secretary, will be to;
a. Agree the agenda with the chair
b. Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board's standing orders
c. Maintain a forward plan of items for the committee
d. Be responsible for the production and quality of the minutes (even if taken by a separate minute taker)
e. Ensure minutes are issued to the chair for review within one week of the meeting, and to committee members within two weeks of the meeting.
f. Ensure actions are captured, notified to relevant staff and followed up
24. Any other administrative arrangements not listed here will be as shown in the standing orders of the board of directors</td></tr>
<tr><td>Date approved by the board</td><td></td><td>Date of next review</td><td></td></tr>
</table>

Quality and safety committee - Terms of Reference

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

The committee will carry out the following on behalf of the board:

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

Assurance functions

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

Clinical effectiveness

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

Patient Safety

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

Patient participation and experience

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

Overall

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

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

<table>
<tr><td colspan="3">Approved by the quality and safety committee</td><td>May 2026</td></tr>
<tr><td>Approved by the board</td><td></td><td>Date of next review</td><td></td></tr>
</table>

Meeting:	Board of Directors
Date:	4 June 2026
Report title:	Governance schedule
Lead executives	N/A
Report Author	Ben Westmancott, Interim Company Secretary
Presented by	N/A
Status	For noting
Link to strategic objectives	N/A

Brief summary of report

The purpose of the governance schedule is to ensure the board notes the register of directors and that there is clarity on committee membership. Similarly, it sets out the governors who make up the Membership Council by constituency.

Action Required/Recommendation.

The board is asked to note the governance schedule.

For Assurance		For decision		For discussion		To note	X

GOVERNANCE SCHEDULE

Board Membership

Name	Title	Designation	Current Term of Office ending:
Tim Briggs	Interim Chair	Non-Executive	Awaiting NHSE sign-off
Adrian Morris	Senior Independent Director	Non-Executive	31 March 2027
Asif Bhatti		Non-Executive	22 May 2028
Andrew Dick		Non-Executive	30 September 2026
David Hills		Non-Executive	31 March 2026
Elena Lokteva		Non-Executive	31 December 2028
Michael Marsh		Non-Executive	3 November 2028
Aaron Rajan		Non-Executive	28 February 2027
Vacant NED position		*Non-Executive*	
Vacant associate NED position		*Associate Non-Executive*	
Peter Ridley	Chief Executive Officer & AO	Executive - voting	N/A
Jon Spencer	Chief Operating Officer	Executive - voting	N/A
Louisa Wickham	Chief Medical Officer	Executive - voting	N/A
Simmi Naidu	Chief Nurse & Director of AHPs	Executive - voting	N/A
Sue Steen	Chief People Officer	Executive - voting	N/A
Arthur Vaughan	Chief Finance Officer	Executive - voting	N/A
Vacant position	*Director of Research & Discovery*	Executive	N/A
Elena Bechberger	Director of Strategy & Partnerships	In attendance	N/A
Victoria Moore	Director of Transformation & Performance Improvement	In attendance	N/A

Updated: 01 June 2026

Committee Membership

Committee	Members
Discovery & Commercial	***Vacant NED position*** **(Chair)**
	Elena Lokteva (Interim Chair)
	Andrew Dick
	Adrian Morris
	Director of Research & Discovery
	Chief Medical Officer
	Chief Executive
	Chief Finance Officer
	Director of Strategy & Partnerships
Audit & Risk	**Asif Bhatti (Chair)**
	David Hills
	Elena Lokteva
	Michael Marsh
Finance & Performance	**Elena Lokteva (Chair)**
	Asif Bhatti
	David Hills
	Vacant NED position
	Chief Finance Officer
	Chief Operating Officer
Major Projects & Digital	**David Hills & Aaron Rajan (Co-chairs)**
	Elena Lokteva
	Adrian Morris
	Asif Bhatti
	Chief Finance Officer
	Chief Operating Officer
	Director of Strategy & Partnerships
	Chief Information Officer
	Director of Estates, Capital & Major Projects
People & Culture	**Aaron Rajan (Chair)**
	Michael Marsh
	Chief People Officer
	Chief Nurse & Director of AHPs
	Chief Medical Officer
	Chief Operating Officer
	Director of Education
Quality & Safety	**Michael Marsh (Chair)**
	Andrew Dick
	Vacant NED position
	Chief Nurse & Director of AHPs
	Chief Medical Officer
	Chief Executive
	Chief Operating Officer
Remuneration & Nominations	**Tim Brigss (Chair)**
	Adrian Morris
	Asif Bhatti
	David Hills
	Elena Lokteva
	Michael Marsh
	Aaron Rajan

Updated: 01 June 2026

Council of Governors

Name	Designation	Constituency	Current Term of Office ending:
Rob Jones	Lead governor / patient governor	Patient	31 March 2027
Allan MacCarthy	Vice chair / public governor	South East London	31 March 2028
Amit Arora	Staff governor	City Road	31 March 2027
Vijay Arora	Public governor	North West London	31 March 2027
Sade Bakare	Staff governor	Network sites	31 March 2028
Emily Brothers	Patient governor	Patient	31 March 2029
Margaret Connor	Public governor	Beds & Herts	31 March 2028
Sean Cooke	Public governor	North East London & Essex	31 March 2027
Robert Goldstein	Public governor	North Central London	31 March 2027
Ian Humphreys	Nominated governor – Partnership	College of Optometrist	Ongoing
Kimberley Jackson	Public governor	South West London	31 March 2028
Yasir Khan	Staff governor	Network sites	31 March 2027
Paul Murphy	Public governor	North Central London	31 March 2027
Junia Rahman	Staff governor	City Road	31 March 2029
John Russell	Public governor	North East London & Essex	31 March 2028
Ursula Smartt	Patient governor	Patient	31 March 2027
Tricia Smikle	Nominated governor – Partnership	Royal National Institute of Blind People	Ongoing
Dinesh Solanki	Public governor	North West London	31 March 2027
Naga Subramanian	Public governor	North East Lonfon	31 March 2027
Emmanual Zurdis	Public governor	South West London	31 March 2028
VACANT		*Beds & Herts*	
VACANT	*Nominated governor – Partnership*	*London borough of Islington*	

Updated: 01 June 2026

Council of Governors sub committees and groups

Non-executive Nominations & Remuneration Committee	**Kimberley Jackson (Chair)** Allan MacCarthy Amit Arora (staff governor) Robert Goldstein Tricia Smikle (appointed governor) Emmanual Zurdis *VACANY*
Members and Patient Engagement Group	**Emily Brothers (Chair)** Ian Humphreys John Russell Paul Murphy Tricia Smikle Vijay Arora
Governance Development Group	**Ian Humphreys (Chair)** Allan MacCarthy Emily Brothers Kimberley Jackson Paul Murphy Rob Jones *VACANY*
Review Group	**Rob Jones (Chair)** Allan MacCarty Emily Brothers Ian Humphreys Rob Jones Paul Murphy Robert Goldstein

Updated: 01 June 2026