Bundle Board of Directors - Part 1 24 September 2026

1 09:00 - Welcome and introductions
Tim Briggs, Interim Chair
260724 TB Part I Item 00 Agenda

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

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

4 Declarations of interest
Tim Briggs, Interim Chair
260924 TB Part I Item 04 Register of interests BoD v2.4

5 Minutes of the previous meeting
Tim Briggs, Interim Chair
260924 TB Part I Item 05 Minutes of Meeting in Public 260730 DRAFT

6 09:30 - Matters arising and actions log
Tim Briggs, Interim Chair
260924 TB Part I Item 06 Action log

7.a 09:35 - Chief Executive's Report
Peter Ridley, Chief Executive
260924 TB Part I Item 07 CEO report public v3

7.b APPENDIX 1: Governance review (BB)
Peter Ridley, Chief Executive
260924 TB Part I Item 07b Governance review update v8.1

8 09:50 - Board assurance framework
Ben Westmancott, Interim Company Secretary
260924 TB Part I Item 08(i) BAF cover
260924 TB Part I Item 08(ii) BAF 2026-27 Sept

9 09:55 - Advance foundation trust application process
Elena Bechberger, Director of Strategy & Partnerships
260924 TB Part I Item 09 Advanced Foundation Trust Status - June 2026

10 10:05 - Oriel update
Jon Spencer, Chief Operating Officer
260924 TB Part I Item 10(i) Oriel cover
260924 TB Part I Item 10(ii) Oriel Summary Report

11 10:10 - Chief Nurse's Report
Simmi Naidu, Chief Nurse and Director of Allied Professionals
260924 TB Part I Item 11 CNO quality report

12 10:15 - Annual safeguarding report
Simmi Naidu, Chief Nurse and Director of Allied Professionals
260924 TB Part I Item 12(i) Safeguarding (CYPADULTS) Annual Report 2025-26
260924 TB Part I Item 12(ii) Safeguarding (CYPADULTS) Annual Report 2025-26

13 10:20 - Learning from deaths
Louisa Wickham, Chief Medical Officer
260924 TB Part I Item 13 Learning from deaths (Q1 2026-27)

14 10:25 - People & Culture Committee Chair's Report
Ken Batty, Non-executive Director
260924 TB Part I Item 14 PCC AAA report

15 10:35 - Finance & Performance Committee Chair's Report
Elena Lokteva, Non-executive Director
260924 TB Part I Item 15 FPC AAA report

16 10:45 - Finance Report - M5
Arthur Vaughan, Chief Finance Officer
260924 TB Part I Item 16(i) M5 2026-27 Public finance report - cover
260924 TB Part I Item 16(ii) M5 2026-27 Public finance report

17 10:50 - Integrated Performance Report - M5
Executive Team
260924 TB Part I Item 17(i) M5 IPR cover
260924 TB Part I Item 17(ii) M5 IPR
260924 TB Part I Item 17(iii) M5 IMM

18 10:55 - MoorConnect update
Jon Spencer, Chief Operating Officer
260924 TB Part I Item 18 MoorConnect update

19 11:00 - Discovery & commercial committee terms of reference
Tracey McNeill, Non-Executive Director
260924 TB Part I Item 19(i) Committee terms of reference
260924 TB Part I Item 19(ii) Terms of reference

20 Starred items:
Tim Briggs, Interim Chair

20.a 11:05 - Governance schedule
Ben Westmancott, Interim Company Secretary
260924 TB Part I Item 20a(i) 2026 Governance Schedule cover
260924 TB Part I Item 20a(ii) 2026 Governance Schedule v1.8

20.b 11:05 - Annual infection prevention control report
Simmi Naidu, Chief Nurse and Director of Allied Professionals
260924 TB Part I Item 21b(i) IPC Annual Report 2025-26 - cover
260924 TB Part I Item 20b(ii) IPC Annual Report 2025-26 Final

21 11:05 - Any Other Business
Tim Briggs, Interim Chair

22 11:10 - Questions from observers
Tim Briggs, Interim Chair

23 11:30 - Date of the next meeting: 26 November 2026

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on Thursday 24 September 2026 at 09:00
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.	Board assurance framework	Note	Enclosed	PR	5
8.	Chief executive's report	Note	Enclosed	PR	15
9.	Advance foundation trust application process	Note	Enclosed	EB	10
10.	Oriel update	Assurance	Enclosed	JS	5
	Quality				
11.	Chief nurse's quality report	Assurance	Enclosed	SN	5
12.	Annual safeguarding report	Approve	Enclosed	SN	5
13.	Learning from deaths	Note	Enclosed	LW	5
	People and Culture				
14.	People and culture committee chair's report	Assurance	Enclosed	AR	10
	Finance and Performance				
15.	Finance & Performance Committee chair's report	Assurance	Enclosed	EL	10
16.	Finance report	Note	Enclosed	AV	5
17.	Integrated performance report	Assurance	Enclosed	Exec team	5
20.	MoorConnect	Note	Enclosed	JS	5
21.	Discovery & commercial committee terms of reference	Approve	Enclosed	TM	5
22.	Starred items *(for discussion by exception only)* a) Governance schedule v1.8 b) Annual infection prevention control report				
23.	Any other business	Note	Oral	TB	5
	11:15 Meeting close followed by questions from members of the public and governors				
	Date of next meeting –24 November 2026 at 9am				

Cover Sheet	
Report title	**Register of interest – September 2026**
Meeting	Board of Directors
Date	24 September 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.

Moorfields Eye Hospital NHS Foundation Trust

NHS

REGISTER OF INTERESTS – last updated July 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
Aaron Rajan	**Non-executive director**	**Chief Digital Officer & VP Consumer Experience, Unilever PLC**	13 March 2026
Adrian Morris	**Non-executive director**	**General Counsel, Haleon PLC**	11 March 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
Asif Bhatti	**Non-executive director**	**Group Director of Risk and Audit, Compass Group PLC** **Non-executive director at House of Lords**	28 May 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**	4 June 2026

Moorfields Eye Hospital NHS Foundation Trust

NHS

		Fractional CFO, Tera Sky LTD **Non-executive director, Technoenergy AG** **Non-executive director Ratnamani Finow Spooling Private Limited** **Board member of Agriculture and Horticulture Development Board** **Board member of Ebbsfleet Development Corporation**	
Ken Batty	**Non-executive director**	**Independent Chair of Nominations Committee, Royal College of Emergency Medicine** **Member of the Appointments Board, Nursing and Midwifery Council** **Council Member, Queen Mary University London** **Independent member of Mayoral Appointments Panel, GLC** **Vice Chair, Inner Circle Educational Trust** **Chair, Mosaic LGBT+ Young Persons Trust** **Vice Chair, Dr Frost Learning**	29 June 2026
Michael Marsh	**Non-executive director**	**Non-executive director and Vice Chair at University Hospitals Dorset, effective September 2025**	17 March 2026
Tracey McNeill	**Non-executive director**	**Nil**	1 June 2026
Arthur Vaughan	**Chief financial officer**	**Nothing to declare**	10 March 2026
Jon Spencer	**Chief operating officer**	**Trustee, Friends of Moorfields** **Director of Moorfields Private West End Ltd**	17 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
Simmi Naudi	**Chief nurse and director of AHPs**	**Nothing to declare**	11 March 2026
Sue Steen	**Chief people officer**	**Trustee, St Margarets Hospice** **Trustee, Victim Support UK**	10 March 2026
Non-voting directors			
Brendan Mahony	**Chief information officer**	**Nothing to declare**	10 March 2026
Dilani Siriwardena	**Director of clinical partnerships and deputy chief medical officer**	**Nothing to declare**	21 January 2026
Elena Bechberger	**Director of strategy & partnerships**	**Trustee, The Brain Tumour Charity**	10 March 2026
Ian Tombleson	**Director of quality & safety**	**Nothing to declare**	19 March 2026
Kieran McDaid	**Director of estates, capital and MP**	**Nothing to declare**	20 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
Victoria Moore	**Director of transformation & performance improvement**	**Nothing to declare**	12 March 2026

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
Minutes of the meeting of the Board of Directors held in public on 4 June 2026
Education Centre, Ebenezer Street, and via MS Teams

Board members:	Professor Tim Briggs (TB)	Interim chair
	Peter Ridley (PR)	Chief executive
	Ken Batty (KB)	Non-executive director
	Asif Bhatti (AB)	Non-executive director
	Elena Lokteva (EL)	Non-executive director
	Adrian Morris (AM)	Non-executive director
	Michael Marsh	Non-executive director
	Tracey McNeill (TM)	Non-executive director
	Simmi Naidu (SN)	Chief nurse and director of allied professionals
	Aaron Rajan (AR)	Non-executive director
	Sobha Sivaprasad (SS)	Acting director of research and innovation
	Jon Spencer (JS)	Chief operating officer
	Sue Steen (SS)	Chief people officer
	Louisa Wickham (LW)	Chief medical officer
In attendance:	Elena Bechberger (EB)	Director of strategy and partnerships
	Justin Betts (JB)	Deputy chief finance officer
	Princess Cole (PC)	Lead FTSU guardian (item 14)
	David Hills (DH)	Associate non-executive director
	Jess Humphries (JH)	Patient experience and customer care manager (2)
	Victoria Moore (VM)	Director of transformation & performance improvement
	Jennie Phillips (JP)	Deputy company secretary
	Ian Tombleson (IT)	Director of quality and safety
	Ben Westmancott (BW)	Interim company secretary

Several staff, governors and members of the public observed the meeting in-person and online.
In the room: Junia Rahman
Online: Vijay Arora, Paul Murphy, Robert Goldstein, Dinesh Solanki, John Russell,

1. Welcome

The chair opened the meeting and welcomed all those present and in attendance. He particularly welcomed Ken Batty to his first board meeting as a non-executive director.

Introductions were completed.

2. Patient story

The board received a patient story which described the patient's experience of accessing ophthalmology services, including both urgent care and planned care.

The patient described the positive impact of clinical care and highlighted the importance of a welcoming, accessible and supportive experience for patients. The board noted the anxiety that patients can experience when accessing urgent eye care and the importance of clear communication, empathy and reassurance.

The board discussed the value of patient insight in shaping improvement work, particularly in relation to patient communications, digital access, and the booking centre. It was noted that patient involvement would continue to be important in ensuring that future service changes were accessible and responsive to the needs of different patient groups.

The board thanked the patient for sharing their experience and for their continued contribution to the Trust's work.

Action: the chief operating officer to consider how the patient's feedback can inform planned work on the booking centre, patient communications, and Oriel readiness.

3. Apologies for absence

Apologies were received from Andrew Dick and Arthur Vaughan.

4. Declaration of interest in relation to the agenda

The chair invited declarations of interest.

The chair made a declaration in relation to his involvement in the national single point of access programme and that he had been appointed chair of the New Hospital Programme Design Authority. He stated that Oriel had progressed to an extent that the likelihood of a conflict between this new role and his role at the trust was minimal. No further declarations were made.

The board noted the declaration and agreed that there were no conflicts with the agenda.

No other declarations were made.

5. Minutes of the previous meeting

The minutes of the meeting held on 4 June 2026 were approved as an accurate record.

6. Matters arising and action log

A query was raised in relation to the number of endophthalmitis cases referred to in the previous minutes compared with the current board report. It was clarified that the cases referred to in the current report were new cases i.e. two cases in the previous report and three new cases in this report.

In relation to complaints, the board heard that significant work had taken place with divisions to acknowledge complaints within three working days. The NHS England target was to respond to complaints within 40 days; however, the trust was working to a stretch-target of 25 days, and 80% of cases were dealt with within this timeframe.

The board noted updates in relation to tackling antisemitism and other forms of racism. The trust has adopted the NIHR definition of antisemitism and was working through, with colleagues across the NHS, what that means in practice e.g. how to reflect this in equality, diversity, and inclusion policies.

Regarding the overrunning clinic and impact of resident doctor hours of work, the chief medical officer stated that there was a particular clinic which regularly overran and that a long-term locum had been in place for a period and this had impacted leadership.

It was agreed that these matters would continue to be monitored at committee level with assurances to the board as appropriate.

7. Board Assurance Framework

The board received the board assurance framework.

The Board noted that the framework had been considered at committee level and by was intended to support the Board in framing its discussion of agenda items.

The Board noted the Board Assurance Framework.

8. Chief executive's report

The chief executive introduced the report and highlighted key matters relating to operational delivery and major programmes.

The board noted that the Oriel programme was progressing, with continued work on building safety regulations, regulator engagement and partner working. The board also noted that work on site was progressing following the short pause.

The chief executive drew attention to the complexity of the MoorConnect programme and the interdependencies requiring active alignment. The board was advised that the trust was increasing the level of independent assurance for the programme to support safe implementation and reduce the risk of an adverse impact on access to services.

The board also noted that final reports from independent governance reviews were expected shortly. These would be brought through the appropriate governance routes, including the membership council and board, with further consideration of recommendations and next steps.

The board noted the new NHS patient standards and noted that an assessment would be carried out and reported to the quality and safety committee for assurance with a subsequent update to the board.

The board welcomed the new NHS leadership framework on culture and stated that it would help support the trust's work on the culture programme.

Attention was drawn to the Nottinghamshire report on maternity and mortuary services and that the findings were about the fundamentals of care. It was also emphasised that a slide with a patient's' tissue sample was just as important as an organ and should be treated with the same level of respect.

The chair added that it was crucial that the trust played its part in supporting the wider system during winter and other periods of pressure. The best way of contributing support was to improve productivity and efficiency including avoiding 'fallow lists'.

The board noted that Pete Thomas would be standing down to pursue other projects and recorded its thanks to Pete for all his work as a consultant and member of the executive team and wished him well.

The Board noted the Chief Executive's report.

9. Oriel update

The Board received an update on the Oriel programme.

The board noted that work on site was progressing and that partner engagement on building safety and regulatory matters was continuing. A new regulator had been appointed to replace CAI. The board also noted the outcome of the national programme readiness assessment, which had resulted in an amber rating. It was reported that the feedback broadly reflected the Trust's own assessment and provided helpful third-party validation.

The board discussed the remaining areas of focus, including the target operating model and move planning. It was noted that these areas had already been prioritised by the programme team. It was confirmed that a thorough assessment on operating models had been carried out one year ago and these were being used as a baseline to measure progress against together with new Oriel models and best practice.

The board considered the relationship between Oriel and MoorConnect and noted the importance of managing EPR and Oriel timelines together.

The board challenged whether staff concerns about IT hardware and reliability were being addressed as part of the move. It was reported that the future position would involve a mixture of new equipment and transferred devices, with work taking place across networking, systems and hardware.

The board sought assurance on the potential cost implications of delays. It was reported that an optimism bias of approximately £5mn was included and that the current assessment was that costs could be covered within that provision, unless further building works were required.

The board queried risks in radiology and sterile services post Oriel. Radiology was mostly about having the right staff and risks here were minimal. Outsourcing sterile services meant that a third party would provide this service off-site. The infection prevention and control committee would receive assurances that the contract was delivering to the required quality. It was noted that disposable surgical kits were available as back-up to minimise the risk of clinical cancellations should there be any problems. The board encouraged close monitoring of service quality, as a poor service could lead to list cancellations.

Benefits realisation remained important and there would be mechanism to monitor this in the context of partnership working with UCL and the MEH charity.

It was confirmed that the CQC had been involved at key stages of the process in order to ensure a smooth CQC registration process.

The board noted the Oriel update and the current assurance position.

Action 26/03: The Oriel programme team to continue reporting on programme readiness, the target operating model, move planning, IT readiness and cost implications through the major projects and digital committee and board as appropriate.

10. Quality & Safety Committee chair's report

The board received the quality and safety committee chair's report and considered the committee's terms of reference.

The board noted the committee's consideration of patient experience, complaints, duty of candour, violence and aggression, and related quality and safety matters. The board noted that duty of candour compliance had dipped to 50% in the most recent month, following stronger performance in the previous three months. It was reported that focused work was taking place with divisions to understand the reasons for this and improve compliance.

The board discussed the reported increase in physical and verbal racist abuse of staff. It was emphasised that violence, aggression and racist abuse were unacceptable and that staff had the right to feel safe at work. The Board noted work to ensure that staff understood the relevant processes and that support was provided when incidents occurred.

There was a discussion on the SurgiCube units at Stratford that had been closed for three weeks following the identification of high particle rates. Work would continue to ensure surgery could recommence as soon as safety was confirmed.

There was a discussion on the three cases of endophthalmitis and the profound effect this has on people who acquire it. The trust was significantly below the national average of 0.2%; however, it was important for assurances to be received that every effort was being made to eliminate infections.

Decision: The board approved the quality and safety committee terms of reference.

Decision: The board noted the quality and safety chair's report.

Action: The chief nurse and divisional teams to continue focused work to improve duty of candour compliance and report progress through the quality and safety committee.

Action: Executive leads to continue work to prevent and respond to violence, aggression and racist abuse of staff, including staff support and clarity of process.

Action: The chief nurse and chief medical officer to work together to provide an assurance on infection control.

11. Chief nurse's report

The chief nurse introduced her report.

Themes had been covered by the committee chair and the discussion covered:

- The need to ensure more even compliance with the duty of candour and ensure better record keeping
- The importance of a zero-tolerance approach to aggression towards staff (it was noted that there were no specific themes at the trust; however, there a national increase had been noted following civil unrest in early July linked to fears over immigration and asylum. It was agreed that islamophobia should be called out as well as antisemitism and other forms of racism if these were evident in order to understand the problem on a more granular level and target support to staff and our organisational response more effectively. Under-reporting was thought likely.
- The chief people officer stated that staff had been making use of staff drop-in sessions for support.
- A recent incident in A&E where a patient had exposed themselves to a member of staff on a video call was flagged and concern expressed that more might need to be done to prevent this sort of behaviour. The chief nurse responded by saying that the trust was reviewing the availability of security staff; that particular incident had been reported to the

police; the trust uses a system of yellow and red cards for patients that behave inappropriately toward staff; and we have staff safety champions in place to advocate for staff.

Action 26/04: It was agreed that the violence and aggression towards staff policy should be reviewed to ensure that it captured explicit types of behaviours that were unacceptable.

Decision: The board received the chief nurse's report for assurance

12. Guardian of safe working

The board received the guardian of safe working report.

There was a discussion on a recent incident involving a resident doctor who was covering the on-call rota at Great Ormond Street Hospital (GOSH) and was called in to carry out urgent surgery overnight. Leaders at Moorfields had met with their counterparts at GOSH in order to refine arrangements for managing acute situations to ensure staff were not exposed to risks relating to long hours.

Decision: The board noted the guardian of safe working report.

13. People & culture committee chair's report

The board received the people and culture committee chair's report.

The board discussed workforce experience, culture, representation, recruitment equity and progression. It was noted that progress had been made in representation, recruitment equity and some structural inequalities. However, the board noted that the papers presented a consistent picture that further work was required on staff experience, progression and career pathways.

The board noted that BME representation had increased from 58% to 61%, remaining above London and national NHS averages. Female representation had increased from 50% to 53%. The board also noted that the mean gender pay gap had improved from 21% to 16%, while recognising that further work was required.

The board discussed the lived experience of disabled staff and BME staff, including issues relating to development, promotion, harassment, bullying and discrimination. The Board noted the links between these areas and the Trust's wider culture programme.

The board also discussed opportunities to strengthen local employment pathways, apprenticeships, volunteering routes and relationships with the local community as part of Oriel and wider workforce planning. It was noted that for entry-level roles, the trust received between 300 and 400 applicants for each role. Opportunities for volunteers to progress into jobs were encouraged.

The board noted that the recently introduced resolution policy was providing a clearer framework to enable staff to address issues; however, it was too early to identify a measurable impact.

Attention was drawn to higher-than-average levels of long-term sickness.

Decision: The board received the people and culture committee chair's report for assurance.

Action 26/05: People and culture leads to continue work on career progression, staff experience, equality, inclusion and local employment pathways, with progress reported through the people and culture committee

14. Freedom to speak up annual report

The board received the freedom to speak up annual report.

The lead freedom to speak up guardian introduced the report, which covered proactive and reactive activity from 1 April 2025 to 31 March 2026. A minor numbering error in the braille version of the report was noted, with confirmation that the data in the report was accurate and that the board pack contained the correct numbering.

The board noted positive progress against the trust's strategic objectives for making speaking up business as usual. This included empowering staff voices, improving data analysis, strengthening collaborative work with stakeholders, and focusing on training and visibility.

The board noted that the freedom to speak up champions network had expanded to 16 champions across the organisation. The board noted that the policy also applied to bank staff.

During questions, a point was raised about whether higher freedom to speak up case numbers compared with other specialist trusts should be interpreted cautiously. It was noted that higher case numbers could reflect visibility of the route but could also indicate the need for continued focus on culture and local resolution before issues escalate.

Attention was drawn to the staff survey data appended to the report and question 25f in particular that showed confidence in raising concerns and believing they would be addressed had fallen from 51.85% to 49.83% from 2024 to 2025. While it was noted that this question in the survey was broader than freedom to speak up, it was nevertheless something to be understood and addressed.

Decision: The board received the freedom to speak up annual report for assurance.

Action: The freedom to speak up guardian and executive lead to ensure future reporting continues to address themes, independence, escalation routes and links to wider culture work.

15. Gender pay gap annual report

The board received the gender pay gap annual report.

The board noted that the mean gender pay gap had improved from 21% to 16%, while recognising that the remaining gap required continued attention.

The board noted the wider context of workforce representation and progression, including improvements in BME and female representation and the need for continued focus on staff experience and career pathways.

The board raised a question about the statistic that 70% of all bonuses were awarded to men in 24/25 despite men making up 57% of the workforce. The chief medical officer stated that this was linked to a higher proportion of senior male consultants. She added that after the recent

reorganisation of senior leadership, women now made up just of half of the senior medical leadership.

Decision: The board received the gender pay gap annual report for assurance.

16. Finance & Performance Committee chair's report

The board received the finance and performance committee chair's report.

The procurement team were congratulated for securing £1.3mn in savings from contract reviews. It was also noted that £9.8mn in cost improvements had been identified overall of which £8mn was recurrent. It was agreed that the BAF entry relating to financial sustainability should demonstrate a trajectory over three years. The board recorded its thanks to the director of transformation and performance improvement for leading the CIP programme as well as the chief commercial officer for the procurement savings.

The committee would be scrutinising plans to achieve longer-term sustainability, noting that there was a forecast £11mn underlying deficit post Oriel.

Decision: The board received the finance and performance committee chair's report for assurance.

17. Finance report

The board received the month three finance report.

The board noted that the capital plan was progressing well and that cash position was stable. Regarding the capital plan, Oriel and MoorConnect had been prioritised. Regarding the savings plan, it was noted that it was not uncommon for such plans to be back-ended.

The chief executive added that the report indicated a positive position for the end of the first quarter; however, urged caution and not to take anything for granted. Regarding capital spend available for equipment and backlog maintenance, Oriel was a mitigation for a significant part of this.

Decision: The board received the finance report for assurance.

18. Integrated performance report

The board received the integrated performance report.

The board noted that the latest National Oversight Framework data for quarter 4 2025/26 ranked the trust sixth out of 134 specialist trusts, placing the trust in the high-performing segment. It was reported that four of the five domains were in the high-performing section and one was above average.

The board noted that the month 3 integrated performance report showed four metrics with special cause improvement. These were areas where targeted improvement programmes were in place. The board also noted that most metrics were within normal range and that three were flagging as concerns. It was noted that June had been a challenging month due to the hot weather and the continued impact of incidents earlier in the year. Being 0.8% below target for RTT indicated that improvements were needed; however, it was thought that improvements would be seen following what had been an exceptional month. The call centre had also experienced operational challenges; although all vacancies had been filled, call numbers were higher than anticipated. In addition, there were some leadership challenges to be addressed.

The board noted strong performance in access to services, reliable complaints acknowledgement, ongoing work on the wider complaints process, and improvements in theatre utilisation and workforce demand. It was also noted that national workforce demand was reducing and that this was reflected in the trust's position.

The board discussed theatre utilisation and noted that theatres in Bedford delivered ten cataract surgeries each list. In the case of patients not attending surgery or other clinics (DNAs), the trust contacted them to rebook; in some cases, a telephone consultation was appropriate. In the case of multiple DNAs, a clinically led discussion took place whether to discharge the patient.

The board discussed targeted improvement work on access, including additional capacity, validation, weekly tracking of 52-week patients and work on patient communications.

The board discussed latest clinically appropriate date (LCAD) and vitreoretinal emergency (VRE) waits and it was confirmed that the quality and safety committee would look at these in further detail.

The board discussed the duty of candour and noted that the ten-day resolution target was challenging to achieve; changing behaviours was key to achieving this target.

The board noted that the integrated performance report was now supported by monitoring metrics, including issues flagged in relation to freedom of information act requests and sickness absence. It was reported that the process was maturing and was highlighting areas requiring further review.

The board also discussed whether the integrated performance report should provide a stronger integrated view of staff experience, including links to violence and aggression, workforce metrics and the trust's culture programme.

The board discussed sickness absence at 4.9% and it was noted that there were some delays with occupational health referrals. The board discussed appraisals and noted that as at the morning of the meeting, 66% of staff had had an appraisal and had it signed off. The target was 80% by the end of July. There would be a grace period for one-month before action being taken.

Decision: The board received the integrated performance report for assurance.

Action: Executive leads to continue targeted improvement work on access, 52-week waits, complaints, theatre utilisation, patient communications, Freedom of Information, sickness absence and integrated staff experience reporting.

19. Governance schedule (starred item)

The board noted the governance schedule.

20. Any other business

There was no other business to discuss.

21. Date of next meeting

The next meeting of the board would take place on the 24 September 2026, venue to be confirmed.

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.

A question was raised about the independence of the senior nursing team in the instance where a FTSU concern was raised about nursing leadership. It was noted that the chief nurse was not normally part of the response process and only stepped in where necessary; furthermore, consideration could be given to whether HR involvement or another route was appropriate depending on the nature of the matter.

The chair thanked everyone for their participation.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

Public Meeting 24 September 2026

No.	Date	Minute item	Item title	Action	By	Update	Open/ closed/due
10/03	05/10/25	8.	IPR	It was agreed to monitor the progress and achievement of the complaints recovery plan and report back to the board in six months' time	Chief Nurse	**Action closed and the quality & safety committee will continue to seek assurances on this.**	March 2026
11/01	27/11/25	12.	Request for action on racism including antisemitism	The Board requested that agreed actions and feedback from staff re the Anti-Semitism Policy be presented to the Board to seek assurance that anti-racism initiatives are substantive and effective.	Chief People Officer	**Action closed and the people & culture committee will continue to seek assurances on this.**	March 2026
26/02	04/06/26	11.	Guardian of safe working	There was an issue with clinics overrunning and training hours being increased to provide cover. There would be a review of whether there were specific clinics that regularly overran or whether it was evenly spread.	Chief Medical Officer	**Action closed and the quality & safety committee will continue to seek assurances on this.**	

26/03	30/07/26	9.	Oriel	The Oriel programme team to continue reporting on programme readiness, the target operating model, move planning, IT readiness and cost implications through the major projects and digital committee and board as appropriate.	COO	**Suggest to close as this will be monitored through the major projects & digital committee (MPDC action 26/14).**	September 2026
26/04	30/07/26	11.	Chief nurse report	It was agreed that the violence and aggression towards staff policy should be reviewed to ensure that it captured explicit types of behaviours that were unacceptable.	Chief nurse	**A violence and aggression working group with representation from different staff groups has been established and will consider actions to take and the policy. The outputs of this working group will be reported to committee.**	September 2026
26/05	30/07/26	13.	People & culture committee chair's report	People and culture leads to continue work on career progression, staff experience, equality, inclusion and local employment pathways, with progress reported through the people and culture committee		**Suggest to close as this will be monitored through the major projects & digital committee (PCC action 26/14).**	September 2026

Cover Sheet	
Report title	Chief Executive's report to the Trust Board
Meeting	Board of Directors
Date	24 September 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 focus on safe operational delivery while progressing its four organisational priorities: the Moorfields and UCL Centre for Eye Health, MoorConnect, digital pathways, and culture improvement. This report highlights material developments since the July Board meeting and relevant national updates.

Chair succession
The recruitment process for a substantive Chair has concluded. Following an open search, assessment and stakeholder engagement process, the Membership Council approved the recommendation made by the interview panel. Completion of the Fit and Proper Person and other processes are underway. Transition arrangements are being finalised ahead of the end of the current Chair's tenure. We are exceedingly grateful to Professor Tim Briggs for all he has done for the trust and for his leadership over a period of uncertainty and change.

Research and Innovation
Professor Sobha Sivaprasad has been appointed as Moorfields' new Director of Research & Innovation. Sobha is a highly respected clinician, researcher and leader. She is director of the NIHR Moorfields clinical research facility and has been covering the research and innovation director role on an interim basis.

In her new role, Sobha will provide strategic leadership for research and innovation across the organisation and help shape the future of our research programme as we prepare to move to our new centre in Camden next year.

Performance and operational delivery
The Trust continues to manage high demand across its services and to maintain a strong focus on quality, access and efficiency.

In the latest National Oversight Framework segmentation and league table results (based on April-June 2026) the Trust is placed in segment one and is rated as joint 4th of 134 Acute and Specialist Trusts in England, up from 6th place in the previous quarter. The trust is the highest ranked in London.

Moorfields and UCL Centre for Eye Health
Work has continued to prepare for the move to the new centre at St Pancras. A shared spaces workstream with UCL is now live, supported by joint workshops on practical operating arrangements and a work package to develop policies for management of the shared building. Proposed governance arrangements, including routes for developing, approving and escalating shared-space policies, have been considered by the Trust Executive Committee. Crown Workspace Ltd has also been appointed to support the move of services and specialist equipment. Staff, patients, students and volunteers are being engaged on matters including furniture, wayfinding and the City Road art and heritage collection.

MoorConnect and digital enablement
Following a comprehensive assurance and readiness review, the working go-live date for MoorConnect has moved to 27 March 2027. The revised timetable reflects the need to resolve dependencies and maintain a safe and effective implementation. Elements of the wider programme, including the clinical services platform, continue to be delivered. The programme remains subject to additional internal and external scrutiny.

Independent governance and culture reviews
The Bevan Brittan review has now been received by the Membership Council and referred to the Board. A summary of the findings of this review and the next steps we will take are appended to this report. The Trust has briefed staff and stakeholders on the outcome and is developing an integrated action and assurance framework to ensure that agreed recommendations are implemented, evidenced and embedded. The second independent review has yet to report.

People, culture and appraisals
The Trust continues work to strengthen organisational culture, staff experience and leadership capability, including support for managers leading teams through significant change. Safer September and Quality Improvement Week have provided a focus for learning, patient safety and improvement. Appraisal rates are significantly up on last year’s figures and consultant job plans are now at 99%.

Annual General Meeting and member engagement
The Trust held its Annual General Meeting on 14 September 2026. The meeting reviewed performance and achievements during 2025/26, the Trust's strategic priorities and the Membership Council's work. Members' Week has also enabled governors to visit sites and engage directly with patients and staff leading to rich feedback from patients, carers, and staff. The feedback is being collated by the governors and will be reported to the board in due course.

Winter planning 2026/27
Winter preparedness has continued in line with national expectations, including maintaining elective activity, vaccination, infection prevention and control, escalation arrangements and staff welfare. NHSE requires us to have a robust clinically led plan and a named executive lead. Our draft plan was completed by the end of August as per requirements and is now in the regional stress-test phase. The Board is scheduled to receive formal assurance on the Trust's winter plan by 30 September 2026, and we are required to submit our board assurance statement by that date. We are working with the ICBs and neighbouring health and care organisations to secure system resilience.

Media coverage
In August Moorfields issued guidance on keeping your eyes safe during the solar eclipse. Our experts appeared on Sky TV and were quoted on BBC, ITV, Channel 4 and in the Sun, Guardian, Telegraph, Mirror, Independent, Express and BMJ before the eclipse and the day after.

In September, research by Moorfields and UCL Institute of Ophthalmology obtained wide coverage for a breakthrough paper on the detection of atrial fibrillation, a condition marked by intermittent irregular heart rhythms, through eye scans. For the first time, it was demonstrated that the thinner a specific retinal layer is, the more likely the person is to develop atrial fibrillation. This was observed in the eyes up to four years before it was diagnosed.

This is particularly important, as atrial fibrillation affects 1.5m people in the UK, is hard to confirm as a diagnosis (as it may not occur during an electrocardiogram test [ECG]) and can lead to strokes and heart disease.

It was featured on Channel 5 and Sky News, BBC R4 Today, Times, Independent, Sun and Daily Express, in local papers and across specialist media, including a podcast by Rory Cellan-Jones.

NATIONAL UPDATES

Leadership
The National NHS College of Leadership and Management has been launched. This will lead the development of leadership standards, accreditation, talent management and leadership development.

2026/27 NHS Payment Scheme
NHS England updated the 2026/27 NHS Payment Scheme in August to reflect final pay arrangements and the resident doctors' deal. The cost uplift factor increased from 2.03% to 3.24%, with updated prices backdated to 1 April 2026. The Trust is assessing the financial effect through its usual planning and reporting arrangements. The scheme also retains changes to ophthalmology prices intended to encourage activity in services with longer waiting lists than cataract services.

NHS Modernisation Bill and foundation trust governance
The Health Bill completed its third reading in the House of Commons on 8 September after report stage proceedings on 7-8 September. It went on for its first reading in the House of Lords on 9 September. The next stage is a further reading in the House of Commons, and the latest schedule suggests a date of 13 October for this. As we have reported previously, the proposed changes to foundation trust governance continue to have potentially significant implications for members and governors. The Trust is maintaining dialogue with the Membership Council and considering how patient, staff, public and stakeholder voice can remain embedded in decision-making under any future arrangements.

Quality implications
Safe implementation of MoorConnect, preparation for the new centre at St Pancras, learning from the independent reviews, and continued focus on patient experience all have direct

quality implications. Detailed assurance is provided through the relevant Board and committee reports.
Financial implications The revised MoorConnect timetable, delivery of the new centre, the updated NHS Payment Scheme and wider operational pressures may affect the Trust's financial position. These are monitored through the Finance and Performance Committee and Board reporting.
Risk implications Principal risks include concurrent delivery of major transformation programmes, implementation capacity, cyber and information governance, workforce pressures, financial control, and the need to embed governance and culture improvements. These risks are reflected in the Board Assurance Framework and committee assurance processes.

Appendix 1
Bevan Brittan independent review into the matters raised by the Consultant's Committee

Introduction

In February 2025, the Trust's Membership Council received a letter from the Chair of the Moorfields Consultant Committee expressing a lack of confidence in the leadership of the organisation, and asking for an independent review into various allegations documented in the letter.

The allegations were of a very serious nature and were described in five areas in the following terms:

1. A coercive (bullying) culture

2. Absence of transparency and honesty

3. Senior staff turnover

4. Financial concerns

5. Relationships with our Major Partners

The Membership Council (MC) considered the letter carefully and resolved to commission two reviews:

- Review 1 - an independent review into the specific issues raised in the letter from the chair of the Consultant Committee (items 2-5 above); and

- Review 2 – an independent review of Board governance, culture and effectiveness (item 1 above).

In commissioning these reviews the MC was at pains to ensure the reviews were impartial and independent of the Trust, the Trust Board, the Consultant Committee and the Membership Council itself

The review process has been overseen by the Governor Review Group (GRG), a sub-group of the MC.

The first of these reviews (Review 1) was undertaken by Bevan Brittan LLP, a leading law firm with recognised expertise in healthcare. The review considered more than 900 documents, over 21,000 pages of evidence and information from a range of witnesses before reaching its conclusions.

This review is now complete and was formally accepted by the Membership Council on 3rd September, with the Membership Council writing to the Board to hand over the review and requiring an action plan and updates on the implementation of this action plan.

Bevan Brittan have provided a summary of their report which is available to staff. We have also carried out a number of briefing sessions to discuss the outcomes of the report and answer questions.

We are grateful to all who contributed evidence throughout the process.

Overall findings

The overall conclusion is that the independent review found **no serious governance failings, no regulatory concerns and no findings that require regulatory reporting**. The review also found **no evidence of individual misconduct**.

However, it is important to note that the review does make a number of recommendations for the Trust, and the Board, around a number of areas of governance. There is also a recommendation that the Consultants' Committee review its terms of reference which is already underway.

The report also recognises that communication and transparency was not sufficient or effective enough between some groups and that although there may not be serious governance or regulatory concerns the findings should not be underestimated. The report describes how all of this contributed to the circumstances that gave rise to the allegations necessitating this investigation.

This provides important assurance that, notwithstanding the concerns that were raised, the Trust has continued to operate within appropriate governance and regulatory frameworks. There are though recommendations for improvements that we must make.

Recommendations and what we need to improve

While the review did not identify serious governance failures, it did identify a number of important areas where we need to improve.

The report concludes that many of the concerns arose from:

- Examples of inadequate audit trails and record keeping.
- Insufficient detail in some meeting minutes and governance records.
- A lack of clarity over how some decisions were documented.
- Inconsistent sharing of information with key stakeholder groups, particularly the Membership Council.
- A lack of clarity across the organisation about what information could legally be shared and what information needed to remain confidential.
- Misunderstandings that developed when incomplete information circulated through informal channels.

The review therefore recommends strengthening governance processes, improving record keeping, clarifying roles and responsibilities and establishing clearer frameworks for information sharing and transparency.

More detailed findings

Bevan Brittan have produced a summary report which is available to all members of staff which provides more detail on findings by section and regarding the specific concerns raised.

Governance of the letter

The report recommends that the Consultants' Committee terms of reference are reviewed and updated where appropriate. This should include the consideration of the role and election of the Chair, how decisions are made and agreed and when and how the committee should meet.

Absence of transparency and honesty

The report found no evidence to support concerns that the findings of reviews carried out in relation to the Reading Centre were inconsistent or that the Trust had failed to respond appropriately to the issues raised in these reviews. Bevan Brittan concluded that reviews were properly commissioned and that recommendations had been acted upon.

The report recognised that some information from these reviews could not be shared more widely due to legal, confidentiality and data protection requirements and so sharing a summary report was appropriate. However, it recommended clearer governance arrangements to define what information should be shared, with whom, and through which forums. It also concluded that the Membership Council should, in some instances, have received more information.

Senior staff turnover

The report considered concerns about senior staff turnover and executive departures. The report describes how it has thoroughly reviewed the circumstances of these executive departures and found that no further detail could or should have been provided about these departures. It concluded that it would have been inappropriate to disclose confidential employment-related information. However the report was satisfied that the reasons for departure were not related to each other.

The review identified some failures to follow processes during the period examined.

Financial concerns

The report provides reassurance regarding the Trust's financial position. It concluded that the Trust remained financially viable and continued to report significant surpluses during the period under review. The review was content that recovery of funds was appropriate and regular reporting of programme expenditure took place.

It does however note that more information should have been made available to Membership Council and Bevan Brittan could not be assured that proper processes and procedures had always been followed in commissioning consultancy and legal advice.

The report also concluded that some concerns regarding future deficits arose from misunderstandings about NHS financial planning and reporting arrangements.

Relationships with our Major Partners

The review examined concerns relating to the Trust's relationships with key partners, including UCL and the NIHR. While it identified opportunities to strengthen communication and governance arrangements, it found no evidence of the pursuit of personal financial gain by Trust leaders or of significant governance failures in relation to commercial activities.

The review was unable to confirm whether all legal advice had been fully followed and could not establish whether all advice had been commissioned in line with Trust procedures. Whilst it found a breakdown in some relationships between senior UCL academics and Trust senior executives there was no evidence of a significant breakdown in the overall partnership between the two organisations.

Publication of the report

In conducting the review, Bevan Brittan considered its legal and regulatory obligations, including data protection, confidentiality and employment law requirements. As a result, they advised that the full report should not be published because it contains confidential and personal information. Instead, an extensive summary report, which excludes individual confidential details, has been made available to staff only.

What happens next

We fully accept the recommendations made within the report. A draft action plan will be presented to the Board for approval. The action plan and progress on delivery will then be regularly reported to both the Board and Membership Council.

The programme of work will further:

- Strengthen governance and assurance processes.
- Improve record keeping and audit trails.
- Update key policies and governance documents.
- Clarify governance roles and responsibilities.
- Improve transparency and information sharing.
- Strengthen communication and engagement with governors, consultants and wider staff groups.
- Ensure lessons from the review are embedded into our future ways of working.

We acknowledge that the concerns which led to this review arose during a period when some important relationships had become strained and there were differing perspectives and concerns across parts of the organisation. The report recognises that communication, transparency and engagement between some groups were not always as effective as they

needed to be, and that this contributed to the circumstances which gave rise to the concerns raised.

Since then, we have worked hard to strengthen how we work together through broader clinical and staff involvement in our committees, expanded medical leadership, and more regular and open communication.

Conclusion

This review provides significant assurance that the Trust's governance arrangements remained fundamentally sound throughout the period examined. It also provides an important opportunity for reflection and learning and describes a number of areas in which we must do better. The report also makes a number of recommendations for the Consultant Committee.

We will use the findings to strengthen our governance, improve transparency, increase understanding of how decisions are made and continue building a culture where concerns can be raised, heard and addressed openly, fairly and constructively.

Thank you to everyone who contributed to this process and to all colleagues who continue to support the Trust, our patients and each other every day.

We will report back on Review 2 when it is completed in due course.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Cover Sheet	
Report title	Board Assurance Framework
Meeting	Board of Directors
Date	24 September 2026
Report from	Peter Ridley, Chief Executive
Prepared by	Ben Westmancott, Interim Company Secretary
Previous forum consideration	Board committees

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

Purpose of report	Assurance	**X**	Decision		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. *Entries 5B and XA have been redacted from the public version of the BAF due to their confidential nature.*

Risk tolerances have been established for each principal risk, aligned to the risk appetite statements considered by the Board on 23 April. The board delegated responsibility of overseeing entries to its committees and this version includes feedback from those meetings.

Executive leads will consider for the next cycle if the actions identified for each risk would be sufficient to align the risk score to risk tolerance and over what period. If currently identified actions would not bridge any gap then further measures will be considered.

What the Board Is Being Asked to Do
The Board is asked to:

1. **Note the BAF entries and use the information within to inform questions and discussion of items on the board agenda.**

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. 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 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.

X Cross-cutting risks

XA. 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.

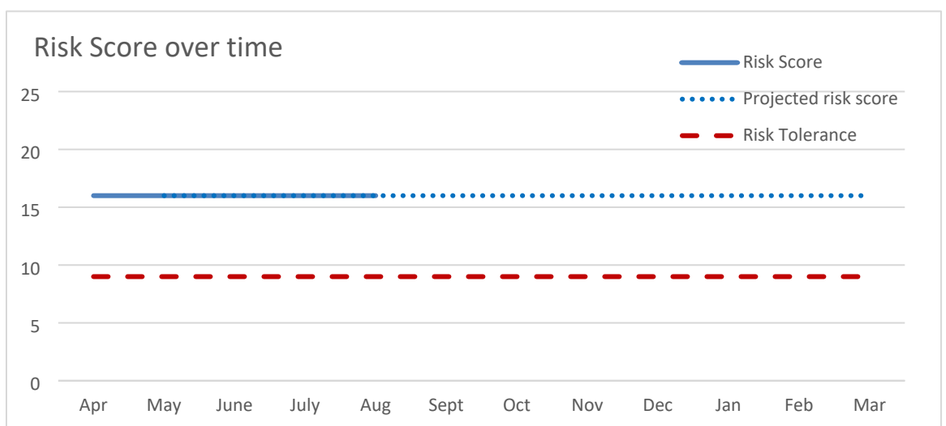
XB. If we do not handle receipt of the external reviews then we risk prolonging a period of disruption leading to attention being diverted from service delivery and patient care.

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	DofR&I	Discovery and Commercial
	2B	Leadership and succession planning in research	DofR&I	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	26 August 2026	Sue Steen	People and Culture Committee	• Culture priority workstream developed aligned to NHS Standards and Trust v Values. • Culture diagnostic completed with priority improvement themes identified. • Leadership Development for Bands 4-7 in second year of roll out. • Executive Development programme secured. • Freedom to Speak Up, staff survey and pulse survey feedback used to identify leadership and behavioural concerns.	• Integrated Performance Report (IPR) and quarterly people performance metrics. • Workforce indicators including turnover, sickness absence, retention and employee relations data. • Annual staff survey & quarterly pulse surveys • FTSU reporting and monitoring of themes.	• As the programme develops, controls will become more explicit. • Significant variation in staff experience. • Insufficient leadership development programme in place. • Over reliance on annual surveys • No current agreed culture dashboard	• As the programme develops, assurances on initiatives will be presented to the people and culture committee for scrutiny. • Limited assurance that behavioural expectations are consistently applied and that poor behaviours are addressed regardless of seniority. • Further assurance required on the impact of the actions from the culture diagnostic.	• Culture diagnostic • Establish a culture dashboard incorporating staff survey, pulse survey, FTSU, WRES, WDES, turnover, sickness indicators and alignment to staff standards KPI's. • Develop divisional culture/staff engagement improvement plans. • Implement enhanced leadership visibility.



Executive Assurance Commentary:

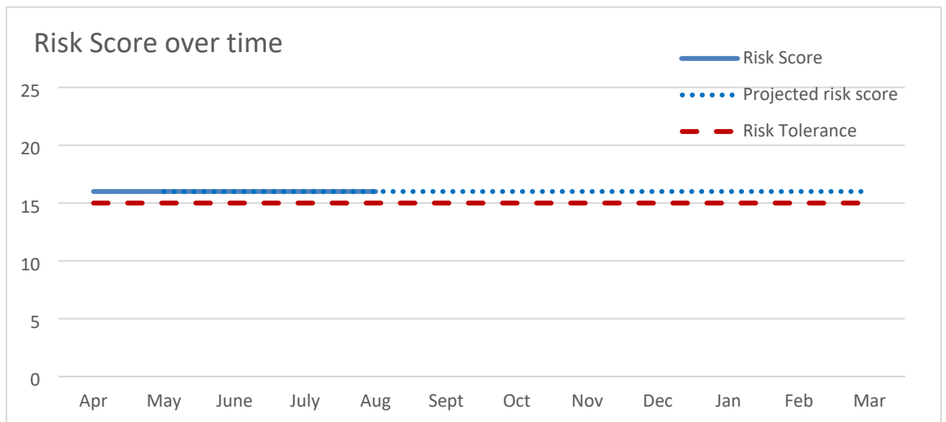
Risk score is likelihood 4 x impact of 4

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:

Following review in July 2026, the People and Culture Committee will receive a September 2026 deep dive into the culture diagnostic and associated Culture Transformation Programme. The Committee will be provided with assurance that actions to address leadership, behaviours, psychological safety and staff experience are being delivered through a structured programme with regular oversight of progress and impact. Resources to support the priority programme and actions is approved and implementation is in train. The meeting will take place after the board paper is finalised.

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	26 August 2026	Sue Steen	People and Culture Committee	• Board agreed four priorities for the year. • Trust strategy and annual planning process to prioritise and sequence major organisational initiatives. • Governance arrangements in place for major change programmes e.g. Oriel and EPR.	• Workforce and People Dashboard • NHS Staff Survey Results • Pulse survey findings • Sickness absence and wellbeing reports • WRES and WDES reporting • Board and Committee progress reports on major strategic priorities.	• Trust wide assessment of cumulative change impact required across multiple programmes. • Lack of leading indicators for staff overload and burnout.	• Limited assurance regarding cumulative impact. • Limited evidence demonstrating whether prioritisation and sequencing decisions are reducing workforce pressures. • How do we measure progress against the four priorities?	• Continued communication to staff of the priorities and what they mean in the context of each team. • Lead indicators to provide early warning of staff overload and wellbeing deterioration.
						• Staff wellbeing interventions • Sickness absence monitoring and targeted interventions. • Flexible working policies. • Staff survey, pulse surveys and FTSU in place.	• People performance metrics reported each quarter	• Variation in leadership capability to manage competing priorities and staff wellbeing.	• Limited assurance regarding the effectiveness of manager-led wellbeing conversations and workload management interventions.	• Reflect in reports the wider impact of long-term sickness including financial.



Executive Assurance Commentary:

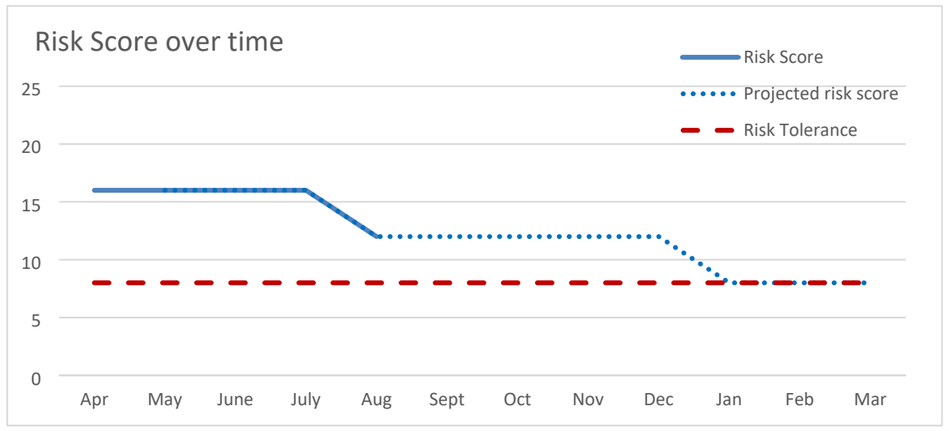
Risk score is likelihood 4 x impact of 4

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

Assurance Committee’s commentary:

The People and Culture committee will assess the risk that whilst governance and workforce monitoring arrangements are in place, further work is required to strengthen the assessment of cumulative change impact, improve visibility of workforce capacity and workload pressures, and ensure organisational priorities are actively sequenced to minimise the risk of staff overload and adverse impacts on wellbeing and performance.

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	9 September 2026	Elena Bechberger	Discovery and commercial committee	• 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



Executive Assurance Commentary:

The work taken forward by the Oriel Partnership Working Group is making good progress, with a comprehensive stocktake of external partnerships across the organisations now complete and a draft framework for the joined up identification and management of priority external partnerships under review. The working group is also advancing plans to further improve the researcher- clinician interface, with the emphasis on utilising the opportunities the new centre will provide, such as for example our new shared innovation hub.

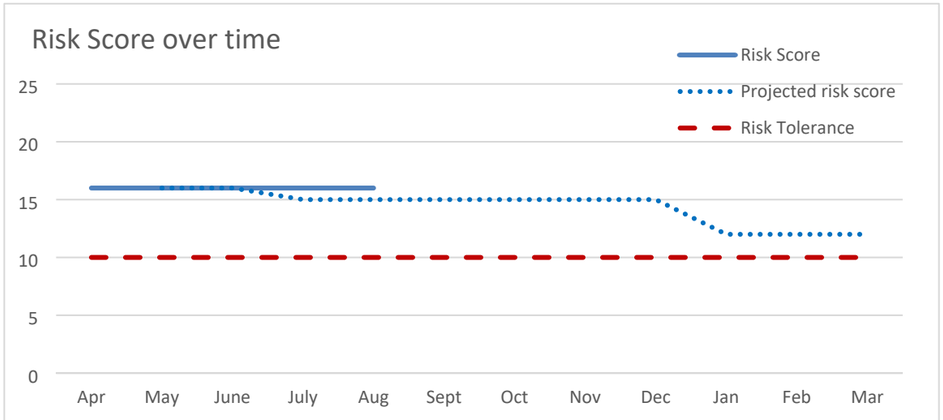
On this basis, the risk score has been reduced to likelihood 3 x impact of 4.

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

Assurance Committee's commentary:

The committee discussed strategic partnerships at its meeting on 9 September and concurred with the reduction in risk score on the basis that the partnership stocktake and strategy has been progressed and is being recommended to the board for approval.

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	9 September 2026	Sobha Sivaprasad	Discovery and Commercial Committee	• Research governance arrangements in place. • New research and innovation leadership in place.	• Reports to the discovery and commercial committee on research income and activity.	• Need for a single governance structure for the whole R&I.	• Additional required assurances to be discussed at the discovery and commercial committee.	• BRC application • To present to DCC a paper on current R&I activities, income and risks and mitigation of risks.



Executive Assurance Commentary:

Risk score is likelihood 4 x impact of 4

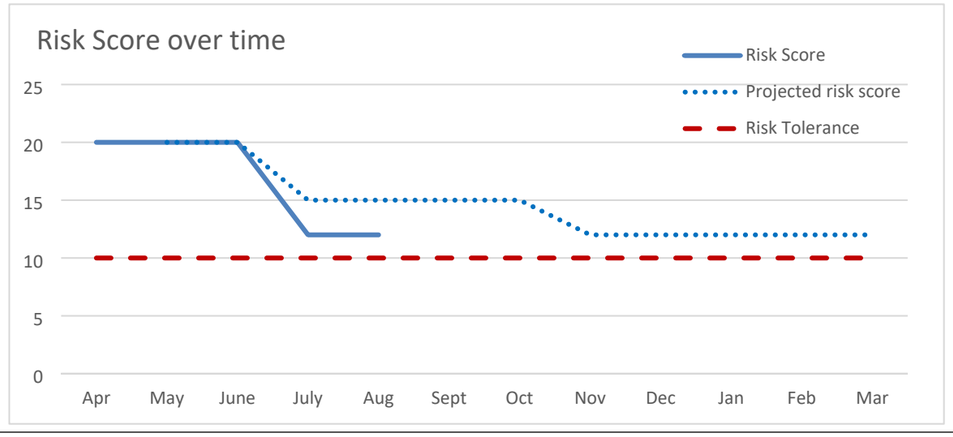
Risk tolerance has been set at 10 i.e. cautious risk appetite with respect to reputation.

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

Assurance Committee's commentary:

At the committee meeting on 9 September the committee reviewed the draft BRC bid which covers a significant part of research income. Objectives are being developed in an iterative way. The committee concurred with this BAF entry. The final bid will be presented to the board in September.

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	9 September 2026	Sobha Sivaprasad	Discovery and Commercial Committee	• New structure for research leadership described and agreed • New director of research and innovation in post.	• Updates to the discovery and commercial committee	• Insufficient succession plan for BRC leadership • Other gaps in medical leadership posts in research and innovation	• The DCC will receive an update agreeing objectives for new postholders and the directorate.	• 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 3 x impact of 4 now that a permanent director of research and innovation is in post. The likelihood and the impact have reduced.

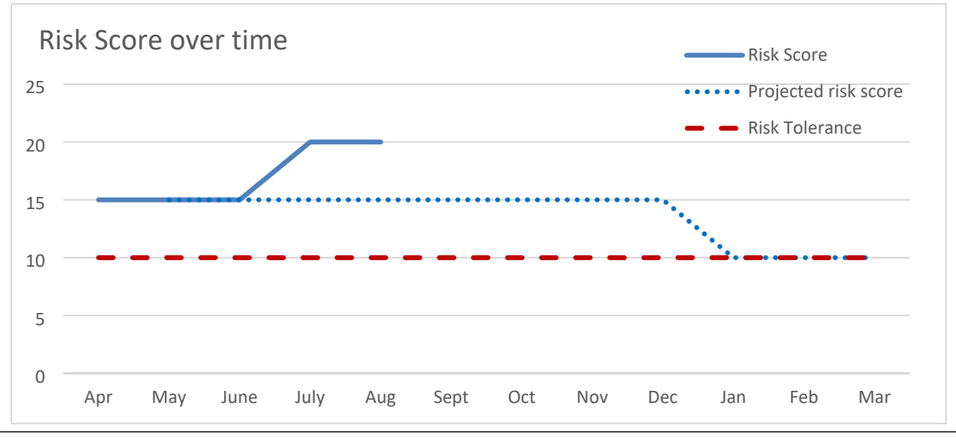
Risk score predicted to drop once an interim director in post and further drop once a permanent appointment has been made.

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

Assurance Committee's commentary:

The committee is satisfied that this risk has been largely mitigated and welcomes the assurance reports it receives from the Director of Research and Innovation. The committee will continue to oversee remaining actions.

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 well as reputational damage, and financial consequences.	3 February 2026	9 September 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	• A risk has materialised relating to the collapse of CAI (building safety inspector for the new centre).	• The regulator is engaging with us regarding our submission to them and notifiable building works are continuing on site.	• Ongoing engagement with the regulator to support their approval of work undertaken to date and our remaining notifiable building works on site.
						• EPR programme management and governance	• Update reports to the Plan Delivery Group and Major Projects and Digital Committee • Third party assurance (currently being procured) • 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 being finalised to learn from the recent IT system upgrades and detailed planning has been undertaken to determine the earliest date that the EPR can safely go live.	• Report back on the after action reviews from the IT upgrades / reset the programme to deliver a revised go live of 27th March 2027 and assess the financial impact of this change.
						• City Road migration project management and governance	• Update reports to the Plan Delivery Group and Major Projects and Digital Committee	• Now that there is a clear roadmap for the programme, ensure that there are no unforeseen resource gaps or interdependencies with other programmes	• Ensure that there is robust oversight of the programme so that it delivers on time and therefore supports the Oriel and EPR go lives.	• Challenge the granularity of the programme plan in further detail



Executive Assurance Commentary:

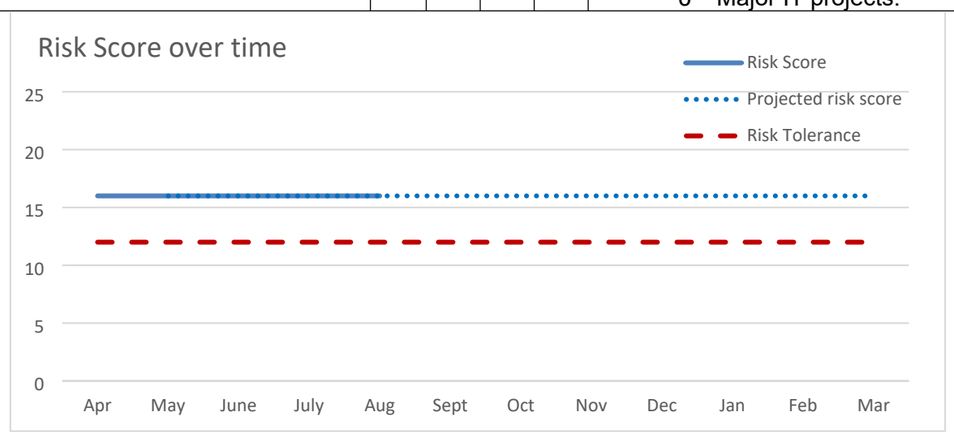
Risk score is likelihood 4 x impact of 5

The previously reported risk of the MoorConnect Programme being delayed has been realised. As a result, the likelihood of this programme causing reputational and financial consequences has led to the overall Major Programme delivery risk rating increasing to 20.

Assurance Committee's commentary:

The committee noted, at its meeting on 17 July, that there would be a delay in the delivery of the MoorConnect programme. This entry has been updated in light of that and the committee received an update on progress at its meeting on 9 September. The committee noted that there is an increased financial risk related to the revied implementation timetable.

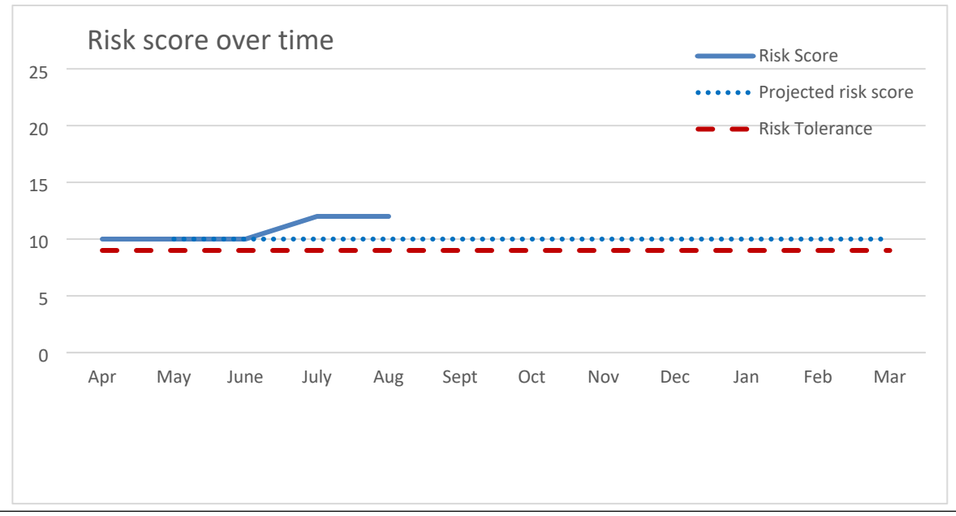
ID	Risk	Opened	Date last reviewed	Lead Executive	Assurance Committee	Controls	Assurance	Gaps in controls	Gaps in assurance	Open Actions
Develop: Are we practically applying our discoveries and global best practice to benefit our patients, staff and the services we provide?										
3B	**Insufficient 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	9 September 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).	• Funding for EPR Delay	• Discussions with NHSE around additional CDEL



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 9 September 2026 and concurred with the risk wording and assessment.

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	14 August 2026	Jon Spencer	Quality and safety committee	• Business Continuity Plan.	• EPRR assurance from NHSE.	There is an increasing threat of a cyber attack and the Trust's current business continuity plans may not be suitable to support the two major programmes (EPR and Oriel) when they go live.	Need to assess our readiness to defend against the developing cyber threat and to update business continuity plans to take account of the major programmes.	Discussion to take place at the quality and safety committee in November on any further actions that could/should be taken and on any further assurances that might be required.



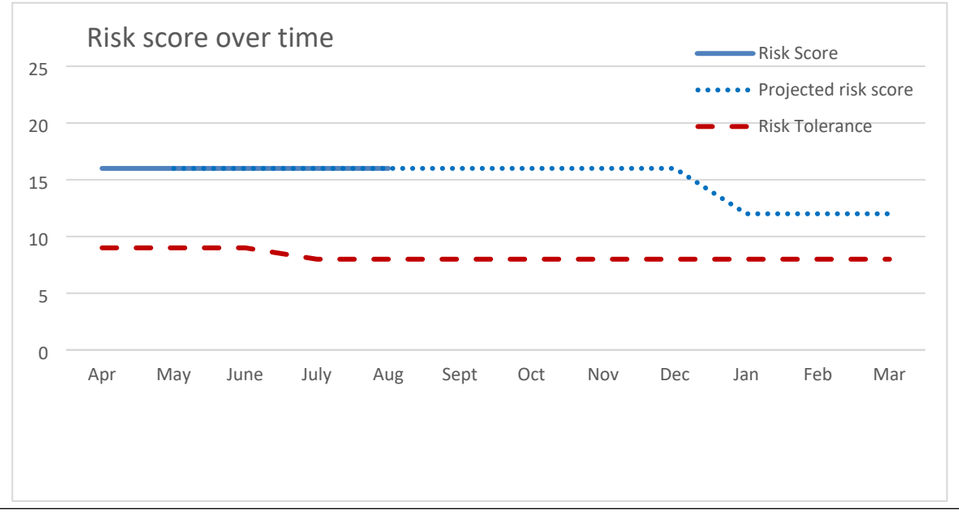
Executive Assurance Commentary:
The risk has been scored at likelihood 3, impact 4. That is, there is a medium likelihood of significant disruption to patient care. The reason for the increase is that the previous score of likelihood 2, impact 5, is considered to understate the risk i.e. nothing has significantly changed other than a reframing of the risk. The constantly developing cyber threat means that we are unlikely to reduce it below 12.

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 committee reviewed this at their meeting on 21 July and agreed to schedule in a review of the business continuity plan and emergency preparedness resilience response arrangements. This will take place at the September meeting.

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	28 August 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. • Youth forum in place advising on standards of care for young people.	• 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. • After actions reviews following recent data breach have been completed and a proposal going to TEC on 1 Sept	• We do not have a consistent and thorough way of providing and testing assurance of digital clinical safety. This will be addressed by the new quality assurance committee.	• Clinical visibility framework to launch 09/26 • Quality assurance committee (every 2 months); mix of peer reviews and deep dives. To be launched as part of the quality restructure – Q4 • Create a digital framework that allows for planning, testing, and wider understanding of clinical risks linked to upgrades and new programmes. • Setting up London-wide children's and young people's ophthalmology clinical network by Q4. (With plans to extend this nationally for adults and children).



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.

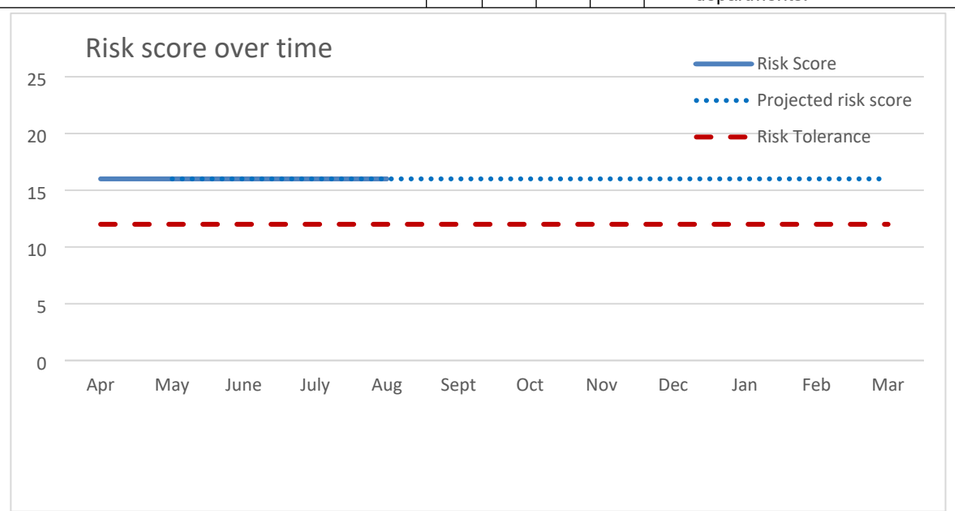
We have held two deep dives into children's and private services at QSC to strengthen assurances and these have been well received.

We have reduced the tolerance to 2x4=8 following feedback from the board in July i.e. likelihood 2, impact 4.

Assurance Committee's commentary:

After reviewing the entry at its meeting on 21 July, the Quality and Safety Committee noted that much of the assurances that the committee receives relate to this entry. The committee welcomed work to reduce the risk; however, it was queried whether the target can really be 3x3: we can reduce the likelihood but not the impact, therefore a likelihood 2 x impact 4 = 8 tolerance might be more appropriate.

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	14 September 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 >£1m • 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. • 2025/26 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 Oriel Projects • 2025/26 Head of Internal Audit Opinion • **Negative** • 2026/27 CIP not fully identified.	• Procurement Strategy • Operational and Financial Benchmarking using Model Hospital and NCC Collection.	• None Identified	• Updated procurement Strategy by November 2026. • Internal benchmarking tool by December 2026



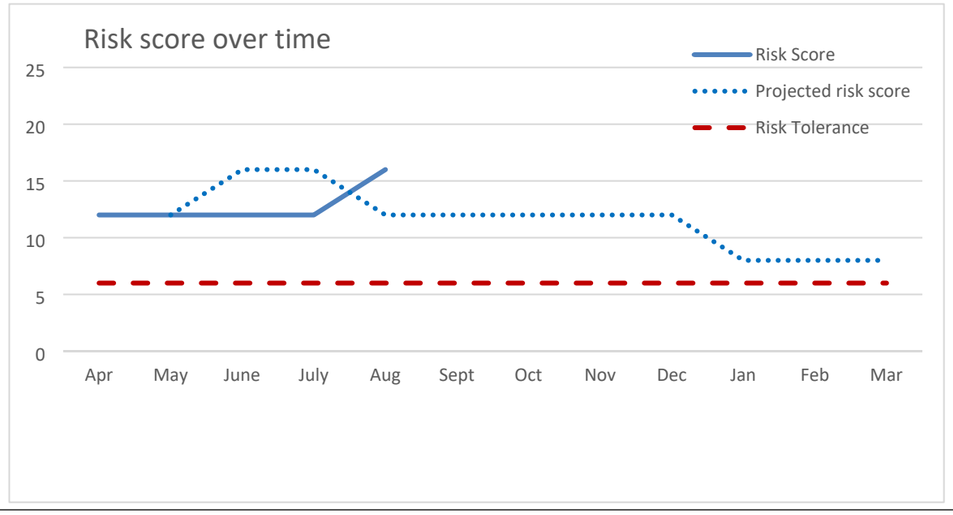
Executive Assurance Commentary:

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 given incremental costs associated with major projects and the efficiency requirements within the financial framework.

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. At the meeting on 13 July the committee asked the executive to consider describing the risk profile over a three-year period rather than 12 months as it is about longer-term financial sustainability rather than achievement of annual targets. It was concluded that this approach would be beneficial to all BAF entries and would be done as part of the strategy review which has commenced.
The committee noted a difference in risk tolerance between the BAF entry and the trust-wide risk register.

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	25 August 2026	Peter Ridley	Trust Board	• Governor led governance structure in place via the governors review group. • Independent advice to governors in place. • Communications plan being followed.	• Once the governors review group have received the reports and instructed the board to take action we will be able to describe assurances. • Meeting of the membership council set for 3 September to receive the Bevan Britan report.	• The Bevan Brittan summary report is expected to be received on 25/26 August. • GGi report will follow after the Bevan Britan report.	• We do not yet know the full detail of what will be in the reports.	• We are strengthening governance mechanisms and will further refine them once we know the recommendations in the reports. • Link the actions from any recommendations to the well-led work.



Executive Assurance Commentary:

There is high likelihood (4) 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 was envisaged that they would be received in June; however, they are now envisaged to be received in August (Bevan Brittan) and September (GGi) hence a difference between the projected risk score and actual.

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

It is suggested that assurances the reports are being suitably acted upon should go to the membership council and, internally, to the audit and risk committee as well as to the board.

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.

Moorfields Eye Hospital NHS Foundation Trust

Advanced Foundation Trust Statu

Board of directors
24 September 2026

Report title	Advanced Foundation Trust Status - update		
Report from	Elena Bechberger, Director of Strategy and Partnerships		
Prepared by	Mark Redhead		
Previously considered at	Trust Executive Committee	**Date**	1 September 2026
Link to strategic objectives	All		

Quality implications None.							
Financial implications None explicit – an application will require staff time to prepare.							
Risk implications Advanced Foundation Trust status is a marker of capability in the new environment, so risk arises if we do not achieve this status.							
Action required/recommendation. For information.							
For assurance		**For decision**		**For discussion**		**To note**	**x**

Advanced Foundation Trust guidance and process

- **Policy Landscape:** The Advanced Foundation Trust (AFT) Programme is designed to push real decision-making power back to frontline hospitals. NHS England expects every trust to achieve this status by 2035.
- **Freedoms:** Gaining AFT status reduces central reporting. It replaces regulatory monitoring with high-level strategic oversight and gives us control over capital spending up to £100m CDEL spend, alongside the right to keep and reinvest annual financial surpluses.
- **Responsibilities:** To earn this autonomy, we must lead broader system changes, specifically supporting the three national shifts: moving care from hospitals to communities, replacing outdated technology with modern digital tools, and focusing on prevention over treatment.
- **Next Steps:** We should apply, though with a strong narrative on our data and analytics capability and our digital strategy. We need to maintain a top-tier position in national performance tables and build demonstrably stronger partnerships with our local Integrated Care Boards (ICBs).

A. Context

1. Following a sector-wide consultation over the winter, NHS England (NHSE) published its updated guidance for the Advanced Foundation Trust (AFT) Programme on 10 June 2026. This new package, which includes a policy framework, an applicant guide, and a detailed assessment annex, establishes AFT status as the new must-do for high-performing trusts.

2. Tied directly to the government's 10 Year Health Plan, the programme represents an attempt to move away from top-down management and restore the principle of earned autonomy.

3. The long-term plan is to assess and support trusts in rolling waves until the entire provider sector reaches this standard by 2035.

4. The guidance states that any trust focusing solely on its own institutional interests at the expense of local patient outcomes, will fail the assessment.

5. Moorfields will have to demonstrate that we are actively supporting the wider NHS, cooperating with our neighbours, and integrating our services into local communities.

B. Earned Autonomy

6. Perhaps the single biggest benefit of securing AFT status is the earned autonomy, giving us the time and space to plan long-term improvements. These flexibilities sit across three main pillars:

Pillar 1: High-Level Planning

1. Annual planning conversations with NHSE regional teams will shift to a high-level, strategic dialogue. Once our broad plans for finances, service delivery, and transformation are agreed upon, day-to-day oversight will be light touch. Regional teams will not step in unless our performance is drastically off track.

Pillar 2: Regulatory Breathing Space

2. Because passing the assessment will demonstrate we have a highly capable leadership team, regulators will give us more time and space to fix operational problems internally. We will need to maintain absolute transparency and operate on a "no surprises" basis. More detail of the rules-based approach to be published shortly.

Pillar 3: Real Financial Controls

3. The financial incentives include:
    - **Capital Agility:** We will no longer need to write cases for central NHSE approval for individual capital schemes worth up to **£100 million**.
    - **Surplus Retention:** We gain the explicit right to fully keep and reinvest any operational or capital surpluses (accumulated since 2024/25) back into our estates, clinics, and research infrastructure.

C. System responsibilities and maintaining standards

7. This independence demands a fundamental shift in how we hold ourselves to account. In exchange for freedom from the centre, we must show a proactive commitment to delivering the three core shifts outlined in the national health strategy (see blue box) and improve standards.

System Leadership and Peer Support

8. Approved AFTs are expected to look beyond their own boundaries. We will be required to act as regional leaders: coordinating eye care pathways across multiple providers, leading initiatives to tackle health inequalities, and providing hands-on peer support to help struggling trusts improve their standards. This will likely include an IHO contract or similar status.

Safeguards and Ongoing Reviews

9. Autonomy can be lost if standards fall. The NHS Oversight Framework (NOF) and national league tables will be the means to monitor performance and trigger greater oversight. We will face a thorough annual deep-dive review to check what we are contributing to the 10 Year Health Plan, and our AFT status will be formally re-assessed every five years. If a trust suffers a serious financial collapse or quality failure, NHSE retains the power to step in.

The Three Strategic Shifts

1. **From Sickness to Prevention:** We must use high-quality local health intelligence and population data to spot visual health issues early, designing targeted interventions for high-risk groups before they require complex hospital treatment.
2. **From Analogue to Digital:** We are expected to embed modern technology across all our clinical settings, hitting all national digital standards, ensuring our systems share data seamlessly with external partners, and using clear tools like AI to improve patient safety and everyday communication.
3. **From Hospital to Community:** We must show that we are actively investing in community facilities and local clinic networks, shifting routine eye care pathways out of hospital sites closer to where patients live.

D. The application process thresholds

10. To be considered for AFT status, we must hit specific performance thresholds:

- The NOF Threshold: We must be positioned in Segment 1 or 2 of the National Oversight Framework for at least two consecutive quarters, demonstrating that we are delivering public priorities and value for money.
- The Quality Domain Scores: We must achieve a score of 3 or better in the core NOF quality metrics (effectiveness, patient experience, and safety) for two consecutive quarters.
- The CQC Rating: Our overall trust-level CQC rating must be "Good" or "Outstanding".
- Leadership Grading: Our annual Provider Capability Assessment must be rated at least "Amber-Green".

11. Three fundamental questions underpinning the assessment are:

a. Is the trust well led, collaborating with system partners to improve population health and tackle inequalities, and responsive to local communities?
b. Does the trust provide high-quality services with robust quality governance in place?
c. Is the trust financially sustainable with a focus on productivity improvement?

12. Boards will have to submit an evidence portfolio and a set of statements. Evidence will draw on:

- board statements and memorandum
- interviews and information provided by the ICB, CQC and NHS England regional teams
- underlying NHS Oversight Framework and performance data, model health system and staff survey
- review of existing information, including board and committee papers, risk

registers, governance structures, internal audit reports
- reports from any relevant externally commissioned reviews, including where in draft form (for example, external Well Led assessments, independent reviews or patient safety investigations)
- assurance actions taken against clinical audit, including prevention of future death report actions, and staff survey reports
- medium-term plan submission
- provider capability self-assessment and digital maturity assessment
- board and committee observations
- "board to board" meeting between applicant board and senior NHS and Department of Health and Social Care (DHSC) leadership.

13. Decisions will be made by an NHSE subcommittee, and post-abolition an independent panel.

14. The timetable appears to have 3 stages and take c. 4-6 months:

    - Preparatory stage – secure support to apply
    - Submission and assessment stage – 3 months
    - Approval, including Board to Board meeting – 1 month.

E: The first waves of applications

15. There have to date been two waves of applications for AFT status. The first wave on 27 May 2026 appeared to prioritise those trusts that were well-placed to be forerunners of Integrated Healthcare Organisations (IHOs). Two of these AFT applicants have since been awarded early IHO status.

    - Alder Hey Children's NHS Foundation Trust
    - Berkshire Healthcare NHS Foundation Trust
    - Central London Community Healthcare NHS Trust
    - Dorset HealthCare University NHS Foundation Trust
    - **Northamptonshire Healthcare NHS Foundation Trust *(IHO assessment)***
    - **Northumbria Healthcare NHS Foundation Trust *(IHO assessment)***

16. The second wave of 16 trusts were subject to streamlined assessment (eligible by consistently remaining in Segment 1 of the NHS Oversight Framework):

    - Guy's and St Thomas' NHS Foundation Trust
    - Imperial College Healthcare NHS Trust
    - Kent Community Health NHS Foundation Trust
    - Liverpool Heart and Chest Hospital NHS Foundation Trust
    - Midlands Partnership NHS Foundation Trust
    - North West Ambulance Service NHS Trust
    - Royal National Orthopaedic Hospital NHS Trust
    - Royal Papworth Hospital NHS Foundation Trust
    - The Christie NHS Foundation Trust
    - The Clatterbridge Cancer Centre NHS Foundation Trust
    - The Royal Marsden NHS Foundation Trust
    - The Royal Orthopaedic Hospital NHS Foundation Trust
    - The Walton Centre NHS Foundation Trust

- University College London Hospitals NHS Foundation Trust
- West London NHS Trust
- Yorkshire Ambulance Service NHS Trust

17. We are hopeful that Moorfields will be accepted as an applicant in Wave 3, expected in October.

F. Priority areas on which to have assurance and build a strong application

18. To be part of the early wave of assessments, five useful focus areas for Moorfields in particular would be:

1. **Our EPR System and wider IT health:** The assessment teams will look closely at whether our technology actively reduces clinical risk and meets national data standards.

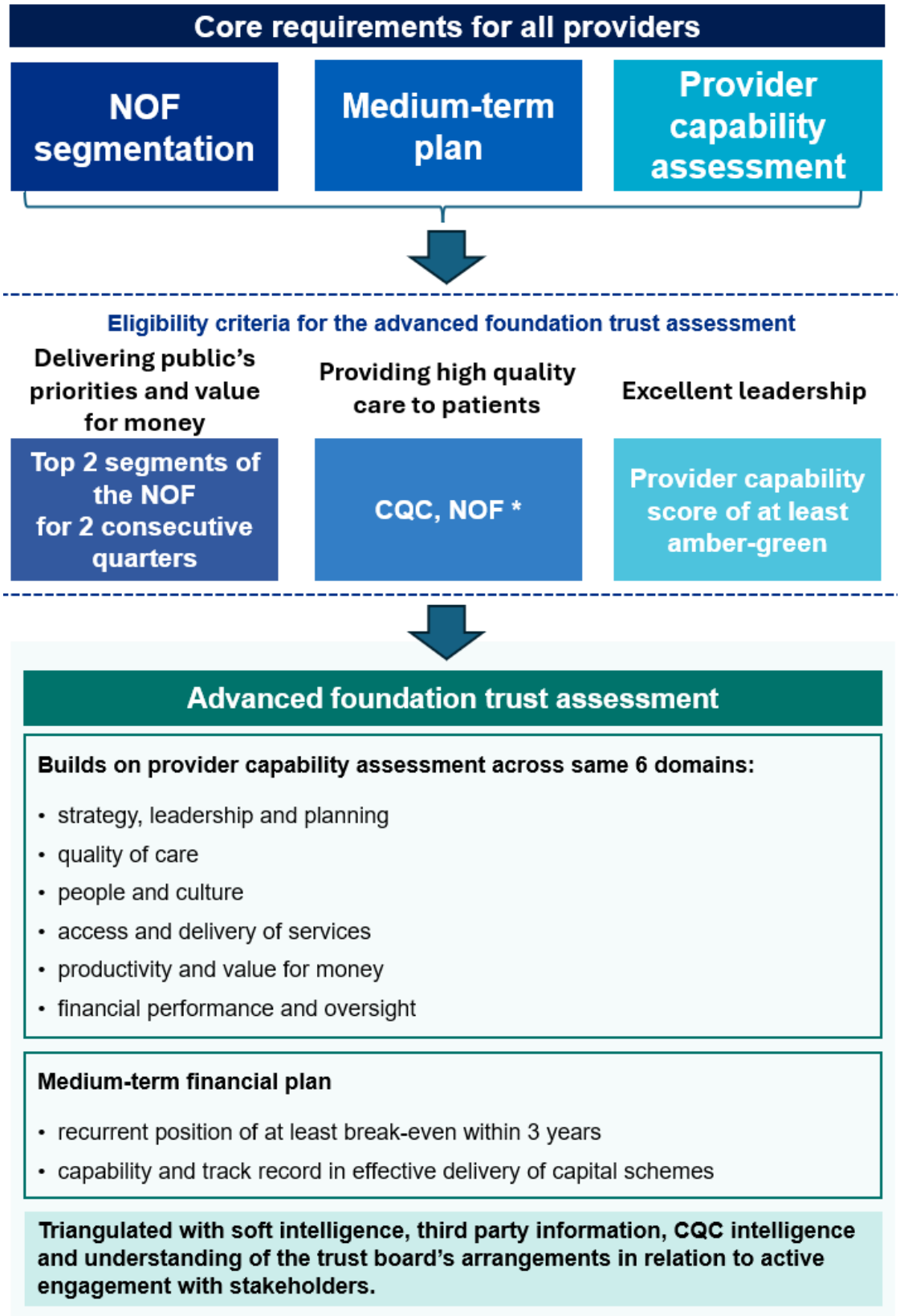
2. **Data and Analytics:** The assessment annex requires board statements to be backed up by verifiable data. The board needs real-time, high-quality analytics to show pathways are improving population health and productivity.

3. **Improve How We Listen to Patients:** The updated June 2026 guidance places a much heavier emphasis on patient and public voice. Regulators will audit exactly how we handle complaints and service feedback. We need clear, simple processes to ensure feedback is systematically used by the board to change how we work.

4. **Strengthen Partnerships with Local ICBs:** We will need the support of our local Integrated Care Boards and regional NHSE leads. We need to work closely with our neighbouring providers and primary care, co-designing integrated eye care networks that prove we are leading the shift from hospitals to local community clinics, while actively closing gaps in care accessibility.

5. **Scale and Share Capabilities:** For example, showing how we can scale up our digital and pathway innovations, shared with other hospitals to help clear their backlogs and improve patient diagnostics, fulfilling the enhanced system-leadership role expected of an AFT.

Appendix: Diagram of process



Cover Sheet	
Report title	Oriel Update
Meeting	Board of directors (in public)
Date	24 September 2026
Report from	Jon Spencer, Chief Operating Officer
Prepared by	Jenni Frost, Joint Oriel Programme Director Laura Brewster, Joint Oriel Programme Director
Previous forum consideration	Major Projects and Digital Committee Oriel Executive Board

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

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

Executive summary

Programme Summary
The programme summary report demonstrates the continued progress of the construction project. The programme continues to forecast delivery within the approved budget, with remaining headroom/optimism bias of £4.5m post-quantitative cost risk analysis (QCRA) (Moorfields £3.5m; UCL £0.9m). QCRA risks continue to be monitored monthly. There is a shift in programme rating from amber to red as 91% of contingency is now committed.

Following the recommencement of notifiable works on 23 June 2026, the revised planned completion date of 5 February 2027 has been accepted, and BYUK currently forecasts contract completion on 19 March 2027. The cost implications of the delay, including those associated with the reversionary application and mitigation measures, are being assessed by cost consultants and contract administrator, and the construction workstream currently shows as “red” due to ongoing assessment of this compensation event.

The information & communication technology (ICT) workstream has identified increased risks across infrastructure and smart building dependencies in the construction plan. Contributing factors to an amber ICT rating: delay to telephony, and risks relating to programme impact of the additional work required to deliver sufficient Wi-Fi and indoor location services data points.

People & culture
- Moorfields workforce impact & sequencing plan has been completed and approved. The plan captures projects across outpatients, admin & operations, surgery, electronic patient records (EPR), estates, and corporate/cross-cutting programmes, and provides assurance that HR support is in place for the change programmes.

- Staff briefing sessions were held in July 2026, to feedback outcomes of the Moorfields staff consultation and share organisational support available for managers. A *reasonable adjustments working group* has been established in response to feedback from the consultation. One Granary Street (1GS) village workshops are ongoing, with the final ones planned for the autumn. An *agile working adoption workstream* is being stood up.

- Site visits: a staff engagement event took place on 14 July 2026 with 88 staff and students in attendance and able to explore the new site. A successful visit also took place with Sir Jim Mackey and members of the New Hospital Programme team.

- External wayfinding workshops took place with transport providers and Camden council to progress work on signage and audio announcements. Station route-mapping visits took place as planned in August 2026, to validate patient journeys and wayfinding routes.

- An open invite to a furniture showcase has gone to staff and patients who wish to be involved in all public facing furniture choices.

- A research study has been approved with UCL to test different materials for the green line, invites have been issued to patients who wish to participate in the trial.

Transformation & building benefits

- Transformation continues to deliver to plan, overseen by Moorfields plan delivery group. Key achievements in month are that pre-assessment transformation project is completed; the radiology operating model has been designed (for approval at trust executive committee (TEC) in August) and relocation of sterile services offsite has been completed.

- Education demand and capacity assessment has now been completed, confirming that combined Institute of Ophthalmology (IoO) and Moorfields education activity can be accommodated within Oriel. Work is continuing to overlay wider Oriel demand and room booking protocol is under development.

- Oriel Moorfields benefits realisation plan is being revised following TEC and CEO feedback, and will return to TEC in September prior to entering New Hospital Programme change control process. Benefits dashboard is being developed by performance & information (P&I) team, with baseline measurement underway, and benefit owner meetings will commence in the autumn.

- A series of workshops were held in July to identify “building operating models” – the joint governance or new ways of working required to enable co-management of the asset by MEH and UCL. The actions from these workshops will be overseen by appropriate exec leads, and further workshops are planned in September on remaining topics.

Operational commissioning & relocation

- Development of the operational commissioning masterplan is now a priority and current focus is on collating a building-wide comprehensive list of commissioning activities. This was a key recommendation from our recent New Hospital Programme project readiness review (PRR) and it will set out how to coordinate different workstreams and teams in commissioning the space once we take ownership of the site.

- The annual business plan, setting out the scope, workplan, financials and governance of Oriel Estates Services, has been approved by Moorfields, and is currently being considered by UCL governance. Procurement of both hard and soft facilities management (FM) services is on track, and approval is being sought for hard facilities management contract award in early September.

- Cat B fit out of One Granary Street is ongoing with completion on track for mid-November. An information communication and technology business case for One Granary Street is progressing through governance, and then procurement will commence.

- Final clinical and operational snagging visits taking place and closure of snagging issues is a key delivery focus. A robust issue and change process is in place to review remaining design or snagging issues, with all requests subject to heavy triage due to limited contingency.

Oriel relocation services procurement update for information *(includes progress since the August programme summary report):*

- The relocation of all departments, services and equipment from current Moorfields and UCL Institute of Ophthalmology (IoO) sites to the new site will be completed by a specialist relocation services company. Moorfields and UCL IoO agreed to jointly procure a single service provider due to the complex logistics of moving two organisations into a single building with a shared loading bay. The procurement tender was issued under the Procurement Act 2023 as a two-stage competitive flexible procedure, with stage 1 launching 10 March 2026 and stage 2 completing at the end of June 2026.

- A relocation services procurement progress update and proposed sign off approach was provided to major projects and digital committee (MPDC) and TEC in May 2026, with MDPC delegating authority to TEC for approving the contract award.

- Following completion of Stage 2, Crown Workspace Ltd was identified as the preferred Tenderer. The Moorfields contract fee for Crown Workspace Ltd is £385,252.00 (excluding VAT). Moorfields have an allowance of £1,060,000 for relocation in the Oriel transition cost plan. This allowance is for the relocation services company contract, along with budget for specialist equipment manufacturers involvement for specialist transfer, decommission and recommission.

- The recommendation of contract award to Crown Workspace Ltd was reviewed and approved by TEC and Oriel executive board (OEB) in July 2026. Moorfields and UCL IoO have entered into separate contracts with Crown Workspace. The Moorfields contract was awarded on 10th August 2026, and work has started on planning the relocation.

Quality implications

The programme continues to ensure quality is a critical priority across all workstreams. The new operational commissioning workstream has a quality and safety sub-workstream to focus on key areas of clinical and research safety.

A joint quality and safety group is in the process of being established which will coordinate progress against the move and future business as usual structures relating to quality and safety.

Financial implications
The Oriel programme is currently forecast to deliver on time and on budget, but with an outstanding compensation event currently being assessed and not yet accepted.

Risk implications
The escalated risks & issues this month relate to

1. **Rescheduling of EPR Go-Live Date (Programme level risk) –** there is a risk to overburdening of managers/teams with needing to lead both the EPR service level change and Oriel service level change, leading to a potential delay in the Oriel Programme. There is also a risk of increased complexity of the move (due to integration ICT dependencies). Joint planning and oversight of the 2 programmes is being established to work through dependencies and co-develop solutions.

2. **Lack of full Architectural Design Docs for BYUK Provided Systems (ICT) -** there remains a significant risk that systems will not be known prior to completion of the infrastructure scope. Mitigations include a collation of systems and build assumptions around the required infrastructure, as well as an early warning notice has been raised about missing design documents to BYUK.

3. **Procurement for Structured Data Archive and IAM timeline (ICT)** - there is a risk that the procurement of the two systems will take longer than building in-house and subsequently putting the timeline for the two services at risk.

4. **The lack of an Oriel critical path to move (via an integrated master schedule) and an operational commissioning plan –** leading to challenges with coordination of activities and leading to potential delay to day 1 readiness. This is being actively developed this month to mitigate this risk.

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Oriel Executive Board Programme Summary Report September 2026

Moorfields Eye Charity

Moorfields Eye Hospital NHS Foundation Trust

NHS

UCL INSTITUTE OF OPHTHALMOLOGY

Programme Summary Report September 2026

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Headlines

- Risks appearing due to slow supplier appointment (PO for CBRE etc)
- Initial Annual Business Plan approval is now critical, as it enables both Hard and Soft FM providers engagement and subsequent activities.
- Operational Commissioning Masterplan is key to supporting Patient Day 1 and identifying opportunities to mitigate impact of PC delay.
- Instructed changes need implementation strategy and resource support – particularly for post-PC changes.

Finance

- The programme continues to forecast delivery within the approved budget, with remaining Headroom/Optimism Bias of £4.5m post-QCRA (MEH £3.6m; UCL £0.9m).
- Formal HMRC review of the PESM application remains ongoing.
- The latest cash flow forecast reflects the current expected timing of programme expenditure, with no emerging funding risk identified.
- QRA risks continue to be monitored monthly, with movements in committed and forecast changes reflected through the contingency position.

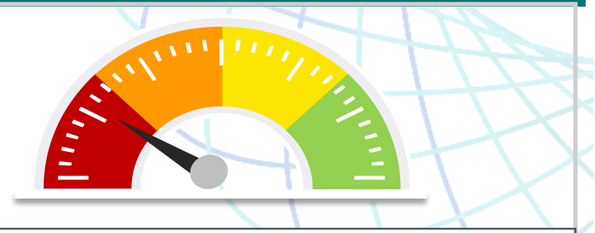
Construction & Design

- AECOM Assurance Assessment gives an AMBER rating for completion confidence and a risk of 2 to 3 week delay to PC.
- Programme is recoverable, but concerns remain on commissioning, certification and occupational readiness.
- BSR Compensation Event assessment is almost complete, indicating an encouraging position – trending back to Amber.
- PfA042 rejected and PfA043 received and under review.
- Incorporation of pre-PC change now limited.

Risks, Opportunities & Decisions

- Movement in the EPR Go-Live Date is the highest related risk.
- Challenges on the Annual Business Plan have introduced risk to dependent activities (Café fit out for example).
- Opportunities do exist for early (pre-PC) access to help mitigate against revised PC date – dependent on the Operational Commissioning Masterplan. No early access requests to date.
- Final approval of Executive Directors Contingency extension.
- No major accidents or near misses resulting in lost time in period.

Delivery Confidence Assessment



91% of MEH contingency and 92% of UCL contingency is now committed or forecast to be utilised, resulting in a Red RAG status for both.

Risks	Assumptions	Issues	Dependencies
7	1	4	0
—	—	↑	—
7	1	3	0

Above relates to number of programme level RAID items

Milestone	Original Contract Date	Forecast Contract Date	Variance
Beneficial Access	20 August 2026	26 November 26	+70d
Project (planned) Completion	06 November 2026	05 February 27	+65d
Contract Completion	19 February 2027	19 March 2027 (30th April – pending compensation event)	+20d
Oriel Operation Date	August 2027	TBC	-
Vacant Possession (City Road)	October 2027	TBC	-

Escalated (R)isks, (A)ssumptions, (I)ssues, and (D)ependencies

R	**Rescheduling of EPR Go-Live Date (Programme) –** EPR SL change and Oriel SI change happening concurrently. There is a risk to overburdening of managers/teams with needing to lead both the EPR service level change and Oriel service level change. Leading to a potential delay in the Oriel Programme. Increased complexity of the move, process and fatigue for staff. ICT risk around integration dependencies on Moorconnect systems - changes to the deployment timeline and implementation approach impact the delivery, testing and readiness of Smart Services systems in Oriel.	
R	**Interface gaps in OES services with ICT and service gaps with MEH & UCL end-user requirements** - Lack of clarity regarding the responsibilities for Oriel ICT systems (including lack of provision of detailed architectural design documentation for BYUK provided systems) resulting in ambiguity in what is being handed over to OES compared with what was expected. Leading to additional programme cost and time to rectify interface gaps.	
R	**Delay in approval of the Initial Annual Business Plan,** leading to delays to OES setup activities and maintenance of the risk that the cost to run the building may exceed expectations	
I	**The lack of an Oriel critical path to move (via an integrated master schedule) and an operational commissioning plan.** Also impacting the equipment workstream through the lack of transfers and logistics planning, and Day 1 Equipment requirements remain unknown until plan is received.	

£589.5m	£589.5m	0
MEH £18.9m	MEH £15.3m	MEH £3.6m
UCL £6.9m	UCL £5.9m	UCL £0.9m

Report Date	28/08/2026	Workstream	Construction	SRO(s)	Kieran McDaid Martin Greenhalf	Lead(s)	AECOM

Workstream RAG

Workstream Narrative on RAG

The latest accepted Programme is PfA041 (demonstrating progress to 02/06/2026). AECOM have conducted Site reviews throughout July noting progress is generally progressing in line with the latest accepted programme (PfA041), with minor delay to the LGF and UGF fitout works. AECOM are monitoring progress of this area.
Workstream RAG **RED** due to Compensation Event not yet being accepted to extend the programme.
BYUK submitted PfA043 on 24/08/2026. AECOM are due to provide their assessment by 07/09/2026.

Key Progress Areas Since Previous Report

Key Progress

1. Fit-Out and Client Inspections Progressing Well
Internal fit-out is now in its final stages, with Level 1 inspections complete, Levels 2–8 progressing through inspections and de-snagging, and corridor, flooring, decoration and FF&E installation works advancing across the building.
2. **Commissioning Activities Accelerating**
The programme has been impacted by missed commissioning milestones and compressed commissioning sequences, with incomplete installations limiting the ability to undertake testing activities. This has resulted in the cancellation of planned witnessing activities, while a significant volume of work remains ongoing and yet to be completed.
3. Building Safety Regulator (BSR) Engagement
Progress throughout July 2026 and August 2026 has continued through regular engagement with the BSR, including a successful site inspection that identified no major concerns and confirmed a high standard of project quality and record keeping. Focus has now shifted to addressing the BSR's multidisciplinary review comments on the Reversion (Transition) Application, covering fire safety, installed works, accessibility, structural submissions, and application scope. BYUK is developing a formal response strategy, while the legal status of Part Final Certificates remains a key outstanding issue.

Planned Progress Areas For Next Month

Key Priorities

1. Complete Commissioning and Validation
Focus will be on ventilation balancing, BMS, fire alarm, security, theatre validation and systems commissioning to support beneficial access milestones.
2. Accelerate Inspections and Snag Closure
Final inspections on Levels 3–5, ongoing client inspections and closure of snagging items will remain a key delivery focus.
3. Progress Regulatory Approvals
Support the BSR inspection process, close outstanding compliance matters and maintain focus on the route to Completion Certification.

Outlook
The project continues to make strong progress towards completion, with primary focus now shifting from construction to commissioning, certification and readiness for handover. The key challenge remains managing Building Safety Act requirements and completing commissioning activities without further programme impact.

Outstanding ICT Matters
- **General Coordination:** Increased engagement between Oriel ICT and BYUK is required to resolve outstanding issues through regular, documented coordination meetings and timely action tracking. Without improved coordination, there is a risk that outstanding activities will not be completed, which could impact the PfA.
- **Temporary Network Implementation (EWRP040):** The CRF approved by PMO for instruction to BYUK contains dates that do not align with either the previously agreed methodology (March 2026) or the PfA. A meeting will be arranged to support coordination between Oriel ICT and BYUK and enable the instruction to be issued.
- **Information Security & Governance (EWRP049):** Oriel ICT is undertaking a review of the vendors and will provide the findings to enable the outstanding issues to be understood and addressed with BYUK. Oriel ICT and BYUK will continue to coordinate on the resolution of these matters.
- **Overlength Data Cabling:** The Contractor's Proposal has been rejected. exi is managing progress through the defects process; however, there is currently no agreed resolution. Oriel ICT and BYUK are to coordinate to identify a suitable way forward.
- **RFID / RTLS Server:** Oriel ICT has advised that the servers can be procured; however, further information is required regarding connectivity. This information was requested at the EW meeting on 26/08/2026. Oriel ICT and BYUK are to coordinate to resolve the outstanding requirements.
- **Data Lakes:** The actions from the subsequent technical meeting remain outstanding. Oriel ICT and BYUK are to coordinate.

Budget Availability

x x

Key Decisions, Escalation, Support Needed

Name & Detail	Date Due	RAG
BSA Construction Activity List Confirmation of what Oriel works are required between BYUK Completion and the First Patient Date to establish an action plan should BSA requirements and/or adverse BSA impacts delay the Oriel Programme.	July 2026	
Further Late Client Changes Will significantly impact BYUK's ability to meet their planned Completion date. Mitigation strategies may lead to some discrete works needing to be concluded post planned Completion but before Completion. Update to be provided in the next reporting period.	Sep 2026	
MRI The MRI delivery date is after BYUK's planned Completion therefore a mitigation strategy is required to limit the impacts of a Compensation Event as BYUK must facilitate delivery by removing construction works along the route and at the entrance to the room.	Sep 2026	
Equipment Coordination Equipment coordination (MEH) has not been adequately completed, and resulting misalignment of transfer equipment requirements may necessitate additional procurement, increasing costs and potentially delaying the Oriel Programme.	August 2026	
Tissue Centre Loan Equipment If the Tissue Centre Loan Equipment delivery dates, amounts and specifications are not confirmed in sufficient time to enable coordination with the BYUK works, this is likely to result in a delay to validation activities and Completion. - Confirmation of specifications, numbers and delivery dates required.	August 2026	
RFID / RTLS If the RFID / RTLS servers are not provided in line with the agreements with BYUK, no later than 08/09/2026, it is likely there will be a delay to Completion, increase in costs and potential to delay the Oriel Programme.	August 2026	
Temporary to Permanent Network The CRF approved by PMO for instruction to BYUK includes dates that do not align to the previously agreed methodology (from March 2026) or the PfA. The current instruction is not suitable to issue to BYUK. A meeting is required to progress this.	August 2026	
Early Access BYUK should be made aware of the initially planned January 2027 operational readiness activities (when planned Completion was thought to be December2026) to facilitate pre-completion access and avoid compressing the limited readiness period ahead of the fixed First Patient Ready date.	August 2026	

Top 5 Key Dependencies

Dependency	Date Due	RAG
Building Safety Regulator (BSR) Approval & Completion Certification Confirmation of requirements and support from the BSR to satisfy client obligations.		
Completion of client inspections, defect resolution and de-snagging Extensive inspections and close-out activities are ongoing across Levels 1–8.		



Oriel Critical Success Factors (CSF)

Report issue date: September 2026
Reporting period to: 27 August 2026

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Critical Success Factors (CSF) Overview

Reporting period to	28 August 2026
Number of milestones	123
Milestones due in reporting period	10
Milestones achieved in reporting period	4

Scoring Guide

Risk RAG Rating

Red: The CSF has a linked red-rated risk (scored 16 or higher)
Amber: The CSF has a linked amber-rated risk (scored 12 or higher)
Green: The CSF has no linked amber or red-rated risks

Milestones RAG Rating

Red: The CSF has a milestone expected delivery date >20 days beyond due date and / or impacts critical path
Amber: The CSF has a milestone expected delivery date within 1-20 days beyond due date
Green: The CSF has a milestone early or on time for expected delivery date

Overall CSF RAG Rating

Red: If either Risk or Milestones is rated Red
Amber: If either Risk or Milestones is rated Amber (and neither is Red)
Green: Only if both Risk and Milestones are rated Green

People & Change Leadership

Ensures staff are consulted, prepared and supported to work in the new centre

Equipment

Ensures the building is safe, equipped, meets all regulatory requirements, and is ready for operational use.

Social Value

Ensures that we deliver a positive user experience, by co-ordinating interior design, wayfinding, donor recognition, community projects and volunteers

Building Ops

Ensures the Joint Delivery Vehicle and the Facilities Management services are ready to run the new centre

Operational Commissioning

Ensures all services in the building have an agreed target operating model, operational commissioning is completed & stage 4 gateway is achieved

Comms & Engagement

Ensures the programme engages with all users from start to end, including managing celebratory events & fundraising achievements

Relocation

Ensures the move is co-ordinated, delivered safely and within budget, and emergency preparedness and resilience is achieved.

ICT

Ensures delivery of the physical ICT infrastructure, the technology, systems and services required for all partners

Transformation & Shared Working

Ensures all new ways of working are defined, agreed and implemented on or before the move

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Note: full risk reporting is included in the main Oriel Summary Report pack. Only new risks raised in period are included in the commentary on this slide.

Key

TREND

- Improving
- No change
- Worsening

People & Change Leadership

Milestones (6)	0
Risk	0

- No Milestones due this month

Equipment

Milestones (10)	2
Risk	2

- #90: Complete specs for Group 3 items (MEH - Exc long lead items) – Minor delay to Sept.
- #95: - Produce a validated equipment list (MEH Only) – Minor delay to Sept.

Social Value

Milestones (17)	1
Risk	1

✓ #34: Agree the volunteer support model for the move – Complete

ICT

Milestone (12)	1
Risk	4

- #105: Wired Active Network Ready – work continuing into September, not expected to have a knock-on impact.
- Risk of Incomplete Infrastructure & Smart Building dependencies within the BYUK PfA has increased

Building Operations

Milestones (9)	1
Risk	3

✓ #84: Hard FM Contract approval – complete, pending JDV formal sign off.
- Risks - Cost to run the building may exceed expectations, Interface gaps in OES services with ICT and service gaps with MEH & UCL end-user requirements.

Operational Commissioning

Milestones (18)	2
Risk	0

- #93: Sign Off Tissue Centre shared governance framework – Update included in OEB paper, Propose rebaseline.
- #104: IoO Target Operating Models to be signed off – Minor delay, to be resubmitted to UCL following board feedback.

Comms & Engagement

Milestones (6)	0
Risk	0

- No milestones due this month.

Relocation

Milestones (21)	1
Risk	0

- #98: Additional 1GS ICT Equipment procurement started – Capital costs approved, revenue costs pending TEC approval. ICT to commence procurement for capital items.

Transformation & Shared Working

Milestones (24)	2
Risk	0

✓ #5: Deliver an offsite model for Sterile Services – Complete
✓ #11: Radiology Operating model approved – Complete

Risk no. = number of risks scored 12 or more

Milestone = number of major milestones in the period

Key activities this period

Milestones achieved

- ✓ #34 Agree the volunteer support model for the move.
- ✓ #11 Radiology operating model approved
- ✓ #5 Deliver an offsite model for sterile services
- ✓ #84 Hard FM contract approved

Workstream activities

- **Building Operations:** Hard and Soft FM approved by UCL with condition to ensure costs sit within the budget. Best and final offers due for Soft FM. Annual business plan being finalised with key items related to insurances and running costs. Recruitment underway for FM projects role.
- **Social Value:** Volunteer support model complete. Creative programme rationalisation plan circulated and Day 1 commissioning task and finish group stood up. Wayfinding signage procurement on track, aiming to conclude mid September.
- **Equipment:** User group meetings for Group 3 items (Exc long lead items) continuing and will conclude by end of September. Staff furniture showcase taking place on 22 Sept.
- **Relocation:** Relocation supplier live and governance in place. Institute library move taking place w.c. 07/09. Room mapping underway. Decommissioning supplier to be appointed. 1GS construction on plan, network procurement live. 1GS end user devices business case approved by BCRG and procurement to be initiated.
- **Operational Commissioning:** Operational commissioning master plan development continuing with regular meetings taking place. Quality and safety group chaired by MEH CNO being stood up.
- **Communications & Engagement:** Patient communications planning via letters and clinical systems underway. 1GS Wayfinding and branding being developed. Support patient recruitment for UCL research study into tactile navigation options.
- **Transformation & Shared Working:** Education – Draft room booking principles out for stakeholder feedback. SOPs being drafted. Innovation hub – TOM going to stakeholders on 24/09. Transformation – Reviewing IT / digital dependencies with pre-assessment TOM to ensure the model that has been launched is sustainable. Additional project resource added to cataract post-ops to support delivery.
- **People & Change Leadership:** Change leadership sessions live. Agile working workstream to be stood up.
- **ICT :** Workstream is reporting amber due to (1) delays to the design and build of the telephony, IAM and data archive solutions; (2) concerns over whether the Smart Building elements of the PFA represent a realistic and credible plan for completion; and (3) the affordability and programme impact of Indoor Location Services (ILS). AV tender live w.c. 07.09.

Major Milestone look ahead - A

*Future milestones identified in month with forecast delivery dates which are beyond the due date will be investigated in the next month to assess impact and a mitigation plan to be put in place.

Critical Success Factors	#	Major Milestones	Baseline Due Date	Revised Due Date	Forecast Due Date	SRO
Relocation	**98**	Additional 1GS ICT Equipment procurement started	Jun-26	Jun-26	Sep-26	Chloe Cox
Operational Commissioning	**93**	Sign off Tissue Centre shared governance framework	Jun-26	Jul-26	TBC	Chloe Cox / Geoff Dunk
Equipment	**90**	Complete user input to specifications for Group 3-items (Exc long lead items) (MEH)	Aug-26	Aug-26	Sep-26	Wayne Sexton
Equipment	**95**	Produce a validated equipment transfer list (MEH Only)	Aug-26	Aug-26	Sep-26	Wayne Sexton
ICT - Infrastructure	**105**	Wired Active network ready	Aug-26	Aug-26	Sep-26	Brendon Mahoney / Lloyd Naylor
Operational Commissioing	**104**	IoO Target Operating Models tobe signed off	Aug-26	Aug-26	Sep-26	David Howard
Transformation & Shared Working	**3**	Transformation governance confirms adult outpatient transformation required for Oriel day 1 is complete	Feb-26	Sep-26	Sep-26	Victoria Banks
Transformation & Shared Working	**10**	Pharmacy workforce model approval	Sep-26	Sep-26	Sep-26	Kerry Tinkler
ICT - Infrastructure	**43**	Wireless Active Network Ready	Mar-26	Sep-26	Sep-26	Brendon Mahoney / Lloyd Naylor
ICT	**47**	EPR Go Live	May-26	Sep-26	Mar-27	Brendon Mahoney
Building Operations	**50**	Soft FM contract approval	Sep-26	Sep-26	Sep-26	Kieran McDaid
Building Operations	**51**	Approval of annual business plan for JDV	Jun-26	Sep-26	Sep-26	Kieran McDaid
Transformation & Shared Working - Education and Innovation hub	**57**	Innovation Hub Target Operating Model complete	Mar-26	Sep-26	Nov-26	Nick Burt & Viren Jeram
Relocation	**63**	MEH Oriel move Champion role established & recruited to	May-26	Sep-26	Sep-26	Chloe Cox
Relocation	**71**	IoO move plan approved	Mar-26	Sep-26	Sep-26	Geoff Dunk
Building Operations	**86**	Finalise draft Post PC plan for day-1 works and building co-ordination.	Jun-26	Sep-26	Oct-26	Kieran McDaid
Transformation & Shared Working - Education and Innovation hub	**106**	Develop timetable that shows all education programmes mapped into the rooms at the centre to identify conflicts & gaps	Sep-26	Sep-26	Sep-26	Rebecca Ellis / Michele Russell
Transformation & Shared Working	**109**	Transformation governance confirms patient support service transformation required for Oriel Day 1 is complete.	Sep-26	Sep-26	Oct-26	Kerry Tinkler
Building Operations	**119**	All notifiable works identified	Sep-26	Sep-26	Sep-26	Kieran McDaid
Relocation	**70**	1GS Move Management and decant plans developed	Jun-26	Sep-26	Sep-26	Chloe Cox
Relocation	**72**	City Road high level Campus Move plan developed	Jun-26	Sep-26	Sep-26	Chloe Cox
People & Change Leadership	**92**	New ways of working “village workshops” completed	Sep-26	Sep-26	Nov-26	Sue Steen
Social Value	**36**	Begin sign & donor recognition manufacture	Oct-26	Oct-26	Oct-26	Kate Falkner / Rachel Jones
ICT - Infrastructure	**44**	Cutover from Temporary Network to Production Network	Mar-26	Oct-26	Oct-26	Brendon Mahoney / Lloyd Naylor
Social Value	**82**	MEC & FOM services completed a Target Operating Model	Oct-26	Oct-26	Oct-26	Kate Falkner / Rachel Jones
Equipment	**88**	Delivery of Group 2 items to instructed location	Mar-26	Oct-26	Oct-26	Wayne Sexton
Social Value	**111**	Atrium furniture aligned to interior design strategy and approved by OEB.	Oct-26	Oct-26	Oct-26	Kate Falkner
Comms & Engagement	**122**	First set of MEH patient communication letters sent out (Digital, text, letter)	Oct-26	Oct-26	Oct-26	Jenni Frost / Laura Brewster
ICT - Smart Building	**46**	Building system integrated with the IOP	Jul-26	Nov-26	Nov-26	Brendon Mahoney / Lloyd Naylor
Relocation	**112**	Move go/no go frameworks for 1GS and the Centre developed and socialised	Nov-26	Nov-26	Nov-26	Chloe Cox / David Howard
Relocation	**113**	Detailed MEH service level move plan developed	Nov-26	Nov-26	Nov-26	Chloe Cox

*Future milestones identified in month with forecast delivery dates which are beyond the due date will be investigated in the next month to assess impact and a mitigation plan to be put in place.

Critical Success Factors	#	Major Milestones	Baseline Due Date	Revised Due Date	Forecast Due Date	SRO
				Nov-26	Nov-26	Chloe Cox
				Dec-26	Sep-26	Victoria Banks
				Dec-26	Dec-26	Victoria Banks
				Dec-26	Dec-26	Louisa Wickham
				Dec-26	Dec-26	Brendon Mahoney
				Dec-26	Dec-26	Jon Spencer / Andrew Dick
				Dec-26	Dec-26	Chloe Cox / David Howard
				Dec-26	Dec-26	Jenni Frost / Laura Brewster / Rachel Jones
				Dec-26	Dec-26	Chloe Cox / David Howard
				Dec-26	Nov-26	Chloe Cox
				Dec-26	Dec-26	Rebecca Ellis / Michele Russell
				Dec-26	Dec-26	Victoria Banks
				Dec-26	Dec-26	Victoria Moore, Geoff Dunk
				Dec-26	Dec-26	Kate Falkner
				Dec-26	Dec-26	Chloe Cox
		Complete user input to specifications for Group 3-items (Exc long lead items) (UCL)		Dec-26	Dec-26	Wayne Sexton / Jill Cowing
				Jan-27	Jan-27	Brendon Mahoney / Lloyd Naylor
				Jan-27	Feb-27	Chloe Cox
				Jan-27	Jan-27	Kathryn Lennon
				Feb-27	Feb-27	Chloe Cox / Geoff Dunk
		Installation - Donor Recognition - Completed		Feb-27	Feb-27	Kate Falkner / Robert Dufton
				Feb-27	Feb-27	Brendon Mahoney / Lloyd Naylor
				Feb-27	Feb-27	Brendon Mahoney / Lloyd Naylor
				Feb-27	Feb-27	Chloe Cox

Major Milestone look ahead - C

*Future milestones identified in month with forecast delivery dates which are beyond the due date will be investigated in the next month to assess impact and a mitigation plan to be put in place.

Critical Success Factors	#	Major Milestones	Baseline Due Date	Revised Due Date	Forecast Due Date	SRO
Social Value	**126**	Finalise intepretation and display plan for arts and heritage	Feb-27	Feb-27	Feb-27	Kate Falkner
Transformation & Shared Working	**8**	Implement a new administrative & digital model for PPU	Mar-27	Mar-27	Mar-27	Elena Bechberger
Equipment	**25**	Installation of equipment (commissioning, testing, user training and handover)	Sep-27	Mar-27	Mar-27	Wayne Sexton
Operational Commissioning	**27**	Home Office BSU testing complete and sign off achieved	Mar-27	Mar-27	Mar-27	Chloe Cox
Building Operations	**31**	Practical completion of the Centre (BYUK handing to Oriel)	Mar-27	Mar-27	Feb-27	Kieran McDaid / Martin Greenhalf
Building Operations	**32**	Technical commissioning complete (Estates handing to Operations)	Mar-27	Mar-27	Feb-27	Kieran McDaid / Martin Greenhalf
Social Value	**37**	All building Wayfinding Signage & Donor Recognition installed	Mar-27	Mar-27	Mar-27	Kate Falkner / Robert Dufton
Social Value	**118**	Strategic direction for branding agreed and Executive branding walkaround complete.	Mar-27	Mar-27	Mar-27	Kate Falkner
Comms & Engagement	**123**	First set of MEH patient appointment letters sent out (Digital, text, letter)	Mar-27	Mar-27	Mar-27	Jenni Frost / Laura Brewster
Social Value	**38**	Finalise Wayfinding MasterPlan	Apr-27	Apr-27	Apr-27	Kate Falkner
Relocation	**76**	Develop and agree clinical admin operating model for move period including approach to double running	Apr-27	Apr-27	Apr-27	Jon Spencer
Operational Commissioning	**81**	Operational commissioning complete - centre ready for occupation	Apr-27	Apr-27	Apr-27	Chloe Cox / Geoff Dunk
Relocation	**107**	Move from Ebenezer Street to the centre complete	Apr-27	Apr-27	Apr-27	Chloe Cox
Transformation & Shared Working	**117**	Complete the asynchronous diagnostic hub relocation.	Apr-27	Apr-27	Feb-27	Victoria Banks
Operational Commissioning	**28**	CQC registration achieved	May-27	May-27	May-27	Sheila Adam
Operational Commissioning	**29**	Regulatory conditions achieved (HTA, MHRA etc)	May-27	May-27	May-27	Chloe Cox
Social Value	**127**	Installation of arts, heritage and Science on Show including new commissions	May-27	May-27	May-27	
Operational Commissioning	**40**	Complete a patient & user pre-move site review	Jun-27	Jun-27	Jun-27	Kate Falkner
ICT - Smart Services	**80**	Smart Hospital Go Live	Jun-27	Jun-27	Jun-27	Brendon Mahoney
Operational Commissioning	**83**	Department of Health Gateway 4 assessment completed and passed.	Jun-27	Jun-27	Jun-27	Chloe Cox
Operational Commissioning	**20**	All staff (MEH & UCL) inducted in their new work environment	Jun-27	Jul-27	Jul-27	Chloe Cox
ICT - Smart Services	**77**	Smart Hospital Transition to BAU	Jul-27	Jul-27	Jul-27	Brendon Mahoney
Relocation	**100**	1GS RIBA S6 Handover	Aug-27	Aug-27	Nov-27	Chloe Cox
Social Value	**103**	Donor engagement and events for Opening Ceremony Complete	Aug-27	Aug-27	Aug-27	Kate Falkner / Robert Dufton
Social Value	**41**	All section 106 obligations discharged	Sep-27	Sep-27	Sep-27	Jenni Frost
Social Value	**65**	Achievement of £80m capital philanthropic target	Sep-27	Sep-27	Sep-27	Robert Dufton
Relocation	**74**	Move completed	Oct-27	Oct-27	Oct-27	Chloe Cox / Geoff Dunk
Relocation	**75**	Decommissioning activities complete	Oct-27	Oct-27	Oct-27	Kieran McDaid/Geoff Dunk
Relocation	**79**	Issue Oriel Programme closure report	Jan-28	Jan-28	Jan-28	Jenni Frost / Laura Brewster



Finance

- In-Month Changes
- Financial Position
- Contingency Management
- Quarterly Quantified Risk Analysis
- Contingency Overview
- Cashflow

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Programme Oriel – August In-Month Movement

Key Message

The programme continues to forecast delivery within the approved funding envelope. Remaining Headroom/Optimism Bias has reduced by £2.3m, from £6.8m to £4.5m (MEH £3.6m; UCL £0.9m).

The reduction is primarily driven by £2.0m forecast costs associated with the restart of notifiable wor h a
£0.3m JDV Executive Allowance, now earmarked following agreement with NHP on the funding of M

Other in-month movements principally relate to updated professional fee forecasts, as set out in the table below.

£'millions	MEH				UCL				Oriel			
	Budget	Forecast	Variance	*Change this month*	Budget	Forecast	Variance	*Change this month*	Budget	Forecast	Variance	*Change this month*
Construction	273.4	275.9	(2.5)	(1.7)	98.9	99.6	(0.7)	(0.6)	372.4	375.6	(3.2)	(2.3)
One Grannary Street (Partly funded by reduced Equipment spend)	3.9	3.9	0.0	0.0	0.0	0.0	0.0	0.0	3.9	3.9	0.0	0.0
Professional fees and project team costs	49.0	49.1	(0.1)	(0.3)	17.5	17.5	(0.0)	(0.1)	69.4	69.5	(0.1)	(0.4)
IT and equipment	30.3	31.6	(1.3)	0.0	12.9	13.4	(0.5)	0.0	40.3	42.0	(1.7)	0.0
Land	30.0	30.0	0.0	0.0	10.0	10.0	0.0	0.0	40.0	40.0	0.0	0.0
VAT	21.5	21.5	0.0	0.0	11.2	11.2	0.0	0.0	32.7	32.7	0.0	0.0
Contingency (midpoint P50 to P80)	22.8	18.9	3.9	2.0	8.1	6.9	1.2	0.7	30.9	25.8	5.0	2.7
Total project budget	**430.9**	**430.9**	**0.0**	**0.0**	**158.6**	**158.6**	**0.0**	**0.0**	**589.5**	**589.5**	**0.0**	**0.0**

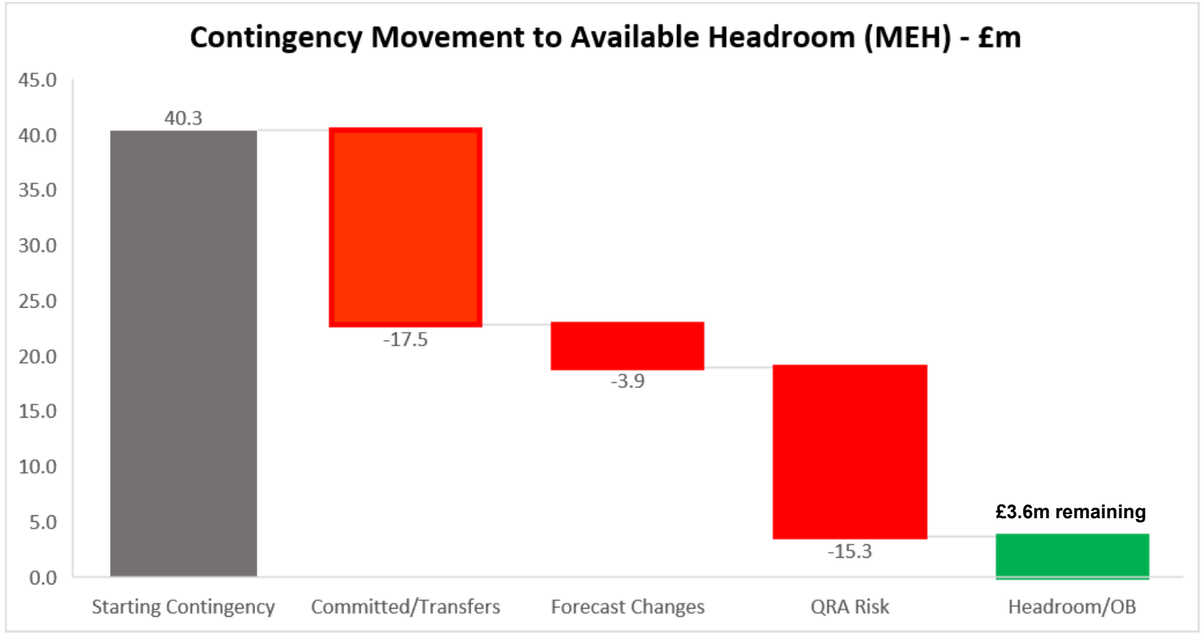
Breakdown of Contingency Movement - Aug (£m)				
	MEH (£m)	**UCL (£m)**	**Oriel (£m)**	
PMI's	1.462	0.542	2.004	PMI 220- Restart of notifiable works following change of RBCA: PMI 225 - Laser Curtain Grouping Change: 230 - Power to LGF and UGF Donor Recognition Walls
Professional Fees	0.33	0.06	0.39	Professional fees for, T&T revised scope, NMA Temporary Substation and Renal Access, G&T extension & additional work, EXI contract uplift, CBRE Geospatial Survey and Aecom Evaluation Fee
JDV Exec Allowance	0.22	0.08	0.32	Earmarked for JDV Exec Allowance
Net Contingency Movement	**2.00**	**0.68**	**2.71**	

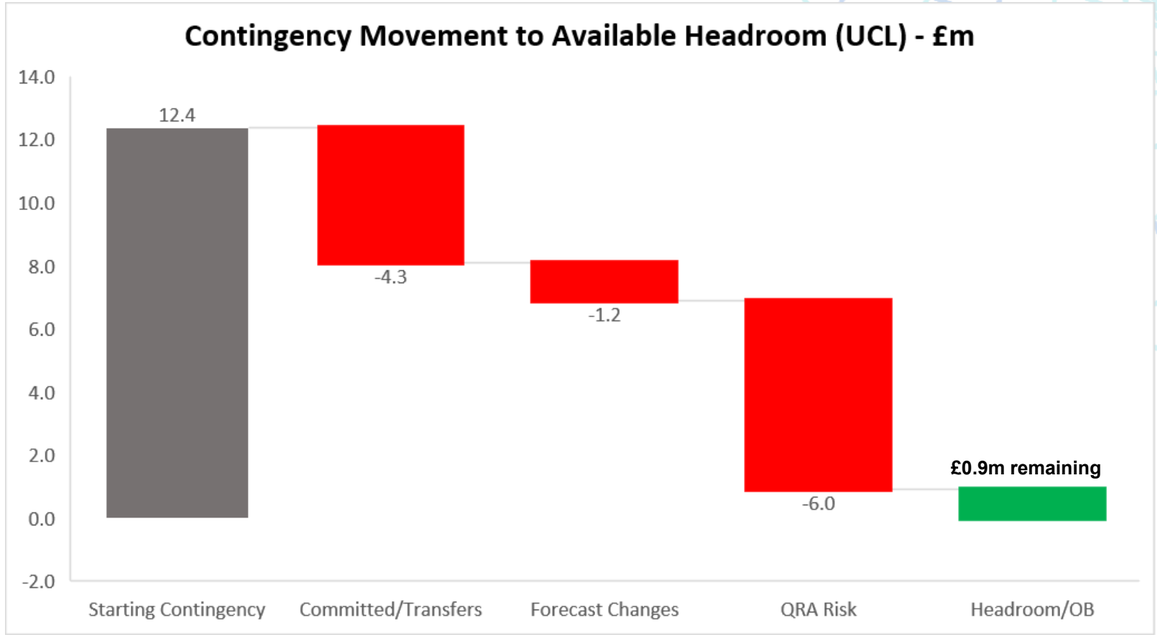
- Remaining Headroom/Optimism Bias: £4.5m

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(Negative = reduction in contingency requirement / release).

Contingency overview





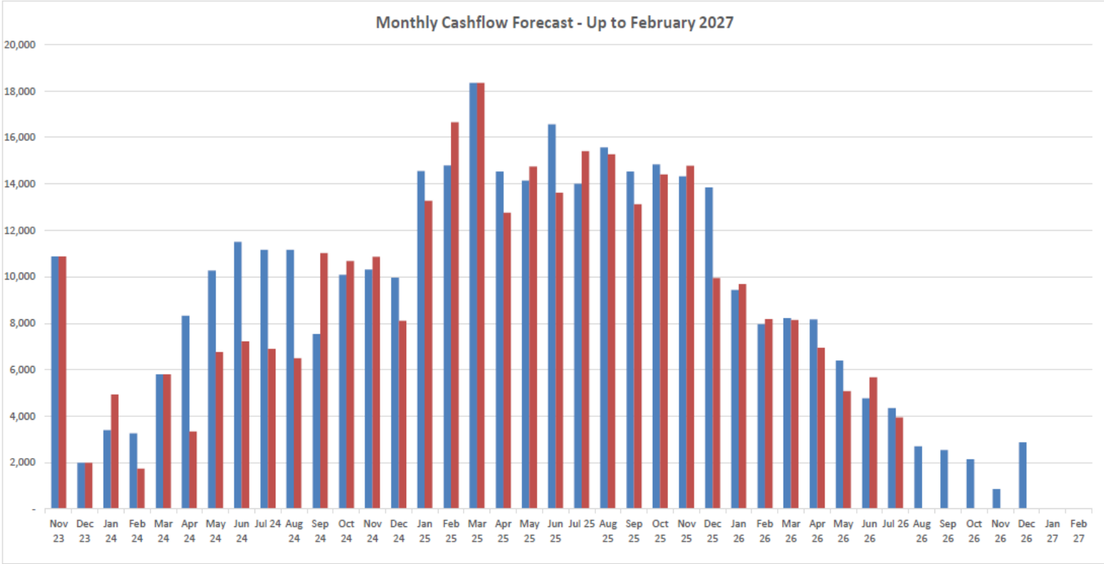
Commentary MEH

- Remaining Headroom/Optimism Bias has reduced from £5.3m to £3.6m, primarily reflecting MEH's £1.5m share of forecast costs associated with the restart of notifiable works following the change of RBCA, together with £0.2m earmarked for the JDV Executive Allowance.
- The remaining position continues to provide coverage against the current modelled QRA risk, with £3.6m Headroom/Optimism Bias remaining post-QRA.
- The programme remains within the approved MEH contingency envelope, with remaining headroom continuing to be closely monitored.

Commentary UCL

- Remaining Headroom/Optimism Bias has reduced from £1.5m to £0.9m, primarily reflecting UCL's £0.5m share of forecast costs associated with the restart of notifiable works following the change of RBCA, together with £0.1m earmarked for the JDV Executive Allowance.
- The remaining position continues to provide coverage against the current modelled QRA risk, with £0.9m Headroom/Optimism Bias remaining post-QRA.
- The programme remains within the approved UCL contingency envelope, although remaining headroom is limited.

Cash Flow Forecast



- Actual expenditure is reflected to August 2026, with forecast expenditure from September 2026 onwards.
- The latest cash flow reflects the current expected timing of programme expenditure and will continue to be updated as cost and delivery forecasts are refined.
- Changes in the timing of expenditure do not change the programme's approved funding envelope or overall forecast outturn.

Programme Contingency

£'000	MEH			UCL	Programme
	Core	NHP	Total		
Original Budgeted Contingency	**18,317**	**22,000**	**40,317**	**12,374**	**52,691**
Movements to date:					
Committed/ Transferred to revised budget (Appendix B)	(15,141)	(2,400)	(17,541)	(4,293)	(21,833)
Forecast changes (Appendix D)	(3,176)	(674)	(3,851)	(1,197)	(5,048)
Contingency position (after known cost pressures before QCRA)	**0**	**18,926**	**18,926**	**6,885**	**25,811**
QRA Modelled Risk (Expected Future Drawdown	(15,320)		(15,320)	(5,982)	(21,302)
Internal allocation from NHP to MEH (subject to governance approval)	15,320	(15,320)	0		0
Available Headroom post QCRA/Optimum Bias	**0**	**3,605**	**3,605**	**903**	**4,508**

Programme Contingency

- The programme retains 4.5m of Headroom/Optimism Bias post-QCRA (MEH £3.6m; UCL £0.9m).
- The programme remains within the approved contingency envelope.

NHP Contingency Utilisation- MEH

- The £22.0m NHP contingency remains the primary funding source for MEH programme risks.
- £2.4m has previously been approved for OGS, with a further £0.7m of forecast pressures now identified for funding from NHP contingency.
- A further £15.3m is currently required to provide coverage for modelled QRA risk, resulting in remaining Headroom/Optimism Bias of £3.6m.
- Further utilisation of NHP contingency remains subject to the relevant governance and approval process.



Risk Management

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Top Risks (12+) across all CSF workstreams

CSF	Risk Title	Risk Score	Risk Description
Programme Wide	**Rescheduling of EPR G0-Live Date**	**16**	There is a risk to overburdening of managers/teams as they are asked to lead both the EPR service level change and Oriel service level change. This also creates increased complexity of the move, processes and fatigue for staff. An Integrated Plan is in development between the teams, additional resource identified, and an assurance framework is in development. Further work is planned with HR OD colleagues to develop a support approach for key staff members.
Building Operations	**Interface gaps in OES services with ICT and service gaps with MEH & UCL end-user requirements.**	**15**	If there is a lack of clarity regarding the responsibilities for Oriel ICT systems (including specs for BYUK supplied systems) then there will be ambiguity in what is being handed over to OES compared with what was expected. Building Ops teams are working with ICT to identify and resolve this risk, creating accountability structures to be agreed.
Construction (AECOM)	**VAT assumptions**	**15**	Oriel budget assumes JDV VAT is recoverable across the life of the project consisting of 77% recovery of VAT costs for MEH and 56% recovery of VAT costs for UCL. In December 2024, HMRC rejected the JDV's initial partial exemption method application for MEH recovery. A revised application has been submitted to HMRC in March 2025, which the JDV's specialist tax advisors believe will be successful. HMRC have confirmed that a successful application will be back-dated to April 2023. UCL's application is being prepared for Q1 submission.
Equipment	**Lack of transfers and Logistics planning**	**12**	There is a risk that equipment will be procured unnecessarily with no provisions in place to transfer the volume of potential equipment that could be transferred. The Trust has procured a removal service to validate the transfer assumptions, it is expected that this risk can be mitigated upon completion of this work.
Programme Wide	**BYUK use of terminal float for non-construction workstreams**	**12**	There is a risk that practical completion and building handover doesn't occur until 19th March 2027. This could result in constrained time to complete activities where access to the building is required, and a potential cost impact to the client for having to retain contractors for longer. Mitigation consists of ongoing review of beneficial access, workstream schedules and development of an integrated master plan and operational commissioning plan.
Building Operations	**Delay in approval of business plan and IABP**	**12**	If the governance approval process is not enacted in a timely manner then there will be a delay in approving the business plan and IABP. Current target completion date of November, no material impact on the construction or move schedules has been identified.
Building Operations	**Cost to run the building may exceed expectations**	**12**	There is a risk that the cost to run the building may exceed expectations. Costs are under review and to be approved via organizational governance routes
ICT	**Integration dependencies on Moorconnect**	**12**	The final deployment approach and associated integration timelines for downstream systems have not yet been agreed, creating uncertainty across Oriel planning and delivery activities. MEH ICT Programme Board has a revised focus on dependency management and an integrated plan has been developed
ICT	**Lack of detailed architectural design documentation for BYUK provided systems**	**12**	There is a risk that Infrastructure requirements of BYUK provided systems may not be known prior to completion of infrastructure scope, due to BYUK not providing the full suite of architectural designs for contractual BMS systems. Vendor workshops have been arranged to obtain correct documentation and cyber security information.
ICT	**Procurement Lead Times & Costs**	**12**	Due to the increasingly challenging geopolitical environment. There is a risk that equipment required for procurement across multiple areas may be subject to longer lead times and increased costs. Critical areas have been identified and prioritized for procurement.
ICT	**Incomplete Infrastructure & Smart Building dependencies within the BYUK PfA**	**12**	The current BYUK PfA does not identify further Infrastructure or Smart Building dependencies after July 2026 for the remaining design, integration, testing, witnessing, validation and handover activities. Work in progress with BYUK to identify and add details to the PfA.

Moorfields Eye Hospital NHS Foundation Trust

Chief nurse quality report
Board of directors
24 September 2026

Report title	**Chief nurse quality report**		
Report from	Suminthra Naidu, Chief Nurse and Executive Director for Allied Professionals		
Prepared by	Ian Tombleson, Director of Quality and Safety/ Kate Falkner Associate Chief Nurse		
Previously considered at	Various management groups/committees	**Date**	NA
Link to strategic objectives	Underpins all strategic objectives		

Executive Summary

This report provides assurance about key nursing-led quality, safety and governance arrangements across Moorfields Eye Hospital NHS Foundation Trust. The report continues to develop and covers a wide range of topics. Overall, appropriate systems and processes are in place to support safe, effective care, with ongoing work to strengthen leadership, learning and assurance.

Pathway to Excellence

The pathway to excellence programme has been a significant achievement at Moorfields over the past three years, providing a structured framework to strengthen professional practice, patient safety, and workforce engagement. Through its six standards, which underpin the fundamentals of high-quality, compassionate care, the programme has served as a powerful catalyst for continuous improvement and shared decision making across services. As we build on the achievements of the past three years, the programme continues to provide a strong foundation for delivering our strategic ambitions in patient safety and quality improvement which will have stronger foundation in the new chief nurse officer (CNO) structure. We will be hosting the International Director of Pathway to Excellence Dr Christine Pabico, in November to share and celebrate achievements.

Infection control

We maintain compliance with infection prevention control (IPC) standards of practice and audits. Key areas to note:

- For the month of August, no trust reportable cases of endophthalmitis
- The team have undertaken four environmental audits, and all scored a compliant green standard
- Trust mandatory infection prevention control training for Level 1 was 96% and Level 2 was 84%
- Further IPC work at Stratford to enable the continued use of Surgicube facilities has included the development of a new standard operating procedure (SOP), revised particle count calculations, analysis of expert reports on ventilation parameters.
- Continue to work on capital planning projects for Oriel, Bedford and Ealing.
- Flu campaign due to launch on the 1st October – target for vaccination set at 60% (last year achieved 51.1%)

Safeguarding

Safeguarding remains a core priority for the Trust, with a continued focus on ensuring that all patients, carers, visitors and staff are protected from harm, abuse, neglect and exploitation. During this reporting period, safeguarding activity has been monitored through established governance arrangements, including regular review of referrals, incidents, learning from safeguarding reviews, and compliance with statutory safeguarding responsibilities.

A particular area of focus during this reporting period has been the management and oversight of allegations against staff, strengthening organisational and multi-agency collaborative working, and improving safeguarding training compliance. These areas have been supported through enhanced governance oversight, targeted staff engagement, and ongoing partnership working with key stakeholders to ensure timely identification, escalation and management of safeguarding concerns.

Adult social care referrals have increased steadily since January 2026, rising from 4 to 10 referrals per month and remaining consistently above the historical average. August 2026 recorded 15 referrals, exceeding the upper control limit and indicating a significant increase in demand. This sustained upward trend and recent spike require monitoring to understand underlying causes and service capacity implications

Safeguarding children and young people queries have demonstrated a sustained upward trend over the reporting period, increasing from 61 in April 2025 to 90 in August 2026. Activity peaked at 99 queries in July 2026, exceeding the upper control limit and indicating a signal of special cause variation. While August 2026 levels reduced slightly, demand remains significantly above the centre line, suggesting a continued increase in safeguarding activity that will require ongoing oversight and monitoring.

Additional deep dive report for DBS certificates and compliance with standards. Improvement workstream with HR to support ongoing work to progress this area.

Safeguarding annual report for noting at board.

Education
Education remains a critical enabler of workforce development, and high-quality patient care across Moorfields. Aligned to the new chief nurse officer structure, there is a clear strategic vision to establish a consistent, multiprofessional approach to developing clinical capability, career progression, and competency assurance across nursing, allied professionals and technicians.

This approach supports the principle of ensuring the right staff, with the right skills, are delivering care to the right patient, in the right place, at the right time. Creating standardised pathways for professional development and competency assessment, means we can strengthen workforce flexibility, support multidisciplinary team working, and ultimately deliver safe, effective, and patient-centred care. This model S.C.O.P.E. (Skills and Capability in Ophthalmic Practice Excellence) underpins the objectives defined for the future workforce strategy. Pilot due to start in October.

Work has also progressed on the development of a unified education faculty model to support Oriel readiness and enhance collaboration across education, research and workforce development activities.

Education programmes continue to expand in response to workforce needs, with growth in advanced and enhanced clinical practice pathways, apprenticeships, leadership development and continuing professional development opportunities.

Violence and Abuse Prevention and Reduction
Moorfields has seen an increase in reported incidents of violence and abuse, including incidents of racism directed towards staff in clinical settings. These behaviours are

unacceptable and have a significant impact on staff wellbeing, psychological safety, retention, and the quality of care provided to patients.

In response, a new multiprofessional violence and abuse prevention group, chaired by the chief nursing officer, has been established to provide strategic oversight and drive improvement across the organisation. Reflecting the recommendations of the Lord Mann review, the group will lead a comprehensive review of existing policies, reporting processes, staff support mechanisms, education and training programmes, and organisational approaches to prevention.

Through this work, the trust aims to create safer environment for staff and patients, strengthen workforce wellbeing and psychological safety, and reinforce its commitment to being an organisation where discriminatory, abusive and violent behaviours are not tolerated. Progress and outcomes will be monitored through incident reporting data, staff experience metrics, and workforce indicators, with regular assurance provided to the Board.

Care Quality Commission (CQC) compliance
The trust continues to maintain oversight of CQC compliance through the clinical governance committee and the quality and safety committee. Work is underway to strengthen readiness for future inspection activity, including ensuring evidence against CQC quality statements and key lines of enquiry, that is current, accessible and clearly owned. The chief nurse officer briefed the CQC prior to completion of the recent external review. The summary report was shared with the CQC. As part of a wider trust exercise, we will be building in learning from these external reviews into our governance arrangements. The organisation has recently responded to one query from the CQC about how we managed three incidents through the work of our incident review group. The next step is to link CQC framework with pathway to excellence and embed as business as usual.

Patient experience and feedback
Patient experience continues to be monitored through multiple sources, including friends and family test (FTT) results, complaints, compliments, patient advice and liaison service (PALS) and targeted engagement activity. Overall performance against our FFT remains consistently strong with good feedback. Mechanisms are in place across the organisation to learn where feedback identifies gaps.

Complaints performance continues to be consistently above the Board targets. The 3-day complaints acknowledgement target (80% within 3-days) is consistently exceeding the target. Performance against the 80% final response target is also consistently exceeding the 25-day response target. For the latest reporting period of July, we responded to 24 of the 27 complaints (88.9%) within key performance indicator (KPI), therefore 3 complaints missed their deadline. As referred to at the previous board meeting other areas of improvement are required relating to complaints performance. At the date of this report there were a total 18 first complaints that had exceeded the trust 25-day KPI and also 36 reopened complaints (where a complainant was not satisfied with their initial response). A recovery plan is being put place to respond to these complaints and remove the backlog, with oversight from the quality and safety committee. In parallel we are working to improve complaints processes.

Our stage one apologies for our duty of candour (DoC) response continues to be inconsistent and below KPI. For July (the trust achieved 67% (6 out 9) which was an improvement on the previous reported figure of 50%. As reported previously we are managing improvement in a number of areas: we are revising the DoC policy and processes, and we are working with divisions and the new clinical site structure to drive consistent performance.

Overall feedback about care and treatment at Moorfields consistently reflects positive patient experiences of staff professionalism and compassion. Key improvement themes remain focused on communication, coordination of care (appointments) and waiting times in some services. Actions arising from patient feedback are monitored through divisional and trust-level governance processes.

The patient experience team continues to support the delivery of the patient experience framework, underpinned by its five principles relating to 'see the whole person'. Delivery of the framework objectives continue to be achieved through effective partnership working with patients, carers, stakeholders and staff. Highlights of key priorities:

- Developing consistent and scalable methods for continuous improvement and ensuring that improvements to the patient experience are clearly evidenced and shared across the organisation.
- Developing further and communicating tangible examples of patient and carer engagement and involvement activities and showcasing the impact and value of trust activity.

We have undertaken a benchmark against the newly published “minimum standards of patient experience” report released by NHS England and are currently working through linking these standards with the Patient experience principles.

Workforce

1. **Restructure**

The chief nurse officer directorate is currently undergoing a restructure to strengthen leadership and create a more integrated approach to quality, safety, professional practice, and workforce development. A key feature of the redesign is the development of a strengthened multiprofessional leadership model, promoting closer alignment between clinical quality, regulation, workforce design and development, and professional practice. This will support greater collaboration across nursing, allied professions, healthcare scientists, technicians, and medical colleagues, ensuring a coordinated approach to delivering safe, effective, and patient-centred care.

In partnership with University College London (UCL), the directorate will move to a joint governance approach for education and innovation. This will strengthen the translation of education programmes into clinical practice, create opportunities for multidisciplinary learning, and support the development of future clinical leaders across professional groups.

The revised structure is intended to enhance organisational capability by providing clearer accountability, reducing duplication, strengthening assurance, and fostering a culture of continuous improvement.

2. **Workforce oversight**

Focus on actions from the gap analysis completed against the Developing Workforce Safeguards standards (2018). This has included;

- Scoping of the safe staffing policy
- Development of the process and procedure for the biannual staffing reviews

3. **Advanced Practice**

Changes at NHS England in regard to oversight for advanced practice are currently being considered by the Moorfields advanced practice team for impact and mitigations. Submission of the annual education training activity plan (ETAP) for 2027 completed -

requested 10 advanced practice education places and supplemented with non-medical prescribing education places. Sixty-four staff members educated to advanced

4. **Nursing and Midwifery Job Evaluation**

The project group continues to make progress against the national requirements for organisations to strengthen the application of the NHS job evaluation scheme and ensuring nurses are paid correctly for the work they are asked to do.

To date job description reviews have been completed for band 6 and band 7 nurses in clinical roles. Prioritisation to the band 5 review is in progress with planned partnership focus groups with band 5 nurses and staff side representatives to ensure the band 5 job descriptions reflect the roles being undertaken by our band 5 nurses. The project team will continue to report for assurance to board and as required nationally through the quarterly provider data submissions.

Quality implications

This report is a high-level summary in support of 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	**X**	**For decision**		**For discussion**		**To note**	

Cover Sheet	
Report title	Integrated Safeguarding Annual Report 2025/2026
Meeting	Trust Executive Board
Date	24 September 2026
Report from	Suminthra Naidu, Chief nurse and director of allied professionals
Prepared by	Jennifer Elliott, named nurse safeguarding adults and safeguarding team lead
Previous forum consideration	Clinical Governance Committee 11/08/2026 To be presented at postponed Quality and Safety Committee 29/09/26

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

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

Executive summary

Situation

Safeguarding remains a key priority for Moorfields Eye Hospital NHS Foundation Trust, with effective systems in place to protect children, young people, and adults at risk. Throughout 2025–2026, the Trust maintained strong governance, leadership, and partnership working to ensure safeguarding responsibilities were met and services remained responsive and person-centred.

Background

The trust has continued to develop its integrated safeguarding model, bringing together children's and adults' safeguarding functions to strengthen the "think family" and "child behind the adult" approaches. This has supported earlier identification of risk, improved recognition of vulnerabilities, and enhanced multi-agency collaboration across safeguarding services.

Assessment

Evidence from audits, performance data, training compliance, and risk management activity demonstrates that safeguarding arrangements are effective and continually improving. Key achievements included improvements to the was not brought (WNB) pathway, expanded safeguarding supervision and training and strengthened multi-agency working, while areas such as documentation consistency and training compliance continue to be monitored and improved.

Remendation

The trust should continue to build on current progress by advancing key priorities for 2026–2027, including reviewing the safeguarding champion model, expanding child protection information sharing (CP-IS) across scheduled care pathways, raising awareness of the non-fatal strangulation pathway and recruiting a learning disability and liaison nurse. Continued

focus on workforce development, partnership working, and service improvement will ensure safeguarding remains embedded across the organisation and responsive to emerging risks and vulnerabilities.

Quality implications

The safeguarding activity undertaken during 2025–2026 has had a positive impact on the quality and safety of care provided across the trust. The continued integration of safeguarding children and adults services has strengthened a holistic approach to care, enabling earlier identification of vulnerabilities, improved risk management, and more coordinated interventions for patients and families. Enhanced safeguarding training, supervision, and reflective practice have increased staff competence and confidence, supporting consistent, person-centred decision-making and improved patient outcomes.

Audit findings, training compliance, and risk management data provide assurance that safeguarding processes are effective, timely, and aligned with national standards. Improvements to pathways such as was not brought (WNB), ongoing development of the non-fatal strangulation pathway, and preparation for Phase 2 child protection information sharing (CP-IS) implementation have strengthened patient safety and service quality. Continued focus on documentation standards, workforce compliance, and service development will further support quality improvement and ensure the trust maintains high standards of safeguarding practice across all services.

Financial implications

Safeguarding activity is delivered within existing business as usual and statutory responsibilities, with investment in safeguarding providing significant value through the prevention of harm and reduction in risk. During 2025–2026, resources were utilised to support safeguarding workforce development, mandatory and specialist training, supervision, safeguarding system improvements, and the continued implementation of key programmes including the was not brought (WNB) pathway, non-fatal strangulation workstream, and child protection information sharing (CP-IS).

The trust has continued to manage safeguarding risks proactively through effective governance and targeted improvement initiatives, helping to mitigate financial and operational risks associated with non-compliance with statutory safeguarding requirements. Planned priorities for 2026–2027, including expansion of CP-IS and recruitment of a learning disability and liaison nurse, will require appropriate resource allocation but are expected to support improved patient outcomes, enhanced quality of care, and continued compliance with national safeguarding standards.

Risk implications

The trust continues to maintain a proactive approach to safeguarding risk management, with safeguarding risks monitored through established governance structures and reviewed regularly via the safeguarding risk register. During 2025–2026, key risks included safeguarding team capacity, mandatory training compliance, Disclosure and Barring Service (DBS) assurance, and effective implementation of the was not brought (WNB) pathway. Targeted mitigation actions have resulted in reduced risk ratings across all identified safeguarding risks, providing assurance that these risks are being effectively managed.

Report

This a summary of the final report that was approved in the integrated safeguarding assurance committee 22/7/2026.

Situation

This report provides assurance to the trust Board that Moorfields Eye Hospital NHS Foundation Trust continues to meet its statutory safeguarding responsibilities for children, young people and adults at risk.

Throughout 2025–2026, safeguarding activity remained a core component of patient safety and quality governance. The trust maintained an integrated safeguarding model, bringing together safeguarding children, safeguarding adults, Mental Capacity Act (MCA), Prevent, domestic abuse and modern slavery responsibilities to support a coordinated and family-centred approach.

Key activity during the reporting period included:

- Continued embedding of the *think family and child behind the adult* approaches.
- Strengthening of the was not brought (WNB) pathway and safeguarding escalation processes.
- Commencement of a trust-wide non-fatal strangulation (NFS) pathway.
- Delivery of enhanced safeguarding training, supervision and safeguarding induction programmes.
- Ongoing partnership working with the Integrated Care Board (ICB), Islington Safeguarding Children Partnership (ISCP), Islington Safeguarding Adults Board (ISAB) and other statutory agencies.
- Review of safeguarding incidents involving children and young people and adult safeguarding incidents.
- Completion of safeguarding audits providing assurance regarding compliance with safeguarding procedures and statutory requirements.

Safeguarding governance remained robust through regular reporting to the safeguarding committee and clinical governance committee, with executive oversight provided by the chief nurse.

Background

The trust has statutory duties under:

- Children Act 1989 and 2004
- Care Act 2014
- Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
- Counter-Terrorism and Security Act 2015 (Prevent Duty)
- Modern Slavery Act 2015
- Mental Health Act 2007
- Domestic Abuse Act 2021

The NHS safeguarding accountability and assurance framework (2024) requires all providers to demonstrate effective safeguarding leadership, governance, training, quality assurance and partnership working.

The trust's integrated safeguarding team provides specialist leadership, advice, supervision, training and operational support to staff across all sites. Quarterly assurance is

provided through established governance structures to provide oversight of safeguarding practice, performance, risks and learning.

Priority areas during 2025–2026 focused on:

- Strengthening safeguarding training and workforce capability.
- Improving identification of vulnerable children through WNB and child protection information sharing (CP-IS) processes.
- Providing support for adults with learning disabilities, autism and dementia.
- Promoting earlier identification of domestic abuse, non-fatal strangulation, mental health concerns and exploitation.
- Improving multi-agency collaboration and information sharing.

Assessment

The report provides strong assurance that safeguarding arrangements across the trust are effective, responsive and compliant with statutory requirements.

Key strengths identified include:

- High compliance with mandatory safeguarding training across substantive staff groups.
- Effective safeguarding governance and executive oversight.
- Successful implementation of enhanced WNB processes resulting in earlier identification and intervention.
- Positive audit outcomes demonstrating robust safeguarding referral and escalation processes.
- Increased staff confidence in recognising safeguarding concerns and applying professional curiosity.
- Strong partnership working with safeguarding boards, local authorities and healthcare partners.
- Improved integrated working between safeguarding children and adult safeguarding services.

Key findings include:

- 74 safeguarding incidents involving children and young people were reviewed, with WNB remaining the most common safeguarding theme.
- 223 adult safeguarding incidents were reviewed, with mental health concerns, domestic abuse, falls and repeated missed appointments being the predominant themes.
- Safeguarding complaints reviews demonstrated appropriate application of safeguarding thresholds and effective oversight.
- All safeguarding risks recorded during the year showed reduced risk scores following implementation of mitigating actions.

Areas requiring continued focus include:

- Implementation of Phase 2 child protection information sharing (CP-IS).
- Improvement of mandatory safeguarding training compliance.
- Review of the safeguarding champion network.
- Recruitment of a learning disability and dementia liaison nurse.
- Ongoing review of safeguarding team capacity and workforce sustainability.

Overall, the evidence demonstrates a mature safeguarding culture that supports continuous improvement and promotes safe, person-centred care.

Recommendation
The Board is asked to:

1. Receive and approve the Safeguarding Annual Report 2025–2026 as evidence that the trust continues to meet its statutory safeguarding responsibilities.

2. Take assurance that safeguarding governance, training, audit, risk management and partnership arrangements remain effective across the organisation.

3. Support delivery of the 2026–2027 safeguarding priorities, specifically:
   - Implementation of Phase 2 CP-IS across scheduled care pathways.
   - Review and strengthening of the safeguarding champion model.
   - Recruitment of a learning disability and autism liaison nurse.
   - Continued enhancement of Mental Capacity Act practice and safeguarding training compliance.
   - Continued development and implementation of the trust-wide non-fatal strangulation pathway.

4. Receive ongoing assurance through quarterly safeguarding reports detailing performance, risks, learning, compliance and progress against agreed priorities.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Safeguarding Annual Report 2025 - 2026

THINK! Family

Version: 1.0
Status: Final
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Ratified: tbc

Report Title:	**Safeguarding Children, Young People and Adults** **Annual Report 2025 - 2026**
Report From:	**Simmi Naidu** Chief Nurse and Director of Allied Professionals / Executive Lead for Safeguarding
Prepared By:	**Jennifer Elliott** Safeguarding Lead and Named Nurse for Adult Safeguarding **Alison McIndoe** Named Nurse Safeguarding Children & Young People (SGC&YP) **Claire Lloyd** Safeguarding Nurse Advisor Chidren & Young People (SGC&YP) **Helen Carpenter** Safeguarding Adults (SGA) Advisor & Mental Capacity Act (MCA) Practice Development Nurse **Karen Wong** Named Doctor for Safeguarding Children, Young People and Adults **Urim Jaha** Safeguarding Co-ordinator & Liaison Manager / Safeguarding Champion
Previously Discussed At:	**Safeguarding Assurance Committee** **Clinical Governance Committee**
Link to Trust Strategic Objectives:	**We will work together to discover, develop and deliver.**

Executive Summary

Safeguarding remains a core priority for Moorfields Eye Hospital NHS Foundation Trust and is embedded across all levels of the organisation. The Trust continues to demonstrate a strong commitment to protecting and promoting the welfare of children, young people, and adults at risk, ensuring compliance with statutory responsibilities and national safeguarding requirements. Through robust leadership, effective governance arrangements, and strong partnership working, the Trust provides assurance that safeguarding systems are effective, responsive, and consistently applied.

During 2025–2026, the Trust further strengthened its integrated safeguarding model, bringing together safeguarding children and adults functions to support a holistic “Think Family” and “Child Behind the Adult” approach. This has enhanced the identification of hidden vulnerabilities, improved multi-agency collaboration, and enabled more coordinated responses to individuals and families experiencing risk.

Governance arrangements remained robust throughout the year. The Integrated Safeguarding Team, led by the Chief Nurse and supported by the Associate Chief Nurse, provided strategic oversight and assurance through quarterly reporting to the Safeguarding Committee and Clinical Governance Committee. Safeguarding activity, risks, performance, training compliance, learning, and service improvements were subject to regular scrutiny, ensuring Board-level oversight and accountability.

Key achievements during the reporting period included:

- Further embedding of the Think Family and Child Behind the Adult approaches across adult and paediatric services.
- Development and delivery of an integrated safeguarding corporate induction programme for all new staff.
- Strengthening of the Was Not Brought (WNB) pathway, including digitisation, audit, and enhanced escalation processes.

- Expansion of safeguarding supervision, reflective practice, and case-based learning opportunities.
- Delivery of specialist training, such as the Oliver McGowan Mandatory Training on Learning Disability and Autism.
- The Non-Fatal Strangulation Working Group is currently in progress, with key stakeholders engaged in reviewing the clinical pathway and available resources.
- Increased visibility and accessibility of safeguarding support services across the Trust.
- Continued improvement in multi-agency working with local authorities, safeguarding partnerships, Integrated Care Boards, and healthcare partners.

Independent audit and assurance activity provided further evidence of effective safeguarding systems. The London Safeguarding Adults Partnership Audit Tool (SAPAT) demonstrated compliance with statutory safeguarding requirements, while an internal audit of safeguarding children incident reporting confirmed strong performance. Of safeguarding incidents reviewed, 100% were escalated within policy timescales, safeguarding team involvement was evident in all cases, and referral thresholds were applied appropriately. Although opportunities were identified to improve consistency in documentation processes, safeguarding practice itself remained robust, timely, and risk-led.

Analysis of safeguarding data demonstrates a growing safeguarding maturity across the organisation. Increased professional curiosity, stronger recognition of cumulative and contextual risk factors, and improved understanding of family dynamics have resulted in earlier intervention and more targeted safeguarding responses. The continued identification of Child Behind the Adult cases highlights staff confidence in recognising vulnerabilities that may otherwise remain hidden.

Training compliance for permanent staff remained strong and above the Trust's target across most safeguarding subjects, with notable improvements seen in Level 3 Adult Safeguarding and specialist Level 4 training. Focused work continues to address lower compliance rates among honorary and locum staff through strengthened monitoring, improved access to training, and enhanced governance oversight.

The Trust maintained a proactive approach to risk management throughout the year. Five safeguarding risks were monitored through the Safeguarding Risk Register, including safeguarding team capacity, mandatory training requirements, Disclosure and Barring Service compliance, and Was Not Brought pathway implementation. Mitigating actions resulted in reduced risk ratings across all identified risks, providing assurance that risks are being actively managed and reviewed.

Significant progress was also made in advancing priority work programmes. A task and Finish group is in place to support the Trust wide Non-Fatal Strangulation pathway strengthened safeguarding responses to high-risk domestic abuse presentations and further supported integrated working between safeguarding adults and children teams. Work to prepare for Phase 2 implementation of the Child Protection Information Sharing (CP-IS) programme has positioned the Trust to strengthen safeguarding visibility across scheduled care pathways during 2026–2027.

The Trust continued to meet its statutory responsibilities across the full safeguarding agenda, including the Children Act, Care Act, Mental Capacity Act, Prevent Duty, Domestic Abuse Act, Modern Slavery Act, and related legislation. Active participation in safeguarding reviews, partnership boards, regional safeguarding networks, and multi-agency forums ensured that national and local learning continued to inform policy, practice, and service development.

Looking ahead to 2026–2027, key priorities include reviewin the Safeguarding Champion model, expanding Child Protection Information Sharing (CP-IS) across scheduled care services, and recruiting a Learning Disability and Liaison Nurse to further improve support for patients with learning disabilities, autism, dementia, and other vulnerabilities.

Overall, the evidence presented within this report provides strong assurance that Moorfields Eye Hospital NHS Foundation Trust continues to maintain a well-governed, responsive, and continually improving safeguarding service. Safeguarding is firmly embedded within organisational culture, supported by effective leadership, strong partnership working, a skilled workforce, and a shared commitment to delivering safe, person-centred care for children, young people, adults at risk, and their families.

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

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

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Introduction

Safeguarding is integral to all care delivered by Moorfields Eye Hospital NHS Foundation Trust. As a healthcare provider, the Trust is required to evidence robust safeguarding leadership and a clear commitment to safeguarding in order to meet its statutory responsibilities.

The purpose of this report is to provide an overview of safeguarding activity and achievements across the Trust, and to offer assurance that statutory duties and national guidance are being met.

The Trust has established an integrated safeguarding model, bringing together the expertise, skills and knowledge of professionals responsible for safeguarding children, young people and adults at risk. This approach supports staff to recognise and respond to safeguarding concerns, take appropriate action, escalate where necessary, and demonstrate professional curiosity. The overarching aim is to ensure that vulnerable individuals are safeguarded effectively and supported to live free from harm and abuse.

This report outlines how Moorfields Eye Hospital NHS Foundation Trust works in partnership with internal and external stakeholders to fulfil its statutory responsibilities in relation to:

- Safeguarding children in accordance with Section 11 of the Children Act (1989 and 2004)
- Safeguarding adults at risk in line with the Care Act (2014)
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007)
- The Counter-Terrorism and Security Act (2015)
- The Modern Slavery Act (2015)
- Prevent Duty (2023)
- The Mental Health Act (2007)
- The Domestic Abuse Act (2021)

The Trust demonstrates effective partnership working with regulators, North Central London Integrated Care Board (ICB), Islington Safeguarding Children Partnership (ISCP), and Islington Safeguarding Adults Board (ISAB). This report will be presented to the Trust Board and, following approval, shared with relevant partner organisations.

Governance and Safeguarding Committee

Accountability and Governance

The *Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2024)* sets out the requirement for all providers to demonstrate that safeguarding is embedded at every level of the organisation, supported by robust governance arrangements. Providers must provide assurance to regulators, commissioners and partner agencies that safeguarding systems, processes and pathways are effective, responsive and consistently applied.

To meet these requirements, Moorfields Eye Hospital NHS Foundation Trust has established clear governance structures and reporting mechanisms to ensure effective oversight and continuous improvement in safeguarding practice.

This includes:

- Clearly defined safeguarding governance arrangements
- Robust policies and procedures aligned with national guidance
- Effective oversight, assurance and reporting processes
- Evidence of strong multi-agency partnership working
- Mechanisms for learning, continuous improvement and quality assurance

Safeguarding Committee

The Trust's Integrated Safeguarding Team comprises a range of professionals with specialist expertise in safeguarding children, young people and adults at risk. The team provides strategic and operational oversight of safeguarding across the organisation, ensuring that vulnerable individuals are appropriately identified, protected and supported.

The team plays a key role in ensuring that staff across the Trust are equipped with the knowledge, skills and confidence to recognise, assess, report and escalate safeguarding concerns in line with Trust policy and statutory guidance. This includes promoting professional curiosity and ensuring timely and proportionate responses to risk.

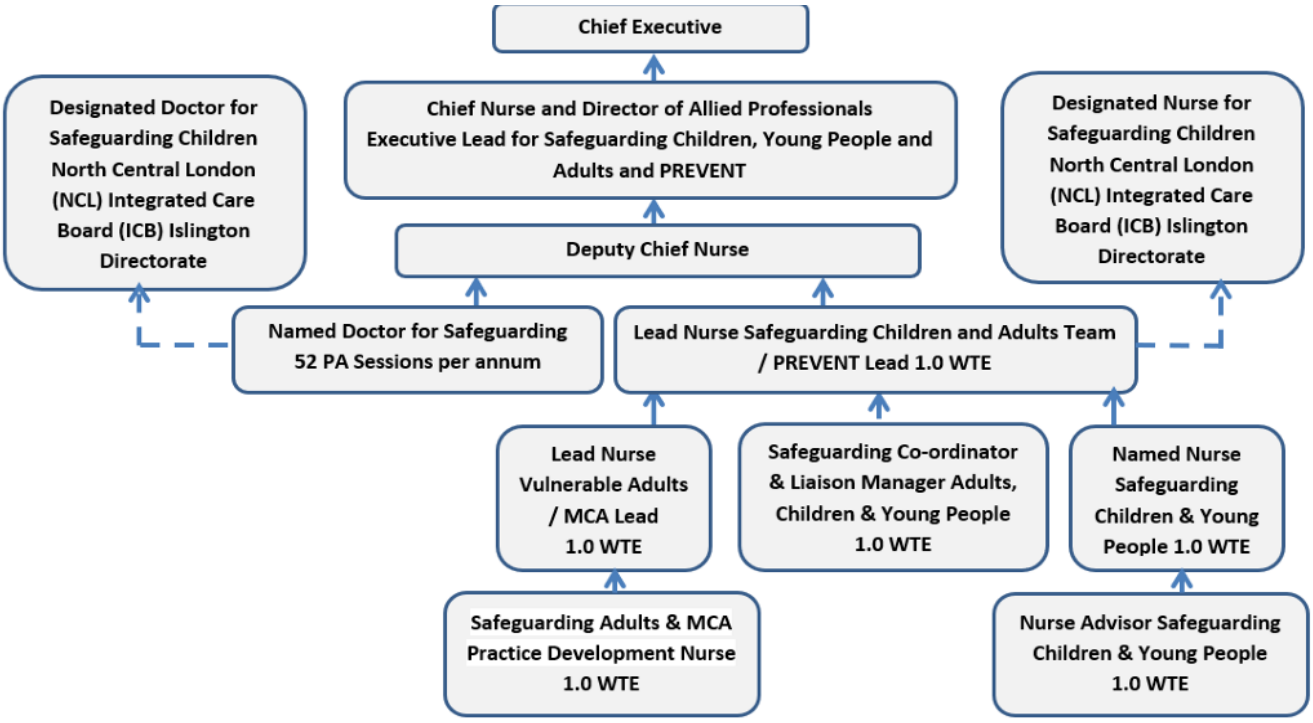
The Safeguarding Team includes a dedicated Safeguarding Coordinator, who supports the day-to-day delivery of safeguarding activity. The role provides administrative and coordination support within a business-as-usual framework, including supporting safeguarding champions and the delivery, monitoring and compliance of safeguarding training across the organisation.

The Chief Nurse holds Executive responsibility for safeguarding and is supported by the Associate Chief Nurse. The Integrated Safeguarding Team reports quarterly to the Safeguarding Committee, providing assurance on safeguarding activity, performance, risks and key areas of learning.

The Safeguarding Committee provides a formal forum for oversight, scrutiny and assurance. It is responsible for monitoring safeguarding performance, reviewing risks, and ensuring that learning from safeguarding incidents, audits and reviews is embedded into practice.

The Safeguarding Committee reports into the Clinical Governance Committee. Committee minutes, key risks, areas of escalation and shared learning are reported on a quarterly basis to ensure appropriate Board-level oversight and to support continuous improvement in safeguarding practice across the Trust.

Accountability Structure



Key Achievements

Safeguarding Children and Adults – Working Together:

- Continued embedding of the 'Child behind the adult' and 'Think family approach' across the Trust, ensuring holistic assessment and intervention that considers the needs of both adults and children within family units.
- Further development of Level 3 Safeguarding Children and Adults training through collaboration with external subject matter experts, strengthening the quality and consistency of training delivery.
- Safeguarding team members successfully completed the *Train the Trainer* programme on non-fatal strangulation, enhancing organisational capability to deliver specialist training and raise awareness of high-risk indicators.
- Development and implementation of integrated safeguarding corporate induction programme, including face to face training, and supporting resources though the Trust learning marketplace to support safeguarding awareness, accessibility and ongoing professional development.
- Increased joint working across safeguarding children and adults' teams, enabling coordinated responses to complex cases involving family-wide risk Improving early identification of risk across adult and paediatric pathways.
- Enhanced visibility and accessibility of safeguarding services, supporting staff across all roles to access timely advice, supervision, and guidance.

Safeguarding Children and Young People:

- Strengthened the Was Not Brought (WNB) pathway, including audit, stakeholder feedback, and digitisation of documentation and risk assessment tools to support earlier identification and consistent escalation.
- Delivered a comprehensive programme of training and education, improving staff confidence in recognising risk, applying safeguarding thresholds, and promoting professional curiosity.

- Enhanced safeguarding supervision and reflective practice, with expanded workshops, case-based learning, and increased accessibility across sites.
- Improved data quality and assurance processes, supporting more consistent categorisation, decision-making, and intelligence-led safeguarding activity.
- Strengthened multi-agency working, with more timely information sharing and engagement with Children's Social Care and partner agencies, supporting coordinated responses to risk.
- Production of the quarterly Safeguarding Children and Young People "Nuggets" Newsletter, strengthening organisational communication and learning through the sharing of key themes, lessons learned, policy updates, safeguarding alerts, and examples of good practice.

Safeguarding Vulnerable and at Risk Adults:

- Consolidation of Mental Capacity Act (MCA) Level 2 training, alongside continued support to staff in undertaking best interests decision-making processes and referrals for Independent Mental Capacity Advocates (IMCAs).
- Delivery of Oliver McGowan Mandatory Training on Learning Disability and Autism to 29 senior leaders, in partnership with an external provider, strengthening leadership capability in inclusive practice.
- Active participation in Safeguarding Adult Reviews (SARs), contributing to multi-agency learning and identifying key recommendations for implementation within Moorfields Eye Hospital NHS Foundation Trust.
- Production and dissemination of Safeguarding Snippets and Caring Voices newsletters, supporting ongoing communication, awareness, and shared learning across the organisation

Audit

London Safeguarding Adults Partnership Audit Tool (SAPAT)

The London Safeguarding Adults Partnership Audit Tool (SAPAT) was completed and submitted to the Islington Safeguarding Adults Board (ISAB) for the reporting period 2025/2026.

The SAPAT is aligned with statutory guidance and recognised best practice. It provides organisations with a consistent framework to assess, monitor and strengthen their safeguarding arrangements.

Completion of the tool supports the Trust in evidencing compliance with statutory requirements, identifying areas of good practice, and highlighting opportunities for further development and continuous improvement in safeguarding across the organisation.

Compliance with Safeguarding Children Incident Reporting Protocols- Internal Audit

As committed in the 2024–2025 Safeguarding Annual Report, an internal audit was undertaken in 2025–2026 to assess compliance with the Trust's Safeguarding Incident Reporting Procedures following implementation of the updated Safeguarding Children and Child Protection Policy (2024).

Twenty-three safeguarding incidents were reviewed. Of these, 19 (83%) met the threshold for referral to Children's Social Care (CSC) and 4 (17%) were appropriately managed through Early Help pathways. All CSC referrals demonstrated appropriate identification of concerns, safeguarding team involvement, and clear clinical documentation. Referrals were made promptly, with 100% submitted within three days and 53% on the same day.

Outcomes received from CSC indicated that referrals were proportionate and appropriately targeted, with cases progressing to statutory assessment, Early Help support, or closure following assessment as appropriate. Safeguarding team liaison and clinical documentation were evident in all cases, providing assurance that concerns were consistently identified, assessed, and managed effectively.

The audit identified some variation in the completion and uploading of Yellow Forms, particularly within unscheduled care settings. While this did not affect the quality of safeguarding practice or outcomes, it highlighted an opportunity to strengthen compliance with documentation requirements. Targeted staff refresher training will be delivered to improve consistency in recording and support governance assurance.

Overall, the audit provides strong assurance that safeguarding processes are well embedded across the Trust, with timely escalation, effective multi-agency working, and robust safeguarding oversight supporting safe and appropriate outcomes for children and young people

Key Risks Mitigations

Safeguarding maintains a dedicated risk register, which is reviewed on a monthly basis and monitored as a standing agenda item at the quarterly Safeguarding Committee.

During the reporting period, five safeguarding risks were recorded. All risks have demonstrated a reduction in their respective risk ratings following the implementation of mitigating actions. Further review of risk ratings and consideration of risk closure, where appropriate, will be undertaken at the Safeguarding Committee meeting in July 2026.

Disclosure and Barring Service (DBS)

In 2023, low compliance with DBS renewal processes was identified. The Safeguarding Committee has since worked in partnership with Human Resources to strengthen oversight and provide assurance that the Trust is meeting its statutory responsibilities in relation to safe recruitment.

Significant progress has been made to improve compliance. A further review of this risk will be undertaken at the Safeguarding Assurance Committee in July 2026.

Safeguarding Team Capacity

A risk relating to safeguarding team capacity was identified due to staff sickness and the subsequent impact on safeguarding activity.

Mitigating actions have included active recruitment to vacant posts and workforce planning to ensure continuity of service delivery. This risk will be reviewed at the Safeguarding Committee in July 2026.

Safeguarding Mandatory Training

A risk was identified in relation to the increasing scope of the safeguarding agenda and the need to expand mandatory safeguarding training provision. There is ongoing national focus on safeguarding training requirements, which will need to be considered as part of planning for the next financial year.

Mitigating actions have been implemented to ensure that the Safeguarding Team continues to deliver training and that staff have access to appropriate learning opportunities. This includes training on the Oliver McGowan Mandatory Training, Mental Capacity Act, and awareness of non-fatal strangulation.

Was Not Brought (WNB)

A risk was identified in relation to safeguarding considerations for children who were not brought to their appointments.

This risk has been mitigated through the implementation of an enhanced Was Not Brought (WNB) pathway, which has now been embedded into practice. This approach supports staff in recognising potential safeguarding concerns and ensures appropriate follow-up and escalation.

Incidents

During 2025–2026, the Safeguarding Children Team reviewed 74 safeguarding-related incidents involving children and young people. Activity was highest during the first half of the year, with 23 incidents in Q1 (31%) and 25 incidents in Q2 (34%), reducing to 15 incidents in Q3 (20%) and 11 incidents in Q4 (15%). This reduction may reflect the continued embedding of safeguarding procedures, improved staff confidence in applying safeguarding pathways, and earlier intervention through alternative escalation routes.

Of the incidents reviewed, 38 (51%) were closed by the Safeguarding Team, 30 (41%) required additional safeguarding information, advice, or actions to support resolution, and 6 (8%) required no further safeguarding input following review. This demonstrates a proportionate, risk-based approach, with safeguarding oversight provided where required.

The most common themes were Was Not Brought (WNB), injury-related presentations, parental factors, child and young person SEMH, and information-sharing concerns.

Analysis highlighted continued application of the Think Family approach, with 8 incidents (11%) identified as Child Behind the Adult cases, reflecting increasing recognition of the impact of adult vulnerabilities on children within the household.

Qualitative analysis identified increasing recognition of contextual and cumulative risk, including repeated WNB episodes, delayed presentations, parental capacity concerns, domestic abuse, and emerging parental mental health needs. The findings also demonstrate growing staff confidence and professional curiosity in identifying concerns that may not initially present as safeguarding issues, supporting earlier intervention, more informed decision-making, and proportionate safeguarding responses.

Overall, the findings provide assurance that incident reporting continues to support the effective identification, assessment, and management of safeguarding risk, underpinned by proportionate safeguarding oversight, effective multi-agency working, and a child-centred approach.

During the 2025/26 financial year, the Adult Safeguarding Team reviewed 223 safeguard incident reports. The predominant themes identified were, repeated missed appointments, falls, mental health-related issues, and domestic abuse.

Of the 223 incidents reviewed, 116 cases required no further safeguarding action following assessment by the Adult Safeguarding Team. The remaining 107 cases required safeguarding intervention, including safeguarding referrals, information sharing with partner agencies, and referrals to Adult Social Care for consideration of a Care Act Assessment in line with the Care Act 2014.

All safeguarding incidents submitted via the safeguard reporting system are reviewed using a multi-disciplinary approach. The Adult Safeguarding Team plays an integral role within the Incident Review Group, providing specialist safeguarding advice, oversight, feedback, and facilitating organisational learning arising from incidents and safeguarding concerns.

Where safeguarding concerns are identified through incident reporting, timely assessment, risk evaluation, and escalation to the relevant statutory and partner agencies are undertaken to ensure that adults at risk receive appropriate support and protection. This process supports effective inter-agency working, promotes safeguarding best practice, and contributes to the organisation's commitment to providing safe and high-quality care

Complaints

During 2025–2026, a total of 21 complaints involving children and young people were reviewed by the safeguarding team.

The majority of complaints related to clinical care, delays in treatment, communication, and service experience, accounting for the predominant themes across the dataset. Specifically, approximately 8 cases (≈50%) related to concerns about clinical care and delays, including diagnostic accuracy and treatment timelines, while 5 cases (≈31%) involved communication issues and staff conduct, such as perceived lack of empathy or professionalism. A smaller proportion, 3 cases (≈19%), related to administrative and service factors, including appointment systems and care coordination.

All complaints were systematically reviewed through a safeguarding framework, including routine CP-IS and NCRS checks alongside review of clinical records and safeguarding history where applicable.

In 100% of cases (16/16), there were no active Child Protection Plan (CPP) or Child Looked After (CLA) alerts identified at the time of review, and no concerns met the threshold for safeguarding referral.

Although no cases required safeguarding escalation, safeguarding input added value by providing contextual review of care pathways and patient engagement, including consideration of WNB history and family context where relevant. In several cases, advice was provided regarding proportionate use of safeguarding processes, ensuring they were not applied in response to service dissatisfaction where thresholds were not met.

Safeguarding review of the complaints also identified opportunities to strengthen communication, documentation, and patient-centred care, including the need for reasonable adjustments and shared decision-making for children with additional needs.

Consequently, all complaints resulted in No Further Action (NFA) from a safeguarding children perspective, demonstrating appropriate threshold application and clear differentiation between safeguarding and service-related concerns.

During the 2025/26 financial year, the Adult Safeguarding Team reviewed 269 complaints**.** The predominant themes identified related to care and treatment and staff attitude and behaviour**.**

The review of complaints enabled the Adult Safeguarding Team to identify potential safeguarding concerns and adults at risk, supporting timely assessment and, where appropriate, escalation to relevant external agencies, including Local Authority Adult Safeguarding Teams.

The Adult Safeguarding Team provides specialist advice and guidance regarding patients' care and support needs, safeguarding risks, and appropriate interventions. Recommendations and learning arising from complaint reviews are shared to support continuous service improvement and enhance the patient experience.

Where concerns relating to abuse or neglect are identified through the complaints process, these are recorded and reported as safeguarding incidents in line with organisational policy. This ensures that quality, safety, and risk issues are appropriately identified, investigated, and addressed, and that learning is embedded to reduce the likelihood of recurrence and improve patient outcomes.

This provides assurance that complaints are consistently reviewed with appropriate professional curiosity, supporting proportionate decision-making. The findings reflect a mature safeguarding system, where safeguarding oversight contributes to organisational learning, and quality improvement,

Overall, the data demonstrates that while complaints predominantly relate to service delivery rather than safeguarding concerns, the application of a robust safeguarding screening process ensures that potential risks are not overlooked.

Collaborative and integrated working practice

Moorfields Eye Hospital remains committed to safeguarding and promoting the welfare of children, young people, and vulnerable adults through strong partnership working with statutory agencies and healthcare partners. The Safeguarding Children and Adults Teams work collaboratively to deliver a holistic, family-centred approach, strengthening the organisation's ability to identify vulnerability, reduce inequalities, and respond proactively to risk. While maintaining distinct statutory roles, this integrated model ensures safeguarding is consistently embedded across all levels of the organisation.

During 2025–2026, integrated working between the Safeguarding Children and Safeguarding Adults teams was further strengthened through the development of a co-produced safeguarding induction training package, delivered face-to-face by the safeguarding team.

This programme provides a clear foundation for all new staff, embedding core safeguarding responsibilities from the outset of employment and reinforcing the Trust's commitment to safeguarding. Designed to support both clinical and non-clinical staff attending corporate induction, it ensures a consistent baseline of knowledge across the workforce.

The induction promotes a Think Family approach, enabling staff to consider how adult vulnerability may impact on children and young people. It supports recognition of early indicators of risk, application of professional curiosity, and understanding of safeguarding pathways, thresholds, and escalation processes. Staff are also guided on how to access Trust safeguarding guidance, advice, and support, enabling confident and appropriate responses to safeguarding concerns.

Child Behind the Adult

Analysis of these cases highlights several key themes.

- Domestic abuse accounted for approximately 38% of cases, remaining the most prominent factor and reinforcing recognition of children as secondary victims.
- Parental mental ill health contributed to around 19% of cases, including presentations involving acute distress and suicidal ideation, with clear consideration given to the impact on dependent children.

- A further 19% of cases related to social vulnerability and early help needs, including housing instability, poverty, and complex family circumstances
- Education-related concerns (≈19%) demonstrated improved recognition of children not attending school or being absent during school hours as a safeguarding indicator.
- Parental capacity and care arrangements (≈10%) were also identified, with staff demonstrating increased attention to supervision, caregiving roles, and safe discharge planning.

Compared to the previous year, there is clear evidence of improved consistency and confidence in identifying safeguarding risk, alongside increased recognition of multi-factorial and cumulative vulnerability, where factors such as mental health, housing instability, and domestic abuse intersect. There is also greater awareness of complex family systems, including households with multiple children and additional support needs.

This work is strengthened through integrated safeguarding team collaboration, enabling a coordinated Think Family response, improved identification of hidden harm, and more proportionate, timely multi-agency intervention. Overall, the data demonstrates a maturing safeguarding culture, with staff increasingly confident in recognising and responding to the needs of children within adult care pathways, providing strong assurance that safeguarding practice is holistic, proactive, and child centred.

(2025–2026) Priority Progress - Non-Fatal Strangulation (NFS) Pathway

During 2025–2026, significant progress has been made in delivering the Trust priority to develop a system-wide Non-Fatal Strangulation (NFS) referral pathway, building on the foundations established in the previous reporting year.

The Safeguarding Children Team worked collaboratively with the Safeguarding Adults Team, Named Doctor, and key stakeholders to establish a dedicated task and finish group, focused on progressing the development and implementation of a consistent Trust-wide approach. This has supported improved alignment between adult and children's safeguarding processes and strengthened a Think Family response to NFS concerns.

To inform pathway development, members of the safeguarding team attended a specialist Non-Fatal Strangulation training workshop facilitated by the Islington Violence Against Women and Girls (VAWG) team, alongside clinical leads from unscheduled care settings across the organisation. This enabled shared learning, increased clinical awareness, and supported the development of a more informed and confident workforce in recognising and responding to NFS as a safeguarding indicator.

This work has enhanced organisational understanding of NFS as a high-risk safeguarding issue and strengthened the framework for identification, documentation, and escalation, ensuring staff are better equipped to recognise potential risk and respond appropriately within both adult and child safeguarding contexts.

Overall, this represents a key step towards the fully implementing and standardising the NFS pathway, supporting earlier identification of risk, improved multi-agency response, and safer outcomes for children and families.

Safeguarding Champions

The Safeguarding Champions Model was introduced in December 2017 with Trust Board endorsement. The model aligns with Trust safeguarding policies and governance, contributing to patient safety and care and improving patient outcomes in relation to children, young people and vulnerable adults.



There are currently 75 active champions across Moorfields, who act as local safeguarding resource and points of contact, supporting and signposting colleagues with safeguarding queries.

The role of the Safeguarding Liaison Manager was established to act as a key link between the corporate Safeguarding Team and the network of Safeguarding Champions. This role supports communication, coordination, and the dissemination of safeguarding messages, learning and training opportunities. The Safeguarding Champions eyeQ intranet page continued to be maintained to support ongoing champions and provide information for staff interested in becoming

a champion. Since its introduction, the model has helped to embed safeguarding more consistently across the Trust.

A review of the model is now underway to ensure that roles, expectations, and escalation processes are clear and applied consistently. The outcome of this review will be presented to the Safeguarding Committee in the next reporting year and will inform the ongoing development of the model.

Safeguarding Children and Young People



“Nothing is more important than children’s welfare. Every child deserves to grow up in a safe, stable, and loving home. Children who need help and protection deserve high quality and effective support.
(Working Together 2026)

Safeguarding Children In Action

Across the 2025 - 2026 reporting year, each quarter, anonymised safeguarding case studies highlight common themes in practice, showcasing Good Practice, Lessons Learned & Clinical Engagement in safeguarding. They demonstrate how clinical vigilance, professional curiosity, and multi-agency working support early identification, timely intervention, and improved outcomes for children and families. Collectively, this learning has strengthened clinical confidence, improved information sharing, and supported better outcomes for vulnerable patients and their families. Some examples are outlined below.

Safeguarding CYP in Action: Shared Learning Vignettes 2025 - 2026

Across the 2025-2026 reporting year, each quarter, anonymised safeguarding case studies highlight common themes in practice, showcasing **Good Practice**, **Lessons Learned & Clinical Engagement** in safeguarding. They demonstrate how **clinical vigilance**, **professional curiosity**, and **multi-agency Working** support early identification, timely intervention, and improved outcomes for children and families. Collectively, this learning has strengthened clinical **confidence**, **improved information sharing**, and supported **better outcomes** for **vulnerable patients** and their **families**. Some examples are outlined below.

Case 1 (Q1)



Erin, aged three, was under Moorfields care for a constant squint and significant myopia requiring glasses and daily patching, alongside complex needs related to prematurity. **Concerns escalated** when she **missed four consecutive appointments** despite repeated attempts to accommodate the family, placing her **at risk of permanent vision loss**. Safeguarding processes led to a **Section 47 Enquiry** and a **Child in Need Plan (CIN)**, addressing wider **concerns of neglect** and **poor engagement**. Erin later re-attended and treatment resumed, although with some reduced vision. **Key message:** Timely escalation and strong clinical engagement are essential to prevent long-term harm when children are not brought to critical appointments.

Case 2 (Q2)



Ella, aged six, required consistent orthoptic care to protect her vision, but **repeated missed appointments** raised safeguarding concerns. Multi-agency Information-Sharing revealed existing Section 47 enquiries linked to **neglect**, prompting coordinated action. **Continued non-attendance** contributed to a **Child Protection Plan (CPP)** and, ultimately, a change in living arrangements under an Emergency Protection Order. Following this, Ella re-engaged with care and school, and her vision improved. **Key message:** Early escalation and effective multi-agency communication can uncover hidden neglect and significantly improve outcomes for vulnerable children.

Case 3 (Q3)

Anna, a 17-year-old research participant, appeared calm and engaged, but **examination revealed injuries** suggestive of **self-harm**. Prompt **safeguarding escalation** enabled a proportionate response that balanced her autonomy with her safety needs. With her consent, information was shared with school and primary care, strengthening her support network while encouraging parental involvement. Anna remained engaged and supported throughout. **Key message:** Proportionate safeguarding, respect for adolescent autonomy, and collaborative working are key to achieving positive outcomes in young people.

Case 4 (Q4)



An adult patient presented with **eye findings inconsistent** with their **history**, alongside **repeated attendances** and a **complex family situation** involving dependent children. Concerns about possible **Non-Fatal Strangulation** led to referral to Children's Social Care and multi-agency discussion, despite no disclosure of abuse. Ongoing professional curiosity and cross-organisational information-sharing supported appropriate escalation and assessment. **Key message:** Even subtle clinical signs can indicate serious Safeguarding risks; maintaining professional curiosity and using a structured, multi-agency approach is critical.

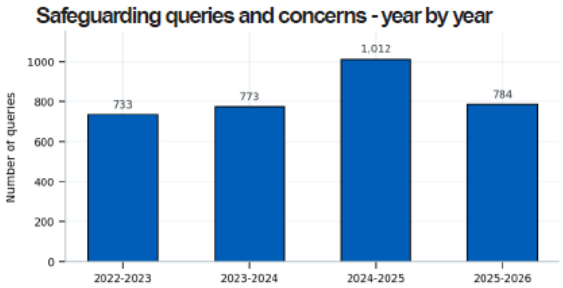
*All names changed to protect identity

SGCYP Activity Dashboard and Overview 2025-2026

Total queries	Top theme	Incidents	Complaints	Referrals to CSC
784	Was Not Brought	74	21	19

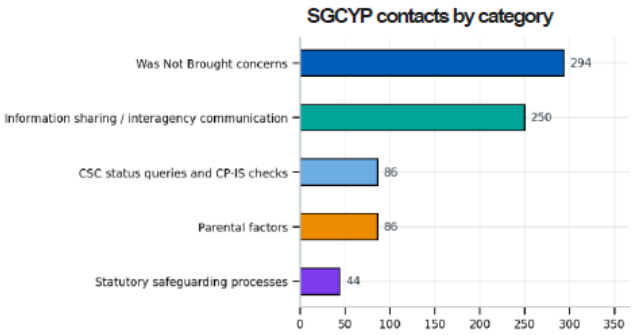
Queries and concerns

In 2025 - 2026, a total of 784 safeguarding queries, including incidents and complaints, were raised with the safeguarding children team, representing a 23% reduction from 1,012 in 2024 - 2025. Despite this decrease, activity remains higher than in previous years, with a 7% increase on 2022 - 2023 (733) and a 1% increase on 2023 - 2024 (773), indicating sustained staff engagement across the organisation.



This trend reflects a stable and embedded safeguarding culture, characterised by continued vigilance alongside more proportionate, confident, and informed use of safeguarding processes.

SGCYPT contacts and escalations



In 2025–2026, safeguarding children team contacts were primarily driven by Was Not Brought (WNB) concerns, accounting for approximately 38% consistently across all quarters, and frequently associated with repeated non-attendance and challenges in engaging families.

Information sharing and interagency communication represented the second largest area of activity at approximately 32%, reflecting regular liaison with Children's Social Care, health partners, and education services to support coordinated, timely decision-making.

A further 11% of contacts related to Children's Social Care status queries and CP-IS checks, while statutory safeguarding processes such as ICPC, RCPC, and CIN meetings accounted for 6%. Parental factors, including domestic abuse, mental ill health, and capacity concerns, also comprised approximately 11% of activity.

Overall, this profile remains consistent with previous years; however, the reduction in safeguarding contacts, particularly WNB-related activity, reflects the successful implementation of the Was Not Brought (WNB) Policy and pathway. This has strengthened early identification, supported more proportionate decision-making and escalation, and provides assurance that safeguarding practice is becoming increasingly timely, targeted, and intelligence-led, with staff applying safeguarding thresholds confidently and effectively in the best interests of children and young people.

Referrals to CSC

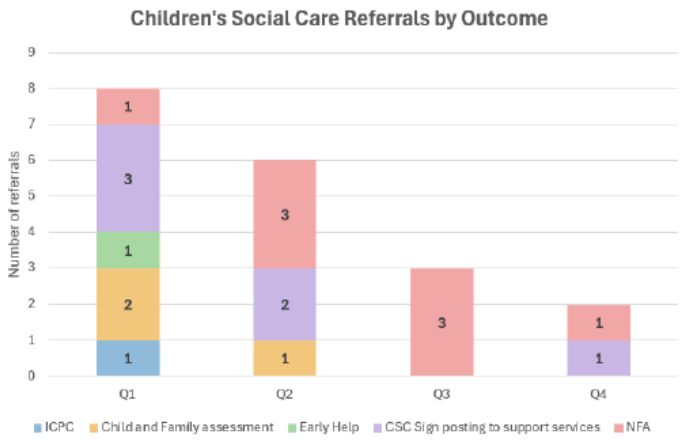
During the 2025 - 2026 reporting period, the organisation made 19 referrals to Children's Social Care, representing a 40% reduction from 32 referrals in 2024 - 2025. This continued downward trend reflects a shift towards more targeted and proportionate safeguarding practice, rather than a reduction in safeguarding need.

Governance review confirms that referrals were appropriate and well-evidenced. A significant proportion led to active intervention, including Child and Family Assessments, Early Help support, and direct contact with families, with one case escalating to an Initial Child Protection Conference, indicating higher levels of risk. Where statutory thresholds were not met, cases were appropriately managed through Early Help or no further action, supported by prior information sharing and safeguarding oversight.

Referrals to CSC - continued

Governance review confirms that referrals were appropriate and well-evidenced. A significant proportion led to active intervention, including Child and Family Assessments, Early Help support, and direct contact with families, with one case escalating to an Initial Child Protection Conference, indicating higher levels of risk.

Where statutory thresholds were not met, cases were appropriately managed through Early Help or no further action, supported by prior information sharing and safeguarding oversight.

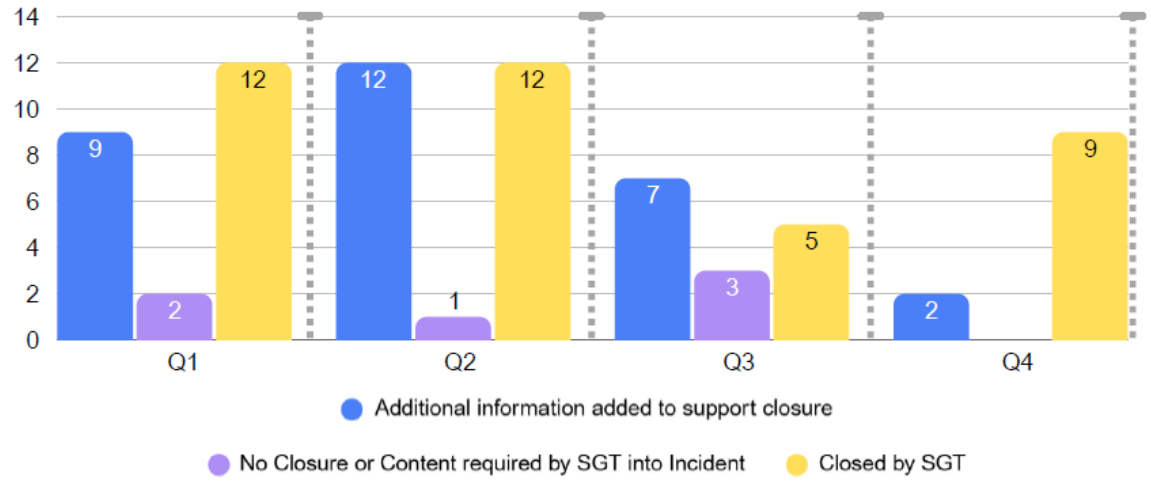


Overall, this provides assurance that referrals are timely, proportionate, and aligned with safeguarding thresholds, ensuring children receive the right level of support and that concerns are escalated appropriately in line with their needs.

Child Behind the Adult

The "Child Behind the Adult" approach continues to strengthen, reflecting an increasingly embedded Think Family model across the organisation. This recognises that adult presentations, particularly where there is vulnerability, may indicate hidden risk to children, including where adults have parental caring responsibilities or where children reside within the same household. In 2025 - 2026, 16 cases were identified (2024 - 2025: 15), demonstrating a small increase (+7%) and, importantly, more consistent identification across all four quarters, indicating that Think Family awareness is now more routinely embedded in practice.

Incidents breakdown



Yearly activity overview and analysis

During 2025–2026, safeguarding activity remained high, with 784 queries and concerns managed alongside 19 referrals to Children's Social Care. Although reduced from the previous year, activity remains above earlier levels, reflecting sustained staff engagement and an embedded safeguarding culture. Compared to 2024 - 2025, there is improved data quality, more consistent categorisation, and stronger multi-agency integration. Overall, the volume and complexity of activity, alongside earlier identification of risk, demonstrate a mature, intelligence-led safeguarding system that supports timely and appropriate escalation.

Was Not Brought (WNB)

Analysis of WNB activity during 2025 - 2026 confirms that Was Not Brought (WNB) remains the predominant safeguarding theme, accounting for the majority of safeguarding contacts and reflecting both high volume and increasing complexity.

In 2024 - 2025, activity was already high, with 400+ recorded WNB-related concerns, highlighting the scale of non-attendance as a key safeguarding issue. However, practice during this period was more variable and reactive, with concerns often escalating only after repeated missed appointments.

In contrast, 2025 - 2026, while reflecting a lower recorded volume (250+ cases), demonstrates a clear shift towards a more proactive, structured, and intelligence-led approach. There is strong evidence of earlier identification of risk, with increased recognition of cumulative non-attendance and the wider family context influencing engagement with services.

WNB activity during 2025 - 2026 showed a peak in Q2 (≈30 - 34%), followed by a gradual decline through Q3 (≈22 - 24%) and Q4 (≈16 - 18%), suggesting improved early intervention and more consistent application of the WNB pathway. Around 10 - 15% of cases required multi-agency escalation, including engagement with Children's Social Care and partner agencies, demonstrating appropriate threshold application and safeguarding response.

Concerns were identified across a wide range of staff groups, including orthoptists (≈35 - 40%), nursing staff (≈25 - 30%), medical staff (≈20 - 25%), and allied health professionals and non-clinical staff (≈10 - 15%), reflecting strong organisational awareness and a whole-system approach to safeguarding.

Importantly, the data highlights a growing recognition of complex and cumulative risk, including persistent non-attendance, co-existing vulnerabilities, and links to wider safeguarding concerns. This is supported by improvements in data quality, consistency of categorisation, and more confident application of safeguarding thresholds, underpinned by strengthened training and clearer pathway implementation.

Multi-agency engagement has also become more consistent, with timelier information sharing and escalation to Children's Social Care and partner agencies. In parallel, there is increased involvement from a broader multidisciplinary workforce, reflecting a more coordinated and whole-system approach to identifying and responding to WNB concerns.

Overall, the scale and pattern of activity provide strong assurance that staff are proactively identifying and escalating WNB, with clear recognition of its significance as a potential indicator of neglect and hidden harm. The strengthened pathway supports earlier identification, consistent decision-making, and timely escalation, reflecting a mature safeguarding system characterised by improved documentation, clearer thresholds, and stronger multi-agency engagement.

Child Protection Information Sharing (CPIS) System

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

CP-IS enables real-time information sharing between health and social care, ensuring that safeguarding risks are visible at the point of contact and that clinical decision-making is informed by the child's wider safeguarding context.

During 2025 - 2026, the Trust continued to strengthen its approach to the Child Protection Information Sharing (CP-IS) system, recognising its critical role in supporting the early identification of children who are subject to Child Protection Plans (CPP) or are a Child Looked After (CLA).

A key focus during the year has been the standardisation of CP-IS checks within unscheduled emergency and urgent care pathways. These presentations represent high-risk opportunities to identify vulnerability; however, internal review has identified variation in compliance, creating a potential risk that safeguarding status is not consistently identified in line with NHS England expectations.

To address this, the Trust has taken steps to reinforce routine CP-IS checks at all unscheduled presentations, supported by targeted staff training, safeguarding newsletter briefings, and the provision of ad hoc guidance to clinical teams, alongside ongoing safeguarding oversight and audit. These actions have improved awareness and practice in some areas; however, further work

is required to achieve consistent compliance across all paediatric service departments and urgent and emergency care pathways and will be a priority for 26/27.

In parallel, the Named Nurse for Safeguarding Children and Young People has actively contributed to the West and North London Integrated Care Board (ICB) CP - IS Task and Finish Group, established to support system-wide readiness for the Phase 2 rollout of CP-IS into scheduled care settings. NHS England guidance recommends full implementation of this phase by December 2026, extending CP-IS checks into planned care pathways to ensure safeguarding visibility at every healthcare contact.

Work will continue in 2026 - 2027 through the establishment of a dedicated internal task and finish group, bringing together key stakeholders across clinical services, digital systems, safeguarding teams, and operational leads. This group will focus on embedding consistent practice, aligning clinical workflows, strengthening staff training, and enhancing system functionality to support routine CP-IS checks across all care pathways.

These developments demonstrate the Trust's ongoing commitment to embedding CP-IS as a core component of safeguarding practice. Continued focus on standardisation and improvement will ensure safeguarding information is consistently accessed and utilised, supporting earlier identification of vulnerable children, strengthening multi-agency information sharing, and enabling more informed, child-centred clinical decision-making.

Child Death Notifications

During 2025 - 2026, a total of 7 child death notifications were identified through safeguarding activity. These were received via a combination of formal processes (including CDOP queries and Child Death Reporting Form B) and informal routes, such as incident reporting systems, multi-agency communication, and the Was Not Brought (WNB) pathway.

Quarterly distribution:

- Q1: 4 notifications, including both formal and informal notifications, with one case linked to a WNB episode
- Q2: 1 formal notification via Child Death Reporting processes

- Q3: 1 informal notification, identified through the WNB pathway
- Q4: 1 informal notification, identified retrospectively following repeated cancellations and WNB pathway.

A key theme is the variation in how notifications are received, with several cases identified informally or retrospectively, rather than through immediate formal escalation. Notably, 3 of 7 cases (≈43%) were identified through WNB or appointment-related concerns, reinforcing the importance of WNB as a potential indicator of vulnerability and the need for robust follow-up.

The notifications were identified across multiple sites and systems, demonstrating the organisation's connectivity with wider safeguarding and child death review processes. However, variation in notification routes highlights the need for continued focus on timely and consistent escalation to the safeguarding team.

The introduction of the Trust Standard Operating Procedure (June 2025) for handling formal and informal child death notifications has strengthened organisational processes, providing clearer guidance on recognition, escalation, and information sharing. This supports improved oversight and ensures appropriate safeguarding input into child death review processes.

Overall, the data provides assurance that child deaths are being identified and escalated through a range of mechanisms, while also highlighting opportunities to further strengthen early identification and consistency of reporting, particularly for cases identified through indirect pathways such as WNB.

Learning and Service Improvement

In line with the Trust's Standard Operating Procedure for the management of child death notifications, review of these cases has identified opportunities to strengthen early identification and consistency of notification processes.

Learning from 2025 - 2026 highlights that variability in how deaths are formally identified and escalated can be addressed through the systematic use of NCRS (National Care Records Service) checks at all points of contact with children and young people.

The implementation of routine NCRS review supports earlier recognition of deceased status, reduces the risk of delayed or indirect notification, and ensures the safeguarding team is informed in a timely manner. This approach also strengthens information sharing across services, improves the accuracy of clinical records, and enhances organisational oversight of vulnerable children.

Embedding this practice across the Trust will support a more consistent and proactive safeguarding response, ensuring that child death notifications are identified promptly and that appropriate safeguarding and governance processes are initiated without delay.

Islington Safeguarding Children Partnership Board Priorities

Throughout 2025–2026, Moorfields Eye Hospital has continued to align its safeguarding practice with the strategic priorities of the Islington Safeguarding Children Partnership (ISCP), ensuring that activity remains focused on addressing vulnerability, reducing inequality, and improving outcomes for children and young people.

Structural Inequalities / Disproportionality

Safeguarding activity reflects increased recognition of wider determinants of vulnerability, including housing instability, access barriers, financial hardship, and parental capacity. The development of the WNB pathway and strengthened use of CP-IS checks have supported earlier identification of children who may be disproportionately affected by systemic inequalities, ensuring that these risks are considered within safeguarding assessment and escalation.

Wellbeing (Early Intervention and Prevention)

There is clear evidence of a shift towards earlier identification and intervention, supported by improved use of Early Help pathways, information sharing, and safety planning. The reduction in CSC referrals alongside sustained safeguarding activity demonstrates a more proportionate response, where concerns are identified earlier and managed at the most appropriate level, preventing escalation wherever possible.

SEMH, SEND and Inclusion

Safeguarding data highlights increasing identification of children with social, emotional and mental health (SEMH) needs, SEND, and additional vulnerabilities, particularly within WNB activity and complex safeguarding cases. Staff training, supervision, and the Think Family approach have

supported improved recognition of these needs and ensured that safeguarding responses are inclusive and responsive to children requiring additional support.

Neglect and Parental Factors

Parental factors, including mental health, domestic abuse, and capacity to engage with services, remain a key theme within safeguarding concerns. The Trust has strengthened its approach to recognising neglect and cumulative harm, particularly through patterns of non-attendance (WNB) and “child behind the adult” presentations. Enhanced multi-agency working and closer collaboration with Children’s Social Care and partner agencies have supported earlier intervention and coordinated responses.

Learning from safeguarding activity during 2025–2026 has been systematically embedded across the organisation to support continuous improvement in practice. Key themes and insights have been shared through safeguarding supervision, multidisciplinary training sessions, incident closure reports, and policy and pathway development.

This structured approach to learning has reinforced a consistent safeguarding culture, enabling staff to reflect on practice, strengthen professional judgement, and apply learning to future cases. Sharing real case examples and outcomes has supported improved understanding of threshold application, risk recognition, and multi-agency working, while also promoting professional curiosity and child-centred decision-making.

Ongoing dissemination of learning ensures that safeguarding practice remains responsive, evidence-informed, and aligned with statutory expectations, supporting high standards of care and improved outcomes for children and young people.

Safeguarding Vulnerable and At Risk Adults

“Safeguarding Is about people and organisations working together to prevent and stop both the risk and the actual experience of abuse or neglect” (Care Act 2014)



Safeguarding In Action

Adult safeguarding remains a key priority across Moorfields Eye Hospital NHS Foundation Trust, supporting the organisation’s commitment to protecting adults at risk from abuse, neglect, and exploitation. The Adult Safeguarding Team works closely with clinical services and partner agencies to raise awareness, provide specialist advice, support timely escalation of concerns, and promote best practice.

During 2025–2026, safeguarding activity continued to increase, reflecting greater staff awareness and confidence in recognising and reporting safeguarding concerns. To support continuous learning and ensure alignment with national priorities, the Adult Safeguarding Team regularly shares learning, emerging themes, policy updates, and examples of good practice through the quarterly *Caring Voices* and *Safeguarding Adults Snippets* newsletters. This helps embed a proactive safeguarding culture and reinforces that safeguarding is everyone's responsibility.

Moorfields Eye Hospital NHS Foundation Trust

Safeguarding Adults in Action: Learning from an Unreported Fall 2025-2026



*Brenda, aged 75, attended the Day Surgery Unit at Croydon for a right entropion correction—a procedure to reposition an eyelid that had turned inward, causing discomfort and irritation to the surface of her eye. She arrived in her **own wheelchair** and was **accompanied** by her **husband**.

During the admission process, while changing into a hospital gown with the assistance of a nurse, Brenda **attempted to stand** using a nearby **chair for support**. She **lost her balance** and **fell**. Nursing staff came to assist, there were no visible injuries, but reported pain. The nursing team **asked Brenda** whether she still wished to proceed with the surgery and after **discussing** this with **her husband**, she chose to go ahead.

To ensure her safety, a **hoist was arranged** for all further transfers and surgery proceeded without complication. Brenda recovered well from the procedure and was discharged later that day.

Later that evening at home, Brenda **experienced another fall**. The following day, she presented to her local A&E with pain in her left leg. Investigations revealed a **right ankle fracture**, and she was **admitted** to **hospital** for **further care**. It is **unclear** if the fracture occurred as a result of the fall at Moorfield's or subsequent fall.

The safeguarding team were not initially aware of the incident, as the **fall had not been reported** at the time it occurred. It came to light when the patient's husband contacted the hospital to inform them that Brenda had been diagnosed with a fracture. The event had **not been documented** or **logged as an incident**, as it was perceived by staff as a **near miss** rather than a **fall**. This also **influenced** the decision not to inform the surgical team prior to the procedure. As a result, there was **no formal record** of the **event** in the **patient's healthcare records**.

In response to these events, an **investigation** was **conducted** and a **safeguarding referral** was **made** to the local authority to **ensure Brenda's safety and well-being**. Following assessment, it was determined that the safeguarding threshold was not met. It was also agreed that an **After-Action Review (AAR)** would be **beneficial** for the **staff** directly **involved**, to **reflect** on the incident and **identify lessons** that could **improve patient safety** and care in the future.

After-Action Review - Key Issues and Lessons Learned



Key Issues Identified:

- **Mobility needs** were **not adequately assessed**; staff relied on the husband's account rather than direct evaluation.
- The **incident** was **not escalated** to the surgical team.
- **Communication breakdown** between the day surgery nursing team and the surgical team.

Lessons identified:

- The team discussed the **importance of documenting** all incidents and **escalating** regardless of **patients declining**.
- **Theatre lists** need to be **reviewed** ensuring **patients** with **health or social conditions** are **positioned** on the **list appropriately** to **allow for extra time** and **no time pressure** passed onto the team.

*Name changed to protect identity

SGA Activity Dashboard and Overview 2025-2026

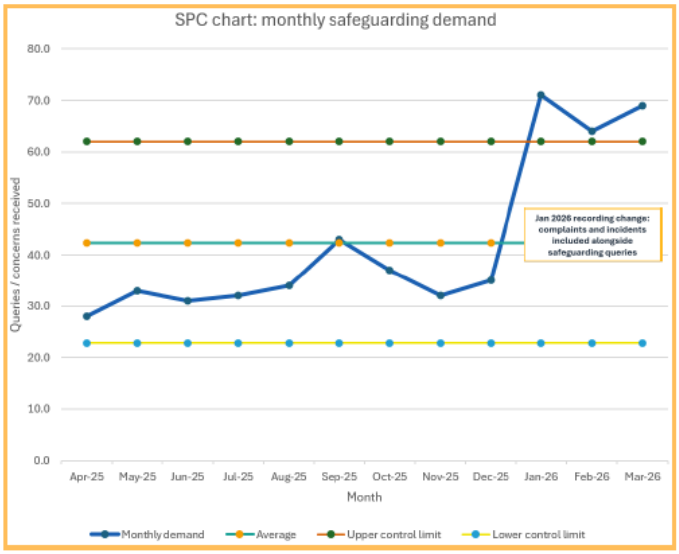
Total queries	Top theme	Incidents	Complaints	Mental Health (MH)	MH Advice Line Signpost
509	Care & Support	95	191	53	21
+26% from 2024-2025	34 (6.7%)	Reviewed only	Reviewed only	10.4% of real activity	4.1% of real activity

Safeguarding Adults Team — Work Capacity

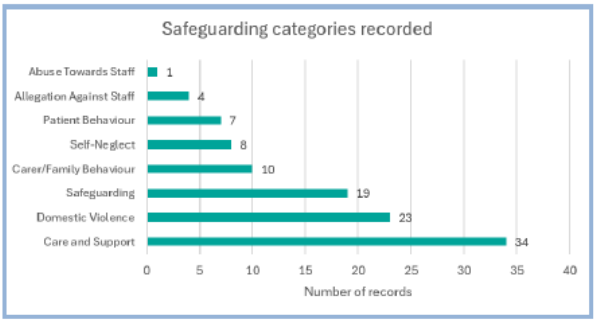
Recorded demand was relatively **stable** from April to December 2025, ranging from 28 to 43 records per month. This suggests a **consistent** baseline workload before January 2026.

From January 2026, recorded **demand increased** because **complaints** and **incidents** began being captured alongside safeguarding queries. This should be interpreted as both a recording-scope change and an **increase in visible workload**.

Future reporting should monitor whether Q4 demand remains **sustained** and separate true demand growth from improved capture/expanded recording.



Safeguarding themes

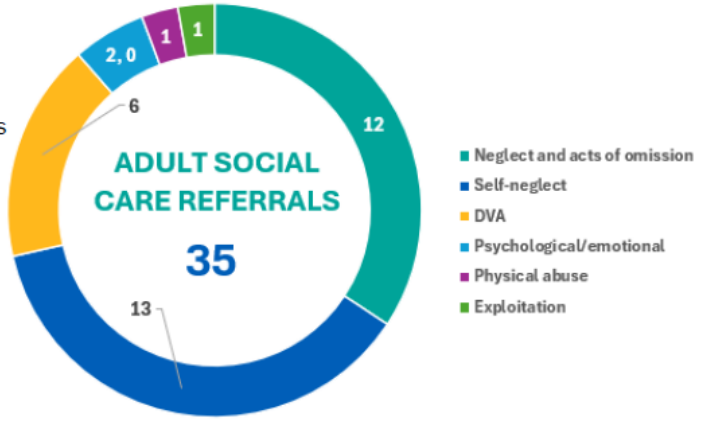


The most frequently recorded safeguarding theme was **Care and Support**, followed by **Domestic Abuse** and general Safeguarding concerns. This indicates that a significant proportion of activity relates to people needing support to remain safe, manage **vulnerability**, or access appropriate care. The presence of **domestic violence**, **self-neglect**, **family/carer behaviour** and **behaviour-related** risks shows the breadth of safeguarding issues being identified. These themes inform training, escalation pathways and partnership working with social care, mental health, domestic abuse services and carers' support.

Safeguarding Referrals

There were **35 referrals** to Adult Social Care, representing 6.9% of the 509 real activity records. This is an increase from 20 referrals in 2024–2025 to **35** in 2025–2026, an uplift of **15 referrals** / **75%**.

This demonstrates increased **multi-agency working** and appropriate **escalation** where **safeguarding concerns** required wider social care input.



Complex Patients Discharge

Complex discharges may arise where patients present with co-morbidities and additional social risk factors, including homelessness and mental health needs. It is recognised that where safe and effective discharge planning is required, a coordinated multi-agency approach and comprehensive risk assessment are essential.

The Safeguarding Team acknowledges the importance of collaborative working with specialist services, including pre-assessment teams, to ensure that patients' care and support needs are identified at an early stage. Early recognition of potential complexity enables timely escalation within the Trust and to external partner agencies, ensuring that appropriate discharge planning and safeguarding measures are implemented.

The Safeguarding Team is committed to promoting organisational learning and supporting staff in managing complex cases. Ongoing safeguarding supervision and debrief sessions are provided to enable reflection, identify learning, and support the consistent application of best practice across clinical divisions.

Homelessness

Homelessness remains a significant safeguarding concern and is associated with increased vulnerability, poorer health outcomes, and reduced access to healthcare services. Patients experiencing homelessness often present with complex needs, including co-morbid physical and mental health conditions, substance misuse, and social exclusion.

Within Moorfields Eye Hospital NHS Foundation Trust, patients experiencing homelessness are identified across outpatient, inpatient, and Accident and Emergency (A&E) settings, where there are key opportunities for early recognition of safeguarding risk and need. Staff are supported to identify indicators of homelessness and associated vulnerabilities and to escalate concerns in line with Trust safeguarding policies and procedures.

The Safeguarding Team works collaboratively with clinical services, inpatient wards, discharge teams, and external partners to ensure that risks are appropriately assessed and managed. A multi-agency approach is adopted to support safe admission and discharge planning, including liaison with local authorities, housing services, and specialist outreach teams.

The Trust remains committed to improving outcomes for this patient group through staff training, strengthened partnership working, and the development of pathways that promote equitable, accessible, and person-centred care.

Mental Health

The Safeguarding Team works collaboratively with practitioners within the Mental Health Service Level Agreement (MH SLA), supported through monthly monitoring meetings with East London NHS Foundation Trust.

Staff at Moorfields Eye Hospital are able to access a dedicated telephone helpline for specialist advice when patients disclose, or present with, mental health concerns. This provides timely support to ensure appropriate assessment, signposting, and escalation where required.

A comprehensive training programme is available to all staff, delivered in partnership with East London NHS Foundation Trust. The Safeguarding Team continues to provide additional guidance and support to staff when mental health concerns are identified within the clinical setting.

A range of resources is available to staff on Eye Q, the Trust intranet, including an advice leaflet and other guidance to support awareness and decision-making in relation to mental health presentations.

It is important to note that there are no Mental Health trained practitioners within the Safeguarding Team, therefore the mental Health Advice line should be the first point of contact for staff. Staff are therefore strongly encouraged to utilise the helpline advisory service to ensure patients receive appropriate specialist input and support.

Modern Day Slavery

The Trust has continued to strengthen awareness of modern slavery, ensuring its integration within the Safeguarding Adults and safeguarding children's practices and associated staff training programmes. A dedicated modern slavery section is accessible via the safeguarding intranet page, providing staff with direct access to key resources, including the Royal College of Nursing (RCN) Modern Slavery Pocket Guide, Metropolitan Police presentations, and the National Modern Slavery Helpline.

The Trust's *Modern Slavery and Human Trafficking Statement*, published on its public website, demonstrates Moorfields' ongoing commitment to meeting the requirements of the Modern Slavery Act 2015 and fulfilling its safeguarding responsibilities.

In response to staff feedback, A targeted training was available in 2025 to enhance awareness and understanding of modern slavery. This training was delivered by an external specialist, a former Detective Police Officer with expertise in modern slavery and human trafficking.

The programme focused on developing staff knowledge and confidence in identifying the different forms of modern slavery and human trafficking, recognising key signs and indicators of exploitation, and understanding appropriate safeguarding actions where there are concerns that a patient or other individual may be at risk of, or experiencing, exploitation or harm.

Dementia, Learning Disability and Autism

Moorfields Eye Hospital NHS Foundation Trust is committed to ensuring equitable and accessible care for patients living with dementia, learning disabilities and/or autism. The Trust continues to work collaboratively with the Patient Experience Team and volunteers to support the delivery of reasonable adjustments and ensure that accessible information is readily available to meet individual patient needs.

As part of the ongoing safeguarding and inclusion agenda, the Trust has explored the recruitment of a Learning Disability and Dementia Liaison Nurse. This role is intended to strengthen internal expertise, enhance multidisciplinary working, and improve collaboration with external partners and stakeholders.

Learning Disability and Autism

The Trust has embedded e-learning packages and 'myth-busting' sessions in line with the Oliver McGowan Mandatory Training on Learning Disability and Autism Code of Practice (2025–2026). These sessions have been well attended, with consistently positive feedback from staff across a range of professional groups.

To further support workforce development and embed best practice, the Trust also commissioned two sessions of the Oliver McGowan Tier 2 training. A total of 29 senior leaders attended these sessions, demonstrating organisational commitment to improving understanding and leadership in this area.

Feedback from participants was highly positive, with attendees reporting increased confidence and awareness in supporting patients with learning disabilities and autism. In response to this feedback, and the identified demand for further training, the Trust is currently developing a business case to commission additional sessions. This will support a wider rollout across staff groups and further embed best practice across the organisation

Dementia

The Trust has prioritised the implementation of NICE guidance relating to dementia, with a particular focus on early assessment of eye health and timely identification and management of conditions such as cataracts. This work aligns with national priorities and supports improved patient outcomes by ensuring appropriate and timely interventions for individuals living with dementia.

A dedicated cataract clinic for vulnerable adults has been established, with a particular focus on patients living with dementia and those with learning disabilities and/or autism. This service is led by two consultant ophthalmologists with a specialist interest in dementia care. The pathway is fully embedded within clinical practice, supporting the delivery of person-centred care tailored to individual needs. The Safeguarding Team is available to provide advice and guidance to clinical staff, particularly in relation to reasonable adjustments and mental capacity considerations, ensuring care is delivered in line with statutory and best practice requirements.

Learning disability, autism and dementia remain key priorities for Moorfields Eye Hospital NHS Foundation Trust. The Trust continues to embed early identification, person-centred care and the implementation of reasonable adjustments into everyday practice.

The proposed recruitment of a specialist liaison nurse will further strengthen partnership working, enhance staff support, and drive continuous improvement in the care of some of the Trust's most vulnerable patients

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act (MCA) 2005 provides a statutory framework to support individuals aged 16 and over who may lack capacity to make specific decisions. The Act is underpinned by five core principles, promoting autonomy and ensuring that any decision made on behalf of an individual is in their best interests and is the least restrictive option.

The Deprivation of Liberty Safeguards (DoLS), introduced as an amendment to the MCA, apply where an individual lacking capacity is subject to restrictions and care arrangements that may amount to a deprivation of liberty within hospitals or care homes.

Assurance and Oversight

To ensure robust and consistent implementation of the MCA and its Code of Practice, a range of key activities were undertaken:

- Provided specialist advice and support to staff across all departments
- Supported and contributed where necessary to Best Interests decision-making processes, ensuring decisions are lawful, proportionate, and person-centred
- Maintained a comprehensive MCA intranet resource, including guidance, templates, and training materials
- Maintained access to trained expertise within the Trust, including a Best Interests Assessor (BIA)
- Continued participation in NHS England London regional MCA/DoLS networks, including Children and Young People and practitioner forums, facilitating shared learning and service development

Training and Workforce Development

- All staff are required to complete a mandatory Mental Capacity Act (MCA) awareness e-learning module, with clinical staff undertaking Level 3 training in line with statutory requirements.

- In response to feedback regarding the length and accessibility of the e-learning for health modules, a bespoke, classroom-based training programme was developed and continues to be delivered with good compliance.
- All staff working in patient-facing roles are expected to undertake this Mental Capacity Act training. New starters are encouraged to attend as part of their onboarding programme, with monthly sessions scheduled throughout the year to accommodate staff availability and clinical service requirements.
- The training is tailored to ophthalmology and Moorfields-specific scenarios, improving relevance to clinical decision-making. Feedback indicates that the programme is well received and enhances staff confidence in applying MCA principles in practice.
- To support consistent, accessible, and legally compliant decision-making, Pocket Prompt guidance in the form of Z-fold cards provide concise, current information on assessing mental capacity, including the key principles of the MCA, practical prompts for conducting and documenting capacity assessments, and clear guidance on who should be involved in best interests decision-making. The cards also signpost escalation routes and sources of further advice.
- The Pocket Prompts are shared with staff at induction, during safeguarding training, and through face-to-face promotional events to increase awareness, accessibility, and day-to-day use of MCA guidance.

Deprivation of Liberty Safeguards (DoLS)

During 2025–2026, the Trust made no referrals to Local Authorities for DoLS authorisation. This aligns with the Trust's ambulatory care model, where inpatient admissions are limited and typically short in duration, meaning the threshold for deprivation of liberty is rarely met.

The Liberty Protection Safeguards (LPS), introduced under the Mental Capacity (Amendment) Act 2019 to replace the Deprivation of Liberty Safeguards (DoLS), have not yet been implemented following the Government's decision in April 2023 to delay rollout.

In October 2025, the Government confirmed that a public consultation on LPS will take place in 2026, indicating renewed progress toward reform of the current system. The Trust continues to

monitor national policy developments closely, and local implementation planning will recommence once further clarity is provided following the 2026 consultation and the anticipated revision of the Mental Capacity Act Code of Practice.

At the time of writing, the Supreme Court judgment in AGNI (2 June 2026) has significant implications for practice. The ruling reinforces the need for a multi-factorial approach when determining deprivation of liberty. As a result, the Trust will undertake a review of relevant policies, staff training, and supporting resources to ensure alignment with the updated legal framework and to support staff in applying the principles of the judgment consistently and lawfully.

PREVENT

PREVENT continues to be a key priority within the Trust's safeguarding agenda, in line with the requirements of the *Counter-Terrorism and Security Act 2015*. Islington and Camden report the highest number of PREVENT referrals per population across London, highlighting the importance of maintaining robust local arrangements and partnerships.

Moorfields Eye Hospital NHS Foundation Trust remains committed to the early identification of individuals who may be vulnerable to radicalisation. The safeguarding team works collaboratively with the Islington PREVENT network to share learning, risk information, and best practice, thereby strengthening the local multi-agency response.

During this reporting period, there have been no PREVENT referrals originating from Moorfields Eye Hospital NHS Foundation Trust.

The Safeguarding Team continues to work collaboratively with Islington Council through the PREVENT network, contributing to shared resources, partnership working, and coordinated multi-agency approaches. During this financial year, the team has strengthened engagement with PREVENT partners through the implementation of the Information Sharing Request (ISR) pathway. This process enables the timely sharing of relevant information to support the Channel process and promote effective safeguarding outcomes. Following the introduction of the Prevent ISR pathway, In Quarter 4, Moorfields Eye Hospital received six Information Sharing Requests (ISRs), demonstrating improved collaboration with partner agencies in identifying and managing individuals at risk of radicalisation.

Training

Safeguarding training continues to be delivered through a rolling three-year programme, with all staff required to complete the level of training appropriate to their role and responsibilities. Training requirements are aligned with the *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff* and *Adult Safeguarding: Roles and Competencies for Health Care Staff* Intercollegiate Documents. These frameworks provide the standards and guidance that underpin Moorfields Eye Hospital's safeguarding training programme, ensuring that staff are equipped with the appropriate knowledge, skills, and competencies to safeguard adults, children, and young people effectively, and to fulfil their statutory safeguarding responsibilities

Safeguarding e-learning modules are accessed via the national e-Learning for Healthcare platform. In addition, Level 3 face-to-face safeguarding training continues to be delivered through a multidisciplinary approach, co-facilitated by a children's social worker for safeguarding children sessions and a former Detective Police Officer for safeguarding adults. This supports the delivery of high-quality, practice-focused training informed by professional expertise. Delivering a multi-disciplinary approach to support learning. Staff also have access to external mandatory training opportunities delivered through local safeguarding partnerships.

Training compliance is routinely monitored through established governance structures, including the Mandatory and Statutory Training (MAST) Committee and the Safeguarding Committee. Quarterly training data is reviewed and submitted as part of the Trust's assurance processes, supporting ongoing monitoring, compliance, and continuous improvement in safeguarding practice.

Other Safeguarding Training

Attendance at additional training opportunities that support learning and staff awareness is actively promoted across the Trust through the dissemination of relevant topics, updates, and development opportunities. Training data is collated and reported via the Learning and Development Department using the INSIGHT system.

During 2025–2026, the Safeguarding Children and Young People Team delivered a programme of targeted training workshops designed to support staff in recognising and responding to safeguarding concerns, with a focus on embedding best practice within clinical settings.

Training was delivered across a range of services and sites, including South Orthoptics and associated clinical teams (June and September 2025), the North Orthoptics Team (July 2025), the City Road Adult Emergency Department (July and November 2025), and the Optometry team (March 2026). These sessions were tailored to the specific risks and needs of each service and addressed key safeguarding themes, including “Was Not Brought” (WNB), the “child behind the adult,” Child Protection – Information Sharing (CP-IS), managing Child Death notifications, and threshold decision-making. This enabled staff to apply safeguarding principles effectively within their day-to-day clinical practice.

In addition, the Safeguarding Team delivered ad hoc, face-to-face teaching sessions to support the WNB digitisation pilot within the Richard Desmond Children Eye Centre (RDCEC) (February 2025). This ensured that staff were confident in accessing and utilising new processes, whilst maintaining consistent and robust clinical risk assessment.

This targeted and responsive approach to training has strengthened staff confidence, professional curiosity, and consistency of safeguarding practice. It has supported the earlier identification of risk and appropriate escalation of concerns, reflecting the Trust’s commitment to delivering needs-led education aligned with emerging themes and service requirements. This contributes to the development of a skilled, competent, and safeguarding-aware workforce.

Table 1: Permanent Staff and Volunteers

MAST Topic	Target %	March 2025	March 2026
Safeguarding Children and Young People:			
Level 1	80%	92%	91%
Level 2	80%	93%	91%
Level 3	80%	81%	83%
Level 4	80%	100%	100%

Safeguarding Adults:			
Level 1	80%	94%	93%
Level 2	80%	93%	92%
Level 3	80%	75%	87%
Level 4	80%	50%	100%
Mental Capacity Act (MCA):			
Mental Capacity Act Awareness - Level 1	80%	92%	92%
Mental Capacity Act (Clinical Staff) - Level 2	80%	83%	82%
Preventing Radicalisation:			
Basic PREVENT Awareness	80%	91%	91%
Workshop To Raise Awareness of PREVENT (WRAP)	80%	93%	92%
Vulnerable and At Risk People:			
Dementia	80%	92%	93%
Learning Disability and Autism	80%	91%	79%

Table 2: Honorary and Locum Staff

MAST Topic	Target %	March 2025	March 2026
Safeguarding Children and Young People:			
Level 1	80%	54%	53%
Level 2	80%	44%	50%
Level 3	80%	73%	69%
Safeguarding Adults:			
Level 1	80%	56%	55%
Level 2	80%	43%	50%
Mental Capacity Act (MCA):			
Mental Capacity Act Awareness - Level 1	80%	48%	52%
Mental Capacity Act (Clinical Staff) - Level 2	80%	33%	38%
Preventing Radicalisation:			

Basic PREVENT Awareness	80%	43%	49%
Workshop To Raise Awareness of PREVENT (WRAP)	80%	49%	48%
Vulnerable and At Risk People:			
Dementia	80%	49%	51%
Learning Disability and Autism	80%	49%	46%

Mandatory and Statutory Training (MAST) compliance for honorary and locum staff remains below the Trust's required target. Targeted actions are ongoing in collaboration with Human Resources and the Medical Resource Lead to strengthen access, monitoring, and accountability for safeguarding training within this staff group.

This includes the development of processes to recognise and record MAST-accredited training completed at other NHS organisations, ensuring accurate capture of compliance and reducing duplication where appropriate.

Progress is subject to regular review through established governance structures, including the MAST Committee and the Safeguarding Committee. This risk is formally recorded on both the Safeguarding Risk Register and the Trust's Corporate Risk Register to ensure appropriate oversight, mitigation, and assurance

Safeguarding Reflection and Supervision

Safeguarding supervision for children and young people (SGCYP) remains a core component of safe and effective practice, providing structured and reflective support to staff managing safeguarding concerns. Building on the strong foundations established in 2024 - 2025, the approach to supervision during 2025–2026 has been further developed to enhance accessibility, consistency, and impact across all services.

Supervision continues to be delivered through a blended and flexible model, including individual and group sessions, ad hoc advice, case discussions, and reflective debriefs. In response to learning from the previous year, there has been a greater emphasis on embedding supervision within everyday practice, ensuring that staff are supported to reflect on decision-making, risk assessment, and escalation in real time.

The established programme of department-based safeguarding workshops has been expanded beyond City Road to additional paediatric and clinical areas, using case-based learning and peer reflection to support staff in managing complex safeguarding scenarios and strengthening professional curiosity.

To further improve access, the safeguarding team has increased its on-site and virtual presence, providing regular, targeted sessions aligned to service need. This has enhanced team visibility and ensured staff can access timely advice and supervision within their clinical environments, supporting consistent and confident safeguarding practice.

Supervision activity continues to be supported at a senior level, with the Named Doctor and Named Nurse maintaining external peer supervision through local safeguarding networks, ensuring alignment with best practice and statutory requirements. In addition, supervision data and themes are routinely monitored through safeguarding governance processes to inform service improvement.

A more structured approach to learning from practice has also been embedded, including the use of anonymised case studies, thematic reviews, and feedback shared through Trust communication channels. This supports organisational learning, promotes reflection, and reinforces examples of good practice alongside areas for development.

Overall, developments during 2025 - 2026 demonstrate a more proactive, embedded, and accessible supervision model, supporting staff to identify risk earlier, make informed safeguarding decisions, and deliver consistent, high-quality care. This approach continues to strengthen safeguarding practice across the organisation and ensures ongoing responsiveness to the needs of children, young people, and families.

Learning from Safeguarding Practice Reviews

Learning from national and local enquiries and reviews, including Child Safeguarding Practice Reviews (CSPRs), Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), and Offensive Weapons Homicide Reviews (OWHRs), continues to be embedded across the organisation through a range of communication methods, training, and forums, recognising that staff engage with learning in different ways.

Action plans arising from these reviews are overseen and monitored by the Safeguarding Committee, ensuring accountability and system-wide learning.

During 2025 - 2026, the Trust was involved in one Child Safeguarding Practice Review, although the child was not known to Moorfields Eye Hospital. The Trust's engagement in the review process reflects a commitment to sector-wide learning and continuous improvement, irrespective of direct organisational involvement.

Key themes identified through the published review will be disseminated across the organisation through safeguarding supervision, training sessions, governance forums, and Trust communications, supporting staff to reflect on practice and apply learning to improve outcomes for children and young people.

Inspections and Monitoring

During the reporting period, there were no inspections undertaken by the Care Quality Commission (CQC). In addition, there were no inspections relating to safeguarding adults, nor any Joint Targeted Area Inspections (JTAI) concerning safeguarding children

Safeguarding Partnership Boards, Meetings and Engagement

External Engagement

The Safeguarding Team continues to work collaboratively with key partners, including the Islington Safeguarding Adults Board, Islington Safeguarding Children Partnership and the Integrated Care Board (ICB). Through these partnerships, the Trust receives regular updates, recommendations, and shared learning, which are used to inform practice, strengthen safeguarding arrangements, and support continuous improvement in service delivery for vulnerable patients.

Moorfields Eye Hospital NHS Foundation Trust remains committed to working in an open and transparent manner. Assurance is provided through established governance structures, including the Safeguarding Committee, where performance, key risks, and learning are routinely reviewed. The Trust also shares safeguarding data and key performance indicators (KPIs) with internal and

external stakeholders, as required, to demonstrate compliance, accountability, and ongoing commitment to safeguarding best practice.

Policies, Procedures and Guidelines Updates

Domestic Violence and Abuse Policy, specifically to the SPECSS DVA Risk Assessment template V2

October 2025: A minor update was made to the Domestic Violence and Abuse (DVA) Policy, specifically to the SPECSS DVA Risk Assessment Template. Version 2 introduced enhanced considerations for adult patients presenting following domestic abuse who have parental or caring responsibilities, strengthening the Think Family approach and supporting more effective identification and management of safeguarding risks affecting both adults and children.

Standard Operating Procedure: Handling Child Death Notifications – Formal and Informal

October 2025: The Trust approved and implemented a Standard Operating Procedure (SOP) for the management of formal and informal child death notifications. The SOP provides staff with clear and consistent guidance on the identification, escalation, and management of child death notifications, ensuring a timely, coordinated, and proportionate response across services in accordance with statutory requirements.

Safer Recruitment

Disclosure and Barring Scheme (DBS) Compliance

The Trust remains committed to ensuring that robust pre-employment safeguarding processes are in place to protect children, young people, and adults at risk. Disclosure and Barring Service (DBS) checks continue to be undertaken in accordance with national NHS Employment Check Standards and Trust policy, ensuring that staff, volunteers, contractors, and other eligible individuals are appropriately vetted prior to commencing employment.

Throughout 2025–2026, DBS compliance was monitored through established workforce and governance processes, providing assurance that staff working in regulated activities held the appropriate level of DBS clearance for their role. Any identified compliance issues were addressed

promptly through local management arrangements and oversight from Human Resources and Safeguarding teams.

Overall, DBS compliance arrangements continue to support the Trust's commitment to safeguarding, safer recruitment, and the provision of safe, high-quality care for patients and their families.

Managing Safeguarding Allegations

The Chief Nurse remains the named senior officer with overall responsibility for ensuring that robust arrangements are in place for the management of safeguarding allegations against staff and volunteers, supported by the Trust's Managing Safeguarding Allegations Policy and Procedures.

The Safeguarding Team continue to work closely with People and Organisational Development team, with professional leads and operational managers, to provide advice and support in the management of such concerns. When appropriate we work with the Local Authority Designated Officer (LADO) or external safeguarding partner agencies. When involved, appropriate external advice was sought to ensure compliance with statutory responsibilities and to support safe decision-making.

This was reviewed in line with Trust governance arrangements, with appropriate safeguarding oversight and risk assessment undertaken. Actions were proportionate to the level of risk identified, and processes followed ensured that staff conduct and safeguarding responsibilities were appropriately addressed.

Overall, this provides assurance that safeguarding allegations are managed in a timely, proportionate, and robust manner, with clear oversight, appropriate engagement with external agencies, and adherence to statutory guidance to protect adults at risk and children and young people.

Priorities 2026 – 2027

Safeguarding Children and Adults

During 2026–2027, the Integrated Safeguarding Team will work in collaboration to review and strengthen the Trust's Safeguarding Champion model.

This review will focus on ensuring robust clinical oversight, clear governance arrangements, and well-defined roles and responsibilities. It will support safeguarding champions to act as effective links between frontline services and the safeguarding teams.

The work will aim to enhance the consistency, visibility, and impact of safeguarding champions across all Trust sites. It will ensure that champions are appropriately supported and equipped with the knowledge, skills, and authority required to promote best practice, offer peer support, and escalate safeguarding concerns in a timely and appropriate manner.

The revised model will also support improved information sharing, earlier identification of risk, and the embedding of a 'Think Family' approach across services. This will help ensure that safeguarding is integral to day-to-day clinical practice across both adult and children's services.

Overall, this priority will strengthen safeguarding leadership at a local level and contribute to a more coordinated, responsive, and embedded safeguarding system across the Trust.

Safeguarding Children and Young People

During 2026 - 2027, a key priority for the Trust will be to embed Phase 2 of the Child Protection – Information Sharing (CP-IS) programme, ensuring that CP-IS checks are consistently undertaken for children and young people accessing scheduled healthcare services, in line with national guidance.

This builds on the successful implementation of Phase 1 during 2025 - 2026, which focused on unscheduled care settings and significantly strengthened the Trust's ability to identify children who are subject to Child Protection Plans (CPP) or who are Looked After Children (LAC) at the point of

contact. This has supported more informed clinical decision-making, improved information sharing, and enabled earlier identification of safeguarding risk.

National guidance from NHS England highlights the importance of CP-IS in facilitating real-time information sharing between health and social care, enabling the identification of vulnerable children and supporting timely and appropriate intervention. The extension of the programme into scheduled healthcare settings (Phase 2) promotes a whole-system approach, ensuring consistent safeguarding visibility at every point of healthcare contact (NHS England, 2024).

This approach is further supported by NICE Guideline NG76: *Child abuse and neglect*, which emphasises the need to share relevant safeguarding information and consider the wider context of the child at all clinical interactions to support early recognition of risk and coordinated, multi-agency care.

Key Areas of Focus

The next phase of implementation will focus on:

- Reinforcing CP-IS checks within unscheduled care settings through targeted training and the dissemination of Trust-wide briefings
- Establishing a dedicated Task and Finish Group with key stakeholders to oversee implementation and provide assurance
- Embedding routine CP-IS checks within outpatient and elective care workflows
- Strengthening staff awareness and training to support consistent, confident, and effective use of CP-IS
- Enhancing clinical systems, alerts, and prompts to improve compliance and reliability
- Developing audit and assurance processes to monitor uptake, compliance, and impact

Expected Impact

This programme of work will ensure that safeguarding information is consistently accessible across all care pathways, supporting a proactive, informed, and child-centred approach to care. It will further strengthen the Trust's ability to identify vulnerable children, facilitate timely multi-

agency communication, and ensure that safeguarding considerations are fully integrated into clinical decision-making at every point of contact.

Safeguarding Adults including Dementia, Learning Disability and Autism:

A key priority for the Trust is the recruitment of a Learning Disability and Liaison Nurse. This role will support the organisation to further embed and enhance the delivery of high-quality, person-centred care for vulnerable adults who may require reasonable adjustments and additional support.

The post will contribute to improving standards of care through the development and delivery of education and training, clinical supervision, and the provision of specialist advice and support to staff. It will also play a key role in identifying gaps and supporting the development of resources to meet the needs of patients with learning disabilities and associated vulnerabilities.

Collaborative working will be central to the role, ensuring effective engagement with multidisciplinary teams and external partners so that staff across the organisation are equipped with the knowledge, skills, and up-to-date understanding of national guidance required to deliver safe and effective care.

As part of this work, there will be a continued focus on strengthening the application of the Mental Capacity Act 2005, including the development of robust pathways for the identification, assessment, and escalation of concerns. This will be supported by ongoing training, advice, and guidance from the Safeguarding Team, ensuring best practice is consistently applied across all clinical areas.

This priority will support the Trust’s commitment to equitable care, improved patient outcomes, and the delivery of safeguarding responsibilities for some of its most vulnerable patient groups

Conclusion

During 2025–2026, Moorfields Eye Hospital NHS Foundation Trust continued to demonstrate strong safeguarding leadership, effective governance, and a clear commitment to protecting children, young people, and adults at risk.

The Trust has met its statutory safeguarding responsibilities and made significant progress in strengthening the Think Family approach, enhancing the Was Not Brought (WNB) pathway, improving training and supervision, and developing integrated safeguarding practices across children's and adults' services. Audit findings, incident reviews, and partnership working provide assurance that safeguarding concerns are identified, assessed, and managed effectively, with timely escalation and appropriate multi-agency collaboration.

While priorities remain for 2026–2027, including CP-IS implementation, strengthening the Safeguarding Champion model, and improving support for patients with learning disabilities, autism, and dementia, the Trust continues to demonstrate a mature safeguarding culture focused on continuous improvement.

The Trust Board can be assured that safeguarding arrangements remain effective, responsive, and embedded across the organisation, supporting the delivery of safe, high-quality, and person-centred care for vulnerable patients and their families.

Appendix 1

Table 1:

Metrics or Reporting	Frequency	Reporting Into
Learning Disability & Autism MAST Compliance	Monthly	NCL ICB
Prevent Duty Data Set Metrics	Quarterly	NHSE
Moorfields Content into Partnership Board Report	Annual	Islington SAB
Moorfields Content into Partnership Board Report	Annual	Islington SCP
Safeguarding Adults Partnership Audit Tool (SAPAT)	Annual	Islington SAB
Section 11 Audit	Biannual	Islington SCP

*Safeguarding Adults Performance Metrics	Quarterly	NCL ICB → NHSE
*Safeguarding Children Performance Metrics	Quarterly	NCL ICB → NHSE
*Includes DBS Compliance, MAST Training Compliance, Safeguarding Activity and Supervision		

Table 2:

Safeguarding Partnership Boards and Meeting Engagement
Access to Acute (A2A) Learning Disability National Network
Islington Child Criminal and Sexual Exploitation Briefings
Islington Dementia Friendly Steering Group
Islington SAB Case Review Subgroup
Islington SAB Prevention and Learning Subgroup
Islington SAB Quality Assurance Subgroup
Islington Safeguarding Children Health Leads Forum
Islington SCP Case Review Subgroup
Islington SCP Quality Assurance Subgroup
Islington SCP Training and Professional Development Subgroup
Islington Violence Against Women and Girls (VAWG) Board
NHSE Learning Disability Leadership Forum
NHSE Safeguarding Adults National Network (SANN)
NCL Oliver McGowan Learning and Development Leads Group
NCL ICS Oliver McGowan Strategic Group
NCL ICS Safeguarding System Learning Conversation
Pan London Counter Terrorism Briefings

Title of Document	Type	Status

Moorfields Eye Hospital NHS Foundation Trust

Learning from deaths (Q1 2026/27)

Board of directors
24 September 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 Q1 2026/27 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, 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 NHS England learning from deaths agenda.

Indicator	Q2 2025/26	Q3 2025/26	Q4 2025/26	Q1 2026/27
Summary Hospital Mortality Indicator (as reported in the integrated performance report)	0	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	1	0	1	1
% of cases (in scope) reviewed under the structured judgement review (SJR) methodology	100	N/A	100	Pending
Deaths considered likely to have been avoidable	0	N/A	0	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 is awaiting final approval by the multi-disciplinary team (MDT) that has been established for this purpose.

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

Notification was received, via a letter of complaint, that a patient had passed away approximately seven weeks after undergoing a surgical procedure at City Road. The family is seeking clarification regarding the nature of the surgical and anaesthetic procedures that were completed. The review of this case remains on-going, with information to support the response having been sought from another provider with which the patient had contact.

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 national quality board (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.

Moorfields Eye Hospital NHS Foundation Trust

People and culture committee chair's report

Board of directors
24 September 2026

Report title	**People and Culture Committee chair's report**		
Report from	Ken Batty NED committee chair		
Prepared by	Ben Westmancott, interim company secretary		
Previously considered at	People and culture committee	**Date**	18 Sept 2026
Link to strategic objectives	Underpins all strategic objectives		

Key messages for the Board following the meeting on 18 September 2026

Assure

1. The committee took assurance from two deep-dives: culture transformation; and oriel workforce.

Advise

2. Discussing the risk of overload, the committee agreed that the executives would increase communication of the four priorities alongside the things that we have agreed we will not do, to help managers and their teams balance priorities.
3. The Oriel move is essentially part of the culture change programme and the committee encouraged the development of culture change metrics to help understand the progress being made more clearly.
4. The committee will undertake a deep dive into Moorfields Private at its next meeting. This will help triangulate assurances with the recent deep dive carried out by the quality and safety committee.
5. The committee will continue to seek assurances on Oriel readiness.

Alert

6. In discussion it was identified that the more attention needed to be paid to reasonable adjustments to support staff transfer to workspaces at St Pancras. This is to respond to health needs, and childcare commitments that staff may have that might be impacted by the moves.

Quality implications
None specifically associated with this report.

Financial implications
None specifically associated with this report.

Risk implications
Risks are set out on the board assurance framework.

Action required/recommendation.
The Board is asked to note this report for assurance.

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

Moorfields Eye Hospital NHS Foundation Trust

Finance and performance committee chair's report

Board of directors
24 September 2026

Report title	**Finance and Performance Committee chair's report**		
Report from	Elena Lokteva, NED committee chair		
Prepared by	Ben Westmancott, interim company secretary		
Previously considered at	People and culture committee	**Date**	11 Sept 2026
Link to strategic objectives	Underpins all strategic objectives		

Key messages for the Board following the meeting on 11 September 2026

Assure

1. The committee noted a positive current-year financial position

Advise

2. The committee identified longer-term financial pressure: only £12 million of validated savings is in place, with a £9 million recurring gap and risks from block-contract changes. This needs to be an important input into the strategy refresh.
3. The committee noted some performance challenges including DNA rates and booking centre performance, and 52-week waits. The result of mitigating actions will be reviewed at future meetings of the committee and the executives will review any examples of learning from other trusts.

Alert

4. The committee noted that current financial controls focus heavily on cost reduction and efficiency programmes, with insufficient attention to income growth opportunities such as private patients, international activity and NHS growth opportunities

Quality implications
None specifically associated with this report

Financial implications
The report flags the longer-term financial sustainability risk as set out on the BAF.

Risk implications
Risks are set out on the board assurance framework

Action required/recommendation.
The Board is asked to note this report for assurance.

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Cover Sheet	
Report title	M5 Finance Performance Report
Meeting	Board of directors - Public
Date	24 September 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 August, the trust is reporting:-

Income and Expenditure

- A £1.11m deficit in-month against a planned £1.64m deficit, £0.53m favourable to plan; and a £1.46m surplus cumulatively against a planned £0.11m deficit, £1.57m favourable to plan.

Efficiency and Productivity

- The trust is forecast to deliver £12.1m of the £17.6m full year efficiency target, £5.5m adverse to plan.
- Delivery year to date is £4.6m compared to a plan of £7.4m, £2.8m adverse to plan.

Capital Expenditure

- Capital expenditure to August totalled £23.2m against an indicative plan of £23.8m.
    - The trust has prioritised £25.3m of capital submissions received via business planning, against an allocation of £17.7m, to £17.3m excluding contingency for unplanned requirements.
    - The trust is prioritising EPR, City Road migration, Oriel, Hoxton and Ealing alongside high priority medical equipment.
    - The capital planning and oversight committee (CPOC) is reviewing and prioritising further capital submissions.

Cash

- The cash balance as at the 31 August was £54.7m, a reduction of £8.0m since the end of March 2026. This equates to approximately 60 days operating cash.

Action Required/Recommendation

- The Board is asked to consider and discuss 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.

Moorfields Eye Hospital NHS Foundation Trust

2026/27 Monthly Finance Performance Report

Operational Financial Performance

Trust Board

24 September 2026

Updated 14 September 2026

Report Period	M05 | August 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 August 2026 (Month 05)

Key Messages

Statement of Comprehensive Income

Financial Position

£1.11m deficit in month

For August, the trust is reporting:-

- A £1.11m deficit in-month against a planned £1.64m deficit, £0.53m favourable to plan
- A £1.46m surplus cumulatively against a planned £0.11m deficit, £1.57m favourable to plan

Key Drivers of the Financial Variance

The trusts financial position is being supported by £1.43m of slippage on major projects expenditure, £0.81m favourable commercial trading and demonstrable reductions in temporary staffing spend, 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 activity.
  - Income levels would be break-even to plan cumulatively as a result of activity levels above plan if based on cost and volume contracts.
- Clinical divisions are reporting operational activity performance below planned levels.
  - Elective activity is 104% in-month (IM) and 101% year to date (YTD);
  - Outpatients Firsts and Procedures are 105% and 95% respectively cumulatively;
  - Bedford activity is now included in the plan
  - Clinical divisions are reporting £1.63m favourable to plan cumulatively, with clinical income being £1.47m favourable (other income £0.10m favourable), pay £0.57m favourable and non-pay including drugs £0.13m adverse. Efficiency under delivery of £0.37m has contributed to the adverse variance.
- Corporate departments are reporting £0.66m favourable to plans cumulatively including £0.69m linked to slippage on Oriel and £0.74m linked to IT projects slippage and pay underspends of £0.93m. The cost improvement programme (CIP) underachievement of £1.20m has offset these underspends.
- Research is reporting a break-even position against plan cumulatively.
- Trading areas are £0.81m favourable to plan cumulatively across all commercial units.

Statement of Financial Position

Cash and Working Capital Position

The cash balance as at the 31st August was £54.7m, a reduction of £8.0m since the end of March 2026. This equates to approximately 60 days operating cash.

The Better Payment Practice Code (BPPC) performance in August was 96% (volume) and 95% (value) against a target of 95% across both metrics.

Capital

(both gross capital expenditure and CDEL)

Capital expenditure for August totalled £23.2m against an indicative plan of £23.8m.

The trust has received £25.3m of capital submissions against an allocation of £17.7m. Initial prioritisation has reduced this to £17.3m.

- £17.3m of capital submission are pre-commitments largely linked to Trust Major Projects including EPR, IT City Road Migration, Oriel, Hoxton, and Ealing.

The capital planning and oversight committee (CPOC) is reviewing and prioritising further capital submissions.

Other Key Information

Efficiencies

£17.6m Trust Target

£4.6m YTD actual

£8.9m 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 £12.3m of schemes, of which the programme has delivered £4.6m in year, £2.8m adverse to plan.

Of the total identified:-

- £8.7m is forecast recurrently; £3.4m is forecast non-recurrently;
- £7.9m is identified central schemes;
- £8.0m identified as non-pay schemes;

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

£0.52m spend YTD

0.6% total pay

Trust wide agency spend totals £0.5m cumulatively, approximately 0.6% 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

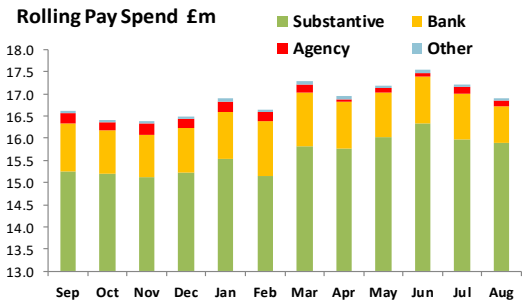
Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income	£377.2m	£27.9m	£27.5m	(£0.5m)	£157.8m	£157.4m	(£0.4m)	(0)%	
Pay	(£206.7m)	(£17.4m)	(£16.9m)	£0.5m	(£86.5m)	(£85.8m)	£0.7m	1%	
Non Pay	(£130.6m)	(£10.4m)	(£9.9m)	£0.5m	(£52.7m)	(£52.0m)	£0.7m	1%	
Financing & Adjustments	(£39.9m)	(£1.8m)	(£1.7m)	£0.1m	(£18.7m)	(£18.1m)	£0.6m	3%	
CONTROL TOTAL	**£0.0m**	**(£1.6m)**	**(£1.1m)**	**£0.5m**	**(£0.1m)**	**£1.5m**	**£1.6m**		
Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income									
Memorandum Items									
Research & Development	(£0.36m)	(£0.08m)	(£0.07m)	£0.01m	(£0.39m)	(£0.39m)	(£0.01m)	(3)%	
Commercial Trading Units	£5.29m	£0.31m	£0.41m	£0.10m	£2.40m	£3.21m	£0.81m	34%	
ORIEL Programme Revenue	(£7.14m)	(£0.42m)	(£0.37m)	£0.06m	(£2.12m)	(£1.43m)	£0.69m	33%	
EPR Programme Revenue	(£2.88m)	(£0.36m)	(£0.28m)	£0.08m	(£1.52m)	(£1.37m)	£0.15m	10%	
IT Projects Revenue	(£4.77m)	(£0.37m)	(£0.22m)	£0.15m	(£1.60m)	(£1.01m)	£0.59m	37%	
Efficiency Schemes	£17.63m	£1.47m	£1.10m	(£0.37m)	£7.35m	£4.57m	(£2.78m)	(38)%	

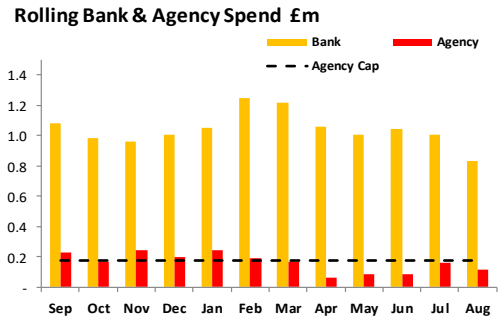
INCOME BREAKDOWN RELATED TO ACTIVITY

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	£254.9m	£105.3m	£105.3m	£0.1m				
Pass Through	£17.3m	£7.1m	£7.1m	(£0.1m)				
Other NHS Clinical Income	£0.5m	£0.2m	£0.3m	£0.0m				
Commercial Trading Units	£47.7m	£19.7m	£19.8m	£0.1m				
Research & Development	£17.1m	£7.0m	£7.0m	£0.0m				
Other	£39.5m	£18.5m	£17.9m	(£0.6m)				
INCOME INCL ERF	**£377.2m**	**£157.8m**	**£157.4m**	**(£0.4m)**				

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	(£204.6m)	(£17.1m)	(£15.9m)	£1.2m	(£85.6m)	(£80.0m)	£5.6m	93%
Bank	(£0.7m)	(£0.1m)	(£0.8m)	(£0.8m)	(£0.3m)	(£4.9m)	(£4.6m)	6%
Agency	(£0.7m)	(£0.1m)	(£0.1m)	(£0.0m)	(£0.2m)	(£0.5m)	(£0.3m)	1%
Other	(£0.7m)	(£0.1m)	(£0.1m)	(£0.0m)	(£0.3m)	(£0.3m)	(£0.0m)	0%
TOTAL PAY	**(£206.7m)**	**(£17.4m)**	**(£16.9m)**	**£0.5m**	**(£86.5m)**	**(£85.8m)**	**£0.7m**	





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

*Agency cap levels set by NHSIE

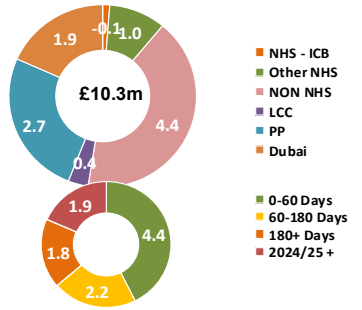
CASH, CAPITAL AND OTHER KPI'S

Capital Programme £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£17.7m)	(£6.5m)	(£3.8m)	(£2.7m)				
Donated/Externally funded	(£103.5m)	(£17.2m)	(£19.3m)	£2.1m				
TOTAL	**£121.2m**	**£23.8m**	**£23.2m**	**(£0.6m)**				

Key Metrics	Plan	Actual	RAG
Cash	72.1	54.7	
Debtor Days	45	10	
Creditor Days	45	39	
PP Debtor Days	65	40	

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

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	272.27	20.89	20.89	(0.00)	112.38	112.40	0.02	0%	
Other NHS Clinical Income	0.53	0.04	0.05	0.01	0.22	0.26	0.04	17%	
Commercial Trading Units	47.75	3.79	3.54	(0.25)	19.71	19.80	0.09	0%	
Research & Development	17.14	1.40	1.42	0.01	6.99	7.00	0.01	0%	
Other Income	39.46	1.81	1.57	(0.24)	18.48	17.90	(0.58)	(3)%	
Total Income	**377.15**	**27.93**	**27.46**	**(0.47)**	**157.78**	**157.36**	**(0.42)**	**(0)%**	
Operating Expenses									
Pay	(206.70)	(17.35)	(16.90)	0.45	(86.49)	(85.78)	0.71	1%	
Of which: Unidentifed CIP	*3.60*	*0.29*	*-*	*(0.29)*	*1.51*	*-*	*(1.51)*		
Drugs	(36.24)	(2.74)	(2.38)	0.35	(14.87)	(14.62)	0.26	2%	
Clinical Supplies	(26.37)	(2.00)	(1.88)	0.12	(10.83)	(10.73)	0.10	1%	
Other Non Pay	(67.98)	(5.67)	(5.68)	(0.02)	(27.00)	(26.70)	0.30	1%	
Of which: Unidentifed CIP	*2.14*	*0.16*	*-*	*(0.16)*	*1.09*	*-*	*(1.09)*		
Total Operating Expenditure	**(337.30)**	**(27.76)**	**(26.84)**	**0.92**	**(139.20)**	**(137.83)**	**1.37**	**1%**	
EBITDA	*39.85*	*0.17*	*0.62*	*0.45*	*18.58*	*19.53*	*0.95*	5%	
Financing & Depreciation	(23.21)	(1.86)	(1.78)	0.08	(9.02)	(8.44)	0.58	6%	
Donated assets/impairment adjustment	(16.65)	0.04	0.05	0.01	(9.67)	(9.63)	0.04	0%	
Control Total Surplus/(Deficit)	**0.00**	**(1.64)**	**(1.11)**	**0.53**	**(0.11)**	**1.46**	**1.57**	14.43	

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

Commentary

Operating Income

£0.47m adverse to plan in month

Total operating income is reporting £27.46m in-month, £0.47m adverse to plan, and £0.42m adverse cumulatively. Key points of note are:-

- Directly commissioned clinical income was £20.89m, break-even to plan.
- Cumulative activity delivery is adverse to plan, as shown on slide five.
- Commercial trading income was £3.54m, £0.25m adverse to plan
- Research and Development income at £1.42m, break-even to plan
- Other income was on £1.57m, £0.24m adverse to plan

Employee Expenses

£0.45m favourable to plan in month

August pay is reporting £16.90m (2,802 whole time equivalent (wte)); £0.45m favourable to plan. Key points of note are:-

- Substantive pay costs (2,648wte) were £15.89m, higher than the prior 12-month average of £15.54m, driven by the 2026/27 pay award.
- Temporary staffing costs were £0.95m in August.
  - Bank costs (149wte) are £0.89m in month, lower than the rolling trend of £1.04m. Bank use continues to be mainly in clinical areas and within the medical and clinical admin staffing group.
  - Agency costs (5wte) are £0.12m in month, lower than the 12-month trend of £0.17m. Use continues mainly on medical staff & administration in clinical areas.
  - £0.29m unachieved pay CIP (£1.51m cumulatively)

Non-Pay Expenses

£0.54m favourable to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in August were £9.94m, £0.46m favourable to plan. Key points of note are:-

- Drugs were £0.35m favourable to plan in month with £2.38m expenditure against a 12-month trend of £3.40m. The reduction in expenditure has been driven by the change to a lower priced AMD injection drug .
- Clinical supplies were £0.12m favourable to plan in month. Costs were £1.88m in month against a 12-month trend of £2.12m in line with a lower activity month.
- Other non-pay was £0.02m adverse in month with £5.68m expenditure against a 12-month trend of £5.05m.
- £0.16m overachieved non-pay CIP (£1.09m cumulatively under achieved)

Clinical Activity Performance

PATIENT ACTIVITY AND CLINICAL INCOME

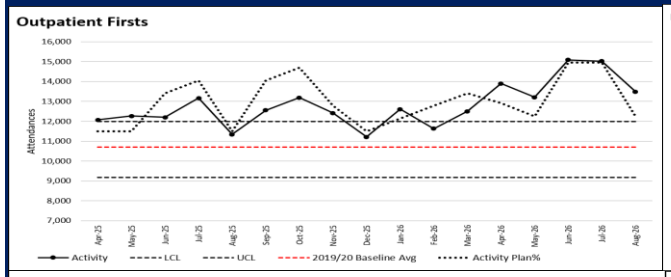
ER	Point of Delivery	Activity In Month				Activity YTD			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	2,870	2,981	111	104%	15,785	15,907	122	101%
	OP Firsts	12,241	13,488	1,247	110%	67,325	70,709	3,384	105%
	OP Procedures	21,544	21,695	151	101%	118,492	112,784	(5,708)	95%
	ERF Activity Total								
Non ERF Activity	OP Follow Ups	19,480	19,026	(454)	98%	107,139	99,069	(8,070)	92%
	High Cost Drugs Injections	4,833	5,251	418	109%	26,582	26,643	61	100%
	Non Elective	226	264	38	117%	1,117	1,273	156	114%
	AandE	6,217	6,990	773	112%	30,682	34,795	4,113	113%
	Total	67,411	69,695	2,284	103%	367,122	361,180	(5,942)	98%

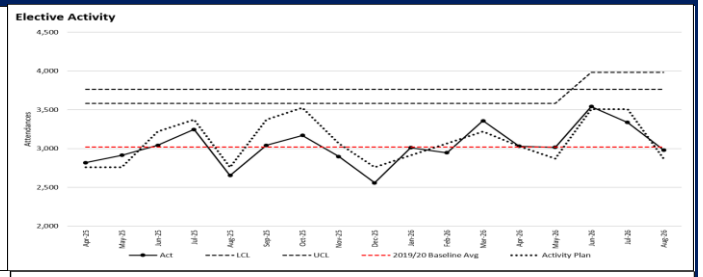
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

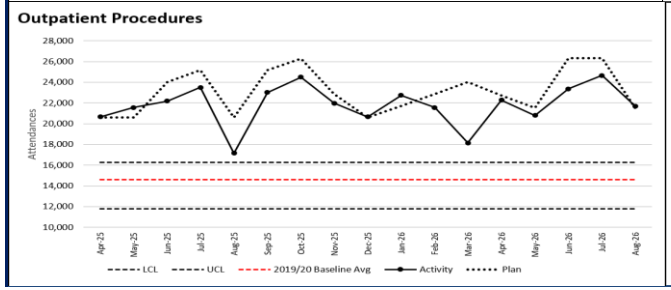
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

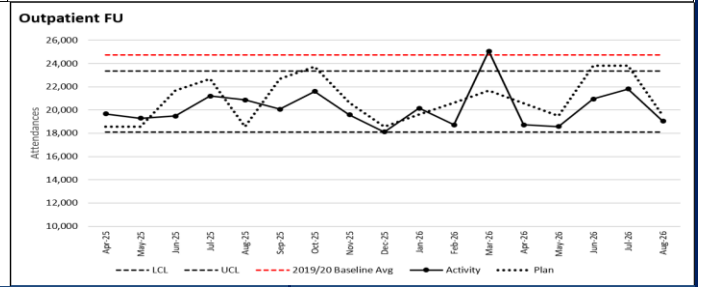
Performance % figures above, represent the Trust performance against the external activity target. Financial values shown are for ERF activity only.

ACTIVITY TREND - ERF COMPONENTS









Commentary

NHS Income

Contractual Status

The trust has finalised contracts from ICB's and signed the documentation on the 28 April. As contracts are finalised, income has been assumed based on the 2026/27 activity delivery to date.

2026/27 Activity performance achievement

- **Inpatient activity** achieved 104% in month and 101% year to date of the plan.
- **Outpatient Firsts Activity** achieved 110% in month and 105% YTD; (95% excluding Bedford YTD)
- **Outpatient Procedures Activity** achieved 101% in month and 95% YTD; Once fully coded this will return to planned levels.

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 109% of activity plans in month and 100% year to date.
- **A&E** achieved 112% of activity plans in month and 113% year to date

Contractual Status

- Block contracts have been agreed with commissioners due to major projects including 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.

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

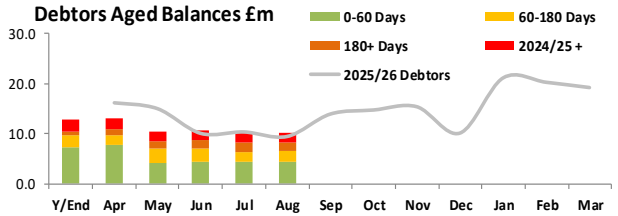
CAPITAL EXPENDITURE

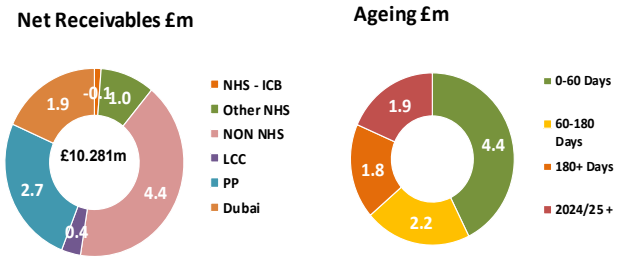
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Medical Equipment	0.5	-	0.1	0.1
Estates	-	-	0.1	0.1
IT	0.3	0.1	0.1	0.0
Commercial	0.5	0.1	0.0	(0.1)
EPR Programme	6.0	3.1	2.9	(0.2)
IT Projects - Oriel Adjacent	3.1	2.5	0.3	(2.1)
Hoxton	1.3	-	0.0	0.0
Ealing	1.0	0.8	0.3	(0.5)
Oriel	105.4	17.2	19.3	2.1
Other & Charity	3.3	-	-	-
TOTAL - TRUST CAPITAL	**121.2**	**23.8**	**23.2**	**(0.6)**

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	-	(0.1)	-	0.0	(0.1)
Other NHS Debt	0.4	0.3	0.2	0.1	1.0
Non NHS Debt	1.9	1.0	0.5	0.9	4.4
Commercial Unit Debt	-	0.9	1.1	0.9	3.0
TOTAL RECEIVABLES	**2.4**	**2.2**	**1.8**	**1.9**	**8.3**





STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Non-current assets	762.6	706.5	646.0	(60.5)
Current assets (excl Cash)	21.2	21.2	24.3	3.0
Cash and cash equivalents	58.9	72.1	54.7	(17.4)
Current liabilities	(41.6)	(41.7)	(54.6)	(12.9)
Non-current liabilities	(405.4)	(372.3)	(329.3)	43.0
TOTAL ASSETS EMPLOYED	**395.8**	**385.8**	**341.0**	**(44.7)**

OTHER METRICS

Use of Resources	Plan	Current Month	Prior Month
BPPC - NHS (YTD) by number	95%	96%	96%
BPPC - NHS (YTD) by value	95%	94%	93%
BPPC - Non-NHS (YTD) by number	95%	96%	96%
BPPC - Non-NHS (YTD) by value	95%	95%	94%

Commentary

Cash and Working Capital

The cash balance as at the 31 August was £54.8m, a reduction of £8.0m since the end of March 2026.

Capital Expenditure/ Non-current assets

Capital expenditure YTD to August totalled £23.2m against an indicative plan of £23.8m

The Trust has prioritised £25.3m of capital submissions received via business planning, against an allocation of £17.7m, to £17.3m excluding contingency for unplanned requirements.

- Re-prioritisation has been required primarily due to the EPR programme forecasting £9m capital expenditure in excess of the £6.0m initially planned requiring re-prioritisation of Trust BAU capital schemes.
- The Trust is prioritising EPR, City Road Migration, Oriel, Hoxton and Ealing alongside high priority medical equipment.

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

Receivables

Receivables have reduced by £2.5m to £10.3m since the end of the 2025/26 financial year. Debt in excess of 60 days shows an increase of £0.1m in August and current debt remains unchanged.

Payables

Payables totalled £17.4m at the end of August, a reduction of £9.4m since the end of March 2026.

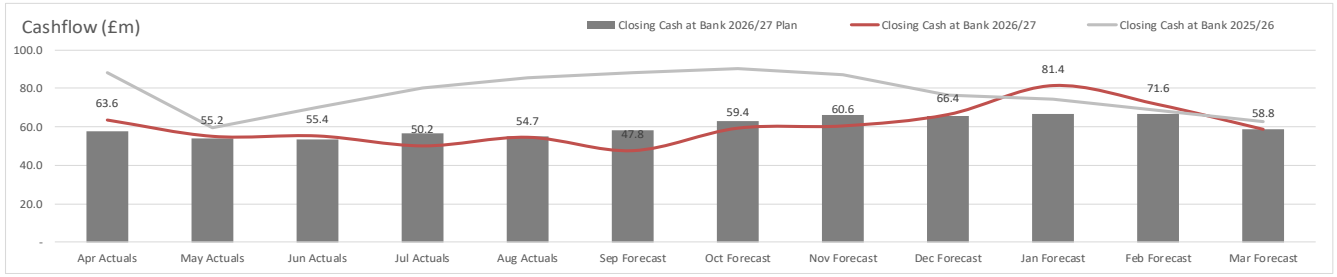
The trust's performance against the 95% Better Payment Practice Code (BPPC) is shown to the left. In aggregate it was:-

- 96% volume of invoices (prior month 96%) and
- 95% 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 Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Aug Forecast	Aug Var
Opening Cash at Bank	**62.8**	**63.6**	**55.2**	**55.4**	**50.2**	**54.7**	**47.8**	**59.4**	**60.6**	**66.4**	**81.4**	**71.6**	**62.8**		
Cash Inflows															
Healthcare Contracts	23.8	23.6	22.3	23.4	27.9	24.2	24.2	23.3	20.6	21.5	22.2	22.4	279.5	26.1	1.7
Other NHS	3.4	1.0	1.6	1.4	1.3	1.4	1.5	1.5	1.3	1.7	1.6	1.6	19.4	1.4	(0.0)
Moorfields Private/Dubai/NCS	3.5	3.8	4.1	4.2	3.3	4.4	4.3	4.4	3.5	4.4	4.0	3.8	47.8	3.9	(0.5)
Research	1.0	0.9	1.2	1.3	1.1	1.6	1.4	1.4	1.4	1.4	1.4	1.6	15.5	1.4	(0.3)
VAT	2.4	-	0.9	-	2.3	1.5	1.5	1.5	1.5	1.5	1.5	1.5	16.0	2.3	(0.0)
PDC / Loan	-	5.0	-	-	3.0	2.0	19.3	4.8	6.0	21.5	4.9	15.8	82.4	3.0	-
Charity Donation	4.9	-	5.0	-	-	-	-	-	5.0	-	-	6.8	21.7	-	-
Other Inflows	0.2	0.2	0.2	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.2	**0.2**	(0.0)
Total Cash Inflows	**39.0**	**34.6**	**35.2**	**30.4**	**39.0**	**35.2**	**52.4**	**37.1**	**39.5**	**52.3**	**35.8**	**53.7**	**484.3**	**38.2**	**0.8**
Cash Outflows															
Salaries, Wages, Tax & NI	(15.8)	(16.1)	(16.3)	(16.5)	(16.2)	(16.3)	(16.3)	(16.3)	(16.3)	(16.3)	(16.3)	(16.3)	(195.1)	(16.3)	0.1
Non Pay Expenditure	(20.0)	(8.6)	(11.2)	(15.1)	(10.1)	(12.2)	(12.2)	(12.2)	(12.2)	(12.2)	(12.2)	(12.2)	(150.5)	(11.5)	1.4
Capital Expenditure	(0.0)	(0.3)	(0.4)	(0.4)	(0.3)	(0.9)	(5.1)	(1.0)	(1.5)	(1.5)	(1.2)	(2.8)	(15.3)	(1.0)	0.7
Oriel	(1.5)	(16.7)	(5.9)	(1.9)	(5.8)	(8.9)	(5.9)	(5.1)	(2.4)	(6.1)	(14.0)	(31.4)	(105.8)	(8.6)	2.8
Moorfields Private/Dubai/NCS	(1.0)	(1.2)	(1.2)	(1.5)	(1.5)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(15.4)	(1.3)	(0.2)
Financing - Loan repayments	-	-	-		(0.6)	(2.5)	-	-	-	-	(0.6)	(2.5)	(6.2)	(0.6)	-
Dividend Payable	-	-	-			-	-	-	-	-	-	-	-	-	-
Total Cash Outflows	(38.2)	(43.0)	(35.0)	(35.5)	(34.5)	(42.2)	(40.8)	(35.9)	(33.7)	(37.4)	(45.6)	(66.5)	**(488.3)**	**(39.3)**	**4.8**
Net Cash inflows /(Outflows)	0.8	(8.4)	0.2	(5.1)	4.5	(6.9)	11.6	1.2	5.9	15.0	(9.8)	(12.8)	(4.0)	(1.1)	5.6
Closing Cash at Bank 2026/27	**63.6**	**55.2**	**55.4**	**50.2**	**54.7**	**47.8**	**59.4**	**60.6**	**66.4**	**81.4**	**71.6**	**58.8**	**58.8**		
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 31 August was £54.8m, a reduction of £8.0m since the end of March 2026. The trust currently has 60 days of operating cash (prior month: 55 days).

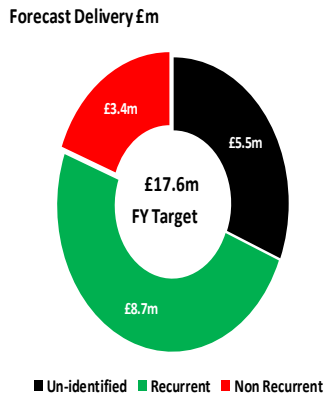
August cashflow saw a £4.5m inflow against a forecast outflow of £1.1m due additional ICB payments and lower than forecast Oriel and supplier payments. The profiling for Oriel loans, PDC and capital payments are currently being refined and will be updated in future cashflow forecasts.

Efficiency Scheme Performance Reporting

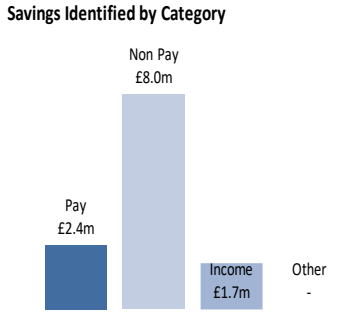
EFFICIENCY SCHEMES PERFORMANCE

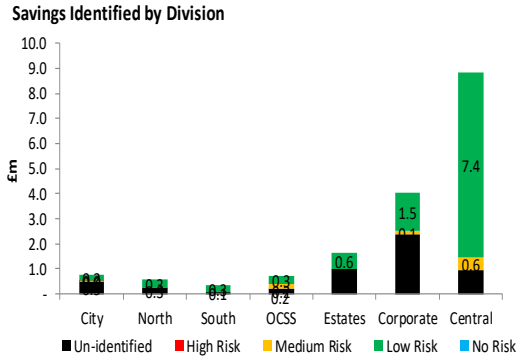
Efficiency Schemes £m	Annual Plan	In Month			Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
City Road	£0.76m	£0.06m	£0.04m	(£0.03m)	£0.32m	£0.12m	(£0.20m)	£0.76m	£0.29m	(£0.47m)
North	£0.57m	£0.05m	£0.03m	(£0.02m)	£0.24m	£0.14m	(£0.09m)	£0.57m	£0.30m	(£0.27m)
South	£0.35m	£0.03m	£0.03m	£0.00m	£0.15m	£0.14m	(£0.01m)	£0.35m	£0.29m	(£0.05m)
Ophth. & Clinical Serv.	£0.72m	£0.06m	£0.06m	£0.00m	£0.30m	£0.22m	(£0.08m)	£0.72m	£0.51m	(£0.21m)
Research & Development	-	-	£0.01m	£0.01m	-	£0.03m	£0.03m	-	£0.08m	£0.08m
Trading	£0.75m	£0.06m	£0.05m	(£0.01m)	£0.31m	£0.12m	(£0.19m)	£0.75m	£0.48m	(£0.27m)
Corporate	£5.34m	£0.45m	£0.23m	(£0.22m)	£2.23m	£0.95m	(£1.27m)	£5.34m	£2.28m	(£3.06m)
DIVISIONAL EFFICIENCIES	**£8.49m**	**£0.71m**	**£0.45m**	**(£0.26m)**	**£3.54m**	**£1.72m**	**(£1.82m)**	**£8.49m**	**£4.24m**	**(£4.26m)**
Central	**£9.14m**	**£0.76m**	**£0.66m**	**(£0.10m)**	**£3.81m**	**£2.85m**	**(£0.96m)**	**£9.14m**	**£7.91m**	**(£1.23m)**
TRUST EFFICIENCIES	**£17.63m**	**£1.47m**	**£1.10m**	**(£0.37m)**	**£7.35m**	**£4.57m**	**(£2.78m)**	**£17.63m**	**£12.14m**	**(£5.49m)**
Actuals Of which non-recurrent			*£0.50m*			*£0.69m*			*£3.40m*	

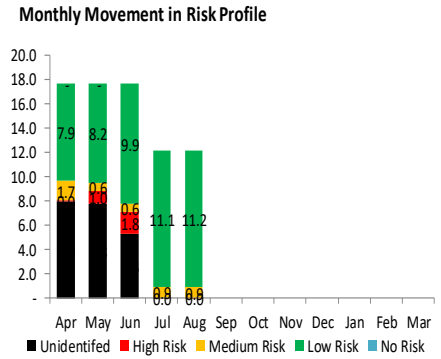
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







* charts may include rounding differences

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 Delivery Group (CIPG).

In Year Delivery

The trust is reporting efficiency savings achieved of:-

- £4.6m in YTD, compared to a plan of £7.4m, £2.8m adverse to plan; and
- £12.1m forecast, compared to a plan of £17.6m, £5.5m adverse to plan.
- £5.5m adverse variance represents the total savings required to bridge both the gap to plan and slippage on existing schemes.
- As at M5 total identified schemes are 69.4% of the total target, 10.6% is required to achieve the 80% target.

Identified Savings

The trust has delivered £4.6m, £2.8m adverse to plan.

Of the total identified:-

- £7.9m is identified central schemes;
- £8.0m identified as non-pay schemes;
- £8.7m is forecast recurrently;
- £3.4m 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.

£8.9m 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.

Moorfields Eye Hospital NHS Foundation Trust

Integrated Performance Report

Board of directors
24 September 2026

Report title	**Integrated Performance Report (IPR) / Integrated Monitoring Metrics (IMM)**
Report from	Executive team
Prepared by	Victoria Moore, Director of Transformation & Performance Improvement Stephen Chinn/Alex George, Performance and Information Department
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**	

Moorfields Eye Hospital NHS Foundation Trust

NHS

Integrated Performance Report

August 2026

Brief Summary of Report

Moorfields Eye Hospital NHS Foundation Trust

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

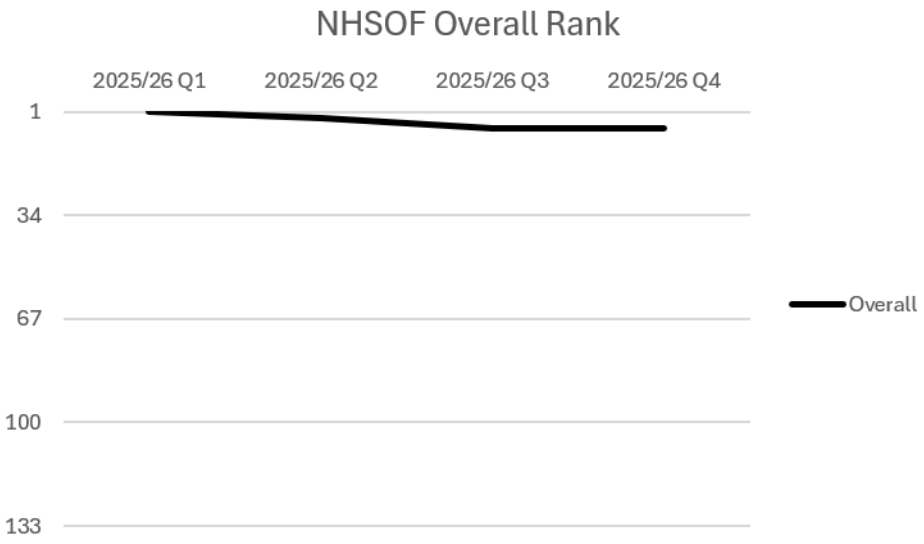
The report uses a number of mechanisms to put performance into context, showing achievement against target, in comparison to previous periods, and as a trend. The report also identifies additional information and narrative for KPIs, including those showing concern, falling short of target, or highlighting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

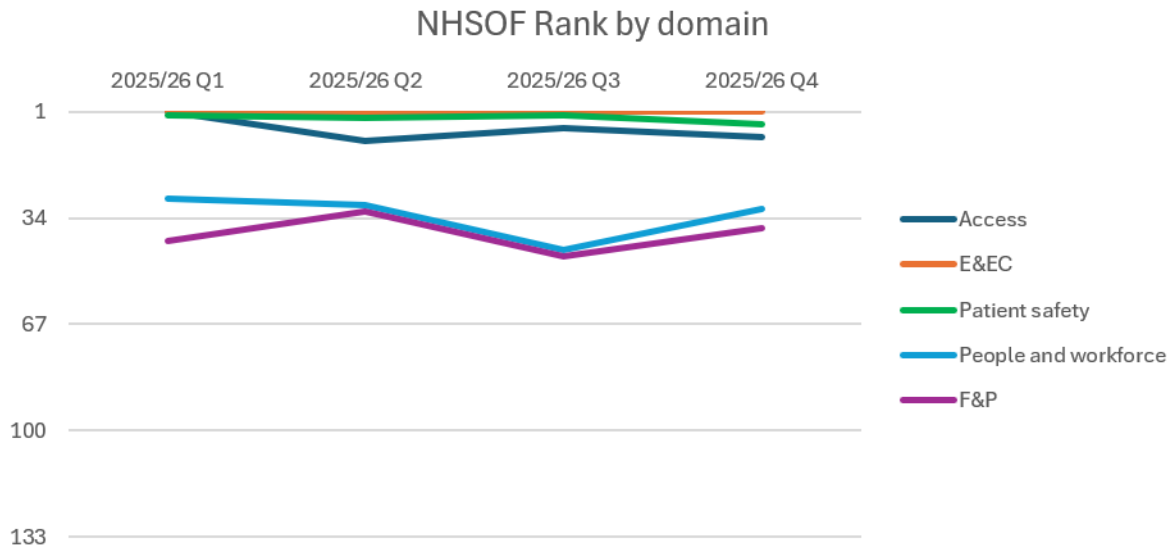
The data within this report represents the submitted performance position, or a provisional position as of the time of report production, which would be subject to change pending validation and submission.



NHS Oversight Framework

Domain Scores	Overall	Access to services	Effectiveness and experience of care	Patient safety	People and workforce	Finance and productivity
Reporting Period	2025/26 Q4	2025/26 Q4	2025/26 Q4	2025/26 Q4	2025/26 Q4	2025/26 Q4
Provider Value	1.50	1.36	1.00	1.58	1.75	1.80
Rank	6 of 134	=9 of 131	=1 of 134	5 of 134	=31 of 134	37 of 134





Provider values are weighted averages of several underlying metrics with a range of 1 to 4 (where 1 is highest) across all trusts.

Performance Overview

Moorfields Eye Hospital NHS Foundation Trust

Metric Name	Committee	Assurance	Variation
% Complaints Acknowledged in 3 days	Q&S	Consistently Hitting Target	Special Cause Improvement
Staff Turnover Rate	P&C	Consistently Hitting Target	Special Cause Improvement
Statutory Mandatory Training Compliance	P&C	Consistently Hitting Target	Common Cause
Cancer 28 Day FDS	F&P	Hit and Miss	Common Cause
Duty of Candour	Q&S	Hit and Miss	Common Cause
Recruitment NIHR portfolio studies	D&C	Hit and Miss	Special Cause Concern
Cataract Eyes Per List	F&P	Consistently Missing Target	Special Cause Improvement
Theatre Utilisation (MEH)	F&P	Consistently Missing Target	Special Cause Improvement
52 Week RTT Incomplete Breaches	F&P	Consistently Missing Target	Common Cause
DNA Rate (First Outpatients)	F&P	Consistently Missing Target	Common Cause
DNA Rate (Follow Up Outpatients)	F&P	Consistently Missing Target	Common Cause
RTT 18w Perf vs. Planned	F&P	Consistently Missing Target	Common Cause
Sickness Absence Rate (Monthly)	P&C	Consistently Missing Target	Common Cause
Average Call Waiting Time	F&P	Consistently Missing Target	Special Cause Concern
Proportion of Temporary Staff	P&C	No Target Set	Special Cause Improvement
Frequency of any Never events	Q&S	No Target Set	Common Cause
% of Research in Time	D&C	No Target Set	Downward Trend
Unexpected Re-Admissions	Q&S	No Target Set	Data Not Available

Executive Summary

During August, the Trust continued to deliver strong performance across a number of important areas.

Financial performance remained favourable, complaints were managed effectively, staff turnover remained low, and compliance with mandatory training continued to exceed required standards. Research activity also remained strong, supporting the Trust's ambition to advance eye care through innovation and clinical research.

There was improvement in operational performance during the month. Outpatient attendance improved following targeted interventions, and progress was seen in both theatre utilisation and cataract productivity. These improvements are important foundations for increasing capacity and helping more patients receive care more quickly.

The trusts key challenge continues to be ensuring timely access to care. Waiting times for some patients remain longer than planned and planned care improvement remains a key organisational priority. Significant work continues to validate waiting lists, increase clinical capacity and improve productivity to ensure patients receive treatment as quickly as possible.

Patient safety performance remained broadly stable during the month. Infection control measures continue to perform well and a further Never Event identified during the period is being reviewed through the Trust's established governance arrangements to ensure learning is shared and improvements are implemented.

Overall, the report demonstrates continued progress across many areas of Trust performance, with a sustained focus on improving access, reducing waiting times and delivering the best possible experience and outcomes for patients.

Access to Services

IPR Metric Overview

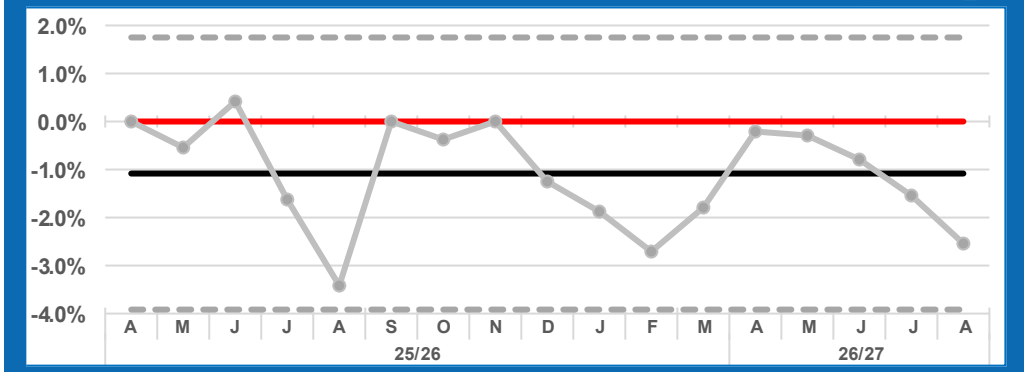
Moorfields Eye Hospital NHS Foundation Trust

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Difference Between Planned and Actual 18 week Performance		F	n/a	-2.54%	≥0%	Jon Spencer	NHS Oversight Framework	Monthly
52 Week RTT Incomplete Breaches		F	70	22	≤5 Breaches	Jon Spencer	NHS Operational Planning	Monthly
Cancer 28 Day Faster Diagnosis Standard		?	90.3%	85.7%	≥80%	Jon Spencer	NHS Oversight Framework	Monthly (Month in Arrears)
Theatre Utilisation (MEH Definition)	H	F	65.3%	65.8%	≥85%	Jon Spencer	Insightful Board	Monthly
Cataract Eyes Per Four Hour Theatre List	H	F	6.3	6.6	≥ 8 Per 4hr List	Jon Spencer	GIRFT Guidance	Monthly
DNA Rate (First Outpatients)		F	13.9%	13.5%	≤9.4%	Jon Spencer	Model Hospital	Monthly
DNA Rate (Follow Up Outpatients)		F	10.3%	10.0%	≤8.1%	Jon Spencer	Model Hospital	Monthly
Average Call Waiting Time	H	F	n/a	799	≤ 2 Mins (120 Sec)	Jon Spencer	Internal Measure	Monthly

Access to Services

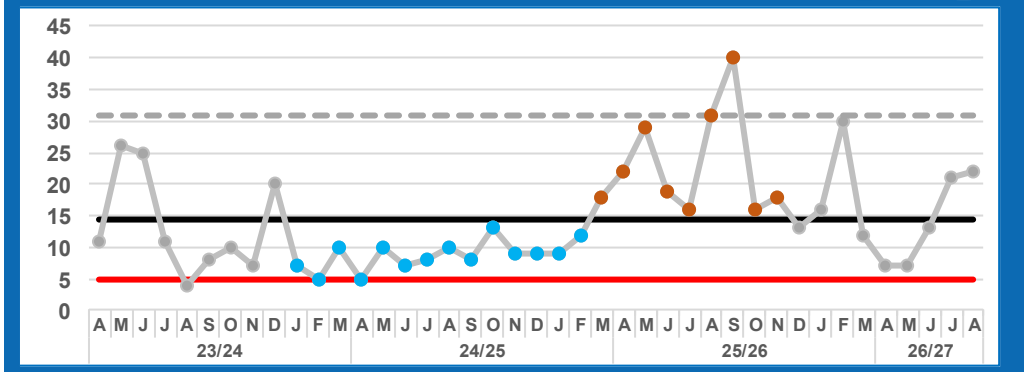
IPR Metrics – Referral To Treatment

Difference Between Planned and Actual 18 week Performance



'Difference Between Planned and Actual 18 week Performance' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at -2.54%.

52 Week RTT Incomplete Breaches



'52 Week RTT Incomplete Breaches' is showing 'common cause variation' with the current process unlikely to achieve the target.The figure is currently at 22.

- The data shows that performance against the 18-week referral to treatment (RTT) standard is below plan for August. The Trust is currently validating the position to ensure reported data is accurate. National reporting deadlines have been extended to allow organisations additional time to complete this work. Validation work is likely to result in some improvement in the reported position; however, there remains a significant risk that the August target will not be achieved.
- The position includes all open RTT pathways for our Bedford site, which has had a greater impact on overall trust performance than was expected at the time the target was set. We have also been unable to increase activity levels in the external service and the number of patients waiting over 18 weeks for treatment is not reducing. We have a number of other areas we are prioritising for improvement, including Cataract at City Road and Strabismus across all sites.

Actions to improve performance and reduce waiting times include:

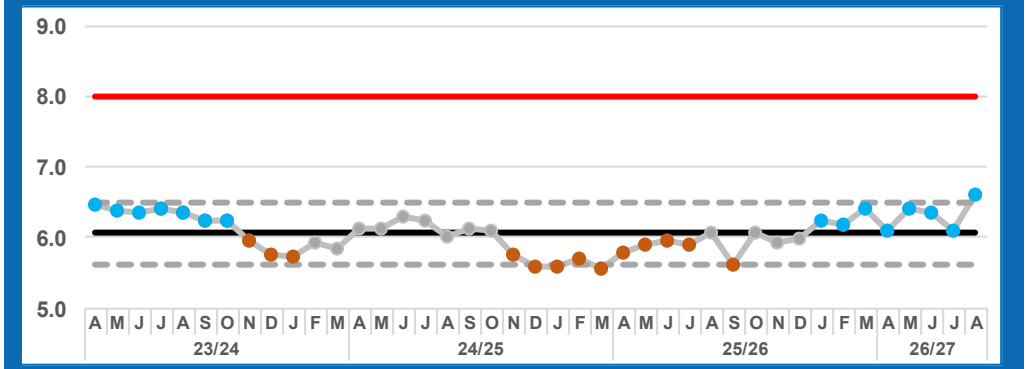
- Continued additional waiting list validation activity, coordinated by the Deputy Chief Operating Officer and Divisional Managers and supported by the central validation team, to ensure waiting lists are accurate and patients receive treatment as soon as possible.
- Additional virtual reviews, outpatient clinics and theatre lists for patients who have waited the longest, delivered in partnership with divisional managers and clinical leads and subject to available funding.
- Development of permanent capacity increases in services with the longest waits. Two business cases to increase capacity in the paediatric and external services have now been approved, with implementation planned from September.
- Increasing the number of first appointments booked directly and improving clinical triage processes to help reduce patient waiting times.
- Continuing to improve key productivity measures, including cataract productivity, theatre utilisation and reducing the number of patients who do not attend appointments.

The number of patients waiting more than 52 weeks remains above target. This was due to a cohort of patients identified through validation, requiring a date for surgery who were not previously on active RTT pathways. Once added to the PTL, they have dated within month, subject to patient availability. This position is also subject to ongoing validation before national reporting is finalised.
All patients waiting more than 40 weeks are reviewed weekly to ensure appointments and treatment are arranged at the earliest opportunity.

Access to Services

IPR Metrics – Theatre Performance

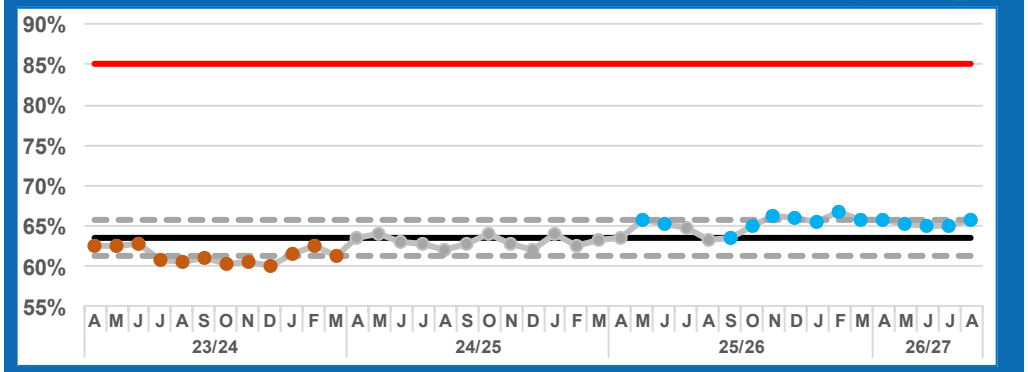
Cataract Eyes Per Four Hour Theatre List



'Cataract Eyes Per Four Hour Theatre List' is showing 'special cause improvement' however the current process is unlikely to achieve the target.The figure is currently at 6.60.

- The data shows that the number of patients treated during each cataract theatre session remains below the level we aim to achieve.
- Most of our cataract list are booked to 8 eyes, in adherence to our booking policy.
- Trust performance is impacted by cancellations on the day of surgery and the complexity of some cases, which can reduce the number of procedures that can be completed during a theatre session.
- Actions to improve performance include:
- A revised criteria for high volume cataract lists has been developed and data made available to review the impact of this. This will ensure we are monitoring the correct lists as part of this metric.
- Implementing overbooking by 1 case on appropriate lists.
- Ensuring lists are appropriately reviewed at least two weeks in advance by clinical teams.
- These actions are being led by the Chief Medical Officer, Service Director for Cataract and Deputy Chief Operating Officer with implementation planned by October 2026.

Theatre Utilisation (MEH Definition)



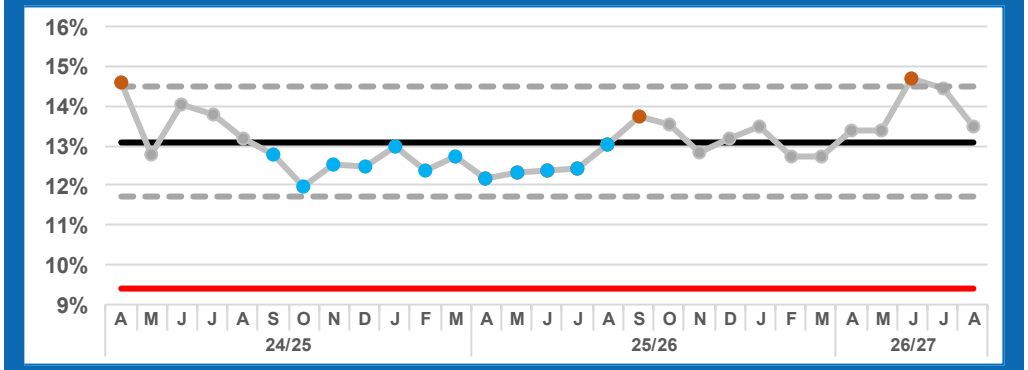
'Theatre Utilisation (MEH Definition)' is showing 'special cause improvement' however the current process is unlikely to achieve the target. The figure is currently at 65.8%.

- The data shows that we are maintaining currently levels of theatre utilisation.
- Performance remains below the 85% stretch target due to the impact of late starts, early finishes and cancellations on the day of surgery, which reduce the amount of operating time available for patient care.
- Theatre oversight groups meet regularly to review performance and agree actions to improve theatre utilisation across sites and services. Current actions include:
- Reviewing theatre start times and testing a new approach to help ensure operating lists begin promptly.
- Improving compliance with the Trust's theatre scheduling process to ensure operating lists are fully booked at least two weeks before surgery.
- Sharing performance data with clinical teams to increase awareness of performance issues and identify opportunities for improvement.
- Implementing service-specific and theatre list-specific improvement actions agreed with clinical leads.
- Progress against these actions is reviewed monthly through theatre oversight groups, with actions assigned to the relevant clinical or operational leads for delivery

Access to Services

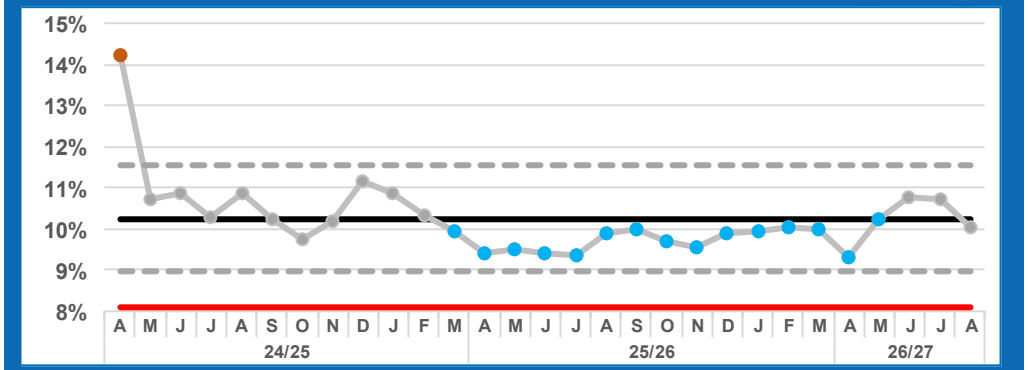
IPR Metrics – Did Not Attend (DNA) Performance

DNA Rate (First Outpatients)



'DNA Rate (First Outpatients)' is showing 'common cause variation' with the current process unlikely to achieve the target. - This is a change from the previous month. The figure is currently at 13.5%.

DNA Rate (Follow Up Outpatients)



'DNA Rate (Follow Up Outpatients)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 10.0%.

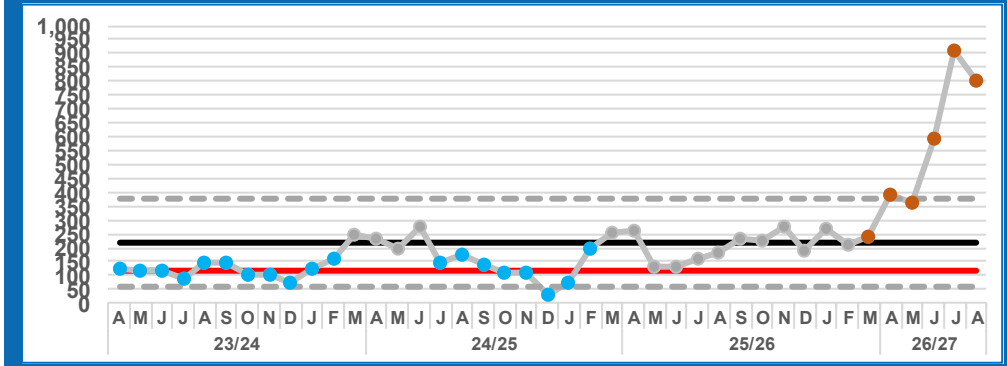
- The data shows the number of patients who did not attend their outpatient appointments reduced in August.
- Following an increase in the DNA rate in June and July linked to periods of hot weather and delays with communication associated with the letters incident, we are now seeing a return to average DNA rates.
- The underlying challenges relating to patient communication and patient choice remain unchanged and we have now evaluated the results of a pilot to test an enhanced appointment reminder system. The findings showed a 50% decrease in the DNA for clinics whose patients were contacted using the system. A business case has been written to assess the costs and benefits of increasing the use of this system. This work is being led by our City Road Division, on behalf of the organisation.

Access to Services

IPR Metrics – Call Centre Performance

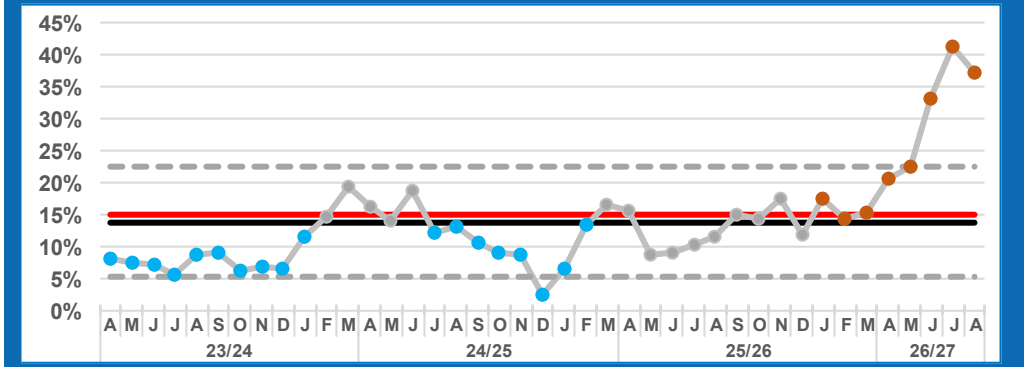
Moorfields Eye Hospital NHS Foundation Trust

Average Call Waiting Time



'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 799.

Average Call Abandonment Rate



'Average Call Abandonment Rate' is showing 'special cause concern' and that the current process is unlikely to achieve the target. - This is a change from the previous month. The figure is currently at 37.1%.

The data shows a small improvement in our response times however, patients continue to wait longer than they should for their calls to be answered and a higher proportion of callers end their call before speaking to a member of staff. June and July saw significant increases in the number of calls received and in August, the volume of calls reduced towards that of April and May. The service continued to experience staffing pressures due to vacancies and sickness absence.

Actions being taken to improve response times include:

- Recruiting to permanent vacancies and reducing reliance on temporary staffing.
- Strengthening management oversight to support day-to-day decision-making and ensure resources are used where they are most needed.
- Improving information available on the Trust website so that patients can access the information they need without having to contact the service.
- Ensuring calls more appropriately managed by other teams, are appropriately handled.

Progress against this improvement plan is reviewed weekly by the directorate and divisional management team. The trust recognises the impact that delays in answering calls has on patients and remains focused on improving access and response times.

Finance Metrics

IPR Metric Overview

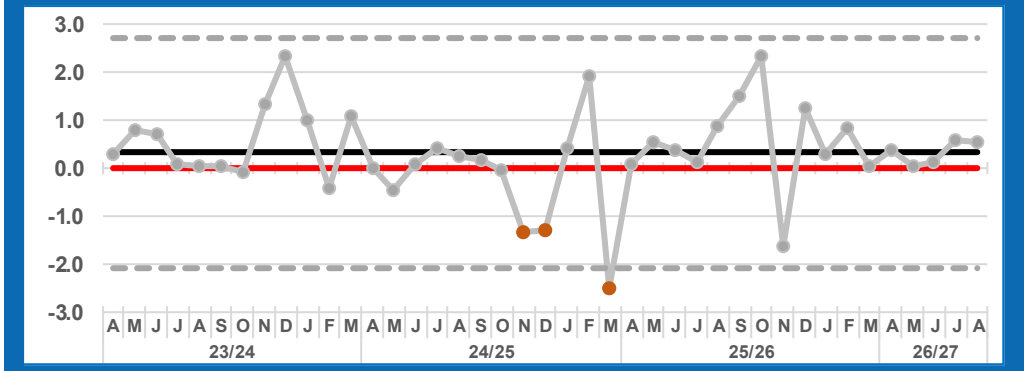
Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Variance year-to-date to financial plan		P	1.57	0.53	≥0	Arthur Vaughan	NHS Oversight Framework	Monthly

The trust's financial position is being supported by £1.43m of slippage on major projects expenditure, £0.81m favourable commercial trading and demonstrable reductions in temporary staffing spend, 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 activity.
- Income levels would be break-even to plan cumulatively as a result of activity levels above plan if based on cost and volume contracts.
- Clinical divisions are reporting operational activity performance below planned levels.
- Elective activity is 104% IM and 101% year to date;
- Outpatients Firsts and Procedures are 105% and 95% respectively cumulatively;
- Bedford activity is now included in the plan
- Clinical divisions are reporting £1.63m favourable to plan cumulatively, with clinical income being £1.47m favourable (other income £0.10m favourable), pay £0.57m favourable and non-pay including drugs £0.13m adverse. Efficiency under delivery of £0.37m has contributed to the adverse variance.
- Corporate departments are reporting £0.66m favourable to plans cumulatively including £0.69m linked to slippage on Oriel and £0.74m linked to IT projects slippage and pay underspends of £0.93m. CIP underachievement of £1.20m has offset these underspends.
- Research is reporting a break-even position against plan cumulatively.
- Trading areas are £0.81m favourable to plan cumulatively across all commercial units.

Variance year-to-date to financial plan



'Variance year-to-date to financial plan' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.53.

Patient Safety & Effectiveness and Experience

IPR Metric Overview

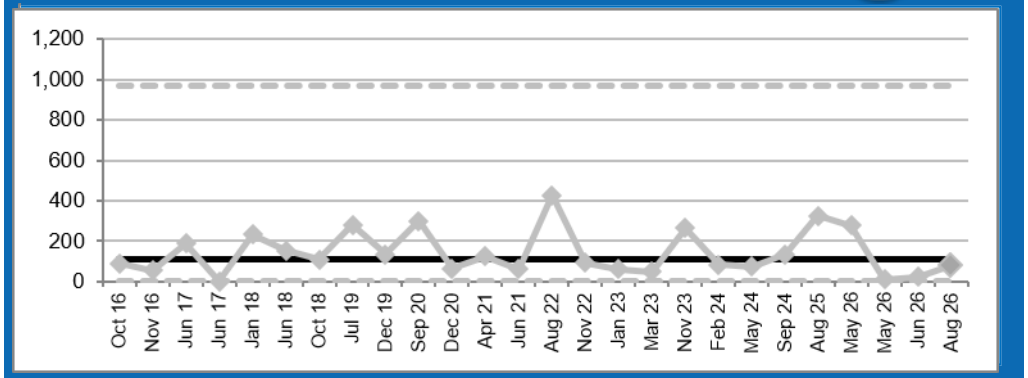
Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Frequency of any Never events (Days Since Last)			n/a	80	No Target Set	Suminthra Naidu	Internal Measure	Days Since Last
Endophthalmitis Rates Within Threshold (Out of 8)			n/a	8	8	Suminthra Naidu	Internal Measure	Quarterly
Percentage of responses to written complaints acknowledged within 3 days			95.8%	91.9%	≥80%	Ian Tombleson	Statutory Submission	Monthly
Unexpected Moorfields Admission Following Surgery			In Dev.	In Dev.	tbc	Louisa Wickham	Internal Measure	Monthly
Duty of Candour (% conversations informing family/carer occurred within 10 working days)			64.7%	67.0%	No Breaches	Suminthra Naidu	Statutory Submission	Monthly (Month in Arrears)

Patient Safety & Effectiveness and Experience

IPR Metrics – Never Events & Duty of Candour

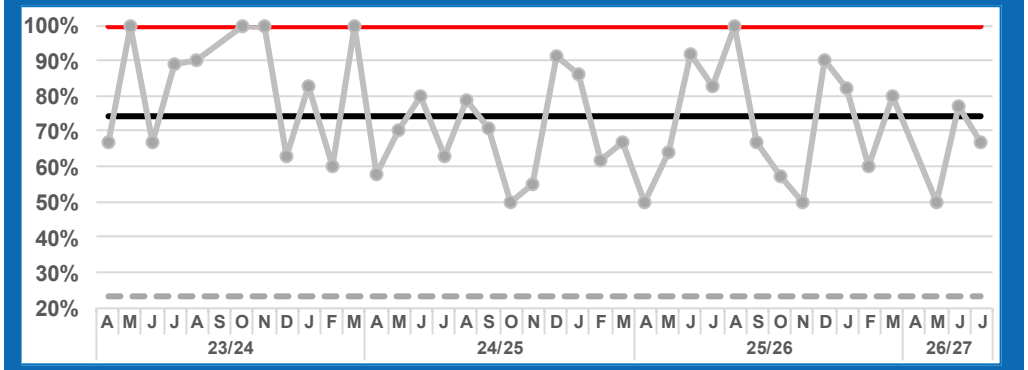
Moorfields Eye Hospital NHS Foundation Trust

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 80.

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' and that the current process is not consistently achieving the target.The figure is currently at 67.0%.

Never Events (NE)

- One further NE, concerning implantation of an incorrect intraocular lens, has been declared and this will show in September data.
- This incident is being reviewed as part of the on-going quality summit combining with 3 previous similar NEs.

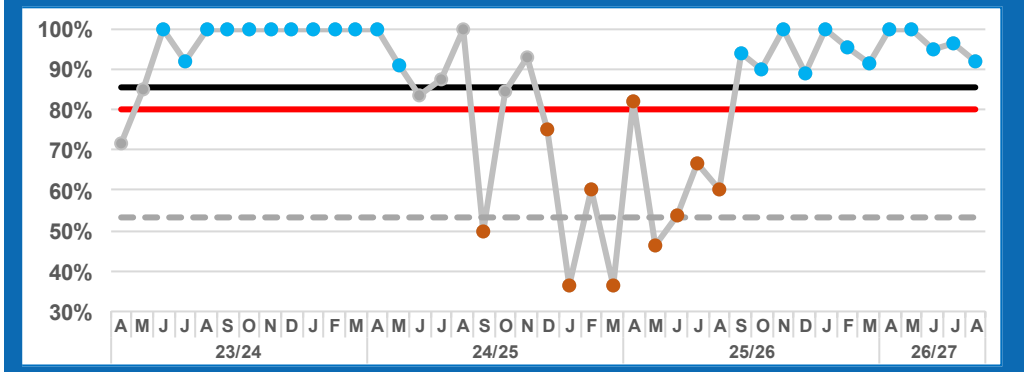
Duty of candour

- The data continues to be reported one month in arrears.
- Six of the nine cases this month were noted to be compliant with the requirement to provide a verbal apology and explanation.
- Where non-compliance has been recorded, this will be followed up with divisional management teams as a priority.

Patient Safety & Effectiveness and Experience

IPR Metrics – Complaints Performance

Percentage of responses to written complaints acknowledged within 3 days



'Percentage of responses to written complaints acknowledged within 3 days' is showing 'special cause improvement' and that the current process will consistently pass the target.The figure is currently at 91.9%.

This target continues to be consistently exceeded

People and Workforce

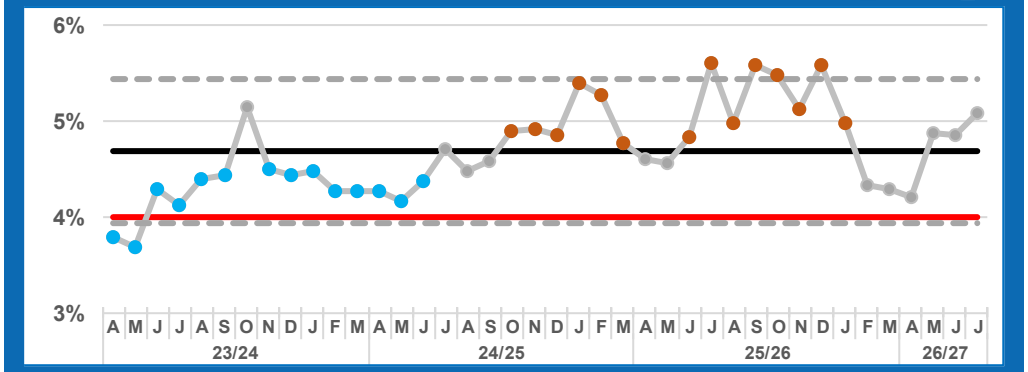
IPR Metric Overview

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Sickness Absence Rate (Monthly)		F	n/a	5.1%	≤4%	Sue Steen	NHS Oversight Framework	Monthly (Month in Arrears)
Staff Turnover (Rolling Annual Figure)	L	P	n/a	7.9%	≤10.0%	Sue Steen	Insightful Board	Monthly (Month in Arrears)
Proportion of Temporary Staff	L		6.6%	5.8%	No Target Set	Sue Steen	NHS Operational Planning	Monthly
Statutory Mandatory Training Compliance	L	P	n/a	85.5%	≥80%	Sue Steen	Internal Measure	Monthly

People and Workforce

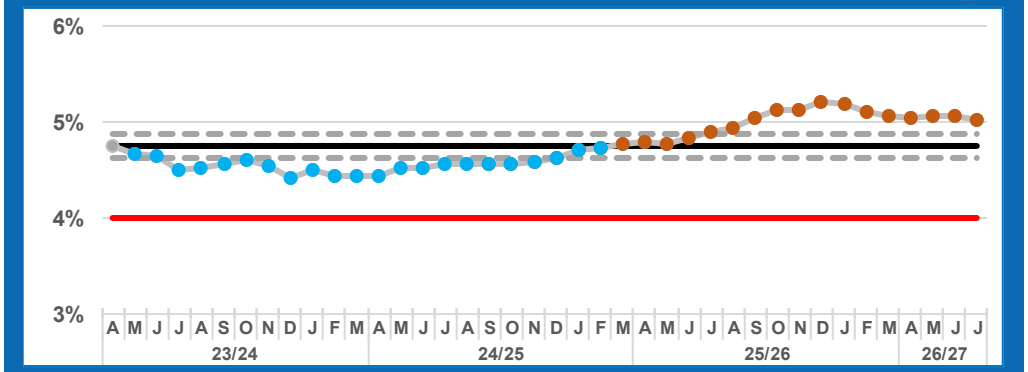
IPR Metrics – Sickness Absence Rate

Sickness Absence Rate (Monthly)



'Sickness Absence Rate (Monthly)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 5.1%.

Sickness Absence Rate (Rolling Annual)



'Sickness Absence Rate (Rolling Annual)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 5.0%.

The current Sickness Rate (12 months rolling) is 5.03%, indicating a cause for concern over the last year. This metric consistently falls short of the 4% target. The top 3 reasons for sickness currently are: “Anxiety/stress/depression/other psychiatric illness”, “Cold, Cough, Flu – Influenza” & “Other musculoskeletal problems.

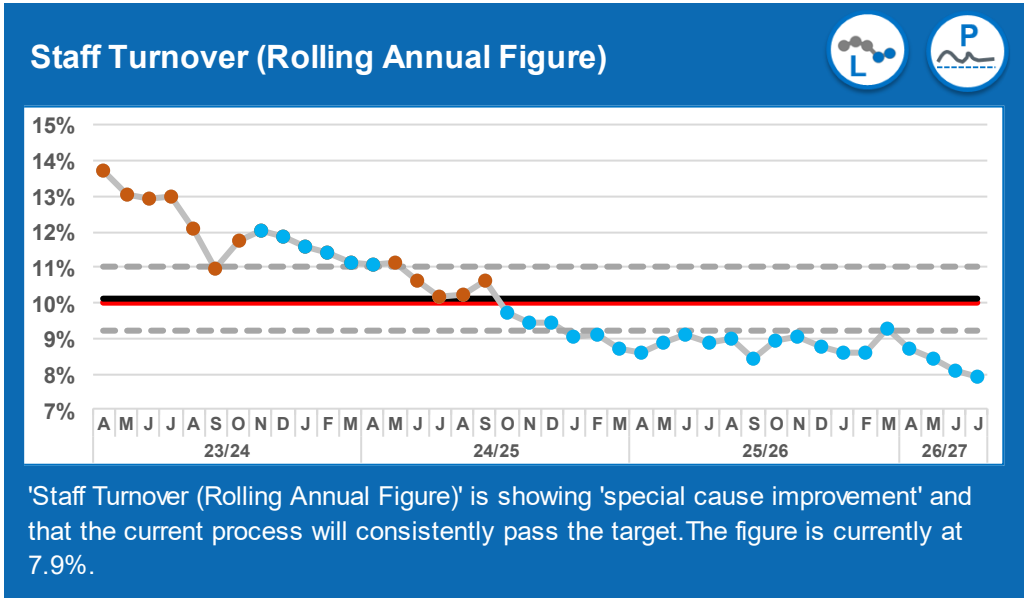
The In Month Sickness Rate is 4.09%, which is increase since last month. The In Month, Short-Term Sickness Rate is 2.32% and Long-Term Sickness Rate is 2.78%.

The 3 Divisions* which currently have the highest 12-month rolling sickness rate are Moorfields North (6.7%), Private Patients (6.7%) and Moorfields South (5.8%). The Staff Groups with the highest rolling sickness rates are currently Additional Clinical Services (6.5%), Nursing & Midwifery (6.4%) and Admin & Clerical (5.6%).

* The hotspot areas for In-Month Sickness in July were Private Patients (7.5%), North Division (7.5%, and City Road (5.6%).

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 7.9%.

The rolling 12-month turnover rate for the period is 7.9% which is below the Trust target. It reflects special cause of an improving nature.

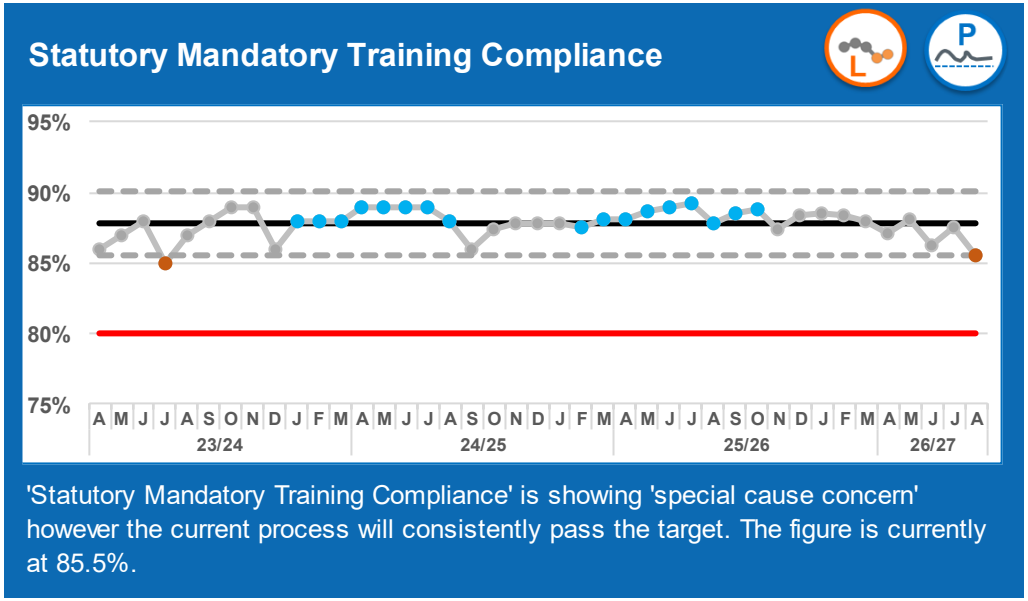
For Divisions with more than 30 staff, Finance Director has the highest turnover rate currently at 24.1% (8 FTE Leavers) followed by People & OD at 15.3% (7.9 FTE Leavers). The clinical division with the highest turnover is North Division at 11.6% (39.5 FTE Leavers). Departments with the highest turnover in that Division are North East Theatres (41.6%), North East Hub (15.4%) and Ealing (14.6%).

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

20.1% of leavers had less than 1 year of service. The staff group with the highest turnover rate is currently Additional Clinical Services at 11%

People and Workforce

IPR Metrics – Statutory Mandatory Training Compliance



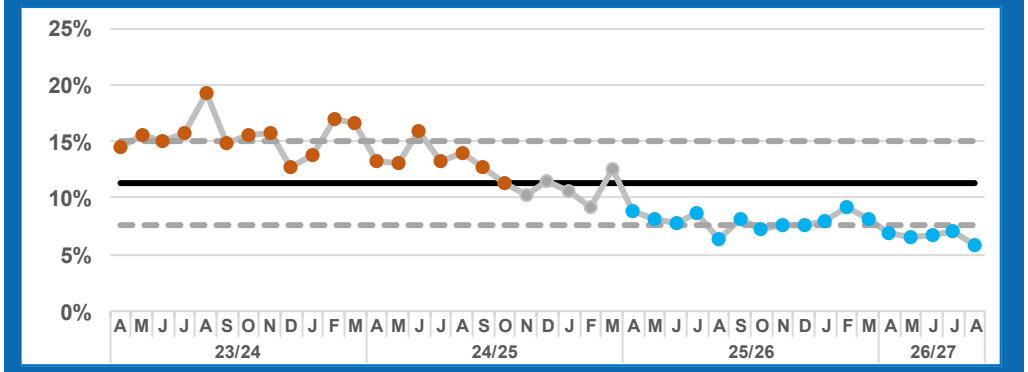
The level of Mandatory Training Compliance Rate reported for the month of August was 86%, this is above the 80% required target level.

Statutory & mandatory training compliance continues to remain relatively stable. Following a slight light downward trajectory recently performance has improved.

People and Workforce

IPR Metrics – Temporary Staff

Proportion of Temporary Staff



'Proportion of Temporary Staff' is showing 'special cause improvement' (decreasing rate).The figure is currently at 5.8%.

The demand for temporary staffing shifts decreased in August by 800 shifts

- 5% of (AFC) shifts were added retrospectively – a significant decrease MoM
- 22% of shifts were added with more than 4 weeks notice – a decrease on LM.

Total temporary staffing spend was £1.16m, £60 lower than our target, driven by Bank spend

Agency spend continues to reduce in Q1, the Trust spent £583k less than the same time last time.

Medical continues to be an area of concern

The introduction of Managed Service Spend into agency spend has increased the Trusts agency spend. Further reporting to be developed.

Advancing Eye Care

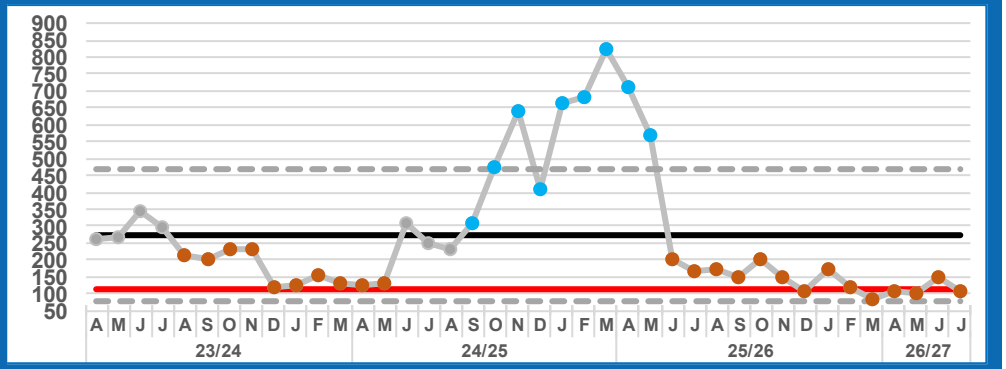
IPR Metric Overview

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Total Patient Recruitment to NIHR Portfolio Adopted Studies			467	109	≥115 (per month)	Viren Jeram	Internal Measure	Monthly (Month in Arrears)
% of Portfolio Clinical Research Studies Set Up in Time (90 day component) - Rolling 3 Months			0%	0%	No Target Set	Viren Jeram	Internal Measure	Monthly

Improving Health and Reducing Inequality

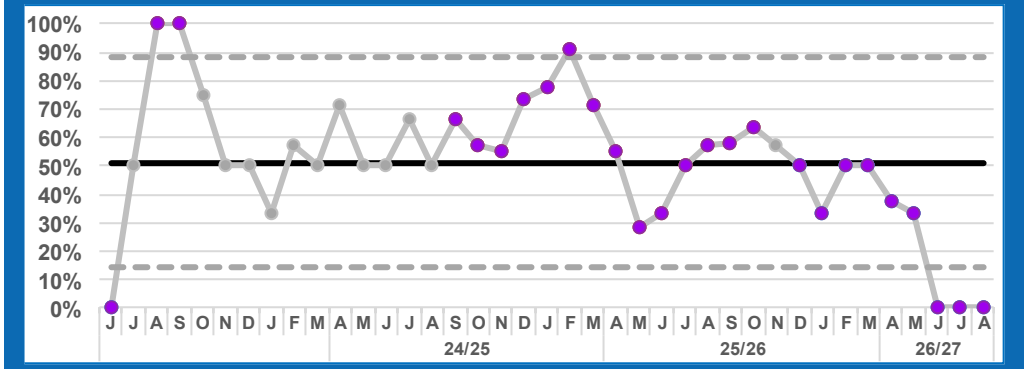
IPR Metrics – Primary Metrics

Total Patient Recruitment to NIHR Portfolio Adopted Studies



'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 109.

% of Portfolio Clinical Research Studies Set Up in Time (90 day component) - Rolling 3 Months



'% of Portfolio Clinical Research Studies Set Up in Time (90 day component) - Rolling 3 Months' is showing an 'special cause variation' (decreasing rate). - This is a change from the previous month. The figure is currently at 0.0%.

At the time of submitting the metrics, 109 patients were recruited to NIHR Portfolio studies, slightly below the monthly target of 115 and down from 148 recorded in May. These recruitment figures are routinely updated following submission as additional activity is confirmed and recorded. Based on previous reporting patterns, July recruitment is anticipated to increase as additional activity is validated and entered into our portfolio. Our current position demonstrates strong recruitment performance despite the closure of several high-recruiting observational studies, which have yet to be fully replaced. Recruitment to higher-value interventional and commercial studies remains stable, and overall recruitment levels continue to compare favorably with those seen prior to the period of exceptionally high recruitment between August 2024 and May 2025. To support sustained growth, the R&I leadership team continues to focus on attracting new grants and awards, progressing studies through set-up, and minimising gaps between study closure and replacement. The recently opened WABS study is expected to contribute to recruitment over the coming months. Most Moorfields studies remain NIHR Portfolio adopted.

Between May and July 2026, rolling three-month performance remained at 0%, which is below the NHS Oversight Framework target of 90%. Performance during this period was heavily influenced by the small number of studies reaching an outcome. The two studies contributing to the measure missed the 90-day target by only five days, reflecting delays in study set-up rather than participant recruitment. No studies reached an outcome during July 2026, meaning there was no additional impact on the reported performance for the month. The average study set-up time since April 2023 is 93 days. Based on the current study pipeline, three studies are expected to reach a positive outcome for August 2026 and will be reported during October submission. Performance is influenced by the small number of studies reaching an outcome during the reporting period, meaning individual studies can have a significant impact on the overall percentage. Delays may arise from study complexity, approvals processes, Capacity and Capability requirements, and the timely completion of study set-up activities. To improve performance, the R&I team continues to monitor study set-up and recruitment timelines and work with study teams to address delays. Measures are also being implemented to strengthen data quality and ensure key study set-up and recruitment milestones are recorded in EDGE in a timely and consistent manner, providing greater confidence that reported performance accurately reflects operational activity. These actions are led by the R&I leadership team and research delivery teams, with performance and data quality reviewed monthly.

Moorfields Eye Hospital NHS Foundation Trust

Appendix



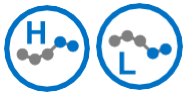
Guide to Chart Icons

Moorfields Eye Hospital NHS Foundation Trust

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

Moorfields Eye Hospital NHS Foundation Trust

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/ Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Access to Services																						
Difference Between Planned and Actual 18 week Performance	Aug-26	-2.54%	≥0%	Monthly	Common Cause	Failing	-1.10%	-3.95%	1.75%	-3.45%	0.00%	-0.38%	0.01%	-1.28%	-1.89%	-2.72%	-1.80%	-0.22%	-0.30%	-0.80%	-1.55%	-2.54%
52 Week RTT Incomplete Breaches	Aug-26	22	≤5 Breaches	Monthly	Common Cause	Failing	14	-2	31	31	40	16	18	13	16	30	12	7	7	13	21	22
Cancer 28 Day Faster Diagnosis Standard	Jul-26	85.7%	≥80%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	76.0%	26.9%	125.1%	66.7%	50.0%	75.0%	66.7%	n/a	0.0%	0.0%	90.0%	94.3%	100.0%	87.5%	85.7%	n/a
Theatre Utilisation (MEH Definition)	Aug-26	65.8%	≥85%	Monthly	Improvement	Failing	63.4%	61.2%	65.7%	63.2%	63.6%	65.0%	66.3%	65.9%	65.4%	66.7%	65.7%	65.8%	65.3%	64.9%	64.9%	65.8%
Cataract Eyes Per Four Hour Theatre List	Aug-26	6.60	≥ 8 Per 4hr List	Monthly	Improvement	Failing	6.06	5.62	6.50	6.10	5.60	6.10	5.90	6.00	6.20	6.20	6.40	6.10	6.40	6.30	6.10	6.60
DNA Rate (First Outpatients)	Aug-26	13.5%	≤9.4%	Monthly	Common Cause	Failing	13.1%	11.7%	14.5%	13.0%	13.7%	13.5%	12.8%	13.2%	13.5%	12.7%	12.7%	13.4%	13.4%	14.7%	14.5%	13.5%
DNA Rate (Follow Up Outpatients)	Aug-26	10.0%	≤8.1%	Monthly	Common Cause	Failing	10.3%	9.0%	11.6%	9.9%	10.0%	9.7%	9.5%	9.9%	10.0%	10.0%	10.0%	9.3%	10.2%	10.8%	10.7%	10.0%
Average Call Waiting Time	Aug-26	799	≤ 2 Mins (120 Sec)	Monthly	Concern	Failing	221	63	379	184	232	222	277	191	269	212	238	394	365	590	908	799
Patient Safety & Effectiveness and Experience																						
Percentage of responses to written complaints acknowledged within 3 days	Aug-26	91.9%	≥80%	Monthly	Improvement	Capable	85.3%	53.2%	117.4%	60.0%	94.1%	90.0%	100.0%	88.9%	100.0%	95.5%	91.3%	100.0%	100.0%	94.7%	96.3%	91.9%
Duty of Candour (% conversations informing family/carer occurred within 10 working days)	Jul-26	67.0%	No Breaches	Monthly (Month in Arrears)	Common Cause	Hit or Miss	74.2%	23.1%	125.3%	100.0%	67.0%	57.0%	50.0%	90.0%	82.0%	60.0%	80.0%	n/a	50.0%	77.0%	67.0%	n/a
People and Workforce																						
Sickness Absence Rate (Monthly)	Jul-26	5.1%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.7%	3.9%	5.4%	5.0%	5.6%	5.5%	5.1%	5.6%	5.0%	4.3%	4.3%	4.2%	4.9%	4.9%	5.1%	n/a
Staff Turnover (Rolling Annual Figure)	Jul-26	7.9%	≤10.0%	Monthly (Month in Arrears)	Improvement	Capable	10.1%	9.2%	11.0%	9.0%	8.5%	8.9%	9.1%	8.8%	8.6%	8.6%	9.3%	8.7%	8.4%	8.1%	7.9%	n/a
Proportion of Temporary Staff	Aug-26	5.8%	No Target Set	Monthly	Improvement	Not Applicable	11.4%	7.7%	15.1%	6.4%	8.2%	7.3%	7.6%	7.6%	8.0%	9.1%	8.1%	6.9%	6.6%	6.6%	7.0%	5.8%
Statutory Mandatory Training Compliance	Aug-26	85.5%	≥80%	Monthly	Common Cause	Capable	87.9%	85.7%	90.1%	87.8%	88.6%	88.8%	87.4%	88.3%	88.5%	88.3%	87.9%	87.1%	88.0%	86.2%	87.5%	85.5%
Advancing Eye Care																						
Total Patient Recruitment to NIHR Portfolio Adopted Studies	Jul-26	109	≥115 (per month)	Monthly (Month in Arrears)	Concern	Hit or Miss	272	78	466	170	147	199	148	109	172	120	86	109	101	148	109	n/a
% of Portfolio Clinical Research Studies Set Up in Time (90 day component) - Rolling 3 Months	Aug-26	0.0%	No Target Set	Monthly	Decreasing	Not Applicable	53.3%	21.3%	85.2%	57.1%	58.3%	63.6%	57.1%	50.0%	33.3%	50.0%	50.0%	37.5%	33.3%	0.0%	0.0%	0.0%

Moorfields Eye Hospital NHS Foundation Trust

NHS

Integrated Monitoring Metrics

August 2026

Brief Summary of Report

Moorfields Eye Hospital NHS Foundation Trust

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

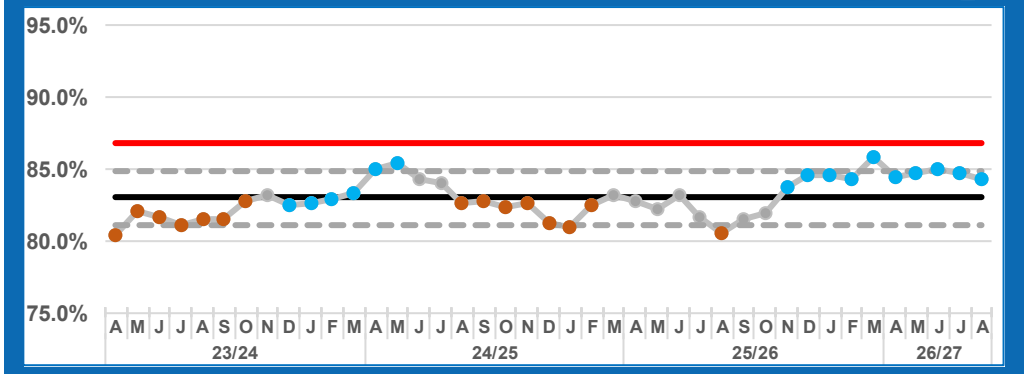
Moorfields Eye Hospital NHS Foundation Trust

August 2026		Assurance		
		Capable Process	**Hit and Miss**	**Failing Process**
Variation	**Special Cause Improvement**	Theatre Utilisation (MH) % 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	% Cancer 31 Day Waits (All) % Cancer 62 Day Waits (All) Elective Activity - % of Phased Plan Total Outpatient Activity (% Plan) Outpatient First Activity (% Plan) Injection Activity (% Plan) Occurrence of any Never events NatPSAs breached % FoI Requests within 20 Days	Theatre Cancellation Rate (NHM)
	Special Cause Concern	FFT Inpatient Scores (% Response) FFT Outpatient Scores (% Response) FFT A&E Scores (% Response)	% A&E Waits Over Twelve Hours	% Diagnostic WT less than 6w HNM Cancelled 28 day breaches Average Call Abandonment Rate Outpatient Flw Up Activity (% Plan) Sickness Absence Rate (Annual)

Performance Overview

Monitoring Metrics - Failing metrics

18 Week RTT Incomplete Performance

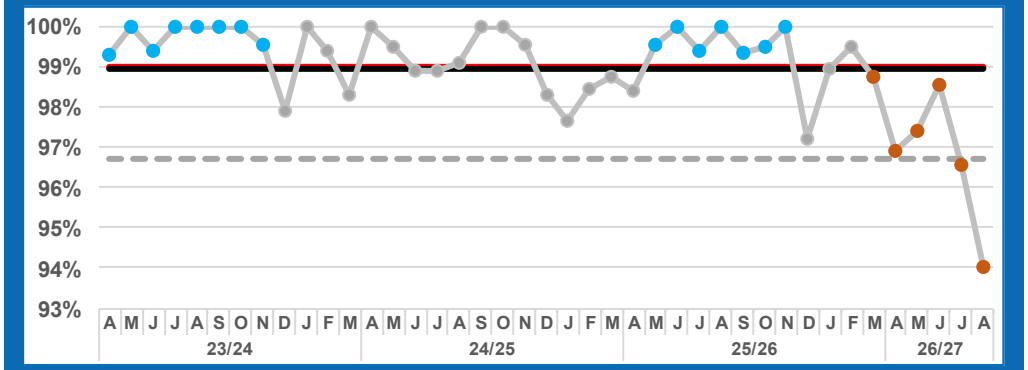


'18 Week RTT Incomplete Performance' is showing 'special cause improvement' however the current process is unlikely to achieve the target. The figure is currently at 84.22%.

Performance Overview

Monitoring Metrics - Failing metrics

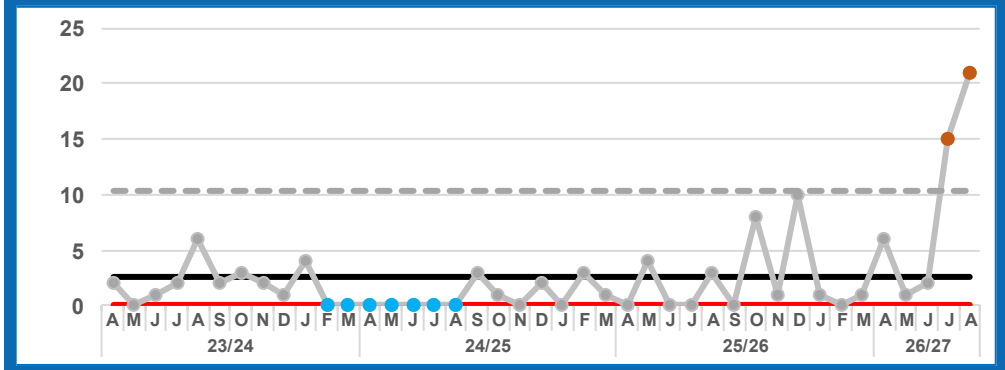
Percentage of Diagnostic waiting times less than 6 weeks



'Percentage of Diagnostic waiting times less than 6 weeks' is showing 'special cause concern' and that the current process is unlikely to achieve the target. - This is a change from the previous month. The figure is currently at 94.0%.

- The data is showing that 11 patients were waiting over 6 weeks for diagnostics at the end of August. The primary reason for this is patient cancellation and patient choice. This position is still being validated, with comments requested from host trusts.

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



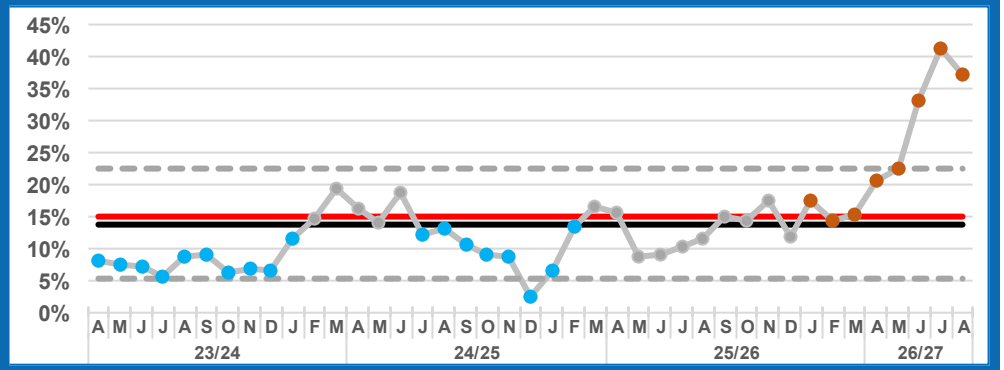
'Number of non-medical cancelled operations not treated within 28 days' is showing 'special cause concern' and that the current process is unlikely to achieve the target. - This is a change from the previous month. The figure is currently at 21.

- The data shows an increase in the number of non-medical cancelled operations not treated within 28 days. A large number of these patients were cancelled due to the temporary closure of stratford theatre and for those patients who did not wish to be transferred to another site, it was challenging to rebook all within 28 days.
- At other sites, operating surgeon leave and patient availability in August, also increased the number not booked within 28 days.
- The rebooking of the patients cancelled on the day is tracked on a weekly basis and new dates prioritised.

Performance Overview

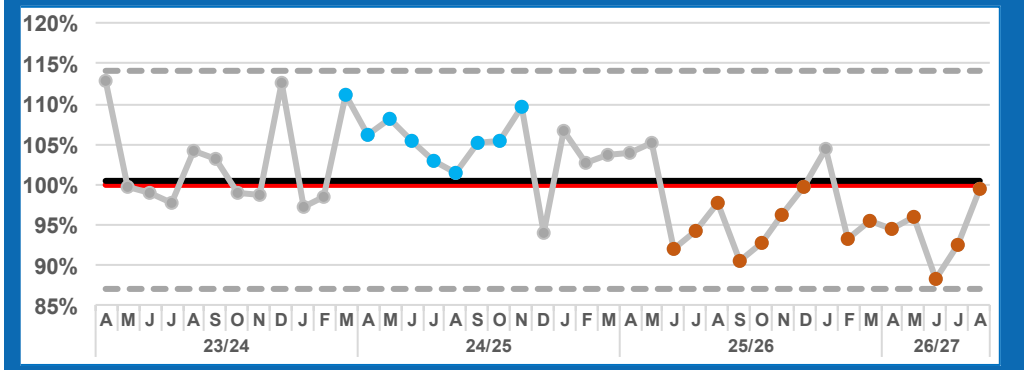
Monitoring Metrics - Failing metrics

Average Call Abandonment Rate



'Average Call Abandonment Rate' is showing 'special cause concern' and that the current process is unlikely to achieve the target. - This is a change from the previous month. The figure is currently at 37.1%.

Outpatient Follow Up Appointment Activity - % of Phased Plan



'Outpatient Follow Up Appointment Activity - % of Phased Plan' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 99.4%.

- The data is showing an improvement in the follow-up outpatient attendance position in August.
- The position is impacted by Bedford activity and particular staffing challenges in some sites and services, which are being managed to ensure activity levels continue to improve.

Access to Services

Secondary 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	H	F	84.58%	84.22%	≥86.76%	Jon Spencer	NHS Oversight Framework	Monthly
RTT Incomplete Pathways (RTT Waiting List)	H		n/a	40040	≤ Previous Mth.	Jon Spencer	NHS Operational Planning	Monthly
RTT Incomplete Pathways Over 18 Weeks			n/a	6318	≤ Previous Mth.	Jon Spencer	NHS Operational Planning	Monthly
% 52 Week RTT Incomplete Breaches		P	0.04%	0.05%	≤1%	Jon Spencer	NHS Oversight Framework	Monthly
% of RTT Patients Waiting For a First Appointment	H		89.3%	89.2%	No Target Set	Jon Spencer	NHS Operational Planning	Monthly
Under 18s Elective Waiting List (Monitoring Growth)			19699	4257	No Target Set	Jon Spencer	NHS Oversight Framework	Monthly

Access to Services

Secondary Metrics – A&E, Cancer, Diagnostics & Theatres

Moorfields Eye Hospital NHS Foundation Trust

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
A&E Four Hour Performance		P	96.5%	97.9%	≥95%	Jon Spencer	NHS Oversight Framework	Monthly
% A&E Waits Over Twelve Hours	H	?	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		?	98.9%	100.0%	≥96%	Jon Spencer	Statutory Submission	Monthly (Month in Arrears)
% Patients With All Cancers Treated Within 62 Days		?	93.8%	80.0%	≥85%	Jon Spencer	NHS Oversight Framework	Monthly (Month in Arrears)
Percentage of Diagnostic waiting times less than 6 weeks	L	F	96.8%	94.0%	≥99%	Jon Spencer	NHS Oversight Framework	Monthly
Theatre Utilisation (Model Hospital)	H	P	93.8%	96.0%	≥85.0%	Jon Spencer	Insightful Board	Monthly
Theatre Cancellation Rate (Non-Medical Cancellations)		F	1.44%	1.21%	≤0.8%	Jon Spencer	Statutory Submission	Monthly
Number of non-medical cancelled operations not treated within 28 days	H	F	45	21	Zero Breaches	Jon Spencer	Statutory Submission	Monthly

Access to Services

Secondary Metrics – Call Centre & Outpatient Efficiency

Moorfields Eye Hospital NHS Foundation Trust

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Average Call Abandonment Rate	H	F	31.4%	37.1%	≤15%	Jon Spencer	Internal Measure	Monthly
% Outpatient Attendances That Were Performed Remotely			6.6%	6.6%	No Target Set	Jon Spencer	Model Hospital	Monthly
% PIFU of Total Outpatient Attendances	↓		0.1%	0.0%	No Target Set	Jon Spencer	NHS Operational Planning	Monthly
Outpatient Cancellation Rate (Hospital cancellations)	↓		3.96%	4.22%	No Target Set	Jon Spencer	Internal Measure	Monthly
Outpatient Rebooking Rate (Hospital cancellations)	↓		7.1%	7.3%	No Target Set	Jon Spencer	Internal Measure	Monthly
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments			n/a	100	No Target Set	Jon Spencer	Internal Measure	Monthly
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	L		n/a	39	No Target Set	Jon Spencer	Internal Measure	Monthly

Access to Services

Secondary Metrics – Activity vs. Plan

Moorfields Eye Hospital NHS Foundation Trust

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Elective Activity - % of Phased Plan		?	100.8%	104.1%	≥100%	Jon Spencer	NHS Operational Planning	Monthly
Total Outpatient Activity - % of Phased Plan		?	96.5%	102.0%	≥100%	Jon Spencer	NHS Operational Planning	Monthly
Outpatient First Appointment Activity - % of Phased Plan		?	105.5%	110.9%	≥100%	Jon Spencer	NHS Operational Planning	Monthly
Outpatient Follow Up Appointment Activity - % of Phased Plan	L	F	93.8%	99.4%	≥100%	Jon Spencer	NHS Operational Planning	Monthly
Injections Activity - % of Phased Plan		?	100.3%	108.8%	≥100%	Jon Spencer	NHS Operational Planning	Monthly

Patient Safety & Effectiveness and Experience

Secondary 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		?	3	0	Zero Events	Suminthra Naidu	Statutory Submission	Monthly
National Patient Safety Alerts (NatPSAs) breached		?	n/a	0	Zero Alerts	Suminthra Naidu	Statutory Submission	Monthly
Freedom of Information Requests Responded to Within 20 Days		?	90.1%	93.6%	≥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

Secondary Metrics – Clinical

Moorfields Eye Hospital NHS Foundation Trust

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Mixed Sex Accommodation Breaches		P	0	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	99.0%	98.6%	≥95%	Suminthra Naidu	Statutory Submission	Monthly
% Emergency re-admissions within 30 days following an elective or emergency spell			3.7%	4.2%	No Target Set	Louisa Wickham	NHS Oversight Framework	Monthly
Safer Staffing - Inpatient (Overnight) Ward Fill Rate	H	P	103.0%	102.0%	≥90.0%	Suminthra Naidu	Statutory Submission	Monthly

Patient Safety & Effectiveness and Experience

Secondary Metrics – Patient Experience

Moorfields Eye Hospital NHS Foundation Trust

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	L	P	37.4%	35.1%	≥30%	Ian Tombleson	Statutory Submission	Monthly
Outpatient Scores from Friends and Family Test - % Response Rate	L	P	29.8%	28.0%	≥15%	Ian Tombleson	Statutory Submission	Monthly
A&E Scores from Friends and Family Test - % Response Rate	L	P	22.9%	22.7%	≥20%	Ian Tombleson	Statutory Submission	Monthly

People and Workforce & Advancing Eye Care

Secondary Metrics

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Sickness Absence Rate (Rolling Annual)			n/a	5.0%	≤4%	Sue Steen	NHS Oversight Framework	Monthly (Month in Arrears)

Metric Description	Variation	Assurance	Year to Date	Current Period	Target	Metric Lead	Metric Source	Reporting Frequency
Average Time Taken to Set Up Portfolio Clinical Research Studies (90 day component)			n/a	n/a	No Target Set	Viren Jeram	Internal Measure	Monthly

Moorfields Eye Hospital NHS Foundation Trust

Appendix



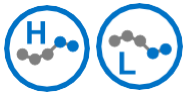
Guide to Chart Icons

Moorfields Eye Hospital NHS Foundation Trust

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**

Cover Sheet	
Report title	MoorConnect Programme Update
Meeting	Board of Directors - public
Date	24 September 2026
Report from	Jon Spencer, Chief Operating Officer
Prepared by	Ryan Lynch, EPR Director
Previous forum consideration	Trust Executive Committee – 04 August 2026

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

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

Executive summary:

The MoorConnect programme is now planning towards a 27 March 2027 implementation date, which remains the earliest date currently considered safe and achievable for introducing the Trust's new electronic patient record system. This date remains a planning assumption rather than a confirmed go-live date, with a final decision to be taken through the programme's formal assurance process in December 2026.

Since the previous update, substantial progress has been made across the areas that previously contributed to delaying the programme. Additional due diligence has been completed covering testing, reporting, technology infrastructure, supplier delivery, clinical services replacement and organisational readiness. This work is providing increasing confidence that 27 March 2027 is a realistic and deliverable implementation target.

The programme has maintained strong momentum. Progress continues across reporting development, data migration, infrastructure readiness, testing preparation, workforce planning and supplier mobilisation. Contractual milestones are now in place for several key dependencies, independent assurance procurement is underway, and integrated planning with the Oriel programme has been established to ensure both programmes can be delivered safely and effectively.

Patient safety remains the programme's overriding priority. The additional time is being used to strengthen testing, validate reporting, complete technical readiness activities, prepare staff and services, and ensure lessons learned from other NHS digital programmes are fully incorporated into delivery plans.

While confidence in a March 2027 implementation continues to increase, further assurance is still required. Between September and December 2026, the programme will complete a series of formal readiness reviews, independent assurance assessments and governance gateways. These activities are designed to provide objective evidence that the Trust is ready to proceed safely. A formal go/no-go decision will then be taken in December 2026.

Overall, the programme's assessment is that March 2027 remains a credible and achievable implementation target. Significant progress has been made since the delay was announced, key risks are better understood, and mitigation plans are in place. The programme's focus now shifts from planning for March 2027 to evidencing that the organisation is genuinely ready to deliver it safely and successfully.

Key Programme Challenges and How They Are Being Addressed:

While confidence in a March 2027 implementation continues to increase, several important challenges remain and collectively form the programme's critical path to go-live. The programme's focus has now shifted from identifying risks to implementing mitigation plans, strengthening governance and generating the evidence required to support a safe and informed implementation decision.

Supplier dependency remains a key consideration, with delivery reliant on a number of external partners. To reduce risk, the programme has actively removed supplier-led activity from the critical path wherever possible, including adopting a lower-risk approach to support the referral to treatment time activities for go-live. This has been supported by strengthened supplier governance, enhanced milestone management and increased executive oversight.

The programme must also be delivered alongside the Oriel programme, infrastructure modernisation, cyber initiatives and day-to-day operational services. To ensure the organisation has the capacity to support these priorities simultaneously, the CIO directorate is undertaking a comprehensive review of workforce capacity, governance, service transition arrangements and critical dependencies. This work is providing assurance that the right skills, leadership and support arrangements are in place, while ensuring appropriate Trust leadership remains actively engaged in readiness planning and decision-making.

The testing, reporting and data warehouse readiness workstreams continue to be major areas of focus. Work is underway to deliver a robust reporting platform, while detailed plans are in place for integration, migration, reporting and user acceptance testing. Additional testing capacity has been identified and actions are being taken to protect testing resources and ensure critical dependencies are delivered on schedule.

The close proximity of MoorConnect and Oriel also requires careful coordination. Weekly integrated planning sessions are now reviewing shared resources, operational readiness, workforce requirements and programme sequencing to ensure both initiatives can be delivered safely and sustainably.

Alongside delivery activity, the programme continues to focus on staff engagement and organisational readiness. Communications, training and readiness planning have been strengthened to maintain momentum and minimise change fatigue across the organisation.

Governance and assurance arrangements have also been significantly enhanced. A workstream assurance matrix has been introduced, formal readiness gateways have been established, and procurement is underway for an independent external assurance partner. Together, these measures provide stronger oversight, independent challenge and clear accountability, ensuring that any decision to proceed is based on demonstrable readiness rather than optimism.

Overall, significant progress has been made in understanding and mitigating the programme's principal risks. While important challenges remain, the focus is now on maintaining delivery momentum and demonstrating the evidence required to support a safe and successful March 2027 implementation.

Overall Assessment:

The programme's assessment is that March 2027 remains a credible and achievable implementation target, with confidence continuing to increase as further assurance activity is completed. Significant due diligence has now been undertaken across the principal drivers of delay, including testing, reporting, IT capacity, supplier dependencies, infrastructure replacement, data warehouse readiness and Oriel integration. This work has provided greater clarity on risks, ownership and mitigation plans, moving the programme from assumption-led planning to evidence-based decision making.

Importantly, programme momentum has been maintained throughout the assurance process. Progress continues across all major workstreams, supported by strengthened governance, integrated Oriel planning, enhanced supplier oversight, the introduction of a workstream assurance matrix and procurement of an independent external assurance partner.

The additional time provided by the revised timeline is being used to strengthen testing, reporting validation, operational readiness, workforce preparation and patient safety assurance. However, 27 March 2027 remains a planning assumption rather than a confirmed go-live date. The programme will continue to test readiness through formal assurance gateways, with a final decision to proceed remaining subject to satisfactory evidence and the December 2026 go/no-go decision.

Overall, the evidence gathered to date demonstrates strong progress and increasing delivery confidence. While important assurance activities remain, 27 March 2027 continues to represent the most balanced, deliverable and strategically viable implementation option for the Trust.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Cover Sheet	
Report title	Terms of reference
Meeting	Board of directors
Date	26 September 2026
Report from	Ben Westmancott, Interim Company Secretary
Prepared by	Jennie Phillips, Deputy Company Secretary
Previous forum consideration & date	Discovery & Commercial Committee – 09.09.26

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

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

Executive summary

The discovery & commercial committee considered and endorsed the changes below to the terms of reference.

New changes for consideration:

- 31a – inclusion of the commercial oversight group
- 22 – inclusion that the committee will review the commercial elements of the education strategy, via the commercial oversight group. The committee should note that Ken Batty will have overarching oversight of the education strategy as he sits on both People & Culture and DCC.

Quality implications

There are no explicit quality implications to this proposal.

Financial implications

There are no explicit financial implications to this proposal.

Risk implications

If the committee does not have clear and appropriate terms of reference, assurance will be weakened.

Recommendation

The Board is asked to approve the terms of reference.

Moorfields Eye Hospital NHS Foundation Trust

NHS

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 research & innovation 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) 22. Commercial elements of the education strategy Other: 23. Specific risks on the board assurance framework allocated by the Board 24. Analyse and challenge appropriate information on performance related to discovery and commercial 25. Annual review and forward look for committee
Reporting and Review	26. 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. 27. Minutes of meetings will be available for any board member on request. 28. 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	29. 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. 30. 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. 31. The committee has established the following sub-committees to help fulfil its duties. a. Commercial oversight group.		
Meeting administration	32. The lead executive for the committee will be the director of discovery and the secretary for the committee will be the company secretary. 33. 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 34. 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

Meeting:	Board of Directors
Date:	24 September 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**

Moorfields Eye Hospital NHS Foundation Trust

NHS

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
Aaron Rajan		Non-Executive	28 February 2027
Asif Bhatti		Non-Executive	22 May 2028
Andrew Dick		Non-Executive	30 September 2026
Elena Lokteva		Non-Executive	31 December 2028
Ken Batty		Non-Executive	29 June 2029
Michael Marsh		Non-Executive	3 November 2028
Tracey McNeill		Non-Executive	28 February 2027
David Hills		Associate Non-Executive	31 December 2027
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 APs	Executive - voting	N/A
Sue Steen	Chief People Officer	Executive - voting	N/A
Arthur Vaughan	Chief Finance Officer	Executive - voting	N/A
Sobha Sivaprasad	Director of Research & Innovation	Executive - voting	N/A
Elena Bechberger	Director of Strategy & Partnerships	In attendance	N/A
Victoria Moore	Director of Transformation & Performance Improvement	In attendance	N/A

Updated: 17 September 2026

Moorfields Eye Hospital NHS Foundation Trust

NHS

Committee Membership

Audit & Risk
Asif Bhatti (Chair)
Elena Lokteva
Michael Marsh

Discovery & Commercial
Tracey McNeill (Chair)
Andrew Dick
Adrian Morris
Ken Batty
Director of Research & Discovery
Chief Medical Officer
Chief Executive
Chief Finance Officer
Director of Strategy & Partnerships

Finance & Performance
Elena Lokteva (Chair)
Asif Bhatti
David Hills
Tracey McNeill
Chief Finance Officer
Chief Operating Officer

Major Projects & Digital
David Hills & Aaron Rajan (Co-chairs)
Adrian Morris
Asif Bhatti
Tracey McNeill
Chief Finance Officer
Chief Operating Officer
Director of Strategy & Partnerships
Chief Information Officer
Director of Estates, Capital & Major Projects

People & Culture
Ken Batty (Chair)
Aaron Rajan
David Hills
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
Ken Batty
Elena Lokteva
Chief Nurse & Director of AHPs
Chief Medical Officer
Chief Executive
Chief Operating Officer

Remuneration & Nominations
Tim Briggs (Chair)
Adrian Morris
Aaron Rajan
Asif Bhatti
Elena Lokteva
Ken Batty
Michael Marsh
Tracey McNeill

Updated: 17 September 2026

Moorfields Eye Hospital NHS Foundation Trust

NHS

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
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
Stephen Edmonson	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	*Public governor*	*Beds & Herts*	
VACANT	*Staff governor*	*Network sites*	
VACANT	*Nominated* governor – *Partnership*	*London borough of Islington*	

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Moorfields Eye Hospital NHS Foundation Trust

Council of Governors sub committees and groups

Non-executive Nominations & Remuneration Committee	**Kimberley Jackson (Chair)** Allan MacCarthy Amit Arora (staff governor) Robert Goldstein Stephen Edmonson (appointed governor) Emmanual Zurdis *VACANY*
Members and Patient Engagement Group	**Emily Brothers (Chair)** Ian Humphreys John Russell Paul Murphy Stephen Edmonson 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: 17 September 2026

Cover Sheet	
Report title	Infection Control Annual Report April 2025-March 2026
Meeting	Board of directors
Date	24 September 2026
Report from	Suminthra Naidu, Chief Nurse and Director of Allied Professionals, Director of Infection Prevention & Control
Prepared by	Catherine Wagland Amita Sharma
Previous forum consideration	c

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

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

Executive summary

This report provides an overview of the Infection Prevention and Control work delivered for the period from 1st April 2025 to the 31st March 2026, demonstrating trust commitment to keeping patients safe from avoidable healthcare associated infections and provide assurance on trust compliance with the ten criteria in the Health and Social Care Act (2008):Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (updated December 2022) and compliance with the IPC Board Assurance Framework.

The Board is asked to note the report which will be presented to the postponed quality and safety committee on 29 September 2026.

Quality implications

The report provides assurance on the Infection Prevention and Control measures that are in place to safeguard patients, visitors and staff from acquiring a healthcare associated infection through surveillance, environmental inspections, audits, staff education and training, antimicrobial stewardship, and ongoing monitoring of compliance with infection prevention standards.

Financial implications

There are no financial implications arising from this report.

Risk implications

A detailed programme of work provides assurance that measures are in place to maintain safety of patients, visitors and staff and ensure compliance with statutory and regulatory requirements. Any risks identified during the delivery of work are managed in accordance with the trusts PSIRF policy.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Infection Control Annual Report

April 2025 – March 2026



Version 1.0
Status: DRAFT
Authors: Catherine Wagland and Amita Sharma
Approved:

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1. Executive Summary

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

This report provides a comprehensive overview of the infection prevention and control activities, achievements and challenges for the period from 1st April 2025 to the 31st March 2026, demonstrating our commitment to keeping patients safe from avoidable healthcare associated infections and provide assurance on trust compliance with the ten criteria in the Health and Social Care Act (2008):Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (updated December 2022).

This report will be published on the trust website to demonstrate good governance.

1.1 The key achievements for 2025/26

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

- All endophthalmitis HCAI's have been below the trust best practice benchmarks, this includes cataracts, vitrectomy, acute glaucoma, intravitreal injections, Ozurdex implants and corneal grafts.
- There have been no cases of bacteraemia or *Clostridioides difficile* for the trust to report.
- The flu vaccine compliance for the Trust was at **51.1%,** the second highest performing trust in the London Region, and an increase of 3% from the preceding year.
- The Annual Infection Control Programme of Work for 2025-26 was fully completed.
- The IPCT successfully extended an SLA to provide services to the Tavistock and Portman trust for an additional six months.
- A Lead IPCN presented at the international Infection Prevention Society conference in September 2025, this is the first time ophthalmology was on the agenda.
- The IPC Support Nurse was awarded the prestigious Daisy Award
- Two service improvement projects were completed by the ICN's focusing on improved patient discharge information and cost-effective and informed specimen test requests.

2.0 Introduction

Welcome to the annual Director of Infection Prevention and Control (DIPC) report for Moorfields Eye Hospital NHS Foundation Trust for the year 2025–26. Moorfields Eye Hospital sees nearly 800 000 patients annually, in addition to approximately 50 000 telephone and telemedicine outpatient consultations held virtually. The trust employs around 2500 staff across 22 sites in the UK, providing healthcare services for the NHS and directly managing three commercial divisions: Moorfields Private, Moorfields Eye Hospital Abu Dhabi and Moorfields Eye Hospital Dubai.

2.1 Compliance and Assurance

We are pleased to report that Moorfields Eye Hospital meets the requirements of the CQC under the Health and Social Care Act 2008 regulations (the Hygiene Code). Our IPC Board Assurance Framework assessment confirms good compliance with these regulations. The trust is fully compliant with 5 domains and partially compliant with the remaining 5 domains. The trust is sighted on areas that are outstanding and where we need to make improvement. The trust is compliant with the National Infection Prevention and Control Manual (NIPCM) agreeing any local specialism requirements at the Infection Control Committee.

2.2 Our Commitment to Safety

This report is based on the Hygiene Code framework and outlines our IPC commitment to deliver excellent healthcare services that are progressing with advancing medicine, responsive to the changing needs of patients and public health and leading in the knowledge transfer of specialist expertise to ensure that ophthalmology patients are protected from healthcare-associated infections. This ensures that our patients, staff and the public can trust we are meeting our obligations for patient safety and clinical governance.

3.0 Organisation and Governance of IPC Services

Criteria 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them.

3.1 Governance Framework

All NHS Trusts' must have a Director of Infection Prevention and Control (DIPC). At Moorfields Eye Hospital the Chief Nurse, Simmi Naidu, is the Executive DIPC, with Catherine Wagland as the IPC Matron and Deputy DIPC.

The Trust's Infection Control Committee (ICC) is chaired by Mr Carlos Pavesio, Professor of Ocular Inflammation and Infections. The ICC overseas all IPC activities and meets quarterly. The ICC receives assurance reports from the IPC Operational Group, Water and Ventilation Safety Group, Sterile Services Department, Cleanliness Operation Group, Antimicrobial Pharmacist, Eye Bank, Estates and Facilities, Occupational Health and clinical leads from each Division, including MEH United Arab Emirates. There is also representation from North London Health Protection Team and the Infection Control Doctor and Deputy DIPC at GSTT.

The ICC reports to the Clinical Governance Committee (CGC), who report into the Quality and Safety Committee (QSC) and directly to Trust Board. The IPC governance reporting structure is set out in **Appendix 1**.

The IPC Operational Group (IPCOG) meetings, chaired by the DIPC or Deputy DIPC, monitor progress on the IPC work plan. These meetings help address operational issues and escalate them to ICC if needed. IPCOG reports contribute to the quarterly ICC reports, summarising IPC activities.

The statutory DIPC Annual Report and Board Assurance Framework (IPC BAF) are presented through the ICC.

3.2 Infection Prevention and Control Team (IPCT)

There is an established infection prevention and control team (IPCT) that provides expert guidance to patients, staff and others on all matters relating to infection risk reduction in healthcare. The IPCT provides this support across all UK trust sites and for services delivered in the United Arab Emirates, who are governed by local legislation.

The IPCT lead on the delivery of the annual programme of work, as required in the Health and Social Care Act (2008), providing education and training, undertaking environmental audits across sites and developing the trust IPC audit programme, monitoring and reporting on mandatory HCAI and ophthalmology specific infections, updating and developing trust policies and guidelines and responding to the needs of the trust by incorporating major programmes and strategic goals into the teams' objectives.

The IPCT work collaboratively with many key stakeholders within the trust including the Lead Antimicrobial Pharmacist, Hira Parvez, to promote safe antimicrobial use, Estates and Facilities leads Peter Foster and Ivor James to ensure standards of cleanliness within the environment

are delivered, water and ventilation safety is monitored and actioned as necessary, and Clinical leads across all services to ensure Board to Ward implementation of IPC is in practice.

The IPCT structure is outlined below as of the 31st of March 2026.

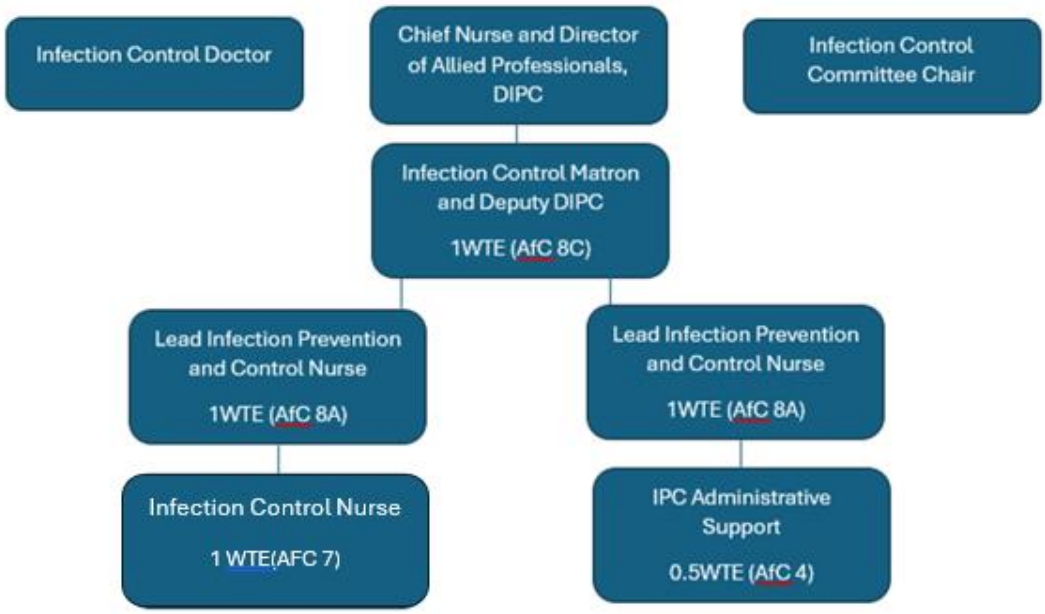


Figure 1 Infection Prevention and Control Team Structure

3.3 Secondment positions within the IPC Team

A Service Level Agreement (SLA) was organised by the IPCT with Tavistock and Portman Mental Health NHS Trust for an IPC Nurse to create a bespoke infection control service providing assurance of statutory compliance for two days a week over 12 months. Initially this SLA was due to conclude at the beginning of September 2025, however, the SLA was extended by a further six months, continuing until the 31st of March 2026 when the trust merged with another provider that had an established IPC service. The SLA generated income for the Trust and supported a development opportunity for an internal staff member, who joined the IPCT as an IPC Support Nurse for one day per week on a 12-month fixed-term contract. The secondment also enabled a senior IPCN to work at an uplifted 8B level and another to a Band 7 for the duration of the SLA.

In February 2025, the part-time IPCT Administrative Support Officer commenced one year of maternity leave. A replacement was appointed to the post on a fixed-term contract for 10 months, which concluded at the beginning of February 2026.

3.4 Infection Prevention & Control Governance Reporting & Accountability Structure

Chief Executive

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

Director of Infection Prevent and Control (DIPC)

The DIPC is a senior executive role responsible for providing strategic leadership and operational oversight to minimize healthcare-associated infections. The DIPC defines the strategic direction of the IPCT based on national legislation and ensures that the trust is compliant with regulatory requirements. The DIPC is the Board's principal advisor on infection prevention and control, accountable for ensuring that effective systems are in place to protect patients, staff, and visitors from avoidable infection harm while providing assurance on compliance, quality, and continuous improvement."

Infection Prevention and Control Team

The Infection Prevention and Control Team are responsible for delivering a programme of work annually to assist in providing assurance and monitoring the trusts compliance with requirements of the Health & Social Care Act (2008) *Code of Practice for the prevention and control of infections.*

The programme includes surveillance, investigation and management of infections, audit, policy development, education and training, and the response to outbreaks and infection incidents to contain and prevent onward transmission. The IPCT Programme of Work for 2025/26 can be found in **Appendix 3.** Working collaboratively within the trust across all departments, the team employ specialist knowledge to improve standards of care for patients and uphold staff and visitor safety. With a focus on cleanliness, decontamination and safety within the estate, the team undertakes risk assessments and sets priorities for action and assurance.

Progress with the programme is regularly reviewed at the monthly IPC Team meetings and the quarterly infection control committee.

Infection Prevention and Control Link Practitioners

The IPC Link Practitioners are clinical staff across all disciplines within the trust who are responsible for undertaking IPC audits, sharing IPC news updates, attending training within the trust and at GSTT for IPC updated knowledge on best clinical practice. The IPC Links champion safe IPC practices and implementation of policies, ensuring a bridge of knowledge between the IPCT and local services.

3.5 IPC Board Assurance Framework (BAF)

The IPC BAF is updated annually to assure the ICC and QSC that IPC arrangements align with the National Infection Prevention and Control Manual (IPCM) and the Health and Social Care Act 2008 (Hygiene Code).

Hygiene Code Criteria	Description	IPC Annual Report Section	BAF Section
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them.	3	1
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.	13 and 14	2
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.	5	3
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.	8	4
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.	4	5
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	7	6
7	The provision or ability to secure adequate isolation facilities.	9	7
8	The ability to secure adequate access to laboratory support as appropriate.	9	8
9	That they have and adhere to policies designed or the individual's care and provider organisations that will help prevent and control infections.	6	9
10	That they have a system or process in place to manage staff health and wellbeing, and organisation obligation to manage infection, prevention and control.	10	10

Health and Social Care Act 2008: Code of Practice on the prevention and control of infection (Hygiene Code)

The IPC BAF includes 54 key lines of enquiry over the 10 domains of the Hygiene Code. The end of year IPC BAF assessment identified 5 domains that were fully compliant and 5 domains where the trust was partially compliant. Of the 54 elements, the trust was fully compliant against 48 and partially compliant with 6. This provides the trust with an overall compliance of 89%.

The areas of partial compliance included

Criteria 2: food hygiene training - the Facilities lead had sourced a training programme and dates for staff across sites were being agreed.

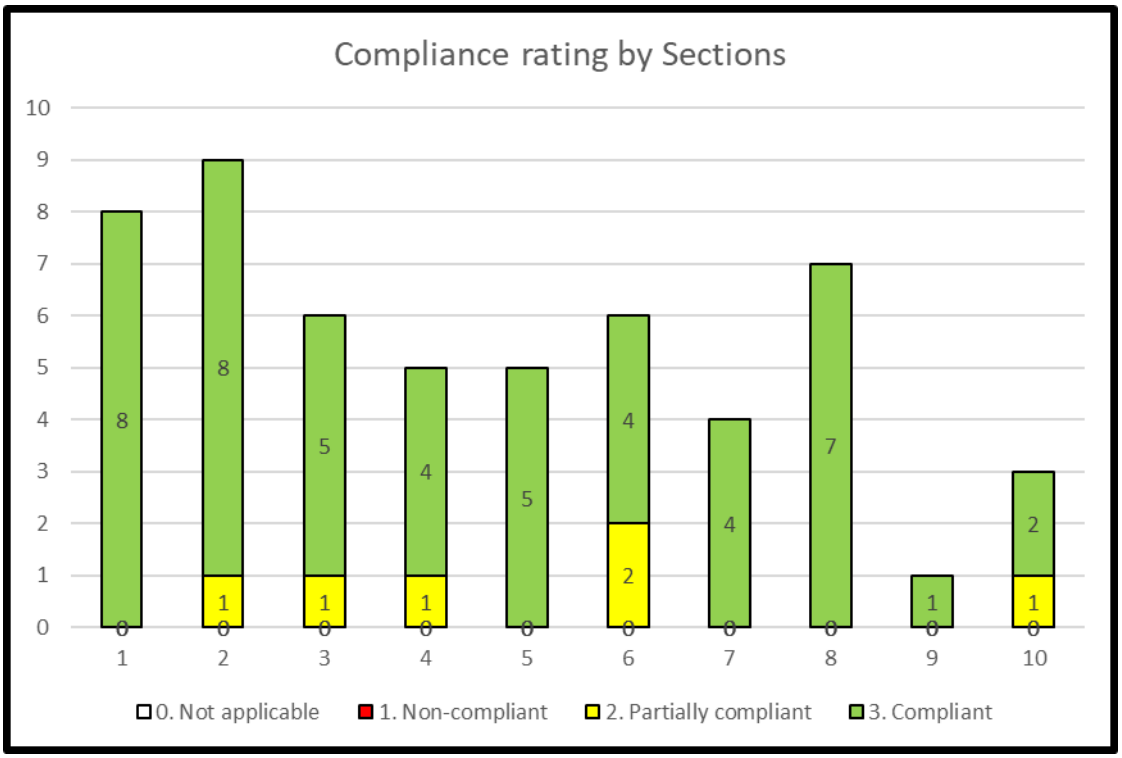
Criteria 3: antimicrobial auditing was limited to oral preparations and the trust National Action Plan on antimicrobial resistance was being developed.

Criteria 4: patient information leaflets were reviewed by patient representatives but further work to enable representation of demographic and diversity requirements was expected.

Criteria 6: staff fit testing for respiratory masks was not achieving full uptake to training and ordering of stock requires managers monitoring.

Criteria 10: staff records of immunity to measles required data transfer and cleansing from Occupational Health, this is being monitored by the ICC and Workforce.

The framework report acts as a gap analysis and allows us to prioritise areas for improvement going forward. Incomplete domains and elements are escalated to the ICC for risk oversight.



MEH IPC BAF compliance March 2026

3.6 Risk Assessment

The IPC Risk Register is reviewed quarterly and had one risk: incomplete staff immunisation records. This risk had a base score of 12 (High) and a residual score of 6 (Moderate). The trust had taken actions to control the risk that included a backlog review of outstanding records, setting up a business case for extra Occupational Health (OH) resources to recall, immunise and update outstanding records of staff. The work involved identifying priority staff groups, undertaking IPCT education programmes with clinical teams, sharing national public health surveillance data updates and regular reporting at seasonal flu meetings and ICC. During this time a new OH provider was appointed and all staff records were transferred over. The current OH provider reported completing a review of all priority staff and new joiners to the trust. The ICC was asked to review this progress and recognise ongoing monitoring with OH screening and vaccination from a business-as-usual approach to close the risk. The ICC agreed to close the risk in July 2025.

3.7 CQC

The CQC last visited the trust to undertake a focus inspection at City Road Surgery department in 2022. There were no IPC elements of recommendation and the CQC rated the department GOOD.

Prior to this, the CQC undertook a wider inspection in 2018 that included City Road, Moorfields at St George's and Moorfields at Bedford. During this inspection staff were recognised as adhering to IPC policies in their practice. The inspection rated the trust as GOOD overall, whilst there were some areas of Excellence.

4. Healthcare-associated Infection Surveillance Mandatory Reporting

Criteria 5: *There is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.*

All Trusts in England must submit monthly data on key healthcare-associated infections to the UK Health Security Agency (UKHSA) Data Collection Scheme (DCS).

The trust provides monthly submissions on all mandatory reportable infections, this includes:

Blood stream infections for MRSA, MSSA, E. coli, Klebsiella species, *Pseudomonas aeruginosa*

and *Clostridioides difficile* infection.

For the year of 2025/26 there have been no cases of mandatory reportable healthcare-associated infections within the trust.

This information is shared with the ICC, Quality and Safety Committee (QSC) and Trust Board.

4.1 Trust Surveillance of Possible Healthcare Associated Infections

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

4.2 Performance Data

	2024/25	Target	2025/26 Q1	Q2	Q3	Q4	YTD
C.diff infection	0	0	0	0	0	0	0
*Bacteraemia	0	0	0	0	0	0	0
MRSA Screening	100%	100%	100%	100%	NA	NA	NA
Endophthalmitis post cataract[º]	0.16	0.40	0.00	0.18	0.00	0.00	0.06
Endophthalmitis post intravitreal injection	0.05	0.30	0.00	0.07	0.07	0.07	0.05
Endophthalmitis post Ozurdex implants	0.00	1.0	0.00	0.00	0.00	0.00	0.00
Endophthalmitis post vitrectomy - simple	0.00	0.80	0.00	0.00	0.00	0.00	0.00
Endophthalmitis post vitrectomy - combined	0.00	2.5	0.00	0.00	0.00	2.98	0.73
Endophthalmitis post acute glaucoma	0.80	1.0	0.00	0.00	0.00	0.00	0.00
Endophthalmitis post Graft-EK	0.00	3.60	0.00	0.00	0.00	0.00	0.00
Endophthalmitis post Graft-PK	0.00	1.60	0.00	0.00	0.00	0.00	0.00
Adenovirus possible hospital acquisition	0.8%	N/A	2.5%	2.8%	0.00	0.0%	1.5%

*Bacteraemia includes MRSA, MSSA, E coli, *Pseudomonas aeruginosa* & Klebsiella Spp.
Endophthalmitis rates are based on cases per 1000 procedures.
[º]The trust Cataract Service has agreed that the cataract benchmark should be divided in two (Simple and Combined/Complex procedures). At present the denominators for this are not available.

4.3 Endophthalmitis

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

- MEH incidence data is based on clinical criteria and not only on those cases which yield a positive microbiology culture.

- All cases of endophthalmitis are reported either as benchmarked or exception reported cases.

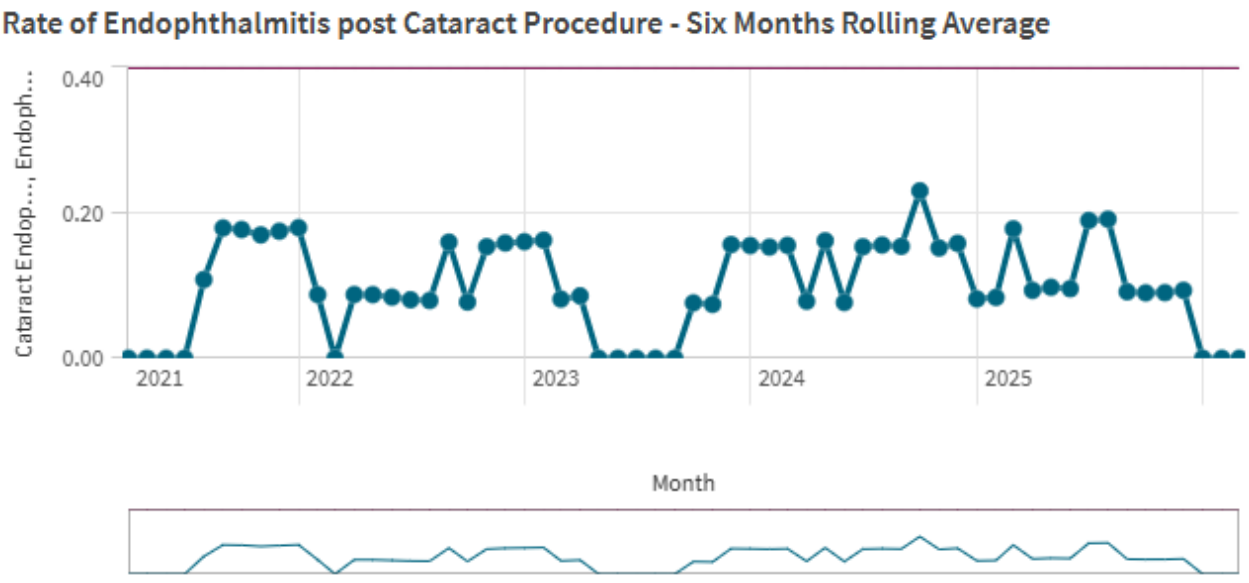
4.3.1 Benchmarked Endophthalmitis

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

A new trust benchmark for simple Phacoemulsification and IOL procedures was agreed with the Cataract Service Leads of **0.02%,** this was in line with RCO NOD's recommended national benchmark, whilst combined Phacoemulsification with other procedures will remain at **0.04%.**

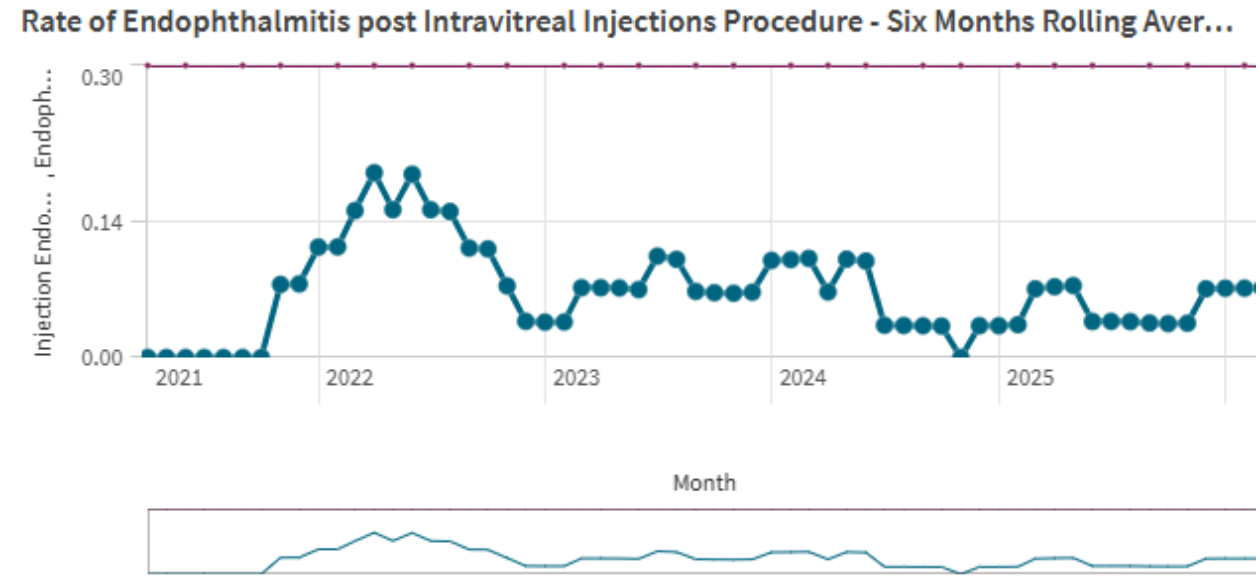
The graphs below (extracted from Qlik sense) show the rates of post-operative endophthalmitis for all the benchmarked procedures for the preceding five years. The red line depicts the benchmark.

4.3.1.1 Cataract Endophthalmitis 6-month rolling average



The rate of infection is 1 in 2400 for all cataract procedures (target 0.4, red line in graph).

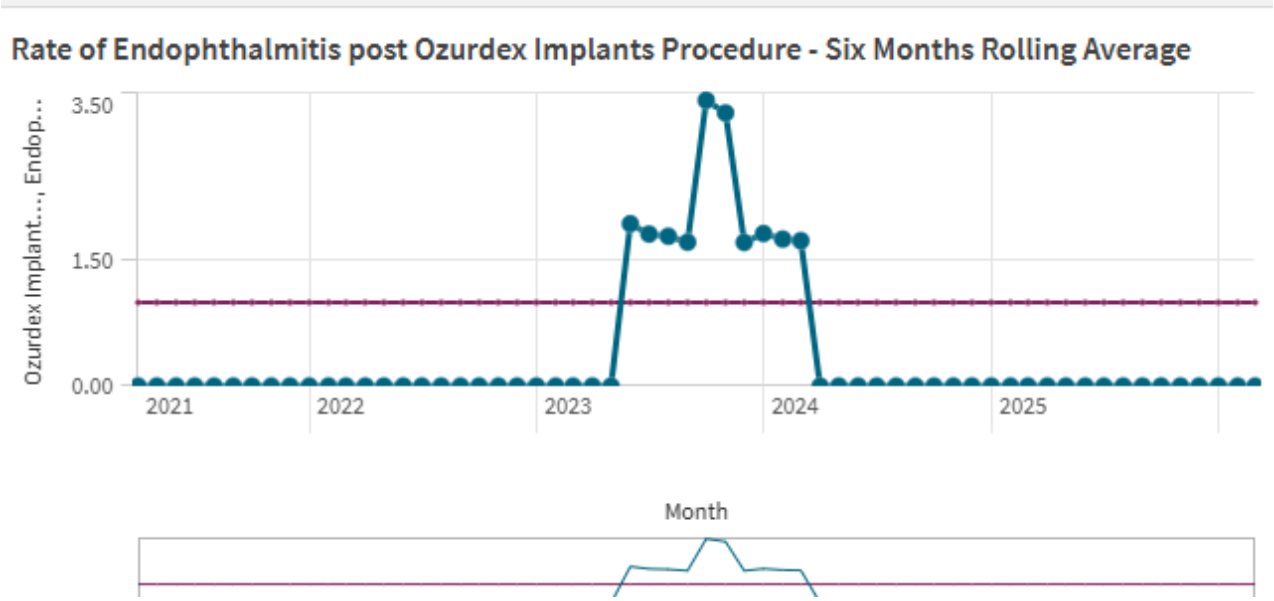
4.3.1.2 Intravitreal Injection Endophthalmitis 6 months rolling average



The expected rate of infection is 1 in 3333 intravitreal injections (target 0.3, red line in graph).

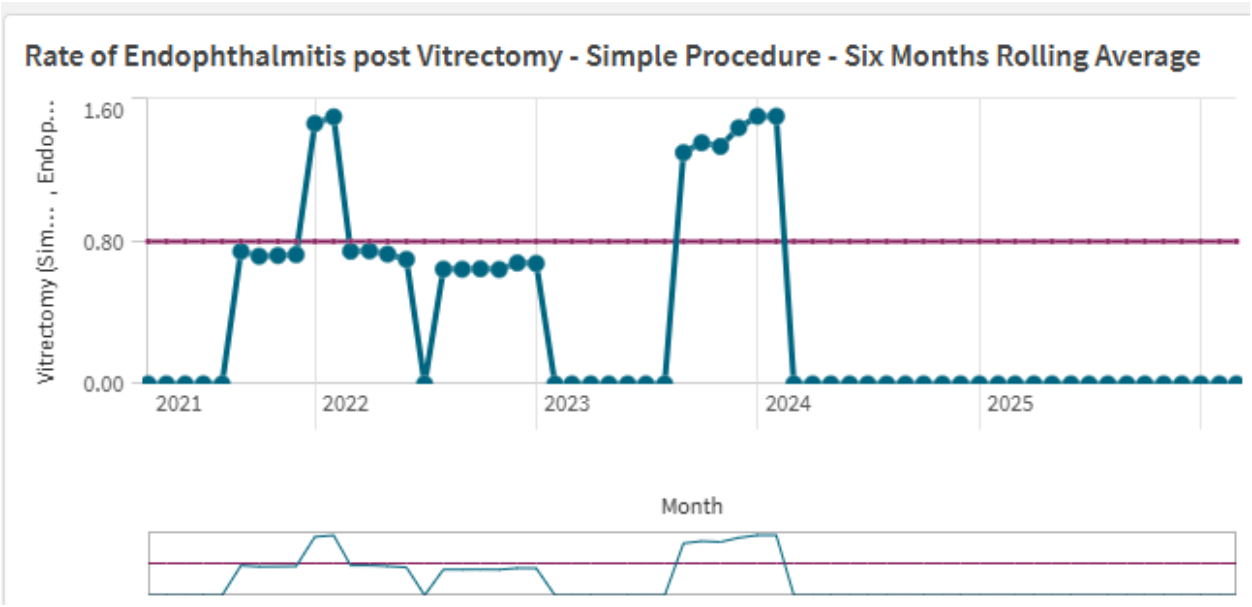
Intravitreal injections consist of medicines such as Lucentis, Avastin, Eylea and Vabysmo. Triamcinolone injections are reported separately.

4.3.1.3 Ozurdex Implant Endophthalmitis 6 months rolling average



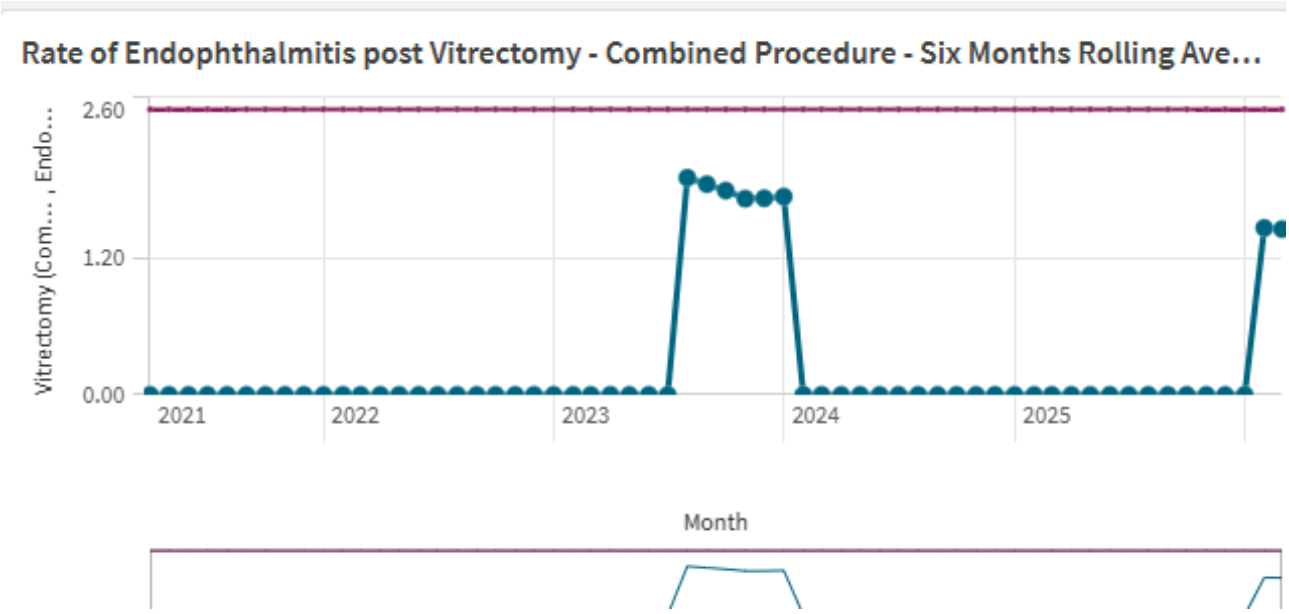
The expected rate of infection is 1 in 1000 Ozurdex implant procedures (target 1.0, red line in graph).

4.3.1.4 Vitrectomy Endophthalmitis– Simple 6-month rolling average



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

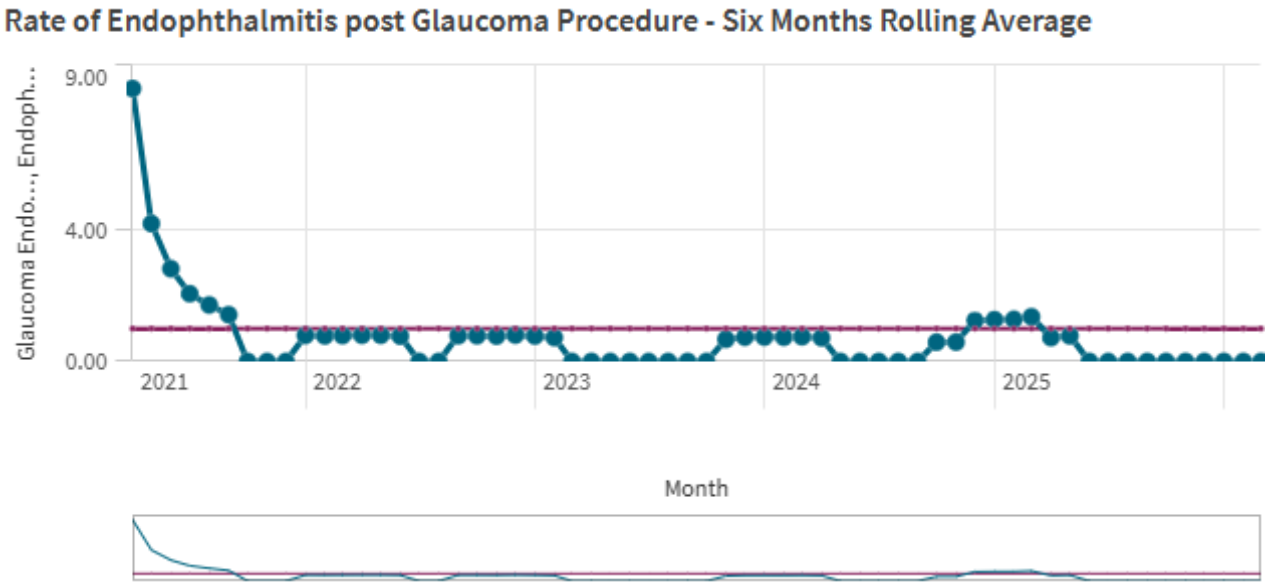
4.3.1.5 Vitrectomy Endophthalmitis – Combined 6-month rolling average



The expected rate of infection is 1 in 400 procedures (target 2.5, red line in graph).

*Rates should be viewed over a longer time frame due to the low number of procedures, e.g. 12-month rolling rate is 0.78.

4.3.1.6 Endophthalmitis Post-acute Glaucoma 6-month rolling average



The expected rate of infection is 1 in 1000 acute glaucoma procedures (target 1.0, red line in graph).

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

4.3.1.7 Endothelial Keratoplasty and Penetrating Keratoplasty

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

4.4 Adenovirus – possible hospital acquisition

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

During this year's reporting period 522 positive adenovirus cases were investigated. Seven cases of possible hospital acquisition were identified. No common epidemiological links were identified between these cases.

During late spring the UKHSA reported an increase in national Adenovirus cases mainly occurring in children under 5 years of age, with an overall positivity rate of 6.6%.

4.5 Methicillin Resistant Staphylococcus Aureus (MRSA) screening

At the Trust, patients previously identified as colonised or infected with MRSA were routinely screened for MRSA carriage in line with the Department of Health national MRSA screening guidance for the NHS (2014).

Following publication of the Getting It Right First Time (GIRFT*) MRSA pre-operative screening guidance* in May 2025, which recommended targeted screening based on high-risk specialties and individual patient risk factors rather than admission type, the Infection Prevention and Control Team (IPCT) undertook a review of the Trust's routine MRSA screening guidance.

A review of local data demonstrated that the trust was undertaking screening on a small number of patients (250 average) with around 12% of these testing positive for MRSA. Further surveillance figures indicated that the risk of MRSA infection following ophthalmic surgical procedures was very low. As a result, and in collaboration with key stakeholders, the IPC Team proposed revisions to the Trust's MRSA screening policy. The revised guidance, implemented in December 2025, no longer requires routine MRSA testing for patients who have a previous history of MRSA colonisation or infection and subsequent prescribing of MRSA decolonisation protocol prior to surgery. Patients will be managed conservatively and on an individual basis.

These changes have been agreed at the ICC and trust PPRG.

4.6 Carbapenemase-producing Enterobacteriaceae (CPE)

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

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

CPE screening

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

4.7 Candidozyma auris (formerly known as Candida auris) screening

In line with national guidance, a process was introduced in October 2025, to ask patients about any previous history for *Candidozyma auris* during the pre operative assessment. To support the safe management of patients who reported a previous history of C.*auris*, the IPC Team developed a standard operating procedure for all staff based on national guidance.

5.0 Antimicrobial Stewardship by Hira Parvez Lead Antimicrobial Pharmacist

Criterion 3: *Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.*

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

5.1 Antimicrobial prescribing and guidelines

The Trust has an adult antimicrobial guideline which is available online on the intranet and via the Eolas medical app. This is an evidence-based document which all healthcare professionals are required to use when using antimicrobials at the Trust. This guideline has migrated as of Sep 2024 from the MicroGuide platform to Eolas Medical app in line with other Trusts nationally. The Trust also has an Antimicrobial Prescribing and Management Policy to promote good principles of antimicrobial stewardship across the Trust.

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

Pharmacy has contributed on numerous activities within the Trust including:

- Maintained supply of sight saving antimicrobials after the closure of Mandeville, the specialist manufacturer that produced these formulations.
- Maintained Rifampicin supply despite national shortages of multiple Tuberculosis (TB) medicines highlighted in the National Patient Safety Alert (29.07.2025).
- Conducted multiple risk assessments for ophthalmic antimicrobial specials
- Updated Antimicrobial Medicines Management Policy

5.2 Audit work

The pharmacy has carried out an audit to investigate whether the prescribing of antimicrobials within Moorfields Private Outpatient Clinic (MPOC) adheres to the Trust's antimicrobial guidelines. Prescriptions were reviewed covering the period of 15.12.2025 to 19.12.2025.

Overall, there is good compliance with dose, frequency and duration of antimicrobials individually. However, there are at times discrepancies with overall compliance of treatment which is being highlighted to relevant personnel. This was a pilot audit conducted and there are plans to reaudit once the new EPR system has launched.

Table 1: Summary of results regarding MPOC antimicrobial audit.

Standard	Standard expected	Standard achieved
Dose of antimicrobial agent prescribed in accordance with Trust's guidelines	100%	93%
Frequency of antimicrobial agent prescribed is appropriate	100%	93%
Duration of antimicrobial agent prescribed is appropriate	100%	82%
Overall, the antimicrobial medicine prescribed is appropriate (including indication)	100%	64%

5.3 National Action Plan (NAP)

UK 5-year action plan for antimicrobial resistance (AMR) 2024 to 2029 was launched in 2024 which has been acknowledged as a Trust. The action plan has 4 themes summarised below (Figure 1).

Figure 1: Summary of the 2024 to 2029 NAP



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

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

- MEH reviews clinical and non-clinical practices to strengthen infection prevention and management.
- The Trust's Infection Control Committee brings together key stakeholders to maintain good practice and reduce infection transmission.
- MEH participates in public health campaigns, including flu vaccination and World Antimicrobial Awareness Week, to promote appropriate antimicrobial use and reduce resistance.

- ICC quarterly meetings review infection surveillance and antimicrobial usage to ensure evidence-based, responsible prescribing.

Theme 2 – Optimising the use of antimicrobials

- Antimicrobial use is guided by evidence-based Trust guidelines to ensure correct indication, dose and duration, reducing resistance risk.
- Education on antimicrobial stewardship is delivered through teachings, inductions and meetings to help staff reflect on and optimise prescribing practices.

Theme 3- Investing in innovation, supply and access

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

Theme 4 – Being a good global partner

- Antimicrobial sensitivity surveillance has been undertaken in key areas within the trust, contributing to national organisations ability to track AMR trends
- MEH shares data with the World Association of Eye Hospitals for global awareness.

5.4 Involvement and contribution

• Quarterly monitoring of Trust-wide oral antimicrobial use, including detailed review of restricted agents.

• Pharmacy input into developing and updating Trust infection-control policies through the ICC.

• Ongoing review of antimicrobial-related incidents with targeted action plans to prevent recurrence and best practice shared within trust newsletters.

• Active management of antimicrobial shortages, ensuring supply for genuine infectious cases and advising clinicians on suitable alternatives.

• Regular teaching at medical inductions to promote responsible antimicrobial prescribing and highlight evidence-based resources.

• Trust-wide coordination and delivery of World Antimicrobial Awareness Week activities to raise awareness among staff and patients.



6.0 Infection Control Policies and Standard Operating Procedures

Criterion 9: *That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.*

In accordance with the Health and Social Care Act 2008 which requires trusts to have a range of IPC policies available for staff, the IPCNs review and update policies, guidelines and standard operating procedures (SOP) to ensure staff are provided with the latest guidance.

IPC guidelines that were reviewed and updated include:

- Six Policies
- Seven SOPs, the following four are new:
    - *Candidozyma auris* (formerly known as *Candida auris*)
    - Use and Management of TOUL
    - Use and Maintenance of Surgicube
    - Management of patients with Head and Body Lice & Scabies

All policies and SOPs were approved in line with the Trust's formal approval process and published on the Trust intranet (EyeQ). These were communicated to staff via Trust-wide communication messages and the monthly Bug Brief (Infection Control Newsletter).
In addition, since the publication of the National Infection Prevention and Control Manual for England (NIPCM)[5] the trust has adopted its use, with the link to the manual being provided in trust policies when updated. The Trust Hand Hygiene and Standard Infection Prevention and Control policies were replaced with the NIPCM for England. The manual is available on the Trust intranet, Infection Control page for staff to access.

7.0 Infection Control Audit

Criterion 6: *Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.*

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

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

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

7.1 Policy and Practice Audits

A total of eleven policy and practice audits were completed during 2025/26.

In addition, the annual trust wide sharps bin audit was undertaken by Daniels Healthcare in January 2026.

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

7.2 Hand Hygiene and Cleaning Audits

Hand hygiene remains one of the most effective measures to prevent infections and limit the spread of antimicrobial resistance.

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

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

The trust target for both audits is 90%
Average scores for 2025/26 were:

Hand Hygiene	Cleanliness
97.5%	96.4%

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

7.3 Environment Audits

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

Environmental audits undertaken in 2025/26 included:

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

All audits achieved an overall compliance score of **Green (compliant)** except for the minor procedure room in A&E that achieved an overall compliance score of **Amber (Partial Compliance).** This room will be revisited within six months for a repeat audit.

Verbal feedback was provided to staff on the day of the audit, in particular highlighting any areas that required immediate actioning. This was followed by a detailed written report outlining the audit findings and including recommendations for improvement. The reports were sent to Department Managers, Matrons, Heads of Nursing, Link Practitioners and the Estates & Facilities Teams. Staff are required to complete an action plan on Tendable based on the audit findings.

8.0 Patient Information

Criterion 4: *The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.*

A variety of patient information leaflets are available on the Trust intranet Infection Control page for staff and on the Trust website for patients to access. During 2025/26, three leaflets, Endophthalmitis, Infection Prevention and Control at Moorfields Eye Hospital and Infection Prevention and Control advice for External Contract Workers and Trust Volunteers were reviewed and updated. In addition, two new patient information leaflets were developed, Scabies and Head and Body Lice.

8.1 Infection Prevention and Control on Trust Website

The IPC Team has developed a dedicated IPC website page outlining the team's purpose, key roles and responsibilities, providing access to patient information leaflets and the teams contact details. The page also includes photographs of team members alongside their professional biographies to enhance visibility and engagement.

The webpage now enables patients to easily identify who to contact for IPC support and advice and contributes to improving patient confidence in safety standards and the quality of care provided.

8.2 Service Improvement Project

An IPCN undertook a service improvement project over a 7-week period, commencing in early August and concluding at the end of September 2025. Patients were selected via a convenience sampling method from those who had undergone cataract surgery, glaucoma procedures or intravitreal injections.

The aim of the project was to assess whether patients received adequate post-discharge information regarding potential adverse symptoms, such as infection, and whether they felt they understood the information regarding the appropriate actions to take should these symptoms occur.

Data was collected using a structured set of six questions sent to patients via a text message through the DrDoctor platform, one week following their procedure.

This project identified that there were some gaps in the information provided to patients during the patient's surgical pathway and in some cases the information provided was not always understood by the patient.

The findings from this project have been presented at relevant committees and shared with the relevant departmental staff to support local improvements.

The IPCN is working with key stakeholders to implement improvements, including reviewing and strengthening discharge communication process and exploring the availability of patient discharge information leaflets in multiple languages to enhance accessibility and patient understanding. The IPCT ambition is to enable patients to present for clinical care at the earliest onset of post-operative complications for the optimum outcome.

9.0 Outbreaks and Incidents

Criterion 7: *The provision or ability to secure adequate isolation facilities.*

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

9.1 Chickenpox exposure

The IPCNs investigated a case of chickenpox exposure at the Bedford site. The patient was promptly isolated in line with Trust policy, and therefore no other patients were exposed. Staff involved in the patient's care were advised to contact Occupational Health for a risk assessment and to determine any necessary actions. No secondary cases were reported.

9.2 Shingles exposure

In February 2026, a paediatric patient who attended the Urgent Care Centre at Moorfields at St Georges Hospital was subsequently diagnosed with shingles. As this patient presented with a rash, the patient was appropriately isolated from other patients and as a result there were no patients who were exposed and contact tracing was not required. Staff involved in the patient's

care were advised to contact Occupational Health for a risk assessment and to determine any necessary follow-up actions.

9.2 Mpox (Monkeypox) incident

The IPC Team investigated two Mpox incidents: one in April 2025 at City Road and another in May 2025 at St George's Hospital Urgent Care Centre. In both cases, eye swabs taken for conjunctivitis tested positive for the Mpox virus. Following review of the cases by the IPCT, Clinicians and the Health Protection Team (HPT), it was confirmed that neither of the patients had typical symptoms of Mpox or any identifiable risk factors. Furthermore, it was confirmed that Mpox testing had not been intentionally requested in either case.

The review highlighted that the Mpox test option on the pathology request form was next to other ophthalmic tests and therefore was ticked unintentionally.

In the absence of all other factors for Mpox, the results were acknowledged as false positives. Following further communication with the laboratory, it was recognised that the analysers were not accredited for eye swabs and therefore the results needed to be acted upon based on the patient's clinical assessment.

In response, the IPC Team worked collaboratively with the A&E clinical team and the pathology department to amend the pathology request process, the Mpox test option was removed from the standard pathology request form, and staff were advised that Mpox testing must be requested separately if clinically indicated.

Further to this, the IPCN's undertook a retrospective review of Mpox test requests over a two-year period to assess the numbers and presentation of suspected cases**.**

The data review showed that some patients who did not meet the clinical criteria for mpox were tested, that the numbers of suspected cases were low and that no actual positive tests had been reported within the time frame. This information has been shared within the trust and the audit department.

Since the amendment of the pathology request form, and the IPC Team working collaboratively with the A&E clinical leads, no further similar incidents have been reported.

9.3 *Neisseria meningitidis – primary meningococcal conjunctivitis*

Criterion 8: *The ability to secure adequate access to laboratory support as appropriate.*

In December 2025, following a pathology request, the IPCT became aware of several unreported positive *Neisseria meningitidis* isolates from conjunctival swabs collected from patients who attended the Accident & Emergency department with symptoms of conjunctivitis. Primary meningococcal conjunctivitis (PMC), identified on a swab, is not a systemic illness, but it can be a precursor for invasive meningococcal disease (IMD).

An analysis of five years historical data identified that, whilst the patients had received appropriate care and treatment, reporting to the IPCT, Health Protection Teams, and forward

sharing of swabs with the Meningococcal Reference Unit had not been undertaken for more than half of the cases.

Meetings were held with TDL (laboratory) Microbiologist, Health Protection Team, UKHSA and clinical leads to discuss the importance of continued surveillance and agree a process for reporting and managing patient cases. Following the meetings, to help strengthen processes, the IPCNs developed a flow chart defining the reporting process for cases and shared this with the UCLH microbiology team, pathology team and the Moorfields A&E Team. The clinicians were to develop a flow chart for A&E staff on the recognition, assessment and management of suspected and confirmed cases and the laboratory staff were advised to routinely send all positive isolates from conjunctival swabs to the Meningococcal Reference Unit.

9.4 High particle counts at Stratford – Surgicube Theatres

In January and March 2026, the IPCT was notified of incidents involving elevated particle counts in both theatres 1 & 2 in which the Surgicube are located at the Stratford site. Daily particle count monitoring is undertaken to provide assurance of environmental standards within the Surgicube mobile ventilation unit.

Both incidents occurred on Mondays, following weekends during which no activity had taken place, including on the preceding Fridays.

The impact of these incidents resulted in planned surgical activity being unable to proceed, leading to cancellation of theatre lists and delayed procedures.

Meetings were held with key stakeholders including engineers from Spectrum company, the manufacturer of Surgicube' s, and an After-Action Review was undertaken to support the identification of any contributing factors. No issues could be identified in relation to theatre cleaning processes, the air handling unit, or the functioning of the Surgicube' s. Actions to undertake calibration for particle count monitors and develop a user guideline have been undertaken by the EBME department.

Further enquiries regarding the air velocity, turbulence points and integrity of the environment are being undertaken by the estates department.

9.5 National IPC Updates

During the year, the Infection Prevention and Control Team (IPCT) received a range of Health Protection Briefing Notes and national updates from the UK Health Security Agency (UKHSA). These included information on an increase in measles cases across London; vector-borne diseases in the UK and Europe; a rise in Mpox cases (clades 1b and IIb) in England; national guidance (2025) for the management of children with viral respiratory tract infections; updates on the epidemiology of toxigenic diphtheria in asylum seekers arriving in England; Marburg virus disease in Ethiopia; and meningitis information following the outbreak at the University of Kent and in the Canterbury area.

The IPCT reviewed all briefing notes and guidance and disseminated the information to key departments, including the Emergency Department, Urgent Care Centres and the Paediatric Team. The updates were also shared with Heads of Nursing and matrons across all sites. Although the likelihood of patients presenting to Moorfields with these conditions is low, sharing the information ensured that, should a suspected case present, staff would be prepared to safely and appropriately manage the case in line with national guidance.

10.0 Seasonal Vaccination Programme

Criterion 10: *They have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection prevention and control.*

10.1 Trust Winter Flu Campaign

The IPCNs supported the annual staff winter vaccination programme, advising on the planning and delivery, key messages for staff and sharing national and regional data for flu. In addition to this, one IPCN trained as a peer vaccinator and delivered roving vaccine clinics and supported the vaccination hub and flu lead throughout the campaign.

The trust achieved **51.1%** compliance with the flu vaccination of staff, the second highest performing trust in the London region. This was an increase of 3% on the preceding year.

10.2 Respiratory guidance for Patients, Visitors and Staff

In response to the increase in the prevalence of flu cases seen in the winter months in 2025, an increase in hospital admissions and A&E attendances nationally and within the region, to help ensure the safety of patients, visitors and staff, the IPCT issued guidance on IPC measures, which included guidance on wearing a surgical face mask if respiratory symptoms were present, adhering to good hand hygiene practices, decontaminating surfaces regularly, keeping rooms well-ventilated and displaying posters on respiratory etiquette in prominent areas for patients and staff awareness. The communications team also developed in collaboration with the IPCN's patient information for the LCD screens regarding respiratory awareness and protection.

11.0 Eye Bank **by David Essex, Head of Life Sciences**

The Human Tissue Authority (HTA) last inspected the Moorfields Lions Eye Bank in November 2024. Four minor findings previously identified were fully resolved prior to the May 2025 deadline. The next scheduled inspection is expected to be in 2027 once the department transitions to new premises at the Moorfields and UCL Centre for Eye Health.

In 2025 supplementary internal and external audits (22 in total) identified no major shortfalls against the HTA standards and three minor findings. These have subsequently been closed; continual improvement is made to the overall Quality Management System.

There were 1457 ocular products from which 1209 corneas/scleral grafts were procured in 2025, overwhelmingly from the United States as a Third Country Supplier. Six Serious Adverse Events and Adverse Reactions (SAEARS) were raised against these tissues, representing a rate of 0.41%, in comparison the SAER rate for NHS Blood and Transplant (NHSBT) that was 1.12% in 2024.

From the six SAER's recorded internally, one was confirmed by the HTA as relating to the quality and safety of the tissue (Tissue suitability release criteria with respect to Descemet Membrane Endothelial Keratoplasty (DMEK) manipulation in theatre vs DMEK manipulation in eye bank). Five were confirmed by the HTA as not being directly related to the quality and safety of the tissue (three DMEK graft failures and two post operative infections not identified in sister corneas).

Venice Eye Bank continue to supply MEH with a maximum of 2 tissues per week. Overall supplier performance remains unstable, but this is reflective of the international ophthalmology climate, with insufficient donation numbers to meet demand. There are no current plans for a return to NHSBT supplied tissues since it was first raised in the February 2026 Ocular Tissue Advisory Group (OTAG) meeting.

12.0 Decontamination **by Steris Contract Provider**

The Trust has outsourced its Sterile Services provision to external company Steris since November 2023. The facility is currently being run from City Road but will transition off-site before the trust relocation to the new Moorfields and UCL Centre for Eye Health.

12.1 Management

Elizabeth Rainforth, STERIS General Manager, manages the CSSD unit with oversight from the trust Clinical Director of Clinical Support Services, Kerry Tinkler. The trust Decontamination Lead is the CNO and DIPC, Suminthra Naidu.

12.2 Accreditation Status

The department maintains its compliance and certification to an international standard ISO 13485:2016 and Medical Device Regulations (2017/745) — Quality management systems — Requirements for regulatory purposes.

The current certification is valid until September 2026 and will remain valid subject to annual satisfactory surveillance audits. The certification to this standard indicates the testament and commitment in place which demonstrates the ability to process reusable medical devices and related services that consistently meet customer and applicable regulatory requirements. All resources used in the department are assessed to meet all applicable regulatory requirements and standards. All equipment utilised in the department are subject to a strict periodic

preventive maintenance schedule to maintain their good condition, reliable performance and prevent future unexpected failures.

12.3 Monitoring and Test Results

Environmental monitoring is undertaken quarterly via an external provider. All air particulate pressure differentials passed. The pressure differentials gauge Is also calibrated frequently. In addition, microbiological samples that are sent for testing quarterly have all passed.

Bioburden Testing

Instruments are sent quarterly to an independent laboratory for testing. All samples sent are within the required limits.

Machinery Testing

All machinery and equipment are managed directly by the Moorfields Estates Department.

AVM carry out the quarterly and annual testing for all autoclaves and washer disinfectors that are in use.

STS carry out weekly testing on all autoclaves and washer disinfectors that are in use.

PPM Reports

Any quarterly or annual reports received by AVM/ Moorfields Estates department have been reviewed with tests meeting specifications required. Should there be any non-conformities with the results, the recommendations are assessed and a corrective and preventive action plan is implemented to prevent re-occurrence and for improvement.

12.4 Staff Training

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

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

Criterion 2: *The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.*

13.1 Water and Ventilation Safety Group

The Trust has a local Water and Ventilation Safety Group (WVSG) which meets quarterly to discuss issues relating to the operational management of water and ventilation systems and assure compliance with the Trust Water Safety Plan and Ventilation Policy. The group identifies

risks and mitigating those risks through testing, action and adherence to Statutory Regulations, HTM's and other respective guidance.

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

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

Water Safety

Statutory water testing at the trust is undertaken by an independent company and the Estates Team is notified of the findings including details of control measures required. All stakeholders are subsequently informed of the actions to take to mitigate risk. Tests for legionella are carried out monthly at all sites that the Trust are responsible for maintaining (City Road sites, Ealing, Northwick Park, St Anns, Stratford, Hoxton, Brent Cross) and every 3 months at Network sites that a Host Trust or Landlord maintain on our behalf. During the year the WVSG have reviewed positive samples and actions taken, assessed the roles and responsibilities between host site and trust estates teams, planned for introduction of pseudomonas testing in high-risk areas, examined the action tracker across all sites and water risk assessments, with input for the Authorised Engineer for Water.

Theatre Ventilation

All theatres are required to have an annual ventilation inspection undertaken by independent companies to ensure that the theatre facilities meet the required minimum standards as per the Health Technical Memorandum (HTM) 03-01: Specialised ventilation for healthcare premises Part B: and are safe for use. During the year the WVSG reviewed ventilation provision for mobile Surgicube facilities, AHU design at a satellite site with input from the Authorised Engineer for Ventilation, planned update of the trust Ventilation Policy, annual verification reports received and a capital planning project at Ealing.

Bolometer Tests

Although surgical facilities outside the main operating theatres such as intravitreal injection rooms and minor procedure rooms are not required to undergo annual ventilation inspections, the IPCT in collaboration with the Estates Team, sought additional assurance by exploring the use of a bolometer to assess air change rates in these areas. This proposal was agreed by the WVSG.

This year 67% of all identified rooms have had a reading for staff assurance. The IPCT are working with the estates department to improve on this trust wide assurance.

13.2 Capital Planning Projects

The IPC Team remain committed to assisting the Estates department and the Divisions in the development of safe and regulatory standards approved projects which includes the building works, water safety and ventilation in accordance with national guidelines.

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

- Ealing- Proposed Modular Theatre and Paediatric Outpatient Department & review of rooms proposed for the delivery of sub-tenon injections
- St Georges Hospital, Duke Elder Ward & Outpatients Department
- City Road-Rooms proposed for sub-tenon injections.

Oriel IPC Support

The IPC Matron has been contributing to the major Oriel project since 2022, providing specialist advice and guidance on safe standards and regulatory requirements. This work has included advising on design layout, fixtures and fittings appropriate to ophthalmology healthcare, site visits to review mock-up design, meetings with construction partners and attendance and response to Water and Ventilation Safety Group meetings and agenda items.

Further to this, the IPC Matron has undertaken reviews and contributions to change request forms, presented to the Oriel Clinical and Operational Oversight Group, reviewed products, gaps in design provision and undertaken risk assessments for the project leads.

The IPCT have started to undertake regular onsite inspections as part of the building assurance process.



IPCT February 2026 in PPE prior to onsite inspection

14.0 Facilities – Cleaning by Ivor James Soft Services Manager

14.1 National Standards for Cleanliness

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

Medirest is the contracted provider for cleaning, security and catering services at City Road, Brent Cross, Hoxton and Stratford.

Over the past year, the trust has been working towards full implementation of The National Standards of Healthcare Cleanliness 2025. In preparation for this, the IPCT were requested to review all Functional Risk (FR) categories as part of a wider stakeholder group, to achieve the Trusts Cost Improvement Plan (CIP). The IPCT dedicated several weeks to the review of each room and recommended that some areas move from enhanced to standard levels of cleaning where clinically appropriate within areas/departments across City Road, Hoxton, Stratford and Brent Cross.

These changes ensure ongoing compliance with the National Standards of Healthcare Cleanliness 2025 while maintaining patient safety. All functional areas have been formally categorised in line with the national cleaning standards, and compliance with the required standards of cleanliness is monitored through an audit programme. The frequency of audits is determined through the functional risk category assigned to the area/department. Any issues with cleaning identified during the audits are fed back to the Medirest front line managers to address and audit reports are shared with the clinical leads.

Cleanliness is also monitored through monthly cleaning audits undertaken by link practitioners, annual environmental audits undertaken by the IPCNs and bi-monthly walkabouts undertaken by facilities, estates, IPCNs, Medirest and matrons at City Road. These walkabouts are undertaken at some network sites with the matron and domestic service provider supervisor. Key concerns related to cleaning, waste, pest control and linen are included in the monthly Soft Services Manager led Cleanliness Operational Group (COG). The group includes representatives from infection control, estates, Medirest, eye bank and matrons. A summary report from the meetings highlighting any areas that require escalation is submitted to the quarterly ICC.

The IPCT developed the trust Cleaning Policy which was approved in October 2025.

Efficacy audits and the display of Star ratings will commence in the 2nd quarter of 2026.

14.2 Reusable sharps bin trial

A trial of reusable sharps bins, led by Soft Services, was conducted in six clinical areas at City Road in February 2025. IPCNs attended meetings and provided infection prevention and control advice and support to staff in the participating areas. Due to a change in management within the

Soft Services department, the evaluation of the trial was repeated. The outcomes will be shared at relevant meetings, where a decision will be made on whether to proceed with wider implementation of reusable sharps bins.

14.3 Patient-Led Assessment of the Care Environment (PLACE)

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

The IPCN's were key contributors to the annual PLACE assessment undertaken at the trust in November 2025. Three sites were inspected, City Road, Brent Cross and Northwick Park network sites.

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

Overall scores for each category for each site were:

Site	Cleanliness	Food-Ward	Privacy, Dignity & Well being	Condition and Appearance	Dementia	Disability
MEH at City Road	99.58%	90.24%	85.51%	100%	93.60%	93.66%
MEH at Northwick Park Hospital	98.08%	NA	78.57%	100%	89.13%	92.5%
MEH at Brent Cross	97.96%	N/A	61.11%	99.04%	N/A	94.12%

An action plan has been developed by the Soft Services Manager to address the issues identified from the assessment. This is being completed by the PLACE Working Group and progress is monitored at the Cleanliness Operational Group.

15.0 Education and Training

15.1 Infection Control Mandatory Training

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

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

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

The trust overall average compliance for clinical staff was **86%** and **93%** for non-clinical staff achieving above the trust target of **80%**.

15.2 Infection Control Link Practitioners

The trust has link practitioners in clinical areas across all sites. The role of the Infection Control Link Practitioner follows the Royal College of Nursing framework "The role of the link nurse in infection prevention and control" (2021). Link practitioners are a key resource for disseminating infection control information and promoting IPC standards locally within their departments and within the organisation.

During 2025/26 two half day in person workshops were held for link practitioners, one in June and then November 2025. The workshops were well attended and included staff from many satellite sites. A variety of topics including sharps management, water safety, environmental cleaning – National Standards of Healthcare Cleanliness 2025, antimicrobial stewardship, IPC Audits and red eye/endophthalmitis were presented. Link practitioners were encouraged to share the learning with their colleagues in their clinical areas.

15.3 Awareness Raising Events

World Hand Hygiene Day May 2025

The theme for World Hand Hygiene Day was *"It might be gloves. It's always hand hygiene*." To mark the day, the IPCNs shared posters and other promotional materials with all departments and network sites, promoted key messages on the importance of hand hygiene and appropriate glove use via the intranet, and delivered educational sessions during a 'Lunch and Learn' for all staff, as well as at a Clinical Governance half-day event held in Bedford.

International Infection Prevention and Control Week October 2025

The theme for the week was "*IPC Champions: Leading the Way to a Safer Healthcare*." The IPCNs used the week to highlight key areas of infection prevention and control and to recognise the vital contribution of all staff working to prevent infections and protect patients.

An IPC awareness stand was held in the restaurant at City Road, where the IPC Team promoted a range of topics, including tuberculosis awareness, shared innovative ideas and products, and discussed how IPC supports the Trust's Green Plan.

Resources were shared with link practitioners across network sites, with many undertaking local activities to support the week. These included running quizzes, developing teaching presentations on antimicrobial resistance, displaying IPC messages on waiting room screens, and hosting display stands.





World Antimicrobial Resistance Awareness Week 17th-21st November

The IPCNs supported the antimicrobial pharmacist during Antimicrobial Resistance Awareness Week by promoting key messages on the appropriate use of antimicrobial agents within ophthalmology and the importance of adherence to good infection control measures to reduce the risk of infection and need for antibiotic treatment. An awareness stand was held in the restaurant at City Road, where staff were engaged on actions that can be taken to reduce antimicrobial resistance and the initiatives currently in place at MEH to help address AMR.

The Infection Control Bug Brief

Each month the IPCNs developed a bug brief (infection control newsletter) for staff. The bug brief covered a variety of infection control topics during the year including hand hygiene, correct use of personal protective equipment, sharps safety, tuberculosis awareness, managaement of patients and staff with respiratory symtoms, flu vaccination information and meningitis awareness.

Presentations at the International Infection Prevention Society (IPS) Conference

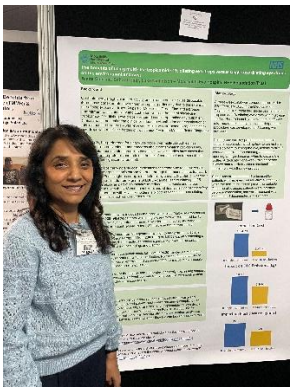
The IPCN's presented some of their work at the two-day Infection Prevention Society (IPS) Conference held in September 2025. The international conference had for the first time included ophthalmology on the agenda and Moorfields was the only provider presenting in this specialist field.

One team member delivered an oral presentation on endophthalmitis following Ozurdex implants, presenting findings from a 10-year review conducted at Moorfields Eye Hospital.



Nadine Grant-McKenzie, Lead IPCN presenting at the IPS Conference, Brighton 2025

Two posters were also presented by the team; the benefits of replacing single-use Tropicamide 1% eye drops with multi-use bottles, demonstrating potential reductions in waste and cost without compromising patient safety, and reducing the rate of post-Ozurdex endophthalmitis, supporting the oral presentation and contributing to the wider discussion on ophthalmic infection prevention. Both posters were published in the IPS journal for wider reading.




Amita Sharma and Nadine Grant-McKenzie with posters at IPS

Overall, the IPCN's participation in the conference demonstrated a strong commitment to advancing infection prevention practices and sharing evidence-based learning within the wider professional community.

IPCN Awards

In May 2025, the Infection Control Nurse was chosen by the trust to receive the prestigious Daisy Award. This recognised the compassion shown by our IPCN in their work with patients and staff, delivering day to day solutions to protect patients and support clinical care, excellence in academic achievements and the ability to go above and beyond in their work for the service and trust.



Temar Teklu, Infection Control Nurse

IPCT Projects

Sustainability

An IPCN is a member of the Trust sustainability steering group and has been involved in providing IPC advice for the trial that was undertaken to replace single use Tropicamide 1% eyedrops with multi-use bottles. The IPCN has attended workshops held in the theatre department at City Road, looking at several initiatives where changes could be made to current practices and procedures to meet the net zero carbon agenda, within the safe guidelines of IPC such as reusable theatre hats, repacement of nail brushes in theatre with nail picks and reusable torniquets.

Conclusion

Overall, the IPC Annual Report for 2025/26 highlights key achievements and areas of improvement through compliance criteria set out in the Health and Social Care Act and the IPC BAF encompassing all aspects of infection prevention and control to safeguard patients and staff.

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

Looking ahead to 2026/27, the IPCT will endeavour to deliver an annual IPC programme of work. This will include supporting antimicrobial stewardship through the development of an action plan aligned with the NAP AMR strategy, in collaboration with the Trust antimicrobial

pharmacist and key stakeholders. The team will lead on the winter flu campaign for the first time and assist with the Trust's two major projects, Oriel and the Electronic Patient Record (EPR) to the fullest extent, whilst supporting the safe implementation and transition for patients, visitors, and staff.

The team will remain committed to maintaining high standards within IPC, taking every opportunity to understand further the contributory factors to infection risks within ophthalmology, working collaboratively with staff, patients, and service users to ensure care is delivered in a clean and safe environment.

References

1.The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015). Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)

2. NHS England » National infection prevention and control Board Assurance Framework

3. The Royal College of Ophthalmologists' National Ophthalmology Database Study of Cataract Surgery: Report 13, monitoring post-cataract surgery endophthalmitis rates—the rule of X, 2024 springernature_eye_2917 1386..1389

4. National Action Plan Confronting antimicrobial resistance 2024 to 2029 - GOV.UK

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

6.Candidozyma auris (formerly Candida auris): guidance for acute healthcare settings - GOV.UK

7. Guide to preoperative testing: Adult MRSA screening and suppression/eradication prophylaxis for patients who are on an elective surgical pathway (May 2025) https://gettingitrightfirsttime.co.uk/wp-content/uploads/2025/05/GIRFT-Guide-to-preoperative-testing-MRSA-May-2025.pdf

8. Patient-Led Assessments of the Care Environment (PLACE), 2025 - NHS England Digital

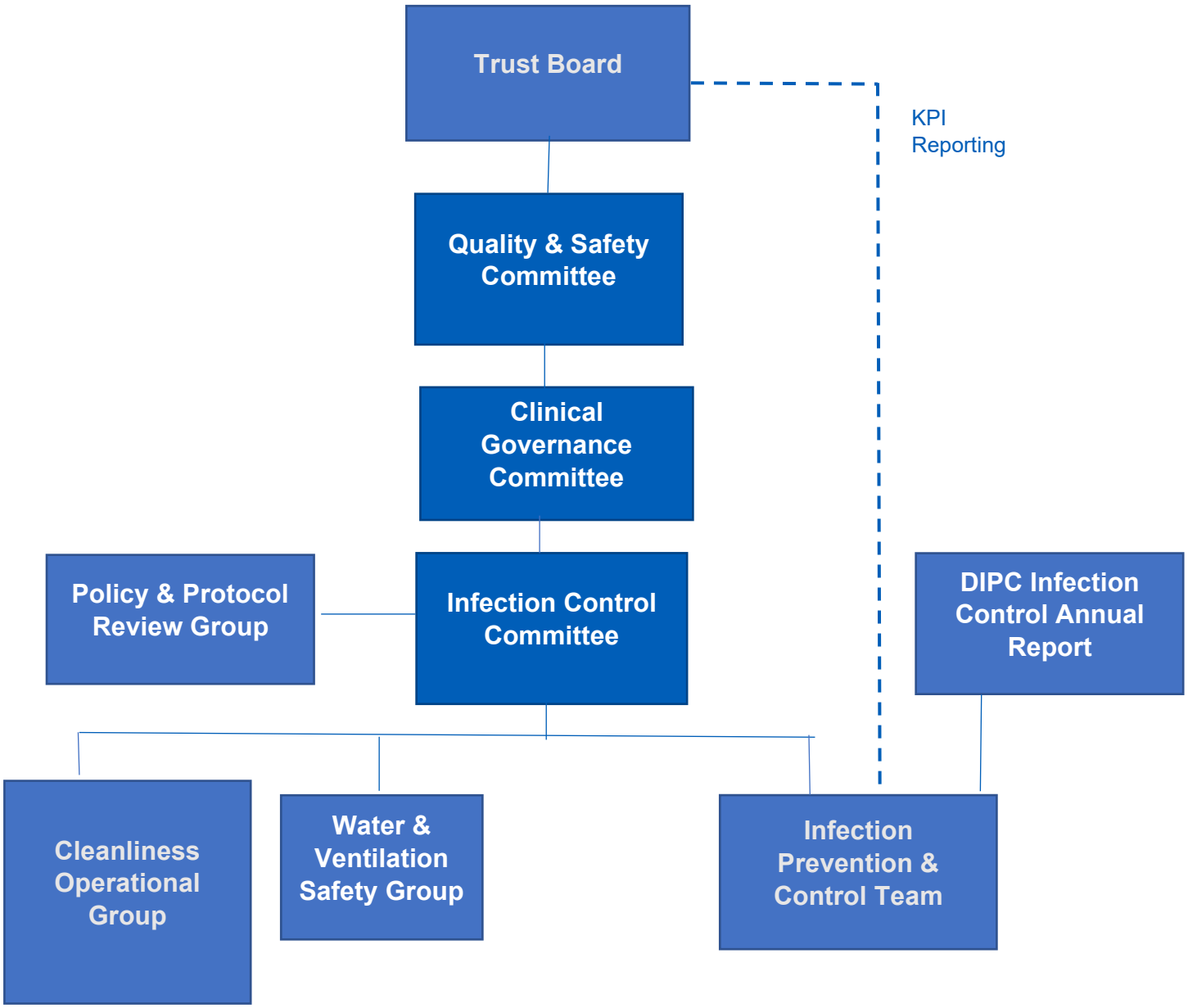
9. World Hand Hygiene Day 2025

10. NHS England (2008) Board to Ward: How to embed a culture of HCAI prevention in acute trusts DEP2009-0635.pdf

Appendix 1

Infection Prevention & Control Governance

Reporting & Accountability Structure



Appendix 2

Moorfields Eye Hospital NHS Foundation Trust

NHS

Terms of reference

Infection Control Committee

1. Authority

The Infection Control Committee has been established by the trust board of directors and reports directly to the Clinical Governance Committee. The Director of Infection Prevention and Control also reports directly to Board.

2. Purpose

The purpose of the Infection Control Committee is:

a) To provide strategic leadership and direction on infection prevention and control activities across the Trust to ensure that the risk of avoidable healthcare associated infections is minimised.

b) To oversee the effective implementation of The Health Act 2008: Code of Practice for the Prevention and Control Infections and all other relevant legislation and guidance

c) To make recommendations as appropriate on infection prevention and control matters to the Board of Directors.

3. Membership

The core membership of the Infection Control Committee will be as follows:

- Chairman of the Committee – Consultant Ophthalmologist
- Director of Infection Prevention and Control (DIPC) – Chief Nurse and Director of AHP's
- Infection Control Doctor – Consultant Microbiologist GSTT
- Deputy DIPC – GSTT
- Infection Control Matron and Deputy DIPC
- Antimicrobial pharmacist
- Infection Prevention & Control Nurses
- Occupational Health Manager
- Head of Facilities Management
- Health Protection Team -UK Health Security Agency Representation

- Heads of Nursing – City Road, North and South divisions, Private Patients
- Clinical Director – Clinical Support Services
- Quality Lead

Representatives may also be required from the other divisions and departments as and when required.

Members are expected to attend at least 75% of meetings. Where a deputy attends, this will count towards the member's attendance.

If a member is unable to attend, then apologies should be sent in advance with details of the nominated deputy.

Members of the committee are required to provide and/or review quarterly documents as evidence of compliance with Code of Practice and address items of concern that may require escalation within the trust.

The key focus of the committee will be to review summary reports from reporting groups and across the trust, focusing on strategic objectives for the trust and IPCT.

4. Quorum

The Committee will be deemed quorate if there is representation of not less than five members from at least three different sections, this must include a senior ICT member. A meeting of the Committee at which the quorum is present will be competent to exercise all of the authorities, powers and duties vested in or exercised by the Committee. If members cannot attend, a nominated deputy will be expected to attend, and this person will count towards the quorum.

5. Attendees

Infection Control administrator and staff outlined in membership of the committee. Members may send a deputy representative.

6. Duties and responsibilities

The Infection Control Committee is responsible for the prevention and control of infections throughout Moorfields Eye Hospital NHS Foundation Trust. The specific duties of the group are:

- To report, advise, minimise and escalate as necessary, areas of risk associated with infection prevention and control.
- To act as infection prevention champions, disseminating information and good practice as appropriate.
- To review incidents involving infections and provide the opportunity for expertise to guide the investigating team if necessary and support implementation of preventative measures.
- To ensure that trust surveillance of infection data are monitored regularly and that any variation from the acceptable standard is identified with corrective actions taken in a timely fashion.
- To provide a forum for discussing issues related to infection prevention and control matters as required under the organisational responsibility in meeting the Health and Social Care Act 2008 (Amended 2015), code of practice for the prevention and control of infection
- To support delivery of the Trust's Infection Control Annual Programme of Work.

- To uphold best practice in antimicrobial stewardship, monitoring compliance with trust prescribing policies and supporting national programmes.
- To monitor and review current and new practices in management of infection prevention in response to alerts/recommendations/instruction from external agencies including UK Health Security agency, Medicines and Healthcare products Regulatory Agency (MHRA), National Institute of Clinical Excellence (NICE), Department of Health, alerts received from via the Safety Alert Broadcast System (CAS).
- To approve the infection control annual report prior to its submission to Clinical Governance Committee and then Quality and Safety Committee.

7. Frequency of meetings

The committee shall meet every three months.

8. Reporting and review

The Committee reports to the Clinical Governance Committee (CGC).

The terms of reference will be reviewed on an annual basis.

9. Administration

The agenda and papers will be circulated one week prior to the meeting. At the discretion of the chair papers may be tabled at the meetings. Draft minutes of the meetings will be formally recorded and distributed to all members prior to the next meeting.

The infection control administrator shall take notes of all meetings of the Committee, including recording the names of those present and in attendance. Notes of the meeting will record actions arising from the meeting.

10. Subgroups

The committee has established the following subgroup/s to help fulfil its duties

- Water and Ventilation Safety Group
- Cleanliness Operational Group
- Infection Prevention & Control Operational Group

Terms of reference for these groups will be approved by this committee.

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 these groups.

Approved by: Infection Control Committee

Date: July 2025

Date of next review: July 2026

Appendix 3

Moorfields Eye Hospital NHS Foundation Trust

NHS

Infection Control Programme of Work 2025/26

Introduction

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

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

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

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

- Surveillance of key alert organisms reported monthly and quarterly.
- A planned programme of training and education
- Audits of policies and practices
- IPCN audits of high-risk areas throughout the trust
- Update or development of policies and protocols as required in accordance with national guidelines.
- Delivering key campaigns and projects for IPCT Action
- Supporting the trusts strategic objectives, to collaborate on delivering major projects of Oriel and EPR

The trust aspires to always be compliant with the Health and Social Care Act 2008 (amended 2022) and registration with the Care Quality Commission (CQC). Actions required to achieve the registration standards will inform the IC Programme of Work. In addition to this, the IPC Board Assurance Framework is reviewed regularly and shared with the QSC bi-annually.

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

The IPCT commit to implement the National Action Plan (NAP) Confronting antimicrobial resistance 2024 to 2029 in accordance with the relevant themes and outcomes for the trust.

Surveillance

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

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

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

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

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

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

Training and Education

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

Programme	Frequency	Mode of delivery	Responsible Person/s
Awareness Training Level 1 – Non-clinical staff	3 yearly	E-Learning	Online
Awareness Training Level 2 – Clinical staff	Annually	E-Learning	Online
Link Practitioners' Workshop	Bi-annual	Face-Face	Infection Prevention and Control Nurses
Education programmes developed as required	Ad-hoc	Online or face to face	Infection Prevention and Control Nurses

Audit

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

Policy	Frequency	Responsible Person/s	Timescale	2023/24	2024/25	2025/26
Standard Precautions	Annually	Link Practitioners	February	97.6%	96.4%	97.5%
Sharps Management	Annually	Link Practitioners	March	98.6%	95.8%	95.5%
Isolation Precautions	Annually	Link Practitioners	June	96.7 %	97.1%	98.4%
Surgical Site Infection	Annually	Link Practitioners	August	100%	100%	100%
Antimicrobial prescribing policy + Antibiotic sensitivity data	Annually	Antimicrobial pharmacist		Fluoroquinolone px audit Antibiotic px compliance in MPEC audit	Voriconazole monitoring audit	

Practices	Frequency	Responsible Person/s	Timescale	2023/24	2024/25	2025/26
Hand Hygiene	Monthly	Link practitioners	ongoing	98.2%	97.7%	97.6%
Cleanliness	Monthly	Link practitioners	ongoing	97.3%	96.5%	97.4%
Toilets and Bathrooms	Annually	Link Practitioners	April	96.5%	96.6%	96.0%
Slit Lamps	6 monthly	Link practitioners	January	97.0%	97%	98.7%
			July	98.4%	98%	98.6%
Venflon Insertion Technique	Annually	Link Practitioners	August	100%	98%	99.6%
Decontamination	Annually	Link Practitioners	September	99.5%	99.5%	99.1%

Practices	Frequency	Responsible Person/s	Timescale	2023/24	2024/25	2025/26
Hand Hygiene Facilities	Annually	Link Practitioners	October	97.8%	98%	98.3
Sharps Bins	Annually	Daniels	January	Completed	96.8%	94.5%
Linen, Curtains and Blinds Audit	Annually	Link Practitioners	February	94.7%	95.1%	89.2%

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

Environmental Audits

Annual environmental audits are undertaken by the IPCNs for the following areas:

Location	2023-24	2024-25	2025-26
Operating theatres			
Stratford x 2	**Opened November 2023**	**New Site 96.4% June**	**94.2% May 2025**
St George's Theatres x 2	**Completed**	**93.7% June**	**95.8% June 2025**
QMR Theatres x 1	**Completed**	**97.1% June**	**Closed**
Potters Bar Theatres x 1	**92.9% June 2023**	**87.5% July**	**91.3% July**
City Road Theatres x 10	**91.6% June 2023**	**91.1% July**	**88.3% July**
CUH Theatres x 1	**93.4% July 2023**	**94.4% September**	**92.6% July**
Ealing Theatres x 1	**94.4% July 2023**	**95.7% September**	**95.7% August 2025**
Bedford Theatres x 1	**94.3% July 2023**	**96.3% September**	**95.5% August 2025**
St Ann's Theatre x 2	**91.4% December 2023**	**88.3% December**	**91.4% October 2025**
Northwick Park Theatres x 1	**95.5% March**	**92.4% December**	**92.9% October 2025**
MPEC Theatre x 1	**92.5% March**	**96.6% February 2025**	**98.5% February 2026**

Intravitreal Injection rooms			
St Ann's Injection room x 2	**90.4% December**	**81% December will be repeated in June 2025**	**91.7% June 2025 95.5% October 2025**
Stratford x 2	**Opened November 2023**	**New site 91.7% June 2024**	**87% May 2025**
RTU - 3rd Floor x 4	**83.3% November 2023 – Due May 2024**	**91.7% June 2024**	**100% June 2025**
St George's Injection Room x 2	**Completed**	**100% June 2024**	**91.7% June 2025**
Clinical Research Unit x 1	**95.8% May 2023**	**91.7% July 2024**	**100% June 2025**
Croydon Injection Room x 2	**81.8% - March Will be repeated in 6 months – Sept 2024**	**87.0% September 2024**	**91.3% July 2025**
Bedford North Wing IV Suite x 2	**95.7% July 2023**	**Now situated in South Wing 95.8% September**	**91.3% August 2025**
Ealing Injection Rooms x2	**91.3% July**	**100% September**	**95.7% August 2025**
MPOC 2nd Floor Injection Room x 1	**95.8% December 2023**	**95.8% December 2024**	**91.3% October 2025**
Northwick Park Injection Rooms x 2	**91.7% March**	**95.8% December 2024**	**95.7% October 2025**
MPEC IV rooms x 1	**95.8% March**	**95.7% February 2025**	**98.5% February 2026**
Sir Ludwigg Guttmann Injection Room	**90.9% July 2023**	**Site closed**	
Minor operation rooms			
MPOC Minor Ops/Treatment Room	**95.7% December 2023**	**87.5% December 2024**	**82.1% October 2025 Will be repeated in 6 months April 2026**
Minor Ops Room (A&E City Road)	**94.6% December 2023**	**89.7% December 2024**	**92% October 2025**
MPEC Ops/Treatment Room x 1		**100% February 2025**	**100% February 2026**
Wards			
Duke Elder Ward		**94.9% June 2024**	**98.2% June 2025**
RDCEC Ward	**94.8% October 2024**	**93.3% October 2024**	**94.9% September 2025**
Mackellar Ward		**93.3% December 2024**	**91.4% September 2025**
Observation Bay		**95.1% December 2024**	**95.4% October 2025**
Sedgwick Ward		**92.3% January 2025**	**95.7% November 2025**
Cumberlege Ward	**95.6% January 2024**	**98% February 2025**	**95.9% February 2026**

A&E/UCC			
A+E RDCEC-Paediatric	**93.3% August**	**94.8% October 2024**	**97.6% September 2026**
A+E City Road-Adults		**92.4% February 2025**	**94.5% February 2026**
UCC St Georges			**96.4% April 2025**
UCC St Bedford			**93.4% August 2025**

Policy Review

Blood Borne Virus	Published November 2025
Clostridioides difficile Infection	Published November 2025
Diarrhoea and Vomiting	Published
Linen Handling and Laundry	Published March 2025
MRSA	Published March 2025
SOP/Protocol/Guidelines	Review Date
Mpox Management	Published November 2025
Surgicube SOP	Published October 2025
Toul Guideline	Published February 2026
Candida auris Management	Published October 2025
Adenovirus (A&E) Protocol	Published March 2025
Enhanced Cleaning of an Intravitreal Injection Room	Published March 2025
Head Lice, Body Lice & Scabies	
Patient & Visitor Information Leaflets	Review Date
Endophthalmitis leaflet	Published June 2025
Head & Body Lice	Published April 2026
Scabies	Published April 2026
TOR	
IPCOG	April 2025
ICC	May 2025

Projects/Campaigns

Project	Timescale/Actions	Responsible Person/s
Develop Trust NAP Action plan in collaboration with key stakeholders	Draft for ICC July 2025	C.Wagland/H.Parvez
Oriel IPC agile working pilot	May to October 2025	ICN's
Oriel and EPR major programme assistance	Ongoing/Continual	C.Wagland
Patient Discharge Information Evaluation Project	Project approval, data retrieval and evaluation by December 2025	A.Sharma

Review the existing environmental standards for Surgicube use and develop the definitive guideline/SOP	September 2025	N.Grant-McKenzie
Discovering innovative IPC means for sustainability and cost savings, sharing for trust implementation	Ongoing/Continual	A.Sharma
Develop a draft IPC Strategy for the trust	December	C.Wagland with key stakeholders
Hand Hygiene and Religious and Cultural Beliefs	May to September	T.Teklu, C.Wagland, A.Sharma, N.Grant-McKenzie
IPC National Awareness Week	October 19 – 25th	T.Teklu, C.Wagland, A.Sharma, N.Grant-McKenzie
World Antimicrobial Awareness Week	November 18 – 24th	ICN's and stakeholders
Revised IPC web page	December	A.Sharma