Bundle Board of directors - Part 1 26 September 2024

1 08:45 - Welcome
240926 TB Part I Item 00 Agenda

2 08:50 - Patient story
Kathy Adams and Ian Tombleson - note

3 Apologies for absence
Laura Wade-Gery - note

4 Declarations of interest
Laura Wade-Gery - note

5 Minutes of the previous meeting
Laura Wade-Gery - approve
240926 TB Part I Item 05 Minutes of Meeting in Public (LWG)

6 09:10 - Matters arising and action log
Laura Wade-Gery - note
240926 TB Part I Item 06 - Actions log

7 09:15 - Chief executive's report
Martin Kuper - note
240926 TB Part I Item 07 CEO report_MK

8 09:25 - Integrated performance report
Jon Spencer - assurance
240926 TB Part I Item 08 Integrated Performance Report - August 2024 (OPEN Version)

9 09:35 - Finance report
Jonathan Wilson - assurance
240926 TB Part I Item 09 Public Finance Performance Board Report - Final

10 09:45 - Medical revalidation
Louisa Wickham - approval
240926 TB Part I Item 10 Appraisal and Revalidation Framework for Quality Assurance - Board Report 2024_final2

11 09:55 - PSIRF implementation review
Kathy Adams and Kylie Smith - assurance
240926 TB Part I Item 11 PSIRF Update FINAL (v.1.0)

12 (to receive) Safeguarding Adult annual report
Kathy Adams - assurance
240926 TB Part I Item 12 Safeguarding Adults Annual Report 2023 - 2024 Final

13 (to receive) Safeguarding Children & Young People annual report
Kathy Adams - assurance
240926 TB Part I Item 13 Safeguarding Children and Young People Annual Report 2023 - 2024 Final (3)

14 10:05 - (to receive) Infection prevention & control annual report
Kathy Adams - assurance
240926 TB Part I Item 14a Infection Control Annual report 23-24 cover sheet
240926 TB Part I Item 14b Infection Control Annual report 23-24 FINAL

15 10:15 - Committee reports
a) Quality & Safety Committee report: Andrew Dick/Laura Wade-Gery - assurance
b) People & Culture Committee report: Aaron Rajan - assurance
c) People & Culture Committee Terms of Reference: Aaron Rajan - approval
d) Membership Council Committee: Laura Wade-Gery - assurance
240926 TB Part I Item 15a QSC summary report
240926 TB Part I Item 15b LWG Report of the People and Culture Committee
240926 TB Part I Item 15c People and Culture Committee ToR
240926 TB Part I Item 15d Membership Council report (LWG final)

16 Identifying any risks from the agenda
Laura Wade-Gery - note

17 Any other business
Laura Wade-Gery - note

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on
Thursday 26 September 2024 at 08:45 at Moorfields Education Hub

No.	Item	Action	Paper	Lead	Mins
1.	Welcome	Note	Oral	LWG	5
2.	Patient story	Note	Oral	KA/IT	20
3.	Apologies for absence	Note	Oral	LWG	5
4.	Declarations of interest	Note	Oral	LWG	
5.	Minutes of the previous meeting	Approve	Enclosed	LWG	
6.	Matters arising and action log	Note	Enclosed	LWG	
7.	Chief executive's report	Note	Enclosed	MK	10
8.	Integrated performance report	Assurance	Enclosed	JS	10
9.	Finance report	Assurance	Enclosed	JW	10
10.	Medical revalidation	Approve	Enclosed	LW	10
11.	PSIRF implementation review	Assurance	Enclosed	KA/ Kylie Smith	10
12.	(to receive) Adult safeguarding annual report	Assurance	Enclosed	KA	10
13.	(to receive) Children safeguarding annual report	Assurance	Enclosed		
14.	(to receive) Infection prevention & control annual report	Assurance	Enclosed		
15.	Committee reports • Quality and Safety Committee • People & Culture Committee & Terms of reference • Membership Council	Assurance Approve Assurance	Enclosed Enclosed Enclosed	AD AR LWG	5
16.	Identifying any risks from the agenda	Note	Oral	LWG	
17.	Any other business	Note	Oral	LWG	
18.	Date of next meeting – 28 November 2024				

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
DRAFT Minutes of the meeting of the Board of Director held in public on 25th July 2024 in the Lecture Theatre at Moorfields Education Hub (and via MS Teams)

Board members:	Laura Wade-Gery (LWG)	Chair
	Martin Kuper (MK)	Chief executive
	Andrew Dick (AD)	Non-executive director
	David Hills (DH)	Non-executive director
	Richard Holmes (RH)	Non-executive director
	Asif Bhatti (AB)	Non-executive director (via MS Teams)
	Rosalind Given-Wilson (RGW)	Non-executive director
	Nick Hardie (NH)	Non-executive director
	Aaron Rajan (AR)	Non-executive director
	Sheila Adam (SAd)	Chief nurse and director of AHPs
	Jonathan Wilson (JW)	Chief financial officer
	Jon Spencer (JS)	Chief operating officer
	Louisa Wickham (LW)	Medical director (MS Teams)
In attendance:		
	Mark Gammage (MG)	Interim director of workforce
	Sam Armstrong (SAr)	Company secretary (minutes)
	Xiang Yin (XY)	Head of nursing for the South (item 2)

A number of staff and governors observed the meeting in the room and online, including: Rob Jones, Emmanuel Zuridis, Professor Naga Subramanian, John Sloper, Allan MacCarthy, Vijay Arora, Dinesh Solanki, Robert Goldstein, Yasir Khan, Nic De Beer (committee secretary) and Pete Thomas (director of digital development and CCIO).

1. Welcome

The chair opened the meeting at 9.00am and welcome all present and in attendance. Introductions by all were completed.

She noted in opening the meeting that it was Ros Given-Wilson's last board meeting as a non-executive director.

2. Staff story

The chair welcomed Xiang Yin to present his staff story to the Board.

MG introduced the item.

XY provided background to his role and the organisational structure he worked within, including the number of staff. It was noted that he held the most senior nursing role in the division. He had joined the Trust in 2010, having previously been trained in renal nursing. He reflected that often people were promoted due to their skills in the function they worked rather than possessing good management and leadership skills.

He was proud of the contribution he made to the division having significant participation in the staff survey. They achieve 72% response rate, which was the highest in the Trust, and a big increase from previous years. They also improved on the metrics within the survey.

XY provided insight to his leadership style. He attended the staff huddles in the morning and believed in the power of personal communication with staff, as well as being approachable. The huddles were an important opportunity to connect with staff on the "shop floor". He reported that he had needed to learn how to communicate effectively, as at first he was given no guidance or training and had not had the experience. He believed in aiming high as even if one misses, there was usually still improvement.

XY turned to some of the challenges he experienced and observed in his division. He reported that while City Road had good rapport with estates colleagues, this was much more challenging at the network sites, since they were typically working with site estates teams that were not Trust staff, belonging to the host Trust and might have different priorities.

Patient transport was a real issue as well. For example, he thought that as St George's Hospital was so much bigger than the Moorfields service, the demands tended to go to the St Georges patients. It was also difficult tracking down the data needed on this. There was also a lack of transport KPIs, which made it difficult to monitor properly.

LWG thanked XY for his presentation. DH reflected and commended XY on his visibility in the division. In response to a question from RH, XY stated he learned that to listen to staff and question to bring out more of their views was very powerful. In response to a follow up question from LWG, he stated that the big difference to his performance as a leader was being able to reflect, which he learned from coaching and mentoring. SAd agreed on the value of coaching and mentoring and suggested it needed to go deeper in the organisation than just senior management.

LWG asked JS how the Trust could ensure support was given to operational teams by other Trusts. JS reported that the Trust met regularly with network site teams to assess and try to build relationships with local trusts and organisations where Moorfields was providing a service. Transport could be challenging, and the Trust team tried to assist with discussion, however it was not always easily fixed. MK stated that improvements were observed at City Road after lots of pressure was applied and this needed to be applied at other sites. St Ann's had a particular challenge as it had no contract and SLAs. The Trust was working to fix this.

The Board noted the staff story and thanked XY for both his leadership and his openness.

3. Apologies for absence

An apology was received from Adrian Morris, non-executive director.

4. Declaration of interest

There were no declarations made.

5. Minutes of the previous meeting

The minutes of the meeting held 6th June were approved as a correct record.

6. Matters arising and action log

The action log and updates were noted.

7. Chief executive's report

MK highlighted key areas of his report, which included:

- It had been a challenging start to the year with diminished activity, however the Trust was responding well;

- As part of the Trust's ongoing mutual aid, the Trust was undertaking work with Royal London, which was proving positive;
- The Trust had been awarded the contract as lead provider for single point of access for NCL. This demonstrated confidence in the Trust. In response to a question from LWG, JS confirmed the contract would commence in December 2024.
- Oriel was progressing well. SAd added that she was leading on the last half mile and a large coalition had been established to assist in these developments, including three governors.
- It had been announced that MEDITECH had been selected as the Trust's preferred EPR partner.
- To complement the staff survey action plan the quarterly pulse surveys had now been reinstated.
- The Trust was broadly on track financially. NCL was financially adequate, however there were significant challenges across the country.
- The Board noted that Sue Steen and Dr Elena Bechberger had been appointed as CPO and director of strategies and partnerships, respectively.

The Board noted the report.

8. Integrated performance report

JS presented the report.

The Trust's 18-week referral to treatment was stable and demonstrating some recent improvements. The number of patients waiting over 52 weeks had improved to seven. While elective activity improved in-month, the Trust was still behind plan year-to-date. Opportunities to increase elective activity were being explored. There were some gaps in rota and training and some variation by site for cataract waits, which all needed further investigation.

The average call waiting time was now showing as a failing process, with both waiting time target and call abandonment rate being below target for six months. The results were driven by an increase in call volumes and by implementation issues with changes to referrals management processes in the Booking Centre.

Sickness absence had improved, as had referrals, however more improvements were necessary in appraisal completion. MG added that a working group was focused on this, which was overseen by People and Culture Committee. There was some preference expressed for the Trust moving to a common annual appraisal date rather than the current individual's start date anniversary. The Trust was also still moving from a paper system to an electronic one. In response to a question from AR it was noted that the staff survey had identified that quality of appraisal was an issue; he suggested working to an end-to-end process and to take into account the right amount of time needed to complete the process.

The Board noted the report.

9. Finance report

JW presented the report.

It was noted that the Trust was reporting an in-month surplus of £0.64m against a planned surplus of £0.55m, which was a £0.09m favourable variance. The cash balance at 30th June was £69.2m, a reduction of £1.5m from the March position. Capital spend at 30th June was £13.9m.

The Trust had a planned efficiency programme of £10m for 2024/25 to deliver control target. The Trust had identified and was forecasting £5.2m, leaving £4.8m to be identified. Stratford was at 42% of ERF activity and mitigations were in place. In response to a question regarding ERF uncertainties, JW confirmed that the Trust was still working to draft guidance only as it had yet to be confirmed.

Contracts agreed were at circa 50% and it was hoped all would be agreed and signed by end of July.

LWG pointed out that recruitment needed to be easier to complete to avoid the Trust needing to use bank and agency. MK added there were ongoing issues with the effectiveness of bank as well. In response to a question from AD, MG advised that there was a shortage of specialist and skilled staff. It was also noted that agency use was now under national scrutiny, which would make using senior and specialist interim staff more difficult.

The Board noted the report.

10. Guardian of safe working

LW presented the report.

It was noted that the current trainees finished at the Trust at the end of July. The Trust was preparing to ensure a good induction for the next cohort in August.

It had been observed that there was a reluctance for those in place to undertake extra hours when gaps appeared, which could be a challenge at times for the Trust. It was thought that in general doctors were not wanting to work more hours. It was added that this was observed in other trusts and more broadly in other industries at present as well.

The Board noted the report.

11. Freedom to speak up

SAd presented the report.

It was noted that the details behind the various cases would be discussed in part two of the meeting.

In response to a question from AB, it was reported that long standing issues had contributed to the current numbers presented for the cohort 'admin and clerical'. Increased opportunities to report via FTSU, including anonymously, had helped resolve some issues. AR suggested that engagements needed positive responses. It was agreed that presenting waiting times was helpful.

In closing the item, LWG noted that previously it was evident that staff were reluctant to speak up so it was an encouraging sign seeing an increase in issues raised.

The Board noted the report.

12. Committee reports

a. Quality and Safety Committee

RGW presented the report.

It was noted that the committee was aware that a comprehensive review of ophthalmology patient referrals at Bedford was being undertaken. No patient harm had so far been identified but detailed investigation was ongoing. The issue had also been escalated to the Bedford Hospital Trust CEO. The switch to Openeyes would be occurring in October, and then IT at Bedford for the Trust eye services would transfer across to the Trust. It was agreed the Trust needed to insist on these developments being completed together with direct commissioning, or it would no longer be willing to provide the service.

The Board noted the report.

b. Membership Council

LWG presented the report.

It was noted that it was a comprehensive report of the last meeting, which was taken as read by the Board and noted.

13. Register of interests

The Board noted the latest register of interests of Board members.

14. Identifying any risks from the agenda

The Board noted two risks during the meeting:

- That related to Trust services hosted at Bedford; and
- Performance of Private.

15. Any other business

LWG thanked RGW for her significant service to the Board and Trust in her over nine years as a non-executive director. She had arrived at a significantly challenging time for the Trust and overseen as a non-executive the move to a clinical leadership model. RGW responded by thanking colleagues and commenting that she had worked with a great group of people, and it was pleasing to observe a united board as she left the Trust.

16. Date of next meeting

It was noted that the next meeting of the Board would take place on 26th September in the Moorfields Education Hub.

The meeting was closed 10.40am.

DRAFT

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

26th September 2024

No.	Date	Minute item	Item title	Action	By	Update	Open/ closed
01/02	23/01/24	8.0	Integrated performance report	Report on research studies in the Trust to be presented to the board, to include breakdown of recruitment to different studies.	LW	To be incorporated in research annual report. Plan to present in November.	Nov 2024
01/03	23/01/24	9.0	Finance report	Provide details on breakdown of agency costs for discussion at Finance and Performance Committee	JW	Not due.	Oct 2024
01/04	23/01/24	10.0	PSIRF	Provide review of implementation and impact of PSIRF to the Trust once fully established	SAd	On agenda. Action closed	Sept 2024
06/01	06/06/24	10.0	Staff survey	Provide updates on progress to the staff survey action plan to the Board	MG	Not due.	Nov 2024

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

Brief summary of report

The report covers the following areas:

- Performance and activity review
- Sector update
- Oriel
- EPR
- Excellence portfolio update
- Discovery update
- Finance performance

Action required/recommendation.

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

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

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD MEETING – 26 SEPTEMBER 2024

Chief Executive's report

Performance and activity review

Following a number of positive months, the number of patients waiting over 18 weeks and 52 weeks respectively for their treatment has increased in month, primarily due to reduced activity caused by staff being on annual leave over the summer period. Overall, performance remains the best in London and we still anticipate achieving 18wk compliance with national standards by the of the financial year.

The Trust's outpatient 1st and elective activity were also reduced in month for the same reason, however elective activity levels are expected to improve now that colleagues from the Royal London have started operating on their patients at our Stratford site.

Sector update

Following confirmation that the Trust was successful in our bid to run a single point of access and to coordinate community optometry provision across the NCL region, we are now standing up this service. Preparation includes the establishment of a group that will focus on using the information generated from our single point of access system to help address inequality in the management of ophthalmology referrals and provision of services across NCL.

In Bedford we are planning to switch the clinical noting system which is being used from the current Medisoft system to Open Eyes in late October. Subject to a successful contract negotiation with the local commissioners, this will then be followed by the Trust taking over the clinical and operational management of ophthalmology patients in the region at the end of the financial year.

Oriel

The construction of the Oriel centre continues to progress well. We are currently working on level 6 of a part of the building and hope to complete level 7 by the end of September.

We are working hard to capture the user requirements which will inform the SMART IT specifications for the centre and are expecting to sign off the 1:50 designs by the end of January 2025.

We have also begun working with clinical teams to assess the transformation which is required for each of them to ensure that they are able to offer optimal patient care in the centre.

Electronic Patient Record System Procurement

In August, we secured NHSE approval for our Electronic Patient Record (EPR) business case. The Trust has continued to progress towards contract finalisation for the supply and implementation of a new Electronic Patient Record System from preferred supplier, MEDITECH. The final steps include completion of the remaining aspects of the contract negotiation and submission to Trust Board for approval to sign the contract.

Excellence Portfolio

In addition to our progress on the EPR, our approach to improving patient experience and reducing Did Not Attends (DNAs) has moved forward with the completion of our new Outpatient Waiting List (OWL) pilot at St George's, which achieved 100% compliance. OWL is a virtual waiting list for patients who require a follow-up appointment more than six weeks ahead of their last appointment. Instead of providing patients with a date for their appointment when they leave clinic, they will be placed on a managed OWL list specific to their condition. With the St George's pilot finished, we have moved into the next phase, and we anticipate that Trust services (except in Beford) will transition to the new booking system from February 1st.

The EDI team have refreshed our Equality Health Impact Assessment process and forms, which have been approved by the EDI steering group. Changes feature a more user-friendly design and streamlined process. We have developed and are progressing our action plan to meet the requirements of the Anti-racism charter, signed earlier this year.

We have completed the first cohort of Patient Experience Principles 'Action Labs', training staff and co-creating approaches to ensure the principles are embedded in everything we do. The principles were co-created by patients, staff, and volunteers, these five principles underpin how we will consistently develop and deliver a compassionate and excellent quality of care to our patients.

We have strengthened our approach to Accessible Information Standards (AIS). An AIS statement has been added to patient letters, and Week 4 of Trust-Wide Safer September will include a focus on AIS.

Further projects have begun, including work to standardise our approach for Urgent and Emergency Care across all Trust Sites.

Discovery update

At the June board, we took a paper on the work done by the Trust to enhance its governance and operating model. As we appoint our new Director of Discovery, I want to update on specific work that has taken place in our discovery function as part of the overall programme of governance enhancement.

The Research and Development/ Discovery function has achieved major success and made important internationally recognised advancements in research, development and innovation. Notwithstanding this, as part of a wider review of the Trust functional model and governance structure, the need for a specific review of the Discovery function became apparent, due to the complexity of the function (including major developments in data, AI as well as innovation more broadly) and its ongoing importance to the Trust.

This review set out to understand the strengths and areas of opportunity to improve the governance and functional model of the Discovery function as it stood, focusing in particular on innovation and the digital agenda and articulating at high level, the optimum future functional model and potential governance structure for the Discovery function.

The report highlighted a number of opportunities to increase effectiveness by addressing current challenges, which included lack of defined structure across Research and Development/ Discovery as a whole resulting in a tendency for siloed working, lack of visibility and potential for duplication of infrastructure and capabilities across key areas of work. There was also limited governance, resulting in lack of clarity over information flows and decision making by Trust leadership.

At the same time, specific concerns were raised by several people about a specific area within the Discovery function, as a consequence of which an investigation was initiated. After these concerns were raised at board level, the

coordination of the investigation was taken over by the chair. The independent investigation resulted in two reports, one outlining general themes and one regarding some confidential, individual issues.

The general themes outlined echoed those already identified through the Moorhouse review ie that the operating model and governance processes within Discovery needed to be clarified, in addition to work to enhance operational policies such as conflicts of interest. Ongoing work has since continued under the leadership of Louisa Wickham (pending appointment of a substantive Director of discovery) to address the issues identified in both reports, with appropriate oversight from the trust board.

We are very pleased that an appointment to the role of Director of discovery has now been made with an announcement to follow as soon as formal checks are complete. The board will continue to receive updates from the Medical Director, Louisa Wickham and subsequently from the incoming Director of discovery, on progress of the functional model and governance approach and implementation at future board meetings.

August Performance

For August the trust is reporting a £0.37m deficit, some £0.25m favourable to plan, with a cumulative surplus of £1.60m, a favourable variance of £0.27m. Patient activity during August was 89% for Elective, 96% on Outpatient First, and 96% against Outpatient Procedures activity respectively against the trust capacity activity plan. The trust cash position was £70.1m, an increase of £4.2m from the prior month, and equivalent to 85 days of operating cash. Capital expenditure was £5.1m in month with the majority relating to the Oriel development, and totals £24.2m cumulatively. This equates to a £9.2m variance to plan, which relates to the Oriel build, although this is expected to be made up in future months. Efficiencies of £6.4m have been identified against the £10m plan with an additional £3m being validated, and an adverse variance of £0.65m cumulatively.

Martin Kuper
Chief executive

Integrated Performance Report
Reporting Period - August 2024

Brief Summary of Report

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

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

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

Performance & Information
Delivering quality data to empower the trust

Skills Development Network
Excellence in Informatics
Level 1

Introduction to 'SPC' and Making Data Count

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

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

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

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

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

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

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

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

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

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

Guide to this Report

Name of the lead responsible for the metric

Why this metric is being reported

The national or local target performance is being measured against

Performance for the most recent period

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

Name of metric/KPI

How often and timing of the reporting of this metric

Performance for the financial year (Apr-Mar)

These are the Variance and Assurance Icons

KPI/Metric Name

Upper/lower Limit

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

Improving Special Cause *

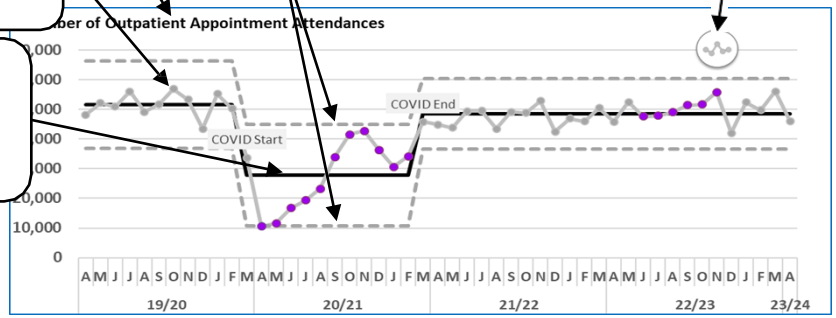
Summary Icons *

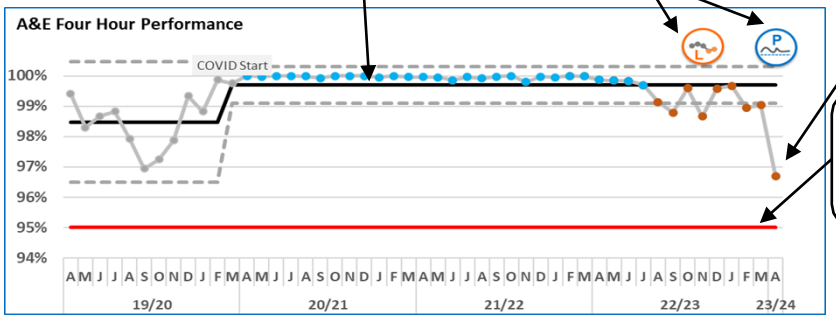
Concerning Special Cause *

Common Cause Variation *

Mean
Average performance for the period

Local or national target





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

Highlights

Metrics With "Failing Process"

- Average Call Waiting Time
- % Freedom of Information Requests within 20 Days
- Appraisal Compliance
- Staff Sickness (Month & Rolling Annual)

Celebrations

- 23 Metrics are showing as a capable process, with 22 showing either an improving or stable performance, this includes:
  - Posterior Capsular Rupture rates
  - All FFT Performance Targets
  - Infection Control Metrics
  - No 28 Day Theatre Non-Medical Cancellation Breaches

  Five metrics are showing an improving position including Referral to Treatment performance and Waiting Lists

Other Metrics showing "Special Cause Concern"

- A&E Four Hour Performance
- Number of Incidents incidents) remaining open after 28 days
- Basic Mandatory IG Training

Other Areas To Note

- A revised phased plan for 2024/25 elective and outpatients has been approved and included within this report
- Against the updated plan, Overall and Follow Up Outpatient vs. Phased Plan remains above plan and as a capable process, however Elective Activity remains below 100% for August and YTD. First Outpatients fell just short of 100% in August, but remains above 100% for the year.

Executive Summary

In August, the Trust's 18 Week referral to treatment time performance reduced to 82.6% of patients receiving their treatment within the required period due to a combination of annual leave and the impact that the Trust has seen of moving to the ERS platform, which has slowed the speed of referrals being triaged.

The number of patients waiting over 52 weeks for their treatment increased slightly to 10, however a number of these patients have now received their treatment in early September.

Elective activity levels were again below plan due to the known issues of reduced cataract referrals being received in the North. A significant amount of work is underway to relocate services between sites, however this is taking longer than anticipated to enact. Colleagues from the Royal London have started to operate on their patients at our Stratford site and this will therefore begin to improve our elective performance.

Outpatient 1st activity was just below plan in month, however it remains ahead of plan year to date and is expected to recover in September.

All cancer standards were met in month and the median outpatient journey times continue to show ongoing improvement.

The Trust's Booking Centre met the average call abandonment rate for a second month in a row, however the average call waiting time increased in month. A number of actions remain in place to improve both of these metrics further.

Despite remaining a passing metric, A&E four hour performance continues to show as concern. Now that the new group of trainee doctors has begun in post, a longer term review of the staffing model in the service is about to begin.

The number of non-medical cancelled operations not treated within 28 days remains an improved a passing process, however the non-hospital medical theatre cancellations has deteriorated in month. There is no obvious reason for this spike and performance will therefore be monitored over the next few weeks.

Appraisal performance has stabilised in month at 73.4%. It is hoped that a review of the accuracy of our data on appraisals and a realignment of dates in which individual's appraisals fall will help to improve this position.

Performance Overview

August 2024		Assurance			
		Capable Process	Hit and Miss	Failing Process	No Target
Variation	Special Cause - Improvement	- Total Outpatient Activity (% Plan) - Total Outpatient FlwUp Activity (% Plan) - % Cancer 62 Day Waits (All) - FFT Inpatient Scores (% Positive) - FFT Outpatient Scores (% Positive) - % SARs Requests within 28 Days - Non-medical cancelled 28 day breaches - Active Commercial Studies - % of patients in research studies	-	-	- 18 Week RTT Incomplete Performance - RTT Waiting List - OP Journey Times - Non-Diagnostic FtF - OP Journey Times - Diagnostic FtF
	Common Cause	- % Cancer 31 Day Waits (All) - Mixed Sex Accommodation Breaches - VTE Risk Assessment - Posterior Capsular Rupture rates - MRSA Bacteraemias Cases - Clostridium Difficile Cases - E. Coli Cases - MSSA Rate - cases - FFT A&E Scores (% Positive) - FFT Paediatric Scores (% Positive) - % Complaints Acknowledged Within 3 days - Summary Hospital Mortality Indicator - Recruitment to NIHR portfolio studies	* See Next Page	- Average Call Waiting Time - % FoI Requests within 20 Days - Appraisal Compliance - Staff Sickness (Month Figure) - Staff Sickness (Rolling Annual Figure)	* See Next Page
	Special Cause- Concern	- A&E Four Hour Performance	- Basic Mandatory IG Training	-	- Number of Incidents open after 28 days
	Special Cause - Increasing Trending	- No. of A&E Arrivals - No. of A&E Four Hour Breaches - No. of Outpatient Attendances - No. of Outpatient First Attendances - No. of Outpatient Flw Up Attendances - No. of Theatre Admissions - No. of Theatre Elective Day Admissions - No. of Theatre Emergency Admissions			
	Special Cause - Decreasing Trending	- RTT Incomplete Pathways Over 18 Weeks			

Performance Overview

Common Cause & Hit and Miss	Common Cause (No Target)
- Elective Activity - % of Phased Plan	- Elective waits over 65 weeks
- Outpatient First Activity (% Plan)	- Proportion of Temporary Staff
- Cancer 28 Day Faster Diagnosis Standard	- Recruitment to All Research Studies
- 52 Week RTT Incomplete Breaches	- No. of Referrals Received
- % Diagnostic waiting times less than 6w	- No. of Theatre Elective Inpatient Adm.
- Average Call Abandonment Rate	
- Emergency readmissions in 28d (ex. VR)	
- % Complaints Responses Within 25 days	
- Occurrence of any Never events	
- NatPSAs breached	
- Serious Incidents open after 60 days	
- Theatre Cancellation Rate (Non-Medical)	
- Recruitment Time To Hire (Days)	

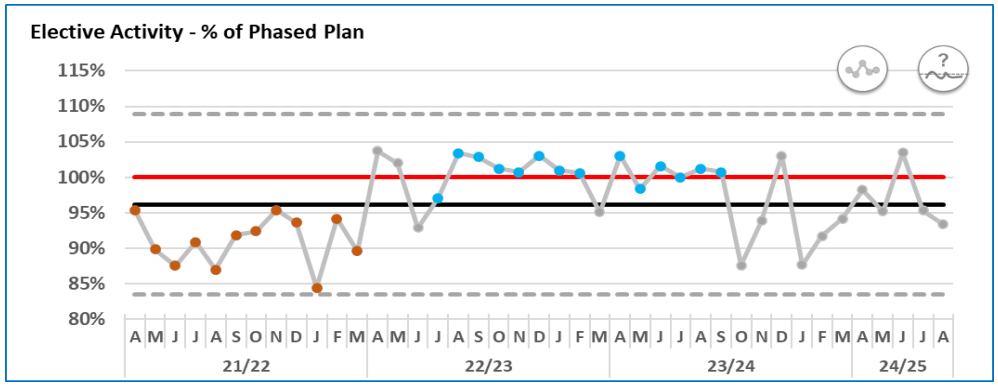
Deliver (Activity vs Plan) - Summary

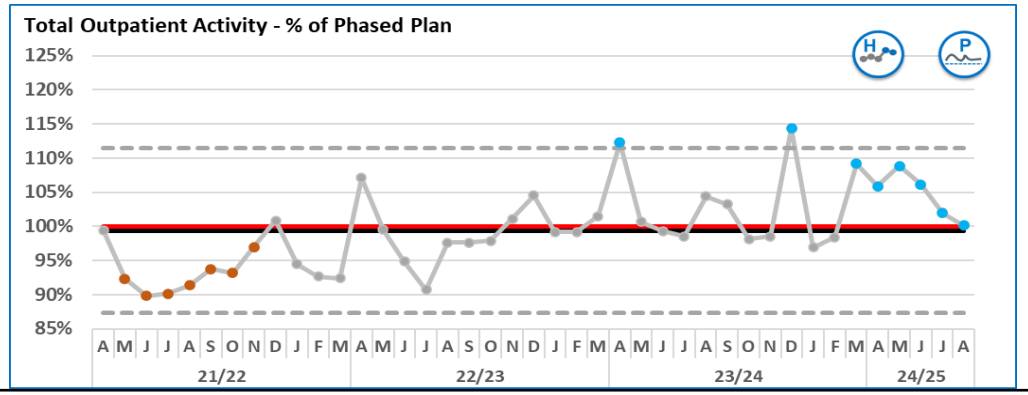
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Elective Activity - % of Phased Plan	Jon Spencer	24/25 Planning Guidance	Monthly	≥100%	97.0%	93.4%		
Total Outpatient Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	104.5%	100.1%		
Outpatient First Appointment Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	106.7%	99.0%		
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jon Spencer	24/25 Planning Guidance	Monthly	≥85%	103.9%	100.4%		

A revised phased plan for 2024/25 has been approved by Management Executive, and going forward figures will be measured against this plan.

Against the previously reported plan:
- Overall, there has been a reduction for the Elective and Outpatient First Appointment Activity Plans
- There has been an increase of the Outpatient Follow Up Appointment Activity Plan (with the Total Outpatient Activity Plan also increasing).

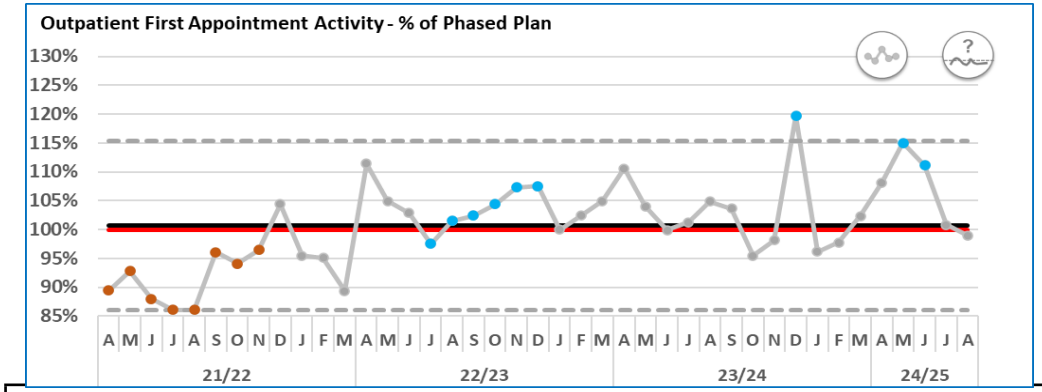
Deliver (Activity vs Plan) - Graphs (1)

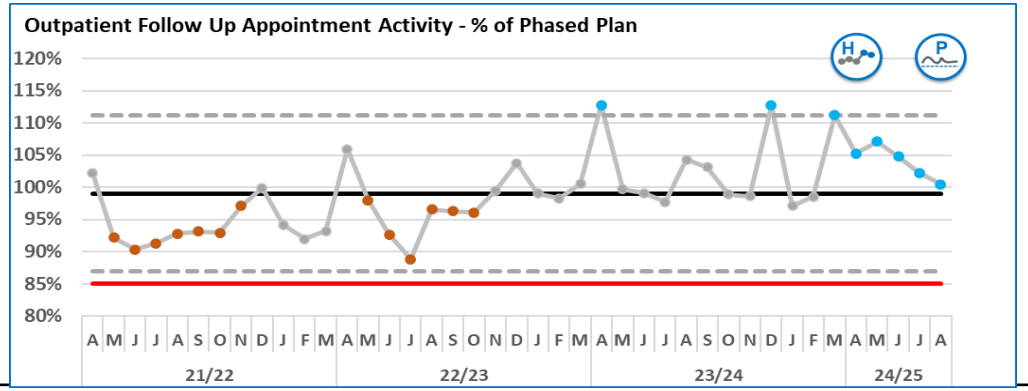




'Elective Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 93.4%.

'Total Outpatient Activity - % of Phased Plan' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 100.1%.





'Outpatient First Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 99.0%.

'Outpatient Follow Up Appointment Activity - % of Phased Plan' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 100.4%.

The elective activity plan was achieved in South and City Road divisions. North delivered 79.6% of plan in month, with the largest shortfalls in Cataract @ Stratford, St Ann's and Northwick Park (NWP) and Medical Retinal @ NWP. Known issues with referral numbers for Cataract were compounded by a delay in the start of the Royal London lists at Stratford and annual leave. Discussions on-going to move cataract lists from City Road to Stratford/St Ann's. City Road patients now being listed for St Ann's from clinic.

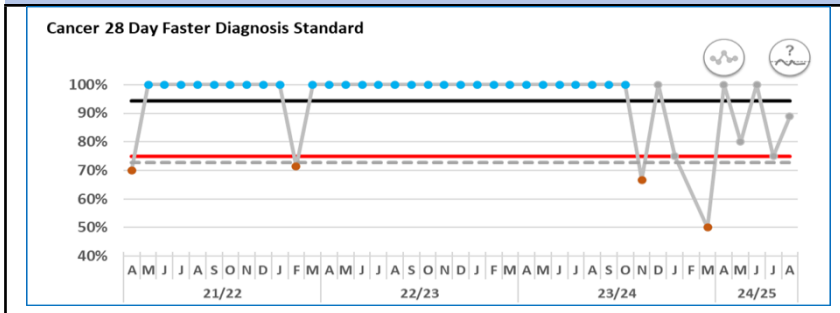
First appointment activity fell to just below plan and was impact by annual leave and sickness in the month of August. Additionally, there were issues with delays for triage at NWP which reduced the number of patients available to book. The triage position has improved with a review of booking rules and the purchase of laptops to improve access to the system. Divisional teams will maximise bookings in September to recover this position.

Review Date: Oct 2024 ***Action Lead:*** Kathryn Lennon

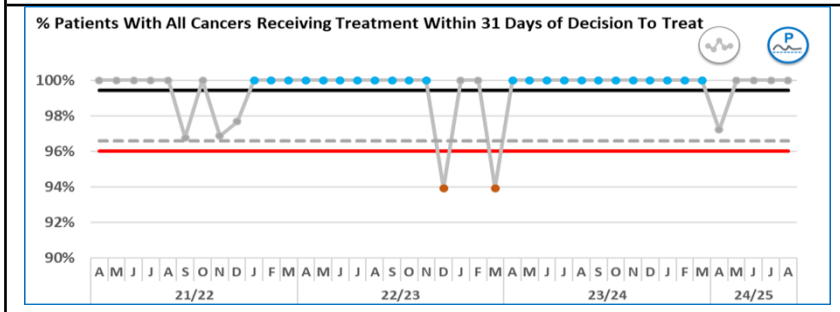
Deliver (Cancer Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	Statutory Reporting With Local Target	Monthly	≥75%	90.0%	88.9%		
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat	Jon Spencer	Statutory Reporting	Monthly	≥96%	99.3%	100.0%		
% Patients With All Cancers Treated Within 62 Days	Jon Spencer	Statutory Reporting	Monthly	≥85%	100.0%	100.0%		

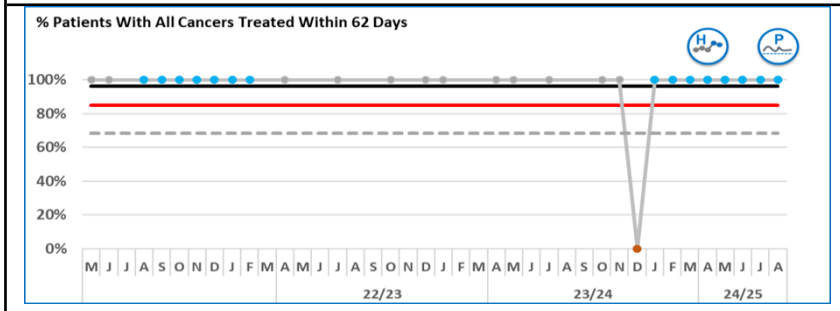
Deliver (Cancer Performance) - Graphs (1)



'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 88.9%.



'% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 100.0%.

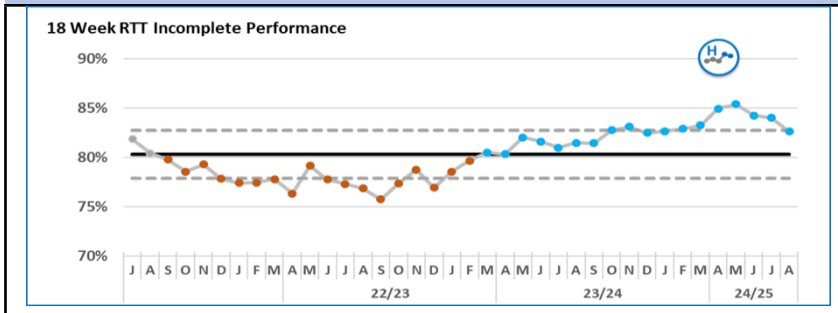


'% Patients With All Cancers Treated Within 62 Days' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 100.0%.

Deliver (Access Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
18 Week RTT Incomplete Performance	Jon Spencer	Statutory Reporting	Monthly	No Target Set	84.3%	82.6%		
RTT Incomplete Pathways (RTT Waiting List)	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	34357		
RTT Incomplete Pathways Over 18 Weeks	Jon Spencer	Internal Requirement	Monthly	≤ Previous Mth.	n/a	5966		
52 Week RTT Incomplete Breaches	Jon Spencer	24/25 Planning Guidance	Monthly	≤5 Breaches	40	10		
Eliminate waits over 65 weeks for elective care	Jon Spencer	24/25 Planning Guidance	Monthly	No Target Set	14	4		
A&E Four Hour Performance	Jon Spencer	24/25 Planning Guidance	Monthly	≥95%	97.5%	98.1%		
Percentage of Diagnostic waiting times less than 6 weeks	Jon Spencer	24/25 Planning Guidance	Monthly	≥99%	99.0%	99.1%		

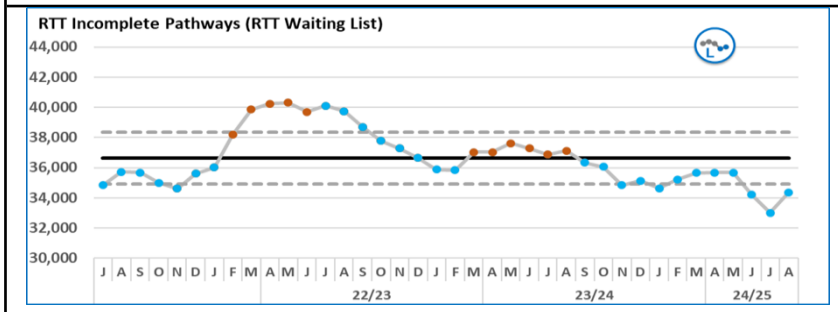
Deliver (Access Performance) - Graphs (1)



'18 Week RTT Incomplete Performance ' is showing 'special cause improvement' (increasing rate). The figure is currently at 82.6%.

Although this indicator is showing special cause improvement, the overall Referral to Treatment (RTT) performance is showing signs of decline from May's high of 85.4% with it now at 82.6%. There will be a renewed focus on performance at subspecialty level, to ensure performance improves towards the 92% target. Focus areas include: paediatrics, external, adnexal, cataract, strabismus and neuro. Initiatives include, reallocation of theatre lists, outpatient drives, recruitment to vacant posts.

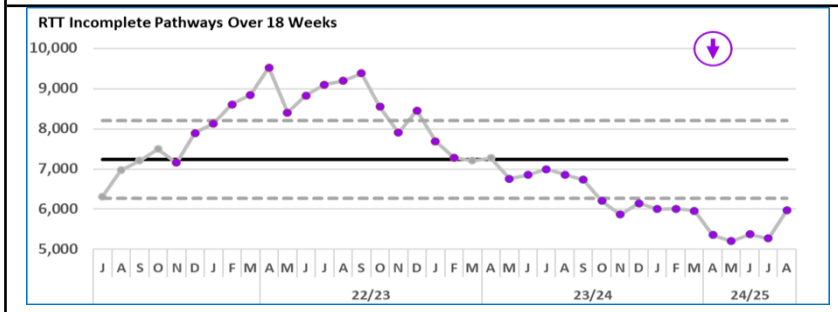
Review Date: Oct 2024 ***Action Lead:*** Kathryn Lennon



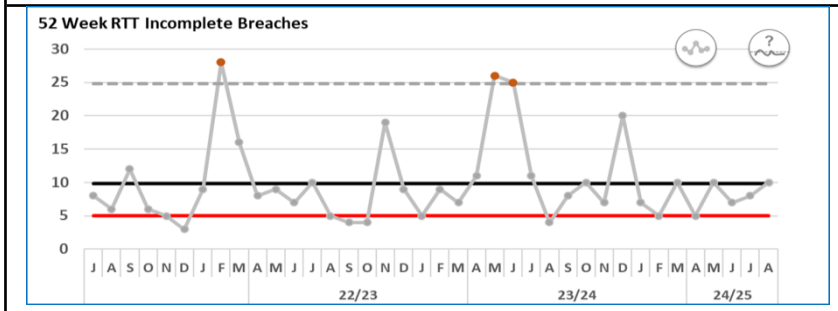
'RTT Incomplete Pathways (RTT Waiting List)' is showing 'special cause improvement' (decreasing rate). The figure is currently at 34,357.

Although this indicator is showing special cause improvement, the overall RTT waiting list has increased to 34,357. This is driven by capacity pressure in adnexal, external, paediatrics and cataract and further componded by staff absences in August. Focus and action to be taken at subspecialty level.

Review Date: Oct 2024 ***Action Lead:*** Kathryn Lennon



'RTT Incomplete Pathways Over 18 Weeks' is showing an 'special cause variation' (decreasing rate). The figure is currently at 5,966.

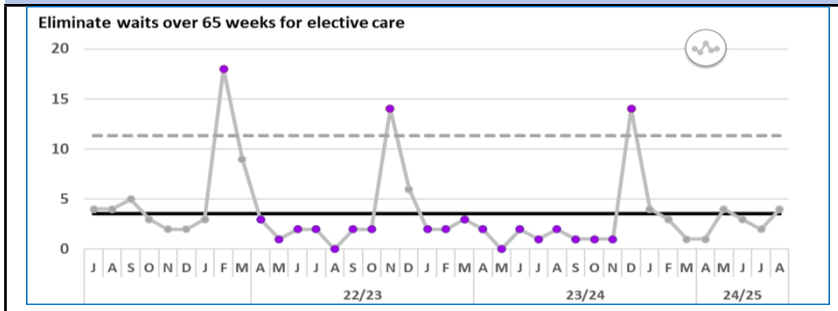


'52 Week RTT Incomplete Breaches ' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 10.

The 10 patients waiting over 52 weeks will receive treatment in September or have already been discharged. Most of these patients are complex, requiring appointments across subspecialties. Weekly PTL meetings will continue to track these patients, with a focus on eliminating patients waiting over 65 weeks and ensuring treatment as early as possible.

Review Date: Oct 2024 ***Action Lead:*** Kathryn Lennon

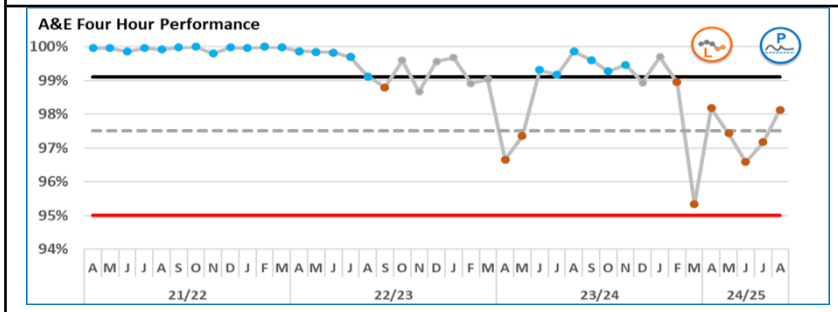
Deliver (Access Performance) - Graphs (2)



'Eliminate waits over 65 weeks for elective care' is showing 'common cause variation'. The figure is currently at 4.

Weekly PTL meetings will continue to track these patients, with a focus on eliminating patients waiting over 65 weeks and ensuring treatment as early as possible.

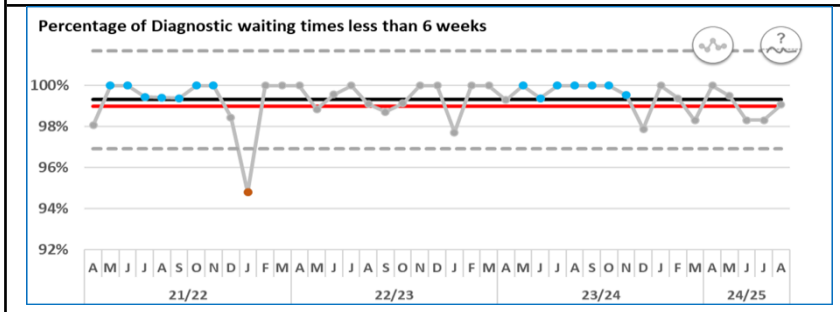
Review Date: Oct 2024 ***Action Lead:*** Kathryn Lennon



'A&E Four Hour Performance' is showing 'special cause concern' however the current process will consistently pass the target. The figure is currently at 98.1%.

- Performance remains above the national target (August was 98.1% vs 95%)
- There has been a general increase in the number of attendances which combined with some staffing shortages (e.g. gaps in the trainee rota) which has made some months challenging
- Attend Anywhere continues to grow (activity is above plan, positively contributing to the Trust's financial position) and has expanded to provide support other services (e.g. Prison)
- The team have been reviewing the staffing model: exploring increasing the number of alternative roles (e.g. Optoms), recruiting clinical fellows, working with sub-specialties to ensure cover and drafting a staffing SOP to ensure minimum staffing levels and escalation steps are clear
- Joint work with the RFH continues, reviewing Emergency Services across NCL – series of meeting have taken place looking at the patient pathway from pre-hospital into the Acute setting

Review Date: Oct 2024 ***Action Lead:*** Kathryn Lennon

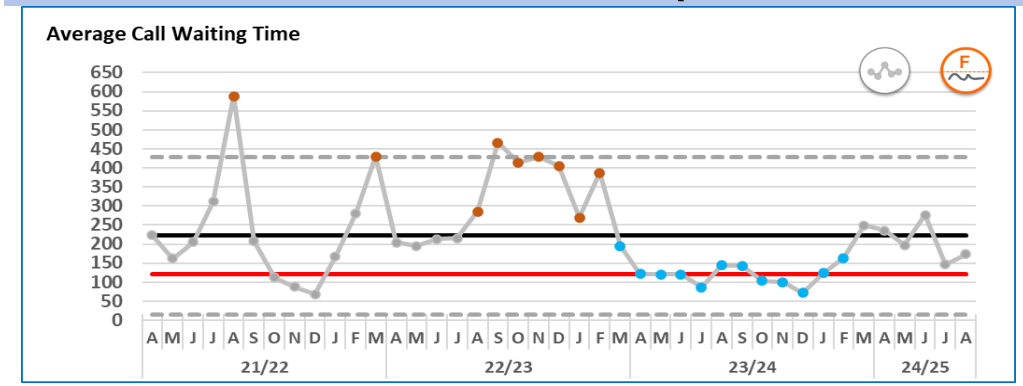


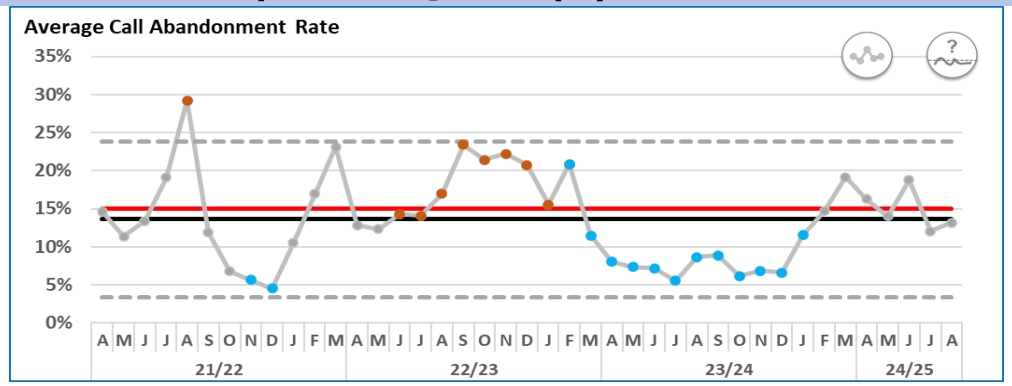
'Percentage of Diagnostic waiting times less than 6 weeks' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 99.1%.

Deliver (Call Centre and Clinical) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Average Call Waiting Time	Jon Spencer	Internal Requirement	Monthly	≤ 2 Mins (120 Sec)	n/a	174		
Average Call Abandonment Rate	Jon Spencer	Internal Requirement	Monthly	≤15%	14.9%	13.2%		
Mixed Sex Accommodation Breaches	Sheila Adam	Statutory Reporting	Monthly	Zero Breaches	0	0		
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Jon Spencer	Internal Requirement	Monthly (Rolling 3 Months)	≤ 2.67%	n/a	0.00%		
VTE Risk Assessment	Jon Spencer	Statutory Reporting	Monthly	≥95%	99.9%	99.7%		
Posterior Capsular Rupture rates (Cataract Operations Only)	Jon Spencer	Statutory Reporting	Monthly	≤1.95%	0.86%	0.75%		
MRSA Bacteraemias Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		
Clostridium Difficile Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		
MSSA Rate - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		

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





'Average Call Waiting Time' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 174.	**'Average Call Abandonment Rate' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 13.2%.**

Average call waiting time target was not achieved.

- There was a 22% increase in calls compared to August 2023

Sickness absence across the month was compounded by planned leave across the summer holiday period

The team have experienced persistent intermittent IT and connection issues requiring escalated IT support to resolve

As per demand and capacity modelling output, the team are not yet at full establishment, despite additional bank support. Limited scope to move booking centre staff to support with calls due to continued embedding of new external referral processes and managing bookings

Actions:

(1) Ongoing review of call reasons and actions taken to manage as needed

(2) Complex long and short term sickness cases supported by HR. One long term sickness case has been concluded and post can now be filled substantively

(3) Local troubleshooting in place where possible for recurrent IT issues that can be managed without IT support.

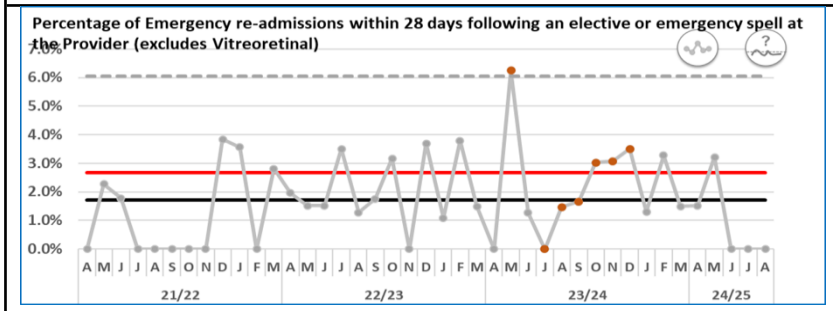
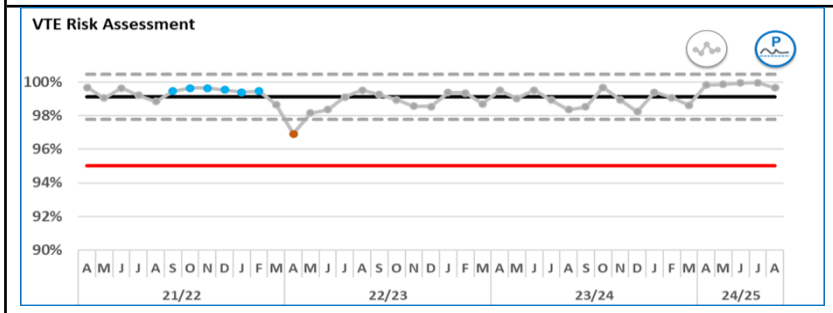
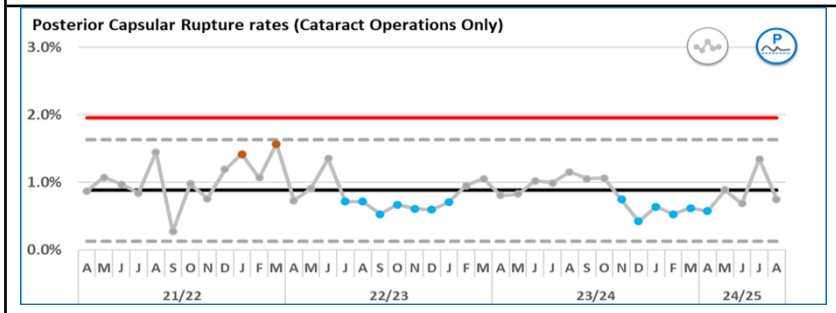
(4) Recruitment in progress. 4.0 WTE required to meet optimal establishment. 3.0WTE recruited - expected start date October 2024. We hope to be fully established by Dec 2024.

(5) Defined escalation points to improve oversight of performance - Ongoing

(6) Web assist functionality to be introduced to reduce call volumes- delayed due to contract signing and supplier lead times - for implementation Sept 2024

Review Date: Oct 2024 ***Action Lead:*** Anoju Devi

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

No Graph Generated, No breaches since June 2017	**'Mixed Sex Accommodation Breaches ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**
	**'Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.00%.**
	**'VTE Risk Assessment' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 99.7%.**
	**'Posterior Capsular Rupture rates (Cataract Operations Only)' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.75%.**

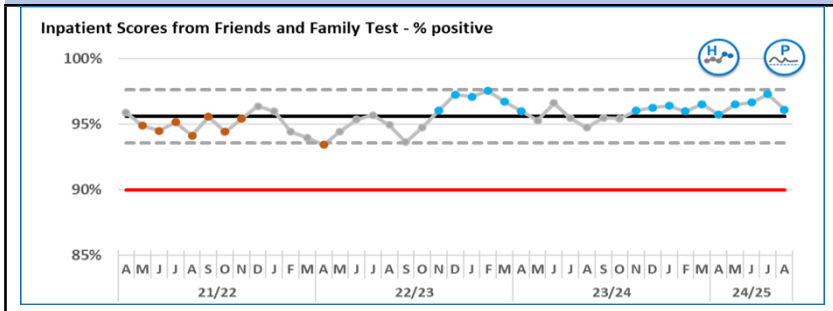
Deliver (Call Centre and Clinical) - Graphs (3)

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

Deliver (Quality and Safety) - Summary

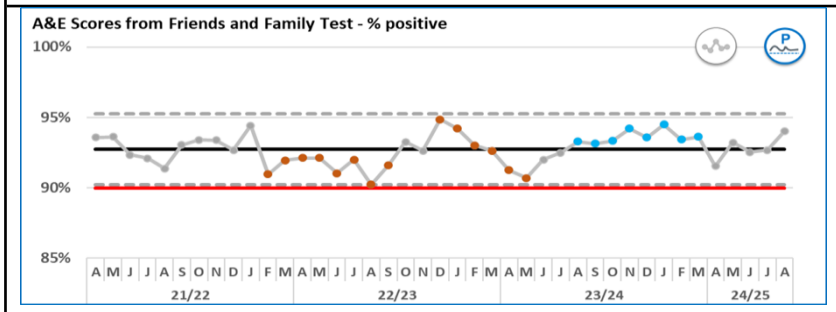
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Inpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	96.5%	96.1%	H	P
A&E Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	92.8%	94.0%		P
Outpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	94.4%	94.4%	H	P
Paediatric Scores from Friends and Family Test - % positive	Ian Tombleson	Internal Requirement	Monthly	≥90%	95.3%	95.8%		P
Percentage of responses to written complaints sent within 25 days	Ian Tombleson	Internal Requirement	Monthly (Month in Arrears)	≥80%	84.6%	87.5%		?
Percentage of responses to written complaints acknowledged within 3 days	Ian Tombleson	Internal Requirement	Monthly	≥80%	98.0%	100.0%		P
Freedom of Information Requests Responded to Within 20 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	82.4%	82.8%		F
Subject Access Requests (SARs) Responded To Within 28 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	97.8%	99.1%	H	P

Deliver (Quality and Safety) - Graphs (1)



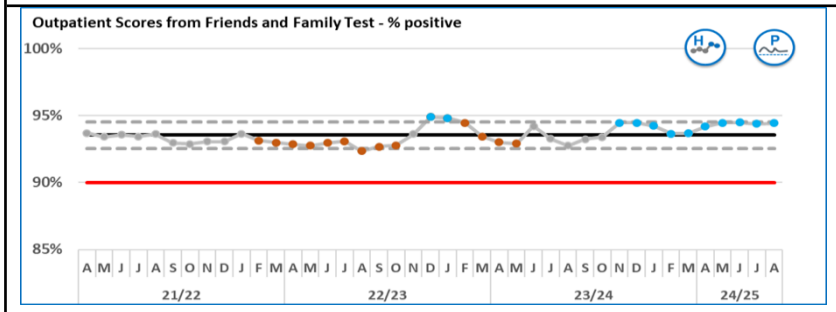
'Inpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 96.1%.

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



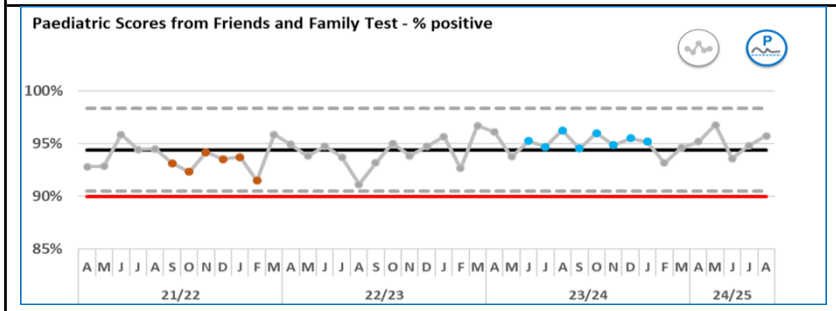
'A&E Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 94.0%.

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



'Outpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 94.4%.

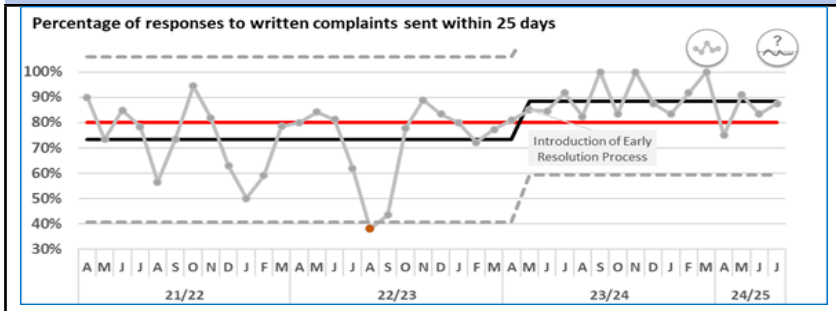
Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.



'Paediatric Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 95.8%.

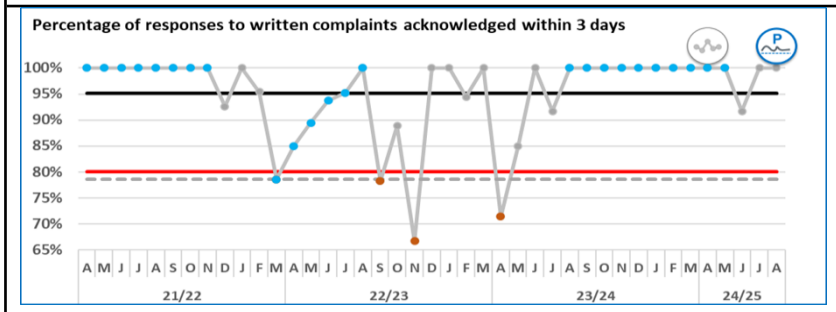
Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.

Deliver (Quality and Safety) - Graphs (2)



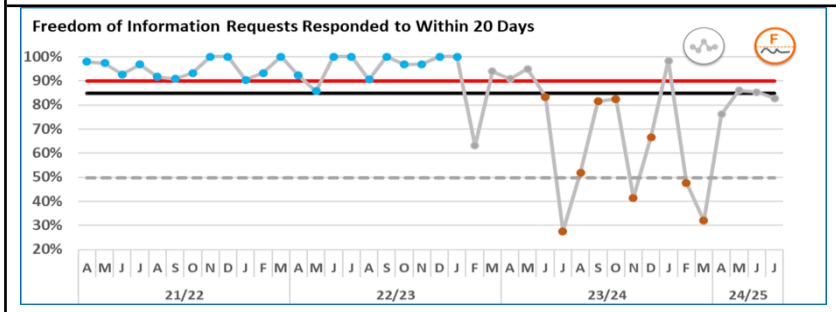
'Percentage of responses to written complaints sent within 25 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 87.5%.

We exceeded the 80% target in July, which has now been achieved in 15 of the last 16 months. We aim to maintain this going forward.



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

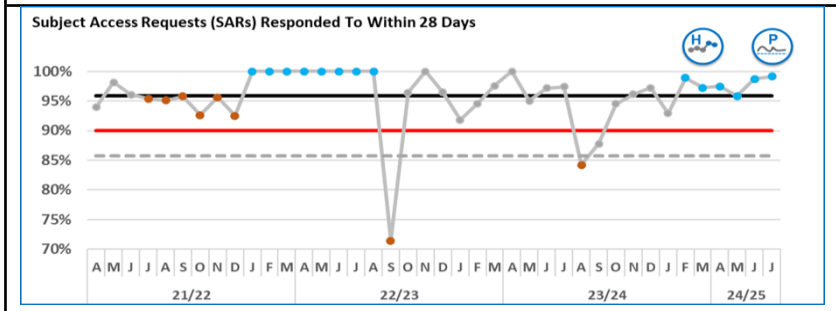
Following tightening of the process to acknowledge receipt of a complaint at the end of 2022, this continues to exceed the 80% performance target with 16 of the last 21 months at 100%



'Freedom of Information Requests Responded to Within 20 Days' is showing 'common cause variation' with the current process unlikely to achieve the target - This is a change from the previous month. The figure is currently at 82.8%.

The following measures will be put into place:
1) Working to update our Freedom of Information dashboard to capture where the Standard Operating Procedure is not being followed and address these areas.
2) Escalation to Senior Management Team/Directors where responses have not been given in time.
3) Working with comms team to get the disclosure log active by next week.

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



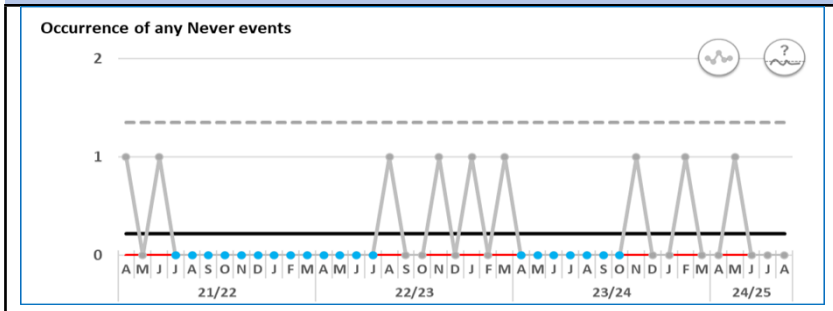
'Subject Access Requests (SARs) Responded To Within 28 Days' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 99.1%.

Following a run of Performance above the 90% target for the previous ten months, this has now returned to being a passing metric, and is now showing as an improving metric. This will continued to be monitored.

Deliver (Incident Reporting) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Occurrence of any Never events	Sheila Adam	Statutory Reporting	Monthly	Zero Events	1	0		
Summary Hospital Mortality Indicator	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		
National Patient Safety Alerts (NatPSAs) breached	Sheila Adam	NHS Oversight Framework	Monthly	Zero Alerts	n/a	0		
Number of Serious Incidents remaining open after 60 days	Sheila Adam	Statutory Reporting	Monthly	Zero Cases	1	0		
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Sheila Adam	Internal Requirement	Monthly	No Target Set	n/a	283		

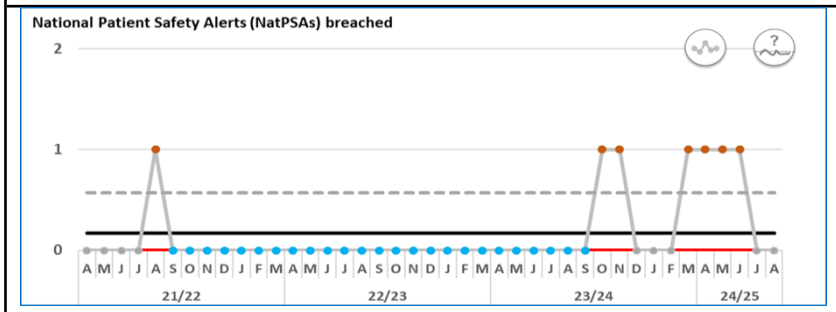
Deliver (Incident Reporting) - Graphs (1)



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

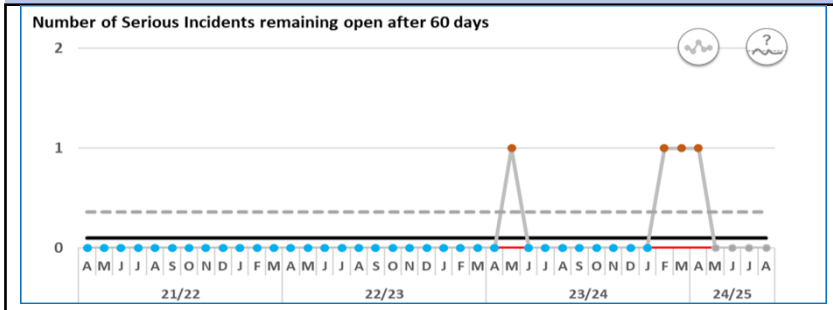
No Graph Generated, No cases reported since February 2017

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

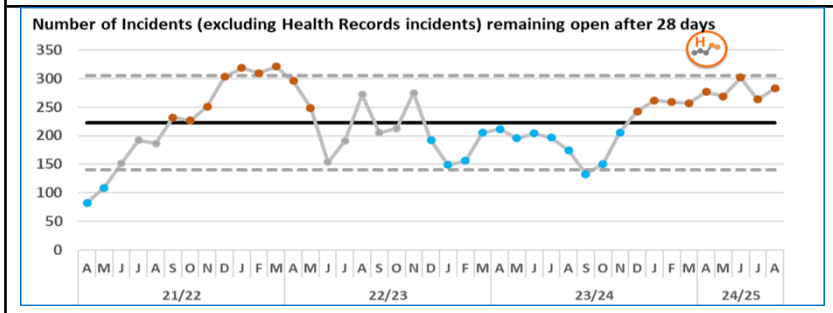


'National Patient Safety Alerts (NatPSAs) breached' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.

Deliver (Incident Reporting) - Graphs (2)



'Number of Serious Incidents remaining Open after 60 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.



'Number of Incidents (excluding Health Records incidents) remaining open after 28 days' is showing 'special cause concern' (increasing rate). The figure is currently at 283.

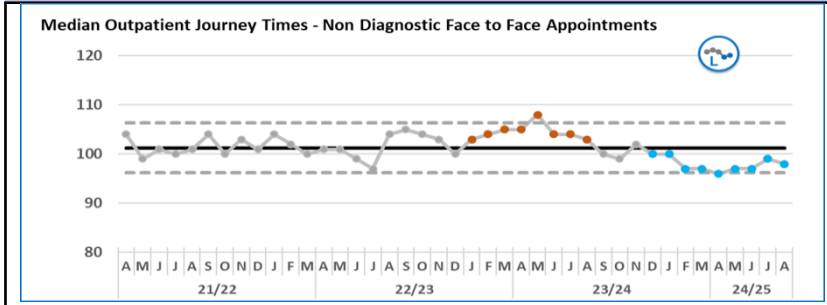
This data continues to be monitored at divisional level, and is reported this way in various forums. Many of the incidents are attributable to Moorfields North, and the central team will continue to work with the division to close these. The priority for all divisions must be the closure of the overdue incidents to which the duty of candour applies.

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

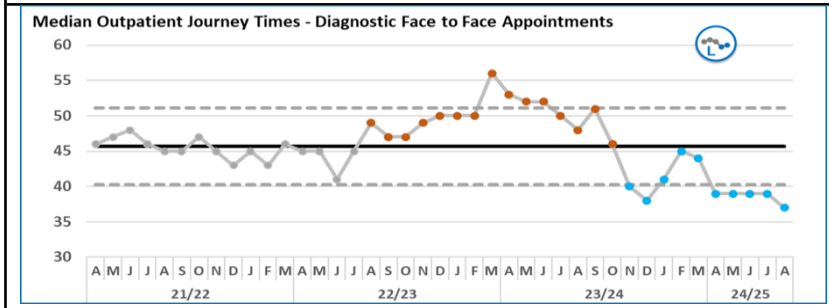
Sustainability and at Scale - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	98		
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	37		
Median Outpatient Journey Times - Virtual TeleMedicine Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	n/a		
Theatre Cancellation Rate (Non-Medical Cancellations)	Jon Spencer	Statutory Reporting	Monthly	≤0.8%	0.84%	1.03%		
Number of non-medical cancelled operations not treated within 28 days	Jon Spencer	Statutory Reporting	Monthly	Zero Breaches	0	0		
Overall financial performance (In Month Var. £m)	Jonathan Wilson	Internal Requirement	Monthly	≥0	0.27	0.25		
Commercial Trading Unit Position (In Month Var. £m)	Jonathan Wilson	Internal Requirement	Monthly	≥0	-0.17	0.17		

Sustainability and at Scale - Graphs (1)

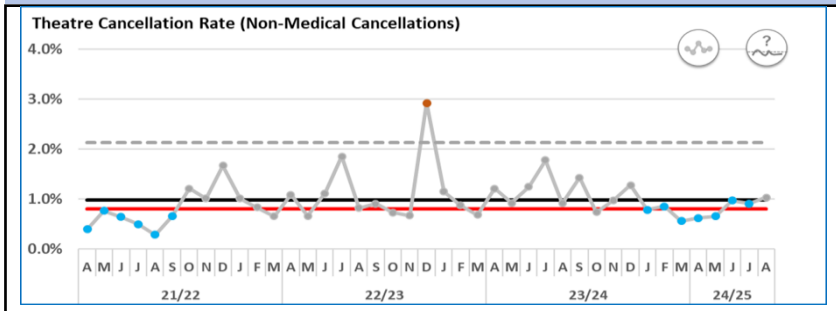


'Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments' is showing 'special cause improvement' (decreasing rate). The figure is currently at 98.

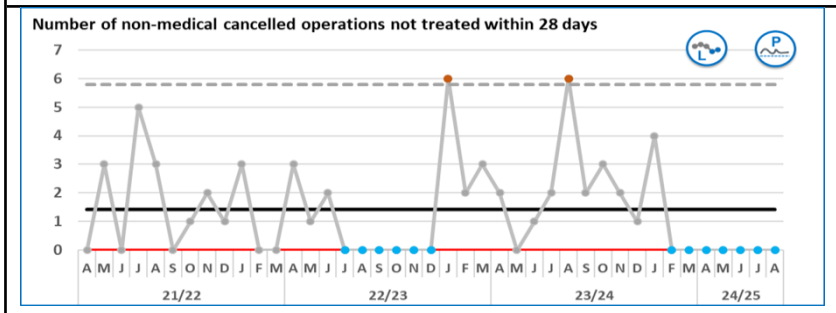


'Median Outpatient Journey Times - Diagnostic Face to Face Appointments' is showing 'special cause improvement' (decreasing rate). The figure is currently at 37.

Sustainability and at Scale - Graphs (2)

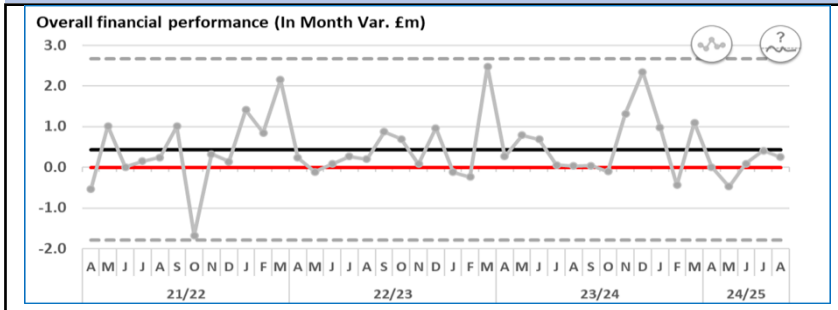


'Theatre Cancellation Rate (Non-Medical Cancellations)' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 1.03%.

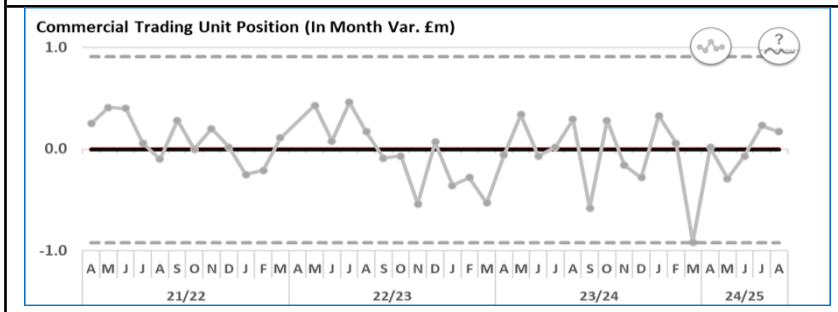


'Number of non-medical cancelled operations not treated within 28 days' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 0.

Sustainability and at Scale - Graphs (3)



'Overall financial performance (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.25.

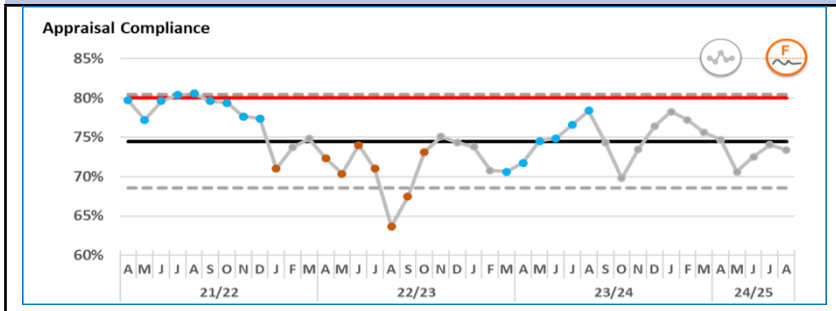


'Commercial Trading Unit Position (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.17.

Working Together - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Appraisal Compliance	Mark Gammage	Statutory Reporting	Monthly	≥80%	n/a	73.4%		F
Basic Mandatory IG Training	Samuel Armstrong	Internal Requirement	Monthly	≥90%	n/a	88.9%	L	?
Staff Sickness (Month Figure)	Mark Gammage	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.7%		F
Staff Sickness (Rolling Annual Figure)	Mark Gammage	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.5%		F
Recruitment Time To Hire (Days)	Mark Gammage	Internal Requirement	Monthly	≤40 Days	n/a	41		?
Proportion of Temporary Staff	Mark Gammage	23/24 Planning Guidance	Monthly	No Target Set	13.9%	13.9%		

Working Together - Graphs (1)



'Appraisal Compliance' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 73.4%.

The Appraisal Improvement Group (AIG) are meeting twice in September (5th and 26th) to ensure the momentum of actions required are carried forward. These include:

• Reviewing current appraisal training and ongoing work to improve appraisal system functionalities. As next step, the Learning and Development team will be leading a trust-wide appraisal process refresh campaign to address current gaps and promote the importance of appraisal completion. As part of this, we are looking into resource requirement for the campaign.

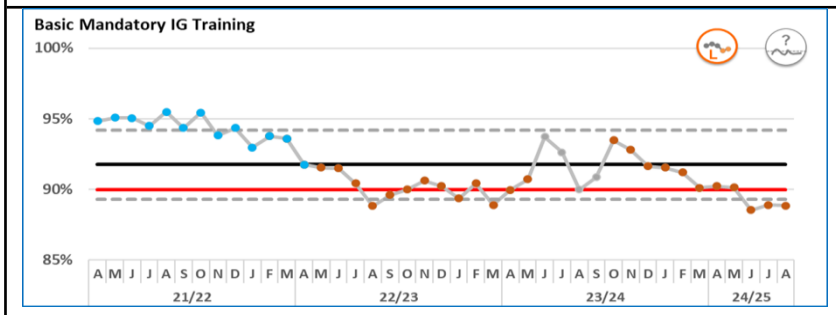
• Reviewing the current Span of Control and the impact on appraisal completion. The output of the review will be reported to the Management Executive.

• Formulation of sub-groups to ensure success in all areas of requirement – Communications, Policy and Process, Technical & Data, Training content, End-User experience.

The Learning and Development Team (LDT) are supporting with the functionality changes on Insight – working with Kallidus to update the Perform application to ensure the layout and recording of Appraisals is accurate and more intuitive to use.

The work to improve the functionality and foster a greater understanding and commitment from the wider Trust, is scheduled over the next 5 months and in the meantime the LDT and HR Business Partners will work closely to keep the messages on point and managers supported to complete appraisals as per their current schedules.

Review Date: Oct 2024 ***Action Lead:*** Jan Lonsdale

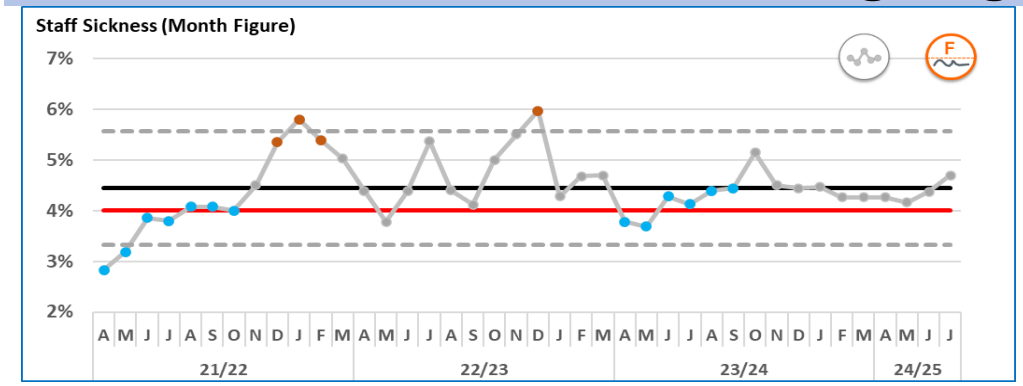


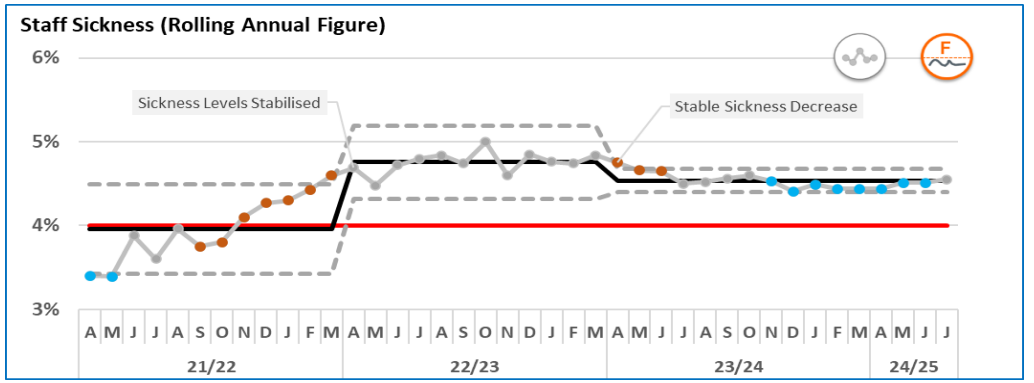
'Basic Mandatory IG Training' is showing 'special cause concern' and that the current process is not consistently achieving the target. The figure is currently at 88.9%.

Monthly performance has now fallen below the 90% target. This metric has now been classed as a 'hit-or-miss' process, noting also the steady decline over the last 11 months. This has been escalated to executive directors and was taken to SMT (for the second time) to identify specific hot spots and put in place remediation plans. Monthly updates will be taken to SMT until performance compliance is restored.

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

Working Together - Graphs (2)





'Staff Sickness (Month Figure)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 4.7%.	**'Staff Sickness (Rolling Annual Figure)' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 4.5%.**

Top 3 reasons for sickness absences continue to reflect as:

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

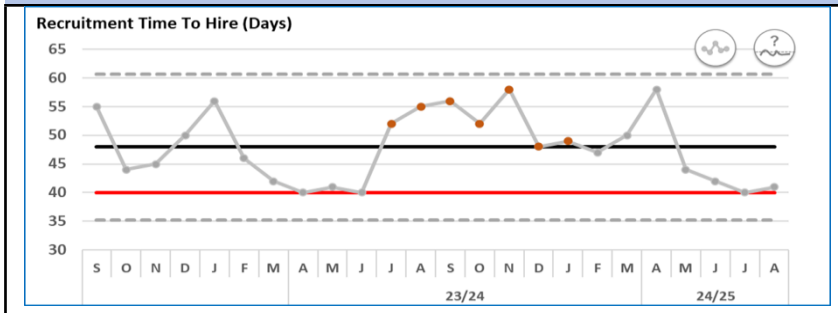
Whilst the overall level of sickness absence performance level remains above trust target, it is to be noted that the NHS average this year is over 5%.

The Employee Relations (ER) team, in collaboration with the HR Business Partners, continue to work closely with line managers as outlined below:

- Progress has been made by the ER team in supporting 5 members of staff on Long Term Sickness (LTS) return to work. 2 staff on LTS, after a Stage 3 hearing process have had contract of employment terminated in accordance with the Trust Sickness Absence Policy.
- Case plans are currently in place for all LTS cases that are over 100 days in terms of next steps in accordance with the Trust's Sickness Absence Policy. This is linked to the ongoing review of the LTS cases against the RAG rating with a key focus placed on absence cases over 100 days. The aim of this is to support the staff members concerned in returning to work as soon as possible, with appropriate reasonable adjustments, if required, put in place to enable this.
- Targeted sickness absence training is ongoing and continues to be delivered by the ER team – with sessions delivered to hotspot areas within the Trust with high short -term sickness absence and long-term sickness rates Hotspot areas that have had a targeted intervention have been City Road, Bedford Nursing and OCSS (Theatres). Targeted interventions are planned for the North and Private Divisions.
- The ER team continues to provide targeted coaching to managers within the Trust in supporting them to manage complex sickness absence cases. The aim being to support and provide managers with confidence and techniques in handling such cases. Hotspot areas requiring targeted intervention have been City Road and the North Division.
- Ongoing promotion of Thrive, Moorfields (Wellbeing Programme) which outlines offers available to staff such as a Pension's Awareness webinar and a Health and Wellbeing event (Potters Bar) – both events to be held in September.

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

Working Together - Graphs (3)

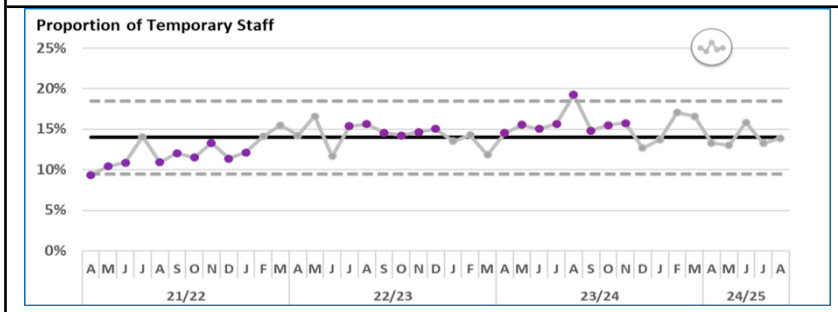


'Recruitment Time to Hire (Days)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 41.

Several improvements and actions have been implemented which have been reported in previous months.
To ensure sustained and ongoing improvements the following actions, led by the Recruitment team, are being undertaken.

- Clarity on visa sponsorship has been included in adverts to avoid delays in Time to Hire (TTH).
- TTH data is being regularly reviewed to enable accurate reporting against Trust target. As part of this review the international recruitment TTH will be excluded as the metrics pertaining to length of time to hire differs from the standard Trust TTH targets. A progress update on the international nurse recruitment will be provided once it commences in Q4.
- TTH performance data is discussed at divisional board meetings with key focus on supporting areas for improvement to TTH. Managers are being sent regular reminders to shortlist to mitigate TTH pertaining to shortlisting.
- Recruitment and selection training for managers has been provided which includes an understanding the TTH metric, process and the recruitment system Trac. This continues to be a priority. Recruitment & Selection training is mandatory for hiring managers to complete once every 3 years as per the new recruitment and selection policy. Compliance is being monitored and stands at 71% as of 1 September, which is up from 43% in March.

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

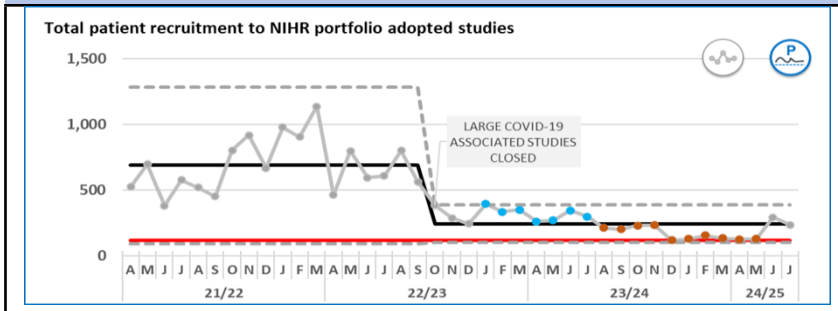


'Proportion of Temporary Staff ' is showing 'common cause variation'. The figure is currently at 13.9%.

Discover - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Total patient recruitment to NIHR portfolio adopted studies	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	≥115 (per month)	781	236		P
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	No Target Set	1045	335		
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	≥44	n/a	59	H	P
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Louisa Wickham	Internal Requirement	Monthly (Month in Arrears)	≥2%	n/a	4.8%	H	P

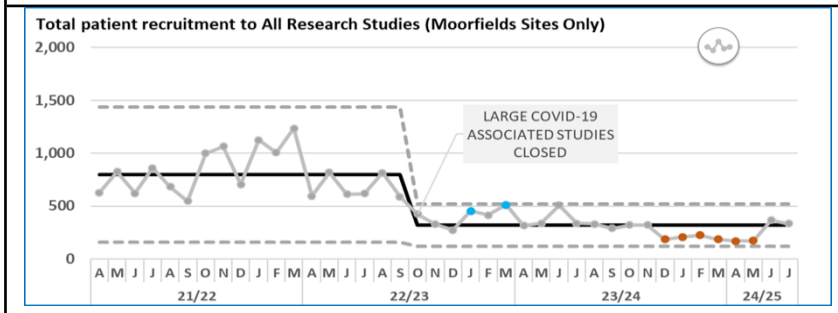
Discover - Graphs (1)



'Total patient recruitment to NIHR portfolio adopted studies' is showing 'common cause variation' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 236.

Please note the recruitment figures have been backdated to accurately reflect activity in previous months, particularly in May 2024. This has had a positive impact and this metric, now provides assurance that our activity meets our recruitment target. The number of patients recruited to NIHR Portfolio studies has decreased and will only increase when we can attract more NIHR grants. We have been awarded 2 NIHR grants this month, one of which will recruit over 800 patients and are awaiting the outcomes of several other applications. We are seeking to diversify our sources of non-commercial research funding and have been successful in obtaining funding for several studies, funded by sub awards from the National Eye Institute in the USA (NEI), one of which opened this month.

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

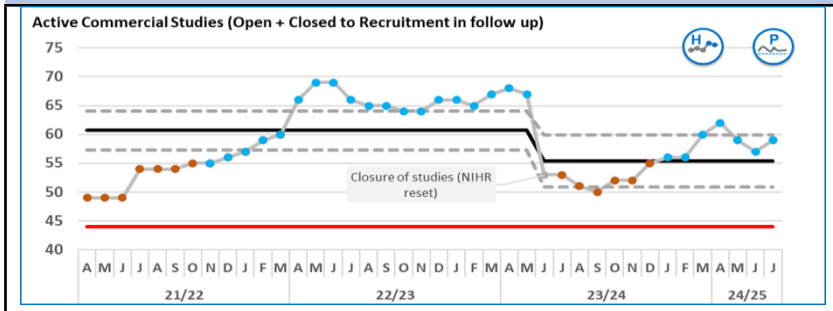


'Total patient recruitment to All Research studies (Moorfields Sites Only)' is showing 'common cause variation'. The figure is currently at 335.

This metric includes commercial and non- commercial studies as well as NIHR portfolio adopted and non-portfolio adopted studies. Recruitment to non-portfolio studies has increased to 173 in June and July, from 91 in April and May. Two large national Bioresource genomic studies will close soon and we are actively seeking to replace them with other genomic studies. Our expanded skilled genetics recruitment team means that we are well placed to recruit to other studies, and we have already attracted two replacement genetic studies. We are making efforts to recruit patients and deliver trials at satellite sites, particularly in Moorfields at St George's in collaboration with the St George's clinical research facility (CRF) and also at the new Moorfield's satellite in Stratford. Please note the recruitment figures have been backdated to accurately reflect activity in previous months, particularly in May 2024.

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

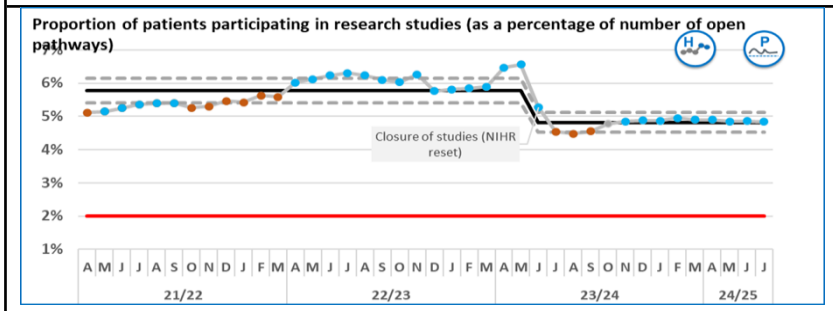
Discover - Graphs (2)



'Active Commercial Studies (Open + Closed to Recruitment in follow up)' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 59.

There are currently 59 commercial studies recruiting and in follow up . This is significantly higher than 2019/20 when we was averaging 44. Our medium term goal is to increase the % of patients recruited to commercial studies from 6% to the NIHR recommended level of 25%. Commercial studies are frequently interventional, requiring intensive investigations by skilled multidisciplinary staff and close monitoring. They give our patients access to new Investigational Medicinal Products (IMP) and devices. The current pipeline of 24 hosted studies in "set up" should ensure that we continue to increase recruitment to commercial studies. 14 of 17 (82%) of commercial studies recruited fully within the target time which meets the NIHR target of 80%. This has increased from 65% of studies in June 2023. Despite this some studies, commercial and non-commercial are still taking too long to be set up. We are actively addressing this and as a result of data cleansing, as well as increased efforts on setting up complex studies, the median set up time has dropped from 103 days in June 2024 to 71 days in September 2024. We have also taken steps to ensure that studies start recruiting as soon they open. Two new commercial ocular oncology studies are opening, one joint with University College London Hospital, which will explore the efficacy of drug treatments for Choroidal Melanoma. The treatment of Choroidal Melanoma has not changed fundamentally for many years and the development of drug treatments for this condition is long overdue. Moorfields, as the largest centre for Choroidal Melanoma treatment in the UK is well placed to offer these treatments to patients should the drugs be shown to deliver better outcomes than current treatment.

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



'Proportion of patients participating in research studies (as a percentage of number of open pathways)' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 4.8%.

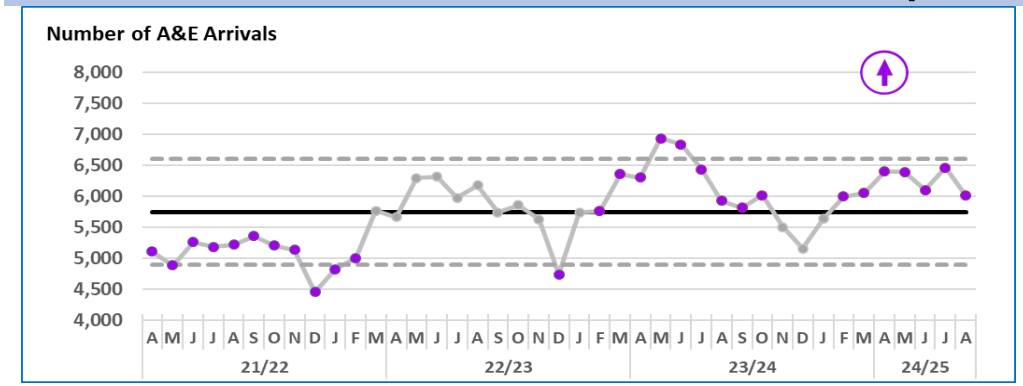
Our aim to have > 2% of our patient population involved in a research study has been achieved and at 4.9% currently exceed this. This reflects our emphasis on and investment in patient and public engagement as part of our NIHR Biomedical Research Centre (BRC) and Clinical Research Facility (CRF) strategy. Our Equity Diversity, and Inclusion strategy for both the BRC and CRF seeks to increase the diversity of our patients recruited to clinical trials as well as provide increased opportunities for patients to contribute to research.

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

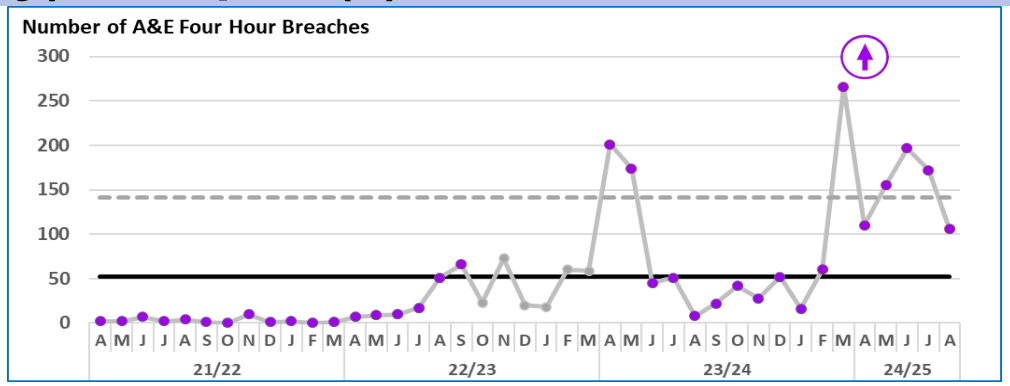
Context (Activity) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Number of A&E Arrivals	Jon Spencer	Internal Requirement	Monthly	No Target Set	31380	6011		
Number of A&E Four Hour Breaches	Jon Spencer	Internal Requirement	Monthly	No Target Set	740	106		
Number of Outpatient Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	280834	53375		
Number of Outpatient First Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	65216	12064		
Number of Outpatient Follow Up Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	215618	41311		
Number of Referrals Received	Jon Spencer	Internal Requirement	Monthly	No Target Set	79227	13569		
Number of Theatre Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	17189	3350		
Number of Theatre Elective Daycase Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	15746	3045		
Number of Theatre Elective Inpatient Admission	Jon Spencer	Internal Requirement	Monthly	No Target Set	372	69		
Number of Theatre Emergency Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	1071	236		

Context (Activity) - Graphs (1)

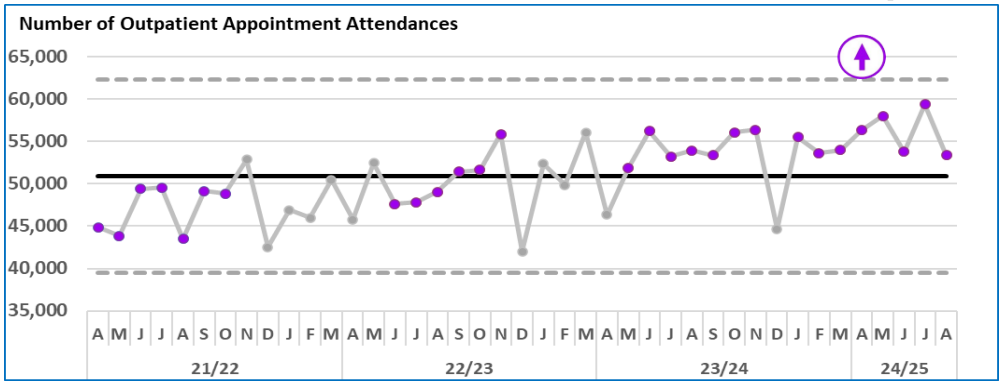


'Number of A&E Arrivals' is showing an 'special cause variation' (increasing rate). The figure is currently at 6,011.

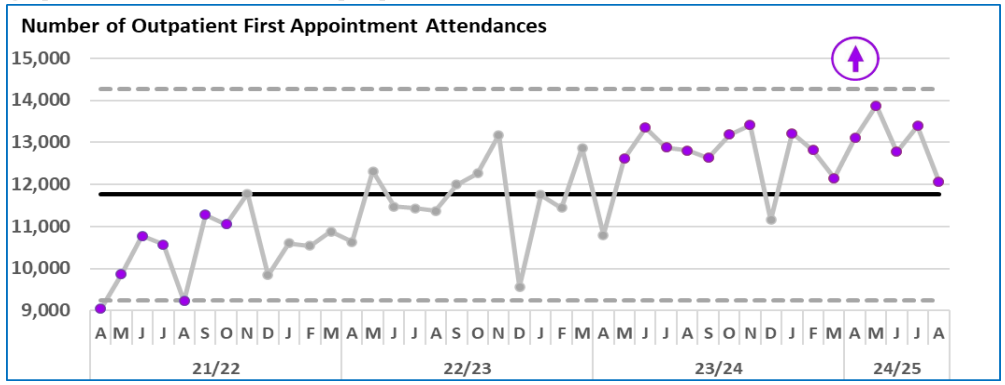


'Number of A&E Four Hour Breaches' is showing an 'special cause variation' (increasing rate). The figure is currently at 106.

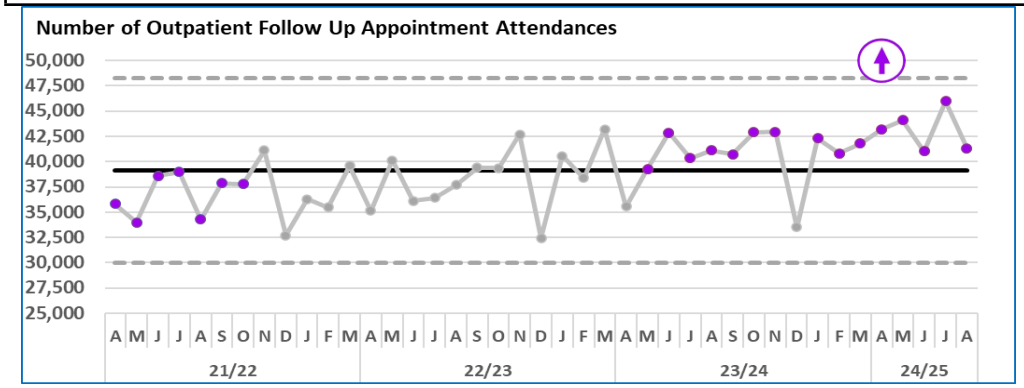
Context (Activity) - Graphs (2)



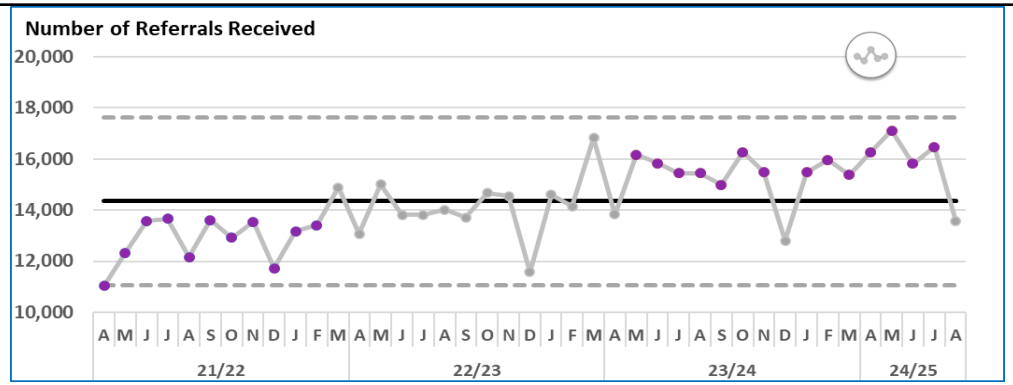
'Number of Outpatient Appointment Attendances' is showing an 'special cause variation' (increasing rate). The figure is currently at 53,375.



'Number of Outpatient First Appointment Attendances' is showing an 'special cause variation' (increasing rate). The figure is currently at 12,064.

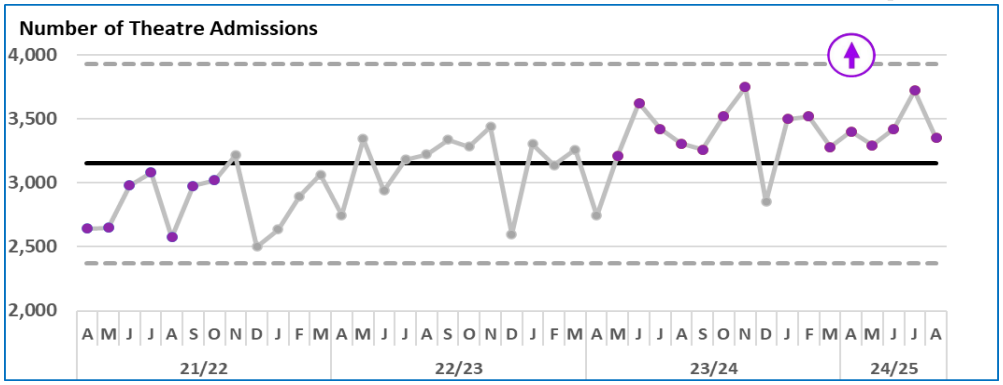


'Number of Outpatient Follow Up Appointment Attendances' is showing an 'special cause variation' (increasing rate). The figure is currently at 41,311.

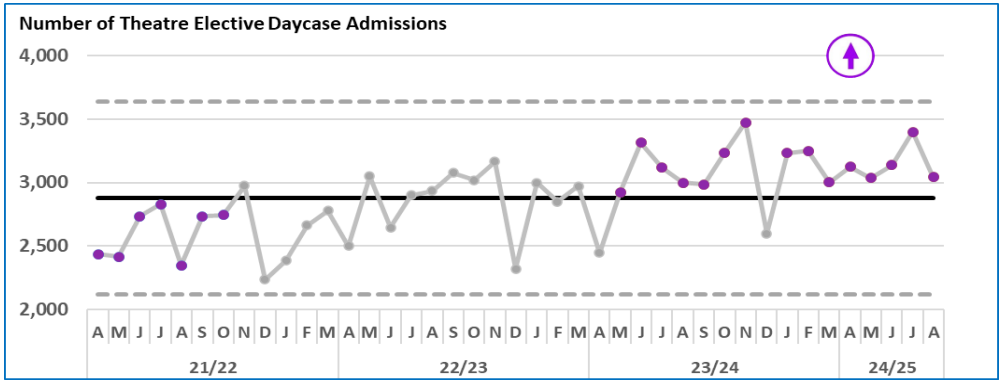


'Number of Referrals Received' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 13,569.

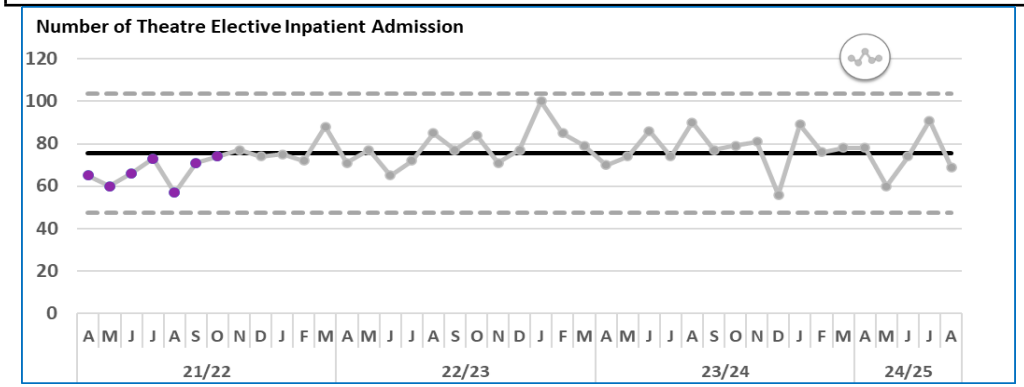
Context (Activity) - Graphs (3)



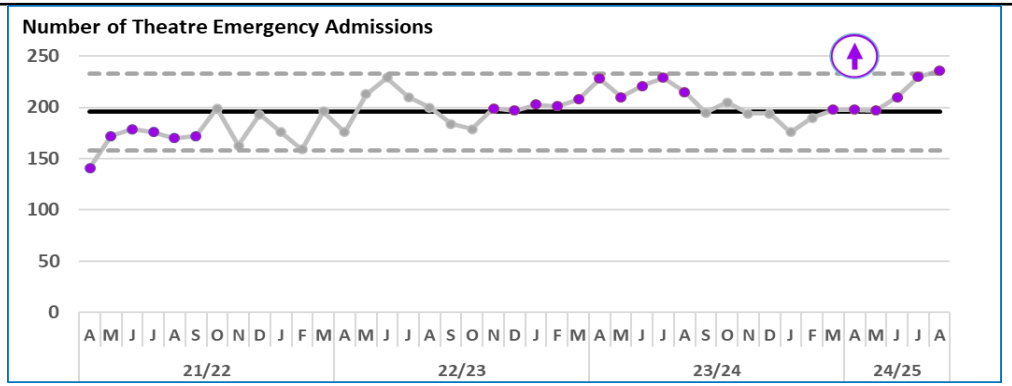
'Number of Theatre Admissions' is showing an 'special cause variation' (increasing rate). The figure is currently at 3,350.



'Number of Theatre Elective Daycase Admissions' is showing an 'special cause variation' (increasing rate). The figure is currently at 3,045.



'Number of Theatre Elective Inpatient Admission' is showing 'common cause variation'. The figure is currently at 69.



'Number of Theatre Emergency Admissions' is showing an 'special cause variation' (increasing rate) - This is a change from the previous month. The figure is currently at 236.

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Deliver (Activity vs Plan)																						
Elective Activity - % of Phased Plan	Aug-24	93.4%	≥100%	Monthly	Common Cause	Hit or Miss	96.2%	83.4%	109.0%	101.2%	100.7%	87.6%	93.9%	103.0%	87.7%	91.7%	94.2%	98.3%	95.2%	103.5%	95.3%	93.4%
Total Outpatient Activity - % of Phased Plan	Aug-24	100.1%	≥100%	Monthly	Improvement (Run Above Average)	Capable	99.4%	87.4%	111.4%	104.4%	103.2%	98.1%	98.5%	114.3%	96.9%	98.4%	109.2%	105.9%	108.8%	106.1%	101.9%	100.1%
Outpatient First Appointment Activity - % of Phased Plan	Aug-24	99.0%	≥100%	Monthly	Common Cause	Hit or Miss	100.7%	86.1%	115.3%	104.9%	103.6%	95.5%	98.2%	119.7%	96.2%	97.8%	102.4%	108.2%	115.0%	111.1%	100.8%	99.0%
Outpatient Follow Up Appointment Activity - % of Phased Plan	Aug-24	100.4%	≥85%	Monthly	Improvement (Run Above Average)	Capable	99.0%	86.9%	111.1%	104.3%	103.1%	98.9%	98.6%	112.7%	97.1%	98.6%	111.2%	105.3%	107.1%	104.8%	102.3%	100.4%
Deliver (Cancer Performance)																						
Cancer 28 Day Faster Diagnosis Standard	Aug-24	88.9%	≥75%	Monthly	Common Cause	Hit or Miss	94.4%	72.9%	116.0%	100.0%	100.0%	100.0%	66.7%	100.0%	75.0%	n/a	50.0%	100.0%	80.0%	100.0%	75.0%	88.9%
% Patients with all cancers receiving treatment within 31 days of decision to treat	Aug-24	100.0%	≥96%	Monthly	Common Cause	Capable	99.4%	96.6%	102.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%
% Patients with all cancers treated within 62 days	Aug-24	100.0%	≥85%	Monthly	Improvement (Run Above Average)	Capable	96.4%	68.4%	124.4%	n/a	n/a	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Deliver (Access Performance)																						
18 Week RTT Incomplete Performance	Aug-24	82.6%	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	80.3%	77.9%	82.8%	81.5%	81.5%	82.8%	83.1%	82.5%	82.7%	82.9%	83.3%	85.0%	85.4%	84.3%	84.0%	82.6%
RTT Incomplete Pathways (RTT Waiting List)	Aug-24	34,357	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	36,622	34,904	38,339	37,130	36,341	36,062	34,842	35,138	34,639	35,233	35,656	35,674	35,682	34,201	33,017	34,357
RTT Incomplete Pathways Over 18 Weeks	Aug-24	5,966	≤ Previous Mth.	Monthly	Decreasing (Run Below Average)	Not Applicable	7,237	6,272	8,203	6,863	6,735	6,210	5,871	6,148	6,000	6,012	5,962	5,361	5,205	5,377	5,271	5,966
52 Week RTT Incomplete Breaches	Aug-24	10	≤5 Breaches	Monthly	Common Cause	Hit or Miss	10	-5	25	4	8	10	7	20	7	5	10	5	10	7	8	10
Eliminate waits over 65 weeks for elective care	Aug-24	4	No Target Set	Monthly	Common Cause	Not Applicable	4	-4	11	2	1	1	1	14	4	3	1	1	4	3	2	4
A&E Four Hour Performance	Aug-24	98.1%	≥95%	Monthly	Concern (Run Below Average)	Capable	99.1%	97.5%	100.7%	99.9%	99.6%	99.3%	99.5%	98.9%	99.7%	98.9%	95.3%	98.2%	97.4%	96.6%	97.2%	98.1%
Percentage of Diagnostic waiting times less than 6 weeks	Aug-24	99.1%	≥99%	Monthly	Common Cause	Hit or Miss	99.3%	96.9%	101.7%	100.0%	100.0%	100.0%	99.5%	97.9%	100.0%	99.4%	98.3%	100.0%	99.5%	98.3%	98.3%	99.1%
Deliver (Call Centre and Clinical)																						
Average Call Waiting Time	Aug-24	174	≤ 2 Mins (120 Sec)	Monthly	Common Cause	Failing	222	15	429	144	143	104	100	72	124	163	249	236	197	276	146	174
Average Call Abandonment Rate	Aug-24	13.2%	≤15%	Monthly	Common Cause	Hit or Miss	13.6%	3.4%	23.9%	8.7%	8.9%	6.2%	6.9%	6.6%	11.5%	14.7%	19.2%	16.3%	14.0%	18.8%	12.0%	13.2%
Mixed Sex Accommodation Breaches	Aug-24	0	Zero Breaches	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Aug-24	0.00%	≤ 2.67%	Monthly (Rolling 3 Months)	Common Cause	Hit or Miss	1.71%	-2.64%	6.06%	1.47%	1.67%	3.03%	3.08%	3.51%	1.30%	3.28%	1.49%	1.52%	3.23%	0.00%	0.00%	0.00%
VTE Risk Assessment	Aug-24	99.7%	≥95%	Monthly	Common Cause	Capable	99.1%	97.8%	100.5%	98.4%	98.5%	99.7%	98.9%	98.2%	99.4%	99.1%	98.6%	99.8%	99.9%	99.9%	100.0%	99.7%
Posterior Capsular Rupture rates (Cataract Operations Only)	Aug-24	0.75%	≤1.95%	Monthly	Common Cause	Capable	0.88%	0.13%	1.63%	1.15%	1.05%	1.06%	0.75%	0.42%	0.64%	0.53%	0.62%	0.57%	0.89%	0.68%	1.35%	0.75%
MRSA Bacteraemias Cases	Aug-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile Cases	Aug-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Aug-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Rate - cases	Aug-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Deliver (Quality and Safety)																						
Inpatient Scores from Friends and Family Test - % positive	Aug-24	96.1%	≥90%	Monthly	Improvement (Run Above Average)	Capable	95.6%	93.6%	97.7%	94.7%	95.5%	95.4%	96.1%	96.3%	96.4%	96.0%	96.5%	95.7%	96.5%	96.7%	97.3%	96.1%
A&E Scores from Friends and Family Test - % positive	Aug-24	94.0%	≥90%	Monthly	Common Cause	Capable	92.7%	90.2%	95.3%	93.3%	93.1%	93.3%	94.2%	93.6%	94.5%	93.4%	93.6%	91.5%	93.2%	92.5%	92.7%	94.0%
Outpatient Scores from Friends and Family Test - % positive	Aug-24	94.4%	≥90%	Monthly	Improvement (Run Above Average)	Capable	93.5%	92.6%	94.5%	92.8%	93.3%	93.4%	94.5%	94.5%	94.2%	93.6%	93.7%	94.2%	94.5%	94.5%	94.4%	94.4%
Paediatric Scores from Friends and Family Test - % positive	Aug-24	95.8%	≥90%	Monthly	Common Cause	Capable	94.4%	90.5%	98.4%	96.3%	94.6%	96.0%	94.9%	95.5%	95.2%	93.2%	94.6%	95.2%	96.8%	93.6%	94.8%	95.8%
Percentage of responses to written complaints sent within 25 days	Jul-24	87.5%	≥80%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	88.4%	59.2%	117.6%	82.4%	100.0%	83.3%	100.0%	87.5%	83.3%	91.7%	100.0%	75.0%	90.9%	83.3%	87.5%	n/a
Percentage of responses to written complaints acknowledged within 3 days	Aug-24	100.0%	≥80%	Monthly	Common Cause	Capable	95.1%	78.6%	111.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%
Freedom of Information Requests Responded to Within 20 Days	Jul-24	82.8%	≥90%	Monthly (Month in Arrears)	Common Cause	Failing	84.8%	49.7%	120.0%	52.0%	81.6%	82.5%	41.5%	66.7%	98.3%	47.7%	32.0%	76.1%	86.0%	85.4%	82.8%	n/a
Subject Access Requests (SARs) Responded To Within 28 Days	Jul-24	99.1%	≥90%	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	95.8%	85.7%	106.0%	84.2%	87.8%	94.6%	96.2%	97.3%	92.9%	98.9%	97.3%	97.5%	95.9%	98.8%	99.1%	n/a
Deliver (Incident Reporting)																						
Occurrence of any Never events	Aug-24	0	Zero Events	Monthly	Common Cause	Hit or Miss	0	-1	1	0	0	0	1	0	0	1	0	0	1	0	0	0
Summary Hospital Mortality Indicator	Aug-24	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Patient Safety Alerts (NatPSAs) breached	Aug-24	0	Zero Alerts	Monthly	Common Cause	Hit or Miss	0	0	1	0	0	1	1	0	0	0	1	1	1	1	0	0
Number of Serious Incidents remaining open after 60 days	Aug-24	0	Zero Cases	Monthly	Common Cause	Hit or Miss	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Aug-24	283	No Target Set	Monthly	Concern (Run Above Average)	Not Applicable	223	141	305	175	133	151	206	243	262	259	257	277	269	302	264	283

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Sustainability and at Scale																						
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Aug-24	98	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	101	96	106	103	100	99	102	100	100	97	97	96	97	97	99	98
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Aug-24	37	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	46	40	51	48	51	46	40	38	41	45	44	39	39	39	39	37
Theatre Cancellation Rate (Non-Medical Cancellations)	Aug-24	1.03%	≤0.8%	Monthly	Common Cause	Hit or Miss	0.98%	-0.17%	2.13%	0.92%	1.43%	0.74%	0.98%	1.28%	0.79%	0.86%	0.56%	0.62%	0.65%	0.97%	0.91%	1.03%
Number of non-medical cancelled operations not treated within 28 days	Aug-24	0	Zero Breaches	Monthly	Improvement (Run Below Average)	Capable	1	-3	6	6	2	3	2	1	4	0	0	0	0	0	0	0
Overall financial performance (In Month Var. £m)	Aug-24	0.25	≥0	Monthly	Common Cause	Hit or Miss	0.44	-1.80	2.67	0.03	0.04	-0.10	1.32	2.35	0.98	-0.44	1.10	0.01	-0.47	0.09	0.41	0.25
Commercial Trading Unit Position (In Month Var. £m)	Aug-24	0.17	≥0	Monthly	Common Cause	Hit or Miss	0.00	-0.92	0.91	0.29	-0.58	0.28	-0.16	-0.28	0.33	0.06	-0.92	0.02	-0.29	-0.07	0.23	0.17
Working Together																						
Appraisal Compliance	Aug-24	73.4%	≥80%	Monthly	Common Cause	Failing	74.5%	68.5%	80.5%	78.4%	74.4%	69.8%	73.5%	76.4%	78.3%	77.2%	75.6%	74.7%	70.6%	72.5%	74.1%	73.4%
Basic Mandatory IG Training	Aug-24	88.9%	≥90%	Monthly	Concern (Run Below Average)	Hit or Miss	91.8%	89.3%	94.2%	90.0%	90.9%	93.5%	92.8%	91.6%	91.5%	91.2%	90.1%	90.2%	90.1%	88.5%	88.9%	88.9%
Staff Sickness (Month Figure)	Jul-24	4.7%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.4%	3.3%	5.6%	4.4%	4.4%	5.2%	4.5%	4.4%	4.5%	4.3%	4.3%	4.3%	4.2%	4.4%	4.7%	n/a
Staff Sickness (Rolling Annual Figure)	Jul-24	4.5%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.5%	4.4%	4.7%	4.5%	4.6%	4.6%	4.5%	4.4%	4.5%	4.4%	4.4%	4.4%	4.5%	4.5%	4.5%	n/a
Recruitment Time To Hire (Days)	Aug-24	41	≤40 Days	Monthly	Common Cause	Hit or Miss	48	35	61	55	56	52	58	48	49	47	50	58	44	42	40	41
Proportion of Temporary Staff	Aug-24	13.9%	No Target Set	Monthly	Common Cause	Not Applicable	14.0%	9.4%	18.5%	19.3%	14.8%	15.5%	15.8%	12.7%	13.7%	17.1%	16.6%	13.3%	13.0%	15.9%	13.3%	13.9%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Discover																						
Total patient recruitment to NIHR portfolio adopted studies	Jul-24	236	≥115 (per month)	Monthly (Month in Arrears)	Common Cause	Capable	243	102	385	211	201	229	231	118	127	153	132	124	128	293	236	n/a
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Jul-24	335	No Target Set	Monthly (Month in Arrears)	Common Cause	Not Applicable	320	121	518	333	290	322	321	187	209	224	185	169	174	367	335	n/a
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Jul-24	59	≥44	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	55	51	60	51	50	52	52	55	56	56	60	62	59	57	59	n/a
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Jul-24	4.8%	≥2%	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	4.8%	4.5%	5.1%	4.5%	4.6%	4.8%	4.9%	4.9%	4.9%	5.0%	4.9%	4.9%	4.8%	4.9%	4.8%	n/a
Context (Activity)																						
Number of A&E Arrivals	Aug-24	6,011	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	5,750	4,893	6,606	5,931	5,819	6,020	5,506	5,161	5,636	6,001	6,053	6,401	6,394	6,105	6,469	6,011
Number of A&E Four Hour Breaches	Aug-24	106	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	52	-36	141	8	22	42	28	52	16	60	266	110	155	197	172	106
Number of Outpatient Appointment Attendances	Aug-24	53,375	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	50,872	39,479	62,265	53,907	53,352	56,088	56,363	44,678	55,530	53,622	53,957	56,320	57,990	53,786	59,363	53,375
Number of Outpatient First Appointment Attendances	Aug-24	12,064	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	11,755	9,234	14,276	12,806	12,630	13,191	13,409	11,152	13,222	12,821	12,152	13,100	13,878	12,778	13,396	12,064
Number of Outpatient Follow Up Appointment Attendances	Aug-24	41,311	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	39,116	29,987	48,246	41,101	40,722	42,897	42,954	33,526	42,308	40,801	41,805	43,220	44,112	41,008	45,967	41,311
Number of Referrals Received	Aug-24	13,569	No Target Set	Monthly	Common Cause	Not Applicable	14,347	11,078	17,616	15,448	14,991	16,265	15,496	12,799	15,488	15,972	15,378	16,258	17,109	15,812	16,479	13,569
Number of Theatre Admissions	Aug-24	3,350	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	3,151	2,373	3,928	3,306	3,259	3,522	3,749	2,850	3,498	3,518	3,279	3,402	3,294	3,421	3,722	3,350
Number of Theatre Elective Daycase Admissions	Aug-24	3,045	No Target Set	Monthly	Increasing (Run Above Average)	Not Applicable	2,880	2,121	3,638	3,001	2,987	3,238	3,474	2,600	3,233	3,252	3,003	3,126	3,037	3,137	3,401	3,045
Number of Theatre Elective Inpatient Admission	Aug-24	69	No Target Set	Monthly	Common Cause	Not Applicable	76	47	104	90	77	79	81	56	89	76	78	78	60	74	91	69
Number of Theatre Emergency Admissions	Aug-24	236	No Target Set	Monthly	Increasing (Higher Than Expected)	Not Applicable	196	158	233	215	195	205	194	194	176	190	198	198	197	210	230	236

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report

Trust Board Report

For the period ended 31st August 2024 (Month 05)

Report Period	M05 | August 2024
Presented by	Jonathan Wilson | Chief Financial Officer
Written by	Justin Betts | Deputy Chief Financial Officer Amit Patel | Head of Financial Management Lubna Dharssi | Head of Financial Control Richard Allen | Head of Income and Contracts

Monthly Finance Performance Report

For the period ended 31st August 2024 (Month 05)

Key Messages

Statement of Comprehensive Income

Financial Position £0.37m deficit in month	For August, the trust is reporting:- • A £0.37m deficit in-month against a planned deficit of £0.62m, £0.25m favourable variance to plan • A £1.60m surplus cumulatively against a planned surplus of £1.33m, £0.27m favourable to plan.

Key Drivers of the Financial Variance	The £0.27m favourable variance cumulatively is comprised of:-
	• £0.9m adverse core operational performance, supported by
	• £1.2m favourable slippage in IT EPR and IT project workstreams.
	
	Key Drivers of adverse core operational performance include:-
	• Clinical divisions and core activity performance are reporting £(0.9)m adverse cumulatively
	  • Elective activity is 92% of funded capacity and 96% of the demand plans
	  • Overall elective activity is £2.2m behind plan, offset by £1.1m price mix gains. reporting £1.1m adverse to plan cumulatively.
	  • Stratford elective activity is 40% of cumulative funded capacity, 66% demand plans
	  • St Annes elective activity is 76% cumulatively funded capacity, 75% of demand plans
	  • Cataract activity is 85% of trust capacity plans
	  • Outpatients Firsts and Follow Ups at 104% and 107% respectively cumulatively, partially offsetting underperformance on elective activity.
	• Research is reporting a £0.9m adverse cumulatively comprised of research costs in excess of study activity, lower than planned commercial IP income, and higher than planned management and strategic project costs.
	• Corporate areas are reporting £0.5m adverse cumulatively, predominantly linked to higher than planned legal fees.
	• Trading, depreciation & financing and central budgets are £1.3m favourable, primarily consisting of £0.6m depreciation and financing linked to capital programme slippage, £0.8m one off benefits, and £(0.3)m adverse for trading units.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 31st August was £70.1m, a reduction of £0.6m from the position at the end of March 2024. The Better Payment Practice Code (BPPC) performance in August was 94% (volume) and 94% (value) against a target of 95% across both metrics.
Capital (both gross capital expenditure and CDEL)	Capital expenditure as of 31st August totalled £24.2m. • Business as Usual capital totals £0.5m. • Other capital totals £23.6.6m with £23.2 of Oriel expenditure and £0.5m EPR expenditure. The trust has committed £6.2m (64%) of the available £9.7m of the available business as usual £9.7m capital allocation whilst strategic schemes including network strategy, IMT transition costs and Granary Street were being finalised.

Other Key Information

Efficiencies £10.00m Trust Target £6.43m Forecast	The trust has a planned efficiency programme of £10m for 2024/25 to deliver the control total. The trust has identified and is forecasting £6.43m, leaving a remaining £3.57m to be identified. Of the total identified:- • £4.6m is identified as income generation schemes • £3.9m is forecast recurrently The CIP programme are working through efficiency scheme delivery with further opportunities of £3.00m to be fully financial validated towards increasing the level of identified and forecast delivery in 2024/25.
Agency Spend £2.99m spend YTD 3.9% total pay	Trust wide agency spend totals £2.99m cumulatively, approximately 3.9% of total employee expenses spend, below the system allocated target of 4.8%. Workforce have instigated temporary staffing committees for oversight in relation to managing and reporting temporary staffing agency usage and reasons.

Trust Financial Performance - Financial Dashboard Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income	£345.9m	£26.3m	£26.2m	(£0.1m)	£143.6m	£142.8m	(£0.8m)	(1)%	
Pay	(£183.7m)	(£15.3m)	(£15.5m)	(£0.2m)	(£75.8m)	(£76.2m)	(£0.3m)	(0)%	
Non Pay	(£123.0m)	(£10.3m)	(£9.6m)	£0.7m	(£52.2m)	(£51.2m)	£1.0m	2%	
Financing & Adjustments	(£33.8m)	(£1.2m)	(£1.4m)	(£0.2m)	(£14.2m)	(£13.8m)	£0.4m	3%	
CONTROL TOTAL	**£5.4m**	**(£0.6m)**	**(£0.4m)**	**£0.2m**	**£1.3m**	**£1.6m**	**£0.3m**		
Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income									
Memorandum Items									
Research & Development	£0.29m	£0.02m	(£0.10m)	(£0.13m)	£0.12m	(£0.82m)	(£0.94m)	(783)%	
Commercial Trading Units	£6.05m	£0.30m	£0.47m	£0.17m	£2.10m	£1.93m	(£0.17m)	(8)%	
ORIEL Revenue	(£0.80m)	(£0.07m)	(£0.05m)	£0.02m	(£0.33m)	(£0.28m)	£0.05m	15%	
Efficiency Schemes	£10.00m	£0.75m	£0.54m	(£0.22m)	£3.33m	£2.69m	(£0.65m)	(19)%	

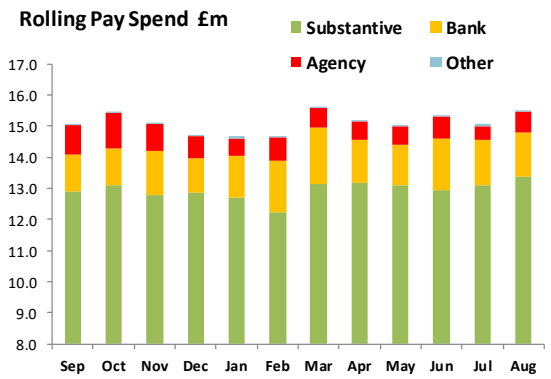
INCOME BREAKDOWN RELATED TO ACTIVITY

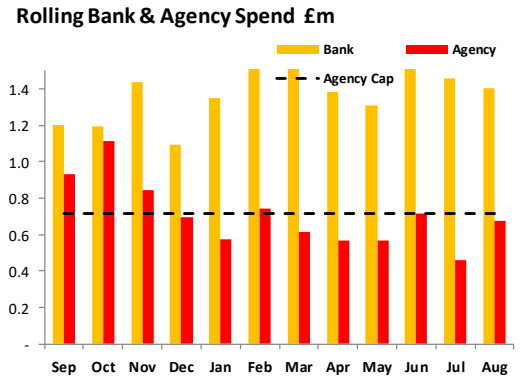
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£204.2m	£85.1m	£84.8m	(£0.3m)				
Pass Through	£39.7m	£16.6m	£16.6m	(£0.0m)				
Other NHS Clinical Income	£9.7m	£4.1m	£4.6m	£0.6m				
Commercial Trading Units	£46.7m	£18.9m	£18.6m	(£0.3m)				
Research & Development	£16.8m	£6.7m	£5.8m	(£0.9m)				
Other	£28.9m	£12.3m	£12.5m	£0.2m				
INCOME INCL ERF	**£345.9m**	**£143.6m**	**£142.8m**	**(£0.8m)**				

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

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	% Total
Employed	(£181.2m)	(£15.1m)	(£13.4m)	£1.7m	(£74.8m)	(£65.7m)	£9.1m	86%
Bank	(£1.6m)	(£0.1m)	(£1.4m)	(£1.3m)	(£0.7m)	(£7.2m)	(£6.5m)	9%
Agency	(£0.4m)	(£0.0m)	(£0.7m)	(£0.7m)	(£0.1m)	(£3.0m)	(£2.9m)	4%
Other	(£0.6m)	(£0.0m)	(£0.1m)	(£0.0m)	(£0.2m)	(£0.3m)	(£0.0m)	0%
TOTAL PAY	**(£183.7m)**	**(£15.3m)**	**(£15.5m)**	**(£0.2m)**	**(£75.8m)**	**(£76.2m)**	**(£0.3m)**	





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

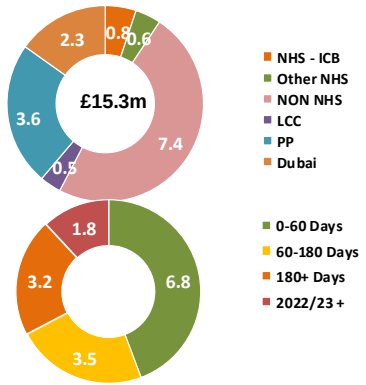
CASH, CAPITAL AND OTHER KPI'S

Capital Programme £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£9.7m)	(£0.5m)	(£0.5m)	(£0.0m)				
Donated/Externally funded	(£116.5m)	(£32.1m)	(£23.2m)	(£8.9m)				
TOTAL	**£126.2m**	**£32.6m**	**£23.7m**	**(£8.9m)**				

Key Metrics	Plan	Actual	RAG
Cash	70.0	70.1	
Debtor Days	45	16	
Creditor Days	45	39	
PP Debtor Days	65	56	

Better Payment Practice	Plan	Actual
BPPC - NHS (YTD) by number	95%	93%
BPPC - NHS (YTD) by value	95%	94%
BPPC - Non-NHS (YTD) by number	95%	94%
BPPC - Non-NHS (YTD) by value	95%	94%

Net Receivables/Ageing £m



Trust Income and Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income									
NHS Commissioned Clinical Income	243.88	19.29	19.48	0.20	101.69	101.38	(0.31)	(0)%	
Other NHS Clinical Income	9.74	0.76	0.76	0.01	4.05	4.63	0.58	14%	
Commercial Trading Units	46.68	3.59	3.78	0.19	18.90	18.58	(0.32)	(2)%	
Research & Development	16.76	1.45	1.17	(0.28)	6.66	5.75	(0.91)	(14)%	
Other Income	28.88	1.19	1.00	(0.19)	12.25	12.45	0.20	2%	
Total Income	**345.93**	**26.27**	**26.19**	**(0.08)**	**143.56**	**142.80**	**(0.76)**	**(1)%**	
Operating Expenses									
Pay	(183.74)	(15.34)	(15.53)	(0.18)	(75.84)	(76.18)	(0.35)	(0)%	
Of which: Unidentifed CIP	*3.03*	*0.25*	*-*	*(0.25)*	*1.23*	*-*	*(1.23)*		
Drugs	(42.57)	(3.44)	(3.27)	0.17	(17.68)	(17.85)	(0.17)	(1)%	
Clinical Supplies	(27.13)	(2.09)	(2.27)	(0.18)	(11.09)	(11.26)	(0.17)	(2)%	
Other Non Pay	(53.34)	(4.82)	(4.09)	0.73	(23.44)	(22.12)	1.32	6%	
Of which: Unidentifed CIP	*1.32*	*0.11*	*-*	*(0.11)*	*0.56*	*-*	*(0.56)*		
Total Operating Expenditure	**(306.78)**	**(25.69)**	**(25.16)**	**0.53**	**(128.05)**	**(127.42)**	**0.63**	**0%**	
EBITDA	*39.15*	*0.58*	*1.04*	*0.45*	*15.51*	*15.38*	*(0.13)*	(1)%	
Financing & Depreciation	(17.92)	(1.25)	(1.45)	(0.20)	(7.43)	(6.98)	0.45	6%	
Donated assets/impairment adjustments	(15.83)	0.05	0.04	(0.01)	(6.75)	(6.79)	(0.04)	(1)%	
Control Total Surplus/(Deficit) Pre ERF	**5.40**	**(0.62)**	**(0.37)**	**0.25**	**1.33**	**1.60**	**0.27**	**21%**	

Commentary

Operating Income

£0.08m adverse to plan in month

Total operating income is reporting £26.19m in-month, £0.08m adverse to plan, and £0.76m adverse to plan cumulatively. Key points of note are:-

- Clinical income was £19.48m, £0.20m favourable to plan in-month primarily due to confirmation of draft inflationary uplift in contracts. However underlying elective activity was at 89% (92% cumulatively) driving an adverse variance partially offset price mix gains.
- Elective activity was significantly below plan in the north-east locality with Stratford activity at 42% and St Anns activity at 81% during August.
- Commercial trading income was £3.78m, £0.19m favourable to plan.
- Research and Development income at £1.17m was £0.28m adverse, driven by reduced levels of planned income across, BRC, grants and Insight.
- Other income was £0.19m adverse to plan

Employee Expenses

£0.18m adverse to plan in month

August pay is reporting £15.53m; £0.18m adverse to plan in month. Key points of note are:-

- Substantive pay costs were higher in month than the prior quarter trend due to medical pay arrears in month including the junior doctor pay award.
- Temporary staffing costs were £2.08m in August
  - Agency costs are £0.68m in month, lower than the 12-month trend of £0.71m. Agency use continues mainly on administration in both clinical and corporate areas, with IMT and Workforce being the highest corporate areas of use.
  - Bank costs are £1.41m in month, slightly lower than the rolling 12-month trend. Medical bank, nursing and clinical admin continue to be the drivers for bank spend.
  - £0.25m unachieved pay CIP (£1.23m cumulatively)

Non-Pay Expenses

£0.51m favourable to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in August were £9.63m, £0.71m favourable to plan. Key points of note are:-

- Drugs was £0.17m favourable in month with £3.27m expenditure in August against a 12-month trend of £3.61m. Injections were at 104% of planned activity in month.
- Clinical supplies was £0.18m adverse to plan in month. Costs were £2.27m in month against a 12-month trend of £2.14m. Costs in City Road Theatres are increasing aligned to the increase in cataract activity, however the driver for the increase was graft activity which was at 178% of planned activity in month.
- Other non-pay is £0.73m favourable in August predominantly reflecting delays in IT (EPR and Projects), and re-profiling of cost pressure funding towards later in the year.
- £0.11m unachieved non-pay CIP (£0.56m cumulatively)

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

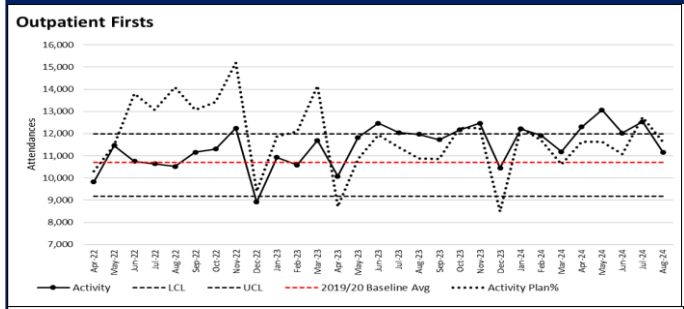
ER	Point of Delivery	Activity In Month				Activity YTD				Weighted YTD Income £m			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	3,432	3,062	(370)	89%	17,322	15,904	(1,418)	92%				
	Of which - SA & ST	806	401	(405)	50%	4,067	2,117	(1,950)	52%				
	OP Firsts	11,624	11,164	(459)	96%	58,671	61,102	2,431	104%				
	OP Procedures	20,896	20,107	(789)	96%	105,474	111,290	5,816	106%				
	ERF Activity Total												
Non ERF Acti	OP Follow Ups	18,671	20,589	1,918	110%	94,246	101,930	7,684	108%				
	High Cost Drugs Injections	4,657	4,843	186	104%	23,507	23,513	6	100%				
	Non Elective	217	235	18	108%	1,071	1,067	(4)	100%				
	AandE	7,521	6,011	(1,510)	80%	37,118	31,380	(5,738)	85%				
	Total	67,018	66,011	(1,006)	98%	337,409	346,186	8,777	103%				

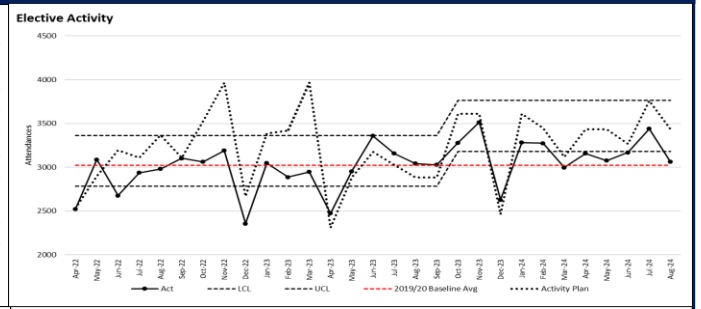
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

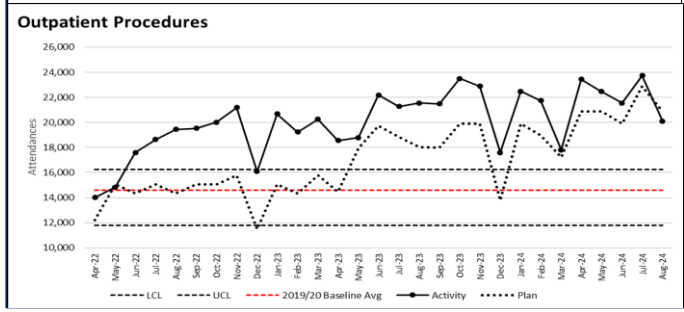
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

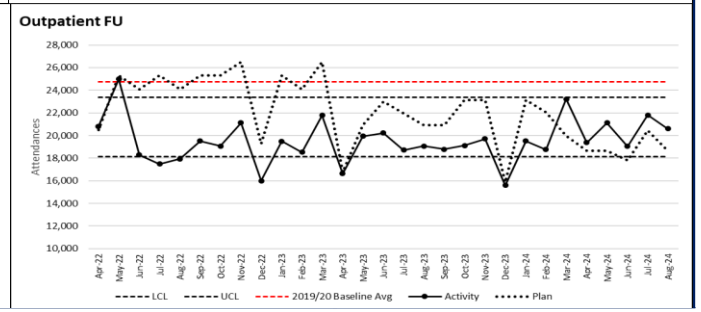
Performance % figures above, represent the Trust performance against the external activity target. Financial values shown are for ERF activity only.

ACTIVITY TREND - ERF COMPONENTS









Commentary

NHS Income

ERF Achievement

ERF performance continues to be based on estimates awaiting national reporting for 2024/25. Nationally ERF reporting for 2023/24 performance remains awaited.

ERF Activity performance achievement

- **Inpatient activity** achieved 89% in August and 92% year to date of the capacity plan.
- The table also splits out Stratford 41% year to date and St Annes 76% year to date to derive 50% overall.
- **Outpatient Firsts Activity** achieved 96% of the capacity plan in August; 104% year to date
- **Outpatient Procedures Activity** achieved 96% of activity plans in August; 106% cumulatively

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 104% of activity plans in August; 100% year to date
- **A&E** achieved 80% of activity plans in August; 85% year to date

Activity plans and ERF

Current activity plans are based on approved funded capacity plans. Amendments to 'Demand' plan levels as part of the Trust Capacity v Demand rectification plans are due to be amended in September upon receipt of further information form operational teams for the pay and CIP allocation aspects of the rectification plans.

- 2024/25 performance for ERF is yet to be confirmed.

Activity Plans

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

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

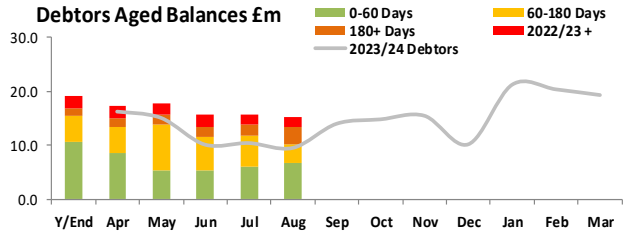
CAPITAL EXPENDITURE

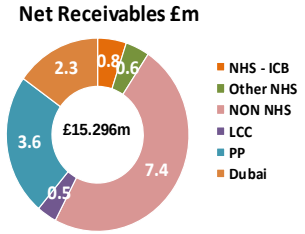
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Medical Equipment	1.3	0.1	0.1	0.0
Estates	0.7	0.0	0.0	(0.0)
IMT	0.2	0.1	0.1	-
Commercial	0.9	0.3	0.3	(0.0)
Network Strategy	-	-	-	-
Other - Trust funded	6.6	-	-	-
TOTAL - TRUST BAU CAPITAL	**9.7**	**0.5**	**0.5**	**(0.0)**
Oriel Programme	116.5	32.1	23.2	(8.9)
EPR Project	11.3	0.8	0.5	(0.3)
NiHR Capital Grant	1.7	-	-	-
Other & Charity	0.3	-	-	-
TOTAL INCLUDING DONATED	**139.4**	**33.4**	**24.2**	**(9.2)**

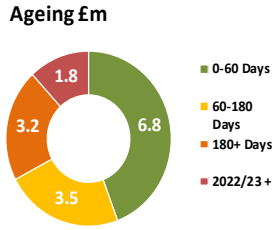
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
ICS Capital Allocation	13.8	13.8	-	100%
Cash Reserves - Oriel	1.0	1.0	-	100%
Cash Reserves - B/Fwd	0.8	0.8	-	100%
Capital Loan Repayments	(1.8)	(1.8)	-	100%
TOTAL - TRUST FUNDED	**13.8**	**13.8**	**-**	**100%**
Externally funded	109.0	109.0	-	100%
Donated/Charity	16.6	16.5	0.2	99%
TOTAL INCLUDING DONATED	**139.4**	**139.2**	**0.2**	**100%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2022/23 +*	*Total*
CCG Debt	(0.0)	0.8	0.0	-	0.8
Other NHS Debt	(0.2)	0.2	0.4	0.3	0.6
Non NHS Debt	3.3	1.3	1.8	1.0	7.4
Commercial Unit Debt	3.8	1.2	1.0	0.5	6.5
TOTAL RECEIVABLES	**6.8**	**3.5**	**3.2**	**1.8**	**15.3**







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	453.8	306.5	287.1	(19.3)
Current assets (excl Cash)	33.9	33.9	37.1	3.2
Cash and cash equivalents	69.7	70.0	70.1	0.1
Current liabilities	(55.7)	(55.8)	(50.5)	5.3
Non-current liabilities	(199.7)	(89.8)	(84.9)	4.9
TOTAL ASSETS EMPLOYED	**301.9**	**264.8**	**258.9**	**(5.8)**

OTHER METRICS

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

Commentary

Cash and Working Capital

The cash balance as at the 31st August was £70.1m, a reduction of £0.6 from the position at the end of March 2024.

Capital Expenditure/ Non-current assets

Capital expenditure as of 31st August totalled £24.2m.

- Business as Usual capital totals £0.5m.
- Other schemes total £23.6m including £23.2m of expenditure for Oriel, and £0.5m on EPR.

The trust has committed £6.2m (64%) of the available £9.7m business as usual capital allocation whilst strategic schemes including network strategy, IMT transition costs and Granary Street were being finalised.

The variance on non-current assets of £19.3m is due to a shortfall in capital expenditure, primarily for Oriel.

Receivables

Receivables have reduced by £3.9m to £15.3m since the end of the 2023/24 financial year. Debt in excess of 60 days reduced by £1.2m in August, which was partially offset by an increase in current debt of £0.8m.

Payables

Payables totalled £14.4m at the end of August, a reduction of £11.7m since the end of March 2024.

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

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

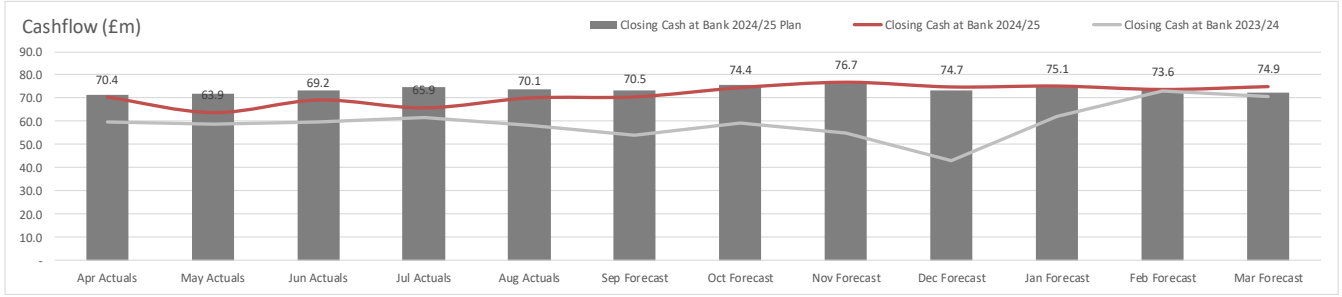
Use of Resources

Use of resources monitoring and reporting has been suspended.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Actuals	Aug Actuals	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Aug Forecast	Aug Var
Opening Cash at Bank	**70.7**	**70.4**	**63.9**	**69.2**	**65.9**	**70.1**	**70.5**	**74.4**	**76.7**	**74.7**	**75.1**	**73.6**	**70.7**		
Cash Inflows															
Healthcare Contracts	20.4	20.3	21.4	21.7	21.1	20.4	23.2	21.3	17.7	22.3	20.3	20.7	250.7	19.5	1.6
Other NHS	2.6	1.3	2.0	0.5	3.4	0.9	1.0	1.0	0.9	1.0	0.9	1.0	16.3	0.9	2.4
Moorfields Private/Dubai/NCS	4.7	3.8	4.0	4.5	3.6	4.1	4.4	4.4	3.4	4.3	4.1	4.3	49.6	3.5	0.1
Research	3.1	1.0	1.3	1.5	0.8	1.4	1.4	1.4	1.4	1.3	1.3	1.3	17.1	1.4	(0.6)
VAT	1.5	1.1	1.0	-	1.8	0.5	0.5	0.5	0.5	0.5	0.5	0.5	8.9	1.5	0.3
PDC	7.8	-	-	2.7	9.1	10.5	11.9	14.0	5.6	12.9	12.8	19.9	107.1	11.0	(1.9)
Other Inflows	0.3	0.4	7.3	0.3	0.3	0.3	0.3	0.3	8.0	0.8	0.8	0.8	19.8	0.2	0.1
Total Cash Inflows	**40.2**	**27.9**	**36.9**	**31.2**	**40.1**	**38.0**	**42.6**	**42.7**	**37.4**	**43.0**	**40.8**	**48.6**	**469.5**	**38.0**	**2.1**
Cash Outflows															
Salaries, Wages, Tax & NI	(13.0)	(13.3)	(12.9)	(12.8)	(13.0)	(12.9)	(12.9)	(12.9)	(12.9)	(12.9)	(12.9)	(12.9)	(155.6)	(12.9)	(0.1)
Non Pay Expenditure	(21.4)	(12.7)	(12.6)	(15.9)	(11.9)	(11.1)	(12.1)	(11.8)	(11.4)	(12.9)	(12.8)	(11.8)	(158.5)	(11.9)	(0.0)
Capital Expenditure	(0.9)	(0.2)	(0.5)	(0.3)	(0.1)	(0.8)	(2.7)	(2.7)	(2.7)	(3.3)	(3.3)	(4.5)	(22.1)	(0.8)	0.7
Oriel	(4.0)	(6.6)	(4.1)	(4.1)	(9.1)	(9.5)	(9.6)	(11.6)	(11.0)	(12.1)	(11.4)	(15.1)	(108.0)	(9.0)	(0.1)
Moorfields Private/Dubai/NCS	(1.2)	(1.5)	(1.6)	(1.3)	(1.2)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	(16.6)	(1.4)	0.2
Financing - Loan repayments	-	-			(0.6)	(0.5)	-	-	-	-	(0.4)	(0.5)	(2.0)	(0.4)	(0.2)
Dividend and Interest Payable	-	-				(1.3)	-	-	-	-	-	(1.3)	(2.5)	-	-
Total Cash Outflows	(40.5)	(34.4)	(31.6)	(34.5)	(35.9)	(37.5)	(38.7)	(40.5)	(39.4)	(42.6)	(42.2)	(47.4)	**(465.4)**	(36.5)	0.5
Net Cash inflows /(Outflows)	(0.3)	(6.5)	5.3	(3.3)	4.2	0.5	3.9	2.3	(2.0)	0.4	(1.4)	1.2	4.1	1.5	2.6
Closing Cash at Bank 2024/25	**70.4**	**63.9**	**69.2**	**65.9**	**70.1**	**70.5**	**74.4**	**76.7**	**74.7**	**75.1**	**73.6**	**74.9**	**74.9**		
Closing Cash at Bank 2024/25 Plan	71.5	72.0	73.1	74.8	73.7	73.5	75.7	76.3	73.4	74.7	73.8	72.2	72.2		
Closing Cash at Bank 2023/24	59.8	58.8	59.8	61.8	58.1	54.0	59.4	55.2	43.2	62.1	72.9	70.7	70.7		



Commentary

Cash flow

The cash balance as at the 31st August was £70.1m, a reduction of £0.6m from the position at the end of March 2024.

The current financial regime has resulted in block contract payments which gives some stability and certainty to the majority of cash receipts. The trust currently has 85 days of operating cash (prior month: 80 days).

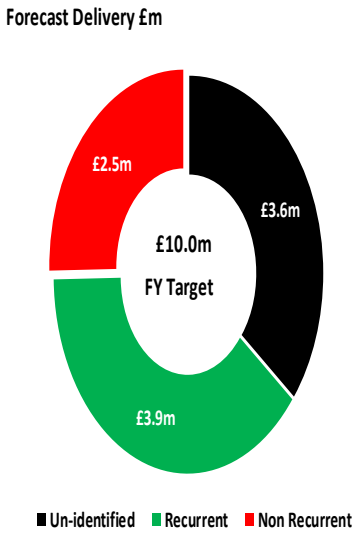
August saw a cash inflow of £4.2m against a forecast of £1.5m inflow due to higher NHS income receipts and lower capital payments than forecast.

Trust Efficiency Scheme Performance

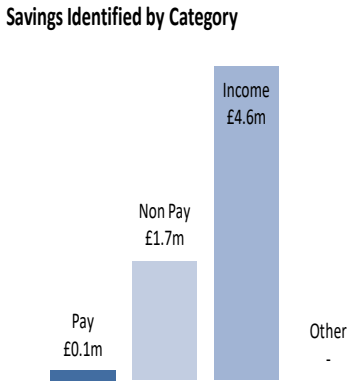
EFFICIENCY SCHEMES PERFORMANCE

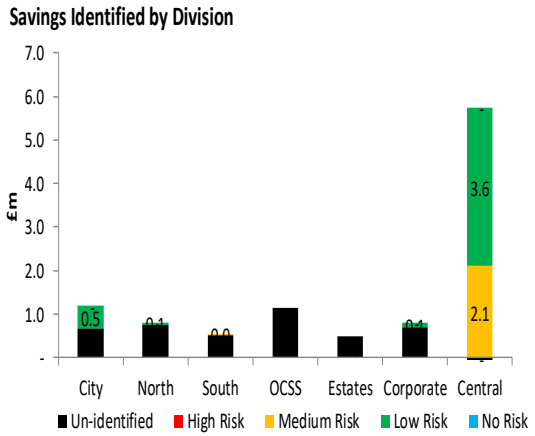
Efficiency Schemes £m	Annual Plan	In Month			Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
City Road	£1.19m	£0.10m	£0.04m	(£0.06m)	£0.40m	£0.21m	(£0.19m)	£1.19m	£0.50m	(£0.69m)
North	£0.81m	£0.07m	£0.01m	(£0.06m)	£0.27m	£0.03m	(£0.25m)	£0.81m	£0.06m	(£0.75m)
South	£0.55m	£0.05m	-	(£0.05m)	£0.18m	-	(£0.18m)	£0.55m	£0.03m	(£0.52m)
Ophth. & Clinical Serv.	£1.16m	£0.10m	-	(£0.10m)	£0.39m	-	(£0.39m)	£1.16m	-	(£1.16m)
Estates & Facilities	£0.49m	£0.04m	-	(£0.04m)	£0.16m	-	(£0.16m)	£0.49m	-	(£0.49m)
Corporate	£0.80m	£0.07m	£0.01m	(£0.06m)	£0.27m	£0.06m	(£0.21m)	£0.80m	£0.10m	(£0.71m)
DIVISIONAL EFFICIENCIES	**£5.00m**	**£0.42m**	**£0.06m**	**(£0.36m)**	**£1.67m**	**£0.30m**	**(£1.37m)**	**£5.00m**	**£0.69m**	**(£4.31m)**
Central										
R&D Income	£3.00m	£0.17m	£0.17m	£0.00m	£1.00m	£0.83m	(£0.17m)	£3.00m	£2.00m	(£1.00m)
Utilities Reduction	£1.00m	£0.08m	£0.14m	£0.05m	£0.33m	£0.68m	£0.35m	£1.00m	£1.64m	£0.64m
Activity Complexity	£1.00m	£0.08m	£0.18m	£0.09m	£0.33m	£0.88m	£0.54m	£1.00m	£2.10m	£1.10m
TRUST EFFICIENCIES	**£10.00m**	**£0.75m**	**£0.54m**	**(£0.22m)**	**£3.33m**	**£2.69m**	**(£0.65m)**	**£10.00m**	**£6.43m**	**(£3.57m)**

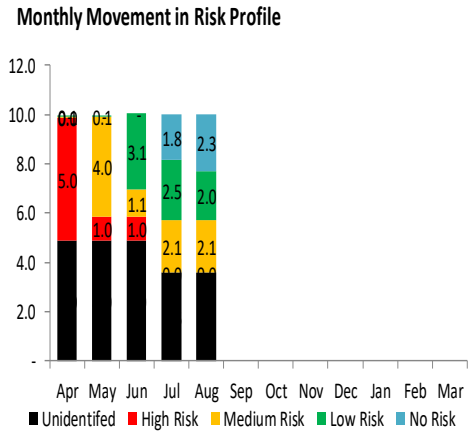
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







* charts may include rounding differences

Commentary

Governance & Reporting

The trust has a planned efficiency programme of £10m for 2024/25 to deliver the Trust control total.

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

Identified Savings

The trust has identified £6.4m, leaving a remaining £3.6m to be identified.

Of the total identified:-
- £5.0m is identified central schemes
- £4.5m is identified as income generation schemes;
- £1.6m is related to utilities price reductions; and
- £3.9m is forecast recurrently;

The CIP programme are working through efficiency scheme delivery with a conservative values of £3.0m to be fully financial validated towards increasing the level of identified and forecast delivery in 2024/25.

In Year Delivery

The trust is reporting efficiency savings achieved of:-
- £0.54m in month, compared to a plan of £0.75m, £0.22m adverse to plan;
- £2.69m year to date, compared to a plan of £3.33m, £0.65m adverse to plan.

Risk Profiles

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

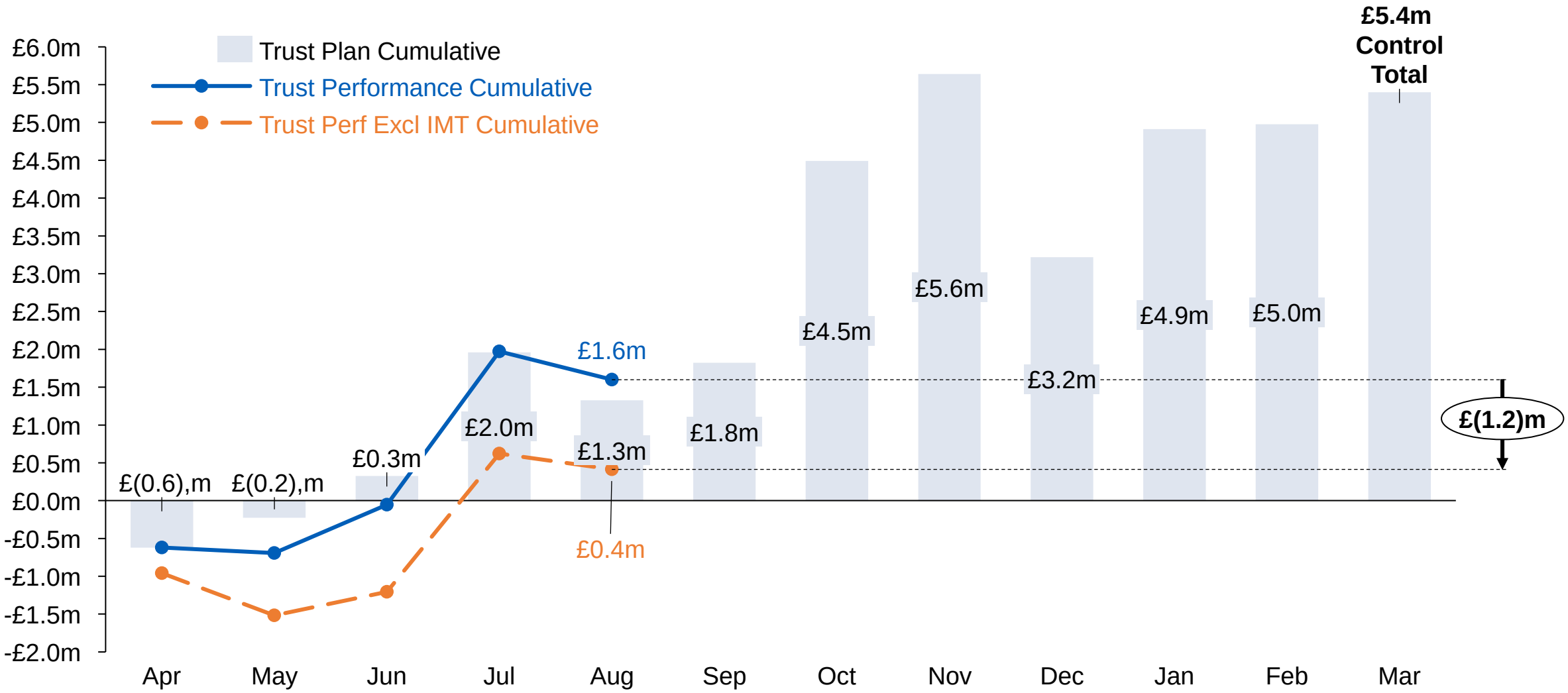
Supplementary Information

Moorfields Eye Hospital NHS Foundation Trust

NHS

Trust Performance against plan

The trust is reporting a £1.601m surplus YTD, £0.274m favourable to a plan of £1.327m. However, excluding IMT favourable surpluses due to slippage, the Trusts financial position is £0.4m, £0.9m less than plan. Adverse core operational performance is being supported by the IT EPR and Project slippage.



Divisional Financial Performance

DIVISIONAL PERFORMANCE

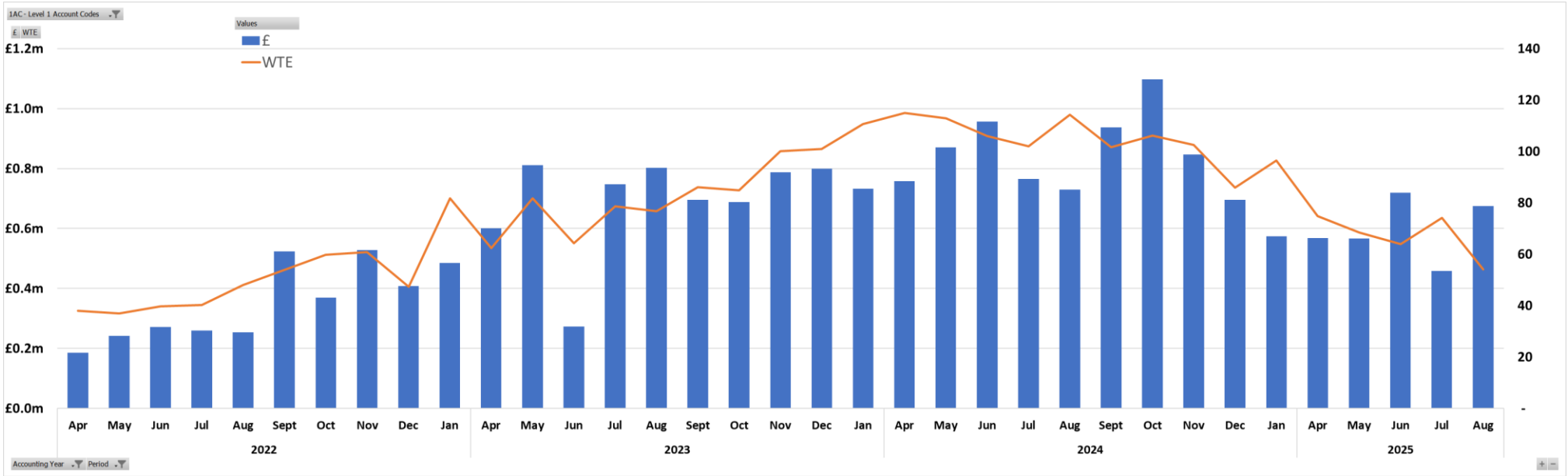
Divisional Contribution £m	Annual Plan	In Month					Year to Date					WTE				
		Plan	Actual	Variance	%	RAG	Plan	Actual	Variance	%	RAG	Plan	Actual	Variance	%	RAG
Cinical Operational Divisions																
City Rd Division	51.46	4.28	4.37	0.10	2%		21.52	22.99	1.47	7%		647	661	(14)	(2)%	
Moorfields North	22.23	1.81	1.43	(0.38)	(21)%		9.26	7.70	(1.57)	(17)%		457	443	15	3%	
Moorfields South	10.44	0.85	0.88	0.02	3%		4.36	5.12	0.76	17%		291	302	(11)	(4)%	
Ophth. & Clin. Serv. Division	(36.53)	(2.99)	(3.65)	(0.66)	(22)%		(15.21)	(16.81)	(1.61)	(11)%		570	578	(8)	(1)%	
Total Operational Divisions	**47.60**	**3.95**	**3.03**	**(0.92)**	**(23)%**		**19.94**	**18.99**	**(0.94)**	**(5)%**		**1,966**	**1,984**	**(18)**	**(1)%**	
Other Operational Areas																
Research And Development	0.29	0.02	(0.10)	(0.13)	(527)%		0.12	(0.82)	(0.94)	(783)%		145	142	3	2%	
Trading Units Summary	6.05	0.30	0.47	0.17	55%		2.10	1.93	(0.17)	(8)%		306	281	25	8%	
Total Other Operational Areas	**6.33**	**0.33**	**0.37**	**0.04**	**12%**		**2.22**	**1.11**	**(1.11)**	**(50)%**		**451**	**423**	**28**	**6%**	
Corporate Areas																
Chief Executive's Office	(2.94)	(0.24)	(0.25)	(0.00)	(2)%		(1.28)	(1.24)	0.04	3%		32	28	4	13%	
Chief Operating Officer	(1.33)	(0.11)	(0.11)	(0.00)	(4)%		(0.58)	(0.62)	(0.05)	(8)%		10	10	1	5%	
Corporate Governance	(1.41)	(0.12)	(0.24)	(0.12)	(106)%		(0.59)	(1.08)	(0.48)	(81)%		21	22	(2)	(7)%	
Director Of Strategy	(2.75)	(0.23)	(0.20)	0.04	16%		(1.14)	(0.93)	0.21	18%		17	15	2	13%	
Education	1.76	0.15	0.13	(0.02)	(14)%		0.73	0.54	(0.20)	(27)%		25	26	(1)	(5)%	
Estates And Facilities	(15.66)	(1.25)	(1.32)	(0.07)	(6)%		(6.44)	(6.64)	(0.20)	(3)%		72	72	0	1%	
Finance Director	(4.25)	(0.35)	(0.36)	(0.01)	(3)%		(1.78)	(1.79)	(0.01)	(0)%		38	36	2	6%	
Human Resources	(5.56)	(0.35)	(0.44)	(0.09)	(24)%		(2.21)	(2.29)	(0.09)	(4)%		67	61	6	9%	
Informatics And It	(13.31)	(0.88)	(0.90)	(0.02)	(3)%		(5.48)	(4.22)	1.25	23%		107	88	19	18%	
Medical Director	(1.06)	(0.11)	(0.13)	(0.01)	(12)%		(0.45)	(0.42)	0.03	8%		6	5	1	22%	
Digital Medicine	(0.85)	(0.17)	(0.02)	0.16	91%		(0.35)	(0.25)	0.11	31%		20	13	7	35%	
Corporate Nursing & Quality	(6.18)	(0.48)	(0.47)	0.01	2%		(2.47)	(2.47)	0.01	0%		48	45	3	5%	
Project Oriel	(0.80)	(0.07)	(0.05)	0.02	27%		(0.33)	(0.28)	0.05	15%		7	8	(1)	(14)%	
Total Corporate Areas	**(54.33)**	**(4.22)**	**(4.35)**	**(0.14)**	**(3)%**		**(22.37)**	**(21.69)**	**0.68**	**3%**		**470**	**428**	**42**	**9%**	
Total Central Expenditure Budgets	**5.79**	**(0.68)**	**0.58**	**1.26**	**186%**		**1.53**	**3.18**	**1.65**	**107%**		**-**	**-**	**-**	**0%**	
Control Total Surplus/(Deficit)	**5.40**	**(0.62)**	**(0.37)**	**0.25**	**40%**		**1.33**	**1.60**	**0.27**	**21%**		**2,886**	**2,834**	**52**	**2%**	

Workforce – Agency Reporting in Board Report

AGENCY SPEND REPORTING

Pay Expense Reporting £m	2022/23 Jan 23	Feb 23	Mar 23	2023/24 Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	2024/25 Apr 24	May 24	Jun 24	Jul 24	Aug 24	YTD £m	YTD %
Agency																						
Clinical Divisions	0.660	0.543	0.520	0.372	0.504	0.508	0.491	0.428	0.592	0.647	0.507	0.351	0.214	0.337	0.162	0.269	0.202	0.217	0.236	0.280	1.204	40%
Coporate Departments	0.047	0.246	0.328	0.261	0.279	0.320	0.281	0.190	0.261	0.310	0.258	0.259	0.295	0.287	0.313	0.247	0.248	0.355	0.156	0.309	1.315	44%
Commercial/Trading	(0.063)	(0.016)	(0.066)	0.025	0.027	0.045	0.020	0.077	0.035	0.097	0.028	0.022	0.031	0.057	0.064	0.063	0.093	0.056	0.026	0.057	0.295	10%
Research	0.089	0.054	0.065	0.100	0.059	0.085	(0.027)	0.035	0.049	0.044	0.053	0.063	0.034	0.059	0.052	0.015	0.023	0.077	0.031	0.020	0.166	6%
Total Agency	**0.733**	**0.827**	**0.847**	**0.758**	**0.871**	**0.957**	**0.765**	**0.730**	**0.937**	**1.097**	**0.846**	**0.695**	**0.573**	**0.740**	**0.591**	**0.595**	**0.567**	**0.705**	**0.449**	**0.665**	**2.980**	
Agency																						
Medical Staff	0.136	0.097	0.068	0.077	0.080	0.098	0.100	0.104	0.103	0.095	0.104	0.078	0.047	0.095	0.086	0.091	0.064	0.072	0.082	0.088	0.398	13%
Nursing Staff	0.201	0.224	0.186	0.186	0.249	0.191	0.140	0.105	0.139	0.273	0.133	0.125	0.140	0.121	0.221	0.100	0.081	0.067	0.043	0.079	0.369	12%
Scientific & Technical	0.116	0.065	0.065	0.039	0.056	0.062	(0.031)	0.051	0.252	0.158	0.125	0.093	0.076	0.069	(0.137)	0.034	0.050	0.042	0.023	0.051	0.201	7%
Allied Health Professionals	-	-	0.001	0.009	0.004	0.001	-	-	0.003	0.016	0.001	0.005	-	0.002	0.005	0.017	0.013	0.017	0.008	0.009	0.064	2%
Clinical Support	0.121	0.104	0.036	0.033	0.110	0.132	0.291	0.143	0.091	0.101	0.073	0.039	0.060	0.055	0.022	0.022	0.043	0.049	0.044	0.037	0.195	7%
Admin And Clerical	0.144	0.324	0.391	0.405	0.360	0.435	0.257	0.282	0.337	0.442	0.400	0.338	0.234	0.376	0.426	0.293	0.324	0.476	0.258	0.412	1.763	59%
Ancillary Services	0.014	0.015	(0.003)	0.010	0.011	0.038	0.008	0.044	0.012	0.013	0.011	0.017	0.016	0.022	(0.005)	0.002	0.000	(0.002)	-	-	0.000	0%
Total Agency	**0.733**	**0.827**	**0.744**	**0.758**	**0.871**	**0.957**	**0.765**	**0.730**	**0.937**	**1.097**	**0.846**	**0.695**	**0.573**	**0.740**	**0.618**	**0.559**	**0.576**	**0.722**	**0.459**	**0.675**	**2.991**	

*Excludes central budgets



Report title	Appraisal and Revalidation Framework for Quality Assurance report to Board
Report from	Louisa Wickham / Dilani Siriwardena
Previously discussed at	N/A
Link to strategic objectives	• We will be an employer of choice, supporting staff to learn, develop and progress in line with our values. • We will consistently provide an excellent, globally leading service.

Executive summary of report

- Dilani Siriwardena has been in post in the role Responsible Officer since 1 September 2023.
- The RO led on the recruitment process for the Clinical Appraisal Lead who commenced in post on 1 November 2023. This role provides support to doctors who are struggling to complete the information for their revalidation and supporting those who are having trouble in preparing for their revalidation.
- The Medical HR support in the trust has been reviewed and substantive appointments made to key positions. A temporary project manager role has been created to support the Medical Director and their principal task in the first instance is to ensure that there is sufficient resource given to medical leadership to meet our needs. This will include establishing a cadre of senior medical leadership position and a medical directorate which reports to the medical director to oversee and lead on these issues, as well as the creation of a senior business manager role to support directorate operations.
- There are some further key areas where improvements need to be made including new doctors being provided with sufficient information about our processes/systems for revalidation and appraisal processes at Moorfields.
- The reprioritisation impact of the pandemic and corresponding reduction of appraisal activity during the years 2020-2022 are still having a knock-on impact on the in-year revalidation deferral run rate within the organisation. Missing appraisal activity and 360 feedback evidence are key reasons for deferrals in 2023/24. While improvements made to the appraisal and revalidation process will undoubtedly yield benefits to the Trust's reported metrics over time, the realisation of these will have a deferred element, as the 'catch-up' process to ensure sufficient appraisals has in-built procedural delay requirements (ie. a requirement to have two additional appraisals to satisfy a minimum of 4 appraisals across the 5-year cycle would require an initial appraisal to be undertaken and then a further appraisal to be undertaken at a minimum 6 months later – therefore a deferral would be required to allow this to occur if the revalidation submission date is prior to that being achieved).
- The Trust have reviewed and approved the Revalidation and Appraisal Policy, with an agreed enabler implementation plan to take forward by the new Medical HR Manager and Head of Medical Workforce from 9th September 2024 onwards. An additional programme of work is also being undertaken with UCL stakeholders to facilitate Clinical Academics

working for MEH via the IoO to have access to a single joint appraisal conducted with input from both organisations, in line with Follett Review recommendations.

- We continue this year to be an outlier from other Trusts who have in place a dedicated appraisal and revalidation support coordinator/officer role, and this is one of the roles being considered within the Medical Director structure review.

Quality implications

- An improved appraisal rate is necessary to support staff development and experience, it is also a key component of the evidence required for doctors to be revalidated and maintain their licence to practice.

Financial implications

- ManEx will consider costs implications for additional staff when the structure is drafted (Autumn 2024)

Risk implications

- To note advice from NHS England regarding uptick in formal cases being brought against Responsible Officers and importance of dedicated resource/processes.
- Earlier support and interventions provided through this process, should reduce the number of concerns escalating to formal stage through MHPS, and those who reach this stage have access and evidence of support to manage the formal process to a satisfactory conclusion.

Action Required/Recommendation

- The Board are asked to approve the revalidation report attached to this cover sheet for submission to NHSE on their report format (template dated Feb 2023).

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

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The Trust Board of Moorfields Eye Hospital NHS Foundation Trust can confirm that:

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

   Yes, Miss Dilani Siriwardena is the RO.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   There has been an in-depth analysis of our current Medical HR services, to evaluate the level of resources and support in place. Substantive appointments have now been made to key positions (Head of Medical HR and the medical workforce manager).

   There is a need to ensure there is adequate support with the Medical Director's team and structure review project has been created to support the Medical Director in ensuring the infrastructure is in place to support all medical leadership activities.

   The new RO led on the recruitment process for the clinical appraisal lead who commenced on 1st November 2023. This role provides support to doctors who are struggling to complete the information for their revalidation and supporting those who are having trouble in preparing for their revalidation.

   During 2023/24 we have reported more wellbeing disclosures being made, through case management. Doctors through revalidation and at informal and informal case management stage, are disclosing health conditions and disabilities.

   We continue this year to be an outlier from other Trusts who have in place a dedicated appraisal and revalidation support coordinator/officer role. This is one of the roles being considered within the Medical Director structure review and supports the advice received from the Regional NHS England team at the Higher Level RO Quality Review visit.

   The Trust have reviewed and approved the Revalidation and Appraisal Policy, with an agreed enabler implementation plan to take forward by the new Medical HR Manager and Head of Medical Workforce from 9th September 2024 onwards.

   Action: A review of current Medical leadership is being completed with a proposed structure to inform a business case by Autumn 2024.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Yes

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes, there is a Trust Appraisal and Revalidation Policy approved June 2024, with an enabler implementation plan to embed within the organisation ongoing.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Higher-Level Responsible Officer Quality Review visit from NHS England on 23rd August 2023 which reviewed processes and governance. The report was positive in tone overall but did highlight our outlier status with respect to revalidation support and the potential risk to the RO without further dedicated resources.

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

Yes. Fellows are supported by the Director of the Fellowship programme. We have identified a solution to the current heavy administrative process for Clinical fellows.

This will allow us to move to a more streamlined electronic process on Prep, at a total one-off cost of £3,400.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Yes

7. Where in the question above this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes

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

Yes. Policy reviewed and approved June 2024.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The average number of appraisals per appraiser is 4.35 (248/57) We continue to provide training for appraisers to ensure a more even distribution of appraisals amongst appraisers.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes, through the appointed Clinical Appraisal Lead, from 1st November 2023

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The Clinical Appraisal Lead plays a key role in auditing appraisals for quality assurance. It is anticipated that the new Medical HR proposed structure together with the implementation of the policy enabler implementation plan will provide earlier quality assurance, and the support/interventions to doctors who fall short of preparing their information to the required standards well in advance of their revalidation dates. The aim is to increase our appraisal rates through earlier engagement, and minimise deferrals being made.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2024	**306 down 29**

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	**236 down 33**
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	**70 down 11**
Total number of agreed exceptions	**0 down 1**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Between 1 April 2023 – 31 March 2024, there were 60 (increased 12) positive recommendations made and 17 (increase 5) deferrals.

The reprioritisation impact of the pandemic and corresponding reduction of appraisal activity during the years 2020-2022 are still having a knock-on impact on the in-year revalidation deferral run rate within the organisation. Missing appraisal activity and 360 feedback evidence are key reasons for deferrals in 2023/24. While improvements made to the appraisal and revalidation process will undoubtedly yield benefits to the Trust's reported metrics over time, the realisation of these will have a deferred element, as the 'catch-up' process to ensure sufficient appraisals has in-built procedural delay requirements (i.e. a requirement to have two additional appraisals to satisfy a minimum of 4 appraisals across the 5-year cycle would require an initial appraisal to be undertaken and then a further appraisal to be undertaken at a minimum 6 months later – therefore a deferral would be required to allow this to occur if the revalidation submission date is prior to that being achieved).

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Recommendations are communicated to doctors upon completion of their required evidence for the onward positive recommendation for revalidation to be made, or where there is insufficient evidence to make a recommendation and therefore where a deferral is needed.

The main reasons for deferrals were:
- Missing appraisal activity over the 5-year revalidation period (gaining momentum to reach the gold standard post Covid is slow)
- Peer and patient feedback not being completed
- Heavy administrative process for Clinical fellows, requires a build to move to a more streamlined electronic process on Prep, at a cost of £3,400, a business case to be prepared, if Education like HR are not able to provide within budget.

Medical HR review of services identified a need for greater support for doctors starting with us and preparation for revalidation at an early stage

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes, doctors are instructed to include all issues about clinical practice, activity and performance in appraisals.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

The national Maintaining High Professional Standards policy is applied.

Moorfields has developed an MHPS, inclusive of 'Just Culture' principles, which is now progressing to approval stage. This policy also has an enabler implementation plan, to support this culture and implementation of policy.

The new role of Medical HR Manager will support both MHPS and Revalidation of Appraisal services delivered for Moorfields. Working on developing and establishing the infrastructure, developing key skills, and supporting the roles and processes throughout the organisation.

Monthly reviews of cases are scheduled with the Medical Director and RO, also accountable for the delivery of both policies and enabling implementation plans.

Early support and wellbeing for doctors, who may need access to reasonable adjustments/recommendations has been identified as a key link before progressing formal investigations, and that support should sit outside of MHPS, through the new Revalidation and Wellbeing Coordinator role (a new role to align support to other NHS organisations)

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

All MHPS cases under part i and ii are assigned a nominated non-executive board member for impartial oversight of the process as being fair and consistent, and a point of contact to the doctor. All formal cases are reported to the Board and analysed to ensure fair application of processes and policies.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes, using the GMC MPIT form.

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

Yes. As described in 4.3

Section 5 – Employment Checks

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

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

NHS pre-employment checks guidance is followed in relation to the recruitment of all staff at the Trust.

Section 6 – Summary of comments, and overall conclusion

The RO has been in post since 1 September 2023 and the Appraisal Lead role, 1 November 2023 and has provided the quality assurances to get doctors over the line for revalidation.

There has been an average appraisal rate of 72% during 2023/24 (down from 75% in Board Report for 2022/2023). This remains below the target of 80%. There are a number of factors which have contributed to this, including those listed above and also the need for our medical leaders to ensure their colleagues are undertaking appraisal.

There is a much broader focus on improving the operating procedures for Medical HR services, from recruitment, to ESR to supporting doctors prepare for revalidation.

The Medical Director structure needs further support and the creation of a new business manager role within the wider medical directorate structure changes will help to ensure the right infrastructure is put in place.

Medical HR has a legacy of under investment and high turnover. Recent changes to the structure and substantive appointments should address these issues over time.

The impending business case for the Medical Directorate structure will help to ensure we have sufficient senior medical leadership to lead on all aspects of doctor careers, appraisals and revalidation.

Section 7 – Statement of Compliance:

The Board Moorfields Eye Hospital NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

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

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _

Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England
Wellington House
133-155 Waterloo Road
London,
SE1 8UG

This publication can be made available in a number of other formats on request.

© NHS England 2023
Publication reference: PR1844

Report title	**Patient safety incident response framework (PSIRF) update**
Report from	Sheila Adam, Chief Nurse and Director of Allied Health Professionals
Prepared by	Ian Tombleson, Director of Quality and Safety
Link to strategic objectives	Links to all the strategic objectives and underpins our core values of Excellence, Equity and Kindness

Executive summary

This paper provides an update for Trust Board regarding the positive impact of the national patient safety initiative, PISRF (patient safety incident response framework) on Moorfields. The report covers an overview of the framework, as well as ongoing improvement work and the implementation plan, to ensure that the full benefits of PSIRF are realised. Quality and Safety Committee has had full oversight of the introduction of this initiative and the development of PSIRF over the past 18 months and since go live on 2 April 2024.

Quality implications

PSIRF has significant positive quality implications. This includes the ability to gain a deeper understanding of the underlying causes of events and incidents, by using a proportionate response and a systems-thinking approach to investigating patient safety incidents (PSIs). It also promotes a culture of safety and continuous improvement, to reduce the risk of future safety events. PSIRF involves patients and families in a more inclusive way than previously, providing greater support for those affected.

Financial implications

No specific financial implications.

Risk implications

Organisations should have a framework and process in place to ensure that learning from incidents leads to meaningful and sustainable improvement, with support provided to those involved. If this is not in place, then the effectiveness of learning and improvement actions following events may be compromised leading to poor patient and staff experiences, and patient harm

Action required

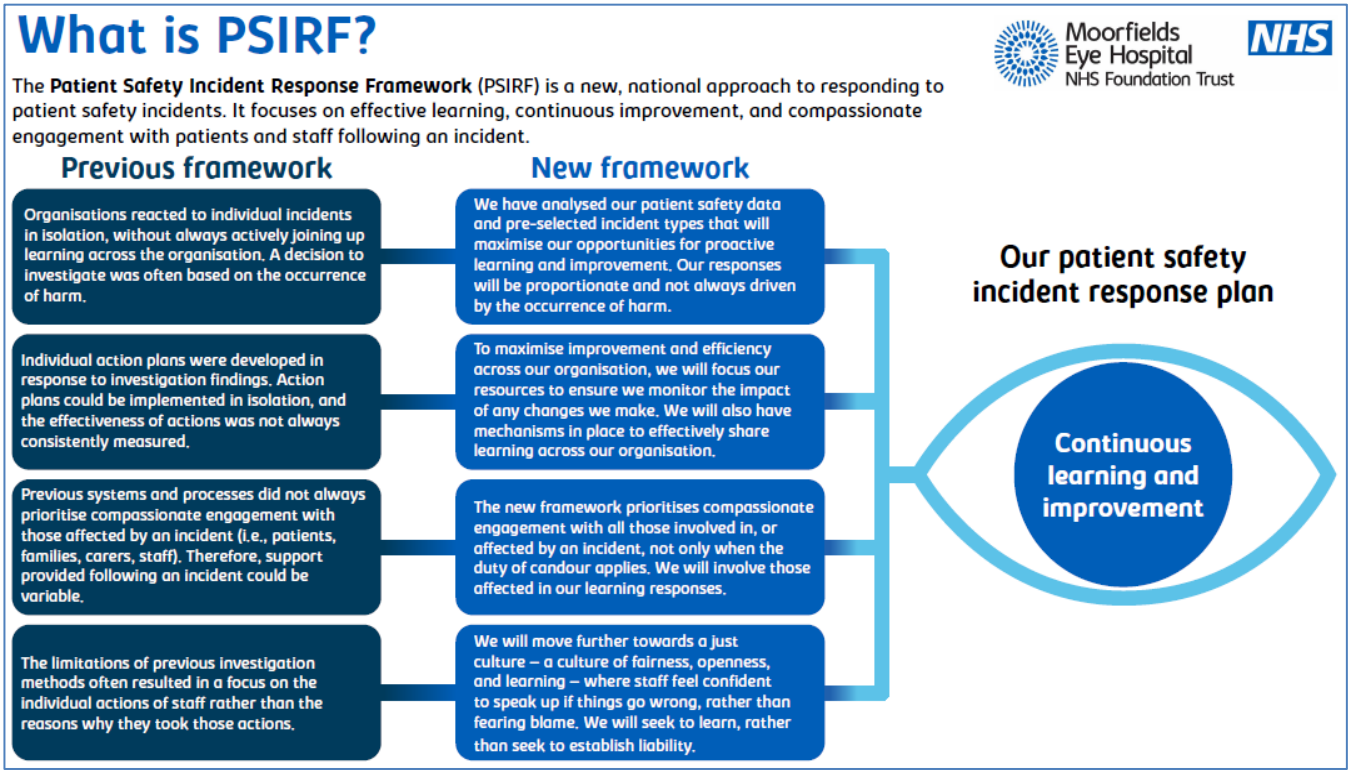
The Board is invited to discuss the contents of this report.

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

1. Background

The Patient Safety Incident Response Framework (PSIRF) is a national patient safety initiative which provides a significant shift in how healthcare organisations, including NHS trusts, manage patient safety incidents. It replaces the Serious Incident Framework (SIF) with a more proactive, system-focused approach that emphasises learning from incidents to improve patient care as described in *figure 1.*

Following an 18-month national development and testing phase, the trust implemented PSIRF on 2 April 2024. This report provides an overview of the framework, as well as ongoing improvement work underway to ensure that the full benefits of PSIRF are realised. We have simplified the way we communicate about PSIRF and what in means in the summary below.



2. Documentation

2.1 Patient Safety Incident Response Policy

Moorfields' policy supports the requirements to meet the four key aims of the PSIRF:

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

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

It also sets out how the trust will approach the development and maintenance of effective systems and processes for responding to Patient Safety Incidents (PSIs) and issues for the purpose of learning and improving patient safety.

2.2 Patient Safety Incident Response Plan (the plan)

Our implementation plan sets out how we will implement PSIRF locally including our list of local incident priorities (see incident priorities section below). The plan has been developed through a co-production approach with the divisions and specialist leads supported by analysis of local data.

3. Learning responses

Our learning responses refer to the tools and approaches taken to investigate incidents. At Moorfields, the following tools are used, as described in our plan.

- **Patient safety incident investigation (PSII)** uses a systems thinking (Systems Engineering Initiative for Patient Safety (SEIPS)) approach to review incidents by analysing how various elements, such as people, tools, tasks, and environments, interact.
- **After-action reviews (AAR)** are structured, reflective processes used to learn from those involved in an event to determine what happened to develop improvement actions.
- **Thematic reviews** provide an analytical method that identifies recurring themes or patterns across incidents to gain insights and inform improvements.

A Moorfields learning system is being developed as a separate project, to help us understand whether wider learning is taking place across the organisation in a genuine data-driven systematic and cumulative way.

4. Incident priorities

4.1 National priorities

National priorities are patient safety issues identified by National Health Service England (NHSE), that require focused attention to reduce harm and improve outcomes. Under

PSIRF, it is mandated that a PSII (systems-based investigation) is undertaken to investigate any incident that meets the national criteria, including:

- Incidents meeting the Never Events criteria
- Patient death thought more likely than not due to problems in care
- Death of a person who has a learning disability
- Child death
- A safeguarding incident in which:
    - babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence
    - adults (over 18 years old) are in receipt of care and support needs from their local authority
    - the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.
- An incident in a diabetic eye screening (DES) programme.

4.2 Local priorities

PSIRF does not impose additional national rules or thresholds that dictate how organisations must respond to incidents for learning and improvement. Instead, it encourages proportionate responses and flexibility to balance efforts between responding to incidents and engaging in exploratory and improvement activities. This approach enables organisations to review their safety profile to respond to incidents and issues with the greatest opportunity for improvement and learning. The trust has identified the patient safety incident types or issues in *table 1* as meeting the criteria as local priorities.

Table 1

Patient safety incident type or issue	Planned learning response
Delayed or missed diagnosis of a tumour in a glaucoma patient referred to the neuro-ophthalmology service	Patient Safety Incident Investigation (PSII)
Unplanned omission/ deviation to intended care or treatment plan because of the use of hybrid health records/systems	After Action Review (AAR) or another agreed learning response, if more appropriate
Clinically unacceptable delay in the review/ treatment of a 'follow-up' patient, where the provision of a timely appointment has not been impacted by clinician instruction or known capacity issues	AAR or another agreed learning response, if more appropriate
Mismanagement of internal referrals between sites and services and referrals from external providers into the organisation	Thematic review of PSIs related to referral management
Communication of patient information between the trust and external organisations (e.g., letters and referrals relating to continuity of care not sent)	Thematic review of new PSIs relating to the external communication of information
Deviation to intended care or treatment plan resulting in intravitreal injection of the wrong drug and/or to the incorrect eye	AAR or another agreed learning response if more appropriate
Any incident or near miss relating to the application of a laser to a patient	AAR or another agreed learning response if more appropriate
Delayed recognition of a deteriorating patient	AAR or another agreed learning response, if more appropriate
Delayed processing or review of a diagnostic test or sample leading to a clinically unacceptable delay in treatment	AAR or thematic review, or another agreed learning response, if more appropriate
Clinically unacceptable delay, not impacted by known capacity issues, in actioning an outcome of a review of a patient managed through a virtual pathway.	AAR or thematic review, or another agreed learning response, if more appropriate
Incident(s) which signify an unexpected level of risk and/or potential for learning and improvement	Assessment by the Incident Review Group to determine if a learning response is required

5. Governance

Implementation of PSIRF is led by the central quality team working across the organisation; there is a Steering Group to support delivery with sub-working groups. Clinical Governance Committee (CGC) is chaired by Moorfields Chief Nurse and has oversight of the implementation and on-going management of PSIRF. Quality and safety committee (QSC) is the delegated committee for Board assurance of PSIRF. The CGC responsibilities are to:

- Ensure the organisation meets national patient safety incident response standards
- Ensure PSIRF is central to overarching safety governance arrangements
- Quality assure learning response outputs.

6. Progress to date

6.1 Incident Review Group (IRG) activity

At a detailed level, an incident review group meets a minimum of weekly to apply the PSIRF principles on day-to-day safety incidents and events.

There is a large volume of review work associated with PSIRF; 221 local and national incident priorities have been reviewed at IRG since 2 April 2024 (PSIRF go live date). The table provides further breakdown.

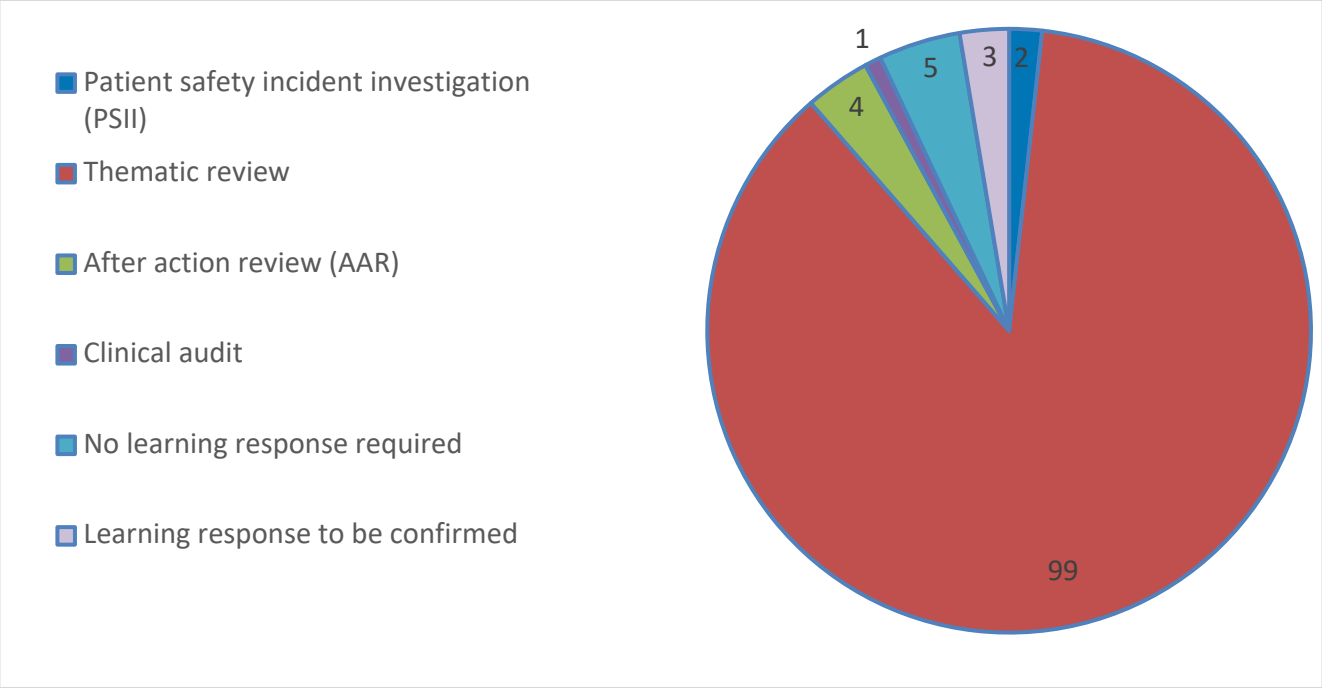
Outcome	This report (cumulative) (05.08.24)
Confirmed NATIONAL priorities	1
Awaiting review – potential NATIONAL priority	0
Confirmed LOCAL priorities	112
Awaiting review – potential LOCAL priority	73
Reviewed - Confirmed NOT LOCAL or NATIONAL priority	35
Total	**221**

Data complete at 12 August 2024

In addition, over the same period, there were 113 confirmed local priority incident types allocated by IRG.

Thematic review (n-99) was overwhelmingly the most frequent learning response applied by IRG since PSIRF was implemented as shown in chart 1. IRG retains full details of the location and numbers of specific learning responses across Moorfields.

Chart 1



7. Improvement

Following completion of learning responses, the response outputs are fed into an appropriate improvement and oversight workstream. This means that any learning is actively put into practice within day-to-day business. This is to support the reduction of the risk of reoccurrence. Organisational improvement routes are mapped so the learning and improvement can be directed to the appropriate Committee/Group.

As part of the preparation for the launch of PSRIF in April 2024, we applied a systems thinking and thematic approach to reviewing ‘wrong intraocular lens’ incidents. This enabled greater insight to guide improvements in lens management and a reduction in related negative events. Additionally, by conducting a thematic review of incidents related to referral management, we identified key administrative improvements that may have been missed if incidents were reviewed individually.

8. Next steps

The embedding of the PSIRF standards and operations is being undertaken by the PRSIF steering group, monitored by the working together board as an Excellence project. The table below describes the responsibilities of the work streams within the group. During the embedding phase data is being collected from key stakeholders to identify opportunities to drive iterative and ongoing improvement of current processes as they develop. The PRSIF policy and plan will be reviewed in 2025, to ensure any learning and/or emerging risks are taken into consideration.

Working group	Responsibilities
Patient and Staff involvement	Develop documents to support patients and staff involved in patient safety incident investigations and other learning responses. Ensure updated duty of candour policy and define support arrangements for both groups.
Communication and education	Develop and distribute information materials on PSIRF, investigations, and support services for both patients and staff, create a sustainable training programme, on-going awareness, enhance existing services to meet PSIRF standards.
Governance and monitoring	Embed oversight structures (CGC and AIR meetings) and develop reporting processes to track PSIRF implementation, decisions, safety actions, learning outcomes and evidence of improvement. Establish KPIs and update policies to include "restorative just culture."
Learning and improvement systems	Develop processes for capturing learning points and safety actions, establish a shared learning system.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Safeguarding Adults Annual Report 2023 - 2024

Report title:	Safeguarding Adults Annual Report 2023 – 2024
Report from:	Sheila Adam - Chief Nurse and Executive Director of Allied Health Professionals / Executive Lead for Safeguarding
Prepared by:	Lucy Howe – Lead Named Nurse Vulnerable Adults Tracey Foster – Lead Nurse Safeguarding Children and Adults Team
Previously discussed:	Safeguarding Adults Committee Clinical Governanace Committee Quality and Safety Committee
Attachments:	Summary Paper Pages 3 - 4
Link to strategic objectives:	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive Summary

This Safeguarding Adults Annual Report sets out the work carried out by Moorfields Eye Hospital NHS Foundation Trust in relation to:

- Providing assurance that the Trust continues to fulfil its statutory duties and responsibilities to safeguard adults, as stated in the Care Act 2014 and the Care and Support Statutory Guidance (updated 2018).
- Providing assurance that the Trust continues to be compliant with the Mental Capacity Act (MCA) 2005 and MCA Code of Practice 2007.
- Providing assurance that the Trust is compliant with the key mandatory elements of the PREVENT duties and responsibilities.
- Providing an update to internal and external stakeholders on the developments in relation to safeguarding adults, MCA, Prevent, dementia and learning disability.
- Identifying areas of risk in relation to its statutory responsibilities during the reporting period.
- Responding to emerging trends and themes in relation to safeguarding adult concerns.

Quality Implications

This report provides assurance of the Trusts response to vulnerable adults and on improving patient safety, outcomes and experience.

Financial Implications

There are no financial implications arising from this report.

Risk

Maintaining effective safeguarding arrangements ensures the wellbeing of patients is upheld and adults at risk are protected and reduces the reputational risk to the Trust or potential regulatory action.

Action Required/Recommendation

The Board is asked to note the report.

For assurance	✓	For decision		For discussion		To note	

Title of Summary Paper	Safeguarding Adults Annual Report 2023 - 2024
Executive Safeguarding Lead	Sheila Adam
Author	Lucy Howe and Tracey Foster

Safeguarding adults remains a high priority within Moorfields Eye Hospital NHS Foundation Trust through a continued commitment to promoting safeguarding as an integral component of practice, and ensuring the Trust fulfils its statutory duties and responsibilities.

This summary paper provides an overview of mandatory and statutory safeguarding adults, Prevent, mental capacity act (MCA), dementia and learning disability activity over the reporting period.

Quality Assurance

During the reporting period the following learning and improvement outcomes have been achieved:

- A total of 401 queries were made to the Safeguarding Adults Team for advice and support from staff across the Trust and external agencies during 2023-2024. This is an increase of 3% in comparison to 2022-2023 and there is a clear escalation in complexity. This demonstrates that staff are continuing to have a greater awareness and understanding of safeguarding and that it is becoming a more integral part of practice.

- Mandatory safeguarding adults training compliance for permanent staff and volunteers at Levels 1 and 2 remained above the 80% target throughout the reporting year along with mandatory Mental Capacity Act (MCA), PREVENT, Learning Disability and Dementia training.

- Incident reporting by staff from a wide range of roles and responsibilities, highlighting a variety of issues regarding adults at risk, increased by 33%. There were no serious incidents during this reporting period that involved a safeguarding adult element. The Team has oversight of all cases discussed at the weekly Incident Review Group and attend the meeting where appropriate. This supports an holistic review of any potential serious incidents.

- The team supported managers to review complaints from adults. This process ensures a high-quality response and understanding of the Trusts legal obligation to safeguard. There have been 7 complaints with a safeguarding/vulnerable adult feature during the reporting period and of these, 3 had a mental health, learning disability or dementia component. There were no complaints requiring a safeguarding referral.

- Systemic learning is supported through a variety of activities including eLearning, via team meetings and briefings, disseminated via Safeguarding Adult Committee members, attendance at meetings, safeguarding champions, the internal Safeguarding Snippets Newsletter and Caring Voices Newsletter, safeguarding activity infographic, safeguarding supervision and the Moorfields News e-bulletin.

Key Achievements

During this reporting period we have:

- Developed the Moorfields training proposal and eLearning package for mandatory learning disability and autism training in line with the draft code of practice.
- Provided Moorfields response to actions raised within Safeguarding Adults Reviews and ensured implementation.
- Developed new face to face Mental Capacity act training, to be included as part of clinical induction.
- Developed and delivered face-to-face Safeguarding Adults training Level 3 supported by an external facilitator
- Participated in a safeguarding audit, undertaken by external auditors RSMUK and all actions completed.
- Continued to respond to emerging safeguarding issues and concerns identified post the Covid-19 global pandemic (2020 – 2023) and the ongoing cost-of-living crisis.
- Provided a safe and effective service despite sickness and unplanned absence.
- Continued to work in partnership with Mencap, Alzheimer's Society, SeeAbility, service users and carers raising awareness of learning disability, dementia and carer issues.
- Promoted Moorfields response to caring for patients with dementia and staff who are carers by supporting national Elf Day for the third consecutive year.
- Supported Islington to continue as a dementia friendly borough.
- Continued to produce the biannual Caring Voices Newsletter to promote understanding of issues and challenges for vulnerable adults and the Safeguarding Snippets Newsletter.
- Delivered bespoke safeguarding sessions across the Trust including pre-Assessment and Governors and provided delivery of safeguarding content as part of the care certificate and preceptor training.
- Worked collaboratively with communications team in development of a training video to encourage and enhance quality of flagging vulnerable patients.
- Completed successfully the Best Interest Assessor (BIA) course by the Safeguarding Adults & Mental Capacity Act Practice Development Nurse bringing the total number of BIA's in the Trust to two.
- Supported the project group in the planning, development and the implementation of the accessible information standard (AIS), including leading on the development of Easy Read information.
- Supported the monitoring of the service level agreement between Moorfields and East London Foundation Trust (ELFT) who provide mental health advice and training for staff in supporting people attending Moorfield's.
- Worked collaboratively with colleagues to strengthen staff awareness of patient mental health concerns, development of training, policies, and staff resources, including a self-harm leaflet.

Key Risk and Risk Mitigation Factors

Safeguarding has a shared Risk Register which is reviewed monthly and discussed as a standing agenda item at the quarterly Safeguarding Adults Committee.

There is a single risk in relation to new legislation and national guidance which requires additional training requirements to be delivered. This impacts upon the work pressures of the existing team, the need to

reprioritise other deliverables and the need to source additional trainers. A business case will be prepared to support the delivery of this safeguarding target.

A deep drive into identifying safeguarding risks that sit in other risk registers across the Trust is planned for the next reporting year. This will ensure the risks are appropriately categorised, that they sit in the correct risk register and will provide the Safeguarding Team with oversight.

Priorities for 2024 - 2025

- To continue delivery of creative Level 3 safeguarding adults training.
- To explore the development of a Vulnerable Adults Group and continue robust links with community groups.
- To continue to review, develop, deliver and evaluate safeguarding related training.
- To launch and implement redesigned learning disability and autism training for Moorfields in line with the draft code of practice and Oliver McGowan training requirements.
- To implement face to face MCA training as part of clinical induction.
- To develop the internet pages for safeguarding, learning disability and dementia.
- To support the development and embedding of the Sexual Safety Charter.

Contents

Introduction

This Safeguarding Adults Annual Report sets out the work carried out by Moorfields Eye Hospital NHS Foundation Trust for the reporting period 01st April 2023 to 31st March 2024 in relation to:

- Providing assurance that the Trust continues to fulfil its statutory duties and responsibilities to safeguard adults, as stated in the Care Act 2014 and the Care & Support Statutory Guidance (updated 2018)
- Providing assurance that the Trust continues to be compliant with the Mental Capacity Act (MCA) 2005 and MCA Code of Practice 2007
- Providing assurance that the Trust is compliant with the key mandatory elements of the PREVENT duties and responsibilities
- Providing an update to internal and external stakeholders on the developments in relation to safeguarding adults, Prevent, MCA, learning disability and dementia.
- Identifying any areas of risk in relation to its statutory responsibilities during the reporting period.
- Responding to emerging trends and themes in relation to safeguarding adult concerns.

The Trust recognises at an operational and strategic level that “safeguarding adults is "everyone’s business". This underpins the strategy to involve Trust staff at every level to ensure that patients are treated with dignity and respect, demonstrate a commitment to promoting well-being and preventing abuse and neglect, and ensuring the safety and wellbeing of patients who have been subject to abuse and/or neglect.

This report is brought to the Trust Board for assurance prior to dissemination to North Central London Integrated Care Board (Islington Directorate) and Islington Safeguarding Adult Board (ISAB).

Throughout this report the Safeguarding Adults Team are referred to as the Team. All resources and documents referenced are available on request from: **moorfields.safeguarding@nhs.net**

Organisation and structure

Safeguarding adults is an integral part of practice at Moorfields. The Chief Nurse and Director of Allied Health Professionals holds the role of Executive Safeguarding and PREVENT Lead and is the safeguarding adult’s representation on the Trust Board. In their absence responsibilities are delegated to the Associate to the chief nurse and director of allied professionals. The Team consists of a Head Nurse for Safeguarding Families and Vulnerable Adults who also leads on the PREVENT agenda, a Lead Named Nurse for Vulnerable Adults who also leads on the learning disability and dementia agenda, a Safeguarding Adults & Mental Capacity Act Practice Development Nurse and a Safeguarding Coordinator and Liaison Manager who works across both adult and children’s safeguarding.

The Designated Safeguarding Adults Professional at Islington Directorate of North Central London (NCL) Integrated Care Board (ICB) provides support and guidance to the Lead Nurse for Vulnerable Adults and the Head Nurse for Safeguarding.

Position	Name	WTE
Chief Nurse / Director of Allied Health Professions and Executive Lead for Safeguarding	Sheila Adam	1.0 WTE as director with safeguarding as required
Lead Nurse Safeguarding Children and Adults Team / PREVENT Lead	Tracey Foster	1.0 WTE
Lead Named Nurse Vulnerable Adults	Lucy Howe	1.0 WTE
Safeguarding Adults & Mental Capacity Act Practice Development Nurse	Helen Carpenter	1.0 WTE
Safeguarding Co-ordinator and Liaison Manager for Adults, Children and Young People	Urim Jaha	1.0 WTE

Safeguarding Adults Committee

The Safeguarding Adults Committee (SAC) met quarterly via MS Teams throughout the reporting year with good attendance. Chaired by the Executive Safeguarding Lead or in her absence the Associate to the chief nurse and director of allied professionals, the committee monitored progress against the safeguarding adults annual work plan, key performance indicators, risks, audits, complaints, incident reporting, serious incidents, training compliance, trends and themes and Islington Safeguarding Adults Board priorities.

Safeguarding adult assurances and any area for escalation are reported bi-monthly to the Clinical Governance Committee (CGC), through submission of SAC meeting minutes and escalation summary reports. This includes any operational issues, trends, training issues, Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs) or Serious Incident (SI) investigations involving safeguarding.

Membership of the SAC includes representation from a variety of disciplines across all Moorfields network. Members delegate a deputy to attend on their behalf if they are unavailable. The Head of Adults Safeguarding at Islington Council and the Designated Professional for Safeguarding Adults at Islington Directorate of NCL ICB attend, providing constructive challenge and expertise. The Terms of Reference for the SAC highlights the function, membership, reporting mechanisms and governance of the committee.

Key achievements

During this reporting period we have:

- Developed the Moorfields training proposal and eLearning package for mandatory learning disability and autism training in line with the draft code of practice.
- Provided Moorfields response to actions raised within Safeguarding Adults Reviews and ensured implementation.

- Development of new face to face Mental Capacity act training, to be included as part of clinical induction.
- Developed and delivered face-to-face Safeguarding Adults training Level 3 supported by an external facilitator
- Safeguarding audit, undertaken by external auditors RSMUK and all actions completed.
- Continued to respond to emerging safeguarding issues and concerns identified post the Covid-19 global pandemic (2020 – 2023) and the ongoing cost of living crisis.
- Provided a safe and effective service despite sickness and unplanned absence.
- Continued to work in partnership with Mencap, Alzheimer's Society, SeeAbility, service users and carers raising awareness of learning disability, dementia and carer issues.
- Promoted Moorfields response to caring for patients with dementia and staff who are carers by supporting national Elf Day for the third consecutive year.
- Supported Islington to continue as a dementia friendly borough.
- Continued to produce the biannual Caring Voices Newsletter to promote understanding of issues and challenges for vulnerable adults and the Safeguarding Snippets Newsletter.
- Delivered bespoke safeguarding sessions across the Trust including pre-Assessment and Governors and provided delivery of safeguarding content as part of the care certificate and preceptor training.
- Collaborative working with communications team in development of a training video to encourage and enhance quality of flagging vulnerable patients.
- Successful completion of the Best Interest Assessor (BIA) course by the Safeguarding Adults & Mental Capacity Act Practice Development Nurse bringing the total number of BIA's in the Trust to two.
- Supported the project group in the planning, development and the implementation of the accessible information standard (AIS), including leading on the development of Easy Read information.
- Supported the monitoring of the service level agreement between Moorfields and East London Foundation Trust (ELFT) who provide mental health advice and training for staff in supporting people attending Moorfield's.
- Worked collaboratively with colleagues to strengthen staff awareness of patient mental health concerns, development of training, policies, and staff resources, including a self-harm leaflet.

Safeguarding Adults Activity

Queries & Safeguarding Concerns

Safeguarding queries and concerns continue to be raised internally to the Team from a wide range of services and staff and from external agencies where adults are known patients of Moorfields.

New referrals to adult social care (ASC) have increased slightly however abuse discussed / identified by staff often related to patients who were already open cases to ASC. Patients may decline a referral to ASC as the Trust has an embedded the Making Safeguarding Personal (MSP) approach with patients' wishes established and acted upon. Supporting patients in making decisions about the safeguarding outcomes and what help they would like to help them keep safe is integral to MSP. Referrals to ASC are not made without consent, unless an exemption is identified for example adult patients presenting with ophthalmic injuries due to domestic abuse who have dependent children. In many cases support is available from third sector or specialist organisations that the patient can access and receive support to meet their needs.

Quarterly activity data is presented and discussed at the Safeguarding Adults Committee including themes identified during the preceding quarter and analysis with previous reporting periods.

Safeguarding Adults Activity Overview 2023 - 2024

1. Queries and Concerns

401 queries were made to the Safeguarding Adults Team for advice and support from staff across the Trust and external agencies. This is an **increase** of **3%** In comparison to 2022-2023 and there is a clear escalation in the complexity and diversity of the queries. This demonstrates staff are continuing to have a greater awareness and understanding of safeguarding and that it is becoming a more integral part of practice.

2. Reasons for discussion

The top five reasons for discussion with the Team were **mental health (48)**, **safeguarding (42)**, **care and support needs (34**), **MCA and best interest decisions (32)** and **non-safeguarding events (37)**.

Non-safeguarding queries include requests for signposting to other services for example Eye Clinic Liaison Officers (ECLOS). Non safeguarding queries have decreased slightly, this may be due to increased staff awareness on what constitutes a safeguarding concern.

3. Category of abuse

Amongst the queries raised within 7 categories of abuse: **Domestic Abuse and Violence (DVA)**, **financial abuse**, **neglect**, self-neglect, **physical abuse**, **psychological abuse**, **sexual abuse** and **self-neglect**, **DVA**, **physical abuse** and **self-neglect** remained the top three categories of abuse identified. Responding to DVA demonstrates the Trusts commitment to responding to **safeguarding the children of adult patients.**

4. Referrals

The Team were informed of **13 new referrals** to Adult Social Care (ASC) predominantly for care and support needs. Information was shared regarding concerns in **2 patients** in whom adult social care were undertaking section 42 investigations.

5. Patient Experience and Outcomes

The Team continued to provide advice and support in relation to vulnerable patients with complex needs including mental health, homelessness, learning disability and dementia. They supported clinical teams in the application of reasonable adjustments to facilitate patient care and variation to pathways at Moorfields, pre-admission preparation, inpatient support and discharge planning, to ensure a positive patient experience.

Tomasz Story and Unwise decisions - Good Practice

Principle 3 of the Mental Capacity Act states that; “People have the right not to be treated as lacking capacity merely because they make a decision that others deem 'unwise'.”

Everyone has their own values, beliefs and preferences which may not be the same as those of other people. The Lid oncology team had a case that tested not only our own values and beliefs, but also our process for undertaking challenging Mental Capacity assessments.

Tomasz* is a 67-year-old Polish gentleman, who is street homeless with his brother and sleeps overnight in a local church provided by St Mungo's homeless charity. He came to Moorfields via another hospital due to a cancerous growth on the inner corner of his right eye growing towards the bridge of his nose.

Tomasz attended the appointment with a support worker from St Mungo’s who interpreted for him. The clinicians recommended a biopsy to confirm suspicions of skin cancer and how to proceed with treatment. He was booked for biopsy the following week and at the clinic appointment he declined the biopsy stating that, “it will disappear, I met someone, and their cancer has disappeared, it will go away”.

Clinicians involved in this case needed to consider firstly what might be influencing **Tomasz** decision and secondly, did he have capacity to make this decision?

In this case, a mental health assessment was obtained to ascertain that there were no underlying mental health concerns before a robust mental capacity assessment was undertaken. Face to face interpreters were booked and two experienced clinicians spent an afternoon with **Tomasz** to explain in simple terms what would happen if this growth was left untreated and then listened to his fears and concerns about surgery and treatment. It was deemed that **Tomasz** did in fact have capacity to make the decision and after the discussion, he agreed to the biopsy.

Well done to the Lid oncology team. You went out of your way to support a very vulnerable gentleman in an extremely challenging case.

***Not real name**

Incident Reporting

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

160 incident reports were completed and submitted under the category of safeguarding adult during 2023 - 2024, an increase of 33%, highlighting a variety of issues regarding adults at risk. Every incident that the team are alerted to will be reviewed and action taken to provide assurance that any safeguarding concerns have been identified and appropriate action taken. Of the 160 incidents, 136 related to patients with potential vulnerabilities, the remaining 24 were highlighted as inappropriately categorised as safeguarding.

Themes identified during this reporting period have again included MCA and consent in patients with dementia not being consented properly or too late, patient falls and transport issues. The appointment of the Safeguarding Adults & MCA Practice Development Nurse has allowed the team to provide increased support and training regarding the MCA and appropriate and timely consenting. The Team are active members of the Falls Committee and ensures a safeguarding overview of patient falls.

Post Covid 19 global pandemic and cost of living crisis

It is acknowledged that the covid-19 global pandemic was declared officially over in the United Kingdom in May 2023.

National and local trends in safeguarding adult concerns post pandemic continues to be reflected at Moorfields, particularly with mental health queries and homelessness. The cost-of-living crisis has also impacted on people's mental health and resilience and although the team have not seen a significant increase in the number of this type of query and concern, the complexity of the concerns has become greater.

Complex Discharges

Complex discharges can arise when staff have been unaware of a persons holistic needs or those who require specialist support or interventions, particularly after an urgent admission. Often complex discharges are multifaceted in nature, for example, homelessness, mental health and substance misuse often go hand in hand and it can prove challenging to access the appropriate support for safe discharge. The Safeguarding team are frequently involved with complex discharges that involve a multiagency approach and work closely with the Surgical Matron, Pre-Assessment and ward teams.

Domestic Violence and Abuse (DVA)

As with the previous reporting years, the most common type of abuse reported and/or discussed with the Team was DVA. The team continued to ensure that robust information and resources were available for staff and patients to address this core safeguarding topic. Improving identification of DVA, enabling disclosure, and ensuring survivors (children and adults) are signposted to specialist and or statutory services is a key priority for the Trust. Addressing DVA also demonstrates the Trusts engagement with the Think Family / Child Behind the Adult Agenda where the adult patient has children under the age of 18 years or is pregnant.

Homelessness

The number of queries that the team received regarding patients who presented as homeless and with complex health, social care and housing needs rose by 21% during this reporting period. The continuing cost of living crisis along with increased pressures on local authorities to meet demand mean that this figure is likely to continue to raise. The Team were contacted to provide advice, signposting and facilitate liaison with external agencies.

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

Modern Slavery

The Trust continued to raise awareness of modern slavery, which is included in the safeguarding adult's policy and training. A Modern Slavery section is included on the safeguarding intranet page with links to the Royal College of Nursing (RCN) modern slavery pocket guide, the Metropolitan Police presentations, and the national modern slavery helpline.

The Safeguarding Adults & Mental Capacity Act Practice Development Nurse attended a workshop run by Islington Council focusing on modern day slavery. The event aimed to share the council's response and actions within the local community and to foster collaboration among partner agencies and help in planning for future strategies. There were several presentations by partner agencies with representation from the National Referral Mechanism and the Human Trafficking Foundation.

The safeguarding team have raised awareness of human trafficking through our safeguarding newsletter, how to recognise potential signs of modern-day slavery and reporting mechanisms.

The **Modern Day Slavery and Human Trafficking Statement** on Moorfields internet site demonstrates the commitment of the Trust to the Modern Slavery Act 2015 and their safeguarding duty. This will be reviewed in the next reporting year.

PREVENT and radicalisation

The Trust is committed to supporting the Government's PREVENT Strategy which is part of the Counter Terrorism Strategy led by the Home Office to prevent vulnerable people being groomed to support and/or commit acts of violent terrorism.

Submission of quarterly PREVENT data to NHS England and Islington Directorate of NCL ICB, monitors Trust compliance with the key elements of the PREVENT duties and responsibilities.

There have been no adult referrals from the Trust in relation to concerns regarding radicalisation and no information sharing requests for Channel Panel assessment received during 2023 - 2024.

In line with the PREVENT Training and Competencies Framework (2017), Basic Prevent Awareness (BPA) is mandatory for all staff and Level 3 Workshop Raising Awareness of Prevent (WRAP) is mandatory for all clinical staff. Competency in WRAP is currently attained by completing a nationally accredited eLearning course. A Trust applicable local information infographic developed by the Team supports the e-learning. and the safeguarding intranet includes a PREVENT page that contains information, flowcharts and guidance.

Training figures are provided by the Learning and Development Department via INSIGHT.

Table 1: PREVENT Mandatory Training Compliance (Permanent Staff and Volunteers)

Area	Target	March 2023	March 2024
Preventing Radicalisation			
Basic Awareness Prevent (BAP)	80%	89%	88%
Workshop To Raise Awareness Prevent (WRAP)	80%	90%	92%

Table 2: PREVENT Mandatory Training Compliance (Locum and Honorary Staff)

Area	Target	March 2023	March 2024
Preventing Radicalisation			
Basic Awareness Prevent (BAP)	80%	47%	50%
Workshop To Raise Awareness Prevent (WRAP)	80%	48%	39%

Complaints and Serious Incidents

The Safeguarding Adults team reviews all complaints to the Trust and scrutinises for any safeguarding adult element. A safeguarding review ensures a high-quality response to the complaint and understanding of the Trusts legal obligation to safeguard. There have been 7 complaints with a safeguarding/vulnerable adult feature during the reporting period and of these, 3 had a learning disability, dementia or mental health component. There were no complaints requiring the need for a safeguarding referral to be made. Transport continues to be a common theme within the complaints.

The Team also has oversight of all cases discussed at the weekly Incident Review Group and attend where appropriate. There were no serious incidents during this period that involved a safeguarding adult element. This provides an holistic process of review of any potential serious incidents.

Key Risk and Risk Mitigation Factors

Safeguarding has a shared Risk Register which is reviewed monthly and discussed as a standing agenda item agenda at the quarterly Safeguarding Adults Committee.

There is one current risk in relation to new legislation and national guidance which requires additional training requirements to be delivered. This impacts upon the work pressures of the existing team, the need to reprioritise other deliverables and the need to source additional trainers. A business case will be prepared to support the delivery of this safeguarding target.

A deep dive into identifying safeguarding risks that sit in other risk registers across the Trust is planned for the next reporting year. This will ensure the risks are appropriately categorised, that they sit in the correct risk register and will provide the Safeguarding Team with oversight.

Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs) and Offensive Weapons Homicide Reviews (OWHRs)

Learning from national and local SARs, DHRs and OWHR's are discussed at the Islington Safeguarding Adults Board and its sub-groups and cascaded via a variety of methods including through training, safeguarding champions, the Safeguarding Adults Committee, the Safeguarding Snippets Newsletter, infographics, safeguarding supervision, quality forums, safety briefings and the Moorfields news e-bulletin.

Actions taken in response to the "Liam" SAR commissioned by Islington around fire safety:

- Highlighted in Safeguarding Snippets Newsletter (August 2023, Issue 9) "A Spark of Knowledge" raising awareness of the incident, promotion of home fire safety checker tool.
- Safer October 2023 'Quality & Safety Bulletin' created by the safeguarding team raising awareness of the SAR and promoting discussion amongst teams around home fire safety referrals with patients and highlighting various support available to staff in learning more about fire safety and support available within the Trust. This included a link for staff to complete the Islington council e-learning session ' Fire Safety in the Home' for carers and support workers.
- Eye Clinic Liaison Officer (ECLO) team held an information session with London Fire Brigade (LFB) and are fully engaged with being the point of contact for advising patients on home fire safety referrals or submission of referrals on patients behalf as appropriate. This is already part of the standard practice for being registered as sight impaired/severely sight impaired, but any other patient identified as at risk will be offered advice and help with a referral when needed.
- Home Fire Safety Referral form available on Trust Intranet, if a patient is unable to complete the self-checker tool or submit a referral online independently, then the ECLO team will assist.
- The safeguarding team worked with the nursing research lead and contributed to the development of a smoking cessation algorithm with a pathway for advising new and current patients on stopping smoking. This pathway will also highlight the importance of recognising the categories which may put a person at higher risk of fire in the home. Staff will be directed to discuss home fire safety referrals with the patient and to refer patients to ECLO team for assistance with making a referral if support needed.
- Trust wide 'Clinical Lunch and Learn' session was held in December 2023 led by a representative of the London Fire Brigade.

The Trust has not been involved in any commissioned SARs, DHRs or OWHRs during 2023 – 2024.

Carer Support

In response to the recognition nationally and locally that the needs of carers is commonly a feature in Safeguarding Adults Reviews and Domestic Homicide Reviews, the Trust has maintained its commitment to support unpaid carers and the recognition of staff who are carers. The Team has maintained strong links with Carers UK to ensure that carers feel supported within the Trust. Information is available for carers on the Moorfields website and staff intranet.

Patient Information

Information to support adults and family/carers continues to be available. Patient information screens display information on safeguarding adults, dementia, learning disability, and carers, detailing how to access support within the Trust and through national specialist organisations. An information panel at the City Road entrance displays the same information. The health information hub at City Road displays safeguarding adults leaflets, domestic abuse and violence support information leaflets, easy read documentation, hospital passports and This is Me leaflets, along with easily accessible information from Mencap, Alzheimer's society and Carers UK.

The team have been involved with a project group to support implementation of the accessible information standard (AIS) and are leading on the development of Easy Read patient information and letters. This includes both reviewing currently available clinical leaflets and the development of Moorfields specific information, such as admission and discharge support.

Staff can access & provide information to patients, family and carers via the comprehensive safeguarding adults intranet pages. Information is available to the public via the Moorfields internet and includes safeguarding support, carer information, learning disability and dementia.

Promoting Best Practice

To support staff and promote good practice, all safeguarding polices, practice guidance, care pathways and templates are available on the comprehensive safeguarding adults intranet, which includes supporting information on homelessness and modern day slavery. Subpages include safeguarding champions, MCA, PREVENT, learning disability, dementia and domestic abuse. The intranet pages are regularly updated by the safeguarding team to ensure they reflect new guidance and information.

To promote understanding of and engagement with the safeguarding agenda, new and revised guidance, good practice, anonymised case studies, information, key learning and national and local priorities regarding safeguarding, Prevent, MCA, learning disability and dementia are included in the Safeguarding Snippets Newsletter and the Caring Voices Newsletter.

The safeguarding adults notice board continued to provide key information quarterly around specific safeguarding topics. Key information is also disseminated throughout the Trust via the Safeguarding Champions for inclusion in local safeguarding information boards and acknowledges that staff may have caring responsibilities, concerns for their own families, their neighbourhoods and communities as well as their workplace. Information includes contact details for support agencies and organisations., and the creation of QR codes to support rapid access of relevant information.

Safeguarding Adults Training

The Trust is committed to ensuring that all staff complete mandatory training to safeguard adults including recognising adults at risk of harm and abuse, and the necessary action required to safeguard.

Training continued to be delivered on a rolling three-year cycle in line with the Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) which outlines the safeguarding adults and MCA minimum training requirements that all staff in healthcare organisations are required to meet. Level 1 is mandatory for all staff and level 2 is mandatory for clinical staff. Face to face Level 3 safeguarding adults training commenced in January 2024 and will continue to roll out over the next 3 years.

Overall training compliance continues to be monitored by the Mandatory and Statutory training (MAST) Committee and the Safeguarding Adults Committee. Each division is responsible for monitoring and maintaining training compliance for their staff groups. Quarterly training data returns on safeguarding adults training, Prevent and MCA, are submitted to NCL ICB (Islington Directorate).

Training figures are provided by the Learning and Development Department via INSIGHT.

Table 3: Safeguarding Adults Mandatory Training Compliance

Area	Target	March 2023	March 2024
Permanent Staff and Volunteers			
Level 1	80%	88%	93%
Level 2	80%	91%	95%
*Level 3	80%		81%
**Level 4	80%	66%	75%
Locum and Honorary Staff			
Level 1	80%	53%	57%
Level 2	80%	44%	41%

*Training commenced in reporting year 2023 - 2024

**4 staff only working in a specialist safeguarding role

Work continues with Human Resources to address non-compliance with staff who are on honorary or locum contracts including data cleansing, onboarding procedure and development of robust honorary and locum policy and procedures. Compliance for this group is discussed at the MAST Committee, escalated to the clinical governance committee and Quality and Safety Committee and entered on the corporate risk register.

Safeguarding Partnerships Boards, Meetings and Networks

Moorfields is represented on a wide variety of safeguarding committees and networks, demonstrating engagement with and commitment to effective partnership working and multi-agency working. The Trust is a member of the Islington Safeguarding Adults Board (SAB) and subgroups represented by the Chief Nurse, Head of Safeguarding or the Lead Nurse Vulnerable Adults.

The Team also attends a wide range of North Central London (NCL), pan London and national network groups, supporting and sharing good practice, gaining updates and contributing to national developments and local policy and procedural decisions. Information from the various meetings is cascaded into the Trust via the Safeguarding Adults Committee.

- Access to Acute A2A Network
- Counter Terrorism Local Profile (CTPL) Annual Briefings
- Islington Dementia Friendly Steering Group
- Islington SAB Quality Assurance Subgroup
- Islington SAB Learning and Development Subgroup
- Islington Learning Disability Mortality Review (LeDeR) Group
- Islington Violence Against Women and Girls (VAWG) Board
- Local Implementation Network for Liberty Protection Safeguards
- National Safeguarding Adults Network (SANN)
- NCL Safeguarding System Learning Conversation
- NHS England Learning Disability Leadership Forum
- NHS Provider Forum for Safeguarding Adults and Prevent Leads
- NCL Safeguarding System Learning Conversation.
- NCLICS Oliver McGowan Strategic Group

Mental Capacity Act (MCA) and Deprivation of Liberty (DOLs) Safeguarding

To support robust implementation of the Act and Code across the Trust, the Team:

- maintained a comprehensive MCA intranet page including templates, policy summaries and videos
- provided support and advice to staff across the Trust
- attended and advised on Best Interest meetings
- sought legal advice and offered guidance on complex cases
- completed additional Best Interest Assessor (BIA) training bringing the total number of BIA's to two.

The Mental Capacity Act (MCA) applies to individuals aged 16 years and over. MCA training is mandatory for all staff who complete a basic awareness e-learning module. To meet their statutory duty to work within the Act and the MCA Code of Practice clinical staff also complete a Level 3 e-learning module with a Trust applicable local information infographic developed by the Team.

The Liberty Protection Safeguards (LPS) system was introduced through the Mental Capacity (Amendment) Act in 2019 as the planned replacement for the Deprivation of Liberty Safeguards (DoLS). Consultation was completed in summer 2022 but the Government made the decision in April 2023 to delay the

implementation of LPS beyond the life of the current Parliament. This was one of a number of decisions taken by the Government as part of prioritising work on social care. Work will continue on preparing Moorfields to implement LPS including an appropriate model within an ambulatory care setting pending publication of the updated Code of Practice which supports LPS.

During 2023–2024 the Trust made no referrals to supervisory bodies (Local Authority) seeking authorisation of a deprivation of liberty. This is to be expected within the context of Moorfields, as an ambulatory model Trust, with few patients admitted overnight and those that are would not usually stay more than one night, and so the threshold for a deprivation of liberty is rarely met.

All training figures are provided by the Learning and Development Department via INSIGHT.

Table 1: Mandatory Training Compliance

Area	Target	March 2023	March 2024
Permanent Staff			
Mental Capacity Act Basic Awareness	80%	88%	90%
Mental Capacity Act Level 3	80%	81%	85%
Locum and Honorary Staff			
Mental Capacity Act Basic Awareness	80%	49%	49%
Mental Capacity Act Level 3	80%	37%	31%

Learning disability and dementia

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

The Trust continues to have robust policies and processes for supporting patients with learning disabilities and dementia, including:

- Identifying and flagging patients with learning disabilities or dementia on PAS and Open Eyes Electronic Healthcare Records
- Offering hospital passports
- Offering This is Me leaflets
- Placing helping hands stickers on the patient's record
- Availability of easy read documentation
- Making reasonable adjustments

- Adult Vision Clinic (AVC). Clinicians have expressed interest in adopting the AVC Model for some of the other Moorfields networks sites.
- Johns Campaign which pledges Moorfields commitment to supporting the carers of patients with dementia.
- Information and support organisations information for patients/family and carers on **dementia** and **learning disabilities** available to the public via the Moorfields internet
- Membership of Islington Dementia friendly steering group, supporting Islington to continue being a Dementia friendly Borough and Moorfields a Dementia friendly hospital.
- Membership of Access to Acute A2A Network for learning disability nurses across London and South of England.
- Close links maintained with Mencap, Alzheimer's Society, Carers UK and SeeAbility.

The Team were again able to raise awareness of dementia during Elf Day in December 2023 by holding an information stall and promoting dementia friendly messages and information. The Team also noted a marked increase in request to activate flags on Trust systems and the safeguarding co-ordinator worked collaboratively with the Communications Team to produce a short instructional video for staff on how to activate flags on patients Open Eyes Electronic healthcare record.

Learning Disability and Autism training

In 2023 a consultation took place on the introduction of the requirement for learning disability and autism training by the Health and Care Act 2022 and publication of the draft Code of Practice took place which informed the current recommendations for training and the promotion of the Oliver McGowan training programme.

Public Health England published evidence in 2020 showing that adults with learning disabilities are 10 times more likely to have serious sight problems than other adults and children are 28 times more likely. People with very high support needs are most likely to have a sight problem.

In light of this, a paper was presented to the board outlining the training currently being delivered at Moorfields and how this can be adapted for staff at Moorfields to meet the needs of our patients and ensure staff training meets the key aspects of the draft Code of Practice. NCL ICB recognised Moorfields specialism and supported the approach to provide an alternative training that meets the requirement of the draft Code of Practice.

This will be achieved with the redesign the current learning Disability and Autism training package, incorporating key themes from the Oliver McGowan training providing evidence of adherence to the draft Code of Practice.

Training figures are provided by the Learning and Development Department via INSIGHT.

Table 1: Mandatory Training Compliance

Area	Target	March 2023	March 2024
Permanent Staff and Volunteers			
Dementia	80%	88%	92%

Learning Disability and Autism	80%	89%	91%
Locum and Honorary Staff			
Dementia	80%	47%	52%
Learning Disability and Autism	80%	46%	49%

Learning Disability Improvement Standards

The Learning Disability Improvement Standards for NHS Trusts are intended to help the NHS measure the quality of service provided to people with learning disabilities, autism or both. A Trust's compliance with these standards demonstrates it has the right structures, processes, workforce and skills to deliver the outcomes that people with learning disabilities, autism or both, their families and carers expect and deserve, as well as a commitment to sustainable quality improvement in the services and pathways for this group of patients.

In December 2023, Moorfields completed and submitted the annual benchmarking audit tool. When published, the results from this audit will be presented to the safeguarding adult committee for review and an action plan developed.

Learning Disability and Dementia Working Group

Due to competing priorities the launch of the vulnerable adults group, post the covid-19 pandemic, was postponed. At the time of the report a review of committees and groups across the Trust is underway including the Learning Disability and Dementia Working Group. However, relationships with local community groups has been maintained to ensure ongoing inclusivity and engagement with service users with learning disabilities, representatives from the Alzheimer's society and carers to support the development of a new vulnerable adults group. The group will monitor and support progress across Moorfields against the Trust's Dementia and Learning Disability Strategies, and national and local dementia and learning disability agendas and have an operational focus.

Mental Health

The team are actively involved in the monitoring of the Mental Health Service Level Agreement (MH SLA) through the monthly monitoring meeting between East London Foundation Trust and Moorfields. The SLA provides an advice service and training for staff in supporting patients attending Moorfield's for care and treatment. The MH SLA monitoring meeting provides assurance to the Safeguarding Adults Committee on a quarterly basis.

We have worked collaboratively with colleagues to strengthen staff awareness of patient mental health concerns, development of training, policies, and staff resources, including a self-harm leaflet. Work to update both the restraint and mental health policies is planned for the new reporting year.

Supervision

Safeguarding supervision offers staff an opportunity to discuss safeguarding concerns and cases either individually or in a group environment to support learning and development and promote good practice. Safeguarding supervision is available to staff across the Trust in a variety of formats including debrief case review sessions, Q&A sessions and after actions reviews and form part of the NCL ICB (Islington Directorate) Quarterly Safeguarding Performance Metrics.

Safeguarding Champions

The safeguarding champion's model was developed in December 2017 to support and promote good safeguarding practice. Champions are an additional resource to raise awareness of safeguarding and support staff within their local department/area, disseminate information and maintain strong links and communication with the Safeguarding Team and alert them of any issues or trends regarding practice. The total number of champions across the Trust, from a wide variety of disciplines and roles is currently 65.

Following a successful business case for additional funding the Safeguarding Co-ordinator took on additional responsibilities as the Liaison Manager to provide support and leadership for the Trust's Safeguarding Champions. Due to sickness and unplanned absence this element of the co-ordinator role has not yet been fully established.

Policies and Procedures

The Trust continues to review systems, policies and procedures to safeguard adults at risk and to ensure compliance with legislation, statutory guidance, national and local guidance, and practice developments. The Safeguarding Adults Committee has a role to: scrutinise any newly published national guidance and legislation, consider any implications for the Trust, ensure policies and procedures are legally compliant and follow national guidance, agree on reviewed and new policies regarding safeguarding adults, PREVENT, MCA, learning disability and dementia. The Policy and Procedure Review Group approves all policies relating to Safeguarding.

Title of Document	Type of Document	Status
Restraint	Policy	Section Reviewed and ratified
Safeguarding Adults	Policy and Procedures	Reviewed and ratified

Performance Metrics and Reporting

Safeguarding reporting provides assurance to the Trust, NHS England, Islington Directorate of NCL ICB, Islington Safeguarding Adults Board (SAB) and Health Education England with the following completed and submitted:

- Assurance report for Islington SAB regarding fire safety following recommendations from 'Liam' Safeguarding Adults Review (SAR)
- Health Education England (HEE) Annual Dementia Training Submission

- Islington SAB Annual SAPAT (Safeguarding Adults Partnership Audit Tool)
- Islington SAB Liam SAR Action Plan
- NCL ICB Quarterly Learning Disability and Autism Mandatory Training Compliance
- NCL ICB Quarterly Safeguarding Adults Performance Metrics
- NHS England Annual Learning Disability Improvement Standards Benchmarking Audit
- Moorfields content for Islington Safeguarding Adults Board Annual Report
- NHS England Quarterly National Prevent Duty Data Set

Safer Recruitment and Employment Practice

Moorfields is committed to minimising risk to patients by ensuring staff who are employed by the Trust are safe. All job descriptions include a statement regarding employee's responsibilities to safeguard vulnerable adults. Compliance with Disclosure and Barring Scheme (DBS) checks on appointment to the Trust continue, led and undertaken by the Human Resources department. DBS compliance remains a standing item agenda reported into the quarterly safeguarding adults committee. There is a process in place, led by Human Resources, to ensure up and coming professional renewal registrations are captured and followed through. There have been no queries raised with the Team regarding new starter or renewal DBS checks.

The Chief Nurse is the named senior officer with overall responsibility for ensuring Moorfields has appropriate arrangements in place including a Managing Safeguarding Allegations Policy and Procedures for the management of allegations of abuse against staff and volunteers. The Team support Human Resources and managers in managing safeguarding allegations against staff. There have been no safeguarding allegations made against staff during this reporting year.

Human Resources support managers in using these documents to manage any of the issues outlined for example: Dignity at Work (Bullying and Harassment) Policy and Procedures Capability Policy, Disciplinary Policy and Freedom To Speak Up (including Whistleblowing) Policy.

Inspections and Monitoring

During this reporting period there have been no inspections by the Care Quality Commission or any inspections related to safeguarding adults.

Priorities 2024 – 2025

- To continue delivery of creative Level 3 safeguarding adults training.
- To explore the development of a Vulnerable Adults Group and continue robust links with community groups.
- To continue to review, develop, deliver and evaluate safeguarding related training
- To launch and implement redesigned learning disability and autism training for Moorfields in line with the draft code of practice and Oliver McGowan training requirements.
- To implement face to face MCA training as part of clinical induction
- To develop the internet pages for safeguarding, learning disability and dementia

- To support the development and embedding of the Sexual Safety Charter.

Conclusion

The Trust continues to take it's safeguarding adults responsibilities extremely seriously and has demonstrated that it is fulfilling its statutory duties by protecting people's health, wellbeing and human rights, and enabling individuals to live free from abuse and neglect.

2023 - 2024 was another busy year for the Safeguarding Adults Team who successfully delivered and implemented key objectives which resulted in positive patient outcomes and provided safety for vulnerable adults. The report details a year of significant activity and improvement and demonstrates that there are robust mechanisms in place to safeguard adults and to continually develop and strive for excellence.

Ensuring safeguarding is maintained as a high priority, all the Team are committed to further improving and developing Moorfields understanding and knowledge that "safeguarding adults is "everyone's business" and is embedded within the Trust response to safeguarding.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Safeguarding Children and Young People Annual Report 2023 - 2024

Report title:	Safeguarding and Promoting the Welfare of Children and Young People (0-18y) Annual Report 2023 – 2024
Report from:	Sheila Adam Chief Nurse / Director of Allied Professionals / Executive Lead for Safeguarding
Prepared by:	Alison McIndoe Named Nurse Safeguarding Children and Young People
Previously discussed:	Safeguarding Children and Young People Committee Clinical Governanace Committee
Attachments:	Summary paper pages 3 - 7
Link to strategic objectives:	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive Summary

This report demonstrates compliance with the statutory and mandatory requirements relating to safeguarding and promoting the welfare of children and young people, including the safeguarding response following the Covid-19 global pandemic. All staff within the Moorfields Eye Hospital NHS Foundation Trust have a responsibility for ensuring that children and young people under our care or associated with the Trust are protected and safe, and to ensure that the safeguarding is an integral part of our governance systems. This report also demonstrates to the Care Quality Commission that the Trust is meeting its responsibilities under statutory Section 11 duties of the Children Act.
It also details how the Trust is assessed on its performance both internally and externally regarding safeguarding children and young people.

Quality Implications

This report provides assurance of the Trust's response to children and young people for whom there are safeguarding and/or child 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 the quality of the services we provide 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 decision		For discussion		To note	

Title of Summary Paper	Safeguarding and Promoting the Welfare of Children and Young People (0-18y) Annual Report 2023 – 2024
Executive Safeguarding Lead	Sheila Adam - Chief Nurse and Director of Allied Professionals
Author	Alison McIndoe – Named Nurse Safeguarding Children and Young People.

All health providers are required to have effective arrangements in place to safeguard children and at risk of abuse or neglect and to assure themselves, regulators, and their commissioners that these are working and effective (Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework NHSEI, 2022.)

Safeguarding children and young people (SGC&YP) remain a high priority throughout Moorfields Eye Hospital NHS Foundation Trust through a continued commitment to promoting safeguarding as an integral component of practice, keeping the child or young person at the centre of safeguarding decision making and ensuring the Trust fulfils its statutory duties and responsibilities.

This includes:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or adults.
- Safeguarding policies and procedures that support local multi-agency safeguarding procedures.
- Effective training of all staff proportionate to their role and in accordance with the intercollegiate competencies for safeguarding children (2023).
- Effective supervision arrangements for staff working with children, young people and families at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Developing and promoting a learning culture.
- Identification of named safeguarding professionals.
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.

The responsibility to safeguard children and promote their welfare is more comprehensive than just protection. To be effective, this requires staff members to recognise their individual responsibility to safeguard and promote the welfare of children and young people who are vulnerable as well as the commitment of Trust management to support them in this.

This report provides an opportunity to celebrate our achievements in the 2023-2024 reporting period and reflect on where we need to focus our efforts with an aim of strengthening practice in the year ahead.

This report provides an overview of the safeguarding children team's activity and assurance that the Trust is meeting its statutory obligations by ensuring staff have access to appropriate training, advice, support and supervision in relation to current UK policy and legislation as it relates to safeguarding children and young people over the period April 1st, 2023 – March 31st, 2024.

Quality Assurance

Our Safeguarding Children and Young People Committee (SCYPC) provides challenge and assurance in respect of the safeguarding arrangements within our Trust.

Moorfields works with many partner agencies and contributes to local multi-agency Safeguarding Children Partnerships, Safeguarding children committees and subgroups across our NCL footprint. The Trust provides external assurance through a variety of methods including Section 11 audits, Self-Assessments and Contractual Standards required by the Integrated Care Boards.

During the reporting period the following activity, assurance, learning and improvement outcomes have been achieved:

- A total of 773 queries were raised to the Safeguarding Children Team for advice and support from staff groups across the Trust as well as external agencies supporting the health and wellbeing of children and young people during 2023-2024. This is an overall increase of 6% in comparison to 2022-2023. This demonstrates that staff are continuing to have a greater awareness and understanding of safeguarding and that it is becoming a more integral part of practice.
- 38% of the children discussed were already open cases to children's social care
- There has been an increase of 20% relating to queries raised with the safeguarding team by external statutory agencies. This demonstrates a 2% increase of queries raised by this professional group in 2022-2023. This goes further to support the efforts made by staff groups throughout the organisation to strengthen information sharing practices as per best practice multi agency working safeguarding guidance (DfE 2023).
- Referrals to children's social care reduced by 13% (from 47 to 41 in the previous reporting year).
- Consistent with previous year's reporting of 36% of referrals were related to the "Child Behind The Adult" predominantly due to domestic violence and abuse and the identification of young carers.
- There were no Serious Incidents relating to safeguarding children during this reporting period.
- 116 internal Ulysses incidents reported in 2023-2024, a 19% decrease from the previous reporting year, and were submitted by staff from a wide range of roles and responsibilities.
- No acts of omission were identified however there has been areas of learning in relation to professional curiosity, prompt referrals to children's social care when concerns reach a threshold for referral and the sharing of specialist ophthalmic information that Moorfields holds with statutory external partners.
- The Team supported managers to review 3 complaints. Two required no safeguarding input. One identified the impact of parental behaviour on the child. The Team made recommendations for appropriate internal and external information sharing to support the child and work in partnership with mother during outpatient appointments. Complaints reviewed by the safeguarding team ensures a high-quality response to the complaint and understanding of the Trusts legal obligation to safeguard. The safeguarding review of adult complaints also considers associated children and young people that may be impacted.
- Mandatory safeguarding children and young people training compliance for permanent staff and volunteers at level 1 and 2 via eLearning for Health sustained above the 80% trust agreed target for the duration of this reporting period along with mandatory Mental Capacity Act (MCA) & PREVENT.

- Level 3 compliance was slightly below target at 73% at the start of this reporting year. With the appointment of a named nurse for safeguarding in May 2023 and the reintroduction of face-to-face training target compliance was achieved above 80% in September 2023 and has remained above this figure throughout.
- Level 4 SGCYP MAST training compliance for practitioners with a specialised identified role in safeguarding, reached 100% during quarter 4 for this reporting period.
- Honorary and locum staff MAST compliance remains below target and ongoing work to address this continues with the Human Resources department and the Medical Resource Lead for this staff group.
- Systemic learning is supported through a variety of activities including training, via team meetings and briefings, disseminated via SGC&YP group members, supervision, distribution of the internal Safeguarding Nuggets Newsletters, attendance at meetings, staff question and answer sessions, the Safeguarding Notice Boards and via comprehensive feedback through incident reporting.
- An external audit of safeguarding processes was undertaken in the reporting year 2023 – 2024 by RSM UK Risk Assurance Services (RSM) with an aim to provide assurance of the processes adopted by the trust in relation to safeguarding children and young people. Recommendations to strengthen safeguarding process and practices were successfully implemented into practice through updating the Trusts child protection policy. An internal audit of the impact of the update to policy will be undertaken in the next financial year 2024-2025.

Key Achievements

During this reporting period the Safeguarding Team have:

- Increased visibility of safeguarding children's team by developing and sustaining a programme of regular network site visits. This provided once quarterly opportunities for additional in person support to colleagues in their departments within host sites.
- Safeguarding supervision was conducted with practitioners during these visits. A record of attendance was maintained to ensure equitable access to this provision.
- Established a sustained pattern of safeguarding supervision workshops at City Road in various paediatric facing departments to strengthen and build on SGCYP practice using case examples from practice to support with tailored learning and reflection within teams.
- Developed and sustained a programme of delivery for Safeguarding Children & Young People Level 3 MAST (L3 SGCYP MAST) in accordance with Intercollegiate Document: Safeguarding Competencies for Health Care Staff (2023). Feedback from qualitative data collected indicated that the course acceptance is good demonstrating a range of staff groups awareness of professional safeguarding responsibilities.
- We continued to explore ways in which professionals are embedding learning into practice. Themes such as Child behind the adult/think family agenda, professional curiosity, trauma informed practice can be evidenced through supervisory liaison contacts with practitioners.
- Improved compliance with L3 SGCYP MAST – Training compliance improved above 80% - achieved September 2023
- Appointment of statutory requirement Named Doctor for SGC&YP to support with strengthening practice within the clinical workforce of medical practitioners was achieved in May 2023

- Completed the Safeguarding Teams Business continuity plan ensuring plans are in place to support with continued safe delivery of safeguarding services.
- Re – established Safeguarding Children Nuggets Newsletter. Following a hiatus, April 2022, the team have successfully re-established the quarterly publication of this document which provides an additional medium to share learning and best practice safeguarding messages across the Trust.
- Developed the Paediatric Data collection sheet to include assessment of Child Protection Information System (CP-IS) review; revised template disseminated and support with CP-IS roll out and implementation across the trust with face to face and virtual teaching.
- Review the SPECCS DVA risk assessment tool with consideration of the Child behind the adult/Think family approach. This update strengthens staff groups awareness of the requirement to consider Children and Young people in instances where service users present with domestic abuse and violence concerns.
- Safeguarding Children and Young People Policy; Updates included: response following Covid-19 pandemic, Child Q recommendation, Governance Chart, War and conflict. In addition, an action from safeguarding processes from RSM external audit recommendations applied with the addition of the paediatric data collection sheet as an appendix.
- Delivered bespoke safeguarding training package for Internationally Educated Nurses – Training provision provided in conjunction with the adults safeguarding team.
- Working in partnership with the safeguarding adults' team, develop and disseminate a safety huddle bulletin to support practitioners insight of safeguarding process application in practice.

Risks

- The Safeguarding Risk Register is reviewed monthly and discussed and monitored as a standing agenda item at the quarterly SGC&YP Committee.
- Over the past reporting year, one risk related to the challenge of recruiting to staff vacancies in the Safeguarding team. This has led to a number of issues including the delay in responding within the specified timeframe to safeguarding children queries and concerns. The increased risk associated with staff shortages due to sickness and unplanned absences resulting in staff not being able to take annual leave and further long-term sickness and absence within the team. The impact has led to an increased workload and capacity demands upon existing team members leading to fatigue and undue pressure. Implementation of a support plan and ongoing re-prioritisation of deliverables by the team combined with successful recruitment to the Safeguarding children's advisor role following interim support has mitigated the impact, however the risk still remains and is closely monitored.
- There is a further current risk relating to the lack of oversight of all safeguarding risks across all Trust risk registers. Work to explore this issue is ongoing led by the associate to the chief nurse with the head of quality.
- There is one persistent and ongoing risk relating to fulfilling increased statutory training requirements as it relates to locum and honorary clinicians working within the organisation. The impact of this risk is that we are unable to provide assurance that this cohort of staff have the skill, knowledge and abilities to appropriately identify safeguarding concerns and take appropriate action. In response to this risk the medical director and the HR lead are working together to establish a way forward; including data cleansing, onboarding procedure and development of robust honorary and locum policy and

procedures. Compliance for this group has been discussed at the MAST Committee, escalated to the clinical governance committee and Quality and Safety Committee and entered on the corporate risk register.

- There is an emerging risk identified in relation to responding to the expanding demands for additional training. With the development of current knowledge, skills, and behaviours required by professionals to appropriately respond to safeguarding concerns additional resources will be required to support the team with delivery across the organisation.

Priorities for 2024 - 2025

Over the next year the Safeguarding Children's Team will continue to work across the organsition to improve safeguarding children's practice as well as focus on priorities from the SG Children partnership board. These include;

- To respond to any emerging safeguarding themes including safeguarding themes of the 21st century – Child exploitation, human trafficking, modern day slavery, medical neglect, Child behind the adult.
- To successfully recruit substantively into the Safeguarding Children's Nurse Advisor vacant post.
- To re-establish the full day safeguarding champion training package for new cohorts across the trust and the half day refresher training package for the existing champions who continue to support the safeguarding agenda locally within their teams acting as a point of contact and guidance and support discussing of themes that required addressing with the safeguarding children team.
- To develop a sustainable plan for the provision of a dedicated safeguarding training budget in order to respond to the expanding demands for training subjects.
- To work in collaboration with department leads, to further develop the Moorfields Eye Charity and Moorfields Private Eye Centre (MPEC) safeguarding children and young people policies and processes.
- To re-establish domestic violence and abuse awareness raising events and bespoke face to face training sessions that were halted due to the covid-19 pandemic.
- To develop the Child Protection Information Sharing Policy, guidance and Training document to support colleagues with increased safeguarding skills in respect of children who access services in unscheduled settings as well as those who are not brought to scheduled health care appointments.
- To support Child Protection Information System (CP-IS) training across paediatric service departments to strengthen safeguarding and information sharing practices amongst colleagues. Allow continued support for the process through a Train the Trainer approach locally, with the SGT available to provide oversight and support as appropriate.
- To contribute to improving outcomes for children and young people set against Islington Safeguarding Children Partnership key priority areas;
    - Improving outcomes for children with additional needs - Develop Paediatric Special Needs and Disability (SEND) Hospital Passport. Utilising the current adult focused Learning Disability Hospital passport, liaise with relevant paediatric stakeholders to develop child focused hospital passport with the input from orthoptics SEND lead.
    - Neglect and parental factors; Contribute to the development of the current paediatric Was Not Brought pathway supporting with building on best practice in providing opportunities for early intervention in cases where appropriate access to healthcare initiates concern.

- To respond to Level 3 SCGYP MAST evaluations and feedback; Collate and analyse to inform training content and development.
- To develop a safeguarding children and young people session to be included in corporate face to face induction once reintroduced.
- To work in partnership with the Named Doctor safeguarding children and young people explore inclusion of training session for face-to-face medical induction across Trust.
- To complete a retrospective audit to establish the impact of referring children to social care on attendance and engagement with services.
- To submit the biannual Section 11 assurance audit to Islington Safeguarding Children Partnership Board in demonstration of the Trusts compliance with all 8 standards.

Contents

"Safeguarding and promoting the welfare of children and young people is defined as protection from maltreatment and abuse, preventing impairment of health and/or development and ensuring children are growing up in circumstances consistent with the provision of safe and effective care."
(Working Together 2023)

"Child protection is a subset of safeguarding and promoting the welfare of children and young people. It refers to the activity undertaken to protect children and young people who are suffering or likely to suffer significant harm under the categories of neglect, emotional, physical and sexual abuse."
(Children Act 1989 and 2004)

Introduction

The safeguarding of children and young people (SGC&YP), including unborn babies, remains a high priority within Moorfields Eye Hospital NHS Foundation Trust through a continued commitment to promoting safeguarding as an integral component of practice and keeping the child or young person at the centre of safeguarding decision making.

Safeguarding is governed by a range of legal and regulatory requirements including: 'Working Together to Safeguard Children (2013)' which sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and 2004 including the duties set out under Section 11 of the Act; the Care Quality Commission Domain 1: is the organisation safe and Regulation 13 on safeguarding service users from abuse and improper treatment; and 'Getting the Right Start', the National Service Framework for Children Standard for Hospital Services (Standard 7).

This SGC&YP annual report sets out the work carried out by Moorfields Eye Hospital NHS Foundation Trust (including the network sites where the Trust provides services), in relation to:

- Providing assurance that the Trust continues to fulfil its statutory responsibilities to safeguard and promote the welfare of children and young people, as defined by Section 11 of the Children's Act 1989/2004.
- Providing assurance that the Trust is maintaining effective safeguarding children and young people systems and processes.
- Providing assurance that the Trust is compliant with CQC key lines of enquiry (safe, effective and responsive).
- Providing an update to internal and external stakeholders on the developments in relation to safeguarding children and young people including progress following the 2022 – 2023 report.
- Identifying any areas of risk in relation to statutory safeguarding responsibilities.
- Responding to safeguarding concerns identified post the Covid-19 global pandemic (2020 – 2023).

Understanding the impact of this work in terms of effectiveness in helping to keep children and young people safe, the quality of work required to safeguard, improving outcomes and to do things differently where needed to improve safeguarding practice is integral to the commitment to our Section 11 duties.

The Trust recognises that safeguarding children extends much further than paediatric services and includes

16 – 18-year-olds being seen in adult services, siblings of paediatric patients, unborn babies and dependent children of adult patients known as the "Child behind the Adult" agenda. The philosophy that 'child protection and safeguarding children and young people is everyone's business' (Laming 2003) underpins our strategy to involve staff at every level in this important endeavour.

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

Throughout this report the SGC&YP Team are referred to as the Team. All resources and documents referenced are available on request from: **moorfields.safeguarding@nhs.net**

Key messages and quality assurance

During reporting period 2023 – 2024 the following improvement and learning outcomes have been achieved:

- A total of 773 queries were raised to the Safeguarding Children's Team for advice and support from staff across the Trust and external agencies during 2023-2024. This is an overall increase of 6% In comparison to 2022-2023.
- A recent audit of trust safeguarding processes found that clarification of the nature of concerns that constitute as safeguarding and in turn require liaison with the team would be a beneficial addition to strengthen practice. This has been achieved through production and dissemination of the safeguarding safety huddle bulletin building on the knowledge of practitioners.
- Mandatory safeguarding children and young people training compliance for permanent staff and volunteers, accessed through eLearning for Health, at level 1 and 2 perdured above the 80% trust agreed target for the duration of this reporting period along with mandatory Mental Capacity Act (MCA) & PREVENT.
- Face to Face mandatory safeguarding children and young people Level 3 training was recommenced, following the appointment of the Named Nurse Safeguarding Children to the team in July 2023. The Named nurse with the support of an external subject matter expert facilitate L3 MAST and successfully achieved compliance above 80% in September 2023. This demonstrates that staff are continuing to have a greater awareness and understanding of safeguarding and that it is becoming a more integral part of practice.
- Was Not Brought (35%) to an outpatient follow up appointment or booked surgery was the most popular pretext for discussion with the Team. An increase of 4% in comparison to the last reporting year. The remaining 2 four Themes for discussion with the team remain consistent with the past five consecutive reporting years: information sharing (9%), internal and external information requests (6%),
- Referrals to children's social care reduced by 13% (from 47 to 41 in the previous reporting year). Consistent with previous reporting of 36% of referrals were related to the "Child Behind The Adult" predominantly due to domestic violence and abuse and the identification of young carers.
- There were no SI's relating to safeguarding children during this reporting period.
- 116 internal Ulysses incidents were submitted by staff from a wide range of roles and responsibilities, a 19% decrease from the previous reporting year.

- No acts of omission were identified however there has been areas of learning in relation to professional curiosity, prompt referrals to children's social care when concerns reach a threshold for referral and the sharing of specialist ophthalmic information that Moorfields holds with statutory external partners.
- The Team supported managers to review 3 complaints. Two required no safeguarding input. One identified the impact of parental behaviour on the child. The Team made recommendations for appropriate internal and external information sharing to support the child and work in partnership with mother during outpatient appointments. Complaints reviewed by the safeguarding team ensures a high-quality response to the complaint and understanding of the Trusts legal obligation to safeguard. The safeguarding review of adult complaints also considers associated children and young people that may be impacted.
- eLearning for Health - Mandatory safeguarding children training compliance at Levels 1 and 2 remained above the 80% target throughout the year. Level 3 compliance was slightly below target at 73% at the start of this reporting year. With the reintroduction of face-to-face L3 training and the appointment of a named nurse for safeguarding in May 2023 target compliance was achieved above 80% in September 2023 and has remained above this figure throughout.
- Level 4 MAST training compliance, for practitioners with a specialised identified role in safeguarding, reached 100% during quarter 4 for this reporting period.
- Honorary and locum staff compliance remains below target and ongoing work to address this continues with the Human Resources department and the Medical Lead for this staff group.
- Systemic learning is supported through a variety of activities including training, via team meetings and briefings, disseminated via SGC&YP group members, via supervision, distribution of the internal Safeguarding Nuggets Newsletters, attendance at meetings, via staff question and answer sessions, via the Safeguarding Notice Boards and via comprehensive feedback through incident reporting.

Key acheivements

During this reporting period we have:

- Increased visibility of safeguarding children's team by developing and sustaining a programme of regular network site visits. This provided opportunities, once quarterly, additional in person support to colleagues in their departments within host sites. Safeguarding supervision is conducted with practitioners during these visits. A record of attendance is maintained to ensure equitable access to this provision.
- Established a sustained pattern of safeguarding supervision workshops at City Road in various paediatric facing departments to strengthen and build on SGCYP practice using case examples from practice to support with tailored learning and reflection within teams.
- Developed and sustained a programme of delivery for Safeguarding Children & Young people Level 3 MAST (L3 SGCYP MAST) in accordance with Intercollegiate Document: Safeguarding Competencies for Health Care Staff (2023). Feedback according to the qualitative data collected illustrates that course acceptance is good providing support to staffing groups in building skills, knowledges, and behaviours as it relates to safeguarding children. The feedback received also demonstrates staff groups awareness of professional safeguarding responsibilities and any individual identified gaps for additional development. We continue to explore ways in which professionals are embedding learning into practice. – Themes such as Child behind the adult/think family agenda, professional curiosity, trauma informed practice can be evidenced through supervisory liaison contacts with practitioners.

- Improved compliance with L3 SGCYP MAST – Training compliance improved above 80% - achieved September 2023
- Appointment of a Named Doctor safeguarding children and young people to support with strengthening practice within the clinical workforce of medical practitioners - achieved May 2023
- Completed the Safeguarding Teams business continuity plan ensuring plans are in place to support with continued safe delivery of safeguarding services.
- Re-established the quarterly publication of the Safeguarding Children Nuggets Newsletter, which provides an additional medium to share learning and best practice safeguarding messages across the Trust.
- Updated the Paediatric Data collection sheet to include assessment of Child Protection Information System (CP-IS) review, disseminate revised template and support with CP-IS roll out and implementation across the trust with face to face and virtual teaching.
- Completed an After-Action Review (AAR) in relation to information gaps identified across the system as it relates to the child death notification and reporting processes. Recommendations and shared learning from the AAR will be shared across the NCL footprint and wider health care systems.
- Reviewed the SPECCS DVA risk assessment tool with consideration of the Child behind the adult/Think family approach. This update strengthens staff groups awareness of the requirement to consider Children and Young people in instances where service users present with domestic abuse and violence concerns.
- Updated the Safeguarding Children and Young People Policy to include: post Covid-19 global pandemic, Child Q recommendation, Governance Chart, War and conflict. Action from safeguarding process external audit recommendations applied with the addition of the paediatric data collection sheet as an appendix.
- Delivered a bespoke safeguarding training package for Internationally Educated Nurses in conjunction with the adults safeguarding team.
- Worked in partnership with the safeguarding adults' team, develop and disseminate a safety huddle bulletin to support practitioners' insight of safeguarding process application in practice in response to recommendations made following an internal audit.

Safeguarding Risk Register

The Safeguarding Risk Register is reviewed monthly and discussed and monitored as a standing agenda item at the quarterly SGC&YP Committee.

- Over the past reporting year, one risk related to the challenge of recruiting to staff vacancies in the Safeguarding Team. This has led to a number of issues including the delay in responding within the specified timeframe to safeguarding children queries and concerns. The increased risk associated with staff shortages due to sickness and unplanned absences resulting in staff not being able to take annual leave and further long-term sickness and absence within the team. The impact has led to an increased workload and capacity demands upon existing team members leading to fatigue and undue pressure. Implementation of a support plan and ongoing re-prioritisation of deliverables by the team combined with successful recruitment to the Safeguarding children's advisor role following interim support has mitigated the impact, however the risk still remains and is closely monitored.
- There is a further current risk relating to the lack of oversight of all safeguarding risks across all Trust risk registers. Work to explore this is ongoing led by the associate to the chief nurse with the head of quality.
- There is one persistent and ongoing risk relating to fulfilling increased statutory training requirements as it relates to locum and honorary clinicians working within the organisation. The impact of this risk is that

we are unable to provide assurance that this cohort of staff have the skill, knowledge and abilities to appropriately identify safeguarding concerns and take appropriate action. In response to this risk the medical director and the HR lead are working together to establish a way forward; including data cleansing, onboarding procedure and development of robust honorary and locum policy and procedures. Compliance for this group has been discussed at the MAST Committee, escalated to the clinical governance committee and Quality and Safety Committee and entered on the corporate risk register.

- There is an emerging risk identified in relation to responding to the expanding demands for additional training. With the development of current knowledge, skills, and behaviours required by professionals to appropriately respond to safeguarding concerns additional resources will be required to support the team with delivery across the organisation.

Governance

- The Chief Nurse / Director of Allied Health Professions is the Executive Lead for Safeguarding, representing the Trust at Islington Safeguarding Children Partnership (ISCP). The safeguarding professionals represent the Trust at ISCP sub-groups. SGC&YP representation on Moorfields Trust Board is via the executive lead.
- The SGC&YP Committee, chaired by the Chief Nurse / Director of Allied Health Professions or her deputy continued to meet quarterly via MS Teams. Aligned with quarterly data and external key performance indicator (KPI) metrics reporting, the committee continued to monitor the progress of the annual work plan, KPI's, training compliance, risks, incident reporting and ISCP priorities.
- The SGC&YP Committee reports into the Clinical Governance Committee (CGC) including submission of agreed quarterly meeting minutes and the sub-committee escalation summary report.
- This annual safeguarding report is presented internally to the SGC&YP Committee, the CGC, the Quality and Safety Committee, the Trust Board and externally to Islington Directorate of NCL ICB and the ISCP. The quality assurance **SGC&YP declaration** to the public is available on the Trust internet site and will be updated after the Board have received this report.

Safeguarding Children and Young People (SGC&YP) / Child Protection Personnel

Position	Name	WTE
Chief Nurse / Director of Allied Health Professions and Executive Lead for Safeguarding	Sheila Adam	1.0 WTE as director with safeguarding as required
Lead Nurse Safeguarding Children and Adults Team / PREVENT Lead	Tracey Foster	1.0 WTE
Named Nurse SGC&YP	Alison McIndoe	1.0 WTE from May 2023
Named Doctor SGC&YP and Adults	Karen Wong	1 PA Session (4 hours per week)
Nurse Advisor SGC&YP Interim Nurse Advisor SGC&YP	Edit Nigliazzo Claire Lloyd	1.0 WTE until February 2024 0.8 WTE From February 2024
Safeguarding Co-ordinator and Liaison Manager for SGC&YP and Adults	Urim Jaha	1.0 WTE

Key priorities Islington Safeguarding Children Partnership (ISCP)

Moorfields remains committed to achieving ISCP key priorities and throughout the reporting period have engaged in a variety of activities to engage staff in their safeguarding responsibilities, meet the priorities and promote the welfare of children and young people.

A selection of these activities are included here:

Child neglect

- **Address the impact of neglect on children and to help them become more resilient.**

  Trauma informed practice has been a theme of discussion during safeguarding supervision sessions as well as a topic that is embedded in the Level 3 mandatory training package currently being delivered. Safeguarding briefings on the partnerships priorities and how they relate to practice within our organisation are circulated and disseminated through bespoke training and dissemination of safeguarding best practice guidance briefings created by the team.

Parental factors

- **Address the consequences of harm suffered by children because of domestic violence, parental mental ill health, and substance abuse, including helping children who have suffered harm to become more resilient.**

  The think family agenda as well as teaching in relation to the child behind the adult is embedded in current training and workshop materials utilised to facilitate training across the trust. Supported with facilitation and co-delivery of training sessions with safeguarding adults' team for staff undertaking the Care Certificate Course further raising awareness of staff in relation to the impact of adult behaviours on the wellbeing of a child. Strengthening of the domestic violence and abuse risk assessment tool to strengthen safeguarding children practice and increase professional curiosity skills of practitioners when treating patients with DVA concerns who may have children, providing an opportunity to ensure the **voice of the child** is embodied during safety planning.

Vulnerability

- **Identify and help children who are vulnerable to sexual exploitation, criminal exploitation, and gangs.**

  During the delivery of multi-agency safeguarding training the emerging themes of, safeguarding in the 21st century continued to raise awareness of County Lines, Child Criminal and Sexual Exploitation, Cyberbullying and Online Radicalisation and Grooming) are discussed. Trauma informed practice has been a theme of discussion during safeguarding supervision sessions as well as a topic that is embedded in the Level 3 mandatory training package currently being delivered. Safeguarding briefings on the partnerships priorities and how they relate to practice within our organisation are circulated and disseminated though bespoke training and dissemination of safeguarding best practice guidance briefings created by the team.

Post Covid- 19 Global Pandemic (2020 – 2024) and Cost of Living Crisis

It is acknowledged that the covid-19 global pandemic was declared officially over in the United Kingdom in May 2023. The impact of lockdowns on vulnerable children and children's development continues to be identified and the cost-of-living crisis also requires safeguarding practice to continue to be robust and adaptable.

The Team have been involved in:

- responding to continued increase in information requests from statutory safeguarding agencies.
- activating child protection flagging on children's electronic healthcare records.
- facilitating effective information sharing with children looked after health teams.
- responding to queries raised by staff in relation to children's mental health.
- Responding to an increase of queries from staff groups relating to children access to healthcare – Child ''Was Not Brought''

Safeguarding children and young people activity

Safeguarding queries and concerns continue to be raised internally to the Trust from a wide range of services and staff and from external agencies where children, young people and/or adults with children are known patients of Moorfields. Quarterly activity data is presented and discussed at the SGC&YP Committee including themes identified, good practice, lessons learned and analysis with previous reporting periods.

Overview of Type of Queries and Concerns Raised with the Team	
Activation of safeguarding risk flags	Invitation to Review CPC
Assaults	Invitation to Strategy Meetings
Care Leavers	Left without Treatment
Child or Young Person's Behaviour	Legal Information Requests
Complaints	Legal Queries
Consent Queries	Mental Ill health
Dog Bite Injuries	Missing Alerts
Domestic Violence and Abuse	Non safeguarding query
Eye Injuries	PALS Inquiry reviews
Housing Concerns	Parental Behaviour / Coping
Information Sharing	Parental Discord
Information Requests – Child in Need	Refugees
Information Requests – Child Protection	Removal of safeguarding risk flags
Information Requests –	Sexually Transmitted Infections
Incident Review Requests	Unaccompanied and Separated Children
Invitation to CIN Meetings	Was Not Brought
Invitation to ICPC	Young Carers

The overall number of new referrals to children's social care decreased by 13% compared to reporting year 2022 – 2023. In the previous reporting year 47 referrals were submitted to children's social care in comparison to this year's total standing at 41. A recent audit of internal safeguarding process recommended

that staffing groups would benefit from having access to additional resources and information detailing the rationale for completing a referral to Children's social care. It had been noted through audit that there were instances that information sharing with CSC was not appropriate as universal health services were best placed to meet the needs of the child. Production and dissemination of a safeguarding bulletin fulfilling the audit recommendation, may go some way to provide context to the decrease.

Moorfields accident and emergency services are level 2 category and do not accept blue light ambulances and the hospital does not have paediatric inpatient beds. These factors can influence the overall rate of new referrals to children's social care. As an ophthalmic hospital Moorfields is part of the assessment pathway in cases of suspected abuse, non-accidental injuries and secondary opinions. To note if concerns are raised in cases where the child is already open/known to children's social care this is not logged as a new referral.

5% of 773 were queries related to child behind the adult. Parental behaviours which may impact on the welfare of a child, for example not bringing a child to their outpatient appointment, encompass child neglect due to the parent's actions or inactions; this reflects national trends in relation to referrals made to children's social care and is a continued theme for continued learning and development delivered through training and dissemination of relevant safeguarding literature supporting ongoing system learning.

The Team challenged children's social care on the outcome of 2 referrals of which both were overturned, and children's social care undertook a safeguarding assessment. The re-assessment led to early help and support interventions being initiated for each family. Engaging with the Child Behind the Adult / Think Family agenda referrals made to children's social care primarily related to domestic violence and abuse and the identification of young/child carers.

Safeguarding Children and Young People Activity Overview

1. Safeguarding Queries and Concerns

773 queries and concerns were raised with the Team in 2023 - 2024, an increase of 5**%** from the previous reporting period: 2022 - 2023.

2. Was Not Brought

Was Not Brought (35%) to an outpatient, follow up appointment or booked surgery was the **most popular pretext** for discussion with the Team. An increase of 4% in comparison to the last reporting year and embodies **ophthalmic medical neglect**.

3. Themes

The remaining top four Themes for discussion with the team remain **consistent** with the **past five consecutive reporting years: information sharing** (9%), internal and external **information requests** (6%), **Information request to support the Child safeguarding practice review process** (4%) **queries not related to safeguarding the health and wellbeing of children** (4%)

4. Children known to Children's Social Care (CSC)

38% of cases raised with the Team were **open to children's social care.**

71% of the 184 children discussed with the team that were open to CSC intervention, required activation of the CPR flag on OE. This action provides staff groups leading in the child/young persons care to have access appropriate safeguarding information to ensure robust multi-agency information sharing in keeping with statutory guidance (Working together to safeguard Children. DfE 2023).

5. Referrals to Children's Social Care

The overall number of referrals **(41)** decreased by **13%** compared to reporting year 2022 – 2023.

6. Think Family / Child Behind the Adult

There were **35** queries raised with the safeguarding team in respect to the think family agenda. **6** of the queries raised resulted in referrals being made to Children's social care requesting an assessment of support needs. 23% of total referrals made were for children of adult patients primarily in relation to domestic violence and abuse and the identification of Young Carers.

7. Safeguarding in the 21st Century

Moorfields has identified themes consistent with national safeguarding trends relating to the emerging risks identified through contextual safeguarding Including child and adolescent mental health concerns, private fostering arrangements, missing children due to exploitation, and medical neglect. These new challenges are balanced by a more sophisticated understanding of how abuse and exploitation may take place, delivered through multi-agency safeguarding training sessions to support staff with developing the skills to enable appropriate sign-posting to targeted support.

Safeguarding Children Vignettes

23 months old attended MEH for diagnostic testing with their mother and grandfather. During the appointment, the toddler became was **upset** about the demands of testing and began to express these feelings by using **language inappropriate for their age**. This raised appropriate concern with the staff member involved in the child's care. **Professional curiosity** skills applied by the member of staff enable sufficient information gathering from the child mother to enable a consented referral to universal health service partners; health visiting services with an aim to support with the appropriate assessment of the child's speech and language development.

Supported by the team **good practice** was demonstrated by staff member in the management of a direct disclosure of domestic abuse. *Carla was referred with an eye injury, to acute services. Building **a professional rapport** and **setting a safe space** Carla was able to make a **direct disclosure** of **domestic abuse**. The member of staff sought advice promptly and with guidance and support discussed the need to make a referral to children's social care, safeguarding the wellbeing of her children in who were reported to live in the household with the alleged perpetrator. Following assessment of the information shared by the MEH staff member, threshold was met to initiate section 17 child and family assessment of need and support.

Good practice was demonstrated by a paediatric nurse who had identified **concerns** around a **child's emotional well-being** and **caring role for their mother**. During the child's inpatient admission for surgery their mother suffered a seizure and there were concerns that the child may have been a **Young Carer**. Contact was made with children's social care it was noted the family were open to support services and information was shared appropriately. Staff play a **key role** in **identifying young carers** are they are **vulnerable** children whose **needs are often hidden**.

A 3yr old female (*Amy) presenting with squint and demonstrating challenging behaviours during review. Vulnerabilities noted by the staff member: - **history of WNB episodes, poor parental engagement, a pattern of being accompanied by maternal grandmother despite continual efforts to engage with mother, attachment and interaction concerns** that brought into question the **appropriate provision of care**.

The professional demonstrated their child centred approach sharing a detailed account during liaison with the team providing the opportunity for the appropriate level of response to be agreed; refer Amy to Children's social care. Feedback received from the responsible Children social care Team: - Amy was previously known to CSC and the concerns highlighted by MEH illustrated the escalation and maternal response to previous support offered. Due to the escalation of concerns and unmet health needs, Amy was made subject to a child protection plan.

***Not real name**

Safeguarding Children Incident and Complaints

116 incident reports related to paediatric safeguarding concerns and Adult safeguarding concerns where children were known to be impacted by the adults' behaviours and there have been no serious incidents involving children.

Incidents including **themes are reported into the quarterly safeguarding children group**. Any referral to children's social care must be entered on an incident.

No acts of omission were identified during this reporting period.

Incidents closed by the Team **provide robust feedback** including good practice, areas for learning, recommendations and using feedback as part of appraisal and/or revalidation.

Nurses (35%) completed the highest number of incident reports, followed by **Orthoptists** (17%) and **medical staff** (9%) each.
15 job roles in total

The highest number of incidents were generated from **RDCEC** (39%), **City Road** (29%), **Croydon and St Georges** (11%) Bedford (5%). **8 Moorfields sites** in total generated incidents. reports.

Incident reports related to **Children not being brought to appointments**

The phrase 'did not attend' (DNA) implies that a child is responsible for attending an appointment and chose not to go. But children can only attend an appointment if their caregiver takes them; Children can't travel independently and may not even know about the appointment.

A shift to recording a missed appointment as 'was not brought' (WNB) reminds practitioners that it is the adult who is responsible for ensuring that a child receives appropriate medical care. The phrase prompts professionals to consider the causes and consequences of the missed appointment.

The WNB policy and flowchart supports best practice in identifying safeguarding concerns in relation to these issues.

Themes were varied and included **assaults, child's behaviour**, **dog bite injuries, domestic violence and abuse, eye injuries, mental health** and **was not brought.**

3 complaints were reviewed. 2 required no safeguarding input. 1 identified the impact of parental behaviour on the child. The Team made recommendations for appropriate internal and external information sharing to support the child and work in partnership with mother during outpatient appointments.

***RDCEC = Richard Desmond Children's Eye Centre**

01st April 2023 - 31st March 2024

Training

The Trust is committed to ensuring that all staff complete mandatory training to safeguard children (0-18 years) from harm and abuse. All health care staff must have the competences to recognise children and young people at risk of harm and abuse, and to take action to safeguard and promote their welfare.

Training continued to be delivered on a rolling three-year cycle via e-learning, with staff identified as requiring each level of training, content and frequency stipulated by the Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2019). The e-learning safeguarding modules are hosted by E-Learning for Health for all levels and quality assured by the Royal College of Paediatrics and Child Health (RCPCH) with a direct link to update staff's INSIGHT learning record automatically once complete.

The delivery of safeguarding training remains a key priority for the safeguarding team, with the requirement that all staff are provided with the appropriate level of training commensurate to their role as defined in the Intercollegiate documents: Safeguarding Children and Young People: Roles and Competences for Healthcare Staff (2023), Looked After Children: Roles and Competences for Healthcare Staff (2020)

The Trust is committed to achieving its target of 80% compliance as set by NHS England (2013) and Islington Clinical Commissioning Group in training Levels 1 – 3 and 100% in Level 4. Overall training compliance continues to be monitored by the SGC&YP group whilst each division is responsible for monitoring and maintaining training compliance for their staff groups. Compliance reminders are generated and sent electronically via INSIGHT and continue to do until compliance is achieved. Training compliance is readily accessible for individual staff and managers to view via INSIGHT.

Other Safeguarding Training

Attendance at other training to support learning and staff awareness is promoted through the dissemination of various topics and opportunities including lunch and learn sessions and learning from child safeguarding practice reviews. During this reporting period attendance has included:

- NCL Safeguarding System Learning conversation
- Islington Borough Briefings - Child Sexual Exploitation and Child Criminal Exploitation
- Mental Capacity Act Application for 16- and 17-year age group
- NHSE Safeguarding Learning Together
- Pan London NHSE Annual Counter Terrorism Police Liaison Briefings
- NHS England Safeguarding Children Multi Agency learning Event

PREVENT Training

PREVENT is part of the Government's Counter Terrorism Strategy led by the Home Office to safeguard vulnerable individuals who may be exploited and groomed to support and/or commit acts of violent terrorism (known as radicalisation). This agenda sits across children, young people and adult safeguarding. All staff complete basic awareness of PREVENT (BAP) and clinical staff complete Workshop to Raise Awareness of PREVENT (WRAP) via credited e-learning. A Trust applicable local information infographic developed by the Team supports the e-learning.

Mental Capacity Act (MCA) Training

The Mental Capacity Act (MCA) applies to individuals aged 16 years and over. MCA training is mandatory for all staff who complete a basic awareness e-learning module. To meet their statutory duty to work within the Act and the MCA Code of Practice clinical staff also complete a Level 3 e-learning module with a supported Trust applicable infographic. Permanent staff were compliant with MCA training from Quarter 3 (July 2021) onwards. There is ongoing work with the MAST Committee and Human Resources Medical Lead to address non-compliance with MCA Training within staff who are on honorary or locum contracts.

Table 1: Safeguarding Children and Young People Training Compliance (Permanent Staff and Volunteers)

Area	Target	March 2023	March 2024
Safeguarding Children and Young People			
Level 1	80%	95%	91%
Level 2	80%	89%	84%
Level 3	80%	74%	87%
*Level 4	80%	66%	100%
Mental Capacity Act			
Basic Awareness	80%	88%	89%
Level 3	80%	81%	85%
Preventing Radicalisation			
Basic Awareness Prevent (BAP)	80%	89%	87%
Workshop To Raise Awareness Prevent (WRAP)	80%	90%	92%

Table 2: Safeguarding Children and Young People Training Compliance (Locum and Honorary Staff)

Area	Target	March 2023	March 2024
Safeguarding Children and Young People			
Level 1	80%	52%	57%
Level 2	80%	49%	47%
Level 3	80%	37%	55%
Mental Capacity Act			
Basic Awareness	80%	49%	51%
Level 3	80%	37%	37%
Preventing Radicalisation			
Basic Awareness Prevent (BAP)	80%	47%	49%
Workshop To Raise Awareness Prevent (WRAP)	80%	48%	47%

Work is currently in progress with the medical director and the HR lead to address non-compliance with staff who are on honorary or locum contracts including data cleansing, onboarding procedure and development of robust honorary and locum policy and procedures. Compliance for this group has been discussed at the MAST Committee, escalated to the clinical governance committee and Quality and Safety Committee and entered on the corporate risk register.

Safeguarding Partnerships Boards, Meetings and Networks

Moorfields is represented on a wide variety of safeguarding committees and networks, demonstrating engagement with and commitment to effective partnership working and multi-agency working. The Trust is a member of the Islington Safeguarding Children Partnership Board and subgroups represented by the Chief Nurse or the Head of Safeguarding / Named Nurse Child Protection.

The Team also attends a wide range of North Central London, pan London and national network groups, supporting and sharing good practice, gaining updates and contributing to national developments and local policy and procedural decisions. Information from the various meetings is cascaded into the Trust via the Safeguarding Children and Young People Committee.

- Islington Child Sexual Exploitation / Child Criminal Exploitation Briefings
- Islington Safeguarding Children Health Leads Forum
- ISCP Case Review Subgroup
- ISCP Quality Assurance Subgroup
- ISCP Training and Professional Development Subgroup
- NCL ICB Disproportionality and Inequality Workstream
- NHSE (London Region) Named Safeguarding Professionals Forum
- NHS Provider Forum for Safeguarding Adults and Prevent Leads
- North Central London (NCL) Safeguarding System Learning Conversation
- Pan London Counter Terrorism Briefings

Child Protection Information Sharing (CPIS) System

This national information sharing system connects the Local Authority (Children's Social Care) IT systems with the NHS Spine Summary care Records identifying children who are on a child protection plan (CPP), who are looked after (in foster care) or pregnant women whose unborn baby is on a CPP. Access is via a code on the NHS Smart Card. Training for staff accessing the programme in accident and emergency is ongoing. NHS Digital is planning a wider roll out to health settings including outpatients. The Team also access the system when vulnerable children are identified on new referrals to Moorfields and when children are not brought to appointments.

Child Safeguarding Practice Reviews (CSPR) / Learning Reviews / Offensive Weapons Homicide Reviews (OWHR's)

Learning from local and national enquiries, child safeguarding practice reviews (replacing serious case reviews – SCRs), Domestic Homicide Review's (DHR's), Offensive Weapons Homicide Reviews (OWHR's) and case learning reviews are discussed at the SGC&YP Committee meetings, paediatric service meetings and cascaded via scenario-based learning, Safeguarding Newsletters, SGC&YP eyeQ Intranet page and assorted internal meetings. Action plans for any reviews are monitored by the SGC&YP Committee.

The Trust was involved in one case of a child known to our services who subsequently became subject to a CSPR convened by City and Hackney Safeguarding Children Partnership (CHSCP). The named nurse completed an Individual Management Review (IMR) of the child's record and participated in the review led by CHSCP. Learning point in relation to information sharing across the wider system was noted.

Moorfields Eye Hospital has efficacious clinical outcome information sharing pathways in place to support with effective communication with primary healthcare providers following contact with our services. This demonstrates the trust's resolve to meet the statutory safeguarding responsibilities, but it is noted that this could be further strengthened in partnership with IT system improvement & development to improve sharing health related information with interested external agencies such as social care and community healthcare providers.

Further discussions with wider digital improvement group to support with potential automation & distribution of clinical outcome letters, with interested external agencies, through copy in function. Recommendations in relation to Children and Young People Services were made to consider the learning from this case; where the benefits of active monitoring had no visual benefit to the Childs' long term visual prognosis due to primary complex health needs. A holistic clinical assessment should be made, with input sort from the wider health and social care teams involved, to determine the most appropriate management in the best interests of the child.

Clinical policies, procedures, guidance and statutory legislation

The Team and the SGC&YP group has a role to scrutinise any newly published statutory and national guidance and consider any implications to the staff and services within the Trust including where approriate to review excisting policy ccontent.

Documents across the Trust with either a safeguarding focus or containing a safeguarding section are developed or reviewed ensuring staff have access to and are working with current best practice policies and processes. There continues to be a recognition by policy owners for the team for to review and/or consider the need for inclusion of SGC&YP content within other Trust policies.

Title of Document	Type	Status
Paediatric Accident and Emergency Department Handbook	Clinical Guide	Safeguarding children section reviewed and updated
Safeguarding Children and Young People	Policy and Procedures	Updated and ratified

Inspections and Monitoring

During this reporting period there have been no inspections by the Care Quality Commission of any Joint Targeted Area Inspections (JTAI) relating to safeguarding children.

Safeguarding Champions

Launched in December 2017, the safeguarding champions model has seen seven cohorts both clinical and non-clinical complete their initial training. The champions are an additional resource to raise awareness of safeguarding and support staff within their local department/area and maintain strong links and communication with the Safeguarding Team and alert them of any issues or trends regarding practice. The total number of champions across the Trust, from a wide variety of disciplines and roles is currently 65.

Activity data presented to the quarterly SGC&YP Committee Meeting includes staff groups and sites. Data captures queries, concerns and incidents submitted by the Safeguarding Champions.

Following a successful business case for additional funding the Safeguarding Co-ordinator took on additional responsibilities as the Liaison Manager to provide support and leadership for the Trust's Safeguarding Champions. Due to long term sickness and unplanned absence within the team this element of the co-ordinator role has not yet been fully established.

Safer recruitment, employment practice and managing allegations

Moorfields is committed to minimising risk to patients by ensuring staff who are employed by the Trust are safe. All job descriptions include a statement regarding employee's responsibilities to safeguard vulnerable adults. Compliance with Disclosure and Barring Scheme (DBS) checks on appointment to the Trust continue, led and undertaken by the Human Resources department. DBS compliance remains a standing item agenda reported into the quarterly SGC&YP committee.

The DBS policy was updated to build on existing measures and reflect the current practice across the UK - ID checking guidelines for standard/enhanced DBS check applications (HM Gov 2021). A review of the internal DBS policy indicated lack of clarity in respect of the staff groups requiring renewals. Led by Human resources, a scoping exercise was conducted, in September 2023, to ascertain clarity in response to the new guidance. Final review of data validation noted 1070 staff required DBS re-checks of which 518 were compliant- 52% non-compliance requiring DBS rechecks. 552 staff non-compliant with DBS re checks. As of April 2024, 93% of the DBS rechecks required had been completed, there were no adverse disclosures encountered during this process, which provides assurance. Challenges faced by the HR team in completing the rechecks, include lack of engagement from employees who require DBS rechecks. To address this, escalation has taken place with the relevant managers as well as planned drop-in sessions, to initiate DBS process, for the departments requiring support to reach compliance. HR continue to explore additional options available by way of the DBS update service for maintaining future compliance. The existing policy for DBS rechecks matches with the approach being undertaken, and the HR team is noted to undertake this work to ensure safety moving forward.

The Chief Nurse is the named senior officer with overall responsibility for ensuring Moorfields has appropriate arrangements in place including a Managing Safeguarding Allegations Policy and Procedures for the management of allegations of abuse against staff and volunteers. The Team support Human Resources and managers in managing safeguarding allegations against staff. There has been consultation with the Local Authority Designated Officer (LADO) on 4 occasions during this reporting period, none of which required referral to professional bodies or the termination of employment with the Trust.

Human Resources support managers in using these documents to manage any of the issues outlined for example: Dignity at Work (Bullying and Harassment) Policy and Procedures Capability Policy, Disciplinary Policy and Freedom To Speak Up (including Whistleblowing) Policy.

Supervision

Safeguarding supervision is fundamental in supporting practitioners in delivering high quality care, providing risk analysis and individual action plans. Supervision ensures that practice is soundly based and consistent with Local Safeguarding Children Partnerships, Safeguarding Adult Boards, and organisational procedures. SGC&YP supervision involves a retrospective review of safeguarding cases identified by staff with a trained safeguarding supervisor and is reported quarterly as part of Safeguarding Key Performance Metrics.

- Throughout this reporting period supervision has been provided both individually and in groups via a number of methods including remotely using MS Teams, telephone, email liaison, safeguarding children workshops, debrief sessions, structured supervision sessions, and after-action reviews.
- A sustained pattern of safeguarding supervision workshops were established at City Road in various paediatric facing departments to strengthen and build on SGCYP practice using case examples from practice to support with tailored learning and reflection within teams.
- Increased visibility of safeguarding children's team by developing and sustaining a programme of regular network site visits. This provided once quarterly opportunities for additional in person support to colleagues in their departments within host sites. Safeguarding supervision was conducted with practitioners during these visits. A record of attendance was maintained to ensure equitable access to this provision.
- Safeguarding children supervision for medical staff was facilitated by the named doctor for safeguarding children and adults and includes a blended approach using ad hoc drop-in sessions, peer reviews and supervision as part of clinical governance sessions.
- The Named Doctor and Named Nurse safeguarding children and young people received peer review supervision provided by Islington Named and Designated Doctors network.

Priorities 2024 - 2025

Over the next year the Safeguarding Children's Team will continue to work across the organisation to improve safeguarding children's practice as well as focus on priorities from the SG Children partnership board. These include;

- To respond to any emerging safeguarding themes including safeguarding themes of the 21st century – Child exploitation, human trafficking, modern day slavery, medical neglect, Child behind the adult.
- To successfully recruit substantively into the Safeguarding Children's Nurse Advisor vacant post.
- To re-establish the full day safeguarding champion training package for new cohorts across the trust and the half day refresher training package for the existing champions who continue to support the safeguarding agenda locally within their teams acting as a point of contact and guidance and support discussing of themes that required addressing with the safeguarding children team.
- To develop a sustainable plan for the provision of a dedicated safeguarding training budget in order to respond to the expanding demands for training subjects.
- To work in collaboration with department leads, to further develop the Moorfields Eye Charity and Moorfields Private Eye Centre (MPEC) safeguarding children and young people policies and processes.
- To re-establish domestic violence and abuse awareness raising events and bespoke face to face training sessions that were halted due to the covid-19 pandemic.

- To develop the Child Protection Information Sharing Policy, guidance and Training document to support colleagues with increased safeguarding skills in respect of children who access services in unscheduled settings as well as those who are not brought to scheduled health care appointments.
- To support Child Protection Information System (CP-IS) training across paediatric service departments to strengthen safeguarding and information sharing practices amongst colleagues. Allow continued support for the process through a Train the Trainer approach locally, with the SGT available to provide oversight and support as appropriate.
- To contribute to improving outcomes for children and young people set against Islington Safeguarding Children Partnership key priority areas;
    - Improving outcomes for children with additional needs - Develop Paediatric Special Needs and Disability (SEND) Hospital Passport. Utilising the current adult focused Learning Disability Hospital passport, liaise with relevant paediatric stakeholders to develop child focused hospital passport with the input from orthoptics SEND lead.
    - Neglect and parental factors; Contribute to the development of the current paediatric Was Not Brought pathway supporting with building on best practice in providing opportunities for early intervention in cases where appropriate access to healthcare initiates concern.
- To respond to Level 3 SCGYP MAST evaluations and feedback; Collate and analyse to inform training content and development.
- To develop a safeguarding children and young people session to be included in corporate face to face induction once reintroduced.
- To work in partnership with the Named Doctor safeguarding children and young people explore inclusion of training session for face-to-face medical induction across Trust.
- To complete a retrospective audit to establish the impact of referring children to social care on attendance and engagement with services.
- To submit the biannual Section 11 assurance audit to Islington Safeguarding Children Partnership Board in demonstration of the Trusts compliance with all 8 standards.

Conclusion

The Team remains committed to ensuring that the Trust effectively executes its duties and responsibilities in child protection and safeguarding and promoting the welfare of children and young people. It is recognised that this is not achievable without the support and collaborative working of our partner agencies.

Significant SGC&YP concerns continue to emerge locally, nationally and globally which require a proactive and robust approach by the Trust. Ensuring safeguarding is maintained as a high priority, all the Team are committed to further improving and developing Moorfields understanding and knowledge of and response to safeguarding and that “safeguarding children and young people is everyone’s responsibility” is embedded within the culture of the Trust and is an integral part of practice.

This report demonstrates continued significant progress against the statutory SGC&YP agenda. The Team will continue to strive to ensure Moorfields safeguarding processes are robust and effective, build on existing systems to further improve and develop the Trusts response to child protection and safeguarding and continue to achieve and improve good compliance against internal and external safeguarding standards.

Report title	Infection Control Annual Report April 2023-March 2024
Report from	Infection Prevention and Control Team
Prepared by	Catherine Wagland and Amita Sharma
Link to strategic objectives	Working together - We will collaborate with one another as individuals, in our teams, with our patients and our partners Develop – We will practically apply our discoveries and global best practice to benefit our patients, staff and the services we provide Deliver – We will consistently provide an excellent, globally recognised service

Executive summary
The purpose of this report is to provide an overview of the work achieved by the infection prevention and control team for the reporting period of 1st April 2023 to 31st March 2024.

The report provides compliance with the IPC Board Assurance Framework and the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare related guidance (Department of Health, 2015).

Quality implications
The report provides assurance on the measures that are in place to safeguard patients, visitors and staff from acquiring a healthcare associated infections through monitoring, inspection, education and surveillance.

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. Risks identified during the delivery of work are managed in accordance with the trusts PSIRF policy.

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

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Infection Control Annual Report

April 2023 – March 2024

Version 1.0
Status: FINAL
Authors: Catherine Wagland & Amita Sharma
Approved: July 2024

Contents

Executive Summary

Moorfields Eye Hospital NHS Foundation Trust (MEH) is committed to ensuring that effective prevention and control of healthcare associated infections (HCAIs) is embedded into everyday practice. Keeping patients safe from avoidable healthcare associated infections remains a high priority for the Trust.

This report demonstrates the continued commitment of the Trust to Infection Prevention and Control (IPC) and provides evidence through delivery of the Trust wide IPC compliance standards for the period from the 1st April 2023 to the 31st March 2024.

The Infection Prevention and Control Nurses (IPCN) provide leadership, advice, and support to ensure compliance with the Health and Social Care Act (2008). The team facilitates learning across the Trust through providing education, training, audits and through lessons learnt from incidents.

A requirement of the Health and Social Care Act (2008) is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control (DIPC). The report provides assurance to the Trust Board that appropriate infection control measures are in place and are being followed to maintain the safety of patients, visitors and staff.

The publication of this report is to demonstrate good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance 10 compliance criteria.

Table 1: Health and Social Care Act 2008: code of practice on the prevention and control of infections compliance criteria

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

8	**The ability to secure adequate access to laboratory support as appropriate.**
9	**That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.**
10	**That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.**

The key achievements for 2023/24

There have been a number of key achievements by the Infection Prevention and Control Team (IPCT) this year and these will be covered in more detail in the report. The rates of infection for the trust overall have remained low in key areas.

- There have been no cases of bacteraemia or Clostridioides difficile for the trust to report and no nosocomial cases of Covid-19.
- Endophthalmitis rates of infection for all benchmarked categories, this includes cataracts, vitrectomy, acute glaucoma, intravitreal injections, and corneal grafts have been below the trust best practice benchmarks.
- The IPCT have developed a new Trust benchmark for Ozurdez Implants, leading globally with standards of performance.
- The IPCT ran the first one day Infection Prevention and Control Conference in Ophthalmology nationally.
- The IPC Matron and Deputy DIPC was awarded the Silver Award by the British Journal of Nursing for 'Infection Prevention Nurse of the year 2023.
- The trust achieved 40.6% compliance with the Covid-19 vaccination coming the third highest in the London region. For flu, the trust achieved 48.9% compliance coming the fourth highest in the London region.
- The IPC Matron and the IPC lead presented at the 8th Annual Infection Control Sterilization and Decontamination in Healthcare Conference held in London in March 2024.

Introduction

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

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

The author acknowledges the valuable contribution of other colleagues to this report.

Delivery of Service

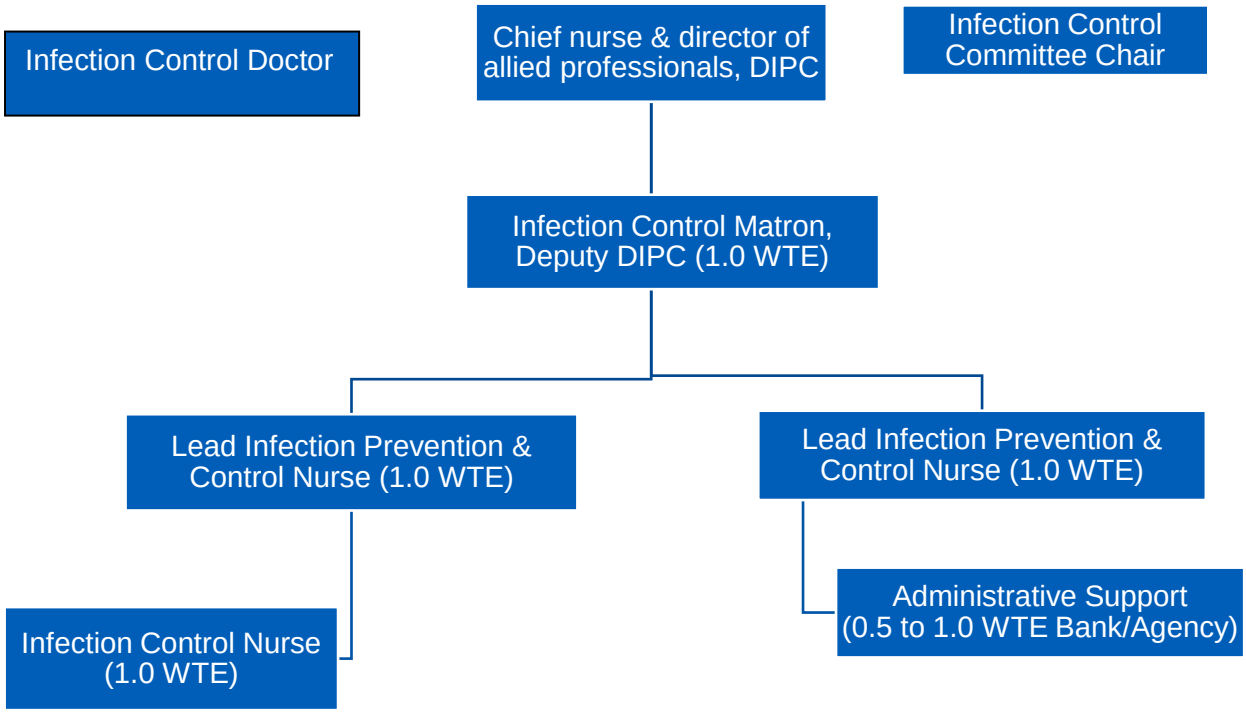
Throughout the reporting period, the IPCT have continued to respond to the Covid -19 pandemic which has continued to have an impact on the normal delivery of the infection control service. However, the IPCT have adopted a strategy of priorities and continued to provide advice and lead on the implementation of the infection control work plan and audit programme, as the pandemic has allowed. As rates recede it has become possible to return to a more normal pattern and focus on infection control

Infection Prevention and Control Team

Director of Infection Prevention and Control

The Director of Infection Prevention and Control holds board level responsibility for all matters relating to the safe delivery of IPC care and practice.

Table 2 shows the organisational structure for the IPC team.



Secondment positions within the IPC Team

During this year the IPCT were offered secondment positions both externally and internally to the trust and IPC team. These opportunities included working on the major government project - The New Hospital Programme and trust strategic objective of project Oriel. On the 1st September 2023 the secondment positions concluded and the IPC team was restored.

A key member of the team, the IPC Administrative Support Officer was seconded to work with the Executive Team and the position was subsequently covered by bank/agency staff.

The Trust also has a:

- Consultant Ophthalmologist who is the chairperson of the Infection Control Committee
- Infection Control Doctor as part of a service level agreement with Guys and St Thomas' NHS Foundation Trust
- A Lead Antimicrobial Pharmacist (WTE).
- The main microbiology and virology laboratory services are provided by an off-site independent company called The Doctors Laboratory this is part of a Service Level Agreement that includes a Microbiologist.
- Additional support is provided by Moorfields Estates and Facilities Teams, Heads of Nursing and Matrons, Infection Prevention and Control Link Practitioners and Sterile Services Department. The Occupational Health service is provided by TP Health on a contracted basis which was taken over by North London Partners Shared Services (NLPSS) from the 1st April 2024.
- The Infection Prevention and Control Team report directly to the DIPC, who is the Trust's Chief Nurse and Director of Allied Professions and the Decontamination Lead. The DIPC is directly accountable to the Chief Executive and has an overarching responsibility for the strategy, policies, implementation and performance relating to infection prevention and control. The DIPC attends the Trust Board and other meetings as planned or required, including the monthly infection control team meetings and quarterly infection control committees.

Infection Prevention & Control Governance Reporting & Accountability Structure

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

Infection Control Committee

- The Trust Infection Control Committee (ICC) is a multidisciplinary committee which meets quarterly. The committee ensures that there are effective systems in place to reduce the risk of infection and where infection does occur, actions to minimise its impact on patients, visitors and staff are implemented.
- The committee is chaired by the Dr Carlos Pavesio, Ophthalmology Consultant in the Medical Retina (MR) Service.

  Membership of the ICC includes representation from key service areas:
  Facilities, Estates, Pharmacy, Theatre, Surgical Services Department, Heads of Nursing, Eye

Bank, Infection Control Nurses, DIPC, Infection Control Doctor & Deputy DIPC from GSTT, Occupational Health, Risk and Safety, NE and NCL HPT, Consultant Ophthalmologist.

Director of Infection Prevent and Control (DIPC) Role

The DIPC attends the Clinical Governance Committee (CGC) and Quality and Safety Committee (QSC) which meet every two months. Minutes from the ICC are sent to CGC and any items for escalation.

Infection Control representation at Committees.

Infection Control has representation on the Risk and Safety Committee, Clinical Audit and Effectiveness Committee and Medical Devices Committee.

Programme of Work

The Infection Prevention and Control team is responsible for ensuring that a coordinated programme of work is agreed at committee and implemented annually.

IC Links

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

Education and Training

- The IPCNs provide education and training throughout the organisation, undertake a programme of audits, policy formulation and updating, alert organism surveillance with associated epidemiology of cases and provide infection control support as required to staff both internal and external to the trust. The matron attends the North Central London DIPC forums virtually. This provides a platform for sharing trust policies and procedures.

Infection Control Programme of Work

IC Programme

- The IPCNs work to an annual programme of work (POW) that is produced 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 POW is set out against the criteria of the Code of Practice and is reviewed and updated annually.
- Progress against the programme of work is discussed at the quarterly ICC and the monthly infection prevention and control team meetings.

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.

In addition to the work related to the pandemic, the surveillance of infections and alert organisms has continued.

Performance Data

The table below shows the Endophthalmitis rate of infection per 1,000 cases for each procedure.

	2022/2023	Target	2023/2024 Q1	Q2	Q3	Q4	YTD
C.diff infection	0	0	0	0	0	0	0
*Bacteraemia	0	0	0	0	0	0	0
MRSA Screening	100%	100%	100%	100%	100%	100%	100%
Endophthalmitis post cataract	0.12	0.40	0.00	0.00	0.32	0.00	0.08
Endophthalmitis post intravitreal injection[1]	0.09	0.30	0.07	0.07	0.07	0.15	0.09
Endophthalmitis post vitrectomy - simple	0.33	0.80	0.00	2.67	0.00	0.00	0.68
Endophthalmitis post vitrectomy - combined	0.00	2.5	0.00	3.55	0.00	0.00	0.85
Endophthalmitis post acute glaucoma	0.38	1.0	0.00	0.00	1.55	0.00	0.36
Endophthalmitis post Graft-EK	0.00	3.60	0.00	10.10	0.00	0.00	2.67
Endophthalmitis post Graft-PK	0.00	1.60	0.00	0.00	0.00	0.00	0.00
Adenovirus possible hospital acquisition	0.9%	N/A	0.00	0.00	2.25	0.00	0.60

*Bacteraemia includes MRSA, MSSA, E coli, Pseudomonas aeruginosa & Klebsiella Spp.

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

Endophthalmitis

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

- MEH incidence data is based on clinical criteria and not only on those cases which yield a positive microbiology culture.
- The trust reports on infections following all procedures MEH and has in preceding years established two specific benchmarks for cataracts and intravitreal injections.
- All cases of endophthalmitis are reported either as benchmarked or exception reported cases.

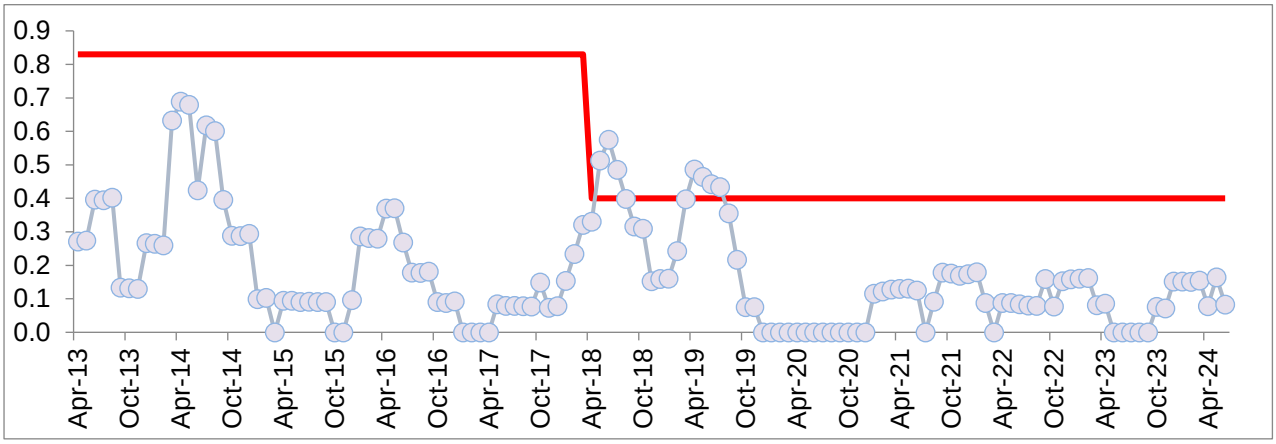
Benchmarked Endophthalmitis

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

The IPCT undertook a review of published studies for endophthalmitis rates following Ozurdex implants and reviewed the Trust endophthalmitis rate from 2014 to 2023 and based on the findings, in collaboration with the Service Lead, a benchmark of 1.0 (1:1000 procedures) was set for Ozurdex implants. This procedure will be reported as a benchmarked procedure from 1st April 2024.

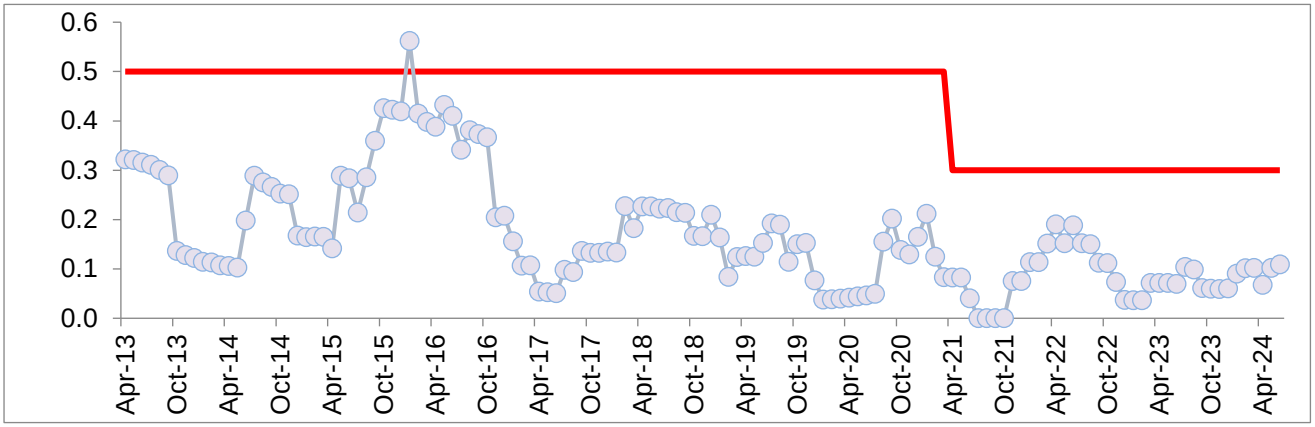
The graphs below show the rates of post-operative endophthalmitis for the benchmarked procedures.

Cataract Endophthalmitis 6 month rolling average



The expected rate of infection is 1 in 2400 cataract procedures (target 0.4).

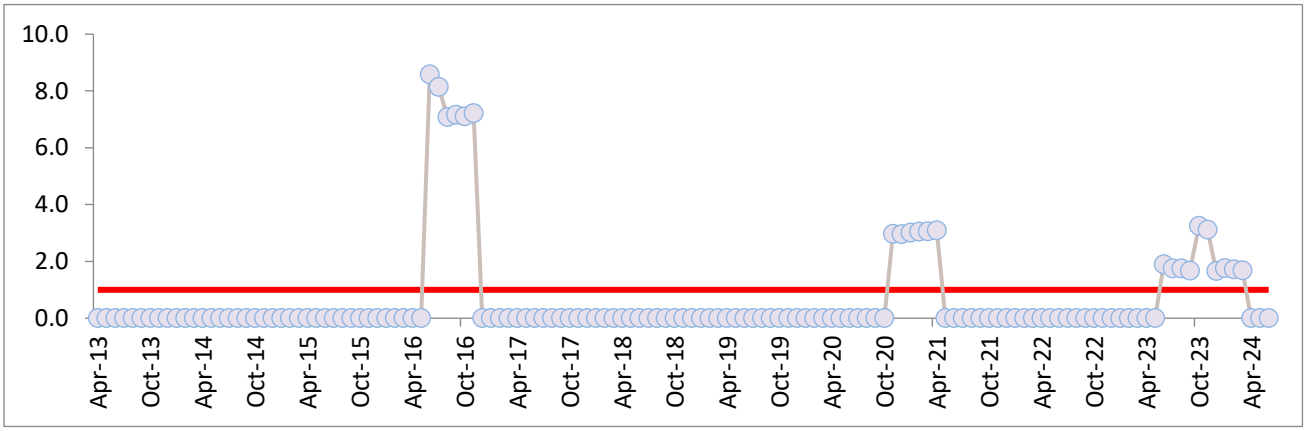
Intravitreal Injection Endophthalmitis 6 months rolling average



The expected rate of infection is 1:3333 intravitreal injections (0.3 per 1,000 injections).

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

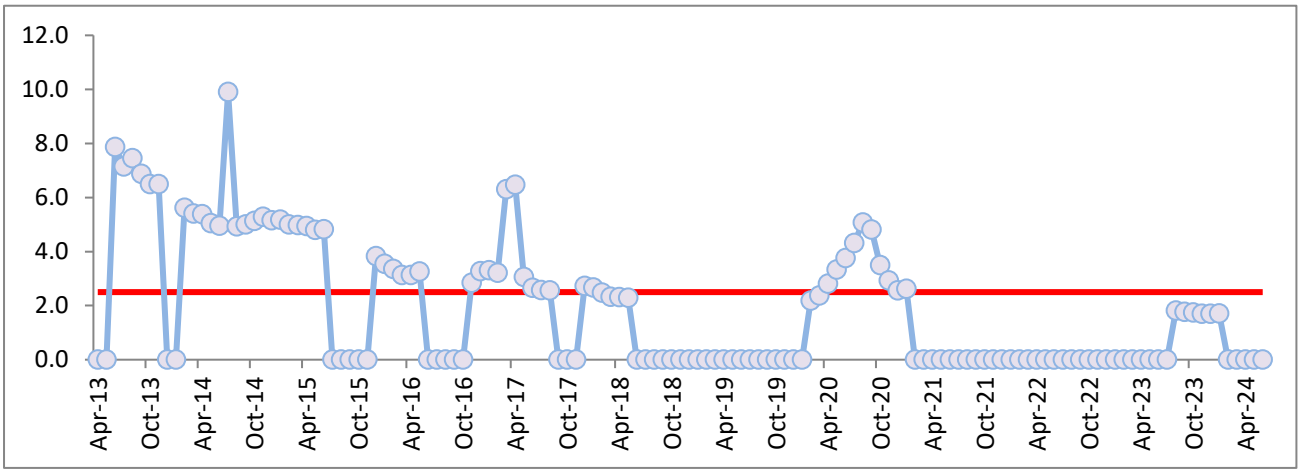
Vitrectomy Endophthalmitis– Simple 6 month rolling average



The expected rate of infection is 0.8:1,000 vitrectomies (1 per 1250 procedures)

* Rates should be viewed over a longer time frame due to the low number of procedures - 12 mth rolling rate = 0.66

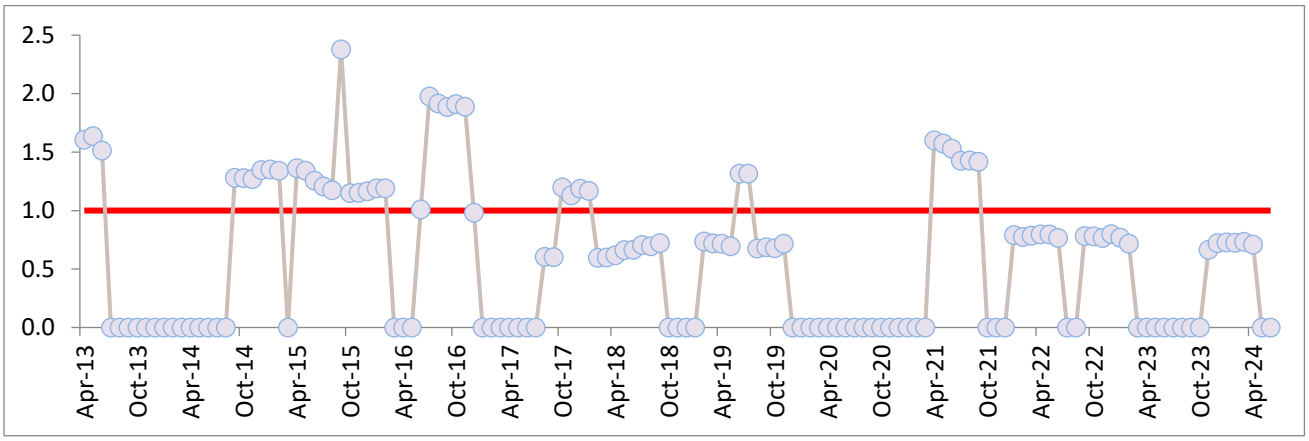
Vitrectomy Endophthalmitis – Combined 6 month rolling average



The expected rate of infection is 2.5:1,000 vitrectomies (1:400)

*Rates should be viewed over a longer time frame due to the low number of procedures - 12 mth rolling rate = 0.78

Endophthalmitis Post-acute Glaucoma 6 month rolling average

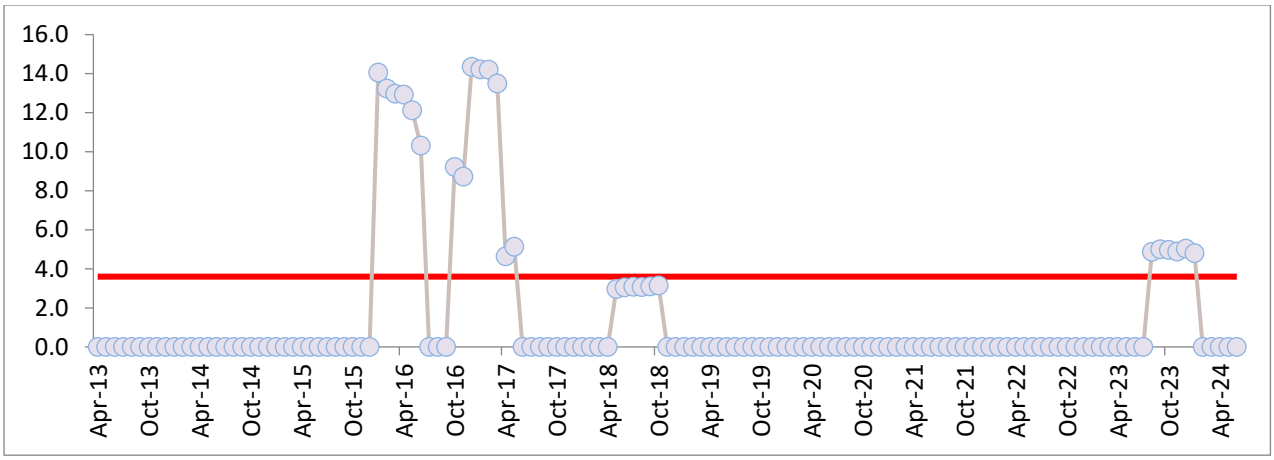


The expected rate of infection is 1:1,000 acute glaucoma procedures.

*Rates should be viewed over a longer time frame due to the low number of procedures-12 mth. rolling rate = 0.35

NB: figures only include cases that are diagnosed within six weeks of surgical procedure that are done in the clinic are not included as the denominator therefore is not captured in the data published.

Endophthalmitis Post Graft-Endothelial Keratoplasty (EK) 6 month rolling average



The expected rate of infection is 0.36:1,000 procedures (3.6:1,000)

*Rates should be viewed over a longer time frame due to the low number of procedures - 12 mth rolling rate = 2.49

Penetrating Keratoplasty

There were no cases of endophthalmitis reported following Penetrating Keratoplasty
The expected rate of infection is 0.16:1,000 procedures (1.6:1000)

Non-Bench Marked Endophthalmitis

There were six endophthalmitis cases reported outside the benchmarked procedures. These included four Vabysmo injections, one in April, one in July 2023 and two in January 2024 and two Ozurdex implants in June and October 2023.

A root cause analysis (RCA) was undertaken for each case by the clinical team supported by the IPCT. The aim of a RCA is to undertake a thorough investigation of the case and identify any lessons that can be learnt to prevent further cases.

Adenovirus – possible hospital acquisition

Adenovirus is an infection that can cause severe viral conjunctivitis commonly involving the cornea. It is caused by different adenovirus serotypes which may be transmitted from person to person in a number of different ways, for example, contact with contaminated surfaces/equipment or contact with an infected persons tear fluid. The trust has identified one case of possible hospital acquisition.

Routine Screening

Methicillin Resistant Staphylococcus Aureus (MRSA)

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

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

MRSA screening trust data

No. Patients Screened	No. Patients MRSA positive	% Patients Positive	% Compliance for Screening Cohort
246	40	15.6%	100%

Carbapenemase-producing Enterobacteriaceae (CPE)

- All patients at the trust are risk assessed for the likelihood of CPE carriage and any patients identified at risk of carriage are managed in accordance with the trust CPE policy.
- The numbers of all suspected or confirmed cases of CPE are monitored by the IPCN's. The numbers of cases for each quarter are included in the surveillance report that is presented at ICC.
- The following is the trust data for CPE YTD 2023/24.

Number of Patients Suspected of Carriage having met risk group criteria	Number of Patients with Confirmed Carriage of CPE
16	0

Antimicrobial Stewardship

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

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

- Optimising the use of antimicrobials through ensuring our guidelines are up-to-date, antimicrobial consumption is closely monitored and wise usage is promoted through effective face-to-face communication with prescribers, education and training for patients as well as clinical and non-clinical staff.
- Encouraging all staff including pharmacy staff to follow good infection control practices that will help prevent the transmission of drug resistant organisms. These include following good hand

hygiene practices and cleaning equipment between each patient use in line with the Trust's Infection Control Policies available on the intranet.

- Continuous surveillance of environmental decontamination including using disinfectants – think slit lamps, telephones, desk space!

Antimicrobial prescribing and guidelines

The Trust has an adult antimicrobial guideline which is available online on the intranet and via the MicroGuide app. This is an evidence-based document which all healthcare professionals are required to use when using antimicrobials at the Trust. The Trust is also currently 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 MicroGuide app and made live.

A new monograph was created by pharmacy and A&E team on 'Gonorrhoea and Administration of intramuscular ceftriaxone.' This project was created after feedback from staff that a quick easy guide is required to prompt staff when managing cases. Since the work, positive feedback has been received from clinical areas.

Intravitreal Ceftazidime dilution instructions were also created combining paediatric and adult dosing information into one to allow ease of prescribing for endophthalmitis. This is available on the pharmacy intranet page.

Pharmacy has also contributed on numerous guidelines and patient information leaflets at the Trust:

- Adult toxoplasmosis
- Ocular syphilis
- A&E adult emergency endophthalmitis guidelines
- Paediatric emergency endophthalmitis guidelines
- Patient Information Letters - Herpes Zoster Ophthalmicus (HZO) and Herpes Simplex Virus Keratitis (HSVK)
- Pharmacy SOP- Supplying Oral Voriconazole

The Medicines and Healthcare products Regulatory Agency (MHRA) has issued a drug safety update on 22nd January 2024 regarding systemic fluoroquinolones. This is following a review into the effectiveness of current measures employed to reduce the risk of disabling and potentially long-lasting or irreversible side effects of fluoroquinolones. In light of the drug safety update, a formal review of the antimicrobial guideline took place alongside the infection control microbiologist, Consultant Microbiologist from UCL and chair of infection control committee. The review concluded that no changes are recommended in the current guidance. The indications at MEH are classed as an emergency and sight threatening for which fluoroquinolones are an appropriate choice. There are limited number of antimicrobials for these indications and these agents have good ocular penetration. This has been shared with relevant stakeholders.

MEH pharmacy also engaged with North Central London (NCL) to reflect MEH's position statement regarding fluoroquinolones. MEH's position does fall within the current NCL Safe prescribing of fluoroquinolones recommendation. A patient letter has also been created to summarise key counselling of fluoroquinolones and what to do should certain side effects arise. This is issued to patients when fluoroquinolones are supplied.

Audit work

The pharmacy has carried out an audit **To investigate whether the prescribing of systemic fluoroquinolones adheres to the Trust's antimicrobial guidelines.** Fluoroquinolone prescriptions were reviewed covering the period of 1/11/23 to 31/01/24 from Moorfields at St George's Hospital and Moorfields at City Road – Daycare, Dispensary and Paediatrics.

Overall, there is good compliance with the use of fluoroquinolones in line with the Trust's antimicrobial guidelines especially for the indication. This is assuring as the NCL join statement also emphasised fluoroquinolones must be prescribed in line with Trust's guidelines. However, there are at times discrepancies with duration of treatment which is being highlighted to relevant personnel.

Table 1: Summary of results regarding fluoroquinolones audit.

Standard	Standard expected	Standard achieved
Indication of fluoroquinolone prescribed is in line with indication according to the Trust's guidelines	100%	96.43%
Dose of fluoroquinolone is in accordance with Trust's guidelines	100%	96.43%
Duration of treatment is in accordance with Trust's guidelines	100%	75%

The pharmacy also carried out an audit to investigate compliance to the MEH antibiotic prescribing protocol at Moorfields Private Eye Clinic (MPEC) previously known as London Claremont Clinic. The audit demonstrated good compliance with antimicrobial guidelines.

Table 2: Summary of results regarding antimicrobial compliance audit at MPEC.

Standard	Standard expected	Standard achieved
The antimicrobial medicine prescribed is appropriate	100%	100%
A treatment plan letter has been produced	100%	98%

Involvement and contribution

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

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

Implementation of active advice from MHRA and UK Health Security Agency (UKHSA) in relation to antimicrobials occurred. For example, managing National patient Safety Alert (NPSA) issued on 7 December 2023 with regards to carbomer-containing ocular lubricants and the risk of contamination with Burkholderia cenocepacia. All carbomer containing lubricants were

quarantined and clinicians advised to use an alternative ocular lubricant. As of 21 March 2024, UKHSA and MHRA are satisfied that the risk associated with this outbreak has now reduced and use of carbomer containing lubricants has resumed.

Pharmacy is also involved in the management of stock shortages of antimicrobials to ensure stock is reserved for true infectious cases which require this. As well as supporting clinicians by recommending alternatives to support continuity of patient care. For example, during the national shortage of Azithromycin 1.5% eye drops (Azyter®), the Trust reserved the medication for true infectious cases rather than blepharitis (a non-infectious condition).

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

Over the course of 1 week pharmacy department across the Trust including network sites celebrated World Antimicrobial Awareness Week (WAAW) from 18 - 24 November 2023. The pharmacy team worked tirelessly to organise this week to raise awareness amongst patients and staff. There were numerous activities on offer during the week.

- There were posters, leaflets and Antimicrobial stickers displayed to spread the message.
- All pharmacy staff members wore blue on Friday 24th November 2023 as part of going **Blue** for Antimicrobial Resistance (AMR).
- A communication piece was showcased on the Trust intranet and staff were encouraged to use the WAAW banner in their email signatures.
- Special webinars hosted by NHS England were on offer to get a glimpse of the work which revolves around antimicrobial stewardship in England.
- A special **stand** was organised in the canteen to promote the week within the hospital for both patients and staff.

Decontamination

The Trust has outsourced its Sterile Services Department (SSD) at the City Road site, to external company Steris at the Royal London for providing decontamination services of reusable medical devices from November 2023.

Management

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

Accreditation Status:

The department has always maintained its compliance and certification to an international standard ISO 13485:2016 Medical devices — Quality management systems — Requirements for regulatory purposes.

The current certification is valid until September 2025 and will remain valid subject to annual satisfactory surveillance audits.

The certification to this standard indicates the testament and commitment in place which demonstrates the ability to process reusable medical devices and related services that consistently meet customer and applicable regulatory requirements.

All resources used in the department meet are assessed to meet all applicable regulatory requirements and standards.

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

Monitoring and Test Results

The trust has received assurance that monitoring of the SSD environment on a quarterly basis to ascertain the cleanliness of the IOS Class – 5SSD Clean Room is fit for purpose before instruments are packed and labelled. Further to this environmental monitoring was undertaken in July 2023 and all air particulate pressure differentials passed. In addition to this the microbiological sample results passed the acceptance criteria.

PPM Reports

The ICC received assurance that all machinery and equipment were routinely tested daily, weekly, quaretly and 6 monthly as applicable to standards. Several PPM tests were performed repeatedly over the course of the year of all equipment utilised in the SSD to meet applicable regulatory/standard requirements.

All tests met specifications required and any non-conformities with the results and recommendations are assessed and a corrective action and a preventive action plan is put in place to prevent re-occurrence and for improvement.

Staff Training

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

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

Infection Control Policy

Policy

During this year the IPCNs have continued to review and update policies, guidelines and standard operating procedures to ensure staff are provided with the most up to date information to enable best evidence-based practice to be delivered to patients.

The IPCNs have worked hard to catch up with the policies due for review and have completed all except three policies that will be reviewed and updated in early 2024/25.

Infection Control Audit

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

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

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

Policy Audit

A total of eleven policy audits were completed.
All practice audits achieved an overall compliance score of **Green = >85%**. A report from each audit is shared with the heads of departments, heads of nursing, matrons and link practitioners with the outcomes and recommendations. In addition, key findings from audits are discussed at the ICC.

Hand Hygiene and Cleaning audits

Hand hygiene and environmental cleanliness audits are carried out monthly by the infection control link practitioners. Auditing staff compliance with “Bare below the elbow” is included in the hand hygiene audit. The audit scores are shared and discussed at the ICC, cleanliness monitoring meetings and are shared with divisional leads and link practitioners.

The trust target for both audits is **90%**.

Hand Hygiene Average score for YTD	Cleanliness Average score for YTD
98.2%	97.3%

Environment Audits

Environmental audits are undertaken by the IPCN’s annually unless otherwise indicated.

All environmental audits of high-risk areas have been completed which has included intravitreal injection rooms and operating theatres across all sites. There are four ward areas that scored green compliance in the preceding year that have been prioritised for completion in early 2024/25.

Number of Audits undertaken for the reporting period:

- Seven operating theatre sites containing seventeen operating facilities.
- Ten intravitreal injection sites comprising of eighteen individual intravitreal injection rooms.
- Two Minor ops Rooms

In addition, audits were undertaken of Cumberledge Ward and the Adult Accident & Emergency Department.

All operating theatre audits, Cumberledge Ward and the adult Accident & Emergency Department achieved an overall compliance score of Green (compliant).

Two intravitreal injection sites achieved an overall compliance score of Amber (Partial Compliance). One intravitreal injection site has been re-audited since and achieved a compliance score of green (compliant) and one intravitreal injection site will be re-audited within the six months due in 2024/25.

Patient Information Leaflets

All patient information leaflets were updated and published.

Infection Control Risk Register

The IPC risk register highlights risks to the trust in relation to IPC. There is one item on the IC risk register which is that Occupational Health (OH) Provider have an incomplete history of staff immunisation status to the MMR vaccine. The OH provider has changed from Optima Health to a new provider NLPSS from the 1st April 2024 and as there has been a delay in transfer of staff data this has caused a delay in the recommencement of the MMR backlog catch up programme.

The IPCT review and update the risk register regularly.

Outbreaks and Incidents

Anthrax

The IPCT were involved in investigating a suspected case of Anthrax at the Trust in March 2023. The IPCT became aware of this patient after the patient had already had a surgical procedure. An After Action Review (AAR) was undertaken with key stakeholders to discuss how the case was managed and whether there was any key learning from this case. One key learning point was that the IPCT should be informed of all suspected infectious cases even if the infectious condition has not been confirmed. This will ensure that the IPCT provide advice and support to staff on the management of cases with regards to the appropraite personal protective equipment required and the safe collection and handling of specimens. This case was confirmed negative to anthrax.

Measles

There was an incident of measles exposure at the trust in January 2024. The incident involved a patient who attended the paediatric A&E department. The IPCT were informed of the measles diagnosis by UK Health Security Agency (UKHSA) in addition to further information about rising numbers nationally. A risk assessment was undertaken, by the ICPN in collaboration with the clinical staff and contact tracing was done for exposed patients. Staff who had been exposed to the case were advised to contact Occupational Health. No secondary cases were identified.

IPC Guidance updates and Documents

Coronavirus (Covid-19) pandemic

The IPCT have continued to review UKHSA guidance for updates or changes in the management of Covid-19. As the pandemic evolved and national guidance was updated, the IPCT advised on changes to Covid-19 testing and isolation requirements for patients and staff, provided data for Covid-19 infections to the trust and to the Infection Prevention and Control Operational Group, updated online information with the communications team and confirmed with Human Resources and Risk and Safety that new starters no longer require a Covid-19 risk assessment. In addition the IPCT assisted the trust in

returning to pre-pandemic IPC practices, specifically regarding the level of Personal Protective Equipment required by staff. This was done through training sessions, during walkabouts and communication messages.

IPC Board Assurance Framework

The Infection Prevention and Control Board Assurance Framework (BAF) is a live document. The aim of the framework is to help providers self-assess compliance with measures set out in the National Infection Prevention and Control Manual, the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UKHSA.

The latest version (0.1) of the BAF has been reviewed and updated by the IPCT and shared with members of the IPCOG, ICC and Quality & Safety Committee.

The compliance for each element has been RAG rated as either Compliant (Green), Partial Compliant (Amber), non-compliant (Red) or not applicable. There are no elements rated as non-compliant, all elements have been rated as either compliant or partial compliant. The BAF will be reviewed and updated regularly with a view to continually improving compliance.

IPC Meetings

Infection Prevention and Control Operational Group (IPCOG)

The IPCOG has been established as a sub-group of the infection control committee that meets twice quarterly to review performance reports and actions to ensure safe running of services and optimum patient outcomes within the trust. The group is chaired by the Chief Nurse/DIPC or a deputy. The membership for this group was reviewed and revised in March 2024. The membership includes IPCT, Matrons/Sisters from each division, leads of departments, communications manager and a consultant Ophthalmologist. Items for escalation and assurances from this group are shared at ICC.

Matters of the Estates

Water Safety and Ventilation Group

The Trust has a local Water Safety and Ventilation Group which meets quarterly to discuss issues relating to the operational management of water and ventilation systems and assure compliance with the Trust Water Safety Plan and Ventilation Policy. The group identifies risks and mitigating those risks through testing, action and adherence to Statutory Regulations, HTM's and other respective guidance.

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

Water Safety

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

Theatre Ventilation

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

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

Facilities – Cleaning

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

On the 29th July 2023 Medirest took over the facilities contract from ISS as the provider for cleaning, security and catering at City Road, Brent Cross, Hoxton and Stratford. Following the takeover by Medirest, the National Standards of Healthcare Cleanliness 2021 was implemented. All functional areas have been categorised according to the functional risk categories and standards of cleaning are monitored through the audit process. The frequency of audits is determined through the functional risk category assigned in accordance with the national standards. Any issues with cleaning identified during the audits are fed back to the Medirest front line managers to address and audit reports are shared with the clinical leads. In addition, cleanliness is monitored through monthly cleaning audits undertaken by link practitioners, annual environmental audits undertaken by the IPCNs and bi-monthly walkabouts undertaken by facilities, estates, IPCNs, Medirest and matrons at City Road. These walkabouts are undertaken at some network sites with the matron and domestic service provider supervisor. Key concerns related to cleaning, waste or linen are included in the quarterly cleanliness monitoring meeting reports.

Three cleanliness monitoring meetings were held for the reporting period, May & September 2023 and February 2024. This meeting is chaired by the Facilities Manager and key stakeholders that attend are representatives from infection control, estates, Medirest, SSD, eye back and the matrons. A summary report from the meeting highlighting any areas that require escalation is submitted to the quarterly ICC.

A deep clean programme was scheduled for the year, and any additional deep cleans or enhanced cleans were requested via the Domestic Service Provider as required.

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 October and November 2023. Three sites were inspected including City Road, Stratford and St Georges Hospital.

Overall scores for each category were:

Category	Score
Cleanliness	**97.84%**
Food-Ward	**89.58%**
Privacy, Dignity & Well being	**86.44%**
Condition and Appearance	**98.09%**
Dementia	**86.76%**
Disability	**85.04%**

An action plan has been developed to address the issues identified from the assessment.

Refurbishments and New Builds

The IPCT remain committed to assisting the Estates department and the Divisions in the development of safe and regulatory standards approved projects.

Projects that the IPCT have been involved with and have provided IPC advice for are:

- New Moorfields Stratford Site
- Bedford Hospital
- Brent Cross
- Re-designs/refurbishments of areas at City Road which have included new ultrasound rooms, counselling rooms, eye bank and a number of clinics.

The IPCNs developed an evaluation document of Capital Planning projects to enable future learning and improved working practices. This was shared with the DIPC and Head of Nursing for the North Division and the aim is for the document to be shared with other key stakeholders.

Oriel IPC Support

The IPC Matron was seconded into assist the Oriel project team for one year on a part time basis to ensure that an in-depth analysis of the design development at Stage 4 RIBA meets the statutory and regulatory obligations of infection prevention and control for the built environment.
In addition to design consultation, the IPC Matron liaised with multiple stakeholders at the build site and external contractors in relation to *Aspergillus* testing and precautions during the demolition phases of the build. Further to communication with UKHSA and Hospital Infection Society working group co-ordinators, a consultation on scoping for national *Aspergillus* guidelines has been undertaken. Moorfields IPCT has

provided feedback for this.

A key achievement by the IPC Matron during this time has been the setting up of the Oriel Water and Ventilation Safety Groups with the addition of the trust Infection Control Doctor to ensure expert guidance on all.

Reports were produced for COOG and ICC with updates on IPC elements of the Oriel build.

A key piece of work included reviewing the ventilation provision to all rooms in Oriel and assisting the engineers at ARUP to understand the intended clinical use of specific rooms. The IPC Matron continues to support the Oriel project.

Other Projects

The IPCNs have been providing advice and/or leading on the folowing projects:

- Providing expertise advice for the outsourcing and transition of the Surgical Services Department to Steris, a facility based at the Royal London Hospital.
- Working in collaboration with the Facilities Manager to risk categorise cleaning standards for functional area and cleaning responsibilities in line with the National Standards of Healthcare Cleanliness 2021.
- Assisting the North-East Division to implement SurgiCube units (a modular system alternative to an operating room) that can be used for ophthalmic surgery.

New Technology

The IPCT have assisted the trust with developing robust risk assessment processes and criteria for new technologies for trials. The IPCNs assisted the clinical team with the risk assessment for the Toul (Mobile Sterile Air Unit) that was trialled at City Road for undertaking intravitreal injections in the anaesthetic room.

Education and Training

Infection Control Mandatory Training

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

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

During the year, the IPCNs have delivered focused face to face training at a number of network sites. The training has included hand hygiene standards, the appropriate wearing of gloves and decontamination of patient equipment.

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

Infection Control Link Practitioners

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

Topics covered included:

- Measles Awareness
- The correct use of Personal Protective Equipment
- Management of a patient with suspected or confirmed Whooping Cough
- Decontamination of Equipment
- Update on new IPC national IPC guidelines

Infection Control One Day Conference

The IPCNs organised and delivered the first infection prevention and control in Ophthalmology conference in June 2023. Presentations were delivered by internal and external speakers. Topics covered included:

- Surveillance in Ophthalmology
- Safe handling of Specimens
- Infection Prevention and Control in the New Build
- Antimicrobial Stewardship
- Hand Hygiene- 'Gloves Off'
- The role of the Integrated Care Board

The day provided an opportunity for staff to network with colleagues from other departments and external staff.

Sharps Safety Awareness Sessions

The IPCNs delivered a programme of **sharps safety awareness sessions** throughout August and September 2023 for all staff. Sessions were held virtually and face to face at various times including early mornings, evenings and weekends to make them accessible for all staff.

Measles awareness sessions

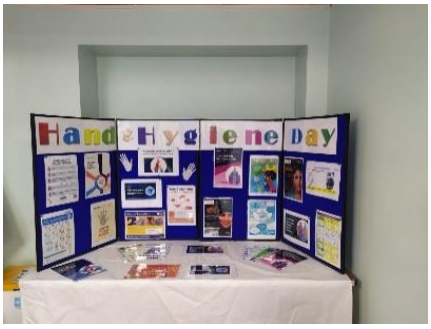
In response to the high number of measles cases reported in London, in March 2024, the IPCNs delivered measles awareness sessions both virtually and face to face for staff in the Accident & Emergency Department, Urgent Care Centres and Paediatrics at City Road and at some network sites. Measles posters were disseminated to all sites for patients, staff and visitors' information and awareness.

World Hand Hygiene Day May 2023

To celebrate world hand hygiene day, the IPCNs held an awareness day promoting best hand hygiene practices, including bare below the elbow guidance, facilitated staff with the opportunity to use the glo-box and reminded staff how this one action can help reduce antimicrobial resistance.

To encourage staff engagement, IPCNs ran a hand hygiene poster competition.

Posters and other promotional materials were shared with all departments and network sites.




Presentation at an external conference.

The IPC Matron and the IPC lead presented at the 8th Annual Infection Control Sterilization and Decontamination in Healthcare Congress in March 2024. The IPCNs delivered a session on 'Do we know the risks related to hospital redevelopment? This provided a platform for the IPCNs to share examples of experiences and challenges with new builds and refurbishments and it also provided an opportunity for networking and sharing IPC experience from an ophthalmic specialist field.

The Monthly Bug Brief

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

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

IPCT Professional Development

The band 6 IPCN has been supported in undertaking the PG Dip in Infection Control at Essex University in February 2023 and is expected to complete the programme by October 2024.

The IPCNs were able to secure three years funding for professional membership with the Infection Prevention Society and Healthcare Infection Society, accessing regular journals and working groups.

British Journal Nursing Award

The IPC Matron and Deputy DIPC was recognised for the work undertaken as part of the trust's planning and control response to monkeypox by the British Journal of Nursing and was awarded the Silver Award in April 2023. This award recognises the vital contribution made to infection prevention in healthcare through innovation, evidence-based care and vigilance in the workplace.

Seasonal Vaccination Programme

The IPC Matron trained as a peer vaccinator for the seasonal vaccination programme, assisted with the programme planning and delivery, advising on key messages for staff and sharing national and regional data and initiatives rates of Covid-19 and flu for the Trust and regional rating.

The trust achieved **40.6%** compliance with the Covid-19 vaccination. This was the third highest in the London region performing trusts. For flu, the trust achieved **48.9%** compliance, which was fourth highest in the London region performing trusts.

Conclusion

Overall, the IPC Annual Report for 2023/24 has demonstrated achievements and areas of improvement. It has been a year of change for both the IPC nursing team, offering new opportunities for development and representing the trust internally and externally at national level.

The surveillance has met all performance standards and the audits have also been meeting high standards. Many programmes raising awareness of key issues have been undertaken by the wider IPC members, including antimicrobial awareness, sharps safety, hand hygiene, measles alerts and seasonal vaccinations.

Looking forward to 2024/25 the IPCT will continue to strive to maintain high standards within IPC and will continue to work in collaboration with staff, patients and other service users to help ensure care is delivered in a clean, safe environment.

References

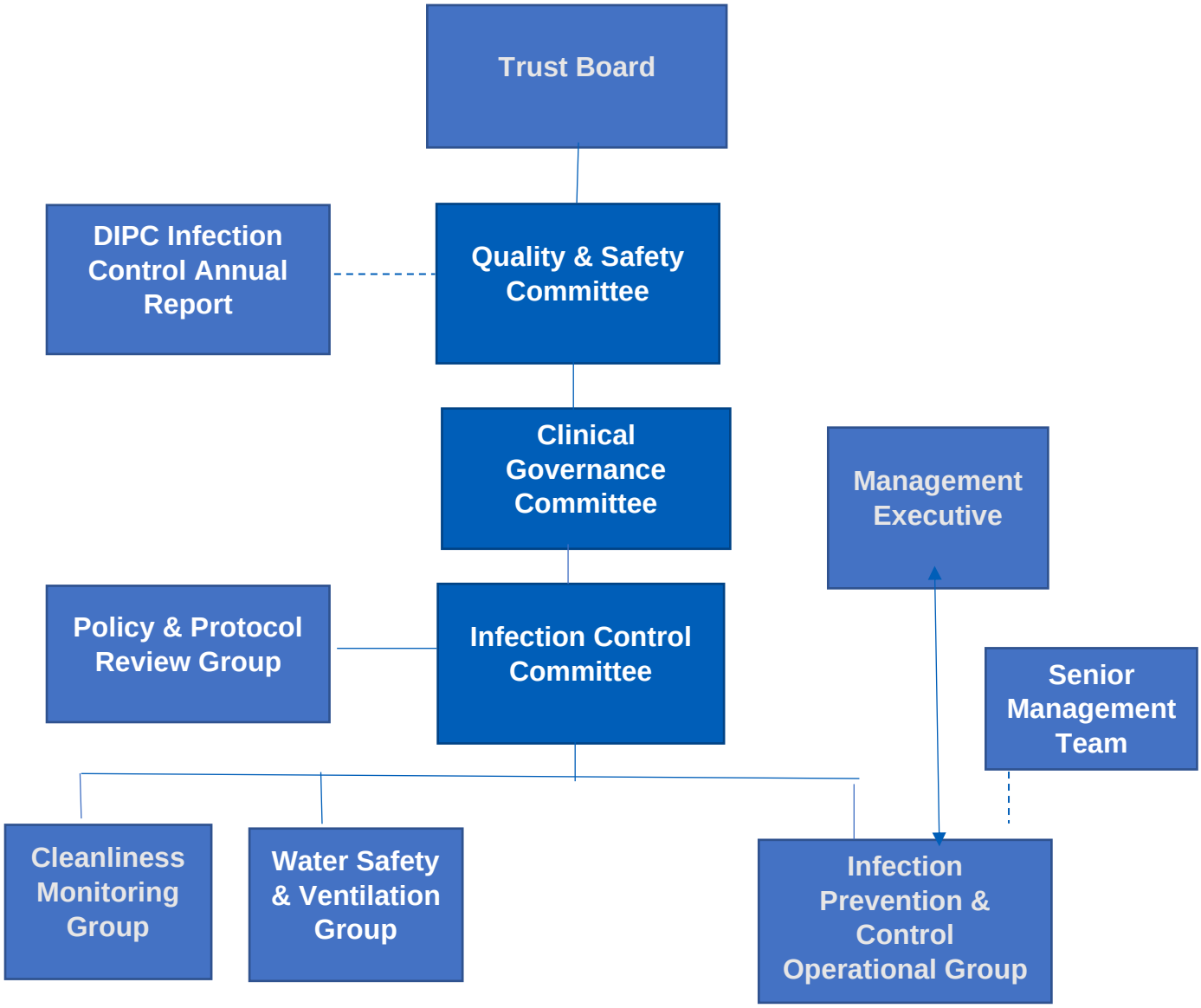
The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015). Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)

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

Appendix 1

Infection Prevention & Control Governance

Reporting & Accountability Structure



Moorfields Eye Hospital NHS Foundation Trust

ITEM xx.xx

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

17 September2024

Committee Governance	• Quorate – Yes • Attendance (membership) – 71% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	**Infection Control Update** The regular infection control (IPC) update was presented. The following areas were highlighted: • Guidance around Mpox (Monkeypox) • Neisseria meningitidis, measles, and TB incidents • Surveillance (including endophthalmitis), including use of surgicubes • Service Level agreement to deliver IPC expertise to Tavistock and Portman NHS Foundation Trust • Flu and COVID-19 Seasonal Vaccination programme (commencing 03/10/2024). **Committee Annual Reports** Annual reports from the following committees were circulated: • Safeguarding (Adults, and Children and Young People) • Resuscitation • Clinical Governance • IPC Annual report. The safeguarding reports were presented individually by the teams. The following issues were raised: • Impact of staffing issues (sickness and other unplanned leave) on safeguarding services • The development of the '*was not brought*' process (Safeguarding Children and Young People) • Flagging of safeguarding concerns, and ensuring accessibility and consistency across all sites. The other annual reports were noted. **Presentation by Moorfields South** The committee received an annual presentation from Moorfields South. The following issues were raised: • Capacity and overcrowding, and the acquisition of a new local site • The transition to *OpenEyes* at Croydon • The trust-wide transport improvement project • The benefits of having a new patient co-ordinator role in Croydon. **Bedford Transformation** This item resulted from an action at July's meeting for updates at each meeting. The background to the issue was explained as was the current position. The following issues were raised:

	• The harm review is currently on-going. To date, there have been no patients identified who have come to harm • IT transformation (waiting list management, electronic paper records, and *OpenEyes*) is critical, and a key priority is to harmonise Bedford with the rest of the Trust. March 2025 is still a viable target for completion • A working group with Bedford Hospital has been set up. **Fire Safety** The committee received its regular fire safety update. Training remains a key topic. The following issues were highlighted: • Fire warden training is currently around 80% (compliance level) • Training has become more flexible, with training being provided at network sites • Site cover nurse training is more challenging, but this is being progressed • Ensuring that the fire safety function can be represented at various committees. **Patient Safety Incidents** The committee received a report about Duty of Candour (DoC). The following issues were raised: • DoC is becoming more 'business as usual' • There is still an issue of logging that DoC has taken place • Whilst the spirit of DoC exists, there is still a tendency to wait until the harm is confirmed before issuing DoC letters • PSIRF transition was also discussed and it was noted that there is one remaining SI report (a Bedford incident) remaining under the old system. **Quality and Safety** The Quality and Safety update included current developments with the CQC, as well as an overview of Safer September (17/09/2024 was World Patient Safety Day). The committee received the WHO audit report for Q4 (2023-24). The following issue was raised: • Where there are instances of repeated 100% compliance and what is being done to investigate/challenge this. **Reports from Other Committees** Summary reports from the following committees were circulated: • Research Quality Review Group (15/07/2024) • Information Governance Committee (30/07/2024) • Clinical Governance Committee (12/08/2024) The new DSPT work including cyber standards was highlighted from the IGC summary report.
Escalations	There were no escalations to the Trust Board.
Date of next meeting	12 November 2024

Meeting:	Public Trust Board
Date:	26 September 2024
Report title:	Summary of the People and Culture Committee (PCC) held on 7 March 2024
Executive Sponsor	Mark Gammage, interim Chief People Officer
Report Author	Jennie Phillips, Deputy Company Secretary
Presented by	Aaron Rajan – Committee Chair
Status	Noting for assurance
Link to strategic objectives	Working Together - We will work together to ensure our workforce supports future care models and a consistently excellent patient and staff experience, in accordance with our values.

Summary of report

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

This report provides a brief summary of the meeting held on 05 September 2024.

The committee terms of reference are also presented for ratifying by the Board. The committee reviewed them at this May meeting.

Action Required/Recommendation.

The board is asked to note the report and approve the term of reference.

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

PEOPLE AND CULTURE COMMITTEE SUMMARY REPORT

Governance	• Quorate – Yes

Current activity	**Workforce priorities and change projects (including programme updates)**
	The Committee received a progress report on workforce priorities and change projects. Updates to the Trust people strategy, priorities and deliverables were noted.
	• The Trust's People strategy programme has achieved all targets for Q1 with the exception of Leadership Development which slipped by two weeks.
	• The Oriel programme is in the process of mapping clinical service requirements for Oriel and working closely with Workforce to analyse and understand:
	  ○ Floor by floor impact on support teams' resource plans
	  ○ Impact by staff group
	  ○ Key themes or interdependencies between staff groups, or other transformation priorities.
	Workforce performance
	The Committee received the Workforce and OD performance report which outlined key performance indicators (KPIs). They remain above target in all areas with the exception of appraisal completion and vacancy rates. Highlights from the report were:
	• Appraisals remain below the Trust target of 80%, sitting at 74%. An appraisal review implementation group was set up to implement recommendations from the recently concluded review of the Trust's appraisal process and system. The working group met twice in August and have agreed terms of reference and an action plan. The group are scheduled to meet twice in September, after which it is planned that they will be meeting monthly, with updates to ManEX and a quarterly report to the People and Culture Committee.
	• The September meetings will focus on considering the recommendation for the Trust to a move to a single electronic system and withdrawal of the paper process. In addition, the group will also consider the options for a new timeframe and appraisals cycle. Following the September meetings, the group will be making a recommendation to ManEx on both issues.
	• In addition to the group's work, the Learning and Development (L&D) team continue to take further actions to improve the compliance rate, such as reviewing appraisal reports with managers and ensuring compliance rates are recorded and captured, which has contributed to the increase in compliance rates, as well as ongoing engagement with Management Executive team and their deputies to improve appraisal completion rates.
	• Vacancy rates increased in July which was expected due to the expansion of the electronic patient records (EPR) project. It is forecast that vacancy rates will continue to fluctuate as the project progresses.
	• The Trust is part of a nationwide payroll improvement project by NHS England.
	• An appraisal review implementation group has launched to improve appraisal completion rates alongside reviewing the appraisal system. Recommendations by this group will come to this Committee in due course.
	
	HR Staffing
	The Committee received the Vacancy Fill rate update report which highlighted that substantive progress continues, with 75% of roles successfully filled in July. This is in comparison to 36% in September 2023.
	
	Freedon To Speak Up (FTSU) Report
	The Committee received the FTSU report, which was a summary of data and themes in Q4 (23/24) and Q1 (24/25) as well as highlighting the progress of the newly introduced FTSU model. Highlights from the report were:
	• The committee noted the Trust has seen an increase in cases being reported which is seen as a reflection of the success of the new model.

	• Work continues on the competencies and qualities needed to help embed compassionate leadership which include:
	  ○ The Trusts own bespoke 6 week 'New Leading with Compassion' leadership programme;
	  ○ Self-awareness and emotional intelligence short course
	  ○ How to gain trust within your team short course
	  ○ Communication and dealing with difficult conversations short course
	  ○ Leadership inspiration sessions
	  ○ Lunch and learn sessions (for clinical and operational managers and supervisors).
	
	Equality, Diversity and Inclusion (EDI) programme
	
	The Committee received the paper was a summary of the 23/24 WRES and WDES data, combined update on EDI programme and introducing the 2024 workforce race and workforce disability standard data. Highlights were:
	
	• Following the Trust Board approving in May 2024; the EDI programme is a type 1 Excellence Delivery Unit (XDU) programme and is made up of three workstreams: Leadership and Culture, Data Driven Change, and Fair Opportunities for All. Each workstreams now have a project team in place and reports monthly to the EDI steering group and the Working Together Board
	• WRES data shows all areas remain the same, with the exception of the improvement of the proportion of BME staff who are going through disciplinary, which is improving.
	• WDES data has marginally improved year on year although the Trust remains behind the national average.
	
	Employee Relations (ER) update
	The Committee received this paper which outlined ER casework over the past 12 months and current position as of June 2024, a summary outline of the Trust HR related policies being updated for 2024/25, and ER improvement plan.
	
	Well-being and Thrive update
	The Committee received this paper which forms the overall employee experience and shows what the Trust is offering staff in terms of health and wellbeing. Highlights were:
	
	• Staff survey shows this is an area the Trust needs to improve with the Trust scoring 54% compared to the average trust of similar size being 61%. Paper captured what the Trust is doing by using the NHS national framework to identify all the areas of health and wellbeing and be more proactive rather than waiting until something is needed. The committee was assured the Trust is in a good place to invest in additional staff health and wellbeing interventions.
	
	Neutral Assessment of Medical Imaging Department report and next steps
	• The Committee noted the paper.
	
	Risk register
	The committee received and noted the latest workforce risk register.

Key concerns	There were no concerns to note.
Date of the next meeting	The next meeting was schedule for November 2024.

People & culture committee - terms of reference

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

	• Director of Nursing and Allied Health Professions • Medical Director • Chief Operating Officer • Director of Education Others may attend as agreed by the committee chair as necessary.
Quorum	The quorum will be four members, including one non-executive director
Frequency of meetings	The committee will meet at least four times per year and members are expected to attend at least 75% of meetings in any year.
Duties	The committee can only carry out functions authorised by the Board, as referenced in these terms of reference. **Delegated Functions** The committee will carry out the following on behalf of the board: • analyse and challenge appropriate information on organisational and operational performance in relation to the committee's purpose. This information should cover: - strategic priorities (e.g. diversity, skills, talent, NHS targets etc (tbc)) - workforce utilisation - health (including sickness) and well being - engagement - financial measures **Assurance Functions** The committee will review the following to provide assurance to the board: • the existence and effective operation of systems to ensure that the trust has in place sufficient capacity and appropriately qualified/skilled to ensure compliance with the conditions of the licence • wellbeing, recruitment, retention, management and development policies and processes • the workforce strategy of the trust and its implementation • the education strategy of the trust and its effectiveness • the approach the trust has to ensuring it fulfils its public sector equality duty for staff, patients and visitors • specific risks on the corporate risk register allocated by the board • the development of workforce governance, including workforce engagement processes **Other duties as agreed by the board** • Exceptional items explicitly requested by the board that fall outside the terms of reference
Reporting and review	Following each meeting of the committee, an update will be provided to the board, in a standard format, showing progress made and highlighting any issues for escalation or dissemination. Minutes of meetings will be available for any board member on request.
Sub-committees	The Committee has the power to establish sub-committees or targeted working groups to address specific tasks. This will be reviewed on an annual basis, or as

	required based on organisational priorities. Any sub-committee will require its own Terms of Reference, approved by this committee. The Committee may also appoint a Workforce advisory group with specific objectives to : - improve engagement between the Committee and the Workforce - to ensure the voice of the employee plays a prominent role in the operations of the committee		
Meeting administration	The lead executive for the committee will be the Chief People Officer and the secretary for the committee will be the company secretary (or an appointee on behalf of the company secretary). The role of the lead executive, in conjunction with the secretary, will be to; • Agree the agenda with the chair • Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board's standing orders • Maintain a forward plan of items for the committee • Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) • Ensure minutes are issued to the chair for review within one week of the meeting, and to committee members within two weeks of the meeting. • Ensure actions are captured, notified to relevant staff and followed up Any other administrative arrangements not listed here will be as shown in the standing orders of the board of directors		
Date approved by the board	TBC – June 2024	**Date of next review**	June 2025

Meeting:	Public Trust Board
Date:	28 September 2024
Report title:	Summary of the Membership Council meeting held on 3 September 2024
Executive Sponsor	Sam Armstrong, Company Secretary
Report Author	Sam Armstrong, Company Secretary
Presented by	Laura Wade-Gery, Trust Chair
Status	For noting
Link to strategic objectives	All of them

Summary of report

The Membership Council forms part of the governance structure of the Trust. The Council comprises of governors elected by the membership (staff, patients and the public) and those nominated by partner organisations. Governors have a number of statutory powers and participate in a range of activities.

Our Membership Council forms a direct link between Moorfields and the communities we serve, and ensures that the voice of the public, patients, service users, carers and staff is used to inform the Trust's decisions, improve care and enhance the patient experience.

The Membership Council meets at least four times a year.

This report provides a brief summary of the discussions held at the last meeting on 3 September 2O24 and is submitted to the Board for noting.

Action Required/Recommendation.

The board is asked to note the report of the Membership Council and gain assurance from it.

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

MEMBERSHIP COUNCIL SUMMARY REPORT - 5 MARCH 2024

Governance	• **Quorate – Yes**
Current activity	**1. CEO Report** Some items highlighted from the report included: • The Trust's current performance position was strong, albeit cataract activity was a little below target. • Waiting lists were stable. • The Trust was successful in its bid to be the NCL Lead Provider of Community Ophthalmology which includes provision of a single point of access for referrals. • As part of the Trust's ongoing mutual aid support, it would provide Royal London Hospital support for some of their patients. • There had been progress on the staff survey action plan, with good engagement observed. • Dr Elena Bechberger, had now joined the Trust as our new director of strategy and partnerships. Recruitment of the director of discovery was nearing completion, and updates would be announced in due course. • Trust finances were on plan, which was pleasing as the NHS was under significant financial pressure across the sector and country. • The VfM feedback from the auditors was noted. Governors discussed and received assurance on access to care at the Trust, the improvement on 18-week waits performance and managing of patient data. **2. Oriel Progress Update** • Governors heard from the Oriel Advisory Group and noted that management was engaging with them on the last half mile. • There was concern expressed in staff retention on the project resulting in loss of relevant accumulated expertise, however it was also noted that this currently was well-staffed and led. • There was a need to unite some for the different patient engagement groups, and to ensure they were fully engaged in the next phase of planning for how the building would be used. It was felt that engagement levels from the programme needed to be improved. • The programme refresh was noted. • It was observed that better focus was needed on the different ways people with differing sight loss used aids, and this would be worked through. **3. Electronic Patient Record System (EPR) update** • The governors received an update on progress on the project and production of the Trust's patient portal. • Governors discussed and received assurance on ensuring that user needs were incorporated while still completing the project on time, and how management was proposing to evaluate the options. • After a discussion it was requested that further assurance be provided on the Trust legal requirement for access being fulfilled and completing the related equality impact assessments (EIA), which the executive would do in due course. It was clarified that the Trust was following the NHSE procurement process for the project, under which the EIA could only be completed once the final contract negotiations were completed, which would be soon.

	4. Moorfields Eye Charity • The governors received a presentation from MEC. • They noted the composition and governance of the charity, its fundraising activity, future strategic plans and its achievements. • The charity had provided £22m towards Oriel construction and more funding was planned. • The Governors acknowledged the charity's important work. **5. Governor Feedback and other activities** • Governors updated the Council on various activities since the last meeting. • The Nominations and Remuneration Committee provided an update on the latest NED recruitment. • The Governance Development Group provided an update on the advancement of governor activities such as NED/governor sessions, governor visits, governor training and plans for the upcoming AGM • The Member and Patient Engagement Group provided an update on development of the membership welcome letter, analysis of membership data and details of the upcoming AGM. It was agreed that the regular patient communication and experience report to Membership Council should also be considered in detail at this meeting going forward. **6. Members week** • The Governors received an update on plans for the upcoming Members Week with everything now in hand. **7. Governor activities** • Governors noted progress on governor activities such as NED/governor sessions, governor visits, governor training and plans for the upcoming AGM.
Key concerns	• No additional concerns were raised.
Date of next meeting	• 28 November 2O24