Bundle Board of directors - Part 1 27 March 2025

1 09:00 - Welcome and introductions
Chair. To note.
250327 TB Part I Item 00 Agenda

2 09:05 - Patient story
Chief nurse. To note.

3 09:25 - Apologies for absence
Chair. To note.

4 Declarations of interest
Chair. To note.

5 Minutes of the previous meeting held 25.01.25
Chair. To approve.
250327 TB Part I Item 05 Minutes of Meeting in Public 250123 DRAFT SA

6 Matters arising and actions log
Chair. To note.
250327 TB Part I Item 06 Action log

7 09:30 - Chief Executive's Report
Interim chief executive officer. To note.
250327 TB Part I Item 07 CEO report

8 09:40 - Integrated Performance Report
Chief operating officer. Assurance.
250327 TB Part I Item 08 Integrated Performance Report - February 2025 (OPEN Version)

9 09:50 - Finance Report
Acting chief finance officer. Assurance.
250327 TB Part I Item 09 Public Finance Performance Board Report - Cover Sheet
250327 TB Part I Item 09 Public Finance Performance Board Report - FINAL

10 10:00 - Staff survey
Chief people officer. To note.
250327 TB Part I Item 11 2024 Staff Survey Report March Rev 5

11 10:15 - EDS annual report
Chief people officer. To approve.
250327 TB Part I Item 11 MEH 2024 EDS Report - Cover Paper
250327 TB Part I Item 11 MEH EDS 2022 Report- February 2025 Rev 7

12 10:25 - Freedom to Speak Up
Chief nurse. To note.
250327 TB Part I Item 12 Public FTSU Report

13 10:30 - Annual Safe Staffing report
Chief nurse. To note.
250327 TB Part I Item 13 Annual safe staffing report coversheet
250327 TB Part I Item 13 Annual safe staffing report

14 10:40 - Guardian of safe working
Medical director. Assurance.
250327 TB Part I Item 14 Guardian of Safe Working report Mar 25

15 10:45 - Learning from deaths
Medical director. Assurance.
250327 TB Part I Item 15 Learning from deaths (Q3 2024-25) March 2025 FINAL

16 10:50 - Committee reports and terms of reference
a) Quality & Safety report 28.01.25 & 11.03.25 Non executive director (MM) Assurance b) People & Culture report 10.03.25 Non executive director (AR) Assurance c) Remuneration & Nominations ToR Company Secretary Approve
250327 TB Part I Item 16a(i) QSC Summary report January 2025
250327 TB Part I Item 16a(ii) QSC Summary report March 2025

250327 TB Part I Item 16b Report of the People and Culture Committee
250327 TB Part I Item 16c(i) 2025 Remuneration & Nominations committee ToR coversheet
250327 TB Part I Item 16c(ii) 2025 Remuneration & Nominations committee ToR

17 Identify risks arising from the agenda
Chair. To note.

18 10:55 - Any other business
Chair. To note.

19 11:00 - Date of the next meeting - 5 June 2025
Chair. To note.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on
Thursday 27 March 2025 at 09.00
Lecture Theatre, 2nd Floor, Ebenezer Street and via MS Teams

No.	Item	Action	Paper	Lead	Mins
1.	Welcome and introductions	Note	Oral	Chair	5
2.	Patient story	Note	Oral	CN	20
3.	Apologies for absence	Note	Oral	Chair	5
4.	Declarations of interest	Note	Oral	Chair	
5.	Minutes of the previous meeting 25.01.25	Approve	Enclosed	Chair	
6.	Matters arising and action log	Note	Enclosed	Chair	
7.	Chief executive's report	Note	Enclosed	iCEO	10
8.	Integrated performance report	Assurance	Enclosed	COO	10
9.	Finance report	Assurance	Enclosed	aCFO	10
10.	Staff survey	Note	Enclosed	CPO	15
11.	EDS annual report	Approval	Enclosed	CPO	10
12.	Freedom to Speak Up	Note	Enclosed	CN	5
13.	Annual Safe Staffing report	Note	Enclosed	CN	5
14.	Guardian of safe working	Assurance	Enclosed	MD	5
15.	Learning from deaths	Assurance	Enclosed	MD	5
16.	Committee updates report and terms of reference a) Quality & Safety 28.01.25 & 11.03.25 b) People & Culture 10.03.25 c) Remuneration & Nominations ToR	Assurance Assurance Approve	Enclosed Enclosed Enclosed	NED (MM) NED (AR) CS	5
17.	Identifying any risks from the agenda	Note	Oral	Chair	5
18.	Any other business	Note	Oral	Chair	
19.	Date of next meeting – 5 June 2025				

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
DRAFT Minutes of the meeting of the Board of Directors held in public on 23 January 2025 at Albert House, Old Street, EC1V 9DD (and via MS Teams)

Board members:	Laura Wade-Gery (LWG)	Chair
	Peter Ridley (PR)	interim Chief executive
	Asif Bhatti (AB)	Non-executive director (via Teams)
	Andrew Dick (AD)	Non-executive director
	David Hills (DH)	Non-executive director
	Michael Marsh (MM)	Non-executive director
	Adrian Morris (AM)	Non-executive director (via Teams)
	Aaron Rajan (AR)	Non-executive director
	Sheila Adam (SA)	Chief nurse and director of AHP
	Justin Betts (JB)	acting Chief financial officer
	Hilary Fanning (HF)	Director of discovery
	Jon Spencer (JS)	Chief operation officer
	Sue Steen (SS)	Chief people officer
	Louisa Wickham (LW)	Medical director
In attendance:		
	Sam Armstrong (SAr)	Company secretary (minutes)
	Victoria Moore (VM)	Director of excellence delivery and chief of staff
	Elena Bechberger (EB)	Director of strategy & partnerships
	Paul Sullivan (PS)	Director of Postgraduate Medical Education (item 2)
	Elenor Lokteva (EL)	incoming Non executive director

A number of staff and governors observed the meeting in the room and online, including: Allan MacCarthy, Kimberley Jackson, Emmanuel Zuridis, John Sloper, Dinesh Solanki, Robert Goldstein, Emily Brothers, Yasir Khan, Ian Humphreys, Paul Murphy, John Russell, Jennie Phillips (deputy company secretary) and Nic De Beer (committee secretary). There was one member of the public observing in person, John Walsh.

1. Welcome

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

She especially welcomed PR to his first meeting as interim chief executive while MK remained absence. She welcomed EL to her first meeting, however noted that technically her appointment as a non-executive director was being delayed pending agreement to alter the Trust constitution.

Introductions were completed.

2. Staff story

The chair welcomed and introduced Paul Sullivan, director of postgraduate medical education, to present his staff story to the Board.

PS provided his background and how he returned to the Trust in 1993 as a consultant, noting that there were many attractions to working at Moorfields in those days, including subspecialisation, partnership with the Institute of Ophthalmology, standalone training, and international partnerships. The shortcomings included long hours, limited surgical supervisions, and that cataract services were not a focus compared to others.

In 2006, PS became the director of postgraduate medical education, and at the time the Trust received the third lowest score in London for training. Strategic goals were set to achieve excellence in education at the

Trust: these included using technology for simulations and e-learning, developing the faculty, creating a supportive environment, and engaging trainees better.

By 2024, the Trust was offering a three-day annual bootcamp for microsurgical and A&E. There was increased simulation space, which was upgraded with external funding. There was ongoing external funding, and the faculty was fully funded, which allowed for such positive results. PS highlighted the improvements made in cataract services. Key personnel in the faculty were noted and PS thanked them and others for their support in achieving improvements.

The latest GMC results were presented. The GMC training survey was noted as one of the few useful metrics available for the quality of training. The very positive results demonstrated that the Trust was continuing to deliver high quality education and training to ophthalmology trainees. Past experiences in other trusts had shown that this survey was also a strong surrogate indicator of safe patient care.

The Board noted the very positive results from the survey. In response to a question from MM, PS noted that the challenges highlighted from the survey related to the curriculum. He added that it was generally thought that there were not enough PAs set aside for training, and that job planning required further development. Burnout was also a related issue.

In response to a question from LWG, PS noted that the Trust was a better place for younger doctors to work at now than it was years ago. One driver of the positive results was that there was now significant demand for doctors to want to train at Moorfields.

LW added that providing good education was important for recruitment and retention of good staff at the Trust. This had also had a positive effect on the Trust's reputation internationally. In response to queries and comments related to discrimination, it was clarified that the results were not broken down to demonstrate demographics as this would likely undermine confidentiality. It was added that Trust policies existed to protect staff, and it was thought that discrimination would be expected to show up in the GMC national training survey results with poor training outcomes and experience. LW added that much interaction occurred with junior staff now and issues related to this had not surfaced.

In response to a question from EL, PS stated that changes in cataract training came from training demands, and that trainees today were very aware of their training needs. PR noted the good developments in training away from the City Road site.

The Board noted the staff story and thanked PS for his work at the Trust.

3. GMC national training survey report 2024

The Board noted the report and that the results had been discussed in the previous item.

4. Apologies for absence

Apologies had been received from Richard Holmes, non-executive director and Martin Kuper, chief executive.

5. Declaration of interest in relation to the agenda

There were no declarations made.

6. Minutes of the previous meeting

The minutes of the meeting held on 28 November 2024 were approved as a correct record.

7. Matters arising and action log

The action log and updates were noted.

8. Chief executive's report

In turning to the item, LWG thanked JS for his work as acting chief executive and the support given by SAd and LW during that time.

JS presented the report as PR had only joined the Trust earlier in the week.

He highlighted key areas of the report, which included:

- The Trust's performance against the 18-week standard worsened slightly in month, driven by staff annual leave;
- The total number of patients waiting to be treated continued to improve;
- Patients waiting over 52 weeks was stable;
- Trust SPoA was now processing the majority of all ophthalmology referrals into secondary care in North Central London;
- Mutual aid had been offered, and the Trust would like to increase the volume of this;
- Moorfields Bedford was now using Open Eyes;
- Progress on Oriel was noted with LWG adding that the focus was shifting from construction work to preparing to occupy and work in the building. Further work to engage patients was underway. AB requested that the Board receive regular updates on progress on the target operating model;
- JS added that cataract referrals had levelled out somewhat and the initial anticipated growth had not occurred. In response to a question, he clarified that SPoA was not designed to divert appointments to the Trust, rather it was to provide patient choice;
- EPR was now branded as Moorconnect. Work continued and there was now a new programme director assisting its implementation.

The Board discussed the update to the staff survey. It was noted that the 2024 survey had been completed and the publication of results was expected in March 2025. Actions in response to the 2023 survey continued to be implemented, including embedding Trust values and leadership development. It was expected that the excellence programme would drive forward changes. AR added that there was demand for leadership opportunities and suggested that leadership development be included with clinical excellence.

It was noted that clinical leadership programmes had been running, however further development of these was expected. PR added that line management skills needed developing at the Trust.

The Board noted the report.

9. Integrated performance report

JS presented the report and highlighted the following:

In December, the Trust's 18-week referral to treatment time performance reduced slightly to 81.2%. The total waiting list size had continued to reduce and was now at 33,039. There were continued capacity challenges in a small number of high-volume specialist services which were seeing a deteriorating position. A workforce plan was being developed to support recruitment and proposals for additional clinical space were being considered.

The number of patients waiting over 52 weeks for their treatment was stable at nine. These patients were a combination of those who have been transferred to the Trust from other trusts through mutual aid or Trust patients that experienced longer waits due to capacity pressures in specialist services. These patients had clear next steps in place to ensure they were seen and treated as quickly as possible.

Elective activity levels were below plan due to the known issue of lower than anticipated cataract referrals. Additionally, the number of staff taking annual leave over the Christmas and New Year period reduced activity in the second half of the month.

Outpatient activity was also below plan in December, due to annual leave, however it remained above plan year-to-date.

SS informed the Board that Trust appraisals would be moving to a single digital solution to ensure all completed appraisals were captured. It was being proposed that appraisals for all staff be conducted at a set time of the year, rather than tying them to the individual anniversaries of employment. LWG added that the issues had concerned the governors and had been discussed at PCC. In response to a question from AR, SS suggested that mandatory training could be linked to annual appraisals.

The Board noted the report.

10. Finance report

JB presented the report.

It was noted that the Trust was reporting a £2.17m surplus year-to-date, which was £1.05m adverse to plan. The adverse variance comprised of £1.49m favourable slippage in EPR and IT project workstreams.

The Trust had engaged with the ICB in regard to a revised full year financial forecast below the original planned £5.4m surplus. Capital expenditure as of 31st December totalled £59.8m.

Activity levels at Stratford and St Ann's were being monitored as they were currently below capacity. Agency spend was lower than the 12-month trend. Agency spend across the NHS was expected to remain as a key national focus.

PR added sector context for the Board. It was noted that next year was expected to be very challenging for providers. There was pressure to deliver plans, and many trusts were busy with existing winter pressures.

The Board noted the report.

11. Constitution amendment

SAr presented the proposal to alter the constitution.

It was noted that the recent appointment of Elena Lokteva had not taken account of her continued role as a non-executive director Essex Partnership University NHS Foundation Trust (EPUFT), which under the current constitution made her ineligible to be appointed to the Trust Board.

It was noted that the restriction on non-executive directors serving on two NHS board was no longer required in the NHS and some trusts had removed the clause altogether. It was added that the proposal allowed for more flexibility for the Trust to recruit non-executive directors, while still ensuring due diligence on issues such as potential conflicts of interest could be considered.

AM and DH spoke in favour of the proposal. MM suggested removing the clause altogether. It was pointed out that there would be a full review of the constitution later in the year, and this could be considered then. The Board noted the process to change the constitution.

The Board approved the proposal to add '*unless the Board of Directors judge that it is in the best interest of the Trust*' to the end of article 8.7.10 to read in full:

8.7.10 he is an executive or non-executive director of another Foundation Trust, or a governor, non-executive director, chairman, chief executive officer of another Health Service Body, or a body corporate whose business includes the provision of health care services, including for the avoidance of doubt those who have a commercial interest in the affairs of the Trust unless the Board of Directors judge that it is in the best interest of the Trust.

The Board also confirmed they were content to declare that it was in the best interests of the Trust for the Membership Council to appoint Elena Lokteva as a non-executive director of the Trust. The Board also concluded that there was no conflict of interest that could not be managed in the usual way, as Elena was a non-executive director of a mental health trust.

The Board having approved the amendment noted that the Membership Council would now consider the proposal.

12. Identifying any risks from the meeting

The Board recognised the financial pressures and related risks.

13. Any other business

There was no other business.

14. Date of next meeting

It was noted that the next meeting of the Board would take place on 27 March 2025 at the Trust Education Centre.

The meeting was closed 10:40.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS ACTION LOG

27 March 2025

No.	Date	Minute item	Item title	Action	By	Update	Open/ closed/due
01/02	23/01/24	8.0	Integrated performance report	Report on research studies in the Trust to be presented to the board, to include breakdown of recruitment to different studies.	HF	To be incorporated in research annual report. Report deferred to May.	May 2025 (revised)

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

Brief summary of report

The report covers the following areas:

- Performance and activity review
- Sector update
- Oriel update
- MoorConnect (EPR)
- Excellence portfolio update
- Financial performance
- Leadership

Action required/recommendation.

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

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

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

PUBLIC BOARD MEETING – 27 MARCH 2025

Chief Executive's report

Performance and activity review

In February, the Trust's performance against the 18-week standard improved in month to 82.5%. The total number of patients waiting to be treated worsened marginally in month, however performance against this standard continues to show special cause improvement.

Performance within a small number of specialist services remains challenging and this has been the main driver behind there being an increase in patients waiting over 52 weeks for their treatment. The elective activity level remains below both the in-month and year-to-date plans.

Sector update

As the lead provider for ophthalmology services in North Central London we have now established a number of regular forums that bring together all providers and other system partners on a regular basis. In these forums we gather and share key information about the delivery of eye care across the system, identify priorities for improvement and progress joint initiatives. Our digital referral management platform, the 'Single Point of Access', is now processing more than 80% of all ophthalmology referrals into secondary care in North Central London and is ensuring that patients are directly referred to the most suitable place for their care. Patients referred for cataract surgery are also provided with transparent information to inform their choice of a provider.

We also provide a Single Point of Access for patient referrals across Inner North East London and are currently in discussions with local commissioners about their plans to continue this service.

Our Elective Surgical Hub in Stratford, North East London, is continuing to provide support to neighbouring NHS trusts who have limited outpatient and surgical capacity in ophthalmology. Suitable patients, including those who might have already waited a longer time for a consultation or treatment, are being transferred to our hub for diagnostic services and elective procedures.

In Bedford we successfully switched the clinical noting system to OpenEyes in January 2025 – all NHS sites now use OpenEyes. 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 Bedford region. The timeframe for this will be driven by the ability to safely transition the remaining IT systems.

Work is currently ongoing to refurbish our Potters Bar site which will improve privacy and dignity for patients as well as improve staff welfare spaces. This is due to complete on 31 March 2025.

Oriel
The superstructure of the Oriel centre is now complete and the façade is being finalised on levels 6, 7 and 8. Detailed design conclaves have been undertaken to support the user sign off of the 1:50 designs in May.

Work on the target operating model specifications is near to completion and has revealed a number of areas which need transforming prior to the centre opening.

The Director of Operational Change is now developing plans to move services from City Road to Oriel and to plan how best to use the building on Granary Street, which will house the administration services which cannot fit into the Oriel centre.

MoorConnect (Electronic Patient Record)
The Programme Director has led the development of a Programme Initiation Document for the programme and this has now been approved by the Programme Board. Project briefs are near to being finalised for the individual projects which will sit underneath the programme. These will inform the work effort which is required and provide a baseline against which progress can be assessed.

A steering group has been established to focus on the delivery of the design of the new system and a patient portal co-design group has met to review how well the Meditech portal will meet the needs of our patients.

Excellence Portfolio
In our Develop and Deliver initiatives, the Outpatient Waiting List initiative is advancing to reduce hospital-initiated cancellations and improve patient communication by providing appointment notifications six weeks in advance.

For Working Together, one of our projects focuses on embedding our values and launching a behaviour framework, both essential to achieving the Trust's goal of outstanding staff satisfaction and fostering a thriving work environment.

Our ambition is to ensure that employee recommendations of the Trust as a workplace are as strong as patient recommendations for care. This initiative is progressing in two phases: phase 1 involves stakeholder engagement to integrate the values and framework, while phase 2 focuses on refining, launching, and embedding the framework, enabling teams to conduct sessions and update policies and processes.

Our Sustain and Scale initiatives align with the NHSE mandate to refresh our Green Plan, embedding sustainable practices to minimise waste and inefficiencies. A key focus is the Paperless and Digital Transformation project, which will drive paper reduction and support sustainability, particularly in preparation for the new MoorConnect (Electronic Patient Record) system.

Our expanding IT capabilities include progress on the MoorConnect programme, with final Programme Implementation Plan now approved, ahead of go-live in May 26. Additionally, the Print Management project proof of concept has been completed, and new printers are set to be rolled out across the Trust from late March.

Finance Performance

For February the trust is reporting a £2.0m surplus, £1.9m favourable to plan, with a cumulative surplus of £6.2m, £1.35m favourable to plan. The current financial position is supported by slippages in IMT projects including EPR, totalling approximately £1.5m cumulatively, partially offsetting elective activity performance at 89% in month, efficiency delivery, and corporate and trading areas below plan.

Patient activity during February was 89% for Elective, 99% on Outpatient First, and 90% against Outpatient Procedures activity respectively against the Trust revised activity demand plan. Efficiencies are reporting £6.5m cumulatively, £3.7m adverse to plan. For the full year £7.1m have been identified against the increased £11.2m plan with further schemes being validated.

The Trust cash position was £61m, equivalent to 74 days of operating cash. Capital expenditure was £84.7m cumulatively with the majority relating to the Oriel development.

Leadership
Adam Dunlop has joined us as interim Chief Information Officer following the departure of Nick Roberts to SECAMB. Adam has worked here previously as interim CIO and so has an understanding of the organisation.

Arthur Vaughan has been confirmed as our new substantive Chief Finance Officer. Arthur is currently deputy CFO at Kings and will join us in the summer.

We continue to work with Governors regarding the concerns raised by consultants over the leadership of the trust. We are supporting the Governors to initiate two reviews – the first specifically relating to the issues raised by consultants and the second being a Board governance review.

Peter Ridley
interim chief executive

Integrated Performance Report
Reporting Period - February 2025

Brief Summary of Report

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

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

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

Performance & 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.

Moorfields Eye Hospital NHS Foundation Trust

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 *

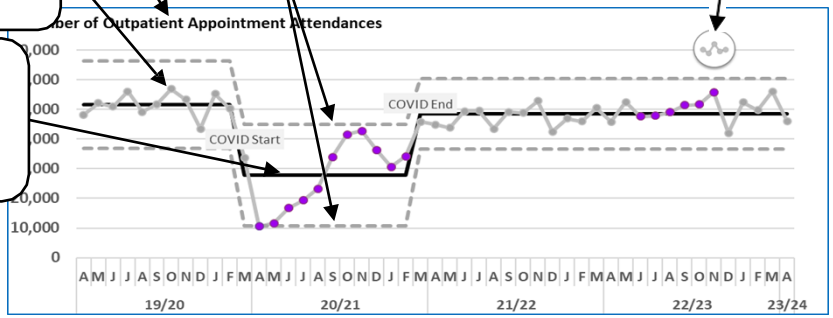
Summary Icons *

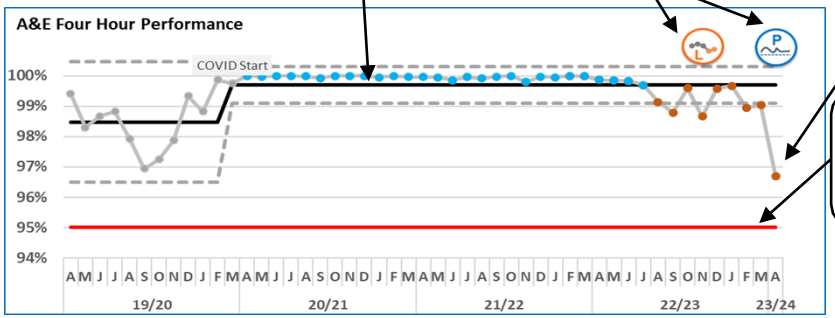
Concerning Special Cause *

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"

- Elective Activity - % of Phased Plan
- 52 Week RTT Incomplete Breaches
- Appraisal Compliance
- Basic Mandatory IG Training
- Staff Sickness (Month Figure and Rolling Annual Figure)

Celebrations

- 20 Metrics are showing as a capable process, with 19 showing either an improving or stable performance, this includes:
  - All Research Metrics
  - Posterior Capsular Rupture rates
  - All FFT Performance Targets
  - Infection Control Metrics
- Six metrics are showing an improving position including Referral to Treatment (RTT) performance and Waiting Lists, Recruitment Time to Hire, and Proportion of Temporary

Other Metrics showing "Special Cause Concern"

- Cancer 31 Day Waits
- Percentage of responses to written complaints sent within 25 days
- Proportion of patients participating in research studies

Other Areas To Note

- SPC charts for several operational metrics have been updated so performance can be monitored against current trends and processes more accurately. This includes Activity vs. Plan, RTT performance and Waiting Lists, 28 day cancer FDS performance, and Call Centre performance.
- All Outpatient Plans remain above plan for February and YTD, with overall and Follow Up Appointments vs. Plan showing as an improving and capable process.
- Elective Activity remains below 100% for February and YTD.

Executive Summary

In February, the Trust's 18 week referral to treatment time performance increased to 82.5% of patients receiving their treatment within the required period. The total waiting list size has increased and is now at 33,406. Longer waiting times in paediatric and adnexal services continue to impact the Trust's overall 18 week position. An outpatient drive is taking place in March to ensure our longest waiting patients are offered an appointment. There is a need to increase paediatric capacity in a sustainable way, which is being discussed as we agree our activity plan for next financial year.

The number of patients waiting over 52 weeks for their treatment has increased to 12. Most of these patients have experienced longer outpatient waits due to capacity pressures in paediatrics and adnexal. All patients over 52 weeks have clear next steps in place to ensure they are seen and treated as quickly as possible.

The Trust's elective activity level was below plan due to the known issue of lower than anticipated cataract referrals, leading to underutilised theatre capacity. The changes in the case mix of patients treated at City Road has continued and additional sessions have been reduced accordingly. South division delivered well above their elective activity plan in February, supporting continued improvement in the 18-week referral to treatment time performance.

Outpatient activity was above plan in February.

Cancer performance deteriorated this month. The cancer 28-day faster diagnosis standard was met,with two patients exceeding the 28-day target. The 31-day standard was not met, with four patients receiving treatment after 31 days, due to delays listing the patients for surgery. All patients have now received treatment. The process for escalation is being reviewed to ensure action can be taken to avoid breaches in future.

The 6-week waiting time target was not met this month. This was due to patient unavailability and communication delays. No capacity issues are present. There is a renewed focus on communication and escalation to try and reduce waiting times.

The Trust's Booking Centre performance deteriorated, following strong delivery in January. This was due to staff absence and some downtime for our telephone system.

Appraisal compliance remains has reduced to 69.7%, reflecting the transition to the new appraisal process. Basic Mandatory IG training is just below the required standard at 89.6% and the staff sickness rates remain above Trust target, increasing to 5.4% in February.

Performance Overview

February 2025		Assurance			
		Capable Process	Hit and Miss	Failing Process	No Target
Variation	Special Cause - Improvement	- FFT A&E Scores (% Positive) - FFT Outpatient Scores (% Positive) - NatPSAs breached - Serious Incidents open after 60 days - Recruitment to NIHR portfolio studies - Active Commercial Studies	- Elective waits over 65 weeks - Recruitment Time To Hire (Days)	-	- RTT Waiting List - Proportion of Temporary Staff - Recruitment to All Research Studies
	Common Cause	- Total Outpatient FlwUp Activity (% Plan) - % Cancer 62 Day Waits (All) - A&E Four Hour Performance - Average Call Abandonment Rate - Mixed Sex Accommodation Breaches - VTE Risk Assessment - Posterior Capsular Rupture rates - MRSA Bacteraemias Cases - Clostridium Difficile Cases - E. Coli Cases - MSSA Rate - cases - FFT Inpatient Scores (% Positive) - FFT Paediatric Scores (% Positive) - Summary Hospital Mortality Indicator	* See Next Page	- Elective Activity - % of Phased Plan - 52 Week RTT Incomplete Breaches - Staff Sickness (Month Figure)	* See Next Page
	Special Cause- Concern	- % of patients in research studies	- % Cancer 31 Day Waits (All) - % Complaints Responses Within 25 days	- Appraisal Compliance - Basic Mandatory IG Training - Staff Sickness (Rolling Annual Figure)	-
	Special Cause - Increasing Trending	-			
	Special Cause - Decreasing Trending	- No. of A&E Arrivals			

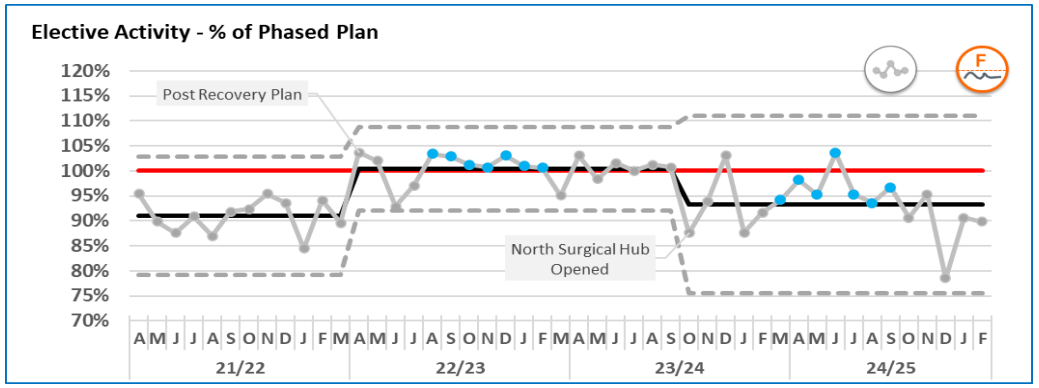
Performance Overview

Common Cause & Hit and Miss	Common Cause (No Target)
- Total Outpatient Activity (% Plan)	- 18 Week RTT Incomplete Performance
- Outpatient First Activity (% Plan)	- RTT Incomplete Pathways Over 18 Weeks
- Cancer 28 Day Faster Diagnosis Standard	- Number of Incidents open after 28 days
- % Diagnostic waiting times less than 6w	- OP Journey Times - Non-Diagnostic FtF
- Average Call Waiting Time	- OP Journey Times - Diagnostic FtF
- Emergency readmissions in 28d (ex. VR)	- No. of A&E Four Hour Breaches
- % Complaints Acknowledged Within 3 days	- No. of Outpatient Attendances
- % FoI Requests within 20 Days	- No. of Outpatient First Attendances
- Occurrence of any Never events	- No. of Outpatient Flw Up Attendances
- Theatre Cancellation Rate (Non-Medical)	- No. of Referrals Received
- Non-medical cancelled 28 day breaches	- No. of Theatre Admissions
	- No. of Theatre Elective Day Admissions
	- No. of Theatre Elective Inpatient Adm.
	- No. of Theatre Emergency Admissions

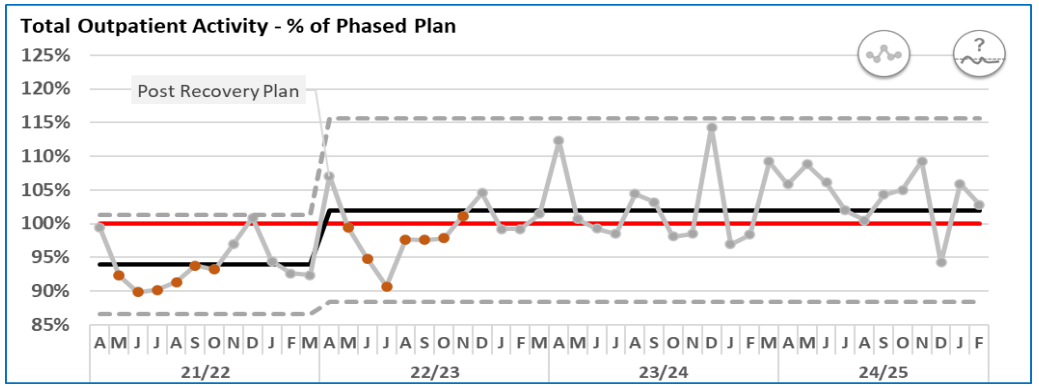
Deliver (Activity vs Plan) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Elective Activity - % of Phased Plan	Jon Spencer	24/25 Planning Guidance	Monthly	≥100%	93.4%	89.9%		
Total Outpatient Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	104.1%	102.8%		
Outpatient First Appointment Activity - % of Phased Plan	Jon Spencer	Internal Requirement	Monthly	≥100%	106.0%	107.9%		
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jon Spencer	24/25 Planning Guidance	Monthly	≥85%	103.6%	101.4%		

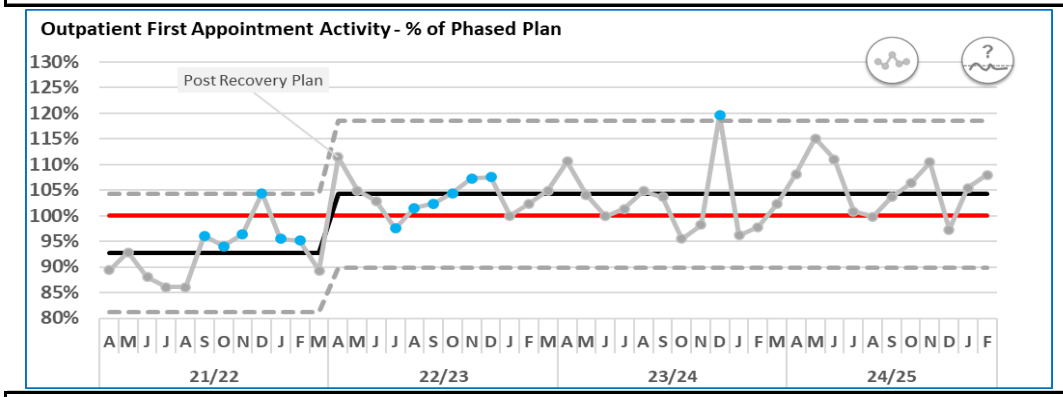
Deliver (Activity vs Plan) - Graphs (1)



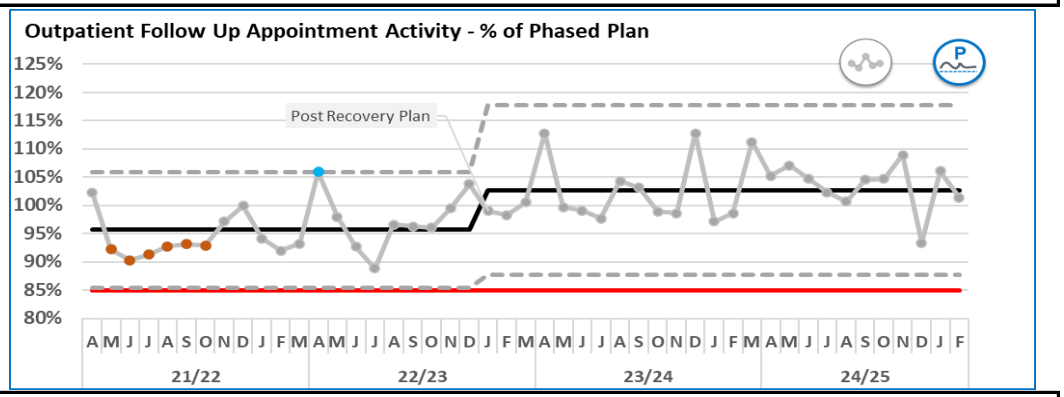
'Elective Activity - % of Phased Plan' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 89.9%.



'Total Outpatient Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 102.8%.



'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 107.9%.



'Outpatient Follow Up Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 101.4%.

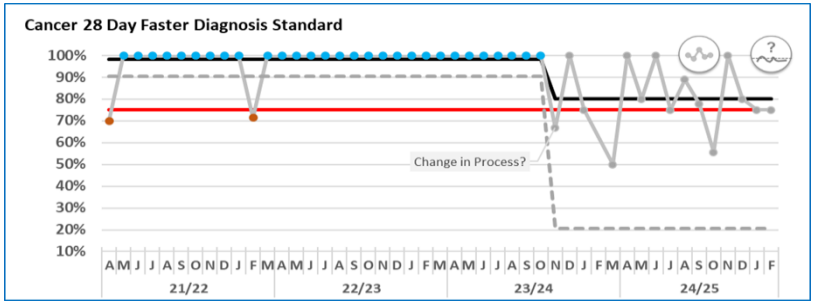
Elective activity remains below plan at 89.9% (-320) cases, with City Road at 93.8% (-86) and North at 74.4% (-306). South delivered above plan at 112.1% (+72). City Road performance was impacted by lower than trend activity in VR and Cataract linked to a reduction in additional sessions. There was a reduction in cataract at Potters Bar due to planned refurbishment works, this was offset by an improved position in cataract activity at Stratford. However, Stratford continues to have the most significant level of under performance due to challenges with demand in the cataract service. Business planning for next year continues, with a focus on ensure there is the right capacity for current demand in our network sites and there is a reduction in additional sessions and temporary staffing spend. This will see changes to the elective activity plan, most notably in cataract and sites in the North division.

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

Deliver (Cancer Performance) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	Statutory Reporting With Local Target	Monthly	≥75%	81.7%	75.0%		
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat	Jon Spencer	Statutory Reporting	Monthly	≥96%	98.0%	83.3%		
% Patients With All Cancers Treated Within 62 Days	Jon Spencer	Statutory Reporting	Monthly	≥85%	98.6%	93.3%		

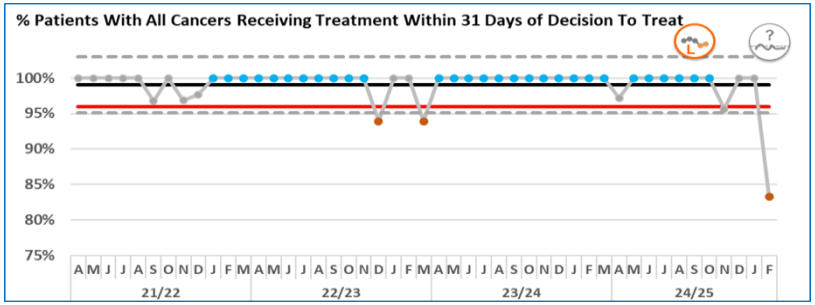
Deliver (Cancer Performance) - Graphs (1)



'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 75.0%.

Performance against the 28 day faster diagnosis standard is common cause with the average reducing to 80%. This is the required standard as set out in the operational planning guidance for 25/26. Whilst breach reasons are known for individual patients, a more comprehensive review of performance and reporting is required to understand the change in performance from consistent delivery of 100% to the fluctuations reported recently.

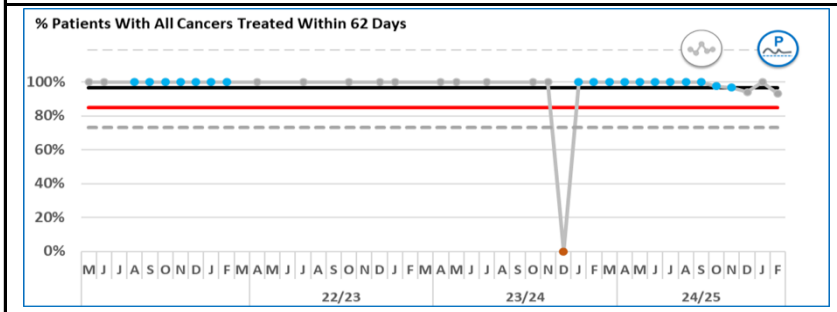
Review Date: Apr 2025 ***Action Lead:*** Kathryn Lennon



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

Four patients received treatment after 31 days, due to delays listing the patients for surgery. All patients have now received treatment. The process for escalation is being reviewed to ensure action can be taken to avoid breaches in future.

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

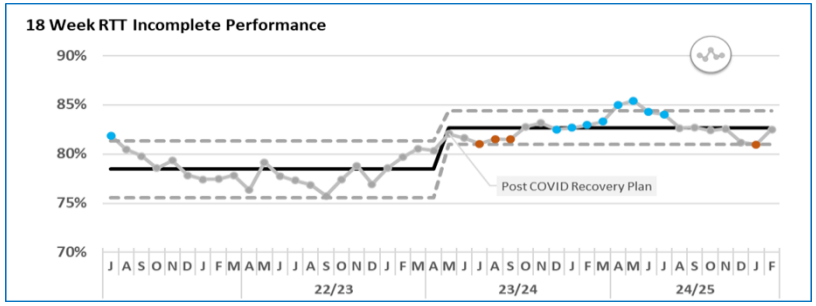


'% Patients With All Cancers Treated Within 62 Days' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 93.3%.

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	83.1%	82.5%		
RTT Incomplete Pathways (RTT Waiting List)	Jon Spencer	Internal Requirement	Monthly	≤ Previous Mth.	n/a	33406	L	
RTT Incomplete Pathways Over 18 Weeks	Jon Spencer	Internal Requirement	Monthly	≤ Previous Mth.	n/a	5849		
52 Week RTT Incomplete Breaches	Jon Spencer	24/25 Planning Guidance	Monthly	≤5 Breaches	100	12		F
Eliminate waits over 65 weeks for elective care	Jon Spencer	24/25 Planning Guidance	Monthly	Zero Breaches	25	3	L	?
A&E Four Hour Performance	Jon Spencer	24/25 Planning Guidance	Monthly	≥95%	97.9%	98.8%		P
Percentage of Diagnostic waiting times less than 6 weeks	Jon Spencer	24/25 Planning Guidance	Monthly	≥99%	99.0%	98.4%		?

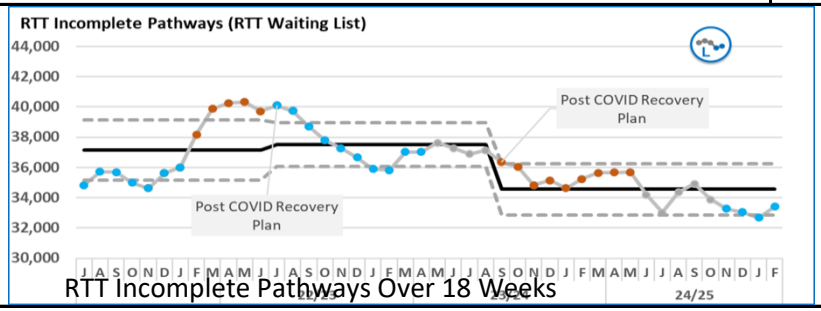
Deliver (Access Performance) - Graphs (1)



'18 Week RTT Incomplete Performance ' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 82.5%.

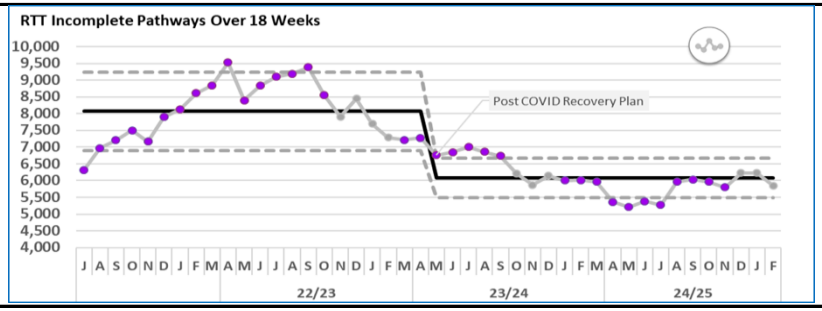
18 week RTT incomplete performance has improved to 82.5% following a period of decline. There remains a significant capacity challenge in paediatrics and adnexal, where patients waiting times are increasing. This is a capacity constraint across London and other providers face similar issues: a specialist workforce which is hard to recruit and retain, variable community provision leading to increases in demand. A paediatric outpatient drive is taking place in March which will increase new outpatient attendances and offer appointments to the longest waiting patients. Whilst the rate of conversation to surgery is low, it is likely that some patients will breach 52 weeks whilst waiting for a date for surgical treatment. Business planning for 25/26 includes increases in paediatric and adnexal activity across the organisation to reduce waiting times.

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

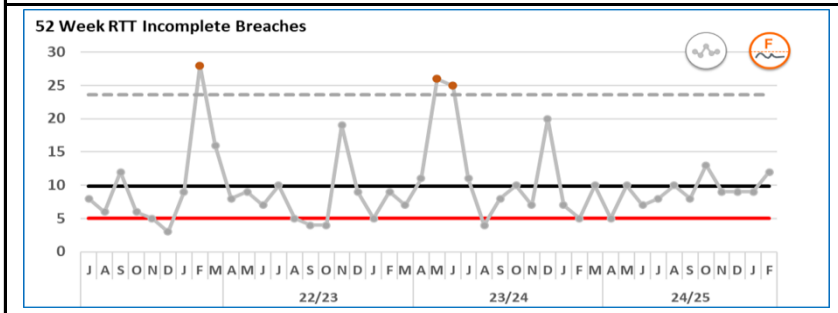


RTT Incomplete Pathways Over 18 Weeks

'RTT Incomplete Pathways (RTT Waiting List)' is showing 'special cause improvement' (decreasing rate). The figure is currently at 33,406.



'RTT Incomplete Pathways Over 18 Weeks' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 5,849.

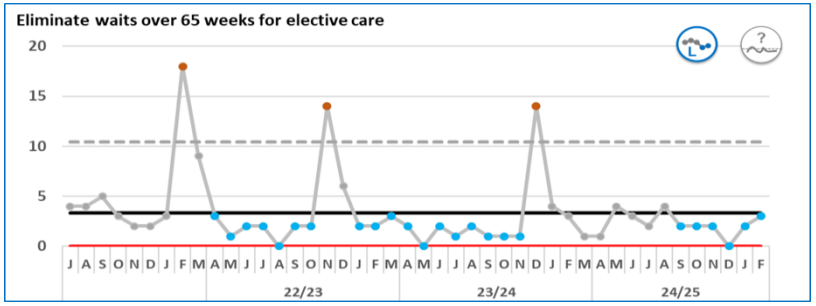


'52 Week RTT Incomplete Breaches ' is showing 'common cause variation' with the current process unlikely to achieve the target. The figure is currently at 12.

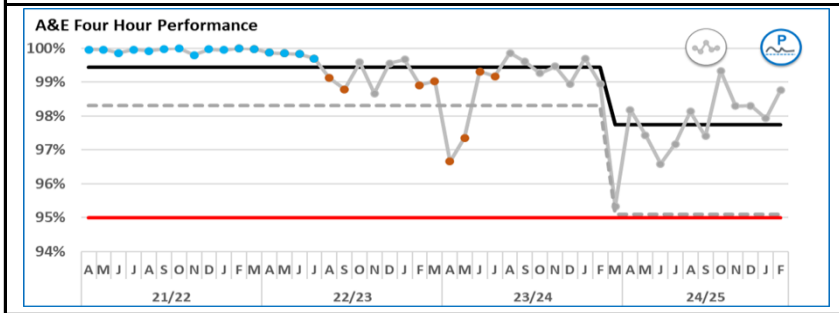
52 week RTT breaches are in common cause. These breaches are due to mutual aid patients, those patients found through validation who come onto the RTT PTL at long weeks wait and also those patients, in paediatrics and adnexal, who have waited longer for their first appointment and breach 52 weeks waiting for definitive treatment. Patients over 52 weeks and those at risk of breaching 52 weeks are tracked on a weekly basis at divisional performance meetings, PTL meetings and the weekly Access meeting. There is a focus on: ensuring patients have a next event, that appointment dates are brought forward, obstacles in a patient pathway are escalated for resolution and the root cause of the long wait is understood for wider learning. Patients will have harm reviews completed and incidents raised for investigation, as appropriate.

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

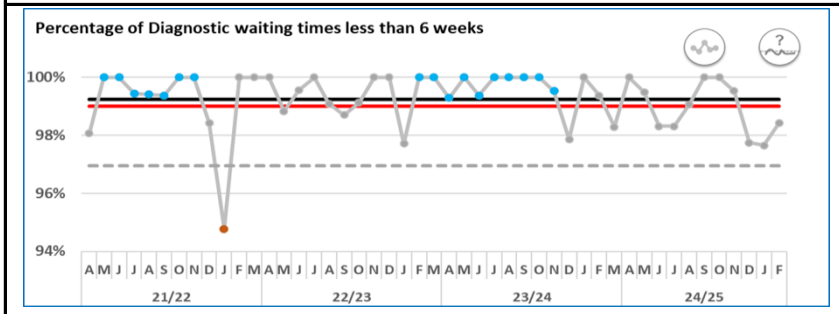
Deliver (Access Performance) - Graphs (2)



'Eliminate waits over 65 weeks for elective care' is showing 'special cause improvement' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 3.



'A&E Four Hour Performance' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 98.8%.



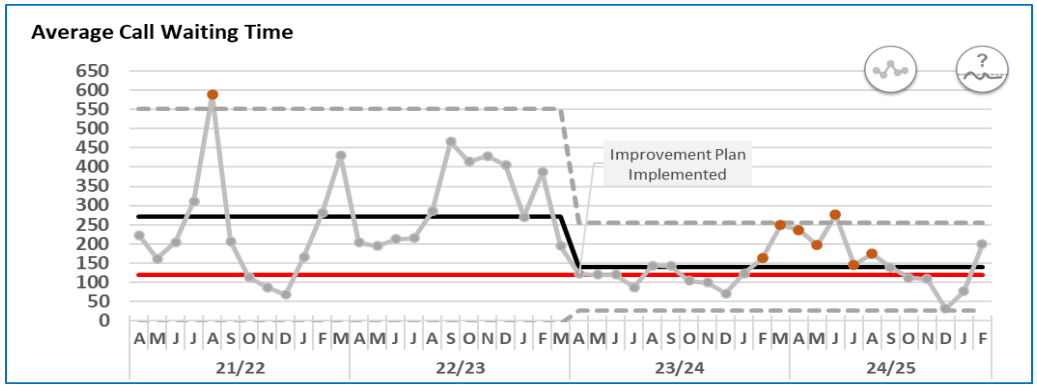
'Percentage of Diagnostic waiting times less than 6 weeks' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 98.4%.

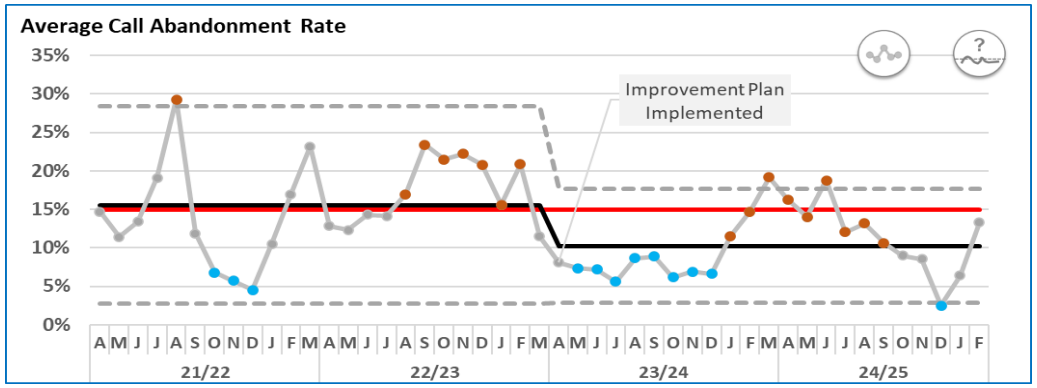
There have been no capacity issues at any of the sites, leading to longer waiting times. The instances where patients have waited longer than 6 weeks for a diagnostic attendance have been due to specific issues related to particular patient pathways such as patients being unwell, a patient lacking capacity to consent, a patient requesting a reschedule. In order to reduce the number of patients waiting more than 6 weeks, there will be a focus on early communication and escalation of any issues preventing a patient receiving their diagnostic test so that action can be taken.

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

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	199		?
Average Call Abandonment Rate	Jon Spencer	Internal Requirement	Monthly	≤15%	11.6%	13.3%		?
Mixed Sex Accommodation Breaches	Sheila Adam	Statutory Reporting	Monthly	Zero Breaches	0	0		P
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Jon Spencer	Internal Requirement	Monthly (Rolling 3 Months)	≤ 2.67%	n/a	1.85%		?
VTE Risk Assessment	Jon Spencer	Statutory Reporting	Monthly	≥95%	99.6%	99.2%		P
Posterior Capsular Rupture rates (Cataract Operations Only)	Jon Spencer	Statutory Reporting	Monthly	≤1.95%	0.92%	0.87%		P
MRSA Bacteraemias Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Clostridium Difficile Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
MSSA Rate - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P



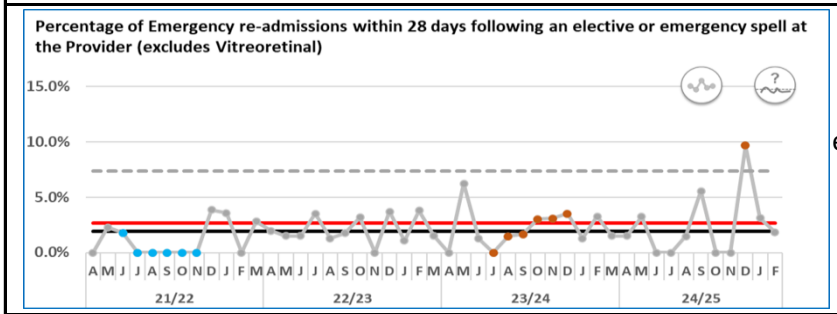
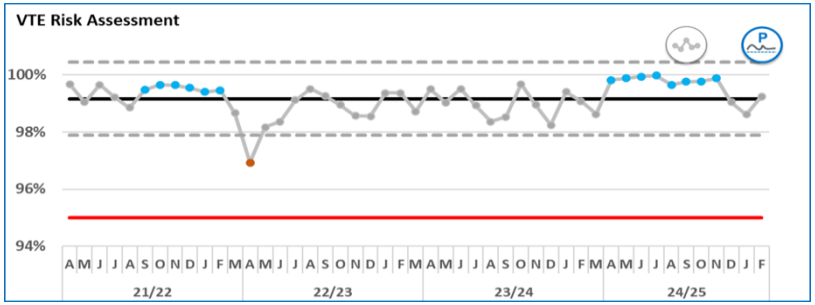
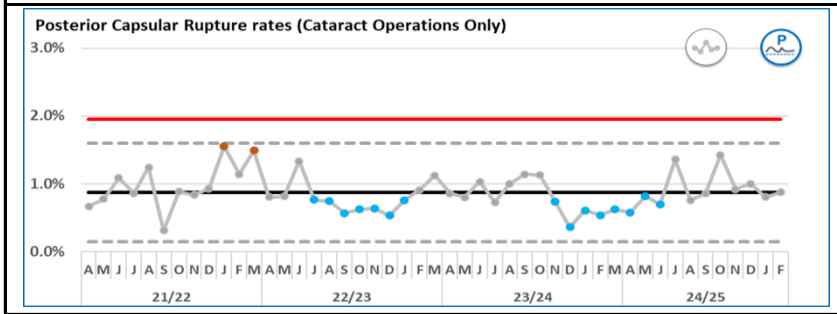


'Average Call Waiting Time' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 199.	**'Average Call Abandonment Rate' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 13.3%.**

Average call waiting time is showing common cause variation. There was an increase in average call waiting time to 199 seconds. This was due to staff absence and incidents of netcall downtime. Annual leave rules have been revised to prevent a similar occurrence and there is a open staff meeting taking place to provide additional support and understand any other reasons for performance levels which the team can address together. Further detail to be provided next month.

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

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

No Graph Generated, No breaches since June 2017	**'Mixed Sex Accommodation Breaches ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**
	**'% Emergency re-admissions within 28 days (excludes Vitreoretinal)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 1.85%.**
	**'VTE Risk Assessment' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 99.2%.**
	**'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 0.87%.**

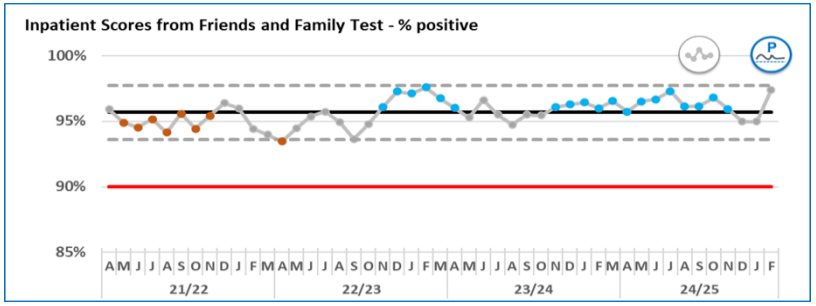
Deliver (Call Centre and Clinical) - Graphs (3)

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

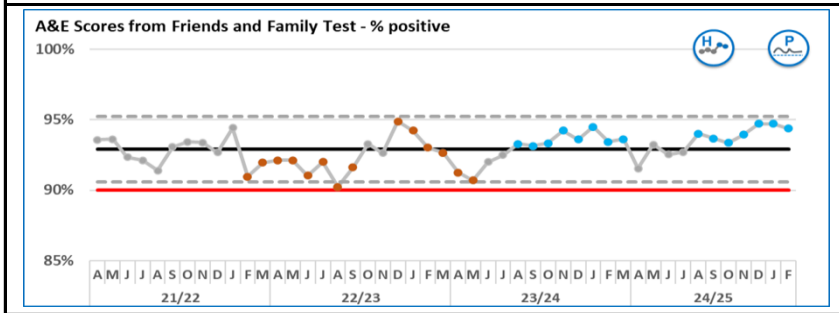
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Inpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	96.4%	97.4%		P
A&E Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	93.5%	94.4%	H	P
Outpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	94.7%	95.5%	H	P
Paediatric Scores from Friends and Family Test - % positive	Ian Tombleson	Internal Requirement	Monthly	≥90%	95.1%	95.0%		P
Percentage of responses to written complaints sent within 25 days	Ian Tombleson	Internal Requirement	Monthly (Month in Arrears)	≥80%	77.1%	33.3%	L	?
Percentage of responses to written complaints acknowledged within 3 days	Ian Tombleson	Internal Requirement	Monthly	≥80%	88.6%	88.9%		?
Freedom of Information Requests Responded to Within 20 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	85.4%	93.8%		?
Subject Access Requests (SARs) Responded To Within 28 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	n/a	n/a		

Deliver (Quality and Safety) - Graphs (1)



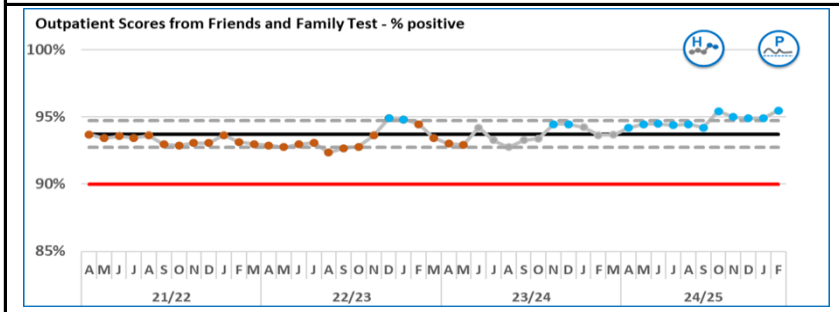
'Inpatient Scores from Friends and Family Test - % positive ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 97.4%.

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.



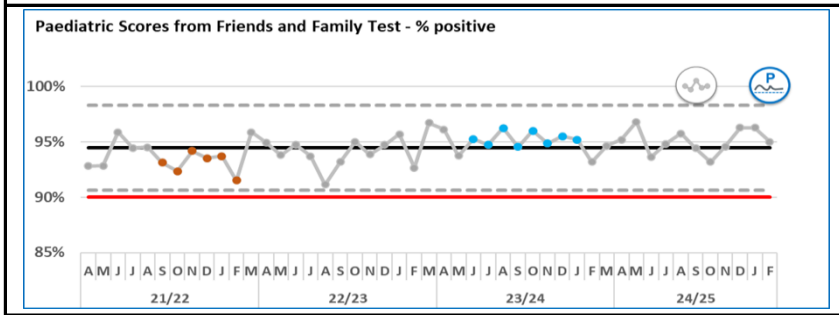
'A&E Scores from Friends and Family Test - % positive' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 94.4%.

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.



'Outpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 95.5%.

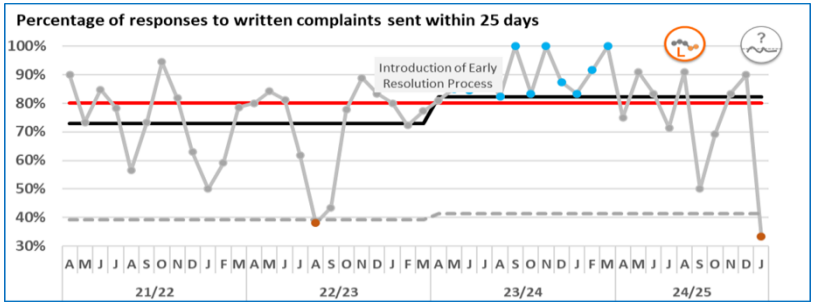
Friends and Family Test Scores continue remain above target, we continue to review this through the divisional performance meetings and Patient Participation and Experience Committee (PPEC) to continuously improve performance.



'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 95.0%.

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.

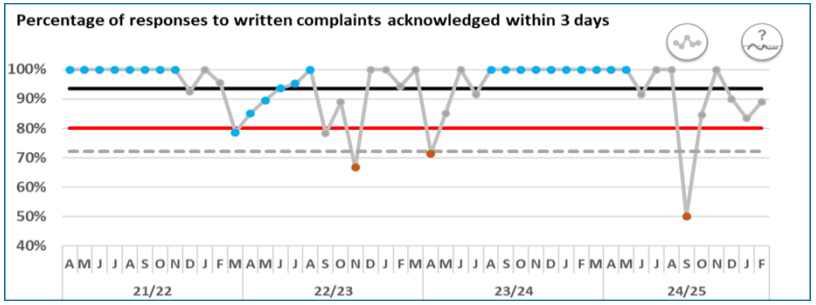
Deliver (Quality and Safety) - Graphs (2)



'Percentage of responses to written complaints sent within 25 days' is showing 'special cause concern' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 33.3%.

Four of the six complaints received in January breached their 25-working-day release target due to slower than required processes – a combination of central and divisional responsibility. Regrettably, 25-day performance for January was negatively affected by sickness and staff turnover in the central team. This is also anticipated to impact February's performance. However, we anticipate a return to regularly achieving the performance target from March onwards.

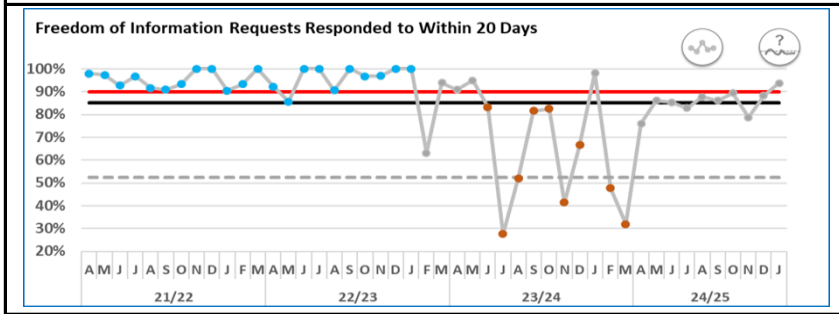
Review Date: Apr 2025 ***Action Lead:*** Robin Tall



'Percentage of responses to written complaints acknowledged within 3 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 88.9%.

The team has worked hard to improve processes and focus, including better vigilance of when deadlines may be missed and improved collaborative working with divisions. The team need to maintain this through consistent application of process, including improved escalations to ensure targets are met on an on-going basis.

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



'Freedom of Information Requests Responded to Within 20 Days' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 93.8%.

Process improvements have been made and FOI response performance has improved but not consistently. The following further measures are in place to ensure that performance is consistent:
1) Continue working to update our Freedom of Information dashboard to capture when the Standard Operating Procedure is not being followed and address these areas. This will support managers in meeting deadlines.
2) Continue to work with communication teams to get the disclosure log active to improve efficiency in responding to requests.

Review Date: Apr 2025 ***Action Lead:*** Jonathan McKee

Metric Under Review

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

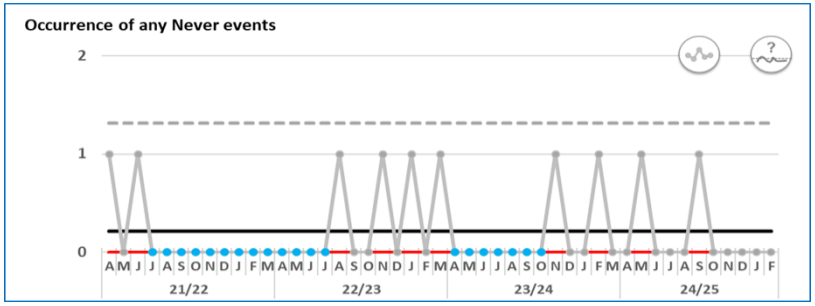
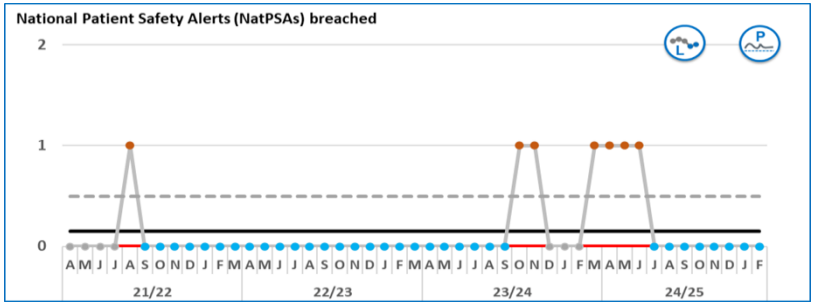
SAR data has been temporarily suspended whilst the operations team re-draft the processes across the Trust to ensure that all sites and teams are reporting accurately; IG support is being provided. When complete, the Trust will be able report on the outturn against the revised process. The Deputy COO has taken on responsibility for Trust-level reporting.

Review Date: Apr 2025 ***Action Lead:*** Jonathan McKee

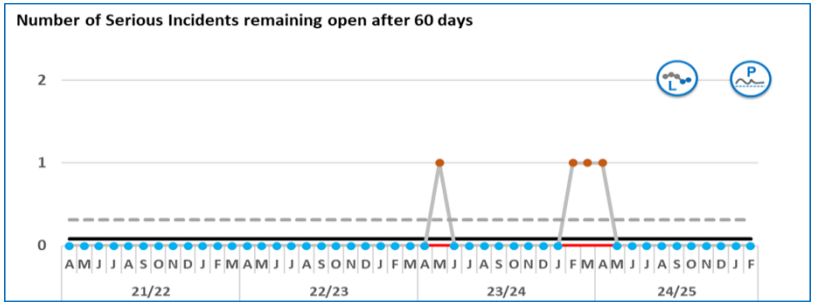
Deliver (Incident Reporting) - Summary

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	2	0		?
Summary Hospital Mortality Indicator	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
National Patient Safety Alerts (NatPSAs) breached	Sheila Adam	NHS Oversight Framework	Monthly	Zero Alerts	n/a	0	L	P
Number of Serious Incidents remaining open after 60 days	Sheila Adam	Statutory Reporting	Monthly	Zero Cases	1	0	L	P
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Sheila Adam	Internal Requirement	Monthly	No Target Set	n/a	284		

Deliver (Incident Reporting) - Graphs (1)

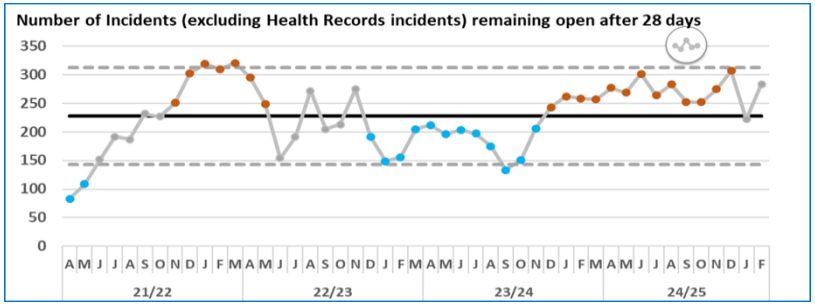
	**'Occurrence of any Never events ' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.**
No Graph Generated, No cases reported since February 2017	**'Summary Hospital Mortality Indicator' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**
	**'National Patient Safety Alerts (NatPSAs) breached' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 0.**

Deliver (Incident Reporting) - Graphs (2)



'Number of Serious Incidents remaining Open after 60 days' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 0.

All serious incident investigations have now been completed. Future reports will monitor patient safety incident investigation (PSII) progress.



'Number of Incidents (excluding Health Records incidents) remaining open after 28 days' is showing 'common cause variation'. The figure is currently at 284.

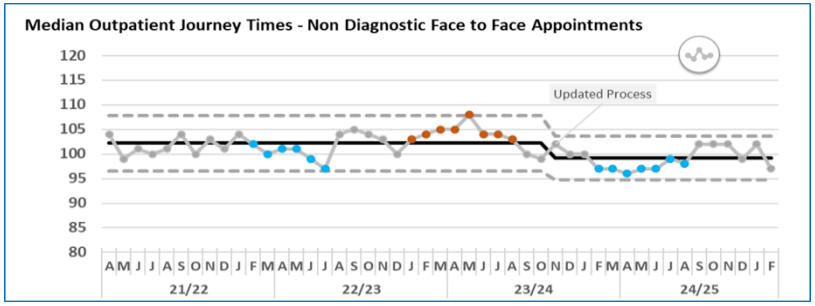
Data from the first week of March shows that the reported figure has since reduced to 250. Special cause concern is shown for the City Road data and the data for the 'others' collective, which includes all areas which are not part of a clinical divisions. For the latter, effective and sustainable strategies to consistently reduce the number of >28 days incidents continue to be explored. This will continue to be closely monitored.

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

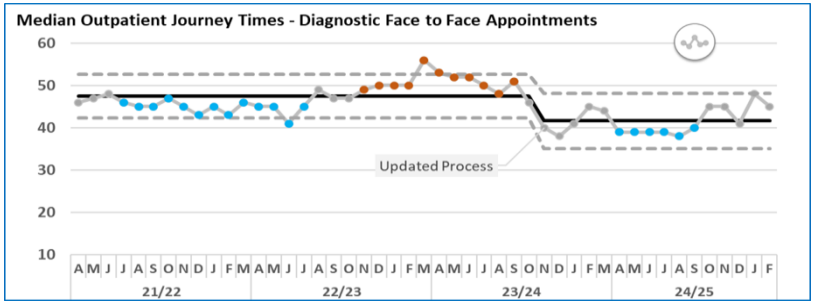
Sustainability and at Scale - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	97		
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jon Spencer	Internal Requirement	Monthly	No Target Set	n/a	45		
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%	0.83%	0.75%		
Number of non-medical cancelled operations not treated within 28 days	Jon Spencer	Statutory Reporting	Monthly	Zero Breaches	9	3		
Overall financial performance (In Month Var. £m)	Justin Betts	Internal Requirement	Monthly	≥0	1.26	1.91		
Commercial Trading Unit Position (In Month Var. £m)	Justin Betts	Internal Requirement	Monthly	≥0	-1.16	-0.14		

Sustainability and at Scale - Graphs (1)

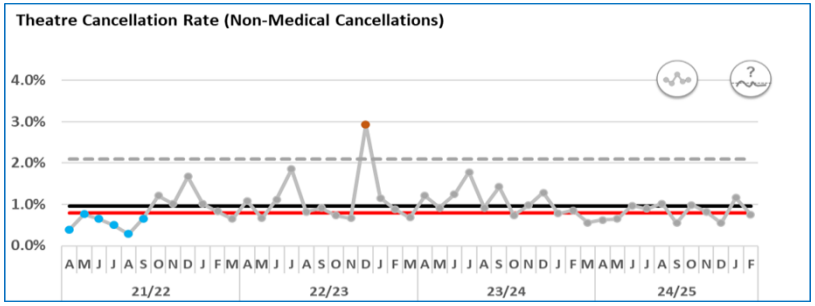


'Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments' is showing 'common cause variation'. The figure is currently at 97.

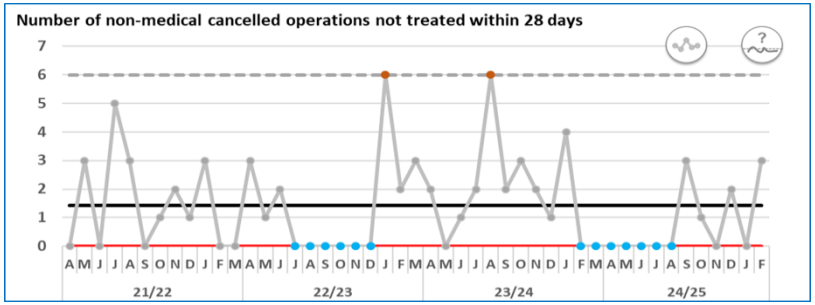


'Median Outpatient Journey Times - Diagnostic Face to Face Appointments' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 45.

Sustainability and at Scale - Graphs (2)

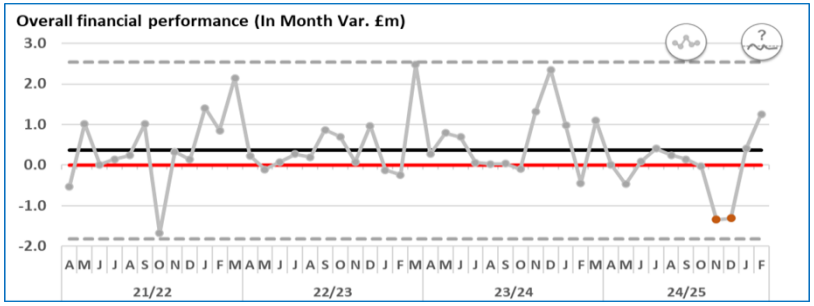


'Theatre Cancellation Rate (Non-Medical Cancellations)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.75%.



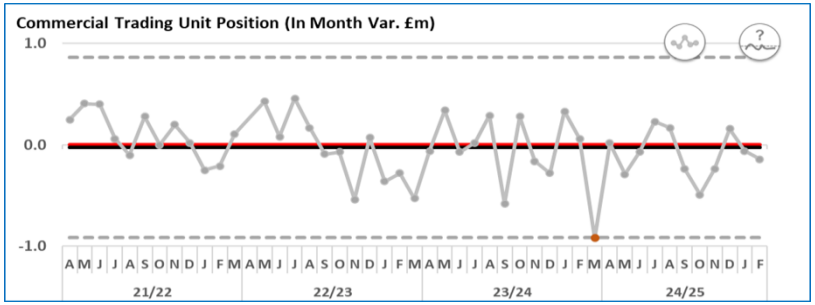
'Number of non-medical cancelled operations not treated within 28 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 3.

Sustainability and at Scale - Graphs (3)



'Overall financial performance (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 1.91.

For further commentary see Finance Report



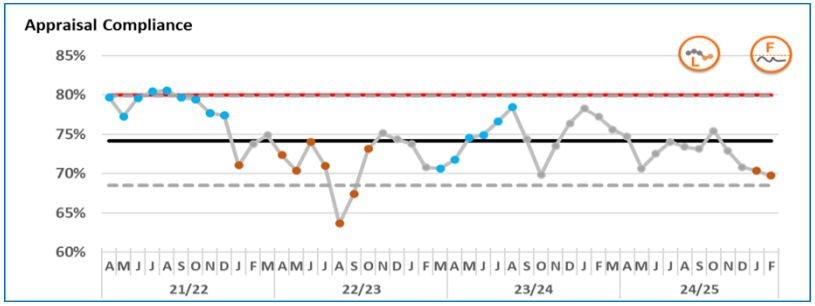
'Commercial Trading Unit Position (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at -0.14.

For further commentary see Finance Report

Working Together - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Appraisal Compliance	Sue Steen	Statutory Reporting	Monthly	≥80%	n/a	69.7%		
Basic Mandatory IG Training	Samuel Armstrong	Internal Requirement	Monthly	≥90%	n/a	89.6%		
Staff Sickness (Month Figure)	Sue Steen	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	5.4%		
Staff Sickness (Rolling Annual Figure)	Sue Steen	23/24 Planning Guidance	Monthly (Month in Arrears)	≤4%	n/a	4.7%		
Recruitment Time To Hire (Days)	Sue Steen	Internal Requirement	Monthly	≤ 40 Days	n/a	40		
Proportion of Temporary Staff	Sue Steen	23/24 Planning Guidance	Monthly	No Target Set	12.20%	9.20%		

Working Together - Graphs (1)



'Appraisal Compliance' is showing 'special cause concern' and that the current process is unlikely to achieve the target - This is a change from the previous month. The figure is currently at 69.7%.

The Appraisal compliance is at 69.7%. The last two months show lower than expected performance. The reducing compliance rates from 70.3% to 69.7% reflects the planned transition to the new appraisal process, using PERFORM, commencing in April.

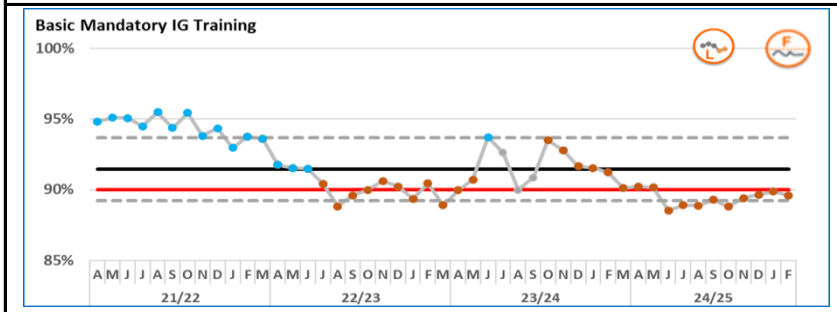
The upgraded online appraisal system (PERFORM) is on track to go live on 1 April.

Workshops are currently being held for managers to support the transition in April. As part of the workshops managers are being informed on how to;

- To support the change over from paper to digital completions, as well as creating a 4-month activity window
- Convert current appraisal activity and dates into the new window, so as not to duplicate previous effort or loose valuable conversations for objectives and development plans already in place.

Work continues on the data cleansing ahead of the 1 April switch-over, to ensure that all staff have the required access to the new online PERFORM system. This will also improve the recording of completions and providing assurance for appraisal reporting.

Review Date: Apr 2025 ***Action Lead:*** Jan Lonsdale

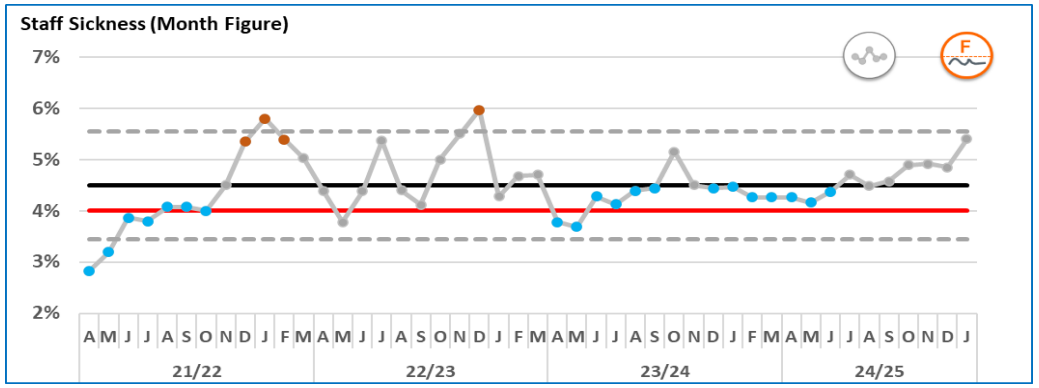


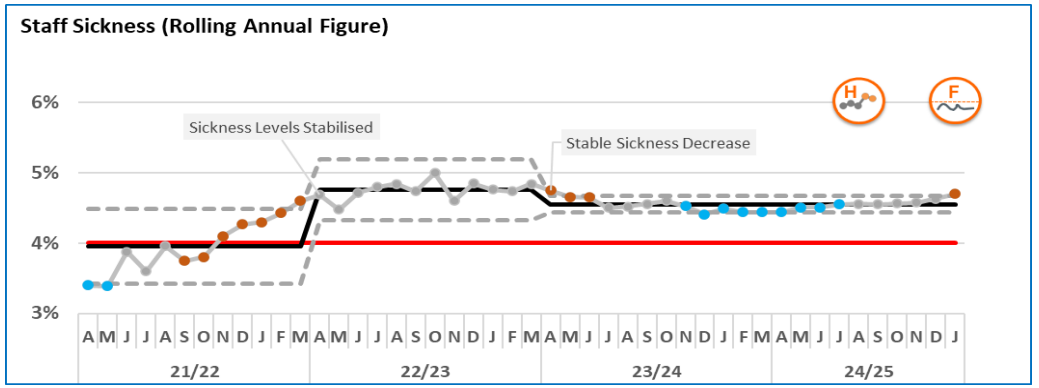
'Basic Mandatory IG Training' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 89.6%.

Monthly performance has fallen just below the 90% target but is consistently very close and the monthly trend is stable performance. This metric has been escalated to Management Executive and is being taken to SMT on a monthly basis to support managers identifying specific hot spots and put in place their remediation plans. Data quality issues have been re-raised with L&D and this is work in progress.

Review Date: Apr 2025 ***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 - This is a change from the previous month. The figure is currently at 5.4%.	**'Staff Sickness (Rolling Annual Figure)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 4.7%.**

The top 3 reasons for sickness absences continues to be:

1. Cold, Cough, Flu – Influenza
2. Anxiety/stress/depression/other psychiatric illness
3. Musculoskeletal problems.

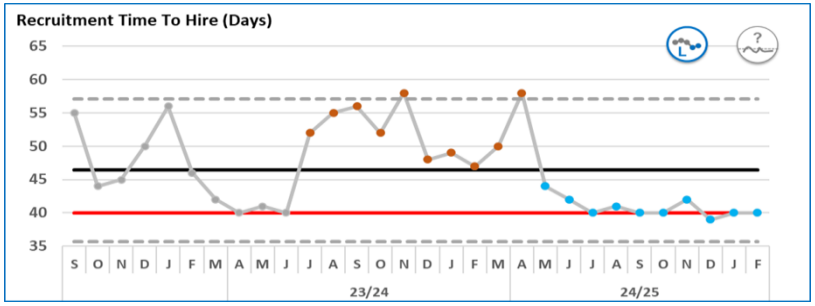
It should be noted Cold, Cough, Flu – Influenza is the top reason for absences. This can be attributed to the time of the year where colds, coughs and flu are prevalent.

Work continues in providing targeted:

- Sickness absence training to hotspot areas with focus on early intervention, policy adherence and on clarity roles and responsibilities of managers.
- Targeted coaching to managers in relation to the management of complex long term sickness absence cases
- Promotion of Thrive, Moorfields (Wellbeing Programme) with focus on stress management and Pilates workshops that are aligned to top reasons for absence.

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

Working Together - Graphs (3)



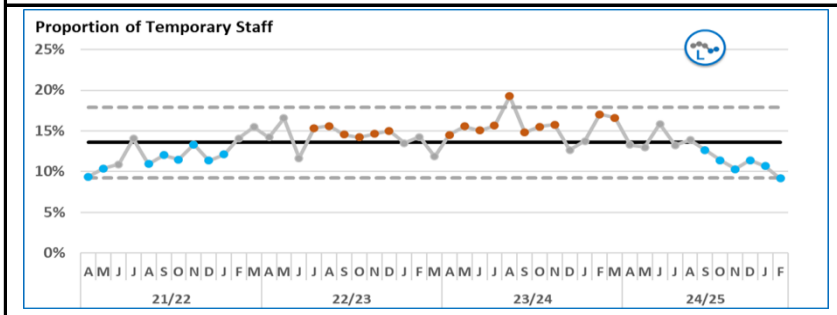
'Recruitment Time to Hire (Days)' is showing 'special cause improvement' and that the current process is not consistently achieving the target. The figure is currently at 40.

The time to hire (TTH) performance for February is 41 days, which is one days over the Trust target.

Sustaining and improving the time to hire target continues with the Recruitment team supporting and advising managers, especially in hotspot areas with focus on “time taken to shortlist” and “update interview outcomes” on the recruitment system, Trac.

Improving the employee experience at the on-boarding stage are currently being explored, like the possibilities of digitalisation of the employee id checks.

Review Date: Apr 2025 ***Action Lead:*** Jenny Donald



'Proportion of Temporary Staff ' is showing 'special cause improvement' (decreasing rate). The figure is currently at 9.2%.

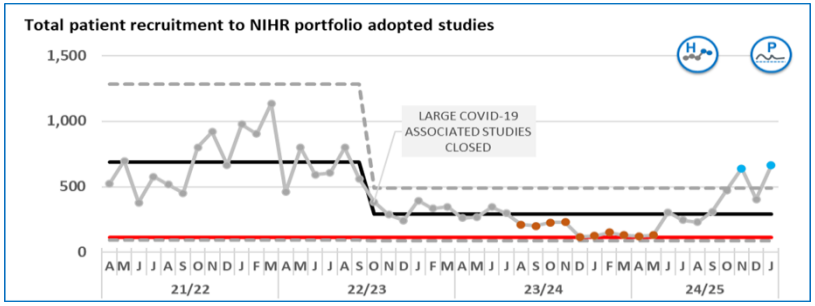
- Agency spends continues in a downward trajectory, with January spend at £300,000. This is a reduction of £18,000 against December 2024 and £273,000 less than the same period in January 2024.
- Year to date the Trust has spent £3,064,000 less than the same period in 24/25 and is outperforming its NCL agency reduction target by £1,829,810. The Trust currently has the largest percentage reduction within NCL.
- The utilisation of bank has grown over the last 12 months to support he Trust’s approach of reducing agency reduction, through the converting of agency to bank utilisation.
- The top three reasons for temporary staffing utilisation and spend continues to be additional shifts, vacancy, and long-term sickness. The temporary staffing team and our supplier, Bank Partners, continue to work with hiring managers reducing utilisation and spend.

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

Discover - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Total patient recruitment to NIHR portfolio adopted studies	Hilary Fanning	Internal Requirement	Monthly (Month in Arrears)	≥115 (per month)	3532	663	H	P
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Hilary Fanning	Internal Requirement	Monthly (Month in Arrears)	No Target Set	5024	712	H	
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Hilary Fanning	Internal Requirement	Monthly (Month in Arrears)	≥44	n/a	61	H	P
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Hilary Fanning	Internal Requirement	Monthly (Month in Arrears)	≥2%	n/a	3.6%	L	P

Discover - Graphs (1)



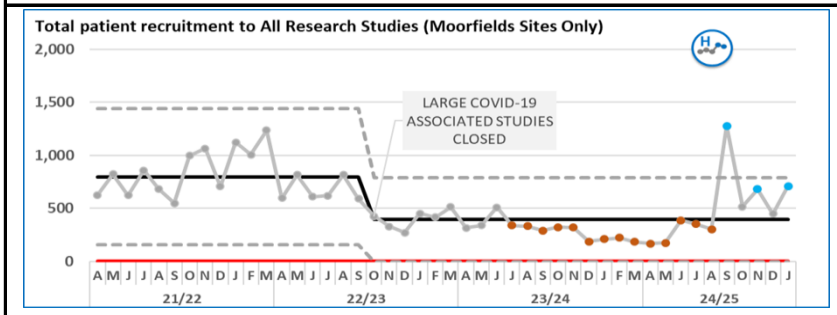
'Total patient recruitment to NIHR portfolio adopted studies' is showing 'special cause improvement' and that the current process will consistently pass the target - This is a change from the previous month. The figure is currently at 663.

The majority of Moorfield's studies are NIHR Portfolio adopted. The percentage split for currently active studies is 82% NIHR portfolio and 18% non- NIHR portfolio. Total recruitment to NIHR portfolio adopted studies this financial year is 3673, an increase of over 1000 compared to the same period last year, so we continue to maintain an upward trajectory of recruitment.

To maintain these recruitment levels, it is important that we continue to attract more grants and awards.
Moorfields Discovery were recently awarded £310,884 from Moorfields Eye Charity (MEC) to support the development of a Grant Application Support Service for Ophthalmology research (GASSO). GASSO will include experts that together can provide all-round support and training to early career researchers in Ophthalmology begin or grow their research careers, and increase the number of investigator-led studies and development awards. The funding from MEC is to fully support a trial methodologist and part fund a Director of Clinical Trials and Statistics for 2 years.

We were also successful in an investigator-initiated trial funded by Alcon. The award of £76,853 to Gus Gazzard will allow the exploration of Direct Selective Laser Trabeculoplasty (DSLT) as a treatment option to reduce intraocular pressure (IOP) in eyes with Ocular hypertension. This treatment option is intended to be less damaging and more comfortable than the currently used SLT. The trial will recruit 50 patients and will investigate over 12 months IOP reduction compared to baseline (when patients were recruited onto the trial).

Review Date: Apr 2025 ***Action Lead:*** Hilary Fanning



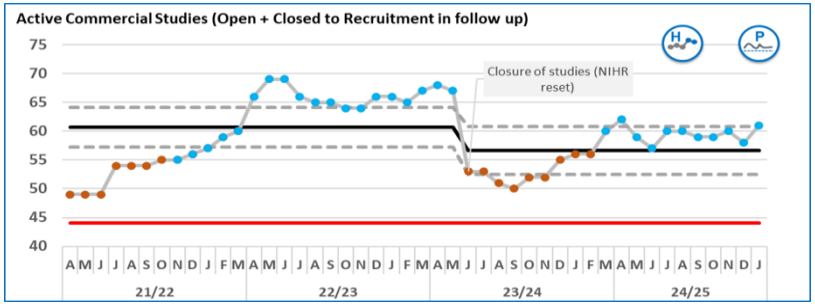
'Total patient recruitment to All Research studies (Moorfields Sites Only)' is showing 'special cause improvement' (increasing rate) - This is a change from the previous month. The figure is currently at 712.

The total patient recruitment in January 2025 across both NIHR portfolio and non NIHR portfolio studies was 712 recruits. This metric includes commercial and non-commercial studies. Our commercial study recruitment varies from month to month, with January having a lower figure of 3 recruits, which is 1% of the monthly total. Recruitment to non-NIHR portfolio studies was to 49 in January (7%), which is a drop compared to the average monthly recruitment of 63 from August to December. The recent decline in recruitment for non-portfolio recruitment studies has been caused by the closing of The NIHR Bioresource Tissue Bank study.

The new questionnaire based study (SIBA) looks to evaluate patient experience and attendance rates in Digital Eye Clinics in London funded by Health Systems Partner, Roche, Ltd., has a target of 1568. This study opened in December 2024 and has already recruited almost a third of its target with 572 recruits to date.

Review Date: Apr 2025 ***Action Lead:*** Hilary Fanning

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 61.

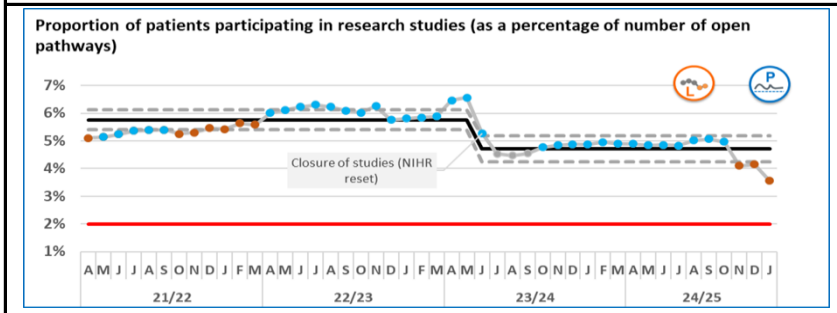
There are currently 61 commercial studies recruiting and in follow up . This is higher than in 2023/24 when we were averaging 55. Our medium-term goal is to increase the percentage of patients recruited to commercial studies, to the NIHR recommended level of 25% of all patient's recruited going into commercial studies. For this financial year our % of recruitment into commercial studies stands at 5%.

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 25 hosted studies in "set up" should ensure that we continue to increase recruitment to commercial studies. 8 out of 11 (73%) of commercial studies recruited fully within the target time. This has increased from 65% of studies in June 2023 but is lower than recent months.

Set-up times for commercial and non-commercial studies continue to improve, some anomalies are still present, mainly due to the complexity of contracting for certain types of studies, which can delay things. The median set-up time for clinical trials has decreased to 85 days in December, compared to 99 days at the end of December 2024. We are actively looking for new innovative methods of shortening the set up time to ensure that studies start recruiting as soon they open.

Our recently opened commercial ocular oncology study has recruited its first patient. The target was one patient, however, we have agreed with the sponsor to continue recruiting. 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.
Interventional Uveitis studies in rare diseases are notoriously difficult to recruit to, and frequently have an intensive treatment and assessment regime. We are pleased to report that the SANDCAT study, a global multi centre study investigating the use of a new monoclonal antibody in the treatment of intra-ocular inflammation, has exceeded its recruitment target.

Review Date: Apr 2025 ***Action Lead:*** Hilary Fanning



'Proportion of patients participating in research studies (as a percentage of number of open pathways)' is showing 'special cause concern' however the current process will consistently pass the target. The figure is currently at 3.6%.

The conclusion of two recent studies, one large non-commercial study, Hercules and one large genetics study, the NIHR Bioresource Tissue Bank, have impacted the number of patients currently participating in research. We continue to exceed the 2.0% target . We continue to place emphasis on and investment in patient and public involvement and engagement (PPIE), delivered through the work of our NIHR Biomedical Research Centre (BRC) and Clinical Research Facility (CRF). Our Equity, Diversity, and Inclusion strategy for both the BRC and CRF seeks to increase the diversity of our patients recruited to clinical trials, as well as provide increased opportunities for patients to contribute to research.

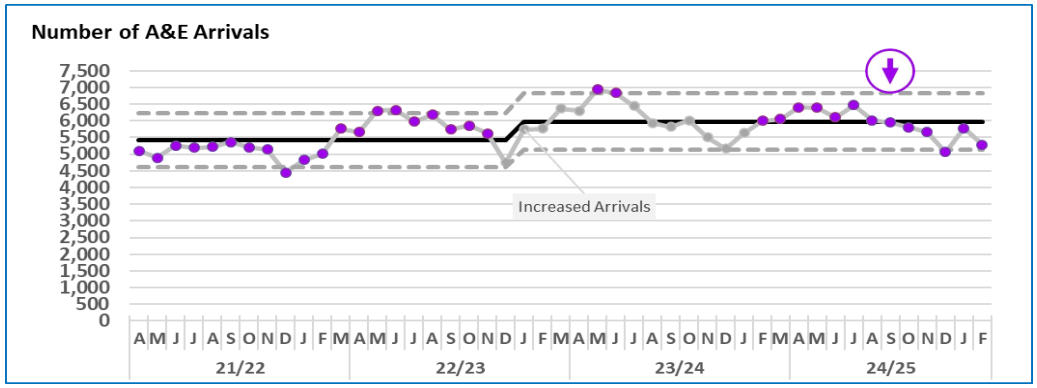
We have redesigned and developed the Research Opportunities at Moorfields (ROAM) platform, which has now launched. This will continue to help raise awareness of the research opportunities available to Moorfields and non-Moorfields patients, and thus attract more patients to research studies.

Review Date: Apr 2025 ***Action Lead:*** Hilary Fanning

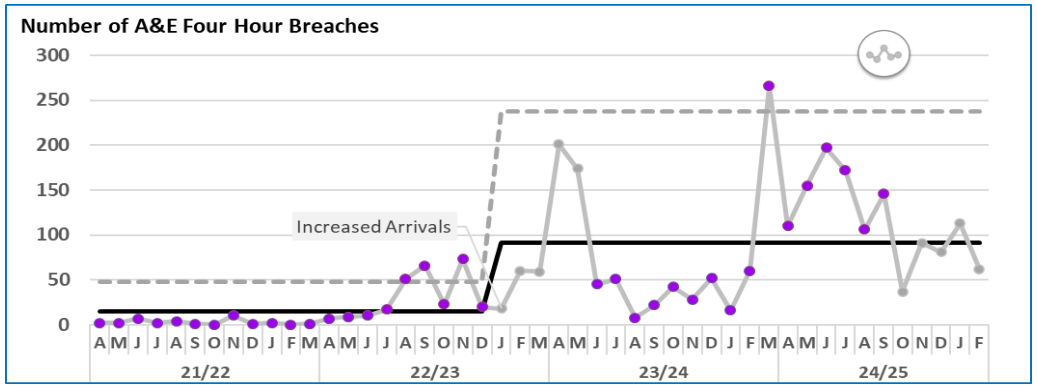
Context (Activity) - Summary

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	64927	5285		
Number of A&E Four Hour Breaches	Jon Spencer	Internal Requirement	Monthly	No Target Set	1270	62		
Number of Outpatient Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	615021	52171		
Number of Outpatient First Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	142803	12554		
Number of Outpatient Follow Up Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	472218	39617		
Number of Referrals Received	Jon Spencer	Internal Requirement	Monthly	No Target Set	178879	14467		
Number of Theatre Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	36914	3090		
Number of Theatre Elective Daycase Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	33757	2822		
Number of Theatre Elective Inpatient Admission	Jon Spencer	Internal Requirement	Monthly	No Target Set	791	81		
Number of Theatre Emergency Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	2366	187		

Context (Activity) - Graphs (1)

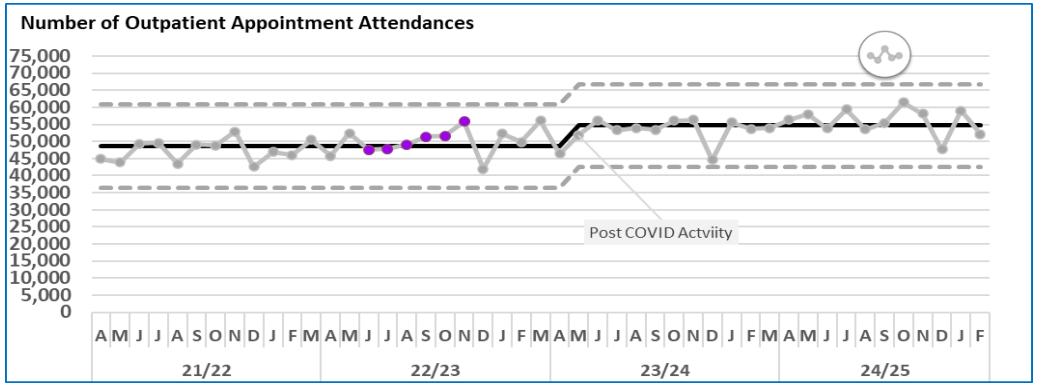


'Number of A&E Arrivals' is showing an 'special cause variation' (decreasing rate) - This is a change from the previous month. The figure is currently at 5,285.

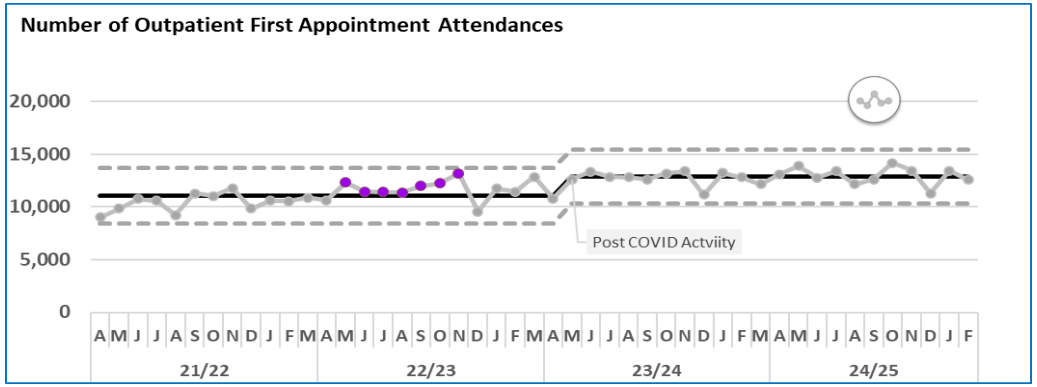


'Number of A&E Four Hour Breaches' is showing 'common cause variation'. The figure is currently at 62.

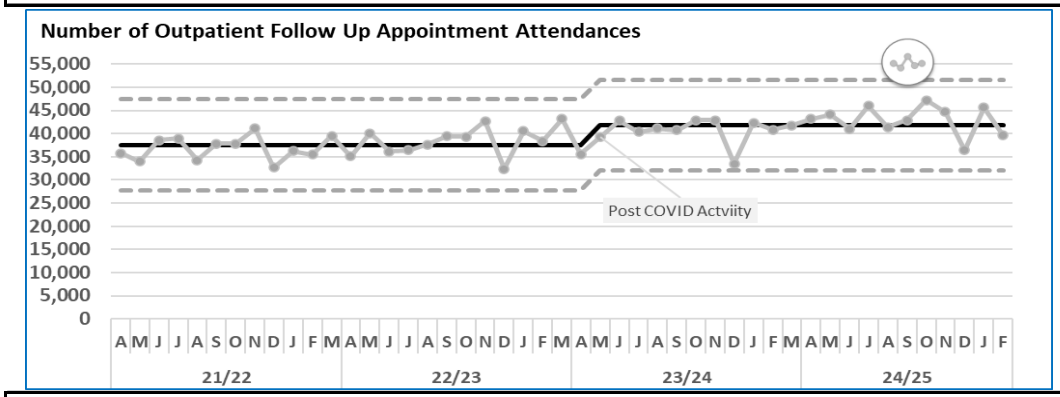
Context (Activity) - Graphs (2)



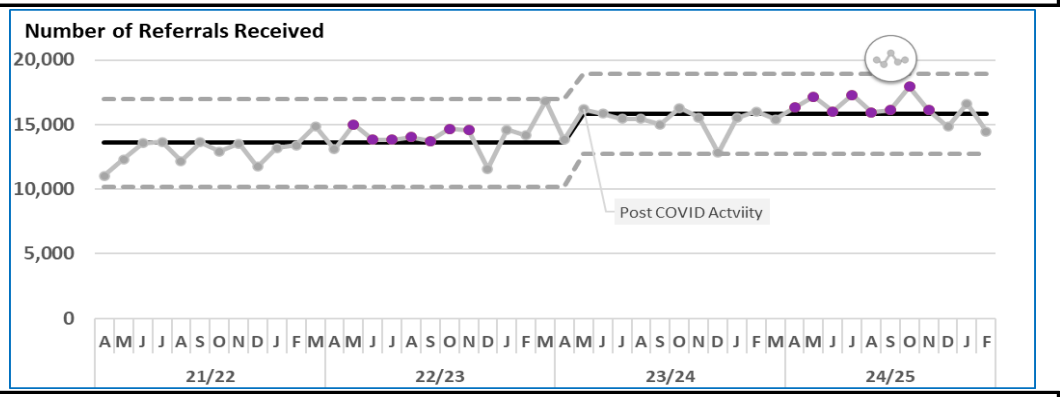
'Number of Outpatient Appointment Attendances' is showing 'common cause variation'. The figure is currently at 52,171.



'Number of Outpatient First Appointment Attendances' is showing 'common cause variation'. The figure is currently at 12,554.

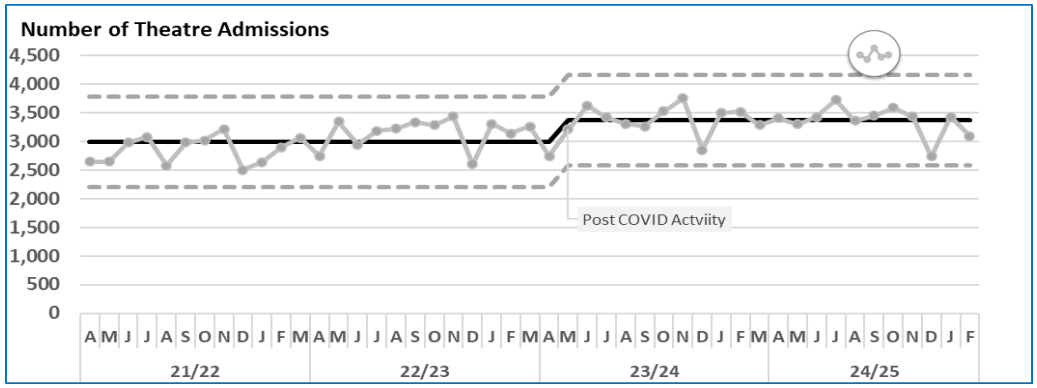


'Number of Outpatient Follow Up Appointment Attendances' is showing 'common cause variation'. The figure is currently at 39,617.

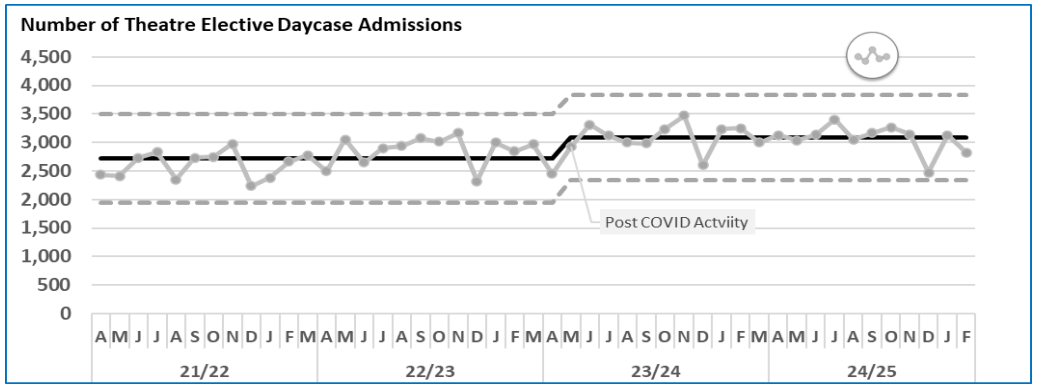


'Number of Referrals Received' is showing 'common cause variation'. The figure is currently at 14,467.

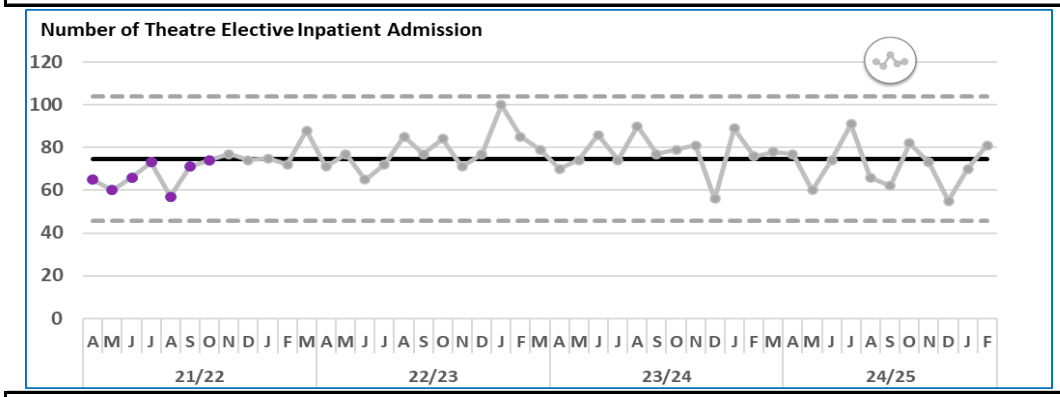
Context (Activity) - Graphs (3)



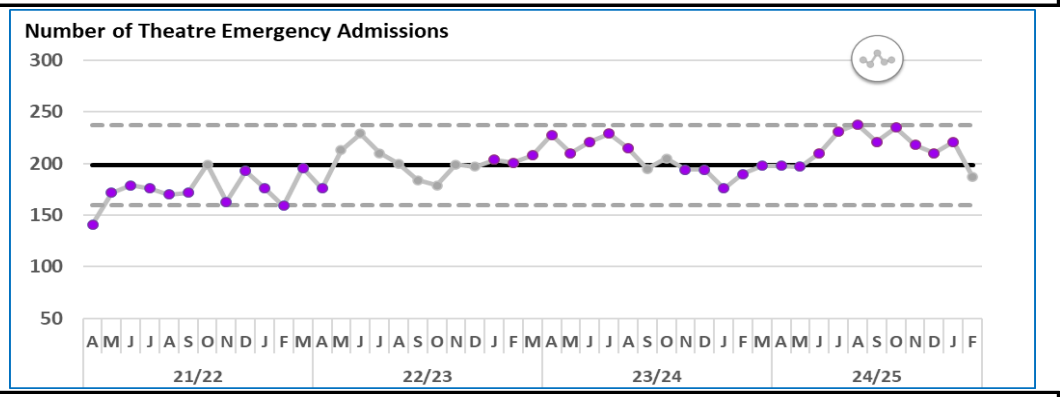
'Number of Theatre Admissions' is showing 'common cause variation'. The figure is currently at 3,090.



'Number of Theatre Elective Daycase Admissions' is showing 'common cause variation'. The figure is currently at 2,822.



'Number of Theatre Elective Inpatient Admission' is showing 'common cause variation'. The figure is currently at 81.



'Number of Theatre Emergency Admissions' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 187.

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Deliver (Activity vs Plan)																						
Elective Activity - % of Phased Plan	Feb-25	89.9%	≥100%	Monthly	Common Cause	Failing	93.3%	75.6%	110.9%	91.7%	94.2%	98.2%	95.2%	103.6%	95.3%	93.6%	96.7%	90.6%	95.3%	78.6%	90.6%	89.9%
Total Outpatient Activity - % of Phased Plan	Feb-25	102.8%	≥100%	Monthly	Common Cause	Hit or Miss	102.0%	88.4%	115.6%	98.4%	109.2%	105.9%	108.8%	106.1%	102.0%	100.5%	104.3%	105.0%	109.3%	94.2%	105.9%	102.8%
Outpatient First Appointment Activity - % of Phased Plan	Feb-25	107.9%	≥100%	Monthly	Common Cause	Hit or Miss	104.2%	89.9%	118.6%	97.8%	102.4%	108.2%	115.1%	111.0%	100.8%	99.8%	103.7%	106.4%	110.5%	97.3%	105.4%	107.9%
Outpatient Follow Up Appointment Activity - % of Phased Plan	Feb-25	101.4%	≥85%	Monthly	Common Cause	Capable	102.7%	87.7%	117.8%	98.6%	111.2%	105.3%	107.1%	104.8%	102.3%	100.7%	104.5%	104.7%	108.9%	93.4%	106.0%	101.4%
Deliver (Cancer Performance)																						
Cancer 28 Day Faster Diagnosis Standard	Feb-25	75.0%	≥75%	Monthly	Common Cause	Hit or Miss	79.9%	20.6%	139.3%	n/a	50.0%	100.0%	80.0%	100.0%	75.0%	88.9%	77.8%	55.6%	100.0%	80.0%	75.0%	75.0%
% Patients with all cancers receiving treatment within 31 days of decision to treat	Feb-25	83.3%	≥96%	Monthly	Concern (Lower Than Expected)	Hit or Miss	99.0%	94.8%	103.1%	100.0%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	83.3%
% Patients with all cancers treated within 62 days	Feb-25	93.3%	≥85%	Monthly	Common Cause	Capable	96.5%	73.3%	119.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.5%	96.7%	94.1%	100.0%	93.3%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Deliver (Access Performance)																						
18 Week RTT Incomplete Performance	Feb-25	82.5%	No Target Set	Monthly	Common Cause	Not Applicable	82.7%	81.0%	84.4%	82.9%	83.3%	85.0%	85.4%	84.3%	84.0%	82.6%	82.7%	82.4%	82.6%	81.2%	80.9%	82.5%
RTT Incomplete Pathways (RTT Waiting List)	Feb-25	33,406	≤ Previous Mth.	Monthly	Improvement (Lower Than Expected)	Not Applicable	34,559	32,858	36,260	35,233	35,656	35,674	35,682	34,201	33,017	34,357	34,932	33,872	33,281	33,039	32,691	33,406
RTT Incomplete Pathways Over 18 Weeks	Feb-25	5,849	≤ Previous Mth.	Monthly	Common Cause	Not Applicable	6,077	5,481	6,673	6,012	5,962	5,361	5,205	5,377	5,271	5,966	6,038	5,963	5,801	6,222	6,229	5,849
52 Week RTT Incomplete Breaches	Feb-25	12	≤5 Breaches	Monthly	Common Cause	Failing	10	-4	24	5	10	5	10	7	8	10	8	13	9	9	9	12
Eliminate waits over 65 weeks for elective care	Feb-25	3	Zero Breaches	Monthly	Improvement (Run Below Average)	Hit or Miss	3	-4	10	3	1	1	4	3	2	4	2	2	2	0	2	3
A&E Four Hour Performance	Feb-25	98.8%	≥95%	Monthly	Common Cause	Capable	97.7%	95.1%	100.4%	98.9%	95.3%	98.2%	97.4%	96.6%	97.2%	98.1%	97.4%	99.3%	98.3%	98.3%	97.9%	98.8%
Percentage of Diagnostic waiting times less than 6 weeks	Feb-25	98.4%	≥99%	Monthly	Common Cause	Hit or Miss	99.3%	96.9%	101.6%	99.4%	98.3%	100.0%	99.5%	98.3%	98.3%	99.1%	100.0%	100.0%	99.5%	97.8%	97.7%	98.4%
Deliver (Call Centre and Clinical)																						
Average Call Waiting Time	Feb-25	199	≤ 2 Mins (120 Sec)	Monthly	Common Cause	Hit or Miss	141	28	255	163	249	236	197	276	146	174	139	112	109	32	77	199
Average Call Abandonment Rate	Feb-25	13.3%	≤15%	Monthly	Common Cause	Capable	10.2%	2.8%	17.7%	14.7%	19.2%	16.3%	14.0%	18.8%	12.0%	13.2%	10.6%	9.0%	8.5%	2.5%	6.4%	13.3%
Mixed Sex Accommodation Breaches	Feb-25	0	Zero Breaches	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Feb-25	1.85%	≤ 2.67%	Monthly (Rolling 3 Months)	Common Cause	Hit or Miss	1.95%	-3.48%	7.39%	3.28%	1.49%	1.52%	3.23%	0.00%	0.00%	1.47%	5.56%	0.00%	0.00%	9.68%	3.13%	1.85%
VTE Risk Assessment	Feb-25	99.2%	≥95%	Monthly	Common Cause	Capable	99.2%	97.9%	100.4%	99.1%	98.6%	99.8%	99.9%	99.9%	100.0%	99.7%	99.8%	99.8%	99.9%	99.0%	98.6%	99.2%
Posterior Capsular Rupture rates (Cataract Operations Only)	Feb-25	0.87%	≤1.95%	Monthly	Common Cause	Capable	0.87%	0.15%	1.59%	0.54%	0.62%	0.57%	0.82%	0.69%	1.36%	0.76%	0.85%	1.42%	0.92%	1.00%	0.80%	0.87%
MRSA Bacteraemias Cases	Feb-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile Cases	Feb-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Feb-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA Rate - cases	Feb-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Deliver (Quality and Safety)																						
Inpatient Scores from Friends and Family Test - % positive	Feb-25	97.4%	≥90%	Monthly	Common Cause	Capable	95.7%	93.6%	97.7%	96.0%	96.5%	95.7%	96.5%	96.7%	97.3%	96.1%	96.2%	96.8%	95.9%	95.0%	95.0%	97.4%
A&E Scores from Friends and Family Test - % positive	Feb-25	94.4%	≥90%	Monthly	Improvement (Run Above Average)	Capable	92.9%	90.6%	95.2%	93.4%	93.6%	91.5%	93.2%	92.5%	92.7%	94.0%	93.7%	93.4%	93.9%	94.7%	94.7%	94.4%
Outpatient Scores from Friends and Family Test - % positive	Feb-25	95.5%	≥90%	Monthly	Improvement (Higher Than Expected)	Capable	93.7%	92.7%	94.7%	93.6%	93.7%	94.2%	94.5%	94.5%	94.4%	94.4%	94.2%	95.4%	95.0%	94.9%	94.9%	95.5%
Paediatric Scores from Friends and Family Test - % positive	Feb-25	95.0%	≥90%	Monthly	Common Cause	Capable	94.5%	90.7%	98.3%	93.2%	94.6%	95.2%	96.8%	93.6%	94.8%	95.8%	94.4%	93.2%	94.6%	96.3%	96.3%	95.0%
Percentage of responses to written complaints sent within 25 days	Jan-25	33.3%	≥80%	Monthly (Month in Arrears)	Concern (Lower Than Expected)	Hit or Miss	82.2%	41.3%	123.0%	91.7%	100.0%	75.0%	90.9%	83.3%	71.4%	90.9%	50.0%	69.2%	83.3%	90.0%	33.3%	n/a
Percentage of responses to written complaints acknowledged within 3 days	Feb-25	88.9%	≥80%	Monthly	Common Cause	Hit or Miss	93.5%	72.1%	114.9%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%	50.0%	84.6%	100.0%	90.0%	83.3%	88.9%
Freedom of Information Requests Responded to Within 20 Days	Jan-25	93.8%	≥90%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	85.2%	52.6%	117.7%	47.7%	32.0%	76.1%	86.0%	85.4%	82.8%	87.8%	86.1%	89.4%	78.7%	88.2%	93.8%	n/a
Subject Access Requests (SARs) Responded To Within 28 Days	Jan-25	n/a	≥90%	Monthly (Month in Arrears)	Not Available	Not Applicable	96.0%	86.1%	105.9%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Deliver (Incident Reporting)																						
Occurrence of any Never events	Feb-25	0	Zero Events	Monthly	Common Cause	Hit or Miss	0	-1	1	1	0	0	1	0	0	0	1	0	0	0	0	0
Summary Hospital Mortality Indicator	Feb-25	0	Zero Cases	Monthly	Common Cause	Capable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
National Patient Safety Alerts (NatPSAs) breached	Feb-25	0	Zero Alerts	Monthly	Improvement (Run Below Average)	Capable	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0
Number of Serious Incidents remaining open after 60 days	Feb-25	0	Zero Cases	Monthly	Improvement (Run Below Average)	Capable	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Feb-25	284	No Target Set	Monthly	Common Cause	Not Applicable	228	143	313	259	257	277	269	302	264	283	253	252	275	307	222	284

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Sustainability and at Scale																						
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Feb-25	97	No Target Set	Monthly	Common Cause	Not Applicable	99	95	104	97	97	96	97	97	99	98	102	102	102	99	102	97
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Feb-25	45	No Target Set	Monthly	Common Cause	Not Applicable	42	35	48	45	44	39	39	39	39	38	40	45	45	41	48	45
Theatre Cancellation Rate (Non-Medical Cancellations)	Feb-25	0.75%	≤0.8%	Monthly	Common Cause	Hit or Miss	0.95%	-0.19%	2.09%	0.86%	0.56%	0.62%	0.65%	0.97%	0.90%	1.02%	0.55%	0.99%	0.82%	0.55%	1.16%	0.75%
Number of non-medical cancelled operations not treated within 28 days	Feb-25	3	Zero Breaches	Monthly	Common Cause	Hit or Miss	1	-3	6	0	0	0	0	0	0	0	3	1	0	2	0	3
Overall financial performance (In Month Var. £m)	Feb-25	1.91	≥0	Monthly	Common Cause	Hit or Miss	0.36	-1.82	2.55	-0.44	1.10	0.01	-0.47	0.09	0.41	0.25	0.15	-0.03	-1.34	-1.31	0.41	1.91
Commercial Trading Unit Position (In Month Var. £m)	Feb-25	-0.14	≥0	Monthly	Common Cause	Hit or Miss	-0.03	-0.91	0.86	0.06	-0.92	0.02	-0.29	-0.07	0.23	0.17	-0.24	-0.49	-0.24	0.16	-0.06	-0.14
Working Together																						
Appraisal Compliance	Feb-25	69.7%	≥80%	Monthly	Concern (Lower Than Expected)	Failing	74.2%	68.5%	79.9%	77.2%	75.6%	74.7%	70.6%	72.5%	74.1%	73.4%	73.1%	75.5%	72.9%	70.8%	70.3%	69.7%
Basic Mandatory IG Training	Feb-25	89.6%	≥90%	Monthly	Concern (Run Below Average)	Failing	91.5%	89.2%	93.7%	91.2%	90.1%	90.2%	90.1%	88.5%	88.9%	88.9%	89.3%	88.8%	89.4%	89.6%	89.9%	89.6%
Staff Sickness (Month Figure)	Jan-25	5.4%	≤4%	Monthly (Month in Arrears)	Common Cause	Failing	4.5%	3.5%	5.5%	4.3%	4.3%	4.3%	4.2%	4.4%	4.7%	4.5%	4.6%	4.9%	4.9%	4.8%	5.4%	n/a
Staff Sickness (Rolling Annual Figure)	Jan-25	4.7%	≤4%	Monthly (Month in Arrears)	Concern (Higher Than Expected)	Failing	4.6%	4.4%	4.7%	4.4%	4.4%	4.4%	4.5%	4.5%	4.5%	4.6%	4.5%	4.6%	4.6%	4.6%	4.7%	n/a
Recruitment Time To Hire (Days)	Feb-25	40	≤ 40 Days	Monthly	Improvement (Run Below Average)	Hit or Miss	46	36	57	47	50	58	44	42	40	41	40	40	42	39	40	40
Proportion of Temporary Staff	Feb-25	9.2%	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	13.6%	9.2%	17.9%	17.1%	16.6%	13.3%	13.0%	15.9%	13.3%	13.9%	12.7%	11.4%	10.3%	11.4%	10.7%	9.2%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Discover																						
Total patient recruitment to NIHR portfolio adopted studies	Jan-25	663	≥115 (per month)	Monthly (Month in Arrears)	Improvement (Higher Than Expected)	Capable	289	87	491	153	132	124	132	306	247	231	310	472	641	406	663	n/a
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Jan-25	712	No Target Set	Monthly (Month in Arrears)	Improvement (Higher Than Expected)	Not Applicable	393	-4	790	224	185	169	174	387	353	304	1,278	516	681	450	712	712
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Jan-25	61	≥44	Monthly (Month in Arrears)	Improvement (Higher Than Expected)	Capable	57	52	61	56	60	62	59	57	60	60	59	59	60	58	61	n/a
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Jan-25	3.6%	≥2%	Monthly (Month in Arrears)	Concern (Lower Than Expected)	Capable	4.7%	4.3%	5.2%	5.0%	4.9%	4.9%	4.8%	4.9%	4.8%	5.0%	5.1%	5.0%	4.1%	4.2%	3.6%	n/a
Context (Activity)																						
Number of A&E Arrivals	Feb-25	5,285	No Target Set	Monthly	Decreasing (Lower Than Expected)	Not Applicable	5,978	5,125	6,832	6,001	6,053	6,401	6,394	6,105	6,469	6,011	5,943	5,807	5,667	5,062	5,783	5,285
Number of A&E Four Hour Breaches	Feb-25	62	No Target Set	Monthly	Common Cause	Not Applicable	91	-55	238	60	266	110	155	197	172	106	146	37	91	81	113	62
Number of Outpatient Appointment Attendances	Feb-25	52,171	No Target Set	Monthly	Common Cause	Not Applicable	54,721	42,614	66,828	53,622	53,957	56,323	57,992	53,777	59,367	53,584	55,497	61,399	58,134	47,728	59,049	52,171
Number of Outpatient First Appointment Attendances	Feb-25	12,554	No Target Set	Monthly	Common Cause	Not Applicable	12,866	10,291	15,442	12,823	12,155	13,102	13,883	12,766	13,400	12,159	12,608	14,191	13,429	11,278	13,433	12,554
Number of Outpatient Follow Up Appointment Attendances	Feb-25	39,617	No Target Set	Monthly	Common Cause	Not Applicable	41,855	32,135	51,575	40,799	41,802	43,221	44,109	41,011	45,967	41,425	42,889	47,208	44,705	36,450	45,616	39,617
Number of Referrals Received	Feb-25	14,467	No Target Set	Monthly	Common Cause	Not Applicable	15,840	12,761	18,918	16,009	15,428	16,316	17,182	16,019	17,290	15,950	16,131	17,956	16,108	14,831	16,629	14,467
Number of Theatre Admissions	Feb-25	3,090	No Target Set	Monthly	Common Cause	Not Applicable	3,370	2,585	4,155	3,518	3,279	3,401	3,294	3,424	3,724	3,357	3,447	3,585	3,433	2,735	3,424	3,090
Number of Theatre Elective Daycase Admissions	Feb-25	2,822	No Target Set	Monthly	Common Cause	Not Applicable	3,087	2,340	3,833	3,252	3,003	3,126	3,037	3,140	3,402	3,053	3,164	3,268	3,142	2,470	3,133	2,822
Number of Theatre Elective Inpatient Admission	Feb-25	81	No Target Set	Monthly	Common Cause	Not Applicable	75	46	104	76	78	77	60	74	91	66	62	82	73	55	70	81
Number of Theatre Emergency Admissions	Feb-25	187	No Target Set	Monthly	Common Cause	Not Applicable	198	159	237	190	198	198	197	210	231	238	221	235	218	210	221	187

Moorfields Eye Hospital NHS Foundation Trust

NHS

Report title	Monthly Finance Performance Report Month 11 – February 2025
Report from	Justin Betts, Acting Chief Financial Officer
Prepared by	Justin Betts, Acting Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

For February, the trust is reporting:-

Financial Performance £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Plan	Actual	Variance
Income	£350.2m	£27.9m	£29.5m	£1.6m	£318.4m	£323.5m	£5.1m
Pay	(£189.4m)	(£16.1m)	(£15.9m)	£0.1m	(£173.5m)	(£173.9m)	(£0.4m)
Non Pay	(£121.6m)	(£10.2m)	(£10.2m)	£0.0m	(£111.4m)	(£115.3m)	(£4.0m)
Financing & Adjustments	(£33.8m)	(£1.6m)	(£1.4m)	£0.1m	(£28.6m)	(£28.0m)	£0.6m
CONTROL TOTAL	**£5.4m**	**£0.1m**	**£2.0m**	**£1.9m**	**£5.0m**	**£6.2m**	**£1.3m**

Income and Expenditure

- A £6.2m surplus year to date compared to a planned surplus of £5.0m; £1.3m favourable to plan.
- The £1.3m favourable variance YTD is comprised of:-
  - £1.53m favourable slippage in IT EPR and IT project workstreams.
  - £0.27m adverse core operational performance.

Capital Expenditure

- Capital expenditure as of 28th February totalled £84.7m.
  - Business as usual capital totals £3.4m.
  - Other capital totals £81.3m with £76.3m of Oriel expenditure, £3.3m EPR expenditure and £1.0m of NIHR research expenditure.
  - IFRS16 lease capital of £0.8m
- Business as usual capital allocations have been fully committed, and forecast.

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

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

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

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

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report

Trust Board Report

For the period ended 28th February 2025 (Month 11)

Report Period	M11 | February 2025
Presented by	Justin Betts| Acting Chief Financial Officer
Written by	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 28th February 2025 (Month 11)

Key Messages

Statement of Comprehensive Income

Financial Position £1.98m deficit in month	For March, the trust is reporting:- • A £1.98m surplus in-month against a planned surplus of £0.07m, a £1.91m favourable variance to plan • A £6.23m surplus cumulatively against a planned surplus of £4.97m, £1.26m favourable to plan.

Key Drivers of the Financial Variance	The £1.26m favourable variance cumulatively is comprised of:-
	• £1.53m favourable slippage in IT EPR and IT project workstreams.
	• (£0.27)m adverse core operational performance
	
	Key Drivers of the adverse core operational performance include:-
	• Clinical divisions and core activity performance including efficiencies under-delivery are reporting £(6.18)m adverse cumulatively.
	  • Elective activity is 89% In March, 93% cumulatively of revised activity plans; reporting £4.1m behind demand plans in terms of volume, offset by £1.8m price mix gains.
	  • Stratford elective activity is 68% of revised demand plans cumulatively.
	  • St Ann's elective activity is 75% of revised demand plans cumulatively.
	  • Cataract activity is 89% of revised demand plans cumulatively.
	  • Outpatients Firsts and Procedures are 99% and 102% respectively cumulatively, partially offsetting underperformance on elective activity.
	• Research is reporting a £(1.28)m 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.
	• Trading areas are £(1.17)m adverse to plan cumulatively across all commercial units.
	• Depreciation & financing, and central budgets are supporting the above position primarily consisting of £1.7m depreciation and financing linked to capital programme slippage and interest on cash balances, and £1.9m non recurrent and prior year benefits.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 28th February was £61.0m, a reduction of £9.7m since the end of March 2024. This equates to approximately 74 days operating cash. The Better Payment Practice Code (BPPC) performance in March was 95% (volume) and 95% (value) against a target of 95% across both metrics.
Capital (both gross capital expenditure and CDEL)	Capital expenditure as of 28th February totalled £84.7m. • Business as usual capital totals £3.4m. • Other capital totals £81.3m with £76.3m of Oriel expenditure, £3.3m EPR expenditure and £1.0m of NIHR research expenditure. • IFRS16 lease capital of £0.8m Business as usual capital allocations have been fully committed, and forecast.

Other Key Information

Efficiencies £11.2m Trust Target £7.1m Forecast £6.9m un-identified and non recurrently identified schemes	The trust has a planned efficiency programme of £11.2m for 2024/25 to deliver the control total. The trust has identified and is forecasting £7.1m, leaving a remaining £4.1m to be identified. Of the total identified:- • £5.9m is identified central schemes • £4.6m is identified as income generation schemes; • £4.3m is forecast recurrently; The CIP programme are working through efficiency scheme delivery for further opportunities to be fully financial validated towards increasing the level of identified and forecast delivery in 2024/25.
Agency Spend £5.49m spend YTD 3.2% total pay	Trust wide agency spend totals £5.49m cumulatively, approximately 3.2% 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	£350.2m	£27.9m	£29.5m	£1.6m	£318.4m	£323.5m	£5.1m	2%	
Pay	(£189.4m)	(£16.1m)	(£15.9m)	£0.1m	(£173.5m)	(£173.9m)	(£0.4m)	(0)%	
Non Pay	(£121.6m)	(£10.2m)	(£10.2m)	£0.0m	(£111.4m)	(£115.3m)	(£4.0m)	(4)%	
Financing & Adjustments	(£33.8m)	(£1.6m)	(£1.4m)	£0.1m	(£28.6m)	(£28.0m)	£0.6m	2%	
CONTROL TOTAL	**£5.4m**	**£0.1m**	**£2.0m**	**£1.9m**	**£5.0m**	**£6.2m**	**£1.3m**		
Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income									
Memorandum Items									
Research & Development	(£0.08m)	£0.05m	£0.07m	£0.02m	(£0.15m)	(£1.29m)	(£1.13m)	(730)%	
Commercial Trading Units	£6.05m	£0.71m	£0.57m	(£0.13m)	£5.41m	£4.25m	(£1.17m)	(22)%	
ORIEL Revenue	(£1.39m)	(£0.18m)	(£0.17m)	£0.01m	(£1.21m)	(£1.49m)	(£0.28m)	(23)%	
Efficiency Schemes	£11.20m	£0.93m	£0.54m	(£0.39m)	£10.27m	£6.54m	(£3.72m)	(36)%	

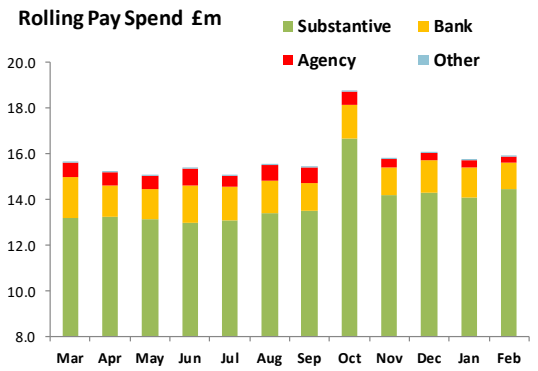
INCOME BREAKDOWN RELATED TO ACTIVITY

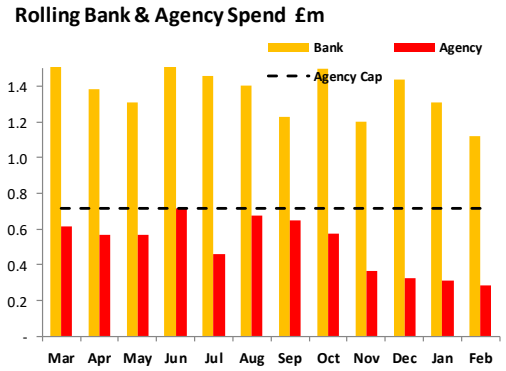
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£209.6m	£192.5m	£194.7m	£2.2m				
Pass Through	£39.7m	£36.4m	£36.5m	£0.1m				
Other NHS Clinical Income	£10.2m	£9.3m	£10.7m	£1.4m				
Commercial Trading Units	£46.7m	£42.6m	£41.4m	(£1.2m)				
Research & Development	£16.5m	£14.7m	£14.7m	(£0.1m)				
Other	£27.5m	£22.9m	£25.5m	£2.7m				
INCOME INCL ERF	**£350.2m**	**£318.4m**	**£323.5m**	**£5.1m**				

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

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	% Total
Employed	(£186.9m)	(£15.8m)	(£14.4m)	£1.4m	(£171.1m)	(£152.8m)	£18.3m	88%
Bank	(£1.6m)	(£0.1m)	(£1.1m)	(£1.0m)	(£1.5m)	(£15.0m)	(£13.5m)	9%
Agency	(£0.4m)	(£0.1m)	(£0.3m)	(£0.2m)	(£0.3m)	(£5.5m)	(£5.2m)	3%
Other	(£0.6m)	(£0.1m)	(£0.1m)	(£0.0m)	(£0.6m)	(£0.6m)	(£0.0m)	0%
TOTAL PAY	**(£189.4m)**	**(£16.1m)**	**(£15.9m)**	**£0.1m**	**(£173.5m)**	**(£173.9m)**	**(£0.4m)**	





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

*Agency cap levels set by NHSIE

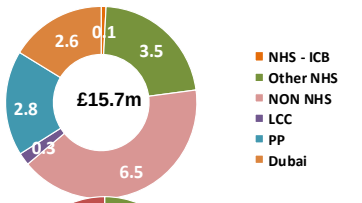
CASH, CAPITAL AND OTHER KPI'S

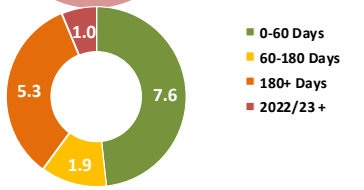
Capital Programme £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£7.4m)	(£7.4m)	(£3.4m)	(£4.0m)				
Donated/Externally funded	(£97.4m)	(£78.6m)	(£76.3m)	(£2.3m)				
TOTAL	**£104.9m**	**£86.0m**	**£79.7m**	**(£6.3m)**				

Key Metrics	Plan	Actual	RAG
Cash	73.8	61.0	
Debtor Days	45	16	
Creditor Days	45	50	
PP Debtor Days	65	43	

Better Payment Practice	Plan	Actual
BPPC - NHS (YTD) by number	95%	91%
BPPC - NHS (YTD) by value	95%	90%
BPPC - Non-NHS (YTD) by number	95%	95%
BPPC - Non-NHS (YTD) by value	95%	95%

Net Receivables/Ageing £m





Trust Income and Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income									
NHS Commissioned Clinical Income	249.34	20.17	20.59	0.42	228.90	231.20	2.29	1%	
Other NHS Clinical Income	10.22	0.89	1.08	0.18	9.33	10.74	1.41	15%	
Commercial Trading Units	46.68	4.12	3.76	(0.36)	42.58	41.36	(1.22)	(3)%	
Research & Development	16.53	1.42	1.82	0.40	14.73	14.67	(0.07)	(0)%	
Other Income	27.48	1.31	2.29	0.98	22.88	25.54	2.66	12%	
Total Income	**350.24**	**27.91**	**29.53**	**1.62**	**318.42**	**323.51**	**5.09**	**2%**	
Operating Expenses									
Pay	(189.45)	(16.05)	(15.91)	0.15	(173.47)	(173.91)	(0.44)	(0)%	
Of which: Unidentifed CIP	*3.07*	*0.28*	*-*	*(0.28)*	*2.79*	*-*	*(2.79)*		
Drugs	(42.53)	(3.42)	(3.55)	(0.14)	(39.01)	(39.75)	(0.74)	(2)%	
Clinical Supplies	(25.22)	(2.02)	(1.81)	0.20	(23.23)	(23.59)	(0.36)	(2)%	
Other Non Pay	(53.90)	(4.79)	(4.84)	(0.05)	(49.13)	(51.99)	(2.86)	(6)%	
Of which: Unidentifed CIP	*0.92*	*0.09*	*-*	*(0.09)*	*0.83*	*-*	*(0.83)*		
Total Operating Expenditure	**(311.09)**	**(26.28)**	**(26.12)**	**0.16**	**(284.84)**	**(289.25)**	**(4.41)**	**(2)%**	
EBITDA	*39.15*	*1.64*	*3.42*	*1.78*	*33.58*	*34.26*	*0.68*	2%	
Financing & Depreciation	(17.92)	(1.58)	(1.45)	0.14	(16.17)	(15.52)	0.64	4%	
Donated assets/impairment adjustments	(15.83)	0.02	0.01	(0.01)	(12.44)	(12.50)	(0.06)	(1)%	
Control Total Surplus/(Deficit) Pre ERF	**5.40**	**0.07**	**1.98**	**1.91**	**4.97**	**6.23**	**1.26**	**25%**	

Commentary

Operating Income

£1.62m favourable to plan in month

Total operating income is reporting £29.53m in-month, £1.62m favourable to plan, and £5.09m favourable cumulatively. Key points of note are:-

- Clinical income was £20.59m, £0.42m favourable to plan in-month.
- Key points of note are:-
- Underlying elective activity was at 89% (93% cumulatively) driving an adverse variance offset by prior year ERF over-performance. Elective activity was below plan in the north-east locality with Stratford activity at 71% and St Anns activity at 67% during March.
- The position includes £0.7m of additional pay award funding from NCL ICB
- Commercial trading income was £3.76m, £0.36m adverse to plan.
- Research and Development income at £1.82m, £0.40m favourable to plan reflecting agreed BRC income related awards with a corresponding non-pay adverse movement.
- Other income was £0.98m favourable following confirmation that NHSE/ICB will not proceed with depreciation underspends clawback.

Employee Expenses

£0.15m favourable to plan in month

March pay is reporting £15.91m; £0.15m favourable to plan in month. Key points of note are:-

- Substantive pay costs were £14.44m in month, higher than the year-to-date average of £14.1m.
- Temporary staffing costs were £1.41m in March.
  - Agency costs are £0.29m in month, lower than the 12-month trend of £0.55m. 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 £1.12m in month, lower than the rolling trend of £1.44m. Bank use continues to be mainly in clinical areas and within the medical staffing group.
- £0.28m unachieved pay CIP (£2.79m cumulatively)

Non-Pay Expenses

£0.14m favourable to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in March were £11.65m, £0.14m favourable to plan. Key points of note are:-

- Drugs was £0.14m adverse in month with £3.55m expenditure against a 12-month trend of £3.60m. Injections were at 99% of planned activity in month.
- Clinical supplies was £0.20m favourable to plan in month. Costs were £1.81m in month against a 12-month trend of £2.19m.
- Other non-pay was £0.05m adverse in month with £4.84m expenditure against a 12-month trend of £4.84m. IT project costs continue to catch-up from earlier in the year of (£0.46m) in month.
- £0.09m unachieved non-pay CIP (£0.83m cumulatively)

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

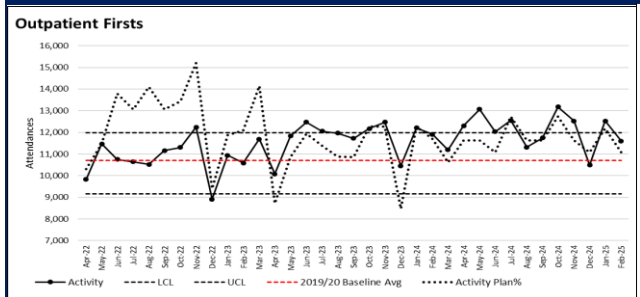
ERF	Point of Delivery	Activity In Month				Activity YTD			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	3,190	2,848	(342)	89%	36,676	34,094	(2,582)	93%
	Of which - SA & ST	606	421	(185)	69%	6,613	4,733	(1,880)	72%
	OP Firsts	11,699	11,603	(96)	99%	134,917	133,335	(1,582)	99%
	OP Procedures	20,358	18,268	(2,090)	90%	237,176	242,325	5,149	102%
	ERF Activity Total								
Non ERF Activ	OP Follow Ups	18,527	20,926	2,399	113%	214,852	224,901	10,049	105%
	High Cost Drugs Injections	4,435	4,408	(27)	99%	51,671	51,952	281	101%
	Non Elective	196	184	(12)	94%	2,339	2,355	16	101%
	AandE	5,620	5,285	(335)	94%	67,035	64,927	(2,108)	97%
	Total	64,025	63,522	(503)	99%	744,666	753,889	9,223	101%

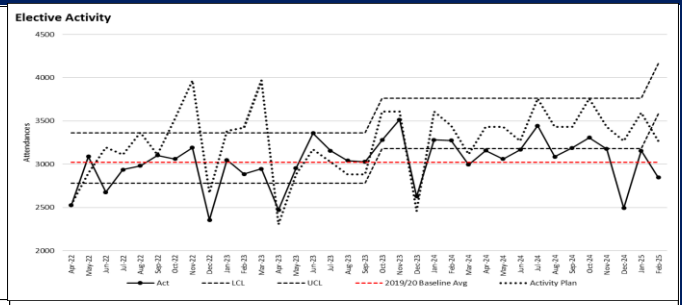
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

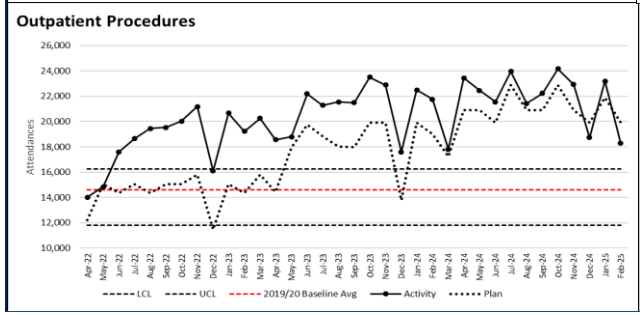
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

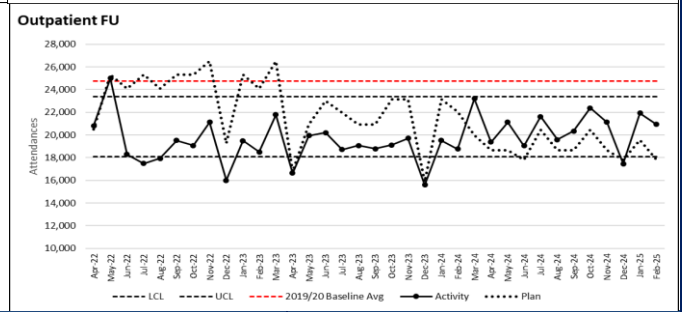
Performance % figures above, represent the Trust performance against the external activity target. Financial values shown are for ERF activity only.

ACTIVITY TREND - ERF COMPONENTS









Commentary

NHS Income

ERF Achievement

ERF performance for 2023/24 has been issued with final payments now made.

ERF performance to November 2024 has been published and is in line with planning expectations and payments were received in December and January with further payments expected in March

ERF Activity performance achievement

- **Inpatient activity** achieved 89% in month and 93% year to date of the revised demand plan.
- The table also splits out Stratford and St Annes activity reported at 69% overall in month, being 71% and 67% respectively, and 72% year to date overall being 68% and 75% respectively.
- **Outpatient Firsts Activity** achieved 99% of the revised demand plan in month; 99% year to date
- **Outpatient Procedures Activity** achieved 90% of revised demand plans in month; 102% cumulatively

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 99% of activity plans in month; 101% year to date
- **A&E** achieved 94% of activity plans in month; 97% year to date

Activity plans and ERF

Current activity and income plans have been amended to the Trust 'Demand' plan levels further to the ratification of the Stratford activity capacity/demand rectification plan.

Pay, non-pay and CIP allocation aspects of the rectification plans have also been received and amended in the finance ledger for reporting purposes based on Information from operational teams.

- 2024/25 performance for ERF is now confirmed to month 6 but with further clarification to come for year end processes.

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

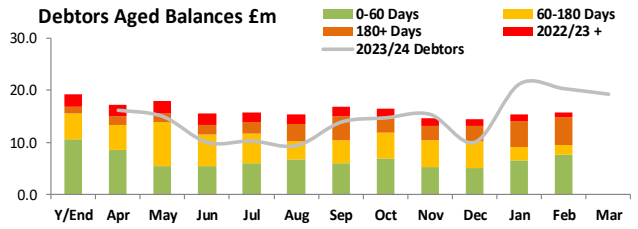
CAPITAL EXPENDITURE

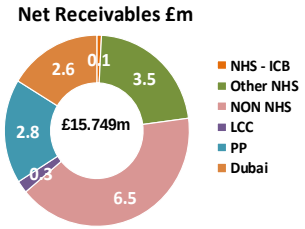
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Medical Equipment	3.9	3.0	1.8	(1.1)
Estates	2.0	1.8	0.4	(1.4)
IMT	0.6	0.4	0.4	0.0
Commercial	1.3	1.3	0.7	(0.6)
Network Strategy	-	-	-	-
Other - Trust funded	(0.5)	0.9	0.0	(0.8)
TOTAL - TRUST BAU CAPITAL	**7.4**	**7.4**	**3.4**	**(4.0)**
Oriel Programme	97.4	78.6	76.3	(2.3)
EPR Project	5.7	4.0	3.3	(0.7)
NiHR Capital Grant	1.7	1.5	1.0	(0.5)
Other & Charity	0.4	0.0	0.0	(0.0)
IFRS16	2.8	2.0	0.8	(1.2)
TOTAL INCLUDING DONATED	**115.4**	**93.5**	**84.7**	**(8.7)**

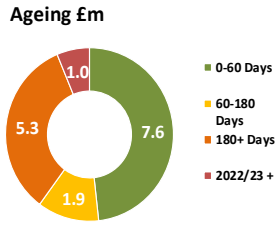
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
ICS Capital Allocation	13.7	13.7	-	100%
Cash Reserves - Oriel	1.0	1.0	-	100%
Cash Reserves - B/Fwd	0.8	0.8	-	100%
Capital Loan Repayments	(1.8)	(1.8)	-	100%
TOTAL - TRUST FUNDED	**13.7**	**13.7**	**-**	**100%**
Externally funded	85.0	85.0	-	100%
Donated/Charity	16.7	16.6	0.1	100%
TOTAL INCLUDING DONATED	**115.4**	**115.3**	**0.1**	**100%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2022/23 +*	*Total*
CCG Debt	0.0	-	0.1	0.0	0.1
Other NHS Debt	3.3	(0.1)	0.2	0.1	3.5
Non NHS Debt	1.2	0.8	3.7	0.7	6.5
Commercial Unit Debt	3.1	1.1	1.3	0.2	5.7
TOTAL RECEIVABLES	**7.6**	**1.9**	**5.3**	**1.0**	**15.7**







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	435.5	364.0	(71.5)
Current assets (excl Cash)	31.4	31.5	29.7	(1.8)
Cash and cash equivalents	72.2	73.8	61.0	(12.8)
Current liabilities	(55.7)	(55.8)	(46.9)	8.9
Non-current liabilities	(199.7)	(185.3)	(116.9)	68.4
TOTAL ASSETS EMPLOYED	**301.9**	**299.6**	**290.8**	**(8.7)**

OTHER METRICS

Use of Resources	Plan	Current Month	Prior Month
BPPC - NHS (YTD) by number	95%	91%	91%
BPPC - NHS (YTD) by value	95%	90%	89%
BPPC - Non-NHS (YTD) by number	95%	95%	95%
BPPC - Non-NHS (YTD) by value	95%	95%	95%

Commentary

Cash and Working Capital

The cash balance as at the 28th February was £61.0m, a reduction of £9.7m since the end of March 2024.

Capital Expenditure/ Non-current assets

Capital expenditure as of 28th February totalled £84.7m, including £0.8m of lease variations.

- Business as usual capital totals £3.4m.
- Other capital totals £81.3m with £76.3m of Oriel expenditure, £3.3m EPR expenditure and £1.0 of NIHR research expenditure.
- IFRS16 leases capital of £0.8m

Business as usual capital allocations have been fully allocated, and forecast, with an allowance for slippage within Other – Trust funded.

The Oriel budget has been re-phased, with a reduction in 2024/25 offset by an increase in later years.

The variance on non-current assets of £70.7m is due to a shortfall in capital expenditure, primarily relating to the Oriel build, which has reviewed it's in year construction cashflows.

Receivables

Receivables have reduced by £3.4m to £15.7m since the end of the 2023/24 financial year. Debt in excess of 60 days reduced by £0.5m in March and current debt increased by £1.0m.

Payables

Payables totalled £17.2m at the end of March, a reduction of £8.9m 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:-

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

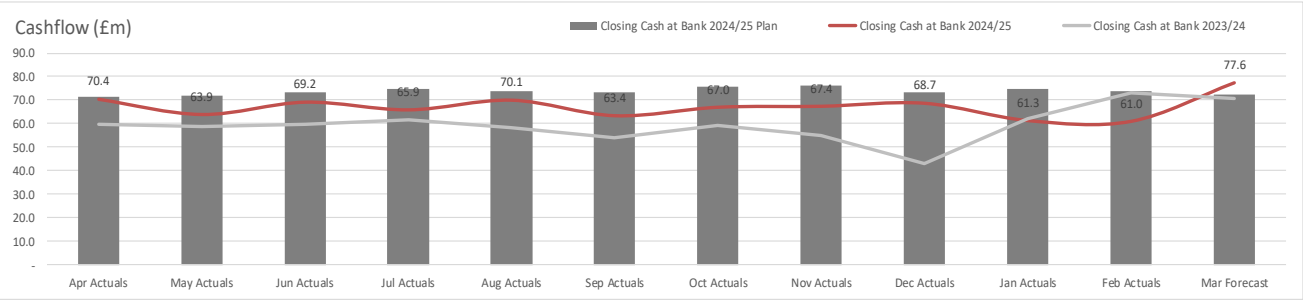
Use of Resources

Use of resources monitoring and reporting has been suspended.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Actuals	Aug Actuals	Sep Actuals	Oct Actuals	Nov Actuals	Dec Actuals	Jan Actuals	Feb Actuals	Mar Forecast	Outturn Total	Feb Forecast	Feb Var
Opening Cash at Bank	**70.7**	**70.4**	**63.9**	**69.2**	**65.9**	**70.1**	**63.4**	**67.0**	**67.4**	**68.7**	**61.3**	**61.0**	**70.7**		
Cash Inflows															
Healthcare Contracts	20.4	20.3	21.4	21.7	21.1	19.1	25.2	20.9	25.3	20.3	24.7	20.7	261.2	20.3	4.5
Other NHS	2.6	1.3	2.0	0.5	3.4	0.8	2.1	3.2	3.9	1.2	1.7	1.4	23.9	1.4	0.2
Moorfields Private/Dubai/NCS	4.7	3.8	4.0	4.5	3.6	4.0	4.8	4.7	3.4	4.4	4.0	4.3	50.1	4.1	(0.2)
Research	3.1	1.0	1.3	1.5	0.8	0.7	2.1	1.0	1.4	1.0	1.1	1.3	16.4	1.3	(0.3)
VAT	1.5	1.1	1.0	-	1.8	2.1	1.0	1.0	1.0	-	2.6	0.5	13.4	0.5	2.1
PDC	7.8	-	-	2.7	9.1	-	3.5	17.6	-	-	-	36.7	77.5	18.0	(18.0)
Other Inflows	0.3	0.4	7.3	0.3	0.3	0.3	0.3	0.3	7.4	0.3	0.2	3.6	20.8	0.8	(0.6)
Total Cash Inflows	**40.2**	**27.9**	**36.9**	**31.2**	**40.1**	**27.0**	**39.0**	**48.5**	**42.5**	**27.0**	**34.2**	**68.6**	**463.2**	**46.5**	**(12.3)**
Cash Outflows															
Salaries, Wages, Tax & NI	(13.0)	(13.3)	(12.9)	(12.8)	(13.0)	(13.1)	(15.1)	(16.0)	(14.5)	(14.3)	(14.2)	(14.5)	(166.9)	(14.5)	0.3
Non Pay Expenditure	(21.4)	(12.7)	(12.6)	(15.9)	(11.9)	(12.7)	(11.6)	(12.5)	(12.4)	(14.2)	(13.3)	(13.1)	(164.3)	(13.2)	(0.1)
Capital Expenditure	(0.9)	(0.2)	(0.5)	(0.3)	(0.1)	(0.3)	(0.3)	(0.5)	(1.0)	(0.4)	(1.1)	(6.0)	(11.6)	(5.3)	4.2
Oriel	(4.0)	(6.6)	(4.1)	(4.1)	(9.1)	(4.1)	(7.0)	(18.0)	(11.9)	(4.1)	(4.1)	(16.0)	(93.1)	(5.0)	0.8
Moorfields Private/Dubai/NCS	(1.2)	(1.5)	(1.6)	(1.3)	(1.2)	(1.3)	(1.4)	(1.1)	(1.4)	(1.4)	(1.3)	(1.4)	(16.1)	(1.4)	0.1
Financing - Loan repayments	-	-			(0.6)	(0.7)					(0.6)	(0.5)	(2.4)	(0.4)	(0.2)
Dividend and Interest Payable	-	-				(1.5)						(0.5)	(2.0)	-	-
Total Cash Outflows	(40.5)	(34.4)	(31.6)	(34.5)	(35.9)	(33.7)	(35.4)	(48.1)	(41.2)	(34.5)	(34.6)	(52.0)	**(456.4)**	(39.8)	5.2
Net Cash inflows /(Outflows)	(0.3)	(6.5)	5.3	(3.3)	4.2	(6.7)	3.7	0.4	1.3	(7.4)	(0.3)	16.6	6.8	6.7	(7.1)
Closing Cash at Bank 2024/25	**70.4**	**63.9**	**69.2**	**65.9**	**70.1**	**63.4**	**67.0**	**67.4**	**68.7**	**61.3**	**61.0**	**77.6**	**77.6**		
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 March was £61.2m, a reduction of £9.5m since 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 74 days of operating cash (prior month: 74 days).

February cashflow saw a £0.3m outflow against a forecast inflow of £6.7m. This was mainly due to delays in completion of the first trance of the Oriel loan offset by slippage in the capital programme payments to March.

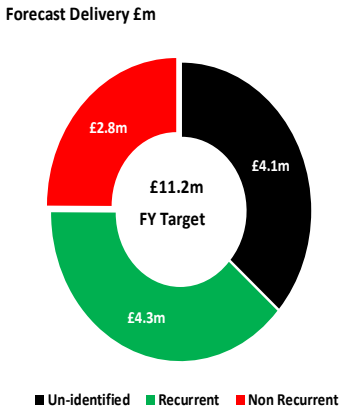
Following February the Trust has agreed a DHSC Orel financing bridging loan in preparation for April increased spend levels. The cashflow will be updated once final draw down dates have been confirmed.

Trust Efficiency Scheme Performance

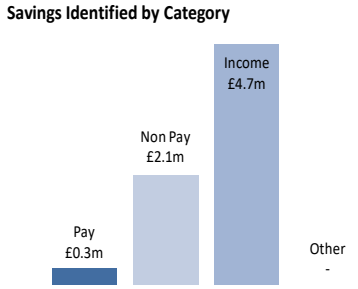
EFFICIENCY SCHEMES PERFORMANCE

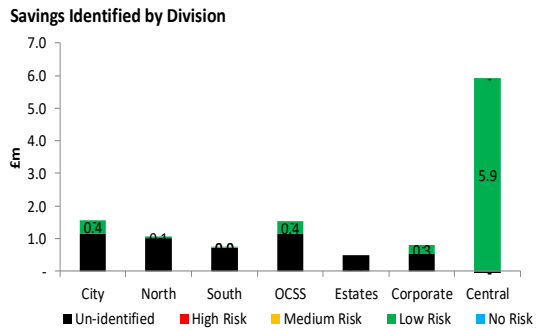
Efficiency Schemes £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Plan	Forecast Actual	Forecast Variance
City Road	£1.57m	£0.13m	£0.02m	(£0.11m)	£1.44m	£0.38m	(£1.06m)	£1.57m	£0.42m	(£1.15m)
North	£1.08m	£0.09m	£0.01m	(£0.08m)	£0.99m	£0.07m	(£0.92m)	£1.08m	£0.07m	(£1.01m)
South	£0.73m	£0.06m	£0.00m	(£0.06m)	£0.67m	£0.01m	(£0.66m)	£0.73m	£0.01m	(£0.71m)
Ophth. & Clinical Serv.	£1.53m	£0.13m	£0.02m	(£0.11m)	£1.40m	£0.38m	(£1.02m)	£1.53m	£0.40m	(£1.13m)
Estates & Facilities	£0.49m	£0.04m	-	(£0.04m)	£0.45m	-	(£0.45m)	£0.49m	-	(£0.49m)
Corporate	£0.80m	£0.07m	£0.01m	(£0.06m)	£0.74m	£0.27m	(£0.47m)	£0.80m	£0.27m	(£0.53m)
DIVISIONAL EFFICIENCIES	**£6.20m**	**£0.52m**	**£0.05m**	**(£0.47m)**	**£5.68m**	**£1.10m**	**(£4.58m)**	**£6.20m**	**£1.18m**	**(£5.02m)**
Central										
R&D Income	£2.20m	£0.18m	£0.18m	(£0.00m)	£2.02m	£2.02m	£0.00m	£2.20m	£2.20m	-
Utilities Reduction	£1.60m	£0.13m	£0.14m	£0.00m	£1.47m	£1.50m	£0.03m	£1.60m	£1.64m	£0.04m
Activity Complexity	£1.20m	£0.10m	£0.18m	£0.08m	£1.10m	£1.93m	£0.83m	£1.20m	£2.10m	£0.90m
TRUST EFFICIENCIES	**£11.20m**	**£0.93m**	**£0.54m**	**(£0.39m)**	**£10.27m**	**£6.54m**	**(£3.72m)**	**£11.20m**	**£7.11m**	**(£4.09m)**

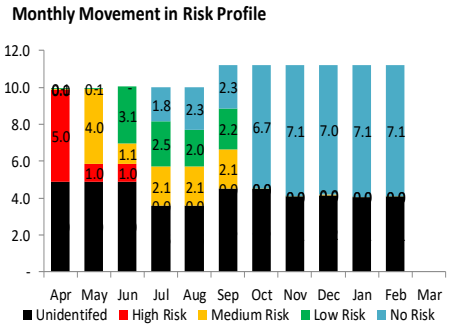
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







* charts may include rounding differences

Commentary

In Year Delivery

The trust is reporting efficiency savings achieved of:-

- £0.54m in month, compared to a plan of £0.93m, £0.39m adverse to plan;
- £6.5m year to date, compared to a plan of £10.2m, £3.72m adverse to plan.

Governance & Reporting

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

This has increased by £1.2m to £11.2m in relation to the Stratford activity capacity and demand rectification plan.

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

Identified Savings

The trust has identified £7.11m, leaving a remaining £4.08m to be identified.

Of the total identified:-

- £5.9m is identified central schemes
- £4.6m is identified as income generation schemes;
- £1.6m is related to utilities price reductions; and
- £4.3m is forecast recurrently;

The CIP programme board are working through further efficiency scheme delivery for full financial validation towards increasing the level of identified and forecast delivery in 2024/25.

£6.9m represents the value of un-identified and non-recurrently identified savings.

Risk Profiles

The charts to the left demonstrates the

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

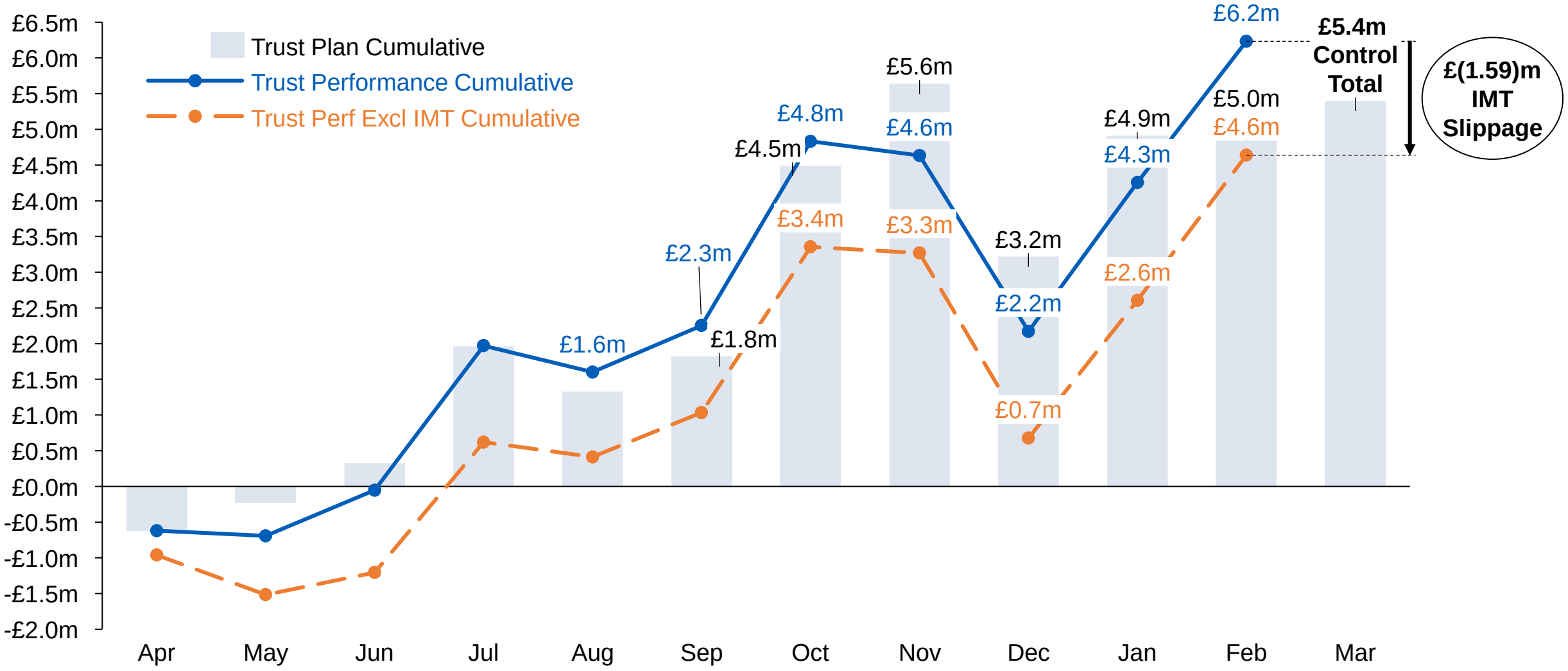
Supplementary Information

Moorfields Eye Hospital NHS Foundation Trust

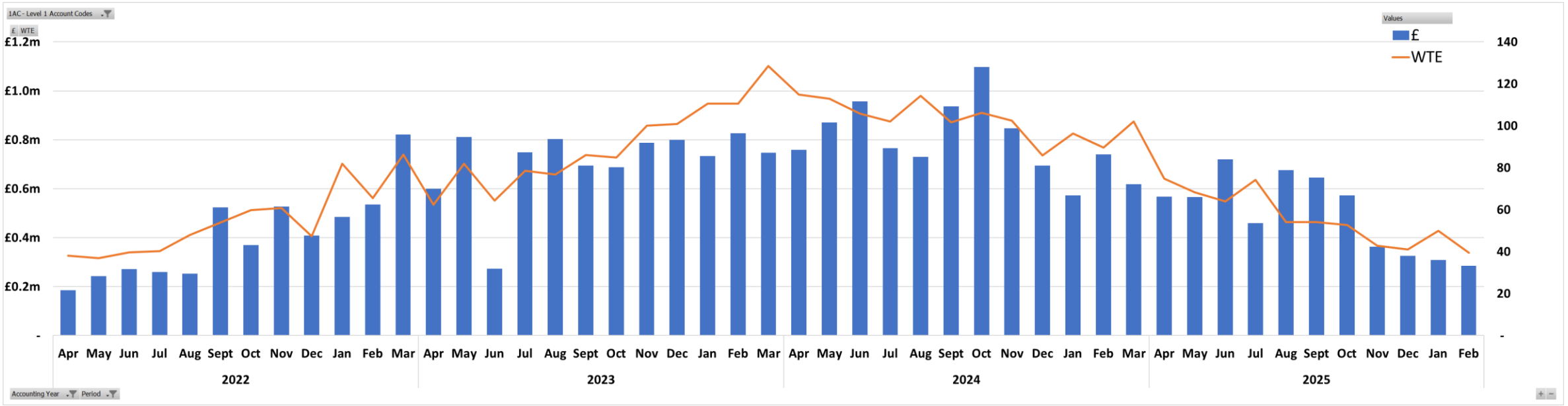
NHS

Trust financial performance is being supported by £(1.59)m IMT underspends

The trust is reporting a £6.2m surplus YTD, £1.2m favourable to a plan of £5.0m. However, excluding IMT favourable surpluses due to slippage, the Trusts financial position is £4.6m, £0.4m less than plan.
Adverse core operational performance is being supported by the IT EPR (£0.95)m and IT Projects slippage (£0.58)m.

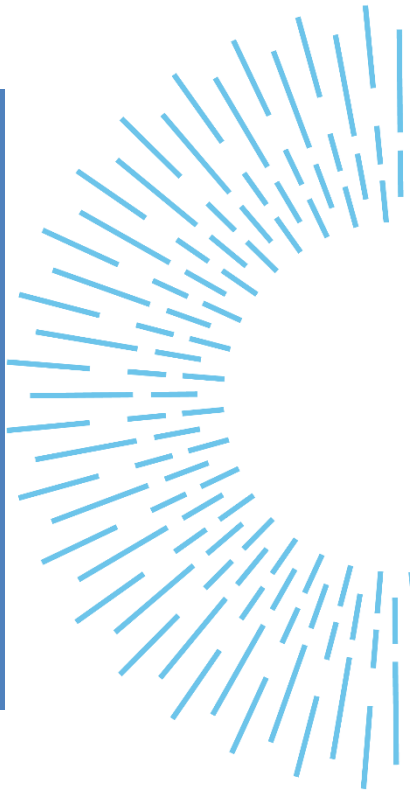


Workforce – Agency Reporting in Board Report



Moorfields Eye Hospital NHS Foundation Trust

Agenda item 11
2024 Staff Survey Report
Board of Directors
27 March 2025



Report title	**2024 Staff Survey Result Report**
Report from	Sue Steen, Chief People Officer
Prepared by	Ade Adetukasi, Associate Director of Employee Experience
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.

Action required/recommendation.

The Board is asked to note the survey report.

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

1.0 Executive Summary

1.1 The NHS staff survey remains a leading indicator of staff engagement and morale which provides valuable insights with which to inform trust's strategy and workforce development initiatives. The trust commissioned Picker Institute to administer the survey.

The survey questions are grouped under the following specific areas:

1. Your Job
2. Your Team
3. People in Your Organisation
4. Your Managers
5. Your Health, Wellbeing and Safety at Work
6. Your Personal Development
7. Your Organisation
8. Background Information i.e. demographic data

The NHS Survey 2024 (hereafter NSS24) was undertaken in October-November 2024. Two-thirds of our workforce completed the survey (n=1789, 69%) an increase of 3% on 2024, and 12% higher than the 57% average response rate benchmarked against the 12 other specialist acute trusts in our national benchmark group.

1.2 Key results

<u>The areas where MEH is performing well:</u>

High percentage of respondents reported that they would be happy for friends and family to receive treatment at MEH (85%) and believe the organisation's top priority is the care of patients (83%). There was a 3% increase in the percentage of staff who would recommend MEH as a place to work (2023 = 63%, 2024 = 66%).

The biggest improvement in scores is in three main areas: appraisals helping to improve job performance, a reduction in bullying, harassment and physical violence, and fewer staff reported working unpaid additional hours.

The slight but steady improvement in the NHS People Promise themes continues year on year. The nursing, and medical and dental staff groups being the highest scoring across all staff groups.

The areas where MEH is performing less well:

Overall, there has been no significant statistical or real change since the last staff survey and no significant improvement across all the NHS People Promise themes.

MEH scored poorly on acting fairly regarding career progression. This is one of the bottom 5 scores and is 11 points below the Picker average and 9 points below the national average.

The free text feedback shows ongoing staff concern about the lack of diversity in senior leadership positions in the trust.

1.3 The advocacy questions

The MEH 2024 results for the three key advocacy questions below shows a 3% increase in the number of respondents stating they would recommend MEH as a place to work. The two other questions indicate the numbers have remained static across the two years.

MEH scores are lower for all three questions when compared to the other acute specialist trusts. Figure 1

Q#	Question	2024 score	2023 score	Average of comparison organisations
Q25c	Would recommend organisation as a place to work	66%	63%	74%
Q25d	If a friend/relative needed treatment would be happy with standard of care provided by organisation.	85%	85%	90%
Q25a	Care of patients/service users is organisation's top priority.	83%	83%	86%

1.4 Other Highlights

The Top 5 MEH scores compared to the Picker average made up of 5 acute specialist trusts: Figure 2

Top 5 scores vs Organisation Average	Org	Picker Avg
q23b. Appraisal helped me improve how I do my job	35%	29%
q14d. Last experience of harassment/bullying/abuse reported	56%	52%
q23c. Appraisal helped me agree clear objectives for my work	42%	39%
q13d. Last experience of physical violence reported	74%	72%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	53%	52%

The Top 5 most improved scores (2023 – 2024): Figure 3

Most improved scores	Org 2024	Org 2023
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	67%	61%
q14d. Last experience of harassment/bullying/abuse reported	56%	51%
q15. Organisation acts fairly: career progression	49%	45%
q11e. Not felt pressure from manager to come to work when not feeling well enough	75%	71%
q24b. There are opportunities for me to develop my career in this organisation	54%	50%

Lowest Score

The Bottom 5 MEH scores compared to other Picker acute specialist trusts: Figure 4

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	67%	79%
q15. Organisation acts fairly: career progression	49%	60%
q5b. Have a choice in deciding how to do my work	45%	56%
q26c. I am not planning on leaving this organisation	52%	62%
q24c. Have opportunities to improve my knowledge and skills	65%	74%

The 5 most declined scores (2023 – 2024): Figure 5

Most declined scores	Org 2024	Org 2023
q13d. Last experience of physical violence reported	74%	81%
q8b. Colleagues are understanding and kind to one another	63%	66%
q7e. Enjoy working with colleagues in team	74%	76%
q7h. Feel valued by my team	67%	69%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	70%	72%

1.5 People Promise themes and highlights

The trend of improvement across all People Promise elements and themes since 2021 continued. The areas of most improvement since 2023 are in the themes: (PP2): We are recognised and rewarded and PP5: We are always learning, particularly regarding appraisals.

Staff Groups

The staff group with the most scores higher than the organisational average is Nursing. All People Promise (hereafter PP) scores for this staff group are above the MEH Average.

This staff group has 11 questions >0.4 points above the MEH average. These high scores are mostly for People Promise 5: We are always learning, and People Promise 6: WE work flexibly. Other high scores are found in Staff Engagement and Morale.

The staff group with the next highest number of high scores are the Medical and Dental staff groups with two scores >0.4 above the MEH average. These higher than average scores are for PP5-1 Development, and M-1 (not) thinking of leaving.

The Additional Clinical Services staff group scores above the MEH average for PP5-2: Appraisals.

1.6 Summary of the 2024 staff survey result

Overall, there has been no significant statistical or real change since the last staff survey and no significant improvement across all the NHS People Promise themes. The only area showing significant statistical improvement since 2019, in relation to staff experience, is staff wellbeing provision. The survey results also highlight that employee experience differs across the trust depending on a combination of factors. Survey data and staff feedback shows evidence of both positive and negatives staff experience.

1.7 Immediate response to the staff survey result

It is important for staff to feel heard and acknowledged, especially given the year-on-year increase in response rates and engagement. This will help foster trust in leadership. Our response should also consider and reflect feedback and concerns raised `by staff through other channels in the trust. Therefore, as well as developing an action plan, including mapping the emerging themes from the staff survey result to ongoing organisational development and staff experience programmes (e.g. EDI programme, Leadership development, Embedding Values, etc.) the following are our immediate next steps.

1. To commence local and central engagement and listening sessions to share staff survey result with staff, working with divisional and local managers, to co-produce solutions and actions for implementation. Through the sessions, we will have deeper understanding of specific concerns and generate ideas for improvement. The first session is scheduled for week beginning 31st March. Each session will be led by a member of the executive and co-facilitated by the Associate Director of Employee Experience.

2. To ensure a triangulated approach in responding to staff feedback from the survey, we will conduct further analysis of the survey data, including considering feedback from other sources. This analysis will help refine, design, and measure both ongoing and future initiatives, particularly those related to our EDI, values, and leadership programmes. This will also include further analysis of data by professional groups and reviewing the staff survey free texts with the Communication team.

3. A detailed action plan, to be created in collaboration with staff during the staff survey feedback and listening sessions, aligned to the new People and Culture strategy currently being developed, will be presented to ManEx in April.

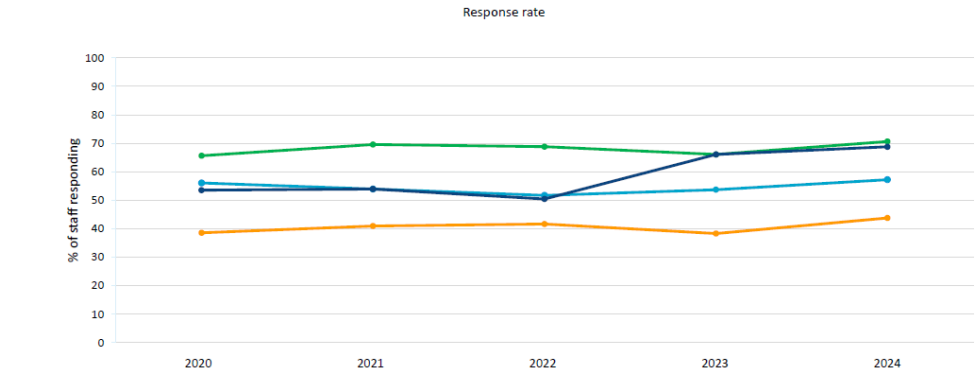
2.0 Introduction

All NHS employers are required to participate in the annual NHS Staff Survey. The survey ran from early October to late November 2024. The trust commissioned Picker Institute to administer the survey. All staff directly employed by the trust on 1st September 2023 were invited to complete the survey.

Survey Response: The survey was completed by 1789 employees (69% of those eligible to complete it) an increase in response of 3% compared to 2023 (66%).

MEH response rate (69%) being 12% higher than the average for other similar acute specialist trusts (57%). There are 12 other acute specialist trusts in our national benchmark group.

Figure 6*: The trend in response rates over the past five years.*

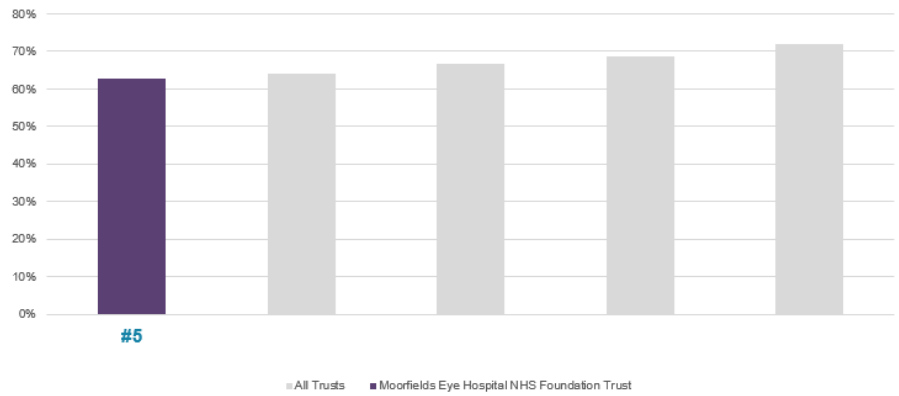


	2020	2021	2022	2023	2024
Your org	53.53%	53.96%	50.43%	66.07%	68.78%
Highest	65.63%	69.56%	68.82%	66.07%	70.63%
Average	56.07%	53.96%	51.70%	53.69%	57.21%
Lowest	38.56%	40.96%	41.63%	38.30%	43.77%
Responses	1184	1232	1176	1589	1789

Figure 7 below, shows the Picker overall positive score of the trust ranked against the four other acute specialist trusts in the Picker benchmark group.

Figure 7

Overall positive score compared to other specialist trusts in the Picker benchmark group.

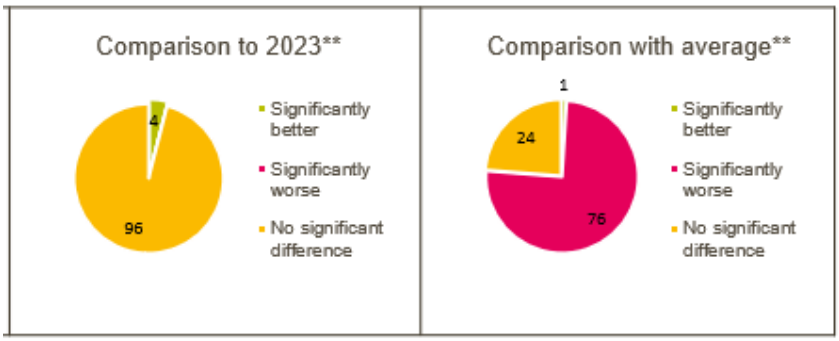


3.0 The NHS People Promise

Since 2021, the NHS Staff Survey results have been aligned to the themes of the NHS People Promise (PP). Compared to the results of the NSS23, 96% of all scores are not significantly different, none are worse, and 4% are significantly better.

Compared to the average scores of the other specialist trusts in our Picker benchmark group, 76% of the trust's scores are significantly worse, 1 is significantly better, and 24% not significantly different. See figure 8 below:

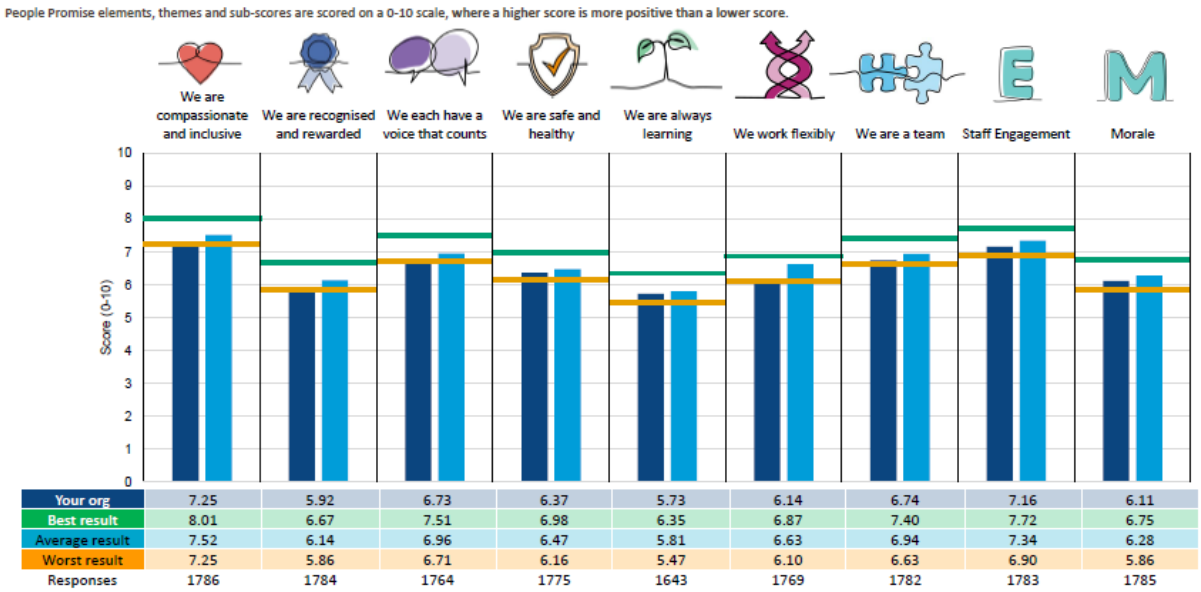
Figure 8*: People Promise scores compared to 2023 results, and the average scores of benchmark group.*



*Bank worker survey results are presented via separate reports for those organisations who took part
**Chart shows the number of questions that are better, worse, or show no significant difference

Across all People Promise themes, the trust's scores are lower than the average of our national benchmark group. The least difference in scores relating to People Promise 5: We are always learning; the greatest difference being People Promise 6: We work flexibly. See figure 9 below.

Figure 9 *People Promise elements and themes overview.*



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.25	5.92	6.73	6.37	5.73	6.14	6.74	7.16	6.11
Best result	8.01	6.67	7.51	6.98	6.35	6.87	7.40	7.72	6.75
Average result	7.52	6.14	6.96	6.47	5.81	6.63	6.94	7.34	6.28
Worst result	7.25	5.86	6.71	6.16	5.47	6.10	6.63	6.90	5.86
Responses	1786	1784	1764	1775	1643	1769	1782	1783	1785

3.1 People Promise scores by Staff Group

The staff group with the most scores higher than the organisational average is *Nursing*. All PP scores for this staff group are above the trust average.

The staff group with the next highest number of high scores are the *Medical and Dental* staff groups with two scores >0.4 above the trust average. These higher-than-average scores are for PP5-1 Development, and M-1 (not) thinking of leaving.

The staff group with the highest number of scores below the trust average are the *Allied Health Professionals*. This staff group has 20 scores below the trust average. Most of the low scores are in the PP5: We are always learning, PP6: We work flexibly, PP7: We are a Team, and Morale.

4.0 Significance testing and trend.

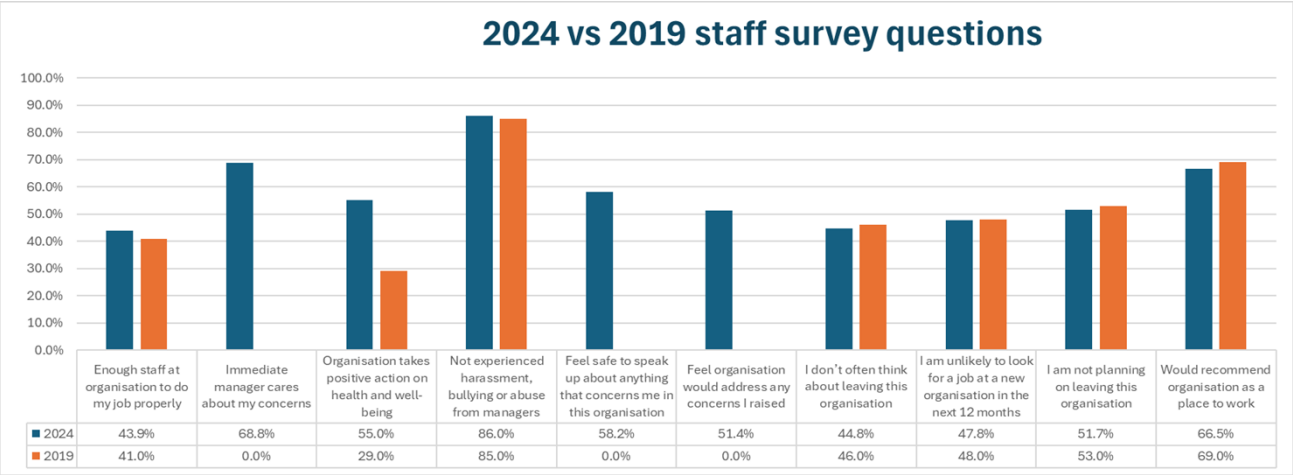
Statistical significance helps determine whether a result is attributable to chance, or some other factor. Figure 10 below shows the significance testing conducted for the NSS23 and NSS24 results.

Figure 10*: Significance rating*

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.18	1586	7.25	1786	Not significant
We are recognised and rewarded	5.83	1582	5.92	1784	Not significant
We each have a voice that counts	6.65	1555	6.73	1764	Not significant
We are safe and healthy	6.30	1475	6.37	1775	Not significant
We are always learning	5.61	1451	5.73	1643	Not significant
We work flexibly	6.09	1574	6.14	1769	Not significant
We are a team	6.68	1580	6.74	1782	Not significant
Themes					
Staff Engagement	7.10	1584	7.16	1783	Not significant
Morale	6.02	1584	6.11	1785	Not significant

There has been no significant statistical or real change since the last staff survey including no significant improvement across all the NHS People Promise themes. Furthermore, the only area showing significant statistical improvement concerning staff experience since 2019 is staff wellbeing provision as shown below.

Figure 11

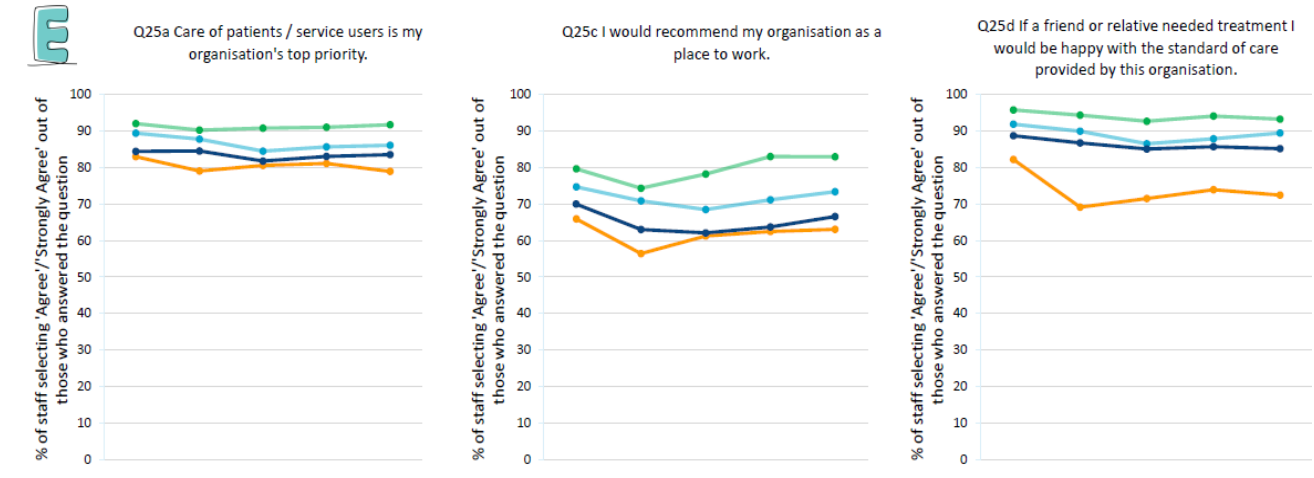


	Enough staff at organisation to do my job properly	Immediate manager cares about my concerns	Organisation takes positive action on health and well-being	Not experienced harassment, bullying or abuse from managers	Feel safe to speak up about anything that concerns me in this organisation	Feel organisation would address any concerns I raised	I don't often think about leaving this organisation	I am unlikely to look for a job at a new organisation in the next 12 months	I am not planning on leaving this organisation	Would recommend organisation as a place to work
2024	43.9%	68.8%	55.0%	86.0%	58.2%	51.4%	44.8%	47.8%	51.7%	66.5%
2019	41.0%	0.0%	29.0%	85.0%	0.0%	0.0%	46.0%	48.0%	53.0%	69.0%

5.0 Engagement and Advocacy

Advocacy scores are a component of the Staff Engagement People Promise theme. Results provide a useful indicator for how staff feel about the trust. Figure 12 below shows the results for Advocacy.

Figure 12



	2020	2021	2022	2023	2024
Your org	84.38%	84.50%	81.74%	83.02%	83.48%
Best result	91.98%	90.20%	90.74%	90.97%	91.69%
Average result	89.38%	87.74%	84.45%	85.64%	86.06%
Worst result	82.94%	79.02%	80.54%	81.07%	78.89%
Responses	1178	1227	1172	1583	1777

	2020	2021	2022	2023	2024
Your org	69.94%	62.97%	62.06%	63.66%	66.53%
Best result	79.60%	74.29%	78.17%	82.98%	82.90%
Average result	74.66%	70.80%	68.45%	71.12%	73.34%
Worst result	65.89%	56.39%	61.22%	62.46%	63.04%
Responses	1177	1228	1172	1583	1774

	2020	2021	2022	2023	2024
Your org	88.67%	86.71%	85.04%	85.67%	85.12%
Best result	95.74%	94.30%	92.64%	94.05%	93.23%
Average result	91.83%	89.92%	86.47%	87.83%	89.44%
Worst result	82.17%	69.10%	71.47%	73.90%	72.39%
Responses	1178	1227	1174	1582	1775

6.0 Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) results

6.1 Workforce Race Equality Standards (WRES) results

The NSS24 includes questions which relate to the NHS England Workforce Race Equality Standards.

The NSS24 was completed by 1789 employees. 1138 (63%) respondents are of mixed/multiple ethnic groups and 626 (35%) are white, and 1.5% did not wish to disclose their ethnicity.

Analysis of responses to the questions grouped under the WRES Indicators indicates that the majority of employees, regardless of their ethnicity have not experienced harassment or bullying from patients or staff in the last 12 months.

6.2 Workforce Disability Equality Standard (WDES) results

The results indicate that half of the employees with a disability had experienced harassment, bullying or abuse from patients which is higher than the MEH average over all score. They also indicate that approximately half of all incidents go un-reported.

Around a third of respondents with a disability feel that MEH provides equal opportunities for career progression and promotion, and a similar percentage have felt pressure from their manager to come to work despite not feeling well enough.

7.0 Qualitative Feedback summary

The NSS24 provides the opportunity for respondents to give qualitative feedback. 420 respondents provided comments. Analysis of the qualitative feedback highlighted several themes, including positive aspects of working at the trust and areas of dissatisfaction.

The most positive themes

1. Pride in the organisation: many employees expressed pride in working at MEH and valued the supportive environment.

2. Team Dynamics: there is a strong sense of teamwork and collaboration among staff, which contributes to a positive work atmosphere.

Summary of the most commonly recurring themes

1. Management and Leadership: Several comments pointed to issues with management, including perceived favouritism, lack of transparency, and inadequate support for staff, particularly in addressing bullying and harassment.

2. Communication: Improved communication between management and staff was a common request, with suggestions for more inclusive decision-making processes and better handling of feedback.

3. Workplace Culture and Bullying: Bullying and harassment are reported as significant issues, with staff feeling unsupported and incidents not being properly addressed.

8.0 Summary of key themes from 2024 staff survey result

Overall, there has been no significant statistical or real change since the last staff survey and no significant improvement across all the NHS People Promise themes. The only area showing

significant statistical improvement since 2019, in relation to staff experience, is staff wellbeing provision.

The survey results highlight that employee experience differs across the trust depending on a combination of factors. Survey data and staff feedback shows evidence of both positive and negatives staff experience.

Slight improvement in the percentage of survey respondents that would recommend the trust as a place to work. This increased from 63% in 2023 to 66% in 2024. This is the highest score for this survey question since 2021, though below our benchmark group average which is 74%.

Qualitative data from the anonymous free text shows that many employees expressed pride in working at Moorfields Eye Hospital and are positive about their local supportive team environment.

Several comments from the free texts point to issues with management, including perceived favouritism, lack of transparency, and inadequate support for staff, particularly in addressing bullying and harassment. There are also reports of discrimination based on ethnicity, and lack of diversity in senior leadership. However, some respondents feel that the organisation is making strides to address these issues, but that there is still a long way to go.

Both quantitative and qualitative data from the survey result show concern about limited opportunities for career advancement and that promotions are often based on favouritism rather than merit.

There are comments regarding the lack of reasonable adjustments for staff with disabilities. For example, some employees with learning difficulties have reported that their workload and responsibilities are not adjusted to accommodate their needs, leading to significant stress and difficulty in performing their duties.

9.0 Immediate response to staff survey result

It is important for staff to feel heard and acknowledged, especially given the year-on-year and notable increase in response rates and engagement. This will help foster trust in leadership. Our response should also consider and reflect feedback and concerns raised `by staff through other channels in the trust. Therefore, as well as developing an action plan, including mapping the emerging themes from the staff survey result to ongoing organisational development and staff experience programmes (e.g. EDI programme, Leadership Development, Embedding Values, etc.) the following are our immediate next steps.

1. To commence local and central engagement and listening sessions to share staff survey result with staff, working with divisional and local managers, and co-produce solutions and actions for implementations. The first session is scheduled for week beginning 31st March. Each session will be led by a member of the executive and co-facilitated by the Associate Director of Employee Experience.

2. To ensure a triangulated approach in responding to staff feedback from the survey, we will conduct further analysis of the survey data, including considering feedback from other sources. This analysis will help refine, design, and measure both ongoing and future initiatives, particularly those related to our EDI, values, and leadership programmes. This will also include further analysis of data by professional groups and working with the Communications team to review the free texts.

3. A detailed action plan, to be created in collaboration with staff during the staff survey result listening and engagement sessions and aligned to the new People and Culture strategy currently being developed, will be presented to ManEx in April.

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 12
Equality Delivery System Report
Board of Directors
27 March 2025

Report title	**Equality Delivery System Report**
Report from	Sue Steen, Chief People Officer
Prepared by	Ade Adetukasi, Associate Director of Employee Experience
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.

Introduction

This paper provides an update on the implementation of the NHS Equality Delivery System 2022 (EDS) framework at Moorfields and introduces the accompanying EDS report. The EDS is a mandatory and comprehensive framework designed to help NHS trusts improve services for local communities and create better working environments for staff. It is implemented through practical steps aimed at continuously enhancing equality and diversity practices.

The EDS is divided into three key domains:

1. **Commissioned or Provided Services**
2. **Workforce Health and Wellbeing**
3. **Inclusive Leadership**

NHS trusts are required to demonstrate that they meet a minimum score of 2 (on a scale from 0 to 3) for all domain outcomes. If a domain falls below this threshold, the trust must outline a plan for improvement. Evidence gathered during the assessment process were reviewed by stakeholder groups, and the outcome of the assessment has been shared with the EDI steering group. The enclosed EDS report, which includes the scorings for the 3 domains and supporting action plan, has been presented to ManEx and the People and Culture Committee for approval. For the EDS ratings and scoring details, please refer to appendix One.

Moorfields has achieved an overall score of 16, indicating full compliance with the EDS framework requirement once the EDS report is published. The scores for each domain are set out below and a breakdown of the scores for all domain outcomes are summarised in appendix 2.

Domain Name	Score
Domain 1: Commissioned or provided services (assessed against 4 outcomes)	5
Domain 2: Workforce health and wellbeing (assessed against 4 outcomes)	6
Domain 3: Inclusive leadership (assessed against 3 outcomes)	5

Based on these scores, Moorfields has been rated as “Developing” under the EDS framework. With the overall score in place, the emerging themes from the assessment process will form part of the foundation for improving our performance on EDI and our EDS ratings. By developing and following an action plan as part our EDS return, we aim to enhance our EDI efforts and address health inequalities, ultimately striving to reach the “Achieving” level and, eventually, “Excelling”.

To meet the domain 1 requirement of selecting three services for assessment, the EDI steering group reviewed the support needed for the services, given that this is the first time the EDS framework is being applied at the trust. As a result, a decision was made to assess two services. For the next EDS cycle, due for publication in February 2026, we will assess three services.

The two services selected for assessment were Glaucoma and Medical Retina. Both services, especially the local staff and managers who contributed to the evidence gathering and assessment process, should be commended for their excellent work. The good practices and lessons learned from these services will be shared across the trust.

Key learning from the domain assessments

- **Domain 1: Commissioned or Provided Services**
  The services assessed lacked a systematic approach to collecting and monitoring demographic data of service users. Improved demographic data collection, including for DA language users, is required to monitor equitable access. The implementation of the new EPR system is expected to significantly enhance the collection and monitoring of patient access data.

- **Domain 2: Workforce Health and Wellbeing**
  Data collection and monitoring must be improved to demonstrate how staff, particularly those from protected characteristic groups at higher risk, are being supported in managing and preventing obesity, diabetes, asthma, COPD, and mental health conditions. Additionally, tracking the uptake and impact of these services is necessary. We are working jointly with employee networks group in raising awareness and health promotion of high risk conditions associated with protected characteristics groups.

- **Domain 3: Inclusive Leadership**
  There is a need for a standardised approach to ensure that Board activities and papers are used effectively to prompt discussions and actions on the allocation, delivery, and monitoring of resources aimed at mitigating inequalities and health disparities. The EDI team will work jointly with the trust secretariat to strengthen Board records and reporting on EDI and health Inequalities.

In conclusion, the EDS report and action plan will serve as an important resource for learning and guiding future efforts to ensure that the trust achieves higher EDS ratings while working to reduce inequalities and health disparities. In developing the action plan, we have reflected learning from other NHS trusts who have successfully implemented the EDS framework and are steadily improving their EDS ratings and EDI performance year-on-year.

Next Steps

1. The EDS report is scheduled to be published in March following Board approval.
2. Following publication of the report, the EDI steering group will provide oversight for the delivery of the EDS action plan and report quarterly to ManEx and the People and Culture Committee.

Quality implications

There is an evidenced correlation between staff experience and patient experience. A focus on improving staff experience, particularly for our staff with protected characteristics, will therefore have a positive impact on patient experience and the quality of the services we provide. It will support the recruitment and retention of quality staff.

Financial implications

A lack of equal opportunities for people in protected characteristic groups and increased levels of harassment are proven to significantly increase sickness absence, presenteeism, and staff turnover.

Risk implications

There is a risk that the trust will not successfully deliver the EDI programme and the new EDI vision due to the significant resource requirements to address deep-rooted EDI issues and multiple workstreams. This risk has been mitigated through the EDI programme resource requirements business case which was approved by BCRG.

Action required/recommendation.

The Board is asked to review and approve the EDS report and action plan.

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

Appendix 1

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rat
Card supporting guidance document has a full explanation of the new rating procedure, and can assist you a
engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score,
Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcon domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** addi scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome sc domains, are rated **Excelling**

Appendix 2

Breakdown of MEH scores for all domain outcomes

Domain	Subdomain	Score Range	Scoring Criteria (Assessment based on evidence)	MEH Score
1: Commissioned or Provided Services	1A - Patient Access & Experience	0-3	0 = No or little activity ensuring protected groups have access. 1 = Basic engagement with some gaps (50%). 2 = Some engagement (75%). 3 = Strong engagement (98%).	1
1: Commissioned or Provided Services	1B - Individual Patients' Health Needs Met	0-3	0 = No or little activity. 1 = Basic efforts but gaps remain. 2 = Some evidence-based changes. 3 = Fully embedded and patient-centered health services.	1
1: Commissioned or Provided Services	1C - Patients are free from harm	0-3	0 = No policies ensuring safety. 1 = Basic safety policies but inconsistent. 2 = Stronger policies in place. 3 = Fully implemented patient safety measures.	2
1: Commissioned or Provided Services	1D - Patients report positive experiences of the service	0-3	0 = No engagement with patient experience. 1 = Some feedback collection but no action. 2 = Data-driven action plans in place. 3 = Patient experiences drive improvements.	1
2: Workforce Health & Wellbeing	2A - Staff support - managing obesity, diabetes, asthma and mental health conditions	0-3	0 = No initiatives. 1 = Basic signposting to resources. 2 = Targeted health interventions. 3 = Fully embedded wellbeing programs supporting all staff.	2
2: Workforce Health & Wellbeing	2B - Staff are free from abuse, harassment, bullying	0-3	0 = No action against bullying/harassment. 1 = Basic policies but weak enforcement. 2 = Anti-bullying measures applied. 3 = Comprehensive policies and accountability.	1
2: Workforce Health & Wellbeing	2C - Staff have access to independent support and advice	0-3	0 = No independent support. 1 = Some support but not widely used. 2 = Active staff networks providing support. 3 = Comprehensive support including independent advocacy.	2
2: Workforce Health & Wellbeing	2D - Staff recommend the organisation	0-3	0 = Over 50% of staff do not recommend. 1 = Over 50% of staff recommend. 2 = Over 70% positive recommendation. 3 = Over 85% positive recommendation.	1
3: Inclusive Leadership	3A - Board members' commitment to equality and health inequalities	0-3	0 = No leadership engagement. 1 = Minimal discussions on EDI. 2 = Leaders hold staff accountable. 3 = Full leadership commitment and integration.	2
3: Inclusive Leadership	3B - Board/Committee papers (including minutes) identify equality and health inequalities	0-3	0 = No mention of equality in board papers. 1 = Some policies exist but no enforcement. 2 = Regular risk assessments conducted. 3 = Fully embedded and action-driven.	2
3: Inclusive Leadership	3C - Board members manage performance and monitor progress	0-3	0 = No performance monitoring. 1 = Some frameworks but weak implementation. 2 = Accountability measures applied. 3 = Full-scale monitoring with regular improvements.	1

The full EDS scoring guidance can be accessed through the link below

EDS Ratings and Score Card Guidance

Classification: Official

Publication approval reference: PAR1262

NHS England

NHS Equality Delivery System 2022

EDS Reporting Template

Version 1, 15 August 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation		**Moorfields Eye Hospital**		**Organisation Board Sponsor/Lead**	
				Sue Steen	
Name of Integrated Care System		NCL			
EDS Lead	Ade Adetukasi		**At what level has this been completed? All 3 Domains**		
				***List organisations**	
EDS engagement date(s)	19/11/2024 16/01/2025 20/01/2025		**Individual organisation**	X	
			Partnership* (two or more organisations)		
			Integrated Care System-wide*		

Date completed	20/01/2025	**Month and year published**	March 2025
Date authorised		**Revision date**	

Completed actions from previous year	
Action/activity	**Related equality objectives**
N/A	N/A

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Interpreting Services** (DA Languages) - DA Languages provide BSL, telephone and face to face interpreting services. They also provide a translation service, and they have over 500 languages covered. **Eye Clinic Liaison Officer (ECLO):** ECLOs provide advice and information about services outside the hospital for patients living with sight loss. ECLOs are available to offer emotional support and practical advice to all patients at Moorfields, their families and carers. ECLOs can help a patient understand their diagnosis and provide information about counselling services at Moorfields and in the community. **Low Vision Service:** Provide low vision assessments. Held clinical lunch and learn to introduce the service and explain what happens during 'Low Vision Assessment (LVA). **Counselling Service:** Counselling service for all ages, Moorfields Charity funds specific children's services expansion. Referrals made by Moorfields staff. **Transport service to eligible patients:** People who require the skills or support of NEPTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by any other means. People with a medical condition(s) that impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.	1	Glaucoma/Medical Retina

		Friends and Family Feedback including an advisory council for patients: The friends and family test is a national measure of patient satisfaction for all providers of NHS care in England. It allows staff to see what patients think of the care they receive when visiting the trust. It helps us understand how we can improve the quality of the services we provide based on what patients are telling us. **Patient Experience Coordinators:** Their role is to ensure patients receive high quality patient care. Feedback from patients has been positive. **PALS:** Our PALS team provides confidential advice and support to patients, carers and relatives to help resolve concerns about their care and guide them through our services. The team helps solve problems quickly and passes on comments and suggestions for improving our services.  Personal-Emergency-Evacuation-Plan-PEEP **Identified area for wheelchair users:** **AA (Attend Anywhere):** Video consultations supporting patients to receive care. A&E virtual waiting room that patients could access from home via smart phones, laptops or iPads. This reduces the risk to patients, who can have underlying health conditions which makes them vulnerable on the journey to City Road or spending time in the hospital. **Staff Training: (ensuring staff are up to date with mandatory training)** - Patient Information Monitors located in every specialist clinic - Bariatric chairs in the clinic waiting area - Stretcher patient processes for reasonable adjustments - Handheld diagnostic machines (handheld slit lamps, ICare, Indirect/Direct Ophthalmoscope)		

		- Volunteers to assist patients when needed e.g. taking patients to pharmacy, giving directions and helping frail patients in managing personal needs (toilet trips). - Porters - OE Flagging – (dementia, learning disability, patient at risk) - MEH Direct Helpline **Policies used to ensure equal access to services:** Equality, Diversity and Inclusion Policy Mental Capacity Act and Deprivation of Liberty Safeguards Policy (Domestic abuse and abuse) Consent Policy Privacy and Dignity Policy Moving and Handling Policy Complaints Policy Data Protection Policy Dementia / Learning Disability Policy Incident Reporting Policy Interpreting and Translation Policy Non-emergency Patient Transport Policy Security Policy Slips, trips and falls Policy		

		Young adults: Designated area to wait, prioritised, reasonable adjustment, safeguarding, inclusion of carer and family member. **E.g.** Transition clinic, play specialists, Emotional support – Counsellors, App, FAQ, Digital Patient Information, PAS flagging system, Giving adequate time in clinic, Safeguarding team, Counselling service, MEH Direct, AA support, WET AMD service, Weekend Clinics, Telephone clinics and virtual service, SMS appointment reminders, Ers online booking service. **Adult & Elderly patients:** **Race** - patient information about their care, consultation information, risk information about their care, Language line interpreting service. **E.g.** Improved interpreting service **Religion and Belief** - multi-faith prayer room, Ramadan patient information, Chaplaincy service, choice of male or female clinician or nurse. **E.g.** Quiet spiritual room, multi-faith room **Sexual Orientation & Gender Identity** – Non-discrimination policy, inclusive care, preferred name, pronunciation of name and gender identity. **E.g.** Education and training for staff, gender neutral toilet **Pregnant/breastfeeding mothers:** Policy drops, accessible toilet, medicine management. Assessment, patient information, prioritise care **E.g.** Contraindicated eye drops, mother and baby room. Comfortable waiting area **Mental health:** Accessible mental health crisis support helpline (02073777000), mental health awareness webinars (Well- being intranet page), Contracted with East London Foundation Trust (ELFT) provides information on clinical		

		management, mental health guidelines, SADPERSON Framework (Under Patient mental health initiative and support line located on EyeQ page), counselling service, safeguarding champion, mental health/welfare champions, referral to GP **E.g.** SADPERSON Framework – (On EyeQ page) **Language and communication:** brochures, signage, language line translation, face to face, text, email, coloured floor markings. **E.g.** Information in Braille. Announcement of waiting time in the clinic done verbally and through the information board **Disability:** Mobility support - wheelchairs, ramp, accessible seating area, portering service, handrails, hoist, lifts, volunteers, patient experience co-ordinator, nursing staff to guide, accessible pharmacy, signage, Toilet call bells, LED green light, sliding doors, portable slit lamp, pachymeter, indirect ophthalmoscope, I-Care, PAS, PEEP ((Patient Emergency Evacuation Plan) Form, priorities, signpost for support **E.g.** Transport provisions/Stretcher support **Visual impairment:** Braille in lift and artworks, green line from old street station leading to MEH), art gallery, floor signpost, British sign language (BSL), large font size sign, volunteers, dog refuge area, patient experience co-ordinator, CVI registration, K-Picture chart, E Chart, Low vision aid, referral to optician, Optometrist, ECLO service, RNIB partnership, sight loss awareness campaign, sight loss awareness training, adequate lighting, Helping hand sticker, Open Eyes Risk Flag, Voice information on lifts (Talking lifts). **E.g.** Larger font for patient information, ECLO and GP for support, navigation device, Floor markings for directions, Patient Experience Coordinators for support, Talking lift		

		Speech/Hearing Impairment: Translator, hearing loop, sensor calling device, caption video in waiting area, patient experience co-ordinator, PAS, Helping hand sticker, Open Eyes Risk, digital information screen. **E.g**. Allocated quiet area, Hearing loop systems Improving NHS Staffing ratio, Staff training, Include family and carer, E-Picture chart / K Picture chart **Neurodiverse:** Assessment, patient information, health information exchange (HIE), CITO Designated waiting area, patient experience co-ordinator, K-picture chart, E-Chart, prioritising and co-ordinating care, inclusion of carer and family member. PAS, helping hand sticker, Open Eyes Risk, policies and guidelines, flagging system, Hospital passport, This is me booklet, Learning Impairment passport. **E.g.** Quiet area sensory – friendly waiting area, time allowance, prioritising, flagging system **Diabetes:** Assessment, following care management hypo or hyperglycaemic protocol, prioritising and co-ordinating care, offering food and drinks, patient information on eye care, wheelchair access, wheelchair access, referral to GP. **Immunocompromised:** PPE, Cito **Autoimmune diseases:** Prioritise care **Infectious disease:** PPE, Designated area, protocols, wipes, hand washing facilities, domestic, infection control team, incident reporting system **Respiratory illness:** assessment, oxygen therapy with prescription, wheelchair access, patient experience co-ordinator, prioritise care		

		Housebound: Hospital transport, ophthalmologist, optometrist, carer and family member, patient experience co-ordinator, portering service, portable slit lamp, ICare, Ishihara, policy, site cover nurse, food and drink. **E.g.** Call bell, Wheelchair access waiting time, Early identification, Safeguarding, Patient education, Include families and carers, Discuss treatment available		
	1B: Individual patients (service users) health needs are met	**Foster Open and Effective Communication:** Active listening – allow patients to share concerns, preferences without interruptions. Reflect back what they've said to confirm understanding. Ask open-ended questions – asking question that will encourage their thoughts. Plain Languages – avoid medical jargon, explain options and procedures in terms the patient can understand. **Provide Information and Education:** Explain All Options – clearly outline risks, benefits or any alternatives of proposed treatment or interventions. Use visual aids / infographics **Respect Patient Preferences and Autonomy:** Informed Consent always ensure that patients have the information they need to make informed choices. Cultural and Personal Considerations like religious beliefs, cultural practices and personal values. **Understand Patient Individual Needs:** Holistic assessment – assess not just physical symptoms but also emotional, social and psychological needs. Cultural sensitivity – show respect for cultural, religious and language needs by offering interpreters. Build Trust – establish rapport by showing genuine care and empathy.	1	Medical Retina/Glaucoma

		Involve Family and Carers when appropriate: If patient agrees involve family members or carers in discussion about care. Family support as needed. **Training of Staff in Patient-Centred Care:** Communication skills which build rapport and gains trust from patients. Awareness of cultural differences be sensitive to the diverse needs of individuals. **Use Feedback to Improve:** Encourage feedback – use surveys ie: FFT to gather on how patients' needs are being met. Act on Feedback – ensures patients feel heard. **Clarification with Patients:** Check with patients and confirm that they understand decisions and agree.		
	1C: When patients (service users) use the service, they are free from harm	**Create a Safe Physical Environment:** Risks assessment regularly assess the clinic for hazards, including trip hazards and faulty equipment. Infection Control follow strict hygiene protocols to prevent any spread of infections. Provide mobility aids like wheelchairs, Zimmer frames. **Prevent Abuse and Neglect**: Safeguarding Training – making sure all staff are trained to recognize and report signs of abuse and neglect promptly. Monitor incident reports. **Respond Quickly to Issues**: Address concerns promptly – investigate and resolve complaints without delay. Apologise when necessary – offer sincere apologies **Foster a Culture of Safety and Respect:** Encourage openness – promote a culture where staff and patients feel safe raising concerns.	2	

		Team Collaboration – team working among staff to share responsibility for protecting patients. Support Vulnerable Patients: Specialised Care – provide targeted support for high risks groups such as the elderly, children and those with mental health challenges. **Communication Support:** Use clear language Encouraged Feedback Active Listening **Ongoing Training and Development:** Safeguarding training Respecting Cultural Diversity Leading with Compassion Training		
	1D: Patients (service users) report positive experiences of the service	PLACE audit – Patient Led Assessment of the Care Environment FFT – Friends and Family Test Incident reports Complaints Compliments / Thank you feedback **Glaucoma Feedback from FFT:** "The customer care was excellent – they really looked after me." "Just wanted to say amazing service and totally put at ease as was very nervous." "Nothing to improve. Well run place. Efficient and courteous staff. Everything explained clearly." "Nothing really, one of the tests the staff member did not wipe the machine clean. Of Course they may have cleaned it straight after the last patient." "Less waiting time."	1	Medical Retina/Glaucoma

		"Brighter illumination but gather you can't do that, department shown on signage on ground floor." **Medical Retina Feedback from FFT:** (Positive and Negative) however unable to identify patient demographics. "I'm very happy with the help from the whole team. They always have worked extra miles to help patients when under pressure. Highly appreciated and grateful "June - who did injection is excellent very professional" "Gold star! Keep up the excellent work" "The staff were excellent with my wife. She was very disruptive, and they were all brilliant handling her. I cannot thank them enough. Please let them know my feelings" "Nothing they were super kind efficient patient, and I didn't have to wait at all 10/10" "It was already perfect! Couldn't be better. Many thinks to the team in Clinic 10 who took care of me. You excelled."		
Domain 1: Commissioned or provided services overall rating			5	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• **Thrive at Moorfields Programme**: This program aims to support both physical and mental health, aligning its structure with evidence from scientific literature, organizational data, and stakeholder insights. Notably, the program includes: • **HealthHero Assist**: An Employee Assistance Program offering free, confidential services, such as counseling, health information, and mental wellness resources. It's accessible 24/7, enabling staff to address both work-related and personal issues. • **Able Futures**: Provides tailored mental health support, offering staff up to nine months of personalized mental health guidance, focusing on resilience and coping strategies for workplace stressors. • **Diet and Wellness Webinars**: Nutrition-focused webinars led by dieticians address the impact of diet on mood, energy, immunity, and sleep. These webinars support physical health while linking these aspects to mental wellness, emphasizing overall health management. • **Diabetes webinar hosted by BeMoor network** **Additional Health & Wellbeing Initiatives**: • **Financial Health**: Services like Price Financial Planning and FinWell offer staff financial guidance, recognizing the mental health impact of financial strain. • **Physical Health Resources**: Access to free or discounted resources, including Pilates at your desk, Vivup benefits (e.g., Cycle to Work), and discounted gym memberships, promotes physical activity and wellness. • **Menopause Advocates and Virtual Cafés**: These resources offer specific support for managing menopause, providing safe and confidential spaces for sharing experiences and accessing information. • **Wellbeing Training Modules**: Sessions like "Managing Stress" and "Leading with Compassion" (including a wellbeing module) equip staff with stress management	2	Wellbeing team

		tools and reinforce leadership empathy in workplace health. • **Headspace**, **Hardship Grants**, **Employee of the Month**, and **Menopause Cafés** • **Cycle to work scheme** • **Posters around the Trust promoting healthy living and healthier choices** • **Occupational health:** provided by NLPSS.		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	**Equity, Diversity, and Inclusion (EDI) Program:** • **Anti-Racism Charter part of Psychological Safety Initiative**: Signed in June 2024, this charter includes 20 pledges aimed at creating an anti-racist work environment. Key pledges address internal and external challenges, provide a robust reporting mechanism for racism and abuse, and promote staff psychological safety. Staff are trained in anti-racism and unconscious bias, with an emphasis on equity in discipline and grievance processes. • **Share Not Declare Campaign**: Aimed at building psychological safety, this initiative encourages open communication about identity and belonging without stigma, bolstering a culture of support and acceptance. **Well-Being and Racism Impact Awareness:** • **Wellbeing initiatives combating racism and supporting workforce**: By creating a focus group involving wellbeing team, union members, FTSU, Staff Networks, colleagues with lived experiences and EDI team we have started the initiative to explore this agenda. • **Working with NHS Muslim National Network for promoting Mental Health and Islamophobia**: We have reached out to the Muslim NHS National network for support. Their priority this year is focusing on wellbeing and mental health. We have requested them to do sessions as part of our BME network. **Staff Networks and Listening Events:** • **Dedicated Networks**: Networks such as BeMoor (BME support), MoorAbility (disability support), and MoorPride (LGBTQ+ support) provide platforms for underrepresented groups to share their experiences safely. They support the organization's inclusive ethos, contribute to initiatives like the Career Sponsorship Program for BME colleagues, and address network-specific challenges (e.g., developing the Trust's Transgender policy). We are also launching Woman's network by next month.	1	Wellbeing team EDI Union ER

		• **Networks involvement on policy creation:** Involving networks to build inclusive policies for example MoorPride Network co creating Transgender Policy and MoorAbilty for Workplace Adjustment Guidance for Managers. • **Action on Bullying and Harassment**: WRES/WDES reports highlight targeted actions. For instance, the organization's 2024 data indicates a reduction in bullying and harassment incidents among BME staff and disabled staff, while continued training and monitoring help identify areas for improvement. Active Bystander training enables staff to intervene in instances of inappropriate behaviour. • **Dignity at work policy**		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	**Thrive at Moorfields Sessions for Staff Networks**
		• **Delivered sessions for all networks**: Oct and Nov 2024 wellbeing team delivered these session for BeMoor, MoorPride and MoorAbility which inclusion information for:
		  ○ **HealthHero Assit – Our EAP**
		  ○ Hardship Grant
		  ○ Menopause support at MEH
		  ○ Health and Wellbeing Opportunity
		  ○ Vivup – employee benefits provider
		  ○ Benefits and Discounts
		  ○ Dedicated page on staff intranet (Health and Wellbeing on eyeQ)
		
		Health and Wellbeing Support Services:
		• **HealthHero Assist and Able Futures**: Both services offer confidential support for emotional issues, including counselling for workplace and personal challenges, and signposting to resources for managing workplace violence, bullying, and harassment.
		Freedom to Speak Up (FTSU) Guardians:
		• **Awareness Campaigns and Support Accessibility**: FTSU Guardians raise awareness through site visits, walkabouts, and presentations at monthly inductions and governance meetings. By distributing informational leaflets and hosting lunch-and-learn sessions, the Guardians inform staff about reporting avenues and the support available.
		• **Work in Confidence Platform**: This anonymous reporting tool has been implemented to offer staff a confidential way to share concerns without fear of retaliation, encouraging a more open reporting culture. Staff concerns average about 15 reports per month, with significant issues like bullying and harassment highlighted for response.
		Training for Empowerment and Protection:
		• **Active Bystander Training**: Equips staff with the confidence and skills to address or report inappropriate
			2	Wellbeing team

		behaviour, supporting a respectful workplace culture. We have trained over 700 colleagues in the Trust. • **Stress Management Workshops**: Sessions offered to all staff provide tools to recognize, manage, and alleviate workplace stress, addressing both individual and systemic stressors. **Wellbeing and Anti-Racism Group:** • **Supporting the Unison Anti-Racism Charter**: Working with different teams including wellbeing, EDI, ER, Unison and FTSU to ensure we provide support to our colleagues.		

	2D: Staff recommend the organisation as a place to work and receive treatment	• **Staff Survey and Pulse Survey Results:** Our 2023 staff survey received a 66% participation rate, with 63.3% of respondents indicating that they would recommend the organization as a place to work—surpassing the national average of 61.12%. Data from the July 2024 Pulse Survey, with 318 respondents, shows that 54.3% expressed positive sentiments about recommending the workplace, while 23.9% were neutral, and 21.8% expressed negative sentiments. • **Psychological Safety and EDI Initiatives:** Our plan is to build psychological safety and championing anti-racism through the new EDI program, enhancing workplace culture, and supporting an inclusive environment that aligns with staff values. • **Trust Commitment:** The organisation's commitment to fostering an inclusive culture, particularly through our new EDI Vision and EDI Programme directly supports these inclusion and belongingness initiatives. The three workstreams: Leadership and Culture, Data Driven Change and Fair Opportunities for All are focused on supporting programs such as the Share Not Declare campaign and the Anti-Racism Charter and have been instrumental in enhancing psychological safety and promoting open communication. These initiatives contribute to building a supportive environment that aligns with Trust and staff values, strengthening their engagement and satisfaction with the workplace.	1	OD
Domain 2: Workforce health and well-being overall rating			6	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**Culture and Strategic Leadership** Moorfields has made significant strides in promoting diversity, equity, and inclusion (EDI) at all levels of its decision-making operations, including within its governance structures. The Board of Directors plays a pivotal role in ensuring that EDI principles are not only integrated into Moorfields' policies and practices but are also seen as central to our culture and patient care. Board members work hard to demonstrate commitment to health inequalities, equality, diversity and inclusion. The Board of Directors plays an essential role in leading, monitoring, and championing diversity, equity, and inclusion within the healthcare system. Through training, reviewing detailed reports and metrics, listening to staff and patient stories, and developing action plans, they are working to ensure that not only is Moorfields an employer of choice but also an equitable healthcare provider for all communities. However, directors recognise that there is much more to be done. At a strategic level, the Board of Directors sets the vision and organisational culture that emphasises EDI. This involves: Leading by Example: The Board leads by example, demonstrating a commitment to diversity, equity, and inclusion in their own behaviour and leadership style. This includes showing respect for diverse perspectives and acting as champions for inclusivity. The Trust Chair is exploring positive action(s) to increase the diversity of Trust Board membership. Accountability: Board members are held accountable by the NHSE, CQC, and Membership Council for progress on EDI goals. This includes involvement in the recruitment of diverse leadership and ensuring that EDI goals are linked to overall organisational performance reviews. In turn, the Board monitors and evaluates the performance of executive delivery at Moorfields. The Annual Report and Accounts contain detailed reporting on EDI across Moorfields, these are submitted to the AGM of our members where senior executives and board members are available to answer any questions. Well-Led: we keep our corporate governance arrangements under review to ensure they meet the standards set out in the NHS England's Well-Led Framework. A Well-Led Developmental Review was conducted in July 2022 by our internal auditor, RSM UK.	2	

		Embedding EDI into Strategy: the Board ensures that EDI is embedded in Moorfields broader organisational strategy. This means ensuring that every aspect of the NHS, from recruitment practices to patient care strategies, reflects EDI principles. The trust's EDI strategic objectives are informed by qualitative and quantitative data, which include our Staff Survey results, our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions, our Gender Pay Gap (GPG) submission, and feedback from our staff networks. They are: • Increase the diversity of our leadership and management teams. • Build a strong and positive culture of inclusion and belonging. • Improve the collection, reporting and transparency of our EDI data. Employee relation cases: are to be reviewed and monitored at Board level from 2025. Diversity information is included to enable themes to be identified and addressed. **Evidence:** Well Led review final report, IPR, Senior Independent Director is Lead of FTSU, Chair of the People & Culture Committee is Lead for Diversity, Annual Report & Accounts, NEDs self-assessment returns, Membership Council holds Board to account (minutes) - , using diversity specialist recruitment agency, strategy. The Board has promoted establishing new position of Associate Non-executive Director as a development programme created and designed to support the next generation of talented people from groups who are currently under-represented on the Moorfields Boards (MS minutes, draft pack). Aaron Rajan (NED) has written a public press article related to racial inclusion as part of his role at Unilever https://techinformed.com/how-unilever-is-ensuring-inclusivity-in-its-ai-powered-beauty-experiences/. **Continuous Learning** At the core of ensuring that the Board of Directors understands and is equipped to drive EDI is comprehensive and ongoing learning. This learning focuses on several key areas: Unconscious Bias Awareness: Directors receive training in identifying unconscious bias, which can influence decision-making and the equitable treatment of staff and patients. They learn to recognise biases based on race, gender, sexual orientation, disability, and other protected characteristics.		

		Cultural Competency: Training helps board members understand and respect the diverse cultural backgrounds of patients and staff, promoting an inclusive environment that respects cultural differences and values diverse perspectives. Inclusive Leadership: Directors are trained in the principles of inclusive leadership, focusing on how to actively engage with and empower underrepresented groups within the workforce. This includes understanding how to promote diversity at all levels of Moorfields workforce. We would like to look at each Board member agreeing to at least one SMART EDI Objective a year. Legal and Regulatory Frameworks: The Board receives training on the legal obligations surrounding equality, such as the Equality Act 2010, which requires organisations to eliminate discrimination, advance equality of opportunity, and foster good relations between different groups. The information the Board receives is updated regularly to reflect new developments in EDI thinking, emerging best practices, and relevant legislative changes. **Evidence:** Mandatory training, briefings, Workforce Reports, other training (NEDs self-assessment returns), Health Inequalities Data Analysis training report. Michael Marsh (NED) has undertaken a Leadership for Inclusion Programme recently, prior to joining MEH as part of his role for NHSE. Pete Thomas has attended anti-racism workshops. Nick Roberts (Exec) commissioned a project for technical enhancements for the Trust Board and Membership Council to try to improve inclusivity and provide a more inclusive environment for colleagues with auditory and visual impairments. **Advocacy and Collaborative Approaches and External Partnerships** The Board receives reports on how Moorfields works with external organisations to strengthen EDI. Some of these include:		

		Partnerships with Community Groups: Moorfields board collaborates with local and national community organisations (including RNIB, members, patient groups) to understand the challenges faced by underserved or vulnerable populations. These groups might provide insights into how our services can be made more accessible or how the workplace culture can be more welcoming. EDI Networks: Moorfields has established networks for staff, such as MoorPride (LGBTQ+ staff networks), MoorAbility (supporting staff with disabilities and long-term health conditions), BeMoor (advancing EDI), women's staff network. The Board ensures these networks are well-supported and that they are assigned executive director leads to ensure a direct line of communication to the wider senior leadership to highlight issues affecting these groups. External Audits and Reviews: To ensure accountability and to identify areas for improvement, the Moorfields sometimes invites external bodies to conduct audits of its EDI policies and practices. These audits evaluate whether we are meeting our legal and moral obligations regarding equality. RSM conducted an internal audit of Diversity and Equality in March 2023 and the report was considered by the Board's Audit & Risk Committee. **Evidence:** Staff groups led by senior executive board directors, audit reports, NEDs attendance at staff groups, NHSE EDI Plan, RSM UK EDI Internal Audit, Anti Racism Charter signature (Excellence Portfolio). Adrian Morris (NED) is the exec sponsor for the disability network at Haleon which hosted an international day for person with disabilities with over 700 attendees. Adrian Morris (NED) is a member of the DEI Council at Haleon. Andrew Dick (NED) has developed and held workshops and activities, to bring inclusive behaviour at the Institute of Ophthalmology (IoO). Encouraging and established diversity in the leadership at the IoO across broad range of activities. Andrew Dick (NED) holds 'Meet the Director' forums through his role at IoO. These are for technical and professional support staff, and early career researchers (ECR) and PhD students (which includes MEH staff).		

		Jon Spencer (Exec) attended network events celebrating Black History Month, lunch events celebrating Eid al-Fitr and Pride events. Jon Spencer (Exec) is the MEH exec lead for MoorPride network group. Jon Spencer (Exec) is a mentor for MEH Darzi's fellows. The topic allocated to both the current and last year's fellows has been health inequalities. Jon Spencer (Exec) is SRO of Oriel and EPR which are programmes making improvements in the way that they engage staff and patients. Examples of this include the co-design of a new patient portal and an independent assessment of patient's views on the use of a single point of access. Sheila Adam (Exec) is the exec sponsor for BeMoor network group. Sue Steen (Exec) is the exec sponsor for MoorAbility network group and was the exec lead for the LGBTQI for the her previous employer. Elena Bechberger (Director of Strategy and Partnerships) is the sponsor of Aurora (women's network), promoting gender equity through mentoring and leadership initiatives. 1. Anti-Racism Charter and Leadership Training: o Executive coaching sessions focus on embedding anti-racism into leadership accountability, ensuring inclusive leadership behaviours (Minutes: 05 Nov 2024). o Anti-Racism Charter Tracker updates shared with leaders, showing progress on pledges and accountability metrics. 2. EDI Leadership Walks: o Executive Floor Walks designed to enhance leader engagement with staff on EDI issues, supported by structured feedback tools and prompts. 3. Inclusive Leadership Development: o Regular updates provided on leadership and culture projects, including sessions addressing racial equity and inclusion within senior management. 4. Support for Diverse Staff Networks: o Regular contributions from network co-chairs on initiatives such as MoorAbility's neurodiversity workshops and MoorPride's LGBTQ+ visibility campaigns.		

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	**EDI Reports and Metrics** To ensure accountability and transparency in EDI efforts, the Board regularly reviews detailed reports and metrics. These reports typically include: Workforce Demographics: These reports provide detailed data on the diversity of NHS staff at various levels, from entry-level positions to senior leadership. This includes information about gender, race, disability status, sexual orientation, and other protected characteristics. Representation Across Senior Roles: Board members assess how diverse the senior leadership team is compared to the overall workforce. There is a gap at Board level, action plans have been created to improve the recruitment, retention, and promotion of diverse talent into leadership roles. Equality Impact Assessments (EIAs): The Board reviews EIAs for major policy changes, staffing decisions, and patient care initiatives. These assessments evaluate how different groups are affected by the changes and whether any groups might experience negative impacts. Staff Satisfaction and Inclusion Surveys: Regular surveys are conducted to measure staff satisfaction with the NHS as an employer, with a particular focus on inclusivity. These surveys help the board understand the lived experiences of staff from diverse backgrounds. The Board has acknowledged that the experience of Moorfields' international educated nurses and staff with a disability and longterm condition needs to improve and has overseen ongoing action. Patient Experience Data: Metrics related to patient care are crucial to EDI advancement. This data includes patient feedback, complaints, and satisfaction levels segmented (when possible) by demographic factors (e.g., ethnicity, age, gender). The Board looks for trends in the data, ensuring equitable treatment of all patient groups. Training and Development Metrics: The Board reviews how well diversity and inclusion training are being adopted across the organisation. This can include participation rates in mandatory EDI training and the impact of such training on our overall culture.	2	

		Setting clear policies: Equality, Diversity and Inclusion (Our EDI policy sets out how we ensure that neither patients nor staff are treated differently because of any protected characteristic they may have), Mental Capacity Act and deprivation of liberty safeguards (Domestic abuse and abuse), Consent Policy, Privacy and Dignity, Moving and Handling, Complaints policy, Data Protection, Dementia Policy / Learning Disability, Incident reporting, Interpreting and Translation policy, Non-emergency Patient Transport, Security, Slips, trips and falls. Health Inequalities: Board oversight of statutory and health policy requirements for monitoring and reviewing health inequalities. A systematic and sustainable approach for concurrently reporting on our performance for any disparities in the delivery of our services as BAU report to Quality & Safety Committee, to Board twice a year and in Trust Report. Excellence Portfolio: The Excellence portfolio is our framework to deliver organisational change. It includes four executive led programme boards, now in their third year. The Board receives regular progress reported including in April 2024 when the status update was presented at the Board Strategy Day. **Evidence:** People & Culture Committee papers, Quality & Safety Committee papers, EDI Annual Report(various reports), EPR Decision EIA and accessibility - minutes and papers, Staff Survey and analysis, integrated performance report, complaints, FTSU reports, Mandatory Training statistics, Excellence Portfolio – Board Strategy Day 25 April 2024, Eye Healthcare Inequalities Improvement Group (EHIIG) papers. 1. **Equality Impact Assessments (EHIAs):** ○ Introduction of improved EHIA templates to ensure equality impacts are systematically reviewed and addressed during decision-making processes (Minutes: 06 Aug 2024). 2. **Data-Driven Decision-Making:**		

		○ Comprehensive EDI Baseline Data analysis presented at regular intervals to identify disparities and propose mitigations in recruitment and promotions. **3. EDI Steering Group Discussions and Papers:** ○ Minutes include strategic reviews of projects like “Leadership and Culture, Data-Driven Change and Fair Opportunities for All”, addressing EDI issues including recruitment biases and promotion disparities, signing up, promoting data transparency by building EDI dashboard and implementation of Anti-Racism Charter. **4. Risk Mitigation Plans:** ○ Use of structured feedback and project updates to evaluate risks, such as disparities in senior leadership representation.		

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	**Championing representation through Staff and Patient Stories** Both staff stories and patient stories play a fundamental role in EDI understanding, providing qualitative insights that complement the quantitative data in reports. Staff Stories: At every meeting the Board of Directors gathers staff experiences, particularly from underrepresented groups this is in-person (and as reported elsewhere also through surveys, interviews, or focus groups). These stories help the Board understand barriers to career progression, feelings of inclusion, or exclusion, and areas where Moorfields can improve its workplace culture. Stories from staff who have faced discrimination or bias can inform policy changes and the development of more inclusive practices. Patient Stories: The Board also prioritises gathering stories from patients about their care experiences, especially from marginalised communities. For example, stories from ethnic minorities, LGBTQ+ individuals, disabled patients, and others offer insights into how patients from different backgrounds experience healthcare. These stories are often shared in patient forums or through patient experience surveys, helping the Board to understand the realities of care and whether patients feel they are treated with dignity, respect, and fairness. **Evidence:** Staff and Patient Stories (minutes), Patient Report Membership Council, FTSU, surveys/feedback. **Active Participation in Action Plans and Progress Reviews** The Board regularly updates action plans to ensure that EDI remains a priority. This includes: Setting Clear Objectives: The Board sets specific, measurable objectives for improving EDI across various areas. This can involve targeting improved representation of minority groups within the workforce, ensuring equal access to training and career advancement, or addressing disparities in patient care outcomes. Regular Progress Reviews: EDI performance is reviewed regularly through meetings where the Board assesses progress against set objectives. These reviews are often backed up with data, such as changes in the diversity of the workforce or improvements in patient satisfaction scores for marginalised groups.	1	

		Feedback Loops: EDI progress is discussed in partnership with key stakeholders, including staff representative groups (such as trade unions and staff networks), patient advocacy groups, and other external partners. This helps the Board ensure that its efforts are aligned with the needs of both employees and patients. **Evidence:** Operational Plan, EDI Programme Pathway at People & Culture Committee, business plan, workforce strategy, integrated performance reports, WRES/WDES statistics, Gender Pay Gap reporting, IPR, feedback loops into People & Culture Committee (papers), oversight of accessibility improvements in a number of areas including the improvement to our Complaints and PALS service, implementation of AIS standards, digitisation of patients letters, handling of queries via our booking centre, the linking of our patient portal to the NHS app and planned introduction of an outpatient waiting list (report). Jon Spencer (Exec) chairs the Divisional Performance reviews for the clinical / operational divisions. As part of the agenda for these meetings, he will challenge the divisional management teams about any areas of their operational performance which is not improving. If local variations in care are identified, then they are reported on the divisional risk register allowing him to advocate for resources to be utilised to address the issues in question. Justin Betts (Exec) attends performance reviews, business planning and efficiency savings reviews which include equality issues relating to equality and health inequalities. Justin Betts (Exec) completes end of employment exit interviews. **Tackling health inequalities** Led by the organisation's consultant in public health and ophthalmology, with the support of the trust's analytical and informatics team, completed initial data analysis into issues of health inequality and disparity in service provision. This focused on uptake and access to services across patient demographics and deprivation levels. Initial findings indicated that once patients are within our system, variations in access and uptake of services were seen for: • Type of Attendance outcomes of booked OPD appointments - by Risk		

		• RTT for surgical episodes completed in 2022-23 - by Deprivation, Risk and Need This important piece of work continues to aid the trust in better understanding how it delivers its activity to Moorfields patients, who have a broad socio-economic and cultural diversity. During the year the work moved into a second phase using the data to establish strategies and actions to address these and act as a focal point for change where required. The recent report ensured that there is a sustainable mechanism for analysis and reporting to ensure that this issue is at the heart of the way in which the trust monitors its service delivery and levels of performance. The Quality & Safety Committee received report Making Better Use of Routine Health Data for concurrent BAU reporting and review of performance and healthcare inequalities. **Evidence**: Health Inequalities report to Quality and Safety Committee May 2024 and MC on 28 November 2024 Andrew Dick (NED) has given talks on equality and opportunity in science and academia (related to health) as part of his role at IoO. Jon Spencer (Exec) oversaw a pilot to test where AI may be able to predict those patients most at risk of not attending their outpatient appointment. Pete Thomas (Exec) has spoken about the single point of access work including the deprivation work extensively. The deprivation work was part of the presentation that lead to MEH winning the HSJ Innovation of the Year 2024. Pete Thomas (Exec) lead the NHS England Eyecare Accelerator for London, and we have recently won the NCL “Lead Provider of Community Ophthalmology” contract. Within that contract we have a commitment actively to tackle inequality in the provision of eyecare. This includes setting up a specific deprivation and inequality steering group, and helping the ICS and all providers to implement changes that improve things from this perspective. Sheila Adam (Exec) attend regular ICB meetings re health inequities. **Further evidence:**		

		1. **Equality Impact Assessments (EHIAs)**: ○ Introduction of improved EHIA templates to ensure equality impacts are systematically reviewed and addressed during decision-making processes (Minutes: 06 Aug 2024). 2. **Data-Driven Decision-Making**: ○ Comprehensive EDI Baseline Data analysis presented at regular intervals to identify disparities and propose mitigations in recruitment and promotions. 3. **EDI Steering Group Discussions and Papers**: ○ Minutes include strategic reviews of projects like “Leadership and Culture, Data-Driven Change and Fair Opportunities for All”, addressing EDI issues including recruitment biases and promotion disparities, signing up, promoting data transparency by building EDI dashboard and implementation of Anti-Racism Charter. 4. **Risk Mitigation Plans**: ○ Use of structured feedback and project updates to evaluate risks, such as disparities in senior leadership representation **Additional Information – Linking to All Three Questions (3A, 3B and 3C)** **Role of EDI Steering Group:** 1. **EDI Steering Group Structure and Role:** Chaired by Sue Steen, Chief People Officer, the EDI Steering Group serves as a central council dedicated to advancing inclusion across the Trust. It directly reports to the Management Executive (ManEx), the Trust’s executive team, highlighting its strategic importance in shaping equality, diversity, and inclusion (EDI) initiatives. Frequency: The group convenes monthly, ensuring consistent progress on EDI objectives and timely responses to emerging issues.		

		Membership: The Steering Group brings together representatives from diverse teams, ensuring a comprehensive and inclusive approach. Members include: • Staff Networks (e.g., MoorAbility, BeMoor, and MoorPride). • Head of Nursing. • Legal Services. • Freedom to Speak Up Team. • XDU (Equality and Diversity Unit) Team. • Major Project Team. This diverse membership ensures holistic decision-making and accountability on EDI-related issues. 2. **Focus on Leadership Accountability:** The agendas and minutes demonstrate a strong emphasis on senior leadership's active involvement in EDI initiatives, ensuring alignment with organisational values and strategic goals. Examples include updates on: • EDI programme – (Leadership and Culture, Data-Driven Change and Fair Opportunities for All) • Staff network updates • EDI Comms updates • Other OD programmes including Leadership training, Values and Behaviours project and review and implementation of inclusion-focused policies. • Regular updates on EDS2022 • Anti-Racism Charter 3. **Alignment with EDS 2022 Framework:** The EDI Steering Group's work aligns closely with the Equality Delivery System (EDS) 2022 framework. Key focus areas include: • Driving progress through robust data analysis. • Strengthening staff engagement mechanisms. • Providing strategic oversight to address health inequalities.		

		4. **Supporting Evidence:** Agendas and minutes from the EDI Steering Group substantiate all outcomes under Domain 3. The group's commitment to fostering inclusivity is evident through: • Consistent focus on leadership and culture projects. • Evaluation of staff network contributions. • Systematic reporting on performance and inclusion metrics.		
Domain 3: Inclusive leadership overall rating			5	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): Leoni Awiah – Staff side	**Independent Evaluator(s)/Peer Reviewer(s):** Natoya Mamby – NCL EDI Lead

EDS Organisation Rating (overall rating): 16

Organisation name(s): Moorfields Eye Hospital

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan				
EDS Lead **Ade Adetukasi, Associate Director of Employee Experience**			**Year(s) active** **2024/25**	
EDS Sponsor **Sue Steen, Chief People Officer**			**Authorisation date**	
Domain	**Outcome**	**Objective**	**Action**	**Completion date**

Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	There is a need to improve data collection and monitoring for patients access to the services, with specific provision for patients from protected characteristics group. To achieve a rating of 2 in the next EDS cycle 12 months, the trust needs to evidence the following: Data and evidence to show relevant patients with higher risks due to a protected characteristic or at risk of health inequalities (75% of those using the service) have adequate access to the service. Patients consistently report good or very good (or the equivalent) when asked about accessing services. Demonstration that the organisation has identified barriers to accessing services	Learning from the EDS assessment on gap in patient access data collection, especially in relation to protected characteristics data, will be escalated to the EPR project team as the implementation of the new EPR system is expected to significantly enhance the collection and monitoring of patient access data. Mitigations for monitoring in meantime include: • To raise awareness amongst frontline staff on the need for collecting demographic data as part of the promotion of the new EHIA protocol. • Local staff and service managers will be supported by the EDI team in improving data collection for patients from protected characteristic groups and those at risk of health inequalities. • To escalate learning from the EDS assessment of services to the Patient and Carer Race Equality Framework (PCREF) implementation working group to ensure inclusion of health inequalities data into trust's leadership and governance arrangements. • To include learning from the assessment in the trust's new EHIA training for managers	Dec 2025

			These actions will guide us toward improving our performance and achieving a rating of 2 in the next EDS assessment cycle in February 2026.	

	1B: Individual patients (service users) health needs are met	To achieve a rating of 2 within the next EDS cycle – the required level of activity the Trust needs to evidence the following: Patients at higher risk due to protected characteristic needs are met in a way that works for them. The organisation often consults with patients with higher risks due to a protected characteristic to commission, designed, increase, decrease, de-commission and cease services provided. The organisation signposts to VSCE organisations and social prescribing. Personalised care is embedded into the care delivered for those with higher risks due to a protected characteristic by the organisation.	EDI team and steering group to reinforce application of the trust's new EHIA protocol across all services related changes and development. To escalate learning from the EDS assessment of services to the Patient and Carer Race Equality Framework (PCREF) implementation working group to ensure inclusion of health inequalities data into trust's governance arrangements. To ensure that quality improvement processes are informed by this data, making patient care continuously more inclusive. These actions will guide us toward improving our performance and achieving a rating of 2 in the next EDS assessment cycle in February 2026.	Dec 2025

	1C: When patients (service users) use the service, they are free from harm	To achieve a rating of 3 within the next EDS cycle, the required level of activity the trust needs to evidence are the following: The organisation has procedures/initiatives in place to enhance safety in services for all patients in protected characteristic groups where there is known H&S risks. Staff and patients are supported and encouraged to report incidents and near misses. The organisation encourages and promotes an improvement culture actively including equality and health inequality themes in safety incidents and near misses. The organisations work with system and community partners to improve safety outcomes for people, using existing data and driven by service need/risk	The EDI team will work with local managers and staff to ensure that there is provision for capturing and monitoring data specific to patients from protected characteristics groups To support services in the introduction of initiatives to enhance safety in services for patients in protected characteristics groups where there is known health and safety risks. To ensure protected characteristics data or information are embedded into local systems to support themes collation and make it easier to identify learning, patterns, and emerging issues requiring more work or support. These actions will guide us toward improving our performance and achieving a rating of 3 in the next EDS assessment cycle in February 2026.	Dec 2025

	1D: Patients (service users) report positive experiences of the service	To achieve a rating of 2 within the next EDS cycle, the required level of activity the trust needs to evidence are the following: The organisations collate data from patients with protected characteristics about their experience of the service. The organisations create evidence-based action plans in collaboration with patients and relevant stakeholders, and monitors progress. The organisation shows understanding of the link between staff and patient treatment and demonstrate improvement in patient experiences	EDI team to support local managers in putting in place systems for - patient feedback to include demographic details -enabling those that English is not their first language to be able provide feedback on services. - ensuring that the unique need of patient from protected characteristics group are catered for -enabling improved data collection for getting a better understanding of the satisfaction of patients with protected characteristics -ensure equal access to patient that don't use technology. These actions will guide us toward improving our performance and achieving a rating of 2 in the next EDS assessment cycle in February 2026.	Dec 2025

Domain	Outcome	Objective	Action	Completion date

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To build on existing staff health and wellbeing resources with provision for supporting staff and protected characteristics groups at risk of developing diabetes, obesity, asthma, and COPD. To achieve a rating of 3 within the next EDS cycle, the required level of activity the trust needs to evidence are the following: The organisation monitors the health of all staff. The organisation supports all staff to actively manage their conditions via various methods. The organisation uses sickness and absence data to support staff to self-manage long term conditions and to reduce negative impacts of the working environment. The organisation actively works to increase health literacy within its workforce. The organisation promotes and provides innovative initiatives for work-life balance, healthy lifestyles, encourages and provides opportunity to exercise. The organisation signposts to national and VSCE support. The organisation uses data to support	Work with our Occupational Health provider and the Staff Wellbeing team to monitor and target interventions by protected characteristic for: ○ Obesity ○ Diabetes ○ Asthma ○ COPD To complete ongoing process for securing charitable funds to support provision of psychological and mental health support. To work jointly with employee networks group in raising awareness and health promotion of high risk associated with protected characteristics groups. To work jointly with health and wellbeing champions to promote work-life balance and healthy lifestyles to monitor and improve uptake by protected characteristic.	Dec 2025

		their workforce in making healthy lifestyle choices.		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To strengthen and evaluate effectiveness of existing systems and process to ensure staff are free from abuse, harassment, bullying and physical violence. To achieve a rating of 2 within the next EDS cycle, the required level of activity the trust needs to evidence are the following: The organisation has a zero-tolerance policy for verbal and physical abuse towards staff. The organisation penalises staff who abuse, harass or bully other members of staff and takes action to address and prevent bullying behaviour and closed cultures, recognising the link between staff and patient experience Staff with protected characteristics are supported to report patients who verbally or physically abuse them. The organisation provides appropriate support to staff and where appropriate signposts staff to VSCE organisations who provide support for those who have suffered verbal and physical abuse.	As part of the EDI programme Data Driven Change workstream, to carry out data triangulation on: - Disciplinary outcomes for harassment against protected characteristic groups, targeting interventions appropriately. - Staff survey results which form the basis of targeted interventions by protected characteristic re: ▪ Harassment, bullying and abuse from patients, relatives, or the public ▪ Harassment bullying and abuse from staff ▪ Physical violence from patients, relatives, or the public ▪ Physical violence from staff As part of the planned commissioning of a trust-wide anti-racism training programme and the new leadership programme, to provide resources for managers and staff on effectively responding to and managing bullying and harassment concerns.	Nov/Dec 2025

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	To fully understand staff experience of accessing independent support and advise (e.g. from FTSU, unions) when required and ensure that the trust monitors, and acts upon, data surrounding staff abuse, harassment, bullying and physical violence. To achieve a rating of 3 within the next EDS cycle, the required level of activity the trust needs to evidence are the following: The organisation facilitates pooling union representatives with partner organisations, to encourage independence and impartiality. Freedom to Speak Up Guardians are embedded and empowered. Relevant staff networks are staff led, funded and provided protected time to support and guide staff who have suffered abuse, harassment, bullying and physical violence from any source. Relevant staff networks are engaged, and equality impact assessments are applied when amending or creating policy and procedures for reporting abuse, harassment, bullying and physical	To triangulate the following sources of data disaggregated by protected characteristic to inform actions: ○ Freedom to Speak Up data ○ Unions membership and activity data ○ Exit interviews data ○ Any additional data showing measurable impact and outcome of independent support for staff	Nov/Dec 2025

		violence. Support is provided for staff outside of their line management structure. The organisation monitors, and acts upon, data surrounding staff abuse, harassment, bullying and physical violence. The organisations use evidence from people's experiences to inform action and change and influence other system partners to do so		

	2D: Staff recommend the organisation as a place to work and receive treatment	To increase the percentage of staff recommending the organisation to over 70%. Current percentage is 66%. To achieve a rating of 2 within the next EDS cycle, the required level of activity the trust needs to evidence are the following: Over 70% of staff who live locally to services provided by the organisation do/would choose to use those services. Over 70% of staff who live locally are happy and regularly recommend the organisation as a place to work. Over 70% of staff who live locally to services provided by the organisation would recommend them to family and friends. The organisation uses sickness and absence data to retains staff. The organisation uses data from end of employment exit interviews to make improvements. The organisation collates and compares the experiences of BAME, LGBT+ and Disabled staff against other staff members, and acts upon the data.	As part of our ongoing EDI, Embedding Values, and the new Leadership Development programmes, the trust will: ○ deliver various initiatives to improve staff experience supported by active engagement and feedback loop to ensure prompt response to staff feedback and concerns. ○ Triangulate staff survey and quarterly pulse survey data to ensure targeted actions to improve staff experience ○ Use exit interview data to identify barriers to satisfaction and put in place targeted improvements.	Nov/Dec 2025

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To ensure board members and senior leaders demonstrate commitment to health inequalities, equality, diversity, and inclusion. To ensure that Board members hold services/departments and leaders to account, allocate resources, and raise issues relating to equality and health inequalities on a regular basis. To achieve a rating of 3 within the next EDS cycle, the required level of activity the trust needs to evidence are the following: Both equality and health inequalities are standing agenda items in all board and committee meetings. Board members and senior leaders meet frequently with staff networks. Staff networks have more than one senior sponsor. Board members and senior leaders sponsor religious, cultural or local events and/or celebrations. Board members and senior leaders enable underserved voices to be heard Board members hold services to account, allocate	The EDI team will work jointly with the trust secretariat to strengthen Board records and reporting on EDI and health Inequalities, by: • Ensuring all board papers have an equality item to prompt discussion and to provide recommendations for allocation of resources to mitigate inequalities and health inequalities. • Introducing a system for planning, recording and reporting Board members activities to support EDI and address health inequalities	July 2025

		resources, and raise issues relating to equality and health inequalities on a regular basis. Board members implement the Leadership Framework for Health Inequalities Improvement. Board members and senior leaders demonstrate commitment to health inequalities, equality, diversity and/or inclusion. Board members and senior leaders actively communicate with staff and/or system partners about health inequalities, equality, diversity and inclusion.		
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To ensure that Board/Committee papers identify equality and health inequalities related impacts and risks and how they will be mitigated and managed. To achieve a rating of 3 within the next EDS cycle, the required level of activity the trust needs to evidence are the following: Both equality and health inequalities are standing agenda items in all board and committee meetings. Equality and health inequalities impact assessments are completed for all projects and	Under the trust's EDI programme, the new and piloted EHIA protocol will be fully implemented trust-wide, including formal ratification of the new protocol forming part of the process for embedding the EHIA into business-as-usual operations. As part of embedding the new EHIA process and supporting training, to ensure EHIA becomes a strategic, sustainable, and impactful tool in decision-making, governance, and policy development across the trust. The EDI team will work jointly with the trust secretariat to strengthen reporting and related governance of	July 2025

		policies and are signed off at the appropriate level where required. Staff risk assessments, specific to those with protected characteristics, are completed and monitored (where relevant). Required actions and interventions are measured and monitored. The WRES, WDES and/or NHS Oversight and Assessment Framework are used to develop approaches and build strategies. Equality and health inequalities are reflected in the organisational business plans to help shape work to address needs	board and senior leadership support for equality and health Inequalities	
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To ensure that Board members, and senior leaders monitor the implementation and impact of actions required and raised by: WRES WDES Gender Pay Gap EDS 2022 EHIAs To achieve a rating of 2 within the next EDS cycle, the required level of activity the trust needs to evidence are the following:	The EDI team will introduce quarterly EDI report for ManEX and the People and Culture Committee monitoring impact of EDI activities and allocation of resources to ensure improvement against the action plans related to WRES, WDES, Gender Pay Gap. And EDS 2022.	

		Board members, system and senior leaders ensure the implementation and monitoring of the relevant below tools. Interventions for unmet goals and objectives are present for the relevant below tools. Those holding roles at AFC Band 8C and above are reflective of the population served Organisations are able to show year on year improvement using Gender Pay Gap reporting, WRES and WDES. Board members, system and senior leaders monitor the implementation and impact of actions required and raised by the below tools: WRES (including Model Employer), WDES, Impact Assessments, Gender Pay Gap reporting, Accessible Information Standard, end of employment exit interviews, PCREF (Mental Health), EDS 2022		

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

Report title	Freedom to Speak Up Q2 2024/25 report
Report from	Sheila Adam, Chief Nurse and Director of Allied Health Professionals
Prepared by	Amnah Shah, interim Lead Freedom to Speak Up Guardian
Link to strategic objectives	Freedom to speak up links to all the strategic objectives and underpins our core values of Excellence, Equity and Kindness

Executive summary

This paper provides the Trust Board with a summary of Q3 2024/25 Freedom to Speak Up (FTSU) proactive and reactive work. The report describes the work being undertaken by the FTSU team and demonstrates that speaking up is valued and championed by Trust Board, Management Executive team, managers and a wide range of other stakeholders across Moorfields.

Quality implications

The Trust's approach to developing and supporting the work of the FTSU Guardians is an important element of providing an open culture, and supporting improvements indicated by the staff survey. If staff feel they are able to raise concerns in a safe environment and that their concerns are acted on, then this will have a positive impact on patient safety and staff well-being and improve the Trust's ability to learn lessons from incidents and support good practice. Trust Board and Management Executive provides leadership and support for effective FTSU service delivery, in order to foster an open and transparent speaking up culture.

Financial implications

No new financial implications.

Risk implications

Organisations should create a culture where staff feel able to voice their concerns safely. Not having this culture can create potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as possible reputational risks and regulatory impact. Moorfields have successfully introduced a new FTSU model to mitigate these risks, which also helps to support organisational cultural improvements.

Action Required/Recommendation

Trust Board are invited to note:

- Overall good progress continues to be made by the FTSU service ensuring key deliverables detailed in the work plan are met.
- The number of concerns raised over the specified period (Q3) and the themes and trends emerging from them.
- Have oversight of the on-going FTSU work activities.

For Assurance	**X**	**For decision**		**For discussion**		**To note**	**X**

1. Introduction and Purpose

This report provides Trust Board with an overview of concerns raised through the Freedom to Speak Up route for the period of Q3 2024/25 (October to December 2024) and gives an update about the progress of business-as-usual Freedom to Speak Up proactive and reactive activities. The format of this report complies with the National Guardian's Office (NGO) and NHS England and Improvement published guidelines, outlined in the NHS Freedom to Speak Up guide.

2. Background

Following substantial staff engagement and co-design, March 2024 saw a new improved FTSU service model introduced at Moorfields. The aim of strengthening the service has been to foster a culture of open communication, improve staff confidence in the speaking up service and to make FTSU more accessible to all staff that wish to use it. Key components of the FTSU service model include a full-time Lead Freedom to Speak up Guardian, implementation of an online anonymous/confidential speaking up platform (Work In Confidence) in January 2024, introduction of FTSU champions and strengthening the support provided by the existing voluntary Guardians. Currently, a new cohort of 8 champions are being recruited.

The FTSU team consists of one full time Lead Guardian supported by an assistant Lead Guardian and four volunteer Guardians. The team's background is very mixed across a range of ethnicity, working professions and physical locations within the geography of the Trust. From September 2024 the Lead FTSU Guardian has been on maternity leave, with cover provided by interim Lead Guardian, Amnah Shah from November 2024 until April 2025.

3. FTSU Data Analysis Q2 2024/25

Concerns raised to the Freedom to Speak Up service Q3 2024/25 (Oct-Dec 24)

There were 38 cases raised in Q3 2024/25, lower than the number of concerns raised in the previous three quarters and the same number of concerns raised in the same period of the previous year.

There has been a total of 8 anonymous cases raised to FTSU via the online platform in quarter 3. Sometimes, where a group of individuals have raised a common concern (within the same team), each individual involved is counted as a case.

Who is speaking up?

Professional/Worker group data is recorded in line with the National Guardian's Office Professional worker group categories.

Table 1. NGO Professional worker group reporting (Q2 2024/25) compared to the previous quarter

Professional worker groups	Q1 24/25	% of cases	Q2 24/25	% of cases	Q3 24/25	% of cases
Additional Clinical Services	8	15%	12	23%	7	18.4%
Additional Professional Scientific Technical	13	25%	6	11%	0	0
Admin & Clerical	10	19%	18	32%	16	42.1%
Allied Health Care professionals	0	0	3	6%	3	7.9%
Estates and Ancillary	5	9%	1	2%	1	2.6%
Health Care Scientist	0	0	6	11%	0	0
Medical	2	4%	1	2%	0	0
Not known	6	11%	1	2%	8	21%
Nursing	9	17%	6	11%	3	7.9%
Total	**53**	**100%**	**54**	**100%**	**38**	**100%**

The data shown in table 1 shows that during Q3 2024/25, admin and clerical staff raised the highest number of concerns.

Nationally, the NGO reports that 38% of concerns involve an element of inappropriate behaviours and attitude and 19% of concerns reported included an element of bullying and harassment (NGO annual report 2023-24). Our figures reflect the national numbers of staff raising concerns about behaviours and bullying and harassment. Moorfields data on highest (admin & clerical) and lowest (medical & dental) workforce groups speaking up is reflective of the national trend.

The recent consultant body letter has highlighted that further work is required to understand and address the barriers faced by the medical workforce and to strengthen the trust in the FTSU process. Additionally, the Guardian team will continue to highlight the service and further targeted work and promotion of the FTSU service will be carried out to ensure that other worker groups (including under-represented groups) also feel supported, safe and confident to raise concerns.

Themes of concerns raised to Freedom to Speak Up

When staff speak up, their concerns are recorded through a set of defined categories/themes.

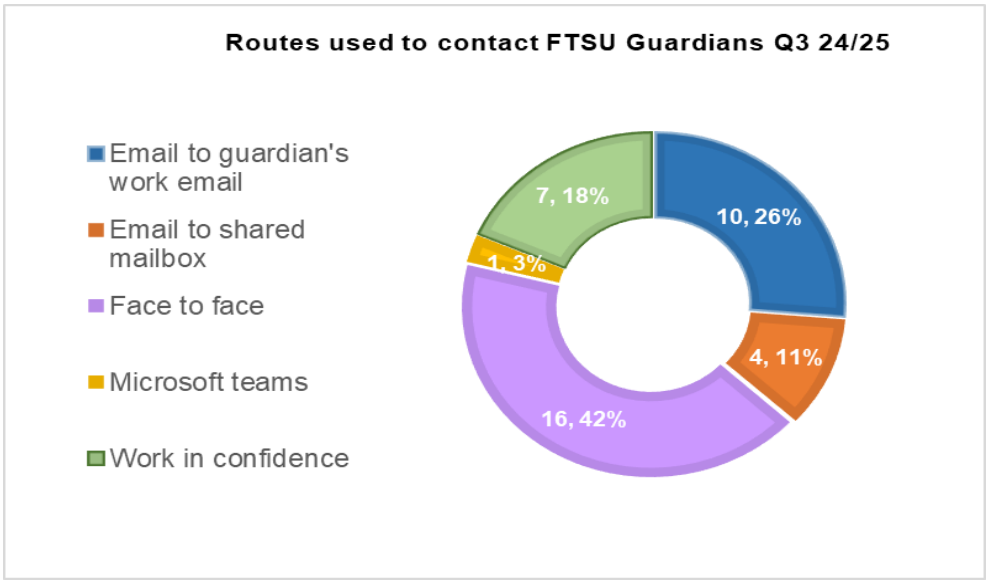
During Q3 2024/25, a large proportion of cases raised to Freedom to Speak Up relate to leadership and management (34.7%) and bullying and harassment (13%), both of which have decreased in number from the previous quarter. There has been a rise in discrimination concerns (10%) from the previous quarter. These show less comparability with previous quarters but with relatively small numbers comparison is limited. More meaningful comparison for all categories will be made when we have a full year of data.

Moorfields is currently running a leadership development programmes for clinical leadership roles in addition to first level leading with compassion training. Further work is being undertaken on defining, developing and supporting behaviour which reflects the trust values.

Work to develop an MDT approach to FTSU is required to strengthen triangulation with the wider Workforce & OD, Staff wellbeing and the FTSU team to establish wider culture or behaviours that require a more joined up approach in addressing concerns and targeted interventions. This will help ensure learning is taken from FTSU concerns to drive improvements in culture, and systemic issues are not overlooked.

How do staff prefer to contact the FTSU team when speaking up?

Fig 1. Routes used by staff to contact FTSU Guardian team (Q3 2024/25)



The most preferable route used by staff to speak up, continues to be through face-to-face interaction with a Guardian (42%). This usually occurs during site visits or listening events, where staff feel safe to speak up in groups or individually. For quarter 3, 10% of staff contacted a Guardian of their choice directly through their work mailbox (the figure was 12% for the previous quarter). The least preferable routes used to contact the team are via emailing the Guardian shared mailbox and Microsoft teams (4%, and 1% respectively) which are similar to the single digit figures reported in the previous report.

19% of Guardian contact has been made using the Work In Confidence (WIC) speaking up platform (which was introduced trust-wide on 24 January 2024) indicating some consistency with previous quarters. Since its launch, there has been a steady increase in the number of staff registering to use the platform (130 registered user accounts, which is 24 more than reported in the previous board report).

From the start of using WIC (24 January 2024) to date, on average, it takes a Guardian 1 day to respond to a conversation from a staff member, and with managers and workforce, approximately 30 days to close a case (previously 47 days). The FTSU team will continue to promote the use of the WIC platform.

4. Freedom to Speak Up Champions

The champion recruitment process, which began in January 2025, consists of three stages and is due to be completed by the end of March 2025. Recruitment was specifically targeted at areas with ongoing concerns. The phased roll out will continue beyond this within Moorfields, allowing additional staff members the opportunity to become champions.

- Stage 1 – application form, including management sign-off. Eleven staff members expressed interest, and 8 have progressed to the second stage.
- Stage 2 – interviews (in person and online for accessibility)
- Stage 3 – champions in person training session.

5. Freedom to Speak Up Work Plan and Strategy

To maintain effective service delivery, a detailed work plan has been drafted by the lead Freedom to Speak Up Guardian, to manage all reactive and proactive activities. The work plan sets out strategic objectives, which centres around 'making speaking up business as usual'. In parallel, to ensure all strategic objectives are met, an overarching FTSU Strategy is being developed by the interim Lead Guardian that reinforces the core values of Excellence, Equity, and Kindness and aligns with the NHS People Promise. The strategy sets clear, measurable outcomes to ensure the FTSU framework is transparent, manageable and effective.

Monitoring of the work plan is provided through regular reporting and progress updates to the Freedom to Speak Steering group and Management Executive with assurance provided to People and Culture Committee and quarterly Trust Board reporting.

Key priorities set out in the strategy are:

- Empowering
- Robust data analysis
- Collaborative working
- Training
- Visibility

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 14
Safer Staffing Report - Nursing
Board of directors
27 March 2025

Report title	Safer Staffing Report (Nursing) January 2024 -2025
Report from	Sheila Adam Chief nurse and director of allied professionals
Prepared by	Kate Falkner Associate to the Chief nurse and director of allied professionals
Link to strategic objectives	Working together Develop Deliver

Quality implications

This paper is intended to provide assurance that arrangements are in place to ensure our patients are provided safe and effective care by staff with the right skills, in the right place and the right time.

Financial implications

N/A

Risk implications

The Trust must be able to demonstrate safe staffing in order to comply with the Care Quality Commission's (CQC) regulatory framework and standards and the fundamental standards on staffing for example in the "well led" framework.

Action required/recommendation.

To be reported annually going forward

For assurance	**x**	**For decision**		**For discussion**		**To note**	

Moorfields Eye Hospital NHS Foundation Trust

NHS

Safer Staffing Report (Nursing)

January 2024- December 2024

Prepared by Kate Falkner Associate to the Chief nurse and director of allied professionals
Presented by Sheila Adam Chief nurse and director of allied professionals

Version: 1.0
Status: For Board

Introduction

This paper is intended to provide assurance that arrangements are in place to ensure our patients are provided safe and effective care by staff with the right skills, in the right place and the right time. Assurance to the Board on safe staffing levels is required by the Care Quality Commission (CQC) and NHS England (NHSE) on a 6-12 monthly basis.

The National Quality Board (NQB) published the Developing Workforce Safeguards (2018) to highlight policy that supports organisations to use best practice in effective staff deployment and workforce planning. The guidance provides advice on governance issues related to redesigning roles and responding to unplanned changes in workforce, and it describes how providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards annually.

This report is to provide the Board with an overview of the registered and unregistered nursing safe staffing data for the trust between October 2023 and September 2024. This is in line with the National Quality Board's Developing Workforce Safeguards (2018) and Standards and Expectations for Safe Staffing (2016) and concludes with the next steps for ongoing reporting.

Background

There are established and evidenced links between patient outcomes and whether organisations have the right staff, with the right skills, in the right place at the right time. There is strong evidence from a range of reports (Hard Truths Department of Health 2013, Francis 2013, Keogh 2013, Berwick 2013, NIHR 2019) that having the right number of staff delivering care in the right place impacts positively on both clinical outcomes and patient experience.

Registered Nurses and Health Care Support Worker staff, working as part of a multi-disciplinary team, play a critical role in delivering safe, high-quality care to patients and service users.

Ensuring we have safe and effective staffing levels ensures that we prioritise the safety and experience of our patients and staff.
The Trust must be able to demonstrate safe staffing in order to comply with the Care Quality Commission's (CQC) regulatory framework and standards and the fundamental standards on staffing for example in the "well led" framework. Furthermore, the Nursing and Midwifery Council (NMC 2015), makes it clear that all Registered Nurses are professionally accountable for safe practice in their sphere of responsibility, ensuring that risk is managed appropriately.

In July 2016, the National Quality Board (NQB) provided an updated set of expectations for nursing and midwifery care staffing, to help NHS providers make local decisions that will support the delivery of high-quality care for patients within the available staffing resource.

Further to this the NQB published Developing Workforce Safeguards (2018) where they recommend fourteen expectations for trusts to consider, and the compliance will be assessed upon to the "triangulated approach" to deciding multi-professional staffing needs. The guidance align to the findings of the significant aforementioned reports and subsequently publications of resources to support trusts were published.

NQB's expectations for safe, sustainable and productive staffing (2016)

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

NQB's guidance Developing Workforce Safeguards (2018) states that providers:

- must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- must use an approach that reflects current legislation and guidance where it is available.
- The NQB guidelines state all three elements of the framework be applied when setting staffing levels through a triangulated approach and where available an evidence-based tool should be applied.

The NQB (2018) also emphasises that "it is critical boards oversee workforce issues and grasp the detail of any risk to safe and high-quality care. NQB highlighted that boards are accountable for ensuring their organisation has the right culture, leadership and skills for safe, sustainable and productive staffing."

As such this paper is intended to provide assurance that arrangements are in place to ensure our patients are provided safe and effective care by staff with the right skills, in the right place and the right time.

Safe Staffing Report- Nursing

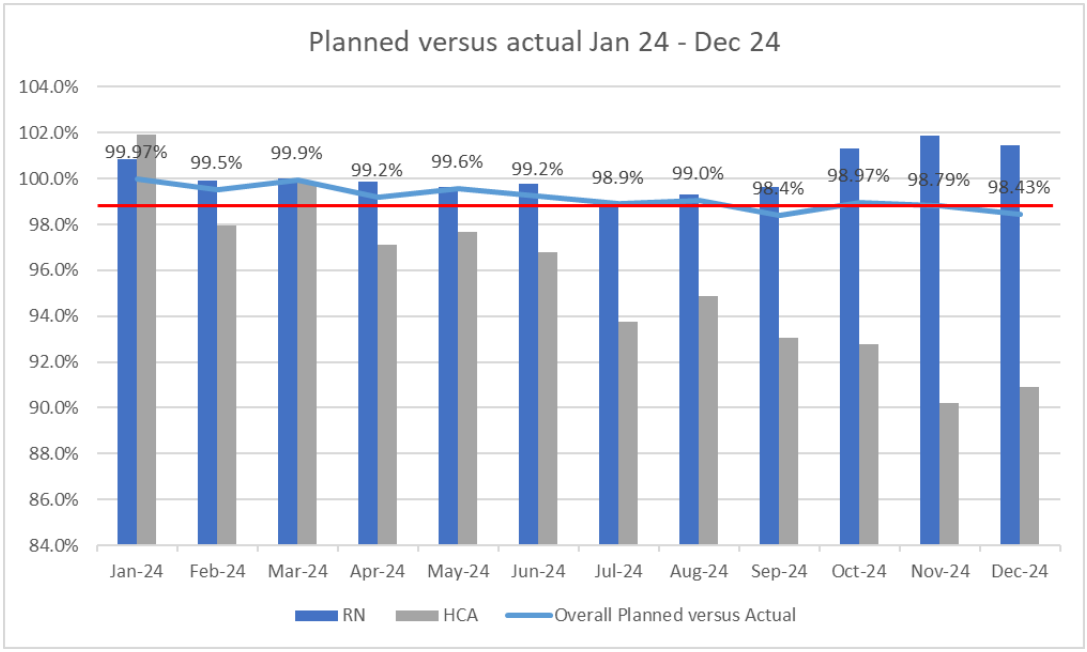
National Safe Staffing Reporting 12 months January 2024 – December 2024 – Nursing

Each month the trust is required to provide safe staffing data as a statutory submission by NHSE under the Care Hours Per Patient Day (CHPPD) Data Provision Notice[1] and includes data on the planned versus the actual levels of staff for inpatient wards.

[1] https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notices/data-provision-notices-dpns/care-hours-per-patient-day-chppd-data-provision-notice#scope-of-the-collection

Data is drawn from our e Roster system through a standardised Unify report and is validated by matrons and ward leaders.

The data we submit includes the Actual vs Planned (AvP) Hours shows the percentage of Nursing & Care staff who worked (including Bank) as a percentage of planned care hours in month. The National Quality Board recommend the parameters should be between 90-110%.



The trust has three overnight stay wards for which we report, and the wards are staffed by at least two registered nurses at all times:

- Observation ward (6 beds)
- Cumberledge Ward (8 Beds – based on need)
- Duke Elder Ward (4 beds)

The expected staffing levels for each inpatient area is set at the minimum of 2 Registered nurses.

All areas also provide day care bed stays for surgical patients and each bed can be used more than once within 24 hours. As such nursing staff are required to support more patients than the bed numbers imply. Although overnight levels of patients may not reach maximum bed occupancy,

the minimum number of n= 2 RNs is required for safe and effective care and the safety and well-being of the staff.

The total planned versus actual staffing for the reporting period has remained within the parameters as outlined by the NQB. However there has been a steady decrease in care hours for Health Care Assistants during this time on nights. (see table 1) and is being monitored by the matrons as to any impact this may have.

	Performance				Overall totals			
Month	Registered midwives/nurses Day	Care staff Day	Registered midwives/nurses Night	Care staff Night	Compliance	RN	HCA	Overall Planned versus Actual
Jan-24	98.9%	102.4%	99.9%	100.0%	100.0%	99.2%	101.9%	100.0%
Feb-24	100.0%	97.4%	100.2%	100.0%	100.0%	100.1%	98.0%	99.5%
Mar-24	99.8%	99.8%	100.4%	100.0%	100.0%	100.0%	99.8%	99.9%
Apr-24	99.8%	96.4%	101.1%	100.0%	100.0%	100.1%	97.1%	99.2%
May-24	100.1%	97.1%	101.1%	100.0%	100.0%	100.4%	97.7%	99.6%
Jun-24	100.6%	95.2%	99.1%	102.3%	100.0%	100.2%	96.8%	99.2%
Jul-24	100.3%	95.8%	103.5%	86.6%	100.0%	101.0%	93.7%	98.9%
Aug-24	100.6%	96.4%	100.9%	89.9%	100.0%	100.7%	94.9%	99.0%
Sep-24	100.4%	93.2%	100.3%	92.6%	100.0%	100.4%	93.1%	98.4%
Oct-24	101.7%	92.5%	100.0%	93.7%	100.0%	101.3%	92.8%	98.97%
Nov-24	102.5%	89.5%	100.0%	92.6%	100.0%	101.9%	90.2%	98.79%
Dec-24	101.7%	89.8%	100.8%	96.8%	100.0%	101.5%	90.9%	98.43%

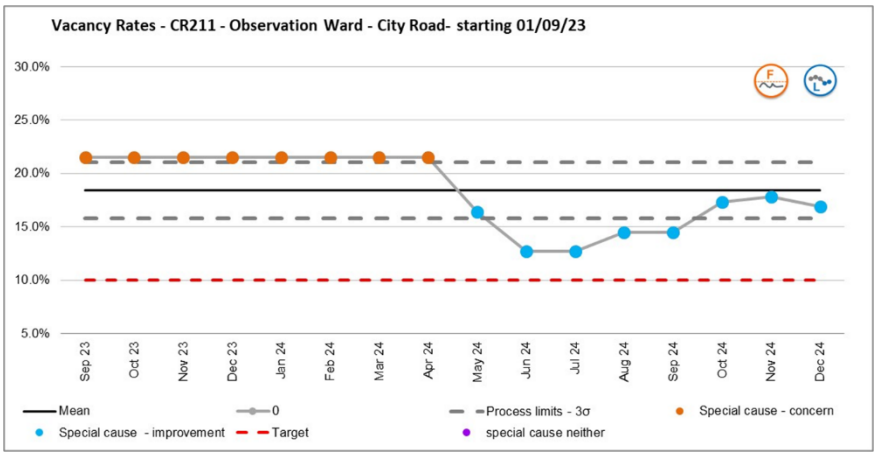
Table 1

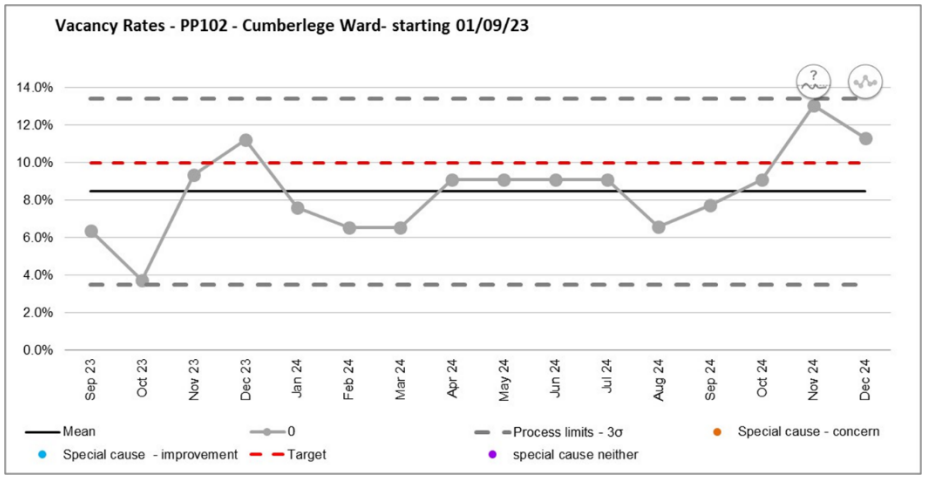
The use of Care Hours per Patient Day data is currently not monitored due to bed occupancy levels at midnight and benchmarking data would not be wholly reliable. This data also would not impact upon the current minimum level of 2 RNs. This will be monitored moving forward and will be reported in the next annual safe staffing report for further assurance of safe and effective inpatient staffing levels.

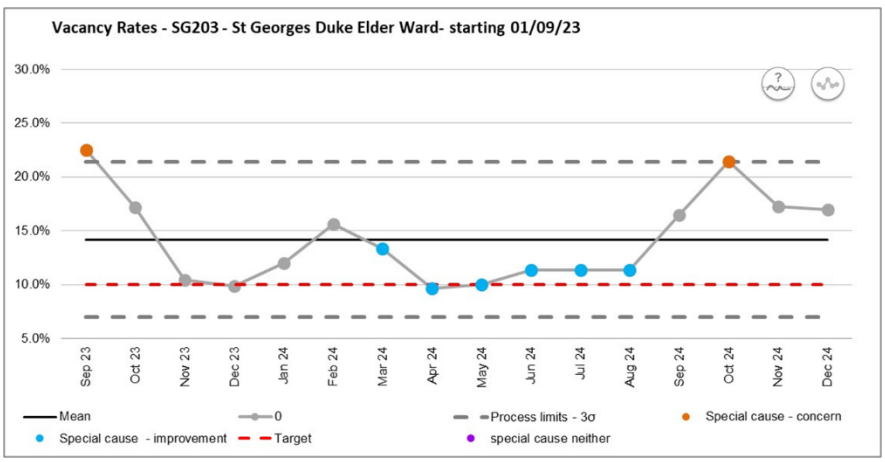
Nursing vacancies in safe staffing reporting areas

The impact of vacancies specifically associated with Safe Staffing reporting areas are described below. Total Vacancy rates for individuals reported areas signify the impact on the fill rate for staff most notable is Duke Elder Ward where there has been an uptick in overall vacancies. There is a

trend emerging in Observation ward. Going forward this data will be monitored by matrons responsible for the areas with oversight by Heads of Nursing.

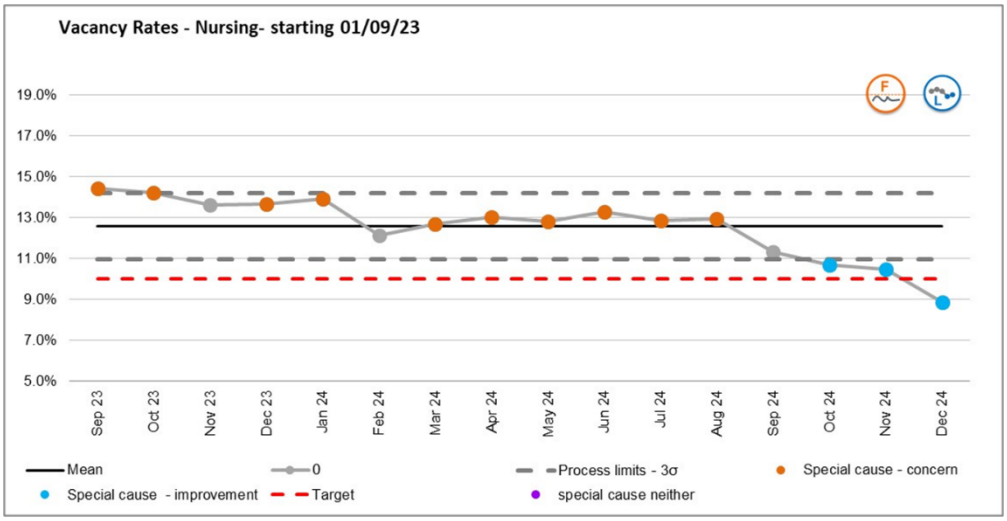




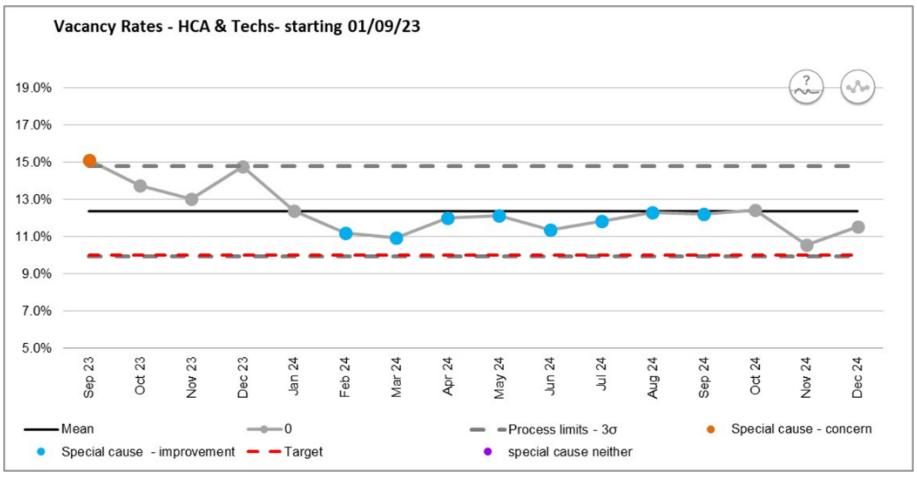


Overall Nursing Vacancies

The overall Trust Nursing Vacancy rate decreased from 14.45% in September 2023 to 8.8% in December 2024. Statistical Process Control Charts (SPC) have been developed to demonstrate improvement and to monitor and for any potential trends occurring.



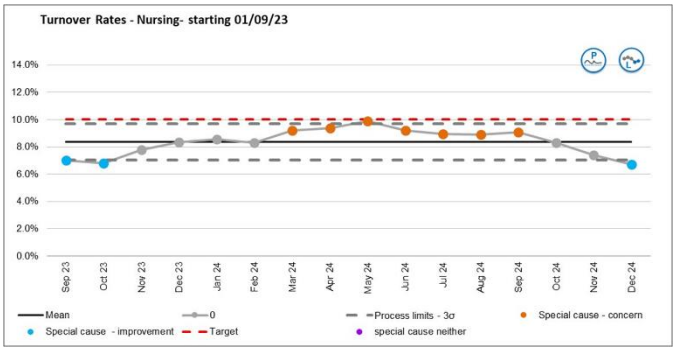
The improvement in the vacancy for RNs over the last year has been supported by the international educated nurse (IEN) recruitment project significantly contributing 41 wte to the trust since August 2022 with only 1wte leaver from the group. There is a phasing plan for this financial year to support up to 10 substantive trust HCAs who are International Educated Nurse through conversion to NMC registration with an option to recruit a further 5 IENs.

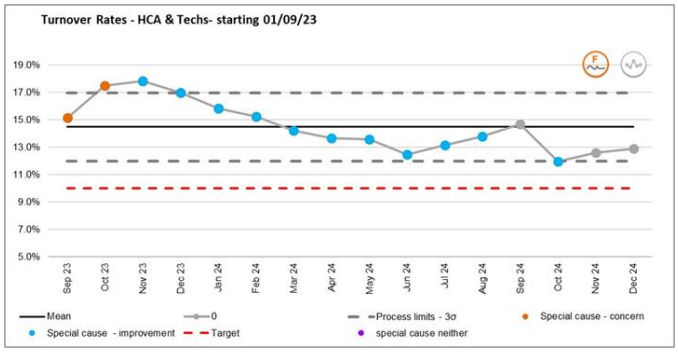


Ophthalmic Technician and Healthcare Assistants vacancies also have reduced overall for the trust but been remained above the KPI of 10% with no evidence currently of any variation to deliver a sustained reduction.

Retention

The Trust has a target of <11% turnover. Performance across the year has improved for Technicians and HCAs but has remained above the target currently at 12.9%.
For Registered Nurses turnover has remained relatively static at below the target and currently is at just below 6.7%.



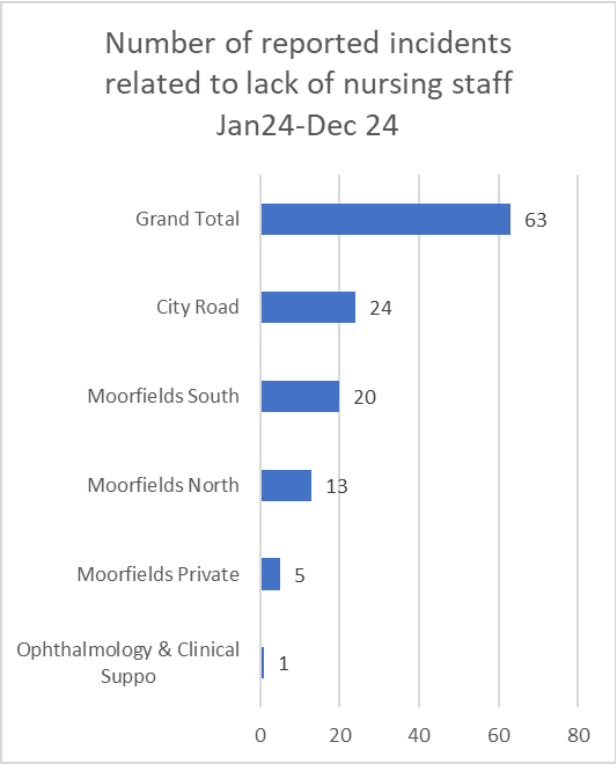


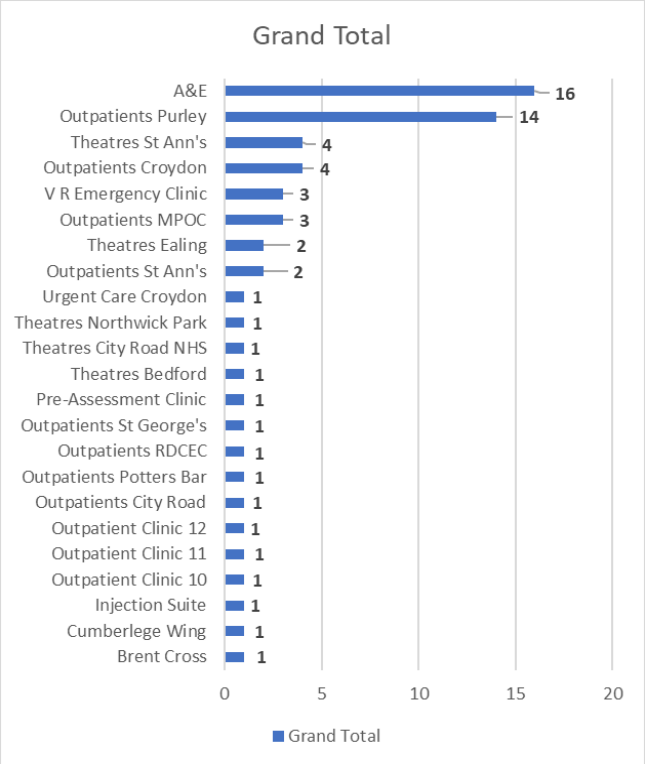
The Trust has recently recommenced a recruitment retention meeting for nursing teams which provides focussed support to trusts aim to improve recruitment but more importantly retention of the nursing workforce. As part of this work, a nursing retention plan will be reviewed with specific actions to be taken which will look at practical ways to improve nursing experience and bring back learning from system wide networks such as Capital Nurse and NCL workforce groups.

Impact on Quality

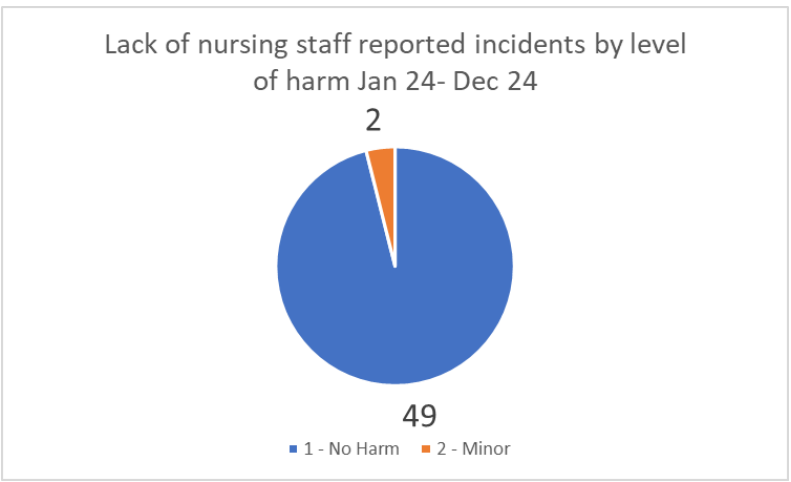
In line with the NQB guidance staffing levels should be triangulated with patient safety and staff experience.
From January 2024 to December 2024 there were n=159 reported incidents related to lack of staffing. There are three categories of lack of staffing for Medical, Admin and Nursing.

51 related to lack of nurse staffing which includes technicians.

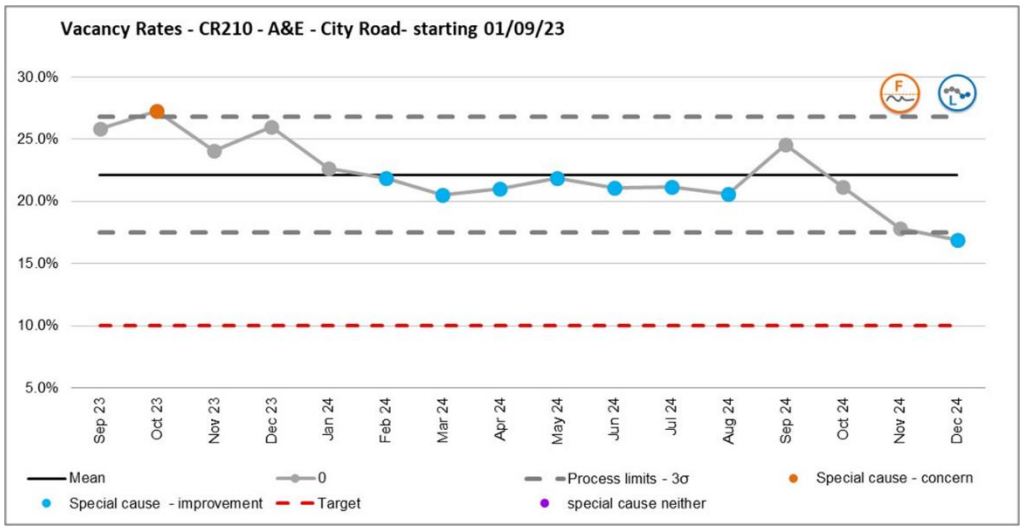




There was only one reported incident of safe staffing in the reporting inpatient areas, for Cumberlege ward following an unplanned admission and staffing was arranged for the overnight stay. However, of all incidents reported the majority were reported as no harm and all have been investigated and closed.



There was two minor harm reported, was reported in A&E in September 2024, where there was a reported lack of nursing staff between 1600-2100 and the investigation no availability for staff to extend or bank cover due to levels of vacancies (circa 25%) as indicated in the chart below further impacted by leave and unplanned absences.



The second incident was reported by the medical retina diagnostic hub at City road by a technician who felt significantly impacted by staffing levels being below the prescribed levels due to high levels of sickness and absence, with additional patients being seen in the hub. Staff had been moved to support and challenges recognised through safety huddles.

There was no identified harm to patients identified in both investigations. Actions related to recruitment to vacancies and escalating to the risk register. A&E is one of the priority areas for international recruitment.

Staff experience

As part of the Tendable Quality round audits the question. “Is there sufficient staffing levels to care for patients safely?” is a line of enquiry.

It can be answered through self-assessment (leaders in the area), peer review and by expert assessment, (expert assessment would be line of enquiries with staff by senior and executive leadership visits to the areas).

From November 2023 until October 2024 n= 641 Quality audits were completed.

- 604 reported the positively that there was sufficient staffing levels to care for patients safely
- 20 responded not applicable
    - These areas included MPEC laser and RDCEC 2nd floor research centre.
- 17 reported that there wasn't sufficient staff to care for patient safely with
    - the highest number of reports being for Purley War Memorial clinic
    - this correlates with a high number of safe staffing level incidents being reported for the same time period (n=22) due to a high level of sickness and absences.

The Emergency Department despite having the highest reported incidents for safe staffing levels (n=39) for the seven quality audits completed all were self-assessed and all responses that there was sufficient staffing levels to care for patient safely.

Conclusion

In conclusion the trust has met the expectation to report upon the compliance with nursing and care hours for the inpatient areas. This data has been triangulated against vacancy and retention data for these reporting areas. There was only one reported incident of safe staffing in these reporting areas for Cumberlege ward following an unplanned admission and staffing was arranged for the overnight stay.

The overall trust vacancy and retention data demonstrates and improvement in terms of vacancy and retention and this has been assessed against safe staffing incident reporting. There was only one incident reported with minor harm and the investigation did not uncover any impact on staff or patient safety. This report will be repeated annually.

Next steps

While we can provide assurance to the board on safe levels of staffing for adult inpatient areas for nursing, there are a number of other specific parts of the Trust, where the same level of assurance cannot be provided.

These areas include our Accident and Emergency Department, Theatres, paediatric and outpatient departments. Whilst clinical judgement accompanied by monitoring of safety incidents and staff satisfaction, gives a certain level of confidence, there is a need for a consistent and if available, evidence-based approach that can be applied particularly in higher risk departments to assure that staffing levels are safe.

As such we will:

1) Establish an oversight group for delivery of safe staffing across the organisation
2) Develop a delivery plan and roadmap based on priority areas requiring assurance of staffing levels
3) Develop a set of principles for each care area for nursing
4) Present reports for each area based against “As Is” and principles for CN for sign off
5) Develop KPIs for effective monitoring for each care area
6) Develop reporting tool and agree reporting and governance
7) Develop a safe staffing policy for the trust for nursing
8) Begin to scope how this can be further developed across the wider multiprofessional workforce

References

NQB (2016) How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability Microsoft Word - how to ensure the right people right skills right place right time FINAL [last accessed 06/12/24]

Robert Francis QC (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: executive summary HC 947, Session 2012-2013 [last accessed 06/12/2024]

Don Berwick (2013) A promise to learn– a commitment to act Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England A promise to learn – a commitment to act – Improving the Safety of Patients in England [last accessed 06/12/24]

NQB (2018) Developing workforce safeguards Supporting providers to deliver high quality care through safe and effective staffing Developing-workforce-safeguards.pdf [last accessed 06/12/24]

NQB (2018[2]) Safe, sustainable and productive staffing. An improvement resource for adult inpatient wards in acute hospital. safe-staffing-adult-in-patient.pdf [last accessed 06/12/24]

NQB (2018[3]) Safe, sustainable and productive staffing. An improvement resource for children and young people's inpatient wards in acute hospitals. safe-staffing-cyp-june-2018.pdf [last accessed 06/12/24]

Association for Perioperative Practice (2022) Staffing for Patients in the Perioperative Setting Fourth Edition

GIRFT (2022) Establishing an effective and resilient workforce for elective surgical hubs

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 15
Guardian of Safe Working
Board of directors
27 March 2025

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

Brief summary of report

The guardian of safe working report summarises progress in providing assurance that doctors are safely rostered, and their working hours are compliant with the 2016 terms and conditions of service (TCS) for doctors in training. This report encompasses the period from 19th November 2024 to 20th March 2025.

Exception Reports:

During this timeframe, there was only one Exception Report filed by an ST3 due to an extra hour of work in clinic (work schedule states that finish time is 17.00 but actual finish was 18.00). Both doctor and supervising consultant are aware that the resident could have been invited to leave at 17:00 but became caught up in the demands of the busy clinic and lost track of time.

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

Feedback:

During the recent residents' forum, I was informed about the current practice in which, when there is no lower house cover, the upper house covers the night shift instead of the day shift and is compensated with locum pay for the 12-hour night shift. After consulting with the BMA, we have confirmed that doctors can use exception reporting to notify their employer when their daily work significantly and/or consistently deviates from the agreed schedule. Residents have been encouraged to exception report these instances moving forward so that we can gather clear evidence and address the matter accordingly.

High level data:

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

Actions/Discussions taking place:

The low frequency of exception reporting reflects the trainees' well-being and satisfaction with their working conditions.

Summary

All Moorfields trainees are safely rostered in compliant rota patterns with no breaches of the terms and conditions of service occurring during this reporting period. All trainees are familiar with the process of exception reporting and there are systems in place to ensure prompt compensation payment for excessive hours worked and mechanisms in place to rectify unfavourable working conditions. Trainee morale is high and working conditions good.

Quality implications

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

Financial implications

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

Risk implications

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

Action required/recommendation.

The board is asked to consider the report for assurance.

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

Moorfields Eye Hospital NHS Foundation Trust

Agenda item 16
Learning from deaths (Q3 2024/25)
Board of directors
27 March 2025

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

Executive summary

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

The trust has identified **zero** patient deaths in Q3 2024/25 that fell within the scope of the learning from deaths policy.

Quality implications

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

Financial implications

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

Risk implications

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

Action required/recommendation

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

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

This report satisfies the requirement to provide the trust board with an update regarding compliance with, and learning from, the NHSE learning from deaths agenda. The Q1 and Q2 2024/25 data is shown in the table below.

Indicator	Q4 2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	0	0	0
% of cases reviewed under the structured judgement review (SJR) methodology	N/A	N/A	N/A	N/A
Deaths considered likely to have been avoidable	N/A	N/A	N/A	N/A

Learning and improvement opportunities identified during Q3

No opportunities for learning from deaths were identified during Q3 2024/25.

Annex 1

Included within the scope of this policy:

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

Excluded from the scope of this Policy:

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

Moorfields Eye Hospital NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

28 January 2025

Committee Governance	• Quorate – Yes • Attendance (membership) – 62.5% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	**Infection Control Update and Board Assurance Framework (BAF) Action Plan** The regular infection control (IPC) update was presented. The following were highlighted: • There is an increase in cold and flu cases, which is to be expected during winter. • There were two reported endophthalmitis cases in December 2024. • There were two notifications from an external agency about patients with respiratory tuberculosis. • Completed audits are all green (an audit at St. Ann's is to be repeated following staff training). Board Assurance Framework (BAF) Action Plan for infection control (this resulted from an action at July's meeting) was presented and discussed. The following were highlighted: • Overall the performance was solid. • PLACE inspections took place in November 2024; the results of these are expected soon. • There are delays in receiving reports in respect of the monitoring of ventilation safety. • Actions in respect of planned maintenance, food hygiene training, Personal Protective Equipment (PPE) fit-testing, and pathology were discussed. Take up of fit-testing is a concern. • The Trust's network will be discussed at the next Board Strategy Day. **Presentation by the North Division** The committee received a presentation from the North Division. The following were highlighted: • There are issues faced by the North West sector including the theatre at Ealing and paediatric provision at Northwick Park. • IT transition at Bedford (phase 1 complete, phase 2 being planned). • The challenges of operating over a wide geographical area. • Improvements across the Division should be considered in the longer term. Significant progress has already been made, but it is probably only half-way to completion. **Bedford transformation** This item resulted from an action at July's meeting, and updates are being presented at every meeting. The following issues were raised: • 1,000 patients have been seen, with only 15 remaining. 1 patient has been identified as coming to harm. • The move to *OpenEyes* is a significant improvement. **St. Ann's site – HSE Letter** This was presented and discussed. It concerns a generator at St. Ann's and its impact on the sites ventilation. The following issues were raised:

	• The incident occurred in October 2023. HSE wrote formally to Moorfields on 17 December 2024 asking about improvements. • Amongst the actions taken were the implementation of an Standard Operating Procedure (SOP) to support staff, and increased ventilation provision for the generator. **Fire Safety** The committee received its regular fire safety update. The following issues were highlighted: • There is strong fire safety management at Moorfields and good relations with the local fire brigade. • There is continuity through to Oriel; this is a two-way process which enables learning and improvement for the current estate. • Take up of fire warden training remains a concern: this will be reported to ManEx. Site cover safety training is a priority. **Patient Safety Incidents** There were no patient safety incident reports for the committee. The regular duty of candour report was presented. The following was highlighted: • It is acknowledged that duty of candour remains a challenge, although it is hoped that the activity in this area (particularly in the North) will result in improved figures in the next report. **Quality and Safety** The committee received the regular Q&S update, quality and safety reports (Trust-wide, Private, and UAE) for Q3, and the Complaints, and the Risk and Safety annual reports. The following areas were highlighted: • The regular catch-up meeting with the CQC took place the previous week. This was positive. • The Q&S Q3 Trust-wide report stresses the importance of learning rather than process. • Incidents open over 28-days in Private remains a challenge. • Issues with the reliability of the IT infrastructure are causing concerns, especially the impact it is having in respect of clinical reporting, investigation of patient safety incidents, and patient communication. **Reports from Other Committees** Summary reports from the following committees were circulated: • Information Governance Committee (26/11/2024) • Research Quality Review Group (02/12/2024) • Clinical Governance Committee (09/12/2024) • Risk and Safety Committee (11/12/2024)
Escalations	There were three escalations to the Trust Board: • Ventilation assurance at all sites, including delays in receiving engineers' reports. • The HSE letter in respect of the generator and ventilation flue at St. Ann's. • IT outage/system issues and the knock-on impact this has on staff usage, incident reporting, and patient communication.
Date of next meeting	11 March 2025

Moorfields Eye Hospital NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

11 March 2025

Committee Governance	• Quorate – Yes • Attendance (membership) – 87.5% • Action completion status (due items) – 100% • Agenda completed – Yes
Current activity and concerns	**Presentation by the City Road Division** The committee received a presentation from the City Road Division. The following issues were highlighted: • Zero tolerance of abuse or violence, particularly in A&E • Transition from children to adult services, including educating young people about their own conditions. There is also an issue with DNA rates amongst 16 to 24 year olds • Staffing levels remain a challenge • Waiting times and patient communication are an on-going issue • Transition of children into adult clinics with the use of the "Ready, Steady, Go" programme • Incident reporting, particularly near misses. **Research Governance** QSC received its annual research governance update. The following points were highlighted: • There are 32 sponsored and 104 contracted studies. Governance is supported by an increasing number of SOPs and SLAs. Overall, the governance structure is now fully formed, and is aided by innovation, especially digital. The number of investigators remains an issue • The service is now able to undertake several types of studies including gene therapy • This year to date, there have been 10 research applications, including 6 NHIR grants. The total NIHR grant is £2.1m. This is part of the notable grant success that has been archived. **SLAs and site strategy** The committee received an update on SLAs and site strategy. This was in response to an action from the May 2024 meeting. The following issues were highlighted: • There was a discussion around the type of leases and how these are described and function, and the associated issues • The current status of leases and SLAs were set out, including who is responsible for maintenance, and how the various relationships are managed • There are priorities around the future size and shape of the Moorfields estate. Clarity around the associated risks is critical. **Quality and Safety** The committee received the regular Q&S update which included the proposed quality priorities for 2025-26. The committee also received the safer surgery checklist report for Q3. The following was highlighted: • The programme of walkabouts was highlighted. Continued NED involvement is welcomed

	• The draft quality priorities for 2025-26 were presented. These follow the standard format of grouping under the three Darzi headings (safety, experience, and effectiveness). The slides highlighted which of the priorities are new, and which are taken forward from 2024-25 • The surgical safety checklist will be re-launched on 1 April 2025. **Bedford transformation** This item resulted from an action at July's meeting, and updates are being presented at every meeting. The following issues were raised: • Six patients await review (out of the original 10,000 patients validated, of which 1,000 were given an appointment). One patient experienced avoidable harm – duty of candour has been completed • There has been a significant reduction in incidents around delayed patient follow-up • The aim is to move to monthly failsafe reporting. **Patient Safety Incidents** There were no patient safety incident reports for the committee. The regular duty of candour report was presented. The following was highlighted: • There are still instances, stretching back several months, where duty of candour has not been completed • Whilst outstanding duty of candour is being progressed via divisional quality forums, it needs to be picked up via respective management forums. This will be escalated to Board. **Annual safe staffing report** This is a new report and is a statutory requirement. This is a two-part report. The first part covers nursing staff and is presented for assurance. The second part covers other staff groups and is presented to make the committee aware of its scope and is work in progress. **Infection Control Update** The regular infection control (IPC) update was presented. The following was highlighted: • The flu season is coming to an end, and in terms of staff vaccination levels, Moorfields has performed well in comparison with other London Trusts, although less than half of Moorfields staff were vaccinated • The two respiratory tuberculosis exposure cases reported at January's meeting have been closed. **Reports from Other Committees** Summary reports from the following committees were circulated: • Research Quality Review Group (27/01/2025); • Information Governance Committee (28/01/2025); • Clinical Governance Committee (10/02/2025).
Escalations	There was one escalation to the Trust Board: • Outstanding duty of candour – this will be progressed via respective management forums.
Date of next meeting	13 May 2025

Meeting:	Public Trust Board
Date:	27 March 2025
Report title:	Summary of the People and Culture Committee (PCC) held on 10 March 2025
Executive Sponsor	Sue Steen, 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 10 March 2025.

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 Oriel workforce priorities and emerging themes)** • The Committee received a progress report which highlighted the Trust's People strategy programme had achieved most targets for Q3, some had been moved to Q4. • The Oriel team had almost completed their review of all (30) sub specialities for the building. • Medium- and high- impact work themes and transformation priorities had been identified and the team would report on the support required at the next meeting. • A joint People, Culture and OD Workstream with UCL had launched, which had begun to identify support required for staff groups transitioning into the new facility. The Committee agreed the support for staff would be crucial to a successful transition. **Workforce performance** • The paper included the Trust's KPIs for February, of which there were no outliers. The Committee requested medical workforce appraisal rates to be shared prior to the next meeting. • Highlights from the recent Overpayments deep dive were shared along with an a robust short- and long- term action plan. **People and OD strategy** • The chief people officer informed the Committee that a consultation was underway involving key groups within the organisation to understand what the issues are across the Trust and outside of EPR and Oriel. A first draft of the strategy was expected at the next meeting. **Freedon To Speak Up (FTSU) Report** • FTSU concerns remained steady albeit higher at 75%. The FTSU team had been working with the OD team in hotspots areas. • There was a discussion around how MEH benchmarks in terms of medics using FTSU; The deputy chief nurse would contact the National Guardian to confirm. • A more detailed FTSU report was due at the March Trust Board meeting. **Medical Workforce Optimisation** • The Committee received a paper giving an update of where the Trust had started, the current position and the plan for the year ahead. • The medical workforce was 100% on e-job with all consultant job plans on Allocate. • Consistency panels were to be stood up imminently and consultants were engaging with that process. • LW and PR had recently met with the consultants group and were working through the feedback to ensure the job plan would be logical and easy for end users. **Equality Delivery System (EDS)** • The Committee received the Trust's first EDS report which was a national EDI and health inequalities framework requirement. The Trust achieved an overall score of 16 which gave resulted in a rating of 'Developing' but having met full compliance with the framework. There were three domains for assessment;

	○ Commissioned or provided service ○ Workforce health and wellbeing ○ Inclusive leadership. • It also included an action plan for the next 12 months which would be developed and implemented via the EDI steering group. • With some additional supporting information, the Committee supported the recommendation for the Board to approve this report. **Staff survey** • The Committee received a report outlining the initial headlines for the 2024 staff survey and next step actions. With the embargo lifting after the Committee meeting, a more detailed report was expected at Trust Board in March. **Committee effectiveness review** • The company secretary had recently conducted a review of the Committee which found it was well attended with regular quorate meetings and fulfilled its duties as per the Committee terms of reference. • There were some minor discrepancies that would require some follow up and were listed in the recommendations from the report.
Key concerns	There were no concerns to note.
Date of the next meeting	The next meeting was scheduled for 5 May 2025.

Report title	Remuneration & Nominations Committee Terms of Reference
Report from	Sam Armstrong, Company Secretary
Prepared by	Jennie Phillips, Deputy Company Secretary
Link to strategic objectives	Deliver: Optimise our systems, infrastructure and capabilities to deliver excellent and efficient care

Executive summary The Board are due to review and approve the terms of reference for the Remuneration & Nominations Committee, which is responsible for appointing (VSM) directors and related conditions.
Quality implications Not applicable
Financial implications Not applicable
Risk implications The committee oversees risk management on behalf of the Board.
Action Required/Recommendation The Board is asked to approve the terms of reference for annual ratification.

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Remuneration and nominations committee – terms of reference

Authority	The remuneration and nominations committee is a formal committee of the board and is authorised to provide assurance to the board and carry out delegated functions on its behalf. These terms of reference have been approved by the board and are subject to annual review.
Purpose	The purpose of the committee is to review, on behalf of the board the following key areas: • The overall remuneration policy for the trust • The remuneration package for executive directors • The appointment of executive directors • The remuneration package that applies to managing directors of the trusts commercial operations • The structure, size and composition of the board • Succession planning and business continuity plans in respect of executive director roles. Where changes to the board (non-executive directors) are proposed these will be recommended to the membership council as appropriate.
Membership	The members of the committee will be appointed by the board, as follows; • Chairman (chair) • All other non-executive directors except the UCL nominated director • Chief executive (when appointing other executive directors)
Quorum	The quorum will be three members
Attendees	The following will also regularly attend the committee; • Chief executive • Director of workforce & OD • Company secretary When discussions relate to the salary of the chief executive he/she will withdraw from the meeting and similarly, when discussions relate to the salary of the director of workforce he/she will withdraw from the meeting.
Frequency of meetings	The committee will meet at least twice per year and members are expected to attend at least 50% of meetings in any financial 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: • Appoint executive directors • Approve remuneration for executive directors, taking into account national guidance, the needs of the organisation, relevant market conditions including the broader environmental context, and organisational and individual performance • Approve remuneration for all staff on VSM contracts. • Approve the overall remuneration policy for the trust. • Approve all non-contractual payments to staff as recommended by the chief executive and the director of human resources
	Assurance Functions The committee will review the following to provide assurance to the board: • that there is sufficient capability at board level to provide effective organisational leadership on the quality of care provided • the existence and effective operation of systems to ensure that it has in place personnel on the board who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the licence • that executive and non-executive directors meet the fit and proper persons requirement (FPPR) • that executive directors have the appropriate competencies and capabilities • that the chief executive carries out appraisals of other executive directors and receive feedback on those appraisals • review contractual redundancy payments above £100,000 • the drafting, review and updating of the remuneration policy • That the trust is meeting its obligations under the public sector equality duty in relation to executive and senior manager appointments and remuneration. **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. The committee will carry out an annual review of its effectiveness against these terms of reference and this will be reported to the board, at the first available meeting after 1 September of each year.

Sub-committees	There are no sub-committees of the remuneration and nominations committee		
Meeting administration	The lead executive for the committee will be the chief executive and the secretary for the committee will be the company secretary. The secretary's role will be to; • Agree the agenda with the chair • Ensure the agenda and papers are despatched five clear days before the meeting, in line with the board's standing orders • Maintain a forward plan of items for the committee • Be responsible for the production and quality of the minutes (even if taken by a separate minute taker) • Ensure 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	March 2025	**Date of next review**	March 2026