Bundle Board of Directors - Part 1 24 July 2025

1 10:00 - Welcome
Tim Briggs, interim Chair
For noting
250724 TB Part I Item 00 Agenda

2 10:05 - Apologies for absence
Tim Briggs, interim Chair
For noting

3 Declarations of interest
Tim Briggs, interim Chair
For noting

4 Minutes of the meeting held 5 June 2025
Tim Briggs, interim Chair
For approval
250724 TB Part I Item 04 Minutes of Meeting in Public 050625 FINAL

5 10:10 - Chief Executive's Report
Peter Ridley, interim Chief Executive Officer
For noting
250724 TB Part I Item 05 CEO report

6 10:20 - Integrated Performance Report
Executive Team
For noting
250724 TB Part I Item 06 IPR coversheet - June 25 (OPEN Version)
250724 TB Part I Item 06 Integrated Performance Report - June 25 (OPEN Version)

7 10:30 - Finance Report
Arthur Vaughan, Chief Finance Officer
For noting
250724 TB Part I Item 07 Public Finance Performance Board Report - Cover Sheet
250724 TB Part I Item 07 Public Finance Performance Board Report

8 10:40 - Risk management strategy
Sheila Adam, Chief Nurse & Director of Allied Health Professionals
For approval
250724 TB Part I Item 08 Risk management strategy cover sheet 1
250724 TB Part I Item 08 Risk Management Policy and Procedure 10.07.25

9 10:45 - Learning from Deaths
Louisa Wickham, Medical Director
For assurance
250724 TB Part I Item 09 Learning from deaths (Q1 2025-26) July 2025

10 10:50 - Freedom to Speak up update
Sheila Adam, Chief Nurse & Director of Allied Health Professionals
For assurance
250724 TB Part I Item 10 PUBLIC FTSU Board Report Q4 24-25 and Q1 25-26 v2

11 10:55 - Green plan refresh
Elena Bechberger, Director of strategy & partnerships
for approval
250724 TB Part I Item 11 Green plan cover sheet
250724 TB Part I Item 11 Moorfields Green Plan - Draft 180725 V2

12 11:00 - Quality & Safety Committee report (oral)
Michael Marsh, Non-executive Director
for noting

13 11:05 - Identify risks arising from the agenda
Tim Briggs, interim Chair
For noting

14 AOB

Tim Briggs, interim Chair
For noting

15 11:10 - Date of the next meeting - 2 October 2025

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
A MEETING OF THE BOARD OF DIRECTORS
To be held in public on Thursday 24 July 2025 at 10.00
at The Rose Centre, St George's Hospital and via MS Teams

The Board will not have a patient story this month as Board members will instead take the opportunity to tour the Moorfields Eye Hospital services at St George's and speak with staff and patients.

No.	Item	Action	Paper	Lead	Mins
1.	Welcome	Note	Oral	TB	5
2.	Apologies for absence	Note	Oral	TB	5
3.	Declarations of interest	Note	Oral	TB	
4.	Minutes of the last meeting	Approve	Attached	TB	
5.	Matters arising and action log • Annual research report (action 01/02)	Note	Enclosed	TB	
6.	Chief executive's report	Note	Enclosed	PR	10
7.	Integrated performance report	Assurance	Enclosed	Exec	10
8.	Finance report	Assurance	Enclosed	AV	10
9.	Risk management strategy	Approve	Enclosed	SAd	5
10.	Learning from deaths	Assurance	Enclosed	LW	5
11.	FTSU update	Assurance	Enclosed	SAd	5
12.	Green plan refresh	Approve	Enclosed	EB	5
13.	Committee reports a) Audit and Risk Committee b) Quality and Safety	 Assurance Assurance	 Oral Oral	 AB MM	10
14.	Identifying any risks from the agenda	Note	Oral	TB	5
15.	Any other business	Note	Oral	TB	
16.	Date of next meeting – 2 October 2025				

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
DRAFT Minutes of the meeting of the Board of Directors held in public on 5 June 2025
Lecture Theatre, 2nd Floor, Ebenezer Street and via MS Teams

Board members:	Professor Tim Briggs (TB)	interim Chair
	Peter Ridley (PR)	interim Chief executive
	Asif Bhatti (AB)	Non-executive director (via Teams)
	David Hills (DH)	Non-executive director
	Michael Marsh (MM)	Non-executive director
	Elenor Lokteva (EL)	Non-executive director (via Teams)
	Adrian Morris (AM)	Non-executive director
	Sheila Adam (SAd)	Chief nurse and director of AHP
	Justin Betts (JB)	acting Chief financial officer
	Hilary Fanning (HF)	Director of discovery (via Teams)
	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)
	Elena Bechberger (EB)	Director of strategy & partnerships
	Victoria Moore (VM)	Director of excellence delivery and chief of staff.

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

1. Welcome

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

Introductions were completed.

2. Staff story

SS introduced Rory, who presented the staff story, and noted his Trust employee of the month award.

The Board noted Rory's journey where he commenced at the Trust in an administrative role at the age of 19. He completed his first course in 2012 and worked in spectacle dispensing for a time. In 2017 he returned to university to undertake optometry. He received pre-registration at the Trust and qualified in 2019.

He continued to invest in his learning and developments and informed the Board he had worked at 11 network sites at the Trust. The Board noted the procedures and techniques he was proficient at in delivering care at the Trust.

Rory had observed in his time at the Trust that the different specialties helped each other out and they felt well integrated, and not fragmented. He felt that the Oriel project was a real opportunity to improve Trust practices, however the challenges were noted.

Rory provided some observations where inefficiencies occurred, particularly between teams when closing a clinic and reopening another one, and he suggested that teams could work better in these regards. His impressions and direct experience with leadership in the Trust was positive, and things felt collaborative from his point of view. Staff tended to uphold the Trust values well from his experiences.

He concluded by stating that the best work done at the trust was through multidisciplinary teams. He remained at the Trust due to the positive experiences around teamwork, rewarding work, and the variety of great work to be done.

In response to a question from MM, Rory provided details of the role of a specialist optometrist detailing the traditional tasks, such as eye exams and prescriptions as a foundation, to the work he undertook in subspecialties and specialised work. DH commented on how motivating it was for the Board to hear a story such as Rory's. HF noted the patient focus in the presentation. In response to a question from PR, Rory informed the Board that various champions promoted good practices to help provide consistency across network sites. In response to a question from SAd, Rory stated that opportunities for development existed, and he had been an example of undertaking them. In closing the item, TB noted that the story provided a good example of how the Trust could develop it staff well.

The Board noted the staff story and thanked Rory.

3. Apologies for absence

Apologies were received from Andrew Dick, non-executive director, and Aaron Rajan, non-executive director.

4. Declaration of interest in relation to the agenda

There were no declarations made.

5. Minutes of the previous meeting

The minutes of the meeting held on 27 March 2025 were approved as a correct record.

6. Matters arising and action log

The action log and updates were noted.

7. Chief executive's report

PR presented the report.

He highlighted key areas of the report, which included:

- the Trust's performance against 18-week standard had deteriorated marginally in-month to 82.7%
- the Trust has a £15.1m internal efficiencies plan for the financial year, reporting £0.3m delivery in April, in line with a lower planned delivery in quarter one whilst efficiency and productivity governance was enhanced.

In response to a question from MM, PR stated that there were many challenges for the Trust at present. There was some clarity on national direction and long-term planning, however more detail was still to come. In response to a question from MM, JB informed the Board that agreed contract totals were now valued at circa £250m and total contract sign off was imminent.

The Board noted the report.

8. Integrated performance report

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

- the Trust's 18 Week referral to treatment time performance reduced slightly to 82.7% of patients receiving their treatment within the required period. The total waiting list size was stable at 33,228
- outpatient and injection activity was above plan

- A&E four-hour performance remained above target at 97.2%
- three patients were waiting longer than 6 weeks for their diagnostic test, which was due to patient unavailability and one unavoidable cancellation
- the Booking Centre was unable to achieve the agreed standard for call waiting time and call abandonment rate, due to the number of staff available to answer calls. Plans were in place to improve this performance, and this would be closely monitored
- appraisal compliance remained below target at 62.8%. The improved process was currently being implemented
- basic mandatory IG training was just below the required standard at 89.8%, which had improved by 0.4% since the last meeting and was now 0.2% under target
- staff sickness rates remained above Trust target, at 4.8% in April, however it was improving.
- complaints data was not available for this report and an audit was being undertaken to confirm all complaints correspondence had been accounted for.

In response to a question from AM, SS stated that this was a year of transition for appraisals, which was challenging to implement. There were some technical issues with data transfer and moving from anniversary for appraisals to a set period of the year. In response to a question from TB, LW pointed out that clinical appraisals needed to be completed otherwise consultants could not undertake private work, which was a good incentive to complete appraisals. To a follow up question, LW clarified that there was work to complete first on job planning before considering linking it these to the appraisals process. In response to a question from AM, it was confirmed that unit cost economics was planned to be added to future IPR.

It was noted that a review of the metrics in the report was underway, and these would be better linked to Board subcommittees. Work was also underway to develop more meaningful research metrics.

The Board noted the report.

9. Finance report

JB presented the report.

It was noted that there was a £1.89m deficit in-month against a planned deficit of £1.97m, a £0.08m favourable variance to plan. NHS Clinical income was assumed in line with planning assumptions, until all commissioner contracts have been received.

Activity was broadly in-line with plans with elective activity at 101% in April. Cataract activity was 103% of revised demand plans cumulatively. Outpatients Firsts and Procedures were 104% and 89%, respectively. .

Capital expenditure was £9.9m in-month. Other capital totalled £9.8m including £9.5m of Oriel expenditure and £0.3m for EPR. The cash balance as at the 30th April was £88.2m.

Efficiency delivery was £0.3m in month, in line with the external efficiency and productivity delivery plan, however when reporting the £15.1m efficiency plan in twelfths reflecting the level of monthly run-rate savings required across the year, the Trust would be £1.0m adverse to plan compared to the £1.3m.

PR added there was more work to be done for CIP development. It was noted this was a much higher challenge for the Trust than in previous years. AS pointed out that the Board needed to be mindful that the CIP plan was heavily backloaded.

The Board noted the report.

10. Summary of Trust 2025/26 operating plan

JB presented the report.

The Board noted the plan, which had been approved in private at the last meeting, and particularly noted the historical trends and capital plan for 2025/26. In response to a question from MM, JB clarified that corporate related figures presented in the CIP slide (slide 6) were based on national benchmarking. PR added that planned guidance required reductions in corporate spend across the NHS.

In response to a follow up question, it was noted that there were risks to delivering the CIP plan. Schemes were quality assessed before being confirmed. It was added that there were potential reductions to be achieved in services due to some highly manual practices currently in place. The Trust would need to ensure there was enough funding available for Oriel and EPR, which may need to be explained.

The Board noted the report.

11. Staff survey

SS presented the report.

The Board had received the report at its last meeting and noted the significant engagement of staff in the survey, its outcomes and actions. The results were generally within the average of other trusts, however there were some encouraging trends for the Trust.

TB observed that different areas of the Trust performed well on related survey metrics to others and requested that there be some focus on making targeted improvements in relevant areas. SS confirmed that 'hotspots' were being identified for focused actions.

In response to a question from EL about how the survey could assist achieving CIP programme, SS advised the Board that it was generally thought that motived and well cared for staff were more likely to assist in productivity gains.

The Board noted the report.

12. Learning from deaths

The paper was taken as read and noted.

13. Standing financial instructions (SFIs)

It was noted that the proposed changes had been reviewed at Audit and Risk Committee and pertained to procurement updates.

The Board approved the proposed updates to the SFIs.

14. Board Assurance Framework

SAr presented the BAF and corporate risk register.

The Board discussed the Trust risk appetite and how best the BAF could be used to drive improvements and the Board agenda. How many risks the board could meaningfully focus on was also discussed, without conclusion. It was noted that board strategy session on the risk management process and BAF to discuss risk appetite would be of benefit (action).

The Board noted the report.

15. Committee reports

a. Quality and Safety Committee and committee annual report

MM highlighted the following from the last two meetings of the committee:

- Updated PPE (personal protective equipment) guidance has been reviewed and appropriate adjustments made.
- The Phase 2 IT transition would be discussed at ManEx and then at Board (5th June 2025). Local commissioners were a little nervous, however the plan was progressing.
- The Board noted the Quality and Safety annual report.

b. People and Culture Committee

MM highlighted the following from the last meeting of the committee:

- The staff survey was reviewed in detail
- EDI and leadership advancement was discussed
- Reviewed long-term sickness.

16. Committee terms of reference

- **Finance and Performance Committee**

The Board approved the terms of reference.

- **Quality and Safety Committee**

The Board approved the terms of reference.

17. Identifying any risks on the agenda

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

18. Any other business

There was no other business.

19. Date of next meeting

It was noted that the next meeting of the Board would take place on 24 July at the Trust Education Centre.

The meeting was closed 10:45am

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

Brief summary of report

The report covers the following areas:

- Performance, Quality and Activity Review
- Sector Update
- Industrial Action
- Oriel update
- MoorConnect (EPR)
- Financial Performance
- Governance
- Moorfields in the News

Action required/recommendation.

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

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

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

PUBLIC BOARD MEETING – 24 JULY 2025

Chief Executive's report

Performance, Quality and Activity Review
In June, the Trust's performance against the 18-week improved in month to 83.1% being treated within the required standard and the total number of patients waiting over 52 weeks for their treatment also improved in month to 19.

Both the elective and outpatient activity levels were under plan in month, however they are both marginally above plan year to date. These in month reductions were due to a combination of the way in which the plans were phased over the first three months and a reduction in the level of elective activity being undertaken at weekends, as part of the Trust's efficiency plans.

Sector Update
There have been a number of pieces of guidance published since we last met as a Board, as well as the 10 year NHS Plan "Fit for the Future".

The NHS Oversight Framework 2025/26 has been published. This describes how NHS England will assess trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. All trusts will be allocated to a segment – with the highest performing trusts in segment 1, through to those needing most support in segment 5. We understand that details on which trust is in which segment, as well as league tables on relative performance across trusts, will be published soon.

All of the data used to assess trust performance will be published. As part of this a new NHS England data dashboard was published on 10 July showing performance on the 7 key performance measures for elective waiting lists, cancer, diagnostics and A&E waits. Moorfields is part of the Acute & Specialist Trust group for ranking purposes. The published performance of Moorfields is primarily based on May performance and is as follows:

- % wating within 18 weeks for elective treatment – 82.2% (ranked 4th of 134)
- % waiting more than 52 weeks for elective treatment – 0.1% (ranked 10th)
- Diagnostic proportion waiting over 6 weeks – 0.5% (ranked 3rd)
- A&E 4 hour performance – 96.0% (ranked 2nd)
- A&E 12 hour waits – 0.0% (ranked 1st)

The NHS 10 year plan (Fit for the Future) has been published. More detail is needed in order to assess the impact however we have welcomed the priorities described in the plan.

The plan's ambitions include three big shifts in the way the health service operates to bring the NHS closer to home and creating a 'neighbourhood health service'. This involves a number of changes – hospital to community with new neighbourhood health hubs; analogue to digital with a focus on digital transformation; and sickness to prevention by keeping people healthier. These changes are intended to tackle waiting lists, deliver more convenient care, and stop health inequalities across the country.

The plan describes priorities that we are already working and delivering on - services closer to home, digital innovation, new pathways of care - and through these we can improve both the experience and outcomes of our patients. Incorporating this into a national desire for longer term planning is welcome.

The plan also includes changes around the foundation trust model which, as a foundation trust, we will need to work through and understand what this means for us. There is also a commitment to utilising technology for the benefit of patients including investing in data, artificial intelligence (AI), genomics, wearable technology, and robotics – that will personalise care, improve outcomes, increase productivity, and boost economic growth.

Separately in June the Secretary of State and the CEO of NHS England wrote to all trusts to reiterate the requirement to reduce spend on agency staffing by at least 30% this financial year and the ambition to eliminate agency use altogether by the end of this government's term of office. We have plans to meet the 30% requirement, building on our significant reduction in 2024/25 and will consider as part of our medium term financial plan how we will reduce further.

Industrial Action

The British Medical Association (BMA) has announced a five-day national strike by resident doctors across England from 7am on 25th of July to 7am on 30th July. This strike action includes Foundation Year 1 and 2 doctors, specialty trainees and Trust employed clinical fellows. The union carried out a ballot which ended in early July. 55% of BMA eligible members voted and 90% of those voted in favour of strike action.

Within Moorfields, we have established a multidisciplinary working group to begin planning for these strikes. We are anticipating that there will be some disruption to our clinical activities during the strike period, however we are seeking to mitigate this as best we can be asking individuals to volunteer if they intend to take strike action and arranging for our critical services to be supported by more senior medical staff and other clinical colleagues. We will be providing regular communication to our staff and patients on the lead up to and during the strike action.

Oriel

The construction of the centre remains on plan, with much of the focus now being on the internal fit out of the floors and individual rooms. The 1:50 floor plans which show the detailed layout of floors and rooms are also on track to be completed by October 2025, which will then signal the end of the elective design change to the centre, prior to opening.

Our non-construction related workstreams are now all close to being fully mobilised. Work is underway to agree the naming of the new centre and to finalise how we will transfer our services from City Road in 2027. The clinical and operational target operating model is close to being confirmed and the work done to date has already fed into the Trust's transformation priorities for this financial year.

We are beginning a new phase of staff engagement for the programme. This has included an event which took place on 8th July in what will be the staff restaurant and roof garden on level 6. There was also a tour down to level 5 so staff could get more of a sense of the space inside the building. Due to its success it is hoped that we will be able to repeat this type of

event on a quarterly basis to enable as many staff as possible visiting the site before it opens.

MoorConnect (Electronic Patient Record)
As part of the developing critical path for the programme, we are focussing on finalising the design of the system by October 2025. This involves an assessment of how best to configure the interactions between the OpenEyes and MoorConnect systems so that they collectively support our clinicians to provide care to patients. All of the design plans for the system are being overseen by a design authority meeting which is chaired by our Chief clinical information officer and this process is now working optimally.

We have also begun the build of the system, which will be undertaken in several stages, with each adding additional complexity. As part of the critical path, we are aiming to have built four versions of the system by October.

We have recruited a number of individuals who will act as clinical champions for the roll out of the new system, helping to advise how best to do this and then providing training and support to their colleagues during the actual roll out.

Financial Performance – Month 3
For June the trust is reporting a £0.38m surplus, £0.37m favourable to the breakeven plan. The YTD deficit is £3.06m, £1.0m favourable to the £4.04m planned deficit.
Patient activity during June was 94% for Elective, 100% on Outpatient First, and 102% against Outpatient Follow Up activity respectively against the trust activity plan. The trust is reporting an over-performance in high-cost drug/injection income which remains a variable payable element under the new contracting arrangements.

The trust has a £15.1m internal efficiencies plan for the financial year. Delivery to date is reporting £0.43m, in line with a lower planned delivery in quarter one. This phasing highlights to external stakeholders the need for internal governance, identification and validation in the earlier part of the year with implementation and execution increasing as the year progresses.

The trust cash position was £69.9m, equivalent to 79 days of operating cash.

Capital expenditure was £31.9m YTD predominantly related to Oriel and for EPR.

Governance
Both the review of the concerns raised by consultants over the leadership of the Trust and the review of board governance are underway after the appointment of independent firms. The reviews are being overseen by a steering group made up of Governors, with reports to the Membership Council as appropriate.

Moorfields' Stars 2025

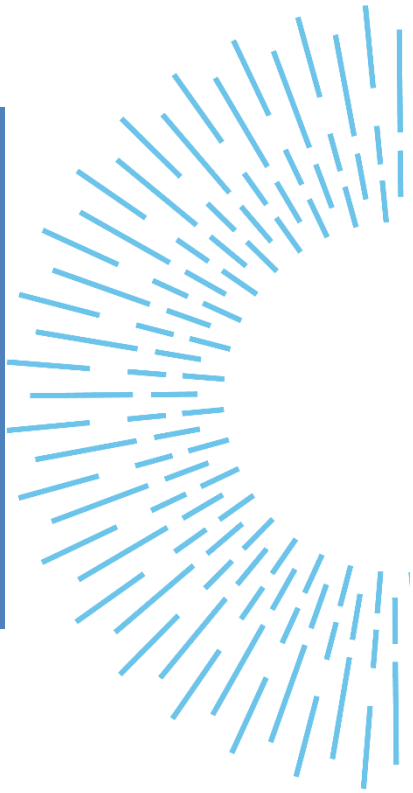
Moorfields' Stars is our annual event to formally recognise and celebrate the achievements and outstanding contribution of our excellent staff and volunteers.

Each year patients and colleagues are invited to nominate individuals, teams and volunteers for a range of awards. Judging panels made up of staff from across the Trust review shortlisted nominations to decide the finalists. For the first time this year, staff were given the opportunity to express interest in being a member of a judging panel; we were delighted to offer every colleague that registered interest a place on a judging panel.

The awards ceremony will take place in London in September and preparations are well underway. In more good news, this year we were thrilled to receive a record number of over 800 nominations setting the stage for a wonderful celebration later this year.

Moorfields Eye Hospital NHS Foundation Trust

Integrated Performance Report
Board of directors – Part I
24 July 2025



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

Executive Summary

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

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

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

Quality implications

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

Financial implications

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

Risk implications

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

Action required/recommendation.

The Board provided with this report for assurance.

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

Integrated Performance Report
Reporting Period - June 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.

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Performance & Information
Delivering quality data to empower the trust

Skills Development Network
Excellence in Informatics
Level 1

Introduction to 'SPC' and Making Data Count

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

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

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

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

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

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

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

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

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

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

Guide to this Report

Name of the lead responsible for the metric

Why this metric is being reported

The national or local target performance is being measured against

Performance for the most recent period

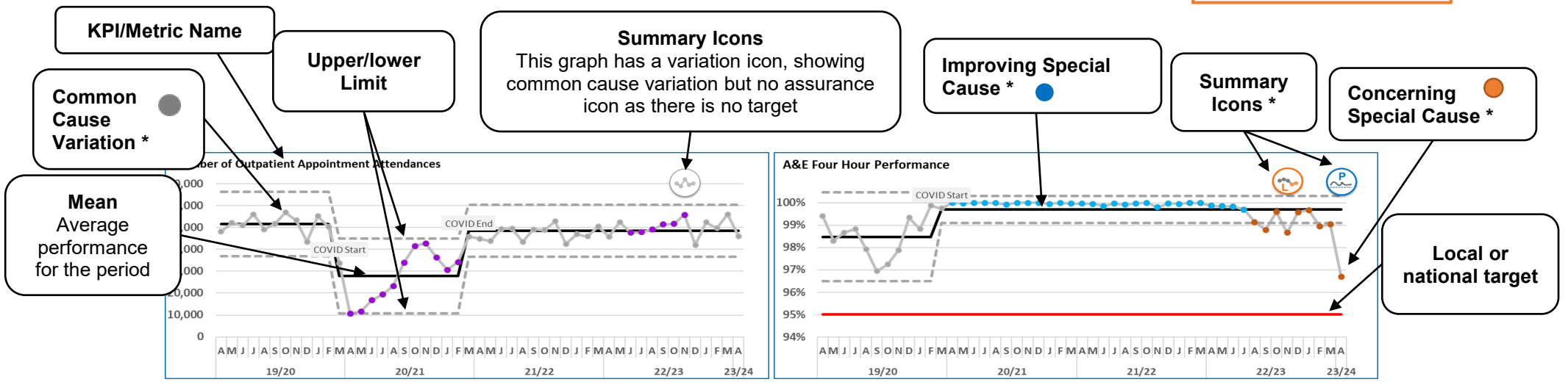
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 2 week waits - first appointment urgent GP referral	Jon Spencer	Statutory Reporting	Monthly	≥93%	100.0%	100.0%		

Name of metric/KPI

How often and timing of the reporting of this metric

Performance for the financial year (Apr-Mar)

These are the Variance and Assurance Icons



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"

- 52 Week RTT Incomplete Breaches
- Eliminate waits over 65 weeks for elective care
- Percentage of responses to written complaints sent within 25 days
- Percentage of responses to written complaints acknowledged within 3 days
- Appraisal Compliance
- Staff Sickness (Month and Rolling Annual Figure)

Celebrations

- 18 Metrics are showing as a capable process, with 17 showing either an improving or stable performance, this includes:
  - All Research Metrics
  - Posterior Capsular Rupture rates
  - All FFT Performance Targets
  - Infection Control Metrics
- 5 metrics are also showing an improving position including proportion of Temporary Staffing

Other Metrics showing "Special Cause Concern"

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

Other Areas To Note

- We are currently reviewing the content of the IPR to ensure all national and local defined metrics are monitored, this will be an ongoing process.
- All Elective and Outpatient Activity plans were not met in June 2025. Elective and First Outpatient Plan remain above the year to date target.
- Although Referral to Treatment Waiting List sizes have increase compared to May's position, we are currently above our trajectory target for 18 Week Performance

Executive Summary

In June, the Trust's 18 Week referral to treatment time performance increased to 83.1% of patients receiving their treatment within the required period. The total waiting list size has increased to 34,491. There are continued waiting list challenges in our high-volume specialist services which are seeing a deteriorating 18-week referral to treatment position. We are offering our patients an appointment at sites with the shortest waits, where possible, to even out waiting times across the organisation. Demand management initiatives such as offering advice and guidance to our referrers and optimising the patient initiative follow-up pathway, are included in this years' transformation programme.

The number of patients waiting over 52 weeks for their treatment has decreased to 19 at the end of June. Enhanced monitoring is in place to ensure patients have their next appointment or treatment booked as quickly as possible.

Elective activity was below plan at 94.4% in June, with the year-to-date position at 100.4%. There were two theatre infrastructure issues in North division in June, leading to on the day cancellations and City Road activity was impacted by planned and unplanned staff absence. Action is being taken to improve the position in July, with a focus on ensuring theatre lists have medical cover in place.

Outpatient and injection activity was below plan in June. The main reasons for this were the timing of service development approval for activity included in the plan; planned absence due to study leave and lower than expected cataract activity due to demand. The on-going impact and required mitigation of this is being included in an activity forecast.

The non-medical theatre cancellation rate was above target at 2.15% due to theatre infrastructure failures at St Ann's and Stratford. Patients have been offered a new date for surgery within 28 days; however, a small number have declined due to their unavailability over the summer period.

We maintained a compliant position for the faster diagnosis standard and diagnostic waiting times standard in June. A&E four-hour performance remained above target, although reduced to 96.2% due to increase attendances on some days.

The Trust's Booking Centre was unable to achieve the agreed standard for call waiting time, due to number of staff available to answer calls because of vacancies. Recruitment has been paused, through the enhanced vacancy control process. This is being reviewed.

Complaints response times have been heavily impacted by staff sickness and staff turnover. A new PALS & Complaints manager has started and is leading an improvement plan to restore performance and provide an overall improvement to the service.

Appraisal compliance remains below target at 54.4%. The new appraisal window closes at the end of July and compliance rates are improving daily. Managers are being sent regular reports on outstanding appraisals. Basic Mandatory IG training is just below the required standard at 89.6% and staff sickness rates remain above Trust target, at 4.5% in June. Staff and managers continue to be supported to reduce sickness rates.

Performance Overview

June 2025		Assurance			
		Capable Process	Hit and Miss	Failing Process	No Target
Variation	Special Cause - Improvement	- FFT Outpatient Scores (% Positive) - Occurrence of any Never events - NatPSAs breached - Recruitment to NIHR portfolio studies - Active Commercial Studies	-	-	- OP Journey Times - Diagnostic FtF - Proportion of Temporary Staff - Proportion of Agency Staff - Proportion of Permanent Staff - Recruitment to All Research Studies
	Common Cause	- A&E Four Hour Performance - 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 A&E Scores (% Positive) - FFT Paediatric Scores (% Positive) - Summary Hospital Mortality Indicator	* See Next Page	- 52 Week RTT Incomplete Breaches - Elective waits over 65 weeks	* See Next Page
	Special Cause- Concern	- % of patients in research studies	- Basic Mandatory IG Training	- % Complaints Responses Within 25 days - % Complaints Acknowledged Within 3 days - Appraisal Compliance - Staff Sickness (Month Figure) - Staff Sickness (Rolling Annual Figure)	- Number of Incidents open after 28 days
	Special Cause - Increasing Trending	- No. of Theatre Emergency Admissions			
	Special Cause - Decreasing Trending	-			

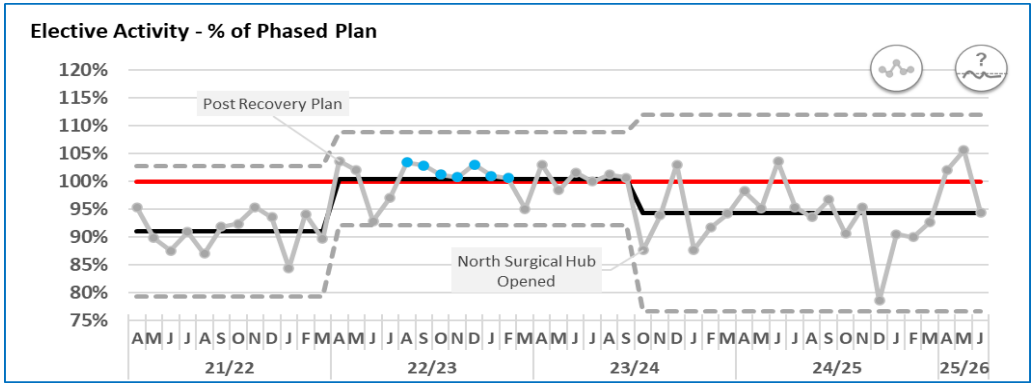
Performance Overview

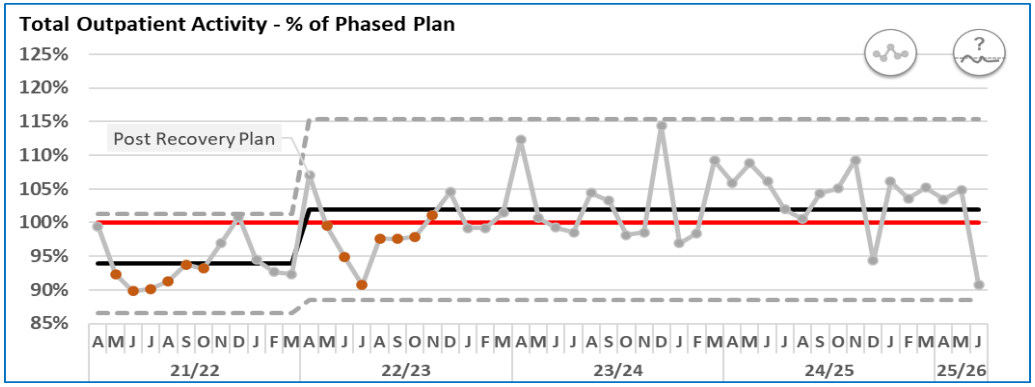
Common Cause & Hit and Miss	Common Cause (No Target)
- Elective Activity - % of Phased Plan	- RTT Waiting List
- Total Outpatient Activity (% Plan)	- RTT Incomplete Pathways Over 18 Weeks
- Outpatient First Activity (% Plan)	- OP Journey Times - Non-Diagnostic FtF
- Total Outpatient FlwUp Activity (% Plan)	- Proportion of Bank Staff
- Cancer 28 Day Faster Diagnosis Standard	- No. of A&E Arrivals
- 18 Week RTT Incomplete Performance	- No. of A&E Four Hour Breaches
- % Diagnostic waiting times less than 6w	- No. of Outpatient Attendances
- Average Call Waiting Time	- No. of Outpatient First Attendances
- Average Call Abandonment Rate	- No. of Outpatient Flw Up Attendances
- Emergency readmissions in 28d (ex. VR)	- No. of Referrals Received
- % FoI Requests within 20 Days	- No. of Theatre Admissions
- Theatre Cancellation Rate (Non-Medical)	- No. of Theatre Elective Day Admissions
- Non-medical cancelled 28 day breaches	- No. of Theatre Elective Inpatient Adm.
- Recruitment Time To Hire (Days)	

Deliver (Activity vs Plan) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Elective Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	100.4%	94.4%		
Total Outpatient Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	99.2%	90.8%		
Outpatient First Appointment Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	100.4%	90.7%		
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jon Spencer	NHS Operational Planning	Monthly	≥100%	98.9%	90.8%		

Deliver (Activity vs Plan) - Graphs (1)





'Elective Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 94.4%.	**'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 90.8%.**

Elective activity was below plan in June, with City Road and North division unable to meet their activity targets. The phasing of the activity plan saw a higher number of cases to be delivered in June and this was challenging to achieve.

At City Road, the cataract elective activity plan is based on 10 sessions running per week but only 8 sessions are being delivered following the decision to cease weekend working and reallocate operating lists to sites in the North division.

At City Road, in the external service there is a high level of sickness amongst the clinical fellows impacting on elective activity numbers. Assurance has been provided that this sickness is being managed appropriately. Additionally, there is duplication in the activity plan under the refractive surgery service, limiting the ability for the external activity plan to deliver in full.

There were a number of operating lists were returned in the glaucoma service, due to high levels of study leave in this month due to a conference. This impacted City Road, Croydon and Stratford activity levels.

In the North, St Ann's and Stratford were both impacted by theatre infrastructure issues. At Stratford, 28 patients were cancelled on the day of surgery due to an electrical failure. The incident impacted two days of operating, with patients transferred to St Ann's to limit further cancellations. At St Ann's, 4 patients were cancelled on the day due to the temperature in theatre during the heatwave.

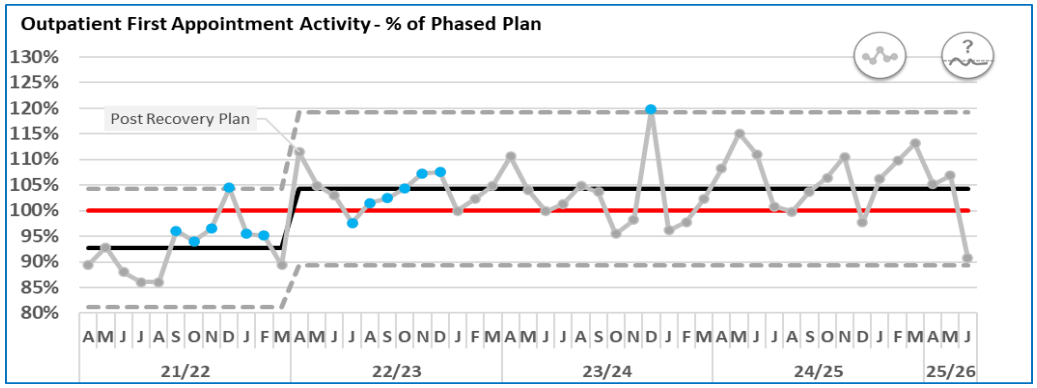
A small waiting list at St Ann's continues to create difficulty in booking lists optimally. Staff consultation to reduce the number of lists running is in progress, to support an improved booking process.

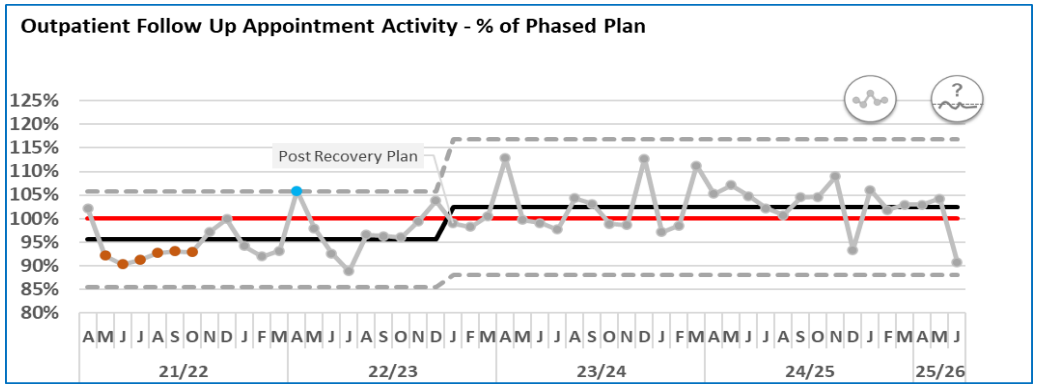
An activity forecast is being worked up and is based on activity delivered in months 1 – 3, with recognition of any challenges and mitigating action. This will allow a review of the allocation of the activity plan at site and service level to consider if any reallocation of target is required. This is particularly relevant to City Road where there are two known issues.

Staff consultation at St Ann's will conclude in August, with a reduced number of sessions running from September. Alongside this, a review of the demand and capacity assumptions made during the business planning process will take place, to understand any material changes and mitigation required. This will also be relevant to the QSIS supported project commencing to scope the closure of theatres.

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

Deliver (Activity vs Plan) - Graphs (2)





'Outpatient First Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 90.7%.	**'Outpatient Follow Up Appointment Activity - % of Phased Plan' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 90.8%.**

First outpatient activity and Follow-up outpatient activity were below plan in June, with all divisions unable to meet their activity plan. The phasing of the activity plan saw a higher number of outpatient attendances to be delivered in June and this was challenging to achieve.

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

In addition to the service development impact, there were higher levels of study leave in glaucoma and paediatrics due to conferences which reduced the number of clinics running in June.

At City Road, cataract clinics were not fully booked due to the low number of patients waiting for a first appointment. This will be kept under review and a demand and capacity exercise undertaken during business planning will be revisited, if required.
In the North, underperformance was mainly attributable to the glaucoma service and in the South, underperformance was mainly attributable to General Ophthalmology and the urgent care service.

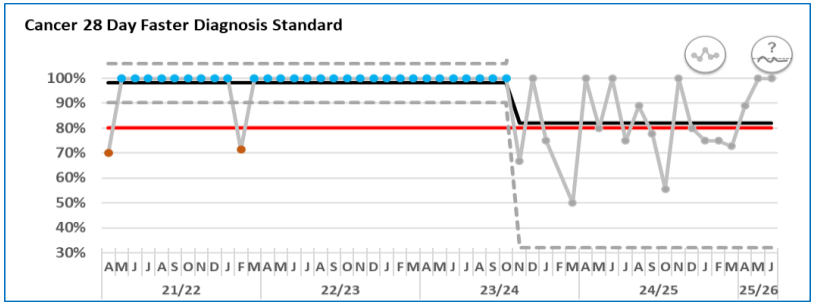
All divisions are forecasting improved positions in July, with the 'one-off' impact of conferences not continuing.

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

Deliver (Cancer Performance) - Summary

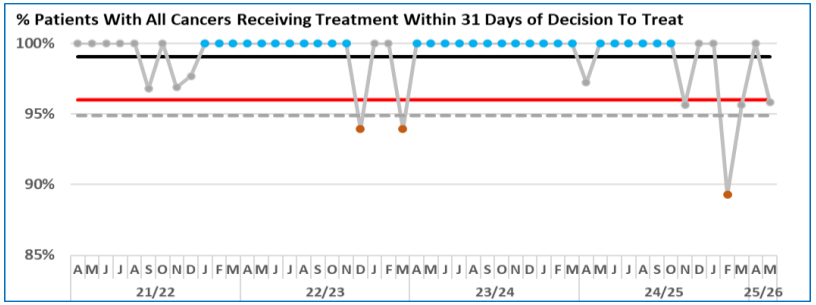
Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Cancer 28 Day Faster Diagnosis Standard	Jon Spencer	Performance Assessment Framework	Monthly	≥80%	93.8%	100.0%		
% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat	Jon Spencer	Statutory Reporting	Monthly	≥96%	97.8%	n/a		
% Patients With All Cancers Treated Within 62 Days	Jon Spencer	Performance Assessment Framework	Monthly	≥85%	96.9%	n/a		

Deliver (Cancer Performance) - Graphs (1)



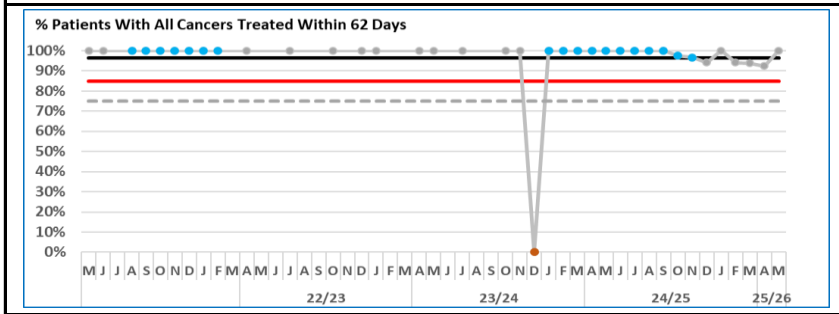
'Cancer 28 Day Faster Diagnosis Standard' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 100.0%.

Provisional Position, confirmed results not expected until end of month



'% Patients With All Cancers Receiving Treatment Within 31 Days of Decision To Treat' for this reporting period not available.

Data for June 2025 not available, confirmed results not expected until end of month



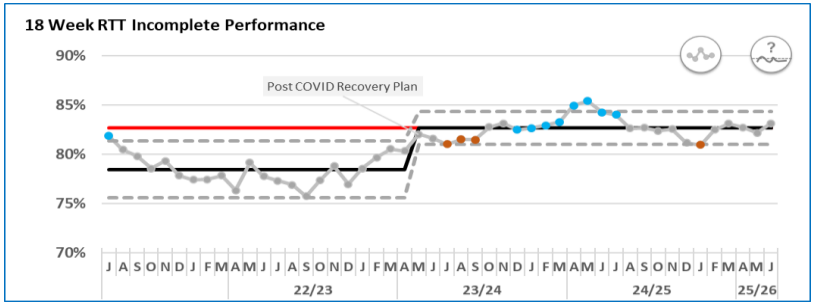
'% Patients With All Cancers Treated Within 62 Days' for this reporting period not available.

Data for June 2025 not available, confirmed results not expected until end of month

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	Performance Assessment Framework	Monthly	≥82.7%	82.7%	83.1%		
RTT Incomplete Pathways (RTT Waiting List)	Jon Spencer	Operational Planning Submission	Monthly	≤ Previous Mth.	n/a	34491		
RTT Incomplete Pathways Over 18 Weeks	Jon Spencer	Operational Planning Submission	Monthly	≤ Previous Mth.	n/a	5814		
52 Week RTT Incomplete Breaches	Jon Spencer	Performance Assessment Framework	Monthly	Zero Breaches	70	19		
Eliminate waits over 65 weeks for elective care	Jon Spencer	24/25 Planning Guidance	Monthly	Zero Breaches	6	1		
A&E Four Hour Performance	Jon Spencer	Performance Assessment Framework	Monthly	≥95%	97.2%	96.2%		
Percentage of Diagnostic waiting times less than 6 weeks	Jon Spencer	Performance Assessment Framework	Monthly	≥99%	99.2%	100.0%		

Deliver (Access Performance) - Graphs (1)



'18 Week RTT Incomplete Performance ' 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 83.1%.

18-week RTT incomplete performance is at 83.1% for June and remains in common cause variation. Performance levels are improving in North and South division and South division is compliant against the 92% standard.

Performance is deteriorating in City Road and this is limiting overall improvement in trust performance. The high volume and deteriorating services are Adnexal, Paediatrics and External.

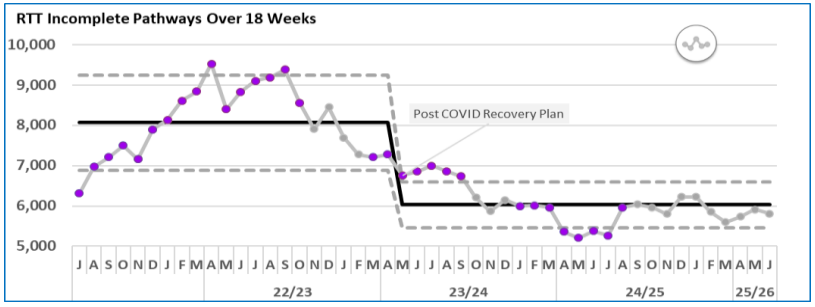
In Adnexal, patients are being redirected internally to new capacity at Stratford and to the South division where waiting times are lower. This has reduced the number of patients waiting over 30 weeks for a first outpatient appointment. Overall performance improvement has been more challenging to achieve. The service proposed a further service development for 25/26 to improve RTT compliance; however, this could not be included in the activity plan due to restrictions on income and has not been approved. Productivity improvements have been identified in Adnexal, with the aim of reducing lost activity due to consultant leave and increasing theatre utilisation by ensuring lists are optimally booked.

In paediatrics, outpatients drives in Q4 2024/5 reduced the number of long waiting patients. However, increasing demand and workforce constraints continues to challenge overall performance. Patients are being redirected to the south to equalise waits. A mutual aid request made to the Royal Free was initially accepted but later rejected due to concerns with capacity there. It is a priority to resolve resourcing for the paediatric service development included in the 25/26 activity plan, as this will increase activity in the most pressured paediatric pathways. Demand management initiatives are critical to improving RTT compliance. There is a pilot for delivering Advice & Guidance in paediatrics in the South and partnership working in development with Specsavers.

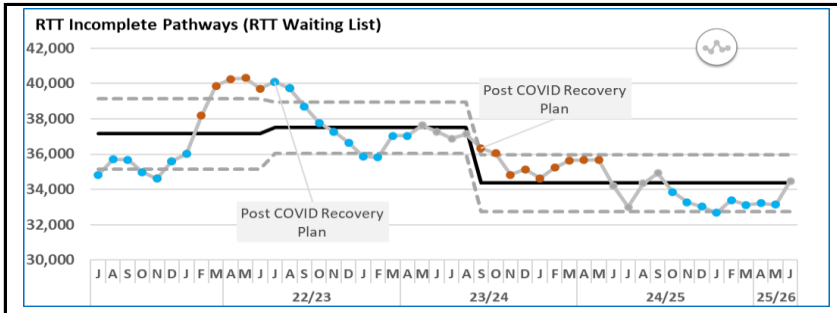
External put forward a service development for growth in 25/26 which could not be included in the activity plan. The service is reviewing how they can further expand asynchronous pathways and where productivity improvements could be made. Patients are being redirected to the south to equalise waits.

RTT improvement plans monitored at monthly executive performance review.

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



'RTT Incomplete Pathways Over 18 Weeks' is showing 'common cause variation'. The figure is currently at 5,814.



'RTT Incomplete Pathways (RTT Waiting List)' is showing 'common cause variation' - This is a change from the previous month. The figure is currently at 34,491.

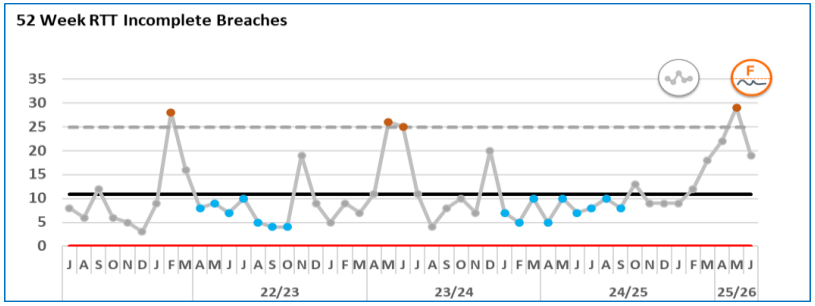
There has been an increase in the number of RTT incomplete pathways to 34,491. This is an increase which is most likely to continue, given to restrictions on activity. We have made decisions to support delivery of the financial plan which is limiting improvements in RTT performance.

- Service developments not included in our activity plan, due to the income cap and / or restrictions on capital expenditure. External, adnexal and paediatrics (NW), Tooting Diagnostic hub.
- Service developments not yet approved due to resource reallocation from North, not delivered in full. Paediatrics City Road.
- Restricting weekend elective and outpatient additional sessions

We are reliant on delivering RTT improvements through demand management and productivity improvements, these include:

- Patient Initiated Follow-up and Advice & Guidance - part of the trust's transformation portfolio in 25/26.
- Productivity gains in focused areas: theatre utilisation/cases per session, DNA rates, consultant job planning
- Outpatient template reviews to release capacity through standardisation / reducing unwarranted variation
- Implementation of the Care Coordination Solution on Federated Data Platform, RTT validation module go-live in July.

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

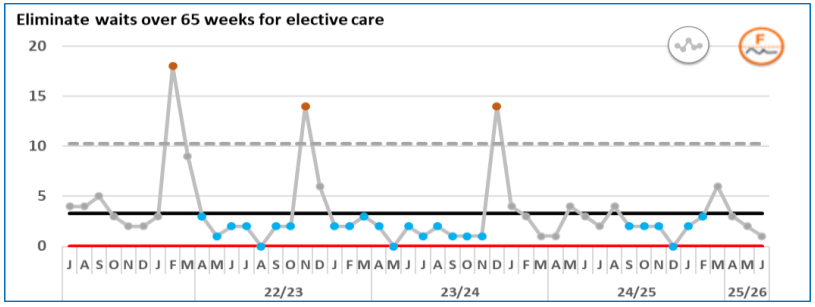


'52 Week RTT Incomplete Breaches ' is showing 'common cause variation' with the current process unlikely to achieve the target - This is a change from the previous month. The figure is currently at 19.

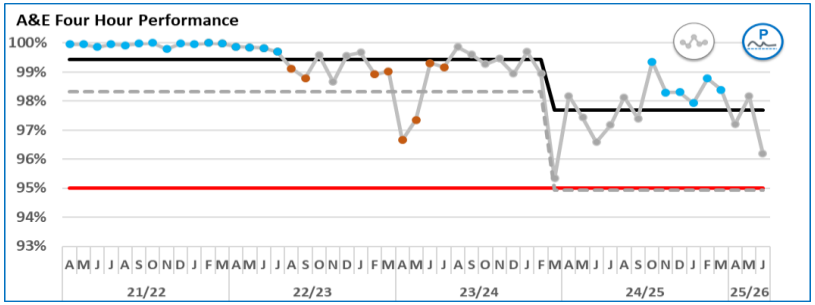
The number of patients over 52 weeks reduced to 19 at the end of June. Additional weekly monitoring meetings chaired by the Deputy COO are in place. Every patient over 48 weeks is reviewed to confirm next steps and forecast the month end 52-week position. Divisions are expediting pathways, to prevent patients tipping in to 52-weeks wherever possible. Key issues include adnexal patients who are added to an admitted waiting list at 48 weeks and above, with limited theatre capacity to prevent 52-week breaches; patients found as part of the internal referral incident and audit; patient choice / unavailability when offered a date before 52 weeks. Additional monitoring will remain in place until the number of 52-week breaches returns to the average position of c 10.

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

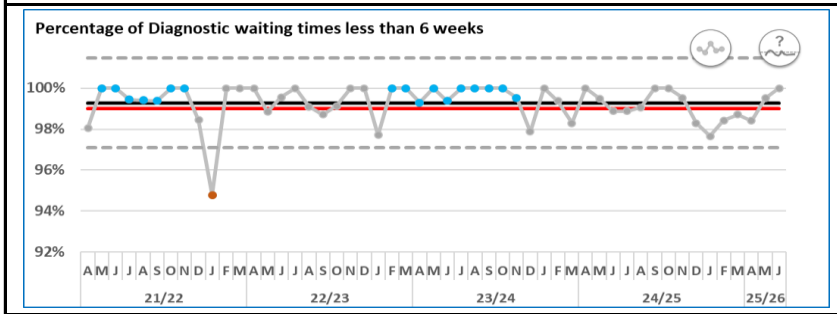
Deliver (Access Performance) - Graphs (2)



'Eliminate waits over 65 weeks for elective care' 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 1.



'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 96.2%.

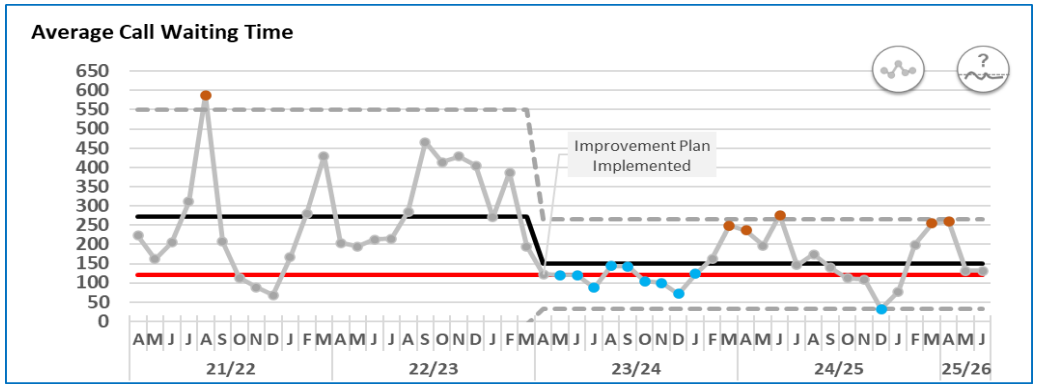


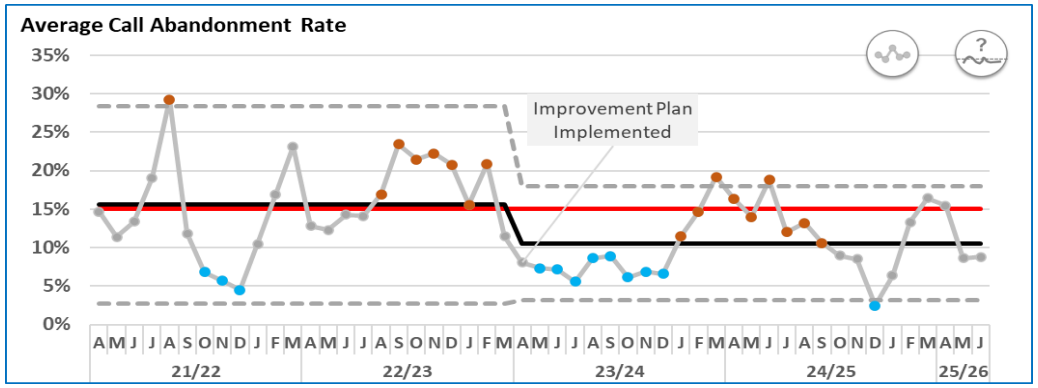
'Percentage of Diagnostic waiting times less than 6 weeks' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 100.0%.

Deliver (Call Centre and Clinical) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Average Call Waiting Time	Jon Spencer	Internal Measure	Monthly	≤ 2 Mins (120 Sec)	n/a	131		?
Average Call Abandonment Rate	Jon Spencer	Internal Measure	Monthly	≤15%	11.0%	8.8%		?
Mixed Sex Accommodation Breaches	Sheila Adam	Statutory Reporting	Monthly	Zero Breaches	0	0		P
Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	Jon Spencer	Internal Measure	Monthly (Rolling 3 Months)	≤ 2.67%	n/a	1.56%		?
VTE Risk Assessment	Jon Spencer	Statutory Reporting	Monthly	≥95%	99.1%	99.0%		P
Posterior Capsular Rupture rates (Cataract Operations Only)	Jon Spencer	Clinical Statutory Reporting	Monthly	≤1.95%	0.76%	0.53%		P
MRSA Bacteraemias Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Clostridium Difficile Cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
MSSA Rate - cases	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P

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





'Average Call Waiting Time' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 131.	**'Average Call Abandonment Rate' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 8.8%.**

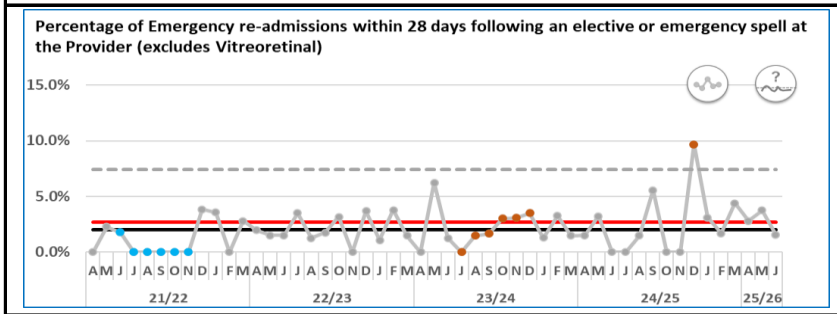
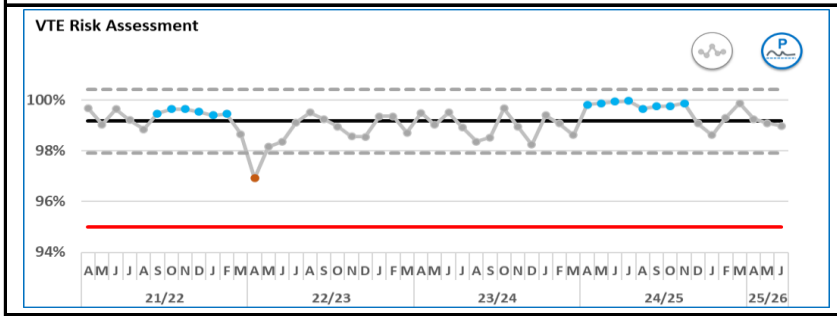
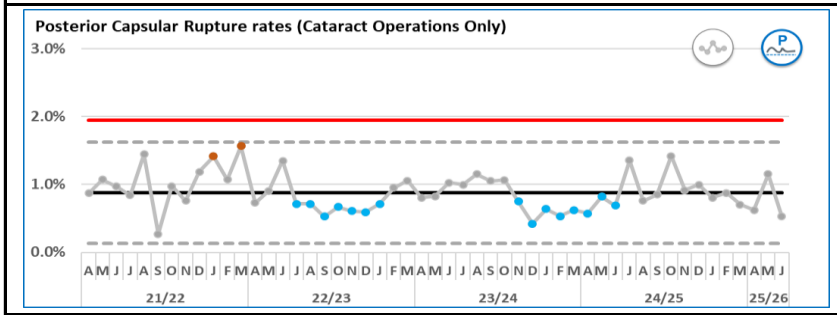
Performance remain above the agreed KPI, due to the number of agents available and an increase in the average duration of calls. Mitigating actions include: appropriate management of absence, on-going training of new staff and support to the team managing new queries associated with the OWL (Outpatient Waiting List). Performance monitored on weekly basis.

Vacancies are out to advert are awaiting divisional and exec approval, with limited capacity to flex resources across the team.

Appraisals have further impacted resource available to take calls. This will continue until the end of July.

Review Date: Aug 2025 ***Action Lead:*** Anoju Devi

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

No Graph Generated, No breaches since June 2017	**'Mixed Sex Accommodation Breaches ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 0.**
	**'% 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 1.56%.**
	**'VTE Risk Assessment' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 99.0%.**
	**'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 0.53%.**

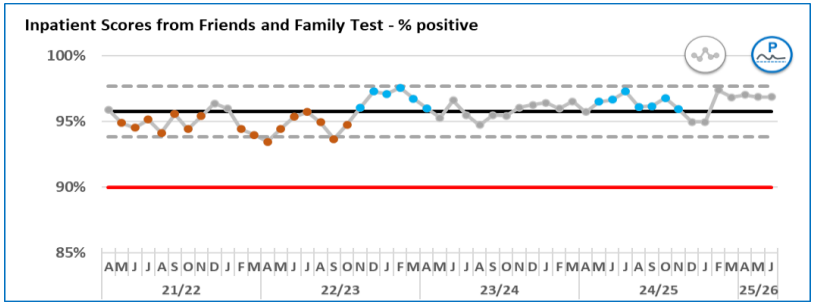
Deliver (Call Centre and Clinical) - Graphs (3)

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.**

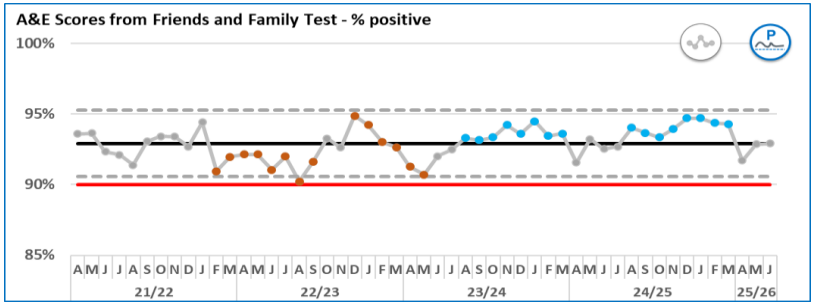
Deliver (Quality and Safety) - Summary

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%	96.9%	96.9%		P
A&E Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	92.5%	92.9%		P
Outpatient Scores from Friends and Family Test - % positive	Ian Tombleson	Statutory Reporting	Monthly	≥90%	95.5%	95.3%	H	P
Paediatric Scores from Friends and Family Test - % positive	Ian Tombleson	Internal Measure	Monthly	≥90%	94.6%	93.4%		P
Percentage of responses to written complaints sent within 25 days	Ian Tombleson	Internal Measure	Monthly (Month in Arrears)	≥80%	30.6%	27.3%	L	F
Percentage of responses to written complaints acknowledged within 3 days	Ian Tombleson	Quality Statutory Reporting	Monthly	≥80%	63.2%	71.4%	L	F
Freedom of Information Requests Responded to Within 20 Days	Ian Tombleson	Statutory Reporting	Monthly (Month in Arrears)	≥90%	98.7%	97.8%		?
Subject Access Requests (SARs) Responded To Within 28 Days	Kathryn Lennon	Statutory Reporting	Monthly (Month in Arrears)	≥90%	n/a	n/a		

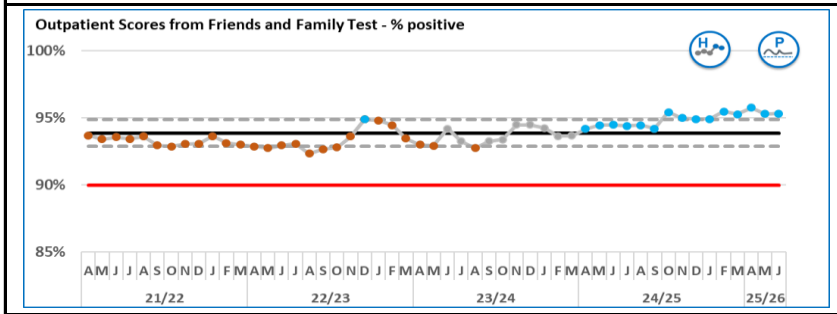
Deliver (Quality and Safety) - Graphs (1)



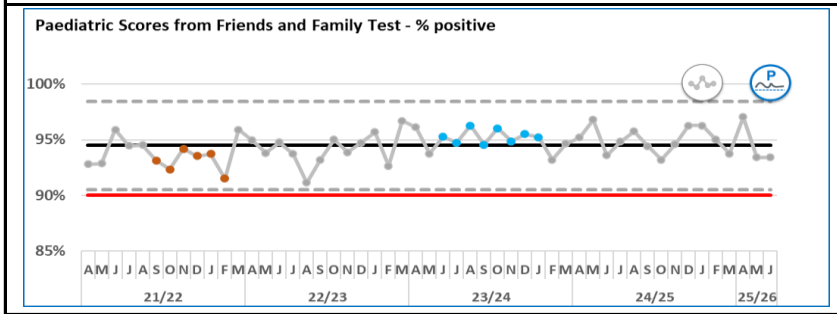
'Inpatient Scores from Friends and Family Test - % positive ' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 96.9%.



'A&E Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 92.9%.

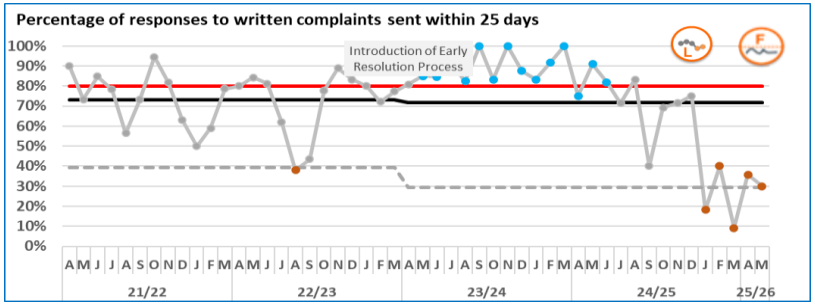


'Outpatient Scores from Friends and Family Test - % positive ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 95.3%.

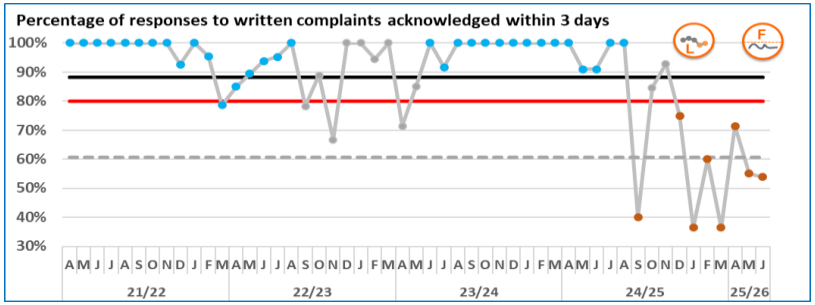


'Paediatric Scores from Friends and Family Test - % positive' is showing 'common cause variation' and that the current process will consistently pass the target. The figure is currently at 93.4%.

Deliver (Quality and Safety) - Graphs (2)



'Percentage of responses to written complaints sent within 25 days' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 30.0%.

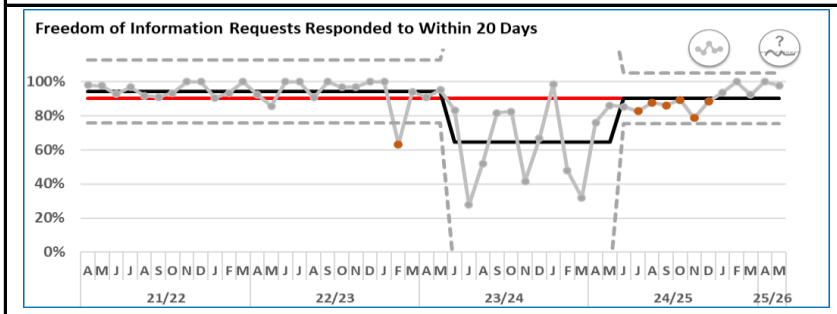


'Percentage of responses to written complaints acknowledged within 3 days' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 53.8%.

Complaints response times have been heavily impacted by staff sickness and staff turnover. A new PALS & complaints manager has started and is leading an improvement plan to restore performance to above target performance and to provide an overall excellent service. An internal audit is about to take place which will support introduction of best practice. The improvement plan contains seven key workstreams:

- Achieve accurate base line complaints data
- Obtain additional support resources
- Accurately monitor complaints progress with divisions on a regular basis
- Improve PALS team performance on complaints and PALS handling
- Improve divisional understanding and focus on complaints resolution to achieve efficient and effective resolution
- Internal audit to complete review to support improvements to complaints process
- Ensure good governance is followed and assurance is provided.

Review Date: Aug 2025 ***Action Lead:*** Robin Tall / Natasha Forster



'Freedom of Information Requests Responded to Within 20 Days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 97.8%.

Metric under review

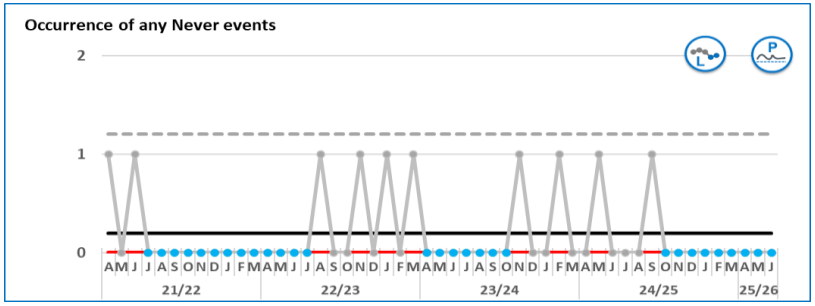
'Subject Access Requests (SARs) Responded To Within 28 Days' for this reporting period not available.

Data Under Review

Deliver (Incident Reporting) - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Occurrence of any Never events	Sheila Adam	Quality Statutory Reporting	Monthly	Zero Events	0	0	L	P
Summary Hospital Mortality Indicator	Sheila Adam	NHS Oversight Framework	Monthly	Zero Cases	0	0		P
National Patient Safety Alerts (NatPSAs) breached	Sheila Adam	CAS (Central Alerting) Requirement	Monthly	Zero Alerts	n/a	0	L	P
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Sheila Adam	Internal Measure	Monthly	No Target Set	n/a	313	H	

Deliver (Incident Reporting) - Graphs (1)

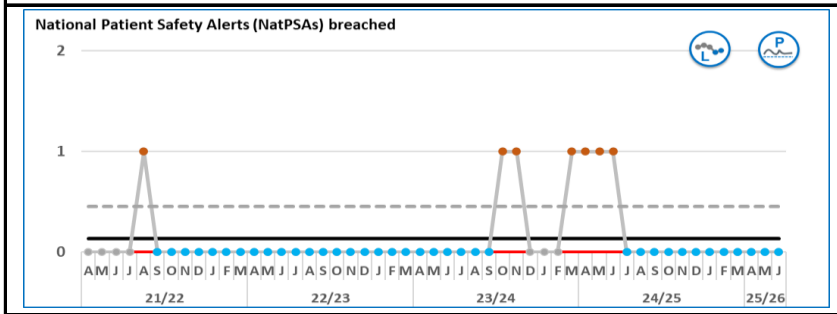


'Occurrence of any Never events ' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 0.

No Never Events Reported since September 2024

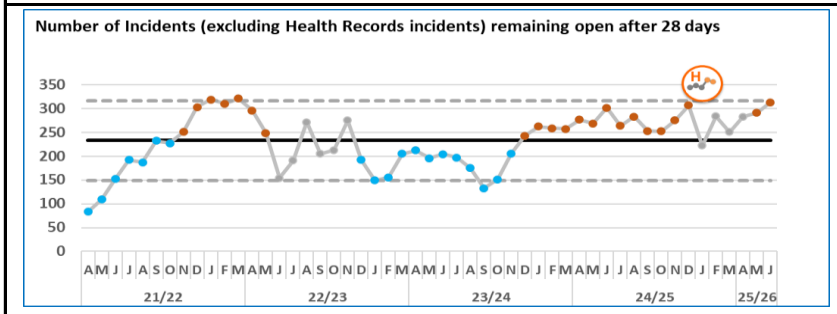
No Graph Generated, No cases reported since February 2017

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



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

No NatPSA breaches reported since Q1 2024/25.



'Number of Incidents (excluding Health Records incidents) remaining open after 28 days' is showing 'special cause concern' (increasing rate) - This is a change from the previous month. The figure is currently at 313.

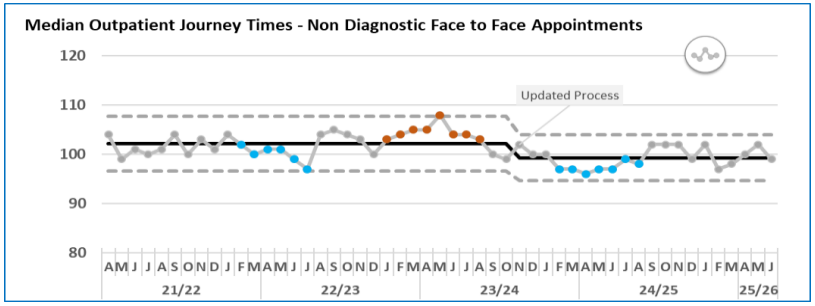
Whilst there is an increase in the number presented for June, it is to be noted that in the last month almost 500 incidents have been closed, and 240 of these have been closed since 1 July. Over 100 more incidents have had outcomes added and are awaiting review and final closure by the Q&S team, and approximately 70 of these are older than 28 days. Closure of these will reduce the number closer to the mean. Improvement work with clinical divisions and corporate directorates remains on-going.

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

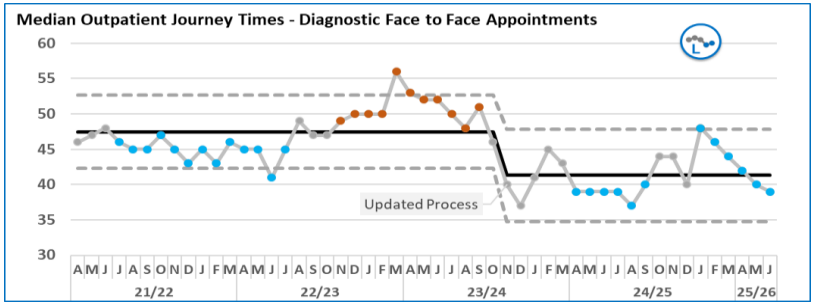
Sustainability and at Scale - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	99		
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	39		
Median Outpatient Journey Times - Virtual TeleMedicine Appointments	Jon Spencer	Internal Measure	Monthly	No Target Set	n/a	n/a		
Theatre Cancellation Rate (Non-Medical Cancellations)	Jon Spencer	Statutory Reporting	Monthly	≤0.8%	1.58%	2.15%		
Number of non-medical cancelled operations not treated within 28 days	Jon Spencer	Statutory Reporting	Monthly	Zero Breaches	4	0		
Overall financial performance (In Month Var. £m)	Justin Betts	NHS Oversight Framework	Monthly	≥0	0.98	0.37		
Commercial Trading Unit Position (In Month Var. £m)	Justin Betts	Internal Measure	Monthly	≥0	0.13	-0.04		

Sustainability and at Scale - Graphs (1)

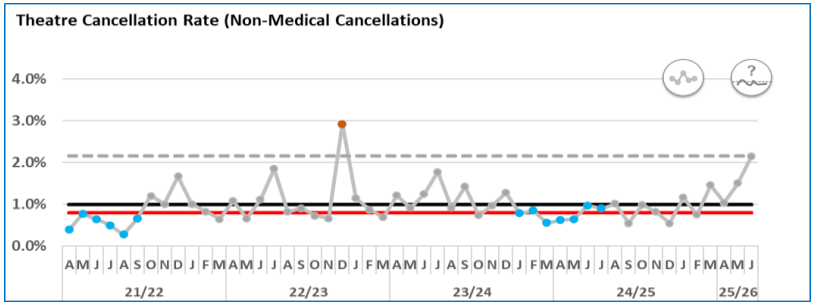


'Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments' is showing 'common cause variation'. The figure is currently at 99.



'Median Outpatient Journey Times - Diagnostic Face to Face Appointments' is showing 'special cause improvement' (decreasing rate) - This is a change from the previous month. The figure is currently at 39.

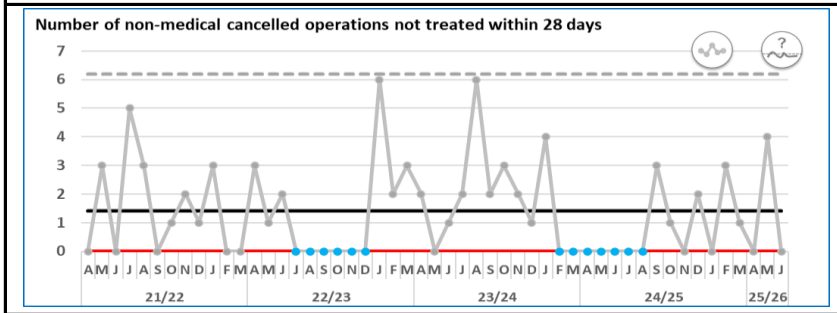
Sustainability and at Scale - Graphs (2)



'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 2.15%.

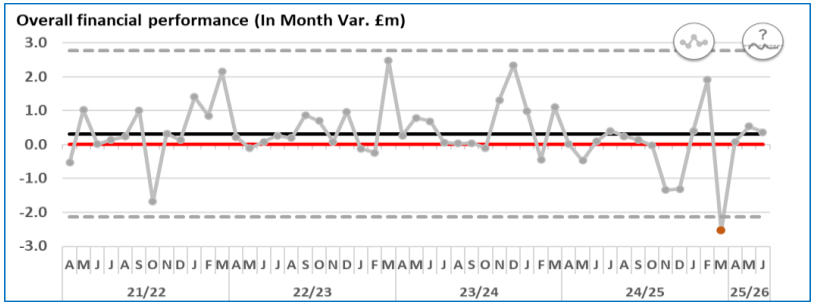
The non-medical cancellation rate increased in month due to estates and facilities issues at St Ann's (temperature), Stratford (electrical) and Queen Mary's (ventilation). Patients have all been offered dates with 28 days of on the day cancellations, but some patients have chosen dates further into the future due to holiday commitments. Actions to prevent reoccurrence include remedial works at St Ann's is scheduled to prevent future temperature rises and Queen Mary's last operating session in July.

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



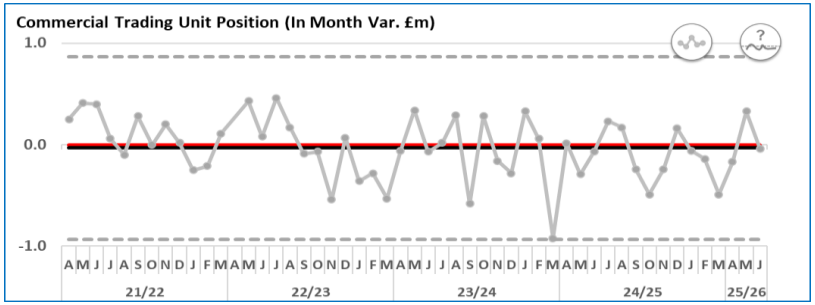
'Number of non-medical cancelled operations not treated within 28 days' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.

Sustainability and at Scale - Graphs (3)



'Overall financial performance (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at 0.37.

For further narrative, see finance report



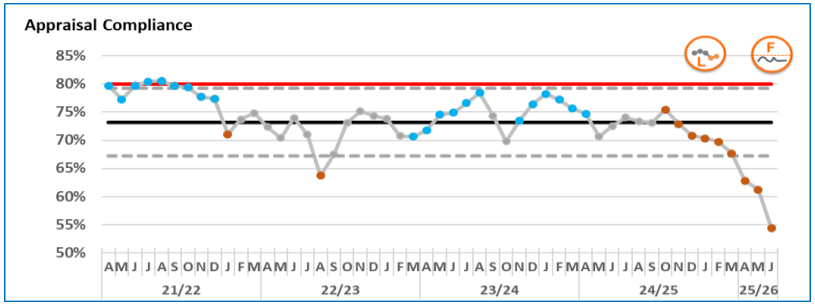
'Commercial Trading Unit Position (In Month Var. £m)' is showing 'common cause variation' and that the current process is not consistently achieving the target. The figure is currently at -0.04.

For further narrative, see finance report

Working Together - Summary

Metric Description	Metric Lead	Metric Source	Reporting Frequency	Target	Year to Date	Current Period	Variation	Assurance
Appraisal Compliance	Sue Steen	Internal Measure	Monthly	≥80%	n/a	54.4%		
Basic Mandatory IG Training	Samuel Armstrong	DSPT Toolkit (Locally Monitored)	Monthly	≥90%	n/a	89.6%		
Staff Sickness (Month Figure)	Sue Steen	Performance Assessment Framework	Monthly (Month in Arrears)	≤4%	n/a	4.5%		
Staff Sickness (Rolling Annual Figure)	Sue Steen	Performance Assessment Framework	Monthly (Month in Arrears)	≤4%	n/a	4.8%		
Recruitment Time To Hire (Days)	Sue Steen	Internal Definition	Monthly	≤ 40 Days	n/a	37		
Proportion of Temporary Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	8.3%	7.8%		
Proportion of Bank Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	6.7%	5.7%		
Proportion of Agency Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	1.6%	2.1%		
Proportion of Permanent Staff	Sue Steen	NHS Operational Planning	Monthly	No Target Set	91.7%	92.2%		

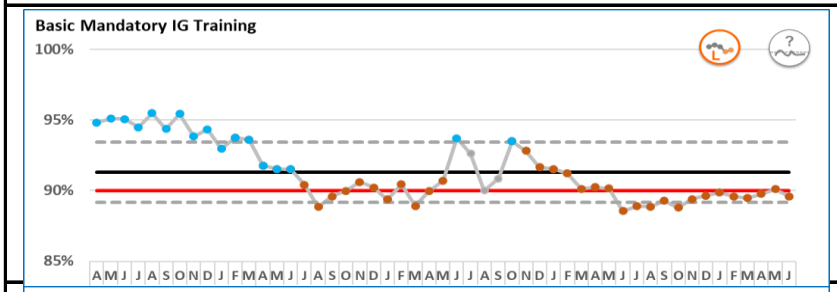
Working Together - Graphs (1)



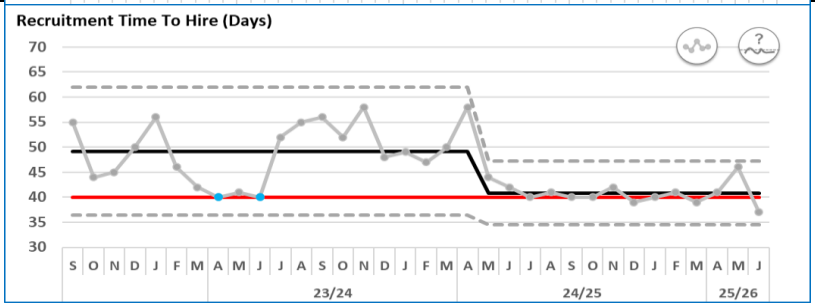
'Appraisal Compliance' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 54.4%.

- The latest appraisal compliance rate is based on data from Perform, the Trust's new online appraisal platform. Following a recent Kallidus system upgrade, reporting directly from Perform now provides more accurate and up-to-date information, correcting previous errors in appraisal compliance data caused by issue with the old MAST reporting template.
- Although the current compliance rate is 55.%, lower than last month's reported 61.2%, recently reported compliance rates were based on the old 12 months appraisal window. The new rate, based on the current appraisal window, offers a more accurate reflection of actual appraisal completion across the Trust.
- The new appraisal compliance reports from Perform is now showing a daily increase in appraisal completion rates, reflecting the high volume of appraisal meetings scheduled for July.
- The improved appraisal data quality is also helping to resolve historical inaccuracies at both divisional and team levels. This, in turn, is helping local managers in effectively planning and scheduling appraisals ahead of the end-of-July deadline.
- We continue to circulate weekly reports to divisions and corporate teams, highlighting outstanding appraisals that require action. These reports are helping teams drive the booking and completion of appraisals.
- To maintain momentum and raise awareness, we have worked with the communication team to launch a screensaver displaying a weekly countdown to the end of the appraisal window.

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



'Basic Mandatory IG Training' is showing 'special cause concern' and that the current process is not consistently achieving the target. The figure is currently at 89.6%.

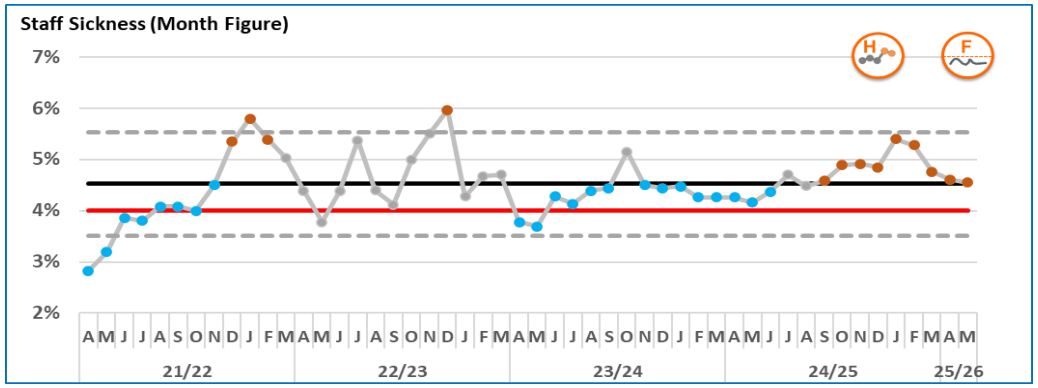


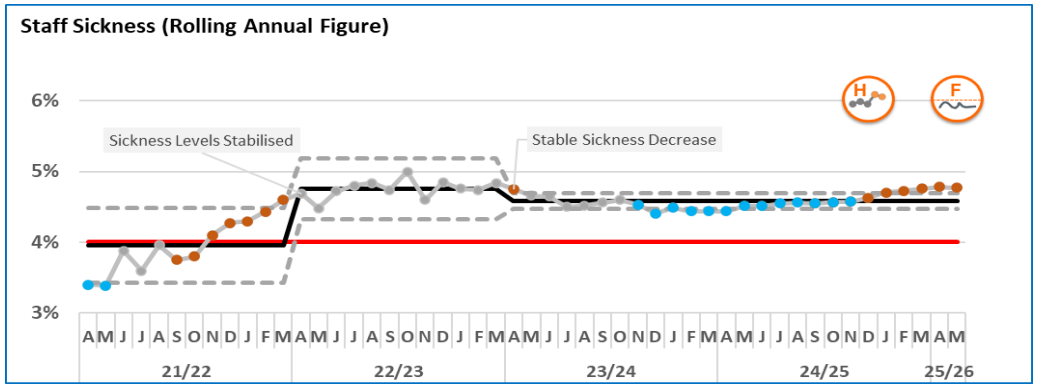
'Recruitment Time to Hire (Days)' is showing 'common cause variation' and that the current process is not consistently achieving the target - This is a change from the previous month. The figure is currently at 37.

The time to hire (TTH) performance for June is 37 days, which is below the Trust target.
Sustaining and improving the time to hire target continues with the Recruitment team supporting and advising managers.
Time to shortlist still remains the KPI which is over target by 5 days.
Time to approve a vacancy has not increased as expected with the introduction of the vacancy escalated approval panel
There has been a decrease in the number of roles the Trust is currently advertising

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

Working Together - Graphs (2)





'Staff Sickness (Month Figure)' is showing 'special cause concern' and that the current process is unlikely to achieve the target. The figure is currently at 4.5%.	**'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 4.8%.**

The sickness rate remains at 4.61% which is still above the 4% target. The top 3 reasons for sickness absences continue to be the same (in month) reporting.

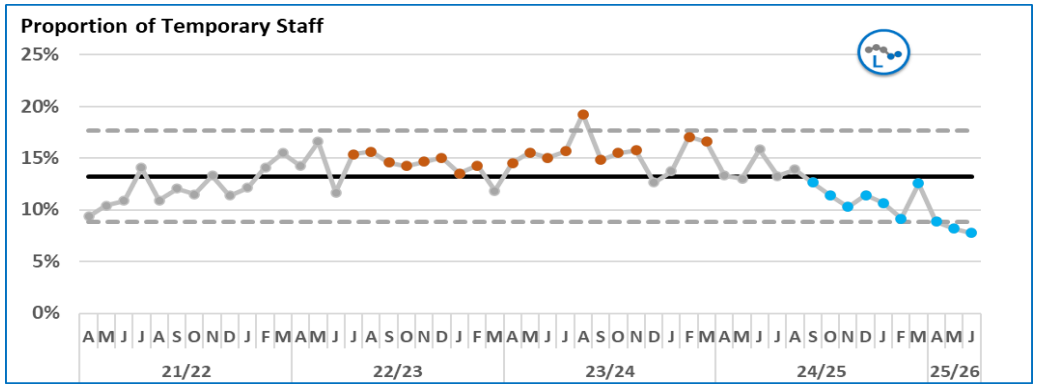
- Anxiety/stress/depression/other psychiatric illness,
- Cold, Cough, Flu – Influenza
- Musculoskeletal problems.

Work continues in providing:

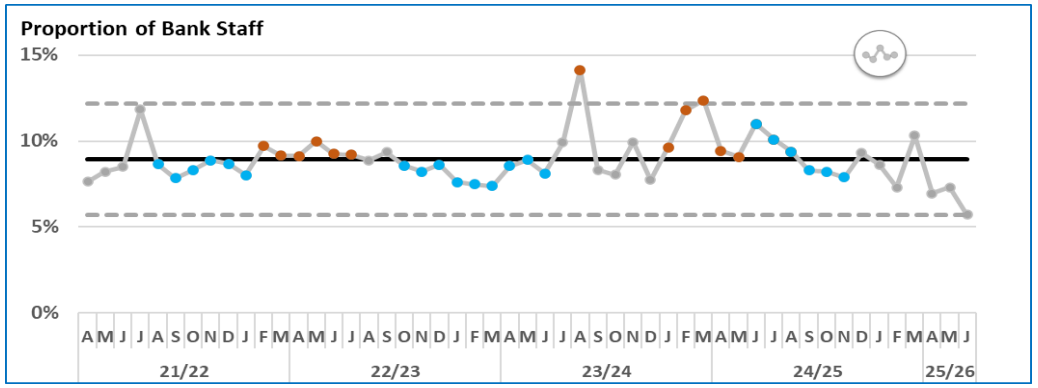
- ER team continues to deliver targeted sickness absence training to those hotspot areas being (North, Corporate, Private and OCSS divisions) with high-level absence rates for both short- and long-term cases.
- The current hotspot areas continue to be Private Patients, Human Resources, and Estates & Facilities – the ER team continues to have monthly meetings with divisional leadership to provide advisory support and guidance for resolution on complex cases.
- Ongoing promotion of Thrive, Moorfields (Wellbeing Programme), which outlines offers available to all staff.

Review Date: Aug 2025 ***Action Lead:*** Jackie Wyse / Emeka Ezechukwu

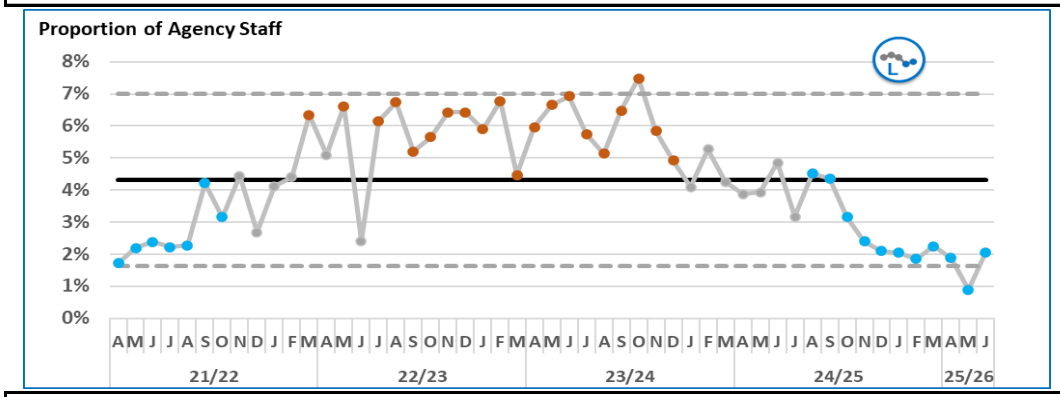
Working Together - Graphs (3)



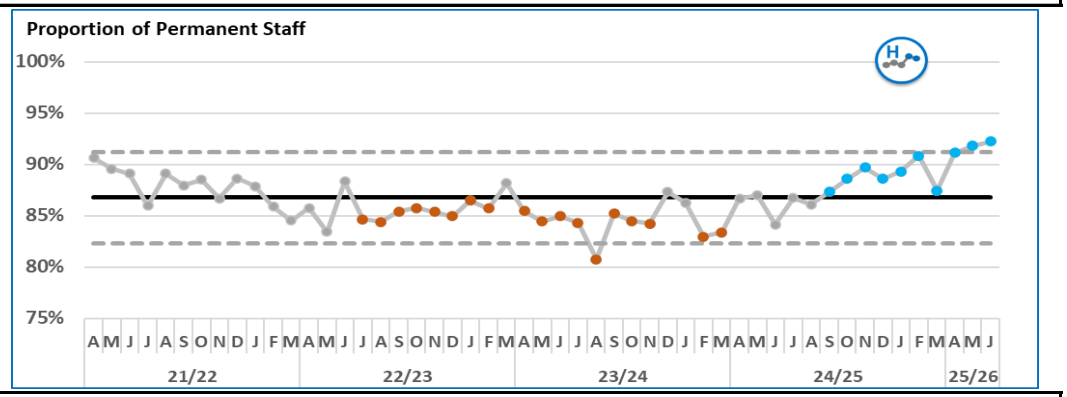
'Proportion of Temporary Staff ' is showing 'special cause improvement' (decreasing rate). The figure is currently at 7.8%.



'Proportion of Bank Staff' is showing 'common cause variation'. The figure is currently at 5.7%.



'Proportion of Agency Staff' is showing 'special cause improvement' (decreasing rate). The figure is currently at 2.1%.



'Proportion of Permanent Staff' is showing 'special cause improvement' (increasing rate). The figure is currently at 92.2%.

The Temporary staffing reduction and eroster optimisation group has refreshed its governance, reporting, and monitoring approach to ensure better; (i) Exec oversight, grip and control pertaining to the utilisation and spend of temporary staff which will also enable delivery of reduction targets for 2025/26.

The Trust has seen a decline is temporary staffing spend since the start of the financial year, the proportion of agency spend against our total pay bill is higher than our NCL target and is addressed as part of the temporary staffing reduction and eroster optimisation group.

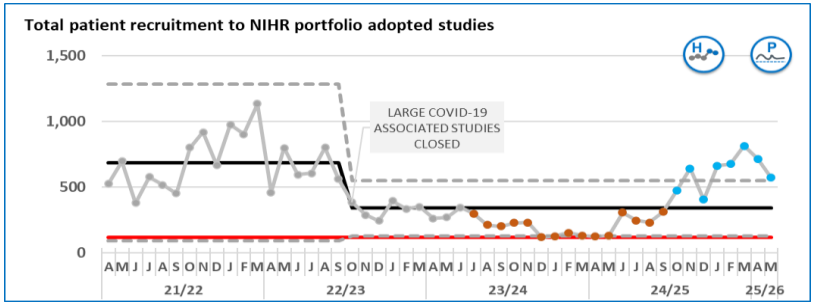
The top three reasons for temporary staffing utilisation and spend continues to be undertaking of additional shifts, covering of vacancy, and long-term sickness absences. The temporary staffing team and our supplier, Bank Partners, continue to work with hiring managers in the utilisation and spend with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

Review Date: Aug 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 Measure	Monthly (Month in Arrears)	≥115 (per month)	1286	571		
Total patient recruitment to All Research Studies (Moorfields Sites Only)	Hilary Fanning	Internal Measure	Monthly (Month in Arrears)	No Target Set	1354	610		
Active Commercial Studies (Open + Closed to Recruitment in follow up)	Hilary Fanning	Internal Measure	Monthly (Month in Arrears)	≥44	n/a	61		
Proportion of patients participating in research studies (as a percentage of number of open pathways)	Hilary Fanning	Internal Measure	Monthly (Month in Arrears)	≥2%	n/a	3.3%		

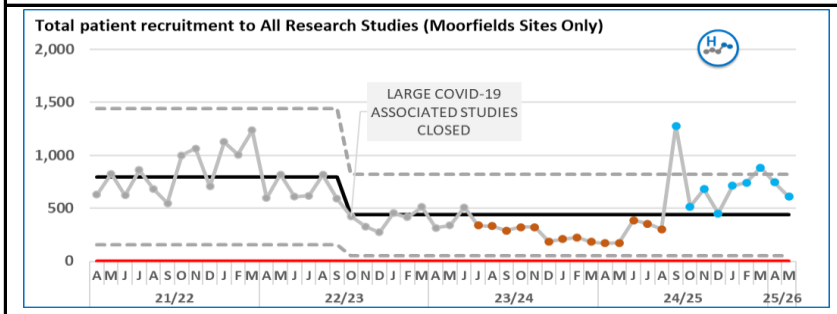
Discover - Graphs (1)



'Total patient recruitment to NIHR portfolio adopted studies' is showing 'special cause improvement' and that the current process will consistently pass the target. The figure is currently at 571.

The majority of Moorfield's studies are NIHR Portfolio adopted. The percentage split for currently active studies is 83% NIHR portfolio and 17% non- NIHR portfolio. Currently our NIHR Portfolio recruitment for this financial year is 1533, and if we maintain the same rates of recruitment we should approach a total of around 6000 by the end of the financial year.
To maintain these recruitment levels, it is important that we continue to attract more grants and awards.
Recently, a project grant funded by Alcon, led by Moorfields and that will be portfolio adopted plans to recruit 310 patients over the age of 45 that require cataract surgery. These patients will be provided with one of two next-generation intra-ocular lenses that will be compared over a period of 3 months in terms of vision quality and patient satisfaction. This project is designed to help ensure that emerging cataract technologies meet the needs of a growing patient population. The award of £677,655 will financially support the study for 28 months.
We are also awaiting outcomes for competitive grants applied to Alcon, Bayer and Boehringer-Ingelheim. These grants are led and will be delivered by Moorfields if investigators are successful in their funding applications. The projects proposed will investigate (i - Alcon) treatment options for patients with ocular hypertension and glaucoma, (ii - Bayer) treatment options for patients with polypoidal choroidal vasculopathy in neovascular age-related macular degeneration, and (iii - Boehringer-Ingelheim) retinal structure of age related macular degeneration to predict new onset.

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



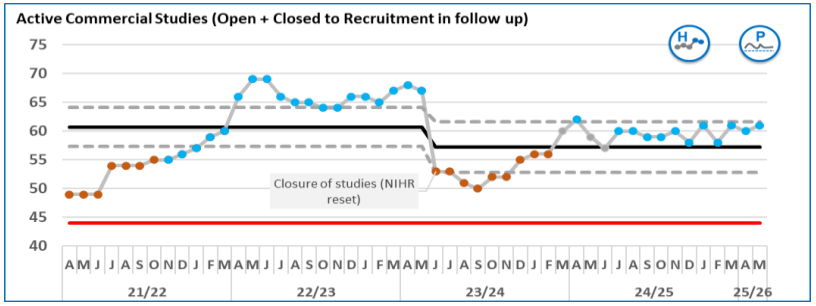
'Total patient recruitment to All Research studies (Moorfields Sites Only)' is showing 'special cause improvement' (increasing rate). The figure is currently at 610.

The total patient recruitment in May 2025 across both NIHR portfolio and non NIHR portfolio studies was 610 recruits. This metric includes commercial and non-commercial studies. Our commercial study recruitment varies from month to month, with May having 19 recruits, which is 3% of the monthly total and slightly higher than the previous months. Recruitment to non-NIHR portfolio studies also varies each month, with 39 in May (6%).

An award to Peter Thomas by NIHR that began in May 2025 will allow Peter to use the NHS England Eyecare Accelerator service in London to address critical under-represented questions, including patient choice, healthcare inequalities, and the clinical and economic outcomes of community-delivered pathways. Peter's work will likely result in a future research programme that will improve the patient experience and inform policy and commissioning decisions. This future research programme has the potential to drive greater patient recruitment to studies.

Review Date: Aug 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 metric displays a good level of consistency. This is keeping in line with our average across 2024/25 which was 58. Our medium-term goal is to increase the percentage of patients recruited to commercial studies, to the NIHR recommended level of 25% of all patient's recruited going into commercial studies. For this financial year our % of recruitment into commercial studies stands at 2.7%.
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 21 hosted studies in "set up" should ensure that we continue to increase recruitment to commercial studies. 13 out of 17 (76%) of commercial studies recruited fully within the target time.
Set-up times for commercial and non-commercial studies continue to improve, some anomalies are still present, mainly due to the complexity of contracting for certain types of studies, which can delay things. The median set-up time for clinical trials has been improving and was down to 9 days in May, compared to 99 days at the end of December 2024. We continue to look for new innovative methods of shortening the set up time to ensure that studies start recruiting as soon they open.
We have successfully recruited the fist patient in the UK to our hosted study: Phase 1/2 Multicentre, Open-label, Dose Escalation, Safety and Efficacy Study of Subretinal Administration of Dual AAV8.MYO7A, AAVB-081 in Participants with Usher Syndrome Type 1B (USH1B) Retinitis Pigmentosahase 1. The project is sponsored by AAVantgarde Bio.

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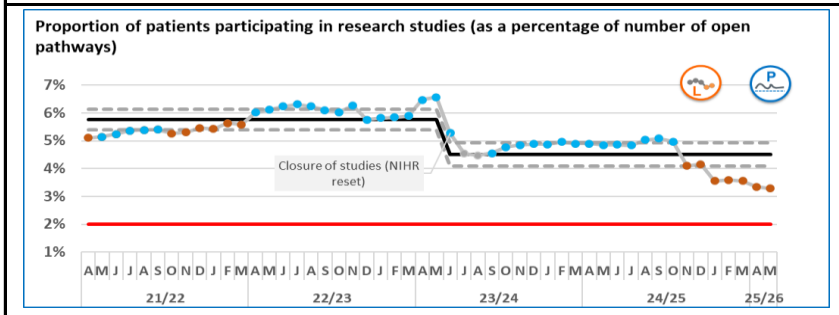

'Proportion of patients participating in research studies (as a percentage of number of open pathways)' is showing 'special cause concern' however the current process will consistently pass the target. The figure is currently at 3.3%.

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

We are giving consideration to the adding of new metrics to give assurance that align to the newly published NIHR guidance for study set up, for implementation in Q3

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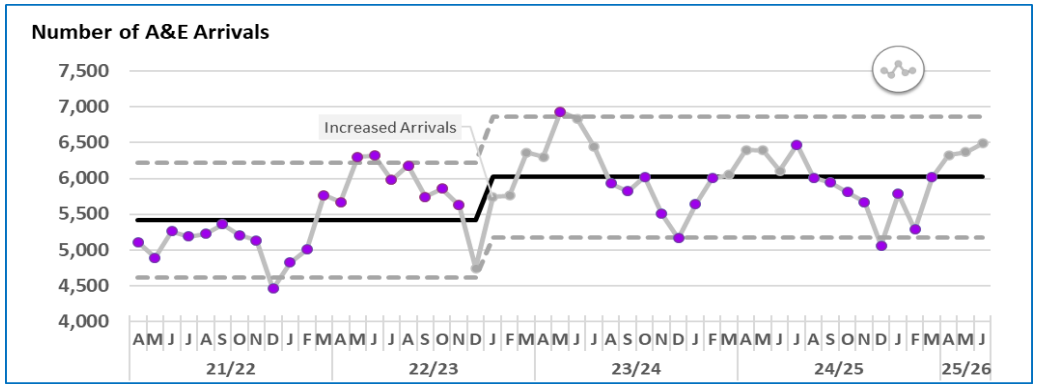
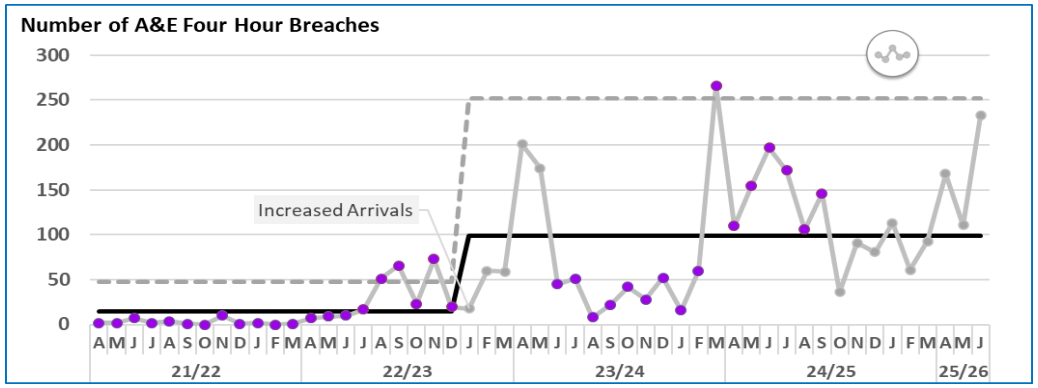
Context (Activity) - Summary

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	19180	6490		
Number of A&E Four Hour Breaches	Jon Spencer	Internal Requirement	Monthly	No Target Set	512	233		
Number of Outpatient Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	163111	54977		
Number of Outpatient First Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	39179	13057		
Number of Outpatient Follow Up Appointment Attendances	Jon Spencer	Internal Requirement	Monthly	No Target Set	123932	41920		
Number of Referrals Received	Jon Spencer	Internal Requirement	Monthly	No Target Set	47787	14816		
Number of Theatre Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	9648	3328		
Number of Theatre Elective Daycase Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	8671	3009		
Number of Theatre Elective Inpatient Admission	Jon Spencer	Internal Requirement	Monthly	No Target Set	208	72		
Number of Theatre Emergency Admissions	Jon Spencer	Internal Requirement	Monthly	No Target Set	769	247		

Context (Activity) - Graphs (1)

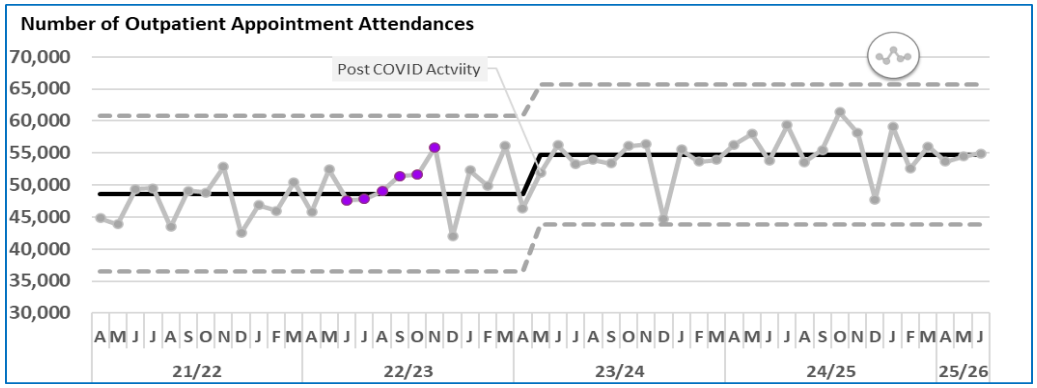


'Number of A&E Arrivals' is showing 'common cause variation'. The figure is currently at 6,490.

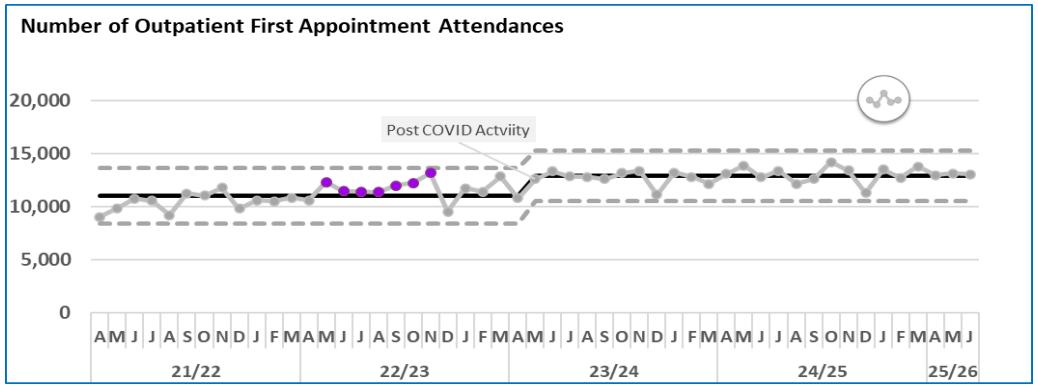


'Number of A&E Four Hour Breaches' is showing 'common cause variation'. The figure is currently at 233.

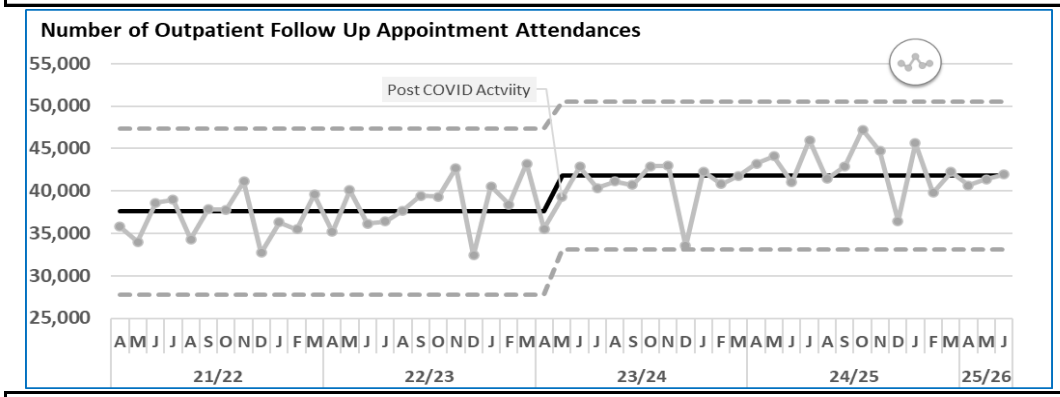
Context (Activity) - Graphs (2)



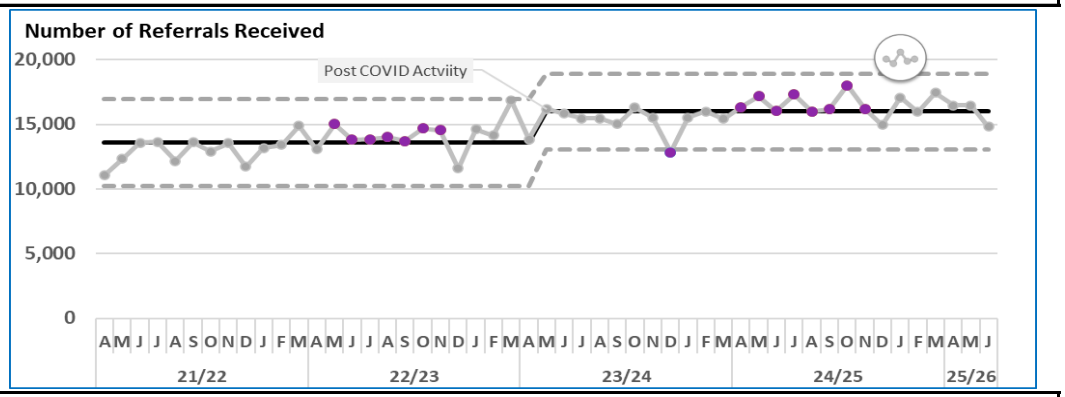
'Number of Outpatient Appointment Attendances' is showing 'common cause variation'. The figure is currently at 54,977.



'Number of Outpatient First Appointment Attendances' is showing 'common cause variation'. The figure is currently at 13,057.

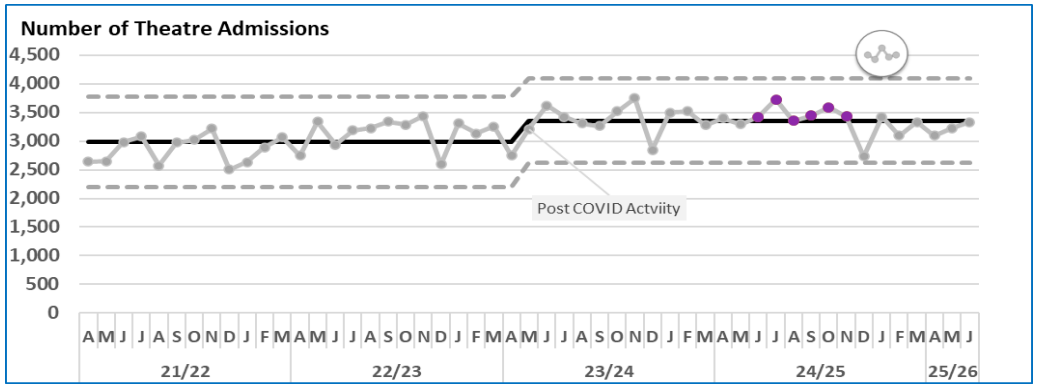


'Number of Outpatient Follow Up Appointment Attendances' is showing 'common cause variation'. The figure is currently at 41,920.

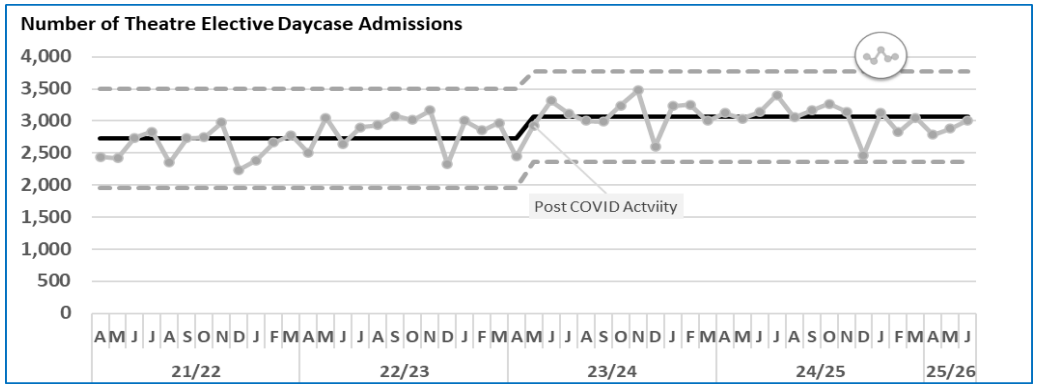


'Number of Referrals Received' is showing 'common cause variation'. The figure is currently at 14,816.

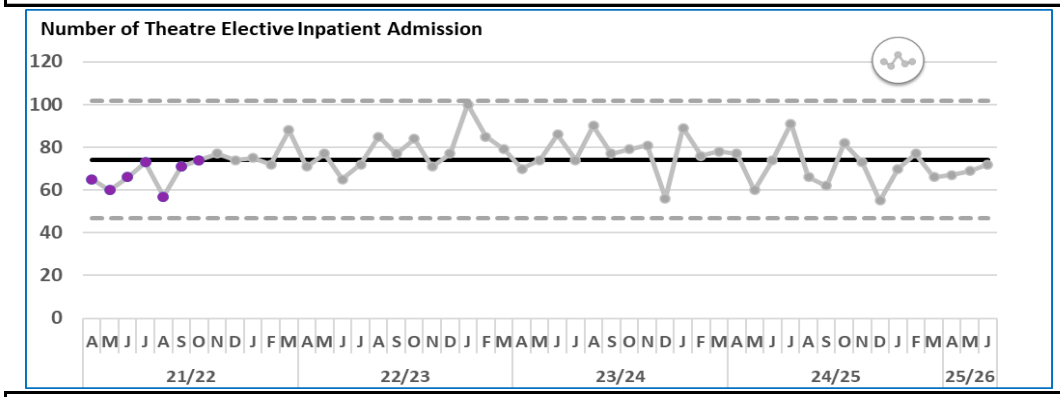
Context (Activity) - Graphs (3)



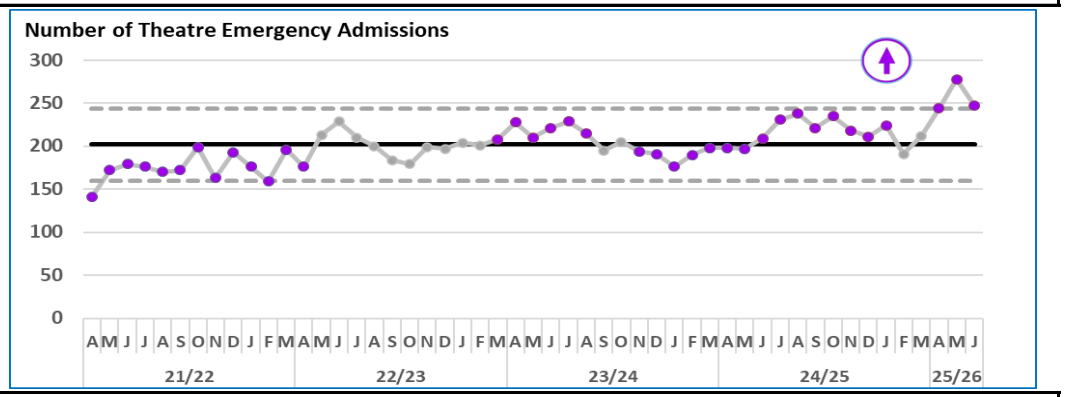
'Number of Theatre Admissions' is showing 'common cause variation'. The figure is currently at 3,328.



'Number of Theatre Elective Daycase Admissions' is showing 'common cause variation'. The figure is currently at 3,009.



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



'Number of Theatre Emergency Admissions' is showing an 'special cause variation' (increasing rate). The figure is currently at 247.

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Deliver (Activity vs Plan)																						
Elective Activity - % of Phased Plan	Jun-25	94.4%	≥100%	Monthly	Common Cause	Hit or Miss	94.3%	76.6%	112.0%	103.6%	95.3%	93.6%	96.7%	90.6%	95.3%	78.5%	90.5%	89.9%	92.7%	102.0%	105.6%	94.4%
Total Outpatient Activity - % of Phased Plan	Jun-25	90.8%	≥100%	Monthly	Common Cause	Hit or Miss	101.9%	88.5%	115.4%	106.1%	102.0%	100.5%	104.3%	105.0%	109.3%	94.3%	106.1%	103.6%	105.2%	103.5%	104.9%	90.8%
Outpatient First Appointment Activity - % of Phased Plan	Jun-25	90.7%	≥100%	Monthly	Common Cause	Hit or Miss	104.3%	89.3%	119.2%	111.0%	100.9%	99.8%	103.7%	106.4%	110.5%	97.7%	106.3%	109.7%	113.1%	105.1%	106.8%	90.7%
Outpatient Follow Up Appointment Activity - % of Phased Plan	Jun-25	90.8%	≥100%	Monthly	Common Cause	Hit or Miss	102.4%	88.0%	116.8%	104.8%	102.3%	100.7%	104.5%	104.7%	108.9%	93.4%	106.1%	101.8%	103.0%	103.0%	104.3%	90.8%
Deliver (Cancer Performance)																						
Cancer 28 Day Faster Diagnosis Standard	Jun-25	100.0%	≥80%	Monthly	Common Cause	Hit or Miss	82.1%	32.1%	132.1%	100.0%	75.0%	88.9%	77.8%	55.6%	100.0%	80.0%	75.0%	75.0%	72.7%	88.9%	100.0%	100.0%
% Patients with all cancers receiving treatment within 31 days of decision to treat	Jun-25	n/a	≥96%	Monthly	Not Available	Not Applicable	99.1%	94.9%	103.2%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	89.3%	95.7%	100.0%	95.8%	n/a
% Patients with all cancers treated within 62 days	Jun-25	n/a	≥85%	Monthly	Not Available	Not Applicable	96.4%	74.9%	118.0%	100.0%	100.0%	100.0%	100.0%	97.5%	96.7%	94.1%	100.0%	94.1%	93.8%	92.3%	100.0%	n/a

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Deliver (Access Performance)																						
18 Week RTT Incomplete Performance	Jun-25	83.1%	≥82.7%	Monthly	Common Cause	Hit or Miss	82.7%	81.0%	84.4%	84.3%	84.0%	82.6%	82.7%	82.4%	82.6%	81.2%	80.9%	82.5%	83.1%	82.7%	82.2%	83.1%
RTT Incomplete Pathways (RTT Waiting List)	Jun-25	34,491	≤ Previous Mth.	Monthly	Common Cause	Not Applicable	34,366	32,761	35,971	34,201	33,017	34,357	34,932	33,872	33,281	33,039	32,691	33,406	33,136	33,228	33,142	34,491
RTT Incomplete Pathways Over 18 Weeks	Jun-25	5,814	≤ Previous Mth.	Monthly	Common Cause	Not Applicable	6,029	5,457	6,600	5,377	5,271	5,966	6,038	5,963	5,801	6,222	6,229	5,849	5,594	5,737	5,910	5,814
52 Week RTT Incomplete Breaches	Jun-25	19	Zero Breaches	Monthly	Common Cause	Failing	11	-3	25	7	8	10	8	13	9	9	9	12	18	22	29	19
Eliminate waits over 65 weeks for elective care	Jun-25	1	Zero Breaches	Monthly	Common Cause	Failing	3	-4	10	3	2	4	2	2	2	0	2	3	6	3	2	1
A&E Four Hour Performance	Jun-25	96.2%	≥95%	Monthly	Common Cause	Capable	97.7%	94.9%	100.4%	96.6%	97.2%	98.1%	97.4%	99.4%	98.3%	98.3%	97.9%	98.8%	98.4%	97.2%	98.2%	96.2%
Percentage of Diagnostic waiting times less than 6 weeks	Jun-25	100.0%	≥99%	Monthly	Common Cause	Hit or Miss	99.3%	97.1%	101.5%	98.9%	98.9%	99.1%	100.0%	100.0%	99.5%	98.3%	97.7%	98.4%	98.7%	98.4%	99.5%	100.0%
Deliver (Call Centre and Clinical)																						
Average Call Waiting Time	Jun-25	131	≤ 2 Mins (120 Sec)	Monthly	Common Cause	Hit or Miss	149	33	264	276	146	174	139	112	109	32	77	199	255	260	131	131
Average Call Abandonment Rate	Jun-25	8.8%	≤15%	Monthly	Common Cause	Hit or Miss	10.5%	3.1%	18.0%	18.8%	12.0%	13.2%	10.6%	9.0%	8.5%	2.5%	6.4%	13.3%	16.4%	15.5%	8.7%	8.8%
Mixed Sex Accommodation Breaches	Jun-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)	Jun-25	1.56%	≤ 2.67%	Monthly (Rolling 3 Months)	Common Cause	Hit or Miss	2.04%	-3.36%	7.45%	0.00%	0.00%	1.47%	5.56%	0.00%	0.00%	9.68%	3.13%	1.69%	4.41%	2.82%	3.75%	1.56%
VTE Risk Assessment	Jun-25	99.0%	≥95%	Monthly	Common Cause	Capable	99.2%	97.9%	100.4%	99.9%	100.0%	99.7%	99.8%	99.8%	99.9%	99.1%	98.6%	99.3%	99.9%	99.3%	99.1%	99.0%
Posterior Capsular Rupture rates (Cataract Operations Only)	Jun-25	0.53%	≤1.95%	Monthly	Common Cause	Capable	0.88%	0.13%	1.63%	0.69%	1.36%	0.76%	0.85%	1.42%	0.92%	1.00%	0.80%	0.87%	0.70%	0.62%	1.16%	0.53%
MRSA Bacteraemias Cases	Jun-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	Jun-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	Jun-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	Jun-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	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Deliver (Quality and Safety)																						
Inpatient Scores from Friends and Family Test - % positive	Jun-25	96.9%	≥90%	Monthly	Common Cause	Capable	95.8%	93.8%	97.7%	96.7%	97.3%	96.1%	96.2%	96.8%	95.9%	95.0%	95.0%	97.4%	96.8%	97.0%	96.9%	96.9%
A&E Scores from Friends and Family Test - % positive	Jun-25	92.9%	≥90%	Monthly	Common Cause	Capable	92.9%	90.6%	95.3%	92.5%	92.7%	94.0%	93.7%	93.4%	93.9%	94.7%	94.7%	94.4%	94.3%	91.7%	92.9%	92.9%
Outpatient Scores from Friends and Family Test - % positive	Jun-25	95.3%	≥90%	Monthly	Improvement (Run Above Average)	Capable	93.9%	92.9%	94.9%	94.5%	94.4%	94.4%	94.2%	95.4%	95.0%	94.9%	94.9%	95.5%	95.3%	95.8%	95.3%	95.3%
Paediatric Scores from Friends and Family Test - % positive	Jun-25	93.4%	≥90%	Monthly	Common Cause	Capable	94.5%	90.5%	98.5%	93.6%	94.8%	95.8%	94.4%	93.2%	94.6%	96.3%	96.3%	95.0%	93.8%	97.0%	93.4%	93.4%
Percentage of responses to written complaints sent within 25 days	May-25	30.0%	≥80%	Monthly (Month in Arrears)	Concern (Run Below Average)	Failing	71.5%	28.9%	114.1%	81.8%	71.4%	83.3%	40.0%	69.2%	71.4%	75.0%	18.2%	40.0%	9.1%	35.7%	30.0%	n/a
Percentage of responses to written complaints acknowledged within 3 days	Jun-25	53.8%	≥80%	Monthly	Concern (Run Below Average)	Failing	88.4%	59.5%	117.3%	90.9%	100.0%	100.0%	40.0%	84.6%	92.9%	75.0%	36.4%	60.0%	36.4%	71.4%	55.0%	53.8%
Freedom of Information Requests Responded to Within 20 Days	May-25	97.8%	≥90%	Monthly (Month in Arrears)	Common Cause	Hit or Miss	90.2%	75.2%	105.2%	85.4%	82.8%	87.8%	86.1%	89.4%	78.7%	88.2%	93.8%	100.0%	92.3%	100.0%	97.8%	n/a
Subject Access Requests (SARs) Responded To Within 28 Days	May-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	Jun-25	0	Zero Events	Monthly	Improvement (Run Below Average)	Capable	0	-1	1	0	0	0	1	0	0	0	0	0	0	0	0	0
Summary Hospital Mortality Indicator	Jun-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	Jun-25	0	Zero Alerts	Monthly	Improvement (Run Below Average)	Capable	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Number of Incidents (excluding Health Records incidents) remaining open after 28 days	Jun-25	313	No Target Set	Monthly	Concern (Higher Than Expected)	Not Applicable	233	150	316	302	264	283	253	252	275	307	222	284	251	283	291	313

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Sustainability and at Scale																						
Median Outpatient Journey Times - Non Diagnostic Face to Face Appointments	Jun-25	99	No Target Set	Monthly	Common Cause	Not Applicable	99	95	104	97	99	98	102	102	102	99	102	97	98	100	102	99
Median Outpatient Journey Times - Diagnostic Face to Face Appointments	Jun-25	39	No Target Set	Monthly	Improvement (Decreasing Trend)	Not Applicable	41	35	48	39	39	37	40	44	44	40	48	46	44	42	40	39
Theatre Cancellation Rate (Non-Medical Cancellations)	Jun-25	2.15%	≤0.8%	Monthly	Common Cause	Hit or Miss	1.00%	-0.17%	2.17%	0.97%	0.90%	1.02%	0.55%	0.99%	0.82%	0.55%	1.16%	0.75%	1.46%	1.04%	1.51%	2.15%
Number of non-medical cancelled operations not treated within 28 days	Jun-25	0	Zero Breaches	Monthly	Common Cause	Hit or Miss	1	-3	6	0	0	0	3	1	0	2	0	3	1	0	4	0
Overall financial performance (In Month Var. £m)	Jun-25	0.37	≥0	Monthly	Common Cause	Hit or Miss	0.32	-2.14	2.77	0.09	0.41	0.25	0.15	-0.03	-1.34	-1.31	0.41	1.91	-2.53	0.08	0.54	0.37
Commercial Trading Unit Position (In Month Var. £m)	Jun-25	-0.04	≥0	Monthly	Common Cause	Hit or Miss	-0.03	-0.93	0.87	-0.07	0.23	0.17	-0.24	-0.49	-0.24	0.16	-0.06	-0.14	-0.49	-0.17	0.33	-0.04
Working Together																						
Appraisal Compliance	Jun-25	54.4%	≥80%	Monthly	Concern (Decreasing Trend)	Failing	73.2%	67.2%	79.2%	72.5%	74.1%	73.4%	73.1%	75.5%	72.9%	70.8%	70.3%	69.7%	67.7%	62.8%	61.2%	54.4%
Basic Mandatory IG Training	Jun-25	89.6%	≥90%	Monthly	Concern (Run Below Average)	Hit or Miss	91.3%	89.2%	93.4%	88.5%	88.9%	88.9%	89.3%	88.8%	89.4%	89.6%	89.9%	89.6%	89.5%	89.8%	90.1%	89.6%
Staff Sickness (Month Figure)	May-25	4.5%	≤4%	Monthly (Month in Arrears)	Concern (Run Above Average)	Failing	4.5%	3.5%	5.5%	4.4%	4.7%	4.5%	4.6%	4.9%	4.9%	4.8%	5.4%	5.3%	4.8%	4.6%	4.5%	n/a
Staff Sickness (Rolling Annual Figure)	May-25	4.8%	≤4%	Monthly (Month in Arrears)	Concern (Run Above Average)	Failing	4.6%	4.5%	4.7%	4.5%	4.5%	4.6%	4.5%	4.6%	4.6%	4.6%	4.7%	4.7%	4.8%	4.8%	4.8%	n/a
Recruitment Time To Hire (Days)	Jun-25	37	≤ 40 Days	Monthly	Common Cause	Hit or Miss	41	35	47	42	40	41	40	40	42	39	40	41	39	41	46	37
Proportion of Temporary Staff	Jun-25	7.8%	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	13.2%	8.8%	17.7%	15.9%	13.3%	13.9%	12.7%	11.4%	10.3%	11.4%	10.7%	9.2%	12.6%	8.8%	8.2%	7.8%
Proportion of Bank Staff	Jun-25	5.7%	No Target Set	Monthly	Common Cause	Not Applicable	8.9%	5.7%	12.2%	11.0%	10.1%	9.4%	8.3%	8.2%	7.9%	9.3%	8.6%	7.3%	10.3%	7.0%	7.3%	5.7%
Proportion of Agency Staff	Jun-25	2.1%	No Target Set	Monthly	Improvement (Run Below Average)	Not Applicable	4.3%	1.6%	7.0%	4.9%	3.2%	4.5%	4.4%	3.2%	2.4%	2.1%	2.0%	1.9%	2.2%	1.9%	0.9%	2.1%
Proportion of Permanent Staff	Jun-25	92.2%	No Target Set	Monthly	Improvement (Run Above Average)	Not Applicable	86.8%	82.3%	91.2%	84.1%	86.7%	86.1%	87.3%	88.6%	89.7%	88.6%	89.3%	90.8%	87.5%	91.2%	91.8%	92.2%

Metric Name	Reporting Period	Period Performance	Target	Reporting Frequency	Variation (Trend/Exception)	Assurance	Recent Average	Lower Limit	Upper Limit	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Discover																						
Total patient recruitment to NIHR portfolio adopted studies	May-25	571	≥115 (per month)	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	340	130	550	306	247	231	310	472	641	406	663	676	815	715	571	n/a
Total patient recruitment to All Research Studies (Moorfields Sites Only)	May-25	610	No Target Set	Monthly (Month in Arrears)	Improvement (Run Above Average)	Not Applicable	437	53	821	387	353	304	1,278	516	681	450	712	741	883	744	610	n/a
Active Commercial Studies (Open + Closed to Recruitment in follow up)	May-25	61	≥44	Monthly (Month in Arrears)	Improvement (Run Above Average)	Capable	57	53	62	57	60	60	59	59	60	58	61	58	61	60	61	n/a
Proportion of patients participating in research studies (as a percentage of number of open pathways)	May-25	3.3%	≥2%	Monthly (Month in Arrears)	Concern (Run Below Average)	Capable	4.5%	4.1%	4.9%	4.9%	4.8%	5.0%	5.1%	5.0%	4.1%	4.2%	3.6%	3.6%	3.6%	3.4%	3.3%	n/a
Context (Activity)																						
Number of A&E Arrivals	Jun-25	6,490	No Target Set	Monthly	Common Cause	Not Applicable	6,021	5,175	6,868	6,105	6,470	6,011	5,943	5,807	5,667	5,062	5,783	5,285	6,016	6,323	6,367	6,490
Number of A&E Four Hour Breaches	Jun-25	233	No Target Set	Monthly	Common Cause	Not Applicable	99	-54	252	197	172	106	146	36	91	81	113	61	93	168	111	233
Number of Outpatient Appointment Attendances	Jun-25	54,977	No Target Set	Monthly	Common Cause	Not Applicable	54,753	43,834	65,672	53,777	59,371	53,584	55,498	61,401	58,136	47,773	59,168	52,550	56,048	53,638	54,496	54,977
Number of Outpatient First Appointment Attendances	Jun-25	13,057	No Target Set	Monthly	Common Cause	Not Applicable	12,939	10,553	15,324	12,766	13,402	12,159	12,612	14,198	13,432	11,321	13,536	12,746	13,805	12,978	13,144	13,057
Number of Outpatient Follow Up Appointment Attendances	Jun-25	41,920	No Target Set	Monthly	Common Cause	Not Applicable	41,814	33,104	50,524	41,011	45,969	41,425	42,886	47,203	44,704	36,452	45,632	39,804	42,243	40,660	41,352	41,920
Number of Referrals Received	Jun-25	14,816	No Target Set	Monthly	Common Cause	Not Applicable	16,008	13,076	18,939	16,046	17,331	16,013	16,162	18,017	16,199	14,971	17,066	15,959	17,438	16,489	16,482	14,816
Number of Theatre Admissions	Jun-25	3,328	No Target Set	Monthly	Common Cause	Not Applicable	3,351	2,616	4,086	3,423	3,725	3,357	3,447	3,585	3,433	2,734	3,425	3,094	3,327	3,094	3,226	3,328
Number of Theatre Elective Daycase Admissions	Jun-25	3,009	No Target Set	Monthly	Common Cause	Not Applicable	3,063	2,360	3,765	3,140	3,403	3,053	3,164	3,268	3,142	2,468	3,131	2,826	3,049	2,783	2,879	3,009
Number of Theatre Elective Inpatient Admission	Jun-25	72	No Target Set	Monthly	Common Cause	Not Applicable	74	47	102	74	91	66	62	82	73	55	70	77	66	67	69	72
Number of Theatre Emergency Admissions	Jun-25	247	No Target Set	Monthly	Increasing (Higher Than Expected)	Not Applicable	202	160	244	209	231	238	221	235	218	211	224	191	212	244	278	247

Moorfields Eye Hospital NHS Foundation Trust

NHS

Report title	Monthly Finance Performance Report Month 03 – June 2025
Report from	Arthur Vaughan, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

For June, the trust is reporting:-

Financial Performance £m		In Month			Year to Date		
	Annual Plan	Plan	Actual	Variance	Plan	Actual	Variance
Income	£368.8m	£34.2m	£33.1m	(£1.1m)	£87.6m	£87.4m	(£0.2m)
Pay	(£192.9m)	(£16.6m)	(£15.9m)	£0.7m	(£49.7m)	(£49.4m)	£0.3m
Non Pay	(£131.7m)	(£11.2m)	(£10.4m)	£0.8m	(£32.9m)	(£32.1m)	£0.7m
Financing & Adjustments	(£44.2m)	(£6.4m)	(£6.5m)	(£0.1m)	(£9.0m)	(£8.9m)	£0.1m
CONTROL TOTAL	**-**	**£0.0m**	**£0.4m**	**£0.4m**	**(£4.0m)**	**(£3.1m)**	**£1.0m**

Income and Expenditure

- A £3.1m deficit year to date compared to a planned deficit of £4.0m; £1.0m favourable to plan.

Efficiency and Productivity

- The Trust has identified £7.5m of the £15.1m target required to achieve a break-even financial plan.
- Delivery in June reported £0.23m, broadly in line with the Trusts delivery plan which is predominantly towards the second half of the year.

Capital Expenditure

- Capital expenditure as of 30th June totalled £31.9m, predominantly linked to Oriel and EPR schemes.
  Business as usual capital £10.2m plan; £6.4m (62%) committed awaiting finalisation of key projects prior to further progression.

Cash

- The cash balance as at the 30th June was £69.9m, a decrease of £16.2m since the end of March 2025, and equivalent to 79 days of operating cash.

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

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

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

Action Required/Recommendation
The board is asked to consider and 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 30th June 2025 (Month 03)

Report Period	M03 | June 2025
Presented by	Arthur Vaughan| Chief Financial Officer
Written by	Justin Betts | Deputy Chief Financial Officer Amit Patel | Head of Financial Management Lubna Dharssi | Head of Financial Control Richard Allen | Head of Income and Contracts

Monthly Finance Performance Report

For the period ended 30th June 2025 (Month 03)

Key Messages

Statement of Comprehensive Income

Financial Position £0.38m surplus in month	For June, the trust is reporting:- • A £0.38m surplus in-month against a planned break-even position, a £0.37m favourable variance to plan • A £3.06m deficit cumulatively against a planned deficit of £4.04m, £0.99m favourable to plan.

Key Drivers of the Financial Variance	Key Drivers of the core operational performance include:-
	• NHS Clinical income is assumed in line with planning assumptions, until commissioner contracts have been received.
	• Clinical divisions and core activity performance are reporting £0.80m favorable to plan cumulatively. Clinical income is £0.94m ahead of plan offset by efficiency under delivery of £1.31m.
	  • Elective activity is 94% in June, 100% cumulatively of the activity plans;
	  • Stratford elective activity is 91% of plans cumulatively.
	  • St Ann's elective activity is 89% of plans cumulatively.
	  • Cataract activity is 104% of plans cumulatively.
	  • Outpatients Firsts and Procedures are 100% and 94% respectively cumulatively.
	• Research is reporting a £(0.31)m adverse position cumulatively comprised of research costs in excess of study activity and income adverse to plan within Insight.
	• Corporate departments are reporting £0.49m favourable cumulatively. Underspends on major IT projects and Oriel has been offset by CIP underachievement
	• Trading areas are £0.13m favourable to plan cumulatively across all commercial units.

Statement of Financial Position

Cash and Working Capital Position	The cash balance as at the 30th June was £69.9m, a reduction of £16.2m since the end of March 2025. This equates to approximately 79 days operating cash. The Better Payment Practice Code (BPPC) performance in June was 97% (volume) and 96% (value) against a target of 95% across both metrics.
Capital (both gross capital expenditure and CDEL)	Capital expenditure as of 30th June totalled £31.9m. • Business as usual capital £10.2m plan; £6.4m (62%) committed awaiting finalisation of key projects prior to further progression. • Externally funded schemes £149m plan; £31.8m cumulative expenditure including £30.8m of Oriel expenditure and £1.0m for EPR. • IFRS16 £5.1m capital plan; nil expenditure cumulatively.

Other Key Information

Efficiencies £15.1m Trust Target £0.7m YTD actual £12.2m un-identified and non recurrently identified schemes	The trust has a planned efficiency programme of £15.1m for 2025/26 to deliver the control total. The trust has identified £7.5m, £7.6m adverse to plan. Of the total identified:- • £2.8m is identified central schemes; • £0.7m is identified as income generation schemes; • £2.9m is forecast recurrently; The CIP programme delivery group are progressing further proposed efficiency scheme documentation for additional opportunities to be fully financial validated towards increasing the level of identified and forecast delivery in 2025/26.
Agency Spend £0.76m spend YTD 1.5% total pay	Trust wide agency spend totals £0.76m cumulatively, approximately 1.5% of total employee expenses spend, below the system allocated target of 2.5%. Workforce have instigated temporary staffing committees for oversight in relation to managing and reporting temporary staffing agency usage and reasons.

Trust Financial Performance - Financial Dashboard Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income	£368.8m	£34.2m	£33.1m	(£1.1m)	£87.6m	£87.4m	(£0.2m)	(0)%	
Pay	(£192.9m)	(£16.6m)	(£15.9m)	£0.7m	(£49.7m)	(£49.4m)	£0.3m	1%	
Non Pay	(£131.7m)	(£11.2m)	(£10.4m)	£0.8m	(£32.9m)	(£32.1m)	£0.7m	2%	
Financing & Adjustments	(£44.2m)	(£6.4m)	(£6.5m)	(£0.1m)	(£9.0m)	(£8.9m)	£0.1m	1%	
CONTROL TOTAL	**-**	**£0.0m**	**£0.4m**	**£0.4m**	**(£4.0m)**	**(£3.1m)**	**£1.0m**		
Income includes Elective Recovery Funding (ERF) which for presentation purposes is seperated on the Statement of Comprehensive Income									
Memorandum Items									
Research & Development	£0.40m	£0.02m	(£0.08m)	(£0.11m)	£0.07m	(£0.23m)	(£0.31m)	(419)%	
Commercial Trading Units	£5.35m	£0.51m	£0.47m	(£0.04m)	£1.23m	£1.36m	£0.13m	10%	
ORIEL Revenue	(£3.90m)	(£0.37m)	(£0.18m)	£0.19m	(£0.90m)	(£0.53m)	£0.36m	40%	
Efficiency Schemes	£18.00m	£0.20m	£0.23m	£0.03m	£0.60m	£0.67m	£0.06m	11%	

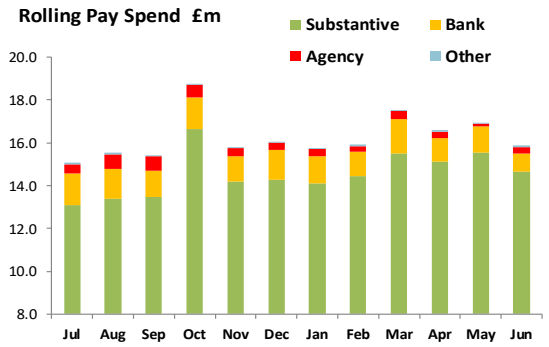
INCOME BREAKDOWN RELATED TO ACTIVITY

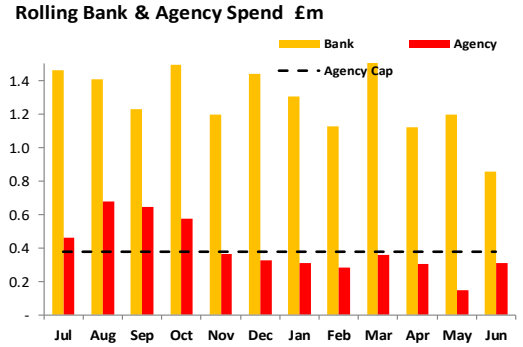
Income Breakdown £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£210.7m	£50.8m	£49.9m	(£0.9m)				
Pass Through	£40.2m	£9.5m	£10.1m	£0.5m				
Other NHS Clinical Income	£11.9m	£2.8m	£3.1m	£0.2m				
Commercial Trading Units	£48.4m	£11.8m	£11.7m	(£0.1m)				
Research & Development	£15.6m	£3.5m	£3.7m	£0.1m				
Other	£42.1m	£9.1m	£9.1m	(£0.0m)				
INCOME INCL ERF	**£368.8m**	**£87.6m**	**£87.4m**	**(£0.2m)**				

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	(£191.3m)	(£16.5m)	(£14.6m)	£1.9m	(£49.3m)	(£45.3m)	£4.0m	92%
Bank	(£0.6m)	£0.0m	(£0.9m)	(£0.9m)	(£0.2m)	(£3.2m)	(£3.0m)	6%
Agency	(£0.4m)	(£0.0m)	(£0.3m)	(£0.3m)	(£0.1m)	(£0.8m)	(£0.6m)	2%
Other	(£0.6m)	(£0.1m)	(£0.1m)	(£0.0m)	(£0.2m)	(£0.2m)	(£0.0m)	0%
TOTAL PAY	**(£192.9m)**	**(£16.6m)**	**(£15.9m)**	**£0.7m**	**(£49.7m)**	**(£49.4m)**	**£0.3m**	





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

*Agency cap levels set by NHSIE

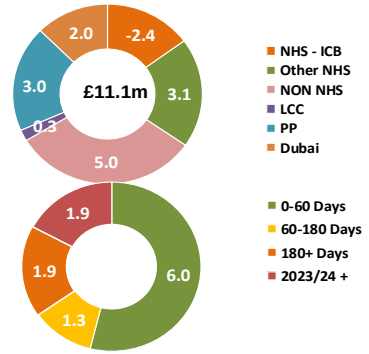
CASH, CAPITAL AND OTHER KPI'S

Capital Programme £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
Trust Funded	(£5.6m)	(£0.1m)	(£0.1m)	(£0.1m)				
Donated/Externally funded	(£145.2m)	(£38.8m)	(£30.8m)	(£8.0m)				
TOTAL	**£150.8m**	**£38.9m**	**£30.8m**	**(£8.1m)**				

Key Metrics	Plan	Actual	RAG
Cash	61.1	69.9	
Debtor Days	45	12	
Creditor Days	45	42	
PP Debtor Days	65	49	

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

Net Receivables/Ageing £m



Trust Income and Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	%	RAG
Income									
NHS Commissioned Clinical Income	250.88	21.72	20.92	(0.79)	60.36	59.97	(0.40)	(1)%	
Other NHS Clinical Income	11.87	1.04	0.97	(0.07)	2.82	3.05	0.23	8%	
Commercial Trading Units	48.42	4.08	3.76	(0.32)	11.78	11.66	(0.12)	(1)%	
Research & Development	15.55	1.21	1.24	0.03	3.54	3.67	0.12	3%	
Other Income	42.11	6.13	6.16	0.03	9.08	9.06	(0.02)	(0)%	
Total Income	**368.84**	**34.18**	**33.06**	**(1.12)**	**87.58**	**87.41**	**(0.18)**	**(0)%**	
Operating Expenses									
Pay	(192.94)	(16.58)	(15.86)	0.71	(49.72)	(49.40)	0.32	1%	
Of which: Unidentifed CIP	*8.54*	*0.61*	-	*(0.61)*	*2.16*	-	*(2.16)*		
Drugs	(43.28)	(3.78)	(3.77)	0.01	(10.67)	(11.51)	(0.85)	(8)%	
Clinical Supplies	(26.96)	(2.44)	(1.88)	0.56	(6.82)	(5.93)	0.89	13%	
Other Non Pay	(61.44)	(4.99)	(4.71)	0.28	(15.39)	(14.70)	0.69	4%	
Of which: Unidentifed CIP	*1.18*	*(0.19)*	-	*0.19*	*0.21*	-	*(0.21)*		
Total Operating Expenditure	**(324.63)**	**(27.79)**	**(26.23)**	**1.56**	**(82.59)**	**(81.54)**	**1.05**	**1%**	
EBITDA	*44.22*	*6.39*	*6.83*	*0.44*	*4.99*	*5.87*	*0.88*	18%	
Financing & Depreciation	(18.93)	(1.43)	(1.39)	0.04	(4.18)	(3.95)	0.23	5%	
Donated assets/impairment adjustments	(25.29)	(4.95)	(5.06)	(0.11)	(4.86)	(4.97)	(0.12)	(2)%	
Control Total Surplus/(Deficit)	**-**	**0.01**	**0.38**	**0.37**	**(4.04)**	**(3.06)**	**0.99**	**24%**	

Commentary

Operating Income

£1.12m adverse to plan in month

Total operating income is reporting £33.06m in-month, £1.12m adverse to plan, and £0.18m adverse cumulatively. Key points of note are:-

- Directly commissioned clinical income was £20.92m, £0.79m adverse to plan in-month.
- Underlying elective activity was at 94% (100% cumulatively). Elective activity was below plan in the north-east locality with Stratford activity at 91% and St Anns activity at 89% during June. QMR was also below plan at 86%, however Croydon and St Georges were above plan at 111% and 109% respectively.
- Commercial trading income was £3.76m, £0.32m adverse to plan.
- Research and Development income at £1.24m, £0.03m favourable to plan
- Other income was on plan. The Trust received £5m of donated income in June linked to Oriel (also reported in donated adjustments).

Employee Expenses

£0.71m favourable to plan in month

June pay is reporting £15.86m (2,794wte); £0.72m favourable to plan. Key points of note are:-

- Substantive pay costs (2,643wte) were £14.64m, lower than the prior average of £15.23m. Pay awards estimated at 2.8% has been accrued in line with national guidance whilst the Trust is now incurring additional employer NI charges of circa 1.9%
- Temporary staffing costs were £1.166m in June.
  - Agency costs (35wte) are £0.31m in month, lower than the 12-month trend of £0.43m. Use continues mainly on administration in both clinical and corporate areas.
  - Bank costs (135wte) are £1.20m in month, lower than the rolling trend of £1.35m. Bank use continues to be mainly in clinical areas and within the medical staffing group.
  - £0.61m unachieved pay CIP (£2.16m cumulatively)

Non-Pay Expenses

£0.77m favourable to plan in month

(non-pay and financing)

Non-Pay (exc. financing) costs in June were £10.36m, £0.85m favourable to plan. Key points of note are:-

- Drugs were break-even to plan in month with £3.77m expenditure against a 12-month trend of £3.64m. Injections were at 94% of planned activity in month.
- Clinical supplies were £0.56m favourable to plan in month predominantly linked to lower activty. Costs were £1.88m in month against a 12-month trend of £2.07m.
- Other non-pay was £0.28m favourable in month with £4.71m expenditure against a 12-month trend of £4.94m.
- £0.19m over-achieved non-pay CIP (£0.21m cumulatively unachieved)

Trust Patient Clinical Activity/Income Performance

PATIENT ACTIVITY AND CLINICAL INCOME

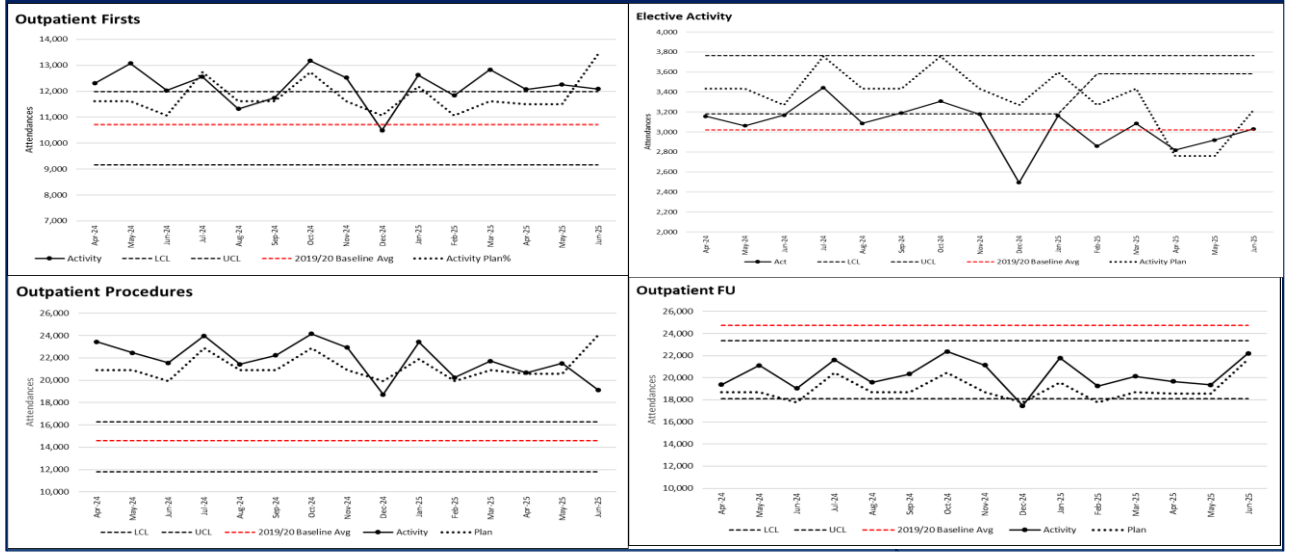
ER	Point of Delivery	Activity In Month				Activity YTD			
		Plan	Actual	Variance	%	Plan	Actual	Variance	%
ERF Activity	Daycase / Inpatients	3,222	3,031	(191)	94%	8,744	8,768	24	100%
	OP Firsts	13,416	12,091	(1,325)	90%	36,414	36,417	3	100%
	OP Procedures	24,015	19,134	(4,881)	80%	65,185	61,305	(3,880)	94%
	ERF Activity Total								
Non ERF Acti	OP Follow Ups	21,662	22,197	535	102%	58,798	61,214	2,416	104%
	High Cost Drugs Injections	4,996	4,695	(301)	94%	13,560	14,399	840	106%
	Non Elective	219	241	22	110%	664	763	99	115%
	AandE	6,016	6,485	469	108%	18,249	19,174	925	105%
	Total	73,546	67,874	(5,672)	92%	201,614	202,040	427	100%

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

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

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

ACTIVITY TREND - ERF COMPONENTS



Commentary

NHS Income

Contractual Status

The Trust is awaiting finalised contracts from ICB's and is expected to sign by 31st July. Until contracts are finalised, income has been assumed based on the 2025/26 planning assumptions and activity delivery to date.

2025/26 Activity performance achievement

- **Inpatient activity** achieved 94% in month and 100% year to date of the revised demand plan.
- **Outpatient Firsts Activity** achieved 90% of the revised demand plan in month; 100% year to date
- **Outpatient Procedures Activity** achieved 80% of revised demand plans in month; 94% cumulatively. Once fully coded this will return to planned levels

Non ERF Activity performance achievement

- **High Cost Drugs Injections** achieved 94% of activity plans in month; 106% year to date.
- **A&E** achieved 108% of activity plans in month; 105% year to date

ERF Achievement

2024/25 ERF performance to February 2025 has been published and full year performance is expected to be finalised in July 2025. Current indications are that ERF performance is in line with planning expectations.

Activity plans and ERF

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

- 2024/25 performance for ERF is now confirmed to month 11 but with the year end performance finalised in July 2025.
- 2025/26 ERF reporting from NHSE will be the same as 2024/25. IAPs are being agreed with commissioners regarding the funded levels of activity for this year.

Activity Plans

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

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

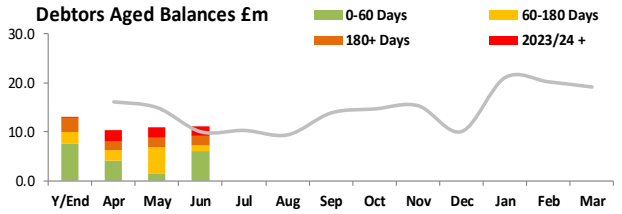
CAPITAL EXPENDITURE

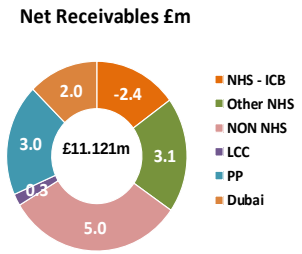
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Medical Equipment	0.2	-	0.0	0.0
Estates	0.4	0.0	0.0	0.0
IMT	0.0	-	-	-
Commercial	0.5	0.1	0.0	(0.1)
Network Strategy	-	-	-	-
Other - Trust funded	4.5	0.0	-	(0.0)
Oriel Programme	145.2	38.8	30.8	(8.0)
EPR Project	7.9	0.9	1.0	0.1
NiHR Capital Grant	-	-	-	-
Other & Charity	0.5	0.1	0.1	(0.0)
IFRS16	5.1	-	-	-
TOTAL INCLUDING DONATED	**164.2**	**39.9**	**31.9**	**(8.0)**

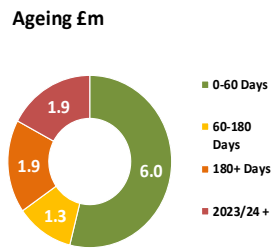
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Depreciation	11.9	11.9	-	100%
Cash Reserves - Oriel	-	-	-	-
Cash Reserves - B/Fwd	0.1	0.1	-	100%
Capital Loan Repayments	(1.8)	(1.8)	-	100%
TOTAL - ICS Allocation	**10.2**	**10.2**	**-**	**100%**
IFRS 16 Leases	5.1	5.1	-	100%
Externally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

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2022/23 +*	*Total*
CCG Debt	0.0	(2.4)	0.0	0.0	(2.4)
Other NHS Debt	2.4	0.5	0.1	0.2	3.1
Non NHS Debt	1.1	1.9	0.9	1.2	5.0
Commercial Unit Debt	2.5	1.4	0.9	0.6	5.3
TOTAL RECEIVABLES	**6.0**	**1.3**	**1.9**	**1.9**	**11.1**







STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Non-current assets	597.3	441.7	458.4	16.7
Current assets (excl Cash)	29.8	29.8	28.4	(1.4)
Cash and cash equivalents	62.7	61.1	69.9	8.9
Current liabilities	(45.9)	(46.1)	(56.6)	(10.4)
Non-current liabilities	(288.0)	(175.0)	(200.2)	(25.2)

OTHER METRICS

Use of Resources	Plan	Current Month	Prior Month
BPPC - NHS (YTD) by number	95%	92%	93%
BPPC - NHS (YTD) by value	95%	94%	94%
BPPC - Non-NHS (YTD) by number	95%	97%	97%
BPPC - Non-NHS (YTD) by value	95%	96%	96%

Commentary

Cash and Working Capital

The cash balance as at the 30th June was £69.9m, a reduction of £16.2m since the end of March 2025

Capital Expenditure/ Non-current assets

Capital expenditure as of 30th June totalled £31.9m, predominantly Oriel related/EPR related.

Business as usual capital £10.2m

- £6.4m (62%) has been committed.
- Critical infrastructure, fire remediation, and high priority EBME equipment have been prioritised along with previously committed expenditure.
- Remaining capital commitments are held in abeyance awaiting finalisation of key projects including, EPR budget programme finalisation, Ealing site options, Oriel adjacent costs and ICT BAU and ICT transition to Oriel cost implications; including potential external funding options thereof for the above.
- IFRS16 expenditure is planned from September 2025 subject to pending leases, rent reviews and negotiations.

Receivables

Receivables have reduced by £1.8m to £11.1m since the end of the 2024/25 financial year. Debt in excess of 60 days reduced by £4.4m in June and current increased by £4.6m.

Payables

Payables totalled £14.7m at the end of June, a reduction of £5.9m since the end of March 2025.

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

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

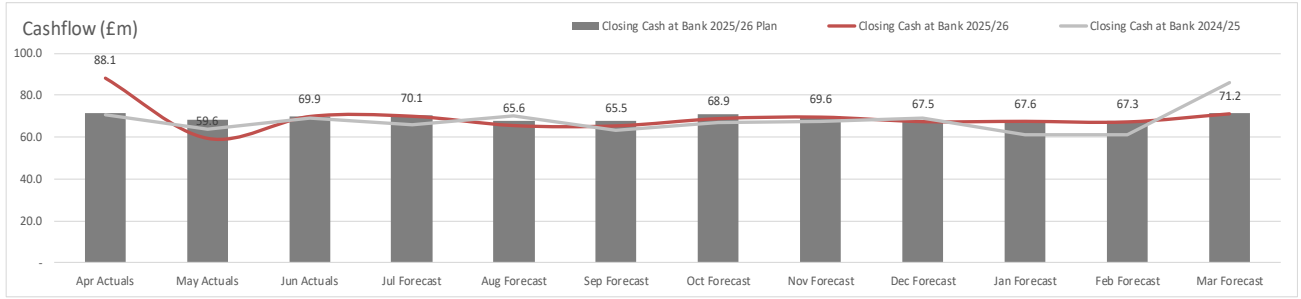
Use of Resources

Use of resources monitoring and reporting has been suspended.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Jun Forecast	Jun Var
Opening Cash at Bank	**86.1**	**88.1**	**59.6**	**69.9**	**70.1**	**65.6**	**65.5**	**68.9**	**69.6**	**67.5**	**67.6**	**67.3**	**86.1**		
Cash Inflows															
Healthcare Contracts	22.0	20.9	22.5	23.7	20.1	23.7	24.6	21.8	20.1	21.0	21.7	22.8	264.9	22.8	(0.3)
Other NHS	4.3	1.6	0.6	1.3	1.2	1.3	1.4	1.4	1.2	1.4	1.3	1.3	18.4	1.4	(0.7)
Moorfields Private/Dubai/NCS	4.4	3.8	4.0	4.1	3.7	4.0	4.2	4.4	3.4	4.6	4.1	4.1	48.9	4.1	(0.1)
Research	0.9	0.9	1.9	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	15.4	1.3	0.6
VAT	2.2	0.0	2.3	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	14.4	1.1	1.2
PDC / Loan	-	-	19.6	14.0	14.5	3.7	12.9	14.2	7.9	10.7	8.7	3.1	109.4	19.6	-
Charity Donation	-	-	5.0	-	-	10.0	-	-	5.0	-	-	5.9	25.9	5.0	-
Other Inflows	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	2.8	**0.2**	(0.0)
Total Cash Inflows	**34.1**	**27.5**	**56.1**	**45.8**	**42.2**	**45.4**	**45.8**	**44.4**	**40.2**	**40.3**	**38.5**	**39.7**	**500.1**	**55.4**	**0.8**
Cash Outflows															
Salaries, Wages, Tax & NI	(14.1)	(14.6)	(14.8)	(14.8)	(15.8)	(15.3)	(15.2)	(15.2)	(15.2)	(15.2)	(15.2)	(15.2)	(180.7)	(14.5)	(0.3)
Non Pay Expenditure	(15.5)	(12.0)	(11.6)	(13.5)	(13.5)	(13.5)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(10.2)	(149.4)	(14.0)	2.3
Capital Expenditure	(0.8)	(0.7)	(0.6)	(2.2)	(1.0)	(1.0)	(1.0)	(2.4)	(1.0)	(1.0)	(1.0)	(2.4)	(15.1)	(0.5)	(0.1)
Oriel	(0.2)	(27.6)	(17.3)	(14.0)	(14.5)	(13.7)	(12.9)	(12.8)	(12.9)	(10.7)	(8.7)	(6.1)	(151.6)	(14.0)	(3.3)
Moorfields Private/Dubai/NCS	(1.4)	(1.1)	(1.4)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(1.3)	(15.6)	(1.3)	(0.1)
Financing - Loan repayments	-	-	-	-	(0.6)	(0.7)	-	-	-	-	(0.6)	(0.7)	(2.6)	-	-
Dividend Payable	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Cash Outflows	(32.0)	(56.1)	(45.8)	(45.7)	(46.7)	(45.5)	(42.4)	(43.7)	(42.4)	(40.1)	(38.8)	(35.9)	**(515.0)**	**(44.3)**	**(1.5)**
Net Cash inflows /(Outflows)	2.1	(28.6)	10.4	0.1	(4.4)	(0.1)	3.4	0.7	(2.1)	0.2	(0.3)	3.9	(14.9)	11.1	(0.8)
Closing Cash at Bank 2025/26	**88.1**	**59.6**	**69.9**	**70.1**	**65.6**	**65.5**	**68.9**	**69.6**	**67.5**	**67.6**	**67.3**	**71.2**	**71.2**		
Closing Cash at Bank 2025/26 Plan	71.4	68.0	69.6	70.5	67.9	67.5	70.7	69.7	67.2	67.6	67.5	71.2	71.2		
Closing Cash at Bank 2024/25	70.4	63.9	69.2	65.9	70.1	63.4	67.1	67.5	68.8	61.4	61.0	**86.1**	86.1		



Commentary

Cash flow

The cash balance as at the 30th June was £69.9m, a reduction of £16.2m since the end of March 2025.

The trust currently has 79 days of operating cash (prior month: 67 days).

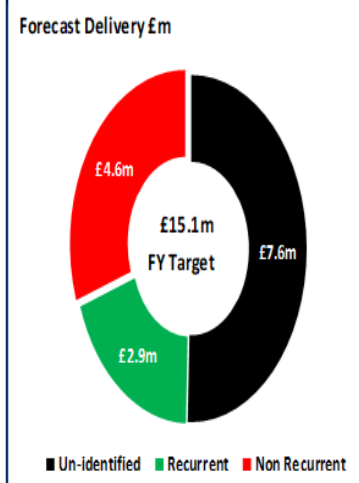
June cashflow saw a £10.4m inflow against a forecast inflow of £11.1m. The current forecast cash balance to the end of the financial year is £71.2m in line with plan.

2025/26 Trust Board Efficiency Scheme Performance Reporting

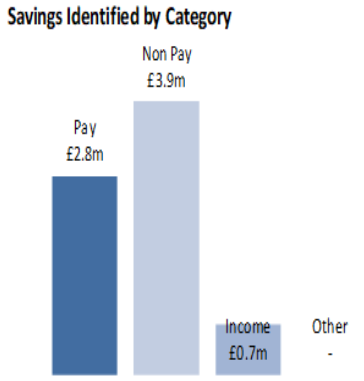
EFFICIENCY SCHEMES PERFORMANCE

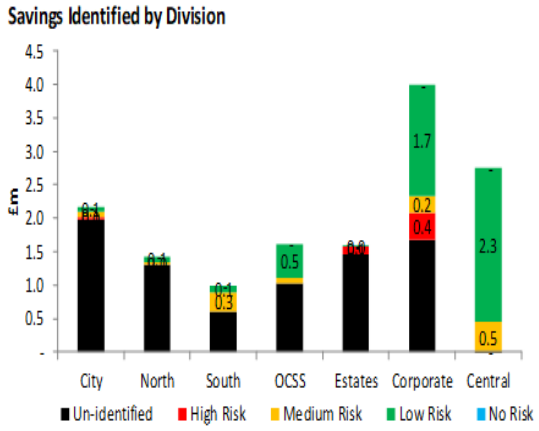
Efficiency Schemes £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Plan	Forecast Actual	Forecast Variance
City Road	£2.17m	£0.18m	£0.04m	(£0.14m)	£0.54m	£0.04m	(£0.50m)	£2.17m	£0.20m	(£1.97m)
North	£1.43m	£0.12m	-	(£0.12m)	£0.36m	£0.00m	(£0.36m)	£1.43m	£0.11m	(£1.31m)
South	£0.98m	£0.08m	£0.06m	(£0.02m)	£0.25m	£0.06m	(£0.19m)	£0.98m	£0.38m	(£0.61m)
Ophth. & Clinical Serv.	£1.62m	£0.13m	£0.15m	£0.01m	£0.40m	£0.15m	(£0.26m)	£1.62m	£0.59m	(£1.03m)
Research & Development	£0.49m	£0.04m	-	(£0.04m)	£0.12m	-	(£0.12m)	£0.49m	£0.50m	£0.01m
Trading	£0.83m	£0.07m	-	(£0.07m)	£0.21m	-	(£0.21m)	£0.83m	£0.50m	(£0.33m)
Corporate	£5.59m	£0.47m	£0.17m	(£0.30m)	£1.40m	£0.42m	(£0.98m)	£5.59m	£2.45m	(£3.14m)
DIVISIONAL EFFICIENCIES	£13.10m	£1.09m	£0.42m	(£0.68m)	£3.28m	£0.67m	(£2.61m)	£13.10m	£4.73m	(£8.38m)
Central	£2.00m	£0.19m	(£0.18m)	(£0.37m)	£0.58m	-	(£0.58m)	£2.00m	£2.75m	£0.75m
INTERNAL EFFICIENCIES	£15.10m	£1.28m	£0.23m	(£1.05m)	£3.85m	£0.67m	(£3.19m)	£15.10m	£7.48m	(£7.63m)
Adjustment to external plan	-	(£1.08m)	-	£1.08m	(£3.25m)	-	£3.25m	-	-	-
TRUST EFFICIENCIES	£15.10m	£0.20m	£0.23m	£0.03m	£0.60m	£0.67m	£0.06m	£15.10m	£7.48m	(£7.63m)

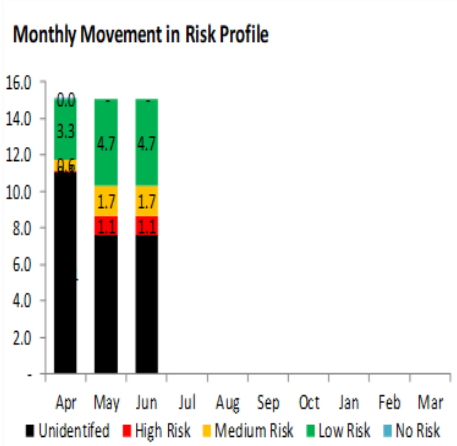
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







* charts may include rounding differences

Commentary

Governance & Reporting

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

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

In Year Delivery

The trust is reporting efficiency savings achieved of:-

- £0.23m in month, compared to a plan of £0.2m, £0.03m favourable to plan; and
- £0.67m year to date, compared to a plan of £0.6m, £0.07m favourable to plan.

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

- Compared to a straight-line savings plan which would assume delivery evenly across the year the Trust would be reporting £1m adverse in month and £3.1m adverse YTD.

Identified Savings

The trust has identified £7.5m, £7.6m adverse to plan.

Of the total identified:-

- £2.75m is identified central schemes
- £0.72m is identified as income generation schemes;
- £2.90m is forecast recurrently;

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

£12.2m represents the value of un-identified and non-recurrently identified savings.

Risk Profiles

The charts to the left demonstrates the

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

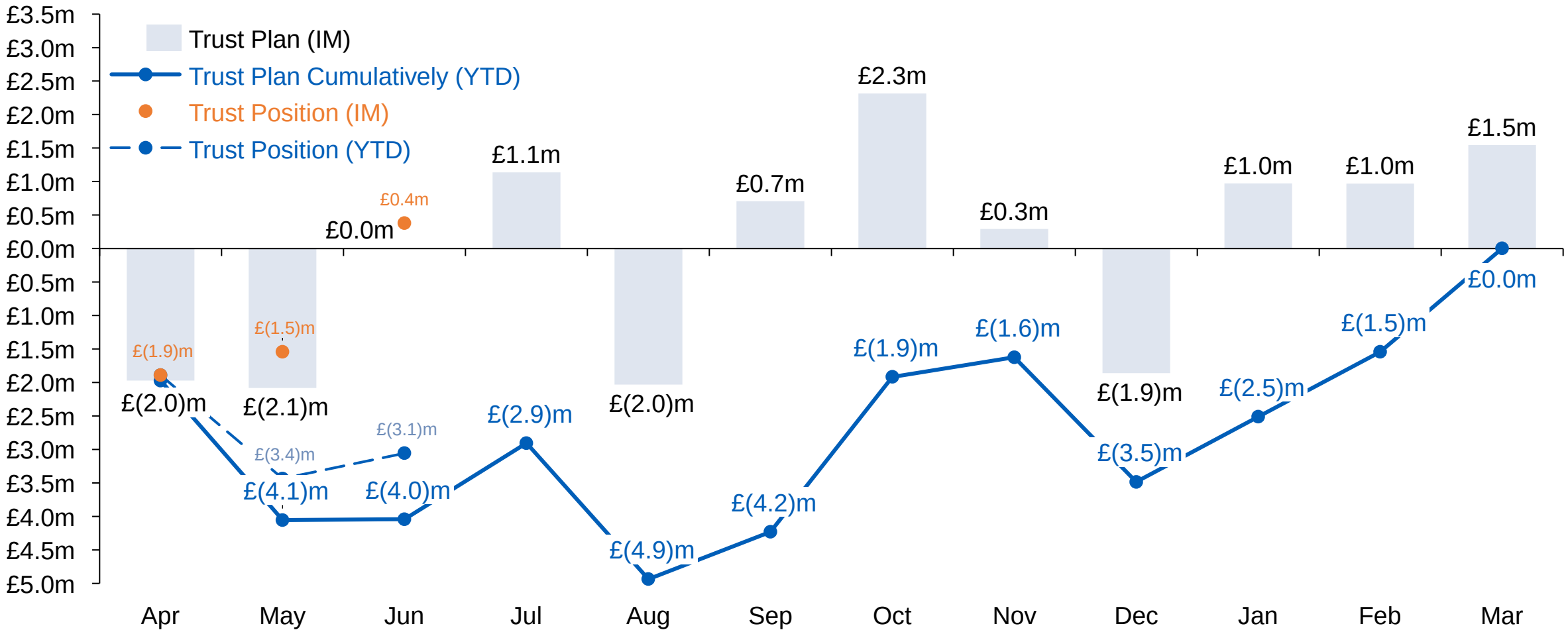
Supplementary Information

Moorfields Eye Hospital NHS Foundation Trust

NHS

The Trust financial performance is £0.4m surplus in month, £3.1m deficit YTD

The Trust is reporting a £0.4m surplus In Month, £0.4m favourable to plan, £3.1m deficit YTD £1.0m favourable to plan.
The Trusts financial plan is predicated on the delivery of efficiency savings of £15.1m which has a material impact on in month and cumulative financial plans.



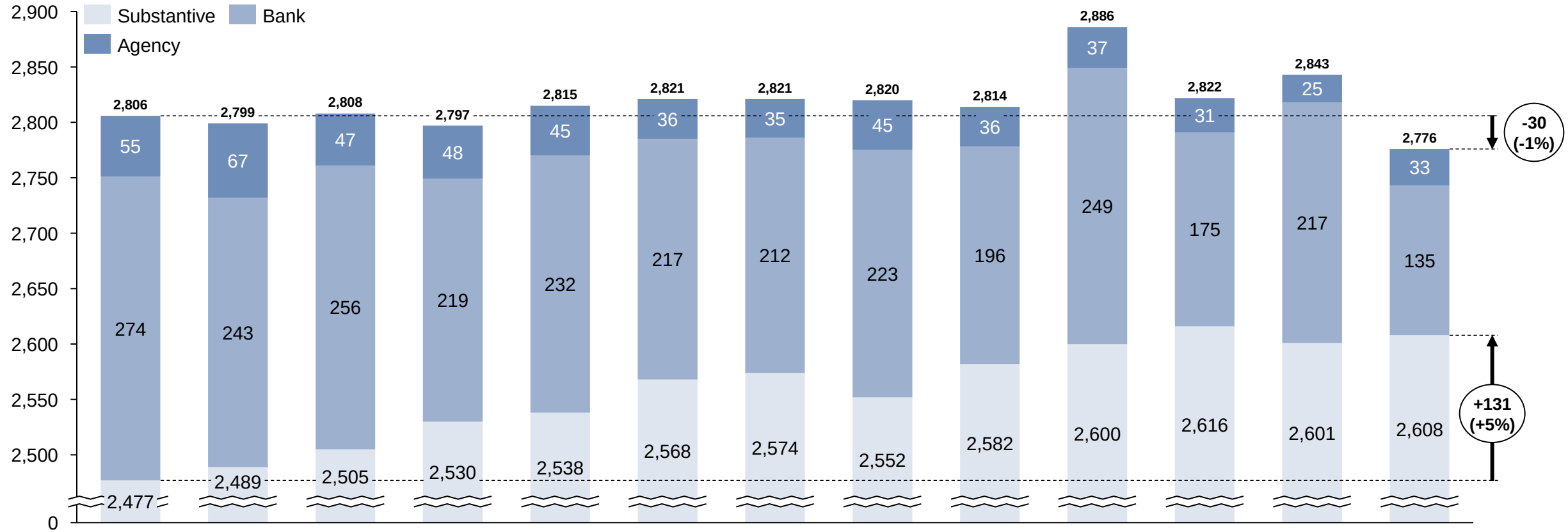
The Trusts financial plan is predicated on typical assumptions for income and expenditure categories as laid out below, including efficiencies which due to its size (£15.1m) has a material impact on in month and cumulative financial plans. Planning assumptions have included:-

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

Workforce WTE Trend reporting

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

- WTE Trends are reported by pay type, staff type, staff group, division and department further in this pack.
- Total WTE excluding EPR/Oriel and IT projects have changed by -30 WTE from the same period last year. Substantive staff have changed by +131 WTE.



	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Total WTE	2,836	2,824	2,834	2,827	2,847	2,857	2,858	2,860	2,861	2,935	2,833	2,857	2,794

&National planning expectations are agency reductions of 30%, bank reductions of 10%, and corporate support functions to reduce growth since 2018/19 by 50% by quarter 3 of 2025/26

*WTE during March is often impacted by annual leave and backfill and can't be used as a baseline WTE for reductions in year.

#Financial ledger WTE reporting has known and legitimate differences to Workforce WTE reporting. Workforce reporting should be used for formal analysis and narrative.

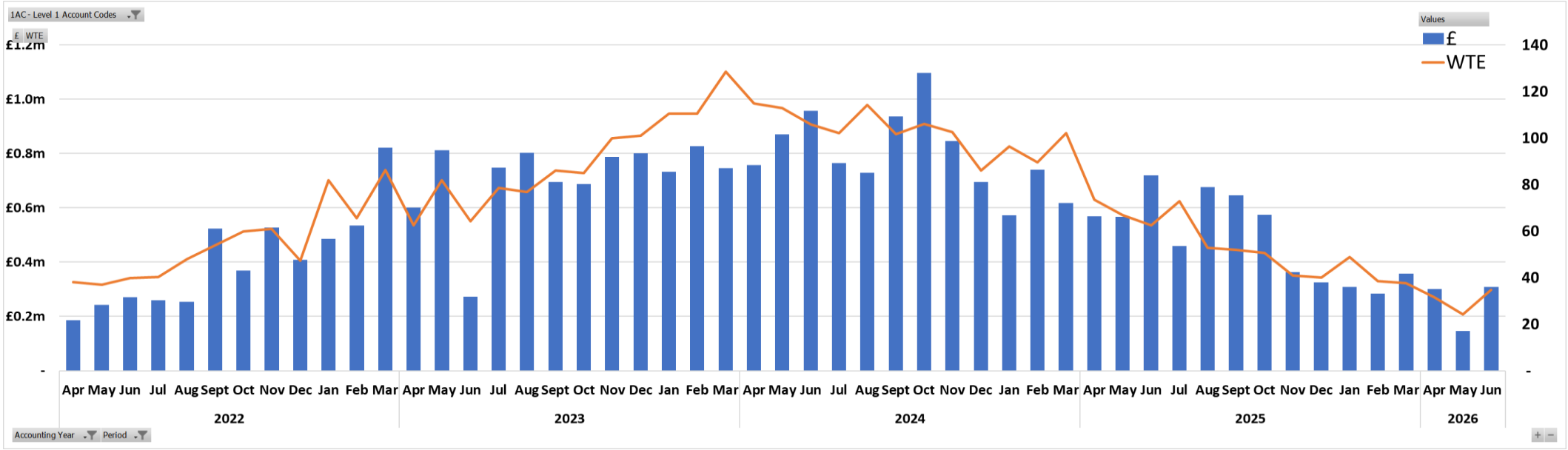
Bank and agency WTE are derived from Healthroster and are subject to staff adding, correcting and finalising rotas in a timely manner, and can including retrospective corrections

Workforce – Agency Reporting in Board Report

AGENCY SPEND REPORTING

Pay Expense Reporting £m	2023/24												2024/25												2025/26			YTD	YTD
	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	£m	%
Agency																													
Clinical Divisions	0.372	0.504	0.508	0.491	0.428	0.592	0.647	0.507	0.351	0.214	0.337	0.162	0.269	0.202	0.217	0.236	0.280	0.237	0.217	0.165	0.195	0.155	0.133	0.171	0.087	0.106	0.125	0.318	42%
Coporate Departments	0.261	0.279	0.320	0.281	0.190	0.261	0.310	0.258	0.259	0.295	0.287	0.313	0.247	0.248	0.355	0.156	0.309	0.292	0.258	0.123	0.078	0.078	0.104	0.074	0.120	(0.008)	0.157	0.268	36%
Commercial/Trading	0.025	0.027	0.045	0.020	0.077	0.035	0.097	0.028	0.022	0.031	0.057	0.064	0.063	0.093	0.056	0.026	0.057	0.069	0.053	0.046	0.040	0.058	0.036	0.083	0.063	0.037	0.034	0.135	18%
Research	0.100	0.059	0.085	(0.027)	0.035	0.049	0.044	0.053	0.063	0.034	0.059	0.052	0.015	0.023	0.077	0.031	0.020	0.044	0.036	0.021	0.005	0.008	0.004	0.024	0.024	(0.014)	0.003	0.013	2%
Total Agency	**0.758**	**0.871**	**0.957**	**0.765**	**0.730**	**0.937**	**1.097**	**0.846**	**0.695**	**0.573**	**0.740**	**0.591**	**0.595**	**0.567**	**0.705**	**0.449**	**0.665**	**0.642**	**0.563**	**0.355**	**0.318**	**0.300**	**0.277**	**0.353**	**0.294**	**0.121**	**0.319**	**0.734**	
Agency																													
Medical Staff	0.077	0.080	0.098	0.100	0.104	0.103	0.095	0.104	0.078	0.047	0.095	0.086	0.091	0.064	0.072	0.082	0.088	0.098	0.100	0.086	0.091	0.060	0.087	0.082	0.079	0.076	0.068	0.222	29%
Nursing Staff	0.186	0.249	0.191	0.140	0.105	0.139	0.273	0.133	0.125	0.140	0.121	0.221	0.100	0.081	0.067	0.043	0.079	0.040	0.036	0.020	0.021	0.011	(0.009)	0.043	(0.006)	(0.000)	0.010	0.004	1%
Scientific & Technical	0.039	0.056	0.062	(0.031)	0.051	0.252	0.158	0.125	0.093	0.076	0.069	(0.137)	0.034	0.050	0.042	0.023	0.051	0.065	0.070	0.032	0.054	0.076	0.045	0.028	(0.009)	0.032	0.023	0.046	6%
Allied Health Professionals	0.009	0.004	0.001	-	-	0.003	0.016	0.001	0.005	-	0.002	0.005	0.017	0.013	0.017	0.008	0.009	0.004	-	(0.002)	-	-	(0.003)	-	-	-	-	-	0%
Clinical Support	0.033	0.110	0.132	0.291	0.143	0.091	0.101	0.073	0.039	0.060	0.055	0.022	0.022	0.043	0.049	0.044	0.037	0.027	0.023	0.020	0.032	0.010	(0.003)	0.010	(0.023)	0.008	0.010	(0.004)	-1%
Admin And Clerical	0.405	0.360	0.435	0.257	0.282	0.337	0.442	0.400	0.338	0.234	0.376	0.426	0.293	0.324	0.476	0.258	0.412	0.407	0.348	0.206	0.123	0.152	0.164	0.185	0.223	0.037	0.182	0.442	59%
Ancillary Services	0.010	0.011	0.038	0.008	0.044	0.012	0.013	0.011	0.017	0.016	0.022	(0.005)	0.002	0.000	(0.002)	-	-	-	-	-	-	-	-	-	-	-	-	-	0%
Healthcare Scientist	0.007	0.004	0.001	-	0.001	-	-	-	-	-	0.002	-	0.009	(0.009)	(0.002)	-	-	0.004	(0.004)	0.001	0.003	0.000	0.005	0.011	0.038	(0.007)	(14)		
Total Agency	**0.765**	**0.875**	**0.958**	**0.765**	**0.731**	**0.937**	**1.097**	**0.846**	**0.695**	**0.573**	**0.742**	**0.618**	**0.568**	**0.567**	**0.720**	**0.459**	**0.675**	**0.646**	**0.574**	**0.363**	**0.325**	**0.309**	**0.287**	**0.358**	**0.302**	**0.146**	**0.308**	**0.755**	

*Excludes central budgets



Moorfields Eye Hospital NHS Foundation Trust

Risk Management Strategy and Policy
Board of directors – Part I
24 July 2025

Report title	Risk Management Strategy and Policy
Report from	Sheila Adam, Chief nurse and director of allied health professions
Prepared by	Ian Tombleson, director of quality and safety Kylie Smith, head of quality and safety Julie Nott, head of risk & safety and patient safety specialist
Link to strategic objectives	Risk management underpins meeting all our strategic objectives

Executive summary

The Risk Management Strategy and Policy has been updated. It has been presented to the Audit and Risk Committee for review, and there has been wide organisational consultation including members of the Risk & Safety Committee and the Information Governance Committee. The key updates are:

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

Quality and risk implications

All NHS trusts require solid risk management arrangements, and a robust risk management strategy and policy is key to this. Failure to have this could lead to serious impacts on the quality of care for our patients and support for our staff. This update includes some practical improvements based on working experience and reviews by the internal auditors (RSM).

Financial implications

There are no specific financial implications of this paper.

Action required/recommendation

The Board is asked to agree the updated risk management strategy and policy.

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Risk Management Strategy and Policy

Policy Summary

This document provides the strategy and policy for the management, monitoring and oversight and scrutiny of risk within the Trust

Version: 12.0

Status: FINAL

Approved: 13 May 2021

Ratified: 3 June 2018

Version history

Version	Date Issued	Brief Summary of Change	Author
3.0	February 2004		Lorna Squires, Risk Manager
4.0	August 2005	Policy reformatted and organisational structure information updated (replaces version 3.0 – May 2004)	Julie Baxter, Risk & Safety Manager
5.0	October 2006	Updated to reflect organisational changes. Review of compliance with NHSLA Risk Management Standards	Julie Baxter, Risk & Safety Manager
6.0	January 2008	Updated to take account of the changes made to the clinical governance arrangements	Julie Baxter, Head of Risk & Safety
7.0	October 2008	Introduction of a new risk matrix. Change in management structure	Julie Nott, Head of Risk & Safety
8.0	December 2010	Updated to reflect organisational changes and changes in management structure	Julie Nott, Head of Risk & Safety
	February 2011	Structure chart added	Julie Nott, Head of Risk & Safety
8.1	April 2011	Structure chart revised	Julie Nott, Head of Risk & Safety
9.0	May 2016	Updated to reflect organisational changes, changes in management structure and amendment to process	Julie Nott, Head of Risk & Safety
10.0	June 2018	Updated to reflect organisational changes, changes in management structure and amendment to process. Incorporates recommendations from the KPMG 2017 risk management review	Julie Nott, Head of Risk & Safety
10.1	December 2019	Interim review – no changes made Document rebranded Full review to take place in April/May 2020	Julie Nott, Head of Risk & Safety
10.2	January 2020	Inclusion of information risk specific information	Julie Nott, Head of Risk & Safety

11.0	May 2021	• Updated to reflect organisational changes • Addition of risk appetite (section 6) • Update to management of third party risk (section 8.4) • Addition of contract risk management (section 8.5) • Addition of frequency of risk register review (section 13.4) • Addition of review and update of action status and progress (section 13.5)	Julie Nott, Head of Risk & Safety
12.0	May 2025	• Updated to meet recommendations of ICO • Updated to meet recommendations of Internal Audit • Risk appetite section refreshed and expanded • Corporate risk register renamed to Trust risk register • Escalation to trust risk register score increased from 12 to 15 • Risk management quick reference guide added as annex 1 • SOPs added as further annex • Trust objectives and appetite updated	Julie Nott, Head of Risk & Safety

For more information on the status of this document, please contact:	Julie Nott Head of Risk & Safety Moorfields Eye Hospital NHS Foundation Trust City Road London EC1V 2PD Email: julie.nott@nhs.net Tel: 07872 422218	
Policy author	Julie Nott, Head of Risk & Safety	
Policy owner	Julie Nott, Head of Risk & Safety	
Accountable director	Ian Tombleson, Director of Quality & Safety	
Department	Risk & Safety	
Applies to (audience):	All staff	
Groups / individuals who have overseen the development of this policy	Quality team	
Committees which were consulted and have given approval (name | date)	Management Executive Quality team	3 June 2019 13 May 2021
Responsible committee/group for approval	Policy and Procedure Review Group	
Ratified by (name | date)	Management Executive	3 June 2018
Date of issue	May 2021	
Date of next formal review	May 2028 (3 years)	

Contents

Executive summary

Moorfields Eye Hospital NHS Foundation Trust (the trust) is committed to implementing the principles of good governance, which is defined as the systems by which the organisation is directed and controlled, to achieve its objectives and meet the necessary standards of accountability, probity and openness. The trust board aims to take all reasonable steps in the management of risk to ensure that the vision and mission, as set out in the Trust strategy, are achieved.

The trust's governance arrangements include an effective risk management system, designed to support delivering improvements in patient safety and care as well as ensuring the safety of its staff and visitors. Risk management includes identifying and assessing risks, responding to them, and the provision of assurance.

As with all public bodies, the trust is required to have a policy for managing risk that identifies accountability arrangements and resources and also contains guidance on what may be regarded as acceptable risk within the organisation. Good risk management awareness and practice, at all levels, is an essential success factor in ensuring that risks are managed systematically and consistently. The trust recognises that identifying risks, and managing them well, provides valuable opportunities to improve patient care and related outcomes.

Risk registers are created and maintained via the use of an electronic system (Safeguard), as described in section 13. Trust leaders and managers are required to manage their staff to deliver the standards set with in this policy and procedure by using this framework and associated processes.

The system includes an audit trail, which makes it possible to track activity (e.g. escalation, de-escalation, allocation and completion of risk mitigation actions) in relation to individual risks; duplication of risks is not required for this reason and the creation of duplicates, other than in exceptional cases, will adversely affect the audit functionality within the system. The risk & safety department will monitor escalation/de-escalation activity on a monthly basis and this will be used as an indicator to help understand the overall effectiveness of the system.

This document applies to all trust staff, suppliers (including honorary contract holders). Responsibilities of managers and staff are identified in section 9.

1. Introduction

Moorfields Eye Hospital NHS Foundation Trust (the trust) manages risk to protect patients, staff, visitors and the trust from harm or adverse outcomes. The trust has a legal responsibility to provide assurance that risks in the organisation are identified and appropriately managed. This is enshrined in legislation and is an explicit requirement of the Care Quality Commission's Fundamental Standards of Quality & Safety.

Risk management is a central part of any organisation's strategic and operational management processes and the recognition and effective management of risk underpins the achievement of the trust's objectives. Effective risk management is imperative not only to provide a safe environment and improved quality of care for service users and staff; it is also integral to the business planning process in order to ensure the organisation can achieve its core objectives. The risk management process involves the identification, evaluation and treatment of risks as part of a continuous cycle aimed at helping the trust and individuals to reduce the incidence and impact of the risks they face. Risk management, undertaken systematically and robustly, will help ensure the trust can deliver care to patients which is safe, effective, caring, responsive and well-led.

A key component of risk management, which impacts every stage of the risk management process, is the trust's commitment to maintain an open dialogue with staff to listen to staff concerns and to communicate effectively to all relevant parties.

2. Purpose

The purpose of this document is to detail the trust's vision and framework within which the trust leads, directs, and controls the risks to its key functions in order to comply with relevant legislation, regulatory licences and its strategic objectives. Through the management of risk, the trust seeks to minimise, though not necessarily eliminate, risks and maximise risk mitigation and opportunities.

This document seeks to ensure that:

- Risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that trust assets are protected.
- Strategy and business plans are delivered in a way that aligns with the organisation's objectives, while identifying and mitigating risks wherever possible.
- There is on-going identification and management of risk via an integrated trust-wide approach.
- Risks are visible and discussed across the organisation to promote collaboration and robust oversight.

3. Scope

This document applies equally to all trust staff[1] working in all areas of the trust. The trust encourages an open culture of reporting. Risk management is everyone's responsibility and staff, at all levels, are expected to take an active lead in ensuring that risk management is a fundamental part of their operational areas.

This policy and procedure do not fully describe the risk management processes associated with information governance (IG), project management (including research) or clinical trials, as these follow their own dedicated risk management processes. The governance, assessment, and escalation of such risks can be found in the relevant SOPs on eyeQ.

4. Risk management statement of intent

The trust is committed to a risk management culture that underpins and supports day to day business and the effective care and treatment of our patients. The trust board aims to take all reasonable steps in the management of risk to ensure that the vision and mission, as set out in the current trust strategy is achieved.

Implementation of the strategy is supported by risk management processes through:

- Raising awareness and developing a culture where all risks are identified, defined and managed.
- On-going assessments of the organisation's objectives and identifying the principal risks associated with failing to achieve these objectives.
- Integrating risk management into the overall arrangements for clinical and corporate governance by developing robust arrangements in all areas for managing risk.
- Ensuring an appropriate system and organisational structure is in place for identification and control of key risks.
- Application of a comprehensive, risk and evidence-based quality and safety assurance model.
- Assurance that key processes are in place to provide reliable information and enable management to make appropriate decisions.
- Integration of risk management into the annual business planning process.

[1] The term 'staff' includes all direct and non-direct employees of Moorfields. The term non-direct is used, in accordance with the induction policy, and includes agency staff, bank staff, volunteers and staff on honorary contracts.

- Encouraging a culture of openness in terms of reporting and learning from events for both staff and patients, that enables and positively encourages organisational wide learning.
- Ensuring that lessons learned from events such as incidents, claims, complaints, and audits are shared and disseminated to foster trust-wide learning.

5. Policy

The trust strives to continuously embed risk awareness and management at the core of its activities and recognises it is vital to develop and maintain systems and procedures that identify and minimise risk to patients, visitors, staff and others if it is to achieve its commitment to providing high quality care in a safe environment.

6. Risk appetite

The trust recognises that positive and managed risk-taking is essential for growth, development and innovation. 'Risk' should never be set as a barrier to change and improvement; instead, risks should be recognised, considered and managed effectively as part of a continual improvement process. The trust employs a risk framework to reduce risk as far as possible and to within agreed tolerances.

Risk appetite is the overall willingness of the trust to accept risk in pursuit of its strategic objectives. It is centred at board-level oversight and focuses on the long-term goals of the organisation and overall risk profile.

The tolerances of our risk appetite are derived based on the definitions from the Good Governance Institute as follows:

Risk appetite level	
None	Avoid – the risk cannot be tolerated at any level.
Low	Minimal – the preference for very safe delivery options that have a low degree of inherent risk and offers limited reward potential'.
Moderate	Cautious – the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	Open – being willing to consider all potential delivery options while also providing an acceptable level of reward (and value for money).

Risk appetite level	
Significant	Seek – to be eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). This can also be described as 'mature' - being confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Trust Objective	Definition
Working together – We will collaborate with one another as individuals, in our teams, with our patients and our partners Our ambition is to: ● Reshape the design of our organisation and develop our workforce to allow new ways of working in how we provide excellent and efficient clinical services ● Be an employer of choice, supporting staff to learn, develop and progress in line with our values ● Collaborate, innovate and help lead across systems to support the delivery of excellent eye care ● Create and collaborate in Oriel, our new centre for advancing eye care, research and education.	**High tolerance** – across all aspects of research, innovation, collaboration and national policy. The Board is open to seek developments within commercial parameters. **Low tolerance** – for those risks impacting staff and patient safety and/or those related to financial and reputational risks. The Board wants minimal risk related to patient and staff safety, ventures that may have negative reputational outcomes and financial risks

Trust Objective	Definition
Discover – We will focus on setting the agenda, pioneering new pathways and treatments Our ambition is to: ● Advance global eye care practice by embedding research and innovation in everything we do ● Realise the full potential of our world-class digital infrastructure and clinical, imaging and biological datasets	**Significant tolerance** – across all aspects of research, innovation, collaboration and national policy. The Board will facilitate the trust seeking to maximise new discoveries and advancement in pathways and treatments **Low tolerance** – for those risks impacting staff and patient safety. The wants minimal risk when implementing new discoveries, ensuring they only do so when known to be safe.
Develop – We will practically apply our discoveries and global best practice to benefit our patients, staff and the services we provide Our ambition is to: ● Develop excellent and equitable clinical care through the implementation of innovation, standardisation and workforce redesign ● Use digital technology and clinical data to transform care pathways and outcomes ● Review and optimise our network of sites to ensure we can provide excellent care as effectively and efficiently as possible ● Create a digital eye care service, offering our expertise at scale so we can provide excellent care to a growing number of people	**Significant tolerance** – across all aspects of research, innovation, collaboration and national policy. The Board will facilitate the trust in seeking new developments in advancing technical and use of new technology to provide better treatments and eyecare. **Low tolerance** – for those risks impacting staff and patient safety. The Board wants minimal risk when implementing new developments to ensure patient and staff safety.

Trust Objective	Definition
Deliver – We will consistently provide an excellent, globally recognised service Our ambition is to ● Work with our patients, staff and charity partners to ensure patients reliably experience high quality care in accordance with our values of excellence, equity and kindness ● Optimise our systems, infrastructure and capabilities to deliver excellent care that addresses inequalities in outcomes, access and experience	**Moderate tolerance** The Board will remain cautious in the trust's continued delivery of high quality services for patients.
Sustainably and at scale – We will use our resources responsibly, safeguarding what we have for the next generation; and we will design our services so that more people can access excellent care Our ambition is to: ● Build our commercial capability to identify and realise new opportunities in support of our financial sustainability ● Work with our partners to minimise our impact on the environment and to add social value to our communities ● Strengthen our operational resilience and financial viability by reducing waste and inefficiency in everything we do	**High tolerance** – relating to aspects of the modernisation of our infrastructure. The Board is open to risk related to developing infrastructure and commercial capability, where it is not a related patient or staff safety risk.

7. Explanation of terms used

See 'glossary/definition of terms' (page 37).

8. Risk management process

The trust adopts a structured approach to risk management. Risks are identified, assessed, controlled and, if appropriate, escalated or de-escalated through governance mechanisms. Risks are events that might happen which could stop the trust achieving its objectives or impact upon its success. Risk management also includes consideration of adverse events which were not planned where there is a potential from those events to happen again, thus requiring mitigating action.

An overview of the risk management process is shown in Figure 1.

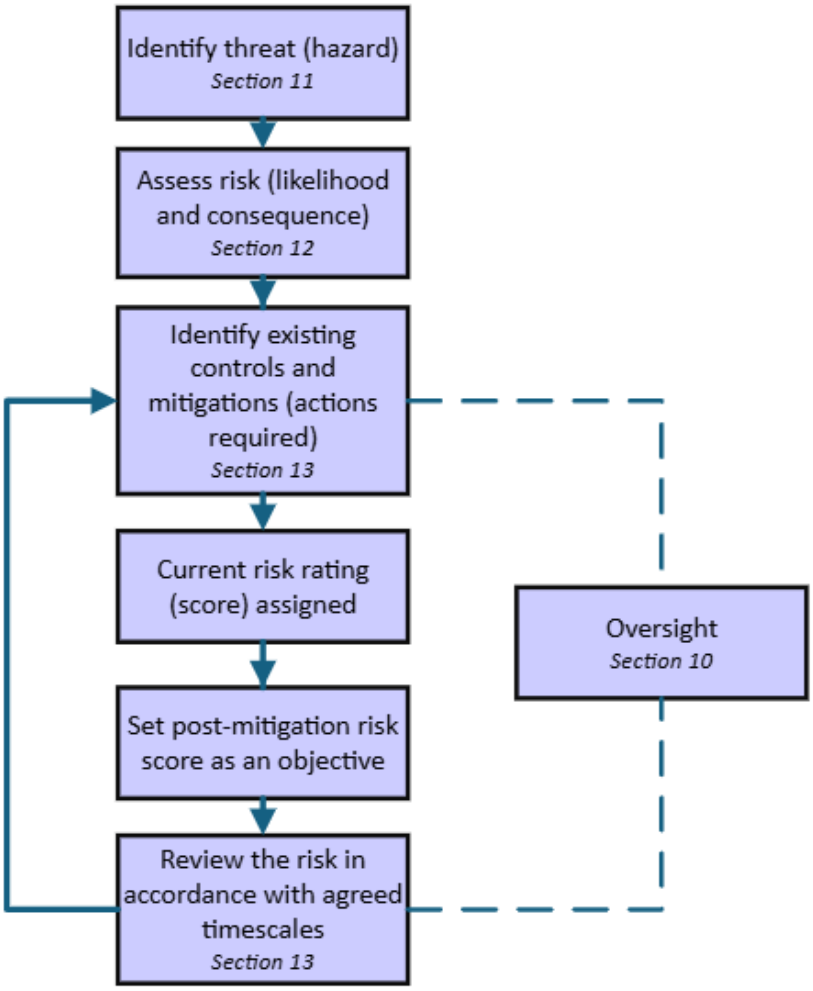


Figure 1: Overview of the risk management process

Further detail on the process can be found in the sections indicated.

8.1 Governance structures to support risk management processes

Risk management occurs at different levels within the organisation:

- Trust board.
- Trust Management Executive (ManEx) (with support from Trust Management Committee (TMC), and the Senior Management Team (SMT)).
- Programme boards (to support projects).
- Divisional/directorate level.
- Team level.

In parallel, some risk types are managed on a pan-trust basis by subject matter experts (SMEs) with the support of a committee (e.g., safeguarding, information governance, infection control).

The trust board has a number of sub-committees, as below (see also section 10 and appendix 3):

- Audit & Risk Committee (ARC).
- Quality & Safety Committee (QSC).
- Discovery and Commercial Committee (DCC).
- People and Culture Committee (PC).
- Remuneration and Nominations Committee (RNC).
- Major Projects and Digital Committee (MPDC)

8.2 Risk register structure

The organisation uses an electronic risk register which is part of the Safeguard suite of applications used by staff. It comprises an organisational on-line risk register, with a hierarchy of trust, divisional and departmental risks. The individual registers contribute to the corporate view of risk, with a hierarchy of registers (i.e., local, divisional, trust) and risks managed at different levels. This structure allows leadership and risk owners to manage and view risks relevant to their areas while maintaining visibility across the entire system. The system enables users to see risks in context, compare different types of risks, and prioritise them accordingly. The risk register is actively used by services and divisions to support risk management. Further details on the process are outlined in Section 11.

8.3 Trust Board assurance and oversight

The trust board has stewardship responsibility to ensure that risk management systems are in place. The Audit and Risk Committee, ManEx and TMC have responsibility to ensure that these systems are, operationalised and working.

Trust board assurance concerning risk management is received via three main mechanisms:

- The Board Assurance Framework (BAF) is the document through which the trust board monitors the principal risks to its strategy.
    - The BAF helps to clarify what risks could compromise the trust's strategic objectives and assists the board in driving its agenda and determining where to make the most efficient use of resources in order to improve the quality and safety of care. The BAF enables the board to focus on the key strategic risks and map out the controls in place to manage those risks, as well as gaining assurance about the effectiveness of those controls.

- The value of the BAF is that it allows identification of priorities and provides oversight of organisational capacity to deliver and assess and mitigate the risks facing the organisation. This informs the Annual Governance Statement (AGS) that is submitted as part of the annual report each year. The AGS, signed by the Chief Executive as the Accountable Officer, sets out the organisation's approach to internal controls. It is produced at year end and is scrutinised as part of the Annual Accounts process by the Audit & Risk Committee.

- The Trust Risk Register (TRR) is used for managing and monitoring risks that may be escalated from divisional risk registers (for example from clinical divisions or corporate directorates, such as finance) and which cannot be managed at that level (i.e., scoring 15 or greater), or are trust wide or strategic in nature.

Review of the TRR and the BAF will take place as follows:

Review by	Frequency of review	
	BAF	TRR
Trust Board	Quarterly	Quarterly
ARC	Quarterly (at each meeting)	Quarterly (included in narrative report)
Board committees	Quarterly (only relevant risks)	Quarterly (only relevant risks)
ManEx	Quarterly	Monthly (risks scoring 15+ and risks for escalation only)
Individually with executives and risk owners	Prior to risk review date, presentation at committee or board	Prior to risk review date

Further assurance is generated through the scrutiny provided by oversight (see section 10).

8.4 Quality and compliance function

The compliance function informs the annual and on-going work plan of the QSC by providing an evidence and risk-based overview of compliance within the organisation. It does this by compiling, comparing and triangulating evidence (e.g., listening, learning, and sharing walkabouts), for example through the quarterly quality and safety report and feeding that into on-going review with the Chair of the quality and safety committee.

8.5 Information governance compliance function

Information governance has its own legal framework. Although managed within this policy, there are some key differences in approach, especially around information asset management, which has a reporting line to the senior information risk owner (SIRO) in parallel to the usual hierarchy.

For detail on how variations apply to information governance risks, please refer to the information risk SOP.

8.6 Management of suppliers and other partners

The trust has an established process to identify, assess and manage supplier or other partner risk. Suppliers and partners are assessed, and due diligence is conducted as part of the selection process before on-boarding. Cybersecurity and data protection requirements for suppliers to ensure the confidentiality, integrity and availability of the trust's information assets are determined and form the basis of whether or not a supplier is selected during the procurement process.

This pre-boarding assessment is currently done as part of the Data Protection Impact Assessment (DPIA) and Information Security review which is driven and governed by the Moorfield's information governance team and information security team. The trust has also implemented checks as part of the procurement process through the use of a technical specification questionnaire. Once the DPIA is completed, the cybersecurity requirements are enacted through formal agreements (e.g. contracts). To ensure clarity, Moorfields communicates to suppliers how cybersecurity and data protection requirements will be verified and validated. Suppliers and third-party partners are registered on the supplier register and they are routinely assessed using audits, DPIAs, assessments or other forms of evaluations to confirm they are meeting their contractual obligations. Recommendations to any issues arising from these assessments are provided, timelines for remediation are agreed upon with the supplier and/or third party and remediation is tracked as necessary. Information security risks, as highlighted by this process, must be acknowledged by the information asset owner/system owner. Risk register entries may be made to support a risk based approach, if required.

8.7 Contract risk management

Contract risk management has been identified within internal audit reports, and centrally by NHSI as a key priority. Risks associated with contracts will be managed in accordance with the systems identified within this document.

Day to day contract management, for ongoing contracts, resides with the information asset owner, responsible director, or divisional manager who procured the service/goods. Typically, the responsible director or divisional manager will be the subject matter experts in their own area and be best placed to understand, monitor and manage the key performance indicators, usage, contract tolerances and financial budgetary implications

as part of regular meetings with the supplier. Advice on general legal terms and conditions needs to be undertaken by the Trust legal advisor, except for data protection matters which are handled by the Data Protection Officer.

Where data is shared in arrangements with partners with whom we would not have a contract, then an information sharing agreement needs to be in place in consultation with the IG team.

9. Duties, roles and responsibilities

Risk management is the responsibility of all staff, irrespective of their level or role. All directors have a responsibility for ensuring that significant operational risks that have been escalated to them are considered for inclusion on the trust risk register. Given the importance of the task, and whilst accountability is key, no individual shall be unsupported in managing risk and all risks should be considered in a relevant meeting or committee, where possible and is explored further in section 13.4.

Specific responsibilities are described below.

9.1 Chief Executive

As Accountable Officer, the Chief Executive is responsible for:

- Organising all governance arrangements, which includes risk management.
- Signing the Statement on Internal Control (SIC), indicating the trust is meeting all statutory requirements and adhering to guidance issued by the Department of Health, NHS England other relevant regulators and specialists (e.g., the National Cyber Security Centre) in respect of governance.
- Chairing TMC and ManEx.

9.2 Director of Quality & Safety

The Director of Quality & Safety drives the development and implementation of the organisation's risk systems and processes, on behalf of the Chief Executive. The role includes responsibility for:

- Developing and implementing risk management systems, with the assistance of the risk & safety department.
- Leading on-going compliance with registration requirements set by the CQC.
- Chairing the Risk & Safety Committee which, as part of its role in ensuring risk systems are in place, directly drives the management of non-clinical risks, chairing the Patient Participation and Experience Committee, being a member of ManEx and TMC, attending the QSC and the trust board.
- Having delegated responsibility for health and safety activity (supported by the Head of Risk and Safety and the Risk/Health & Safety Adviser).

- Ensuring there are processes to satisfy the requirement that all risks are included on local and divisional/corporate team risk registers and that there is an associated process to ensure that they are appropriately reviewed and escalated.
- Ensuring that the trust board, via ManEx, is assured that appropriate health and safety procedures are in place through the Risk and Safety Committee.

9.3 Company Secretary

The company secretary is responsible for managing the process of the development and ongoing monitoring/maintenance of the BAF and TRR.

9.4 Medical Director

The Medical Director supports and drives the identification and management of clinical risks. The division of responsibility between the Medical Director and the Chief Nurse and Director of Allied Health Professions in relation to patient safety is shown in appendix 4a and appendix 4b. The Medical Director is a member of the Quality and Safety Committee and the trust board.

9.5 Chief Operating Officer (COO)

The COO has responsibility for performance management and ensuring that the risk management strategy and policy is adhered to throughout the operational management of the organisation. The COO chairs the divisional performance meetings, at which performance and compliance in relation to risk identification, escalation and mitigation will be reviewed and challenged.

9.6 Chief Nurse and Director of Allied Health Professions

The Chief Nurse and Director of Allied Health Professions is the Director of Infection Prevention and Control (DIPC) and the executive lead for safeguarding adults and children (see also 9.4).

9.7 Chief Finance Officer

The Chief Finance Officer has responsibility for financial governance and associated financial risk and is also the named lead for security risk.

9.8 Senior Information Risk Owner (SIRO)

The SIRO is a senior advocate for data security and protection matters and is a board member; their responsibilities include:

- Influencing the board to foster a culture that values, protects and uses information for the success of the organisation and benefit of its patients and service users.
- Staying informed about data security and protection risks and managing those risks; validating recommendations from the Head of IG on the DSPT.

- Considering high severity cyber alerts and accepting appropriate residual risk; taking ownership of the organisation's risk management.
- Ensuring the organisation's risk policy is implemented consistently by Information Asset Owners (IAOs), through reporting to the information governance committee.

At Moorfields, this role is fulfilled by the director or quality and safety.

9.9 Head of Information Governance (IG)

The Head of IG has overall responsibility for the Trust's IG policy and strategy, including setting guidelines and establishing goals and key performance standards, outcome indicators and associated assessments, reporting, and risk oversight.

9.10 Head of Quality & Safety

The Head of Quality & Safety is accountable to the Director of Quality & Safety and, in the absence of the Director, will assume all responsibilities in 9.2 (with the exception of SIRO). The Head of Quality & Safety is responsible for ensuring that there is a coordinated and integrated approach to risk management and policy development and that all processes are delivered in a timely way with adequate monitoring.

9.11 Head of Risk & Safety (Patient Safety Specialist)

The Head of Risk and Safety is accountable to the Head of Quality & Safety and is responsible for ensuring that risk systems are working effectively on a day to day basis, providing advice on, and facilitating the effective management of risk. This responsibility includes establishing dynamic systems and processes that form an integral part of routine organisational and departmental activity, so creating and enabling a framework for all individuals and departments to achieve effective risk management. Key responsibilities are:

- Provision of advice, guidance and recommendations about clinical and non-clinical risk management to the trust board.
- Membership of the Risk & Safety Committee and the Clinical Governance Committee (and various sub-committees/groups).
- Identification (via internal and external sources), management and monitoring of risks; providing reports, information and training as appropriate.
- Advising on other specialist risk management groups and committees, and project groups for proposed developments and initiatives to ensure these are compliant with good risk management practice.
- Provision of advice and support regarding the development and maintenance of local risk registers.

- Competent person for health and safety (alongside the Risk/Health & Safety Adviser).
- Information asset owner for the Safeguard risk management system, including management of the incident reporting module and associated functions (e.g., the Learn from Patient Safety Events, LFPSE, service).

9.12 Risk/Health & Safety Adviser

The Risk/Health & Safety Adviser supports the Head of Risk and Safety and has specific responsibility for health and safety systems. The R/H&S Adviser is responsible for identifying new health and safety legislation, drawing this to the attention of relevant bodies and ensuring that current training programmes address this. The R/H&S Adviser runs the annual programme of risk and safety inspections.

9.13 Head of Clinical Governance

The Head of Clinical Governance supports the Medical Director and Director of Nursing and Allied Health Professions in all aspects of clinical governance, including clinical audit.

9.14 General risk responsibilities of ALL staff

All employees have a responsibility to be aware of, and apply, risk management principles and must ensure they:

- Work in accordance with all trust policies and procedures.
- Are aware of, and comply with, their duty of care under legislation to take reasonable care for their own safety and the safety of all others who may be affected by the trust's business.
- Attend induction, and regular mandatory and specific update training on risk management policy and procedures.
- Identify, through risk assessment, any risks they feel exist within their department or during the delivery of their service and escalate these to their manager.
- Provide incident reports and supporting documentation for any unexpected event or incident they are involved in.
- Comply with the standards of any professional bodies.
- Work as individuals, work with managers and work with teams to learn from risk management processes and other events, including incidents, to improve care, treatment and services.
- Promote, and participate in, the sharing of learning following events and the implementation of improvement measures identified in the spirit of the trust's quality strategy that everyone can make a difference.

9.15 General risk responsibilities of directors, managers and committee chairs

All directors, divisional managers, heads of department and managers are:

- Responsible for fostering a fair, open and just culture which encourages individuals to take responsibility for risk.
- Responsible for ensuring that they engage with the risk management objectives in section 4 of this document, in order to ensure that their clinical and managerial responsibilities for risk management are met.
- Responsible for maintaining their entries to the risk register so that they can demonstrate that they have considered risks both reactively and proactively, and that they have effective plans in place to control these risks.
- Expected to take ownership of risks related to their management role. They are responsible for implementing and monitoring the effectiveness of any identified and appropriate risk management control measures within their designated areas and scope of responsibility. In situations where significant risks have been identified, and where local control measures are considered to be potentially inadequate, managers are responsible for seeking local resolution. Where this cannot be achieved, they must identify these on local (ward/department/site/service/committee) and divisional/directorate registers and escalate for consideration for inclusion on the TRR (see section 13 and appendix 6).
- Responsible for ensuring that staff are aware of their responsibilities in terms of risk and safety and have received the mandatory training plus any training appropriate to their role.
- Responsible for ensuring compliance with the CQC Fundamental Standards of Quality and Safety and in managing any areas of non-compliance to minimise risks to staff, patients and visitors.
- Responsible for considering the risk to the rights and freedoms of individuals, especially those relating to privacy.
- Ensure that, within the division, directorate or clinical service, defined mechanisms exist for sharing learning from events and that the risks of not having robust mechanisms in place are understood and assessed.
- Ensure that when staff start or move position, they have training and support in those roles and that there are no gaps in provision.
- Ensure that when staff leave a position there is no gap in service provision.

9.16 Ownership of risks and risk mitigations (actions)

Each director or divisional head is required to identify a sufficient number of staff who are trained to support risk management within their area. These people, following risk register training, will be given access to the electronic risk register.

A risk owner is responsible for:

- Managing and updating those entries on the risk register that are within their responsibility, ensuring that all entries are reviewed for suitability and completeness.
- Escalating risks for further consideration if indicated by the score (see process in section 11).
- Ensuring that risks are shared with, and discussed by, local teams (the frequency of sharing should be proportionate based on the level of risk).
- Ensuring that all risks have appropriate risk mitigation actions assigned and that the actions are SMART (specific, measurable, achievable, realistic, timebound).
- Ensuring that all actions have progress updates added to show active management, where an action is open for a period of more than one month.
- Assessing and recording the:
    - Effectiveness of existing risk controls.
    - Gaps in control, and the action required to address any gaps.
    - Assurance that exists to demonstrate the effectiveness of a risk control.
    - Gaps in assurance and the action required to address any gaps.

Risk mitigation (action) owners (if different from the risk owner) are responsible for:

- Delivering the actions assigned to them, as set out in the risk mitigation section of the form.
- Reporting to the risk owner regarding the implementation status of the action (this can be achieved through the addition of progress updates).
- On completion of the action, marking it as complete.
- Providing the risk owner with an assessment of the effectiveness of completed actions, and the assurance regarding effectiveness that exists (i.e., what is in place to evidence that a mitigation is reducing the risk), so that a judgement can be made regarding when a completed action becomes an ‘existing risk control’.

9.17 Individual clinicians

Individual clinicians have a responsibility to be aware of and apply risk management principles to their clinical practice and must:

- Ensure they practice within the standards of their professional bodies, any other national standards and any locally determined clinical polices and guidelines to ensure their practice is as risk free as possible.
- Identify, through their own department's self-assessment process and line management arrangements, any risks they feel exist within the service and their practice.
- Provide incident reporting forms and supporting documentation for any unexpected event or incident arising from clinical care or treatment provided.
- Ensure they attend both general and local induction and regular mandatory and specific update training on risk management policy and procedures.

9.18 Project managers

Project managers are responsible for logging any risk that will transfer to business as usual on the final project report, and for making arrangements for a permanent owner to manage any residual risk after the project is closed.

10. Oversight structure (supporting those managing, monitoring and scrutinising risks)

The diagrams in appendices 3, 4a and 4b, which show the interrelationships between various committees and groups responsible for various aspects of risk management and scrutiny, should be referred to alongside the descriptions set out below. Information regarding the detailed committee structure is available in the Quality Governance Framework (QGF).

10.1 Trust board

The role of the trust board is to assure itself that effective risk management processes are in place and functioning. The board must assure itself that the organisation has properly identified and recorded all risks that it faces, including for example patient safety, non-patient safety, financial, and reputational risks and that it has the processes and controls in place to mitigate those risks and the impact they have on the organisation and all its stakeholders. It will receive updates regarding the TRR quarterly. The board is assisted by the board committees and senior management committees in carrying out its functions.

10.2 Management Executive (ManEx)

ManEx is responsible for ensuring that appropriate strategies, policies and procedures are in place for managing and reviewing risks, scrutinising all risks with a risk score of 15 or more on a monthly basis, considering proposals from executive directors on adding new risks of 15 or more, closing risks, and considering reports from performance reviews, divisional boards and Trust management committee (TMC).

10.3 Trust Management Committee (TMC)

TMC is responsible for reviewing divisional risk registers and for considering if there is a requirement to escalate a risk to the TRR. TMC also considers and advises on whether each risk rating is valid (see section 12.1).

10.4 Quality & Safety Committee (QSC)

The QSC is an overview and scrutiny committee which provides the board of directors with a means of independent and objective review of the governance of all aspects of quality and safety relating to the provision of care and services in support of achieving the best clinical outcomes, the best patient experience and the safest environment for the patients of Moorfields and all other recipients of our services. The committee provides assurance to the trust board that the trust is aligned to the statutory quality and safety demands of existing legislation relating to all areas of the business. The committee also receives assurance from the Head of Information Governance on all matters relating to information governance. The QSC is chaired by a non-executive director of the trust. Following each meeting a summary paper is provided to the trust board, to provide assurance that QSC is compliant with its terms of reference, in addition to an annual report.

10.5 Audit & Risk Committee (ARC)

The ARC is an oversight and scrutiny committee which, as part of its role, reviews the adequacy of the BAF and the trust's risk management arrangements. It is comprised of three non-executive directors supported by executive directors, external and internal audit and the local counter fraud team. The audit committee assists the board in in fulfilling its oversight responsibilities in terms of the integrity of the trust's accounts, risk management and internal control arrangements, compliance with legal and regulatory requirements, the performance, qualifications, performance and independence of the auditors. It has a focus of reviewing risks relating to financial systems and controls. The ARC is chaired by a non-executive director of the trust and an annual report is provided to the trust board.

10.6 Divisional/directorate performance reviews

Performance reviews play a key role in the trust's risk management oversight by providing an opportunity to assess how effectively risks are being identified, managed, and mitigated. The performance review structure enables senior leadership to evaluate whether risk controls are functioning as intended, ensure alignment with strategic objectives, and identify emerging risks or areas requiring additional attention or escalation to the TRR.

10.7 Quality forums

Quality forums bring together the multidisciplinary team to assess trends, incidents, and performance indicators, ensuring that quality risks are identified early and addressed

effectively. They support continuous improvement by facilitating shared learning, monitoring the effectiveness of mitigation actions, and aligning quality assurance with strategic risk priorities. Through regular dialogue and data-driven discussions, quality forums enhance transparency and accountability in managing risks that impact service delivery and outcomes.

11. Risk identification

Risks may be identified from a wide range of sources, as illustrated (non-exhaustively) in the diagram in appendix 5. The diagram also identifies established systems that enable existing and potential risks to be identified, eliminated or reduced. Furthermore, each action by a staff member involves an analysis of the situation and a weighing up of the risks and the benefits of the available solutions. This document sets out a systematic approach adopted across the trust to identify risks and to manage them once they have been identified. This promotes confidence that all risks are being identified and once identified they are actively dealt with in a consistent and appropriate manner.

Risks will continue to be identified through recommendations, comments, and guidelines of external bodies and internally through incident forms, complaints, claims, risk assessments, audits and other methods. To assist with this, and in order to provide a more cohesive system, the trust uses an integrated risk management database which facilitates the aggregation and triangulation of information to identify areas of potential concern. The database is used for recording risks, incidents, complaints, litigation, PALS issues, safeguarding concerns (adults and children), audits and requests for information (Freedom of Information (FOI) and subject access requests (SARs).

11.1 Risk assessments

See section 12.

11.2 Incident reporting

The routine reporting of all adverse incidents, including near misses, is an essential requirement of the trust's risk management strategy. Divisions/directorates, clinical services and risk management committees (with specific responsibilities e.g. resuscitation, medical devices), are responsible for reviewing, discussing and learning from incident data independently.

To achieve consistency of reporting and investigation the trust uses a risk scoring matrix for grading all types of risks identified (appendix 2). This should be used for assessing the severity of risk of incidents, complaints, claims and also for risk assessments.

The term 'incident' is used to describe incidents that could have, or did, cause harm. The process for managing incidents is identified in the Incident Reporting Policy and Procedure. Staff are required to immediately report ALL incidents, including those that did

not result in any harm to an individual or the organisation and events that were prevented from actually occurring because of a control measure that was in place (i.e., near misses).

When reviewing incidents, any indications for risk management should be captured and added to the risk register.

11.3 Complaints

Complaints may also be the patient/relative/member of the public's perception of risks that exist within the organisation. It is therefore essential that the complaint management system is integrated with the trust's other risk management systems.

The trust's head of patient experience ensures that all complaints are managed in line with national requirements however responsibility for investigation, local response and implementation of action has been devolved to the divisional management teams and local managers.

When reviewing complaints, any indications for risk management should be captured and added to the risk register.

11.4 Claims

The effective management of all claims will contribute to lessons being learnt within the trust that will in turn help to reduce risk.

When reviewing claims, any indications for risk management should be captured and added to the risk register.

11.5 Data comparison, aggregation, and trend analysis

An essential part of understanding and learning from data is aggregation and comparison (sometimes known as triangulation). Data is compared and aggregated at different levels within the trust, including quality forums, divisional boards and performance meetings, risk and safety and clinical governance committees and the Quality and Safety Committee. Major tools for data aggregation are the Quality and Safety dashboard, for day to day use, and the Quality and Safety quarterly report.

Issues and risks identified from aggregation and comparison will be actioned or added to the risk register as appropriate.

11.6 External inspections and audits

The work of external bodies (e.g., regulators, Royal Colleges) at the trust may provide invaluable insight and the reports following inspections and visits often include risk-related recommendations.

12. Assessment and control of risks

12.1 Risk assessment

Risk assessments are undertaken by staff in relation to a range of tasks where risks are likely to arise. This includes, but is not limited to:

- **Clinical safety:** e.g., infection prevention, patient falls, local clinical risks, medical devices.
- **Environmental issues:** e.g., fire, security, physical environment, ventilation.
- **General health and safety:** e.g., non-patient falls, control of substances hazardous to health (COSHH), first aid requirements.
- **Staff safety:** e.g., moving and handling, lone working, pregnant workers, young workers, display screen equipment (DSE), workplace stress, safe use of medical sharps.
- **Operational performance:** procedures, patient management systems, strategies, contract management.
- **IT and information:** systems, data protection[2] and cyber security.
- **Finance:** fiduciary, income and expenditure, budget.
- **Public relations:** e.g. reputation or publicity.

The following are exceptions:

- Information governance risks are not assessed using this process in the first instance, instead being assessed by using a parallel process using the IG Risk Assessment SOP.
- Risks associated with projects are not assessed using this process and should follow the project risk assessment guidance here. Should any risk remain following the completion of a project, these should be added to the relevant risk register for monitoring as business as usual.

Risk assessments must be undertaken when a new hazard is identified. The expectation is that risks assessments will be reviewed annually, as a minimum, but more frequently if a change occurs (e.g., in process or environment) that necessitates a review. Any hazards identified must be fully assessed (i.e., an assessment of the likelihood and consequence of harm occurring) and appropriate controls should be identified, regardless of the type of risk that is being considered (e.g., clinical, non-clinical or financial). Completed assessments will be reviewed for suitability and sufficiency by the Risk/Health & Safety

[2] The risks to the rights and freedoms of individuals are captured in the data protection impact assessment (see IG risk assessment SOP).

Adviser as part of the annual risk and safety inspection of wards and departments, as described within the Health and Safety Policy. The outcome of any risk assessments must be communicated to staff, along with notification of the actions that are required by them to reduce associated risks.

Training packages and tools have been developed which assist staff in carrying out assessments and ensure there is consistency of the risk grading (see appendix 2). Where a different scoring system is being used (e.g. by an external assessor) then every effort will be made to align in with the trust's system in appendix 2. Specialist risk assessment forms (e.g., moving and handling) have been devised to provide specific prompts to assessors. It is not a requirement that these are used, providing the assessment is suitable and sufficient. Each department is responsible for maintaining a local register of risks and controls.

The national patient safety syllabus (NPSS), available on the trust's learning management system (Insight) provides training on the principles of risk mitigation and assessment.

12.2 Process for assessing risks to not meeting a business plan priority

The risks associated with not meeting a priority identified through business planning should be added to the appropriate risk register based on score. Each year, targets to meet the strategic objectives are included within the trust's business plans. The TRR contains a section that assesses risks against the trust's strategic objectives which provides useful context that informs development of the BAF.

12.3 Process for assessing project risks

The risk associated with not delivering a project are included on the risk register. It is for the risk owner to facilitate discussion and understanding of each risk and mitigations. Higher level risks need to be escalated the project's manager to the respective programme board. Any residual risk needs to be assessed by the relevant project board/TMC at the close of a project.

12.4 Authority within the trust to act according to the level of risk

Not all risks can be avoided/fully mitigated and it is inevitable that there is a level of identified risk in some areas that is agreed as acceptable. The decision to accept the level of risk will be based on any effect it may have on service provision, financial capacity, and the extent to which it can be minimised. The higher the level of risk, the closer to the board the associated oversight needs to be.

Risk owners are responsible for managing levels of risks as follows (see also appendix 6):

Risk Score	Severity	Risk register level	Action required	Oversight/assurance/ review frequency
1 – 3	LOW risk	Department	Managed locally by team, ward, or department managers. No escalation required.	Local team meetings (3 to 6 months)
4 – 6	MODERATE risk	Department	Managed locally by team, ward, or department managers. No escalation required.	Local team meetings (3 to 6 months)
8 – 12	HIGH risk	Divisional (unless otherwise agreed)	Action required. Escalate for possible inclusion on the divisional risk register (if not already included). For review by divisional board. TMC reviews for possible inclusion on the Trust Risk Register.	Divisional board meetings (monthly)/ TMC (rotational)
15 – 25	EXTREME risk	Trust	Urgent/immediate action required. Director reviews and escalates to Trust Risk Register.	ManEx (monthly)

Where risk controls require explicit additional funding to implement, which cannot be managed within local budgets (e.g. reflect significant non-recurring expenditure or where the costs may impact significantly on service funding) then these should be reviewed by the relevant management team and presented as part of the business planning process. Where urgent action is required outside of the normal business planning process, this

should be escalated to the relevant director for resolution. This would be expected to occur where risks are deemed particularly significant with a score of 15 or above.

12.5 Acceptable level of risk

The level of an acceptable risk will generally be within the judgement of the risk owner, according to the risk profile (see section 12.3). Most risks will be handled at team level, though in respect to those with a risk score of 15 or more it would for the ManEx to agree inclusion on the TRR and for the respective executive director to provide assurance to the trust board in terms of justifying that level of risk in the organisation.

As a guide, an acceptable level of risk will normally be anything that scores less than 15 in accordance with the flowchart in section 13.7.

A risk that is scored as 15 or above must be escalated, via the electronic risk register, to the divisional manager/head of corporate department who will, in turn, be responsible for advising the responsible director. Where an identified risk can be managed and reduced effectively then it is deemed appropriate for the relevant director to oversee this process.

12.6 Risk treatment options

Management of risk should take place on a day to day business in all clinical and non-clinical areas. The hierarchy below, shown in priority order, should be followed:

TYPES OF RISK CONTROL	
Terminate	Eliminates the risk completely
Treat	Containment: Reduces the likelihood and/or the impact
	Contingent: Establishes a contingency to be enacted should the risk happen
Transfer	Passes the risk to a third party who bears or shares the impact
Tolerate	Accepts the risk: subject to monitoring

Risk acceptance should be considered as a reasonable action providing it is done in accordance with the requirements identified in this document (see section 12.3).

When considering what action to take, the cost of mitigating a risk must be considered as this may have a bearing on the decision. Key questions to be considered are:

- Action taken to manage a risk is likely to have an associated cost – is the cost proportionate to the risk that is being controlled?
- Consider whether the risk mitigations introduce new, change the profile of existing risks, or affect other people in ways which they need to be informed about;

- What if the risk were to materialise? are sufficient business continuity plans in place?

13. Risk register management

13.1 Addition of new risks

It is a requirement that all identified risks, excluding those that relate to individual patients or staff are recorded on the risk register at the appropriate level. All new entries to divisional risk registers will be reviewed by the TMC periodically.

13.2 Formulating a risk statement

All risk descriptions, relating to all levels and types of risk, must be presented in the format 'IF…, THEN…, LEADING TO….' to ensure a consistent approach and to ensure that all risk descriptions are clear and unambiguous.

13.3 Managing risk register entries (ward/department/site/committee)

Risks which are identified and are assessed as 'low' (risk score 1 – 3) or 'moderate' (risk score 4 – 6) will be entered onto the local (department, site, committee) risk register and local teams are responsible for identifying and implementing any required actions. Risks which are deemed 'high' (risk score 8 – 12) are recoded on local risk registers and must be escalated to the appropriate divisional/directorate risk register for consideration and identification of further actions as described in section 13.4.

It is a requirement for wards and departments to have local risk registers, which reflect the local risks as identified from the risk sources shown in appendix 5. Smaller network sites (i.e. not hubs) may have a local site risk register but this must be comprehensive and include all known risks. It must also be presented at team meetings for oversight.

13.4 Divisional/directorate risk registers

Each division and directorate is responsible for maintaining a risk register for the coverage of its business. The lead for maintaining this is the divisional general manager/directorate director, supported by the divisional head of nursing/relevant management team/quality partner. Divisional managers must work with the associated divisional/clinical and service directors to ensure that all operational and clinical risks are captured.

It is the responsibility of the division/directorate to ensure that the wards/departments/sites within their scope of responsibility have appropriate risk registers in place and that those risk registers inform the divisional/directorate and TRR, where appropriate (see section 12.3). There is not a requirement for divisional/directorate risk registers to include all risks identified by the wards/departments that they manage; risks with a score of 8 and above must be reviewed for inclusion. Divisions/directorates may aggregate risks, where appropriate.

A divisional management team/directorate may agree that where a department is very small a departmental risk register is not required. In this instance, evidence will be required to demonstrate that the risks associated with this particular area have been included directly on the divisional/directorate risk register.

The director and senior managers must ensure that all staff within their departments understand their responsibilities and populate their local risk registers on a regular basis. They must also ensure that their risks register are regularly reviewed and updated and presented to the most relevant assurance group/committee for assurance and oversight.

13.5 Trust risk register

The TRR will be informed by local and divisional risk registers. It is expected that all 'Extreme' (risk score 15 – 25) risks, as a minimum, will be escalated to the relevant director for presentation to ManEx. ManEx will consider the application and collectively approve or dismiss the risk for inclusion on the TRR. Risks with a risk score of 12 or below may be escalated for possible inclusion on the TRR, either by TMC, a division/directorate (via a performance meeting), or risk management committee.

13.6 Frequency of risk register review

It is a requirement of the trust that all risks be reviewed and updated periodically. The frequency of the review required will be dependent on a number of variables, including the level of risk register on which the risk currently sits and the risk rating (likelihood and/or consequence) applied to an individual risk.

No risk should be left for a single person to review, the line manager or other senior colleague, should support risk owners with higher level reviews (see section 13.7).

The frequency of risk review required is as follows:

- All open risks must be reviewed at least once in a 12 month period
- The following risks must be reviewed a minimum of monthly:
    - All risks with a risk score of 12 or more
    - All risks that have a consequence score of major or above
    - All risks that have a likelihood score of likely or above
- Any person undertaking a review of an open risk must create a log of that review (i.e. date of review and any changes made) and schedule the next review in accordance with the prescribed rules.

13.7 Review and update of action status and progress

Where a need for action to mitigate a risk is identified, the action required must be documented as part of the risk, along with details of the person that is responsible for

completing the action, the person that must be notified when the action is complete and the target deadline for action completion.

As actions are completed, or progress towards completing an action is made, the person responsible for completing the action is required to provide progress updates and eventually confirmation that the action is complete.

On completion of an action, the current risk status must be reviewed and updated to take account of the further risk mitigation, where it is confirmed that the action is effectively reducing the risk score. It is acceptable for the current risk rating to not be updated immediately following completion of an action; this enables an assessment of control effectiveness, and likely impact on the risk rating, to be undertaken.

13.8 Assurance regarding the effectiveness of risk controls

When taking account of the effectiveness of either existing or new risk controls, risk owners must consider and record the following information on the risk form:

- A description of the control that is in place.
- Any gaps in the control that exist.
- An assessment of how effective the control is at reducing the risk (i.e., significantly reduces, partially reduces, slightly reduces, no impact on the risk).
- What assurance there is that the control measure is reducing the risk (i.e., how do you know it is working).
- What gaps are there in the assurance (i.e., what would give you more confidence that the risk is being produced).
- Identify any actions that need to be taken in relation to the control measure (e.g., can action be taken to either improve effectiveness of the control or to enhance assurance).

Where either a gap in control or a gap in assurance is identified, this should be supported by the inclusion of an action. Without clear actions to address identified gaps in control and lack of clear implementation due dates, there is a risk of actions to gaps in control being delayed or overlooked which could cause risks to escalate.

13.9 Escalation/de-escalation of risks

Risks can be escalated up to the next level within the trust as and when it is deemed necessary. This would normally be done in accordance with section 12.3. Figures 2 and 3 show the pathway that escalated and de-escalated risks must follow and the associated oversight.

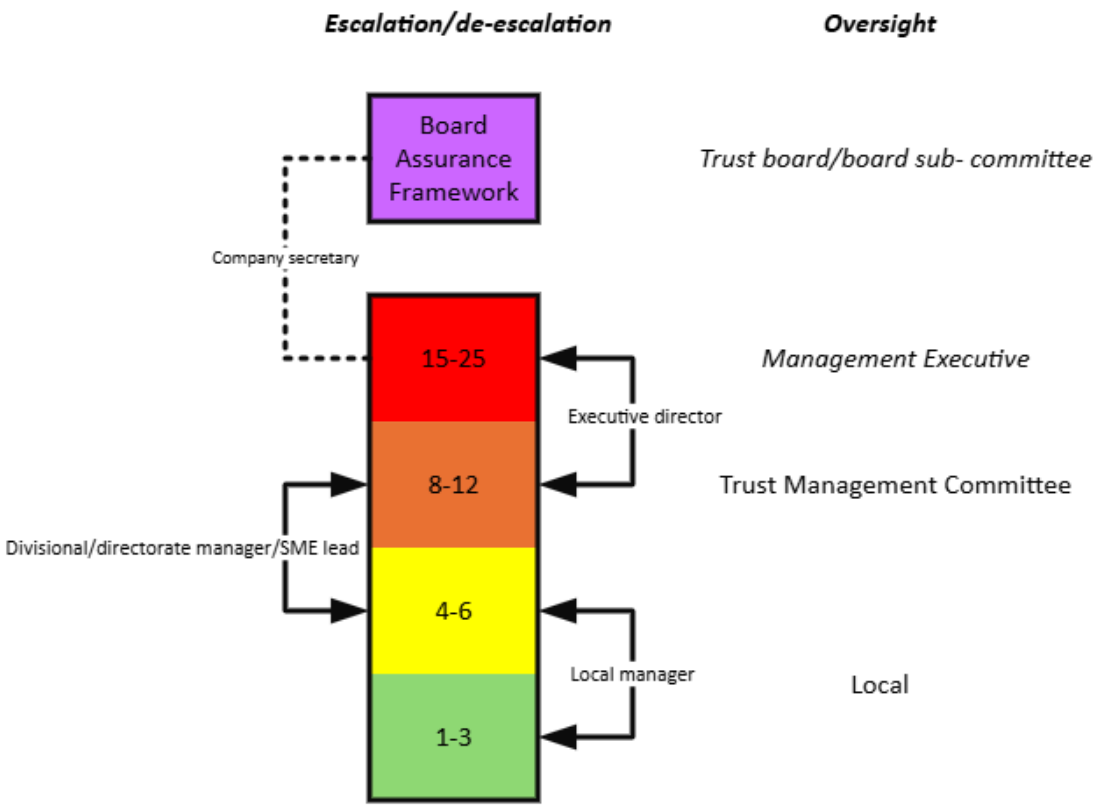


Figure 2: Movement of risks and associated oversight

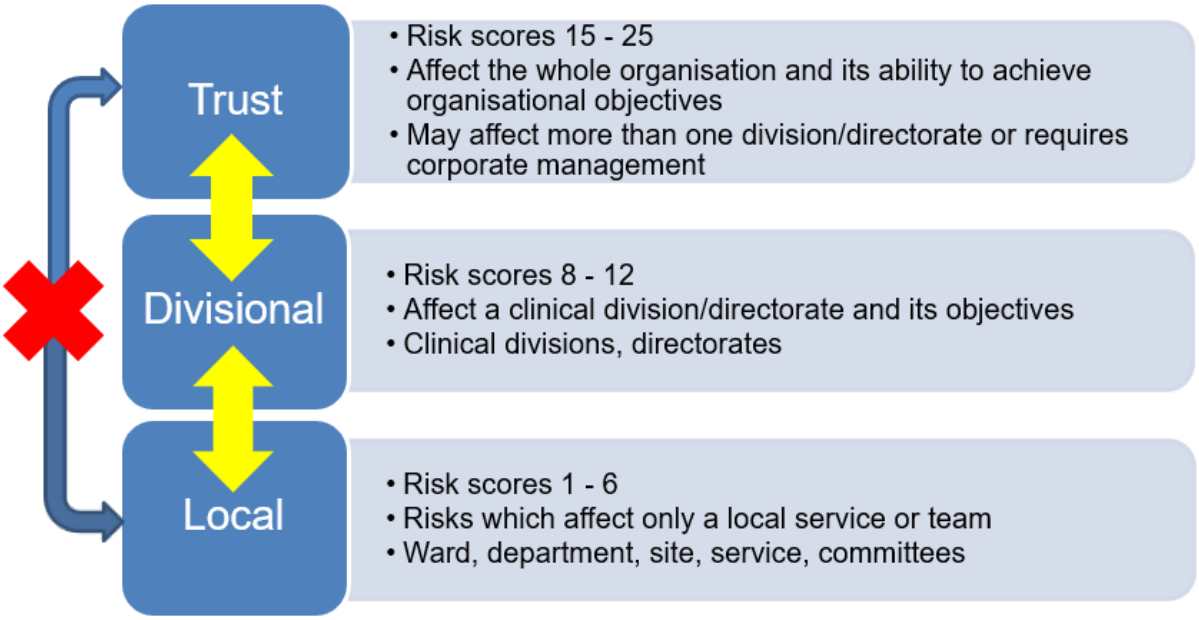


Figure 3: Escalation/de-escalation pathway for risks

Under no circumstances should risks be escalated to trust risk register without first being discussed with the relevant executive and agreed at ManEx. To do so would bypass the scrutiny applied by the divisional/directorate management team.

13.10 Accessibility of risk register to all staff

The trust risk register will be available for all staff to review, as a read only document, and will be accessed via the Safeguard risk management web homepage that includes the link to incident e-reporting[3], risk registers and audit.

13.11 Transfer of risks following the completion of a project

Following completion of a project it is the responsibility of the project manager to ensure that any outstanding risks are transferred to an existing risk register (e.g. department/site/committee, divisional or corporate) for on-going management and review.

13.12 Closing a risk

The decision to close a risk on a local or divisional risk register can only be made by the risk owner. A risk may be closed when:

- It has been eliminated, or
- When all planned mitigating action has been taken, the residual (target) risk score has been achieved, and the risk is being tolerated, or
- If there has been an administrative oversight (e.g., duplicate risk entered unnecessarily).

A quarterly audit of closed risks on a local or divisional level risk register will be undertaken and will be presented to risk and safety committee and included in the report to TMC.

Authority to close a risk on the TRR can only be granted by ManEx, and a summary of the risks closed during the reporting period will be provided in monthly reports.

14. Assurance

The trust seeks evidence that risk management activities and systems are being appropriately identified with assurance provided through the following:

- Quarterly reports of the trust risk register to the trust board.
- Regular review of the TRR at ManEx.
- Review of divisional risk registers by TMC, at every meeting on a rotational basis.
- Annual scrutiny of risk management processes by the ARC.
- Annual review of risk management processes (report to the Management Executive).

[3] It is anticipated that divisional and local risk registers will be available as read only documents for all staff.

- Regular review of risks (as part of the programme of annual health and safety inspections).
- The Board Assurance Framework.
- The annual Statement on Internal Control (SIC).
- Receiving assurance from internal and external audit that the trust's risk management systems are being implemented.
- Review of the Risk Management Strategy and Policy every 3 years (or sooner if a need is identified).
- On-going review of individual and aggregate incident, complaint and claim data and associated reports.
- Internal and external audit.
- Reports and recommendations from regulators.

15. Business planning

Where business planning processes are subject to risk assessment processes these should be followed as appropriate. This also includes the trust's annual plan which will be informed by the identification of risks in order to support development of organisational priorities.

16. Training

Training for users of the electronic risk register is mandatory, for those staff who require editable access to the risk register. Managers must undertake training needs analysis on their staff so that training needs are identified and delivered so that individuals can deliver their tasks safely.

The trust recognises the need for staff training at all levels of the organisation and has developed a comprehensive risk awareness training package. The training is a selection of clinical and non-clinical modules, some of which are mandatory and others that are more role-specific and includes the National Patient Safety Syllabus levels 1 and 2 training and that which is specific for members of the trust board.

All staff must engage in the mandatory and statutory training (MAST) modules within the time periods specified on Insight. Training requirements are role-based and as described on Insight.

17. Stakeholder engagement and communication

As part of the engagement process, this policy was sent to the following staff groups for review:

- Director of Quality & Safety (accountable director for the policy).

- Divisional management teams (manager, heads of nursing and director).
- All directors (including clinical and service).
- Monitoring lead(s).
- Members of the Risk & Safety Committee.
- Members of the Clinical Governance Committee.
- Information Governance Committee.

18. Approval and ratification

The trust Management Executive will approve and ratify this policy in conjunction with Policy and Procedure Review Group are responsible for ratifying this document. The director of quality and safety has overall responsibility for the dissemination, implementation and review of this policy.

19. Dissemination and implementation

This policy will be made available to all staff, through the intranet (eyeQ). Awareness of any new content/change in process will be through:

- the staff bulletin.

cascade by divisional management teams/directorates. Notification of a substantive revision or minor amendment to this policy will, in the first instance, be communicated via the staff e-bulletin, which is published by the Marketing and Communications team on a weekly basis.

Following approval of a minor amendment by ManEx, the Head of Risk & Safety will e-mail the staff identified within section 17 to advise that a change has been made, along with a request that the information be cascaded.

On-going support and advice in relation to the implementation of this document and the associated procedures will be provided by the risk & safety department and the quality partners.

Where a substantive revision is made (e.g. a process changes) then a separate plan for communicating and implementing this change will be devised by the Policy Owner and will be tailored specifically to reflect the change that has been made.

20. Review and revision arrangements

The Policy Owner is required to undertake a review of the document, at least once every 3 years (trust standard). This may happen at intervals of shorter than 3 years if a gap in existing policy/procedure is identified, or if further national guidance is released that needs to be incorporated. A review of this policy may also be triggered should its on-going monitoring highlight any gaps or issues to be addressed.

21. Document control and archiving

The current and approved version of this document can be found on the trust's intranet site. Should this not be the case, please contact the Quality and Compliance manager.

Previously approved versions of this document will be removed from the intranet by the Quality and Compliance team and archived in the policy repository. Any requests for retrieval of archived documents must be directed to the Quality and Compliance manager.

22. Monitoring compliance with this policy

The Trust will use a variety of methods to monitor compliance with the processes in this document, including the following methods:

Measurable policy objective	Monitoring/ audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/committees, including responsibility for reviewing action plans
Development and maintenance of a BAF	Board and ARC meeting minutes	A minimum of quarterly	Company secretary	Trust board and any other risk management committee as deemed appropriate
Suitable and sufficient risk assessments are being undertaken	Risk & Safety Committee minutes	Quarterly	Head of Risk & Safety	Risk & Safety Committee (as a minimum)
	Completed annual health and safety inspections	On-going and ad-hoc	Head of Risk & Safety	Risk & Safety Committee (as a minimum)
	Annual report for the Risk & Safety Committee	Annual	Head of Risk & Safety	Risk & Safety Committee (as a minimum)
	Internal audit	Annual	Internal audit	Audit and risk committee

Measurable policy objective	Monitoring/ audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/committees, including responsibility for reviewing action plans
Divisional/ corporate department risk registers (process and content)	Risk register audit	Quarterly	Head of Risk & Safety	Risk & Safety Committee Monthly divisional presentation to TMC
	Review of divisional boards and quality forums	Annual	Internal audit	Risk & Safety Committee
	Annual summary compliance report for the Risk & Safety Committee	Annual	Head of Risk & Safety	Risk & Safety Committee
Completion of risk registers	Review of the quality of risk register entries (e.g. format of risk description, identification of risk mitigations (control measures) and additional risk treatments, frequency of review)	Quarterly	Risk & Safety team	Risk & Safety Committee (quarterly) Individual feedback to divisions

Measurable policy objective	Monitoring/ audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/committees, including responsibility for reviewing action plans
National patient safety syllabus training compliance	Review of MAST compliance figures, with a view to identifying and targeting areas of non-compliance	Quarterly	Mandatory and Statutory Training Committee	Management Executive Quality & Safety Committee
Assessment to the risks of breach of privacy	Completion of DPIAs	Bi-monthly	Information Governance Committee	Management Executive Quality & Safety Committee

As a minimum, the following will be used to monitor the effectiveness of implementation of this Strategy and Policy:

- Each agenda for the Quality and Safety Committee, the Clinical Governance Committee and the Risk and Safety Committee, will include a standing agenda item entitled 'Reports from Sub-Committees (or an equivalent). This will be included in the Quality and Safety Committee annual report to the Trust Board;
- At the first meeting of a new financial year a review of attendance at Quality and Safety and Audit & Risk Committee meetings held during the previous financial year will be undertaken. Any issues regarding non-attendance will be addressed by the Chair of the relevant committee. This will be included in the Quality and Safety Committee annual report to the Trust Board;
- The number of meetings of the Quality & Safety and Audit & Risk Committees held per year will be monitored by the committee secretaries. Any issues will be reported to the relevant Chair. This will be included in the committee annual reports to the Trust Board;

In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps, or as a

result of the identification of risks arising from the policy prompted by incident review, external reviews or other sources of information and advice.

This monitoring may include commissioned audits and reviews, detailed data analysis or another focussed study, for example. Results of this monitoring will be reported to the committee and/or individual responsible for the review of the process and/or the risks identified.

Monitoring at any point may trigger a policy review if there is evidence that the policy is unable to meet its stated objectives.

23. Supporting documents

Supporting documents	Owner
Trust strategy	Trust board
Trust business plan	Management Executive
Complaints Policy	Head of patient experience
Claims Policy	General counsel
Incident reporting policy and procedure	Head of risk & safety
Clinical audit policy	Head of clinical governance
Annual audit plan	Head of clinical governance
Mandatory training policy	Chief people officer
Induction policy	Chief people officer
Health and safety policy	Head of risk & safety
Trust risk register and Board Assurance Framework	Company secretary
Information security policy	Chief information officer
Information risk SOP	Head of information governance
Information Governance Policy	Head of information governance

Glossary/definition of terms

Term	Definition
Acceptable risk	When there are adequate control measures in place and the risk has been managed as far as is considered reasonably practicable
Assurance	The confidence the Trust has, based on sufficient evidence, that controls are in place, operate effectively and objectives are being achieved
Assurance on controls	How the efficacy of the key controls is evaluated
Clinical risk	Those risks which affect patient care and may cause physical or psychological harm to the patient
Corporate team	These include those functions other than clinical or research teams.
General risk	The general risks of running a hospital that would be expected to be on any provider's risk register. The severity of these may increase or decrease with time, but are rarely expected to be fully mitigated
Current risk rating	The term used to indicate the severity of the harm, which will reflect how long the harm will last, how much impact it has upon the functioning of the individual or the organisation and how much it will cost to put right
Governance	The systems and processes by which the Trust lead, direct and control in order to achieve organisational objectives, safety, and quality of services, and in which it relates to the wider community and partner organisations.
Harm	Refers to any injury, damage or loss that may arise from a hazard and includes, for example, physical injury, mental distress, financial losses and damage to material
Hazard	Something with the potential to cause harm
Information governance	Includes matters relating to corporate and personally identifiable data use, including transparency; availability; confidentiality and protection, asset and records management, quality, risk appetite, and freedom of information.

Term	Definition
Likelihood	Refers to the frequency with which harm might be expected to arise as a result of a particular hazard
Operational risk	Risks that are escalated from departmental or divisional registers which, when mitigated, will be removed and will feature only on local (ward/department/site) risk registers if the need remains
Residual risk	Risk remaining following treatment/actions
Risk	The chance of something happening, or a hazard being realised, that will have an impact on individuals and/or objectives. It is measured in terms of consequence and likelihood
Risk appetite	The amount of risk at board level that an organisation is willing to take in order to meet their strategic objectives
Risk management	System of processes for identification, analysis, evaluation, and control of existing and potential risks which pose a threat to patients, visitors, and staff within the trust and its reputation. The assessment, analysis and management of risks. It recognises which events (hazards) may lead to future harm and minimising their likelihood (how often) and consequence (how bad)
Risk reduction	Refers to the actions which are taken within the organisation to put in place effective systems through which harm is made less likely
Risk register	A log of risks of all kinds that threaten an organisation's success in achieving its declared aims and objectives. It is a dynamic, living document, which is populated through the organisation's risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated
Strategic risk	The trust implements its strategy on an annual basis via its corporate priorities. These risks identify where we may not meet the corporate priorities and therefore do not effectively implement the trust's strategy

Term	Definition
Threat	Anything that might compromise a strategic or operational objective, process, asset, or individual.
Trust risk register	Risks that score 16 or more, and those escalated to ManEx as an exception.

Appendix 1: ACTION CARD TO BE ADDED

Appendix 2: Risk scoring matrix[4]

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for up to 3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

[4] This does not apply to information governance risks, to score information governance risk use the IG Risks Assessment and Management SOP

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency of occurrence.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 3 Risk rating = consequence x likelihood (C x L)

Consequence scores (C)	**Likelihood scores (L)**				
	1	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	LOW risk
4 - 6	MODERATE risk
8 - 12	HIGH risk
15 - 25	EXTREME risk

Instructions for use

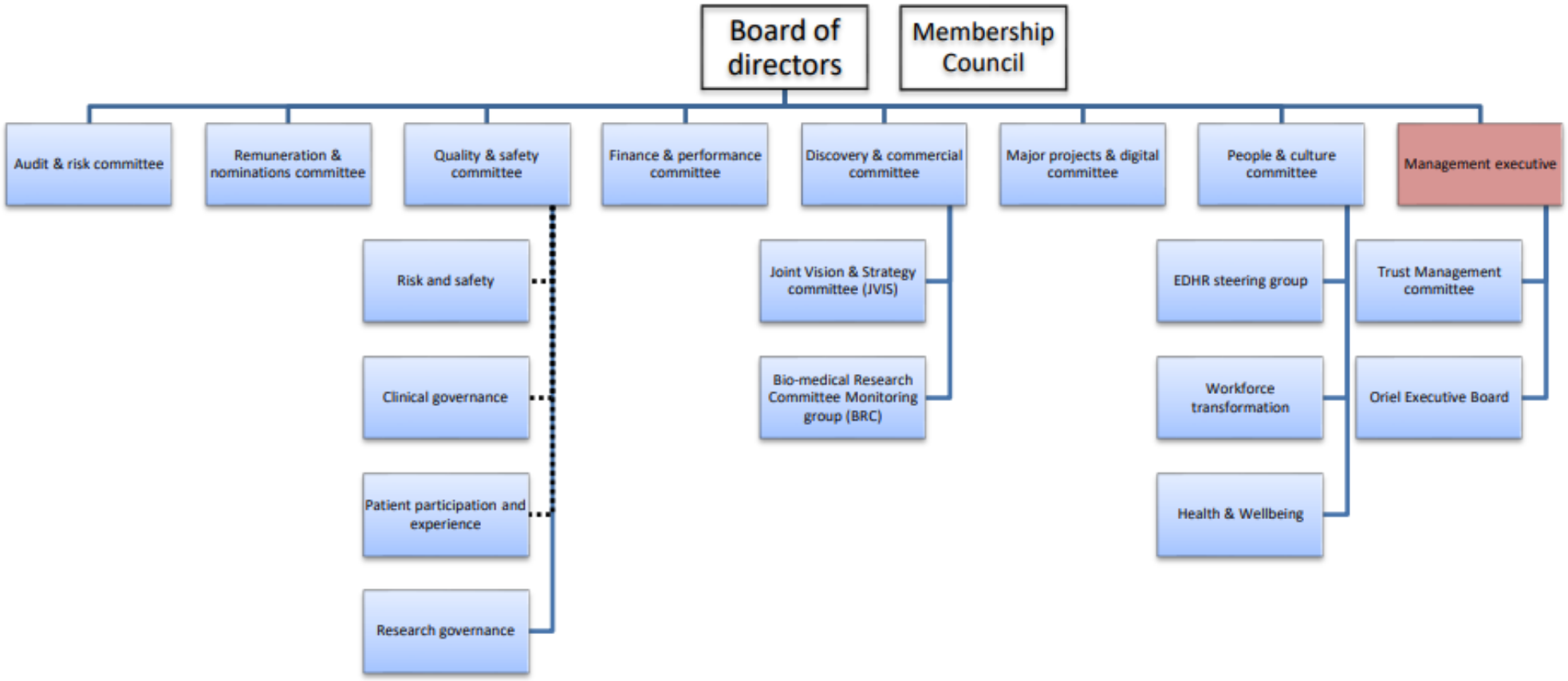
1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.

3. Calculate the risk rating by multiplying the consequence score by the likelihood score:

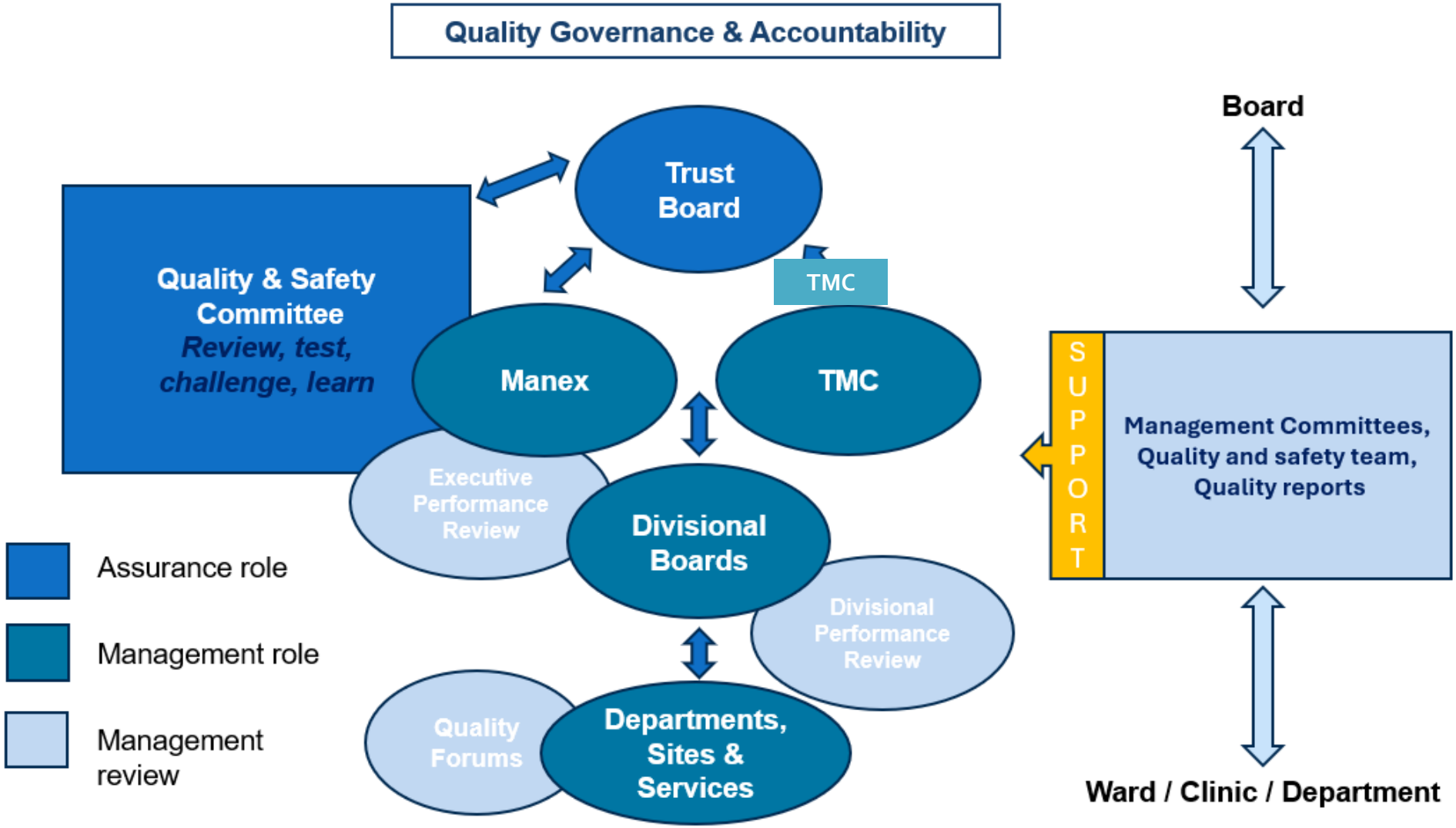
   C (consequence) x L (likelihood) = R (risk score)

4. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Appendix 3: Board committee structure (June 2025)

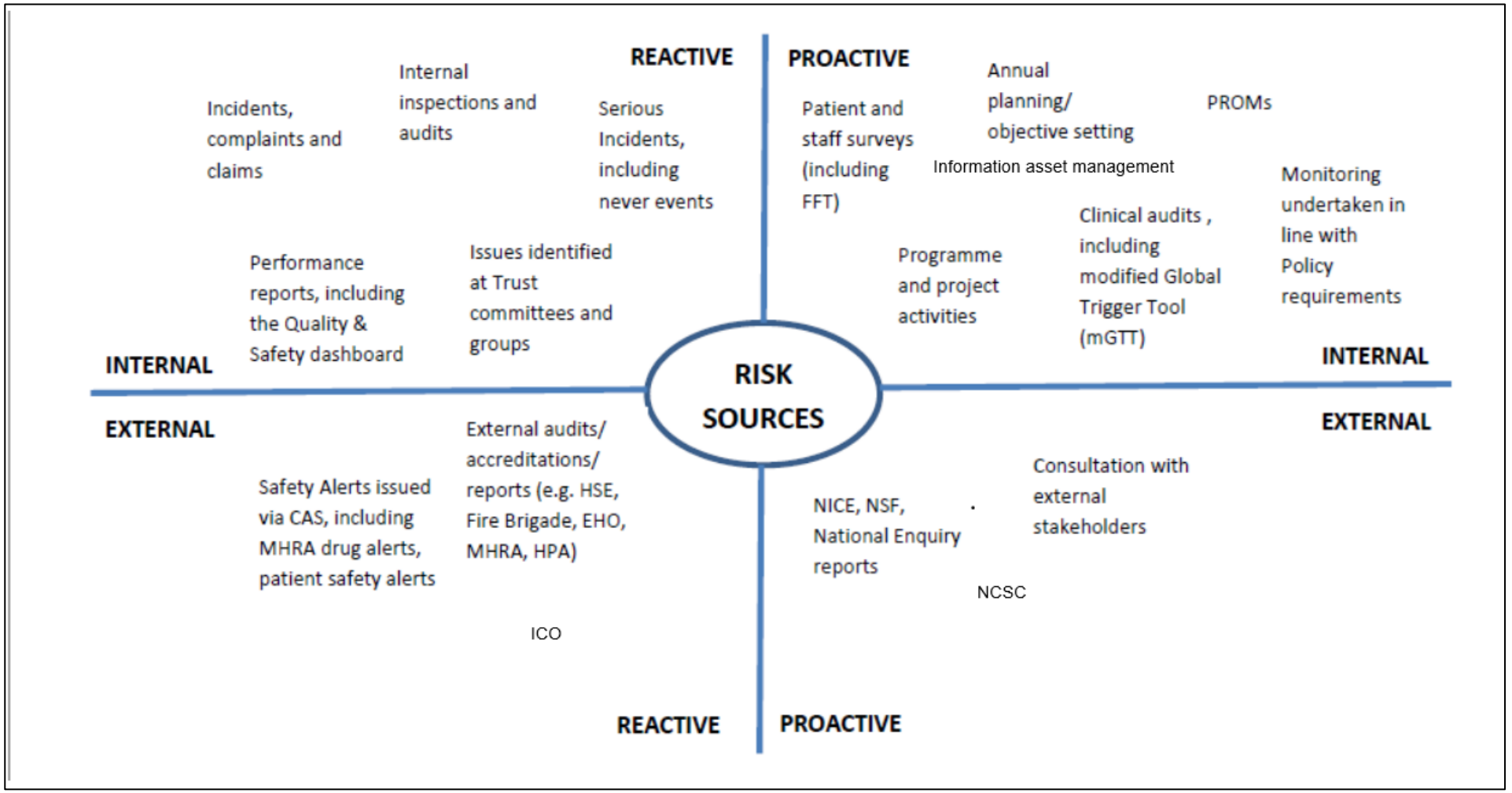


Appendix 4a: Quality & Safety structure – accountability (July 2025)



Appendix 4b: Quality & Safety structure (July 2025)

Appendix 5: Sources of risk



Appendix 6: Policy applicability to trust sites

This document applies to all premises occupied by Trust staff/activities, unless explicitly stated otherwise.

List all excluded sites:

None

Where the list indicates that the policy does not apply, this implies that the Trust will adhere to the policy of the host. Where a query exists then this must be referred, in the first instance, to either the:

- Divisional management team/ Head of Nursing
- Policy owner
- Accountable director
- Service director

Moorfields Dubai will adhere to their own local policies and procedures and trust-wide documents will not apply, unless explicitly stated otherwise.

Appendix 7: Equality Impact Assessment

The equality impact assessment is used to ensure we do not inadvertently discriminate as a service provider or as an employer.

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Comments/evidence
1	Which groups is the policy/guidance intended for? Who will benefit from the policy/guidance? (refer to appropriate data)	All groups
	• Race	N/A
	• Gender (or sex)	N/A
	• Gender Reassignment	N/A
	• Pregnancy and maternity	N/A
	• Marriage and civil partnership	N/A
	• Religion or belief	N/A
	• Sexual orientation including lesbian, gay and bisexual people	N/A
	• Age	N/A
	• Disability (e.g. physical, sensory or learning)	N/A
2	What issues need to be considered to ensure these groups are not disadvantaged by your proposal/guidance?	None
3	What evidence exists already that suggests that some groups are affected differently? (identify the evidence you refer to)	None
4	How will you avoid or mitigate against the difference or disadvantage.	N/A
5	What is your justification for the difference or disadvantage if you cannot avoid or mitigate against it, and you cannot stop the proposal or guidance?	N/A

If you have identified a potential discriminatory impact of this procedural document, please refer it to the director of quality & safety, or the human resources department, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the director of quality & safety (ext. 6564).

Please ensure that the completed EIA is appended to the final version of the document, so that it is available for consultation when the document is being approved and ratified, and subsequently published.

Appendix 8: Checklist for the review and approval of documents

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: **Risk Management Strategy and Policy**

Policy (document) Author: **Julie Nott, Head of Risk & Safety**

Policy (document) Owner: **Julie Nott, Head of Risk & Safety**

		Yes/No/ Unsure/ NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	Yes	
	Is the purpose of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	Yes	
	Who was engaged in a review of the document (list committees/ individuals)?		See section 17
	Has the policy template been followed (i.e. is the format correct)?	Yes	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?		

		Yes/No/ Unsure/ NA	Comments
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	N/A	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	Yes	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Yes	

Committee Approval (Policy and Procedure Review Group)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair:	Ian Tombleson	Date:	13 May 2021
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: 3 June 2018			

Moorfields Eye Hospital NHS Foundation Trust

Learning from deaths (Q1 2025/26) Board of directors 24 July 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 Q1 2025/26 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 the service is ever required.

Risk implications

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

Action required/recommendation

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

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

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

Indicator	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	0
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	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 Q1 (including those outside the criteria set out in Annex 1)

1. Concerns raised by family member

Notification of a patient death was received from a family member of the deceased. The complex case has previously been reviewed by multiple clinicians, but a request has been made for the case be re-examined to ensure that there is not any learning that can benefit future patients. The Medical Examiner who reviewed the case at the hospital in which the patient died has confirmed that no concerns had been identified.

This case is being reviewed as out of scope as no ‘significant concerns’ have been highlighted by the family member. A structured judgement review format will be followed, and learning identified will be shared accordingly.

2. Notification of a child death

Notification has been received regarding the death of a child, whose care has been reviewed as a patient safety incident investigation. The trust is required to contribute to, and participate in, the child death overview process. Learning from this review will be shared in a future report.

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

Freedom to Speak Up Report
Q4 2024-25 and Q1 2025-26
Board of directors
24 July 2025

Report title	Trust Board Report Part I- Freedom to Speak Up Report January – June 2025 (Q4 2024-25 and Q1 2025-26)- Public Report		
Report from	Sheila Adam, Chief Nurse and Director of Allied Health Professionals		
Prepared by	Princess Cole, Lead Freedom to Speak Up Guardian		
Previously considered at	ManEX	**Date**	15/07/2025
Link to strategic objectives	Freedom to speak up links to all the strategic objectives and underpins our core values of Excellence, Equity and Kindness		

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 has successfully introduced a new FTSU model to mitigate these risks, which also helps to support organisational cultural improvements.

Action required/recommendation.

Trust Board is invited to:

- Note and have oversight of FTSU proactive and reactive activities from January 2025- June 2025. Overall good progress has been made to ensure key deliverables detailed in the FTSU work plan are being met.
- Note the number of concerns raised over the specified periods and the themes and trends emerging from them, in addition to the wider triangulation of FTSU data.

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 Q4 2024/25 (January-March 2025) and Q1 2025/26 (April-June 2025) and gives an update on 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.

Since moving to BAU activities, the Freedom to Speak Up service has been guided by a robust workplan that sets out five strategic objectives centring around 'making speaking up business as usual'.

2. FTSU Data Analysis Q4 2024-25 and Q1 2025-26 (Jan - June 2025)

Concerns raised to the Freedom to Speak Up team during Q4 24/25 and Q1 25/26

When speaking up, staff may do so anonymously (no one knows any identifiable information, only the matters of their concern), confidentially (only the guardian knows who they are and data is not disclosed to anyone else without seeking their consent) or openly (staff member has consented for all to know identifiable data and matters of their concern).

There were 42 cases raised through the Freedom to Speak Up route in Q4 24/25. This increased to 46 cases in Q1 25/26. The total number of cases raised from Jan 2025 to June 2025 (Q4 24/25-Q1 25/26) was 88. Anonymous cases raised in in Q4 24/25 were 6. This increased to 14 cases in Q1 25/26. During Q4 24/25 and Q1 25/26, there were 68 confidential cases, and 20 anonymous cases raised in total to the guardian team. This is a good indication that a high proportion of staff (77%) using the FTSU service feel safe to speak to the guardian team, and trust that their confidential information will be maintained whilst matters are investigated by an appropriate senior leader/manager.

Table 1.1 No. of FTSU Cases raised for Q1-Q4 24/25 and Q1 25/26

Quarter	No. of Cases
Q1 24/25 (Apr-Jun 2024)	53
Q2 24/25 (Jul-Sep 2024)	54
Q3 24/25 (Oct-Dec 2024)	40
Q4 24/25 (Jan-Mar 2025)	42
Q1 25/26 (Apr-Jun 2025)	46
Total	**235**

The data shown in table 1.1 shows the highest number of cases were raised in Q1 and Q2 24/25 (53 and 54 respectively). This can be attributed to the team's heavy promotion of the Work In Confidence (WIC) platform. For a number of concerns raised, a group of individuals have raised a common concern, in this situation, each individual involved is counted as a case.

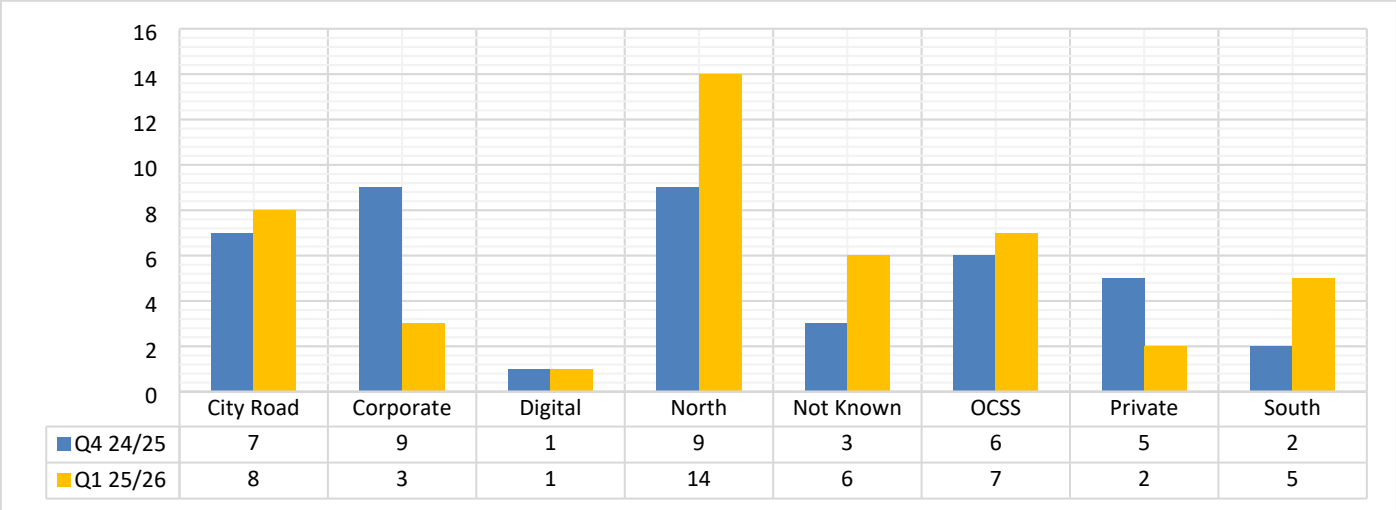
Case numbers dropped considerably in Q3 24/25 (40) as the guardian team worked closely with divisional leads to close a large number of historical concerns and cases involving large groups of staff speaking up collectively.

Where are staff speaking up from?

Table 1.2 Number of concerns raised by division Q4 2024/25 and Q1 2025/26

Division	Q4 24/25	Q1 25/26
City Road	7	8
Corporate	9	3
Digital	1	1
North	9	14
Not Known	3	6
OCSS	6	7
Private	5	2
South	2	5
Quarter Total	42	46
Q4 24/25-Q1 25/26 Total	**88**	

Fig 1.1 No. of FTSU cases raised by division Q4 24/25 and Q1 25/26



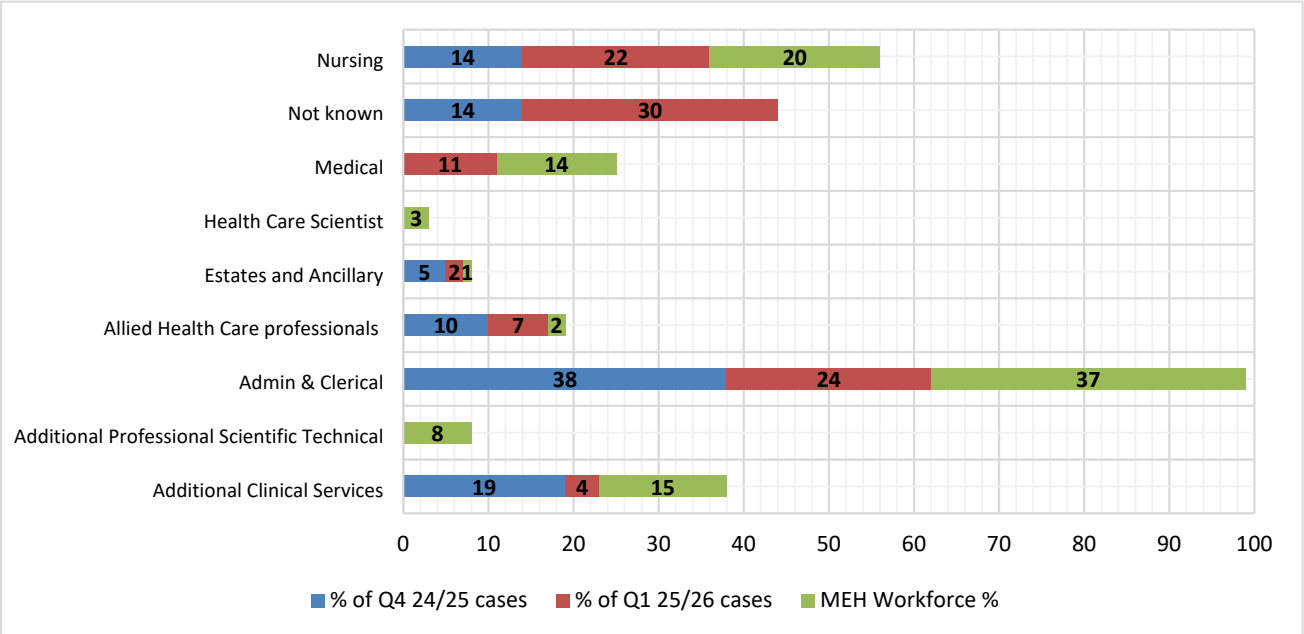
	City Road	Corporate	Digital	North	Not Known	OCSS	Private	South
Q4 24/25	7	9	1	9	3	6	5	2
Q1 25/26	8	3	1	14	6	7	2	5

Fig 1.1 shows a fluctuation in case reporting for divisions during the period of Q4 24/25 and Q1 25/26, as the FTSU team worked with senior leadership/management to resolve concerns, whilst new cases were opened when staff contacted the guardian team. When staff speak up, it can be an indication that there is a healthy speaking up culture, where they feel safe to raise concerns knowing that matters will be investigated appropriately. It is positive to note that divisions such as Corporate, where there is usually low speaking up activity, staff are gaining confidence to use the FTSU service to have their voices heard.

Who is speaking up?

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

Fig 1.2 below shows the percentage of FTSU cases raised by each worker group against MEH worker group proportions Trust wide during Q4 24/25 and Q1 25/26.



During Q4 24/25 admin and clerical staff raised the largest number of concerns (38%) through the FTSU route, however this worker group also accounts for the largest proportion of staff at MEH (37%). Nursing staff speaking up reported 14% of FTSU cases during Q4 24/25, but account for 20% of the workforce. In Q1 25/26, reporting rates for nurses (22%) reflected the MEH workforce for this staff group more fairly.

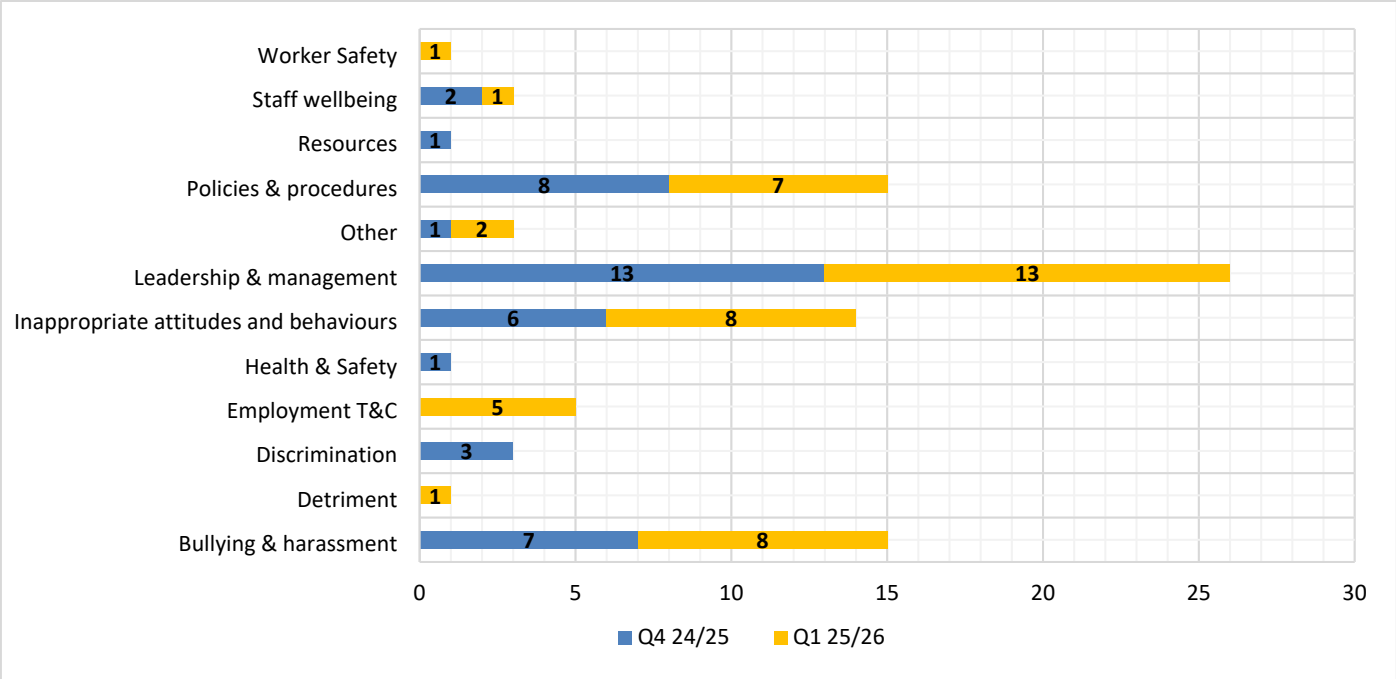
There were no cases raised for both Q4 24/25 and Q1 25/26 by healthcare scientists and additional professional scientific technical staff. The guardian team will continue with targeted work to promote the FTSU service, so that worker groups who may not be speaking up, are supported fully to feel safe and confident to raise concerns.

There were no cases raised during Q4 24/25 by MEH medical workforce. Nationally, there are also low reporting rates for medics. It is however positive to note that during Q1 25/26, 11% of FTSU cases were raised by medics, which indicates that some medical staff felt safe to speak up and chose to do so through the FTSU route. To further improve the levels of reporting by medical staff at MEH, the FTSU team will be looking to work collaboratively with the General Medical Council (GMC) and will be encouraging medical staff to attend online webinars promoting speaking up.

Themes of Concerns Raised to Freedom to Speak Up

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

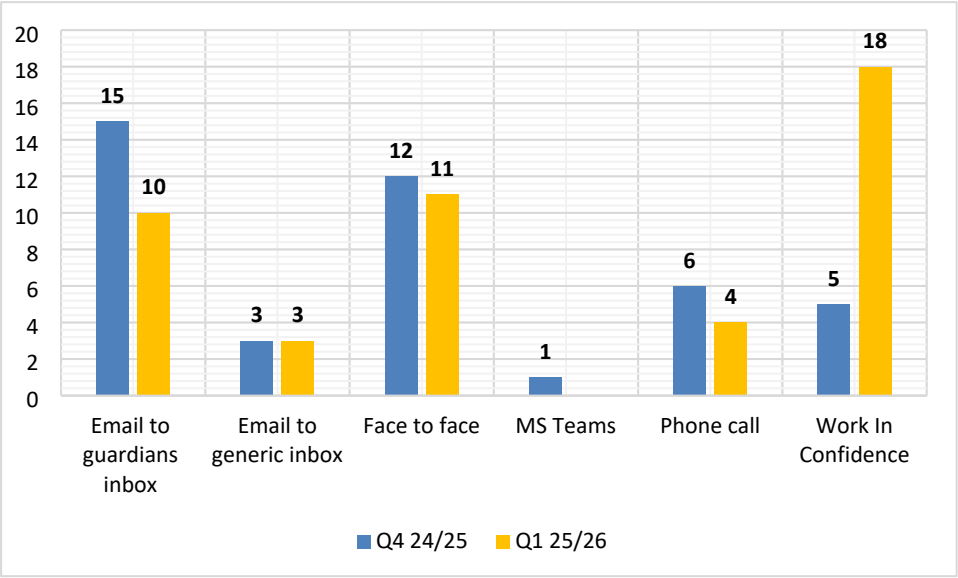
Fig 1.3 Concerns raised by themes (Q4 24/25 and Q1 25/26)



Please note that there were no cases raised with themes regarding patient safety, sexual misconduct, pay, finance or fraud during Q4 24/25 and Q1 25/26. Anonymised case information regarding patient safety is reported to the patient safety team and anonymised sexual misconduct case information, reported to the Co-Chair of the Auro (women's) network and the sexual safety steering group for oversight. To support Moorfields commitment to meeting the principles of the NHS England sexual safety charter, the FTSU service not only reports on sexual misconduct cases/themes, but have also pledged to ensure all freedom to speak up guardians and FTSU champions complete in-house sexual safety training, to be able to appropriately support staff who experience inappropriate sexual behaviours or sexual assault in the workplace.

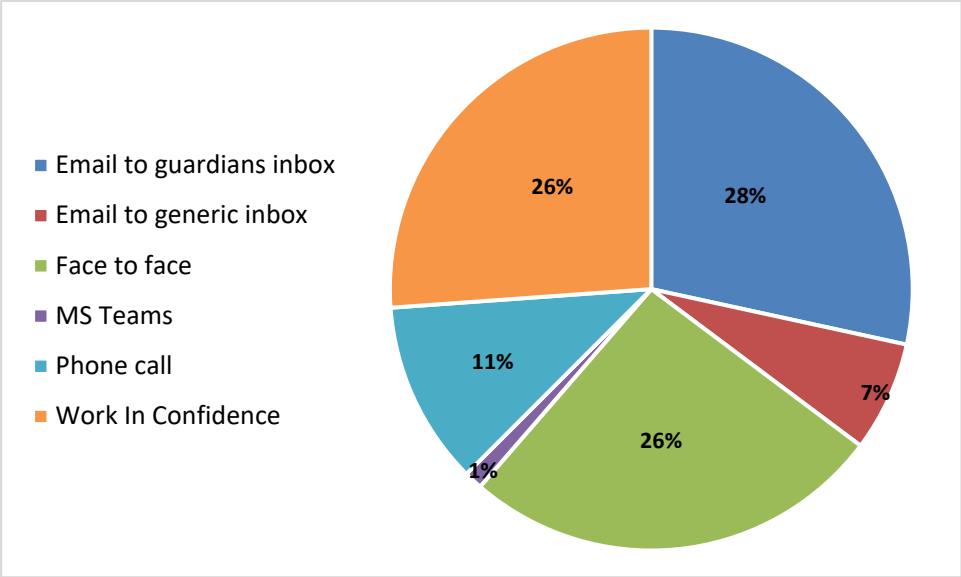
How do staff prefer to contact the FTSU guardian team when speaking up?

Fig 1.4 Routes used by staff to contact FTSU Guardian team (Q4 24/25 and Q1 25/26)



During Q4 24/25 the preferred route used by staff to contact the guardian team was through direct contact with a guardian of their choice via email. Following this, was face to face reporting to a guardian. The preferred method of contact changed in Q1 25/26 to the Work In Confidence (WIC) platform. It is positive to note that the guardian's promotion of the speaking up platform during site visits, listening events, Trust induction and through targeted communication messaging have increased the use of the platform.

Fig 1.5 Routes used by staff to contact FTSU Guardian team (Q4 24/25 to Q1 25/26)



Since the launch of the WIC platform in January 2024, there continues to be a steady increase in the number of staff registering to use the platform (169 registered user accounts as of June 2025). On average, it takes a guardian up to 3 days to respond to a conversation from a staff member and approximately 64 days to close a case. The guardian team will continue to promote the use of the WIC platform Trust wide, to offer further accessibility for staff wishing to use the FTSU route to speak up.

3. National Guardians Office (NGO)

The National Guardians Office announced on 30th June 2025 that the service will be closing. Following the publication of the government's 10 year health plan, the function of the NGO will be changing. The government plans to align the functions of the NGO with the other staff voice functions in NHS England and NHS England will take on the National Guardian's national functions. NHS England will transfer, in due course, to the Department of Health and Social Care. The role of guardians will remain across the health service.

Trust Board will be provided with further updates on the progress of this and of any implications to the delivery of the Freedom to Speak Up service at MEH.

4. Freedom to Speak Up Proactive and Reactive Work – Q4 24/25 and Q1 25/26 Update

Development of a Freedom to Speak Up strategy 2025-2028: The main objective of the strategy is to build a safe, open and inclusive speaking up culture, without staff fearing detriment. The FTSU strategy has been drafted and shared with key stakeholders (EDI, HR, People and Culture Committee, staff networks, Divisional Directors and managers, Heads of Nursing and the FTSU steering group) for review and feedback. Minor amendments to be made to strategy before being finalised.

Freedom to Speak Up Annual Report: The FTSU annual report (April 2024-March 2025) is being drafted by the lead FTSU guardian and will be presented to Board in September 2025.

Expansion of the FTSU Champions network Trust wide: Recruitment and selection for cohort 1 has taken place. There are currently 8 champions to support FTSU proactive and reactive activities. The guardian team will begin recruitment for cohort 2 in August 2025. The FTSU champions network will develop and expand to reflect the diverse staff population at Moorfields, to ensure all staff are represented when speaking up.

Improved FTSU training for staff and managers: We are pleased to report that South division were the first to meet our target compliance rate of 80% for both modules. Work continues to promote FTSU training Trust wide.

Table 1.7 Trust wide compliance rates on 25th June 2025 for FTSU training modules

Average Trust wide compliance: 76%

Requirement	Compliant	Non-Compliant	Staff Total	Compliant %	Target %
Freedom to Listen Up	538	203	741	73	80
Freedom to Speak Up	2090	542	2632	79	80

Promotion of the 'Work In Confidence' speaking up platform: Promotion of the platform continues at Trust induction and during site visits. Further targeted work will be conducted to promote and increase the use of the WIC speaking up platform.

Launch of the FTSU Quarterly Newsletter: The first edition of the FTSU newsletter was launched in October 2024. The newsletter contains information about the service, guardians, key statistics and other useful information for staff. The team also distribute paper copies of the newsletter and encourage the FTSU champions to print copies for their respective teams, to ensure wider accessibility for all staff.

Strengthened collaborative working between FTSU and all key stakeholders: Work with the divisional teams continues to monitor cases and address concerns appropriately. The Qliksense FTSU dashboard was launched in July 2024 and can be used by divisional teams to view their respective FTSU data. The guardian team will begin planning for phase 2 development of the FTSU Qliksense dashboard, with the aim of incorporating FTSU training metrics and employment relations (ER) case data for wider triangulation of information for teams. FTSU demographic data used for triangulation will also be strengthened with the introduction of the FTSU equality monitoring form.

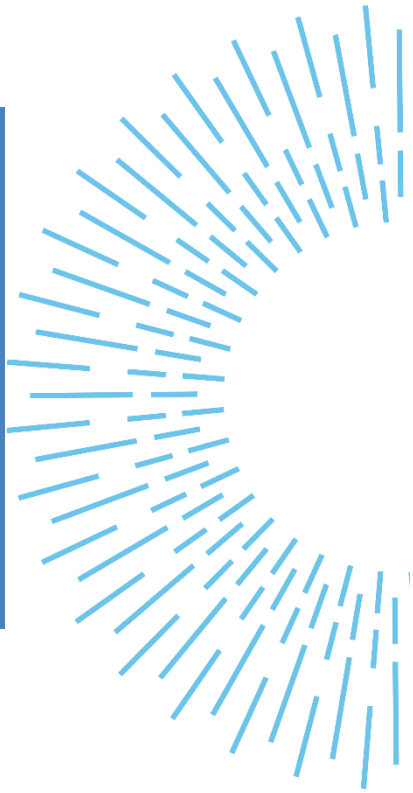
The FTSU/HR & People MDT group has been created to strengthen collaborative networking to share themes, soft intelligence, establish better FTSU/HR processes/procedures and share Trust wide learning from cases raised through the FTSU route. All information shared will be anonymised to protect the confidentiality of those speaking up.

Review and update of the FTSU Communications plan: The Freedom to Speak Up communications plan has been revised. Updated activities include: scheduled site visits, lunch and learn webinars, quarterly FTSU news articles, prominent guest speakers, promotion of Work In Confidence, introduction of FTSU champions, FTSU polls and GMC speaking up webinars. Significant consideration will be given to planned activities for October Freedom to Speak Up month 2025.

Continued effective service delivery of FTSU core activities: This continues to be led by the lead FTSU Guardian with support from the assistant to the lead FTSU guardian, 4 volunteer Speak Up Guardians and the FTSU Champions network.

Moorfields Eye Hospital NHS Foundation Trust

Moorfields Green Plan 2025-28
Board of directors
24 July 2025



Report title	**Moorfields Green Plan 2025-2028**		
Report from	Elena Bechberger, Director of Strategy and Partnerships		
Prepared by	Sarah Haspell, Divisional Manager OCSS and Sustainability Lead		
Previously considered at	Management Executive	**Date**	8 July 2025
Link to strategic objectives	Sustain & Scale		

Quality implications

The plan sets out a number of planned innovations – from the more widespread roll-out of digital pathways, to the introduction of multi-use eyedrops and re-usable theatre equipment – that have a direct impact on our care pathways and clinical work. All of the proposed actions are subject to the same rigorous quality impact assessment processes as with any other clinical transformation work.

Financial implications

The plan does not commit the trust to any actions which require any additional resources to those already committed. However, it outlines the areas in which further work is required in future to establish what specific actions the trust might want to undertake to progress its sustainability goals and a decision about related resources will need to be taken at this point in time.

Risk implications

Moorfields recognises that the impacts of climate change – ranging from extreme heat and flooding to infrastructure disruption – pose increasing risks to patient safety and service continuity. The green plan sets out our approach to integrated climate adaptation and how it relates to our wider emergency preparedness programme.

Action required/recommendation.

There is a national requirement for all NHS Trusts to publish a refreshed Green Plan by the 31 July 2025, with all Integrated Care Boards also publishing separate plans at the same time. The plans need to outline the trust actions against a defined set of national requirements but should also include individual trust priorities for the time period from 2025 to 2028. The plans are also required to include Key Performance Indicators for each of the actions.

The Board are asked to approve the core content for the refreshed trust green plan and to agree for a final version, with an additional foreword and final design and minor editorial changes, to be published on the trust website by 31 July 2025.

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

Green plan template structure

Moorfields green plan 2025-2028

Foreword

You may wish to include a foreword from your board-level net zero lead, chief executive and/or other key senior leaders, demonstrating their support for the plan and celebrating progress to date.

- Foreword from Peter to be added

Introduction

About us

For over 200 years, Moorfields Eye Hospital NHS Foundation Trust has led the way in ophthalmic care, education, and research. As one of the oldest and largest centres of eye health globally, we are proud to deliver world-class treatment, supported by our talented and diverse workforce.

With more than 2,500 dedicated staff, Moorfields provides almost 50% of all ophthalmic care in London, serving patients across all demographics and leading in services for age-related conditions such as glaucoma and cataracts. Moorfields is one of 20 designated Biomedical Research Centres in the UK, conducting cutting-edge research into eye diseases and disorders.

Our main site is currently located at City Road, London, however, a joint initiative between Moorfields Eye Hospital NHS Foundation Trust, the UCL Institute of Ophthalmology, and Moorfields Eye Charity will see us move our City Road services to a new centre for advancing eye health in Camden in 2027.

Alongside our main site, Moorfields has a network of over 20 sites across London and Bedford. Our network sites enable us to provide expert treatment closer to patient's homes. As part of our efforts to improve patient pathways and to reduce unnecessary travel and waiting times, we have introduced a number of diagnostic centres and surgical hubs which patients access through a “digital first” referral. We are continuing to build on this successful model that avoids unnecessary appointments at our main hospital sites and provides a more efficient and productive joined-up service. We will do this by working closely in partnership with our colleagues in primary care – GPs and high street optometrist practices, including collaborations with other NHS organisations.

As we look to the future, Moorfields is deeply committed to sustainability and environmental stewardship. The implementation of this green plan builds on our legacy of innovation and leadership, ensuring we remain a global centre of excellence while delivering care that is not only pioneering, but also environmentally responsible.

Why do we need a green plan?

As a world-renowned centre of excellence in ophthalmic care, research and education, Moorfields Eye Hospital NHS Foundation Trust has long been a pioneer in advancing health outcomes. Through this green plan, we deepen our commitment to innovation by recognising and addressing climate change, one of the greatest health and societal challenges of our time.

The NHS is responsible for approximately 4% of England’s total carbon emissions. In response, it has launched an ambitious campaign to achieve net-zero emissions, aiming for:

- 2040 for emissions it controls directly (Scopes 1 and 2), and
- 2045 for indirect emissions (Scope 3), with interim ambitions for an 80% reduction by 2028–2032.

This green plan sets out Moorfields’ strategic response, aligning with NHS-wide goals while championing sustainable eye care. We have reviewed:

- where we work – our facilities and infrastructure
- how we work – our operational and clinical practices

- who we help – our diverse patient population and workforce

Our aim is to embed sustainability at every level, not only meeting national expectations, but also pursuing leadership in sustainable ophthalmology, working collaboratively across the NHS and beyond.

Climate change is already impacting health through increased air pollution, rising temperatures, and more frequent extreme weather events. NHS England data shows:

- up to 38,000 deaths annually are linked to air pollution, disproportionately affecting vulnerable groups and deepening health inequalities.
- the economic cost of climate-related mortality is projected to rise from £6.8 billion/year in the 2020s to £14.7 billion/year by the 2050s.

Climate action offers direct benefits:

- Improved public health outcomes
- Reduced strain on NHS resources
- Enhanced equity for the most deprived communities
- Support for the UK's vision of a clean energy future

Through the implementation of this green plan, Moorfields takes responsibility for its role as a global healthcare leader – delivering not only pioneering eye care – but also responsible, sustainable, resilient systems that protect our environment and people.

Developing this plan

The refresh of Moorfields' green plan has been driven by meaningful engagement with staff and partners across the system. We have shifted away from reliance on external sustainability support, investing instead in internal expertise and leadership to deliver a robust and inclusive strategy.

Staff involvement has been central to this process. Through our recently established staff sustainability champion network, MoorGreen, we are providing space for all our staff to share ideas for a greener future. In early 2025, we held a number of interactive workshops and will continue to support cross-departmental, grassroots innovation across departments and services.

In parallel, our sustainability steering group has steered the development of our green plan via designated leads, with regular updates to track progress. Contributions from our green theatres working group and our emerging green champions network has also informed planning – highlighting frontline opportunities to embed sustainable practices.

We have carefully considered equality and legal duties, ensuring voices across the trust are heard – including clinical, non-clinical and operational input. To support transparency and collaboration, we launched an open-access green networking log, enabling staff to capture external sustainability engagement and to share insights across teams.

Working with our partners

Our sustainability journey has been shaped by wide-ranging collaboration, both within our system and beyond. Moorfields actively participates in the ICB green partnership group, the North Central London ICS oversight meetings, and the NCL travel & transport working group. These platforms help facilitate the exchange ideas, align on shared goals, and standardise best practice.

We've connected with peer trusts – including UCLH, Imperial, West London NHS Trust, Royal National Orthopaedic Hospital, Barts, and East Sussex – to share learning, join engagement exercises, and strengthen regional sustainability network. Engagement with organisations such as GHASP and Greener by Default has informed approaches to greener operations and procurement.

Our key strategic partners bring important sustainability commitments. For example:

- Alcon aims to achieve carbon neutrality and zero landfill waste at its global sites by 2030.
- Bywaters, our recycling partner, continues to support improvement in waste segregation.
- Medirest, our soft services partner, operates its own sustainable catering initiatives
- DHL enforces an anti-idling policy, helping reduce emissions linked to deliveries.

We also focus efforts locally, including working with the Islington Sustainable Partnership, and have participated in Islington resilience forums to further strengthening our focus on emergency preparedness and climate risk.

Governance and accountability

Moorfields' governance structure has evolved significantly since our last green plan. Sustainability delivery is now coordinated through an established sustainability steering group, which reports into our sustain and scale board, ensuring strategic oversight at senior levels.

We have a designated senior sustainability lead in operations, supported by a cross-functional network of directors and chapter leads who contribute to the development and implementation of green plan priorities.

We are committed to providing an annual summary of green plan progress to the board and will also be reporting this publicly in our annual report. These updates on progress will include:

- a narrative summary of key milestones, actions and achievements
- The identification of delivery risks and challenges
- quantitative data reflecting progress against carbon and sustainability targets

Through structured governance, strong leadership and a culture of collaboration, Moorfields is well-positioned to deliver a credible, resilient and innovative response to the climate emergency – while maintaining our position as a world-leading provider of ophthalmic care.

New centre for advancing eye health in Camden

In 2027, Moorfields will open its new home for advancing eye health: a purpose-built centre in Camden, delivered in partnership with the UCL Institute of Ophthalmology and Moorfields Eye Charity. This transformative move from City Road marks a pivotal moment in our history – bringing together clinical care, research, and education under one roof to accelerate breakthroughs in patient treatment and experience.

The new centre will foster seamless collaboration between clinicians and researchers, creating opportunities for earlier patient involvement in clinical trials and expediting the delivery of cutting-edge therapies. With inclusive design at its core, the centre aspires to be a national exemplar for accessibility, carefully tailored to meet the diverse needs of our patient population.

From a sustainability perspective, the centre represents a bold step forward. The development has been shaped around net-zero readiness, incorporating the latest energy-efficient technologies and building standards. The centre will help Moorfields meet the NHS climate commitments while elevating our environmental performance across estates and operations.

Over the next two years, our focus is on adapting working practices to ensure a smooth transition, embedding sustainable behaviours and systems that will continue seamlessly at the new centre. This phase presents a unique opportunity to align every aspect of our delivery with sustainability principles – and many of the initiatives outlined in this green plan have been designed with that goal in mind.

Areas of focus

This section will outline our nine areas of focus and progress.

1. Workforce and leadership

Our progress so far

Since the publication of our previous green plan, Moorfields has transitioned from external sustainability support towards developing robust internal expertise. This strategic shift reflects our commitment to embedding sustainability into the heart of our culture, operations, and workforce – reflecting our long-term ambitions.

We have established three staff-led sustainability groups:

1. **Sustainability steering group –** A formal monthly forum comprising around 30 senior clinical and non-clinical leaders. Originally supported externally, the group became completely internally managed in April 2023 and was revitalised with refreshed membership in October 2024. It provides strategic oversight for sustainability initiatives across the trust and reports directly into our excellence delivery programme.

2. **MoorGreen – Our staff sustainability network –** A self-elected group of sustainability champions who operate less formally than the steering group. MoorGreen provides an opportunity for staff across the organisation to pitch and develop ideas to make Moorfields greener. The group was launched in December 2024 and hosts interactive workshops, encouraging wide staff participation. The group meets quarterly.

3. **Green theatres working group –** Dedicated to driving environmentally conscious practices in surgical settings. This group is explored in detail in the following chapter.

In October 2024, we signed a contract with On Purpose, a career development programme supporting emerging leaders in the social and environmental impact space. Through this partnership, two sustainability project managers have since joined the trust on six-month apprenticeships. They have played a pivotal role in convening and supporting the above staff groups, as well as advancing key sustainability initiatives.

Moorfields staff continue to demonstrate exceptional commitment to sustainability, with many holding training and qualifications such as:

- **NHS Green Leadership Programme**
- **Sustainable Quality Improvement (SusQI)**
- **IEMA Sustainability Skills for the Workforce and for Managers**
- **Carbon Footprinting in Healthcare**
- **Florence Nightingale Foundation Green Healthcare Leadership Programme**

We have introduced an open-access green training log to identify and track opportunities for upskilling staff – ensuring sustainability knowledge is not only acknowledged and valued but also shared more widely across the trust.

Recognising and rewarding staff contributions is central to our sustainability journey. We proudly celebrate these efforts through nominating our staff members for initiatives such as the Net Zero Hero Awards and the QIPP Prize, helping sustain momentum and morale across the trust.

Workforce and leadership plan

Proposed eleven actions:

Action	KPIs
Secure net-zero leadership to oversee green plan delivery	
Appoint a designated board-level net-zero lead with clearly identified operational support	• Net-zero lead confirmed by October 2025 • Additional leadership in operations and professions to be reviewed during business planning 2026-2027
Assess workforce capacity and skill requirements	
Utilise present resourcing and governance structures to promote engagement with green plan delivery	• As part of business planning 2026-2027, consider resourcing of green plan delivery
Position sustainability steering group for green plan delivery	• Terms of reference and reporting lines revised by March 2026

Ensure commitment of sustainability steering group	• Sustainability responsibilities defined in job descriptions for key staff involved in green plan delivery by June 2026
Launch a 'who's who' Moorfields sustainability directory and listing of qualifications gained across the trust in sustainability	• Directory uploaded to Moorfields intranet by November 2025 • Sustainability training log fully updated by all sustainability steering group members during 2026 and ongoing
Conduct training and information needs analysis in relation to net-zero agenda	• Undertake top level training needs analysis, then consider uptake targets
Promote general/generic healthcare sustainability training and set uptake targets	
Promote training and review what to include in core training via a structured review process based on training needs analysis	Example training: • **'Building a Net Zero NHS'** • **'Carbon Literacy for Healthcare eLearning Pathway'** • **Carbon Literacy for Healthcare Leaders'** • **Sustainability Leadership by Greener Health and Care'**
Build on SusQI training for relevant staff groups	• **'Environmental Sustainability in Quality Improvement'** maintain links to centre for sustainable healthcare and relate to service improvement work informally during 2025 and 2026
Promote sustainability champions training for MoorGreen members	• Roll out discretionary training such as **'Stickerbook sustainability champion training'** for all green champions during next three years
Review requirement for in-house Moorfields-specific mandatory training	• Conduct a lessons-learned review from other NHS trusts on value of in-house training with a decision on applicability for Moorfields by end of 2027
Promote specialist healthcare sustainability training for relevant staff groups	
Promote training for the following groups: ➢ clinicians on climate change and illness prevention ➢ soft services team on healthcare waste management ➢ procurement team on net-zero and social value	• Integrate the 'air pollution' and 'climate change' modules of the **All our health programme** into our training provider's online portal by ADD DATE • Healthcare Waste Management and Disposal - elearning for healthcare (e-lfh.org.uk) • Net Zero & Social Value Training • NHS Net Zero Building Standard Training - NHS England

➢ estates team on the NHS net-zero building standard ➢ pharmacists on sustainable pharmaceutical practice ➢ anaesthetists on sustainable anaesthetic practice	• Centre for Pharmacy Postgraduate Education (CPPE) - Environmental sustainability • Environmentally Sustainable Anaesthetic Practice

2. Net-zero clinical transformation

Our progress so far

Our chosen clinical area for net-zero clinical transformation is our operating theatres. We chose to focus on theatres to build on our success in eliminating desflurane and nitrous oxide eliminated from anaesthetic procedures.

Using capacity generated from the On Purpose placement, we established a multi-disciplinary green theatres working group which meets every three weeks. The group is co-chaired by our OCSS director and transformation programme manager – and one of our clinical leads for green theatres is a consultant anaesthetist. Its membership comprises a range of roles – including surgeons, anaesthetists, logistics manager, theatre practitioner, medical equipment manager, soft services manager, and procurement partners. During March 2025, the group ran two face-to-face workshops at City Road theatres for staff in that area.

The group's primary focus is transitioning from single-use to reusable theatre equipment and clothing. We have already successfully phased out single-use cryoprobes and phacospeculums at our City Road site and have stopped the use of disposable gowns at City Road.

Net-zero clinical transformation plan

Action	KPI(s)
Net-zero clinical leadership	
Formalise net-zero clinical lead position	• For consideration post new medical leadership structure to be implemented in the second half of 2025
Progress with general green theatre projects	
Complete quality improvement projects in theatres that focus on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities	• Consider developing a Moorfields-specific green theatres checklist (based on Royal College of Surgeons template) • Conduct productivity drives within the trust to ensure good utilisation of our theatre space and resources and to improve our carbon impact by reducing downtime

Share learnings and outcomes through clinical networks	• Publish success stories on Future NHS – Greener NHS Hub during the life of the green plan • Explore opportunities for international collaboration on green theatre projects with eye centres around the world
Promote green theatres e-learning for all staff working in theatres	• Review **'Green Operating Theatres'** e-learning and explore opportunities to incorporate into our training plan
Digital pathway management	• Move away from face-to-face pre-assessment and follow-up post surgery, where clinically appropriate, to reduce patient travel
Build on relationships with our suppliers to transition from single-use to reuseable items in theatres	
Transition to reusable theatre equipment	• Transition to reusable or more sustainable versions of theatre equipment products and measure the resultant reduction of carbon emissions. Develop a pipeline for implementation in 2025.
Transition to reusable theatre clothing	• Replace single-use hats with reusable hats • Transition to reusable gowns
Improve theatres waste management and reduction rates	
Reduce theatre waste via bin installations	• Roll out reusable sharps bins by the end of 2025 • Roll out green recycling bins by the end of 2025
Reduce use of paper in theatres and measure the resultant reduction of carbon emissions	• Paper usage eliminated by June 2026 in line with Electronic Patient Record (EPR) go-live
Use of Genesis inventory management software to improve management of stock	• Reduction in expired consumables
Optimise energy use in theatres	
Optimise airflow management prior to move	• Measure and monitor air change rates continuously

3. Digital Transformation

Our progress so far

Information systems

Since the publication of our last green plan in 2021, Moorfields' digital teams have made strides in maximising the benefits of digital transformation to improve sustainability and patient care. Central to this work has been the ongoing development of OpenEyes, our bespoke clinical software solution. We are in the process of integrating OpenEyes with Meditech Expanse to develop our Electronic Patient Record (EPR), a solution which is set to go live in June 2026.

As a result of OpenEyes development and work with our digital patient portal provider, we have rationalised our communication with patients – both appointment letters and outcome letters. Our patient appointment letters are now sent digitally as standard unless a patient specifically requests a paper copy. Benefits of this include faster communication and reduced loss of correspondence, which has improved patient experience while also reducing costs to the trust and CO2e emissions.

There are approximately 657,000 appointments per year at Moorfields, each appointment resulting in 0.64kgCO2e per letter for paper and postage. The digitalisation of these appointment letters represents an estimated annual reduction in CO2e of 420,250.9kg CO2e. We also digitised clinical outcome letters in July 2025, which is projected to result in 218,553 avoided paper letters annually, equivalent to approximately 139,873.9kg CO2e.

In terms of forms, we have introduced:

- Digital consent forms as an option for patients and staff using a platform called Concentric. There is a potential reduction of circa 100,000 pieces of paper per year by moving to a digital solution using both Concentric and OpenEyes.

- Use of the WHO injection forms checklist reduces the need for approximately 49,000 paper sheets per year

- Use of the Safer surgery checklist on OpenEyes reduces approximately 50,000 paper forms per year.

Moorfields went live with the NHS App in March 2024 and NHS app-appointment notifications and messages went live in June 2024. The app enables a raft of paper reduction opportunities and patient experience improvements relating to patient access to health information and communication.

By leveraging the NHS app as part of the Wayfinder Programme, we have achieved reductions in environmental impact of travel to appointments and appointment DNAs. This initiative received the HSJ Digital Award in June 2025 for reducing environmental impact of patient appointments while improving the patient experience.

We have removed paper print and scan from our external referrals process – the booking team now move scans directly from external referral emails into CITO/digital storage. This saves 380,000 sheets of paper per year at 0.009005 kgCO2 per sheet (3,421.9 kgCO2 per year).

Hardware

We are upgrading printer and scanner stock across the trust. Our new hardware leasing and service contract with Xerox ensures increased energy efficiency and performance monitoring, which will help the trust to target print reduction activities further. We have rolled out new digital experience

monitoring on desktops and laptops, which provides a dashboard view of sustainability metrics related to desktop and laptop use.

Change in practice

For paper reduction, the health records team has been working with clinical and operational colleagues across services to reduce requests for paper notes at outpatient clinics by improving reliance on electronic records.

Paper notes are stored near Coventry and driven to hospital sites when requested for clinics. Reducing these requests provides cost savings to the trust and has the potential to deliver CO2e savings if deliveries can be stopped.

We have reduced the number of clinics requesting and using paper health record notes by 75% via the development and embedding of OpenEyes (our specialist Ophthalmology care software) into care workflows and we continue with our efforts to reduce this even further.

For staff, we have been utilising digital tools such as Microsoft Teams and SharePoint in working practices, enabling the trust to operate flexible combinations of office and home working, and the associated sustainability benefits. In addition, we have established an artificial intelligence (AI) working group and have considered automated processing.

Over the last years we have also substantially transformed our approach to patient referrals and the way patients can access our care through digital innovation. In 2023, we started streamlining direct referrals via our single point of access (SPoA) pathway to improve patient experience, minimise unnecessary travel, and increase building resource utilisation efficiency. Our implementation of local diagnostic hubs has brought care significantly closer to patients, significantly reducing the need for face to face appointments at our main hospital sites and reducing average appointment durations by 50%.

Earlier this year, we developed a virtual neovascular age-related macular degeneration (nAMD) pathway and implemented rapid virtual triage across all sites. This project improved cost and sustainability of the pathway, for which we won the Aylward QIPP (quality innovation productivity and prevention) award. This project kickstarts our exploration of the broader applicability of virtual triage for other urgent ophthalmic conditions

Partnership working

We engaged Servita to review our digital strategy, and their innovative approach was recognised with two HSJ sustainability awards in 2025, reinforcing the strength of our collaboration.

Digital transformation plan

Maximise the benefits of digital transformation within our clinical services to reduce emissions and improve patient care.	
Actions	**KPIs**

Develop OpenEyes software capabilities and fully implement our Electronic Patient Record (EPR) solution	• Digitalise 100% referral request forms, 40% A&E letters, 100% clinics and theatres by June 2026 • Improve staff access to digital tools and staff digital literacy (e.g. by May 2026 ensure all areas have access to the appropriate end user devices, complete digital literacy skills pilot and expand to all member of staff who need additional support by December 2025) • Move all appropriate patient to digital pre–op (number is in pre-op brief) avoiding appointments/travel and reducing paper
Reduce paper usage for clinical notes by introducing AI ambient voice transcription tool	• Complete ambient voice pilot and business case to expand to all areas of the trust by December 2025
Reduce print associated with patient information leaflets via the promotion of digital access methods	• Trial use of QR codes in patient information leaflets and patient letters by September 2025 • Roll out patient information QR codes across clinic screens. 50% by December 2025, 100% by September 2026
Digitalise patient consent forms	• Use Concentric to digitalise consent forms, with paper saving to be calculated
Continue to expand virtual patient pathways which reduce travel miles and the associated emissions for both patients and staff	• Increase remote working for clinicians – review clinicians' job plans/rotas and equipment so that clinicians can work from home or other sites ahead of our move to our new site • Expand the use of virtual pathways for all suitable pathways and patients, as part of our move to our new centre (Oriel) • Transition from face-to-face to online translation where clinically appropriate, taking into account inequalities, by 2028
Explore AI opportunities via our AI working group to streamline executive, operational, and clinical workflows to achieve sustainability gains	• Trial AI agents • Incorporate Smart Hospital technologies into new centre
Embed sustainability in digital services by using circular and low-carbon approaches to IT hardware management.	
Reduce the energy consumed by idle equipment through cultural and technical initiatives to promote proper switching off energy drains on devices not in use	• Identify education needs and approach around switching off computers

Build up energy using monitoring across the IT portfolio and work towards a joined-up whole system of real-time monitoring to enabled targeted efficiency and sustainability initiatives	• Replace City Road data centre and Ebenezer Street data centre with two state-of-the-art data centres • Take up energy improvements around shift to new data centres.
Provide digitally excluded patients with donated devices, reducing trust waste and CO2 emissions via reuse	• Consider scale of the potential in 2026 and agree next steps
Embed sustainability in IT Infrastructure, data management, and engagement with digital suppliers.	
Use low carbon hosting as move to digital transformation	• Replace City Road data centre and Ebenezer Street data centre with 2 state-of-the-art data centres
Promote good data hygiene via deduplication and archiving	• As part of MoorConnect, decommission a set of legacy systems and optimise data hygiene by June 2026
Reduce carbon emissions from discretionary changes including staff email signatures, green search engines and other initiatives	• Remove images from staff email signatures via MoorGreen promotion in 2026

4. Medicines

Our progress so far

Moorfields has successfully implemented key actions outlined in NHS England's green plan guidance on medicines. We eliminated desflurane from anaesthetic use in 2022, followed by the complete discontinuation of nitrous oxide in anaesthetic procedures at our City Road site in 2025. Furthermore, we transitioned surgical cryotherapy from nitrous oxide to carbon dioxide, which has a nearly 300 times lower global warming potential.

Recognising our progress against national benchmarks, Moorfields has proactively moved beyond standard NHS guidance to explore innovative and specialty-specific sustainability practices in ophthalmic medicine. Our continued focus is on reducing the environmental impact of treatments while maintaining the highest standards of patient care.

Moving from single use eye drops

The Moorfields medical retina service, with support from pharmacy and infection prevention and control, has led a pioneering sustainability project with the potential to significantly reduce the carbon footprint and plastic waste associated with eye care via eye drops.

Single-use eye-drop formulations, while convenient and sterile, generate substantial amounts of plastic waste and carbon emissions. As part of a green initiative, the medical retina service, with support from pharmacy, launched a project to trial the use of multi-use eye-drop bottles, following approval from the infection prevention and control team.

The three-week pilot involved transitioning 953 patients from single-use minims to multi-use bottles, alongside comprehensive training for technicians and nurses on proper handling and administration techniques. The results were promising and once implemented across all medical retina satellite sites, this is projected to result in the avoidance of 67.6 kg of plastic waste, 141.89 kg CO_2e, and savings of £86,953.93 annually.

Given that ophthalmology is the busiest outpatient specialty in the UK, even modest changes like this can yield major environmental and financial benefits. Our specialty doctor in medical retina shared the success of the project in an online presentation at the 2025 London Greener Celebration event series.

Recycling pharmacy waste

In 2025, our A&E nursing team worked with our pharmacy team to re-label and return mislabelled stock deposited in a designated box. The team also set up a designated box in A&E for staff to return mislabelled medication. As proof of concept, the pharmacy team relabelled and returned stock to A&E, helping to reduce both waste and cost. The pharmacy team is currently collecting mislabelled medications twice a week as part of business as usual.

Medicines plan

Reduce waste from medication	
Action	**KPI(s)**
Reduce plastic waste by transitioning to multidose eyedrops	• Complete roll out of Tropicamide multidose eyedrops across medical retina by end of 2026. Potential to save 67.6 kg of plastic waste, 141.89 kg CO_2e annually • Aspire to promote multiuse eyedrops outside of medical retina specialty (e.g. Latanoprost use by patients in the community during 2026 (estimated potential to save up to 21,087 kgCO2e per year)
Reduce waste and costs, and improve patient safety by relabelling and returning stock	• Continue collecting and returning mislabelled medications from A&E twice a week
Build on work done to date to rationalise procedure packs to inform general use of clinical consumables	• Review high-use packs by 2028 – as an example, review of retinal therapy unit injection packs
Reduce drug wastage during high seasonal temperatures by	• Revise standard operating procedures (SOPs)
Reduce plastic waste by recycling eyedrop bottles	• National initiatives in this area to be considered for Moorfields

5. Travel and transport

Our progress so far

A Moorfields representative attends the quarterly travel and transport meetings organised by the North Central London ICB. This forum, which is attended by representatives from trusts across the ICB, ensures coordination of travel and transport initiatives and provides opportunities to jointly address challenges, exchange ideas and share experiences.

Staff travel survey and launch of vehicle lease scheme

The trust conducted a staff travel survey in 2023 which highlighted the following:

- Most respondents to the survey (69%) were based at our City Road site or attend that site on a regular basis, however, responses included staff from nearly all our 22 sites. A third of respondents lived outside Greater London.
- The survey showed that the majority (73%) of Moorfields staff usually travel to work using public transport. Up to 8% of respondents indicated that they use a bike to commute, but bike use was sporadic for some of these; and up to 11% of staff include a walk in their commute. Staff indicated they would be interested in active travel options if safer routes, better facilities (e.g. more showers) and cycle training would be available.
- Most staff commute for less than an hour to get to work (63%) but 13% of respondents travel more than 90 minutes each way. The median distance travelled was 16 miles per day (when working on site).

As a London trust, we focus on active travel and public transport and the trust already has a number of initiatives to encourage staff to travel to work sustainably, including a Cycle to Work scheme; season ticket loan scheme; our staff bike user group, EyeBike; and a car lease scheme for hybrid and electric vehicles only. Based on the survey results, the trust will continue to promote active and sustainable travel to staff.

In 2024, we implemented a vehicle sacrifice scheme for hybrid and electric vehicles. Nine members of staff have engaged with the scheme since the launch. As a London trust, we focus on active travel and public transport.

Cycle focus

Through our Cycle to Work Scheme, staff can save up to 42% on bikes and bike accessories via salary sacrifice and can participate in prize draws for cycling equipment. There have been 117 orders since the scheme was set up in 2017. The scheme is managed by our Health and Wellbeing team and administered by our external employee benefits provider, Vivup.

EyeBike successfully lobbied to increase the Cycle to Work spending cap from £2.5K to £10K per year, which has made the scheme more accessible and inclusive. For example, if staff live further away, they are able to purchase high quality electric bikes. Likewise, for our staff with disabilities or health conditions, adapted/bespoke bicycles (which can be very expensive) have become more accessible.

Create a sustainable travel plan focusing on active travel, public transport and zero-emission vehicles, supported by a clear understanding of staff commuting	
Action	**KPI(s)**
Collect staff travel data to inform the development of our sustainable travel plan	• Review previous survey and consider amending and re-issuing in 2025/2026
Publish our sustainable travel plan for all MEH sites including our new centre in Camden	• Incorporate into annex of green plan by December 2026 • Refresh and re-submit Oriel-specific travel plan to Camden Council by December 2026 • Include a 'travel hierarchy' infographic to help staff make sustainable decisions about their commuting practices
Develop a communication plan for our staff cycling network to increase membership and participation	
Promote council-run cycle maintenance and repair sessions through our EyeBike network and social cycling events	• Include dates for upcoming sessions in each EyeBike newsletter • Signpost London cycling events with a focus on health and Islington / Camden - e.g. London Cycling Campaign published on EyeBike intranet page in 2026
Publicise EyeBike's digital presence	• Socialise Eye Bike Teams channel through newsletter monthly
Increase EyeBike membership	• Membership increase by end of 2026 and annually thereafter to reach 10% total of staff
Consider opportunities to encourage use of electric vehicles	
Continue to promote recently launched vehicle salary sacrifice scheme to increase uptake and promote focus on electric vehicles	• Consider phasing out hybrid cars in vehicle sacrifice scheme / transition to EV only within the span of the green plan timeline
Patient transport	• Explore initiatives to reduce use of patient transport via virtual appointments and better use of electric vehicles in transport
Courier transport	• Engage with DHL to influence electric car policies, who are actively working on replacing all of their vehicles

6. Estates and facilities

Our progress so far

Moorfields continues to lead on environmental performance, with its use of technology-driven air monitoring across its surgical operating suite at City Road. An example of progress since the last green plan is the ability to measure and monitor air change rates continuously, allowing us to be flexible with our fan speeds. By switching them to lower speeds or off completely when it is safe to do, we are saving as much energy as possible.

As part of our future-facing digital strategy aimed at creating a SMART building, we have partnered with BYUK to deliver our new centre in Camden, integrating sustainability from the outset. The new facility, aiming for BREEAM (Building Research Establishment Environmental Assessment Method) excellence, is fossil fuel free and harnesses renewables through photo-voltaic panels and ground and air source heat pumps.

Since the last green plan, we have instigated utilities monitoring with real time energy reporting at our City Road site. When moving to our new facility, we will align with a smart work ordering system which ensures prompt action should any parameters be detected as outside of the commissioned values.

At our City Road site, which is scheduled for decommissioning within the next two years, we have adopted a high scrutiny approach to further infrastructure investment. Given diminishing returns, such as a £75 annual saving from installing LED lighting at 15p per kilowatt-hour, any upgrades are evaluated through a cost-benefit lens aligned with long-term value and carbon savings.

Alongside our focus on the sustainable development of our new facility we have made significant improvements at our current sites:

- 80% of all lighting fittings at City Road have already transitioned to LED.
- At Brent Cross, Hoxton, and Stratford, LED installations reached 100% coverage within the last three to four years.
- These upgrades form part of our wider energy efficiency and renewable energy plan, designed to deliver long-term reductions in energy consumption and emissions.

At our Stratford site, we removed the fossil fuel boilers and replaced with air source heat pumps and solar systems alongside electric based cooling systems.

In support of cleaner energy sourcing, Moorfields purchases electricity through the Renewable Energy Guarantees of Origin (REGO) scheme, ensuring our supply chain aligns with national net-zero commitments.

Our waste streams are a target for continuous improvement, and at present we are achieving the highest recycling rate within the North Central London Integrated Care System (NCL ICS) at over 85% for offensive waste and 75%-80% for domestic recycling.

In 2025, we also began working with CollectEco, an organisation that redistributes surplus, high-quality office furniture and equipment to avoid waste. Through this partnership, we sourced

refurbished furnishings across the trust, reducing environmental impact while supporting circular economy principles.

City Road's environmental achievements were also quantified through its SmartCarbon rating of 23.24, a clear benchmark demonstrating our energy performance relative to sector peers.

Improve energy efficiency of buildings	
Action	**KPI(s)**
Maintain utilities dashboard	• Ongoing monitoring of utilities usage at part of main site with focus on efficiencies and sustainability
Improve energy efficiency of current main site	• For occasional replacement of bulbs, opt for LED at City Road until our move in 2027
With the new Camden site achieve BREEAM (Building Research Establishment Environmental Assessment Method) Excellence Status indicating improved environmental impact of Moorfields estate	• Receive BREEAM certificate of 80% or above and submit to local authority by end of construction stage (March 2027)
Maximise the environmental benefits of our new site	• For example, install windows with high performance glazing and shading to reduce heat transfer whilst allowing good light transmittance and appropriate levels of winter heat gain by 2027
Develop a heat carbonisation plan to replace fossil fuel heating systems with lower carbon alternatives	
Identify and prioritise the phasing out of all existing fossil-fuel primary heating systems by 2032 and seek to remove all oil primary heating systems by 2028	• Replace all fossil fuel systems with either ground-source heat-pumps or air-source heat-pumps, or refrigerant as we have done in our new renovation at Stratford • For any new site that we take over to provide services in (rather than being hosted) ensure heating systems are fossil-fuel free where we can • For Hoxton and Brent Cross which are leased sites with gas boilers, explore opportunities to influence owners to replace with lower carbon alternatives
Consider Local Area Energy Plans and opportunities from heat networks and other low-carbon solutions	• Our new building has pre-installed connection points to future-proof the heating/cooling network options
Identify any installations in scope of the UK Emissions Trading Scheme and outline plans to reduce emissions in line with allocated targets	• Identify relevant KPIs and measurement approach
Invest in on- or near-site renewable energy generation to meet NHS energy demand	

By moving to the new site, we will have renewable energy e.g. solar panels on the roof	• Approximately 300 panels providing 10% of the total maximum load
Explore opportunities in entering PPAs (Private Power Agreements) to get access to renewable energy	• Incorporate either a PPA or fixed futures pricing in Energy Efficiency and Renewable Energy plan for 2027
Develop business cases for estates and facilities sustainability initiatives	
Develop business cases to deliver the measures outlined in the heat decarbonisation plan	• Any new property refurbishments will include measures for decarbonisation.
Develop business cases to deliver energy efficiency interventions	• Based on energy monitoring – cases will be prioritised against returns on investment
Develop business cases to deliver renewable energy interventions	• Via the business case review group, deputy director of estates and facilities will review for possible renewable energy schemes
Submit funding application through the PSDS (Private Sector Decarbonisation Scheme) if projects cannot be financed through internal budgets	• Where applicable this will be one route for funding.
Ensure all applicable new building and major refurbishment projects are compliant with the NHS Net Zero Building Standard	• Achieve carbon savings of 383.7tCO2 annually, which is 27% of site regulated carbon emissions of 1401 tCO2/year. This will be tested at PC, when the As Built Asset is tested by the energy consultant
Reduce waste by improving on-site waste segregation	
Transition from single-use products to reusables	• Through clinical and infection control working groups – products will be tested for suitability.
Continue roll out of green recycling bins	• Install in theatres by October 2025
Transition to reusable sharps bins	• Project is in trial stage, with evaluation and next steps agreed in late 2025
Introduce food waste stream	• Food waste steam implemented by 2025
Engage in waste education / communication to patients and staff	• Signage to be fully reviewed and a business case produced by October 2025
Waste initiatives at new Camden centre	• Listed as: Bryson PPE Recycling Scheme, Protec Closed Loop Scheme, Pallet Loop initiative

7. Supply chain and procurement

Our progress so far

At Moorfields, we recognise that the supply chain is a critical lever in advancing sustainability and driving meaningful environmental change. Our approach is focused on ethical procurement, operational efficiency, and a shift towards circularity within clinical practices.

Embedding social value

We have started to use the social value portal, hosted via Guy's and St. Thomas' NHS Foundation Trust, as a platform to ensure sustainability and community benefits are integrated into procurement processes. Senior members of staff have completed training on the portal, enabling consistent application in decision-making.

Through this portal, we have already contracted tenders across soft facilities management, including our soft services and sterile services contracts. These arrangements embed measurable social and environmental outcomes, supporting local employment, reducing carbon, and improving waste practices.

Inventory management and waste reduction

To strengthen operational efficiency, we have implemented the Genesis Inventory Management System across all nine surgical sites within the trust. This system allows real-time tracking and analysis of consumables used in theatre, offering enhanced visibility and control. With improved forecasting and stock control, Genesis supports a significant reduction in clinical waste and over-ordering – aligning with both sustainability goals and financial stewardship.

Transitioning to reusable clinical products

We are making tangible progress in transitioning away from single-use consumables across multiple clinical areas. Notably, at our City Road site, we have phased out the use of disposable cryoprobes and phacospeculums, replacing them with reusable alternatives. These changes not only reduce environmental impact but also enhance long-term cost effectiveness.

Through ongoing collaboration with suppliers and internal teams, Moorfields remains committed to expanding reusable options trust-wide and standardising best practices where clinically appropriate.

Embed NHS net-zero supplier roadmap requirements into all relevant procurements	
Action	**KPI(s)**
Apply the social value model to all regulated procurement activity, with clear scoring and reporting expectations. Ensure the requirement for carbon reduction plans is embedded in specifications, evaluations, and contracts	• Develop boilerplate line of questioning for tender panel and upload – date to be set • Begin regular reporting on sustainable procurement performance through the procurement board and green plan leads – date to be set • Finalise internal procurement sustainability guidance and scoring templates – date to be set

Engage with key suppliers to align sustainability priorities and seek joint improvement opportunities	
Encourage suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment and improve visibility of supply chain impacts, including packaging, logistics, delivery models and stockholding	• Evergreen guidance sent to 100% suppliers in 2026 • Confirmation requested from suppliers that they are engaging with Evergreen
Ensure inclusivity by increasing participation from SMEs, VCSE, and local suppliers	
Ensure the requirement for net-zero and social value submissions is clearly set out for smaller suppliers who may have less resource to complete a tender process.	• Ensure the social value requirement set is proportionate, linked to the subject matter of the contract, and specific to the contract delivery. • Engage in pre-market consultation to ensure smaller suppliers fully understand both the process and requirement
Reduce reliance on single-use products	
Transition from single-use consumable products to reusable versions in clinical areas	• Reduction in procurement of single-use consumables – target to be set in business planning for 26/27
Explore sustainability opportunities highlighted through our inventory management system	
Continue to review and reduce expiring and expired stock, stock surpluses, and stock wastage	• Train finance team to use Genesis cost analysis portal so that they can drive spending decisions informed by wastage data by the end of 2025 • Continue to review stock and set reduction targets monthly • Reduce overstocking of assets by expanding barcode system – date to be set
Reduce deliveries where possible through smarter stock control and consolidated ordering	• Reduction in mileage by optimised delivery logistics

8. Food and nutrition

Our progress so far

As a predominantly outpatient and day-case provider, Moorfields does not operate a large-scale patient catering programme. We do, however, provide meals for the eight inpatient beds on site, ensuring patients receive appropriate nutrition during their stay.

Our on-site restaurant, available to both patients and staff, is managed by our soft services partner Medirest, who actively champion sustainability through a variety of initiatives. These include:

- Installing reusable cups at our water fountains to reduce single-use plastics
- Promoting health and wellbeing with recipe leaflets curated by their in-house dietitians
- Offering a 25p discount to customers who bring their own reusable cups for hot drinks

Medirest has also formed partnerships with food waste organisations to further minimise environmental impact including:

- Olio, which redistributes surplus food to people in need, including those experiencing homelessness
- TooGoodToGo, a platform that sells unsold food at reduced prices to prevent waste
- Lifecycle Oils, which turns cooking oil into sustainable biofuel
- Additional services to responsibly recycle animal fluid waste

In 2025, Moorfields began working with the non-profit organisation Greener by Default, with plans to launch a 12-week behavioural science pilot aimed at encouraging healthier and more environmentally sustainable food choices among diners.

Food and nutrition plan

Measure and reduce food waste	
Action	**KPI(s)**
Measure food waste	• Continue submitting Estates Returns Information Collection (ERIC) data annually
Set food waste reduction targets	• Education campaign as part of contract management • Proposed 10% reduction in year 1, 10% year on year for consideration
Introduce food waste recycling stream	• Food waste bins installed in catering and dining areas from July 2025 • Consider food waste segregation downstream in next iteration of contract

Consider opportunities to make menus healthier and lower carbon by supporting the provision of seasonal menus high in fruits and vegetables and low in heavily processed foods	
Action	**KPI**
Conduct a pilot with non-profit greener by default to create a choice architecture that nudges diners towards more sustainable food choices using behavioural science	• Pilot to be set up during 25/26
Communicate with patients to pre-empt flexibility in dietary requirements	• As required in ward settings and for consideration in 25/26
Educate patients and staff on the link between nutrition, sustainability, and healthcare	
Provide tips for sustainable eating after discharge	• Consider how we can incorporate into patient information

9. Adaptation

Our progress so far

Moorfields recognises that the impacts of climate change – ranging from extreme heat and flooding to infrastructure disruption – pose increasing risks to patient safety and service continuity. To ensure resilience in the face of these challenges, we have integrated climate adaptation into our wider emergency preparedness programme.

Our adverse weather plan is reviewed regularly and informed by national guidance, with updates from the UK Health Security Agency (UKHSA). It forms part of the emergency preparedness, resilience and response (EPRR) training programme, where real-world exercises are used to identify improvement opportunities. Any lessons learned are captured and fed into the EPRR steering group – reinforcing a cycle of continual adaptation and readiness.

We maintain a dedicated EPRR risk register, based on the national risk register, which specifically includes climate-related risks. This ensures that environmental threats – such as heatwaves and service disruptions linked to extreme weather – are considered in our planning, mitigation, and response protocols.

For the past two years, Moorfields has been fully compliant with all core standards for emergency preparedness, as set out by NHS England. In 2024, we also met all 11 deep-dive standards on cybersecurity and IT response – demonstrating our operational resilience in a digitally reliant era.

By embedding climate risks within our emergency governance, and aligning with national frameworks, Moorfields is strengthening its ability to operate safely and effectively under changing environmental conditions. This is a critical component of our wider sustainability ambition – supporting patient care, protecting staff, and future-proofing our specialist services.

Adaptation plan

Comply with the NHS adaptation provision to support business continuity	
Action	**KPI(s)**
Comply with NHS core standards for 2025, 2026, 2027	• Report to the board on the EPRR assurance and an action plan on any partially compliant standards
Action any relevant operational updates from the LHRP subgroup - greener EPRR (these updates come via regional colleagues at NHS London	• Deliver updates to the EPRR steering group should any actions from the greener EPRR group be relevant to Moorfields
Engage with local networks	• Continue sending a representative to the local borough resilience forums
Set out actions to prepare for severe weather events and improve climate resilience of local sites and services.	
Review and update current business continuity exercises embedding climate-related or adverse weather scenarios (heatwave, flooding, power outage, etc)	• Business continuity audit document is reviewed at each EPRR steering group to ensure all departments are compliant with their business continuity plans • Publish reviewed business continuity plans by 2026 • Review and upload by 2027 • Embed climate considerations by 2028
Develop a new business continuity exercise specifically for digital services using a climate-related scenario	• Consider during next round of business continuity plan updates (Jan- March 2026) • Exercise developed and successfully held – date to be confirmed
Review adverse weather plan regularly as part of the EPRR plans and policies cycle	• Update and sign off adverse weather plan with recently completed heatwave learning set by August 2025 • Continue to update when new national advice is available or aspects change within the trust
Factor in the effects of climate change when making infrastructure decisions and designing new facilities	
Include enhancements like improved green spaces, drainage systems and passive cooling solutions.	• This forms part of all new business cases for refurbishments of facilities. For example, any new cooling systems are designed to cater for outside air temperatures of 38 degrees celcius.

Ensure adequate cascading of weather health alerts and relevant messaging across the organisation	
Provide updates on health alerts in order to plan appropriately and look for sustainability benefits	• Continue posting all government weather health alerts on Moorfields account and our intranet, EyeQ