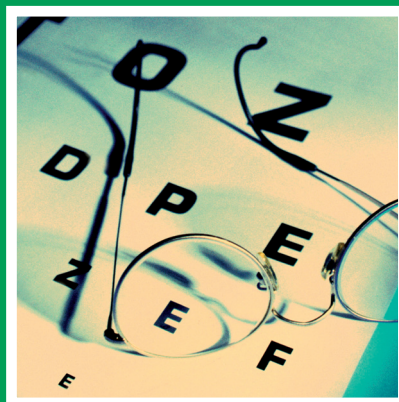
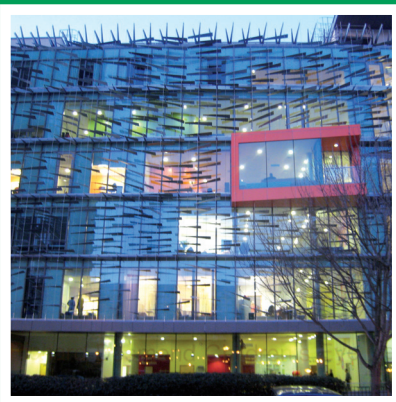


# Annual report and accounts 2007/08



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Presented to Parliament pursuant to Schedule 7, paragraph 25(4)  
of the National Health Service Act 2006.

# **Moorfields Eye Hospital NHS Foundation Trust**

**Annual Report and Accounts 2007/08**

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# Chairman's introduction

It gives me great pleasure to introduce the 2007/08 annual report and accounts for Moorfields Eye Hospital NHS Foundation Trust.

I have been in post as chairman for only a short time, but already, I have been greatly impressed with the calibre of staff I have met throughout the Trust. Their commitment to continuing to improve the world-class service we provide to our patients is apparent, and puts us in a good position to build on our current successes and rise to future challenges.

The year has seen many successes. Patient activity increased in most categories and we achieved the interim milestones against the national target to treat all patients within 18 weeks of referral. We also opened a further outreach centre in Bedford, enabling more people to access services provided by our expert clinicians.

On the research front, we were delighted at the positive findings from our clinical trials to test a revolutionary gene therapy treatment for a type of inherited blindness. Financially, we performed satisfactorily, recording an underlying surplus of just over £2 million, which can be reinvested to improve the services we offer our patients.


We also maintained our excellent record in avoiding MRSA and completed a deep clean of our facilities. Furthermore, our commercial activities enjoyed a successful year, with healthy income growth being achieved by Moorfields Pharmaceuticals and Moorfields Private, and the opening of our new facility in Dubai.

At the same time, the year has not been without its challenges. There remains much to be done to improve our performance against cancer waiting time targets and our systems for booking patients in for treatment. We also need to press on with the much-needed refurbishment of our estate and to continue to develop our existing model of care as a specialist hospital with integrated teaching and research facilities, in conjunction with our academic partners.

This has also been a year of change in our personnel, with several departures from the board and many new faces. I would like in particular to pay tribute to Sir Thomas Boyd-Carpenter, who chaired Moorfields so ably for seven years and guided us through the transition to becoming one of the country's first foundation trusts, and to our former chief executive, Ian Balmer, who moved on in March 2008 after 15 years at the helm. I would also like to extend my thanks to former colleagues Maggie Van Reenen, Sarah Watson-Fisher and Ian Knott for their many and various contributions to Moorfields over several years. On behalf of the board, I wish them all every success in the next phases of their lives.

In their places, I am delighted to welcome our new chief executive, John Pelly, who joined us in April 2008. John is a highly experienced NHS professional with nearly 18 years' experience in health care. He joins us from the Queen Elizabeth Hospital NHS Trust in Woolwich, where he was chief executive. Prior to that, he had held positions as the chief operating officer and the director of finance at Guy's and St Thomas' before it became an NHS foundation trust. I am confident that John's experience will provide us with expert leadership as we go forward.

John is joined by Mark Cubbon, who started work at Moorfields in September 2007 as our new chief operating and nursing officer, and by Ian Hollows, our executive finance director, who was previously a non-executive director with us. Furthermore, we welcome several new non-executives to the board: Deborah Harris, Sir Roger Jackling, Andrew Nebel and Lesley Potter. Together with our foundation trust governors, they provide a wealth of wisdom and experience, which sets us in good stead for the future.

A handwritten signature in black ink, appearing to read 'Rudy Markham', written over a light grey rectangular background.

**Rudy Markham**  
**Chairman**

# Directors' report

## (incorporating the operating and financial review)

### History and background to Moorfields Eye Hospital

Moorfields was founded in 1804 and is the oldest and one of the largest centres for ophthalmic treatment, teaching and research in the world. More patients come to Moorfields than to any other eye hospital or clinic in the UK because of our world-famous reputation, based on the expertise of our clinical staff and the cutting-edge research that takes place on the site.

Moorfields Eye Hospital became an NHS trust in April 1994 and was then one of the first hospitals to be authorised as an NHS foundation trust in April 2004.

Our mission statement is:

- To be the leading international centre for excellence in the care and treatment of eye disease and to be at the forefront of research and teaching in the field
- To provide a flexible and responsive service guided by patient needs

### Moorfields' principal activities

The main focus of our activities is the treatment and care of NHS patients with a wide range of eye problems, from common complaints to rare conditions, which require treatment that is not available anywhere else in the UK. We provide these services from our main hospital base in City Road, London as well as at 11 other sites in and around London.

Moorfields is also a postgraduate teaching centre and a national centre for ophthalmic research involving, with the UCL Institute of Ophthalmology, the largest ophthalmic research programme in the world.

We also directly manage three commercial businesses: Moorfields Private, Moorfields Pharmaceuticals and Moorfields Eye Hospital Dubai.

### How we performed in 2007/08

Moorfields' performance in 2007/08 was mixed – we saw a record number of patients in the year and delivered a strong financial performance, but failed to meet a small number of national performance targets.

#### Patient activity

Almost all categories of patient activity were higher than in 2006/07, as the table opposite shows.

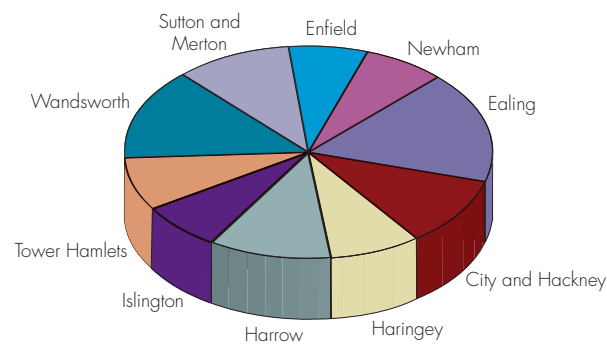
Ten London primary care trusts (PCTs) account for almost 50% of the total NHS contracted activity, with the largest contracts held with Ealing, City and Hackney, Harrow and Wandsworth PCTs. The Trust has contracts with approximately 70 PCTs from across the country and also receives referrals for non-contracted activity.

Trust activity increased quite significantly during 2007/08, reflecting the changes to services at other providers, particularly for ophthalmic A&E, and the drive to achieve the milestones for the 18-week referral to treatment targets by March 2008.

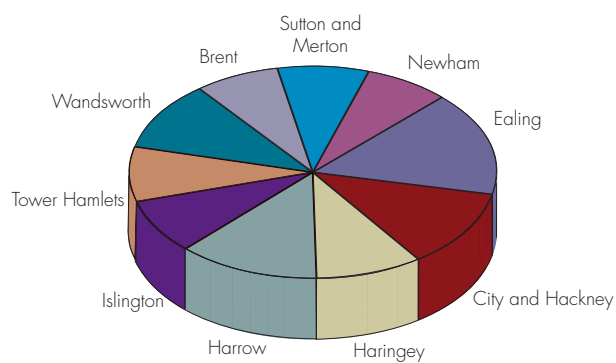
## Patient activity 2007/08

Activity	2007/08	2006/07	Change
First outpatient attendances	74,824	70,971	+ 5.4%
Total outpatient attendances	257,576	255,163	+ 0.9%
A&E attendances	59,629	54,177	+ 10.1%
Admissions	24,962	23,381	+ 6.8%
Lasers	7,421	7,520	- 1.3%

### First outpatient attendances - breakdown between 10 PCTs with greatest activity



### Total admissions - breakdown between 10 PCTs with greatest activity



## National targets

Performance against the key national performance targets relevant to the Trust was mixed, as summarised in the table below.

Indicator	Measure	Target	Trust position 2007/08	
All cancers – two-week wait	Proportion of patients seen within two weeks of urgent GP referral for suspected cancer to first outpatient appointment	98%	N/A**	
All cancers – one month diagnosis to treatment	Proportion of patients treated within one month of diagnosis	98%	N/A**	
All cancers – two-month urgent GP referral to treatment	Proportion of patients treated within two months of urgent GP referral	95%	N/A**	
Cancelled operations	Proportion of elective admissions cancelled on the day of, or after admission for non-clinical reasons	<5%	1.1%	
Cancelled operations not admitted within 28 days	Proportion of elective admissions cancelled on the day of, or after, admission for non-clinical reasons, where the patient is not offered another date within 28 days	0%	4.4%	
Convenience and choice – provider information	Evidence of processes in place to ensure that nhs.net page kept up to date throughout the year	Yes	Yes	
Convenience and choice – slot availability	Number of services and bookings which were directly bookable and for which there were no slot issues	TBD*	TBD* (pilot since November 07)	
Inpatients or day cases waiting longer than the standard	Number of patients waiting longer than 26 weeks for an elective admission	<10	6	
Outpatients waiting longer than standard	Number of patients waiting longer than 13 weeks for a first outpatient admission following GP referral	<13	12	
Total time in A&E – four hours or less	Proportion of patients waiting four hours or less in A&E from arrival to admission, transfer or discharge	98%	98.6%	

Indicator	Measure	Target	Trust position 2007/08	
Access to genito-urinary medicine (GUM) clinics	Proportion of patients waiting less than 48 hours for an appointment	100%	N/A**	
Clostridium difficile data quality	Timely C diff data submissions, proportion of cases with valid NHS number and setting of local targets	Fully compliant	Fully compliant	
Data quality on ethnic group	Proportion of patient admissions for whom a valid 2001 census code for ethnic category is recorded	90%	92%	
Drug misusers – information screening and referral	Provision of posters, leaflets and other information and appropriate screening and referral arrangements for drug misusers	Fully compliant	50% compliant	
MRSA bacteraemia	To achieve the target trajectory reduction in the number of incidents of MRSA bacteraemia	0	0	
18-week wait milestone – admitted patients	Proportion of admitted patients starting treatment within 18 weeks	85%	86.6%	
18-week wait milestone – non-admitted patients	Proportion of non-admitted patients starting treatment within 18 weeks	90%	95.5%	
Waiting times for diagnostic tests	Proportion of patients waiting more than six weeks for certain diagnostic tests	0%	0%	
Obesity – compliance with NICE guidance	Existence of plans to develop policies to prevent and manage obesity in the workforce in line with NICE guideline 43	Yes	No	
Self harm – compliance with NICE guidance	Compliance with NICE guideline 16 on prevention and management of patients at risk of self harm	Yes	No	

\* Information not yet available

\*\* Trust unable to provide information

We were particularly pleased with our performance on the key national priorities of 18 weeks, A&E four-hour waits and numbers of MRSA bacteraemia. However, we were unable to comply with the cancer waiting time targets or the genito-urinary medicine (GUM) access target, and have not yet fully complied with NICE guidance on obesity and self-harm.

As far as the cancer targets are concerned, recognising that we would be unable to ensure compliance for our specialist ocular oncology service, we negotiated a transfer of this service to Barts and The London NHS Trust with effect from December 2007. This transfer would have left us with a number of breaches during the first eight months of the year. However, the situation was made worse when it became clear that we were not recording and tracking a significant number of other patients with actual or suspected cancer. No patient treatment delays are believed to have resulted from these failings, and a programme of work has been put in place to rectify the problems such that we do not expect any further breaches of the cancer targets in 2008/09.

We also have a very small GUM service, which we are unable to organise to ensure compliance with the 48-hour access target. This recognition led us to agree the transfer of the service, also to Barts and The London NHS Trust, although certain difficulties prevented the transfer from taking place during 2007/08. We now hope to effect the transfer by the end of the first quarter of 2008/09.

Although we reduced significantly the number of breaches of the outpatient waiting time standard in 2007/08, there remained a concern during the year that the underlying booking processes were vulnerable to failures, and a major external review of these was therefore commissioned. This has resulted in an ambitious improvement project which is expected to be completed by October 2008.

We are disappointed that these failings are likely to result in a further rating of 'weak' for the quality of our services when the Healthcare Commission publishes its annual healthcheck in October 2008, but we have put in place plans to improve significantly our performance on these targets in 2008/09.

### **Standards for Better Health**

We improved significantly our compliance with the core standards within the Department of Health's Standards for Better Health, achieving compliance with all four standards for which in 2006/07 we assessed ourselves as being non-compliant. For 2007/08 we have, however, assessed ourselves as having insufficient assurance in relation to two other standards, both concerned with the management of medical devices. This was because, although there was no evidence to suggest non-compliance with these standards, the Trust's governance committee did not have available to it the documentation it needed to assure itself of compliance. Our Standards for Better Health declaration can be found on our website at [www.moorfields.nhs.uk](http://www.moorfields.nhs.uk) in the publications and resources section.

## **Moorfields Pharmaceuticals**

Moorfields Pharmaceuticals specialises in the manufacture and supply of ophthalmic unlicensed medicines known as 'specials'. With a range of more than 110 products, many offering preservative-free formulations, Moorfields Pharmaceuticals has become a strong player in the ophthalmology market, with products supplied to a wide range of customers across the UK and Ireland.

Sales income at £5.79 million, including third party sales of £5.09 million, for 2007/08 represents a year-on-year increase of 43.6%. Sales growth has developed through increased penetration into the UK market and the development of stronger promotional activities, including PR, advertising, an updated web site and exhibiting at relevant exhibitions and conferences. Several contracts to manufacture products for other companies were also secured during the year.

In the past 12 months, a project to improve our product packaging was completed, giving the products a more professional appearance, clearer instructions and clearer product name and strength identification. The design also developed the Moorfields colour-coding system, with each product group carrying a unique colour to aid dispensing and ease of use for patients. In addition, bar codes were added to all products to aid logistics and enable customers to incorporate them into their electronic stock control systems.

The production facility is monitored by the Medicines and Healthcare Products

Regulatory Agency (MHRA) and during the year we had a successful audit by their inspectors. SGS UK Ltd, a notified body, also conducted a successful audit, which enables a Moorfields-developed product (HPMC) to be marketed as a CE-marked medical device. The HPMC 2% product is used in cataract surgery and the CE mark will enable us to make it available widely across the UK.

Developing the organisation to ensure customers and patients receive the best possible service continues to be a key priority for Moorfields Pharmaceuticals. Improvements in operating systems and the development and training of staff are an ongoing feature of the organisation.

## **Moorfields Private**

Moorfields Private is located on, and adjacent to, the City Road site and also has facilities in Wimpole Street. We enjoyed another successful year in 2007/08, exceeding our financial targets by £0.27 million and receiving positive patient satisfaction feedback. Total inpatient and day-case admissions increased by 5% and we undertook more than 4,000 laser refractive procedures.

During the year, Serco Associates were commissioned to undertake a detailed analysis of the current and predicted future trends of the private market and this will be used to develop the unit's plans for the future.

Plans to develop a refractive suite for private patients are now well underway, and building work has commenced on the 4th floor of Moorfields' City Road site. The new suite will include a day-case club

lounge, an intra-vitreous injection suite, and accommodation for two laser machines. The project will take 32 weeks to complete and will provide significantly enhanced facilities for patients, including the re-provision of hostel facilities for NHS patients.

### **Moorfields Eye Hospital Dubai**

Moorfields Eye Hospital Dubai (MEHD) is part of a large medical complex in the heart of Dubai known as Dubai Healthcare City. It currently employs 28 staff, including three consultants who specialise in retinal, corneal and ophthalmic diseases. It hosts a well appointed outpatient department, three fully equipped operating theatres and a laser in situ keratomileusis (LASIK) suite for refractive surgery.

MEHD began seeing and treating patients in July 2007, some three months later than planned. Patient volumes have

grown steadily since then, with 1,860 outpatients, almost 100 operations and 23 LASIK treatments having been undertaken to March 2008. Activity is expected to continue to grow progressively during 2008/09, although it is unlikely that surgical activity levels will reach the levels forecast in the business plan for a considerable time to come.

MEHD earned income of £0.54 million in 2007/08, incurred costs of £2.11 million and posted a loss of £1.57 million. This was £0.34 million worse than plan, a creditable result in view of the delayed start and slower build-up of surgical activity than expected.

Moorfields' board of directors remains committed to supporting MEHD towards profitability. In addition to growing MEHD's core business, other opportunities to develop the business exist, including managing the academic department of

All figures in £million	2007/08		
	Plan	Actual	Variance
<b>Income</b>			
Clinical income -			
• NHS	65.11	65.97	0.86
• Private patients	10.76	9.04	(1.72)
• Moorfield Pharmaceuticals	5.11	5.01	(0.10)
Non-clinical income	16.10	16.60	0.5
<b>Total income</b>	<b>97.08</b>	<b>96.62</b>	<b>(0.47)</b>
<b>Expenditure</b>			
Pay costs	59.59	58.39	1.20
Non-pay costs	30.85	29.71	1.14
<b>Total expenditure</b>	<b>90.44</b>	<b>88.10</b>	<b>2.35</b>
<b>Earnings before interest, tax, depreciation and amortisation</b>	<b>6.64</b>	<b>8.52</b>	<b>1.88</b>
<b>Net surplus</b>	<b>0.37</b>	<b>2.24</b>	<b>1.87</b>

ophthalmology in the new university hospital being built on the site, and expanding MEHD's small presence within the Imperial College London Diabetes Centre in Abu Dhabi.

### **Financial report**

A surplus of £2.24 million was generated for 2007/08, a significant advance on plan. The size of the surplus enabled the Trust to remain at a strong financial risk rating of four with our regulator, Monitor, throughout the year. The table below presents a high-level comparison between the plan and actual performance for the year.

### **NHS clinical income**

An over-performance of 1.3% (£0.86 million) in NHS clinical income is reported for the year, mainly due to the opening of the Trust's first outreach site outside of London, in Bedford. This generated additional income of £1.7 million, partially off-setting a shortfall centred around lower than expected growth in outpatient activity of £0.93 million, with a further £0.36 million attributed to the transfer of the ocular oncology service. A&E activity continued to grow, with income over-achieving by 13% (£0.5 million) against plan.

### **Income from private patients**

Private patients now include income from Moorfields Eye Hospital Dubai (MEHD), which opened in July 2007. Private patient income was £1.72 million down on plan, with MEHD reporting negative performance of £1.99 million.

There were two significant reasons for this shortfall at MEHD:

- The delayed opening of the facility from April until July 2007 – this three-month delay also resulted in the facility opening at a seasonally quiet time of year
- Anticipated patient activity converting from outpatient to surgical activity being much lower than anticipated

Through containment of costs, however, the result for the year of MEHD was only an adverse £0.34 million against plan.

The results at the core UK private patient unit were encouraging. The plan was exceeded by £0.27 million, with strong inpatient and LASIK eye surgery results being recorded.

### **Moorfields Pharmaceuticals**

Moorfields Pharmaceuticals, the Trust's trading arm for the manufacture of pharmaceutical products, enjoyed rapid growth through the year and narrowly missed achieving plan by 2% (£0.1 million) on the back of strong promotional and marketing activity. Sales were £1.7 million higher than the prior year, and the unit remains primed for further growth.

**Other income**

Other income, representing 17.2% of total income, is analysed in the table below.

Other income areas were in line with expectations, with the exception of £0.55 million of unplanned funding in relation to the payment of high-cost area pay supplements by the Trust's host commissioner.

**Pay costs**

Pay was underspent against plan by £1.2 million, despite £0.65 million of unbudgeted pay costs of the new Bedford outreach. Core to this underspend was a £0.43 million saving against plan by Moorfields Eye Hospital Dubai, and the continued impact of the financial recovery plan launched in the prior financial year.

**Non-pay costs**

The main components of non-pay spend are shown in the table opposite.

The delay in operations at Moorfields Eye Hospital Dubai (MEHD) and the opening of the Bedford outreach has led to several areas of variance to costs.

These include:

- Drugs expenditure – saving of £0.3 million against plan due to the delayed opening of MEHD; the balance of the variance in this category is due to tight control of expenditure
- Premises and establishment expenses – overspends in these areas are largely as a result of the unplanned operating costs of Bedford
- Other – savings of £0.95 million associated with MEHD are present in this category, together with the contingency reserve

**Cash flow**

At 31 March 2008, the Trust had net current assets of £2.83 million compared with net liabilities of £13.59 million at the previous year-end, when it had been required to show all its borrowings as falling due within one year, in accordance with accounting standards. Net cash inflow of £5.16 million (2006/07: £7.31 million) and the receipt of public dividend capital of £2.83 million enabled the Trust to end the year with short-term investments and cash at bank of £11.96 million (2007: £4.04 million).

<b>Other income</b>	<b>Plan</b>	<b>Actual</b>	<b>%</b>
Research and development	6.14	6.14	36.98
Education and training	3.40	3.34	20.15
Charitable and other contributions to expenditure	1.19	1.18	7.10
Transfers from donated asset reserve	0.72	0.85	5.12
Various fees and charges	4.64	5.09	30.65
	16.10	16.60	100.00

Expense type	Plan	Actual	%
Drug costs	4.79	3.93	13.21
Clinical supplies and services	8.43	8.51	28.63
Establishment expenses	3.74	4.25	14.29
Transport	1.98	2.18	7.33
Premises	7.00	7.75	26.07
IT expenditure	0.88	0.97	3.27
Other	4.03	2.14	7.20
	30.84	29.71	100.00

### **Borrowing**

Since attaining foundation status, the Trust has taken out long-term loans from the Foundation Trust Financing Facility. No further loans were taken out during the year. Borrowings of £0.8 million were repaid in 2007/08 by the Trust, leaving an outstanding balance of £12.44 million.

### **Going concern**

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

### **Better payment practice**

The Trust's policy is to pay its suppliers in accordance with the contractual terms agreed with or applying to the supplier. It largely complied with that policy during the year. It did not pay any interest under the Late Payment of Commercial Debts (Interest) Act 1998.

### **External audit services**

The Trust employs the services of Deloitte and Touche LLP to carry out external audit functions. The type of service and costs are detailed below.

Statutory audit services	£57,000
Regulatory reporting	£41,000
Other services	£55,000

The Trust and Deloitte have safeguards in place to avoid the possibility that the external auditors' objectivity and independence could be compromised. The audit committee reviews the annual report from the external auditors on the actions they take to comply with professional and regulatory requirements and best practice designed to ensure their independence from the Trust.

The audit committee also reviews the statutory audit, tax and other services provided by Deloitte, and compliance with the Trust's policy, which prescribes in detail the types of services which the external auditors can and cannot provide:

- External audit services
- Other audit services – work which regulators require the auditors to undertake, such as on behalf of the Healthcare Commission
- Tax services – all significant tax consulting work is put out to tender, except where the auditors are best placed to do this, such as in relation to value added tax
- Internal audit – the external auditors may not perform internal audit assignments
- General consulting – the external auditors may not tender for such engagements

All engagements with the external auditors over a specified amount require the advance approval of the chair of the audit committee. The policy is regularly reviewed and, where necessary, amended in the light of internal developments, external requirements and best practice.

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware and the directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

### **Counter-fraud arrangements**

The Trust has established a counter-fraud policy and response plan to minimise the risk of fraud or corruption, together with a code of conduct and whistle-blowing policy to be followed in the event of any suspected wrong-doing being reported. The policies and related materials are

available on the Trust's intranet and counter-fraud information is prominently displayed on the Trust's premises.

The Trust's local counter-fraud specialist (LCFS) reports to the finance director and performs a programme of work designed to provide assurance to the board in regard to fraud and corruption. He attends audit committee meetings at which he presents the programme and the results of his work. The LCFS gives regular fraud awareness sessions for the Trust's staff. He investigates concerns reported by staff and, if they are substantiated, the Trust takes appropriate criminal, civil or disciplinary measures.

### **Accounting policies**

The accounting policies for the Trust are set out on pages 54 to 60.

### **Senior employees' remuneration**

Details of senior employees' remuneration, including pension entitlements, are disclosed on pages 65 and 66.

## **Service developments**

Moorfields has had an exciting few years, with service developments such as the new outreach service at Bedford Hospital, the opening of the Richard Desmond Children's Eye Centre and of Moorfields Eye Hospital Dubai, and moving to a model of ambulatory care. The emphasis for 2008/09 will be on consolidation rather than new developments, enabling us to improve the consistency and quality of care across our services and the estate, thereby enhancing the patient experience.

## **Pre-assessment**

Over the past year, we have made considerable progress in rolling out a 'one-stop' pre-assessment service, which aims to be more convenient for patients and to improve access to the service. This is also an essential step towards improving theatre efficiency across the Trust. Further work will continue over the next year to implement this across all sites.

## **Achieving the 18-week referral to treatment target**

Moorfields achieved the national milestones in March 2008 for the 18-week referral to treatment target, putting us on progress to achieve the final targets in December 2008.

Achieving the milestones of 90% of non-admitted patients having their first definitive treatment within 18 weeks, and 85% of admitted patients having their first definitive treatment within 18 weeks by March 2008 was a major step forward for Moorfields, especially given the information challenges we faced during the year.

We are now working towards the target for December 2008, which is to achieve 95% for non-admitted journeys and 90% for admitted journeys. To do so, we will need to add in any additional temporary capacity required, as calculated in a Trust-wide capacity review, in order to reduce the total number of patients waiting. While this is important, it will not deliver the target alone. There is a clear need to continue the service improvement work already underway across the Trust, and this will require an extensive review of clinical pathways, from referral through

to treatment, to identify opportunities to reduce delays and to improve the patient experience. This work is being undertaken in collaboration with our host commissioner, Islington Primary Care Trust.

## **Reaching out to our communities *Moorfields at Bedford***

Moorfields has continued to build on the successes made possible by our NHS foundation trust status throughout 2007/08, with the addition of a further outreach service in Bedford.

This collaborative initiative with Bedford Hospital NHS Trust became a reality in September 2007 and has already led to the development of a more comprehensive ophthalmic service with easier access for the local population.

## ***Moorfields at Northwick Park***

We are also finalising plans for the redevelopment of Moorfields at Northwick Park Hospital to provide a dedicated, purpose-built outpatient and surgical ophthalmic facility within a different building on the site. This long-awaited project will greatly improve the environment for our patients and staff in one of our largest outreach facilities.

## ***Other developments in our outreach services***

In parallel with pursuing these opportunities, the Trust intends to focus on improving the arrangements for supporting and integrating outreach-based staff, and on introducing full site-based income and expenditure accounting and reporting for our outreach services.

Improvements to the paediatric services provided at outreaches will be rolled out across the Trust in the next stages of implementation of our paediatric services action plan. This will include dedicated children's outpatient facilities and play specialists at a number of designated sites.

### **Improving clinical quality**

Moorfields continues to strive to achieve the highest possible standards of clinical quality. Our large patient base, active research programme and range of sub-specialty services means that we are able to recruit clinical staff of the highest possible standard.

Innovative use of electronic patient records allows us accurately to record complication rates and carry out more accurate clinical audit. For example, an accepted complication rate of cataract surgery – the most common operation performed in the NHS – is the rupture of the posterior capsule. Our capsule rupture rate is considerably lower than figures collected in national audits. Another example is the success rate of surgery for retinal detachment, a relatively common cause of sudden blindness. We have recently published the largest ever prospective series of results for the use of vitrectomy in the treatment of retinal detachment. Our single operation success rate was 84.4%, which compares favourably with the results in a recently published European trial which achieved a figure of only 63.8% in similar patients.

During the last year, we moved all our paediatric services into a dedicated, brand new, children's eye hospital. This

provides a state-of-the-art environment in which we can better deliver modern paediatric ophthalmology.

We have reviewed and modified our clinical governance structures over the last 12 months, appointing a clinician as head of clinical governance, and revising our clinical governance strategy. This has resulted in clearer reporting lines, particularly in the area of risk management. Transparent investigation and reporting of serious untoward incidents has improved both learning and patient safety.

### **Improving the patient experience**

Moorfields has invested in several initiatives to assist in the evaluation of the patient experience at our hospital and in our community services. These include commissioning the Picker Institute to survey a sample of patients accessing our services, using a tool specific to the treatment pathways for our patients. In addition, the use of mystery visitor audits has enabled us to identify opportunities to improve the customer care aspects of our services and to provide feedback to staff on the many positive results that are reported.

The introduction of the patient experience tracker (PET), a real-time patient survey tool, is planned for 2008/09. Significant work has been undertaken to define the areas where this tool is to be introduced and to develop the survey questions. The involvement of patients and their representatives has been important throughout this process.

In response to feedback from patients, we have significantly improved the accessibility of on-the-day pre-assessments for patients who require surgery. This

eliminates the need for most patients to return to the hospital for an additional appointment prior to their procedure being performed.

### **Improving infection control**

Moorfields' infection control team has undertaken significant work to ensure that we are fully compliant with the national hygiene code. Our well-established team is complemented by a control of infection committee, chaired by consultant ophthalmologist, Mr John Dart.

The risk of reportable MRSA and Clostridium Difficile episodes at Moorfields is significantly lower than at other hospitals, due to the nature of our work and the fact that we treat patients mainly on an ambulatory care basis. That said, we acknowledge our critical responsibility towards the prevention and control of infection, and the Trust board receives regular reports on the subject.

A deep-clean programme supported by NHS London was undertaken at Moorfields towards the end of the financial year, and a new system of cleanliness monitoring was introduced within all clinical departments. Weekly cleanliness inspections and hand-washing hygiene audits are now routinely undertaken by clinical staff in all clinical departments.

Moorfields was one of the trusts selected to receive a hygiene code inspection by the Healthcare Commission in the fourth quarter of 2007/08. Overall, we were assessed as compliant against all three of the key duties. Of 19 sub-duties, we were found to be in breach of one only, concerning

the public availability of cleaning schedules in all ward areas. Action is now being taken to address this issue.

### **Providing advice and support Patient Advice and Liaison Service (PALS)**

The PALS team at Moorfields provides patients, relatives and carers with confidential advice and support. The team aims to resolve problems swiftly and effectively, assisting patients with any difficulties they face whenever they arise.

Acting as a catalyst for change and improvement, the PALS team is an important source of information and feedback for the Trust and provides an early-warning system by monitoring trends and gaps in services and reporting these to the Trust management team for action. In addition, the team passes on comments and suggestions to the relevant staff to improve services for future patients.

During 2007/08, the PALS office dealt with 930 patient enquiries. The majority of queries related to patient transport or appointments.

### **Complaints**

In the context of the provision of some 340,000 episodes of care in 2007/08, Moorfields received 320 formal complaints. Most complaints were non-clinical and were fairly diverse in nature, but several arose due to changes we made in the booking process for hospital appointments.

As we improved our processes and telephone response rates, these complaints diminished significantly.

Other types of complaints received were about the attitude of Trust staff (especially when answering the telephone), clinical notes going missing, a failure to provide appointment letters in Braille, and the eligibility of carers to accompany patients on hospital transport. Each of these issues is followed up appropriately and processes and communication improved to try to prevent other patients experiencing the same problems.

The response time for completion of complaints investigations within a maximum of 25 working days is stipulated by the Department of Health, and every effort is made to respond sooner, where possible. The average completion rate for the year within the target time was 81%.

### **One-stop shop for patient support**

Since April 2007, our PALS, complaints, certificate of visual impairment (CVI) registration and patient information teams have been integrated into a new patient advice and support services team. This follows an earlier review of the teams when the decision was made to establish a one-stop shop to support patients and to deal with any queries and complaints.

A new information leaflet for patients – *We are here to help* – about our PALS and complaints services, is now in circulation. For a copy, please call 020 7566 2054 or 2325.

### **Working in partnership**

Moorfields staff continued to work closely with governors and members of the Moorfields Patient and Public Involvement Forum (PPIF) to review our services, the information we provide and the environment.

Our disability focus group is a good example of partnership working, with representation from staff, governors, Disability Action Islington, the Royal National Institute of Blind People (RNIB), and Seeability. One positive outcome from their work is the improved signage and patient information for the pharmacy at Moorfields' City Road site.

We are also members of Islington's Safeguarding Children board and of the steering group for the development of the borough's local involvement network (LINk). LINks will progressively replace PPIFs across the country during 2008/09. We are also members of the Hackney enterprise and training network.

### **Consulting with local groups and organisations**

Moorfields did not undertake any formal consultation with local primary care trusts or the overview and scrutiny committee in 2007/08.

The annual general meeting was held at St Luke's LSO in September 2007 and was attended by staff and approximately 300 members of the public.

### **Improving the patient environment**

The Richard Desmond Children's Eye Centre, which was opened by Her Majesty the Queen in February 2007, has been a great success, significantly enhancing the quality of the environment and the experience of the children we treat, as well as that of their parents and carers.

The centre won two more awards for its innovative design in 2008.

The first, from the Civic Trust, recognised its architecture, while the second commended the centre for its unique exterior lighting at The Lighting Design awards 2008.

“The innovative street facade is functional yet wonderfully different, with the design of the louvres based on birds in flight,” said a spokesperson for the Civic Trust. “The sense of scale within the building is successful, and has been carefully considered to accommodate children.”

Civic Trust awards are given to projects that are of benefit culturally, socially or economically at the same time as making an outstanding contribution to the quality and appearance of the environment.

The centre’s lighting scheme, which interacts with the sculptured façade, was designed by Lightscape Projects, part of the Light Projects Group, and garnered the top lighting prize in the Lighting Design awards for exterior project of the year. The judges were unanimous in their decision, describing the constantly shifting light display that animates the front of the building as a “visual delight”.

Regrettably, a design fault concerned with the building’s internal pipework has become apparent, and extensive remedial works will be required to address the problem. These will take place in a phased programme of work to minimise any disruption to patient services.

## Research and development

During 2007/08, Moorfields continued to work with the National Institute for Health Research (NIHR) to implement the national NHS research strategy described in *Best Research for Best Health 2006*, together with our academic partners at the UCL Institute of Ophthalmology.

Our joint work this year has included:

- The establishment and first-year operation of the NIHR specialist Biomedical Research Centre (BMRC) for Ophthalmology. This recognition of our worldwide reputation for excellence and investment in our partnership has already enabled us to attract charitable donors and industry from the UK and around the world to help support our research programmes. Capital funding from the NIHR has also allowed us to develop an extended clinical research facility with state-of-the-art diagnostic and imaging facilities.
- Contribution to the work of the national comprehensive research network through the development of integrated systems for the management of research and development information, governance, advice and authorisation processes with our network partners locally.
- Contribution to the development of the NIHR faculty and the successful nomination of a senior investigator.
- National and local contribution to the development of a specialty group for eyes within the national network.

To underpin both the translational research of the BMRC and the development of clinical research, we collaborated closely with our partner organisations to develop joint research strategies and prioritised programmes of work for funding and fast-tracking where appropriate. This included the development of a joint R&D database with the Institute of Ophthalmology as an essential support system to the establishment of a joint research office.

We have also continued to develop our capacity for health services research, management/systems research and secondary research, which includes:

- Community eye health services, certification for visual impairment and contributions to epidemiology
- Research resource groups, eyes and vision specialist library (within the National Library for Health), 'Do Once and Share' programmes
- Cochrane eyes and vision group

### **World's first gene therapy for inherited blindness improves vision**

Results from the world's first clinical trial to test a revolutionary gene therapy treatment for a type of inherited blindness have shown that the experimental treatment is safe and can improve sight.

UK researchers from the UCL Institute of Ophthalmology and Moorfields Eye Hospital announced the findings on 27 April 2008 in the *New England Journal of Medicine*. The results are a landmark for gene therapy technology and could have a significant impact on future treatments for eye disease. The research

was also commended by the Department of Health as representing the first major outcome from the 12 biomedical research centres that were established by the NIHR in April 2007.

The trial, conducted in the NIHR Biomedical Research Centre, represented a world first when it began in February 2007. It involves young patients with Leber's congenital amaurosis (LCA), a rare inherited eye disease, which appears at birth or in the first few months of life and causes progressive deterioration and loss of vision. There are currently no effective treatments available. The trial's purpose was, first, to find out whether gene therapy for retinal disease is safe, and, secondly, whether it can benefit vision in young adults who already have advanced retinal disease.

Crucially, the experimental treatment was found to cause no side effects in this trial. Furthermore, one of the three patients benefited from significantly improved night vision.

The researchers believe the operation's success for this particular patient could be because his disease had not progressed to the same extent as the others. The other two patients may also still benefit from the new treatment in the future, but it will be some time before this becomes apparent. The team has already begun to trial the technique in younger patients, where they hope to achieve even better results.

The team conducting the trial is led by Professor Robin Ali and includes eye surgeon Mr James Bainbridge and retinal specialist Professor Tony Moore.

## Effective low-vision services

Research undertaken in 2007/08 at Moorfields demonstrated that our current low-vision service adequately meets patients' needs. Hospital-based low-vision services in the UK generally involve a single one-hour consultation with an optometrist in the hospital eye service, with no further training in the use of low-vision devices.

We conducted a randomised controlled trial to investigate the efficacy of a further one-hour training visit with a low-vision support worker. Ninety participants were randomised to receive conventional care or a further appointment with a low-vision support worker, who reviewed the handling of low-vision devices. Two weeks after the follow-up appointment, patients were contacted by telephone and a questionnaire was administered to determine their level of visual disability.

Both groups showed significantly reduced task difficulty after their low-vision appointment, but there was no significant difference in improvement between the group who received the extra visit and the group with standard care.

Our study demonstrates that existing low-vision intervention services are effective. We were unable to determine an extra benefit for a further training visit, although this could be due to the relatively simple nature of devices prescribed in UK hospital-based low-vision services.

## Home-based eccentric viewing training

Eccentric viewing training (EVT) is widely recommended for people with central

visual field loss. This is a skilled procedure, which commonly involves as much as 12 hours of contact time and is not widely available in UK hospital-based low-vision clinics.

This year, Moorfields researchers undertook a study in which we developed and evaluated an audio CD-based eccentric viewing training system for people with macular disease to use at home. Twenty-five participants with established, bilateral age-related macular disease (AMD) attended a one-hour introductory session and were issued with an audio CD containing 14 graded exercises to practise at home. Participants performed each exercise once on two consecutive days before listening to the next exercise.

Following training, there was a significant improvement in visual acuity and a reduction in the amount of magnification required to read, suggesting that an audio CD-based eccentric viewing system for use at home could be useful where formal eccentric viewing training is not available.

## Supporting our staff

Moorfields recognises that our staff are our greatest assets and that ensuring they are properly supported is crucial to our ability to provide high-quality patient care and to undertake leading-edge research.

During 2007/08, the average number of employees in full-time equivalent posts with Moorfields Eye Hospital NHS Foundation Trust was 1,210. Of these, 83% have been in post for more than a year, a good indication of workforce stability. Our turnover rate was 11.9%, which also compares well against other

organisations in central London. Just one grievance was raised during 2007/08, and 11 disciplinary hearings were held. Moorfields is currently compliant with the requirements of the European Working Time Directive.

### **One of Britain's top employers**

In 2008, for the third year running, the Corporate Research Forum/*Guardian* Britain's Top Employers list placed Moorfields among the country's top employers.

"A tangible sense of wanting to care pervades all the hospital's sites," stated the report. "Not just the doctors and nurses, but all the staff are motivated by the assistance they can offer to patients."

Moorfields is one of only two NHS trusts to feature on the list, which also includes major organisations such as Cadbury Schweppes, JD Wetherspoon, L'Oreal Ltd and Shelter.

Employers, who cannot nominate themselves for inclusion on the list, are judged and rated by an independent panel of experts on how they performed in areas such as pay and benefits, career and training, knowledge management, and employee relations and diversity.

In addition, the *Nursing Times* top 100 list of the best places to work as a nurse again included Moorfields in 2008.

"This hospital is internationally known for its specialist care – and it should also be known as a good employer according to staff," said the report. "They praise the opportunities for professional development

and networking, as well as the management. Senior nurses are 'doing their best to engage nurses at all levels in the decision-making processes' as one of the nurses at Moorfields told the survey."

The *Nursing Times* top 100 is generated through a survey of employers and nursing employees, with applications to take part in the survey open to any organisation where nurses work, whether NHS or independent employers.

The survey looks at how well employers manage personal training and development, family-friendly practices, flexible working leading to staff retention, equality and diversity, and the strength of the nursing voice within an organisation.

### **Communicating with our staff**

Moorfields has a system of regular communication with staff through a weekly e-bulletin and a bi-monthly newsletter, *Review*. In addition, a programme of chief executive open meetings, to which all staff are invited to attend, continued throughout the year. The chief executive and other directors also visited our outreach centres on a regular basis to ensure that staff who are not based at the City Road hospital are kept informed of developments and have an opportunity to raise any issues and concerns with management.

The joint staff consultative committee, involving trades union representatives and management, met regularly throughout the year to discuss matters of mutual interest.

## Improving Working Lives

The Improving Working Lives (IWL) group has a wide staff membership, which includes representation from the staff governors. During 2007/08, the group continued to review ways of supporting staff to achieve a good work/life balance based on the original principles of the IWL initiative.

In 2007/08, members of the IWL group have been working through a programme of visits to our outreach facilities, including our newest centre in Bedford, talking to staff, gathering suggestions for change or improvements and looking for areas of good practice.

Although only a sample of staff is required to participate in the national annual staff survey, Moorfields has always felt that all staff should have the opportunity to take part. For the 2007/08 survey, the IWL group worked closely with recognised trades unions and staff governors to encourage as many staff as possible to complete the survey – 40% did so, and the results are now being analysed.

Results of the 2006/07 annual survey, for which findings were made available during 2007/08, provided very useful information across a variety of issues important to staff in the Trust, such as long working hours, bullying and harassment, communication, and training and development. These issues were addressed in several ways, including:

- Provision of performance and stress management courses throughout the year
- Redesign of the Essential Communication programme

- Engagement of an external organisation to recruit and train several Trust staff as harassment advisors to support staff in dealing with harassment/bullying issues

Acknowledging the hard work and commitment of staff is a further important part of the work of the IWL group. To this end, patients as well as staff can now nominate individuals for our Employee of the Month award – in future, winners will be presented with their certificate at Trust board meetings. In addition, the group has continued to work with a range of organisations who offer benefits to NHS staff.

## Occupational health

Moorfields staff have access to a full-time occupational health service at the City Road site, provided by the Royal Marsden Hospital. The service is nurse-led, with medical staff on site once a month – although medical staff are available at all times from other locations. In addition, all staff have access to our employee assistance programme, supplied by Dovedale Counselling. This telephone counselling service also provides face-to-face support as necessary.

## Learning and development

By making learning and development information readily available to staff and their managers, we aim to increase ownership of individuals' own learning and development and help Moorfields to become a learning organisation.

In 2007/08, our learning and development department launched My Learning Centre, a key strategic tool to increase the knowledge and skills of staff

and an important part of the intranet. My Learning Centre provides access to information stored on the central learning and development database, which means that staff can view their entire learning and development record and record their own external learning and development events to create a continuing professional development (CPD) record. Managers can also view records for any of their staff. My Learning Centre plays an important role in ensuring compliance with mandatory requirements by enabling individuals to identify the mandatory skills and knowledge required for their role and any training that is overdue. Similarly, managers can monitor mandatory compliance for each of their staff.

The new system has been very well received by both staff and managers, and will be expanded to offer greater functionality, including access to advice, information and data such as links to learning and development websites, resources and documents over the next 12 months.

Staff development is supported by the learning and development strategy group, which brings together senior and influential clinical and non-clinical staff to provide a focused strategy across the entire organisation.

This year, the group has provided guidance for several projects to support staff at Moorfields, including My Learning Centre (see above). It has also piloted ManageMentor, a radical new approach to skills development, which provides an online performance support tool for management and team-leading skills. In addition, the group has supported a radical change to our induction

programme, which aims to provide a more welcoming and stimulating introduction to the life and culture of Moorfields. Many more such initiatives are planned for the coming year.

### **Disabled employees and equal opportunities**

Moorfields has policies and procedures in place in relation to disabled employees and equal opportunities. These are widely available to staff through the intranet, and advice is available through the human resources lead for equality and diversity. The disability forum group is held bi-monthly to discuss issues concerning both staff and patients, and to monitor the disability equality scheme action plan.

### **Consultation with staff groups**

Three staff consultations took place in 2007/08, dealing with the structure and management of the pharmacy services and the transfer of the staff providing, first, the ocular oncology service and, secondly, the genito-urinary service, both to Barts and The London NHS Trust.

## **Charitable support at Moorfields**

Three independent charities work together under the umbrella of Moorfields Eye Hospital Charities to support the Trust's work. Together, they support high-profile projects such as Moorfields' ground-breaking gene therapy research and the award-winning new children's eye centre as well as other smaller, but significant initiatives to improve the lives of patients, staff and visitors.

Over the last year, the charities received nearly £2.6 million in legacy income, a record-breaking amount, which is enabling them to fund a wide-range of important research projects and further to enhance services and facilities.

### **Special Trustees – charity number 228064**

The Special Trustees of Moorfields Eye Hospital is an independent charity that works closely with the hospital. The Special Trustees predominantly supports research and clinical trials to provide new treatments for a wide range of eye conditions, as well as funding rehabilitation programmes for people who are visually impaired.

### **The Friends of Moorfields – charity number 228637**

The Friends of Moorfields is an active and dedicated body of volunteers, whose primary aim is to enhance the comfort and well-being of patients and their visitors. The Friends manages a wide range of work, assisted by more than 100 volunteers, adding to the services provided by the hospital. This year, its annual EyeBall raised more than £43,000 for equipment for a new diagnostic suite for research and treatment into age-related macular regeneration. Funding was also provided for several other items of equipment, as well as for furniture and toys for the new children's eye centre.

Over the coming year, the Friends plans to support refurbishment work to the outpatients' areas of the main hospital. It is also hoping to assist with a new vision-related performance laboratory, helping elderly people to remain independent.

### **Moorfields Eye Hospital Development Fund – charity number 282806**

The Development Fund is an independent charity, which is principally involved with specific appeals associated with the hospital. Its principal focus to date has been the development of the Richard Desmond Children's Eye Centre, adjacent to the main hospital building in central London.

## **Addressing our environmental, social and community responsibilities**

Moorfields continues to implement the sustainability agenda across the organisation, looking at the main areas of energy, water, waste, transport and local involvement.

We are part of the NHS procurement arrangements (PASA), which account for environmental impact and improved efficiency. We are also in the process of renewing our waste management contract to focus on reducing our environmental impact and, where waste is unsuitable for landfill or recycling, we will be looking for alternative technology that will result in energy production. A carbon footprint survey will shortly be underway. We recycle as much as possible, including batteries, cardboard, and cooking oil, and we collect old spectacle frames and send them to a charitable foundation in Africa.

We do not provide car parking facilities, which encourages patients, visitors and staff to travel by public transport, and we offer staff an interest-free season ticket loan. In April 2007, we launched a Ride 2 Work scheme in partnership with a local cycling shop, to encourage staff to cycle for at least part of their journey to or from work. Under the scheme, the costs of buying bikes and cycling accessories are deducted direct from salaries, which means that staff benefit through the non-payment of tax, national insurance and pension contributions on this amount.

We have been undertaking a project in Ealing, west London, with the local community to improve awareness and uptake of early screening for glaucoma, and we work with the primary care trusts where we provide our outreach services in the development and provision of services that are appropriate to the local population.

Our site at City Road is a major business in the local area, and we are looking to increase our engagement with local schools, particularly with regard to NHS careers.

## Looking ahead

In the short term, the focus of directors' attention will be on enhancing Moorfields' management arrangements, with a particular focus on ensuring that key national performance targets and standards are met; that our outreach sites are supported and developed; that the many ongoing and planned estates improvement projects are successfully implemented; and that our strong financial management record continues. We will

also be directing our efforts towards improving further the experiences of our patients and their carers, and to supporting our staff as the demands on their time, experience and expertise grow.

Looking further ahead, the external environment has the potential to have a significant impact on Moorfields. The development of the concept of academic health sciences centres has recently begun to take shape, and Moorfields is already in discussion with UCL and some of its NHS partners with a view to developing such a centre across north central and north east London. These discussions are progressing apace and could lead to decisions in principle about such an arrangement being made during the summer of 2008.

The outcome of the consultation on Healthcare for London is not yet known, but the proposals for care closer to home for patients with long-term conditions or who otherwise should not need to go to hospital for their treatment and care needs, as well as the potential development of polyclinics, will both have implications for Moorfields. We are already well positioned to support the local development of services with our arrangements for outreach clinics and services, and we are working actively with primary care trusts on the development of local diabetic retinopathy screening and on improving awareness and access to glaucoma screening. We are also working with community optometrists to develop and improve the arrangements for direct referrals for cataract surgery.

At the time of writing, Lord Darzi's review of the NHS, *Our NHS Our Future*, has yet to be published, although the Prime Minister has already outlined the key elements of the government's NHS Reform Bill. These include: an NHS constitution detailing patients' rights to minimum standards of access, quality and safety; patients being given greater control over information about their care as well as access to individualised budgets; measures for payment being based on patient satisfaction and health outcomes; and a new comprehensive NHS performance management regime.

Although the details of these measures are not yet known, Moorfields is already well placed in relation to some of them, such as patient satisfaction and clinical outcomes, and we will need to ensure that we respond appropriately in those areas where we need to do more.

# Our governance arrangements

Moorfields Eye Hospital NHS Foundation Trust is authorised to operate as a public benefit corporation under the National Health Service Act 2006, and as such has governance arrangements that differ to those of other NHS organisations. The Trust is led by the board of directors, which is accountable to the membership council (board of governors). The responsibilities of both boards are laid out in the constitution, which is a key component of the terms of authorisation. The roles and responsibilities of each are described in the following sections of the report.

## Membership council

The membership council has a duty under the NHS Act 2006 to represent the views of foundation trust members and stakeholders to the board of directors and the management of the Trust. The membership council comprises elected and nominated governors as shown in the table below and has decision-making powers defined by statute. These powers are described in the constitution and principally refer to the appointment and removal of, and the remuneration for, the non-executive directors on the board of directors; the appointment and removal of the Trust's external auditors; and the provision of views on the Trust's forward/strategic planning.

The council met five times during 2007/08 to discuss Moorfields' business agenda and its service and strategic development plans, and held an extraordinary meeting to ratify the appointment of the new chief executive.

Governors played an active role in the review of our strategic objectives and mission statement during an awayday held in June 2007, and also in the assessment of the role specifications for the chairman and non-executive directors.

The council has two formal sub-committees – remuneration for non-executive directors, and the nominations committee for the appointment of non-executive directors, including the chairman of the board. Both committees met during the year and their recommendations were ratified by the membership council.

The board of directors and the governors meet together at least once a year. Executive directors routinely attend membership council meetings, while non-executive directors are linked to one or more of the public and patient constituencies and are encouraged to attend membership council meetings. This provides a direct link for governors to a member of the board, and acts as a bridge between the two bodies. Governors receive the minutes and agenda of the board of directors' public meetings, and the board's business agenda remains a standing item on the council agenda.

## Composition of the membership council

Elected governors	Representing	Other responsibilities
Malcolm Barrow	Public: Bedfordshire and Hertfordshire	Vice chair
Jane Colebourn	Public: Bedfordshire and Hertfordshire	
Bill Tidmas	Public: North East London and Essex	Remuneration committee
Paul Murphy	Public: North Central London	Nomination committee Membership development
John Green	Public: North Central London	Remuneration committee
Victor Stone	Public: North East London	Remuneration committee
Patricia Campbell	Public: North West London	Disability focus group Membership development
Brian Watkins	Public: North West London	Membership development
Christopher Hough	Public: South East London	Clinical effectiveness committee
Solomon Parry	Public: South East London	Risk and safety committee
Andrew Hill	Public: South West London	Chair, nomination committee Chair, remuneration committee
Alex Nicholson	Public: South West London	
John Bird	Patient	Remuneration committee
Robert J Jones	Patient	
Michael O'Dwyer	Patient	Membership development
Alison Davis	Staff	Improving Working Lives
Eilis Kennedy – elected from September 07	Staff	
Ali Safiee	Staff	Disability focus group
Colin Carter – elected from December 07	Staff	Improving Working Lives
Nominated governors	Represented organisation	
Cllr Ruth Polling	London Borough of Islington	
Jonathan McInerney (until July 2007) Colin Brown (from September 2007)	Royal National Institute of Blind People (RNIB)	
Valerie Greatorex	International Glaucoma Association	
Professor Peter Mobbs	University College London	
John Lawrenson	City University	
Anna Stewart	Islington Primary Care Trust	

All elected governors hold the position for three years unless otherwise indicated as two years. Nominated governors are proposed by their host organisation and hold the position until otherwise notified. Each nomination is reviewed within three years.

A record is kept of the number of meetings attended by individual governors and is available on request, as is the register of interests of individual governors – please see contact details in the section on the register of interests for the board of directors on page 39.

### Membership

Moorfields continues to grow its membership and we currently have about 11,000 members, an increase of 3,000 since our authorisation as an NHS foundation trust in 2004.

Membership numbers in each public constituency reflect the size of the outreach service provided in the area. For example, North West London has the greatest number of members and also provides two of the largest outreach facilities. As new outreach sites emerge, we will carry out further membership recruitment drives both for staff and patients. If the outreach is already located within one of the public constituencies, this will be taken into account in the method of recruitment.

In 2007/08, we recruited more staff members when we opened the new outreach service at Bedford Hospital, and a recruitment drive is planned for patients and the public to join the Bedfordshire and Hertfordshire public constituency.

### Representing our membership

Members are represented by elected patient, public and staff governors on the membership council (see page 31), which meets five times a year. Governors participate in a range of activities such as membership development and involvement, reviewing evidence for Standards for Better Health, and reviewing business cases. They also sit on several committees, including governance, risk and safety, and clinical and cost effectiveness, as well as on our disability focus group and editorial group.

We draw our public membership from six geographic constituencies, based on the populations served by the hospital at City Road and the outreach sites as follows:

- Bedfordshire and Hertfordshire
- North Central London
- North East London and Essex
- North West London
- South East London
- South West London

Any member of the public who resides in one of these areas and is aged 14 years or more can join as a public member. Any patient aged 14 years or more can join the wider patient constituency. All staff are automatically registered as members, but can opt out if they so wish.

There were two elections in 2007/08 for staff governors to represent each category within the staff constituency – outreach and City Road. A staff governor was elected for City Road in September 2007 and, in December 2007, a by-election took place for the outreach position, which was unopposed.

All elections are held in accordance with the election rules set out in the constitution. This has been confirmed by the returning officer for the elections held during 2007/08.

Members who want to contact their representative governor or a member of the board may do so through the Director of Corporate Governance, Moorfields Eye Hospital NHS Foundation Trust, 162 City Road, London, EC1V 2PD, or by email to [foundation@moorfields.nhs.uk](mailto:foundation@moorfields.nhs.uk).

## Board of directors

The board of directors is the decision-making body for strategic direction and the overall allocation of resources. It delegates decision-making for the operational running of the Trust to the executive directors and senior managers – the management executive – who take decisions consistent with the strategy.

Non-executive directors and the chairman are appointed by the nominations committee of the membership council initially for a period of three years and for no more than three terms of office (a total of nine years). Executive directors are appointed by the nominations committee of the board of directors on permanent contracts.

Board meetings are held in public every month. The bracketed numbers in the table overleaf refer to the number of public board meetings attended during 2007/08 out of a possible 11. The board also holds a confidential meeting every month. The board of directors believes that it has the appropriate balance and completeness in its composition to meet the requirements of an NHS foundation trust.

<b>Board member</b>	<b>Position</b>	<b>Date and length of appointment</b>
Sir Thomas Boyd-Carpenter (11) (Background – armed forces)	Chairman Chair of remuneration committee	1 April 2004, renewed for three years from 1 April 2005
Clive Nickolds (10) (Background – retail director)	Deputy chair and senior independent director (non-executive) Chair of governance committee	1 April 2004, renewed November 2005 for three years
Ian Hollows (8 out of 8) (Background – accountant)	Non-executive director Chair of audit committee to December 2007	1 December 2004 to 31 December 2007
Maggie Van Reenen (8) (Background – PR management)	Non-executive director	1 April 2004, renewed 1 April 2005 for three years until 31 March 2008
Deborah Harris (3 out of 3)	Non-executive director Chair of audit committee from January 2008	1 January 2008 for three years
Rudy Markham (10) (Background – finance director)	Non-executive director Chair of the strategy and investment committee from May 07	1 April 2007 for three years, but appointed as Trust chairman from 1 April 2008
Professor Phil Luthert (10) (Background – ophthalmic pathologist and research scientist)	Non-executive director Director of the Institute of Ophthalmology	February 2006 for three years
Ian Balmer (10) (Background – health service management)	Chief executive (to 30 March 2008)	–
John Pelly (Background – accountant and health service management)	Chief executive (from 31 March 2008)	–
Ian Knott (10) (Background – accountant)	Director of finance (to 29 February 2008)	–
Sarah Watson-Fisher (1 out of 1) (Background – registered nurse)	Director of nursing and operations (to May 2007)	–
Mark Cubbon (7 out of 7) (Background – registered nurse and health service management)	Director of nursing and operations/chief operating and nursing officer (from 24 September 2007)	–
Bill Aylward (8) (Background – ophthalmic surgeon)	Medical director	–
Professor Roger Hitchings (9) (Background – ophthalmic surgeon)	Director of research and development	–

## Committees of the board

### Audit committee

The audit committee is comprised of three independent non-executive directors. The directors have satisfied themselves that all the members of the committee are competent in financial matters and that at least one has recent and relevant experience. The committee's meetings are attended, by invitation, by the chairman, chief executive, finance director, director of corporate governance, the internal auditors, the local counter-fraud specialist and the external auditors.

The audit committee assists the board in fulfilling its oversight responsibilities in respect of the integrity of the Trust's accounts, risk management and internal control arrangements, compliance with legal and regulatory requirements, the performance, qualifications and independence of the external auditors and the performance of the internal audit function.

Management supplies the audit committee with all the information necessary for the performance of its duties. The internal auditors, the local counter-fraud specialist and the external auditors have direct access to the audit committee separately from management.

The table below shows the attendance of members at audit committee meetings for the year ended 31 March 2008.

### Governance committee

The governance committee is responsible for the establishment and maintenance of an effective system of internal control and risk management for clinical and corporate governance, quality, information governance and performance.

Membership of the governance committee is as follows:

- Clive Nickolds, non-executive director (chair)
- All executive directors
- Chairs of clinical risk, clinical effectiveness, and risk and safety committees
- Director of corporate governance
- Director of personnel
- Public health lead
- Two public governors
- Islington Primary Care Trust representative
- Ex-officio member – head of internal audit

Details of individual attendance at this committee are available on request in writing – please see contact details in the section on the register of interests for the board of directors on page 39.

Name	Attendance*
Ian Hollows, chair (resigned 31 December 2007)	3 of 3
Deborah Harris, chair (appointed 1 January 2008)	1 of 1
Clive Nickolds	4 of 4
Maggie van Reenen	3 of 4

\* Attendance is expressed as the number of meetings attended out of the number eligible to attend.

## Remuneration committee

The remuneration committee is responsible for setting the pay and terms of employment of executive directors and other board-level posts. The committee is chaired by the Trust's chairman and comprises all non-executive directors.

The remuneration committee determines the pay of the chief executive and other directors, as well as taking an overview on reward in the Trust. The committee's decisions are informed by benchmarking information derived from published reward research, such as the IDS NHS Boardroom Pay Report, and surveys of other trusts' remuneration for similar posts.

## Nominations committee

Moorfields has two nominations committees. One deals with the appointment of executive and senior director positions and is established when required. The other handles the appointment of non-executive directors.

The nominations committee for the appointment of executive directors met three times during 2007/08 for the

recruitment of the chief executive, the director of finance and the director of nursing and operations. All three posts were advertised externally and, in the case of the chief executive appointment, external search consultants were employed. The selection panels for each were as follows:

- Chief executive: Sir Thomas Boyd-Carpenter (chairman), Rudy Markham (non-executive director), Professor Phil Luthert (non-executive director), Maggie van Reenen (non-executive director), Cally Palmer (external assessor), Ken Gold (director of personnel), Ian Knott (director of finance) and Bill Aylward (medical director)
- Director of finance: Clive Nickolds (deputy chair and non-executive director), Ian Balmer (chief executive), Ian Knott (director of finance), Ken Gold (director of personnel), Alan Goldsman (external assessor) and Shirley Chase (patient representative)

Date	In attendance at the remuneration committee
26/4/2007	Sir Thomas Boyd-Carpenter, Clive Nickolds, Maggie van Reenen, Ian Hollows, Professor Phil Luthert, Rudy Markham; Ian Balmer and Ken Gold in attendance
31/5/2007	Sir Thomas Boyd-Carpenter, Maggie van Reenen, Ian Hollows, Professor Phil Luthert; Ken Gold in attendance
26/7/2007	Sir Thomas Boyd-Carpenter, Clive Nickolds, Maggie van Reenen, Ian Hollows, Professor Phil Luthert, Rudy Markham; Ian Balmer and Ken Gold in attendance
28/2/2008	Sir Thomas Boyd-Carpenter, Clive Nickolds, Professor Phil Luthert, Rudy Markham, Deborah Harris; Ken Gold and Ian Knott in attendance

- Director of nursing and operations: Sir Thomas Boyd-Carpenter (chairman), Ian Balmer (chief executive), Ken Gold (director of personnel), Cathy Geddes (external assessor) and Shirley Chase (patient representative)

The nominations committee for the appointment of non-executive directors met twice during 2007/08 to appoint the chairman of the board of directors and four non-executive directors. The committee is chaired by a public governor and the membership includes, as a minimum, two elected governors, two board members and an independent assessor. Attendees at the two meetings in 2007/08 were as follows:

- Appointment of the chairman of the board of directors: Andrew Hill (public governor and chair of the nominations committee), Paul Murphy (public governor), Bill Aylward (medical director, Moorfields), Clive Nickolds (non-executive director, Moorfields), Tessa Green (chair, Royal Marsden NHS Foundation Trust) and Judith Alderton (independent assessor)
- Appointment of four non-executive directors: Andrew Hill (public governor and chair of the nominations committee), Paul Murphy (public governor), Sir Thomas Boyd-Carpenter (chairman, Moorfields), Mark Cubbon (director of nursing and operations, Moorfields) and Judith Alderton (independent assessor)

Appointments of non-executive directors are made for three years. After the first term, re-appointment is by recommendation by the nominations committee to the membership council. For second and subsequent terms, appointment may be

made only following open advertisement of the position, and a selection process undertaken by the nominations committee, with recommendations to the membership council. Removal of a non-executive director requires the approval of three-quarters of the members of the membership council.

### **Strategy and investment committee**

This committee was established in May 2007 and met five times during the year to conduct an independent and objective review of strategic direction, investment policy and performance issues. The committee was chaired by a non-executive director, with a second non-executive director, the chief executive and the director of finance as members.

### **Managing risk**

The chief executive has overall responsibility for risk management, and delegates elements of the role to the following executives:

- Risk and assurance – director of corporate governance
- Clinical risk and governance – medical director
- Performance management – chief operating and nursing officer
- Financial risk – finance director

The governance and audit committees are chaired by non-executive directors, and oversee the system of internal control, risk and assurance on behalf of the board of directors. The strategy and investment committee, also chaired by a non-executive director, is tasked with conducting independent and objective reviews of strategic direction and investment policy.

The governance committee is supported by a structure of committees that manage specific areas of risk. The principal committees are risk and safety and clinical governance, which report to the governance committee on the activities of the following groups:

- Clinical effectiveness
- Control of infection
- Drugs and therapeutics
- Emergency/contingency planning
- Health records strategy
- Information governance
- Laser safety
- Medical devices
- Medical gases
- Medicines management
- Radiation protection
- Resuscitation

The governance structure is reviewed regularly to ensure that the controls in place to manage risk are sufficient and appropriate to provide assurance to the board of directors.

### **External review of risk**

#### ***Risk management standards***

Moorfields has maintained level 2 of the clinical negligence standards for trusts (CNST) and is undergoing assessment against the NHS Litigation Authority's risk management standards in December 2008. We expect to achieve level 2 as a minimum.

#### ***Strategic risk assessment***

Moorfields underwent an independent review of its strategic risks in August 2006, from which the board subsequently identified the top six strategic risks facing the Trust and built these into the assurance framework for 2007/08. A further review is planned for 2008/09.

### **Healthcare Commission annual health check**

Moorfields received ratings of 'good' for use of resources and 'weak' for quality of services in the annual health check published by the Healthcare Commission in October 2007, based on performance in 2006/07. The disappointing rating for the quality of our services was principally the result of the Trust's failure to demonstrate that it was complying with all of the national cancer waiting time standards. This state of affairs continued in part throughout 2007/08, which is likely to lead to a further rating of 'weak' when the next annual health check results are published later in 2008. Improved arrangements for capturing, monitoring and reporting cancer waiting times have since been introduced and further breaches of these targets are no longer expected.

Compliance with the core Standards for Better Health improved during 2007/08, with the board of directors having 'insufficient assurance' in relation to just two standards, compared with four in the previous year, where the board judged the Trust to be 'non-compliant'.

### **Performance assessment of the board**

The chief executive evaluates the performance of each executive and senior director, while the chairman carries this out for the non-executive directors. The deputy chairman/senior independent director leads the evaluation of the chairman of the board of directors.

The board underwent a performance review in October 2006, facilitated by external consultants, and the action plan

was incorporated into the overall business plan for 2007/08. The priority areas for focus were strategic planning, performance management and review, and clinical governance and leadership. Significant progress has been made since the initial assessment, with strengthened clinical risk and governance arrangements, and a more inclusive approach to strategic planning.

## Register of interests for the board of directors

The register of interests of individual directors is available to the public on request in writing to the Director of Corporate Governance, Moorfields Eye Hospital NHS Foundation Trust, 162 City Road, London EC1V 2PD. Tel 020 7566 2490 or email [info@moorfields.nhs.uk](mailto:info@moorfields.nhs.uk)

There were no significant conflicting commitments of the chairman.

## Statement of compliance with the NHS foundation trust code of governance

The board of directors and the membership council are committed to the principles of good corporate governance as detailed in the NHS foundation trust code of governance. Following publication of the code of governance, a detailed review of the compliance position was undertaken by the board and the council to establish progress towards meeting the code provisions.

The code provisions were discussed by the board of directors, which agreed that the Trust would declare non-compliance in the following areas:

- C1.3: the chairman or an independent non-executive director should chair the committee(s).

*Our response* – a public governor chairs the nominations committee for the appointment of the chairman and non-executive directors of the Trust board to ensure there is objective evaluation of the balance of skills, knowledge and experience on the board.

- C.2.1 Re-election: all directors should be submitted for re-appointment or re-election at regular intervals. The board of directors should ensure planned and progressive refreshing of the board of directors. All other executive directors should be appointed by a committee of the chief executive, the chairman and non-executive directors and subject to re-appointment at intervals of no more than five years.

*Our response* – Executive directors have permanent contracts of employment, which do not provide for their periodic re-appointment. The board will give consideration to the implications of altering these contracts to bring them in line with the code of governance during 2008.

## Remuneration report

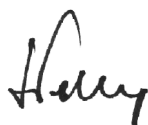
Performance is judged initially by the chief executive for the directors and by the chairman for the chief executive, set against objectives from the previous year.

The chief executive's recommendations are discussed by the remuneration committee at its meeting and agreements reached.

Remuneration is not split into different elements. The committee is always mindful of the national NHS pay uplift for staff and the system within which staff are remunerated when considering each individual, but the final determination of the pay level to any particular individual is based on performance assessment.

All contracts are open ended. The chief executive is on six-months' notice and other directors on three-months' notice. There are no termination payments built into the contracts and there are no contractual provisions for early termination beyond that required by the law. In certain circumstances, an individual may benefit from the provisions of the NHS pension scheme. The Trust does not provide any non-cash benefits within the remuneration package.

One payment for compensation for loss of office was made during 2007/08.



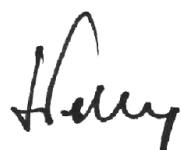
John Pelly,  
Chief executive

# Annual accounts 2007/08

41

## Foreword to the accounts

The accounts for the year ended 31 March 2008 have been prepared by Moorfields Eye Hospital NHS Foundation Trust in accordance with The National Health Service Act 2006.



John Pelly  
Chief executive  
June 2008

## Accounting officer's statement of responsibilities

### Statement of the chief executive's responsibilities as the accounting officer of Moorfields Eye Hospital NHS Foundation Trust

The National Health Service Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including his responsibility for the propriety and regularity of the public finances for which he is answerable and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the independent regulator of NHS foundation trusts ("Monitor").

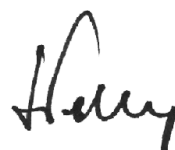
Under the National Health Service Act 2006, Monitor has directed Moorfields Eye Hospital NHS Foundation Trust to prepare for each financial year a Statement of Accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Moorfields Eye Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cashflows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the *NHS Foundation Trust Financial Reporting Manual*, and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Financial Reporting Manual* have been followed and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis

The accounting officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.



John Pelly  
Chief executive  
June 2008

# Statement on internal control 2007/08

## 1 Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that the resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

## 2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Moorfields Eye Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Moorfields Eye Hospital NHS Foundation Trust for the year ended 31 March 2008 and up to the date of approval of the annual report and accounts.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with.

## 3 Capacity to handle risk

### 3.1 Leadership

The Trust board is responsible for risk management across the organisation and delegates authority to the governance and audit committees, while the management executive is responsible for decision-making on business cases and recommendations to the board on the use of resources. Governance and audit are formal sub-committees of the board and are chaired by non-executive directors with executive and senior management support. Accountability for risk management is co-ordinated through governance for clinical and non-clinical risk and audit for financial risk, and there is substantial crossover between the two committees to ensure all elements of risk are considered.

As chief executive, I am the accountable officer for internal control and, therefore, risk management. The director of corporate governance leads the assurance and risk management processes, with day-to-day co-ordination of non-financial risk management led by the head of risk and safety. The finance director leads the financial risk management and governance processes, and the medical director is the lead for clinical risk and clinical governance.

The director of corporate governance manages the compliance processes with the remit of review of all external reports and acting as the link between the Trust and its main regulators – Monitor and the Healthcare Commission.

The role of the director of operations and nursing was strengthened to become chief operating and nursing officer, recognising the breadth of the operational portfolio.

### 3.2 Staff training

There are extensive training programmes available to all groups of staff, which reflect the requirements for mandatory training and competency assessments, thereby equipping staff for their duties, and to manage risk appropriately. Representatives from all departments and functional areas attend either the clinical governance committee or the risk and safety committee, ensuring that they have an ongoing awareness of the current operational and strategic risk issues for the organisation.

Ongoing training is provided for all groups of staff wherever and whenever appropriate and particularly for new procedures and equipment. All new staff receive risk awareness training in their two-day induction programme and this includes fire and security management, risk awareness and incident reporting, and health and safety.

## 4 The risk and control framework

Risk management starts at Trust board level. The board approves all strategy and policy updates and receives regular reports from the chairs of the audit and governance committees who are non-executive directors of the board.

Each of the risk management work streams produces an annual report for the Trust board. Serious incidents are reported to the board, with further reporting following action and outcomes.

### 4.1 Strategy and policy

The Trust board reviewed and approved the risk management strategy and policy in January 2008. The key elements of the strategy are to develop and maintain a clear and effective structure of responsibility and accountability across the whole Trust, with clear systems for identifying and managing risks, so that all employees will be able to play their part in dealing with risk, leading to measurable improvements in patient safety. The strategy is supported by a number of key policies such as:

- Major incident plan
- Health and safety policy
- Incident reporting and investigation policy
- Infection control manual
- Complaints policy
- Consent policy

It is reviewed annually.

The strategy describes the ways of identifying and managing risk from the business planning and controls assurance levels through to incident reporting and the maintenance of a risk register, as well as clinical governance, major incident planning and health and safety. The risk management strategy and linked policies are available to all staff and can be readily accessed via the intranet.

Risk management is embedded in the activities of the organisation through the risk management structure and the range of committees and groups that have

identified risk as a key element of their terms of reference, and through the range of training that is available to staff. Risk also forms part of the project management process for any new development or work stream.

The Trust provides services at a number of other NHS trust sites and the head of risk and safety has an agreement with those trusts' risk managers about communication and lines of responsibility. Wherever possible, the Trust has formal service level agreements in place with the host trusts that clarify risk management processes and responsibilities locally. These are being reviewed and updated.

#### **4.2 Assurance framework**

The Trust board manages its six key risks through the assurance framework, supported by the corporate risk register. Each of the key risks has a board-level co-ordinator who has responsibility for reviewing the controls and assurances required for each of the risks. The audit committee and governance committee oversee the management of the key risks on behalf of the Trust board. The framework and process for managing this has been reviewed during 2007/08, with the support of internal audit. Where scope for improvement was found, recommendations were made and the appropriate action undertaken.

#### **4.3 Information governance**

Information governance and the use of the toolkit is directed and monitored by the information governance steering group. This group reports to the risk and safety committee, which in turn reports to the governance committee. The group meets at least quarterly and is chaired by the head of performance and information, who also

acts as the data protection officer. The medical director is the Caldicott guardian. The Trust board made a qualified declaration on information governance and data security at its meeting in January 2008. An action plan is in place and monitored by the information governance steering group.

#### **4.4 Stakeholders**

The context for risk management is described within the strategy document and incorporates the view of risk and its potential impact upon patients, visitors, staff, the organisation and the external view of the organisation. The priorities and objectives of the risk management strategy best describe how the Trust involves public stakeholders, including:

- The use of effective risk management in setting and achieving the Trust's objectives and as an integral part of its business and corporate planning activities
- The use of risk management to learn from our work in a fair way and for us to develop in every area to ensure the best patient care possible, provided in a safe and financially viable environment.

The Trust has an established complaints management policy, which is an important element of the risk management process. The Trust now has a public and patient membership of approximately 12,000.

The governance committee includes a representative from Islington PCT and two public governors from the membership council. One public governor is a member of the risk and safety committee, and there is patient representation on the clinical effectiveness committee.

In addition to this, the patients' forum and the membership council have reviewed the evidence for Standards for Better Health.

### **5 Review of economy, efficiency and effectiveness of the use of resources**

The board of directors formally reviews the use of resources every month and further detailed work is carried out by the audit committee. In addition, external audit reviews the Trust's arrangements for obtaining value for money. The internal auditors carry out specific value-for-money reviews as required and report their findings to the audit committee.

### **6 Review of effectiveness and significant control issues**

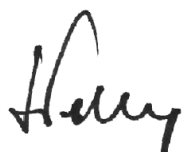
As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit and governance committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place. The board of directors reviewed the assurance framework in April 2007 following review by the governance committee and the changes during the year to the major risks facing the Trust. The executive team has provided reports throughout the year on the management of risk, performance, and clinical governance.

The audit and governance committees provide the board of directors with an independent and objective review of financial and corporate governance, and internal financial control within the internal and external auditors' review systems, controls and processes, and their reports have been reviewed by the audit committee. This work has included identifying and testing the effectiveness of the control, governance and risk management processes that are in place. An external review of the booking management processes was undertaken early in 2008 reflecting the problems that had occurred during the year with potential breaches of the outpatient waiting times targets. Where scope for improvement was found, recommendations were made and the appropriate action plans agreed with management.

To conclude, there are no significant control issues identified.

**The opinion of the head of internal audit is included here:**

Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk and in some areas have resulted in only limited assurance being given. It is my view, however, that in these cases, it is unlikely that significant or material errors or losses will have occurred. We have in all instances provided recommendations, and management has developed action plans for improvement.



John Pelly  
Chief executive  
June 2008

# Independent auditors' report to the membership council and board of directors of Moorfields Eye Hospital NHS Foundation Trust

We have audited the financial statements of Moorfields Eye Hospital NHS Foundation Trust for the year ended 31 March 2008 under the National Health Service Act 2006 ("the Act") which comprise the Income and Expenditure Account, Balance Sheet, Statement of Total Recognised Gains and Losses, Cash Flow Statement and the related notes 1 to 24. These financial statements have been prepared in accordance with the accounting policies set out therein.

This report is made solely to the membership council and board of directors ("the boards") of Moorfields Eye Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of schedule 5 of the Health and Social Care (Community Health and Standards) Act 2003. Our audit work has been undertaken so that we might state to the boards those matters we are required to state to them in an auditors' report and for no other purpose. To the fullest extent permitted by law, we do not, in giving our opinion, accept or assume responsibility to anyone other than the Trust and the boards, as a body, for this report, or for the opinions we have formed.

## Respective responsibilities of directors and auditors

As described in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of the financial statements in accordance with directions issued by

Monitor – the independent regulator of NHS foundation trusts.

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements (including statute and the Audit Code of NHS Foundation Trusts) and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor – the independent regulator of NHS foundation trusts. We also report if, in our opinion, the accounts have not been prepared in accordance with directions made under paragraph 25 of schedule 7 of the Act, the accounts do not comply with the requirements of all other provisions contained in, or having effect under, any enactment applicable to the accounts, or proper practices have not been observed in the compilation of the accounts.

We review whether the Statement on Internal Control reflects compliance with the requirements of Monitor contained in the *NHS Foundation Trust Financial Reporting Manual*. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the Statement on Internal Control covers all risks and controls.

We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We read the other information contained in the annual report as listed on the contents page and consider whether it is consistent with the audited financial statements. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

### **Basis of audit opinion**

We conducted our audit in accordance with the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (UK & Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

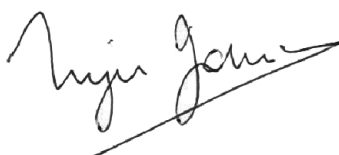
We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

### **Opinion**

In our opinion, the financial statements give a true and fair view of the state of affairs of Moorfields Eye Hospital NHS Foundation Trust as at 31 March 2008 and of its income and expenditure for the year then ended in accordance with the accounting policies directed by Monitor – the independent regulator of NHS foundation trusts.

### **Certificate**

We certify that we have completed the audit of the accounts in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.



Nigel Johnson, senior statutory auditor  
For and on behalf of Deloitte and  
Touche LLP  
Chartered Accountants  
St Albans  
16 June 2008

# Income and expenditure account for the year ended 31 March 2008

	NOTE	2007/08 £000	2006/07 £000
<b>Income from activities</b>	3.1-3.2	<b>75,920</b>	65,469
<b>Other operating income</b>	3.3	<b>20,696</b>	17,878
<b>Total income</b>		<b>96,616</b>	83,347
<b>Operating expenses</b>	4-5	<b>(92,341)</b>	(80,650)
<b>SURPLUS BEFORE INTEREST</b>		<b>4,275</b>	2,697
Interest receivable	6.1	<b>373</b>	212
Interest payable	6.2	<b>(630)</b>	(596)
Other finance costs – unwinding of discount	14	<b>(3)</b>	(3)
<b>SURPLUS FOR THE FINANCIAL YEAR</b>		<b>4,015</b>	2,310
Public Dividend Capital dividends payable	19	<b>(1,780)</b>	(1,471)
<b>RETAINED SURPLUS FOR THE YEAR</b>	15	<b>2,235</b>	839

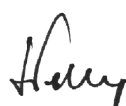
All income and expenditure is derived from continuing operations.  
Notes 1 to 24 form part of these accounts.

# Balance sheet as at 31 March 2008

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	NOTE	31 March 2008 £000	31 March 2007 £000
<b>FIXED ASSETS</b>			
Intangible assets	7	436	457
Tangible assets	8	79,377	74,170
		<u>79,813</u>	<u>74,627</u>
<b>CURRENT ASSETS</b>			
Stocks and work-in-progress	9	2,050	2,117
Debtors	10	6,021	6,724
Investments	11	7,830	–
Cash at bank and in hand		4,130	4,036
		<u>20,031</u>	<u>12,877</u>
<b>CREDITORS:</b> Amounts falling due within one year	12	<u>(17,377)</u>	<u>(26,464)</u>
<b>NET CURRENT ASSETS/(LIABILITIES)</b>		<b>2,654</b>	<b>(13,587)</b>
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>		<u>82,467</u>	<u>61,040</u>
<b>CREDITORS:</b> Amounts falling due after more than one year	12	<b>(11,896)</b>	–
<b>PROVISIONS FOR LIABILITIES AND CHARGES</b>	14	<b>(838)</b>	<b>(399)</b>
<b>TOTAL ASSETS EMPLOYED</b>		<u><u>69,733</u></u>	<u><u>60,641</u></u>
<b>FINANCED BY:</b>			
<b>TAXPAYERS' EQUITY</b>			
Public dividend capital	18	31,279	28,449
Revaluation reserve	15	14,386	10,544
Donated asset reserve	15	16,661	16,647
Income and expenditure reserve	15	7,407	5,001
<b>TOTAL TAXPAYERS' EQUITY</b>		<u><u>69,733</u></u>	<u><u>60,641</u></u>

John Pelly  
Chief executive  
16 June 2008



# Statement of total recognised gains and losses for the year ended 31 March 2008

	<b>2007/08</b> <b>£000</b>	<b>2006/07</b> <b>£000</b>
Surplus for the financial year before dividend payments	<b>4,015</b>	2,310
Unrealised gain on fixed asset revaluations	<b>4,428</b>	–
Net increases in the donated asset reserve due to receipt of donated assets	<b>449</b>	5,246
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	<b>(850)</b>	(399)
<b>Total gains and losses recognised in the financial year</b>	<b><u>8,042</u></b>	<b><u>7,157</u></b>

# Cash flow statement for the year ended 31 March 2008

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	NOTE	2007/08 £000	2006/07 £000
<b>OPERATING ACTIVITIES</b>			
Net cash inflow from operating activities	16.1	11,600	7,552
<b>RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:</b>			
Interest received		366	204
Interest paid		(613)	(598)
Interest element of finance lease rental payments		(17)	-
<b>Net cash outflow from returns on investments and servicing of finance</b>		<b>(264)</b>	<b>(394)</b>
<b>CAPITAL EXPENDITURE</b>			
Payments to acquire tangible fixed assets		(4,334)	(12,819)
Payments to acquire intangible assets		(99)	(174)
<b>Net cash outflow from capital expenditure</b>		<b>(4,433)</b>	<b>(12,993)</b>
<b>DIVIDENDS PAID</b>			
		(1,780)	(1,471)
Net cash inflow/(outflow) before management of liquid resources and financing		5,123	(7,306)
<b>MANAGEMENT OF LIQUID RESOURCES</b>			
Purchase of current asset investments		(37,260)	(84,493)
Sale of current asset investments		29,430	87,743
<b>Net cash (outflow)/inflow from management of liquid resources</b>		<b>(7,830)</b>	<b>3,250</b>
<b>Net cash outflow before financing</b>		<b>(2,707)</b>	<b>(4,056)</b>
<b>FINANCING</b>			
Public dividend capital received		2,830	-
Loans received from Foundation Trust Financing Facility		-	829
Loans repaid to Foundation Trust Financing Facility		(800)	(767)
Other capital receipts		807	4,845
Capital element of finance lease rental payments		(36)	-
<b>Net cash inflow from financing</b>		<b>2,801</b>	<b>4,907</b>
<b>Increase in cash</b>		<b>94</b>	<b>851</b>

# Notes to the accounts

## 1 Accounting policies

The independent regulator of foundation trusts, Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *NHS Foundation Trusts Financial Reporting Manual*, which shall be agreed with HM Treasury. Consequently, the financial statements have been prepared in accordance with the 2007/08 *NHS Foundation Trust Financial Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified for the revaluation of tangible fixed assets at their value to the business by reference to their current replacement costs. NHS foundation trusts, in compliance with the HM Treasury's *Financial Reporting Manual*, are not required to comply with the FRS3 requirements to report "earnings per share" or historical profits and losses.

### 1.2 Income recognition

Income and expenditure is accounted for in accordance with the accruals convention. The main source of income for the Trust is contracts from commissioners for the provision of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to

be delivered in the following financial year, that income is deferred.

### 1.3 Expenditure

Expenditure is accounted for by applying the accruals convention.

### 1.4 Tangible fixed assets

#### Capitalisation

Tangible fixed assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- Individually have a cost of at least £5,000; or
- Form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

#### Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed

asset are not capitalised but are charged to the Income and Expenditure Account in the year to which they relate.

All land and buildings are revalued to current value using professional valuations in accordance with Financial Reporting Standard 15 every five years. A three-yearly interim valuation is also carried out.

An interim professional valuation was carried out during the year ended 31 March 2008 with an effective date of 1 April 2008. The valuation was carried out in accordance with the Royal Institution of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*. This valuation was carried out by Gerald Eve, an external firm of chartered surveyors, with the basis of valuation being depreciated replacement cost. Further detail is shown in Note 8.1.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets in the course of construction are valued at cost and are valued by independent professional valuers as part of the three or five-yearly valuations or when they are brought into use.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

### **Depreciation, amortisation and impairments**

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land or assets surplus to requirements.

Assets in the course of construction are not depreciated until the asset is brought into use.

Buildings, installations and fittings are depreciated over the estimated remaining life of the asset as assessed by the independent professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated over the estimated life of the asset, which varies from five to fifteen years for all equipment.

Fixed asset impairments resulting from losses of economic benefits are charged to the Income and Expenditure Account. All other impairments are taken to the revaluation reserve and reported in the Statement of Total Recognised Gains and Losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

### **1.5 Intangible fixed assets**

Intangible assets are capitalised when they are capable of being used in the Trust's activities for more than one year, they can be valued, and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are amortised over the estimated life of the

asset on a straightline basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be fully recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful economic lives.

### **1.6 Donated fixed assets**

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve.

Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the Income and Expenditure Account. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated assets is transferred from the donated asset reserve to the income and expenditure reserve.

### **1.7 Liquid resources**

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the Cash Flow Statement. These assets, and other current assets, are valued at cost less any amounts written off to represent any impairments in value, and are reviewed annually for impairments.

### **1.8 Government grants**

Government grants are grants from government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three-star status, are accounted for as government grants, as are grants from the Big Lottery Fund. Where the government grant is used to fund revenue expenditure, it is taken to the income and expenditure account to match that expenditure. Where the grant is used to fund capital expenditure, the grant is held as deferred income and released to the Income and Expenditure Account over the life of the asset on a basis consistent with the depreciation charge for that asset.

### **1.9 Stocks and works-in-progress**

Stocks and work-in-progress are valued at the lower of cost and net realisable value. Work-in-progress comprises goods in intermediate stages of production.

### **1.10 Cash, bank and overdrafts**

Cash, bank and overdraft balances are recorded at the current values of these balances in the NHS Foundation Trust's cash book. These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients (see "third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases, overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

### 1.11 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- There is a clearly defined project;
- The related expenditure is separately identifiable;
- The outcome of the project has been assessed with reasonable certainty as to:
  - Its technical feasibility;
  - Its resulting in a product or service which will eventually be brought into use;
- Adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Income and Expenditure Account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS foundation trusts disclose the total amount of research and development expenditure charged in the income and expenditure account separately. However, where research and development activity cannot be separated from patient care activity, it cannot be identified and is therefore not separately disclosed.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

### 1.12 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate

of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

### 1.13 Clinical negligence costs

The NHS Litigation Authority (NHS LA) operates a risk pooling scheme, under which the NHS Foundation Trust pays an annual contribution to the NHS LA, which, in return, settles all clinical negligence claims. Although the NHS LA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHS LA on behalf of the NHS Foundation Trust is disclosed in note 14.

### 1.14 Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

### 1.15 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.pensions.nhsbsa.nhs.uk](http://www.pensions.nhsbsa.nhs.uk). The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales.

The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year.

An outline of these follows:

#### **a) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates, was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are

on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

#### **b) FRS Accounting Valuation**

In accordance with FRS17, a valuation of the scheme liability is carried out annually by the scheme actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point, the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the Scheme Actuary Report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

#### **Scheme provisions as at 31 March 2008**

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last three years' pensionable pay for each year of service. A lump sum normally equivalent to three years' pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on

changes in retail prices in the 12 months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement, employees can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

### ***Scheme provisions from 1 April 2008***

From 1 April 2008, changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website [www.pensions.nhsbsa.nhs.uk](http://www.pensions.nhsbsa.nhs.uk).

### **1.16 Value added tax**

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### **1.17 Foreign exchange**

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure Account.

### **1.18 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them.

No such assets were held during the 2007/08 financial year.

### **1.19 Leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease.

The asset and liability are recognised at the inception of the lease and are de-recognised when the liability is discharged, cancelled or expires.

The interest element of the finance lease payment is charged to the income and expenditure account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the payment is charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

### **1.20 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS trust.

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple mean of opening and closing net relevant assets.

### **1.21 Corporation tax**

Corporation tax is payable on non-patient related healthcare profits over a value of £50,000. Moorfields Eye Hospital NHS Foundation Trust has no non-patient healthcare related activities.

## 2 Segmental analysis

The Trust has two geographical business segments – United Kingdom (UK) and the United Arab Emirates (UAE).

	<b>UK</b>	<b>UAE</b>	<b>Total</b>
<b>2007/08</b>	£000	£000	<b>£000</b>
<b>Income by segment</b>			
Income from activities	75,383	537	<b>75,920</b>
Other operating income	20,696	–	<b>20,696</b>
	<u>96,079</u>	<u>537</u>	<u><b>96,616</b></u>
Surplus/(deficit) before interest	5,849	(1,574)	<b>4,275</b>
<b>Total assets employed</b>	<u><u>67,688</u></u>	<u><u>2,045</u></u>	<u><u><b>69,733</b></u></u>

	<b>UK</b>	<b>UAE</b>	<b>Total</b>
<b>2006/07</b>	£000	£000	£000
<b>Income by segment</b>			
Income from activities	65,469	–	65,469
Other operating income	17,878	–	17,878
	<u>83,347</u>	<u>–</u>	<u>83,347</u>
Surplus before interest	2,697	–	2,697
<b>Total assets employed</b>	<u><u>59,423</u></u>	<u><u>1,218</u></u>	<u><u>60,641</u></u>

### 3. Income

#### 3.1 Income from activities by type

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
Elective income	<b>24,636</b>	22,437
Non-elective income	<b>5,275</b>	5,361
Outpatient income	<b>23,880</b>	22,678
A&E income	<b>6,156</b>	5,444
Total income at full tariff	<b>59,947</b>	55,920
Payment by results clawback*	–	(3,769)
Net income from full tariff activities	<b>59,947</b>	52,151
Non-tariff NHS income	<b>6,021</b>	4,589
Non-NHS – other	<b>909</b>	834
Private patient income	<b>9,043</b>	7,895
	<b>75,920</b>	65,469

\* This was previously the gain on the new national tariff for NHS activity that was repaid to PCT commissioners in 2006/07.

#### 3.2 Income from activities by source

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
NHS foundation trusts	<b>180</b>	200
NHS trusts	<b>2,111</b>	231
Strategic health authorities	<b>457</b>	–
Primary care trusts	<b>45,546</b>	42,748
Department of health	<b>17,518</b>	13,560
Non-NHS:		
- Private patients	<b>9,043</b>	7,895
- Overseas patients (non-reciprocal)	<b>13</b>	–
- Road Traffic Act	<b>5</b>	1
- Other	<b>1,047</b>	834
	<b>75,920</b>	65,469

### 3.3 Other operating income

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
Research and development	<b>6,137</b>	5,319
Education and training	<b>3,456</b>	3,384
Charitable and other contributions to expenditure	<b>672</b>	892
Transfers from donated asset reserve	<b>850</b>	399
Pharmaceutical drug sales	<b>5,009</b>	3,247
Other income	<b>4,572</b>	4,637
	<b><u>20,696</u></b>	<u>17,878</u>

### 3.4 Private patient income

	<b>2007/08</b>	2002/03
	<b>£000</b>	£000
Private patient income	<b>9,043</b>	6,376
Total patient-related income	<b>80,929</b>	46,404
	<b><u>11.17%</u></b>	<u>13.74%</u>

NHS foundation trusts under section 15 of the Health and Social Care (Community Health and Standards) Act 2003 are required to ensure that the proportion of private patient income to total patient-related income does not exceed the proportion in the base 2002/03 financial year, which was 13.74%.

### 3.5 Income by protected and non-protected services

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
Protected income	<b>82,564</b>	72,205
Non-protected income	<b>14,052</b>	11,142
	<b><u>96,616</u></b>	<u>83,347</u>

Protected services are those that are required for the mandatory provision of healthcare services.

## 4. Operating expenses

### 4.1 Operating expenses comprise:

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
Services from NHS foundation trusts	<b>656</b>	616
Services from other NHS trusts	<b>2,751</b>	1,931
Services from other NHS bodies	<b>312</b>	233
Executive directors' costs	<b>1,140</b>	643
Non-executive directors' costs	<b>95</b>	82*
Staff costs	<b>57,154</b>	51,891
Drug costs	<b>3,925</b>	3,293
Supplies and service – clinical (excluding drug costs)	<b>7,558</b>	6,725
Supplies and services – general	<b>613</b>	626
Establishment	<b>1,752</b>	1,327
Transport	<b>1,590</b>	1,587
Premises	<b>6,956</b>	5,927
Increase in disputed debt provision	<b>411</b>	318**
Depreciation and amortisation	<b>4,232</b>	3,135
Auditors' fees – statutory audit	<b>57</b>	49
Auditors' fees – regulatory reporting	<b>41</b>	33
Other auditors' remuneration	<b>55</b>	16
Clinical negligence	<b>359</b>	319
Other	<b>2,684</b>	1,899
	<b><u>92,341</u></b>	<b><u>80,650</u></b>

\* Non-executive directors' costs were not disclosed separately in 2006/07

\*\* Increase/(decrease) in bad debt provision were included within Other in 2006/07

### 4.2 Operating lease rentals

#### 4.2.1 Operating expenses include:

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
Hire of plant and machinery	<b>447</b>	468
Other operating lease rentals	<b>830</b>	944
	<b><u>1,277</u></b>	<b><u>1,412</u></b>

#### 4.2.2 Annual commitments under non-cancellable operating leases are:

	<b>Land and buildings</b>		<b>Other leases</b>	
	<b>2007/08</b>	<b>2006/07</b>	<b>2007/08</b>	<b>2006/07</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Operating leases which expire:				
Within 1 year	<b>437</b>	645	-	51
Between 1 and 5 years	<b>45</b>	722	-	-
After 5 years	<b>446</b>	276	<b>648</b>	341
	<b><u>928</u></b>	<b><u>1,643</u></b>	<b><u>648</u></b>	<b><u>392</u></b>

### 4.3 Salary and pension entitlements of senior managers

#### a) Remuneration

Name and title	2007/08		2006/07	
	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000
Mr G Aylward, medical director	175 – 180	–	145 – 150	–
Mr I A J Balmer, chief executive (1)	155 – 160	225 – 230	125 – 130	–
Mr M Cubbon, chief operating and nursing officer (2)	40 – 45	–	–	–
Ms S Fisher, nursing director (3) *	5 – 10	–	–	–
Mr R A Hitchings, research director	65 – 70	–	65 – 70	–
Mr I J Hollows, finance director (4)	0 – 5	–	–	–
Mr I M Knott, finance director (5)	95 – 100	25 – 30	100 – 105	–
Mr J Pelly, chief executive (6)	0 – 5	–	–	–
Sir T P J Boyd-Carpenter, chairman	35 – 40	–	25 – 30	–
Mr I J Hollows, non-executive director (4)	10 – 15	–	10 – 15	–
Prof P. Luthert, non-executive director	10 – 15	–	5 – 10	–
Mr R Markham, non-executive director	10 – 15	–	5 – 10	–
Mr C Nickolds, non-executive director	10 – 15	–	10 – 15	–
Ms M A van Reenen, non-executive director	10 – 15	–	5 – 10	–
Ms D Harris, non-executive director (7)	0 – 5	–	–	–

\* Ms S Fisher withheld consent to disclose salary details in 2006/07.

(1) Mr I A J Balmer – left 31 March 2008

(2) Mr M Cubbon – joined 24 September 2007

(3) Ms S Fisher – left 30 April 2007

(4) Mr I J Hollows – left 31 December 2007 as a non-executive director and joined 1 March 2008 as finance director

(5) Mr I M Knott – left 2 March 2008

(6) Mr J Pelly – joined 31 March 2008

(7) Ms D Harris – joined 1 January 2008

**b) Pension benefits**

<b>Name and Title</b>	<b>Value of automatic lump sums at 31 March 2008 (bands of £2,500) £000</b>	<b>Real increase in year in the value of automatic lump sums (bands of £2,500) £000</b>	<b>Cash Equivalent Transfer Value at 31 March 2008 (bands of £1,000) £000</b>	<b>Real increase in Cash Equivalent Transfer Value in 2007/2008 (bands of £1,000) £000</b>
Mr G Aylward, medical director	140.0 – 142.5	12.5 – 15.0	728 – 729	59 – 60
Mr I A J Balmer, chief executive (1)	152.5 – 155.0	35.0 – 37.5	792 – 793	141 – 142
Mr I M Knott, finance director (2)	80.0 – 82.5	25.0 – 27.5	–	–
Mr R A Hitchings, research director	–	–	–	–
Mr M Cubbon, chief operating and nursing officer (3)	22.5 – 25.0	0 – 2.5	80 – 81	12 – 13
Ms S Fisher, nursing director (4)	77.5 – 80.0	0 – 2.5	371 – 372	4 – 5
Mr J Pelly, chief executive (5)	75.0 – 77.5	0 – 2.5	443 – 444	0 – 1
Mr I Hollows, finance director (6)	–	–	–	–

(1) Mr I A J Balmer – left 31 March 2008

(2) Mr I M Knott – left 2 March 2008

(3) Mr M Cubbon – joined 24 September 2007

(4) Ms S Fisher – left 30 April 2007

(5) Mr J Pelly – joined 31 March 2008

(6) Mr I Hollows – joined 31 March 2008, with no prior NHS pension entitlement

Non-executive directors do not receive pensionable remuneration.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the Pension Scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

## 5. Staff costs and numbers

### 5.1 Staff costs

	<b>Total</b>	<b>Permanently employed</b>	<b>Other</b>	
	<b>2007/08</b>	<b>2007/08</b>	<b>2007/08</b>	2006/07
	<b>£000</b>	<b>£000</b>	<b>£000</b>	£000
Salaries and wages	<b>46,204</b>	46,204	–	41,759
Social security costs	<b>3,647</b>	3,647	–	3,777
Employer contributions to NHSPA	<b>4,910</b>	4,910	–	4,764
Other pension costs	<b>343</b>	343	–	–
Agency staff	<b>3,285</b>	–	3,285	2,233
	<b><u>58,389</u></b>	<b><u>55,104</u></b>	<b><u>3,285</u></b>	<b><u>52,533</u></b>

### 5.2 Average number of persons employed

	<b>Total</b>	<b>Permanently employed</b>	<b>Other</b>	
	<b>2007/08</b>	<b>2007/08</b>	<b>2007/08</b>	2006/07
	<b>Number</b>	<b>Number</b>	<b>Number</b>	Number
Medical and dental	<b>205</b>	205	–	220
Administration and estates	<b>492</b>	492	–	479
Healthcare assistants and other support staff	<b>47</b>	47	–	46
Nursing, midwifery and health visiting staff	<b>304</b>	304	–	299
Scientific, therapeutic and technical staff	<b>190</b>	190	–	229
Agency staff	<b>109</b>	–	109	77
Total	<b><u>1,347</u></b>	<b><u>1,238</u></b>	<b><u>109</u></b>	<b><u>1,350</u></b>

### 5.3 Employee benefits

	<b>2007/08</b>	<b>2006/07</b>
	<b>£000</b>	<b>£000</b>
Various employee taxable benefits in kind*	<b>3</b>	9
	<b><u>3</u></b>	<u>9</u>

\*In respect of Moorfields Surgeons Association organised staff activities.

### 5.4 Retirements due to ill-health

During 2007/08, there were no early retirements on ill-health grounds (2006/07:3), at a cost of £nil (2006/07:£125,071). These retirements represent nil per 1,000 active scheme members. This information has been supplied by the NHS Pensions Agency.

## 6. Interest

### 6.1 Interest receivable

	<b>2007/08</b> <b>£000</b>	2006/07 £000
Held to maturity money market investments	<b>73</b>	111
Office of HM Paymaster General	<b>300</b>	101
<b>Total</b>	<b>373</b>	212

### 6.2 Interest payable

	<b>2007/08</b> <b>£000</b>	2006/07 £000
Loans from Foundation Trust Financing Facility	<b>589</b>	582
Finance leases	<b>17</b>	–
Working capital facility charge	<b>–</b>	14
Other	<b>24</b>	–
<b>Total</b>	<b>630</b>	596

## 7. Intangible fixed assets

	<b>Software licences</b> <b>£000</b>	<b>Development expenditure</b> <b>£000</b>	<b>Total</b> <b>£000</b>
Gross cost at 1 April 2007	745	196	941
Additions – purchased	99	–	99
Gross cost at 31 March 2008	<b>844</b>	<b>196</b>	<b>1,040</b>
Amortisation at 1 April 2007	390	94	484
Provided during the year	115	5	120
<b>Accumulated amortisation at 31 March 2008</b>	<b>505</b>	<b>99</b>	<b>604</b>
<b>Net book value</b>			
- Purchased at 1 April 2007	332	102	434
- Donated at 1 April 2007	23	–	23
<b>- Total at 1 April 2007</b>	<b>355</b>	<b>102</b>	<b>457</b>
- Purchased at 31 March 2008	321	97	418
- Donated at 31 March 2008	18	–	18
<b>- Total at 31 March 2008</b>	<b>339</b>	<b>97</b>	<b>436</b>

## 8 Tangible fixed assets

### 8.1 Tangible fixed assets at the balance sheet date comprise the following elements:

	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2007	11,550	52,226	1,218	21,661	189	8,705	1,084	96,633
Additions purchased	-	1,947	-	1,118	-	1,515	-	4,580
Additions donated	-	288	-	161	-	-	-	449
Reclassifications	-	1,218	(1,218)	-	-	-	-	-
Other revaluations	1,280	852	-	-	-	-	-	2,132
Disposals	-	(142)	-	-	-	-	-	(142)
<b>At 31 March 2008</b>	<b>12,830</b>	<b>56,389</b>	<b>-</b>	<b>22,940</b>	<b>189</b>	<b>10,220</b>	<b>1,084</b>	<b>103,652</b>
Depreciation at 1 April 2007	-	2,264	-	13,377	185	6,261	376	22,463
Provided during the year	-	1,752	-	1,425	1	865	69	4,112
Other revaluations	-	(2,296)	-	-	-	-	-	(2,296)
Disposals	-	(4)	-	-	-	-	-	(4)
<b>Accumulated depreciation at 31 March 2008</b>	<b>-</b>	<b>1,716</b>	<b>-</b>	<b>14,802</b>	<b>186</b>	<b>7,126</b>	<b>445</b>	<b>24,275</b>
<b>Net book value</b>								
- Purchased at 1 April 2007	11,550	36,023	1,218	5,947	4	2,334	392	57,468
- Donated at 1 April 2007	-	13,939	-	2,337	-	110	316	16,702
<b>Total at 1 April 2007</b>	<b>11,550</b>	<b>49,962</b>	<b>1,218</b>	<b>8,284</b>	<b>4</b>	<b>2,444</b>	<b>708</b>	<b>74,170</b>
- Purchased at 31 March 2008	12,830	40,520	-	6,116	3	2,944	366	62,779
- Donated at 31 March 2008	-	14,153	-	2,022	-	150	273	16,598
<b>Total at 31 March 2008</b>	<b>12,830</b>	<b>54,673</b>	<b>-</b>	<b>8,138</b>	<b>3</b>	<b>3,094</b>	<b>639</b>	<b>79,377</b>

### 8.2 Analysis of protected and unprotected tangible fixed assets

	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Net book value	11,610	44,409	-	8,138	-	3,094	-	56,019
- Protected assets at 31 March 2008	1,220	10,264	-	8,138	3	3,094	639	23,358
- Unprotected assets at 31 March 2008	-	-	-	-	-	-	-	-
<b>Total at 31 March 2008</b>	<b>12,830</b>	<b>54,673</b>	<b>-</b>	<b>8,138</b>	<b>3</b>	<b>3,094</b>	<b>639</b>	<b>79,377</b>

Protected assets are those that are required for the mandatory provision of healthcare services.

**8.3 The net book value of land and buildings at 31 March 2008 comprised:**

	<b>31 March 2008</b>	31 March 2007
	<b>£000</b>	£000
Freehold	<b>17,000</b>	1,003
Long leasehold	<b>50,503</b>	60,509
<b>TOTAL</b>	<b><u>67,503</u></b>	<u>61,512</u>

**9. Stocks and work-in-progress**

	<b>31 March 2008</b>	31 March 2007
	<b>£000</b>	£000
Raw materials and consumables	<b>298</b>	250
Finished goods	<b>1,752</b>	1,867
<b>TOTAL</b>	<b><u>2,050</u></b>	<u>2,117</u>

**10. Debtors****10.1 Debtors at the balance sheet date are made up of:**

	<b>31 March 2008</b>	31 March 2007
	<b>£000</b>	£000
<b>Amounts falling due within one year:</b>		
NHS debtors	<b>2,642</b>	2,868
Provision for irrecoverable debts	<b>(1,204)</b>	(792)
Other prepayments and accrued income	<b>1,158</b>	763
Other debtors	<b>3,334</b>	3,733
Sub total	<b><u>5,903</u></b>	<u>6,572</u>
<b>Amounts falling due after more than one year:</b>		
NHS debtors	<b>91</b>	152
<b>TOTAL</b>	<b><u>6,021</u></b>	<u>6,724</u>

**10.2 Provision for impairment of NHS debtors**

	<b>31 March 2008</b>	31 March 2007
	<b>£000</b>	£000
Balance at 1 April	<b>469</b>	380
Provision for debtors impairment	<b>287</b>	190
Debtors written off during year as uncollectable	<b>(6)</b>	(101)
Balance at 31 March	<b><u>750</u></b>	<u>469</u>

**10.3 Analysis of impaired debtors**

	<b>31 March 2008</b>	31 March 2007
	<b>£000</b>	£000
<b>Ageing of impaired debtors</b>		
Up to three months	<b>139</b>	–
In three to six months	<b>74</b>	195
Over six months	<b>991</b>	598
Total	<b><u>1,204</u></b>	<u>793</u>

**Ageing of non-impaired debtors past their due date**

Up to three months	<b>546</b>	830
In three to six months	<b>321</b>	315
Over six months	<b>753</b>	107
Total	<b><u>1,620</u></b>	<u>1,252</u>

## 11. Current asset investments

	<b>31 March 2008</b>	31 March 2007
	<b>£000</b>	£000
Balance at 1 April	-	3,250
Additions	<b>37,260</b>	84,493
Disposals	<b>(29,430)</b>	(87,743)
	<hr/>	<hr/>
Balance at 31 March	<b><u>7,830</u></b>	<u>-</u>

All investment transactions have been short-term cash deposits with the National Loans Fund.

## 12. Creditors

### 12.1 Creditors at the balance sheet date are made up of:

	<b>31 March 2008</b>	31 March 2007
	<b>£000</b>	£000
<b>Amounts falling due within one year:</b>		
Current instalments due on loans	<b>800</b>	13,242
Interest payable	<b>48</b>	48
Payments received on account	<b>477</b>	-
NHS creditors	<b>4,606</b>	3,816
Tax and social security costs	<b>1,892</b>	1,787
Obligations under finance leases and HP contracts	<b>39</b>	-
Capital creditors	<b>1,120</b>	425
Other creditors	<b>5,815</b>	4,766
Accruals and deferred income	<b>2,580</b>	2,380
<b>Sub total</b>	<b><u>17,377</u></b>	<b><u>26,464</u></b>
<b>Amounts falling due after more than one year:</b>		
Long-term loans	<b>11,642</b>	-
Obligations under finance leases and HP contracts	<b>141</b>	-
Other	<b>113</b>	-
<b>Sub total</b>	<b><u>11,896</u></b>	<u>-</u>
<b>TOTAL</b>	<b><u>29,273</u></b>	<b><u>26,464</u></b>
NHS creditors include:		
Outstanding pension contributions	<u><b>5</b></u>	<u>5</u>

## 12.2 Loans

	<b>31 March 2008</b> <b>£000</b>	31 March 2007 £000
Amounts falling due:		
In one year or less	<b>800</b>	13,242
Between one and two years	<b>800</b>	–
Between two and five years	<b>2,401</b>	–
Over 5 years	<b>8,441</b>	–
<b>TOTAL</b>	<b><u>12,442</u></b>	<u>13,242</u>

	<b>31 March 2008</b> <b>£000</b>	<b>31 March 2007</b> <b>£000</b>
Of which:		
- wholly repayable within 5 years	<b>4,001</b>	13,242
- wholly repayable after five years, by instalments	<b>8,441</b>	–
	<b><u>12,442</u></b>	<u>13,242</u>

The loans that the Trust has with the Foundation Trust Financing Facility, shown in note 12.2, were categorised as at 31 March 2007 as falling due within one year due to an inadvertent breach of the Prudential Borrowing Code. The loans have been categorised at 31 March 2008 by their due date of repayment.

The Trust has three loans with the Foundation Trust Financing Facility:

- £4,640,000 - The Trust is paying this loan in two tranches. Tranche A of this loan is for £1,120,000, with an interest rate of 4.65%. Tranche B of this loan is for £3,520,000 with an interest rate of 4.6%. Capital of £320,000 is being repaid in instalments each year and the loan will be redeemed in 2030.
- £7,005,680 - The Trust is paying the loan in three tranches. Tranche A of the loan is for £1,536,000, with an interest rate of 4.5%. Tranche B of this loan is for £520,080 with an interest rate of 4.45%. Tranche C of this loan is for £4,949,600, with an interest rate of 4.4%. Capital of £447,160 is being repaid in instalments each year and the loan will be redeemed in 2031.
- £795,840 - The Trust is paying this loan in one tranche, with an interest rate of 5.05%. Capital of £33,160 is being repaid in instalments each year and the loan will be repaid by 2032.

### 13. Finance lease obligations

	<b>31 March 2008 £000</b>	31 March 2007 £000
Amounts falling due:		
- within one year	<b>53</b>	–
- between one and five years	<b>160</b>	–
- after five years	<b>–</b>	–
Sub total	<b>213</b>	–
Finance charges allocated to future periods	<b>(33)</b>	–
<b>Net obligations</b>	<b>180</b>	–

### Minimum lease payments

	<b>Gross £000</b>	<b>Finance charges £000</b>	<b>Net £000</b>
- within one year	53	14	39
- between one and five years	160	19	141
<b>Total</b>	<b>213</b>	<b>33</b>	<b>180</b>
	<b>Gross £000</b>	<b>Finance charges £000</b>	<b>Net £000</b>
<b>Balance as at 31 March 2007</b>			
Lease entered into	304	50	254
Payments effected	(91)	(17)	(74)
<b>Balance as at 31 March 2008</b>	<b>213</b>	<b>33</b>	<b>180</b>

### 14. Provisions for liabilities and charges

	Pensions relating to former directors £000	Pensions relating to other staff £000	Provision relating to HMRC £000	Other £000	<b>Total £000</b>
At 1 April 2007	127	25	247	–	<b>399</b>
Arising during the year	–	–	672	31	<b>703</b>
Utilised during the year	(10)	(10)	–	–	<b>(20)</b>
Reverse unused	–	–	(247)	–	<b>(247)</b>
Unwinding of discount	3	–	–	–	<b>3</b>
<b>At 31 March 2008</b>	<b>120</b>	<b>15</b>	<b>672</b>	<b>31</b>	<b>838</b>
<b>Expected timing of cashflows:</b>					
Within one year	10	10	672	31	<b>723</b>
Between one and five years	40	5	–	–	<b>45</b>
After five years	70	–	–	–	<b>70</b>
At 31 March 2008	<b>120</b>	<b>15</b>	<b>672</b>	<b>31</b>	<b>838</b>

Pensions provisions relate to pre-1995 pension-related costs on early retirements.

The HMRC provision relates to VAT partial exemption claims for prior years.

£315k is included in the provisions of the NHS Litigation Authority at 31 March 2008 in respect of clinical negligence liabilities of the Trust (31 March 2007, no notification).

## 15. Movements on reserves

Movements on reserves in the year comprised the following:

	Revaluation reserve £000	Donated asset reserve £000	Income and expenditure reserve £000	<b>Total £000</b>
At 1 April 2007	10,544	16,647	5,001	<b>32,192</b>
Transfer from the Income and Expenditure Account	–	–	2,235	<b>2,235</b>
Surplus on revaluations of fixed assets	4,013	415	–	<b>4,428</b>
Receipt of donated assets	–	449	–	<b>449</b>
Transfers to the income and expenditure account for depreciation	–	(850)	–	<b>(850)</b>
Other transfers between reserves	(171)	–	171	<b>–</b>
At 31 March 2008	<b><u>14,386</u></b>	<b><u>16,661</u></b>	<b><u>7,407</u></b>	<b><u>38,544</u></b>

## 16. Notes to the Cash Flow Statement

**16.1 Reconciliation of operating surplus to net cash flow from operating activities:**

	<b>2007/08 £000</b>	2006/07 £000
Total operating surplus	<b>4,275</b>	2,697
Depreciation and amortisation charge	<b>4,232</b>	3,135
Transfer from donated asset reserve	<b>(850)</b>	(399)
Decrease/(increase) in stocks	<b>67</b>	(578)
Decrease in debtors	<b>703</b>	828
Increase in creditors	<b>2,734</b>	2,002
Increase/(decrease) in provisions	<b>439</b>	(133)
Net cash inflow from operating activities	<b><u>11,600</u></b>	<u>7,552</u>

**16.2 Reconciliation of net cash flow to movement in net debt**

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
Increase in cash in the period	<b>94</b>	851
Cash inflow from new debt	<b>(216)</b>	(829)
Cash outflow from debt repaid	<b>836</b>	767
Cash inflow/(outflow) from movement in liquid resources	<b>7,830</b>	(3,250)
Change in net debt resulting from cashflows	<b>8,544</b>	(2,461)
Net debt at 1 April	<b>(9,206)</b>	(6,745)
Net debt at 31 March	<b>(662)</b>	(9,206)

**16.3 Analysis of changes in net debt**

	At 1 April 2007 £000	Cash changes in year £000	<b>At 31st March 2008 £000</b>
Commercial cash at bank and in hand	29	151	<b>180</b>
Office of the Paymaster			
General cash at bank	4,007	(57)	<b>3,950</b>
Debt due within one year	(800)	–	<b>(800)</b>
Debt due after one year	(12,442)	800	<b>(11,642)</b>
Finance leases	–	(180)	<b>(180)</b>
Current asset investments	–	7,830	<b>7,830</b>
	<b>(9,206)</b>	<b>8,544</b>	<b>(662)</b>

**17. Capital commitments**

Commitments under capital expenditure contracts as at 31 March 2008 were £3,008,807 (2006/07: £2,437,000).

**18. Movement in public dividend capital**

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
Public dividend capital as at 1 April	<b>28,449</b>	28,449
New public dividend capital received	<b>2,830</b>	–
Public dividend capital as at 31 March	<b>31,279</b>	28,449

## 19. Movement in taxpayers' equity

	<b>2007/08</b>	2006/07
	<b>£000</b>	£000
Surplus for the financial year	<b>4,015</b>	2,310
Public dividend capital dividends	<b>(1,780)</b>	(1,471)
Surplus on revaluations of fixed assets and current asset investments	<b>4,013</b>	–
New public dividend capital in year	<b>2,830</b>	–
Additions to donated asset reserve	<b>14</b>	4,847
Net increase in taxpayers' equity	<b>9,092</b>	5,686
Opening taxpayers' equity	<b>60,641</b>	54,955
Closing taxpayers' equity	<b>69,733</b>	60,641

## 20. Financial performance

### 20.1 Public dividend capital dividend

The Trust is required to make a public dividend capital dividend at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital totalling £1,780,000 bears to the average relevant net assets of £44,554,000, that is 3.5%

In 2007/08, the dividends paid totalled £1,780,000, based on the average relevant net assets of £44,554,000, that equated to 4%.

### 20.2 Performance against Prudential Borrowing Limit

The Trust is subject to a Prudential Borrowing Limit. This is made up of two elements:

- The maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long-term borrowing limit.
- The amount of any working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the independent regulator of foundation trusts.

The Trust had a Prudential Borrowing Limit of £13,800,000 in 2007/08 (2006/07:£12,445,000). The Trust has not drawn down further borrowings in 2007/08 (2006/07:£829,000). Total borrowings are shown in note 12.2.

Performance against the approved Prudential Borrowing Limit (PBL) ratios is shown below:

<b>Financial ratios - 2007/08</b>	<b>Actual ratios</b>	<b>Approved PBL ratios</b>
Maximum debt/capital ratio	<b>12.46%</b>	<b>&lt;25%</b>
Minimum dividend cover	<b>4.63</b>	<b>&gt;1x</b>
Minimum interest cover	<b>15.01</b>	<b>&gt;3x</b>
Minimum debt service cover	<b>6.36</b>	<b>&gt;2x</b>
Maximum debt service to revenue	<b>1.44%</b>	<b>&lt;3%</b>

<b>Financial ratios - 2006/07</b>	<b>Actual ratios</b>	<b>Approved PBL ratios</b>
Maximum debt/capital ratio	<b>15.16%</b>	<b>&lt;15%</b>
Minimum dividend cover	<b>3.70</b>	<b>&gt;1x</b>
Minimum interest cover	<b>10.25</b>	<b>&gt;3x</b>
Minimum debt service cover	<b>4.34</b>	<b>&gt;2x</b>
Maximum debt service to revenue	<b>1.67%</b>	<b>&lt;3%</b>

The Trust has an approved working capital facility of £6,000,000 (2006/07: £6,000,000).

## **21. Related party transactions**

Moorfields Eye Hospital NHS Foundation Trust is a public benefit corporation established under the Health and Social Care (Community Health and Standards) Act 2003.

During the year, none of the board members or members of the key management staff, or parties related to them, has undertaken any material transactions with Moorfields Eye Hospital NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year, Moorfields Eye Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent company.

The Trust has also had a significant number of material transactions with the Friends of Moorfields, Special Trustees of Moorfields Eye Hospital, and Moorfields Eye Hospital Development Fund. These three charities work closely with the Trust and should be regarded as related parties.

Income/donations for the year from Friends of Moorfields was £299,895 (2006/07: £285,285), whilst debtors were £136,215 (2006/07: £192,723). There was no in-year expenditure or year-end creditor.

Income/donations for the year from the Special Trustees of Moorfields Eye Hospital was £478,231 (2006/07: £575,694), whilst debtors were £140,319 (2006/07: £94,188). There was no in-year expenditure or year-end creditor.

Income/donations for the year from Moorfields Eye Hospital Development Fund was £33,886 (2006/07:£5,265,926), whilst debtors were £30,175 (2006/07:£465,012). There was no in-year expenditure or year-end creditor.

## 22. Financial instruments

*FRS13 Derivatives and Other Financial Instruments* requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Because of the continuing service-provider relationship that the Foundation Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by other business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which *FRS13* mainly applies.

The Foundation Trust has power to borrow in accordance with with the Prudential Borrowing Code issued by the independent regulator for foundation trusts. Surplus funds may also be invested in accordance with the investment policy as approved by the Trust board. Financial assets and liabilities are generated by day-to-day operational activities and are not held to change the risks facing the foundation trust in undertaking its activities.

As allowed by *FRS13*, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile.

### Liquidity risk

A large proportion of the Foundation Trust's net operating costs are incurred under annual service agreements with primary care trusts, which are financed from resources voted annually by Parliament. Capital expenditure has been financed from internal funds and donations. In addition, the Foundation Trust Financing Facility has been set up to provide a source of capital funding for foundation trusts, and has funds allocated to it for this purpose from the Treasury. Moorfields Eye Hospital NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

### Foreign currency risk

The Trust has negligible foreign currency income or expenditure.

#### 22.1 Financial assets

	<b>Floating rate £000</b>
Denominated in £ sterling	16,491
In other currencies, restated in £ sterling	257
<b>Gross financial assets as at 31 March 2008</b>	<b>16,748</b>
Denominated in £ sterling	9,942
In other currencies, restated in £ sterling	–
<b>Gross financial assets as at 31 March 2007</b>	<b>9,942</b>

## 22.2 Analysis of financial liabilities

	<b>Floating rate £000</b>
Denominated in £ sterling	29,236
In other currencies, restated in £ sterling	205
<b>Gross financial assets as at 31 March 2008</b>	<b><u>29,441</u></b>
Denominated in £ sterling	26,616
In other currencies, restated in £ sterling	–
<b>Gross financial assets as at 31 March 2007</b>	<b><u>26,616</u></b>

## 22.3 Fair values of financial assets at 31 March 2008

Set out below is a comparison, by category, of book values and fair values of the Trust's financial assets and liabilities at 31 March 2008.

	<b>Book value</b>	<b>Fair value</b>	<b>Basis of fair valuation</b>
	<b>£000</b>	<b>£000</b>	
	<b>31 March 2008</b>	<b>31 March 2008</b>	
<b>Financial assets</b>			
Debtors over 1 year:			
- Agreements with commissioners to cover creditors and provisions	91	91	Note a
Investments	7,830	7,830	Note b
Cash	4,130	4,130	
<b>Total</b>	<b><u>12,051</u></b>	<b><u>12,051</u></b>	
<b>Financial liabilities</b>			
Creditors over 1 year	(255)	(255)	
Provisions under contract	(838)	(838)	Note c
Loans	(12,442)	(12,442)	Note d
<b>Total</b>	<b><u>(13,535)</u></b>	<b><u>(13,535)</u></b>	

### Notes

- a These debtors reflect agreements with commissioners to cover creditors over 1 year for early retirements and provisions under contract, and their related interest charge/unwinding of discount. In line with note d, below, fair value is not significantly different from book value.
- b The figure here is the short-term investment with the National Loans Fund. It is expected that book value equals fair value.
- c Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.
- d These are loans from the Foundation Trust Financing Facility where it is expected that the book value will equal fair value.

### 23. Intra-government and other balances

	<b>Debtors: amounts falling due within one year</b>	Debtors: amounts falling due within one year	<b>Creditors: amounts falling due within one year</b>	Creditors: amounts falling due within one year
	<b>2007/08 £000</b>	2006/07 £000	<b>2007/08 £000</b>	2006/07 £000
NHS foundation trusts	<b>236</b>	161	<b>436</b>	301
English NHS trusts	<b>564</b>	271	<b>1,722</b>	1,185
Department of Health	<b>75</b>	236	<b>1,527</b>	1,845
English strategic health authorities	<b>183</b>	–	<b>–</b>	–
English primary care trusts	<b>1,584</b>	2,119	<b>800</b>	479
RAB special health authorities	<b>–</b>	81	<b>121</b>	6
Other WGA bodies	<b>281</b>	510	<b>1,895</b>	1,787
<b>Total</b>	<b><u>2,923</u></b>	<u>3,378</u>	<b><u>6,501</u></b>	<u>5,603</u>

	<b>Debtors: amounts falling due after more than one year</b>	Debtors: amounts falling due after more than one year	<b>Creditors: amounts falling due after more than one year</b>	Creditors: amounts falling due after more than one year
	<b>2007/08 £000</b>	2006/07 £000	<b>2007/08 £000</b>	2006/07 £000
English primary care trusts	<b>91</b>	152	<b>–</b>	–
<b>Total</b>	<b><u>91</u></b>	<u>152</u>	<b><u>–</u></b>	<u>–</u>

### 24. Losses and special payments

There were 65 cases of losses and special payments (2006/07: 92 cases), totalling £13,737 (2006/07: £227,000) approved during 2007/08. Bad debts accounted for £10,120 during 2007/08 (2006/07: £224,000).

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment exceeded £100,000 (2006/07: nil cases).

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