

**Moorfields Eye Hospital NHS Foundation Trust**  
Annual Report and Accounts 2008/09





**Moorfields Eye Hospital NHS Foundation Trust**  
Annual Report and Accounts 2008/09

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



# Contents

Section	Title	Page
	Chairman's welcome	9
<b>1</b>	<b>An introduction to Moorfields Eye Hospital</b>	<b>11</b>
1.1	Who we are	11
1.2	What we do	11
1.3	Our mission statement	11
<b>2</b>	<b>Directors' report</b>	<b>13</b>
2.1	Directors during 2008/09	13
2.2	Operational performance	13
2.2.1	Patient activity	14
2.2.2	Commissioning arrangements	14
2.2.3	National targets	15
2.2.4	Care Quality Commission Standards for Better Health	17
2.2.5	Specialist eye services in the community	17
2.2.6	Commercial divisions	17
2.2.6.1	Moorfields Pharmaceuticals	17
2.2.6.2	Moorfields Private	18
2.2.6.3	Moorfields Eye Hospital Dubai	18
<b>2.3</b>	<b>Patient care</b>	<b>18</b>
2.3.1	Patient services	18
2.3.2	Clinical excellence	19
2.3.2.1	Strong clinical outcomes	19
2.3.2.2	Expertise in vitreoretinal treatments	20
2.3.2.3	New injection suite for age-related macular degeneration treatment	20
2.3.2.4	Specialist multi-disciplinary team cancer clinics	20
2.3.2.5	Laser safety accreditation programme	20
2.3.2.6	Largest single provider of national screening of diabetic and other images	21
2.3.3	Listening to our patients	21
2.3.3.1	Patient experience tracker	21
2.3.3.2	Mystery visitors and callers	21
2.3.3.3	Patient surveys	22
2.3.3.4	Complaints	22
2.3.4	Booking review process	23
2.3.5	Waiting times in clinics	23
2.3.6	New text messaging reminder service	23
2.3.7	Dignity champion	23
2.3.8	Infection control	23
2.3.9	Improving the patient environment	24
2.3.9.1	Patient Environment Action Team results	24
2.3.9.2	Major refurbishment projects	24

<b>Section</b>	<b>Title</b>	<b>Page</b>
<b>2.4</b>	<b>Research and development</b>	<b>25</b>
2.4.1	One of the UK's first academic health science centres	25
2.4.2	Closer working with the UCL Institute of Ophthalmology	25
2.4.3	Cutting-edge research initiatives	26
2.4.3.1	World's first gene therapy for inherited blindness	26
2.4.3.2	National award for motion displacement test	26
2.4.3.3	London Project to Cure Blindness	26
2.4.3.4	Early positive results for 'bionic eye' trials	26
<b>2.5</b>	<b>Education and teaching</b>	<b>27</b>
2.5.1	Medical education	27
2.5.2	Nurse education	27
2.5.3	Learning and development team	27
<b>2.6</b>	<b>Working with our staff</b>	<b>28</b>
2.6.1	One of Britain's top employers	28
2.6.2	National staff survey	28
2.6.3	Communicating with our staff	29
2.6.4	Improving working lives	29
2.6.5	Occupational health and staff wellbeing	29
2.6.6	Disabled employees and equal opportunities	29
2.6.7	Consultation with staff groups	30
<b>2.7</b>	<b>Working in partnership – stakeholder relations</b>	<b>30</b>
2.7.1	Statutory consultations	30
2.7.2	New partnerships	30
2.7.3	Charitable support	30
2.7.4	Social and community initiatives	31
2.7.5	Environmental responsibilities	31
<b>2.8</b>	<b>Looking ahead</b>	<b>32</b>
<b>3</b>	<b>Quality report</b>	<b>35</b>
<b>3.1</b>	<b>Quality narrative</b>	<b>35</b>
3.1.1	Chief executive's statement	35
3.1.2	Quality improvement priorities	36
3.1.2.1	Patient experience – improving outpatient waiting times	36
3.1.2.2	Patient experience – improving the environment	37
3.1.2.3	Patient safety – implementing the National Patient Safety Agency surgical safety checklist	37
3.1.2.4	Clinical effectiveness – establishing at least one clinical outcome indicator per sub-specialty	38
3.1.3	Externally raised challenges	38
<b>3.2</b>	<b>Quality overview</b>	<b>39</b>
3.2.1	Performance against key indicators in 2008/09	39
3.2.2	Performance against national priorities	40

Section	Title	Page
<b>4</b>	<b>Governance arrangements</b>	<b>41</b>
4.1	Membership council	41
4.1.1	Composition of the membership council in 2008/09	42
4.1.2	Register of interests for the membership council	43
4.1.3	Membership	43
4.1.4	Representing our membership	44
4.1.5	Membership council elections	44
4.2	Board of directors	45
4.2.1	Composition of the board of directors in 2008/09	46
4.2.2	Committees of the board	47
4.2.2.1	Audit committee	47
4.2.2.2	Governance committee	48
4.2.2.3	Strategy and investment committee	48
4.2.2.4	Remuneration committee	49
4.2.2.5	Nominations committee	49
4.2.3	Managing risk	50
4.2.3.1	External review of risk	50
4.2.4	Performance assessment of the board	51
4.2.5	Register of interests for the board of directors	52
4.3	Statement of compliance with the NHS foundation trust code of governance	52
<b>5</b>	<b>Remuneration report</b>	<b>53</b>
<b>6</b>	<b>Financial report</b>	<b>55</b>
6.1	Income	55
6.1.1	NHS clinical income	55
6.1.2	Income from private patients	56
6.1.3	Moorfields Pharmaceuticals	56
6.1.4	Non-clinical income	56
6.2	Expenditure	56
6.2.1	Pay costs	56
6.2.2	Non-pay costs	57
6.3	Impairment of fixed asset values	57
6.4	Cash flow	57
6.5	Borrowing	57
6.6	Going concern	57
6.7	Better payment practice code	58
6.8	External audit services	58
6.9	Counter-fraud arrangements	58
6.10	Accounting policies	59
6.11	Senior employees' remuneration	59
6.12	Cost allocation and charging requirements	59

<b>Section</b>	<b>Title</b>	<b>Page</b>
<b>7</b>	<b>Annual accounts</b>	<b>61</b>
7.1	Foreword to the accounts	61
7.2	Statement of the chief executive's responsibilities as accounting officer	62
7.3	Statement on internal control	62
7.4	Independent auditors' report	67
7.5	Income and expenditure account	69
7.6	Balance sheet	70
7.7	Statement of total recognised gains and losses	71
7.8	Cash flow statement	72
7.9	Notes to the accounts	73

## Chairman's welcome

It gives me great pleasure to introduce the 2008/09 annual report and accounts for Moorfields Eye Hospital NHS Foundation Trust. I became chairman of the trust in April 2008 and was joined by several new non-executive directors and a new chief executive. I think I speak for us all when I say that our initial positive impressions of Moorfields and its excellent staff have only been enhanced over the past 12 months.

In this year, the trust has achieved a number of significant successes, many of which are covered in greater detail in this report. To pick out just a few, we welcomed record levels of patient demand and met, or exceeded, all but one of the national priority performance targets, including those relating to 18-week waits, infection control standards and waiting times in A&E.

We also successfully eliminated earlier problems relating to cancer waiting times, all of which means that we expect to be rated as at least 'good' for the quality of our services in the Care Quality Commission's annual health check for 2008/09, compared to the 'fair' rating we achieved for 2007/08 and the 'weak' rating in the year before that. At the same time, we maintained our strong financial performance, achieving an 'excellent' rating – the highest possible – for our use of resources for 2008/09.

Our outreach centres have continued to deliver specialist eye care closer to patients' homes, a pattern that was extended this year when we entered into partnership with GPs in the London Borough of Harrow to provide more services in the local community.

Of equal importance, I was delighted at the feedback we received from patients in several surveys and the satisfactory outcome of external inspections, including those undertaken by the NHS Litigation Authority and in relation to the national hygiene code.

Along with our partners at the UCL Institute of Ophthalmology, we continued to lead the field in research and development of eye disease, with several well-publicised and high-profile successes around our work into stem cell therapies, retinal implants and new ways of detecting glaucoma. Research activity received a further boost during the year when UCL Partners, of which Moorfields is an integral part, was formally accredited as one of the UK's first academic health science centres by the Department of Health.

As ever, the year was not without its challenges. In particular, the physical environment in which we treat many of our patients requires considerable improvement. To this end, I am pleased that the preparatory work completed in 2008/09 means that we are now in a position to begin the refurbishment of our clinic areas at the main City Road hospital and commence improvements to our facility at Northwick Park hospital, along with other environmental improvement projects. Equally, and in common with almost every other business in the UK, we have to operate in a somewhat volatile and depressed financial climate, a state of affairs that we can expect to persist for some time yet.

That said, I and my board colleagues are confident that Moorfields now has the people with the dedication and commitment to overcome these challenges and ensure that we continue to provide the high-quality and innovative clinical care on which our reputation, built over many years, rests.



**Rudy Markham, chairman.**



# 1

## An introduction to Moorfields Eye Hospital NHS Foundation Trust

### 1.1 Who we are

Established in 1804, Moorfields Eye Hospital is one of the largest centres for ophthalmic treatment, teaching and research in the world, as well as the oldest. 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 we undertake.

In 2009, we celebrated five years as one of the first 10 trusts across England and Wales to achieve NHS foundation trust status. We continue to be at the forefront of new NHS developments, demonstrated most recently in March 2009 when UCL Partners, of which Moorfields is an integral part, was designated as one of the UK's first academic health science centres. This new partnership will enable us to build on our already strong record of collaboration and world-class excellence, deepening and widening our areas of expertise, so that we can offer patients in London and beyond even better care and treatment.

### 1.2 What we do

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 that require treatment that is not available anywhere else in the UK. We provide these services from our main hospital base in London's City Road as well as at 11 other sites in and around the capital.

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.

In addition, Moorfields Eye Hospital NHS Foundation Trust directly manages three commercial divisions:

- Moorfields Private
- Moorfields Pharmaceuticals
- Moorfields Eye Hospital Dubai

### 1.3 Our mission statement

We aim 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. At the same time, we strive to provide a flexible and responsive service guided by patient needs.

During 2009/10, we will be reviewing our mission, vision and values as part of a wider strategic planning exercise involving clinicians, management, the board and the membership council, together with other key stakeholders. This work is expected to be completed by December 2009 and its outputs will be reflected in our plans for 2010/11 and beyond.



# 2 Directors' report

## 2.1 Directors during 2008/09

Chairman	Rudy Markham	
Chief executive	John Pelly	
Non-executive directors	Deborah Harris-Ugbomah Sir Roger Jackling Professor Phil Luthert Andrew Nebel Clive Nickolds Lesley Potter	Until 31 October 2008
Medical director	Mr Bill Aylward	
Chief operating and nursing officer	Mark Cubbon	
Finance director	Ian Hollows	
Director of research and development	Professor Roger Hitchings	Until 31 July 2008
Director of research and development	Professor Peng Tee Khaw	From 1 August 2008

Three further directors attend board meetings, but do not have voting rights. They are:

Director of corporate governance	Sandra Adams	
Director of personnel	Ken Gold	
Director of information technology	Mike Andersson	

## 2.2 Operational performance

Moorfields saw a steady improvement in performance throughout 2008/09. Total attendances, both for outpatients and inpatients, exceeded those of the previous financial year and we met all but one of the main national performance targets. We are optimistic that this much better level of performance overall will result in a rating of at least 'good' for the quality of our services when the new Care Quality Commission publishes its annual health check in October 2009, compared to the 'fair' we received for 2007/08 and the 'weak' in the year before that.

Financially, we also performed well, generating a surplus of £640,000 (£2.2 million before impairment) in 2008/09, which was better than planned. The surplus enabled the trust to maintain a financial risk rating of four with our regulator, Monitor, throughout the year. Further details of our financial performance are contained in our financial report at section 6.

### 2.2.1 Patient activity

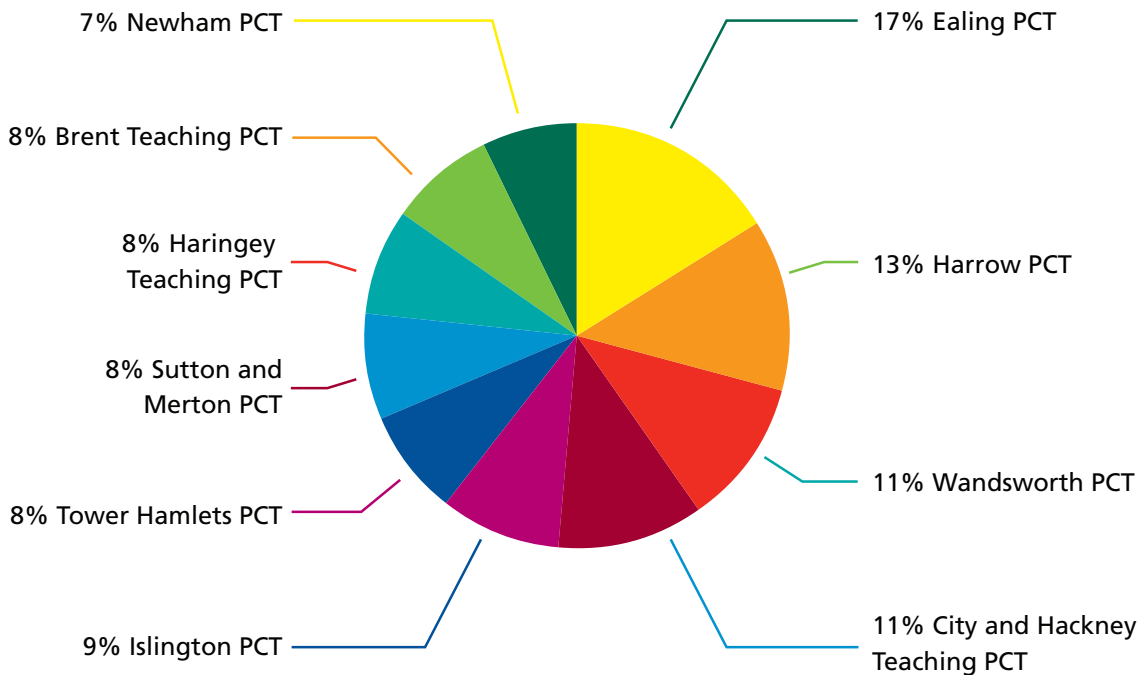
All categories of patient activity were higher than in 2007/08, as the table below shows. In general terms, levels of new outpatient attendances stabilised towards the end of the year, but there was an increase in follow-up outpatient attendances.

Activity	2008/09	2007/08	% change
Total outpatient attendances	292,452	257,576	+ 13.5%
A&E attendances	64,807	59,629	+ 8.7%
Total inpatient and day-case admissions	27,742	24,962	+ 11.1%
Laser eye surgery treatments	7,520	7,421	+1.3%

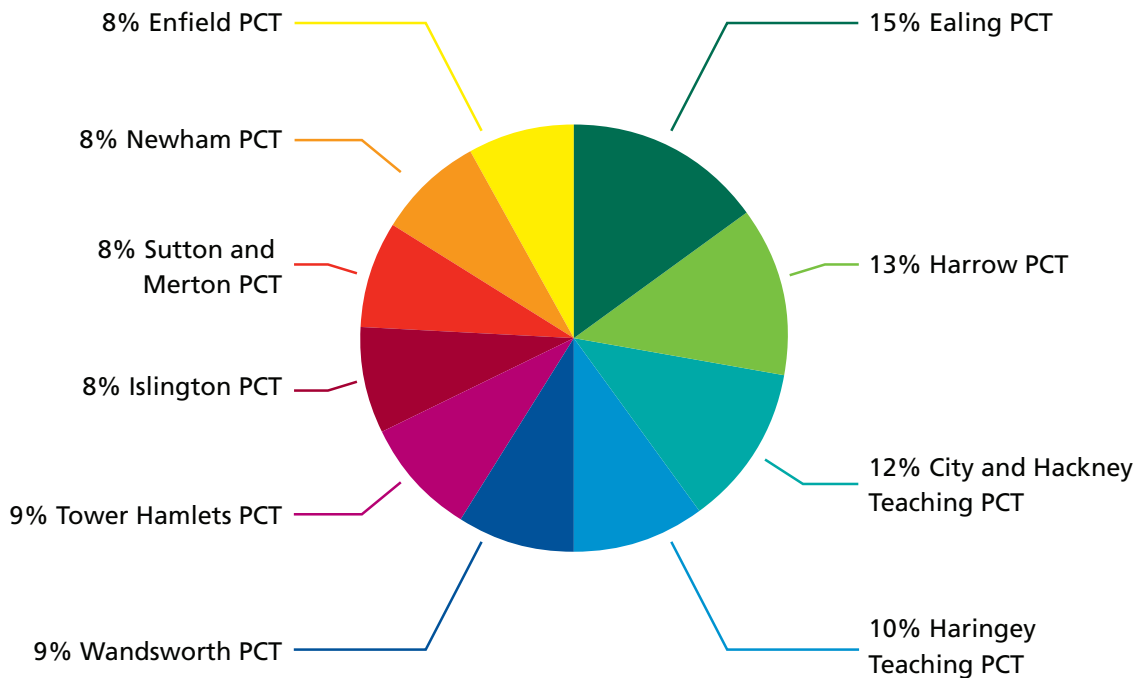
### 2.2.2 Commissioning arrangements

Ten London primary care trusts (PCTs) account for almost 50% of the total NHS contracted activity. Moorfields’ largest contracts are with members of the North Central London Acute Commissioning Agency (Barnet, Camden, Enfield, Haringey and Islington PCTs), and with Ealing, Wandsworth and City and Hackney PCTs. Moorfields has contracts with more than 80 PCTs from across the country and also receives referrals for non-contracted activity.

#### First outpatient attendances 2008/09 – breakdown between 10 PCTs with greatest activity



**Total admissions 2008/09 – breakdown between 10 PCTs with greatest activity**



**2.2.3 National targets**

For 2008/09, Moorfields met or exceeded nearly all of the key national performance indicators and targets. In particular, we exceeded the national priority target to treat 90% of admitted patients and 95% of non-admitted patients within 18 weeks of their referral by a GP by December 2008. Moorfields’ figures for December stood at 93.4% for admitted and 96.4% for non-admitted patients. By the end of March 2009, these figures had risen to 94.9% and 97.8% respectively.

Similarly, we consistently met the maximum four-hour wait in A&E throughout the year, and we maintained our excellent record on infection control, with no reported cases of either Clostridium difficile or MRSA bloodstream infections during 2008/09.

Earlier remedial action to address poor performance against cancer referral targets also bore fruit in 2008/09, with no reported breaches of any of the targets throughout the year. In addition, the planned transfer of our small GUM service to Barts and The London NHS Trust in the first quarter of 2008/09 meant that there were no further breaches against this target for the remainder of the year.

As part of our drive to improve outpatient waiting times, we have now implemented an ambitious improvement project, which is already producing positive results. Perhaps of greater importance to patients, we are also planning improvements during the next 12 months to ensure that waiting times once patients arrive for outpatient or day-case appointments are reduced too.

We failed to meet the national target in just one area relating to the last-minute cancellations of operations for non-clinical reasons. Against a national target of less than 0.8%, Moorfields scored 1.18%, compared to 1.06% in 2007/08. This can be partly explained by adverse weather conditions during February 2009, crucial repairs to the air conditioning at our St Ann’s outreach centre and other general maintenance issues. The number of cancellations has been more rigorously managed in the latter part of 2008/09, resulting in performance of 0.75% in March 2009, which is within the tolerance rate.

Description of target	Target 2008/09	Performance 2008/09
<b>Infection control</b>		
*MRSA – maintaining the annual number of bloodstream infections at less than half the 2003/04 level	<2	0 – achieved
*Clostridium difficile year-on-year reduction	<2	0 – achieved
<b>Waiting times</b>		
*Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	99.6% – exceeded
*Pathways where patients are admitted for hospital treatment should be completed within 18 weeks	90%	94.9% – exceeded
*Pathways that do not end in admission should be completed within 18 weeks	95%	97.8% – exceeded
Patients should not wait more than 26 weeks for an inpatient admission	<0.03%	0 – achieved
Patients should not wait more than 13 weeks for a first outpatient appointment	<0.03%	0 – achieved
<b>Cancer waiting times</b>		
*No patient to wait more than two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer cases	0	0 – achieved
*No patient to wait more than 31 days from diagnosis to treatment of all cancers	0	0 – achieved
*No patient to wait more than 62 days from urgent referral to treatment for all cancers	0	0 – achieved
<b>Cancelled operations</b>		
Total number of last-minute cancellations	<0.8%	1.18% – not achieved
Cancelled operations not admitted within 28 days	<5%	0.2% – achieved
<b>Data completeness</b>		
18 weeks – admitted patients	90 – 110%	101.2% – achieved
18 weeks – non-admitted patients	90 – 110%	93.7% – achieved
Ethnic coding	85%	93.6% – exceeded

\* Targets annotated with an asterisk denote those that form part of our Monitor compliance framework, presented at every board meeting as part of a monthly performance report.

## 2.2.4 Care Quality Commission Standards for Better Health

We submitted a declaration of full compliance against 23 out of 24 of the core standards which will form part of the quality of services rating from the Care Quality Commission. We were unable to confirm compliance with C9 – records management – due to a lack of relevant and up-to-date evidence. We have implemented an action plan which includes an audit of the quality of clinical records and continuation of the mapping exercise of information systems and risks. Our declaration can be found on our website at [www.moorfields.nhs.uk](http://www.moorfields.nhs.uk) in the publications and resources section.

## 2.2.5 Specialist eye services in the community

Moorfields provides services at 11 'outreach centres' in and around London, as well as at our main hospital base in the city centre. In 2008/09, we have focused on collating more robust data about these centres to enable us to determine how best to manage and develop them in future. We also revised our arrangements for supporting outreach centres as part of a restructure of the operational and nursing management teams. The new structure includes three new service delivery units, each led by a general manager and supported by a nurse manager, and one of these units has a specific remit to provide support to the outreach centres.

At the same time, we continue to explore new opportunities for extending our expertise into new areas. Since December 2008, we have been part of a new service for residents in the London Borough of Harrow, working closely with the local primary care trust and with Harrow Health Ltd, a company formed by GPs in the area. This new enterprise ensures the provision of specialist eye services in the community, reducing the need for hospital referrals, and includes a consultant ophthalmologist, a local GP with a special interest in eye care and local optometrists.

## 2.2.6 Commercial divisions

### 2.2.6.1 Moorfields Pharmaceuticals

Moorfields Pharmaceuticals, our specialist pharmaceutical manufacturing arm, ensures that we have a guaranteed supply of the specialist products we need to treat our patients. It also provides us with a steady income source, with nearly 90% of its income coming from external customers.

With an estimated 40% of market share in the manufacture and supply of ophthalmic unlicensed medicines known as 'specials', Moorfields Pharmaceuticals is the leader in its field. It produces around 120 products, of which 85% are unique, and supplies around 5,000 customers, processing some 100 orders every day. Fifty-four staff are employed by Moorfields Pharmaceuticals, many of whom are recruited from the pharmaceutical industry.

Established as an autonomous business unit in April 2004, Moorfields Pharmaceuticals also supplies a small range of ophthalmic licensed pharmaceutical products. In addition, it undertakes contract manufacturing and testing for third parties, with a focus on sterile liquid products in small to medium-sized batches – for example, products for use in clinical trials.

Moorfields Pharmaceuticals continued to perform well throughout 2008/09, with a 20% growth in sales and an above-target increase of £459,000 in operating profit. These improvements are the result of strong demand for the products, in particular those used in the treatment of wet age-related macular degeneration (AMD), and the introduction of new products to meet clinical demands.

During 2008/09, the board approved a five-year strategy for the business, which will include a continued focus on identifying new products to market to customers, as well as exploring opportunities to participate in Moorfields' research projects and developing stronger links through new strategic partnerships with pharmaceutical companies.

### 2.2.6.2 Moorfields Private

Moorfields Private is located on, and adjacent to, the City Road site and also has facilities in Wimpole Street. Although there was a slight drop in outpatient activity in 2008/09, inpatient activity increased by 2.4% on the previous year and income from private patients exceeded our financial target by £0.2 million.

Refurbishment work was completed during the year to improve facilities for our private patients at our City Road site. A new suite located on the fourth floor comprises a day-case club lounge, an intra-vitreous injection suite and a refractive laser suite that includes two procedure rooms.

We have also been laying the ground work for improved marketing activity in future, including rebranding our patient literature and website to give them a more modern look and feel and attract patients to our services in future.

### 2.2.6.3 Moorfields Eye Hospital Dubai

Opened in July 2007, 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 oculoplastics diseases. It hosts a well-appointed outpatient department and three operating theatres, including a laser insitu keratomileusis (LASIK) suite for refractive surgery.

MEHD had a more successful year in 2008/09, with both income and activity ahead of target by 31 March 2009. Increased activity was always anticipated as the hospital became more established in the region, but has also been supported by enhanced marketing and promotional activities throughout the year, with a particular emphasis on Moorfields' heritage as the oldest centre in the world for ophthalmic treatment, teaching and research.

This year, MEHD also increased its presence at the Imperial College London diabetes centre in Abu Dhabi from one consultant one day a week to one consultant and a junior doctor each on two days a week, effectively more than trebling the number of clinic slots and providing future capacity to see more patients without diabetes who have eye problems.

During the latter part of the year, Moorfields' board, through its strategy and investment committee, undertook a thorough review of the performance and prospects of our Dubai business. The principal conclusion of this review was that, although the business environment in the Gulf region is uncertain, not least during the current world economic downturn, activity and revenues were growing satisfactorily and the prospects for the business remained good. It was also confirmed that MEHD's current losses are more than offset by the surpluses generated by our other two commercial businesses, Moorfields Private and Moorfields Pharmaceuticals, providing assurance that NHS funds are not being used to subsidise the trust's commercial activities.

## 2.3 Patient care

### 2.3.1 Patient services

Moorfields treats patients with a wide range of eye problems, from common complaints to rare conditions that require treatment not available elsewhere in the UK. Our services include large-volume general diseases such as cataract as well as smaller sub-specialties, including neuro-ophthalmology, ophthalmic genetics and inherited eye disease, paediatric glaucoma, paediatric cornea and cataract and rehabilitation services.

Patient services are organised into 10 ophthalmic specialties as follows:

- Accident and emergency and primary care
- Adnexal
- Anaesthetics

- Anterior segment
- Cataract
- Glaucoma
- Medical retina
- Paediatrics
- Strabismus
- Vitreoretinal

As well as providing services at our main site in London's City Road, our experts also see patients in 11 outreach centres in and around the capital as follows:

- Bedford hospital
- Ealing hospital
- Homerton hospital, Hackney
- Mayday hospital, Thornton Heath
- Mile End hospital, Whitechapel
- Northwick Park hospital, Harrow
- Potters Bar community hospital
- St Ann's hospital, Tottenham
- St George's hospital, Tooting
- Upney Lane health centre, Barking
- Watford general hospital

This outreach model ensures that patients can be seen initially for a range of ophthalmic conditions in locations closer to their homes.

Operationally, patient services are supported by three service delivery units, covering the following areas:

- Clinical services
- Capacity, access and theatres
- Outreach and support services

In addition, our nursing directorate oversees infection control and patient advice and support services, which includes our Patient Advice and Liaison Service (PALS) and complaints team.

## 2.3.2 Clinical excellence

We continue to explore new ways to enhance the quality of the clinical care that we offer to our patients and to take advantage of new developments in ophthalmology.

### 2.3.2.1 Strong clinical outcomes

Recent outcomes of clinical audits at Moorfields confirm that clinical outcomes match the best published outcomes, both for high-volume procedures as well as highly specialised procedures.

For retinal detachment, a relatively common cause of sudden blindness, successful treatment at Moorfields recorded 84.4% in a recently published European trial, compared to 63.8% for similar patients elsewhere.

Similarly, recent audit and research data confirms that Moorfields' clinical outcomes and complication rates following glaucoma surgery are considerably better than the national rates. The significant complication rate at one year after surgery was 3% at Moorfields compared to the national reported rate of 20.2%, irrespective of whether the surgery was performed by sub-specialty trained glaucoma surgeons or trainees.

In 2008/09, we also completed an audit of 15,000 cataract cases, the largest ophthalmic audit from a single institution, which demonstrated better outcomes than those collated for an earlier national audit.

### **2.3.2.2 Expertise in vitreoretinal treatments**

Our vitreoretinal service performs more than 3,000 surgical procedures every year. This unique case-mix and volume means that each surgeon can develop expertise in different areas of the sub-specialty and results in our seeing a very high proportion of complex cases – 60% compared to 40% nationally.

### **2.3.2.3 New injection suite for age-related macular degeneration treatment**

This year, we significantly enhanced our capacity to provide an increased number of ranibizumab (Lucentis) injections, following the publication in August 2008 of new guidance by the National Institute for Health and Clinical Excellence (NICE), which recommended the use of ranibizumab as an option for the treatment of wet age-related macular degeneration (AMD).

To address the increased demand for this treatment, we opened a new, tailor-made and fully equipped injection suite at our main hospital in London's City Road. The new suite enables us to deliver the treatment safely and efficiently to large numbers of patients. In 2008/09, we carried out 4,500 treatment procedures for AMD.

Demand for this newly-developed treatment continues to increase and Moorfields expects to deliver an extra 2,000 treatments in 2009/10. We will achieve this by recruiting new staff and increasing the number of our outreach centres that provide the service, which will enable more patients to receive the treatment nearer their homes.

### **2.3.2.4 Specialist multi-disciplinary team cancer clinics**

Specialist multi-disciplinary clinics were introduced at Moorfields in 2008/09 to deal with oculoplastics oncology cases. The clinics provide an opportunity for cases to be discussed by all the professionals involved in the patient's care and ensure that they receive the most appropriate treatment for their condition. Managing cases in this way also means that we can provide much better documentation. Multi-disciplinary team (MDT) working is an important facet of the national cancer plan, designed to ensure that all cancer treatments conform to a high national standard, wherever they are provided.

### **2.3.2.5 Laser safety accreditation programme**

Moorfields now provides an online training programme to ensure that staff providing laser treatments have received the appropriate training to enable them to operate safely and effectively. Staff who have undertaken the correct training are issued with a pin code number, which enables them to use the necessary equipment. The new system replaces a paper-based system first introduced at Moorfields in 1996.

### 2.3.2.6 Largest single provider of national screening of diabetic and other images

Moorfields' reading centre is accredited for national screening of diabetic and other images. Our diabetic retinopathy grading service supervises and provides quality assurance for community digital photographic screening services for 150,000 diabetic patients to National Screening Centre standards, making us the largest single provider of such a programme.

### 2.3.3 Listening to our patients

We have 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 Europe 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.

#### 2.3.3.1 Patient experience tracker

Since June 2008, the patient experience tracker (PET), an electronic feedback system, has provided us with a straightforward and user-friendly way of capturing and analysing patient satisfaction with the care they receive at Moorfields. Initially designed for the retail and service sector, many NHS trusts across England and Wales are using the PET to help develop and maintain their services.

The system uses an electronic keyboard on which patients push buttons in response to questions about their experience during their visits to Moorfields. Topics include communication, privacy, staff attitude and the information patients have received.

Ten PET units are in place across the trust, and more than 12,500 responses have been captured to date, providing us with vital information about where we need to improve and, equally importantly, where we are doing well.

We plan to roll out the PET to a further 20 clinical areas from summer 2009 and will also be adapting the questions to ensure that feedback is as useful as possible.

#### 2.3.3.2 Mystery visitors and callers

The mystery visitor programme has been running since December 2007 and focuses on customer care and environment. Visitors and callers ask several questions to obtain information about services and availability of resources. The compliance score is set at 90% with the aim of a month-on-month improvement and consistency thereafter.

For the final quarter of 2008/09, compliance for the mystery visitor programme stood at 92% compared to 82% for the previous three months, but compliance for the mystery caller component worsened, falling to 83% compared to 91% for the previous quarter. Staff in those areas identified as having poorer results have been reminded of the importance of answering calls correctly and have been provided with a telephone etiquette prompt card to assist them in this regard. Managers closely monitor day-to-day performance to ensure that reception staff in particular remain patient-focused, pro-active and consistent.

In addition, essential communication training is a mandatory requirement for all staff, while selected staff can undertake National Vocational Qualifications in customer care at level 2 and 3, with further support provided by the practice development team.

Our average score for 2008/09 was 88% for the mystery visitor programme and 86% for the mystery caller programme. In response, we have developed a specific action plan for all local and general managers detailing where each area has scope for improvement, suggested actions, timescales and named responsibility. Since May 2009, visitors and callers are using a revised set of questions, giving extra weighting to issues designed to enhance customer service. Our new booking centre will also be included in the programme in future.

### 2.3.3.3 Patient surveys

Surveys of both day care and outpatients were carried out by the Picker Institute Europe on behalf of the trust in the latter part of 2008. The questionnaires are the same as those used on a national basis for all NHS trusts in England and Wales, but with a few alterations to reflect the specialist nature of Moorfields' services, agreed with the involvement of our patients.

For 2008, 500 day care and 750 outpatient surveys were sent out, generating a response rate of 54%, slightly above the national average. Overall, the responses were positive. In the day care survey, 96% of respondents rated their care as good or excellent, while 95% said that doctors and nurses worked well together. The main issues of concern for respondents to the day care survey related to choice and quality of food, the level of information and explanation given regarding surgery and pain management, the degree of the patient's sense of involvement in their care, and the availability of information about how to complain.

Among respondents to the outpatient survey, 92% rated their care as good or excellent, while 95% stated that they would probably or definitely recommend Moorfields to family or friends and 94% said that they would probably or definitely choose Moorfields for a future appointment. Waiting times and expectations in clinics and communications between patients and staff were the main causes of concern for respondents to the outpatients survey.

An action plan is being developed to respond to the issues raised in both surveys and how these relate to other patient experience initiatives.

In a Healthcare Commission survey published in January 2009, our A&E department was rated as one of the best in London. Nationally, we were in the best performing 20% of trusts for 12 of the 29 questions applicable to our patients. Patients reported that they were treated with dignity and respect, were listened to by their clinicians, and involved in decisions about their care and treatment. They also felt that doctors and nurses were good at sharing information and discussing with them any anxieties about their condition or treatment. Receptionists were also praised for giving patients enough privacy when they first arrived in the department.

We performed less well on two questions only – how long patients waited before being examined by a nurse or doctor and whether patients thought that hospital staff did everything possible to help control their pain.

For these areas, as well as those where we scored towards the lower end of the intermediate 60% of trusts, we are working with patients to understand how best to address their specific needs as ophthalmic patients who require urgent treatment. An action plan is being implemented to ensure improvements in both areas in future.

### 2.3.3.4 Complaints

Moorfields received a total of 295 complaints during 2008/09, compared to 320 in 2007/08. More than three quarters of these – 224 in total – related to concerns about non-clinical issues.

Complaints are reported to the board on a quarterly basis, broken down by service delivery unit and specialty. Our monitoring identifies trends and action is taken in response. The main causes of complaint in 2008/09 concerned communication with patients and customer care issues, including telephones not being answered, messages not being returned and staff attitude.

To ensure that action is taken in response to complaints, all service delivery unit managers are now required to complete a standard feedback form outlining how they have implemented the actions cited in the complaint response.

From summer 2009, we will establish a new 'learning from experience' group, which will include managerial and clinical representatives from each service delivery unit along with patients. The group will review and discuss complaints and share experience that might inform changes in practices.

### 2.3.4 Booking review process

An independent review was undertaken between January and March 2008 to look at our processes for managing waiting lists and bookings. The review team identified 10 key issues which contributed to problems with the existing system and made 11 main recommendations, the majority of which have been implemented during 2008/09. Specifically, our booking centre is now responsible for booking all first outpatient appointments and re-booking all outpatient cancellations and we have created an inpatient booking centre to handle all inpatient, pre and post-outpatient appointments and to rebook cancellations for these appointments. In addition, team and management accountabilities have been clarified and capacity and patient pathway management has been strengthened at both senior management level and within operational teams. These actions have significantly improved our booking processes and reduced much of the previous frustration felt by patients and staff alike.

### 2.3.5 Waiting times in clinics

Many patients admitted for surgery at our City Road hospital have an unsatisfactory experience due to long waits. Similarly, we are aware that the flow of patients through our outpatient clinics is not as good as it should be. To address these issues, we commissioned two independent reviews to examine these problems in detail, involving both staff and patients. These reviews have highlighted several areas for improvement, which are now being implemented. In particular, we have now put in place measures to ensure that appointment times are honoured, providing additional training and support to our clerical staff and creating a 'patient contract' setting out clearly what patients can expect when they visit our clinics.

### 2.3.6 New text messaging reminder service

All outpatients at Moorfields who provide us with a mobile phone number now receive a text message to remind them of any forthcoming appointments. The aim is to reduce the number of patients who fail to attend for their appointments and to enable us to manage clinic slots more effectively. Although the service is not suitable for all patients, it provides an additional mechanism to reduce the number of patients who do not attend their appointment.

### 2.3.7 Dignity champion

A steering group was set up in 2008/09 to address the Department of Health's Dignity in Care campaign and the Royal College of Nursing's Dignity at the Heart of Everything We Do campaign. As part of this, we have a nominated nurse dignity champion. The dignity champion and steering group will work together to raise awareness, provide training as necessary, network with other trusts and benchmark good practice and engage patients in setting the dignity agenda.

### 2.3.8 Infection control

Moorfields has an excellent track record on infection control, with no recorded cases either of MRSA bloodstream infections or of Clostridium Difficile to date. In April 2009, we were registered unconditionally with the new Care Quality Commission, having been assessed as meeting government regulations for managing infection.

Continued observance of our 'bare below the elbows' policy is crucial in maintaining this performance, as is ongoing monitoring of compliance against cleanliness and hand hygiene standards. Since October 2008, we have met our self-imposed targets of 85% compliance in weekly hand hygiene audits and we have exceeded our 90% target for environmental cleanliness every month since March 2008. All departments at City Road and in the outreach centres undertake weekly inspections of the environment and hand hygiene observations, with the results published monthly on the intranet.

For the hygiene code, against which we were assessed by the former Healthcare Commission in

January 2009, we met five out of six requirements in full. In one area relating to the decontamination of instruments, we were assessed as not fully meeting all the requirements. In particular, the assessment team felt that there was insufficient evidence to support our robust systems for the local cleaning of instruments in some parts of the hospital. This minor breach, which had no impact on patient care, has now been addressed by implementing additional training and guidance for staff responsible for the local cleaning of clinical instruments and Moorfields is now fully compliant with this standard.

## **2.3.9 Improving the patient environment**

### **2.3.9.1 Patient Environment Action Team results**

An inspection for the 2009 Patient Environment and Action Team (PEAT) assessment took place in March 2009. Under the PEAT programme, every inpatient healthcare facility in England with more than 10 beds is assessed annually and given a rating of excellent, good, acceptable, poor or unacceptable for three key areas – environment, food and privacy and dignity.

The assessment teams consist of NHS staff, including nurses, matrons, doctors, catering and domestic service managers, executive and non-executive directors, dieticians and estates directors. They also include patients, patient representatives, foundation trust governors and members of the public. The 2009 assessment included an external assessor to ensure that scores were applied fairly and that the inspection was carried out in accordance with the most recent guidance.

Our inspection was generally positive, with 'good' ratings for environment and privacy and dignity. For food, we were rated as 'acceptable' and we took immediate action to address those areas identified for improvement by the end of April 2009.

### **2.3.9.2 Major refurbishment projects**

Preparations were made throughout 2008/09 to enable us to progress with a series of inter-related projects to enhance facilities at our main hospital in City Road. Detailed plans for each of these projects, which are scheduled to get underway in phases from the summer of 2009, are now being finalised to ensure that any inconvenience is kept to an absolute minimum and that affected staff and patients are given as much notice of any changes as possible. Wherever possible, we are using the opportunities presented by these projects to ensure that services are more sensibly co-located and to make access as easy as possible for our patients.

A £1.3 million programme to refurbish the ground and lower-ground floor clinics at City Road and to address statutory maintenance issues is due to start in summer 2009, with generous financial support from the Special Trustees and the Friends of Moorfields. The 12-month project will see improvements to the lighting, décor, seating and toilet facilities, as well as a lift upgrade. At the same time, we will be enhancing access for disabled users and improving our signs to make it easier for visitors to find their way around. In March 2009, our contractors established a mock-up area to give staff and patients a feel for how the refurbished areas might look – and to tell us what they think.

The new vision research and treatment centre, funded as part of Moorfields' designation as a biomedical research centre, will provide a unique joint facility for the identification, pheno-typing and counselling of patients and families with inherited and acquired ocular disease, who may then benefit from trials of the latest novel treatments under development at Moorfields and the UCL Institute of Ophthalmology. There will also be a centre assessing the effects of different visual problems and their effect on real-life activities and quality of life. The centre's activities will integrate with and more than double the capacity of the existing clinical trials unit. Once preparatory work is complete, the project itself is planned to start in autumn 2009 and should be complete by the following spring.

From autumn 2009, there will be a phased closure over about 15 months of the Richard Desmond Children's Eye Centre. This work relates to a fault with the initial installation of the building's pipework, which now needs to be rectified to prevent future problems.

Work will get underway later in 2009 to expand our service at Northwick Park by adding a theatre suite adjacent to the current facility and providing an outpatient area on the floor above.

Work to the private patients refractive laser suite on the fourth floor at City Road, completed in April 2009, has doubled our laser capacity, provided a club lounge day-case area and seen the development of an intra-vitreous injection suite.

For the longer-term, Moorfields is developing an estates strategy to determine what our facilities should look like in future, given assumptions about how clinical services will be developed in the next five to 10 years. A review of service and organisational priorities is underway so that realistic plans can be developed to ensure that our facilities are used in the best way to provide a safe and functional environment for patients and staff in future.

## 2.4 Research and development

Our joint research portfolio with the UCL Institute of Ophthalmology currently includes 143 open projects, including the largest number of National Institute for Health Research high-priority projects in ophthalmology in the UK. As well as headline-grabbing pioneering research (see examples below), our staff also work on many projects to ensure that patients receive effective support to deal with their eye conditions.

We are one of just 12 sites nationally to be awarded National Institute for Health Research (NIHR) biomedical research centre status for translational research, which facilitates the attraction of extra funding to support our research programmes and to fast-track exciting new developments more rapidly to benefit patients.

### 2.4.1 One of the UK's first academic health science centres

In March 2009, UCL Partners, of which Moorfields is an integral part, was designated as one of the UK's first academic health science centres. The designation was awarded by an international panel following a competitive process. This new partnership will enable us to build on our already strong record of collaboration and world-class performance, expanding and strengthening our areas of expertise, so that we can offer patients in London and beyond even better care and treatment.

UCL Partners comprises University College London, Great Ormond Street Hospital for Children NHS Trust, Moorfields Eye Hospital NHS Foundation Trust, The Royal Free Hampstead NHS Trust and University College London Hospitals NHS Foundation Trust. It supports more than 3,500 scientists, senior researchers and consultants, and has a combined annual turnover of around £2 billion.

The partnership will focus initially on seven areas of excellence, including one on eyes and vision, with a further disease-based theme and two community initiatives under development.

### 2.4.2 Closer working with the UCL Institute of Ophthalmology

We are working closely with our colleagues at the UCL Institute of Ophthalmology to ensure that research and teaching are aligned as much as possible across both organisations. In particular, work is now underway to unify infrastructure support, with an ambition to create an integrated research office and minimise duplication of functionality. Specific pieces of work are being undertaken to implement a joint database for research, integrate research governance arrangements, unify the process for grants submissions and formally review the requirements of our existing joint research library.

We are also working together to increase the amount of collaborative research undertaken by both organisations and to co-ordinate fundraising activity to optimise our overall charitable income. At the same time, there is substantial potential to expand teaching on the joint site and we are exploring opportunities to develop this alongside organisations in UCL Partners and other third parties.

## **2.4.3 Cutting-edge research initiatives**

### **2.4.3.1 World's first gene therapy for inherited blindness**

Researchers from Moorfields and the UCL Institute of Ophthalmology achieved a landmark for gene therapy technology in April 2008, which could have a significant impact on future treatments for eye disease. The results of a trial, the first of its kind in the world, to test a revolutionary gene therapy treatment for a type of rare inherited blindness showed that the experimental treatment is safe and can improve sight.

The trial involves young patients with Leber's congenital amaurosis (LCA), for which no effective treatment is currently available. The team is now trialling the technique in younger patients, where they hope to achieve even better results.

### **2.4.3.2 National award for motion displacement test**

An innovative computer-based technology to test for glaucoma developed by experts at Moorfields, in partnership with the UCL Institute of Ophthalmology and City University London, was named as overall winner in the Medical Research Council translational research innovation award category of the 2008 Medical Futures competition in December 2008.

The Moorfields motion displacement test (MDT), which tests a patient's field of vision, is designed to run on a laptop computer, which means that it might offer an affordable, portable method of detecting glaucoma in the community. At the same time, the test is easily understood – the patient is asked to look at a central white spot and to click the computer mouse each time a line on the screen is seen to move.

### **2.4.3.3 London Project to Cure Blindness**

The London Project to Cure Blindness, a joint initiative between Moorfields and the UCL Institute of Ophthalmology, received a major boost in April 2009 when pharmaceutical company Pfizer entered into a collaboration and licence agreement with University College London to support the project's development. The London Project is researching possible potential treatments for age-related macular degeneration (AMD) using stem cell therapies. Treatments are currently being developed in the laboratory with patient clinical trials due to start in 2011.

### **2.4.3.4 Early positive results for 'bionic eye' trials**

Surgeons at Moorfields carried out two successful operations to implant an artificial electronic retinal device into the eyes of two blind patients in April 2008 as part of an international phase I clinical study, the first time that such devices have been implanted in the UK.

The trial aims to restore a basic level of useful vision, in the form of spots of light and shades of light and dark, to people suffering blindness due to retinitis pigmentosa, a group of inherited eye diseases that affect the retina.

Just a year after the pioneering surgery, one of the patients featured in a BBC television documentary, demonstrating how he can already sort his socks and navigate along a straight line. The clinical trial continues.

## 2.5 Education and teaching

### 2.5.1 Medical education

Moorfields is a major force in ophthalmic teaching in the UK, for students, ophthalmologists and other health professionals. Regular courses in various specialist areas are run at the main site in London's City Road, many of them in association with the UCL Institute of Ophthalmology. We also provide extensive sub-speciality training in all types of modern ophthalmology to a substantial number of fellows, some of whom are from the UK and Europe, with others coming from as far as Australia, New Zealand, South Africa, India and Brazil. Moorfields welcomes doctors from around the world to observe its renowned treatment of eye diseases and injuries.

In 2008/09, Moorfields received a very favourable assessment in the Postgraduate Medical Educational and Training Board's confidential survey of junior doctors' attitudes to their training, achieving some of the highest scores in London for overall satisfaction and quality of teaching. Our undergraduate training programme for students from University College London has also been rated very highly. In addition, our medical education team has been successful in attracting external funding to enhance our teaching facilities, including £20,000 for simulation equipment and £20,000 for faculty development.

Our staff also give many lectures and courses internationally, bringing new knowledge to centres all over the world. This year, professors from Moorfields and the UCL Institute of Ophthalmology gave the main honour lectures at the UK Royal College of Ophthalmology, the American Academy of Ophthalmology and the Association for Research in Vision and Ophthalmology in the USA.

### 2.5.2 Nurse education

Post-graduate nurse education is provided in-house by our own practice development team, which is supported by City University London. We have developed a masters-level programme to prepare nurses for advanced nurse practitioner roles across the trust. Throughout the year, the team has developed a competency-based framework for all nursing positions at Moorfields, which will be implemented in 2009/10. We also provide placements for undergraduate nurse training for Middlesex University.

In January 2009, we ran an ophthalmic nurses conference in collaboration with City University London. This year's event was themed around how the patient experience of ophthalmic nursing can be improved, and attracted nurses from across the UK and beyond.

### 2.5.3 Learning and development team

Moorfields' learning and development team runs a range of courses for staff at all levels, to support both mandatory training requirements and to help staff to develop their careers. My Learning Centre, a strategic tool to increase the knowledge and skills of staff, provides access to information stored on a central database, allowing staff to view their entire learning and development record and to record attendance at external events to create a complete continuing professional development record. We also provide ManageMentor, an online performance support tool for management and team-leading skills.

In 2008/09, we introduced a range of new courses for managers and supervisors to help them with their increasingly demanding role and held two workshops to support staff working towards becoming specialist bullying and harassment advisors. We also improved our corporate induction programme for new starters and introduced a local induction checklist to support managers in helping new employees to settle in.

In October 2008, the team's IT trainers were awarded the prestigious Trainer Assessment Programme (TAP) Gold Partner status. The award means that Moorfields has become one of only five NHS trusts to have achieved gold status, the highest awarded by the Training Foundation. TAP is a best-practice model for training design, delivery and facilitation roles and has been the NHS standard for all IT trainers for several years.

## 2.6 Working with our staff

Almost 1,400 staff are employed by Moorfields Eye Hospital NHS Foundation Trust. Of these, 80% have been in post for more than a year, a good indication of workforce stability. Our turnover rate was 13%, which also compares well against other organisations in central London. Sickness absence data showed between 3.5% and 4%, although work is underway to improve our systems for capturing this information to give us a fuller picture in future. Three grievances were raised during 2008/09, and five disciplinary hearings were held. Moorfields is currently compliant with the requirements of the European Working Time Directive.

### 2.6.1 One of Britain's top employers

Moorfields was named as one of Britain's top employers for the fourth year running in April 2009. The Corporate Research Forum Britain's Top Employers list 2009 includes 44 organisations, which are judged and rated by an independent panel of experts on how they perform in areas such as pay and benefits, career and training opportunities, knowledge management and employee relations and diversity. Moorfields is one of only two NHS organisations to achieve top employer status.

### 2.6.2 National staff survey

Generally, Moorfields performed well in the national NHS staff survey, the results of which were published in March 2009, with positive scores compared to the national average on most key issues as follows:

Key issue	Moorfields	National mean
Trust help staff work/life balance	54%	42%
Appraisal/review in last year	45%	63%
Have clear planned goals	68%	66%
Cannot meet conflicting demands	24%	40%
Satisfied with extent trust values work	42%	31%
Senior managers involve staff	30%	27%
Care of patients top priority	70%	57%
Trust communicates what trying to achieve	52%	50%
Work-related stress in the last year	22%	28%

The response from Moorfields staff to the survey was slightly improved from last year, rising from 36% to 40%, although this still lags some way behind the national average of 52% for other acute hospital trusts.

Our improving working lives group (see below) is now studying the detailed report into findings from Moorfields staff and will be drawing up an action plan to address key areas of concern, in conjunction with union representatives. They will be looking in particular at appraisal arrangements and access to policies and support services, including bullying and harassment advisors and staff counselling. The group will also be asking Quality Health, who administered the survey on our behalf, for a break-down of responses to some questions to determine whether specific staff groups are particularly affected by certain issues and to develop solutions accordingly.

Since the staff survey data was published, our appraisal rate has risen to 70%, well above the national average.

### 2.6.3 Communicating with our staff

Almost all teams and departments at Moorfields hold local departmental meetings to enable two-way communications between staff and line managers. In addition, improvements were made to Moorfields' regular staff communications channels during 2008/09. The weekly staff update, distributed via email and posted on the intranet, now lists items under a series of broad topic headlines, making it easier for staff to find information about specific interests. Our staff magazine, *Review*, which is distributed every other month, has also been redesigned to give it a more lively and professional feel. In addition, work is underway to enhance our intranet, aligning it more closely with other staff communication methods.

Our programme of chief executive open meetings, to which all staff are invited to attend, continued throughout the year, and 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.

The joint staff consultative committee, involving trade union representatives and management, aims to meet four times a year to discuss matters of mutual interest.

A survey is now underway to establish what staff think of the various communications channels to ensure further improvements in future in line with their needs.

### 2.6.4 Improving working lives

Moorfields' staff have access to a wide range of benefits to help them achieve a better work-life balance. Activity is co-ordinated by the trust's improving working lives (IWL) group, which includes a range of senior managers and staff governors.

Members of the group work together to improve and assist staff development, morale and well-being, review and raise awareness of existing staff benefits and develop new initiatives. As appropriate, issues are taken up with other relevant corporate committees. The group also hosts regular IWL events, which offer staff a chance to find out more and to meet with many of the organisations that provide our staff benefits.

A programme of visits to our outreach centres continued throughout the year, with IWL group members talking to staff, gathering suggestions for change or improvements and looking for areas of good practice.

### 2.6.5 Occupational health and staff wellbeing

Moorfields' staff have access to a full-time occupational health service, 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.

### 2.6.6 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. Our disability forum group met twice in 2008/09 to discuss issues concerning both staff and patients, and to monitor the disability equality scheme action plan.

Our recruitment and selection policy allows for disabled applicants who meet the selection criteria in the job specification to be automatically interviewed. We also have processes in place to ensure that anyone who becomes disabled receives suitable training and that necessary adjustments are made to enable them to continue to work with us. In terms of training, career development and promotion, all of our policies are non-discriminatory. The focus of our learning and development activity is to provide all staff with the opportunity to be properly skilled for the job for which they have been employed, regardless of any disability.

### 2.6.7 Consultation with staff groups

Three formal staff consultations took place in 2008/09. These covered proposals to restructure the estates and facilities team, new arrangements for handling patient bookings and a new operational and nursing management structure. All three consultations received positive responses and the proposals were implemented during the course of the year.

## 2.7 Working in partnership – stakeholder relations

### 2.7.1 Statutory consultations

Moorfields did not undertake any formal consultations with local primary care trusts or the overview and scrutiny committee in 2008/09.

### 2.7.2 New partnerships

Moorfields is a founder member of UCL Partners, designated in March 2009 as one of the UK's first academic health science centres. The new partnership, initially announced in August 2008, includes University College London, Great Ormond Street Hospital for Children NHS Trust, Moorfields Eye Hospital NHS Foundation Trust, The Royal Free Hampstead NHS Trust and University College London Hospitals NHS Foundation Trust. Together, the partners aim to produce more world-class research in key areas, including ophthalmology, and deliver the benefits more rapidly to patients.

In December 2008, we entered into partnership with Harrow Health Ltd, a company formed by GPs in the London Borough of Harrow. This new enterprise ensures the provision of specialist eye services in the community, including a consultant ophthalmologist, a local GP with a special interest in eye care and local optometrists.

### 2.7.3 Charitable support

Three independent charities work together under the umbrella of Moorfields Eye Hospital Charities to support the trust's work.

The Special Trustees of Moorfields Eye Hospital (charity number 228064) has a wide remit to support Moorfields' main objectives. It predominantly supports research aimed at providing better treatments, which ranges from laboratory research such as stem cells for corneal repair, to clinical trials on new treatments, including rehabilitation for those with sight impairment, to clinic and community-based schemes to improve care.

The Friends of Moorfields Eye Hospital (charity number 228637) is an active and dedicated body of voluntary fundraisers, whose main aim is to provide extra services and equipment for patients and their visitors. The charity is assisted by more than 100 volunteers, who support Moorfields' work and complement existing services and staff.

Finally, Moorfields Eye Hospital Development Fund (charity number 282806) is principally involved with specific appeals, such as the development of our new children's eye centre, which opened in 2007.

Funds for charitable initiatives come from a variety of sources, including gifts left by people in their wills and from donations from grateful patients and their families, charitable trusts, companies and philanthropists, as well as from events, collections and other fundraising activities. Together, these contributions enable our charities to fund a wide range of important research projects and to improve our services and facilities.

Moorfields' small fundraising team's principal focus during 2008/09 was on securing major gift support for a range of research projects and raising £3 million to establish an ophthalmic surgical training and treatment centre in Accra, Ghana, as a way to help significantly reduce avoidable blindness in west Africa. To date, some 60% of the campaign goal has been committed, largely from three pledges, and work to design the facility is now underway. Construction of the building will not start until nearer 80% of the required funds have been secured.

We also work closely with external charities, including the Royal National Institute for Blind People, the International Glaucoma Association and Fight for Sight to ensure that we maximise our potential to support initiatives to improve the lives of people with visual impairments.

#### **2.7.4 Social and community initiatives**

In 2008/09, staff from Moorfields worked to support two important international initiatives to raise awareness of visual impairment. Staff at Moorfields at Bedford, our newest outreach centre, marked World Sight Day in October 2008 by providing information on a range of eye conditions and treatments, while several of our consultants participated in a series of media appearances to promote the day. In addition, the International Glaucoma Association ran an awareness stall at City Road.

We also helped to promote the second World Glaucoma Day in March 2009, working alongside the Royal National Institute for Blind People and the International Glaucoma Association. Experts from Moorfields participated in a test session at the House of Commons for the all-party parliamentary group for eye health and visual impairment to demonstrate new technologies for diagnosing glaucoma, as well as working with the media to promote awareness of the condition.

In addition, in autumn 2008, we embarked on a rolling programme of health promotion sessions at the City Road site. The sessions, which included promoting fitness in arthritis, diabetes care and smoking cessation, were very well received by patients, visitors and staff. To arrange these events, the health promotion team worked closely with local community health colleagues from NHS Islington and NHS City and Hackney and with national charities, including Diabetes UK, Arthritis Care and Help the Aged.

In January 2009, Moorfields was invited to make a presentation to the Islington health and wellbeing committee, focusing on our performance against key national quality standards. The presentation was well received and led to positive feedback to support our core standards declaration (see section 2.2.4 on page 17).

As Moorfields covers many local council areas, we provided our public governors with details of the relevant Local Involvement Network (LINK) co-ordinator so that they could engage directly with other local community groups. We also continue to work closely with Islington LINK, whose co-ordinator has attended membership council meetings in 2008/09.

Moorfields' deputy director of nursing represents the trust both on Islington's Safeguarding Children and Safeguarding Adults boards to ensure that Moorfields is compliant with national directives in these areas.

#### **2.7.5 Environmental 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. In 2008/09, we renewed our waste management contract to focus on reducing our environmental impact, which has improved our waste segregation processes. 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. We also have 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.

In 2008/09, a report by external consultants Drivers Jonas in relation to our longer-term estates strategy made several recommendations about how we could reduce our carbon footprint, many of which are included in our business plans for 2009/10. These include:

- A linen policy focusing on reducing waste and the energy used on washing
- Improving ventilation plant control for our theatres to reduce energy consumption
- Re-tuning our chiller plant controls to ensure that the plant operates more efficiently at City Road
- Installation of new lighting as part of the outpatient refurbishment project (see section 2.3.9.2 on page 24) to improve lighting in clinical areas and reduce energy consumption

At the same time, we are developing further comprehensive strategies to address the sustainability agenda. These will introduce better management accountability for key deliverables at board level, as well as robust monitoring systems against performance on energy, water and waste.

## 2.8 Looking ahead

Our strategic planning for the future is set in the context of national, regional and local priorities and challenges.

Nationally, the most important feature is likely to be the serious economic situation facing the UK, and the probable financial consequences of this for the NHS over the next three to five years, which will mean that Moorfields will need to find substantial cash-releasing efficiency savings to ensure that high-quality services to patients can be maintained.

Lord Darzi's report *High Quality Care for All*, with its particular focus on quality improvement, the establishment of the Care Quality Commission and the likely introduction of corporation tax in 2010/11 on the commercial activities of NHS foundation trusts are also important national considerations.

Regionally, NHS London's *Healthcare for London* will have medium-term implications for Moorfields, to which we will need to respond intelligently and effectively to protect our activity base. Similarly, we will need to play our part in shaping emerging plans to reduce healthcare expenditure in the north central London sector in order to protect and enhance our interests.

The other significant regional development is the establishment of UCL Partners, one of five nationally designated academic health science centres in the UK. The new partnership offers significant opportunities for greater collaboration with UCLP's partner organisations, raising the profile of the clinical and academic excellence of Moorfields and the UCL Institute of Ophthalmology, attracting new revenues to the site, and reducing costs by outsourcing or merging back-office and other support functions.

At a local level, we need in particular to focus on patient satisfaction issues, estates improvements and on implementing our new informatics and marketing and communications strategies. At the same time, we will need to respond to a range of primary care initiatives in and around London and strengthen further our management capacity, systems and information.

In parallel with all of this, we will be developing our recently-started organisational and business strategy to guide our planning and decision-making in the medium term.

Recognising the context and challenges set out above, we have developed eight corporate objectives for 2009/10 as follows:

- **Demonstrating excellence in clinical safety and effectiveness:** to establish an enhanced focus on clinical safety and effectiveness to ensure that Moorfields can, over time, demonstrate that its culture, systems, practices and outcomes are consistently among the best internationally
- **Enhancing the patient experience:** to improve the experiences of Moorfields' patients, focusing on the areas of concern most frequently raised by patients and visitors through complaints and other feedback mechanisms
- **Improving our environment:** to progress the implementation of an agreed estate improvement programme

- **Leading eye research and innovation:** to maintain and improve the position of Moorfields and the UCL Institute of Ophthalmology as the premier site for eye research nationally and internationally
- **Developing, supporting and rewarding staff:** to work towards the establishment of Moorfields as an employer of choice where staff are well managed, appropriately rewarded and attaining high levels of performance
- **Strengthening our communications:** to develop an increased awareness and understanding of Moorfields' work among our main audiences to maximise support for all aspects of our work, build on our strong reputation and underpin the delivery of all corporate objectives
- **Achieving better organisational performance:** to demonstrate that Moorfields is a high-performing organisation through the achievement of excellent levels of clinical, financial and operational performance in the measures to be used by Monitor and the Care Quality Commission
- **Establishing the right structures, systems, processes and people:** to ensure that Moorfields has the management structures, systems, processes and people necessary to maximise its prospects of achieving its objectives

Each objective is supported by a high-level action plan and is reflected in the business plans developed by our service delivery units and corporate directorates.

We also have in place a range of service improvement plans for 2009/10, including a significant increase in our capacity to provide treatment for age-related macular degeneration and several joint initiatives with other providers to enhance ophthalmology services locally.



# 3 Quality report

## 3.1 Quality narrative

### 3.1.1 Chief executive's statement

Moorfields Eye Hospital NHS Foundation Trust is already rightly recognised for the quality of clinical care that we provide to our patients. Now, in common with other NHS organisations, we understand that we need to extend this commitment to quality to other areas of our work. Specifically, and in line with the recommendations of Lord Ara Darzi's national report *High Quality Care for All*, we need to ensure that our commitment to quality reflects three core themes – clinical effectiveness, patient safety and patient experience. To assist with this, we have successfully attracted funding for two Darzi fellows, who will start work with us during 2009/10.

For 2009/10, we have developed eight corporate objectives, three of which explicitly recognise the quality agenda:

- **Demonstrating excellence in clinical safety and effectiveness:** to establish an enhanced focus on clinical safety and effectiveness to ensure that Moorfields can, over time, demonstrate that its culture, systems, practices and outcomes are consistently among the best internationally
- **Enhancing the patient experience:** to improve the experiences of Moorfields' patients, focusing on the areas of concern most frequently raised by patients and visitors through complaints and other feedback mechanisms
- **Improving our environment:** to progress the implementation of an agreed estate improvement programme

That is not to say that quality has not been a part of our activity in 2008/09. We are participating in two important benchmarking projects for cataract treatments, one with the Foundation Trust Network and the other with the World Association of Eye Hospitals. We have also put in place mechanisms to ensure that we maintain our strong record on infection control, not just with regard to the national priorities concerning MRSA and Clostridium difficile infections, but against endophthalmitis, an infection that specifically affects patients who have eye surgery. In addition, we have implemented several measures to help us measure our patients' experience of the services they receive.

National targets have also provided a helpful framework in delivering quality and we are especially pleased that, throughout 2008/09, we met the requirement to treat or discharge 98% of patients presenting for care at our specialist A&E department within four hours. We also met the priority target to treat 90% of day-care patients and 95% of outpatients within 18 weeks of their referral by a GP by December 2008, and sustained this performance for the remainder of 2008/09.

In December 2008, we achieved level 2 in the NHS Litigation Authority's assessment, scoring a total of 48 out of 50. This positive result proves that Moorfields has in place approved processes for managing risk in five key areas, all of which contribute to the quality agenda for patients. In addition, we submitted a declaration of full compliance against 23 out of 24 of the core standards that will form part of the quality of services rating from the Care Quality Commission.

Importantly, both our board and our membership council receive regular updates on these issues, alongside reports about our operational and financial performance.

This quality report is designed very much as a starting point. We will be developing measures in future in close collaboration with our key stakeholders, including our commissioning partners, the

local health and wellbeing committee and our membership council, which includes patient representatives, to ensure that what we aim to achieve truly reflects what they think is most important. At the same time, we will be putting in place systems to ensure that we can measure our performance against these targets, so that we can track improvements and take remedial action in areas where we fall short.



**John Pelly**, chief executive

### 3.1.2 Quality improvement priorities

Quality improvement initiatives are an integral part of several of our corporate objectives for 2009/10, which have been developed in line with known national and agreed local priorities. From these, we have identified four priorities specifically to address the quality agenda as set out below.

#### 3.1.2.1 Patient experience – improving outpatient waiting times

**Objective:** To improve the patient experience in the outpatient setting by reducing avoidable delays, specifically by undertaking a diagnostic review of every outpatient clinic across the trust and redesigning processes according to patient and individual service needs to eliminate avoidable delays.

**Description of issue and rationale for prioritising:** The outpatient pathway for many ophthalmic patients can be rather complex, frequently resulting in a range of diagnostic tests or assessments being undertaken during a single outpatient consultation. Despite the complexity of the pathway, there is evidence that patients are experiencing avoidable delays in their journey due to several outdated and inefficient administrative processes. This is not acceptable and we need to ensure that as much of the non-value added (waiting) time spent in the outpatient department, is re-designed out of the administrative process. Addressing this priority will enable us to improve the process for booking new outpatient appointments, resulting in a more effective booking process for patients.

**Action:** In 2008/09, we enlisted additional external service improvement expertise from PA Consulting, who developed and then piloted a diagnostic tool to reduce delays in five outpatient clinics across the trust. Use of the specifically designed diagnostic tool encourages a whole-team approach, using both quantitative and qualitative data, sourced both from staff and patients, to identify constraints and bottle necks. Each team in the pilot areas has used the information to redesign the pathway within the clinic and test out the improvements that have been made. These improvements are now being tracked through performance monitoring. During 2009/10, we plan to introduce the diagnostic tool to all outpatient clinics across the trust.

### 3.1.2.2 Patient experience – improving the environment

**Objective:** To improve the quality of the patient environment in the outpatient setting, specifically through the delivery of two key investment schemes:

- City Road outpatient refurbishment project, a year-long project due to start in July 2009
- Moorfields at Northwick Park redevelopment, a year-long project due to start in October 2009

**Description of issue and rationale for prioritising:** Moorfields needs to ensure that the environment in which patients are seen and treated is of a sufficiently high standard to support the delivery of high quality clinical care. We face several challenges in achieving this aim, predominantly due to the age of the estate. At the same time, we need to ensure that, during any upgrade of our facilities, we can continue to deliver services with as little disruption as possible. We believe that we have done well to achieve ‘good’ scores for the quality and cleanliness of the environment in our annual Patient Environment Action Team (PEAT) report, despite these particular challenges, but we are determined to do better.

**Action:** Detailed planning has taken place throughout 2008/09 to ensure that these major refurbishment projects can proceed quickly and effectively, with the minimum possible disruption to clinical services. Wherever possible, we have sought to ensure that any relocations necessitated by the refurbishments result in the logical co-location of services in future. For the outpatient project, our contractors have created a sample area adjacent to one of our existing clinics to give patients and staff an idea of how the new areas might look, which has enabled us to generate useful feedback on lighting, colour schemes, signs and seating. A detailed eight-phase programme is now in place, with work due to commence in July 2009. At Northwick Park, agreement has now been reached with the owners of the site, North West London Hospitals NHS Trust, which means that we are now in a position to initiate the design phase of the project, with a view to starting work on site later in 2009.

### 3.1.2.3 Patient safety – implementing the National Patient Safety Agency surgical safety checklist

**Objective:** To ensure that the National Patient Safety Agency (NPSA) surgical safety checklist is used for all surgical activity across Moorfields.

**Description of issue and rationale for prioritising:** The implementation of the NPSA's surgical safety checklist, developed with the World Health Organisation, has been shown to reduce surgical errors and adverse events in the theatre environment. Additional positive benefits include improved team working and increased efficiency.

**Action:** During 2008/09, we reviewed the original NPSA checklist and modified it slightly to ensure that it is appropriate and tailor-made to address key risk issues specific to ophthalmology. This was done in collaboration with the relevant professional colleges. We also started a pilot of the modified checklist in theatres at Moorfields. The pilot will continue in the early part of 2009/10 and further modifications will be made in light of its findings. We will then implement a programme of awareness raising and staff training sessions to support the introduction of the modified checklist during the year.

### 3.1.2.4 Clinical effectiveness – establishing at least one clinical outcome indicator per sub-specialty

**Objective:** To identify at least nine clinical outcome metrics across the trust, with systems in place to record, monitor and report data accurately.

**Description of issue and rationale for prioritising:** It is essential that we are able to measure and compare our clinical outcomes to those of other ophthalmology units, nationally and internationally. This will reaffirm our belief that we provide a world-class standard of clinical care to our patients. In order to do this, we need to have agreed specific clinical outcome measures for each sub-specialty across the trust.

**Action:** Many evaluations are already underway to assess the outcome of particular treatments and, approaches to disease management, under the guise of our local clinical audit programme and, crucially, as part of our research activity. Reviewing outcomes in this way does not lend itself to monitoring for continuous improvement, which means that we need now to define agreed metrics to monitor improvements over time. This work is being led by senior clinicians across the trust, with the first outcome measure for cataract surgery – posterior capsule rupture rate – being reported in 2008/09.

### 3.1.3 Externally raised challenges

We met in full five out of six requirements of the national hygiene code, against which we were assessed by the former Healthcare Commission in January 2009. In one area relating to the decontamination of instruments, we were assessed as not fully meeting all the requirements. In particular, the assessment team felt that there was insufficient evidence to support our robust systems for the local cleaning of instruments in some parts of the hospital. This minor breach, which had no impact on patient care, has now been addressed by implementing additional training and guidance for staff responsible for the local cleaning of clinical instruments.

An inspection for the 2009 Patient Environment and Action Team (PEAT) assessment took place in March 2009. Our inspection was generally positive, with ‘good’ ratings for environment and privacy and dignity. For food, we were rated as ‘acceptable’ and we took immediate action to address those areas identified for improvement by the end of April 2009.

Moorfields successfully achieved level 2 in the NHS Litigation Authority’s risk assessment completed in December 2008, scoring a total of 48 out of 50. This positive result proves that we have in place processes for managing risk in five key areas: governance, competent and capable workforce, safe environment, clinical care and learning from experience.

Finally, and in common with all NHS organisations, we were conscious of the need to draw on the findings of the former Healthcare Commission’s report into patient safety at Mid Staffordshire NHS Foundation Trust. A thorough assessment concluded that there are no major concerns in terms of Moorfields’ services in light of the report, although we are now finalising and implementing a plan to address some minor issues to assure ourselves of our ability to continue to provide safe care to all our patients.

## 3.2 Quality overview

### 3.2.1 Performance against key indicators in 2008/09

Indicator	Source	2007/08	2008/09
<b>Patient experience</b>			
% of patients who would recommend Moorfields to a friend or relative, responding yes, definitely	Picker survey – outpatients	N/A	77.8%
% of patients who would recommend Moorfields to a friend or relative, responding yes, definitely	Picker survey – day care	N/A	84.4%
% of patients who felt they were treated with dignity and respect, responding yes, all of the time	Picker survey – outpatients	N/A	78.8%
% of patients who felt they were treated with dignity and respect, responding yes, all of the time	Picker survey – day care	N/A	89.3%
% of patients who rated their overall care as good, very good or excellent	Picker survey – outpatients	N/A	92.5%
% of patients who rated their overall care as good, very good or excellent	Picker survey – day care	N/A	96.5%
% of patients who spent less than four hours waiting in A&E	Internal performance monitoring	99.11%	99.6%
<b>Patient safety</b>			
% overall compliance against environmental cleanliness standards	Internal performance monitoring	N/A	93.5%
% overall compliance with hand hygiene standards	Internal performance monitoring	N/A	83.5%
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0
Number of reportable Clostridium difficile cases	Internal performance monitoring	0	0
Incidence of endophthalmitis per 1,000 cataract cases	Internal performance monitoring	N/A	0.8
<b>Clinical effectiveness</b>			
% implementation of NICE guidance	Clinical effectiveness committee	100%	100%
Proportion of surgical admissions that did not result in an operation	Internal performance monitoring	0.15%	0.22%
Posterior capsule rupture rate for cataract surgery	Moorfields Eye Hospital clinical audit of cataract outcomes 2008	N/A	1.8%

### 3.2.2 Performance against national priorities

Moorfields has established a Monitor compliance framework, which is presented to every meeting of the board as part of a monthly performance report. The framework demonstrates progress against key quality indicators, as set out in the table in section 2.2.3 on page 16.

We submitted a declaration of full compliance against 23 out of 24 of the core standards that will form part of the quality of services rating from the Care Quality Commission. We were unable to confirm compliance with C9 – records management – due to a lack of relevant and up-to-date evidence. We have implemented an action plan which includes an audit of the quality of clinical records and continuation of the mapping exercise of information systems and risks.

# 4 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 from those of other NHS organisations. The trust is led by the board of directors, which is accountable to the membership council, also known as the 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.

## 4.1 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 and strategic planning. The council met five times during 2008/09 to discuss an agenda ranging from the patient experience through to Moorfields' business agenda and its service and strategic development plans.

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. The remuneration committee met once during 2008/09 to review the remuneration of the chair and non-executive directors and its 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 are actively encouraged to attend the meetings, and the board's business agenda remains a standing item on the council's agenda.

#### 4.1.1 Composition of the membership council in 2008/09

<b>Elected Governors</b>	<b>Representing</b>	<b>Other responsibilities</b>
Malcolm Barrow	Public: Bedfordshire and Hertfordshire Governance committee	Vice chair
Jane Colebourn	Public: Bedfordshire and Hertfordshire	
Bill Tidmas	Public: North East London and Essex	Remuneration committee Representative at the Foundation Trust Governors' Association
Paul Murphy	Public: North Central London Membership development	Nomination committee
John Green	Public: North Central London Governance committee	Remuneration committee
Victor Stone to 31 March 2009	Public: North East London	Remuneration committee
Patricia Campbell	Public: North West London Membership development	Disability focus group
Brian Watkins	Public: North West London	Membership development
Christopher Hough to 31 March 2009	Public: South East London	Clinical effectiveness committee
Solomon Parry	Public: South East London	Risk and safety committee
Andrew Hill	Public: South West London committee Chair, remuneration committee	Chair, nomination
Alex Nicholson to 31 March 2009	Public: South West London	
John Bird to 31 March 2009	Patient	Remuneration committee Representative at the Foundation Trust Governors' Association
Robert J Jones to 31 March 2009	Patient	
Michael O'Dwyer	Patient	Membership development
Alison Davis to 31 December 2008	Staff – outreach class	Improving working lives group
Eilis Kennedy	Staff – City Road class	Improving working lives group
Ali Safiee to 31 March 2009	Staff – City Road class	Disability focus group
Colin Carter	Staff – outreach class	Improving working lives group

Nominated Governors	Representing	Other responsibilities
Cllr Ruth Polling	London Borough of Islington	
Colin Brown	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 – please see contact details in section 4.1.2 below.

#### 4.1.2 Register of interests for the membership council

The register of interests of individual governors on the membership council 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 [foundation@moorfields.nhs.uk](mailto:foundation@moorfields.nhs.uk).

#### 4.1.3 Membership

Moorfields continues to grow its membership and we currently have about 14,000 members, an increase of 6,000 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 for both 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.

Recruitment activity in 2008/09 has been co-ordinated by the membership development group, with a two-stage campaign to target patients new to Moorfields. In June 2008, we sent mail shots to all of the 10,000 'new' patients who attended a Moorfields clinic appointment between December 2007 and May 2008. In a longer-term initiative, all 'new' patient appointment letters now include a letter of introduction from the chief executive and a membership application form. New members are automatically allocated to the relevant public constituency within which they reside, unless they specifically request to join the patient constituency. The majority of our members are patients but are allocated to the public constituencies.

In addition, a series of membership days is planned at each of our outreach centres, as well as membership events for participants to find out more about Moorfields' work and about specific eye conditions. Governors visit local outreach sites to engage with patients and the public with a view to recruitment, and they also run an annual membership week to coincide with our open day, which, for 2008/09, took place in July 2008 to coincide with the 60th anniversary of the NHS.

All members are invited to our annual general meeting, with seats allocated on a first-come, first-served basis. This year's AGM, held on 24 September 2008 at St Luke's LSO, attracted more than 200 members.

The break-down of our membership between constituencies is as follows:

Constituency	Number of members
Patient constituency	3,977
Bedfordshire and Hertfordshire public constituency	648
North Central London public constituency	1,972
North East London and Essex public constituency	2,168
North West London public constituency	2,441
South East London public constituency	537
South West London public constituency	1,031
Staff constituency – City Road	1,235
Staff constituency – outreach	130

#### 4.1.4 Representing our membership

Members are represented by elected patient, public and staff governors on the membership council (see section 4.1.1 on pages 42 and 43), which meets at least 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 membership of recruitment panels for consultant and senior management appointments. 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.

#### 4.1.5 Membership council elections

Elections were held in January 2009 in several seats, where governors had come to the end of their tenure or chosen to stand down. The following candidates were elected from ballot:

- North Central London public constituency: Paul Murphy
- North West London public constituency: Patricia Campbell
- Patient constituency: Brenda Faulkner and Michael O'Dwyer

In addition, candidates were elected unopposed in the following constituencies:

- Bedfordshire and Hertfordshire public constituency: Malcolm Barrow
- North East London and Essex public constituency: Bill Tidmas
- South East London public constituency: Solomon Parry
- Staff constituency, City Road class: John Carmichael

By-elections are scheduled for June 2009 for the following constituencies, for which we received either no nominations or insufficient nominations in January 2009 to fill all vacancies:

- South West London public constituency
- North East London and Essex public constituency
- South East London public constituency
- Staff constituency, outreach class

We will also be holding a by-election for one seat in the patient constituency at the same time following the resignation of Robert J Jones.

Full details of the composition of the membership council from 1 April 2009 and of the election results are posted on our website at [www.moorfields.nhs.uk/getinvolved/membership](http://www.moorfields.nhs.uk/getinvolved/membership).

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 2008/09.

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).

## 4.2 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 team), 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). Our constitution also allows for the UCL Institute of Ophthalmology to have a representative on the trust board, which means that this non-executive appointment does not need to go through the usual appointment processes. Executive directors are appointed by the nominations committee of the board of directors on permanent contracts.

#### 4.2.1 Composition of the board of directors in 2008/09

Board member	Position	Date and length of appointment
Rudy Markham (10) (Background – finance director)	Chairman Chair of remuneration committee	1 April 2008 for three years
Deborah Harris-Ugbomah (10) (Background – chartered accountant)	Non-executive director Chair of audit committee	1 January 2008 for three years
Sir Roger Jackling (9) (Background – civil service)	Non-executive director Deputy chair and senior independent director (non-executive) from 1 November 2008 Chair of strategy and investment committee	1 April 2008 for three years
Professor Phil Luthert (9) (Background – ophthalmic pathologist and research scientist)	Non-executive director Director of the Institute of Ophthalmology Chair of governance committee from 1 November 2008	1 February 2006
Andrew Nebel (9) (Background – marketing and communications director)	Non-executive director	1 April 2008 for three years
Clive Nickolds (5 out of 6) (Background – retail director)	Deputy chair and senior independent director (non-executive) to 31 October 2008 Chair of governance committee to 31 October 2008	1 April 2004, renewed November 2005 for three years until 31 October 2008
Lesley Potter (10) (Background – communications and public relations consultant)	Non-executive director	1 April 2008 for three years
John Pelly (10) (Background – accountant and health service management)	Chief executive	
Mr Bill Aylward (8) (Background – ophthalmic surgeon)	Medical director	
Mark Cubbon (10) (Background – registered nurse and health service management)	Chief operating and nursing officer	
Professor Roger Hitchings (2 out of 4) (Background – ophthalmic surgeon)	Director of research and development until 31 July 2008	

Board member	Position	Date and length of appointment
Ian Hollows (10) (Background – chartered accountant)	Finance director	
Professor Peng Tee Khaw (6 out of 6) (Background – ophthalmic surgeon and clinician scientist)	Director of research and development from 1 August 2008	

All board meetings were held in public and the bracketed numbers in the table above refer to the number of public board meetings directors attended during 2008/09 out of a possible 10. The board may also hold a confidential meeting each month if required. 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.

## 4.2.2 Committees of the board

### 4.2.2.1 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. The chair has recent and relevant financial experience and is also the chair of the Association of Financial Non-Executive Directors (AFNED). 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 following table shows the attendance of members at audit committee meetings for the year ended 31 March 2009:

Date	In attendance
27 May 2008	Deborah Harris-Ugbomah (chair), Clive Nickolds
9 June 2008	Deborah Harris-Ugbomah (chair), Roger Jackling
18 September 2008	Deborah Harris-Ugbomah (chair), Clive Nickolds, Roger Jackling
4 December 2008	Deborah Harris-Ugbomah (chair), Roger Jackling, Lesley Potter
*5 February 2009	Deborah Harris-Ugbomah (chair), Roger Jackling, Lesley Potter
*23 April 2009	Deborah Harris-Ugbomah (chair), Roger Jackling, Lesley Potter

\* Audit committee meetings for January and March 2009 were rescheduled for February and April respectively to address issues relating to 2008/09.

#### 4.2.2.2 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) until 31 October 2008
- Phil Luthert, non-executive director (chair) from 1 November 2008
- 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 in section 4.2.5 on page 52.

#### 4.2.2.3 Strategy and investment committee

This committee, which met five times during the year, conducts independent and objective reviews of strategic direction and investment policies. The committee is chaired by a non-executive director, with a second non-executive director, the chief executive and the finance director as members.

Date	In attendance
19 June 2008	Roger Jackling (chair), Andrew Nebel (non-executive director), John Pelly (chief executive) and Ian Hollows (finance director)
25 September 2008	Roger Jackling (chair), Andrew Nebel (non-executive director), John Pelly (chief executive), Ian Hollows (finance director), and Bill Aylward (medical director)
18 December 2008	Roger Jackling (chair), Andrew Nebel (non-executive director), John Pelly (chief executive), Ian Hollows (finance director), and Bill Aylward (medical director)
26 February 2009	Roger Jackling (chair), Andrew Nebel (non-executive director), John Pelly (chief executive), and Ian Hollows (finance director) and Declan Flanagan (deputy medical director)
4 March 2009	Roger Jackling (chair), Andrew Nebel (non-executive director), John Pelly (chief executive), and Ian Hollows (finance director)

#### 4.2.2.4 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.

Date	In attendance
26 June 2008	Rudy Markham (chair) and non-executive directors Deborah Harris-Ugbomah, Roger Jackling, Phil Luthert, Clive Nickolds and Lesley Potter. In attendance: John Pelly (chief executive) and Heather Wilcox (PA to the chief executive and chair).
26 November 2008	Rudy Markham (chair) and non-executive directors Deborah Harris-Ugbomah, Roger Jackling, Phil Luthert, Andrew Nebel and Lesley Potter. In attendance: John Pelly (chief executive) and Ken Gold (director of personnel).
28 January 2009	Rudy Markham (chair) and non-executive directors Deborah Harris-Ugbomah, Roger Jackling, Phil Luthert, Andrew Nebel and Lesley Potter. In attendance: John Pelly (chief executive) and Ken Gold (director of personnel).

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.

#### 4.2.2.5 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 and is chaired by a public governor with membership including, as a minimum, two elected governors, two board members and an independent assessor.

The executive nominations committee met on 10 June 2008 for the appointment of a new director of research and development. Membership of the committee was as follows:

- Bill Aylward, medical director
- Neil Barnes, external assessor
- Phil Luthert, non-executive director
- Rudy Markham, chairman
- John Pelly, chief executive

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.

### 4.2.3 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.

#### 4.2.3.1 External review of risk

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

Moorfields successfully achieved level 2 in the NHS Litigation Authority's risk management standards assessment completed in December 2008, scoring a total of 48 out of 50. This positive result proves that we have in place processes for managing risk in five key areas: governance, competent and capable workforce, safe environment, clinical care and learning from experience.

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

Moorfields received ratings of 'excellent' for use of resources and 'fair' for quality of services in the annual health check published by the former Healthcare Commission in October 2008, based on performance in 2007/08. Compliance with the core standards for better health improved during 2008/09, with the board of directors declaring 'insufficient assurance' in relation to just

one standard, compared with two in the previous year, and full compliance with all other core standards.

### Monitor risk ratings

The trust continued to improve and strengthen its performance against national targets, indicators and standards, and this led to green risk ratings for each of the four quarters of the year from our regulator, Monitor, for governance and the provision of mandatory services, and a risk rating of four for financial management, where one is the worst, and five the best.

### Serious untoward incidents involving data loss or confidentiality breach

We reported one serious untoward incident involving personal data in 2008/09 as follows:

Date of incident	Nature of incident	Nature of data involved	Number of people potentially affected
February 2009	Unauthorised disclosure	Email addresses	1,000

**Notification steps:** the investigating panel considered the issue of notification to the email addressees, but considered that to do so would raise the level of risk of further potential damage to the individuals. NHS London, the trust board and our membership council were all notified of the incident.

**Further action on information risk:** a new process has been put in place to ensure that such unauthorised disclosure of personal email addresses cannot happen again.

### Summary of other personal data related incidents in 2008/09

Category	Nature of incident	Total
I	N/A	0
II	Loss of inadequately protected paper documents from outside secured NHS premises	1
III	Insecure disposal of paper documents	3
IV	Unauthorised disclosure	1
V	N/A	0

#### 4.2.4 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 chief executive and the non-executive directors. The deputy chairman/senior independent director leads the evaluation of the chairman of the board of directors.

The process for evaluating the performance of the board overall took place in March 2009. As the majority of non-executive directors only joined the trust in April 2008, the focus of the evaluation was on the core responsibilities of the board as described in the code of governance for NHS foundation trusts. The key areas arising from the report, such as induction for new directors, are described in a report and action plan that will be fully implemented by 31 March 2010.

#### 4.2.5 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.

### 4.3 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 provide for a notice period of up to six months.


# 5 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 and finance director are 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.

No payment for compensation for loss of office was made during 2008/09.



John Pelly, chief executive



# 6 Financial report

A surplus of £640,000 (£2.2 million before impairment) was generated for 2008/09, which was better than planned. The surplus enabled the trust to maintain a financial risk rating of four throughout the year. The table below presents a high-level comparison between the plan and actual performance for the year.

All figures in £million	2008/09		
	Actual	Plan	Variance
<b>Income</b>			
Clinical income			
– NHS	78.8	73.4	5.4
– Private	11.3	10.3	1.0
– Moorfields Pharmaceuticals	6.1	5.5	0.6
Non-clinical income	16.3	15.0	1.3
<b>Total income</b>	<b>112.5</b>	<b>104.2</b>	<b>8.3</b>
<b>Expenditure</b>			
Pay costs	65.2	62.9	(2.3)
Non-pay costs	38.7	34.6	(4.1)
<b>Total expenditure</b>	<b>103.9</b>	<b>97.5</b>	<b>(6.4)</b>
Earnings before interest, tax, depreciation and amortisation	8.6	6.7	1.9
Impairment of fixed assets	1.6	–	(1.6)
Net surplus	0.6	0.4	0.2

## 6.1 Income

### 6.1.1 NHS clinical income

The issuing in August 2008 of a recommendation by the National Institute for Health and Clinical Excellence (NICE) for the use of Lucentis in the treatment of wet age-related macular degeneration (AMD) led to increased activity and income from AMD treatments was £4.4 million, exceeding plan by £3.3 million. Outpatient activity, including that related to AMD, was higher than expected with income £1.4 million more than planned. In its second year, the activity at Moorfields at Bedford continued to grow and income was £3.6 million, £0.5 million higher than plan.

## 6.1.2 Income from private patients

Income of £2.4 million from Moorfields Eye Hospital Dubai in its second year of operations was satisfactory, exceeding plan by £0.8 million. Income from Moorfields Private in London was £8.9 million, £0.2 million greater than plan.

## 6.1.3 Moorfields Pharmaceuticals

Moorfields Pharmaceuticals enjoyed another year of rapid growth with income increasing to £6.1 million and beating plan by £0.6 million. The decline in sales of bevacizumab, used in the treatment of AMD, following the NICE recommendation for the use of Lucentis, was much less than expected and sales were £0.5 million higher than plan. External sales of £5.7 million of other unlicensed products were £0.3 million ahead of plan but this was largely offset by sales of licensed hypermellose unit dose being less than plan.

## 6.1.4 Non-clinical income

Non-clinical income, representing 14.5% of the total, is analysed in the table below:

All figures in £million	2008/09		
	Actual	Plan	Variance
Non-clinical income			
Research and development	6.2	6.0	0.2
Education and training	3.7	3.3	0.4
Charitable and other contributions to expenditure	0.9	1.0	(0.1)
Transfers from donated asset reserve	0.7	0.7	–
Various fees and charges	4.8	3.5	1.3
	16.3	15.0	1.3

Within fees and charges, Islington PCT, the host commissioner, paid the trust an incentive of £0.2 million for exceeding the 18-week target. Also, VAT reimbursements were £0.3 million higher than expected.

## 6.2 Expenditure

### 6.2.1 Pay costs

Pay costs exceeded plan by £2.3 million, reflecting higher than expected activity. Medical staff costs of £19.8 million exceeded plan by £0.9 million because of higher than planned activity. Nursing staff costs of £15.6 million were in accordance with the plan. Temporary staff costs exceeded plan by £0.6 million, largest in the estates and medical records departments. An additional payment for all staff, excluding certain directors, was paid and this contributed to a pay cost variance of £0.3 million.

## 6.2.2 Non-pay costs

The main components of non-pay expenditure are shown in the table below:

Expense type (All figures in £million)	2008/09		
	Actual	Plan	Variance
Drug costs	7.4	4.4	(3.0)
Clinical supplies and services	10.5	8.9	(1.6)
Establishment expenses	5.0	4.1	(0.9)
Transport	2.5	2.5	-
Premises	4.8	5.1	0.3
IT expenditure	1.0	1.0	-
Other	7.5	8.6	1.1
	38.7	34.6	(4.1)

Drug costs were over budget because of higher than planned activity, which related in particular to the use of £3 million of high-cost drugs for age-related macular degeneration (AMD) treatments referred to above. Costs of clinical supplies exceeded plan because of higher activity and the increased prices of AMD packs and intraocular lenses. Establishment costs were higher than plan because of increased utilities prices (£0.3 million) and higher than expected use of consultants (£0.5 million) for information and performance and other projects. The variance in the 'other' category represents the unused contingency and development reserves.

## 6.3 Impairment of fixed asset values

A review of the future cash flows expected from Moorfields Eye Hospital Dubai indicated that they will not support the carrying value of the capitalised fit-out and start-up costs and so an impairment charge of £1.6 million was recorded.

## 6.4 Cash flow

At 31 March 2009, the trust had net current assets of £5.2 million compared with net assets of £2.7 million at the previous year-end. After net cash inflow of £3.9 million (2007/08: £0.1 million inflow), the trust ended the year with short-term investments and cash at bank of £8.0m (2007/08: £12.0 million).

## 6.5 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 2008/09 by the trust, leaving an outstanding balance of £11.8 million.

## 6.6 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.

## 6.7 Better payment practice code

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.

## 6.8 External audit services

The trust employs the services of Deloitte LLP as external auditor and for other services. The type of services and costs are detailed below.

	2008/09	2007/08
	£000	£000
Statutory audit services	70	57
Regulatory reporting	27	41
Other services	100	55

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 Care Quality 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.

## 6.9 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.

She attends audit committee meetings at which she presents the programme and the results of her work. The LCFS gives regular fraud awareness sessions for the trust's staff. She investigates concerns reported by staff and, if they are substantiated, the trust takes appropriate criminal, civil or disciplinary measures.

### **6.10 Accounting policies**

The accounting policies for the trust are set out in the annual accounts on pages 73 to 78.

### **6.11 Senior employees' remuneration**

Details of senior employees' remuneration, including pension entitlements, is disclosed in the annual accounts on pages 84 and 85.

### **6.12 Cost allocation and charging requirements**

Moorfields Eye Hospital NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.




# 7 Annual accounts 2008/09

## 7.1 Foreword to the accounts

Moorfields Eye Hospital NHS Foundation Trust

The accounts for the year ended 31 March 2009 have been prepared by Moorfields Eye Hospital NHS Foundation Trust in accordance with the National Health Service Act 2006.



John Pelly, chief executive

8 June 2009

## 7.2 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 cash flows 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  
8 June 2009

## 7.3 Statement on internal control

### 7.3.1 Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, while 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 NHS foundation 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.

### 7.3.2 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 2009 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.

### 7.3.3 Capacity to handle risk

#### 7.3.3.1 Leadership

The trust board is responsible for risk management across the organisation and delegates authority to the governance and audit committees to monitor the implementation of risk management arrangements, while the management executive is responsible for decision-making on business cases and recommendations to the board on the use of resources.

The governance, audit and strategy and investment committees 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 the governance committee for clinical and non-clinical risk and through the audit committee for financial risk. There is substantial crossover between the two committees to ensure all elements of risk are considered and co-ordinated. One non-executive director is a member of both committees and the director of corporate governance provides executive continuity between the two.

As accounting officer, I am responsible for the system of internal control and therefore risk management. The director of corporate governance leads the assurance and risk management processes. Day-to-day co-ordination of non-financial risk management is 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.

#### 7.3.3.2 Staff training

There are extensive training programmes available to all groups of staff that 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 supporting the service delivery units 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 facing 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 there is an ongoing programme of risk and safety management, provided by the risk trainer.

### 7.3.4 The risk and control framework

Risk management starts at the trust board. Risks are captured and documented on the risk register. The board or the relevant sub-committee approves all strategy and policy updates and the chairs of the audit, governance, and strategy and investment committees give regular reports to the board. Serious incidents are reported to the board, with further reporting following action and outcomes.

#### 7.3.4.1 Strategy and policy

The trust board reviews and approves the risk management strategy and policy annually. 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 policy has been disseminated throughout the trust and is available for staff on the intranet.

Risk management is embedded in the activities of the organisation and operational responsibility for risk identification and control is delegated to individual directors and senior managers who have functional responsibility within their areas of management.

The trust provides services at 11 other sites that are run by other NHS trusts 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. The risks identified at each outreach site are reported and managed through the service delivery unit operational structure, and where relevant, risks will be added to the risk register.

#### 7.3.4.2 Information governance

Information governance and the use of the toolkit is directed and monitored by the information governance committee. This group reports to the risk and safety committee which in turn reports to the governance committee. The group meets monthly and is chaired by the medical director who is also the Caldicott guardian. The director of corporate governance is the senior information risk owner and has received appropriate training through NHS London.

Information risks are included in the incident reporting processes and are investigated and monitored in the same way as other incidents. Particular emphasis has been made during 2008/09 to ensure staff awareness of their responsibilities for managing confidential information and personal identifiable data. During 2008/09, we reported and investigated one serious untoward incident relating to the erroneous release of data. This did not relate to patient data. Action plans have been put in place and the lessons learned have been disseminated and are being monitored by the information governance committee.

#### 7.3.4.3 Involving public stakeholders

The priorities and objectives of the risk management strategy and policy 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 Primary Care Trust 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 membership council has reviewed the evidence for the core standards for better health. We have also invited and received third-party commentaries as assurances of compliance with the core standards for better health.

#### **7.3.4.4 Equality, diversity and human rights**

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

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

The board reviews the use of resources every month and further detailed work is carried out by the audit committee. In addition both internal and external audit carry out specific value-for-money reviews as requested and report their findings to the audit committee.

#### **7.3.6 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 within the NHS foundation trust 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 process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been reviewed by:

- The board working within an integrated programme of business that ensures the key compliance and regulatory requirements are reported and reviewed and the key risks to compliance are considered.
- The audit and governance committees providing the board of directors with an independent and objective review of financial and corporate governance, and internal financial control within the trust. There have been programmes in place with the internal and external auditors to review systems, controls and processes, and the outcomes of 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.

The trust was assessed for and awarded level two of the NHS Litigation Authority's risk management standards in December 2008. The process and evidence for standards for better health were reviewed by our internal auditors who gave an opinion of substantial assurance. The trust's final declaration in April 2009 confirmed compliance against all but one of the core standards, with insufficient assurance declared for C9, records management, due to the lack of available evidence to confirm the quality of records. This had also been identified during the NHSLA assessment. Processes are in place now to audit the quality of clinical records routinely, and the mapping of information assets including records continues. Our internal auditors recently completed the review of information security and gave an opinion of substantial assurance.

We investigated three serious untoward incidents during 2008/09. One concerned the erroneous use of ephedrine on a patient undergoing general anaesthesia. This investigation was completed, action taken, and the final report made to the board in September 2008. The second incident concerned a potential breach of research governance arrangements for a clinical trial. The investigation has been completed and the final outcomes report is due to be made to the board in June 2009. The third incident related to information governance and is described in section 7.3.4.2.

To conclude, there are no significant control issues identified.

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

Significant 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 weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk.



John Pelly, chief executive  
8 June 2009

## 7.4 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 2009 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.

### 7.4.1 Respective responsibilities of directors and auditors

The accounting officer's responsibilities for preparing the financial statements in accordance with directions issued by Monitor, the independent regulator of NHS foundation trusts, are set out in the statement of accounting officer's responsibilities.

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 to you whether in our opinion the information given in the directors' report is consistent with the financial statements.

In addition, we report to you 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 financial statements.

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.

### 7.4.2 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 and 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.

### 7.4.3 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 2009 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; and
- The information given in the directors' report is consistent with the financial statements

### 7.4.4 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 FCA, BA (Hons), senior statutory auditor**

For and on behalf of Deloitte & Touche LLP  
Chartered accountants  
St Albans  
8 June 2009


## 7.5 Income and expenditure account for the year ended 31 March 2009

		31 March 2009	31 March 2008
	NOTE	£000	£000
<b>Income from activities</b>	3.1-3.2	<b>90,219</b>	75,920
<b>Other operating income</b>	3.3	<u><b>22,231</b></u>	<u>20,696</u>
<b>Total income</b>		<b>112,450</b>	96,616
<b>Operating expenses</b>	4-5	<u><b>(109,740)</b></u>	<u>(92,341)</u>
<b>SURPLUS BEFORE INTEREST</b>		<b>2,710</b>	4,275
Interest receivable	6.1	<b>325</b>	373
Interest payable	6.2	<b>(566)</b>	(630)
Other finance costs - unwinding of discount	14	<b>(3)</b>	(3)
<b>SURPLUS FOR THE FINANCIAL YEAR</b>		<u><b>2,466</b></u>	<u>4,015</u>
Public Dividend Capital dividends payable	19	<u><b>(1,826)</b></u>	<u>(1,780)</u>
<b>RETAINED SURPLUS FOR THE YEAR</b>	15	<u><u><b>640</b></u></u>	<u><u>2,235</u></u>

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

## 7.6 Balance sheet as at 31 March 2009

		31 March 2009	31 March 2008
	NOTE	£000	£000
<b>FIXED ASSETS</b>			
Intangible assets	7	385	436
Tangible assets	8	73,815	79,377
		<u>74,200</u>	<u>79,813</u>
<b>CURRENT ASSETS</b>			
Stocks and work-in-progress	9	2,425	2,050
Debtors	10	10,496	6,021
Investments	11	7	7,830
Cash at bank and in hand		8,031	4,130
		<u>20,959</u>	<u>20,031</u>
<b>CREDITORS: Amounts falling due within one year</b>	12	<u>(15,782)</u>	<u>(17,377)</u>
<b>NET CURRENT ASSETS</b>		<u>5,177</u>	<u>2,654</u>
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>		<u>79,377</u>	<u>82,467</u>
<b>CREDITORS: Amounts falling due after more than one year</b>	12	<u>(11,597)</u>	<u>(11,896)</u>
<b>PROVISIONS FOR LIABILITIES AND CHARGES</b>	14	<u>(1,070)</u>	<u>(838)</u>
<b>TOTAL ASSETS EMPLOYED</b>		<u><u>66,710</u></u>	<u><u>69,733</u></u>
<b>FINANCED BY:</b>			
<b>TAXPAYERS' EQUITY</b>			
Public dividend capital	18	31,279	31,279
Revaluation reserve	15	10,649	14,386
Donated asset reserve	15	15,982	16,661
Income and expenditure reserve	15	8,800	7,407
<b>TOTAL TAXPAYERS' EQUITY</b>		<u><u>66,710</u></u>	<u><u>69,733</u></u>



John Pelly, chief executive  
8 June 2009

## 7.7 Statement of total recognised gains and losses for the year ended 31 March 2009

	31 March 2009	31 March 2008
	£000	£000
Surplus for the financial year before dividend payments	2,466	4,015
Unrealised (loss)/gain on fixed asset revaluations	(3,121)	4,428
Net increase in the donated asset reserve due to receipt of donated assets	162	449
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	(704)	(850)
<b>Total gains and losses recognised in the financial year</b>	<b>(1,197)</b>	<b>8,042</b>

## 7.8 Cash flow statement for the year ended 31 March 2009

		2008/09	2007/08
	NOTE	£000	£000
<b>OPERATING ACTIVITIES</b>			
<b>Net cash inflow from operating activities</b>	16.1	<b>2,468</b>	11,600
<b>RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:</b>			
Interest received		<b>344</b>	366
Interest paid		<b>(555)</b>	(613)
Interest element of finance lease rental payments		<b>(14)</b>	(17)
<b>Net cash outflow from returns on investments and servicing of finance</b>		<b>(225)</b>	(264)
<b>CAPITAL EXPENDITURE</b>			
Payments to acquire tangible fixed assets		<b>(3,543)</b>	(4,334)
Payments to acquire intangible assets		<b>(70)</b>	(99)
<b>Net cash outflow from capital expenditure</b>		<b>(3,613)</b>	(4,433)
<b>DIVIDENDS PAID</b>		<b>(1,826)</b>	(1,780)
<b>Net cash (outflow)/inflow before management of liquid resources and financing</b>		<b>(3,196)</b>	5,123
<b>MANAGEMENT OF LIQUID RESOURCES</b>			
Purchase of current asset investments		<b>(113,287)</b>	(37,260)
Sale of current asset investments		<b>121,110</b>	29,430
<b>Net cash inflow/(outflow) from management of liquid resources</b>		<b>7,823</b>	(7,830)
<b>Net cash inflow/(outflow) before financing</b>		<b>4,627</b>	(2,707)
<b>FINANCING</b>			
Public dividend capital received		-	2,830
Loans repaid to Foundation Trust Financing Facility		<b>(800)</b>	(800)
Other capital receipts		<b>113</b>	807
Capital element of finance lease rental payments		<b>(39)</b>	(36)
<b>Net cash (outflow)/inflow from financing</b>		<b>(726)</b>	2,801
<b>Increase in cash</b>		<b>3,901</b>	94

## 7.9 Notes to the accounts

### 1 Accounting policies and other information

The independent regulator of NHS foundation trusts, Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual, which shall be agreed with HM Treasury. Consequently, the financial statements have been prepared in accordance with the 2008/09 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 to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with the HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical cost profits and losses.

#### 1.2 Income recognition

Income 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 operational 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 independent 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 2009 with an effective date of 31 March 2009. The valuation was carried out in accordance with the Royal Institution of Chartered Surveyors 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.

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 valued at open market value.

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

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.

Residual interests in off-balance sheet private finance initiative (PFI) properties are included in assets under construction within tangible fixed assets at the amount of unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in the fair value of the residual as estimated at the start of the contract and at the balance sheet date.

Operational equipment is valued at historic 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. The lives of tangible fixed assets are:

- Buildings – 60 years
- Plant and machinery – five to 15 years
- Transport equipment – five years
- Information technology – five years
- Furniture and fittings – five years

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 NHS foundation trust's 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 15 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 straight-line 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 work-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 (NHSLA) operates a risk-pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA 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 NHSLA 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 pension 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 2009**

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 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 were 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 2008/09 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).

	UK	UAE	Total
2008/09	£000	£000	£000
<b>Income by segment</b>			
Income from activities	87,826	2,393	<b>90,219</b>
Other operating income	22,231	–	<b>22,231</b>
	<u>110,057</u>	<u>2,393</u>	<u><b>112,450</b></u>
Surplus/(deficit) before interest	4,016	(1,306)	<b>2,710</b>
<b>Total assets/(liabilities) employed</b>	<u>66,750</u>	<u>(40)</u>	<u><b>66,710</b></u>
	UK	UAE	Total
2007/08	£000	£000	£000
<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 before interest	5,849	(1,574)	<b>4,275</b>
<b>Total assets employed</b>	<u>67,688</u>	<u>2,045</u>	<u><b>69,733</b></u>

### 3 Income

#### 3.1 Income from activities by type

	2008/09	2007/08
	£000	£000
Elective income	<b>28,168</b>	24,636
Non-elective income	<b>5,846</b>	5,275
Outpatient income	<b>25,963</b>	23,880
A&E income	<b>6,825</b>	6,156
Total income at tariff	<b>66,802</b>	59,947
Non-tariff NHS income	<b>11,065</b>	6,021
Non-NHS Other	<b>1,023</b>	909
Private patient income	<b>11,329</b>	9,043
	<b>90,219</b>	75,920

#### 3.2 Income from activities by source

	2008/09	2007/08
	£000	£000
NHS foundation trusts	<b>238</b>	180
NHS trusts	<b>4,319</b>	2,111
Strategic health authorities	-	457
Primary care trusts	<b>53,574</b>	45,546
Department of Health	<b>19,454</b>	17,518
Non NHS:		
- Private patients	<b>11,329</b>	9,043
- Overseas patients (non-reciprocal)	<b>13</b>	13
- Road Traffic Act	<b>2</b>	5
- Other	<b>1,290</b>	1,047
	<b>90,219</b>	75,920

### 3.3 Other operating income

	2008/09	2007/08
	£000	£000
Research and development	6,014	6,137
Education and training	3,716	3,456
Charitable and other contributions to expenditure	884	672
Transfers from donated asset reserve	704	850
Pharmaceutical drugs sales	6,097	5,009
Other income	4,816	4,572
	<u>22,231</u>	<u>20,696</u>

### 3.4 Private patient income

	2008/09	2002/03
	£000	£000
Private patient income	11,329	6,376
Total patient-related income	96,316	46,404
	<u>11.76%</u>	<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

	2008/09	2007/08
	£000	£000
Protected income	95,024	82,564
Non-protected income	17,426	14,052
	<u>112,450</u>	<u>96,616</u>

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

## 4 Operating expenses

### 4.1 Operating expenses comprise:

	2008/09	2007/08
	£000	£000
Services from NHS foundation trusts	936	656
Services from other NHS trusts	4,359	2,751
Services from other NHS bodies	240	312
Executive directors' costs	822	1,140
Non-executive directors' costs	129	95
Staff costs	64,221	57,154
Drug costs	3,798	3,925
Supplies and services – clinical (excluding drug costs)	11,262	7,558
Supplies and services – general	786	613
Establishment	1,797	1,752
Transport	1,556	1,590
Premises	9,634	6,956
Increase in disputed debt provision	306	411
Depreciation and amortisation	4,213	4,232
Fixed asset impairments	1,601	–
Auditors fees – statutory audit	70	57
Auditors fees – regulatory reporting	27	41
Other auditors' remuneration	100	55
Clinical negligence	283	359
Other	3,600	2,684
	<b>109,740</b>	<b>92,341</b>

## 4.2 Operating lease rentals

### 4.2.1 Operating expenses include:

	2008/09	2007/08
	£000	£000
Hire of plant and machinery	894	447
Other operating lease rentals	735	830
	<u>1,629</u>	<u>1,277</u>

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

	Land and buildings		Other leases	
	2008/09	2007/08	2008/09	2007/08
	£000	£000	£000	£000
Operating leases which expire:				
Within one year	198	437	–	–
Between one and five years	278	45	429	–
After five years	259	446	341	648
	<u>735</u>	<u>928</u>	<u>770</u>	<u>648</u>

## 4.3 Salary and pension entitlements of senior managers

## a) Remuneration

Name and Title	2008/09		2007/08	
	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	140 – 145	40 – 45	135 – 140	40-45
Mr J Pelly – chief executive	145 – 150	–	0 – 5	–
Mr I J Hollows – finance director	120 – 125	–	0 – 5	–
Mr M Cubbon – chief operating and nursing officer	85 – 90	–	40 – 45	–
Prof P Khaw – director of research and development (1)	115 – 120	–	–	–
Prof R Hitchings – director of research and development (2)	20 – 25	–	65 – 70	–
Mr R Markham – chairman (3)	35 – 40	–	10 – 15	–
Prof P. Luthert – non-executive director	15 – 20	–	10 – 15	–
Ms D Harris-Ugbomah – non-executive director	15 – 20	–	0 – 5	–
Sir R Jackling – non-executive director (4)	15 – 20	–	–	–
Mr C Nickolds – non-executive director (5)	5 – 10	–	10 – 15	–
Mr A Nebel – non-executive director (6)	10 – 15	–	–	–
Ms L Potter – non-executive director (7)	10 – 15	–	–	–
Mr I J Hollows – non-executive director (8)	–	–	10 – 15	–

(1) Prof P Khaw – joined 1 August 2008

(2) Prof R Hitchings – left 31 July 2008

(3) Mr R Markham – chairman from 1 April 2008.

Mr Markham waived £20,550 (2007/08: £15,000)

of his remuneration and asked that the sum be

donated to the Special Trustees of Moorfields Eye Hospital

(4) Sir R Jackling – joined 1 April 2008

(5) Mr C Nickolds – left 31 October 2008

(6) Mr A Nebel – joined 1 April 2008

(7) Ms L Potter – joined 1 April 2008

(8) Mr I J Hollows – left 31 December 2007 as a

non-executive director and joined 1 March 2008 as finance director

### 4.3 Salary and pension entitlements of senior managers

#### b) Pension benefits

Name and Title					
	Value of automatic lump sums at 31 March 2009 (bands of £2,500) £000	Real increase in year in the value of automatic lump sums (bands of £2,500) £000	Cash equivalent transfer value at 31 March 2009 (bands of £1,000) £000	Real increase in cash equivalent transfer value in 2008/09 (bands of £1,000) £000	
Mr G Aylward – medical director	155.0 – 157.5	10.0 – 12.5	1,037 – 1,038	291 – 292	
Mr J Pelly – chief executive	82.5 – 85.0	5.0 – 7.5	653 – 654	198 – 199	
Mr I J Hollows – finance director	2.5 – 5.0	2.5 – 5.0	36 – 37	36 – 37	
Mr M Cubbon – chief operating and nursing officer	30.0 – 32.5	5.0 – 7.5	123 – 124	41 – 42	

Prof P Khaw is not a member of the NHS pension scheme.

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

	Total 2008/09	Permanently employed 2008/09	Other 2008/09	2007/08
	£000	£000	£000	£000
Salaries and wages	<b>51,391</b>	51,391	–	46,204
Social security costs	<b>3,965</b>	3,965	–	3,647
Employer contributions to NHSPA	<b>5,371</b>	5,371	–	4,910
Other pension costs	–	–	–	343
Agency staff	<b>4,445</b>	–	4,445	3,285
	<b><u>65,172</u></b>	<b><u>60,727</u></b>	<b><u>4,445</u></b>	<b><u>58,389</u></b>

### 5.2 Average number of persons employed

	Total 2008/09	Permanently employed 2008/09	Other 2008/09	2007/08
	Number	Number	Number	Number
Medical	<b>214</b>	214	–	205
Administration and estates	<b>495</b>	495	–	492
Healthcare assistants and other support staff	<b>57</b>	57	–	47
Nursing, midwifery and health visiting staff	<b>294</b>	294	–	304
Scientific, therapeutic and technical staff	<b>190</b>	190	–	190
Agency staff	<b>133</b>	–	133	109
Total	<b><u>1,383</u></b>	<b><u>1,250</u></b>	<b><u>133</u></b>	<b><u>1,347</u></b>

### 5.3 Employee benefits

	2008/09	2007/08
	£000	£000
Various employee taxable benefits in kind*	8	3
	<u>8</u>	<u>3</u>

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

### 5.4 Retirements due to ill-health

During 2008/09 there were three early retirements on ill-health grounds (2007/08: 0), at a cost of £43,000 (2007/08: £nil). These retirements represent 2.62 per 1,000 active scheme members. This information has been supplied by the NHS Pensions Agency.

## 6 Interest

### 6.1 Interest receivable

	2008/09	2007/08
	£000	£000
Held to maturity money market investments	110	73
Office of HM Paymaster General	215	300
Total	<u>325</u>	<u>373</u>

### 6.2 Interest payable

	2008/09	2007/08
	£000	£000
Loans from Foundation Trust Financing Facility	552	589
Finance leases	14	17
Other	–	24
Total	<u>566</u>	<u>630</u>

## 7 Intangible fixed assets

	Software licences	Development expenditure	Total
	£000	£000	£000
Gross cost at 1 April 2008	844	196	<b>1,040</b>
Additions – purchased	70	–	<b>70</b>
Disposals	(231)	–	<b>(231)</b>
<b>Gross cost at 31 March 2009</b>	<b><u>683</u></b>	<b><u>196</u></b>	<b><u>879</u></b>
Amortisation at 1 April 2008	505	99	<b>604</b>
Provided during the year	116	5	<b>121</b>
Disposals	(231)	–	<b>(231)</b>
<b>Accumulated amortisation at 31 March 2009</b>	<b><u>390</u></b>	<b><u>104</u></b>	<b><u>494</u></b>
<b>Net book value</b>			
– Purchased at 1 April 2008	321	97	<b>418</b>
– Donated at 1 April 2008	18	–	<b>18</b>
<b>– Total at 1 April 2008</b>	<b><u>339</u></b>	<b><u>97</u></b>	<b><u>436</u></b>
– Purchased at 31 March 2009	280	92	<b>372</b>
– Donated at 31 March 2009	13	–	<b>13</b>
<b>– Total at 31 March 2009</b>	<b><u>293</u></b>	<b><u>92</u></b>	<b><u>385</u></b>

## 8 Tangible fixed assets

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

	Land	Buildings	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	12,830	56,389	22,940	189	10,220	1,084	103,652
Additions purchased	–	987	1,285	–	646	146	3,064
Additions donated	–	82	177	–	2	–	261
Impairment	–	(1,874)	–	–	–	–	(1,874)
Other revaluations	(2,600)	(1,655)	–	–	–	–	(4,255)
Disposals	–	(1,355)	(8,984)	(180)	(3,240)	(132)	(13,891)
<b>At 31 March 2009</b>	<b>10,230</b>	<b>52,574</b>	<b>15,418</b>	<b>9</b>	<b>7,628</b>	<b>1,098</b>	<b>86,957</b>
Depreciation at 1 April 2008	–	1,716	14,802	186	7,126	445	24,275
Provided during the year	–	1,547	1,439	1	1,033	72	4,092
Impairment	–	(273)	–	–	–	–	(273)
Other revaluations	–	(1,134)	–	–	–	–	(1,134)
Disposals	–	(1,297)	(8,969)	(180)	(3,240)	(132)	(13,818)
<b>Accumulated depreciation at 31 March 2009</b>	<b>–</b>	<b>559</b>	<b>7,272</b>	<b>7</b>	<b>4,919</b>	<b>385</b>	<b>13,142</b>
<b>Net book value</b>							
– Purchased at 1 April 2008	12,830	40,520	6,116	3	2,944	366	62,779
– Donated at 1 April 2008	–	14,153	2,022	–	150	273	16,598
<b>Total at 1 April 2008</b>	<b>12,830</b>	<b>54,673</b>	<b>8,138</b>	<b>3</b>	<b>3,094</b>	<b>639</b>	<b>79,377</b>
– Purchased at 31 March 2009	10,230	38,346	6,415	2	2,617	471	58,081
– Donated at 31 March 2009	–	13,669	1,731	–	92	242	15,734
<b>Total at 31 March 2009</b>	<b>10,230</b>	<b>52,015</b>	<b>8,146</b>	<b>2</b>	<b>2,709</b>	<b>713</b>	<b>73,815</b>

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

	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Land	Buildings	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total		
Net book value									
– Protected assets at 31 March 2009	9,260	43,675	–	–	–	–	52,935		
– Unprotected assets at 31 March 2009	970	8,340	8,146	2	2,709	713	20,880		
<b>Total at 31 March 2009</b>	<b>10,230</b>	<b>52,015</b>	<b>8,146</b>	<b>2</b>	<b>2,709</b>	<b>713</b>	<b>73,815</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 2009 comprised:

	31 March 2009	31 March 2008
	£000	£000
Freehold	16,400	17,000
Long leasehold	45,845	50,503
<b>TOTAL</b>	<b>62,245</b>	<b>67,503</b>

### 9 Stocks and work-in-progress

	31 March 2009	31 March 2008
	£000	£000
Raw materials and consumables	318	298
Work-in-progress	97	–
Finished goods	2,010	1,752
<b>TOTAL</b>	<b>2,425</b>	<b>2,050</b>

### 10 Debtors

#### 10.1 Debtors at the balance sheet date are made up of:

	31 March 2009	31 March 2008
	£000	£000
<b>Amounts falling due within one year:</b>		
NHS debtors	5,779	2,642
Provision for irrecoverable debts	(1,124)	(1,204)
Other prepayments and accrued income	674	1,158
Other debtors	4,990	3,334
Sub Total	10,319	5,930
<b>Amounts falling due after more than one year:</b>		
NHS debtors	177	91
<b>TOTAL</b>	<b>10,496</b>	<b>6,021</b>

## 10.2 Provision for doubtful debtors

	2009	2008
	£000	£000
Balance at 1 April	1,204	792
Provision for debtors impairment	306	427
Debtors written off during year as uncollectable	(386)	(15)
Balance at 31 March	<u>1,124</u>	<u>1,204</u>

## 10.3 Analysis of impaired debtors

	31 March 2009	31 March 2008
	£000	£000
<b>Ageing of doubtful debtors</b>		
Up to three months	474	139
In three to six months	337	74
Over six months	313	991
Total	<u>1,124</u>	<u>1,204</u>
<b>Ageing of non-provided debtors past their due date</b>		
Up to three months	971	546
Three to six months	324	321
Over six months	679	753
Total	<u>1,974</u>	<u>1,620</u>

## 11 Current asset investments

	31 March 2009	31 March 2008
	£000	£000
Balance at 1 April	7,830	–
Additions	113,287	37,260
Disposals	(121,110)	(29,430)
Balance at 31 March	<u>7</u>	<u>7,830</u>

## 12 Creditors

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

	31 March 2009	31 March 2008
	£000	£000
<b>Amounts falling due within one year:</b>		
Current instalments due on loans	800	800
Interest payable	45	48
Payments received on account	–	477
NHS creditors	1,501	4,606
Tax and social security costs	2,085	1,892
Obligations under finance leases and HP contracts	42	39
Capital creditors	832	1,120
Other creditors	7,558	5,815
Accruals	233	120
Deferred income	2,686	2,460
Sub total	<u>15,782</u>	<u>17,377</u>
<b>Amounts falling due after more than one year:</b>		
Long-term loans	10,842	11,642
Obligations under finance leases and HP contracts	98	141
Other	657	113
<b>Sub total</b>	<u>11,597</u>	<u>11,896</u>
<b>TOTAL</b>	<u><u>27,379</u></u>	<u><u>29,273</u></u>
NHS creditors include:		
Outstanding pension contributions	<u>5</u>	<u>5</u>

## 12.2 Loans

	31 March 2009	31 March 2008
	£000	£000
Amounts falling due:		
In one year or less	800	800
Between one and two years	800	800
Between two and five years	2,401	2,401
Over five years	7,641	8,441
<b>TOTAL</b>	<b>11,642</b>	<b>12,442</b>

	31 March 2009	31 March 2008
Of which:	£000	£000
– wholly repayable within five years	4,001	4,001
– wholly repayable after five years, by instalments	7,641	8,441
	<b>11,642</b>	<b>12,442</b>

The trust has three loans from the Foundation Trust Financing Facility:

– £4,320,000 – The trust is paying this loan in two tranches. Tranche A of this loan is for £960,000, with an interest rate of 4.65%. Tranche B of this loan is for £3,360,000 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.

– £6,558,520 – The trust is paying the loan in three tranches. Tranche A of the loan is for £1,344,000, with an interest rate of 4.5%. Tranche B of this loan is for £480,120 with an interest rate of 4.45%. Tranche C of this loan is for £4,734,400, 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.

– £762,680 – 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

	31 March 2009	31 March 2008
	£000	£000
Amounts falling due:		
– within one year	53	53
– between one and five years	106	160
Sub total	159	213
Finance charges allocated to future periods	(19)	(33)
<b>Net obligations</b>	<b>140</b>	<b>180</b>

## 14 Provisions for liabilities and charges

	Pensions relating to former directors	Pensions relating to other staff	Provision relating to HMRC	Other	<b>Total</b>
	£000	£000	£000	£000	£000
At 1 April 2008	120	15	672	31	<b>838</b>
Arising during the year	–	126	155	–	<b>281</b>
Utilised during the year	(11)	(10)	–	–	<b>(21)</b>
Reverse unused	–	–	–	(31)	<b>(31)</b>
Unwinding of discount	3	–	–	–	<b>3</b>
At 31 March 2009	<b>112</b>	<b>131</b>	<b>827</b>	<b>–</b>	<b>1,070</b>

### Expected timing of cashflows:

Within one year	10	10	827	–	<b>847</b>
Between one and five years	41	40	–	–	<b>81</b>
After five years	61	81	–	–	<b>142</b>
At 31 March 2009	<b>112</b>	<b>131</b>	<b>827</b>	<b>–</b>	<b>1,070</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.

£652,000 is included in the provisions of the NHS Litigation Authority at 31 March 2009 in respect of clinical negligence liabilities of the trust (31 March 2008: £315,000).

## 15 Movements on reserves

Movements on reserves in the year comprised the following:

	Revaluation reserve	Donated asset reserve	Income and expenditure reserve	<b>Total</b>
	£000	£000	£000	£000
At 1 April 2008	14,386	16,661	7,407	<b>38,454</b>
Transfer from the income and expenditure account	–	–	640	<b>640</b>
Deficit on revaluation of fixed assets	(2,984)	(137)	–	<b>(3,121)</b>
Receipt of donated assets	–	162	–	<b>162</b>
Transfers to the income and expenditure account for depreciation	–	(704)	–	<b>(704)</b>
Other transfers between reserves	(753)	–	753	<b>–</b>
At 31 March 2009	<b>10,649</b>	<b>15,982</b>	<b>8,800</b>	<b>35,431</b>

## 16 Notes to the cash flow statement

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

	2008/09	2007/08
	£000	£000
Total operating surplus	2,710	4,275
Depreciation and amortisation charge	4,213	4,232
Fixed asset impairments	1,601	–
Transfer from donated asset reserve	(704)	(850)
(Increase)/decrease in stocks	(375)	67
(Increase)/decrease in debtors	(4,449)	703
(Decrease)/increase in creditors	(760)	2,734
Increase in provisions	232	439
Net cash inflow from operating activities	<u>2,468</u>	<u>11,600</u>

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

	2008/09	2007/08
	£000	£000
Increase in cash in the period	3,901	94
Cash (inflow) from new debt	–	(216)
Cash outflow from debt repaid	840	836
Cash (outflow)/inflow from movement in liquid resources	(7,823)	7,830
Change in net debt/funds resulting from cashflows	<u>(3,082)</u>	<u>8,544</u>
Net debt at 1 April	(662)	(9,206)
Net debt at 31 March	<u>(3,744)</u>	<u>(662)</u>

### 16.3 Analysis of changes in net debt

	At 1 April 2008	Cash changes in year	At 31 March 2009
	£000	£000	£000
Commercial cash at bank and in hand	180	3	<b>183</b>
Office of the Paymaster General cash at bank	3,950	3,898	<b>7,848</b>
Debt due within one year	(800)	–	<b>(800)</b>
Debt due after one year	(11,642)	800	<b>(10,842)</b>
Finance leases	(180)	40	<b>(140)</b>
Current asset investments	7,830	(7,823)	<b>7</b>
	<u>(662)</u>	<u>(3,082)</u>	<u><b>(3,744)</b></u>

### 17 Capital commitments

Commitments under capital expenditure contracts as at 31 March 2009 were £3,783,000 (2007/08: £3,009,000). A further £200,000 had been committed at 31 March 2009 to commence development work for a surgical and training facility in Ghana. This commitment will be reimbursed through charitable donations.

### 18 Movement in public dividend capital

	2008/09	2007/08
	£000	£000
Public dividend capital as at 1 April	<b>31,279</b>	28,449
New public dividend capital received	–	2,830
Public dividend capital as at 31 March	<u><b>31,279</b></u>	<u>31,279</u>

## 19 Movement in taxpayers' equity

	2008/09	2007/08
	£000	£000
Surplus for the financial year	<b>2,466</b>	4,015
Public dividend capital dividends	<b>(1,826)</b>	(1,780)
(Deficit)/surplus on revaluations of fixed assets and current asset investments	<b>(3,121)</b>	4,013
New public dividend capital in year	–	2,830
Net (reductions)/additions to donated asset reserve	<b>(542)</b>	14
Net increase in taxpayers' equity	<u><b>(3,023)</b></u>	<u>9,092</u>
Opening taxpayers' equity	<b>69,733</b>	60,641
Closing taxpayers' equity	<u><b>66,710</b></u>	<u>69,733</u>

## 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 £1,826,000 bears to the average relevant net assets of £49,001,000, that is 3.7%. 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 NHS foundation trusts 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 £14,800,000 in 2008/09 (2007/08: £13,800,000). The trust has not drawn down further borrowings in 2008/09 (2007/08: £nil). Total borrowings are shown in note 12.2.

Performance against the approved prudential borrowing limit (PBL) ratios is shown below:

<b>Financial ratios – 2008/09</b>	<b>Actual ratios</b>	<b>Approved PBL ratios</b>
Maximum debt/capital ratio	<b>12.40%</b>	<b>&lt;25%</b>
Minimum dividend cover	<b>3.66</b>	<b>&gt;1x</b>
Minimum interest cover	<b>12.80</b>	<b>&gt;3x</b>
Minimum debt service cover	<b>5.16</b>	<b>&gt;2x</b>
Maximum debt service to revenue	<b>1.25%</b>	<b>&lt;3%</b>

<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>

The trust has an approved working capital facility of £6,000,000 (2007/08: £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, the 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 £109,855 (2007/08: £299,895), while debtors were £8,735 (2007/08: £136,215). There was no in-year expenditure or year-end creditor. Income/donations for the year from the Special Trustees of Moorfields Eye Hospital was £516,803 (2007/08: £478,231), while debtors were £32,490 (2007/08: £140,319). There was no in-year expenditure or year-end creditor. Income/donations for the year from Moorfields Eye Hospital Development Fund was £145,225 (2007/08: £33,886), while debtors were £116,976 (2007/08: £30,175). 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 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 a branch in Dubai, with transactions conducted in pounds sterling and United Arab Emirates dirhams. Due to the size of the operation, the trust has limited exposure to currency exchange fluctuations.

### **Interest rate risk**

The trust is not exposed to changes in interest rates as all borrowings are at fixed rates.

## 22.1 Financial assets by category

	31 March 2009	31 March 2008
	£000	£000
NHS debtors	5,956	2,733
Provision for irrecoverable debts	(1,124)	(1,204)
Other debtors	4,990	3,334
Current asset investments	7	7,830
Cash at bank and in hand	8,031	4,130
Total	<u>17,860</u>	<u>16,823</u>

## 22.2 Financial liabilities by category

	31 March 2009	31 March 2008
	£000	£000
NHS creditors	1,501	4,606
Other creditors	8,260	5,976
Accruals	233	120
Capital creditors	832	1,120
Loans	11,642	12,442
Finance lease obligations	140	180
Provisions	1,070	838
Total	<u>23,678</u>	<u>25,282</u>

## 22.3 Fair values of financial assets at 31 March 2009

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 2009.

	Book value	Fair value	Basis of fair valuation
	£000	£000	
	31 March 2009	31 March 2009	
<b>Financial assets</b>			
Debtors over one year:			
- Agreements with commissioners to cover creditors and provisions	177	177	Note a
Total	<u>177</u>	<u>177</u>	
<b>Financial liabilities</b>			
Creditors over one year -			
finance lease obligations	(98)	(98)	
Provisions under contract	(1,070)	(1,070)	Note b
Loans	(10,842)	(10,842)	Note c
Total	<u>(12,010)</u>	<u>(12,010)</u>	

### Notes

- a These debtors reflect agreements with commissioners to cover creditors over one year for early retirements and provisions under contract, and their related interest charge/unwinding of discount. In line with note b, below, fair value is not significantly different from book value.
- b 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.
- c 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 2008/09</b>	Debtors: amounts falling due within one year 2007/08	<b>Creditors: amounts falling due within one year 2008/09</b>	Creditors: amounts falling due within one year 2007/08
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
NHS foundation trusts	<b>386</b>	236	<b>331</b>	436
English NHS trusts	<b>1,093</b>	564	<b>670</b>	1,722
Department of Health	<b>3</b>	75	–	1,527
English strategic health authorities	<b>52</b>	183	–	–
English primary care trusts	<b>4,233</b>	1,584	<b>280</b>	800
RAB special health authorities	<b>12</b>	–	<b>220</b>	121
Other whole of government accounts bodies	<b>492</b>	281	<b>2,085</b>	1,895
Total	<b><u>6,271</u></b>	<u>2,923</u>	<b><u>3,586</u></b>	<u>6,501</u>

	<b>Debtors: amounts falling due after more than one year 2008/09</b>	Debtors: amounts falling due after more than one year 2007/08	<b>Creditors: amounts falling due after more than one year 2008/09</b>	Creditors: amounts falling due after more than one year 2007/08
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
English primary care trusts	<b>177</b>	91	–	–
Total	<b><u>177</u></b>	<u>91</u>	<u>–</u>	<u>–</u>

## 24 Losses and special payments

There were 129 cases of losses and special payments (2007/08: 65 cases), totalling £403,000 (2007/08: £13,737) approved during 2008/09.

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless journey where the net payment exceeded £100,000 (2007/08: nil cases).





**Moorfields Eye Hospital NHS Foundation Trust**

162 City Road, London EC1V 2PD

Tel: 020 7253 3411

[www.moorfields.nhs.uk](http://www.moorfields.nhs.uk)

Published by Moorfields communications team

Design: Fountainhead creative consultants

Print: Evolve

© July 2009, Moorfields Eye Hospital NHS Foundation Trust