A MEETING OF THE BOARD OF DIRECTORS

To be held in public on

Thursday 22 October 2020 at 09:30am

via Life size video link

AGENDA

No.	Item	Action	Paper	Lead	Mins	S.O
1.	Apologies for absence	Note	Verbal	TG		
2.	Declarations of interest	Note	Verbal	TG		
3.	Minutes of the meeting held on 24 September 2020	Approve	Enclosed	TG	00:05	
4.	Matters arising and action points	Note	Enclosed	TG	00:05	
5.	Chief Executive's report	Note	Enclosed	DP	00:20	All
6.	People plan overview	Discussion	Enclosed	SD	00:30	5
7.	Learning from deaths	Assurance	Enclosed	NS	00:05	1
8.	Guardian of safe working	Assurance	Enclosed	NS	00:10	1
9.	Integrated Performance report	Assurance	Enclosed	JQ	00:10	6
10.	Finance report	Assurance	Enclosed	JW	00:10	1
11.	Provider alliance	Discussion	Enclosed	DP	00:10	7
12.	Report from the quality and safety committee	Assurance	Enclosed	RGW	00:10	5
13.	Report from the audit and risk committee	Assurance	Enclosed	NH	00:10	1
14.	Report from the people and culture committee	Assurance	Enclosed	SS	00:10	6
15.	Identify any risk items arising from the agenda	Note	Verbal	TG	00:05	5
16.	AOB	Note	Verbal	TG	00:05	6
17.	**Date of the next meeting – Thursday 26 November 2020 09:30am**					

* Strategic Objectives

1 Care 2 Research 3 Knowledge sharing 4 Policy 5 People 6 Infrastructure 7 Finance 8 Enterprise

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON
THURSDAY 24 SEPTEMBER 2020

Attendees:	Tessa Green (TG)	Chairman
	Vineet Bhalla (VB)	Non-executive director (via video link)
	Ros Given-Wilson (RGW)	Non-executive director (via video link)
	Nick Hardie (NH)	Non-executive director (via video link)
	David Hills (DH)	Non-executive director (via video link)
	Richard Holmes (RH)	Non-executive director (via video link)
	Sumita Singha (SS)	Non-executive director (via video link)
	Steve Williams (SW)	Non-executive director (via video link)
	Peng Khaw (PK)	Director of research & development (via video link)
	Tracy Luckett (TL)	Director of nursing and AHPs
	John Quinn (JQ)	Chief operating officer
	Nick Strouthidis (NS)	Medical director
	Jonathan Wilson (JW)	Chief financial officer
In attendance:	Nora Colton (NC)	Joint director of education
	Sandi Drewett (SD)	Director of workforce & OD
	Richard Macmillan (RM)	General counsel
	Johanna Moss (JM)	Director of strategy & business development
	Ian Tombleson (IT)	Director of quality & safety
	Nick Roberts (NR)	Chief information officer
	Helen Essex (HE)	Company secretary (minutes)
Governors:	Allan MacCarthy	Vice chair of the membership council
	John Sloper	Public governor, Beds & Herts
	Ian Wilson	Public governor, NWL
	Ella Preston	Staff governor, City Road
	Roy Henderson	Patient governor
	Kimberley Jackson	Public governor, SWL
	Rob Jones	Patient governor
	Naga Subramanian	Public governor, SEL

20/2481 Apologies for absence

Apologies were received from Andrew Dick and David Probert.

20/2482 Declarations of interest

There were no declarations of interests.

20/2483 Minutes of the last meeting

The minutes of the meeting held on the 23 July 2020 were agreed as an accurate record.

20/2484 Matters arising and action points

All actions were completed or attended to via the agenda.

20/2485 Chief executive's report

The board received feedback on the recent cataract drive, in which 730 operations were performed over the course of the week. The trust was assisted by 80 volunteers from St John's Ambulance and Friends of Moorfields/Moorfields Eye Charity. The drive was a success with lots of positive media coverage. This model had not been attempted before but the support and infrastructure put in place allowed operations to be performed more quickly. This made it very successful as a proof of concept.

The trust has been involved in the development of the first international standards for reporting of clinical trials. These standards are designed to make sure systems are resilient and provide assurance about the security of data so this is positive for both Moorfields and ophthalmology in general.

Discussion took place about the development of a provider alliance which aims to set out how systems work together and gain the benefits of the wider whole. The board has shared early thoughts on the proposals to NCL concerning sovereignty, overlap with the ICS and other sectors and systems. MEH sits in a number of ICSs so it is particularly problematic although does also provide opportunities. The next draft will be discussed at the October board and membership council.

JQ advised that the Croydon service had been highly commended for their rapid access clinic. The team reviewed the best pathway for patients and worked with the local hospital trust to put in place a model that improves the patient experience.

Public consultation continues for the planning application to London Borough of Camden in October. Current focus is on the proposed design of the facility and the location on the five acre site. There has been positive engagement so far and meetings with separate stakeholders from the local community. Feedback so far has been helpful and constructive.

A collaborative document has been developed between providers across each ICS about parameters for surgical hubs, and agreement reached as to what a surgical hub will look like. The most mature collaboration is the paediatric service at the Royal Free, which is looking for Moorfields to accommodate its surgical paediatric ophthalmological activity. This will therefore allow Royal Free surgeons to use trust facilities along with MEH surgeons. There are other plans in development aiming to support NWL, SEL and SWL.

20/2486 Integrated performance report

Activity is still below historical averages although beginning to increase. Results relating to cancer targets are still positive and a testament to the service. There is continued challenge with 52-week waits. The position is current 149 but this is projected to be below 30 by the end of the year. Appraisal rates remain low but teams are starting to get back into the normal rhythm and format.

The DNA rate relates to when a patient doesn't attend their appointment. There is also a refusal rate for those that don't want an appointment. The refusal rate is high and at the moment the teams are contacting four patients in order to get one to come in for a cataract operation. The DNA rate is above the normal average, which is usually under 10% but up to 19% in some services. The trust would normally overbook clinics to counteract this but is unable to do so due to social distancing requirements. This presents a challenge for activity although is mitigated financially in part by being on a block contract.

There was acknowledgement that the trust is going to be challenged going forward, and that there are likely to be issues that affect performance that will be beyond trust control. In relation to a potential second wave the centre is expecting hospitals to remain open and find ways to manage activity around Covid. The way services have been re-established and pathways modified means that the trust will be able to continue providing the best ophthalmic care for patients. It is important to balance the issues of quality and safety and continue to monitor the infection control measures that remain in place.

20/2487 Finance report

The position for August is a continuation of the trend with improved income and activity. Under-utilisation of block is at £7.1m, with total under-utilisation YTD just under £2.9m. NHS income is up by £0.7m and this is against a tight trajectory, showing an upward move in day case and elective activity.

In relation to costs the team is continuing work reviewing medical increments that amount to around £200k which relates to an uplift in substantive pay. There has also been an increase in bank and agency which specifically relates to pre-assessment and theatres and is linked to the 'super Saturdays' put in place to prepare for the cataract drive.

The cash position has improved to £82m. In terms of Capex the trust has spent more than plan (£0.7m YTD) and this is due to the front-loading of medical equipment purchases early in the year.

The board noted the increasing importance of the ICS who will hold and release increments and release. Clarity is yet to be provided as to how this will work, e.g. if one organisation under performs then how is the risk reserve used and will it be used to bail out under performing organisations. There will be a risk that organisations offset balances against each other.

It was agreed that the new financial regime does represent a significant risk to a specialist trust and that clarity is needed as to the financial implications.

20/2488 WRES and WDES

SD advised that the full reports had been discussed at the people and culture committee and presented a summary of results. 51% of the workforce identifies as BAME and since last year we expected to make progress on a number of indicators.

WRES – there has been an improvement on five of the indicators and improved representation of BAME staff in more senior positions. In comparison to the national average the trust is above average in six categories and below average in two. The key issue is access to training and CPD, where there are still dome difficulties in accessing data not held centrally. There has also been an increase in white staff accessing online training during lockdown which has affected the figures.

SD noted that there is a significant variance across the BAME experience and that the trust needs to look at how to reduce the variation although this is a huge issue for the NHS, particularly in London. A report was commissioned a report on 11 indicators and these broke down the experience of different ethnic groups within the 'BAME' category. This showed how critical it is to look into intersectionalities and look at diversity within ethnic groups.

The board asked whether staff been disadvantaged by lockdown in ways that we might not have thought of. SD advised that it is too early to be able to assess this but enough data has been gathered to start an analysis.

WDES – these are new standards mandated in 2019. Less than 2% of MEH staff identify as disabled. The dataset is therefore from a small group of staff and the trust needs to work towards improving people's confidence in their ability to report their disability.

Out of ten indicators the trust improved in three areas, and in particular reporting incidents of bullying and harassment which has had a focus in the last year.

In comparison to the national average the trust is better on seven indicators and worse on three. There is still a significant way to go in order to get where we should be, particularly in relation to visual or sensory impairment. A governance framework is in place but the trust needs to invest some resource to support the agenda. The four objectives identified by the equality, diversity and human rights group are:

- Improving career progression for BAME staff.
- Improving the maturity of staff networks
- Patients accessing services
- Improving staff experience in bullying and harassment.

A question was asked as to whether the trust needs to make sure the information that comes out of the Covid risk assessment is linked to ESR. SD advised that there is a level of detail that sits under the low/medium/high risk information which is held at a local level with the line manager and is confidential. However, it is hoped that staff will be more likely to disclose if they are required to shield in future. The trust will be advised by the centre as to whether another risk assessment required along with a review of IPC guidance.

The board asked how much the trust should look at improving inclusive career progression overall rather than focus on BAME staff. SD replied that it is impossible to do everything at once and that the best model is to put in a programme of work that focuses on one protected characteristic. The evidence is that this improves the

experience of staff with other protected characteristics as organisations are seen as more inclusive and perceptions of staff improve across the board.

20/2489 Q1 Freedom to speak up report

IT advised that FTSU is a way of creating a culture that allows staff to raise concerns in a safe space without fear of reprisal. The trust has in place a diverse team of four guardians across professions and geographies and that they work together as a team to support each other.

The team has hosted open sessions for BAME staff and in particular around their susceptibility to Covid. This session added value and assisted teams and managers to resolve their concerns. October is FTSU month and the team is always looking for different ways to improve things, promote the service and be available. The guardians meet regularly with the chair and chief executive to report concerns and themes that are arising from staff.

20/2490 Conflict of interest update

NS referred to the new policy which was developed through consultation with consultants and other stakeholders. An escalation pathway has been added whereby any conflict that has the potential to be problematic will be reviewed by a declaration of oversight panel which has expert and independent representation.

This particularly refers to those whose research integrity might be challenged by a financial interest. The process protects the clinician, patient and reputation of the organisation.

Conflicts are reviewed to see whether they meet the threshold and if so a panel is convened where the individual will present a management plan as to how they mitigate any risk. This is particularly challenging in the area of research and clinicians that have a number of different interests across organisations.

The first panel is meeting next week and this will act as a test bed to see how the process works. Where the issue cannot be resolved by the panel then it will be escalated to the board.

The board agreed that trust academics are very high performing and it is critical to make sure their reputations and that of the trust is protected. Disclosure and transparency are the key issues. SW will sit on the DoO panel to provide independent scrutiny.

20/2491 Identification of any risks arising from the agenda

The financial risk relating to the ICS and block payment regime is already on the board assurance framework and kept under close review. Assuming there will be a second wave of Covid, there is likely to be more pressure on clinical services and staff availability. This will be a limiting factor on the trust's ability to recover. The inability to achieve outpatient targets is a reputational risk but not a clinical risk.

20/2492 AOB

None.

20/2493 Date of next meeting – Thursday 22 October 2020

BOARD ACTION LOG

Meeting Date	Item No.	Item	Action	Responsible	Due Date	Update/Comments	Status
05.09.19	19/2345	Workforce strategy	Update on progress to be provided in six months	SD	28.01.20		Open
03.10.19	19/2362	Service improvement reports	Targets and milestones to be reported in programme format with tracker for the next report	JQ	TBA		Open
05.12.19	19/2374	Matters arising and action points	Update on the work of the leading and guiding group to be provided in three months	TL	28.01.20	Group has now restarted	Open
23.01.20	20/2395	Administration and booking process	Update to be provided in six months	JQ	28.01.20		Open
28.05.20	20/2448	Finance report	Advise on suitable timeline for CIP review	JW	22.10.20	JW to update on current position	Open
23.07.20	20/2473	Integrated performance report	To provide an update on timescales at the next meeting	JQ	24.09.20		Closing

NB Items greyed out have been completed and will be removed from the next log

Bold shows updates

Moorfields Eye Hospital NHS Foundation Trust

NHS

Glossary of terms – October 2020	
Oriel	A project that involves Moorfields Eye Hospital NHS Foundation Trust and its research partner, the UCL Institute of Ophthalmology, along with Moorfields Eye Charity working together to improve patient experience by exploring a move from our current buildings on City Road to a preferred site in the Kings Cross area by 2023.
AAR	After action review
AHP	Allied health professional
AI	Artificial intelligence
ALB	Arms length body
AMRC	Association of medical research charities
ASI	Acute slot issue
BAF	Board assurance framework
BAME	Black, Asian and minority ethnic
BRC	Biomedical research centre
CCG	Clinical commissioning group
CIP	Cost improvement programme
CPIS	Child protection information sharing
CQC	Care quality commission
CQRG	Commissioner quality review group
CQUIN	Commissioning for quality innovation
CR	City Road
CSSD	Central sterile services department
CTP	Costing and transformation programme
DHCC	Dubai Healthcare City
DMBC	Decision-making business case
DSP	Data security protection [toolkit]
ECLO	Eye clinic liaison officer
EDI	Equality diversity and inclusivity
EDHR	Equality diversity and human rights
EMR	Electronic medical record
ENP	Emergency nurse practitioner
EU	European union
FBC	Full business case
FFT	Friends and family test
FRF	Financial recovery funding
FT	Foundation trust
FTSUG	Freedom to speak up guardian
GDPR	General data protection regulations
GIRFT	Getting it right first time
GoSW	Guardian of safe working
HCA	Healthcare assistant
I&E	Income and expenditure
IFRS	International financial reporting standards
IOL	Intra ocular lens

IPR	Integrated performance report
iSLR	Integrated service line reporting
KPI	Key performance indicators
LCFS	Local counter fraud service
LD	Learning disability
LOCSSIP	Local Safeguarding Standards for Invasive Procedures
MFF	Market forces factor
NCL	North Central London
NHSI/E	NHS Improvement/England
NIHR	National institute for health research
NIS	Network and information systems
NMC	Nursing & midwifery council
OBC	Outline business case
OD	Organisation development
PALS	Patient advice and liaison service
PAS	Patient administration system
PbR	Payment by results
PDC	Public dividend capital
PID	Patient identifiable data
PP	Private patients
PPE	Personal protective equipment
PROMS	Patient related outcome measures
PSF	Provider sustainability fund
QIA	Quality impact assessment
QIPP	Quality, innovation, productivity and prevention
QSC	Quality & safety committee
QSIS	Quality service improvement and sustainability
RAG	Red amber green [ratings]
RCA	Root cause analysis
R&D	Research & development
RTT	Referral to treatment
SCC	Strategy & commercial committee
SGH	St Georges University Hospital
SI	Serious Incident
SLA	Service level agreement
ST	Senior trainee
STP	Sustainability and transformation partnership
TMC	Trust management committee
UAE	United Arab Emirates
UCL	University College London
VFM	Value for money
WDES	Workforce disability equality standards
WRES	Workforce race equality standards
YTD	Year to date

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 05
Chief executive's report
Board of directors 22 October 2020

Chief Executive's report

I would like to provide continued assurance to the board about the **Trust response to the COVID-19** pandemic.

The trust continues to follow all guidance from Public Health England (PHE), NHS Executive and Improvement (NHSE/I) and the Department of Health and Social Care (DHSC). We continue to fulfil our obligations as a major public body and health provider with regard to **emergency planning and contingency** during a Level 3 national incident (although the incident level remains at a 4 for the NHS) and continue to provide high quality care elective and outpatient care across all our network sites.

There are currently no concerns within the trust around provision of **PPE (personal protective equipment).** The trust is part of the procurement partnership service (PPS) which is managing stock controls for a number of trusts across North Central London (NCL).

The trust continues to work within the principles for **Infection Prevention and Control guidance for London**, this includes the appropriate level of PPE in the clinical practice settings and adherence to the broader guidance for hospitals such as wearing of face masks for all staff in communal areas. The introduction of a one way system at city road and at other Moorfields' sites and the continuation of symptom checks are all additional measures to protect patients and staff.

In accordance with ICP London guidance we continue to test staff who care for patients on the elective surgical pathway and we also offer tests to staff who have Covid symptoms. All patients who are admitted as emergencies and those who may require an overnight stay are also tested. We continue to recruit into the Public Health England research study (SIREN) and to date we have recruited over 250 staff.

The focus for the trust internally continues to be on the **recovery of clinical services** and detailed plans continue to be developed by services and divisions to make sure this is done in adherence to infection control procedures and social distancing measures. The recovery oversight committee continues to provide oversight and assurance to the board on the development and implementation of the trust recovery plan, including the quality and safety impact, financial impact, workforce impact, any proposed system-wide approach and the strategic alignment between research & development, education and operational delivery.

Quality

As part of the annual internal audit programme, KPMG has given the highest rating of green assurance for their detailed review of clinical audit at Moorfields. Clinical audit is an important method that clinical teams use to ensure that the highest outcome standards are achieved when we treat our patients. These outcomes are reviewed by the Quality and Safety Committee and published for all our subspecialties every year.

KMPG identified that all areas of our processes are strong and efficient, that there is solid governance, that the methods of sharing learning from audit and closing actions are in place and working, and these were communicated well across the organisation.

Research & development

The trust has received a three year funding award from the National Institute for Health Research (NIHR). This grant will be used to research endophthalmitis, a rare but serious complication following eye surgery. Mr Mahi Muqit and Professor James Bainbridge will be the Joint Lead Investigators for this trial.

The project, known as the **'EVIAN trial'**, will take place as a national randomised controlled trial for patients suffering from acute endophthalmitis following any type of eye surgery and will be the first clinical trial to explore early vitrectomy surgery as a treatment for endophthalmitis since the 1990s.

People and awards

I am pleased to advise the board that Anthony Khawaja has been awarded the UKRI Future Leaders Fellowship, which aims to develop, retain, attract and sustain research and innovation talent in the UK. This competitive scheme cuts across all research disciplines and aims to provide long-term, flexible funding to tackle difficult and novel challenges, and support adventurous, ambitious programmes. Glaucoma is the world's leading cause of irreparable blindness and a growing burden to society as the population ages. Anthony's research programme aims to develop clinical prediction tools using genetic information and next-generation omics techniques. These tools will enable effective earlier detection of glaucoma in the population and more personalised care in the clinic, preventing blindness and also preventing costs and side effects for patients who will not benefit from treatments. Additionally, Anthony is leading an international multidisciplinary effort to identify modifiable lifestyle risk factors for glaucoma, aiming to empower patients with behaviours that can help protect their vision.

Financial position

The trust achieved a breakeven position in-month without the need for further central funding support. It is to be noted that September was the last month of the funding regime instigated for the initial Covid response with core funding based on an average of trust received commissioner income for the period November 2019 – January 2020, with additional top-ups to meet any expenditure shortfalls. The reduction in actual patient activity under plan reduced to 37% in September, a significant improvement on the prior months 50%. NHS patient income now stands at 62% below plan on a cumulative basis. Unutilised central support now stands at £2.09m. Cash balances stood at £83.6m at the end of September, an increase of £1.6m on the prior month, and significantly in excess of plan and equating to 126 days (prior month: 124 days) of working capital liquidity. Capital expenditure in September was £0.5m, taking overall expenditure to £4.8m, some £0.2m over plan.

David Probert
Chief Executive
October 2020

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 06

People plan review

Board of directors 22 October 2020

Report title	**People Plan**
Report from	**Sandi Drewett Director of workforce and OD**
Prepared by	**Sandi Drewett**
Link to strategic objectives	**We will attract, retain and develop great people**

Executive summary

The People Plan actions are prescriptive but fit well with the objectives of our Workforce Strategy. The purpose of this report is to provide the Board with an outline of the NHS People Plan, published on 06/08/20. It also aims to identify where the NHS people synergises and deviates with the existing workforce strategy approved by the board in September 2019.

Finally, a conclusive view of the priorities for the Trust people strategy in 2020/21 is provided for agreement.

Financial Implications

As yet unquantified but additional resource will be required over and above what has been identified to implement the workforce strategy.

Risk implications

The delivery of actions to support the national NHS People Plan will also support the actions to mitigate the following strategic risks:

If the trust does not have a **robust workforce plan** in place then there will be staff shortages and skill gaps leading to insufficient numbers of staff available in key areas and a subsequent impact on the quality of patient care, pressure on staff and a decrease in morale which will affect both the staff and patient experience.

If the trust fails to put in place sufficient support for staff and processes/procedures to manage **staff health and wellbeing**, both during and after the pandemic, then this will lead to increased stress and sickness absence, poor staff engagement with the organisation, poor recruitment and retention and a significant impact on staff morale.

The CQC 'Well Led' framework requires a current workforce strategy to be in place giving shape to priority setting.

Action Required/Recommendation

The Board is asked to:

- Note the content of the recently published 'We are the NHS: People Plan 2020/21' and 'Our People Promise '
- Note the requirement for Board level Wellbeing Guardians and agree the Non-Executive Director Guardian
- Note the process that we have undertaken to review all actions within the national plan
- Note the actions that have been identified to be included in our People Strategy Implementation Plan 2020/21.
- Note that some of the actions identified to be included in the implementation plan are already in progress.

For Assurance		**For decision**	**√**	**For discussion**		**To note**	

1. Introduction

The NHS People Plan for 2020/21, 'We are the NHS' was released on 30 July 2020 with a republished version released on 6 August. The publication of the NHS People Plan has been long awaited since the publication of the Interim People Plan in 2019. Its publication has been delayed by the impact of COVID-19, but this has also served to further shape the key principles within it, noting the significant impact on the workforce in terms of resilience, wellbeing, morale, new ways of working, and also the positive public opinion of the NHS and the potential for this to have an impact on recruitment.

The full plan and analysis against Moorfields local objectives, NCL objectives, London objectives, phase 3 letter and London WRES strategy has been discussed at People and Culture committee.

NHS People Plan 2020/21

The NHS People Plan and promise was published on 6th August 2020 building on the previous interim plan and the response to the pandemic, an overview and summary is provided here. 103 priority areas have been identified

Key Themes

The overarching message of the plan in that the NHS needs more people, working differently, in a compassionate and inclusive culture. The plan stipulates systems should work together to deliver the plan's principles, with emphasis on working with the social care sector.

No financial allocations included, many areas to be covered in greater detail with bespoke reports to be released in due course. The plan is divided into six key areas, summarised below

Responding to new challenges and opportunities

Positive changes to the NHS workforce brought about by the COVID-19 pandemic should be viewed as a "springboard" for further change and innovation, governance and decision-making processes should be simplified. Impact of workforce changes from the pandemic should be measured for effectiveness and embedded – metrics to track impact of people plan across the system coming in September 2020

- **Great focus on health and wellbeing of staff** – Schwartz rounds, wobble rooms, carers passport
- **Reducing inequalities** – disproportionate impact of Covid-19 on BAME staff spotlights need for change towards BAME groups, including involvement with decision-making, leadership and board level input
- **Flexible and remote working –** review how this can continue effectively, including remote patient consultations
- **Innovative roles, returning/new staff** – innovative use of roles during pandemic has resulted in bringing back staff, upskilling existing staff, applying skills to new settings and work, and increasing multidisciplinary team working
- **Volunteers** – surge during pandemic but not fully utilised, partly due to the challenges of safe and effective deployment
- **Research Teams –** Covid-19 research which has been supported by the recruitment of research nurses and clinical trial assistants

Looking after our people

This section sets out four key areas through which we will look after our staff and introduces the NHS People Promise.

- **NHS People Promise**
  - Aims to make the NHS "the best place to work" – 7 pledges to become reality by 2024
  - Staff survey to be redesigned to align with pledges

- **Staff Safety**
  - Infection risk, PPE, Risk Assessments, flu vaccine
  - Bullying and harassment – March 2021 will see a staff civility and respect toolkit released
  - Violence against staff – December 2020 will see an NHS violence reduction standard released

- **Staff physical and mental wellbeing**

From September 2020, H&W conversations to be held with all staff and personalised plans developed which include H&W, flexible working, ED&I. From October 2020, all starters to have an H&W induction. Other topics covered:

  - Rest and respite/support to switch off from work/safe spaces in workplace/physically healthy work environments
  - Wellbeing guardian mandatory for all bodies
  - Home-working support
  - Travel – free parking for those travelling in during pandemic, cycle-to-work scheme a must
  - Psychological treatment and support available
  - Support through sickness absence

- **Flexible working**
  - Flexibility by default from day one: Employers should be open to all clinical and non-clinical permanent roles being flexible, no justification for flexi request required
  - Flexible working conversations to be normalised, role-modelling from exec level, e-rostering rollout to be accelerated
  - Flexibility for GP and Junior Doctor are a priority for NHSE/I and HEE respectively
  - Particular emphasis on flexibility for those with caring responsibilities
  - Further guidance expected December 2020

Belonging in the NHS

- NHS Race and Health Observatory formed to provide analysis and policy recommendations to improve health outcomes for NHS patients, communities and staff
- NHSE/I to provide ED&I education toolkits from October 2020 onwards
- The below to be overhauled/introduced by set deadlines:
- Recruitment and promotion practices – October 2020

Belonging in the NHS

- NHS Race and Health Observatory formed to provide analysis and policy recommendations to improve health outcomes for NHS patients, communities and staff
- NHSE/I to provide ED&I education toolkits from October 2020 onwards
- The below to be overhauled/introduced by set deadlines:
- Recruitment and promotion practices – October 2020
- H&W Conversations – September 2020
- Leadership diversity – progress to be published against Model Employer goals – evidence base for action to be released September 2020
- Tackling the disciplinary gap – by the end of 2020, 51% of organisations to have eliminated the gap in relative likelihood of BAME staff entering into disciplinary process
- Accountability/governance frameworks for ED&I changing
  - Staff networks – by December 2021 governance processes will require contribution from cross-organisational staff networks
  - Chief Execs to be responsible for ED&I; new board-level competency to include accountability for ED&I by March 2021
  - CQC will report on measurable progress ED&I under 'well-led' criteria

New ways of working and delivering care

The plan sets out the following areas that employers must focus on going forwards in order to make the most of skills in teams:

- **Safe redeployment** of staff during pandemic following NHSE/I guidance
- **Upskilling staff** in partnership with local system and local higher education institutions. HEE developing a professional development opportunity for staff to attain a nationally-recognised critical care qualification
- **Technology-enhanced learning** – advised to adopt HEE's e-Learning for Healthcare (e-LfH) programme and new online Learning Hub

- Supporting HEE to develop **Generalist skills (medical) and Primary Care teams**

This section also covers utilising volunteers to help deliver care and current/future HEE support to help educate/train our people for the future. HEE will be offering new funding equivalent to £1,000 per person over three years for CPD and a £10m fund for nurses, midwives and allied health professionals to drive increased placement capacity.

Growing for the future

The plan highlights the importance of capitalising on the public interest in the NHS by enhancing recruitment and retention efforts. The plan signals that growth should be tackled through system partnership working.

- Recruitment will focus on international, local and return to practice
- Retention will focus on role design, retaining staff approaching retirement, retire and returnees and GP retention initiatives. Online support portal available from NHSE/I
- Shortages identified and priority/additional funding given by HEE to mental health, cancer, advanced clinical practice, shortage specialities, undergraduate places (nursing, midwifery, allied health professions, and dental therapy and hygienist courses) and developing new clinical pharmacists. Suggestions for expansion provided e.g. apprenticeships, local hubs to coordinate international recruitment, HEE return to practice scheme, expanding staff bank

Practical point to note: introduction of Health & Care Visa August 2020

Supporting our NHS people for the long term

Reaffirms the central themes of the interim plan and emphasises changes since this was released due to pandemic; stresses that like the interim plan, the People Plan's key focus is for "more staff, working differently, in a compassionate and inclusive culture".

1. Moorfields position

The objectives in the NHS people plan have been summarised, mapped to the existing workforce strategy and a response is provided at appendix 1. Having undertaken a preliminary assessment against the objectives set out in the people plan the following is apparent

1) Our Moorfields strategy has a greater focus on workforce planning, skill mix and organisational design which is key to delivering transformational change in line with our aspirations and we should not lose sight of this focus in the face of a national agenda.
2) Whilst we are good at keeping staff safe there is more work to be done on supporting more flexible working, keeping staff healthy at work and enabling flexible working, this is in line with the health and wellbeing aspirations of the workforce strategy, however the timescales for delivery are much shorter than outlined locally.
3) Many recommendations are reliant on central specification, therefore our ability to locally design solutions to issues may need to 'fit' with system and national approaches
4) Full implementation of health roster and maturity of ESR will be necessary for many of the objectives to be achieved, as we are further behind many trusts in this respect this will need urgent attention and resource.
5) Equality and Diversity, throughout all these new strategic documents there is a strong theme of improvement in ED&I metrics, governance and consequences for failure to improve. Moorfields needs to significantly invest in this area and overhaul its processes and outcomes to ensure change happens at the pace identified.
6) There are omissions in the NHS People Plan. Very little is said about the realities of restart and recovery, where workforce challenges are multiple and some staff are unable to fulfil the roles they held before the pandemic. The redeployment of staff and their flexibility in supporting the Trust and wider system through future months are of paramount importance.

Action that we need to take

Each of the four People Plan commitments has detailed asks of employers and systems. There are over 100 actions in the People Plan and we are working through each of them to ensure that we either have activities already in place or are clear about the action to be taken in response, these are summarised in appendix 1.

Metrics will be developed by NHSE/I in September 2020 with the intention to track progress using the NHS Oversight Framework.

The table at appendix 1 pulls out some key areas where we need to augment our current priorities or work across the ICS to ensure that the actions are taken

We need to review and commission work programmes to meet the asks of the NHS People Plan and assign resources accordingly

Review the Trust's metrics and goals for the people strategy and propose a revised set to the Trust Board in November 2020.

Play an active part in the consultations that will accompany some of the actions of the NHS People Plan; such as the development of the board Leadership competency framework.

Work with partners across NCL to develop the People Plan for the STP

In the meantime, we have updated the Trust People Strategy priorities for 2020/21 to reflect the People Plan actions this will be further revised in line with our business and operational plans

The revised list of People strategy priorities are attached at appendix 2.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Appendix 1

NHS people plan objectives			
	Looking after our people commitment and action	**Our response**	
	Action	**Owner**	
	Put in place effective infection prevention and control procedures Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it. All frontline healthcare workers should have a flu vaccine provided by their employer	Provider	We have good response to infection control and PPE and our vaccination programme is always well responded to.
	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed. Ensure people working from home can do safely and have support to do so, including having the equipment they need Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way.	Provider	All risk assessments undertaken and embedded in on-boarding processes. Support for working from home budget identified and support package being offered.
	Prevent and tackle bullying, harassment and abuse against staff, and a create a culture of civility and respect Prevent and control violence in the workplace – in line with existing legislation Appoint a wellbeing guardian Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work Ensure that all staff have access to psychological support	Provider	More work needed on behaviours needs to be undertaken on bullying and harassment overseen by wellbeing guardian

	Identify and proactively support staff when they go off sick and support their return to work Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout Every member of NHS staff should have a health and wellbeing conversation All new starters should have a health and wellbeing induction Be open to all clinical and non-clinical permanent roles being flexible Cover flexible working in standard induction conversations for new starters and in annual appraisals	Provider	With the support of MEC we are looking to develop a wellbeing hub as part of our wider range of wellbeing support. We are planning to co-create a health and wellbeing plan with our staff overseen by the health and wellbeing sub group of people committee. We have updated our facilities and access to refreshments in line with the BMA rest and facilities charter. There is an immediate need to support managers with health and wellbeing conversations with their staff, recent risk assessment processes will help however there is a real training need identified in this area. The appraisal process is one area where we can improve the focus on health and wellbeing and we will need to quickly develop this, providing guidance to both managers and staff to support conversations Covid has seen staff working in a more agile way and support for staff working in an agile way.
	Belonging in the NHS		
	Board members must give flexible working their focus and support Roll out the new working carers passport to support people with caring responsibilities Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets Support organisations to achieve the above goal, including establishing robust decision-tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce	Provider	Our priorities set at EDHR reflect these priorities We need to overhaul our recruitment processes and priorities to change how we recruit – starting with senior posts and those above band 8a for AfC staff. Our approach to supporting staff to progress will need expansion and support.

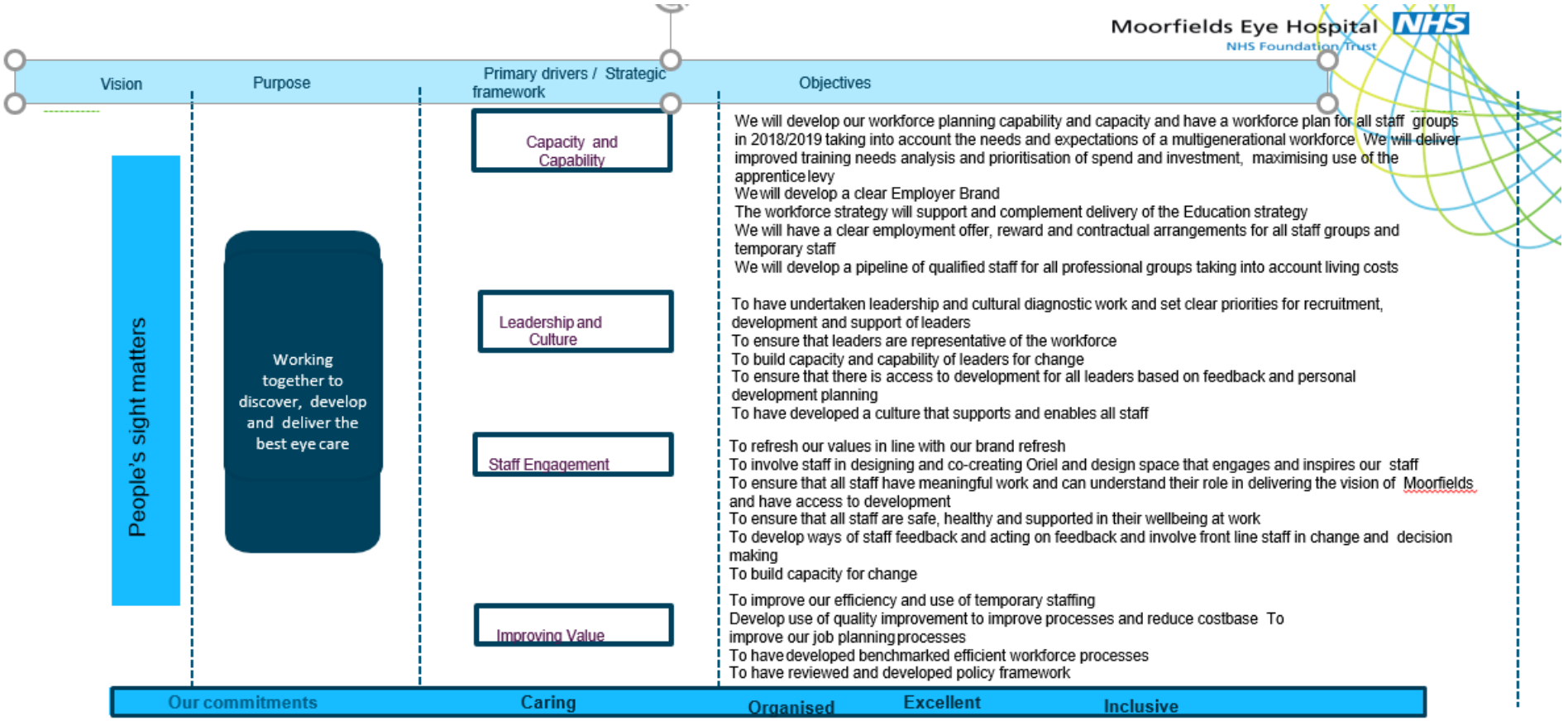
	Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation Publish competency frameworks for every board-level position in NHS provider and commissioning organisations. By March 2021. These will reinforce the responsibility of the Chief Executive to lead on equality diversity and inclusion and of all senior leaders to hold each other to account for progress. CQC will place greater emphasis on evidenced improvements in equality, diversity and inclusion from 2020/21	Provider	This is an area where we need to make improvements in line with national guidance We will need to make improvements in our workforce composition, staff experience and approach to inform PIR and evidence preparation.
	Growing for the future		
	Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression. Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response. To provide even more patient-centred care, a sustainable supply of prescribing pharmacists with enhanced clinical and consultation skills will be created. Working with stakeholders, and under the leadership of the General Pharmaceutical Council, the aim is to start this new approach from Summer 2021, building on HEE's Interim Foundation Programme that will commence in September 2020		Our workforce transformation plans are central to delivery of these objectives and have been accelerated in response to changes made during covid.
	Work with employers and systems to improve existing staff banks' performance on fill rates and staff experience	System	Working closely with STP for corporate workstreams.

	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health	Providers	
	Work with HEE and NHSEI regional teams to further develop competency based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it	Providers	
	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision making processes.	Providers	

	Promote and encourage employers to complete the free online just and learning culture training and accredited learning packages, and take demonstrable action to model these leadership behaviours	CQC	
	All central NHS leadership programmes to be available in digital format and accessible to all.	HEE	
	Work with the medical Royal Colleges and regulators to ensure that competencies gained by medical trainees while working in other roles during COVID-19 can count towards training (national HEE)	HEE	
	Develop the educational offer for generalist training and work with local systems to develop the leadership and infrastructure required to deliver it (national HEE)		
	Support the expansion of multidisciplinary teams in primary care	HEE	
	Work with the National Guardians office to support leaders and managers to foster a listening, speaking up culture	HEE	
	Provide refreshed support for leaders in response to the current operating environment	NHSE/I	
	Work with the Faculty of Medical Leadership and Management to expand the number of placements available for talented clinical leaders each year	NHSE/I	
	Update the talent management process to make sure there is greater prioritisation and consistency of diversity in talent being considered for director, executive senior manager, chair and board roles	NHSE/I	
	Launch an updated and expanded free online training material for all NHS line managers, and a management apprenticeship pathway for those who want to progress	NHSE/I	
	Publish resources, guides and tools to help leaders and individuals have productive conversations about race, and to support each other to make tangible progress on equality, diversity and inclusion for all staff	NHSE/I	
	Publish competency frameworks for every board-level position in NHS provider and commissioning organisations	NHSE/I	
	Launch a joint training programme for Freedom to Speak Up Guardians and WRES Experts, and recruit more BAME staff to Freedom to Speak Up Guardian roles	NHSE/I	
	Publish a consultation on a set of competency frameworks for board positions in NHS provider and commissioning organisations	NHSE/I	

Moorfields Eye Hospital NHS Foundation Trust

Appendix 2



Moorfields Eye Hospital NHS Foundation Trust

www.moorfields.nhs.uk

Workstream 1 – Capacity and Capability	Workstream 2 – Leadership and Culture
Develop workforce planning capability at speciality level Design and introduce workforce planning tool for oriel FBC Supporting workforce transformation, drawing on new models of care and agree temporary and permanent changes to workforce design in 1) Glaucoma 2) Diagnostic Hubs 3) Outpatients 4) Medical Retina 5) Anaesthetics 6) Administration Prepare for 2nd wave, upskilling staff and working with ICS and London to determine redeployment needs and model for supply Review recruitment model to support redesign	Recruit to executive and non-executive vacancies Engage with our staff to undertake reflection from experience of COVID to inform future planning Undertake board diagnostic interviews to inform plan for the well led framework Business case and procurement for clinical leadership programme to support transformation Management development programme for management basics Use people plan as opportunity to have a bigger conversation about what it means to be a moorfields……
Workstream 3- staff engagement and health and wellbeing	**Workstream 4 – Improving Value**
Develop and expand support for agile working Reset our approach to ED&I with 4 objectives set by EDHR steering group Reform recruitment practice to improve inclusion Invest in staff health and wellbeing and establish plans for the longer term via the health and wellbeing subgroup of people committee Build on the reporting of discrimination and harassment and actions to tackle bullying and harassment Embed risk assessments Achieve 100% flu vaccination	Review staff bank and recruitment arrangements across the STP Implement Job Planning policy and e-job planning Workforce model for private practice review Review of workforce systems and implementation of recomendations Improve internal processes in workforce directorate Develop helpdesk and associated processes

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 07
Learning from deaths
Board of directors 22 October 2020

Report title	Learning from deaths
Report from	Nick Strouthidis, medical director
Prepared by	Julie Nott, head of risk & safety
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive summary

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

The trust has identified 0 patient deaths in Q2 that fall within the scope of the learning from deaths policy.

Quality implications

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

Financial implications

Provision of the medical examiner role for Moorfields may have cost implications for the organisation.

Risk implications

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

Action Required/Recommendation

The quality & safety committee is asked to receive the report for assurance and information.

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

Learning from deaths Board paper

This report satisfies the requirement to provide the trust board with an update regarding compliance with, and learning from, the NHS Improvement learning from deaths agenda.

The Q2 2020/21 data, as at 9 October 2020, is shown in table 1 below.

Indicator	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0		
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	0		
% of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident panel	N/A	N/A		
Deaths considered likely to have been avoidable	N/A	N/A		

Table 1

Learning and improvement opportunities identified during Q2

- No opportunities for learning from deaths have been identified during Q2.

- **Medical examiner role (update)**

Two national medical examiner update publications have been released by NHS Improvement since the Q1 report:

- July 2020 https://www.england.nhs.uk/wp-content/uploads/2020/08/July_NME_bulletin_.pdf

- August 2020 https://www.england.nhs.uk/wp-content/uploads/2020/09/august-2020-nme-bulletin.pdf

Annex 1

Included within the scope of this Policy:

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

Excluded from the scope of this Policy:

- People who are not patients who become unwell whilst on trust premises and subsequently die;

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 08
Guardian of safe working
Board of directors 22 October 2020

Report title	Guardian of Safe Working Report
Report from	Nicholas Strouthidis, medical director
Prepared by	Andrew Scott, guardian of safe working
Link to strategic objectives	We will attract, retain and develop great people

Brief summary of report

The guardian of safe working report summarises progress in providing assurance that doctors are safely rostered and their working hours are compliant with the 2016 terms and conditions of service (TCS) for doctors in training. This report covers the period from 18/05/20 – 14/10/20.

Exception Reports

During the last quarter, which includes lockdown and recovery period, there have been no exception reports despite repeated reminders to trainees to exception report if necessary. There have been no reported instances of breach of the minimum 8 hours rest requirement between shifts; no instances of a breach of the 48-hour average working week (across the reference period agreed); no instances of a breach of the maximum 72-hour limit in any seven days; and there have been no reports of any trainee missing greater than 25% of their natural breaks.

I gave a virtual induction lecture to all junior doctors joining Moorfields in August and all were given an allocate account and instruction on how to exception report. During recent Junior doctor forums, I have been given assurance by the senior residents and trainees that working hours are compliant. There are no rota gaps and it was felt that the absence of exception reports is a reflection of this. There have been some issues with some residents being unable to have lunch breaks before starting an afternoon A&E shift. This has been communicated to Gordon Hay, clinical director for A&E and an email was sent to all consultants to ensure that residents are allowed adequate lunch breaks before the 1.30 pm A&E shift.

Surgical training issues

There are significant concerns about training because many trainees are behind the College mandated targets, especially in cataract numbers. The following training issues have been brought to my attention:

1. Some ST3 trainees are very low on cataract numbers and need support with their training. A plan to place some trainees on an intensive cataract firm attachment to upskill them in a short space of time has been previously discussed but this plan has not yet been taken forward.

2. A few have theatre sessions on their regular timetable that have not been running since the start of the training year (Aug'20). They need to be reassigned another list if there are no immediate plans to reinstate these lists.

3. Our only ST1 this year did not have a formal theatre list until very recently. The trainee was struggling to learn the basics such as pre-op clerking, cleaning, draping etc, whilst ST1s in other sites have had access to a list since the start of the year.

Fine Money and £30,000 Health Education England Grant

This money has now all been spent on items to improve Junior doctors working conditions e.g. coffee pods, bluetooth speakers for theatres, sofas for mess etc. The surplus has been put toward the upkeep of the EyeSi simulator. Ability to provide this in house and to repair the cataract module when it (inevitably) fails will save the trainees from making a trip to the College. Providing such facilities is especially important in the post-covid era when opportunities for surgical training may

be reduced.

High level data

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

Actions/Discussions taking place:

- To ensure that surgical training targets are factored in the Trust's recovery plan for surgery
- To investigate whether poor surgical training for lower house trainees is a result of lack of capacity for training or whether it is due to a failure in organising and implementing this training

Summary

All Moorfields trainees are safely rostered in compliant rota patterns with no breaches of the terms and conditions of service occurring during this reporting period. Most trainees are familiar with the process of exception reporting and there are systems in place to ensure prompt compensation payment for excessive hours worked. Despite the Covid pandemic, trainee morale is high and working conditions good with no exception reports in this quarter. The trainees' main concern is reaching training targets particularly in surgery during and after the pandemic.

Quality implications

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

Financial implications

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

Risk implications

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

Action required

The board is asked to consider the report for assurance.

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

Report to Trust Board	
Report Title	**Integrated Performance Report - September 2020**
Report from	John Quinn, Chief Operating Officer
Prepared by	Performance And Information Department
Previously discussed at	Trust Management Committee
Attachments	

Brief Summary of Report

The Integrated Performance Report highlights a series of metrics regarded as Key Indicators of Trust Performance and cover a variety of organisational activities within Operations, Quality and Safety, Workforce, Finance, Research, Commercial and Private Patients . The report uses a number of mechanisms to put performance into context, showing achievement against target, in comparison to previous periods and as a trend. The report also identifies additional information and Remedial Action Plans for KPIs falling short of target and requiring improvement.

Executive Summary

The IPR continues to reflect the Trust performance during the COVID period. Activity still remains below historical averages. The cataract drive was undertake at City Road which has boasted elective activity. Feedback from patients and staff has been positive. Recovery is in progress and the Trust is improving its activity weekly. The Trust has now submitted its forecast centrally as requested in response to the phase 3 letter compliance. We will monitor performance against this forecast in future months. The addendum to the IPR outline this activity. Also further planning for recovery during the next six months is in progress and the Trust will be submitting a forecast to NHSI at the end of September.

For performance the Trust continues to perform strongly on the agreed KPIs overall. Cancer is performing well the 2 week wait target has improved from last month although the 14 day locally agreed target has dropped just under the 93% target. The other access targets remain challenged due to COVID. The number of patients waiting more than 52 weeks has improved in month and this is expected to continue in October.

There has been one never event outlined in the report. A formal investigation is underway and will be reported through the Quality and Safety Committee governance structures.

Appraisal rate remain below target which was due to a decision made during the Covid response to refocus this. However as staff return to work more normally managers are now picking appraisal back up and this is expected to improve over the coming months.

Action Required/Recommendation

The report is primarily for information purposes but will inform discussion regarding how the Trust is performing against its key organisational measures. This may in turn generate subsequent action.

For Assurance	X	For decision		For discussion		To Note	

Trust Executive Summary By Scorecard Domain - September 2020

Service Excellence (Ambitions)

Patient Centred Care

	G	A	R
Total	**28**	**0**	**5**
Cancer	4	0	1
Access & Outpatients	1	0	3
Admitted	6	0	0
Quality & Safety	17	0	1
Private Patients	0	0	0

Collaborative Research

G	A	R
1	0	0

Innovation & Education

G	A	R
0	**0**	**0**

Influence National Policy

G	A	R
In Development		

People (Enablers)

Workforce Metrics

G	A	R
1	**0**	**2**

Staff Satisfaction & Advocacy

G	A	R
0	**0**	**0**

Infrastructure & Culture (Enablers)

Digital Delivery

G	A	R
2	**0**	**0**

Research

G	A	R
3	**0**	**0**

Financial Health & Enterprise (Enablers)

Overall Plan

G	A	R
0	**0**	**1**

Commercial Operations

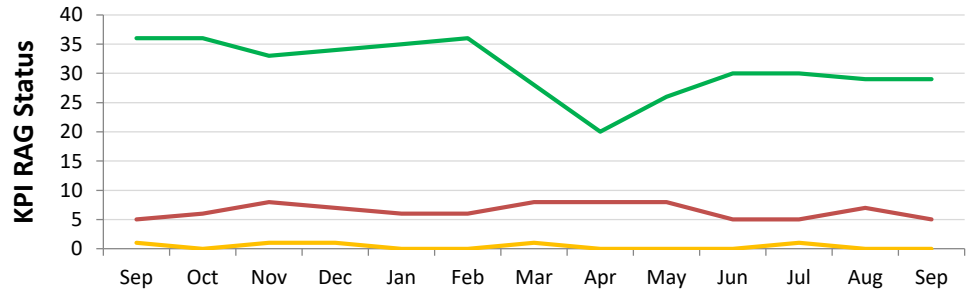
G	A	R
1	**0**	**1**

Cost Improvement Plans

G	A	R
0	**0**	**0**

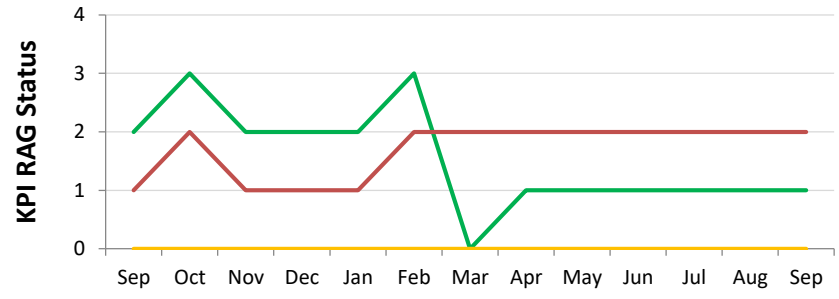
Executive Summary - Scorecard Domain Trends

Service Excellence (Ambitions)



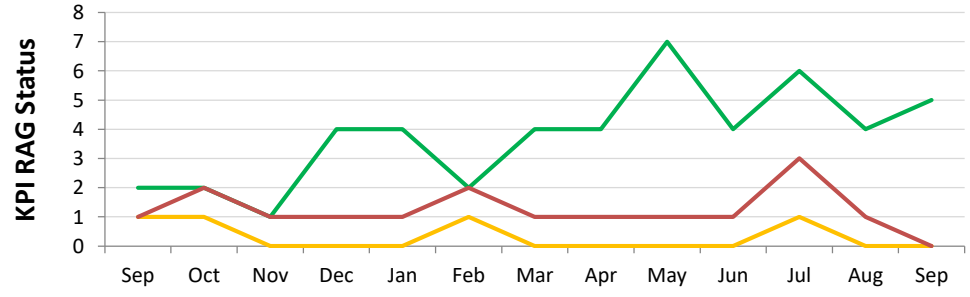
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Green	36	36	33	34	35	36	28	20	26	30	30	29	29
Amber	1	0	1	1	0	0	1	0	0	0	1	0	0
Red	5	6	8	7	6	6	8	8	8	5	5	7	5

People (Enablers)



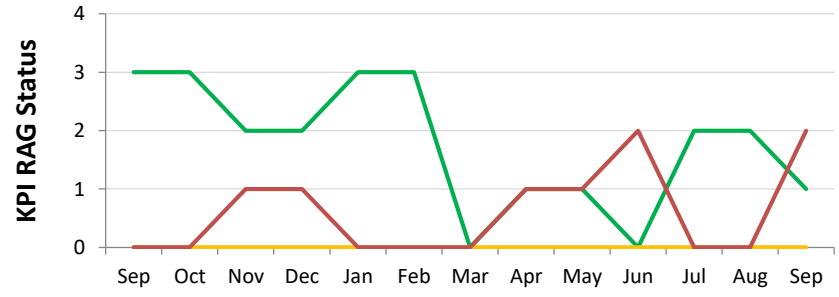
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Green	2	3	2	2	2	3	0	1	1	1	1	1	1
Amber	0	0	0	0	0	0	0	0	0	0	0	0	0
Red	1	2	1	1	1	2	2	2	2	2	2	2	2

Infrastructure & Culture (Enablers)



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Green	2	2	1	4	4	2	4	4	7	4	6	4	5
Amber	1	1	0	0	0	1	0	0	0	0	1	0	0
Red	1	2	1	1	1	2	1	1	1	1	3	1	0

Financial Health & Enterprise



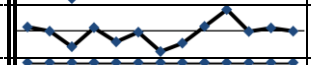
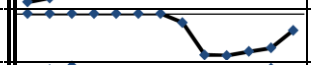
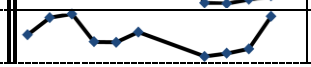
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Green	3	3	2	2	3	3	0	1	1	0	2	2	1
Amber	0	0	0	0	0	0	0	0	0	0	0	0	0
Red	0	0	1	1	0	0	0	1	1	2	0	0	2

Context - Overall Activity - September 2020

		September 2020		Monthly Variance	Year To Date		YTD Variance
		2019/20	2020/21		2019/20	2020/21	
Accident & Emergency	A&E Arrivals (All Type 2)	8,413	5,749	- 31.7%	51,312	31,007	- 39.6%
	Number of 4 hour breaches	249	4	- 98.4%	822	9	- 98.9%
Outpatient Activity	Number of Referrals Received	11,809	7,501	- 36.5%	73,818	28,772	- 61.0%
	Total Attendances	51,649	33,113	- 35.9%	307,325	111,143	- 63.8%
	First Appointment Attendances	11,467	5,982	- 47.8%	68,143	20,958	- 69.2%
	Follow Up (Subsequent) Attendances	40,182	27,131	- 32.5%	239,182	90,185	- 62.3%
Admission Activity	Total Admissions	3,365	2,710	- 19.5%	19,856	5,924	- 70.2%
	Day Case Elective Admissions	3,022	2,540	- 15.9%	17,785	4,773	- 73.2%
	Inpatient Elective Admissions	92	63	- 31.5%	603	268	- 55.6%
	Non-Elective (Emergency) Admissions	251	107	- 57.4%	1,468	883	- 39.9%

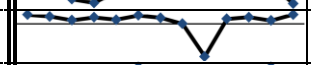
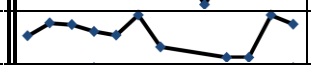
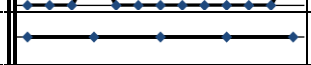
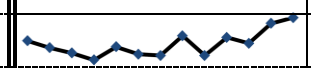
These figures are not subject to any finance or commissioning business logic. They present all activity, whether chargeable or not

Domain	Service Excellence (Ambitions)	September 2020

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Jun 20	Jul 20	Aug 20	Sep 20	13 Month Series	vs. Last
Patient Centred Care (Cancer)	Cancer 2 week waits - first appointment urgent GP referral	≥93%	G		97.5%	Monthly	100.0%	100.0%	91.7%	100.0%		↑
	Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	≥93%	R		94.1%	Monthly	100.0%	92.7%	93.9%	92.9%		↓
	Cancer 31 day waits - Decision to Treat to First Definitive Treatment	≥96%	G		100.0%	Monthly	100.0%	100.0%	100.0%	100.0%		→
	Cancer 31 day waits - Decision to Treat to Subsequent Treatment	≥94%	G		100.0%	Monthly	100.0%	100.0%	100.0%	100.0%		→
	Cancer 62 days from Urgent GP Referral to First Definitive Treatment	≥85%	G		n/a	Monthly	n/a	n/a	100.0%	100.0%		→
	Cancer 28 Day Faster Diagnosis Standard	≥85%			87.5%	Monthly	100.0%	100.0%	100.0%	75.0%		↓
Patient Centred Care (Access & Outpatients)	18 Week RTT Incomplete Performance	≥92%	R		50.7%	Monthly	45.4%	29.4%	36.0%	47.7%		↑
	52 Week RTT Incomplete Breaches	Zero Breaches	R		414	Monthly	31	98	149	125		↓
	A&E Four Hour Performance	≥95%	G		100.0%	Monthly	100.0%	100.0%	100.0%	99.9%		↓
	Percentage of Diagnostic waiting times less than 6 weeks	≥99%	R		38.6%	Monthly	23.0%	30.3%	36.7%	69.0%		↑
	Average Call Waiting Time	≤ 3 Mins (180 Sec)			n/a	Monthly	49	58	122	n/a		

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Domain	Service Excellence (Ambitions)	September 2020

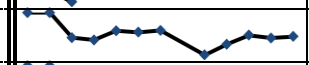
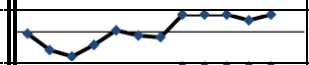
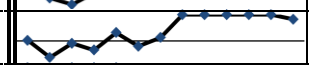
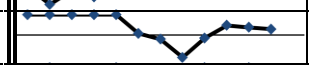
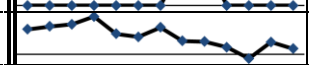
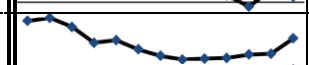
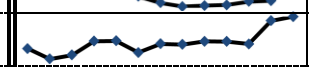
Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Jun 20	Jul 20	Aug 20	Sep 20	13 Month Series	vs. Last
Patient Centred Care (Access & Outpatients)	Median Clinic Journey Times - New Patient appointments: Year End Target of 95 Mins	Mth:≤ 95Mins			n/a	Monthly	85	92	87	98		↑
	Median Clinic Journey Times -Follow Up Patient appointments: Year End Target of 85 Mins	Mth:≤ 85Mins			n/a	Monthly	76	79	78	82		↑
Patient Centred Care (Admitted)	Theatre Cancellation Rate (Overall)	≤7.0%	G		6.2%	Monthly	6.6%	6.6%	5.9%	6.8%		↑
	Theatre Cancellation Rate (Non-Medical Cancellations)	≤0.8%	G		0.48%	Monthly	0.15%	0.72%	0.84%	0.42%		↓
	Mixed Sex Accommodation Breaches	Zero Breaches	G		0	Monthly	0	0	0	0		→
	Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	≤ 2.67%	G		n/a	Monthly (Rolling 3 Months)	6.85%	4.21%	3.67%	0.93%		↓
	VTE Risk Assessment	≥95%	G		97.3%	Monthly	97.3%	98.2%	96.5%	99.5%		↑
	Posterior Capsular Rupture rates	≤1.95%	G		1.01%	Monthly	0.00%	0.00%	1.40%	1.10%		↓
Patient Centred Care (Quality & Safety)	Occurrence of any Never events	Zero Events	R		1	Monthly	0	0	0	1		↑
	Endopthalmitis Rates - Aggregate Score	Zero Non-Compliant	G		0	Quarterly	0	n/a	n/a	0		→
	MRSA Bacteraemias Cases	Zero Cases	G		0	Monthly	0	0	0	0		→
	Clostridium Difficile Cases	Zero Cases	G		0	Monthly	0	0	0	0		→
	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Zero Cases	G		0	Monthly	0	0	0	0		→
	MSSA Rate - cases	Zero Cases	G		0	Monthly	0	0	0	0		→
	Inpatient (Overnight) Ward Staffing Fill Rate	≥90%	G		99.2%	Monthly	98.7%	97.5%	101.6%	102.8%		↑

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

Moorfields Eye Hospital NHS Foundation Trust

NHS

Domain	Service Excellence (Ambitions)	*September 2020*

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Jun 20	Jul 20	Aug 20	Sep 20	13 Month Series	vs. Last
	Inpatient Scores from Friends and Family Test - % positive	≥90%	G		95.5%	Monthly	95.7%	96.0%	96.2%	95.3%		↓
	A&E Scores from Friends and Family Test - % positive	≥90%	G		94.4%	Monthly	95.0%	94.7%	93.9%	94.0%		↑
	Outpatient Scores from Friends and Family Test - % positive	≥90%	G		93.3%	Monthly	92.8%	93.8%	93.5%	93.6%		↑
	Paediatric Scores from Friends and Family Test - % positive	≥90%	G		94.6%	Monthly	95.3%	95.2%	94.1%	95.7%		↑
Patient Centred Care (Quality & Safety)	Summary Hospital Mortality Indicator	Zero Cases	G		0	Monthly	0	0	0	0		
	NHS England/NHS Improvement Patient Safety Alerts breached	Zero Alerts	G		n/a	Monthly	0	0	0	0		→
	Percentage of responses to written complaints sent within 25 days	≥80%	G		98.4%	Monthly (Month in Arrears)	100.0%	100.0%	93.3%	100.0%		
	Percentage of responses to written complaints acknowledged within 3 days	≥80%	G		98.9%	Monthly	100.0%	100.0%	100.0%	96.4%		↓
	Freedom of Information Requests Responded to Within 20 Days	≥90%	G		90.3%	Monthly (Month in Arrears)	88.5%	94.7%	93.8%	92.9%		
	Subject Access Requests (SARs) Responded To Within 28 Days	≥90%	G		98.5%	Monthly (Month in Arrears)	100.0%	94.9%	100.0%	97.6%		
	Number of Serious Incidents remaining open after 60 days	Zero Cases	G		2	Monthly	0	0	0	0		→
	Number of Incidents (excluding Health Records incidents) remaining open after 28 days	≤ 20 Open			n/a	Monthly	59	53	78	46		↓
Collaborative Research	Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	≥1800			258	Monthly	15	38	43	148		↑
	Percentage of Trust Patients Recruited Into Research Projects	≥2%	G		n/a	Monthly	3.7%	3.6%	4.8%	5.0%		↑

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

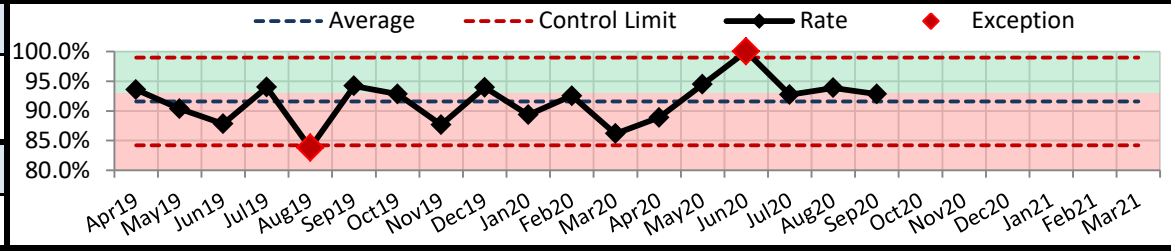
Remedial Action Plan - September 2020

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Cancer)
Lead Manager	Alex Stamp	Responsible Director	John Quinn

Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)

Target	Rating	YTD	Jun-20	Jul-20	Aug-20	Sep-20
≥93%	Red	94.1%	100.0%	92.7%	93.9%	92.9%

Divisional Benchmarking (Sep 20)	City Road	North	South
	92.9%	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No previously identified issues			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
5 breaches in September. Four were due to patient choice and one due to internal referral issue.	All patient choice breaches escalated to CNS to phone and encourage earlier attendance (where possible).	October 2020

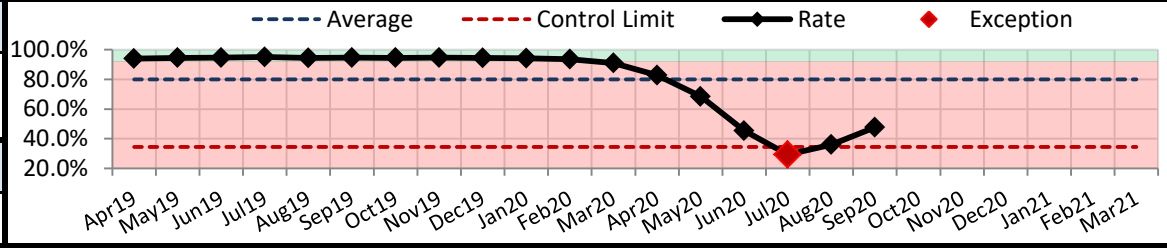
Remedial Action Plan - September 2020

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Access & Outpatients)
Lead Manager	Alex Stamp	Responsible Director	John Quinn

18 Week RTT Incomplete Performance

Target	Rating	YTD	Jun-20	Jul-20	Aug-20	Sep-20
≥92%	Red	50.7%	45.4%	29.4%	36.0%	47.7%

Divisional Benchmarking (Sep 20)	City Road	North	South
	62.2%	17.1%	32.3%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Impact on performance due to Covid-19 deferral of activity.	Ongoing review of activity which can be safely stepped up in line with national and regional guidance. Plan for WL to be back at pre-Covid-19 levels by May 2021.	May 2021	

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Impact on performance due to Covid-19 deferral of activity.	Ongoing review of activity which can be safely stepped up in line with national and regional guidance. Plan for WL to be back at pre-Covid-19 levels by May 2021.	May 2021

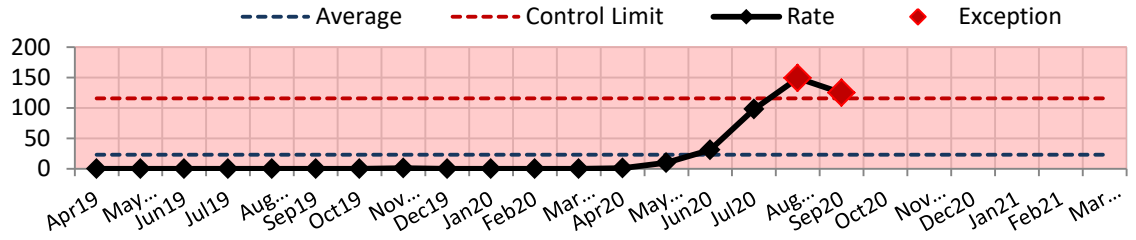
Remedial Action Plan - September 2020

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Access & Outpatients)
Lead Manager	**Alex Stamp**	**Responsible Director**	**John Quinn**

52 Week RTT Incomplete Breaches

Target	Rating	YTD	Jun-20	Jul-20	Aug-20	Sep-20
Zero Breaches	Red	414	31	98	149	125

Divisional Benchmarking (Sep 20)	City Road	North	South
	n/a	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Backlog of surgical cases due to deferral of all bar P1 and P2 surgery.	Weekly PTL meetings with division to focus on all patients 46 weeks+ and identify plans for patients both over 52 weeks and at risk of tipping over.	Oct 2020	

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Backlog of cases due to Covid cancellation. Delays with 52 week clearance due to patient choice and specialism of cases.	Weekly PTL meetings with division to focus on all patients 46 weeks+ and identify plans for patients both over 52 weeks and at risk of tipping over.	November 2020

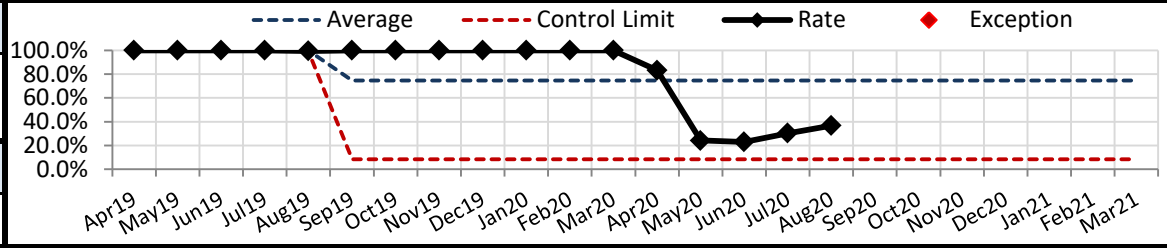
Remedial Action Plan - September 2020

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Access & Outpatients)
Lead Manager	Alex Stamp	Responsible Director	John Quinn

Percentage of Diagnostic waiting times less than 6 weeks

Target	Rating	YTD	Jun-20	Jul-20	Aug-20	Sep-20
≥99%	Red	38.6%	23.0%	30.3%	36.7%	69.0%

Divisional Benchmarking (Sep 20)	City Road	North	South
	n/a	n/a	n/a



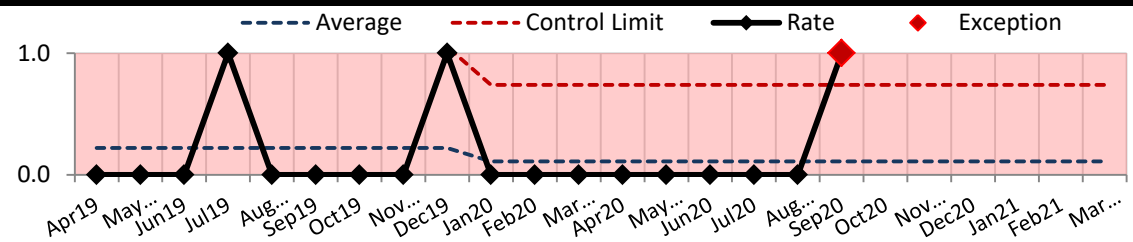
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Backlog clearence following suspension of medium and low risk activity.	Additional clinics implemented and 6 week waiters (excluding patient choice) will be cleared by december 2020.	Dec 2020	

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Backlog clearence following suspension of medium and low risk activity.	Additional clinics implemented and 6 week waiters (excluding patient choice) will be cleared by December 2020.	December 2020

Remedial Action Plan - September 2020	Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Quality & Safety)
Occurrence of any Never events	Lead Manager	Julie Nott	Responsible Director	Ian Tmbleson

Target	Rating	YTD	Jun-20	Jul-20	Aug-20	Sep-20
Zero Events	Red	1	0	0	0	1

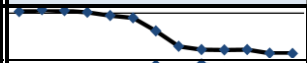
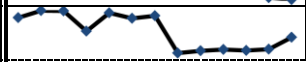
Divisional Benchmarking (Sep 20)	City Road	North	South
	0	0	0



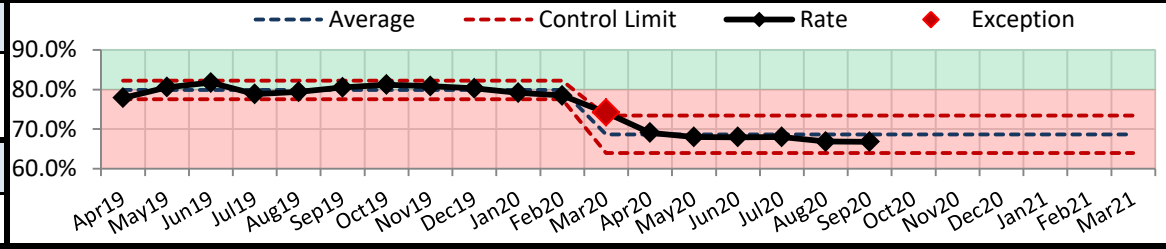
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Previously Identified Issues	None	December	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
A patient was consented for left phaco and insertion of an IOL under local anaesthesia with sedation. Prior to the start of surgery the patient had the incorrect (right) eye blocked. The error was identified immediately and the patient received an apology. The incident was reviewed by the SI panel and formally reported as a Never Event.	None	

Domain	People (Enablers)	*September 2020*

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Jun 20	Jul 20	Aug 20	Sep 20	13 Month Series	vs. Last
Workforce Metrics	Appraisal Compliance	≥80%	R		n/a	Monthly	68.0%	68.0%	66.8%	66.8%		→
	Information Governance Training Compliance	≥95%	R		n/a	Monthly	94.3%	93.1%	92.6%	92.0%		↓
	Staff Turnover (Rolling Annual Figure)	≤15%	G		n/a	Monthly	11.4%	n/a	10.2%	10.0%		↓
	Proportion of Temporary Staff	RAG as per Spend			5.2%	Monthly	4.9%	4.7%	5.0%	7.7%		↑

Remedial Action Plan - September 2020							Domain	People (Enablers)	Theme	Workforce Metrics
Appraisal Compliance							Lead Manager	Nicky	Responsible Director	Sandi Drewett
Target	Rating	YTD	Jun-20	Jul-20	Aug-20	Sep-20				
≥80%	Red	n/a	68.0%	68.0%	66.8%	66.8%				
Divisional Benchmarking (Sep 20)				City Road	North	South				
				n/a	n/a	n/a				



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
At the start of the Covid-19 period an executive decision was made to suspend the appraisal process. The appraisal process has now restarted with new Covid-19 specific guidance but it is recognised that recovery towards target will take some time as working restrictions are still in place.	The development of support and guidance for virtual appraisal is on-going and a process of reminder emails to managers is now in operation. HR Business Partners are communicating appraisal rates with Divisional Management Teams on a monthly basis.	Mar 2020	In Progress (No Update)

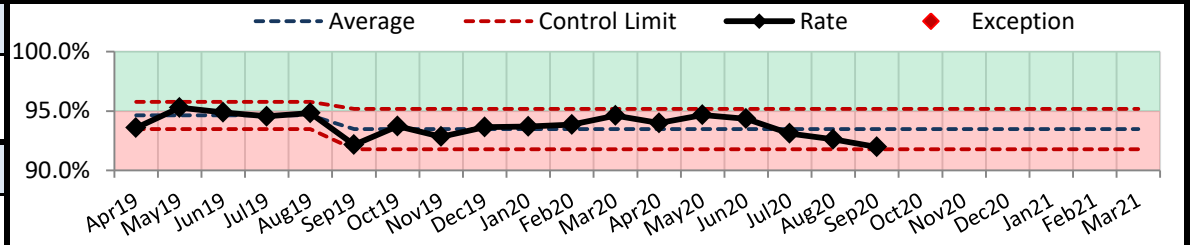
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date

Remedial Action Plan - September 2020

Domain	People (Enablers)	Theme	Workforce Metrics
Information Governance Training Compliance	**Lead Manager**	**Jo Downing**	**Responsible Director**	**Ian Tombleson**

Target	Rating	YTD	Jun-20	Jul-20	Aug-20	Sep-20
≥95%	Red	n/a	94.3%	93.1%	92.6%	92.0%

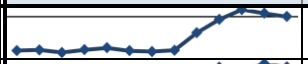
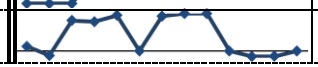
Divisional Benchmarking (Sep 20)	City Road	North	South
	n/a	n/a	n/a



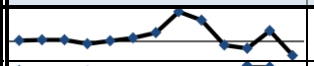
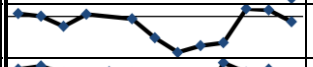
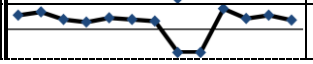
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Organisational performance for IG training remains very good and close to the 95% target. This continues to stand up well during the COVID recovery phase and has shown good stability. However, issues have been identified with data quality and new starters not always completing their mandatory training before starting.	The IG team is working with L&D, IMDQG and SMTC to 1) improve data quality 2) ensure all staff receive IG training before they start the organisation 3) ensure that reminders are sent to the organisation focusing on those who are about to fall out of compliance (sent by L&D) or those that demonstrate long term poor compliance (for a variety of posssible reasons) - sent by IG. This requires continuous maintenance.	Dec 2020	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Organisational performance for IG training remains very good and close to the 95% target. This continues to stand up well during the COVID recovery phase and has shown good stability. However, issues have been identified with new starters not always completing their mandatory training before starting and data quality. The IGC and ITSG are concerned that all staff must have current IG training before being provided with passwords for our systems.	The IG team is working with L&D and IMDQG to 1) ensure all staff have IG training before they start the organisation 2) ensure that reminders are sent to the organisation focusing on those who are about to fall out of compliance or those that demonstrate long term poor compliance (for a variety of posssible reasons) - sent by IG 3) fix any data quality issues. This requires continuous maintenance.	

Domain	Infrastructure & Culture (Enablers)	*September 2020*

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Jun 20	Jul 20	Aug 20	Sep 20	13 Month Series	vs. Last
	Data Quality - Ethnicity recording (Outpatient and Inpatient)	≥94%	G		93.1%	Monthly	93.7%	94.9%	94.4%	94.0%		↓
	Data Quality - Ethnicity recording (A&E)	≥94%	G		100.0%	Monthly	100.0%	100.0%	100.0%	100.0%		→
Research	70 Day To Recruit First Research Patient	≥80%	G		96.6%	Monthly	93.3%	93.3%	93.3%	100.0%		↑
	Percentage of Research Projects Achieving Time and Target	≥65%	G		70.5%	Monthly	72.7%	72.7%	72.7%	69.2%		↓
	Percentage of Patients Recruited Against Target (Studies Closed In Month)	100%	G		100.5%	Monthly	100.0%	87.3%	87.6%	100.0%		↑

Domain	Financial Health & Enterprise (Enablers)	*September 2020*

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Jun 20	Jul 20	Aug 20	Sep 20	13 Month Series	vs. Last
Overall Plan	Overall financial performance (In Month Var. £m)	≥0	R		3.17	Monthly	-0.35	-0.63	0.91	-1.23		↓
Commercial Operations	Commercial Trading Unit Position (In Month Var. £m)	≥0	R		3.55	Monthly	-0.94	0.28	0.23	-0.2		↓
	Private Patients Enquiry Line Conversion Rate	≥40%	G		35.4%	Monthly	75.5%	58.6%	64.1%	55.5%		↓

Where issued for a metric, the page number of the Remedial Action Plan (RAP) can be found in column 'RAP Pg'

September Integrated Performance Report Addendum – Weekly Activity Data

Measure	Level	09-Aug-20	16-Aug-20	23-Aug-20	30-Aug-20	06-Sep-20	13-Sep-20	20-Sep-20	27-Sep-20	04-Oct-20	11-Oct-20	Corresponding 2019/20 week	Trend
Total pathways	Trust	31256	31461	31884	31910	32155	32397	32129	32264	31929	32014	28616	
Over 18 week pathways	Trust	21529	21518	21021	20415	20092	19366	18206	17314	16502	15675	1570	
Over 18 week performance	Trust	31.1%	31.6%	34.1%	36.0%	37.5%	40.2%	43.3%	46.3%	48.3%	51.0%	94.5%	
Over 18 week non admitted performance	Trust	34.3%	34.8%	37.3%	39.2%	40.6%	43.0%	45.1%	47.8%	49.4%	51.9%	97.1%	
Over 18 week admitted performance	Trust	18.1%	18.2%	20.4%	22.0%	23.4%	26.5%	33.3%	37.4%	41.4%	45.9%	84.9%	
Over 18 week non admitted pathways	Trust	16559	16494	16183	15844	15691	15328	15000	14446	13869	13265	648	
Over 18 week admitted pathways	Trust	4970	5024	4838	4571	4401	4038	3206	2868	2633	2410	922	
Over 40 week non admitted pathways	Trust	534	538	572	624	783	890	1105	1281	1217	1252	5	
Over 40 week admitted pathways	Trust	840	885	973	1025	1125	1132	915	877	782	731	6	
Over 52 week non admitted pathways	Trust	30	31	30	27	24	26	36	31	32	30	0	
Over 52 week admitted pathways	Trust	113	98	101	119	133	134	102	96	94	91	0	
New pathways not seen over 14 weeks	Trust	3520	3527	3623	3753	3851	3985	4143	4279	4446	4632	1132	
New pathways not seen over 18 weeks	Trust	2803	2808	2930	3001	3099	3181	3261	3337	3412	3460	170	
New pathways (RTTSD last 7 days)	Trust	125	107	123	129	149	134	128	194	196	248	343	
New surgical pathways (DTA last 7 days)	Trust	74	113	120	54	89	69	61	107	165	153	0	
Percentage WL size vs Feb 2020	Trust	110.6%	111.3%	112.8%	112.9%	113.8%	114.7%	113.7%	114.2%	113.0%	113.3%	101.3%	
Median wait	Trust	165	168	173	178	181	185	185	167	143	119	42	
Median wait non-admitted	Trust	162	165	167	172	176	178	173	149	131	115	62	
Median wait admitted	Trust	191	194	199	203	208	210	208	209	208	208	62	
Avg wait to first appt	Trust	63	64	64	65	67	68	70	71	73	77	79	
Cancelled appointments no stratification	Trust	68073	69073	74152	76686	79644	83069	92353	96094	99885	103622	n/a	
DNA rate	Trust	12.7%	13.5%	13.0%	14.9%	16.6%	16.9%	11.7%	12.7%	13.1%	13.1%	10.8%	
Face to Face DNA rate	Trust	12.3%	14.1%	13.4%	15.3%	17.4%	17.3%	11.7%	12.7%	13.1%	13.2%	10.9%	
Non Face to Face DNA rate	Trust	14.9%	8.6%	10.4%	11.5%	9.4%	13.1%	11.8%	12.8%	12.6%	12.6%	n/a	

Measure	Level	09-Aug-20	16-Aug-20	23-Aug-20	30-Aug-20	06-Sep-20	13-Sep-20	20-Sep-20	27-Sep-20	04-Oct-20	11-Oct-20	Corresponding 2019/20 week	Trend
New Outpatient Attendances	Trust	901	985	970	903	899	1078	1180	1425	1171	1225	2854	
	% of last year	34.3%	37.5%	38.4%	44.2%	34.5%	40.6%	42.1%	51.5%	43.1%	42.9%		
New Virtual Outpatient Attendances *(subset of New Outpatients Attendances figures above not additional)*	Trust	-	-	-	-	-	88	98	144	133	129	n/a	
Follow Up Outpatient Attendances	Trust	4010	4168	4561	4613	3833	4989	6009	6570	5054	5347	9759	
	% of last year	44.7%	46.5%	51.7%	59.8%	41.1%	52.5%	62.6%	65.7%	53.9%	54.8%		
Follow Up Virtual Outpatient Attendances *(subset of Follow Up Outpatients Attendances figures above not additional)*	Trust	-	-	-	-	-	549	523	634	406	450	n/a	
Elective Surgery	Trust	157	272	249	289	252	420	884	508	490	499	778	
	% of last year	21.5%	37.2%	39.6%	48.9%	35.0%	56.2%	118.8%	66.5%	70.2%	64.1%		
	% of Phase 3 Target*	30.7%	55.0%	56.6%	69.9%	43.7%	70.3%	148.5%	83.1%	87.8%	71.3%		
Elective Surgery - potential performance *(details contained within the Divisional Admin Pack)*	Non-discharged Admissions	n/a	n/a	n/a	n/a	11	8	20	52	42	28		
	Missed Admissions	n/a	n/a	n/a	n/a	30	33	29	14	56	35		
	Potential % of last year	n/a	n/a	n/a	n/a	40.6%	61.7%	125.4%	75.1%	84.2%	72.2%		
Elective Surgery LESS 25 AVE FOR DVH	Trust	157	272	249	289	252	420	884	508	490	499	753	
	% of last year	22.2%	39.9%	41.3%	51.1%	36.2%	58.2%	122.9%	68.7%	72.8%	66.3%		
	% of Phase 3 Target*	31.8%	57.1%	59.0%	72.9%	45.3%	72.7%	153.7%	85.9%	91.0%	82.8%		

* Phase 3 Targets

New Outpatients: August = 90% of last years activity; September onwards = 100%
Follow Up Outpatients: August = 90% of last years activity; September onwards = 100%
Elective patients: August = 70% of last years activity; September = 80%; October = 90%;November onwards = 100%

Moorfields Eye Hospital NHS Foundation Trust

NHS

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 10

Finance report

Board of directors 22 October 2020

Report title	Monthly Finance Performance Report Month 06 – September 2020
Report from	Jonathon Wilson, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

Since the NHS emergency response to COVID in March 2020, Operational planning nationally has been formally suspended. The Annual Plan and in-month plan values in this report represent the Trusts draft 2020/21 Financial Plan approved by the Trust Board and submitted to NHS Improvement on the 5th March 2020 with efficiency savings removed.

Please note therefore that variances to plan provide an indication only as to how income and expenditure patterns have changed.

For September the Trust is reporting :-

- **a deficit of £4.30m** prior to block payment support; (£50.14m deficit YTD)
- **a breakeven position** adjusting for block payment income support.

Compared to initial plans, the Trust is reporting:-

- **£6.53m less income** than would be expected, (£67.46m YTD) offset by
- **£0.25m less pay**, and
- **£0.99m less non pay** operating expenditure.

Financial Performance £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Budget	Actual	Variance
Income	£249.7m	£22.4m	£19.9m	(£2.4m)	£123.9m	£106.1m	(£17.7m)
Pay	(£138.8m)	(£11.5m)	(£11.2m)	£0.3m	(£69.2m)	(£62.4m)	£6.9m
Non Pay	(£102.4m)	(£8.8m)	(£7.8m)	£1.0m	(£53.1m)	(£38.9m)	£14.2m
Financing & Adjustments	(£9.4m)	(£0.8m)	(£0.8m)	(£0.0m)	(£4.7m)	(£4.9m)	(£0.1m)
CONTROL TOTAL	**(£0.8m)**	**£1.2m**	**£0.0m**	**(£1.2m)**	**(£3.2m)**	**£0.0m**	**£3.2m**

Efficiency scheme performance will remain unreported during the Covid-19 response period. Within the plan submitted to board these totalled £2.861m YTD.

Quality implications

Patient safety has been considered in the allocation of budgets.

Financial implications

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

Risk implications

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

Action Required/Recommendation

The board is asked to consider and discus the attached report.

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report
For the period ended 30th September 2020 (Month 06)

Presented by	Jonathan Wilson; Chief Financial Officer
Prepared by	Justin Betts; Deputy Chief Finance Officer Amit Patel; Head of Financial Management Lubna Dharssi, Head of Financial Control

Monthly Finance Performance Report

For the period ended 31st August 2020 (Month 05)

Key Messages

Statement of Comprehensive Income

Operational Planning	Since the NHS emergency response to COVID in March 2020, Operational planning nationally has been formally suspended. The Annual Plan and in-month plan values in this report represent the Trusts draft 2020/21 Financial Plan approved by the Trust Board and submitted to NHS Improvement on the 5th March 2020. Please note therefore that variances to plan provide an indication only as to how income and expenditure patterns have changed.
Financial Position £4.30m deficit pre support	For September the Trust is reporting :- • **a deficit of £4.30m** prior to block payment support (£50.14m YTD); • **a breakeven position** adjusting for block payment income support. Compared to initial plans, the Trust is reporting:- • **£6.53m less income** than would be expected; offset by • **£0.25m less pay**; and • **£0.99m less non pay** operating expenditure (£0.51m drugs).
Income £6.53m less than plan	Total Trust income is £6.53m less than would be expected, consisting of:- • Clinical activity income losses £5.77m; (£55.80m YTD) • Commercial income losses £0.39m; (£6.62m YTD) • Research income losses £0.04m; (£3.54m YTD) and • Other income losses of £0.32m (£1.50m YTD). Activity income, if reimbursed by normal contracting arrangements would total £11.39m compared to a plan of £17.39m - £5.77m adverse to plan.
Expenditure £1.24m less than plan (pay, non pay, excl financing)	Pay costs are £0.25m below plan, with bank and agency costs £0.54m (50%) less than 2019/20 average expenditure levels. Non-pay costs are £0.99m below plan mainly due to Drugs (£0.51m), Clinical Supplies (£0.29m).

Statement of Financial Position

Cash and Working Capital Position	The cash balance at the 30th September is £83.6m significantly higher than initially planned, primarily due to block income payments in advance, and top-up payments received by the Trust to ensure NHS organisation have sufficient cash to deal with the initial emergency COVID response.
Capital (both gross capital expenditure and CDEL)	Revised capital allocations for Trusts, and STP's were notified in May with a Trust funded limit of £13.7m for Moorfields. Current capital plans have been reviewed and amended in light of post COVID recovery and responses. Capital spend to September totalled £4.8m primarily linked to Oriel and purchases of new medical equipment.
Use of Resources	Current use of resources monitoring has been suspended.

Trust Financial Performance - Financial Dashboard Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	%	RAG
Income	£249.7m	£22.4m	£19.9m	(£2.4m)	£123.9m	£106.1m	(£17.7m)	(14)%	
Pay	(£138.8m)	(£11.5m)	(£11.2m)	£0.3m	(£69.2m)	(£62.4m)	£6.9m	10%	
Non Pay	(£102.4m)	(£8.8m)	(£7.8m)	£1.0m	(£53.1m)	(£38.9m)	£14.2m	27%	
Financing & Adjustments	(£9.4m)	(£0.8m)	(£0.8m)	(£0.0m)	(£4.7m)	(£4.9m)	(£0.1m)	(3)%	
CONTROL TOTAL	**(£0.8m)**	**£1.2m**	**£0.0m**	**(£1.2m)**	**(£3.2m)**	**£0.0m**	**£3.2m**	100%	
Memorandum Items									
Research & Development	(£2.18m)	(£0.18m)	(£0.16m)	£0.02m	(£1.08m)	(£4.72m)	(£3.64m)	(338)%	
Commercial Trading Units	£5.42m	£0.56m	£0.36m	(£0.20m)	£2.10m	(£1.45m)	(£3.54m)	(169)%	
ORIEL Revenue	(£2.45m)	(£0.24m)	(£0.13m)	£0.12m	(£1.05m)	(£0.46m)	£0.59m	56%	

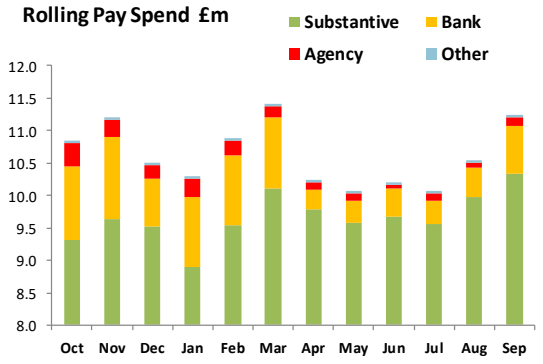
INCOME BREAKDOWN RELATED TO ACTIVITY

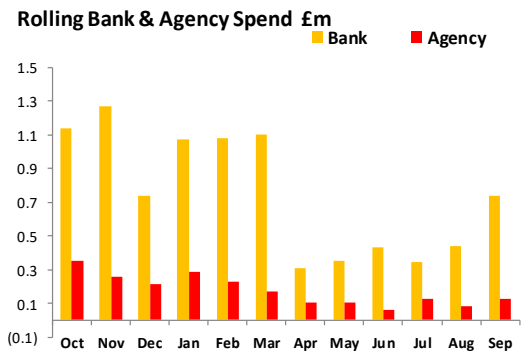
Income Breakdown £m	Annual Plan	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£145.5m	£72.3m	£25.2m	(£46.8m)		-	-	-
Pass Through	£38.9m	£19.6m	£13.4m	(£6.2m)		-	-	-
Other NHS Clinical Income	£9.8m	£4.9m	£2.0m	(£2.8m)		-	-	-
Commercial Trading Units	£34.0m	£16.0m	£9.4m	(£6.6m)		-	-	-
Research & Development	£12.0m	£6.2m	£2.7m	(£3.5m)		-	-	-
Other	£8.7m	£4.4m	£3.3m	(£1.5m)		-	-	-
INCOME PRE TOP-UP	**£248.8m**	**£123.4m**	**£56.0m**	**(£67.5m)**		**-**	**-**	**-**
FRF/Block Payment Top Up	£0.8m	£0.4m	£50.1m	£49.7m		-	-	-
TOTAL OPERATING REVENUE	**£249.7m**	**£123.9m**	**£106.1m**	**(£17.7m)**		**-**	**-**	**-**

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

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	% Total
Employed	(£136.5m)	(£11.3m)	(£10.3m)	£0.96m	(£68.1m)	(£58.9m)	£9.14m	94%
Bank	(£1.8m)	(£0.2m)	(£0.7m)	(£0.58m)	(£0.9m)	(£2.6m)	(£1.69m)	4%
Agency	£0.0m	£0.0m	(£0.1m)	(£0.13m)	£0.0m	(£0.6m)	(£0.61m)	1%
Other	(£0.5m)	(£0.0m)	(£0.0m)	£0.00m	(£0.2m)	(£0.2m)	£0.01m	0%
TOTAL PAY	**(£138.8m)**	**(£11.5m)**	**(£11.2m)**	**£0.25m**	**(£69.2m)**	**(£62.4m)**	**£6.86m**	





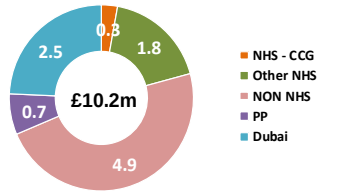
CASH, CAPITAL AND OTHER KPI'S

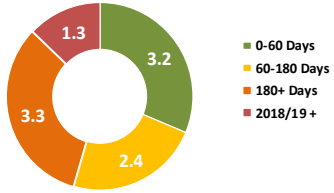
Capital Programme £m	Annual Plan	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Budget	Forecast Actual	Forecast Variance
Trust Funded	(£13.7m)	(£4.6m)	(£4.7m)	£0.2m		-	-	-
Donated/Externally funded	(£1.4m)	(£0.0m)	(£0.1m)	£0.1m		-	-	-
TOTAL	**£15.1m**	**£4.6m**	**£4.8m**	**£0.2m**		**-**	**-**	**-**

Key Metrics	Plan	Actual	RAG
Cash	35.5	83.6	
Debtor Days	45	28	
Creditor Days	45	50	
PP Debtor Days	65	53	

Use of Resources	Plan	Actual
Capital service cover rating	-	-
Liquidity rating	-	-
I&E margin rating	-	-
I&E margin: distance from fin. plan	-	-
Agency rating	-	-
OVERALL RATING	**-**	**-**

Net Receivables/Ageing £m





Trust Income & Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	In Month %	In Month RAG	Year to Date Plan	Year to Date Actual	Year to Date Variance	Year to Date %	Year to Date RAG
Income											
NHS Commissioned Clinical Income	184.39	16.53	10.87	(5.44)	(33)%		91.94	38.56	(52.96)	58%	
Other NHS Clinical Income	9.80	0.86	0.52	(0.33)	(39)%		4.86	2.02	(2.84)	58%	
Commercial Trading Units	34.01	3.03	2.64	(0.39)	(13)%		16.02	9.41	(6.62)	(41)%	
Research & Development	11.95	1.05	1.00	(0.04)	(4)%		6.23	2.69	(3.54)	57%	
Other Income	8.69	0.69	0.58	(0.32)	(46)%		4.39	3.30	(1.50)	34%	
Total Income	**248.85**	**22.15**	**15.63**	**(6.53)**	(29)%		**123.44**	**55.98**	**(67.46)**	**55%**	
Operating Expenses											
Pay	(138.80)	(11.49)	(11.24)	0.25	2%		(69.21)	(62.36)	6.86	10%	
Drugs	(36.38)	(3.45)	(2.94)	0.51	15%		(18.31)	(12.41)	5.90	32%	
Clinical Supplies	(21.92)	(1.96)	(1.67)	0.29	15%		(10.87)	(5.95)	4.92	45%	
Other Non Pay	(44.06)	(3.42)	(3.24)	0.19	5%		(23.91)	(20.53)	3.37	14%	
Total Operating Expenditure	**(241.17)**	**(20.32)**	**(19.09)**	**1.24**	6%		**(122.30)**	**(101.25)**	**21.05**	17%	
EBITDA	*7.68*	*1.83*	*(3.46)*	*(5.29)*	(289)%		*1.13*	*(45.27)*	*(46.41)*	*4,092%*	
Financing & Depreciation	(10.04)	(0.87)	(0.89)	(0.02)	(2)%		(5.06)	(5.15)	(0.09)	(2)%	
Donated assets/impairment adjustments	0.68	0.06	0.05	(0.01)	(15)%		0.34	0.29	(0.05)	15%	
Control Total Surplus/(Deficit) Pre FRF/Top Up Payments	**(1.67)**	**1.02**	**(4.30)**	**(5.32)**	(523)%		**(3.59)**	**(50.14)**	**(46.55)**	(1,296)%	
Provider PSF/FRF	0.84	0.21	-	(0.21)	(100)%		0.42	-	(0.42)	100%	
Covid Block Payments Received	-	-	4.25	4.25	0%		-	52.23	52.23	0%	
Covid Top Up Payments	-	-	0.05	0.05	0%		-	(2.09)	(2.09)	0%	
Post PSF/FRF Control Total Surplus/(Deficit)	**(0.84)**	**1.23**	**-**	**(1.23)**			**(3.17)**	**-**	**3.17**		

Commentary

Operating Income

£6.53m below plan pre support

The trust received block income payments during September based on an average of 2019/20 income levels to offset anticipated lower activity levels, and potentially greater costs during the emergency COVID response.

Clinical activity levels recorded were 33% lower than would normally have been expected during September If the Trust was reimbursed under activity-based contracting arrangements, this income would have totalled £11.40m - £5.78m lower than plan.

In addition to the above, trust income losses included Commercial Trading income (£0.33m lower than plan), Research (£0.04m adverse), and Other Income adverse to plan by £0.32m partly linked to confirmation received not to invoice national Clinical Excellence Awards.

This was compensated for via 'block' payments received, shown at the bottom of the table to the left, with organisations reporting break-even positions.

Employee Expenses

£0.25m below plan

Total pay costs were £0.25m below plan, with bank and agency costs £0.54m (50%) less than 2019/20 average expenditure levels.

During September Medical pay award arrears were paid totalling £0.29m. There were increase in the use of bank staff across all staff groups in clinical areas as activity increased. There were also additional staffing requirements due to weekend working, social distancing, additional sessions, ward layout changes, and additional Administration staff were also required to reduce patient booking backlogs.

Non Pay Expenses

£0.99m below plan

(non pay and financing)

Non pay costs are £0.99m below plan mainly due to reduced Drugs (£0.51m), Clinical Supplies (£0.29m) spend, whilst other expenditure underspent by £0.19m. These variances were all linked to reduced activity levels against the plan. However, there was a significant increase in expenditure on prior months.

Cost improvement saving reporting is currently suspended during the COVID response.

Trust Patient Clinical Income Performance

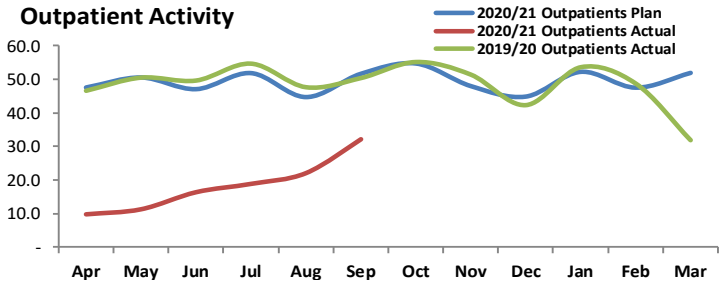
PATIENT ACTIVITY AND CLINICAL INCOME

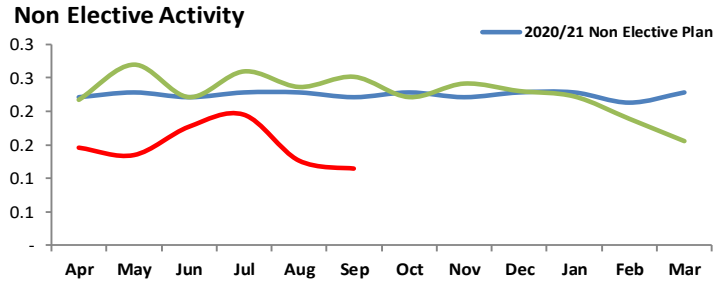
Point of Delivery	Activity In Month				Activity YTD				YTD Income £'000			
	Plan	Actual	Variance	%	Plan	Actual	Variance	%	Plan	Actual	Variance	%
AandE	8,935	5,749	(3,186)	64%	53,869	31,011	(22,858)	58%	£8,401	£4,535	(£3,866)	54%
Daycase / Inpatients	3,372	2,556	(816)	76%	18,850	5,001	(13,849)	27%	£21,049	£6,300	(£14,749)	30%
High Cost Drugs	4,948	4,327	(621)	87%	27,661	20,044	(7,617)	72%	£18,060	£13,408	(£4,653)	74%
Non Elective	247	115	(132)	47%	1,507	895	(612)	59%	£2,945	£1,742	(£1,204)	59%
OP Firsts	11,915	4,832	(7,083)	41%	66,614	18,122	(48,492)	27%	£11,450	£3,121	(£8,329)	27%
OP Follow Ups	43,326	27,393	(15,933)	63%	242,230	92,860	(149,370)	38%	£24,952	£8,404	(£16,548)	34%
Other NHS clinical income									£2,129	£386	(£1,743)	18%
Total	72,743	44,972	(27,771)	63%	410,731	167,933	(242,798)	38%	£88,986	£37,895	(£51,091)	43%

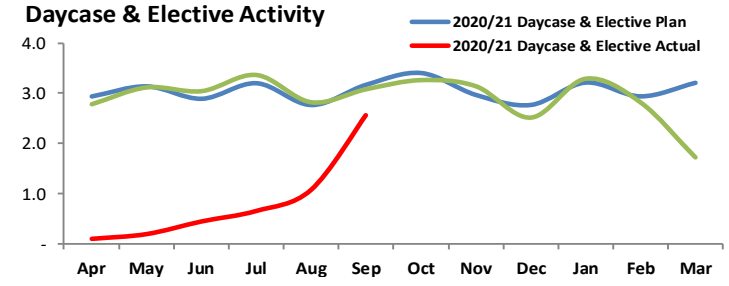
Income Figures Excludes CQUIN, Bedford, and Trust to Trust test income.

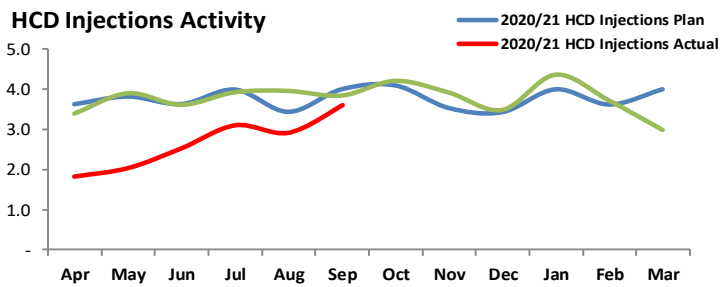
RAG Ratings Red to Green colour gradient determined by where each percentage falls within the range

ACTIVITY TREND









Commentary

NHS Income

Activity levels recorded during September was 37% below the 2020/21 activity plan levels (prior month: 50%).

Please note this is a different metric to NHSI's assessment of performance for Pre-COVID activity levels based on prior year activity levels.

The charts to the left demonstrate the in year activity levels compared to previous years highlighting the material shift in activity as a result of COVID, and the pace of recovery towards pre-COVID activity levels.

NHS Patient Clinical activity income in September was £10.7m if reimbursed via activity based contracting arrangements £5m less than planned prior to top-up income shown on slide four.

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

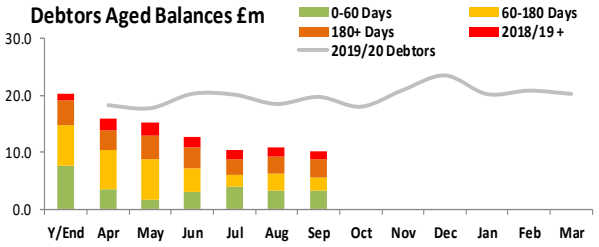
CAPITAL EXPENDITURE

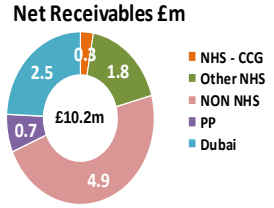
Capital Expenditure £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Plan	Actual	Variance
Estates - Trust Funded	1.6	0.2	0.2	(0.0)	1.0	0.6	(0.4)
Medical Equipment - Trust Funded	3.3	0.3	0.1	(0.2)	0.9	1.5	0.7
IT - Trust Funded	1.3	0.2	0.1	(0.2)	0.5	0.3	(0.1)
ORIEL - Trust Funded	5.8	0.2	0.1	(0.0)	2.0	1.9	(0.1)
Dubai - Trust funded	0.5	0.0	0.0	(0.0)	0.2	0.2	0.0
Other - Trust funded	1.3	0.0	-	(0.0)	0.0	0.1	0.1
TOTAL - TRUST FUNDED	**13.7**	**1.0**	**0.5**	**(0.5)**	**4.6**	**4.7**	**0.2**
Donated/Externally funded	1.4	-	0.0	0.0	0.0	0.1	0.1
TOTAL INCLUDING DONATED	**15.1**	**1.0**	**0.5**	**(0.4)**	**4.6**	**4.8**	**0.2**

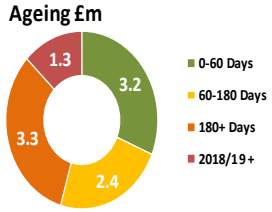
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Planned Total Depreciation	8.0	8.0		100%
Cash Reserves - B/Fwd cash	7.6	7.6		100%
Capital investment loan funding (approved)				0%
Cash Reserves - Other (PSF)				0%
Capital Loan Repayments	(1.8)	(1.8)		100%
TOTAL - TRUST FUNDED	**13.7**	**13.7**	**-**	**100%**
Donated/Externally funded	1.4	1.4		100%
TOTAL INCLUDING DONATE	**15.1**	**15.1**	**-**	**100%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2018/19 +*	*Total*
CCG Debt	-	(0.0)	0.2	0.1	0.3
Other NHS Debt	0.3	0.3	0.8	0.4	1.8
Non NHS Debt	1.5	1.5	1.7	0.3	4.9
Commercial Unit Debt	1.4	0.6	0.7	0.4	3.2
TOTAL RECEIVABLES	**3.2**	**2.4**	**3.3**	**1.3**	**10.2**







STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date		
		Plan	Actual	Variance
Non-current assets	108.2	99.9	96.7	(3.2)
Current assets (excl Cash)	20.4	21.4	18.1	(3.2)
Cash and cash equivalents	29.3	35.5	83.6	48.1
Current liabilities	(34.5)	(35.4)	(71.2)	(35.8)
Non-current liabilities	(35.4)	(35.3)	(37.2)	(1.9)
TOTAL ASSETS EMPLOYED	**88.1**	**86.0**	**90.0**	**4.0**

OTHER METRICS

Use of Resources	Weighting	Plan YTD	Score
Capital service cover rating	20%	-	-
Liquidity rating	20%	-	-
I&E margin rating	20%	-	-
I&E margin: distance from financial	20%	-	-
Agency rating	20%	-	-
OVERALL RATING		**-**	**-**

Commentary

Cash and Working Capital

The cash balance as at the 30th September is £83.6m, significantly higher than initially planned, largely due to block income and top-up payments in advance received by the Trust. It is to be noted that both cash balances and current liabilities have increased by £18m over plan due to cash having been received in advance.

Capital Expenditure

Revised capital allocations for Trusts, and STP's were notified in May with a limit £13.7m for the Trust.

Capital spend to September totalled £4.8m primarily linked to Oriel and purchase of new medical equipment.

Use of Resources

Use of resources monitoring and reporting has been suspended.

Receivables

Receivables have reduced by £10.0m since the end of the 2019/20 financial year to £10.2m A reduction of £0.6m was recorded in September from the August position.

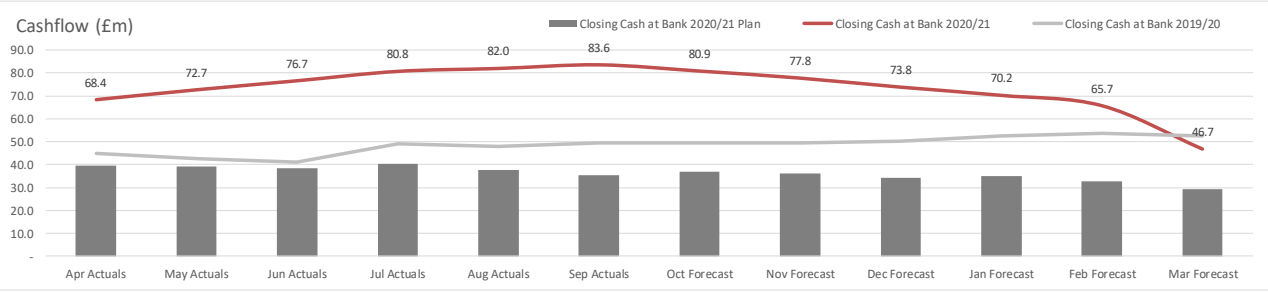
Payables

Payables totalled £10.6m at the end of September, a reduction of £5.2m since March 2020. The reduction is partly due to the Trust adopting the new Prompt Payment guidance issued to NHS bodies and a reduction in operating expenses.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Actuals	Aug Actuals	Sep Actuals	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Sep Plan	Sep Var
Opening Cash at Bank	**52.4**	**68.4**	**72.7**	**76.7**	**80.8**	**82.0**	**83.6**	**80.9**	**77.8**	**73.8**	**70.2**	**65.7**	**52.4**		
Cash Inflows															
Healthcare Contracts	33.3	15.2	15.2	15.2	15.2	15.1	14.8	14.5	14.8	14.8	14.8	-	182.5	15.2	(0.0)
Other NHS	3.9	2.6	1.6	1.9	0.5	1.2	1.5	1.4	1.4	1.4	1.4	1.5	20.3	1.5	(0.3)
Moorfields Private/Dubai	1.4	0.9	1.6	2.6	2.8	3.3	2.9	2.8	2.6	2.7	2.7	3.0	29.3	2.8	0.5
Research	1.1	0.6	1.0	2.7	0.8	1.1	1.0	1.0	1.0	1.0	1.0	1.0	13.0	0.5	0.6
VAT	0.4	0.5	0.2	-	0.5	-	0.4	0.4	0.4	0.4	0.4	-	3.6	0.4	(0.4)
PDC	-	-	-	0.3	-	-	-	-	-	-	-	0.4	0.8	-	-
PSF	-	0.2	-	-	-	-	-	-	-	-	-	-	0.2	-	-
Other Inflows	0.2	1.8	0.4	0.4	0.3	0.4	0.3	0.3	0.3	0.3	0.3	0.4	5.6	0.3	0.1
Total Cash Inflows	**40.3**	**21.8**	**19.9**	**23.1**	**20.1**	**21.1**	**20.8**	**20.4**	**20.4**	**20.6**	**20.5**	**6.3**	**255.3**	**20.6**	**0.5**
Cash Outflows															
Salaries, Wages, Tax & NI	(9.6)	(9.6)	(9.4)	(9.4)	(9.4)	(9.6)	(9.7)	(9.7)	(9.7)	(9.7)	(9.7)	(9.7)	(114.9)	(10.2)	0.5
Non Pay Expenditure	(10.6)	(6.7)	(5.4)	(8.1)	(7.3)	(7.8)	(10.6)	(11.1)	(11.1)	(11.1)	(11.4)	(10.9)	(112.0)	(10.5)	2.7
Capital Expenditure	(1.0)	(0.4)	(0.4)	(0.6)	(0.5)	(0.2)	(0.2)	(0.2)	(0.6)	(0.4)	(0.5)	(0.9)	(6.0)	(0.6)	0.4
Oriel	(2.3)	(0.1)	(0.1)	(0.2)	(0.2)	(0.3)	(1.4)	(1.4)	(2.0)	(1.8)	(1.7)	(1.3)	(12.9)	(1.1)	0.8
Moorfields Private/Dubai	(0.9)	(0.7)	(0.8)	(0.6)	(0.7)	(0.8)	(0.9)	(1.1)	(1.1)	(1.2)	(1.1)	(1.1)	(10.9)	(0.8)	(0.0)
Financing - Loan repayments	-	-		-	(0.7)	(0.8)	-	-	-	-	(0.6)	(0.8)	(2.9)	(0.8)	-
Dividend and Interest Payable				-			(0.7)	-	-	-	-	(0.7)	(1.4)	(0.7)	0.7
Total Cash Outflows	(24.4)	(17.5)	(16.0)	(19.0)	(18.8)	(19.5)	(23.5)	(23.4)	(24.4)	(24.2)	(25.1)	(25.3)	**(261.0)**	(24.7)	5.2
Net Cash inflows /(Outflows)	15.9	4.3	4.0	4.1	1.3	1.6	(2.7)	(3.1)	(4.0)	(3.6)	(4.5)	(19.0)	-	(4.0)	5.6
Closing Cash at Bank 2020/21	**68.4**	**72.7**	**76.7**	**80.8**	**82.0**	**83.6**	**80.9**	**77.8**	**73.8**	**70.2**	**65.7**	**46.7**	**46.7**		
Closing Cash at Bank 2020/21 Plan	39.5	39.1	38.6	40.4	37.7	35.5	36.8	36.2	34.4	34.8	32.8	29.3	29.3		
Closing Cash at Bank 2019/20	45.1	42.6	41.0	48.9	47.8	49.6	49.6	49.5	50.3	52.6	53.8	52.4	52.4		



Commentary

Cash flow

The cash balance at the 30th September is £83.6m, significantly higher than initially planned.

The interim financial regime introduced to support NHS organisations during the CVOID response has contributed to significantly higher cash balances than previously planned, designed to ensure sufficient cash is available to the NHS to implement any required changes. The Trust currently has 126 days (prior month: 124 days) of operating cash.

As a result the Trust has an additional focus towards liquidity and working capital management to ensure sufficient cash is available to respond to emergency demand for supplies, staff, and suppliers payments.

In addition all NHS organisation received additional guidance on Prompt Payment to suppliers of the NHS, to ensure their cash flows are supported wherever possible.

September saw a cash inflow of £1.6m against a plan of a £4.0m outflow as non pay spend continues to be lower than forecast.

Moorfields Eye Hospital NHS Foundation Trust

NHS

NCL Provider Alliance

Headline proposal and early Moorfields commentary for discussion

October Board 2020

Summary: Proposal for NCL Provider alliance

All NHS provider Boards working in North Central London (NCL) are invited to consider whether they wish to join the North Central London Provider Alliance as a Member from 1st November 2020

Membership of the NCL Provider Alliance requires:

- Signing up to the Provider Alliance Charter
- Active participation in the NCL Provider Alliance and commitment to supporting the creation and delivery of the agenda for the first 12 months. We would encourage appointment of a liaison from the Executive to the Provider Alliance 'working group'

A proposed process for the appointment of a Chair and two Vice Chairs of the NCL Provider Alliance is set out (and views on this are requested at the Partnership Board).

Moorfields commentary:

- We cover many integrated care systems and could be asked to join many of these, geographically, and at a specialty / specialty level.
- As a smaller provider organisation resourcing to support the PA may be a concern.

NCL Integrated Care System: context and structure

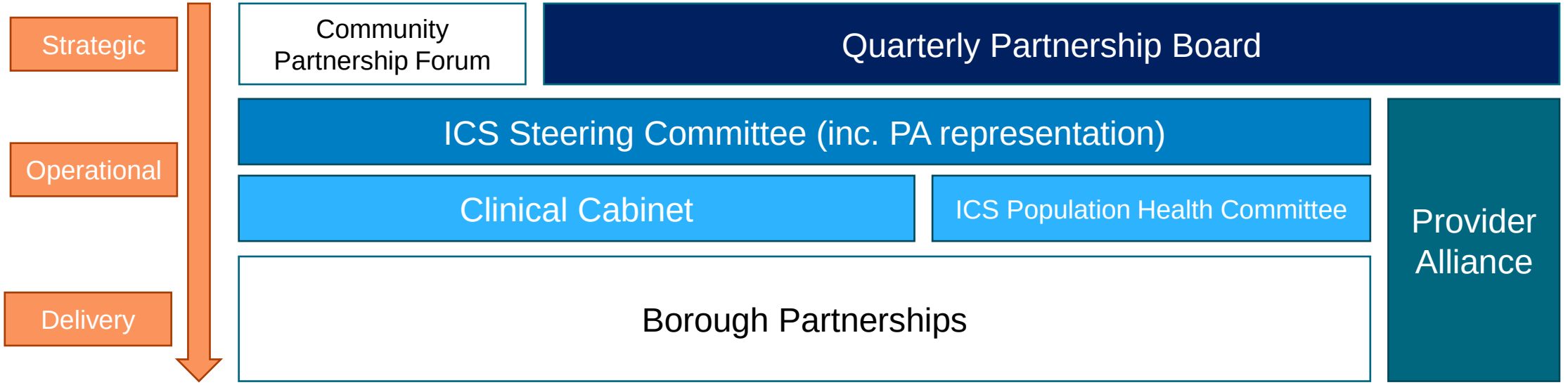
The immediate constituent members of the broad partnership that is the ICS are:

Borough councils; the CCG; primary care providers (including primary care networks); voluntary and community service groups; independent care sector providers; NHS providers as individual organisation as well as collaborating through a Provider Alliance.

From January 2021 the broad ICS structure is likely to include:

Moorfields commentary:

No specific commentary on this.



NCL Provider Alliance

Proposed to be:

- A membership organisation
- Creating synergy between providers, so they can achieve more than if they acted alone
- Focused on value = healthy life expectancy / costs
- Clear academic and research focus, exploring a possible link with UCL (badging the PA as UCL Health and Care Partnership is floated)
- The proposal is aware of opportunities for whole pathways but sees the proposal as secondary care in the first instance.

Moorfields commentary:

- The minimum requirements of membership are not yet clear – in terms of cost, commitment, participation and exit.
- The existing UCLP is seen as taking forward the research and academic agenda; the PA proposal seems to want to bring a lot of existing architecture together in a coherent whole – a risk is that it adds to and confuses the landscape rather than streamlining and clarifying it.
- Without primary and social care the proposal might be slightly limited (though for understandable reasons). Our current links with primary care optometry could be seen as comparatively advanced and there could be mileage for us here – i.e. showcase our optometry interface work as a quick win for the alliance.

Charter

Principle of decision by consensus

<u>Purpose and Scope</u>

- **Governing objective:** we exist to improve health value (healthy life expectancy/costs) for the population we collectively serve; we do this by improving the quality and reducing the cost of health services above and beyond what can be achieved by partners working on their own

- **Tri-partite mission:** our scope will cover health services, education and research.

- **Total system and total person perspective:** we consider whole pathways from prevention through to complex tertiary treatment, and both physical and mental health needs. We will commit to playing our part in taking actions to help deliver the wider population health management ambitions.

Moorfields commentary

Population health is much talked about in health policy circles, but it is difficult to give it effect. What could Moorfields do as part of its strategy refresh around population health management, that might also link into PA work? How does this fit with our existing strategy?

Approach

1. **Delivery at pace**
2. **Collaboration as the default:** we will only ‘opt out’ where an existing binding contract precludes us from participation
3. **Devolution**: we will be biased towards devolving delivery accountability to individual partners to act on behalf of the overall partnership
4. **Sovereignty**: all partner boards will remain sovereign and will delegate authority for collective decision making to the provider alliance for an agreed agenda of shared initiatives
5. **Mutual support**: we will expect each partner to act on behalf of the system/resident and taxpayer interest even when that is not in individual institutional benefit, but the quid pro quo is that we will strive to “keep each other whole”/we will work to ensure no partner fails
6. **No duplication and shared resources**: ICS-HQ workstreams and Provider Alliance-delivery work should be stepped-up and stepped-down in lockstep –we will avoid duplication and be clear about accountability. We should seek to share resources across partner organisations to enable health services, education and research to be focused on the population we serve. A number of people will have different roles / ‘wear different hats’ and we will use this to be as efficient as possible.
7. **Embedded with the system team:** Same set of people in the room wherever we can (transparency between ICS HQ and Provider Alliance Board for example)
8. **Data and analysis**: we will make data-driven decisions and monitor our performance.
9. **Honest and transparent**: we do difficult things, we talk about difficult things, we are direct and transparent with each other
10. **Learning system**: we have an ethos of ‘continuous improvement’ adopting a QI approach. Innovation and the spreading of proven best practice will be key.

Moorfields commentary

- Real examples would be helpful here to bring theory to life and evaluate properly.
- The approach to leadership of systems and organisations is likely to be a recurring tension. This would be important to clarify as we move forward.

Focus

Clinical Support Services
Pathology – how to digitise at pace; Decontamination; Diagnostic hubs; Pharmacy; A sector wide approach to quality improvement

Clinical Services
- Start with post Covid lead provider work led by ICS and used Alliance as delivery vehicle
- Pick one or two specific topics e.g., Community Discharge, or patients living with long-term conditions
- Establish an optimal model for mental health service delivery
- Establish an optimal model for community health care service delivery
- Deeper integration between all parts of health and social care to improve patient pathways

Research and Education
- Education key to 'sustainable' workforce development and joined up working
- Research recognised as a NCL differentiator
- Research and development opportunities

Corporate Services
- Consolidation of corporate services where appropriate e.g., a subset of finance processes, procurement
- Workforce innovation, work to improve recruitment and retention e.g., building on the capital nurse programme
- Data and analytics, digital, IT to enable 'joined up' patient data for providers to access and use for residents and patients' benefit and in time a patient/resident 'digital passport'. In addition will help with being able to agree and track patient/resident/service user benefits in any actions we take
- Estates and facilities management
- Commercial capabilities
- ICS Corporate Services work to 'shift home' and be delivered through the Provider Alliance starting with Occupational Health and transactional HR services

Moorfields commentary

The document says that this list will be prioritised so that quick progress can be made in year one.

It will also cover commercial and income generating activities. It is not clear what the common agenda is here

An opportunity to take forward diagnostic hubs at system level and ensure they are effective and efficient.

Concerns and clarifications

- The difference between the ICS and PA
- Meeting overload and duplication
- Putting data and evidence at the heart of decisions
- The relationship with NCL Gold meetings
- Exclusion of primary and social care
- Concerns about adding another layer of decision making and reporting (the PA “is not a structure, it is a set of processes and behaviours”).
- Is the PA centralising how we work?
- What is the structure of the PA
- Governance: who is accountable for what?
- Can I belong to more than one PA?
- How does membership work
- How will work be prioritised
- How will it be resourced?

Moorfields commentary

- The questions highlighted opposite show that people’s concerns (or desire for more detail) relate to governance, decision making and additional structures and processes.

Next Steps

- Agreeing the agenda
- Working out how to design inclusive and efficient decision making
- Appointing a chair and two vice chairs (process led by Mike Cooke and an independent panel of 3)

- Do we want to put ophthalmology on the agenda as a possible year one priority?

Proposal for a North Central London Health and Care Provider Alliance for Consideration by Boards

Mike Cooke
Independent Chair North Central London Integrated Care System
October 2020

Executive Summary

- All NHS Provider Boards working in North Central London (NCL) are invited to consider whether they wish to join the North Central London Provider Alliance as a Member from 1st November 2020
    - Membership of the NCL Provider Alliance requires:
        - Signing up to the Provider Alliance Charter
        - Active participation in the NCL Provider Alliance and commitment to supporting the creation and delivery of the agenda for the first 12 months. We would encourage appointment of a liaison from the Executive to the Provider Alliance 'working group'

Introduction

Extensive discussions have taken place over the past four to five months about the establishment of a Provider Alliance for North Central London. These have included informal discussions with the Boards as well as various individual discussions with chairs and chief executives and with strategy directors of most trusts. These discussions have directly shaped the proposal that is now in this report.

The informal feedback about the emerging proposal for a Provider Alliance has been very supportive in most cases. During the extensive engagement process there were a number of questions and queries raised, some of which were answered in the moment and some of which are responded to in this report. However it is important to emphasise that not everything can be answered immediately and, arguably, nor should it be: it is preferable for the Alliance to be formed and to work through various details in the course of the first year.

The report begins by responding to one of the most crucial points raised during the engagement discussions, namely how the Provider Alliance fits with the Integrated Care System (ICS). It then summarises the purpose of the Provider Alliance, before setting out a proposed charter and way of it commencing.

The NCL Integrated Care System

The NHS Long Term Plan envisaged a "new service model" for the NHS for the 21st Century. It was set out that this would involve boosting out of hospital care, reducing pressure on emergency hospital services, giving people more control over their own health and more personalised care when they need it, delivering digitally enabled primary and outpatient care and moving to an increased focus on population health with Integrated Care Systems (ICS) everywhere.

The purpose of any ICS is to create a collaborative process of local leadership in order to achieve the delivery of a more joined up system of health and care, centred around

the residents/patients. At the same time, at the heart of any ICS is the aim of improving the health of the population and this puts front and centre of our work, the imperative of addressing the profound and unacceptable health inequalities that exist in North Central London. In order to achieve this we need to bring to bear the whole range of 'levers' of change including the essential wider determinants of health that local councils bring to bear (such as housing, education and learning, employment, green spaces, leisure facilities) and the wider support from strong communities that is so vital to living well and independently.

An articulation of the purpose of an ICS is being developed across London as: "improving health and care outcomes and reducing health and care inequalities for the local population on a sustainable basis, both environmentally and economically."

Our local executive leadership team are developing an outcomes framework that will bring some more NCL specific statements of ambition: they are using as a key framework: "start well; live well; age well; and work well". This mirrors the discussion that the emergent NCL Partnership Board has had which has emphasised the importance of focussing on children and young people.

What this means in practice involves us working together to make major inroads into, for example: the fact that men in some parts of NCL will have a life expectancy 12 years less than men of the same age in another part of our area; the still unacceptably high levels of childhood obesity; the high levels of addiction and dependence in our communities; the relatively poor general health outcomes for people with mental illness.

The immediate constituent members of the broad partnership that is the ICS are:
- borough councils.
- the CCG.
- primary care providers including primary care networks.
- Voluntary and community service groups.
- Independent care sector providers.
- NHS providers as individual organisations as well as collaborating through a Provider Alliance.

Over time we would want to broaden the partnership so that a wide range of organisations, such as schools, colleges and universities as well as employers, are all working to improve health and well being of the populations we collectively serve.

The ICS provides direction for existing delivery organisations and vehicles and is a way of partners working together to ensure that the whole system is working effectively to achieve our aims and ambitions. It will therefore take a wide, strategic, and long term view.

During discussions about the Provider Alliance there has been concern expressed about the overlap of meetings and the risk of too many taking place. That alone would be a strong reason for clarifying the ICS governance and meeting arrangements for the next phase of its development. In addition, it will also be expected that we maintain oversight of the whole system to ensure learning and improvements to performance and sound financial management. This is a further reason for ensuring that we

develop our ICS governance so that it is transparent, participative, yet efficient, and ready to take on these roles.

I am therefore proposing that from January 2021 the arrangements will be as follows:

- **Borough partnerships** will continue to be a primary focus for the integration of services and for local partnership working to address local population health priorities identified by local Health and Wellbeing Boards. By definition, borough partnerships are delivery focused.
- A **quarterly Partnership Board** (of all NHS trust Chairs, CCG Chair, Primary Care representative and representatives of the local authority leaders) which will be accountable for setting the overall strategy and overseeing and supporting its delivery.
- A **quarterly Community Partnership Forum** to discuss and aid the development of the design of strategies and services including by enabling resident involvement.
- An **ICS Steering Committee** (to meet 9 times a year) to steer the successful integration and development of services and the system including the system work programme (suggested membership: Independent Chair; System Lead; Accountable Officer ; CCG Chair; LA Leader and Chief Executive; Provider Alliance x 4 chairs and x 2 Chief Executives; Primary Care representative).
- The **Clinical Cabinet** to continue.
- The establishment of an **ICS Population Health Committee** to support our collective work on health inequalities (with the option of establishing other specialist or task and finish committees as needed).

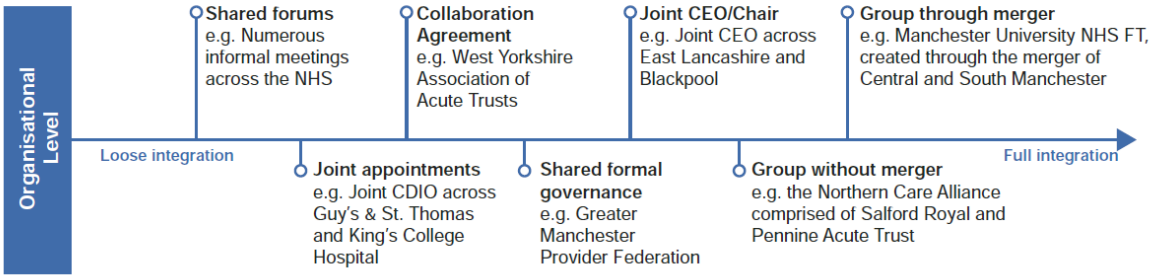
Whilst these ICS governance proposals do not form part of the proposal for a Provider Alliance, they are set out here to provide vital context and in response to the discussions which have been taking place.

Proposal for a Provider Alliance in NCL

The concept of a provider alliance is not new. The Dalton Review in 2014 highlighted the issue of variation across the NHS and suggested this would only be addressed through provider collaboration in the NHS. There have been various attempts at bilateral alliances within NCL over the years, to varying degrees of success. What has changed is the fact that the global pandemic and the national emergency brought about by Covid-19 has accelerated provider collaboration across NCL and shown the power of deep, joint working across providers. However it was the ‘common enemy’ of the pandemic that brought organisations together in away that we have not seen before. The challenge is how to build this into a sustainable collaboration that stands the test of time and enables a strategic approach to be taken.

There are a range of different possible approaches to provider collaboration: the Kings Fund describe some of them in the following diagram:

Figure 2: Spectrum of organisational level collaboration



Across London, various approaches are emerging but the trend appears to be for different alliances between acute hospitals, between mental health providers and between specialist providers.

Local context is always important and it is considered that for NCL we need a bespoke approach that brings together as many NHS providers as possible in the first instance to deliver collaboration and ensure synergies between acute, mental health community and specialist providers. The linkages between physical and mental health and between hospital and community settings need to improve significantly and a holistic provider alliance will be an aid to this.

The purpose of the NCL Provider Alliance is to create a membership organisation where members work together to improve health value (healthy life expectancy/costs) for the population we collectively serve; by improving the quality and reducing costs of health services (for patients/service users, residents, and staff) above and beyond what each member organisation could achieve working on its own. The scope will cover health services, education and research. The focus will be on both physical and mental health needs and considering whole pathways, working with other partners, from prevention through to complex tertiary treatment to address health inequality and access to treatment and care. The focus will be on delivery.

We have some world class health care currently and we know that research and innovation is key to our journey of continuous improvement. It is proposed that the Provider Alliance is underpinned by strong research and academic underpinnings. We are blessed with strong research and education capabilities within North Central London. A number of providers are members of UCLP and it is intended that UCLP play a key role in supporting the research ambitions. At the same time it makes sense for us also to explore potential linkages with University College London given its considerable capability. Indeed badging the Provider Alliance as a UCL Health and Care Partnership would signal our intent and leverage the strength of UCL's brand and reputation and our intended ambition to be bold in the actions we take as a membership organisation to improve the health of the populations we serve.

Linkages to and relationships with primary care, social care, local care networks and the voluntary sector will be critically important to be able to take a whole pathway and system based approach to the delivery of services. We will work in the first instance to ensure we collaborate with primary care and social care on specific topics, for example community discharge services, mental health services for young people, or orthopaedic services across the NCL population. Alongside this the Provider Alliance

would remain open to social care and primary care providers to join if they wished to do so, and we recognise that this is likely to emerge over time.

All partner boards would remain sovereign and would delegate authority for collective decision-making to the provider alliance only for those shared initiatives and activities with resident or taxpayer benefit across more than one borough. It is currently proposed that the provider alliance would be run on a devolved partnership model with partner trusts able to opt-in to shared initiatives and activities and seeking devolved accountability to partners wherever possible.

Provider Alliance Charter

During the feedback from across the system gathered during July - September 2020 it became clear that an organic approach to the development of the Provider Alliance would be preferred. Rather than try and resolve all the issues and answer all questions now, it was recognised that starting soon and learning by working together would be important. The provider alliance is expected to make key decisions by consensus and will need to agree a procedure for resolving any differences during its inception phase. Feedback from the engagement that has been taking place is that agreeing a Charter to articulate the principles that will underpin how it operates would be a great help.The principles that have emerged from discussions are as follows:

Purpose and Scope

- **Governing objective:** we exist to improve health value (healthy life expectancy/costs) for the population we collectively serve; we do this by improving the quality and reducing the cost of health services above and beyond what can be achieved by partners working on their own

- **Tri-partite mission:** our scope will cover health services, education and research.

- **Total system and total person perspective:** we consider whole pathways from prevention through to complex tertiary treatment, and both physical and mental health needs. We will commit to playing our part in taking actions to help delivier the wider population health management ambitions.

Our approach

1. **Delivery at pace**: the ethos of the partnership will be to deliver results and prove itself by getting things done, and fix things as we go to deliver patient/service user, staff and tax payer benefits
2. **Collaboration as the default:** we will only ‘opt out’ where an existing binding contract precludes us from participation
3. **Devolution**: we will be biased towards devolving delivery accountability to individual partners to act on behalf of the overall partnership
4. **Sovereignty**: all partner boards will remain sovereign and will delegate authority for collective decision making to the provider alliance for an agreed agenda of shared initiatives
5. **Mutual support**: we will expect each partner to act on behalf of the system/resident and taxpayer interest even when that is not in individual institutional benefit but the quid pro quo is that we will strive to “keep each other whole”/we will work to ensure no partner fails

6. **No duplication and shared resources**: ICS-HQ workstreams and Provider Alliance-delivery work should be stepped-up and stepped-down in lockstep –we will avoid duplication and be clear about accountability. We should seek to share resources across partner organisations to enable health services, education and research to be focused on the population we serve. A number of people will have different roles / 'wear different hats' and we will use this to be as efficient as possible.
7. **Embedded with the system team:** Same set of people in the room wherever we can (transparency between ICS HQ and Provider Alliance Board for example)
8. **Data and analysis**: we will make data-driven decisions and monitor our performance.
9. **Honest and transparent**: we do difficult things, we talk about difficult things, we are direct and transparent with each other
10. **Learning system**: we have an ethos of 'continuous improvement' adopting a QI approach. Innovation and the spreading of proven best practice will be key.

Possible Areas for Initial Focus

The discussions over the last 4 months have created a long list of ideas for what the Provider Alliance could focus on in its first 12 months. The proposals that emerged are:

Clinical Support Services

- Pathology – how to digitise at pace
- Decontamination
- Diagnostic hubs
- Pharmacy
- A sector wide approach to quality improvement

Clinical Services

- Start with post Covid lead provider work led by ICS and used Alliance as delivery vehicle
- Pick one or two specific topics e.g., Community Discharge, or management of patients living with mental health and physical long term conditions
- Establish an optimal model for mental health service delivery
- Establish an optimal model for community health care service delivery
- Deeper integration between all parts of health and social care to improve patient pathways e.g., for management of patients living with complex co morbidity long term conditions or mental and physical health issues

Research and Education

- Education key to 'sustainable' workforce development and joined up working
- Research recognised as a NCL differentiator
- Research and development opportunities

Corporate Services

- Consolidation of corporate services where appropriate e.g., a subset of finance processes, procurement

- Workforce innovation, joined up programme of work to improve recruitment and retention e.g., building on the capital nurse programme
- Data and analytics, digital, IT to enable 'joined up' patient data for providers to access and utilise for the benefit of residents and patients and in time a patient/resident 'digital passport'. In addition will help with being able to agree and track patient/resident/service user benefits in any actions we take
- Estates and facilities management
- Commercial capabilities
- ICS Corporate Services work to 'shift home' and be delivered through the Provider Alliance starting with Occupational Health and transactional HR services

One of the first tasks for the Alliance will be to determine a small number of priorities from this long list, to make rapid progress on during the first 12 months.

Other feedback from proposed Provider Alliance members

A formal request was made in July 2020 to potential member Boards asking them to confirm their commitment in principle. A period of further engagement took place during August and September 2020 to enable further discussion. Outlined below are a number of the key questions that have come up during the period of engagement in August and September 2020:

Are the ICS and the Provider Alliance one and the same thing?
This paper has sought to explain the differences. Clearly there is an overlap because provider alliance members will be part of and work within the ICS. The ICS is a whole system view with a wide and whole population health remit. It is an enabling set of leadership relationships. The Provider Alliance will be a critical part of the wider system focused on delivering and improving quality and sustainable services . By having a self sustaining Provider Alliance, the focus of the ICS can shift to some critical areas that need focus such as a strategic review of mental health needs and how these are best met.

There are too many meetings - how do we avoid duplication?
A key principle that we will follow in order to be meeting 'efficient' is to ensure that we use existing meetings for as many purposes as possible, obviously so long as it makes sense and there are no conflicts of interest. This paper includes details of revisions to the ICS meeting arrangements which are designed to contribute to some streamlining of meetings.

Data and evidence is key to our work, can you reassure us that this is at the heart of the planning and development of the Provider Alliance and the ICS?
We agree completely with this and have made it a core principle of the Provider Alliance. As we have set out we aim to ensure that strong links with UCLPartners are maintained to support us in this endeavour. In fact as an STP we made strong inroads into some important building clocks for data and evidence by leading the introduction of shared records and a public health information system. The CCG as the strategic commissioner within our system makes clinically led, evidence based decisions and will continue to do so.

Isn't NCL Gold the delivery vehicle for the collective Provider Alliance agenda?

NCL Gold is focused on our NCL response to the Covid – 19 pandemic, and co-ordinates a response specifically on the issues directly and indirectly resulting from the pandemic.

Why are primary care and social care not included in the Provider Alliance?
It is not proposed to exclude primary or social care providers - being realistic they are unlikely to join at the current time. Once the Alliance is up and running and has a track record, it may then be a more realistic option for other providers.

Is the Provider Alliance another layer of decision making and reporting?
The provider Alliance is not a structure, it is a set of processes and behaviours to enable us to make progress on a shared agenda to deliver improved health value to the population we collectively serve.

Is the Provider Alliance model centralising 'how we work'?
The model is biased towards devolving delivery accountability to individual partners to act on behalf of the overall partnership e.g., as a supplier of medical revalidation on behalf of other members, or as a co-ordinating role as a lead provider for other members for ophthalmology.

What is the structure of the Provider Alliance?
The provider alliance is not first and foremost an organisational structure it is a group of member organisations working collaboratively together to an agreed agenda for achieving synergies though deep collaboration and sharing resources to deliver per initiative e.g., implementation of a shared occupational health service, or shared pathology service, or shared workforce education programmes. It will need to develop a way of the Members making decisions together.

How does Governance work? Who is accountable for what?
All Partner Boards would remain sovereign and would delegate authority for collective decision making to the provider alliance only for those shared initiatives on an agreed agenda. It will be necessary to develop an approach to making decisions together about the future and work of the Alliance.

Can I belong to more than one Provider Alliance?
Yes, in fact we actively encourage and expect this to be the case e.g., Specialist Providers to be in a national network, for example GOSH to be in a national network of acute specialist children services.

What is the scope of services that the Provider Alliance will focus on?
(1) Clinical Support Services, (2) Corporate Services, (3) Clinical Services, (4) Research, Education, Commercial Income Generation

How will we prioritise what the Provider Alliance focuses on during the first 12 months?
In the dialogue to date there is agreement that we should try to ensure we strike a balance between building momentum and delivering benefit (staff, patient or tax payor) as soon as possible and tackling some medium term challenges AND ensuring the agenda is reflective of the breadth of our membership acute, mental health, community and specialist providers.

Will we have two tiers of membership?
Following the feedback to date it is now proposed to have one type of membership

Can a member exit from the alliance and how?
The Provider Alliance is not a contractual relationship it is a 'coalition of the willing' with the principle of collaboration as the default and that for the agreed agenda members will only 'opt out' where an existing binding contract precludes us from participation.

How will the Provider Alliance get started?
It is proposed to convene an initial session of all member representatives by mid November 2020 to discuss and agree our immediate agenda for the first 12 months and key priorities to make fast progress on our shared agenda.

How will the Provider Alliance be resourced?
The proposal is that the Provider Alliance would receive 'de minimis' funding by partner subscription with resourcing devolved in to partner trusts and delivery vehicles with cost sharing between partners wherever possible, rather than through overhead being developed at the provider alliance level.

Getting started

As mentioned above, not all the questions about the Provider Alliance can be or should be resolved immediately. Instead, it is important to get going and learn together by making progress on a small number of fronts, being adaptable along the way.

The key tasks of the member organisations will be to agree and progress the agenda of the Provider Alliance for the first twelve months and outline a road map and vision for the first three years. There will be regular discussion and consultation with member organisations and the Provider Alliance will engage with the CEO and Chairs of the member organisations through the existing regular meeting structures already in place for each of these peer groups.

One of the early discussions for the membership will be how best to strike the balance between members being involved in key decisions and in steering its development, whilst also addressing the feedback that it needs to be efficient and avoid undue amounts of meetings. The original proposal was for a corporate style board that meets with the wider membership from time to time as needed, in order to strike that balance.

In order to oversee the next phase of the Provider Alliance's development from its inception on 1 November 2020, I am proposing that the first task will be to appoint a Chair and two Vice Chairs of the Provider Alliance drawn from the membership. In order to give some independence to the process I am proposing to lead this process after which I would hand over to the newly appointed Chair and Vice Chairs.

Conclusion

We are inviting all NCL NHS Boards to consider whether they wish to join the North Central London (NCL) Provider Alliance as a Member from 1st November 2020

- Membership of the NCL Provider Alliance requires:
    - Signing up to the Provider Alliance Charter
    - Active participation in the NCL Provider Alliance and commitment to supporting the creation and delivery of the agenda for the first 12 months. We would encourage appointment of a liaison from the Executive to the Provider Alliance ‘working group’

/ Ends

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 12

Reports of the quality & safety committee

Board of directors 22 October 2020

ITEM 47.20

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

21 July 2020

Committee Governance	• Quorate – Yes • Attendance (membership) – 87.5% • Action completion status - 95% • Agenda completed – Yes

Current activity	• The committee approved the minutes, summary and action tracker from its meeting on **19th May 2020**.
	• As part of its focus on COVID19, the committee received and discussed the **Infection prevention and control board assurance framework**.
	• The committee received a presentation on **COVID-19 governance** and progress with the Trust's recovery plan.
	• **Moorfields Private** presented its response to COVID-19.
	• The **Quality and Safety and complaints reports** for the period April to June 2020 were presented.
	• The **UAE quality and safety report** for quarter 1 2020/21 was presented.
	• The **WHO Surgical Safety Checklist Compliance Audit Report** for Q1 was received.
	• The **Quality and Safety update** included incident closure, CQC, and polices.
	• The committee reviewed and approved the Trust's **Quality Account**.
	• Summary reports were received for the following meetings:
	  ○ **Clinical Governance Committee** (1st June 2020)
	  ○ **Information Governance Committee** (20th May 2020)
	• The latest **SI tracker** was presented.
	• A single **SI report,** *Missed diagnosis of a brain tumour,* was received.
	• The committee received the following annual reports:
	  ○ **Clinical Governance and Clinical Audit**
	  ○ **Safeguarding Children & Young People**
	  ○ **Infection control**

Key concerns	• The main challenges of COVID-19 from an infection control perspective are: testing, PPE, communal rest areas, and ensuring standards are maintained at network sites (cleaning, testing). • Occupational health in relation to COVID-19 is a challenge – this is not Moorfields specific but is a geographic challenge as well. • The Trust is preparing for future spikes/outbreaks of COVID-19 which will occur. • The 'central' governance process in London via North Central London had led to delays in communication (and occasionally, some confusion). • The issue of 'lost' patients remains a concern; however there are a number of measures in place to manage this: audit, knowing the gaps, cancellation safety net, and visibility of data. • Recovery was very fast, and did result in a number of issues, including pace of change, inconsistent central messages, infection control guidance, recovery process management (Priority (P)1 to P2 to P3 to P4 (Priority 1 is the most urgent) – currently the Trust is about to commence P3). • It is likely that the Trust will need to be at 100% elective surgery by the autumn. • COVID-19 has impacted on some parts of the activity and performance reported

	in the quality and safety reports for April-June 2020.
Key learning	• The Infection prevention and control board assurance framework is structured around the existing 10 criteria set out in the IPC code of practice which links to Regulation 12 of the health and social care act. • Drive-through COVID-19 test facilities are being set up (subject to confirmation) with Tottenham Hotspur Football Club. • Planning is in place for future PPE supply. • Staff are feeling more comfortable due to the PPE processes in place and the variety of equipment now available. • Green and blue pathways are still being finalised, and as red is very unlikely, the focus is on blue and green. • There is positive feedback from staff and patients about the COVID-19 front-door process. • Moorfields' recovery commenced on 16th April – Moorfields was one of the first Trusts in the country to move to recovery • 180,000 appointments have been rescheduled, and the current backlog sits at 12,016 new patients, 75,556 follow-up, and 5,752 surgical. • There are systems in place for the triage of high risk patients. • Recovery is underway in Moorfields Private – there is a gradual build-up of patients (currently at 500 per-week; the pre-COVID level was 950 per week). • Information technology is being heavily utilised during recovery. • COVID-19 has presented considerable opportunities for the development and enhancement of services. • An overview of the Trust's Quality Account has been presented to, and positively received by Islington's Health Scrutiny Committee. • There was one SI report presented and discussed – due to COVID-19 there had been some slight delays to the report. The investigation was undertaken with Moorfields due diligence, and systems improved for failsafe requesting and receipt of diagnostic results. • The learning contained within the *Safeguarding Children and Young People* annual report was highlighted.
Escalations	There were no escalations raised
Date of next meeting	15 September 2020

Moorfields Eye Hospital NHS Foundation Trust

NHS

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

15 September 2020

Committee Governance	• Quorate – Yes • Attendance (membership) – 87.5% • Action completion status - 98% • Agenda completed – Yes

Current activity	• The committee approved the minutes, action tracker and summary from its meeting on **17 July 2020**.
	• As part of its focus on COVID-19, the committee received and discussed **an update about infection control**.
	• The committee received a presentation about **communicating with our patients during recovery**.
	• A presentation about **Artificial Intelligence (AI)** was received and discussed.
	• An update on **Fire Safety** was presented to the committee.
	• The **Quality and Safety update** for July to September was presented.
	• Summary reports were received for the following meetings:
	  ○ **Clinical Governance Committee** (27/07/2020)
	  ○ **Information Governance Committee** (23/07/2020)
	  ○ **Risk and Safety Committee** (15/07/2020)
	• The latest **SI tracker** was presented (there were no SI reports presented).
	• The committee received the **Safeguarding Adults** annual report.
	• An update on **COVID-19 related audits** was received.
	• The committee's draft **terms of reference** were presented.

Key concerns	• There had been four positive (unconnected) notifications via test and trace. • In light of the current live outbreaks in London hospitals, Moorfields' infection control 'airport security' is solid however we need to remain vigilant for potential outbreaks. • There is a national testing programme which was not operating effectively and Moorfields was putting in contingencies wherever possible. • There are some concerns with communication with outpatients and whether another letter should be sent. • There are discussions about how *AI* would be funded. Although there is national direction and support this will run out. There is also support from Moorfields Eye Charity. There is also commercial potential. • There is continuing concern about loose filing – this seems to happen regularly (although this is picked up more frequently because of the increase in diligence). Administrative audits are on-going as business as usual. Going paper-lite should also reduce the loose filing incidents. • Instances of aggression from patients towards staff are increasing, resulting from on-going public anxiety. The security function has been strengthened to help manage this.

Key learning	• New guidance has been issued in respect of infection control/COVID-19 (NICE guidance, 27 July, and National guidance, 21 August). Moorfields has reviewed all its documents as a result of the new guidance. • The Trust's PPE audit took place in September 2020 – there were no breaches reported. A second audit is in preparation. • The pan-London review by Directors of Infection Prevention and Control (DIPC) concluded that the Trust's infection control processes are very thorough. • A walkabout (including reception and technical staff) that took place on 15 September found that all staff seen were wearing masks. • At network sites, Moorfields continues to screen patients at all local entrances. Infection control is discussed at all divisional quality forums, and local cleaning has also been increased. • A review looking at communication with patients during recovery has been undertaken accumulating all available date. This includes data from FFT (a COVID-19 specific question has been added to the questionnaire) and PALS. Further data will be collected from individual patient surveys. • The development and use of artificial Intelligence (*AI* - also referred to as 'computer vision' at Moorfields), is increasing across Moorfields (this includes the *ChatBot* tool, the use of which is also being looked at for non-clinical purposes). • The committee learned how these technologies could drive a 'smart service', and what *AI* actually is. The committee was also informed of the issues and what is currently happening at Moorfields. • The committee discussed the current governance arrangements for *AI*, and whether the Trust needs a dedicated department for digital medicine. • Fire safety management is at its pre-COVID-19 position. • The Clinical Governance Committee meeting reported the use of a new app in A&E, and the quality improvement project for the surgical safety checklist which is currently underway. • The principle focus of the Information Governance Committee meeting was about the ICO information collection process around loose filing (the previous incident at St. George's was referred to). It was unclear whether this might progress to anything more formal. There is significant divisional and Trust-wide learning as a the result of this type of incident. • The Risk and Safety Committee meeting highlighted concerns around aggression towards staff, emphasising the security measures in place and the excellent support received from the security team. • There were no SI reports for this meeting. The tracker of current SI actions was presented which resulted in discussion about Duty of Candour reporting (the on-going re-evaluation of harm has improved the report numbers). • The Safeguarding Adults annual report was presented: there were no issues to be highlighted or escalated. • Since March, the safeguarding processes in both Adults and Children have continued, e-learning has increased, and there has been a successful audit of Learning Disability services. • As part of the update about COVID-19 related audits, the committee was informed that currently, there are 25 audits, of which, four have been completed, and a further two will be presented to the World Association of Eye Hospitals. • It is an expectation that all amended patient pathways are audited. • The item about recovery in the Uveitis service item would be coming to the next meeting. There were neither concerns nor any immediate questions from the committee. • The committee's revised terms of reference has been circulated to the membership for comment.

Escalations	The following escalations were raised: • COVID-19 infection control, COVID-19 testing and maintaining vigilance. • COVID-19 patient communication during recovery phase • The structure to support, and the application of Artificial Intelligence • Aggression from patients towards Moorfields staff
Date of next meeting	17 November 2020 (the dates for the committee's meetings during 2021 have now been scheduled)

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 13
Report of the audit and risk committee
Board of directors 22 October 2020

Report title	Report of the audit and risk committee
Report from	Nick Hardie, chairman, audit and risk committee
Prepared by	Helen Essex, company secretary
Link to strategic objectives	We will have an infrastructure and culture that supports innovation We are able to deliver a sustainable financial model

Brief summary of report

Attached is a brief summary of the audit and risk committee meeting that took place on 6 October 2020

Action Required/Recommendation.

Board is asked to note the report of the audit and risk committee and gain assurance from it.

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

AUDIT AND RISK COMMITTEE SUMMARY REPORT – 6 OCTOBER 2020	
Governance	• Quorate – Yes • Attendance (membership) - 100%
Current activity (as at date of meeting)	***Internal audit*** *Core financial systems* • Significant assurance with minor improvements. Focused on accounts payable and treasury management and how we flexed the working environment for Covid. *SBS management* • Partial assurance with improvements required. • The recommendation is to use a transactional procurement service and the plan is to make substantive the ad-hoc advice it brings in for contracts, e.g IOL lenses. • In relation to the SBS contract there are gaps over KPIs and a contractual management plan. Ideally there should have been a more joint process between workforce and finance on the intial transfer. • The issue was raised as to how we manage contracts as an organisation and putting in a framework for better management of the contract and escalation touch points. • Agreed with recommendation to appoint procurement/contract specialist and include legal in the conversation. *Culture of controls* • This audit was done to see if we could get a better understanding as to why individuals may not adhere to financial processes we have in place. • This raised issues such as individuals becoming disengaged from budget controls, clarity in escalation mechanisms, reduce errors in data. • Very small sample in terms of numbers, would want to involve managers and budget holders in the culture of controls process but good as a starting point for the conversation. *Clinical audit* • Significant assurance in a critical area which is about the quality of care and reinforcement of international and national standards. • Lots of areas of good practice identified and commended and confirms that there is an excellent clinical audit function. *Job planning* • Policy being ratified by LNC and BMA and appendix for Covid flexibility and job planning included so that policy does not need to be amended too regularly. • Team job planning starting to be embedded. Now have an integrity score and next steps in terms of what needs to be done in terms of data cleansing and hierarchy. ***Board assurance framework*** • Decrease in the risks relating to Covid-19 and commercial activity although still remain significant in terms of their risk score. • No significant changes reported to other key risks including Oriel, which are on relatively stable platforms at this stage. • Discussion took place about issues that are affecting other providers as well as the trust such as waiting lists and system dynamics as well as organisational accountability. Discussion needs to be had about how we best collaborate and use resources efficiently as a system but retain our organisation brand and reputation.

	Counter fraud report • In the process of finalising the report and this will come to the next committee. • Three areas of compliance being reviewed; invoice, pre-contract procurement and pre-employment checks. • Lots of work taking place on the awareness side. ***External audit*** • New NAO code of practice will come into effect and affect how auditors will carry out their vfm work. • Not yet clear as to when IFRS 16 will come back on the agenda.
Key concerns	• Culture of controls – need to stop custom and practice from being embedded and make sure people understand their responsibilities in terms of financial management. • Internal audit timescales need to be realistic and dates not pushed back. • Lack of a robust framework for centralised contract management.
Items for discussion outside of committee	• Need to think about how to make sure we have the right staff in place to manage the job planning process in the future. • Counter fraud - engagement generally good but communications channels in the organisation need to be reviewed and make sure information is cascading.
Date of next meeting	• 12 January 2021

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 14
Report of the people and culture committee
Board of directors 22 October 2020

Report title	Report of the people and culture committee
Report from	Sumita Singha, chairman, people and culture committee
Prepared by	Debbie Bryant, Executive Assistant
Link to strategic objectives	We will have an infrastructure and culture that supports innovation We will attract, retain and develop great people

Brief summary of report

Attached is a brief summary of the people and culture committee meeting that took place on 15 September 2020.

Action Required/Recommendation.

Board is asked to note the report of the people and culture committee and gain assurance from it.

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

People & culture committee summary report – 15 September 2020

Governance	• Quorate – Yes • Attendance (membership)
Discussion points	***Over payments / incorrect payments to staff*** • Taskforce now set up to investigate on a case-by-case basis. Intranet advice now updated and process mapping is clearer. ***Workforce recovery*** • An overview of the capability and capacity work stream presented. • A multi professional learning and development group will meet monthly to support local L&D. • Clinical pathway mapping is underway for glaucoma but competencies are still required. 17 technicians have been recruited. • L&D will set up a comprehensive training programme. • An options appraisal for workforce redesign is planned for December. • Vacancies will require a skill mix review. • Assessing the pros and cons of intermediary staff vs permanent contracts. • The workforce recovery document explains all the return to work actions. • Space allocation is priority and shared between direct clinical, support to clinical then indirect to clinical, corporate and admin staff. • The audit on corporate and admin staff working patterns showed 80 desks are required in Kemp House but home workers need to have a full package of support. • New staff will be risk assessed. • Psychological wellbeing support is available with an in-house psychologist. • There is learning from redeployment and after action reviews. • Line management for remote working particularly for the non-clinical staff is a key issues and this should be an important focus. ***Workforce strategy progress*** • The NHS People plan has now significantly changed with 103 priority areas with a short time frame. • The phase 3 planning letter has an overlap of the people plan but with specific requirements. • London workforce cell with 6 key work streams that overlap schematically. • WRES has 16 priorities. • Moorfields strategy has a greater focus on workforce planning, skill mix and organisational design, which is key to delivering transformational change in line with aspirations and will remain the focus in the face of a national agenda. • Many recommendations are reliant on central specification, therefore the ability to locally design solutions to issues may need to 'fit' with system and national approaches • Full implementation of health roster and maturity of ESR will be necessary for many of the objectives to be achieved; the trust is further behind many trusts. This will need urgent attention and resource. • Equality and diversity - Prefer to develop a culture of inclusion for all the protected characteristics.

	WRES and WDES • WDES is a new submission to the committee and this is the first year to report on. • WRES indicators have improved except indicator 4. Twice as many white staff accessed the training. ***Workforce metrics and risks*** • The workforce plan remains on the risk. • Staff health and wellbeing is a new risk and ensuring there is the right support to avoid high absence. • 130 priorities could also be a risk. Important to identify what the Trust are trying to do.
Key concerns	• NHS people plan and Phase 3 priorities for Moorfields • Workforce recovery • Full implementation of health roster and maturity of ESR. • Health and wellbeing group to be established
Escalations	• Two board level appointments are required on WRES and H&WB.
Date of next meeting	• 17 November 2020