A MEETING OF THE BOARD OF DIRECTORS

To be held in public on

Thursday 27 February 2020 at 09:30am

In the Boardroom, 4th Floor, Kemp House, 152 – 160 City Road, EC1V

AGENDA

No.	Item	Action	Paper	Lead	Mins	S.O
1a.	**Oriel OBC**	**Discuss**	**Present**	**JM**	**00:45**	**1**
1.	Apologies for absence	Note	Verbal	TG		
2.	Declarations of interest	Note	Verbal	TG		
3.	Minutes of the meeting held on 23 January 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	00:10	All
6.	Integrated Performance Report	Assurance	Enclosed	JQ	00:10	1
7.	Finance Report	Assurance	Enclosed	JW	00:10	7
8.	Staff survey	Assurance	Present	SD	00:20	5
9.	Guardian of safe working	Assurance	Enclosed	NS	00:10	1
10.	Learning from deaths	Assurance	Enclosed	NS	00:05	1
11.	Freedom to speak up quarterly report	Assurance	Enclosed	IT	00:10	1
12.	Report from the quality and safety committee	Assurance	Enclosed	RGW	00:10	1
13.	Report from the people and culture committee	Assurance	Enclosed	SS	00:10	5
14.	Membership council report	Note	Enclosed	TG	00:05	3
15.	Identify any risk items arising from the agenda	Note	Verbal	TG	00:05	6
16.	AOB	Note	Verbal	TG	00:05	
17.	**Date of the next meeting – Thursday 26 March 2020 09:30am**					

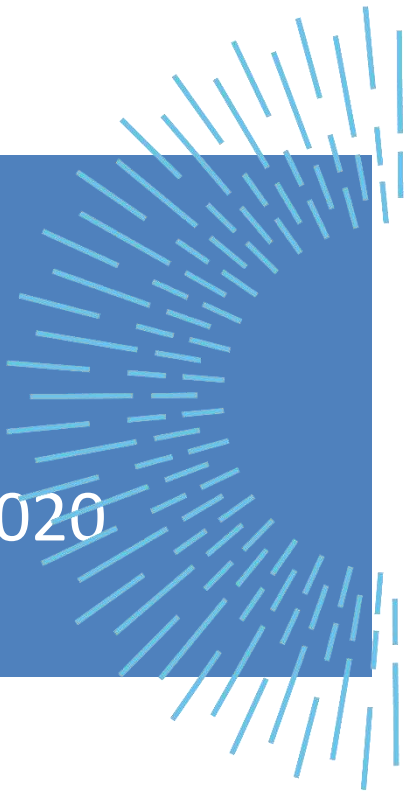
* Strategic Objectives

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

Agenda item 01

Oriel public presentation

Board of directors 27 February 2020



Report title	Oriel Outline Business Case (OBC) FINAL
Report from	Jo Moss (Director of Strategy and Business Development)
Prepared by	Anna Farndale (Currie & Brown) Nick Day (Head of Project Finance for Oriel)
Previously discussed at	S&C committee Jan 2020, Trust Board Jan 2020
Link to strategic objectives	The outline business case links to all strategic objectives

The Oriel OBC contains commercially sensitive information about the sale of the City Road site. The main document has therefore been shared with the board as part of their Part 2 papers. The finance case will be discussed in detail at a private board meeting immediately prior to the public board meeting. A presentation will be given to the public board meeting providing an overview of all non-commercially sensitive aspects of the OBC.

In line with regulatory requirements, a redacted version of the OBC will be published within 1 month of approval by regulators.

Executive summary

Introduction

Attached is the final draft of the Outline Business Case (OBC) for Oriel, for review and approval by trust board before submission to regulators. The NHSE/I and DHSC review is expected to be completed by September 2020.

The OBC has been drafted in line with NHSE/I, DHSC and Treasury guidelines. It aligns with the Decision Making Business Case (DMBC) which was approved by commissioners on 12 February 2020. The DMBC can be viewed at https://oriel-london.org.uk/committees-in-common-documents/. Key points to note are:

- The DMBC includes commissioner-led demand modelling which assumes 3.1% growth in outpatients, which could be reduced to 2.6% growth with re-provisioning. The OBC finance case is based on 3.1% growth.
- The DMBC sets out recommendations, which Moorfields commit to deliver. These are set out on p.70 of the OBC, and p.18 of the DMBC.

The OBC specifically covers the capital, revenue and commercial implications for Moorfields – the impact on UCL will be covered by a separate business case to be submitted to the UCL Council in June 2020. The quality case is consistent across both cases. Finance and commercial colleagues have worked closely to ensure that shared assumptions underpinning the Finance and Commercial cases of each business case are consistent.

Appendices are available to board members on request.

Document overview

In line with guidance, this OBC consists of six chapters:

- **Strategic Case** – sets out the strategic context, case for change, activity and capacity modelling and the investment objectives.
- **Clinical Quality Case** – describes the service models (including education and research) and the benefits these will bring, the IT and workforce implications of the proposals, and the building design.
- **Economic Case** – sets out the options considered, and how these were appraised from a financial and non-financial perspective to identify the preferred option.
- **Finance Case** – sets out the capital and revenue impact of the proposals on the trust.
- **Commercial Case** – describes the planned procurement route, disposal (City Road) and acquisition (St Pancras) strategies, and outlines the rationale for establishing a JDV.
- **Management Case** – describes how proposals will be delivered, including programme plan and risk register.

Assurance to date

The following review has been undertaken of the OBC:

Chapter	Internal review of chapter	Internal review of supporting documents	External review of chapter
Strategic case	S&C May 2019 and Jan 2020. Trust Board in Jan 2020	Activity and capacity modelling reviewed at TMC.	Detailed comments received from NHSI. Positive feedback received on second draft.
Clinical quality case	S&C in Nov 2019 and Jan 2020. Trust Board Jan 2020.	Clinical models reviewed at TMC. Designs have been subject to detailed review by clinical and estates colleagues. IT and workforce strategies reviewed at ManEx.	Draft shared with NHSE/I / DHSC in Dec 2019 (comments incorporated).
Economic case	Finance committee, S&C and Trust Board Jan 2020.	Options shortlisting and benefits quantification undertaken by PA consulting with significant input from clinical and other project stakeholders.	Early draft shared, no comments received to date.
Finance case	Finance committee, S&C and Trust Board Jan 2020.	n/a	Early draft shared, no comments received to date.
Commercial case	S&C Sept 2019 and Jan 2020. Trust Board Jan 2020.	• Disposal of City Road – S&C Nov 2019 • Acquisition of St Pancras – S&C Jan 2018 • Procurement strategy – Capital Scrutiny committee Jul 2019, Trust Board Oct 2019 • JDV proposals – S&C Nov 2019	Comments from NHSI have been incorporated.
Management case	S&C Sept 2019 and Jan 2020. Trust Board Jan 2020.	Risk register reviewed by audit committee in Jan 2020. Programme and risk register developed with Director of Strategy and Director of Estates, Capital and Major Projects	Draft shared with NHSE/I / DHSC in Dec 2019 (no comments received to date).

Quality implications

Oriel will result in improvements to the quality of the physical environment, clinical services, research and education capabilities of Moorfields and UCL.

Financial implications

The financial implications of Oriel are set out in the Finance Case of the OBC.

Risk implications

Top risks included in the Management Case (p.23) of the OBC.

Action Required/Recommendation

Trust Board are asked to:

- Approve this OBC, for submission to NHSE/I and DHSC
- Approve the spend of £13.5m of fees prior to FBC approval
- Approve continued spend (in line with the defined budget above) at risk prior to regulatory OBC approval in order to:
    - Commence preparation for sale of the City Road site.
    - Commence contractor procurement process.

o Prepare town planning submission for the St Pancras site.							
For Assurance		**For decision**	✓	**For discussion**		**To note**	

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON
THURSDAY 23 JANUARY 2020

Attendees:	Tessa Green (TG)	Chairman
	David Probert (DP)	Chief executive
	Andrew Dick (AD)	Non-executive director
	Ros Given-Wilson (RGW)	Non-executive director
	Peng Khaw (PK)	Director of research & development
	Nick Hardie (NH)	Non-executive director
	David Hills (DH)	Non-executive director
	Tracy Luckett (TL)	Director of nursing and AHPs
	Johanna Moss (JM)	Director of strategy and business development
	John Quinn (JQ)	Chief operating officer
	Sumita Singha (SS)	Non-executive director
	Nick Strouthidis (NS)	Medical director
	Jonathan Wilson (JW)	Chief financial officer
	Steve Williams (SW)	Vice chair and senior independent director
In attendance:	Sandi Drewett (SD)	Director of workforce and OD
	Helen Essex (HE)	Company secretary (minutes)
	Kieran McDaid (KM)	Director of estates, capital and major projects
	Ian Tombleson (IT)	Head of quality and safety
	Richard MacMillan (RM)	Head of legal services
Governors present:	Allan MacCarthy	Vice chair, membership council
	Brenda Faulkner	Patient governor
	Emily Brothers	Public governor
	John Sloper	Public governor
	Jane Bush	Public governor
Public:	Matt Preston	CQC relationship manager
	Jagdish Dave	Friends of Moorfields volunteer

20/2388 Apologies for absence

Apologies were received from Nora Colton and Elisa Steele.

20/2389 Declarations of interest

There were no declarations of interests.

20/2390 Minutes of the last meeting

The minutes of the meeting held on the 5 December 2019 were agreed as an accurate record.

20/2391 Matters arising and action points

All actions were completed or attended to via the agenda.

20/2392 Chief Executive's Report

The trust is currently at 76% compliance with the flu vaccination target and confident that the target of 80% will be achieved by March.

DP was pleased to see that trust staff continue to lead the way nationally and internationally with awards for AHP teams and the innovation award for Telehealth.

Education is the third pillar of the trust strategy and last week saw the launch of the new education hub at Ebenezer Street. It was agreed to arrange a visit for non-executives to see the unit.

HE to arrange visit – 27.02.20

JM updated the board on the Oriel decision-making process and the new timetable. The NCL JHOSC will take place on 31 January and this group will then provide any comments they want commissioners to take into consideration when making their decision. The committees in common will take place on 12 February and this will be held in public. It is hoped that a public statement will be made on that evening. Emily Brothers is a representative on the Oriel Advisory Group and will be speaking at both meetings. TG thanked EB on behalf of the board for her commitment and contribution to the project. If the decision is favourable to the proposal then the trust will be able to proceed with the outline business case which will come to the public meeting of the board in February and then submitted to the regulator at the end of February.

DP referred to a number of recent articles in the HSJ about lack of capacity in the system for ophthalmic patients nationally and patients that are lost to follow-up. The trust takes the issues raised extremely seriously and started the process to address the problem a number of years ago, putting in place key mitigations to make sure the RTT target is met. The executive team has requested a further review of processes and for assurance to go through the quality and safety committee. Moorfields is seen as an exemplar in the field although it is important to remain focused on the issue.

The main focus is on the glaucoma subspecialty and NS provided an update on how clinics are managed and assured the board that discharge outcomes and other processes including fail safes are being reviewed. The service also goes through a process of risk stratification and there is a mechanism in place to make sure the highest risk patients are flagged within the system. Patients with lower acuity are to be seen by the most appropriate people in the clinic (those that have glaucoma specialty training). The trust is in a position to take a lead in this area and assist ophthalmic colleagues around the NHS in how to transform their glaucoma clinics.

It was noted that one of the drivers for follow-ups being moved in favour of new appointments was the tariff difference which commissioners need to review. Providers also need national guidance on a KPI that looks at the number of patients that are awaiting follow-up. The QSC will look at this in detail at the next meeting.

On a broader point it was acknowledged that there is a shortage of qualified specialists to do the work and board members asked about the trust role in teaching best practice nationally. The trust has influence at a national level and with the Royal College and is confident of the effectiveness of its screening and process of virtual appointment with consultant review. Other organisations are not as able to adapt to new ways of working so the trust needs to help share best practice. Work is taking place with Simon Stevens and David Sloman to do this at regional and national level.

20/2393 Integrated performance report

A&E continues be above plan and growth is being monitored. The trust is likely to end the year above 100,000 attendances. M9 was challenging for activity due to the Christmas effect and shortage of fellows.

Performance against national targets remains strong although there was one 52-week breach which has been reported to commissioners. The patient has had a harm review and suffered no harm.

There have been particular issues with theatre cancellations in the South. This was due to issues around medical and non-medical staffing, although there is confidence that this can be addressed through improved pre-assessment. There was a four to six week period where there was a particular problem in the supply of a specific glaucoma drug. It was noted that pharmacy did a good job at assisting clinicians to minimise the impact on patients.

SS said that ethnicity recording was poor in outpatients and inpatients although it is taking place in A&E. JQ replied that this is often to do with how the trust processes the patient and a lot of information is gathered at the A&E visit. There is also a lot of patient check-in done via the kiosks which could potentially be used as a solution.

Moorfields South is significantly better than CR or the North on median patient journey times. This is not natural variation but about how patients move through the system and how the pathway is designed to maximise patient flow. It was acknowledged that using the median hides the extremes and in future the reporting of virtual and normal clinics will be split out.

There has been a rise in complaints primarily due to transport and an increase in waiting times for patients to be collected. A weekly call is taking place to keep on top of KPIs. Eligibility criteria are another key issue and TL is chairing the regional steering group to review the criteria with DHL, the contract provider.

20/2394 Finance report

The position was £0.2m adverse to plan in December due to non-achievement of NHS income. Year to date performance is a deficit of £0.8m compared to a planned deficit of £0.9m (a favourable variance of £0.1m). Total income is £2.2m favourable to plan YTD. Pay costs are £2.1m favourable to plan primarily due to vacancies across all staff

groups, with the exception of registered nursing.

Key risks relate to non-pay, health records, City Road clinical supplies and drugs. There is also a required adjustment with the joint venture partner leading to an adverse variance in clinical supplies. This was due to having a base budget that did not take into account invoices within the system. Goods received were not invoiced and had not made their way through the system. This may pose a closing budgetary problem.

The position is £50k ahead of plan so there is still confidence about achieving the revised year-end target. Surplus is at £1.3m and the trust is coming up to strong quarter of the year.

Cash position remains positive with £50m+ available in December. PSF is higher than planned and there has been a reduction in debt but the capital programme is £7.1m against a £15.5m outturn. This is an area of risk in terms of non-achievement.

Debt is at £3.4m and needs continued focus. However agreement has been reached on territorial debt that goes back to 2010.

In relation to CIP the position is moving to £6.04m outturn although there is still a gap and impact on next years' delivery and plan.

The trust saw strong activity and elective performance in January and is outperforming the use of resources metric to achieve 1 (against plan of 2).

20/2395 Administration and booking process

JQ presented the update report requested by the board to provide assurance about the ongoing review of the trust's admin and booking processes.

Waiting list management – the current process is that patients are booked into slots and then the appointments are rescheduled if needed. The trust does not offer a partial booking system as it can pose problems for lost to follow up patients. Operations are pulling together an options appraisal about the different systems on offer and what is safer for patients. The trust holds a weekly access meeting to raise issues about any patients that have not had an appointment following attendance at a clinic.

Overbooking of clinics – the current patient administration system (PAS) allows overbooking from other sites which can lead to problems. A new system will be piloted in St Ann's to see how this might be improved.

It was noted that the paper provides a timeline of a year to rewrite the templates and the board asked if this could be accelerated if more resource was available. JQ replied that this was possible but would need to be managed appropriately and with caution.

Patient experience of calling – the trust is in the process of procuring a patient portal that allows patients to interact with the trust in a different way. The TMC will choose the provider in February following additional work on the business case.

Communications in clinic – patients now have access to buzzers which are in place as business as usual.

Whiteboards – the long-term plan is to use the patient information screens and contact has been made with the supplier in order to get a quote so that the business case can be written.

It was agreed that the key areas in which we would want to make substantial progress are telephones and patient information screens.

It was acknowledged that there are challenges in putting IT in to old buildings, with the building layout also being a factor. It was noted that potential suppliers will be fully aware of the complexity of patient need. It was accepted that what would be an improvement for the majority of patients would not necessarily work for patients who have more complex needs. However, there are lots of volunteers and patient experience co-ordinators that will be able to help the trust address the personal issues as well as digital solutions.

The board to see a progress report in six months - JQ

20/2396 Report from the audit and risk committee

NH reported that this was the first committee attended by Grant Thornton who replaced Deloitte as external auditors. The trust also has a new head of financial control.

The committee received a number of internal audits. Outcomes were generally positive with the main focus of time spent on the A&E audit. This audit was requested following the qualification given on A&E as part of the 2018/19 quality report audit. The KPMG report was done on larger samples. The rate of error is high, although it was acknowledged that this is usual when hospitals have paper and electronic systems. The audit found an acceptable degree of error, but the problem warrants more investigation. It has previously been suggested that the expense of putting in a single system is prohibitive but the committee felt that this should be challenged.

Audits on core financial systems and UAE were positive with good controls in place. The divisional governance audit was positive although there is variance across the divisions which should be standardised.

The internal audit programme was agreed with a more robust process in place. The committee was keen to see cyber-security and intellectual property included although these issues sit within other areas of audit. There is an overarching piece of work to be done to look at issues that overlap between the QSC and audit and risk committee.

The board agreed that the reputational risk of patient data not working properly in a research context is high and that appropriate discussion should be given to the issue. It was agreed to ask Pearse Keane to come to the board and membership council to clarity position on research governance.

The committee discussed the BAF and corporate risk register and agreed that further thought is needed about scrutiny of IT, estates and Oriel risks and where they sit within the committee structure. This will be an item on the board agenda next month.

20/2397 Identifying risks arising from the agenda

It was agreed to make sure that the risks highlighted around research data are addressed. Alongside UHB the trust has the largest pool of ophthalmic research data in the world. It was acknowledged as an exciting opportunity but important to understand the risk. It becomes more difficult to put a value on data as we collaborate with other organisations. It was stressed that accountability for the management of the trust's data sits with the board and as such the board must have appropriate assurance about its use. The main concern expressed by patients is identifying who might be able to access their clinical record. Processes and procedures must therefore be effectively stress tested.

20/2398 AOB

SS thanked the trust for enabling her to write a book on future healthcare design and presented a copy to DP for the trust.

20/2399 Date of next meeting – Thursday 27 February 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	26.03.20		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	26.03.20		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	26.03.20		Open
23.01.20	20/2392	Chief Executive's Report	Arrange a visit to the new education hub	HE	27.02.20		Closing
23.01.20	20/2395	Administration and booking process	Update to be provided in six months	JQ	23.07.20		Open

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 – February 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
AIS	Accessible information standard
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
EU	European union
FBC	Full business case
FFT	Friends and family test
FRF	Financial recovery funding
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
NCL JHOSC	North Central London Joint Health Overview and Scrutiny Committee
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
PAM	Premises assurance management
PAS	Patient administration system
PDC	Public dividend capital
PID	Patient identifiable data
PP	Private patients
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
STP	Sustainability and transformation partnership
TMC	Trust management committee
UAE	United Arab Emirates
UCL	University College London
UHB	University Hospitals Birmingham
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 27 February 2020

Report title	Chief executive's report
Report from	David Probert, chief executive
Prepared by	David Probert and the executive team
Previously discussed at	Management Executive
Link to strategic objectives	The chief executive's report links to all eight strategic objectives

Brief summary of report

The report covers the following areas:

- Coronavirus planning
- Flu vaccination update
- New appointments
- Financial position M10
- Awards and recognition
- EDHR inaugural meeting
- Launch of NHS LGBT badges
- NCL STP – responding to the LTP
- Oriel update

Action required/recommendation.

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

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

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST

PUBLIC BOARD MEETING – 27 FEBRUARY 2020

Chief Executive's report

Quality

The trust was notified of the outbreak of **coronavirus (covid19)** on the 23rd of January 2020 with a subsequent request from Public Health England (PHE) to ensure that adequate precautions were introduced at the trust to protect patients and staff from onward transmission. The trust responded to this request in the first instance by convening a preparedness group whose remit is to evoke the national guidance distributed via a formal cascade from PHE. In line with this guidance the trust has taken steps to identify suitable facilities to appropriately isolate patients in urgent care settings and continues to work to the guidance in relation to the appropriate triage of patients and, when necessary, liaising with PHE to risk assess individual patients and provide further advice.

The trust has also issued guidance for staff, outlining the actions to be taken should they potentially be deemed at risk from exposure. At the time of writing my report, the trust has had no confirmed cases of patient or staff exposure to covid19.

Trusts are being asked to achieve near universal **flu vaccination** of Trust staff this year, as was the case in 2018/19. The CQUIN associated with the program for improving the vaccination of front line staff has increased to a target of 80% of front line staff in 2019/20. To date the trust has achieved 79% of the required total. The vaccination program concludes at the end of February and remains on trajectory to achieve the target by the end of March 2020.

Financial

The trust over-achieved against the **financial plan** in January with a surplus of £0.63m against a planned surplus of £.059m - £0.04m favourable. The year to date position is now stands a deficit of £0.19m – a favourable variance of £0.10m. Outturn Cost Improvement Plan (CIP) performance for the year is now forecast at £6.0m and just behind the target and this continues to be an area of focus. Cash balances stood at £52.60m at the end of January, aided by a reduction in receivables of £3.20m in-month, and lower than originally forecast capital expenditure. The trust remains on target to achieve this year's control total and all financial performance metrics.

People

I was delighted to host the inaugural meeting of the **Equality Diversity and Human Rights** steering group in January. This group of patient and staff representatives will oversee priorities and governance across this important agenda. We agreed the terms of reference for the group and have identified actions that will enable us to focus our attention and develop a set of core measurable objectives to deliver improvement in patient and staff access and experience. The group will also ensure that we are meeting continuing to meet our statutory and regulatory duties.

MoorPride, our LGBT+ network for staff and patients, launched the **NHS rainbow badges initiative** in February 2020 as part of our LGBT History Month celebrations. NHS rainbow badges are a way to show that Moorfields offers open, non-judgemental and inclusive care for people who identify as LGBT+. The badges are an important way to support the whole Moorfields workforce and help ensure an inclusive culture and workplace for our staff. An LGBT History Month celebration event is being held on Thursday 27 February from 1:30pm in the foyer at City Road.

I am pleased to announce that jointly with UCL we have appointed two **deputy directors of education**, Gordon Hay (Moorfields) and Martin Fruttiger (UCL).

Congratulations go to the optometry-led glaucoma and urgent care service that won the hospital optometry team of the year at the **Association of Optometrists awards 2020**. The team won the award for improving patient experience and increasing capacity whilst maintaining clinical standards and running safe and efficient clinics.

Congratulations also go to **Professor Lyndon da Cruz**, consultant retinal surgeon and medical retina specialist, who has been awarded 'Australian of the Year in the UK, 2020'. Lyndon was awarded the honour in recognition of his outstanding career achievements, including being the clinical lead for the London Project to Cure Blindness and teaching surgery and ophthalmology to doctors in developing countries.

The trust celebrated **National Apprenticeship Week 2020** with a variety of activities, including visiting local schools to promote apprenticeships at the trust, two events with the Institute to discuss Advanced Clinical Practice apprenticeships and a Twitter Q&A where the trust apprenticeship lead took over the trust twitter handle. The week was supported by the communications team who developed case studies with existing apprentices at the trust to bust common myths about apprenticeships and published them on the intranet as well as launching some promotional videos for both internal and external audiences.

Research and innovation

Congratulations to **Professor Ted Garway-Heath**, who has received two prestigious awards for his glaucoma clinical care and research. Ted's significant contribution to the NHS has been recognised with a gold clinical excellence award and the American Glaucoma Society will present him with its international scholar award for his worldwide contribution to glaucoma research, education and patient care.

Dr Roxanne Crosby-Nwaobi, head of research nursing, has secured a highly sought after clinical lectureship as part of the integrated clinical academic (ICA) lectureship programme, run by Health Education England and the National Institute for Health Research.

An HTA grant has been awarded by the NIHR to assess the role of novel digital technologies in ophthalmology to look at the role of AI and tele-medicine in detecting and referring patients with retinal disease. This work is being led by **Dr Konstantinos Balaskas**.

Laura Edwards, optometrist, has been awarded the George Giles postgraduate research prize by the College of Optometrists. Designed to recognise and celebrate outstanding contributions to research in the fields of optometry, optics and vision science; Laura's PhD work focused on ways to improve the uptake of eye health screening tests in the general population.

Strategy

On Wednesday 12 February our lead commissioners gave the go-ahead to our proposal to build a new centre of excellence for eye care, research and education at St Pancras, London. This is an exciting milestone for Oriel and means we can proceed to the next stage of planning.

The decision was made by the **committees in common** which represents the 14 lead clinical commissioning groups (CCGs) that plan and purchase most of Moorfields' services. The committee considered the decision making business case that outlines the full proposal and the public consultation which ran between 24 May and 16 September 2019.

All the information gathered throughout the consultation has been incorporated into design briefs which our architects are now using to create preliminary designs for the new centre. We aim to involve colleagues and patients as much as possible in the design process so that we create a centre that meets the needs of staff, patients and visitors.

As colleagues are aware as part of the Long Term Plan (LTP) the trust has been engaged in the development of the **NCL Sustainability and Transformation plan (STP)**. The STP has been formed to look at how better the providers of health and social care can work across NCL to ensure the highest standards of care are always delivered in the most efficient way. The aim of the STP is to form and develop the basis of the Integrated Care Systems (ICS) which will roll out across the country from April 2021.

As we work our way through this changing healthcare landscape and understand its potential impact on our wider governance and financial landscape I thought it useful to attach a number of documents regarding the STP to my CEO report. The first comes from the NCL STP and outlines how across NCL we plan collectively to focus on delivery of the Long Term Plan. This paper is being shared across all provider boards in NCL over the month of January and February. The paper sets out the work which has been undertaken by the STP over the past year, its current and future focus as well as the opportunities it presents.

The second few slides come from our Head of Systems Partnership, Mark Redhead. Their aim is to start to set out the role that Moorfields and ophthalmology could play in delivery of the LTP both in NCL and beyond. As the landscape around us continues to change I will ensure I bring regular briefings from the NCL STP and ensure we are aware of the role Moorfields is being asked to play in the LTP development moving forward.

David Probert
Chief Executive
February 2020

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North Central London's sustainability and transformation partnership

NHS

Delivering the Long Term Plan in NCL and integrating care to improve outcomes

NCL Trust Boards

January 2020

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Context and purpose of paper

As part of the 2019 planning process STP areas were required to respond to the NHS Long Term plan with a collective set of plans.

This paper sets out a high level summary of the North Central London response to the NHS Long Term Plan.

This plan will be the basis for continued engagement and the development of more detailed work with our staff, local residents and our partners.

The board is asked to:

- Comment and endorse the direction of travel
- Note and discuss areas for opportunity/risk for improving outcomes for residents, reducing inequalities and reducing system costs
- Agree the best approach for continued engagement to enhance and deliver the plans at the different levels of delivery

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Overview

1. Introduction and overview of plan
2. The plan is an evolution of work already underway
3. We want residents to start well, live well, age well
4. What this means for residents
5. We need to work differently to spend public money in the best possible way
6. We ware listening to local people on what is important to them
7. Developing integrated care
8. How we deliver the changes
9. Towards a single plan
    - Delivery mechanisms
    - Working together as a system

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1. Introduction and summary of plan

Our aim is to help residents to live the fullest lives possible, stay well, and to recover from ill health more quickly. We want to tackle the long-standing problems in North Central London (NCL) that mean some residents experience inequalities in their health.

The health and care system has never been busier, caring for an ageing population with more complicated needs, supporting people with long term conditions, and providing access to new treatments that are more expensive. We know that families work hard to pay their taxes and that's why we will make sure every penny is invested on the things that matter most, by getting the basics right, providing high quality lifesaving treatment and care for patients and their families, reducing pressure on our staff and investing in exciting new technologies.

To do this, we will work with partners to integrate services where this improves care and reduces waste, spend public money effectively and support our staff to work in new ways and improve the lives of our residents and communities. For residents, this means that it will be easier for you to get the support and care that you need. More care will be closer to where you live, with less time spent in hospital, if you need to go there, and you will be actively involved in shared decision-making about your health and care.

The organisations that provide health, care and voluntary services in Barnet, Camden, Enfield, Haringey and Islington (North Central London) are working together to try and have the greatest positive impact on the lives of our 1.5 million residents. Our plan sets out what we are aiming to achieve together to deliver improvements over the next five years, and what this will mean for residents. It can be found here:

www.northlondonpartners.org.uk/draftresponseLTP

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2. The Long Term plan builds on the work done so far in NCL

The NCL direction of travel was closely aligned to that set out in the NHS Long Term Plan and as a system, we have used the opportunity to refresh plans our in areas that may need strengthening or additional focus. Our plan set out:

How we need to work differently as partners to help residents start well, live well and age well through:

- Working as partners to integrate care where it improves outcomes
- Fixing the basics and reducing waste and duplication
- Shifting to prevention and early intervention
- Support individuals to have personalised care
- Moving to population health based planning approach

We will change services to:

- Integrate and develop a wide range of out of hospital, community and mental health services to improve health and wellbeing of residents and communities
- Support hospitals to work together more often to deliver excellent, efficient services

This is supported by actions to:

- Better support our staff across health and care
- Take advantage of the opportunities of digital technology
- Manage our estates in a coordinated way
- Ensure finance supports the changes we need to make

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3. We want residents to start well, live well, age well

Evidence shows that as little as 10% of a population's health and wellbeing is linked to access to healthcare. We need to work with partners to look at the bigger picture, including:

This is why we need to work together across the public sector to make sure residents in North Central London, start well, live well, and age well.

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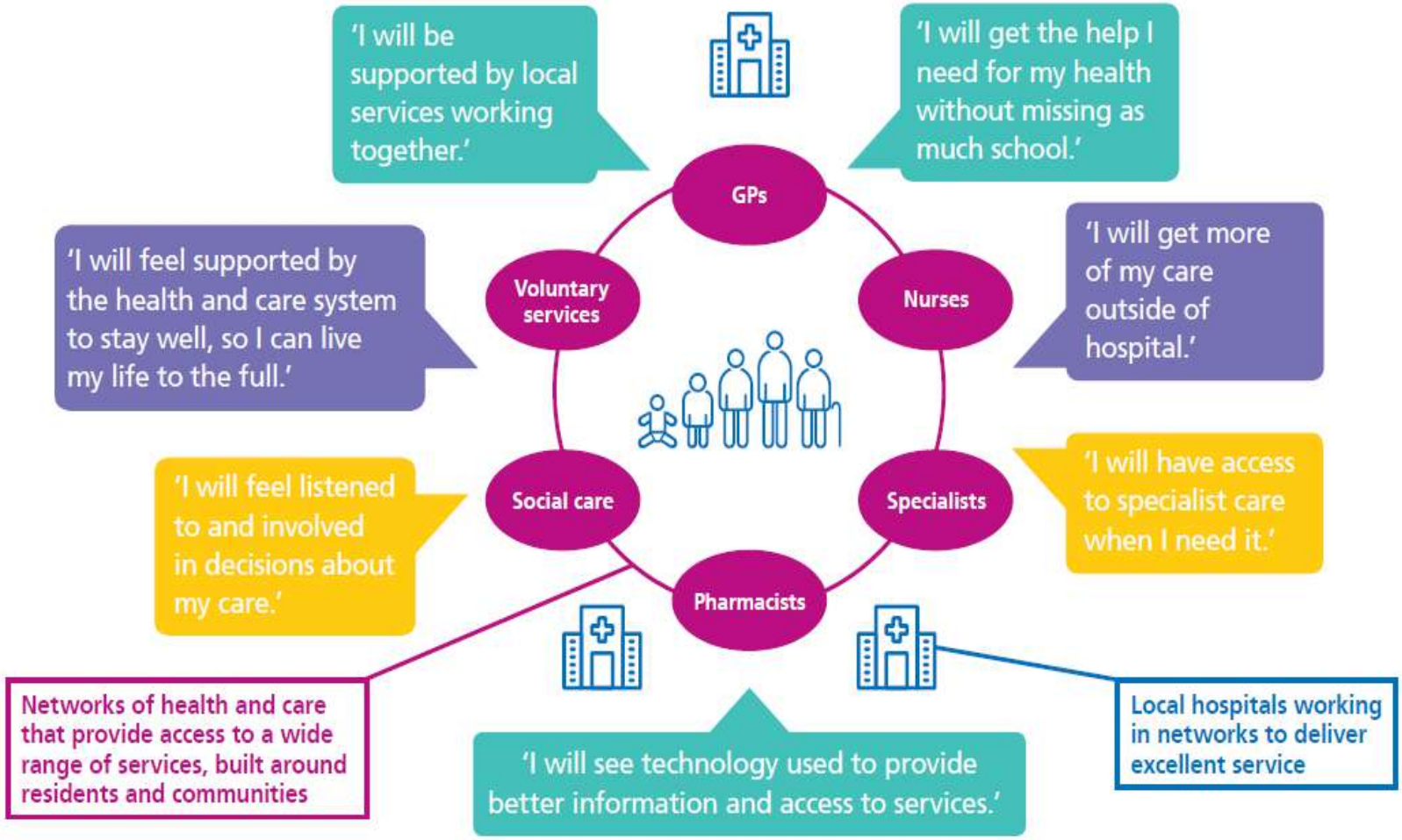
4. A vision of what this will mean for residents



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4. A vision of what this will mean for residents

What will be different?

Joan is 80 years old and lives at home in Camden. She has heart disease and diabetes, and sometimes forgets to take her medication. She has found it more difficult to manage over the last six months but wants to stay living at home. Joan's GP has developed a Care Plan – in discussion with Joan – so that the practice, district nursing team and social care work together to help Joan stay well and living at home safely. If Joan's GP becomes concerned about something, he uses the Rapid Response service to assess her the same day at home, which helps avoid trips to A&E. When Joan did fall last year and needed to be seen at hospital, she was assessed within two hours and a plan was in place quickly to get her home as soon as she was ready.

What will be different?

12-year-old Ali's asthma had been getting worse. He missed a lot of school last year and had several trips to A&E. Ali's school has recently signed up to become an asthma-friendly school which means that his teachers are aware of what Ali needs to do to stay well, like using his inhaler before PE. Ali's GP suggested that he and his mum take part in group consultations with other kids with asthma and their parents and they have picked up some tips on inhaler technique. Ali has started an asthma self-management programme and he now regularly sees a community asthma nurse in the surgery near his home. Ali has been managing his asthma much better and he and his parents are really pleased that he is missing less school and spending less time in hospital.

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5. We need to work differently to spend public money in the best possible way

Across NCL we collectively spend around £4 billion per year on our health and care services. We need to make sure we are making the best use of this money. To do this we need to work together as partners to:

Reduce waste in the system – for example, reducing unnecessary repeat tests by joining up information, and reducing the number of cancelled operations through better coordinated care across organisations.

Support staff, our biggest asset, to work in new ways – for example sharing nurses across organisations, placing pharmacists in GP surgeries, and developing multi-disciplinary teams across health and social care.

Invest in proactive care, support people to better look after their own health and prevent ill health through closer working – for example, making sure people with high blood pressure have the right medication early and working across health and social care to ensure older people can live in their community and stay active.

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5. We've already started, this is the next step…

In NCL we have already been working closely together as partners and have been making changes that we will build upon:

- We've developed integrated networks based around neighbourhoods: this will make it easier to get appointments in primary care and the community and will help to improve the quality of care.
- We've worked to help make sure people are treated closer to home: we have invested in a unit to treat women who require intensive mental health care closer to their family and communities, and residents are able to self refer to a physiotherapist in their GP surgery.
- We've been working to simplify urgent and emergency care: ensuring more residents and and healthcare professionals calling NHS 111 speak to a clinician, as well as making discharge from hospital quicker and safer.
- We've been improving planned care and outpatient care: GPs can now access specialist advice without referring a patient to hospital.
- We're using our workforce and digital technology to drive and support change: we're investing in joining up health and care records to better organise care and have launched a portal to support the recruitment of social care staff.

We want to keep what is working well, and make changes where we think we can do better.

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6. We are listening to local people about what is important to them

We've been speaking with residents and communities across North Central London to make sure we understand what is important to them. Here are some examples of what is in our plans to address these priorities.

What residents told us was important	Examples of what we are doing...
Better access to services	Introducing care navigators to signpost people to the right services
Patients involved in discussions and shared decisions about their care	Children and young people with epilepsy and their families being involved in the development of local epilepsy services
Access to clear and accessible information, including easy read versions and access to interpreters	Healthy Futures providing clear, accessible information for people with diabetes on how to look after their condition
Empathy and understanding around cultural or disability-related needs	Trialling a new pathway for women who do not take up a smear test by offering them a self-sampling kit
Patients given knowledge about how to keep themselves well and support wellbeing	Social prescribing in GP practices to support people to stay active, eat well, reduce isolation and contribute to their communities
Patients given choice and care is planned and delivered to meet each individual's needs	Residents supported to have personal health budgets, including for mental health, to best meet their individual needs for care
Use of technology both to increase access to services and to health information	Residents to have access to online and video consultations
Better joint working between health and social care	Working across NHS, public health and social care to identify people at risk of long term conditions
A focus on prevention and proactive care	Increased community teams and ensure physical health checks for adults with serious mental illness and learning disabilities are being carried out
Everyone gets the same quality of care regardless of where they live	Whole system approach to tackle some issues, such as childhood asthma, to ensure everyone gets the same high-quality care

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6. We have a strong partnership approach to build on

We have been collaborating in NCL over a number of years to better plan and deliver health and care services.

- **NCL CCGs –** one Accountable Officer and Chief Finance Officer across Barnet, Camden, Enfield, Haringey and Islington.
- **Provider partnerships and joint working:** where this improves outcomes and reduces costs
- **CCG and Local Authority relationships** – strong, well-established partnerships across boroughs and through NCL programmes of work.
- **NCL local primary care transformation** – Federations and GP Neighbourhoods in place, with emerging Primary Care Networks across NCL.
- **North London Partners** – providers, commissioners, local authority, other key organisations and residents working together in a Sustainability and Transformation Partnership.

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6. Working differently will help us improve health and wellbeing

- Where we can have a greater impact and there is a benefit for residents, we have an opportunity to work together as partners rather than acting as individual organisations.
- We have fantastic organisations with nationally recognised and world-class services and we need them to continue this amazing work and spread good practice across North Central London.
- Our partnership will work to build on the strengths of organisations and their staff.
- We recognise the important role that health and care services play within the local economy as employers and part of local communities.
- We will work together to simplify how the system works for residents and staff.
- We will plan and deliver better services that meet the needs of residents and their communities.

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7. Developing an integrated care system across NCL

Integrated care means teams and organisations that are responsible for health and care are working together, sharing resources and information to support the needs of individuals, increase our impact and reduce waste. Integration of health and care services will happen in different ways.

Locally, at neighbourhood level: Staff from across health and care working to proactively support residents and communities to stay well and live full lives. This includes different professionals such as nurses, pharmacists, doctors and social workers, working together to care for local people. For example, GP practices will work with care workers and health visitors to improve access to support around employment and community activities, as well as offering high quality clinical care.

Across each borough – within 'Borough Partnerships': This will support services to work together to best meet the needs of local residents. For example, Health and care organisations will jointly plan health and care services to support older residents, rather than individuals receiving care from several teams from different organisations.

Across North Central London – through an 'Integrated Care System': This will allow plans for services for the five boroughs together where it make sense. For example, delivering orthopaedic services as a network, so we cancel fewer operations and more patients get quicker access to a specialist.

We will also tackle long-term issues where a single organisation can not solve it on their own such as taking collective action to reduce air pollution, or creating a joined-up health and care record so residents don't have multiple files at different organisations.

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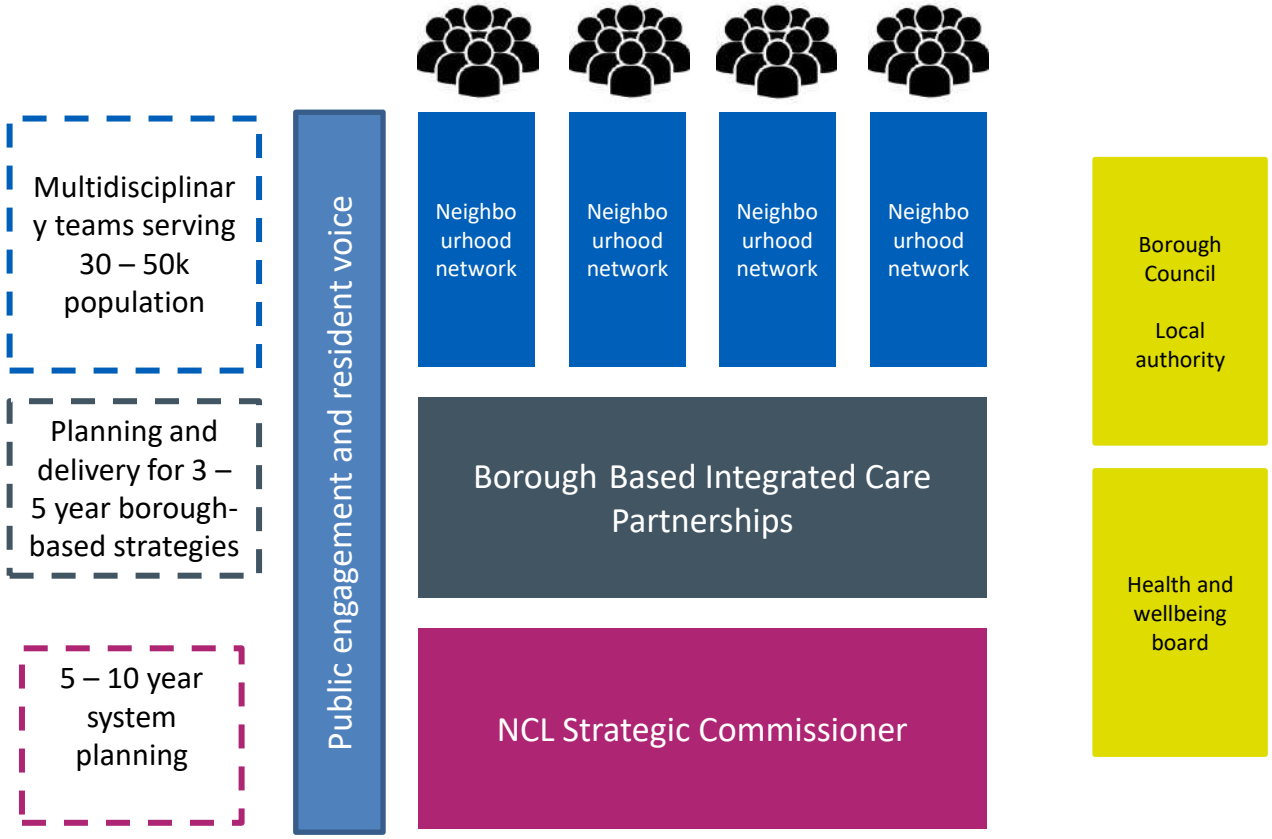
7. Working towards an NCL integrated care system 2019/20

Together, system partners have begun to design what our Integrated Care System (ICS), with borough-based Integrated Care Partnerships, might look like.



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7. Through this, NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services

What?	Where?	Why?	How?
Single CCG for North Central London	One Clinical Commissioning Group for North Central London, building on joint arrangements already in place for the five NCL CCGs	To redesign the way that we commission NHS services to enable and support the new Integrated Care Partnerships	Review of how commissioners work to reduce transactional costs of the system and support ICPs
Borough-based Integrated Care Partnerships	Five borough based Integrated Care Partnerships, aligned to borough boundaries	To enable borough based collaboration to improve service delivery and increase the focus on residents, communities and prevention	Jointly developed by leaders in each borough from the CCG, local authority, and service providers based on population needs
Integrated Care System	One Integrated Care System across NCL, building on our work together through the STP	To transform the way we plan services based on population health to maximise the impact we can have and reduce health inequalities in NCL	Bringing together boroughs to decide where consistency will improve outcomes for resident and which activities take place across NCL

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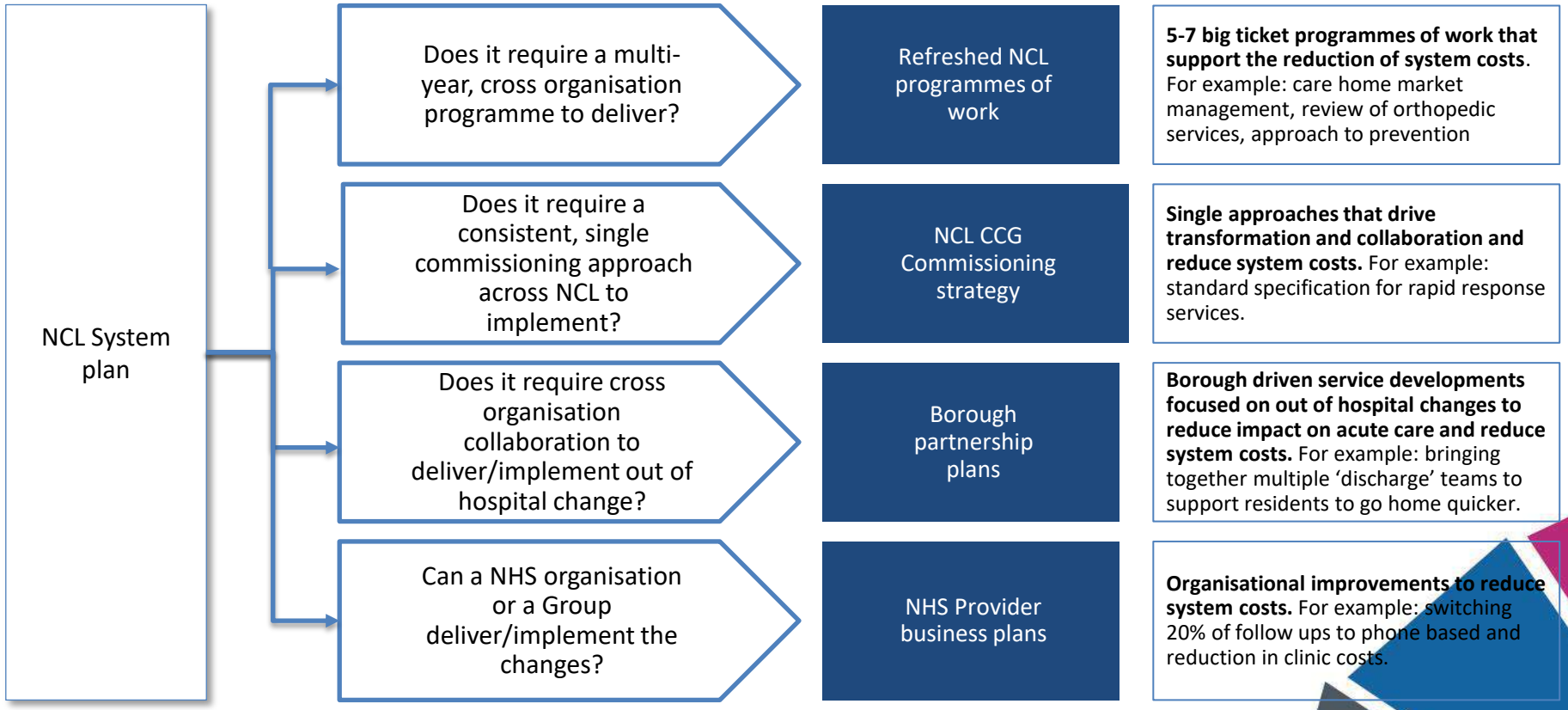
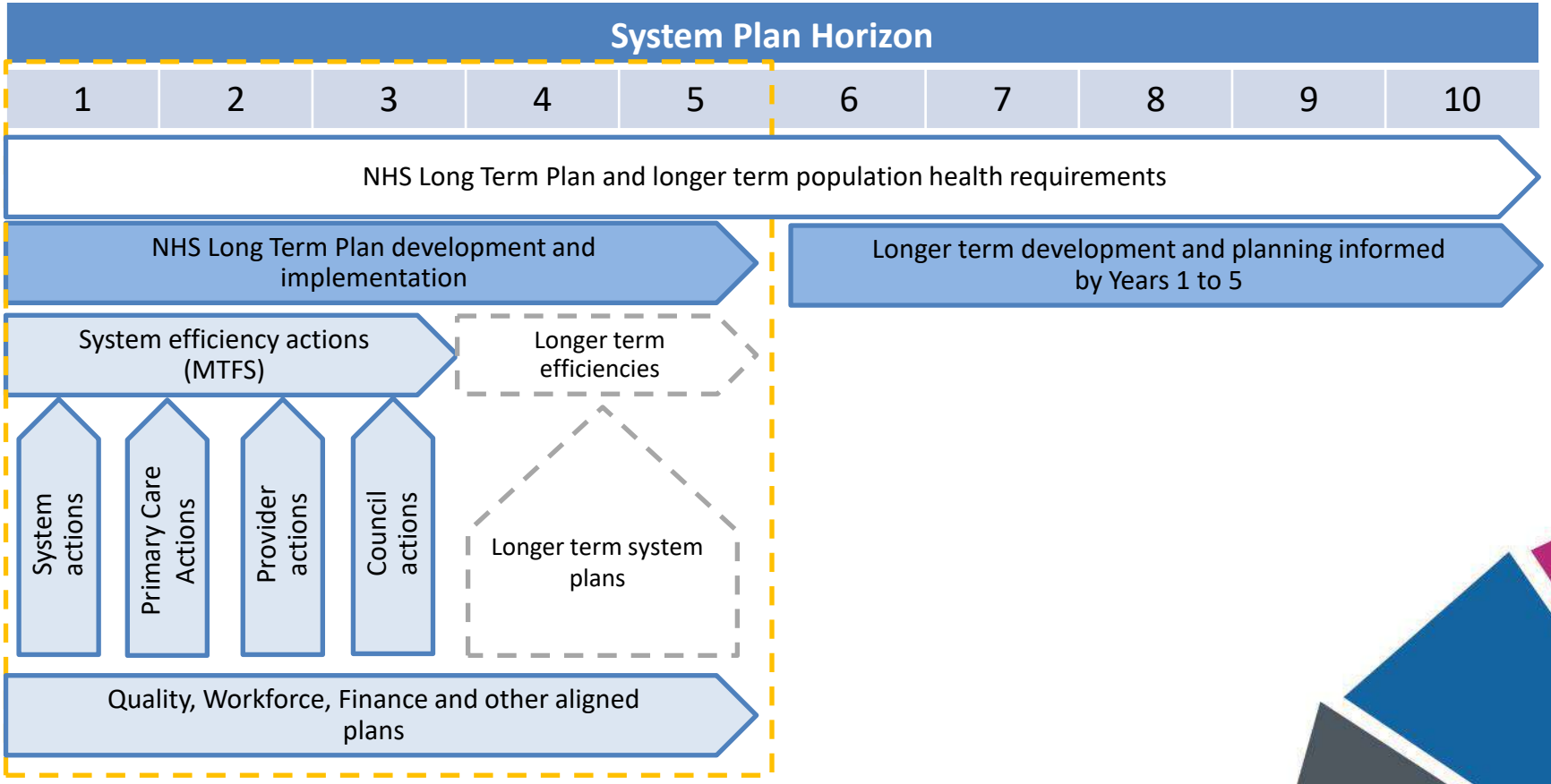
8. How will the changes we need to make be delivered?

The NCL System plan will 'flow' through into organisational planning for the next years via business plans, STP programmes of work and the borough partnerships. The majority of work will require delivery through organisations, supported by a single commissioning approach and collaborations via borough partnerships. There will be a small set of system wide programmes required.



9. We are starting to describe a single plan that describes the changes we need to make together.

- NHS Long Term plan implementation framework sets out requirements for the health systems for the next five years.
- **Recovery of the financial position in NCL is a key enabler and prerequisite for being able to deliver on the longer term ambitions of the Long Term Plan.**
- The NCL System plan includes short term actions we need to take to reduce system costs, as well as the longer term transformation required.
- This work needs to come together as a single programme of work bringing together the current STP programmes, financial recovery work and longer term transformational work in line with the NHS Long Term Plan.
- This will need a step change in terms of adoption of new financial principles, rigour around management of programmes and measurement of success. This needs to be adopted across NHS organisations and programmes across NCL whether these focus on quality, finance or safety.



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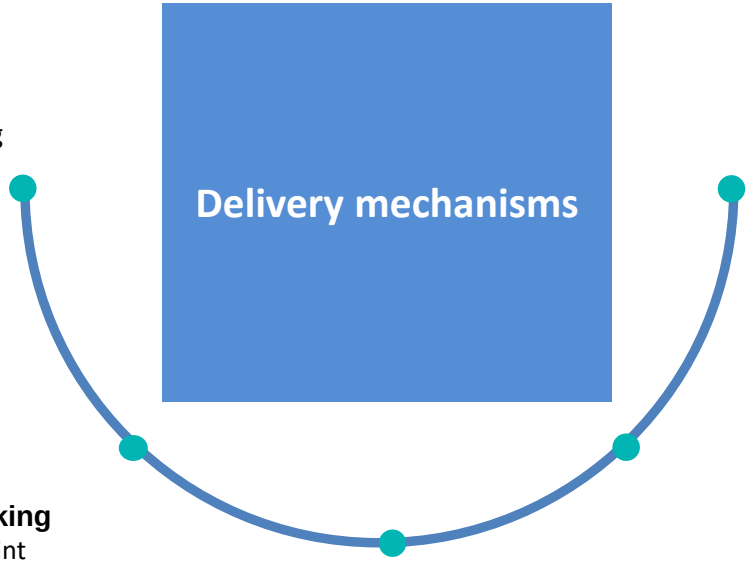
9. We need to put the following in place to support us to deliver



Starting to develop a single NCL System Plan

- Creation of a single NHS plan bringing together the Long Term Plan, system efficiency action, commissioner QIPP and NHS provider CIP
- Implementation of a series of quick wins across all partners
- Build on the above in next stage of plan, working even closer with local authority partners

Governance and accountability

- A description and approach for each borough ICPs linked to a focus on organisational development from 2020/21.
- Review of roles and responsibilities of SRO and programme teams across the STP
- Establishment of system delivery board
- Decision rights framework and ICP architecture

Principles aligned with system working

- A series of financial principles around joint system working (described in Financial Principles paper)
- An agreed level of CIP for each provider which the system effiency programme forms a part
- A contracting set of principles and processes
- Other aligned principles (Workforce, Estates, PMO & Planning)

Closer alignment with Social Services

- Understand from council colleagues how best to build a single NCL system plan
- Ensure the system plan builds on what works locally between local councils and CCGs
- The system plan should be underpinned by a joint vision
- Ensure councils are involved at the right levels of planning / delivery
- Governance against these plans should be truly joint from the outset in setting direction / planning

Programme support and resourcing

- An assessment of the capacity and capability to deliver the plan across organisations
- Review of resources required to deliver
- Commissioning of external support in key areas based on clear return on investment (partners may be required to resource)

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System Principles - Working together

Our priorities

- We are focused on improving the health of the population in North Central London with our available resources
- Addressing health inequalities across the sector and within our boroughs is a priority
- We will maximise what we do locally in NCL

The way we work

We will focus on the benefit to the system, not on the impact to the individual organisation	We will ensure no individual organisation loses out for doing something in the benefit of the wider system	Strong clinical and operational engagement in everything we do
Close working with local authority partners	Shared acknowledgement that system working will be required to address the challenges we face	We will be open and transparent with each other and share data and financial information
We will implement joint planning and more standardised processes across the system	We will hold each other individually and jointly accountable for system sustainability	We will focus on reducing the cost of service delivery, not income generation

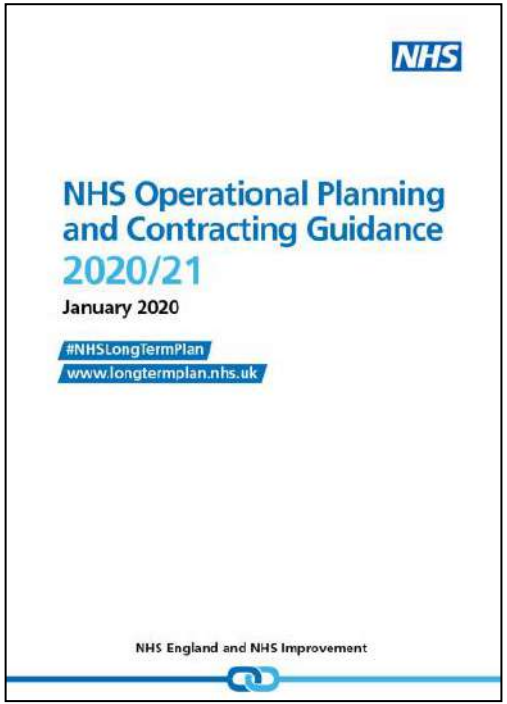
Moorfields Eye Hospital NHS Foundation Trust

NHS

The changing health and care landscape: Adapting to the new system

Strategy and Business Development
February 2020

NHS planning guidance 2021-22



Chris Hopson
@ChrisCEOHopson

1/15 Important new NHS 20/21 planning guidance issued today. What to make of it if you're a senior NHS provider sector leader? My new fifteen tweet thread below. Overwhelming impression is of an NHS in a big and important period of transition.

11:05 PM · Jan 30, 2020 · Twitter for iPad

Chris Hopson
@ChrisCEOHopson

2/15 Today's planning guidance shows NHS transition. FROM overwhelming focus on single institutions, particularly hospitals, treating illness TO integrated systems with a much greater focus on prevention and wellbeing. Long journey to go on here, but shape increasingly clear.

11:05 PM · Jan 30, 2020 · Twitter for iPad

Mark Redhead
@markredhead

Replying to @ChrisCEOHopson

I really like this articulation of the exam question Chris, thanks. There are further layers of complexity and opportunity for regional and national providers but the foundation is this.

10:20 AM · Feb 1, 2020 · Twitter for Android

Long-held assumptions about the system are changing

Significant changes to NHS structures and incentives are taking place, presently in the absence of legislative change. There is an unanswered question about where power and authority lies in the new system, and how resources are deployed effectively across boundaries. The work we are doing in Croydon is a foretaste of what can be expected from more areas.

Current system	New system
• Organisation focus with boards held to account by the regulators and FT governors.	• Integrated System with presumption of working together across boundaries to achieve economies of scale.
• Hospital-delivered reactive episodic care with resources focused on those accessing services.	• Population health, prevention, multi-morbidities, chronic conditions. Targeting resource where it is most effective.
• Competition between providers to drive up quality and support the best (via patient choice) to expand.	• Collaboration and lead provider models. Far less clear what the rules of the game are, at least in the short – medium term.
• Tariff that incentivises efficiency and activity; money follows patient (but for a while, in the wider system at least, tariff has not covered costs and often is contested by commissioners).	• Block contracts that put risk onto providers; demand pressures are the new provider efficiency requirement. Blended payments may offer some short term respite.
• Multi-commissioner environment with clarity between specialised and general services, national, regional and local.	• Strategic commissioning and consolidation of CCGs to be far fewer in number – but has net bureaucracy reduced?
• Light touch, rules-based regulatory framework	• What regulation? (though lots of information still requested and meetings held)
• Compartmentalised systems separated by differences in accountability (regulation, incentives) – e.g. primary, secondary care, community, mental health and social care.	• Trying to integrate systems and join up the way people experience care. Primary Care Networks, horizontal and vertical integration.

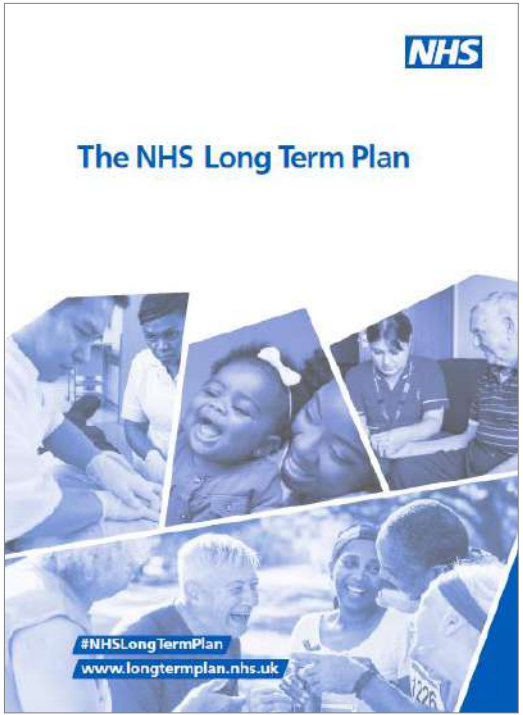
The National Context

The NHS Long Term Plan was published in January 2019. Prior to publication it was known as the 10 year plan: this remains the assumed horizon. The headlines are:

- Integrated care systems by 2021
- Regional plans (5 years): Medium Term Financial Strategy
- Reduction in face to face outpatient appointments by 30%
- Getting the system back into balance.

Where next?
Following the 2019 General Election and the increased government majority, it is unclear how the system might change. What is known is that the needs and actions of the system are at risk of running ahead of the current legislative provisions – so there is likely to be some “tidying up”. Will legislation consolidate and enable the current direction of travel or will it disrupt it? Is authority at the right level in the system?

In early February it was reported that Ministers wanted to assert more direct authority over the health service (NHS England). How is Moorfields positioned to take advantage of this? How far are we the answer to the questions they are asking?

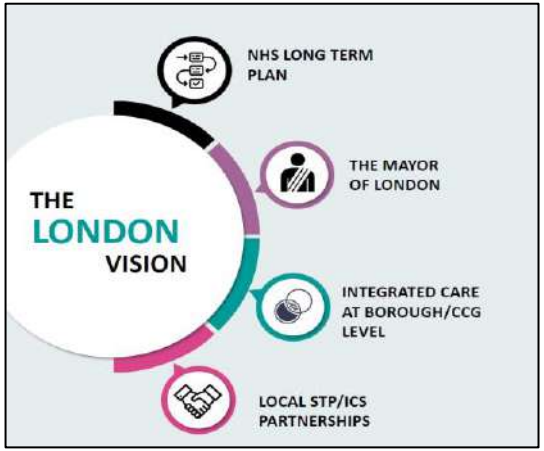


More action of prevention and health inequalities | Improving care quality and outcomes | New service models and integrated care | Supporting staff | Digitally enabled | Value for money

The 2020 NHS London vision on a page

To be the world's healthiest global city

To be the best global city in which to receive healthcare



The vision for London is to tackle healthcare issues at every level:

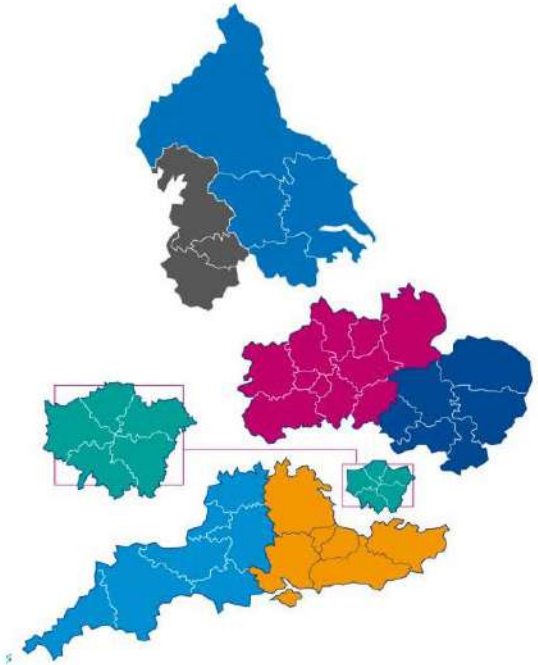
- Through shared decision-making
- Through joint service provision
- By harnessing the power of digital innovation to predict, manage and prevent poor health
- By transforming London's health and care buildings and land
- By **WORKING TOGETHER** to make the best use of our resources for Londoners

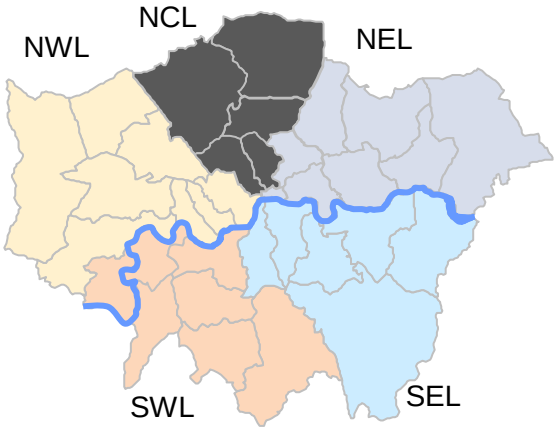
- Reduce childhood obesity
- Improve mental health and progress towards zero suicides
- Improve tobacco control and reduce smoking
- Improve the health of homeless people
- Support Londoners with dementia to live well
- Improve the emotional wellbeing of children and young Londoners
- Improve air quality
- Reduce the prevalence and impact of violence
- Improve services and prevention for HIV and other STIs
- Improve care and support at the end of life

Structural changes in the system

1

There is a new regional structure across England. NHS England and NHS Improvement have put a joint management structure in place.





2

Within London, there are five Sustainability and Transformation Partnerships (STPs). These are to be re-labelled as Integrated Care Systems (ICS) by April 2021.

In advance of this, many of London's 32 CCGs are planning to merge – e.g. in NCL, SEL and SWL.

The boundaries will live on however, because of the need to work with local authorities, which remain unchanged. This means that below an ICS there are going to be integrated borough partnerships (IBP), that deliver care in conjunction with the borough councils.

3

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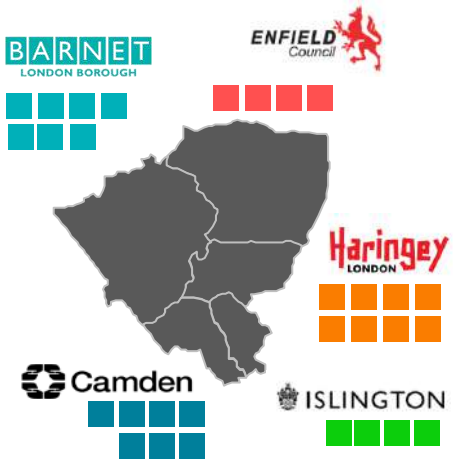
Within NCL, our "home" STP/ ICS, the five CCGs will merge to form NCL CCG, but IBPs will be in place in Camden, Enfield, Haringey, Islington and Barnet.

Below the IBPs are a series of Primary Care Networks (PCNs) which serve footprints of c. 30 - 120 000 people. NCL has 30 PCNs.



Changing our frame of reference as a single specialty provider: Four current challenges

Integrated Care Systems

- We aren't anchored in one ICS – we have a regional and national reach – and we are not top of any one ICS agenda: can we change this, e.g. through outpatient transformation or providing replicable proof of concepts for regional and national application?
- Who are our advocates in the system and what do we need to do to secure their ongoing support? What are other specialist hospitals doing?
- What might we need to consider to succeed in future? How do we frame success?

Strategic commissioning

- Strategic commissioning and consolidation of CCGs could help us…
- For example, a regional strategic commissioning framework could help a lot – can we ask this of the system? What would they ask in return?
- What is our appetite to "direct" ophthalmology for London?
- What is our appetite for system leadership – and what do we do if it is low?

Population health

- A critical aspect of implementing population health is defining your served populations. Is our population a regional or even a national one?
- Is our main focus as a specialist trust bringing a research profile to prevention?
- Do we more deliberately and visibly work with charities and the primary care optometry sector? In what ways?
- Can we link our population health narrative to management of multi-morbidities and conditions highlighted in the long term plan, such as diabetes, vascular disease and dementia?

Horizontal and vertical integration

- Population health and funding challenges will lead the NHS towards scale, consolidation and horizontal / vertical integration.
- Croydon is an early example of this where we have experience, but it is yet to be fully evaluated.
- There is already demand for similar models from other geographies (including NCL). What do we need to do to make sure that future models are rolled out in a financially sustainable way?

National Context (what is Moorfields' narrative?)

Opportunity and Impact

50%
of all sight loss in the UK is preventable.

Demand

Ophthalmology is the largest OP specialty in the NHS. It makes up
8%
of all activity
(over 7.5m appointments a year)

The majority of care relates to chronic disease which requires ongoing OP assessment

Capacity

85% of trusts are unable to meet demand: since 2010 around
2000
people have suffered a degree of permanent vision loss due to delays.

There are currently
136
unfilled consultant ophthalmologist posts

Moorfields Eye Hospital NHS Foundation Trust

NHS

Ophthalmology sits well with the ambition in the Long Term Plan – and is positioned to deliver.

New Service Models

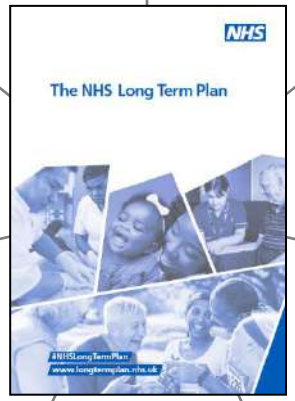
Ophthalmology is the largest OP specialty and is well positioned to reduce face to face appointments through pathway redesign, system working and digital innovations to provide care closer to home.

Wider social goals

Investing in eye care and prevention of sight loss will benefit society by enabling more people to play a full part in their communities. The overall economic burden of sight loss in the UK is estimated at £28bn.

Prevention and health inequalities

50% of all sight loss is preventable and the UK ophthalmology sector is developing innovative interventions and treatments to make prevention more likely. Stem cell treatments for wet AMD at Moorfields prevent sight loss. **(better examples needed here….)**



Value

There are a large number of opportunities for optimising value through system working and technology, as well as traditional operational improvements. For example, in cataracts, there is an efficiency opportunity of 14% (from 7 cases per list to 8 cases per list) to offset predicted 25% growth in demand over ten years.

Care Quality and outcomes

Many of the conditions prioritised in the LTP have implications for people's sight – including diabetes and cardio-vascular disease. Eye conditions are under-diagnosed in people with dementia. A focus on eye health as part of healthy ageing is critical.

Digital

Ophthalmology has the opportunity to demonstrate rapidly and compellingly the potential for technological advances. Changes to pathways involving community settings, nonmedical staff and IT connectivity will provide the basis for rapid upscaling of the current fast-paced research and pilots in telemedicine, clinical decision support and automation, remote monitoring and replacement of routine follow ups with rapid access.

People

Ophthalmology is well placed to make innovative use of new roles and develop better system working across primary and secondary care. More can be done by practitioners in non-consultant roles, AHPs and optometrists (together with the benefits of machine learning and AI).

Report to Trust Board	
Report Title	**Integrated Performance Report - January 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 Board is asked to note the IPR which is grouped into four scorecards in order the Board can identify the areas that contribute to our ambition of service excellence. Though good financial health with good infrastructure and culture as enablers and good people as enablers this should ensure the Trust delivers service excellence.

Context

A&E activity has been higher than expected all year and we now expect this to continue until the end of the year. Attendances are expected to be approximately 100,000, this will be 2,500 attendances above the previous year.

Month 10 activity picked up from the previous month all areas are up against the previous year. Activity was above plan for electives, follow-ups and injections but slightly below plan for news for January. For the end of the year activity is already booked above plan for Follow-ups and injections.

Service excellence

Overall performance remains strong and the Trust continues to meet the national access targets year to date and this month hit all national Cancer targets. The 14 day commissioner standard was just below the threshold at 89.3% which was mainly due to patient choice.

Journey times have plateaued. A review of this will come back to the Board first quarter in the new financial year.

Complaints are above trajectory for the year however the trend is downward and the way this is currently measured is being reviewed for next year.

Incidents open above 28 days has shown a small improvement in month. This remains closely monitored at the weekly Senior Management Team meeting with the NHS and private divisions. Performance is expected to improve further and this will be continue to be closely monitored.

People (enabler)

Overall figures for appraisal and Mandatory Training Compliance remain above the target however there is been a fall in Information Governance Training Compliance which will be closely monitored in early 2020.

Infrastructure and culture (enabler)

Ethnicity recording remains just under the target and has done for some months. City Road and South divisions are near to this target and are actively looking at how they can deliver this. South division are slightly further behind and further work is required to understand this.

Financial Health and Enterprise

Activity in Month 10 was good as discussed above. CIP delivery for the year is positive and is forecast to be 86%, detail will be covered in the finance report.

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 - January 2020

Service Excellence (Ambitions)

Patient Centred Care

	G	A	R
Total	**33**	**0**	**6**
Cancer	3	0	1
Access & Outpatients	5	0	2
Admitted	6	0	1
Quality & Safety	19	0	2
Private Patients	0	0	0

Collaborative Research

G	A	R
2	0	0

Innovation & Education

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

Influence National Policy

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

People (Enablers)

Workforce Metrics

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

Staff Satisfaction & Advocacy

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

Infrastructure & Culture (Enablers)

Digital Delivery

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

Research

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

Education

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

Financial Health & Enterprise (Enablers)

Overall Plan

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

Commercial Operations

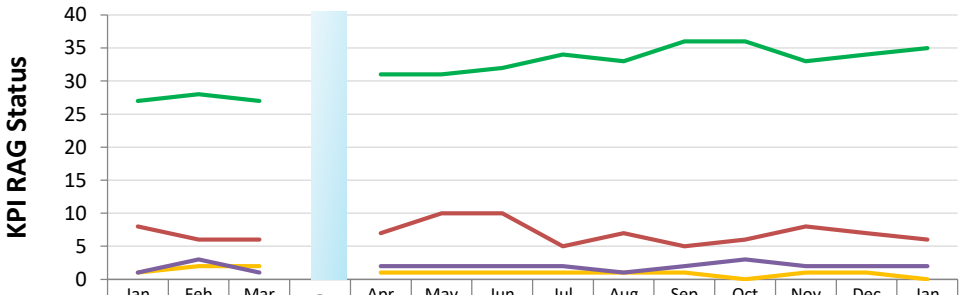
G	A	R
1	**0**	**0**

Cost Improvement Plans

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

Executive Summary - Scorecard Domain Trends

Service Excellence (Ambitions)



	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Green	27	28	27		31	31	32	34	33	36	36	33	34	35
Amber	1	2	2		1	1	1	1	1	1	0	1	1	0
Red	8	6	6		7	10	10	5	7	5	6	8	7	6
Green	1	3	1		2	2	2	2	1	2	3	2	2	2

People (Enablers)

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

Infrastructure & Culture (Enablers)

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

Financial Health & Enterprise

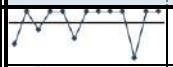
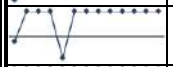
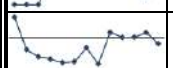
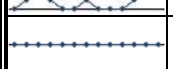
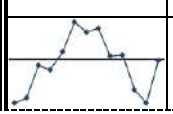
	Jan	Feb	Mar	-	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Green	1	1	2		1	1	1	0	1	3	3	2	2	3
Amber	0	0	0		0	1	0	0	0	0	0	0	0	0
Red	2	2	1		2	1	2	3	3	0	0	1	1	0

Lines split by financial year due to different number of metrics

Context - Overall Activity - January 2020

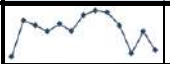
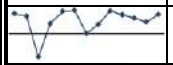
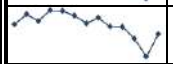
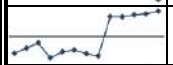
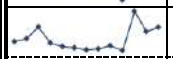
		January 2020		Monthly Variance	Year To Date		YTD Variance
		2018/19	2019/20		2018/19	2019/20	
Accident & Emergency	A&E Arrivals (All Type 2)	8,007	8,206	+ 2.5%	81,029	83,230	+ 2.7%
	Number of 4 hour breaches	35	92	+ 162.9%	1,258	1,355	+ 7.7%
Outpatient Activity	Number of Referrals Received	11,897	12,015	+ 1.0%	116,655	121,290	+ 4.0%
	Total Attendances	54,144	55,094	+ 1.8%	500,910	515,626	+ 2.9%
	First Appointment Attendances	12,078	11,924	- 1.3%	113,910	114,605	+ 0.6%
	Follow Up (Subsequent) Attendances	42,066	43,170	+ 2.6%	387,000	401,021	+ 3.6%
Admission Activity	Total Admissions	3,279	3,542	+ 8.0%	32,074	33,056	+ 3.1%
	Day Case Elective Admissions	2,960	3,203	+ 8.2%	28,891	29,631	+ 2.6%
	Inpatient Elective Admissions	108	117	+ 8.3%	933	1,028	+ 10.2%
	Non-Elective (Emergency) Admissions	211	222	+ 5.2%	2,250	2,397	+ 6.5%

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

Patient Centred Care (Cancer)	Cancer 2 week waits - first appointment urgent GP referral	≥93%										→
	Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	≥93%										↓
	Cancer 31 day waits - Decision to Treat to First Definitive Treatment	≥96%										→
	Cancer 31 day waits - Decision to Treat to Subsequent Treatment	≥94%										→
	Cancer 62 days from Urgent GP Referral to First Definitive Treatment	≥85%										
Patient Centred Care (Access & Outpatients)	18 Week RTT Incomplete Performance *	≥92%										↓
	52 Week RTT Incomplete Breaches *	Zero Breaches										→
	A&E Four Hour Performance	≥95%										↓
	Percentage of Diagnostic waiting times less than 6 weeks	≥99%										→
	Average Call Waiting Time	≤ 3 Mins (180 Sec)										↓
Patient Centred Care (Access & Outpatients)	Median Clinic Journey Times - New Patient appointments: Year End Target of 95 Mins	Mth:≤ 97Mins										↑
	Median Clinic Journey Times -Follow Up Patient appointments: Year End Target of 85 Mins	Mth:≤ 87Mins										↑
Patient Centred Care (Admitted)	Theatre Cancellation Rate (Overall)	≤7.0%										↓
	Theatre Cancellation Rate (Non-Medical Cancellations)	≤0.8%										↓
	Number of non-medical cancelled operations not treated within 28 days *	Zero Breaches										↓
	Mixed Sex Accommodation Breaches	Zero Breaches										→
	Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	≤ 2.67%										↑

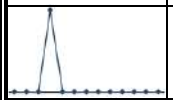
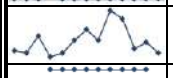
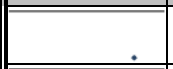
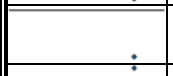
* Provisional Figure for January 2020

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

	VTE Risk Assessment	≥95%										↓
	Posterior Capsular Rupture rates	≤1.95%										↓
Patient Centred Care (Quality & Safety)	Occurrence of any Never events	Zero Events										↓
	Endopthalmitis Rates - Aggregate Score	Zero Non-Compliant										
	MRSA Bacteraemias Cases	Zero Cases										→
	Clostridium Difficile Cases	Zero Cases										→
	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Zero Cases										→
	MSSA Rate - cases	Zero Cases										→
	Inpatient (Overnight) Ward Staffing Fill Rate	≥90%										↑
	Inpatient Scores from Friends and Family Test - % positive	≥90%										↑
	A&E Scores from Friends and Family Test - % positive	≥90%										↓
	Outpatient Scores from Friends and Family Test - % positive	≥90%										↑
	Paediatric Scores from Friends and Family Test - % positive	≥90%										↑
	Inpatient Scores from Friends and Family Test - % response rate	≥30%										↓
	A&E Scores from Friends and Family Test - % response rate	≥20%										↑
	Outpatient Scores from Friends and Family Test - % response rate	≥15%										↑
	Paediatric Scores from Friends and Family Test - % response rate	≥15%										↑

* Provisional Figure for January 2020

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

Patient Centred Care (Quality & Safety)	Summary Hospital Mortality Indicator	Zero Cases										→
	NHS England/NHS Improvement Patient Safety Alerts breached	Zero Alerts										→
	Number of Written Complaints	YTD ≤ 203										↓
	Freedom of Information Requests Responded to Within 20 Days	≥90%										
	Subject Access Requests (SARs) Responded To Within 28 Days	≥90%										
	Number of Serious Incidents remaining open after 60 days	Zero Cases										→
	Number of Incidents (excluding Health Records incidents) remaining open after 28 days	≤ 20 Open										↑
Collaborative Research	Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	≥1500										↑
	Percentage of Trust Patients Recruited Into Research Projects	≥2%										→
Innovation & Education	Income Generated From Short Courses £k (Year Period - Sep 19 to Aug 20)	YE: ≥£400k Qtr: tbc										
	Delegate Numbers Across Short Courses (Year Period - Sep 19 to Aug 20)	YE: ≥900 Qtr: tbc										
	Average Delegate Satisfaction Scores (Year Period - Sep 19 to Aug 20)	≥ 4.0										

* Provisional Figure for January 2020

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

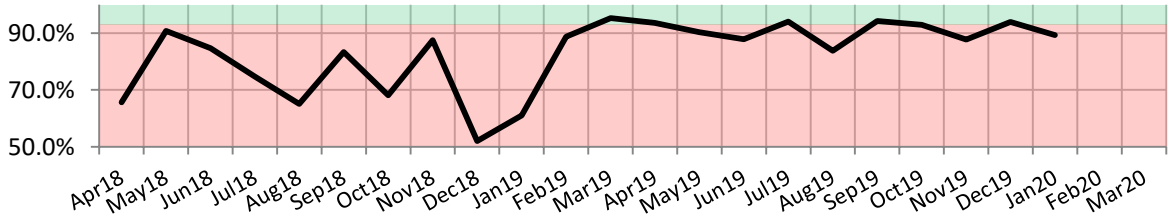
Remedial Action Plan - January 2020

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	Oct-19	Nov-19	Dec-19	Jan-20
≥93%	Red	90.7%	92.9%	87.7%	93.9%	89.3%

Divisional Benchmarking (Jan 20)	City Road	North	South
	89.3%	n/a	n/a



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Previous Outstanding Issues			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Total patients seen in January were 75 with 8 breaches: 7 due to patient choice and 1 due to administrative error.	1. The patient appointment booking script has been reviewed and strengthened to support/encourage patients to book within 14 days. This now includes escalation to a clinical nurse specialist – if required. 2. The human error was discussed with the staff member and training provided. This is being closely monitored by the service manager on a weekly basis.	May 2020

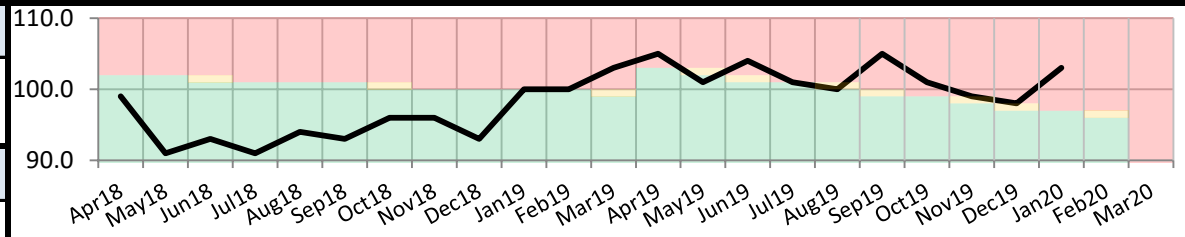
Remedial Action Plan - January 2020

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

Median Clinic Journey Times - New Patient appointments: Year End Target of 95 Mins

Target	Rating	YTD	Oct-19	Nov-19	Dec-19	Jan-20
Mth:≤ 97Mins	Red	n/a	101	99	98	103

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



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Although still not on trajectory, median new journey times continue to show a decrease from last month. Again this remains due to ongoing small changes contributing to an overall improving position, although this is still within normal statistical variance.	Ongoing roll out of the sub-specialty clinical stratifiation models for glaucoma and medical retina, moving patients into diagnostic only and optometry led pathways througout 2019-20. To enable this the following have been completed: - An ongoing gap analysis of activity, resource (kit, space, personnel) and how the service for MR and Glaucoma on a site and clinic level demonstrates improvements in the roll out of diagnostic only and/or optometry led clinics. - Extended roll out of stratified care in City Road, Croydon, Northwick Park, Ealing and St George's are underway.	Apr 2020	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Staffing issues within the Medical Imaging service have had a significant impact on the flow of Medical Retina and Ocular Oncology clinics in City Road.	Staffing levels are being reviewed by the Medical Imaging department.	April 2020

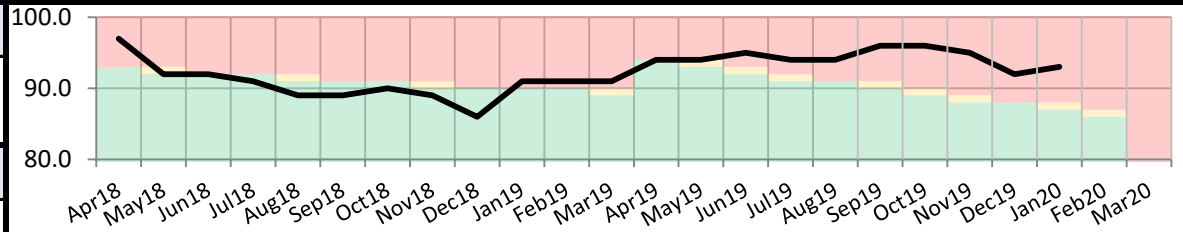
Remedial Action Plan - January 2020

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

Median Clinic Journey Times -Follow Up Patient appointments: Year End Target of 85 Mins

Target	Rating	YTD	Oct-19	Nov-19	Dec-19	Jan-20
Mth:≤ 87Mins	Red	n/a	96	95	92	93

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



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Follow-up journey times demonstrate a slight decrease which is not significantly higher than normal variance levels.	Ongoing roll-out of the sub-specialty clinical stratification models for glaucoma and medical retina, which will reduce outpatient journey times - as part of this a significant proportion of follow-up patients are being moved into more efficient digital imaging pathways throughout 2019-20. - Demand & capacity modelling work will allow more detailed analysis of the workforce, kit and space resource required per sub-specialty. - Data completeness continues to be reviewed in weekly divisional performance meetings.	Apr 2020	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Staffing issues within the Medical Imaging service have had a significant impact on the flow of Medical Retina and Ocular Oncology clinics in City Road.	Staffing levels are being reviewed by the Medical Imaging department.	April 2020

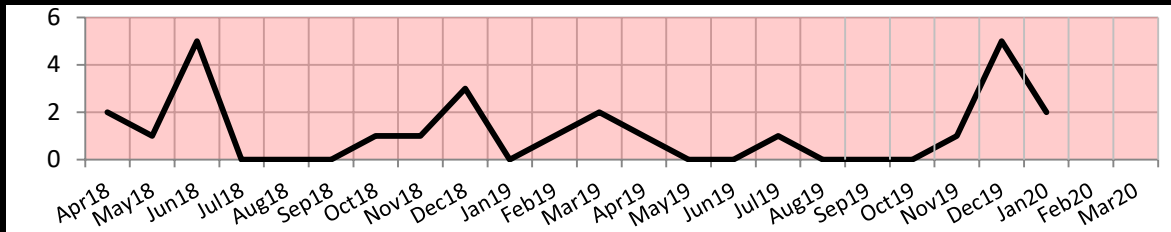
Remedial Action Plan - January 2020

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

Number of non-medical cancelled operations not treated within 28 days

Target	Rating	YTD	Oct-19	Nov-19	Dec-19	Jan-20
Zero Breaches	Red	5	0	1	5	2

Divisional Benchmarking (Jan 20)	City Road	North	South
	1	0	1



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
The breaches in December were due to unplanned consultant sickness and inability to source alternative cover for specialist procedures.	For this cohort, the division will be working with the service lead to discuss cover arrangements, such as pooled lists and/or cross cover.	Mar 2020	Complete

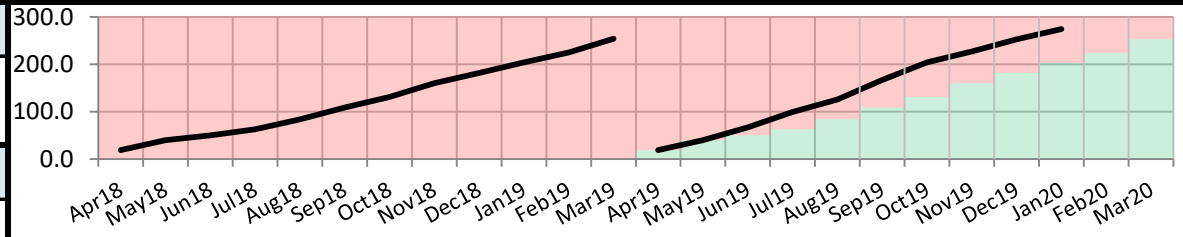
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The City Road patient was as a result of patient choice. An appointment with an alternative consultant was offered to the patient, however, declined as the patient preferred to be seen by this particular surgeon.	Service is undertaking a review of how waiting lists are currently managed with the view of implemeting pooled waiting lists and also communicating this to patients in clinics.	April 2020
Patient booked to next available list in error.	Admissions team reminded of 28 day rebook target, new weekly reporting process put in place to ensure all NMC booked within 28 days, including escalation process if capacity not available	March 2020

Remedial Action Plan - January 2020

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Quality & Safety)
Number of Written Complaints	**Lead Manager**	**Tim Withers**	**Responsible Director**	**Ian Tombleson**

Target	Rating	YTD	Oct-19	Nov-19	Dec-19	Jan-20
YTD ≤ 203	Red	274	37	23	26	21

Divisional Benchmarking (Jan 20)	City Road	North	South
	10	3	5



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
The number of complaints for December was 26. Though a notable reduction on previous months still higher than the previous year's average. There were eight complaints (under City Road) regarding the new transport provider DHL and ranged from communication with DHL to the suitability of transport provided.	DHL/ Royal Free, the transport provider is embedding the service and weekly meetings are reviewing performance.	Mar 2020	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
The number of complaints for January was lower than previous months, particulalry as the figure includes six complaints regarding transport. We anticipate that numbers will continue to decrease as transport issues are resolved	Weekly meetings continue with DHL/Royal Free to identify and address issues	April 2020

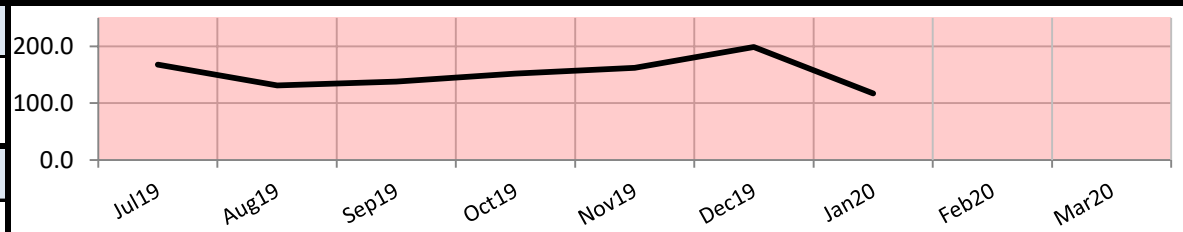
Remedial Action Plan - January 2020

Domain	Service Excellence (Ambitions)	Theme	Not Set
Lead Manager	Julie Nott	Responsible Director	Ian Tombleson

Number of Incidents (excluding Health Records incidents) remaining open after 28 days

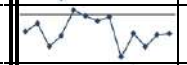
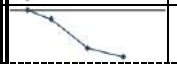
Target	Rating	YTD	Oct-19	Nov-19	Dec-19	Jan-20
≤ 20 Open	Red	n/a	152	162	199	117

Divisional Benchmarking (Jan 20)	City Road	North	South
	28	9	24



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Divisions continue with their targeted reviews. A/L leave during December 2019 is likely to have contributed to the recent increase in the number of open incidents >28 days. In December there were 2 new/1 on-going SIs which may have reduced routine monitoring by divisions.	Targeted reviews of those areas in which there has been a significant increase in open incidents are being led by the risk & safety team. There is a cohort of incidents that are not managed by the corporate divisions (research and IT), that accounts for a third of the overall figure. Recent escalations have been made to raise awareness with specific teams to help bring the numbers down.	Feb 2020	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Figures for January 2020 show a significant decrease in the number of open incidents that are older than 28 days; more recent data shows that this has reduced further across all clinical divisions. Approximately half of these incidents are awaiting closure by a management unit other than City Road, North or South.	We expect targeted reviews to continue to improve performance. The KPI will be refreshed during March 2020 to better reflect divsional performance	March 2020

Workforce Metrics	Appraisal Compliance	≥80%										
	Information Governance Training Compliance	≥95%										
	Staff Turnover (Rolling Annual Figure)	≤15%										
	Proportion of Temporary Staff	RAG as per Spend										
Staff Satisfaction & Advocacy	Percentage of Staff agreeing with the staff survey statement "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	≥90%										
	Percentage of Staff agreeing with the staff survey statement "I would recommend my organisation as a place to work"	≥70%										

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

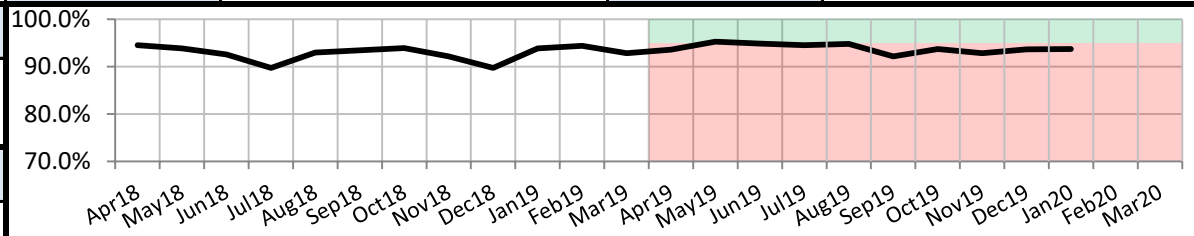
Remedial Action Plan - January 2020

Domain	People (Enablers)	Theme	Workforce Metrics
Lead Manager	**Nicky Wild**	**Responsible Director**	**Sandi Drewett**

Information Governance Training Compliance

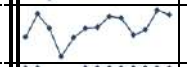
Target	Rating	YTD	Oct-19	Nov-19	Dec-19	Jan-20
≥95%	Red	n/a	93.7%	92.8%	93.6%	93.7%

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



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
Some data queries (inclusion of staff on long term absence, some minor data cleansing needed)	IG identifying data cleansing needs. Then IG to meet with IT and HR to resolve. Regular emails to individual staff (copying in their line managers) where their training is out of date. Revised Statutory & Mandatory training policy to be enforced Email to go out to all staff about the importance of completing IG training.	Feb 2020	In Progress (No Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
	Previous actions on-going	

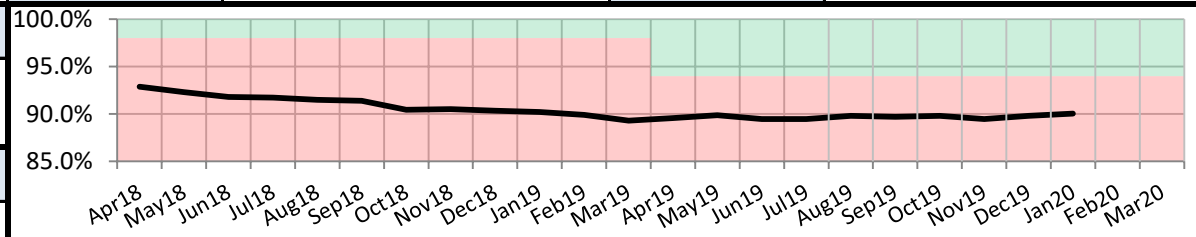
Digital Delivery	Data Quality - Ethnicity recording (Outpatient and Inpatient)	≥94%										↑
	Data Quality - Ethnicity recording (A&E)	≥94%										↓
Research	70 Day To Recruit First Research Patient	≥80%										→
	Percentage of Research Projects Achieving Time and Target	≥65%										→
	Percentage of Patients Recruited Against Target (Studies Closed In Month)	100%										↑

Remedial Action Plan - January 2020

Domain	Infrastructure & Culture (Enablers)	Theme	Digital Delivery
Data Quality - Ethnicity recording (Outpatient and Inpatient)	**Lead Manager**	**Donna Flatt**	**Responsible Director**	**John Quinn**

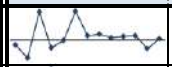
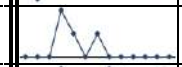
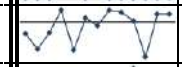
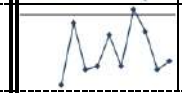
Target	Rating	YTD	Oct-19	Nov-19	Dec-19	Jan-20
≥94%	Red	89.7%	89.8%	89.5%	89.8%	90.0%

Divisional Benchmarking (Jan 20)	City Road	North	South
	91.0%	85.2%	93.3%



Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
This is a long standing issue for the organisation and whilst benchmark performance is better than many other trusts the national target has never been achieved and is extremely stretching. Underlying reasons include the lack of comprehensive operating procedures, customer service training and the inherent sensitivities surronding the collection of these data.	A Patient Ethnicity report has been devised and published to the first meeting in December of the Weekly Access (Performance) meeting. It will be used to discuss and monitor performance.	Dec 2019	In Progress (Update)

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
This is a long standing issue for the organisation and whilst benchmark performance is better than many other trusts the national target has never been achieved and is extremely stretching. Underlying reasons include the lack of comprehensive operating procedures, customer service training and the inherent sensitivities surronding the collection of these data.	The introduction of the regular reporting has shown some signs of influencing improved performance and will continue to be produced. Improvements are also anticipated on the introduction of new Standard Operating Procedures and an audit programme will be initiated from April will support data quality improvement across all outpatient procedures.	April 2020

Overall Plan	Overall financial performance (In Month Var. £m)	≥0										↑
	Distance from Financial Plan (Current in Trust Metric : Trust Underlying Overall Position - Surplus / Deficit)	1										→
Commercial Operations	Commercial Trading Unit Position (In Month Var. £m)	≥0										→
Cost Impovement Plans	Cost Improvement Plan Variance	≥0										↑

For commentary on Financial KPIs please refer to Board Finance Report

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 07

Finance report

Board of directors 27 February 2020

Report title	Monthly Finance Performance Report Month 10 – January 2020
Report from	Jonathan Wilson, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

The Trust has reported a control total surplus of £0.6m in January, compared to a planned surplus of £0.6m, a break-even position. Year to date the Trust has reported a £0.2m deficit, a favourable variance against plan of £0.1m.

Financial Performance £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Budget	Actual	Variance
Income	£242.4m	£21.2m	£20.9m	(£0.3m)	£201.6m	£203.4m	£1.9m
Pay	(£132.5m)	(£10.4m)	(£10.3m)	£0.1m	(£110.3m)	(£108.2m)	£2.2m
Non Pay	(£100.9m)	(£9.5m)	(£9.3m)	£0.3m	(£83.9m)	(£87.4m)	(£3.5m)
Financing & Adjustments	(£9.0m)	(£0.7m)	(£0.7m)	(£0.1m)	(£7.7m)	(£8.1m)	(£0.4m)
CONTROL TOTAL	**(£0.0m)**	**£0.6m**	**£0.6m**	**£0.0m**	**(£0.3m)**	**(£0.2m)**	**£0.1m**

Efficiency scheme performance is reporting delivery of £0.6m in January, compared to a planned £0.9m an adverse variance of £0.3m. Year to date delivered savings are £4.8m against a planned £5.4m, an adverse variance against plan of £0.6m.

The Trust is forecasting £6.0m of savings schemes inclusive of £0.3m red risk rated schemes from the planned £7.0m target. There remains a forecast gap of £1.0m.

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 31st January 2020 (Month 10)

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 30th January 2020 (Month 10)

Key Messages

Statement of Comprehensive Income

Financial Position	The Trust is reporting a surplus of £0.6m in January, compared to a planned surplus of £0.6m; a break-even position. Year to date performance is a deficit of £0.2m compared to a planned deficit of £0.3m; a favourable variance of £0.1m.
Income	Total income is £1.9m favourable to plan YTD. NHS commissioned clinical income is £1.6m favourable to plan YTD, and £0.1m favourable in month. The cumulative variance is due to positive Inpatient and Outpatient activity being £0.4m and £0.8m above plan respectively. Commercial income is £0.5m adverse to plan, with Moorfields Private activity being lower than plan (£0.7m).
Expenditure (pay, non pay and financing)	Pay costs are £2.2m favourable to plan YTD primarily due to vacancies across all staff groups, with the exception of registered nursing. Non pay expenses are £3.5m adverse to plan YTD including, Health Records (£1.1m), City Road clinical supplies (£1.5m), and non-delivered efficiencies (£0.6m). Agency costs are below NHSI plan levels and reflect the positive move to increase substantive recruitment
Research	R&D is reporting a £1.1m adverse variance to plan YTD due to reductions in national income compared to costs.
Commercial Trading Units	Trading units are reporting a £0.2m adverse variance to plan YTD. Moorfields Private are £0.4m adverse YTD, whilst Moorfields Dubai is reporting a favourable variance of £0.20m.
Efficiency Programme	The Trust is reporting YTD efficiency savings achieved of £4.8m compared to a plan of £5.4m, an adverse variance of £0.6m. There are currently £0.8m of unidentified savings schemes, and a further £0.3m schemes assessed as high risk. Current forecast delivery is £6.0m, compared to the £7.00m full year target, representing a gap of £1.0m.

Statement of Financial Position

Cash and Working Capital Position	The cash balance at the 31st January is £52.6m, £12.4m above plan primarily due to a reduction in receivables, higher than planned 2018/19 PSF receipts, and a £5.6m capital expenditure underspend.
Capital (both gross capital expenditure and CDEL)	Total capital expenditure YTD is £8.3m (gross and on a CDEL basis). Expenditure includes investment in clinical estate, IT and medical equipment. Capital forecast for the year has been revised to £14.50m from £18.10m further to the requested review of planned in year capital spend.
Use of Resources	The Use of Resources rating is 1 against the planned rating of 1. The year end rating is forecast to be 1.
Receivables	Trust receivable debt has reduced by £0.6m to £20.2m since the start of the financial year. The reduction in month is due to improved debt recovery.
Payables	Trust creditors have reduced by £6.1m to £10.5m since the start of the year. Payment of invoices YTD is at 87% by volume for Non NHS suppliers.
Forecast	The Trust is forecasting to meet its planned full year control total of breakeven, and is reviewing and preparing potential mitigations in respect of known challenges such as efficiency programme identification levels, and operational financial risks.

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	Forecast Budget	Forecast Actual	Forecast Variance
Income	£242.4m	£21.2m	£20.9m	(£0.3m)	£201.6m	£203.4m	£1.9m		£242.4m	£243.1m	£0.7m
Pay	(£132.5m)	(£10.4m)	(£10.3m)	£0.1m	(£110.3m)	(£108.2m)	£2.2m		(£132.5m)	(£130.8m)	£1.7m
Non Pay	(£100.9m)	(£9.5m)	(£9.3m)	£0.3m	(£83.9m)	(£87.4m)	(£3.5m)		(£100.9m)	(£102.8m)	(£1.9m)
Financing & Adjustments	(£9.0m)	(£0.7m)	(£0.7m)	(£0.1m)	(£7.7m)	(£8.1m)	(£0.4m)		(£9.0m)	(£9.4m)	(£0.4m)
CONTROL TOTAL	**(£0.0m)**	**£0.6m**	**£0.6m**	**£0.0m**	**(£0.3m)**	**(£0.2m)**	**£0.1m**		**(£0.0m)**	**(£0.0m)**	**£0.0m**
Memorandum Items											
Research & Development	£0.74m	£0.01m	(£0.24m)	(£0.25m)	£0.68m	(£0.41m)	(£1.09m)		£0.7m	(£0.5m)	(£1.23m)
Commercial Trading Units	£4.77m	£0.63m	£0.71m	£0.08m	£3.78m	£3.63m	(£0.15m)		£4.8m	£4.5m	(£0.23m)
ORIEL Revenue	(£2.50m)	(£0.16m)	£0.03m	£0.19m	(£2.19m)	(£1.91m)	£0.28m		(£2.5m)	(£2.4m)	£0.10m
Efficiency Schemes	£7.00m	£0.87m	£0.60m	(£0.28m)	£5.37m	£4.80m	(£0.57m)		(£7.0m)	(£6.0m)	(£1.02m)

INCOME BREAKDOWN RELATED TO ACTIVITY

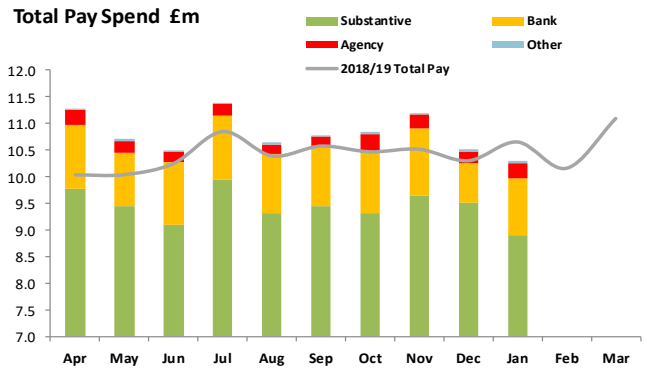
Income Breakdown £m	Annual Plan	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Budget	Forecast Actual	Forecast Variance
NHS Clinical Income	£138.1m	£115.1m	£116.1m	£1.0m		£138.1m	£178.9m	£40.7m
Pass Through	£38.6m	£32.2m	£32.8m	£0.6m		£38.6m	-	(£38.6m)
Other NHS Clinical Income	£9.8m	£8.1m	£8.1m	(£0.0m)		£9.8m	£9.7m	(£0.1m)
Commercial Trading Units	£31.2m	£25.6m	£25.1m	(£0.5m)		£31.2m	£30.1m	(£1.1m)
Research & Development	£14.5m	£12.1m	£12.5m	£0.4m		£14.5m	£13.8m	(£0.7m)
Other	£10.3m	£8.5m	£8.9m	£0.4m		£10.3m	£10.7m	£0.4m
TOTOAL OPERATING REVENUE	**£242.4m**	**£201.6m**	**£203.4m**	**£1.9m**		**£242.4m**	**£243.1m**	**£0.7m**

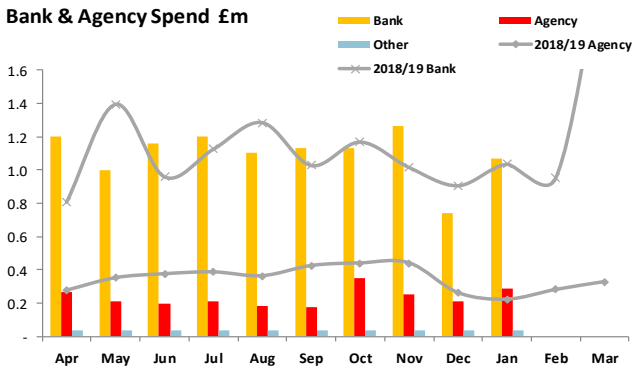
RAG Ratings

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	(£128.8m)	(£10.1m)	(£8.9m)	£1.19m	(£107.2m)	(£94.0m)	(£13.21m)	87%
Bank	(£2.8m)	(£0.2m)	(£1.1m)	(£0.84m)	(£2.3m)	(£11.0m)	£8.66m	10%
Agency	(£0.5m)	(£0.0m)	(£0.3m)	(£0.25m)	(£0.4m)	(£2.8m)	£2.36m	3%
Other	(£0.4m)	(£0.0m)	(£0.0m)	(£0.00m)	(£0.3m)	(£0.4m)	(£0.02m)	0%
TOTAL PAY	**(£132.5m)**	**(£10.4m)**	**(£10.3m)**	**£0.10m**	**(£110.3m)**	**(£108.2m)**	**(£2.20m)**	





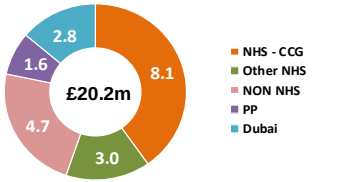
CASH, CAPITAL AND OTHER KPI'S

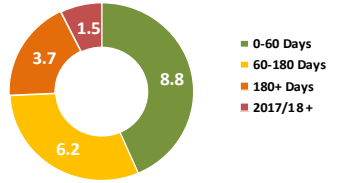
Capital Programme £m	Annual Plan	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Budget	Forecast Actual	Forecast Variance
Trust Funded	(£17.7m)	(£13.9m)	(£8.3m)	(£5.6m)		(£17.7m)	(£14.4m)	(£3.2m)
Donated	(£0.4m)	-	-	-		(£0.4m)	(£0.1m)	(£0.4m)
TOTAL	**£18.1m**	**£13.9m**	**£8.3m**	**(£5.6m)**		**£18.1m**	**£14.5m**	**(£3.6m)**

Key Metrics	Plan	Actual	RAG
Cash	40.2	52.6	
Debtor Days	45	30	
Creditor Days	45	33	
PP Debtor Days	65	68	

Use of Resources	Plan	Actual
Capital service cover rating	1	1
Liquidity rating	1	1
I&E margin rating	3	3
I&E margin: distance from fin. plan	1	1
Agency rating	1	1
OVERALL RATING	**1**	**1**

Net Receivables/Ageing £m





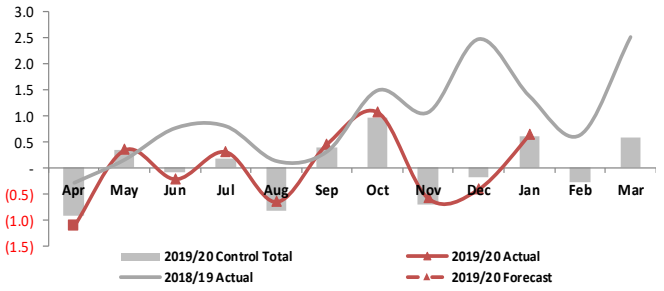
Trust Income & Expenditure Performance

FINANCIAL PERFORMANCE

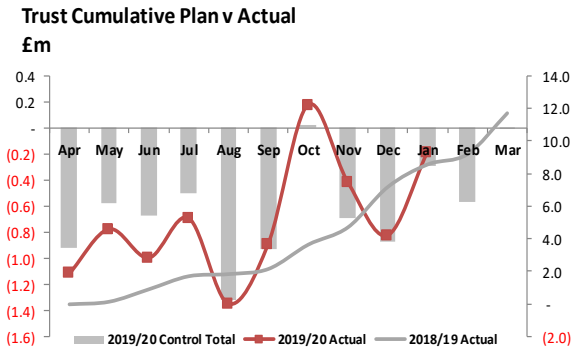
Statement of Comprehensive Income £m	Annual Plan	In Month			Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance	Budget	Actual	Variance
Operating Income										
NHS Commissioned Clinical Income	176.72	15.73	15.81	0.08	147.28	148.92	1.65	176.72	178.86	2.14
Other NHS Clinical Income	9.80	0.89	0.82	(0.07)	8.09	8.05	(0.04)	9.80	9.67	(0.13)
Commercial Trading Units	31.17	2.74	2.32	(0.42)	25.64	25.10	(0.54)	31.17	30.12	(1.05)
Research & Development	14.47	0.95	0.88	(0.07)	12.07	12.46	0.39	14.47	13.75	(0.72)
Other Income	10.25	0.88	1.07	0.19	8.50	8.91	0.42	10.25	10.69	0.44
Total Income	**242.43**	**21.18**	**20.90**	**(0.28)**	**201.58**	**203.45**	**1.87**	**242.43**	**243.09**	**0.67**
Operating Expenses										
Employee Expenses	(132.49)	(10.39)	(10.29)	0.10	(110.32)	(108.15)	2.16	(132.49)	(130.84)	1.65
Non Pay Expense	(100.89)	(9.55)	(9.27)	0.28	(83.88)	(87.38)	(3.49)	(100.89)	(102.83)	(1.94)
Total	**(233.39)**	**(19.94)**	**(19.56)**	**0.38**	**(194.20)**	**(195.53)**	**(1.33)**	**(233.39)**	**(233.67)**	**(0.29)**
EBITDA	*9.04*	*1.24*	*1.34*	*0.10*	*7.38*	*7.92*	*0.54*	*9.04*	*9.42*	*0.38*
Financing & Depreciation	(9.58)	(0.70)	(0.76)	(0.06)	(8.12)	(8.53)	(0.41)	(9.58)	(9.92)	(0.33)
SURPLUS / (DEFICIT)	**(0.54)**	**0.54**	**0.59**	**0.04**	**(0.75)**	**(0.61)**	**0.13**	**(0.54)**	**(0.49)**	**0.05**
Donated assets adjustments	0.54	0.04	0.05	0.00	0.46	0.42	(0.04)	0.54	0.49	(0.05)
CONTROL TOTAL SURPLUS / (DEFICIT)	**(0.00)**	**0.59**	**0.63**	**0.04**	**(0.29)**	**(0.19)**	**0.10**	**(0.00)**	**(0.00)**	**(0.00)**

PERFORMANCE AGAINST PLAN

Trust Monthly Plan v Actual



Trust Cumulative Plan v Actual



Commentary

Operating Income

The Trust is reporting income of £20.90m in January, compared to a plan of £21.18m, an adverse variance of £0.28m.

Commissioned patient care activity income is £0.08m favourable to plan in January with Inpatient activity (£0.10m) being a key contributor. Over-performance on Injection activity of £0.30m was also recorded, although this was off-set by under-performance across other points of delivery.

Commercial income was adverse to plan in January by £0.42m, whilst non-commissioned clinical income (primarily Bedford) was adverse by £0.07m.

Employee Expenses

Total pay was £0.10m favourable to plan in January due to Medical staff vacancies across the Trust, and lower bank and agency use in month across all staff groups.

Medical additional/locum session payments during January totalled £0.25m of which £0.18m relates to specialties at City Road, whilst a further £0.07m relates to satellite sites.

Non Pay Expenses

(non pay and financing)

Non pay reported a favourable variance of £0.28m in January, due to the reduction in Project Oriel accrued costs of £0.20m and unutilised contingency of £0.1m. Health Records continues to over-spend (£0.14m), and reflects the on-going trend in-year. Cost improvement savings were behind plan in January by £0.28m.

Financing, depreciation and adjustments were on plan in month as donated asset income and favourable variances following the Trusts estate revaluation exercise performed in 2018/19, off-set by the impairment to the Electronic Medical Records system.

Trust Patient Clinical Income Performance

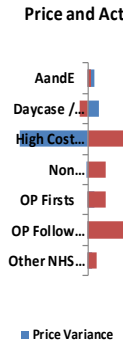
PATIENT CLINICAL INCOME

Point of Delivery	Activity YTD			YTD Income £'000			RAG
	Plan	Actual	Variance	Plan	Actual	Variance	
AandE	82,922	83,229	307	£12,896	£13,022	£126	
Daycase / Inpatients	30,484	30,391	(93)	£33,558	£33,592	£34	
High Cost Drugs	42,022	45,913	3,891	£32,180	£32,783	£602	
Non Elective	2,251	2,366	115	£4,343	£4,564	£221	
OP Firsts	106,197	107,591	1,394	£18,013	£18,338	£325	
OP Follow Ups	388,412	393,621	5,209	£39,575	£40,108	£534	
Other NHS Clinical Income	17,540	18,103	563	£3,522	£3,685	£162	
Total	669,827	681,214	11,387	£144,087	£146,091	£2,004	

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

PRICE & ACTIVITY VARIANCE

Average price			£000's	
Per Plan	Received	Variance %	Price Variance	Activity Variance
£156	£156	1%	£78	£48
£1,101	£1,105	0%	£136	(£102)
£766	£714	-7%	(£875)	£1,478
£1,930	£1,929	0%	(£2)	£223
£170	£170	0%	£88	£237
£102	£102	0%	£3	£531
£201	£204	1%	£49	£113
			(£522)	£2,526

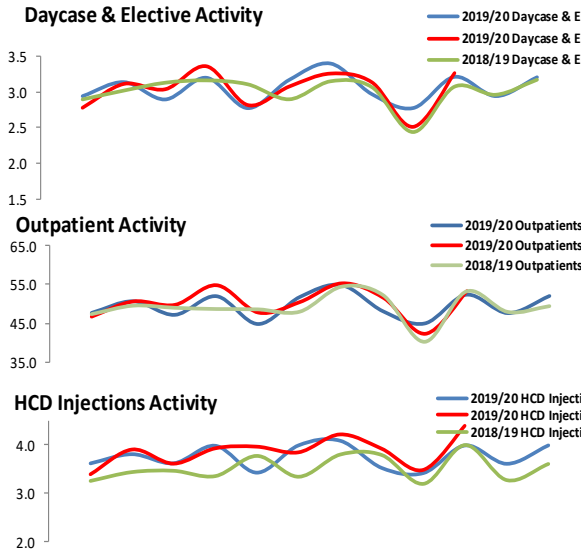


CONTRACT SLA PERFORMANCE

Divisional Income Performance £m	Activity			YTD Income £'000		
	Plan	Actual	Variance	Plan	Actual	Variance
City Road	421,342	423,956	2,614	£88,748	£88,457	(£291)
North	133,821	138,613	4,792	£30,829	£32,404	£1,575
South	114,615	116,319	1,704	£24,220	£25,067	£847

Top CCG's	Activity			YTD Income £'000		
	Plan	Actual	Variance	Plan	Actual	Variance
NHS Croydon CCG	48,752	48,527	(224)	£10,528	£10,433	(£95)
NHS Ealing CCG	33,631	36,001	2,370	£7,771	£8,598	£827
NHS Wandsworth CCG	27,385	30,339	2,954	£5,952	£6,839	£887
NHS Harrow CCG	27,110	27,955	845	£6,267	£6,539	£271
NHS City and Hackney CCG	30,707	30,970	263	£6,320	£6,453	£133
NHS Islington CCG	20,692	22,160	1,468	£4,257	£4,658	£400

ACTIVITY TREND



Commentary

NHS Income

Overall NHS Patient Clinical activity income in January is above plan. Income is reporting a favourable variance to plan YTD of £2m.

Outpatients

Outpatient activity over-performed planned levels during January, activity plan YTD is currently above planned levels, representing an increase in activity compared to the same period last year.

Day case and Inpatient

Activity was above plan during January, and is also appearing above plan YTD. Key specialities where YTD activity is behind plan include Adnexal and Medical Retina. Strabismus and Cataract are over-performing YTD.

High Cost Drugs/ Injections

Activity was above planned levels for January and is above plan YTD by £0.39m.

High Cost Drugs/injections represent a pass through cost for the organisation and any under/over performance within income is compensated within non pay, therefore not affecting the Trusts overall financial performance.

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

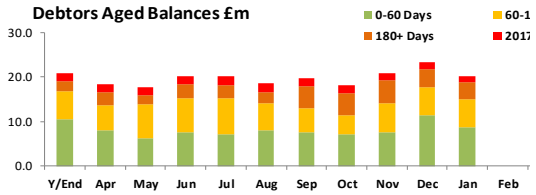
CAPITAL EXPENDITURE

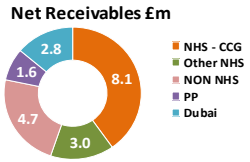
Capital Expenditure £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Plan	Forecast Actual	Forecast Variance
Estates - Trust Funded	4.1	3.8	1.3	(2.5)	4.1	3.2	(0.8)
Medical Equipment - Trust Funded	3.3	1.6	2.0	0.4	3.3	2.9	(0.4)
IT - Trust Funded	4.0	3.4	1.0	(2.3)	4.0	2.7	(1.3)
ORIEL - Trust Funded	6.0	4.9	3.7	(1.2)	6.0	5.3	(0.7)
Dubai - Trust funded	0.3	0.2	0.3	0.0	0.3	0.3	-
Other - Trust funded	-	-	-	-	-	-	-
TOTAL - TRUST FUNDED	**17.7**	**13.9**	**8.3**	**(5.6)**	**17.7**	**14.4**	**(3.2)**
IT - Externally Funded	0.4	-	-	-	0.4	0.1	(0.4)
TOTAL INCLUDING DONATED	**18.1**	**13.9**	**8.3**	**(5.6)**	**18.1**	**14.5**	**(3.6)**

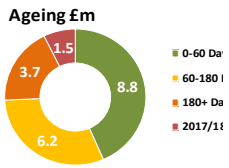
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Planned Total Depreciation	7.1	7.1		100%
Cash Reserves - B/Fwd cash	8.7	8.7		100%
Capital investment loan funding	-			
Cash Reserves - Other (PSF)	3.6	3.6		100%
Capital Loan Repayments	(1.8)	(1.8)		100%
TOTAL - TRUST FUNDED	**17.7**	**17.7**	**-**	**100%**
Externally funded	0.4		0.4	0%
TOTAL INCLUDING DONATE	**18.1**	**17.7**	**0.4**	**98%**

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2017/18 +*
CCG Debt	3.8	2.2	2.0	0.0
Other NHS Debt	1.3	0.5	0.7	0.5
Non NHS Debt	2.0	1.9	0.4	0.4
Commercial Unit Debt	1.6	1.6	0.6	0.6
TOTAL RECEIVABLES	**8.8**	**6.2**	**3.7**	**1.5**

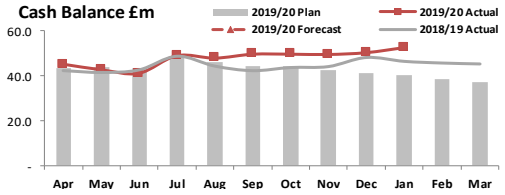






STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date Plan	Year to Date Actual	Year to Date Variance
Non-current assets	102.9	100.0	91.1	(8.9)
Current assets (excl Cash)	19.6	20.1	25.2	5.1
Cash and cash equivalents	37.3	40.2	52.6	12.4
Current liabilities	(39.9)	(39.8)	(42.2)	(2.4)
Non-current liabilities	(36.1)	(37.0)	(38.8)	(1.8)
TOTAL ASSETS EMPLOYED	**83.8**	**83.5**	**87.9**	**4.5**



OTHER METRICS

Use of Resources	Weighting	Plan YTD	Score
Capital service cover rating	20%	1	1
Liquidity rating	20%	1	1
I&E margin rating	20%	3	3
I&E margin: distance from financial	20%	1	1
Agency rating	20%	1	1
OVERALL RATING		**1**	**1**

Working Capital Metrics	KPI	Dec 19	Jan 20
BPPC - NHS (YTD) by number	95%	64%	66%
BPPC - NHS (YTD) by value	95%	49%	48%
BPPC - Non-NHS (YTD) by number	95%	87%	87%
BPPC - Non-NHS (YTD) by value	95%	88%	87%
Debtor Days (YTD)	45	35	30
Creditor Days (YTD)	45	41	33
PP Debtor Days (YTD)	65	58	68

Commentary

Cash and Working Capital

The cash balance at the 31st January is £52.6m, £12.4m above plan primarily due to £5.6m slippage in capital expenditure, reduction in receivables, and higher than planned 2018/19 PSF receipts.

Capital Expenditure

Total capital expenditure YTD is £8.3m (gross and on a CDEL basis). Expenditure includes investment in clinical estate, IT and medical equipment. Capital forecast for the year has been revised to £14.50m from £18.10m further to the requested review of planned in year capital spend.

Use of Resources

The overall Use of Resources rating is 1, compared to a plan of 1 for January.

Key points to note are:-

- I&E margin metric is reporting a 3 for January, as per plan of 3.
- Capital Service rating of 1 is on plan.

Receivables

Receivables totalled £20.2m in January, a reduction of £0.6m since March 2019. There is also a reduction of £3.2m from Month 9 as over-performance debt is cleared as it becomes due.

Payables

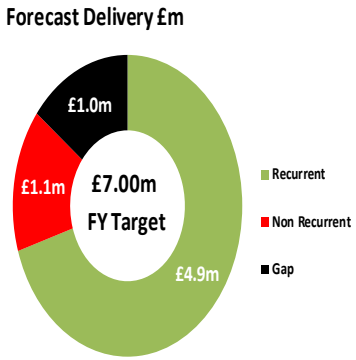
Payables totalled £10.5m in January, a reduction of £6.1m since March 2019.

Efficiency Schemes Performance

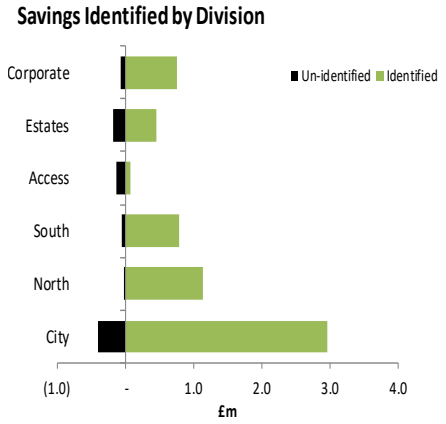
EFFICIENCY SCHEME PERFORMANCE

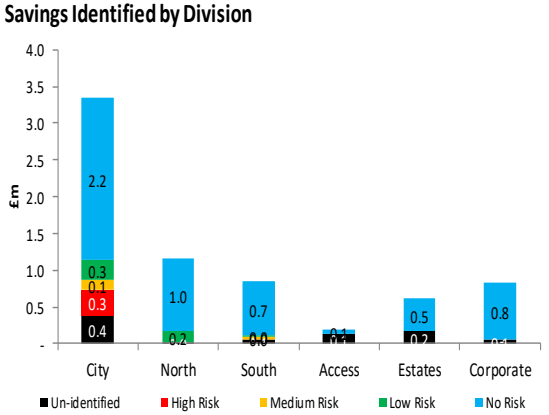
Efficiency Schemes £m	Annual Plan	In Month			Year to Date			Forecast		
		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
City Road	£3.35m	£0.41m	£0.28m	(£0.13m)	£2.47m	£2.21m	(£0.27m)	£3.35m	£2.76m	(£0.59m)
North	£1.15m	£0.08m	£0.08m	£0.00m	£1.00m	£0.81m	(£0.19m)	£1.15m	£1.13m	(£0.03m)
South	£0.85m	£0.09m	£0.07m	(£0.02m)	£0.67m	£0.62m	(£0.05m)	£0.85m	£0.79m	(£0.06m)
Access	£0.20m	£0.05m	£0.01m	(£0.04m)	£0.10m	£0.05m	(£0.04m)	£0.20m	£0.07m	(£0.13m)
Estates & Facilities	£0.62m	£0.08m	£0.03m	(£0.06m)	£0.45m	£0.40m	(£0.06m)	£0.62m	£0.45m	(£0.17m)
Corporate	£0.82m	£0.16m	£0.13m	(£0.04m)	£0.68m	£0.71m	£0.03m	£0.82m	£0.78m	(£0.04m)
TOTAL EFFICIENCIES	**£7.00m**	**£0.87m**	**£0.60m**	**(£0.28m)**	**£5.37m**	**£4.80m**	**(£0.57m)**	**£7.00m**	**£5.98m**	**(£1.02m)**

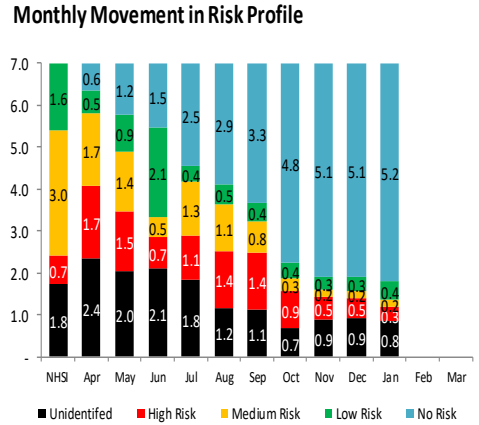
TRUST WIDE FORECAST



DIVISIONAL REPORTING & OTHER METRICS







Commentary

In Year Delivery The Trust is reporting efficiency savings achieved of £0.60m in January, compared to a plan of £0.87m. YTD efficiency savings achieved are £4.80m compared to a plan of £5.37m, an adverse variance of £0.57m.

Identified Savings There are currently £0.80m of unidentified savings schemes, and a further £0.3m of schemes assessed as high risk.

The divisional reporting segment highlights the level of identified schemes by division and the corresponding risk profile for these schemes.

Risk Profiles The chart to the left demonstrates the changing risk profiles of identified schemes Trustwide since the beginning of the year.

Forecast Of the planned target for £7m efficiency savings, the currently assessed forecast achievement based on the level of identified schemes, and risk profile is £5.98m, an adverse forecast of £1.02m compared to plan.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 09
Guardian of safe working
Board of directors 27 February 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 quarterly report covers the period from 25/09/19 – 17/02/20.

Exception Reports

During the last quarter, there have only been 4 exception reports by 4 trainees working outside of their allocated rota. Three exceptions for delayed clinics (1.5-2 hours overtime) were reported by an ST1, ST2 and ST5. All were due to overbooked clinics with complex patients. It is reassuring to note that one of the trainees stated that it was his clinical supervisor who encouraged him to exception report. The fourth exception was reported by an ST6 working as second on call at St Georges on a Saturday. This trainee reported overtime work on site as well as interrupted sleep overnight due to an excessive number of calls (16).

In this quarter there have been no 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.

Rota Gaps

Currently there are only 2 rota gaps on the City Road Lower House rota within the trust that are currently being filled by locums and 1 gap in the Upper House rota which is being filled by the existing registrars . On the Georges on-call rota, there are 2 gaps on the upper house rota which are currently being filled by locums.

Issues raised at Junior Doctor Forum

An issue was raised at the Junior Doctor Forum regarding when the allocated break would occur if a trainee was working the normal working day (9am-5pm) and was then scheduled to work an evening on-call shift (5pm-9pm). It was decided that 30 minute breaks are to be given at 6pm (rather than 5 pm when the shifts starts and handover is taking place). This was communicated to all trainees who were encouraged to report if this was not being implemented.

Another issue raised was the difference in leave policies across different firms, which is creating confusion

amongst trainees. We have therefore collated the various leave policies from the rota co-ordinators of all the subspecialties to help us understand these differences. A table with the different leave policies has been sent to all trainees in order to make it easy for them to find this information and help them plan leave in advance.

Trainees have also raised concerns about Project Oriel's plan to have a multidisciplinary room rather than a doctors' mess. Doctors require beds to rest during night shifts and it is felt that this cannot be achieved if beds are placed in multidisciplinary rooms.

Fine Money

It has been agreed by trainees that fine money for breaches of the Junior Doctors Contract will be used in part to fund expenses for the upcoming Residents Review at the Moorfields Alumni meeting.

£30,000 Health Education England Grant

We are delighted that Moorfields Eye Hospital NHS Foundation Trust will receive the sum of £30,000 from Health Education England to make improvements that will impact positively on the working conditions of junior doctors. This money has been shared between Georges and City Road I have instructed trainees to identify needs according to the BMA Fatigue and Facilities Charter and produce a list of items they would like to purchase from this fund. This was generated from a survey amongst Junior doctor trainees from the North and South rotations. This list was discussed at Junior Doctor Forums and further meetings have taken place to prioritise items for purchase, liaise with Estates Department and finalise procurement. So far part of the fund has been spent to purchase coffee machines, coffee pods, coffee cups, armchairs, sofas, tables and chairs for mess, USB chargers and lockers.

High level data

Number of doctors in training (total):	47
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

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. In general trainee morale is high and working conditions good. There are relatively very few exception reports from on-call rotas and clinics. Moorfields Eye Hospital NHS Foundation Trust will receive the sum of £30,000 from Health Education England to make improvements that will impact positively on the working conditions of junior doctors who are actively involved in the allocation and spending of this funding.

Quality implications There are clear implications for patient care if the trust does not make sure it is adhering to the new contract and stricter safer working limits, reduction in the maximum number of sequential shifts and maximum hours that a junior doctor is able to work.
Financial implications The guardian of safe working may impose fines if specific breaches of the terms of conditions of service occur where doctor safe working has been compromised.
Risk implications The risk implications are detailed in the report in terms of reasons for exception reporting and potential impacts on the quality of care provided to patients if there are breaches in the contract.
Action Required/Recommendation The board is asked to consider the report for assurance.

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

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 Q3 2019/20 data, as at 28 January 2020, is shown in table 1 below.

Indicator	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	0	1	
% of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident panel	N/A	N/A	1	
Deaths considered likely to have been avoidable	N/A	N/A	0*	

Table 1

*Completion of the investigation and the SJR in respect of this patient is on-going. The Q3 data will be updated in Q4.

Learning and improvement opportunities identified

- A review of the way in which requests for imaging are managed by the neuro-ophthalmology service will be undertaken.

Medical examiner role (update)

NHS England and NHS Improvement continues to provide monthly updates in relation to the development of the roles of medical examiners and medical examiner officers (managers of a medical examiner office). Good practice guidelines are being developed to help ensure medical examiners implement a consistent approach across England and Wales and host organisations follow the national model during the non-statutory period. These will combine learning from medical examiner offices that are up and running and information about principles and operational matters that addresses many of the questions host organisations are asking.

Moorfields will receive medical examiner support from University College London Hospitals NHS Foundation Trust. It is understood that the post, which is to be available by 1 April 2020, was to be advertised in January 2020.

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 10
Learning from deaths
Board of directors 27 February 2020

Report title	Learning from deaths (Q3)
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 1 patient death in Q3 that falls within the scope of the learning from deaths policy. This death is being investigated as a Serious Incident (SI). The medical director has met with the patient's family and the duty of candour process has been initiated.

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 board 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 Q3 2019/20 data, as at 28 January 2020, is shown in table 1 below.

Indicator	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
Summary Hospital Mortality Indicator (as reported in the IPR)	0	0	0	
Number of deaths that fall within the scope of the learning from deaths policy (see annex 1)	0	0	1	
% of cases reviewed under the structured judgement review (SJR) methodology/ reviewed by the Serious Incident panel	N/A	N/A	1	
Deaths considered likely to have been avoidable	N/A	N/A	0*	

Table 1

*Completion of the investigation and the SJR in respect of this patient is on-going. The Q3 data will be updated in Q4.

Learning and improvement opportunities identified

- A review of the way in which requests for imaging are managed by the neuro-ophthalmology service will be undertaken.

Medical examiner role (update)

NHS England and NHS Improvement continues to provide monthly updates in relation to the development of the roles of medical examiners and medical examiner officers (managers of a medical examiner office). Good practice guidelines are being developed to help ensure medical examiners implement a consistent approach across England and Wales and host organisations follow the national model during the non-statutory period. These will combine learning from medical examiner offices that are up and running and information about principles and operational matters that addresses many of the questions host organisations are asking.

Moorfields will receive medical examiner support from University College London Hospitals NHS Foundation Trust. It is understood that the post, which is to be available by 1 April 2020, was to be advertised in January 2020.

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 11

Freedom to speak up report

Board of directors

27 February 2020

Report title	Q3 Freedom to Speak Up report (1 October 2019 - December 2019)
Report from	Ian Tombleson, director of quality and safety
Prepared by	Ian Tombleson, director of quality and safety
Attachments	None
Link to strategic objectives	We will have an infrastructure and culture that supports innovation We will attract, retain and develop great people We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience

Executive summary

This paper provides a Q3 report for the Freedom to Speak Up (FTSU) Guardians. It covers the period 1 October 2019 to 31 December 2019.

The report provides assurance to the Board that FTSU Guardians are providing an effective service in line with requirements and also the expectations of National Office for Freedom to Speak Up Guardian. FTSU Guardians are accessible and staff are able to raise concerns. The numbers of concerns raised and the broad themes are set out in the report.

The report includes some new and effective ways that Guardians have made themselves more accessible to staff. Feedback to the Guardians about their role is always very positive.

Quality implications

The Trust's approach to developing and supporting the work of the FTSU Guardians is a key element of providing a supportive and open culture. If staff feel that they are supported in raising concerns in a safe environment and that their concerns are acted on, then this will have a positive impact on patient safety and improve the trust's ability to learn lessons from incidents and support good practice. The Trust Board provides leadership and support to enable an open and transparent culture.

Financial implications

There are no direct financial implications arising from this paper.

Risk implications

Organisations need to have a culture where staff feel able to safely voice their concerns. Not having this culture can create potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as possible reputational risks and regulatory impact. There is no evidence of any of these impacts at Moorfields.

Action Required/Recommendation

The Board is asked to:

- Discuss and note the content of the paper.

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

1. Summary

This paper provides the Q3 report from the Freedom to Speak Up (FTSU) Guardians covering the period from 1 October to 31 December 2019.

As the Board is aware the Management Executive has recently reviewed the FTSU arrangements and considers them effective and fit for purpose. This report therefore provides assurance that FTSU guardians are in place, that they are accessible and that staff are able to raise concerns. It also highlights areas where there are opportunities to improve the service. The number of concerns raised and the broad themes that have been raised are set out in the report.

2. Background

All NHS trusts are required to have FTSU Guardians. At Moorfields five FTSU Guardians are in place:

- Dr Ali Abbas, locum consultant, City Road and St George's
- Farhana Sultana-Miah, deputy general manager, Moorfields North
- Carmel Brookes, lead nurse for clinical innovation and safety, City Road
- Aneela Raja, optometrist, Bedford
- Ian Tombleson, director of quality and safety (lead guardian).

If individuals are not happy to raise concerns via the Guardians, or their concern is about the Guardians themselves, or is at Trust Board level, then these can be raised with Steve Williams Vice Chairman of the Board and Senior Independent Director.

Moorfields has a FTSU policy which sets out the scope of our arrangements. FTSU has a much broader definition than the previous term 'whistleblowing ', which was often only used in the most extreme circumstances and was viewed negatively. FTSU is viewed as way to provide additional support to staff to resolve concerns. It provides a set of flexible arrangements to get the best outcomes for staff and management and works alongside all other relevant polices.

Examples of potential FTSU concerns in the policy include, but are by no means restricted to:

- Unsafe patient care
- Unsafe working conditions
- Inadequate induction or training for staff
- Lack of, or poor, response to a reported patient safety incident
- Suspicions of fraud
- A bullying culture (usually across a team)
- A criminal offence has been committed, is being committed or is likely to be committed
- That the environment has been, is being, or is likely to be damaged.

FTSU guardians meet regularly to discuss the impact of their role and how to make themselves available and accessible to staff who require their services, including the communication routes that should be used.

3. Initiatives

The FSTU Guardians have been very active in their role to make themselves accessible. Guardians have been visiting network locations to make themselves available to staff should they want to raise concerns, either at that time or at another opportunity. These visits include speaking to staff around the site about how they are feeling, making them aware of how to raise concerns more broadly through their management line and also to make them aware of the FTSU role. This also helps staff feel relaxed and makes them aware they could raise concerns to the FTSU Guardians in a confidential way. During Q3 two visits have taken place, to Bedford and to Moorfields Private Division. There are plans to visit more sites and to maintain a rolling programme in 2020.

Other initiatives during this period included participating in October's national freedom to speak up month; a new event was the introduction of 'tea and coffee' with the Guardians in the staff dining area. This relaxed event in an open environment led to the raising of a few FTSU concerns and was felt to be very worthwhile and will be repeated in 2020. Further initiatives in Q3 included attendance at staff network events, promotion via the intranet and a stand at the well-attended annual staff clinical governance conference in November 2019.

Guardians continue to have regular catch-ups with the Chair and Chief Executive to discuss how the process is functioning, activities and key themes. They pay a keen interest and ensure that the Guardians are fully supported and feel enabled in their roles. The Chief Executive promotes the role of FTSU Guardians during his regular staff induction sessions.

4. Further developments

The Guardians will continue to promote their roles across the network reaching out to staff more widely. Other plans include:

- Reaching out further to networks/staff meetings/raising awareness with harder to reach groups.
- Increasing links/joint working with contact/bullying and harassment officers.
- Considering extending the freedom to speak up model by having FTSU Champions as well as Guardians.
- Ensuring that we are learning and taking forward any recommendations from National FTSU case reviews.

5. Concerns raised during 1 October to 31 December 2019

The experience of the FTSU guardians is that in practice Guardians provide staff with someone to go to if they wish to raise a concern that they believe is serious and they are unable to resolve themselves without additional impartial support. Some have raised a concern either directly or indirectly with their line manager or have sought support from HR. Sometimes concerns are raised as a result of frustration because of delay or an impasse in process has arisen.

Quarter 3 2019/20 concerns/issues

Sometimes concerns cover more than one area and these have been indicated as primary and secondary themes. During Q3, fourteen concerns were raised compared to the six raised in Q1/Q2 combined. The additional concerns raised are attributed to the success of the new initiatives where Guardians have proactively made themselves available in a range of more accessible staff environments. It interesting to note that no concerns were raised except those prompted by these visits or events and therefore the Guardians will do more of these across the network.

Theme	Primary	Secondary
Culture/Behaviour [1]	10	One of these issues related to a potential patient safety concern
Process[2]	3	3 related to potential patient safety issues
Training	0	
Patient safety/quality[3]	1	A process issue was a secondary concern
Total	14	

1 = definition includes a range of behaviours from poor management visibility, poor communication, putting staff under undue pressure, potential bullying and harassment and poor working culture

2 = definition includes issues around what process is required or whether a specific process has been followed

3 = definition includes a very wide range of issues from potential concerns about specific harm to patients, to service quality, to poor customer care.

It is important to note that no serious patient safety concerns have been raised where death or serious harm had been or was about to be caused directly or indirectly to patients.

Going forwards for Q4, Guardians have are now starting to record specific sign posting activity, where issues have been discussed with a Guardian but do not lead to a concern being raised formally; rather there is sign posting activity for example to their line manager, HR or possibly the bullying and harassment pathway.

6. Conclusions and learning

The most successful activities which have led to concerns being raised are bespoke events, either visits to network sites, or other opportunities where Guardians are available. Guardians will continue to liaise with the HR team if there are other ways they can support the effective management of concerns or issues raised by staff, or to act as conduits to other parts of the support system.

The Board is asked to note that the FTSU Guardians are in place and are accessible to staff. They function independently from management and in line with best practice from the National Freedom to Speak Up Office. Guardians continue to promote their role and speaking up generally which is fully consistent with the culture set by the Board and senior leadership at Moorfields.

There are processes in place to resolve concerns as they arise. The Chair and Chief Executive have regular confidential conversations with FTSU guardians to keep them informed about activity and themes.

Ian Tombleson
Director of Quality and Safety
19 February 2020

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 12

Report of the QSC

Board of directors 27 February 2020

Report title	Report of the quality and safety committee
Report from	Ros Given-Wilson, chairman, quality and safety committee
Prepared by	David Flintham, quality and safety compliance manager
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinic outcomes and excellent patient experience We will have an infrastructure and culture that supports innovation

Brief summary of report

Attached is a brief summary of the quality and safety committee meeting that took place on 21 January 2020.

Action Required/Recommendation.

Board is asked to note the report of the quality and safety committee and gain assurance from it.

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

Moorfields Eye Hospital NHS Foundation Trust

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QUALITY AND SAFETY COMMITTEE
SUMMARY REPORT
21 January 2020

Committee Governance	• Quorate – Yes • Attendance (membership) - 75% • Action completion status - 99% • Agenda completed – Yes

Current activity	• An update on the **staff assault action plan** which resulted from an incident on the observation ward at the end of 2018 was received.
	• The **Children and Young People's service** delivered a comprehensive deep dive presentation about its activity.
	• The **committee's actions** from the last meeting were reviewed.
	• Summary reports were received for the following meetings:
	  ○ **Clinical Governance Committee** (18th November 2019)
	  ○ **Information Governance Committee** (26th November 2019)
	  ○ **Risk and Safety Committee** (11th December 2019)
	  ○ **Patient and Carer Forum** (3rd December 2019).
	• The latest **SI tracker** was presented. All actions from SIs are on track.
	• A single **SI report** *Missed diagnosis in A&E* was received.
	• An update about **fire safety** was received. This included fire safety checklists and the personal emergency evacuation plan (PEEP)
	• The **Quality and Safety update** included incident closure, CQC, quality dashboard, quality priorities for 2020/21 and Listening, learning and sharing walkabouts.
	• The quarterly **quality and safety report** for the period October to December 2019 was presented.
	• The **WHO Surgical Safety Checklist Compliance Audit Report** for Q3 was received.

Key concerns	• Concerns relating to IT disruptions to clinical work and data loss due to infrastructure issues were raised during the meeting. • There is a need to improve joint working with managers/estates and host trusts, for example to improve signage. It was noted that the on-going management of SLAs is being improved. • Fire compliance is an on-going issue with the need for estates and management to work together. The reported return rates for fire safety checklists by some sites is poor. Better engagement and compliance by all involved is required. • The issue of 'lost to follow up' in ophthalmology has been reported in external media. An update will be brought to the March meeting.
Key learning	• The staff assault action plan included a review of Admission, Transfer and Discharge policy, and potential adoption of a frailty process. Also focussed on improving consultant and MDT oversight of more complex and longer stay in-patients.

	• Following the loose filing serious incident (St George's), administration reviews are being undertaken to look for any loose filing elsewhere.
	• The patient transport issue is now showing improving performance.
	• The Quality and Safety update included several CQC-related items:
	  ○ Action planning (actions on target – most complete or nearing completion);
	  ○ CQC inspection during 2020 likely. Planning is underway.
	  ○ CQC relationship manager – positive visit to A&E, very good meeting with central quality team with excellent follow up feedback to the team
	• Moorfields Private has appointed a Quality Partner.
	• The Quality and Safety report for quarter 3 was presented. This included learning from incidents, claims and patient feedback.

Escalations	Two escalations: • Fire compliance is an on-going issue with the need for estates and management to work together. The reported return rates for fire safety checklists by some sites must be improved; • There is a need to improve joint working with managers/estates and host trusts (signage for example). There is on-going work to improve SLA management.
Date of next meeting	17 March 2020

Moorfields Eye Hospital NHS Foundation Trust

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Agenda item 13
Report of the people committee
Board of directors 27 February 2020

Report title	Report of the people and culture committee
Report from	Sumita Singha, chairman, people and culture committee
Prepared by	Helen Essex, company secretary
Previously discussed at	N/A
Attachments	N/A
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 21 January 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 – 21 January 2020

Governance	• Quorate – Yes • Attendance (membership)
Discussion points	***Workforce restructure*** • The committee received an update on progress with the consultation. • One of the key objectives of the new function will be to help train managers to deal with issues that are currently performed within HR but that should be management responsibility. • Discussion took place about the trust's model of clinical leadership and how the organisation supports clinicians who have undertaken leadership training to help them take this forward. • Other issues covered related to the L&D function, the employment relations process and medical staffing, with additional support required to work with the leads for fellows and job planning. ***Workforce strategy implementation*** The following areas were identified as those that require focus: • Infrastructure – this includes the establishment of a helpdesk, improved policy writing, better use of intranet and chatbots for FAQs • Capacity and capability – establishing a workforce model for Oriel (and the lead up to Oriel) and undertaking training needs analysis. • Leadership and culture – undertaking diagnostic work with the board on leadership and how the board gets assurance about the culture within the organisation. • Staff engagement – establishment of an admin forum/conference and continuation of a programme of executive walkabouts. • Improving value – system housekeeping and addressing legacy system issues, working with operations to make sure divisions have better oversight of issues such as salary overpayments. • Bank staff arrangements – working with the STP on standardising bank pay rates across London and mitigating any risk to doing so. ***Staff health and wellbeing*** • The committee discussed various initiatives taking place as part of the action plan. • These include the establishment of a choir, participation in the global walking challenge and other initiatives that could potentially be supported by the charity. • Other issues that need to be on the agenda focus on late career working, pension advice and flexibility around retirement. • A new health and wellbeing group will be established as a subgroup of the people committee to look at mental health awareness and wellbeing, monitoring of Validium and other forms of counselling or OH contract.

	Workforce metrics • Key issues raised were the increase in turnover, some of which relate to fixed term contracts and managerial changes in private. These issues will be monitored going forward. • There was a high level of sickness across all divisions over August although this may be to do with improved reporting. • Medical and dental figures cover 13 consultant vacancies although bank use is higher than vacancy so clinical safety is assured. ***Staff survey headlines*** • The top level data shows a 55.5% completion rate which is up 7.1% from last year. However, the best acute specialist trust response was 69%. • The response rate by north was 55.8% south 60.3% and City road 45.8% which was the lowest of the groupings. • Moorfields private has seen overall improvement although corporate departments have seen a dip with the exception of finance. • Least improved is appraisal which has dropped from 91% to 86%. • Reports of harassment and bullying have increased by more than 6% also this may be due to an improvement in the reporting culture and shows people feel safe to report. • More detailed results will be reported to the board when available.
Key concerns	• Short-term sickness appears to be high, more work needs to be done with divisions and professions such as nursing to see how this can be addressed. • More data required on a number of the staff survey headlines but concern expressed on results for some corporate departments and for harassment/bullying/reporting violence.
Discussions outside the cttee	• Further work going on within the STP re: bank pay rates with an update to come to the next meeting. • Implementation of requirements of the people plan (i.e. access to hot drink and rest area for staff) in network sites
Escalations	• None
Date of next meeting	• 17 March 2020

Moorfields Eye Hospital NHS Foundation Trust

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Agenda item 14
Membership Council report
Board of directors 27 February 2020

Report title	Membership council report
Report from	Tessa Green, chair
Prepared by	Helen Essex, company secretary
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience We will have an infrastructure and culture that supports innovation

Brief summary of report

Attached is a brief summary of Membership Council meeting that took place on 30 January 2020.

Action Required/Recommendation.

Board is asked to note the membership council report

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

REPORT FROM THE MEMBERSHIP COUNCIL MEETING – 30 JANUARY 2020

Report from the remuneration committee

The membership council approved the following:

- The reappointment of Steve Williams and Sumita Singha as non-executive directors for a further term of office of one year.
- The appointment of Vineet Bhalla and Richard Holmes as non-executive directors, each for a period of three years.

External audit appointment

Governors approved the appointment of Grant Thornton as the trust's external auditors for a period of two years, with the option to extend for another two years.

Feedback from governors

The **governance development group** discussed the outputs of the membership council self-assessment and agreed that there is no need to review the constitution at this stage. This will be done as the trust moves closer to Oriel.

The **membership development group** discussed a number of topics including the content of the next issue of the trust magazine and refreshed the membership engagement plan to the end of the financial year.

The **patient carer forum** discussed the friends and family test which has had a more positive response since the implementation of a text system. However, the issues of patient communication and risk relating to increased data security issues due to more use of text in health were highlighted.

Governors considered the report from **Members' Week** held at the end of November, along with the responses received from the divisional teams to their reports.

Governors received an update from the **Oriel Advisory Group** which discussed consultation findings and the trust response as well as having an input into the paper going to the JHOSC.

Governors received a number of **reports from the executive** including the chief executive's report, integrated performance report, Q2 complaints report and board report on progress made on the issues surrounding the administration and booking process. Governors received assurance that new systems would be tested for accessibility and make the best use of assisted technology.

Governors received a briefing from David Hills, chair of the **capital scrutiny committee**, on the work committee over the last year. The work of the committee is likely to increase as Oriel progresses from OBC to FBC.

Governors were assured about some of the key processes that are the responsibility of the committee, such as the re-engagement of Henry Riley, Gardner and Theobald and AECOM who are key contractors for Oriel. Governors were notified of the reappointment of CBRE who provide the trust with the relevant expertise on the disposal of the City Road site, approval of the procurement strategy, oversight of the Oriel master programme as well as the overarching capital programme for the trust. The committee reviews costs and assures itself that resources are being used effectively.

Governors were also assured that there is a clear line of sight from CSC to the board on the Oriel governance structure, making sure that decisions made around the design and build of the hospital

and strategy come from clinicians. Questions were asked about the governance structure going forward.

Membership council self-assessment – separate session

Governors undertook a self-assessment at the end of December 2019 and held a separate session to discuss the results and develop a plan to address any gaps. Key themes were as follows:

Trust strategy and forward planning

- Governors would like more clarity on what changes are made to the strategy and forward plans based on the views of the membership council. There needs to be more follow up once input has been given.
- There is a lot of opportunity to be involved in Oriel but less so with other strategic work.
- Governors felt that senior managers report honestly and responsively and this ensures positive governor input.

Board interactions

- Interactions between governors and all board members are seen as generally good or excellent with the majority of scores given as a 4 or 5 when asked to score the relationships between the council and the chair, non-executives, chief executive and executives.
- Governors would like more opportunity to interact with NEDs at existing meetings.
- Governors also want to make sure they are not just getting 'good news' stories.
- Governors need to be better at asking the 'right' questions.
- Briefings provided by NEDs work well and more governors need to attend.
- Governors were keen to know how NEDs and executives might assess their performance.

Governor representation of members

- Good initiatives in place such as Members' Week, 'meet your governor' event and other site visits.
- Governors would ideally like better representation from young people, children and families and people with disabilities.
- More open and accessible lines of communication are required.

Information and training

- Governors are generally happy with the information they receive and the training that is available although would like more specific training on finances.
- Governors generally work well as a group but are keen to make sure everyone is involved and that they find better ways of communicating with each other outside formal meetings.

Overall, the results were positive with some key areas of focus that could be made more robust and useful going forward. A plan has now been developed as to how these changes can be made over the next year and this will include an extension of the lunch session following the public board meeting to allow more interaction between governors and board members.