A MEETING OF THE BOARD OF DIRECTORS

To be held in public on
Thursday 23 July 2020 at 09:30am
via Life size video link

AGENDA

No.	Item	Action	Paper	Lead	Mins	S.O
1.	Apologies for absence	Note	Verbal	TG		
2.	Declarations of interest	Note	Verbal	TG		
3.	Minutes of the meeting held on 23 June 2020	Approve	Enclosed	TG	00:05	
4.	Matters arising and action points	Note	Enclosed	TG	00:05	
5.	Chief Executive's Report	Note	Enclosed	DP	00:20	All
6.	Integrated Performance Report	Assurance	Enclosed	JQ	00:05	1
7.	Finance Report	Assurance	Enclosed	JW	00:05	7
8.	2019/20 Quality Account	Approve	Enclosed	TL	00:15	All
9.	Learning from deaths	Assurance	Enclosed	NS	00:05	1
10.	Report from the audit and risk committee	Assurance	Enclosed	RGW	00:10	6
11.	Identify any risk items arising from the agenda	Note	Verbal	TG	00:05	6
12.	AOB	Note	Verbal	TG	00:05	
13.	**Date of the next meeting – Thursday 25 September 2020 09:30am**					

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

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON
THURSDAY 25 JUNE 2020

Attendees:	Tessa Green (TG)	Chairman (via video link)
	David Probert (DP)	Chief executive (via video link)
	Vineet Bhalla (VB)	Non-executive director (via video link)
	Ros Given-Wilson (RGW)	Non-executive director (via video link)
	Peng Khaw (PK)	Director of research & development (via video link)
	Nick Hardie (NH)	Non-executive director (via video link)
	David Hills (DH)	Non-executive director (via video link)
	Richard Holmes (RH)	Non-executive director (via video link)
	Tracy Luckett (TL)	Director of nursing and AHPs
	John Quinn (JQ)	Chief operating officer
	Sumita Singha (SS)	Non-executive director (via video link)
	Nick Strouthidis (NS)	Medical director
	Jonathan Wilson (JW)	Chief financial officer
In attendance:	Sandi Drewett (SD)	Director of workforce & OD
	Johanna Moss (JM)	Director of strategy & business development
	Nick Roberts (NR)	Chief information officer
	Helen Essex (HE)	Company secretary (minutes)
	Rob Jones	Patient governor
	Allan MacCarthy	Vice chair of the membership council
	Paul Murphy	Public governor, NCL
	John Sloper	Public governor, Beds & Herts
	Ian Wilson	Public governor, NWL
	Brian Watkins	Public governor, NWL

20/2455 Apologies for absence

Apologies were received from Steve Williams and Andrew Dick.

20/2456 Declarations of interest

There were no declarations of interests.

20/2457 Minutes of the last meeting

The minutes of the meeting held on the 28 May 2020 were agreed as an accurate record.

20/2458 Matters arising and action points

All actions were completed or attended to via the agenda.

DRAFT

20/2459 Report from the audit and risk committee

NH advised that the audit committee had met on 11 June to review the final annual report and accounts.

The internal audit on the DSP Toolkit provided significant assurance with improvement opportunities. The overall feeling is that the trust is on an improving trend as far as controls are concerned.

One of the key functions of the committee is to concern itself that the accounts have been prepared on an appropriate basis. The committee reviewed the plan for 20/21 which is for break-even notwithstanding the change in environment and assumptions being made about the future funding regime. The committee gained assurance that the accounts have been prepared on a going concern basis.

Grant Thornton have been able to undertake their external audit and extended compliments to the finance team. There have been some changes to the accounts in relation to the presentation of the group accounting basis as the trust has subsidiary and associate investments. The letter of representation confirms that there is nothing that management is aware of that auditors need to know.

The committee heard from DP as the accounting officer who was satisfied with the process this year. The committee also agreed that the issue of risk appetite should be carried forward to a future board strategy session.

Discussion took place about the nature of a 'cultural review' which was scheduled but has been postponed. This form of review attempts to get under the skin of an organisation or a department and assess what is happening behind the controls. It is generally more subjective than a lot of the work internal audit do and focuses on behaviours rather than the hard control environment. It was agreed that any scope or terms of reference should be clear on how behaviours are measured.

The committee recommended the approval of the accounts to the board.

20/2460 Annual report and accounts 19/20

Non-material changes relating to wording and grammar are the only amendments that have been made since the audit committee meeting.

The board approved the 19/20 annual report and accounts and thanked the teams involved for their achievement in what has been a particularly challenging set of circumstances.

20/2461 Annual compliance statements

The board approved the annual compliance statements G6 and FT4.

DRAFT

20/2462 Chief executive's report

The trust continues to fulfil its statutory duties and it was noted that the NHS is still in a level 4 incident although the country has moved down to level 3. There is still a gold, silver and bronze command structure in place.

There are no immediate concerns in relation to PPE provision and stock is being managed well. There have been no escalations from people have not had access to the relevant PPE although the provision of FFP3 is under close review.

Patients that require day-case surgery are now only required to isolate for seven days and it is hoped that this will be a positive step forward in being able to bring patients back in to the trust.

The trust is rolling out a programme of risk assessments to look at underlying conditions of patients and staff and this is in line with other providers in NCL. 70% of staff working in the hospital have been risk assessed and this equates to 40% of all staff. There is a strong belief in the value of risk assessments and the plan is to have 100% of staff to be risk assessed within a month. VB asked about the scoring of risk assessments and whether is it common amongst all hospitals or bespoke to the trust. SD replied that a number of trusts have adopted the trust's model although all hospitals have different environments and will need to adapt the model accordingly. It is important for the trust to focus on high, medium and low risk assessments, making sure reasonable adjustments are made.

The trust continues to recover clinical services and is returning to priority three and priority four cataract surgery in a pilot at St Ann's.

There is a clear testing regime available for patients which is 14-day isolation for general anaesthetic and 7-day isolation for local anaesthetic procedures. Testing is undertaken 72-hours prior to surgery and a testing facility is available for those that can drive.

The trust continues to work with ICSs in London on wider recovery. JM is leading the elective surgical recovery for London and DP has been appointed as chief executive lead for the programme.

DP welcomed Nick Roberts to the trust as the new chief information officer.

A grant from the Moorfields Eye Charity has been given to the Friends of Moorfields in order to support the volunteer programme. DP confirmed that all volunteers returning to the trust will be appropriately risk-assessed back into the environment.

A question was asked about how the trust is ensuring that infection control procedures put in place are being maintained. DP replied that there is a culture of challenge within the organisation and that policies are generally being well adhered to. There are a number of different communication channels in place to keep staff up to date. There is also a new framework for IPC and a process of audit that will be discussed at the next quality and safety committee.

DRAFT

TG also asked how we anticipate track and trace working. At the moment if a member of staff identifies as positive they would be sent home to isolate. If contacted by the national track and trace system, the trust would ask the member of staff to go home and isolate and then test them. There has already been some experience of this.

Black, Asian and minority ethnic staff make up a significant number of the trust workforce. The trust has signposted corporate and individual messaging to the celebration of diversity and its zero tolerance policy. There are five freedom to speak up guardians across the network and they continue to encourage staff to contact and speak to them. The trust has also held open meetings for staff to discuss any concerns they have, as well as joining up with national programme. There is a lot of activity under way but there needs to be real change in the dynamic and leadership of NHS organisations. The trust has in place a diverse workforce from middle to senior management and is committed to moving this through to executive level.

20/2463 Integrated performance report

JQ presented the IPR and KPIs that are focused on recovery and advised that the context has changed in terms of what the IPR is designed to look at. Activity is down although the trust is still delivering the national access targets for cancer patients. A&E is still delivering the national constitutional targets.

JQ referred to a data issue in some of the quality parameters and in particular incidents open after 28 days where it appears there has been a reduction in May from the previous months. The executive is also querying the complaints performance in City Road and Moorfields South.

Seek an update on the figures and advise the board – JQ/TL

The KPIs reflect how the trust is monitoring the recovery, how many sites will be opened up over time, the number of patients required in terms of site throughput, etc. Services are still seeing moderate to urgent patients which is a requirement.

It will be critical to monitor the backlog and how patients are referred back in as well as reviewing the DNA rate and RTT performance. It was acknowledged that access targets are not at the same percentages that the board is used to seeing. In relation to whether people understand the urgency of their own situation, this is currently variable. The DNA rate at St Ann's on the first day of the pilot was 0%. There is a 60% refusal rate overall. Clinicians continue to work with patients directly to try and provide reassurance.

The uveitis service sees some of the highest risk patients who are at risk of sight loss and suffer immunosuppression and co-morbidities. This is a high risk but small group of patients but they have been well managed and communicated with directly. This cohort of patients understand the importance of continuing their medication.

The VR service is managing retinal detachments and have worked through the backlog of priority two and priority three cases and is seeing a refusal rate of approximately 40%.

DRAFT

The glaucoma service is working through the backlog and the refusal rate is high but the expectation is that going through the second cycle of patient contact will bring back some patients that have previously refused.

Add what 'normality' looks like on the KPIs in order to see the comparison – JQ

Discussion took place about the backlog number and the dynamics in terms of the movement in the number. There are different ways of looking at the backlog and the trust counts those patients whose appointments have been cancelled and rescheduled as backlog patients. There is an attempt to get consensus about the definition of a backlog in the sectors where the trust is the lead provider and how this is different from the normal waiting list.

RGW asked whether the figures relate only to face to face appointments or whether they include digital appointments. JQ advised that all types of appointments are included.

Agreed to separate face to face and digital appointments - JQ

20/2464 Finance report

The M2 position exclusive of central block support is a £10.5m deficit (a £1m improvement on M1). There is an increase in NHS patient activity, in particular A&E and injection as opposed to outpatients and elective. The trust is not currently utilising the full amount of block funding available.

Commercial income is adverse in month although recovery in the UAE is likely to be quicker than the UK. Pay is £1.4m favourable and drugs £1.1m favourable. There has been a re-phasing of Oriel revenue costs.

Debt is at £0.6m and lower than in the previous month. The trust has seen payments of £1.9m in June and its largest debtor settled their account in June.

The cash position is favourable in month although the reduction in activity has bled through into cash payments. The trust is well-positioned in terms of what it might face going forward. The block contract will be in place at least until the end of M4. It will be critical to understand the volume of activity expected and how variations will be addressed. If the trust takes on a pan-London role any funding would need to reflect the additional activity.

In relation to private capacity, the trust will be able to start to offer services from 6 July. The service has only been dealing with urgent cases during the pandemic. It was acknowledged that it is critical to bring in a private revenue stream in order to support the continuation of NHS service provision.

In terms of scenario planning the assumption has been made that commercial services won't return to normality until October.

20/2465 Oriel engagement update

One of the key challenges the trust has been facing as a consequence of the pandemic is how to approach future user engagement. Work has been ongoing to assess the areas of focus, who to engage with and how to best engage. One of the critical issues is that we don't want to exclude people that are not digitally enabled.

DRAFT

There are two main areas that require engagement which are the planning application and the fit out design. At this stage the timetable is still being clarified but it is important to maintain dialogue with staff and patients about what the building will look like on the inside.

It has been agreed that the Oriel Advisory Group should continue and its role will be even more critical going forward. It is also proposed that two new groups be established (staff advisory group and partner advisory group) in order to develop ideas about how to adapt the engagement strategy going forward.

Discussion took place about whether there is confidence that the project will be able to attract sufficient input and engagement into the solutions. JM advised that it is unlikely we would be able to attract the same level of engagement as we had previously but that health planners want us to make sure we have addressed the accessibility issues raised as part of the consultation.

DH acknowledged the importance of engaging but also cautioned against setting aspirations that are unachievable due to the technical aspects as to what is possible. It is important to be honest and clear at the outset about what is included and not in our remit.

There are a number of practical issues that need to be thought through and worked on with the local authority. Public attitudes are likely to have changed in relation to public transport, etc. so the focus of the conversation will be about signposting and the above ground experience.

20/2466 Report from the quality and safety committee

The committee will continue to meet virtually and this month dealt with standard Q&S business. Main focus of the meetings going forward will be around COVID and assurance on various quality and safety issues.

The committee reviewed the structure of the governance and risk stratification of patients, as well as how we are ensuring the treatment of urgent patients. Future focus will be on IPC, testing, staff risk assessment and PPE. The committee will also begin to look at the way pathways are changing.

There were four areas of escalation which relate to how the situation results in a balance of risks, e.g. safety and outcomes, impact on patient experience and governance around recovery. It was acknowledged that there is pressure to restart but very strict controls around what we are able to do.

The committee will focus on clinical outcome audits alongside putting in new pathways and will be careful not to overlap with the work being done by the recovery oversight committee. The committee will also monitor the infection prevention and control risks.

DRAFT

20/2467 Report from the people and culture committee

SS reported from the first committee held online. The committee discussed salary overpayments and staff risk assessments which are an important tool in helping us ensure the safety and wellbeing of staff.

Workforce is a key part of the recovery process and in particular a focus on the capacity and capability work stream and skill mix. There will also be an increased focus on staff health and wellbeing and what staff value about the enhanced health and wellbeing offer.

20/2468 Membership council report

The board noted the report from the membership council. TG advised that the meeting was very well attended with a number of questions submitted beforehand and follow-up afterwards. Issues raised by the governors are highlighted to executives for response and follow up.

20/2469 Digital governance audit

The audit demonstrates how the trust has met its statutory and regulatory obligations over the last three months. Attendance has been good and overall the governance framework has not been significantly affected. However it is important to understand where they may be gaps and how they might be addressed.

The membership council had raised the issue of how we manage a continued understanding of the patient experience in light of their inability to conduct site visits or being able to invite patients to talk to the board or membership council. It was agreed that this needed further thought although the trust is still monitoring patient complaints and FFT scores. There are no other particular issues that are being raised from an executive perspective.

As a new non-executive VB thanked the executive for their provision of wider access to the organisation. RH advised that he had had a similar experience and that the ability to use technology has been helpful.

RGW said that there are advantages to this way of working as it cuts out travel time and allows better attendance, working particularly well for one to one meetings. However there needs to be a mix between the digital format and needing to get people in the room to discuss things in a less structured or formal way.

Further discussion to take place on how to plan for the next six months.

20/2467 Date of next meeting – Thursday 23 July 2020

DRAFT

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	23.07.20	Postponed	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	23.07.20	Postponed	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	23.07.20	Postponed	Open
23.01.20	20/2395	Administration and booking process	Update to be provided in six months	JQ	23.07.20	Postponed	Open
28.05.20	20/2448	Finance report	Advise on suitable timeline for CIP review	JW	23.07.20		Open
28.05.20	20/2452	Identify any items for the risk register arising from the agenda	Circulate BAF prior to the next audit committee meeting in July	HE	07.07.20		Closing
25.06.20	20/2463	Integrated performance report	Seek an update on the figures relating to open incidents and complaints and advise the board	JQ	23.07.20		Closing
25.06.20	20/2463	Integrated performance report	Add what 'normality' looks like on KPIs in order to see the comparison	JQ	23.07.20		Open
25.06.20	20/2463	Integrated performance report	Separate face to face and digital appointments	JQ	23.07.20		Open
25.06.20	20/2469	Digital governance audit	Further discussion to take place on how to plan for the next six months.	TG/HE	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 – July 2020	
Oriel	A project that involves Moorfields Eye Hospital NHS Foundation Trust and its research partner, the UCL Institute of Ophthalmology, along with Moorfields Eye Charity working together to improve patient experience by exploring a move from our current buildings on City Road to a preferred site in the Kings Cross area by 2023.
AAR	After action review
AHP	Allied health professional
AI	Artificial intelligence
ALB	Arms length body
AMRC	Association of medical research charities
ASI	Acute slot issue
BAF	Board assurance framework
BAME	Black, Asian and minority ethnic
BRC	Biomedical research centre
CCG	Clinical commissioning group
CIP	Cost improvement programme
CPIS	Child protection information sharing
CQC	Care quality commission
CQRG	Commissioner quality review group
CQUIN	Commissioning for quality innovation
CR	City Road
CSSD	Central sterile services department
CTP	Costing and transformation programme
DHCC	Dubai Healthcare City
DMBC	Decision-making business case
DSP	Data security protection [toolkit]
ECLO	Eye clinic liaison officer
EDI	Equality diversity and inclusivity
EDHR	Equality diversity and human rights
EMR	Electronic medical record
ENP	Emergency nurse practitioner
EU	European union
FBC	Full business case
FFT	Friends and family test
FRF	Financial recovery funding
FT	Foundation trust
FTSUG	Freedom to speak up guardian
GDPR	General data protection regulations
GIRFT	Getting it right first time
GoSW	Guardian of safe working
HCA	Healthcare assistant
I&E	Income and expenditure
IFRS	International financial reporting standards
IOL	Intra ocular lens

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 05
Chief executive's report
Board of directors 23 July 2020

Chief Executive's report

The COVID-19 Pandemic

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

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

There are currently no concerns within the trust around provision of **PPE (personal protective equipment).** The trust is part of the procurement partnership service (PPS) which is managing stock controls for a number of trusts across North Central London (NCL). Divisions continue to receive daily reports on stock which is being controlled from a central point within the organisation.

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

In accordance with ICP London guidance we have commenced **antigen testing (swabbing)** of asymptomatic patients and staff as part of the St Ann's pilot and will be further rolled out to staff groups who are considered to work in higher risk areas. All patients who are admitted as emergencies and those who may require an overnight stay are also tested. Staff who become symptomatic continue to follow the PHE guidance and are advised to access a test and self-isolate.

The trust has offered all staff the opportunity to have a Covid 19 antibody test as part of the national PHE surveillance programme. To date approximately 1,600 trust staff have been tested.

The **test and trace facility** is now in place and to date there have been no notifications to the trust. Staff who become symptomatic are managed in accordance with Public Health England guidelines.

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

People and awards

In recognition of their **academic and research excellence**, a number of our clinical team have achieved promotions with our partner in Oriel, UCL. Four of them have been admitted to the highest academic rank at UCL; these new professors are Mariya Moosajee, Frank Larkin, Stephen Tuft and Ananth Viswanathan. Dawn Sim and Adam Dubis have become Associate Professors and Narciss Okhravi has been promoted to Professorial Teaching Fellow.

Florence (Flossie) Donovan has been recognised by her professional body, and awarded the **Healthcare Play Specialist Education Trust (HPSET) award** for going above and beyond in providing exceptional play specialist services to our paediatric patients.

Kenneth Essex turns 100 this week and has set himself a goal to walk 10km in 10 days to raise £15,000 for **Moorfields Eye Charity** which is supporting research into macular degeneration at Moorfields. Kenneth has been receiving treatment for macular degeneration at Moorfields and, after being inspired by the efforts of Captain Tom Moore, he wanted to find a way to give back to Moorfields.

Financial position

The trust again achieved a breakeven position in-month without the need for further central funding support. The funding regime instigated for the April to July period consists of core funding based on an average of commissioner income for the period November 2019 – January 2020, with additional top-ups to meet any expenditure shortfalls. The reduction in actual patient activity under plan reduced to 67% from 70% in the prior month, whilst reductions in the trust cost base associated with these activity reductions resulted in total costs being lower than the funding received in June. Cash balances stood at £76.7m at the end of June. Capital expenditure in June was £0.7m, of which £0.4m related to Oriel.

Oriel

Following discussion at the board meeting last month, work on **Oriel engagement and stakeholder management** is progressing, initially in support of the planning application which we hope to submit to the London Borough of Camden in the autumn. As part of this we will be working with our patients, the public, our staff, governors and partner organisations to develop the design of the new centre.

David Probert
Chief Executive
July 2020

Report to Trust Board	
Report Title	**Integrated Performance Report - June 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

Due to COVID 19 a number of key performance targets remain affected. The organisational focus in June moved recovery from the response phase in May and previous months. Although Trust activity has gone down through the recovery phase and planned reintroduction of more urgent patients activity has gone up in June. Also the scorecard still shows the Trust has more green performance than red.

RTT and access targets are low and are likely to remain so through the rest of the year. Once the recovery plan is complete then a performance trajectory can be mapped. Cancer is still delivering the national targets and also the locally agree 14 day target.

Workforce metrices are lower than the standard however this is expected and recovery of these metrices will map the general recovery plan.

Due to COVID financial performance differs and this is covered in the finance report.

The KPI addendum is monitoring the Trusts recovery response.

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 - June 2020

Service Excellence (Ambitions)

Patient Centred Care

	G	A	R
Total	**29**	**0**	**5**
Cancer	5	0	0
Access & Outpatients	2	0	3
Admitted	5	0	1
Quality & Safety	17	0	1
Private Patients	0	0	0

Collaborative Research

G	A	R
1	0	0

Innovation & Education

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

Influence National Policy

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

People (Enablers)

Workforce Metrics

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

Staff Satisfaction & Advocacy

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

Infrastructure & Culture (Enablers)

Digital Delivery

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

Research

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

Financial Health & Enterprise (Enablers)

Overall Plan

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

Commercial Operations

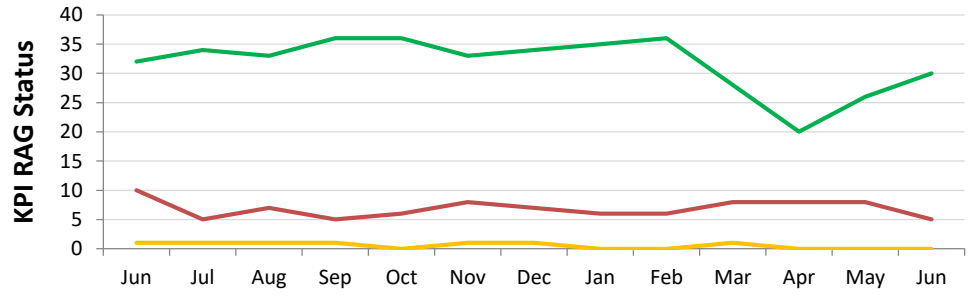
G	A	R
0	**0**	**1**

Cost Improvement Plans

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

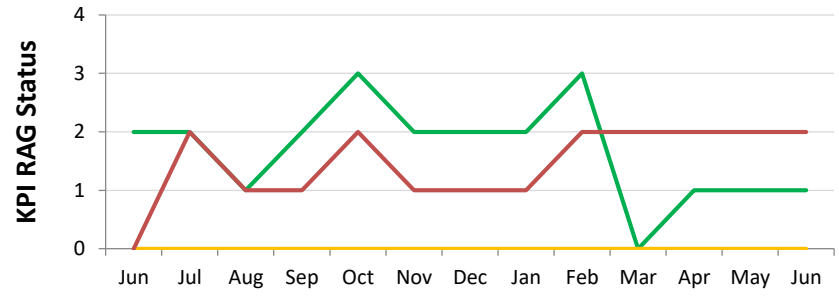
Executive Summary - Scorecard Domain Trends

Service Excellence (Ambitions)



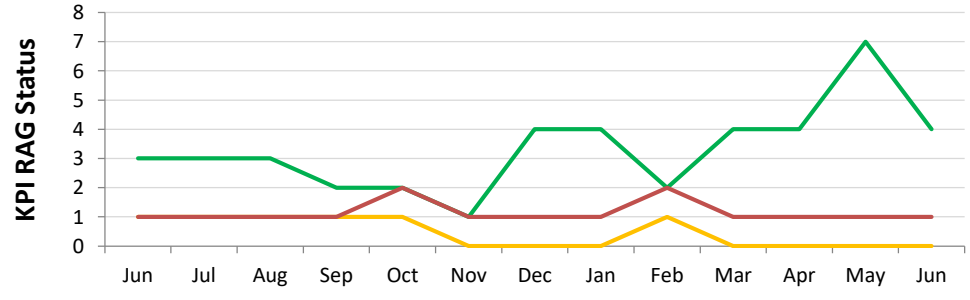
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Green	32	34	33	36	36	33	34	35	36	28	20	26	30
Amber	1	1	1	1	0	1	1	0	0	1	0	0	0
Red	10	5	7	5	6	8	7	6	6	8	8	8	5

People (Enablers)



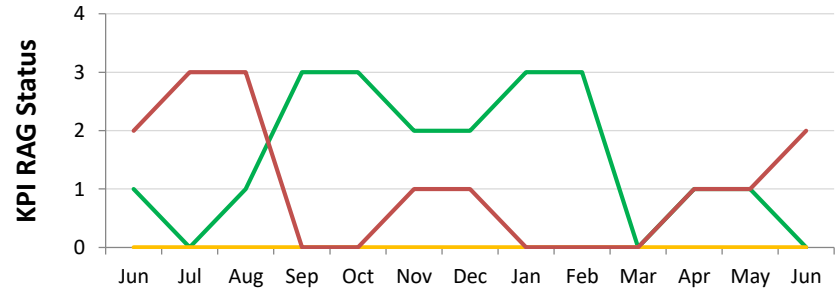
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Green	2	2	1	2	3	2	2	2	3	0	1	1	1
Amber	0	0	0	0	0	0	0	0	0	0	0	0	0
Red	0	2	1	1	2	1	1	1	2	2	2	2	2

Infrastructure & Culture (Enablers)



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

Financial Health & Enterprise



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

Context - Overall Activity - June 2020

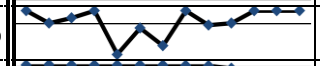
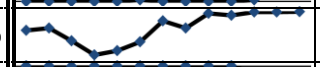
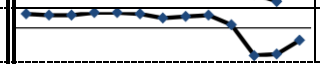
		June 2020		Monthly Variance	Year To Date		YTD Variance
		2019/20	2020/21		2019/20	2020/21	
Accident & Emergency	A&E Arrivals (All Type 2)	8,515	5,594	- 34.3%	25,738	14,040	- 45.5%
	Number of 4 hour breaches	110	0	- 100.0%	305	3	- 99.0%
Outpatient Activity	Number of Referrals Received	12,126	4,072	- 66.4%	37,154	9,096	- 75.5%
	Total Attendances	50,752	16,476	- 67.5%	150,649	36,255	- 75.9%
	First Appointment Attendances	11,340	2,993	- 73.6%	33,297	7,333	- 78.0%
	Follow Up (Subsequent) Attendances	39,412	13,483	- 65.8%	117,352	28,922	- 75.4%
Admission Activity	Total Admissions	3,278	616	- 81.2%	9,732	1,179	- 87.9%
	Day Case Elective Admissions	2,952	407	- 86.2%	8,706	621	- 92.9%
	Inpatient Elective Admissions	104	33	- 68.3%	304	104	- 65.8%
	Non-Elective (Emergency) Admissions	222	176	- 20.7%	722	454	- 37.1%

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Domain	Service Excellence (Ambitions)	*June 2020*

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Mar 20	Apr 20	May 20	Jun 20	13 Month Series	vs. Last
Patient Centred Care (Cancer)	Cancer 2 week waits - first appointment urgent GP referral	≥93%	G		100.0%	Monthly	100.0%	100.0%	100.0%	100.0%		→
	Cancer 14 Day Target - NHS England Referrals (Ocular Oncology)	≥93%	G		95.9%	Monthly	86.2%	88.9%	94.4%	100.0%		↑
	Cancer 31 day waits - Decision to Treat to First Definitive Treatment	≥96%	G		100.0%	Monthly	100.0%	100.0%	100.0%	100.0%		→
	Cancer 31 day waits - Decision to Treat to Subsequent Treatment	≥94%	G		100.0%	Monthly	100.0%	100.0%	100.0%	100.0%		→
	Cancer 62 days from Urgent GP Referral to First Definitive Treatment	≥85%			n/a	Monthly	100.0%	n/a	n/a	n/a		
	Cancer 28 Day Faster Diagnosis Standard	≥85%	G		100.0%	Monthly	85.7%	100.0%	100.0%	100.0%		→
Patient Centred Care (Access & Outpatients)	18 Week RTT Incomplete Performance *	≥92%	R	7	65.2%	Monthly	90.9%	82.7%	68.4%	45.4%		↓
	52 Week RTT Incomplete Breaches *	Zero Breaches	R	8	42	Monthly	0	1	10	31		↑
	A&E Four Hour Performance	≥95%	G		100.0%	Monthly	99.7%	100.0%	100.0%	100.0%		→
	Percentage of Diagnostic waiting times less than 6 weeks	≥99%	R	9	41.8%	Monthly	100.0%	83.2%	24.2%	23.0%		↓
	Average Call Waiting Time	≤ 3 Mins (180 Sec)	G		n/a	Monthly	n/a	n/a	43	49		↑
	Median Clinic Journey Times - New Patient appointments	Mth:≤ 95Mins			74	Monthly	99	71	64	85		↑
	Median Clinic Journey Times -Follow Up Patient appointments	Mth:≤ 85Mins			70	Monthly	87	65	66	76		↑

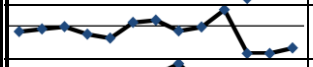
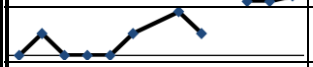
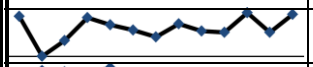
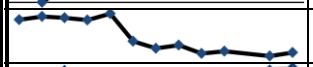
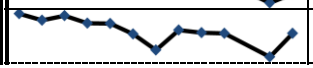
* Figures Provisional for June 2020

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

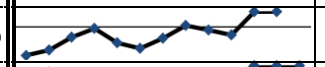
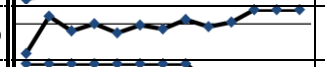
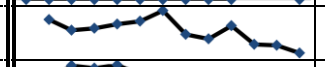
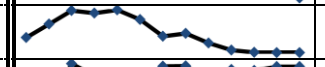
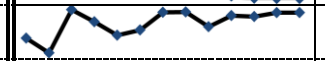
Domain	Service Excellence (Ambitions)	*June 2020*

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Mar 20	Apr 20	May 20	Jun 20	13 Month Series	vs. Last
Patient Centred Care (Admitted)	Theatre Cancellation Rate (Overall)	≤7.0%	G		5.2%	Monthly	10.4%	2.5%	4.3%	6.6%		↑
	Theatre Cancellation Rate (Non-Medical Cancellations)	≤0.8%	G		0.08%	Monthly	1.27%	0.00%	0.00%	0.15%		↑
	Number of non-medical cancelled operations not treated within 28 days	Zero Breaches			n/a	Monthly	n/a	n/a	n/a	n/a		
	Mixed Sex Accommodation Breaches	Zero Breaches	G		0	Monthly	0	0	0	0		→
	Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)	≤ 2.67%	R	10		Monthly (Rolling 3 Months)	3.53%	2.42%	3.09%	6.85%		↑
	VTE Risk Assessment	≥95%	G		91.8%	Monthly	97.9%	95.0%	79.0%	97.3%		↑
	Posterior Capsular Rupture rates	≤1.95%	G		0.00%	Monthly	0.35%	n/a	n/a	0.00%		♦
Patient Centred Care (Quality & Safety)	Occurrence of any Never events	Zero Events	G		0	Monthly	0	0	0	0		→
	Endopthalmitis Rates - Aggregate Score	Zero Non-Compliant	G			Quarterly	0			0		♦
	MRSA Bacteraemias Cases	Zero Cases	G		0	Monthly	0	0	0	0		→
	Clostridium Difficile Cases	Zero Cases	G		0	Monthly	0	0	0	0		→
	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) - cases	Zero Cases	G		0	Monthly	0	0	0	0		→
	MSSA Rate - cases	Zero Cases	G		0	Monthly	0	0	0	0		→
	Inpatient (Overnight) Ward Staffing Fill Rate	≥90%	G		97.3%	Monthly	94.9%	99.0%	94.9%	98.7%		↑
	Inpatient Scores from Friends and Family Test - % positive	≥90%	G		95.6%	Monthly	95.9%	n/a	95.4%	95.7%		↑
	A&E Scores from Friends and Family Test - % positive	≥90%	G		94.8%	Monthly	94.1%	n/a	94.7%	95.0%		↑
	Outpatient Scores from Friends and Family Test - % positive	≥90%	G		92.2%	Monthly	94.3%	n/a	91.6%	92.8%		↑
	Paediatric Scores from Friends and Family Test - % positive	≥90%	G		93.4%	Monthly	95.3%	n/a	91.9%	95.3%		↑

* Figures Provisional for June 2020

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

Domain	Service Excellence (Ambitions)	June 2020

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Mar 20	Apr 20	May 20	Jun 20	13 Month Series	vs. Last
Patient Centred Care (Quality & Safety)	Summary Hospital Mortality Indicator	Zero Cases	G		0	Monthly	0	0	0	0		→
	NHS England/NHS Improvement Patient Safety Alerts breached	Zero Alerts	G		n/a	Monthly	0	0	0	0		→
	Percentage of responses to written complaints sent within 25 days	≥80%	G		100.0%	Monthly (Month in	76.0%	69.6%	100.0%	100.0%		
	Percentage of responses to written complaints acknowledged within 3 days	≥80%	G		100.0%	Monthly	82.6%	100.0%	100.0%	100.0%		→
	Freedom of Information Requests Responded to Within 20 Days	≥90%	R	11	85.9%	Monthly (Month in	90.7%	87.9%	78.9%	88.5%		
	Subject Access Requests (SARs) Responded To Within 28 Days	≥90%	G		100.0%	Monthly (Month in	98.1%	93.9%	100.0%	100.0%		
	Number of Serious Incidents remaining open after 60 days	Zero Cases	G		2	Monthly	0	1	1	0		↓
	Number of Incidents (excluding Health Records incidents) remaining open after 28 days	tbc				Monthly	147	83	80	53		↓
Collaborative Research	Total patient recruitment to NIHR portfolio adopted studies (YTD cumulative)	≥1800			41	Monthly	29	15	13	13		→
	Percentage of Trust Patients Recruited Into Research Projects	≥2%	G		n/a	Monthly	3.6%	3.6%	3.7%	3.7%		→

* Figures Provisional for June 2020

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

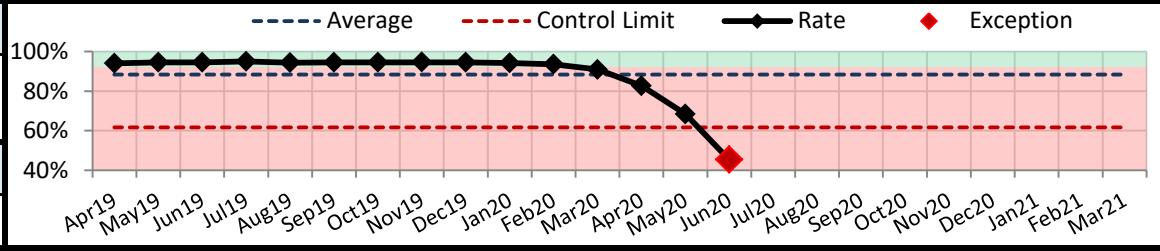
Remedial Action Plan - June 2020

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

18 Week RTT Incomplete Performance

Target	Rating	YTD	Mar-20	Apr-20	May-20	Jun-20
≥92%	Red	65.2%	90.9%	82.7%	68.4%	45.4%

Divisional Benchmarking (Jun 20)	City Road	North	South
	57.4%	31.4%	37.5%



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

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

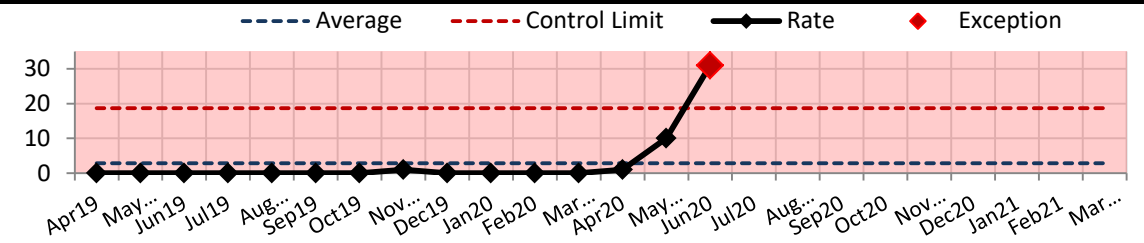
Remedial Action Plan - June 2020

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

52 Week RTT Incomplete Breaches

Target	Rating	YTD	Mar-20	Apr-20	May-20	Jun-20
Zero Breaches	Red	42	0	1	10	31

Divisional Benchmarking (Jun 20)	City Road	North	South
	8	13	10



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

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Backlog of surgical cases due to deferral of all bar P1 and P2 surgery.	Plans for P3 and P4 surgery to restart in next two months.	September 2020

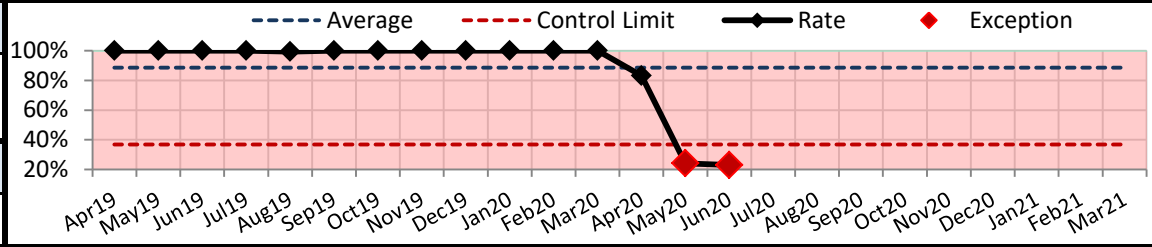
Remedial Action Plan - June 2020

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

Percentage of Diagnostic waiting times less than 6 weeks

Target	Rating	YTD	Mar-20	Apr-20	May-20	Jun-20
≥99%	Red	41.8%	100.0%	83.2%	24.2%	23.0%

Divisional Benchmarking (Jun 20)	City Road	North	South
	Not Available		



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

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
All appointments except those clinically confirmed urgent patients were stratified and postponed as at 23rd March 2020. They were transferred onto the pending waiting list in the radcentre (booking system) due to Covid 19. Following the NHSE Clinical Prioritisation Categories for every New and Backlog imaging test request, the list was re-stratified into Red, Amber, Green. Referring clinicians were contacted where necessary.	High Risk: Red stratified oncology patients and new oncology patients have and continue to be seen throughout for their diagnostics alongside their clinic appointment. A new diagnostic hub in oncology clinic 11 has been established and allows for one stop streamlined care.	November 2020

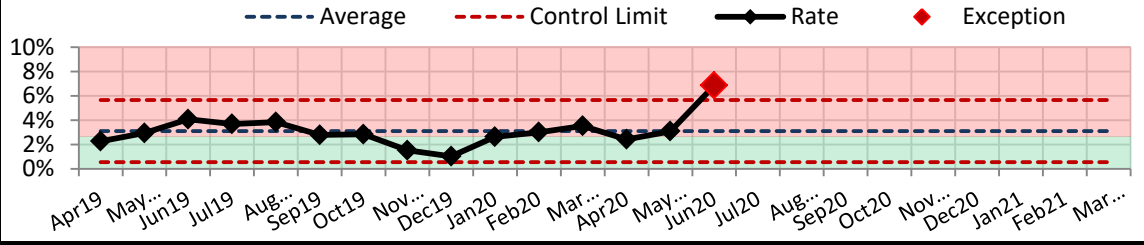
Remedial Action Plan - June 2020

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

Percentage of Emergency re-admissions within 28 days following an elective or emergency spell at the Provider (excludes Vitreoretinal)

Target	Rating	YTD	Mar-20	Apr-20	May-20	Jun-20
≤ 2.67%	Red	n/a	3.53%	2.42%	3.09%	6.85%

Divisional Benchmarking (Jun 20)	City Road	North	South
	7.04%	n/a	0.00%



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

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
For the month of June, there are three patients: 1. Adnexal patient who had a series of planned steroid IV infusions. This is not a repeat surgical admission and not reflective of any clinical failure. 2. Elderly glaucoma patient who had laser treatment to reduce pressure prior to their definitive treatment of cataract surgery. No element of treatment failure - appropriate to get pressure down and then conduct cataract surgery as soon as is safe to do so. This was clinically necessary. 3. Severe complex case under the External Disease service, where an amniotic membrane graft had to be repeated after the first melted.	The Deputy Divisional Director continues to review all cases of readmission within 28 days in order to understand reasons behind underperformance. In these cases, no further action was required.	August 2020

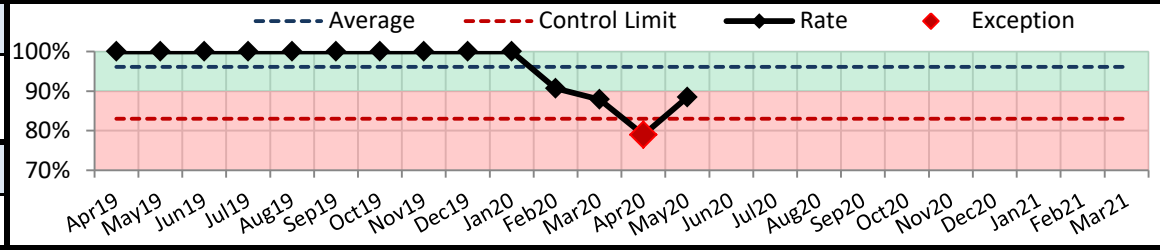
Remedial Action Plan - June 2020

Domain	Service Excellence (Ambitions)	Theme	Patient Centred Care (Quality & Safety)
Lead Manager	Jo Downing	Responsible Director	Ian Tombleson

Freedom of Information Requests Responded to Within 20 Days (Month in Arrears)

Target	Rating	YTD	Mar-20	Apr-20	May-20	Jun-20
≥90%	Red	85.9%	90.7%	87.9%	78.9%	88.5%

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



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

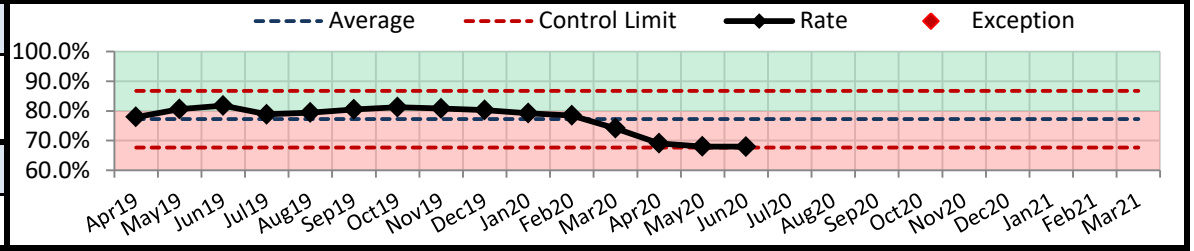
Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Organisational responsiveness to FOI requests has temporarily dropped through the COVID period but performance has returned to near normal in June and is expected to continue to improve for next months performance.	The IG team contine to emphasize the need to meet organisational performance and compliance requirements and this is expected to restore performance shortly.	August 2020

Domain	People (Enablers)	*June 2020*

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Mar 20	Apr 20	May 20	Jun 20	13 Month Series	vs. Last
Workforce Metrics	Appraisal Compliance	≥80%	R	13		Monthly	74.2%	69.1%	68.0%	68.0%		→
	Information Governance Training Compliance	≥95%	R	14		Monthly	94.6%	94.0%	94.7%	94.3%		↓
	Staff Turnover (Rolling Annual Figure)	≤15%	G		n/a	Monthly	n/a	12.6%	12.2%	11.4%		↓
	Proportion of Temporary Staff	RAG as per Spend			4.5%	Monthly	12.6%	4.1%	4.6%	4.9%		↑
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%			n/a	Quarterly		n/a				
	Percentage of Staff agreeing with the staff survey statement "I would recommend my organisation as a place to work"	≥70%			n/a	Quarterly		n/a				

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

Remedial Action Plan - June 2020							Domain	People (Enablers)	Theme	Workforce Metrics
Appraisal Compliance							Lead Manager	Nicky Wild	Responsible Director	Sandi Drewett
Target	Rating	YTD	Mar-20	Apr-20	May-20	Jun-20				
≥80%	Red	n/a	74.2%	69.1%	68.0%	68.0%				
Divisional Benchmarking (Jun 20)				City Road	North	South				
				n/a	n/a	n/a				



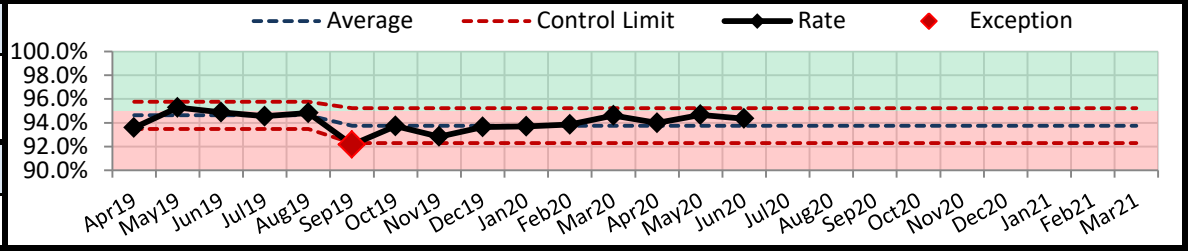
Previously Identified Issues	Previous Action Plan(s) to Improve	Target Date	Status
No Outstanding Issues or Actions			

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
At the start of the Covid-19 period an executive decision was made to suspend the appraisal process. The appraisal process has now restarted with new Covid-19 specific guidance but it is recognised that recovery towards target will take some time as working restrictions are still in place.	The development of support and guidance for virtual appraisal is on-going and a process of reminder emails to managers is now in operation.	

Remedial Action Plan - June 2020					Domain	People (Enablers)	Theme	Workforce Metrics
Information Governance Training Compliance					Lead Manager	Jo Downing	Responsible Director	Ian Tombleson

Target	Rating	YTD	Mar-20	Apr-20	May-20	Jun-20
≥95%	Red	n/a	94.6%	94.0%	94.7%	94.3%

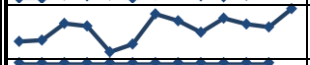
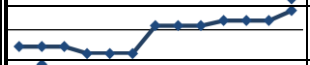
Divisional Benchmarking (Jun 20)	City Road	North	South
	n/a	n/a	n/a



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

Reasons for Current Underperformance	Action Plan(s) to Improve Performance	Target Date
Organisational performance for IG training remains very good but is 0.7% below the target. This has stood up well duing the COVID period with relatively little change	The IG team continues to send out reminders to the organisation focusing on those who exhibit long term poor compliance to push performance beyond 95%	September 2020

Domain	Infrastructure & Culture (Enablers)	*June 2020*

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Mar 20	Apr 20	May 20	Jun 20	13 Month Series	vs. Last
Digital Delivery	Data Quality - Ethnicity recording (Outpatient and Inpatient)	≥94%	R	16	91.7%	Monthly	89.6%	89.7%	92.0%	93.7%		↑
	Data Quality - Ethnicity recording (A&E)	≥94%	G		99.9%	Monthly	99.9%	99.9%	99.9%	100.0%		↑
Research	70 Day To Recruit First Research Patient	≥80%	G		98.0%	Monthly	100.0%	100.0%	100.0%	93.3%		↓
	Percentage of Research Projects Achieving Time and Target	≥65%	G		69.8%	Monthly	68.8%	68.8%	68.8%	72.7%		↑
	Percentage of Patients Recruited Against Target (Studies Closed In Month)	100%	G		166.3%	Monthly	180.3%	186.6%	186.6%	100.0%		↓

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

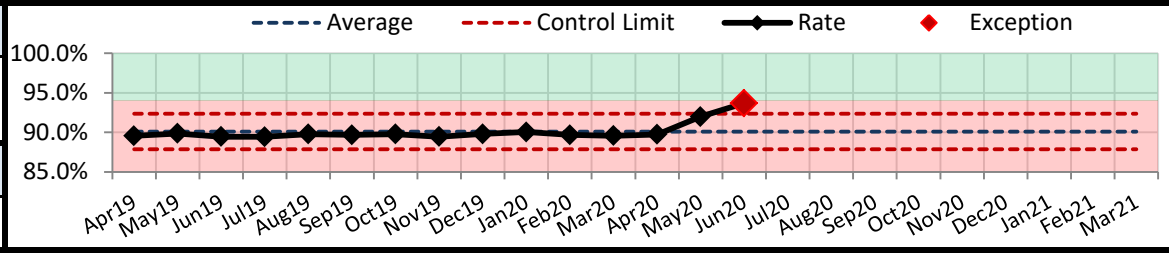
Remedial Action Plan - June 2020

Domain	Infrastructure & Culture (Enablers)	Theme	Digital Delivery
Lead Manager	**Donna Flatt**	**Responsible Director**	**John Quinn**

Data Quality - Ethnicity recording (Outpatient and Inpatient)

Target	Rating	YTD	Mar-20	Apr-20	May-20	Jun-20
≥94%	Red	91.7%	89.6%	89.7%	92.0%	93.7%

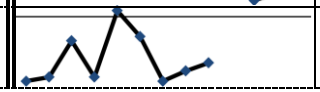
Divisional Benchmarking (Jun 20)	City Road	North	South
	95.0%	87.6%	95.7%



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

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. This has been delayed due to COVID 19 however will be picked up in the current DQ Audit programme and reported to operational leads through the audit reports. Collection methods have also been introduced in the Booking Centre pre-COVID which we hope will see improvement in collection overall.	March 2021

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

Theme	Metric Description	Target	Current	RAP Pg	Year to Date	Reporting Frequency	Mar 20	Apr 20	May 20	Jun 20	13 Month Series	vs. Last
Overall Plan	Overall financial performance (In Month Var. £m)	≥0	R	*	-4.03	Monthly	0.74	2.56	1.82	-0.35		↓
	Distance from Financial Plan (Current in Trust Metric : Trust Underlying Overall Position - Surplus / Deficit)	1			n/a	Monthly	1	n/a	n/a	n/a		
Commercial Operations	Commercial Trading Unit Position (In Month Var. £m)	≥0	R	*	-3.30	Monthly	-0.77	-1.29	-1.05	-0.94		↑
Cost Impovement Plans	Cost Improvement Plan Variance	≥0			n/a	Monthly	n/a	n/a	n/a	n/a		

**** No Remedial Action Plans, for commentary see Financial Report***

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

IPR ADDENDUM - WEEKLY RECOVERY KPI DATA

Measure	Level	19/20 Wkly Av.	Week ending 10-May-20	17-May-20	24-May-20	31-May-20	07-Jun-20	14-Jun-20	21-Jun-20	28-Jun-20	05-Jul-20	12-Jul-20	Trend
Number of Sites Open	Trust	n/a	7	7	7	7	7	10	9	8	9	10	
Outpatient Activity	Trust	11559	2076	2721	2806	2438	2312	2189	2247	2345	2580	2712	
Surgical Activity	Trust	648	37	23	48	55	83	132	128	165	152	156	
Injections	Trust	871	380	502	525	513	433	615	606	597	591	631	
A&E Activity	Face-to-face	n/a	774	744	822	893	519	919	976	962	996	900	
	Tele-medicine	n/a	321	361	365	258	274	329	358	314	336	319	
	Trust	1837	1095	1105	1187	1151	793	1248	1334	1276	1332	1219	
Non face to face outpatient attendances (Total)	Telephone	n/a	557	600	626	438	441	1468	1143	874	985	669	
	Video	n/a	-	-	-	-	-	234	191	191	216	183	
	Trust	n/a	557	600	626	438	441	1702	1334	1065	1201	852	
Backlog - patients cancelled with no future booking	Trust	n/a	0	0	0	0	0	83345	82948	83976	92639	98593	
Number of patients stratified	High Risk	n/a	3564	-	4690	-	7855	14010	13907	14295	15440	15856	
	Medium Risk	n/a	4084	-	6989	-	15549	20399	20241	20627	21868	22172	
	Low Risk	n/a	41017	-	55045	-	80582	93796	93506	94660	105292	108258	
Backlog - % of patients stratified	City Road	n/a	42.2%	-	46.3%	-	58.0%	66.60%	66.6%	66.52%	69.88%	70.29%	
	North	n/a	3.8%	-	11.7%	-	70.7%	87.06%	87.2%	86.84%	86.74%	85.13%	
	South	n/a	29.0%	-	48.2%	-	67.9%	70.30%	70.0%	71.58%	72.21%	72.02%	
Number of new referrals received	Trust	2789	539	642	717	701	477	717	609	604	742	631	
DNA Rate	Trust	10.80%	11.2%	9.8%	10.6%	10.9%	9.5%	7.7%	8.7%	10.0%	9.7%	10.5%	
RTT - Performance	Trust	94.10%	80.5%	77.3%	73.2%	68.5%	64.4%	49.4%	50.3%	46.4%	40.6%	35.1%	
RTT - 18 weeks+	Trust		5247	6232	7362	8746	9857	14253	13990	15219	16992	18782	
RTT - 52 weeks+	Trust	0	9	10	10	15	15	22	22	31	50	53	
Outpatient Clinic Median Journey Times (mins)	Trust	95	66	65	61	74	77	75	78	78	76	76	
Percentage of Outpatient Journey Times less than 2 hours	Trust	66.60%	80.7%	78.9%	78.8%	70.2%	74.1%	75.9%	72.5%	74.9%	74.0%	74.1%	
Number of Written Complaints	Trust	5	0	1	1	2	4	4	5	2	2	5	
Call Handling - Average Time To Answer (secs)	Trust	TBC	-	-	-	-	-	-	51	42	56	64	
Call Handling - Percentage of Calls Answered	Trust	TBC	-	-	-	-	-	-	95.0%	97.0%	95.0%	94.0%	
Friends & Family Test A&E - Percentage Positive Responses	Trust	92.6%	93.6%	95.1%	94.9%	94.5%	95.7%	94.0%	95.8%	94.8%	93.4%	93.8%	
Friends & Family Test Outpatients - Percentage Positive Responses	Trust	95.0%	92.3%	92.8%	90.8%	91.0%	90.9%	93.7%	92.8%	94.0%	93.0%	89.4%	
Friends & Family Test Inpatients - Percentage Positive Responses	Trust	98.40%	88.9%	90.0%	100.0%	100.0%	94.9%	100.0%	100.0%	92.1%	96.5%	94.1%	

Recovery IPR Document - Metric Definition Document

Metric	Description
Number of Sites Open	Moorfields Eye Hospital sites which have recorded activity during the week period
Outpatient Activity	Count of Outpatient Appointment activity recorded
Surgical Activity	Count of Surgical activity recorded
Injections	Count of Outpatient Appointment activity
A&E Activity	Count of Accident & Emergency activity
Non face to face outpatient attendances (Total)	Count of patients seen by a method other than a physical presence appointment
Backlog - patients cancelled with no future booking	Number of patients without an appointment date on the Patient Administration System which require booking (METRIC UNDER REVIEW)
Number of patients stratified	Number of patients that as part of the patient cancellation exercise have been recorded as being at High-, Medium- or Low- risk
Backlog - % of patients stratified	Percentage of patients that as part of the patient cancellation exercise have been recorded as being at High-, Medium- or Low- risk
Number of new referrals received	Count of new patient referrals received by the trust
DNA Rate	Percentage of appointments for which patient did not attend
RTT - Performance	Percentage of patients that have received treament with the
RTT - 18 weeks+	Number of Referral To Treatment applicable patients waiting in excess of 18 weeks
RTT - 52 weeks+	Number of Referral To Treatment applicable patients waiting in excess of 52 weeks
Outpatient Clinic Median Journey Times (mins)	Median length of time taken for a patient appointment measured from arrival time to departure time
Percentage of Outpatient Journey Times less than 2 hours	Percentage of Oupatient appointments with a duration time from arriaval to departure of less than 2 hours.
Number of Written Complaints	Volume of patient/carer complaints received by the trust
Call Handling - Average Time To Answer (secs)	Duration of time taken by the booking centre to answer an external telephone call
Call Handling - Percentage of Calls Answered	Percentage of external telephone calls answered by the booking centre
Friends & Family Test A&E - Percentage Positive Responses	Percentage of Accident & Emergency patients expressing a positive response to the Friends and Family Test satisfaction questionnaire.
Friends & Family Test Outpatients - Percentage Positive Responses	Percentage of Inpatients expressing a positive response to the Friends and Family Test satisfaction questionnaire.
Friends & Family Test Inpatients - Percentage Positive Responses	Percentage of Outpatients expressing a positive response to the Friends and Family Test satisfaction questionnaire.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 07

Finance report

Board of directors 23 July 2020

Report title	Monthly Finance Performance Report Month 03 –June 2020
Report from	Jonathon Wilson, Chief Financial Officer
Prepared by	Justin Betts, Deputy Chief Financial Officer
Link to strategic objectives	Deliver financial sustainability as a Trust

Executive summary

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

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

For June the Trust is reporting :-

- **a deficit of £8.65m** prior to block payment support; (£30.64m deficit YTD)
- **a breakeven position** adjusting for block payment income support.

Compared to initial plans, the Trust is reporting:-

- **£13.69m less income** than would be expected, (£40.59m YTD) offset by
- **£ 1.34m less pay**, and
- **£ 3.52m less non pay** operating expenditure.

Financial Performance £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Budget	Actual	Variance
Income	£251.7m	£22.1m	£16.9m	(£5.2m)	£60.3m	£50.1m	(£10.2m)
Pay	(£138.7m)	(£11.5m)	(£10.2m)	£1.3m	(£34.6m)	(£30.5m)	£4.1m
Non Pay	(£104.5m)	(£9.5m)	(£6.0m)	£3.5m	(£27.3m)	(£17.1m)	£10.2m
Financing & Adjustments	(£9.4m)	(£0.8m)	(£0.7m)	£0.0m	(£2.3m)	(£2.5m)	(£0.1m)
CONTROL TOTAL	**(£0.8m)**	**£0.3m**	**(£0.0m)**	**(£0.3m)**	**(£4.0m)**	**£0.0m**	**£4.0m**

Efficiency scheme performance will remain unreported during the Covid-19 response period. Within the plan submitted to board these totalled £1.149m YTD.

Quality implications

Patient safety has been considered in the allocation of budgets.

Financial implications

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

Risk implications

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

Action Required/Recommendation

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

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Monthly Finance Performance Report
For the period ended 30th June 2020 (Month 03)

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 June 2020 (Month 03)

Key Messages

Statement of Comprehensive Income

Operational Planning	Since the NHS emergency response to COVID in March 2020, Operational planning nationally has been formally suspended. The Annual Plan and in-month plan values in this report represent the Trusts draft 2020/21 Financial Plan approved by the Trust Board and submitted to NHS Improvement on the 5th March 2020. Please note therefore that variances to plan provide an indication only as to how income and expenditure patterns have changed.
Financial Position £8.65m deficit pre support	For June the Trust is reporting :- • **a deficit of £8.65m** prior to block payment support (£30.64m YTD); • **a breakeven position** adjusting for block payment income support. Compared to initial plans, the Trust is reporting:- • **£13.69m less income** than would be expected; offset by • **£ 1.34m less pay**; and • **£ 3.52m less non pay** operating expenditure (£1.3m drugs).
Income £13.69m less than plan	Total Trust income is £13.69m less than would be expected, consisting of:- • Clinical activity income losses £10.34m; (£30.71m YTD) • Commercial income losses £1.54m; (£5.45m YTD) • Research income losses £0.79m; (£2.12m YTD) and • Other income losses including Bedford £0.29m (£0.72m YTD). Activity income, if reimbursed by normal contracting arrangements would total £5.95m compared to a plan of £16.51m - £10.56m adverse to plan.
Expenditure £3.52m less than plan (pay, non pay, excl financing)	Pay costs are £1.30m below plan, with bank and agency costs £0.97m (66%) less than 2019/20 average expenditure levels. Non-pay costs are £3.52m below plan mainly due to Drugs (£1.30m), Clinical Supplies (£1.24m), of which Commercial expenditure is (£0.61m).

Statement of Financial Position

Cash and Working Capital Position	The cash balance at the 30th June is £76.7m significantly higher than initially planned, primarily due to block income payments in advance, and top-up payments received by the Trust to ensure NHS organisation have sufficient cash to deal with the initial emergency COVID response.
Capital (both gross capital expenditure and CDEL)	Revised capital allocations for Trusts, and STP's were notified in May with a Trust funded limit of £13.7m for Moorfields. Current capital plans are being reviewed in light of post COVID recovery and responses. Capital spend to June totalled £1.8m primarily linked to Oriel (£1.0m).
Use of Resources	Current use of resources monitoring has been suspended.

Trust Financial Performance - Financial Dashboard Summary

FINANCIAL PERFORMANCE

Financial Performance £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	%	RAG
Income	£251.7m	£22.1m	£16.9m	(£5.2m)	£60.3m	£50.1m	(£10.2m)	(17)%	
Pay	(£138.7m)	(£11.5m)	(£10.2m)	£1.3m	(£34.6m)	(£30.5m)	£4.1m	12%	
Non Pay	(£104.5m)	(£9.5m)	(£6.0m)	£3.5m	(£27.3m)	(£17.1m)	£10.2m	37%	
Financing & Adjustments	(£9.4m)	(£0.8m)	(£0.7m)	£0.0m	(£2.3m)	(£2.5m)	(£0.1m)	(6)%	
CONTROL TOTAL	**(£0.8m)**	**£0.3m**	**(£0.0m)**	**(£0.3m)**	**(£4.0m)**	**£0.0m**	**£4.0m**	100%	
Memorandum Items									
Research & Development	(£2.18m)	(£0.18m)	(£0.84m)	(£0.66m)	(£0.56m)	(£2.70m)	(£2.14m)	(381)%	
Commercial Trading Units	£5.42m	£0.41m	(£0.53m)	(£0.95m)	£0.89m	(£2.46m)	(£3.29m)	(371)%	
ORIEL Revenue	(£2.45m)	(£0.16m)	£0.00m	£0.17m	(£0.36m)	(£0.12m)	£0.24m	66%	
Efficiency Schemes	£7.00m	£0.93m	£0.52m	(£0.42m)	£0.36m	£7.00m	(£1.09m)	(302)%	

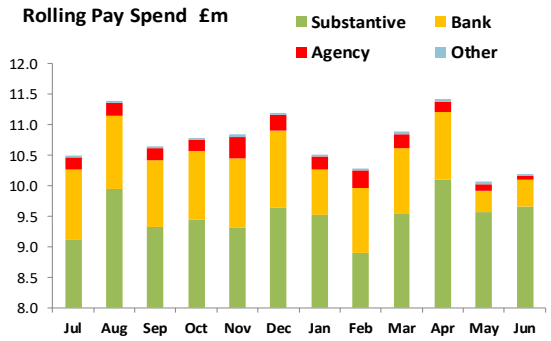
INCOME BREAKDOWN RELATED TO ACTIVITY

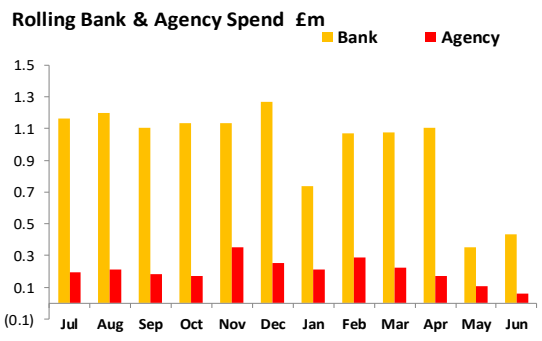
Income Breakdown £m	Annual Plan	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Plan	Forecast Actual	Forecast Variance
NHS Clinical Income	£145.5m	£34.8m	£8.1m	(£26.5m)		-	-	-
Pass Through	£41.1m	£9.8m	£5.6m	(£4.2m)		-	-	-
Other NHS Clinical Income	£9.8m	£2.3m	£0.7m	(£1.6m)		-	-	-
Commercial Trading Units	£34.0m	£7.6m	£2.2m	(£5.4m)		-	-	-
Research & Development	£11.9m	£3.3m	£1.1m	(£2.1m)		-	-	-
Other	£8.6m	£2.2m	£1.7m	(£0.7m)		-	-	-
INCOME PRE TOP-UP	**£250.9m**	**£60.0m**	**£19.4m**	**(£40.6m)**		**-**	**-**	**-**
FRF/Block Payment Top Up	£0.8m	£0.2m	£30.6m	£30.4m		-	-	-
TOTOAL OPERATING REVENUE	**£251.7m**	**£60.3m**	**£50.1m**	**(£10.2m)**		**-**	**-**	**-**

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

PAY AND WORKFORCE

Pay & Workforce £m	Annual Plan	In Month Plan	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	% Total
Employed	(£136.4m)	(£11.3m)	(£9.7m)	£1.68m	(£34.1m)	(£29.0m)	£5.03m	95%
Bank	(£1.8m)	(£0.2m)	(£0.4m)	(£0.28m)	(£0.5m)	(£1.1m)	(£0.63m)	4%
Agency	-	-	(£0.1m)	(£0.06m)	-	(£0.3m)	(£0.27m)	1%
Other	(£0.5m)	(£0.0m)	(£0.0m)	£0.00m	(£0.1m)	(£0.1m)	£0.01m	0%
TOTAL PAY	**(£138.7m)**	**(£11.5m)**	**(£10.2m)**	**£1.34m**	**(£34.6m)**	**(£30.5m)**	**£4.14m**	





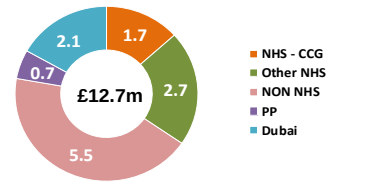
CASH, CAPITAL AND OTHER KPI'S

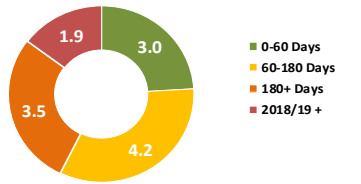
Capital Programme £m	Annual Plan	Year to Date Budget	Year to Date Actual	Year to Date Variance	RAG	Forecast Budget	Forecast Actual	Forecast Variance
Trust Funded	(£13.7m)	(£1.4m)	(£1.7m)	£0.3m		-	-	-
Donated/Externally funded	(£1.4m)	-	(£0.1m)	£0.1m		-	-	-
TOTAL	**£15.1m**	**£1.4m**	**£1.8m**	**£0.4m**		**-**	**-**	**-**

Key Metrics	Plan	Actual	RAG
Cash	38.6	76.7	
Debtor Days	45	33	
Creditor Days	45	57	
PP Debtor Days	65	34	

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

Net Receivables/Ageing £m





Trust Income & Expenditure Performance

FINANCIAL PERFORMANCE

Statement of Comprehensive Income £m	Annual Plan	In Month					Year to Date				
		Plan	Actual	Variance	%	RAG	Plan	Actual	Variance	%	RAG
Income											
NHS Commissioned Clinical Income	186.60	16.51	5.95	(10.34)	(63)%		44.59	13.68	(30.71)	69%	
Other NHS Clinical Income	9.80	0.86	0.13	(0.73)	(85)%		2.32	0.73	(1.60)	69%	
Commercial Trading Units	34.01	2.69	1.15	(1.54)	(57)%		7.65	2.20	(5.45)	(71)%	
Research & Development	11.86	1.16	0.37	(0.79)	(68)%		3.25	1.14	(2.12)	65%	
Other Income	8.58	0.71	0.62	(0.29)	(41)%		2.23	1.71	(0.72)	32%	
Total Income	**250.86**	**21.92**	**8.23**	**(13.69)**	(62)%		**60.04**	**19.45**	**(40.59)**	**68%**	
Operating Expenses											
Pay	(138.66)	(11.53)	(10.20)	1.34	12%		(34.65)	(30.50)	4.14	12%	
Drugs	(38.59)	(3.37)	(2.07)	1.30	39%		(9.10)	(5.31)	3.80	42%	
Clinical Supplies	(21.85)	(1.92)	(0.68)	1.24	65%		(5.17)	(1.87)	3.30	64%	
Other Non Pay	(44.07)	(4.19)	(3.21)	0.98	23%		(13.02)	(9.92)	3.10	24%	
Total Operating Expenditure	**(243.18)**	**(21.00)**	**(16.15)**	**4.85**	23%		**(61.94)**	**(47.61)**	**14.34**	23%	
EBITDA	*7.68*	*0.91*	*(7.92)*	*(8.84)*	(967)%		*(1.90)*	*(28.16)*	*(26.26)*	*(1,382)%*	
Financing & Depreciation	(10.04)	(0.83)	(0.78)	0.05	6%		(2.51)	(2.62)	(0.11)	(4)%	
Donated assets/impairment adjustments	0.68	0.06	0.05	(0.01)	(14)%		0.17	0.14	(0.03)	15%	
Control Total Surplus/(Deficit) Pre FRF/Top Up Payments	**(1.67)**	**0.14**	**(8.65)**	**(8.79)**	(6,341)%		**(4.24)**	**(30.64)**	**(26.39)**	(622)%	
Provider PSF/FRF	0.84	0.21	-	(0.21)	(100)%		0.21	-	(0.21)	100%	
Covid Block Payments Received	-	-	9.21	9.21	0%		-	31.67	31.67	0%	
Covid Top Up Payments	-	-	(0.55)	(0.55)	0%		-	(1.04)	(1.04)	0%	
Post PSF/FRF Control Total Surplus/(Deficit)	**(0.84)**	**0.35**	**-**	**(0.35)**			**(4.03)**	**-**	**4.03**		

Commentary

Operating Income

£13.69m below plan pre support

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

Clinical activity levels recorded were 67% lower than would normally have been expected during June. If the Trust was reimbursed under activity-based contracting arrangements this income would have totalled £5.95m - £10.34m lower than plan.

In addition to the above, the Trust income losses included Commercial Trading income (£1.54m lower than plan), Research (£0.79m adverse), and Other NHS and Other Income adverse to plan (£0.79m and £0.29m adverse respectively).

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

Employee Expenses

£1.40m below plan

Total pay costs were £1.30m below plan, with bank and agency costs £0.97m (66%) less than 2019/20 average expenditure levels.

Aside from weekend sessions in A&E all medical local payments have stopped, whilst non-medical clinical temporary staffing is at low levels.

Non Pay Expenses

£3.52m below plan

(non pay and financing)

Non pay costs are £3.50m below plan mainly due to Drugs (£1.30m), Clinical Supplies (£1.24m), whilst other expenditure underspent by £1.08m, all linked to reduced activity levels.

Cost improvement saving reporting is suspended during the COVID response.

Trust Patient Clinical Income Performance

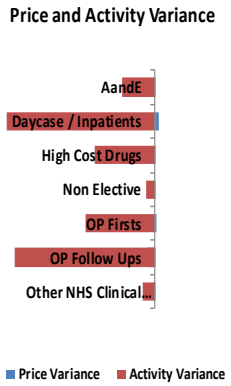
PATIENT CLINICAL INCOME

Point of Delivery	Activity YTD Plan	Activity YTD Actual	Activity YTD Variance	YTD Income £'000 Plan	YTD Income £'000 Actual	YTD Income £'000 Variance	RAG
AandE	26,918	14,044	(12,874)	£4,198	£2,056	(£2,142)	
Daycase / Inpatients	8,922	624	(8,298)	£9,926	£948	(£8,979)	
High Cost Drugs	13,268	8,157	(5,111)	£9,336	£5,554	(£3,782)	
Non Elective	746	454	(292)	£1,459	£876	(£583)	
OP Firsts	31,728	6,515	(25,213)	£5,442	£1,124	(£4,318)	
OP Follow Ups	114,966	29,437	(85,529)	£11,794	£2,554	(£9,240)	
Other NHS Clinical Income	4,532	1,103	(3,429)	£1,017	£127	(£890)	
Total	201,080	60,334	(140,746)	£43,173	£13,238	(£29,935)	

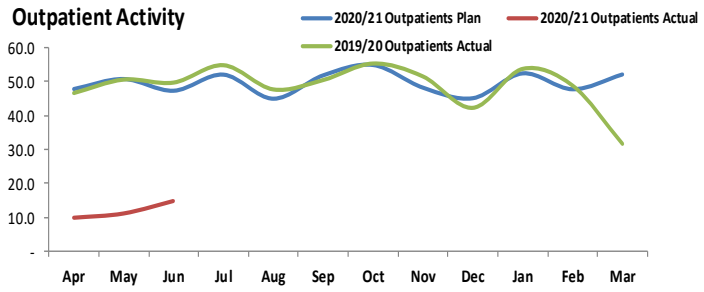
Excludes CQUIN, Bedford, and Trust to Trust test income.

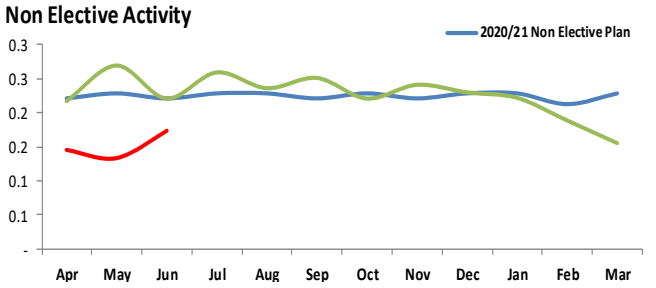
PRICE & ACTIVITY VARIANCE

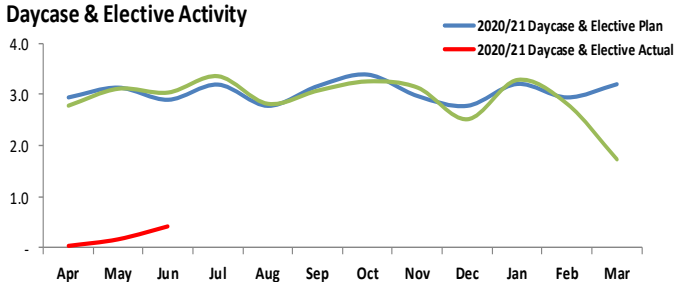
Average price Per Plan	Average price Received	Variance %	£000's Price Variance	£000's Activity Variance
£156	£146	-6%	(£135)	(£2,008)
£1,113	£1,519	37%	£254	(£9,232)
£704	£681	-3%	(£6)	(£3,774)
£1,956	£1,930	-1%	(£12)	(£571)
£172	£173	1%	£6	(£4,325)
£103	£87	-15%	(£466)	(£8,774)
£224	£115	-49%	(£121)	(£770)
			(£480)	(£29,453)

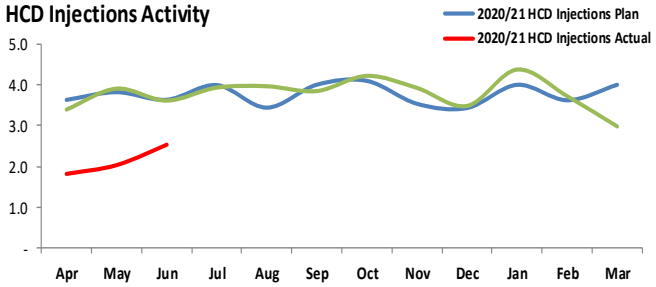


ACTIVITY TREND









Commentary

NHS Income Activity levels recorded during June were 67% below anticipated levels, across all points of delivery.

The charts to the left demonstrate the material shift in activity compared to last financial year and March 2020.

NHS Patient Clinical activity income in June was £5.9m if reimbursed via activity based contracting arrangements.

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

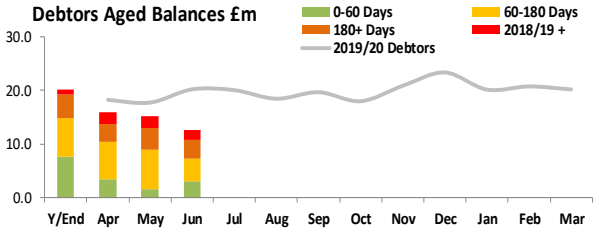
CAPITAL EXPENDITURE

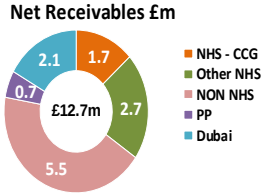
Capital Expenditure £m	Annual Plan	In Month			Year to Date		
		Plan	Actual	Variance	Plan	Actual	Variance
Estates - Trust Funded	-	-	0.1	0.1	-	0.1	0.1
Medical Equipment - Trust Funded	-	-	0.1	0.1	-	0.2	0.2
IT - Trust Funded	-	-	(0.1)	(0.1)	-	0.0	0.0
ORIEL - Trust Funded	5.8	0.5	0.4	(0.0)	1.4	1.0	(0.4)
Dubai - Trust funded	-	-	-	-	-	0.2	0.2
Other - Trust funded	7.9	-	0.2	0.2	-	0.2	0.2
TOTAL - TRUST FUNDED	**13.7**	**0.5**	**0.7**	**0.2**	**1.4**	**1.7**	**0.3**
Donated/Externally funded	1.4	-	0.0	0.0	-	0.1	0.1
TOTAL INCLUDING DONATED	**15.1**	**0.5**	**0.7**	**0.2**	**1.4**	**1.8**	**0.4**

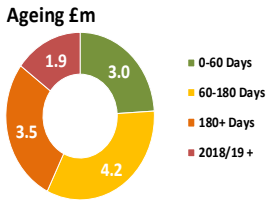
Capital Funding £m	Annual Plan	Secured	Not Yet Secured	% Secured
Planned Total Depreciation	8.0	8.0		100%
Cash Reserves - B/Fwd cash	7.6	7.6		100%
Capital investment loan funding (approved)				0%
Cash Reserves - Other (PSF)				0%
Capital Loan Repayments	(1.8)	(1.8)		100%
TOTAL - TRUST FUNDED	**13.7**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

RECEIVABLES

Net Receivables £m	*0-60 Days*	*60-180 Days*	*180+ Days*	*2018/19 +*	*Total*
CCG Debt	-	0.2	1.3	0.2	1.7
Other NHS Debt	0.3	1.0	0.8	0.6	2.7
Non NHS Debt	1.9	2.3	0.9	0.5	5.5
Commercial Unit Debt	0.8	0.8	0.6	0.6	2.8
TOTAL RECEIVABLES	**3.0**	**4.2**	**3.5**	**1.9**	**12.7**







STATEMENT OF FINANCIAL POSITION

Statement of Financial Position £m	Annual Plan	Year to Date		
		Plan	Actual	Variance
Non-current assets	108.2	97.6	95.9	(1.7)
Current assets (excl Cash)	20.4	21.9	20.0	(1.8)
Cash and cash equivalents	29.3	38.6	76.7	38.1
Current liabilities	(34.5)	(36.8)	(65.4)	(28.6)
Non-current liabilities	(35.4)	(36.2)	(37.2)	(1.0)
TOTAL ASSETS EMPLOYED	**88.1**	**85.1**	**89.9**	**4.9**

OTHER METRICS

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

Commentary

Cash and Working Capital

The cash balance at the 30th June is £76.7m, significantly higher than initially planned, largely due to block income and top-up payments in advance received by the Trust to ensure NHS organisation had sufficient cash to deal with the initial emergency COVID response. It is to be noted that both cash balances and current liabilities have increased by £18m over plan due to cash having been received in advance.

Capital Expenditure

Revised capital allocations for Trusts, and STP's were notified in May totally a limit £13.7m for Moorfields. Current capital plans are being finalised in light of the post COVID recovery.

Capital spend to June totalled £1.8m primarily linked to Oriel.

Use of Resources

Use of resources monitoring and reporting have been suspended.

Receivables

Receivables have reduced by £7.6m since the end of the 2019/20 financial year to £12.7m A reduction of £2.6m was recorded in June from the May position as NHS commissioners cleared substantial elements of prior-year debt.

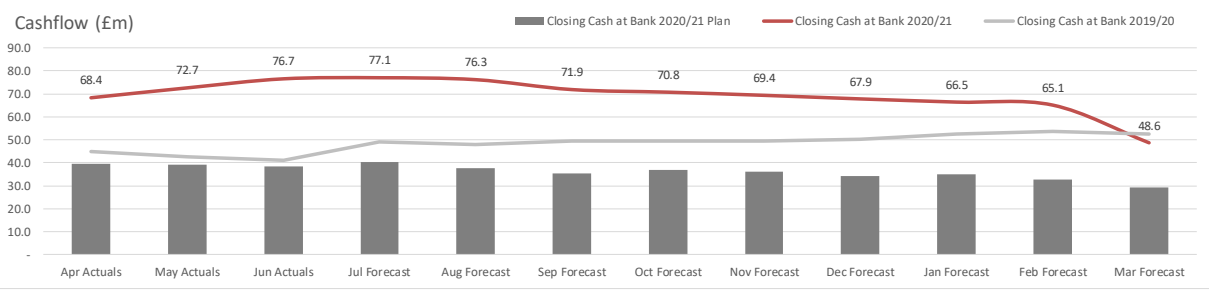
Payables

Payables totalled £10.8m at the end of June, a reduction of £5.0m since March 2020. The reduction is partly due to the Trust adopting the new Prompt Payment guidance issued to NHS bodies and a reduction in operating expenses.

Trust Statement of Financial Position – Cashflow

Cash Flow

Cash Flow £m	Apr Actuals	May Actuals	Jun Actuals	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Outturn Total	Jun Plan	Jun Var
Opening Cash at Bank	**52.4**	**68.4**	**72.7**	**76.7**	**77.1**	**76.3**	**71.9**	**70.8**	**69.4**	**67.9**	**66.5**	**65.1**	**52.4**		
Cash Inflows															
Healthcare Contracts	33.3	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	15.2	-	184.8	15.2	0.0
Other NHS	3.9	2.6	1.6	1.5	1.4	1.5	1.5	1.4	1.4	1.4	1.4	1.5	21.0	1.5	0.1
Moorfields Private/Dubai	1.4	0.9	1.6	1.7	1.5	1.6	2.9	2.8	2.6	2.7	2.7	3.0	25.5	2.8	(1.2)
Research	1.1	0.6	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	11.3	1.0	0.0
VAT	0.4	0.5	0.2	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	4.7	0.4	(0.2)
PDC	-	-	-	-	-	-	-	-	-	-	-	1.4	1.4	-	-
PSF	-	0.2	-	-	0.5	-	-	-	-	-	-	-	0.7	-	-
Other Inflows	0.2	1.8	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	5.5	0.3	0.1
Total Cash Inflows	**40.3**	**21.8**	**19.9**	**20.1**	**20.3**	**19.9**	**21.2**	**21.1**	**20.8**	**21.0**	**20.9**	**7.7**	**255.0**	**21.1**	**(1.2)**
Cash Outflows															
Salaries, Wages, Tax & NI	(9.6)	(9.6)	(9.4)	(9.7)	(9.7)	(9.7)	(9.7)	(9.7)	(9.7)	(9.7)	(9.7)	(9.7)	(115.4)	(9.7)	0.2
Non Pay Expenditure	(10.6)	(6.7)	(5.4)	(8.6)	(8.6)	(10.6)	(10.6)	(10.6)	(10.6)	(10.6)	(9.8)	(9.3)	(111.9)	(10.7)	5.3
Capital Expenditure	(1.0)	(0.4)	(0.4)	(0.3)	(0.3)	(0.6)	(0.2)	(0.2)	(0.6)	(0.4)	(0.5)	(1.9)	(6.8)	(0.4)	0.0
Oriel	(2.3)	(0.1)	(0.1)	(0.7)	(1.1)	(1.1)	(0.9)	(0.9)	(0.5)	(0.5)	(0.5)	(0.8)	(9.5)	(1.0)	0.9
Moorfields Private/Dubai	(0.9)	(0.7)	(0.8)	(0.4)	(0.8)	(0.8)	(0.9)	(1.1)	(1.1)	(1.2)	(1.1)	(1.1)	(10.9)	(0.5)	(0.2)
Financing - Loan repayments	-	-		-	(0.7)	(0.8)	-	-	-	-	(0.6)	(0.8)	(2.9)	-	-
Dividend and Interest Payable				-	-	(0.7)	-	-	-	-	-	(0.7)	(1.4)	-	-
Total Cash Outflows	(24.4)	(17.5)	(16.0)	(19.6)	(21.1)	(24.3)	(22.3)	(22.4)	(22.4)	(22.4)	(22.3)	(24.2)	**(258.8)**	(22.3)	6.4
Net Cash inflows /(Outflows)	15.9	4.3	4.0	0.5	(0.9)	(4.3)	(1.1)	(1.4)	(1.6)	(1.4)	(1.3)	(16.5)	-	(1.2)	5.1
Closing Cash at Bank 2020/21	**68.4**	**72.7**	**76.7**	**77.1**	**76.3**	**71.9**	**70.8**	**69.4**	**67.9**	**66.5**	**65.1**	**48.6**	**48.6**		
Closing Cash at Bank 2020/21 Plan	39.5	39.1	38.6	40.4	37.7	35.5	36.8	36.2	34.4	34.8	32.8	29.3	29.3		
Closing Cash at Bank 2019/20	45.1	42.6	41.0	48.9	47.8	49.6	49.6	49.5	50.3	52.6	53.8	52.4	52.4		



Commentary

Cash flow

The cash balance at the 30th June is £76.7m, significantly higher than initially planned.

The interim financial regime introduced to support NHS organisations during the CVOID response has contributed to significantly higher cash balances than previously planned, designed to ensure sufficient cash is available to the NHS to implement any required changes. The Trust currently has 114 days of operating cash.

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

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

June saw a cash inflow of £4.0m against a plan of £1.2m outflow as the decreases in non-pay expenditure for the year to date presented in cash terms.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 08

2019/20 Quality Account

Board of directors 23 July 2020

Report title	Draft 2019/20 Quality Account report
Report from	Director of Quality and Safety, Ian Tombleson
Prepared by	Head of Quality and Safety, Niloufar Hajilou
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience Research - We will be at the leading edge of research making new discoveries with our partners and patients We will innovate by sharing our knowledge and developing tomorrow's experts We will have an infrastructure and culture that supports innovation

Executive summary

Attached is the draft 2019/20 quality account report. The report has been shared with our external stake holders such as Islington CCG, Health watch, Health watch scrutiny committee as well as our governors. The draft report has also gone through various committees internally including Quality and Safety Committee for final sign off. It is worth noting that as requested by Islington CCG, their final comment will be added once the report has been signed off by the board. This year due to the impact of COVID 19 pandemic the quality account report did not go through external assurance audit as guided by NHS Improvement NHS England.

Action Required/Recommendation

The Board is required to finally sign off this document.

For Assurance		**For decision**	**x**	**For discussion**		**To note**	

Quality Account 2019/20

Our commitment to quality excellence

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Part 1: Statement on quality

1.1 Statement on quality from the Chief Executive

There are so many things that make me proud to work at Moorfields. Again during 2020/21 I have been particularly struck by the extensive achievements, dedication and professionalism of our staff. We strive to provide the best quality care and we have again been recognised nationally and internationally for the high quality, safety and effectiveness of our services and like any true learning organisation we remain committed to do more to continually improve. Everything we do embodies our values of being caring, organized, excellent and inclusive. Despite these important achievements, what is likely to remain at the forefront of many people's minds is the coronavirus pandemic. Whilst the outstanding dedication and commitment of our colleagues in response to the pandemic cannot be overstated, I would also like to pay tribute to their leadership and achievements throughout the year.

This quality report sets out our approach to improving quality, safety and our patient experiences. It reflects on what we did and how we performed in 2019/20, and sets out our ambitions and aspirations for the year ahead. 2019/20 has been an important year for Moorfields which included a successful CQC inspection report, improving on our last inspection of 2016. The trust has been given a rating of 'Good' overall with the CQC rating the trust 'Outstanding' for being effective. City Road services were rated 'Outstanding' overall which is a great achievement. Surgical services at City Road were also rated 'Outstanding', testament to our surgical services being regarded internationally as world leading in many sub-specialty areas, and we remained 'Outstanding' for 'caring' at City Road. All of our services were rated 'Good' for 'safe'. Importantly, and in recognition of the hard work of the teams, Bedford and St George's improved from 'Requires improvement' to 'Good' overall. The trust's clinical outcomes and safety record remains excellent, with ophthalmic clinical outcome performance amongst the best in the world.

In 2018 we launched our 'Patient Participation Strategy' following a period of consultation with our staff, stakeholders and most importantly, our patients. We have launched our quality governance framework which is a tool for measuring successful implementation of our quality strategy. This will help us to further embed quality within the organisation and in our journey from 'Good' to 'Outstanding'.

Our quality account reflects our quality performance in 2019/20. Overall we have made good progress with most of our indicators. In particular performance against national targets remains consistently excellent. We have made very good progress with improving use of the WHO surgical safety checklist and our team culture supporting this and we achieved the CQUIN targets for this objective. In 2020/21 we will be rolling out checklists in other areas where invasive procedures take place.

We remain committed to being a learning organisation, to make sure we learn from good and less good events which can occur across the organisation. As we continue this process, it is pleasing to see the contribution our patient and carer forum has made to the development of our quality priorities for 2020/21.
To the best of my knowledge the information in the document is accurate subject to the limitations explained later in this report.

David Probert

Chief Executive

1.2 Introduction to the Quality Account 2019/20

Quality Accounts help NHS trusts improve public accountability for the quality of care they provide. The Quality Account is a key mechanism to provide demonstrable evidence of improving the quality of the trust's services. The Quality Account also describes the organisation's quality priorities and aims for the coming year.

The Quality Account incorporates all the requirements of the Quality Accounts Regulations as well as those of NHS Improvement's (NHSI) additional reporting requirements. The purpose of the account is to:

- promote quality improvement across the NHS
- increase public accountability
- enable the trust to review its services
- demonstrate what improvements are planned
- respond and involve external stakeholders' to gain their feedback including patients and the public

Our Quality Account provides an appraisal of achievements against our priorities and goals set for 2019/20.

At Moorfields the quality of the services provided has always been at the heart of decisions taken by the Board. Our quality strategy is a call to action for everyone to make a difference and be part of the Moorfields journey from Good to Outstanding. Underpinned by the three key drivers for quality, the trust's 'Quality Structure' creates robust arrangements for driving improvement and providing a clear and accountable process for scrutiny and assurance for delivery of the Quality Account.

1.3 Moorfields Hospital approach to improving quality

At Moorfields our core belief is 'people's sight matters' and our purpose is 'working together to discover, develop and deliver the best eye care'. We define quality as 'providing safe care, outstanding outcomes, and positive experience and involvement for all our patients'.

Quality is our core philosophy, and at the heart of every decision we make. In a time of rapid technological advances, Moorfields' expertise, reputation and network places us in a unique position to lead the way in delivering quality eye care. We want to harness all of our skills and enthusiasm for learning and sharing to deliver excellent clinical care and world-leading research, so that we deliver the outstanding quality our patients deserve, and to truly live up to our name as a world-leading organisation.

Our priorities are consistent with the objectives set out in our quality strategy and form an important part of its implementation. It is both ambitious and aspirational by design. Throughout the document, Moorfields sets out its priorities under the three well established headings of Patient Safety, Patient Experience and Clinical Effectiveness.

The events following COVID 19 pandemic have had an impact on the majority of the KPIs both locally and nationally within this report. This includes 2020/21 quality priorities where the organisation may need to change its priorities as a result of our COVID 19 recovery response. Moorfields will continue following advice and guidance from NHS Improvement and NHS England to ensure patients continue to receive high quality care. NHS Improvement/NHS

England has confirmed that NHS providers are no longer expected to obtain assurance from their external auditor on their quality account /quality report for 2019/20.

The Quality and Safety Committee on behalf of the Board takes responsibility for overseeing the development and delivery of the Quality Account and quality priorities. For any information on this quality account report please contact Niloufar Hajilou, Head of Quality and Safety at niloufar.hajilou@nhs.net.

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Progress with 2019/20 priorities

We set ambitious priorities to drive high quality care and respond to the challenge of meeting the health needs of our diverse community. Moorfields identified six priority areas for 2019/20. We developed these with patients, staff, and host commissioners, NHS Islington Clinical Commissioning group and supported by the membership council. Trust's governors have also considered the contents of the quality report and were supportive of the quality priorities. Our Patient and Carer Forum contributed their views to shaping the quality priorities and the staff were also consulted through a staff survey. The rationale behind the priorities was based on the progress made with the 2018/19 priorities as well as other key drivers such as staff and patient feedback. The quality priorities were approved by the trust board on 4th April 2019.The identified six priorities were based on three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience.

Having set ambitious aims the trust has demonstrated progress against all targets although full achievement has not always been possible. As a result, some priorities will continue into 2020/21, please see a list of 2020/21 priorities from page 53 onwards.

Summary of the 2019/20 quality priorities:

Domain	No	Description	Priority continued from 2018/19
Safety	**1**	To support safer care for patients undergoing invasive procedures through developing LOCSSIPs according to National recommendations (NATSSIPs)	✓
	2	Ensure our quality governance framework is implemented and embedded across the organisation.	New
	3	Ensure that evidence of lessons learnt and changes to practice are captured, recorded and disseminated in a systematic way	New
Effectiveness	**4**	Embed a culture that supports ongoing changes to practice by developing quality improvement capabilities	New
Patient Experience	**5**	To involve and engage our patients across the organisation in true participation activities including in service reviews and developments	New
	6	To ensure that from a patient perspective appointments management is effective, efficient and responsive	New

Quality Domain: Safety **Priority 1:** To support safer care for patients undergoing invasive procedures through developing LOCSSIPs according to National recommendations (NATSSIPs)	
Our priority for 19/20 is to (see data table below) :	**1.1** Quarter 1: Identify all areas within the trust where invasive procedures are performed. **1.2** Quarter 1 and 2: Develop a self- assessment form tool against NatSSIPs **1.3** Quarter 4: Set up a programme of regular audits on NatSSIPs compliance due to commence in 2020/21

What did we achieve to date?

- Identification of areas in which invasive procedures are performed. This was informed by a procedure list provided by the performance and information team.
- Completion of a LocSSIP review and subsequent audit of:
  - Intravitreal injections (all sites that perform injections) to ensure that practice is safe and consistent across the whole organisation. The audit was undertaken in Q3 and the report was shared in January 2020. An action plan is being developed and this has been shared throughout the organisation
  - Review of refractive laser process (private and NHS at City Road) to ensure that practice is safe and consistent for all patients. An audit was completed by the service and the report was shared with relevant teams in 2019/20.
  - The head of clinical governance created an audit tool for the review of LocSSIP compliance, which can be adapted for the review of other invasive procedures.

What will we do in 2020-21 to continue with progress?

Good progress has been made with this priority and due to the geographical spread of the organisation and the number of invasive procedures taking place the trust has decided to continue with this priority in 2020/21. This will ensure robust processes are in place to ensure invasive procedures take place according to best practice and national guidance.

Quality Domain: Safety **Priority 2:** Ensure our quality governance framework is implemented and embedded across the organisation.	
Our priority for 2019/20 has been to:	**2.1** Q1: Use of standardised minimum data sets in all quality forums **2.2** Q1&Q2: All relevant quality dashboard users to have received Qliksense training so it can be used operationally to inform decision making, **2.3** Q1&Q2: Regular review of quality dashboards at divisional quality forums (Q1 &2) **2.4** Q4: Existence of divisional exception reports for the divisional executive performance review

What did we achieve to date?

The Quality Governance Framework (QGF) launched in April 2019 clearly sets the expectations for divisions in ensuring standardisation of information shared within the quality forums. This includes existence of minimum quality agenda items:

- A standard agenda item has been developed and used by all divisions in their quality forums.
- The central quality team in collaboration with the performance and information (P&I) team and quality partners reviewed and further developed the quality dashboards to ensure relevance and accuracy of data within the dashboards. This review will continue as dashboards are used to support the divisions in review and scrutiny of quality KPIs.

  Central quality team and divisional quality partners have received Qliksense and quality dashboard training.
- The quality partners have been providing monthly reports to divisional boards about relevant KPIs including minimum standardised agendas. Further scrutiny is undertaken by the director of nursing and allied health care professionals and chief operating officer at monthly divisional executive performance reviews.
- A divisional self-assessment of implementation of the QGF was undertaken by divisions to ensure gaps (if any) were highlighted and appropriate mitigations were in place to support continuous compliance with the framework. Feedback about the self-assessment has been very successful and will support the organisation in its journey to outstanding in ensuring quality remains high priority across the networks.

What will we do in 2020-21 to continue with progress?

This priority has been achieved fully and will continue to be embedded across the organisation. We will support use of the quality dashboards within the divisions by continuously developing them to ensure relevancy of quality KPIs. We will further develop the QGF in response to the national recommendations following implementation of national safety strategy.

Quality Domain: Clinical Effectiveness
Priority 3: Ensure that evidence of lessons learnt and changes to practice are captured, recorded and disseminated in a systematic way

Our priority for 2019/20 has been to:	**3.1** Existence of divisional newsletters to include learning from audits, SIs, incidents, complaints and PALs **3.2** Timely review of risk registers at divisional quality forums **3.3** Programme of planned divisional and local walkabouts to cover all sites and departments **3.4** Sharing learning and completing actions through the central data base (Safeguard)

The central quality and safety team have been working with the divisions to ensure learning from events continues to be high on the agenda. This has been supported by the QGF where learning is a key item for discussion at the quality forums.

- Development of a trust learning framework, which describes the opportunities that exist within the trust for all staff, across the whole network and in all locations, to learn from events that have resulted in harm as well as those events that have gone well.

Learning is shared through various methods such as:

  - The LIFEline bulletin which is produced by the central quality team to share learning specifically associated with serious incidents (SIs) or events (e.g. incidents, claims, complaints) that have been discussed at the weekly SI panel;
  - A quarterly central quality and safety team bulletin which includes shared learning from events, in particular incidents, across the organisation;
  - A quarterly clinical audit newsletter has been developed by the clinical audit team;
  - The 3 NHS clinical divisions now have a newsletter, which is shared with divisional staff. There is also a newsletter in the commercial division based in the United Arab Emirates.

- All risk registers are now electronic and managed through Safeguard system. The divisions review their risk registers on a monthly basis at the quality forums and divisional boards where relevant.
- An annual programme of executive (listening, learning, and sharing) walkabouts was developed. These take place over a 12-month rolling programme; executives have planned their walkabouts using a multidisciplinary/peer review approach. These walkabouts ensure executive visibility as well as supporting staff to raise concerns as well as ideas for improvement and sharing areas of good practice.
- The action module on Safeguard is now being actively used by the divisions, as is the facility to be able to record learning. The learning that is highlighted within individual records is used by the central quality team to inform the quarterly quality and safety report which is presented to a sub-committee of the trust board.
- A learning framework containing the principles of sharing learning across all our sites has been developed and is going through staff consultation. This will include a hub to allow staff to share learning in a safe environment.

What will we do in 2020-21 to continue with progress?

- This priority has been achieved for 2019/20and to ensure learning is embedded across the organisation we have decided to continue this priority into 2020/21. This priority is a key element of our journey to excellence and implementation of the learning framework will be a key objective in 2020/21.

Quality Domain: Clinical Effectiveness
Priority 4: Embed a culture that supports ongoing changes to practice by developing quality improvement capabilities

Our priority for 2019/20 is to:	**4.1** All divisions to have identified quality service improvement champions **4.2** All quality service improvement champions to have received training on QSIR training **4.3** All divisions to be working on 2-3 QI projects as identified by local service improvement priorities **4.4** All divisions to be engaged with trust wide service improvement projects

What did we achieve to date?

The trust's Quality Service Improvement & Sustainability priorities for 2019-2020 were:

- Develop a trust culture and capability for change and improvement by QSIR training and project delivery
- Provide assurance and support the development of schemes to deliver the cost improvement plan and embedding a PMO approach to CIP programme
- Development and implementation of sub-specialty strategies for new models of care
- Ongoing improvement and standardisation of administration processes.

Some of the key achievements of the 2019-20 programme include:

- QSIR Fundamentals - 51 staff trained and will continue in the new financial year
- QSIR Practitioner – 28 trained to date, this will continue in 2020
- Staff accredited to teach – we currently have 3 staff accredited, with 3 more scheduled to complete their assessment in April 2020

The initial feedback on the training is very positive, with 90.5% of those who have completed their introductory training rating the day as good or very good and 100% of participants said that they would recommend the training to a colleague.

In addition, 3 members of staff from both QSIS team and City Road Division, qualified in the NHSI Demand and Capacity train the trainer programme, in July 2019. They are now supporting the modelling of services to help us effectively plan our capacity and support transformation of how we deliver our services.

<u>Service Improvement</u>

- High volume cataract lists started; now running at City Road, Northwick Park & St Ann's. Plan to deliver lists in the South division.
- Glaucoma gap analysis completed: following work supported by QSIS 25% of Glaucoma patients in City Road are managed in non-medically led pathways. Progress is being monitored against an action plan to support the South & North divisions, site by site to embed non-medically led care.

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monitored against an action plan to support the South & North divisions, site by site to embed non-medically led care.

- All divisions have enrolled relevant staff including quality partners to be trained in QSIR methodology (fundamentals and practitioner). Regular dates are available monthly and continue into 2020/21.

- All divisions are engaged in the trust wide service improvement projects:
  - Cataract: in progress in City Road, North (St Ann's, Northwick Park) & South (St George's, Croydon)
  - Outpatient: in progress in City Road, North (Northwick Park, Mile End, Barking) & South (Croydon, St George's)
  - A&E/UCC/ Ricin progress in City Road, North (Bedford) & South (St George's & Croydon)
  - Clinical admin: in progress in all divisions with engagement from all at fortnightly clinical admin transformation group meetings.

- The QSIS team has continued to work in partnership with operational colleagues and commissioners in Croydon and as part of NCL STP to support ophthalmology pathway transformation work. This is to ensure both that change and improvement are supported at pace and that any change implemented in one area of the trust is in line with trust-wide standards and strategy.

What will we do in 2020-21 to continue with progress?

The objectives set within this priority has been achieved and will continue in 2020/21. Progress is monitored through bimonthly QSIS meetings. Quality Improvement project updates are also provided at Clinical Governance Committee which will support shared learning across all sites and services.

Quality Domain: Patient experience
Priority 5: To involve and engage our patients across the organisation in true participation activities including in service reviews and developments

Our priority for 19/20 has been to:	**5.1** Q2&3 All major network sites and City Road services (16) will have involved/engaged patients in at least one patient participation activity during 2019-20. These are: City Road: External Disease, City Road: Glaucoma, City Road: Medical Retina, City Road: Optometry, City Road: Paediatrics, City Road: Uveitis, City Road: Vitreo-Retinal, Bedford, Darent Valley (Ebsfleet), Ealing, Northwick Park, St Ann's, Croydon, St George's, City Road Day Care, Accident and Emergency **5.2** Q4: All network sites and City Road services (as above) will have established a patient reference group for their network site or service by the end of 2019/20, Q4 **5.3** Q2, Q3 and Q4: Divisions will establish two local service patient experience KPIs in Q1 and measure and report them at the end of Q4

What did we achieve to date?

Patient participation and reference groups have been run in eleven network sites and city road services during quarter three. These have included patient support groups, in your shoes sessions and education forums. Several have engaged patients looking at the introduction of new patient pathways and new ways of working. Some sites and services not included in 5.1 have undertaken patient participation sessions and some such as A&E and Moorfields North West have yet to establish groups. There have been 16 patient participation events during 2019/20 across the trust with seven planned for the first two quarters of 2020/21.

The reference groups will be established as part of the participation events noted at 5.1. Patient will be invited to return during 2020/21.

Moorfields North have established two criteria:
1. Reducing the number of cancelled out-patient appointments by end of Q4.
2. Reduction of cancelation of same day, day surgery patients by end of Q4
This measure is deferred due to Covid-19

Moorfields City Road have established two criteria:
1. A project to have letters normally written to the GP and copied to the patient changed, so that letters are written to patients and copied to GPs. This work has not been implemented although work is currently being undertaken by the QSIS team towards this. Patient focus groups have been held to determine the format and content of these letters. A trial is anticipated in the Glaucoma service.

2. To reduce, by end of Q4, the number of PALS concerns that convert to formal complaints. This measure was discontinued due to the negligible number of complaints that had previously been PALS concerns

Moorfelds South are working on establishing their measures following establishment of the management team.

What will we do in 2020-21 to continue with progress?
As per 5.2, network sites and City Road services will establish reference groups to review the work undertaken this year and those sites etc. that have yet to hold events will be encouraged to do so and this may require the formation of 'virtual' patient and carer reference groups. One of these has been held already.

The letters project will continue into 2020/21. Work toward the reduction in surgery cancellations in Moorfields North will continue.

Quality Domain: Patient experience **Priority 6:** To ensure that from a patient perspective appointments management is effective, efficient and responsive	
Our priority for 19/20 has been to:	**6.1 Set PALS key performance measures by end of Q2, 2019/20** **6.2 KPI for PALS and Complaints numbers.** - A) 20% Reduction in the number of PALS enquiries around CR appointments management by Q4. - - B) 50% Reduction in the number of complaints (all sites) regarding appointments management by Q4 compared to 2018/19 - C) Establishment of patient portal or email facility by the end of Q4, 2019/20. **6.3 City Road, MEH North and South divisions to show a reduction of hospital cancelled appointments against a set KPI by end of Q4, 2019/20** A) 100% reduction in the number of patients waiting over 52 weeks on an active RTT pathway by the end of Q2. B) Reduction in the number of hospital patient cancelled appointments to fewer than 3%. C) Reduction in the number of patients whose surgery is cancelled on the day and are rebooked over 28 days by the end of Q4 to zero tolerance. **6.4 Access division to demonstrate telephone answering response times and returned calls meet established criteria by the end of Q3, 2019/20** - Average call waiting times to be reduced to less than 3 minutes by the end of Q4 - Reduction in the number of abandoned calls per day by the end of Q4 to 20%

What did we achieve to date?

Progress has been made with some of the key measurable and the organisation will continue measuring progress with this priority in 2020/21. Please see a list of 2020/21 priorities from pages 53 onwards.

- KPI for appointment, PALS and Complaints were identified as above
- Reduction in the number of complaints by 48% against a target of 50%.
- Potential providers for Patient Portal have been identified and proposals presented to key stakeholders. This work has been impacted by COVID 19 pandemic and will continue in 2020/21.
- The trust has not declared a 52 week breach this financial year.
- Average call wait times were 2.35 at the end of March 2020 and has remained consistently below 03:00 minutes.
- Number of abandoned calls for March was 18% reaching the set target.

What will we do in 2020-21 to continue with progress?
The organisation will continue monitoring progress with this priority in 2020/21 as well as specific priority to improve response time to patient calls. Continued focus on our responsiveness to our patients particularly in light of COVID-19 response to focus on call wait times and abandoned calls. Main focus will be on managing our large volume of cancelled patients to ensure any risks are mitigated as much as possible.

2.2 Core clinical outcomes

Progress in 2019/20

The trust's performance against the core outcome standards demonstrates excellent clinical care, with almost every standard being met and many being far exceeded. The complete core outcome data is tabulated below. Of particular note is that the majority of outcomes are for all relevant patients across the trust over a full year. This increases the robustness of the data when compared to sample audits. All services with modules for collecting electronic patient records (EPR) should be commended for their increasing use of EPR which facilitates analysis of larger amounts of data than is possible manually. This culture change is allowing more comprehensive data analysis. The EPR system, linked in with performance and information in many cases, allows generation of core clinical outcomes, at the 'touch of a button' for Cataract, Medical Retina, Accident and Emergency, Cornea and Refractive services. Other services, such as glaucoma, are looking to engage with EPR development to make routine analysis of clinical outcome data possible electronically too.

The external diseases service previously circumvented delay in receiving corneal graft failure rates from the NHS blood and transplant services by generating this data internally. This was possible through the establishment of a specific post-graft follow-up clinic with collaborative working to set up a database for measuring outcomes on these patients. Now Moorfields provides the national organisation with the graft survival data prospectively rather than waiting for retrospective analysis from them. This year, the core outcomes for corneal grafts are compared with the national data from the previous year. The only core outcome in this section which was not achieved was the survival of penetrating keratoplasties at Moorfields at 88% compared to the national rate for the previous year of 89%. This reflects the fact that Moorfields performs penetrating keratoplasties on a greater percentage of complex, high-risk for failure cases and so is not a cause for concern.

The serious complications of strabismus surgery for every such operation across the trust was 0.70% (6 out of 852), slightly higher than previous years and the standard, but not significantly different statistically (the 95% confidence interval for the value is 0.1%-1.3%). In relation to the indicators about glaucoma tube surgery and ROP screening compliance the sample sizes are smaller than in previous years and therefore these results are not statistically significant compared to the standards. Both the mandatory use of EPR in the future and the hope of resumption of more normal working should enable a more accurate assessment of these metrics in the future.

Specialty	Metric	Standard	2017/8	2018/9	2019/20
Cataract	Posterior capsule rupture (PCR) in cataract surgery*	<1.95%	1.06%	0.95%	0.77%
Cataract	Endophthalmitis after cataract surgery*	<0.04%	0.02%	0.037%	0.025%
Cataract	Biometry accuracy in cataract	>85%	91%	91%	92%

	surgery				
Cataract	Good vision after cataract surgery*	>90%	91%	91%	92%
Glaucoma	Trabeculectomy (glaucoma drainage surgery) success	>85%	97%	96%	100%
Glaucoma	Tube (glaucoma drainage surgery) success	>90%	N/A	92.5%	89%
Glaucoma	PCR in glaucoma patients*	<1.95%	1.00%	1.56%	0.98%
MR	Endophthalmitis after intravitreal anti-VEGF injections*	<0.05%	0.01%	0.02%	0.01%
MR	Visual improvement after injections for macular degeneration*	>20%	22.2%	20.2%	21.1%
MR	Visual stability after injections for macular degeneration*	>80%	93.6%	90.3%	92.1%
MR	PCR in Medical retina pts*	<4%	2.5%	1.2%	2.04%
MR	Time from screening to assessment of proliferative diabetic retinopathy*	80%	90%	90%	89%
VR	Success of primary retinal detachment surgery	>75%	78%	77%	80%
VR	Success of macular hole surgery	>80%	85%	88%	87%
VR	PCR in vitrectomised eyes*	<NOD	3.3%	3.2%	2.6%
NSP	Serious complications of strabismus surgery*	<0.43%	0.14%	0.26%	0.70%
NSP	Premature baby eye (ROP) screening compliance*	99%	99.7%	99.4%	98%
A&E	Patients seen within 4 hours*	>95%	98.5%	98.4%	98.6%
Ext Dis	Success of corneal cross-linking at 12 months*	>90%	98.1%	96.8%	96.3%
Ext Dis	Corneal cross linking safety: Same or better corrected vision at 12 months*	>97%	99.3%	98.1%	97.9%
Ext Dis	PK corneal graft survival rate*	89%	81%	85%	88%
Ext Dis	DALK corneal graft survival rate*	94%	100%	94%	97.5%
Ext Dis	DMEK corneal graft survival rate*	80%	91%	88%	86%

Refractive	Accuracy LASIK (laser for refractive error) in short sight*	>85%	93.4%	93.2%	92.3%
Refractive	Loss of vision after LASIK*	<1%	0.3%	0.1%	0.2%
Refractive	Good vision without lenses after LASIK*	≥80%	91.9%	90.2%	92.7%
Adnexal	Ptosis surgery success	>85%	94%	95%	95%
Adnexal	Entropion surgery success	>95%	93%	100%	100%
Adnexal	Ectropion surgery success	>80%	96%	95%	97%

*Indicators marked with an asterisk are based on a whole year's data for all relevant cases. All other indicators are based on a sample of cases collected over at least a 3 month period during 2019/20.

2.3 Performance against key local indicators for 2019/20

Overall, Moorfields has achieved good performance against its suite of quality indicators. However in some areas, the performance indicators have been affected to some extent by the impact of the COVID-19 pandemic. For completeness, all KPIs reflect the full year position despite March data being a significant performance outlier in many instances.
Each of the indicators listed below was selected to provide comparable data over time but as previously identified the impact of COVID-19 will distort that comparison. Some indicators were new for 2019/20 and the rationale for changing or selecting new indicators was set out in the 2018/19 quality report.

2019/20 key indicators

INDICATOR	SOURCE	2017/18 RESULT	2018/19 RESULT	2019/20 Target	2019/20 RESULT
PATIENT EXPERIENCE					
Reduce patient journey times in glaucoma and medical retina	Internal (QSIS) programme	Indicator not in use	New=94 minutes Follow-up= 90 minutes.	New=91 minutes Follow-up= 100	New=94 minutes Follow-up= 101
Improve patient experience through digital patient check-in kiosks	Internal (QSIS) programme	Indicator not in use	Indicator not in use	60%	26.7%*
Data completeness for clinic journey time (Total)	Internal (QSIS) programme	Indicator not in use	46.6%	80%	61.4%
Data completeness for clinic journey time (Glaucoma)	Internal (QSIS) programme	Indicator not in use	59.9%	80%	75.5%
Data	Internal	Indicator not	55.2%	80%	64.6%

completeness for clinic journey time (MR)	(QSIS) programme	in use			
Reduce the % of patients that do not attend (DNA) their first appointment	Internal performance monitoring	12.3%	11.6%	≤10%	11.8%
Reduce the % of patients that do not attend (DNA) their follow up appointment	Internal performance monitoring	Indicator not in use	10.4%	≤10%	10.5%
% of patients whose journey time through the A&E department was three hours or less**	Internal performance monitoring	78.4%	76.6%	≥80%	75.5%
Theatre sessions starting late	Internal performance monitoring	Indicator not in use	33.8%	≤33.8%	32.0%
Theatre cancellation rate (overall)	Internal performance monitoring	Indicator not in use	7.1%	≤7.0%	6.8%
Theatre cancellation rate (non-medical cancellations)	Internal performance monitoring	Indicator not in use	0.8%	≤0.8%	0.76%
Number of outpatient appointments subject to hospital initiated cancellations (medical and non-medical)	Internal performance monitoring	2.9%	3.52	≤3%	4.58%
SAFETY					
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	99.6%	99.5%	95%	99.6%
% overall compliance with hand hygiene	Internal performance monitoring	95.7%	99%	≥95%	99.0%

standards					
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0	0	0
Number of reportable clostridium difficile cases	Number of reportable clostridium difficile cases	0	0	0	0
Incidence of presumed endophthalmitis per 1,000 cataract cases	Internal performance monitoring	0.22	0.35	≤0.6	0.16 (To Dec 2019)
Incidence of presumed endophthalmitis per 1,000 intravitreal injections for AMD	Internal performance monitoring	≤0.15	0.17	≤0.5	0.10 (To Dec 2019)
Incidence of presumed endophthalmitis per 1,000 Glaucoma cases	Internal performance monitoring	N/A	N/A	≤1	0.48 (To Dec 2019)
Number of serious Incidents (SIs) open after 60 days	Internal performance monitoring	N/A	N/A	0	0
CLINICAL EFFECTIVENESS					
% implementation of NICE guidance***	Internal performance monitoring	98.7%	95.7%	95%	100%
Posterior capsule rupture rate for cataract surgery (cataract service)	Internal performance monitoring	0.99%	1.13%	≤1.95%	0.85%
Number of registered clinical audits past their deadline date	Internal performance monitoring	N/A	N/A	≤10%	1.65%
Number of breached policies	Internal performance monitoring	N/A	N/A	≤10%	6%

* This is linked with the impact of COVID 19 leading to the trust only operating on an emergency model
** A late start being a session that started more than 15 minutes later than the planned start time.
*** The trust is 100% (110/110) compliant with all NICE publications identified as relevant to the trust (including all guidelines and quality standards). This is based on data from April 2013 to 31st March 2020.

2.4 Performance against 2019/20 national performance and core indicators

Moorfields reports compliance with NHS Improvement's requirements, the NHS Constitution and NHS outcomes framework to the trust board both as part of monthly Integrated Performance Report (IPR) and as specific, issue-focused papers. Moorfields Eye Hospital NHS Foundation Trust considers that this data is as described in the sections and tables below because of our internal and external data checking and validation processes, including audits, but is subject to the caveats raised in the statement of directors' responsibilities. An integral part of the IPR process is to identify not just the performance against the numerical target but to add value to the reporting process by articulating, through the use of Remedial Action Plans, any corrective actions the Trust is taking to address areas of underperformance.

National performance data

All NHS foundation trusts are required to report performance against a set of core indicators using data made available to the trust by NHS digital. Where the required data is made available by NHS digital, a comparison has been made with the national average and the highest and lowest performing trusts. The data published is the most recent reporting period available on the NHS digital website and may not reflect the trust's current position *(please note that the data period refers to the full financial year unless indicated)*.

Overall Moorfields achieves a very good performance against national performance indicators as set out in the table below.

National Performance measures

Description of target	Performance 2018/19	Target 2019/20	Performance 2019/20	Average for applicable trusts 2019/20	Highest performing trust 2019/20	Lowest performing trust 2019/20
Infection control						
MRSA – meeting the objective	0	0	0	0.77 (to Jan 2020)	0 (to Jan 2020)	3.53 (to Jan 2020)
Clostridium difficile year on year reduction	0	0	0	9.6 (to Mar 2019)	0 (to Mar 2019)	79.09 (to Mar 2019)
Screening all elective inpatients for MRSA	100%	100%	100%	N/A	N/A	N/A
Risk assessment of hospital-related venous thromboembolism (VTE)	98.2%	95%	98.4%	96.36% (to Q3 19/20)	99.89% (to Q3 19/20)	71.59% (to Q3 19/20)
Waiting Times						
Two-week wait from urgent GP referral for suspected cancer to	94.3%	93%	96.4%	92.71% (As at Oct 2020)	100% (As at Oct 2020))	65.4% (As at Oct 2020)

Description of target	Performance 2018/19	Target 2019/20	Performance 2019/20	Average for applicable trusts 2019/20	Highest performing trust 2019/20	Lowest performing trust 2019/20
first outpatient appointment						
Cancer 31-day waits –diagnosis to first treatment	97.8%	96%	99.2%	97.51% (Apr-Dec)	100% (Apr- Dec)	80.85% (Apr-Dec)
All 62 days from urgent GP referral to first definitive treatment	100%	85%	85.7%	84.26% (As at Oct 2019)	100% (As at Oct 2019)	22.73% (As at Oct 2019)
Four-hour maximum wait in A&E from arrival admission, transfer or discharge	98.4%	95%	98.5%	82.85% (As at Feb 2020)	100% (As at Feb 2020)	63.05% (As at Feb 2020)
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks	94.5%	92% national	94.1%	85.0% (As at Jan 2020)	98.46% (As at Jan 2020)	66.07% (As at Jan 2020)
Maximum 6 week wait for diagnostic procedures	100%	99%	99.9%	98.26% (As at Jan 2020)	100% (As at Jan 2020)	69.69% (As at Jan 2020)
Other						
28-day Emergency readmission rate (over 16 years old) – excluding retinal detachment	2.92%	2.64%	2.81%	N/A	N/A	N/A
28-day Emergency readmission rate (over 16 years old) – retinal detachment only*	7.88%	n/a	7.09%	N/A	N/A	N/A
28-day readmission rate (0-15 years old)	0%	n/a	3.33%	N/A	N/A	N/A

**The readmission rate for retinal detachment is recognised to be higher than overall surgical re-admission rates; therefore this is shown separately in the table above. The NOD reported benchmark UK-NOD Jackson et al. Eye 2013 is 13%.*

Referral to treatment (RTT 18 weeks) performance

The ways the trust is required to report RTT18 are:

- The incomplete standard is the sole measure of patients' constitutional right to start treatment within 18 weeks
- The Number of New Clock Starts
- The admitted and non-admitted operational standards were abolished in 2015/16, but the trust continues to report this information.

The table below identifies the performance of our full suite of RTT waiting time measures for the financial year and with a quarterly breakdown.

Measure	Target	Q1	Q2	Q3	Q4	Year end 2019/20
18-weeks referral to treatment incomplete*	92%	94.31%	94.61%	94.50%	92.9%	94.1%
18-weeks referral to treatment incomplete with DTA**	N/A	83.74%	84.51%	85.63%	81.8%	83.9%
18-weeks referral to treatment admitted*	≥ 90%	77.47%	76.47%	76.78%	79.0%	77.4%
18-weeks referral to treatment non-admitted*	≥ 95%	94.12%	94.15%	94.29%	94.1%	94.2%
New RTT periods (clock starts) all patients ***	N/A	37754	37457	37074	32063	144348

*As reported in the Integrated Performance Report (IPR) for March
**No longer a reportable KPI and removed from the IPR
***Taken from RTT weekly submission

Performance of the measure of the RTT18 incomplete pathway (the key RTT18 performance indicator) has exceeded the annual target but has decreased when compared to the previous year's figure of 94.5%. Performance has decreased for the admitted (which was 79.9% for 2018/19) and for the non-admitted pathways (which were at 94.5%). The decrease in admitted performance since the last financial year was due to reporting and operational issues on the St George's site and capacity issues in the North directorate. . Numbers of patients waiting significantly over 18 weeks have reduced to lowest levels in several years. The North division has continued to see an exponential increase in cataract referrals particularly within the North West sites and Darent Valley Hospital site.

The measurement and reporting of performance against these targets is subject to a complex series of rules and guidance published nationally, but the complexity and range of the services offered at Moorfields means that local policies and interpretations are required, including those set out in our access policy. Moorfields is also challenged by the geographical distance between sites, as moving patients to provider care outcomes sooner is often possible, but patients are reluctant to attend a different site. This particularly affects the smaller sites, as while some have capacity issues; some have spare capacity that cannot be utilised due to the above issue.

As a tertiary provider receiving onward referrals from other trusts, a key issue is reporting pathways for patients who were initially referred to other providers. We are required to report performance against the 18-week target for patients under our care, including those referred from other providers.

Depending on the nature of the referral and whether the patient has received their first treatment, this can either 'start the clock' on a new 18-week treatment pathway, or represent a continuation of their waiting time, which began when their GP made an initial referral. To report waiting times accurately, we need other providers to share information on when each patient's treatment pathway began.

Although providing this information is required under the national RTT rules, and there is a defined inter-provider administrative data transfer minimum data set to facilitate sharing the required information, we do not always receive this information from referring providers despite extensive chasing. This means that for some patients we cannot know definitively when their treatment pathway began. The national guidance assumes that the clock start can be identified for each patient pathway and does not provide guidance on how to treat patients with unknown clock starts in the incomplete pathway metric.

While internal and external audits have shown instances of this to be markedly reducing, it is still an issue for Moorfields as a tertiary centre.

Our approach for reporting the indicators is as follows:

- Incomplete: we include these patients in the calculation with some form of assumption about the start date.*
- Admitted: we exclude from the calculation and report as unknown clock starts in national data submission.
- Non-admitted: we exclude from the calculation and report as unknown clock starts in national data submissions.

*For incomplete pathways, the trust makes the performance calculation on the assumption the pathway is started on the date the referral is received by the trust. These referrals are then investigated to see whether an earlier 'clock start' date is required to measure the whole pathway. If we cannot ascertain an accurate clock start, the pathways are counted as unknown.

Performance Indicator Data Quality

A vital pre-requisite to robust governance and effective service delivery is the availability of high quality data across all areas of the organisation. The organisation requires high quality data to support a number of business objectives, including safe and effective delivery of care, and the ability to accurately demonstrate the achievement of key performance indicators. The trust Data Quality Policy sets out the specific roles and responsibilities of staff and management in ensuring that data is managed effectively from the point of collection, through its lifecycle until disposal.

The trust continues to utilize the Data Quality Assurance Framework which has previously been identified as good practice by external auditors. This process comprises of a regular review of a range of information sources used within the Trust and is carried out by the Data Quality Manager on a rolling program across the year.

Data Quality has been given a higher profile this year with the inclusion of a greater range of directly related Key Performance Indicators published within the Integrated Performance Report which is presented to the Board each month. These KPIs now include:

- Data Quality - Ethnicity recording (Outpatient and Inpatient)
- Data Quality - NHS Number recording (Outpatient and Inpatient)
- Data Quality - GP recording (Outpatient and Inpatient)
- Data Quality - Ethnicity recording (A&E)
- Data Quality - NHS Number recording (A&E)
- Data Quality - GP recording (A&E)

In addition, the Data Quality audit team have designed and implemented a new audit process. This is a process whereby the Trusts external data submission processes will be subject to systematic audit. This will help to assure the organisation that all data submissions to bodies such as NHS Improvement, NHS England and NHS Digital are of a continued high standard.

The team are also working closely with the Operational teams to develop a process which supports the Trust-wide implementation of standard operating procedures by undertaking a series of compliance audits. This will ensure that information capture processes are standardized and adhering to guidance and thus ensure accuracy and completeness.

2.4.1 National Core Indicators

No	Prescribed information	NHS outcomes Framework Domain
1	Readmission rate (within 28 days) for patients aged I : 0-15: and II: 16 and over	Helping people to recover from episodes of ill health or following injury
2	The trust's responsiveness to the personal needs of its patients during the reporting period	Ensuring that people have a positive experience of care
3	Percentage of staff who would recommend the trust as a provider of care to their family or friends	Ensuring that people have a positive experience of care
4	Patients admitted to hospital who were risk assessed for venous thromboembolisms (VTE)	Treating and caring for people in a safe environment and protecting them from avoidable harm
5	C-difficile infection rate per 100,000 bed days	Treating and caring for people in a safe environment and protecting them from avoidable harm
6	Rate of patient safety incidents; and number and percentage that resulted in severe harm or death	Treating and caring for people in a safe environment and protecting them from avoidable harm

28 day emergency readmission rate

The information below is gathered on our internal dataset. The trust is unable to provide national comparative data for this measure due to data not being available on the NHS Digital website.

The trust considers that this data is as described for the following reasons:

The trust has a robust clinical coding and data quality assurance process and readmission data is monitored through the trust management committee on a monthly basis.

	2016/17	2017/18	2019/20
28 days Readmission rate (Adult: 16+)- excluding retinal detachment	3.57%	3.98%	2.81%
28 days Readmission rate (Adult: 16+)- retinal detachment only	6.27%	6.70%	7.09%
28 days Readmission rate (Child: 0-15)	2.60%	0%	3.33

Moorfields hospital intends to/or has taken the following actions to improve this indicators and so the quality of its services by:

- improving electronic data capture using our improved electronic systems.
- continuing to audit data capture and use the results to improve data recording accuracy through monthly monitoring.
- further improving standard operating procedures and maintaining staff training programmes which is being led by the A&E service.
- using the data assurance framework to strengthen data capture across several defined criteria
- Emergency readmissions are reviewed on a monthly basis by the Deputy Clinical Director for City Road.

Our dedicated information management & data quality group which supports improvement meet on a monthly basis and will monitor readmission rates.

The trust's responsiveness to the personal needs of its patients during the reporting period (2019/20 FFT performance)

Friends and family Test (FFT):

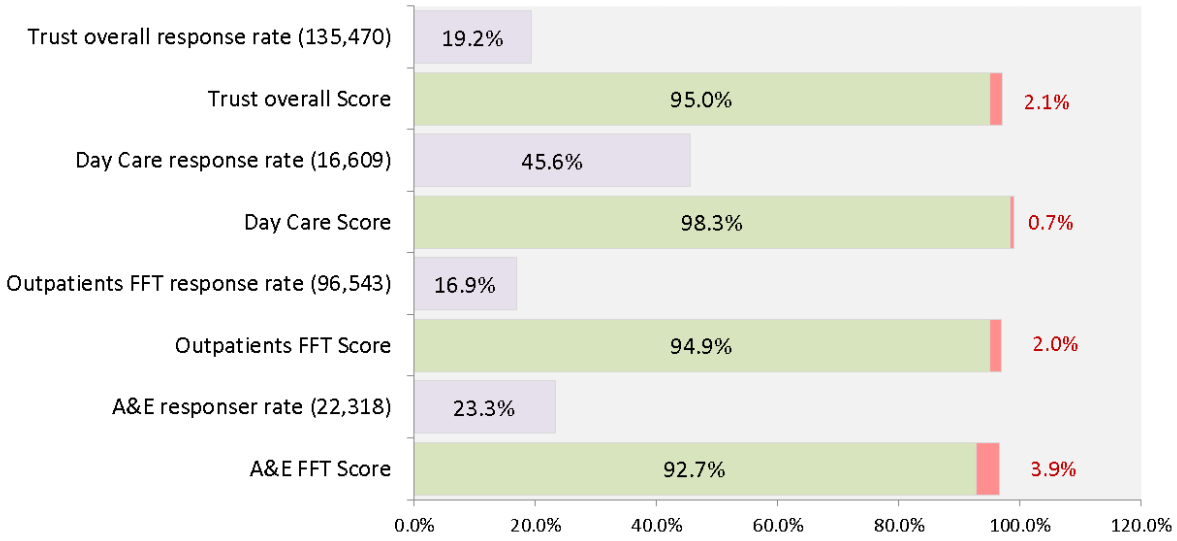
Since April 2015 all patients seen within the Moorfields network, whether they are inpatients, outpatients or attended the A&E department, have been asked to rate the care they received. They are also asked to provide feedback regarding their experiences, in response to the question 'What would have made your visit better?'

During 2019/20 over 100,000 Moorfields patients undertook the test, the results of which are reported to NHS England monthly. In October 2019, a process by which patients are texted the question (as opposed to completing a card), was introduced which increased the response rate notably and increased the number of comments that could be themed and used for service improvement. It has also freed up the reception and nursing staff time allowing them more time to interact with patients.

The majority of comments praise staff for their friendly, caring, professional attitude suggesting individualised care is one of the trust's strengths. There are also areas for improvement identified, around waiting times in clinic, communication (being kept informed of delays, being told what to expect etc.), and the environment (all issues related to delays). Work being undertaken by the QSIS team looking at patient pathways continues. Local changes have included A&E patients being better informed of refreshments available whilst waiting.

Fig 1.FFT by response rate and satisfaction score: 2019/20 (green=would recommend)

KPI: A&E 20% OPD 15% Day-care 30% Positive satisfaction score 90%



- **NHS National Surveys**

There were a number of national surveys which Moorfields took part in the latter part of 2018 which were then reported in the autumn of 2019.

- **CQC Emergency and Urgent care survey 2018**

Overall, the results of the CQC survey were positive and very similar to the previous survey in 2016, with a good performance compared to other trusts and scoring particularly high on questions relating to information giving and discharge from the department. For 57% of comparable questions there was either a marginal improvement or the result was the same as the previous survey. Where the department was less strong was in the questions around delays in initially being seen and examined, being informed of waiting times, communication regarding side effects of medication and taking patients home situation into account prior to discharge. When compared to other trusts, Moorfields was better in 12 of the 34 questions. For 21 of the questions the trust scored 8 or above (out of a possible 10) and only 1 scored lower than 5. An action plan has been developed within the A&E team to address the issues where improvement could be made.

- **CQC Children and young People's Inpatient and Day Case Survey (2018)**

The survey asked 54 questions about all aspects of the care pathway for children and young people undergoing day care treatment at Moorfields (parents were also asked).
Overall, Moorfields is identified as performing 'better than expected' for both the experiences of children aged 0 to 7 and the experiences of children aged 8 to 15. This is because, for both age groups, the proportion of respondents who answered positively to questions about their care, was significantly above the other 129 other trust average. There is very little change against the previous survey, which was also very good. The trust was shown to be 'Better' than expected when compared with other trusts in 22 of the 54 questions and 'worse' than expected for none. Moorfields scored particularly well in several aspects of information giving and the friendliness of staff. Areas where improvements identified were around appointments management and Wi-Fi provision.

- **NHS Cancer Survey 2019**

The national patient cancer survey is an annual survey which monitors national progress on cancer care to drive local quality improvements, assist commissioners and providers of cancer care, and inform the work of the various charities and stakeholder groups supporting cancer patients. The survey asked adult patients from the Moorfields oncology and adnexal oncology services a range of questions about their treatment pathway and the support they received. 40 questions were relevant to Moorfields and of these, 21 received a positive score of 80% or above, and 11 of the questions scored higher than the national average score.

Areas in which Moorfields did particularly well include that Patients felt that they were involved as much as they wanted to be in decisions about their care and treatment. Patients said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment. Patients felt that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist. Overall, the patient's average rating of care out of ten (very good) was 8.3.

- **Patient Participation**

In 2018 Moorfield's patient participation strategy was launched which has been promoted across the trust at meetings, clinical governance half days and divisional and quality meetings. The main element of the patient participation strategy, involving and engaging our patients across the organisation in participation activities including service reviews and developments, has continued throughout 2019/20. Actions have arisen following sessions which are being implemented by local teams. Examples of patient participation forum where patients are involved in developing services include:

- Adnexal Service: Botulinum service (blephrospasm) patient pathway review
- Croydon /Purley: Joint working between MEH and Croydon Community Ophthalmology
- Bedford: AMD Patient Group
- CR ECLO's: Living with sight loss
- Glaucoma, City Road: newly diagnosed glaucoma patients
- Uveitis, City Road: New service review
- Trust Quality Priorities: External stakeholder forum
- RDCEC / Research: Young People's Advisory Group (YPAG)
- Mile End: Patient Reference Group (Review of service)
- St Ann's: Patient Reference Group and open day
- Darent Valley: Patient Reference Group and open day
- City Road Optometry: LVA Service review
- Ocular Prosthetics: Patient Reference Group
- Trust QSIS project reference

The Patient and Carer Forum, chaired by a trust governor, oversees the implementation of patient participation at Moorfields and has been meeting quarterly since March 2018. It reviews and advises on how patients are engaged with at Moorfields on issues such as local trust participation activities, project oriel, and trust wide tender processes i.e. transport, catering and research.

The Patient Participation and Experience Committee, is a committee, chaired by the director of quality and safety, comprising of senior divisional managers, divisional quality partners and the patient experience team. It reviews patient feedback from all sources and reviews the actions taken in response, both to specific issues and wider trust wide approaches.

➢ Complaints and PALS concerns

Complaints and PALS concerns are a valuable source of patient feedback about services, outcomes and individual performance and provide scope for learning and service improvement. The Trust received a total of 282 complaints in 2019/20 (0.05% of patients seen), compared to the 254 received the previous year. The rise is due to an increase in the number of transport complaints following the introduction of a new transport provider in Q3.

Complaints

With the specific exception of transport issues, clinical concerns continue to be the cause of the majority of complaints. Concerns focus around treatment outcomes, mis-diagnosis, questioning treatment or lack of information relating to their care. All complaints responses relating to clinical care are reviewed by the Medical Director and shared with the risk and safety and safeguarding teams. Where appropriate, complaints are discussed at the trust's serious incident panel.

Complaints investigations are undertaken at divisional level and if the complainant remains unsatisfied or has remaining concerns a further review will take place. If they continue to be dissatisfied a meeting will be offered (if not done earlier) and advice given on contacting the Parliamentary and Health Service Ombudsman (PHSO) for an independent review.

PALS Concerns

PALS received 4051 enquiries in 2019/20**.** Of these, 116 were compliments, 1558 were requesting information and 2367 were concerns (a 15% increase on the previous year). Of the concerns the largest number related to appointments management, followed by transport concerns, communication (including telephone responses) and questions about clinical care or treatment.

Compliments

The number of compliments received by PALS is relatively low, with more being received locally by individual teams. Most patients prefer to compliment staff through the Friends and Family Test, the overwhelming majority of which are complimentary as noted above. Around 200 to 250 staff are mentioned personally in the comments each month for their extra kindness and service.

Fig. 2 Formal Complaints by type per quarter 2019/20**.**

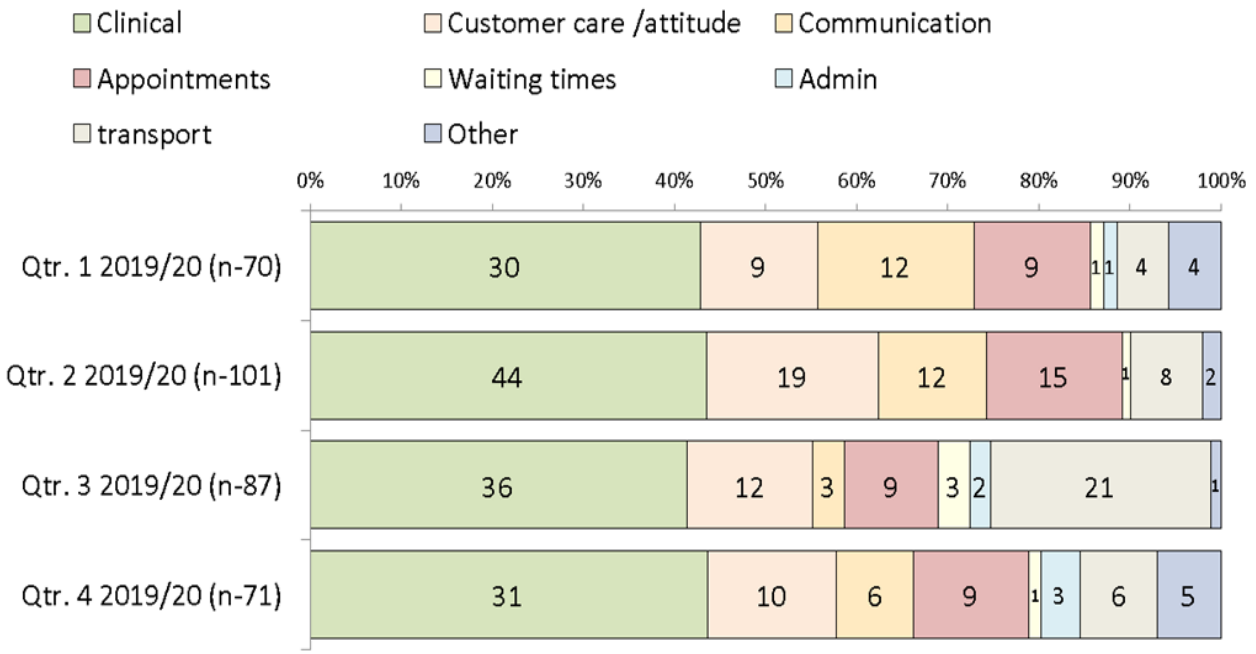


Fig. 3 Formal Complaints by type 2016/17 to 2019/20**.**

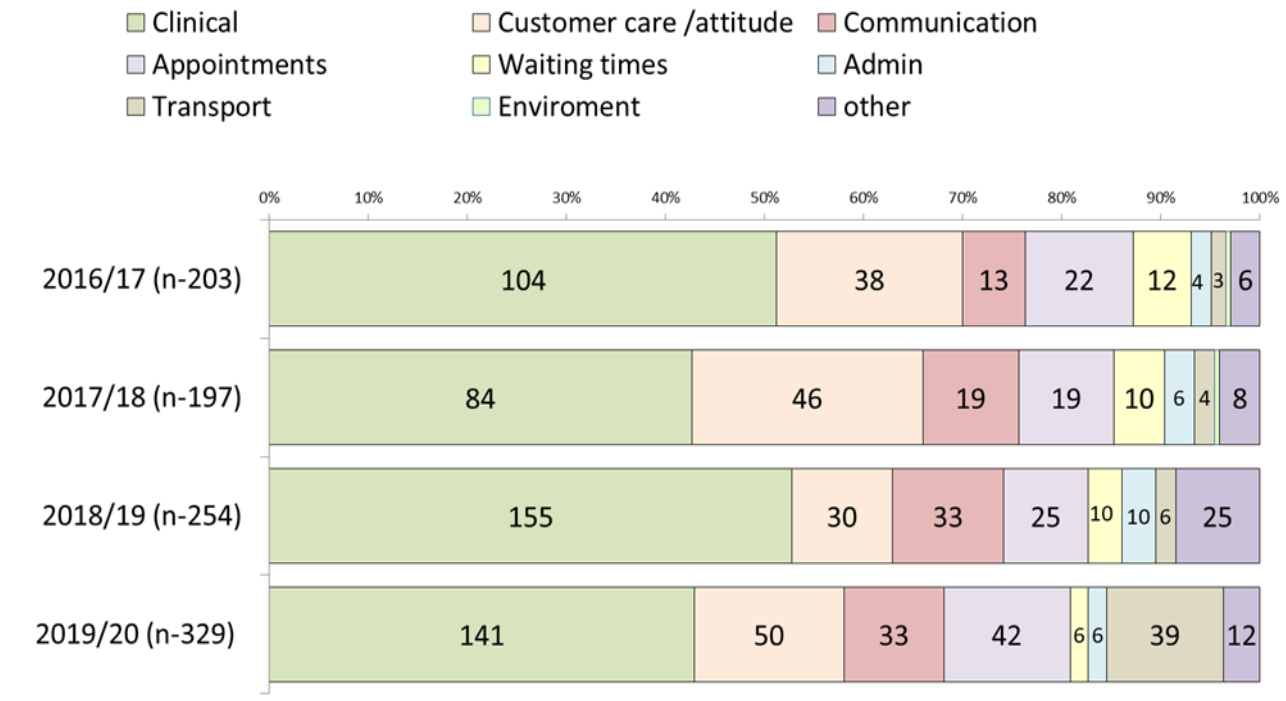


Fig.4 Response rate: Q1 2018/19 to Q4 2019/20**.**

*All five PHSO referrals are outstanding. There have been no upheld cases for several years.

KPI	Target	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20*
Response	**80%**	31%	59%	67%*	83%**
Acknowledgment	**80%**	84%	88%	78%	93%
Reopened cases	**NA**	17%	11%	3%	3%
PHSO referrals*	**NA**	1	1	2	4

*Excluding transport complaints managed by DHL/Royal Free though registered under MEH. If transport complaints included response rate is * 58% and **80%.

Percentage of staff who would recommend the trust as a provider of care to their family or friends

We value the feedback that we get from our staff; we use this across the Trust to improve our staff experience by shaping our strategies and informing our plans.
Our staff friends and family test (FFT) is conducted quarterly and we send the survey to all staff, however the response rate is small and not statistically valid. The FFT questions are also included in the annual national staff survey, which is sent to all substantive staff in Q3 and has a higher response rate, making it a better representation of the opinions of our staff. Monitoring staff engagement and maintaining staff satisfaction is a key part of our strategy to attract, retain and develop great people.

Therefore, we are aiming to improve the response rate for the Q1, Q2 and Q4 FFT surveys, increasing engagement by adding in additional questions and using it as a measure for the workforce strategy work streams. The FFT questions ask staff to tell us whether they would recommend Moorfields as a place to receive treatment and also whether they would recommend it as a place to work. Moorfields Eye Hospital NHS Foundation trust considers that the data in the table below is as described because we regularly review and share the results from FFT with our staff. We assure that this information is correct and has been validated internally.

Moorfields Eye Hospital NHS Foundation trust intends to improve this indicator through implementation of the workforce strategy linked to the interim NHS people plan, particularly the best place to work stream. We will use the quarterly FFT to measure the impact of the strategy.

The results for the national questions show that the majority of our staff are proud to recommend Moorfields as a place for treatment and likewise as a place to work, keeping us in a good position compared to all NHS organisations. We recognise the impact of internal change on our staff and their perceptions of the working environment and are investing in leadership to support change processes.

	2017/18				2018/19				2019/20			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4*
% staff recommending Moorfields as a place for treatment	96	95	92	99	97	96	90	96	(92.95) 93	(94.8) 95	89	N/A
% staff recommending Moorfields as a place to work	71	67	73	85	77	72	70	67	(57.96) 58	(54.7) 55	69	N/A
response rate/ completions	n/a	n/a	57% 1153	679	n/a	n/a	48% 1008	161	156	115	56% 1204	N/A

*Following advice from NHS England and NHS Improvement and due to COVID 19 pandemic there has been no data submission (including Q4 data) or publication until further notice.

Patients admitted to hospital who were risk assessed for venous thromboembolisms (VTE)

Moorfields Eye Hospital NHS Foundation trust considers this data is as described for the following reasons:

All patients admitted for day surgery or as overnight inpatients have their nursing assessments using our Integrated Care Pathway document. 'VTE Risk Assessment and Treatment Plan' forms part of the risk assessments for all patients admitted.

The majority of ophthalmic treatment or ophthalmic surgery poses low risk for hospital acquired VTE. So far, there hasn't been any recorded incidents of hospital acquired VTE via our incident reporting systems and the incident reviewing system including Serious Incident Panel.

Moorfields Eye Hospital continues to take actions to continue to improve this indicator and so the quality of our services as below:

For those paediatric patients who are between the age of 16 and 18, and are being operated on and admitted onto paediatric wards rather than admitted via adult wards, we have been carrying out VTE assessment using the Paediatric Integrated Care Pathway document. This has been an improvement from the last financial year.

Patient safety incidents (PSIs)

The incident reporting system continues to be effective and available for use by all staff at all locations, including the UAE. This is demonstrated by the consistently high number of reported incidents during 2019/20, particularly in comparison with other acute specialist trusts. Throughout the year the risk & safety team has continued to make adjustments and improvements to the system to ensure continued ease of use. The reporting functionality has improved and divisions are able to monitor their own progress locally. The changes have been made in conjunction with service users which, in turn, encourages reporting.

The timely management of incidents, including their reporting, investigation and closure, means that the opportunities to learn and take appropriate action to minimise future reoccurrence, can be maximised. There has been sustained trust wide focus on the timely closure of incidents and reports have been consistently generated throughout the year, both by the central quality team and locally by divisions, which provides an overview of performance and which demonstrates areas in which improvement is required. Performance has been variable throughout the year and has continued to be affected by events such as annual leave, therefore re-enforcing the importance of having robust plans to ensure business continuity during absence. Overall, the improvement demonstrated with the 28 day investigation and closure target over the last 12 months has been considerable. It is recognised that further improvement is both required and achievable; therefore this will remain a focus over the next year.

In 2019/20, we declared 7 serious incidents, 2 of which were classified as never events (which are wholly preventable untoward events, which have the potential to cause serious patient harm or death, that are deemed to be serious enough that they should never occur – for example, surgery on the wrong eye muscle, implantation of the incorrect intraocular lens). Of the 7 SIs reported during 2019/20, 5 were submitted on time, with 2 having been formally granted an extension, and none remained under investigation at the time of report production. Robust investigations, supported by clinical harm reviews where required, were undertaken in all 7 cases and learning from each incident was shared across the organisation. Moorfields Eye Hospital NHS Foundation trust considers that the incident data is as described for the following reasons:

- The trust uses an electronic reporting system, which undergoes continual improvement in order to satisfy the needs of reporters and internal subject matter experts. The incident reporting system includes a complex range of notification rules to ensure that the correct managers are notified when an incident is reported;
- The incident reporting policy, and the associated KPIs, was updated during the year to ensure that the detail contained within is accurate and fit for purpose.
- The trust has a weekly SI panel, chaired by a consultant ophthalmologist, which considers in detail those incidents that fall within the scope of the terms of reference (e.g. incidents, excluding complications, graded as moderate or above harm, potential never events). The terms of reference for this group were revised in March 2020, and the increased focus on shared learning and improvement has been sustained throughout 2019/20.

The trust intends to take the following actions to improve this data, and therefore the quality of its services by:

- On-going scrutiny of the incident reporting KPIs (as described above).

Summary of Serious Incidents (SIs)

Never Event title	Brief details
Injection of Botulinum Toxin (Botox) to the incorrect ocular muscle*	One case of a patient having potentially received an injection of Botox into the incorrect ocular muscle
Insertion of the incorrect strength intraocular lens (IOL)	One case of a patient receiving an IOL which was different to that which had been selected by the surgeon prior to commencement of surgery

*the investigation was unable to confirm that the incorrect muscle had been injected. It remains possible that the patient was demonstrating convergence spasm.

The other serious incidents occurred across a range of areas as set out in the table below:

Serious Incident title	Brief details
Delayed provision of a glaucoma follow-up appointment	A patient was not reviewed at a 9-month interval, as requested, but instead was reviewed at 28 months. Investigation of the incident as an SI was prompted by the patient's death, from a non-glaucoma related condition
Missed diagnosis in A&E	Investigation of a missed diagnosis of which the trust first became aware of via a letter of claim. The claimant had not been reviewed by the trust since the one A&E attendance in 2017
Loose filing of documentation	A large quantity of unorganised and unfiled information (circa. 8000 individual items) was found in an administrative area. Whilst a quantity could be disposed of, some formed part of patient health records. The Information Commissioners Office (ICO) was notified of the data breach
Insertion of the incorrect strength IOL	One case of a patient receiving an IOL which was the incorrect lens strength based on the patient's desired refractive outcome
Neuro-ophthalmology missed diagnosis	A patient did not have an MRI scan performed that had been requested by a consultant and the absence of the scan was not recognised. The patient passed away.

All completed serious incident investigations have associated action plans, which are formally approved by an executive panel as part of the report sign-off process. Implementation of the action plan is then monitored by the central risk & safety team and the Serious Incident (SI) panel. Periodic thematic reviews of serious incidents are completed and learning is shared via various mechanisms, such as clinical governance half days, divisional quality forums, divisional and quality team newsletters and learning and improvement following events (LIFE) bulletins (LIFEline).

The table below shows the total number of reported PSIs during the period April 2017 to March 2020, where data has been made available. The NHS Digital files are not updated when new data is released and this accounts for the discrepancy between the Moorfields local record data and that which has been published by NHS Digital for the same period. Moorfields continues to demonstrate high reporting levels for the acute specialist trust cohort.

Total number of reported PSIs

	Reporting Period		
	2017/18	2018/19	2019/20
Moorfields (trust local record)	6773	8600	6449
Moorfields (NHS Digital)	6396	7423	Data not available
National average*	2902	2963	Data not available
Lowest performing trust**	649	573	***573
Highest performing trust**	6396	7423	***7423

*based on the average of 'Acute Specialist trusts' (NHS digital data)
**figures available on NHS digital
*** Benchmarking data refers to 2018/19 as no current data available at the time of this report.

The table below presents a summary incident reporting rate for the trust, during the period April 2017 to March 2020. Because Moorfields primarily provides ambulatory care, the organisation calculates a reporting rate based on incidents per 1000 events. The reporting rates shown have been extracted from the Moorfields quality & safety dashboard. These rates are not comparable against the reporting rates published by NHS Digital, which are calculated per 1000 bed days.

Rate of PSIs reported

	Reporting Period		
	2017/18	2018/19	2019/20
Moorfields (trust local record)	10.6	10.8	8.5

The table below presents a summary update of the total number of PSIs which resulted in severe harm or death that were reported at the trust from April 2017 to March 2020. The trust has a dynamic incident reporting process and records are continually reviewed and updated.

Number of PSIs resulting in severe harm or death

	Reporting Period		
	2017/18	2018/19	2019/20
Moorfields (trust local record)	6	9	11
Moorfields (NHS Digital)	9	8	Data not available
National average*	5.9	3.9	Data not available
Lowest performing trust**	25	14	***14
Highest performing trust**	0	0	***0

*based on the average of 'Acute Specialist trusts' (NHS digital data)
**figures available on NHS digital
*** Benchmarking data refers to 2018/19 as no current data available at the time of this report.

The table below presents a summary update of the percentage of PSIs resulting in severe harm or death. The percentage data in the table has been calculated based on the number of severe harm/death incidents as a proportion of the total number of PSIs reported during the period.

Percentage of PSIs resulting in severe harm or death

	Reporting Period		
	2017/18	2018/19	2019/20
Moorfields (trust local record)	0.09%	0.10%	0.17%
Moorfields (NHS Digital)	0.14%	0.11%	Data not available
National average*	0.20%	0.13%	Data not available
Lowest performing trust**	0%	0%	***0%
Highest performing trust**	0.59%	0.38%	***0.38%

*based on the average of 'Acute Specialist trusts' (NHS digital data)
**figures available on NHS digital
*** Benchmarking data refers to 2018/19 as no current data available at the time of this report.

Being open with our patients - Duty of Candour (DoC)

Moorfields has continued to strengthen and promote systems to support an open and transparent culture when things go wrong and shows a willingness to report and learn from incidents. Adherence with the individual elements of the process continues to be captured within the electronic incident reporting system and the risk & safety team and divisional quality partners monitor compliance on an on-going basis. Where potential non-compliance with requirements is identified, clinicians are challenged regarding adherence and supported to have conversations and provide documented accounts to patients. Enhanced scrutiny is now applied by the risk & safety team, and individual incidents are not now closed by the central team until assurance is received from clinical divisions that the DoC has been appropriately applied.

In 2019/20 the trust undertook a re-audit of DoC compliance and compared the results with the previous audit report that was completed in June 2018. Overall an improvement in compliance was identified; however there remain areas in which further improvement can be achieved, such as the need to fully document discussions in the health record and address DoC letters to patients rather than the patient's GP. The content of the existing e-learning package, for which compliance was noted to be 92% at the end of April 2020, will be reviewed to ensure that the improvement opportunities are adequately addressed. In addition the frequency of required completion will be reduced to once every two years. A further re-audit, of data covering the period 1 April 2019 to 31 March 2020, will be undertaken during the first six months of 2020/21.

Learning from deaths

The trust recognises that deaths of patients who are in our care are an extremely rare event. The scope of our learning from deaths policy is deliberately broad in order to make the best provision for potential learning opportunities; the scope includes not only the mandatory inclusion requirements (e.g. an inpatient death, the death of an individual with a learning disability or mental health needs, the death of an infant or child) but also, for example, deaths within 48 hours of surgery, deaths of patients who are transferred from a Moorfields site and who die following admission to another hospital and deaths about which the trust becomes aware of following notification, and a request for information, by HM Coroner. In order to further encourage the internal reporting of deaths of patients of which clinicians became aware, the central risk & safety team added the additional harm impact classification 'notification of a patient death received' to the incident reporting system. Specific review of incidents reported using this classification provides the trust with the opportunity to consider whether or not a more detailed review is warranted. The death referenced below did not occur

at a Moorfields site; however following a review of the care and treatment that the patient received, and the opportunities for learning and improvement, the case was reported and investigated as a serious incident.

The following statements meet the requirement set by NHS Improvement.

27.1 During the period 1 April 2019 to 31 March 2020, 1 of Moorfields Eye Hospital NHS Foundation Trust patients died (of which 0 were neonatal death, 0 were still births, 0 were people with learning disabilities and 0 had a severe mental illness).
This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 0 in the first quarter;
- 0 in the second quarter;
- 1 in the third quarter;
- 0 in the fourth quarter.

27.2 By 31 March 2020, 1 case record reviews and 1 investigations have been carried out in relation to all 1 deaths included in section 27.1.
In one case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 0 in the first quarter;
- 0 in the second quarter;
- 1 in the third quarter;
- 0 in the fourth quarter.

27.3 one death, representing 100% of the patient deaths during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 1 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using a modified version of the Royal College of Physicians Structured Judgement Review methodology, which is a retrospective case record review of the quality of clinical care provided.

27.4 The case record review, and SI investigation, that was undertaken into the one patient death highlighted an issue regarding the robustness of the procedure within the neuro-ophthalmology service for requesting diagnostic imaging and identifying where either it has not been undertaken or an imaging report has not been received. The trust learned that where electronic systems do not exist for the requesting, recording and subsequent review of imaging, it is essential that there are robust, auditable administrative processes in place to ensure that information and activity is not overlooked. Further, that details of all diagnostic tests (e.g. bloods, imaging) requested must be communicated in a letter to the patient and to the GP. This will also make it available, on OpenEyes or in Medisoft (the trust electronic patient record systems), for review by all other clinicians and administrative staff.

27.5 The trust has only recently concluded the investigation into the one patient death that has been recorded. An action plan has been developed to ensure that improvements are made

to the processes in which weaknesses were identified. The incident occurred during Q1 2018/19 and, prior to detection of the incident in Q4 2019/20, improvements such as the appointment of a dedicated neuro-ophthalmology service director had already been implemented. Following completion of the investigation the trust has also developed a standard operating procedure for the handling of neuro-ophthalmology diagnostic imaging requests and this has been communicated to relevant clinicians. The significant action that remains outstanding is the need to undertake a comprehensive review of the process for the management of imaging request forms and make recommendations for improvement. The review will include identification of the requirements, costs and timescales associated with implementation of an electronic system for imaging management, known and potential restrictions, such as compatibility with existing electronic patient records (i.e. OpenEyes, Medisoft and Silverlink PAS) and how the important interface between the radiology department and patients, when MRI scans are requested, will be managed.

27.6 The actions referred to in 27.5 have either only recently been completed or remain outstanding, and due for completion in 2020/21, therefore it is not possible to make an assessment of the impact of the actions.

27.7 Zero case record reviews took place and zero investigations were completed after 31 March 2019 which related to deaths which took place before the start of the reporting period.

27.8 Zero cases, representing 100% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the internal Serious Incident investigation process.

27.9 In 2018/19, zero of the deaths reviewed or investigated during that year were judged to be more likely than not to have been due to problems in the care provided to the patient. This represented 0% of the deaths that occurred during that financial year.

3. Statements of assurance from the Board

The board receives assurance about quality and safety from the quality and safety committee which provides assurance about quality and safety activities across the trust. The quality and safety committee receives a number of annual quality and safety reports including a twice yearly thorough review of quality and safety covering the three domains of patient safety, patient experience and clinical effectiveness led by the medical director and director of nursing and allied health professions. The board receives briefings from the chair of the quality and safety committee at each meeting. The board also receives reports about quality and safety as per its statutory responsibilities.

Review of Trust services

During 2019/20 Moorfields Eye Hospital NHS Foundation trust provided ophthalmic NHS services covering a range of ophthalmic sub-specialties (A&E, adnexal, anaesthetics, cataract, cornea and external disease, glaucoma, medical retina, neuro- ophthalmology, optometry, orthoptics, paediatrics, strabismus and vitreo-retinal).

Moorfields has reviewed all the data available on the quality of care in all the ophthalmic services that we provide. At Moorfields, we regularly review all healthcare services that we provide. During 2019/20, we will continue with our programme of reviewing the quality of care and delivery of services through our quality and service improvement and sustainability programme (QSIS).

The income generated by the NHS services under review in 2019/20 represents the total income generated from the provision of NHS services.

Freedom to Speak up

All NHS trusts are required to have Freedom to Speak Up (FTSU) guardians and a policy setting out FTSU arrangements. From September 2018 there have been five FTSU guardians in place:

- Dr Ali Abbas, locum consultant, City Road and St George's
- Farhana Sultana-Miah, divisional manager, Moorfields North
- Carmel Brookes, leader 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 these 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 trust board and senior independent director. Moorfields has a FTSU policy dated May 2018, 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 of circumstances and was viewed negatively. FTSU is viewed as way to provide additional support to staff. 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 ensure that staff concerns are resolved through the necessary route, for example additional advice may be needed. They also ensure that staff are supported during the period their concern is being addressed and staff can provide feedback directly to guardians about their experience of how their concern has been resolved. A recent example is that staff felt they had learnt a tremendous amount through raising their FTSU concern and that should the situation arise again they would feel better equipped to deal with the issues and would not need the services of the guardians.

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 what communication routes should be used. Quarterly FTSU reports are produced for the trust board and data is also submitted to the National Guardian's office quarterly.

Provision of seven days services

The trust is compliant with the relevant clinical standards that apply. These include:

- Clinical standard 2 – the trust is 100% compliant with this standard, with all patients seeing a consultant level subspecialist within 14 hours of submission
- Clinical standard 5 – relates to access to diagnostic services. Services are available for microbiology, CT and ultrasound. MRI is only available on weekends via formal arrangement off-site
- Clinical standard 6 – the only element that applies is access to emergency surgery which is available on weekdays and weekends
- Clinical standard 8 – as a single specialty ophthalmology hospital we do not admit patients with high dependency needs so CS8 does not generally apply.

Relevant standards are audited as part of the clinical audit programme. The 7DS template is submitted to the board twice a year for assurance purposes.

Guardian of safe working

As per Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in training (England) 2016, the board receives quarterly reports from the guardian of safe working and an annual report that provides assurance on rota gaps and the plans in place to reduce them. As at the end of quarter 4 in 2019/20 and following a measured response to COVID 19 pandemic, there was no gaps in rota identified.

Participation in clinical audits and national confidential enquiries

The national clinical audits and national confidential enquiries that Moorfields Eye Hospital NHS Foundation Trust was eligible to participate in during 2019-20 are as follows:

National Audits
National Audit of Corneal Graft Outcomes
National Ophthalmology Database (NOD) Cataract Audit

National Confidential Enquiries
Perioperative Diabetes Management
Mental Health in Young People and Young Adults (2019)

The national clinical audits and national confidential enquiries that Moorfields Eye Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2019-20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	***Numbers of cases submitted & relevant***
National Audit of Corneal Graft Outcomes	*1237/1512 (82%)* *(data from 01/04/2019-31/03/2020)*
National Ophthalmology Database (NOD) Cataract Audit	**23,070/23,490 (98.2%)* *(data from 01/09/2018-31/08/2019)*

**Data from NOD is provisional data collated on 1st April 2020 and awaiting validation by local surgical teams involved (data is expected to be finalised in July 2020): (ghn-tr.nod@nhs.net)*

National Confidential Enquiries	***Numbers of cases submitted & relevant***
Perioperative Diabetes Management	*Not applicable*
Mental Health in Young People and Young Adults (2019)	*Not applicable*

The Trust submitted data to allow the formulation of a denominator for both the Perioperative Diabetes Management and Mental Health in Young People and Young Adults enquiries. As a result of Moorfields' 'Acute Trust' status, we are deemed to fall into a qualifying group as contributors but, more often than not (as is the case in these situations) we are excluded by virtue of not having in-patient admissions for these cases.

Although the Trust did not qualify for submission for the NCE Perioperative Diabetes Management and many of the resulting recommendations were not relevant to the specialist nature of Moorfields, the outcome did result in the development of a Trust guideline. Anaesthetic leads presented plans at the Clinical Audit and Effectiveness Committee for the development of a Trust guideline consisting of information relating to the care of diabetic patients who comply poorly with the advice they are given, emergency situations when patients arrive with high blood sugar levels, and referral of extreme cases directly to clinic. To assist the complex needs of diabetic patients, a new diabetic nurse has been recruited in the Trust to lead a new diabetic clinic.

Of the 1512 ocular transplant forms received from the NHS Blood and Transplant team from 1st April 2019 – 31st March 2020, the trust has completed and returned 1237 (82%); however some of the forms received are for planned appointments yet to take place. The corneal graft clinic described above (Clinic 10) will also proactively submit details to the NHS Blood and Transplant team without waiting for receipt of a form. Since 1st April 2019, the trust has also submitted a number of forms received during the previous year. In total during 2019-20, the trust has actually submitted details of 1546 patients to the NHS Blood and Transplant team.

From the 2 national clinical audits where the trust contributed data, only one report was received from the National Ophthalmology Database during 2019-20. This was shared with Cataract Service consultants and any incorrect data was challenged.

National Audit Report	Discussed	Actions
National Ophthalmology Database Audit report 2019 (included data from Sept 2017 – Aug 2018)	Cataract Service	Report shared with Medical Director and Cataract Service. All clinicians involved in data that indicated that they had complications responded to the report and this information was shared with the NOD where errors were made in the original report. The report has since been updated. Findings to be presented at CAEC in March 2020.
None	Discussed within the clinical audit team and at the Clinical Audit and Effectiveness Committee.	The NHS Blood and Transplant team were contacted to provide an updated report; however admitted in December 2019 to having outstanding transplants to include and that an early distribution may not be a fair representation. A report is now expected in April 2020.

During the period 1 April 2019 to 31 March 2020, Moorfields proposed 20 audits assessing national clinical standards/guidelines* (many of which have been completed or were re-audits).

*National audits are those that are registered by all trusts where benchmarking and comparisons can be made between organisations. Due to the single specialty nature of Moorfields, many national audits are not relevant. Moorfields therefore also audits against standards and guidelines set by relevant national bodies such as the Royal College of Ophthalmologists, National Institute for Health and Care Excellence (NICE) and national service frameworks. These are referred to as 'nationally derived' audits whereby all trusts must undertake them but there is no benchmarking as these are done individually by trusts.

The 37 clinical audits derived from national standards and guidelines that Moorfields proposed in from 1 April 2019 to 31 March 2020 were:

Audit project title	Sites	Service	Reason
Modified Global Trigger Tool (mGTT), City Road CA19/A&E/07-308	City Road	A&E	Royal College of Ophthalmology (mGTT)
Paediatric uveitis service and amblyopia (mGTT) CA19/AD/14-324	City Road	Orthoptics / Paediatric	Royal College of Ophthalmology (mGTT)
Shared Decision Making in Anaesthesia for Cataract Surgery at Moorfields (CA19/ANA/02-342)	City Road	Anaesthetics	Royal College of Ophthalmology
Theatre Identification & Communication Survey (TICS) (CA19/ANA/06-457)	City Road	Anaesthetics	Patient Safety First
Modified Global Trigger Tool (mGTT) - Audit on the Accuracy of Autorefractor Outcomes at Moorfields Ealing Cataract Service CA19/CT/09-315	Ealing	Cataract	Royal College of Ophthalmology (mGTT)
No Health without Mental health (CA19/ER/03-332)	City Road	Education and Research	Patient Safety First
Treatment audit for people referred from diabetic eye screening programmes (CA19/MR/18-398)	RDCEC	Medical Retina	National Audit (not part of NCAPOP)
Modified Global Trigger Tool (mGTT), City Road Medical Retina CA19/MR/27-428	City Road	Medical Retina	Royal College of Ophthalmology (mGTT)

Audit project title	Sites	Service	Reason
Evaluating adherence to clinical referral and time-to-treatment treatment guidelines for age-related macular degeneration (CA19/OPT/01-374)	City Road	Optometry	Royal College of Ophthalmology
Modified Global Trigger Tool (mGTT), Audit of Paediatric Ophthalmology clinic and Children's Vision Clinic at Darent Valley CA19/PA/05-386	Darent Valley	Paediatrics	Royal College of Ophthalmology (mGTT)
Modified Global Trigger Tool (mGTT), of Thursday afternoon Paediatric Clinic @ Moorfields St George's CA19/PA/13-401	St George's	Paediatrics	Royal College of Ophthalmology (mGTT)
Modified Global Trigger Tool (mGTT), Audit of new Strabismus Service at DVH CA19/ST/03-387	Darent Valley	Strabismus and Neuro-Ophthalmology	Royal College of Ophthalmology (mGTT)
Neuro-Ophthalmology Modified Global Trigger Tool (mGTT), (re-audit) CA19/ST/07-155v2	St George's	Strabismus and Neuro-Ophthalmology	Royal College of Ophthalmology (mGTT)
Modified Global Trigger Tool PB/Cataract CA19/CT/18-492	Potters Bar	Cataract	Royal College of Ophthalmology (mGTT)
Long term complications of betaradiation for trabeculectomy (CA19/GL/11-495)	City Road	Glaucoma	Patient Safety First
mGTT Audit of medical retina clinics at St Ann's Satellite Centre CA19/MR/34-509	St. Ann's	Medical Retina	Royal College of Ophthalmology (mGTT)
Intraocular gas - patient information (CA19/ANA/06-451)	City Road	Anaesthetics, Nursing, Vitreo-Retinal	Royal College of Anaesthetists
Ozurdex Use in Uveitis Affecting the Posterior Segment - A continuation and re-audit (CA20/UV/01-546)	City Road, St George's , Croydon	Uveitis	NICE
Iluvien use in Uveitis Affecting the Posterior Segment - ILIUS Project (CA20/UV/02-547)	City Road and St George's	Uveitis	NICE
Audit of Hydroxychloroquine Retinopathy Surveillance (CA20/MR/01-548)	Croydon and St George's	Medical Retina	Royal College of Ophthalmology

These 37 nationally derived audit 'proposals' can be summarised as:

- 2 Department of Health (DH)
- 2 National Audits (not part of the National Clinical Audit and Patient Outcomes Programme)
- 1 National Audit (part of the National Clinical Audit and Patient Outcomes Programme)
- 7 National Institute for health and Care Excellence (NICE)
- 1 Patient Reported Outcome Measure (PROM) *(a second sedation PROM was proposed in 2018-19 and results are due 2020-21)*
- 4 Patient Safety First

- 1 Royal College of Anaesthetists
- 9 Royal College of Ophthalmologists (RCO)
- 10 Royal College of Ophthalmologists – Modified Global Trigger Tool (RCO mGTT)

Participation in clinical research

The numbers of patients receiving relevant health services provided or sub-contracted by Moorfields Eye Hospital NHS Foundation Trust during 2019/20, that were recruited during that period to participate in research approved by a research ethics committee, was 2485.

Moorfields continues to be a national and international leader in the field of high quality ophthalmic research and highlights during 2019-20 include:

1. INSIGHT

Moorfields Eye Hospital is one of seven new health data research hubs that aim to give patients across the UK faster access to pioneering new treatments. Led by Health Data Research UK, these hubs bring together different types of health data, making it more easily accessible for research, while maintaining strict controls around data privacy and consent.

INSIGHT is the Health Data Research Hub for eye health and is a partnership between Moorfields Eye Hospital and University Hospitals Birmingham NHS Foundation Trust. We are using the power of large scale data and artificial intelligence to enable researchers to tackle blinding diseases, and unlock new discoveries into our general health, across common conditions such as diabetes and dementia.

INSIGHT provides a unique opportunity for discovery and innovation in eye health, and the application of eye imaging as a window to make discoveries that improve people's lives.

2. Deciphering AMD by deep phenotyping and machine learning (Pinnacle)

Age-Related Macular Degeneration (AMD) is the commonest cause of blindness in the elderly. Moorfields is working with many international collaborators to support the Pinnacle study, by providing thousands of retinal images from Moorfields AMD patients for computer analysis. By teaching computers to analyse high resolution images of the inside of the eye, we will be able to better understand why AMD develops and how best to treat AMD patients. This will help us develop better treatments and enter the most appropriate patients into new clinical trials.

3. The Fenetre Study

The FENETRE study is a multi-site prospective research project looking at the potential for monitoring patients with stable AMD in the community by trained optometrists. This would alleviate pressures on hospital-based eye clinics and lead to a better experience of care for our patients closer to home.

This large, multi-site prospective study was funded by the NIHR in 2019. We will look at how care for patients with stable AMD can be devolved to community optometry practices. We will explore the role of digital technologies and artificial intelligence decision support to facilitate the process of monitoring patients with stable AMD closer to home, reducing the pressures on busy hospital-based eye clinics.

4. *LiGHT: Moorfields team wins award for excellence in glaucoma care*

Professor Gus Gazzard and the team delivering the LiGHT trial have won an award from the International Glaucoma Association (IGA) for excellence in glaucoma care. The LiGHT trial findings are set to change the way glaucoma is treated in the NHS in future.

The LiGHT trial evaluated whether using a laser-based treatment on newly diagnosed cases of glaucoma was more successful and cost-effective than the current method of using pressure lowering eye drops. It was found that the laser-based treatment had better outcomes for patients and could save the NHS a significant amount of money.

5. Topol Digital Fellowship awarded to Roxanne Crosby-Nwaobi

In September 2019, Health Education England awarded a Topol Digital Fellowship to Moorfields' Head of research nursing, Dr Crosby-Nwaobi. The project involves using a cloud-based web-app to enable community nurses to use a portable retinal camera at GP surgeries that can transfer images to a specialist centre.

This cloud-based platform has the capability to provide immediate feedback of the results to the healthcare professional and a patient portal that lends itself to patient education and home monitoring. It is envisaged that this method is likely to improve patient experience, up-skill community nurses in eye health, increase screening uptake and reduce the risk of blindness.

6. Digital Surgery – Moorfields Cataract Surgery Collaboration

Moorfields Eye Hospital, jointly with Digital Surgery, have been awarded a £1 million grant from Innovate UK to assess artificial intelligence (AI) cataract surgery technology developed by Digital Surgery to help train surgeons, improve theatre flow, develop surgical teams and help analyse and reduce risks of cataract surgery.

Led by George Saleh at Moorfields, the AI cataract surgery platform will enable procedure tracking during surgery that can be displayed in real-time on screens in theatres along with post-operative analytics that will support surgical teams to adapt the way they undertake surgery. This is a first for cataract surgery.

7. COVID19 response by Moorfields Research and Development

In response to the COVID19 crisis, some adjustments were made to the delivery of research activities, to ensure the safety of our patients and staff and preserve high quality research. 77 studies were suspended temporarily so not to expose the participants on the study to unnecessary health risk while attending follow-up appointments. 10 studies were kept open for follow-up appointments as patients on the study were at high risk of sight or life loss if the study was suspended. In addition, Moorfields Research and Development staff were redeployed to support non-ophthalmic COVID19 research studies at other London NHS Hospitals.

Commissioning for quality and innovation (CQUIN) framework

The CQUIN payment framework enables commissioners to reward providers by linking a proportion of the provider's income to the achievement of local quality improvement goals. Some CQUINS are national requirements but others are developed locally in discussion with commissioners. A proportion of Moorfields Eye Hospital Foundation NHS Trust income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed

between Moorfields Eye Hospital Foundation NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Due to the current suspension of the contracting process further guidance will be required after July to ascertain whether CQUINs will be required for 2020-21. Discussions with commissioners will continue in order to be prepared for any guidance that is likely to be disseminated from NHS England.

Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically on the Trusts website once finalised: https://www.moorfields.nhs.uk/CQUIN.

Registration with the Care Quality Commission (CQC)

Moorfields Eye Hospital NHS Foundation trust is required to be registered with the Care Quality Commission (CQC) and is currently registered without conditions. The CQC has not taken any enforcement action against Moorfields Eye Hospital NHS Foundation Trust in 2019/20, nor at any time previously. Moorfields Eye hospital NHS Foundation trust has not participated in any special reviews or investigations by the CQC during the 2019/20.

The Trust's most recent CQC inspection occurred in November 2018 at Bedford, City Road, and St George's, and was unannounced. This was followed by a Well-led assessment in December 2018. The report was published on 12 March 2019, covering:

- The trust overall;
- Bedford (Outpatients and Surgery)
- City Road (Outpatients and Surgery)
- St George's (Outpatients only)

The trust has been given an overall rating of 'Good', with all the services being rated as 'Good' or 'Outstanding'. Effectiveness was rated as 'Outstanding'.

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Outstanding ☆
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Services at City Road were rated 'Outstanding 'overall, as were surgical services at Bedford. In addition, both Bedford and St George's improved from 'Requires improvement' to 'Good' overall.

The rating tables for each site are below:

City Road

Ratings for Moorfields Eye Hospital - City Road

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Surgery	Good ↑ Mar 2019	Outstanding ↑ Mar 2019	Outstanding ↑ Mar 2019	Outstanding ↑ Mar 2019	Good →← Mar 2019	Outstanding ↑ Mar 2019
Services for children and young people	Good Jan 2017	Good Jan 2017	Outstanding Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Outpatients	Good Mar 2019	N/A	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Overall*	Good ↑ Mar 2019	Outstanding ↑ Mar 2019	Outstanding →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Outstanding ↑ Mar 2019

St. Georges

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good Mar 2019	N/A	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Overall*	Good Mar 2019	N/A	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019

Bedford

Ratings for Moorfields at Bedford

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good ↑ Mar 2019	Outstanding ↑ Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019
Outpatients	Good Mar 2019	N/A	Good Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019
Overall*	Good ↑ Mar 2019	Outstanding ↑ Mar 2019	Good →← Mar 2019	Requires improvement →← Mar 2019	Good →← Mar 2019	Good ↑ Mar 2019

In addition to the ratings themselves, the CQC found a number of areas of outstanding practice:

- The service was innovative in its approach to access and flow. In particular there was a highly effective pre-assessment process which included the use of telephone consultations.
- The service provided excellent emotional support and practical support to patients experiencing sight loss, providing counselling and support in registering for certification of visual impairment.
- Moorfields Eye Hospital and University College London had set up the London Project to Cure Blindness which restored the sight of the first patients receiving a new treatment derived from stem cell technology.

- Their collaborative and pioneering research study with an artificial intelligence company showed that artificial intelligence helped to diagnose eye diseases.
- The National Institute for Health Research granted a clinical trial for finger prick autologous blood (FAB) to treat severe dry eyes. The cataract and corneal services had recruited 15 patients to date.
- Know your drops service at St George's: this entails direct pharmacist support to ensure patients are able to use drops appropriately from their devices. This has been used to encourage patient engagement in treatment decisions. The initiative was showcased nationally and received several awards.

A further indication of the significant improvements that the trust has made over the past two years is in the number of recommendations contained within the 2019 report which has been reduced from 78 in 2017 to 18. Progress with the recommendations made by CQC continues and embedding of the resulting enhancements is part of the trust's journey to excellence.

Information Governance

Information Governance at Moorfields is overseen by the Information Governance Committee which reports to the Quality and Safety Committee (a Board committee). The Information Governance Committee is chaired by the Senior Information Risk Owner (SIRO) who is the Director of Quality and Safety; membership includes the Caldicott Guardian, Deputy Caldicott Guardian, Chief Information Officer and Head of Information Governance who is also the Trust's Data Protection Officer.

The information governance agenda is driven by key standards set down in the NHS Operating Framework and measured by compliance with the Data Security and Protection Toolkit (DSPT).

The Trust is required to process information (personal and corporate) in line with the standards set out in statute, regulation and guidance. Information Governance at Moorfields includes strategy, policy and procedures that enable staff to handle information in line with these requirements. Annual data security awareness training is mandatory for all staff. In 2019/20 Moorfields agreed a new IG training strategy and work is underway to roll out specialist IG training to key staff.

The DSPT annual submission is used to demonstrate compliance with IG standards and the national Data Security Standards. The trust's 2019/20 submission met 116 of the 116 mandatory compliance requirements. Therefore the Trust submitted a compliant 'Standards Met' toolkit. This compares to 95 out of 100 mandatory items in the 2018/19 submission. In addition to the mandatory items, Moorfields completed 52 of the 61 non-mandatory items, achieving compliance with 95% of standards met overall. The trust was rated as 'significant assurance with minor improvement opportunities' during KPMG's audit of its DSPT submission preparation.

Data quality & Audit

Moorfields Eye Hospital submitted records during 2019/20 to the secondary uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data (April 19 to February 20). The percentages of records in the published data, which included the patient's valid NHS number, were:

- 99.5% for admitted patient case
- 99.6% for outpatient care
- 96.7% for accident and emergency care.

The percentages of valid data which included the patient's valid general practitioner registration code were:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care.

This year, the trust has not been subject to the usual Data Quality and Assurance audit carried out by KPMG. This is on the basis of the previous year's audit (2017/18) moving from partial assurance with improvements required to significant assurance with minor improvement opportunities.

There have been other external audits carried out which have included recommendations regarding data quality related issues, namely the A&E audit.

Below are the data quality related recommendations made from those audits:

- We recommend that the Trust focuses its Data Quality audit, sample selection on individuals that are within 30 Minutes of breach time. This should be selected for 35 individuals that are non breaches and 15 individuals which are breaches.

This recommendation is subject to an action plan and will be monitored during 2020/21.

The trust continues to hold the amalgamated the Data Quality Working Group and the Information Management Group in order to ensure a better synergy between the two related issues. This group continues to meet every two months and discusses core data quality areas including audit results.

Clinical Coding and Payment by results

Moorfields was subject to the annual Clinical Coding audit as part of the Data Security & Protection Toolkit (DSPT) during November 2019, which this year was carried out by D&A Clinical Coding Consultancy Ltd. The aim of these audits is to improve the data quality of clinical record coding, which underpins hospital management and planning, commissioning of services for the population, clinical research and financial flows. The audit's objectives are to evaluate the accuracy and completeness of coded clinical data against patient case notes, or electronic patient records (EPR) and the impact of data collection procedures which underpin the coding process. This helps sustain high standards of reliable clinical information and target improvements where required.

The final report indicated there was an excellent standard of primary and secondary diagnosis and procedure coding. The accuracy rates published in the audit report were:

Audit Year	Diagnosis		Procedure	
	Primary	Secondary	Primary	Secondary
DSPT Audit 19/20	99.00%	97.23%	97.94%	99.54%
DSPT Audit 18/19	98.50%	98.73%	100%	99.69%
DSPT Audit 17/18	100%	98.85%	100%	100%

DSPT Standard 1 Data Quality - The Trust has achieved the following attainment level – Standards Exceeded

DSPT Standard 3 Training - The Trust has achieved the following attainment level – Standards Exceeded

It was also noted that the Trust and coding team showed high commitment levels to improving the clinical coding function for the Trust and as well as to the enhancement and maintenance of coding data quality.

Over and above this audit the Trust has this year received external recognition of its excellent approach to clinical coding by winning the CHKS Data Quality in Clinical Coding award in May 2018 and again in May 2019

Below are the data quality related recommendations made from those audits:

- Improve the cataract data collection in *OpenEyes*™ (EPR) as part of the Trust's digital technology improvement strategy. (Source: Clinical Coding DSPT Audit – D&A Clinical Coding Consultancy Ltd)

- Provide immediate training within the Clinical Coding Department to address generic errors highlighted in this audit. (Source: Clinical Coding DSPT Audit - D&A Clinical Coding Consultancy Ltd)

- Provide Clinical Coders with an in-house training session with a focus to acute/chronic conditions will always affect the patient's episode of care, as soon as possible. (Source: Clinical Coding DSPT Audit - D&A Clinical Coding Consultancy Ltd)

- Involve 'Clinical Coding' as part of the 'Expert Working Group' with the EPR providers, at the earliest opportunity. (Source: Clinical Coding DSPT Audit - D&A Clinical Coding Consultancy Ltd)

3.1 Priorities for improvement in 2020/2021

The development of this quality report was led by the head of quality and safety and the director of quality and safety in close liaison with the trust's executive quality and safety leads, who are the director of nursing and allied health professions and the medical director, in consultation with the chief operating officer.

This quality report and our quality priorities have been developed from a wide range of information about quality from all parts and levels within the organisation. As part of our consultation process, a forum was arranged with our key external stakeholders including representations from patients, The Royal National Institute of Blind (RNIB), our host clinical commissioning group (CCG), Islington clinical commissioning group, Health Watch, and representations from our governors. Our staff view was also sought through a survey and the priorities continue to be influenced by CQC's inspection report findings and are consistent with the commissioning for quality and innovation (CQUIN) framework. The membership council, our host commissioners, NHS Islington clinical commissioning group and other external bodies such as Healthwatch have also considered the contents of the quality report and were supportive of the quality priorities for 2020/21.

The identified priorities will each have specific metrics to demonstrate and measure performance throughout year. However, due to the impact of COVID 19 pandemic and any possible change of focus some/all priorities may not be achievable during 200/21. The set measurables for each priority may also be impacted as a result of the recovery plan following the pandemic. Moorfields will continue following advice and guidance from NHS Improvement and NHS England to ensure patients continue to receive high

quality care as much as possible within current limited resources and capacity which are outside organisational controls.

The Quality and Safety Committee on behalf of the Board takes responsibility for overseeing the development and delivery of the Quality Account and quality priorities.

This quality account has been reviewed by the trust management committee and the quality and safety committee and has been finalised as a balanced representation of the trust's priorities across the three areas of patient safety, patient experience and clinical effectiveness.

Please see table below for the list of identified priorities:

Proposed Quality Account Priority		Quality Domain	Underpinning drivers					
			Trust objective	Links to The Quality Strategy	National initiative	Learning from serious Incidents/Complaints	Themes from Patient engagements	Carried over from 2019/20- Y/N
1	To support safer care for patients undergoing invasive procedures through developing LOCSSIPs according to National recommendations (NATSSIPs)	Safe	✓	x	✓	✓	✓	Y
2	Continue improving systems and processes through a learning framework to share and embed learning		✓	✓	✓	✓	✓	Y
3	3a: Continue providing reasonable adjustments to deliver person centred care by improving the use of helping hands stickers for vulnerable patients with additional support needs 3b: Improve patient care by embedding the use of the pain assessment tool for all patients who are known to have cognitive impairment and communication difficulties	Effective	✓	✓	x	✓	✓	N

4	Improve staff access to health and wellbeing initiatives and increase the number of staff using Moorfields Health & Wellbeing initiatives		✓	✓	✓	x	✓	N
5	Improving the experience of our patients through improved customer care - *Pilot at Private division*	**Patient experience**	✓	✓	x	✓	✓	N
6	Improve overall patient call response time to improve patient experience		✓	✓	✓	x	✓	Y

2020/21 Quality priorities

Due to the operational response to the COVID 19 pandemic, below priorities and their set measurables may be impacted whilst the organisation is responding to the crisis during recovery. Moorfields will continue following advice and guidance from NHS Improvement and NHS England to ensure patients continue to receive high quality care within current limited resources and capacity which are outside organisational controls.

Safe: Priority 1

Objective: To support safer care for patients undergoing invasive procedures through developing LOCSSIPs (Local Surgical Standards for Invasive Procedures) according to National recommendations (NATSSIPs- National Surgical Standards for Invasive Procedures)

Rationale:
This priority is a continuation of making care and treatment safer through learning from implementation and embedding of WHO checklists across the organisation.

What success will look like by the end of March 2021:

- Development and implementation of a suite of LocSSIPs, that are available trust wide via the intranet, to ensure that practice for amalgamated groups or individual invasive procedures is standardised across all Moorfields locations;
- An annual audit plan that incorporates all LocSSIPs and evidence of at least one audit of each group of invasive procedures having taken place during the 12-month period.

What we will measure and when:

- Undertake a review of the list of invasive procedures compiled in 2019/20, in conjunction with clinical divisions and clinical services, to ensure that it is compliant with all NatSSIPs. This will include identification of relevant LocSSIPs and their associated LocSSIP owners (Q1)
- Complete a review of the abbreviated surgical safety checklist, which is used outside the theatre environment, to ensure that it is compliant with NatSSIPs (Q1)
- Implement the revised abbreviated surgical safety checklist, where amendments have been made (Q2)
- Audit/re-audit of all LocSSIPs to assess compliancy to be undertaken (Q2-Q4) and be included in the annual audit planner.
- Annual activity summary and thematic review of audit findings to be completed, the outcome of which will inform the annual work plan 2021/22.

Safe: Priority 2

Objective: Continue improving systems and processes through a learning framework to share and embed learning

Rationale:
Moorfields has a number of ways it shares learning such as clinical governance half days and quality and safety newsletters. We will ensure that ways to learn from patient safety incidents and other safety events are clearly defined and embedded in systems and processes, and clearly communicated to staff. This priority is a continuation from last year to ensure we continue developing systems to capture and disseminate learning across our organisation.

What success will look like by the end of March 2021:
LIFE hub will be available for review by all staff at all locations and populated with shared learning resources; Staff will be aware of the learning framework and will be able to provide examples of learning that has been shared with them;

All clinical divisions will have produced a minimum of 3 newsletters during a 12-month period;
Two 6-monthly thematic reviews of the findings from executive-led reviews will have been undertaken and the outcomes communicated to operational teams via divisional management teams.

What we will measure and when:

- Launch the learning framework across the organisation, for implementation by all staff at all locations (Q1)
- Develop the learning and improvement following events (LIFE) hub on the intranet, as a repository for shared learning and learning materials (LIFE hub) (Q1/Q2)
- Ensure that all clinical divisions routinely produce quarterly newsletters (Q1-Q4)
- Continue the annual programme of executive (listening, learning and sharing) walkabouts and develop the ways in which thematic feedback can be shared across the organisation (Q1-Q4)

Effective: Priority 3

Objective 3a: Further provision of reasonable adjustments to deliver person centred care by improving the use of helping hands stickers for vulnerable patients with additional support needs

Rationale:
Moorfields Eye Hospital currently has helping hands stickers available for patients with a learning disability or dementia who feel that they need additional support during their hospital visit. The stickers are not consistently used throughout the trust and the trust does not have a clear process regarding recording the support needs of the patient or what reasonable adjustments are required.
By reviewing and improving the helping hands process, we aim to deliver high quality care and an enhanced patient experience to those who need reasonable adjustments to the way that their care is delivered.

What success will look like by the end of March 2021:

- Consultation will have taken place on helping hands stickers with patient groups, and people with a learning disability or dementia.
- The trust will have a clear process and guidance in place to ensure the appropriate and consistent use of helping hands stickers.
- Staff throughout the trust will be familiar with the process through regular feedbacks and training. Staff will have discussions with patients with additional support needs regarding helping hands stickers, their individual support needs, and consent the patient to its use.
- All patient records with a helping hands sticker will have recorded the individual's needs and reasonable adjustments inside the patient record. This will state the reason for the sticker and what reasonable adjustments should be delivered

What we will measure and when:

- An information sticker to record individual need and reasonable adjustments inside patient records will have been developed and commissioned by Q2.

- All network sites and City Road services will have received updated helping hands guidance by Q3.

- The Learning Disability Policy and the Caring for Patients with Dementia Policy, and the respective policy summaries will have been updated to reflect the new guidance and communicated to staff by Q3.

- Changes to the guidance to be reflected within corporate induction, safeguarding champions training, and bespoke learning disability and dementia training by Q3.

- All patient records with a new helping hands sticker will have the individual's support needs and reasonable adjustments recorded and clearly identifiable by Q4.
- An audit to review the use of helping hands stickers and the new guidance will have been completed by Q4

Objective 3b: Improve patient care by embedding the use of the pain assessment tool for all patients who are known to have cognitive impairment and communication difficulties

Rationale:
Moorfields Eye Hospital currently does not have a generic pain assessment tool for patients with a cognitive impairment who are unable to communicate their pain to staff.

This was highlighted during the CQC inspection in November 2018 where it was raised that all individual pain needs may not have been met in the Bedford satellite site. To address this, the local team worked closely with the host trust to improve the care that was being provided for patients who are unable to communicate their pain needs.

Nationally there are a number of tools in use i.e.: Disdat tool and Abbey pain score. Due to the complexity of these tools, the Trust adapted the Abbey Pain tool and modified it to meet the needs of patients who attend Moorfields for surgery or treatment.

We aim to deliver high quality care and patient experience, ensuring that pain is assessed and managed appropriately for patients with a cognitive impairment who lack the ability to communicate.

What success will look like by the end of March 2021:
- A vulnerable patient pathway SOP including pain assessment for vulnerable patients will be available for all staff to use.
- The Trust will have a clear process and guidance in place to ensure the appropriate and consistent use of the pain tool.
- All staff involved in surgical pathways will have received training to enable them to use the pain tool to record and respond to individual pain needs.
- Staff throughout the trust will be familiar with the process.

What we will measure and when:
- A roll out plan for the use of the pain assessment tool across the networks and City Road by Q1
- Updating the Learning Disability Policy and the Caring for Patients with Dementia Policy will to reflect the new guidance and communicated to staff via "Moorfields News", divisional quality forums and "Safeguarding Newsletter" by Q1.
- Changes to the guidance to be reflected within bespoke learning disability and dementia training and regularly delivered to all staff involved in surgical care pathways to enable them to use the pain tool to record and respond to individual pain needs in Q1.
- Implementation and embedding use of the pain assessment tool will continue in Q2, Q3.
- An audit to review the use of the pain assessment tool across the organisation will be undertaken in Q3 and Q4.

Effective: Priority 4

Objective: Improve staff access to health and wellbeing initiatives and increase the number of staff using Moorfields Health & Wellbeing initiatives

Rationale:
At Moorfields we strive to provide staff with an environment that encourages and enables them to lead healthy lives and deliver an excellent and caring service to our patients.
A key objective of the Moorfields Workforce Strategy is 'to ensure that all staff are safe, healthy and supported in their wellbeing at work

What success will look like by the end of March 2021:

- Staff will have clear understanding and access to health and wellbeing initiatives
- There will be improved participation and staff survey results

What we will measure and when:

- Organising awareness sessions on current health and wellbeing issues such as the mental health, menopause, pensions etc. starting in Q1
- Explore introducing Health & Wellbeing champions and Mental Health First Aiders (with clear lines of responsibility) by Q2
- Introduce a clear platform/portal that staff can access health and well being offerings by the end of Q4
- Work towards London Healthy Workplace Award by Q4

Patient experience: priority 5

Objective: Improving the experience of our patients through improved customer care - Pilot at Private division

Rationale:
Moorfields is developing a customer care programme to deliver customer care excellence across the whole organisation. A programme is being developed in association with the Institute of Customer Services. A pilot will take place in Moorfields Private during 2020/2021 to transform team behaviours and working arrangements for teams to deliver outstanding customer care.

What success will look like by the end of March 2021:

- Customer Service benchmarks, both from the number of returns and quality KPI's to have been achieved in the In-Patient Satisfaction Survey
- Improved staff satisfaction from the 2019 staff survey through completion of actions within an agreed plan and subsequent increase in both the returns and scores in the 2020 staff survey
- A reduction in the average Moorfields Private staff turnover rates from 22.5% from December 2019 to come in line with the average Moorfields Eye Hospital of 14.5% in the same period.
- A further Survey in 2021 to include Benchmarked stakeholders (other Moorfields Eye Hospital staff, Patients and Consultant and Practice Managers) as well as another survey of Moorfields Private staff to understand whether the perception/experience shows whether we are providing better customer service

What we will measure and when:

- to obtain analysed baseline data about customer requirements through completion of questionnaires (Q1)
- develop and commence delivery of improvement plans (Q2&Q3)
- evaluation and prepare for roll out across NHS divisions (Q4)

Patient experience: Priority 6

Objective: Improve overall patient call response time to improve patient experience

Rationale:
Currently appointments and difficulties reaching Moorfields Eye Hospital via telephone is a recurrent theme captured through complaints and PALs enquiries. Improving the responsiveness of our service and the information we give to patients remains a key priority at Moorfields in order to improve the quality of our services.

What success will look like by the end of March 2021:

- Patients will except to wait no longer than 2 minutes to speak with a Moorfields staff member.
- Less patients will have to call the hospital as they will have clear information via a patient portal system and improved correspondence via letters and text messages.
- Improved coverage and monitoring of calls across the Trust through increased system coverage.
- Reduction in complaints and PALs enquiries about appointments.

What we will measure and when:

- Reduce the average call waiting time that a patient has to wait to speak to Moorfields Eye Hospital via the Booking/Contact Centre to 2 minutes (currently at 3 minutes) by Q3.
- Reduce the frequency with which calls to the booking centre are abandoned to from 20% to 15% by Q3.
- Increase the number of sites with a local call management system in place to six (currently only City Road) by Q4.
- Reduce the volume of calls into Booking Centre by 5% through introduction of a Patient Portal by Q4.

3.2 Key indicators for 2020/21

Moorfields Eye Hospital NHS Foundation trust monitors quality through a wide range of standards and indicators many of which support delivery of the quality priorities. These are all areas where we seek quality improvement to increase the benefits to our patients, either by improving experiences directly or by making processes more efficient and less onerous for staff and patients. There are also a number of indicators in the areas of safety that we have been tracking over a number of years and believe they should continue to be tracked as key indicators of our performance. The process for choosing our indicators include consultation with the board, divisions, our staff and other enablers such as CQC recommendations and feedback from our patients or external stakeholders. Please see table below for the indicators we have chosen moving forward in 2020-21.

It is to be noted that the performance indicators for 2019/20 have all been affected to some extent by the impact of the Covid-19 virus. However, for completeness, all KPIs reflect the full year position despite March data being a significant performance outlier in many instances.

Each of the indicators listed below was selected to provide comparable data over time but as previously identified the impact of Covid-19 is likely to distort that comparison. The targets set for 2020/21 may also change during the year as a result of recovery following the pandemic.

2020/21 local indicators

Indicator	Source	2017/18 result	2018/19 result	2019/2020 target	2019/20 result	2020/21 target
Patient experience						
Reduce patient journey times in glaucoma and medical retina	Internal (QSIS) programme	Indicator not in use	New=94 minutes Follow-up= 90 minutes	New=91 minutes Follow-up= 100	New = 126 minutes Follow Up = 105 minutes	New=91 minutes Follow-up= 100
Improve patient experience through digital patient check-in	Internal (QSIS) programme	Indicator not in use	Success will be measured from April onwards once use of kiosks are embedded.	60%	26.7%*	60%
Data completeness for clinic journey time (Total)	Internal (QSIS) programme	Indicator not in use	46.6%	80%	61.4%	80%
Data completeness for clinic journey time (Glaucoma)	Indicator not in use	Indicator not in use	59.9%	80%	75.5%	80%
Data completeness for clinic journey time (MR)	Indicator not in use	Indicator not in use	55.2%	80%	64.6%	80%
Reduce the % of patients that do not attend (DNA) their first appointment	Internal performance monitoring	12.3%	11.6%	≤10%	11.8%	≤10%
Reduce the % of patients that do not attend (DNA) their follow up appointment	Internal performance monitoring	Indicator not in use	10.4%	≤10%	10.5%	≤10%
% of patients whose journey time through the A&E department was three hours or less**	Internal performance monitoring	78.4%	76.6%	≥80%	75.5%	≥80%
Theatre sessions starting late	Internal performance monitoring	Indicator not in use	33.8%	≤33.8%	32.0%	32.0%
Theatre cancellation rate (overall)	Internal performance monitoring	Indicator not in use	7.1%	≤7%	6.8%	≤7%
Theatre cancellation	Internal	Indicator	0.8%	≤0.8%	0.76%	

Indicator	Source	2017/18 result	2018/19 result	2019/2020 target	2019/20 result	2020/21 target
rate (non-medical cancellations)	performance monitoring	not in use				≤0.8%
Number of outpatient appointments subject to hospital initiated cancellations (medical and non-medical)	Internal performance monitoring	2.9%	3.52	≤3%	4.58%	≤3%
Patient safety						
% overall compliance with environmental cleanliness	Internal performance monitoring	99.6%	99.5%	≥95%	99.6%	≥95%
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	99.6%	99.5%	95%	99.6%	95%
% overall compliance with hand hygiene standards	Internal performance monitoring	95.7%	99%	≥95%	99%	≥95%
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0	0	0	0
Number of reportable clostridium difficile cases	Number of reportable clostridium difficile cases	0	0	0	0	0
Incidence of presumed endophthalmitis per 1,000 cataract cases	Internal performance monitoring	0.22	0.35	≤0.6	0.16 (To Dec 2019	≤0.6
Incidence of presumed endophthalmitis per 1,000 intravitreal injections for AMD	Internal performance monitoring	≤0.15	0.17	≤0.5	0.10 (To Dec 2019)	≤0.5
Incidence of presumed endophthalmitis per 1,000 Glaucoma cases	Internal performance monitoring	N/A	N/A	≤1	0.48 (To Dec 2019)	≤1 (MR review at end of year)
Incidence of presumed endophthalmitis per	Internal performance monitoring	N/A	0.22	0.6	0.58	0.6

Indicator	Source	2017/18 result	2018/19 result	2019/2020 target	2019/20 result	2020/21 target
1,000 Vitrectomy cases						
Incidence of presumed endophthalmitis per 1,000 EK Corneal Graft cases	Internal performance monitoring	N/A	2.58	3.6	0	3.6
Incidence of presumed endophthalmitis per 1,000 PK Corneal Graft cases	Internal performance monitoring	N/A	0.0	1.6	0	1.6
Number of Serious incidents (SIs) open after 60 days	Internal performance monitoring	N/A	N/A	0	0	0
Clinical Effectiveness						
% implementation of NICE guidance	Internal performance monitoring	98.7%	95.7%	≥95%	100%	≥95%
Posterior capsule rupture rate for cataract surgery	Internal performance monitoring	0.99%	1.13%	≤1.95%	0.85%	≤1.6
Number of breached policies	Internal performance monitoring	N/A	N/A	≤10%	6%	≤10%

* This is linked with the impact of COVID 19 leading to the trust only operating on an emergency model
** A late start being a session that started more than 15 minutes later than the planned start time.

Part 3 Other information including Statements from commissioners, local Health Watch organisations and overview and scrutiny committees

The Health and Care Scrutiny Committee

“Due to the impact of COVID 19 pandemic, the Health and Care Scrutiny Committee have not met to consider and comment on Moorfields 2019/20 Quality Account”.

Peter Moore,

The Heath and care scrutiny committee

Heathwatch Islington commented as follows:

Although we have not visited Moorfields in 2019-20, we did feed in to their consultation on possible new hospital site for City Road. The consultation was clear and engaging and we look forward to working with Moorfields on ensuring that the views of residents, patients and carers continue to feed in to these developments.

Emma Whitby, Chief Executive, Healthwatch Islington.

NHS Islington CCG commented as follows:

NHS Islington Clinical Commissioning Group

To be added following Board sign off

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20*
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period 1st April 2019 to 31st March 2020
    - papers relating to quality reported to the board over the period 1st April 2019 to 31st March 2020
    - feedback from commissioners dated 29th June 2020
    - feedback from governors received 4th June 2020

- feedback from local Health watch organisations dated 25th June 2020
- feedback from the Health and Care Scrutiny Committee dated 27th May 2020
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 9th July 2019.
- the 2019 national staff survey 18th February 2020
- CQC inspection reports dated 12th March 2019.

- the quality report represents a balanced picture of the NHS foundation trust's performance over the period covered.
- the performance information reported in the quality report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measure of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS improvement's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board,

Date Chairman

Date Chief Executive

Limited assurance statement from external auditors

Latest guidance from NHS Improvement NHS England within FT Annual reporting manual 2019/20 which was published in April 2020 confirms below:

" *following the expectation for quality accounts, there is no requirement for a foundation trust to prepare a quality report and include it in its annual report for 2019/20. There is no requirement for a foundation trust to commission external assurance on its quality report for 2019/20".*

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 09

Learning from deaths

Board of directors 23 July 2020

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

Executive summary

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

The trust has identified 0 patient deaths in Q1 that fall within the scope of the learning from deaths policy. The Serious Incident (SI) investigation into the death that occurred during Q3 2019/20 has been completed and the report has been shared with the next of kin.

Quality implications

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

Financial implications

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

Risk implications

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

Action Required/Recommendation

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

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

Learning from deaths Board paper

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

The Q1 2020/21 data, as at 6 July 2020, is shown in table 1 below.

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

Table 1

*Completion of the investigation and the SJR in respect of this patient is on-going.

Learning and improvement opportunities identified during Q1

- The investigation into the one death that occurred during Q3 was concluded during Q1, following application of an extension due to the onset of the COVID-19 pandemic. The report concluded that there was not a robust process within the neuro-ophthalmology service for ensuring that requests for imaging are transferred to the radiology department. At the time of this incident the process was solely reliant on a paper imaging request form being delivered to the radiology department by the patient, who will possibly be sight-impaired. An interim process has been agreed, supported by a documented standard operating procedure, pending the completion of a comprehensive review of the process which will consider the introduction of an electronic solution. The learning was identified as follows:
    - Where electronic systems do not exist for the requesting, recording and subsequent review of imaging, it is essential that there are robust, auditable administrative processes in place to ensure that information and activity is not overlooked;
    - Details of all diagnostic tests (e.g. bloods, imaging) requested must be communicated in a letter to the patient and to the GP. This will also make it available, on OpenEyes or in Medisoft, for review by all other clinicians and administrative staff.

Medical examiner role (update)

A national medical examiner update publication was released by NHS Improvement in June 2020. https://improvement.nhs.uk/documents/6638/June_2020_NME_bulletin.pdf

Annex 1

Included within the scope of this Policy:

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

Excluded from the scope of this Policy:

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

Moorfields Eye Hospital NHS Foundation Trust

NHS

Agenda item 10
Report of the audit and risk committee
Board of directors 23 July 2020

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

Brief summary of report Attached is a brief summary of the audit and risk committee meeting that took place on 7 July 2020							
Action Required/Recommendation. Board is asked to note the report of the audit and risk committee and gain assurance from it.							
For Assurance	✓	**For decision**		**For discussion**		**To note**	

AUDIT AND RISK COMMITTEE SUMMARY REPORT – 7 JULY 2020	
Governance	• Quorate – Yes • Attendance (membership) - 100%
Current activity (as at date of meeting)	***Matters arising – consultant job planning*** • The trust is able to use the current system for electronic job planning and adapt the system to use the sessional approach. • The policy has been updated and brought it into line with best practice to make sure it is consistent and transparent. • The intention is to implement team level job planning in order to understand what activity and work needs to be done by the division and service which can then feed in to individual job plans. • Job planning workshops are being planned for September and the plan is to get current job plans on to Allocate by September. • The committee was pleased with the progress made and will receive an update in October. ***Security management report*** • All trusts have to take responsibility for their own security measures as they relate to property, assets and staff rather than IT or IG. • The trust has in place a security management director (Kieran McDaid) and NED responsible for security (NH as chair of the audit committee). • The committee was taken through the key roles and responsibilities of the Local Security Management Specialist as they relate to staff, facilities management, site visits and liaison with external agencies. • There have been 287 incident reports recorded under the security heading although not always security related. • 19 yellow card warnings have been issued and two patients excluded from the trust. • In relation to host trusts, the host trust security team provides on site support through an SLA. • In relation to access controls the trust has put in place much stronger measures following Covid. ***Internal audit*** • Three terms of reference have been issued this week. • In relation to the cultural review, workshops had been scheduled pre-Covid and we would want to stand those back up if the appropriate technology is in place. • A programme of audits is being set up around Covid pathways. ***Board assurance framework*** • The Oriel risk has been increased due to a number of factors relating to Covid that have had an impact although there is sufficient agreed budget to continue joint working through until January. • Four key areas of the programme are to be progressed; planning application, JDV, sale of City Road and contractor procurement. • Commercial activity risk – key issue is the pace for recovery for both UK private and UAE operations. • The financial risk has changed from the previous method of operating on a PbR basis and now operating within affordability envelopes and the change to the external environment in which we are operating.

	• The risk on staff engagement has been amended to take into account the need for a much closer focus on staff health and wellbeing, both during the pandemic and post-pandemic. • The committee agreed that it is possible to separate those risks that are outside trust control and those where the trust can have a direct impact. However the challenge is that all the risks are interconnected in some way. ***Counter fraud report*** • Work for the next quarter will include the cyber fraud review. • A summary document that sets out the changes to the counter fraud, corruption and bribery policy was approved. • Cyber fraud – there are principles within the standards for providers about issues such as how you assess risk and raise awareness as well as take principles and apply them to the broader risk. There has been a huge spike in incidences of cyber fraud and cyber crime as the workforce operates in a different way, adapting to processes and controls. ***Terms of reference and work plan*** • There are a number of changes that have been agreed in the last few months which include more on the BAF and deep dives on specific areas and post event reviews. • Programme for deep dives would be cyber security at the next meeting and R&D in January. A programme of deep dives will be mapped out. • Discussion took place about clinical audit and whether the committee need to look at the way clinical audit is organised as an additional piece of annual assurance.
Key concerns	• No significant concerns raised
Items for discussion outside of committee	• It was agreed that CIP risks should still be on the BAF in light of the need to ask questions as to how we can keep up quality standards and maintain the way our pathways work.
Date of next meeting	• 6 October 2020