Moorfields Eye Hospital NHS
NHS Foundation Trust

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Annual Report and Accounts 2013/14

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Contents

1 Chairman's foreword

It is a great pleasure to be able to introduce the 2013/14 annual report and accounts for Moorfields Eye Hospital NHS Foundation Trust, which this year completed 10 years as a foundation trust.

Once again, Moorfields achieved a great deal in the past financial year. Patient attendances rose again, with increases both at our main hospital in London's City Road and in our various satellite locations in and around the capital. Our satellite network itself continues to grow, with work completed during the year to allow us to start running two new services in the Croydon area from 1 April 2014. This is important, not only to ensure that the local population has easy access to high quality eye care, but strategically as it extends Moorfields' reach into a new part of Greater London.

To support the growing numbers of patients, we introduced several new services and increased the number of key senior clinical appointments during the year. These included a new service to treat diabetic macular oedema with intravitreal injections and a nurse-led approach to collagen cross-linking treatment for keratoconus, a progressive condition that affects the shape of the cornea and predominantly affects younger people.

Financially, we performed very well, returning a surplus of £9.3 million, well ahead of that planned at the start of the year. It is important to note that, as an NHS foundation trust, we can reinvest this surplus in improvements for all our patients. Such improvements this year included a thorough refurbishment of our ever-busier ophthalmic A&E and our orthoptics department, as well as the start of work to enhance the environment at our satellite centre at Ealing Hospital.

Surpluses are also important as investments for the future, as we continue with plans to relocate our main hospital to the King's Cross/Euston area and integrate clinical services more comprehensively and coherently with the complementary research activity undertaken by our partners at the UCL Institute of Ophthalmology. A lot of important groundwork took place on this project during 2013/14, including the development of a design brief for the new building and the completion of a 12-week engagement programme to gather views from a wide section of our patients and other stakeholders.

Our commercial divisions – Moorfields Pharmaceuticals, Moorfields Private and, increasingly, Moorfields Eye Hospital Dubai – collectively make an important contribution to our financial health, and Moorfields Private in particular performed well again this year, despite the challenging financial climate.

Donations to our affiliated charities also provide vital financial support, and I am very grateful to everyone involved in our fundraising activities for their continued support, both now and in the future, when philanthropic giving will be increasingly important. We also recognise the generosity of all those who give to the hospital's affiliated charities.

The year has not been without its challenges. It is particularly disappointing that we failed to meet targets for referral-to-treatment times in the final quarter of 2013/14. I am, however, confident that the great efforts that have been made to understand the factors impacting on our performance in

this area, and the steps being taken to address them, will bear fruit shortly and that our previous strong record will rapidly be restored.

There also remains a good deal of work to do to reduce the amount of time that patients wait once they arrive for appointments in our clinics and to improve our surgical pathways. We continue to make progress, as detailed in this annual report, but have much further to go to transform this area of our operations, and meet the higher expectations of our patients.

Continuing to improve our services while responding to the growth in demand is a key challenge both for our board and our foundation trust governors. In the latter group, I am pleased formally to welcome Bernard Dolan and Allan MacCarthy to our membership council, representing residents of South East and South West London. On the trust board, I am also delighted that we were joined this year by a new chief operating officer, Mary Sherry, and a new non-executive director, Sumita Sinha. Steven Davies, who has been with us for several years, also joined the board as a non-voting member following his appointment to a new role as NHS finance director and deputy chief financial officer. All of these people bring with them a wealth of knowledge and experience which will be invaluable to our continued success in future.

I would also like to thank our former chief operating officer Ruth Russell, who retired during the year, for her sterling work with us over almost five years. She will be a hard act to follow.

The hospital was very proud to learn from the 2013 Queen's birthday honours list that our director of research and development, Professor Sir Peng Tee Khaw, was knighted for services to ophthalmology. Peng is without doubt one of the foremost ophthalmic surgeons and clinician scientists of his generation, and this external recognition is richly deserved.

Finally, on behalf of the board, I offer very warm thanks to all our staff. I say it every year, but they genuinely are our greatest asset and their continued commitment is crucial to ensuring that Moorfields remains where it should be – at the forefront of eye treatment, research and education in the best interests of our patients, and recognised by our patients for the quality of care we provide.

Rudy Markham, chairman

2 Strategic report

2.1 About Moorfields

2.1.1 Who we are

Moorfields Eye Hospital NHS Foundation Trust is the leading provider of eye health services in the UK and a world-class centre of excellence for ophthalmic research and education. We have a reputation, developed over two centuries, for providing the highest quality of ophthalmic care. Our 1,800 staff are committed to sustaining and building on our pioneering legacy and ensuring we remain at the cutting edge of developments in ophthalmology.

We were one of the first NHS organisations to become a foundation trust in 2004 and are founder members of UCL Partners, one of the UK's first academic health science centres. With our partners at the UCL Institute of Ophthalmology, we are members of Vision 2020, an organisation committed to raising public awareness of blindness and vision impairment as major public health issues.

Moorfields is registered without conditions with the Care Quality Commission (CQC), the independent regulator of health and social care in England.

2.1.2 What we do

Our mission is to be the leading international centre in the care and treatment of people with eye disorders, driven by excellence in research and education. This is supported by a set of values, which build on those in the NHS constitution, but also reflect Moorfields' particular philosophy:

- We strive to give people the best possible visual health so that they can live their lives to the full
- We put patients at the centre of everything we do by treating everyone with respect and compassion
- We undertake to use our resources effectively and efficiently to provide high-quality care
- We seek to build on our pioneering legacy by leading innovations in eye health
- We recognise the worth of our staff by providing rewarding careers and supporting personal and professional development
- We aim to provide seamless care through professional teamworking and strong, innovative partnerships
- We are committed to acting responsibly and being held accountable for all we do

Our main focus is the treatment and care of NHS patients with a wide range of eye problems, from common complaints to rare conditions that require treatment not available elsewhere in the UK.

Our patient services are sub-divided into four clinical directorates, as follows.

Outpatient and diagnostic services

The outpatient and diagnostic services directorate comprises all outpatient services at City Road, clinical support services, our specialist A&E department, the clinical sub-specialties focused on paediatric and emergency care and chronic disease management, and a general ophthalmology service. The directorate is also responsible for our joint working arrangements with Barts Health and Great Ormond Street Hospital for Children.

Surgical services

The surgical services directorate comprises all elements of the surgical pathway at City Road, as well as the theatre and recovery staffing and facilities at the majority of our satellites. It also includes the medical secretariat and the records library, and the clinical sub-specialties focused principally on the surgical pathway.

Moorfields South

Moorfields South centres on our district hub at St George's Hospital in Tooting and encompasses responsibility for the management of all our other satellite locations in south-west London, including our new services in Croydon.

Moorfields North

Moorfields North covers our three district hubs to the north of the river (Bedford, Ealing and Northwick Park hospitals) and the satellite locations that support them, along with the smaller satellite sites that make up Moorfields East (Barking, Harlow, Homerton, Mile End and St Ann's).

Our unique patient case-mix and the number of people we treat mean that our clinicians have expertise in discrete ophthalmic sub-specialties as listed below.

Clinical service	What it does
Accident and emergency	Treats urgent eye problems, 24 hours a day, seven days a week
Adnexal	For treatments for the accessories or anatomical parts attached to the eyeball, such as the eyelids, extraocular muscles, orbit and tear glands
Cataract	A common eye condition, in which the lens becomes progressively opaque, resulting in blurred vision
External disease and corneal	For conditions related to the outside of the eyeball, including the cornea, iris and sclera (the tough outer layer of the eye), especially infective, allergic and auto-immune eye conditions and those requiring corneal grafts to improve vision
General ophthalmology (formerly primary care)	Treatment for general eye problems, including those that might need referral to one of our more specialist services
Glaucoma	For treatments for the signs and symptoms of this common condition, including increased pressure in the eyeball, which can cause gradual loss of sight if left untreated
Medical retina	Provides medical treatments for conditions at the back of the eye, using drugs, eye drops or lasers, and including diabetic screening and age-related macular degeneration (AMD), an increasingly common eye condition, especially among older people, in which central vision gradually worsens

Clinical service	What it does
Ocular oncology	Treats cancers of the eye; provided by Barts Health NHS Trust
Paediatrics	Services for children's eye conditions, including those provided jointly with Great Ormond Street Hospital for Children NHS Foundation Trust and others
Refractive	For the treatment of refractive errors using precision lasers
Strabismus and neuro-ophthlamology	Treats squints and visual problems related to the nervous system
Vitreo-retinal	Provides treatments for conditions at the back of the eye that require surgical interventions, including retinal detachments

We also have service directors for anaesthetics and for theatres, providing clinical leadership in these important areas.

In addition, we provide a range of specialist clinical support services, including:

- Electrodiagnostics
- Eye bank, which stores tissue for transplantation
- Medical imaging
- Ocular prosthetics
- Orthoptics
- Optometry, including medical contact lens, refraction, low-vision aid and spectacle dispensing services
- Pathology (provided by the UCL Institute of Ophthalmology)
- Pharmacy
- Radiology and ultrasound

We are a postgraduate teaching centre and a national centre for ophthalmic research involving, with the UCL Institute of Ophthalmology, one of the largest ophthalmic research programmes in the world. We also manage three commercial divisions: Moorfields Private, Moorfields Pharmaceuticals and Moorfields Eye Hospital Dubai. This year, we established a new entity, MEH Ventures, a vehicle through which we intend to channel and conduct our future commercial activities.

2.1.3 Where we work

We treat people at our main hospital in London's City Road and in 20 locations in and around the capital, which enables us to provide expert treatment closer to patients' homes. These satellite services are organised into four main categories as set out below.

District hubs

Co-located with general hospital services, our district hubs provide comprehensive outpatient and diagnostic care as well as more complex eye surgery and will increasingly serve as local centres for eye research and multidisciplinary ophthalmic education. Moorfields runs district hubs in the following locations:

- Bedford Hospital
- Croydon University Hospital (from 1 April 2014)

- Ealing Hospital
- Northwick Park Hospital, Harrow
- St George's Hospital, Tooting

Local surgical centres

These centres provide more complex outpatient and diagnostic services alongside day-case surgery for the local area and can be found in the following locations:

- Mile End Hospital, Whitechapel
- Potters Bar Community Hospital
- Queen Mary's Hospital, Roehampton
- St Ann's Hospital, Tottenham

Community-based outpatient clinics

These clinics focus predominantly on outpatient and diagnostic services in community-based locations closer to patients' homes. Moorfields runs such clinics in the following locations:

- Barking Community Hospital
- Bedford Enhanced Services Centre (North Wing)
- Bridge Lane Health Centre, Battersea
- Loxford Polyclinic, Redbridge
- Purley War Memorial Hospital (from 1 April 2014)
- Teddington Memorial Hospital

Partnerships and networks

In this model, Moorfields offers medical and professional support and joint working to eye services managed by other organisations. We have partnership arrangements with the following organisations:

- Croydon Health Services NHS Trust, based in Croydon University Hospital (until 31 March 2014)
- Homerton University Hospital NHS Foundation Trust, based in Homerton Hospital in Hackney
- The Princess Alexandra NHS Trust, based in Princess Alexandra Hospital in Harlow
- West Hertfordshire Hospitals NHS Trust, based in Watford General Hospital
- Harrow Health Ltd, a company formed by local GPs, based in the Visioncare eye medical centre in Wealdstone
- Direct Local Health (DLH), a local practice-based commissioning group, based in Boots Opticians in the Harlequin shopping centre in Watford

We also provide clinical leadership to various diabetic retinopathy screening services and to networks across London that deal with retinopathy of prematurity, an eye condition that affects premature babies.

2.2 The strategic context

2.2.1 Our Vision of Excellence

Our Vision of Excellence, a 10-year strategy for Moorfields published in September 2010, provides the framework for our annual planning processes. Since its initial publication, we have merged two of the five enabling themes into one – our people – and now have four strategic and four enabling themes as set out below.

Vision

The strategy sets out a vision of where we want to achieve by 2020:

- Providing a comprehensive range of eye care services, operating through a network of centres linked to a state-of-the-art facility in central London
- Shaping the development and delivery of the eye health agenda nationally
- Known for providing the highest standards of patient experience, outcomes and safety across all of our sites
- At the forefront of international research with our partners
- Maintaining our leading role in the training and education of eye care clinicians

Strategic themes

- **What we do:** how Moorfields' service portfolio will evolve
  Moorfields will remain the leading provider of specialist ophthalmic care nationally, but should also aim to become a leader in community-based eye services. We will also continue to be at the forefront of research and education in ophthalmology.
- **Where we work:** how our geographical reach will develop
  Moorfields will provide services through a structured network of facilities across London and the south east, supported by a state-of-the art centre in London, which will be the focus for our most specialist and complex clinical services.
- **Our reputation and quality:** how we will ensure quality is the defining characteristic of all we do
  Wherever patients use our services, Moorfields will be the safest place to have ophthalmic treatment, the provider with the best outcomes for routine and specialist treatments, and be known for offering an excellent patient experience. We want Moorfields to provide training set apart by its high quality, and research that continues to be world leading.
- **Our role and influence:** the part we will play as the market leader in eye care
  We will seek to retain our autonomy and identity, and use our knowledge, skills and experience to help shape, rather than simply respond to, the ophthalmic agenda.

Enabling themes

- **Improving our estate and facilities:** we will redevelop our facilities to provide a central London hospital and local services in accommodation that is fit for the 21st century and provides a consistently excellent patient environment.
- **Increasing our productivity and efficiency:** we will develop and implement a programme to maximise productivity and efficiency in all our clinical and non-clinical services.

- **Our people:** we will recruit, retain, develop and reward the best staff.
- **Improving our IT and information:** we will put in place the IT and information so that we understand what we do and how well we do it, and maximise the potential of technology to reduce our cost base and improve the care we give.

2.2.2 Priorities for the year

Our annual plan for 2013/14 continued to use the strategic and enabling themes of *Our Vision of Excellence* as the framework for the year's strategic priorities. These priorities did not include issues that had become business as usual.

Our priorities for 2013/14 were as follows:

What we do: how our portfolio will evolve

- Business development – seek further growth in a sustainable manner
- Commercial business development – use the opportunities available with the changes to the private patient cap to exploit the brand and our expertise to generate new areas of business
- Research and development – implement our joint R&D strategy with the UCL Institute of Ophthalmology to ensure that we maintain our world-leading status and maximise translational research opportunities and income generation
- Education – focus effort on developing the components of an education strategy that produce the most impact in 2013/14, and then go on to shape the wider strategic issues

Where we work: how our geographical reach will develop

- NHS service development – respond to the requirements of our patients and commissioners, and rebalance NHS activity in line with our strategic direction, optimising our capacity and efficiency
- International business – continue to develop our international business through profitable expansion of our activities in the UAE and exploration of other opportunities as they arise

Our quality and reputation: how we will ensure quality is the defining characteristic of all we do

- Quality – continue to maintain high standards of clinical quality, and demonstrate our excellence by providing our clinicians, patients, commissioners and other stakeholders with regular, up-to-date information on the success of most of our interventions
- Patient experience – maintain our commitment to improving our patients' experience, focusing on the areas that they tell us are important

Our role and influence: the part we play as the market leader in eye care

- Communications – implement the external communications and engagement strategy to improve our specialist standing, public profile and brand recognition so that we are known for being the 'best'
- Influencing – enhance our ability to capture and track existing activity, and develop supportive new relationships in key areas

Improving our estate and facilities

- New hospital project – continue with the planning for the replacement of the City Road hospital, to provide an improved patient experience, by finalising the location for the new hospital and completing the business case for investment

- Satellite locations – further refine our networked model, and ensure that our satellites are able to provide our rebalanced clinical activities

Increasing our productivity and efficiency

- Transformation – change the way we work to provide the most effective and efficient services
- Technology – lead the field in the translation of medical technology research into clinical practice, ensuring that we deliver services in the most efficient manner
- Efficiencies – deliver the financial efficiencies and income growth required to maintain our financial risk rating and planned surplus levels

Our people: recruiting, retaining, developing and rewarding the best staff

- Clinical leadership – engage all staff fully in the implementation of our vision and support them, through development, technology, and clear incentives, including reward, to provide the highest quality of care for our patients, and be as productive as they can be
- Staff engagement – develop and implement an internal, two-way communications strategy, and a well-being strategy, to provide an engaged workforce that hears consistent messages about efficiencies, our strategy, and our new hospital, and is sufficiently informed to contribute to the debate

Improving our IT and information

- OpenEyes – continue to develop and implement our bespoke electronic patient record (EPR) system and maximise its impact internally and across the ophthalmic world
- IT infrastructure – modernise our IT systems and infrastructure to support the provision of clinical services

For each of our priorities, we agreed objectives and action plans and monitored progress against them through quarterly reports to the board throughout 2013/14.

Our performance across all the priorities has generally been good, with significant achievements being made across a broad and ambitious range of objectives. This annual report, including the quality report at appendix 1, contains many examples of the progress we made against these priorities.

2.3 Performance and business review

2.3.1 Patient activity

Moorfields provides care in a variety of settings, either via contracts with commissioners, where we charge directly for our activity, or through partnerships where another party charges the commissioner for the work we provide. An example of the latter is at Bedford Hospital, where we provide the ophthalmology service, but do not directly charge the local commissioners; similarly, we have a number of joint medical appointments providing support to the ophthalmology service at the Princess Alexandra Hospital in Harlow where we charge the hospital for the work our consultants undertake. We are also increasingly providing services closer to patients' homes under the community services contract.

The total NHS care provided by Moorfields grew across all settings in 2013/14 as shown in the table overleaf.

Activity	2013/14	2012/13*	% change
Total outpatient attendances	432,197	**404,932	+ 6.7%
A&E attendances	88,208	82,435	+ 7.0%
Total inpatient and day-case admissions	33,405	31,248	+ 6.9%

*Figures differ to those stated in the annual report and accounts 2012/13 as final figures ('freeze' position) were not available as the report went to press; figures for 2013/14 are also likely to change slightly once frozen for the same reason.

**In addition to the 'freeze position' adjustment, this figure is also different as it now includes activity undertaken through community contracts, which were not included in last year's figures, but excludes optometry and orthoptic activity previously included (see commentary) to allow for a like-for-like comparison against this year's figures.

These figures cover all activity where we are clinically responsible for an entire service, not just those for which we are directly contracted. They include around 16,500 intravitreal injections and 9,000 laser treatments, which are provided in a variety of settings, and are classified either as outpatient or inpatient activity according to the local service model.

In addition to these figures, there were 44,772 optometry and orthoptic attendances during 2013/14; these have not been included in the total figure for outpatients as we charged for these appointments only for the final quarter of 2012/13, and their inclusion would have artificially inflated the overall percentage growth.

Despite the increased activity, we maintained a high standard against the majority of internal and external targets during the year, although we did not meet the 18-week referral to treatment target in the last quarter. Details of our performance against these standards can be found in our quality report at appendix 1.

2.3.2 Clinical care developments

We continued to invest in new staff and services to respond both to increased demand for our services and to new developments in eye care. This section provides a snapshot of a few of these developments during 2013/14.

New service for diabetic macular oedema

We started a new service in June 2013 to treat diabetic macular oedema (DMO), a complication of diabetes and one of the largest causes of certifiable blindness in patients of working age. The new service followed approval by the National Institute for Health and Care Excellence (NICE) in February 2013 of ranibizumab, more commonly known by its brand name of Lucentis, as an NHS treatment for DMO. Lucentis, already licensed to treat age-related macular degeneration (AMD), is injected directly into the eye and improves visual acuity for 50% of DMO patients, compared to just 20% using laser therapy, previously the only available treatment for the condition.

The new service has been introduced initially in five of our locations where we already provide intravitreal injection services for AMD patients – City Road, Ealing, Northwick Park, Bedford and St George's – but we will look at expanding it further once it is established on those sites.

The investment in the new service included the introduction of a new diabetic nurse specialist role to provide health promotion and education for diabetic patients, whom we treat in significant numbers, as well as to offer assessment, triage and clinical decisions regarding diabetic retinopathy.

Enhanced nurse-led intra-vitreal injection service

We have 15 nurses specially trained to provide injections, with a further 15 in training, who work across all locations where we offer intra-vitreal injections for age-related macular degeneration (AMD).

These nurses provide between one and three injection sessions per week, creating much needed additional capacity, especially now that we also offer injections for DMO (see above).

Importantly, the Royal College of Ophthalmologists revised its guidance on the use of healthcare practitioners who are not doctors to undertake intra-ocular injections in May 2013. The College now considers it acceptable for non-medical healthcare practitioners to administer anti-VEGF agents (the drugs used to treat AMD and DMO) as long as certain stipulations are met. This change was the result not only of increasing demand for these treatments, but also because of the evidence provided by Moorfields and others that it is safe to allow appropriately trained clinicians other than doctors to undertake this procedure.

Our leadership of the nurse-led injection initiative has attracted a great deal of international interest and, under the auspices of the European Association of Eye Hospitals, we received a delegation from Rotterdam Eye Hospital and the ophthalmology department of University Hospitals Leuven during the year to learn about our AMD clinical pathway and the role of the nurse injector. The initiative was also shortlisted for a Guardian Healthcare Innovation award for 2013.

Extra capacity for corneal collagen cross-linking treatment

One of our clinical nurse specialists became the first nurse in the UK to perform collagen cross-linking (CXL), following extensive training during 2013. CXL is an effective treatment to halt disease progression in patients with keratoconus, a progressive condition that affects the shape of the cornea. The introduction of a nurse-led approach to the treatment follows increased demand for this service, which was introduced at Moorfields in May 2012 for NHS patients. Additional nurses are now being trained to perform the procedure in future.

Additional consultant resource

We expanded our consultant capacity during 2013/14, creating new posts or enhancing existing roles to support our paediatric, vitreo-retinal, neuro-ophthalmology, medical retina and general ophthalmology services. We also appointed five further new consultants during the year, all of whom have confirmed start dates in the first half of 2014/15. The majority of these new roles are predominantly to support our new eye centre in Croydon, and provide additional capacity in our adnexal, corneal and glaucoma services. They also include a joint post for our adnexal and A&E services to boost consultant cover in A&E and allow the development of a new outpatient and surgical adnexal service at our St Ann's and Northwick Park satellite locations.

Dedicated cancer nurse specialist

We created a new cancer nurse specialist role to support our specialist lid oncology service, which reviews and treats skin cancers around the eyes for patients from a wide geographical area. The new post is an essential part of the multi-disciplinary team for lid oncology, which we run in conjunction with Guy's and St Thomas' NHS Foundation Trust, and provides several benefits, including a better patient experience and compliance with national cancer peer review mandatory requirements and with National Institute for Health and Care Excellence (NICE) guidance.

New pharmacy services

We opened new pharmacies at our eye centres in Northwick Park and St George's hospitals. Both improve the patient experience by providing a more convenient service dispensing specialist medicines to our patients, which prevents them from having to visit chemists elsewhere for their prescriptions. The new pharmacies also ensure a steady supply of medicine stocks for the services provided in the two satellite locations. A third satellite pharmacy is located in our eye centre at Ealing Hospital. We also extended the opening hours for our main pharmacy in the City Road hospital later into the evening and on Saturdays to provide a more convenient service for patients.

2.3.3 Quality and safety initiatives

Quality and safety are central to *Our Vision of Excellence*, our 10-year strategy, and are covered in greater detail in our quality report at appendix 1. We also publish a quality performance review twice a year. This provides a complete overview of all clinical quality and safety data for each quarter, ensuring a joined up approach to tackling any safety issues, and offering assurance as to the overall quality and safety of our care. In addition, we produce more detailed reports every six months on clinical audit and effectiveness, patient safety and patient experience.

Much of our work around quality and safety this year has been informed by the work undertaken in 2012/13 to create an action plan to address the recommendations of the Francis report into events at Mid Staffordshire NHS Foundation Trust. Relevant themes were identified and were linked to existing priorities.

We are currently graded at band 6 in the Care Quality Commission's (CQC) intelligent monitoring system, introduced in October 2013. Under the new system, all NHS trusts are grouped into one of six priority bands for inspection, based on the likelihood that people might not be receiving safe, effective and high quality care. Band 1 contains the highest priority trusts and band 6 the lowest.

In addition, reports received during the year on visits by the CQC to our main City Road hospital and to our eye centres at Ealing and Northwick Park hospitals found us to be fully compliant with the relevant standards.

The section below highlights just a few examples of how we have sought to improve quality and safety for our patients during 2013/14.

Waiting times

We know that many of our patients continue to wait for too long once they arrive for appointments. Although we have undertaken a good deal of work to address this issue, there is much more to do. Work this year has focused not just on improving processes to ensure that patients are seen more quickly, but also on the provision of better information so that patients are given reasons for any long waits.

We introduced a new way of working in some of our glaucoma clinics at our main hospital in City Road based on the findings of an earlier pilot in our eye centre at St George's Hospital, Tooting. This includes ensuring that clinics start and finish 'clean', which involves having everything ready to start clinics on time and tidying everything up at the end of the day, and ensuring that patients are seen and treated by a single professional, instead of several different members of staff. We also worked on the development of technician roles and the expansion of the nursing role to accommodate education and patient information duties in glaucoma clinics.

In addition, we ran a pilot for a virtual glaucoma service at City Road, in which patients undergo diagnostic imaging in a dedicated facility separate from the consultant-led glaucoma clinic. These images and other biometry are then reviewed remotely by a consultant and a decision taken on the best clinical management plan for the patient. The service is currently provided to patients new to the glaucoma service and a limited number of suitable stable patients. We plan to review the new system in summer 2014, with a view to adopting it in other areas.

To ensure that patients receive better information about waiting times and the reasons behind them, we have provided further guidance to clinic reception staff about the importance of updating the clinic status white boards, refreshing patient information screens and talking to patients about waiting times and delays, without waiting to be asked.

In A&E, we installed screens to display real-time information about waiting times, introduced a more organised and user-friendly patient queuing system, and introduced a 'meet and greet' desk to help patients navigate the department and to provide information.

For patients having an operation, we created a new patient pathway co-ordinator role to improve communication and the transfer of patients between wards and theatres, and introduced administrative resource to the pre-assessment department to enable nurses to focus on nursing duties and patient care. In addition, a pharmacist is now present on wards to dispense medication directly to patients, reducing the time they have to spend in hospital after their operation and enabling them to ask any questions about their medication.

Telephone communications

We completed a scoping exercise in September 2013 to consider in detail the common themes highlighted in patient feedback, with a view to improving our existing telephone call handling arrangements. At present, many patients tell us that they have difficulty getting through to us in the first place and that, when they do, we are not good at answering or returning calls.

We are now implementing a range of solutions to address these issues. These include extending the operational hours of our nurse-led helpline, Moorfields Direct, to 9pm on weekdays and 5pm on Saturdays, and extra support to our outpatient and optometry teams to help them deal more effectively with callers to their services. In addition, we have included direct dial numbers for all sub-specialty departments on our new website, making it easier for patients to reach the department they need, without having to go via our busy main switchboard.

We have also invested in a new software system for our telephones, which means that we can undertake detailed analysis of the performance of our switchboard and its operators, so that we can improve callers' experience of our service in future. The new system includes a queuing facility, which lets callers know where they are in the queue and how long it is likely to take for their call to be answered. Equally importantly, we have recruited additional support for the switchboard team, enabling callers who opt not to use the automatic system to be connected more quickly to a real person.

Discharge information

We reviewed and re-designed the discharge information we give to our day-care patients during the year. The information now includes specific advice about whom to contact should a patient suffer pain, vision loss or feel unwell following their surgery. It also now contains sections which can be personalised for individual patient needs. All nursing staff who discharge patients have been issued with discharge prompt cards stressing the importance of telling patients about potential medication side effects and whom to contact in an emergency. Day-care areas also have laminated medication cards to help explain to patients the side effects of commonly used eye drops.

Clinical outcome measures

All sub-specialties continue to report regularly on three clinical outcome measures, which are generated through a combination of electronic data capture, prospective data collection and retrospective analysis of case notes. The standards for achievement are based on an analysis of national and international scientific literature and benchmarks for other ophthalmic institutions where available. We also maintain close links with members of the World Association of Eye Hospitals, for which we participated in a project to enable sharing of outcome results for benchmarking purposes.

A full list of our performance against all clinical outcome measures is included in our quality report at appendix 1, with the following showing especially good results:

- Lid surgery for ptosis (drooping), in-turned and out-turned eyelids
- Infection rates after cataract surgery and intravitreal injections
- Complications during and refractive results after cataract surgery
- Complications of strabismus (squint surgery)
- Results and complications of refractive laser surgery

In addition, outcome measures for the number of 'never events' (wrong patient or side procedure, incorrect intraocular lens insertion in cataract surgery) have been introduced and demonstrate improvement from last year.

Work was also completed during the year to develop additional outcome measures for each sub-speciality to ensure that we are measuring clinical performance on the matters of most importance to our patients and referrers.

Dementia awareness

We trained almost 750 of our front-line staff in dementia awareness during the year as part of the '12,000 trained in dementia' project led by UCL Partners (UCLP), the academic health science centre of which Moorfields is a founding partner. In addition to staff training sessions, we also ran an awareness raising event, including posters and leaflets, an email campaign for staff and sent out messages via our social media channels.

Dementia awareness is particularly relevant at Moorfields given the older age of most of our patients, which makes them more likely to suffer from dementia.

Medical revalidation

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Revalidation is designed to give further assurance to patients that licensed doctors are up to date and fit to practise.

Moorfields is a designated body for 256 doctors who work for us and hold a full General Medical Council (GMC) licence to practise. Doctors can have only one designated body, so those with joint contracts are normally designated to the organisation where they carry out most of their clinical work.

Doctors must revalidate, usually every five years, via regular appraisals based on core guidance for the medical profession entitled 'Good Medical Practice'. Based on these appraisals, the doctor's responsible officer will make a recommendation to the GMC that their licence to practise should be revalidated. Between April 2013 and March 2014, 207 of our designated doctors completed appraisals as part of this process.

Sixty-five of our doctors were scheduled for revalidation by 1 April 2014. Of these, 63 had a positive recommendation and two were deferred.

Improved facilities

Several projects were completed during 2013/14 to improve the environment in which we see and treat our patients.

Our busy A&E department in our main hospital in City Road underwent a major refurbishment costing £1.4 million, which was completed on time and to budget in October 2013. By relocating our observation ward to another part of the hospital, we were able to increase the physical size of the department at the same time as improving its configuration and generally making it a more pleasant

environment, with new flooring, lighting and decoration. Feedback both from patients and staff has been very positive.

Also at City Road, we completed a project to expand and upgrade our orthoptics department in May 2013. The scheme included dedicated examination rooms, improved waiting facilities and a better reception area for this busy department.

In May 2013, the new mayor of Brent, Councillor Bobby Thomas, formally opened our newly refurbished eye centre at Northwick Park Hospital. The refurbishment, completed in the previous financial year, doubles the size of our outpatient unit and adds new facilities including a permanent operating theatre to replace the previous temporary arrangements.

In non-clinical areas, we formally opened our refurbished prayer room and chapel at our main hospital in City Road. A brand new Costa Coffee franchise was also established at the hospital.

For the future, we approved investments during 2013/14 to expand and improve our eye centres at Ealing and St George's hospitals. At Ealing, the £500,000 investment will create additional clinic and injection space in front of our existing unit, enabling us to improve the patient experience, accommodate additional equipment and capacity, and provide a better working environment for our staff who currently provide high levels of service within very cramped conditions. This project will shortly be underway and is due to be completed by summer 2014.

At St George's, work will start during 2014/15 to create a stand-alone, purpose-built facility on the hospital campus to house two operating theatres, substantially increased outpatient space, an intravitreal injection suite and administration offices. We will also have weekly access to operating lists in the St George's main theatres for our paediatric patients and for adult patients who are too systemically unwell to be treated within the new Moorfields unit.

External review of environment

The annual Patient-Led Assessment of the Care Environment (PLACE) visit took place in June 2013 at our City Road hospital. Staff from various specialties met with the equivalent number of patient representatives to review mandatory areas in the hospital, including outpatient clinics, the A&E department and wards.

Our scores were as follows:

- Cleanliness of wards, including bathrooms, furniture, fixtures and fittings: 93.7% against a national average of 96%
- Condition, appearance and maintenance of sites, including decoration, signage, linen and car park access: 91.9% against a national average of 89%
- Privacy, dignity and wellbeing, including changing and waiting facilities, appropriate separation of single-sex facilities, telephone access and appropriate patient clothing: 89.3% against a national average of 89%
- Patient food and hydration, including assessment of choice, taste, temperature and availability over 24 hours: 100% against a national average of 85%

Issues around cleanliness, where we scored slightly below average, have already been addressed and will continue to be monitored.

A further PLACE review took place in March 2014 and informal feedback suggests that our scores have improved since the first visit.

2.3.4 A new central London facility

Planning continued throughout the year for the proposed move of our main hospital in City Road to a more modern, purpose-built facility in the King's Cross/Euston area.

The proposed move is being planned in partnership with our research colleagues at the UCL Institute of Ophthalmology. Together, our ambition is to create a fully integrated and flexible modern facility enabling us to combine, for the first time, patient-focused eye research, education and healthcare in a truly coherent way.

We need a new facility for several reasons. Most of our existing buildings in City Road are more than 100 years old and were built at a time when hospital care was provided very differently to how it is now, and they are no longer suited to the provision of 21st-century clinical care, research or education. Our ageing infrastructure is also growing increasingly difficult and costly to maintain. At the same time, the configuration of our existing buildings offers little scope for true integration between the clinical, research and teaching elements of our work. Although intermediate refurbishments go some way to improving the environment for our patients and staff, they are no substitute for purpose-built accommodation.

A range of user groups, including clinicians and managers, met throughout the year to discuss the clinical, research and academic needs for the new facility and to develop a design brief for the new building. The brief includes operational policies, describing how we will work, a schedule of accommodation showing how much space we need and the major required adjacencies, and design quality standards. Each of the 22 user groups met several times during the year and reported back to a design steering group which ensured that the various plans all work well together.

We also continued to explore various options to secure a site for the new building. Although we have looked at, and will continue to consider, other parts of central London, we are focusing our search on the King's Cross/Euston area for a variety of reasons:

- It is close to our current location, which will make any move easier for existing patients and staff
- The area is undergoing extensive regeneration, which means that there is land available on which to build, as well as other redevelopment opportunities
- The area is a national and international major transport hub, providing easy access from London and beyond
- Moving to this area will bring us closer to other important health and health research partners, including University College London and Great Ormond Street hospitals, and the new Francis Crick Institute

Between November 2013 and February 2014, we ran a 12-week engagement exercise to determine general support for our proposals and to understand the most important factors to take into account when we make a final decision about a new site. The vast majority of respondents were positive about our plans, with accessibility, the continuity of clinical care during construction and future flexibility topping the list of priorities.

Members of the team managing this project also visited eye facilities at the Aravind Eye System in southern India and Rotterdam during the year, and are using our membership of the World Association of Eye Hospitals to share best practice and identify new ideas that could be implemented in our new facility.

2.3.5 IT improvements

We introduced new clinical modules for our cataract, glaucoma and medical retina services to OpenEyes, our bespoke electronic patient record for ophthalmology, during 2013. Work is now

focused on enhancing the functionality of the deployed modules in response to issues reported by the clinical and operational teams who use them. Once this is complete, modules for the remaining sub-specialty services will be introduced.

OpenEyes is an open source project, which means that the software is available free of charge in most cases. This encourages other eye specialists and units to contribute ideas and code and means that everyone can make use of the best ideas, speeding up future developments. NHS England supports the use of open source solutions for the health service and considers OpenEyes one of the leading technologies in the field.

In September 2013, Secretary of State for Health Jeremy Hunt visited Moorfields to announce the Government's formal response to Dame Fiona Caldicott's report on information governance in the NHS. Moorfields was chosen for this event because of the potential of electronic patient records such as OpenEyes to help balance the need for data protection with the obligation to share information with others where appropriate. As part of the visit, we gave the Secretary of State a short demonstration of OpenEyes, showing its power and flexibility, including how it will improve recruitment to clinical trials.

OpenEyes is a collaborative effort led by Moorfields, which should ultimately replace the vast majority of paper records, allowing clinicians to have access to good quality and comprehensive information about their patients in the right place at the right time, and enabling them to provide better patient care. The system's ability to capture data in a structured way will also help to provide better decision-support and improved research opportunities in future.

The OpenEyes project has gained national and international attention, attracting £1.1 million of funding from NHS England. It is part of the Commonwealth Eye Health Consortium which has been granted £7 million from the Queen Elizabeth Diamond Jubilee Trust. Orbis, the international eye charity, selected OpenEyes for their electronic patient record following an extensive procurement process.

We also completed a significant piece of work this year to update and strengthen our IT infra-structure, which has been recognised as essential to realising our future ambitions for informatics. This work included upgrades to our local area network (LAN) to enable clinical applications and medical devices to operate securely, interactively, resiliently and responsively. We also upgraded our wide area network (WAN) to ensure robust connectivity for our satellite locations and greatly enhance speed and performance. Improvements were additionally made to our wireless access, using the latest WiFi and radio-frequency identification (RFID) technology, to enable the introduction of mobile technology, patient and equipment tracking, and better firewall security and storage capability and capacity.

2.3.6 Research and development

Along with our academic partners at the UCL Institute of Ophthalmology (IoO), Moorfields is recognised as a leading centre of excellence in eye and vision research. Together, we form one of the largest ophthalmic research sites in the world, with the largest patient population in Europe or the USA. We publish more scientific papers than any other eye and vision research site, and have an extensive joint research portfolio, with 340 live studies and studies in follow-up.

Our joint strategy for research and development was approved in 2013 and is now being implemented. It sets out a clear direction to allow us to continue as a world-leading organisation in eye-disorder prevention and treatment, as well as enabling us to remain agile enough to respond to new developments and opportunities. It plans to achieve this by:

- Conducting fundamental research and rapidly translating it by focusing on high-patient-impact research programmes, while also strengthening our fundamental research base
- Attracting, training and developing premier research talent, to drive research output, discovery and innovation in new treatments
- Developing an integrated culture to foster an inspirational environment for collaborative research to boost innovation
- Heading some of the largest, world-leading partnerships with other institutions and with industry, to bring complementary skills to bear on some of the most challenging research questions

The strategy identifies three main areas – glaucoma, diabetic retinopathy and age-related macular degeneration – on which to focus research activity, but also highlights essential scientific platforms such as stem cell therapy and genetics that will underpin this activity and require further development. Examples of projects undertaken in 2013/14 to support these themes are included below in the section on research activity this year.

National Institute for Health Research biomedical research centre

We remain one of only 11 sites nationally to be awarded National Institute for Health Research (NIHR) biomedical research centre (BRC) status for translational research, which helps us to attract extra funding to support our research programmes and to fast-track exciting new developments from the laboratory to benefit patients more rapidly.

Our BRC houses the applied clinical trials unit investigating vision and eyes (ACTIVE), which works with other clinical trials units (CTUs) to increase clinical trial activity in ophthalmology, by ensuring that clinical trials throughout the country are carried out safely and to a high scientific standard. We are also home to an NIHR clinical research facility (CRF), which complements the predominantly academic focus of CTUs and enables us to accelerate the transfer of breakthroughs in experimental medicine into treatment trials to benefit patients with eye diseases.

We hosted a successful open day in our CRF in May 2013 to celebrate international clinical trials day. This free event offered a chance for the public to find out more about the science and research that lies behind eye treatments and to learn more about the innovative research undertaken at Moorfields.

In June 2013, the CRF was visited by representatives from the Department of Health and the NIHR Central Commissioning Facility for its first routine inspection. During the visit, our team presented their annual report and gave demonstrations of current clinical research projects. Patients taking part in clinical trials were on hand to explain the benefits that they had experienced from participating in these trials, and investigators shared their thoughts on the additional value that having a dedicated research facility has had on the delivery of their studies. The feedback from the visit was extremely positive, the inspectors commending us on our good progress to date and inviting us to help with initiatives to spread good CRF practice across other NIHR sites.

UCL Partners

We are a founding member of UCL Partners (UCLP), which was designated one of 15 academic health science networks (AHSNs) in England in May 2013, alongside its existing role as an academic health science centre (AHSC). UCLP was also successfully designated to continue as an AHSC for the next five years in November 2013, having been one of the first to achieve AHSC accreditation when the initiative was introduced in 2009.

The UCLP network brings together 40 organisations and serves a population of six million people across North East and North West London, as well as Hertfordshire, Bedfordshire and Essex. It aims to ensure that innovation and best practice are spread across the network, providing tangible

patient and population health gain locally, nationally and globally through new models of care, enhanced multi-professional education and medical advances.

Moorfields' director of research and development, Professor Sir Peng Tee Khaw, is the programme director for the eyes and vision theme of the partnership, which aims to drive forward translational research programmes targeting the blinding diseases that pose the greatest burden to patients and society, and to increase our capacity and support for high-quality research programmes.

Research activity this year

We took delivery of an adaptive optics scanning light ophthalmoscope (AOSLO) – a special type of microscope – during the year, the first of its kind outside of the USA. The AOSLO provides a level of data in real time in living eyes not previously possible; one hour of use provides 10 hours of data for analysis. Operated by a highly qualified advanced imaging specialist, also appointed during 2013/14, the machine will enable a better understanding of the architecture and functionality of, for example, photoreceptors (the light sensitive cells in the retina) and provide more information about the retina's relationship with the brain. It has potential relevance for all retinal diseases, meaning that we should ultimately be able to provide insights into both common conditions such as age-related macular degeneration (AMD) and diabetic retinopathy, as well as rare genetic diseases like achromatopsia or choroideremia, which will help in the development of new treatments in future.

Our researchers were involved in an international study that identified a new rare gene variant that predisposes people to AMD. This will be important in understanding the genetics of AMD and should eventually lead to new treatments for the condition. For the study, which looked at more than 2,000 patients with the condition, the researchers sequenced DNA from 10 regions of the genome that had been previously linked to AMD, and identified two rare variants in the complement factor 3 (C3) gene that are associated with an increased risk of developing the condition.

The October 2013 edition of *Ophthalmology* carried the findings of the UK Glaucoma Treatment Study (UKGTS), a trial designed and led by a Moorfields consultant. UKGTS is the world's first randomised placebo-controlled trial assessing the vision preserving effects of medical treatment for glaucoma, and was conducted at Moorfields and nine other participating centres in the UK. It showed that prostaglandins – a type of topical eye drop already prescribed to control eye pressure in patients with the disease – reduced the amount of vision loss by up to 50% compared to placebo drops. The study also proved that a two-year observation period for patients in a medical treatment trial of this sort is viable. Proving that the design of clinical trials can be altered so that treatment effects can be demonstrated in a shorter time frame is important, as it has the potential to speed up the rate at which treatments can be developed and made available to patients, as well as reducing costs.

Also for glaucoma, research led by a Moorfields consultant and published in July 2013 identified a common genetic marker for elevated intraocular pressure (IOP) – a major risk factor in the development and progressive worsening of glaucoma. The discovery is of particular relevance as the only proven effective treatments to date for glaucoma work by lowering IOP. It could eventually enable the more effective identification of people at risk of raised IOP, as well as the development of new treatments for glaucoma, which affects 80 million people worldwide.

Results from the first clinical trial of a gene therapy for an inherited cause of progressive blindness called choroideremia, which involved Moorfields patients and consultants, were published in early 2014. The promising initial results at the six month stage for the first six patients were published in *The Lancet* and surpassed the expectations of the researchers leading the study. The aim of the treatment in this study was to get the gene therapy into the cells in the retina without causing damage. After six months, however, the patients actually showed improvements in their vision in dim light and two of the six were able to read more lines on the eye chart.

In March 2014, we were named as one of 11 expert institutions from across the Commonwealth who have come together for the first time as the Commonwealth Eye Health Consortium. This consortium is supported by the Queen Elizabeth Diamond Jubilee Trust, which was established to celebrate HRH the Queen's 60-year contribution to the Commonwealth and a life of public service. Co-ordinated by the International Centre for Eye Health at the London School of Hygiene and Tropical Medicine, the consortium will pursue vital research into the diagnosis and treatment of conditions such as trachoma (an infectious disease causing scarring of the corneal window) and diabetic retinopathy, which leave millions without sight, and will build capacity across the Commonwealth to tackle avoidable blindness and provide quality care to those affected or at risk.

As part of this initiative, our reading centre is participating in an innovative project to trial a smart-phone-based system that carries out a full range of ophthalmic diagnostic tests in even the remotest of settings. Known as PEEK (portable eye examination kit), this mobile app and clip-on hardware transforms a low-cost Android smartphone into an eye examination and diagnostic suite, capable of running a range of tests, including visualisation of the back of the eye. It is currently being trialled in Kenya where detailed clinical information is gathered by the app and sent for grading to assess the extent of the disease by our reading centre. Easy to use, affordable and portable, the system stores contact information and GPS data for each patient and uses Google-map integration to create a novel way to follow-up and treat patients.

2.3.7 Education, teaching and training

Moorfields provides four main education functions:

- We are the largest provider of NHS funded ophthalmology education and training, contracted through Health Education England (HEE) as a Local Education Provider (LEP)
- As an employer, we invest in the development of our employees including our leaders, managers and non-clinical staff as well as continuing to be pioneers in developing new ways of training our clinicians
- We supply education and training in the open market to healthcare professionals in the wider NHS, and independent learners from the UK and abroad
- We educate patients and their relatives about their eye conditions empowering them to identify problems and manage their conditions with our support

This section and those below (2.3.8 and 2.3.9) provide examples of some of our achievements in education, teaching and training in 2013/14.

A new education strategy

We completed work during 2013/14 on a new education strategy. Approved in April 2014, this document sets out the current education landscape in ophthalmology and explores what we will need to do if we are to develop education as a key component of our overall strategy, *Our Vision of Excellence*.

Between September and December 2013, we held a series of workshops to inform the development of the strategy, which identified four strategic themes for education in the future:

- Leadership and operational excellence
  - We will use the opportunities presented by Moorfields' unique position and reputation to shape eye education both now and in the future for the benefit of all
  - We will drive multi-professional learning, improving access and quality through an integrated education function

- Sustainability
  - We will increase our understanding of our existing and potential customers and their current and future needs
  - We will enhance the profile and reputation of education offered at Moorfields by meeting the needs of key learner populations and stakeholders, and celebrating success
- Product innovation
  - We will strengthen and grow Moorfields' education offer by optimising the learning on offer for all staff groups
  - We will agree a position on investment in digital learning (scope, scale, timeline, budget)
- Strategic partnerships
  - We will develop a formal strategic, but not necessarily exclusive, partnership with the UCL Institute of Ophthalmology and University College London

Medical education

Moorfields provides ophthalmic training and education for doctors at all levels, including undergraduate medical students, post-graduate specialty registrars and fellows, academic clinical fellows and lecturers, nurses and allied health professionals. Regular courses in various specialist areas are run at the main hospital in London's City Road, many of them in association with the UCL Institute of Ophthalmology. We also welcome doctors from around the world to observe our renowned treatment of eye diseases and injuries.

We provide undergraduate teaching in ophthalmology to around 1,250 medical students from Barts and The London School of Medicine and Dentistry, University College London (UCL) and St George's, University of London. We have dedicated, ring-fenced service increment for teaching (SIFT) funding, which enables us to provide teaching fellows and consultants with protected time for teaching and to encourage continued professional development for post-graduates in medical education.

Once again, we received positive feedback from undergraduate medical students at St George's, where we teach the majority of the ophthalmology content of their studies, with 77% saying that their ophthalmic training was 'excellent' or 'good', and nobody reporting dissatisfaction.

One of the recommendations of the Keogh review of quality of care and treatment, which arose from the Francis report was that medical trainees should be given a greater role in hospital management. This group of doctors is highly intelligent and motivated and, as they rotate between different hospitals, they experience different models of care and therefore have a unique perspective. Moorfields recognises the value of this and has taken active steps to empower trainees by ensuring that they are represented on the majority of trust committees. In addition, we have 35 trainee-led quality improvement projects underway.

We secured external funding during the year to develop human factors simulation training, which aims to prevent common errors in ophthalmic surgery such as surgery on the incorrect eye and incorrect choice of intraocular lens. The training achieves this by improving adherence to established protocols and enhancing team working and communication. This approach has been used to improve the safety of air travel, and is commonly used in some medical specialties, especially anaesthesia, but has never been used in ophthalmology before.

Several medical staff received external recognition for educational achievements this year. Dr Stacey Strong, one of our teaching fellows, won an award for excellence in student education from Barts

and The London School of Medicine and Dentistry. This is an award for which students nominate teachers who have inspired them or provided exceptional teaching in their NHS hospital placements.

Dr Hari Jayaram, a fellow in the glaucoma service, was awarded a prestigious Fulbright scholarship, a highly competitive programme which enables the recipient to study, conduct research or exercise their talents in the USA. Hari's scholarship was awarded in partnership with the charity Fight for Sight and he will use his time in the USA to expand his expertise in basic experimental glaucoma research at the renowned Casey Eye Institute in Portland, Oregon.

One of our senior ophthalmic trainees, Daniel Gore, won the medical trainee of the year award provided by Health Education North Central and East London. This was for his work in training the first nurses in the UK to deliver corneal cross linking, a new and effective treatment for patients with keratoconus.

Several of our doctors in training also enjoyed success during the year in poster competitions at a range of professional meetings.

Nurse education

Work continued this year to implement our nursing strategy, *Focusing on the Future*, which sets out four main aims:

- To develop a nursing workforce that is fit to deliver eye care in the 21st century
- To educate nurses and support workers to provide the best clinical care, and become a respected provider of ophthalmic nurse education, with national recognition
- To develop and retain the best clinical leaders of the future, equipping them with the skills and competencies to act as ambassadors for the organisation
- To provide evidence-based, safe care with dignity and compassion

Applications opened in January 2014 for a new post-graduate certificate in ophthalmic practice for nurses and allied health professionals. Accredited by Moorfields and University College London (UCL), the programme is the first of its kind to be introduced between Moorfields and UCL, and will be accessible to Moorfields staff and candidates from ophthalmic units across the UK. It will be delivered through a blended learning approach, including lectures, e-learning and practical assessments, to ensure that participants can be released from their workplace with minimal disruption to staffing levels.

Our pioneering nurse-led injection service for patients with age-related macular degeneration (AMD) was endorsed this year by the Royal College of Ophthalmologists, provided certain conditions are met. This is a major boost for this well-received initiative which helps to expand the nursing skill-set at the same time as freeing up doctors to concentrate on more complex cases.

We established a range of study days for nurses to increase their understanding of specialist conditions, including long-term management and compliance with treatment. Any profits from the days are used to support nurses and allied health professionals with educational needs. Involving delegates from outside and within Moorfields, feedback from participants and speakers is positive. Topics covered to date include biometry, cataracts, emergency care, glaucoma, theatres, and nurse prescribing and pharmacology. We also ran an update day for healthcare assistants and technicians, a course to enhance skills in writing for publications and making presentations, and a half-day slit lamp workshop.

The first cohort of students completed a first ophthalmic course for our healthcare assistants and technicians. The course is delivered by two external and experienced teachers over five weeks and

covers anatomy and physiology of the eye, common ophthalmic conditions and the development of new skills.

In November 2013, 12 of our band 7 nurses started a six-month leadership programme, and a further two programmes for band 6 nurses commenced in January 2014. For these programmes, participants were required to complete a project based on a quality indicator associated with the recommendations from the Francis report.

Allied health professionals education

In optometry, we now have 31 specialist optometrists who have successfully achieved the College of Optometrists DipTP(IP) professional higher qualification and are registered as independent prescribers. This means that they can co-ordinate all the medication a patient requires within their area of expertise. Together with our nurse prescribers, this initiative frees up doctors' time to spend on more complex or difficult cases.

We also run two optometric-led glaucoma laser lists, one at City Road and one at St George's where optometrists undertake a range of laser procedures.

Our partnership with the UCL Institute of Ophthalmology became the first to offer a College of Optometrists higher qualification, following the development of a professional higher certificate in glaucoma during 2013/14. This qualification will be delivered as part of a post-graduate certificate in advanced clinical optometry (glaucoma), a nationally recognised qualification to develop advanced specialist skills and knowledge. This is part of a suite of specialist postgraduate awards to enable optometrists to provide extended services in key areas such as low vision, contact lens practice and medical retina.

We have also developed the role of specialist optometrists in cataract clinics and community pathways. Hospital optometrists' role in cataract management is initially the post-operative management of uncomplicated surgery and the discharge of patients; our specialist optometrists are then trained to consent for second eye surgery and the management of a range of post-operative complications, pre-operative assessment and refractive planning. We have developed extensive clinical guidance, training courses and audit, and now have a highly skilled experienced workforce of specialist optometrists capable of managing significant clinical workloads.

We have well developed and excellent audit outcomes of our community optometrist cataract pathway schemes in Bedford which has led to comparable schemes being set up in Potters Bar. We are now working with Camden Local Optometric Committee to facilitate direct referral to our City Road hospital, with the hope that comparable schemes can be developed London-wide. Within the scheme, we have trained and accredited 150 community optometrists to assess and refer patients with cataracts to our surgical centres in Bedford and Potters Bar. This has improved the pathway for patients by reducing the number of hospital visits, and has additionally lowered costs, while maintaining quality and safety.

We are also working with the College of Optometrists to develop national postgraduate qualifications in cataract management.

Academic role models

Three colleagues from Moorfields and the UCL Institute of Ophthalmology featured on a list of 40 academic role models developed by the academic careers office of UCL's School of Life and Medical Sciences (SLMS). Julie Daniels, professor of regenerative medicine and cellular therapy and director of our Cells for Sight tissue bank, Christiana Ruhrberg, professor in neuronal and vascular development, and Professor Sir Peng Tee Khaw, our director of research and development, were included on the list, published in June 2013.

The list followed an initiative launched the previous year in which nominations were sought for individuals within the four SLMS faculties who have had a major impact on others and are passionate about what they do. To be nominated, role models needed to influence the career choices of others, have a positive attitude towards junior colleagues, be committed to excellence and growth, affect the attitudes, behaviours and outlook of others and, essentially, emulate and stimulate those around them.

Sharing our expertise

Our staff have a deeply embedded culture for sharing research, knowledge and specialist clinical expertise. Clinicians from all disciplines, and non-clinical experts, are proactively engaged in speaking at conferences and professional forums worldwide. They also work in and with some of the best universities in the UK and abroad and provide support to Ghana's largest teaching hospital. A handful of examples from 2013/14 are included below.

We brought together glaucoma experts from around the world to discuss the latest treatments and innovations in their field at two successful events. The first saw Moorfields consultant ophthalmologist, Keith Barton, welcome 45 internationally renowned experts and more than 260 glaucoma specialists as delegates to a two-day symposium. The meeting was also simultaneously webcast to 300 further delegates at five centres in Europe and the Middle East.

The second was the UK Paediatric Glaucoma Society meeting, which attracted 30 delegates, many from abroad. This included a symposium on the outcome of tube drainage implants in paediatric glaucoma, and a talk on glaucoma following congenital cataract surgery.

Also in glaucoma, several of our consultants were involved in the development of a new app, which simulates the devastating effects of glaucoma through the eyes of a patient. Developed by pharmaceutical company Merck, in association with Moorfields and the International Glaucoma Association (IGA), the app works by using a sliding function on smartphone cameras to demonstrate how vision can deteriorate if the condition is not regularly managed. Just 17% of patients in the UK recognise that glaucoma can cause blindness if not treated.

The 2013 meeting of the Association of Research in Vision and Ophthalmology (ARVO), the world's largest eye and vision research organisation, attracted more than 11,500 delegates, including many clinicians and researchers from Moorfields and the UCL Institute of Ophthalmology.

The president of ARVO at the 2013 meeting was Moorfields' director of research and development, Professor Sir Peng Tee Khaw, the first UK-based president in the organisation's 84-year history. The president sets the theme and chooses the speakers for the meeting, which this year was 'life-changing research', emphasising how research changes the lives of millions of people around the world, including our patients at Moorfields.

As the world's leading site for eye and vision research, Moorfields and the Institute were very well represented at the meeting, giving many dozens of presentations. There was also a new video competition around the 'life-changing research' theme, in which our researchers featured prominently amongst the prize winners.

In April 2013, five Ghanaian nurses visited us as part of the Moorfields Lions Korle Bu Trust's project to create a community-based eye care and training centre in the country's capital. Ghana is in critical need of ophthalmic professionals, as it currently has only 46 ophthalmologists to cover a population of 25 million patients. Once complete, the new centre will enable eye specialists from across West Africa to be trained in high-volume cataract surgery, treatment for glaucoma and river blindness and other conditions.

Later in the year, we provided a 'train the trainer' course in slit lamp examination for 10 ophthalmic nursing staff from across Ghana at Korle Bu Hospital.

Several of our consultants gave presentations at the inaugural 100% Optical event held at London's Excel Centre in February 2014. The event attracted around 10,000 visitors from a range of specialities including opticians, ophthalmologists and orthoptists from NHS and independent practices, from the UK and internationally.

In addition, our chief executive is a trustee of the St John of Jerusalem Eye Hospital Group, the only charitable provider of expert eye care in the West Bank, Gaza and East Jerusalem. In the occupied Palestinian territories, the rate of blindness is ten times higher than in the west, and our links to the charity help ensure that our expertise is available to support people in this challenging region.

2.3.8 Working with patients and partners

Moorfields works with a wide range of groups and individuals, including patients, other healthcare organisations, academic partners, foundation trust members and charities. We engage with them in a variety of ways both face-to-face and in writing, whether via traditional publications or digital media.

Our new website went live in February 2014. The site's development was informed by focus groups of staff and patients and an online survey to ensure that the new site is easy to navigate and that its structure reflects what users want and need. Further testing is now underway and, once we are confident that the site is working as it should be, we will start work on a phased plan for further enhancements and new content.

Between November 2013 and February 2014, we ran an engagement exercise to seek views on our plans to move our main central London hospital to the King's Cross/Euston area and identify those factors most important to patients, carers and others in selecting a new location. Further information is included at section 2.3.4 above.

In May 2013, the *British Journal of Ophthalmology* carried a research paper written by staff at Moorfields about the importance of patient and public involvement in healthcare decisions and research. The piece used the previous year's Birdshot Uveitis Patient Day, in which several of our staff played an important part, as an example of positive patient and public involvement. The paper described the aims, delivery, evaluation and impact of the day on patients with this rare condition, their carers and health professionals.

We increasingly use social media channels to communicate with patients and the public, supporting specific events and awareness raising activity with key messages and useful tips via our Facebook and Twitter feeds.

Listening to our patients

We use a range of mechanisms to find out what our patients think of our services and to make improvements in response. These include comment cards, feedback posted on NHS Choices, other websites or via social media sites, a patient narrative programme and surveys.

The national Friends and Family test, a standardised measure of patient satisfaction, was launched in April 2013, and we now use this across A&E, day-care and outpatient areas. Moorfields has performed well since the first results were published in July 2013. Just over 51,000 of our patients completed the test during 2013/14, with 97% saying they would be likely or extremely likely to recommend Moorfields.

Accompanying comments suggest that professionalism, caring attitude, good organisation and clinical outcomes are the main reasons for our high scores. Waiting times in clinics were cited as the main area where patients felt we could improve.

The results of our annual day care and outpatient surveys were published in June 2013. Each year Moorfields commissions the Picker Institute to conduct an 80-question patient survey of around 1,500 patients who have visited our outpatient clinics or had day-case surgery. The 2012/13 surveys showed that although our patients receive an overall good service, it is a service that is not always consistent.

In response, we have re-written our patient discharge information and personalised it, with clear instructions on whom to contact in an emergency. We are also exploring ways to shorten pre-operative waiting times and to make clear the reasons for any delays.

The formal complaints process also remains vital in identifying trends and areas for improvement. In 2013/14, we received a total of 247 complaints, compared with 291 in 2012/13. The main causes of complaints in 2013/14 were around clinical issues regarding treatment or outcome. We received 84 complaints about clinical care, which represents 34% of the total, followed by 37 complaints about staff attitude (15%) and 35 about appointment concerns (14%).

In January 2014, we introduced a new system, under which the majority of patients who make a written complaint are called by our complaints staff to clarify exactly what their issues are and how they would like to see the problem resolved. This has meant that several concerns that would previously have been automatically treated as a formal complaint are now dealt with more quickly, and, more importantly, to the patient's satisfaction via a different route. Complaints relating to clinical care or staff attitude continue to be addressed via the formal process.

Complaints activity is provided to the trust board on a quarterly basis, along with information about other activity undertaken by our patient advice and liaison service (PALS) and a more detailed report is submitted on an annual basis.

Patient days

We held four interesting patient days during 2013/14 covering paediatric uveitis, corneal conditions, glaucoma, and low vision awareness. The paediatric uveitis day was a pilot event held in the Richard Desmond Children's Eye Centre, adjacent to our main hospital. Twenty families attended and exchanged information with healthcare professionals and researchers, capturing experiences about uveitis disease and treatment from the perspectives of paediatric patients, their siblings, parents, and healthcare professionals.

The Glaucoma Think Tank in Birmingham attracted 120 people and was the second of its kind, involving research clinicians from across the UK along with the International Glaucoma Association, and provoked some insightful discussions with patients about the potential benefits of new approaches to research, as well as key concerns about disease progression and treatment.

The corneal day attracted more than 100 patients, who joined doctors and researchers to find out more about the latest studies and new treatments and give their opinions on research priorities.

The low vision awareness day was held at our eye centre in St George's Hospital in Tooting and included information and advice from external companies and charities about the range of equipment and devices available for people who require low vision aids.

Equality, diversity and human rights

Equality, diversity and human rights are one of the cornerstones of the NHS and of work at Moorfields. We are committed to ensuring that no individual employed by us, providing a service to

us, or receiving care and treatment from us, should receive less favourable treatment because of any protected characteristic they might have. We believe that equality and diversity is everyone's responsibility and provides an opportunity to improve the care we deliver to our patients.

We have several policies in place to support our staff in fulfilling our commitment to equality, diversity and human rights, including:

- Equality, diversity and human rights policy
- Grievance policy
- Harassment and bullying policy

We also have an equality, diversity and human rights management group and a separate steering committee which provides a forum to share learning from a broad group of stakeholders from across the organisation.

Social and community initiatives

In September 2013, the RNIB's futuristic EyePod visited our main hospital as part of National Eye Health Week. The pod is a sight simulator with giant eyes connected to viewers, though which visitors look to experience what it is like to suffer from glaucoma, cataracts, diabetic eye disease and age-related macular degeneration.

A month later, we participated in World Sight Day 2013. Alongside the RNIB, Smoke Free Islington and RP Fighting Blindness, our staff offered patients advice on a wide range of topics. These included how smoking can damage your sight, advice on the best ways to put eye drops in and information about medications from our pharmacy team.

In March 2014, our nurse-led health promotion team ran information stands to support World Glaucoma Week. Our glaucoma nurse specialists provided individual patient-centred education and tips to help patients effectively instil eye drops and offered further information. The event was supported by charities the International Glaucoma Association and Spectrum Thea, and was backed up by a social media campaign highlighting facts about glaucoma and tips on eye drops.

Also this year, our orthoptics team organised an information awareness event to promote their work as part of the first World Orthoptic Day in June 2013. During the event, patients were encouraged to find out more about how eye muscles work, try out prisms to correct vision defects, and experience double vision through special glasses. Again, the event was supported by a social media campaign.

We attend meetings with the Islington health overview and scrutiny committee as required and liaise with Islington Healthwatch. In addition, Moorfields' director of nursing and allied health professions represents the trust on both the Islington safeguarding children board and the Islington safeguarding adults partnership to ensure that Moorfields protects these vulnerable groups as well as possible and in line with national guidance.

Charitable support

All charities affiliated to Moorfields Eye Hospital are independently constituted charities, registered with the Charity Commission.

Moorfields Eye Charity (charity number 1140679) raises funds, above and beyond those normally provided by the NHS, to enable us to continue to provide the highest quality care for our patients and their families and help ensure we remain a world-class centre of excellence for eye research and education.

Two other charitable organisations also provide dedicated support for our work. The Special Trustees of Moorfields Eye Hospital (charity number 228064) is a grant-giving body, which primarily supports leading-edge research carried out at the hospital and with our research partners at the UCL Institute of Ophthalmology. The Friends of Moorfields Eye Hospital (charity number 228637) is an active and dedicated body of voluntary fundraisers, whose main aim is to provide extra services and equipment for patients and their visitors. The charity is assisted by more than 100 volunteers, who complement existing services and staff.

Funds donated to our affiliated charities come from a variety of sources, including gifts left by people in their wills, donations from grateful patients and their families, charitable trusts, companies and philanthropists. Events, collections and other fundraising activities also make an important contribution. Together, these donations enable our charities to fund a wide range of important research projects and to improve our services and facilities.

Projects supported in 2013/14

A range of projects was supported during the year including:

- OpenEyes in Scotland, working initially in collaboration with NHS Fife on cataract module implementation
- Creating the most advanced retinal imaging technology in Europe, which will improve our understanding of retinal disease and facilitate the development of new therapies over the coming years
- The purchase of a selective trabeculoplasty laser and the replacement and upgrade of 30 Humphrey visual field machines, which are important in delivering world-class treatment for glaucoma patients
- A new fast protein liquid chromatography (FPLC) based virus vector production system to significantly increase the efficiency and productivity of gene and cell therapy research aimed at restoring sight
- Efforts to tackle avoidable blindness and visual impairment across West Africa through the development of a new eye centre and surgical training facility in Ghana which is scheduled to be completed in June 2014, and a sub-specialty surgical training programme which is to begin early in 2015
- Moorfields' integrated patient support service, comprising eye clinic liaison officers and nurse counsellors
- Equipping a new paediatric consultation room in the Richard Desmond Children's Eye Centre with assessment equipment
- Leading-edge research projects, including assessment of gene mutations identified in Leber's Congenital Amaurosis patients recruited for a gene therapy clinical trial; investigating potential therapeutic targets to modulate scarring following, for example, ocular surgery; and research to evaluate vitamin D as a protective factor in retinal inflammation

Events also took place during the year to mark the Friends of Moorfields' 50th anniversary. These included a celebratory Tea on the Thames in May 2013, attended by more than 100 of the charity's members and supporters, and the inaugural Moorfields's Got Talent staff event. Held in the Great Hall at Barts Hospital, Moorfields's Got Talent attracted entries from a wide range of staff and was attended by about 150 colleagues.

New partnerships

We completed the planning to establish a major new satellite service in Croydon during 2013/14, and started to provide all eye care services at both Croydon University Hospital (CUH) and Purley Memorial Hospital in April 2014. The change means that patients in Croydon are now seen by Moorfields clinicians and have access to all the specialist services we offer closer to home.

We had been providing significant clinical and managerial support to the Croydon eye unit for some time and, following extensive discussions with both Croydon Health Services, who run the hospitals, and Croydon Clinical Commissioning Group, a decision was made last year to transfer the service in its entirety to Moorfields.

The service at CUH becomes our fifth district hub, in which services are co-located with general hospital services, and provide comprehensive outpatient and diagnostic care as well as more complex eye surgery. Purley is one of our community-based outpatient clinics, focusing predominantly on outpatient and diagnostic services.

These new sites bring our total number of satellite locations to 20 and are strategically important as they expand our reach further into south London.

Our shared care cataract pathway for patients who live in areas covered by East and North Hertfordshire Clinical Commissioning Group (CCG) got underway in June 2013. This is a quality and access development initiated by Moorfields to offer an improved experience for patients and build closer links with our community optometrist colleagues. It follows the successful introduction of the same scheme for optometrists in Bedford. Under the new arrangement, accredited optometrists assess patients with cataracts in the community. If the patient is assessed as being visually disabled by the condition and in need of surgery, they are offered a choice of provider and, if they subsequently choose Moorfields, the optometrist can refer them directly for their surgery to our satellite centres at Potters Bar or Bedford, instead of having to refer via a GP. After surgery, the patient is followed up by the same optometrist locally.

We started work during 2013/14 on a new strategy for Moorfields East, which comprises our satellite locations in St Ann's, Mile End, Loxford, Harlow, Barking and Homerton. Each presents challenges in terms of limited space for clinicians and equipment, and restrictions on the number of days that can be used for Moorfields' activity, and the strategy seeks to address these issues and to set out a coherent approach for the future in this important and growing part of London.

For the short-term, the focus for Moorfields East will be on maximising the use of the six existing sites, and developing a broader range of sub-specialty eye services wherever possible. At the same time, we are also looking at running eye services for residents in Newham from the new Sir Ludwig Guttmann Health and Wellbeing Centre, the former Olympic site medical centre, purpose-built for the games. The building is currently being adapted to make it more suitable for use as a health and wellbeing centre both for the new community and for the existing Newham population.

For the longer-term, we are keen to create a new surgical hub for Moorfields East so that we can expand the range of services we can offer in east London, attract new referrals and enable some patients who currently have to visit City Road for more complex care to be treated closer to home.

Influencing

We are steadily assuming a more strategic approach to influencing activity as part of our work to raise the profile of eye health. Examples from 2013/14 include a submission to the London Health Commission's call for evidence on a range of health-related questions. The London Health Commission is an independent inquiry established in September 2013 by the Mayor of London to consider how London's health and healthcare can be improved for the benefit of the population.

The call for evidence covered four broad themes: improving the quality and integration of care; enabling high quality and integrated care delivery; healthy lives and reducing inequalities; and health economy, research and education. For each theme, our response sought to ensure that our perspective as a specialist ophthalmic provider is heard, alongside broader issues relating to eye health and sight impairment.

We also responded to a consultation by the National Institute for Health and Care Excellence (NICE) requesting views on potential topics for quality standard development to help improve the quality of public health. NICE quality standards are a concise set of prioritised statements, designed to drive measurable quality improvements within a particular area of health or care, and are already being developed for alcohol, obesity and smoking, among others. Our submission was a collective response on behalf of Moorfields, the Clinical Council for Eye Health Commissioning and the constituent members of the Vision 2020 (UK) ophthalmic public health committee.

Thirdly, the European Coalition for Vision (ECV), of which Moorfields is a member, and its manifesto for the European Parliament elections, were launched at the European Parliament in Strasbourg in February 2014. The ECV is an alliance made up of professional bodies, patient groups, European NGOs, disabled people's organisations and trade associations representing suppliers. It exists to raise the profile of eye health and vision, help prevent avoidable visual impairment and secure an equal and inclusive society for those with irreversible blindness or low vision in Europe. Its manifesto called on the European Parliament to use its significant powers to improve the lives of people affected by vision impairment or at risk of vision loss, and included four calls to action for candidates in the elections to the European Parliament in May 2014.

2.3.9 Working with our staff

Moorfields employs around 1,800 staff across a variety of professional disciplines at our main hospital in London's City Road and at our various satellite facilities in and around the capital. Of these, 96% have been in post for more than a year, an indicator of high workforce stability. Our annual rolling staff turnover rate was 8.7%. Recorded sickness absence across the year was 2.84%. Moorfields is currently compliant with the requirements of the European Working Time Directive.

We are committed to the principle of equality of opportunity regarding both the employment of staff and our service provision. Our equality, diversity and human rights policy covers equality of opportunity in all aspects of service provision and employment, including recruitment, selection, training, development, promotion and service provision. This policy aims to promote fair access to employment, conditions of service and service provision for everyone, to ensure that no individual suffers detrimental or less favourable treatment as a result of their age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation, or pregnancy and maternity.

In common with much of the NHS, our workforce is predominantly female, with women making up 65% of our staff. Our trust board comprises nine male and four female directors, and our wider executive team is made up of 10 men and four women.

We introduced a new HR and payroll system in October 2013, a significant investment to ensure that we have accurate, up-to-date management information and electronic processes to support our business.

The first phase of the new web-based system allows employees to access and update their personal information, have access to view and print on-line payslips, update their bank account details, complete exit interviews and view their sickness absence records. For managers, the system will ultimately provide a comprehensive reporting system that will include an intuitive dashboard with the ability to drill down into dynamic information on sickness, turnover, pay costs and so on.

The system replaces several manual and paper based processes with e-forms supported by an intuitive electronic workflow, and the ability to track progress and to alert managers when they need to complete certain tasks.

Staff engagement

We are keen to engage with our staff, and our annual staff survey (see appendix 2) shows that our staff feel positive about working for us. Teams and departments hold local departmental meetings to enable two-way communications between staff and line managers. The chief executive hosts open meetings every other month, to which all staff are invited, and the chief executive and other directors visit our satellite locations on a regular basis to ensure that staff based away from the main hospital are kept informed of developments and have an opportunity to raise any issues or concerns.

A newsletter from the chief executive is circulated most weeks, and provides updates on key developments, achievements and other items of note from across the trust. This is complemented by a weekly e-bulletin, which provides a quick overview of news, developments, operational information and useful dates, with links to further information on the intranet for those who want to find out more. The appointment of a dedicated resource for staff communications at the end of 2012/13 has enabled work to get underway to update and improve the quality of information posted on the intranet. All staff also have access to *In Focus* magazine, which is additionally distributed to our foundation trust members and around our locations, and includes a dedicated 'Around Moorfields' section focusing on staff activities and achievements.

These regular communication channels are supported by face-to-face and targeted communications on key topics, including our programme to build a new central London facility, bullying and harassment focus groups (in response to the national staff survey), and new requirements around mandatory training and increments.

Our four staff governors remain active and have a dedicated presence on our intranet. They host regular drop-in sessions or walkabouts to gather views from other staff and regularly attend membership council and trust board meetings. We also have a joint staff consultative committee, which enables face-to-face contact between management, staff governors and representatives from all trades unions whose members work in the trust.

The national staff survey is a further useful mechanism for engaging with staff and receiving feedback from them. Results of the most recent survey were published in March 2014. Moorfields was rated as the fourth best acute hospital trust in the country for staff recommending the trust as a place to work or receive treatment. Staff engagement scores were very positive, but there is further work to do to improve disappointing scores for bullying and harassment, discrimination and incident reporting. Further details of the survey are provided at appendix 2 of this report.

Developing, supporting and rewarding our staff

Focus groups held to address problems identified by the 2012/13 national staff survey and other discussions with staff this year suggested the need for a less formal means of raising concerns than through our established whistle-blowing procedures. In response, we have advertised internally for volunteers to undertake a new staff contact officer role. These staff will be trained so that they are confident in helping colleagues understand what their options are and how best to deal with issues that are bothering them, which they do not feel comfortable discussing with their line manager or more senior members of staff.

We also presented a new appraisal scheme to several team briefings and identified areas in which to test it out. If successful, we plan to introduce the new system across the organisation during 2014/15.

Our employee assistance programme, open to staff and their immediate family members, provides confidential counselling, information and signposting services, designed to assist staff with personal or work-related issues that might be affecting their health and wellbeing. Staff can also access occupational health support via a service provided by Barts Health NHS Trust. The team runs an on-site service at our main hospital in City Road three days a week and can be accessed at other times via telephone or at The Royal London Hospital in Whitechapel. At the same time, our staff benevolent fund is available to all permanent staff who are experiencing severe financial difficulty or who need self-development in areas that fall outside the scope of learning and development funded by the trust. The fund is administered by the Special Trustees of Moorfields Eye Hospital.

We provide several benefits to our staff, ranging from sabbatical leave opportunities to free contact lens and VDU eye examination clinics. Staff also have access to a discounted corporate membership scheme at a gym and swimming pool local to the main City Road hospital.

Our fifth annual Moorfields' Stars ceremony took place in March 2014. The stars awards recognise and reward staff for academic achievement and long service, as well as those named as employees of the month over the previous 12 months. There are also several special awards for which staff nominate their colleagues and teams. These special awards recognise an outstanding individual, the team of the year, and innovation in patient care, research or education. We also gave stars awards to staff who were recognised nationally or internationally by other organisations during 2013, and those nominated by the public via the national NHS Heroes awards.

Learning and development

All staff at Moorfields have access to a range of learning and development courses and materials, including health and safety training. These are provided by both the trust and the joint library of ophthalmology, which is run in conjunction with our colleagues at the UCL Institute of Ophthalmology and offers a range of courses and access to many journals and other helpful resources.

Our programmes include traditional taught courses and online learning via My Learning Centre, our bespoke learning portal, which lists the training considered essential for staff to perform their jobs safely and effectively. The list is reviewed regularly by our multi-disciplinary mandatory training group. This group has also developed a range of flexible approaches to training by introducing online assessment for some topics, grouping several mandatory subjects into single or half days to make better use of staff time and implementing a system through which managers can identify online, by subject, which of their staff are up to date and which are not. Individual staff can also use this system to check their own compliance status. The mandatory training group also reviews compliance data on a regular basis to identify problems and address them as necessary.

This year, all staff were additionally offered access to NHS leadership and career development programmes, and we commissioned three clinical leadership courses for nurses. We also launched an online 'Coaching for Excellence' programme, and developed coaching masterclasses for staff in senior leadership roles. In addition, work is underway to agree a process for talent management and succession planning, to ensure that we retain our best people.

2.3.10 Commercial divisions

Moorfields has three commercial divisions – Moorfields Pharmaceuticals, Moorfields Private and Moorfields Eye Hospital Dubai. These units exist entirely to augment and support the care we provide to NHS patients by generating income from outside the NHS, which can then be reinvested in services for all our patients.

Despite the difficult financial climate, our three commercial divisions earned total income of £31.8 million, up from £29.5 million last year, and returned a joint surplus of almost £4.9 million in

2013/14, up from £4.5 million. In 2013/14 our commercial activities generated more than half Moorfields' surplus (all the surplus in 2012/13), emphasising the vital contribution these businesses make to Moorfields' ability to benefit our patients through clinical care, research and education. Moorfields would not be able to plan for the level of investment it intends in equipment and buildings without these surpluses.

Work has also been completed this year to develop MEH Ventures LLP, the partnership vehicle we will use in future to develop our commercial business activities.

Moorfields Pharmaceuticals

Moorfields Pharmaceuticals celebrated 10 years at its manufacturing facility in Nile Street during 2013. The facility, one of very few in central London, makes a comprehensive range of niche, unlicensed ophthalmic medicines (known as specials) that are often not available anywhere else in the UK. These products are used to treat the special clinical needs of patients both at Moorfields and across the UK.

The unit paused production of its specials range in the final quarter of 2013/14 to allow improvements to be made to its manufacturing facility and quality systems in order to ensure that the highest quality standards are maintained. This pause in specials production is likely to continue into the first half of 2014/15.

Despite this pause, Moorfields Pharmaceuticals edged income up to £10.4 million from £10.3 million although the unit's surplus declined from £1.2 million to £0.5 million this year.

In addition to its specials range, Moorfields Pharmaceuticals has a growing portfolio of licensed ophthalmic products and acts as a contract manufacturer for third parties producing licensed products and clinical trials supplies. This year saw the release of a new product, Dropodex ®, a preservative-free eye drop in convenient single-dose units for treating inflammatory conditions at the front of the eye. This is a prescription-only medicine and has been successfully introduced as the product of choice in many NHS hospitals.

The team is also involved in the development of the first approved drug for the safe and effective treatment of acanthamoeba keratitis (AK), a rare but severe corneal infectious disease. The project to develop and license the drug is being carried out by a pan-European partnership known as ODAK, and is funded by a substantial grant from the European Union. Moorfields Pharmaceuticals' role is to manufacture and test the products for use in stability studies and clinical trials, which are currently scheduled for later in 2014.

Moorfields Private

Moorfields Private, our private patient unit in London, enjoyed a particularly successful year in 2013/14, making a net contribution of £4.6 million for the year, an increase of over 60% on the previous year and well ahead of budget. Profits were derived from a 12% increase in revenues together with careful management of the cost base.

Moorfields Private includes a 12-bed ward area with individual rooms, each with en suite facilities, a day-case club lounge, two refractive laser theatres and outpatient consulting rooms and diagnostic facilities in three locations, all in close proximity to the City Road hospital. In addition, there are private consulting rooms at Upper Wimpole Street in London's West End.

During 2013/14, the management team developed a 10-year activity and capacity plan and sensitivity analysis to support the planning assumptions for the trust's proposed new hospital development (see section 2.3.4 above). A detailed market analysis was commissioned and this will feed into the development of a five-year strategic plan for the development of our private patient services and further refine the capacity plan.

Looking ahead, Moorfields Private will continue to develop the business, consolidating the revenue and cost improvements of 2013/14. The primary focus will be on managing its facilities to deliver the additional capacity required to meet the projected increase in activity in 2014/15, while new marketing and branding initiatives are formulated to support the identified growth opportunities.

Moorfields Eye Hospital Dubai

Moorfields Eye Hospital Dubai (MEHD), our private patient facility in the United Arab Emirates (UAE), continued to grow. We now have 10 consultants permanently based in Dubai, covering all the major ophthalmic sub-specialties. These are supported by a team of nurses, optometrists and orthoptists. Since opening its doors to patients in 2007, MEHD has treated more than 33,000 patients from more than 90 countries, and is now widely regarded as the place to go for eye care in the UAE.

For 2013/14, the unit achieved a modest operating surplus in local currency terms as we continue to invest in growth to support the full range of sub-speciality ophthalmic medicine for which Moorfields is known. Income grew by nearly 10% to £6.3 million, while the operating cash surplus translated into a modest accounting (non-cash) loss for the year due to exchange rate fluctuations.

During 2013/14, we worked closely with United Eastern Medical Services (UEMS) to develop plans to establish a clinical facility in Abu Dhabi, as part of our expansion plans in the UAE. UEMS is a respected local provider of healthcare in Abu Dhabi that already has a strong track record of partnership with European and Asian clinical partners. Under this partnership arrangement, UEMS will provide the physical and administrative infrastructure while Moorfields will provide the clinical expertise.

Combined with our existing provision in Dubai, we expect the Moorfields/UEMS joint venture to embed our multi-speciality offering across the UAE and support our growth ambitions for the region.

In addition, our historical relationship with Imperial College London Diabetes Centre in Abu Dhabi and Al Ain, where we provide eye clinical services to diabetes patients, was ratified and consolidated during the year.

Also this year, MEHD signed a memorandum of understanding with Dubai Healthcare City (DHCC) to promote the development of specialised eye healthcare in the UAE, including education and research. Since the signing, MEHD has commenced regular teaching sessions in collaboration with DHCC as well as participating in scientific meetings supported by different pharmaceutical companies. Ultimately, education and research in the Gulf will benefit both the local population and the Arabic population in the UK.

The establishment of MEHD was the first time an NHS hospital had opened an overseas hospital. In January 2014, a delegation from Healthcare UK made a study visit to MEHD. Healthcare UK is a joint initiative of the Department of Health, UK Trade and Investment and NHS England, which aims to help UK healthcare providers to do more business overseas.

2.3.11 Financial report

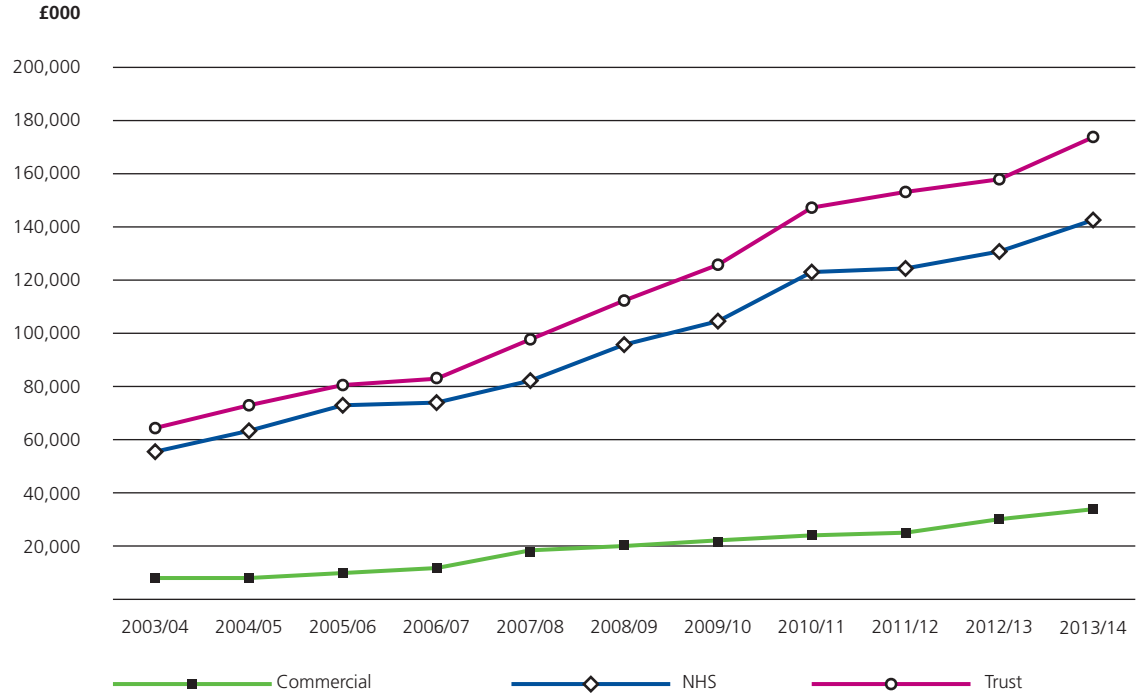
Overview

Moorfields had a successful year financially. The trust's income grew strongly in the year, by 10% or £15.8 million to £173.9 million from £158.1 million. Costs rose by 7% or £10.8 million to £164.6 million from £153.8 million. As a result, the trust's surplus increased by £5.1million to £9.3 million from £4.2 million. The surplus enabled us to maintain a continuity of services risk rating of four at the end of the year (where one is the worst and four is the best rating).

The trust again generated substantial cash with which it funded £9 million of capital expenditure (the highest level of capital investment since the children's centre was constructed in 2007), eliminated its outstanding debt of £4.8 million and was able to add modestly to the cash reserves being accumulated towards the trust's prospective new central London building – the largest capital project the trust has ever undertaken.

Moorfields was founded more than 200 years ago, and the year to 31 March 2014 was its 10th year as an NHS foundation trust. The diagram below charts Moorfields' income over the decade to 2013/14. During this time, direct NHS income has grown by two and a half times while commercial income has grown by three and a half times. The more rapid growth of commercial income has lifted it from 16% of NHS income to 22% over the decade, helping to strengthen Moorfields' ability to earn surpluses to invest in NHS patient care.

Income



In the next 10 years, Moorfields' financial outlook is dominated by the costs of replacing our Victorian central London building at City Road. The financial planning for the new central London building has advanced considerably and it is clear that this represents a very substantial challenge over the next few years. Accordingly, the trust's surpluses are a crucial part of funding the new building – both directly through accumulating a significant cash contribution and also through using higher surpluses to meet the costs of the substantial debt that will be needed. Fundraising and some development proceeds from the City Road site will also help fund the project.

The level of surplus needed over the next 10 years will be refined as Moorfields' planning for the new building advances. If the last three years of austerity are taken as a whole, Moorfields has achieved a surplus of 4% of income with an annual low of 2.7% in 2012/13 and a high of 5.3% this year. It is likely that Moorfields' surplus performance needs to improve ahead of the new building.

Review of 2013/14

Statement of comprehensive income

The trust's income grew strongly in the year, by 10% or £15.8 million to £173.9 million from £158.1 million. Operating expenses rose by £10.9 million or 7% to £162.5 million from £151.7 million. The overall cost of finance, including dividends on public dividend capital (PDC), fell marginally from £2.2 million to £2.1 million as a result of repaying the trust's outstanding loans and leases in the last two years despite the PDC dividend rising year on year. Total costs rose by 7% or £10.8 million to £164.6 million from £153.8 million. As a result, the trust's surplus increased by £5.0 million to £9.3 million from £4.2 million.

After arriving at the surplus for the year, the statement of comprehensive income deals with non-cash revaluation effects, principally the market value in continuing use of land and buildings. Following a standard mandatory change in the valuation methodology last year that saw a reduction in values of £6.0 million, this year saw £2.7 million added to asset values principally due to the assessed value of buildings. The result of the improved surplus and valuation turnaround was a sharply higher total comprehensive income result for the year of £12.0 million, up from a loss of £1.8 million the previous year.

Income and expenditure

The table below presents a high-level comparison between 2013/14 and 2012/13; segmental information for the year is given at note 2 to the accompanying accounts.

All figures in £million	2013/14 Actual	2012/13 Actual
Income		
Income from activities		
– NHS income	122.7	111.4
– Private	21.6	19.5
Total income from activities	**144.3**	**30.9**
Other operating income		
– Moorfields Pharmaceuticals	9.5	9.4
– Non-clinical income	20.0	17.8
Total other operating income	**29.5**	**27.2**
Total income	**173.9**	**158.1**
Expenditure		
Pay costs	90.7	86.6
Non-pay costs	65.7	59.6
Depreciation and amortisation	6.1	5.5
Total expenditure	**162.5**	**151.7**
Operating surplus	**11.3**	**6.4**
Interest and dividends	**2.1**	**2.2**
Net surplus	**9.3**	**4.2**

Our total income grew by 9.9% to £173.9 million from £158.1 million last year. The principal growth areas were NHS income (£11.3 million), private and overseas income (£2.1 million) and other non-clinical income sources (£2.3 million).

NHS clinical income is paid for at prices generally set by the Department of Health (DH). Although prices fell compared with the previous year, reflecting the Government's requirement for increased NHS efficiency, activity and other price increases meant that our income from NHS activities grew by £11.3 million (10.2%), from £111.4 million in 2012/13 to £122.7 million in 2013/14. Strong growth in outpatient and elective income, the increased use of Lucentis in the treatment of wet age-related macular degeneration (AMD) and income from activities where prices are not set centrally by the DH were higher than expected. These activities include patient treatments as well as reimbursement for certain drugs deemed to be 'expensive' under the relevant DH rules.

Income from our private and overseas patient activities in London and Dubai rose to £21.6 million, compared with £19.5 million in 2012/13. Moorfields Pharmaceuticals made sales of £9.5 million to other organisations during the year, a small increase compared with 2012/13 (£9.4 million).

Non-clinical income arises from activities including research and development, education and training, charitable income and other income. Total non-clinical income rose by £2.3 million (12.7%) to £20.0 million from £17.8 million in the previous year.

The Health and Social Care Act 2012 requires that our income from the provision of goods and services for the purposes of the health services in England must be greater than our income from the provision of goods and services for any other purpose. During 2013/14, we met this requirement. Our principal source of income from other purposes is through our commercial divisions, and we do not assess these as adversely impacting on our provision of NHS healthcare. The divisions exist entirely to augment and support the care we provide to NHS patients by generating income from outside the NHS which can then be reinvested in services for all our patients.

Expenditure grew by £10.9 million (7.2%) to £162.5 million from £151.7 million last year, following investments and growth in our core NHS clinical services. Pay costs of £90.7 million rose by £4.3 million (4.7%) from £86.6 million in 2012/13, an increase due mainly to the higher number of staff required to treat increased numbers of patients, combined with investments made in our staffing base during the year. Note 5 within the annual accounts provides further details.

Non-pay costs increased by £6.1 million, or10.2%, from £59.6 million last year to £65.7 million during the year. The main components of non-pay expenditure are shown in the table below. Drug costs fell due to reductions in the drug price used for the treatment of age-related macular degeneration (AMD). Costs of clinical supplies increased during the year, mainly due to increased clinical activity, but offset by savings in this area. Premises costs increased due to consultancy costs, estates maintenance, engineering and building contracts, rents and leases and clinical equipment repairs, combined with costs for our new building project.

Expenses type All figures in £million	2013/14 Actual	2012/13 Actual
Drug costs	17.0	17.9
Clinical supplies and services	13.6	11.9
Establishment	4.4	4.1
Transport	2.6	2.3
Premises	16.8	12.8
Other	11.3	10.3
Total	**65.7**	**59.6**

Cost improvement

Our cost improvement programme (CIP) has achieved £6.4 million in efficiencies at the same time as maintaining the quality of our services. As part of our CIP assurance process during the year, the medical director and the director of nursing and allied health professions were required to scrutinise and approve proposed savings schemes against a range of quality standards before they were agreed.

Statement of financial position

The balance sheet totals increased by £12.8 million from £80.9 million to £93.7 million, principally reflecting the surplus of £9.3 million and asset revaluations of £2.7 million.

Non-current assets increased by £5.4 million to £82.3 million from £76.9 million due mainly to revaluation of land and building assets, as recommended by our property valuers, alongside capital expenditure across asset types partially offset by the year's depreciation charge.

Current assets increased by £7.3 million, from £36.8 million to £44.1 million during the year as trade and other receivables increased along with cash holdings. Cash holdings were £24.3 million (2012/13: £20.6 million).

Current liabilities increased to £32.1 million (2012/13: £27.9 million) due to normal variations in the timing of payments to suppliers. Non-current liabilities fell to £0.6 million from £4.9 million, due to repayment of borrowings.

Public dividend capital increased to £32.0 million (2012/13: £31.3 million) due to a cash grant from the Department of Health for use in certain capital projects.

Taxpayers' equity rose by £12.8 million to £93.7 million from £80.9 million in the year. The taxpayers' equity section (augmented by the statement of change in taxpayers' equity) highlights that the principal funding drivers of the increase in total assets employed were the year's surplus of £9.3 million and the revaluation of buildings of £2.7 million along with the issue of public dividend capital.

Statement of cash flows

Moorfields had another strong cash performance, generating net cash of £18.2 million from operations, up £1.2 million from £17.0 million last year.

The strong operating surplus was offset by slower collections from debtors, and higher payments on capital infrastructure to trade creditors and to loan creditors. The net result was a cash inflow of £3.7 million in year, compared with a cash inflow of £2.1 million in 2012/13, as cash and cash equivalents rose from £20.6 million in 2012/13 to £24.3 million in 2013/14.

In both 2013/14 and 2012/13 the main uses of cash generated were capital expenditure (equipment, software and buildings) and debt repayment. In 2013/14, Moorfields' capital expenditure was £9.0 million (£7.3 million in 2012/13) – the highest level since construction of our children's centre in 2006/07. Moorfields paid off its final debt balances of £4.8 million this year having repaid £6.0 million in the previous year.

The trust needs retained cash balances to fund the monthly pattern of income and expenditure as it grows. Nevertheless, within total cash, although the monies on hand for the new central London building are welcome, we are still significantly short of the minimum £30 million of retained cash identified as needed for this project. This emphasises the continued need for a strong operating and financial performance at Moorfields.

Borrowing

Since attaining foundation trust status, Moorfields has taken out long-term loans from the foundation trust financing facility. No further loans were taken out during 2013/14. Given very low returns on bank deposits and a good cash position, borrowings of £4.8 million were repaid in 2013/14, leaving outstanding borrowings of nil.

Counter-fraud arrangements

Moorfields has established a counter-fraud policy and response plan to minimise the risk of fraud or corruption, together with a code of conduct and a whistle-blowing policy to be followed in the event of any suspected wrong-doing being reported. The policies and related materials are available on the intranet and counter-fraud information is prominently displayed on our premises. The trust's local counter-fraud specialist (LCFS) reports to the chief financial officer and performs a programme of work designed to provide assurance to the board in regard to fraud and corruption. The LCFS attends audit committee meetings to present the programme and the results of counter-fraud work. The LCFS also gives regular fraud awareness sessions for Moorfields' staff and investigates concerns reported by staff; if these are substantiated, the trust takes appropriate criminal, civil or disciplinary measures.

Accounting policies and other declarations

The accounting policies for the trust are set out in note 1 of the notes to the accounts in the annual accounts section at appendix 5.

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

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

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

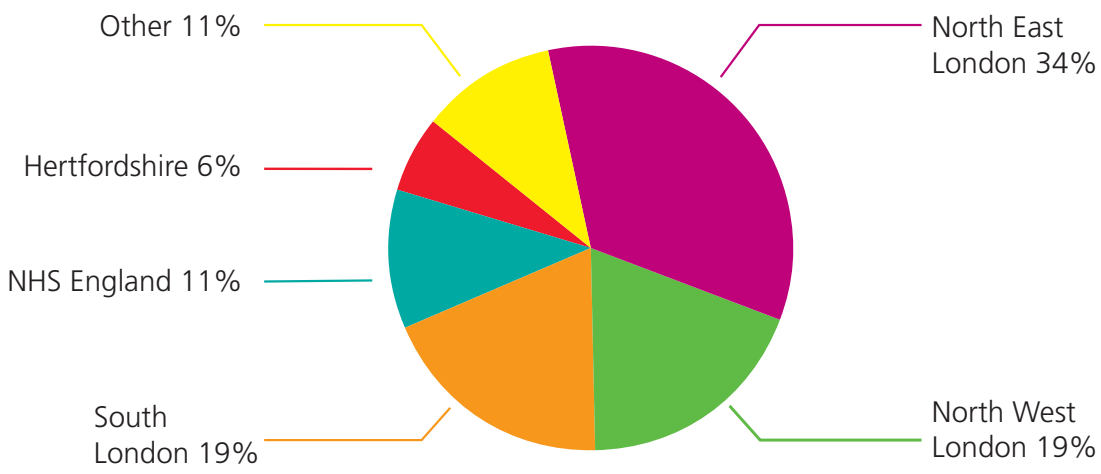
Commissioning arrangements

Moorfields undertook £113 million of contracted clinical activity in 2013/14 for commissioners from across the UK. Of this, £110 million relates to our contracts with more than 70 clinical commissioning groups (CCGs) and £3 million relates to referrals outside contract (non-contracted activity).

Our NHS income includes this contracted activity, but also includes other items, principally activity at Bedford that is not under our main acute contract, some non-contract high cost drugs and amounts

we have billed where the number of patients we have seen have been in excess of those planned for in our contract.

Our largest contracts are with North West London CCGs, South London CCGs, North East London CCGs, NHS England, and Hertfordshire CCGs, as set out in the pie chart below. Together, these clusters account for 89% of our total contracted activity.



Financial outlook for 2014/15

Moorfields faces the challenge of improving financial performance while the funding environment continues to tighten as a result of the current period of austerity in government finances. Moorfields has set a surplus budget for 2014/15 and indicated a further surplus budget in 2015/16 in its filings with its regulator, Monitor. However, there are a number of significant uncertainties, particularly for 2015/16, including the unknown nature of the tariff mechanism by which NHS clinical income is paid to Moorfields for the care it provides. Moorfields will continue to seek opportunities for both growth and cost control as it works to secure future surpluses.

2.3.12 Looking ahead

In agreeing our priorities for the next two years, we have taken account of a range of external factors that will influence our future delivery of services and quality of care.

These include, but are not limited to:

- The formalisation of clinical commissioning groups and the impact of their commissioning responsibilities with increased tendering of ophthalmic services
- Implementing the relevant recommendations in the Francis report and other subsequent quality reviews
- The introduction of a new Care Quality Commission (CQC) inspection regime for hospitals
- The changing role of Monitor as sector regulator
- The establishment of Local Education and Training Boards (LETBs) which have a major influence on commissioning and funding of clinical education
- New clinical research network (CRN) arrangements that are challenging historic clinical research metrics

We are also conscious of the need to support the key objectives of the Government's mandate with the NHS Commissioning Board, which include seven-day working, greater transparency and choice, listening to patients and increasing their participation, better data, informed commissioning and improved outcomes, and higher standards and safer care.

The national drive to improve and scrutinise performance, quality and safety will be strengthened with revisions to the NHS mandate, new hospital star ratings, levelling of clinical outcomes and further emphasis on recommendations of the Francis and other reports. The Friends and Family test will be extended to all hospital services and patients will be able to access their electronic records more freely than previously. Further opportunities are anticipated for patients to express their views about services.

An unprecedented affordability gap is forecast for the healthcare system and this will impact most noticeably in 2015/16. This is likely to include increased tendering and competition, changes to the national tariff system and severe pay restraints, as well as the renegotiation of staff terms and conditions of employment.

Finally, London has a growing and ageing population, with increasing numbers of frail and older people and an ever greater incidence of chronic disease. At the same time, the public rightly expects ever higher standards of safety, quality and access to services coupled with greater expectations arising from medical innovations and future research and development. These factors will impact on the demand for our services.

Our annual plan is the delivery vehicle for our overall strategy, *Our Vision of Excellence* (see section 2.2.1), but our 2013/14 plan contained 18 priority areas grouped within the eight strategic and enabling themes. These priority areas include 48 subsidiary actions, many of which contained multiple workstreams. While this approach has served us well for the last three years, we considered that we needed to refresh our approach to ensure that we were able to concentrate on the key issues and accelerate the implementation of critical workstreams. We have therefore decided that our strategic priorities should only represent these core activities, and that the trust board and trust management board will focus on monitoring these priorities.

We will continue to deliver many other workstreams, without distracting our focus from the strategic priorities, as 'business as usual' and will monitor these through regular management reviews.

Our priorities for 2014-16 are to:

- Improve the patient experience and our organisational efficiency by delivering an operational redesign programme across all sites to improve the way Moorfields delivers care, encompassing patient communications and administration, operational planning and performance, cost efficiency and investment, workforce planning, leadership and management
- Deliver an electronic clinical record and a paper-light environment, through full implementation of OpenEyes as the clinical record across all sites and services, with the minimum of day-to-day disruption, and benefits realisation through cultural change
- Deliver our quality plan as quality and safety for our patients is paramount; the plan will be agreed by staff and patients with a focus on patient experience and outcomes, include intelligible and meaningful metrics and ensure that we deliver excellent care
- Continue the development of our new joint facility with the UCL Institute of Ophthalmology, acquiring a site for the new facility, completing the design and supporting business cases, commencing fundraising and agreeing partnering arrangements with UCL

- Realise our vision of excellent education, through our education strategy, ensuring that Moorfields becomes a pro-active leader in this field

We will also ensure that these new priorities are reflected in local departmental and directorate plans and aligned to appraisals and personal objectives so that everyone is clear how they can contribute to achieving our goals.

Our full operational plan for 2014 to 2016 contains further detail and is published on our website.

John Pelly, chief executive

29 May 2014

3 Directors' report

Moorfields Eye Hospital NHS Foundation Trust is authorised to operate as a public benefit corporation under the National Health Service Act 2006. The trust is led by the board of directors, which is accountable to the board of governors, known at Moorfields as the membership council. The responsibilities of both are laid out in the trust's constitution, which is a key requirement of the trust's provider licence. The roles and responsibilities of each are described in this section and in the membership report at section 4.

3.1 Board of directors

The board of directors holds overall accountability for the organisation and is responsible for strategic direction and the high-level allocation of resources. It delegates decision-making for the operational running of the trust to the chief executive.

Our board comprises seven non-executive directors and, all of whom are considered to be independent, and six executive directors.

Non-executive directors and the chairman are appointed by the membership council following recommendations from the nominations committee for non-executive directors (see section 4.2 below). During 2013/14, the committee considered the reappointments of four non-executive directors, including the chairman, who had completed two three-year terms, via a formal and rigorous interview process composed of a panel consisting only of governors. Following this panel, the committee recommended the reappointment for one year of all four non-executive directors and it also recommended a process for the annual assessment of non-executive directors in line with the new statutory requirements introduced by the Health and Social Care Act 2012. The membership council agreed all of these recommendations.

Our constitution also allows for the UCL Institute of Ophthalmology to have a representative on the trust board, which means that this non-executive appointment is not subject to the usual selection processes. Executive directors are appointed by the nominations committee of the board of directors.

Directors during 2013/14

Board member	Position	Date and length of appointment
Rudy Markham (10) (Background – finance director)	Chair Chair of remuneration and nomination committees	1 April 2008 for three years; renewed 1 April 2011 for three years; renewed 1 April 2014 for one year
Deborah Harris-Ugbomah (11) (Background – chartered accountant)	Non-executive director Chair of audit committee	1 January 2008 for three years; renewed 1 January 2011 for three years; renewed 1 January 2014 for one year
Sir Roger Jackling (9) (Background – civil service)	Non-executive director Vice chair and senior independent director Chair of strategy and investment committee	1 April 2008 for three years; renewed 1 April 2011 for three years; renewed 1 April 2014 for one year
Professor Phil Luthert (8) (Background – ophthalmic pathologist and research scientist)	Non-executive director Director of the UCL Institute of Ophthalmology Chair of quality and safety committee	1 February 2006
Andrew Nebel (11) (Background – marketing and communications director)	Non-executive director Chair of new hospital committee	1 April 2008 for three years; renewed 1 April 2011 for three years; renewed 1 April 2014 for one year
Sumita Sinha (10) (Background – architect)	Non-executive director	22 April 2013 for three years
Steve Williams (8) (Background – lawyer)	Non-executive director	15 March 2012 for three years
John Pelly (10) (Background – accountant and health service management)	Chief executive	
Rob Elek (1/1) (Background - health service management and consultancy)	Interim chief operating officer (from 16 August to 6 October 2013)	
Mr Declan Flanagan (10) (Background – ophthalmic surgeon)	Medical director	
Professor Sir Peng Tee Khaw (11) (Background – ophthalmic surgeon and clinician scientist)	Director of research and development	
Tracy Luckett (9) (Background – registered nurse)	Director of nursing and allied health professions	
Charles Nall (11) (Background – finance and corporate services management)	Chief financial officer	
Ruth Russell (4/4) (Background – qualified nurse and health service management)	Chief operating officer (until 15 August 2013)	
Mary Sherry (6/6) (Background – health service management)	Chief operating officer (from 7 October 2013)	

All board meetings were held in public and the bracketed numbers in the table above refer to the number of public board meetings directors attended during 2013/14 out of a possible 11, unless otherwise noted. The board also holds a confidential meeting each month as required. The board of directors believes that it has the appropriate balance and completeness in its composition to meet the requirements of an NHS foundation trust.

The following directors, who are formally associate directors, also attend board meetings, but do not have voting rights:

Job title	Name	Comments
Director of NHS finance and deputy CFO	Steven Davies	From 1 September 2013
Director of strategy and business development	Rob Elek	
Director of human resources	Sally Storey	
Director of corporate governance	Ian Tombleson	

3.2 Committees of the board

Audit committee

The board of directors is required to maintain a sound system of internal controls to safeguard its NHS clinical services, assets, and non-NHS commercial services and investments. The existence of an independent audit committee (in conjunction with the other board committees) is a means by which this board receives evidence of independent checks on the trust's system of governance (both clinical and corporate), financial risk management and the systems and internal controls of the organisation. It is also a means used by the board to assure itself of the quality and effectiveness of arrangements in these areas.

The audit committee is an independent source for the review, monitoring and reporting to the board about the trust's attainment of effective integrated governance, control systems and financial reporting processes. In particular, the committee's work focuses on the framework for mitigating financial management risks and financial reporting risks, internal controls and related assurances that underpin the delivery of the trust's corporate strategy.

The audit committee seeks to satisfy itself that the board is sufficiently informed to enable it adequately to complete regular and robust reviews of the board assurance framework and evaluate the effectiveness with which critical business risks are addressed. The committee uses the trust's board assurance framework to guide its work.

The audit committee advises the board about the adequacy and effectiveness of the trust's systems of internal control, its arrangements for governance processes, service quality and trust economy, efficiency and effectiveness ('value for money'). The committee also offers recommendations to the board for approval of the trust's annual accounts and financial statements, management letter of representation and (if supplied for committee review) the annual report. Together with the quality and safety committee, the audit committee also offers recommendations to the board for approval of the trust's annual quality report.

In carrying out its duties, the audit committee draws on, but is not limited to, the work of internal and external audit, the local counter-fraud specialist, financial and performance reports of management and evidenced assurances from management.

The audit committee provides interim activity reports and an annual report to the board. These reports comply with the additional requirements from the code of governance and increase the visibility of the audit process to stakeholders. In addition, the audit committee submits an annual report to the membership council. Reports draw on information supplied by internal audit, external audit, the local counter-fraud specialist, management reviews and other assurance providers relied upon during the period.

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

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

The audit committee comprises three non-executive directors. The directors have satisfied themselves that all the members of the committee are competent in financial matters. The chair has recent and relevant financial experience and is also the chair of the Association of Audit and Financial Non-Executive Directors (AFNED). The committee's meetings are attended, by invitation, by the chief executive, chief financial officer, director of corporate governance, the internal auditors, the local counter-fraud specialist, the external auditors and others as required.

During 2013/14, the audit committee met as follows:

Members/dates	20/5/13	16/7/13	16/10/13	12/12/13	30/1/14	6/3/14	Totals
Deborah Harris-Ugbomah	✓	✓	✓	✓	✓	✓	6/6 (100%)
Roger Jackling	✓	✗	✓	✓	✓	✓	5/6 (83%)
Andrew Nebel	✗	✓	✓	✓	✓	✓	5/6 (83%)
Total attendance	**2/3 (67%)**	**2/3 (67%)**	**3/3 (100%)**	**3/3 (100%)**	**3/3 (100%)**	**3/3 (100%)**	

Significant issues considered by the audit committee

The audit committee workplan covers a wide range of issues. The members received reports during 2013/14 from a number of sources. Key issues that were considered included the need to improve data quality across the organisation; the adequacy of plans to resource the trust's growth in activity and size; the implementation of IT projects and the oversight of governance processes to support IT implementations. The audit committee received expert advice as required in consideration of management assurances for these issues.

Internal audit

The trust's internal audit function is performed by KPMG LLP. The role of internal audit is to focus on reviewing areas that either complement or underpin delivery of the trust's strategy, based on risk

assessment. KPMG provide written updates on progress against an annual internal audit workplan and any recommendations made to management at audit committee meetings. This enables the committee to track both the timely completion of the workplan and the implementation of recommendations by management.

Where internal audit reviews indicate a material, significant or repeated theme of concern, the committee also makes appropriate, timely recommendations for the board to assess and seek adequate assurance from executive management as necessary.

External audit

Moorfields' external auditor is Deloitte LLP. The type of services and costs are detailed below.

	2013/14 £000	2012/13 £000
Statutory audit services	73	83
VAT consultancy services	26	68

Deloitte's work on VAT delivered total recoveries of £0.1 million in 2013/14 (2012/13: £0.2 million).

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

The audit committee also reviews the statutory audit, tax and other services (as relevant) provided by Deloitte, and compliance with the trust's policy which prescribes in detail the types of services which the external auditors can and cannot provide. The services provided relate to:

- External audit
- Other audit services, for example work which regulators require the auditors to undertake, such as on behalf of Monitor
- Some tax services, for example value added tax (VAT) consultancy

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

Council of governors (membership council)

Following completion of the work of the external auditors, the audit committee did not identify any matters where it considered that action or improvement was needed and therefore has made no recommendations to the membership council. In light of this, the committee made a positive report to the governors, which included that the external audit was of a sufficiently high standard and the fees were reasonable and in line with the agreed contract.

New hospital committee

The new hospital committee has six principal roles relating to the development and construction of a new facility to replace the existing City Road campus: to provide assurance that all aspects of the project have been appropriately managed by the project board; to scrutinise and challenge the key decisions of the project board; to ensure that the project is affordable within the envelope set by the financial strategy approved by the strategy and investment committee and represents value for money; to endorse the overall project programme; to work collaboratively with the strategy and investment

committee to ensure that business requirements and cases are jointly approved by both committees and that the trust complies with Monitor and other relevant investment guidance; and to provide assurance that project risks are appropriately recorded and mitigated by the project board.

The core membership of the committee was changed during the year, and now comprises three non-executive directors, one of whom chairs the committee, the chief executive and the director of strategy and business development, with an open invitation to all other non-executives to attend. Other directors and senior managers are invited to attend as appropriate.

During 2013/14, the new hospital committee met as follows:

Members/dates	30/5/13	17/10/13	4/12/13	4/3/14	Totals
Rob Elek	N/A	N/A	N/A	✓	1/1 (100%)
Andrew Nebel	✓	✓	✓	✓	4/4 (100%)
John Pelly	✓	✓	✓	✓	4/4 (100%)
Sumita Sinha	N/A	N/A	N/A	✓	1/1 (100%)
Steve Williams	✗	✗	✗	✗	0/4
Total attendance	**2/3 (67%)**	**2/3 (67%)**	**2/3 (67%)**	**4/5 (80%)**	

Nominations committee

The nominations committee makes recommendations to the board about the appointment of executive and other director positions and is established when required. The committee is chaired by the trust's chairman and comprises all non-executive directors and the chief executive. A rigorous selection process took place during 2013/14 to recruit a new chief operating officer via a competitive external process and the trust board agreed a recommendation to recruit to this post.

During 2013/14, the nominations committee met as follows:

Members/dates	15/5/13	9/8/13	5/9/13	Totals
Deborah Harris-Ugbomah	✓	✓	✓	3/3 (100%)
Roger Jackling	✓	✓	✓	3/3 (100%)
Phil Luthert	✓	✗	✗	1/3 (33%)
Rudy Markham	✗	✓	✓	2/3 (67%)
Andrew Nebel	✗	✓	✓	2/3 (67%)
John Pelly	✓	✗	✓	2/3 (67%)
Sumita Sinha	✗	✗	✓	1/3 (33%)
Steve Williams	✓	✓	✓	3/3 (100%)
Total attendance	**5/8 (63%)**	**5/8 (63%)**	**7/8 (88%)**	

Remuneration committee

The remuneration committee is responsible for setting the pay and terms of employment of executive directors and other board-level posts, as well as taking an overview of performance reward in the trust. The committee is chaired by the trust's chairman and comprises all non-executive directors. The committee's decisions are informed by benchmarking information derived from published reward research, such as the IDS NHS Boardroom Pay Report, and surveys of other trusts' remuneration for similar posts.

During 2013/14, the remuneration committee met as follows:

Members/dates	27/6/13	9/8/13	5/9/13	Totals
Deborah Harris-Ugbomah	✓	✓	✓	3/3 (100%)
Roger Jackling	✗	✓	✓	2/3 (67%)
Phil Luthert	✓	✗	✗	1/3 (33%)
Rudy Markham	✓	✓	✓	3/3 (100%)
Andrew Nebel	✓	✓	✓	3/3 (100%)
Sumita Sinha	✓	✗	✓	2/3 (67%)
Steve Williams	✗	✓	✓	2/3 (67%)
Total attendance	**5/7 (71%)**	**5/7 (71%)**	**6/7 (86%)**	

The chief executive and the director of human resources attend meetings of the remuneration committee in an advisory capacity.

Strategy and investment committee

This committee conducts independent and objective reviews of strategic direction and investment policies, and has specific responsibilities in relation to risk. The committee is chaired by a non-executive director, with a second non-executive director, the chief executive, the chief financial officer, the medical director and the director of strategy and business development as members. The NHS finance director/deputy CFO became a formal member of the committee in November 2013.

During 2013/14, the strategy and investment committee met as follows:

Members/dates	9/5/13	10/7/13	12/9/13	7/10/13	7/11/13	9/1/14	13/3/14	Totals
Steven Davies	N/A	N/A	N/A	N/A	✓	✓	✓	3/3 (100%)
Rob Elek	✓	✓	✓	✓	✓	✓	✓	7/7 (100%)
Declan Flanagan	✓	✓	✓	✓	✓	✓	✗	6/7 (86%)
Roger Jackling	✓	✓	✓	✓	✓	✓	✓	7/7 (100%)
Charles Nall	✓	✓	✓	✓	✓	✗	✓	6/7 (86%)
Andrew Nebel	✓	✓	✓	✗	✓	✓	✓	6/7 (86%)
John Pelly	✓	✓	✓	✓	✓	✓	✓	7/7 (100%)
Total attendance	**6/6 (100%)**	**6/6 (100%)**	**6/6 (100%)**	**5/6 (83%)**	**7/7 (100%)**	**6/7 (86%)**	**6/7 (86%)**	

Quality and safety committee

The quality and safety committee provides independent and objective review of all aspects of quality and safety at Moorfields. It also has specific responsibility for ensuring that risks relating to quality and safety are scrutinised. The committee is chaired by a non-executive director and its membership also includes two non-executive directors, the chief executive, the chief operating officer, the director of nursing and allied health professions, the medical director, the clinical director of quality and safety and the director of corporate governance. Two governors from the membership council are also invited to attend.

During 2013/14, the quality and safety committee met as follows:

Members/dates	22/5/13	19/7/13	18/10/13	13/12/13	28/2/14	Totals
Declan Flanagan	✓	✓	✓	✓	✓	5/5 (100%)
Melanie Hingorani	✗	✓	✓	✓	✓	4/5 (80%)
Tracy Luckett	✓	✓	✓	✓	✓	5/5 (100%)
Phil Luthert	✓	✓	✓	✗	✗	3/5 (60%)
John Pelly	✓	✓	✓	✓	✓	5/5 (100%)
Ruth Russell	✗	✓	N/A	N/A	N/A	1/2 (50%)
Mary Sherry	N/A	N/A	✗	✓	✓	2/3 (67%)
Sumita Sinha	✓	✗	✓	✓	✓	4/5 (80%)
Ian Tombleson	✓	✓	✓	✓	✓	5/5 (100%)
Steve Williams	✗	✗	✗	✗	✓	1/5 (20%)
Total attendance	**6/9 (67%)**	**7/9 (78%)**	**7/9 (78%)**	**7/9 (78%)**	**8/9 (89%)**	

3.3 Managing risk

The chief executive has overall responsibility for risk management, which is managed through the trust management board and the management executive team, as well as the groups and committees that report to them. Individual directors have specific accountabilities for different categories of risk. This is explained further in the annual governance statement, included in the annual accounts at appendix 5.

Risk management standards

Moorfields was accredited at level 3 for the NHS Litigation Authority's (NHSLA) risk management standards following an assessment completed in December 2011. This is the highest level possible and means that Moorfields has demonstrated that our risk management processes are solid and well controlled. It is also financially beneficial, as contributions to the NHSLA's clinical negligence and risk pooling schemes, which provide insurance against claims for negligence, are lower for trusts at level 3. Work continued throughout 2013/14 to ensure that systems are in place to maintain compliance with the level 3 standard. During 2013/14, the NHSLA ceased to operate its assessment system and going forward for 2014/15, Moorfields has devised a comparable system to maintain the equivalent standards to those of NHSLA level 3.

Registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator for all health and social care services in England, and has responsibility for licensing providers of such services and for ensuring that they meet a wide range of essential quality and safety standards. In order to be licensed, providers must demonstrate they meet these standards, and are then subject to periodic assessments of their continuing compliance with them. At Moorfields we have separate CQC registrations for each of the sites from which we provide surgical services, nine in all, including our new eye centre at Croydon University Hospital, which opened on 1 April 2014.

During 2013/14, our satellite centres at Ealing and Northwick Park hospitals were assessed as being fully compliant against six of the essential standards of quality and safety for which they were assessed during unannounced CQC inspections in September 2013 and May 2013 respectively.

Monitor risk ratings

Monitor, the independent regulator for NHS foundation trusts, assesses trusts on a quarterly basis on three key performance measures as follows:

- Financial risk rating (FRR), rated 1 to 5, where 1 represents the highest and 5 the lowest risk; this measure was replaced from quarter 3 of 2013/14 by the continuity of service risk rating (CoSRR), rated 1 to 4, where 1 represents the highest and 4 the lowest risk
- Governance risk rating, rated red, amber or green
- Mandatory services, rated as red, amber or green

Moorfields' performance against these measures in 2013/14 is set out below, alongside data for 2012/13 where applicable for comparative purposes.

	2013/14	2012/13
Financial risk rating		
Annual plan	4	3
Quarter 1	5	4
Quarter 2	5	4
Quarter 3	N/A	4
Quarter 4	N/A	4
Continuity of service risk rating		
Annual plan	4	N/A
Quarter 1	N/A	N/A
Quarter 2	N/A	N/A
Quarter 3	4	N/A
Quarter 4	4	N/A
Governance risk rating		
Annual plan	Green	Green
Quarter 1	Green	Green
Quarter 2	Green	Green
Quarter 3	Green	Green
Quarter 4	Green	Green
Mandatory services		
Annual plan	Green	Green
Quarter 1	Green	Green

	2013/14	2012/13
Quarter 2	Green	Green
Quarter 3	Green	Green
Quarter 4	Green	Green

Serious incidents involving data loss or confidentiality breach

We reported one serious incident involving personal data in 2013/14 as follows:

Date of incident	Nature of incident	Nature of data involved	Number of people potentially affected
November 2013	Briefcase was stolen from a clinician's car	Medical images, USB stick containing personal data relating to Moorfields patients	15
Notification steps: Individuals potentially affected notified by post; staff bulletin message was issued to remind staff of their responsibilities			

Further action:

1. A staff leaflet about information governance will be revised to reflect best practice
2. Lessons learned from this incident will be covered during information governance training, the monthly learning incidents digest, and other publications across the trust
3. Information governance guidance published on the trust's intranet will be revised to reflect best practice

The table below represents a summary of other personal data related incidents in 2013/14:

Category	Breach type	Total
A	Corruption or inability to recover electronic data	None
B	Disclosed in error	29
C	Lost in transit	1
D	Lost or stolen hardware	None
E	Lost or stolen paperwork	1
F	Non-secure disposal – hardware	None
G	Non-secure disposal – paperwork	5
H	Uploaded to website in error	None
I	Technical security failing (including hacking)	None
J	Unauthorised access/disclosure	None
K	Other	15

3.4 Performance assessment

The chief executive evaluates the performance of each of the executive and other directors who report directly to him, while the chairman carries this out for the chief executive and the non-executive directors. The vice chairman/ senior independent director leads the evaluation of the chairman of the board of directors, in association with the vice-chairman of the membership council.

3.5 Register of interests for the board of directors

The register of interests of individual directors is available to the public on request in writing to the director of corporate governance, Moorfields Eye Hospital NHS Foundation Trust, 162 City Road, London EC1V 2PD, by email to foundation@moorfields.nhs.uk or telephone 020 7566 2490. There were no significant conflicting commitments of the chairman.

4 Membership report

This section sets out the roles and responsibilities of the board of governors, known at Moorfields as the membership council, along with other relevant information about our foundation trust membership arrangements.

4.1 Membership council

The membership council has a duty under the NHS Act 2006 to represent the interests of NHS foundation trust members and the public and trust staff in the governance of an NHS foundation trust. The membership council includes elected and nominated governors as shown in the table below and has decision-making powers defined by statute. These powers are described in our constitution and are mainly concerned with holding to account the non-executive directors individually and collectively for the performance of the trust board; the appointment, removal and remuneration of the chairman and non-executive directors; the appointment and removal of our external auditors; the provision of views about our annual plan; and scrutiny of our annual accounts and the quality account.

The council met five times in general meetings during 2013/14 to discuss a wide range of subjects, including quality and safety, the patient experience, Moorfields' business agenda and our strategic plans. The membership council meets from time to time to discuss confidential matters as required.

Executive and non-executive directors routinely attend membership council meetings, and non-executive directors are linked to one or more of the public and patient constituencies. This provides a direct link for governors to a member of the board, and acts as an additional bridge between the two bodies. Governors receive the minutes and agenda of the board of directors' public meetings and are actively encouraged to attend the meetings. A summary of board meetings is included as a standing item on the council's agenda.

Composition of the membership council 2013/14

The number in brackets after each name in this table represents the number of general membership council meetings attended during the year out of a total of five (unless otherwise noted).

Elected governors	Representing	Other responsibilities
Jane Colebourn (4)	Public: Bedfordshire and Hertfordshire	Non-executive director nomination committee
Ron Wallace (2)	Public: Bedfordshire and Hertfordshire	
Bill Tidmas (5)	Public: North East London and Essex	Vice chair Chair, non-executive director remuneration committee Non-executive director nomination committee Chair, membership development group Patient environment action team
Istvan F Selmeczi (3)	Public: North East London and Essex	Non-executive director remuneration committee
Paul Murphy (5)	Public: North Central London	Non-executive director remuneration committee Non-executive director nomination committee Catering forum Patient experience committee
Mir Habibur Rahman (5)	Public: North Central London	
Simon Mansfield (3)	Public: North West London	
Brian Watkins (5)	Public: North West London	Non-executive director remuneration committee
*Allan MacCarthy (from June 2013) (4/4)	Public: South East London	
Suryanarayanan Naga Subramanian (4)	Public: South East London	Quality and safety committee Non-executive director nomination committee
Patricia Davies (3)	Public: South West London	
*Bernard Dolan (from June 2013) (2/4)	Public: South West London	
Brenda Faulkner (4)	Patient	Patient experience committee Equality and diversity committee Non-executive director nomination committee Arts committee
Robert Jones (4)	Patient	Chair, non-executive director nomination committee Employment of visually impaired staff working group
Jill Wakefield (4)	Patient	Quality and safety committee
Alexandra Edwards (5)	Staff – City Road class	Catering forum
Eilis Kennedy (5)	Staff – City Road class	Catering forum
Colin Carter (4)	Staff – satellite class	
Mary Masih (1)	Staff – satellite class	

Nominated governors	Represented organisation
Cllr Robert Khan (0)	London Borough of Islington
Fazilet Hadi (2/3)	Royal National Institute of Blind People (RNIB)
Valerie Greatorex (3)	International Glaucoma Association
Professor Peter Mobbs (0)	University College London
John Lawrenson (0)	City University
**Vacant	Commissioners

* These positions were vacant between April and June 2013

** From 1 April 2014 this position has been removed by the changes introduced by the Health and Social Care Act 2012

Elected governors normally hold their positions for three years. Nominated governors are proposed by their host organisation and hold the position until a new nomination is made, or they are otherwise notified.

4.2 Sub-committees of the membership council

The council has two formal sub-committees – a remuneration committee for non-executive directors, and a nominations committee for the appointment of non-executive directors, including the chairman of the board. Both committees are chaired by a governor to maintain their independence, and both met during the year.

The remuneration committee reviewed the remuneration of the non-executive directors and recommended a 2.5% increase.

The role of the nominations committee of the membership council is the appointment, reappointment and termination of appointment of the chairman and non-executive directors.

During 2013/14, the nominations committee considered the reappointments of four of the non-executive directors (including the chairman), who had completed two three-year terms, via a formal and rigorous interview process composed of a panel consisting only of governors. Following this panel, the committee recommended the reappointment for one year of all four non-executive directors and it also recommended a process for the annual assessment of non-executive directors in line with the new statutory requirements introduced by the Health and Social Care Act 2012.

The membership council agreed all of these recommendations.

4.3 Register of interests for the membership council

The register of interests of individual governors on the membership council is available to the public on request in writing to the director of corporate governance, Moorfields Eye Hospital NHS Foundation Trust, 162 City Road, London EC1V 2PD, by email to foundation@moorfields.nhs.uk or telephone 020 7566 2490.

4.4 Our membership

Moorfields continues to grow its membership and we currently have more than 20,000 members, an increase of more than 11,500 since our authorisation as an NHS foundation trust in 2004 and about an 11% increase since 31 March 2013. In the past year, the largest growth has occurred in our patient constituency, with an increase of close to 16%. The increase in the public constituency membership has been just over 5%.

Membership numbers in each public constituency reflect to some degree the size of the satellite service provision in the area. For example, North West London has the greatest number of members because it includes two of our largest satellite facilities. As new satellites emerge, we will carry out further membership recruitment drives.

A successful membership week was held in July 2013, during which governors spent time at our main hospital in London's City Road, gathering feedback from patients. Recruitment drives took place at several of our satellite locations during the year. Feedback from the governors (many of whom are also patients) is passed to the patient experience committee as well as to the membership council so that learning and improvement can take place. A programme for similar membership drives is planned throughout 2014/15.

All members are invited to our annual general meeting (AGM), with seats allocated on a first-come, first-served basis. Last year's AGM, held on 18 September 2013, attracted more than 300 members.

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

Constituency	Number of members
Patient constituency	10,541
Bedfordshire and Hertfordshire public constituency	569
North Central London public constituency	1,589
North East London and Essex public constituency	1,993
North West London public constituency	2,359
South East London public constituency	472
South West London public constituency	905
Other public	7
Staff constituency – City Road and satellite	1,930
TOTAL	**20,365**

Representing our membership

Members are represented by elected patient, public and staff governors on the membership council (see above), which meets at least five times a year. Governors participate in a range of activities, such as membership development and engagement, reviewing quality initiatives, and attending recruitment panels for executive director appointments. They are also represented on the quality and safety and patient experience committees.

We draw our public membership from six geographic constituencies, set out in the table above. Any member of the public who lives in one of these areas and is aged 14 years or over can join as a public member. Any patient aged 14 years or over can join the wider patient constituency. All staff are automatically registered as members, but they can opt out if they wish.

Members who want to contact their representative governor or a member of the board may do so through the director of corporate governance, Moorfields Eye Hospital NHS Foundation Trust, 162 City Road, London, EC1V 2PD, or by email. Details of individual email addresses are posted on our website at www.moorfields.nhs.uk/membership.

Elections

Elections were held in the first quarter of 2013/14 and two governors were elected in June 2013.

Constituency	Number of seats	Successful candidate(s)
South East London	1	Allan MacCarthy
South West London	1	Bernard Dolan

Full details of the composition of the membership council from 1 April 2014 and of election results are posted on our website at www.moorfields.nhs.uk/membership.

All elections are held in accordance with the election rules set out in the constitution. This has been confirmed by the returning officer for the elections held during 2013/14.

5 Code of governance

The board of directors and the membership council are committed to the principles of good corporate governance as detailed in the NHS foundation trust code of governance. The code of governance was first published in September 2006, with a revised version coming into effect from 1 April 2010. A second revision was completed during 2013/14 and took effect from 1 January 2014.

NHS foundation trusts are required to provide a specific set of disclosures in their annual report to meet the requirements of the code of governance. The location of these disclosures is as follows:

Relating to	Code of governance reference	Location of disclosure
Board and council of governors	A.1.1	Sections 3.1 and 4.1
Board, nomination committee(s), audit committee, remuneration committee	A.1.2	Sections 3.1 and 4.1
Council of governors	A.5.3	Section 4.1
Board	B.1.1	Section 3.1
Board	B.1.4	Section 3.1
Nomination committee(s)	B.2.10	Sections 3.2 and 4.2
Chair/council of governors	B.3.1	Section 3.5
Council of governors	B.5.6	Section 4.4
Board	B.6.1	Section 3.4
Board	B.6.2	N/A
Board	C.1.1	Annual governance statement (appendix 5)
Board	C.2.1	Annual governance statement (appendix 5)
Audit committee/control environment	C.2.2	Section 3.2
Audit committee/council of governors	C.3.5	N/A
Audit committee	C.3.9	Section 3.2
Board/remuneration committee	D.1.3	N/A
Board	E.1.5	Section 4.1
Board/membership	E.1.6	Section 4.4
Membership	E.1.4	Section 4.4

Where there is divergence from a requirement of the code which does not have to be disclosed, this is explained in the text of this annual report.

6 Remuneration report

Performance is judged initially by the chief executive for the executive directors and by the chairman for the chief executive against objectives agreed for the year. The chief executive's recommendations are subsequently discussed by the remuneration committee, which agrees on the necessary action. Details of the remuneration committee can be found in section 3.2 above.

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

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

Details of senior managers' pay and pension entitlements, including a single total figure for remuneration for each senior manager, can be found in note 4.3 of the notes to the accounts in the annual accounts section at appendix 5.

Information relating to off-payroll arrangements is included in note 5.5 to the accounts in the annual accounts section at appendix 5.

Acting on the recommendations of the Hutton review of fair pay and the reporting requirements of HM Treasury, the trust makes the following declarations:

- The median remuneration of staff employed at the trust during the 2013/14 financial year was £33,463 (2012/13: £33,146). The calculation is based on full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis.
- The mid-point of the banded remuneration of the highest paid director of the trust during the same period was £162,500 (2012/13: £157,500) – only those directors whose remuneration the trust is directly able to determine are included in this calculation.
- The ratio of the two amounts is 4.86:1 (2012/13: 4.75:1) – that is, the mid-point of the banded remuneration of the highest paid director of the trust was 4.86 times that of the median remuneration for all staff employed at the trust.

No payments for compensation for loss of office were made during 2013/14.

As required by section 156(1) of the Health and Social Care Act 2012, I declare that the total out-of-pocket expenses paid to governors of the trust in 2013/14 were £5,044 (2012/13: £2,305), and that the total out-of-pocket expenses paid in 2013/14 to the directors were £3,538 (2012/13: £4,415).

Further detail is shown in note 4.5 to the accounts in the annual accounts section at appendix 5 below.

John Pelly, chief executive

29 May 2014

Appendices

Quality report

Staff survey

Sustainability report

Equality and diversity report

Annual accounts

Appendix 1

Quality report 2013/14

1 Chief executive's statement on quality

Quality is central to our 10-year strategy, *Our Vision of Excellence*, where it is listed as one of the four strategic themes. It is also embedded in our business planning process and forms a central focus in our 2014/15 business plan, where the development of a quality plan is identified as one of five corporate objectives.

Progress against the specific quality themes of clinical effectiveness, patient safety and patient experience are described in section 2 below.

Our work around quality this year has been informed by the work undertaken in 2012/13 to create an action plan to address the recommendations of the Francis report into events at Mid Staffordshire NHS Foundation Trust. This plan has been reviewed and updated during 2013/14 following the Government's formal response to the Francis report in November 2013, which also took into account the findings of the six other reviews commissioned by the Government to help inform the focus of further work on quality. Many of the themes that we identified arising from the Francis report link to existing priorities and are being addressed through those and this is explained in the trust's business plan.

Moorfields aims to provide a good quality service for all its patients, but regrettably we are not always able to achieve this. During the year, seven complaints were referred to the Parliamentary and Health Service Ombudsman (out of a total of 247 complaints received in 2013/14) and two were upheld, one of which was non-clinical. The other complaint related to concerns raised following a cataract operation and the ombudsman concluded there were serious issues with the level of service that had been provided for that patient. This complaint was discussed at the board, and the medical director has led an action plan to remedy the concerns that were raised.

National targets remain a helpful framework for delivering quality. We maintained our strong performance for the four-hour target in A&E and infection control measures. However, we were disappointed not to achieve the 18-week standard from point of referral to treatment for admitted patients which was the result of a number of factors including capacity and process shortcomings and which we are working rapidly to improve.

In addition, we are registered without conditions with the Care Quality Commission (CQC) and we received positive feedback from the CQC inspections of our satellites in Ealing and Northwick Park that took place during the year.

The board and membership council, which includes patient representatives, continue to work closely in developing quality initiatives for the future. We also engage directly with patients through an enhanced programme of patient information days and via a wide range of feedback systems. We operate a well embedded quality and safety reporting system for the trust board.

We work alongside our commissioning partners, the Islington health and wellbeing committee and other partners to ensure our plans reflect those issues of importance to the wider community.

To the best of my knowledge the information included in this quality report is accurate.

John Pelly, chief executive

2 Progress against priorities for improvement during 2013/14

For 2013/14, Moorfields identified eight priority areas for quality improvement as set out below. These priorities were identified in consultation with patients, staff and governors and were supported by the membership council and approved by the trust board.

2.1 Patient experience – transformational change programme – designing services to deliver only what is of value to patients

Objective:

To extend the transformation programme to include all sub-specialties at St George's and make decisions on subsequent roll-out to further sites and services.

Progress in 2013/14:

Between August 2012 and July 2013, the glaucoma service at St George's was the pilot for our transformational change programme. The multi-disciplinary team at St George's worked with Vanguard Consulting Ltd to redesign glaucoma outpatient services using the systems thinking methodology.

The eight operating principles (which form the Vanguard method) are:

1. Only do work that has value to the patient
2. Single piece flow – ensuring as far as possible that patients are seen by a single clinician and reducing handovers
3. Set up and finish 'clean' – staff and equipment are ready on time and patients leave with all their tests done and all the information they require, and clinic staff complete all tasks associated with that clinic
4. Patients are seen by the right person with the right skills, with additional expertise pulled in as and when necessary
5. To learn and make changes and take decisions based on data
6. Existing rules, regulations and practices are challenged
7. Services are designed based on demand
8. Always have the right measures of capability

Using the Vanguard method, a number of small trials have been undertaken on the St George's site to test out the concept (called proof of concept), with a view to subsequent wider adoption. These are the main outcomes from the tests:

- **Clinic management:** Clinic profiles were reviewed and it was found that no one individual was accountable or took ownership of clinics; indeed, different staff were responsible for clinic reception and preparation for clinics, which has led to an inconsistent service for patients. To address this, named individuals have been allocated to clinics; that member of staff is now responsible for preparing clinics, providing resources for reception and scheduling follow-up appointments. This is a new more holistic approach to the management of clinics, giving individuals responsibility and ownership.

  This trial has led to a review of the provision of clinic support staff and clinic processes across all clinics, resulting in a revised set of standard operating procedures and revisions to the staffing establishment, enabling new standards, including about behaviours, to be rolled out across all clinics.

- **Start clean and finish clean:** One of the principles of the Vanguard work has been to ensure clinics are ready for patients when they arrive; that health records are fully prepared with no notes missing; receptionists arrive on time; and nurses are present to support and coordinate clinics. There has been renewed customer focus, with patients being met on arrival. During clinics, patients have been updated with progress about their appointments and all patients have left with either a follow-up appointment or have been discharged. Notes have been tracked back to the appropriate location – to the health records library, to a future clinic, or for the patient to be booked for surgery.

  This trial has also contributed to the review of standard operating procedures. Staffing gaps have affected the consistency of the roll-out, but this is being addressed through recruitment and training. Further work to ensure staff are present on time at the start of clinics will continue during 2014/15.

- **Clinic templates:** These are new tools to help organise clinics. All clinics now have desk schedules which indicate the numbers of doctors present and numbers of patients booked per doctor. This is presented daily in clinics and forecasts six weeks in advance the number of patients scheduled. Clinic clerks now work with medical staff to book patients into the right clinics matching the available capacity with the numbers of patients. The results of this trial have been patchy, which is also related to capacity issues. More work will be completed in 2014/15 to balance capacity and demand across clinics, which will also help preparation for the Moorfields' City road site replacement build.

- **Saturday clinics:** These clinics were introduced to deal with capacity concerns in medical retina and glaucoma where patients with stable conditions are reviewed and monitored. These clinics have proved very successful to relieve pressure on some Monday to Friday clinics.

- **Clinic coordinator:** This role evolved as a result of some of the issues mentioned above to help facilitate the working arrangements of busy clinics and to make them run efficiently.

- **Manager of the day:** The aim of manager of the day is to ensure there is a visible managerial presence to support the administrative and clerical team and also to ensure that concerns that arise during clinics are managed in a timely manner. The practice tested in these two trials is now embedded fully in standard operating procedures and contributes to better organisation of clinics.

- **Single piece flow:** This operating principle is about ensuring that as far as possible patients are seen by a single clinician, there is good coordination between all the clinical staff that patients see and there is good transfer of information between those staff. Using this principle more widely is proving harder to embed as not all clinicians support all of the ideas. This will be worked on further during 2014/15.

In summary, there has been progress in testing a number of the operating principles, but not as much as we would have wanted for a range of reasons. To progress the work relating to the concept of only doing things that add value directly to patients, significant work has commenced in preparation for the Moorfields main site replacement build. All of this work will be incorporated in the service redesign and transformation programme for 2014/15.

The transformation programme in 2013/14 started to be rolled out at the City Road site. It was decided that this work would not involve Vanguard directly; internal resource was identified to lead the work based on the eight operating principles.

The following small-scale projects have been carried out:

- Patient information screens have been installed in A&E which include real-time waiting times information
- A more organised and user-friendly patient queuing system has been introduced in A&E
- A meet-and-greet desk has been introduced in A&E to improve wayfinding and the provision of patient information
- A patient pathway coordinator role has been introduced on wards to improve communication and the transfer of patients between theatres and wards (see further explanation in section 2.3)
- The start and finish clean principle is being tested through the use of freezing lists as early as possible (list lock down) and reinforcing this at team briefings at the start and end of sessions
- Administrative resource has been allocated to the pre-assessment department to support nurses and enable them to focus on patient care
- A pharmacist is now present on wards to carry out near-patient dispensing (dispensing directly to patients) to reduce the time patients wait on wards post-operatively and to allow queries regarding medication to be addressed

On a larger scale, we have successfully transferred some of the learning derived from the Vanguard work at St George's to Friday glaucoma clinics at City Road. This learning is based on the start and finish clean operating principle and that concerning patients being seen and treated by a single professional. Further work has been undertaken in glaucoma clinics about developing technician roles and expanding nursing roles to include provision of information to patients and also patient education.

In addition, a virtual glaucoma service has commenced at City Road. This enables patients to access diagnostic imaging in a dedicated space separate to glaucoma clinics. This imaging is reviewed remotely by consultants and decisions are taken about patients' clinical management plans. We expect to review this service formally in June 2014 and discussions are taking place to potentially adopt this system in other parts of Moorfields.

2.2 Patient experience – improving patient information and communication

Objective:

- To improve how we communicate with our patients, specifically about waiting times and delays to the outpatient clinics
- To make it easier for patients to contact the right person when they need to change or confirm appointments

- To improve the quality of the discharge information we give to patients with an emphasis on medication side effects.

Progress in 2013/14:

Communication in outpatient clinics

Clinic reception staff have been briefed about the importance of keeping patients informed of estimated waiting times by updating the clinic status white boards in each clinic, updating the patient information screens in a timely manner and being more proactive in orally communicating with patients about waiting times and delays.

Clinic reception staff have been issued with a prompt sheet reminding them to explain why there is a delay; to apologise if required; to provide estimates of the likely time before patients will be seen; to reassure patients they can leave their seats without the worry of losing their appointment slot; and to invite patients to obtain more information and discuss issues of concern.

The introduction of volunteers in outpatient areas has improved patient wayfinding as the volunteers are able to direct patients to the right clinic.

Although some improvements have been made, it is recognised that there is inconsistency in the impacts and effectiveness of these improvements across outpatient clinics and considerable work is still required to monitor, maintain and improve performance in this area in 2014/15.

Contacting the right person regarding appointment enquiries

Scoping work has looked in detail at the common themes highlighted from patient feedback with a view to understanding our current call handling arrangements, as well as the options available for improving the service we currently offer. This scoping work indicated that many of those trying to access Moorfields have issues with contacting us and that, when they do, we are not good at answering or returning calls. In addition, inefficient call handling is a prominent feature of patient communications and PALS enquiries; patient call handling complaints centre on unanswered calls, unreturned voicemail messages and a lack of knowledge of whom to contact.

Some improvements were made in 2013/14 to start to remedy this. Medical secretariat resources were pooled to control more tightly the retrieval and response to voicemail messages and the importance of good telephone etiquette was reinforced with the medical secretariat. As a result, call response rates have improved. A comprehensive business case has been developed further to improve patient communications during 2014/15 – please see section 5 below.

Improving discharge information

Day-care patient discharge information has been reviewed and redesigned to make it clearer for patients. It also now includes specific advice about whom to contact should a patient suffer pain, vision loss or feel unwell following their surgery, as well as sections which can be personalised for individual patient needs. All nursing staff who discharge patients have been issued with discharge prompt cards stressing the importance of telling patients about potential medication side effects and whom to contact in an emergency.

Day-care areas also have laminated medication side effect cards to help explain to patients the side effects of commonly used eye drops. A programme of near-patient dispensing has been partially rolled out, where a pharmacist dispenses medication on a ward directly to the patient and can discuss fully any contraindications or side effects. A repeat day-care survey, due to report in June 2014, will reveal any improvement compared to the survey results achieved prior to these initiatives.

Monitoring and learning

Complaints are discussed at weekly multidisciplinary team meetings to ensure lessons are learnt. Complaint letters are shown to the staff identified by patients so they can learn from the feedback. In addition, patients are contacted to be advised that their complaints are being reviewed. Patient feedback has resulted in clinics being re-profiled to match the staff resource to the patient attendance which also helps improve patient experience.

2.3 Patient experience – improving the surgical pathway

Objective:

- To complete year two of T-POT (a project to assess the efficiency of operating theatres) including participation in the Foundation Trust Network (FTN) theatre benchmarking exercise and rolling out the programme beyond City Road to all Moorfields sites undertaking surgical activity
- To roll out the surgical pathway improvements to ophthalmic specialties
- In line with our transformational programme, to review and redesign the current patient pathway for all ophthalmic services at City Road – this will involve process-mapping the current pathway and working with clinicians, nursing staff and patients to develop the optimum patient pathway

Progress in 2013/14:

A surgical services redesign project has been set up which pulls together all previous service improvement projects, including T-POT, the FTN benchmarking exercise and the surgical pathway improvement project.

The aim of the surgical services redesign project is to improve patients' experiences of their surgical pathway on the day of surgery at City Road. One example is to ensure that theatre lists are starting on time which is beneficial for everyone. Initially, the focus has been on Monday morning theatre lists involving the cataract, adnexal, glaucoma, vitreo-retinal (VR) and corneal services. Three work streams were set up: pre-assessment, wards and theatres. All involve a clinical lead, a nurse lead and a senior manager who meet regularly to discuss the issues within their areas and identify potential solutions.

As part of the service redesign project and to address the reasons for lists starting late due to delays in patients arriving from the wards, a patient pathway coordinator has been introduced on the ward on a Monday morning. The role of this coordinator is to liaise closely with the theatre coordinators and to be the single point of contact on the wards, freeing up nurses so they can focus on patient care. A member of the theatre team now collects the first patient on the ward at the start of the list in order to minimise further delays. In addition, a direct telephone communication link has been made between theatre staff and the wards which alleviates the need for theatre staff to leave the theatre to make contact with the wards.

Progress with the redesign work is monitored through a bi-weekly surgical services redesign steering group which is chaired by the clinical director for surgical services. Membership includes the anaesthetic service director, general manager and nurse manager. Further monitoring takes place at monthly directorate performance meetings chaired by the chief operating officer.

Further objectives for 2013/14:

- As part of the planning exercise for Moorfields' new central London hospital and in line with our objective to provide care as close to patients' homes as possible and to optimise the use of our satellite network, operational management staff will work with patients and senior clinical colleagues to move surgical work away from City Road to existing and, where appropriate, new satellite locations
- To develop and formalise a standard operating procedure for theatres

Progress in 2013/14:

There is now an external/corneal outpatient service at our Northwick Park and St Ann's sites and several patients have been moved out of City Road. So far, 120 patients have had their appointments moved to a site closer to where they live.

We continue to develop other services outside City Road: a glaucoma surgical list has commenced on a Thursday afternoon at Northwick Park and an outpatient and surgical adnexal service is due to commence in Northwick Park and St Ann's in 2014/15. Where appropriate, patients will be moved from City Road to these sites.

In relation to standard operating procedures for theatres, a first draft was made available at the beginning of April 2014 and we aim to implement this as soon as possible.

2.4 Patient experience – improving the environment

Objective:

- The successful completion of the City Road A&E project
- The successful completion of the project to expand and refurbish the orthoptics department
- The completion of the redevelopment project at our eye centre in Ealing Hospital
- Significant progress on the redevelopment project at our eye centre at St George's Hospital, Tooting

Progress in 2013/14:

- Work began on the A&E refurbishment project in February 2013 and was completed on time and to budget in October 2013. The layout of the facility has been improved as has the flooring and lighting. Feedback from staff and patients has been excellent.
- The orthoptics expansion and refurbishment was successfully completed in quarter 2 of 2013/14, delivering improvements in the patient pathway and a greatly enhanced patient experience.
- The Ealing expansion project is currently under construction with an anticipated completion date of quarter 2 of 2014/15. The project has been delayed due to contractual difficulties caused by the impending merger of Ealing and North West London hospital trusts.
- In October 2013, the trust board agreed a £14 million business case to build a new state-of-the-art ophthalmic centre on the St George's site. This facility will deliver outpatient clinics and surgery in all ophthalmic subspecialties, including paediatrics. The anticipated start date for services in the new facility is January 2016.

2.5 Clinical effectiveness – expansion of clinical outcomes and performance indicator programme

Objective:

- To continue to report and publish routinely on at least three clinical outcome indicators for each major sub-specialty across the trust; to review standards for achievement against national and international benchmarks and medical literature; to include results in quality reports (see below) and on the new website.
- To expand the number of services reporting on outcomes developed with input from patients and stakeholders.
- To integrate the routine collection of clinical outcomes data into the relevant module of the trust's new electronic patient record system (OpenEyes) so that, as each goes live, automated generation of results can take place.

Progress in 2013/14:

All subspecialties continue to report regularly on three outcomes which are generated through a combination of electronic data capture, prospective data collection and retrospective analysis of case notes. The standards for achievement are based on an analysis of national and international scientific literature and benchmarks for other ophthalmic institutions where available. We maintain close links with members of the World Association of Eye Hospitals and have led a joint project with members to enable sharing of outcome results for benchmarking purposes. The results are published and made available externally in our quality and clinical audit and effectiveness reports. Work is in progress to add the data to the website in an appropriate format, along with other quality and patient experience data.

The results are included later in the report and demonstrate excellent results for many outcomes particularly:

- Results of lid surgery for drooping, in-turned and out-turned eyelids.
- Infection rates after cataract surgery and intravitreal injections.
- Complications during and refractive results after cataract surgery.
- Complications of strabismus (squint surgery).
- Results and complications of refractive laser surgery.
- In addition, outcome measures for the number of never events (wrong patient or site procedure, incorrect intraocular lens insertion in cataract surgery) have been introduced and demonstrate improvement from last year.
- Results for the timing of diabetic retinal screening (DRS), which is part of the medical retina service, did not reach the standard required. This measures a process, not an outcome, and is used because it is a nationally required standard due to the need to review urgently such patients, and the difficulties in identifying an easily measureable and widely accepted visual or ocular outcome, with available published standards. There is no evidence of patient harm, and an audit demonstrated that patients safely received any required laser therapy. However, a robust process has been put in place trust-wide to ensure these patients are specifically identified and receive a timely appointment. This includes a process for managing patients who fail to attend initial appointments. The result for this measure will be re-audited in June 2014.

- For cataracts, a new indicator of good vision after surgery has been introduced. Results for the accuracy of biometry have reduced this year, but continue to achieve the required standard. We believe this is due to difficulties with ensuring clinicians always record an individualised target refraction for every patient rather than a drop in performance. Several actions have been taken, using both paper records and the OpenEyes cataract module and operation note, to ensure the accurate target is always recorded rather than the default of zero refractive error.

Stakeholder input into the development of more outcomes has taken place for all services apart from external disease, paediatrics and strabismus, which are due to complete shortly. This has led to an agreed expanded set of outcomes for each service and has been used to ensure that, as OpenEyes modules are developed, clinical data is routinely collected to allow generation of the outcomes that are most important to our patients and those who refer patients to us.

The roll-out of clinical modules for OpenEyes has this year concentrated on cataract, glaucoma and medical retina. This has required intensive work to address issues of usability and there has been variable use of data entry, so many outcomes still require collection of data from paper records. An automated outcome audit was performed on 1,000 cataract surgery patients using OpenEyes which demonstrated the simplicity and feasibility of this, but also demonstrated that back-up paper audits were still required until the remaining issues with the system are addressed. The aim is to enter all cases on the system using OpenEyes with all the data fields being completed accurately.

2.6 Patient safety – roll-out of patient safety walkabout and case note review procedures to cover all areas

Objective:

- To present the safety walkabout pilot results widely and develop a process to ensure that it can be continued across all sites and areas, possibly in combination with other internal visits and inspections, to minimise disruption and repetition.
- To ensure the regular use of modified global trigger tool (mGTT) audits in all sites and services; the audits will be prioritised and staff supported to ensure at least one is undertaken annually at each major site and service.

Progress in 2013/14:

In 2013/14, the walkabout process was separated into quality performance data reviews, safety walkabouts and Care Quality Commission (CQC) style walkabouts. Quality performance data reviews have taken place in two areas this year – in A&E at City Road and at Mile End. The clinical director for quality and safety and head of clinical governance met with the clinical/service directors and senior managers for these areas to discuss all aspects of quality and safety performance, including incidents, complaints and claims, infection control rates, patient experience results, mandatory training compliance, clinical audits, survey results, and overall clinical governance structure and handling. Support and advice was given and many actions for improvement have been completed, are underway or have been planned.

Safety walkabouts were undertaken at Mile End, St George's, and in Sedgwick ward and the optometry department at City Road. The head of clinical governance was joined by the risk and safety team, patient experience manager and security manager to speak with front-line staff about their concerns relating to safety and quality of care. Concerns were relayed to managers and senior staff in the departments for discussion and action.

The first CQC-style walkabout was completed at St George's, using structured questionnaires for patients and staff. The purpose was to assess the environment to prepare departments for potential inspections from external organisations, to compare quality and safety across departments and sites, and to enable members of the board to engage with front-line staff and patients using a structured format. Staff and patients responded very positively to this process. Findings and the progress of actions from the walkabouts are monitored at directorate meetings and key findings and concerns presented to the clinical governance committee and the trust management board.

All sites and services have been continually reminded and encouraged to undertake mGTT audits as a pro-active method of assessing quality. In 2013/14, the clinical audit and assessment committee (CAAC) approved 17 proposals for mGTT audits and received and approved seven completed mGTT reports. With the exception of vitreo-retinal, Northwick Park, Potters Bar and Dubai, all major sites and services submitted proposals or reports.

2.7 Patient experience and clinical effectiveness – developing patient reported outcome measures (PROMs) tools

Objective:

- To complete the validation of the general ophthalmology PROM, make any further adjustments to the tool as necessary, and introduce it for regular use at sites providing general ophthalmology clinics.
- To continue our work in developing PROMs for cataract surgery and paediatric ophthalmology, to support the work being undertaken in research for a glaucoma PROM and to begin to use these tools once development work is completed.

Progress in 2013/14:

Following the pilot of the general ophthalmology PROM using the patient reported eye symptom score (PRESS) in general ophthalmology clinics at City Road, the validation of the PROM against the scores for the disease severity was completed in Ealing. Thirty-three patients at their first and final discharge attendance provided valuable information regarding which elements of the PROM were easy for patients to use, and which indicated symptom improvement, or that they were feeling better. These results also demonstrated excellent correlation between the clinical severity of their condition and the PROM score. As a result of this work, the card for recording the scores has been revised, with input from patients and clinical staff, and a final pilot for 40 patients is underway. The learning from this project will be used as the basis for developing and piloting a similar PROM for children's general ophthalmic conditions.

A large project is nearing completion which assesses the use of four existing PROM and quality of life tools for cataract patients undergoing surgery. We have recruited 120 patients who have completed all four questionnaires pre-operatively and two weeks post-operatively and most at three months post-surgery, although we are awaiting the data for some of those final visits. Initial results demonstrate that one PROM seems to be the most effective at detecting improvement for patients and also is the most usable, but we await the final data and analysis for confirmation.

2.8 Patient safety and clinical effectiveness – developing regular quality reporting

Objective:

- To develop further the process of quality and safety reporting so that it incorporates an "at a glance" overview of all quality performance indicators, and provides an appropriate level of detail, analysis and explanation.
- To continue to develop and roll out directorate performance and quality dashboards.

Progress in 2013/14:

We have continued to publish our quality performance report twice yearly, which provides a complete overview of all clinical quality and safety data for each quarter, and enables the analysis of aggregate data on adverse safety events from many different sources (incidents, claims, complaints, audit and outcome data etc). This ensures a joined-up approach to tackling safety issues and provides assurance to the organisation, patients and other stakeholders about the overall quality and safety of the care provided. In addition, three more detailed reports are now produced six monthly: the clinical audit and effectiveness report, the patient safety report, and the patient experience report. This allows much more detailed presentation of data with greater analysis, more room for qualitative assessment and an opportunity to explore learning and actions for improvement. It also contains information on the numerous streams of work and those planned for the future, which are driving change for better patient care.

Over the year, directorate dashboards and scorecards have started to include more data on quality and safety of care, including patient feedback, incidents and complaints. We have been working to join together the many different electronic data sources for quality and safety information, including the incident management system, patient experience data, audit and outcomes data, and infection control management systems, together with more traditional clinical performance and activity data. This is creating a data system which automates the population of the dashboards and has the potential to provide data at more detailed site, clinic and ward levels. A pilot system has been created and is ready to start testing.

3 Performance against key indicators for 2013/14

Each of the indicators listed below was selected to provide comparable data over time to demonstrate compliance with the agreed corporate objectives for 2013/14 relating to our quality and safety agenda. Some indicators were new for 2013/14 and the rationale for changing or selecting new indicators was set out in the 2012/13 quality report.

Achievement against each of the indicators has been assessed using a red, amber, green (RAG) rating; a green rating indicates that the indicator has been fully achieved, an amber rating indicates partial achievement and a red rating indicates little or no progress.

Indicator	Source	2011/12 result	2012/13 result	2013/14 target	2013/14 result
Patient experience					
Composite indicator consisting of five questions from the trust's bespoke day-care survey	Picker day-care survey	73%	73%	>83%	Results available June 2014
20% decrease in the number of complaints about communicating the reasons for delays and/or accessing the most appropriate person to deal with appointments	Internal performance monitoring	N/A – new indicator	65 complaints	<52 complaints	48 complaints
% of patients whose journey time through the A&E department was three hours or fewer	Internal performance monitoring	N/A – new indicator	81.7%	>80%	82.3%
% reduction in average patient journey time for cataract surgery patients at City Road	Internal performance monitoring	4hrs 56 mins	18% reduction – 4hrs 4mins.	* see below	* see below
**% of all City Road theatre lists starting on time	Internal performance monitoring	N/A – new indicator	59%	90%	74% for all adult lists (best result 91% for Monday morning lists)
Development of a standard operating procedure for operating theatres	Internal performance monitoring	N/A – new indicator	N/A – new indicator	As per indicator description	Not achieved
Progress on the transformation programme	Internal performance monitoring	N/A – new indicator	N/A – new indicator	Staff in all subspecialty clinics at St George's to have been involved in a systems- thinking intervention to improve their service. The focus in all clinics will be delivering increased value as defined by patients	There has been progress in testing a number of operating principles, but not as much as we had wanted. The service redesign and transforma-tion programme is being updated fully in 2014/15
Patient safety					
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	N/A – new indicator	91.5%	90%	87.5%***
% overall compliance with hand hygiene standards	Internal performance monitoring	96%	97%	95%	97%

Indicator	Source	2011/12 result	2012/13 result	2013/14 target	2013/14 result
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0	0	0
Number of reportable Clostridium difficile cases	Internal performance monitoring	0	0	0	0
Incidence of endophthalmitis per 1,000 cataract cases	Internal performance monitoring	0.48	0.29	<0.8	0.38****
Incidence of endophthalmitis per 1,000 intravitreal injections for the treatment of AMD	Internal performance monitoring	0.30	0.35	<0.5	0.18
Site and service safety review: patient safety walkabout and use of mGTT	Internal performance monitoring	N/A – new indicator	N/A – new indicator	20 mGTT audits to be conducted during the year, the new walkabout process to be agreed and in regular use	17 proposals and 7 completed reports for mGTT audits have been received and approved With the exception of vitreo-retinal, Northwick Park and Potters Bar, all major sites and services have submitted audits The walkabout process is agreed and in use
Clinical effectiveness					
% implementation of NICE guidance	Internal performance monitoring	100%	100%	100%	100%
Posterior capsule rupture rate for cataract surgery	Internal performance monitoring	1.34%	0.8%	<1.5%	0.9%
Comprehensive clinical outcome indicators in place via OpenEyes	Internal performance monitoring	N/A – new indicator	N/A – new indicator	Outcome metrics generated electronically for all clinical specialty modules in live use on OpenEyes	Comprehensive range of outcomes are generated but only a portion are currently generated electronically due to the pace of OpenEyes roll-out

Indicator	Source	2011/12 result	2012/13 result	2013/14 target	2013/14 result
Developing quality reporting – overview and detail	Internal performance monitoring	N/A – new indicator	Corporate clinical quality and safety report in use and regularly presented to the trust board	Trust-wide clinical quality and safety performance report published twice per year, supplemented with detailed reports on clinical effectiveness, patient safety and patient experience	Reports in use as planned
Developing PROMs	Internal performance monitoring	N/A – new indicator	As per indicator	General ophthalmology PROM validated and in regular use in all relevant clinics	Final validation almost complete and regular use to start shortly

*This target has not been monitored as, at an early stage following further consideration, the project redefined its objectives, expanding the work to look at the whole surgical pathway, as well as work on the theatre start times (above). Two projects have been worked on to improve the overall pathway: i) ward coordinator and ii) telephone link between theatres and the ward. Taken together, there has been an average reduction in overall journey time of 4%.

**This indicator was defined erroneously in previous reports.

***We marginally underperformed against this indicator. The overall performance figure is a composite of several different elements. These elements are audited each year and this year the audit indicated that staff were not always aware of the time that the slit lamp cleaning should take place. This led to a reduced score in that element and a reduced score in the composite indicator. The infection control team will work with staff to improve this compliance.

**** The results for the rate of endophthalmitis after cataract surgery are slightly higher this year (0.38/1000 cases) compared with last year (0.29/1000 cases) although the result is less than in 2011/2 (0.48/1000 cases) and well within the trust standard of 0.8/1000 cases. The infection control team monitors endophthalmitis cases and uses the Endophthalmitis Monitor Alert data system to calculate the probable number of endophthalmitis cases, given the expected rate and the widely accepted natural fluctuation in the number of cases over time. Calculations are based on a Poisson probability distribution. This informs the team as to whether the number of cases reported at a site or across the trust as a whole indicates that sites should continue with service provision, be reviewed by the infection control team or suspend procedures. All trust-wide indicators for control of hospital acquired endophthalmitis have remained within the target and the probability of the numbers occurring this year has been checked using the trust probability tool, which shows that this number of cases appears to be a short-term fluctuation and not clinically significant, and all sites are deemed safe to continue with operations.

4 Performance against national indicators

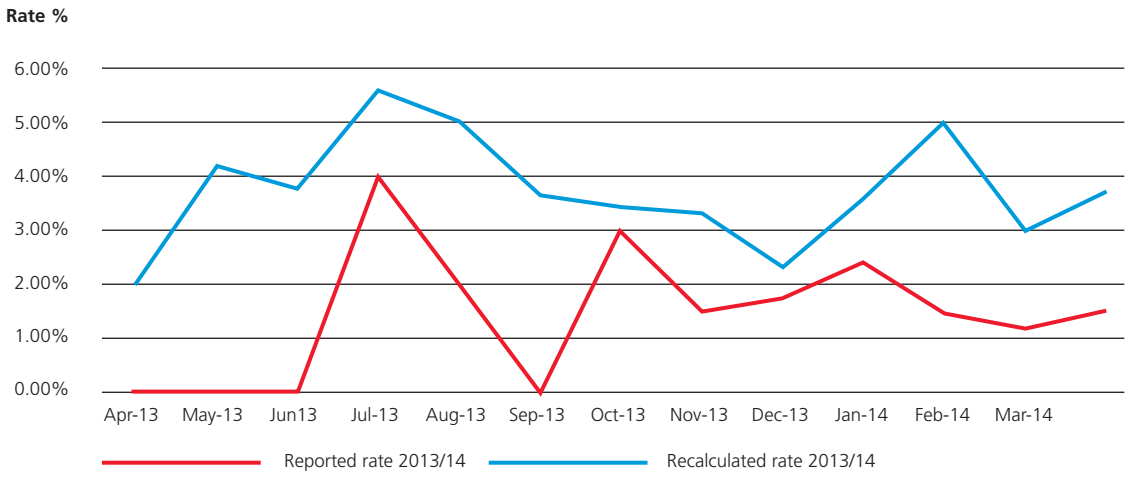
Moorfields reports compliance with the requirements of Monitor's compliance framework (risk assessment framework from 1 October 2013), the NHS constitution and NHS outcomes framework to every meeting of the trust board as part of monthly operational performance reports.

In relation to the Clostridium difficile data, the 28-day emergency readmission indicators and the patient safety incidents indicator (which are the NHS outcomes applicable to the trust) and a range of other indicators on which we report, Moorfields Eye Hospital NHS Foundation Trust considers that this data is described accurately in the tables below. Where required, we provide analysis with actions to support improving the quality of our services.

- **Clostridium difficile:** In May 2013, the infection control team were informed that a patient who had been treated for bleb-related endophthalmitis at Moorfields had developed Clostridium difficile following discharge. This case was attributed as a community case to Hertfordshire Clinical Commissioning Group, but there was a possibility that it was acquired at Moorfields due to intensive antibiotic therapy that the patient required. Following a review by a microbiologist, the trust took the following actions to learn from this occurrence by:
  - Reviewing the antibiotic protocol for the glaucoma service
  - Raising awareness among staff of symptom management and the use of the Bristol Stool Chart

- Raising awareness among staff about this case in relation to antibiotic prescribing
- Developing a patient information leaflet to explain to patients the importance of hand cleansing and other infection control precautions in hospital in relation to Clostridium difficile
- Reviewing ward decontamination procedures following the incidence of a patient with Clostridium difficile

- **28-day emergency readmissions (for inpatients):** In 2013/14, Moorfields calculated readmissions based on the number of patients who were admitted as an emergency within 28 days of an elective admission. There was an error in this calculation. Following a review of the guidance, this has been corrected and the position for 2013/14 has been restated to reflect the number of emergency admissions within 28 days of all admissions rather than those resulting purely from elective cases. The average result for 2013/14 of 3.8% is higher than the previously stated 1.5% average, but compares favourably with the most recent average data available for trusts of 11.45% (for 2011/12). Moorfields has compared the restated data month by month with the data it had previously published through trust board performance reports. The revised figures are higher in every month, but follow a very similar pattern of distribution. Therefore the board (or any reader) would not have been likely to make different interpretations based on the pattern of the two data sets. This is illustrated in the graph below.



- **Patient safety incidents:** The benchmarking data for a specialist peer group indicates that Moorfields continues to evidence a good incident reporting rate, which has increased each year for the last three years. The increase is largely attributable to the introduction of a new trust-wide e-reporting system. This system has made it easier to report incidents, but has also raised further the awareness of patient safety throughout the trust. Moorfields continues to implement the new system across the trust and, once fully implemented, we envisage that not only will reporting to the national reporting and learning system (NRLS) become more efficient and timely, but that we will be able to analyse proactively the various patient safety themes emerging from the data and use this to increase our learning and improve aspects of our service delivery and care.

  We are below average when compared against the 2012/13 rate per 100 admissions (the method of calculation is different for Moorfields; because of our unusually low number of inpatients, we calculate this figure by adding inpatients and outpatient day cases to obtain the admissions denominator). Last year's quality report stated that we believed better ophthalmic benchmarks were required to obtain meaningful comparisons, particularly for the rate per 100 admissions and numbers of severe harm or death. At the time of producing this report, the NRLS had not released any national data sets. Therefore, we have compared this year's performance with last year's national data set and note that the trust is improving in all the patient safety indicators.

Our number of severe harm or death incidents (noting that no deaths occurred) is 11 over a 12-month period. Although this is a rise compared to the previous year, it compares more favourably as previous figures are reported over a six-month period. This point is further illustrated through the calculation of severe harm or death as a percentage of total incidents where the result is almost half of the 2011/12 result and compares well with the best result nationally.

We are disappointed that during 2013/14, performance against the 18-week referral-to-treatment target (RTT18) has dropped, resulting in a failure for the year in the admitted pathway standard due to deterioration in quarter 4. This has been partly driven by a steady rise in referrals throughout the year and constraints on capacity due to staffing and available space. In addition, we have identified that it is no longer appropriate to apply clock pauses on the admitted pathway for patients choosing a particular site and this practice ceased with effect from 1 March 2014 with the agreement of both our host commissioner and the Intensive Support Team (a team that provides help nationally to improve the processes that support care and treatment). Overall, this resulted in our performance in March 2014 deteriorating to 79.2% against a target of 90%.

An internal audit of RTT18 data quality was undertaken during the year and raised a concern about data quality. However, a further review identified that although our end of pathway validation process was effective in ensuring correct reporting of pathways, we need to improve our front-end reporting of information in our clinics, booking centre and admissions offices. We have taken immediate action to improve this and we are also widening the scope of that work through an end-to-end review of the whole RTT18 system, supported by the Intensive Support Team.

The data for these and other national reportable indicators for two years is set out in the tables below:

Description of target	Performance 2012/13	Target 2013/14	Performance 2013/14	Average 2013/14	Highest performing trust 2013/14	Lowest performing trust 2013/14
Infection control						
MRSA – meeting the objective	0	0	0	N/A	N/A	N/A
Clostridium difficile year-on-year reduction	0	0	0	N/A	N/A	N/A
Screening all elective inpatients for MRSA	100%	100%	100%	N/A	N/A	N/A
Risk assessment of hospital-related venous thromboembolism (VTE)	96.1%	95%	98.4%	96% (based on Jan 2014 data)	100%	75%
Waiting times						
Two-week wait from urgent GP referral for suspected cancer to first outpatient appointment	100%	93%	97%	95.6% (based on Q3 data)	100%	90.2% (lowest performing trust where >100 cases)
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	99.3%	95%	99.7%	95.2% (based on Q4 data)	100%	85.9%

Description of target	Performance 2012/13	Target 2013/14	Performance 2013/14	Average 2013/14	Highest performing trust 2013/14	Lowest performing trust 2013/14
18-week standard from point of referral to treatment for admitted patients	91.1%	90%	89.8%	89.0% (based on Feb 2014 data)	100%	71.9%
18-week standard from point of referral to treatment for non-admitted patients	96.0%	95%	95.3%	96.2%	100%	87.6% (lowest performing trust where >100 cases)
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	92%	92.1%	92.5%	96.8%	89.9%
6-week diagnostic test waiting time	100%	99%	100%	92%	100%	84% (based on Feb 2014 data)
Cancelled operations						
*Patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	0	0	2	22 (based on Q3 data)	0 (based on Q3 data)	45 (based on Q3 data)
Other						
Mixed-sex accommodation breaches	0	0	0	1	0 (based on Feb 2014 data)	3 (based on Feb 2014 data)
28-day emergency readmission rate (over 16 years old)	1.3%	N/A	3.8%	**11.5%	N/A	N/A
28-day emergency readmission rate (0 to 15 years old)	0%	0%	0%	N/A	N/A	N/A
Certification against compliance with the requirement regarding access to health care for people with learning disabilities	Full compliance	Full compliance	Full compliance	N/A	N/A	N/A

*The full explanation of this indicator is that patients who have operations cancelled for non-clinical reasons should be offered another binding date within 28 days, or treatment should be funded at the time and hospital of the patient's choice (this is reported as breaches of the 28-day standard for cancelled operations)

**The most recent national average figure obtainable for readmission rates is from 2011/12

Patient safety incidents data						
Indicator	Moorfields data			National comparisons – 20 acute specialist trusts***		
	2011-12	2012-13*	2013-14**	Best result nationally 2012/13	Worst result nationally 2012/13	National average 2012/13
Patient safety incident number sent to NRLS	826	1137	2735	1720	36	722
Rate per 100 admissions	2.6	3.7	4.51	24.9	1.4	7.5
Number of severe harm or death incidents	7	8	11	0	26	3.4
Severe harm or death as a % of total incidents	0.9	0.7	0.4	0	1.8	0.5

*The 2012/13 data is based on six months of incidents (April – Sept 2012) as the full year's data was not available at the time of publication

**The 2013/14 data is based on a 12-month data set of all the incidents reported to the NRLS for the period 1 April 2013 to 31 March 2014. This figure may be lower than that which the NRLS will publish in late May 2014 and the lag can be attributed to the following reasons: there will be some incidents which occurred within the time period stated above but reported after the close of the year – they have not, therefore, been analysed as they fall outside the reporting period; there are some incidents which are waiting to be downloaded by the NRLS and therefore have not been counted as the NRLS are yet to receive and ratify them

***The national data comparisons are derived also from six months of NRLS data for a group of specialist trusts (April to September 2012), as the full year was not available at the time of publication

Despite occurring within the time period stated above, a number of incident reports have not been submitted to the NRLS because they are still under investigation or are being quality checked by our risk and safety team for any errors due to the uptake of the new e-reporting system.

Serious incidents and never events

In 2013/14, we declared 11 serious incidents, two of which were classed as never events (which are untoward clinical events that are deemed to be serious enough that they should never occur – for example, surgery on the wrong limb).

The never events concerned a retained object under the eyelid following surgery, and insertion of an incorrect strength intraocular lens which needed to be replaced.

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

Serious incident title	Brief details
Lost to follow up, medical retina (MR), City Road	The patient was discharged from the MR pathway in error when a referral to another service (glaucoma) was made. MR follow-up was still required.
Delayed diagnosis – failure to check intraocular pressure (IOP)	A patient had been reviewed by the MR service since December 2010. The MR service had failed to check the patient's IOP during this time and raised IOP was detected by another service in January 2013. The patient was referred to the glaucoma service for on-going management of the condition.
Lost to follow-up, glaucoma, St George's	A three-month follow-up appointment was requested in November 2008 but the appointment was never made. In April 2013 the patient was identified (as part of a trust-wide lost to follow-up review) as having been lost to follow-up.
Lost to follow-up, glaucoma, St George's	A three/four month review was not booked following an appointment in February 2008. This was identified in March 2013 as part of a trust-wide review.
Community optometrist management of patients	Following the retirement in 2010 of a glaucoma consultant at Moorfields, a community optometrist continued to review patients unsupervised for one session a month at a community clinic. A total of 17 patients had been regularly reviewed.
Missing controlled drug, theatres, City Road	Missing ampoule of fentanyl.
Theft of patient information from a vehicle	Theft of briefcases, containing patient confidential data relating to 15 patients, from a staff member's car. The briefcases were found approximately one week later and the information was intact.
Lost to follow-up, glaucoma, City Road – investigation not complete	A patient with left angle closure glaucoma was seen in a glaucoma clinic in October 2012 and although referred to the MR service, was also planned to have a glaucoma follow-up in three months. The follow-up appointment not made.
Insertion of incorrect IOL, theatres, City Road – investigation not complete	A patient had the incorrect strength IOL inserted. The lens was not exchanged.

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. Periodic thematic reviews of serious incidents are completed and learning is shared via various mechanisms, such as clinical governance half days and through aggregate data reports.

Friends and Family Test for patients

The Friends and Family Test (FFT) requirement for 2013/14 was to have, by 1 April 2013, a process to capture the views of at least 15% of adult NHS patients using the services in A&E and patients admitted for overnight care. The response rate was achieved or exceeded except for during quarter 1 in A&E. In one instance, a 100% response rate was achieved. There was no target FFT score, though it would be expected that the score would rise, or at least remain consistent over time.

For 2013/14, an internal red, amber, green (RAG) rating was set by the patient experience committee using the following thresholds: <69 = red, 70 – 84 = amber, >85= green. From April 2014, this was changed to individualise the scores for the previous six month's average for each area, red being below the average, amber the same and green above.

Both A&E and overnight admissions FFT scores were consistently in the top 25% of the 170 NHS England hospitals for FFT. In November 2013, we performed the best of all trusts nationally for the FFT inpatient scores.

Moorfields believes that the FFT results are generally a good reflection of how positively patients view the organisation. Within the coming year, we will focus on the patients who did not provide a positive indication of our performance.

We are currently exploring ways of capturing the FFT via the trust website and via telephone, text and SMS messaging.

The response rates and the scores are shown in the tables below.

	Response rate					
	2013/14 performance					2014/15
	Q1	Q2	Q3	Q4	Yearly average	Apr-14
A&E City Road	12%	17%	23%	23%	19%	27%
Observation bay	61%	31%	40%	100%	58%	78%
Cumberlege (NHS)	61%	52%	56%	63%	58%	52%
Duke Elder	29%	41%	85%	70%	58%	86%

	Scores					
	2013/14 performance					2014/15
	Q1	Q2	Q3	Q4	Yearly average	Apr-14
A&E City Road	76	73	79	76	76	76
Observation bay	88	93	96	86	90	98
Cumberlege (NHS)	91	85	92	85	88	70
Duke Elder	62	90	85	95	83	83

5 Priorities for 2014/15

The development of our quality report was led by the director of corporate governance in close liaison with the clinical director of quality and safety, the director of nursing and allied health professions, the medical director and the chief operating officer.

The trust management board (TMB) has had oversight of the trust's quality and safety performance against the three internationally recognised areas of patient safety, patient experience and clinical effectiveness during the year. This quality account has been reviewed by the management executive and the quality and safety committee and has been finalised as a balanced representation of our priorities across the three areas. The trust governors have provided their views about the contents of the quality report, which was agreed by the trust board on 27 May 2014.

5.1 Patient experience – service redesign and transformation

Objective: To build on the outcomes of the service redesign and transformation work of 2013/14 across all sites and all sub-specialties, including improving efficiency in theatres.

Rationale for inclusion: The results in section 2.1 indicate that there have been a number of successes achieved by using the operational principles established with the support of Vanguard, both at St George's and in City Road. This programme will be extended at St George's and across the whole organisation. Lessons learned will be applied in terms of the allocation of resources to support this work, the need for clear and robust measuring and monitoring systems and increased attention to engaging staff across the board in a service where transformation is planned. Section 2.3 demonstrates some improvements to the surgical pathway have been made, but considerably more needs to be done.

How we will monitor, measure and report on progress: The programme is being constructed, drawing on the lessons from the work done in 2013/14, as a linked programme of work, summarised as follows:

1. Clinical pathway redesign by specialty and by site, based on the Vanguard operating principles and lean methodology, including mapping of pathways, detailed analysis of patient journey times, identification of blockages and understanding demand and capacity. This work will concentrate in detail on the running of both theatres and outpatients, building on the progress made in 2013/14, but expanding the scope and pace of the work.
2. Demand and capacity planning by specialty and by site, supported by a modelling tool.
3. Developing values and behaviours by implementing 'The Moorfields Way', a programme of staff and patient engagement to support service improvement across the organisation.
4. Taking a 'back to the floor' management development approach, including reviewing spans of control to ensure that the organisation has a service-focused and capable management, and scrutiny of business processes across the organisation, intended to reduce bureaucracy and excessive process and build in capacity for day-to-day running, floor-based management, change and redesign, as well as an increased ability to deal with variation.
5. Continuing workforce development and redesign enabling the expansion of skill sets and increasing flexibility in the workforce.
6. Further developing six and seven-day working by introducing a significant project to understand how we resource and organise our hospital to operate over extended days and also at weekends.

The most significant lesson learned from 2013/14 is that this work needs sufficient resourcing, with a combination of internal staff being released, supported by a level of outside resource to enhance skill sets and provide outside challenge. This work will be supported by a dedicated service improvement and project/programme management resource. It is recognised that this programme will take place over at least two to three years and will evolve.

5.2 Patient experience – improving patient information and communication

Objective:

- To be more customer focused by continuing to improve how we communicate with our patients while they wait in clinics.
- To make it easier for patients to obtain information about eye conditions by opening a health information hub at City Road – this facility will provide written and electronic information on eye conditions and other public health information.
- To improve how the trust manages and responds to telephone enquiries.

Rationale for inclusion: Patient feedback obtained from surveys, complaints and patient advice and liaison service (PALS) enquiries continues to inform us that we need to improve how we communicate with our patients, particularly while they wait in clinics. We have made some progress, as patient feedback shows that staff are generally more courteous and polite to patients. The appointment of the new outpatient matron has been positive and the visible clinical management has been welcomed by patients and staff. Although these changes are good, more effort is required to ensure that they are consistent.

A priority for 2014/15 will be the delivery of a comprehensive development programme for administrative clinic staff. This will form part of the redesign programme. The opening of the health information hub will make patient information about eye conditions easier to find and will help inform patients about their care and treatment. The hub will provide electronic and written information about ophthalmic conditions and other health topics.

As explained in the section about 2013/14, patient feedback indicates strongly that we are not good at answering or responding to telephone calls. Improvements have been made within the year such as the introduction of additional phone lines, but more investment is required to achieve large-scale change. A comprehensive business case was agreed in 2013/14 for improving communications with patients. Initially, this work will focus on City Road, but further consideration is also being given to the future provision of these services at our satellites. Improvements include:

- The recruitment of additional clinical staff to increase the resources available for the Moorfields Direct advice line, as well as extending its hours of opening, and the provision of specific clinical expertise to provide advice to patients, the public and others who require it.
- The establishment of dedicated resources within each of the clerical teams with one telephone number per service.
- The provision of additional administrative resource to optometry to address specific issues in this department about poor responsiveness to callers' queries about spectacles and contact lenses.
- Introduction of a new telephone best practice policy, supported by telephone etiquette training to improve the customer service provided to patients by telephone.

- Further improvements to the telephone infrastructure, including a call queuing system with live dashboards, a patient call-back facility and call recording.

How we will monitor, measure and report on progress : All of the above will be monitored through a set of key performance indicators (KPIs). We will continue to monitor improvement through quarterly reviews of the numbers of complaints and PALS enquiries relevant to this objective and this will be reported and reviewed at the patient experience committee.

5.3 Patient experience – improving the environment

Objective:

- Commence and complete expansion of the ocular prosthetics department (paediatric and adult).
- Complete the installation of a liquid oxygen supply to replace the current bottled gas supply.
- Commence and complete phase one of the refurbishment of the Croydon district hub.
- Complete the expansion of Moorfields' outpatient facilities at Ealing Hospital and work with the local health economy to support the long-term planning of the Ealing Hospital site.
- Continue the work for full reprovision and expansion of our services at St George's Hospital in Tooting.
- Develop an outline business case and design brief for a new build to replace the current hospital building at City Road.

Rationale for inclusion: We continue to need to ensure that the environment in which patients are seen and treated is of a sufficiently high standard to support the delivery of high quality clinical care. Good progress has been made in previous years and there is less need for further substantial upgrade work at City Road prior to the completion of the new build, as a result of earlier projects such as the A&E upgrade.

Work continues to improve our satellites. This includes the development of new facilities at our St George's site which will be completed in 2016, and the refurbishment of our new eye centre in Croydon.

Our focus for the future, as set out in our annual plan, is to continue the development of our new joint facility with the UCL Institute of Ophthalmology, acquiring a site and completing the design with supporting business cases.

How we will monitor, measure and report on progress : Progress of the trust's major capital projects is monitored by our capital planning group and, in turn, by the trust board. The quality of the patient experience before, during and after the completion of projects is monitored through a variety of mechanisms, such as patient surveys, complaints and comments cards.

5.4 Clinical effectiveness – expansion of the clinical outcomes programme

Objective:

- To continue to report on at least three clinical outcome indicators for each major sub-specialty across the trust, with comparison against standards for achievement from national and international benchmarks and medical literature; and to include results in regular trust-wide quality reports and directorate reports (see below).

- To publish our outcomes on the new website and to share the results of our work with major international eye units in comparing and standardising outcomes internationally, both by presenting work at international scientific meetings and publishing it in major ophthalmic scientific journals.
- To complete the work on ensuring all our sub-specialty services report on outcomes developed with input from stakeholders, including patients.
- To continue to integrate the routine collection of clinical outcome data into the relevant module of OpenEyes and to ensure that automated generation of outcome results is occurring at a minimum for those modules which are already live.

Rationale for inclusion: This work will provide up-to-date information on the results and safety of our care, in the areas that really matter to patients, commissioners and referrers, supporting informed choice for professionals and patients when they select their ophthalmic care provider. Information will be generated from routine clinical data entry, and the increasing use of OpenEyes will free up clinical time from onerous audits conducted by hand. In addition, this work will provide guidance, more national and international collaboration, and consistency in assessing and comparing results of ophthalmic care across the globe.

How we will monitor, measure and report on progress : Through surveys, we will obtain the opinions of patients, users, commissioners and service/clinical staff on which outcomes to measure in the remaining services, and incorporate data fields to be able to generate these outcomes in all the clinical modules in OpenEyes. Results will be published via the corporate quality reporting systems and in the directorates (see below) and will be available on the new website. We will have presented and published internationally on the collaborative outcome work performed with other major eye institutions.

5.5 Patient safety – roll-out of the patient safety walkabouts and case note reviews

Objective:

- To roll out the successfully piloted patient safety walkabout and safety review program, and to continue regular mGTT case note reviews across all sites and areas in a planned fashion, for this and future years.
- To ensure reports are presented and actions monitored at directorate performance meetings and that key findings and issues are reported to executive and board level via the appropriate clinical quality and safety reports.

Rationale for inclusion: Patient and staff safety walkabouts, reviews of local quality and safety data and regular reviews of case notes, are a proactive way of identifying and changing poor practice before it reaches the level of an incident or serious incident. It also helps identify good practice. The regular site visits allow two-way communication between very senior staff, including board members, clinical staff, and patients. It provides visibility of senior staff on the 'shop floor', allows them to see care at first hand and hear directly the patient voice and staff concerns, and ensures that safety and quality are discussed and acted on at the highest level in the organisation. The multidisciplinary nature of the visits also provides a method of internal peer review and ensures that staff from one site can learn both from excellent care (which they can replicate), and any inadequate care (which they can avoid), in another area of the trust. In addition, it helps to prepare sites and staff for the experience of regulatory visits. These factors are particularly important for Moorfields given our many satellite locations.

How we will monitor, measure and report on progress : The findings of and actions from the case note audits and site visits will be monitored and measured via directorate performance meetings with support from the staff in the quality team. Progress against the programme of work, key findings, significant safety issues and any actions required will be reported via the patient safety report.

5.6 Patient experience and clinical effectiveness – developing patient-related outcome measures (PROMs)

Objective:

- We will complete the pilots and analyses of our PROMs projects in adult general ophthalmology and cataract surgery, publish the results and begin use of these tools in routine clinical care.
- We will complete the development of a paediatric general ophthalmology PROM and pilot this with patients.
- We will work collaboratively with the UCL Institute of Ophthalmology to support the joint development of PROMs tools for clinical and research work.

Rationale for inclusion: The use of PROMs will supplement our clinical outcome work to measure whether the care that we deliver benefits patients not only in relation to the clinical measures of success and safety, but also in relation to their quality of life and symptoms suffered from their condition. There remain no nationally approved ophthalmic PROMs, and Moorfields can help to lead the development of usable and practical measures of how patients recover after ophthalmic care. In addition, working where possible with the Institute optimises use of resources and will, we hope, provide tools to support both the assessment of routine care and of new treatments as they arise.

How we will monitor, measure and report on progress : The PROMs pilots in adult general ophthalmology and cataract surgery will be completed, presented and/or published in ophthalmic meetings and journals as well as being used to assess care, managed via the clinical audit department. A PROM for paediatric general ophthalmology will have been developed and piloted and Moorfields staff will be working with Institute staff on developing PROMs.

5.7 Patient safety and clinical effectiveness – further development of quality reporting

Objective:

- To continue to produce twice-yearly global quality and safety performance reports supplemented with more detailed reports for greater analysis, qualitative data, including representation of the patient voice and clear analysis of actions taken, and future plans for improvement.
- Directorate performance dashboards will include a standardised minimum data set of quality and safety data, with provision of or access to a single data system mapped against directorates and sites. Clinical governance and risk staff will attend quarterly directorate performance meetings, which will include a minuted item on quality and safety performance, noting any actions required.

Rationale for inclusion: We need to ensure we can provide an overview of quality and safety within the trust, at the same time as being able to explore more deeply key areas of patient safety, quality of care and the patient experience, reflecting how patients feel about services and monitor improvement over time. In addition, we wish to ensure each area of the trust can assess its own performance in clinical quality compared with other areas, has the time and space to discuss and act on this, and is supported by staff who are expert in assessing what such data means and how to create change for the better.

How we will monitor, measure and report on progress : The clinical quality and safety performance report will be produced twice yearly with more detailed reports on one of patient safety, clinical effectiveness and patient experience also produced twice yearly; these reports will contain opinions and views from patients following their experiences of our services. The directorate performance and quality dashboards will contain a standard set of quality and safety data; minutes of quarterly meetings will demonstrate attendance and involvement of governance staff and will evidence the discussions and actions arising from analysis of quality data.

6 Key indicators for 2014/15

We have made some changes to the indicators for 2014/15 as set out in the table below. Significant changes can be summarised as:

- In relation to the five question composite indicator based on our bespoke day-care survey, no survey is planned for 2014/15 so this indicator will not apply.
- The target for reducing the number of complaints about communicating the reasons for delays and/or accessing the most appropriate person to deal with appointments has been increased to achieve a 25% reduction in 2014/15 (compared to 20% the previous year).
- The target of 90% relating to the percentage of theatre lists starting on time was not achieved for all lists in 2013/14 and has been rolled over into 2014/15.
- A standard operating procedure for the management of theatre operating lists was not developed in 2013/14, so this forms a target for 2014/15.
- The plans for transformation are explained fully in section 5.1. New indicators will be developed in 2014/15 and this is explained briefly in the table.
- The target for posterior capsule rupture rate for cataract surgery has been reduced to <1.3% continuing the year-on-year trend of stretching this target.

Indicator	Source	2011/12 result	2012/13 result	2013/14 result	2014/15 target
Patient experience					
Composite indicator consisting of five questions from the trust's bespoke day-care survey	Picker day-care survey	73%	72%	Results not yet available	N/A (see above)
25% decrease in the number of complaints about communicating the reasons for delays, and/or accessing the most appropriate person to deal with appointments	Internal performance monitoring	N/A – new indicator	65 complaints	48 complaints	<36 complaints
% of patients whose journey time through the A&E department was three hours or less	Internal performance monitoring	N/A – new indicator	81.7%	82.3%	80%

Indicator	Source	2011/12 result	2012/13 result	2013/14 result	2014/15 target
% reduction in average patient journey time for cataract surgery patients at City Road	Internal performance monitoring	4hrs 56 mins	18% reduction - 4hrs 4mins	See first footnote to the table in section 3	See first footnote to the table in section 3. Further use of this indicator is under consideration and others are likely to be developed
% increase in all City Road theatre lists starting on time	Internal performance monitoring	N/A – new indicator	59%	74%	90%
Development of a standard operating procedure for operating theatres	Internal performance monitoring	N/A – new indicator	N/A – new indicator	Not achieved	This indicator has been rolled over into 2014/15
Progress on the trans-formation programme	Internal performance monitoring	N/A – new indicator	N/A – new indicator	There has been progress in testing a number of operating principles, but not as much as we had wanted	The service redesign and transformation programme is being updated fully in 2014/15

Patient safety					
% overall compliance with equipment hygiene standards (cleaning of slit lamp)	Internal performance monitoring	91.5%	90%	87.5%	90%
% overall compliance with hand hygiene standards	Internal performance monitoring	96%	97%	97%	95%
Number of reportable MRSA bacteraemia cases	Internal performance monitoring	0	0	0	0
Number of reportable Clostridium difficile cases	Internal performance monitoring	0	0	0	0
Incidence of presumed infective endophthalmi-tis per 1,000 cataract cases	Internal performance monitoring	0.48	0.29	0.38	<0.8
Incidence of presumed infective endophthalmitis per 1,000 intravitreal injections for AMD	Internal performance monitoring	0.30	0.35	0.18	<0.5

Indicator	Source	2011/12 result	2012/13 result	2013/14 result	2014/15 target
Site and service safety review: patient safety walkabout and use of mGTT	Internal performance monitoring	N/A – new indicator	N/A – new indicator	17 proposals and 7 completed	mGTT audits to be conducted during the year in all main sites and services; the walkabout process to be in regular use reporting via directorates and patient safety report
Clinical effectiveness					
% implementation of NICE guidance	Internal performance monitoring	100%	100%	100%	100%
Posterior capsule rupture rate for cataract surgery	Internal performance monitoring	1.34%	0.8%	0.9%	<1.3%
Comprehensive clinical outcome indicators in place via OpenEyes	Internal performance monitoring	N/A – new indicator	N/A – new indicator	Comprehen-sive range of outcomes generated but only a portion are currently generated electronically	Outcome metrics generated elec-tronically for all clinical specialty modules in live use on OpenEyes
Developing quality reporting – overview and detail	Internal performance monitoring	N/A – new indicator	Corporate clinical quality and safety report in use and regularly presented to the trust board	Trust-wide clinical quality and safety performance report published twice a year and biannual detailed reports on clinical effectiveness, patient safety and the patient experience	Trust-wide clinical quality and safety performance reports, plus detailed reports on clinical effectiveness, patient safety and the patient experience biannually; quarterly directorate quality performance reports in use
Developing PROMs	Internal performance monitoring	N/A – new indicator	N/A – new indicator	General ophthalmology PROM validation near completion; regular clinical use to start early in 2014/15	General ophthalmology and cataract PROM in regular clinical use

7 Statements of assurance

Review of services

Moorfields Eye Hospital NHS Foundation Trust provides ophthalmic NHS services covering a range of sub-specialties. We regularly review all healthcare services that we provide. During 2014/15, we will continue with our rolling programme of reviewing the quality of care and delivery of services.

The income generated by the NHS services under review represents all of the total income generated from the provision of NHS services by Moorfields for 2013/14.

Participation in clinical audits and national confidential inquiries

During 2013/14, Moorfields Eye Hospital NHS Foundation Trust continued to undertake one ongoing national clinical audit. There were no national confidential enquiries relevant to the trust in 2013/14.

Due to the single specialty nature of the hospital, most national audits are not relevant to the trust. The trust therefore aims to audit against standards and guidelines set by the Royal College of Ophthalmologists. During 2013/14, 157 clinical audits were registered on the trust's clinical audit webtool (CLAW) database, 22 of which were as a result of Royal College of Ophthalmology recommended standards.

The national clinical audits and Royal College of Ophthalmology standard audits in which the trust was eligible to participate in during 2013/14 were as follows:

National audits

- UK ocular tissue transplant audit – NHS Blood and Transplant

Royal College of Ophthalmology audits

- Modified global trigger tool – St George's/medical retina
- Modified global trigger tool – City Road/medical retina
- Modified global trigger tool – St Ann's/cataract
- Modified global trigger tool – City Road/corneal and external disease
- Modified global trigger tool – City Road/adnexal
- Modified global trigger tool – City Road/strabismus
- Modified global trigger tool – Ealing/primary care (general ophthalmology)
- Modified global trigger tool – Ealing/orthoptics
- Modified global trigger tool – City Road/anaesthetics
- Modified global trigger tool – City Road/neuro-ophthalmology
- Modified global trigger tool – Bedford/A&E
- Modified global trigger tool – City Road/vitreo retinal
- Modified global trigger tool – City Road/optometry
- Modified global trigger tool – Loxford/glaucoma
- Modified global trigger tool – Barking Hospital/glaucoma

- Evaluation of visual outcomes of cataract surgery in patients with 6/9 or better pre-operative visual acuity (St Ann's and City Road/cataract)
- Compliance with guidelines on rapid access for wet AMD (Bedford/medical retina)
- Audit of personal cataract surgery (City Road, Ealing, Northwick Park and Potters Bar/cataract)
- Audit of 50 consecutive cataract cases (City Road and St Ann's/paediatrics)
- Core outcome of ectropion surgery (City Road)
- Core outcome of entropion surgery (City Road)
- Core outcome of ptosis surgery (City Road)
- Complication rate post-intravitreal therapy for macular degeneration (all sites)
- Endophthalmitis after intravitreal injections (all sites)
- Core outcomes of aqueous shunt (tube) devices (City Road)
- Core outcomes of corneal grafting (City Road)
- Retrospective evaluation of outcomes for Lucentis therapy in macular degeneration (Bedford)
- Retrospective audit of Ozurdex cases of endophthalmitis (all sites)
- Core outcome audit for cataract surgery (all sites)
- Core outcomes for macular hole surgery (City Road)
- Core outcomes of retinal detachment surgery
- Core outcomes of refractive laser surgery (City Road)
- Core outcomes of screening for ROP (Ealing, Bedford, Homerton, St George's)
- Investigations for retinal vein occlusions (City Road)
- Occlusion treatment for amblyopia (City Road)

Participation in clinical research

The numbers of patients receiving relevant health services provided or sub-contracted by Moorfields Eye Hospital NHS Foundation Trust during 2014/15 who were recruited during the year to participate in research approved by a research ethics committee was 4,293.

Use of the 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 the commissioners. For 2013/14, Moorfields had six CQUIN requirements and 2.5%, or £2 million, of our income was conditional on achieving quality improvement and innovation goals agreed with Islington clinical commissioning group through the CQUIN framework; the total for 2012/13 was 2.5%, or £2.3 million. Set out below are the CQUINs for 2013/14 and 2014/15.

2013/14

CQUIN progress in 2013/14 included the following achievements:

- Over 95% compliance of inpatients risk-assessed for VTE
- Exceeding the national target for Friends and Family response and in the top quartile of trusts for staff recommending the hospital to family and friends
- Improvement of indicators based on children's feedback about their care in the children's hospital
- Meeting the targets associated with asking patients about whether they smoked, and providing appropriate advice and guidance to stop smoking services
- Demonstration, through audit, of improved learning from never events and implementation of recommendations from incident investigations
- Introduced improvements to the way we work by piloting new systems of work and patient flows in some of our clinical areas

2014/15

The trust is currently in discussion with the CCG to agree and sign off the CQUIN schemes for 2014/15. The schemes have been discussed thoroughly by clinical representatives from the trust and the CCG, with a focus on quality schemes that will have the greatest positive impact for patients. Individual CQUINs are divided into national and local requirements and focus on patient and staff experience (including vulnerable groups), and the safety and improvement of patient pathways by the continued implementation of the redesign programme. The proposed list for 2014/15 is as follows.

National

Friends and Family Test (FFT) for patients and staff with the following KPIs:

- Target response rate of 30% for inpatient areas, 20% for A&E,15% for day care and outpatient areas
- Staff FFT; to remain in the top quartile of trusts in the 2014/15 staff survey

Caring for patients with dementia with the following KPIs:

- Enhance the flagging system that identifies patients with dementia
- Create an online training and assessment resource and achieve a 50% increase in training based on the 2013/14 benchmark numbers

Domestic abuse:

- Increase the uptake of staff having completed domestic violence training by 50% based on 2013/14 benchmark numbers; this includes a comprehensive training package for high-risk areas such as A&E
- Enhance the referral pathway for patients who disclose domestic abuse

Local

A communication project based on listening and acting on patient feedback:

- This is explained in more detail in section 5.2 of this report

Patient safety – never events:

- Implement the learning from never events and audit to demonstrate learning has taken place

Service redesign:

- Expand the service redesign project based on the learning from the transformation projects undertaken in 2013/14; this will include a whole-systems approach review of the patient pathway, and is explained in section 5.1 of this report

The CQUIN programme has key milestones for reporting progress. Progress on the implementation of the CQUINs will be monitored at the clinical quality review group meetings with the CCG.

Registration with the Care Quality Commission

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 2013/14, nor at any time.

In May 2013, Northwick Park, one of the trust's satellites, received an unannounced inspection against six essential standards of quality and safety and was found to be compliant against all of them. In September 2013, another of the trust's satellites, at Ealing, also received an unannounced inspection against six essential standards and was also found to be fully compliant.

Moorfields Eye Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Quality of data

Moorfields Eye Hospital NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentages of records in the published data which included the patient's valid NHS number were:

- 99.1% for admitted patient case
- 99.3% for outpatient care; and
- 95.8% for accident and emergency care.

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

- 99.9% for admitted patient care
- 99.9% for outpatient care; and
- 99.1% for accident and emergency care.

The information governance assessment report overall score for 2013/14 was 69% and was graded green.

Moorfields Eye Hospital NHS Foundation Trust was not subject to the payment by results clinical coding audit during 2013/14.

Moorfields Eye Hospital NHS Foundation Trust will be taking the following actions to improve data quality during 2014/15:

- A data assurance framework to improve data quality systems and processes will be implemented across the trust
- A review of patient administration system (PAS) training and all aspects of data quality procedures will take place as part of the data assurance framework implementation
- The current data quality policy (which was revised in 2013/14) will be reviewed again in late 2014/15 to ensure that it reflects the implementation of the data assurance framework
- A data cleansing exercise of the PAS/data warehouse will be undertaken to improve the quality of the data held within these systems
- Data quality reporting and dashboards will be further developed as part of the data assurance framework implementation
- The current data quality audit programme will be expanded to include areas currently not audited
- Clinic process and signage audits established in 2013/14 at the City Road site will continue and will be rolled out across the satellite sites during 2014/15
- Improved communication of all data quality targets and improvement action plans will take place

8 Statement of support from partner organisations

Our quality report for 2013/14 has been shared with our membership council as well as with colleagues at our host clinical commissioning group (NHS Islington), the London Borough of Islington's health and wellbeing scrutiny committee and Islington's Healthwatch. The CCG commented as follows:

Commissioners' statement for 2013/14 quality accounts

NHS Islington Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from Moorfields Eye Hospital NHS Foundation Trust on behalf of the population of Islington and over 75 associate CCGs. NHS Islington CCG welcomes the opportunity to provide this statement on Moorfields' quality accounts.

This account has been reviewed within NHS Islington, associate CCGs, NHS England specialised commissioning and by colleagues in NHS North and East London Commissioning Support Unit. Commissioners were not involved in stakeholder engagement events this year, but dialogue has been held through the regular contract review meetings with the trust and we have been able to contribute our views on consultation and content.

We have reviewed the content of the account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We confirm that we have reviewed the information contained within the account and checked this against data sources where these are available to us as part of existing contract/performance monitoring discussions and the data is accurate in relation to the services provided.

Over the last 12 months, Islington CCG has had the opportunity to develop a good working relationship with the trust since the CCGs became authorised in 2013.

Over 2013/14, we note that there has been greater emphasis on improving patient experience and communication; improving clinical outcomes and patient reported outcome measures; and a focus on improving safety and increasing staff engagement.

As commissioners, we welcome the focus on the areas above and that these are reflected in the priorities for 2014/15 and continue to remain the trust's objectives. As a priority for 2014/15, we will continue to monitor the trust's progress in improving patient experience within outpatient settings and the overall patient referral-to-treatment pathway; and implementing the learning from serious incidents.

We look forward to the year ahead and working with associate commissioners and the trust across its satellite sites.

Alison Blair,
Accountable officer, NHS Islington Clinical Commissioning Group

9 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 2010 to prepare quality accounts for each financial year.

Monitor 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 foundation trust boards should put in place to support the 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 2013/14;
- The content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to May 2014.
  - Papers relating to quality reported to the board over the period April 2013 to May 2014.
  - Feedback from the commissioners dated 29 May 2014.
  - On 30 April, a meeting of nine governors took place, involving the director of corporate governance and the director of nursing and allied health professions, to consult with governors about their views on the draft quality report. A range of views were fed into the discussion and these were considered and subsequently added to further versions of the document.
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 19 December 2013.
  - The 2013 national staff survey.
  - The head of internal audit's annual opinion over the trust's control environment dated May 2014.
  - CQC quality and risk profile dated 11 March 2014.

- The quality report presents 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 measures 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; and
- The quality report has been prepared in accordance with Monitor'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,

Rudy Markham, chairman

29 May 2014

John Pelly, chief executive

29 May 2014

10 Further information

Further information about this quality account can be obtained from the director of corporate governance at Moorfields Eye Hospital NHS Foundation Trust. This report will be available on the NHS Choices website from June 2014.

11 Independent auditor's report to the council of governors of Moorfields Eye Hospital NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Moorfields Eye Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Moorfields Eye Hospital NHS Foundation Trust's quality report for the year ended 31 March 2014 (the "quality report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Moorfields Eye Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting Moorfields Eye Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2014, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Moorfields Eye Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the 28-day emergency readmissions national priority indicator, as mandated by Monitor, and, a locally determined performance indicator – incidence of endophthalmitis per 1,000 intravitreal injections for the treatment of AMD – chosen by the membership council. We refer to these collectively as the "indicators".

Since the trust is excluded from the requirement to report on cases of Clostridium difficile and the national cancer 62-day waiting times target, due to its low reportable levels, these indicators are not subject to limited assurance.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the quality report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the quality report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2013 to 27 May 2014;
- papers relating to quality reported to the board over the period April 2013 to 23 May 2014;
- feedback from the commissioners;
- the 2013 national staff survey;
- Care Quality Commission quality and risk profiles;
- Care Quality Commission intelligent monitoring;
- the head of internal audit's annual opinion over the trust's control environment dated 31 March 2014; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) code of ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Testing key management controls
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the quality report
- Reading the documents

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Moorfields Eye Hospital NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the quality report is not consistent in all material respects with the sources specified in the statement of directors' responsibilities in respect of the quality report; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP
Chartered Accountants
St Albans

29 May 2014

Annex to the quality report – core outcomes

				Moorfields performance	
Speciality	Metric		Standard	2012/13	2013/14
Cataract	Posterior capsular rupture rate (PCR)	% phaco operations complicated by PCR	<1.8%	0.80%	0.94%
Cataract	Endophthalmitis after cataract surgery	% phaco operations with postoperative endophthalmitis	<0.08%	0.03%	0.04%
Cataract	Biometry accuracy in cataract surgery	% postoperative refraction +/- 1D of that planned in those undergoing phaco	>85%	97.60%	85%
Cataract	Good vision after cataract surgery (new indicator)	% postoperative corrected visual acuity ≥ 6/12 after phaco	>90%		91%
Glaucoma	Trabeculectomy (glaucoma drainage surgery) failure	% failed trabeculectomies at 12 months post-op	≥15%	8.2%	6%
Glaucoma	PCR in glaucoma patients	% phaco surgery complicated by PCR in those with glaucoma	<NOD*	2.15%	1.04%
Glaucoma	Glaucoma tube drainage	% drainage tube failure after 1 year	<10%	5.20%	8%
Medical retina	Endophthalmitis after injections for macular degeneration	% suspected infective endophthalmitis after intravitreal Lucentis for wet AMD	<0.05%	0.04%	0.03%
Medical retina	Visual improvement after injections for macular degeneration	Visual acuity (VA) improvement: % gaining ≥ 15 letters at 12 months.	>20%	30.50%	20.7%
Medical retina	Visual stability after injections for macular degeneration	Avoiding VA loss: % losing <15 letters at 12 months	>80%	85.70%	90.2%
Medical retina	Time from referral to assessment of proliferative diabetic retinopathy	% patients referred from screening with R3 attending clinic within 4wks	80%	90.3%	51.5% **
Vitreo retinal	Success of primary retinal detachment (RD) surgery	% cases with attached retina 3 months after primary RD operation	>75%	80%	88.3%
Vitreo retinal	Success of macular hole surgery	% cases with macular hole closed 3 months after primary macular hole surgery	>80%	81%	80.6%

				Moorfields performance	
Speciality	Metric		Standard	2012/13	2013/14
Vitreo retinal	PCR in cataract surgery in vitrectomised eyes	% phaco surgery complicated by PCR in those with previous vitrectomy	<NOD	4%	1.6%
Neuro-ophthalmology, strabismus and paediatrics	Serious complications of strabismus surgery	% serious intra-op or postop complications in strabismus surgery	<2.2%	0.30%	0.3%
Neuro-ophthalmology, strabismus and paediatrics	Premature baby eye (ROP) screening compliance	% adherence to ROP screening guidelines	99%	100%	100%
Neuro-ophthalmology, strabismus and paediatrics	Success of probing for congenital tear duct blockage	% success rate lacrimal probing in young children	>85%	85.70%	86%
External disease	DSAEK corneal graft failure rate	% failure DSAEK graft by 1 year	≤12%	11%	8.9%
External disease	PK corneal graft failure rate	% failure primary PK graft by 1 year	UKTS***	16%	8.5%
External disease	DALK corneal graft failure rate	% failure DALK graft by 1 year	UKTS	11%	6.7%
Refractive	Accuracy LASIK (laser for refractive error) in short sight	% +/- 0.5D planned after LASIK in myopia up to --6D	>85%	88.80%	88.7%
Refractive	Loss of vision after LASIK	% losing 2 or more lines of vision after LASIK	<1%	0%	0%
Refractive	Good vision without lenses after LASIK	% uncorrected visual acuity > 6/12 after LASIK	≥80%	97.80% (6/12)	87.9%
Adnexal	Ptosis surgery failure	% patients undergoing primary ptosis procedure requiring further ptosis procedure	<15%	3%	5%
Adnexal	Entropion surgery success	% patients undergoing primary entropion repair who require further procedure in 1 year	>95%	100%	97.5%
Adnexal	Ectropion surgery success	% patients undergoing primary ectropion repair who require further procedure in 1 year	>80%	100%	100%
A&E	Unplanned re-attendances	% unplanned adult re-attendance at A&E within 7 days	<5%	0.10%	1.5%

				Moorfields performance	
Speciality	Metric		Standard	2012/13	2013/14
Trustwide	Wrong patient	Number of patients undergoing surgical, laser or injection procedure where wrong patient treated	0	0	0
Trustwide	Wrong side/site	Number of patients undergoing surgical, laser or injection procedure where wrong side or site treated	0	1	0
Trustwide	Wrong IOL	Number of patients undergoing cataract surgery where wrong intraocular lens implanted	0	3	2

* NOD = Royal College of Ophthalmologists National Ophthalmic Dataset

** Further explanation of performance against this indicator can be found in section 2.5 above

***UKTS UK national transplant service

Appendix 2

National staff survey

The NHS staff survey offers us the opportunity to understand the views of our staff and their experiences throughout their employment with us. Following the survey process, the results, which draw on four of the seven pledges within the NHS constitution, are analysed and published nationally against a defined benchmark group. Our benchmark group includes about 20 specialist acute trusts.

This year we surveyed all our staff, not just a sample. This has given us the opportunity to see results by department or directorate, provided a sufficient number of responses was received to ensure anonymity.

In 2013/14, 30% of our staff responded, a drop from the 44% response rate in the previous year, and below the national average for acute specialist trusts.

Where we are doing well

Overall we have some very positive messages arising out of the staff survey, demonstrating that our people take pride in the care they deliver, and recommend the trust as a place to work and receive treatment.

The five areas where we are doing best are:

- Staff feel satisfied with the quality of work and patient care they are able to deliver
- Staff agree that their role makes a difference to patients
- Staff feel motivated and enthusiastic about their work
- The overall work pressure felt by staff is lower than the national average
- The appraisals our managers conduct are well structured

The area in which we have improved the most is the coverage of appraisals, although we are still short of the benchmark average.

With all of these positive messages, our level of staff engagement is higher than average.

Where we need to improve

There are five main areas in which we need to do some more detailed work. Some repeat the themes from previous years and include:

- The proportion of staff feeling bullied, harassed or abused by other staff remains higher than the benchmark group
- The number of staff feeling bullied, harassed or abused by patients or service users also remains higher than the benchmark group
- A high proportion of staff feel they have been discriminated against at work
- Fewer staff have received equality and diversity training than in our benchmark group
- Staff feel we do not provide equal opportunities for career progression or promotion

Top four ranking scores for 2013/14

2013/14 score		2012/13 score		Trust improvement/ deterioration
Moorfields	National average for acute specialist trusts	Moorfields	National average for acute specialist trusts	
Statement 1: Work pressure felt by staff				
2.64	2.85	2.63	2.88	Improvement
Statement 2: Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver				
89	82	88	82	Improvement
Statement 3: Percentage of staff reporting well structured appraisals				
49	42	43	36	Improvement
Statement 4: Percentage of staff feeling that their role makes a difference to patients				
94	91	91	91	Improvement

Bottom four ranking scores 2013/14

2013/14 score		2012/13 score		Trust improvement/ deterioration
Moorfields	National average for acute specialist trusts	Moorfields	National average for acute specialist trusts	
Statement 1: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months				
29	22	23	23	Deterioration
Statement 2: Percentage of staff experiencing harassment, bullying or abuse from patients/relatives or the public in the last 12 months				
31	21	27	21	Deterioration
Statement 3: Percentage of staff experiencing discrimination at work in the last 12 months				
19	9	17	8	Deterioration
Statement 4: Percentage of staff receiving equality and diversity training in the last 12 months				
49	66	43	61	Improvement

Future priorities and targets – acting on staff feedback

Key actions and next steps:

- Present detailed report to management executive, trust management board and joint staff consultative committee (completed in March 2014)
- Launch staff engagement programme 'The Moorfields Way – developing a culture of courage and ownership', tackling areas of concern including bullying, harassment, discrimination and incident reporting, through refreshing our values and associated behaviours
- Develop and deliver directorate-based plans to improve targeted areas
- Review decision in 2012 to replace face-to-face equality and diversity training with a detailed information pack and assessment questionnaire
- Publish action plan and progress made
- Assess improvements through the introduction of the staff Friends and Family Test from June 2014

Appendix 3

Sustainability report

1 Introduction

NHS trusts, primary care trusts and strategic health authorities are required by the Department of Health to produce a sustainability report as part of their annual report. This requirement does not apply to foundation trusts, which may include it at their discretion. Moorfields recognises the importance of reporting on our sustainability objectives, so has produced a sustainability report using the guidance provided by HM Treasury and the NHS sustainability development unit.

2 Summary of performance

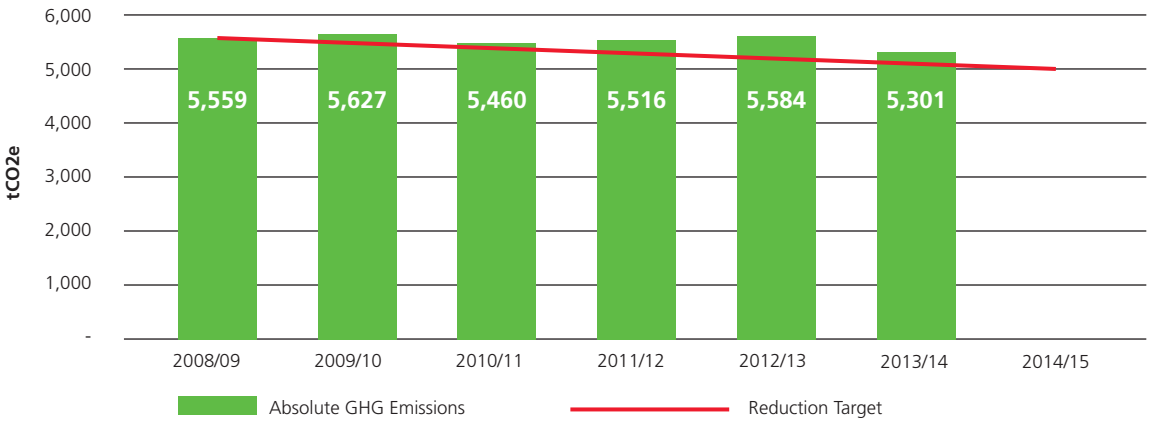
Moorfields is at the early stages of reviewing our sustainability performance. Our primary focus is to reduce our energy consumption, improve asset efficiency and meet all statutory requirements such as the Carbon Reduction Commitment (CRC) energy efficiency scheme. Measures to improve energy efficiency include a review of the building management system (BMS), continued upgrade of the lighting with light-emitting diodes (LED), and the installation of a new energy monitoring and targeting system to allow more accurate reporting and voltage optimisation. A new waste reporting procedure is being implemented alongside a complete review of our waste management process. We are also reviewing procedures to monitor and report water consumption.

Moorfields is current reviewing its performance against the new Good Corporate Citizenship assessment tool and aims to incorporate its principles into the trust's sustainable development management plan.

Greenhouse gas emissions

Moorfields has a target to reduce carbon emissions by 10% (to 5,003 tonnes of carbon) by March 2015 from the 2008/2009 baseline level of 5,559 tonnes of carbon. We follow the guidelines of the Greenhouse Gas Protocol, which provides the most commonly used standard methodology for emissions reporting worldwide.

Total direct and indirect Greenhouse Gas emissions by weight (tCO2e)



Our current target relates to direct greenhouse gas emissions from all the assets where Moorfields is responsible for the procurement of energy.

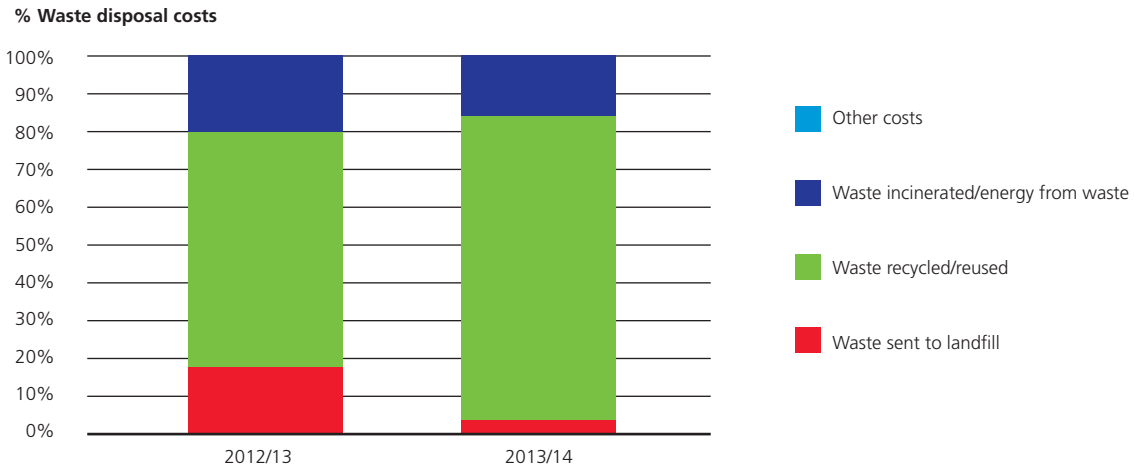
We currently do not measure emissions resulting from transport or waste as the appropriate monitoring systems are not in place although the trust is implementing measures for this to be established in future years.

The total carbon emissions for the trust from April 2013 to March 2014 are 5,301 tonnes, compared with the baseline year of 5,559 tonnes, a reduction of 258 tonnes, or 4.6%.

Waste

The new head of facilities has reviewed all of the processes related to waste management. We are now diverting 96% of waste from landfill. This will continue to be measured and reviewed with the aspiration to become a 'zero landfill' organisation.

A current breakdown of the operational waste for 2013/14 has been provided using financial indicators.

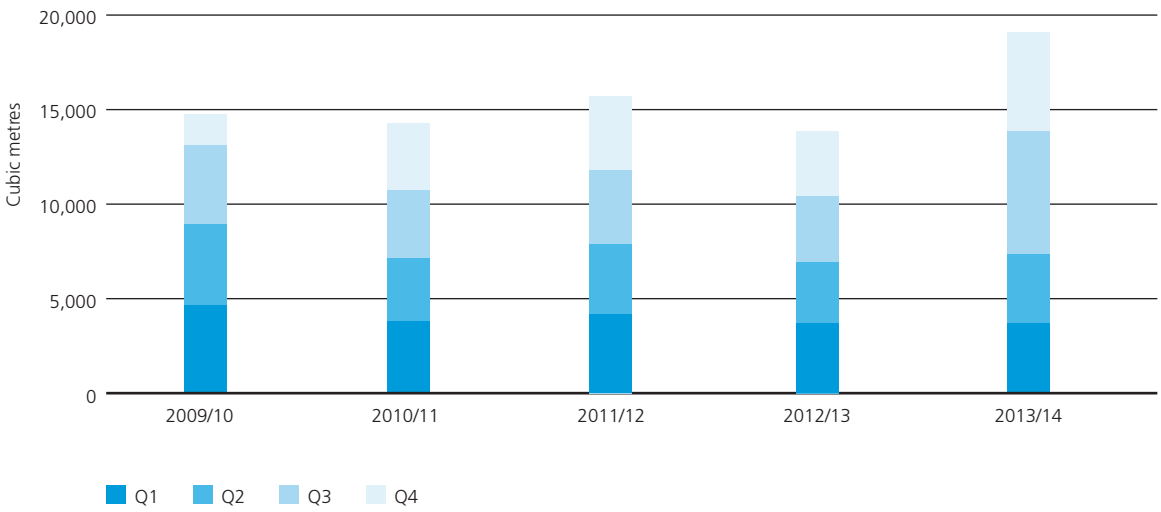


Use of finite resources – water

Water consumption has increased 30% over the last five years. This is primarily due to increased patient activity numbers which rose 20% between 2009/10 and 2012/13.

Although a target has yet to be established as a part of our sustainable development management plan, sustainable resource consumption will be considered as part of the trust's Good Corporate Citizenship commitments.

Water consumption



Sustainable procurement

We are in the process of implementing the 'Good Corporate Citizen' process whereby procurement will be required to report extensively on all matters relating to procurement sustainability.

3 Governance

Moorfields' sustainable development management plan is being updated. This will ensure that we continue to fulfil our commitment to conducting all aspects of our activities with due consideration to sustainability at the same time as providing high quality patient care. To ensure we are meeting Environment Agency compliance requirements, we have recently undertaken an external audit of our Carbon Reduction Commitment energy efficiency scheme procedures. Moorfields was found to be compliant in all areas including best practice requirements.

4 Good Corporate Citizen

The Good Corporate Citizenship (GCC) assessment model has recently been updated, and we are reviewing its progress against the assessment criteria to ensure the wider considerations of sustainability are embedded within the organisation's business processes.

Appendix 4

Equality and diversity report

Moorfields published its first equality report, *Focus on Inclusion*, in January 2012. The report was part of our response to the requirements of the public sector equality duty, which supports organisations carrying out public functions to consider the needs of those that use services; in shaping policy and the provision of services; in relation to their own employees and in relation to local communities. It outlined our approach to equality, diversity and inclusion and provided details of some of the demographic profile (age, gender and ethnic background) of our patients, staff and foundation trust members.

In relation to equality, diversity and inclusion, our ambition is to be an organisation that:

- Has the confidence and respect of our patients, the community, our staff and partners
- Provides high-quality ophthalmic services, including promotion of better eye care and the prevention of eye problems, that meet the needs of different communities
- Enhances our patients' quality of life through a more holistic approach to their physical and emotional needs
- Has equality, diversity, inclusion and dignity embedded in its culture
- Works with our members, our patients, their families and our partners to maximise opportunities for community engagement so that we can continue to improve our services
- Recruits, supports and retains a diverse and skilled workforce by providing training and guidance which enables and empowers them to provide a first-class service with confidence

To realise our ambitions, we set ourselves three main objectives, supported by a series of outcomes, measures and actions:

- To create an organisation that is increasingly sensitive to equality and diversity issues when dealing with patients, their carers and visitors to the trust
- To provide high quality ophthalmic services, including promotion of better eye care and the prevention of eye problems that better meets the needs of different communities and has a positive impact in the communities where the trust provides services
- To attract, maintain and develop a diverse workforce, ensuring the widest labour market is accessed and the best employees are secured, taking into consideration the needs of the trust

We report on progress against these objectives annually, by producing an updated version of *Focus on Inclusion*. The first of these was published in February 2013, and the second in January 2014.

Much was achieved during the second year, which covers most of the 2013/14 financial year. Highlights include:

- The start of engagement with community groups and users in relation to the design of the new hospital, in order to ensure that the building meets the needs of all patients, visitors and staff (for example, in terms of access)

- A better understanding of our patients' specific needs through our patient days
- The completion by nearly 500 staff of an online training and assessment module in caring for those with learning disabilities and cognitive impairments such as dementia
- The appointment of a staff interpreter (Punjabi) and an eye clinic liaison officer at Northwick Park and Ealing who are trained to assist patients and visitors with specific needs to access the services of the trust
- The successful relaunch of equality and diversity training for all staff, with a 67% completion rate

The report from the second year's activities concludes that the trust has demonstrated continuing compliance against the Equality Act and that a wide range of activity in the area of equality and diversity has taken place with very good progress against the objectives.

A full copy of *Focus on Inclusion* and our equality and diversity objectives are available on our website.

Appendix 5

Annual accounts 2013/14

1 Foreword to the accounts

The accounts for the year ended 31 March 2014 have been prepared by Moorfields Eye Hospital NHS Foundation Trust in accordance with The National Health Service Act 2006.

John Pelly, chief executive
29 May 2014

2 Accounting officer's statement of responsibilities

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

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

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

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed and disclose and explain any material departures in the financial statements; and
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- Prepare the financial statements on a going concern basis

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

The accounting officer is responsible for the maintenance and integrity of the corporate and financial information included on the trust's website. Legislation in the United Kingdom governing the preparation and dissemination of financial information differs from legislation in other jurisdictions.

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

John Pelly, chief executive
29 May 2014

3 Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Moorfields Eye Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Moorfields Eye Hospital NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The trust, through the board of directors, ensures that systems of internal control are in place. As accounting officer I have overall responsibility for risk management. I chair the trust management board and management executive through which executive responsibility for risk management is exercised.

The overall strategy of the trust is to maintain systematic and effective arrangements for recognising and managing all risks within the organisation. The director of corporate governance has responsibility for the design, development and maintenance of operational risk systems, policies and processes, with the day-to-day working of the risk systems being managed through the trust's operational management teams. The director of corporate governance chairs the risk and safety committee, which provides additional management review of risks and risk mitigation, and also supports the day-to-day risk management processes across the organisation.

The trust's board assurance framework (BAF) details the principal risks to the organisation, including the risks of not achieving aspects of the trust's strategy and how they are being mitigated. The BAF is integrated with the trust's corporate risk register, which sets out the key risks to the organisation and how they are being managed. The corporate risk register and BAF have been reviewed during the year by the management executive and board, in line with risk management policies.

Management reviews of the BAF include evaluation of the status of known risks and the addition of any new risks, including risk scores, understanding mitigation and, where needed, introducing further actions and mitigations. Board reviews test assurances, the strength of mitigating actions, the possible impact of risks on the organisation and the capacity to manage risks.

The trust has a broad set of training provision, some of which is mandatory and much of which contributes to the mitigation of risks, both clinical and non-clinical. Relevant examples of mandatory training related to risk mitigation are child protection, safeguarding adults, fire, general health

and safety, incident reporting for managers, infection control, information governance and risk and safety management. Different roles and responsibilities have specific training requirements; for example, those staff who work most closely with children are required to have level 3 child protection training (the highest level), while all staff are required to have a minimum of level 1.

The risk and control framework

The trust has a risk management strategy and policy; levels of accountability and responsibility for risk are detailed within this. The trust has risk management systems in place for recording, evaluating, monitoring and controlling risks. The systems are comprehensive across all operational areas and are subject to overview and scrutiny by the trust board and its committees. The management of risks is embedded in management roles at all levels of staff, and primary control of those risks takes place through the directorates and frontline teams. Processes for monitoring all types of activity, both clinical and non-clinical, are in place within the directorates, and performance dashboards are available to support the monitoring of activity and are in development for quality governance.

The general risk appetite in relation to patient safety within the organisation is to minimise avoidable risk. The mitigation of risks will vary considerably depending on whether a risk is strategic or operational and therefore needing to be resolved quickly. The trust was assessed by the NHS Litigation Authority (NHSLA) in December 2011 and achieved a level 3 assessment (the highest level) with a score of 47 out of 50. The trust continues to believe that its process risks remain low and because the NHSLA has ceased to operate its risk assessments processes, the trust has designed a new in-house risk assessment system, which will involve external assessment. In 2013/14 the trust introduced electronic incident reporting to replace its paper-based system. This has resulted in a considerable increase in the reporting of incidents of low classification (little or no harm) and thus encouraging a more open reporting culture. I expect this to continue in 2014/15 as the whole organisation becomes fully trained and adapts to the new incident reporting system. The electronic incident reporting systems also facilitate providing more rapid and clearer feedback to staff about remedial or improvement actions once incidents have been reported, something that has been raised in successive years in the trust's staff survey.

The trust has quality governance systems in place, which include systems for collecting, assessing and presenting quality and safety information at different levels within the organisation from the board to operational level. Oversight and scrutiny of these governance arrangements is provided by the quality and safety committee, which is a committee of the board. These quality systems are described in the annual quality report which forms part of the annual report. As well as the day-to-day management of the quality of care by front line staff, the trust has a range of quality systems which have evolved over the past few years and now consist of a range of activities. These include regular patient safety data reviews, which together in one place consider all the patient safety data, any trends and the need for remedial actions. There are also patient safety walkabouts which involve the quality and safety team visiting the trust's multiple sites where data and information on the frontline is reviewed, and staff have the opportunity to discuss issues with the team. A further quality and safety review which commenced in 2013/14 is a process of Care Quality Commission (CQC) style walkabouts. These involve peer review based inspections of the trust's sites based on the CQC's methodology, and also include board members and governors. These help the trust to assess both its ongoing compliance with CQC standards of registration and help teams prepare for CQC inspections. Quality performance is monitored robustly through a range of quality reports that are provided for the trust management board and the trust board. These reports are based on the three internationally recognised quality themes of patient experience, patient safety and clinical effectiveness. All of these processes in combination provide assurance about the CQC's essential standards of quality and safety. The trust is fully compliant with the registration requirements of the CQC.

The trust's annual plan provides a comprehensive view of the risks across the whole organisation; the key risks assessed for the next two years are identified below:

Quality and safety

Risk	Mitigation
Failure to identify and/or address existence of poor clinical standards due to inconsistent implementation of good clinical practice across the trust that could lead to an undesirably wide range of outcomes	Existing controls generally enable the existence of good standards, and improvements to enhance closer supervision to create better consistency are being addressed along with continuous review and update of clinical guidelines, scheduled clinical governance workshops and developing wider learning from the global trigger tool
Failure to have in place adequate systems to ensure good quality data impacting on quality of patient care, performance and income	We have in place a structure for a data assurance framework and associated review of data areas that is underway; individual data sets are subject to differing levels of scrutiny and some are subject to detailed audit within the scheduled quality audit plan
Failure to address significant patient experience concerns resulting in little or no improvement to patient waiting times, motivating patients to seek alternative care and rising complaints	More floor walkers to ensure patient experience concerns are addressed in clinic and improvements to our pathways that have been implemented and their further expansion and development initiatives to improve capacity and service availability
Inability to maintain high standards and functions within available resources due to affordability impact	We have robust financial planning and modelling within the trust and are looking at sustainable productivity and cost improvement programmes
Major IT systems failure from poor IT infrastructure	Significant improvements are being made to trust IT infrastructure and the business continuity plan is reviewed and up-to-date. OpenEyes releases are being reviewed to identify and implement improvements with further modular functionality being specified from a wider clinical base and more succinct programme management

Operational risks

The most significant risk to our operational capacity will be the availability of the additional staff needed to improve our 18-week referral-to-treatment (RTT) performance, at the same time as continuing to address increased demand for our services – in particular our injection services.

There are also constraints in developing new pathways resulting from our existing estate, and the associated restrictions in our physical capacity. We will seek to mitigate these risks by continuing to invest appropriately in our facilities and expanding capacity through our capital investment programme.

The implementation of OpenEyes will be paramount in improving data capture, not only to improve performance, but to assess clinical effectiveness and support R&D projects. These risks will be mitigated through strengthened project management and a reprioritised development programme that addresses administrative systems as well as clinical records.

Financial risks

Risk	Mitigation
Changes to tariff structures for CCG and specialist commissioned activity are detrimental to our financial position	The trust has limited contingency reserves (1% of NHS costs) for this eventuality. We would need to seek to generate additional savings and revenues in order to maintain contingency reserves for other uncertainties, such as commissioner intentions.
Anticipated growth for our commercial businesses may not materialise with consequent impact on profitability	Formal submitted plans only address activities known to be going ahead. New opportunities are likely to crystallise to some degree. Residual risk is accepted in line with past practice.
Inflation is above expectations, leading to pay and non-pay pressures that are not fully funded	The trust has limited contingency reserves (1% of NHS income) for this eventuality. We would need to seek to generate additional savings and revenues.
Capital costs increase substantially to support service capacity improvements	Current good working knowledge of the resource requirements of patient pathways is being formalised alongside data environment improvements.This should allow the trust to seek opportunities to further optimise the utilisation of its infrastructure and to ensure that new infrastructure is closely targeted to patient requirement.
Cash balances adversely impacted from an array of poor practices and processes	The trust has existing cash resources and will seek debt finance for its current pipeline of major incremental projects, for example, St George's Hospital building and site acquisitions.
Broader health system planning changes adversely impact on our operational and financial position	Engagement, where offered, in the relevant consultation processes.
Short-term planning cycles do not represent or enable the trust to illustrate strategic financial performance based on our significant growth opportunities	Discussions are taking place with Monitor over flexibility to change planning assumptions and resulting plans and metrics over time; for example opening new satellites where care is currently poor would diminish short term financial results whilst improving patient care and potentially the trust's medium term financial performance.

Governance risks

The trust is required to report risks of non-compliance with NHS foundation trust condition 4 (concerning the governance of foundation trusts) of its licence.

All trusts have the potential to miss governance concerns or issues that may lead to more serious failures if insufficient oversight or review of the trust's governance systems takes place. This oversight is supported by the trust's board governance arrangements, which are explained in section three of this annual report. In order to maintain the effectiveness of the board's governance structures, the trust's chairman regularly liaises with the non-executive directors to understand their views about the organisation including its governance. The trust's chairman also has six-monthly

reviews with the chairs of the board committees to review the effectiveness of their committees. The board aims to undertake an annual self-assessment of its performance, which includes consideration of the effectiveness of the trust's governance arrangements. The trust received the highest rating following an internal audit which assessed the trust's systems for monitoring compliance with its licence conditions. The trust assesses the potential for non-compliance of condition 4 through a risk assessment prior to submission of its corporate governance statement to Monitor. That risk assessment is agreed by the board. During that risk assessment the board considers the supporting evidence for compliance with the statement, for example how assurance is obtained through board committees.

Stakeholder involvement in risk management

Trust governors, who include patient, public, staff and nominated (stakeholder) governors, are involved in a number of groups and committees across the organisation. These groups have responsibilities in supporting the identification and management of risks. Non-executive directors, governors and patients support the work of the patient experience committee, which has responsibility for improving key aspects of the patient experience, identified through patient surveys and other sources of patient feedback.

Other routes whereby stakeholders can feed in risks and issues to the organisation include:

Patients and the public

- Patient advice and liaison service (PALS)
- Complaints processes
- Specific patient groups
- The trust's annual general meeting
- The national patient survey programme
- Healthwatch

Staff

- The annual staff survey
- Chief executive's briefing sessions
- Responding to the chief executive's newsletter
- Raising concerns through the trust's contact officers

Health partners

- Clinical commissioning group (CCG) engagement through the clinical quality review group (CQRG) meeting provides a regular forum for the discussion of issues and risks and a review of the corporate risk register with a focus on quality performance
- The London Borough of Islington through their health and wellbeing scrutiny committee

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure that all employer obligations contained within the scheme's regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and

payments into the scheme are in accordance with the scheme rules and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

The foundation trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaption reporting requirements are complied with.

Information governance

Data security is addressed through the trust's information governance arrangements. Responsibility for the leadership of the information governance agenda is delegated from the chief executive to the senior information risk owner (SIRO) who is the director of corporate governance. The SIRO is responsible for ensuring that information governance risk management systems and processes are in place and operating effectively.

The information governance committee (IGC) is chaired by the SIRO and is responsible for overseeing the trust's information governance processes, systems and practices across all the trust's sites, and provides the board with assurance that the trust is compliant with and is managing risks to compliance in the following areas:

- Information governance management
- Information security assurance
- Confidentiality and data protection assurance
- Clinical information assurance
- Secondary use assurance
- Corporate information assurance

All key areas of the trust are represented on the IGC. The IGC reports to the management executive and has several sub-groups covering specific areas such as corporate records, information management and IT security.

One part of the IGC's responsibilities is to oversee the annual information governance (IG) toolkit assessment, which has to be submitted by 31 March each year. The IG toolkit assessment reported an overall score for 2013/14 of 69% and was graded green (satisfactory compliance), which is slightly lower than the 75% achieved the previous year. The score did not improve partly because a number of issues relating to data quality still remain, but with the implementation of a data quality assurance framework in 2014/15 it is anticipated that this score will improve. More detail about the actions being taken to improve data quality is set out in the quality report.

During 2013/14, there was one serious incident involving personal data, which was reported to the information commissioner in accordance with national guidance. The incident related to personal data being stolen from a vehicle; all data was subsequently retrieved. This incident was investigated and the resulting recommendations fully implemented. The trust continues to take steps to ensure the secure management of patient and staff information. This has been facilitated through enhancements to our information security systems and processes, embedding clear policies and procedures in our staff's daily work.

Review of economy, efficiency and effectiveness of the use of resources

The trust has an annual programme of internal audit, which is prepared taking into consideration the views of management and the audit committee. The audit committee monitors progress against the audit programme and addresses any improvement actions identified. The management executive, trust management board and trust board review the trust's financial position and savings programme monthly and further scrutiny is undertaken by the audit committee as required.

In the case of internal audit, the two main reviews cover the trust's financial management (financial controls and processes), financial stewardship, financial throughput of central systems and interdependencies with operational systems, cash and working capital management, the use and understanding of financial targets; and financial reporting (scrutiny of finances at an operational level), empowering staff to manage budgets and be held accountable for them, information and analysis supplied to the board and its committees. Both reviews gave the highest of three possible levels of assurance regarding the trust's systems of financial management and reporting. A more detailed discussion of trust performance and key performance indicators can be found in the annual report.

Financial data generated and relied upon by the trust is subject to a number of tests as to accuracy and the extent to which internal controls can be relied upon. Assurance is given regarding these controls through a system of internal audit, the outcome of which is described above and is principally concerned with how the information is generated and used internally.

The accuracy of clinical coding is subject to an annual audit; for 2013/14 the trust was not subject to a risked-based 'payment by results' audit. The accuracy of data more broadly is subject to scrutiny by the information management group via bi-monthly reports, which includes data completeness reports for national and contractual targets.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports, which incorporates the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The development of the trust's quality report has this year been led by the director of corporate governance in close liaison with the clinical director of quality and safety, the director of nursing and allied health professions, the medical director and the chief operating officer.

The trust management board has had an overview of the trust's quality priorities during the year, which fall into the three areas of patient safety, patient experience and clinical effectiveness. The quality report was reviewed by the trust's management executive and the quality and safety committee; views were also provided by the membership council's governors, many of whom are patients. The quality report was finalised as a balanced representation of the trust's priority areas across patient safety, patient experience and clinical effectiveness. The trust governors have fed their views into the development of the quality report, which was agreed by the trust board on 27 May 2014.

The quality priorities for 2014/15 are consistent with the trust's agreed strategic priorities. A number of stakeholders have been consulted during the development of the quality priorities, including clinicians, governors (many of whom are patients), commissioners, the quality and safety committee, Healthwatch and Islington's health and wellbeing scrutiny committee. The quality priorities have been included in the annual plan and have been approved by the trust board.

The trust has a data quality assurance framework which includes the trust's key indicators and those that are included in the quality report, but this must be implemented fully during 2014/15 to improve data quality systems and processes. In addition the data quality policy will be reviewed in late 2014/15 to ensure that it reflects the implementation of the data assurance framework.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the board, the audit committee and the quality and safety committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review of the effectiveness of the systems of internal control is informed by executive directors and managers within the organisation.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal controls has involved:

- The trust board, working with an integrated programme of business, ensuring that the key compliance and regulatory requirements are reported and reviewed and that key risks are considered.
- The audit committee providing the board with independent and objective review of the financial controls within the trust. There has been a programme of internal audit to review the systems, controls and processes and the outcomes of these reports have been reviewed by the audit committee. This work has included identifying and testing the effectiveness of the risk management and assurance processes that take place.
- The activities of a number of management committees, which provide the additional mechanisms for the internal controls within the organisation, particularly the clinical governance committee, the risk and safety committee and the information governance committee.
- Internal financial controls are implemented through finance systems and automated processes, physical measures, and manual processes, all governed by the standing financial instructions and reported through the audit committee.

Conclusion

To conclude, there are no significant control issues identified, but areas where improvements are in progress are indicated in the text above.

The opinion of the head of internal audit is that substantial assurance can be given that there is generally a sound system of internal controls which is designed to meet trust objectives and that generally controls are being consistently applied in all the core areas reviewed, but that work already underway to improve the operation of systems to assure the board over the quality of data it receives will further enhance the control environment in place at the trust.

John Pelly, chief executive
29 May 2014

4 Independent auditor's report to the board of governors and board of directors of Moorfields Eye Hospital NHS Foundation Trust

We have audited the financial statements of Moorfields Eye Hospital NHS Foundation Trust for the year ended 31 March 2014 which comprise the statement of comprehensive income, the statement of financial position, the statement of cash fows, the statement of changes in taxpayers' equity and the related notes 1 to 23. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – independent regulator of NHS foundation trusts.

This report is made solely to the board of governors and board of directors ("the boards") of Moorfields Eye Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the audit code for NHS foundation trusts and international standards on auditing (UK and Ireland). Those standards require us to comply with the auditing practices board's ethical standards for auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the accounting officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- Give a true and fair view of the state of the trust's affairs as at 31 March 2014 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by Monitor, the independent regulator of NHS foundation trusts; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- The part of the directors' remuneration report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- The information given in the strategic report and the directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the audit code for NHS foundation trusts requires us to report to you if, in our opinion:

- The annual governance statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the annual governance statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- Proper practices have not been observed in the compilation of the financial statements; or
- The NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the audit code for NHS foundation trusts.

Deloitte LLP

Craig Wisdom, senior statutory auditor
For and on behalf of Deloitte LLP
Chartered accountants and statutory auditor

3 Victoria Square
Victoria Street
St Albans,
AL1 3TF

29 May 2014

5 Statement of comprehensive income

	Note	31 March 2014 £'000s	31 March 2013 £'000s
Income from activities	2, 3.1–3.2	**144,336**	130,872
Other operating income	2, 3.3	**29,529**	27,202
Total income		**173,865**	158,074
Operating expenses	4–5	**(162,518)**	(151,666)
OPERATING SURPLUS		**11,347**	6,409
Finance income	6.1	**46**	52
Finance expense – financial liabilities	6.2	**(164)**	(446)
Finance expense – unwinding of discount on provisions	13	**(4)**	(5)
Public dividend capital dividends paid	18	**(1,942)**	(1,761)
SURPLUS FOR THE YEAR		**9,283**	4,248
Other comprehensive income			
Revaluation gains/ (losses) on property, plant and equipment	14	**2,726**	(6,037)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**12,008**	(1,789)

All income and expenditure is derived from continuing operations.

Notes 1 to 23 form part of these accounts.

6 Statement of financial position

	Note	31 March 2014 £'000s	1 April 2013 £'000s
NON-CURRENT ASSETS			
Intangible assets	7	**2,840**	2,179
Property, plant and equipment	8	**79,506**	74,724
TOTAL NON-CURRENT ASSETS		**82,346**	76,903
CURRENT ASSETS			
Inventories	9	**3,508**	3,206
Trade and other receivables	10	**16,291**	13,007
Cash and cash equivalents		**24,287**	20,609
TOTAL CURRENT ASSETS		**44,086**	36,821
CURRENT LIABILITIES			
Trade and other liabilities	12	**(30,050)**	(26,871)
Borrowings	12	**–**	(447)
Provisions for liabilities	13	**(2,113)**	(608)
TOTAL CURRENT LIABILITIES		**(32,162)**	(27,926)
TOTAL ASSETS LESS CURRENT LIABILITIES		**94,269**	85,798
NON-CURRENT LIABILITIES			
Trade and other liabilities	12	**(451)**	(396)
Borrowings	12	**–**	(4,323)
Provisions for liabilities	13	**(131)**	(151)
TOTAL NON-CURRENT LIABILITIES		**(581)**	(4,870)
TOTAL ASSETS EMPLOYED		**93,687**	80,928
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	17	**32,029**	31,279
Revaluation reserve	14	**6,271**	3,743
Income and expenditure reserve	14	**55,387**	45,907
TOTAL TAXPAYERS' EQUITY		**93,687**	80,928

The financial statements on pages 123 to 175 were approved by the board and signed on their behalf by:

John Pelly, chief executive
29 May 2014

7 Statement of changes in taxpayers' equity

	Public dividend capital £'000s	Revaluation reserve £'000s	Income and expenditure reserve £'000s	Total £'000s
At 1 April 2013	**31,279**	**3,743**	**45,907**	**80,928**
Surplus for year	–	–	9,283	9,283
Revaluation losses on property, plant and equipment	–	2,726	–	2,726
Other transfers between reserves	–	(197)	197	–
Public dividend capital received	750	–	–	750
At 31 March 2014	**32,029**	**6,271**	**55,387**	**93,687**

	Public dividend capital £'000s	Revaluation reserve £'000s	Income and expenditure reserve £'000s	Total £'000s
At 1 April 2012	**31,279**	**9,912**	**41,527**	**82,717**
Surplus for year	–	–	4,248	4,248
Revaluation gains on property, plant and equipment	–	(6,037)	–	(6,037)
Other transfers between reserves	–	(132)	132	–
At 31 March 2013	**31,279**	**3,743**	**45,907**	**80,928**

8 Statement of cash flows

	2013/14 £'000s	2012/13 £'000s
Operating surplus	**11,347**	**6,409**
Non-cash income and expense:		
Depreciation and amortisation	6,098	5,462
Impairments	–	330
Loss on disposal of fixed assets	159	–
(Increase) in trade and other receivables	(3,517)	(956)
(Increase)/decrease in inventories	(303)	47
Increase in trade and other payables	2,526	5,425
Increase in other liabilities	455	41
Increase in provisions	1,481	256
NET CASH GENERATED FROM OPERATIONS	**18,246**	**17,014**
Cash flows from investing activities		
Interest received	46	52
Sale of financial assets	–	852
Purchase of intangible assets	(1,222)	(1,582)
Purchase of property, plant and equipment	(7,760)	(5,745)
Sale of property, plant and equipment	163	–
Net cash used in investing activities	**(8,772)**	**(6,423)**
Cash flows from financing activities		
Public dividend capital received	750	–
Loans repaid	(4,771)	(4,470)
Capital element of finance lease rental payments	–	(1,551)
Interest paid	(165)	(376)
Interest element of finance leases	–	(41)
PDC dividend paid	(1,611)	(2,070)
Net cash used in financing activities	**(5,796)**	**(8,508)**
INCREASE IN CASH AND CASH EQUIVALENTS	**3,677**	**2,083**
Cash and cash equivalents at 1 April	**20,609**	**18,527**
Cash and cash equivalents at 31 March	**24,287**	**20,609**

9 Notes to the accounts

1 Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trusts Annual Reporting Manual ("FT ARM"), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2013/14 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual ("FReM") to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets.

NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the International Accounting Standard 33 requirements to report "earnings per share" or historical cost profits and losses.

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

Subsidiary entities are those over which the trust has the power to exercise control or a dominant influence so as to gain economic or other benefits.

The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the statement of financial position.

The trust established MEH Ventures LLP during 2013/14, a wholly-owned subsidiary of the trust. Transactions entered into by MEH Ventures LLP during 2013/14 were at a level which were considered to be immaterial for the purposes of consolidation into the trust's accounts, therefore no entries have been made in respect of that entity.

When MEH Ventures LLP transaction values reach an appropriate level (expected during 2014/15), they will be consolidated into the trust's results in accordance with relevant International Financial Reporting Standards.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

With regard to partially completed spells, if the trust can demonstrate that it is certain to receive the income for a treatment or spell once the patient is admitted and treatment begins then the income for that treatment or spell can start to be recognised at the time of admission and treatment starting. Costs of treatment are then expensed as incurred. Income relating to those spells which are partially completed at the financial year-end should be apportioned across the financial years on a pro rata basis. This basis may be the expected or actual length of stay or may be based on the costs

incurred over the length of the treatment. It is for the trust to establish a suitable pro rata basis, and where material, disclose this in the accounting policy note.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the NHS Pension scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers' pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably;
- Individual items have a cost of at least £5,000; or
- Items form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial set-up cost of a new building or refurbishment of a ward or operational unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives – e.g. plant and equipment – then these components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

Significant land and buildings are revalued to current value using independent professional valuations in accordance with International Accounting Standard 16 every five years. Annual desktop valuations are also carried out. Desktop valuations were carried out on properties at 162 City Road, the Richard Desmond Children's Eye Centre (RDCEC), the pharmacy manufacturing unit and Northwick Park during the year ended 31 March 2014 with an effective date of 1 April 2014. The valuation was carried out by Gerald Eve, an external firm of chartered surveyors, with the basis of valuation being modern equivalent asset.

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

Operational equipment is valued at historic cost. Equipment surplus to requirements is valued at its net recoverable amount.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the statement of comprehensive income in the period in which it is incurred.

Depreciation

Items of plant and equipment are depreciated over their remaining useful economic lives on a straight-line basis, which varies from five to 15 years.

Freehold land is considered to have an infinite life and is not depreciated.

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

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the statement of comprehensive income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve.

Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- The sale must be highly probable, ie:
  - Management are committed to a plan to sell the asset;
  - An active programme has begun to find a buyer and complete the sale;
  - The asset is being actively marketed at a reasonable price;
  - The sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
  - The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less selling costs' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.6 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights.

They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust for more than one year; where the cost of the asset can be measured reliably; and where that cost is at least £5,000.

Software

Software that is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

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

Costs relating to internally generated software are capitalised as intangible fixed assets and amortised over the anticipated useful economic life of the resulting software.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Intangible fixed assets held for operational use are valued at historical cost and are amortised over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be fully recoverable.

Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.7 Government grants

Government grants are grants from Government bodies other than income from clinical commissioning groups or NHS trusts for the provision of services. Where the Government grant is used to fund revenue expenditure it is taken to the statement of comprehensive income to match that expenditure.

Where the grant is used to fund capital expenditure it is also taken to the statement of comprehensive income in full, unless conditions are specified at the time of the grant which require a certain usage profile over the life of the asset thus obtained.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method within the pharmacy department, and the first-in, first-out (FIFO) method for all other balances.

Work-in-progress comprises goods in intermediate stages of production.

Where inventory is found to be obsolete or expired, the carrying value of that inventory is immediately recognised as an expense.

1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables, or 'available-for-sale financial assets'. Financial liabilities are classified as 'other financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions cost, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the

rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the statement of comprehensive income, except where agreements with counterparties specify otherwise.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the statement of financial position date, the trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of comprehensive income and the carrying amount of the asset is reduced directly.

1.10 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The trust intends to complete the asset and sell or use it;
- The trust has the ability to sell or use the asset;
- How the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- Adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
- The trust can measure reliably the expenses attributable to the asset during development.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the statement of comprehensive income on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred.

Where possible, NHS foundation trusts disclose the total amount of research and development expenditure charged in the income and expenditure account separately. However, where research and development activity cannot be separated from patient care activity, it cannot be identified and is therefore not separately disclosed.

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

1.11 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the statement of financial position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.8% (2012/13: 2.9%) in real terms.

1.12 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 13 but is not recognised in the NHS foundation trust's accounts.

1.13 Non-clinical risk pooling

The NHS foundation trust participates in the property expenses scheme and the liabilities to third parties scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but would be disclosed as a note to the accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but would be disclosed as a note to the accounts, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

The trust has no such assets as at 31 March 2014 or for reported prior years.

1.15 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay, and that the scheme operates on a sound financial basis. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 13.3% of their pensionable pay depending on total earnings.

Scheme provisions as at 31 March 2008

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last three years' pensionable pay for each year of service. A lump sum normally equivalent to three years' pension is payable on retirement.

Scheme provisions from 1 April 2008

The scheme is a final salary scheme and is split into two pension 'sections':

- The "1995 section", which has an annual pension based on the 1/80th of the best of the last three years' service and a lump sum normally equivalent to three years' pension for staff with pensionable service pre-April 2008 and less than a five-year gap in service.
- The "2008 section" which has an annual pension based on 1/60th of the best three out of the last 10 years' pensionable pay for each year of service; no lump sum is payable on retirement.

General

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the 12 months ending 30 September in the previous calendar year. This was based on consumer prices with effect from 1 April 2012.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through mental or physical infirmity. A death gratuity is payable for death in service or after retirement, the terms of which differ depending on the section to which the member belonged.

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

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

Scheme members have the option to transfer their pension between the NHS Pensions scheme and another scheme when they move into or out of NHS employment.

Where a scheme member ceases NHS employment with more than two years' service, they can preserve their accrued NHS pension for payment when they reach the scheme's retirement age.

Where a scheme member is made redundant, they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

Further details of both schemes, including the changes made in 2008, can be found on the NHS Pensions website www.nhsbsa.nhs.uk/pensions.

1.16 Value added tax (VAT)

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

1.17 Foreign exchange

The functional and presentational currencies of the foundation trust are sterling, with the exception of the branch office in Moorfields Dubai. The functional currency of Moorfields Dubai is United Arab Emirates dirhams and the presentational currency is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the foundation trust has assets or liabilities denominated in a foreign currency at the statement of financial position date:

- Monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the statement of financial position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, where they exist they would be disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.19 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the statement of comprehensive income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.20 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.21 Corporation tax

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

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature, they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.23 Critical accounting judgements and key sources of estimation uncertainty

In the application of the trust's accounting policies, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Key areas to which this policy applies include:

- Assumptions underlying the likelihood and outcome of material provisions
- Assumptions regarding the valuation of certain properties
- Assessments of the recoverability of debtor balances

1.24 Accounting standards issued but not yet effected

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and the International Financial Reporting Interpretations Committee (IFRIC) but are not yet required to be adopted or are not yet effective:

Change published	Published by IASB	Financial year for which the change first applies
IFRS 9 Financial instruments	October 2010	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project
IFRS 10 Consolidated financial statements	May 2011	Effective date of 2014/15*
IFRS 11 Joint arrangements	May 2011	Effective date of 2014/15*
IFRS 12 Disclosure of interests in other entities	May 2011	Effective date of 2014/15*
IFRS 13 Fair value measurement	May 2011	Effective date of 2013/14 but not yet adopted by HM Treasury
IAS 27 Separate financial statements	May 2011	Effective date of 2014/15*
IAS 28 Associates and joint ventures	May 2011	Effective date of 2014/15*
IAS 32 Financial instruments: Presentation – Amendment Offsetting Financial assets and liabilities:	December 2011	Effective date of 2014/15*

(*) This reflects the EU-adopted effective date rather than the effective date in the standard.

2 Segmental analysis

The trust has four reportable segments – Moorfields Private, Moorfields Dubai, Moorfields Pharmaceuticals, and NHS activity.

2013/14	NHS £'000s	Moorfields Private £'000s	Moorfields Dubai* £'000s	Moorfields Pharmaceuticals £'000s	Intra-trust elimination £'000s	Total £'000s
Income by segment						
Income from activities	123,002	15,007	6,327	933	(933)	**144,336**
Other operating income	20,031	–	–	9,497	–	**29,529**
	143,033	15,007	6,327	10,430	(933)	**173,865**
Operating and other expenditure	(138,673)	(10,389)	(6,533)	(9,919)	933	**(164,582)**
Surplus for the year	**4,360**	**4,618**	**(206)**	**511**	**–**	**9,283**

2012/13	NHS £'000s	Moorfields Private £'000s	Moorfields Dubai* £'000s	Moorfields Pharmaceuticals £'000s	Intra-trust elimination £'000s	Total £'000s
Income by segment						
Income from activities	111,641	13,465	5,766	835	(835)	**130,872**
Other operating income	17,774	–	–	9,428	–	**27,202**
	129,415	13,465	5,766	10,263	(835)	**158,074**
Operating and other expenditure	(129,616)	(10,624)	(5,370)	(9,051)	835	**(153,826)**
Surplus for the year	**(201)**	**2,841**	**396**	**1,212**	**–**	**4,248**

* Moorfields Dubai includes the impact of foreign exchange fluctuations in its overall results, arising from the conversion of transactions in its functional currency (United Arab Emirates dirham) to sterling. If this impact was removed from the segmental analysis, Moorfields Dubai would have shown a surplus of £281,000 & £78,000 for 2012/13 & 2013/14 respectively.

Where possible, income and expenditure has been directly attributed to each of the four segments.

No segment information on the statement of financial position is presented routinely to management and is not disclosed here.

Where balances were not directly attributable to segments, the following allocation bases were used for material items:

- Pharmacy: proportion of issues to each segment
- Estates and central overheads: floor space occupied by each segment
- Theatres: activity levels attributable to each segment
- Stores and supplies: proportion of orders made by each segment
- Information technology and personnel: headcount

3 Income

3.1 Income from activities by type

	2013/14 £'000s	2012/13 £'000s
Elective income	**29,170**	26,442
Non-elective income	**5,375**	4,501
Outpatient income	**51,890**	44,460
A&E income	**8,283**	7,685
Total income at tariff	**94,718**	83,088
Non-tariff NHS income	**28,284**	28,553
Private patient income	**21,334**	19,231
	144,336	130,872

3.2 Income from activities by source

	2013/14 £'000s	2012/13 £'000s
NHS foundation trusts	**228**	375
NHS trusts	**8,378**	6,346
Primary care trusts (to 31 March 2013)	**_**	103,705
Clinical commissioning groups (from 1 April 2013)	**99,156**	_
NHS England (from 1 April 2013)	**13,527**	_
Non NHS:		
– Total private patients activity	**21,334**	19,231
– Overseas patients (non-reciprocal)	**263**	237
– Other	**1,450**	978
	144,336	130,872

3.3 Other operating income

	2013/14 £'000s	2012/13 £'000s
Research and development	**9,373**	10,013
Education and training	**3,789**	3,875
Charitable and other contributions to expenditure	**746**	768
Pharmaceutical drugs sales	**9,497**	9,427
Other income	**6,122**	3,119
	29,529	27,202

3.4 Income from the provision of goods and services

	2013/14 £'000s	2012/13 £'000s
NHS income	**143,737**	133,541
Non-NHS income	**25,229**	22,834
Income from the provision of goods and services	**168,967**	156,375
Other income	**4,898**	1,699
Total income	**173,865**	158,074
Ratio of 'non-NHS income' to 'income from the provision of goods and services'	**14.93%**	**14.60%**

Private patient income is equal to the aggregate of services delivered to private patients through Moorfields Private, Moorfields Dubai, and sales apportionment within Moorfields Pharmaceuticals.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Moorfields Eye Hospital NHS Foundation Trust has met this requirement in 2012/13 and 2013/14.

3.5 Income by protected and non-protected services

	2013/14 £'000s	2012/13 £'000s
Protected income	**123,002**	113,461
Non-protected income	**50,864**	44,613
	173,865	158,074

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

4 Operating expenses

4.1 Operating expenses comprise:

	2013/14 £'000s	2012/13 £'000s
Services from NHS foundation trusts	**258**	301
Services from NHS trusts	**3,111**	2,495
Services from other NHS bodies	**–**	202
Purchase of healthcare from non-NHS bodies	**792**	872
Employee expenses – executive directors	**1,153**	1,049
Employee expenses – non-executive directors	**122**	100
Employee expenses – staff	**89,410**	85,497
Drug costs	**16,996**	17,947
Supplies and services – clinical (excluding drug costs)	**13,630**	11,865
Supplies and services – general	**814**	940
Establishment	**4,383**	4,053
Transport	**2,569**	2,283
Premises	**13,876**	9,998
Lease rental	**2,967**	2,764
Increase in bad debt provision	**(38)**	(74)
Depreciation on property, plant and equipment	**5,537**	5,328
Amortisation on intangible assets	**561**	133
Impairments of property, plant and equipment	**–**	330
Audit services – statutory audit	**73**	83
Audit services – taxation	**26**	68
Audit services – other	**159**	628
Clinical negligence insurance premium	**372**	263
Legal fees	**564**	623
Training, courses and conferences	**450**	904
Other	**4,728**	3,012
	162,518	151,666

4.2 Operating lease rentals

4.2.1 Operating expenses include:

	2013/14 £'000s	2012/13 £'000s
Other operating lease rentals	**2,967**	2,764
	2,967	2,764

4.2.2 Total future lease payments:

	2013/14 £'000s	2012/13 £'000s
At the balance sheet date, the trust had outstanding commitments for future minimum lease payments under non-cancellable operating leases, which fall due as follows:		
Within one year	**2,967**	2,798
Between one and five years	**3,476**	4,045
After five years	**2,397**	3,019
	8,840	9,862

4.3 Salary and pension entitlements of the board of directors

(a) Remuneration – 2013/14

2013/14 Name and title	Executive salary (bands of £5,000) £'000s	Clinical/research salary (bands of £5,000) £'000s	Total entitlement £'000s
Mr J Pelly – chief executive	160 – 165	–	160 – 165
Mr C Nall – chief financial officer	125 – 130	–	125 – 130
Mr D Flanagan – medical director	40 – 45	100 – 105	140 – 145
Prof Sir P Khaw – research director	30 – 35	185 – 190	215 – 220
Ms T Luckett – director of nursing and allied health professions	90 – 95	–	90 – 95
Ms R Russell – chief operating officer[1]	35 – 40	–	35 – 40
Ms M Sherry – chief operating officer[5]	55 – 60	–	55 – 60
Mr R Markham – chairman[2]	30 – 35	–	30 – 35
Prof P Luthert – non-executive director	15 – 20	–	15 – 20
Ms D Harris-Ugbomah – non-executive director	15 – 20	–	15 – 20
Sir R Jackling – non-executive director	20 – 25	–	20 – 25
Mr A Nebel – non-executive director	15 – 20	–	15 – 20
Mr S Williams – non-executive director	10 –15	–	10 – 15
Ms S Sinha – non-executive director[4]	10 – 15	–	10 – 15

Remuneration – 2012/13

2012/13 Name and title	Executive salary (bands of £5,000) £'000s	Clinical/research salary (bands of £5,000) £'000s	Total entitlement £'000s
Mr J Pelly – chief executive	155 – 160	–	155 – 160
Mr C Nall – finance director	120 – 125	–	120 – 125
Mr D Flanagan – medical director	35 –40	95 – 100	135 – 140
Prof Sir P Khaw – research director	30 –35	185 – 190	215 – 220
Ms T Luckett – director of nursing and allied health professions	85 – 90	–	85 – 90
Ms R Russell – chief operating officer(1)	105 – 110	–	105 – 110
Mr R Markham – chairman(2)	30 – 35	–	30 – 35
Prof P Luthert – non-executive director	15 – 20	–	15 – 20
Ms D Harris-Ugbomah – non-executive director	15 – 20	–	15 – 20
Sir R Jackling – non-executive director	20 – 25	–	20 – 25
Mr A Nebel – non-executive director	15 – 20	–	15 – 20
Ms L Potter – non-executive director (3)	10 – 15	–	10 – 15
Mr S Williams – non-executive director	10 – 15	–	10 – 15

(1) Ms R Russell resigned as chief operating officer with effect from 15 August 2013.

(2) Mr R Markham waived his remuneration in 2012/13 and 2013/14, and requested that this be donated for use within Moorfields Eye Hospital charities.

(3) Ms L Potter resigned as a non-executive director with effect from 31 March 2013.

(4) Ms S Sinha was appointed as a non-executive director with effect from 22 April 2013.

(5) Ms M Sherry was appointed as chief operating officer with effect from 7 October 2013.

(b) Pension benefits

Name and title	Value of accrued pension at 31 March 2013 (bands of £5,000) £'000s	Value of accrued pension at 31 March 2014 (bands of £5,000) £'000s	Real increase in year in the value of accrued pension (bands of £2,500) £'000s
Mr J Pelly – chief executive	40 – 45	40 – 45	55.0 – 57.5
Mr C Nall – chief finance officer	5 – 10	5 – 10	42.5 – 45.0
Ms T Luckett – director of nursing and allied health professions	25 – 30	25 – 30	37.5 – 40.0
Ms M Sherry – chief operating officer	30 – 35	30 – 35	52.5 – 55.0

Name and title	Value of automatic lump sums at 31 March 2013 (bands of £5,000) £'000s	Value of automatic lump sums at 31 March 2014 (bands of £5,000) £'000s	Real increase in year in the value of automatic lump sums (bands of £2,500) £'000s
Mr J Pelly – chief executive	120 – 125	130 – 135	5.0 – 7.5
Mr C Nall – chief financial officer	Nil	Nil	N/A
Ms T Luckett – director of nursing and allied health professions	80 – 85	85 – 90	2.5 – 5.0
Ms M Sherry – chief operating officer	90 – 95	100 – 105	5.0 – 7.5

Name and title	Cash equivalent transfer value at 31 March 2013 (bands of £5,000) £'000s	Cash equivalent transfer value at 31 March 2014 (bands of £5,000) £'000s	Real increase in cash equivalent transfer value in 2013/14 (bands of £1,000) £'000s
Mr J Pelly – chief executive	Nil	Nil	N/A
Mr C Nall – chief financial officer	59 – 60	87 – 88	26 – 27
Ms T Luckett – director of nursing and allied health professions	456 – 457	508 – 509	41 – 42
Ms M Sherry – chief operating officer	675 – 676	762 – 763	71 – 72

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

Mr D Flanagan ceased to be a member of the NHS pension scheme during 2011/12.

Mr J Pelly remains a member of the NHS pension scheme but during 2012/13 reached the age at which scheme transfers are no longer possible, therefore the cash equivalent transfer value is now nil.

Non-executive directors do not receive pensionable remuneration.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

The value of trust contributions to the NHS pension scheme in 2013/14 in respect of executive directors was £95,815 (2012/13: £94,515).

4.4 Hutton disclosure

Government bodies are required to disclose the ratio of remuneration received by the highest paid director of the trust to the median remuneration of all staff at the trust.

Two directors receive remuneration for clinical or research activities, and this has been excluded from the assessment of executive remuneration. Therefore, for the purposes of this disclosure, the trust has used the total remuneration of the chief executive as the highest paid director.

- The median remuneration of all staff as at 31 March 2014 at the trust was £33,463 (2012/13: £33,146).
- The remuneration of the highest paid director was £162,500 (2012/13: £157,500) [mid-point of declared remuneration in note 4.3].
- The required ratio was therefore 4.86:1 (2012/13: 4.75:1).

4.5 Expenses paid to executive directors and governors

Total out-of-pocket expenses paid to governors of the trust in 2013/14 were £5,044 (2012/13 £2,305).

	2013/14	2012/13
Governors receiving expenses	16	7
Number of governors	22	21
Aggregate sum paid	5,044	2,305
Average sum paid	315	329

All of the above expenses were travel-related as the governors represent geographical areas in and around London.

Directors' duties include meetings with suppliers, funders and professional groups principally in the UK, occasionally overseas and also management supervision of Moorfields Eye Hospital Dubai. As a result, directors incur expenses that are reimbursed in accordance with the trust's expenses policy. These are detailed below.

Total out-of-pocket expenses paid to the directors shown in note 4.3 in 2013/14 were £3,538 (2012/13: £4,415).

	2013/14	2012/13
Directors receiving expenses	5	6
Number of directors	13	13
Aggregate sum paid	3,538	4,415
Average sum paid	708	736

Category of expense	2013/14	2012/13
Travel & subsistance	1,303	2,362
Hotel	2,006	1,837
Other	230	215
Total paid	**3,538**	**4,415**

5 Employee expenses and costs

5.1 Employee expenses

	Total 2013/14 £'000s	Permanently employed 2013/14 £'000s	Other 2013/14 £'000s	2012/13 £'000s
Salaries and wages	**70,978**	70,978	–	66,766
Social security costs	**5,894**	5,894	–	5,662
Employer contributions to NHSPA	**7,635**	7,635	–	6,896
Termination benefits	**288**	288	–	302
Agency staff	**7,006**	–	7,006	7,422
	91,801	84,795	7,006	87,048

5.2 Average number of employees

	Total 2013/14 Number	Permanently employed 2013/14 Number	Other 2013/14 Number	2012/13 Number
Medical	**292**	292	–	256
Administration and estates	**618**	618	–	499
Healthcare assistants and other support staff	**83**	83	–	85
Nursing, midwifery and health visiting staff	**354**	354	–	345
Scientific, therapeutic and technical staff	**236**	236	–	315
Agency staff	**168**	–	168	156
Bank staff	**50**	–	50	–
Total	**1,801**	1,583	218	1,656

5.3 Employee benefits

	2013/14 £'000s	2012/13 £'000s
Various employee taxable benefits in kind	**88**	30
	88	30

5.4 Retirements due to ill-health

During 2013/14 there was one early retirement on ill-health grounds (2012/13: nil) at a cost of £12,000 (2012/13: nil). This information has been supplied by the NHS Pensions Agency.

5.5 Off-payroll engagements

All off-payroll engagements as at 31 March 2014 (for more than £220 per day and that last for longer than six months)	
Total number of existing engagements as at 31 March 2014	30
of which	
Number existing for less than one year as at 31 March 2014	8
Number existing between one and two years as at 31 March 2014	14
Number existing between two and three years as at 31 March 2014	5
Number existing between three and four years as at 31 March 2014	3
Number existing for four or more years as at 31 March 2014	0

The trust confirms that all existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements, or those that reach six months in duration, between 1 April 2013 and 31 March 2014 (for more than £220 per day and that last for longer than six months)	
Total number of new engagements, or those that reached six months in duration, during the financial year	12
The number of these engagements which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	12
The number for whom assurance has been requested	12
of which	
The number for whom assurance has been requested and received	12
The number for whom assurance has been requested but not received	0
The number that have been terminated as a result of assurance not being received	0

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2013 and 31 March 2014	
Total number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	1
Total number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	11

The engagement referred to above was for an interim IT director, reporting to the chief financial officer, to lead a period of significant change in the trust's IT provision alongside a restructuring of IT services. This was ongoing as at 31 March 2014 and the arrangement has been in place since March 2012. The individual does not work solely for Moorfields.

6 Interest

6.1 Finance income

	2013/14 £'000s	2012/13 £'000s
Interest on loans and receivables	**46**	49
Interest on held-to-maturity financial assets	**–**	3
Total	**46**	52

6.2 Finance expense – financial liabilities

	2013/14 £'000s	2012/13 £'000s
Loans from Foundation Trust Financing Facility	**164**	394
Finance leases	**–**	52
Total	**164**	446

7 Intangible assets

	Licences and trademarks £'000s	Information technology (internally generated) expenditure £'000s	Development expenditure £'000s	Total £'000s
Gross cost at 1 April 2013	1,758	927	520	3,204
Additions – purchased	292	929	1	1,222
Gross cost at 31 March 2014	**2,050**	**1,856**	**521**	**4,426**
Amortisation at 31 March 2013	556	52	417	1,025
Provided during the year	243	291	27	561
Accumulated amortisation at 31 March 2014	**799**	**343**	**444**	**1,586**
Net book value				
– Purchased at 31 March 2013	1,199	875	103	2,177
– Donated at 31 March 2013	2	–	–	2
– Total at 31 March 2013	**1,201**	**875**	**103**	**2,179**
– Purchased at 31 March 2014	1,248	1,513	77	2,838
– Donated at 31 March 2014	2	–	–	2
– Total at 31 March 2014	**1,250**	**1,513**	**77**	**2,840**

During the course of the year the costs of an internally-developed patient records management system (OpenEyes) were capitalised. These costs are shown above as 'information technology (internally generated)'.

8 Property, plant and equipment

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

	Land £000	Buildings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2013	11,690	58,479	29,436	5	9,469	1,266	110,345
Additions purchased	–	2,743	1,908	–	2,951	179	7,781
Additions donated	–	–	135	–	–	–	135
Gains/(losses) on revaluation	160	2,566	–	–	–	–	2,726
Disposals	–	–	(1,215)	–	(138)	–	(1,353)
At 31 March 2014	**11,850**	**63,788**	**30,264**	**5**	**12,282**	**1,445**	**119,634**
Depreciation at 1 April 2013	–	8,074	18,892	5	7,982	667	35,621
Provided during the year	–	1,982	2,461	–	946	147	5,537
Disposals	–	–	(892)	–	(138)	–	(1,030)
Accumulated depreciation at 31 March 2014	**–**	**10,056**	**20,462**	**5**	**8,791**	**815**	**40,128**
– Purchased at 31 March 2013	11,690	38,404	8,949	1	1,487	482	61,012
– Finance lease at 31 March 2013	–	–	656	–	–	–	656
– Donated at 31 March 2013	–	12,001	940	–	–	117	13,057
Total at 31 March 2013	**11,690**	**50,405**	**10,544**	**1**	**1,487**	**599**	**74,724**
– Purchased at 31 March 2014	11,850	40,974	8,491	–	3,491	546	65,352
– Finance lease at 31 March 2014	–	–	478	–	–	–	478
– Donated at 31 March 2014	–	12,757	834	–	–	85	13,676
Total at 31 March 2014	**11,850**	**53,732**	**9,803**	**–**	**3,491**	**631**	**79,506**

Where the trust has received donated assets or funds to purchase assets, no conditions attach to those donations beyond a requirement to purchase the specified assets.

8.2 Analysis of protected and unprotected tangible fixed assets

	Land £000	Buildings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Net book value							
– Protected assets at 31 March 2014	10,780	46,609	–	–	–	–	57,389
– Unprotected assets at 31 March 2014	1,070	7,123	9,803	–	3,491	631	22,118
Total at 31 March 2014	**11,850**	**53,732**	**9,803**	**–**	**3,491**	**631**	**79,506**

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

9 Inventories

	31 March 2014 £'000s	31 March 2013 £'000s
Raw materials and consumables	**437**	380
Work in progress	**18**	29
Finished goods	**3,052**	2,796
TOTAL	**3,508**	3,206

The value of inventories recognised in expenses during 2013/14 was £28,354,000 (2012/13: £30,689,000).

10 Receivables

10.1 Trade receivables

	31 March 2014 £'000s	31 March 2013 £'000s
Current:		
NHS debtors	**12,765**	9,423
Provision for irrecoverable debts	**(3,409)**	(3,652)
Other prepayments and accrued income	**2,088**	2,069
Other debtors	**4,847**	5,167
TOTAL	**16,291**	13,007

10.2 Provision for impaired receivables

	31 March 2014 £'000s	31 March 2013 £'000s
Balance at 1 April	**3,652**	3,846
Increase in provision for debtors impairment	**3,045**	3,653
Debtors written off during year as uncollectable	**(205)**	(120)
Unused provision reversed	**(3,083)**	(3,726)
Balance at 31 March	**3,409**	3,652

10.3 Analysis of impaired debtors

	31 March 2014 £'000s	31 March 2013 £'000s
Ageing of doubtful debtors		
Up to three months	**118**	304
In three to six months	**669**	719
Over six months	**2,622**	2,628
Total	**3,409**	3,652

	31 March 2014 £'000s	31 March 2013 £'000s
Ageing of non-provided debtors past their due date		
Up to three months	**2,993**	537
Three to six months	**755**	297
Over six months	**2,438**	497
Total	**6,186**	1,331

The provision for impaired receivables is determined initially within operating segments, i.e. NHS, non-NHS, Moorfields Pharmaceuticals, Moorfields Private, and Moorfields Dubai.

The provision for impaired receivables is inherently uncertain, as debts known with certainty to be irrecoverable are written off rather than provided for.

Assessments are made of the overall level of disputed debt, the overall level of aged debt, and factors specific to individual debtors where appropriate. A combination of these factors is used to arrive at an opinion as to the recoverability of debts and the provisions therein.

11 Other financial assets

	31 March 2014 £'000s	31 March 2013 £'000s
Held to maturity investments		
Balance at 1 April	**–**	852
Additions	**–**	–
Disposals	**–**	(852)
Balance at 31 March	**–**	**–**

12 Trade and other liabilities

12.1 Trade and other liabilities are made up of:

	31 March 2014 £'000s	31 March 2013 £'000s
Amounts falling due within one year:		
NHS creditors	**2,142**	1,989
Tax and social security costs	**2,862**	2,705
Receipts in advance	**4,160**	3,808
Capital creditors	**358**	202
Other creditors	**10,463**	8,830
Accruals	**6,940**	6,762
PDC payable	**96**	–
Deferred income	**3,029**	2,573
Sub total	**30,050**	26,871
Amounts falling due after more than one year:		
Other trade payables	**451**	396
Sub total	**451**	396
TOTAL	**30,500**	27,267

The Better Payment Practice Code requires the trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

A total of 35,750 trade invoices were paid during 2013/14 at a value of £57.9m. 35,090 of those invoices were paid within the target time at a value of £49.3m, i.e. 98.2% volume and 85.1% value respectively.

The trust achieves the aims of the Better Payment Practice Code in the majority of cases, and works with staff and suppliers throughout the year to minimise the remaining cases.

12.2 Borrowings are made up of:

	31 March 2014 £'000s	31 March 2013 £'000s
Amounts falling due within one year:		
Loans	**–**	447
Obligations under finance leases	**–**	–
	–	447
Amounts falling due after more than one year:		
Loans	**–**	4,323
Obligations under finance leases	**–**	–
	–	4,323
TOTAL	**–**	4,770

The trust made two scheduled repayments and one redemption payment on one loan from the Foundation Trust Financing Facility during 2013/14 (see note 12.3).

12.3 Loans

	31 March 2014 £'000s	31 March 2013 £'000s
Amounts falling due:		
In one year or less	–	447
Between one and two years	–	447
Between two and five years	–	957
Over five years	–	2,918
TOTAL	–	4,770
of which:		
– wholly repayable within five years	–	1,852
– wholly repayable after five years, by instalments	–	2,918
	–	4,770

The trust repaid its loan from the Foundation Trust Financing Facility during 2013/14, prior to its full term:

- £4,769,880 as at 1 April 2013. The trust was paying the loan in three tranches. Tranche A of the loan was for £1,159,262, with an interest rate of 4.5%. Tranche B of this loan was for £362,269 with an interest rate of 4.45%. Tranche C of this loan was for £3,248,348, with an interest rate of 4.4%
- Capital of £447,160 was repaid in instalments during the year, and the remaining £4,322,720 loan was redeemed on 21 March 2014.

13 Provisions for liabilities

	Pensions relating to former directors £'000s	Pensions relating to other staff £'000s	Other £'000s	Total £'000s
At 1 April 2013	75	99	585	**759**
Arising during the year	–	–	2,089	**2,089**
Utilised during the year	(12)	(12)	(256)	**(280)**
Unwinding of discount	2	3	–	**4**
Reversed during the year	–	–	(329)	**(329)**
At 31 March 2014	**65**	**90**	**2,089**	**2,244**
At 1 April 2012	85	108	311	**504**
Arising during the year	–	–	585	**585**
Utilised during the year	(12)	(11)	(311)	**(334)**
Unwinding of discount	2	3	–	**5**
Reversed during the year	–	–	–	–
At 31 March 2013	**75**	**99**	**585**	**759**
Expected timing of cashflows:				
Within one year	12	12	2,089	**2,113**
Between one and five years	49	46	–	**95**
After five years	4	32	–	**36**
At 31 March 2014	**65**	**90**	**2,089**	**2,244**

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

'Other' opening balance 2013/14 refers to a general provision for administrative and clerical pay, settled during the year.

'Other' closing balance 2013/14 refers to provisions for staff-related payments, historic taxation, and board-approved charitable support.

£3,608,041 is included in the provisions of the NHS Litigation Authority (NHSLA) at 31 March 2014 in respect of clinical negligence liabilities of the trust (31 March 2013: £1,301,930). It should be noted that these amounts represent the gross value of claims made to the NHSLA prior to assessment of the validity of any individual case, and do not represent the expected settlement values. The trust's claim record is reflected in large part in the premiums charged to it by the NHSLA (note 4.1), showing a substantial reduction in 2013/14 (£159,000) compared to 2012/13 (£628,000).

14 Movements on reserves

Movements on reserves in the year comprised the following:

	Public dividend capital £'000s	Revaluation reserve £'000s	Income and expenditure reserve £'000s	Total £'000s
At 1 April 2013	31,279	3,743	45,907	**80,928**
Transfer from the income and expenditure account	–	–	9,283	**9,283**
Revaluation gains on property, plant and equipment	–	2,726	–	**2,726**
Public dividend capital issued	750	–	–	**750**
Other transfers between reserves	–	(197)	197	**–**
At 31 March 2014	**32,029**	**6,271**	**55,387**	**93,687**
At 1 April 2012	31,279	9,912	41,527	**82,717**
Transfer from the income and expenditure account	–	–	4,248	**4,248**
Revaluation gains on property, plant and equipment	–	(6,037)	–	**(6,037)**
Other transfers between reserves	–	(132)	132	**0**
At 31 March 2013	**31,279**	**3,743**	**45,907**	**80,928**

15 Analysis of changes in net debt

	At 31 March 2013 £'000s	Cash changes in year £'000s	At 31 March 2014 £'000s
Commercial cash at bank and in hand	4,016	(755)	**3,261**
Government Banking Service cash at bank	16,592	4,434	**21,026**
Debt due within one year	(447)	447	–
Debt due after one year	(4,323)	4,323	–
	15,838	8,449	**24,287**

16 Capital commitments

Commitments under capital expenditure contracts as at 31 March 2014 were £2,350,000 (2012/13: £1,444,000).

	2013/14 £'000s	2012/13 £'000s
Authorised	**1,990**	1,199
Authorised and committed	**2,350**	1,444
	4,341	2,643

17 Movement in public dividend capital

	2013/14 £'000s	2012/13 £'000s
Public dividend capital as at 1 April	**31,279**	31,279
Public dividend capital received	**750**	–
Public dividend capital as at 31 March	**32,029**	31,279

18 Movement in taxpayers' equity

	2013/14 £'000s	2012/13 £'000s
Surplus for the financial year	**11,225**	6,009
Public dividend capital dividends payable	**(1,942)**	(1,761)
Public capital received	**750**	–
Surplus/(deficit) on revaluations of fixed assets and current asset investments	**2,726**	(6,037)
Net increase/(decrease) in taxpayers' equity	**12,759**	(1,788)
Opening taxpayers' equity	**80,928**	82,717
Closing taxpayers' equity	**93,687**	80,928

19 Financial performance

19.1 Public dividend capital dividend

The trust is required to make a public dividend capital dividend at a rate of 3.5% of average relevant net assets.

In 2013/14 average relevant net assets totalled £55,492,000 (2012/13: £50,307,000) and a dividend of £1,942,000 was calculated (2012/13: £1,761,000).

19.2 Availability of working capital facility

The trust has an approved working capital facility of £6,000,000 (2012/13: £6,000,000).

20 Related party transactions

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

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

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

The trust has also had a significant number of material transactions with the Friends of Moorfields, Special Trustees of Moorfields Eye Hospital, and Moorfields Eye Charity. While these bodies are not related parties, the transactions with them are included here in acknowledgement of their valuable contribution to the work of the hospital.

This year, the Friends of Moorfields directly paid £199,100 (2012/13: £94,229) to Moorfields Eye Hospital in income/donations. The Friends also made commitments of over £200,000 to support the hospital. This is in addition to the work of their team of volunteers, estimated at £100,000 per annum.

There was a year-end creditor of £2,145 (2012/13: nil). There was no in-year expenditure. The Friends also pay directly for a number of items for Moorfields, including a three-year art-in-hospital grant, medical equipment, fish tanks, flower boxes, children's distraction toys, magazines, etc.

Income/donations for the year from Special Trustees of Moorfields Eye Hospital was £154,503 (2012/13: £498,760), while debtors were £360,912 (2012/13: £522,111). There was no in-year expenditure or year-end creditor.

Income/donations for the year from Moorfields Eye Charity was £445,317 (2012/13: £391,311), while debtors were £187,812 (2012/13: £28,950). There was no in-year expenditure or year-end creditor.

The table on page 172 shows significant related parties (individually >1% of revenue), their relationship to the trust, and the nature of the transactions entered into. There were no individually significant transactions to report.

Name of related party	Total revenue £'000s	Total expenditure £'000s	Nature of relationship to the trust
NHS England	13,527	0	Patients of NHS body treated by the trust
Department of Health: core trading & NHSSC	11,122	248	Patients of NHS body treated by the trust
Bedford Hospital NHS Trust	7,573	2,833	Patients of NHS body treated by the trust (income)/costs of operating satellite site at NHS body (expenditure)
NHS Ealing CCG	6,931	0	Patients of NHS body treated by the trust
NHS Harrow CCG	5,743	0	Patients of NHS body treated by the trust
NHS Wandsworth CCG	5,472	1	Patients of NHS body treated by the trust
NHS City and Hackney CCG	5,268	0	Patients of NHS body treated by the trust
NHS Tower Hamlets CCG	3,677	0	Patients of NHS body treated by the trust
NHS Islington CCG	3,626	0	Patients of NHS body treated by the trust
NHS Haringey CCG	3,608	0	Patients of NHS body treated by the trust
Health Education England	3,480	1	Education, training and personal development of NHS staff
NHS Newham CCG	3,477	0	Patients of NHS body treated by the trust
NHS East & North Hertfordshire CCG	3,468	0	Patients of NHS body treated by the trust
NHS Enfield CCG	3,416	0	Patients of NHS body treated by the trust
NHS Barnet CCG	3,306	0	Patients of NHS body treated by the trust
NHS Merton CCG	3,260	0	Patients of NHS body treated by the trust
NHS Redbridge CCG	3,212	0	Patients of NHS body treated by the trust
NHS Brent CCG	3,177	0	Patients of NHS body treated by the trust
NHS Herts Valleys CCG	3,145	0	Patients of NHS body treated by the trust
NHS Barking & Dagenham CCG	2,144	0	Patients of NHS body treated by the trust
NHS Croydon CCG	2,113	0	Patients of NHS body treated by the trust
NHS Camden CCG	2,069	0	Patients of NHS body treated by the trust
NHS Waltham Forest CCG	2,049	0	Patients of NHS body treated by the trust
NHS Havering CCG	1,967	0	Patients of NHS body treated by the trust
NHS Lambeth CCG	1,851	0	Patients of NHS body treated by the trust
NHS Richmond CCG	1,558	0	Patients of NHS body treated by the trust
Barts Health NHS Trust	1,527	386	Patients of NHS body treated by the trust
NHS Hounslow CCG	1,390	0	Patients of NHS body treated by the trust
NHS Slough CCG	1,379	0	Patients of NHS body treated by the trust
NHS Bromley CCG	1,374	0	Patients of NHS body treated by the trust
NHS Greenwich CCG	1,276	0	Patients of NHS body treated by the trust
NHS Hillingdon CCG	1,109	0	Patients of NHS body treated by the trust
NHS Lewisham CCG	1,045	0	Patients of NHS body treated by the trust
NHS Pension scheme	0	7,635	Employer pension contributions
National Insurance Fund	0	5,894	Employer NI contributions

21 Financial instruments

IFRS7 Financial Instruments Disclosures requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Because of the continuing service-provider relationship that the foundation trust has with clinical commissioning groups, and the way those bodies are financed, the foundation trust is not exposed to the degree of financial risk faced by other business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS7 mainly applies.

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

Liquidity risk

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

Market risk

The foundation trust has a branch in the United Arab Emirates (Dubai), with transactions conducted in United Arab Emirates dirhams. The branch accounts are consolidated into the overall trust accounts, converted using spot and average exchange rates as appropriate, with exchange gains or losses reported as expenses as and when they occur. Due to the size of the operation, and the fact that the majority of cost and income are denoted in local currency, the trust has limited exposure to currency exchange fluctuations.

The trust is not exposed to changes in interest rates as all borrowings have been settled during 2013/14, and were at fixed rates when active.

21.1 Financial assets by category

	31 March 2014 £'000s	31 March 2013 £'000s
Trade and other receivables	**13,654**	10,330
Cash and cash equivalents	**24,287**	20,609
TOTAL	**37,941**	30,939

21.2 Financial liabilities by category

	31 March 2014 £'000s	31 March 2013 £'000s
Borrowings excluding finance lease liabilities	**–**	4,770
Trade and other payables	**22,861**	20,488
Provisions under contract	**155**	174
TOTAL	**23,016**	25,432

21.3 Fair values of financial assets and liabilities at 31 March 2014

Set out below is a comparison, by category, of book values and fair values of the trust's financial assets and liabilities at 31 March 2014.

	Book value At 31 March 2014 £'000s	Fair value At 31 March 2014 £'000s	Basis of fair valuation
Financial liabilities			
Creditors over one year	(451)	(451)	
Provisions under contract	(131)	(131)	**Note a**
TOTAL	**(582)**	**(582)**	

a) Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 1.8% in real terms.

22 Intra-Government and other balances

	Debtors: amounts falling due within one year 2013/14 £'000s	Debtors: amounts falling due within one year 2012/13 £'000s	Creditors: amounts falling due within one year 2013/14 £'000s	Creditors: amounts falling due within one year 2012/13 £'000s
NHS foundation trusts	**288**	362	**113**	70
English NHS trusts	**2,436**	1,900	**1,740**	1,585
Department of Health	**–**	235	**150**	91
English strategic health authorities	**–**	–	**–**	1
English primary care trusts	**–**	7,149	**–**	127
English clinical commissioning groups	**10,065**	–	**–**	–
Other whole of Government accounts bodies	**–**	12	**235**	147
Total	**12,765**	9,658	**2,274**	2,021

English primary care trusts were abolished as at 31 March 2013, and their roles were taken up by English clinical commissioning groups.

23 Losses and special payments

There were 808 cases of losses and special payments (2012/13: 235 cases) totalling £209,000 (2012/13: £164,000) approved during 2013/14.

Of these 808 cases, 88 were in relation to fruitless payments (£5,203) and 716 were in relation to bad debts and claims abandoned excluding cases between the trust and other NHS bodies (£87,044).

These amounts are reported on an accruals basis but excluding provisions for future losses.

There were not payments for clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless journey where the net payment exceeded £100,000 (2012/13: nil cases).

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